

# 7.6

## Protection of Vulnerable Groups: A Human Rights' Approach to Tobacco Control

Good health should be an entitlement of every citizen. However, it is widely recognized that social, economic, and political conditions and forces influence both the underlying determinants of health and public policy, with conflicts of interest and contradictions featuring as causes and consequences. These contradictions in public policy are especially evident in the case of tobacco and its impact on health.

What is often not recognized, in the context of tobacco control, is the particular vulnerability of certain population groups for becoming the victims of tobacco. These include the poor, the young and women. In virtually every region of the world, the poor consume tobacco more frequently than the affluent sections of the society. Education, in particular, has a major effect on tobacco consumption. The higher the level of education, the less likely is tobacco use. The poor have less access to education and hence are more vulnerable to acquiring and maintaining tobacco use. The youth and women of all countries, but especially those of developing countries, have become prime targets for the tobacco industry, which seeks multitudes of new customers each year to replace the millions who die from the deadly effects of tobacco. They too are vulnerable in many respects, especially when poverty intertwines with their age- or gender-based susceptibility.

This requires that tobacco control policies must encompass a human rights' approach intended to protect vulnerable groups from the hazards of tobacco. This is particularly important because

the tobacco industry frequently raises the bogey of tobacco control policies infringing the individual's right to free choice and also sounds the false alarm of the poor being adversely affected by such policies (see Box 7.9). This section examines the impact of tobacco on the poor and addresses issues related to tobacco control from a human rights' perspective.

### Box 7.9 Tobacco control: Resolving the paradox of poverty

The poor use tobacco more frequently but the products that they use most often are not taxed because policy-makers are wary of increasing the tax burdens of the poor. However, the high burden of tobacco-related diseases among the poor, which will result from such a policy, are ignored. This paradox, of sparing the poor from tobacco taxes but not saving them from tobacco-related deaths, needs to be resolved through a tax policy that taxes all tobacco products and uses a large fraction of that revenue for welfare programmes intended to serve the poor.

The false argument advanced by the tobacco industry that tobacco control will propel many farmers and workers into poverty, is unquestioningly accepted by some policy-makers who oppose tobacco control measures. Yet, the poor (who consume tobacco in much larger numbers) are the worst victims of the tobacco trade, as indeed are the children who miss school to roll *beedis* and remain entrapped in the cycle of poverty. It must be recognized that tobacco control will alleviate poverty rather than cause it.

### The poor are more affected by tobacco

A recent report by Economic and Social Council (ECOSOC) of the United Nations states that "Tobacco consumption is a major direct contributor to increasing noncommunicable diseases and an associative contributor to communicable diseases such as tuberculosis. Poverty facilitates the spread of diseases and their treatment can impose a heavy financial burden on poor households. Tobacco entails heavy opportunity costs for poor households in which addicted tobacco users spend a significant amount of household resources on tobacco consumption. In developing countries, among

poor families, the proportion of household expenditures used to purchase tobacco products can easily represent up to 10 per cent of total household expenditures. This means that these families have less money to spend on basic items such as food, education and health care. In addition to its adverse health effects, tobacco use can lead to increased health-care costs and premature death. It also contributes to worsened malnutrition and a higher illiteracy rate if money that could have been used for food and education is spent on tobacco instead'.<sup>96</sup>

Globally and in India, smoking and smokeless tobacco use is higher among the poor than the rich and is accompanied by an increased risk and prevalence of tobacco-related disease and premature death.<sup>97</sup> *Beedis* and chewed tobacco (*gutka*, *paan masala*, etc.) constitute the largest percentage of tobacco use in India. Cigarettes used by the richer, more educated social segment account for only about 20% of tobacco use. *Beedis*, used to a larger extent by low-income groups, deliver more toxic products to the smoker than other smoked tobacco products. Thus, the burden of tobacco-related diseases is higher in this group. Increased taxes on cigarettes since the 1970s resulted in an increased consumption of *beedis*, which do not have the same taxation or legal requirements for packing and labelling as cigarettes, thus keeping their costs lower.

A study by Gajalakshmi *et al.* in Chennai,<sup>98</sup> found higher smoking rates among less educated men from the lower socioeconomic segments of society. Among illiterates, 64% of adult men smoked: in those with less than 6 years of schooling 58% smoked; with 6–12 years of schooling 42% smoked; and with more than 12 years of schooling 21% of adult men smoked. This marked gradient is in accordance with the worldwide trend of a higher smoking prevalence among the poor and uneducated.

An analysis of the National Family Health Survey (NFHS), conducted in 1998–1999, shows that tobacco smoking is inversely associated with educational status, with an illiterate person being three times more likely to smoke than a

person with postgraduate education.<sup>99</sup> The scheduled castes and tribes, who constitute a socially and economically vulnerable group, were also more likely to smoke than other castes. A similar gradient was observed between the household standard of living and smoking, with smoking being 2.5 times more common in the lowest of five grades compared to the highest.<sup>99</sup> Smoking was also more common in rural areas and towns than in large cities.

Similarly, strong gradients were also observed for chewing of tobacco. The least educated were 1.8 times more likely to chew tobacco than the most educated. Scheduled castes and tribes were more likely to chew tobacco than other castes, and the houses with the lowest standard of living were twice as likely to chew as compared to the houses with the highest standard.<sup>99</sup> The National Sample Survey of 1995–1996 also reported that, across India, those below the poverty line have a 37% higher prevalence of regular use of non-smoking tobacco compared to those below the poverty line, an 8% higher rate of smoking, and a 28% higher rate of regular alcohol consumption. It is therefore likely that the poor will disproportionately suffer the sequelae of these risks in the future.<sup>100</sup>

Studies show that the poor consume the most toxic tobacco products, e.g. unbranded *beedis* manufactured with poor quality control and sometimes laced with other narcotic drugs. Tobacco quid is used by poor women and men to ward off hunger during long tedious work in agriculture, construction and other labour. Of the pavement dwellers in Mumbai, 86% used tobacco, 49% consumed raw tobacco 5 times a day, 20% chewed 7–8 sachets/day of *gutka*, 30% smoked 11–12 *beedis*/day, 24% chewed *paan* 4 times a day, and 8% smoked cigarettes.<sup>101</sup> On an average, 15% of their monthly earnings of Rs 4500 were spent on tobacco, in preference to meeting basic needs. Street children in Mumbai have a high rate of tobacco usage—46% use *gutka*, 39.5% *beedi*, 28% cigarettes and 14% plain *tambaku*.<sup>101</sup> In an informal study, 70%–80% of the over 100,000 street children in Bangalore were found to use tobacco products.

**Table 7.9** Influence of education on tobacco consumption in north Indian males

<b>Educational level</b>	<b>Urban (Delhi) <i>n</i>=1456 Age: 35–64 years (%)</b>	<b>Rural (Haryana) <i>n</i>=1070 Age: 35–64 years (%)</b>	<b>Industrial (suburban) <i>n</i>=2273 Age: 22–58 years (%)</b>
Illiterate	61.4	83.3	78.6
Semi-literate	48.6	88.1	73.7
Undergraduate	41.3	70.3	52.8
Graduates/ postgraduates	22.3	44.2	35.6

**Table 7.10** Influence of occupation on tobacco consumption in north Indian males

<b>Professional class</b>	<b>Urban (Delhi) <i>n</i>=1456 Age: 35–64 years (%)</b>	<b>Rural (Haryana) <i>n</i>=1070 Age: 35–64 years (%)</b>	<b>Industrial (suburban) <i>n</i>=2273 Age: 22–58 years (%)</b>
Professional/big business/landlord	17.6	33	24.8
Clerical/middle-level business/middle-level farmer	32.1	61	36
Skilled labourer/small businessman/marginal landowner	57.1	81	45.2
Unskilled and semi- skilled labourer	64.1	82.4	63.5

Cross-sectional surveys conducted by the All India Institute of Medical Sciences during the 1990s revealed that tobacco consumption among males was inversely related to the level of education, with a higher prevalence among the illiterate and semi-illiterate (Table 7.9). This was true of urban, rural and industrial populations.<sup>102</sup> When analysed by professional class, a similar inverse relationship was observed, with unskilled and semi-skilled labourers being the worst affected by tobacco use (Table 7.10).

The ECOSOC report<sup>96</sup> also highlights similar facts from other developing countries:

- Some street children and other homeless people in India spend more on tobacco than on food, education or savings;
- A recent study in Bangladesh showed that over 10.5 million currently malnourished people could have an adequate diet if money spent on tobacco was spent on food instead;
- Poor, rural households in Southwest China spend over 11% of their total expenditure on cigarettes;
- Preliminary results from an ongoing study in 3 provinces of Viet Nam found that over the

course of a year, smokers spent 3.6 times more on tobacco than on education, 2.5 times more on tobacco than on clothes, and 1.9 times more on tobacco than for health care;

- A study in Poland, in 1996, showed that the contribution of smoking to the risk of premature death among males at 35–69 years of age varies by education level; the risk of dying during middle age due to tobacco-related diseases was 5% among people with higher education and nearly double (9%) among persons with only primary and secondary education.

According to the WHO, tobacco and poverty create a vicious circle, from which it is often difficult to escape. 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.<sup>103</sup> Based on this evidence, WHO observed the World No Tobacco Day 2004, with the theme of Tobacco and Poverty, conveying the main message that tobacco increases the poverty of individuals, families and nations. This is in contrast to over-simplistic and widespread arguments that tobacco provides wealth to governments and growers.

## Interplay of poverty and gender vulnerability

The ECOSOC report draws attention to the global upward trend in women smoking, which is now becoming an issue in the developing world as well. It states “The tobacco industry has already understood it and is heavily targeting women to gain a part of the market which was not available in the past. Tobacco advertising vehicles images for women featuring vitality, slimness, glamour, emancipation, etc... The new gender behaviour can also have adverse social and economic consequences. For example, it is known that women often have less disposable income than men and are more likely to spend it on their children. When more women start consuming tobacco at a higher rate, the diversion of scarce family resources for tobacco may significantly contribute to malnutrition and higher rates of school drop-out, with potential long term negative consequences.”<sup>96</sup>

## Tobacco control and human rights

In 2001, the National Human Rights Commission (NHRC) of India considered the issues related to tobacco control from the perspective of human rights and concluded that the following rights of an individual are violated due to lack of tobacco control mechanisms in India:<sup>104</sup>

1. *Right to clean air*
  - A non-smoker is forced to inhale tobacco smoke in public areas.
2. *Rights of children*
  - Rights of born and unborn children are violated when they are exposed to tobacco smoke (active and passive) in the home or public areas. They are the most vulnerable and worst affected.
3. *Right to information*
  - Both the smoker and non-smoker are not provided with adequate information about the harmful effects of tobacco products

and, in fact, are bombarded with misinformation about tobacco products through advertisements/events/celebrity-and role model-linked promotion.

4. *Right to education*
  - Both the smoker and non-smoker are not adequately educated about the drastic ill-effects of tobacco on their personal and public health.
5. *Right to redressal*
  - Both the smoker/non-smoker do not have any redressal mechanism for the injuries/ill-effects suffered by them due to tobacco products.
6. *Right to tobacco cessation programme/activities (as part of right to health)*
  - The smoker and his/her family have a right to have access to various cessation strategies.

In addition, there are also some rights of the smoker which may be violated by regulatory measures intended for tobacco control. However, these have to be superseded in the interest of public health and human rights of the larger community.

Based on this assessment, the NHRC recommended that:

- A comprehensive national tobacco policy should be evolved at the highest level, in consultation with all the stakeholders in public health.
- A multisectoral national-level nodal agency should be established for tobacco control with strong representation from the legal, medical and scientific communities.
- The right of people to access correct information related to the effects of tobacco consumption must be promoted through programmes of information, education and communication. Such programmes should be adequately supported through dedicated resource allocation.
- Assistance for smoking cessation should be integrated into the health care services.

### Role of the government

Given the objectives of protecting and promoting public health, enabling conditions need to be created to help individuals make informed choices, to isolate the changing patterns of vulnerability and develop effective response mechanisms for combating the same. It is important to realize that the human rights' paradigm cannot operate in a legal vacuum. Some existing authority needs to enunciate the law and put into place appropriate enforcement and redressal mechanisms. This is where the government (state) comes in. To be able to respect, protect and fulfil its human rights' obligations, the government has to bring about well-defined legislation to facilitate the functioning of legal systems.

Today, the philosophy of 'responsive communitarianism' is gaining popularity among wide sections of society. This essentially means

balancing individual rights with social responsibilities, or individuality with the community. The collective rights of the community must have precedence over the rights of the individual smoker, especially since tobacco is now well recognized to be a 'public bad'. In asserting these principles, the government must also recognize the special obligation to provide for the poor and less educated sections of society whose right to correct information is least respected by the tobacco industry. Even in the safeguarding of rights, special protection needs to be provided to vulnerable groups.

The fundamental reciprocity between health and human rights is well established and the need to put in place a proper regulatory framework to aid and nurture this synergy should be the guiding lights of policy-makers and analysts in this field. This is even more true of tobacco control than of many other policies related to public health.

## 7.6 PROTECTION OF VULNERABLE GROUPS: A HUMAN RIGHTS' APPROACH TO TOBACCO CONTROL

### KEY MESSAGES

- The poor, the young and women are particularly vulnerable for becoming the victims of tobacco.
- Tobacco control policies must encompass a human rights' approach to protect vulnerable groups from the hazards of tobacco.
- Tobacco smoking is inversely associated with educational status.
- Homeless people in India spend more on tobacco than on food, education or savings.
- Enabling conditions must be created to help individuals make informed choices.