Original Article

Substance abuse in a Rural Community of Uttar Pradesh- Some Socio-demographic Correlates

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Abstract

In a study of 3307 individuals from the villages around Rural Health Training Centre, Satrikh of Hind Institute of Medical Sciences Safedabad, Barabanki, 1180 (35.7%) were found to be addicted to one or the other items. The commonest addiction was of smoking (16.6%) followed by betel chewing (9.4%), alcoholic intake (4.1%), tobacco chewing (2.8%), arecanut & catechu chewing (1.7%) and cannabis intake (0.6%). Addiction was more in males (27.8%) than in females (7.8%). It was more frequent amongst Muslims (42.7%) than in Hindus (34.4%). Addiction was higher in individuals of both upper and lower social class compared to middle class subjects and it was higher among illiterates.

Keywords: Addiction, Rural area, Prevalence, Smoking, Alcohol.

Introduction

Substance abuse and its associated problems are a global concern. A WHO estimate shows a burden of worldwide addiction habit of around 2 billion alcohol users, 1.3 billion smokers and 185 million drug users (The global burden of substance abuse, 2016). Substances such as tobacco, alcohol, cannabis and various allopathic drugs have been widely abused by students for various reasons despite their known ill effects. Studies conducted worldwide (Meressa et al, 2016; Epidemiologic trends in drug abuse, 2016) including India have estimated a prevalence rate of addiction habit to be around 20-40 percent (Jagnany et al, 2008; Arora et al, 2016).

Tobacco use in different forms is one of the most common substance abuse indulged by adolescents world-wide. Nearly 6 million deaths due to tobacco use occur every year, which may increase to 8 million deaths/year by 2030. Of these, 70% deaths will occur in the developing countries, mainly China and India. Young people are the most vulnerable segment and adolescence is found to be the most susceptible time for initiating tobacco use (Bagchi et al, 2014).
Problematic drinking is frequently associated with persistent smoking, less success at quitting smoking and smoking relapse (Falk et al, 1996; Kessler et al, 1995), while the concurrence of smoking and drinking represents a significant risk factor for cancer-related illness and mortality (Lubin et al, 2009; Hart et al, 2010). Some community-based rural studies have shown the prevalence of tobacco and alcohol use as 31%-42% and 10%, respectively in those ≥60 years of age. As almost three-fourths of the elderly live in rural India, there is a need to know the prevalence of tobacco and alcohol use in these areas to plan for educational efforts directed towards this group (Swathi, 2016).

In India, tobacco is consumed in several forms, which include smoking as well as smokeless tobacco. While “bidis,” which are small, thin hand-rolled cigarettes comprising of tobacco wrapped in tendu leaves, are predominantly smoked in rural India, other available varieties are hookah, chutas, cigarettes, and cigars (Dillman et al, 2009). Tobacco is also chewed extensively in India; use of chewable tobacco is in the form of paan masala, gutka, and other locally prepared mixtures of tobacco, areca nut, and additives. Paan is made from piper betel leaf filled with sliced areca nut, lime, catechu, and other spices chewed with or without tobacco (Gupta, 2013). Chewing of paan with tobacco is a popular habit that has been integrated into customs and traditions in rural India. Habitual chewing of betel quid or use of tobacco in smoking or smokeless forms by men and women in India is due to less awareness of its health hazards or because of prevalent socio-cultural perceptions of its beneficial effects (Kahar et al, 2016).

The present study was planned to elucidate the pattern of tobacco and alcohol consumption in a rural community of Uttar Pradesh, India.

Material and Methods

This was a cross-sectional study design conducted in the villages under RHTC of Hind Institute of Medical Sciences. The consent was taken from each participant before including in the study. A total of 15 villages were covered comprising 3170 families with total population being 17816. Of these, 20% of the families were sampled (634 families) and 596 families were studied. A total of 3307 subjects were interviewed. The subjects under 5 years of age were excluded from the study.

Data collection

The data was collected on pre-designed questionnaire. The multi-stage sampling was used to select the study subjects. In first stage, the villages were selected. In the second stage, households were selected and in last stage, study subjects were selected. For the selection of households, a landmark was fixed in the village and then first household was selected. If there were no subject in the selected household, next household was selected, and the subjects were interviewed.

Data analysis

Descriptive statistics such as percentages is being presented.

Results

Out of the total 3307 studied subjects, 1180 (35.7%) were found to be addicted to one or the other addiction habit. Addiction was more in males (52.5%) than in females (16.7%). The commonest addiction was smoking (12.8%) followed by betel chewing (7.3%), alcoholic intake (4.1%), tobacco chewing (2.8%), arecanut & catechu chewing (1.8%) and cannabis intake (0.6%). There was much difference in smoking, betel chewing and alcohol intake between male and females being higher among males (Table-1). The addiction habit was observed to be more common among the subjects of age ≥25 (49.2%) followed by 15-24 (31.7%) and 5-14 (17.2%) years. The addiction habit was observed to be more common among Muslims (42.7%) compared to Hindu (34.4%) subjects. Out of those subjects belonging to Hindu community, the addiction habit was higher among upper caste (40.2%) than
scheduled caste (34.2%) and backward case (26.4%). The addiction was more common among the subjects of backward caste of Muslims. The addiction habit was observed to be higher among illiterates than other educational status. The addiction habit was higher among the subjects belonging to social class I (63.1%) than IV (41.1%), II (39.2%), V (33.8%) and III (29.9%) (Table-2).

Table-1: Prevalence of addiction in relation to sex of the respondents

| Type of Addiction       | Male          | Female         | Both sexes  |
|-------------------------|---------------|----------------|-------------|
|                         | (n=1753)      | (n=1554)       | (n=3307)    |
| No.                     | %             | No.            | %           |
| Smoking                 | 375           | 47             | 422         | 12.8 |
| Betel chewing           | 178           | 63             | 241         | 7.3  |
| Alcohol                 | 128           | 8              | 136         | 4.1  |
| Gutkha                  | 126           | 69             | 195         | 5.9  |
| Tobacco chewing         | 47            | 47             | 94          | 2.8  |
| Arecanut & Catechu chewing | 33         | 25             | 58          | 1.8  |
| Cannabis                | 21            | 0              | 21          | 0.6  |
| Others                  | 13            | 0              | 13          | 0.4  |
| Total                   | 921           | 259            | 1180        | 35.7 |

Table-2: Prevalence of addiction in relation to socio-demographic profile

|                        | No. studied | No. with addiction | Prevalence percent |
|------------------------|-------------|---------------------|--------------------|
| Age in years           |             |                     |                    |
| 5-14                   | 862         | 148                 | 17.2               |
| 15-24                  | 978         | 310                 | 31.7               |
| ≥25                    | 1467        | 722                 | 49.2               |
| Religion/Caste         |             |                     |                    |
| Hindu                  | 2787        | 958                 | 34.4               |
| Upper caste            | 908         | 365                 | 40.2               |
| Backward caste         | 640         | 169                 | 26.4               |
| Scheduled caste        | 1239        | 424                 | 34.2               |
| Muslim                 | 520         | 222                 | 42.7               |
| Upper caste            | 450         | 177                 | 39.3               |
| Backward caste         | 70          | 45                  | 64.3               |
| Literacy status        |             |                     |                    |
| Illiterate             | 1124        | 552                 | 49.1               |
| Primary                | 789         | 251                 | 31.8               |
| Middle                 | 679         | 190                 | 28.0               |
| High School            | 547         | 176                 | 32.2               |
| Technical              | 115         | 4                   | 3.5                |
| University/Higher      | 53          | 7                   | 13.2               |
| Social class*          |             |                     |                    |
| I                      | 19          | 12                  | 63.1               |
| II                     | 130         | 51                  | 39.2               |
| III                    | 971         | 290                 | 29.9               |
| IV                     | 1197        | 492                 | 41.1               |
| V                      | 990         | 335                 | 33.8               |

*Prasad (1970)

Discussion
In this study, a higher (35.7%) percentage of subjects were found to be addicted to one or the other addiction habit being higher in males (52.5%). We found smoking was the most common addiction habit being 12.8% which was almost similar to a study from the rural area of Bangalore (13.3%) (Swathi et al, 2016). The
alcohol intake was 4.1% in this study which was lower than the study Swathi et al (2016) in which prevalence of alcohol use was 18.3%. However, a study in north India reported the prevalence of tobacco smoking being 56.5% (71.8% males 41.4% females) (Goswami et al, 2005). The addiction habit was higher among higher age groups which was similar to the study by Swathi et al (2016).

In another north Indian study addressing the same issue, the prevalence of alcohol consumption among the elderly men was 17% and 7% among their female counterparts (Dar, 2003). Even among the south Indian states there seems to be a variation in tobacco consumption, in rural Andhra Pradesh tobacco smoking is more prevalent than chewing (Gupta and Ray, 2003), where as in our study tobacco smoking was more common.

In the present study, the addiction habit was more common among illiterates. In a study, both tobacco chewing and smoking were more prevalent among illiterate population (Tomar et al, 2016). In a study by Rani et al (2003) found tobacco consumption was the highest in the least educated, lower socioeconomi-class. We also found the higher addiction habit in the lower social class.

**Conclusion**

In rural areas, people are very much addicted to addiction of tobacco and alcohol, so there is need to con duct effective interventions to control tobacco use. Thus, awareness about the ill effects of tobacco and alcohol use should be increased through national and local media and facilities be made available for those wishing to quit.

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