

## **Background**

South Africa is at the forefront of tobacco control worldwide in terms of legislative interventions as well as public health research. Furthermore South Africa has played a significant role in the process of developing and adopting the Framework Convention on Tobacco Control which was adopted on the 21<sup>st</sup> of May, 2003 at the 54<sup>th</sup> World Health Assembly.

Sir Richard Peto quantifies the scale of the challenge of tobacco by stating that 'There were 100 million deaths from tobacco in the 20<sup>th</sup> century, but if current smoking patterns continue then there will be about 1,000 million this century: the annual numbers killed by tobacco will increase from about 4 million now to 10 million in 2030. Worldwide, there are almost 2 billion people who already smoke, or who will smoke when they reach adulthood, and about half of all persistent cigarette smokers are eventually killed by their habit — unless they quit. Even in middle age stopping smoking avoids most of the risk of being killed by tobacco, and stopping earlier avoids almost all of it – indeed, only if there is widespread quitting will many of the tobacco deaths of the next few decades be avoided, as reductions in uptake rates will have relatively little effect until the middle of the century. Tobacco control then, is the greatest public health challenge of the first half of the 21<sup>st</sup> century, particularly smoking cessation.

The World Health Organisation estimates that tobacco is the second most important risk factor for disease after under nutrition. It further estimates that the number of tobacco-attributable deaths in the year 2000 was 4.9 million – more than the number of AIDS-related deaths. The number of tobacco-related deaths is increasing – with most of the increase in developing countries (World Health Report, 2002).

The Framework Convention on Tobacco Control is the first international treaty in WHO's history. It aims to decrease smoking and other forms of tobacco use responsible for innumerable number of illnesses and deaths. The treaty requires governments to develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies, plans and programmes relating to price and tax measures to reduce the demand for tobacco, protection from exposure to tobacco smoke, regulation of the contents of tobacco products, packaging and labeling of tobacco products, education, communication, training and public awareness, tobacco advertising, promotion and sponsorship, demand reduction measures concerning tobacco dependence and cessation, illicit trade in tobacco products, sale to and by minors among others.

Policy development on tobacco control in South Africa preceded the establishment of surveillance systems. Nevertheless it is necessary to have continuous monitoring and evaluation systems in place such that scientific data can be used to motivate for amendments to the policy and programmes. The Global Youth Tobacco Survey is the first tobacco surveillance systems to be established in South Africa, providing robust and coherent information on tobacco use among school going youth. The data is also internationally comparable.

South Africa was one of the first countries in the world to attempt to monitor tobacco-related mortality through inclusion since 1998 of the smoking history of the deceased on the death certificate. A 5% sample of all the deaths registered in one particular year was used to generate 13 000 certificates in order to conduct a case control study. The study indicated a significantly increased relative risk of

deaths due to lung (RR=3.3), oesophageal (RR=4.1), stomach (RR=2.2), digestive diseases (RR=1.6), tuberculosis (RR=2.5) and other lung diseases (RR=1.6) among the deceased who had smoked 5 years prior to their death.

Tobacco-related disease and deaths have a lag time of a few decades. For this reason reliable surveillance is critically important in predicting disease trends of the future. This is particularly important in developing countries such as South Africa where 50% of the populace are under 18 years of age. The GYTS is therefore particularly important for both policymakers and healthcare workers in both predicting the disease burden of the future (cancer, chronic lung disease and heart disease); as well as measuring the impact of smoking prevention and cessation interventions.

The World Health Organisation and Centres for Disease Control initiative to conduct school based studies on youth smoking rates across the WHO member states, therefore presented an ideal opportunity for South Africa to collect national as well as internationally comparable data. In 1999, South Africa was one of 12 WHO member states to conduct the Global Youth Tobacco Survey<sup>13</sup>. It reported that 46.7% of learners had ever smoked a cigarette and that 23% of learners were current smokers (smoked cigarettes on one or more days in 30 days preceding the survey). Among the current smokers, 10.1% of learners reported smoking on 20 or more days of the past 30 days preceding the survey. Regarding the age at initiation, 18.5% of learners reported first smoking a cigarette before the age of 10.

In 1999, 29.7% of learners reported being offered a free cigarette from a tobacco representative, 40.2% of learners reported seeing advertisements in magazines and papers, and 41.2% of never smokers, followed by 81.8% of current smokers had someone smoke in a place other than their homes in their presence in the past 7 days preceding the survey. The banning of the free distribution of cigarettes, banning of tobacco advertising as well as the limiting of smoking in public places via the Tobacco Products Control Amendment Act regulations of 2001, followed the GYTS that was conducted in 1999.

The GYTS conducted in 2002 is therefore provides an opportunity to evaluate the effect of the changes in legislation upon adolescent smoking behaviour. A cross country comparison of 13-15 year old learners who participated in GYTS across 43 countries (tobacco use among youth, a cross country comparison), shows that in the African countries, South Africa reported consistently higher rates of learners who ever smoked cigarettes, currently used any tobacco products, and currently smoked cigarettes. However, South Africa reported lower rates of ever smokers who first smoked cigarettes before the age of 10. As the comparison report suggests, further investigation is needed into why smoking rates are lower in other African countries but the age at initiation among the smokers in these countries are higher. South Africa also reported consistently higher rates of learners who saw cigarette advertisements in magazines and newspapers, were offered cigarettes by a tobacco company and were exposed to smoke from others in public places.

South Africa was one of four WHO member states to repeat the Global Youth Tobacco Survey in 2002.