

The International Tobacco Control Policy Evaluation Project ITC Zambia National Report

FINDINGS FROM THE WAVE 1 AND 2 SURVEYS (2012-2014)

DECEMBER 2015



Promoting Evidence-Based Strategies to Fight the Global Tobacco Epidemic



THE UNIVERSITY OF ZAMBIA



REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH



International Tobacco Control
Policy Evaluation Project



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WATERLOO



Findings from the ITC Zambia Wave 1 and 2 Surveys

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“ITC Zambia data showing that smokers are not fully aware of the harms of smoking further point to the urgent need for large, pictorial health warnings. Zambia has the lowest percentage of male smokers who believe that smoking causes lung cancer (79%) among 12 ITC countries; the second lowest percentage who believe that smoking causes stroke (45%) of 20 ITC countries; and the third lowest percentage that smoking causes heart disease (74%) of 14 ITC countries.”

Dr. Fastone Goma,
MB ChB(UNZA), MSc(Lon), PhD(Leeds), Cert.PH(UAB)
President of the Heart and Stroke Foundation, Zambia



Message

Rising tobacco use in Zambia and the African region continues to take a heavy toll on society through increasing rates of non-communicable diseases such as lung cancer and heart disease. Proven strategies and tools for fighting the global tobacco epidemic are clearly articulated in the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) – a global health treaty which Zambia ratified in 2008. Parties to the FCTC are obligated to implement comprehensive tobacco control legislation as set out in the treaty and its Guidelines.

This report presents alarming evidence indicating how far Zambia has fallen behind other countries in implementing the FCTC and protecting Zambian people from the harms of tobacco. The findings are based on the Wave 2 Survey of the International Tobacco Control Policy Evaluation Project (the ITC Project) in Zambia – a cohort study of approximately 1,500 tobacco users and 600 non-users in Zambia conducted between August and October 2014.

ITC cross-country comparisons clearly convey the impact of Zambia's absence of large, visible, rotating health warnings on at least 50% of the package in the country's principal language by 2011 (3 years after ratification) as required by the FCTC. Zambia has the lowest percentage (22%) of male smokers and quitters who "often" or "very often" noticed the health warnings on cigarette packs among 11 low- and middle-income countries. In contrast, more than three-quarters (78%) of male smokers noticed the warnings in Mauritius, where pictorial health warnings cover 60% of the front and 70% of the back of the pack. Furthermore, only 45% of Zambian smokers were able to read the single English text warning easily, 14% read it with difficulty, and 40% were not able to read the warning at all. ITC Zambia data showing that smokers are not fully aware of the harms of smoking further point to the urgent need for large, pictorial health warnings. Zambia has the lowest percentage of male smokers who believe that smoking causes lung cancer (79%) among 12 ITC countries; the second lowest percentage who believe that smoking causes stroke (45%) of 20 ITC countries; and the third lowest percentage who believe that smoking causes heart disease (74%) of 14 ITC countries.

I urge policymakers to carefully consider the findings and recommendations of this important study. Without strong implementation of the WHO FCTC across all policy domains, Zambians will not be protected from the devastating health, social, environmental and economic consequences of tobacco use.

Sincerely,

A handwritten signature in black ink, appearing to read 'Fastone Goma'. The signature is written in a cursive style and is positioned above a horizontal line.

Dr. Fastone Goma, MB ChB(UNZA), MSc(Lon), PhD(Leeds), Cert.PH(UAB)
President of the Heart and Stroke Foundation, Zambia

EXECUTIVE SUMMARY

Evaluation of Tobacco Control in Zambia - The ITC Zambia Survey

In 2010, Dr. Fastone Goma and colleagues at the University of Zambia (UNZA) and the Ministry of Health partnered with Dr. Geoffrey T. Fong, Chief Principal Investigator of the International Tobacco Control Policy Evaluation Project (ITC Project) and the ITC Project team in Canada at the University of Waterloo to create the ITC Zambia Project. The ITC Zambia Project is an evaluation of the country's efforts to implement tobacco control policies under the WHO Framework Convention on Tobacco Control (FCTC) – a global health treaty which Zambia ratified in 2008. The FCTC and its Guidelines provide the foundation for countries to implement evidence-based tobacco control policies to reduce the prevalence of tobacco use. The ITC Project measures the effectiveness of implementation of the FCTC in Zambia and 22 other countries. Two waves of surveys have been conducted in Zambia among a nationally representative sample of approximately 1,500 tobacco users and 600 non-users aged 15 years and older. The ITC Zambia Survey is a cohort survey, so the respondents who participated in Wave 1 in 2012 were recontacted in Wave 2 in 2014 to answer the follow up survey. The Wave 1 ITC Zambia National Report was released in Lusaka in May 2014 (see www.itcproject.org/resources/view/1660). The new Wave 2 National Report (see www.itcproject.org) assesses Zambia's progress in tobacco control two years later and six years after ratification of the FCTC, and compares progress in Zambia against other ITC countries around the world.

Main Findings from the ITC Zambia Wave 2 National Report

The ITC Zambia Wave 1 National Report found that although Zambia has enacted tobacco control laws across the major policy domains of the FCTC under the National Public Health Act (1992), these policies and their implementation fall short of the treaty requirements and FCTC Guideline recommendations. The report concluded that without urgent action to strengthen Zambia's tobacco control policies including improved enforcement of smoke-free laws, implementation of large pictorial warnings, increases in tax and prices of tobacco products and introducing a ban on sales of single cigarettes, the threat to public health and the economy caused by tobacco would continue to escalate. However, since the Wave 1 Survey, there has been little progress on tobacco control in Zambia. The Wave 2 Survey results provide evidence that Zambia is falling further behind other countries in the implementation of strong FCTC policies. However, support for further government action on tobacco is strong among both tobacco users and non-users.

High use of menthol cigarettes

ITC cross-country comparisons indicate that 40% of male smokers in Zambia who have a regular brand smoke menthol cigarettes – the highest percentage among 19 ITC countries. These findings are of particular concern for youth uptake of smoking. Menthol masks the harsh properties of tobacco smoke and lures young people to initiate smoking, and possibly sets them up for a lifetime addiction to cigarettes. Although all conventional cigarette brands are equally harmful, approximately one-third (31%) of smokers believe that menthol cigarettes are less harmful than regular cigarettes.

Zambian smokers want to quit

Wave 2 findings show that approximately half (51% vs. 42% at Wave 1) of smokers have “ever” tried to quit smoking and more than a quarter (27% vs. 23% at Wave 1) plan to quit smoking within the next 6 months – the third-highest percentage among 11 ITC low- and middle-income countries (LMICs). Quit attempts and quit intentions are less likely among smokeless tobacco users – about one-third (34%) of smokeless users have “ever” tried to quit, and only 12% (vs. 8% at Wave 1) of smokeless users plan to quit within the next 6 months.

Zambians are not protected from secondhand smoke in bars and workplaces

Scientific evidence has clearly established the dangers to health from exposure to secondhand smoke (i.e., causes lung cancer and heart disease among non-smokers). Article 8 of the WHO FCTC requires countries to adopt and implement effective measures to provide protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places, and other public places. Although Zambia strengthened legislation to ban smoking in public places in 2008, the Wave 2 Survey shows continuing high rates of exposure to secondhand smoke in bars (74% of tobacco users and 52% of non-users noticed people smoking at last visit) and indoor workplaces (30% of tobacco users and 9% of non-users noticed people smoking in the last 30 days). However, rates of smoking are much lower in restaurants (5% of tobacco users and 3% of non-users noticed people smoking) and on public transport (5% of tobacco users and non-users noticed people smoking). Zambia leads 20 ITC countries in the implementation of complete bans on smoking in the home: at Wave 2, 74% of male smokers and quitters reported that they “never allow” smoking in their home.

Zambia’s single text-only health warning is ineffective

Large pictorial warnings on tobacco packages are a proven no-cost means of informing users about the harms of tobacco use, motivating smokers to quit, and preventing ex-smokers from starting again. Article 11 of the FCTC requires Parties to adopt and implement effective packaging and labelling measures within 3 years of ratification, but Zambia has not yet complied with this requirement. The current single text-only warning covers less than 30% of the bottom front and back of the cigarette package and is only available in English. Among 11 LMICs in the ITC Project, Zambia has the lowest percentage of male smokers and quitters (22%) who “often” or “very often” noticed warnings. In contrast, in Mauritius, where pictorial warnings cover 60% of the front and 70% of the back of the pack, 78% of male smokers noticed the warnings.



40% of Zambian smokers are unable to read the health warning

Zambian tobacco users have low awareness of the harms of tobacco use and secondhand smoke

Article 12 of the FCTC requires Parties to promote and strengthen public awareness of tobacco control issues and to adopt and implement measures to raise public awareness of matters related to tobacco control. The Wave 2 findings suggest an increased presence of anti-smoking information since Wave 1, but also comparatively low awareness of the harms of tobacco relative to other ITC countries. At Wave 2, more than one-quarter of tobacco users noticed anti-tobacco messages on the radio (31%) and on tobacco packages (28%). However, there were no significant increases in knowledge of the harms of smoking among smokers between survey waves. In fact, male smokers and quitters in Zambia have:

- the lowest awareness that smoking causes lung cancer (79% at Wave 2) among 12 ITC countries;
- the third lowest awareness that smoking causes heart disease (74%) among 14 ITC countries;
- the second lowest awareness that smoking causes stroke (45%) among 20 ITC countries;
- the third lowest awareness that secondhand smoke causes heart disease in non-smokers (64%) among 9 LMICs.

Smokeless tobacco users in Zambia also have low awareness of the harms of smokeless tobacco use. About one-third or less of smokeless users were aware that smokeless tobacco causes harm to unborn child (19%), difficulty to open mouth (24%), gum disease (31%), throat cancer (30%), mouth cancer (29%), and heart disease (35%).

The entertainment media is a main source of tobacco promotion

Article 13 of the FCTC obligates Parties to take appropriate measures to ban tobacco advertising, promotion, and sponsorship (TAPS) within 5 years after ratification. However, Zambia has not met the requirement to implement a comprehensive ban on TAPS and continues to allow tobacco advertising through newspapers, radio, television, cinema, billboards, posters, magazines, and videos. Wave 2 findings show that the entertainment media continues to expose about a quarter (22%) of tobacco users to tobacco promotion. Shops and bars are the main venues for tobacco advertising as 15% of tobacco users noticed tobacco product advertising in shop windows or inside shops and 14% noticed advertising in bars.

Hand-rolled cigarettes and singles make smoking affordable for Zambians

Increasing taxes on tobacco products is the single most cost-effective strategy to reduce tobacco use, particularly among youth. Article 6 of the FCTC calls on Parties to adopt and maintain taxation and pricing measures that will contribute to the health objectives aimed at reducing tobacco consumption. At Wave 2, more than half (59% vs. 49% at Wave 1) of Zambian smokers smoked only or mainly factory-made cigarettes, 39% (vs. 48% at Wave 1) smoked only or mainly hand-rolled cigarettes and 2% (vs. 3% at Wave 1) smoked both factory-made and hand-rolled cigarettes equally. The majority (88% vs. 78% at Wave 1) of those who smoke mainly hand-rolled cigarettes said they do so because of price. About half (51% vs. 46% at Wave 1) of smokers stated that their last purchase of cigarettes was loose (single) cigarettes. Price was one of the least mentioned reasons to quit (32% of smokers; 21% of smokeless users at Wave 2) among the twelve reasons given in the survey. ITC cross-country comparisons indicate that of 20 ITC countries, Zambia has the third lowest percentage of male smokers and quitters who reported that price led them to think about quitting “somewhat” or “very much” in the last 6 months. These findings indicate that cigarettes are highly affordable in Zambia and that prices are currently too low to motivate smokers to quit and to prevent youth from starting.

Zambian tobacco users support stronger policies

The Wave 2 Survey findings provide evidence of growing support among Zambian tobacco users for stronger action on tobacco control:

- 95% of tobacco users support a complete smoking ban in restaurants; 86% support a complete smoking ban in workplaces; 70% support a complete ban on smoking in bars;
- 87% of tobacco users “support” or “strongly support” a total ban on tobacco products within 10 years, if the government provided assistance such as cessation clinics;
- 79% of tobacco users (vs. 71% at Wave 1) think that cigarette packages should have more health information;
- 74% of smokers (vs. 56% at Wave 1) support an increase on cigarette taxes;
- 73% of smokers, 62% of smokeless users, and 91% of non-users support a tax increase on hand-rolled tobacco;
- 54% of smokeless users (vs. 37% at Wave 1) support an increase on smokeless tobacco taxes.

Among 20 ITC countries, Zambia has the highest percentage of male smokers and quitters (77%) who think that cigarette packages should have more health information than they do now.

RECOMMENDATIONS

The steps forward for Zambia to meet its obligations under the FCTC and to protect the public from the harms of tobacco are very clear. There is a need to accelerate the implementation of the following recommendations, despite the significant challenges facing policymakers. There is a growing recognition that multisectoral “whole of government” approaches are the best way to realize the full benefits of the FCTC.

1. Increase the price and taxation of tobacco products and ban the sale of single cigarettes.
2. Design and implement pictorial health warnings that occupy at least 50% of the top part of the front and back of tobacco packages as called for in the Article 11 Guidelines.
3. Strengthen the smoke-free law by ensuring strong and consistent enforcement, particularly in bars and indoor workplaces, including strong penalties for violations.
4. Implement a comprehensive ban on tobacco advertising, promotion, and sponsorship of tobacco products, including the entertainment media, with no exceptions.
5. Design and implement health information and mass media campaigns to further educate the public regarding the harms of tobacco and to keep messages salient.
6. Increase government support for cessation services and training of health care workers to strengthen their role in cessation.
7. Ban misleading, false, or deceptive packaging and labelling, including descriptors such as “light”, “mild”, or “low tar”, as well as the display of quantitative or qualitative statements about tobacco constituents and emissions that might imply that one brand is less harmful than another. Consider plain packaging to reduce the appeal of tobacco products.

“This report presents alarming evidence indicating how far Zambia has fallen behind other countries in implementing the FCTC and protecting Zambian people from the harms of tobacco. Without strong implementation of the WHO FCTC across all policy domains, Zambians will not be protected from the devastating health, social, environmental and economic consequences of tobacco use.”

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ITC POLICY EVALUATION PROJECT IN ZAMBIA

The International Tobacco Control Policy Evaluation Project (the ITC Project) is a multi-country prospective cohort study designed to measure the psychosocial and behavioural impact of key policies of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) in 23 countries.

The ITC Zambia Survey is a face-to-face survey of a nationally representative cohort sample of approximately 1,500 tobacco users and 600 non-users. The Wave 1 Survey was conducted between September 7, 2012 and December 20, 2012. Wave 2 was conducted approximately two years later (August 18, 2014 – October 30, 2014). This report presents the results from the most recent wave (Wave 2) of the ITC Zambia Survey and compares progress on tobacco control in Zambia against other ITC countries.

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Zambia 2012-2014

BACKGROUND

The ITC Project Surveys

The International Tobacco Control Policy Evaluation Project (the ITC Project) is the first-ever international cohort study of tobacco use. Its overall objective is to measure the psychosocial and behavioural impact of key national level policies of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC). The ITC Project is a collaborative effort with international health organizations, researchers, and policymakers in more than 20 countries (see back cover) so far, inhabited by more than 50% of the world's population, 60% of the world's smokers, and 70% of the world's tobacco users. In each country, the ITC Project is conducting longitudinal cohort surveys to assess the impact and identify the determinants of effective tobacco control policies in each of the following areas:

- Health warning labels and pack descriptors
- Pricing and taxation of tobacco products
- Tobacco advertising and promotion
- Smoke-free legislation
- Education and support for cessation

ITC surveys evaluate the effectiveness of current policies and provide evidence of successes or the need for stronger action in each of the policy domains. The longitudinal design of the ITC surveys allows for a rigorous evaluation of whether the introduction of new policies such as smoke-free laws or tax increases led to greater impact on tobacco use behaviour. In addition to policy evaluation, the ITC Project is improving the understanding of patterns of tobacco use and cessation over time and across countries, including factors that predict quit attempts and successful quitting. For example, ITC research is evaluating a broad range of influences on cessation such as policy relevant factors, demographic factors, environmental factors, and beliefs and attitudes such as perceived risk, beliefs about the acceptability of smoking and use of other forms of tobacco, and reports of whether significant others are supportive of quitting. Such findings have important implications for the design and implementation of effective individual and population level programs and policies to support cessation.

All ITC surveys are developed using the same conceptual framework and methods, and the survey questions, which include more than 150 questions directly relating to policy impact, are designed to be identical or functionally equivalent across all ITC countries in order to allow strong cross-country comparisons. The ITC Project aims to provide an evidence base to guide policies enacted under the FCTC, and to systematically evaluate the effectiveness of these legislative efforts.

The ITC Zambia Survey

In 2010, the ITC Project at the University of Waterloo, Canada began a partnership with Dr. Fastone Goma and colleagues at the University of Zambia (UNZA), School of Medicine, Zambia, and the Ministry of Health in Zambia. The three organizations began to work together to create the ITC Zambia Project. The ITC Zambia Wave 1 and Wave 2 Surveys, conducted from September to December 2012 (Wave 1) and August to October 2014 (Wave 2), were made possible with funding from the Canadian Institutes of Health Research (CIHR), the Ontario Institute of Cancer Research (OICR), and the U.S. National Cancer Institute (NCI).

This report presents findings from the ITC Zambia Wave 2 Survey of tobacco users and non-users and compares these with findings in more than 20 other ITC countries. The report provides an overall picture of the effectiveness of tobacco control policies in Zambia and identifies several key areas where urgent action to strengthen the implementation of the FCTC is necessary.

The ITC Zambia Survey is a national survey conducted by researchers from the University of Zambia (UNZA) School of Medicine (Lusaka, Zambia) in collaboration with the ITC Zambia Project team centered at the University of Waterloo in Canada. The main objectives of the ITC Zambia Survey are to:

1. Examine the prevalence and patterns of tobacco use behavior in Zambia. The survey provides information about tobacco users' knowledge, beliefs, attitudes, and opinions about using tobacco.
2. Examine the impact of specific tobacco control policies that have been, or will be, implemented in Zambia, on tobacco use and tobacco-related behavior.
3. Compare the psychosocial and behavioural effects of national-level tobacco control policies and programs in Zambia with findings from the other 22 ITC countries.
4. Provide evidence-based recommendations for strengthening tobacco control policies in Zambia.

The ITC Zambia Wave 1 (2012) and Wave 2 (2014) Surveys were conducted after the implementation of several major tobacco control policies in Zambia:

- In 1992, Zambia passed the Public Health (Tobacco) Regulations, which banned smoking in a number of public places, banned sales to minors, and required a single text warning label on tobacco packages.
- On May 23, 2008, Zambia ratified the Framework Convention on Tobacco Control (FCTC).
- In April 2008, the Ministry of Local Government enacted Statutory Instrument No. 39 — a law that extended the smoking ban regulation to all public places, including health-care facilities, educational facilities, public transport, universities, restaurants, and government facilities except for indoor offices. A public awareness campaign about the new law was carried out in May 2009.
- In 2009, the Ministry of Health took further steps to enhance enforcement of the smoke-free law by creating penalties for violation in the form of a fine or up to two years of imprisonment.
- In 2008, the health warning regulation was amended to require the single text warning in English to be placed on both the front and back of pack, in bold letters against a contrasting background (i.e., either black on white, or white on black).
- In 2012, taxes were reduced on the most popular cigarette brand (from 34% in 2008 to 27.6% in 2012 for a pack of 20 cigarettes).

This report presents findings from the ITC Zambia Wave 2 Survey of tobacco users and non-users and compares these with findings in more than 20 other ITC countries. The report provides an overall picture of the effectiveness of tobacco control policies on tobacco users and non-users in Zambia and identifies several key areas where urgent action to strengthen the implementation of the FCTC is necessary.

THE TOBACCO LANDSCAPE IN ZAMBIA

This section provides an overview of tobacco use and tobacco control policies in Zambia up to the time that the ITC Zambia Wave 1 (September 7 to December 20, 2012) and Wave 2 (August 18 to October 30, 2014) Surveys were conducted. Zambia acceded the WHO Framework Convention on Tobacco Control (FCTC) on May 23, 2008 and ratified the treaty on August 21, 2008.¹ The Zambian government had already enacted tobacco control legislation prior to ratifying the FCTC through the National Public Health Act of 1992; however, the Regulations of the 1992 Act remain vague and weakly enforced and do not fulfill Zambia's obligations under the FCTC.

Prevalence of Tobacco Use

The prevalence of smoking in Zambia was first measured in 1998 by the Ministry of Health and Central Statistical Office. At that time it was estimated that smoking prevalence rates were 35.0% for males and 10.0% for females over 18 years of age.² A study by WHO Regional Surveillance System for Tobacco Control in 2001 showed a 5% increase among males (40.0%) and a 3% decrease for females (7.0%).³ The WHO's World Health Survey in 2003 indicated that the prevalence of daily tobacco smokers among males was 14.8% and 3.2% among females.⁴ The 2013-14 Zambia Demographic and Health Survey (ZDHS) conducted by the Ministry of Health and Central Statistical Office found that the tobacco use prevalence (i.e., those who smoke cigarettes, pipe, or use other tobacco products) was 19.3% among males and 1.6% among females aged 15-49 years.⁵ Discrepancies among the various survey results are due to different methodologies used in the surveys, inconsistent age criterion of respondents, and the lack of distinction between "daily" smoker and "current" smoker. The "current" smoker definition includes both those who smoke daily and those who smoke occasionally. The 2001 WHO Regional Surveillance System for Tobacco Control prevalence estimates above seem to report "current" estimates.⁶

According to the 2013-14 ZDHS, tobacco use prevalence among females aged 15-49 years old living in rural areas is higher (1.7%) than among females living in urban areas (1.4%).⁵ Males living in rural areas also had higher tobacco use rates than in urban areas (21.4% vs. 16.9%).⁵ Lower education and lower socioeconomic status were also found to be significant predictors of tobacco use prevalence.⁵

The WHO Global Youth Tobacco Survey (GYTS) was conducted among students aged 13-15 years in four districts in Lusaka province: Lusaka, Kafue, Chongwe, and Luangwa in 2002 and 2007. A national-level GYTS was conducted in Zambia in 2011. The Lusaka 2007 GYTS found that about one-quarter (25.6%) of students currently used any form of tobacco (25.7% boys; 25.6% girls). 6.8% currently smoked cigarettes (6.7% boys; 6.8% girls) and 22.8% currently used some other form of tobacco (22.8% boys; 22.8% girls).⁷

In Kafue in 2007, almost 3 in 10 students (28.8%) currently used any form of tobacco (30.1% boys; 27.8% girls). 8.6% currently smoked cigarettes (11.3% boys; 6.6% girls), while one-quarter (25.1%) currently used other tobacco products (25.6% boys; 24.7% girls).⁷

In Chongwe and Luangwa, almost 3 in 10 students (28.5%) currently used any tobacco products (28.7% boys; 27.7% girls). 12.1% currently smoked cigarettes (14.0% boys; 11.0% girls), while more than 1 in 5 (23.7%) currently used some other form of tobacco (23.6% boys; 23.3% girls).⁷

The national-level GYTS conducted in 2011 found similar results to the 2007 surveys. In 2011, one-quarter (25.6%) of students currently used any form of tobacco (24.9% boys; 25.8% girls). 6.2% of students currently smoked cigarettes (6.2% boys; 5.7% girls), and 24.0% currently used other tobacco products (23.7% boys; 24.2% girls).⁷

Several tobacco control advocacy organizations have recently called attention to the threat of a tobacco epidemic in the African Region and the urgent need for action on tobacco control. It is estimated that without immediate, strong action to implement and enforce tobacco control measures called for in the FCTC, smoking prevalence in the African region will increase by nearly 39% by 2030 – the largest expected regional increase globally.⁸ The Network of African Science Academies warns that while Asia is the epicenter of the current global smoking epidemic, Africa presents the greatest threat with respect to future growth in smoking. Youth smoking looms ominously as smoking prevalence among boys is higher in Africa than in other developing regions and smoking prevalence among African girls is higher than among African women.⁹

Smoke-Free Public Places

Article 8 of the FCTC requires the adoption of effective measures to provide protection from exposure to tobacco smoke. Guidelines for Article 8 of the FCTC, adopted at the Second Conference of the Parties (COP2) in 2007, established the core principles for achieving 100% smoke-free environments, including monitoring and evaluation of enforcement of legislation.¹⁰ Article 8 Guidelines recommend a comprehensive ban on smoking in public places and workplaces, without exemptions.

Although Zambia has national legislation banning smoking in public places under the 1992 Public Health Act, and more recent Local Government Regulations implemented in 2008 aimed at improving enforcement of the ban; the existing laws are not fully compliant with FCTC Article 8 Guidelines and continue to be weakly enforced.

The 1992 Public Health (Tobacco) Regulations (Statutory Instrument No. 163) Section 5 prohibits smoking in nine specified public places: hospitals, health centres, nursing homes, kindergartens and schools for adolescents up to 21 years of age, cinema halls, theatres, elevators, and public transport. The scope of the ban on smoking in public places was broadened in April 2008 when the Ministry of Local Government and Housing enacted Statutory Instrument No. 39, the Local Government (Prohibition of Smoking in Public Places) Regulations.¹¹ Under the new Regulations, the definition of “public places” was expanded to include “any building, premises, conveyance or other place to which the public has access”. The Health Ministry took further steps to enhance enforcement of the law in 2009 by making smoking in public places punishable by a fine of 400 Zambian Kwacha (ZMW) (approximately USD \$32) or up to two years of imprisonment. However, the enforcement of the smoke-free law has remained weak.⁶

In 2009, the Zambia Tobacco Control Campaign (ZTCC) launched a smoke-free campaign in the capital city of Lusaka. The purpose of the campaign was to raise awareness of the smoke-free law through various activities and events, and increase enforcement and compliance with the law. While there has been no clear evidence of improved compliance with smoke-free legislation resulting from the campaign, it has received enormous support and interest, even from many of the highest level officials in Lusaka, and campaign efforts are ongoing.¹²

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In addition to the ongoing smoke-free campaign in Lusaka, recent national efforts have been made to improve enforcement of existing smoke-free legislation, as well as to pursue new comprehensive smoke-free laws under a Comprehensive National Tobacco Products Act that would be fully compliant with the FCTC Guidelines. The ITC Zambia Wave 1 National Report was launched in Lusaka on World No Tobacco Day (WNTD) 30 May 2014 by Dr. Joseph Kasonde, the Honorable Minister of Health. Dr. Kasonde made a statement regarding the Zambian Government's commitment to oblige to the implementation of the FCTC recommendations (including smoke-free environments). However, to date, follow up and enforcement remains weak.

Packaging and Labelling of Tobacco Products

Article 11 of the FCTC states that each Party shall adopt and implement effective packaging and labelling measures and calls for specific requirements on the content, position, and size of the health warnings. Article 11 states that health warnings shall be rotating, large, clear, visible, and legible; should not use misleading descriptors such as “light” and “low tar”; and shall be in the country's principal language. Article 11 Guidelines adopted in November 2008 further state that warnings should include graphic images, cover at least 50% of the front and back of the pack, and include two or more sets of rotating warnings with a range of messages.¹⁰

Article 11 states that all Parties must adopt health warning measures within 3 years of entry into force. For Zambia, the timeframe for the adoption of Article 11 measures was August 21, 2011. It has now been 7 years since Zambia ratified the FCTC, and the government still has not introduced health warnings on tobacco packages that meet the requirements of the treaty.

Health warnings were introduced on tobacco packages in Zambia in January 1993 under the 1992 Public Health (Tobacco) Regulations. The legislation requires all tobacco packages to be clearly labelled with the following single text warning: “Warning: Tobacco is Harmful to Health”. The law was amended in 2008 through the Local Government Statutory Instrument #39 to further require the warning to appear on both sides of the larger surface area of the package (i.e. the front and back), in bold letters against a contrasting background (i.e., either black on white, or white on black), and not in a place where there is a risk of being damaged when the package is opened, or on any wrapping or paper outside the package itself.

The existing legislation fails to meet the Article 11 requirements on several points (see Table 1): it does not mandate a minimum size or position for warnings; there are no actual language regulations for the health warnings — the single text-only warning appears only in English, which is the official language of communication and instruction in Zambia, but is used by only 1.7% of the population according to the 2010 census. There are seven main local languages of which the three most widely used are Bemba, Nyanja, and Tonga.¹³ There are currently no requirements for pictorial warnings, and the single text-only warning does not meet the rotation requirement of the FCTC.

Another area where Zambia has not met its requirements under Article 11 is banning the use of false, misleading or deceptive terms such as “light”, “mild”, or “low tar” on tobacco packages. There is currently no ban on the use of these terms.

In May 2014, the Zambia Tobacco Control Consortium met to discuss how they could translate or operationalize the 8 key recommendations from the ITC Zambia Wave 1 National Report to strengthen tobacco control policies in Zambia. The team chose to focus on the implementation of pictorial health warnings to replace the current ineffective single text-only health warning. In response to their suggestion, an evidence-based health warning brief titled “Pictorial Tobacco Health Warnings for Zambia: Recommendations for Action” was written and presented to the Minister of Health on August 20, 2014. This brief provides a call to action for the Zambian Government to implement a Statutory Instrument (SI) to introduce large, frequently rotated pictorial warnings that cover a minimum of 50% of the top of the front and the back of cigarette and smokeless tobacco packages as recommended by the WHO FCTC Article 11 Guidelines.

Table 1. Summary of Zambia’s current health warnings with respect to WHO FCTC Article 11 requirements and Guidelines

Are Zambia’s current warnings meeting the requirements of WHO FCTC Article 11 and in line with the Article 11 Guidelines?		
	YES	NO
WHO FCTC Article 11 Requirements		
Shall be rotating		X There is only one text-only warning.
Shall be large, clear, visible, and legible.		X The text warning is required to be printed on the front and back of the pack in bold letters against a contrasting background (i.e., either black on white, or white on black), and not in a place where there is a risk of being damaged when the package is opened, or on any wrapping or paper outside the package itself.
Should be 50% or more of the principal display areas but no less than 30%.		X There is no minimum warning size specified in the legislation.
May be in the form of or include pictures or pictograms.		X The warning is text-only.
Shall require warnings and other textual information in its principal language.		X There are no language requirements. The warning is in English only.
Article 11 Guidelines for maximizing effectiveness of warning labels		
Should appear on both front and back of pack.	√ The text-only warning is on both the front and back of the pack.	
Should be at the top of the pack.		X The warning is at the bottom of the pack.
Should include full-colour pictures.		X The warning is text-only.
Should include a range of warnings and messages.		X The warning includes only one message “Warning: Tobacco is Harmful to Health”
Should provide advice about cessation.		X The warning does not include information about where or how to get help to quit.

To improve the implementation and enforcement of smoke-free laws, UNZA, ZACA, and the Ministry of Health collaborated in the formation of the Zambia Tobacco Control Campaign (ZTCC).

Education, Communication, and Public Awareness

Article 12 of the FCTC calls for Parties to promote and strengthen public awareness of tobacco control issues through education and public awareness programs on the health risks of tobacco consumption and the benefits of cessation, and provide public access to information on the tobacco industry.

Multiple civil society organizations have been actively involved in the tobacco control movement in Zambia.¹² The Zambia Consumer Association (ZACA) (<http://www.consumerzambia.com>), established in 2000, is a consumer advocacy organization that works in collaboration with national regulatory bodies to monitor and address consumer complaints. With support from international organizations including the Bloomberg Initiative's Campaign for Tobacco-Free Kids (CTFK), ZACA played a critical role in Zambia's ratification of the FCTC in 2008. Increasing awareness and educating the public on the consequences of tobacco use remains a critical objective of their campaign. The Zambia Anti-Smoking Society (ZASS) also played an instrumental role in working with the Ministry of Health to instigate the ratification of the FCTC, and remains an active partner in tobacco control lobby groups.

The Tobacco Free Association of Zambia (TOFAZA) is another leading anti-smoking group that regularly collaborates with the private and public sector of agriculture, including agricultural research organizations and the Ministry of Agriculture. TOFAZA has mostly been involved in lobbying activities as well as research, data analyses, and scientific dissemination of information. Since 2012, they have participated in several awareness and advocacy campaigns in Lusaka (George, Chawama and Kabanana compounds; Katuba Rural Community, Lilanda), Eastern Province (Chipata district), Southern Province (Kalomo district), and Central Province (Kabwe district). They also urged the government (i.e., news articles in the Daily Nation dated August 27, 2014 and March 2, 2015) to raise taxes on tobacco products in response to the WNTD 2014 theme (Raise Taxes).

The Mental Health Association of Zambia (MHAZ) and the University of Zambia (UNZA) have also contributed to tobacco control efforts by helping with cessation programs and providing evidence-based tobacco control research to inform campaigns.

To improve the implementation and enforcement of smoke-free laws, UNZA, ZACA, and the Ministry of Health collaborated in the formation of the Zambia Tobacco Control Campaign (ZTCC). The ZTCC consists of non-governmental organizations (NGOs), policymakers, researchers, and other tobacco control interest groups, particularly those involved in increasing public education and awareness about the dangers of tobacco use. These organizations have also played an important role in building research capacity to inform stronger tobacco control efforts in Zambia.

Tobacco Advertising, Promotion, and Sponsorship

Article 13 of the FCTC calls for Parties to implement effective measures against tobacco advertising, promotion, and sponsorship. Guidelines for Article 13 recommend a comprehensive ban on tobacco advertising, promotion, and sponsorship (or apply restrictions that are as comprehensive as possible). Included among the recommended measures are bans on: cross-border advertising, promotion and sponsorship; display of tobacco products at point of sale; tobacco product vending machines; internet sales; and attractive packaging and product features.¹⁰

In 1992, Zambia passed several tobacco-related bills under The Public Health (Tobacco) Regulations. Policies included provisions that prohibited the direct or indirect encouragement of tobacco use by commercial advertising.¹⁴ However, the 1992 regulations permit the advertising of tobacco products to the general public through newspapers, radio, television, cinemas, billboards, posters, magazines, and videos if the following is provided:

- The name and address of the manufacturer, importer, or distributor;
- The name and nature of the product;
- The brand and its symbol;
- The tar and nicotine levels; and
- Information on the price and quantity.

In other words, the regulations allow the industry to use mass media to promote their products with few restrictions. Ironically, tar and nicotine levels, which have been proven to have little validity with respect to actual uptake of harmful smoke by smokers, have been used by tobacco companies to market “light” and “low tar” brands to smokers as less harmful choices, when in fact there is no evidence that such brands are indeed less harmful. Requiring the industry to list tar and nicotine levels actually perpetuates the myth of “light/mild” cigarettes.

Additional regulations require advertisements in the form of a poster or a billboard to be no larger than nine square meters in surface area and limit one poster per brand. Newspaper advertisements are limited to half a page and periodical advertisements are restricted to one page. All oral or television advertisements must be followed by clearly audible or legible warnings.

Although the 1992 Public Health (Tobacco) Regulations prohibit the provision of any form of tobacco product as a prize, the tobacco industry has a strong presence in Zambia through sponsorship activities. British American Tobacco (BAT), in particular, is active in “Corporate Social Responsibility” activities in the country. For example, BAT remains actively involved among Zambia’s youth by interacting directly with schools through donations and sponsoring interscholastic trophies for athletic competitions.¹² Given the broad parameters of Zambia’s regulations, compliance with FCTC Article 13 remains poor. Despite the statements made by the Minister of Health at the 2013 WNTD, there have not been any deliberate efforts to implement a comprehensive ban on tobacco advertising, promotion, and sponsorship in Zambia.

Pricing and Taxation of Tobacco Products

Increasing taxes on tobacco products is considered to be the most effective component of a comprehensive tobacco control strategy.^{15, 16} Numerous economic studies from high-income countries have shown that in general a 10% increase in retail price leads to about a 4% decrease in tobacco consumption, with about half of that due to lower prevalence.¹⁷ There is evidence that the decrease in consumption could be even higher in LMICs.¹⁸ Therefore, if taxes are increased on tobacco products, to the extent that it is passed on as an increase in retail price, this could result in substantial reductions in tobacco prevalence and consumption. At the same time, because the relation between price and demand (i.e., consumption) of tobacco products is relatively inelastic (the percentage reduction in consumption resulting from a 1% increase in price is less than 1%), this means that an increase in tax and price will lead to increases in tobacco tax revenue at the same time as it leads to decreases in tobacco use. In this way, increasing taxes on tobacco products represents a “win-win” situation – achieving health goals of reducing tobacco use while also increasing tax revenue.

Article 6 of the FCTC obligates countries that have ratified the treaty to adopt tax and price policies aimed at reducing tobacco consumption.¹⁹ Guidelines for effective implementation of Article 6 were adopted by the Parties in 2014. The Guidelines recommend using the simplest and most efficient tax system, considering specific or mixed excise systems over ad valorem systems, monitoring tax rates regularly to account for inflation and income growth, taxing all tobacco products in a comparable way to minimize shifts to cheaper products, dedicating tax revenue to tobacco control programmes, and considering sales restrictions and limitations on international travelers importing tax and duty-free tobacco products.²⁰

Although nominal cigarette prices in Zambia have been increasing over the last decade, price adjustments have not kept in line with increases in inflation and income, and cigarettes have therefore become more affordable over the last 10 years. Affordability is expected to increase even further over the next decade (2011-2020) if significant tobacco control interventions are not initiated.²¹ Unfortunately, taxation as a tobacco control strategy in Zambia is almost non-existent, with low taxes on tobacco products, and no mention of tax measures in current tobacco control legislation. Cigarette excise taxes were only adjusted three times in the last decade, one of which was a decrease in taxes.^{12, 21}

In addition, Zambia has not banned the sale of loose (single) cigarettes, resulting in frequent purchases of cigarettes by the stick. A study published using ITC Zambia Wave 1 data reported that the majority of factory-made cigarette smokers (90%) last purchased their cigarettes as a single stick, and that smokers purchasing single cigarettes seem to be paying a similar price per stick as those who are purchasing by the pack.²²

There are currently three types of taxes that apply to cigarettes in Zambia: import duty, excise taxes, and Value Added Tax (VAT). The import duty of 25% of the Cost, Insurance, and Freight (CIF) value only applies to cigarettes from a country which Zambia does not have a free trade agreement. But since over 90% of Zambia's imported cigarettes come from Kenya (which they have an agreement with), the import duty is effectively zero. The VAT that applies to all goods and services in Zambia, including cigarettes, is 17.5%. Finally, excise taxes consist of both an ad valorem and a specific excise tax, though only the higher of the two is applied. According to calculations by Chelwa (2012), the total cigarette excise tax for consumers is at least 21% of the retail price, and total taxes (excise taxes plus VAT) are 36% of the price. This makes Zambia's tobacco tax rates one of the lowest in the African region.²¹ The use of ad valorem taxes in Zambia results in significant price differentials between brands of cigarettes, which is why WHO recommends the use of specific excise taxes to reduce the gap between brands and discourage switching to cheaper alternatives.²²

One of the suggested evidence-based recommendations from the 2012 ITC Zambia Wave 1 findings was to urge the Zambian government to increase the price and taxation of tobacco products in order to reduce tobacco use in Zambia, especially among the youth. However, there has not been any particular effort made to implement this recommendation in the last 2 years.³⁸

Taxation as a tobacco control strategy in Zambia is almost non-existent, with low taxes on tobacco products, and no mention of tax measures in current tobacco control legislation.

Cessation

Compared to high-income countries, the rates of smokers who want to quit and who actually try to quit are lower in LMICs; therefore, it is even more urgent for governments in LMICs to provide assistance to smokers to help them quit.^{23, 24}

Article 14 of the FCTC obligates Parties to take effective measures to promote cessation of tobacco use and provide adequate treatment for tobacco dependence. Guidelines for Article 14 recommend a broad range of cessation interventions including population-based approaches that have wide reach (mass communication, brief advice, and quitlines) and, where resources permit, more intensive individual approaches (specialized treatment services like behavioural support and medications). Recognizing that LMICs will not have the resources to implement a comprehensive cessation strategy, the Guidelines outline a “stepwise approach” to building infrastructure for cessation and treatment for tobacco dependence.¹⁰

A comprehensive cessation program has not yet been developed in Zambia. According to WHO data as of 2014, there are currently no cessation services offered in most public healthcare facilities in Zambia, although some cessation support is available through health professionals.²⁵ Nicotine replacement therapies (NRT), as well as bupropion and varenicline, are available from private pharmacies with a prescription, but they are not covered by national health insurance and thus many smokers cannot afford them. There is also no national toll-free quitline available specifically for smokers who want help to quit in Zambia.

A comprehensive cessation program has not yet been developed in Zambia. There are currently no cessation services offered in most public healthcare facilities in Zambia, although some cessation support is available through health professionals.

ITC SURVEY METHODS

Overview

The International Tobacco Control Policy Evaluation Project (the ITC Project) is an international research collaboration across 23 countries – Canada, United States, United Kingdom, Australia, Ireland, Thailand, Malaysia, Republic of Korea, China, Mexico, Uruguay, New Zealand, France, Germany, the Netherlands, Bhutan, Mauritius, Brazil, India, Bangladesh, Kenya, Zambia, and United Arab Emirates.

The primary objective of the ITC Project is to conduct rigorous evaluation of the psychosocial and behavioural effects of national-level tobacco control policies of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC). The ITC Project is conducting large-scale annual prospective cohort surveys of tobacco use to evaluate FCTC policies in countries inhabited by over 50% of the world's population, over 60% of the world's smokers, and over 70% of the world's tobacco users. The ITC Survey includes key measures for each FCTC policy domain that are identical or functionally similar across ITC countries to facilitate cross-country comparisons. The evaluation studies conducted from the ITC Surveys take advantage of natural experiments created when an ITC country implements a policy: changes in policy-relevant variables in that country from pre- to post-policy survey waves can be compared to other ITC countries where that policy has not changed. This research design provides high levels of internal validity, allowing more confident judgments regarding the possible causal impact of the policy. For a description of the conceptual model and objectives of the ITC Project, see Fong et al. (2006)²⁶; for a description of the survey methods, see Thompson et al. (2006).²⁷



The ITC Zambia Survey

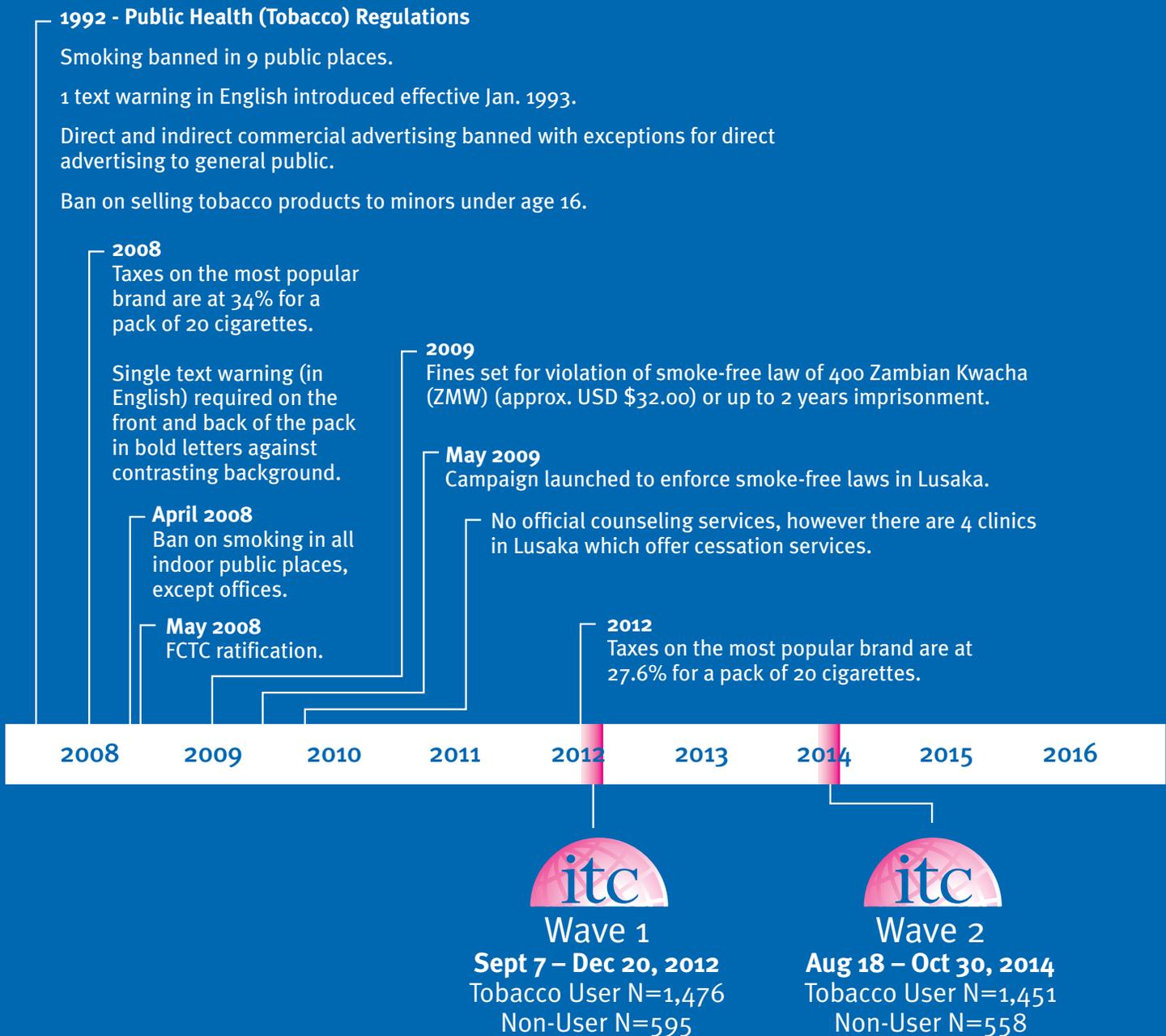
The International Tobacco Control Policy Evaluation Project in Zambia (the ITC Zambia Survey) was created in 2012 as a system for evaluating the psychosocial and behavioural effects of tobacco control legislation in Zambia, using methods that the ITC Project has employed in many other countries. The project objective was to provide an evidence base to guide policies enacted under the FCTC and to systematically evaluate the effectiveness of these legislative efforts. As with all ITC surveys, the ITC Zambia Survey was tailored for the tobacco control environment in the country.

Figure 1 provides an overview of the ITC Zambia Survey dates in relation to the implementation of tobacco control policies in Zambia.

Sampling Design

The ITC Zambia Survey is a nationally representative probability sample of tobacco users and non-users of tobacco selected through a multi-stage clustered sampling design. Specifically, the design was stratified by province and sampled a total of 150 clusters/enumeration areas (EAs), allocated to the provinces in numbers proportional to population size (see Table 2). Design calculations were based on 2010 census data. Within each EA, approximately 10 tobacco users and 4 non-users of tobacco were interviewed. At Wave 1, approximately 70 households in each EA were enumerated to attain 10 tobacco users.

Figure 1. Zambia's tobacco control policy timeline in relation to the ITC Zambia Surveys



In each of the 10 provinces in Zambia, two districts were sampled with inclusion probability proportional to size. Within each district, two wards were sampled except in the large Lusaka ward (the capital) in which four wards were sampled. Therefore, the total number of wards sampled was 42 (see Table 2). Within the two districts of a province, an equal number of wards (except for rounding) were sampled with inclusion probability proportional to size. Within each ward, clusters/EAs were sampled with inclusion probability proportional to size. Depending on the size of the province, the number of clusters/EAs ranged from two to six (two was a lower bound constraint).

The sample scheme was slightly changed in Lusaka province because Lusaka district, the capital, made up more than half of the population. Out of the four districts in this province, Lusaka district was purposively sampled and one additional district of the remaining three was also sampled.

Table 2. Sampling design for the ITC Zambia Wave 2 Survey

Province	Districts sampled	District	Wards sampled	Clusters sampled
Central	2	Chibombo	2	15
		Kabwe	2	
Copperbelt	2	Kitwe	2	21
		Mufulira	2	
Eastern	2	Chipata	2	18
		Petauke	2	
Luapula	2	Kawambwa	2	11
		Samfya	2	
Lusaka	2	Chongwe	2	26
		Lusaka	4	
Muchinga	2	Chinsali	2	8
		Mafinga	2	
Northern	2	Kasama	2	12
		Mungwi	2	
Northwestern	2	Mufumbwe	2	8
		Solwezi	2	
Southern	2	Kalomo	2	18
		Namwala	2	
Western	2	Kalabo	2	10
		Shang'ombo	2	
TOTAL	20		42	147

At Wave 1, a total of 2,299 households randomly selected from 151 Enumeration Areas (EAs) were enumerated to establish an accurate sampling frame from which survey participants were randomly drawn. In Wave 1, a total of 1,476 tobacco users and 595 non-users of tobacco aged 15 and older were surveyed via face-to-face interviews. For the Wave 2 Survey, the sample constructed in Wave 1 was re-contacted for participation in Wave 2. Respondents lost to follow-up at Wave 2 were replaced by adults of the same tobacco use status in newly enumerated households, within the same EA, sampled using the same procedure as in Wave 1. In Wave 2, 775 tobacco users, 136 quitters and 365 non-users were re-contacted (retention rate of 61.3% for tobacco users and 62.4% for non-users). This retention rate is low among longitudinal cohort surveys (on average, retention rates of ITC Surveys are between 70% and 80%). To replace those tobacco users and non-users who could not be reached at Wave 2, 1,995 new households were enumerated at Wave 2 and two additional EAs were added to the sampling frame. From these new households, 540 new tobacco users and 193 new non-users were randomly selected for participation at Wave 2. As such, 36.5% of the Wave 2 sample was generated by replenishment. This resulted in a total sample of 1,451 tobacco users and 558 non-users.

Further information on the Wave 1 and Wave 2 sampling design, construction of sampling weights, and retention rates is provided in the ITC Zambia Wave 2 Technical Report at <http://www.itcproject.org/countries/zambia>.²⁸

Characteristics of the Wave 1 and 2 Sample

Table 3 presents the demographic characteristics of the Wave 1 and 2 ITC Zambia Survey respondents.

Table 3. Demographic characteristics of the ITC Zambia Wave 1 and 2 Survey respondents

	Wave 1 (N=2,071)		Wave 2 (N=2,009)	
	N	%	N	%
Gender				
Male	1,491	72.0	1,438	71.6
Female	580	28.0	381	28.4
Age Group				
15-17	53	2.6	43	2.1
18-24	308	14.9	257	12.8
25-39	820	39.6	778	38.7
40-54	468	22.6	506	25.2
55+	422	20.4	425	21.5
Household Income (Income groups, using World Bank definitions of income)				
Low	1,084	52.3	878	43.7
Moderate	278	13.4	222	11.1
High	421	20.3	712	35.4
Non-response	288	13.9	197	9.8
Education Level				
Low (illiterate/< primary)	295	14.2	293	14.6
Moderate (some/completed primary)	1,039	50.2	997	49.6
High (secondary or higher)	720	34.8	712	35.4
Non-response	17	0.8	7	0.4
Marital Status				
Married	1,335	65.2	1341	66.8
Divorced or Separated	137	6.7	142	7.1
Widowed	146	7.1	162	8.1
Single	427	20.9	362	18.0
Non-response	1	0.1	2	0.1
Religion				
Roman Catholic	541	26.1	513	25.5
Protestant/Other Christian	1,375	66.4	1,372	68.3
Muslim	4	0.2	3	0.2
Hindu	1	0.1	1	0.1
Buddhist	0	0	1	0.1
No Religion	106	5.1	103	5.1
Other	23	1.1	8	0.4
Non-response	21	1.0	8	0.4

Content of the ITC Zambia Survey

The ITC Zambia questionnaire was developed by an international transdisciplinary team of tobacco control experts. Most of the survey methods and virtually all of the survey items were taken from the standardized protocols used in ITC nation-wide surveys conducted in more than 20 countries around the world. The questionnaires were adapted by the ITC Zambia and Waterloo teams to ensure that they were relevant to the Zambian context.

For the purposes of the ITC Zambia Survey, tobacco users were divided into three categories, each of whom received a different survey:

- **Cigarette smokers:** adult respondents who currently smoke cigarettes at least once a month but do not use smokeless tobacco products at least once a month.
- **Smokeless tobacco users:** adult respondents who currently use any smokeless tobacco products at least once a month but do not smoke at least once a month
- **Mixed tobacco users:** adult respondents who currently smoke cigarettes and use smokeless tobacco products at least once a month.

A non-user of tobacco was defined as respondents who do not currently smoke cigarettes or use smokeless tobacco at least once a month.

In the ITC Zambia Survey, each participant who was categorized as a tobacco user responded to the following types of questions:

1. **Tobacco use behaviour and cessation questions** i.e., past and present use of smoked and smokeless tobacco products, tobacco dependence, cigarette/smokeless brand choice and purchasing, and quitting behaviours and use of cessation assistance.
2. **Knowledge and basic beliefs about smoking** i.e., knowledge of the health effects of smoking/smokeless tobacco use and important beliefs relevant to smoking/smokeless tobacco use and quitting, perceived risk and perceived severity of tobacco-related diseases.
3. **Policy-relevant questions** i.e., awareness of, impact of, and beliefs relevant for each of the FCTC demand reduction policy domains (warning labels, taxation/price, advertising/promotion, light/mild, and smoke-free policies).
4. **Other important psychosocial predictors** of smoking behaviour/use of smokeless tobacco products and potential moderator variables (e.g., normative beliefs, self-efficacy, intentions to quit).
5. **Individual difference variables** relevant to smoking/use of smokeless products (e.g., depression, stress, time perspective).
6. **Demographics** e.g., age, gender, marital status, education, occupation.

Respondents who were categorized as non-users of tobacco were asked to respond to similar survey items, with the exception of the smoking- and cessation-relevant questions. The phrasing of questions was revised as where necessary for the non-user context.

In addition, each head of the household also responded to questions relevant to:

1. **Tobacco cultivation** i.e., involvement in tobacco farming, tobacco leaves price, profits/losses, tobacco farming related loans, switching to alternative crops or livelihood, and awareness of government support to facilitate switching from tobacco farming to other crops;
2. **Wealth index** i.e., assets and livestock/poultry owned by the household;
3. **Income and expenditures** i.e., monthly household income, household expenditures and purchases.

The ITC Zambia Wave 1 and 2 Survey fieldwork was conducted by trained bilingual field interviewers from the University of Zambia, School of Medicine. The Surveys were first developed in English and then translated into five local languages (Bemba, Nyanja, Kaonde, Tonga and Lozi). The average length of time required for respondents to complete the Wave 1 and 2 Surveys was 60 minutes for tobacco users and 30 minutes for non-users of tobacco. Full copies of the questionnaires are available on the ITC Project website at www.itcproject.org/surveys.

Data Processing, Security and Cleaning Procedures

Following data collection, the ITC Zambia Survey data were manually entered into computer files using the freely available EpiData software (<http://www.epidata.dk/>). Data entry templates were programmed by an ITC programmer at the University of Waterloo and reviewed by the in-country data manager. Data entry templates were programmed to ensure correct skip patterns were followed and to prevent data entry clerks from entering invalid values.

Data entry was performed by two separate data entry clerks. Each clerk entered the data once. Such duplicate data entry helped minimize data entry errors since it is unlikely that two different people will make the same data entry error for a given value. Once the double data entry was completed by the in-country data clerks, the data files were transferred securely to the University of Waterloo using ITC's secure internal website, which can only be accessed by users who have an account on the website. To maintain security, data files are encrypted prior to uploading them to the website as an extra security measure.

After the data were successfully transferred, the University of Waterloo data analyst commenced data cleaning. The data analyst conducted duplicate entry comparisons of the data files, using the SAS statistical software and identified discrepancies between the two data files. A list of these discrepancies was sent to the in-country data manager for verification and correction. The in-country data manager sent the corrections to the University of Waterloo data analyst for verification.

After discrepancies had been identified and corrections sent by the in-country data manager, the University of Waterloo data analyst conducted additional checks on the data to ensure that all skip patterns had been correctly followed and to ensure that the data did not contain invalid values. Respondent identifier codes were also checked thoroughly to ensure the data could be correctly linked within a survey wave and between waves over time. Any additional discrepancies that were identified were also sent back to the in-country data manager for verification. This back and forth communication between the University of Waterloo data analyst and the in-country data manager continued until the data were deemed clean by the University of Waterloo data analyst.

Following data processing and cleaning, sampling weights were constructed for the dataset and the cleaned datasets were released to the country team, by posting them on the secure internal ITC website. The University of Waterloo data analyst used the cleaned weighted data to conduct analyses for this national report.

Analytic Approach

The ITC Zambia Wave 1 and Wave 2 Surveys employed a stratified multistage cluster sampling design. To adjust for potential disproportionate selection of adult tobacco users and non-users in sub-groups, enumeration and survey weights were computed for each enumerated household and survey respondent. Estimates of descriptive statistics (i.e., means and proportions) reported here are derived from the survey samples weighted by the cross-sectional sampling weight, unless stated otherwise. The sampling weight for a given respondent is interpreted as the number of people in the population represented by that respondent.

To accommodate potential design effects arising from the complex sampling strategy, the sampling weight is used in conjunction with the design information (i.e., sampling strata defined by provinces and primary sampling units defined by wards) to estimate means and proportions. Standard errors and 95% confidence intervals for the descriptive statistics also accounted for the design effect. Differences in estimated proportions between waves were tested using logistic regression models appropriate for complex survey data. Estimated proportions having wide confidence intervals are due to small sample sizes and should be interpreted with caution.

Similarly, since country samples vary in their composition, survey logistic regression models were used to estimate standardized or adjusted descriptive statistics (proportions) in cross-country comparisons. For the cross-country comparisons, age group, smoking status, and time-in-sample were included in the model as covariates. Time-in-sample represents the number of times a respondent has participated in the survey and controls for the variation in responses among respondents who were newly recruited compared to those who completed one prior wave, who vary from those who completed two waves and so on. These documented “time-in-sample” effects have been found in other surveys including other ITC Surveys.²⁹⁻³³

It should also be noted that the percentages for Zambia presented in cross-country comparisons may vary slightly from the Wave 2 Survey results provided in the text, due to differences in adjustment methods.

In particular, if the same measures were asked in both waves and those outcomes were dichotomous, then complex survey logistic regression models were estimated to produce adjusted proportions for each wave of the ITC Zambia Survey. Adjusted proportions predicted from the regression models controlled for several confounding factors, including sex, age group, city, smoking status, survey wave and time-in-sample. For continuous outcomes (e.g., cigarettes smoked per day), complex survey linear regression models were estimated to produce adjusted means across waves of the ITC Zambia Survey. Such regression-based adjustments are analogous to direct standardization methods used in epidemiology and demography for comparing mortality rates in different populations.

Note that any adjusted means and percentages depend on the set of covariates included in the regression models. Unless otherwise indicated, adjusted estimates controlled for gender, age group, smoking status (daily smoker, nondaily smoker, and quitter, if appropriate), wave, and time-in-sample. These adjusted estimates are generically referred to as “adjusted for time-in-sample” throughout this report. Adjusted estimates are shown in figures illustrating changes between waves unless otherwise indicated. SAS 9.3 and SUDAAN 10.0 and 11.0 were used to estimate both unadjusted and adjusted means and percentages.

For cross-country comparisons, the same type of adjustment was applied because the composition of the sample of smokers also varied across ITC countries. Multi-country comparisons are based on smokers and quitters where relevant and control for differences in age, gender, smoking status (daily vs. non-daily smokers), and time-in-sample. Unless otherwise noted, cross-country comparisons presented in this report are based on male smokers only. It should also be noted that adjusted percentages for Zambia presented in cross-country comparisons may vary slightly from the Wave 2 Survey results provided for the same measures due to differences in adjustment methods.

FINDINGS

TOBACCO USE BEHAVIOUR AND BELIEFS

The ITC Zambia Wave 1 (2012) and Wave 2 (2014) Survey findings presented in this section provide an assessment of tobacco use and consumption patterns, and beliefs and attitudes towards tobacco use and tobacco companies among a nationally representative sample of Zambian tobacco users aged 15 years and older.

Prevalence of Tobacco Use

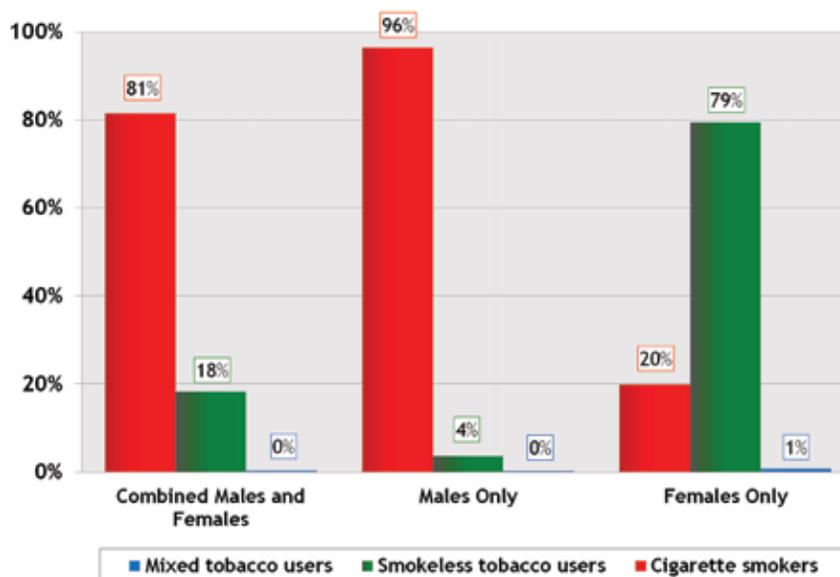
Tobacco is the single most preventable cause of death globally, killing about 6 million people each year³⁴ with 600,000 of these deaths resulting from exposure to secondhand tobacco smoke. More alarming is that 80% of these deaths are occurring in LMICs.¹⁷ There is a scarcity of tobacco use prevalence data in many African countries, including Zambia. The most recent 2013-14 Zambia Demographic Health Survey (ZDHS) reported that 20% of men and 2% of women aged 15-49 years smoked cigarettes, a pipe, or used other tobacco products.⁵

The ITC Zambia Wave 2 (2014) Survey found that 13.2% of adults (23.6% of men and 3.3% of women) aged 15-49 in Zambia use tobacco products. This estimate is based on the enumeration data collected at Wave 2 and the enumerated household sampling weights. These data suggest that current tobacco use prevalence among both men and women may be higher than the estimates reported in the Demographic Health Survey; however, caution must be taken when making prevalence comparisons with other national surveys because of differences in survey methodologies, small sample sizes, and cluster sampling.

Types of Tobacco Use

The ITC Zambia Wave 2 findings showed that most tobacco users in Zambia were cigarette smokers (81%), while 18% were smokeless tobacco only users (i.e. oral snuff, nasal snuff, and Kuber), and less than 1% (n=4) were mixed tobacco users (i.e. currently use both smoked and smokeless tobacco). However, the type of tobacco product used differs between men and women: almost all (96%) Zambian male tobacco users smoked cigarettes, while smokeless tobacco products were used by the majority (79%) of female tobacco users (see Figure 2).

Figure 2. Type of tobacco users in Zambia at Wave 2, by gender

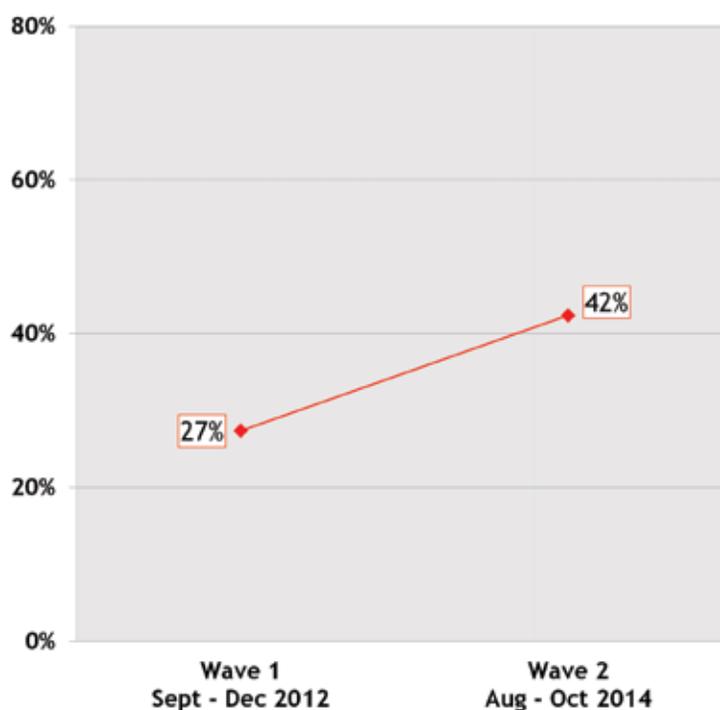


Cigarette Consumption

At Wave 2, the majority (87% vs. 86% at Wave 1) of smokersⁱ reported that they smoked cigarettes daily or almost daily. They smoked an average of 7.8 cigarettes per day (vs. 7.0 at Wave 1).

Among smokers who had a usual brand of cigarettes (65% of smokers), 42% (vs. 27% at Wave 1) reported that their usual cigarette brand was menthol flavoured (including menthol, export menthol, or sweet menthol) (see Figure 3). Cross-country comparisons of these findings with other ITC countries where the survey specifically asked about menthol use among those who have a regular brand indicate that Zambia has the highest percentage of male smokers who smoke menthol cigarettes (40%) among male smokers in 19 ITC countries (see Figure 4).

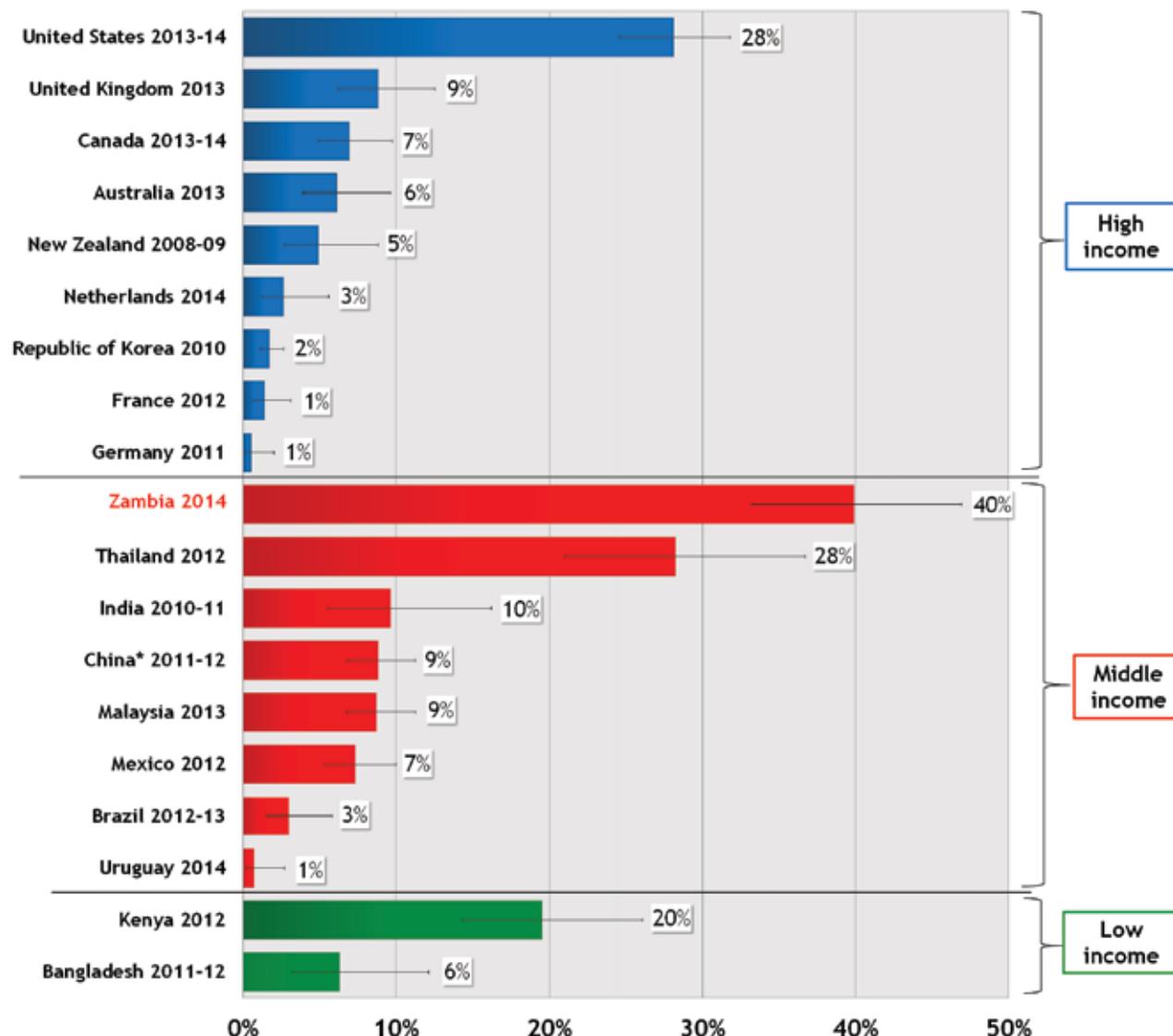
Figure 3. Percentage of smokers who usually smoke menthol cigarettes, among smokers with a usual brand, by wave



Zambia has the highest percentage of male smokers who smoke menthol cigarettes among male smokers in 19 ITC countries.

i. In this report “smokers” include those who currently smoke cigarettes (and may also smoke other tobacco products such as bidis or pipes), as well as “mixed users” (those who smoke both smoked and smokeless products), unless otherwise stated. “Smokeless users” include those who currently only use smokeless tobacco products, as well as mixed users, unless otherwise stated.

Figure 4. Percentage of male smokers[†] who reported smoking menthol cigarettes among those who have a regular brand[‡], by country



[†] 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

[‡] In United States, United Kingdom, Canada, Australia, and Mexico, results were calculated among all smokers, not just those who have a regular brand.

^{*} In China, the question asked about the brand the respondent reported smoking most often in the last month.

Use of Other Tobacco Products

Overall, the use of other smoked tobacco products is low in Zambia. At Wave 2, the most common smoked tobacco product other than cigarettes was cigars: 8.5% (vs. 10.7% at Wave 1) of all survey respondents reported that they currently smoked cigars at least once a month or less than once a month. Few respondents reported smoking other tobacco products at least once a month or less than once a month: bidis (1.3% vs. 1.6% at Wave 1), pipe (1.3% vs. 2.0% at Wave 1), cigarillos (0.7% vs. 2.5% at Wave 1), Hookah (1.0% vs. 1.9% at Wave 1), Kreteks (0.7% vs. 2.2% at Wave 1), and Cheroots (0.7% vs. 2.0% at Wave 1).

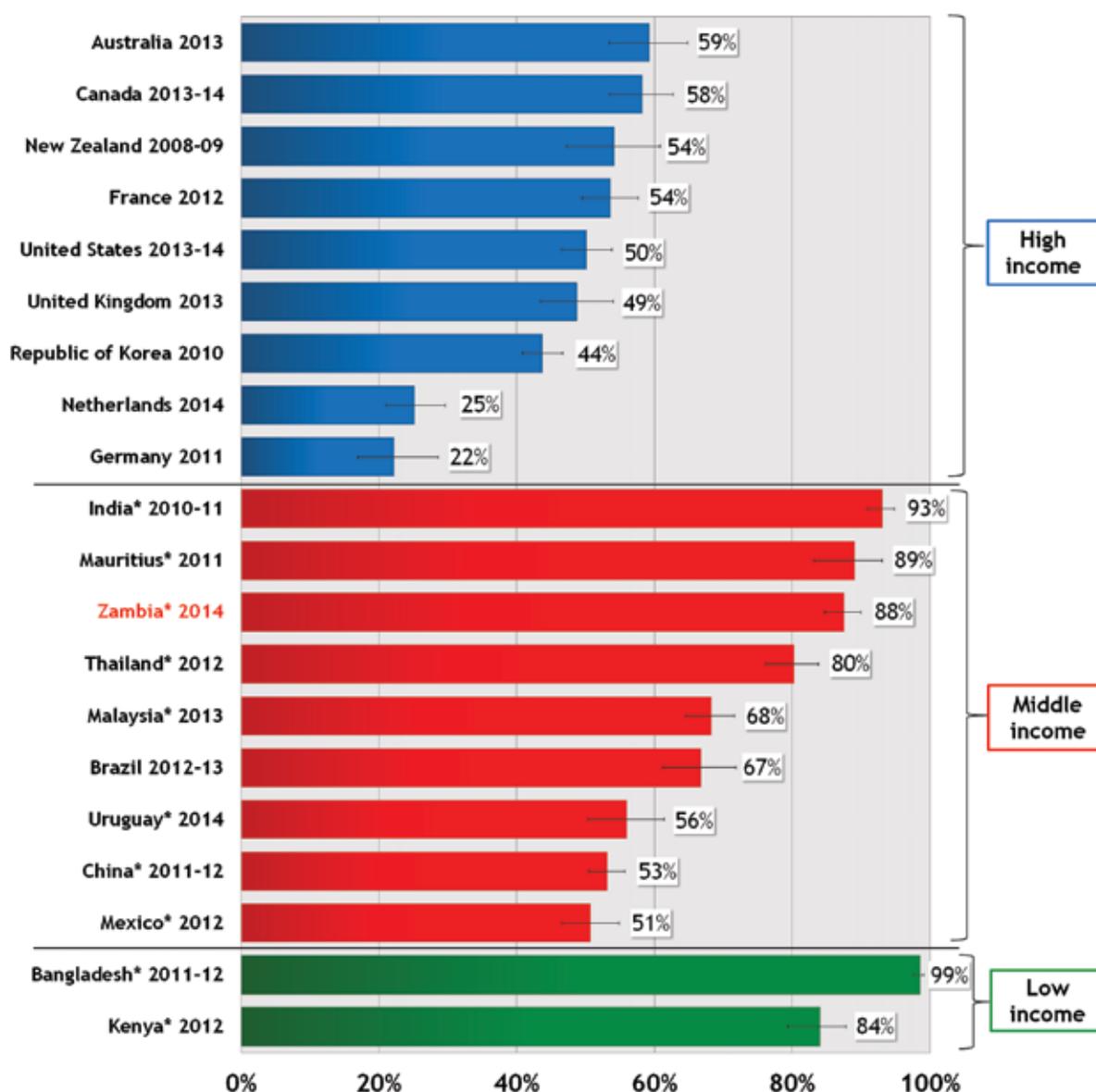
Smokeless tobacco users were asked how often they used their usual smokeless tobacco product. Almost all (88% vs. 89% at Wave 1) smokeless users reported that they used these products daily or almost every day.

The majority (74% vs. 85% at Wave 1) of smokeless users used nasal snuff at least once a month or less than once a month. Smokeless users also reported that they used oral snuff (38% vs. 28% at Wave 1), Kuber (20% vs. 16% at Wave 1), and plain chewing tobacco (20% vs. 15% at Wave 1) at least once a month or less than once a month.

Opinions and Perceived Norms about Smoking

The majority of Zambians have a negative opinion about smoking. When asked about their overall opinion about smoking cigarettes, the percentage of smokers who said that smoking is “bad” or “very bad” increased at Wave 2 (89%) compared to Wave 1 (75%). ITC cross-country comparisons indicate that Zambia has the fourth highest percentage of male smokers (88%) at Wave 2 who have a negative opinion of smoking among 20 countries (see Figure 5).

Figure 5. Percentage of male smokers† and quitters whose overall opinion of smoking is “negative” or “very negative”, by country



† ‘Smokers’ refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

* In these countries, response options were “bad” or “very bad”.

At Wave 2, more than half of Zambian smokers (60% vs. 54% at Wave 1), smokeless users (52% vs. 43% at Wave 1), and non-users (63% vs. 46% at Wave 1) “agreed” or “strongly agreed” with the statement “Zambian society disapproves of smoking.” Perceived society disapproval was lower for smokeless tobacco – 42% (vs. 33% at Wave 1) of smokeless users “agreed” or “strongly agreed” with the statement “Society disapproves of smokeless tobacco use” (see Figures 6 and 7).

The rate of perceived societal disapproval among Zambian male smokers is lower than in most high-income countries where tobacco control is typically more well established.

ITC cross-country comparisons reveal that Zambia has the fourth highest percentage of male smokers who agree that society disapproves of smoking (65%) among 11 ITC LMICs. However, the rate of perceived societal disapproval among Zambian male smokers is still lower than in most high-income countries where tobacco control is typically more well established (see Figure 8).

Figure 6. Society disapproval of smoking, by type of tobacco user and wave

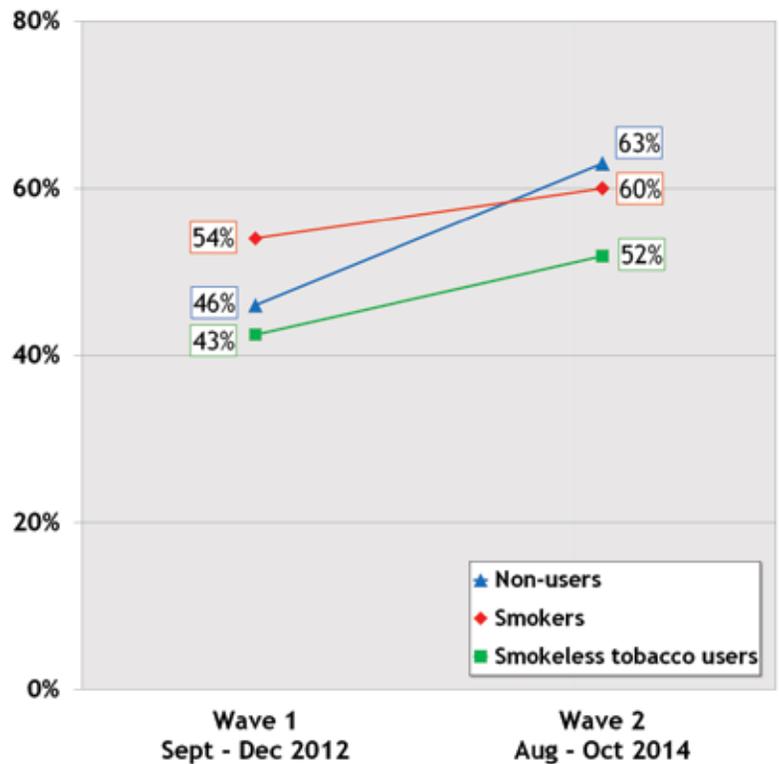


Figure 7. Society disapproval of smokeless tobacco use, by type of tobacco user and wave

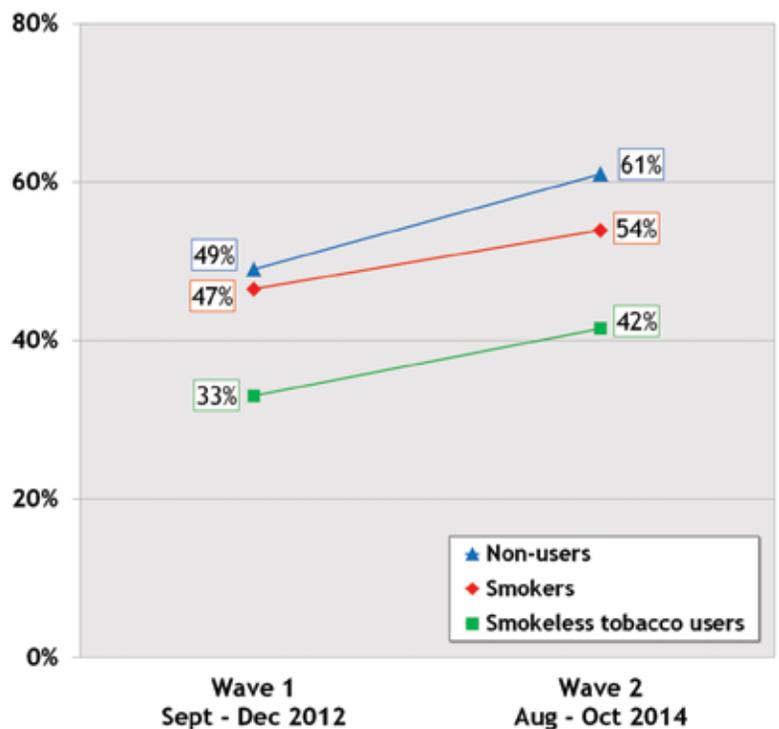
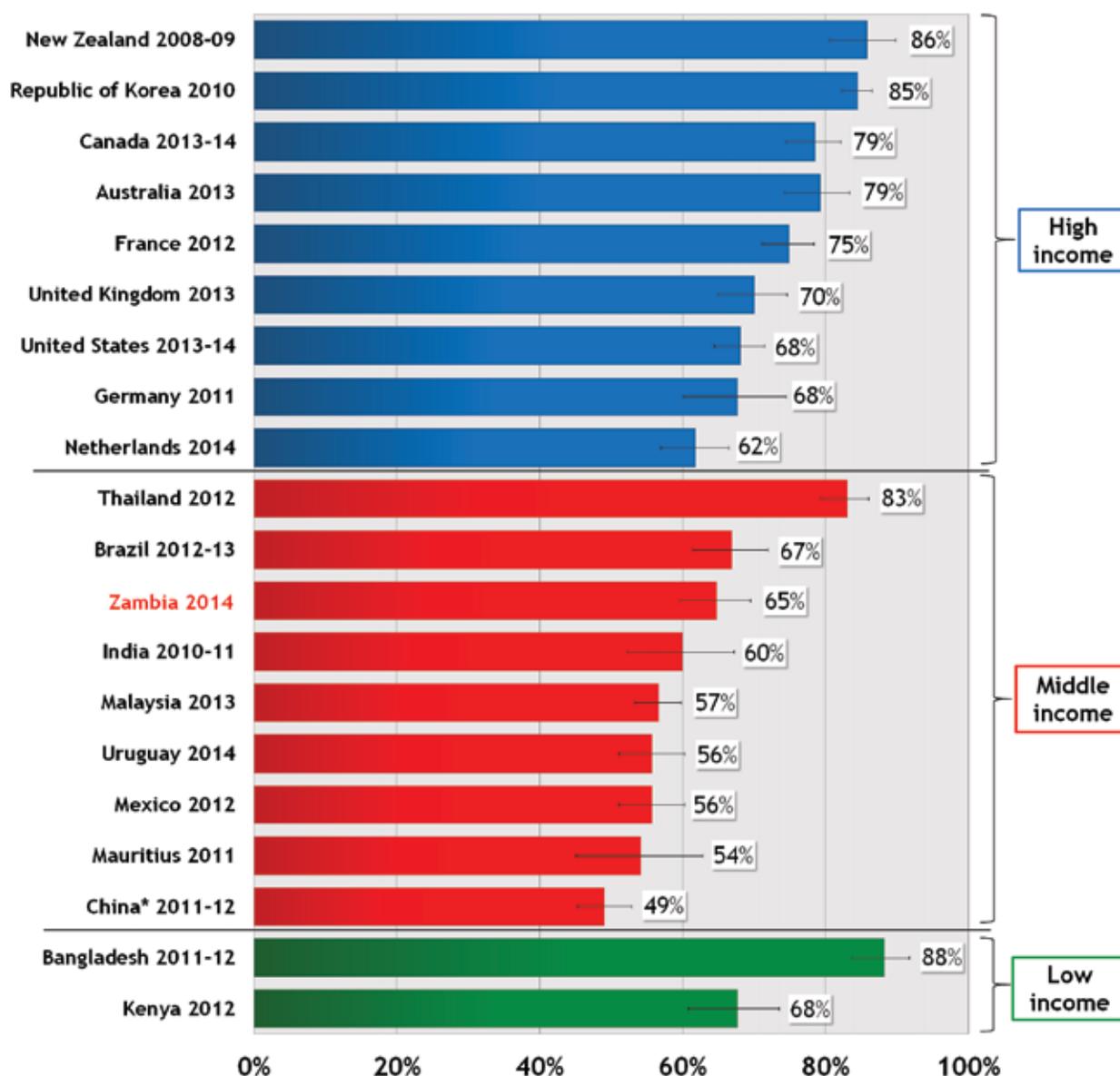


Figure 8. Percentage of male smokers† and quitters who “agree” or “strongly agree” that society disapproves of smoking, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

* In China, the question was worded differently, with response options: "society approves"/"society disapproves"/"society neither approves nor disapproves" of smoking, so results are shown for the "society approves" option.

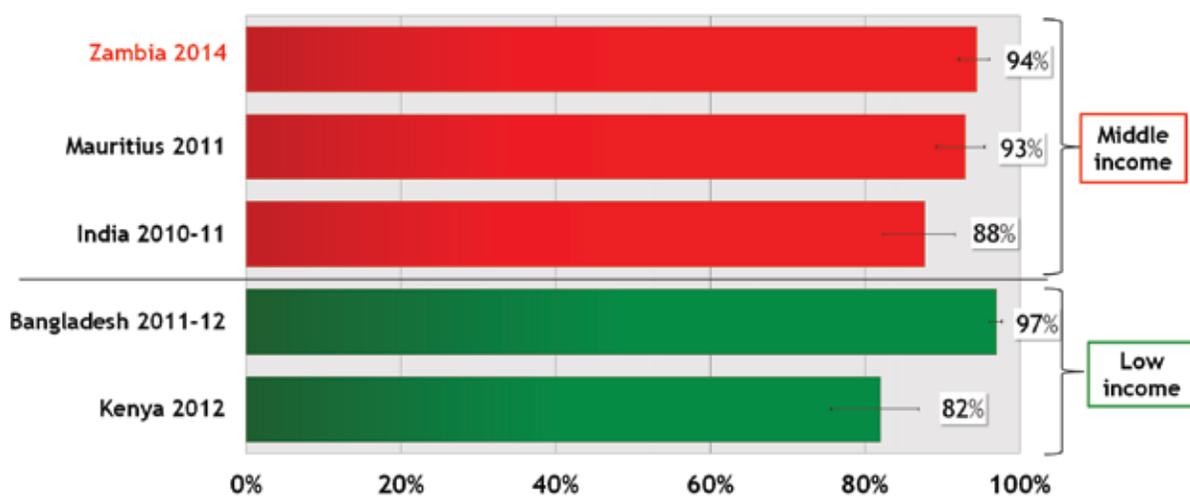
Respondents were also asked whether they think it is acceptable for females to smoke or use smokeless tobacco. At Wave 2, 12% (vs. 17% at Wave 1) of smokers, 8% (vs. 11% at Wave 1) of smokeless users, and 5% (vs. 6% at Wave 1) of non-users “agreed” or “strongly agreed” that it is acceptable for females to smoke cigarettes. While perceived acceptability of female smoking appears to have decreased from Wave 1 to Wave 2, recent reports note that African women are disproportionately targeted by the tobacco industry using marketing strategies that present smoking as a symbol of strong women and of having modern values.⁸ Therefore, this social acceptability measure will be an important indicator to track over time.

Perceived acceptability of female smokeless tobacco use in Zambia was higher overall than it was for cigarette smoking: 16% of smokers (vs. 21% at Wave 1), 41% of smokeless users (vs. 59% at Wave 1), and 11% of non-users (vs. 9% at Wave 1) “agreed” or “strongly agreed” that it is acceptable for females to use smokeless tobacco.

Perception of Harm

The majority of tobacco users and non-users are generally aware that smoking is harmful to health; however, there is a lower level of awareness of the specific harms of tobacco (see Education, Communication, and Public Awareness section). At Wave 2, most smokers (93% vs. 85% at Wave 1), smokeless only users (90% vs. 79% at Wave 1), and non-users (99% vs. 98% at Wave 1) agreed that smoking cigarettes is “not good for your health.” ITC cross-country comparisons among male smokers in Zambia (94%), Mauritius (93%), and Bangladesh (97%) show similar high levels of awareness that smoking cigarettes is harmful, while male smokers in India (88%) and Kenya (82%) were slightly less likely to agree that smoking is not good for health (see Figure 9).

Figure 9. Percentage of male smokers[†] who think that smoking cigarettes is “not good for your health”, by country



[†] ‘Smokers’ refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

While the majority of smokers said that smoking cigarettes is “bad” or “very bad” for their health, smokeless tobacco users were less negative about the harms of using smokeless tobacco products. At Wave 2, only 63% of smokeless users said that smokeless tobacco use is “not good for your health”. In contrast, most smokers (88%) and non-users (96%) agreed that smokeless tobacco use is “not good for health.” Of concern is the finding that almost one-quarter (24%) of smokeless users thought that smokeless tobacco use is good for their health.

At Wave 2, about half (51%) of smokeless users believed that smokeless tobacco is less harmful than cigarettes, while 45% said that they are equally harmful. Additionally, about half (49% vs. 38% at Wave 1) of smokeless users believed that the smokeless tobacco product they use might be “a little less harmful” than other brands/types of smokeless products.

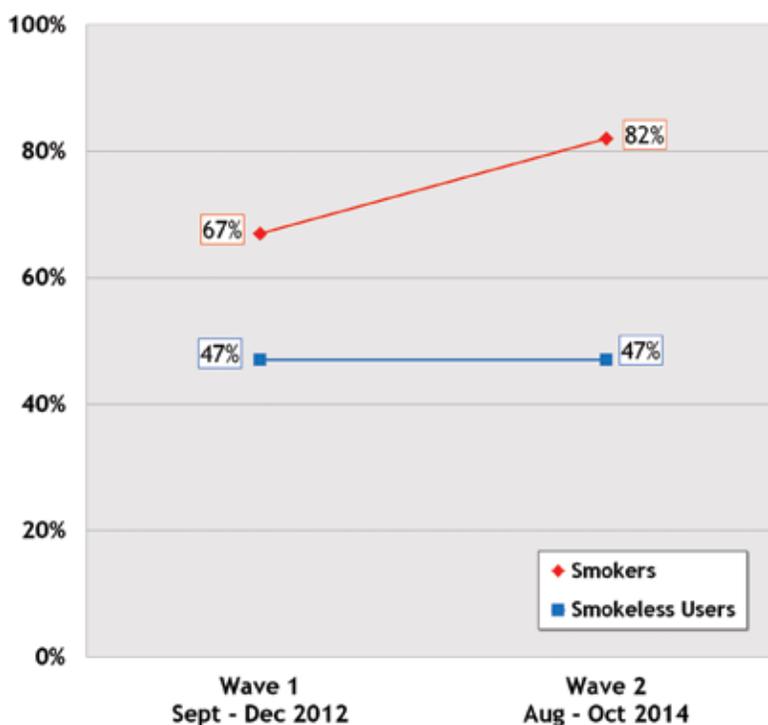
On the other hand, almost three-quarters (73% vs. 69% at Wave 1) of smokers said that there is no difference in harm between cigarettes and smokeless tobacco and 19% (vs. 19% at Wave 1) of smokers believed that smokeless tobacco is more harmful than cigarettes. Most smokers (88% vs. 88% at Wave 1) and smokeless users (84% vs. 83% at Wave 1) believed that hand-rolled cigarettes are more or equally harmful to health than factory-made cigarettes.

Most of the survey respondents – both tobacco users and non-users – were aware of the addictive properties of tobacco. At Wave 2, most smokers (90% vs. 91% at Wave 1), smokeless only users (83% vs. 80% at Wave 1), and non-users (81% vs. 73% at Wave 1) “agreed” or “strongly agreed” that smoking is addictive. Similarly, 85% of smokers (vs. 82% at Wave 1) and 84% of smokeless users (vs. 83% at Wave 1) “agreed” or “strongly agreed” that smokeless tobacco is addictive. The majority (71% vs. 69% at Wave 1) of smokers considered themselves to be “somewhat” or “very” addicted to cigarettes.

Regret for Tobacco Use

The most striking phenomenon in tobacco use is the fact that many smokers simply do not want to smoke.³⁵ The ITC Zambia Survey assessed the extent to which smokers regret that they smoke by measuring the proportion of smokers who “agree” or “strongly agree” with the statement: “If you had to live your life again, you would not have started smoking cigarettes.” At Wave 2, the majority of smokers (82% vs. 67% at Wave 1) “agreed” or “strongly agreed” with this statement. Additionally, about half (47% vs. 47% at Wave 1) of smokeless users “agreed” or “strongly agreed” with this statement regarding their use of smokeless tobacco products (see Figure 10).

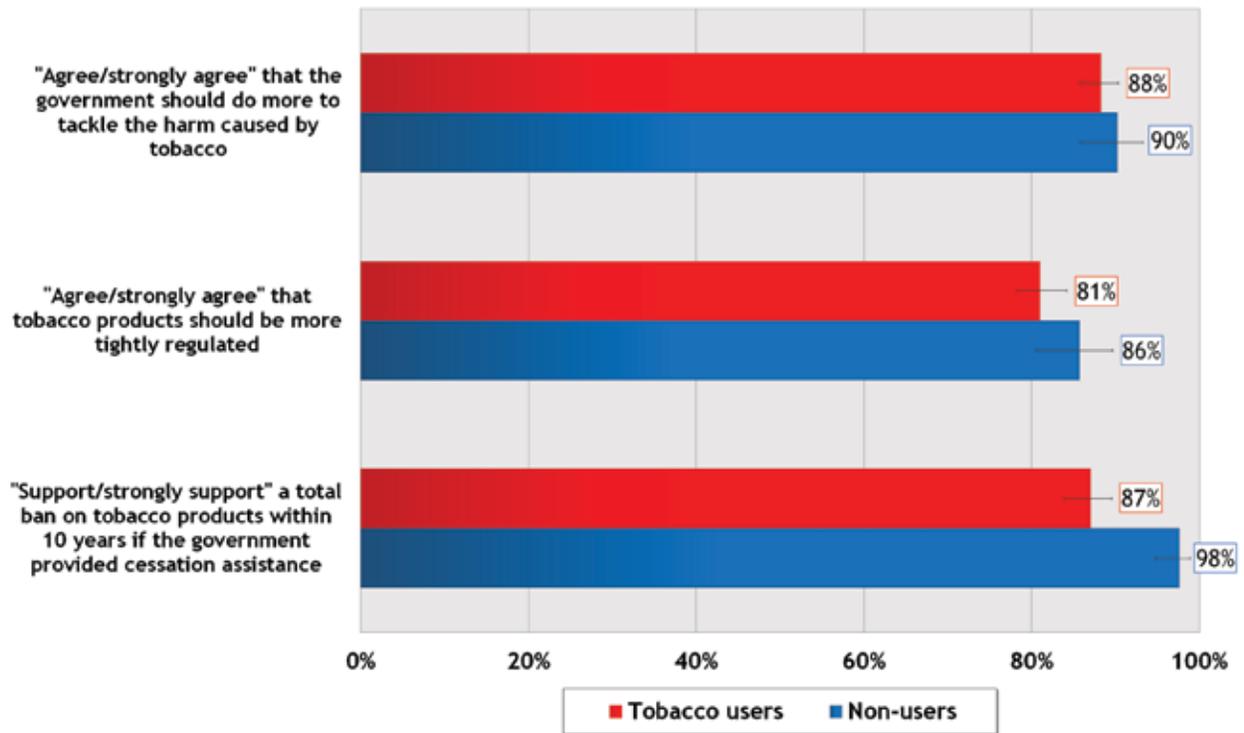
Figure 10. Percentage of smokers and smokeless tobacco users who regret starting to use tobacco



Support for Government Action

It is important to note that the vast majority of tobacco users themselves support stronger action by the Zambian government in tobacco control – at levels that are quite close to the level of support of tobacco non-users (see Figure 11). At Wave 2, most tobacco users (88% vs. 79% at Wave 1) and non-users (90% vs. 87% at Wave 1) “agreed” or “strongly agreed” that the government should do more to tackle the harm done by using tobacco. Most tobacco users (81% vs. 66% at Wave 1) and non-users (86% vs. 79% at Wave 1) “agreed” or “strongly agreed” that tobacco products should be more tightly regulated.

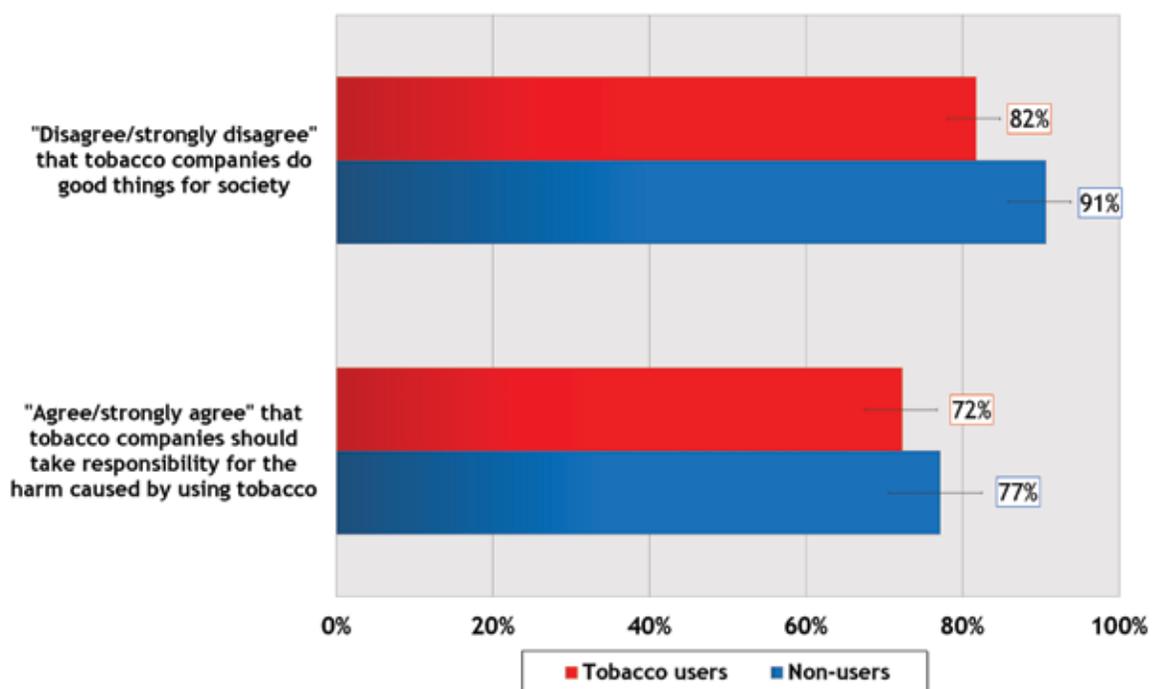
Figure 11. Tobacco users' and non-users' opinions about government responsibility at Wave 2



Opinions about Tobacco Companies

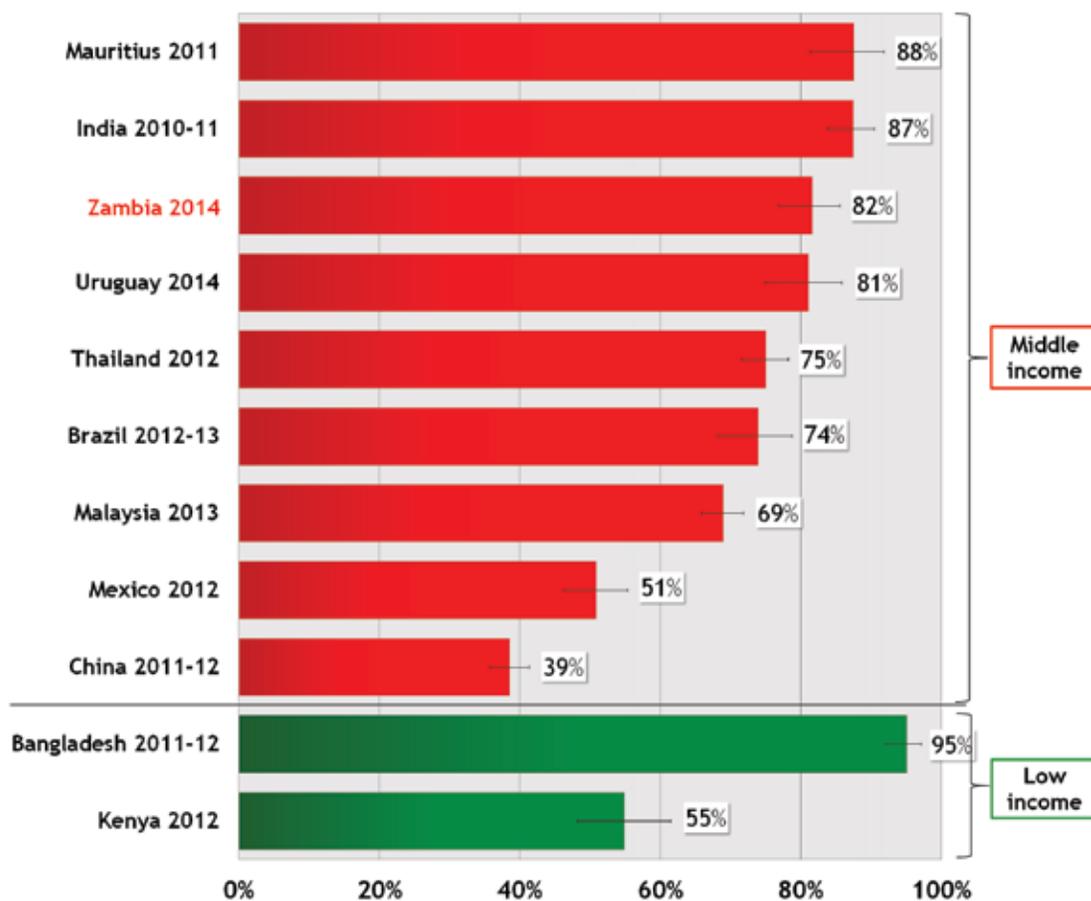
Tobacco users and non-users have a negative opinion of tobacco companies and believe that tobacco companies should take responsibility for the harm caused by tobacco. At Wave 2, the majority of tobacco users (82% vs. 74% at Wave 1) and non-users (91% vs. 88% at Wave 1) “disagreed” or “strongly disagreed” that tobacco companies do good things for society. Similarly, 72% (vs. 75% at Wave 1) of tobacco users and 77% (vs. 83% at Wave 1) of non-users “agreed” or “strongly agreed” that tobacco companies should take responsibility for the harm caused by using tobacco (see Figure 12).

Figure 12. Tobacco users' and non-users' opinions about tobacco companies at Wave 2



Compared to 10 other ITC LMICs, Zambia has the fourth highest percentage of male smokers and quitters (82%) who “disagree” or “strongly disagree” that tobacco companies do good things for society (see Figure 13).

Figure 13. Percentage of male smokers† and quitters who “disagree” or “strongly disagree” that tobacco companies do good things for society, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

Zambians have a negative opinion of tobacco companies. Cross-country comparisons show that 82% of male smokers and quitters “disagree” or “strongly disagree” that tobacco companies do good things for society, ranking 4th highest of 11 ITC LMICs.

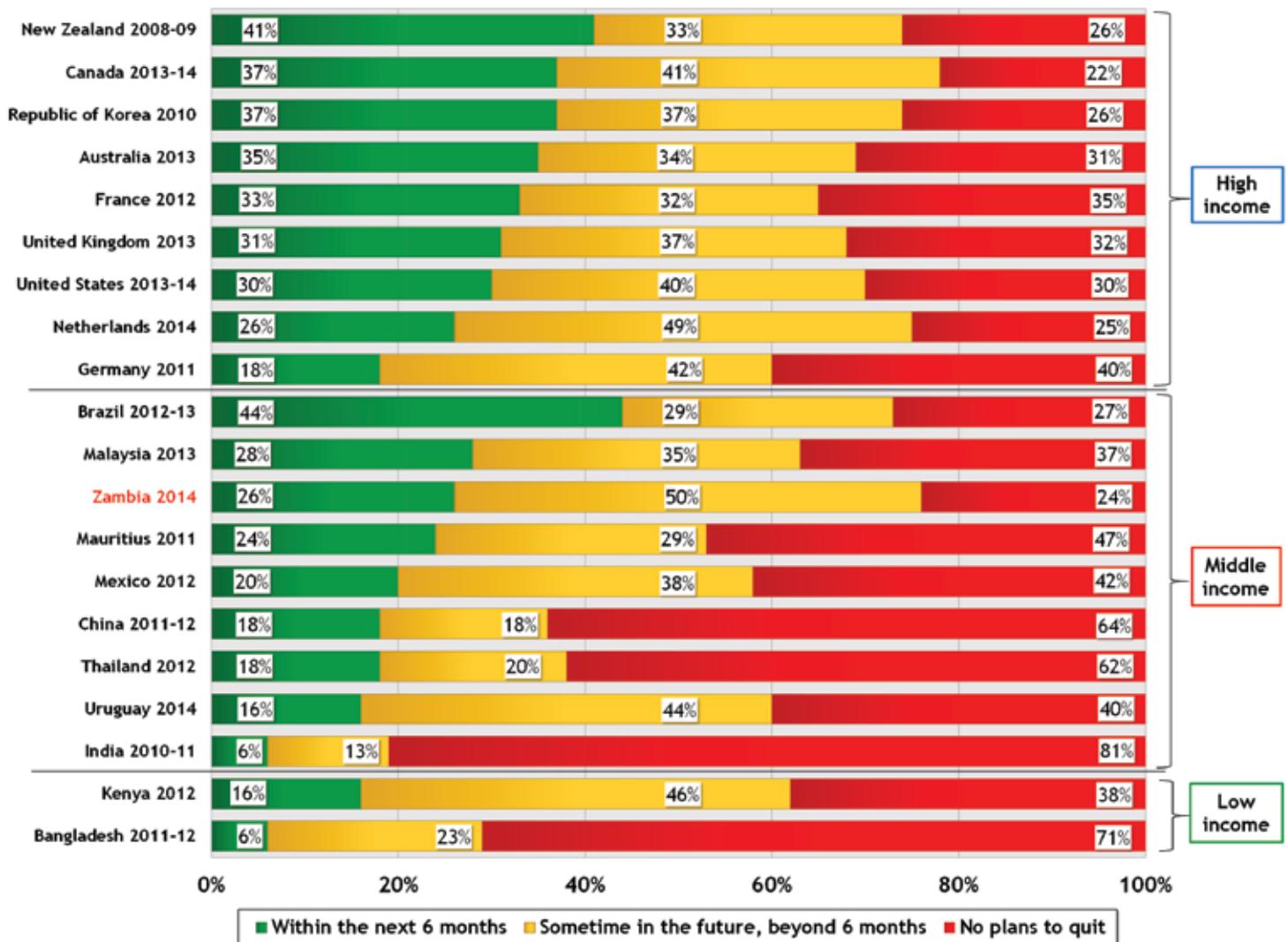
SMOKING CESSATION

Article 14 of the FCTC obligates Parties to take effective measures to promote smoking cessation and provide treatment for tobacco dependence. The ITC Zambia Survey measured tobacco users' intentions to quit, past quit attempts, reasons to quit tobacco use, use of cessation assistance, and attitudes toward government support for cessation.

Quit Intentions and Quit Attempts

Of the Wave 1 smokers who were recontacted at Wave 2, 16% (n=112) reported that they had quit smoking. Overall, at Wave 2, approximately half (51% vs. 42% at Wave 1) of smokers reported that they had “ever” tried to quit smoking and more than a quarter (27% vs. 23% at Wave 1) of smokers planned to quit smoking within the next 6 months. ITC cross-country comparisons indicate that the percentage of male smokers in Zambia who plan to quit in the next 6 months is the third highest among 11 LMICs (26%), similar to Mauritius (24%), but higher than in Kenya (16%) (see Figure 14).

Figure 14. Intentions to quit smoking among male smokers[†], by country



[†] 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

Less than half of all smokers at Wave 2 indicated that warning labels, smoking restrictions in public places or workplaces, anti-tobacco advertisements, and cigarette prices, led them to think about quitting.

Of the Wave 1 smokeless users who were recontacted at Wave 2, 13% (n=24) reported that they had quit. Overall, at Wave 2, about a third (34%) of smokeless users had “ever” tried to quit, and only 12% (vs. 8% at Wave 1) of smokeless users reported plans to quit smokeless use within the next 6 months.

Reasons to Think About Quitting

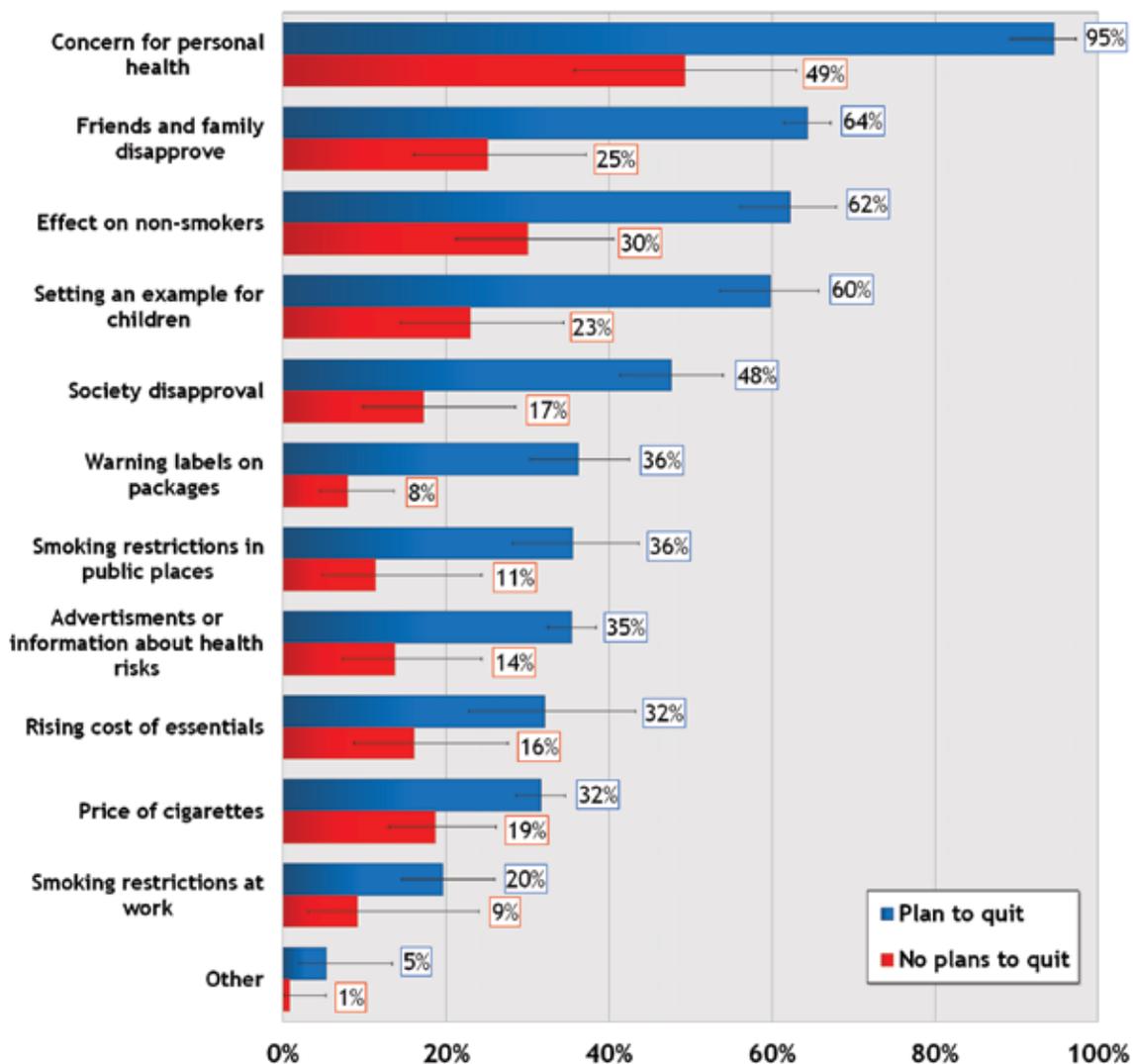
The ITC Zambia Survey asked smokers which of several reasons led them to think about quitting. At Wave 1, only those smokers who said they were planning to quit were asked this set of questions. Among smokers who were planning to quit at Wave 1, the most commonly mentioned reasons for thinking about quitting were: concern for their health, setting an example for children, close friends and family disapprove of smoking, and the effect of their smoke on non-smokers (about half or more smokers agreed with each of these reasons).

At Wave 2, all smokers were asked about reasons that led them to think about quitting, regardless of whether they planned to quit or not. The most common reasons at Wave 2 were the same as those at Wave 1. However, the percentage of smokers who said that each reason led them to think about quitting at Wave 2 was significantly higher among those who had plans to quit compared to those who said they are not planning to quit (see Figure 15). For example, 95% of smokers who plan to quit said that concern for their personal health led them to think about quitting, compared to only 49% of smokers with no intention to quit.

It is concerning that less than half of all smokers at Wave 2 indicated that policy-relevant factors, such as warning labels, smoking restrictions in public places or workplaces, anti-tobacco advertisements, and cigarette prices, led them to think about quitting. This represents a missed opportunity for motivating Zambian smokers to quit through effective tobacco control policies, as research shows that these policies have the potential to have the greatest impact in reducing smoking prevalence.

Similar to smokers, among smokeless users who plan to quit, the most commonly mentioned reasons for thinking about quitting at Wave 2 included concern for their health (87%), disapproval by friends and family members (40), society disapproval (38%), setting an example for children (29%), price of smokeless products (21%), advertising or information about health risks (21%), and rising costs of essentials like food or fuel (20%).

Figure 15. Smokers' reasons that led them to think about quitting smoking at Wave 2, among those who have plans to quit smoking* vs. no plans



* Those who have plans to quit are smokers who said at Wave 2 that they are planning to quit either in the next month, next 6 months, or sometime in the future beyond 6 months, vs. those who said they are not planning to quit.

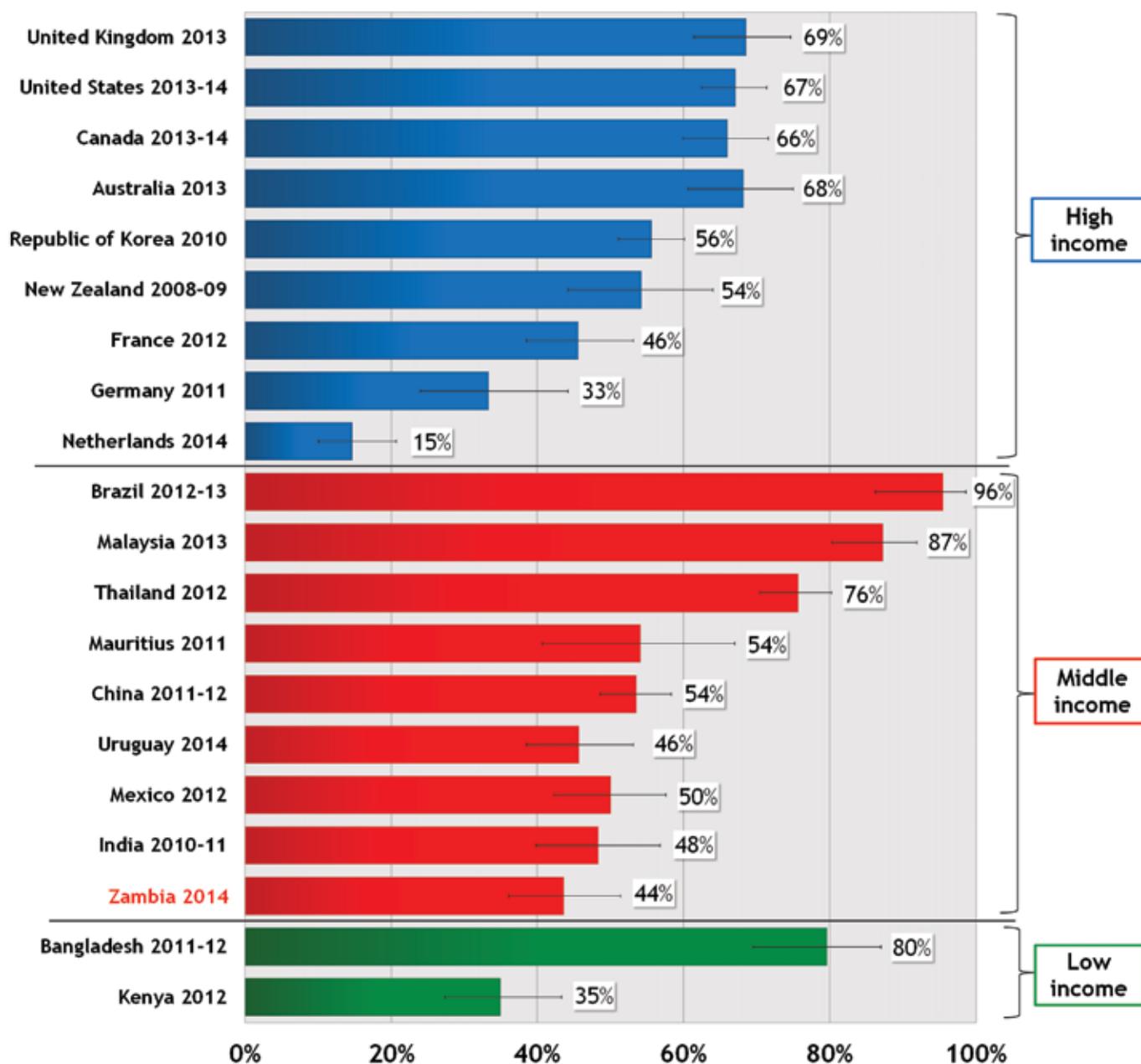
Availability and use of cessation services and assistance in Zambia

At Wave 2, about one quarter (27% vs. 17% at Wave 1) of tobacco users reported that they had visited a doctor or health provider in the last 6 months. Among smokers who had visited a doctor, less than half (43% vs. 36% at Wave 1) were given advice to quit smoking cigarettes. ITC cross-country comparisons indicate that the percentage of male smokers who received advice to quit from a doctor in Zambia (44%) is the second lowest among 11 LMICs and the fourth lowest overall among 20 ITC countries. This rate is lower than what has been achieved in other LMICs such as Mauritius (54%), Mexico (50%), India (48%), and Uruguay (46%) (see Figure 16).

Existing research shows that advice to quit from a physician or health professional is a powerful motivator for quitting. Of those who were given advice to quit at Wave 2, most Zambian smokers (92% vs. 71% at Wave 1) reported that the advice made them think about quitting cigarettes.

Overall, few smokers (9% vs. 6% at Wave 1) reported that they had heard about medications to help people stop smoking (e.g., Nicotine Replacement Therapies like nicotine gum or the patch, or Zyban), and only 4% (vs. 7% at Wave 1) reported that they had used Zyban or bupropion in the last year.

Figure 16. Percentage of male smokers[†] who received advice to quit from a doctor or health provider, among those who visited a doctor in the last 6 months[‡], by country



[†] 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

[‡] In Canada, Australia, US, and UK, the question asked either about the last 12 months, or since the last survey date.

At Wave 2, most tobacco users (87% vs. 78% at Wave 1) and nearly all non-users (98% vs. 89% at Wave 1) unanimously "support" or "strongly support" a total ban on tobacco products within 10 years, if the government provided assistance such as cessation clinics to help smokers quit (see Figure 11).

PACKAGING AND LABELLING OF TOBACCO PRODUCTS

Article 11 of the FCTC requires Parties to implement large, visible, rotating health warnings in the country's principal language within 3 years of ratification. Guidelines for the implementation of Article 11 adopted in November 2008 call for warnings that include full-colour pictures covering at least 50% of the principal display areas of the package.¹⁰

Health warnings were introduced in Zambia in January 1993 under The Public Health (Tobacco) Regulations, 1992 mandating that all tobacco packages be clearly labelled with the following text-only warning: "Warning: Tobacco is Harmful to Health." Although the health warning regulation was amended in 2008 to require the text-only warning on both sides of the pack and to strengthen the legibility of the text warning, the current single English text warning fails to meet the minimum size (no less than 30% of the principal display areas) and position requirements (top of the package) of Article 11. In addition, the warning does not meet the recommendations in the Article 11 Guidelines for messages to be in a culturally appropriate language, to include rotating full-colour pictures, and for packs to include qualitative statements that convey the relative harmfulness of the tobacco product emissions.

The ITC Zambia Wave 2 Survey findings described below provide evidence of the urgent need to improve the current text-only warnings in order for Zambia to meet its obligations to the FCTC and to most effectively provide tobacco users in Zambia with information on the harms of tobacco use.

Awareness and Impact of Health Warnings

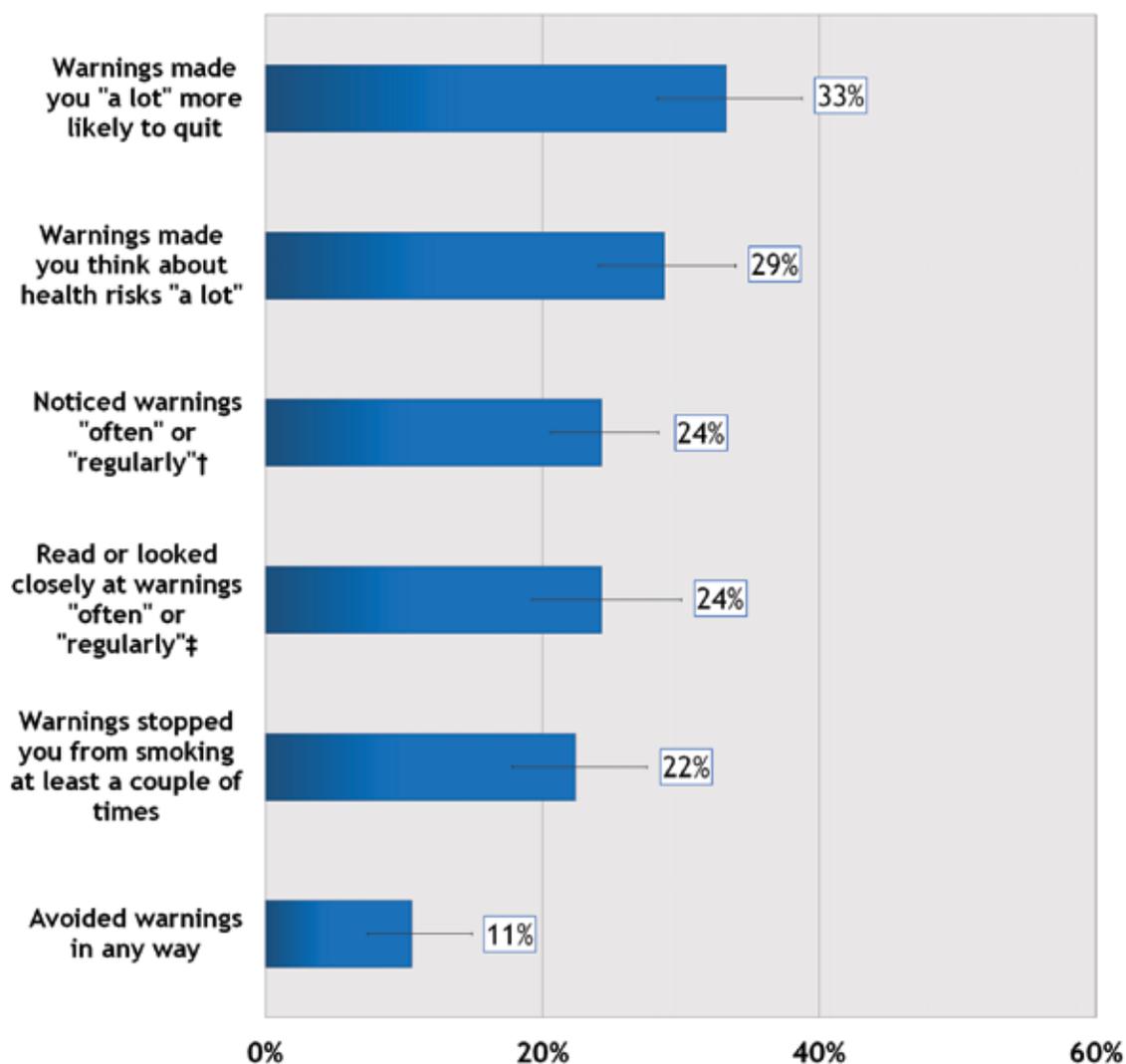
The main purpose of health warnings is to communicate the health risks of tobacco use and encourage tobacco users to quit. Evidence from the ITC Zambia Survey indicates that the current single text-only health warning in English is failing to serve this purpose. At Wave 2, less than one quarter (24% vs. 26% at Wave 1) of smokers said they noticed the health warning "often" or "regularly" in the last month prior to the survey, and 24% (vs. 12% at Wave 1) reported that they read or looked closely at the warning labels "often" or "regularly" in the last month (see Figure 17). Less than one third (29% vs. 20% at Wave 1) of smokers stated that the health warnings made them "a lot" more likely to think about the health risks of smoking cigarettes. One third (33% vs. 19% at Wave 1) of smokers reported that health warnings made them "a lot" more likely to quit smoking cigarettes.

Less than one quarter (22% vs. 18% at Wave 1) of Zambian smokers stated that warning labels stopped them from smoking cigarettes at least a couple of times in the last month (versus never). Only 11% (vs. 9% at Wave 1) of smokers said they made any effort to avoid the warning labels in the last month. This finding suggests a lost opportunity to motivate cessation as research conducted in Brazil has shown that avoidance creates strong negative associations with tobacco in the minds of smokers and may motivate quitting.³⁶

Evidence from other countries has shown the potential to significantly increase the effectiveness of warning labels by implementing large pictorial warnings. For example, Mauritius' switch from text-only warnings to pictorial warnings on 60% of the front and 70% of the back of the pack in 2009 increased the percentage of smokers who noticed the warnings "often" or "very often" in the last month from 58% to 83%.³⁷ Similarly, the percentage of smokers who read or looked closely at the warnings increased from 30% to 52%. Smokers who reported thinking about smoking-related health risks "a lot" increased from 25% to 42% and smokers who reported considering quitting "a lot" increased from 14% to 27%.

Of the smokers who had a cigarette pack and were willing to show it at the time of the Wave 2 Survey (n=95), 69% had a visible health warning in English on the pack and 14% had a warning in another language. 18% of packs had no visible warning. When the interviewers showed smokers the English text warning on a laminated card and asked them to read it, only 45% of all smokers were able to read the health warning easily, 14% read with difficulty, and 40% were not able to read the warning at all.

Figure 17. Impact of health warnings on smokers' perceptions and behaviours in the last month* at Wave 2



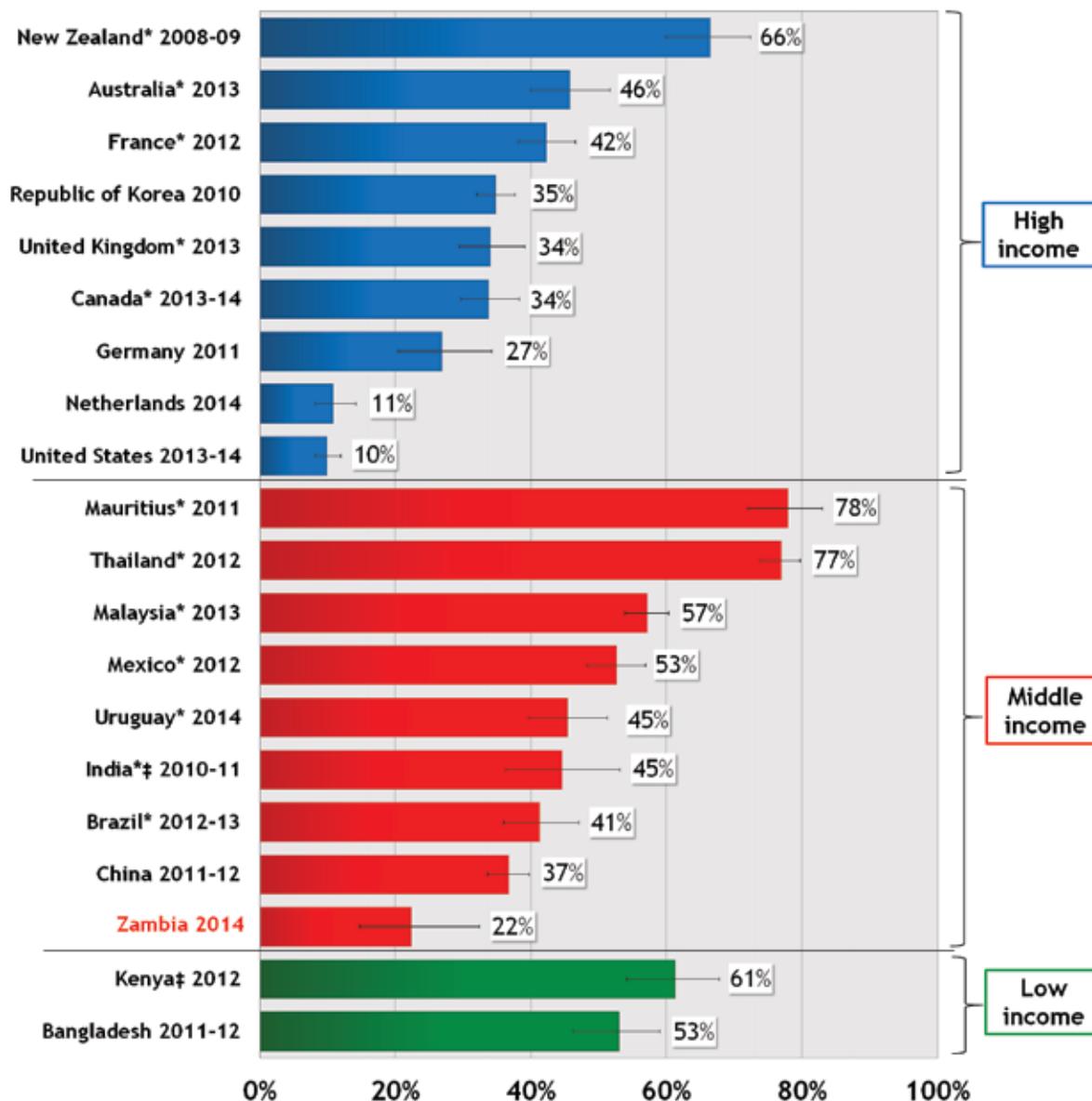
* All questions included a time frame of 30 days, except for whether warnings made you think about the health risks of smoking, and whether warnings made you more likely to quit smoking, which did not include a timeframe.

† The result shown for this question is the unadjusted percentage for Wave 2. This is due to changes in the way the question was asked at Wave 2, and a strong time-in-sample effect among the cohort respondents who participated at both waves, which affected the adjusted results.

‡ At Wave 2, those who said they "never" noticed the warnings skipped the next question asking whether they read the labels closely, so these respondents were categorized as "never" having read the labels closely in the last month.

ITC cross-country comparisons demonstrate that Zambia's text warning is performing poorly compared to health warnings in other ITC countries. Among all male smokers and quitters surveyed, Zambia had the lowest percentage (22%) of those who "often" or "very often" noticed warnings among 11 LMICs in the ITC Project (see Figure 18). In contrast, in Mauritius, where pictorial health warnings cover 60% of the front and 70% of the back of the pack, 78% of male smokers noticed the warnings. This demonstrates the vast potential for increasing the effectiveness of health warnings in Zambia with the implementation of large pictorial warnings, as called for by Article 11 of the FCTC.

Figure 18. Percentage of male smokers[†] and quitters who “often” or “very often” noticed warning labels, by country



[†] 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

* Countries with pictorial warnings at time of survey.

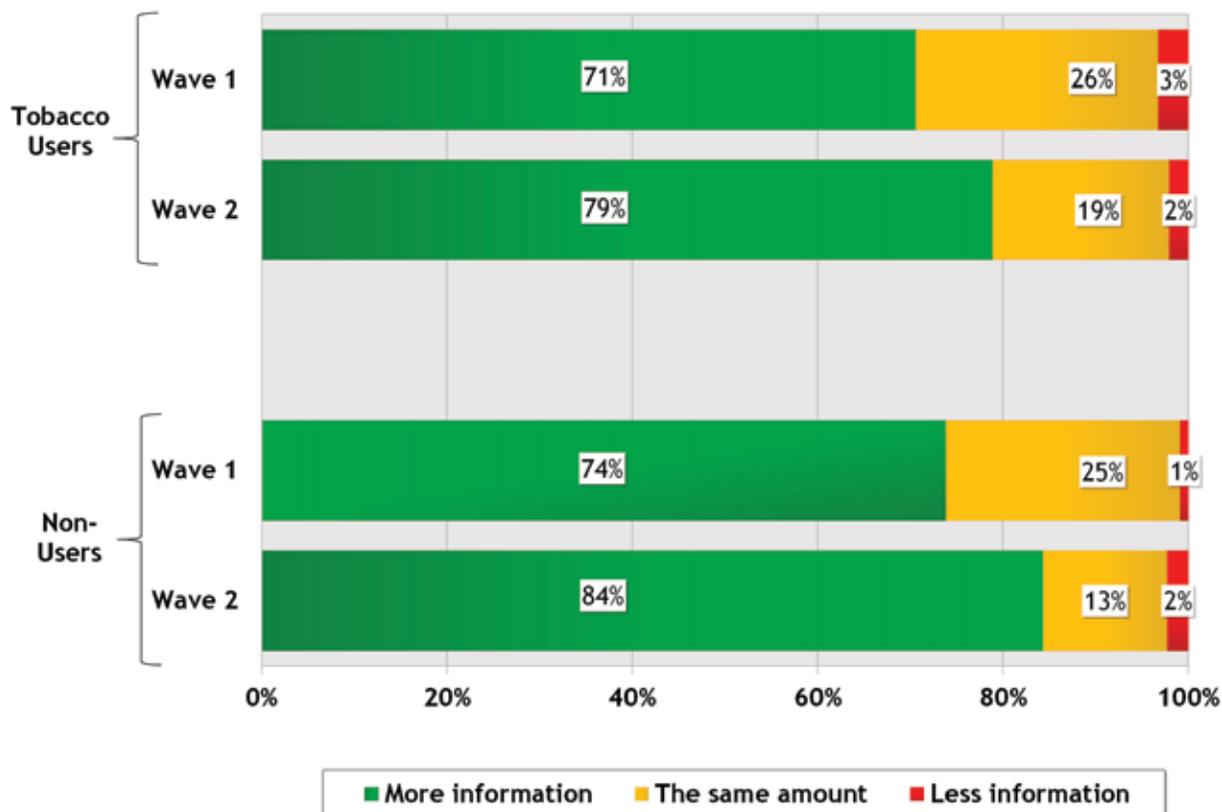
‡ In India and Kenya, there was an extra filter that asked "As far as you know, do any smoked tobacco/cigarette packages in India/Kenya have warning labels?". If the respondent answered "no" then noticing warning labels was set to "never".

Results shown are for responses of "often" or "very often" except for the following: In Zambia, results are for responses of "often" or "regularly". In India and Kenya, results are for "often" or "whenever I smoke". In China, results are for "often" only as there was no "very often" option.

Support for Enhanced Health Warnings

At the same time that the ITC Zambia Survey has shown that the current health warning is very weak, the survey results also indicate that there is very strong support among Zambian tobacco users and non-users for strengthening the health warnings on cigarette packages. At Wave 2, the majority of Zambian tobacco users (79% vs. 71% at Wave 1) and non-users (84% vs. 74% at Wave 1) thought that cigarette packages should have more health information (see Figure 19).

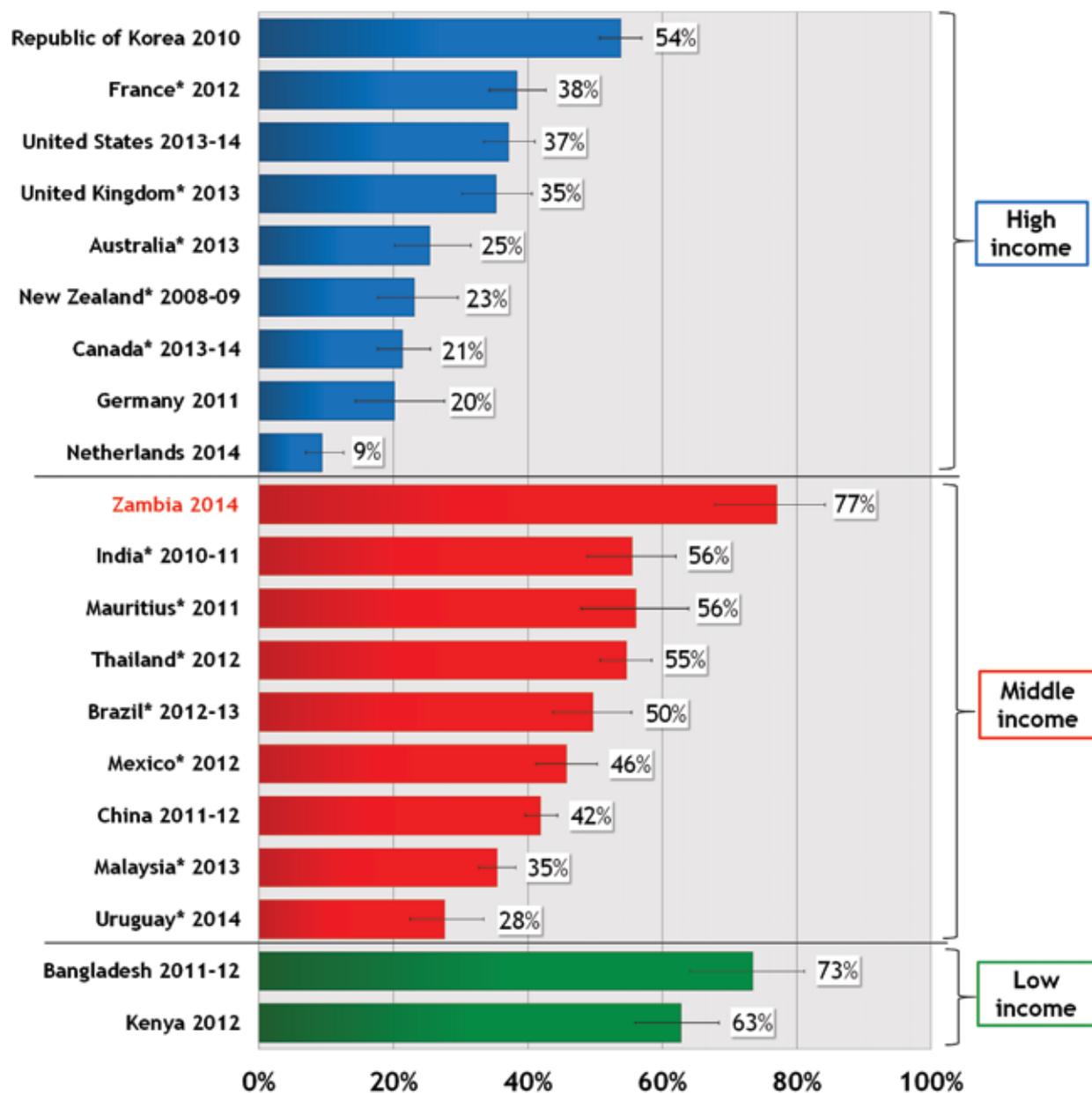
Figure 19. Percentage of tobacco users and non-users who think there should be more, less, or the same amount of health information on tobacco packages, by wave



ITC cross-country data indicate that the level of support for more health information on cigarette packages is high in Zambia compared to other countries. Zambia has the highest percentage of male smokers and quitters (77%) who think there should be more health information on tobacco packages among 20 ITC countries (see Figure 20). In general, support for enhanced health warnings is higher in countries without pictorial warnings, including Zambia, Bangladesh (73%), and Kenya (63%).

Zambian tobacco users and non-users strongly support having stronger health warnings on cigarette packages. Zambia has the highest percentage of male smokers and quitters (77%) who think there should be more health information on tobacco packages among 20 ITC countries.

Figure 20. Percentage of male smokers[†] and quitters who think there should be more health information on tobacco packages, by country



[†] 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

* Countries with pictorial warnings at time of survey.

SMOKE-FREE POLICIES

Article 8 of the FCTC requires the adoption of effective measures to provide protection from exposure to tobacco smoke. Guidelines for Article 8 of the FCTC adopted in 2007 established the core principles for achieving 100% smoke-free environments, including strong enforcement of legislation and educational campaigns to raise awareness of the harms of secondhand smoke.¹⁰ Article 8 Guidelines recommend a comprehensive ban on smoking in indoor workplaces, public transport, indoor places, and other public places as appropriate, without exemptions.

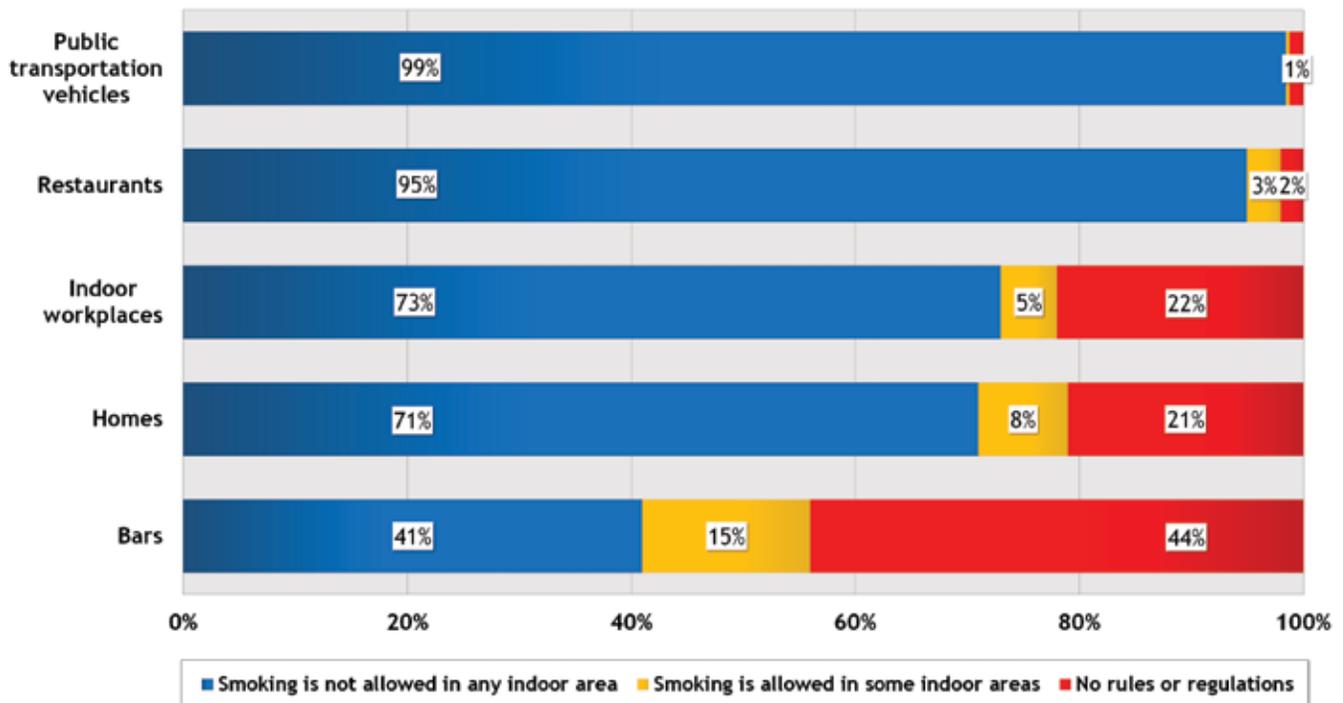
The 1992 Public Health Act of Zambia banned smoking in certain public places, including schools, health care facilities, cinema halls, on public transportation, and in government buildings. The scope of the ban on smoking in public places was broadened in April 2008 when the Ministry of Local Government and Housing enacted the Local Government (Prohibition of Smoking in Public Places) Regulations.¹¹ Under the Regulations, smoking is not allowed in any public places, defined as “any building, premises, conveyance or other place to which the public has access.” Therefore, under the new law, all public places, including restaurants, bars, and indoor workplaces, are smoke-free; however, enforcement of this law has been weak.³⁸

Evidence from the ITC Zambia Survey indicates that despite the smoking ban, Zambians are not fully protected from exposure to tobacco smoke in workplaces and bars; however, the majority of smokers and non-smokers support complete smoking bans in these venues.

Smoking on Public Transportation

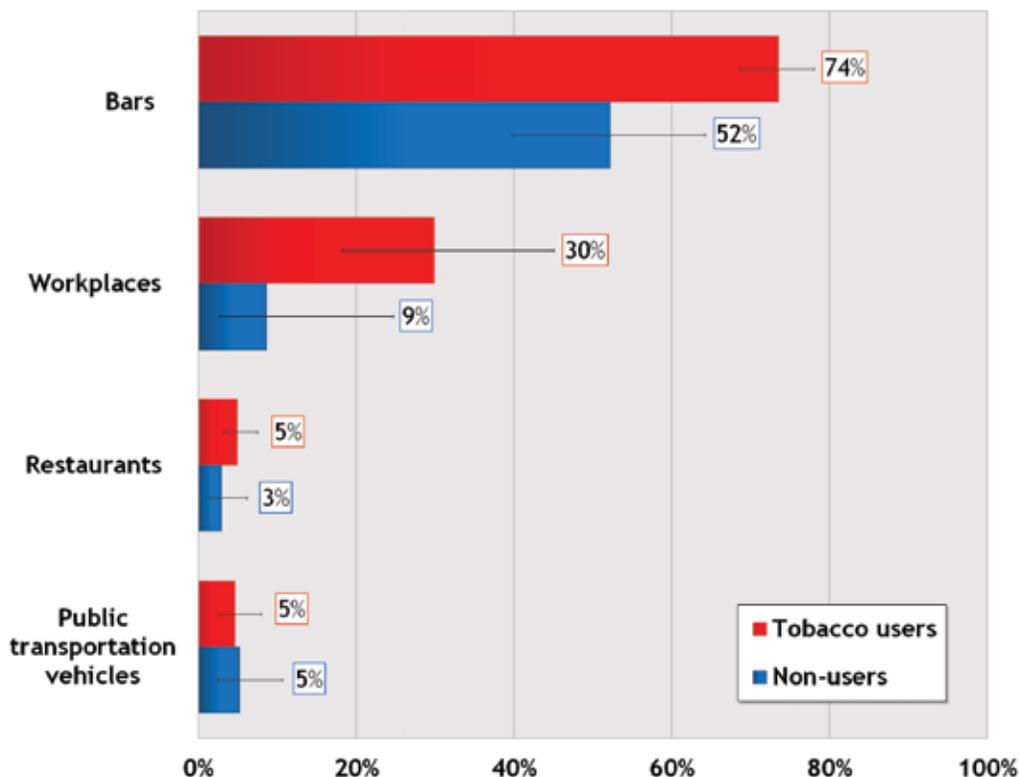
The ITC Zambia Wave 2 Survey findings show that almost all tobacco users (99% vs. 96% at Wave 1) and non-users (94% vs. 93% at Wave 1) who use public transportation are aware of the current smoking ban on any mode of public transport (e.g., buses, ferries, and trains) (see Figure 21).

Figure 21. Awareness of smoking rules in public places, and rules about smoking at home among tobacco users at Wave 2



At Wave 2, only 5% (vs. 5% at Wave 1) of tobacco users and 5% (vs. 4% at Wave 1) of non-users who used public transportation reported noticing people smoking inside a bus, ferry, or train during their last trip (see Figure 22). Additionally, only 4% (vs. 3% at Wave 1) of smokers who used public transportation said that they smoked inside the vehicle during their last trip.

Figure 22. Percentage of tobacco users and non-users who noticed people smoking indoors in various venues* at Wave 2

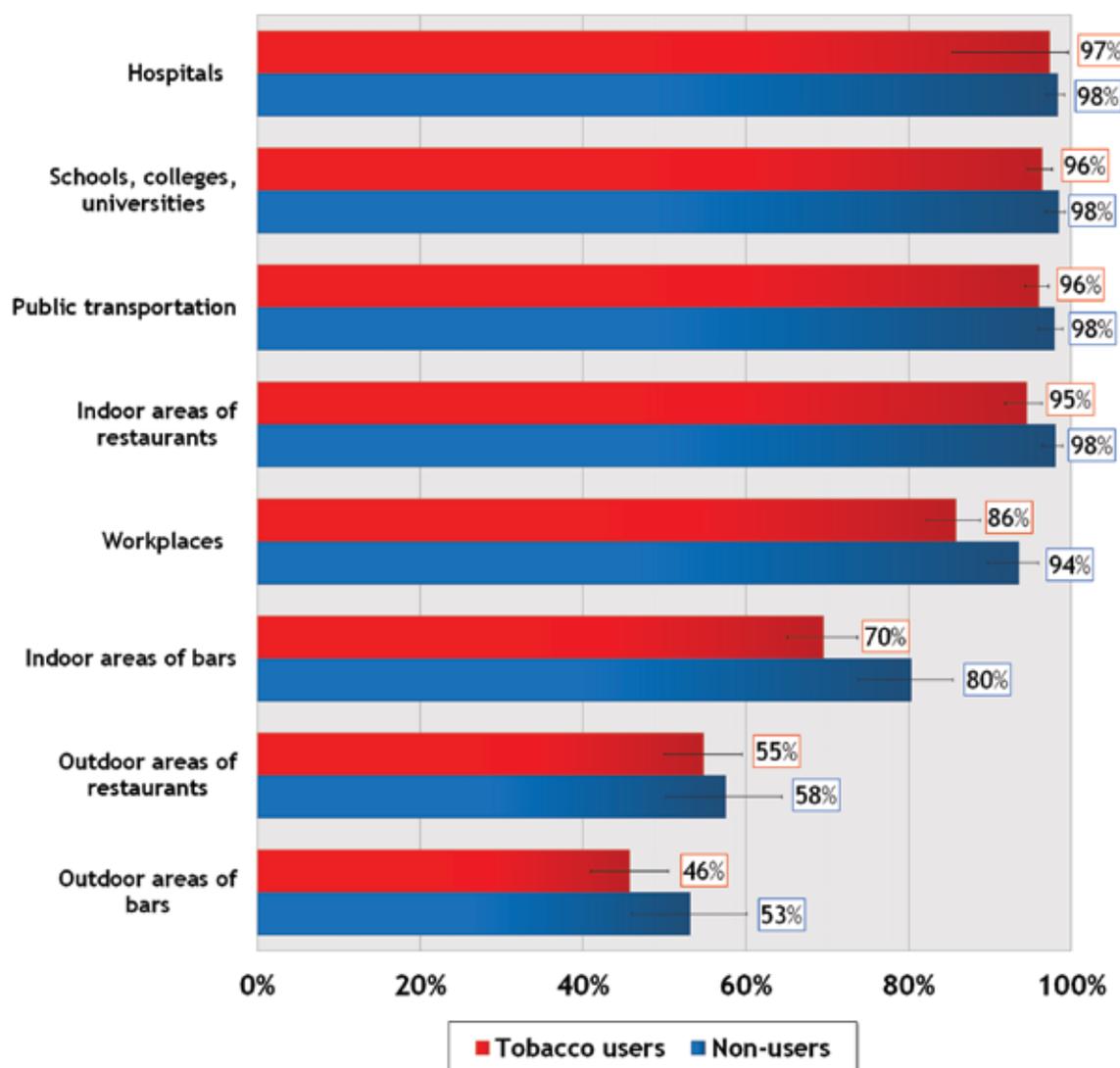


Note: For workplaces, respondents were asked whether people smoked indoors in the last 30 days. For other venues, they were asked whether people were smoking during their last visit (for restaurants and bars) or their last ride on public transportation.

Almost all tobacco users (96% vs. 95% at Wave 1) and non-users (98% vs. 98% at Wave 1) support the complete ban on smoking in public transportation vehicles (see Figure 23).

There is strong compliance with the ban on smoking in public transportation at Wave 2 as only 5% of tobacco users and 5% of non-users who used public transportation reported noticing people smoking during their last trip.

Figure 23. Percentage of tobacco users and non-users who think smoking should not be allowed in any indoor or outdoor areas at Wave 2



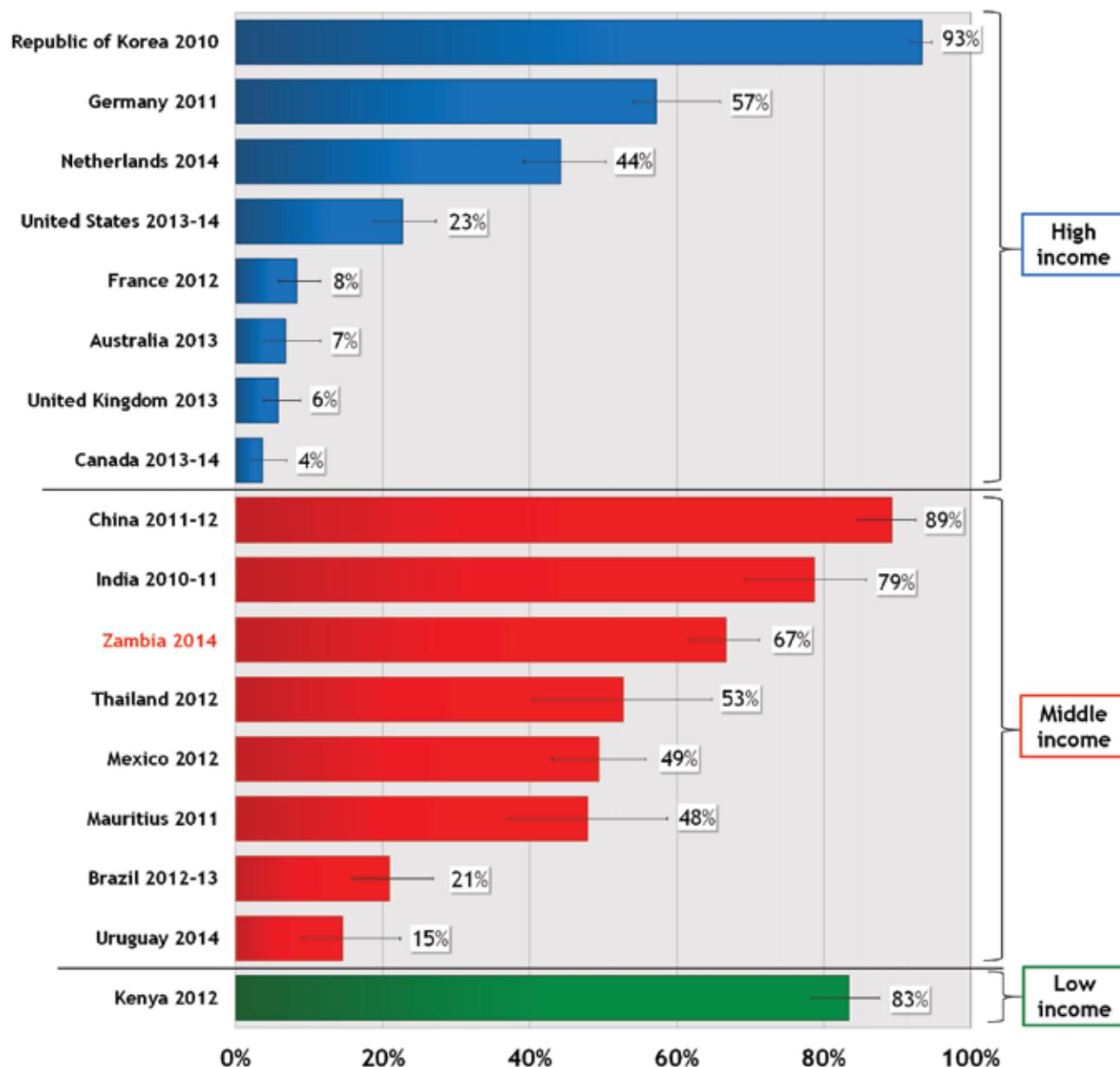
Smoking in Bars

The Wave 2 Survey findings demonstrate a lack of awareness and compliance with the smoking ban in bars. At Wave 2, less than half (41% vs. 55% at Wave 1) of tobacco users and 56% (vs. 54% at Wave 1) of non-users who go to bars stated that smoking was not allowed in any indoor areas of these venues, while more than a third (44% vs. 31% at Wave 1) of tobacco users and 37% (vs. 28% at Wave 1) of non-users indicated that there were no rules or restrictions regarding smoking in bars (see Figure 21). The remainder (15% vs. 14% at Wave 1) of tobacco users and 7% (vs. 18% at Wave 1) of non-users said that smoking was allowed only in some indoor areas in the bar.

Although approximately half of all respondents reported that there was a complete ban on smoking indoors in bars, there is evidence for weak compliance with bans in these venues. Among those respondents who had visited a bar at Wave 2, 74% (vs. 65% at Wave 1) of tobacco users and 52% (vs. 62% at Wave 1) of non-users reported that they noticed people smoking inside the bar during their last visit (see Figure 22). Additionally, about two-thirds (64% vs. 55% at Wave 1) of smokers said that they smoked inside the bar during their last visit.

ITC cross-country comparisons show that Zambia has a high level of smoking in bars compared to other countries. The percentage of male smokers in Zambia who noticed people smoking the last time they visited a bar (67%) was the fourth highest percentage among 9 LMICs, and the fifth highest percentage overall among 17 ITC countries (see Figure 24).

Figure 24. Percentage of smokers† and quitters who noticed smoking in cafés and pubs among those who visited a bar, café or pub in the last year, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

About 70% (vs. 73% at Wave 1) of tobacco users and 80% (vs. 79% at Wave 1) of non-users supported a complete ban on smoking in indoor areas in bars. However, only 46% of tobacco users (vs. 36% at Wave 1) and 53% (vs. 41% at Wave 1) of non-users supported a smoking ban in the outdoor areas of a bar (see Figure 23).

Smoking in Restaurants

At Wave 2, the majority of tobacco users (95% vs. 93% at Wave 1) and non-users (94% vs. 95% at Wave 1) who go to restaurants indicated that there is a complete ban on smoking inside restaurants, demonstrating a high level of awareness of the 2008 ban on smoking in restaurants (see Figure 21).

Among those respondents who visited restaurants at Wave 2, only 5% (vs. 8% at Wave 1) of tobacco users and 3% (vs. 4% at Wave 1) of non-users reported that they noticed people smoking inside the restaurants during their last visit (see Figure 22). Additionally, 4% (vs. 3% at Wave 1) of smokers said that they smoked inside the restaurant during their last visit. The level of smoking inside restaurants in Zambia is quite low compared to other ITC countries – the percentage of male smokers in Zambia who noticed smoking in their last restaurant visit (4%) is the second lowest among 10 ITC LMICs (see Figure 25). This may reflect a stronger norm in Zambia against smoking inside restaurants relative to other ITC countries.

An overwhelming majority of tobacco users (95% vs. 94% at Wave 1) and non-users (98% vs. 97% at Wave 1) support the complete ban on indoor smoking in restaurants (see Figure 23). However, fewer tobacco users (55% vs. 48% at Wave 1) and non-users (58% vs. 57% at Wave 1) supported a ban on smoking in outdoor areas of restaurants.

Smoking in Workplaces

The findings from the ITC Zambia Wave 2 Survey showed that 73% (vs. 74% at Wave 1) of tobacco users and 90% (vs. 75% at Wave 1) of non-users who worked inside a building were aware that smoking was not allowed in any indoor area at work (see Figure 21).

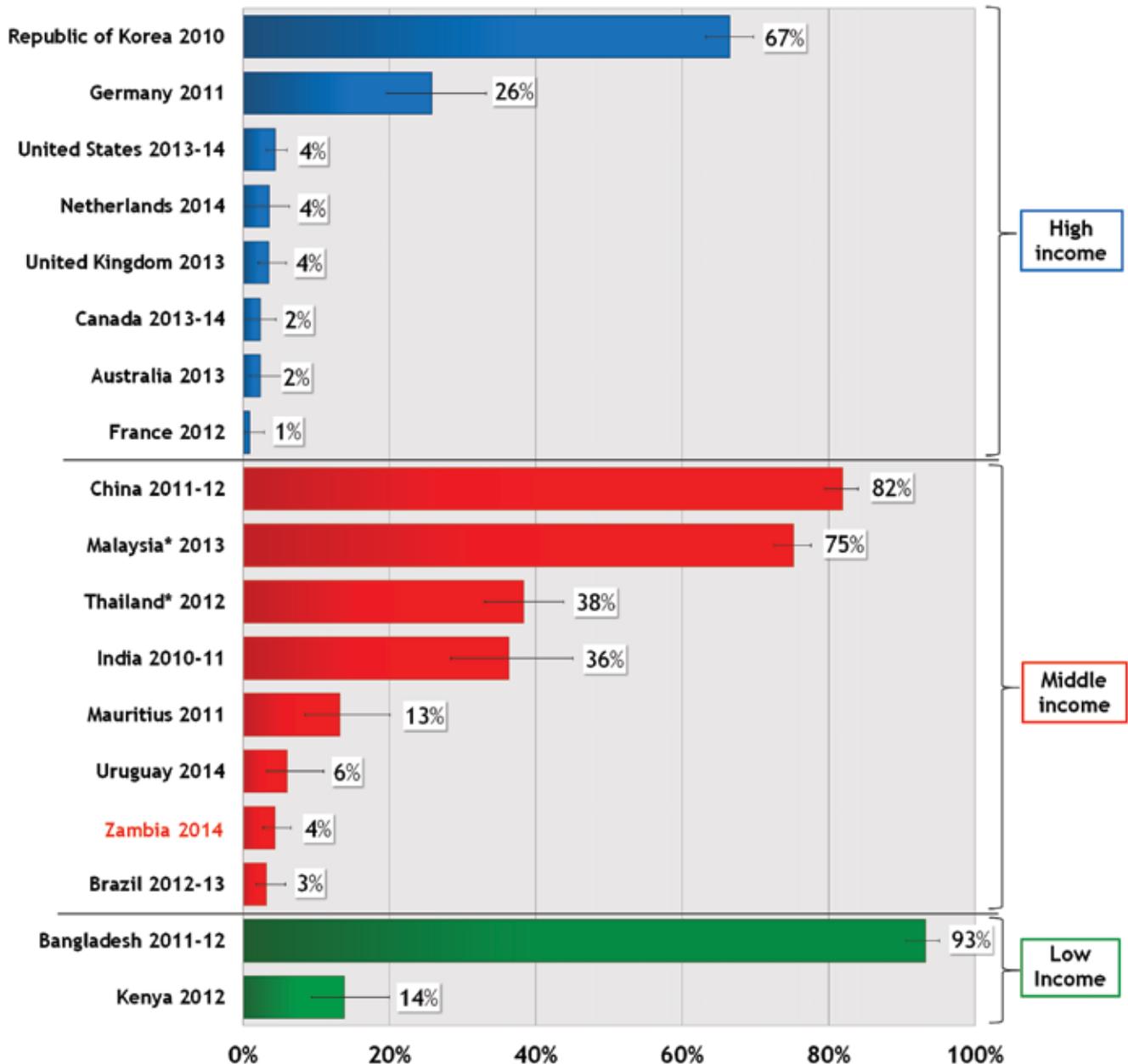
Among those who worked inside a building, 30% (vs. 30% at Wave 1) of tobacco users and 9% (vs. 21% at Wave 1) of non-users noticed people smoking indoors at work in the last month (see Figure 22). Moreover, about a third (31% vs. 33% at Wave 1) of smokers reported that they smoked in indoor areas at work in the last month prior to the survey.

The level of smoking in workplaces in Zambia is low compared to other ITC LMICs – Zambia has the fourth lowest percentage of male smokers (22%) who said they noticed people smoking in their indoor workplace in the last month among 11 LMICs (see Figure 26).

It is notable that although about a third of smokers reported smoking indoors at work, the majority of tobacco users (86% vs. 88% at Wave 1) and 94% (vs. 90% at Wave 1) of non-users support a complete ban on smoking in all indoor areas of workplaces (see Figure 23).

The majority (70%) of tobacco users and non-users (80%) supported a complete ban on smoking in indoor areas in bars at Wave 2.

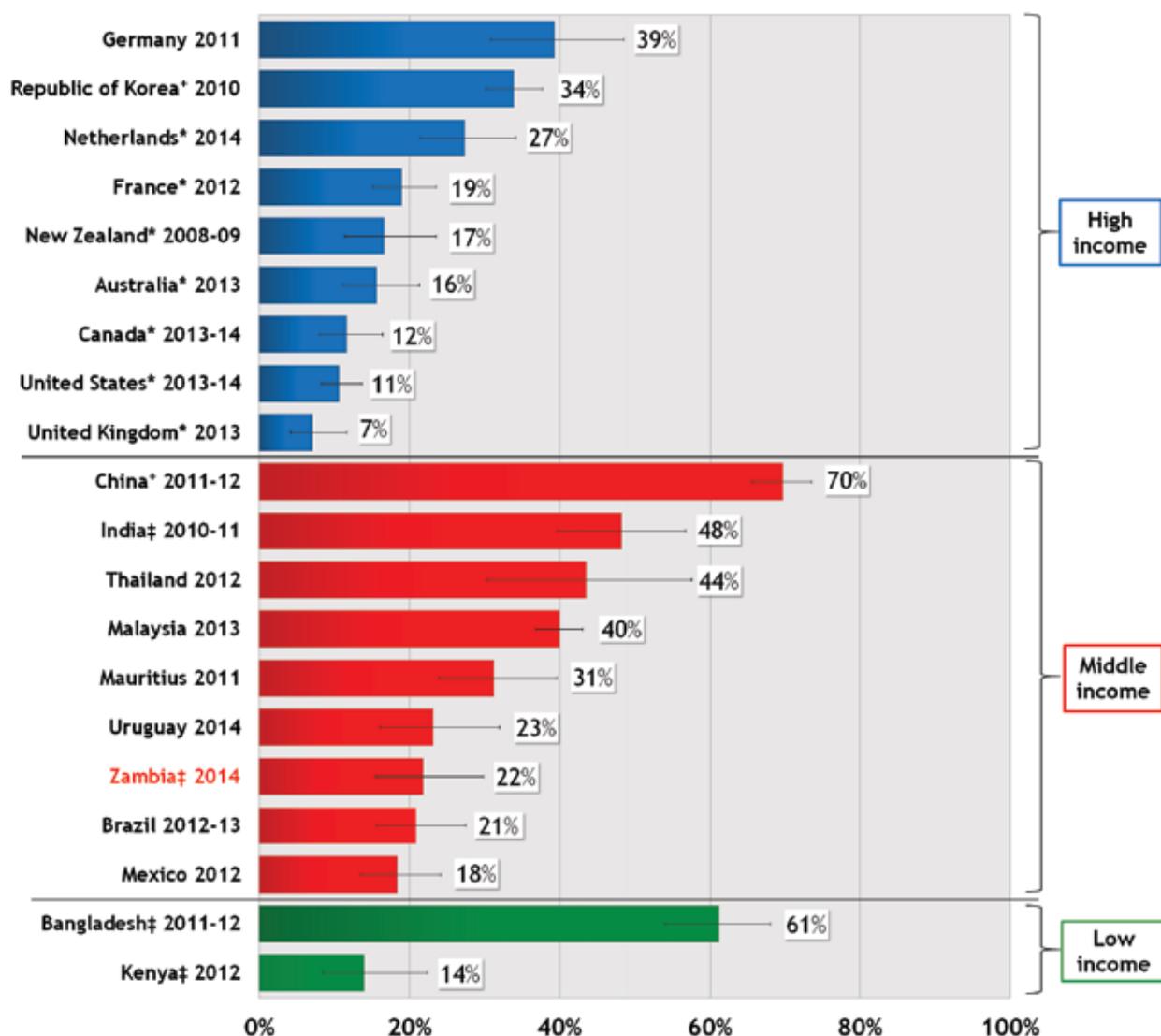
Figure 25. Percentage of smokers† and quitters who noticed smoking in restaurants among those who visited a restaurant in the last year, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

* In Malaysia and Thailand, the results are the average between indoor air-conditioned restaurants and the non-smoking areas of non-air-conditioned/outdoor restaurants.

Figure 26. Percentage of male smokers[†] and quitters who reported noticing people smoking indoors in workplaces in the last month, by country



[†] 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

* In these countries, responses include all those who were employed outside of home, regardless of whether the workplace was indoors or outdoors. In all other countries, respondents who worked outdoors only were excluded.

‡ In these countries, the question asked about smoked tobacco in general, rather than cigarette smoke.

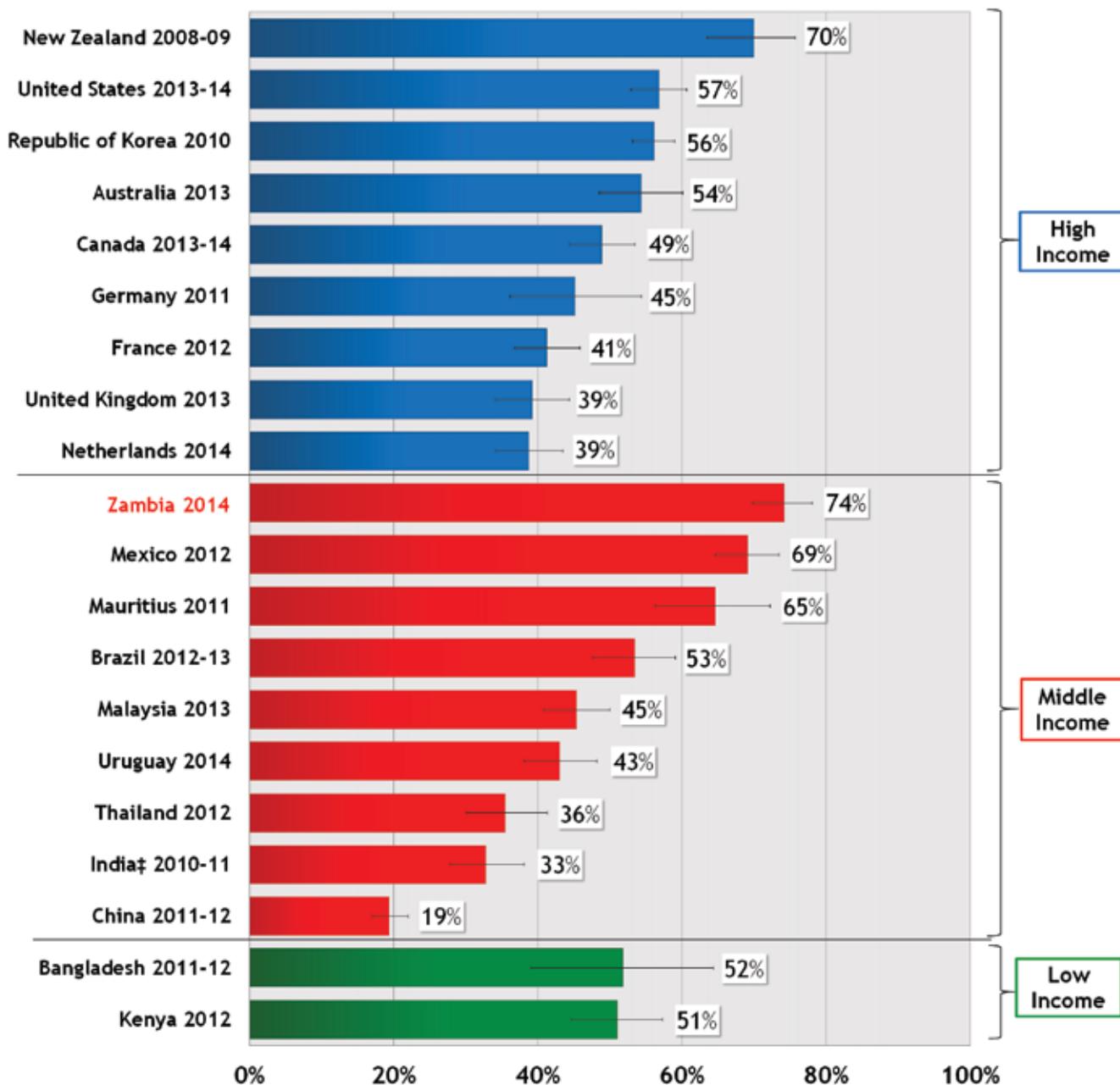
* In China and Korea, respondents were asked about noticing smoking in the last 6 months.

Smoking in the Home

Complete bans on smoking inside the home are common in Zambia. At Wave 2, 80% of all respondents reported that they had a complete ban on smoking in the home. Specifically, 71% (vs. 74% at Wave 1) of smokers and 94% (vs. 89% at Wave 1) of non-users reported that they do not allow any smoking inside their homes (see Figure 21). In addition, 8% (vs. 7% at Wave 1) of smokers and 2% (vs. 2% at Wave 1) of non-users only allow smoking in some rooms inside the home. 22% (vs. 19% at Wave 1) of smokers and 4% (vs. 9% at Wave 1) of non-users reported that they do not have any rules or restrictions in their homes.

ITC cross-country comparisons indicate that male smokers in Zambia report the highest percentage of home smoking bans (74%) of all 20 ITC countries (see Figure 27).

Figure 27. Percentage of male smokers[†] and quitters who “never allow” smoking in their home, by country



[†] 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

Support for Smoking Bans in Other Public Places

At Wave 2, almost all tobacco users and non-users supported complete smoking bans in hospitals (97% of tobacco users; 98% of non-users) and schools, colleges or universities (96% of tobacco users; 98% of non-users) (see Figure 23).

TOBACCO ADVERTISING, PROMOTION, AND SPONSORSHIP

Article 13 of the WHO FCTC calls for Parties to implement comprehensive bans on tobacco advertising, promotion and sponsorship. To date, Zambia has not made efforts to ban advertising of tobacco products to the general public. The current law permits the advertising of tobacco products through newspapers, radio, television, cinemas, billboards, posters, magazines, and videos with few restrictions. Thus, compliance with Article 13 remained poor at both ITC Zambia Survey Waves (2012-2014).



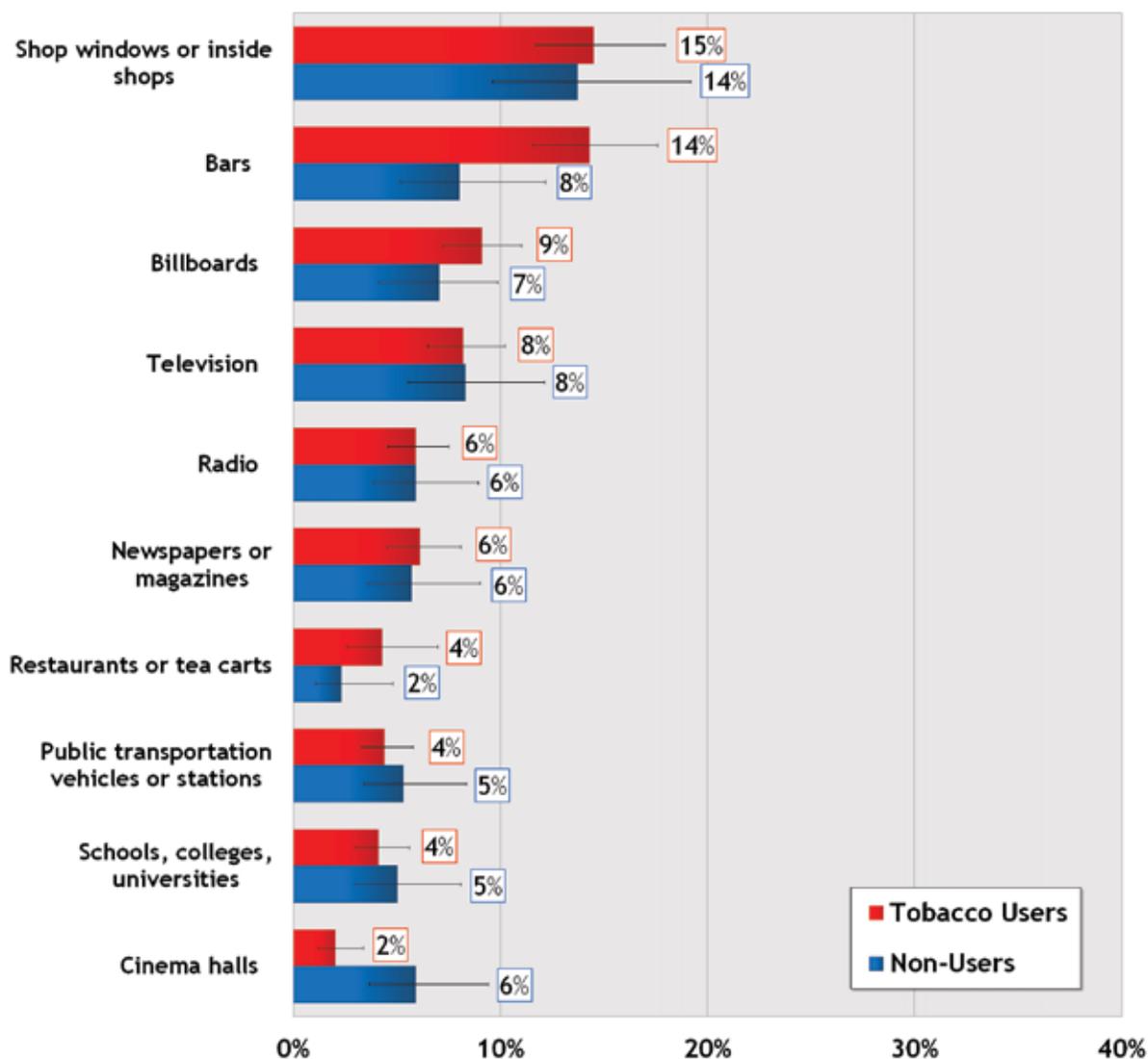
Example of prominent tobacco advertising in Zambia.

Tobacco Advertising

The ITC Zambia Survey asked tobacco users and non-users how often they had noticed any form of tobacco promotion or advertising in the last 6 months. At Wave 2, 11% (vs. 13% at Wave 1) of tobacco users and 7% (vs. 14% at Wave 1) of non-users said that they noticed things that are designed to encourage tobacco use at least once in the last 6 months. Specifically, in the last 6 months, advertisements for tobacco products were most commonly noticed by tobacco users in the following places: on shop windows or inside shops (15%), in bars (14%), on billboards (9%), and on television (8%) (see Figure 28). Non-users also reported noticing tobacco advertising most often in these places, although they were less likely to notice advertising in bars (8%). Few tobacco users and non-users reported noticing advertising through other venues including: radio (6% of tobacco users), newspapers or magazines (6%), restaurants/tea carts (4%), public transportation vehicles or stations (4%), schools/colleges/universities (4%), and cinema halls (2%).

In the last 6 months, advertisements for tobacco products were most commonly noticed by tobacco users on shop windows or inside shops (15%), in bars (14%), and on billboards (9%). Almost one-quarter (22%) of tobacco users and 19% of non-users saw people using tobacco products in the entertainment media in the last 6 months.

Figure 28. Percentage of tobacco users and non-users who noticed tobacco products being advertised in various venues in the last 6 months at Wave 2

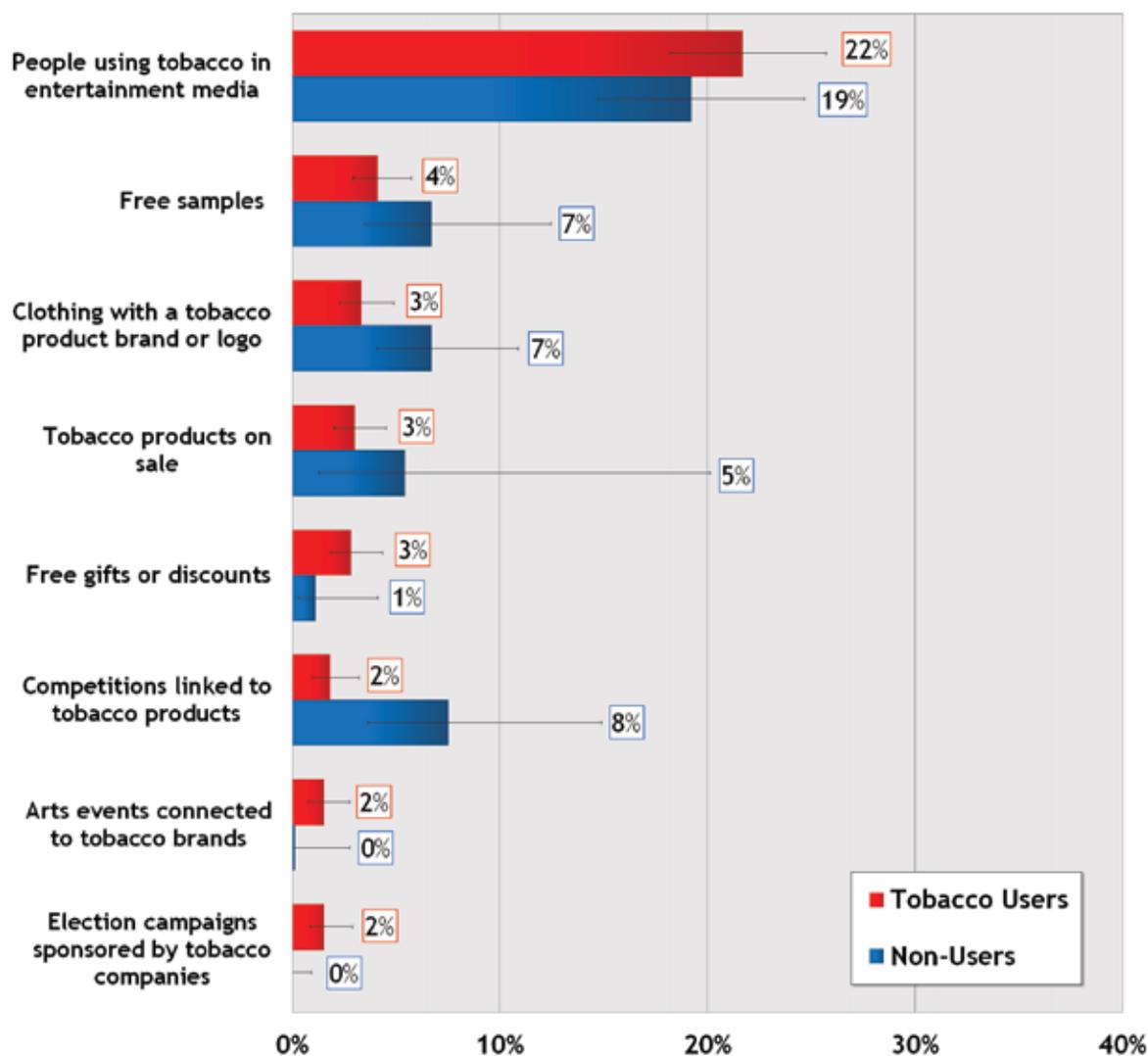


Tobacco Promotion and Sponsorship

Findings from the ITC Zambia Wave 2 Survey showed that tobacco users and non-users infrequently noticed other forms of tobacco promotion, including: free samples of tobacco products (4% of tobacco users), clothing or other items with a tobacco product brand or logo (3%), tobacco products on sale (3%), free gifts or discounts (3%), competitions linked to tobacco products (2%), Arts events (music, theatre or fashion) (2%), or election campaigns sponsored by tobacco companies (2%) in the last 6 months (see Figure 29).

However, 22% of tobacco users at Wave 2 (vs. 19% at Wave 1) and 19% of non-users (vs. 15% at Wave 1) stated that they saw people using tobacco products in the entertainment media (e.g., movies, TV, and magazines) “often” or “once in a while” in the last 6 months. This is not surprising because the 1992 Zambian Public Health (Tobacco) Regulations permit the advertising and promotion of tobacco products to the general public through newspapers, radio, television, cinemas, billboards, posters, magazines, and videos. These findings are of concern as numerous studies have proven that there is a causal association between the depiction of smoking in the entertainment media and the initiation of youth smoking and progression to regular smoking.^{39, 40}

Figure 29. Percentage of tobacco users and non-users who noticed various types of tobacco promotion in the last 6 months at Wave 2



Support for TAPS Ban

The ITC Zambia Surveys asked all respondents whether they support complete bans on all tobacco advertisements at shops and stores. Even though stores were the most commonly reported place for noticing tobacco advertisements, the majority of tobacco users (58% vs. 47% at Wave 1) and non-users (75% vs. 82% at Wave 1) said they would support a complete ban “a lot”. An additional 25% of tobacco users (vs. 26% at Wave 1) and 10% of non-users (vs. 9% at Wave 1) said they “somewhat” support a complete ban on tobacco advertisements at shops.

EDUCATION, COMMUNICATION, AND PUBLIC AWARENESS

Under Article 12 of the WHO FCTC, Parties are required to promote and strengthen public awareness of tobacco control issues through education and public awareness programs on the health risks of tobacco consumption and the benefits of cessation, and provide public access to information on the tobacco industry.

Multiple civil society organizations have been actively involved in the tobacco control movement in Zambia; however, there is a lack of sustained funding for campaigns to increase public awareness of the harms of smoking. This is evident in the ITC Zambia Survey findings presented in this section, including awareness of the specific health effects of smoking, beliefs about light or mild cigarettes, and awareness of anti-tobacco campaigns.

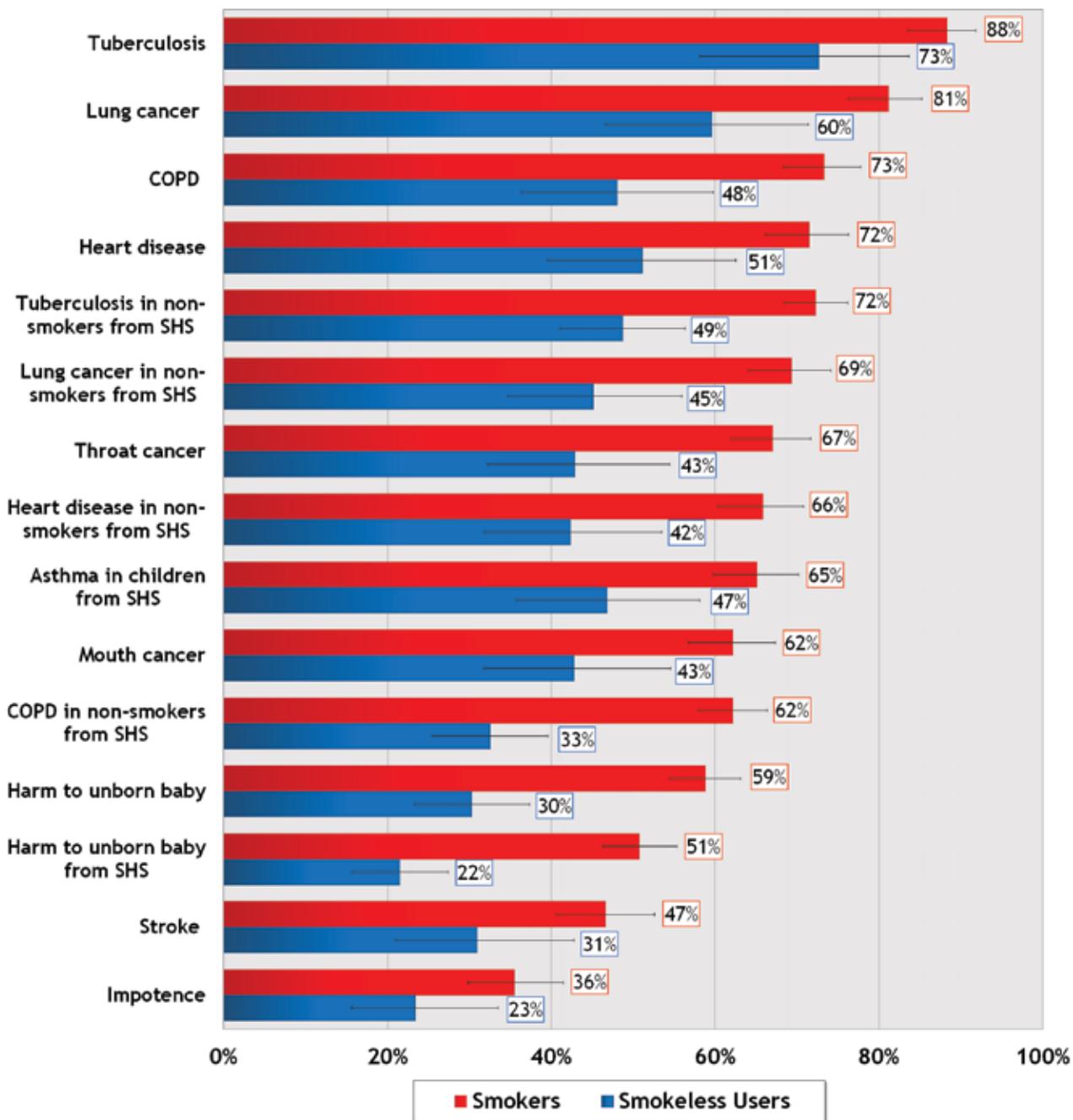
Knowledge of the Harms of Smoking

The ITC Zambia Wave 2 Survey measured awareness of a range of health effects associated with smoking cigarettes. Overall, at Wave 2, Zambian smokers demonstrated a higher level of awareness of smoking-related health effects compared to smokeless tobacco only users (see Figure 30). The majority of smokers correctly believed that smoking causes tuberculosis (88% vs. 73% of smokeless users), lung cancer (81% vs. 60%), chronic obstructive pulmonary disease (COPD) (73% vs. 48%), heart disease (72% vs. 51%), throat cancer (67% vs. 43%), mouth cancer (62% vs. 43%), and harm to the fetus (59% vs. 30%). However, less than half of smokers believed that smoking causes stroke (47% vs. 31% of smokeless users), or impotence in male smokers (36% vs. 23%).

Overall, Zambian tobacco users were less likely to be aware of the harms of secondhand tobacco smoke, particularly among smokeless tobacco only users. At Wave 2, smokers believed that secondhand smoke causes the following health effects in non-smokers: lung cancer (69% vs. 45% of smokeless users), tuberculosis (72% vs. 49%), heart disease (66% vs. 42%), asthma in children (65% vs. 47%), COPD (62% vs. 33%), and harm to the fetus (51% vs. 22%) (see Figure 30).

Although smokers are generally more aware of the harms of smoking compared to smokeless tobacco users, ITC cross-country comparisons reveal that Zambian male smokers are less likely to be aware of several important smoking-related health effects such as lung cancer, heart disease, and stroke compared to male smokers in most other ITC countries.

Figure 30. Percentage of smokers and smokeless users who know or believe that smoking or secondhand smoke (SHS) exposure causes various health effects at Wave 2

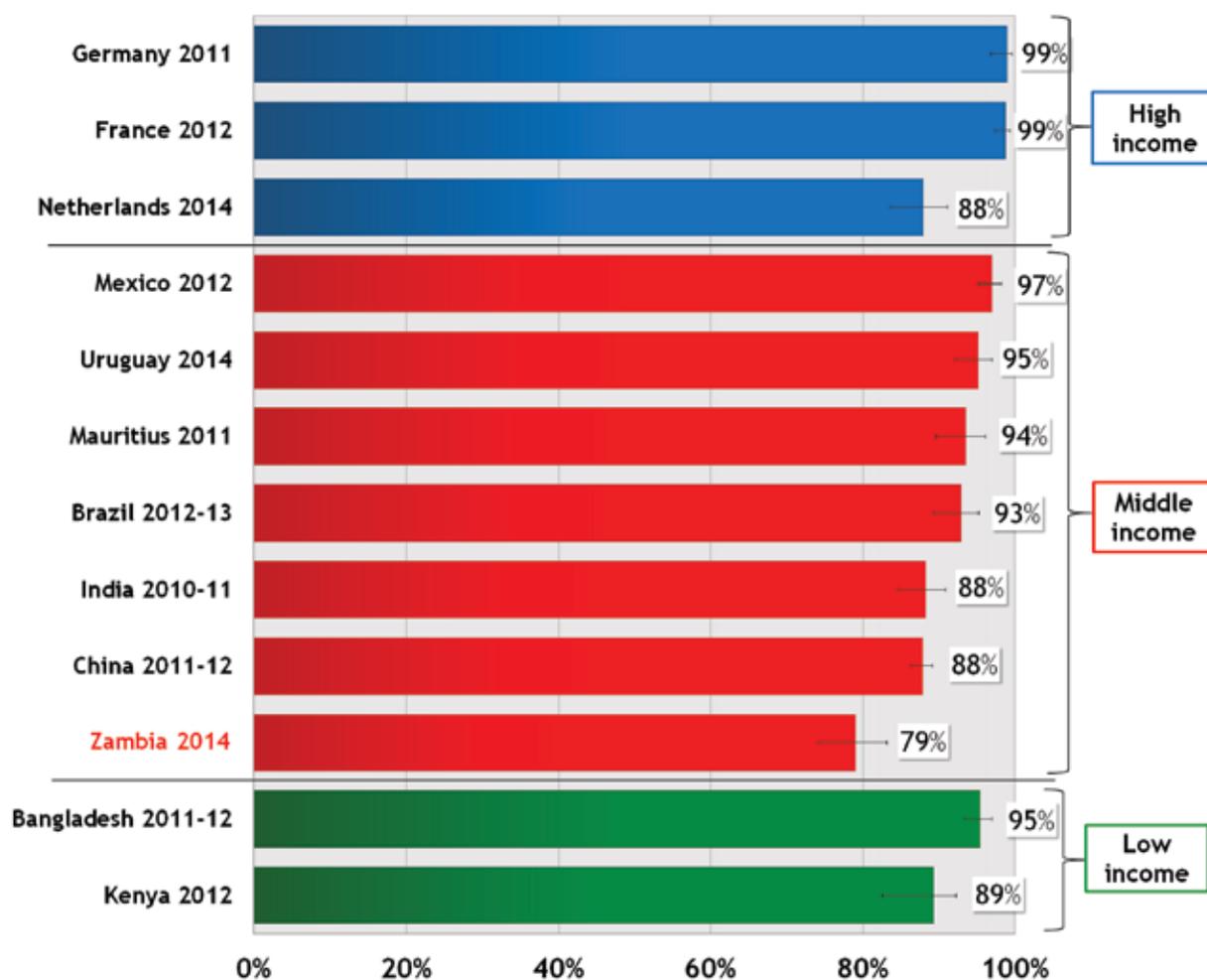


Overall, there were few significant differences in knowledge of health effects of tobacco among smokers across the two survey waves (2012-2014). Only knowledge of impotence (23% at Wave 1; 35% at Wave 2), lung cancer in non-smokers from secondhand smoke (62% at Wave 1; 69% at Wave 2); and heart disease in non-smokers from secondhand smoke (55% at Wave 1; 66% at Wave 2) increased among smokers between Wave 1 and Wave 2. This is not surprising because there have not been any sustained public education campaigns in Zambia between the two survey waves.

Although the survey findings indicate that smokers are generally more aware of the harms of smoking compared to smokeless tobacco users, ITC cross-country comparisons reveal that Zambian male smokers are still less likely to be aware of several important smoking-related health effects compared to male smokers in most other ITC countries.

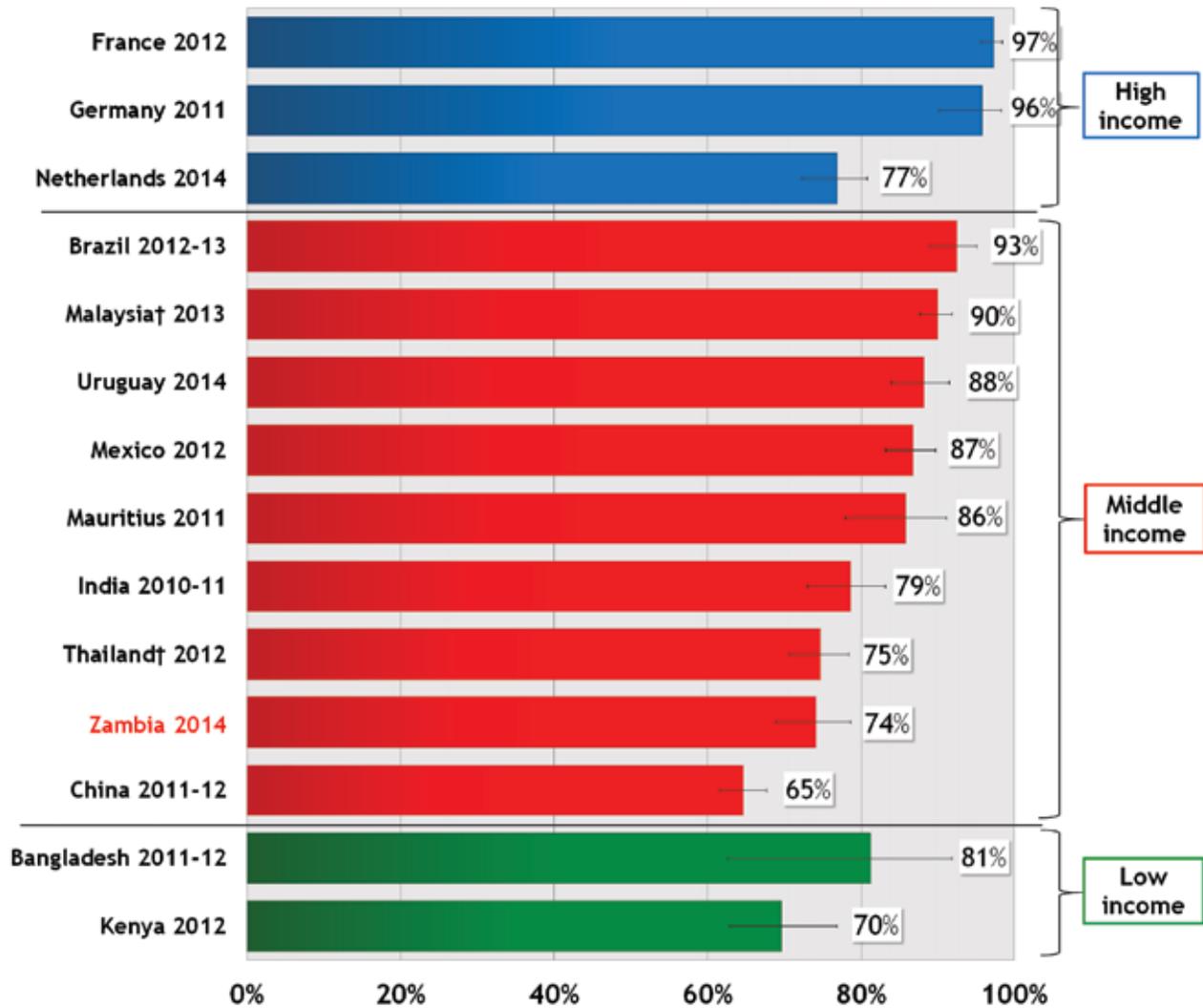
For example, Zambia has the lowest percentage of male smokers who believe that smoking causes lung cancer (79%) among male smokers in 12 ITC countries (see Figure 31). Zambia also has the third lowest percentage of male smokers who believe that smoking causes heart disease (74%) among 14 countries (see Figure 32), and the second lowest percentage of male smokers who believe that smoking causes stroke (45%) among 20 countries (see Figure 33).

Figure 31. Percentage of male smokers† and quitters who believe that smoking causes lung cancer, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

Figure 32. Percentage of male smokers[†] and quitters who believe that smoking causes heart disease, by country

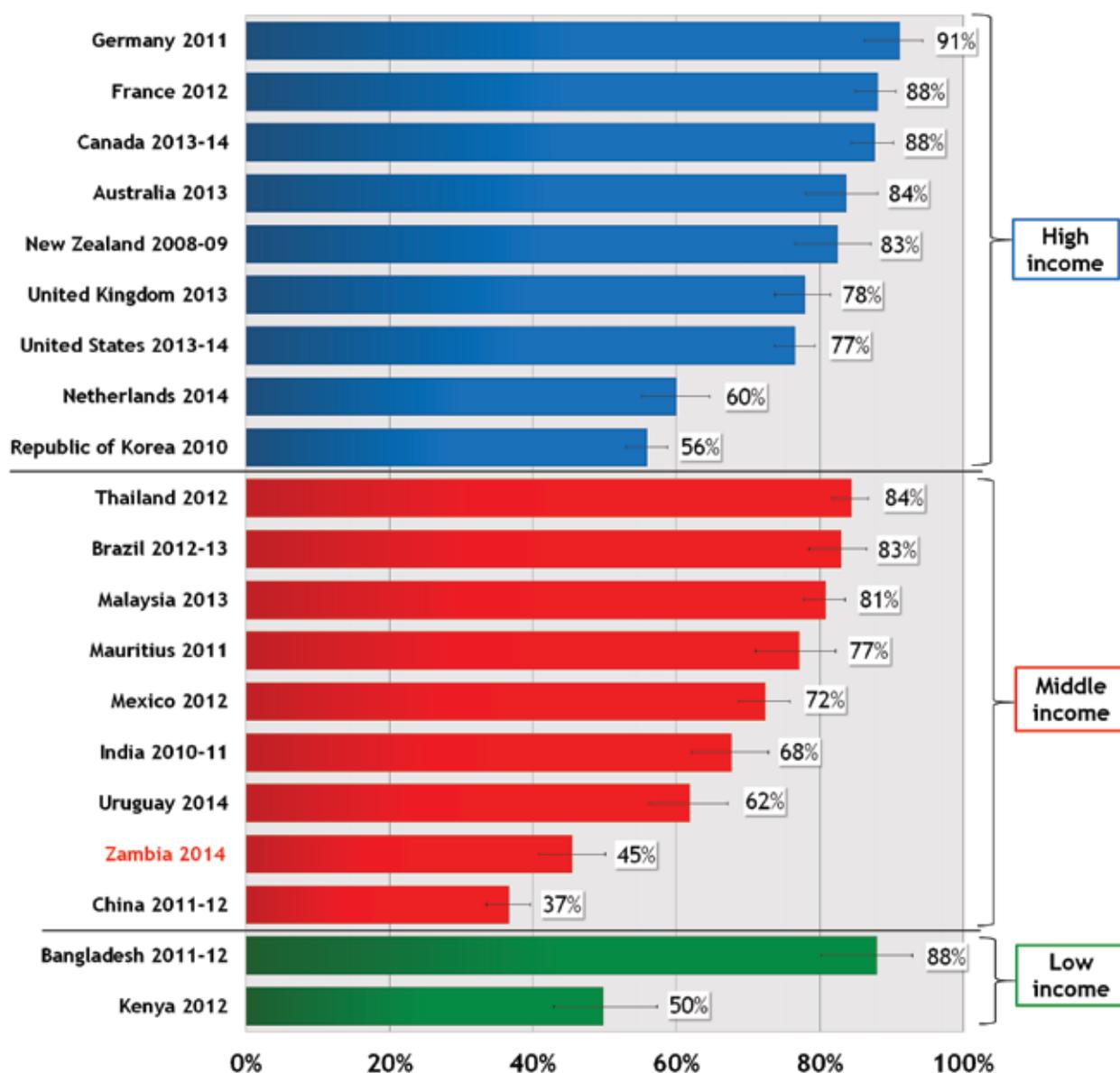


[†] 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

[‡] In Malaysia and Thailand, respondents were asked about 'heart failure'. In all other countries, they were asked about heart disease or CHD.

Zambia has the third lowest percentage of male smokers who believe that smoking causes heart disease (74%) among 14 countries.

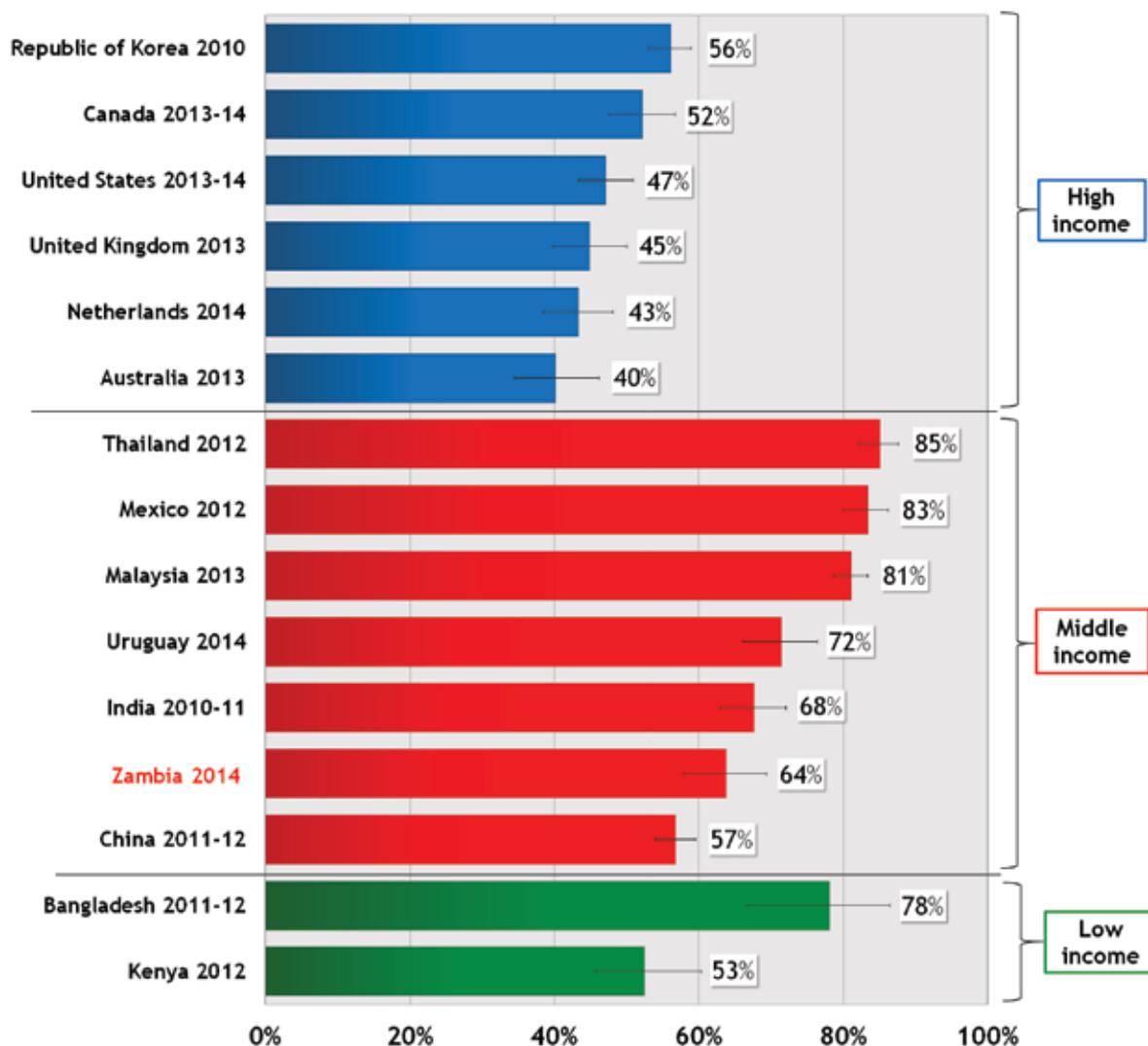
Figure 33. Percentage of male smokers† and quitters who believe that smoking causes stroke, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

Knowledge of the harms of secondhand smoke (SHS) in Zambia is also low compared to other ITC countries – Zambia has the third lowest percentage of male smokers and quitters (64%) who believe that SHS causes heart disease in non-smokers among 9 LMICs (see Figure 34).

Figure 34. Percentage of male smokers[†] and quitters who believe that secondhand smoke causes heart disease in non-smokers, by country



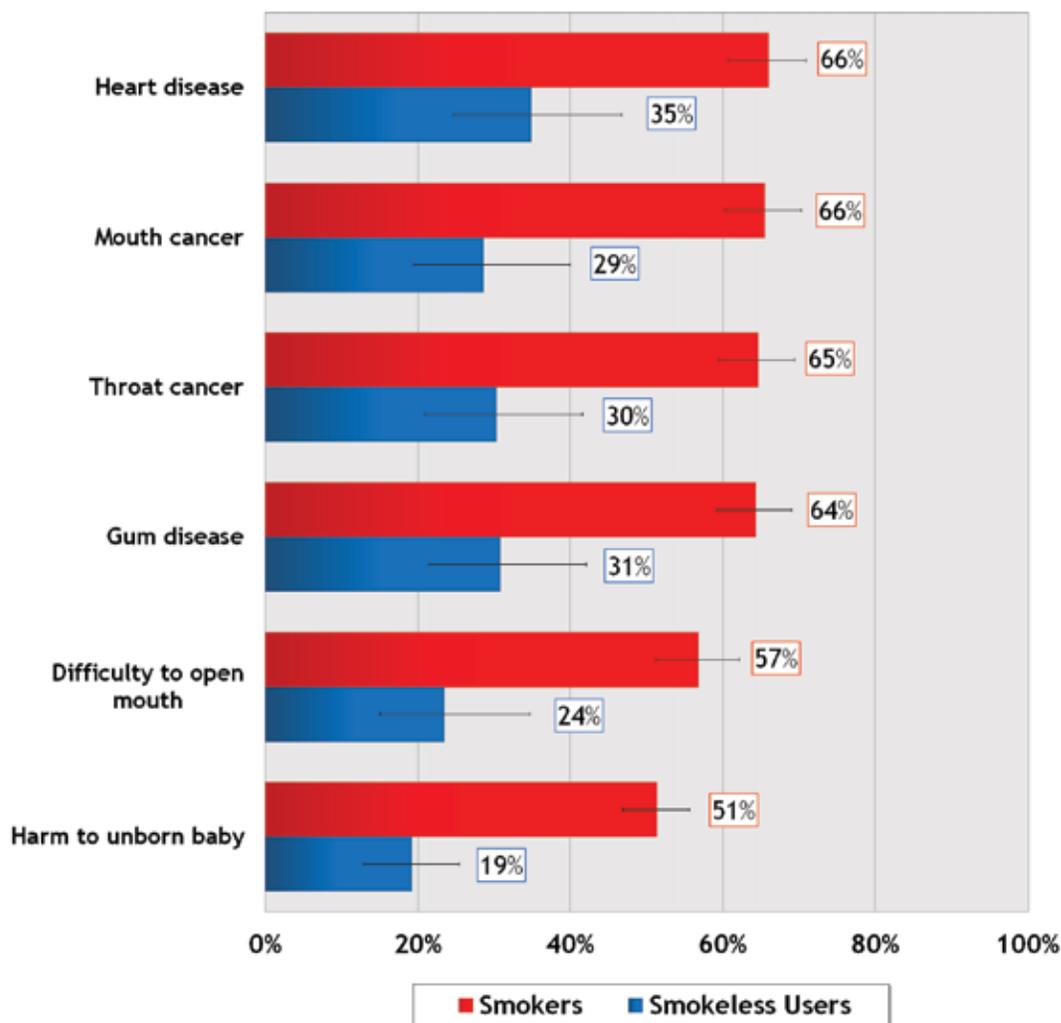
[†] 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

Note: In India, Zambia, and Kenya, the question asked about "passive smoking" instead of secondhand smoke. In Bangladesh, the question asked about "tobacco smoke pollution".

Knowledge of the Harms of Smokeless Tobacco Products

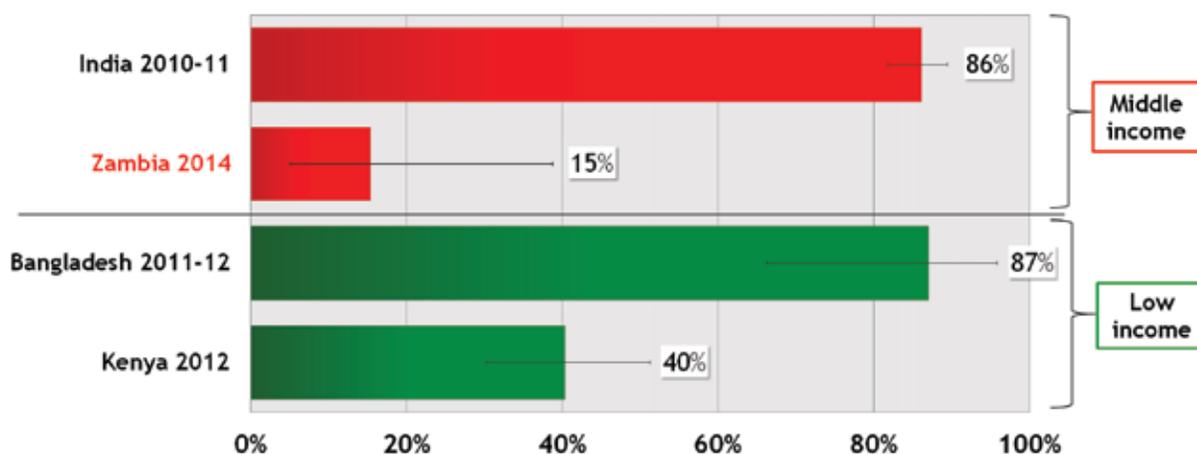
The ITC Zambia Wave 2 Survey measured tobacco users' awareness of a range of health effects associated with using smokeless tobacco products. Overall, knowledge of the specific health effects caused by smokeless tobacco is low, especially among smokeless tobacco users, as about one-third or less of smokeless users were aware of each health effect at Wave 2, compared to over half of smokers who were aware of most of the health effects caused by smoking or smokeless use. Less than half of smokeless users were aware that smokeless tobacco causes heart disease (35% vs. 66% among smokers), mouth cancer (29% vs. 66%), throat cancer (30% vs. 65%), gum disease (31% vs. 64%), difficulty to open mouth (24% vs. 57%), and harm to unborn child (19% vs. 51%) (see Figure 35). Awareness of the harms of smokeless tobacco use among smokeless users increased significantly between survey waves only for heart disease (from 23% at Wave 1 to 35% at Wave 2) and difficulty to open mouth (from 14% at Wave 1 to 24% at Wave 2).

Figure 35. Percentage of smokers and smokeless users who know or believe that smokeless tobacco use causes various health effects at Wave 2



ITC cross-country comparisons reveal that awareness that smokeless tobacco causes mouth cancer is lowest among male smokeless users in Zambia (15%) compared to Kenya (40%), India (86%), and Bangladesh (87%) (see Figure 36). These findings point to the need for campaigns to educate the public about the harms of smokeless tobacco – particularly among women (because the vast majority of smokeless users are women).

Figure 36. Percentage of male smokeless tobacco and mixed tobacco users who believe that smokeless tobacco use causes mouth cancer, by country



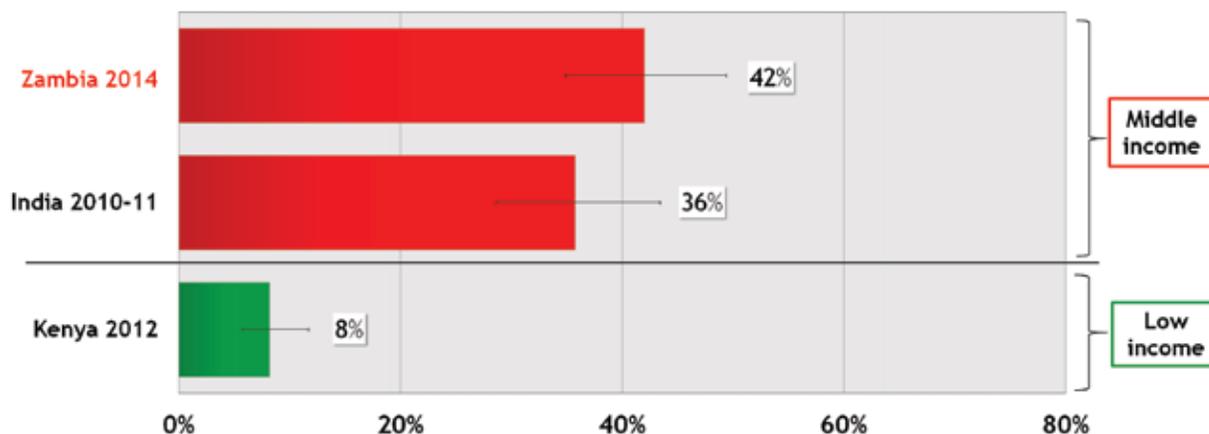
Beliefs about Light/Mild and Menthol Cigarettes

Currently, Zambia has not banned the use of false, misleading or deceptive terms such as “light”, “mild” or “low tar” on tobacco packages as required under FCTC Article 11.

At Wave 2, 42% (vs. 25% at Wave 1) of smokers who had a usual brand of cigarettes stated that their usual cigarette variety was “mild” or “extra mild”. Data from other ITC countries shows that the percentage of Zambian male smokers who report smoking light or mild cigarettes (42%) is higher than in India (36%) and Kenya (8%) (see Figure 37). Almost half (42% vs. 27% at Wave 1) of smokers reported that they usually smoked menthol flavored (menthol, export menthol, or sweet menthol) cigarettes. The ITC Zambia Wave 2 Survey findings suggest that smokers have false beliefs about “light” and menthol cigarettes. Almost half (45% vs. 45% at Wave 1) of Zambian smokers “agreed” or “strongly agreed” that light cigarettes are less harmful than regular cigarettes, and more than half (58%) agreed that light cigarettes are smoother on the throat and chest. About one-third (31%) of smokers “agreed” or “strongly agreed” that menthol cigarettes are less harmful than regular cigarettes.

Among smokers who had a usual brand at Wave 2, over one quarter (27% vs. 25% at Wave 1) thought that the cigarette brand that they usually smoke is “a little less harmful” compared to other cigarettes. However, it is well established that all conventional cigarette brands present the same level of risk to smokers – light, menthol, and low tar cigarettes are no less harmful to a smoker’s health than regular cigarettes.⁴¹ To curb these false beliefs, Guidelines for Article 11 prohibit the display of quantitative or qualitative statements about tobacco constituents and emissions that might imply that one brand is less harmful than another; however, Zambia has not yet implemented this policy.

Figure 37. Percentage of male smokers[†] who reported smoking light or mild cigarettes among those who have a regular brand, by country



[†] 'Smokers' refer to dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco).

* The terms differed across countries - In India, the percent represents those who smoke either 'light', 'light/regular', 'mild', 'ultra mild', or 'very mild' cigarettes, whereas in Zambia it is those who smoke 'mild' or 'extra mild' cigarettes, and in Kenya it is those who reported smoking 'lights'.

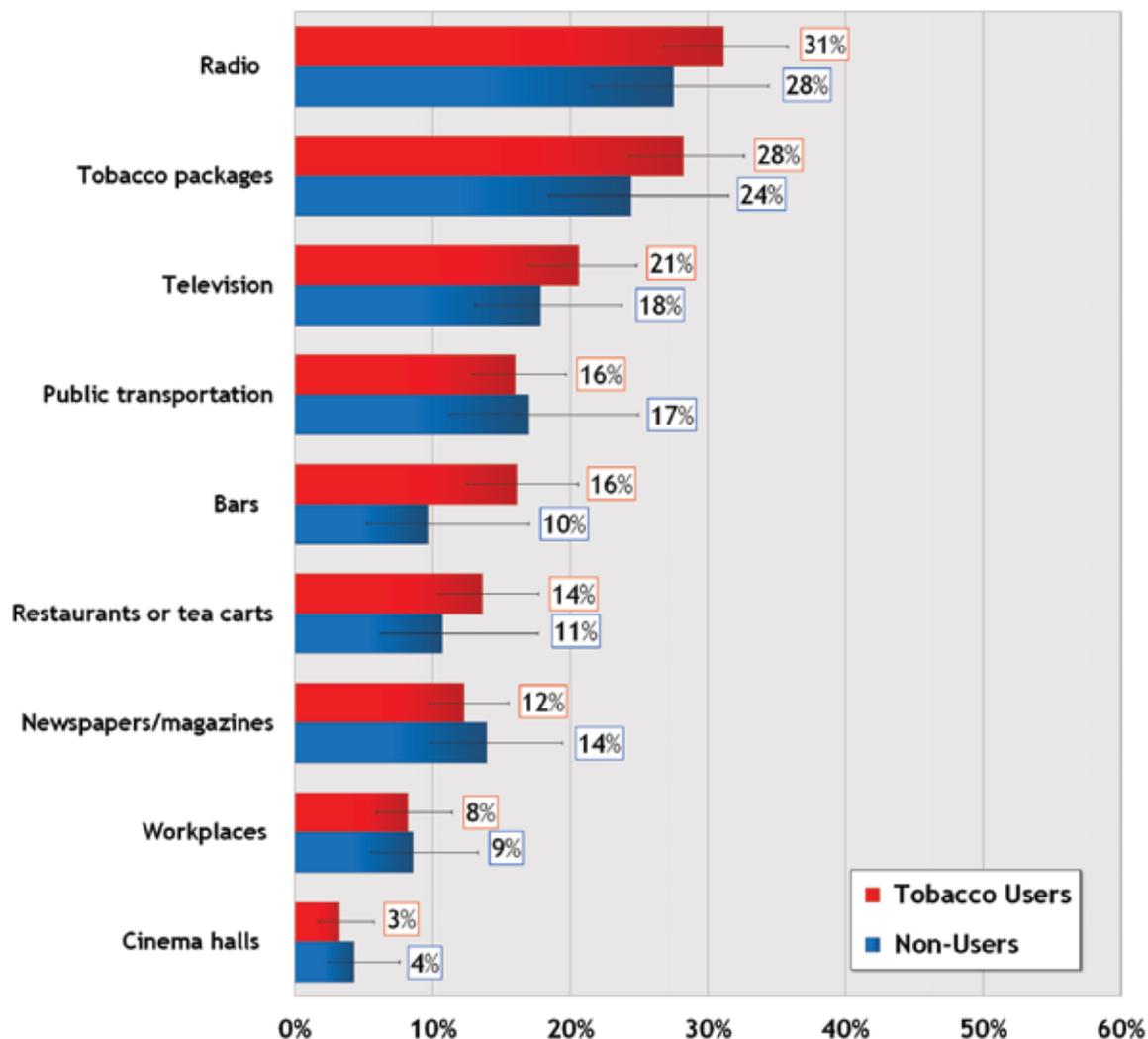
Exposure to Anti-Tobacco Messages

The Wave 2 Survey findings indicate that the majority of Zambians are not regularly exposed to messages about the harms of tobacco. At Wave 2, the most commonly cited places where tobacco users and non-users reported noticing or hearing about anti-tobacco messages were: on the radio (31% of tobacco users vs. 28% of non-users), tobacco packs (28% vs. 24%), television (21% vs. 18%), public transportation (16% vs. 17%), bars (16% vs. 10%), restaurants (14% vs. 11%), and newspapers/magazines (12% vs. 15%) (see Figure 38). Less than 10% of tobacco users and non-users reported noticing anti-tobacco information in workplaces or cinemas. From Wave 1 to Wave 2, there were significant increases in the percentage of tobacco users reporting noticing anti-tobacco messages on television, radio, and tobacco packages.

At Wave 2, about half of tobacco users (50% vs. 66% at Wave 1) and non-users (47% vs. 67% at Wave 1) reported that the anti-tobacco advertising made using tobacco “a little” or “a lot” less socially acceptable and only 37% (vs. 40% at Wave 1) of tobacco users said that the anti-tobacco advertising made them more likely to quit using tobacco.

In sum, the ITC Zambia Survey findings provide evidence of very low awareness of the harms of tobacco use among tobacco users and low exposure to anti-tobacco messages. The findings point to the clear need for sustained funding for anti-tobacco mass media campaigns, in addition to large pictorial warnings in order to raise awareness among Zambians on the harms of both smoked and smokeless tobacco.

Figure 38. Percentage of tobacco users and non-users who noticed anti-tobacco advertising in various venues in the last 6 months at Wave 2



The Wave 2 Survey findings indicate that the majority of Zambians are not regularly exposed to messages about the harms of tobacco. At Wave 2, the most commonly cited places where tobacco users and non-users reported noticing or hearing about anti-tobacco messages were: on the radio (31% of tobacco users vs. 28% of non-users), tobacco packs (28% vs. 24%), and television (21% vs. 18%).

TOBACCO PRICE AND TAXATION

Increasing tobacco taxes and prices is widely recognized as the single most cost-effective strategy to reduce the prevalence of tobacco use, particularly among youth. Article 6 of the FCTC encourages countries that have ratified the treaty to adopt tax and price policies aimed at reducing tobacco consumption. Guidelines for Article 6 state that effective tobacco taxes (leading to higher prices) lower consumption and prevalence and thereby improve the health of the population; are economically efficient and reduce health inequalities; and are an important source of government revenue.²⁰

Previous research using data from 1999-2011 has shown that although nominal cigarette prices in Zambia increased over this period, price adjustments have not kept in line with increases in inflation and income, and cigarettes have therefore become more affordable.²¹ Affordability is expected to increase even further over the current decade if significant price increases are not initiated.

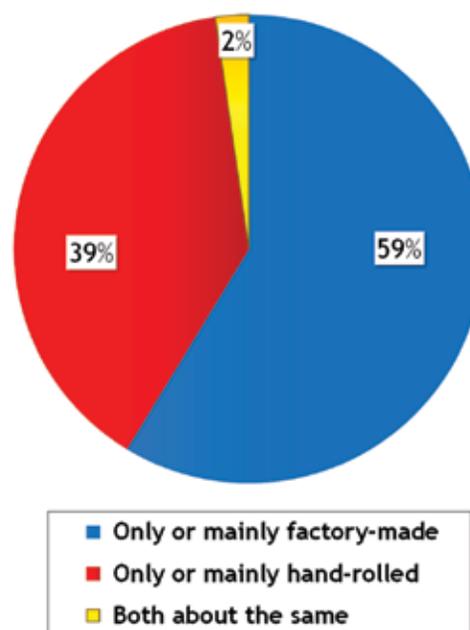
The ITC Zambia Survey collected extensive information on purchasing and price of tobacco products. Smokers were asked to determine the extent to which the price of cigarettes influenced their brand selection and thoughts about quitting, as well as their perceptions of the cost of their smoking. The findings presented in this section suggest that cigarettes are becoming more affordable in Zambia and that prices are too low to motivate Zambian smokers to quit.

Factory-made vs. Hand-rolled Cigarettes

At Wave 2, the majority of smokers in Zambia (59% vs. 49% at Wave 1) said they smoked only factory-made cigarettes or mainly factory-made cigarettes. More than one-third of smokers (39% vs. 48% at Wave 1) reported smoking only or mainly hand-rolled cigarettes; and the remainder (2% vs. 3% at Wave 1) smoked both factory-made and hand-rolled cigarettes equally (see Figure 39).

The finding that a large proportion of smokers in Zambia smoke hand-rolled cigarettes is concerning, as their reasons for choosing hand-rolled cigarettes suggest that there are considerable cost savings associated with smoking hand-rolled cigarettes over factory-made cigarettes. The Wave 2 findings suggest that price is a strong motivating factor for smoking hand-rolled cigarettes, as the majority (88% vs. 78% at Wave 1) of those who smoke only or mainly hand-rolled cigarettes said they do so because of price. Other reasons for choosing hand-rolled cigarettes included the taste (33% vs. 29% at Wave 1) and the belief that they are less harmful (10% vs. 10% at Wave 1) (see Figure 40).

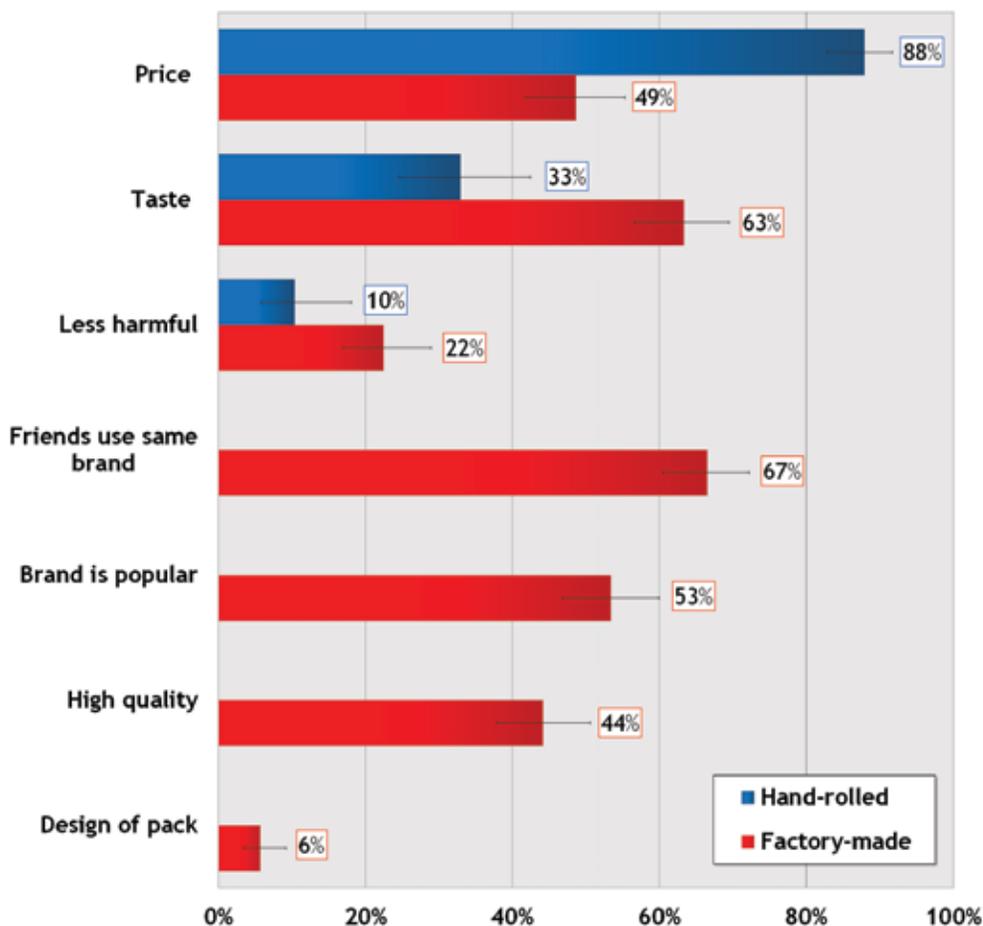
Figure 39. Percentage of smokers by cigarette type at Wave 2



Reasons for Choosing a Specific Brand

The most frequently selected reasons for cigarette brand selection among smokers who had a usual brand at Wave 2 were: friends smoke the same brand (67% vs. 62% at Wave 1), the taste (63% vs. 56% at Wave 1), it is a popular brand (53% vs. 46% at Wave 1), and the price (49% vs. 45% at Wave 1). Less than one-quarter of smokers (22% vs. 14% at Wave 1) said they chose their brand because it is less harmful, and only 6% (vs. 4% at Wave 1) chose their brand because of the design of the pack (see Figure 40).

Figure 40. Smokers' reasons for choosing hand-rolled cigarettes or their brand of factory-made cigarettes at Wave 2



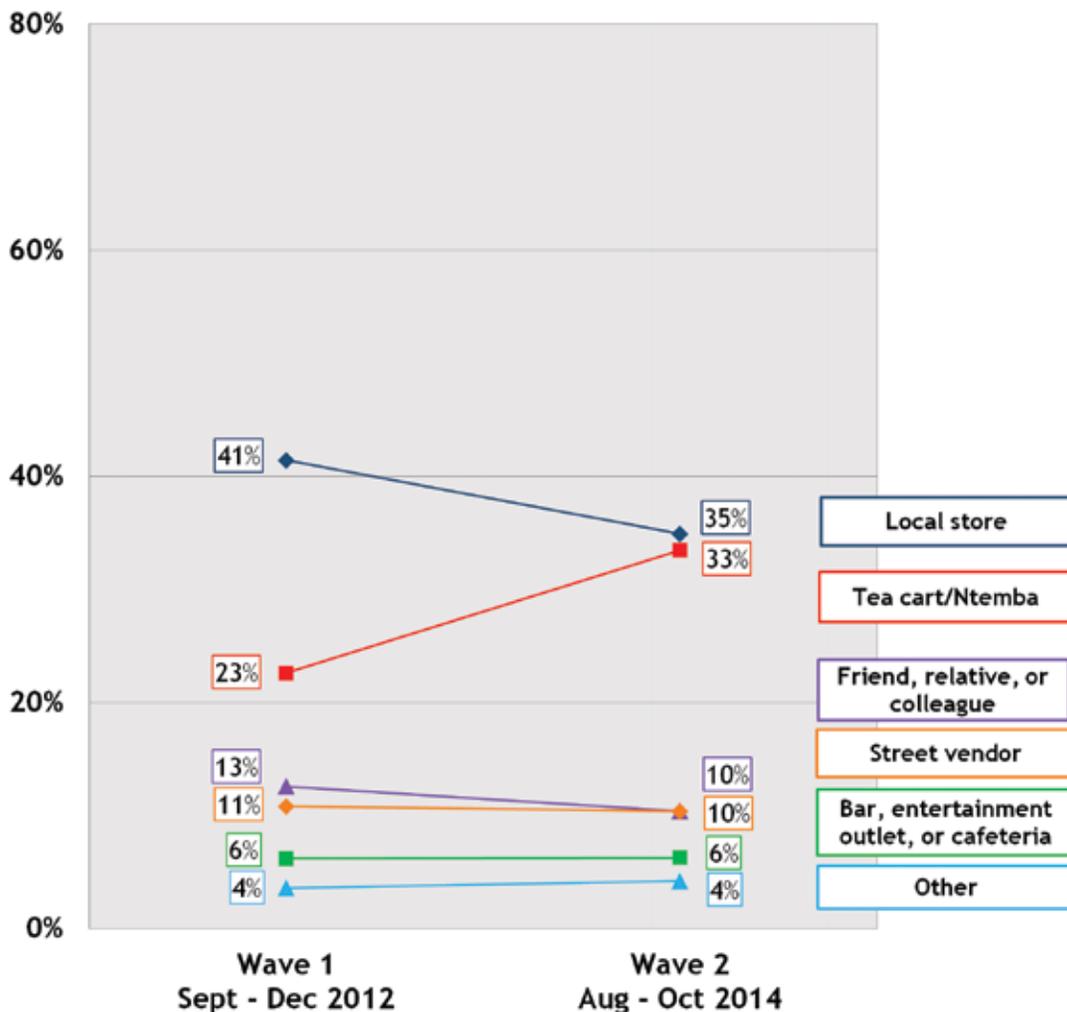
Note: The question about reasons for choosing hand-rolled cigarettes included only three options (price, taste, and less harmful).

At Wave 2, among smokeless users with a usual smokeless brand, the most commonly cited reasons for choosing their usual smokeless brand were: because friends used the same brand (58% vs. 54% at Wave 1), the popularity of the brand (55% vs. 64% at Wave 1), taste (39% vs. 18% at Wave 1) and price (24% vs. 33% at Wave 1).

Sources of Last Purchase of Cigarettes

At Wave 2, most smokers reported that they made their last purchase of cigarettes from a local store (35%), or a tea cart or *Ntemba* (kiosk) (33%). Other sources included: from a friend/colleague/relative or employer (10%), a street vendor (10%), or from a bar (6%) (see Figure 41). The most common sources of purchase remained the same from Wave 1 to Wave 2.

Figure 41. Source of last purchase of cigarettes among smokers, by wave

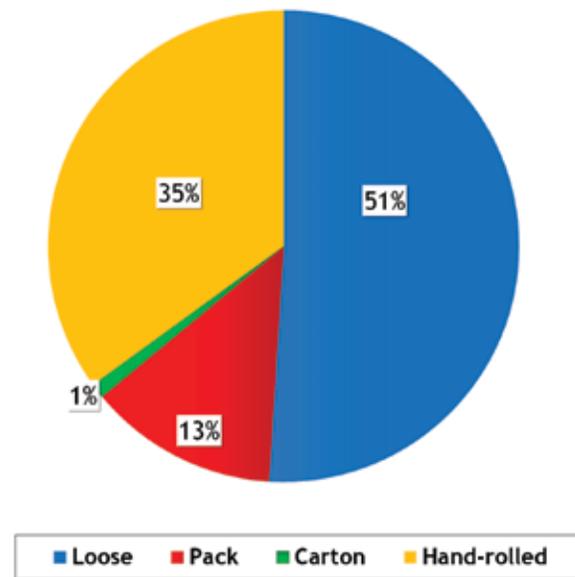


At Wave 2, most smokers reported that they made their last purchase of cigarettes from a local store (35%), or a tea cart or Ntemba (kiosk) (33%).

Loose Cigarette Purchases

Currently, Zambia has not regulated the sale of loose (single) cigarettes in *Ntembas* (kiosks). At Wave 2, about half (51% vs. 46% at Wave 1) of smokers stated that their last purchase of cigarettes was loose (single) cigarettes (see Figure 42). About a third of smokers (35% vs. 44% at Wave 1) last purchased hand-rolled cigarettes, while 13% (vs. 8% at Wave 1) last purchased a pack of cigarettes, and 1% (vs. 8% at Wave 1) last purchased a carton of cigarettes.

Figure 42. Percentage of smokers who last purchased cigarettes loose, by the pack, by the carton, or hand-rolled at Wave 2



Affordability of Cigarettes

Data from the ITC surveys also allows for an analysis of the affordability of manufactured cigarettes across countries, which refers to the quantity of resources (or income) that is required to purchase a pack of cigarettes, and is a ratio of household income to the price of tobacco products. Higher affordability, for example, means that the price of a pack of cigarettes would require a lower percentage of one's daily income.

An Affordability Index was constructed using data from 18 ITC countries to determine changes in cigarette affordability between the first and most recent survey waves, including Waves 1 and 2 of the ITC Zambia Survey. This analysis took into account ITC data on price paid for the most recent factory-made cigarette purchase, number of cigarettes smoked per day, and household income. The Affordability Index was calculated as the reciprocal of the percentage of daily household income spent on a pack of cigarettes (cigarette price per daily income ratio or CPDIR); therefore, higher numbers of the Affordability Index represent greater affordability (a lower percentage of income spent on cigarettes).

The results show that factory-made cigarettes are less affordable in Zambia in 2014 compared to 8 other ITC LMICs at the most recent survey wave (see Figure 43). In Zambia, the average household income was only 5.45 times greater than the amount spent on cigarettes, whereas in Uruguay, household income was almost 16 times greater than the amount spent on cigarettes. In other words, a greater proportion of household daily income was spent on cigarettes in Zambia in 2014 compared to other countries.

However, the change in affordability calculated from the first to last survey wave shows that between 2012 and 2014, cigarettes became MORE affordable in Zambia, with an average increase of 1.3% per year. Therefore, even though cigarettes are not very affordable for most Zambian smokers, it is concerning that cigarettes appear to be getting more affordable each year, demonstrating the need to increase taxes on factory-made cigarettes to prevent further increases in affordability.

Figure 43. Affordability of manufactured cigarettes (percentage of daily household income spent on a pack of cigarettes) among male smokers who purchased cigarettes by the pack, and average change in affordability per year, by country

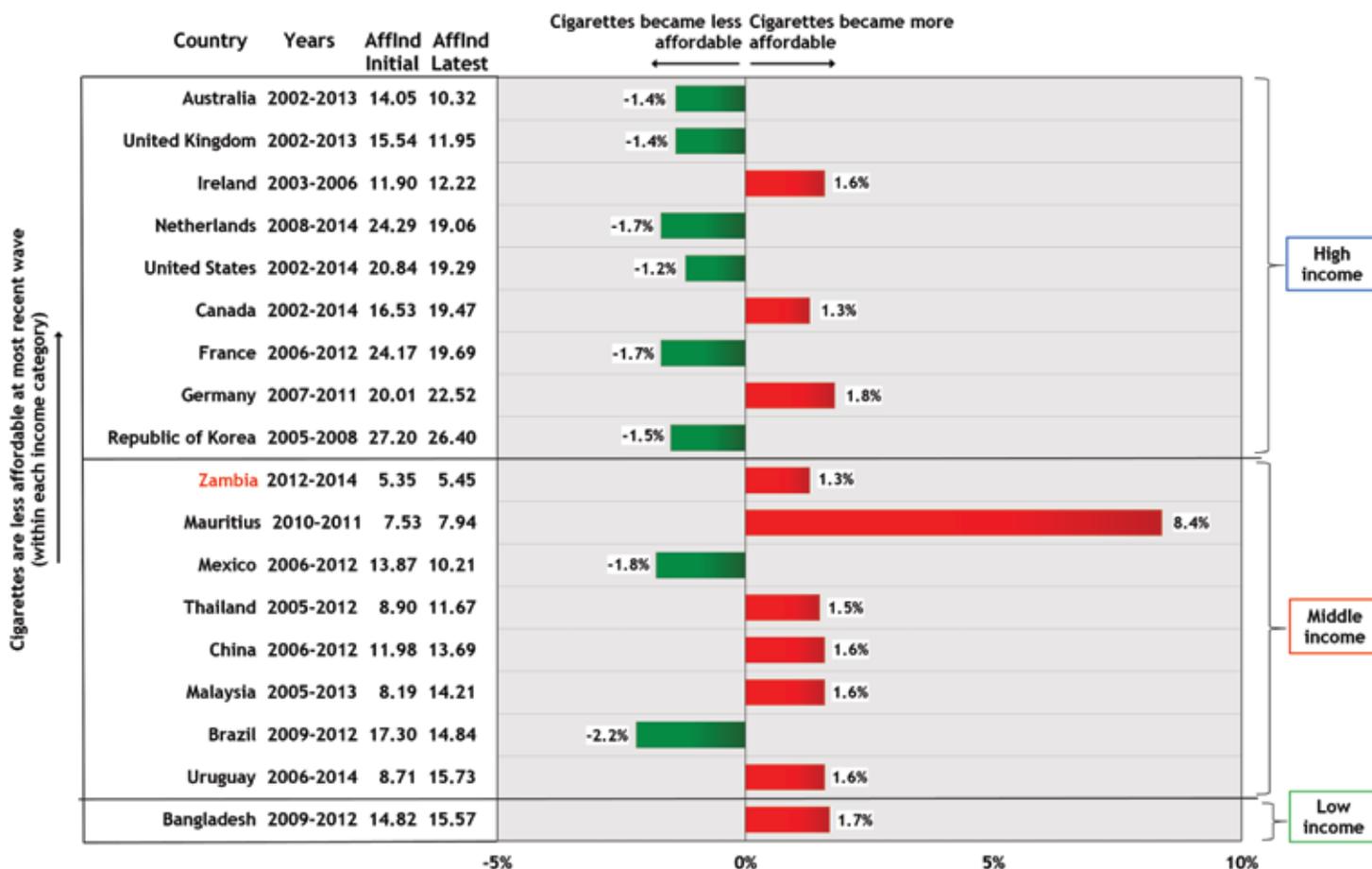


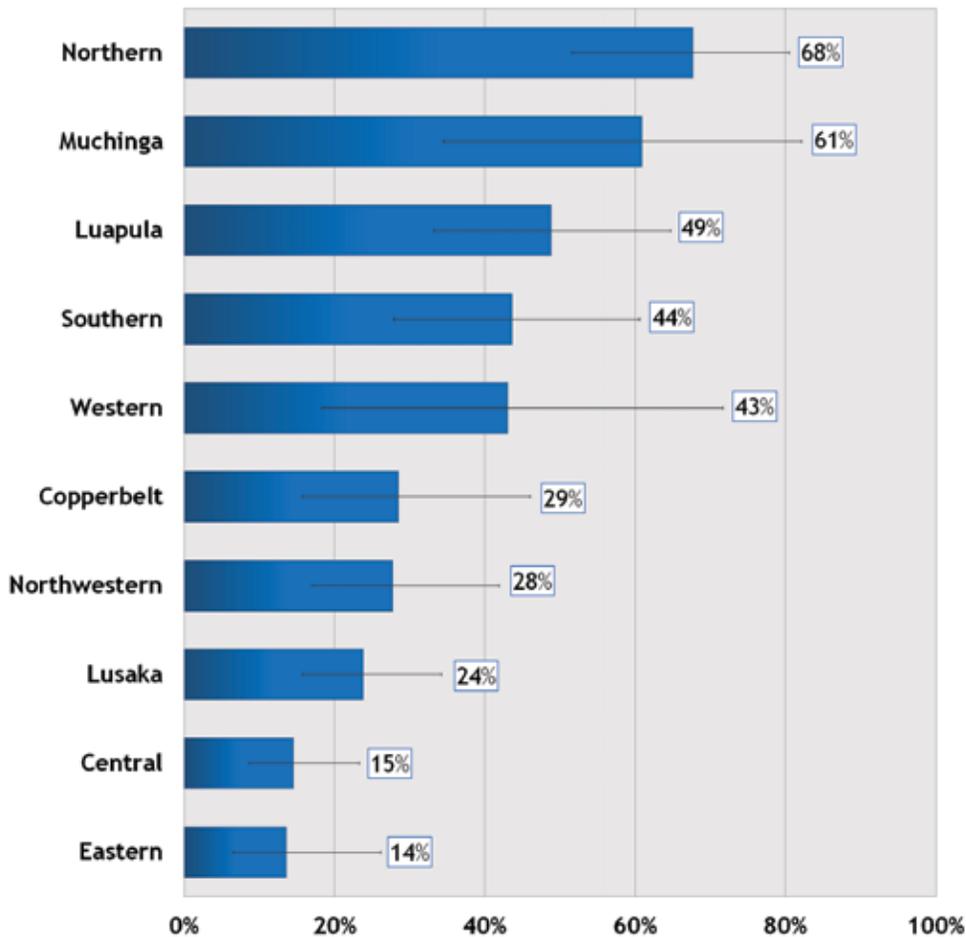
Figure 43 presents data for 18 ITC countries (among male factory-made cigarette smokers only): (a) Estimates were adjusted for age group, smoking status (daily/non-daily), number of adults in the household, and time in sample. (b) Data presented for Mauritius is for Wave 2 (2010) and Wave 3 (2011). Data for the South Korea is presented for Wave 1 (2005) and Wave 2 (2008). Data for all other countries is for the year of the first survey wave and of the most recent wave, which were combined and modelled together to make the results comparable (c) **Affnd Initial**: the Affordability Index (the reciprocal of the cigarette price per day to daily income ratio or CPDIR) for the initial wave, which is the percentage of household income spent on cigarettes (d) **Affnd Latest**: the Affordability Index (the reciprocal of CPDIR) for the most recent wave.

Results are graphed for the Change in Affordability Index per year in each country = $(\% \text{ change in Affnd between the first survey wave and the most recent survey wave}) \times [1 / (\text{Difference between the date at the } 1/3 \text{ timepoint of the first survey wave interviewing period and the date at the } 1/3 \text{ timepoint of the most recent survey wave interviewing period, in years})]$. The date corresponding to 1/3 of the survey wave interviewing period was chosen because it was the approximate point at which 50% of the respondents had been interviewed for that survey wave in each country.

Concern about Money Spent on Cigarettes

At Wave 2, almost two-thirds (65% vs. 59% at Wave 1) of smokers “agreed” or “strongly agreed” that they spend too much money on cigarettes. More than a third (35% vs. 26% at Wave 1) of smokers reported that their spending on cigarettes resulted in not having enough money for household essentials like food. Figure 44 shows that the results vary by province from 68% in Northern province to 14% in Eastern province. Smokeless tobacco users were less likely than smokers to “agree” or “strongly agree” that they spend too much money on smokeless tobacco products at Wave 2 (47% vs. 39% at Wave 1).

Figure 44. Percentage of smokers who said the money they spent on cigarettes resulted in not having enough money for household essentials like food in the last 6 months, by province



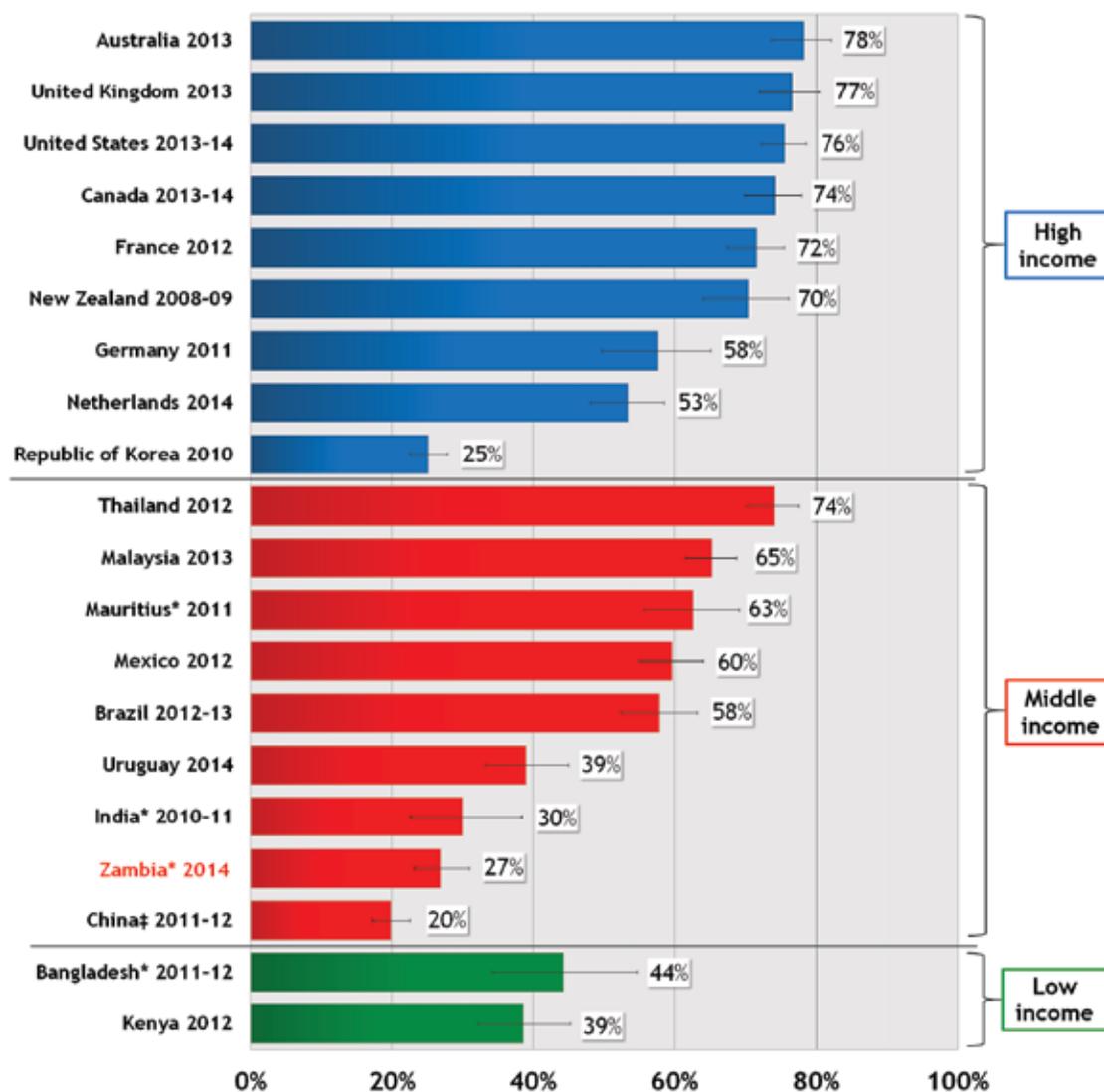
Smokers were also asked whether they had done anything in the last 6 months to save on the amount of money they have spent on cigarettes. In response, 54% (vs. 40% at Wave 1) said that they had considered quitting, 49% (vs. 35% at Wave 1) had reduced the number of cigarettes smoked per day, 20% (vs. 26% at Wave 1) had switched to a cheaper brand, 18% (vs. 19% at Wave 1) had purchased their usual brand from a cheaper source, and 13% (vs. 12% at Wave 1) had bought in bulk.

Price as a Reason to Quit Smoking

At Wave 2, among smokers who were planning to quit smoking, the price of cigarettes was identified by only one-third (32% vs. 23% at Wave 1) as a reason to think about quitting – one of the least frequent reasons among twelve reasons given in the survey (see Figure 15).

Given the proven link between tobacco price increases and reduction of smoking initiation and increased cessation, it is of concern that the price of cigarettes was among the least frequently cited reasons for thinking about quitting. In ITC countries where there are strong tobacco tax policies leading to higher prices, price is one of the MOST frequently cited reasons for thinking about quitting. ITC cross-country comparisons indicate that of 20 ITC countries, Zambia has the third lowest percentage of male smokers and quitters (27%) who reported that price led them to think about quitting “somewhat” or “very much” in the last 6 months (see Figure 45). The findings show that cigarettes are highly affordable in Zambia and that prices are currently too low to act as a powerful force to motivate smokers to quit and to prevent youth from starting, as they have in many other countries.

Figure 45. Percentage of male smokers and quitters who reported that the price of cigarettes led them to think about quitting (or to stay quit) “somewhat” or “very much” in the last 6 months, by country



† ‘Smokers’ refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported using both smoked tobacco and smokeless tobacco) were also included in the analysis.

Results were calculated for smokers who reported that they plan to quit, and for those who had quit more than 6 months ago.

* In Bangladesh, India, Mauritius, Zambia, and Kenya, the response options were yes/no versus very much/somewhat/not at all. The percentage of respondents who answered “yes” is shown. In these countries, there was also no time frame of 6 months.

‡ In China, instead of “somewhat” the response option was “a little”.

Tax Evasion

Article 15 of the FCTC requires Parties to implement effective measures against all forms of illicit trade in tobacco products including smuggling, illicit manufacturing, and counterfeiting. In fact, a new treaty to combat illicit trade in tobacco – the Protocol to Eliminate Illicit Trade in Tobacco Products (ITP) was created from the FCTC in 2012. Zambia did not sign the ITP; however, as a measure to curb illicit trade of tobacco products in Zambia, cigarette packs have official tax stamps issued by the Zambian Ministry of Finance.

At Wave 2, survey interviewers asked respondents to voluntarily show them their cigarette packs. Respondents were also requested to voluntarily give the empty cigarette packs to the interviewers. Fewer than 1 in 10 (9%) smokers showed the interviewers a cigarette pack. Of 75 cigarette packs shown, 22% did not have tax stamps, nor any sign that a stamp was ever present.



Example of required tax stamp from Zambia Revenue Authority

Support for Tax Increases

The ITC Zambia Survey asked respondents whether they think the government should increase the taxes on tobacco products. There was strong public support for raising tobacco taxes at Wave 2, including from tobacco users themselves. Support for tax increases on cigarettes and smokeless tobacco increased significantly between Wave 1 and 2 among smokers, smokeless users, and non-users. Overall, most respondents (78%) thought the government should increase taxes on cigarettes, including 74% of smokers (vs. 56% at Wave 1), 67% of smokeless users (vs. 52% at Wave 1), and 78% of non-users (vs. 64% at Wave 1) (see Figure 46).

Similarly, 76% of all respondents support an increase in taxes on smokeless tobacco, including 73% (vs. 56% at Wave 1) of smokers, 54% (vs. 37% at Wave 1) of smokeless users, and 76% (vs. 62% at Wave 1) of non-users (see Figure 47). About three-quarters (73%) of smokers, 62% of smokeless users, and 91% of non-users support a tax increase on hand-rolled tobacco (RYO) at Wave 2.

Figure 46. Percentage of respondents who think the government should increase taxes on cigarettes, by type of tobacco user and wave

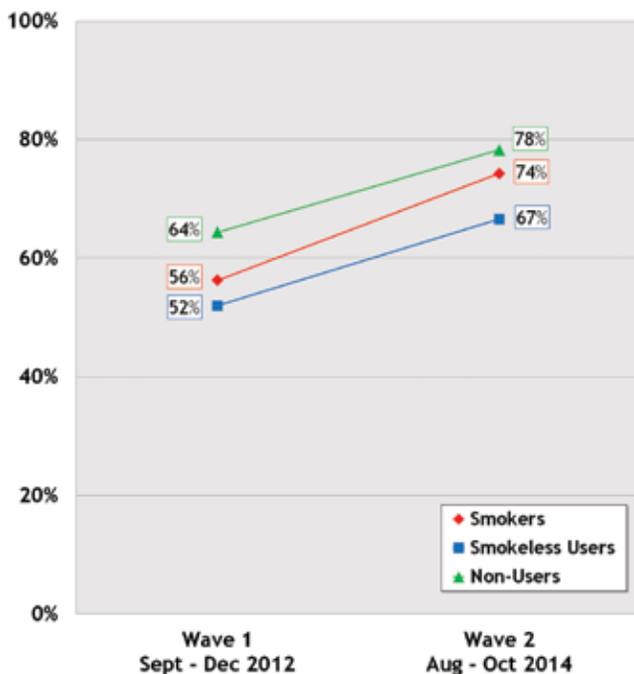
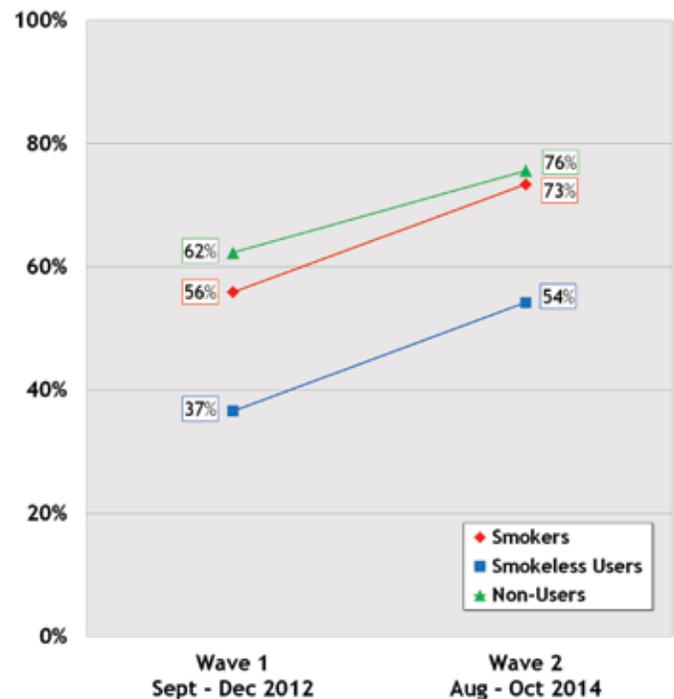


Figure 47. Percentage of respondents who think the government should increase taxes on smokeless tobacco, by type of tobacco user and wave



CONCLUSIONS AND RECOMMENDATIONS

The ITC Zambia Wave 2 (2014) findings show that there has been little progress towards strengthening the implementation of the WHO Framework Convention on Tobacco Control (FCTC) in Zambia in the two-year period after the Wave 1 Survey was conducted in 2012. ITC Project cross-country comparisons provide evidence that Zambia has fallen far behind many other countries in educating tobacco users and non-users on the devastating health consequences of tobacco use and the harms of secondhand smoke.

However, strong support among tobacco users and non-users for more effective tobacco control policies suggests that Zambia is well-positioned to address weaknesses in the 1992 Public Health (Tobacco) Regulations across several policy domains. Almost three-quarters of smokers support a tax increase on hand-rolled tobacco (73%) and cigarettes (74%) – one of the most cost-effective ways to reduce tobacco use, particularly among youth. Of 20 ITC countries, Zambia has the highest percentage of male smokers and quitters (77%) who think that cigarette packages should have more health information than the current small single text-only health warning.

These findings are a call to action for policymakers to demonstrate a renewed commitment to implementing the FCTC in order to protect the health of Zambians. There is a need to accelerate the implementation of the FCTC, despite the significant challenges facing policymakers. There is a growing recognition that multisectoral “whole of government” approaches are the best way to realize the full benefits of the FCTC.

The steps forward for Zambia to meet its obligations under the FCTC and to protect the public from the harms of tobacco are very clear. Based on the ITC Zambia Wave 2 Survey findings, the research team offers following recommendations for strengthening tobacco control in Zambia:

1. Increase the price and taxation of tobacco products and ban the sale of single cigarettes.

Increasing taxes on tobacco products is the single most cost-effective strategy to reduce tobacco use, particularly among youth. Article 6 of the FCTC calls on Parties to adopt and maintain taxation and pricing measures that will contribute to the health objectives aimed at reducing tobacco consumption. At Wave 2, more than half (59%) of Zambian smokers smoked only or mainly factory-made cigarettes, 39% smoked only or mainly hand-rolled cigarettes and 2% smoked both factory-made and hand-rolled cigarettes equally. The majority (88%) of those who smoke mainly hand-rolled cigarettes said they do so because of price. About half (51%) of smokers stated that their last purchase of cigarettes was loose (single) cigarettes. Price was one of the least mentioned reasons to quit (32% of smokers; 21% of smokeless users at Wave 2) among the twelve reasons given in the survey. ITC cross-country comparisons indicate that of 20 ITC countries, Zambia has the third lowest percentage of male smokers and quitters who reported that price led them to think about quitting “somewhat” or “very much” in the last 6 months. These findings indicate that cigarettes are highly affordable in Zambia and that prices are currently too low to motivate smokers to quit and to prevent youth from starting.

2. Design and implement pictorial health warnings that occupy at least 50% of the top part of the front and back of tobacco packages as called for in the Article 11 Guidelines.

Large pictorial warnings on tobacco packages are a proven no-cost means of informing users about the harms of tobacco use, motivating smokers to quit, and preventing ex-smokers from starting again. Article 11 of the FCTC requires Parties to adopt and implement effective packaging and labelling measures within 3 years of ratification, but Zambia has not yet complied with this requirement. The current single text-only warning covers less than 30% of the bottom front and back of the cigarette package and is only available in English. Among 11 LMICs in the ITC Project, Zambia has the lowest percentage of male smokers and quitters (22%) who “often” or “very often” noticed warnings. In contrast, in Mauritius, where pictorial warnings cover 60% of the front and 70% of the back of the pack, 78% of male smokers noticed the warnings. This demonstrates the vast potential for increasing the effectiveness of health warnings in Zambia with the implementation of large pictorial warnings, as called for by Article 11 of the FCTC.

3. Strengthen the smoke-free law by ensuring strong and consistent enforcement, particularly in bars and indoor workplaces, including strong penalties for violations.

Scientific evidence has clearly established the dangers to health from exposure to secondhand smoke (i.e., causes lung cancer and heart disease among non-smokers). Article 8 of the WHO FCTC requires countries to adopt and implement effective measures to provide protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places, and other public places. Although Zambia strengthened legislation to ban smoking in public places in 2008, the Wave 2 Survey shows continuing high rates of exposure to secondhand smoke in bars (74% of tobacco users and 52% of non-users noticed people smoking at last visit) and indoor workplaces (30% of tobacco users and 9% of non-users noticed people smoking in the last 30 days).

4. Implement a comprehensive ban on tobacco advertising, promotion, and sponsorship of tobacco products, including the entertainment media, with no exceptions.

Article 13 of the FCTC obligates Parties to take appropriate measures to ban tobacco advertising, promotion, and sponsorship (TAPS) within 5 years after ratification. However, Zambia has not met the requirement to implement a comprehensive ban on TAPS and continues to allow tobacco advertising through newspapers, radio, television, cinema, billboards, posters, magazines, and videos. Wave 2 findings show that the entertainment media continues to expose about a quarter (22%) of tobacco users to tobacco promotion. Shops and bars are the main venues for tobacco advertising as 15% of tobacco users noticed tobacco product advertising in shop windows or inside shops and 14% noticed advertising in bars.

5. Design and implement health information and mass media campaigns to further educate the public regarding the harms of tobacco and to keep messages salient.

Article 12 of the FCTC requires Parties to promote and strengthen public awareness of tobacco control issues and to adopt and implement measures to raise public awareness of matters related to tobacco control. The Wave 2 findings suggest an increased presence of anti-tobacco information since Wave 1, but also comparatively low awareness of the harms of tobacco relative to other ITC countries. At Wave 2, more than one-quarter of tobacco users noticed anti-tobacco messages on the radio (31%) and on tobacco packages (28%). However, there were no significant increases in knowledge of the harms of smoking among smokers between survey waves. In fact, male smokers and quitters in Zambia have:

- the lowest awareness that smoking causes lung cancer (79% at Wave 2) among 12 ITC countries;
- the third lowest awareness that smoking causes heart disease (74%) among 14 ITC countries;
- the second lowest awareness that smoking causes stroke (45%) among 20 ITC countries;
- the third lowest awareness that secondhand smoke causes heart disease in non-smokers (64%) among 9 LMICs.

Smokeless tobacco users in Zambia also have low awareness of the harms of smokeless tobacco use. About one-third or less of smokeless users were aware that smokeless tobacco causes harm to unborn child (19%), difficulty to open mouth (24%), gum disease (31%), throat cancer (30%), mouth cancer (29%), and heart disease (35%).

The Government should consider funding ongoing mass media campaigns to educate the public on the harms of tobacco use and to encourage quitting, as called for in Article 12 of the FCTC. Studies have shown that launching such campaigns in co-ordination with the introduction of pictorial warnings can boost the increase in public awareness of the harms of tobacco use and can increase motivation to quit.

6. Increase government support for cessation services and training of health care workers to strengthen their role in cessation.

Wave 2 findings show that approximately half (51%) of smokers have “ever” tried to quit smoking and more than a quarter (27%) plan to quit smoking within the next 6 months – the third-highest percentage among 11 ITC LMICs. Quit attempts and quit intentions are less likely among smokeless tobacco users – about one-third (34%) of smokeless users have “ever” tried to quit, and only 12% of smokeless users plan to quit within the next 6 months.

Existing research shows that advice to quit from a physician or health professional is a powerful motivator for quitting. ITC cross-country comparisons indicate that the percentage of male smokers who received advice to quit from a doctor in Zambia (44%) is the second lowest among 11 LMICs and the fourth lowest overall among 20 ITC countries. This rate is lower than what has been achieved in other LMICs such as Mauritius (54%), Mexico (50%), India (48%), and Uruguay (46%). There is strong support among Zambian tobacco users for cessation services. At Wave 2, the majority (87%) of tobacco users “support” or “strongly support” a total ban on tobacco products within 10 years, if the government provided assistance such as cessation clinics to help smokers quit.

7. Ban misleading, false, or deceptive packaging and labelling, including descriptors such as “light”, “mild”, or “low tar”, as well as the display of quantitative or qualitative statements about tobacco constituents and emissions that might imply that one brand is less harmful than another. Consider plain packaging to reduce the appeal of tobacco products.

Zambia has not banned the use of false, misleading or deceptive terms such as “light”, “mild” or “low tar” on tobacco packages as required under FCTC Article 11. Research has shown definitively that “light” and “mild” cigarettes are no less harmful and tar numbers are not a valid measure of how much tar is produced by the burning cigarette or the amount of tar that is taken in by the smoker. Yet, cigarette packaging and labelling is designed to mislead smokers into thinking that this is the case.

In the absence of a ban on misleading descriptors such as “light”, “mild”, or “low tar”, Zambian smokers believe that some cigarettes are less harmful than others. At Wave 2, 42% of smokers who had a usual brand of cigarettes stated that their usual cigarette variety was “mild” or “extra mild”. Almost half (45%) of Zambian smokers “agreed” or “strongly agreed” that light cigarettes are less harmful than regular cigarettes, and more than half (58%) agreed that light cigarettes are smoother on the throat and chest. Among smokers who had a usual brand at Wave 2, over one quarter (27%) thought that the cigarette brand that they usually smoke is “a little less harmful” compared to other cigarettes.

To curb these false beliefs, Zambia should ban the use of false, misleading, or deceptive terms such as “light”, “mild”, or “low tar” on tobacco packages as obligated under Article 11. In addition, the display of quantitative or qualitative statements about tobacco constituents and emissions that might imply that one brand is less harmful than another should be prohibited as recommended in the Guidelines for Article 11.

It is also known that tobacco companies use the brand or variety name or other elements of pack design such as colour to market some cigarettes as less harmful than others. Article 11 and 13 Guidelines suggest that Parties adopt plain packaging (cigarette packs which contain the brand name and warning labels, but no brand identifying colours or logos) in order to eliminate package design techniques that may suggest that some products are less harmful than others. Plain packaging is gaining international momentum as a strategy to curb the industry’s use of misleading and promotional packaging elements, increase the effectiveness of health warnings, and decrease tobacco use. Plain packaging was implemented in Australia in 2012 and is forthcoming in 2016 in Ireland and the United Kingdom, and is being seriously considered in various other countries, such as Norway, Hungary, Sweden, Finland, France, Canada, New Zealand, Singapore, Turkey, and South Africa.

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The International Tobacco Control Policy Evaluation Project

The ITC Project

Evaluating the Impact of FCTC Policies in...

20+ countries • 50% of the world's population
60% of the world's smokers • 70% of the world's tobacco users

Australia
Bangladesh
Bhutan
Brazil
Canada
China (Mainland)
France

Germany
India
Ireland
Kenya
Malaysia
Mauritius
Mexico
Netherlands

New Zealand
Republic of Korea
Thailand
United Kingdom
Uruguay
United Arab Emirates
United States of America
Zambia

