Research Article

HOW ARE SOCIAL CLASS AND SPATIAL DISPARITIES RELATED TO THE SMOKING HABITS OF THAI MONKS?

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Abstract

Background and Objectives: Since the United Nations announced the Sustainable Development Goals in 2015, countries worldwide have prioritized achieving these targets, particularly in the aftermath of the COVID-19 pandemic, when ensuring good health has become a central, collective concern. To achieve good health, it is imperative to consider the social determinants shaping health outcomes. Thailand places strong emphasis on well-being and holistic health. Smoking poses a major challenge in achieving this goal as it constitutes a risky health behavior that negatively affects overall health outcomes. This study examines smoking among Thai Buddhist monks, an issue that has remained underexplored in existing scholarship. Smoking among monks not only directly affects their health, but also intersects with the sensitivities of monastic disciplinary principles (Vinaya). To analyze this phenomenon, the objective of this study was to examine how social class and spatial disparities revealed the social complexity underlying the smoking behavior of Thai monks.

Methodology: The study aimed to understand the differences in smoking decisions among Thai monks, who represent a culturally specific population. It drew on the concepts of social class and spatial disparities to explain smoking patterns among monks. This quantitative research used secondary data from a questionnaire administered to 911 monks and novices. After managing the dataset, statistical analyses were conducted using ordered logistic regression.

Main Results: Important considerations regarding population health and sustainable development must account for the obstacles to achieving good health within the contexts of social environments, cultural patterns, and the lifestyles of particular population groups. The results demonstrate the relationship between social class, spatial disparities, and smoking among Thai monks. When considering the dimensions of educational attainment, ordination hierarchy, region of residence, and place of residence, a correlation with smoking behavior among Thai monks was observed.

Involvement to Buddhadhamma: This article is situated within Applied Buddhism, focusing on understanding the relationship between health risks and Buddhism. Health risks arising from smoking reflect relevant Buddhist principles, particularly the Five Precepts, in which tobacco

is regarded as an addictive substance and a form of vice. Smoking not only has adverse effects on physical health but is also associated with diminished mental, intellectual, and social well-being. Although the monastic disciplinary code (Vinaya) does not explicitly prohibit or permit smoking, the practice remains a matter of concern. Nevertheless, an important tool of Buddhist principles, the Four Noble Truths, provides a fundamental framework that can be practically applied to support smoking cessation. The process begins with recognizing that smoking leads to suffering (Dukkha, Unsatisfactoriness), followed by identifying the reasons or causes underlying the smoking habit (Samudaya, The Origin of Suffering). Once these causes are identified, monks who are determined to quit smoking can set personal goals to eliminate the source of suffering (Nirodha, The Cessation of Suffering). This understanding can then be translated into practical actions in their daily lives, such as gradually reducing cigarette consumption until complete cessation is achieved (Magga, The Path Leading to The Cessation of Suffering). Furthermore, monks who intend to quit smoking can apply the principle of yoniso manasikāra (Wise Reflection) by considering the harms of smoking, seeking information from credible sources about the health risks associated with tobacco use, and committing themselves to the reduction and eventual cessation of smoking.

Conclusions: Thai Buddhist monk's decision to smoke may stem from underlying social and cultural structures, which increase their health risks and hinder the achievement of the Sustainable Development Goals.

Keywords: Social Class, Spatial Disparities, Health Disparities, Smoking, Thai Buddhist Monks, Buddhism

Introduction

Smoking is considered a health-related lifestyle choice and is closely linked to the social and cultural practices of individuals within society. Currently, the United Nations has included the World Health Organization Framework Convention on Tobacco Control (FCTC) as an indicator for achieving the Sustainable Development Goals related to good health and well-being. It set the minimum age for smoking at 15, with a global target of reducing the number of smokers by at least 50 million by 2022 (United Nations, 2024). Thailand is among the countries that have strictly regulated smoking in accordance with the FCTC. Currently, Thailand has 10,676,362 smokers and 527,839 cigarette retailers, ranking fourth in Southeast Asia in terms of the size of the smoking population (Lian & Dorotheo, 2018). The 2021 Health Behavior of Population Survey, conducted by the National Statistical Office of Thailand, reported that the smoking rate among the Thai population has continued to decline since the signing of the FCTC. Heavy smokers are predominantly males aged 25-44, first-time smokers usually start between ages 18 and 22, and habitual smokers typically begin between ages 19 and 23 (Statistical Forecasting Division National Statistical Office, 2021). Scholars have often examined smoking behavior using a quantitative approach that focuses on the relationship between smoking, gender, and age, particularly among teenagers who may perceive smoking as a way to appear more attractive and mature. Consequently, research on smoking behavior frequently involves cohort studies of adolescents (Amrock et al., 2014); (Hammond et al., 2008); (Parkinson et al., 2009). In addition to gender and age, some scholars have examined socio-economic determinants and noted

that occupational groups and social classes also influence smoking (Barbeau et al., 2004); (Mentis, 2017). Although smoking behavior has been examined through quantitative studies, some ethnographic works have shown that the decision to smoke is closely linked to social lifestyle. Smoking contributes to the regulation of negative emotions, enables individuals to cope with social stress, and functions as a form of stress management. It is also associated with social class, with cigarettes often serving as a social lubricant that facilitates the sharing of feelings between individuals (Nichter, 2015); (Nichter & Nichter, 2016).

Thailand is a country with diverse social and cultural dynamics that shape the health and lifestyle of its people. In previous national smoking data projections, monks were often included within the general male population for simplification purposes (Statistical Forecasting Division National Statistical Office, 2021), overlooking important social dimensions, despite monks living under the monastic disciplinary framework, a distinct social structure that guides their practices and daily actions. Therefore, the health of monks differs from that of other population groups because their health behavior cannot be isolated from their social structure (Cockerham, 2017); (Panyachit, 2025). However, when viewed through the Social Determinants of Health framework, the components of social indicators that shape health outcomes can be conceptualized across three major dimensions: Structural, functional, and quality. The structural dimension emphasizes the environments and interactions in which individuals live, including social networks, living arrangements, and various forms of social status. The functional dimension highlights social needs, including social interaction and engagement. Finally, the quality dimension concerns subjective perceptions of one's social position, encompassing feelings of connectedness, social cohesion, and overall life satisfaction (Holt-Lunstad, 2022).

Considering specific writings on smoking by monks, most studies have focused on behavioral health sciences (Kungskulniti et al., 2011); (Vanphanom et al., 2009). Therefore, research from a sociological perspective that seeks to understand the smoking behavior of Thai monks remains limited. Unlike other studies, this study focused on social class and spatial disparity dimensions as key factors in revealing the social complexity underlying the smoking behavior of Thai monks. The authors hope that this study will contribute to expanding the discussion and education on monastic health. The findings may inform the development of policies aimed at the prevention and control of smoking.

Objectives

The objective of this study was to examine how social class and spatial disparities revealed the social complexity underlying the smoking behavior of Thai monks.

Methodology

This study drew on nationally representative survey data from the Project to Strengthen the Buddhist Institute of Wellness for Risk Factor Reduction, supported by the Thai Health Promotion Foundation (Thai Health). Data were collected between 2023 and 2024 across seven regions participating in the Workshop on Health Risk Factor Reduction: Surat Thani, Lampang, Uthai Thani, Ubon Ratchathani, Si Saket, Lamphun, and Nong Khai.

The survey was based on a questionnaire designed to gather information on smoking habits, involving 1,857 respondents, including monks and novices. The collected data were considered particularly valuable compared to previous surveys conducted by government organizations in Thailand. Among the respondents, 911 were monks and novices. Therefore, this study used secondary data to analyze how social class and spatial disparities contributed to smoking behavior among Thai monks.

Measures

To examine smoking prevalence among Thai monks, the outcome variable was measured on an ordinal scale with three categories: Non-smokers, moderate smokers, and heavy smokers. In the original data prior to the sampling, among monks and novices, 73.60% were non-smokers, 5.64% were moderate smokers, and 20.76% were heavy smokers.

This study was to examine how social class and spatial disparities revealed the social complexity underlying the smoking behavior of Thai monks (See Table 1). The variables include:

1. Social class: It referred to the social status of monks, reflecting social stratification. It also encompassed variables indicating symbolic capital expressed through social status, such as seniority, social acceptance, and prestige, which were considered determinants of health (Diemer et al., 2012); (Elo, 2009); (Thongsawang et al., 2020). The social class variables in this study included age group, educational attainment, Pali educational attainment, Dhamma educational attainment, ordination hierarchy, and social status within the temple.

2. Spatial disparities: While examining the smoking decisions of Thai monks, analyzing health disparities through spatial disparities highlighted how living in different locations could contribute to variations in health outcomes (Stillwell et al., 2010). Accordingly, this study considered the region and place of residence as variables for spatial disparities.

Table 1 Independent Variables Descriptions, Measurements, Means, Medians, and Standard Deviations

Variables	Measurements	Percentage	Mean	Median	S.D.
Age	11-87	-	33.69	30	18.40
Educational attainment	Lower-secondary education	39.31	-	-	-
	Upper-secondary education	32.14			
	Bachelor's degree	18.68			
	Master's degree or higher	9.87			
Pali educational attainment	Uneducated	85.71	-	-	-
	Educated	14.29			
Dhamma educational attainment	Uneducated	4.88	-	-	-
	Educated	95.12			
Ordination hierarchy	Nawaga	24.84	-	-	-
	Middle monk	27.74			
	Thera	10.77			
	Mahathera	36.65			

Table 1 Independent Variables Descriptions, Measurements, Means, Medians, and Standard Deviations (Continued)

Variables	Measurements	Percentage	Mean	Median	S.D.
Social status in Temple	Not holding administrative position	72.43	-	-	-
	Holding an administrative position	27.57			
Region of residence	North	12.60	-	-	-
	Northeast	59.12			
	Central	24.31			
	South	3.98			
Place of residence	Rural	77.93	-	-	-
	Urban	22.07			

Statistical methods

Ordered logistic regression was a statistical approach employed to analyze the smoking behavior of Thai monks. Unlike binary logistic regression, which could only analyze variables divided into two groups, ordered logistic regression allowed for the analysis of ordinal dependent variables (Fullerton, 2009). In this study, smoking variables were divided into three categories: Non-smokers, moderate smokers, and heavy smokers.

Before conducting the logistic regression, cross-tabulations and chi-square tests of independence were performed. These analyses helped examine the relationships between the independent variables and the smoking behavior of Thai monks.

Results and Discussion

Monks and smoking

The classification of Thai monks' smoking behavior based on social class and spatial disparities using cross-tabulation indicated that, in general, most monks were non-smokers. However, the proportion of moderate smokers exceeded that of heavy smokers among middle monks, as well as monks residing in the Northeast region, as shown in Table 2.

Among key variables, age showed notable differences: Monks aged ≤ 15–29 had the highest proportion of moderate smokers (55.0%) compared with other age groups. With regard to education, monks with lower-secondary education were predominantly non-smokers (41.2%), whereas monks with upper-secondary education tended to be moderate smokers (40.2%). Meanwhile, monks with a bachelor's degree were found to be heavy smokers (50.0%).

In ordination hierarchy, monks at the Mahathera level reported lower smoking rates compared with those from other groups (41.9%). Monks at the middle level tended to be moderate (38.2%) or heavy smokers (64.7%). With regard to the spatial perspective, there were both moderate smokers (56.1%) and heavy smokers (41.7%) among monks living in the Northeast region, which was the largest proportion compared to other groups.

Table 2 Cross-tabulation of Thai Monks' Smoking

Social Class and Spatial Disparities	Thai Monks' Smoking		
	Non-smokers	Moderate Smokers	Heavy Smokers
Age Group (p-value = 0.005)			
≤ 15-29	38.6	55.0	26.3
30-44	21.3	23.3	26.3
45-59	25.7	14.0	26.3
60+	14.3	7.8	21.1
Educational Attainment (p-value = 0.000)			
Lower-secondary education	41.2	35.2	22.7
Upper-secondary education	31.0	40.2	18.2
Bachelor degree	16.1	22.1	50.0
Master's degree or higher	11.7	2.5	9.1
Pali Educational Attainment (p-value = 0.009)			
Uneducated	84.5	93.8	76.2
Educated	15.5	6.2	23.8
Dhamma Educational Attainment (p-value = 0.537)			
Uneducated	5.1	4.8	0.0
Educated	94.9	95.2	100.0
Ordination Hierarchy (p-value = 0.000)			
Nawaga	23.0	36.8	17.6
Middle-level monk	24.0	38.2	64.7
Thera	11.1	10.5	0.0
Mahathera	41.9	14.5	17.6
Social Status in Temple (p-value = 0.002)			
Not holding administrative position	69.9	84.2	78.3
Holding an administrative position	30.1	15.8	21.7
Region of Residence (p-value = 0.000)			
North	11.1	16.2	37.5
Northeast	60.1	56.1	41.7
Central	27.4	12.2	8.3
South	1.4	15.5	12.5
Place of Residence (p-value = 0.124)			
Rural	79.0	67.9	86.7
Urban	21.0	32.1	13.3

Smoking prevalence based on monk categories

The cross-tabulation between social class and spatial disparities used in analyzing smoking behavior among Thai monks, examined through the ordered logistic regression model (Table 3), was presented across three models. Model 1 represented only variables related to the general social population and spatial differences, such as region and urban–rural residence. Model 2 incorporated variables specific to monks, including Pali and Dharma education, ordination during

Lent, and social status within the temple. Model 3 combined all variables related to social class and spatial disparities.

In Model 1, educational level, region of residence, and place of residence were all found to be correlated with smoking among Thai monks. Monks with a lower secondary education were more likely to be heavy smokers than their counterparts holding a master's degree or higher (p = 0.02). Similarly, monks with a bachelor's degree were more likely to be heavy smokers than those with a master's degree or higher (p = 0.00). In terms of regional differences, monks living in the Central region were more likely to be non-smokers than those living in the Southern region (p = 0.00), and monks living in rural areas were more likely to be heavy smokers compared with those living in urban areas (p = 0.01).

Model 2, which focused on variables related to monks, found that those whose ordination age placed them in the middle monk hierarchy smoked more heavily than monks in the Mahathera group (p = 0.01). Model 3 presented results that further clarified these categories. Monks who graduated with a bachelor's degree were more likely to become heavy smokers compared with those holding a master's degree or higher (p = 0.02), while monks in the middle monk hierarchy were more likely to become heavy smokers than those in the Mahathera group (p = 0.01). Furthermore, monks living in rural areas were heavier smokers than their counterparts living in urban areas (p = 0.01).

Table 3 Ordered Logistic Regression Model of Thai Monks' Smoking

Variables	Thai Monks' Smoking					
	Model 1		Model 2		Model 3	
	OR	S.E. (p-value)	OR	S.E. (p-value)	OR	S.E. (p-value)
Age Group (Reference Group: 60+)						
≤ 15-29	0.25	0.24 (0.30)			-0.07	0.36 (0.85)
30-44	0.20	0.22 (0.37)			0.14	0.33 (0.67)
45-59	0.08	0.22 (0.72)			-0.04	0.30 (0.88)
Educational Attainment (Reference Group: Master's Degree or Higher)						
Lower-secondary ducation	0.62	0.26 (0.02)			0.44	0.41 (0.29)
Upper-secondary ducation	0.31	0.23 (0.18)			0.41	0.36 (0.26)
Bachelor degree	0.87	0.23 (0.00)			0.75	0.32 (0.02)
Pali Educational Attainment (Reference Group: Educated)						
Uneducated			0.28	0.15 (0.06)	0.55	0.29 (0.06)
Dhamma Educational Attainment (Reference Group: Educated)						
Uneducated			0.18	0.66 (0.78)	0.46	0.94 (0.63)
Ordination Hierarchy (Reference Group: Mahathera)						
Nawaga			0.31	0.22 (0.15)	0.61	0.37 (0.10)
Middle-level Monk			0.56	0.20 (0.01)	0.82	0.29 (0.01)
Thera			-0.17	0.23 (0.45)	0.33	0.37 (0.37)

Table 3 Ordered Logistic Regression Model of Thai Monks' Smoking (Continued)

Variables	Thai Monks' Smoking					
	Model 1		Model 2		Model 3	
	OR	S.E. (p-value)	OR	S.E. (p-value)	OR	S.E. (p-value)
Social Status in Temple (Reference Group: Holding an Administrative Position)						
Not holding administrative position			0.29	0.17 (0.09)	0.33	0.26 (0.21)
Region of Residence (Reference Group: South)						
North	-0.22	0.35 (0.53)			-0.13	0.40 (0.74)
Northeast	-0.52	0.36 (0.15)			0.19	0.47 (0.68)
Central	-1.11	0.31 (0.00)			-0.55	0.41 (0.18)
Place of Residence (Reference Group: Urban)						
Rural	0.55	0.23 (0.01)			0.67	0.27 (0.01)
Cox and Snell R2		0.156		0.105		0.231
N		295		292		159

Discussion

Drawing on secondary data analysis, this study relied less on data collected at the local level and more on information obtained from the National Statistical Office of Thailand, which conducts surveys every three years. There are several noteworthy findings. The 2021 Health Behavior of the Population Survey, conducted by the National Statistical Office of Thailand, showed that the highest smoking rates were concentrated in the Southern region, which is consistent with the findings of this study (Statistical Forecasting Division National Statistical Office, 2021). However, differences in smoking by residential area between urban and rural settings suggest that place of residence is not necessarily correlated with smoking (Hammond et al., 2008); (Jitnarin et al., 2010). Nonetheless, the data analysis in this study showed that monks living in rural areas were more likely to smoke than those living in urban areas. These findings confirm that spatial disparities contribute to smoking behaviors.

In terms of social class and health, scholars have applied Bourdieu's analysis to understand the social field of health from different perspectives; this study focused on the smoking behavior of monks. However, the application of Bourdieu's framework often reflects different health outcomes of individuals or health disparities that overlap with habitus, field, and capital, contributing to shaping health practices. Educational level, as a form of cultural capital, is considered an important factor in determining smoking behavior (McGovern & Nazroo, 2015); (Oncini & Guetto, 2018); (Williams, 1995).

Previous studies on monks' health have broadly emphasized general health and lifestyle practices, rather than specific health outcomes. Earlier research has made important contributions by pioneering the study of monks' health in Thai society, while also highlighting the influence of social structures and patterned social arrangements in shaping monks' health outcomes (Jeamjitvibool et al., 2022); (Panyachit, 2025). This study, however, focused on a more specific

health concern by examining cigarette smoking among Thai Buddhist monks. It reveals how smoking behaviors are shaped by the interplay between social class and spatial disparities, which collectively contribute to variations in smoking patterns across different groups of monks.

In Thailand, a movement has emerged to promote the health of monks in a sustainable manner through "Well-Being" and "Health Literacy," as outlined in the National Sangha Health Charter B.E. 2023. Regulating monks' health through the Constitution reflects the view of monks as rational actors who can assume responsibility for their own health, in accordance with the principles of Dharma. The emphasis is on health literacy education that recognizes smoking as a major obstacle to achieving the goal of "Healthy Monks, Sustainable Temples, and Happy Communities" (National Health Commission Office (NHCO) Thailand, 2024). In addition, this study helped address gaps in the stereotypical view of monastic health by highlighting distinctions in health from a sociological perspective, which may inform future policy development.

Originality and Body of Knowledge

Figure 1 illustrates the social factors associated with smoking among Thai Buddhist monks, analyzed through two dimensions: Social class and spatial disparities. This knowledge is derived from research, as studies examining these two factors remain relatively limited. The decision of Thai Buddhist monks to smoke may be influenced by underlying social and cultural structural conditions, which increase their health risks and hinder the achievement of the Sustainable Development Goals. Nevertheless, the novelty of this study lies in its application of sociological perspectives while analyzing Buddhist monks in Thailand, an area in which scholarly work remains markedly limited. The study further advances this field by situating monks' health issues within broader social structural conditions and spatial disparities in Thai society.

Figure 1 The Social Factors Associated with Smoking Among Thai Buddhist Monks

Conclusions and Recommendations

This study determined the relationship between social class, spatial disparities, and Thai monks' smoking habits. When considering the dimensions of educational attainment, ordination hierarchy, region of residence, and place of residence, a correlation with smoking was observed among Thai monks. Monks holding a master's degree or higher are less likely to be heavy smokers compared to monks with lower educational attainment. Regarding the ordination hierarchy, which is based on the period of ordination, middle-level monks are more likely to become heavy smokers than monks in other hierarchies. With regard to the regions where monks live, it is found that those living in the Central region are less likely to become heavy smokers compared to those from the Southern region, while monks living in rural areas are more likely to become heavy smokers compared to their counterparts in urban areas. Future research should expand survey coverage to include all regions of Thailand in order to reduce geographical bias in the findings. Moreover, subsequent studies could adopt a mixed-methods design integrating qualitative approaches to provide deeper insights into monks' smoking-related health issues, particularly by uncovering the cultural backgrounds and belief systems embedded within individual experiences. In addition, future work may advance quasi-experimental research by implementing health intervention programs aimed at modifying smoking behaviors among Buddhist monks. For policy recommendations, relevant government and public health agencies should develop targeted campaigns to reduce smoking rates among Buddhist monks. Simultaneously, it is imperative to empower monks to serve as community role models and mobilizers to encourage smoking cessation among laypeople in local communities.

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