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A comparative study of youth's perception regarding the effects of smoking in Himachal Pradesh

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Abstract
Although smoking has various harmful consequences, some people see some benefits to it. The purpose of this study article is to investigate how youths living in rural and urban parts of Himachal Pradesh, perceive the effects of smoking. To accomplish this, a descriptive research approach was used, with five hundred respondents completing a questionnaire. The data were examined with the arithmetic mean, standard deviation, t-test, and ANOVA. The data show that the attitudes of urban and rural youth differ considerably by gender, age and caste.

Keywords: Urban youth, rural youth, effects of smoking

Introduction
Young people nowadays are impacted by a wide range of issues. These young people nowadays live in complex social and cultural environments that provide them with a great deal of social engagement but can also provide challenges. Today's youth choose the conditions under which they will develop and mature. They could be relocating to new social circles where there is a chance they will overcome obstacles. There may be underlying reasons why people smoke that have to do with their personal or societal perspectives. A person's desire to exhibit independence or mature behaviour may be the driving force for living or sharing a certain lifestyle, but joining a circle may also be a social perspective (Hoffmann & Kersten, 2002) [8].

The modern world is undergoing profound transformation. Numerous problems affecting the entire public, particularly the youth, are becoming more prevalent. One such problem is smoking; thus, it is critical to identify the precise causes of smoking to develop effective countermeasures for this epidemic. Use of tobacco among the youth in India and throughout the world is reaching worrisome scale. According to World Bank research, every day over 80,000 children and youths worldwide start smoking. It is predicted that half of these smokers would carry on into maturity, while the other smokers would most likely pass away before their time owing to illnesses associated with smoking. Moreover, smoking would kill nearly two hundred million people if the current pace persists (Jha *et al*., 2011) [10].

Tobacco usage in any form is influenced by social and cultural variables. The influence that parents have on their children is crucial, and children of smokers are more likely to develop a smoking habit. Numerous studies have demonstrated a substantial correlation between a mother's smoking and her daughter's decision to become a smoker, with female youths being more likely to smoke if both of their parents' smoke. A child being raised in homes where parents or either one of the parents is in a practice of smoking does make their child more sensitive to tobacco consumption. Additionally, it has been shown that children of smokers have easier access to cigarettes and are less likely to confront their child's smoking behaviour (Aaro *et al*., 1981) [1].

Some people smoke because they think it will make them more accepted by their peers and help them fit in. Smoking is now even considered a lifestyle choice and a sign of membership in many groups. According to certain studies, the risk of currently smoking doubles when one has smoking companions. A crucial point to consider is the impact that young minds receive from their role models. Pop singers, movie and television actors, fashion models, and other celebrities present smoking as a very attractive and lucrative lifestyle choice, which encourages these youngsters to start smoking. Smoking is viewed by youths as "cool," and they begin to perceive it as a prerequisite for membership in many social groups.

Smoking throughout younger years can result in several immediate health issues as well as some serious issues that could develop suddenly later in life. Numerous studies have shown suggestions that nicotine dependence may occur quickly and that youths may become very dependent on it; this can result in symptoms that cause problems at different phases of life. If most people who smoke regularly consider quitting, they will face significant difficulties (US Department of Health, 1994).

Any type of smoking is harmful to one's health and can result in a wide range of illnesses. Premature smoking initiation causes the development of a potentially unstable nicotine addiction. Any person's youth years are a time of evolution when many factors may readily impact conduct. Tobacco corporations utilize sophisticated marketing strategies to encourage individuals to start smoking at a young age, among other indirect means of promoting their goods. This is especially based on the idea that a young who starts smoking will continue to do so for the rest of their lives.

Smoking can undoubtedly increase the chance of acquiring asthma at a younger age and increase the risk of other respiratory issues. Young smokers' surveys have revealed the presence of rhinitis and asthma/wheezing, especially in females (Burr *et al*., 1999) [3]. In addition, youngsters who smoke may experience wheezing, coughing up mucus, and shortness of breath. Even smoking irregularly can lead to breathing related illnesses primarily in age groups of eighteen to twenty years. According to confirmed research, certain Finnish men had a higher prevalence of bronchitis (a persistent cough and production of phlegm) than those who smoked every day (Hamari et al., 2010) [7].

When compared to non-smokers, young smokers are probably going to experience more pain. Numerous problems have been linked to these smokers, including the possibility of severe headaches, backaches, and declining general health (Botello *et al*., 2010) [2]. According to US Navy research, some young recruits, who were on average nineteen years old, were hospitalized for smoking-related illnesses and were experiencing discomfort. Additionally, it was discovered that daily smokers were admitted to the hospital for a noticeably greater number of days than smokers who either never smoked at all, smoked sometimes, or smoked tentatively (Woodruff *et al*., 2003) [18].

According to the findings of certain research on young smokers, smokers tend to be less physically fit than their peers who do not smoke, and this aptness level does decrease as tobacco use increases. Physical performance throughout the latter stages of life is impacted by smoking mixed with the early start. Researchers did discover that smokers performed less physically when they were fifty years of age or older. Vigorous smoking usually has a worsening effect on the lungs. Tobacco use has an impact on lung growth as well since it deteriorates lung development (US Department of Health, 2011).

Early-life smoking can have a negative impact on one's heart and lead to certain cardiovascular disorders. In addition, it may damage the cardiovascular system and result in the development of atherosclerosis, strokes, or chronic obstructive pulmonary disease (COPD). According to a Taiwanese university research, compared to non-smokers, young smokers had a markedly increased risk of circulatory and haematological conditions, such as hypertriglyceridemia and neutrophilia (Kung *et al*., 2008) [11]. In addition, smoking has been linked to psychological health issues like stress and anxiety. It is believed that smoking relieves tension and anxiety among smokers. Both adults and youths have the preconceived notion that smoking reduces stress. Smoking, on the other hand, really causes stress and worry in its stead. The momentary feeling of calmness quickly gives way to increased desires (Picciotto *et al*., 2002) [14].

Smoking increases the risk of depression. According to empirical data, smokers are twice as likely as non-smokers to have depression and related disorders. Use of tobacco products is associated with an increased risk of major depression. According to some research, individuals with depression have relatively low levels of dopamine (a neurotransmitter linked to the brain's incentive and inclination epicentres), which causes them to smoke to temporarily increase their dopamine levels (Mendelsohn, 2012) [13]. On the other hand, smoking reduces the amount of dopamine in the brain, which causes an opposite mode of action that leads to smoking behaviours (Campion, 2008) [4].

Even though smoking is a centuries-old problem, several persistent attempts have been made to raise public awareness of its harmful consequences. With time, it has emerged as the most likely reason for the decline in overall public health, as smoking-related illnesses are killing millions of people globally. Smoking has long been a source of concern for many people worldwide. The world's most serious preventable health problem is smoking. Eliminating the admission of new smokers, particularly those in the younger age range, is the most important strategy to cease smoking's widespread use. Despite the health risks associated with smoking in any form, most regular young smokers continue to smoke throughout adulthood, which may contribute to the long-term health effects of smoking.

The study is conducted in the twelve districts of Himachal Pradesh (Administrative setup of Shimla, n.d.). Comparison research identified certain urban and rural areas based on the level of smoking, which is a growing problem. The researcher's field of study involves addressing several societal challenges, with smoking being the most severe. Smoking stands out as the most severe issue that has influenced many young people's growing habits and led them to start the harmful habit of smoking cigarettes at a young age. This problem has had a huge, unavoidable negative influence on society that is irreversible.

History of tobacco

Historically, tobacco goes a long way back. Even the Mayan civilisation, (1200 -1000 BC) was aware about tobacco and its various forms (one of which was smoked). It is said that the Mayan civilisation was using tobacco frequently in smoked form to attain a state of trance and encounter the world of spirits Christopher Columbus, when landed in Cuba (1492), saw local men and women smoking something that he later found were tobacco. The import of tobacco in Europe started for the first time in 1556. Europeans were quick in adapting this substance which was formerly known for herb and leisure medical purposes only. It was being used as lotion, oil, powder, syrup and even as a smoke enema. The crushed tobacco form was suggested to cure ulcers, headaches, and asthma. Some disorders like shortness of breath, kidney stones and stomach pain were also repairable by tobacco. 'The Great Plague' of 1664 saw individuals smoking tobacco with the credence that it would

help them evade transition of diseases (Robicsek, 1978) [16].
By the 1600s, tobacco had become widely popular in its smoked form and was commonly used for enjoyment and leisure. In 1604, King James I argued that tobacco was harmful to people's internal organs and criticized its expense. Later, in 1828, Wilhelm Heinrich and Karl Ludwig also noted that tobacco contained nicotine, highlighting its dangers. Additionally, various influences suggested that tobacco was primarily used for frivolous reasons, leading to a decline in its legitimate medical applications (Museum of the Royal Pharmaceutical Society, 2012).
The origins of the word "tobacco" have sparked various theories. Some studies suggest it comes from the Arabic term *tabaq* which translates to "euphoria-producing herb." Tobacco seems to have a history as ancient as human civilization itself. Certain research indicates that the cultivation of tobacco dates back around 8,000 years, with the American Indians spreading two species - Nicotiana rustica and Nicotiana tabacum - throughout North and South America. Archaeological findings in Mexico and Peru have revealed tobacco seeds in settlements dating back to 3500 BC. Tobacco belongs to the Solanaceae family, commonly known as the nightshade family, which includes about sixty species, such as potatoes and the genus Nicotiana (Luthra *et al*., 1992) [12].
In warm climates, a green, leafy plant known as tobacco is cultivated. After harvesting, the leaves are dried and ground, and can be used in various forms. The final product can be smoked in cigarettes, pipes, or cigars, or it can be chewed or inhaled. One of the most addictive substances in tobacco is nicotine, which contributes to its habit-forming properties. When tobacco is smoked, chewed, or snorted, nicotine enters the bloodstream, prompting the body to crave more. This presence of nicotine classifies tobacco as a drug, as it affects the body by acting as an intoxicant that accelerates the nervous system (Jacobs, 1995) [9].
In North America, tobacco was the first crop cultivated for profit. The settlers of Jamestown, Virginia, were among the first to grow tobacco as a cash crop, starting in 1612. By the 1800s, many individuals began using small amounts of tobacco, primarily chewing it, or smoking it in pipes, cigarettes, or cigars. Some studies even indicated that, on average, people smoked about 40 cigarettes per year. In 1865, Washington Duke produced the first sellable cigarettes on his 300-acre farm in Raleigh, North Carolina, primarily selling them to soldiers (Jacobs, 1995) [9].
In 1881, a significant development transformed the tobacco industry. James Bonsack invented a cigarette-making machine capable of producing over 120,000 cigarettes a day. He partnered with James Duke, and together they manufactured approximately 10 million cigarettes in their first year, reaching around one billion within five years. They went on to establish The American Tobacco Company, which became the largest manufacturer by 1900. By 1902, many cigarette companies emerged, primarily targeting male consumers (Jacobs, 1995) [9].
The entire landscape changed during the World Wars. Soldiers received free cigarettes regularly, leading to an increase in domestic production and a push to market cigarettes to women as well. With the Second World War, women gained more freedoms, further expanding the cigarette market. By 1944, cigarette production peaked at around 300 billion annually. In the early 1960s, the U.S. Surgeon General, the country's chief health official, warned about the dangers of smoking, citing the cancer risks associated with nicotine and tar in cigarettes. In response, the U.S. government enacted several regulations in 1965 to address the rising threats from tobacco companies. By the 1980s, tobacco firms began introducing new cigarette brands, marketing them as lower in tar and nicotine (Jacobs, 1995) [9].
Many cultures around the world have incorporated tobacco into their social gatherings and communal activities. These cultural practices have embedded smoking and tobacco into shared values, traditions, beliefs, customs, history, and folklore. India, with its rich tapestry of cultures, is one such example. According to Ayurvedic texts and Indian tradition, the practice of smoking dates back centuries. Lord Shiva is often depicted as a cannabis smoker, believed to have used it to reach a supreme state of trance. Numerous portraits and figures of Shiva highlight his role as a fierce yoga teacher, with cannabis providing him the energy needed for his practices. Folklore suggests that Lord Shiva smoked bhang (cannabis) to consume all the poison, thereby protecting the earth and its inhabitants. Some forms of smoked tobacco are thought to have originated in the Middle East before spreading to the Indian subcontinent. Smoking became a social activity, often involving the use of hookahs, which were introduced by the Muslim community. Culturally, hookah gained significance and was commonly used in various celebrations, including wedding ceremonies (Gilman & Zhou, 2004) [6].
Tobacco was introduced to India by the Portuguese around 400 years ago. They played a key role in establishing the tobacco trade in the colony of Goa. However, it was the "Bruisers" who first initiated tobacco production for commercial purposes. The Portuguese brought tobacco to the royal courts, where it quickly became a valued commodity in barter trade, also being used to acquire Indian textiles. The initial appreciation for tobacco among Indian royals soon spread to the broader population, and by the seventeenth century, tobacco began to gain a strong foothold in India (Report on Tobacco Control in India, 2004).
Tobacco was first introduced in Adil Shahi, the capital of Bijapur, now located in Karnataka, South India. During 1604-1605, Asad Beg, an ambassador of Mughal Emperor Akbar, visited Bijapur and brought back large quantities of tobacco to the Mughal Empire. He presented it as an "herb" to several nobles, including Emperor Akbar, who received it with appreciation. According to Sikh texts, the tenth and final guru of the Sikhs, Guru Gobind Singh, established a rule for Sikhs to abstain from smoking, stating, "Wine is bad, bhang destroys one generation, but tobacco destroys all generations." Similarly, in Parsi customs and culture, the use of tobacco is discouraged (Chattopadhayya, 1993) [5].
The onset of British rule in India marked a dramatic expansion in the commercial scale of tobacco production and consumption. British traders began importing American tobacco to finance Indian goods. Following the American colonies' declaration of independence in 1776, the British East India Company redirected its efforts toward India, initiating tobacco plantations. Numerous initiatives were undertaken to increase the area dedicated to tobacco cultivation and enhance the quality of the leaves produced (Report on Tobacco Control in India, 2004).
In India, tobacco is primarily consumed in five forms. Beedis are made from crushed and dried tobacco wrapped in tendu leaves and are notably smaller than cigarettes. Cigars

consist of tobacco rolled in leaf, while cigarettes are rolled in paper and may feature filters, and come in variations such as thin, low-tar, menthol, and flavoured options. Chillums involve smoking tobacco from a clay pipe, which can also be used for narcotics like opium. Hookah smoking employs a device that heats the tobacco and passes it through water before inhalation. Finally, *Chuttas* resemble cigars but are coarser and are typically smoked in coastal regions of India (Report on Tobacco Control in India, 2004).

India ranks as the second-largest tobacco producer in the world. In terms of exports, the country supplied tobacco to over 80 nations across all continents, with multinational corporations like British American Tobacco and Philip Morris sourcing tobacco from India. The oldest beedi manufacturing industry was established in 1887. Due to the price difference between cigarettes and beedis, the latter became the preferred choice for the working class, as it was significantly more affordable. Furthermore, post-independence tax policies favoured beedi production, despite the government's stringent regulations and laws (Report on Tobacco Control in India, 2004).

The combination of robust prices, domestic consumption, export demand, and low costs has significantly propelled the growth of the tobacco industry. However, current government policies regarding tobacco are mired in controversy. On one hand, tobacco is an irrigated, easy-to-cultivate crop that provides extensive employment opportunities and generates substantial tax revenue through exports. On the other hand, the public health issues associated with smoking and the rise of young smokers nationwide have created considerable challenges for the government. Despite the adverse health consequences, the tobacco industry continues to receive support from various sectors due to its contributions to employment and national production (Report on Tobacco Control in India, 2004).

Research Gap

Although a lot of literature can be found on smoking and its effects related to behavioural change, not much of the literature has been found on perception youth carry regarding smoking especially in rural areas of Himachal Pradesh, therefore through this study an attempt has been made to study the same.

Objectives of the study

The purpose of this research paper is to find out the moderating effect of demographics on youth's perception about effects of smoking in rural and urban parts of Himachal Pradesh.

Research Hypothesis

To achieve the objectives of the present study the following hypothesis were formulated:

Following hypotheses have been tested in this research paper:

H_1: There would be a significant difference in urban and rural youth's perception about effects of smoking based on gender.

H_2: There would be a significant difference in urban and rural youth's perception about effects of smoking based on age.

H_3: There would be a significant difference in urban & rural youth's perception about effects of smoking based on caste.

Research Methodology

(a) **Research Design:** To have a better understanding about the issue descriptive research design was used.

(b) **Sample Design:** 250 youth from urban area and 250 from rural area, aged between 15-29 were selected & interviewed for the completion of study.

(c) **Research Instrument:** Data was collected using a pre-tested self-administered questionnaire. A five-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree), was utilized to assess the effects of smoking. Eight items were included to examine the negative effects of smoking, while 15 items were chosen to explore the positive effects. The scoring ranges for these dimensions were as follows: negative effects (8-40) and positive effects (15-75).

(d) **Analysis:** The collected data was analysed using various statistical tools, including the arithmetic mean, standard deviation, t-test, and ANOVA.

Analysis & Interpretations

1. Demographic Profile of Respondents

The table 1 is presenting the demographic profile of respondents i.e. gender, age, and caste.

Table 1: Demographic profile of respondents

Particulars	Classification	Urban		Rural	
		N	Percentage	N	Percentage
Gender	Male	201	80.4	229	91.6
	Female	49	19.6	21	8.4
Age	15 to 21 Years	96	38.4	103	41.2
	22 to 29 Years	151	60.4	145	58
Caste	General	180	72	140	56
	SC	25	10	62	24.8
	ST	20	8	13	5.2
	OBC	10	4	5	2
	Other	15	6	30	12

2. Comparison of Urban & Rural youth's perception about effects of smoking

This section presents a comparison of urban and rural youth's perceptions of the effects of smoking, organized into the following subsections:

2.1 Difference in urban & rural youth's perception about effects of smoking based on gender

The t-test (Table 2) revealed a significant difference in male and female youth's perceptions of the negative effects of smoking.

However, no significant difference was found between urban and rural youth's regarding the positive effects of smoking. Therefore, hypothesis H1, which posits a significant difference in urban and rural youth's perceptions of smoking effects based on gender, is partially accepted.

Table 2: T-test comparing the urban & rural youth's perception about effects of smoking based on gender

	Gender									
	Male	**N**	**Mean**	**S.D.**	**t-value**	**Female**	**N**	**Mean**	**S.D.**	**t-value**
Negative perception towards smoking	Urban	195	28.82	4.91	4.957*	Urban	48	32.55	5.09	3.028*
	Rural	235	29.13	4.66		Rural	22	35.19	3.44	
Positive perception towards smoking	Urban	195	48.21	7.21	0.307	Urban	48	40.19	7.11	0.823
	Rural	235	50.44	7.53		Rural	22	42.11	7.22	

*0.05 level of Significance, Tabulated Value = 1.96

2.2 Difference in urban & rural youth's perception about effects of smoking based on age

The t-test (table 3) indicated that there was significant difference in the perception about effects of smoking of urban & rural youths for the age group of 15 to 21 years. For the age group of 22 to 29 years the difference was significant for negative effects of smoking only. Thus, hypothesis H2, for significant difference in the perception about effects of smoking of urban & rural youths based on age was partially accepted.

Table 3: T-test comparing the urban & rural youth's perception about effects of smoking based on age

	Age									
	15 to 21	**N**	**Mean**	**S.D.**	**t-value**	**22 to 29**	**N**	**Mean**	**S.D.**	**t-value**
Negative perception towards smoking	Urban	100	31.49	4.92	5.563*	Urban	155	34.66	5.68	4.335*
	Rural	102	32.42	3.56		Rural	143	30.88	3.93	
Positive perception towards smoking	Urban	100	48.29	6.78	2.085*	Urban	155	42.253	5.11	0.003
	Rural	102	46.31	6.71		Rural	143	44.13	5.31	

*0.05 level of Significance, Tabulated Value = 1.96

2.3 Difference in urban & rural youth's perception about effects of smoking based on caste

According to the t-value (table 4), there was a significant difference in perceptions of smoking effects between general and other caste youths in urban and rural areas. However, no significant differences were found for the other categories (i.e., SC, ST, and OBC) regarding the perceptions of urban and rural age youths. Therefore, hypothesis H3, which posits a significant difference in urban and rural youth's perceptions of smoking effects based on caste, is partially accepted.

Table 4: T-test comparing the urban & rural youth's perception about effects of smoking based on caste

	Caste									
	General	**N**	**Mean**	**S.D.**	**t-value**	**SC**	**N**	**Mean**	**S.D.**	**t-value**
Negative perception towards smoking	Urban	180	38.19	4.55	12.13*	Urban	28	30.32	4.12	2.112
	Rural	141	32.21	3.80		Rural	62	31.22	5.12	
Positive perception towards smoking	Urban	180	46.21	6.81	3.528*	Urban	28	43.61	5.84	0.422
	Rural	141	44.23	5.11		Rural	62	44.11	6.26	
	ST	N	Mean	S.D.	t-value	OBC	N	Mean	S.D.	t-value
Negative perception towards smoking	Urban	20	30.11	5.21	1.251	Urban	13	33.13	4.15	0.582
	Rural	13	34.25	4.10		Rural	8	31.42	5.03	
Positive perception towards smoking	Urban	20	48.13	7.85	0.544	Urban	13	49.41	4.15	1.113
	Rural	13	45.32	7.62		Rural	8	44.53	5.09	
	Other	N	Mean	S.D.	t-value					
Negative perception towards smoking	Urban	16	31.12	3.23	2.652*					
	Rural	31	34.26	4.11						
Positive perception towards smoking	Urban	16	42.77	3.28	5.225*					
	Rural	31	48.51	3.52						

*0.05 level of Significance, Tabulated Value = 1.96

Conclusions

From this research it can be concluded that the perception of urban & rural youths about the effects of smoking significantly differs with respect to the age & gender but no significant difference has been identified according to caste. This study indicates that a primary reason many young people smoke is their mistaken belief that it is a normal part of life. Consequently, concerned authorities should implement more effective and ongoing interventions at various levels to combat smoking.

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