

**FACTORS INFLUENCING THE ADOPTION OF CIGARETTE SMOKING
AMONG ARTISAN MALE APPRENTICES IN IBADAN NORTH-WEST
LOCAL GOVERNMENT AREA, OF OYO STATE**

BY

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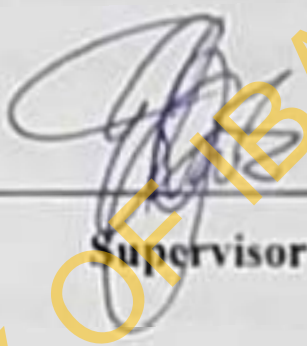
DEDICATION

I dedicate this project work to the Trinity; God the Father, God the Son and God the Holy Spirit.

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CERTIFICATION

I certify that this project was carried out by Adeolu Abidemi ADEOYE of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, under my supervision.



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ABSTRACT

Cigarette smoking among youths has become a growing problem globally, especially in developing countries such as Nigeria. The consequences of cigarette smoking in later life have been a major public health concern in the country. Previous studies focused on determination of prevalence of cigarette smoking among in-school youths, to the exclusion of out-of-school youths who are also vulnerable. This study was therefore undertaken to determine the factors influencing adoption of cigarette smoking habit among male artisan apprentices in Ibadan North-West Local Government Area Oyo State, Nigeria.

The study was descriptive and cross-sectional in design. A five-stage random sampling technique was used to randomly select, wards, 6 communities, 30 streets, workshops and 400 consenting respondents. A semi-structured, interviewer-administered questionnaire was used to elicit information on respondents' socio-demographic characteristics and factors influencing intention to smoke, initiation of smoking, and maintenance of smoking habit. Knowledge of respondents on health risks of smoking habit was measured on a 14-point scale. Scores ≤ 5 , $> 5-10$ and > 10 were categorised as poor, fair and good, respectively. Qualitative data were collected through 4 in-depth interviews (IDIs) with vocational skill tutor and six with artisan apprentices. Quantitative data were analysed using descriptive statistics, Chi-square test and logistic regression at $p=0.05$, while data from IDIs were analysed thematically.

Respondents' age was 19.6 ± 2.7 years. 65 respondents (16.3%) are currently undergoing tailoring, and 35 (8.8%) automobile mechanic trainings. Factors influencing intention to smoke include peer pressure (60.8%), trainer's influence (40.0%), attraction to cigarette (49.8%), personality boosting (46.0%), and media influence (49.8%). Majority (65.3%) of respondents who had initiated smoking reported easy access to cigarette, 69.3% reported road side shops as their main source, and 54.4% reported they do not have cigarette brand preference. Majority (73.5%) of the respondents reported smoking does not cause lung cancer while 70.8% reported smoking could cause black lips. Respondents' knowledge were good, fair, poor knowledge as (18.8%), (33.2%) and (48.0%) respectively. Average money spent daily by respondents on

cigarette smoking was between ₦91 - ₦120. Above half, (61.4%) reported smoking at least once a day. Almost all who smoked (95.5%), reported that smoking helps them to relax. Proportion of artisan apprentices who smoked was significantly higher (23.8%) among automobile mechanics compared to other apprentices (72.2%). Respondents with 4-6 years of apprenticeship were more likely to smoke cigarette compared to those with lesser years (OR= 2.4; CI= 2.1-3.5). Respondents who reported easier access to cigarette were more likely to initiate smoking compared to those with limited access (OR= 3.5; CI= 3.2-4.9). Respondents opined that cigarette smoking could have various side effects such as cough, black lips, and chest pain and body odour. Also peer pressure, easy access and personality boosting were the major factors influencing cigarette smoking.

Initiation of cigarette smoking habit was high among apprentices in Ibadan North-West Local government and is reinforced mostly by peer pressure and easy access. Therefore, peer-education and use of information, education and communications materials should be used to discourage smoking among artisan apprentice.

Keywords: Intention to smoke, Initiation of smoking, maintenance of smoking habit, Artisan apprentice.

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LIST OF ABBREVIATIONS

MPH:	Master of Public Health
M.Sc:	Master of Science
OND:	Ordinary National Diploma
USA:	United States of America
WHO:	World Health Organisation

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OPERATIONAL DEFINITION OF TERMS

- Adolescent:** Young people between ages 10-19years. Adolescence is a period in human growth and development that occurs after childhood and before adulthood
(from ages 10-19years)
- Artisan:** Individual with a mastery of a craftwork
- Apprentice:** An individual learning a craftwork
- Apprenticeship:** The act of learning a craftwork
- Cigarette:** A brand of tobacco product
- Smoking:** The act of using a tobacco product usually by dragging and blowing of breath.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Smoking has become a rapidly growing problem worldwide, even in many developing countries. It is projected that over the next five decades, close to 450 million deaths would be caused by tobacco use (Odeyemi, 2009). By the year 2030, tobacco is expected to be the single biggest cause of death worldwide causing more deaths than HIV, malaria, tuberculosis, maternal mortality, automobile crashes, homicides and suicides combined (WHO, 2002). Furthermore, it is expected that tobacco-related diseases will account for 11% of all deaths in developing countries by the year 2025 (WHO, 2002). No other consumer product has even come close to inflicting this degree of harm on the world community.

While it has been established that many smokers start before the age of 18 years, (Simantov, 2000) of serious concern is the increasing trend in smoking prevalence among youths and the likelihood that many of these young people who begin to smoke at an early age will continue to do so throughout adulthood (Osungbade, 2008).

A number of factors influence an individual to start smoking. Based on studies in the past, peer pressure, easy access to cigarette and related products, affordability, poor knowledge of health risks, effects of promotion, imitation of behaviour, among others have been reported as factors that could influence adoption of smoking among youths. This study aimed at highlighting various factors influencing smoking in artisan male apprentices in Ibadan North-West Local Government Area, Oyo State. Factors associated with increasing uptake of smoking behavior among youths include low self-esteem, stressful life events, friends who smoke, advertisement and living with a smoker (Oinokhodion, 2007). However, many of the factors associated with adverse health behaviors which may include smoking initiation and persistence are known to be commoner amongst male apprenticeship in Ibadan North-West Local Government Area, Oyo State.

Out-of-school youths are especially vulnerable to wrong information from sources that lack credibility. Because they are outside a formal school system, they also miss out of the opportunity for learning in conducive environments (Buttross et al, 2003). Also, Out-of-school adolescents sometimes go through many stressful life events compared to their in-school counterparts. Often, many of these youths have non-stable sources of income. Stressful life events have been shown to be associated with increased risk for smoking and alcohol use (Simantov et al, 2000).

Ibadan North-West local Government Area, Oyo State, is one of the five heavily urbanized LGA in Oyo State. It harbors numerous number of artisans and craftwork, hence it is appropriate to obtain a large number of apprentices for this study.

The study was therefore designed to determine the factors influencing the adoption of cigarette smoking among male artisan apprentices in Ibadan North-West Local Government Area, Oyo State.

1.2 Statement of the problem

Adolescent and teenage smoking have been studied widely, and it has been found in developed countries that nearly one-half of school age students who have reached the age of 18 have already established the habit of smoking with some degree of regularity, and it is a rather unrealistic hope on the part of adults to expect that children will abstain until reaching the adult approved age of decision (Vardavas, 2010).

The adolescent age is a critical period in the formation of the smoking habit. Most smokers start smoking during their adolescence or early adult years. The earlier they start to smoke, the more likely they are to become regular smokers (CDC, 2006).

Presently, this group is under-studied and under-represented in smoking prevention interventions in Nigeria. Generally speaking, literature is lacking on the availability of a sound theoretical basis for developing interventions aimed at adolescent smoking cessation (Adebiyi et al, 2010).

Cigarette smoke contains over 4,000 chemical compounds, 200 of which are known to be poisonous, and more than 60 have been identified as carcinogenic (CDC 2005). Consequently, it is no wonder that the effects of smoking are so widespread and utterly destructive.

Adolescence is the time of life when people are more interested in taking risks and testing the boundaries of the world outside as well as their own limits. Throughout history countless adolescents has smoked tobacco. This habit carries on into adult life and we find that of the 6.6 billion people on this planet, 1.3 billion are smokers and 1 billion of these are males (Naing, 2004).

However, it is believed that the general prevalence of smoking behaviour may be greatly reduced if initiation of smoking habit is largely reduced at adolescent or teen age. The assumption here is that adolescents are capable of taking best decisions for their health, if provided with adequate knowledge and awareness. Hence, it is possible that most teenagers and adolescents who engage in smoking habit are unaware of the risks involved, and are often addicted before learning about them. Furthermore, the years of potential life lost attributable to tobacco related diseases will continue to increase if we do not target interventions to prevent smoking initiation among youths (Omokhodion, 2007).

1.3 Justification of the study

Out of school youths, of which male artisan apprentices under study belongs, are often neglected when planning for tobacco prevention programs, whereas they are more vulnerable (Buttross et al, 2003). Few studies exist in Nigeria about their pattern of tobacco use to serve as the basis for effective policy formulation (Adebiyi et al, 2010).

Many factors associated with adverse health behaviors such as smoking initiation and maintenance are known to be common among out-of-school youth because of their aggregation in areas lacking adult supervision. These youths are a diverse group who may have completed elementary school but could not further their education, dropped out, or never started school. Many often become apprentices in several artisan professions. The term apprentices refer to those who participate in non formal school programs.

Artisans are workers in a skilled trade or vocations, especially those that involve making things by hand. They are craftsmen or skilled manual workers who make items that may be functional or strictly decorative, including furniture, sculpture, clothing, jewellery, automobile mechanic,

household items and tools or even hair dresser. Apprentices, in this context, refer to learners in the skill acquisition process of the various vocations or artistries training.

This study focuses mainly on male adolescents as past studies have shown that cigarette smoking habit is commoner among the gender than their female counterpart, especially in Nigeria. Also, globally, lung cancer which is often linked to tobacco smoking has a higher prevalence among males artisan apprentices.

The results are useful for the formulation of appropriate policies especially the State and Federal Ministry of Health regarding smoking among artisans in Oyo State and the country at large. This study is important since many National Policy makers are increasingly interested in the high rate of smoking among artisan male artisan apprentice and youths in the State and the Nation at large. Therefore, it is hoped that this study would provide appreciable information and recommendation for the derivation of a theory-based approach to effective cigarette-smoking prevention among male artisan apprentice.

1.4 Research Questions

The following research questions were set for the study;

1. What are the factors that influence the intention to smoke cigarette among artisan male apprentices in Ibadan North-West Local Government Area, Oyo State?
2. What are the factors that enhance the initiation of cigarette smoking habit among artisan male apprentices in Ibadan North-West Local Government Area, Oyo State?
3. What are the factors that promote maintenance of cigarette smoking among artisan male apprentices in Ibadan North-West Local Government Area, Oyo State?
4. What is the prevalence of cigarette smoking among male artisan apprentices in Ibadan North-West Local Government Area, Oyo State?
5. What is the knowledge of male artisan apprentices on health risk of cigarette smoking in Ibadan North-West Local Government Area, Oyo State.

1.5 Broad Objective.

This broad objective of the study was to determine the factors influencing the adoption of cigarette smoking among male artisan apprentices in Ibadan North-West Local Government Area, Oyo State.

Specific Objectives

The specific objectives of the study were to:

1. Determine the factors that influence the intention to smoke cigarette among artisan male apprentices in Ibadan North-West Local Government Area.
2. Identify the factors that enhance initiation of cigarette smoking among artisan male apprentices in Ibadan North-West Local Government Area
3. Identify the factors that promote the maintenance of cigarette smoking among artisan male apprentices in Ibadan North-West Local Government Area.
4. Determine the prevalence of cigarette smoking habit among artisan male apprentices in Ibadan North West-Local Government Area.
5. Assess the knowledge of artisan male apprentices on health risk of cigarette smoking in Ibadan North-West Local Government Area.

1.6 Research Hypotheses

The following null hypotheses were tested;

1. There is no significant association between respondents' level of education and cigarette smoking habit.
2. There is no significant association between respondents' easy access to cigarette and cigarette smoking habit
3. There is no significant association between respondents' effects of peer pressure and cigarette smoking habit.

CHAPTER TWO

LITERATURE REVIEW

2.1 CONCEPTUAL REVIEW

2.1.1 Effects of smoking among youths

The link between cigarette smoking and many non-communicable diseases have been established (National Cancer Institute, 2003). In the general population, important consequences of exposure to both active and passive smoking include cardiovascular and respiratory disorders, and cancers. Cigarette smoking is also known to be an aggravating factor in pulmonary tuberculosis, hypertension and diabetes mellitus. In fact, the use of cigarettes and other tobacco products constitute one of the most important modifiable risk factor in many non-communicable diseases. Furthermore, for adolescents undergoing the rigors of learning, smoking and the associated vices, are potent distractions to academic activities. This is because substance abuse has the potential to drive the abuser toward violent behavior, crime, truancy and absenteeism. There is also the tendency toward the twin social vice of alcohol abuse which altogether compounds the sexual and reproductive problems of adolescents (National Policy on Population, 2004). In recent times, tobacco smoking is by far the most popular form of smoking ahead of pipes, cigars and chewing tobacco and is practiced by over one billion people in the majority of all human societies resulting in nearly 2 billion people, that is a third of the world's population being exposed to pulmonary tuberculosis pathogen (Cobb, 2010; WHO, 2002).

Smoking has been shown to be a leading cause of premature mortality and morbidity resulting in several millions of deaths globally. It has been predicted that if the pattern currently seen among youth continues, a lifetime of tobacco use would result in the deaths of 250 million children and young people alive today, most of them in developing countries (WHO, 2002).

National Population Commission (2009) submitted that Nigeria is one of the most populous countries in Africa, with an estimated population of 162 million people of which youth are estimated to be more than 30%. In Nigeria, the prevalence of tobacco use among adults

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National Population Commission (2009) submitted that Nigeria is one of the most populous countries in Africa, with an estimated population of 162 million people of which youth are estimated to be more than 30%. In Nigeria, the prevalence of tobacco use among adults

(12.3% males <1% in females) is generally lower than in more developed countries, however, prevalence among youth tends to be higher than among adults, a mean lifetime smoking prevalence of 26.4% was reported among secondary school students with values ranging from 7.2% to 42.9% (Odeyemi, Odukoya, Oyeemi and Updhyay, 2013).

2.1.2 Substances that are commonly smoked

Tobacco smoking among the youth is a public health concern because of the immediate and long-term health risks associated with tobacco use such as asthma, chronic cough, chronic obstructive airways disease, cancers and cardiovascular diseases (CDC, 2009). Adolescent tobacco use has also been linked to other risky health-related behaviours, mental health problems, suicide, motor vehicle accidents, violent crime and even dental problems (US Department of Health and Human Services, 2004). Furthermore, research on the sequence of drug use suggests that cigarette smoking may serve as a gateway to illicit drugs (Paudel D, 2003). Tobacco use in any form is dangerous and addictive and every effort should be made to discourage its use.

According to Greaves (2002); Aryal U,(2011), substances that are smoked include: Marijuana (cannabis), Tobacco, clarified butter (ghee), Fish offal, Dried snake skin, and pastes molded around incense sticks. Similarly, USDHHS (2010) hinted that smoked tobacco products which may be cigarettes, pipes, cigars or hand-rolled tobacco are particularly harmful because the burning process releases a dangerous cocktail of about 7,000 chemicals of which about 70 are known carcinogens.

2.1.3 Types of Smokers

Individuals who smoke tobacco can be categorized into active smokers, passive smokers and non smokers (Ajzen I, 2001). According to them, active or actual smokers are those that voluntarily inhale tobacco smoke; passive smokers are also known as secondhand smokers and this is the involuntary inhalation of smoke from tobacco products, scientific evidences have shown that exposure to second-hand tobacco smoke causes death, diseases and disability and it is on the basis of the risk that passive smokers are exposed to that led

to the prohibition of tobacco smoking in public places because second-hand (passive) smokers are exposed to the same problems as active smokers; lifelong non-smokers with partner who smoke in the home have 20-30% greater risk cancer and those exposed to cigarette smoke in the work place have an increased risk of 16-19%; nonsmokers are those who do not inhale tobacco smoke voluntarily or involuntarily which is a very rare thing.

There are three types of smokers, viz:

- a) **Primary or Active Smokers:** These are habitual smokers. They just cannot do anything if they have not smoked.
- b) **Secondary or Passive Smokers:** This category of smokers are occasional smokers, they sometimes indulge in it to socialize.
- c) **Tertiary Smokers:** They can be said to be unintentional smokers. They inhale the smoke because of their closeness to the scene of the smoke e.g. waiters and waitresses in bars.

2.1.4 Tips on Quitting Smoking

According to WHO (2002) West and Adelman, (2001), the following tips can help in quitting smoking:

Once smoking has begun, cessation is difficult and smoking is likely to be a long-term addiction because many professors of medicine and doctors who despite the quitting smoking:

i. Support:

Good role-modeling especially by parents, educational and religious leaders will help them in quitting. The right support from friends and family members who are committed to helping can make the first week after quitting much easier. Support can also be found on-line in various groups and forums.

ii. **Preparing for Cravings:** It means preparing for the cravings one will have ahead of time. Healthy diet should be taken to minimize the withdrawal symptoms and keep the energy up.

iii. **Exercise:** Exercise is one of the best things one can do during the first weeks because it helps to reinforce ones commitment to his/her health. It helps to remove the toxins and nicotine from the body.

- iv. **Drink Plenty of Water:** Water is important for someone who just quit smoking because the body is struggling to wash impurities out of the body and the main avenue for doing that is with water.
- v. **Take Vitamins:** Smoking cigarettes robs the body of vital nutrients. Taking a multivitamin every day can help the body get through the toughest first weeks and allow the body to acclimatize.
- vi. **Inclusion in School Curriculum:** Including smoking education in the school curriculum will bring knowledge about the implication of smoking closer to these adolescents.
- vii. **Enforcement of Government Policies:** Policies prohibiting the advertisement and use of tobacco in public places should be properly enforced.
- viii. **Inclusion in School Curriculum:** Including smoking education in the school curriculum will bring knowledge about the implication of smoking closer to these adolescents.
- ix. **Enforcement of Government Policies:** Policies prohibiting the advertisement and use of tobacco in public places should be properly enforced.

2.2 EMPIRICAL REVIEW

2.2.1 Implications of cigarette smoking

According to National Cancer Institute, (2003), smoking causes certain fatal diseases, such as COPD (emphysema and chronic bronchitis), cancer and ischemic heart disease. Between 1950 and 2000, approximately 70 million people died due to tobacco use; over the next fifty years, another 450 million might die from smoking-related diseases; annually, 8 million people become ill with pulmonary tuberculosis and 2 million people die from this disease worldwide (CDC, 2009).

WHO (2007) hinted that the implications of smoking include health implication, social implication, financial implication, psychological implication, educational implication, and air pollution. They are underneath discussed:

a) **Health Implication:** Medical studies have proven that smoking tobacco is among the leading causes of many diseases such as lung cancer, heart attacks, erectile dysfunction and can also lead to birth defects. Others are:

- i). **Gastro intestinal disorder:** such as mal-absorption, ulcers, inflammation of the gastro intestinal tract e.t.c. **Metabolic disturbance:** such as hypokalemia, hypomagnesemia e.Lc.
- ii). **Cardiovascular problem:** The disturbance caused include hypertension, atherosclerosis, cardiomyopathy e.t.c.
- iii). **Endocrine system disorder:** The problem include diabetes and pancreatitis.
- iv) **Central nervous system:** The problem include depression, organic brain syndrome, sleep disturbances, memory loss e.t.c.
- v). **Neuro-muscular problem:** The problem include myopathy.
- vi). **Psychological Implication:** It can cause personality disorder. They become irresponsible, maladjusted, poor dressing habit.

Tobacco smoke contains chemicals that are harmful to both smokers and non-smokers. Breathing even a little tobacco smoke can be harmful (US Department of Health and Human services, 2004, 2006, and 2010). Of the more than 7,000 chemicals in tobacco smoke, at least 250 are known to be harmful, including hydrogen cyanide, carbon monoxide, and ammonia (US Department of Health and Human services, 2004, 2006, and 2010). Among the 250 known harmful chemicals in tobacco smoke, at least 69 can cause cancer.

These cancer-causing chemicals include the following (US Department of Health and Human services, 2004, 2006, and 2010).

- o Arsenic
- o Benzene
- o Beryllium (a toxic metal)
- o 1,3-Butadiene (a hazardous gas)
- o Cadmium (a toxic metal)
- o Chromium (a metallic element)
- o Ethylene oxide
- o Nickel (a metallic element)
- o Polonium-210 (a radioactive chemical element)
- o Vinyl chloride

Other toxic chemicals in tobacco smoke are suspected to cause cancer, including the following (US Department of Health and Human services, 2004, 2006, and 2010)

- o Formaldehyde
- o Benzo(a) pyrene
- o Toluene

Smoking harms nearly every organ of the body and diminishes a person's overall health. Millions of Americans have health problems caused by smoking. Smoking is a leading cause of cancer and death from cancer. It causes cancers of the lung, oesophagus, larynx, mouth, throat, kidney, bladder, pancreas, stomach, and cervix, as well as acute myeloid leukaemia (US Department of Health and Human services, 2004, 2006, and 2010). Smoking also causes heart disease, stroke, aortic aneurysm (a balloon-like bulge in an artery in the chest), chronic obstructive pulmonary disease (COPD) (chronic bronchitis and emphysema), asthma, hip fractures, and cataracts. Smokers are at higher risk of developing pneumonia and other airway infections (US Department of Health and Human services, 2004, 2006, and 2010). A pregnant smoker is at higher risk of having her baby born too early and with an abnormally low birth weight. A woman who smokes during or after pregnancy increases her infant's risk of death from Sudden Infant Death Syndrome (SIDS) (US Department of Health and Human services, 2004, 2006, and 2010). Men who smoke are at greater risk of erectile dysfunction (Austoni et al, 2005).

Cigarette smoking and exposure to tobacco smoke cause more than 440,000 premature deaths each year in the United States (US Department of Health and Human services, 2004, 2006, and 2010). Of these premature deaths, about 40 percent are from cancer, 35 percent are from heart disease and stroke, and 25 percent are from lung disease (CDC, 2005).

- a) **Financial Implication:** Smoking brings additional spending. It drains the purse of the smoker thereby causing (sometimes) serious financial hardship for the individual.
- b) **Educational Implication:** Adolescents who smoke easily engage in gangsterism, truancy, vandalism and all sorts of vices that may eventually lead to poor performance, repeat and eventual withdrawal or expulsion.

Other toxic chemicals in tobacco smoke are suspected to cause cancer, including the following (US Department of Health and Human Services, 2004, 2006, and 2010)

- Formaldehyde
- Benzo[α] pyrene
- Toluene

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- c) **Social Implication:** Adolescents may engage in stealing so as to gratify their desire to smoke. Hence it brings social stigma.
- d) **Environmental Implications:** Air Pollution, the smoke released during smoking serves as pollutant to the environment.

2.3 THEORETICAL REVIEW

2.3.1 THEORY OF ADOPTION

People consider the implications of their actual behaviors before they decide to engage or not engage in a given behavior (Fishbein, 2001).

There are a series of stages that young smokers go through, each of which is influenced by different factors. The stages can progress in any direction and restart any number of times.

2.3.2 Intention stage

Generally speaking, people will have strong intentions to perform a given action if they evaluate it positively and if they believe that important others think they should perform it. The relative importance of the two factors may vary across behaviors and populations.

Stage of Intention focus mainly on information necessary for an individual to either initiate a health behavior or not. It considers the advantage or benefits as well as hazards of adopting such behavior.

Many factors have been found to influence the intention-behavior relationship. For instance, anticipating feeling of regret if one does not perform a behavior or perceiving a strong moral norm to act, have both been found to significantly increase the intention-behavior relationship (Cooke and Sheeran, 2004). Sheeran and Abraham (2003) showed how intention stability helps to moderate the intention-behavior relationship, and that intention stability mediated the effect of other moderators of the intention-behavior relationship (e.g., anticipated regret, certainty). Thus, the mechanism through which these moderators may have their effect on intention-behavior relationships is through changing the temporal stability of intentions. Hence, factors that might be expected to make individual intentions more stable over time would be expected to increase the impact that these intentions have on behavior and so increase the intention-behavior relationship.

A number of psychosocial theories have been developed to predict, explain, and change health behaviors. These theories can be divided into two main groups which are commonly referred to as social cognition models and stage models, respectively. The term social cognition models' refers to a group of similar theories each of which specifies a small number of cognitive and affective factors ('beliefs and attitudes') as the proximal determinants of behavior.

The five models that have been used most widely by health behavior researchers in recent years are: the health belief model, protection motivation theory, self-efficacy theory, the theory of reasoned action, and the theory of planned behavior. Stage models use similar concepts but organize them in a different way. According to this approach, behavior change involves movement through a sequence of discrete, qualitatively distinct, stages e.g. the dominant stage model of health behavior, the Trans-theoretical model. Recent research has sought to integrate such models (Fishbein et al, 2001). Current research has focused on intention stability as an important mediating variable explaining the impact of health cognitions on behavior. Other work is examining affective influences on health behaviors and how the formation of implementation intentions promotes the performance of behavior.

The Health Action Process Approach (Schwarzer, 1992/2001) argues for a distinction between (a) Pre-intentional motivation processes that lead to a behavioral intention and (b) Post-intentional volition processes that lead to actual health behavior.

One focus of current interest is the 'intention-behavior gap.' Researchers in the health behavior field are using Gollwitzer's (1993) concept of implementation intentions (the intention to do X in situation Y) and related ideas to explain why some people who have strong intentions to achieve a goal succeed whereas others fail, and to try to close this gap using simple interventions (Orbell et al, 1997). Related to this is the increasing interest in models of self-regulation (Abraham and Johnston 1998). Another trend, which has been apparent in social psychology in recent years and is now being imported into research on health behaviors, is to regard attitudes as being activated automatically (Fazio, 1990). Although this seems to pose a challenge to social cognition models, the two approaches are not necessarily incompatible, especially if the idea is extended to automatic activation of previously formed intentions.

Theory of Reasoned Action specifies the determinants of attitude and subjective norm. Attitude is held to reflect the person's salient behavioral beliefs concerning the possible personal consequences of the action. For example, a person who believes that performing a given behavior will lead to mostly positive personal consequences will hold a favorable attitude towards the behavior. Specifically, attitude is held to be a function of the sum of the person's salient behavioral beliefs concerning the outcome of the action each weighted by their evaluation of that outcome. An indirect, belief-based, measure of attitude can be created by multiplying each behavioral belief by its corresponding outcome evaluation and then summing over outcomes. In a similar way, subjective norm is a function of the person's beliefs that specific individuals or groups think he or she should, or should not, perform the behavior. A person who believes that most significant referents think he or she should perform the behavior will perceive social pressure to do so. Specifically, subjective norm is held to be a function of the person's salient normative beliefs with respect to each referent, each weighted by their motivation to comply with that referent. An indirect measure of subjective norm can be created by multiplying each normative belief by its corresponding motivation to comply and then summing over referents.

Perceived behavioral control is a function of control beliefs in just the same way as subjective norm is a function of normative beliefs (Ajzen, 2001). It is assumed to have a direct influence on intention. For desirable behaviors, greater perceived behavioral control should lead to stronger intentions. Perceived behavioral control may also have a direct predictive effect on behavior, through two different mechanisms. First, holding intention constant, an individual with higher perceived behavioral control is likely to try harder and to persevere for longer than an individual who has lower perceived control. Second, people may have accurate perceptions of the amount of actual control they have over the behavior.

Another study revealed that risk factors for initiation of cigarette smoking in adolescents include gender (Nang, 2004), smoking parents or siblings (GYTSCG 2002; Lawton, 2007) smoking peers (Conrad, 1992), advertisement (GYTSCG 2002). Other risk factors include the perception that smoking is not harmful (Simantov, 2000) or makes them look mature (GYTSCG, 2002) and having excess pocket money (Moran et al., 2004). Initiation of smoking is closely followed by

addiction (GYTSCG). Unfortunately, addicted smokers from the developing countries are unlikely to quit the habit as there are no smoking cessation programs (WHO, 2007). Currently, very little information is available on the magnitude of the problem of tobacco use among adolescents (WHO, 2007; GYTSCG, 2002).

2.3.3 Perceived risks and benefits of cigarette smoking

The perceived risks and benefits of smoking may play an important role in determining adolescents' male apprentice susceptibility to initiating smoking. Studies have examined the perceived risks and benefits of smoking among adolescents who demonstrated susceptibility or non susceptibility to smoking initiation.

Principal component analysis extracted the following perceived risk and benefit components:

- a) **Physical/Health risks** (lung cancer, heart disease, wrinkles, bad colds, bad cough, bad breath, trouble breathing);
- b) **Social risks** (getting into trouble, smelling like an ashtray);
- c) **Social benefit** (looking cool, feeling relaxed, becoming popular, and feeling grown-up).
- d) **Addiction risks** To discourage or prevent male artisan apprentice from initiating smoking, future intervention programs should focus on communicating not only the health risks but also the social and addiction risks as well as counteract the social benefits of smoking.

2.3.4 Initiation Stage

Owing to the presence of impressionable curious minds, adolescents are highly prone to a number of influences within and outside home, leading them to experiment with tobacco. The addictive nature of tobacco is potent enough to turn these experimental users to addicts. The commonest access to cigarette or smoking habit initiation are hereby outlined;

2.3.4a Parental, sibling and peers influence

Many studies have shown that parental smoking behaviour can facilitate the smoking habit in children, due to the behavioural example set and the availability of cigarettes in the home. Such easy access to cigarettes also causes early direct biochemical stimulation of the nicotinic receptors, which are acquired through inheritance (Simons-Morton B et al, 1999).

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Similarly, the presence of siblings and friends who smoke has been shown to be strongly associated with smoking experimentation and current smoking of the students. The influence of smokers in the same age bracket as the adolescent is particularly strong in the initial phases of tobacco use, since the first attempts to experiment with smoking frequently occur with siblings and friends, and these may provide expectations, reinforcement and subsequent suggestions in favor of the maintenance of the habit. Various studies on smoking during adolescence are unanimous in pointing out these associations (Mantler T, 2012).

There are a number of interpersonal relationships that greatly influence the likelihood that an adolescent will become a smoker. People who encounter smoking on a regular basis will be desensitized to cigarettes and will not likely see the health risks as readily. Parents are the greatest influence on their children's behavior. Children whose parents smoke are twice as likely to become smokers themselves (UICC, 2010). Perceived parental opinion is also a major contributing factor in youth smoking. If children believe their parents disapprove of smoking they will be less likely to become smokers. In addition to parental influence, sibling also serves as contributors to youth smoking. Overall, smoking families are much more likely to raise children who will become future smokers than families that instill a negative opinion of cigarettes in their children. Tobacco use by parents is likely to influence adolescents, as they perceive tobacco use as a positive and acceptable behaviour, and develop favourable personal beliefs and subjective norms towards tobacco use.

Friends and social circles have a huge influence on youth smoking. It is not necessarily peer pressures that encourage or discourage smoking, but a bonding mechanism among peers. Adolescents may smoke because they want to belong to a particular group, others may lack the skills to refuse a cigarette offered by a friend or someone they want to get to know. Tutors or trainers in a learning environment can also contribute to youth opinions of smoking. If a learner sees that his tutor smokes, that tutor makes cigarettes seem safe and acceptable. School policy must address smoking among both students and teachers. Learning environments with a non-smoking policy in place have been shown to have the lowest smoking prevalence among their subjects (UICC, 2010).

The common age of first experimenting with tobacco in India is 14-15 years. Curiosity and peer pressure were the main reasons for experimenting with tobacco during adolescence (Paudel D, 2003). The relationship with the peer group becomes stronger than family member and the young people are influenced more by the habits of their friends. Qidwai et al, 2007, reported that imitating the behavior of friends is a common practice among adolescents (Erikson theory). However, other studies have reported somewhat similar observations showing initiation of tobacco use at the age of 13-14 years in most of the countries (Conrad et al 1992).

The proportion of experimenting with tobacco is higher in boys than girls. Boys in Indian culture enjoy higher level of freedom regarding their individual behavior than girls both in the family and society (Jindal, 2006). The recent study from Turkey also showed that boys were more likely to use tobacco as compared to girls. The most popular form, among adolescents who had experimented tobacco products has been smokeless tobacco (Nevbahar, 2007). Many use smokeless tobacco to "treat" toothache, headache and stomach ache, this false impression promotes tobacco use among youths (WHO, 2002).

In addition smokeless tobacco products were convenient to hide from their parents and teachers and they are less expensive, easier to use and easily available. Tobacco use by family members is likely to influence adolescents; they are more likely to perceive tobacco use as a positive and acceptable behavior. This helps them develop favorable personal beliefs and subjective norms on tobacco use. Adolescent students who live in homes where the members regularly use tobacco were 1.46 times more likely to use tobacco than those not exposed to environmental tobacco smoke at home (Deepak, 2003). This has been reflected in other studies conducted around the world showing that the parents who used tobacco at home had greater impact on their children to experiment tobacco product as it grants them easy access to tobacco products in the household. Although majority of adolescents have good knowledge of the hazards of tobacco on health, the lack of complete knowledge, to some extent, had influenced adolescent experimenting with tobacco (De Vries et al, 2003, WHO, 2002).

Smoking and the use of other tobacco products kill 15,000 people in Nepal each year (Ministry of Health and Population, NEPAL, 2011). A recent study suggested that 3.41% of Nepalese adolescents between 10 and 14 years of age and 16.74% between 15 and 19 years of age smoke

(Ministry of Health and Population, NEPAL, 2012). Smoking prevalence varies among schools (2%–19%) and districts (7%–29%) (Kainulainen, 2011). Studies among school-age and college students report that most students begin smoking between 13–16 years of age and that initiation age ranges between 5–18 years (Paudel, 2003; Aryal, 2011). Therefore, preventing tobacco use and smoking initiation in adolescents is a public health concern that aims to reduce many chronic degenerative diseases (e.g., cardiovascular diseases, chronic respiratory diseases, and cancer) (United State Department of Health and Human Services, 1994). (Further, cardiovascular risk factor studies reported that the risk of acute myocardial infarction is 2.61-fold higher (95% CI: 1.99–3.44) in South Asian smokers (Nepal, Bangladesh and Sri Lanka) compared with individuals outside South Asia and population attributable risk is 43% (Joshi, et al 2007).

Adolescents may incorrectly believe that cigarette smoking is less risky than other behaviors, such as alcohol consumption and drug use, and they do not understand the short-term effect and addictive nature of smoking (Slovic, 2000). Many adolescent smokers understand the risks of smoking in general terms but greatly underestimate the personal risks, largely because they believe they can quit before becoming addicted (Weinstein, 1998). Adolescents underestimate the effects of smoking and overestimate their ability to quit before smoking affects their health (Weinstein, 1998). A systematic review revealed that youthful optimism and self-exempting beliefs about the likelihood of addiction, health risks, and consequences of smoking associate with smoking behaviour (Mantler, 2012). Thus, adolescents begin smoking and progress toward becoming established smokers, moving from the preparation phase to a stable level of addiction (Pierce et al, 1996).

In the preparation phase, non-smoking adolescents are cognitively vulnerable or susceptible to smoking (Lawton, 2007). Susceptibility to smoking is a good predictor of smoking initiation, as measured by acceptance of friends' smoking and the sentiment that they would like to smoke in the future (Pierce et al 1996). To predict the different stages of smoking behaviour among adolescents, Pierce et al. and other studies successfully measured susceptibility to smoking (Prokhorov, 2002). Several factors associate with susceptibility, including people's knowledge, attitudes, and perceptions about cigarette smoking (Unger et al, 2001). Different health behaviour theories have explained that psychosocial risks and protective factors, including

beliefs about the risks and perceived benefits of smoking, are related to behavioural phases of smoking (Flay, 1999). Adolescents who are susceptible to smoking begin to sketch ideas about perception of risks and benefits of smoking. For some, perceived risks and perceived benefits of smoking motivate them either to refuse cigarettes or to experiment (Unger et al, 2001).

2.3.4b Influence of Price on smoking habit (Affordability)

The economic issue involved in the habitual use of cigarettes has been evaluated in some market studies, showing that a marked increase in the prices of cigarettes significantly reduces smoking among young people, who are more sensitive to price variations than are adult smokers (Elders et al, 1994).

The consistently low prices of tobacco products, maintained in part by their availability on the streets, as well as the sale of single cigarettes at other places frequented by adolescents, facilitate the access of teenagers to cigarettes (WHO, 2007).

2.3.4c Influence of Advertising and Promotion

Advertising is an important influence on tobacco use initiation and maintenance, as documented in Preventing Tobacco Use among Young People (USDHHS, 1994). Cigarette advertising and promotion may stimulate cigarette consumption by

- (1) Encouraging children and adolescents to experiment with and initiate regular use of cigarettes,
- (2) Deterring current smokers from quitting,
- (3) Prompting former smokers to begin smoking again, and
- (4) Increasing smokers' daily cigarette consumption by serving as an external cue to smoke (CDC, 2009).

In addition, cigarette advertising appears to influence the perceptions of youths and adults about the pervasiveness of cigarette smoking and the images they hold of smokers (USDHHS, 1994).

Cigarette advertising also may contribute to the perception that smoking is a socially acceptable, safe behavior and may produce new perceptions about the functions of cigarette smoking in social situations. All of these perceptions have been shown to be risk factors for the initiation of cigarette smoking (USDHHS 1994).

Convenience store owners often are eager to promote tobacco products, which account for about 26.5 percent of their total sales (National Association of Convenience Stores, 1993). In such stores, tobacco companies frequently promote their products through special displays and point-of-sale promotions that provide monetary or product allowances for the store owners (Cummings et al. 1991; Wilkey et al. 1992; USDHHS, 1994). In a study of 23 supermarkets and convenience stores in San Diego, Wilkey and colleagues (1992) found that 52 percent of store owners reported receiving payments from tobacco companies for displaying advertisements in their stores and that 69 percent of the stores displayed tobacco advertisements on the outside walls, windows, or parking lot signs.

Also, Cigarette sale promoters encourage initiation and maintenance by distributing free products at youth social gatherings such as youth parties, night clubs, campus rallies, carnivals, motor parks and community youth centres (USDHHS, 1994).

2.3.5 Maintenance stage

Promoters of cigarette smoking often work on the belief system of smokers to influence the maintenance of the act (Moran et al, 2004).

People often fall prey to some myths about smoking. It is believed that these are largely influenced by tobacco advertising, society, and other smokers who proclaim these false beliefs. It's also one's addiction warping the truth and tricking by the subconscious mind. In a desperate attempt to keep you smoking, your addiction is eager to accept and even come up with such ideas, and it probably subscribes to at least a few of these, even if they aren't true.

2.3.5a Common myths about cigarette smoking. (Laser Wellness Centre, 2005).

These are merely myths, and only aid smokers to maintain the habit.

A: If I stop smoking, I'll gain weight.

B: Smoking relaxes me relieves tension.

C: I like the taste.

D: It makes me appear to be more sophisticated (more glamorous ... vtrile).

E: Smoking helps me to relieve boredom.

F: I'm one of those people who needs it ... a certain type.

G: Smoking gives me a lift.

H: Smoking aids digestion.

- I: It acts as a laxative.
- J: It helps me concentrate; solve problems.
- K: Smoking contributes to romance.
- L: Smoking is satisfying.
- M: Smoking is my only vice.
- N: If I didn't spend my money on cigarettes, I'd spend it on something else.
- O: It's nearly impossible to quit.
- P: Smoking is social; I like the companionship with other smokers.
- Q: Smoking adds something to the good times.
- R: Smoking gets me through times of crisis.
- S: Smoking is the only thing I do for myself.
- T: Smoking doesn't hurt anyone but me, so why not?

Also, smoking is perceived by college students to aid in social interaction, particularly with potential mates i.e. members of the opposite sex. Tobacco companies use this conception advertising. Companies produce ads depicting sexual images of men and women (Moran et al, 2004).

Smoking is viewed, by some youths, as a way to socialize and take learning work breaks (Moran et al, 2004). Smoking is also correlated with alcohol use among college students, this is significant because alcohol use is highly prevalent among college students (Moran et al, 2004). College students view smoking while drinking as a more acceptable practice relative to smoking while sober. Students who smoke while inebriated feel less judged by their peers (Moran et al, 2004). The most effective public health interventions that aim to reduce cigarette smoking among college students target both alcohol and nicotine use (Moran et al, 2004). The tobacco industry is particularly concerned with younger audiences because they constitute the future of smoking and tobacco profits. In an insider document from Philip Morris, the company states "It is important to know as much as possible about teenage smoking patterns and attitudes. Today's teenager is tomorrow's potential regular customer, and the overwhelming majority of smokers first begin to smoke while still in their teens, the smoking patterns of teenagers are particularly important to Philip Morris." (Mackay, et al, 2002)

Tobacco advertisements target youth and try to market cigarettes as a way to cope with changing environments. College is considered a crucial time in the lives of adolescents and is a time for change, experimentation, and discovery, which makes it an ideal time for tobacco companies to advertise and gain future consumers (Moran et al. 2004).

The industry refers to new smokers as "replacement smokers" because they are in effect, replacing smokers who have quit or died, whether from smoking or other causes, over the years (Sepe et al. 2002). Young people, including college students, constitute the majority of replacement smokers, and tobacco companies have created marketing campaigns targeting this age group. These advertisements show smoking as modern, hip, cool, fun, and adventurous (Sepe et al. 2002). The Joe Camel cartoon character is famously known as RJ Reynolds' tool to entice younger audiences towards cigarette smoking.

Smoking is a behavior that is maintained by physical addiction, psychological dependence, and habit. Nicotine, the addictive substance in cigarettes, has various mood-altering effects that contribute to and reinforce the highly controlled or compulsive pattern of drug use through smoking (Haire-Joshu et al. 1999). The pharmacological and biochemical effects of nicotine are powerful, with mood-lifting pleasurable effects along with tension-reducing effects. In addition, through conditioning, smoking becomes associated with daily events, situations, activities, and emotions. Smoking becomes a ritualized means of coping, woven into daily life, with powerful and immediately reinforcing physical effects (Fisher, et al. 1993). Genetic factors have also been implicated in the initiation and cessation outcomes of smokers (Pomerleau et al. 1993). In sum, powerful physical and psychological processes support compulsive nicotine use and make it difficult for smokers to quit (Haire-Joshu et al. 1999).

Smoking bears similarities to other high-risk behaviors. Tobacco dependence and threat of physical withdrawal, for example, help to maintain smoking behaviors much like other substance abuse and dependence disorders. Smoking behavior is often conditioned and linked to activities of daily life and habits and is sometimes used as a way to cope with psychological stress, as are eating habits and dietary patterns. Many of the same methods used to address smoking have been used to prompt behavioral change, both addressing physical and psychological aspects of the

high-risk behaviors while taking into account a patient's readiness to change (e.g. using motivational interviewing) (Perkins et al, 2001).

2.4 Conceptual framework

A conceptual framework presents a systematic way of understanding events and situation. It is a set of concepts, definitions, and proportions that explains or predict these events or situations by illustrating the relationships between variables (National Cancer Institute, 2003).

The purpose of the theory in research is to help the researcher to be able to explain the dynamics of the health behavior, including processes of changing them, and the influences of many forces that affect health behaviours, such as social and physical environments. Theory and frameworks also provide planners the most suitable information such as target audiences, methods for fostering change, and outcome evaluation before planning and implementing health promotion intervention.

2.4.1 Conceptual framework used for this work is the "Social learning theory model

Other than the Theory of Reasoned Action (TRA) which has been explained earlier, the social learning theory could also be used for this study. This is a theory that emphasizes the importance of observing and modeling of behaviours, attitudes, and emotional reaction of others. Social learning theory explains behaviour in terms of continuous reciprocal interaction between cognitive behavioural and environmental influences.

- **Reciprocal Determinism:** The dynamic interaction of the person, behaviour and the environment in which the behaviour is performed.
- **Environment:** Factors that physically external to the person, and include opportunities for social support.
- **Observational Learning:** Behavioural acquisition that occurs by watching the action and outcomes of others' behaviour within the environment.
- **Self-Efficacy:** The person's confidence in performing a particular behaviour.
- **Expectations:** Anticipatory outcomes of a behaviour, ... and
- **Expectancies:** The values that a person places on a given outcome

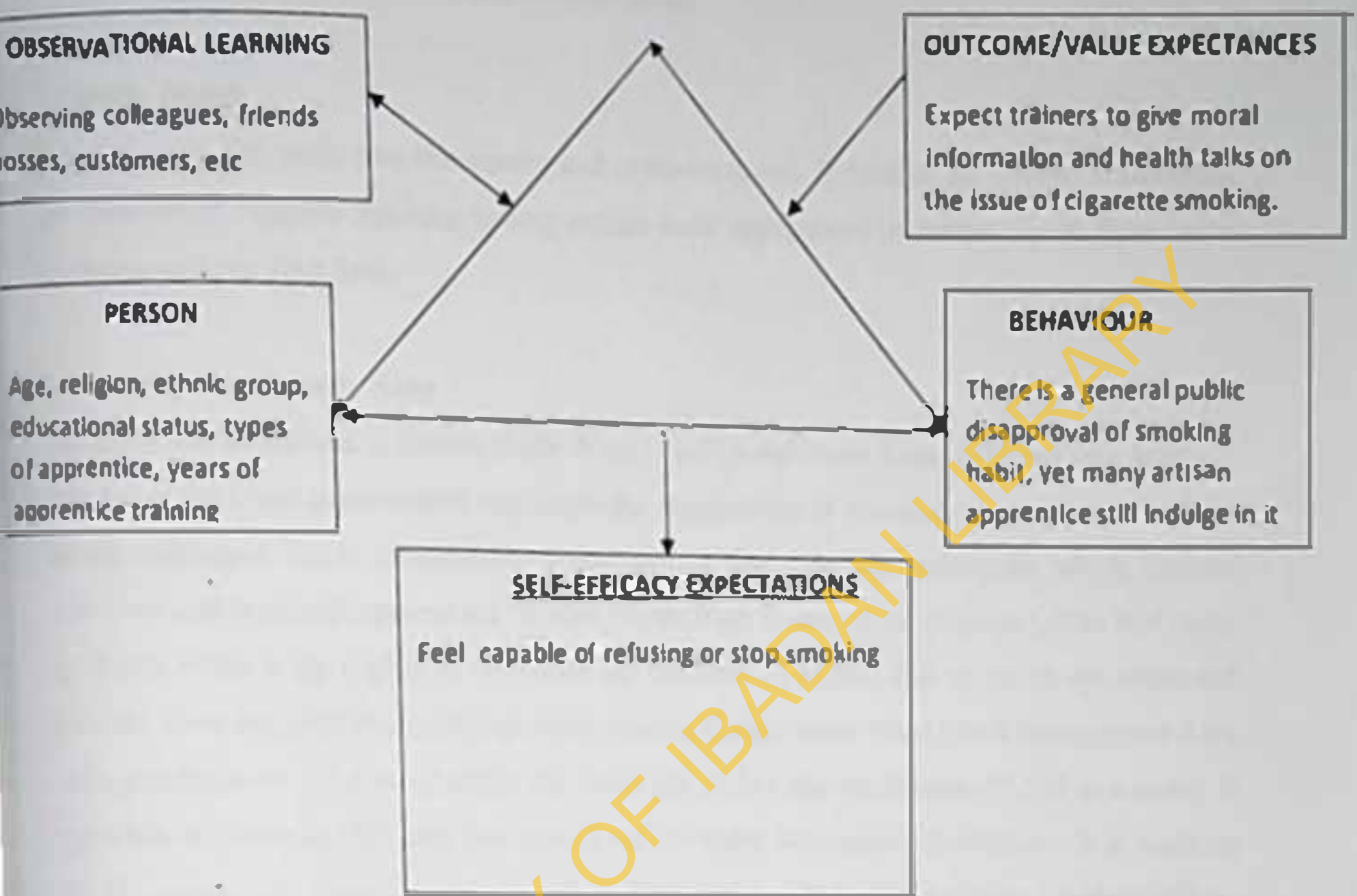


Fig. 2.1: Social Learning Theory Model

CHAPTER THREE

METHODOLOGY

3.1 Study Design

The design for the study was descriptive and cross-sectional. It focuses on 'factors influencing the adoption of cigarette smoking among artisan male apprentices in Ibadan North-West Local Government Area, Oyo State.

3.2. Description of Study Area

The study was carried out in Ibadan North-West Local Government Area (LGA) of Oyo State. It is one of the Local governments that meets the requirement of this study in that it is one of the heavily urbanized Local Government Areas among the 5 in the metropolis which harbors numerous craftwork and apprentices. Ibadan North-West is one of the 5 urban LGAs that make up Ibadan which is the capital of Oyo state and contains 11 LGAs; five of which are urban and six rural. From the 2006 National population census, Ibadan North-West Local Government Area has a population of 152,834, of which the males are 75,311 and the female, 77,523 in number. It came into existence in 1991 and was carved out of Ibadan Municipal Government. It is made up of 11 wards, of which some includes Bere/Ayere, Opoyejoja/Asukuna, Agboje/Idikan, Oriemeta/Ori-eju, and Idikan/Olorisa-oko. Others are Abebi, Ekotedo, Inalende, Afonta, Eleyele, and Olopomewa. It also contains Eleyele water works, army and police barracks, as well as a golf course.

3.3 Population of the study

Study population consist of all male apprentices in any artisan discipline and undergoing training in a workshop within Ibadan North West Local Government Area, Oyo State

3.4 Research variables

The variables were categorized into two namely, the Independent variables, and the Dependent variables.

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3.4.1 Independent variables.

The independent variables are the socio-demographic characteristics such as age, years of apprenticeship, level of education, and factors influencing adoption of cigarette smoking such as peer pressure, easy access to cigarette, affordability, etc.

3.4.2 Dependent variables.

The dependent variable is the adoption of the cigarette smoking habit. These are categorized into intention, initiation and maintenance of cigarette smoking habit.

3.5 Inclusion Criteria

- Respondents must be a male apprentice currently undergoing learning (between the age of 10-24)
- Respondents must be permanent residents in the selected community during the period of the study.

3.6 Exclusion Criteria

- apprentices who are equally attending school in the morning and reporting at workshop in the afternoon at the time of the study were excluded
- apprentices who cannot give a consent on his own were also excluded
- apprentices who are not residents of the study community were also excluded

3.7 Determination of sample size

The sample size is to be calculated using (Leslie Kish's 1965) sample size determination:

$$N = Z^2 pq / d^2$$

Where n= minimum sample size

Z= 1.96 (level of significance of 5%)

P= 33.9% (Obtained from a study on Cigarette smoking habits among adolescents in northeast Nigeria by Salawu et al, 2009)

$$Q = 1 - P = 0.661$$

d= 5% (degree of accuracy i.e precision) constant

Therefore,

$$n = (1.96^2) \times (0.339) \times (1-0.339) / 0.05^2$$

$$n = (1.96^2) \times (0.339) \times (0.661) / 0.05^2$$

$$n = 344$$

A non response rate of 10% of 34 was added to sample size calculated in order to address any possible case of attrition or incomplete response;

$$10\% \text{ of } 344 = \frac{344 \times 10}{100} = 34.4$$

$$n = 344 + 34.4$$

$$n = 378 \text{ (The sample size 'n' was rounded to 400)}$$

3.8 Sampling Technique

The study was conducted in order to investigate the factors influencing the adoption of cigarette smoking among male apprentices' artisan in Ibadan North-West Local Government Area, Oyo State.

In order to select a valid sample for the purpose of this study, a multi stage sampling technique will be employed. the stages include;

Stage one: use of purposive sampling to select Ibadan North-West Local Government Area; 1 out of the 11 local government areas in Ibadan.

Stage two: The 11 wards in the local government were listed and stratified into 3 categories based on the number of communities in each;

Category 1 : wards with only 1-2 communities, which are 3 in number.

Category 2 : wards with 3-4 communities which are 6 in number.

Category 3 : wards with 5 or more communities which is only 2 in number.

Stage three: communities are selected from each category, using proportionate sampling method;

$$\text{Category 1; } \frac{3 \times 6}{11} = 1.6 \approx 2 \text{ communities}$$

Hence 2 communities are selected from ward III, IV and VI, using simple random technique.

$$\text{Category 2; } \frac{6 \times 6}{11} = 3.3 \approx 3 \text{ communities}$$

Hence 3 communities are selected from I, II, V, VII, VIII and XI, using simple random technique.

Category 3: $2 \times 6 = 12$

11

≈ 1 community

Hence, 1 community is selected from ward IX and X, using simple random technique.

~~Stage four:~~ At this stage, workshops was selected within the communities using random sampling technique (balloting); where there are more than one eligible respondent (more than one apprentice) in a single workshop, simple random sampling was used to determine the respondents who participated. This procedure continue until the targeted total sample is achieved (see appendix 1)

Therefore a total of 6 communities are selected from the eleven wards.

~~Category 1 :~~ Using simple random technique, the two (2) selected communities from a total of five (5) communities in ward III, IV and VI are;

1. Agbeni
2. Idikan

~~Category 2 :~~ Using simple random technique, the three (3) selected communities from a total of twenty-one (21) communities in Ward I,II,V,VII,VIII, and XI are;

1. Olopo newa
2. Ayeje
3. Bere

~~Category 3:~~ Using simple random technique, one community selected from a total of fourteen (14) communities from ward IX and X are;

- i. Asoota

See appendix 1 for the ward selections

3.9 Methods of Data Collection

A mixed method was used to collect data consisting of In-depth interview (IDI) guide and a questionnaire.

3.9.1 Instrument for Data collection

(i) In-depth Interview

In-depth interview (IDI) constitutes 10 questions (Appendix IV for the IDI). The questions were framed and tailored to give further insights into factors influencing the adoption of cigarette smoking among artisan male apprentices in Ibadan North-West Local Government Area, Oyo State was used to facilitate the discussions.

(ii) Questionnaire

The collation of the quantitative data was done by means of semi-structured questionnaire (Appendix V). The questionnaire was developed after a review of the literature. The questionnaire used to elicit quantitative data from the respondents consists of four sections labeled A-D. Section A sought information on Age, level of education, Religion, Ethnic group, years of apprenticeship and other socio-demographic characteristics of the respondents. Section B contained questions that were used to determine the factors influencing intention to smoke cigarette. Section C sought information on initiation of cigarette smoking. Section D focused on eliciting information's on maintenance of cigarette smoking.

3.10 Validity of the instrument

In order to determine the validity of the instrument (the questionnaire and IDI guide) for data collection; the semi-structured questionnaire was used;

1. The drafts of the questionnaire were developed by consulting relevant literature. The draft of the instrument underwent an independent review from peers and expert researchers in the Faculty of Public Health, College of Medicine, and University of Ibadan. The experienced researchers consisted of specialists in Health Promotion, Education, Population and Reproductive Health.
2. Pre-test of the instrument was conducted between 7th-12th May 2014 using Ibadan North LGA based on similarities in characteristic with the study population.
3. Supervisor review was used in fine-tuning the instrument.

Forty questionnaires were administered in two selected communities (Yemetu and Gate market). The completed questionnaires were edited and responses code and entered into a computer. The data were analyzed using descriptive statistics.

Based on the pre-test results, the following recommendations and changes to the main study were made:

- i) The title of the study was modified to read "Factors influencing the adoption of cigarette smoking among artisan male apprentices in Ibadan North-West Local Government Area, Oyo State"
- ii) Owing to the bulky nature of the 8-page questionnaire, average administration time per questionnaire was recorded as 33 minutes

3.11 Reliability of the Instrument

In order to determine the reliability of the instruments (the questionnaire and the IDI guide) were reviewed for quality and consistency. The instruments were translated into Yoruba language which is the local language of the target population (Appendix VI and VII) by Yoruba language expert. Another Yoruba Language expert translated it back to English language. The two instruments were pre-tested to ascertain sustainability and appropriateness to field situation, determine whether the questions were clear and simple enough for participants comprehension and determine the trend in the response of participants and the amount of time it took to administer the questionnaire.

The IDI guide was pre-tested among male apprentices artisan in Ibadan North LGA Oyo State. Forty apprentices artisan were interviewed using the questionnaire (representing 10% of the actual sample size for this study) at Yemetu and Gate market in Ibadan North, LGA. The questionnaire was cleaned, coded and entered into the computer. The reliability of the questionnaire was determined using the Cronbach's Alpha model technique of SPSS (version 15)

The reliability correlation co-efficient of 0.92 was obtained, which indicated that the instrument was very reliable.

3.12 Training of Research Assistants

The research assistants were trained for two days 26th- 27th June, 2014. A training manual, plan and time-table were developed and approved by the project supervisors for the training. A time table was drawn for this period of 3 hours 9a.m.-12 noon daily in the AFU/EC conference room, Department of Health Promotion and Education, Faculty of Public Health University College Hospital. The training commenced with introduction of the trainer or the principal investigator and trainees. The trainees were given training materials, and went through training sessions which introduced them to the research study, objectives and methodology, role-plays on the data collection procedure (entry processes, seeking consent of potential cases for the study, signing of confidentiality assurance form and administration of questionnaire). The appropriate training methods and materials for facilitation were selected. These methods included a combination of largely active training methods such as participatory discussions, demonstration and return demonstrations, role-play and lectures to make the training participatory. Reciprocal questions for monitoring and assessing trainees' comprehension was asked from time to time.

Demonstrations was used to transfer skills for conducting IDI, transcriptions and report writing of findings, and especially for the correct interpretation of each item. The questionnaire and the IDI guide was revised with them during the training after which the RAs were equipped with copy of the instrument each to be taken home and read over for better understanding with aim of answering any burning question that may result the following day. The questionnaire was further reviewed to ensure the consistency in the numbering and the adequacy of the skip instructions.

Negotiations and logistic plans for data collection were discussed and stipends paid to RAs. The researcher facilitated the training with supervision by staff members of the Department of Health Promotion and Education. This team helped to assess and score trainees and based on the assessment scores, the final four research assistants were selected for the study. Each RA was assigned potential dates and units for data collection and were directly supervised by the researcher. Each RA received a copy of the field manual, copies of the questionnaire, one copy of the ethical approval from the State Ministry of Health and writing materials all contained in a clear water proof bag. All RAs participated in the data collection for the pre-test of the questionnaire in Ibadan North LGA, Oyo State

3.13 Data Collection Procedure

The study was carried out from July 7th - August 28th 2014 with the assistance of four trained Research Assistants. The researcher with the four trained research assistants administered the questionnaire to the respondents in Ibadan North-West local Government Area of Oyo State. The research assistance were trained in the following areas; the objectives of the study, the Sampling procedure, how to secure respondents informed consent; importance of collecting valid data; procedures for questionnaire administration and techniques for reviewing the items in the questionnaire. The manual of field operation was prepared to explain how entries would be made, and how variables would be coded. The research assistants with the researcher were involved in the collection of the data. Data collection took place in the month of July to August 2014 mostly in the morning on week days and in the afternoon on weekends. Short debriefing sessions were also held at the end of each day where the days work was reviewed and the next plan of action disseminated to the research assistants.

3.13.1 Qualitative Method

IDI was conducted separately with each of six male artisan apprentices in August, 2014 for two days. The sessions were conducted in a venue that was free of distraction. The venues were carefully selected with input of craft masters. The venues used were conducive for the participants to discuss freely. Each IDI session lasted for a minimum duration of 45 minutes. The discussion sessions were conducted by a moderator, one note taker, who documented discussants responses using a tape recorder and through verbatim writing of proceedings. The discussants were provided with full details of the study and an assurance of confidentiality of the disclosed information. Permission to use a tape recorder was sought and verbal consent was obtained from discussants prior to commencement of each session. Each discussion was highly interactive as discussants took turns to air their views in respect of the issues raised for discussion. Discussants were encouraged to feel free to express themselves. Each of the IDI was later transcribed and the information used to support the report generated by the note-takers.

3.13.2 Quantitative Method

The quantitative data was collected with the use of a semi-structured interviewer administered questionnaire that was administered by the principal investigator with the help of four trained

field assistants. A total of 400 questionnaires were administered and they were all retrieved. Face-to-face interview was conducted for the respondents in an ensured confidential location, this is to avoid distraction. Secluded places such as; inside the shops, under the tree and veranda was used to ensure comfort-ability of the respondents. The data collection process included the following steps; visit to each of the ward, coupled with identification visit to each of the ward to the heads of each of the selected artisan apprentices union to seek a permission to conduct interviews and administer questionnaire on the respondents. The semi-structured questionnaire was interviewer administered. The sections in the questionnaire include the socio-demographic characteristics of the respondents while other section contains information on variables of the study.

3.14 Data management and Analysis

The tape-recorded response from the IDI were transcribed verbatim and used to update the write up of the recorder. The IDI report was analyzed manually by the researcher. Content and context analysis using a thematic approach involving the grouping together of similar themes in each transcript was followed by identifying emerging trends and differences across transcript.

In respect to data analysis from the questionnaire the following were done.

1. All the administered questionnaires were checked one by one and edit them for purpose of completeness and accuracy.
2. Serial numbers was written on the questionnaires for easy identification and recall of any instrument with problems. Serial number was assigned to each questionnaire for identification and for correct data entry and analysis.
3. A coding scheme guide was developed after carefully reviewing the responses and appropriate scoring was done.
4. The data was manually coded and entered into the computer for analysis.

Respondents' knowledge on the risk of smoking were measured using knowledge scale. Seven knowledge questions were asked and points allotted to each of the knowledge questions (1 points). Responses that were very close to the most correct answer were allotted 1 points each. Any response that was incorrect carried no point. (i.e zero point). The total knowledge score and

the maximum obtainable score for each respondent was calculated. The Knowledge scores ≤ 5 , $>5-10$ and >10 were categorised as poor, fair and good respectively.

The data were analyzed using IBM/ Statistic Package for Social Science (SPSS) (Version 16) statistical package Microsoft excel version 2007 for windows were used in the data analysis. The descriptive statistical tools used were mean, standard deviation and the inferential statistics of Chi-square (χ^2) and logistic regression test was used for the analysis. Frequency and percentage tables were generated and Cross tabulations of some variables done using Chi-square (χ^2) test. The research hypotheses were tested to establish associations between the independent and dependent variables using the Chi-square test at 5% probability level for rejecting the null hypotheses. Cross tabulation of dependent and independent variable was also done to establish associations between the variable. The results were summarized and presented in chapter four of this dissertation.

3.15 Ethical Considerations

The proposal was submitted for approval and reviewed by the Oyo State Ethical Review Committee. Informed consent was obtained from the respondents by giving them an informed consent form to fill by explaining it to the best of their understanding. The informed consent form spell out the title of the study, purpose of the study, justifications for doing the study as well as the benefit that will be derived at the end of the study. The respondent that cannot read or write verbal information consent was sought from the respondents before the commencement of the filling of the questionnaire.

Participation was voluntary and there was no criticism of respondents who refused to participate. Participants' identities like name or address was not written on the questionnaire so as to keep the information given by each respondent as confidential as possible. However, participants' were given equal opportunities to withdraw their consent freely during the study. Confidentiality of each participant was maximally maintained during and after the collection of his information. Information gathered from the respondent was stored in a computer system for analysis by the researcher while the questionnaire filled by the respondent was kept for maximum of ten years after which it is believed that the purpose of the study would have been accomplished.

3.16 Limitation of the study

One of the limitations encountered during this study is that some respondents were not able to recall information accurately.

Another similar limitation encountered is that some of respondents were not willing to divulge vital information that is crucial to the relevance of this study

The researcher minimized these limitations by creating a very relaxed atmosphere which enhanced detailed recall of relevant experiences, not being discriminatory or judgmental, and assuring them of confidentiality to encourage their total cooperation.

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CHAPTER FOUR

RESULTS

The results of this study are presented in this chapter. The chapter consists of socio-demographic characteristics, intentions of the respondents to smoke, initiation of smoking and maintenance of smoking habit.

4.1: Socio-demographic characteristics

The age of the respondents ranged from 13 to 24 years with a mean of 19.6 ± 2.7 years. More than half (55.8%) were in the 17 to 20 year age group as shown in figure 4.1. Majority (62.8%) of the respondents has been an apprentice between 1-3 years while 15.2% has been an apprentice for up to 4-6 years, the mean years of apprenticeship is 2.5 ± 1.2 (See table 4.1a and 4.1b).

The distribution of the respondents based on their type of apprenticeship shows that; few (16.3%) of the respondents were tailoring apprenticeship, followed by 11.3% who were trading apprenticeship and 8.7% who were mechanic and bricklaying apprenticeships. Majority (63.3%) of the respondents were Muslims, almost all (99.5%) of the respondents were Nigerians while majority (75.3%) of the respondents were Yorubas. The distribution of the respondents' level of education shows that majority (64.2%) had secondary, 28.0% had primary education while just few (3.5%) had no formal education.

Table 4.1a Socio-demographic characteristics of the respondents.

Age		
13-16 years		
17-20 years	106	26.5%
21-24 years	223	55.8%
Mean for age	71	17.7%
	19.6±2.7	
Years of apprenticeship		
<1 year		
1-3 years	88	22.0%
4-6 years	125	62.8%
Mean for years of apprenticeship	61	15.2%
	2.5±1.2	

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Table 4.1 b: Socio-demographic characteristics of the respondents (N=100)

Types of apprenticeship	No %
Tailoring	65 (16.3)
Trading	45 (11.3)
Plumber	17 (4.3)
Mechanic	35 (8.7)
Painter	12 (3.0)
Bricklayers	35 (8.7)
Vulcanizer	32 (8.0)
Barber	13 (3.3)
Furniture/Carpentry	30 (7.5)
Grinder	11 (2.7)
Electrician	10 (2.5)
Radionic/Radio repairer	9 (2.3)
Patent Medicine Vendor/ Chemist	12 (3.0)
Cobbler	13 (3.3)
Engineer/ Phone Engineer	8 (2.0)
Tinker	15 (3.7)
Baker	15 (3.7)
Photographer	15 (3.7)
Aluminum furniture work	8 (2.0)

Table 4.1c Socio-demographic characteristic

Socio-demographic characteristics	(N=100)
	No (%)
Religion	
Christianity	147 (36.7)
Islam	253 (63.3)
Nationality	
Nigerian	398 (99.5)
Non-Nigerian	2 (0.5)
Tribe	
Yoruba	301 (75.3)
Hausa	24 (6.0)
Igbo	75 (18.7)
Level of education	
No formal education	14 (3.5)
Primary	112 (28.0)
Secondary	257 (64.2)
Post Secondary	17 (4.3)

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4.2: Intention to smoke cigarette among the respondents

This section discussed the factors influencing respondents' intention to smoke. Forty six percents of the respondents assumes apprentices build intentions to smoke because they believe it will boost their personality, almost half (49.7%) of the respondents stated that cigarette smoking is made attractive and glamorous, hence could build intention, while few (21.3%) of the respondents reported that apprentices plans to smoke cigarette just to copy their boss. Majority (60.8%) of the respondents said apprentices could plan to smoke because of parental influence while 40.5% of the respondents asserted that trainer's influence may lure them. Majority (60.8%) of the respondents reported peer pressure is a key factor that builds intention to smoke among apprentices, few (29.0%) of the respondents reported that apprentices plans to smoke just out of curiosity while (31.0%) of the respondents mentioned other family members or siblings who smokes may influence decision to smoke among apprentices too.

Forty-three percents reported they were familiar with cigarette advertisement on the media and they gave the following media as their source, print/posters/magazine (43.6%), bar/club house (37.2%) while just few (2.9%) of the respondents gave television as their media source. Almost all (95.9%) of the respondents reported that the advert seen/heard give them image of confidence about smokers while 82.0% of the respondents stated that the advert seen/heard give them image of luxury about smokers. Majority (73.8%) of the respondents reported the advert seen/heard give them image of affluence or high social status about smokers while 62.8% of the respondents opined that the advert seen/heard give them image of success about smokers. Majority (67.6%) of the respondents reported the advert suggested that they should do something.

Almost all (92.4%) of the respondents reported that the advert emphasized the harm of smoking and they stated the health warnings heard as follows; smoker will die young (23.1%), smoking leads to asthma (20.6%) and smoking leads to dark chest, cough, sore throat and burnt teeth. Almost half (47.0%) of the respondents gave their opinion that cigarette smoking is not a good habit, majority (71.5%) stated that the perceived impression of the society on cigarette smoking is bad while 67.3% of the respondents mentioned they have never seen any health warning messages on cigarette packages. For the few (32.8%) respondents who have seen health warning

messages on cigarette packages only few (24.4%) of the respondents stated that they don't believe the health warning messages seen on cigarette packages.

Few (14.3%) of the respondents mentioned that their trainer was a smoker and fifty-six percents of them claimed they have been sent on errand to buy cigarette before. Almost half (48.5%) said they have a "No smoking" restriction at their work place, 41.8% of the respondents declared that restriction has reduced smoking among apprentices. Few (34.8%) of the respondents stated that they have been told at work about the health risk of cigarette smoking and they stated what they were told as follows; smokers are liable to die young (5.7%), smoking is dangerous to the health (9.2%) and it can shorten one's life or cause death (7.1%). Majority (76.8%) don't think they have more to gain or lose by smoking.

4.3 Knowledge of artisan male apprentice on risk of smoking cigarette

This segment significantly showed the knowledge of artisan male apprentices on risk of smoking. Knowledge scale was used to assess the level of knowledge of the respondents on the risk of smoking. Respondent who scored ≤ 5 , were rated as having poor knowledge. Those who $>5-10$ were rated as fair in knowledge and respondents with >10 were rated as having good knowledge. Majority of the artisan apprentice (48.0%) had good knowledge on the risk of smoking in comparison to those who were rated fair (33.2) and poor (18.8) in knowledge of risk of smoking. Conclusively, the mean knowledge score of respondents was 12.8 ± 2.9 and 76.3% of them had good knowledge (Table 4.2. and Figure 4.3).

It is fundamental to state that majority (50.25%) of the respondents attested to the fact that smoking cigarette can lead to health problems. 75.0% said that smoking cigarettes can lead to chest infection. Majority (72.5%) reported that smoking cigarette cannot lead to chronic obstructive airway disease. Seventy-five percent attested that cigarette smoking can lead to lung cancer while almost all (75.8%) of the respondents said that cigarette smoking cannot lead to hypertension. Some respondents (85.0%) reported that cigarette smoking cannot result into peptic ulcer, and slightly above half (51.5%) said that smokers are liable to die young. Majority, (81.3%) respondents claimed that cigarette smoking can cause black lips, 72.6% attested to the fact that smoking gives smokers bad body odour. Also, (51.5%) believes cigarette smoking causes the eye-balls to become red. (Table 4.2).

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1.1 Quotes from IDI discussion on the dangers associated with smoking

The following are quotes from IDI discussion;

"I was told that smoking can lead to asthma and black lips but my brother knew that I am smoking "Benson" but he cannot tell our parents because he too smokes"

"smoking of cigarette can lead to other criminal activities such as stealing and truancy, smoking Indian hemp and alcohol consumption. I started smoking when I was in Lagos before I was brought to Ibadan to learn automobile mechanic work. Smoking of cigarette can also lead to heart problem, cancer, red eyes and body odour."

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Table 4.2 Knowledge of health problems associated with cigarette smoking. N=400

Variables	No	%
Can health problems result from smoking cigarette?		
Yes		
No	201	(50.3)
Can smoking cigarettes leads to chest infection?	199	(49.7)
Yes		
No	300	(75.0)
Smoking cigarette cannot leads to chronic obstructive airway disease ?	100	(25.0)
Yes		
No	190	(47.5)
Can smoking cigarette leads to lung cancer?	210	(72.5)
Yes		
No	301	(75.3)
Smoking cigarette cannot leads to hypertension?	99	(24.7)
Yes		
No	303	(75.8)
Smoking cigarette can leads to peptic ulcer disease or digestive problem?	97	(24.2)
Yes		
No	340	(85.0)
Smokers are liable to die young?	60	(15.0)
Yes		
No	206	(51.5)
Smoking cigarette can leads to black Lips ?	184	(48.5)
Yes		
No	325	(81.3)
Smoking cigarette can leads to Body odour?	75	(18.7)
Yes		
No	290	(72.6)
Smoking cigarettes cannot leads to red eyes	110	(27.4)
Yes		
No	206	(51.5)
	194	(48.5)

Table 4.3a: Factors influencing respondents' intention to smoke

Factors influencing intension to smoke		N=400
		No. (%)
It boosts my personality		
Yes		
No		184 (46.0)
It is attractive		
Yes		216 (54.0)
No		199 (49.7)
To copy my boss		
Yes		201 (50.3)
No		85 (21.3)
Parental influence		
Yes		315 (78.8)
No		243 (60.8)
Trainers' influence		
Yes		157 (39.3)
No		162 (40.5)
Peer pressure		
Yes		238 (59.5)
No		243 (60.8)
Curiosity		
Yes		157 (39.3)
No		116 (29.0)
		284 (71.0)

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Table 4.3b Factors influencing respondents intention to smoke**(N=400)**

Variables	No (%)
Family/ Siblings smoke	
Yes	
No	124 (31.0)
Are you familiar with any cigarette advertisement on the media?	276 (69.0)
Yes	
No	172 (43.0)
If yes, which of the media? (n=172)	227 (57.0)
Television	
Radio	5 (2.9)
Print/Posters/Magazine	8 (4.7)
Billboard	75 (43.6)
Cinema	5 (2.9)
Bar/Club house	15 (8.7)
Did the advert seen/heard give you image of confidence about smokers?	64 (37.2)
Yes	
No	165 (95.9)
Did the advert seen/heard give you image of luxury about smokers?	7 (4.1)
Yes	
No	14 (82.0)
Did the advert seen/heard give you image of affluence about smokers?	31 (18.0)
Yes	
No	127 (73.8)
	45 (26.2)

Table 4.3c Factors influencing respondents intention to smoke

	N₀ (%)
Did the advert seen/heard give you image of success about smokers?	
Yes	
No	108 (62.8)
Did the advert suggest that you should do something?	64 (37.2)
Yes	
No	188 (67.6)
If yes, what did it ask you to do?	80 (32.4)
Yes	
No	54 (28.7)
I don't know	85 (50.6)
Did the advert emphasized the harm of smoking	29 (17.3)
No	158 (92.4)
State the harms the advert emphasized (multiple response)	13 (7.6)
Dangerous to one's health	28 (16.6)
Dark chest, cough, sore throat and burnt teeth	29 (17.3)
Smoker would die young	37 (23.1)
Kidney damage	18 (10.7)
Causes cancer	19 (11.3)
Heart and brain damage	4 (2.5)
Leads to asthma	33 (20.6)
In your opinion, do you think cigarette smoking is a good habit (N=400)	
Yes	32 (8.0)
No	368 (92.0)

Table 4.3d Factors influencing the intention to smoke (N=400)

	No (%)
What impression do you perceive your society have on cigarette smoking habit	
Good	6 (1.5)
Bad	286 (71.5)
Indifferent	108 (27.0)
Have you ever seen health warning messages on cigarette packages	
Yes	131 (32.8)
No	269 (67.3)
If you have seen the warnings, do you believe the health warnings (N=131) that you see on the cigarette	
Yes	32 (24.4)
No	99 (75.6)
Was your trainer a smoker	
Yes	57 (14.3)
No	224 (56.0)
I don't know	119 (29.8)
If yes, has he ever sent you an errand to buy cigarette (N=57)	
Yes	32 (56.1)
No	25 (43.9)
Is there a "No smoking" restriction at your work place (N=400)	
Yes	194 (48.5)
No	206 (51.5)
If there is no smoking restriction at your place of work, in your opinion, has the restriction reduce smoking among apprentices (N=194)	
Yes	143 (73.7)
No	51 (26.3)

Table 4.3c Factors influencing adoption of cigarette smoking N=400

Have you ever been told at work about the health risk of cigarette smoking	No (%)
Yes	
No	139 (34.8)
State what you were told (n=139)	261 (65.3)
Dangerous to my health	
It can cause cancer problem	13 (9.2)
It can cause kidney problem	12 (8.5)
It can cause tuberculosis	7 (5.0)
It can cause heart problem	7 (5.0)
It can affect the brain	11 (7.8)
It can shorten one's life or cause death	9 (6.4)
It can lead to loss or cause black teeth at old age	10 (7.1)
Smokers are liable to die young	11 (7.8)
It can cause dark lips and black fingers	8 (5.7)
It can cause body smell	9 (6.4)
It can cause cough and chest pain	14 (9.9)
It can cause asthma	9 (6.4)
It can cause red eyes, sore throat and mouth odour	9 (6.4)
Do you think if you smoke you have more to gain than to lose? N=400	
Yes	71 (17.8)
No	329 (82.3)

5: Initiation of cigarette smoking

This session discussed the respondents' initiation of smoking. Majority (64.4%) of the respondents stated they are present smoker while 35.6% of the respondents mentioned they were past smokers. Sixty-one percents of the respondents reported they smoked their first cigarette before becoming an apprentice while 39.1% of the respondents mentioned they smoked their first cigarette after becoming an apprentice. Few (39.1%) of the respondents reported their first cigarette was shared puff and majority (61.9%) of the respondents said their peer was their first point of initiation. Majority (64.4%) mentioned they smoked in the last few days, majority (65.3%) of the respondents describe their access to cigarette as easy while 68.8% of the respondents said they usually source for cigarette from sellers and majority (60.9%) of the respondent stated that the selling point is road side shops and from friends.

Almost all (91.6%) of the respondents reported that cigarette sellers have never refused to sell cigarette to them, only few (25.2%) of the respondents stated that their father knew about their smoking habit and 41.2% of the respondents reported their father disapprove of it. Few (37.6%) of the respondents reported that their mother/guardian know about their smoking habit and majority (61.8%) of the respondents opined they disapprove of it. Half of the respondents claimed that their trainer knew that they smoked and almost all (94.1%) stated he disapprove of it. Few (3.5%) of the respondents reported to have ever attended a cigarette promoter-sponsored event or occasion and they all mentioned that cigarette was distributed at free price or sold at subsidized rate, majority (85.7%) of the respondents stated they collect or buy cigarette at the occasion.

Only few (4.5%) of the respondents mentioned they spend more than ₦250 on cigarette each day, 29.2% of the respondents stated they spend between ₦90 and ₦120 while few (11.9%) of the respondents spend less than ₦30. Few (12.4%) said they get the money to buy the cigarette from your boss, more than half (54.5%) said they got the money to buy the cigarette from their parents, majority (70.4%) said they got the money to buy the cigarette from their colleagues at work (see table 4.4).

Table 4.4a: Respondents' initiation of cigarette smoking

N=202

Initiation of smoking

What is your smoking status?

No (%)

Past smoker

Present smoker

72 (35.6)

When did you smoke your first cigarette?

130 (64.4)

After becoming an apprentice

Before becoming an apprentice

79 (39.1)

How was your first cigarette?

123 (60.9)

A whole cigarette

A left over stump

50 (24.8)

A shared puff

73 (36.1)

79 (39.1)

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Table 4.4b Respondents' initiation of cigarette smoking
Who would you conclude as your point(s) of initiation?

N=202

Peer	
Boss	125 (61.9)
Parents	31 (15.3)
Advert	17 (8.4)
Promoters	24 (11.9)
Have you smoked in the last few days?	5 (2.5)
Yes	
No	130 (64.4)
If yes, how would you describe your access to cigarette?	72 (35.5)
Difficult	
A bit difficult	25 (12.4)
Easy	60 (29.7)
	117 (57.9)

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4.4b Respondent initiation to smoke cigarette

N=202

Where do you usually source for cigarette?	No (%)
Promoters	
Sellers	24 (11.9)
Siblings	139 (68.8)
Boss/trainer	4 (2.0)
Friends/colleagues	9 (4.5)
If your source is from the seller, at what selling point?	26 (12.9)
Road side shops	
Hawkers	123 (60.9)
Friends	34 (16.8)
Has any seller refused to sell you cigarette?	45 (22.3)
Yes	
No	17 (8.4)
Did your father know that you smoked?	185 (91.6)
Yes	
No	51 (25.2)
I don't know	107 (53.0)
If yes, how did he feel about your smoking habit?	44 (21.8)
He approves it	
He was indifferent	3 (5.9)
He disapproves it	27 (52.9)
Did your mother/guardian know that you smoked?	21 (41.2)
Yes	
No	76 (37.6)
I don't know	73 (36.1)
	53 (26.2)

4.4c Respondents initiation to smoke cigarette

	N=202	No (%)
If yes, how did she feel about your smoking habit?		
She approves it		
She was indifferent		3 (3.9)
She disapproves it		26 (34.2)
Did your trainer know you smokes?		47 (61.8)
Yes		
No		101 (50.0)
I don't know		74 (36.6)
If yes, did he approved it?		27 (13.4)
Yes		
No		6 (5.9)
Have you ever attended a cigarette promoter-sponsored event or occasion?		95 (94.1)
Yes		
No		7 (3.5)
If yes, was cigarette shared for free or sold at subsidized rate?		195 (96.5)
Yes		
If yes, did you collect or buy any cigarette at the said occasion?		7 (100.0)
Yes		
No		6 (85.7)
How much do you spend on cigarette each day?		1 (14.3)
1-30		
31-60		24 (11.9)
61-90		37 (18.3)
91-120		36 (17.8)
121-150		59 (29.2)
151-250		19 (9.4)
250 and above		18 (8.9)
		9 (4.5)

Table 4.40 Respondents initiation to smoke cigarette N=202

	No (%)
Do you usually get money to buy cigarette from your boss?	
Yes	25 (12.4)
No	177 (87.6)
Do you often get money to buy cigarette from your parents?	
Yes	110 (54.5)
No	92 (45.5)
Do you usually get money to buy cigarette from your peers?	
Yes	142 (70.4)
No	60 (29.6)
Do you often get money to buy cigarette from your colleagues at work	
Yes	106 (52.5)
No	96 (47.5)

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4.6: Maintenance of cigarette smoking

This section discussed the respondents' maintenance of smoking habit. Majority (61.4%) of the respondents reported they smoke once every day, majority (71.3%) of the respondents stated that they usually smoke 1-5 cigarette sticks daily while 73.3% of the respondents said they think smokers would be addicted to cigarette smoking habit. Majority (63.9%) of the respondents believed it is impossible to quit smoking, 62.9% believed that smoking will hurt the smoker and the people around him while 88.1% of the respondents reported they think smoking helps people to relax. Almost all (93.6%) of the respondents stated that they think smoking can help people when they are bored, majority (85.1%) of the respondents mentioned they think smoking helps one concentrate or work better while 94.1% of the respondents opined they think smoking helps them in terms of crisis.

Majority (95.5%) of the respondents believes smoking cools the nerves, all the respondents were of the opinion that smoking is social and that they enjoy the company of other smokers while 66.8% of the respondents stated they are brand specific. Few (39.1%) of the respondents smoked their particular brand because their friends smoke the same brand, 32.7% of the respondents smoked their specific brand because their parents smoke the same brand, while few (19.3%) of the respondents smoked the brand of cigarette they do because they like its peculiar taste. Few (6.6%) of the respondents smoked the brand of cigarette they do because their boss smoke the same brand while more than half (58.4%) of the respondents smoked the brand of cigarette they do because that is the only available brand around them.

Few (13.9%) of the respondents reported they know some cultural, social, sporting and other event that has been sponsored by tobacco promoters, 10.2% of the respondents stated they attended a cigarette promoter-sponsored event(s) where access to free or subsidized cigarette was provided, while only few (5.9%) of the respondents reported they take advantage of the free or subsidized cigarette that was provided (see tables 4.5a-c).

Table 4.5a: Respondents' Maintenance of cigarette smoking

Maintenance of smoking habit	N=202	Freq (%)
How often do you smoke?		
Once in a while		
One stick per day		29 (14.4)
Several times a day		124 (61.4)
How many cigarette stick(s) do you usually smoke daily?		49 (24.2)
1-5 sticks		
6-10 sticks		144 (71.3)
11-15 sticks		23 (11.4)
16-20 sticks		29 (14.4)
Do you think smokers will be addicted to cigarette smoking habit ?		6 (3.0)
Yes		
No		148 (73.3)
I don't know		19 (9.4)
Do you think it is impossible to quit smoking?		35 (17.3)
Yes		
No		129 (63.9)
I don't know		71 (35.1)
Do you belief that smoking does not hurt anyone else but the smoker alone ?		2 (1.0)
Yes		
No		40 (19.8)
I don't know		162(80.2)
Do you think smoking helps you to relax?		35 (17.3)
Yes		
No		174 (86.1)
		28 (13.9)

4.5b Respondents maintenance of smoking

	N=202	No (%)
Do you think smoking can help people when they are bored?		
Yes		
No		189 (93.6)
Do you think smoking helps you concentrate or work better?		13 (6.4)
Yes		
No		172 (85.1)
Do you think smoking helps you in terms of crisis?		30 (14.9)
Yes		
No		190 (94.1)
Do you think smoking cools the nerves?		12 (5.9)
Yes		
No		193 (95.5)
Are you of the opinion that smoking is social so that you enjoy the companying of other smokers?		9 (4.5)
Yes		202 (100.0)
No		0 (0.0)
Do you usually smoke the same brand?		
Yes		135 (66.8)
No		67 (33.2)
Do you smoke this brand because your friends smoke the same brand?		
Yes		79 (39.1)
No		123 (60.9)
Do you smoke this brand because your parents smoke the same brand?		
Yes		66 (32.7)
No		136 (67.3)
Do you smoke this brand because you like the taste		
Yes		39 (19.3)
No		163 (80.7)

Table 4.5c Respondent maintenance of cigarette smoking N=202

	No (%)
Do you smoke this brand because your boss smoke the same brand?	
Yes	
No	13 (6.6)
Do you smoke this brand because that is the only available brand?	185 (93.4)
Yes	
No	118 (58.4)
Did you know any cultural, social, sporting or any other event sponsored by tobacco promoters?	84 (41.6)
Yes	28 (13.9)
No	174 (86.1)
Did you ever attend such cigarette promoter- sponsored event(s) where access to free or subsidized cigarette was provided?	
Yes	22 (10.9)
No	180 (89.1)
Did you take advantage of such opportunity as stated above?	
Yes	12 (5.9)
No	190 (94.1)

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4.7 Hypothesis Testing

The study tested three hypotheses. All the hypotheses were proposed as null hypotheses at 95% confidence level and 5% level of statistical significance otherwise referred to as limit of error with p value of 0.05. The appropriate test statistics used to determine the existence or absence of relationship between the variable of interest for the study was Chi-square (χ^2) and logistic regression model. The research hypotheses were tested by comparison between factors influencing the adoption of cigarette smoking among the respondents through their socio-demographic variables against their cigarette smoking habit.

Hypothesis One

The first null hypothesis which stated that there is no significant association between respondents' level of education and cigarette smoking habit.

Table 4.7 shows the cross tabulation of respondents' level of education with respondents' cigarette smoking habit using Chi-Square statistic. There was a significant association between respondents' level of education and their cigarette smoking habit at 95 per cent confidence interval ($p < 0.05$). Respondents' level of education has a role to play in their cigarette smoking habit. The null hypothesis was therefore rejected.

Hypothesis Two

The second null hypothesis which stated that there is no significant association between respondents' easy access to cigarette and their cigarette smoking habit.

Table 4.7 shows the cross tabulation of respondents' easy access to cigarette with respondents' cigarette smoking habit using Chi-Square statistic. There was a significant association between respondent's easy access to cigarette and cigarette smoking habit at 95 per cent confidence interval ($p < 0.05$). Respondents' easy access to cigarette has a role to play in their cigarette smoking habit. The null hypothesis was therefore rejected.

Hypothesis three

The third null hypothesis which stated that there is no significant association between effect of peer pressure on respondents and their cigarette smoking habit.

Table 4.9 shows the cross tabulation of effect of peer pressure on respondents with respondents' smoking habit using Chi-Square statistic. There was significant association between effect of peer pressure on respondents and the prevalence of smoking cigarette at 95 per cent confidence interval ($p < 0.05$). Effect of peer pressure on respondents has a role to play in their cigarette smoking habit. The null hypothesis was therefore rejected.

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Table 4.6: Level of education and cigarette smoking habit

Level of education	Have you smoked in the last one month	
	Yes Freq. (%)	No Freq. (%)
No formal education	14 (6.9)	0 (0.0)
Primary	37 (18.3)	14 (6.9)
Secondary	79 (39.1)	58 (28.7)
Total	130 (64.4)	72 (35.6)

$\chi^2 = 11.921$

$df = 2$

$p = 0.003$

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Table 4.7: Easy access and cigarette smoking habit

Easy access	Frequency of smoking		
	Once in a while Freq. (%)	Once every day Freq. (%)	Several times a day Freq. (%)
Very difficult	6 (3.0)	11 (5.4)	3 (1.5)
Slightly difficult	14 (6.9)	12 (5.9)	19 (9.4)
Easy	9 (4.5)	101 (50.0)	27 (13.4)
Total	29 (14.4)	124 (61.4)	49 (24.3)

$\chi^2 = 49.493$

df = 4

p = 0.001

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Table 4.8: Peer pressure and cigarette smoking habit

How often do you smoke?	Peer pressure on smoking habit of the respondents	
	Yes Freq. (%)	No Freq. (%)
Once in a while	11 (5.4)	18 (8.9)
Once every day	43 (21.3)	81 (40.1)
Several times a day	12 (5.9)	37 (18.3)
Total	66 (32.7)	136 (67.3)

$\chi^2 = 2.083$

$df = 2$

$p = 0.353$

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4.8 Binary logistic regression

Categorically, after effecting adjustment, it was revealed that respondents with 4-6 years of apprenticeship were 2.4 times more likely to smoke cigarette compared to those with lesser years (Table 4.10).

Respondents who reported easier access to cigarette were more likely to initiate smoking compared to those with limited access 3.5 more likely to smoke cigarette compared to those with limited access (Table 4.11).

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Table 4.9: Binary logistic regression of years of apprenticeship

Variable	Odds ratio (95% CI)	p-value
years of apprenticeship		
1-6 (reference)	2.4	p = 0.002
>4 years	(2.1-3.5)	

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Table 4.10: Binary logistic regression on access to cigarette and initiation of cigarette smoking

Variable	Odds ratio (95% CI)	P-value
Access to cigarette		
Easier access	3.5	p = 0.001
Limited access	(3.2-4.9)	

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DISCUSSION, CONCLUSION AND RECOMMENDATIONS

4.7 Discussion of findings

4.7.1 Factors influencing the intention to smoke cigarette among artisans

The IDI findings of this study also supported the existing reports that peer pressure, lack of parental guidance, and poor knowledge of health risk of cigarette smoking are the most common cause of smoking intentions among the respondents.

In agreement with the aforementioned facts, motivations identified by smokers for picking up a cigarette to smoke included both positive and negative emotions. These motivations which could be described as instantaneous are different from reasons for initiating smoking such as peer pressure, social acceptance and tobacco adverts which have been documented by other authors (Awotodu et al 2006, Mantler, 2012). The greater percentage (63.4%) could not identify any such motivation. This is in tandem with general behavioural patterns among many adolescents who are merely excited about life and growing up having yet to chart a definite course in life. The research ascertained that the respondents' knowledge about smoking habit could be said to be poor. Below half of the respondents reported that they smoke cigarette. The outcome of the study was not in support of the study conducted by Aigbiremolen et al (2013) where the respondents had good knowledge of health risks of cigarette smoking. Another study shows that lack of awareness or, more importantly, inadequate knowledge is a major contributing factor to smoking among all age groups (Naing et al, 2004).

5.1.2 Factors that enhance initiation of cigarette smoking among artisan

The study revealed various factors that enhance initiation of cigarette smoking among artisan to include peer pressure, family influence. The outcome of this study was in agreement with the finding of Goldade et al, 2012 where peer pressure, and desire to belong or be accepted in a group were identified. Other factors that have been documented to be important in influencing young people to initiate and continue smoking include parental or family influence, media influence, emotional challenges, and being around shops or joints where cigarette smoking is rampant (easy access) (Goldade et al, 2012).

The high prevalence of cigarette smoking 50.5% was observed in the current study supports the view expressed in the Abikoye et al study (Abikoye, Kashimawo and Eze, (2013). The study shows that the respondents who smoked cigarette reported a prevalence rate (current smokers) of 33.9% in Northeast Nigeria, and Obot (1990) reported a prevalence rate of 22.6% in a sample of 1,271 Nigerians, other researchers have found relatively lower prevalence rates. Odey et al. (2012) reported a prevalence rate of 6.4% among adolescents in Calabar, South-eastern Nigeria. Fawibe and Shittu (2011) reported a prevalence rate of 5.7% in Ilorin, North-Central Nigeria.

Artisan apprentices are known to practice cigarette smoking despite their young ages. Another study by (Naing et al, 2004), revealed that over 11% of respondents admitted to smoking cigarette. This is higher than values in Nigerian National Survey (NPC and ICF MACRO, 2009). Also, prevalence rate for smoking is higher in out-of school adolescents as documented by Salawu et al (2000). Higher prevalence for smoking among young people not in the confines of school walls well reflect the impact of being under the watchful eyes of the school authority as compared to the relative "freedom" enjoyed by others who may be hawking or engaging in some form of apprenticeship. But overall, majority of new smokers are young people. (Aigbiremolen et al, 2013).

Importantly, the outcome of this study revealed that the majority of the respondents started smoking in their early age. Majority of the respondents were above 14 years when they initiated cigarette smoking. This is an agreement with a findings of whose record mean age at smoking debut was approximately 16 years while age at regular smoking was 17 years. There seems to be a point of convergence that age of smoking debut for majority of current smokers was below the age of 18 years (Abikoye and Fusigboye, 2010; Adeyeye, 2011; Fawibe and Shittu, 2011; Salawu et al., 2007).

The outcome of the study was in line with a research conducted by Akinlaro Opeyemi. (2009) which documented that tobacco companies have hand in getting people to start smoking because they know that 90 percent (90%) of smokers started smoking when they were younger than 18 years of age. The artisan apprentice training attracts mostly young people who are looking for a source of income or alternative source of income to support family expenses.

The finding that the average age of smoking debut was less than sixteen years is consistent with recent findings in Nigeria (for example, Abikoye and Fusigboye, 2010; Salawu et al., 2009; Fawibe and Shittu, 2011).

5.1.3 Factors that promotes the maintenance of cigarette smoking habit among artisan

Distinctively, factors that promote the maintenance of cigarette smoking habit among artisan have been found to include: Free access to cigarette, affordable, lack of strong law prohibiting the sales of cigarette to minor. The prevalence of smoking in Nigerian males is 9%, while 7.4% of males aged 15-24 years smoke; the highest prevalence among men, 12.1%, is in the south-south (National Population Commission and ICF Macro, 2009).

Most of the respondents that smoked took 1-5 sticks of cigarette per day which is in line with other similar studies (Babatunde, Oniwaye, Alawode, Omede and Olomofe, 2012) Slightly higher consumption rates have been reported (Fawibe and Shittu, 2011) Studies have shown that in Nigeria, most smokers are light smokers (Abikoye and Fusigboye 2010) From the foregoing, it is clear that whether passive smoker, heavy smoker or light smokers is inconsequential; smoking is detrimental to health no matter the degree or intensity of smoking (Abikoye, Kashimawo and Eze, 2013).

The findings of this study revealed that the majority of the male apprentices smoked for relaxation, to reduce stress to increase concentration at work and to feel more social. The outcome of this study supported the outcome of a study conducted by Raji Abubakar, Oche and Kaoje (2013) which stated multi-various reasons ranging from stress relief, cooling off, relaxation, mental alertness, concentration, and enhancing sexual performance were given for indulging in smoking.

5.2 Implications for health education

Health education focuses on the modification of people's behavior and behavioural antecedents (Green and Kreuter, (1999). Health education is thus concerned with helping people to change their negative attitudes to positive ones. Health education principles and strategies can be used to address the challenges identified in this study.

Results from this study documents a higher prevalence of cigarette smoking among artisan male apprentices. Majority were initiated into cigarette smoking by their friends (peers) or boss, and they smoked in order to relax, stay awake, be sociable, and to relief stress. Effective health promotion and education strategies such as public enlightenment through the information education and communication media will help to address the scourge in the study area, and the country at large.

Findings from this study revealed that artisan male apprentices had a poor knowledge of health risk associated with smoking. The findings of this study was in agreement (Abikoye and Fasipoye, 2010; Fawibe, 2011; Salawu et al. 2009) Given the large number of smokers in Nigeria and the fact that prognosis for unaided smoking cessation is very poor. Therefore, Artisans should be informed on the needs to visit the youth friendly clinic (Association for Reproductive and family health) for counseling and proper health education on the dangers of cigarette smoking.

5.3 Conclusion

Based on the findings of the study, the prevalence of cigarette smoking among artisan male apprentices population is of public health interest.

Most of the apprentices who smoked were initiated by their peers. Easy access to cigarette also influence initiation of smoking habit. The finding also implies that male artisan apprentices had probably acquired the smoking habits before and after becoming an apprentice, from previous or other sources such as family members and media sources.

Majority of the respondents had appreciable knowledge of the health risk of cigarette smoking such as lung cancer, tooth decay, black lips, digestive disorders and body odour.

5.4 Recommendations

Based on the findings of the study, the following recommendations were made;

1. The government and NGOs should organise intervention programmes targeted at artisan apprentices and trainers to provide them useful health education information in order for them to make informed decision on their health behavior.
2. Legislation that bans sale of cigarette to children and adolescents should be enforced.

- 3 Government should use the media extensively, especially the television and print media, to discourage cigarette smoking habit.
- 4 The use of "No smoking" labels should be enforced in every artisan offices or workshops by law enforcement agents.
- 5 Government at all levels and NGOs must promote more public awareness of the harmful effects of smoking and ensure availability and affordability of treatment options for tobacco dependence.
- 6 The efforts and current initiatives by the government and NGOs in providing youth friendly health services.

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REFERENCES

- Abikoye GE, Kashimawo AJ and Eze CU. 2013. Tobacco smoking and awareness of smoking-cessation products in a university community: *J. Public Health Epidemiology*. 5(8); 2013: 351-356.
- Abikoye GE and Fusigboye A. (2010). Gender locus of control and smoking habits of undergraduate students. *African Journal of Drug & Alcohol Studies*. 9(2); 2010: 71-80
- Adebiyi A.O, Babalola, Faseun, Adcola .O. Sangowawa, Eme T, Owoaje 2010. Tobacco use among out of school adolescent in Ibadan North Local Government Area, Oyo State.
- Adelman WP, Duggan AD, Hauptman P, et al. Effectiveness of a high school smoking cessation program. *Pediatrics* 2001; 107:E50.
- Adeyele O. O 2011, cigarette smoking among senior secondary school students in Lagos South West Nigeria. *Int. J. Bio. Med. Res.* 2. 2011. 1047-1050 [31]
- Aigbiremolen AO, Asnlu BO, Ejiyere H, Momoh JA, and Ogi SE (2013). Cigarette Smoking And Adolescent Health: A Survey Of Selected Senior Secondary Schools In Ekpoma *International Journal of Community Research* <http://www.unrescentpub.com> ISSN: 2315 – 6562 IJCR 2013; 2(2): 28-33. 28
- Ajzen, I. (2001). Nature and operation of attitudes. *Ann Rev Psychol*, 52, 27–58. Aryal U, Lohani S: Perceived risk of cigarette smoking among college students. *J Nepal Health Res Counc* 2011, 9(19):176-180..
- Akinwo Opeyemi 2009; The menace of tobacco smoking among Nigerian adolescents.
- Aryal U, Lohani S: Perceived risk of cigarette smoking among college students. *J Nepal Health Res Counc* 2011, 9(19):176-180. PubMed Abstract
- Ausoni E, Mirone V, and Parazzini F, (2001–2002). Smoking as a risk factor for erectile dysfunction: Data from the Andrology Prevention Weeks 2001–2002. A study of the Italian Society of Andrology (S.I.A.). *European Urology* 2005; 48(5):810-818.
- Awoledu AA, Jordan ER, Ndukwana OZB, et al. The smoking habits, attitudes toward smoking and knowledge regarding anti smoking legislation of students in institutions of higher learning in the Eastern Cape Province of South Africa. *Fam Pract* 2006; 48: 14–18. 25.

- Bobstunde OA, Omowaye OA, Alawode DA, Omede O, Olomofe COO and Akinyandenu J. (2012). Smoking Prevalence, Willingness to Quit and Factors Influencing Smoking Cessation among University Students in a Western Nigerian State. *J. Asian social science*. 8 (7):149
- Butross LS, and Kastner JW: A brief review of adolescents and tobacco: what we know and don't know. *American Journal of Medical Science* 2003, 326.
- Centers for Disease Control and Prevention. Trends in cigarette smoking among high school students – United States, 1991–2001. *MMWR Morb Mortal Wkly Rep* 2002; 51:409–12.
- Centres for Disease Control (2006): Tobacco use among students aged 13–15 years-Kurdistan Region, Iraq, 2005. *MMWR* ; 55: 556–59.
- Centers for Disease Control and Prevention *Morbidity and Mortality Weekly Report*. 2. Vol. 58. 2009b. State-specific smoking-attributable mortality and years of potential life lost – United States, 2000-2004; pp. 29–33.
- Cobb C, Ward KD, Maziak W, Shihadeh AL, Eissenberg T, (2010). Waterpipe tobacco smoking: An emerging health crisis in the United States. *American Journal of Health Behavior* 2010; 34(3):275–285.
- Conrad KM, Flay BR, Hill D. (1992), Why children start smoking cigarettes: Predictors of onset. *Br J Addict* ;87:1711-24.
- Cooke, R., and Sheeran, P. (2004). Moderation of cognition-intention and cognition-behaviour relations: a meta-analysis of properties of variables from the theory of planned behaviour. *Br J Soc Psychol*, 43, 159–186.
- Cummings S, Rubin S, and Oster G (1989): The cost-effectiveness of counseling smokers to quit. *JAMA* 261:75–79
- Darpan P, (2003). Tobacco use among adolescent students in secondary schools of Pokhara sub metropolitan city of Nepal. A thesis submitted to Tribhuvan University Kathmandu. 2003.
- De Vries H, Engels R, Kremers S, Welzel J, and Mladic A, (2003). Parents and friends smoking status as predictors of smoking onset: Findings from six European countries. *Health Education Research* 2003;18:627-36 W

- Ebirim C I C, Amadi A N, Abanobi O C, Ioh G U P. 2014; The prevalence of cigarette smoking and knowledge of its health implication among adolescent in Owerri, South Eastern Nigeria.
- Elders M J, Peery C L, Eriksen M P, and Giovino G A (1994). 'The report of the Surgeon General: preventing tobacco use among young people. *American Journal of Public Health* 84(4):543-7.
- Fowibe AE and Shittu AO. Prevalence and characteristics of cigarette smokers among undergraduates of the University of Ilorin, Nigeria. *Nigerian Journal of Clinical Practice* 14; 2011: 201-5.
- Fazio, R H, (1990). Multiple processes by which attitudes guide behavior: the MODE model as an integrative framework. *Advances in Experimental Social Psychology*, 23, pp. 75–109.
- Flay B.R (1999): Understanding environmental, situational, and intrapersonal risk and protective factors for youth tobacco use: the Theory of Triadic Influence. *Nicotine Tobacco Res* 1(Suppl 111):114.
- Fishbein, M., Triandis, H. C., Kanfer, F. H., Becker M., Middlestadt, S. E., and Eichler, A. (2001). Factors influencing behavior and behavior change. In A. Baum, T. A. Revenson, & J. E. Singer (Eds.), *Handbook of Health Psychology* (pp. 3–17). Mahwah, NJ: Lawrence Erlbaum Associates.
- Fisher E Jr, Lichtenstein E, and Haire-Joshu D (1993): Multiple determinants of tobacco use and cessation. In *Nicotine Addiction: Principles and Management*. Orleans C, Slade J, Eds. New York, Oxford University Press, 1993
- Global Youth Tobacco Survey Collaborating Group: Differences in worldwide tobacco use by gender: findings from the Global Youth Tobacco Survey. *J Sch Health* 2003; 73: 207–15.
- Goldade K, Choi K, Bemat D H, Klein E.G, 2012. Multilevel predictors of smoking initiation among adolescents: findings from the Minnesota Adolescent Community Cohort (MACC) study. *Preventive Med.*.....2012.
- Gollwitzer, P M, (1993). Goal achievement: the role of intentions. *European Review of Social Psychology*, 4, pp. 141–185.
- Green L W, Kreuter, M W, 1999, *Health promotion Planning ;An educational and environmental approach*, 2nd Edition, Mayfield Publishing Company

- Haire-Joshu D, Glasgow R, Tibbs T (1999): Smoking and diabetes (Technical Review). *Diabetes Care* 22:1887-1898.
- Jackson C: Cognitive susceptibility to smoking and initiation of smoking during childhood: a longitudinal study. *Prev Med* 1998, 27(1):129-134.
- Jarvison P, and Romer D: What do young people think they know about the risks of smoking? *In* Smoking risk, perception, and policy. Edited by Slovic P. Thousand Oaks, California: Sage Publications; 2001:51.
- Jindal SK, Aggarwal AN, Chaudhry K, Chhabra SK, D'Souza, Gupta D, et al 2006. Tobacco smoking in India: Prevalence, quit-rates and respiratory morbidity. *Indian J Chest Dis Allied*
- Joshi P, Islam S, Pais P, Reddy S, Dorairaj P, Kazmi K, Pandey MR, Haque S, Mendis S, Rongorajan S: Risk factors for early myocardial infarction in South Asians compared with individuals in other countries. *JAMA* 2007, 297(3):286
- Kainulainen S, Kivela S: I Will Never Smoke. Results of Anti-Tobacco Teaching and Investigation in Schools in Nepal Helsinki: Diaconia University of Applied Sciences; 2012.
- Lawton, R., Conner, M., and Parker, D. (2007). Beyond cognition: predicting health risk behaviors from instrumental and affective beliefs. *Health Psychol*, 26, 259-267.
- Lawton, R., Conner, M., and McEachan, R. (2009). Desire or reason: predicting health behaviors from affective and cognitive attitudes. *Health Psychol*, 28, 56-65.
- Loewenstein, G. (1996). Out of control: visceral influences on behavior. *Organiz Behav Hum Dec Proc*, 65, 272-292.
- Mackay J: Combating addiction in developing countries. *In* Smokers: Why Do They Start – And Continue? Volume 16 Edited by Chapman S. World Health Forum; 1995:1-27.
- Mantler T (2012): A systematic review of smoking Youths' perceptions of addiction and health risks associated with smoking: Utilizing the framework of the health belief model. *Addiction Research & Theory*, 0(0):1-12
- Ministry of Health and Population [Nepal] (2011): *Tobacco Control Reference Book*. Kathmandu: Ministry of Health and Population; 2011.
- Moran, S., Wechsler, H., & Rigotti, N. A. (2004). Social Smoking Among US College Students. *Pediatrics*, 114 (4), 1028-1034

- Naing N N, Ahmad Z, Musa R, et al. Factors related to smoking habits of male adolescents. *Tobacco Induced Diseases* 2004; 2: 133-40.
- Naing N N, Ahmad Z, Musa R, Abdul Hamid I'R, Ghazali H, and Abu Bakar M H, (2004). Factors related to smoking habits of male adolescents. *Tobacco Induced Diseases* 2004; 2: 133-140.
- National Cancer Institute. *Cancer Progress Report 2003*. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, 2004.
- National Population Commission (NPC) [Nigeria] and ICF Macro: Nigeria Demographic and Health Survey 2008 Abuja, Nigeria: National Population Commission and ICF Macro; 2009.
- National Population Commission Abuja: 2006 Population and Housing Census of the Federal Republic of Nigeria Priority Tables (Volume 1) 2009.
- Nevbahar Eras (2007). Factors associated with stages of cigarette smoking among Turkish youth. *Eur J Public Health* ;17: 155-61.
- Obot I S, 1990, The use of tobacco product among Nigerian adult, a general population survey.
- Odey F A, Okokon I B, Ogbeche J O. Prevalence of cigarette smoking among adolescents in Calabar City, South East Nigeria. *Journal of Med.* 2012 tobaccocontrol.ng
- Odeyemi KA, Osibogun A, Akinsete A O, and Sadiq L 2009: The Prevalence and Predictors of Cigarette Smoking among Secondary School Students in Nigeria. *Niger Postgraduate Med J.* 16(1):40-5.
- Owonaro, Peter A and Eniojukan, Joshua F. 2015. Who are the Smokers and what Factors Influence Smoking among Amassoma Community in South-South Nigeria?. *IOSR Journal Of Pharmacy (e)-ISSN: 2250-3013, (p)-ISSN: 2319-4219 www.iosrphr.org Volume 5, Issue 9 (September 2015), PP 24-31 24*
- Omokhodion F O, and Faseru B O (2007): Perception of cigarette smoking and advertisement among senior secondary school students in Ibadan, Southwestern Nigeria. *West African J Med* 2007, 26(3):206-9.
- Orbell, S, Hodgkins, S and Sheeran, P. (1997). *Personality and Social Psychology Bulletin*, 23,pp. 945-954.

- Osungbade K O, and Oshiname F O: Determinants of cigarette smoking among senior secondary school students in a rural community of southwest Nigeria. *Niger J Med* 2008. 17(1):40-4.
- Paudel D: Tobacco use among adolescent students in secondary schools of Pokhara sub metropolitan city of Nepal. Kathmandu: Institute of Medicine; 2003.
- Perkins KA, Marcus MD, Levine MD, D'Amico D, Miller A, Broge M, Ashcom J, Shiffman S: Cognitive-behavioral therapy to reduce weight concerns improves smoking cessation outcome in weight-concerned women. *J Consult Clin Psychol* 69:604-613, 2001
- Pierce J P, Choi W S, Gilpin E A, Farkas AJ(1996), and Merritt R K 1996: Validation of susceptibility as a predictor of which adolescents take up smoking in the United States. *Health Psychol* , 15(5):355-361.
- Pomerleau O, Collins A, Shiffman S, and Pomerleau C: *Why some people smoke and others do not: new perspectives*. *J Consult Clin Psychol* 61:723-731, 1993
- Prokhorov AV, de Moor CA, Hudmon KS, Ilu S, Kelder SH, Gritz ER: Predicting initiation of smoking in adolescents: Evidence for integrating the stages of change and susceptibility to smoking constructs. *Addict Behav* 2002, 27(5):697-712.
- Raji MO, Abubakar IS, Oche MO and Kwoje AU (2013). Prevalence and determinants of cigarette smoking among in school adolescents in Sokoto metropolis, Northwest Nigeria. *International Journal of Tropical Medicine*, 8 (3), 2013: 81-86.
- Salawu F.K, Donburam A, Desalu O O, Olokoba A B, Agbo J, and Midala J K, Cigarette smoking habits among adolescents in northeast Nigeria; 2009
- Sandberg, T., and Conner, M. (2008). Anticipated regret as an additional predictor in the theory of planned behaviour: a meta-analysis. *Br J Soc Psychol*, 47, 589-606.
- Schwarzer, R. (1992) "Self efficacy in the adoption and maintenance of health behaviours: theoretical approaches and a new model", I N Schwarzer, R. (Ed) *Self Efficacy: Thought Control of Action*, pp217-243. Washington, DC: Hemisphere.
- Schwarzer, R. (2008). Modeling health behavior change: How to predict and modify the adoption and maintenance of health behaviors. *Applied Psychology: An International Review*, 57(1), 1-29.

- Sepe, E., Ling, P.M., and Glantz, S.A. (2002) Smooth Moves: Bar and Nightclub Tobacco Promotions that Target Young Adults *American Journal of Public Health*, 92 (3), 414-419
- Sheeran, P., and Abraham, C. (2003). Mediator of moderators: temporal stability of intention and the intention-behavior relationship. *Pers Soc Psychol Bull*, 29, 205-215.
- Simantov, E., Schoen C, and Klein J D (2000): Health - compromising behaviours: why do adolescents smoke or drink. *Pediatric and Adolescent Medicine* 154:1025-1033
- Simons-Morton B, Crump AD, Hayne DL, Saylor KE, Eitel P, Yu K. Psychosocial, school, and parent factors associated with recent smoking among early-adolescent boys and girls. *Prev Med*. 1999;28(2):138-48.
- Slovic, P (2000): What does it mean to know a cumulative risk? Adolescents' perceptions of short-term and long-term consequences of smoking. *J Behavior Decision Making*, 13(2):259-266.
- Sutton, S. (2005). Stage models of health behaviour. In M. Conner & P. Norman (Eds.), *Predicting Health Behaviour: Research and Practice with Social Cognition Models*, 2nd Ed (pp. 223-275). Maidenhead: Open University Press.
- Unger JB, Yan L, Chen XG, Jiang X, Azen S, and Qian G, (2001). Adolescent smoking in Wuhan, China: Baseline data from the Wuhan smoking prevention trial. *American Journal of Preventive Medicine*; 21 (3): 162-169.
- Unger JB, Yan L, and Shakib S, et al (2002). Peer influences and access to cigarettes as correlates of adolescent smoking: a cross - cultural comparison of Wuhan China and California. *Preventive Medicine*; 34(4): 476-484.
- US Department of Health and Human Services (1994). Preventing tobacco use among young people. A report of the Surgeon General. Atlanta, Georgia: Public Health Service, Centers for Disease Control and Prevention, Office on Smoking and Health, 1994; (US Government Printing Office Publication No S/N 017-001-00491-0.).
- U.S. Department of Health and Human Services (2004). *The Health Consequences of Smoking: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

- U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
- U.S. Department of Health and Human Services (2010). *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
- Vardavas C: Key points in preventing tobacco use among adolescents. *Tobacco Induced Diseases* 2010, 8:1
- Weinstein, N D, Rothman, A J and Sutton, S R. (1998). Stage theories of health behavior: conceptual and methodological issues. *Health Psychology*, 17, pp. 290-299.
- Willey M B, Woodruff S I, Agro A, Keay K D, 1995 Sustained effects of educating retailers to reduce cigarette sales to minors, *Public health* 1995
- World Health Organization. 2002. Tobacco Free Initiative , Tobacco and youth in the South East Asian region. *Indian J Cancer* 2002, 39(1):1-33.
- World Health Organization, 2007 . Tobacco Free Initiative (TFI) Geneva: Why is tobacco a public health priority? World Health Organization, 2007
- Qidwai W, and Zahid N (2005). Characteristics of smokers and their knowledge about smoking at a teaching hospital in Karachi. *Pak J Med Sci* ;21:109-11.

APPENDICES

APPENDIX I

Table 1: List of wards in Ibadan North-West Local Government Area and their constituent communities

Wards	Community	Community selected
Ward one I	1 Asukuna 2 Elekuso 3 Bere 4 Ayeye 5	
Ward two II	1 Agbede adodo 2 Oke-Are 3 Opoycosa	
Ward three III	1 Ayeye 2 Agbeni	
Ward four IV	1 Idi Kan 2 Ori-Eru	
Ward five V	1 Olorisaoko 2 Oke-Padi 3 Falaye	
Ward six VI	1 Adebí	
Ward seven VII	1 Dugbe 2 Ekotedo 3 Adamasingba	
Ward eight VIII	1 Inolande 2 Atowoda 3 Omitoyoju 4 Ode-Ola (Left)	
Ward nine IX	1 Onireke 2 Lekan- Salami Stadium 3 Afonta 4 Onireke GRA 5 Links Reservation	

Ward ten X	<ul style="list-style-type: none"> 1 Eleyele 2 Industria Estate 3 Letmuck Barracks 4 Eleyele 5 Benjami 6 Eleyele Police Barracks 7 Jericho GRA 8 Ili-Ishin 9 Nihori Quarters 	
Ward eleven XI	<ul style="list-style-type: none"> 1 Olopomewa 2 Ijokoto 3 Eleyele Water Works 4 Askar Prints 	
11	40	Total 6

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APPENDIX II

INFORMED CONSENT

Dear Respondent,

My name is Adeoye, Adeolu Abidemi. I am a Masters student of the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am presently conducting a study titled '*Factors influencing the adoption of cigarette smoking habit among artisan male apprentices in Ibadan North-West Local Government Area, Oyo State*'. The purpose of this study is to investigate the factors that influence the adoption of cigarette smoking.

This questionnaire is designed to gather information concerning intention to smoke, initiation pattern, and maintenance of cigarette smoking habit among artisan male apprentices in Ibadan North-West Local Government Area, Oyo state.

The questionnaire was designed based on the ethical principles guiding the use of human participants in research. All information provided shall be kept confidential and in a secured place where no other persons will have access to the information given by the respondents.

Thank you for your cooperation.

QUESTIONNAIRE

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Age at last birthday.....
2. Years of apprenticeship.....
3. Type of Apprenticeship.....
4. Religion: Christianity Islam None Others
5. Nationality: Nigerian Non-Nigerian
6. Tribe: Yoruba Hausa Igbo Other
7. Level of Education:
No formal education Primary Secondary Post secondary

SECTION B: INTENTION TO SMOKE

8. Why do you think people of your apprenticeship start to smoke?
 - i) It boosts my personality 1. Yes 2. No
 - ii) Its attractive 1. Yes 2.No
 - iii) To copy my boss 1. Yes 2. No
 - iv) Parental influence 1. Yes 2. No
 - v) Trainer's influence 1. Yes 2.No
 - vi) Peer pressure 1. Yes 2 No
 - vii) Curiosity 1.Yes 2.No
 - viii) Family/Sibling smokes 1.Yes 2 No
 - ix) Others (specify).....
9. Are you familiar with any cigarette advertisement on the media? Yes No
10. If Yes in '8', in which form of media?
 - i) Television Yes No
 - ii) Radio Yes No
 - iii) Print Yes No
 - iv) Billboard Yes No
 - v) Others (specify).....

11. What image did the advert seen/heard conveyed to you about smokers?

- i) Confidence Yes No
- ii) Luxury Yes No
- iii) Affluence Yes No
- iv) Success Yes No
- v) All of the above Yes No
- vi) None of the above Yes No
- vii) Others (specify).....

12. Did the advert suggest you should do something? Yes No I don't know

13. If Yes to Question '11' above, What did it ask you to do? (Open answers)

.....

14. Did the advert seen/heard emphasize the harm of cigarette smoking? Yes No

15. If Yes in '13' above, state the harm it emphasized (open answer)

.....

16. In your opinion, do you think cigarette smoking is a good habit? 1. Yes 2. No
I don't know

17. What impression do you perceive your society have on cigarette smoking habit?

Good Bad Indifferent Others.....

18. Have you ever seen health warning messages on cigarette packages? 1. Yes 2. No

19. If Yes in '16' above, do you believe the health warnings that you see on the cigarette packages? 1. Yes 2. No

20. Have you ever been told at work about health risks of cigarette smoking?

1. Yes 2. No

21. Do you think if you smoke, you will have more to gain than to lose?

Yes No I don't know

KNOWLEDGE OF HEALTH PROBLEMS ASSOCIATED WITH CIGARETTE SMOKING.

All the following health problems may result from cigarette smoking. Please tick Yes or No to the following questions

22. Can health problems result from smoking cigarette? 1. Yes 2. No
23. Can smoking cigarettes leads to chest infection, 1. Yes 2. No
24. Smoking cigarette cannot leads to chronic obstructive airway disease
1. Yes 2. No
25. Can smoking cigarette leads to lung cancer. 1. Yes 2. No
26. Smoking cigarette cannot leads to hypertension. 1. Yes 2. No
27. Smoking cigarette can leads to peptic ulcer disease. 1. Yes 2. No
28. Smokers are liable to die young. 1. Yes 2. No
29. Smoking o cigarette can leads to black Lips 1. Yes 2. No
30. Smoking o cigarette can leads to Body odor 1. Yes 2. No
31. Smoking cigarettes cannot leads to red eyes 1. Yes 2. No

SECTION C: INITIATION OF SMOKING HABIT (Past or Present Smokers Only)

32. What is your smoking status? Past smoker Present smoker
33. Age when you first smoked.....
34. When did you smoke your first cigarette?
i) After becoming an Apprentice Yes No
ii) Before becoming an apprentice Yes No
35. Do you smoked in the last 3 months.....
36. How was your first cigarette? (Tick one)
(i) A whole cigarette (ii) A left over stump (iii) A shared puff
37. Have you smoked in the last few days? 1. Yes 2. No
38. If Yes to Question 24, how would you describe your access to cigarette?
Difficult Easy I don't know
39. Where do you usually source your cigarette?
Promoters Yes No

Sellers Yes No

Siblings Yes No

Parents Yes No

Boss/trainer Yes No

Friends /colleagues Yes No

Others

40. If you source from 'Sellers' in '26' above, then at what selling point?

Road side shops Yes No

From friends seller Yes No

Hawkers Yes No

Others.....

33. Has any seller ever refused to sell you cigarette? Yes No

34. Did your father know that you smoked?

1. Yes 2. No

35. If yes in '29' above, how did he feel about your smoking?

He approved He was indifferent He disapproved

36. Did your mother/guardian know that you smoked?

1. Yes 2. No

37. If yes in '31' above, how did she feel about your smoking?

She approved She was indifferent she disapproved

38. Was your trainer a smoker? Yes No

47. If Yes in '33' above, did your trainer ever sent you on errand to buy cigarette?

Yes No

48. Did your trainer know you smoked? Yes No

49. If Yes in '35' above, did he approve of your smoking?

No Yes Indifferent

50. Is there a 'No smoking' restriction at your work place? Yes No

51. If Yes in '37' above, in your opinion, has the restriction reduced smoking among

Apprentices? Yes No

52. Have you ever attended a cigarette promoter-sponsored event or occasion?

Yes No

53. If Yes in '39' above, was cigarette shared for free or sold at subsidized rate?

1. Yes 2. No

54. If Yes in '40' above, did you collect or bought any cigarette at the said occasion?

Yes No

55. About how much money do you spend on cigarette each day? (state amount)

.....

56. Where do you often get the money to buy cigarette?

From boss Yes No

From work Yes No

From parent Yes No

From friends Yes No

From siblings Yes No

Others (state).....

SECTION D: MAINTENANCE OF SMOKING HABIT

57. How often do you smoke?

Once in a while Once everyday Several times a day

58. How many cigarette stick(s) do you usually smoke daily?

59. Do you think people can become addicted to cigarette smoking habit?

Yes No I don't know

60. Do you think smoking helps people to relax? Yes No

61. Do you think smoking can help people when they are bored? Yes No

62. Do you think smoking cool the nerves? Yes No

63. Do you think it helps to concentrate when at work Y 143 N

64. Do you think it keeps you relevant among smoking friends and colleagues? 1. Yes

2. No

65. Do you usually smoke the same brand? 1. Yes 2. No

66. Why do you smoke the brand of cigarette that you do?

Popular guys smoke the same brand Yes No

My friends smoke the same brand Yes No

My parent(s) smoke the same brand Yes No

I like the taste

Yes

No

Those are the ones available

Yes

No

Other reasons (specify)

67. Do you know any cultural, social, sporting or any other event sponsored by tobacco

Promoters? Yes No

68. Have you ever seen advertisement of such event(s) sponsored by tobacco promoters?

Yes No

69. If Yes in '53' above, state where?

Bill board Yes No

Magazine/Newspaper Yes No

Television Yes No

Shop/supermarket Yes No

Motor parks Yes No

Cinemas Yes No

Others

70. Have you ever attended such cigarette promoter-sponsored event(s) where access to free or subsidized cigarette was provided?

Yes No

71. Did you take advantage of such opportunity as stated above in '55'?

Yes No

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APPENDIX III

INFORMED CONCENT

Dear Respondent,

My name is Adeoye, Adeolu Abidemi. I am a Masters student of the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am presently conducting a study titled ' Factors influencing the adoption of cigarette smoking habit among male apprentices artisan in Ibadan North West Local Government Area, Oyo State'. The purpose of this study is to investigate the factors that influence the adoption of cigarette smoking habit.

This questionnaire is designed to gather information concerning intention to smoke, initiation pattern, and maintenance of cigarette smoking habit among artisan male apprentices in Ibadan North-West Local Government Area, Oyo state.

The questionnaire was designed based on the ethical principles guiding the use of human participants in research. All information provided shall be kept confidential and in a secured place where no other persons will have access to the information given by the respondents.

Thank you for your cooperation.

DRAFT IN-DEPTH INTERVIEW GUIDE ON FACTORS INFLUENCING THE ADOPTION OF CIGARETTE SMOKING AMONG ARTISAN MALE APPRENTICES IN IBADAN NORTH-WEST LOCAL GOVERNMENT AREA, OYO STATE

Good day sir, My name is.....,this study is being conducted as part of requirements for the award of (MPH) Degree of Department of Health Promotion and Education in the Faculty of Public Health, University of Ibadan.

The study is designed to investigate *the factors that influence the adoption of cigarette smoking among artisan male apprentices in Ibadan North-West Local Government Area, Oyo State.*

Your participation in this interview is to enable me understand in details the factors that influence the intention to smoke, the initiation of smoking and the maintenance of smoking among artisan male apprentices.

Please note that your participation in this interview is voluntary, hence you may agree or decline to participate. There are no wrong or right answers, all responses are very important to this study. I also seek your permission to capture this interview on a recorder, to ensure no part of this interview is lost during analysis.

Thank you.

Would you like to participate?

Yes

No

ADEOYE Adcolu A.

Adcoycadeolu48@yahoo.com

08033870564

SN	QUESTIONS	PROBE
1	What is your view of smoking habit among apprentices?	Why do you think apprentices indulge in such habit?
2	What factors do you think can cause non-smoking apprentices to build the intention to smoke cigarette?	<p>Does smoking boost their social importance?</p> <p>Is it a mark of success?</p> <p>What information do you think the apprentices have heard or seen that motivates them?</p>
3	What are the factors that make apprentices to initiate cigarette-smoking habit?	<p>Is it friends/peers?</p> <p>Is it parents /siblings/family?</p> <p>Is it their boss/masters at workshop?</p> <p>Is it the influence of the media?</p> <p>Is it the cost (price) of cigarette?</p>
4	What are the factors that promote the maintenance of cigarette smoking habit among apprentices?	<p>Could it be that it is very affordable?</p> <p>Could it be motivation from advertisement?</p> <p>Do they have free access to cigarette such as during public promotion?</p> <p>Do they benefit from cigarette smoking, such as reduction of stress? Or improves concentration? etc</p>
5	Do you think cigarette smoking among male youths such as apprentices is of serious health concern in your community?	<p>How common do you think cigarette smoking habit is among apprentices?</p> <p>How many out of every ten (10) apprentices do you think indulge in cigarette smoking?</p>

SN	QUESTIONS	PROBE
1	What is your view of smoking habit among apprentices?	Why do you think apprentices indulge in such habit?
2	What factors do you think can cause non-smoking apprentices to build the intention to smoke cigarette?	<p>Does smoking boost their social importance?</p> <p>Is it a mark of success?</p> <p>What information do you think the apprentices have heard or seen that motivates them?</p>
3	What are the factors that make apprentices to initiate cigarette-smoking habit?	<p>Is it friends/peers?</p> <p>Is it parents /siblings/family?</p> <p>Is it their boss/masters at workshop?</p> <p>Is it the influence of the media?</p> <p>Is it the cost (price) of cigarette?</p>
4	What are the factors that promote the maintenance of cigarette smoking habit among apprentices?	<p>Could it be that it is very affordable?</p> <p>Could it be motivation from advertisement?</p> <p>Do they have free access to cigarette such as during public promotion?</p> <p>Do they benefit from cigarette smoking; such as reduction of stress? Or improves concentration? etc</p>
5	Do you think cigarette smoking among male youths such as apprentices is of serious health concern in your community?	<p>How common do you think cigarette smoking habit is among apprentices?</p> <p>How many out of every ten (10) apprentices do you think indulge in cigarette smoking?</p>

ASOMO I

IWE IBEERE LORI AWON OKUNFA GBIGBESI LATI JE OMUSIGA LAARIN AWON OMO OKUNRIN TI N KO ISE OWO NI AGBEGBE IJOBA IBILE ARIWA IWO-OORUN IBADAN, IPINLE OYO

E ku deede iwoyi o, Oruko mi niIwadi yi je eyi ti akoko nipa ilera ara ilu, eka ti n kopa nipa ilosiwaju ati imo nipa ilera, lati eka ti n ko nipa ilera ara ilu ti ile iwe giga ilu Ibadan.

Ise yi wa lati se iwadi lori awon okunfa ti o n fa igbese lati je omusiga laarin awon odomokunrin ti n ko ise owo ni agbegbe ijoba Ipinle Ariwa-Iwo oorun Ibadan, Ipinle Oyo. Inu mi yoo dun lopolopo fun idahun yin tooto si awon ibere ti a ba bi yin. Siwaju sii, a o se ipamo gbogbo oun ti e ba ba wa so daradara, nitori pe ise yi wa fun eto eko ati ilosiwaju imo nikan soso. A ti gba ase ati iyonda lowo igbimo to n se amojuto ise iwadi imo ijinle eka ti ipinle Oyo. E jowo e ti ami si eye ti o ba ye lati fi ipinnunyun han lati ko pa tabi beeko.

E seun pupo.

N je e se lati kopa?

Beeni

Beeko

Fun lilo awon Osise

Adeoye A Adeolu

Adeoyeadeolu48@yahoo.com

08033870564

Onka

Oruko Oluforowanifenuwo.....

Oruko agbegbe.....

ABALA A: AWON OHUN TI O JE MO OLUKOPA NINU IWADI

1. Ojo on olukopa ni ojo ibi ti o gbehin:
2. Iye odun lenu ise kiko
3. Iru ise owo kiko
4. Esin : igbagbo musulumi Esin Ibile awon to sekun
5. Ipinle : Naijina Ipinle miran
6. Eya : Yoruba Hausa Igbo Awon ti o sekun
7. Ipele iwe ti e ka: N ko ka iwe rara Iwe mela Iwe mewa ile iwe giga

ABALA B: ERONGBA LATI MU SIGA

8. Kini e lero wipe o n fa ki omo ekose bere sii mu siga?
O pon mi le Beeni Beeko
O fa ni mora Beeni Beeko
lati se awokose Oga mi Beeni Beeko
lati se awokose obi mi Beeni Beeko
Awokose awon oluko lenu ise Beeni Beeko
Awokose awon elegbe mi Beeni Beeko
Igbiyanju lati wa fin-in idi kooko Beeni Beeko
Awokose ara tabi ebi Beeni Beeko
Awon to sekun
9. N je e ti se akijesi ipolowo siga Kankan ni? Beeni Beeko
10. Bi idahun yin si ibeere kejo ba je beeni, iru ibo ni e ti akijesi ipolowo yii?
Ero amohun-mawoian Beeni Beeko
Ero asoro-magbesi Beeni Beeko
Iwe iroyin Beeni Beeko
Aworan ipolowo legbe titi Beeni Beeko
Awon ti o sekun
11. Iru eniyan wo ni ipolowo ti e ri tabi gbo yii fun omu-siga?
Eni ti o gboya Aworan olowo Aworan gbajumo Awomni eni ti o yege
Gbagbo re lapopo ko si okan ninu aworan wunyi Awon ti o sekun
12. N je ipolowo naa n fe ki e se ohun kan ni pato? Beeni Beeko

13. Bi idahun yin si ibeere kokanla ba je beeni, ki ni ohun ti o fe ki e

se?.....

14. N je ipolowo ti ri tabi gbo se aloka ewu ti o n be ninu siga mimu? Beeni Beeko

15. Bi idahun yin si ibeere ketala ba je beeni, e so awon ewu naa.

.....

16. N je eyin funrara yin lero wipe siga mimu je iwa ti o dara? Beeni Beeko N ko mo

17. Iru oju wo le ro wipe awujo yin li n wo siga mimu? Oju daradara ni Oju ti ko dara ni
won ko li oju kankan wo Awon ti o sekun.....

18. N je e ti ri ikilo nipa ewu ailera siga mimu ti won ko sara paali sigaa ri? Beeni Beeko

19. Bi idahun yin si ibeere ketadinlogun ba je beeni, n je e gba ewu ailera yi gbo bi? Beeni
Beeko

20. N je awon Oga lenu ise se alaye ewu ti n be ninu siga mimu yii fun yin nibi ise ii? Beeni
Beeko

21. Bi e ba mu siga, n je eyin lero wipe yoo se yin ni anfaani pupo ju ibi lo? Beeni
Beeko

ABALA C. IPINNU LATI MU SIGA

22. Kini ipo siga mimu yin bayi?

Mo ti mu siga ri ni igba kan Beeni Beeko

Mo si n mu siga lowolowo bayi Beeni Beeko

23. Ni igba wo le koko mu siga?

Ki n to bere ise kiko Beeni Beeko

Leyin ti mo bere ise kiko Beeni Beeko

24. Bawo ni e se bere siga mimu ?

Odindi siga Beeni Beeko

Amukun siga Beeni Beeko

Siga pinpin mu Beeni Beeko

25. N je e ti mu siga lenu ijo meta yii? Beeni Beeko

26. Bi idahun yin si ibeere kerinlelogun ba je beeni, ba wo ni a ti ri siga ra se se si?

O nira O ronun pupo N ko mo Awon to sekun.....

27. Nibo ni pato le ti ma n ri siga ti e n mu?

Oni ipolowo Beeni Beeko

Iodo awon ti n ta Beeni Beeko

Awon ara Beeni Beeko

Awon Obi Beeni Beeko

Awon Oga ise Beeni Beeko

Awon Ore Beeni Beeko

Awon ti o ba sekun.....

28. Bi idahun yin si ibeere kerindinlogbon ba je 'awon ti n ta', nibo ni pato ni oju tita naa?

Soobu egbe titi Beeni Beeko

Awon ore Beeni Beeko

Awon ti o n kiri Beeni Beeko

Awon ti o sekun.....

29. N je eni ti o n ta siga tile fi igba kan ko lati ta siga fun yin nitori idi kaa tabi omiran bi?

Beeni Beeko

30. N je baba yin mo wipe e n mu siga? Beeni Beeko

31. Bi idahun yin si ibeere kokandinlogbon ba je 'beeni', iha wo ni e lero wipe won ko si iwa siga mimu yin? Won ti owo sii Won ko kobi ara sii Won ko towo sii rara

32. N je iya yin mo wipe e n mu siga? Beeni Beeko

33. Bi idahun si ibeere kokandinlogbon ba je 'beeni', iha wo ni won ko si iwa siga mimu yin?

Won ti owo sii Won ko kobi ara sii Won ko towo sii rara

34. N je oga yin ni ibi ise yii n mu siga bi? Beeni Beeko

35. Bi idahun yin si ibeere ketadinlogbon ba je beeni, n je oga naa ti ran yin lati ta siga ri bi?

Beeni Beeko

36. N je oga yin mo wipe e n mu siga? Beeni Beeko

37. Bi idahun yin si ibeere karundinlogbon ba je beeni, n je o farano siga mimu yin?

Beeni Beeko ko bikita

38. N je akole idkun wipe "ma se mu siga nihin" wa ni ibi ise yin? Beeni Beeko

39. Bi idahun yin si ibeere ketadinlogoji ba je beeni, n je akole yii ti dekun iwa siga mimu laarin

awon omo ekose ni ibi ise yin? Beeni Beeko N ko mo

40. N je e ti lo si ibi eto tabi ariya ti awon onipolowo siga se onigbowo tabi agbateru re bi?
 Beeni Beeko
41. Bi idahun yin si ibeere kokandinlogoji ba je beeni, n je won pin siga ofe tabi ki won ta ni edinwo ni ibi ipade bee?
 Beeni Beeko
42. Bi idahun yin si ibeere ogoji ba je beeni, n je e kopa ninu anfaani edinwo tabi siga ofe yi?
 Beeni Beeko
43. Eelo ni pato ni e maa n na lojumo lori siga mimu?
44. Ni bo ni pato ni e ti maa n ri owo ti e ti n na siga?
 Lati owo Oga ise Lati owo ise Lati owo obi Lati owo ore Lati owo ebi
 Lati ibi miiran (e daruko ibe).....

ABALA D : TITESIWAJU NINU IWA SIGA MIMU

45. Bi igba melo ni e n mu siga lojumo ?
 Bekookan cekan lojumo aimoye igba lojumo
46. Bi igi siga melo ni e maa n mu lojumo kan?
- 1-5 6-10 11-15 16-20 Above 20
47. N je e lero wipe o seese ki eniyan mu siga debi wipe ko nira lati ti sile mo?
 Beeni Beeko N ko mo
48. N je e lero wipe siga mimu le ran eniyan lowo lati ni ifokanbale?
 Beeni Beeko
49. Bi gbogbo nkan ba su eniyan, n je e lero wipe siga mimu le se iranlowo?
 Beeni Beeko
50. N je e lero wipe siga mimu le je ki ara eniyan bale?
 Beeni Beeko
51. N je iru siga kan soso ni e maa n mu bi?
 Beeni Beeko
52. Ki ni idi ti e ti n mu iru awon siga ti e maa n mu wunyi ?
- | | |
|---|---|
| Iru siga ti awon cyan nla n mu niyen | Beeni <input type="checkbox"/> Beeko <input type="checkbox"/> |
| Iru siga ti awon ore mi n mu niyen | Beeni <input type="checkbox"/> Beeko <input type="checkbox"/> |
| Iru siga ti awon obi mi n mu niyen | Beeni <input type="checkbox"/> Beeko <input type="checkbox"/> |
| Mo fero adun re lenu | Beeni <input type="checkbox"/> Beeko <input type="checkbox"/> |
| Iru awon siga ti o wa ni agbegbe mi niyen | Beeni <input type="checkbox"/> Beeko <input type="checkbox"/> |
| Awon idi miiran..... | |

53. N jẹ e mo nipa eto ere idaraya labi ayeye ti awon oluta siga se agbateru re ?

Beeni Beeko

54. N jẹ e ti se akiyesi eto ipolowo fun iru awon ayeye ti awon oluta siga se onigbowo bayi fun ri ?

Beeni Beeko

55. Bi idahun yin si ibeere ketaleladota ba je beeni, e so ni pato ibi ti e ti se akiyesi yii.

Aworan egbe titi Beeni Beeko

Iwe irohin Beeni Beeko

Ero amohun-maworan Beeni Beeko

Ile itaja Beeni Beeko

Ibulo-oko Beeni Beeko

Ile ere ori-itage Beeni Beeko

Awon ibi miiran.....

56. N jẹ e ti lo si iru ibi ayeye ti a se apejuwe ni ibeere kejileladota ri ?

Beeni Beeko

57. N jẹ e yin na je ninu anfaani siga edinwo labi ote naa?

Beeni Beeko

UNIVERSITY OF IBADAN LIBRARY

**IWE TTONISONA FUN IJIRORO LORI AWON OKUNFA GBIGBESE LATI JE OMUSIGA
LAARIN AWON OMOKUNRIN TI N KO ISE OWO NI AGBEGBE IJOBA
IBILE ARIWA-IWO OORUN IBADAN, IPINLE OYO**

E ku deede iwoyi o. Oruko mi ni oniko enikeji mi

ni wa lati eka ti n kopa nipa ilosiwaju ati imo nipa ilera ara ilu, ti
ile iwe giga ilu Ibadan

Gbigbe iwadi yi kale ni lati se ofintoto awon okunfa gbigbese lati je omusiga laarin awon
omokunrin ti n ko ise owo ni agbegbe ijoba ipinle Ariwa-Iwo oorun Ibadan, Ipinle Oyo. Kikopa
ti e fe kopa ninu ijiroro yi yoo mu ki o le ye wa ni kikun awon obun ti o n fa erongba lati mu
siga, ipinnu lati mu siga, ati itesiwaju lati ma mu siga laarin awon omo eko se ni ijoba ibiler yii.
E jowo, mo fe ki e mo wipe kikopa yin ninu iwadi yii je eyi to gbodo ti okan yin wa, eyi tumo si
wipe e le gba lati kopa, tabi ki e ko lati kopa, atii wipe ko si idahun ti ko wulo. Siwaju sii, bi e ba
gba wa laye, o wun wa lati gba ohun yin sile lati ni daju wipe a le ni atunyawo ohun ti a ba so nibi
bi a ba gbagbe ohunkohun ninu idahun yin

E xun pupo

N je e fe lati kopa?

Bee ni Bee ko

Adeoye A Adeolu

Adeoyeadeolu48@yahoo.com

08033870564

Onka
Onko Olufi orowanlenuwo
Oruko agbegbe

SN	IBEERE	AFIKUN IBEERE
1	Ki ni e ri si iwa siga mimu laarin awon omo ti o n ko ise owo ni agbegbe yi ?	Kin ni e lero wipe o fa a ti awon omo ekose ti n hu inu iwa bee ?
2	Awon okunfa wo le lero wipe o le je ki awon omo ekose ti ko mu siga ri tele le bere erongba lati mu un ?	N je siga mimu maa n si kun gbi gbajunwo eni ni awujo ? N je siga mimu je apcere sise onire ? Awon ituyin wo ni o seese ti awon omo ekose ti gbo. tabi si oju ni, ti o faa ti won si n mu siga ?
3	Awon okunfa wo le lero wipe o le je ki awon omo ekose bere siga mimu ?	N je awon ore labi egbe kiko ni ? N je awon Obi, tabi ara-ile ni ? N je Oga ni ibi ise ni ? N je ipolowo lorisirisi oaa ni ? N je iye owo siga li ko won rara ni ?
4	Ki ni awon okunfa ti o le je ki omo ekose ti o n mu siga tun bo tera mo siga mimu ?	N je nitori siga ko won rara lati ra ni ? N je awon ipolowo ni o n ran won lowo ni ? N je won n n siga ofe gba nibi ajeye ipolowo ni ? N je won n ni ohun kan gba ninu siga mimu ni? Fun apcere, boya o maa n je ki ori won pe pupo? Tabi o maa n je ki ara won bale pupo ?
5	N je e lero wipe siga mimu laarin awon odo omokunrin, paapa julo, awon ti n ko ise owo, je atoka wahala ailera ti o ye ki a mu ojuto laarin awujo ?	Ba wo ni e lero wipe siga mimu laarin awon omo ekose se wopo si? Bi a ba ko omo ekose mewa sile, melo iunu won ni e lero wipe o seese ko maa mu siga ?

TELEGRAMS.....

TELEPHONE.....



MINISTRY OF HEALTH
DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION
PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No.
All ~~communications~~ should be addressed to
the Honorable ~~Minister~~ ~~of Health~~
Our Ref. No. AD 12/ 479/ 230

March, 2015

The Principal Investigator,
Department of Health Promotion and Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Ibadan.

Attention: Adeyemi Adesola
Ethical Approval for the Implementation of your Research Proposal in Oyo State

This acknowledges the receipt of the corrected version of your Research Proposal titled:
"Factors Influencing the Adoption of Cigarette Smoking Habit among Artisan Male
Apprentices in Ibadan North West Local Government Area, Oyo State."

2. The committee has noted your compliance with all the ethical concerns raised in
the initial review of the proposal. In the light of this, I am pleased to convey to you the
approval of committee for the implementation of the Research Proposal in Oyo State,
Nigeria.

3. Please note that the committee will monitor closely and follow up the
implementation of the research study. However, the Ministry of Health would like to
have a copy of the results and conclusions of the findings as this will help in policy
making in the health sector.

4. Wishing you all the best.

Signature & Date
Sola Akande (Dr)
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethical Review Committee