Status of shisha and *kuber* use in Kenya

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Introduction

Every year, the use of tobacco products causes a heavy toll of deaths and severe human diseases worldwide. The number of deaths per year due to tobacco related diseases is about 5 million (WHO, 2007). Tobacco use and exposure comes in both smokeless and smoking forms. Smokeless tobacco is consumed in un-burnt forms through chewing or sniffing and contains several carcinogenic, or cancer-causing, compounds. Smokeless tobacco has been associated with oral cancer, hypertension, heart disease and other conditions. Smoking tobacco, by far the most commonly used form globally, contains over 4,000 chemicals, of which 50 are known to be carcinogenic (WHO, 2011).

In Kenya, the current use of tobacco among the population aged 15-65 years stands at 9.1%. Cigarette smoking is the most common form of tobacco in Kenya with 8.6% of the population being current users. Other commonly used forms include sniffed/ chewed tobacco (0.7%), kuber (0.3%) and shisha (0.2%). Statistics also show that 4.5% or approximately 900,000 of the population between 15-65 years are dependent on tobacco use (NACADA, 2012).

Non communicable diseases (NCDs) kill more than 36 million people each year. In terms of attributable deaths, the leading NCD risk factor globally is raised blood pressure followed by tobacco use (9%). In light of these challenges and given the increasing consumption of tobacco, particularly among the youth, and the emerging tobacco products like shisha and kuber, the study sought to assess the status of shisha and *kuber* use in Kenya. Further, the survey sought to collect random samples of shisha, *kuber* and smokeless tobacco for analysis of heroin, cocaine, marijuana and amphetamine contamination.

Methodology

A cross-sectional survey design was conducted covering the eight regions of Kenya namely; Nairobi, Central, Eastern, North Eastern, Rift Valley, Nyanza, Western and Coast. The survey primarily relied on non-probability sampling methods. A total of 17 counties and 21 sub-Counties were covered in the survey. From each sub-County, one location was randomly selected. The Focus Group Discussions (FGDs) were held at the sub-location level and participants were youth currently using shisha, *kuber* or any form of smokeless tobacco. The individual responses from the FGDs were captured both electronically by use of a digital tape recorder and in writing.

Sampling of shisha and kuber and other forms of smokeless tobacco was conducted at the sub-County level

where they were readily available. Samples of shisha were collected at the point of use, in pubs, cafes and restaurants. For kuber and other forms of smokeless tobacco, the samples were collected from the retail shops and alcohol selling outlets. After sampling, samples were labeled and packaged in an envelope. The samples were then delivered to the Government Chemist for laboratory analysis to determine the presence of the following products: nicotine levels, heroin (opiates), cocaine, marijuana and amphetamines. The results from each test were recorded either as positive or negative.

Findings

A. *Kuber*

- The use of kuber and other forms of smokeless tobacco like snuff was widespread in Kenya, both in the rural and urban areas.
- Majority of those using kuber and other forms of smokeless tobacco were aged 14-25 years.
- Kuber was also reported to be easily accessible by underage children and with only ksh 10, one could purchase a dose of the drug. Kuber was therefore very affordable even to school going children.
- The major sources of kuber included; Indian retail shops, market centres, candy shops, miraa selling outlets, kiosks and bodaboda/ matatu terminus.

B. Shisha

- The use of shisha was biased towards the urban centres of major towns like Nairobi, Nakuru, Eldoret, Kisumu, Mombasa, Kilifi, Malindi and other Muslim dominated towns like Garissa and Isiolo.
- Shisha was not easily accessible to the underage and majority of the users were aged 18-35 years.
- It was reported that the culture of smoking shisha was gaining popularity among students of higher institutions of learning.
- The major sources of shisha included; shisha clubs, bars, recreation centres, sports clubs and known dealers.

C. Laboratory analysis

- A total of 100 samples were collected across the country and were divided into five categories namely shisha, kuber (with sachets labeled kuber), formulated kuber/ tamboo (not in a sachet and dispensed into smaller quantities), kuber others (other forms of chewing tobacco in sachets) and snuff.
- Among the total samples collected, 24% were shisha, 14% kuber, 22% formulated kuber/ tamboo, 18% kuber (others) and 22% snuff.
- The average level of nicotine in mg/g of sample collected shows that kuber has the highest level at 4.41mg/g followed by snuff at 3.95mg/g, kuber (others) at 3.52mg/g, formulated kuber/ tamboo at 3.49mg/g while shisha had the lowest levels of nicotine at 0.9mg/g.
- Of all the 100 samples tested for heroin/opiates, 25% were positive. In terms of individual samples, shisha was leading contributing 19% of the total samples followed by formulated kuber/ tamboo

contributing 4% and finally kuber (others) 2%. Snuff and kuber samples were negative for heroin.

- Laboratory results also showed that 79.2% off all shisha samples collected were positive for heroin while the remaining 20.8% tested negative.
- 11.1% of all kuber (others) samples collected were positive for heroin and one specific brand, Gutkha was singled out.
- Findings also showed that 18.2% off all kuber/ *tamboo* samples collected were positive for heroin.
- Further, of all the 100 samples tested for marijuana/bhang, only 1% was positive. In terms of sample category, laboratory results confirmed that this was actually a sample of formulated shisha (shisha flavor mixed and ready for use).
- However, none of all the samples collected tested positive for cocaine or amphetamines.

Recommendations

The study recommends the following:

1. The Tobacco Control Act, 2007 provides for protection of the health of persons under the age of eighteen years by preventing their access to tobacco products. The Act also provides for strict adherence to the packaging requirements for all types of tobacco products. This therefore calls for the relevant agencies to enforce these provisions of the Act to deter access, availability and affordability of tobacco products among the underage.
2. Students are citizens and potential future consumers, and with respect to these roles it is appropriate for the Ministry of Education to integrate instruction on the health consequences, addictive nature and mortal threat posed by consumption of tobacco in subjects taught in public and private schools at all levels of education, including informal and non-formal and indigenous learning systems.
3. Under schedule 1 of the Narcotic Drugs and Psychotropic Substance (Control) Act of 1994, heroin (diacetylmorphine) and cannabis/ bhang have been listed under the first schedule of narcotic drugs in Kenya. Therefore, there is need for the relevant agencies to undertake regular market surveillance to protect the health of the public from potential harm associated with the consumption of these narcotic drugs without their knowledge.
4. The enforcement agencies should regulate the smokeless tobacco products that have permeated to every corner of this country such that only verified importers and manufacturers that satisfy the legal and regulatory requirements for these products are allowed.
5. There is need to enact a law that will regulate the sale of kuber and shisha in the country.