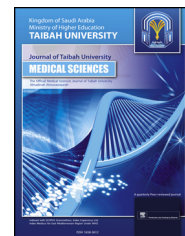




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Original Article

Knowledge, attitudes and practice with regard to the articles of the Framework Convention on Tobacco Control among Egyptian adults



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المخلص

أهداف البحث: وقعت مصر على اتفاقية نظام مكافحة التبغ في عام 2003م وتم التصديق عليها في فبراير 2005م من قبل البرلمان المصري. وعلى الرغم من وجود معظم بنود نظام الاتفاقية في القوانين والأنظمة المصرية، إلا أنه نادراً ما يتم تنفيذ هذه الأنظمة لعدة أسباب وعقبات. تهدف هذه الدراسة إلى تقييم المعرفة والسلوك والممارسة تجاه اتفاقية نظام مكافحة التبغ بين البالغين في مصر.

طرق البحث: استخدمت الدراسة المستعرضة الحالية استبانة للمقابلة الشخصية شملت المعرفة والسلوك والممارسة فيما يتعلق بنظام الاتفاقية في محافظتين في مصر.

النتائج: معدل انتشار التدخين يتفاوت بين الفئات السكانية. حيث كان التدخين أعلى بين الرجال 97% بالمقارنة بالنساء 3%. وبين البالغين الذين تقل أعمارهم عن 55 عاماً. تنخفض حالة التدخين مع التقدم في العمر. يعرف معظم المدخنين (74%) بأن التدخين غير مسموح للأطفال والشباب، وأنه يحتوي على القطران والنيكوتين، اللذان يشكلان خطراً على الصحة. يتجاهل نصف المدخنين وجود علامات التحذير على العلب. يعلم غالبية المدخنين (66.8%, 67.8%, 64.3%). 83.9% على التوالي أن الإعلان عن السجائر غير مسموح، وأنه ليس هناك مساعدة من وسائل الإعلام للوقاية من التدخين. وأنها لا تعطي ما يكفي من

المعلومات حول مخاطره، وعدم وجود حملة إعلامية ضد التدخين. يعتقد غالبية المدخنين (62.2%) بعدم وجود استراتيجية فاعلة ضد التدخين، و77.3% بعدم وجود سياسة حكومية ضد التدخين. كما يعتقد نصف المدخنين (50.4%) بعدم وجود المهتمين في المجتمع للعمل على منع التدخين، وأن العاملين في الخدمات الطبية هم الذين باستطاعتهم وضع سياسات منع التدخين، وأخيراً استنتج 70.7% بأنه لم يتم القيام بالكثير من الجهود لمنع التدخين.

الاستنتاجات: يمكن أن تستخدم البيانات في هذه الدراسة كمقياس أساسي للتقييم المستقبلي لبرامج مكافحة التبغ التي تنفذها وزارة الصحة في الحكومة المصرية.

الكلمات المفتاحية: اتفاقية نظام مكافحة التبغ; البالغين; المدخنين; مصر

Abstract

Objectives: Egypt signed the Framework Convention on Tobacco Control (FCTC) in 2003, and it was ratified by the Egyptian Parliament in February 2005. Although most of the articles of the FCTC are reflected in Egyptian law and regulations, enforcement is rare for many reasons. The aim of the study was to evaluate knowledge, attitudes and practice toward the FCTC among Egyptian adults.

Methods: Cross-sectional survey with an interview questionnaire about knowledge, attitudes and practice as regards the FCTC among 2941 people from them 1584 smokers (97% men, 3% women) in two governorates of Egypt.

Results: The prevalence of smoking varied, being higher among men (97%) than women (3%) and was higher

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among adults under the age of 55 years. Most smokers (74%) knew that smoking by children and adolescents was not allowed, and that tobacco contains tar and nicotine, which are hazardous to health. Half of the smokers were unaware of the presence of warning signs on boxes. Most smokers knew that advertising of cigarettes is not allowed (66.8%), the media do not advocate for smoking prevention (67.8%), not enough information is given about its hazards (64.3%), and there is no media campaign against smoking (83.9%).

Most smokers (62.2%) considered that there is no active strategy against smoking, and 77.3% said that there was no Government policy against smoking. Half the smokers (50.4%) thought that people in the community were not interested in smoking prevention, and medical personnel should help; 70.7% concluded that little was being done to prevent smoking.

Conclusion: The data from this study could be used as a baseline for future evaluations of tobacco control programmes implemented by the Ministry of Health of Egypt.

Keywords: Adults; Egypt; FCTC; Smokers

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Introduction

Tobacco use is one of the major public health disasters of the past and present century. There are more than 1.25 billion smokers in the world today, representing about one third of the world's population over 15 years of age. Cigarette smoking is one of the main causes of preventable death worldwide and the leading cause of preventable death in industrialized countries; however, the epidemic of disease and death is rapidly shifting to developing and transitional market economies. At current levels of tobacco consumption, the epidemic is expected to kill about 10 million people per year by 2020, with two thirds of these deaths occurring in developing countries.¹

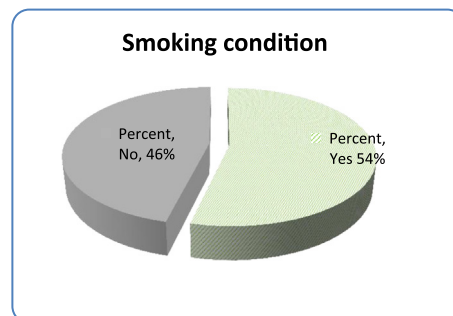
The WHO Framework Convention on Tobacco Control (FCTC) is designed to strengthen national and international coordination to combat the tobacco epidemic. Formally negotiated by WHO Member States over a period of 4 years, the treaty incorporates a variety of measures to encourage State Parties to curb the growth of tobacco production and use. Some measures constitute concrete obligations, while other measures are framed as goals or recommendations.² Recognizing that price and tax measures are effective in reducing tobacco consumption, particularly among young people, the treaty calls for enacting and implementing tax and price policies on tobacco products that will contribute to reducing tobacco consumption. Similarly, the treaty calls for testing, measuring and regulating the content and emissions of tobacco products and for effective legislative, executive and administrative measures requiring manufacturers and importers to disclose to governmental authorities the contents and emissions of tobacco and for governments to provide public disclosure of the toxic

constituents and emissions of tobacco products.³ The FCTC was designed as a dynamic, incremental approach to international tobacco control, modelled on the framework convention – protocol approach that has been used with some success, particularly in environmental law.⁴

Egypt has the highest tobacco consumption in the Arab world, with a total consumption of 61.8 billion cigarettes in 2003, which was a marked increase from 12 billion in 1970. While population growth in Egypt only doubled, the reported fivefold rate of increase in tobacco consumption reflects a marked increase in the number of smokers and probably in the amount of tobacco consumed by smokers.⁵ In a national survey in 2004 of a representative sample of 6871 individuals over the age of 20 years (3040 men and 3831 women), the prevalence of smoking in Egypt was estimated to be 47% among adult males, peaking at 55% among those aged 50–60 years.⁶ The age at initiation was shown to be 11 years in a school survey in rural Egypt in 2002, whereas previous studies had shown initiation at later ages.⁷ The number of smokers is estimated to increase by 8% annually and is expected to continue to increase over the next 20 years.⁶ The death rate due to smoking is increasing, mainly from cancer-related illness. A study by the Egyptian Smoking Prevention Research Institute showed that the number of deaths attributable to smoking increased from 23,000 in 1999 to 34,000 in 2004 (Figures 1–3).

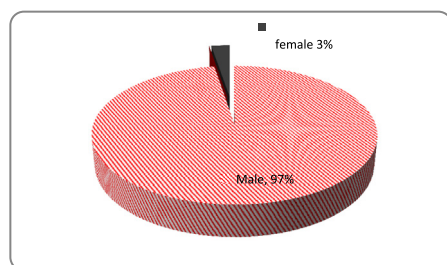
Egypt has many laws regulating the tobacco industry and consumption, mainly focussing on banning advertising and smoking in enclosed public places. Advertising is banned in all forms of public media (newspapers, television and radio), and a maximum tar level of 15 mg per cigarette has been set for the cigarette industry. The specific laws and regulations issued for tobacco control in Egypt include:

- Law 52/1981, which forbids smoking in public places and on public transport, and sets a maximum of 15 mg of tar per cigarette;
- Law 137/1981, which forbids smoking in work places;
- Law 4/1994, which prohibits smoking in enclosed public places and introduces a fine (LE 10) for smoking on public transport; and
- Ministerial decree 344/1997, which was promulgated in order to convene a steering committee for a national programme on smoking control. The committee comprises representatives from the ministries of health, information, education, social labour, awqaf (religious affairs), tourism, internal affairs and environmental



We found the current smoker constitute 53.8% form the studied group

Figure 1: Smoking distribution among studied group.



The majority of the smokers were males constitute 97.4% and only 2.6 % were females

Figure 2: Sex distribution among smokers.

affairs, as well as the high assembly of youth, sports and nongovernmental organizations working in the field. The main responsibilities of the committee are to develop a national programme for smoking control, define interventions and activities and identify the role of each participating ministry and agency.

Egypt's anti-smoking legislation is not, however, adequate to make a noticeable difference, especially as most smokers are unaware of these regulations. Enforcement is therefore the main obstacle to success in controlling tobacco.

The WHO FCTC was adopted by the Fifty-sixth World Health Assembly in May 2003 and became international law on 27 February 2005.⁸ The Convention is the driving force behind the global response to the pandemic of tobacco-induced death and disease. It implies coordinated, effective, urgent action to curb tobacco consumption, laying out cost-effective tobacco control strategies for public policies, such as bans on direct and indirect tobacco advertising, tobacco tax and price increases, promoting smoke-free public places and work places and prominent health messages on tobacco packaging. One important feature of the WHO FCTC is the call for countries to establish programmes for national, regional and global surveillance.

Egypt signed the FCTC in 2003, and it was ratified in February 2005 by the Egyptian Parliament. Although most of the articles of the FCTC are reflected in Egyptian laws and regulations, they are seldom enforced, for many reasons. One important obstacle is the absence of a well-defined policy for national implementation; another is cultural factors, as smoking is considered socially acceptable, unlike in western countries. Quantification of the magnitude and seriousness of exposure of non-smokers to second-hand smoke should help to change social acceptance of tobacco use and apathy about implementing the existing regulations.

The aim of the study was to evaluate the knowledge, attitudes and practice of Egyptian adults to the FCTC and to determine differences according to smoking status.

Materials and Methods

Type of study

A cross-sectional survey with an interview questionnaire about knowledge, attitudes and practice as regards the FCTC was conducted in two governorates of Egypt, Cairo representing an urban population and Qualiobia a rural

population. Eligible participants were adults over the age of 18 years, who were interviewed in public places (hospitals, schools, universities, public transport and public recreational places) with a questionnaire. A total of 2941 people from them 1584 smokers (97% men, 3% women).

Instrument

The 33-item questionnaire was designed to assess personal and demographic characteristics; attitudes, values and beliefs about tobacco control policy in society and roles in helping people to stop smoking; and knowledge about quitting tobacco use and methods available for quitting.

Statistical analysis

The data were tabulated with SPSS version 19. A chi-squared test was used to test significance.

Ethical considerations

This study was approved by the National Liver Institute Research Ethics Committee, Cairo, Egypt.

Results and discussion

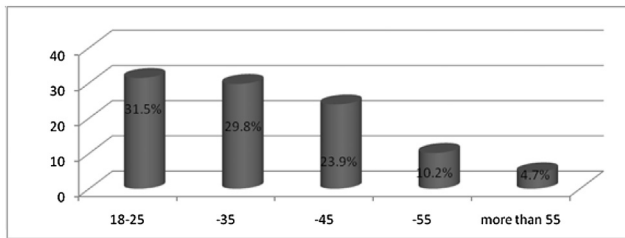
More than half the population were smokers (53.8%). The prevalence among men was 97% and was higher among adults under the age of 45 years, the prevalence increasing with decreasing age.

Table 1 shows that most smokers (82%) considered that the hazards of smoking should be taught at school, 74.4% knew that children and adolescents are not allowed to smoke, 3.7% did not know whether children and adolescents were allowed to sell or buy cigarettes, and 6.5% did not know whether the bans on smoking and selling and buying cigarettes by children and adolescents were always respected.

Smoking rates in the United States dropped by half between 1965 and 2006, falling from 42% to 20.8% of adults. Current smoking was more prevalent among men (23.9%) than women (18.1%).⁹ In Canada, the prevalence of current smoking declined between 1985 and 2001 for both sexes and all age groups except for those aged 15–24 years. Even larger decreases were seen between 1991 and 2001, while current smoking by adolescents did not significantly change between 1985 and 1994–1995.¹⁰ The first study on smoking habits in Sweden was performed in 1946, when 50% of men and 9% of women were smokers; in 1977, 32% of women and 41% of men were smokers.⁸ In Algeria, the smoking rate for men was 29.9 ± 2.5 , while that for women was 0.3 ± 0.2 .

In general, smoking may be up to five times more prevalent among men than women in some communities, although the gender gap usually declines with younger age. In some developed countries, smoking rates for men have peaked and begun to decline, while for women they continue to climb.¹¹

In this study, the majority of smokers reported that they had been taught about the hazards of smoking at school (82.4%) and that smoking by children and adolescents



The Figure shows that the smoking status decreases with increase age

Figure 3: Age group distribution among smokers.

(74.4%) and selling the cigarettes (74.5%) were not allowed. This finding reflects a strong negative association between what was taught at school and current smoking, especially among smokers. Although most of the smokers knew about the prohibition on smoking and selling cigarettes to children and adolescents, they knew that the bans were not respected and considered that the regulations should be applied. A similar result was obtained by Sinha et al. in India.⁹

Smokers were statistically significantly more aware (50.9%) than non-smokers (49.1%) about health warnings on cigarette packs. Thus, the desire to smoke is stronger than an attempt to stop them from smoking, especially after they have bought the cigarettes. This was confirmed by their awareness about the percentages of tar and nicotine written on the box and the benefits of decreasing them. The percentages of smokers who were aware of these warnings (73.9%, 77.2%) were significantly higher than those of non-smokers (26.1%, 22.8%).

Smokers in our study, and, to a lesser extent, non-smokers had a negative view and a poor evaluation of the anti-smoking role of the media. The effectiveness of media interventions in preventing young people from starting to smoke, reducing smoking among adults and motivating smokers to give up by not advertising cigarettes and creating a negative impression about smoking have been studied by many authors. There is evidence that tobacco control programmes that include mass media campaigns can be effective

in changing smoking behaviour and significantly reducing smoking prevalence.^{12,13} This was not seen in our study, as Egypt's anti-smoking media campaign lacks effectiveness and has no real support from the Government. Advertising should be used routinely as an essential component of any population smoking reduction strategy.

Several studies provide evidence that increasing the price of cigarettes through excise taxes reduces smoking among adolescents and young adults, who are particularly price-sensitive.^{14–16} In our study, most non-smokers (80.9%) agreed to increased taxes on cigarettes, while half the smokers (51%) disapproved of this intervention, perhaps indicating its importance and effectiveness. Van Walbeek found that an increase in tax is generally the most effective measure for tobacco control: in South Africa, a 10% increase in the real price of cigarettes decreased cigarette consumption by 6–8%.¹⁶

Most smokers (62.2%) agreed that there was no active strategy against smoking, 77.5% stated that there was no Government smoking prevention policy, and 70.7% assumed that nothing was being done to prevent smoking. These views present a challenge to Egypt's Government to develop, implement and evaluate its tobacco-control programme. If effective programmes are not implemented soon, future morbidity and mortality attributable to tobacco will probably increase.

Smoking is a major contributor to deaths from chronic disease. The findings from the Global Youth Tobacco Survey suggest that the number of deaths from smoking will double by 2020 (from 5 to about 10 million), but this might be an underestimate because of, high levels of exposure to second-hand smoke and indirect pro-tobacco advertising.¹⁷ Synergy in the community at all levels, specially with health personnel, will be needed to develop, implement and evaluate a comprehensive tobacco-control policy that will improve our future health. Our study shows that both smokers (50.3%) and non-smokers (44.5%) consider that no one in the community is working on smoking prevention, although more than half of all participants found that

Table 1: Knowledge about smoking hazards and prevention among kids.

		Smoking condition				<i>P</i> value
		Yes		No		
		No	%	No	%	
Smoking hazards teach as part of curriculum	Yes	1305	82.4%	972	71.6%	0.000
	No	158	10.0%	210	15.5%	
	I do not know	121	7.6%	175	12.9%	
Smoking was not allowed for kids and youth	Yes	1178	74.4%	809	59.5%	0.000
	No	310	19.6%	372	27.4%	
	I do not know	95	6.0%	178	13.1%	
Sailing cigarettes was not sold for kid and youth	Yes	1179	74.5%	782	57.5%	0.000
	No	346	21.9%	445	32.7%	
	I do not know	58	3.7%	133	9.8%	
Those instructions (about sailing cigarettes and smoking cig, for kids) done all the time	Yes	66	4.2%	68	5.0%	0.000
	No	1414	89.3%	1138	83.7%	
	I do not know	103	6.5%	153	11.3%	

The majority of smokers think that smoking hazards teach as part of school curriculum about 82% of smokers, 74.4% they know that smoking was not allowed for kids and youth, 3.7% of smokers they do not know if the selling cigarettes or buying it not allowed or not, 6.5% of smokers they do not know if the selling cigarettes or buying and smoking it is not allowed or not.

Table 2: Knowledge about smoking hazards.

		Smoking condition				P value
		Yes		No		
		No	%	No	%	
Health warning present in cigarettes box	Yes	751	50.9%	724	49.1%	0.000
	No	791	61.0%	505	39.0%	
	I do not know	43	25.0%	129	75.0%	
Percent of tar and nicotine in cigarettes	Yes	1288	73.9%	454	26.1%	0.000
	No	214	23.6%	691	76.4%	
	I do not know	83	27.9%	214	72.1%	
Benefits for decreasing tar and nicotine in the cigarettes	Yes	887	77.2%	262	22.8%	0.000
	No	581	40.2%	863	59.8%	
	I do not know	117	33.3%	234	66.7%	

The majority of smokers do not know the presence of health warning in cigarettes box 61%. About 73.9% of smokers they know the Percent of tar and nicotine in cigarettes and benefits of decreasing tar and nicotine in the cigarettes.

Table 3: Attitudes in the community to decrease smoking (media role).

		Smoking condition				P value
		Yes		No		
		No	%	No	%	
Advertising about cigarettes is not allowed for	Yes	1058	66.8%	661	48.7%	0.000
	No	363	22.9%	478	35.2%	
	I do not know	164	10.3%	218	16.1%	
Media help the efforts for smoking prevention	Yes	431	27.2%	536	39.5%	0.000
	No	1072	67.8%	645	47.5%	
	I do not know	79	5.0%	176	13.0%	
Media gives enough information about hazards of smoking	Yes	478	30.3%	481	35.4%	0.000
	No	1016	64.3%	691	50.8%	
	I do not know	86	5.4%	187	13.8%	
There is a public culture about smoking prevention	Yes	224	14.1%	314	23.1%	0.000
	No	1139	71.9%	780	57.4%	
	I do not know	222	14.0%	266	19.6%	
Presence of media campaign against smoking all the time	Yes	160	10.1%	232	17.1%	0.000
	No	1328	83.9%	951	70.0%	
	I do not know	94	5.9%	175	12.9%	

The majority of smokers know the advertising for cigarettes is not allowed 66.8%, they think there is no media help in smoking prevention 67.8%, media not gives enough information about hazards of smoking 64.3%, with no public culture about smoking prevention 71.9% and there is no media campaign against smoking 83.9%.

medical personnel helped in preventing smoking. In a study in India,¹⁸ there was a high prevalence of tobacco use and a general lack of training of health professionals in techniques for counselling patients in cessation.

In 2001, Egypt passed an act banning smoking in public places; however, this study shows that 82.3% of smokers and 77.8% of non-smokers were unaware of this law. Similar percentages of smokers and non-smokers (76.7% and 77.1%,

Table 4: Practices in the community to decrease smoking (increase taxes).

		Smoking condition				P value
		Yes		No		
		No	%	No	%	
Increase taxes as method for smoking prevention	Yes	695	43.8%	1100	80.9%	0.000
	No	808	51.0%	162	11.9%	
	I do not know	82	5.2%	98	7.2%	
Use part of taxes to finance the health system	Yes	1233	77.8%	1199	88.2%	0.000
	No	283	17.9%	78	5.7%	
	I do not know	69	4.4%	82	6.0%	

Only 43.8% of smokers agree about increase taxes as method for smoking prevention, majority of smokers agree that use these taxes for support the health system and there is no active strategy against smoking.

Table 5: Governmental effort for stop smoking.

		Smoking condition				<i>P</i> value
		Yes		No		
		No	%	No	%	
Presence of active strategy against smoking	Yes	346	21.8%	528	38.9%	0.000
	No	986	62.2%	575	42.3%	
	I do not know	252	15.9%	256	18.8%	
Government put smoking prevention policy	Yes	277	17.5%	417	30.7%	0.000
	No	1228	77.5%	824	60.7%	
	I do not know	80	5.0%	117	8.6%	
Smoking prevention initiative is effective	Yes	288	18.2%	346	25.5%	0.000
	No	1069	67.5%	766	56.4%	
	I do not know	227	14.3%	245	18.1%	
Feel a lot of efforts to prevent smoking	Yes	351	22.2%	384	28.3%	0.000
	No	1119	70.7%	823	60.7%	
	I do not know	113	7.1%	149	11.0%	

Smoker think there is no active strategy against smoking 62%. There is no governmental policy against smoking 77.3%, the smoking prevention initiative is not effective 67.5% and there is no lot of effort for prevent smoking 70.7%.

respectively) knew that there are places in which smoking is prohibited, but there are no effective warnings about smoking in schools; cafes and hospitals are the only places where there are warnings. Sinha et al.¹⁷ found that 80% of participants favoured a ban on smoking in public places. More smokers (60.2%) than non-smokers (39.6%) did not know that smoking is prohibited in work-places, implying greater exposure to environmental smoke. Moher et al.¹⁹ found that tobacco bans decreased cigarette consumption during the working day, but their effect on total consumption was less certain, and evidence is lacking about the cost-effectiveness of work-place programmes. Interventions for individual smokers were found to increase the likelihood of their quitting smoking. These include advice from a health professional, individual and group counselling and pharmacological treatment to overcome nicotine addiction. Self-help interventions are less effective. Interventions are effective whether offered in the work-place or elsewhere. Although smokers who take up these interventions are more likely to stop, the absolute numbers that quit are low. In our study, 64.6% of smokers considered that there is no effective help for

quitting, 60.6% that there is no encouragement to quit, 59.6% that the treatment offered for quitting is expensive and 54.7% that there is no system for quality assurance of the health services provided for smokers.

The findings of this study show that knowledge that selling cigarettes to children is illegal and about the hazards of smoking was better among smokers and that their attitude to the elements of the FCTC was positive, but they considered that not enough was being done to prevent tobacco use. The findings could be used as a baseline for future evaluation of the tobacco control programmes implemented by the Ministry of Health in Egypt (Table 2).

In order to reduce the access of children and adolescents to cigarettes, the prohibition on selling cigarettes should be enforced and the price increased through excise taxes. The warning signs on cigarette boxes should be effective before the cigarettes are bought and not after. Anti-smoking television advertising should be transmitted routinely. The rights of non-smokers to clean air supersede the right of smokers to smoke; therefore, the prohibition on smoking in public places should be enforced to

Table 6: Practices to decrease smoking (community help).

		Smoking condition				<i>P</i> value
		Yes		No		
		No	%	No	%	
There is a lot of interested people working in smoking prevention	Yes	416	26.3%	444	32.7%	0.000
	No	796	50.3%	605	44.5%	
	I do not know	371	23.4%	310	22.8%	
Doctors help smoking prevention policy	Yes	877	55.4%	806	59.3%	0.000
	No	654	41.3%	461	33.9%	
	I do not know	53	3.3%	92	6.8%	
Nurses help smoking prevention policy	Yes	816	51.5%	767	56.4%	0.000
	No	682	43.0%	484	35.6%	
	I do not know	87	5.5%	108	7.9%	

Smokers think that there is no interested people in the community working in smoking prevention 50.4%, medical personnel help the smoking prevention policy more than 50% agreement among the smokers.

Table 7: Practices to decrease smoking (smoking laws).

		Smoking condition				P value
		Yes		No		
		No	%	No	%	
Smoking prevention laws done	Yes	125	7.9%	120	8.8%	0.005
	No	1303	82.3%	1058	77.8%	
	I do not know	156	9.8%	182	13.4%	
Generally there are places where smoking prohibited	Yes	1215	76.7%	1048	77.1%	0.000
	No	317	20.0%	206	15.1%	
	I do not know	53	3.3%	106	7.8%	
Effective warning for smoking prevention in schools	Yes	679	42.9%	842	62.0%	0.000
	No	846	53.4%	453	33.4%	
	I do not know	59	3.7%	63	4.6%	
Effective warning for smoking prevention in work places	Yes	595	37.6%	733	53.9%	0.000
	No	954	60.2%	538	39.6%	
	I do not know	35	2.2%	89	6.5%	
Effective warning for smoking prevention in public places	Yes	755	47.6%	634	46.7%	0.000
	No	794	50.1%	627	46.1%	
	I do not know	36	2.3%	98	7.2%	
Effective warning for smoking prevention in hospitals	Yes	1207	76.2%	1148	84.5%	0.000
	No	358	22.6%	190	14.0%	
	I do not know	19	1.2%	21	1.5%	
Effective warning for smoking prevention in coffee	Yes	27	1.7%	53	3.9%	0.000
	No	1534	96.8%	1204	88.5%	
	I do not know	23	1.5%	103	7.6%	

There are places where smoking is prohibited 76.7%, there is no effective warning from smoking prevention in schools, public places, coffee and the only places where there is effective warning is hospitals.

Table 8: Quitting help in the community.

		Smoking condition				P value
		Yes		No		
		No	%	No	%	
Effective help to quit	Yes	369	45.0%	451	55.0%	0.000
	No	1035	64.6%	568	35.4%	
	I do not know	180	34.7%	339	65.3%	
Great efforts to encourage smokers to use effective ways for quit	Yes	143	36.2%	252	63.8%	0.000
	No	1250	60.6%	813	39.4%	
	I do not know	191	39.5%	293	60.5%	
Treatment offered for smokers to quit expensive	Yes	351	59.6%	238	40.4%	0.000
	No	225	43.0%	298	57.0%	
	I do not know	1009	55.0%	824	45.0%	
System for quality insurance in the health services provide for smokers	Yes	119	43.6%	154	56.4%	0.000
	No	884	54.7%	732	45.3%	
	I do not know	582	55.2%	472	44.8%	

Smokers think that there is no effective help for quit 64.6%, there is no efforts for encourage quit 60.6%, treatment offered for quit is expensive 59.6% and there is no system for quality insurance in health services provide for smokers 54.7%.

protect the environment from exposure to tobacco smoke. Interventions to decrease tobacco use among smokers and especially the young (e.g. increasing excise taxes, media campaigns, school programmes, community interventions and reduced access of minors to tobacco) must be broad-based, focused on boys and girls, and have components directed towards initiation, prevention and cessation. If effective programmes are not developed and implemented soon, the morbidity and mortality attributable to tobacco will increase. The Government of Egypt must consider new, stronger provisions and strong enforcement measures. Synergy among countries in tobacco control laws

and regulations by ratifying and complying with the WHO FCTC can be helpful to each country (Tables 3–8).

Conflict of interest

The authors have no conflict of interest to declare.

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