Survey of sociodemographic characteristics of tobacco use among 99 598 individuals in Bombay, India using handheld computers

Prakash C Gupta

Abstract

Objectives – To study the diversity and sociodemographic characteristics of tobacco use in Bombay, India.

Design – Population-based, cross-sectional, house-to-house survey with face-to-face interviews in the city of Bombay during 1992–94. Data was input directly into a programmed, handheld computer (electronic diary).

Participants – Permanent residents of the city of Bombay aged 35 years and older.

Main outcome measures – Tobacco use in various smoking and smokeless forms.

Results – 99 598 individuals were interviewed (60% women, 40% men). Among women, prevalence of tobacco use was high (57.5%) but almost solely in the smokeless form. Among men, 69.3% reported current tobacco use and 23.6% were smokers. The most common smokeless tobacco practice among women was mishti use (44.5% of smokeless users) and among men betel quid with tobacco (27.1%). About half of smokers used bidi and half smoked cigarettes. Chewing areca nut without tobacco was rare (< 0.5% of smokeless users). Educational level was inversely associated with tobacco use of all kinds except cigarette smoking.

Conclusions – The pattern of tobacco use varies across India and, in Bombay, is very different from other areas. Using handheld computers to collect data in the field was successful.

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Keywords: tobacco use; Bombay, India

Introduction

Tobacco is used in a wide variety of ways in India, encompassing smoking and smokeless use. India is the third largest producer and consumer of tobacco in the world and the available information shows that the prevalence of tobacco use is high. Reliable, quantitative information on the prevalence of tobacco use is, however, scanty.

The most reliable and extensive information on prevalence in rural Indian populations has come from house-to-house surveys for studies of oral cancer and oral precancerous lesions. These studies established that tobacco use ranged from 33% to 80% among men and 15% to 67% among women, depending on the area.1–3 Other studies from different parts of India also show a similar range.4–9 These stud-
were completely excluded whereas, in other areas, fewer than 10% of polling stations were excluded.

For a selected polling station, all eligible people (aged 35 years and older) listed in its electoral roll were approached by investigators and about 30% of subjects were interviewed. Sometimes individuals not listed on the electoral roll were also interviewed and included in the sample if they insisted that they were permanent residents. Such people formed about 5% of the sample. Their residence status was confirmed through their listing in "ration cards" that are issued by the Bombay Municipal Corporation. Every householder keeps the card because, apart from getting certain food items at subsidised prices, it proves residence, allowing the person access to all city and state government services.

The interviews were conducted by trained investigators using handheld computers (electronic diaries) from February 1992 to May 1994. The diary had a language compiler installed in its Read Only Memory (ROM). The questionnaire was programmed on a personal computer and transferred to a storage device in the diary. The computer program provided appropriate sequencing of questions, skipped irrelevant questions for an individual, accepted only valid codes for answers, and performed range and consistency checks on the spot. These computers, along with their storage devices, were brought back to the office once a week, and the data were electronically transferred first to a PC and then to a mainframe computer.

The interviews were conducted in local languages (Marathi, Hindi) but the information was recorded in English. Mostly, the responses were recorded as codes because almost all questions were close-ended.

In addition to cigarette smoking, a large variety of tobacco practices are prevalent in Bombay. The most common smoking practice is *bidi*. This is a cheap smoking stick, hand-made by rolling a dried, rectangular piece of tembuni leaf (*Diospyros melanoxylon*) with 0.15–0.25 g of sun-dried, flaked tobacco into a conical shape and securing the roll with a thread. The length of a *bidi* varies from 4.0–7.5 cm.

The most common smokeless tobacco use in Bombay is the use of *mishri*. This is a black powder obtained from tobacco by roasting and powdering it. It is applied on the gums by a finger. Initiation of this practice is generally as a dentrifice.

Another common form of smokeless tobacco use that is prevalent throughout India is betel-quid chewing. Betel quid is a combination of betel leaf, areca nut, slaked lime, tobacco, and condiments according to individual preferences.

Other smoking and smokeless tobacco practices prevalent both in Bombay and in many other parts of India have been described elsewhere.10

**Results**

Figure 1 shows the age and sex distribution of the 99,598 individuals who were interviewed. The male:female ratio was about 2.5. More women than men were interviewed in all age groups. Propportionately more women were interviewed in the age group 35–54 years than in older age groups.

Table 1 shows the distribution of current and past tobacco use practices. Among women, 57.5% reported current tobacco use and 2.2% reported past use. Almost all of their tobacco use was smokeless and only 0.4% reported current smoking. Among men, 69.3% reported current tobacco use and 4.5% reported past use. Men reported smoking much more often (23.6%) than women, but smokeless use remained the dominant (55.6%) form of tobacco use among men.

Table 2 shows details of smokeless use. *Mishri* was the dominant form of use among women (44.5% of smokeless users), whereas among men chewing betel quid with tobacco was somewhat more popular (27.1%) than *mishri* use (22.7%). Men used tobacco in other ways as well, mostly by combining it with lime (7.5%). The use of areca nut without any tobacco was rare: 0.5% among women and 0.4% among men.

Figure 2 shows the distribution of the frequency of *mishri* use among men and women. Almost all men and over 90% of

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Table 1  Current and past tobacco use

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th></th>
<th>Male</th>
<th></th>
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<tr>
<td></td>
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<td>5494</td>
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<td>9.9</td>
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<td>4.1</td>
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<td>62050</td>
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<td>824</td>
<td>2.1</td>
<td>2108</td>
<td>2.1</td>
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<td>Smoking</td>
<td>16</td>
<td>*</td>
<td>692</td>
<td>1.7</td>
<td>708</td>
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<tr>
<td>Smokeless and smoking</td>
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<td>*</td>
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<td>3089</td>
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<td>10494</td>
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<td>34459</td>
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<td>40071</td>
<td>100</td>
<td>99598</td>
<td>100</td>
</tr>
</tbody>
</table>

* Less than 0.05%.

**Figure 1** Age and sex pyramid of 99,598 individuals in the sample.
women used misri less than three times a day. This low frequency is consistent with its use as a dentificative.

Figure 3 shows the frequency of other smokeless practices among men and women. These were higher than the frequency of misri use but still not very high. Most users (nearly 60% of men and 75% of women) used smokeless tobacco 2–5 times a day. The frequency was somewhat higher among men (median = 4.5 times a day) compared with women (median = 3.8).

Table 3 presents data on smoking practices. Among men bidis and cigarettes were the dominant form of smoking, but bidis were slightly more popular (13.3% of men) than cigarettes (11.3%). Among women, smoking was very rare; among those who did smoke, most smoked bidis (0.3% of women). Other forms of smoking that are popular in different parts of India were rare in Bombay.

Table 4 shows the frequency of bidis and cigarette smoking among current smokers. About half of male cigarette smokers smoked five or fewer cigarettes a day and an additional third smoked 6–10 cigarettes per day. Compared with cigarettes (median = 5 per day), more bidis were smoked (median = 12). Frequency of smoking among women (median = 4.7 for bidis) was much lower than among men.

Figure 4 shows the cumulative percentage distribution of the age before which the practice started for misri users, chewers, and smokers. Misri users tended to start their practice rather early; more than 50% before the age of 10 years and more than 80% before the age of 20 years. For betel-quid chewers and smokers, the distribution was similar with a median of about 20 years of age, although smokers also showed an earlier initiation at older ages. The data for men and women were combined in this graph because the shapes of the distributions were similar. The only difference was that men tended to begin their smokeless tobacco use (misri and betel quid) slightly later than women.

Figure 5 shows the relationship between educational level and tobacco use among men.
and women. Cigarette smoking prevalence among men increased with increasing educational level. On the other hand, there was an inverse relationship between the prevalence of tobacco use and educational level among women. However, if cigarette smokers are excluded, the relationships for men and women are similar.

Figure 6 shows the relationship between religion and tobacco use. Smokeless tobacco practices were very high (83.5%) among Buddhist women but rather low (16.7%) among Christian women. Hindu women formed the largest portion of the sample and 57.4% of them used smokeless tobacco. Chewing among men followed a similar pattern. Smoking prevalence was higher among Muslims (42.4%) and Christians (35.1%), but lower (18.3%) among Buddhist men. Adjustment by level of education among different religions did not change these patterns.

The distribution of tobacco practices among migrant groups from different parts of the country can be assessed by examining tobacco practices by mother tongue (Figure 7). The local language in Bombay is Marathi and those with Marathi as their mother tongue formed the bulk (74%) of the sample. Smokeless tobacco use by men as well as women was very high among Marathi-speaking people whereas smoking prevalence was quite low. Among women of migrant groups, the prevalence of tobacco use was comparatively lower, except among Urdu-speaking women. Smoking prevalence in Marathi-speaking men was less than 20%, whereas among men of all other linguistic groups it was more common (30–50%). This pattern was unaffected after adjusting the prevalence for educational level.

Table 5 shows the percentage of past users among ever-users for selected tobacco practices, according to level of education. The overall percentage was 3.6% among female smokeless tobacco users, 4.3% among male smokeless tobacco users, 5.4% among male bidi smokers and 12.9% among male cigarette smokers. Among female and male smokeless tobacco users and among male cigarette smokers, quit rates among the more educated group (high school and over) were more than twice those among the less educated. Among male bidi smokers, the difference in quit rates was trivial but in the opposite direction.

Discussion

Earlier reports from different parts of India have shown the prevalence of tobacco use to be quite high. Despite this knowledge, the extent of tobacco use revealed in this study is surprising. About 75% of men and 60% of women aged 35 years and older reported ever-use of tobacco, with a very small fraction reporting past use only. The pattern of tobacco use varies across India and in Bombay, it appears to be quite different from all other parts of India. The only comparable report that is available is from a rural area about 200 km from Bombay, where 101 761 villagers aged 15 years and older were interviewed. In that study, about 62% of men and 50% of women reported using tobacco. Women reported using tobacco only in smokeless form and the overwhelming majority used it in the form of mishri. Among men mishri use was less common and most of them reported chewing tobacco and lime as their main practice. Smoking among men was uncommon (8%), and most of this was bidi smoking. Except for a higher proportion of smokers and mishri users among men, findings in Bombay were not very much different from those in nearby rural areas.

The census figures (1991) show that there are 1223 men per 1000 women in Bombay. In our sample, however, the male:female ratio was about 2:3. More women than men were interviewed in all age groups but the proportion was more skewed in the age group 15–55 years. This was due to the absence of working men from home at the time of the interview. This trend of having more women than men in the sample became apparent from the early stages in the study. Despite considerable efforts, such as repeating the visits in the early morning and late evening, and on Sundays and holidays, this ratio could not be improved much further. It turned out that men who were working, active, and busy were out of the house most of the time.

It is well known in the West that most smokers start smoking in the early teenage years, and the initiation of tobacco use after the age of 20 or 25 is uncommon. In Bombay, mishri use seems to begin at a comparatively earlier age whereas betel-quid chewing and smoking start at a somewhat later age. The differences may be due to the fact that mishri, as a convenience, is available as a common household item whereas betel quids and bidis need to be purchased from the market and therefore require pocket money or earning capability.

An inverse association between level of education and prevalence of tobacco use has been reported earlier. In our study, although overall tobacco use showed a strong inverse association, cigarette smoking showed a strong positive association with level of education.

![Figure 5 Relationship between prevalence of tobacco use, cigarette smoking, and educational level among men and women. Primary = 5–7 years; middle = 8–11 years; secondary = 12 years upwards.](image-url)
may also be attributable to the higher cost of cigarettes compared with other tobacco products.

The analysis by religion revealed a rather unexpected finding. Prevalence of smokeless tobacco use was highest among men and women of the Buddhist religion. Although Buddhism originated in India about 2500 years ago and then spread to different parts of Asia, it disappeared from India during the middle ages. The current Buddhists are Neo-Buddhists who have converted to Buddhism during the last half-century. They originally belonged to lower castes among Hindus (Untouchables) and thought that they would not receive social justice within the caste-based Hindu religion. Following the call of their leader, Dr BR Ambedkar, who was a well-known lawyer and an architect of the Indian Constitution, they converted to Buddhism. It is surprising that they have such high rates of smokeless tobacco use. Perhaps prevalence among low-caste Hindus is equally high, but that information is not available. These differences could not be explained by differences in educational level.

Tobacco use prevalence was low in the religion category “others”, mainly due to the inclusion of Sikhs in this category. Sikhs do not use tobacco because it is prohibited by their religion. There were no Zoroastrians or Parsees in the sample (who also do not use tobacco for religious reasons), because they form a rather small proportion of the population (about 1%) and because they generally belong to upper income levels (which, for the most part, were not included in the sample).

The pattern of differences in tobacco practices among different linguistic groups reinforces the fact that tobacco use patterns vary widely across India. Low rates of smoking are a specific feature of Maharashtra state and Marathi-speaking men. Smoking rates are higher among men who immigrated to Bombay from other regions. Although level of education has emerged as a strong correlate of overall tobacco use, it did not explain differences between religions and linguistic groups. These differences may be associated with specific social norms and cultural preferences in different regions.

The city of Bombay has a population-based cancer registry reporting incidence rates since 1964. The findings from our study help to explain some of the characteristics of the reported incidence rates. A rather puzzling finding has been that the incidence of lung cancer among men is not high in Bombay—the 1983–87 age-standardised rate (ASR) was 14.6 per 100,000 in 1983–87 and the increase over the years is also small (the 1964–66 ASR was 13.3 per 100,000)—compared with other parts of the world.

This is now easily explained by the low prevalence of smoking among men in Bombay, the high age at initiation (median = 21.5 years), and the low frequency of use (median = 12 bidi or five cigarettes per day). The reasons for the low prevalence, late initiation, and low frequency of use may be financial, at least in part.
Cigarettes are eight to 10 times more expensive than bidis. Bidis are also somewhat more expensive than betel quids, which are more expensive than mishri. Financial considerations may also partly explain the high proportion of past cigarette smokers and the low proportion of past smokeless tobacco users.

The carcinogenicity of betel-quid chewing with tobacco is well established. There are no specific epidemiological reports, however, about the carcinogenicity of mishri, although laboratory studies show similar pharmacokinetics compared with other forms of smokeless tobacco use. Because mishri was the most common form of tobacco use among women, one way to assess the carcinogenicity of mishri would be to consider the male:female ratio of the age-adjusted incidence rates of cancer at various sites in the Bombay Cancer Registry. For sites that are more affected by smoking, such as the larynx (International Classification of Diseases (ICD) code 161), lung (ICD code 162), and pharynx (ICD codes 144, 148, and 149), the sex ratios were quite high (7.3, 4.7, and 4.1, respectively), whereas for oral cavity (ICD codes 140, 141, 143-145) (which is equally affected by smoking and smokeless tobacco use), the incidence rate among women was high (ASR = 7.1) and the male:female ratio was only 1.9. This points out that mishri use perhaps carries a considerable amount of excess risk for oral cancer.

The methodology of using handheld computers for collecting survey data in the field was developed and tried for the first time in India. Like most other equipment, computers have an image of being bulky, expensive, and breaking down or developing snags at the most inconvenient moments. They are said to be sensitive to environmental conditions of heat, dust, and humidity. They do not seem to be ideal for use in the field, therefore, especially over the simple paper-and-pencil technology that is typically used.

The handheld computers used in this project were not actually computers but electronic diaries, with one important difference: the diaries had a built-in computer language compiler in their ROM. As a result, it was possible to program a questionnaire and input it. The diaries were powered by a dry-cell battery that was easily available everywhere, and a spare one could always be kept. Being a mass product for general use rather than a specialised one, they cost much less than a computer. They weighed about 290 g, so bulk was not a problem.

The computers functioned admirably well. In Bombay, the daytime ambient temperatures are generally in the 30s (degrees Celsius), atmospheric pollution is high, and humidity is very high. During the months of monsoon—that is, June to September—the city receives almost all of its 2000 mm of annual rainfall and the humidity is close to 100%. Thus the field conditions were not ideal for a sensitive instrument, but not one computer stopped functioning in the field. A few units did stop functioning in the office when they were mishandled or when procedures for transferring data to a personal computer were not followed properly.

The overall assessment has been that the desktop computers in air-conditioned environments with voltage stabilisers gave more trouble more often than the handheld computers in the field. Perhaps one reason for this is that these computers had no moving parts: no floppy drive, no moving head of the hard disk, no collection of storage devices was through pins. There was no operating system software (such as DOS), so there was no possibility of such software getting corrupted.

The use of these computers for data collection offered many advantages. The data checking for validity of codes and internal consistency was carried out by the program while the answers to the questionnaire were being input. As a result, a clean data set that could be directly analysed was available every day. Data did not have to be rekeyed, saving a considerable amount of time and expense. Admittedly, a large investment of resources was required to buy the handheld computers and necessary peripherals, and to convert the questionnaire into computer programs during the preparatory phase but, over a period of time, the advantages balanced the high initial costs.

A long-term follow-up of this cohort, using the death records of the Bombay Municipal Corporation, is planned in order to estimate cause-specific mortality rates among tobacco users and non-users. In addition to age and sex, other identification variables are name and address, which are transcribed in a roman script independently in our study and in the Bombay Municipal Corporation. To match these two very large lists is a challenge for the future.

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