How influences on teenage smoking reflect gender and society in Mali, West Africa

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Summary

Objectives To provide further understanding and discussion on the influences on smoking in young people in Mali.

Design A generic qualitative methodological approach was used following Caelli's generic principles. Six focus group discussions were conducted with a total of 31 participants followed by two semi-structured interviews. A reflexive account was kept to record development in the researcher's theoretical position

Setting The setting was recreational areas of Bamako, capital city of Mali, West Africa.

Participants Participants aged 13–15 years were recruited opportunistically in a recreational area of Bamako.

Mainoutcome measures To develop further understanding of the influences of teenage smoking in Mali, West Africa.

Results Five main categories that explained influences on youth smoking emerged: knowledge and awareness of smoking; associations with smoking; influential people; key messages in Malian society; and access to tobacco. The results showed that influences were complex and interwoven, notable gender differences were revealed, and the role of elder members of the community proved decisive in participants' smoking experiences. Participants described vague knowledge of the impact on health of smoking and reported trying smoking from an early age. Often contact with smoking was through elders and being sent to buy and sometimes light cigarettes for them. Associations with smoking were influenced by gender with smoking more desirable for boys than girls.

Conclusions Any approach to preventing smoking initiation in young people requires an understanding of the social influences and pressures on young people. A tobacco control strategy is required to look at all areas of influence on smoking behaviours. Different needs should also account for the differing characteristics and perceptions of specific population groups.

Background

This study explores the influences on smoking in 13–15-year-olds in Bamako, Mali. Work analysing the effectiveness of smoking prevention stresses caution in the application of prevention methods which have not been based on evidence from the target populations.[1] An understanding of the social influences on young people's perceptions of smoking is shown to be helpful to inform tobacco control policies such as regulation of the sale and promotion of tobacco and prevention of initiation.[1]

Mali is a French and Banbara-speaking country in the centre of West Africa. The capital city is Bamako, which has a population of 1.3 million – one-eighth of the country's inhabitants. The vast majority of the population is Muslim although Christianity and indigenous beliefs are also practised. Approximately one-third of the population of Bamako lives below the poverty line and the majority of the population are under 20 years old. The UN Human Poverty Index (HPI), rates Mali as the third poorest of the 135 countries assessed, reflecting its poor health record.[2] In 2005, Mali signed the WHO Framework Convention on Tobacco Control (FCTC). The WHO recorded in 2002 that it was not known whether Mali had a tobacco control committee. It also reported that there is a partial smoking ban in some public places (that are not specified) and that advertising is also partially restricted.[3,4]

The observations of the researcher in the reflexive account reported that branding for cigarettes was displayed at the point of sale and the domestically produced brand on billboards in Bamako. While we do not have sufficient evidence regarding smoking trends in Mali, import data show an increase from 6 million sticks in 1970 to 1030 million sticks in 1990.

Other research examining the health behaviours of young people in Mali has attributed influence particularly to the impact of Malian society and culture. Specifically the role and relationships with elder members of the family and community in shaping the behavioural norms.[5–7]

Researchers have commented that a young person's gender in Mali determines their attitude to behaviours interwoven with health such as sexual risk-taking.[5–7] The Malian cultural norms for men and women have been shown to be distinct and separate.[5] Research has highlighted a taboo associated with discussing health issues in Mali and it was for this reason a pilot group was held to assess whether sensitivities around discussing tobacco in a group would not inhibit participants.[7]

For the purposes of this research, manufactured white cigarettes are used as the definition of tobacco smoked, as opposed to use of hand-rolled or chewing tobacco common in other countries and this is supported by evidence.[3]

Youth smoking is monitored by the Global Youth Tobacco Survey (GYTS).

The 2002 GYTS in Bamako reported that just over one-fifth (21.2%) of 13–15-year-olds in Mali had one parent that smokes. Smoking among 13–15-year-olds was reported as 42.6 % (95% CI 36.3–49.2) in boys and 7.4% (95% CI 4.8–11.5) in girls.[3] The male smoking rates were one of the highest in the West African region. The 2008 survey was repeated in others areas of Mali and showed a lower rate of 17.5% in boys and 2.5% in girls (CI not stated).

Public health professionals have stated that tobacco promotion in developing nations has increased since the introduction of stringent smoking bans in developing countries. The WHO surveys in 2002 and 2008 reported that over one in 10 participants had been offered free cigarettes by tobacco company representatives. Comprehensive examples of how to challenge tobacco promotion can be found in other countries such as South Africa[8–10] and Malians do not have access to free stop-smoking support.

In 2009 total taxes on the bestselling tobacco brand were 21% in Mali (Burkina Faso 20%, Senegal 28%, South Africa 45%). The overall national budget for tobacco control activities was $11,000 (Burkina Faso $10,238, Senegal $77,201, South Africa $302,618) (at official 2009 exchange rates).[10] In an effort to understand the influences on tobacco use and inform policy development, the attitudes to smoking of male and female adolescents has been examined in many different countries.[1,11–13] Other than the GYTS, no research on smoking has yet to be conducted in Mali.

Methods

Caelli's generic methodological framework was used to allow the pragmatic use of all qualitative

research tools available (interviews, focus groups, the researcher's observations and reflections). Examination showed other interpretive methods (grounded theory, ethnography and phenomenology) have distinguishing features, which in the circumstances of this research may also limit their applicability.[14] Factors such as the time required and complexities of assimilating into the participants' surroundings made these options incompatible with the conditions.

Methodology is the 'framework for how the research should proceed' (Caelli), whereas the methods are the tools and techniques used to obtain the data. The quality of the research is dependent on the understanding of these concepts and much criticism of generic methodology has been due to a failure to state clearly the methodological approach adopted. Qualitative work must be assessed on its rigour and the strategies for this set out so that the reader can assess the quality of the research. To ensure the approach was robust, systematic criteria were followed to achieve rigour throughout the entire research process.[15] This was done by ensuring stages defined by Caelli's methodology were clearly defined and addressed in the approach taken.

The notion of a researcher's value as a neutral observer has long been challenged and overturned.[16] Therefore the personal history, motives and presuppositions of the researcher were examined clearly in the reflexive account. As thoughts and emotions emerged they were acknowledged and attempts were made to account for these in the reflexive account and incorporated into the analytical process. Examples such as this attempted to record and establish rigour in the process.

The study used six focus groups and two semi-structured interviews; interviews were held with participants who contributed points in the focus group that required further exploration. The research engaged with 31 participants, all aged 13–15 years old, in Bamako. This age group aligned with the only other research on young people and smoking (GYTS) in Mali and so allowed this to provide some context. Participants were recruited opportunistically in recreational areas of Bamako to take part in discussion. The ages of participants were used as the inclusion criteria for the research, although as age was self-reported, a risk is acknowledged with this process. All focus groups and interviews used a Banbara-to-English trained interpreter (Banbara is the local language, spoken by 80% of Malians). Careful training, briefing and debriefing of the interpreter was undertaken. To establish a rigorous process a set research protocol was followed for rapport building. The affect on participants and the research of a non-Malian researcher is acknowledged, and attempts were made to minimize this by dressing in line with Malian expectations and using a local interpreter.

Participants were not asked if they smoked during the research and it was emphasized that the research was to explore their attitudes not their current behaviour and that data would be anonymously recorded. Informed consent was gained through a briefing read out (to avoid any literacy issues[17]) in Banbara, which detailed the purpose of the research. The briefing was read out.

A focus group plan was developed based on literature on smoking influences in other countries, particularly in Africa and evidence around previously explored factors influencing health behaviours in Mali while always being open to new avenues based on participant's responses. The planned topics to probe included adult smoking behaviours, culturally defined taboos and norms, gender dynamics and common myths.[1,5,6,13]

Analysis

The interviews and focus groups were recorded using handwritten notes. Taped recordings were trialled in a pilot but participants seemed distracted by the process of recording and the background noise in the areas where children congregated made accurate transcribing impossible.

The data was analysed sequentially to allow the researcher to refine the approach. This type of approach proved inevitable as the researcher is affected on an ongoing basis by what they are hearing and recording, but also it was necessary to review and revisit issues as they emerged. Emerging themes were recorded and checked on an ongoing basis throughout the research period. Indexing was then applied as each transcript was written.[16,18] Saturation was undertaken by constant comparison and indexing until no new data emerged. Sensitivity was displayed in acknowledging disconfirming evidence and contradictory interpretations between the data.[18]

Results

Awareness and knowledge of health and smoking

Investigating the level of awareness of health issues connected with smoking, was central to the understanding of the participants influences as it determined if they were equipped to make informed choices about smoking.[16] When asked to describe their knowledge of smoking, although some positive links with smoking were outlined, participants made an overall and agreed assumption that smoking and health were linked and that smoking was not good for your health:

'Its not good for your health – not good for your insides.' (F)

'If you're angry or upset it is good for you.' (M)

'I would like people to stop… It blackens your insides – liver and tummy.' (F)

Participants had views, often incorrect, or seemed confused on the effects of smoking and it was clear that this theme was made complex with myth-like and varied perceptions. This confusion was reinforced by the absence of a common or definite source of information on smoking described by the groups, many just describing that 'people' had told them things. Consequently at the end of each session there were many questions:

'… But when you're cold it can warm you up.' (M)

'If you drink milk after you smoke, it helps.' (F)

'What does smoking do to your body and where?' (F)

'Why do they allow cigarettes in Mali if they are bad for people?' (M)

Associations with smoking

Participants consistently reported high levels of adult smoking and being aware of smoking from an early age:

'I think at least 80% of adults smoke.' (M) – all focus group agree

'90% of boys and between 5% and 20% of girls smoke.' (M) – all focus group agree

'Most of my friends smoke.' (M)

'I saw butts everywhere' … 'Me too that is what I remember.' (F, F)

A prominent theme that emerged in every session was the different social rules in Mali for smoking among girls and boys. It was more culturally acceptable for boys to smoke than for girls. There was a strong association between smoking and 'bad' behaviour in girls, and this was expressed by both sexes:

'Bad habits are better in boys than girls.' (F)

'Girls don't smoke as it's not what they are supposed to do.' (M)

'A well-bred one.' (F – describing the type of girl that does not smoke)

'I have never seen a girl smoking apart from prostitutes.' (M)

'Young people that smoke around you are bandits or delinquents.' (F)

It was implied by boys that a girl seen smoking was a reason for people to not associate with her and that smoking was associated with prostitution. Boys also described the masculinity associated with smoking, whereas girls who participated in the research, described that they were unlikely to try smoking or ever want to:

'Men are tougher. They practise more sport. It is better for men to smoke than women.' (M)

'It looks good like a rapper or a bandit.' (M)

Influential people

The messages about children smoking were described as unclear and inconsistent, and this was reinforced as many older male members of families and communities smoked themselves:

'Some parents wold punish you, some would not.' (M)

'They would never admit to their parents.' (F)

It became evident that while some thought it bad for children to smoke, many older members of families and communities sent children to buy and even light cigarettes for them, and this was reported consistently as the children's contact with smoking. Despite the disapproval of girls and women smoking this behaviour seemed indiscriminate of gender – creating confusion to the messages displayed by Malian adults on smoking.

The common phenomenon of sending children on any kind of errand was an observation of the researcher and moreover it was observed normal and expected that the child would obey the older person whether they knew the adult or not. Participants reported this as a major and consistent contact with tobacco, providing an opportunity to try smoking and often being the first smoking experience. This was again reinforced in the reflexive account when, after one of the first focus groups was finished, the interpreter, who did not know any of the participants prior to the session, sent a participant to buy cigarettes for him:

'… When I am sent to buy some for my brother and sometimes to light it.' (M)

'Because our headmaster is a smoker and sometimes he sends kids to buy them.' (F)

'They light it for people, but do not always inhale; people send me to light it… people in my house, including my family.' (F)

'My uncle sends me to go and light it.' (M)

Key smoking messages in Mali

A smoking ban in some buildings is evidenced in the GYTS (2002) in Mali, but knowledge of this was not reported by the participants and neither were partial restrictions upon advertising.[3] Generally participants often referenced cigarette brand names and the branded boards used by street sellers but no other explicit tobacco advertising:

'We don't know of any laws but that doesn't mean there aren't any.' (F)

Access to smoking

The link with older family or community members was described by participants as a method of obtaining cigarettes – either through smoking their butts or by being given them. There seemed to be no problem in buying cigarettes from sellers on the street as this was repeatedly described. It was noticeable that cigarettes were commonly legally sold singly rather than in packs. This made cigarettes more affordable for children and adults:

'Some buy packets but kids just by them in ones, twos or threes.' (M)

'People throw them from cars.' (F)

'I smoke the stubs from the ground.' (M)

'I get them from my uncles and brothers.' (M)

Discussion

Main findings of this study

Awareness and knowledge of health and smoking

While most groups commented that smoking was bad for your health, there was no consistency in views on the effect or risks of smoking on health. Comments were vague, and some included 'mistruths' about the effect of smoking. A prerequisite to challenging smoking initiation as part of a tobacco control agenda and as stated in the Framework Convention for Tobacco Control (FCTC) and other evidence from Africa, is well-dispersed, quality information about its health consequences.[19–22]

Associations with smoking

Much discussion in the reflexive account related to the observed gender roles within Malian society and views about what constituted gender-specific behaviour proved to be distinct, describing defined smoking rules for boys and girls. Participants reported girls and women who smoked were frowned upon and often believed to be prostitutes. In many instances, people would not associate with women who smoked. This is supported by the reflexive account and research stating lower

smoking prevalence over all ages in girls and women than boys and men.[11,20] The popular association of smoking with masculinity, fighters or those in the media like 'rappers', meant that it tends to be portrayed as socially desirable. The difference in the perceptions of girls and boys smoking described stark cultural associations to smoking, a conclusion further confirmed by the evidence from girls who participated in this research that they were unlikely to try smoking.

In developed countries tobacco companies tend to target women, but the tobacco industry continues also to target men in other countries: smoking is portrayed as a manly habit linked to happiness, fitness, wealth, power and sexual success.[21] Any messages on smoking should consider the differences on gender and be compatible with all motivations to smoke in Mali.

Influential people

Participants reported that older people smoked around them from an early age, and this was supported by research.[23] We know from other countries, that young people who are around adults smoking in the home, and particularly parental smoking habits, are more likely to smoke.[11,24] Other work in Mali has attributed much importance to the shaping of norms by figures of authority in the community and this was echoed both in the researcher's observations and the participants' discussions.[5] The participants described parents' or elders' behaviour as being a major contact with smoking. The impact of sending a child to buy and possibly light cigarettes is two-fold: on the one hand, it leads to the creation and consolidation of social norms in children about smoking, and on the other it also increases the opportunity to try smoking. Both of these factors have been shown to be associated with increased likelihood of regular smoking in adolescent and adult life.[11,25] Participants described being around second-hand smoke from an early age. Evidence shows that an effective tobacco control agenda is required to protect people from smoke through regulation and enforcement of smokefree environments.[22]

Key smoking messages in Mali

The WHO's FCTC states that legislation to promote smoke-free environments is instrumental in reducing tobacco-related harm. In Mali there is a legislative restriction on smoking in some public places, but levels of enforcement of this legislation are not known.[3] Observational evidence tended to confirm the general ignorance of the smoking ban. It was unknown if there was a tobacco control campaign in Mali at the time of writing. The passion for sport, particularly football, in Mali was observed constantly during the fieldwork. Only one participant cited the link between sport and smoking as a deterrent (Interview 2), and further assessment of this strategy would be advisable.

Access to smoking

Young people who participated in the study described having easy access to smoking, and this was particularly attributed to availability for sale of single cigarettes. Affordability and decreasing demand through price increases is a highly evidence-based preventative measure. A new piece of legislation plans to restrict the sale of single cigarettes and the sale of cigarettes to under 16s (Law 08), measures such as these if properly enforced could form part of an effective tobacco control strategy in Mali.[27–29]

What is already known on this topic

Previous work on reproductive health in Mali concluded that young people were poorly informed and that this was a major barrier to reducing sexual risk-taking and family planning.[19] Good practice in tobacco control can be learnt from other African countries such as South Africa that have established a strong tobacco control policy base, including effective advocacy from tobacco control campaigning groups.

Other countries have older smoking traditions and offer useful insights for reducing the uptake of smoking. Research has previously shown gender to be a decisive determinant of young people's health behaviours in Mali.[6,19,20] The lower prevalence of smoking in boys aged under 16 years than girls in some European countries has been attributed to the raised awareness that smoking could inhibit sporting performance, as well as to a disassociation between smoking and sportspeople.[26,27] Encouraging alternative activities is also detailed in the FCTC.[22]

The development and effective enforcement of regulations on tobacco promotion have been shown in other African countries to be an essential tool in protecting young people from smoke. The WHO states based on evidence that Mali should ban advertising of tobacco products.[10]

Conclusions

Smoking is likely to become a significant burden on resources in Mali in the years to come, and there is little doubt of the challenges faced to preventing an increase in smoking.[20] The most cost-effective intervention on smoking is to prevent smoking initiation in young people.[11] The findings of this research show that young people themselves are greatly influenced by societal factors in their smoking behaviour, especially by adult smoking behaviour, and the cultural and gender-specific associations of smoking.

The development of a basket of effective policies on tobacco, building on the evidence base from other countries, will be instrumental in reducing the effect of smoking on Malians in years to come. Work analysing the effectiveness of smoking prevention, stresses caution in the application of prevention methods which have not been evidenced on the target population.[1] It is hoped this paper will contribute to further understanding of the issue required to underpin a reduction in the harm caused by tobacco in Mali.

Limitations of the study

Due to the opportunistic sampling techniques adopted in one area of Bamako, the diversity of opinions cannot be applied to all young people in Bamako. While other sampling and other settings were considered, they were not feasible. Quotes from participants also appeared shorter than expected and this may have been due to the interpreter summarizing participants' responses, although clear training and instruction was given to avoid this. It is acknowledged that there may be an effect of conducting research in a different country and using a different language, and that a local researcher, who spoke the local language and had local information, may have been able to probe into issues further and had different resources at their disposal.

What this study adds

There is no published scientific literature on smoking influences in Mali, so the findings of this contribute to the beginnings of an evidence base on the topic. The issues presented here are consistent with other research on Malian health behaviours[5,6] but this study specifically provides insights into the decisive factors that shape perceptions of smoking for the emerging young Malian populations. It also affirms the use of generic methodology, to gain an understanding of a phenomenon while utilizing all the data collection tools available.

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