A COMPARATIVE STUDY ON CIGARETTE SMOKING CONTROL STRATEGIES USED IN TANZANIA AND THE UNITED KINGDOM, AUGUST TO SEPTEMBER 2005

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ABSTRACT

Objective: To identify and compare different smoking control strategies used in the United Kingdom and United Republic of Tanzania

Design: Descriptive cross-sectional study

Methodology: Data was collected by an interview and observation at various institutions and clinics in Dar Es Salaam, Tanzania and London, UK and analysed using Epi-Info 2002.

Results: It was found that both the two countries have very good strategies against cigarette smoking but UK has a better organized system which is more effective in lowering down smoking prevalence.

Conclusion: More efforts is needed to put into action the Tanzanian tobacco products regulation act 2003 because this act has very concrete objectives that if achieved as soon as possible will reduce the impending tobacco burden that is posing a big threat to our country.

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INTRODUCTION

Tobacco is a plant whose leaves are cultivated, dried, and adulterated for use in smoking, chewing and sniffing. A person can get deleterious effects of tobacco either directly through smoking or by passive smoking. Passive smoking is the exposure of people who do not smoke tobacco products to the toxic gases exhaled by the smoker or released into the environment as the cigarette burns (side stream smoke)[1].

Tobacco is the second major cause of death in the world. Half the people that smoke today -that is about 650 million people- will eventually be killed by tobacco.[2]

The economic costs of tobacco use are equally devastating. A 1994 report estimated that the use of tobacco resulted in an annual global net loss of US$ 200 billion, a third of this loss being in developing countries. [2]

Comprehensive tobacco control policies can have a major impact on tobacco use prevalence, consumption and public health. The most effective tobacco control programmes are comprehensive and cover a wide range of interventions, including cessation, public awareness campaigns on danger of tobacco use, surveillance and evaluation measures, networking and partnership building and policy and regulations. In a broad policy framework, each country's mix of interventions depends on political, social, cultural and economic factors. Public support is a crucial determinant for success of any tobacco control programme. [2]

METHODOLOGY

Descriptive cross sectional study was carried in Dar es Salaam, Tanzania and London, United Kingdom. The study was conducted for eight weeks, two for the data collection in Tanzania and the remaining six in the UK. Data was collected from different centers that are dealing with smoking control through interviews and observation and then were entered into a checklist for analysis. In the UK, data were collected mainly from Islington borough of London. The author was working with Islington Stop Smoking Team (ISST) where he visited several clinics which were located in the general practice surgery, in the community centers, in the work places and hospitals. He interviewed service providers in those clinics as well as other members of the ISST.

Analysis was done by Epi-Info software.

Permission to conduct the study was sought from MUCHS and international Health and Medical Education Center in University College London.

RESULTS

The government of the United Republic of Tanzania through its ministry of health has developed a policy to regulate tobacco products focusing mainly in five components that is: protecting persons under eighteen and other non smokers from inducements to use tobacco products; protecting non smokers from exposure to tobacco smoke; ensuring that the population is adequately informed about the risk of using tobacco products and exposure to second hand tobacco smoke and about the benefits available for quitting smoking; ensuring that tobacco products are modified to reduce harm and promoting a climate that will lead to a smoking-free atmosphere in all walks of life.

The United Kingdom has developed a policy that is based mainly on the following aspects: reducing exposure to secondhand smoke - making smoke-free environments the norm at work and at leisure**;** Media/education campaigns; reducing availability of tobacco products and regulating supply including action on shops that sell cigarettes to children and further reductions in tobacco smuggling; Further improvements to National Health Services, Stop Smoking Services and increased availability of Nicotine Replacement Therapy (NRT) to help smokers quit; Reducing tobacco promotion including further restrictions on tobacco advertising; Regulating tobacco - for example, proposals to put hard hitting picture warnings on cigarette packets.

Several economic strategies have been developed to bring down the prevalence of cigarette smoking in the UK, for example increase in cigarette prices and/or taxes. The UK government has gone further and come up with strategies to help and encourage smokers to quit. These strategies are based mainly in NHS and this was set up in 1999 that is NHS stop smoking service. These services include community stop smoking drop-in clinics where people from the community just drop in for stop smoking services; workplace-based stop smoking clinics where workers can go for services in their free time; general practice-based clinics-these are conducted in the General Practice, surgery and community quit stalls in the streets where people are being informed and educated on how to go about in seeking help to quit smoking; hospital-based clinics where patients and health care workers can go for services. In those clinics people are given options whether they want to quit smoking with others that is in stop smoking groups or alone, and after stopping smoking they are encouraged to join stay stopped groups where they meet once monthly to make sure they stay stopped. There are also special clinics for some ethnic groups like Somali, Turkish, and Bangladeshi who have higher prevalence of cigarette smoking. To access these services a person can just call for free the primary care trust or go directly to the stop smoking clinic. NHS through its primary care trusts is encouraging use of nicotine replacement therapy (NRT) or zyban® (bupropion hydrochloride) to ensure successful quitting. This is because only 2 to 3 people in every 100 manage to stop smoking on

their own and smokers who attend specialist smoking service are 10 times more likely to succeed. NRT is being given in six different types that is skin patch, gum, nasal spray, inhalator, lozenge and sublingual tablets. The recommended duration to use is 8 to 12 weeks and combining the patch with other forms of NRT has been shown to be more effective and safer than patch alone. In Tanzania so far there is no form of organized stop smoking service.

DISCUSSION

This study was put forward to identify and compare different strategies to combat cigarette smoking between Tanzania and the United Kingdom. Both the two policies have the same aim but they are at different stages. While in the UK they are planning to increase the availability of NRT, making all enclosed places smoke free, strengthening the stop smoking services by having several campaigns like '**don't give up giving up**' etc, here in Tanzania we are only starting. There are very concrete objectives as per tobacco products regulation act 2003 but are not yet into action. This difference can be due to the fact that as a developing country, Tanzania has no enough funds to support those stop smoking services but also lack of long term plans could be another factor.

In the UK: children under sixteen are not allowed to purchase tobacco products; tobacco promotions and advertisement are not allowed; cigarette packets are labeled with large lettered health warnings but in Tanzania: children can buy cigarettes; tobacco products are allowed to be promoted and advertised through media, ceremonies etc; the cigarettes are allowed to be sold with very small lettered health warnings on their packets.

Cigarettes are very expensive in the UK and this is due to the effective strategies to increase tobacco

taxes but in Tanzania cigarettes are sold at such a cheaper price that most of the people can afford to buy one or two. This has a great impact in that adolescents in primary and secondary schools can start smoking quite easily and also that people are more likely to continue smoking even if they don't have enough income.

In Islington borough where the author spent most of his time, it has the third highest death rates in London due to smoking related diseases. It has the smoking prevalence of 37% compared to total UK prevalence of 26%. They have three interlinked strands of work to reduce smoking prevalence that is prevention; cessation support and working towards smoke free work and public places. These have shown significant results as the following places are now smoke free: Islington primary care trust premises; Camden and Islington mental health trust premises; the Whittington hospital.

Smoking cessation and prevention team which is a product of those strands of work has the following core responsibilities; services to either one to one or to groups; supporting general practice teams; training of health care workers to provide stop smoking services; publicity; evaluation of the project; and supporting researches.

These NHS based services has been shown to increase number of quitters as is shown below for Islington. The targets for 2002/3 were 651 and they succeed to make 448 quit. In 2003/4 target being 1057, and 708 were able to quit. In 2004/5 target being 1582 and 1346 were able to quit and for the year 2005/6 the target is 1933 and so far 474 has quit.

Most of the people prefer quitting by using NRT than using zyban® and this is because zyban® has been shown to have several side effects. Zyban is contraindicated in pregnancy; breastfeeding women; people with history of blackouts, fits, head injury or a brain tumor; those withdrawing from high alcohol intake or tranquillizer/antidepressants-type drugs.

CONCLUSION

In general United Kingdom has done a lot in controlling cigarette smoking compared to the United Republic of Tanzania. UK has a well-organized stop smoking services through its NHS primary care trusts while in Tanzania so far there are no any nationally organized stop smoking services. Great efforts must now be done to put into action the Tanzanian tobacco products regulation act 2003 because this act has a very concrete objectives that if achieved as soon as possible we will do away with the impending tobacco burden that is posing a big threat to our country.

Tanzanian Ministry of Health should set up a national campaign to educate the citizens about effects of cigarette smoking, as most of the civilians are not aware of them.

Health care workers especially doctors should be encouraged to give a brief advice on tobacco related diseases for every patient they attend. This will be very effective as people in Tanzania have a lot of respect for doctors.

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