

EDITORIAL

TOBACCO USE IN DEVELOPING COUNTRIES

Evidence exists to indicate that man has used tobacco since pre-historic times and that the habit originated in the Americas(1). Currently the World Health Organisation (WHO) estimates that 1.1 thousand million people, representing a third of the world population above the age of 15 years, use tobacco principally in the form of the manufactured cigarette. Of these smokers, 800 million live in developing countries, 700 million of whom are males(2). While smoking rates have been declining in the developed world, these rates have increased by as much as 50% in developing countries, especially those of Asia and the Pacific region, over the last decade(3). Smoking is therefore a major habituation in developing countries.

It is imperative to ask the question, why do people smoke? By and large smoking initiation occurs in adolescence and is the result of the natural tendency of youth at this age to experiment, peer pressure, tobacco promotion especially advertising and the availability and accessibility of cigarettes(4). Unfortunately experimentation with cigarettes exposes the youth to nicotine, an integral part of tobacco and one of the most addictive substances known(5,6). Nicotine, acting via cholinergic receptors has multiple effects on the nervous system that overall lead to psychoactive and rewarding effects at doses as small as 0.2 mg(6-8). The cigarette is the most efficient nicotine delivery system to the brain and enables the smoker to load the brain with the desired nicotine level by varying the depth and frequency of smoking, what is referred to as "puff by puff fingertip control"(5-7). The "beneficial effects" of smoking are, however, far outweighed by the deleterious effects on health. Close to three million people die every year from tobacco-related diseases and this figure is projected to reach ten million by the year 2020 if current trends continue(2). Tobacco prevention measures need to urgently be implemented if these deaths are to be averted. However, as in many other situations where voluntary human behaviour contributes to disease causation, there are major obstacles in getting people to "quit" this habit. The delivery of information and knowledge may be insufficient to effect behaviour change. It has been demonstrated that medical students increased their smoking in the latter years at medical school despite increasing knowledge of the dangers of smoking(9). This same review indicated that there were substantial deficiencies in the teaching of tobacco-related diseases in the undergraduate curriculum in most medical schools around the world(9). This means that the people expected to take the lead role in the fight against tobacco are not adequately prepared for the task.

In this issue of the journal, Peltzer presents data on the smoking prevalence in two urban communities in the northern province of South Africa, which generally reveals unexplained low rates of smoking especially among blacks at only 11.2%(10). Although many studies on smoking

prevalence in Africa have been carried out in urban communities and have involved relatively small numbers of study subjects, in general smoking rates among adults in the Africa region have been found to be about 50% in males and under ten per cent in females(2,11). The study by Peltzer is, however, interesting in that it reveals a high awareness of the association between smoking and lung cancer but a low awareness about the association between smoking and cardiovascular disease including hypertension. Is this low awareness of the other dangers of smoking, apart from lung cancer, the general trend in developing countries? As lung cancer has remained relatively uncommon in Africa(12,13), probably from a low intensity of smoking and or underreporting, communities in this region may feel relatively safe from tobacco-related diseases while being maimed and killed by smoking-related vascular diseases. In the absence of morbidity and mortality data on tobacco-related diseases in many developing countries, it may be difficult to convince governments in this part of the world to institute tobacco control measures. Over-emphasis on the visible economic benefits of the tobacco industry without taking into account current or future health care costs is worrying and certainly wrong. Tobacco researchers and activists from the developing world need to start generating data on tobacco-related morbidity and mortality to get the economic equation right. As these countries improve their economies smoking is likely to increase both in prevalence and intensity and the price of this increase, in terms of tobacco-related morbidity and mortality will surely have to be paid a few years later. One of the critical ways to control use is through legislation. In this regard, it is imperative to note that the Kenya Medical Association (KMA), who are the publishers of this journal, has been heavily involved in drafting a tobacco control bill that is yet to be debated in the Kenyan parliament. The tobacco companies in Kenya are vehemently opposed to this draft bill and it is possible that what KMA has proposed in the bill will not be what becomes law eventually. The developed world has learned the hard way. Are governments in the developing countries listening?

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