

SMOKING PATTERNS AMONG PEOPLE IN JAMMU REGION OF JAMMU AND KASHMIR STATE

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ABSTRACT

Cigarette smoking is a major preventable cause of morbidity and mortality worldwide. Most adult smokers start smoking regularly some time before 18 years of age. The aim of this study was to determine the age at which children begin cigarette smoking, to study the environmental factors that influence children to smoke, and to understand the reasons why children smoke. The results of this study may help lead to the development of more effective smoking prevention programs. The study was carried out by a cross-sectional survey of 200 youth selected from two districts (ages: 18 to 60 years) in Jammu region of Jammu and Kashmir State, using a specifically designed questionnaire. The respondents were asked questions regarding the age at which they began smoking, initiation, their smoking habits, their reasons for smoking, and their views on people who smoke. The results revealed that out of the 200 respondents who answered the questionnaire, only 20% stated that they had smoked at least once and that they were currently smoking also. There was a sharp increase in experimental smoking after 16 to 20 years. Having a friend who smoked substantially increased the likelihood of smoking, whereas parental smoking or having a sibling who smoked did not increase the likelihood of smoking. The most common reason for starting to smoke was "to try something new". There was a significant difference between the views of respondents with different smoking statuses regarding people who smoke: non-smoking respondents associated more negative characteristics to smoking. All of the respondents studied were well aware of the health hazards of cigarette smoking. It was concluded that cigarette smoking is a common problem among the people of Jammu region of Jammu and Kashmir State. The respondents were characterized by certain socio-demographics, patterns of smoking that were somewhat similar to national and international research. However, present study did not directly address the role of government in preventing the drug use. Finally, in addition to identifying the underlying risk factors in community based studies, future intervention research should explore the role of psychosocial and drug therapies in the management of tobacco/drug addiction.

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KEY WORDS

Smoking; Cigarettes; Bidis; Hookah; knowledge; Respiratory morbidity; prevalence

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[I] INTRODUCTION

Tobacco use including both the smoking and the nonsmoking forms of tobacco is common in Jammu and Kashmir. In India few reports of tobacco use in different population groups report its prevalence from about 15% to over 50% among men [1-5]. Tobacco smoking in most parts of India except Punjab, Maharashtra and Sikkim is reported in about one fourth to half of adult men of over 15 years of age. Amongst women, smoking was more common in the North Eastern states, Jammu & Kashmir and Bihar, while most other parts of India had prevalence rates of about 4 percent or less [6]. In other reports, ever smoking among the school going youth of 13- 15 years age, studied as a part of the Global Youth Tobacco Survey (GYTS) study was reported on an average in upto about 10 percent individuals [7]. All these reports clearly indicate a

higher prevalence of tobacco smoking in adult men. Detailed information on the type of smoking forms, amount smoked and relationship with different demographic variables is relatively small. The present report provides information on the population prevalence of smoking habits of people of district Udhampur and Jammu of J&K state studied with the help of question items included in the questionnaire for the above mentioned study.

[II] MATERIALS AND METHODS

The study was carried out in district Udhampur and Jammu, Jammu region of J&K state in India during 2009-10. A sample of 200 subjects comprised of both rural and urban residents in the age range of 18-60

years were selected. Information on smoking habits, demographic and exposure variables were collected with the help of a single, pre-validated respiratory symptom questionnaire employing a two-stage stratified sampling design. Both rural and urban samples were studied with a village or an urban locality as the first stage unit and a household as the second stage unit. In this cross-sectional study, a structured questionnaire was employed to collect information from the respondents. The respondents were given information by the investigators about the objectives of the study. They were assured of confidentiality in their responses and they were informed that the research is for academic purpose only. The data was scrutinized, categorized, coded and statistically analyzed using statistical software SPSS version 17.0. Suitable statistical tools were used to assess the statistical significance of differences

[III] RESULTS AND DISCUSSION

According to our study, 20% respondents were current smokers and the remaining (80%) were either ex-smokers or non-

smokers. Non-smokers and ex-smokers (8%) gave the following overlapping reasons not to smoke: smoking is prohibited, or not allowed in religion, smoking is disliked, smoking is injurious to health and cigarette buying is a waste of money. Bidi, the hand rolled form of tobacco, wrapped in the dried tendu leaf and Hookah smoking, the more traditional way in which tobacco is kept in a earthen pot (chillum) along with the burning coal and smoked through a water container with the help of a long pipe, was the common smoking product in this study especially in the rural population. The results obtained are in consistent with the earlier studies [1, 8]. Ex-smokers quit smoking because of health problems, advice from elders and death of a close relative or a friend attributed to smoking. **Table-1** reveals that out of 200 respondents 122 were urban and 78 rural residents. It has been observed that education, occupation, marital status and income of respondents and smoking habits were related statistically.

Table. 1: Socio-demographic characteristics of respondents (%)

Variable	Number of Respondents	Smokers (n=40)	Non-Smokers (n=160)	χ^2	P-value
Residence					
Urban	122	22 (18.03)	100 (81.97)	0.757	>0.05
Rural	78	18 (23.07)	60 (76.93)		
Education					
Illiterate	128	17 (13.28)	111 (86.71)	10.031	<0.01
Literate	72	23 (31.95)	49 (68.05)		
Occupation					
Employed	88	12 (13.64)	76 (86.36)	3.977	<0.05
Unemployed	112	28 (25.00)	84 (75.00)		
Religion					
Muslim	82	13 (15.85)	69 (84.15)	1.493	>0.05
Non-Muslim	118	27 (22.88)	91 (78.12)		
Marital Status					
Married	81	08 (9.88)	73 (90.12)	8.720	<0.01
Unmarried	119	32 (26.89)	87 (73.11)		
Income (Rs)					
3000-5000 (Low)	25	8 (32.00)	17 (68.00)	10.201	<0.01
5000-10000 (Middle)	141	20 (14.18)	121 (85.82)		
10000 & above (High)	34	12 (35.29)	22 (64.71)		

Table-2 reveals that majority of the respondents are aware of the ill-health effects of smoking. It was observed that 93.75% non-smokers and 70.0% smokers agree that smoking/drug use is prohibited in religion ($p < 0.01$). Among smokers 70%

had made attempts to quit. Majority of the respondents disclosed that the main reasons for smoking are marital disorder, job problems, financial difficulties and residential difficulties.

Table. 2: Distribution of Respondents on religious beliefs about smoking/drug behavior

Variable	Smokers (%)	Non-smokers (%)	χ^2	P-value
Smoking is prohibited in religion	28 (70.0)	150 (93.75)	18.437	<0.01
Smoking has no religious meaning	12 (30.0)	10 (6.25)		

Table-3 presents the reasons given by smokers for smoking. Majority of the smokers were either unhappy or anxious or had experienced peer pressure prior to smoking.

Approximately 50% smokers smoked 10 or more cigarettes daily anytime anywhere they chose to. A good portion of smokers were also using alcohol and a minor portion of

smokers were using drugs. Statistically, it is observed that smoking and situations in the life of a person are significantly

related (P -value <0.01). The results obtained are in agreement with the earlier study [9].

Table 3: Inventory of smoking/drug taking situations

Statement	Never	Rarely (%)	Frequently (%)	Almost Always (%)
(i) When I was depressed about things in general	160 (80.00)	24 (12.00)	12 (6.00)	4 (2.00)
(ii) When I was happy	154 (77.00)	18 (9.00)	16 (8.00)	12 (6.00)
(iii) When I felt there was nowhere left to turn	170 (85.00)	14 (7.00)	12 (6.00)	4 (2.00)
iv. When felt tense or uneasy in the presence of some one	164 (82.00)	28 (14.00)	8 (4.00)	0 (0)
v. When unable to express feeling to some one	166 (83.00)	16 (8.00)	14 (7.00)	4 (2.00)
vi. When I had trouble sleeping	168 (84.00)	20 (10.00)	10 (5.00)	2 (1.00)
vii. when other people reject or did not like to see me	166 (83.00)	22 (11.00)	12 (6.00)	0 (0)
viii. When alone	170 (85.00)	22 (11.00)	2 (1.00)	6 (3.00)
ix. When felt anxious or tense about something	164 (82.00)	8 (4.00)	26 (13.00)	2 (1.00)
x. When felt family pressure	166 (83.00)	12 (6.00)	20 (10.00)	2 (1.00)
xi. To increase enjoyment	160 (80.00)	14 (7.00)	8 (4.00)	18 (9.00)
xii. When felt overwhelmed and wanted to escape	164 (82.00)	20 (10.00)	10 (5.00)	6 (3.00)
xiii. When there was fights at home	166 (83.00)	20 (10.00)	14 (7.00)	0 (0)
xiv. When I was with a group of people and everyone was using drugs	170 (85.00)	8 (4.00)	20 (10.00)	2 (1.00)
xv. When failed in love affair	178 (89.00)	16 (8.00)	6 (3.00)	0 (0)
xvi. When failed in examination	172 (86.00)	12 (6.00)	16 (8.00)	0 (0)
xvii. When failed to get a job	180 (90.00)	12 (6.00)	2 (1.00)	6 (3.00)
$\chi^2 = 178.056$, P -value < 0.01				

The data presented in Table-4 reveals that variety of medical diseases, the majority of which were associated with smoking, were found in smokers ($P>0.05$). Non-smokers were protected from smoking-related medical diseases. Smoking is a major risk in more than 20 medical diseases, in particular, chest and

cardiovascular diseases that are preventable [10]. Indeed, smoking and drug is a slow suicidal and homicidal killer, and hence, there should be culturally sensitive and effective means to prevent and treat both smoking and addiction worldwide [11, 12].

Table 4: Distribution of Medical Diseases by smoking/drug status

Medical disease	Smokers (%)	Non-smokers (%)	Z	P-value
Chest disease	08 (20.0)	31 (19.375)	0.09	>0.05
Trauma	14 (35.0)	51 (31.875)	0.37	>0.05
Metabolic diseases	08 (20.0)	35 (21.875)	0.26	>0.05
Cardio Vascular diseases	05 (12.5)	15 (9.375)	0.55	>0.05
Miscellaneous conditions	07 (17.5)	28 (17.5)	0.01	>0.05

[IV] DISCUSSION

According to our study, 20% respondents were current smokers and the remaining (80%) were either ex-smokers or non-smokers. Non-smokers and ex-smokers (8%) gave the following overlapping reasons not to smoke: smoking is prohibited, or not allowed in religion, smoking is disliked, smoking is injurious to health and cigarette buying is a waste of money. Bidi, the hand rolled form of tobacco, wrapped in the dried tendu leaf and Hookah smoking, the more traditional way in which tobacco is kept in a earthen pot (chillum) along with the burning coal and smoked through a water container with the help of a long pipe, was the common smoking product in this study especially in the rural population. The

results obtained are in consistent with the earlier studies e.g., Chhabra et al (2001) and Reddy and Gupta (2004). Ex-smokers quit smoking because of health problems, advice from elders and death of a close relative or a friend attributed to smoking.

[IV] CONCLUSION

Despite some limitations of our study, we concluded that cigarette smoking is a common problem among the people of Jammu region of Jammu and Kashmir State. The respondents were characterized by certain sociodemographics, patterns of smoking that were somewhat similar to national and international research. The quit-rates of smoking have been

low in spite of the anti-tobacco/drug measures. The main reason for quit smoking was the presence of one or other respiratory symptoms. The main reasons for increasing in smoking were unemployment, marital problems and residence (environment). Similar observations are made in Western literature [13]. Government can play a major role in preventing the drug use; although present study did not directly address the role of government in preventing the drug use. Finally, in addition to identifying the underlying risk factors in community based studies, future intervention research should explore the role of psychosocial and drug therapies in the management of tobacco/drug addiction. It is reported that a good percentage of women are also involved in smoking/drug use. For future research, it is suggested that sample size should be increased and women should be included in the study to get a good picture of the society.

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CONFLICTS OF INTEREST

All authors declare that we have no conflicts of interest.

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