<table>
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<tr>
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<th>A comprehensive study of smoking in primary school children in Hong Kong: Implications for prevention</th>
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<tr>
<td><strong>Author(s)</strong></td>
<td>Peters, J; Hedley, AJ; Lam, TH; Betson, CL; Wong, CM</td>
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A comprehensive study of smoking in primary school children in Hong Kong: implications for prevention

Jean Peters, Anthony Johnson Hedley, Tai-Hing Lam, Carol Lane Betson, Chit-Ming Wong

Abstract
Study objective—To identify factors associated with smoking behaviour in primary school children in Hong Kong.
Design—A cross sectional survey in which both children and parents completed questionnaires. The main outcome measure was the smoking status of the children; and risk factors (knowledge of and attitude to smoking and demographic and socioeconomic background) were identified as predictors of ever/never smoking.
Setting and subjects—Altogether 9598 primary school children, aged 8–13 years, and attending 27 schools from two districts in Hong Kong participated.
Main results—The prevalence of ever-smoking was 12% (1119) —15% (760) in boys and 7% (359) in girls. It ranged from 3% in 8 year old girls to 52% in 13 year old boys. The factors associated with ever-smoking included the following: being a boy (adjusted odds ratio 2.21; 95% confidence interval 1.89, 2.59), increasing age per year (1.48; 1.40, 1.57), living in Kowloon district (1.29; 1.10, 1.50), having one or more smokers at home (2.07; 1.78, 2.39), and having a father who was not working (1.41; 1.19, 1.67). Children who were ever-smokers had both seen and approved of their friends’ smoking (8.79; 5.33, 14.50), had a more positive attitude towards smoking (3.35; 2.21, 5.09), and were more successful in recognising cigarette brand names and logos (1.67; 1.42, 1.96), but they lacked confidence (1.78; 1.32, 2.39).
Conclusions—The influences on child smoking are multifactorial and programmes in Hong Kong are failing to curb them. The control of these risk factors must be incorporated in the smoking prevention policy of Hong Kong and supported by future enforced legislation.

Department of Community Medicine, The University of Hong Kong, Patrick Manson Building, South Wing, 7 Sassoon Road, Hong Kong
J Peters
A J Hedley
T-H Lam
C L Betson
C-M Wong
Correspondence to: Professor A J Hedley
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The overall prevalence of smoking in the Hong Kong population is relatively low at 29% for men and 3% for women, but levels of smoking among young people, and young women in particular, are higher and increasing. Although the health risks of smoking, both active and passive, are well documented, and smoking is the single most preventable cause of death in Hong Kong, children do not seem to perceive future health risks as relevant to their current smoking behaviour.

With current targets to reduce smoking in children unlikely to be met in England, for example, this may be an appropriate time to re-examine the multiple factors associated with smoking in children. It has long been recognised in the west and more recently in South East Asia that the smoking behaviour of children is influenced or even condoned in some instances, by other family members, and by aggressive marketing activities of the transnational tobacco companies. The tobacco industry denies that its products are targeted at children, although in the Asia-Pacific rim marketing is aggressive, especially pitched at young people, and includes the cartoon image of Joe Camel which has been successfully identified as a cigarette logo by children as young as 3 years of age.

Public health authorities have little information on the knowledge of health risks, and attitude towards and practices of smoking in Hong Kong primary school children. In studies of secondary school children the smoking prevalence varied from 18%–33%. In the only previous study of primary school children, 8% declared they had smoking experience. This study aims to identify the social, demographic, and environmental factors among primary school children in Hong Kong that are associated with smoking experience and may contribute to the children’s decision to become regular smokers. The acceptability and acceptability of smoking prevention programmes in Hong Kong depends upon identifying these factors and then ensuring that they are addressed when smoking prevention policies are developed.

Methods
CHILDREN AND PARENTS
A four year study, commencing in 1989, was carried out to examine respiratory health and smoking behaviour in children attending primary classes three and four (aged 8–10 years) in 17 schools in two districts of Hong Kong. These districts were Kowloon (a heavily industrialised and densely populated area) and Southern (predominantly residential). The original selection of districts was based on the differences in air quality. The principal criterion for selection of schools in Kowloon was that they should be located in a subdistrict with poor air quality as rated by local officials and
the Government Environmental Protection Department. In Southern district, because of its better air quality, all schools were situated in areas of low air pollution. The initial decision to recruit from classes primary three and four was based on the requirement for children whose lungs would be responsive to respiratory insult but who were also capable of filling in a questionnaire with little help and were less likely to have smoked. Details of the initial study design, the selection of schools and classes in 1989, and any sociodemographic differences between the two districts have been reported elsewhere. In the third year of the study, the original cohort, now in primary five and six (aged 11–13 years) were re-examined along with children currently in primary three and four. The study population was also extended with the recruitment of primary three and four children from an additional 10 schools situated in the same two districts and close to schools already participating in the study. This paper reports on the third year results.

**Questionnaires**

Questionnaires written in Chinese were completed by both the children and their parents. Questions asking about the children’s respiratory symptoms were taken and translated from internationally recognised standard questionnaires and were repeated on both the parents’ and children’s questionnaires. In addition, the children’s questionnaire included questions on smoking: their smoking practice; smoking by family members in the child’s home; source of cigarettes; age at first smoking; and number of cigarettes smoked per day. Other questions examined knowledge of smoking and health; recognition of a selection of heavily advertised and popular brand names and logos, including tobacco brands, and the child’s attitude to smoking.

The parents’ questionnaire contained questions on: their own smoking history and current smoking status; smoking practice of others living in the family home; their opinion on children smoking; own educational attainment; housing type and size; current employment status; and occupation, given a list of options compiled from Hong Kong census guidelines.

Parents’ questionnaires were sent home and returned to the school in a sealed envelope. Children’s questionnaires were completed in the classroom, supervised by trained research workers with no teachers present. The questionnaires were checked by the research team before leaving the school and any ambiguities or missing answers were followed up with the child concerned.

**Analysis**

The child’s smoking status was determined from a positive answer to one of six questions as follows: have never smoked; tried smoking a few times; used to smoke, but do not now; smoke sometimes, but less than 1 cigarette per week; smoke 1–6 cigarettes per week; smoke more than 6 cigarettes per week? A positive answer to the first question defined a child as a never-smoker. All those who answered any of the other five questions positively were considered ever-smokers.

Eight new summary variables were compiled as aggregates of answers to groups of variables, the individual variable answers being treated as binary responses and coded as 1 for “correct” or “yes” and 0 for all alternatives.

**Knowledge**

Responses to eight questions on knowledge related to smoking and health, eg “smoking makes it difficult for you to breathe” (table 3). Answer options were “true”, “false”, and “don’t know”.

**Attitude**

Responses to eight statements on smoking; eg “smoking is fun” (table 3). Answer options were “yes”, “no”, and “don’t know”.

**Confidence**

Responses to four questions on how confident children felt: in their school work, in sports, with friends, and in themselves. Answers were categorised from a five point scale into positive (“very confident”, “confident” or “fairly confident”) coded 0 and negative responses (“no” or “very poor confidence”) coded 1 (table 3).

**Family smoking**

Responses to four questions relating to those who smoked and lived in the child’s home, given as: mother, father, siblings, others. Responses were coded as the presence of “none”, “one”, or “two or more” of these smoker categories.

**Parental influence**

The sum of responses by the child (coded 1 for negative answers and 0 for positive) to the two questions “Would your mother (father) interfere if you smoked?” and dichotomised

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**KEY POINTS**

- Recruitment of children to smoking is strongly associated with an environment in which the social acceptability of smoking is vigorously promoted.
- Tobacco advertising using images that young people find attractive is the most dominant factor overall.
- The tobacco industry is targeting children in Hong Kong and the Asia Pacific region and is funding campaigns to fight tobacco controls in both Hong Kong and mainland China.
- From a public health perspective enacting comprehensive legislation on advertising and sponsorship must be a priority for the new Special Administrative Region of Hong Kong.
Table 1: Population studied and smoking status in relation to age and sex in Hong Kong children

<table>
<thead>
<tr>
<th>Age (y)</th>
<th>Population studied</th>
<th>Prevalence of ever-smokers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys (%)</td>
<td>Girls (%)</td>
</tr>
<tr>
<td>8</td>
<td>810 (16)</td>
<td>825 (18)</td>
</tr>
<tr>
<td>9</td>
<td>1525 (27)</td>
<td>1414 (30)</td>
</tr>
<tr>
<td>10</td>
<td>1160 (23)</td>
<td>1129 (24)</td>
</tr>
<tr>
<td>11</td>
<td>976 (20)</td>
<td>800 (17)</td>
</tr>
<tr>
<td>12</td>
<td>524 (11)</td>
<td>417 (9)</td>
</tr>
<tr>
<td>≥13</td>
<td>150 (3)</td>
<td>88 (2)</td>
</tr>
<tr>
<td>Total</td>
<td>4925 (100)</td>
<td>4672 (100)</td>
</tr>
</tbody>
</table>

into 1 (two negative responses) compared with 0 (one or no negative responses).

Teacher influence
The sum of responses to the questions; “Do you think a teacher would interfere if you smoked?” (negative responses coded as 1, positive as 0) and; “Have you seen a teacher smoke?” (positive responses coded as 1, negative as 0). Answers were dichotomised into 1 (for a response total of 3) and 0 (for all other total response options).

Peer influence
The sum of responses (positive coded as 1, negative as 0) to the two questions; “Have you seen your classmates smoke?” and “Do you consider it acceptable for your classmates to smoke?” with the total dichotomised into 1 (two positive answers) and 0 (one or no positive answers).

Brand recognition
Successful recognition of 13 brand names and logos as one of four categories, given the following five options for answers: “Food”, “drink”, “cigarettes”, “other”, and “don’t know”. The brand names and logos included in the questionnaire were as follows:

- **Food**: McDonald’s (logo), Cadbury (name), Garden bakery (logo),
- **Drink**: Carlsberg (logo and name), Martell (name), Coca Cola (logo),
- **Cigarette**: Salem (logo and name), Marlboro (logo and name),
- **Other**: Colgate (logo and name).

All analyses were carried out using SPSS/PCA.0. The completion rate for all questions on the children’s questionnaire was 99% or higher with the exception of the question relating to the recognition of the McDonald’s logo. This question caused confusion in the children as it could be answered in three of the five categories and 5% gave no answer. Responses with missing data were excluded from relevant scores.

Crude prevalence ratios and 95% confidence intervals (CI) were calculated. Differences were examined between the children who were never and ever-smokers for demographic, social, and environmental factors and smoking behaviour using t tests and χ² tests as applicable. The association between potential independent factors and child smoking was examined by calculating the odds ratios (OR) with 95% CI. The scores from the eight computed variables were examined for association with smoking behaviour by inclusion in a logistic regression model together with age, sex, attained parental education level (no formal education compared with primary, lower, upper or post secondary), parental occupational status (not in work compared with working), housing type (public housing compared with all other) and district of residence (Kwai Tsing compared with Southern). The adjusted OR (95% CI) were determined for all these factors. The final logistic regression model included all variables significant at p<0.05.

**Results**
**Response rate and demography**
Responses from schools (100%) and parents (96%) were good. A total of 9657 children completed questionnaires—over 98% of the total study population. There were no refusals and the only questionnaires missing were from the 119 children absent from school on the day of the fieldwork. The final data set consisted of 9598 children who answered the question on their smoking status (table 1).

There were no differences between the two districts in gender mix ($\chi^2 = 1.27$, p = 0.26) or age ($t = -1.22$, p = 0.22). The children living in Southern district had a mean age of 10.3 years (95% CI 10.3, 10.4), and those in Kwai Tsing had a mean age of 10.4 years (10.3, 10.4). Boys (10.4 (10.4, 10.5) years) were slightly older than the girls (10.3 years (10.2, 10.3) ($t = -5.99$, p<0.001))

**Smoking practice**
Twelve percent (1119) of the children—15% boys (760) and 7% girls (359)—declared they had smoking experience. Ever-smokers were on average older (mean age 11.1 (11.0, 11.2) years) than never smokers (10.2 (10.2, 10.3) years) ($t = -20.64$, p<0.001). Boys who smoked were older (mean age 11.2 (11.1, 11.3) years) than smoking girls (10.9 (10.7, 11.0) years) ($t = 3.22$, p<0.001) and smoking prevalence increased with age (table 1).

Ever-smokers started smoking, on average, at 7.8 (7.6, 7.9) years, with no differences between girls and boys ($t = -0.26$, p = 0.79) and overall they had smoked 0.5 (0.4, 0.6) cigarettes in the last 24 hours. For those 230 children who claimed to have smoked at least one cigarette since yesterday, the mean number smoked was 2.1 (1.8, 2.5), with no differences between girls and boys.

The ever-smoking children bought their cigarettes from a number of outlets, mainly shops (table 2). There were no differences by sex for place of purchase with the exception of supermarkets (OR = 1.61; 95% CI 1.17, 2.20). Other than purchase, these children obtained cigarettes from friends and family, with fathers being the biggest providers (table 2).
Table 2 Source of cigarettes for ever-smokers

<table>
<thead>
<tr>
<th>Source</th>
<th>Boys (n=759)</th>
<th>Girls (n=368)</th>
<th>Total (n=1167)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Purchased from:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shops</td>
<td>44</td>
<td>45</td>
<td>44</td>
</tr>
<tr>
<td>Supermarkets</td>
<td>30</td>
<td>21</td>
<td>27</td>
</tr>
<tr>
<td>Stalls</td>
<td>26</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Others</td>
<td>27</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Acquired from:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Father</td>
<td>19</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>Elder siblings</td>
<td>6</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Younger siblings</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Grandparents</td>
<td>9</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Relatives</td>
<td>17</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Classmates</td>
<td>12</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Friends</td>
<td>18</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Others</td>
<td>15</td>
<td>11</td>
<td>14</td>
</tr>
</tbody>
</table>

Note: Percentages do not add up to 100% as more than one answer may be given.

KNOWLEDGE, ATTITUDE, AND CONFIDENCE

Nine per cent (796) answered all eight knowledge questions correctly. The mean score was 5.5 (5.4, 5.5) with no differences between the ever and never-smoking children ($t = -0.32$, $p = 0.75$). Responses to individual knowledge and attitude questions in relation to child smoking status are given in table 3 and show ever-smokers as having a more positive attitude towards smoking with the exception of “Smoking is a waste of money.” Ever-smokers had less confidence than never-smokers in their schoolwork, with friends, and in themselves but there were no differences for sport (table 3).

Differences in the children’s level of knowledge of the health risks of smoking, attitude towards smoking, and lack of confidence in relation to age and sex are shown in table 4. Significant improvements in knowledge occur with increasing age in both sexes and there are considerable differences between boys and girls, with the boys having the better knowledge in every case except for smoking causing dandruff, where the girls were better informed. In general, the overall level of knowledge was good and the children were well aware of health risks such as smoking causes lung problems and cancer. In contrast, for attitude, there were fewer differences across the age groups. There was increased agreement with the view that smoking is “for showing off” and “a waste of money”, and for the girls only, with increasing age, reduced numbers were of the opinion that smoking makes you “look tough”, “feel grown-up” and “gives you confidence”. For every statistically significant difference in response between the sexes in the attitude questions, a higher proportion of boys gave the answer “yes”. Lack of confidence in schoolwork, sport, and with friends increased with age for the girls but not for the boys. Overall boys were less confident in their schoolwork and girls in sport.

SOCIAL AND ENVIRONMENTAL FACTORS

About 40% of the children, both the ever and never-smokers, lived in public housing with 55% (584) of the ever-smoking children living in Kwai Tsing and 45% (484) in Southern district.

The ever-smoking children tended to have mothers who were out of the house at work, but whose fathers were unemployed (table 5). There were also differences in the type of job done with a higher proportion of mothers of the ever-smoking children working in manufacturing and sales and fewer in professional and clerical jobs ($\chi^2 = 35.9, p < 0.001$). For fathers, although there were differences in relation to occupation ($\chi^2 = 12.7, p < 0.05$), the pattern was less clear cut.

Eighteen per cent of the ever-smoking children compared with 14% of the never-smokers had mothers who had received no formal education (table 5).

Thirty-three per cent (3164) of the children lived in a family with one smoker category and 10% (922) with two or more. There were strong associations between the children’s smoking experience and smoking by other household members: mother (OR = 3.26; 95% CI 2.49, 4.26); father (1.70; 1.49, 1.93); siblings (4.92; 4.05, 5.98); others (1.53; 1.29, 1.82).

One per cent (79) of parents had no objection to their child smoking—this proportion was 3% in the smoking and 0.7% in the non-smoking parents (OR = 3.86; 95% CI 2.43, 6.12). The ever-smoking children were more likely to believe that neither their parents or their teachers would interfere if they smoked and to have seen both their classmates and teachers smoke, and consider it acceptable for them to do so (table 5).

Differences related to the children’s age and sex in these opinions reflect the different patterns of smoking seen in the two sexes. A higher proportion of boys claimed that their parents would not interfere if they smoked, that they had both seen their classmates and teachers smoke, and considered it acceptable for them to do so. Both sexes showed significant changes in opinion with age, with the exception of the girls’ opinion that their parents would not interfere if they smoked (table 4).

Table 3 Knowledge of health risks, attitude to smoking, and confidence in relation to the smoking status of the child

<table>
<thead>
<tr>
<th>Question</th>
<th>Ever-smoker (n=1056-1065)</th>
<th>Never-smoker (n=8470-8517)</th>
<th>OR (95% CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge: % answering correctly Smoking causes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathing difficulties</td>
<td>64</td>
<td>69</td>
<td>0.80 (0.70, 0.92)</td>
<td>0.001</td>
</tr>
<tr>
<td>Coughing</td>
<td>76</td>
<td>77</td>
<td>0.96 (0.85, 1.12)</td>
<td>0.64</td>
</tr>
<tr>
<td>Dandruff</td>
<td>64</td>
<td>86</td>
<td>0.92 (0.80, 1.05)</td>
<td>0.15</td>
</tr>
<tr>
<td>Lung problems</td>
<td>92</td>
<td>89</td>
<td>1.40 (1.11, 1.76)</td>
<td>0.004</td>
</tr>
<tr>
<td>Heart problems</td>
<td>58</td>
<td>57</td>
<td>1.05 (0.92, 1.19)</td>
<td>0.49</td>
</tr>
<tr>
<td>Cancers</td>
<td>82</td>
<td>80</td>
<td>1.17 (0.99, 1.38)</td>
<td>0.08</td>
</tr>
<tr>
<td>Colds</td>
<td>29</td>
<td>28</td>
<td>1.02 (0.88, 1.18)</td>
<td>0.82</td>
</tr>
<tr>
<td>Addiction</td>
<td>83</td>
<td>81</td>
<td>1.08 (0.92, 1.28)</td>
<td>0.38</td>
</tr>
<tr>
<td>Attitude: % answering yes Smoking:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It fun</td>
<td>6</td>
<td>2</td>
<td>4.23 (3.11, 5.76)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Calms your nerves</td>
<td>14</td>
<td>8</td>
<td>2.19 (1.83, 2.62)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Makes you look tough</td>
<td>7</td>
<td>4</td>
<td>1.95 (1.49, 2.53)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>In a waste of money</td>
<td>86</td>
<td>86</td>
<td>1.02 (0.85, 1.22)</td>
<td>0.89</td>
</tr>
<tr>
<td>Makes you feel mature</td>
<td>8</td>
<td>3</td>
<td>2.41 (1.88, 3.10)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Gives you confidence</td>
<td>5</td>
<td>2</td>
<td>2.53 (1.81, 3.52)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Is for showing off</td>
<td>17</td>
<td>8</td>
<td>2.55 (1.85, 3.53)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Makes you lose weight</td>
<td>9</td>
<td>4</td>
<td>2.49 (1.79, 3.47)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Confidence: % answering no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have confidence</td>
<td>13</td>
<td>6</td>
<td>2.45 (2.01, 2.99)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>In schoolwork</td>
<td>7</td>
<td>4</td>
<td>1.16 (0.91, 1.49)</td>
<td>0.27</td>
</tr>
<tr>
<td>With friends</td>
<td>6</td>
<td>4</td>
<td>1.60 (1.22, 2.11)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>In self</td>
<td>9</td>
<td>4</td>
<td>2.27 (1.78, 2.88)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
Table 4 Percentage response to questions on knowledge, attitude, opinion, and confidence in relation to age and sex

<table>
<thead>
<tr>
<th>Age (y)</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p (age)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Knowledge: % answering correctly to smoking cause:

- Breathing difficulties: 67.3, 68.1, 70.6, 71.8, 69.0, 0.028
- Coughing: 69.2, 75.6, 77.7, 80.7, 76, <0.001
- Dandruff: 68.1, 67.5, 64.1, 60.5, 57.3, <0.01
- Lung problems: 84.7, 88.2, 91.9, 94.3, 92.4, <0.001
- Heart problems: 58.8, 55.5, 59.4, 65.7, 67.2, <0.001
- Cancer: 73.4, 80.0, 85.5, 88.3, 89.6, <0.001
- Colds: 33.7, 33.3, 28.4, 26.9, 27.9, 0.003
- Addiction: 76.8, 82.2, 80.0, 86.7, 84.0, <0.001

Attitude: % saying "yes" to smoking:

- Is fun: 2.3, 2.5, 2.7, 1.7, 1.9, NS
- Calms your nerves: 11.3, 11.4, 10.9, 11.3, 10.9, NS
- Makes you look tough: 5.4, 4.5, 3.8, 3.9, 4.6, NS
- Is a waste of money: 81.9, 85.8, 87.2, 90.0, 89.0, <0.001
- Makes you feel mature: 5.9, 4.4, 4.4, 4.2, 3.4, NS
- Gives you confidence: 2.1, 3.0, 2.5, 1.7, 2.5, NS
- For showing off: 6.0, 9.1, 9.4, 14.6, 14.1, <0.001
- Makes you lose weight: 2.1, 2.3, 3.4, 3.0, 2.1, NS

Opinion: % saying for smoking:

- Father interferes (n): 5.1, 3.6, 2.4, 1.5, 2.3, <0.001
- Mother interferes (n): 4.2, 2.8, 1.7, 1.4, 1.7, <0.001
- Teacher interferes (n): 6.0, 4.8, 3.6, 3.1, 3.2, 0.003
- Seen teachers (n): 2.7, 4.8, 7.0, 9.1, 11.2, >0.05
- Seen classmates (n): 1.5, 3.5, 1.5, 16.5, 27.9, <0.001
- OK for teacher (n): 6.6, 12.9, 17.1, 21.0, 14.1, <0.001
- OK for classmates (n): 1.5, 2.2, 5.1, 8.2, 10.6, <0.001

Confidence: % answering no confidence:

- In schoolwork: 6.1, 6.9, 8.7, 7.7, 8.7, NS
- In sports: 6.0, 4.3, 5.7, 6.9, 6.5, NS
- With friends: 4.9, 4.6, 4.1, 3.8, 3.8, NS
- In self: 5.3, 5.1, 4.5, 4.2, 4.8, NS

Note: children aged 13 and over excluded from the table because of small subject numbers but not from the statistical analysis; (n) = no, (y) = yes, ns = not significant p>0.05.

Table 5 Factors associated with smoking behaviour

<table>
<thead>
<tr>
<th>Factor</th>
<th>Ever-smoker (n=1022-1066)</th>
<th>Never-smoker (n=8021-8530)</th>
<th>Grade OR (95% CI)</th>
<th>Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td>71</td>
<td>49</td>
<td>2.58 (2.25, 2.97)</td>
<td>2.21 (1.89, 2.59)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>1.48 (1.40, 1.57)</td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td>122</td>
<td>76</td>
<td>1.00 (0.86, 1.16)</td>
<td>0.96 (0.84, 1.10)</td>
</tr>
<tr>
<td>Correct attitude</td>
<td>122</td>
<td>76</td>
<td>0.70 (0.51, 1.00)</td>
<td>0.67 (0.43, 1.07)</td>
</tr>
<tr>
<td>Confidence</td>
<td>122</td>
<td>76</td>
<td>2.03 (1.74, 2.37)</td>
<td>1.33 (1.13, 1.57)</td>
</tr>
<tr>
<td>District</td>
<td>122</td>
<td>76</td>
<td>1.31 (1.15, 1.49)</td>
<td>1.29 (1.10, 1.50)</td>
</tr>
<tr>
<td>Housing</td>
<td>122</td>
<td>76</td>
<td>0.96 (0.84, 1.10)</td>
<td>0.92 (0.79, 1.08)</td>
</tr>
<tr>
<td>No employment</td>
<td>122</td>
<td>76</td>
<td>1.64 (1.25, 2.14)</td>
<td>1.41 (1.19, 1.67)</td>
</tr>
<tr>
<td>No formal education</td>
<td>122</td>
<td>76</td>
<td>1.27 (1.06, 1.52)</td>
<td>1.23 (1.02, 1.49)</td>
</tr>
<tr>
<td>Family smoking</td>
<td>122</td>
<td>76</td>
<td>2.36 (1.96, 2.85)</td>
<td>2.14 (1.76, 2.61)</td>
</tr>
<tr>
<td>Parental</td>
<td>122</td>
<td>76</td>
<td>1.71 (1.50, 1.94)</td>
<td>1.67 (1.42, 1.96)</td>
</tr>
<tr>
<td>Brand</td>
<td>122</td>
<td>76</td>
<td>5.80 (4.98, 6.77)</td>
<td>5.73 (4.93, 6.65)</td>
</tr>
<tr>
<td>Food</td>
<td>122</td>
<td>76</td>
<td>0.94 (0.81, 1.08)</td>
<td>0.91 (0.78, 1.07)</td>
</tr>
<tr>
<td>Drink</td>
<td>122</td>
<td>76</td>
<td>2.48 (2.17, 2.83)</td>
<td>2.46 (2.15, 2.87)</td>
</tr>
</tbody>
</table>

BRAND RECOGNITION
The ever-smoking children were more successful in recognising cigarette brand names and logos than the never-smokers (table 5). Twenty eight per cent of 8 year old children recognised all four tobacco-related names and logos correctly, and success increased with age to 72% in 13 year olds. Out of all the 13 brand names and logos given, the two most successfully identified (both 95% correct) were the Salem logo and Marlboro name.

ESTIMATED ADJUSTED ODDS RATIOS
Logistic regression analysis resulted in nine factors remaining as significant predictors of smoking behaviour with correct prediction of 89% of these children as ever or never-smokers. Compared with the never-smokers, the ever-smokers tended to be boys and to live in a smoking family. They had, and approved of, friends who smoked, had a positive attitude to smoking, and could recognise cigarette brands more successfully, although they were equally successful at recognising other brands. These ever-smokers, although more likely to be older, had less confidence, lived in the mixed industrial residential urban area of Kwai Tsing, and had a father currently unemployed. The adjusted OR and 95% CI for these nine risk factors are given in table 5. In terms of the relative importance of the background factors, likelihood ratio tests for each variable included and not included in the logistic model showed that district (\( \chi^2 = 12.18, df = 3, P < 0.001 \)), father not working (\( \chi^2 = 16.29, df = 1, P < 0.001 \)) and to lesser extent, mother working (\( \chi^2 = 3.97, df = 1, P < 0.05 \)) made a significant impact on
the prediction of a child as an ever-smoker but parental education and housing seemed less important and were non-significant (p>0.05).

Discussion

Factors associated with childhood experimentation with smoking, although well documented in the west have not been fully explored in Hong Kong and other areas of the Asia Pacific region. This study, the first in Hong Kong to model such a comprehensive range of potentially influencing factors, indicates that Hong Kong children are experimenting with smoking from a very early age. By the age of 12, one in five has tried smoking, and a clear increasing trend in ever-smoking prevalence is evident in Hong Kong primary school children aged 8 through to secondary school children aged 15.12,21,22

Although these responses have not been validated with cotinine studies, validity can be inferred from the consistency found in the estimated excess risks in child smokers, of cough, wheeze, and phlegm over the four years of this study,24-28 and the high level of agreement between parental and children's responses on questions relating to smoking practice. Personal reporting of smoking behaviour has also been shown to be reliable.51

While socioeconomic factors, measured by housing type, education and occupation, appear to have less of an influence in Hong Kong than in other countries9,10,32 these ever-smoking children were more likely to have an unemployed father in a territory where, at the time of the survey, employment was higher than 98%.33 Family influence remains important in Hong Kong11,12 as in other countries.6,9,10,13 These children were found to be twice as likely to smoke if they lived in a home where one or more members of the family household smoked and, in some instances, family members were prepared to provide them with the cigarettes.

Fathers gave cigarettes to one fifth of the child smokers in this study. Outside of the family, peer pressure was found to be a major influential factor in this study as elsewhere.8-14 Evidence of an influential role by teachers is limited,14 and we found no association between the child's opinions of their teachers smoking and their own practice after adjustment for other influential factors. However, as role models with credibility from a child's viewpoint, parents and teachers both have an opportunity to influence acceptance of the "no smoking" message by not smoking themselves. Such action would not only provide a healthy role model but also lead to a reduction in passive smoking, a health hazard in its own right5 and a greater risk for children's respiratory problems in the Territory than ambient air pollution.24-26

It is essential that initiatives to tackle child smoking include promotion of negative attitudes to smoking in adults.

The ever-smoking children in this study, as elsewhere,10 believe that smoking is fun and makes you look grown up, images which some children perceive as portrayed by cigarette advertisements.15 Even though ever-smoking children are more successful in identifying advertised tobacco brand names and logos, non-smokers are not unsuccessful.29,35 In Hong Kong the tobacco industry continues to use advertisements targeted at children17,20 and sponsorship of sports and cultural events regarded as exciting and glamorous by young children; this is a major obstacle for smoking prevention programmes to overcome. Despite a partial ban on tobacco advertising, children's exposure to tobacco advertisements in Hong Kong, as elsewhere, is not prevented nor is their subsequent ability to recall them limited.20,23 A total ban on advertising is needed, including sponsorship by the tobacco industry of cultural and sporting events. There is evidence that such bans can work,37 and Hong Kong residents, including smokers, have consistently expressed support for such bans over the last seven years.38-40 Fiscal measures, such as hypothecated taxes, which have been successfully implemented in Australia,41 are unlikely to directly dissuade children from smoking. But the use of such revenue, not only to fund health care services and health promotion but also sponsorship of sports and cultural events, at least removes the tobacco industry's advertising impact from such events. Legislation introduced since this survey was completed has banned sales of tobacco products to those below 18 years but rigorous enforcement will be necessary as children in this study aged 8-12 years were able to purchase cigarettes.

Changing intentions to smoke needs to start in the classroom with specifically trained teachers and a spiral curriculum suitably structured to cater for the significant development seen in children's knowledge, attitude, opinions, and confidence with increasing age and the wide diversity occurring in some instances between the sexes, as demonstrated in this study. Educational programmes need to focus on encouraging a sense of internal control in the children, rather than external prohibition, as this is more effective in helping children to resist temptations. Improving knowledge levels alone is not enough as we found these to be reasonable in both our never and ever-smoking children. Programmes need to include "inoculation" against tobacco advertising, the boosting of self confidence, and development of refusal skills for children to resist the influence and pressure, real or apparent, of peers and family. Resistance to temptation to smoke can be increased in children by labelling them as "able" in resisting temptation, thereby contributing to their greater sense of self efficacy.43 Evidence shows that smokers rate smoking benefits as greater, and costs as less, than non-smokers.44 The intention to smoke is, therefore, amongst other things, a function of the person's positive or negative evaluation of smoking and their perception of whether any referents, such as peers (as is demonstrated very clearly in this study), approve or disapprove of smoking.44 So anti-smoking education programmes need to focus on attitudes towards smoking. More particularly, concentrating on increasing the children's sense of their own effectiveness, both in being socially effective without cigarettes and...
in resisting temptation to adopt indulgent be-

haviours generally, and towards tobacco, spe-
cifically. Tobacco advertising can increase
social discontent among young people by gen-
erating or strengthening desires for promoted
products.43 so sustained media campaigns to
deglamourise smoking behaviour need to be
run in tandem with anti-smoking promotions
in schools and elsewhere. Such programmes
must begin at primary school level as children
with a smoking history by 9 years of age are
more likely to still be smokers at 13.46

The problem is not unique to Hong Kong
and the Hong Kong Government needs to learn
from the efforts of other countries. It needs to
target sets, as in other countries,3 for a reduction
in smoking prevalence with special attention to
specific high risk groups, such as children. In
conjunction with this it needs to provide an
adequately resourced unified approach through
legislation, education, ongoing monitoring, and
evaluation. This study indicates that smoking
is a paediatric problem in Hong Kong and that
in primary school children it is associated with
marked respiratory illness effects.24-26 There
is a need to act now if we wish to reduce, or
even contain, the predicted levels of mortality
and morbidity from tobacco related diseases
into the next century.4

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