



AN OVERVIEW ON THE PREVALENCE OF DRUG ABUSE AMONG CHILDREN WITH SPECIAL REFERENCE TO TOBACCO USE IN DEVELOPED AND DEVELOPING COUNTRIES

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ABSTRACT

The impacts caused by tobacco extend beyond the well-reported links with cancer, heart disease and respiratory illnesses. It also can cause family breakdown, low self esteem, poor social relationship, impotence, ulcers and fertility problems and it does not harm only smokers. Passive smoking causes lung cancer and is linked to death, glue ear and asthma in children. The review of literature showed that most of the researches talk about the consumption of tobacco and its influence on cancer and other related diseases. However there are few studies (Kandel, 2002; Gupta, 2004; Singh, 2004; Kumar, 2008) which cover social and psychosocial factors of tobacco consumption and its effects on people. These studies revealed that tobacco not only harms the individual but also the family, community and the whole society. In this paper attempt has been made to review tobacco consumption among children in India as well as other western countries to understand the present scenario.

Keywords: Tobacco Consumption, Passive smoking, cigarette

INTRODUCTION

Patterns of Tobacco Consumption

Studies⁷ pertaining to tobacco use shows that tobacco consumption had been a problem from long back not only in our country but it's becoming a global problem. The following section discussed about global problem of tobacco which revealed that prevalence of tobacco found in all most every part of western countries.

An Overview on the Prevalence of Tobacco Use among Children in Developed Countries

The initiation of tobacco starts at a much younger age in developed countries than in developing countries. According to a survey on 11 to 15 year-old school children of European, Russian and Scandinavia countries, the rates for tobacco experimentation were found at the ages of 9-11 years. Regular smoking was found in every country between the ages of 13 - 15 years, but in some countries this was also the case between ages 11 and 13 years. For example, both Northern Irish and Welsh data illustrate a 1 % rate at age 11 year, a 9 % rate at age 13 year and a 23 % rate at age of 15 year. These daily smoking data also illustrate inter country differences. This was most striking amongst 15 year-old girls, where the rates range between 6 % in Lithuania to 56 % in Greenland. Interestingly, girls in Greenland report more daily smoking than boys in all the three age groups¹. (WHO) Another cross-sectional school-based survey reported in London that 41.4 % of children had tried smoking in the 6th class, with prevalence increasing from 21 % in class 6th to 60 % in class 12th. Smokeless tobacco was reported by 19.3 % children, with prevalence increasing from 12 % in class 6th to 29 % in class 12th. The prevalence of regular use of smokeless tobacco was one-third that of cigarette smoking, 4 % (n = 21) and 12 % (n = 66) respectively. Smoking initiation began as early as kindergarten, with 16 % initiating by 4th grade and 43 % initiating by 6th grade in London. Smokeless tobacco initiation began as early as second grade, with 11 % having tried chewing tobacco by 4th grade and 33 % by 6th grade. The study concluded that initiation of smoking and smokeless tobacco use began in early

elementary school of rural areas of London. It concluded that there was a need of tobacco prevention strategies in early elementary school and addresses both smoking and smokeless tobacco use². A study by assessed the prevalence and correlates of tobacco use among high school children (3909 children of 8th and 11th graders) of public and private schools in Buenos Aires, Argentina. The study revealed that among 8th and 11th graders, 20 % and 43 %, respectively, were classified as current smokers. Overall, 29 % of males and 32 % of females were found to be current smokers. Children attending public schools were more likely to smoke than those in private schools. Current smoking was associated with having a best friend who smokes, reporting that more than 50 % of friends of the same sex smoke, having positive attitudes and beliefs toward smoking, and having a positive intention to smoke within the next year. The study concluded that over 20 % of the 8th graders in the sample were current smokers and the use of tobacco mind-altering chemicals had deleterious effects on school performance. Children under the influence of tobacco were not ready to learn and were at risk of long-term impairment of cognitive ability and memory³. On the other hand, in Sweden, a survey reported that snuff use was the most common form of tobacco use among school children. This survey shows that about 20 % of Swedish boys use tobacco regularly, as do boys in other European countries. However, specific patterns of tobacco use differ strikingly between Swedish boys. In contrast, the prevalence of smoking among girls is almost 2.5 times that of boys in Sweden. The study shows that Swedish parental tobacco use influences tobacco use among children. For example, boys whose father used snuff were three times more likely to use snuff compared to boys whose fathers were tobacco-free. Similarly, mothers' smoking was associated with smoking in their children. The study revealed that tobacco in the form of snuff was a major problem among school children rather than cigarette smoking⁴. The above studies show that prevalence of tobacco consumption has become a major problem in almost every part of the world. However the prevalence rates are different from country to country.

Prevalence of Tobacco in Developing Countries

Basic epidemiological information is lacking in many developing countries, some of which have still not undertaken a national survey. Of those that have, few reliable or country-wide surveys were done earlier than 10 years ago, so that information on trends is scanty. In general, patterns of tobacco are different in developing and developed countries: more men (50-60 %) but fewer women (2-10 %) used tobacco in developing countries compared with developed countries, where approximately 25-30 % of both men and women smoke⁵. Girls in developing countries start smoking later than boys as smoking has been considered socially unacceptable for women (with exceptions in certain areas of India, Nepal, Papua New Guinea, northern Thailand, and for Maoris). There may be religious constraints, for example in Muslim countries women have had less spending power than men to buy cigarettes; rural women adhere to traditional methods of smoking, e.g. hubble-bubble pipes, and are therefore exposed to a lower dosage of tobacco; and in some areas, such as parts of India and the Middle East, women use tobacco in other forms, such as chewing tobacco⁶. There may be significant underreporting of smoking among women in countries where it is culturally less acceptable for women to smoke. Because of poverty in South Africa, many smokers can only afford a few cigarettes per day. Even in Asia, smokers smoke on average fewer cigarettes than in western countries. For example, smokers in China smoke on average 11-15 cigarettes daily. In many areas of India, while only 3 % of women smoke manufactured cigarettes, 50-60 % chew tobacco. In the eastern Mediterranean, approximately 40-50 % of men smoke, but smoking by eastern Mediterranean women is often considered to be vulgar and improper even immoral. Female smoking is still low but increasing in professionals in the Middle east and North African region. In Israel, a study on tobacco smoking via a water-pipe among school children reported that 41 % smoke a water-pipe at various frequencies and 22 % smoke at least every weekend. The study found that Water-pipe smoking was 3 times more frequent than cigarette smoking. Surprisingly it found that girls were heavier smokers than boys, of either water pipe or cigarette smoking. The main reasons for water-pipe smoking were the pleasure achieved and the intimacy that it adds to the youngsters' meetings. 30 % of all the school children believed that water-pipe smoking is not healthy, but at least 70 % believed it was less harmful than cigarettes. According to regular users, 40 % of their parents were current or ex-smokers of water-pipes, in contrast with 10 % of parents to non-smoking children and about a quarter of the children who smoke also do so together with their parents⁷. The study shows that tobacco smoking via water-pipes was a very common phenomenon among middle and high school children in Israel. School children and their parents perceive that tobacco smoking via water-pipe was much safer than cigarette smoking. Tobacco got the social sanction in Muslim countries which could be one of the major reasons for high prevalence of tobacco use in Israel⁸. Tufts University, have linked tobacco use in developing countries to malnutrition in children. The study found that in Indonesia, where 18 percent of the population lives below the poverty line, the smoking rate is approximately 3 percent for women and 60 percent for men. The World Bank estimates that tobacco is the nation's second-biggest business and the second-largest expenditure among the country's poor. The study found that households of non smokers spend on average 75 percent of their budget on food, whereas households in which at least one person

smokes allocate 68 percent of their budget to food and 10 percent to cigarettes. This suggests that 70 percent of the expenditures on tobacco products are financed by a reduction in food expenditure. Households with smokers allocate a larger portion of their food budget to rice, a low-nutrient food, whereas those of non smokers spend more on high-quality foods, like meats and vegetables, for example, 2.1 per cent on health, 1.8 per cent on education. It was found that households with smokers were dedicating a very large amount of money on tobacco and this has serious welfare implications for the rest of their family. It also found that the average height among preschool children living with smokers is slightly lower than that of children in non smoking households, which suggests that the decreased food expenditure in smoking households negatively impacts children's health. Parental education, which has been linked to reduced smoking and improved quality and quantity of food choices, also coincides with increasing average height of preschool children⁹.

Tobacco Control in Developed and Developing Countries

A study was done on prices and cigarette demand: evidence from youth tobacco use in developing countries. This study estimated the impact of cigarette prices on youth smoking in lower-income countries (Africa, Europe, Americas, Southeast Asia, Middle East, and Western Pacific) in various years from 1999 to 2006. It captures prevalence, access, media exposure and attitudes related to tobacco use among individuals in school grades corresponding to ages 13 year to 15 years. It found that cigarette price is an important determinant of both smoking participation and conditional demand. The study revealed that anti-smoking sentiment, cigarette advertising and youth access restrictions, influence the decision to participate in smoking but not the intensity of cigarette consumption among current smokers. It also shows that anti-tobacco media campaigns may be effective in reducing both participation and intensity¹⁰. Another survey done on the effect of advertising bans on the prevalence of youth smoking in developed and developing countries. The present study examined youth smoking prevalence in a sample of 24 developed countries and 42 developing countries, using survey-based data obtained from the World Health Organization for youth between the ages of 13 and 15 years. The survey data on smoking prevalence (weekly, 30-day, ever smoked) were supplemented with data covering policy variables (advertising bans, health warnings, antismoking messages, bans on sales to minors, prices); socio-economic conditions (income, health care spending, urbanization, religion, gender); and social environment (peers' smoking, school classes on smoking dangers, ability to buy smokes in stores). Several variables emerge as important determinants of smoking outcomes among youth, but advertising bans are never statistically significant. For the developed countries, higher cigarette prices and greater health care spending have negative effects on youth smoking prevalence, but income has a positive effect. Girls with a strong liking for school are less likely to smoke, although the same is not true for boys. In the developed countries, urbanization has a negative effect on the ever-smoked prevalence for both boys and girls. In addition, youth in countries that were part of the Soviet Union have higher rates of smoking. Advertising bans are not a factor in developing countries, regardless of severity. Policy variables of greater importance include bans of sales to minors, health care spending, and school classes on the dangers of smoking,

which are associated with reduced smoking prevalence among youth. Ease of purchase from stores also is important, especially for girls. Higher incomes reduce smoking in developing countries, but urbanization has a positive effect. Smoking by peers is especially important in developing countries. Smoking rates in the former Soviet Union countries are much greater. The results suggest a very limited ability of advertising bans to alter youth misperceptions of smoking prevalence among peers, at least for the age group in question. These results agree with the general findings from past econometric studies of youth smoking in the United States. On the other hand, various results in this survey suggest that school classes and other education efforts could be effective as a means to improve youth risk perceptions¹¹. A National survey in Scotland reported 39 % reduction in smoking after the introduction of smoke-free legislation. The study concluded that the Scottish smoke-free legislation has reduced exposure to secondhand smoke among young people. The study concluded that the Scottish smoke-free legislation has thus had a positive short term impact on young people's health, but further efforts are needed to promote both smoke-free homes and smoking cessation¹².

CONCLUSION

Tobacco use among adolescents is influenced by multiple etiological factors, including individual, socio-cultural and environmental factors. Adolescent tobacco use is a complex behavior. Factors like, social bonding, social learning, refusal skills, risk-taking attitudes and intentions have been highlighted as reasons for the onset of tobacco use in studies in developed countries (Conrad, 1992). The most common reasons cited for children to start using tobacco are peer pressure, parental tobacco habits and pocket money given to children (Mohan, Sankara-Sarma and Thankappan, 2005). Majority of the researches (Aggarwal, 1998; Jayant, 1991 and Kumar, 2000) have also indicated that a decision to take to tobacco is associated with factors such as: peer smoking, peer attitudes and norms, stress, health concerns, risky behaviors, parental smoking, family income, parental attitudes, sibling addiction, attachment to family and friends, depression, and self-esteem. It has been found that Cigarette smoking, in the

developed world, has been the major habit among children for both boys and girls. They usually take to the habit while in school before the age of 18. It has been observed that smoking prevalence among 11 to 16 year olds in many Western countries has historically followed adult patterns. In fact teenage prevalence has hardly changed in many countries despite concurrent declines in adult prevalence (ICMR, 2000). The progressive increase in the consumption of tobacco amongst adolescents is emerging as a complex and multidimensional problem. It continues to occupy a premier position as public health concern in almost all countries. Tobacco is the most common hazardous substance because it is legally available, heavily promoted and widely consumed by our future generations.

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