INTRODUCTION

Current Situation

The World Health Organisation (WHO) estimates that about four million deaths result each year from tobacco use. This figure is expected to reach 8.4 million by 2020[1]. Non-communicable chronic diseases such as diseases of the heart and lung, stroke, diabetes and hypertension are accepted as being linked to tobacco use, which has the effect of ultimately resulting in premature death. Of concern to the WHO is that the smoking percentage rate among adolescents is rising while the age of initiation is falling as children begin to smoke at younger ages.

If smoking trends continue, it is estimated that 250 million children and adolescents alive today will die from tobacco-related causes, the most in developing countries[2].

General Response

In response to compelling evidence of the adverse health effects of tobacco, public health officials in many industrialized countries have called for tough legal restrictions on cigarette marketing and use, as well as for education campaigns that encourage smokers to quit and that persuade young people not to begin smoking.

Legislative action, which has been taken by these countries to curtail cigarette advertising, impose new taxes on cigarettes and prohibiting smoking in public places, has generally, resulted in decreased tobacco consumption. In response to declining sales, the tobacco transnational corporations have begun focussing their attention on Third World markets, where tobacco consumption has increased dramatically in recent years.

Another response of the tobacco industry to legislation and to the subsequent drop in tobacco sales was its shift of focus to the young. Studies show that in the developed countries, most regular adult smokers begin smoking before age 18 years[3]. However, as adults successfully quit smoking to improve their health, the number of smokers begins to shrink.

As a result, promoting and marketing tobacco products to young people are essential to maintaining or expanding tobacco sales. Early exposure to tobacco use, therefore, increases the chances that the experimenting young person of today will become a regular smoker as an adult and will replace adult smokers who quit.

The Effects of Tobacco Control Interventions

The history of tobacco regulations in most countries was marked by two phases. In Phase I regulations primarily sought to enable citizens to make more informed choices. They required cigarette companies to print health warnings on cigarette packages, and in some cases, in magazine and billboard advertisements.

In many countries there were also bans on television and radio advertising of tobacco products. The result was that smoking rates fell gradually and by 1985, in the United States, most of Americans were aware of the health hazards of smoking.

Yet it is precisely at this point that the industry's clever marketing techniques to recruit and retain other segments of the market came into play. The youth, especially those from the lower classes, began to take up smoking in large numbers. Tobacco companies that had been banned from television, re-channelled millions of advertising dollars into magazines, billboards and sponsored sporting events. Study after study found highly significant links between high promotional expenditure on the part of tobacco companies and adolescent smoking.

In the second phase of controls therefore activists sought laws requiring larger, more stark and more specific warning labels on cigarette packages. They urged total bans on mass media advertising and on tobacco-company sponsorship of athletic events. They demanded much higher cigarette taxes, high enough to discourage use. A complementary movement sought to control the behaviour of smokers themselves (rather than that of tobacco companies) by lobbying for laws and regulations that would prohibit smoking in public places and offices. The objective was to brand smoking as socially unacceptable behaviour by making it inconvenient to smoke and by ostracizing smokers.

Evaluation studies of the effects of tobacco control interventions on consumption have not always provided clear results. However, the evidence with respect to the effect of bans on advertising clearly shows that partial bans have shown little or no effect. A recent study of 22 high-income countries based on data from 1970 to 1992 concluded that comprehensive bans on cigarette advertising and promotion can reduce smoking, but more limited partial bans have little or no effect.[4]. For example, a study in China [5]found that partial restrictions on cigarette advertising in China failed to prevent a large portion of the population from seeing and understanding the advertisements (in this case foreign brands such as Marlboro and Kent). It concluded that stricter restrictions were needed as previous ones had failed to achieve their intended effects.

The Trinidad and Tobago Situation

Although tobacco use is considered to be relatively high in Trinidad and Tobago, there are insufficient data being collected on a continuous basis to confirm the extent of such use or to adequately determine the effects which tobacco use is having on the health status of the nation. Indeed, only three studies, all of which have been conducted prior to 1996, can be identified as addressing this information gap.

The first was the St. James Cardiovascular Survey[6]; a 10-year community survey that sought to identify predictive risk factors for cardiovascular events. It questioned 1343 men and 1149 women between the ages of 35 and 64 about their smoking habits.

The results showed current smokers comprised of 39.4% men of African descent; 46.1% men of East Indian descent; 39.9% men of Mixed descent and 36.7% men of European descent. Heavy smoking (20 + a day) was present in 17.1% of men of African descent, 23.9% in men of East Indian descent, and 17.2% and 26.3% for the two other groups respectively. Current smokers among women comprised less than 10% and heavy smokers less than 2% except in European women.

The second study[7] which was conducted in 1988, surveyed 1603 secondary school students aged 14-18 years assessing their drug, alcohol and tobacco use. 34.8%

admitted to having used tobacco at some time and 10.5% had used it in the last month preceding the survey. Most of the group had tried their first cigarette between 14 and 16 years of age.

The third study[8] was in fact a component of a National Health Needs Assessment Survey conducted in 1995. Part of this Study examined tobacco use among persons 15 years and older. The results showed a smoking percentage figure of 29.8% among males and 5.1% among females nationally. The respective figures for past smokers (i.e., those who would have quit) were 11.5% and 3.5%.

The lowest percentage was recorded in Tobago (18.9% male and 2.2% female for current smokers and 10.9% male and 1.5% female for past smokers). Highest percentage was found in the 35-44 age group (43.2%) and the lowest in the 15-24 age group (13.4%). Female smoking was consistent with this pattern. Overall, most current smokers were found in the 35-44 age group and most quitters were in the 65+ age group. Smoking increased with age and showed an inverse relation with education and income.

Among the leading causes of death and illness, for the past three decades, in Trinidad and Tobago have been cardiovascular disease, cerebrovascular disease, cancers and diabetes mellitus. A large proportion of those who suffer from diabetes mellitus also suffer from hypertension. Smoking is a known factor, which contributes to these diseases.

In spite of these statistics, sales of cigarettes have been on the increase although increases in taxes have been imposed intermittently. On average, cigarette production increased 22% per annum between 1995 - 1999[9]. Manufacture and distribution of tobacco products are conducted mainly by one company, which occupies a monopoly position (98.5% in 1998)[10] within the industry. This company has become an icon in terms of its support and sponsorship of local cultural and sporting activities and is a major contributor to the endowment fund of the University of the West Indies. Its logo has become an entrenched symbol at the community level. The company conducts a very extensive advertising campaign year round and this campaign has become known for its glamorisation of cigarette use especially among the youth population.

Current legislation related to smoking is minimal and not consistently enforced. None of this legislation controls advertising and promotions. Also there is no sustained public education or effective lobby to control tobacco use or advertising. In the context of such lax regulatory mechanisms the local tobacco manufacturing company has a free hand in advertising and promotion and has succeeded in building a very impressive corporate image as a company that supports athletic, cultural and educational activities in the country.

The Ministry of Health though, even in the absence of confirmed tobacco-related morbidity and mortality data, or data on consumption patterns, has gone ahead and publicly stated national support for a tobacco-free lifestyle. It has stated its intention also to institute measures to curb tobacco use.

The Global Youth Tobacco Survey (GYTS)

It is in this context that the baseline data provided by the Global Youth Tobacco Survey become extremely timely. This

project, sponsored by the WHO, UNICEF and the Centre for Disease Control (CDC), and initiated in 1998, has already been conducted in several countries. The GYTS is a school-based specific survey, which focuses on children age 13-15 years old.

Objectives of the GYTS

The objectives of the Study are:

- To document and monitor the percentage of tobacco use including: cigarette smoking, and current use of smokeless tobacco, cigars or pipes.
- To obtain an improved understanding of and to assess learner's attitudes, knowledge and behaviours related to tobacco use and its health impact, including: cessation, environmental tobacco smoke (ETS), media and advertising, young people's access, and school curriculum.
- To provide information to guide programming and advocacy work addressing youth tobacco use.

Coordination

Undertaking the GYTS was viewed as being quite opportune for Trinidad and Tobago since it would have provided data on youth smoking patterns that would support and augment measures, which the Ministry of Health had begun implementing to reduce the levels of tobacco use. The project was discussed with the Ministry of Education as it would have been of interest to both Ministries. Having given its approval, the Ministry of Education wrote to Principals informing them of the survey and enlisting their support for it.

Methodology

Sampling

The GYTS has a two-stage, randomised, stratified sample design. The first stage is at the level of the school and the second at the level of class. The probability of a school being selected is proportional to its enrolment size and this is based on country data on enrolment figures within age groups for all schools. The focus is on grades or forms in which most 13-15 year olds are to be found. The class or classes to be surveyed were selected based on a random selection table. Based on the total enrolment number of 13-15 years olds in Trinidad and Tobago, the sample size decided on (with a 0.05 confidence interval) was 1875. This allowed for 375 non-response due to absenteeism, reduced classes, etc. the minimum allowable sample size was 1500.

Questionnaire

The GYTS questionnaire contained 57 core questions - all of which were to be included. Countries had the option to add questions depending on their interest, up to a maximum of 99. The Trinidad and Tobago questionnaire contained 61 items. Modifications were made to 15 of the core items of the GYTS questionnaire to make them more culturally relevant to students. The questionnaire was pilot tested and further adjustments were made.

The questionnaire was self administered unless severe reading deficits were detected. Where this occurred, Survey Administrators read the questions aloud to