Smoking behaviour and attitudes of medical students towards smoking and anti-smoking campaigns: a survey in 10 African and Middle Eastern Countries

Jean Francois Tessier, Paul P Fréour, Chakib Nejjari, Dominique Belougne, John W Crofton, for the Tobacco and Health Committee of the International Union Against Tuberculosis and Lung Disease

Abstract

Objective **To assess the behaviour, knowledge, and attitudes towards smoking of medical students in Africa and to stimulate interest in the problem among both students and their teachers.**

Design **As part of a global survey, first and final year medical students in one centre in each of five sub-Saharan African (southern Africa) and five North African and Middle Eastern countries (northern Africa) replied anonymously to a multiple choice questionnaire in French or English according to country.**

Subjects **87% of first year students and 84% of final year students participated in the survey. A total of 1564 replies were analysed, 875 from first year students and 689 from final year students. Women comprised 37% of the overall sample, but with considerable differences between countries.**

Results **In northern Africa the prevalence of daily smoking (both sexes combined) was 8% among first year students and 19% among final year students; in southern Africa the corresponding figures were 9% and 20%, respectively. For men the figures were 13% and 22%; for women, 2% and 6%. Combining daily with occasional smoking, overall figures for both sexes combined were 19% for the first year and 27% for the final year. 9% of male students were ex-smokers in northern Africa and 20% in southern Africa; for women the corresponding figures were 5% and 12%, respectively. A serious attempt to quit had been made by 53% of smokers; 49% thought that they would no longer smoke in five years' time. Over 80% of students thought smoking was harmful to health, but there was considerable underestimation of its causal role in a number of diseases – notably, oral, laryngeal, and bladder cancer; emphysema; coronary and peripheral arterial disease; and neonatal mortality. There were important defects both in knowledge and motivation regarding counselling patients to stop smoking. Only a minority appreciated the value of tobacco taxation in decreasing consumption.**

Conclusions **The proportion of daily smokers in male medical students was similar in Africa to that in Europe, previously reported, but in females the rate was much lower. As in Europe, overall there was much ignorance of smoking as a cause of specific diseases; lack of knowledge and motivation regarding counselling patients; and only a partial grasp of preventive measures. We hope that the survey will stimulate relevant improvements in medical education.**

Introduction

In recent years there has been increasing concern that the tobacco epidemic, fuelled by the marketing practices of multinational companies, is gaining momentum in countries of the Third World,[1–3] adding to their formidable burdens of malnutrition and communicable diseases. Health professionals in these countries are beginning to realise that anti-tobacco activity must have a place in their priorities.

The Tobacco and Health Committee of the International Union against Tuberculosis and Lung Disease (IUATLD), with the support of the World Health Organisation (WHO), has conducted a global survey of the behaviour, knowledge, and attitudes of medical students regarding tobacco. The study has covered more than 5000 students in 42 countries. The survey has yielded data which enable comparisons to be made between countries and medical schools and provide a baseline from which further progress can be measured. An important aim was to stimulate the interest of these future doctors and their teachers. Results from the African section of the survey are reported here.

A pilot study[4] in five countries and results from 14 European countries[5] and nine Asian countries[6] have already been published.

Subjects and methods

The survey covered a single medical school in each of five countries in North Africa and the Middle East (Algeria, Egypt, Kuwait, Morocco, Tunisia – summarised here as northern Africa) and five countries in sub-Saharan

L'Unité INSERM 330, University of Bordeaux, rue Léo Saignet, 33076 Bordeaux Cédex, France
J F Tessier
P P Fréour
C Nejjari
D Belougne

University of Edinburgh, Edinburgh, United Kingdom
J W Crofton

Correspondence to: Sir John Crofton, 13 Spylaw Bank Road, Colinton, Edinburgh EH13 0JW, United Kingdom.

Africa (Benin, Kenya, Madagascar, Nigeria, Senegal – summarised here as southern Africa). To examine the possible effects of medical education, first and final year students were surveyed. Students answered a structural questionnaire (see appendix) adapted from one designed by WHO, in cooperation with the International Union against Cancer and the American Cancer Society[7]; the initial questionnaire was slightly modified after our pilot study.[4] The English or French version was used in this section of the survey.

The questionnaire was administered by a coordinator in each centre using whatever method was locally most convenient, usually a single session in a classroom. The coordinator was asked to ensure that there was no pressure on students as to the nature of their answers. The aim was to obtain questionnaires from all the students, but inevitably some were absent. Participation was 87% for first year and 84% for final year students.

To avoid bias by a single large centre, where the number of students for any one year in any one centre was substantially above 200, a random sample of 200 was analysed. As not all students answered all questions, there are slight variations among the totals in some of the tables. The analysis was carried out by l'Unité INSERM 330 and the Département d'Informatique of the University of Bordeaux II, France. The chi square test for significance was used for comparisons, either between two categories or for trends among more than two categories; 95% confidence intervals are given in the text where appropriate.

Ex-smokers were those who formerly smoked but no longer did so. Never smokers is self explanatory. Smokers were divided into those who smoked daily and those who smoked occasionally – that is, less than daily.

Results

DEMOGRAPHIC DETAILS

The total numbers analysed were 1564, 875 from first year students and 689 from final year students. Overall, women comprised 37% but there were considerable differences among countries (table 1) and between northern (46%) and southern Africa (28%) ($p < 0.001$). In northern Africa only 8% of students came from rural areas; in southern Africa 16% ($p < 0.001$). There was little difference in age between the two areas (mean 22(95% confidence interval 18 to 26) years and 23(18 to 28) years respectively.

Table 1 Demographic date for first and final year students combined by sex and country

Country	Sex (%)		Total No of students
	Male	Female	
Northern Africa:			
Algeria	57	43	179
Egypt	40	60	102
Kuwait	40	60	77
Morocco	63	37	200
Tunisia	55	45	199
Southern Africa:			
Benin	95	5	87
Kenya	78	22	188
Madagascar	55	45	200
Nigeria	78	22	200
Senegal	64	36	130
All countries	63	37	1562

PREVALENCE OF SMOKING

Table 2 gives the results for the two years combined by sex and by centre. In general the rates increased between the first and final years (though of course these were different cohorts): 8% to 19% for daily smoking (both sexes combined) in northern Africa and 9% to 20% in southern Africa. Combining daily with occasional smokers, overall figures were 19% for first year and 27% for final year students ($p < 0.007$).

For male daily smokers the rates for the first and final years were 13% and 22%, for occasional smokers, 14% and 13%. For women the equivalent rates were 2% and 6% for daily smokers and 6% and 4% for occasional smokers, but there was much variation among countries (table 2).

Most student smokers smoked filter tipped cigarettes. Northern African students smoked more cigarettes a day (11(4 to 18) compared with 7(1 to 13) in southern Africa, $p < 0.001$), and women smokers smoked less than men (6(1 to 11) compared with 9(4 to 14), $p < 0.001$).

Table 2 Smoking behaviour for first and final year students combined by sex and country

	Daily smokers (%)		Occasional smokers (%)		Ex-smokers (%)		Never smokers (%)		All students	
	M	F	M	F	M	F	M	F	M (n = 987)	F (n = 575)
Northern Africa:										
Algeria	33	4	14	5	14	3	39	88	102	77
Egypt	3	2	3	0	0	0	94	98	41	61
Kuwait	6	0	10	9	3	7	81	84	31	46
Morocco	18	0	14	0	11	9	57	91	125	75
Tunisia	28	7	11	10	7	6	54	77	109	90
All countries*	22	3	12	5	9	5	57	87	408	349
Southern Africa:										
Benin	8	0	5	0	24	33	63	67	83	4
Kenya	20	2	17	5	15	10	48	83	148	41
Madagascar	22	3	8	6	14	9	56	82	109	91
Nigeria	7	2	21	2	23	19	49	77	157	43
Senegal	14	8	17	11	30	13	39	68	83	47
All countries*	14	4	15	6	20	12	51	78	579	226

* $p < 0.001$ between figures for males and females for each smoking category.

Table 3 Reasons why students themselves do not smoke, by smoking status, both years combined

	% Who "strongly agree"			
	Smokers (n = 351)	Ex-smokers (n = 196)	Never smokers (n = 984)	p value
1 Protect your health	70	79	76	< 0·03
2 Example children	52	59	56	NS
3 Example patients	47	52	55	NS
4 Self-discipline	47	71	66	< 0·001
5 Symptoms	39	37	40	NS
6 Discomfort	31	36	40	< 0·001
7 To save money	25	27	25	NS
8 Example adults	16	29	35	< 0·001
9 Example health workers	25	34	39	< 0·001
10 Pressure of colleagues	9	10	13	NS

* The question asked was, "How do you personally assess the importance of the reasons for not smoking yourself?"

QUITTING SMOKING

There was a notable proportion of ex-smokers, especially in southern Africa (table 2). Even among current smokers 53 % had made at least one serious attempt to quit, ranging from 35 % in Senegal to 68 % in Algeria. Moreover, 49 % thought that they would no longer be smoking in 5 years' time (ranging from 33 % in Egypt to 83 % in Benin).

REASONS FOR NOT SMOKING (TABLE 3)

Protection of the student's own health was the most frequent reason given for not smoking, followed, among never and ex-smokers, by self discipline. Personal rather than professional factors therefore predominated; nevertheless, setting a good example to children was listed by over half. Understandably, for most reasons the figures for smokers tended to be lower.

KNOWLEDGE OF THE DANGERS OF TOBACCO

The majority, whatever their smoking status, thought tobacco was dangerous to health: 89 % in northern Africa and 81 % in southern Africa.

KNOWLEDGE OF TOBACCO AS A MAJOR CAUSE OF SPECIFIC DISEASES

Table 4 indicates the percentage of first and final year students who considered tobacco to be a major cause of the listed diseases. There were important deficiencies in knowledge, especially about oral, laryngeal, and bladder cancer; pulmonary emphysema; coronary artery disease; peripheral vascular disease; and neonatal death. Among final year students the proportion of positive replies to "major cause" from different countries varied from 7 % to 50 % for emphysema, from 10 % to 60 % for coronary artery disease, and from 0 to 28 % for bladder cancer. For a number of diseases there was little improvement from the first to final year.

Table 4 Percentage answering "Yes" to the question, "Is cigarette smoking a major cause of these diseases?", all countries combined

	First year students (%) (n = 875)	Final year students (%) (n = 689)
Lung cancer	62	62
Chronic bronchitis	46	57
Oral cancer	27	26
Pulmonary emphysema	29	15
Laryngeal cancer	31	35
Coronary disease	22	24
Leukoplakia	19	22
Soft tissue lesion	16	13
Peripheral vascular disease	16	19
Neonatal death	13	7
Bladder cancer	5	10

ATTITUDES OF STUDENTS TO SMOKING IN PATIENTS

In response to the question, "In the following situations would you, as a future doctor, advise patients against smoking?" three situations were proposed, the students being asked, in reply, to choose between "often," "sometimes," "rarely," or "never." The overall percentage answering "often" is given by smoking status in table 5 and by country in table 6.

Situation 1 A patient presenting with a smoking related disease (if recognised by the student!). Almost all students claimed they would advise quitting smoking.

Situation 2 A patient himself raises the question of his smoking. The majority of final year students would advise him to quit.

Situation 3 A patient who is a smoker but has no symptoms or diagnosis of a smoking-related disease and does not himself raise the question of smoking. Only 31 % of final year students would intervene.

The responses were little affected by the student's smoking status, except for situation 3. Table 6 indicates that there was little difference among countries.

Table 5 Percentages of final year students answering "often" to the question, "In these three situations would you, as a future doctor, advise patients against smoking?"

Situation*	Smokers (n = 351)	Ex-smokers (%) (n = 196)	Never smokers (n = 984)
1	92	92	86
2	72	83	72
3	27	30	32

* See text for explanation.

Table 6 Percentages of final year students answering "often" to the question, "In these three situations would you, as a future doctor, advise patients against smoking?"

	Situation* (%)			Total No of students
	1	2	3	
Northern Africa:				
Algeria	95	77	29	179
Egypt	53	43	30	102
Kuwait	82	82	35	77
Morocco	94	84	41	200
Tunisia	92	82	32	199
Southern Africa:				
Benin	91	88	33	87
Kenya	91	77	26	188
Madagascar	87	64	24	200
Nigeria	95	81	40	200
Senegal	100	90	20	130
All countries	88	77	31	1562

* See text for explanations.

Table 7 Student attitudes on the role of the doctor in smoking cessation and prevention by smoking status and curriculum year

	% Who "strongly agree"*						
	According to smoking status				According to year		
	Smokers (n = 351)	Ex-smokers (n = 196)	Never smokers (n = 984)	p value	First year (n = 875)	Final year (n = 689)	p value
It is the doctors' responsibility to convince people to stop smoking	49	58	61	< 0·001	57	58	NS
Smokers could stop if they wanted	53	60	59	NS	58	59	NS
Doctors should set a good example by not smoking	50	66	79	< 0·001	73	69	NS
Most people will not quit smoking even if their doctor tells them to	32	35	34	NS	34	34	NS
Doctors should be more active in speaking to lay groups about smoking	71	75	71	NS	71	73	NS
Doctors would be more likely to advise quitting if they knew a good approach	64	50	61	< 0·007	61	59	NS
Your current knowledge is sufficient as a basis to counsel on quitting	40	37	37	NS	32	45	< 0·001
At every contact you should dissuade a patient from smoking	53	55	59	NS	56	59	NS

* The exact wording of the statement was: "Indicate the extent to which you agree or disagree with each of the statements...."

THE DOCTOR AND PREVENTION OF TOBACCO-RELATED DISEASES

In posing the role of the doctor in prevention, the student was asked to state his or her degree of agreement with eight propositions. Table 7 indicates the percentage of students, according to smoking status and year of study, who replied "strongly agree." Only 45% of final year students thought that they had adequate knowledge to counsel patients on stopping smoking.

The answers to some questions were influenced by smoking status. In particular, as might be expected, fewer smokers thought the doctor should set a good example or had a responsibility to convince people to stop smoking. There was little change between years of study except in knowledge of counselling, which improved from 32% in the first year to 45% in the final year (with a range of 27–54% in different centres).

ATTITUDES TOWARDS LAWS AND REGULATIONS FOR CONTROLLING SMOKING

As before, the student was asked to state his degree of agreement or disagreement with a series of propositions. The percentage stating "strongly agree" is given by year and smoking status in table 8.

Overall, the great majority of students, whatever their smoking status, agreed that it should be illegal to sell cigarettes to children and that smoking should be restricted in hospitals and public places. On the other hand, significantly fewer smokers would ban tobacco advertising or increase the tax on tobacco. Taxation as a smoking deterrent attracted the least support, though it is one of the most effective ways of decreasing consumption.[8]

Discussion

The use of a standard protocol and a standard questionnaire should make results between countries comparable. There could, of course, have been misstatements, particularly about smoking behaviour. In a global study in many countries it was not practicable to use carbon monoxide or cotinine markers, and these have seldom been used in community studies. In a worldwide study the number of African countries we could cover had to be limited. However, the geographical distribution and the high participation rate suggests that the results may be reasonably representative.

In general the frequency of smoking in men was similar to that in European students.[5] For instance, in final year male students the proportion of daily smokers was 27% in northern Africa and 18% in southern Africa (22% overall), compared with 21% in Europe. Occasional smoking was 13% in northern Africa and 14% in southern Africa, compared with 4% in Europe.

The amount of smoking by women was very different in Europe and Africa. In the European survey smoking rates were almost ident-

Table 8 Student opinions on smoking control policies by smoking status and curriculum year

	% Who "strongly agree"*						
	According to smoking status				According to year		
	Smokers (n = 351)	Ex-smokers (n = 196)	Never smokers (n = 984)	p value	First year (n = 875)	Final year (n = 689)	p value
Health warning on cigarette package	69	72	69	NS	65	76	< 0·001
Complete ban on advertising	58	60	67	< 0·001	65	64	NS
Tobacco in public places restricted	80	82	84	NS	79	88	< 0·001
Price of tobacco increased	35	50	53	< 0·001	52	46	NS
Sale of tobacco to children prohibited	85	82	88	NS	87	87	NS
Smoking in hospital restricted	80	80	78	NS	79	79	NS

* The exact wording of the questions was: "A number of opinions have been expressed about how to reduce smoking through legislative action. Would you agree or disagree with the following opinions?"

ical in the two sexes. In Africa, as in Asia,[6] the proportion of smokers was much lower in women: in both years combined only 3% of students were daily smokers in northern Africa and 4% in southern Africa.

Data for smoking in the general adult population in African countries are limited. Most are derived from small scale local studies and they may not differentiate between daily and occasional smoking. The following figures for smoking prevalence[9 10 11] may be compared with those for students in table 2: Tunisia males 58%, females 6%; Egypt 33% and 2%; Kuwait 52% and 12%; Morocco 60% and 20%[12]; Algeria 53% (mostly male)[13]; Senegal 44% and 33%; Nigeria 53% and 13%; Benin 28% (both sexes combined).[14] Overall, the prevalence of smoking in medical students seems to be less than in the general population of their countries. In general, reasons for not smoking were predominantly personal rather than professional (such as setting a good example).

It would be interesting to compare the smoking prevalence among medical students with the prevalence among doctors in the same countries. Figures are not available for most of the countries, but for Morocco a survey showed a rate for male doctors of 44% compared with 32% for medical students (daily plus occasional smoking) and for female doctors 22% compared with 0 in students.[15]

In general, ignorance of tobacco as a major cause of specific diseases was similar to that among European students.[5] For instance, it was cited as a major cause of pulmonary emphysema by only 15% of final year African students compared with 18% of European students. For cancer of the larynx the figures were 35% and 41%, respectively and for coronary artery disease, 24% and 29%. (The questionnaire was devised before smoking had been established as a cause of stroke and before environmental tobacco smoke had been established as a cause of lung cancer.)

As in Europe there was a low level of interest in preventive action with patients. Only 45% of African final year students thought that they were equipped to counsel patients on smoking (compared with 27% in Europe). Similarly 69% of African and 68% of European students would not advise patients to stop smoking if they had no smoking related symptoms and did not raise the question themselves. As in Europe, many African students were ignorant of the value of tobacco taxation in reducing consumption.[8]

Currently, there is considerable concern that the "tobacco pandemic" is spreading to Africa.[1 16–18] We hope that this survey will have achieved one of its aims if it stimulates the interest of medical students and their teachers in the problem. Interest may be further stimulated by publication of each country's results in its own national press.

The deficiencies in knowledge and skills noted above are similar to those we found in the European[5] and Asian[6] sections of our global survey. Such deficiencies in final year students must reflect a failure, on average, of medical education, though there was a variation among countries. Centres in the different countries will receive their own results and copies of this report for comparison. We hope this will lead, where necessary, to remedial action in medical education. In the case of our European survey a summary of results (and the revealed deficiencies in medical education)[5] has been circulated, jointly by the International Union against Tuberculosis and Lung Disease and the European Region of WHO, to the deans of all European medical schools, with a brief questionnaire on their curriculum's tobacco module and an inquiry about any proposed action. We hope to explore similar initiatives in Asia and Africa.

We give our sincere thanks to the coordinators in each medical school for their cooperation in meticulously carrying out the survey. These were Algeria: Professor M Khellaf (Constantine), Dr M Messadi (Anaba); Benin: Professor B Monteiro (Cotonou); Egypt: Professor S El 'Sayed (Cairo); Kenya: Dr P Wangai (Nairobi); Kuwait: Professor A M Karnik (Kuwait-City); Madagascar: Dr A Razakamenana (Tananarive); Morocco: Professor M Bartal (Casablanca); Nigeria: Professor B O Onadeko, Dr A Awotedu (Ibadan); Senegal: Professor P A Kane (Dakar); Tunisia: Professor R El Gharbi, Professor A Chabou (Tunis). We acknowledge with gratitude the provision of facilities from the University of Bordeaux II, France; the collaboration of the Unité INSERM 330 and the Département d'Informatique de l'Université de Bordeaux II (Professor R Salamon); the technical help of Mrs S Redon, Assistante Ingénieur of INSERM, Bordeaux; and the secretarial help of Miss M A Audibert and Mrs E A Pretty. We are grateful for the support and a financial grant from WHO Geneva, and for generous grants from the Danish National Association against Tuberculosis and Lung Disease and the Chest, Heart and Stroke Association, Scotland.

Appendix

The following is a summary of the questions asked in the questionnaire.

Personal details

Age, sex, where lived before attending university (city, suburb, town, village).

Smoking status

Whether ever smoked; whether ever smoked for six months or more; whether now smoke daily (at least once a day), occasionally, or not at all. Type of cigarette, pipe, or cigar/cheroot currently smoked. Whether ever made a serious attempt to stop smoking. Probable smoking status five years from now.

Reasons for not smoking

How do you personally assess the following reasons for *not* smoking yourself? Possible answers of "high", "moderate", "low", or "none" to 10 items: symptoms; good example for health workers; to avoid discomfort to others nearby; save money; good example to others in social environment; good example to children; good example for patients; comply with pressure from professional colleagues; protect own health; self discipline.

Harm from smoking

Do you think smoking is harmful to your health? Choice of "strongly agree," "mildly agree," "don't know," "mildly disagree," "strongly disagree."

Smoking as a cause of diseases

Choice of whether smoking is a major or contributory cause, is associated with, has no association with, or

"don't know" regarding: bladder cancer, coronary artery disease, lung cancer, chronic bronchitis, oral cancer, pulmonary emphysema, laryngeal cancer, peripheral vascular disease, leukoplakia of mouth/lip, any soft tissue lesion of mouth/lip, neonatal death.

Advising patients against smoking
Choice of "often", "sometimes," "seldom," "never" when patient (*a*) has symptoms/confirmed diagnosis of smoking related disease, (*b*) raises question of smoking himself, (*c*) is smoker but has no symptoms/diagnosis of smoking-related disease and does *not* raise the question of smoking.

Questions relevant to doctor-patient attitudes:
Choice of "strongly agree," "somewhat agree," "neither agree or disagree," "strongly disagree" to nine statements: "It is the doctor's responsibility to convince people to stop smoking"; "Most smokers could stop if they wanted to"; "It is annoying to be near a person who is smoking"; "Doctors should set a good example by not smoking"; "Most people will not give up smoking even if their doctor tells them to"; "Doctors should be more active than they have been in speaking to lay groups about smoking"; "Doctors would be more likely to advise people to quit smoking if they knew a good approach that really worked"; "Your current knowledge is sufficient as a basis for counselling patients who want to stop smoking"; "At every contact with a patient, where it would be natural to do so, you should dissuade him from smoking."

Reducing smoking through regulative/legislative action:
Choice of replies as in questions relevant to doctor-patient attitudes to proposals for health warnings on cigarette packets; complete ban on advertising of tobacco; restricted smoking in public places; sharp increase in price of tobacco (taxation); prohibiting tobacco sales to children; restricting smoking in hospitals to special areas; specific training of health professionals in how to support patients who want to stop smoking.

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Translations of abstract

Comportement tabagique et attitudes des étudiants en médecine face aux campagnes pour et contre le tabac: une enquête dans 10 pays africains et du Moyen-Orient

Jean Francois Tessier *et al*

Résumé

Objectif: Evaluer le comportement, la connaissance et les attitudes face au tabagisme des étudiants en médecine en Afrique et stimuler l'intérêt des étudiants et des enseignants pour cette question.
Méthode: Dans le cadre d'une enquête globale, des étudiants en médecine de première et de dernière année de chacun des cinq pays africains sub-sahariens (Afrique du sud) et des cinq pays d'Afrique du nord et du Moyen-Orient (Afrique du nord) ont répondu anonymement à un questionnaire à choix multiple en français ou en anglais selon le pays.
Sujets: 87 % des étudiants de première année et 84 % des étudiants de dernière année ont participé à l'enquête. 1564 réponses ont été analysées, 875 d'étudiants en première année et 689 en dernière année. Les femmes représentaient 37 % de l'échantillon global mais avec d'énormes différences entre les pays.
Résultats: En Afrique du nord la prévalence du tabagisme quotidien (les deux sexes confondus) était de 8 % parmi les étudiants de première année et 19 % parmi les étudiants de dernière année; en Afrique du sud, ces chiffres étaient respectivement de 9 % et 20 %. Pour les hommes les chiffres étaient de 13 % et 22 %; pour les femmes 2 % et 6 %. Les chiffres globaux pour les deux sexes, fumeurs occasionnels et réguliers confondus, étaient de 19 % pour la première année et 27 % pour la dernière année. 9 % des étudiants de sexe masculin étaient des ex-fumeurs en Afrique du nord, et 20 % en Afrique du sud; pour les femmes, ces chiffres étaient respectivement de 5 % et 12 %. 53 % des fumeurs ont sérieusement essayé d'arrêter de fumer; 49 % pensaient qu'ils ne fumeraient plus dans cinq ans. Plus de 80 % des étudiants pensaient que le tabagisme est mauvais pour la santé, mais ils sous-estimaient de beaucoup son rôle causal pour plusieurs maladies, dont notamment le cancer du larynx, de la bouche et de la vessie; l'emphysème; les maladies coronariennes et des artères périphériques; et la mortalité néonatale. Il y avait beaucoup de lacunes dans la connaissance et la motivation pour conseiller aux patients d'arrêter de fumer. Une minorité seulement reconnaissait l'importance de la taxation des produits du tabac dans la baisse de la consommation.
Conclusions: La proportion de fumeurs réguliers de sexe masculin était la même en Afrique qu'en Europe, mais le pourcentage était beaucoup plus faible chez les femmes. Comme c'est le cas en Europe, il y a globalement une grande ignorance du fait que le tabagisme cause certaines maladies spécifiques; un manque de connaissance et de motivation pour conseiller aux patients d'arrêter de fumer; et seulement une compréhension partielle des mesures préventives.

Comportamientos de tabaquismo y actitudes de los estudiantes de medicina respecto del tabaquismo y las campañas contra el tabaquismo: encuesta realizada en 10 paises Africanos y del Medio Oriente

Jean Francois Tessier *et al*

Resumen

Objetivo: Evaluar el comportamiento, el conocimiento y las actitudes hacia tabaquismo de los estudiantes de medicina en Africa y estimular el interés en el problema tanto de los estudiantes como de sus profesores.

Diseño: Como parte de una encuesta global, los estudiantes de medicina del primero y del último año de un centro de estudios de cada uno de cinco países al sur del Sahara (Africa meridional) y cinco países de Africa del Norte y del Medio Oriente (Africa septentrional) respondieron en forma anónima a un cuestionario de selección múltiple en francés o inglés según el pais.

Sujetos: 87% de los estudiantes del primer año y 84% de los estudiantes del último año participaron en la encuesta. Se analizaron 1564 respuestas, 875 de los estudiantes del primer año y 689 de los estudiantes del último año. Las mujeres representaban el 37% de la muestra general, pero con considerables diferencias entre los países.

Resultados: En Africa septentrional la prevalencia del tabaquismo cotidiano (en los dos sexos en conjunto) fue 8% entre los estudiantes del primer año y 19% entre los estudiantes del último año; en el Africa meridional, las cifras correspondientes fueron 9% y 20%, respectivamente. Para los hombres, las cifras fueron 13% y 22%; para las mujeres, 2% y 6%. Las cifras generales para los dos sexos de tabaquismo cotidiano y ocasional combinadas fueron 19% durante el primer año y 27% para el último año. En Africa septentrional, el 9% de los estudiantes masculinos eran ex fumadores y en Africa meridional, el 20%; las cifras correspondientes para las mujeres fueron el 5% y el 12%, respectivamente. Un 53% de los fumadores había intentado seriamente dejar de fumar; 49% de ellos creían que en un lapso de 5 ãnos ya no fumarían más. Si bien más del 80% de los estudiantes creían que el tabaquismo era nocivo para la salud, subestimaban enormemente su papel causal en varias enfermedades – en particular, el cáncer oral, laríngeo y vesical; el enfisema; enfermedad coronaría y vascular periférica; y la mortalidad neonatal. Se comprobaron defectos importantes tanto en el conocimiento como en la motivación en la orientación de los pacientes para que dejaran de fumar. Solo una minoría reconocía el impacto de la tributación al tabaco en la reducción del consumo.

Conclusiones: La proporción de fumadores cotidianos entre los estudiantes de medicina masculinos en Africa fue similar a la de Europa, si bien en las mujeres la tasa fue muy inferior.

Al igual que en Europa, en general existía un gran desconocimiento del papel del tabaquismo como causa de enfermedades específicas; falta de conocimiento y motivación en lo referente a la orientación de los pacientes, y solo una comprensión parcial de las medidas preventivas.

医学生吸烟行为及他们对反吸烟运动的态度

一项在 10个非洲和中东国家中进行的调查

佛朗克斯·塔塞　国际防痨病肺病联盟的吸烟与健康委员会

研究目的：分析评价非洲的医学生吸烟行为及与吸烟有关的知识和态度，进而激发学生和教师对吸烟问题的兴趣。

研究设计：调查在五个南非和五个北非及中东国家的医疗中心进行，在每个研究中心，新入学的和将毕业的医学生用英文或法文，以不记名的方式填写多项选择问卷。

研究对象：87% 的新生和 84% 的毕业生参加了调查，共收集了 1564 份问卷，其中 875 份来源于新生，689 份来源于毕业生。女性占总调查人数的 37%，但在不同的国家间存在着很大的差异。

研究结果：在北非，新生和毕业生吸烟率（男女合计，每日吸烟）分别是 8% 和 19%；在南非相应的数字为 9% 和 20%。其中男性吸烟率分别为 13% 和 22%，而女性吸烟率分别为 2% 和 6%。在北非新生和毕业生的吸烟率（男女合计，每日吸＋偶尔吸）分别为 19% 和 27%。另外，在北非和南非分别有 9% 和 20% 的男性曾吸过烟；女性的相应数字分别为 5% 和 12%。有 53% 的吸烟者曾尝试戒烟，有 49% 的吸烟者计划在未来的五年内戒烟。80% 以上的学生知道吸烟危害健康，但他们显著低估了吸烟对某些疾病的致病作用，如口腔癌、咽喉癌、膀胱癌、肺气肿、冠心病、周围动脉血管疾病和新生儿死亡。大多数医学生缺乏劝阻病人吸烟的意识和动机，仅少数人知道到烟草税在降低烟草消费中的作用。

结论：非洲男性医学生每日吸烟率与欧洲的相似，但女性吸烟率则显著的低。与欧洲的情形一样，医学生普遍忽视吸烟对特定疾病的致病作用，缺乏对病人进行戒烟咨询的知识和动机，对如何预防疾病知之甚少。

（中国健康教育研究所烟草控制与疾病预防研究室　潘学雷译）