



PROCEEDING

conference and exhibition.

Addressing Tobacco Problems n Developing Countries

conomic Impact of Tobacco Use

ocial Determinants of Tobacco Use and Demand Reduction Intervention

Lulture, Employment and Agriculture: Between Tobacco Myth and Reality

obacco Use and Health

outh, Cigarettes, and Drugs



Wednesday-Thursday, Deceember, 5-6, 2012

niversity of Muhammadiyah Yogyakarta

Addressing Tobacco Problems In Developing Countries

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SEED RESEARCH GRANT

Abstract

SMOKING AMONG THE POOR AND THE IMPACT ON ECONOMY AND HEALTH IN BALI*

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ABSTRACT

Bali Health Research Data Base in 2007 showed that the population aged 10 years and over who smoke by 20.2%. National Socio-Economic Survey Data in 2005 showed that the prevalence of poor male smokers by 63%. Karangasem is one of regency in Bali which has high poverty rate, while there are many people also live below poverty line in the city of Denpasar.

The study is cross sectional study (survey). About 289 samples are selected using multistage random sampling method. Data are collected using questionnaires and analyzed quantitatively.

The results show that the prevalence of poor families who smoke are 68.5%. The proportion of cigarette expenditure among poor families was 1.25%. The non-communicable disease is 19.5%. Moreover, the prevalence of stillbirth among poor families is 9.7%. Prevalence of miscarriages among poor families is 56%. Prevalence of Birth with low weight among poor families is 18.4%.

The prevalence of poor families in urban areas who smoke cigarette expenditure is greater than in the rural areas. Prevalence of stillbirth and low birth weight in rural areas is greater than urban. However, the prevalence of miscarriage in urban areas is greater than in rural areas.

Keywords: Smoking, Poor Families, Economic, Health

Full Paper

SMOKING AMONG THE POOR AND THE IMPACT ON ECONOMY AND HEALTH IN BALI*

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INTRODUCTION

Health status is strongly related to the behavior of people, which one of it is smoking. Based on the WHO data on 30 January 2004 stated that the number of deaths by smoking is about 5 million cases annually. Word Bank reported in 1970 to 1990, cigarette consumption in developed countries fell 10%, otherwise in developing countries increased by 60%.1

Indonesia is the third largest number of smokers in the world after China and India. Data in 2010 showed that the prevalence of smokers at 34.7%, 76.6% of them smoked in the house with other family members. Based on Bali Provincial Health Research Association 2007 data showed that the proportion of population aged 10 years and over who smoke by 20.2%.2

National Socio-Economic Survey Data (NSES) in 2005 showed that the prevalence of smokers from poor family by 63%. Moreover the consumption of cigarettes in poor families (22%), greater than the expenditure staple food such as rice (19%).3 Unwittingly smoking behavior in the community, particularly in the poor family have greater risk to health due to the limited ability to access better health services. In addition, smoking behavior also decrease the level of the poor economy, because of the high expenses for unwitting consumption of cigarettes has reduced the costs for basic needs such as nutritious food.4 One of the regency in Bali which has a high poverty rate is Karangasem, meanwhile there are also many poor communities in urban area in the city of Denpasar. Therefore it is necessary to explore the behavior of smoking among the poor in Bali and its impact on the economic and health.

METHOD

This study is cross sectional study (survey). The sample size in this study is 289 poor families which are recorded in Karangasem regency and Denpasar. Samples were selected using multistage random sampling method. From rural and urban were chosen 4 district each then each district had 2 villages as representative. Totally was gained 8 districts and 16 villages, then from each village samples were selected by simple random sampling. Data were collected by interview using questionnaire. The data then analyzed descriptively and presented in tabular and narrative.

RESULT AND DISCUSSION

The poor families in Karangasem regency less educated or not educated and tend to be a higher prevalence of smokers. This is consistent with several studies showing that the prevalence of low education of adult smokers more than smokers with higher education.5 About 198 poor families (68.5%) had a family member who smoked. Poor families in Denpasar who smoke arehigher (75.9%) than Karangasem (61.8%). This is probably supported by the easier access to cigarette (58.4%). The high number of smoker is also supported by the religious activity that

always provides cigarettes (61.4%). They smoke average nine rods cigarettes per day, however the difference of the number of cigarettes smoked per day was not so significant between the two areas.

Three of the four families in Indonesia have accumulated to buy cigarettes. Group of the poor families would have a higher prevalence of smoking than the rich families group. The proportion of expenditure for cigarettes monthly at the poorest families (12%) which is also higher than the richest families (7%).6 The proportion of expenditure on cigarettes with total expenses for a month for the urban area is on average 0.29. While the proportion of expenditure on cigarettes in rural area average of 0.21. In smoking families, expenditure on tobacco is average of 10.4%; or 4-fold greater than the expenditure for meat, eggs, and milk.

Most of the poor families who smoke suffer from respiratory infection (upper respiratory tract infection) 25%. The prevalence of non-communicable diseases such as heart disease, hypertension, tuberculosis, and tumor are 19.5%. For other diseases such as gastritis, common fever, conjunctivitis, toothache, tumors, and other are (65.5%).

The number of stillbirths in poor families in rural areas 17.4% of the total number of births that occur in smoking families and 9.8% of the total number of births to poor families in rural areas. Meanwhile, poor families in urban areas, the number of stillbirths by 5.1% of the total number of births that occur in poor smoking families and 3.4% of the total number of births to poor families in urban areas. So, this study shows that the numbers of stillbirths in poor families who smoke in rural area are higher than urban areas. This is consistent with results from several studies which showing that the risk of death of infants from smoking families is 14% in urban and 24% rural, or 1 of 5 mortality associated with smoking behavior of parents.7

The number of miscarriage in poor families in rural areas 12.5% of total births that occur in poor smoking families and 7.3% of the total births in poor families. This proportion is not so differ if compared with the prevalence of miscarriage in poor not smoking families in rural areas (9.7%) of the total births of poor families. Moreover the results showed that the prevalence of miscarriage in poor smoking families in urban 54.3% of total births that occur in poor smoking families, and 42.4% of the total births in poor families in urban areas. This figure is much larger if compared with the prevalence of miscarriage in poor not-smoking families only 3.9% of the total births in poor families in urban areas.

The results also showed the prevalence of birth with low weight among poor families in rural 21.7% of the total births in poor smoking families, and 14.7% of total births in poor families. In urban areas, the prevalence of birth with low weight among poor families 15.4% of the total births in poor smoking families and 12.5% of the total births in poor families. If we compare the prevalence in both urban and rural areas, the poor smoking families in rural areas experience more birth with low weight than poor smoking families in urban areas.

CONCLUSION

The prevalence of poor families in urban areas who smoke cigarette expenditure is greater than in the rural areas. The prevalence of infectious diseases is more frequent than the non-communicable diseases. Prevalence of stillbirth and low birth weight in rural areas is greater than urban. However, the prevalence of miscarriage in urban areas is greater than in rural.

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