REPORT ON THE RESULTS OF THE GLOBAL YOUTH TOBACCO SURVEY IN ZIMBABWE (GYTS ZIMBABWE)

HARARE & MANICALAND REGIONS, ZIMBABWE
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INTRODUCTION

WHO Resolution

Between 1970 and 1995, WHO adopted 14 resolutions on the need for both national and international tobacco control policies. Four of the 14 resolutions are relevant to the UNF-project—GYTS survey. Member states were encouraged to implement comprehensive tobacco control strategies that contain the following:

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

Public Health Impact

Despite widespread knowledge of the harm caused by smoking, only modest success has been achieved in global tobacco control initiatives. WHO estimates that there are currently 3.5 million deaths a year from tobacco, a figure expected to rise about 10million by 2030. By that date, 70% of those deaths will occur in developing countries.

Tobacco use is considered to be one chief preventable cause of death in the world. WHO is concerned about the decreasing age of smoking initiation. Data revealed that in many countries, the median age of smoking initiation was under the age of 15. This is of particular concern, since starting to smoke at younger ages increases the risk of death from a smoking-related cause. Among those who continue to smoke throughout their lives, about half can be expected to die from a smoking-related cause, with half of those deaths occurring in middle age. Therefore, adolescents and school-aged children should be a primary focus for intervention strategies. Carefully designed strategies should provide a clear picture of the risk factor behaviors of young and school-aged children which then can be used to set up more effective and comprehensive tobacco control policies.

Tobacco Use in Zimbabwe

Tobacco is the main foreign currency earner in Zimbabwe, accounting for 33% of Zimbabwe's agricultural earnings and 30% of foreign earnings. The three main types of tobacco grown in Zimbabwe are Virginia (flue-cured), Burley (cured) and Oriental. Tobacco accounts for about 12%

of workforce. Tobacco use is significantly prevalent, even among the youth. Total cigarette consumption rose from 1billion in 1995 to 1.05 billion in 1997. The prevalence of tobacco smoking ranges from 19% to 35% and males smoke more than twice as much as women and the smoking rates increase with age. According to a study amongst young people done in Harare, prevalence was 16% among children under 14 years, 21% among 15 – 16 year olds, 28% among 17 – 20 year olds and 33% among over 20 years olds.

Rules & regulations for tobacco control are mainly for protection and promotion of the growing of tobacco. However, the Children's Protection & Adoption Act [Chapter 5:06 of the Statute Law of Zimbabwe] prohibits the sale of liquor, tobacco and drugs to children (below age 18). There has been a health policy since October 1995 for the control of tobacco, which includes a health clause that reads "Smoking may be hazardous to your health". This warning clause and in addition tar & nicotine levels in cigarettes are displayed on every cigarettes packet. Smoking was banned in hospitals & health clinics in 1992, and theatres, cinemas, supermarkets and all pharmacy outlets do not allow smoking on their premises. All local Zimbabwean flights do not allow smoking during flying. Some of the local bus companies (e.g. ZUPCO) forbid smoking on their buses.

Additionally, Zimbabwe commemorates World-No-Tobacco Day and there are regular radio & television educational talks, to sensitise people on the effects of tobacco smoking. The Ministry of Health & Child Welfare has launched awareness campaigns to the public, school education groups, youths- in & out of school, pregnant women. There are however, some disparities in the dissemination of information on the dangers of tobacco as well as gaps in information and behaviour change.

BACKGROUND TO THE GLOBAL YOUTH TOBACCO SURVEY

UNF Project

The Tobacco Free Initiative (TFI/WHO) has recently been awarded by the United Nations Foundations for International Partnerships (UNFIP) what is probably the largest single tobacco prevention grant to initiate a joint project with UNICEF titled "Building alliances and taking action to create a generation of tobacco free children and youth". The aim of the project is to pool together the evidence, technical support, and strategic alliances necessary to positively address the negative impact of tobacco and to encourage and support children and adolescents in leading healthy and active lives free of tobacco. The project will be focused in a small group of developing countries, one per WHO region and will draw upon the combined technical expertise and operational resources of a number of UN agencies—in particular WHO, UNICEF and the World Bank. The agencies will work together with the global scientific community, government and non-government agencies, institutions and systems within countries, the media, and with young people to show that together they can make a difference in this important public health issue.

The project is conceived as a dynamic and interactive process, whereby the activities and products of each phase will be used to inform and guide subsequent activities. The project will consist of three distinct overlapping phases. The first phase will focus on harnessing the evidence for action: synthesizing the existing evidence from countries, some of which may participate in subsequent phases; undertaking new areas of research to support actions; and establishing the research-based evidence for developing future actions.

The second phase will be the activating phase. Country Activating Groups (CAGs) with broad membership, will be formed in each of the participating countries as the coordinating and implementing mechanisms at the country levels to select and develop the components of a comprehensive country-based approach to addressing tobacco use among children and young people. Opportunities to promote the exchange of experiences and issues between countries and global activities will be developed and strengthened.

The third phase will involve taking the project to scale: producing and disseminating resources; strengthening regional capacity to sustain activities; integrating the products and results of the project into ongoing tobacco control work at the national, regional and global levels; transferring technology and experience between countries and regions; and strengthening cooperation ad collaboration at all levels.

Seven countries have been selected to participate in the activating phase (Phase 2) of this project: China, Jordan, Sri Lanka, Fiji, Venezuela, Zimbabwe and Ukraine. As a first step in this Phase,

f1 = a school-level non-response adjustment factor calculated by school size category (small, medium, large)
f2 = a class-level non-response adjustment factor calculated for each school
f3 = a student-level non-response adjustment factor calculated by class
f4 = a post stratification adjustment factor calculated by form

RESULTS

A total of 2254 questionnaires were completed for both Harare and Manicaland. 24 schools were sampled in Harare and 1080 students were sampled from these schools but 896 completed the questionnaires, giving a response rate of 83%. 33 schools were sampled in Manicaland, 1514 students were sampled from these schools and 1358 questionnaires were satisfactorily completed, giving a response rate of 89.7%.

Background Characteristics of Respondents

Sex, age, form and type of residential area for students - Harare and Manicaland regions, Zimbabwe

Characteristic		**Manicaland n (%)**	**Harare n (%)**
Total		1358	896
Sex	Male	633 (48.7)	419 (47.6)
	Female	666 (51.3)	454 (52.4)
Form	One	412 (31.6)	332 (35.9)
	Two	402 (29.6)	215 (24.0)
	Three	493 (38.7)	333 (40.2)
Age	<12	103 (7.8)	33 (3.6)
	13	114 (8.6)	166 (17.6)
	14	236 (17.2)	238 (25.3)
	15	350 (25.7)	217 (25.0)
	16+	539(40.8)	237 (28.5)
Type of residential area	High Density	322 (24.2)	439 (51.6)
	Low Density	336 (24.8)	312 (33.9)
	Communal Area	488 (36.9)	68 (7.6)
	Commercial Farm	137 (10.4)	30 (3.3)
	Other	51 (3.8)	34 (3.7)

There was a fair representation of male and female students in both regions. There were significant differences ($t=6.084$, $p=0.000$) in the age distributions between the two regions, with Harare having a slightly younger population of Forms one to three, with a mean age of 14.56, and 14.94 for Manicaland. There were also significant differences in ages between males and females for both regions (Harare $t=4.84$, $p<0.05$ and Manicaland $t=5.86$, $p<0.05$). Male students were significantly older than their female counterparts in both regions.

Harare, 25.6% (95% C.I. [13.5, 37.7] of males usually smoke at a friend's place and 23.9% [7.5, 40.3] of females also usually smoke at a friend's place.

On average, nearly a third of the current smokers get their cigarettes from a store, although the proportions were slightly higher for Harare than Manicaland between sexes, ages and forms. Overall 44.7% of current smokers in Harare bought their own cigarettes from a store as compared to 34.1% for Manicaland. The differences are however not significant at the 95% Confidence Interval.

A huge proportion of current smokers bought cigarettes and were not refused because of their age. The majority of those that were not refused were in Harare as compared to Manicaland, for the different sexes, ages and forms. For Harare, 69.7% of students bought cigarettes and were not refused because of their age. 51.7% were not refused in Manicaland. For Harare, more females were not refused (77%) as compared to males (61%) and in Manicaland it was the opposite, more males were not refused (57.4%) as compared to females (47.5%). In Harare more students in the lower form (Form 1, 73.9%) were not refused compared to those in the higher form (Form 3, 63.8%). In Manicaland more students in the higher form (Form 3, 61.1%) were not refused compared to the lower form (Form 1, 37.0%).

Nearly 8 in every 10 students from Harare had seen anti-smoking media messages, as compared to 7 in every 10 from Manicaland. These differences were quite significant, with no noted differences between males & females, different forms and ages within the same region. Exposure to anti-smoking messages at sporting and other public events were slightly less, with 15 in every 20 students from Harare having seen the messages and 13 in every 20 from Manicaland.

The school environment also offers a good opportunity to deliver anti-smoking messages and a number of questions were asked on lessons and discussions in school on the effects of smoking. More students from Manicaland 52% (95% C.I [48.1, 55.9]) said they discussed the effects of smoking in a school class, as compared to Harare, 36.3% (95% C.I. [31.3, 41.3])

Exposure to cigarette advertisements was also quite high. On students who had seen cigarette billboard advertisements, three quarters had seen these from Harare, with 30% having seen these advertisements a lot and three fifths had seen these from Manicaland, with also 30% having seen these advertisements a lot. Nearly similar proportions had seen advertisements for cigarettes from newspapers and magazines, with higher proportions having seen the ads amongst the current smokers (e.g. 83.1% from Harare).

Students with access to a television (78% for Manicaland and 92% for Harare) were asked how much exposure they had had of cigarette brand names. Nearly eight in every ten students with access to a television had seen cigarette brand names on sporting & other events, with more students from Harare (84.2%) having seen the brand names, compared to Manicaland (74.1%).

smokers (42.6% for Manicaland and 56.8% for Harare). The current smokers could have been exposed to their own smoking or they associated or frequented places where they could also smoke.

Attitudes towards smoke from other people differed between current and never smokers. When asked if smoke from other people was harmful to them, 31.9% and 46.4% of never smokers from Manicaland and Harare respectively said it definitely was and 25.8% and 33.5% of current smokers said the same. These percentages were significantly different between regions amongst never smokers, with more students from Harare saying smoke from other people was harmful to them. This same group had more students exposed to smoke from other people as can be seen from the table (56.8% from Harare).

Suprisingly though, not many students were in favor of banning smoking in public places, with less than half saying they were in favor. The percentages were not different between current and never smokers from both regions (32.4% current and 33.3% never from Manicaland and 43.6% current and 43.9% never from Harare)

DISCUSSION

The Global Youth Tobacco Survey is a school-based survey, conducted among Form 1 - Form 3 school children. Even though the survey was undertaken among school going 13 - 15 year olds, it presents a clear picture of the magnitude of the problem of tobacco use among the youths. The survey in Zimbabwe was done in two regions, which differ in main land use, with Harare being predominantly urban and Manicaland rural. The two regions present slightly differing risky behaviors amongst youths from urban and rural settings, as well as access to information on tobacco.

Prevalence, Cessation and Addiction

Tobacco use is quite high amongst the youths, where nearly one in every five youths is currently using tobacco products, with the onset of cigarette smoking being as young as age 10. The question that was asked for the onset of cigarette smoking was 'How old were you when you first tried a cigarette', and of those that had smoked cigarettes in the past 30 days (current smokers), approximately 33% had initiated before the age of 10, with some even as young as age 7, approximately 13%. There could have been some breaks in the smoking but the message that is clear is, some of the youths who experimented with smoking at a very young age, later developed this practice and could not stop. This is also supported by the difficulties some of the current smokers expressed in quitting smoking, with over half having tried to quit in the previous year with no success. The students however, still believe quitting was within their control, with over three in every four saying they were able to stop smoking if they wanted to, more so students from Harare. Young people frequently experiment with new and sometimes risky behaviors. However they often don't take into serious consideration the long-term consequences of such behaviors. For youths, the risks of tobacco use are perceived to be remote and are outweighed by what they see as the immediate benefits. They tend to underestimate the addictiveness of nicotine and the difficulties associated with quitting, believing it is easier for young people to quit than adults.

One other salient feature that emerged from this survey is the high use of other tobacco products especially by youths from Manicaland (rural & commercial farming areas). Manicaland is one region where most tobacco is grown and this evidence shows the easy access to these products the youths have. Also, in other studies, it had been shown that male youths smoke four times as much as females, but this shows a different trend, with more and more females smoking just as much as males.

Harmful Effects of Smoking

Studies have shown the strong relationship between smoking prevalence and lung cancer patterns. Because smoking is the major cause of lung cancer and lung cancer commonly takes 20 or more

years to develop, smoking prevalence is an important predictor of future lung cancer patterns. Likewise, today's lung cancer patterns are a good indicator of the smoking prevalence of previous decades. Furthermore the younger a person is when they take up smoking, the greater their chances of contracting cancer later in life. Given the above-mentioned trends in smoking prevalence, it can safely be assumed that a majority of the youths that are current smokers will develop lung cancer before they reach the age of 35. Besides lung cancer, there are other diseases that studies have shown to be caused by smoking, which include heart diseases, strokes and a range of respiratory diseases.

Public Awareness and Knowledge about the Dangers of Tobacco

In Zimbabwe, a number of programs have been initiated to raise awareness on the dangers of tobacco smoking, and some of these have been directly targeted at youths. However, this information has been diffused with other contradicting messages, which portray 'positive' images of smoking and using tobacco products. These images are portrayed through advertisements in the media, on billboards, at public events and also through other means like movies, music etc. Youths are made to believe that smoking is 'cool', fun, glamorous, modern and Western, and watching their role models smoke further encourages them to smoke too. Efforts being made at sending anti-smoking messages to the youths are being diluted by these 'positive' images of smoking. Students in Harare are more exposed to both types of messages because generally more people have access to televisions, newspapers & magazines. Most billboards are erected and more sporting events, especially soccer matches, the most popular sporting events in Zimbabwe, are held in urban areas.

Interactive Communication Methods to Increase Knowledge

The use of media for providing information reaches a bigger audience but is non-interactive. The survey explored other interactive communication methods, discussions in a classroom environment. Students were asked if they were told or had discussed in class, the effects of smoking as well as why young people of their ages smoked. About half the students from Manicaland and only a third from Harare, had discussed the effects of smoking in a class, and even less had discussed the reasons why young people smoked, 28% from Harare and 38% from Manicaland. These are very small percentages, even for Manicaland, considering the magnitude of the problem (the high prevalence of smoking & the young ages these youths start smoking), the harmful effects and the opportunity the school environment presents for campaigning against smoking. The school curriculum in Zimbabwe does not necessarily include education on tobacco and drug abuse, but these topics are usually covered in the HIV/AIDS Education. Due to the high prevalence of HIV/AIDS in Zimbabwe, a number of school based intervention programs have been initiated to curb the spread of the disease. Due to the proven association between high-risk behaviors like tobacco & drug abuse and HIV transmission, most of the school-based programs are now touching on the dangers of tobacco but

mainly in relation to HIV transmission. As shown by the percentages above, clear messages on the health hazards of smoking are not being adequately given within the school environment. Also, parents as the main custodians or duty bearers of children and young people are not playing their role in educating their children on the dangers of smoking. Only half the students who smoke had discussed the harmful effects of smoking with a family member. Some parents are not good role models for their children since more than half of the current smokers reported that their parents smoked too. This has a great influence on children's behaviors, especially adolescents.

Regulations in Zimbabwe to Control Smoking in Young People

Chapter 5:06 of the Statute Law of Zimbabwe prohibits the sale of alcoholic beverages or tobacco products to persons below the age of 18. All students interviewed in this survey were below the age of 18 and of the current smokers, more than half of them obtained their cigarettes from a store and of these more than half were not refused because of their age, more so for Harare (nearly three-quarters). This shows that there is a gap in the above law and the practice. Most of the shopkeepers are well aware of the age restriction but due to the need for increased sales, they do not adhere to the requirements. Because of lack of enforcement of this law, the practice is further worsened because the shopkeepers know that nobody will prosecute them. Parents, guardians or adults on the other hand are not helping in this case. Some parents are known to send their under aged children to buy cigarettes on their behalf. With some of these adults it's a clear lack of knowledge regarding the regulations as well as the consequences of such actions. The other complication to this scenario is the influx of street vendors, especially in Harare. Most of these street vendors who sell their wares at every street corner of Harare are not licensed and they are more worried of being caught vending without a license than be concerned with their customers' ages.

Environmental Tobacco Smoke

Some effort is being made to ban smoking in public places but at an individual level. Some service providers have banned smoking or have a smoking and a no-smoking zone in their premises. These efforts to protect non-smokers are not being supported at the policy level, in order to effectively protect non-smokers from passive smoking. Most of the places frequented by the youths interviewed in the survey do not have anti-smoking rules within their premises, as shown by the large percentages of youths who said they were around others who smoked in the previous week, some being exposed to ETS on a daily basis. Besides the obvious discomfort of being around someone who smokes, the harmful effects of passive smoking are not that obvious to the youths. Very few are aware of the dangers of smoke from other people's cigarettes with yet fewer in favor of banning smoking in public places. This is unmistakably a lack of knowledge on the dangers of environmental tobacco smoke to one's health. During the past two or so decades, research has been undertaken worldwide to reveal the evidence on the health effects of passive smoking. These

reviews have concluded that passive smoking increases the chances of contracting or aggravating a range of illnesses including:

- cardiovascular disease
- lung cancer
- asthma (particularly in children)
- acute irritation of the respiratory tract
- bronchitis, pneumonia and other chest illnesses in children

RECOMMENDATIONS

In Zimbabwe, the adoption of recommendations especially at policy level, are hampered by the economic use of tobacco. Tobacco is the main foreign currency earner in Zimbabwe and its use locally is increasing. One huge problem that cannot be overshadowed by the economic use of tobacco is its increased use by young people and the long-term effects to their health.

From this survey, the increased use of cigarettes and other tobacco products by young people has been shown and many recommendations especially specific intervention programmes can be drawn. From the discussion above, three broad recommendations are given:

1. Awareness campaigns on the dangers of cigarette smoking & tobacco products need to be intensified. Most school based anti-smoking campaigns are done on the World-No-Tobacco Day but there is need for regular education on the dangers of tobacco. Also, anti-smoking campaigns should not just target people with access to television and radio, but should also be targeted for those without access. In the rural areas, use of other tobacco products is rampant as shown and information on the dangers of these should be provided, through means accessible to the rural people, who are the majority, constituting over 60% of the population in the country. However, due to insufficient government funding for information dissemination various information, education and research initiatives can also be developed and implemented by NGOs operating within communities.
2. Educational programmes and health promotion campaigns can serve a useful role in tobacco control, particularly in areas where the harms of tobacco use are not widely known. However, unless they are backed up by strong public policies, which help young people refrain from using tobacco, educational programmes have only modest results. Such education programmes and health promotion campaigns should be placed in the overall context of strong and coherent tobacco control policies.
3. Due to the fact that children are likely to start smoking if they grow up in an environment where tobacco advertising is prolific, where smoking rates are high among adults (including those that serve as role models for young people), where tobacco products are cheap and easily accessible, and where smoking is unrestricted in public places, the tobacco control policies need to take this into consideration. Besides drafting such policies, their enforcement and public awareness need to be considered. The starting point could be the law already in place on the sale of tobacco products to children aged below 18, which does not seem to be adequately enforced or known to the public.