Table 4 Cigarette smoking and other socioeconomic variables in a logistic regression analysis among men 21 years of age or older, 2006 (n = 11,688)

Characteristics	Current smokers		
	OR	95% CI	
		Lower	Upper
Ages			
21-30	**2.66***	2.27	3.12
31-40	**2.60***	2.28	2.95
41-50	**2.37***	2.1	2.68
51-60	**1.76***	1.55	2.01
61 and older	Reference		
Education			
Lower Education	**3.15***	2.74	3.62
Middle Education	**2.18***	1.91	2.5
High Education	Reference		
Region			
Bangkok	**0.79***	0.65	0.95
Central	**0.83***	0.75	0.92
North	**0.73***	0.66	0.81
Northeast	Reference		
South	**1.30***	1.14	1.48
Marital status			
Single	**0.69***	0.57	0.82
Married	**0.76***	0.66	0.88
Others marital status	Reference		
Household income quintile			
1 (lowest)	**1.91***	1.66	2.2
2	**1.55***	1.35	1.77
3	**1.23***	1.08	1.4
4	1.03	0.9	1.17
5 (highest)	Reference		

* Significant at $p < 0.05$

**Age more than 61 years old, High education, Northeast region, marital status of "Other", and Quintile 5 as reference groups.

quintile 1, 2, 3, and 4) compared with the richest quintile 5.

Discussion

The results showed that 41.5% of adult Thai male population were smokers. A number of socio-demographic factors were associated with smoking status: younger age, lower income, lower education, residents of South region, and the other marital status. Observed social gradients in smoking are steeper in younger age group than in older age group.

Inverse associations between smoking and socioeconomic status are addressed earlier studies carried out in developed countries [2-5,7]. Tobacco use is now more prevalent among low education, manual occupation, and low income. Studies in developing countries [13-18] found a social gradient similar to that in Western countries. However, accumulated effects of multiple factors, such as education and age groups are not addressed in studies with limited number of subjects. Evidence to address particular groups with high smoking prevalence helps identify most vulnerable populations that anti-smoking programs should be provided with priorities.

Success of tobacco control programs was reported on the basis of analysis of policies in the USA, Canada, Sweden, UK and Australia [21]. Their measures included increasing tobacco taxation, limits on advertising and sponsorship, restrictions on smoking in public places, provision of nicotine-replacement therapy, intensive counseling for smoking cessation, and prohibitions of sales to children and health education campaign and have shown a number of successful achievements [22-24]. In Scotland [25], the number of hospitalizations due to acute coronary syndrome declined after the implementation of smoke-free legislation. Price increase has shown to be particularly influential to low socioeconomic class. A review of policies aimed at reducing inequalities in smoking, 10% price increase reduces smoking consumption by about 4% in high-income countries and 8% in low-income countries [26].

We found that smoking prevalence in Thailand were particularly high among younger adults from low-socioeconomic class. The rate of smoking prevalence among low and high education groups among 21-30 age group was higher than that among other age groups. Such a greater difference of smoking prevalence by educational levels would result in greater inequal distribution of health risks in later life by social class.

Low smoking prevalence in Thailand in high education group was remarkable. Reduction of number of people of few educational histories will also contribute to reduce smoking prevalence. Therefore general scaling up of education definitely contribute to reduce smoking prevalence and increase healthy populations. General improvement of socioeconomic status of the society will lead to healthy populations.

Roll-your-own cigarettes are not highly taxed and are sold at affordable price. Such cigarettes of affordable price are accessible for people in low income classes and young adults. Free nicotine-replacement therapies are not available in this country. High pricing policies for both manufactured and non-manufactured cigarettes would be effective to reduce smoking among young and low socio economic status in Thailand. To plan and implement evidence-based anti-smoking policies, there are needs for research on the impact of smoking control policies on reduction of smoking prevalence in low socioeconomic classes.

Our finding suggests that the smoking epidemic still exists in Thailand. Socioeconomic inequalities in smoking, particularly among younger generation are concerned. It is recommended that for better and more