Policy brief

Title- Social disparities in tobacco consumption in rural India, the roles of caste and education

Location of research: Birbhum Population Project (BIRPOP), a demographic surveillance site (DSS) BIRPOP, operational since 2008, a place in the state of West Bengal, India

Context and issue

Tobacco consumption is responsible for 4.9 million annual deaths globally. (1) Annually, 1.4 million cancer deaths are the result of tobacco consumption. (1) WHO has projected an increasing trend of tobacco use in developing countries ranging from 4.9 million in 2000 to more than 10 million by 2020. Despite these facts, tobacco is still the single most preventable cause of death in the world today. Tobacco kills more than five million people -- more than Tuberculosis, HIV/AIDS and Malaria combined. The contribution of tobacco to premature death and disease is well documented.

However, little attention has been paid to the link between tobacco and poverty. Tobacco tends to be consumed by those who are poorer. In turn, it contributes to poverty through loss of income, loss of productivity, disease and death. Together, tobacco and poverty form a vicious circle from which it is often difficult to escape. Tobacco consumption in India has a distinct socioeconomic and spatial distribution; the disadvantaged population groups are at greater risk of consuming tobacco.

Tobacco not only impoverishes many of those who use it, it puts an enormous financial burden on countries. The costs of tobacco use to countries include increased health-care costs, lost productivity due to illness and early death, foreign-exchange losses, lost revenues on smuggled cigarettes and environmental damage. Unfortunately, our current policy has no such coverage for this disadvantaged section who are most vulnerable to the tobacco-related health hazards.

A new study from West Bengal, India looks at one strategy to address the problem, focusing on education to reduce the hazard of tobacco consumption.

The purpose of this policy brief is to inform the policy makers about the health concerns of tobacco, and also to enable them forming effective legislations in the fight for tobacco control. While forming the legislations they must think about the health disparity between the different sections of the society in terms of education, caste, etc. and how to mitigate it by effective legislation.

Approaches

Data for the present study were drawn from Birbhum Population Project (BIRPOP), a demographic surveillance site (DSS) BIRPOP, operational since 2008 (funded by the Department of Health and Family Welfare, West Bengal)

The present study used data from the tobacco consumption survey, which was conducted between October 2010 and January 2011.

The study was done by administering questionnaire to the householders (35,208) of the DSS. The questionnaire investigated whether the member (15 years and above) consumes tobacco in any form or not and if he consumes so, what is its form.

Results and Conclusions

The study showed 24.9% of the study population smoked tobacco; 25.31% of the study population consumed by chewing or other means; and 44.7% of the study population either smoked or chewed tobacco.

Biri is the most common variety of tobacco smoking (almost 95%).

The Hindu Scheduled Caste (SC) community were more likely to smoke than the others (almost 13% more).

The Hindu SC community were found to have 3 times more possibility of consuming smokeless variety of tobacco than the general caste people.
But the uneducated persons were 6 times more likely to smoke and almost 3 times more likely to chew than their educated (11 years and more education) counterparts.

Educational Status (Smoking & Chewing):

Religion-Caste (Smoking & Chewing):

Tobacco Use:

Type of Smoking

- Biri (91.41%)
- Both biri and cigarette (4.86%)
- Others (0.27%)
- Cigarette (3.46%)
The education emerged to be the major determinant of tobacco consumption. Although caste has a definite role on tobacco consumption, it is overshadowed by the effect of education. Education emerged as a relatively stronger predictor than household wealth and caste, both among men and women. It is likely that poor and less educated people are: less aware of the health hazards of tobacco consumption. Hence they are more likely to find themselves in conditions predisposing them to initiation of smoking and chewing of tobacco; and more likely to have higher overall risk taking behavior. For the smokeless variety the peer group influences and cultural habits are major determinants.

The high levels of tobacco consumption among disadvantaged population groups may lead to a doubling of the disease burden in these social groups from chronic illnesses related to tobacco consumption as well as from communicable and nutrition related diseases, which still account for a large share of total disease burden in the disadvantaged social groups in India.

A study of smoking prevalence among men in Chennai in 1997 showed that the highest rate was found among the illiterate population (64%). This prevalence decreased by number of years of schooling, and declined to 21% among those with more than 12 years of schooling — less than a third of illiterate men’s smoking prevalence. (2)

Implications and recommendations

A special focus on the uneducated group is required because the knowledge, awareness as well as the threat perception of these population is somewhat lower than their educated counterparts (asymmetric information). Improving the educational status of populations in India is required to control adverse lifestyle associated diseases leading to amelioration of the epidemic of non-communicable diseases and related health inequities. Tobacco use by the least educated is in large measure practiced in ignorance of the health consequences, with belief in medicinal properties of tobacco and a desire for a low cost source of pleasure and satisfaction. The illiterate cannot read statutory health warnings.

Regardless of the possible reasons for higher prevalence of tobacco use among the less educated, community intervention studies in India have proven that educational interventions on the adverse effects of tobacco combined with support for quitting this addiction receive a positive response and are successful in getting educationally deprived users to quit. (3) The vulnerable population can thus be prevented from the disproportionate health burden. Tobacco chewing is increasing among people, children and adolescents possibly due to the smoking ban in public places and also tobacco industry strategies to shift their focus to smokeless tobacco products which is not affected by current tobacco control policies. Tobacco use leads to many chronic non-communicable diseases, treatment of which puts economic burden on the people pulling them below the poverty line.

Chewing tobacco is increasing among the people, due to a false perception that its not as hazardous as smoking. The social taboo on smoking is also another cause.
These are the recommendations -

- Health awareness is the major solution to bring down the occurrence. As education is the major player, the basic education should be strengthened in every form.
- The pictorial warnings should be displayed in every major place of gathering, focus should be on pictures, not on writings as the major target audience is uneducated.
- Anti-tobacco campaigns should focus on those who are less educated, have manual occupations, are in poorer economic groups.
- As a part of health promotion program, accompanying movies/cinemas with anti-smoking/anti-tobacco messages could be useful.
- Special stress should be given on tobacco chewing, which has occupied the major share among the consumers. Tobacco chewing is the major cause of oral cancer, it should not be forgotten. Tobacco in any form should be forbidden and taxed as the cigarettes.
- The results showed almost 96% of the rural people used to smoke Biri (low cost handmade tobacco leaves). Unfortunately in India, the taxation on Biri is minimal. So on one hand, the state is losing its revenue and on the other, the major smokers are not being prevented from the act by taxation. Hence taxation on Biri should be at par the cigarettes.
- Tobacco needs to be the most discussed topic now. The health administrators, health policy makers, and other related persons should regularly sit and discuss about the health consequences. There should be a separate session in the Parliament (both houses) for the members.

References

2) Gajalakshmi CK and Peto R. Studies on Tobacco in Chennai, India. Presented at the 10th World Conference on Tobacco or Health, Chinese Medical Association, Beijing, 1997.