Women, Children and Tobacco

Author

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Women and children are the two most vulnerable groups who become affected by tobacco – not necessarily by consuming tobacco themselves but also by being around people and in environments which are filled with tobacco smoke. Then there are those women and children who work on tobacco plantations and those who work for the bidi industry. In either of the cases, they get affected, they suffer and many die. In many countries there is very little political will focusing on this problem. WHO is going to draw the attention of politicians and governments all around the world with the Framework Convention on Tobacco Control which is going to strengthen these governments and NGOs, as well as individuals who wish to take legal actions against tobacco and pursue policies which will protect people against tobacco. This is to be viewed as a very serious step towards recognizing the comprehensive rights of women and children.

This paper will present patterns and dynamics of tobacco use among women and children and the intervention attempts to wean them away from this potent weed. Also it will report on the involvement of women and children in the “Bidi Industry” in India to point out how they are exploited by the tobacco industry.

THE EUROPEAN CHARTER AGAINST TOBACCO SAYS “EVERY CHILD AND ADOLESCENT HAS THE RIGHT TO BE PROTECTED FROM ALL TOBACCO PROMOTION AND TO RECEIVE ALL NECESSARY EDUCATIONAL AND OTHER HELP TO RESIST THE TEMPTATION TO START USING TOBACCO IN ANY FORM”.

Ample evidence exists to show that the tobacco industry has been targeting women and children to lure them to the addictive substance. There is a growing concern that the number of women and children taking up the tobacco habit is going up in the majority of the countries all over the world. For example in the regions of America and Europe, the prevalence of smoking for women is the highest at over 20% especially in Denmark, Norway, Czech Republic, Fiji, Israel and Russian Federation. This is true in developing countries also where people do not even have the advantage of health education which includes the ill effects of tobacco. On the contrary the tobacco industry puts up attractive ads which give the impression to women and children that tobacco is the “In” thing and that they should not be left behind. According to one African study in 1973 fewer than 3% of Nigerian females students smoked but by 1982, the figure had increased to 24% among female university and polytechnic students and 52% among female trainee teachers.

Children

In the developed world cigarette smoking has been the major habit among children both boys and girls. They usually take to the habit while in school before the age of 18.

Prevalence (%) of smoking among 15- year olds in ten developed countries, 1986
<table>
<thead>
<tr>
<th>Country</th>
<th>Smoke daily</th>
<th>Smoke weekly</th>
<th>Smoke less than weekly</th>
<th>Do not smoke (have tried)</th>
<th>Have never smoked</th>
<th>No. of subjects</th>
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<tr>
<td>All countries</td>
<td>Boys 15.0</td>
<td>Girls 13.8</td>
<td>6.5</td>
<td>39.9</td>
<td>34.2</td>
<td>5754</td>
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<tr>
<td>Austria</td>
<td>Boys 11.8</td>
<td>Girls 13.1</td>
<td>6.5</td>
<td>10.3</td>
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<td>476</td>
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<td>Belgium</td>
<td>Boys 16.6</td>
<td>Girls 13.5</td>
<td>5.0</td>
<td>5.1</td>
<td>32.7</td>
<td>603</td>
</tr>
<tr>
<td>Finland</td>
<td>Boys 29.1</td>
<td>Girls 20.1</td>
<td>6.3</td>
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<td>39.9</td>
<td>539</td>
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<tr>
<td>Hungary</td>
<td>Boys 20.4</td>
<td>Girls 14.1</td>
<td>5.9</td>
<td>8.2</td>
<td>39.9</td>
<td>562</td>
</tr>
<tr>
<td>Israel</td>
<td>Boys 5.7</td>
<td>Girls 4.1</td>
<td>3.5</td>
<td>3.5</td>
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<td>402</td>
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<td>Norway</td>
<td>Boys 16.2</td>
<td>Girls 17.6</td>
<td>4.1</td>
<td>9.1</td>
<td>43.2</td>
<td>627</td>
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<tr>
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<td>Boys 14.7</td>
<td>Girls 15.6</td>
<td>2.6</td>
<td>3.6</td>
<td>39.8</td>
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<td>47.0</td>
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<td>Switzerland</td>
<td>Boys 9.5</td>
<td>Girls 10.5</td>
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<td>10.2</td>
<td>35.8</td>
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</tr>
<tr>
<td>Wales</td>
<td>Boys 13.1</td>
<td>Girls 15.1</td>
<td>2.4</td>
<td>4.4</td>
<td>41.9</td>
<td>954</td>
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Source: WHO Gross National Study on Children’s Health Behaviour.

It has been observed that smoking prevalence among 11 to 16 year olds in many Western countries has historically followed adult patterns. In fact teenage prevalence has changed relatively little in many countries despite concurrent declines in adult prevalence.

Looking at the incidence rate the youth is smoking today the problem is serious enough to be taken up on a war footing. The matter of special concern is that young girls
have become equal partners and in many cases they surpass young boys in their habit. Young people both boys and girls take to smoking of cigarettes to conform to their group of friends. Peer pressure and parental smoking are often quoted reasons for young taking up the habit. Boys are attracted by the macho image - smoking projects and they report to feel good, cool, smart, independent, sexy, attractive to girls, sportive free spirited while smoking. Girls often mention that they smoke because their boy friends, best girl friends or mothers and older sisters smoke. They report to smoke to be confident, sophisticated, care free and in control of themselves.

The South East Asian Region, produces and consumes tobacco in many forms.

SMOKING TOBACCO: Like everywhere else in the world, cigarette smoking is the most prominent form of tobacco use in most countries in South East Asia. In India however, tobacco is smoked more in the form of bidi, a cheaper product made by hand by rolling a small amount of flake tobacco (about 0.2 g) in a tendu leaf (Diosyros melanoxylon). In Indonesia the most popular type of cigarette is the kretak or clove flavoured cigarette, strong in flavour, nicotine and tar. It is smoked by 80 percent of current smokers. Imported cigarettes represent a small but significant part of tobacco consumption in the Region. There are several other ways of smoking tobacco which are prevalent in specific areas of the Region, such as various forms of pipes (wooden, clay, metal etc.), the hookah (also known as the hubble bubble or water pipe), cheroots (or chuttas) and dhumtis.

SMOKELESS TOBACCO: The use of tobacco in various smokeless forms is very common in India and to a small extent in Bangladesh and Nepal. The tobacco may be used in raw, processed mixtures and pyrolised forms. The raw forms that are generally sun-cured or air-cured, consist of flakes of plain tobacco leaves mixed with other ingredients especially lime, areca nut and / or other condiments. The pyrolised forms (mishri, bajjar etc) are used as dentifrice. Oral use of snuff is also practiced in some specific areas.

Within each country of the region there is great variation in consumption patterns. Rural populations tend to use tobacco more heavily than urban ones.

Bangladesh reports smoking of 16 percent among male students between the ages of 11 to 16.

In India - The National Sample Survey Organisation (NSSO) has provided smoking data for 1993 - 94.

The prevalence rates of any form of tobacco use among male rural youth aged 10-14 and 15 - 24 years were found to be 1.6 and 21 percent respectively. For females, the corresponding rates were 1.1 and 5.1. In Urban areas, prevalence rates among male youths in the age groups 10-14 and 15-24 years were lower: 0.5 and 10 percents, respectively. Among girls, the corresponding values were 0.3 and 1.4.
Specific studies on tobacco use have been done in India demonstrating very high rates of tobacco use among students (30 to 50%) and non-student youth in urban and rural areas. Not only that, smoking among medical students has been observed to be 20-40% in some areas.

Indonesia - Survey data of 1993 reports indicate the prevalence of smoking for males age 10-19 years to be 27.7 percent and for females, 0.6 percent. In a study conducted on 71 fourth year medical and dental students, 5.6 percent were current smokers and another 5.6 percent were ex-smokers. Three different studies on child street vendors showed that well over half were smokers.

Nepal - A household survey of the hilly district of Jhumpa, found that smoking was by far the predominant form of tobacco use in this area. Prevalence of smoking (both cigarettes and bidis) among youth, was found to be highest between 16 and 19 years for both boys (39 percent) and girls (16 percent).

Thailand - The National survey conducted in 1996 showed that smoking prevalence for boys aged 11-14 years was 0.4 percent, which jumped to 18.3 percent and 47.7 percent in the age groups of 15-19 and 20-24 years respectively. In girls, the corresponding figures were much lower, 0.3, 0.3 and 1.1 percent in the three successive age groups.

The South East Asia Region thus presents a varied picture with Thailand currently having the lowest prevalence rates.

The teenage years are the most important period in which decisions about tobacco use are first made. A lot of experimentation occurs and at this time many occasional users become regular users. Singapore has taken strong action and has implemented a strong tobacco control policy. Due to this there has been an overall decrease from 20% in 1984 to 15% in 1998. Of concern is the smoking among young women aged 18-24. There has been a twofold increase from 2.8% in 1992 to 5.9% in 1998.

The scene is very similar in Africa as well as in countries of South America where young are observed to smoke. The incidence though not available in many countries, small studies undertaken have shown that they are starting early, many before teens and there are equal if not more girls than boys smoking. Also there are reports on out of school children who have been observed to be addicted to nicotine very early on in their lives and do not show any signs of changes.

What makes them take up the habit?

Almost everywhere the young smokers seem to take up the habit because they are in an environment where the significant people in their lives smoke and chew.

Bangladesh - Peer influence and parental smoking habits were found to be major factors influencing urban high school students to start smoking.
India - Studies of high school students in Patna and college students in Mumbai showed that tobacco use usually started at the suggestion of friends. In a study of student tobacco users in Maharashtra, in 1998, two thirds of the addicts to pan / masala / gutka were introduced to the products by friends.

A few studies seem to indicate that tobacco use is more common among youth who are living away from their parents (college students, street children), have poor parental supervision or whose elders use tobacco.

Reasons for starting (and/or using) tobacco use among youth often included a warm feeling of sharing among friends. Forcing by friends or relatives, a direct form of peer pressure, was found in two out of eight studies. Other important reasons were fun/enjoyment or to remove boredom and to pass time. Some young smokers said they smoked to relieve feelings of anxiety / stress / failure. The desire to enhance one’s image, adding to one’s status, appearing grown up or macho were reasons cited by many. Working children also included the necessity to keep awake as a prominent reason. Children generally started with experimentation and occasional use but with appearance of withdrawal symptoms, addiction soon took over.

In one study of over 300 college students conducted in Mumbai in 1999, 40 percent admitted to be influenced by advertisements and said that sports and film personalities (for boys) and stylish lifestyles (for girls) were the most influential factors in these. Children in a large study in Uttar Pradesh (Mainpuri) were impressed by advertising depicting a high lifestyle, which included smoking, drinking, good clothes and affluent surroundings.

Indonesia - Cigarettes are usually offered at social gatherings in both urban and rural areas. Tips are called “Cigarette money”. Young people are thus influenced by their elders and by society. A 1995 study of 250 street vendors (below 14 years of age) of whom 20 percent also sell cigarettes reported on the reasons why they smoke. Reasons for starting were for fun, the taste, to feel proud to be a smoker and to be macho.

Nepal - The youth reported taking up smoking for fun and recreation. The adults were a great influence as well, since smoking was highly prevalent among them (> 60 percent).

Thailand - The national Survey showed that male youth, smoked for fun and due to peer influence. Females often smoked out of lonliness or insecurity.

Thus whenever surveyed, young people in developed and developing countries cite boredom, curiosity and wanting to feel good (or better) or a part of a group as the main reasons for use. Other functions served by substance use are: to relieve hunger, to adopt a rebellious stance, for peer / social acceptance, to relieve pain, keep awake or get to sleep, or to dream.
The pathways for young people who develop patterns of regular and problematic or harmful use appear to differ from those who merely experiment or maintain irregular habit or do not smoke. Personality characteristics, individual differences in vulnerability, family difficulties, association with substance using peers, differential exposure to substances, shared and non-shared environments, and accumulations of social disadvantage all play a role.

WHAT CAN BE DONE?

Today there are many experts who believe that it is not easy to wean youth away from tobacco even though in principle it should be easier since they have not been long under the influence. It seems like youth have no desire, no motivation, no urgency to give up the habit. If you tell children that they should not smoke because it will affect their health, you are telling them the wrong thing. They could care less about lung cancer and stroke.

A great variety of interventions have been tried on children and young adults which have met with varied success. Some prominent ones are presented:

SMARTER THAN SMOKING

THE WESTERN AUSTRALIAN SMOKING PREVENTION PROJECT

Objectives:

- To deglamourise smoking and encourage young people to question the social desirability of smoking.

- To make the immediate and short term consequences of smoking more personally relevant to 10-14 yr olds.

- To increase the awareness amongst the target group of the social factors that influence their decision whether to smoke or not.

The strategy mix of mass media advertising, school based resources, advocacy activities, sponsorship of youth oriented activities, research, and evaluation formed the basis upon which the project has built its brand image and personality.

The project has involved young people in all stages of its planning and development. It has steered clear of traditional ‘just say no’ smoking prevention messages and acknowledged that many young people may experiment with smoking and therefore other strategies are needed to communicate to this group. It endeavors to educate and skill young people to make more informed choices conducive to health.

BE smoke FREE
THE NORWEGIAN SCHOOL-BASED INTERVENTION PROJECT

BE smoke FREE is school-based intervention program targeted at children aged 12-15 and based on social skills training. The main idea is to show pupils what it means to be a free and independent person. The goals were:

- to be free and independent.
- consciousness about making their own decisions.
- other ways to reach their goals.
- exposing and resisting manipulation.

The training focuses on freedom and independence. Students learn to see that they largely can choose their own behaviour and that they also can have influence on others.

Students discuss alternative ways of reaching their goals - if a girl wants to stay slim how can she achieve that with means other than tobacco? If a boy wants to feel more secure how can he become that without tobacco?

The ban on advertising of tobacco products has had a marked and beneficial influence upon tobacco consumption and young people’s smoking rates in Norway. However, the effect of legislation could have been even better if the ban had been accompanied by a much more active and offensive use of other smoking control measures, in particular, health information and education.

SMOKING CONTROL PROGRAMME AMONG YOUNG PEOPLE IN SINGAPORE

Based on the following:

1. DEVELOP PERSONAL SKILLS TO INCREASE RESILIENCE.
2. STRENGTHEN COMMUNITY PARTICIPATION.
3. PROVIDE AND IMPROVE SMOKING CESSATION SERVICES.
4. CREATE SUPPORTIVE ENVIRONMENT.

There is a need for a concerted effort to encourage young people to stay smoke-free. A co-operative, collaborative, co-ordinated and continuous effort among various sectors of the society is needed for successful smoking control among young people.

COMMUNITY INTERVENTIONS:
STRATEGIES FOR REDUCING YOUTH TOBACCO CONSUMPTION.

ASH
THAILAND

ASH tries to work to empower people to campaign themselves (rather than run all projects ourselves) but ASH does support these campaigns with media campaigns and a high profile for tobacco control in the Thai press. Young people are not only targets but
also change agents. All of ASH’s successful youth campaigns reinforce the fact that young people are effective community educators and that the most effective way to influence young people is to put them in control.

Besides these interventions there were also those which were school based and child/youth centered.

Experts feel that these have not been very effective in bringing down the rates though they are aware that in the absence of these the rates might have gone up much more than they are today.

Why do school-based, youth-centered smoking interventions have little effect on behaviour?

- Smokers and potential smokers are most likely to be absent from school.
- Many smokers reject school values.
- Children learn remarkably little from school lessons.
- Those who learn best are academic and least likely to smoke.
- The needs of small specific groups are not met in a general classroom context.
- Social influences are very strong.
- Warning of risk and also sales restrictions can make smoking seem even more attractive.
- Smoking education is affective and does not fit an examination-oriented curriculum.
- Teachers are often unfamiliar with the theories and methods needed.
- Teachers modify the programmes.

How can school-based interventions, if they are used at all, be made more effective?

- Involve the young people in planning.
- Target small specific groups.
- Use social reinforcement approaches.
- Train teachers in theory and methods needed.
- Involve parents for younger children.
- Involve peers.
- Develop school “no-smoking” policy for staff and students.

PREVENTING TEENAGE SMOKING - WHAT HAVE WE LEARNT FROM TWO DECADES OF ACTION?

- School health education programs have generally proved ineffective in practice.
- Comprehensive smoking control programs aimed at all age groups are more likely to reduce teenage smoking than programs aimed at youth alone.
* All mass campaigns are more likely to be effective in the absence of tobacco advertising and sponsorship.
* Price increases reduce adult prevalence and may also have favourable effects on teenagers.
* Efforts to prevent the sales of cigarettes to under-age youth have proved generally ineffective and do not necessarily reduce prevalence.
* Programmes decline in effectiveness when taught in schools remote from the original developers.
* Few schools are willing to provide sufficient time in the curriculum for the sophisticated methods required for optimum effect.

Schools can probably contribute more to tobacco control by concentrating on comprehensive approaches, such as “Health Promoting School” programs, which involve complete bans on smoking in schools, among many other measures. Furthermore, since smoking is linked with poor educational performance and alienation from school, schools may have more effect by attending to the needs of their weakest performers than by promoting intensive programs focusing solely on smoking.

After twenty years of research and development, we still do not have a simple, cost-effective method for reducing teenage smoking on a large scale. Comprehensive multi-faceted strategies aimed at all age groups seem to offer the best prospects for success—although even this cannot be guaranteed.

Sophisticated methods requiring extensive time commitments, such as the more advanced school programs and cessation courses, are unlikely to reach large numbers of teenagers. The focus should always be on large-scale methods such as publicity and tax increases, which can influence on whole society’s behaviour and attitudes related to smoking.

A growing body of research clearly demonstrates that macro level policies and other interventions lead to reductions in tobacco use in all segments of the population. Some of these policies, particularly tobacco tax increases and, possibly, comprehensive bans on tobacco advertising and promotion have their greatest impact on youth and young adults.

Despite the difficulties described above there are ways to reduce uptake of smoking among adolescents, but they are oblique and they involve behavioural change in adult smokers. First, parents and family members of pre-teens and teens need to stop smoking. It has been known for a long time that parental and sibling smoking is a risk factor for smoking in adolescents. It now seems that quitting by parents reduces the likelihood of offspring taking up smoking.

**Conclusion:**

The experts in tobacco control are beginning to warn that even where the trends had started to lower down, it has the tendency to come up or at best to plateau. Does it mean we cannot do anything? No, this is not what the conclusion is. The conclusion should be
to understand that there are several fronts on which the efforts have to be made and that
too almost side by side.

1. We have to publicise what the tobacco industry is doing to people. We have to show
how it hooks us on a product which harms us when we use it the way they
recommend it. Also we have to be vigilant at all times of their new tricks and efforts.
The U.S anti tobacco lobby is becoming very concerned about
the new trend among some of the young who have started smoking bidis imported
from India. They believe bidis are not harmful like cigarettes and find them very
exciting because of the way they are made and presented.

2. Price increase - This has been demonstrated effectively in the World Bank report.
Children /youth are sensitive to it and it truly deters new enterants.

3. Ban smoking in all public places. What is important is not only the ban but its
implementation or carrying out. The ineffective implementation in reality confuses
people and might lead to contrary of what we want.

4. A complete ban on direct and indirect advertising and promotion. This includes
banning it from TV programmes and films. It has been seen that in many countries of
the developing world children especially boys in urban slums smoke not so much
because the father smokes (they do not want to immitate or follow the father because
he is no good. He comes home drunk and beats the mother and takes away all the
money to leave them starving). Also these same boys do not want to immitate their
peers for they are just like them with no hopes and dreams. They want to immitate
their TV and movie heroes.

5. Last but not the least helping children to grow up with life skills necessary to face
challenges not only from tobacco but from anything else which weakens their
energies to become slaves and dependent. Life skill which gives them power to think,
to problem solve, to be assertive, to negotiate and to be themselves.

Further they should be given information that they need, counseling that they require
and guidance which makes them wiser. The long term sustainable action will come when
they see the significant people in their lives inspiring them with themselves staying away
not only from tobacco but all those lifestyles that harm children in their right development
and obstructs the actualization of their potentials.

WOMEN:

Smoking among women is also of a great concern because of the resultant
morbidity and mortality. The advertising and promotion of tobacco directly influences
women because it is so specifically targetted to their needs and desires. “You have come a
long way baby” - appeals to her so well. The smoking woman in ads looks so confident
carefree and cool. These ads create a special space which the woman lacks when she
cares for the children, the elderly, the busy husband and the household chores. Smoking
relieves the boredom from her life, she so strongly believes. It perks her up, rejuvenates her and gives her energy, she reports. In her desire to be free and in control of herself, she forgets the terrible consequences of these habits - not only disease, disabilities and death but also her slavery to the habit because of its addictive nature. She wants to leave it but she cannot because of the strong withdrawal symptoms attached to it and because of her belief that she will put on weight and loose her charm. Thus fostered, encouraged and motivated by the persistent effort of the tobacco industry by their slick advertising, many many young girls and women have fallen a prey to the habit of smoking cigarettes.

The tobacco industry spends a lot of money and time devising strategies to get women to start smoking and maintain this habit.

The internal documents of the tobacco industry reveals that it is overjoyed at finding that women smokers are likely to increase as a percentage of the total. The industry is happy to find that women are adopting more dominant roles in society, they have increased spending power, they live longer than men and they seem to be less influenced by anti-tobacco campaigns.

- The industry proceeds by identifying views and desires of women who according to them appear more driven by lifestyles and image campaigns. It tries to develop a clearer understanding of attitudes, values and motivations of women as it stands now and how the social changes are going to impact them. The industry does much to identify trends among women as consumers, which could relate to lifestyles and purchase behaviour.

- The industry feels women respond well to tender imagery in advertising, imagery which reflects intimacy and closeness, tenderness and gentleness, loving, caring and sharing. Women who are not working outside the home respond better to escape and factasy and career women react positively to imagery associated with elegance and success.

- The industry feels they know why women smoke - it is started as a social thing. It is like a forbidden fruit and every daring person wants to taste it. Young girls feel more mature if they smoke.

- The industry still sees a lot of work ahead especially to woo the women in the developing world. It has brought two new brands of cigarettes for women in China. It is also luring women in Sri Lanka by offering them free cigarettes.

Large amounts of money are spent by the tobacco industry to promote the use of its products. This is done not only by promotion through the traditional media like TV, radio, newspapers and billboards, but also by giving allowances to retailers by direct-mail advertising, free samples and sponsorships. Though the industry claims loudly that the advertising and promotional activities are not to initiate smoking among young girls and women and to increase sales, but simply to encourage competition and to promote brand choice of adult smokes.
Women in particular have been strongly targeted by the tobacco industry as a potential growth market and the media campaigns have been geared towards presenting smoking as a liberating, socially acceptable, sophisticated, sexy and slimming. Cigarette companies have also portrayed smoking as a “torch of freedom”, a “tool of beauty” and sign of progress. Advertising in women’s magazines not only encourages smoking among women but also determines whether these magazines will report on the risks of smoking to women’s health. Women’s magazines that accept cigarette advertising have significantly fewer articles about health hazards of smoking and cessation than magazines that do not carry ads. Cigarette companies have other ways of targeting women, such as through female sports sponsorship and support of women’s organizations and funding other activities. There is now considerable evidence from developed countries that children are aware of tobacco advertising, that tobacco promotion influence whether young people start and continue to smoke. Young people experiment with smoking and become regular smokers. Advertising and promotion also reduce the willingness of current smokers to quit, on the contrary it is likely to serve as a stimulus to increase their daily consumption. Additionally advertising and promotion could induce former smokers to resume their smoking behaviour by reinforcing the attractions of smoking.

In the developing countries advertisements influence young girls even more as they may have little to no knowledge about the harmful effects of smoking. At present tobacco advertising in the developing countries tends to be directed at the general public although there are attempts to make women as special like in China, Sri Lanka and the Philippines.

A lot of advertising and promotion is done for chewing tobacco in India where it has attracted young and old, men and women. Women especially take to it for it is much more socially acceptable than smoking. It does not bode well for women for very soon the habit gets addictive. Villages do not have much advertising but the tobacco companies have very clever ways of doing a lot but doing little. They put posters of famous movie and TV personalities in a prominent place in a village showing him/her chewing tobacco. This is enough to girls and women take up the habit or practice it without feeling bad.

As public awareness of the health effects of tobacco has grown in many countries, the tobacco companies have responded by increasing the amount and variety of tobacco products and promotions that are targeted specifically at women. A common characteristic of these efforts is an attempt to allay health concerns by introducing cigarettes with lower tar and nicotine yields: which do not actually lower the risk of many tobacco diseases. Informed women who switch to low nicotine cigarettes often compensate for the reduction by inhaling more deeply or smoking more often. The tobacco industry lures women by introducing “women only” brands and by presenting cigarette in beautifully coloured packets and tastes to give women the impression that if they smoke they will be successful, youthful, happy and healthy. This marketing is often complemented by tobacco sales in places frequented by women, such as dress shops, beauty parlours and also where women go to play cards, etc. Some attempts have been
made to appeal to women by selling cigarettes in packages containing fewer cigarettes. All these efforts by the tobacco companies are not only limited to developed countries but developing as well. In India, a woman ‘brand’ was promoted in 1990 (which failed due to the pressure of anti-smoking lobby especially of women). The tobacco companies are doing the same in China presently and promoting cigarettes by distributing free samples to young girls at disco houses. In India and Pakistan they sell chewing tobacco in colourful pouches and boxes which women can put in their purse to be readily accessible.

In the world today there are 200 million women who smoke reports WHO. This does not include the number of women in South East Asia who practice habits other than cigarette smoking like smoking bidis and chhutas and chewing tobacco with other ingredients or alone, rubbing burnt tobacco on her gums and teeth and plugging tobacco quid under her tongue or in the cheek.

The consequences of tobacco use affects the health of a woman and her children throughout her life cycle. From birth, girl hood, womanhood, pregnancy and birth again as a mother, tobacco harms the health of the girl, woman and baby.

Evidence is beginning to come out that the health consequences of tobacco are indeed more serious in women. Lung cancer has been reported among women smokers as among men smokers but now it is coming out that women smokers develop lung cancer earlier than men despite starting smoking at a later age and smoking fewer cigarettes or bidis than men.

The risk of lung cancer among women smokers increases with the number of cigarettes / bidis smoked per day, duration of smoking behaviour, degree of inhalation, age of starting to smoke and amount of tar in the smoking material. While the number of cigarettes smoked per day and the duration of smoking behaviour both leads to risk; the effect of duration of smoking is greater than that of daily consumption.

Lung cancer is over taking breast cancer as the commonest malignancy of women in the parts of the world where smoking is increasing like in countries of central and Eastern Europe and also in Western Europe whereever women have not refrained from smoking the weed. Although women who smoke cigarettes and bidis are likely to die of lung cancer, those who smoke bidis and chutas and chew tobacco will end up getting many cancers such as mouth, lip, tongue pharunx, larynx and oesophagus. This is because when you smoke, you smoke through your mouth and after the mouth, the smoke goes to larynx, pharynx and oesophagus, the back of the throat, the windpipe and ultimately you breathe smoke into your lungs. Whereever the smoke goes, it can cause cancer there. The highest reported incidence rate in the world for cancer of the mouth is among women in Bangalore, India where women have considerably higher rates than men; this pattern is also found in Madras again in India.

From the lung toxic by products of smoking such as nicotine go into the blood system and circulate around through the liver into the other parts of the body, increasing the risk of carcinoma of the liver. Ultimately the kidneys will remove the by-products
from the blood, which will go through the urine, also increasing risk for cancer of the bladder where urine is held. In addition there are cancers of renal pelvis and renal body, which are the two components of the kidney plus a number of other sites, such as the pancreas and stomach. Though these sites are away from the lungs evidence has shown that smoking contributes to these diseases. Also there is solid evidence that once women cease to smoke, their risk of these diseases starts to decrease and with total abstinence the risk can be reduced to that of a lifetime no-user.

Women, just like men, or even more, suffer from bronchitis, emphysema and ischaemic heart disease and other diseases of the vascular system. The more they smoke the higher the rate of getting these diseases. However if they give up their habit, there is a sure respite from these diseases.

Pregnancy is vulnerable to smoking. The more a woman smokes the greater the risk for her to develop ectopic pregnancy. Since women who smoke are susceptible to infections of the reproductive track, they could have problems conceiving and in fact may not be able to conceive at all.

It has been firmly established that expectant women who smoke are prone to spontaneous abortions. This is because tobacco smoke contains nicotine, carbon monoxide and minute amounts of cyanide. Nicotine being a vasoconstrictor renders the blood supply to the foetus through lack of blood in the placenta. The carbon monoxide, which ends up in the blood when one smokes a cigarette, reduces the oxygen carrying potential of haemoglobin and as a result reduces oxygen supply to the foetus. If a woman smokes over intense period, she may build up enough cyanide to cause damage to the nervous system of the foetus through depletion of Vitamin 12. The risk of spontaneous abortion is 80% more in women who smoke than those who do not. Due to the same kind of mechanism a smoking mother is likely to deliver a low birthweight baby. Smoking can cause growth retardation of the foetus. Research carried out in India is of special significance because of the habits of not only smoking bidis but also chewing tobacco. This reasearch has confirmed that babies born to women who smoke bidis during pregnancy are on an average 200 g low in body weight. A dose response relationship has also been established i.e with increase in maternal smoking during pregnancy a corresponding decrease has been observed in baby’s birthweight. Further more all parameters of foetal growth with head and chest circumference, body length etc. are reduced in babies of women who smoke. In fact the child’s development up to 11 years is adversely affected by maternal smoking in pregnancy. Women who chew tobacco gave birth to babies weighing anywhere from 100 to 400 g less than those delivered by women with no habit. The crude still birth rate per 1,000 births was 50 in women who chewed tobacco as compared to a rate 17.1 who did not use tobacco.

Also in India women exposed to passive smoking has been reported to deliver low birth weight babies with a proportion of 1.8 to 1 who are not exposed. Women who chewed tobacco during pregnancy were more prone to still birth as compared to women who did not.
In Bangladesh women who were passive smokers of “biris” (as the bidi is called in Bangladesh) during pregnancy had twice the number of perinatal death than those women from similar background characteristics but companion with no tobacco habit. A study in Osaka, Japan reported that the rate of low birth weight increased with the intensity of exposure to tobacco smoke. The prevalence was 3.8% for women whose partners were non-smokers but 5.6% for women whose partners were smokers. All this is reported to be associated with a decrease in mean gestation period. However the good news is that if an expectant mother is able to give up smoking or/ and chewing, she stands a chance of having normal delivery giving birth to a normal healthy child!

Fewer male foetuses were born to women who chewed tobacco (50 males for 100 females) compared to women who did not (109 per 100 females). Similarly women who had the habit of oral application of burnt tobacco had fewer male new borns (81 males per 100 females) compared to women who did not (106 males to 100 females).

France, Germany and the United Kingdom have reported 20 - 25% of all infant deaths due to smoking.

Young girls who smoke have problems with their menses. It can be erratic. Also women who smoke go through menopause earlier. This leads to oestrogen deficiency resulting in osteoporosis. Smoking leads to weaker, mineral deficient bones by reducing blood supply and the number of bone-forming cells. If the risk of bone fracture in a non-smoker is 1.0, the risk rises to 1.5 in a smoker and the fractures are more severe.

In smokers the risk of periodontal disease is 2 to 3 times higher than in non-smokers. The periodontal disease in smokers is not only higher but also more severe. It is also likely to result in bone loss. Smoking produces bad breath, gum disease, dental diseases, tooth erosion and gingival recession. This contributes to loss of good looks in women which they value so much and which the tobacco advertising misleadingly shows to be related to smoking.

Nicotine reduces the circulation of blood and the uptake of oxygen affecting women’s hair, skin and eyes. Skin wrinkling is found to be enhanced and occurring earlier in women who smoke. THERE SEEMS TO BE NO POSITIVE EFFECTS OF SMOKING.

Once again as in the case of children and youth intervention efforts are not terribly successful. The studies carried out report the following.

- Women are less likely to plan to quit smoking than are men.
- Women are likely to smoke for tension reduction and weight control.
- Women quit smoking at the same rate as men but are less able to maintain cessation long-term.
- Physicians are as likely or more likely to intervene with female smokers as compared to male smokers.
The Clinical Implications of these Research Findings Are the following:

- Smoking interventions for women may need to emphasize strategies to help them to develop confidence to stop smoking, to make a commitment to cessation and to develop strategies for maintaining cessation for long periods of time.
- Smoking interventions for women should emphasize tension reduction techniques.
- Smoking interventions for women should emphasize weight control techniques.
- Physicians need to tailor their interventions for women by targeting concerns of tension reduction and weight control.

These when combined with the following elements

1) Legislation
2) Total bans on advertising whether directly or indirectly (ban and strict implementation)
3) Smoking in public places
4) Increase in prices

INVolVEMENT OF WOMEN AND CHILDREN IN THE BIDI INDUSTRY

I now want to report on an industry which utilizes women and children as if they have no rights - including the most basic right to live decently in an environment which does not threaten their health and well being. This is the bidi industry in India. India takes pride of running an industry which employs so many people to give them livelihood, who will otherwise starve as they will have no jobs and a source of income - we are reminded again and again.

Child Labour is one of the burning problems of our society. The fruit of development has spread unevenly, giving rise to pockets of intolerable poverty. Child Labour in bidi industry is one such industry where in spite of legislation, there seems to be no justice. The industry though export oriented; because of its low inputs of technology and its low requirement of technical skill has remained within the purview of unorganised sector, though the figures of the earnings in the export market makes it difficult to think of it as an unorganised one.

It is aptly stated that the state of children in any society is an indicator of its level of development. A country in which many children have no childhood cannot be regarded as one to be looked up to. It is indeed a grim social reality that even today as we approach the 21st century, we have not gotten rid of many ills that should have been eliminated from the face of the earth long time back. Child Labour is one such ill that need to be done away with. Attempts have been made by producing legislation which prohibits employment to children but it has not produced as desirable results as deemed necessary.

India is the major producer of bidis in the world. It is very difficult to estimate the number of children working in the bidi industry as only a few of them work in bidi factories,

1) Bidi is mostly a home based industry and all children are required to help out.
2) There are fewer factories and because of labour regulation, the factory owners are careful to employ children below 14.
3) Girls are almost never sent to factories - unless they are with their mothers.

Bidi industry is like no industry so intriguing, so conniving, so ruthless. The industry is the largest employer after agriculture and construction sector, at times the biggest and occasionally the only employer in the area. About 40 million men and boys are engaged in collecting ‘Tendu’ leaves used as wrappers for the bidis. Another 60 million are busy rolling bidis. These are mainly women and girls though also boys women comprising 65% and children around 15 to 25%.

It is very important to understand the functioning of bidi industry in order to appreciate the role of women & children in this industry.

The production process and relations

Bidi production is labour intensive and is in various stages at various levels. As said before a factory employs very few workers while a major portion of the bidi production is typically outside the factory in the workers’ homes. The factory owner who is the principal employer operates through a number of branches of the company within a state or across a number of states. Each branch has a specific geographical jurisdiction marked for operation. A typical branch has two major functions: first, getting bidis rolled by workers in villages through contractors or sattedars; and secondly, collecting, sorting, grading, roasting, labelling and packing of bidis that are produced. Each branch of a company has a manager and a number of employees who perform the activities of distribution of raw materials to sattedars, checking finished products and all other related activities.

At any given time a branch has a number of sattedars attached with it. Each sattedar has a specific area to operate, this may be just one village or a cluster of adjoining villages. It is also possible that in a village there may be more than one sattedar each for a different bidi company. The converse of this, namely one worker rolling bidis for different sattedars at the same time, does not usually happen. Often large villages with a concentration of bidi workers have more than one sattedar.

The branch supplies the raw materials namely, tendu leaves, tobacco and yarn in large quantities to a contractor, to supply back rolled bidis proportionate to the amount of raw materials supplied. The sattedar in turn distributes the raw materials in smaller quantities to several workers who take these to their home for rolling the requisite number of bidis specified by the sattedar.

The worker brings the raw materials home and shares the work with other members in the family including children. This is necessary because the process of rolling bidis involves several stages all of which are time consuming and it is not possible for one worker to perform all the work alone, to produce the required number of bidis in a day.
First the tendu leaves are cleaned and cut as per the size required by the brand of bidis to be rolled. The cut leaves are then soaked in water for a few hours to make them more malleable. At the next stage the bidi is rolled using tobacco and leaf, after which the edges of the rolled bidis are turned in and tied with yarn. Finally, the rolled bidis are tied in bundles of 12 or 24 as per the requirement of the sattedar. Thus, the raw materials are converted into a final product and returned to the sattedar. After checking the quality, the sattedars stack the bidis of each worker separately and sends the day’s collection to the branch office through a carrier known as ‘Relaiwala’. The worker in turn collects the raw material for the next day’s production. Thus, the process goes on.

In the branch the bidis brought by the relaiwala are first checked for quality. Each bundle, consisting of 12 or 24 bidis, is thoroughly checked for size and quantity of tobacco filled. The defective bidis are removed and discarded. Then the bidi bundles are counted and stacked in mesh trays. This is taken as the final production of the contractor for that day.

The process of production outlined above appears to be simple, but is in fact a complicated one. The complications arise primarily because of the informal relations of production at every level and the unorganised nature of the workers involved in production. Given this, there is widespread exploitation at each level in various forms. Thus, any discussion on the production process in the bidi industry would be incomplete without an understanding of the dynamics of exploitation involved therein.

Exploitation takes place at both levels of production - the branch exploits the sattedars and they in turn exploit the workers mercilessly. However, it is the worker who has ultimately to bear the brunt.

Exploitation of Workers by the Sattedar

1) A common practice adopted by the sattedar is wetting the tobacco prior to distribution to workers. This is done in order to make the tobacco heavier. Thus, in reality the quantity of tobacco given to workers is less than what is needed for rolling bidis. The contractor in this way earns on the tobacco saved.

2) It is an accepted fact that 800 gms of tendu leaves and 240 gms of tobacco are required to roll 1,000 bidis, provided the tendu leaves are not defective. Usually tendu leaves are given to workers without checking their quality. Poor quality or damaged leaves in the bundle given to the workers would necessarily mean shortage of leaves to roll the bidis. In addition to this, shortage of tobacco may occur due to one or more of the following reasons:

a) the sattedar takes a fistful of tobacco after weighing it, as parampara - a traditional practice.
b) the tobacco which was wet at the time of distribution dries up and thus weighs less in the final check; and

c) a sudden gust of wind may blow away some amount of tobacco from the open trays the workers use while rolling the bidis.

Shortage of tobacco and tendu leaves as outlined naturally results in a reduction in the bidis rolled and the worker is held responsible for this. A reduction in the bidis rolled leads to a cut in the wages. This wage cut is supposed to be proportionate to the shortage in the number of bidis produced. However, there is no standard norm observed in cutting wages and it is as per the whims and fancies of the contractor.

In order to avoid a wage cut arising due to shortage of raw material, the workers often resort to purchase of raw material on their own to replenish the shortage. The inherent advantage of this practice is that it would work out to be cheaper compared to the wage cut. Unfortunately, in many villages workers have to purchase raw material from sattedars as there would be no other alternative source.

The price that the workers pay to purchase the raw materials from the sattedar is also quite high compared to the market price. The only person who benefits in this whole transaction is again the sattedar.

3) About 10 percent of the bidis rolled by a worker are taken away as ‘standard deduction’ by the sattedar, to replace defective bidis. This is done regardless of the number of bidis rejected during the checking process or ‘chant’ done in the branch.

4) Bidis brought by the sattedar to the branch are again subjected to checks for quality. During this process, if one bidi in a bundle turns out defective, then at least one bidi each in all the bundles are rejected. The rejected bidis are not given back to the workers but retained by the branch. The sattedar in turn cuts the cost of that many bidis from the workers wages. The workers would not know the exact number of bidis rejected on any particular day. Thus, there are usually at least 20 to 25 per cent of rejects in a day per worker.

5) The amount of work that a worker receives depends on whether or not he or she is in the good books of the sattedar. The sattedar distributes the quantum of work to each worker depending on his will. This situation proves to be very vulnerable for the workers. This is purposefully done so that no worker can lay any claims on the contractor to benefits of any kind. Further since bidi production is suspended during the monsoon, all workers are laid off for a period of two months or so. Apart from this, the sattedar resorts to devious means to show impermanency of worker’s tenure by either changing the names in the register every three months and / or by excluding the names of women workers which in turn affects children who work for their mothers. Children are never in the sattedar’s register.
6) The worker does not keep as a practice accounts of work done and wages paid. The sattedar generally maintains two registers one pukka register in which the proper details of 10 to 20 workers are noted and another kuchha register in which all the workers names are entered. However, no pass book is maintained by the sattedar, as required by law for each worker separately.

7) In most of the villages, the sattedar, plays multiple roles, He is also generally the village moneylender, sometimes the local grocery shopkeeper, the village landlord or the Sarpanch. These roles enhance his hold on the workers, and provides him with several avenues to exploit the workers. The workers have no option but to accept the situation.

8) The sattedar makes weekly payments to workers. Sometimes he charges an interest claiming that he has borrowed money to pay them because the branch has delayed the payment to him. This may or may not be true. However, the sattedar often uses this excuse as a source of additional income. The workers are compelled to accept the arrangement since they have no alternative. Apart from this, at some places the sattedars charge a sum of Rs. 1.50 per week as ‘manageri’ from each worker for running the establishment.

Relations between Branch Office and the Sattedar

Thus goes the relationship between the sattedar and the worker in which the former takes undue advantage of the situation. The roots of this exploitative relationship lies not merely in the contractors’ need to appropriate more but also in his nebulous position vis-a-vis the employer. It is precisely the relationship between the two which determines to a large extent what follows. He is treated extremely shabbily by the establishment and is reprimanded for anything going wrong.

Bidi industry is a cottage industry no matter whether it is in rural or urban area. Every year 900 billion bidis are made by approximately 10 million workers. The majority of these are poor and illiterate women and children. Bidi workers are not an organized group. Because of being illiterate and unaware of their rights, they get amply exploited. They are unfamiliar with the welfare schemes that the government has launched. Not only that some of them are so pathetically ignorant that they do not even know the name of their employer. The managers remove or change the names of the bidi workers in their registers every 2 months so that he does not have to pay the welfare that the government has fixed.

The only positive thing that can be said about bidi industry is that it does not discriminate either on the basis of sex or religion. The rolling is mostly done by children and women. Many Muslim women who would not work at all, work in this industry because it allows them to work at home. Only 10% of bidis are made in the factories. The rest are made at home. As of April 1999 the government of India states that there are an estimated total of 43,99,644 bidi workers but the unofficial figures are more like 100,00,000 (6 million rolling bidi, 4 million collecting leaves). A big chunk of these are
belonging to backward classes & castes. Since it involves working at home it includes children especially girls. Only a proportion of them are registered workers who are issued identity cards. It is not in the interest of bidi employer to get their workers cards because then they will have to give them work benefits and welfare facilities. Like out of 43,99,644 official workers 35,85,018 have ID cards.

At present in bidi industry minimum wages are fixed separately for each state and region resulting in disparity.

<table>
<thead>
<tr>
<th>State</th>
<th>Rs. Per 1000 bidis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rajasthan</td>
<td>Rs. 22</td>
</tr>
<tr>
<td>Bihar</td>
<td>Rs. 26</td>
</tr>
<tr>
<td>U.P</td>
<td>Rs. 35</td>
</tr>
<tr>
<td>M.P</td>
<td>Rs.22.50</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>Rs.20.35</td>
</tr>
<tr>
<td>Gujrat</td>
<td>Rs.18.50</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>Rs. 16.25</td>
</tr>
<tr>
<td>West Bengal</td>
<td>Rs. 14.50</td>
</tr>
<tr>
<td>Kerala</td>
<td>Rs.25.20</td>
</tr>
<tr>
<td>Karnataka</td>
<td>Rs.16.25</td>
</tr>
<tr>
<td>Andhara Pradesh</td>
<td>Rs.17.85</td>
</tr>
</tbody>
</table>

Employers tend to shift the industries to states or even across borders into Nepal and Bangladesh where they have to pay less to the workers. Thus the threat of shifting industry always looms large for the workers are likely to loose jobs.

In the present existing system of contract the bidi workers are exploited due to the absence of direct relationship with the employer. As the middle man takes a share each time, the workers lose.

The government has introduced welfare schemes but the rules are so crooked as well as they lack any reference to ground realities. For example for the entitlement of almost all the welfare schemes the total family income cannot exceed Rs. 3,500/- per month, which is extremely absurd. The workers are to observe a small family norm viz will not have more than two children. This condition does not make sense to them as all children contribute in making bidis.

All bidi workers are eligible for medical and health benefits. But the dispensaries are not located according to their conveniences. Also many dispensaries do not have doctors. Even the medicines are not available in the quantity required and many TB and cancer patients do not get proper care. Only Rs. 70/- are paid towards prescription glasses which is far from realistic. Rs. 250/- are paid towards delivery and Rs. 50 as an incentive for sterilization.

Loans for building or repairing houses are inadequate to say the least.
There is a proposal that the bidi workers be given a loan of Rs. 10,000 and be also given Rs. 3000/- as ‘gratis. However it has been next to impossible to secure these loans as the rules get twisted and manipulated.

The government has also made a provision that the children of the bidi worker be given scholarship to go to school. The following has been approved.

<table>
<thead>
<tr>
<th>Class</th>
<th>Scholarship Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 4</td>
<td>Rs. 125 per year</td>
</tr>
<tr>
<td>5 - 6</td>
<td>Rs. 250 per year</td>
</tr>
<tr>
<td>7 - 10</td>
<td>Rs. 450 per year</td>
</tr>
<tr>
<td>11 - 12</td>
<td>Rs. 700 per year</td>
</tr>
<tr>
<td>For degree course</td>
<td>Rs.1000 per year.</td>
</tr>
<tr>
<td>For medical, engineering</td>
<td>Rs. 3000 per year.</td>
</tr>
</tbody>
</table>

There is also provision to show films, arrange other entertaining activities for the bidi workers especially children however this works mostly for those areas which have cooperatives formed by the workers.

As pointed out before, the workers are illiterate and because of being continuously exploited, get timid. In most of the cases they do no understand their rights. Even if they did they get so discouraged because they are required to go to different authorities for redressal of different grievances.

Provision for the education of the children of the bidi workers was made way back. Evidence exists that the children of the bidi workers have been harnessed to the gruelling process of bidi making instead of being sent to school. As most of the women are being kept out of official registrations children are doubly exploited - first by the industry and the state because their mothers are not recognized as workers, secondly by the family by engaging them for long hours whereby they can neither go to school nor play.

The tyranny of the household gets multiplied when the home becomes the work place, its arbitrariness and flexibility making it into a machine of exploitation. Women continue to be cheated by all the tiers of this industry and but worse they end up sacrificing the lives of their children to the unhealthy dreariness of bidi industry for hours on end that stunts their future growth and aspirations.

The workers who sat on the floor are surrounded by trays containing tobacco and cut or uncut, wrapper leaves, the latter soaked in water emits a peculiar odour while the tobacco leaves have a characteristic smell too. The mixture of these smells pervades the whole house. Women and children, heaps of waste, remnants of wrapper leaves and tin trays stuffed with tobacco or newly made bidis, dirty and torn mats here and there present a picture almost unbearable and unforgiveable.
In a landmark judgement passed in November 1991 the Supreme Court ordered that a survey should be conducted to identify the actual workers who rolled bidis so as to ensure provident fund and other benefits conferred upon the adult worker. This was ordered as a pass book that should rightfully be kept under the names of women workers. Also

a. The government should examine abolishing the contract system.

b. Child Labour should be prohibited.

However it seems like this directive was never followed as the evidence in the field shows.

The exploitation of both women and children continues.

The women and children in the bidi making are prone to occupational diseases - like T.B. caused by continuous inhaling of tobacco. They also have other rheumatic syndromes resulting from long hours of continuous sitting cross legged in an unhealthy atmosphere doing a monotonous job. They also suffer from chronic asthma, allergies, backache, stomach troubles and piles. Also sitting together for hours a T.B patient or one suffering from chronic cold passes on germs to her fellow workers.

As pointed out before in almost all setups of bidi workers 65% happen to be women while there are 15% children mostly girls. Women are paid less than men and children the least of all for the same work. Children have no wage structure of their own. It is the adult male who securs orders on behalf of their females and children as the latters are utilized as helping hands only. In most cases, neither the women, nor the children have any mention of them in the employers registers. Raw material and wages are paid to the male head of the family, providing ample scope for the dishonest employers and their agents to deny the existence of child labour. There is no mention of I.D cards of children. Though many of the children join school, the drop out rate is very high and very often the children are used as farm hands as well in addition to rolling bidis.

Including major trade unions nobody has done any work in organising children in the bidi industry.

There is never any sound rationale presented for paying lower wages to women and children. It comes down to plain gender bias. Some male bidi workers remarked “women and girls’ lack skill and their production is not up to the standard. Bidis produced by a man taste much better, the tobacco is evenly distributed throughout the length of the bidi and the leaves are evenly cut“.

However this is not borne out as the majority of the rollers in each and every area are women and girls they are preferred as well. This is also because women and girls being illiterate, the employers can take advantage of them. Also the fact remains that they are not organized as a group to fight back and protect their rights. Also they are reluctant to join openly in any movement. When women themselves were asked why they are paid less, the majority said that it was a ‘convention’, only a handful remarked that the employers were taking advantage of their ignorance. In addition even when women do
realize that an injustice is done to them they said they have no choice. If they did not roll bidis they and their families will starve. There are examples of cooperatives formed here and there by the bidi workers and in such cases, there is no discrimination. Not only the women and children get paid the same amount as men but they are able to avail of the welfare benefits. The cooperative enables them to have ID cards as one women said ID card is a must for any bidi roller especially if the roller is a women. Without it she will not get any maternity benefit, any house building loan or medical benefit. If she is a T.B patient she would not be provided any free treatment. When a roller without IDC dies her nearest relative or dependent is denied the stipulated compensation. Inspite of this many rollers stay without IDC.

Apart from poverty, ignorance and illiteracy, there are some other factors which enables the employers to exploit women and children rollers of bidi. Though Hindu women might be shy to deal with the men contractors in the beginning, they get over it and start working and interacting with them. This is not true of Muslim women and girls who have to stay under Purdha (in vail) as soon as she starts menstruating which imposes restrictions on her to deal with men who are non relatives. It is because of this that many cannot secure ID cards in their own names. Not only that they are also absent in the ledger books of the contractors. This adds to exploitation.

Forming cooperatives have been a hopeful factor because the trickaries of the contractor has no place here. There is higher pay, no rejection, no stealing raw material and no abuses. Inspired and empowered by the society the rollers working in a non-cooperative set up next to the cooperative ask for equal wages and they end up getting those. The difficulty is that a lot of money is needed to set up cooperatives. Also the management of funds is not easy and corruption is likely to crept up. But the fact remains that a cooperative society can pressurise the concerned agencies for the issuance of the ID cards. The block administration is the authority to issue cards and the trade unions have to recommend it to get all the benefits. But the machinery is so complicated.

Prolonged hours at bidi making in an enclosed place which is also their living quarters, pervaded by a noxious smell of the Tendu leaves and raw tobacco, children end up suffering often from many diseases. When children get sick they go to private clinics or traditional medicine practitioners because the welfare health centres are somehow not within their reach. Also because of shortage of medicines and absence of doctors the health center is rarely frequented by the bidi rollers.

Playing in childhood is almost taken for granted. Very few bidi rolling children have an occasion to play outdoor, some play in door but the majority has no time to play. In most of the settings 2/3 of the children never watch television, only 1/3 occasionally. Cinema is a rare thing to experience though radio listening is much more common than in average Indian house. The major source of entertainment is visiting relatives or friends or occasionally going to the village fair.

Mankind owes to the child, the best it has to give. The child shall enjoy special protection and shall be given opportunities and facilities by law and by other means, to
enable him to develop, physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. The child shall be protected against all forms of neglect, cruelty and exploitation. We have to aim for it and nothing short of it will have to be acceptable.

Child Labour regulation (1956) prohibits employment of children in hazardous occupations. The distinction between child work and child labour has a lot of loopholes. Section 3 of legislation exempts employment of children in home based work. There is high incidence of child work in families on piece rate basis formed out to them by the production units to circumvent the laws that prohibits children to work. Stringent laws are required. Employment of children should be uneconomical to bring about an end to it.

Work that denies children education and childhood, needs a holistic regulation suitable to strengthen enforcement machinery, enhanced access and improved quality of primary education, an effective nonformal education program, strengthening socio economic development program, participatory efforts by different partners including government, NGO and civil society.

For a long time we have been hearing the wise say “If you have got your health you have got everything”. Now all of a sudden we are told that the opposite is true as well. If you have got just about everything, you probably got your health as well”. What about its flip side namely if you have nothing and are poor, can you have even the remotest possibility that you might enjoy good health. By coincidence you might but as a rule no possibility say the poor. What would happen if in addition to being poor you are also rolling bidis. It is a hopeless situation tells the Medical Officer working in a primary health center in Andhra. He has seen healthy women turning sickly, children losing their luster and simply vegetating.

It is important to indicate that if tobacco exploitation has to be put an end to we have to come up with policies that are gender specific not only for adults but for children and youth as well. It is recognized that we understand the needs of women and children, not only needs but their rights to health, well-being, knowledge and protection from the tobacco industry. The Convention on the Rights of the Child (CRC) and the Convention on the Elimination of Discrimination Against Women (CEDAW) are potent tools for children and women to exert and demand that the tobacco industry put an end to its efforts to make tobacco so attractive to women and children, and to stop exploiting them both as consumers and workers.

Full implementation of these two conventions necessarily entails implementation of effective tobacco control measures in every country. Governments must ensure that the best interests of the child and woman override the power and influence of the tobacco industry and recognize that the long term economic and social costs of tobacco use outweigh the immediate political and financial costs of controlling it.

Both these conventions include articles indicating access to health education and interventions which can form a powerful framework within which women and children
have the right to seek, receive and impart information and ideas. The links between the rights to information and tobacco control are most obvious with regard to the portrayal of tobacco in the media including advertising. Media influences that lead to the development of positive attitudes to tobacco use and misleading information and a lack of objective information about the dangers of tobacco use pose serious threats to women’s and children’s rights as provided for in the two conventions.

It is helpful to use both the conventions as a tool to force change in institutional structures at the national level, i.e. using an international legal instrument to challenge governments to correct unjust situations at national level. This way it is possible to take the global and make it local to enforce it. This is particularly important when a government is unwilling to address human rights issues.

WHO can strengthen the role of women in global tobacco control by linking the Framework Convention against Tobacco (FCTC) with CEDAW. Both CEDAW and CRC are going to prove helpful to strengthen FCTC as well. FCTC will inspire each country to fight for its rights to be protected from tobacco through policies and legislation. “We need an international response to an international problem” as Dr Brundtland has said. These three conventions can also capitalize on the Beijing Platform for Action and the United Nations Declaration on Violence Against Women, the International Covenant on Economic Social and Cultural Rights and help fight the industry to uproot the dangerous consumable article which harms when used as recommended.