

Original Research

Tobacco related knowledge and support for smoke-free policies among community pharmacists in Lagos state, Nigeria

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Received (first version): 3-Jul-2014

Accepted: 7-Jan-2015

ABSTRACT*

Background: There are no safe levels of exposure to second hand smoke and smoke-free policies are effective in reducing the burden of tobacco-related diseases and death. Pharmacists, as a unique group of health professionals, might be able to play a role in the promotion of smoke-free policies.

Objective: To determine the tobacco-related knowledge of community pharmacists and assess their support for smoke-free policies in Lagos state, Nigeria.

Methods: A cross-sectional descriptive study design using both quantitative and qualitative methods was employed. Two hundred and twelve randomly selected community pharmacists were surveyed using a pre-tested self-administered questionnaire. In addition, one focus group discussion was conducted with ten members of the Lagos state branch of the Association of Community Pharmacists of Nigeria.

Results: The quantitative survey revealed that the majority (72.1%) of the respondents were aged between 20 and 40 years, predominantly male (60.8%), Yoruba (50.2%) or Igbo (40.3%) ethnicity and had been practicing pharmacy for ten years or less (72.2%). A majority (90.1%) of respondents were aware that tobacco is harmful to health. Slightly less (75.8%) were aware that second hand smoke is harmful to health. Among the listed diseases, pharmacists responded that lung (84.4%) and esophageal (68.9%) cancers were the most common diseases associated with tobacco use. Less than half of those surveyed associated tobacco use with heart disease (46.9%), chronic obstructive pulmonary disease (27.8%), bladder cancer (47.2%), peripheral vascular disease (35.8%) and sudden death (31.1%). Only 51.9% had heard of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC). A little over half of the respondents (53.8%) were aware of any law in Nigeria controlling tobacco use. The majority of respondents supported a ban on smoking in homes (83.5%), in public places (79.2%), and in restaurants, nightclubs and bars (73.6%). For every additional client attended to daily, knowledge scores increased by 0.022 points. Current smokers were 1.3 times less likely to support smoke-free policies compared with non-smokers. The findings emanating from the focus group discussion

reinforced the fact that the pharmacists were in support of smoke-free policies particularly in homes and public places. It also demonstrated that most of them were aware of the health risks associated with tobacco use and second hand smoke however some misconceptions seemed to exist.

Conclusion: The pharmacists surveyed expressed support of smoke-free policies and most of them were aware of the health risks associated with tobacco use. However, awareness of WHO FCTC and country-level tobacco legislation was low. Current smokers were less likely to support smoke-free policies. Community pharmacists should therefore be considered worth engaging for the promotion of smoke-free policies. Efforts should also be made to educate pharmacists about country level smoke-free laws.

Keywords: Smoking; Smoking Cessation; Smoke-Free Policy; Pharmacists; Pharmacies; Professional Role; Nigeria

INTRODUCTION

There is an overwhelming amount of evidence demonstrating the negative health effects of involuntary exposure to second hand smoke.¹ Worldwide, it is documented that more than half a million non-smokers die from passive smoking however, the burden of tobacco related morbidity and mortality is considerably higher in developing countries.² The 2012 Nigeria Global Adult Tobacco Survey reported that 5.6% (4.7 million) Nigerian adults currently use tobacco products; 3.9% (3.1 million) smoke tobacco and 2.9% (2.4 million) are daily smokers.³ A considerable amount of Nigerians are exposed to second hand smoke (SHS).^{3,4} More than two million non-smoking adults are exposed to second hand smoke at home (6.6%), in the workplace (16.2% of adults who work indoors), and in public places (27.6% of adults who visited restaurants, 16.4% in government buildings, and 9% in public transportation) in the preceding month.³

There are no safe levels of exposure to tobacco smoke.¹ SHS contains more than 7,000 chemicals of which about 70 are known carcinogens.⁵ SHS is associated with coronary heart disease, stroke, and lung cancer.^{6,7} SHS also causes numerous health problems in infants and children, including more frequent and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome.⁵⁻⁷

As the consequences of SHS have become increasingly clear, the protection of all people from these health risks has become a global public

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health priority. Article 8 of the World Health Organization Framework Convention for Tobacco Control (WHO FCTC), a global treaty to curb the menace of tobacco, clearly supports the implementation of smoke-free policies particularly through implementation of clean indoor air laws.⁸ In addition to an overall reduction in cardiovascular disease mortality, the public health rewards of smoke-free policies include a decrease in tobacco consumption and youth smoking initiation.⁹⁻¹²

About a decade ago, Nigeria signed the WHO FCTC and ratified it a year later. However, efforts to domesticate the WHO FCTC have not yielded much result. Unlike the existing Tobacco Control Act of 1990, the Nigeria Tobacco Control Bill (NTCB) which was developed in 2007, contains clear provisions for the protection of all Nigerians from the effects of second hand smoke. However, despite several efforts, primarily from civil society groups, this bill has not yet been enacted into law. The exact reasons for this remain unclear. However it is possible that the lack of support from professional groups and a paucity of locally generated evidence for the passage of the bill might be contributory.

Health care workers may play an important role in the promotion of tobacco control policy particularly if they are aware of the negative effects of tobacco and if they are supportive of such policies.¹³⁻¹⁵ Many studies have focused on the role of physicians and to a lesser extent nurses in tobacco control advocacy often leaving out other important cadre of health workers like pharmacists.¹⁶⁻¹⁸ Community Pharmacy is an important branch of the pharmacy profession and involves a registered pharmacist with the education, skills and competence to deliver the professional service within the community. Community pharmacists in Nigeria deal directly with people in their local areas and have responsibilities including counseling, checking and dispensing of prescription and over-the-counter drugs to their clients.¹⁹ A Community pharmacist in Nigeria must be registered with the Pharmacists Council of Nigeria.

Unlike in more developed countries, in many parts of Nigeria, the community pharmacies are usually the first point of call for people with medical issues and the community pharmacist in Nigeria has a high level of contact with patients and clients. These pharmacists, are therefore uniquely positioned within the Nigerian community to advocate for pro-public health policies, however their possible role as advocates for the promotion and implementation of smoke-free policies within their communities and nationally has largely been ignored. Existing studies on pharmacists in tobacco control research have focused on their role in providing tobacco cessation services largely ignoring their possible roles in promoting policy.^{20,21} Pharmacists' knowledge of tobacco and their attitudes towards smoke-free policies may influence their role as advocates for smoke-free policies within their communities. However, literature is sparse on the knowledge of health-related effects of tobacco and the attitudes towards smoke-free policies among pharmacists in Nigeria. Therefore in this study, we used both

quantitative and qualitative techniques to determine the knowledge of tobacco and its health effects and assess their support for smoke-free policies among community pharmacists. The outcome of this research may be used as evidence-based information for involving community pharmacists in advocating for promotion of smoke-free policies and encourage a smoke-free environment in Nigeria.

METHODS

Lagos state is the commercial capital of Nigeria, the most populous country in Africa. The Pharmacists Council of Nigeria (PCN) is the governing body that licences pharmacists in Nigeria and there were 634 licensed retailing premises registered with the PCN in Lagos state at the time of the study. This cross-sectional descriptive study using qualitative and quantitative techniques was carried out among registered community pharmacists operating in retail pharmaceutical premises within the state. The minimum sample size was calculated for the study using the formula for descriptive studies and based on the relevant findings of a previous study.²² Considering a confidence level of 95%, an alpha of 0.05 and a precision of 5% and an expected non-response rate of 20%, the final sample size for the study was 212.

A list of the 634 licensed retailing pharmaceutical premises in Lagos state stratified by local government areas was obtained from the Lagos state branch office of the Pharmacists Council of Nigeria. Local government areas were randomly and sequentially selected from this list and all eligible pharmaceutical premises were visited and included in the study after obtaining informed consents. Only one eligible and consenting pharmacist in each pharmaceutical premise in the selected local government areas was randomly selected and included in the study. This process was continued till the sample size was attained. In total, nine local government areas were used for the study. Eligible pharmacists had to be licensed with the Pharmacists Council of Nigeria with at least six months working experience. Interns were excluded from the study.

A cross-sectional descriptive study design was employed using both quantitative and qualitative techniques. Quantitative data was collected using self-administered questionnaires given to the selected pharmacists in each pharmacy outlet. The questionnaires were developed by the authors based on a review of existing literature and a local knowledge of pharmacy practice in Nigeria. The questionnaire was pre-tested and appropriate corrections made thereafter. Reliability testing showed a Cronbach's alpha of 0.823. The questionnaire elicited information on respondents' socio demographic details, characteristics of the pharmaceutical premise, smoking status, knowledge of tobacco and its health related risks and attitudes towards smokers and smoke-free bans. Each questionnaire took approximately 20 minutes to complete. Quantitative data collection was carried out over a period of five weeks (between the first week of September and the

Table 1. Question guide for the focus group discussion

What is tobacco? What are the forms of tobacco that you know of?
What are the health risks associated with tobacco use?
What are the health risks associated with second hand smoke exposure?
What is your opinion about banning tobacco smoking in designated places in Nigeria? Probe for public places, Restaurants and bars, Private homes and other places

second week of October, 2013) and entered using Epi-Info 2007 and analysed using SPSS 17.0 statistical software. There were seventeen knowledge related questions used to score respondents tobacco related knowledge. Each correctly answered question was awarded a score of one point while each incorrectly answered question was awarded a score of zero. Support for smoke-free bans was elicited using a five-point Likert scale to assess attitudes towards statements on support for smoke-free bans in three distinct categories of place: home, restaurants / bars / nightclubs and other public places. The most positive response was awarded a score of 4 points while the most negative a score of zero points. Frequency tables were constructed for categorical variables and means and standard deviations (SD) for continuous variables. Chi-squares and T-tests were carried out to test for associations. Linear regression models were constructed to determine the factors associated with pharmacists' knowledge and support for smoke-free bans. P values of <0.05 were considered statistically significant.

In addition, one focus group discussion (FGD) was carried out among ten members of the state branch of the Association of Community Pharmacists of Nigeria in Lagos state, after an informed consent. The FGD was designed to further explore the knowledge and attitudes of the pharmacist regarding tobacco use and smoke-free bans. The FGD was carried out using a set of questions designed by the researchers based on a review of relevant literature, a local knowledge of pharmacy practice in Nigeria, and after an assessment of the quantitative survey findings (See Table 1 for the FGD discussion guide). Participants for the focus group were selected by convenience sampling. We met with the representatives of the state branch of the Association of Community Pharmacists of Nigeria and some members were requested to attend the FGD. In total ten members were present at the FGD. The FGD took place at a neutral location and was conducted in the English language. No incentives were offered. Participants initially answered a short demographic survey eliciting information on their ages, gender, and years of experience and smoking status (see Table 2). An informed consent was obtained from participants prior to the discussion and they were guaranteed strict confidentiality. The FGD was moderated by the second author (OOO) and took approximately 45 minutes. Discussions were audio-taped and transcribed verbatim by two trained research assistants and typed immediately after the FGD. Analysis was conducted manually. Two authors independently read through and inductively coded the transcripts by hand. Based on the

Table 2. Focus group demographics

Gender	Age	Years of working experience
Male	48	20
Male	30	5
Female	46	20
Male	42	18
Male	59	30
Male	34	9
Female	36	10
Male	45	18
Female	37	10
Male	52	21

interview guide and initial reading of the transcripts, thematic areas were identified and documented. Standard text analysis was employed.

Ethical approval was obtained from the ethics and research committee of the Lagos University Teaching Hospital. Permission for this study was also obtained from the Pharmacists Council of Nigeria.

RESULTS

Quantitative data

Most (72.1%) of the respondents were aged between 20 and 40 years with a mean age of 35.2 (SD=10.8) years (Table 3). A considerable proportion erroneously thought that cannabis (47.2%) and cocaine (57.5%) were forms of tobacco (Table 4). The majority of the respondents supported a ban on smoking in homes, public places and even in restaurants, nightclubs and bars (Table 5). Both bivariate and multivariate analyses showed that the number of clients attended to daily was the only factor in the model that was associated with increasing knowledge (Table 6). For every point increase in the number of clients (i.e. one more client) attended to daily, knowledge score increased by 0.022 points. Bivariate analyses showed that age, years of practice and smoking status were associated with pharmacist support for smoke-free bans (Table 7). Only smoking status remained significant in the multivariate model indicating that current smokers were 1.3 times less likely to support smoke-free bans compared with non-smokers.

Qualitative data: Focus group discussion

There were ten participants in the focus group discussion, seven males and three females, all of which were practicing community pharmacists in the state. Their ages ranged from 30-59 years and they had between 5 and 30 years of experience (See Table 2).

The pharmacists were aware of the health risks associated with tobacco use but some misconceptions existed:

Most of the pharmacists were aware of the negative health effects of tobacco use: All of the pharmacists agreed that tobacco use is harmful to health. They were also aware of the specific health risks of tobacco use like cancers, chronic cough and cardiovascular disease as evidenced by some of the following responses; "*Tobacco is harmful to health, it predisposes to cancer*"; "*It predisposes to*

Table 3. Socio demographic details of the survey respondents (n=212)

Variable(s)	Frequency (%)
Age (in years) Mean±SD	35.2±10.83
≥20	3(1.4)
21-30	84 (39.6)
31-40	69 (32.5)
41-50	37 (17.5)
51-60	13 (6.1)
>60	6 (2.8)
Sex	
Male	129 (60.8)
Female	83 (39.2)
Ethnicity	
Igbo	85 (40.3)
Yoruba	106 (50.2)
Hausa	14 (6.6)
Others	6 (2.8)
Religion	
Christianity	164 (77.4)
Islam	48 (22.6)
Years of practice of respondents Mean±SD	9.1±8.6
1-5	93 (43.9)
6-10	60 (28.3)
11-15	20 (9.4)
16-20	19 (9.0)
>20	20 (9.4)
Average number of clients seen daily Mean±SD	24.1±18.8
1-10	38 (17.9)
11-20	94 (44.3)
21-30	36 (17.0)
31-40	13 (6.1)
41-50	14 (6.6)
>50	17 (8.0)
Smoking status of respondents	
Ex-smoker	31 (14.6)
Current smoker	18 (8.5)
Never smoker	163 (76.9)
Ethnicity 'Others' included Cross river, Niger delta, Edo, Efik, Ibibio, Kogi, and Urhobo	

constant cough"; "It is a risk factor for cardiovascular disease".

Misconceptions regarding tobacco use: It was, however, observed that there seemed to be some misconceptions among some pharmacists. A few of them reported that tobacco smoking does have some perceived benefits, notably stress relief, digestion and a reduction in appetite. As one pharmacist reported "There are some advantages of smoking tobacco, it makes some people feel higher and helps people to forget their problems". Another also said... "When I was in the university I smoked. If I take a cigarette in the morning, it 'ties' my tummy and my tummy does not ache me". Other comments included, "It helps in digestion", "Most people who smoke don't have appetite".

There seemed to be a disparity between the pharmacists' professional-related knowledge and personal experiences. One pharmacist reported that "Tobacco is not harmful to health, my profession says so, but in my family, my grandfather and all his brothers and sisters all used tobacco and they all lived longer than 100 years". Some pharmacists appeared to have some deep-seated personal or cultural convictions. As another pharmacist reported, "My dad was great smoker. He died at the age of 101 years, he said it makes the bowels

move. It has to do with genetics! I don't think it is bad to everyone!"

Awareness of the forms of tobacco was generally high however some gross misconceptions also existed:

Tobacco can be used in several forms. The knowledge of these forms of tobacco might be useful in helping patients quit tobacco use. The quantitative survey showed that some respondents erroneously believed that cocaine and cannabis were forms of tobacco. This was further explored in the FGD. We observed that the majority of the participants were aware of the common forms of tobacco particularly cigarettes, snuff and chewed tobacco. One respondent reported "Chewing tobacco is a form of tobacco, some people lick the powder". However several misconceptions existed as some of them felt that cannabis (marijuana) and coffee were also forms of tobacco. One respondent said "snuff and Marijuana forms of tobacco"; Another pharmacist reported, "People smoke nescafe (coffee)," however he was immediately corrected by another pharmacist who said, "caffeine is not tobacco but it has the same effect".

Awareness of the health risks of second hand smoke also existed but appeared to be primarily among vulnerable groups:

The support for smoke-free laws is contingent on the awareness of the health risks of exposure to second hand smoke. Most of the respondents were aware that passive smoking is dangerous to health. These notions were reported to be particularly strong among vulnerable groups like children and asthmatics. One pharmacist reported "Passive smoking causes lung cancer"; another reported, "Passive smoking is harmful to those who have asthmaand to children". However the effects of SHS were reported to be dose-dependent as

Table 4. Knowledge of the forms of tobacco and the health risks associated with tobacco use (n=212)

Variable(s)	N (%)
Knowledge of forms of tobacco	
Cigarettes	202 (95.7)
Cigars	189 (89.2)
Chewed tobacco	165 (78.2)
Snuff	122 (57.5)
Cocaine	80 (37.7)
Cannabis	100 (47.2)
Knowledge of harmful use of tobacco to health	191 (90.1)
Knowledge of second hand smoke harmful to health	160 (75.8)
Knowledge of addictive use of tobacco	177 (83.5)
Knowledge of tobacco related diseases:	
Lung cancer	179 (84.4)
Heart disease	105 (46.9)
COPD	59 (27.8)
Bladder cancer	100 (47.2)
Oesophageal cancer	146 (68.9)
Peripheral vascular disease	76 (35.8)
Prematurity/miscarriage/still birth	65 (30.7)
Sudden death	66 (31.1)
Had heard of the WHO FCTC	110(51.9)
Aware that Nigeria is a signatory to the WHO FCTC (n=110)	74(67.3)
Aware of any law in Nigeria controlling tobacco use	114(53.8)

Table 5. Support for smoking bans. n(%)

Variables (n=212)	Strongly Agree	Agree	Undecided	Disagree	Strongly disagree
Smoking should be prohibited within enclosed spaces in private homes	59(27.8)	118(55.7)	16(7.5)	15(7.1)	4 (1.9)
Smoking should be prohibited at public places	77(36.3)	91(42.9)	25(11.8)	15(7.1)	4 (1.9)
Smoking should be prohibited at restaurants, nightclubs and bars	57(26.9)	99(46.7)	34(16.0)	16(7.5)	6 (2.8)

indicated in the statement, "Passive smoking is only harmful if you are exposed for a long time".

Attitudes towards smoke-free bans:

Pharmacists are in a position to lend their voice to support smoke-free laws and their opinions about potential smoke-free bans were explored. A majority of the participants expressed support for smoke-free laws in Nigeria however some believed that smoking should be allowed in some designated public places. One participant expressed that smoking should be disallowed everywhere including in private homes. Many of them believed that it was the duty of the government to enforce smoke-free bans.

One pharmacist reported that, "It is good to ban cigarette smoking in public places because of the effect of passive smoking", and "The government should enforce smoking bans in public places; smoking should be banned everywhere even in private homes".- However, others reported, "It depends on the place, in some places like bars and nightclubs, it is expected that people can smoke there", and "There should be designated smoking areas".

DISCUSSION

This study demonstrates that the majority of community pharmacists support smoke-free bans to reduce the burden of tobacco related diseases. This is consistent with studies among physicians and nurses.^{18,23} If appropriately engaged, these pharmacists may be in a position to lend their voice to advocate for the promotion of smoke-free policies. While the majority of pharmacists support complete smoking bans in homes, workplaces and other public places, some believed that smoking could be allowed in some specific public places. It is not clear if this is a reflection of the level of knowledge of these pharmacists regarding dangers of second hand smoke, as there are no safe levels of exposure to second hand smoke.¹ In engaging pharmacists to support tobacco control policies, their existing knowledge of the health effects of tobacco use must be considered. Understanding the negative health effects of second hand smoke might also play a role in their support for smoke-free policies. As with many other categories of healthcare professionals, pharmacists are aware of the general health related effects of tobacco use.^{24,25} However, despite the generally high levels of tobacco related knowledge exhibited by the pharmacists, there seemed to be some

Table 6. Bivariate analysis of the factors associated with knowledge of tobacco use

Variable(s)	Knowledge score	F value	P value
Age (in years)		0.42	0.797
<30	10.52(2.3)		
31-40	10.17(2.4)		
41-50	10.03(2.3)		
51-60	10.57(2.5)		
>60	10.00(2.4)		
Sex		0.015*	0.904
Male	10.32(2.4)		
Female	10.28(2.4)		
Ethnicity		1.86	0.120
Igbo	10.11(2.3)		
Yoruba	10.59(2.4)		
Hausa	9.86(3.0)		
Others	8.50(2.0)		
Religion		0.339	0.561
Christianity	10.25(2.5)		
Islam	10.48(2.2)		
Years of practice of respondents		0.882	0.475
1-5	10.61(2.4)		
6-10	10.17(2.3)		
11-15	9.85(2.8)		
16-20	9.74(1.9)		
>20	10.25(2.4)		
Average number of customers attended to daily		2.988	0.013
1-10	10.24(2.6)		
11-20	10.06(2.4)		
21-30	9.89(2.4)		
31-40	11.00(1.9)		
41-50	10.14(1.5)		
>50	12.24(2.6)		
Smoking status of respondents		0.002	0.965
Current smoker	10.28(2.4)		
Non-smoker	10.30(2.4)		

Variable(s)	Attitude score	Chi-square	P-value
Age (in years)		5.73 [#]	0.000
<30	9.59(2.1)		
31-40	8.87(1.7)		
41-50	9.03(2.1)		
51-60	7.07(2.0)		
>60	7.86(2.8)		
Sex		0.145	0.703
Male	8.98(2.0)		
Female	9.10(2.2)		
Ethnicity		1.656	0.162
Igbo	8.86(1.9)		
Yoruba	9.10(2.2)		
Hausa	9.00(1.8)		
Others	8.50(2.0)		
Religion		0.949	0.331
Christianity	9.10(2.1)		
Islam	8.77(2.0)		
Years of practice of respondents		2.735	0.030
1-5	9.39(2.0)		
6-10	9.00(1.7)		
11-15	8.80(1.9)		
16-20	8.95(2.1)		
>20	7.75(2.9)		
Average number of customers attended to daily		0.767	0.574
1-10	9.45(2.2)		
11-20	8.99(1.9)		
21-30	9.14(1.8)		
31-40	8.23(2.5)		
41-50	8.79(2.6)		
>50	8.88(2.3)		
Smoking status of respondents		7.315	0.007
Current smoker	7.78(2.9)		
Non-smoker	9.14(1.9)		

[#]F statistic

misconceptions among some of them as a few of them reported that tobacco use does have some perceived benefits in the focus group discussion. Similarly, in both the quantitative and qualitative surveys, it was observed that some misconceptions existed about tobacco use. In positioning pharmacists for the effective promotion of tobacco control policy, efforts should be made to improve their knowledge of tobacco and its control. A similar study in Lagos state among pharmacy students highlighted the need to include tobacco training in the pharmacy curriculum.²⁶ In developing this curriculum and training programs, efforts should be made to identify and correct some of these misconceptions.

In this study, it was observed that pharmacists who worked in larger establishments tended to be more knowledgeable about tobacco and its health related risks. While it seems that the work environment is associated with knowledge, it remains to be known whether it is the work environment and the fact that the pharmacists attend to a relatively higher number of clients, that may have prompted them to take measures to increase their health-related knowledge, or if larger establishments tend to employ more knowledgeable pharmacists. Further research may be needed to explore this relationship.

Despite the fact that Nigeria signed the WHO FCTC over 10 years ago, the knowledge of tobacco related policy among the pharmacists was low. Similarly, pharmacy students in Nigeria were

reported to exhibit low levels of awareness of tobacco related public health policy.²⁶ Awareness about existing tobacco policies might influence the effectiveness of this group of health professionals as advocates for the support of smoke-free policies in Nigeria.²¹ Relevant programs to increase awareness about existing tobacco control laws will be beneficial to pharmacists. Their current lack of knowledge about existing tobacco control laws within their environment may need to be addressed in designing these programs.

This study also shows that smoking status affects pharmacists' support for smoke-free policies. This is consistent with studies among other groups of health workers, current smokers are significantly less likely to support smoke-free policies when compared with ex-smokers or never smokers.^{24,27} Therefore, it is important to provide tobacco cessation treatment options for pharmacists who are smokers as this may affect their willingness to support smoke-free policies.

This is one of the first studies that used both quantitative and qualitative techniques to assess the support of smoke-free policies among pharmacists within Nigeria. However, it does have some limitations as the cross sectional nature of the study does not allow for any causal inference. In addition, the pharmacists were drawn from Lagos state, the commercial capital of the country and one of the most populous states in Nigeria, therefore the findings cannot be generalized to the entire country.

CONCLUSIONS

The majority of community pharmacists were aware of the harmfulness of tobacco to the smoker and to a lesser extent, the non-smoker while most of them were unaware of the current country-level tobacco control policies. Nevertheless, the majority of community pharmacists did support smoke-free policies. Community pharmacists should therefore be considered worth engaging in the promotion of smoke-free policies. Efforts should be made to educate pharmacists about tobacco related health risks and country-level smoke-free laws.

ACKNOWLEDGEMENTS

The authors are grateful to Dr. Memuna Esan of the Department of Community Health, Lagos University Teaching Hospital and Mary T. Hynek of the Department of Preventive Medicine and Public Health, University of Kansas Medical Center, Kansas City, KS, USA for proof reading the final manuscript.

Author contributions: EOP & OOO conceived the research idea. ABA and BF revised the study design and methodology for intellectual content. EOP and OOO performed the initial analysis of both the quantitative and qualitative findings. This was refined by ABA and BF. All authors contributed towards the drafting and final review of the manuscript.

CONFLICT OF INTEREST

None declared.

CONOCIMIENTO SOBRE EL TABACO Y APOYO A LAS POLÍTICAS DE SIN HUMO ENTRE LOS FARMACÉUTICOS COMUNITARIOS DEL ESTADO DE LAGOS, NIGERIA

RESUMEN

Antecedentes: No hay niveles seguros de exposición de fumador pasivo y las políticas de sin-humo han mostrado ser efectivas en la reducción del daño de las enfermedades y muertes producidas por tabaco. Los farmacéuticos, como grupo destacado de profesionales de la salud, pueden jugar un papel en la promoción de políticas sin-humo.

Objetivo: Determinar el conocimiento sobre el tabaco de los farmacéuticos comunitarios y su apoyo a políticas sin-humo en el estado de Lagos, Nigeria.

Métodos: Se utilizó un estudio transversal usando tanto métodos cuantitativos como cualitativos. Se entrevistó a 212 farmacéuticos comunitarios aleatoriamente seleccionados utilizando un cuestionario auto-administrado pre-pilotado. Además, se realizó una discusión en grupo focal con 10 farmacéuticos de la sección del estado de Lagos de la Asociación de Farmacéuticos Comunitarios de Nigeria.

Resultados: El cuestionario cuantitativo reveló que la mayoría (72,1%) de los respondientes tenían entre 20 y 40 años, eran predominantemente hombres (60,8%), de las etnias Yoruba (50,2%) o Igbo (40,3%) y estaban ejerciendo durante 10 años o menos (72,2%). La mayoría (90,1%) sabía que el tabaco es malo para la salud. Ligeramente menos (75,8%) sabía que ser fumador pasivo es malo para la salud. Entre las enfermedades identificadas, los farmacéuticos respondieron que los cánceres de pulmón (84,4%) y de esófago (68,9%) eran las enfermedades más frecuentemente asociadas con el tabaco. Menos de la mitad de los entrevistados asoció el tabaco con enfermedad cardíaca (46,9%), enfermedad pulmonar obstructiva crónica (27,8%), cáncer de vejiga (47,2%), enfermedad vascular periférica (35,8%) y muerte súbita (31,1%). Sólo el 51,9% había oído sobre el World Health Organization Framework Convention on Tobacco Control (WHO FCTC). Algo más de la mitad de los respondientes (53,8%) conocía la ley en Nigeria sobre el control de tabaco. La mayoría de los respondientes apoyaba la prohibición de fumar en los hogares (83,5%), en lugares públicos (79,2%) y en restaurantes, clubs nocturnos y bares (73,6%). Por cada cliente de más atendido en la farmacia, las puntuaciones de conocimiento crecían en 0.022 puntos. Los actuales fumadores tenían 1,3 veces menos de probabilidad de apoyar políticas sin-humo que los no fumadores. Los hallazgos del grupo focal reforzaron el hecho de que los farmacéuticos apoyan las políticas sin-humo, especialmente en los hogares y lugares públicos. También demostraron que la mayoría de ellos conocían los riesgos del tabaco y de los fumadores pasivos, aunque parecía haber algunos errores de concepto.

Conclusión: Los farmacéuticos entrevistados apoyaron las políticas sin-humo y la mayoría conocía los riesgos asociados al uso de tabaco. Sin embargo, el conocimiento del WHO FCTC y de la legislación era bajo. Era menos probable que los fumadores apoyasen las políticas sin-humo. Debería considerarse valioso enrolar a los farmacéuticos comunitarios en la promoción de políticas sin-humo. Deberían realizarse esfuerzos para educar a los farmacéuticos sobre la legislación nacional sobre tabaco.

Palabras clave: Hábito de Fumar; Cese del Tabaquismo; Política para Fumadores; Farmacéuticos; Farmacias; Papel Profesional; Nigeria

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