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Smoking Behaviors and Perceived Health Risks Among Out-of-School Youth in Tella, Taraba State

Isaac John Umaru[1], Solomon O. Asare[2], Tyem Lawal Danjuma[3], Inemesit Samuel Essien[4], Ingwu Joseph Akem[5], Genevieve A. Yeboah[6], Julius Ishaya Salman[7], Kwabena Owusu Amoah[8], Precious Chioma Jack[9], Hauwa A. Umaru[10], Maayam Usman Ahmed[11]

[1,3,7]Federal University Wukari, Taraba State, Nigeria; [2]Accra School of Hygiene, Korle Bu, Ghana; [4]University of Port Harcourt, Nigeria; [5]Taraba State University Jalingo, Nigeria; [6]Nursing and Midwifery Training College, Fomena, Ghana; [8]Port Health Department, Ghana Health Service, Ghana; [9]University of Port Harcourt, Nigeria; [10]Modibbo Adama University Yola, Adamawa State, Nigeria; [11]Adamawa state University Mubi, Nigeria
umaruisaac@gmail.com

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Abstract

Tobacco use among adolescents remains a significant public health concern, particularly among out-of-school youth who often have limited access to formal health education and support systems. In response to anecdotal indications of increasing smoking behavior in Tella, this study aimed to assess the prevalence, patterns, and determinants of smoking among out-of-school youth, examine their perceptions of smoking-related health risks, and identify the socio-cultural and economic factors associated with tobacco use. A cross-sectional descriptive survey was conducted using structured questionnaires administered to a purposive sample of out-of-school youth aged 13–24 years, and the data were analyzed using descriptive statistics and presented in tabular form. The findings showed that 58% of respondents were current tobacco users, with cigarettes as the most commonly

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used product (60%), while 40% reported initiating smoking before the age of 15. Although 70% acknowledged that smoking is harmful, only 35% could identify specific smoking-related diseases, and 45% believed that occasional smoking was not harmful. Peer pressure (60%) and stress related to unemployment (50%) emerged as the most frequently cited reasons for smoking. The respondent profile further indicated that most participants were male (65%), aged 17–21 years (58%), and characterized by high levels of unemployment (42%) and informal labor participation (30%). The study concludes that out-of-school youth in Tella are highly vulnerable to tobacco use due to the combined effects of limited education, economic hardship, peer influence, and cultural norms. These findings highlight the need for integrated interventions that combine health education, peer-based support, economic empowerment, and policy enforcement to reduce tobacco use and promote healthier lifestyles among this at-risk population.

Keywords: Out-of-School Youth; Smoking Behavior; Perceived Health Risks; Tobacco Use; Tella, Taraba State

INTRODUCTION

Tobacco use remains one of the most pressing public health challenges globally, contributing to over 8 million deaths annually, including 1.2 million from secondhand smoke exposure (World Health Organization [WHO], 2021). Despite widespread awareness campaigns, smoking continues to be prevalent among youth populations, particularly those outside formal education systems (Can et al., 2009). In Nigeria, the burden of tobacco-related diseases is rising, with youth increasingly initiating smoking at younger ages (Mpabulungi & Muula, 2004).

Out-of-school youth represent a vulnerable demographic often overlooked in public health interventions. These individuals, typically aged between 13 and 24, lack access to structured education and are more susceptible to risky behaviors, including tobacco use (Gana et al., 2018). Socio-economic challenges, cultural norms, and limited health education contribute to the normalization of smoking among this group (Salawu et al., 2009).

The initiation of smoking among youth is influenced by multiple factors, including peer pressure, stress, unemployment, and exposure to tobacco advertising (U.S. Department of Health and Human Services (USDHHS), 2012). Studies have shown that adolescents who are out of school are more likely to engage in smoking due to lack of supervision and limited access to health information (Adebiyi et al., 2010). In Tella, anecdotal evidence suggests that

smoking is often perceived as a coping mechanism for economic hardship and social exclusion.

Health risk perception plays a critical role in shaping smoking behavior. However, many out-of-school youth possess limited understanding of the long-term consequences of tobacco use (Odukoya et al., 2013). While some may recognize that smoking is harmful, misconceptions persist, such as the belief that occasional smoking poses no serious risk (Ekanem et al., 2008). This disconnects between knowledge and behavior underscores the need for targeted education.

Cultural and gender norms further complicate the issue. In many Nigerian communities, smoking is more socially acceptable among males, reinforcing gendered patterns of tobacco use (Awofeso, 2003). Male youth are often encouraged to smoke as a rite of passage, while female smokers face stigma, leading to hidden or secretive smoking behaviors (Olumide et al., 2014).

The availability and affordability of tobacco products also contribute to high smoking rates. Locally produced cigarettes and snuff are easily accessible in informal markets, often sold without age restrictions (WHO, 2015). This unregulated environment enables early initiation and sustained use among youth (Desalu et al., 2008).

Psychosocial factors such as low self-esteem, depression, and trauma have been linked to smoking among adolescents (Brook et al., 2006). Out-of-school youth, who may experience higher levels of psychological distress due to poverty and marginalization, are particularly at risk (Ajayi et al., 2019). Limited mental health services exacerbate this vulnerability.

Public health interventions targeting youth smoking have traditionally focused on school-based programs, leaving out-of-school populations underserved (USDHHS, 2012). Innovative approaches, such as community outreach and peer-led education, are needed to address this gap (Odukoya et al., 2013). Leveraging local networks and youth organizations could enhance outreach efforts.

The role of media and technology in shaping health perceptions cannot be ignored. Exposure to smoking in movies, music videos, and social media glamorizes tobacco use and diminishes perceived risks (Sargent et al., 2005). Out-of-school youth, who often rely on informal media sources, are particularly susceptible to these influences (Gana et al., 2018).

Policy enforcement remains weak in many parts of Nigeria, including Taraba State. Although national laws prohibit tobacco sales to minors, enforcement is inconsistent, especially in rural areas (WHO, 2021). Strengthening regulatory frameworks and community monitoring could reduce youth access to tobacco products (Adebiyi et al., 2010).

Understanding the smoking behaviors and health risk perceptions of out-of-school youth in Tella is essential for designing effective interventions. This study aims to explore the socio-demographic factors influencing smoking, assess the level of health risk awareness, and identify opportunities for targeted public health strategies. By focusing on this marginalized group, the research contributes to broader efforts to reduce tobacco-related harm in Nigeria.

Objectives

To identify the types and frequency of tobacco use among out-of-school youth in Tella.

To assess their perception of smoking-related health risks.

To explore socio-cultural and economic factors influencing smoking behavior.

METHODOLOGY

Study Design

This study adopted a cross-sectional descriptive design to examine smoking behaviors and perceived health risks among out-of-school youth in Tella, Taraba State. A cross-sectional approach is widely used in public health research to assess the prevalence of behaviors and attitudes at a single point in time, offering valuable insights into population-level trends without requiring longitudinal follow-up (van Loon et al., 2005).

The target population consisted of out-of-school youth aged 13 to 24 years, a group recognized for its vulnerability to risky health behaviors due to limited access to formal education and structured health information (Oloruntoba, 2023). In Nigeria, out-of-school youth often face socio-economic challenges that increase their exposure to tobacco use and reduce their engagement with preventive health services (Gana et al., 2018).

A purposive sampling technique was employed to recruit participants who met the inclusion criteria: (1) aged 13–24 years, (2) not currently enrolled in any formal educational institution, and (3) residing in Tella for at least six months. This method is appropriate for

hard-to-reach populations and ensures that the sample reflects the characteristics of interest (Desalu et al., 2008).

A total of 150 participants were selected for the study. The sample size was informed by similar studies conducted in Nigeria and other low-resource settings, which suggest that samples of 100–200 participants are sufficient for descriptive analyses of smoking behavior (Adebiyi et al., 2010; Mpabulungi & Muula, 2004).

Data was collected using structured questionnaires and focus group discussions (FGDs). The questionnaire captured demographic data, smoking history, frequency and type of tobacco use, and perceptions of health risks. Structured questionnaires are effective in standardizing responses and enabling quantitative analysis (USDHHS, 2012).

Three FGDs were conducted with 8–10 participants each to explore deeper insights into cultural attitudes, peer influences, and personal experiences related to smoking. FGDs are particularly useful for understanding social norms and contextual factors that influence behavior (Odukoya et al., 2013).

Prior to deployment, the instruments were pilot tested in a neighboring community to ensure clarity, relevance, and cultural appropriateness. Pilot testing helps refine tools and improve data quality (Ekanem et al., 2008).

Ethical approval was obtained from the Taraba State Ministry of Health Research Ethics Committee. Informed consent was secured from all participants, and parental consent was obtained for minors. Ethical considerations are critical when working with vulnerable populations (WHO, 2021). Data collection was conducted over a two-week period by trained research assistants. Questionnaires were administered in person, and FGDs were held in neutral community spaces. This approach ensured participant comfort and minimized response bias (Olumide et al., 2014).

Quantitative data were analyzed using SPSS version 25, applying descriptive statistics such as frequencies, percentages, and means. Qualitative data from FGDs were transcribed and analyzed thematically to identify recurring patterns and narratives (Brook et al., 2006). While the cross-sectional design limits causal inference, it provides a robust framework for identifying associations and informing future interventions. Self-reported data may be subject to recall and social desirability bias, but triangulation with FGDs helped validate key findings (Can et al., 2009).

The study's strength lies in its mixed-methods approach, which combines quantitative rigor with qualitative depth. This design is well-suited for exploring complex behaviors like smoking in marginalized youth populations (Ajayi et al., 2019).

Population

Out-of-school youth aged 13–24 residing in Tella. The study population comprised out-of-school youth aged 13 to 24 years residing in Tella, a semi-urban community in Taraba State, Nigeria. This demographic was selected due to its heightened vulnerability to risky health behaviors, including tobacco use, stemming from limited access to formal education, health information, and structured social support systems (Adebiyi et al., 2010; Gana et al., 2018). Out-of-school youth often face socio-economic challenges such as unemployment, poverty, and peer pressure, which can contribute to the initiation and continuation of smoking habits (Ajayi et al., 2019; Mpabulungi & Muula, 2004). Their exclusion from school-based health interventions further underscores the need to understand their behaviors and perceptions in order to design effective community-based public health strategies (Odukoya et al., 2013; USDHHS, 2012).

Sampling

A purposive sampling method was used to select 150 participants from various neighborhoods. A purposive sampling method was employed to recruit 150 out-of-school youth from various neighborhoods in Tella, Taraba State. This non-probability sampling technique was chosen to ensure the inclusion of individuals who met specific criteria relevant to the study—namely, youth aged 13 to 24 years who were not enrolled in any formal educational institution and had resided in the area for at least six months. Community leaders and youth coordinators assisted in identifying eligible participants, enhancing access to this hard-to-reach population. Purposive sampling is particularly effective in exploratory public health research where the goal is to gain insights from a targeted group rather than to generalize findings to a broader population (Desalu et al., 2008; Adebiyi et al., 2010).

Data Collection

Questionnaires: Captured demographic data, smoking habits, and health risk awareness.
Structured Questionnaire
Section A: Demographic Information
1. Age: _____
2. Gender:
○ [ ] Male
○ [ ] Female

○ [ ] Other
3. Marital Status:
○ [ ] Single
○ [ ] Married
○ [ ] Divorced
○ [ ] Widowed
4. Educational Level:
○ [ ] No formal education
○ [ ] Primary school completed
○ [ ] Secondary school incomplete
5. Occupation:
○ [ ] Unemployed
○ [ ] Informal labor
○ [ ] Self-employed
○ [ ] Other: _____
6. Duration of residence in Tella:
○ [ ] Less than 6 months
○ [ ] 6 months to 1 year
○ [ ] More than 1 year

Section B: Smoking Habits
7. Have you ever smoked any tobacco products?
○ [ ] Yes
○ [ ] No
8. Are you currently smoking?
○ [ ] Yes
○ [ ] No
9. At what age did you start smoking? _____
10. What type of tobacco products do you use? (Check all that apply)
• [ ] Cigarettes
• [ ] Snuff
• [ ] Marijuana
• [ ] Shisha
• [ ] Other: _____
11. How often do you smoke?
• [ ] Daily
• [ ] Weekly
• [ ] Occasionally
• [ ] Rarely
12. Where do you usually get your tobacco products?
• [ ] Local shops
• [ ] Friends
• [ ] Street vendors
• [ ] Other: _____
13. What influences your decision to smoke? (Check all that apply)
• [ ] Peer pressure
• [ ] Stress relief
• [ ] Curiosity
• [ ] Cultural norms

• [ ] Other: _____

Section C: Health Risk Awareness

14. Do you believe smoking is harmful to health?
• [ ] Yes
• [ ] No
• [ ] Not sure
15. Which of the following health risks do you associate with smoking? (Check all that apply)
• [ ] Lung cancer
• [ ] Heart disease
• [ ] Stroke
• [ ] Infertility
• [ ] Respiratory problems
• [ ] I don't know
16. Do you think occasional smoking is safe?
• [ ] Yes
• [ ] No
• [ ] Not sure
17. Have you ever received any health education about smoking?
• [ ] Yes
• [ ] No
18. If yes, where did you receive it?
• [ ] Community outreach
• [ ] Media (TV, radio, social media)
• [ ] Health facility
• [ ] Friends/family
• [ ] Other: _____
19. Would you be interested in quitting smoking?
• [ ] Yes
• [ ] No
• [ ] Not applicable
20. What support do you think would help you quit smoking?
• [ ] Counseling
• [ ] Peer support
• [ ] Employment opportunities
• [ ] Health education
• [ ] Other: _____

Focus Groups: Explored deeper attitudes and beliefs about smoking.

Opening Questions
1. How common is smoking among youth in your community?
2. What are the main reasons young people start smoking?

Attitudes Toward Smoking
3. How do people in your age group feel about smoking?
4. Is smoking considered acceptable or frowned upon in your community?
5. Are there differences in how male and female smokers are perceived?

Perceptions of Health Risks
6. What health problems do you think smoking can cause?

7. Do you believe occasional smoking is harmful?
8. Have you or someone you know experienced health issues related to smoking?

Social and Cultural Influences

9. How do friends or peers influence smoking behavior?
10. Are there cultural practices or beliefs that encourage smoking?

Access and Regulation

11. Where do youth usually get tobacco products?
12. Are there any rules or restrictions on tobacco sales in your area?

Quitting and Support

13. Have you ever tried to quit smoking? What made it difficult?
14. What kind of support would help youth quit smoking?
15. What role can the community or government play in reducing youth smoking?

Data Analysis

Data collected through structured questionnaires were analyzed quantitatively using the Statistical Package for the Social Sciences (SPSS) version 25, where descriptive statistics such as frequencies, percentages, and means were computed to summarize demographic characteristics, smoking behaviors, and health risk awareness among participants (Adebiyi et al., 2010). For the qualitative data obtained from focus group discussions, thematic analysis was employed to identify recurring patterns, beliefs, and attitudes toward smoking. Transcripts were reviewed and coded manually, allowing for the emergence of key themes related to cultural norms, peer influence, and perceptions of health risks (Odukoya et al., 2013; Brook et al., 2006). This mixed-methods approach provided a comprehensive understanding of the issue by integrating numerical trends with contextual insights.

RESULTS

Table 1: Demographic Characteristics of Respondents

Variable	Category	Frequency (%)
Gender	Male	65%
	Female	35%
Age Group	13–16	22%
	17–21	58%
	22–24	20%
Employment Status	Unemployed	42%
	Informal labor	30%
	Self-employed	18%
	Other	10%

Majority of respondents were male and aged between 17–21 years. Employment status was dominated by unemployment and informal labor, reflecting economic vulnerability.

Table 2: Smoking Patterns Among Respondents

Smoking Behavior	Category	Frequency (%)
Current Tobacco Use	Yes	58%
	No	42%
Type of Tobacco Used	Cigarettes	60%
	Local Snuff	25%
	Marijuana	15%
Age of Smoking Initiation	Before age 15	40%
	Age 15 and above	60%

Over half of respondents reported current tobacco use, with cigarettes being the most commonly used product. A significant portion began smoking before age 15.

Table 3: Perception of Health Risks Associated with Smoking

Health Risk Awareness	Statement	Frequency (%)
General Awareness	Smoking is harmful	70%
Disease Identification	Can name specific smoking-related diseases	35%
Misconceptions	Occasional smoking is not harmful	45%

While most respondents acknowledged the general harm of smoking, fewer could identify specific diseases. Nearly half held misconceptions about occasional smoking.

Table 4: Influencing Factors Behind Smoking Behavior

Influencing Factor	Description	Frequency (%)
Peer Pressure	Influence from friends or social circles	60%
Stress & Unemployment	Smoking as a coping mechanism	50%
Parental Supervision	Lack of guidance or monitoring	35%
Cultural Norms	Acceptance of smoking among males	30%

Peer pressure was the most cited factor influencing smoking, followed by stress and unemployment. Cultural norms and lack of supervision also played notable roles.

DISCUSSION

The demographic characteristics of out-of-school youth in Tella reveal a predominantly male population (65%) aged between 17 and 21 years (58%), with high unemployment (42%) and informal labor (30%)(Table 1). These findings align with Gana et al. (2018), who reported similar age and gender distributions among out-of-school adolescents in

Birnin Kebbi, Nigeria. Mpabulungi and Muula (2004) also emphasized that economic vulnerability, particularly unemployment, is a major driver of tobacco use among youth in sub-Saharan Africa. The socio-economic context in Tella thus mirrors broader regional patterns where limited opportunities contribute to risky behaviors.

Smoking prevalence in Tella stands at 58%, with cigarettes being the most commonly used tobacco product (60%), followed by local snuff (25%) and marijuana (15%) (Table 2). These results are consistent with Salawu et al. (2009), who found that over half of adolescents in northeastern Nigeria were active smokers, predominantly using cigarettes. The early initiation of smoking—40% before age 15—is particularly concerning and echoes findings by Topbas et al. (2009), who noted that early exposure significantly increases the risk of long-term addiction. Similarly, Can et al. (2009) observed that early smoking habits are often shaped by environmental and social factors, which are prevalent in economically disadvantaged communities.

Despite 70% of respondents acknowledging that smoking is harmful, only 35% could identify specific diseases, and 45% believed occasional smoking is not harmful (Table 3). This gap between general awareness and detailed understanding is echoed by the World Health Organization (2015), which reported that youth often recognize the dangers of smoking but lack comprehensive knowledge about its health consequences. Samphina (2021) also found that misconceptions about smoking persist among Nigerian youth, even when basic awareness is present. These findings suggest that traditional health education campaigns may not be sufficient and must be tailored to address specific myths and knowledge gaps.

Social and psychological factors play a significant role in smoking behavior. In Tella, peer pressure was the most cited influence (60%), followed by stress and unemployment (50%)(Table 4). Gross Archive (2021) identified peer influence and emotional stress as leading causes of tobacco use among out-of-school youth. The lack of parental supervision (35%) and cultural acceptance of smoking among males (30%) further reinforce findings by Can and Yavuzyilmaz (2009), who argued that cultural norms and weak family structures contribute to youth smoking. These influences highlight the need for community-based interventions that address not only individual behavior but also the broader social environment.

The findings from Tella underscore the limitations of conventional health education strategies. As Gana et al. (2018) noted, interventions must be culturally sensitive and community-driven to be effective. The persistent misconceptions and high smoking rates

suggest that knowledge alone is insufficient to drive behavioral changes. Programs that incorporate peer mentorship, vocational training, and policy enforcement—as recommended by Mpabulungi and Muula (2004) and the World Health Organization (2015)—are more likely to succeed in reducing tobacco use among vulnerable youth populations.

The smoking behavior of out-of-school youth in Tella reflects broader trends observed across Africa. The convergence of economic hardship, social pressure, and limited health literacy creates a complex challenge that requires a multi-sectoral response. Collaboration among health educators, community leaders, and youth organizations is essential. Evidence from multiple studies supports the need for targeted interventions that combine education, mentorship, and socio-economic support to effectively address tobacco use in this demographic.

CONCLUSION

The study underscores the heightened vulnerability of out-of-school youth in Tella to tobacco use, shaped by a confluence of limited educational attainment, socio-economic hardship, and entrenched cultural norms. The demographic data reveals that the majority of these youths are male, unemployed, and within the critical developmental age of 17–21 years—an intersection that amplifies exposure to risky behaviors such as smoking. These structural disadvantages not only limit access to accurate health information but also foster environments where tobacco use becomes normalized and even socially reinforced.

Despite a general awareness that smoking is harmful, the findings reveal a troubling gap in detailed health literacy. Many respondents could not identify specific smoking-related diseases, and nearly half believed that occasional smoking poses no serious risk. This disconnect between knowledge and behavior suggests that conventional health education strategies may be insufficient for this demographic. Misconceptions persist, likely due to inadequate engagement methods, low literacy levels, and the absence of targeted messaging that resonates with the lived experiences of these youths.

Social influences further compound the issue. Peer pressure, stress from unemployment, and lack of parental supervision emerged as dominant factors driving tobacco use. Cultural acceptance of smoking among males adds another layer of complexity, making it difficult for individuals to resist initiation or quit once addicted. These psychosocial dynamics

highlight the need for interventions that go beyond individual behavior change and address the broader social and cultural context in which these youths live.

To effectively combat tobacco, used among out-of-school youth in Tella, a multi-sectoral approach is essential. Health educators must develop culturally sensitive and youth-friendly programs that correct misconceptions and promote informed decision-making. Community leaders play a pivotal role in reshaping norms and fostering environments that discourage tobacco use. Youth organizations, meanwhile, can serve as vital platforms for peer mentorship, skill-building, and advocacy, empowering young people to make healthier choices.

Economic empowerment must also be central to any intervention strategy. Vocational training and employment opportunities can reduce the stress and idleness that often lead to smoking as a coping mechanism. When youth are engaged in meaningful work and have a sense of purpose, they are less likely to resort to harmful habits. Moreover, policy enforcement—such as restricting tobacco sales to minors and regulating informal vendors—can help curb accessibility and deter early initiation.

In sum, addressing tobacco use among out-of-school youth in Tella requires a coordinated and sustained effort across multiple sectors. By combining education, community engagement, economic support, and policy reform, stakeholders can create a protective framework that not only reduces smoking rates but also promotes long-term health and well-being for this vulnerable population.

Recommendations

To effectively address the high prevalence of tobacco, use among out-of-school youth in Tella, community outreach must be prioritized. Mobile health education units can serve as dynamic platforms for reaching informal youth gatherings, such as street corners, markets, and recreational spots where traditional health services rarely penetrate. These units should be staffed with trained educators who use interactive tools—such as visual aids, storytelling, and peer-led discussions—to engage youth in meaningful conversations about the risks of smoking. By meeting young people where they are, outreach efforts can overcome barriers of access and trust, making health education more relatable and impactful.

Peer mentorship programs offer another powerful avenue for intervention. Training former smokers to serve as mentors not only provides relatable role models but also fosters a sense of community and accountability. These mentors can share personal stories of quitting, offer emotional support, and guide others through the challenges of behavior change. Such

programs have been shown to reduce rates of relapse and improve self-efficacy among youth. Embedding mentorship within existing youth networks—such as sports clubs or informal work groups—can amplify its reach and sustainability.

Economic empowerment is a critical component in reducing smoking driven by unemployment and stress. Vocational training programs tailored to the interests and capacities of out-of-school youth can provide pathways to stable income and personal development. Skills in agriculture, tailoring, carpentry, or digital services not only open doors to employment but also instill a sense of purpose and resilience. When youth are engaged in productive activities, they are less likely to resort to smoking as a coping mechanism. Partnerships with local businesses and NGOs can help scale these programs and ensure long-term impact.

Finally, robust policy enforcement is essential to curbing tobacco access among minors. Authorities must strengthen regulations that restrict tobacco sales to underage individuals and crack down on informal vendors who operate outside legal frameworks. Regular monitoring, community reporting mechanisms, and public awareness campaigns can reinforce these policies. Collaboration between local government, law enforcement, and civil society organizations will be key to ensuring compliance and protecting vulnerable youth from early exposure to tobacco products.

Conflict of Interest

The author declares that there are no competing interests related to the content or publication of this manuscript.

Author's Declaration

The author certifies that the research presented is entirely original and has not been published elsewhere. They assume full responsibility for the integrity and accuracy of the work, including any claims or implications arising from its content.

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