

Smoking in Viti Levu, Fiji

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Introduction

Smoking is widely recognised as one of the single biggest preventable causes of premature morbidity and mortality in developed nations¹. Developing countries have to date been concerned primarily with the control of communicable disease, however the rapid morbidity and mortality transition underway in Fiji and the Pacific more generally, makes a response to the control of non communicable diseases a priority². Cardiovascular disease, especially ischaemic heart disease, has been the principal cause of mortality in Fiji since 1985 and the second or third most common cause of hospital admission over the same period³. In common with many other developing countries, effective regulations governing the sponsorship and advertising of cigarettes and the provision of clear, easily understood, information to users in Fiji is lacking.

The move towards an informed debate on smoking and its effects on health, and the development of appropriate responses require, inter alia, information on the extent of the problem. Resources for research are scarce in developing countries, and they do not have priority over service demands, consequently data on key topics is scarce. Population based data on smoking prevalence in Fiji has to date been limited to one 15 year old study (sourced externally) which indicated a overall smoking prevalence of 45% with males, rural dwellers and indigenous Fijians having the highest rates⁴. Other small ad hoc studies have been done but in selected populations.

This study sought to provide:

- data on the extent of smoking in Fiji;
- some environmental factors related to the commencement and continuation of the habit; and

- views on one facet of restricting environmental tobacco smoke exposure

Fiji is a country of over 300 inhabited islands with a total population of approximately 790,000; 45% of the population being indigenous melanesian, 45% of indian ethnic background and 10% of mixed race.

Methodology

The prevalence survey was carried out using a pretested, structured questionnaire on the main island of Viti Levu (70% of Fiji total population) in September 1994. Subjects over the age of 15 were chosen randomly from five geographically separate rural settings and the two principal urban areas (Suva and Lautoka)

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Results

A total of 930 people were surveyed, acceptance rates exceeded 90%. 50% of the respondents were domiciled in rural areas and 50% in urban settings. The ages ranged from 15 to 70 years with 44% of respondents being female and 56% male. The overall smoking prevalence was 38%. Fifty five% of adult males smoked and 20% of adult females. In rural areas 65% of males smoked compared to 42% in urban areas. For females these figures were 19% and 22% respectively.

Ethnicity & gender: Indigenous Fijians showed an overall smoking prevalence of 50%, with rates of 40% in males and 24% in females. Fijian Indians had corresponding rates of 41%, 44% and 13% respectively.

Domicile: 48% of rural dwellers (n=494) smoked, with rates of 67% in males and 22% in females. In urban areas the

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rates were 30%, 42% and 19% respectively.

Age: For males the rates were 55% in the 15-30 age group; 67% in the 31-45 age group and 74% in the 46-60 age group. For females the rates were 34%, 21% and 26% respectively.

Environmental determinants of smoking: Both males and females over the age of thirty specifically identified smoking with kava drinking, cigarette consumption varying according to the length of the kava drinking session, with some respondents smoking up to 40 cigarettes during one session. The 15-30 age group commonly expressed the view that they started smoking as a result of peer pressure, and saw no harm in the habit as their parents and other adult role models smoked.

Attitudes towards prohibiting smoking on public transport: 444 people were surveyed. 96% supported prohibiting smoking on all public transport. This comprised 95% support amongst rural dwellers ($n = 329$) and 86% support from urban dwellers ($n = 97$). Duration of journey was not an important factor in determining response, with the rates for short, medium and long journeys being 80%, 84% and 99% respectively. Of the 444, two hundred and forty seven (56%) were themselves smokers, comprising 30% of the urban dwellers and 52% of the rural dwellers.

Discussion

The overall prevalence of smoking at 38% is significantly greater than most metropolitan countries. The lack of significant change since 1980 is disappointing but not altogether surprising. The groups showing the highest rates in 1980 (i.e. rural, male Fijians) are again prominent, but with Indian males now showing higher rates than their Fijian counterparts.

The rates of 55% overall in males and 67% in the 31-45 age group suggest that the current epidemic of cardiovascular disease in Fiji is likely not only to continue but to worsen for the foreseeable future, especially when one considers that the prevalence of smoking in individuals with ischaemic heart disease presenting to hospitals in Fiji is already high at approximately 60%⁴.

The high rate of smoking in females in the 15-30 age, compared to other age groups of women, mirrors high smoking rates in young women seen in other countries (e.g. New Zealand) where these rates have translated into negative health outcomes for women.

It is notable that the vast majority of people, including smokers, see it as desirable to limit their exposure to smoke, in at least one situation where they currently have no option to avoid it. It suggests that government or other initiatives of such a nature would find favour with a wide cross section of the public.

This study shows smoking to be associated with leisure and relaxation; specifically, consumption of the mildly narcotic kava or yaqona (akin to its association with alcohol consumption in other countries). Similarly, as has been shown elsewhere, peer pressure, implicit adult sanction and adult smokers as role models would appear to promote commencement and continuation of smoking in the young⁵.

The rates of both smoking and cardiovascular disease described are a cause for concern; in the absence of an active, appropriately resourced, strategy for the control of smoking related ill health they constitute a major public health problem. Making resources available for further work on the extent of the problem and the implementation of appropriate measures should be a public health priority.

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