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Brief Report

Addressing the High Prevalence of Smokeless Tobacco Use in Pastoralist Communities of Ethiopia's Adult: A Call to Action

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Executive Summary

The use of smokeless tobacco, which includes snuff and chewing tobacco, is low in majority of the countries when examined for both women and men. In general, the use of smokeless tobacco among men is more common in South and Southeast Asia than in any other region. Yet large portions of the Borena's adult pastoral communities are smokeless tobacco users. It is needed a call to action for policymakers and health professionals to improve the health and well being of pastoral communities of Ethiopia's adults by increasing their access to anti notice information on smokeless tobacco use.

Introduction

Scope of the problem

Smokeless tobacco use has a significant health risk and may lead to the cause of many diseases [1]. Over 300 million people use Smokeless tobacco worldwide. Unlike cigarettes and other forms of tobacco, smokeless tobacco is not burned. Instead, nicotine is absorbed into the body through direct contact of the tobacco with mucous membrane in the mouth or nose. In addition to Nicotine, Smokeless tobacco contains over 3,000 chemicals [2], including 28 known Carcinogens (cancer-causing agents) [3]. The countries with the highest use of smokeless tobacco among men are India (37 percent), Nepal (36 percent), Uzbekistan (32 percent), Madagascar (23 percent) and Bangladesh (20 percent) [4]. In a recent study of percentage of adults using smokeless tobacco in Pastoral communities is 45 percent (Men 28 percent and women 17.3 percent).

Effects of SLT use

Some of the effects of SLT use include Bad Breath, Stained Teeth, Ulcers, Cavities, Gingivitis, High Blood Pressure, Addiction, Ruins sense of taste and smell, Mouth Sores (70% of Smokeless tobacco users have sores), Decreased athletic ability, Dizziness and nausea, disease, including heart attack and stroke, Tooth and bone loss, Leukoplakia and Cancer of the mouth, esophagus, pharynx, larynx, stomach and pancreas, etc. Smokeless tobacco and Snuff contain 3,000 chemicals [5] including 28 Carcinogens (cancer-causing agents) [6]. Nicotine, a highly addictive substance is the main ingredient in smokeless tobacco. The amount of nicotine in a can of smokeless tobacco is roughly 144 milligrams, which is equal to about 80 cigarettes. In other words, one can of snuff or dip equals about four packs of cigarettes [7]. Nicotine from smokeless tobacco stays in the bloodstream for a longer time when compared to cigarettes [8]. Adolescents who use smokeless tobacco are more likely to become cigarette smokers [6]. Smokeless tobacco users are 4-6 times more likely to develop oral cancer compared to non-users and these cancers can form within 5 years of regular use [9]. Smokeless tobacco use has been shown to be a gateway drug not only leading to cigarette smoking, but the use of other drugs such as alcohol, marijuana, cocaine and inhalants [10].

A thirty-minute chew gives you the same amount of nicotine as three cigarettes and a two can/week snuff dipper delivers the same nicotine as a 1 ½pack-a-day cigarette habit [11].

Justification

Lack of evidence for national policy intervention on TC in particular, on smokeless tobacco use and associated factors. Therefore, this study can contribute to the intervention of national police on tobacco and provide baseline information to support establishment or strengthening cessation services on smokeless tobacco use.

Approaches

- Study conducted among 634 adults in pastoralist community of Borena Zone, Ethiopia.
- Purposive and simple random samplings were used to select Zone, Districts, Kebeles and Households.
- Interviewer administered questionnaires, in-depth interviews and key informant interviews were used.

Key Results

- 45.3% of adults were current smokeless tobacco users (28% men and 17.3% women).
- 96.7% of adults reported that they were not noticed anti SLT use information in the last 30 days.
- 67.9% of participants reported that they were not advised to quit smokeless tobacco use by health care providers in the past 12 months.
- 64.1% of adults had poor health risk perception of smokeless tobacco use.
- 59.2% of adults had insufficient knowledge about smokeless tobacco use health effect.
- 56.4% of current smokeless tobacco users who were reported that they had high social pressure towards smokeless tobacco use.
- Among current smokeless tobacco users, 80.5% of adults reported that their close friends were smokeless tobacco users.
- Among current smokeless tobacco users, 58.1% of adults were Wakefata in religion.
- Among daily users, 79.5% of adults reported that on average they were used SLT products more than 5 times a day.

Conclusions

- There was high prevalence of smokeless tobacco use among adults. One out of two adult is smokeless tobacco user currently.
- Adults are unaware of risks related to smokeless tobacco use and are influenced by religion, social norm, attitude and health risk perception factors.

Implications

- In countries like Ethiopia where smokeless tobacco is already in use, restriction on STL use is vital to prevent any increase, and reduce the prevalence of its use in the population.
- There are missed opportunities in the using of broad definitions to include all smokeless tobacco products in new tobacco control legislation of Ethiopia.
- Without a change in the current trend:
    1. Smokeless tobacco use can lead to nicotine addiction or dependence as a significant reason for exposing to disease, harmful to the environment, social embarrassment and family conflict.
    2. Increased health care expenditures on treatment of tobacco to the national governments from tobacco related conditions.
    3. Increased risk of population exposure to carcinogens (cancer-causing agents).
    4. Increased problems associated with spitting and the disposal of chewed tobacco.

A Call to Action

General (MoH)

- Health improvement strategies with a focus on proper information, education, and communication on Smokeless Tobacco use is essential which could help them changing practices or behaviors should be designed and implemented.

To local health sector officials (Oromia Health Bureau and Borena Zone Health Offices)

- Anti-tobacco media campaigns should be expanded through all possible means, such as mass media (TV, radio) and Inter-Personal Communication (IPC) like community group discussion, men's clubs, and women's clubs to discuss smokeless tobacco use in the community. The capacity of existing community volunteers should be built to provide education on smokeless tobacco and help community quit using smokeless tobacco.
- Tobacco control in the community should start with the fundamental steps of educating the community people (male and female) on smokeless tobacco use-related diseases. Community should be encouraged to work together to prevent smokeless tobacco initiation and cessation. Capacity building should focus on skills to analyze the impact of smokeless tobacco use on the health and economy of individuals, families and the community.
- Community tobacco control should focus on changing people's knowledge, attitudes, perceptions and social norms with regard to smokeless tobacco use.

To health care providers

- Health education for adults with current use of smokeless tobacco use, in particular, needs to be targeted for cessation programs.
- Community people should be trained on knowledge and skills to quit using smokeless tobacco. Proper help should be identified to assist them to quit using smokeless tobacco uses.

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