

THE GLOBAL YOUTH TOBACCO SURVEY

ZIMBABWE 2003

REPORT

Compiled by Dr. EGV Sithole
egvsithole@hotmail.com

Introduction

Tobacco is the second major cause of death in the world. It is currently responsible for about five million deaths each year. It is estimated that 4.9 million smoking related deaths occurred in 2002 and if current smoking patterns continue, it will cause some 10 million deaths each year by 2025. It is estimated that there are 1.2 billion smokers worldwide with 800 million in developing countries.¹

Previous studies in Zimbabwe

Previous studies done in Zimbabwe amongst secondary school students in a rural population, showed that alcohol was the commonest “ever taken” substance (34.9%) followed by tobacco (18.5%).⁴ Another study by Munodawafa in secondary school pupils showed that nearly 17% of the sample had used alcohol, 8% had used tobacco, and 5% had used marijuana during the past seven days prior to the questionnaire.⁵ In contrast to the survey done on health workers whereas only 4.8% were current users and 8.9% had ever smoked. However this was also due to the predominant number of nurses who were mostly females. For the doctors who are predominantly male there was 10.2% current smoking rate and 18.8% reported having ever smoked.⁶

Tobacco and economy in Zimbabwe

Zimbabwe is the fourth largest producer of tobacco in the world and the country’s economy is heavily dependent on tobacco. Tobacco accounts for 30% of Zimbabwe’s foreign currency earnings and contributes 10% of the Gross Domestic product (GDP). Zimbabwe is one of the largest tobacco exporters in the world. This has resulted in tobacco control policies getting very low priority. This has been worsened by the fact that most of the tobacco is exported earning the country much needed foreign currency.

In August 2004, on the sidelines of the Southern Africa Development Community (SADC) Head of States Summit, five SADC tobacco producing countries met to discuss ways of helping small holder farmers get better pricing and benefit from growing the crop. The meeting was called by the President of Malawi and attended by the head of states from Zimbabwe, Zambia, Tanzania and Mozambique. Amongst the issues discussed was how to assist farmers in getting inputs and better pricing and also noting the need for value addition as most of the tobacco is exported raw.² This clearly illustrated the dilemma faced by developing countries in implementing tobacco control.

Framework Convention on Tobacco Control (FCTC)

At the 56th World Health Assembly, World Health Organization's (WHO) 192 member states unanimously adopted the world’s first public health treaty, the WHO Framework Convention on Tobacco Control.³ Negotiated under the auspices of WHO, this treaty is the first legal instrument designed to reduce tobacco related deaths and disease around the world. The major objective of FCTC is “to protect present and future generations from the

devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the parties at the national, regional and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke” (article 3).

Legislation in Zimbabwe

The major piece of legislation on tobacco control is Statutory Instrument 264 of 2002, Public Health (Control of Tobacco) Regulations, 2002 and the Child Protection Adoption Act (Chapter 5:06) of the Statute Law of Zimbabwe, which prohibits sale of liquor, tobacco and drugs to children.

Legislation in Zimbabwe compared to the FCTC

Article 5 of the FCTC states that each party shall establish or reinforce and finance a national coordinating mechanism of focal point for tobacco control and Section 12 of our Control of Tobacco Regulation establishes a Committee known as the Tobacco Control Committee.

Whilst Article 8 OF the FCTC seeks to ensure protection from exposure to tobacco smoke Section 3 of the Control of tobacco regulations also seeks to control smoking in public premises. For the Regulation of Tobacco Product disclosures the FCTC Article 10 requires manufactures and importers of tobacco to disclose information about contents and emissions of tobacco products whereas Section (7) of the Zimbabwe regulations states that every tobacco product should bear accurate information.

Packaging and labeling of Tobacco Products is covered under Article 11, which states that packaging, and labeling should not promote a tobacco product by any areas that are false. These may include forms such as “low form”, light, mild but the Zimbabwe regulations are silent on this. Article 11 also labeling of tobacco packaging, which is also very clear in our regulations.

Article 13 of the FCTC recommends comprehensive issues on advertising, promoting and sponsorship but our regulation only limits advertising and promoting of productions to adults above 18 years. No promotions are allowed in health facilities or educational establishments. Whilst Article 16 prohibits sale of tobacco products to minors and endeavour to prohibit the sale of cigarettes individually or in small products, which increase affordability, Section 6 of the local regulations only prohibits the trading of tobacco to or by minors.

Part VII of the FCTC covers research, surveillance and exchange of information and encourages parties to develop and promote national research and Zimbabwe is already participating in Global Youth Tobacco Survey.

Even, with so many similarities in the regulations, Zimbabwe failed to sign the FCTC before the deadline expired because of financial and economic reasons as described under

Article 26 on Financial Resources, which recognizes the important role that financial resources play in achieving the objective of this convention. Whilst Parties were to provide financial support in respect of its national activities and the Conference of Parties will look into mechanisms to establishing a voluntary global fund or appropriate financial mechanism to developing countries, Parties with economies in transition were to assist them in meeting the objectives of the convention. Zimbabwe was skeptical of this imaginary fund.

The Global Youth Tobacco Survey (GYTS)

The World Health Organization together with Centers for Disease Control Atlanta developed the Global Youth Tobacco survey to track tobacco use among youths across countries using a core methodology and core questionnaire. The GYTS is expected to enhance the capacity of countries to design, implement and evaluate tobacco control and prevention programmes. The GYTS is a school based tobacco specific survey, which focuses on adolescents aged 13 to 15 years.

The GYTS is composed of self-administered questionnaire designed to gather data on the following areas:

- a) Prevalence of cigarette smoking and other tobacco use among young people
- b) Knowledge and attitude of young people towards tobacco smoking
- c) Role of media and advertising on young people's use of cigarettes
- d) Access to cigarettes
- e) Tobacco related school curriculum
- f) Environmental tobacco smoke
- g) Cessation of cigarette smoking

METHODS

The 2003 Zimbabwe GYTS was a school based cross sectional survey designed to cover three of the nine administrative provinces as per the Ministry of Education structures. The three provinces were purposively selected to represent an urban area, Harare province and a predominantly rural and agricultural population Manicaland province. These provinces were also selected as they had taken part in the previous GYTS survey in 1999 to allow for comparisons. The third province Bulawayo Matebeleland included both the rural and urban population and represented a predominantly Ndebele population which is the second biggest population in the country.

Sampling

A two-stage cluster sample design was used to produce a representative population for each of the three regions. All secondary schools with forms 1 to 3 classes were included in the sampling frame. Forms one to three classes were selected because they contained the target groups of the 13 to 15 year age groups. Enrolment of schools was obtained from the MOE but the current ones were not available and instead we used the enrolments of the previous years.

In the first stage of sampling schools were selected with the probability proportional to school enrolment ensuring that that larger schools has a greater chance of being selected. The second stage of sampling consisted of systematic equal probability sampling with a random start of classes from each school that participated in the survey. All classes in the selected school were included in the sampling frame.

A weighting factor was applied to each student record to adjust for non-response and for varying probability of selection.

Questionnaire

The questionnaire consisted of 72 questions of which were made up of core questions and country specific questions. The core questions allowed for comparison amongst countries and the country specific questions were unique to Zimbabwe. The questionnaire consisted of multiple-choice type of questions where each student was expected to answer all questions by choosing one answer that best described what they believed and felt to be correct. Answers were to be put on a separate scannable answer sheet where the correct answer was shown by shading the corresponding bubble.

Data Collection

The national survey coordinator and provincial coordinators coordinated data collection. In each province, 8 survey administrators were selected and trained. These consisted of health promotion officers and the Masters in Public Health students.

Letters were sent to all heads of schools inviting them to participate in the GYTS. Each letter had a self-addressed return envelope the consent form and a section where the school enrolment was to be indicated. Follow up was made to those who had not responded. In ten schools, sampling was only done on the day of administration of the questionnaires these schools were too far to be visited and did not have any means of communication.

The answer sheet consisted of scannable sheets and after checking for errors these were shipped to Atlanta for scanning.

Ethical Consideration

Permission to carry out the survey was obtained from the Ministry of Health and Child Welfare who then applied to the Ministry of Education for permission to carry out the survey. Consent was also obtained from the Provincial Medical Directors and the Regional Director of Education. These consent forms were then used to obtain permission from the schools. No difficulties were faced once the school heads saw the confirmation letters from the regional office. Although parent notification and consent forms had been printed, we were later informed that they were not necessary as long as no invasive procedure was to be done on the students.

Confidentiality for the students was guaranteed by ensuring that they did not write their names on the forms and that members of staff were asked to excuse themselves at the time of questionnaire administration.

RESULTS

Participation:

TABLE 1a) participation rates by region

Region	Selected school	School participation rate	Student response rate	Number of students who participated
Harare	25	100	85.4	1 979
Manicaland	25	100	90.4	1 985
Matebeleland North	26	100	81.1	1 748

Table 1 b) Participation by age and sex

Number of all the students participating									
Age (years)	Harare			Manicaland			Matebeleland		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
11	11	15	26	80	37	117	27	17	44
12	13	25	38	57	60	117	23	25	48
13	119	193	312	78	99	177	75	87	162
14	212	334	546	126	253	379	153	251	404
15	240	324	564	169	270	439	149	277	426
16	165	160	325	197	205	402	173	221	394
17	54	41	95	145	61	206	117	71	188
Missing	73		73	148			82		82
Total	814	1 092	1 979	852	985	1 985	717	949	1 748

Participation by class and by region				
Class	Harare	Manicaland	Matebeleland	Total
Form 1	706	686	524	1 916
Form 2	740	802	561	2 103
Form3	515	438	636	1 589
Missing	18	59	26	103
Total	1 979	1 985	1 748	5 711

A total of 5 711 students participated in the survey. The participation rate ranged from 81.1% to 90.4% (Table 1a) and the majority of the students were in the 13 to 16 years age group (table 1b) with more females participating in all the three regions.

Prevalence

Table 2: Percent of students who use tobacco

(Figures in parentheses are 95% confident intervals)

Category	Ever Smoked Cigarettes,	Current Use			Never Smoked Susceptible to Initiating Smoking
		Any Tobacco Product	Cigarettes	Other Tobacco Products	
Bulawayo-Matebeleland					
Total	26.3 (±5.4)	16.9 (±2.2)	10.7 (±1.5)	9.9 (±2.1)	22.6 (±3.9)
Sex					
Male	35.8 (±6.5)	22.1 (±3.0)	15.7 (±2.9)	11.2 (±2.1)	24.3 (±4.4)
Female	16.6 (±6.1)	11.6 (±3.1)	5.4 (±2.4)	8.8 (±2.7)	21.0 (±6.0)
Manicaland					
Total	21.3 (±4.4)	19.8 (±3.9)	10.5 (±2.9)	14.8 (±3.0)	26.4 (±6.2)
Sex					
Male	25.6 (±5.6)	23.0 (±3.1)	13.4 (±3.5)	16.9 (±3.1)	27.4 (±7.3)
Female	15.6 (±4.2)	14.8 (±4.4)	6.5 (±2.4)	11.5 (±3.3)	25.5 (±7.1)
Harare					
Total	16.9 (±3.2)	11.8 (±1.7)	6.0 (±1.5)	7.8 (±1.5)	18.7 (±2.5)
Sex					
Male	24.4 (±3.5)	14.9 (±2.7)	8.5 (±2.2)	9.5 (±2.4)	21.1 (±4.5)
Female	9.9 (±4.0)	8.2 (±1.8)	3.6 (±1.6)	5.7 (±1.4)	17.1 (±2.6)

The number of students who had ever smoked ranged from 16.9% to 26.3% (table 2). Matebeleland province had the highest percentage of ever smokers (described as taking even one or two puffs) with almost 1 in 4 pupils reporting ever having smoked cigarettes. In Matebeleland province over 1 in 3 boys reported as ever had smoked which was the highest percentage in all regions by sex.

In all the three regions, boys were significantly more likely to have ever smoked than girls with the ratio almost two to one.

In Harare, the percentage of current smokers (described as smoked at least once in the last 30 days) was 6% whilst for the other regions almost 1 in 10 pupils were current smokers. In all regions, as in the category of ever smokers, boys were significantly more likely to have smoked than girls with the ratio almost 2 to 1.

For those students who had not yet started smoking the susceptibility to initiating smoking (measured as likely to start smoking in the next year) was highest in Manicaland (26.4%) and lowest in Harare (18.7%). There was no significant difference in susceptibility between the sexes.

Table 3: School Curriculum

(Figures in parentheses are 95% confident intervals)

Category	Percent taught dangers of smoking	Percent discussed reasons why people their age smoke
Bulawayo Matebeleland		
Total	44.7 (±5.6)	42.2 (±4.0)
Sex		
Male	44.3 (±8.1)	40.6 (±5.7)
Female	45.3 (±6.3)	43.4 (±4.9)
Manicaland		
Total	55.3 (±7.5)	45.0 (±4.2)
Sex		
Male	57.1 (±6.3)	43.7 (±4.5)
Female	54.8 (±9.5)	46.9 (±5.4)
Harare		
Total	53.8 (±4.1)	43.4 (±3.4)
Sex		
Male	54.6 (±3.3)	42.8 (±3.5)
Female	54.3 (±5.1)	44.8 (±4.6)

Only about half of the students had been taught dangers of smoking during the past 12 months (table 3). The number was not significantly different among regions and sexes.

The percentage of those reporting having discussed further on why the people their ages smoke was less than 50% in all regions.

Table 4: Cessation

(Figures in parentheses are 95% confident intervals)

Category	Current Smokers	
	Percent desire to stop	Percent tried to stop this year
Bulawayo-Matebeleland		
Total	78.3 (± 9.6)	75.9 (± 9.5)
Sex		
Male	88.7 (± 8.9)	76.3 (± 9.4)
Female	#	#
Manicaland		
Total	67.5 (± 12.5)	61.5 (± 8.2)
Sex		
Male	69.6 (± 12.7)	65.5 (± 10.5)
Female	#	#
Harare		
Total	70.6 (± 11.6)	65.5 (± 15.7)
Sex		
Male	#	#
Female	#	#

= Number less than 35

Between two-thirds and three quarters of students who currently smoke cigarettes indicated their desire to stop smoking (table 4), with Matebeleland reporting the highest figure (78.3%) and Manicaland the lowest (61.5%). An almost equal percentage of students had tried to stop smoking the same year.

Table 5: Environmental Tobacco Smoke

(Figures in parentheses are 95% confident intervals)

Category	Exposed to smoke from others in their home		Exposed to smoke from others in public places		Percent think smoking should be banned from public places		Definitely think smoke from others is harmful to them	
	Never Smokers	Current Smokers	Never Smokers	Current Smokers	Never Smokers	Current Smokers	Never Smokers	Current Smokers
Bulawayo-Matshabeleland								
Total	21.8 (±3.3)	60.1 (±13.3)	51.0 (±3.2)	78.5 (±6.4)	47.1 (±10.2)	51.3 (±11.0)	47.8 (±6.3)	37.7 (±11.6)
Sex								
Male	25.4 (±4.4)	54.3 (±16.1)	51.5 (±3.9)	74.3 (±6.6)	47.5 (±8.7)	55.2 (±12.8)	48.3 (±7.9)	40.8 (±12.9)
Female	19.3 (±3.5)	73.0 (±13.7)	51.2 (±4.1)	84.6 (±12.0)	46.8 (±12.7)	42.9 (±14.2)	48.3 (±6.9)	32.4 (±17.3)
Manicaland								
Total	20.3 (±2.4)	72.6 (±7.3)	43.7 (±6.9)	83.5 (±6.0)	37.0 (±11.3)	44.2 (±7.2)	43.0 (±7.5)	31.5 (±5.8)
Sex								
Male	20.3 (±3.8)	70.9 (±10.9)	45.0 (±8.0)	79.9 (±9.3)	37.6 (±13.3)	38.8 (±7.9)	40.4 (±8.0)	37.8 (±8.9)
Female	20.2 (±2.9)	67.5 (±8.3)	43.0 (±7.7)	87.7 (±10.4)	36.9 (±10.3)	51.2 (±18.7)	46.1 (±8.6)	26.2 (±9.5)
Harare								
Total	24.2 (±2.8)	56.4 (±13.0)	52.8 (±2.1)	81.9 (±7.7)	43.8 (±5.8)	51.6 (±9.0)	55.2 (±3.4)	41.4 (±8.5)
Sex								
Male	23.4 (±3.3)	60.7 (±15.2)	52.0 (±4.2)	82.1 (±9.5)	47.8 (±6.5)	56.3 (±11.6)	55.8 (±4.6)	48.3 (±11.0)
Female	24.6 (±4.2)	48.7 (±17.5)	53.9 (±3.3)	79.4 (±15.2)	40.4 (±7.1)	43.9 (±15.9)	54.9 (±4.0)	28.5 (±14.0)

Between 1 in 4 (Harare) and 1 in 5 (Manicaland) of never smokers had been exposed to smoke from others in their homes as compared to between 6 in 10 (Harare) and 7 in 10 (Manicaland) of the current smokers. Current smokers were significantly more likely to have been exposed to smoking in both their homes than the never-smokers. Exposure in the home did not vary according to sex.

Among the never smokers, almost 1 in 2 reported smoke exposure from others in the public places compared to 4 in 5 amongst current smokers. The current smokers were significantly more likely to have been exposed to smoke in public places than never smokers. There was no variation according to sex.

Only about 2 in 5 of the never smokers believe that smoking should be banned from public places whilst almost 1 in 2 of the current smokers believe that smoking should be banned from public places.

However only about half the never smokers felt that smoking from others was harmful to them and 2 in 5 if the current smokers believed that smoking from others was harmful to them.

Table 6: Knowledge and Attitudes

(Figures in parentheses are 95% confident intervals)

Category	Think boys who smoke have more friends		Think girls who smoke have more friends		Think smoking makes boys look more attractive		Think smoking makes girls look more attractive	
	Never Smokers	Current Smokers	Never Smokers	Current Smokers	Never Smokers	Current Smokers	Never Smokers	Current Smokers
Bulawayo-Matebeleland								
Total	50.1 (±4.7)	41.5 (±7.1)	22.7 (±4.4)	20.0 (±7.2)	19.5 (±3.1)	24.9 (±9.4)	14.3 (±2.5)	17.2 (±9.4)
Sex								
Male	45.3 (±7.5)	41.8 (±9.0)	20.0 (±4.7)	19.6 (±8.5)	18.4 (±2.7)	20.3 (±10.1)	13.4 (±2.7)	17.8 (±11.2)
Female	53.5 (±6.2)	39.3 (±16.4)	24.4 (±5.7)	25.6 (±16.5)	20.0 (±5.2)	38.9 (±17.4)	14.7 (±3.8)	20.7 (±20.4)
Manicaland								
Total	39.5 (±5.2)	37.2 (±7.6)	16.2 (±2.9)	18.5 (±5.4)	16.9 (±4.6)	27.0 (±3.8)	11.3 (±3.0)	17.6 (±5.8)
Sex								
Male	37.0 (±8.2)	39.8 (±6.8)	16.9 (±4.5)	20.6 (±8.4)	18.8 (±5.2)	26.3 (±7.0)	14.7 (±4.2)	21.0 (±11.4)
Female	41.1 (±3.8)	29.8 (±13.8)	15.2 (±2.8)	17.4 (±8.0)	14.4 (±4.6)	23.4 (±10.5)	8.8 (±3.3)	8.7 (±8.2)
Harare								
Total	39.8 (±2.8)	41.1 (±12.7)	20.0 (±1.9)	22.5 (±9.3)	10.2 (±2.7)	25.7 (±9.8)	7.7 (±2.4)	12.7 (±6.9)
Sex								
Male	37.5 (±4.8)	41.3 (±13.2)	20.6 (±3.8)	18.0 (±8.9)	11.1 (±2.9)	23.2 (±12.8)	8.6 (±3.2)	13.1 (±9.1)
Female	41.9 (±3.5)	41.1 (±15.9)	19.5 (±2.2)	29.4 (±18.0)	9.4 (±3.2)	30.8 (±15.2)	7.0 (±2.6)	5.7 (±7.9)

In Manicaland and Harare about 2 in 5 of both the never smokers and current smokers believed that boys who smoke had more friends. In Matebeleland, 1 in 2 of the never smokers thought the same. However only about 1 in 5 students in all regions believed that girls who smoke have more friends. In both responses there was no significant difference between the smokers and never smokers and also between sexes.

In all three regions, a higher percentage of students believed that smoking makes boys look more attractive than girls.

Table 7: Media and Advertising
(Figures in parentheses are 95% confident intervals)

Category	Percent Saw Anti-Smoking Media Messages	Percent Saw Pro-Tobacco Messages in Newspapers and Magazines		Percent Who Had Object With a Cigarette Brand Logo On It		Percent Offered aFree@ Cigarettes by a Tobacco Company Representative	
		Never Smokers	Current Smokers	Never Smokers	Current Smokers	Never Smokers	Current Smokers
Bulawayo-Matebeleland							
Total	76.2 (±3.2)	68.6 (±4.0)	66.9 (±9.2)	9.0 (±1.8)	24.1 (±7.3)	12.0 (±1.8)	23.6 (±8.2)
Sex							
Male	77.1 (±4.5)	67.3 (±7.2)	69.4 (±10.7)	8.1 (±2.1)	22.3 (±9.5)	11.5 (±4.8)	20.2 (±9.6)
Female	76.2 (±2.9)	69.3 (±3.3)	62.1 (±16.5)	9.0 (±2.9)	28.1 (±11.1)	11.8 (±1.6)	27.0 (±16.4)
Manicaland							
Total	70.5 (±5.6)	60.2 (±5.6)	71.3 (±9.1)	15.7 (±2.7)	28.4 (±11.1)	13.4 (±3.2)	34.6 (±7.9)
Sex							
Male	71.4 (±5.6)	61.2 (±6.0)	78.6 (±8.9)	17.7 (±4.2)	28.0 (±11.1)	15.1 (±5.2)	36.9 (±8.3)
Female	69.1 (±6.7)	59.2 (±6.1)	58.2 (±16.8)	14.0 (±2.8)	27.8 (±15.5)	11.2 (±2.0)	24.9 (±13.0)
Harare							
Total	85.5 (±2.1)	69.7 (±2.9)	78.8 (±11.4)	8.4 (±1.5)	20.1 (±9.5)	7.9 (±1.8)	20.0 (±9.7)
Sex							
Male	85.3 (±2.7)	71.1 (±5.3)	77.7 (±13.5)	8.7 (±2.4)	19.0 (±10.8)	8.4 (±2.1)	18.4 (±9.8)
Female	86.0 (±2.7)	68.2 (±2.2)	79.5 (±13.8)	7.8 (±1.5)	23.6 (±17.0)*	7.1 (±2.2)	24.4 (±18.7)*

Table 7 shows student exposure to various forms of messages. Exposure to anti smoking media messages was high in all regions. Harare reported the highest percentage at 85.5%. There was no difference between the sexes.

However, an equally high number ranging from 6 in 10 to 7 in 10 amongst never smokers and 7 in 10 to 8 in 10 amongst current smokers had been exposed to pro-tobacco messages in the newspapers and magazines. There were no significant differences in exposure between the never smokers and current smokers.

In Harare and Matebeleland, almost 1 in 10 amongst never smokers had an object with a cigarette logo on it compared to the current smokers where almost 1 in 5 of the students had an object with a cigarette logo on it. The ratio of 1 to 2 was statistically different. There was no difference between the sexes. The current smokers were significantly more likely to have been offered a free cigarette by a tobacco company representative.

Table 8: Access and Availability

(Figures in parentheses are 95% confident intervals)

Category	Percent Current Smokers who Usually Smoke at Home	Percent Current Smokers who Purchased Cigarettes in a Store	Percent Current Smokers Who Bought Cigarettes in a Store Who Were Not Refused Because of Their Age
Bulawayo-Matebeleland			
Total	22.5 (±7.5)	37.4 (±11.6)	44.5 (±16.7)
Sex			
Male	22.5 (±8.8)	40.1 (±9.0)	#
Female	#	25.8 (±20.0)	#
Manicaland			
Total	23.2 (±8.8)	38.5 (±13.1)	69.8 (±12.5)
Sex			
Male	26.8 (±7.3)	44.3 (±14.6)	#
Female	20.3 (±19.5)	32.2 (±12.8)	#
Harare			
Total	22.9 (±11.5)	39.7 (±8.0)	#
Sex			
Male	20.7 (±11.3)	40.7 (±12.4)	#
Female	27.2 (±17.1)	39.7 (±11.7)	#

Less than 35 cases

About 1 in 5 students among the current smokers reported smoking at home and this figure was almost similar in all three regions. Almost 2 in 5 of the current smokers reported purchasing their cigarettes from stores. In Manicaland 7 out of 10 of those who bought cigarettes from shops indicated that they were not denied because of their age and for Manicaland the figure was almost 1 in 2.

DISCUSSION

Prevalence

The prevalence of students who had "ever smoked" varied among the regions with Harare reporting the lowest prevalence of 16.9% and the highest prevalence of 26.3% was reported in Matebeleland. In two of the regions (Manicaland and Harare) there is a higher use of other tobacco products other than cigarettes. This might be due to the issue of affordability.

More worrying, is the high proportion of between 1 in 5 and 1 in 4 of never smokers who reported being susceptible to initiating smoking in the following year. The number does not differ sexes. This vulnerable group needs to be targeted as cessation has been shown to be difficult.

These figures reported above are lower when compared to results from Seychelles in 2003 where 49.1% of the students had ever tried smoking ⁷. In South Africa in 1999 the reported rate of ever smoked amongst students was 44.2%. Like in most other studies, males still make up the higher proportion of smokers.

School Curriculum

Overall, only about half of the students reported having being taught the dangers of smoking at school (table 3). This indicates the need for review on the school curriculum not to only increase the number of sessions where the effects of tobacco are taught but also review the content of curriculum. More importantly a lower percentage of students indicates having discussed further the reason why people their age smoke.

In a project in rural Zimbabwe among rural school age populations, student nurses on community deployment were used to provide structured health instructions to students. A quasi-experimental design with an intervention group and control group was used. The curriculum focused on prevention of sexually transmitted diseases, HIV and AIDS and drugs (alcohol, tobacco and marijuana). Students in the intervention group increased their post-test scores significantly⁹. This illustrates the importance of a properly structured curriculum.

Cessation

Over two thirds of the students in Manicaland who are current smokers and almost 4 in 5 of current smokers in Matebeleland indicated the desire to stop smoking. The greater majority of these students had tried to stop smoking in the current year. This indicates the high desire amongst the students to quit smoking.

This finding indicates the need to expand the drug education efforts in schools to ensure that the susceptible group does not initiate smoking at all as they would having problems in quitting. There is also need for further research to develop effective strategies to assist teenagers in quitting the smoking habit.

Environmental Tobacco Smoke

Current smokers were significantly more likely to have been exposed to smoking in both their homes and public places than non-smokers. It is recognized that environmental tobacco smoke increases the risk of cancers and cardiovascular diseases. This marked difference calls for necessary legislation to reduce exposure of the youths to tobacco. Zimbabwe already has Statutory Instrument 264 of 2002. Public Health (Control of Tobacco) Regulation, which ensure protection from exposure to tobacco smoke under section 3. However, this finding indicates need to enforce this law.

However, despite this negative exposure less than half of the never smokers believed that smoking should be banned from public places and an equally smaller number believes that smoke from others is harmful to them. This calls for the review of the school curriculum, which does not seem to address this fundamental demonstrated harmful effect.

Knowledge and Attitudes

Whilst knowledge of the harmful effects of tobacco were low, 4 out of 10 students amongst both groups thought that boys who smoke have more friends and half the number thought that girls who smoke have more friends. The percentage that thought that boys and girls who smoke look more attractive was lower indicating poor perception on this important perception.

Media and Advertising

Whilst exposure to antismoking media messages was high (greater 70%) (Table 7) there was an equally high coverage of pro-tobacco messages in newspapers and magazines with more than 3 in 5 of the students reporting having these messages. This reflects the lack of legislation in the country to limit exposure to pro-tobacco adverts.

Interestingly by in all regions the current smokers were more likely to have a product with a cigarette logo on it than the never smokers and they also reported being offered a free cigarette by a tobacco company representative. This issue needs to be followed up further in studies and focus group discussion as no other reports in Zimbabwe have indicated this phenomenon.

CHANGES IN TOBACCO USE AMONG 13-15 YEAR OLDS
BETWEEN 1999 AND 2003

Findings from the Two Repeat GYTS Sites

Table 9: Factors Influencing Tobacco Use, GYTS; 1999 to 2003
(Figures in parentheses are 95% confident intervals)

Characteristic	Harare		Manicaland	
	1999	2003	1999	2003
Prevalence				
Ever smoked cigarette	25.8 (+5.1)	16.9 (+3.2)	23.0 (+4.3)	21.3 (+4.4)
Male	30.1 (+6.9)	24.4 (+3.5)	29.0 (+5.6)	25.6 (+5.6)
Female	21.5 (+4.0)	9.9 (+4.0)	16.3 (+4.9)	15.6 (+4.2)
Current smoker	11.2 (+3.5)	6.0 (+1.5)	11.4 (+3.4)	10.5 (+2.9)
Male	11.4 (+2.9)	8.5 (+2.2)	12.6 (+3.6)	13.4 (+6.5)
Female	10.1 (+4.0)	3.6 (+1.6)	9.7 (+4.0)	6.5 (+2.4)
Current other	11.1 (+2.5)	7.8 (+1.5)	22.0 (+5.0)	14.8 (+3.0)
Susceptible	29.8 (+6.8)	18.7 (+2.5)	36.6 (+5.9)	26.4 (+6.2)
Male	31.2 (+8.4)	21.1 (+4.5)	34.7 (+6.2)	27.4 (+7.3)
Female	28.5 (+7.6)	17.1 (+2.6)	37.6 (+7.2)	25.5 (+7.1)
School				
Taught dangers	37.2 (+5.1)	53.8 (+4.1)	52.5 (+5.5)	55.3 (+7.5)
Male	36.1 (+6.2)	54.6 (+3.3)	54.8 (+6.4)	57.1 (+6.3)
Female	38.5 (+5.7)	54.3 (+5.1)	50.7 (+4.9)	54.8 (+9.5)
ETS				
Exposed at home	37.7 (+4.1)	27.7 (+3.0)	35.0 (+5.1)	33.9 (+5.2)
Male	38.3 (+6.0)	28.0 (+4.1)	34.1 (+5.4)	35.1 (+4.8)
Female	37.0 (+5.6)	27.1 (+3.8)	34.9 (+6.5)	30.8 (+5.6)
Exposed in public	61.9 (+4.3)	55.3 (+2.4)	51.5 (+6.3)	52.0 (+4.5)
Want ban	45.1 (+9.5)	45.2 (5.4)	35.3 (+7.2)	37.4 (+8.8)
Cessation				
Desire to stop	66.2 (+15.7)	70.6 (+11.6)	70.6 (+8.0)	67.5 (+12.5)
Media				
Saw anti	80.6 (+2.9)	85.5 (+2.1)	67.9 (+4.7)	70.5 (+5.6)
Saw pro billboard	75.4 (+4.8)	75.6 (+2.9)	62.4 (+3.8)	63.6 (+4.9)
Saw pro newspaper	73.4 (+4.5)	70.5 (+2.9)	65.3 (+3.7)	62.5 (+4.4)
Have object	11.1 (+2.9)	9.6 (+1.7)	15.5 (+3.5)	19.7 (+3.1)
Offered free cigarettes	8.4(+3.2)	9.0 (+1.9)	15.3 (+3.3)	20.1 (+3.6)
Access				
Bought store	44.7 (+13.3)	39.7 (+8.0)	34.1(+6.6)	38.5 (+13.1)
Not refused	84.9 (+12.7)	67.4 (+18.9)	59.2 (+21.0)	69.8 (+12.5)

The GYTS report is also designed to monitor several important indicators over time. This will assist programmes in monitoring changes over a certain period of time. This will also assist in measuring the effectiveness of interventions that might have been put in place. This section of the report will compare the results from two sites, namely Harare and Manicaland where the GYTS survey was done in 1999 and a repeat survey done in 2003.

Table 9 indicates selected factors influencing tobacco use as comparison between findings from sites for the GYTS in 1999 and 2003. The highlighted changes are statistically significant as determined by non-overlapping 95% confident intervals.

Prevalence

In Manicaland there was no change in the proportion of students who had ever smoked cigarettes (even one or two puffs), where about 1 in 5 students reported ever had smoked in 1999 and 2003. In Harare however, there was a significant drop in the proportion of ever smokers that dropped from 1 in 4 students in 1999 to almost 1 in 6 students in 2003. This significant decrease was noted in the rate of smoking in females in Harare which dropped by about 50% in the ever smokers category and by two-thirds in the current smokers from 1999 to 2003. No change was noted for the males in Harare in the period under review. There was no change by sex in the Manicaland. In the two regions there was no difference in the current use of other tobacco products.

In Manicaland, data on susceptibility (measured as likely of never smokers initiating smoking in the next year) was not statistically different in the two periods including for both sexes. Susceptibility in Harare dropped from 3 in 10 to 2 in 10 over the four-year period. The difference was significant only for the females and not the males.

School curriculum

There was a 44.6% increase in Harare on students who had been taught the dangers of smoking in class. This increase was uniform to both sexes. No change was noted in Manicaland. However the coverage of around 55% for education programmes on tobacco, in the two sites remains a cause of concern and should be improved to about 80%.

Environmental Tobacco Exposure

Data for Harare showed a reduction in ETS at home by 26.5%. This was significant for both boys and girls. In both sites there was no significant change in the exposure in public. The number of students, who want smoking in public banned, remains disappointingly low. In Harare, 42.1% of the students supported the ban and in Mutare 37.4% of the students supported the ban. This also corresponds to the poor input on tobacco being given in schools. Not only is the number of lectures few but also the content seems inadequate.

Cessation

The proportion of smokers who intend to cease smoking remains about 7 in 10 for the current smokers. This figure is constant in all two sites. It also clearly illustrates the need for students to get a program to assist in quitting smoking.

Media

In Harare, more than 8 in 10 students reported seeing antismoking information in the media and in Manicaland 7 in 10 students reported the same. However it is disappointing that more than 7 in 10 students in Harare and 6 in 10 students in Manicaland also pro-tobacco messages on billboards and newspapers. There has been no change over the years.

Data for Manicaland showed that 1 in 5 students had an item with a cigarette logo on it and for Harare 1 in 10 students reported the same. The two figures for the respective sites also correspond to those of students offered free cigarettes by a cigarette company representative. These issues need to be explored further in a focus group discussion.

Access

In both sites almost 2 in 5 of the current smokers still report buying cigarettes from the stores and more than two thirds of them are not denied access by the shopkeepers. This is despite the fact that there is a law in place to stop selling of cigarettes and alcohol to minors.

Conclusion

Harare data shows a **decrease in the smoking levels** of both the current smokers and ever smokers and this is only noted in the females and not males. **Females in Harare are also less susceptible** to initiate smoking than in 1999. Changes noted might be due to the fact that students in Harare, of both sexes, have received significantly **more education** on dangers of smoking over the four-year period and there has been a **decline in ETS at home**. However, both the content and frequency of **education remains poor**.

There has been no change in the smoking habits in Manicaland.

The vast majority of students who are current smokers wish to quit and have to be helped.

RECOMMENDATIONS

1. The number of students reporting receiving education from school on the harmful effects of tobacco remains low. Harare reported lower prevalence rate associated with an increase in the number of students taught in school about the effects of smoking. This calls for an increase in the lessons on tobacco.
2. The number of students not aware of harmful effects of tobacco and who do not wish to have smoking in public banned is also low. There should be a review of the school curriculum to focus not only on the number of lessons given but also the content taught.
3. The susceptible group of students who have not yet started smoking needs to be protected and discouraged from starting the habit, as cessation will be difficult.
4. The majority of current smokers wish to stop and therefore there is need for a comprehensive cessation programme to assist the students.
5. Pro-tobacco media advertising is as high as the anti-tobacco media advertising and there is need for legislation to stop tobacco advertising in media accessible to the youth.
6. Students continue to buy cigarettes from shops and they are not denied access. There is need for the enforcement of the existing "Child Protection and Adoption Act" provisions that call for a ban in selling alcohol and tobacco products to minors.
7. A decrease in prevalence of smoking was noted in Harare after a corresponding decrease in exposure at home. Parents should therefore abstain from smoking in homes in the presence of their children.
8. There is need to make explore further the incidents reported by youths where they are given free tobacco products by tobacco representatives.
9. The GYTS survey should continue periodically in order to track changes and risk factors.

REFERENCES

1. World Health Organization. WHO Sites. Tobacco Free Initiative
2. The Chronicle (Newspaper) Wednesday 18th August 2004. SADC leaders discuss tobacco pricing policy
3. Framework Convention on Tobacco Control
4. Central Afr J Med. 1996 Aug; 42(8): 223-9. Substance use among rural secondary schools in Zimbabwe: patterns and prevalence. Khan N, Arnott R
5. J. Sch. Health. 1992 Dec; 62(10): 471-4. Drug uses and anticipated reaction among rural school pupils in Zimbabwe. Munodawafa D, Marty PJ, Gwede C
6. Zishiri C (Unpublished 2002). Prevalence of tobacco use among government employed doctors and nurses in Zimbabwe.
7. Pascal B, Bharathi V, Wick W. The global youth tobacco survey in Seychelles 2002 (Unpublished)
8. Bulletin of the World health Organization 2000; 78(7): 868-876. Tobacco use by youth: a surveillance report from the Global Youth tobacco Survey Project. Warren C, Riley L, Asma S, Eriksen M, Green L.
9. Int. J. Nurs. Stud. 1995 Feb; 32 (1) 27-38. Effectiveness of health instruction by student nurses in rural secondary schools of Zimbabwe: a feasibility study. Munodawafa D, Marty PJ, Gwede C