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Importance of Deleterious Habits in Family and Relatives of Tobacco Users Reporting to Tobacco Control Unit of Burdwan Dental College and Hospital

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ABSTRACT

Despite significant efforts over the last several decades to combat tobacco smoking, it remains the leading cause of a variety of preventable diseases. Tobacco usage is projected to kill more than 5 million people worldwide each year. Furthermore, the epidemic of tobacco addiction is spreading from developed to underdeveloped countries. To study the influence of family and relatives in tobacco users. The present study was an Observational Descriptive Study. This Study was conducted from January 2020-December 2023. Total 1036 patients were included in this study. In our study, 402 (38.8%) patients had Relative Father as tobacco user. The value of z is 10.1935. The value of p is<.00001. The result is significant at p <.05. In our study, 76 (7.3%) patients had Relative Brother. The value of z is 38.8407. The value of p is<.00001. The result is significant at p<.05. In our study, 67 (6.5%) patients had Relative Others. The value of z is 39.6316. The value of p is <.00001. The result is significant at p<.05. In our study, 409 (47.3%) patients had No Relatives as tobacco user. The value of z is 2.4605. The value of p is .0139. The result is significant at p<.05. We concluded that family and relatives play an important influence in influencing people's tobacco use and cessation. Strong familial support can considerably drive tobacco users to stop, as emotional connections and shared beliefs frequently lead to healthier lifestyle choices.

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Key Words

Cessation, education, prevention and intervention

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INTRODUCTION

Despite significant efforts over the previous decades in the fight against tobacco use, it remains the leading cause of different preventable diseases[1]. Tobacco usage is projected to kill more than 5 million people worldwide each year[2]. Furthermore, the epidemic of tobacco addiction is moving from developed to poor countries[3]. India is the world's second-largest tobacco consumer and this has had a substantial influence on public health. India alone accounts for one-sixth of global tobacco-ailments and is predicted to face an exponential spike in tobacco-related mortality from 1.4% in 1990-13.3% in 2020[4]. It is critical to identify the elements that contribute to the commencement of tobacco use in order to develop an effective plan for controlling tobacco use and preventing it in the early stages. The socio-cultural elements and familial environment that promote the onset of tobacco use vary from nation to nation, developed to emerging countries, region to region and culture to culture[5]. The family has the most direct and enduring impact, not only on education and psycho-intellectual development, but also in establishing values, attitudes, manners and habits in children[6]. It is considered that tobacco use is mostly learned at home., consequently, successful tobacco control approaches should begin with the home setting. However, a multifaceted strategy should still be applied in tobacco use prevention. For example, tobacco consumption has been high in the Jamnagar district of Gujarat's Saurashtra area. A previous prevalence research conducted in Jamnagar discovered that among tobacco users, consumption was spread as follows: Only tobacco chewing: 66.2%., only smoking: 14.6%., with smoking and tobacco chewing: 19.2%[7]. Another study discovered that four out of every 10 residents were exposed to chewing tobacco. Approximately 63.9% of current tobacco chewers and 48.2% of quitters have a history of another family member using tobacco in some way[8]. However, no reports on the effect of the family environment on tobacco addiction in this geographical area are currently available. As a result, we aimed to investigate tobacco consumption practices and patterns in families of tobacco users. We also investigate the influence of tobacco use on siblings and offspring of tobacco users in this geographic area.

RESULTS AND DISCUSSIONS

Table 1: Distribution of Relative Father, Relative Brother, Relative Others, No Relatives

Relative		Frequency	Percent
Relative Father	**No**	634	61.20%
	Yes	402	38.80%
	Total	1036	100.00%
Relative Brother	**No**	960	92.70%
	Yes	76	7.30%
	Total	1036	100.00%
Relative Others	**No**	969	93.50%
	Yes	67	6.50%
	Total	1036	100.00%
No Relatives	**No**	546	52.70%
	Yes	490	47.30%
	Total	1036	100.00%

Table 2: Association Between Demographic Parameter

Demographic Parameter		No Relatives		
		No	**Yes**	**Total**
Age in Group	**<20**	23(4.2%)	25(5.1%)	48(4.6%)
	21-30	137(25.1%)	113(23.1%)	250(24.1%)
	31-40	149(27.3%)	117(23.9%)	266(25.7%)
	41-50	140(25.6%)	130(26.5%)	270(26.1%)
	51-60	71(46.1%)	83(16.9%)	154(14.9%)
	61-70	21(3.8%)	21(4.3%)	42(4.1%)
	>71	5(0.9%)	1(0.2%)	6(0.6%)
	Total	546(100%)	490(100%)	1036(100%)
Sex	**Female**	17(3.1%)	17(3.5%)	34(3.3%)
	Male	529(96.9%)	473(96.5%)	1002(96.%)
	Total	546(100%)	490(100%)	1036(100%)

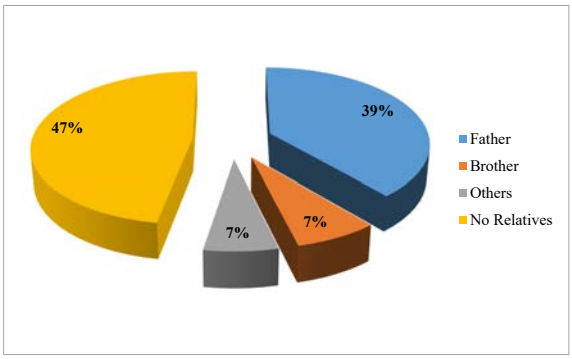

Fig. 1: Among Patients' Relatives Who Use Tobacco

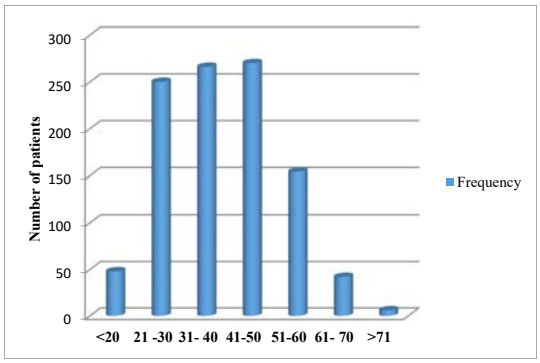

Fig. 2: Distribution of Age in Group

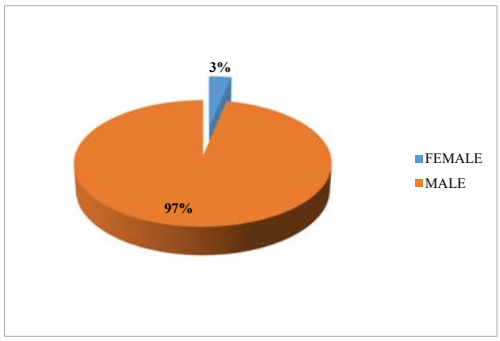

Fig. 3: Distribution of Sex

In our study, 402 (38.8%) patients had Relative Father. The value of z is 10.1935. The value of p is<.00001. The result is significant at p<.05. In our study, 76 (7.3%) patients had Relative Brother. The value of z is 38.8407. The value of p is<.00001. The result is significant at p<.05. In our study, 67 (6.5%) patients had Relative Others. The value of z is 39.6316. The value of p is < .00001. The result is significant at p<.05.

In our study, 409 (47.3%) patients had No Relatives. The value of z is 2.4605. The value of p is .0139. The result is significant at p<.05. In Without, 23 (4.2%) patients were ≤20 years of age, 137 (25.1%) patients were 21 -30 years of age, 149 (27.3%) patients were 31- 40 years of age, 140 (25.6%) patients were 41-50 years of age, 71 (13.0%) patients were 51-60 years of age, 21 (3.8%) patients were 61-70 years of age and 5 (0.9%) patients were >71 years of age. In With, 25 (5.1%) patients were ≤20 years of age, 113 (23.1%) patients were 21 -30 years of age, 117 (23.9%) patients were 31- 40 years of age, 130 (26.5%) patients were 41-50 years of age, 83 (16.9%) patients were 51-60 years of age, 21 (3.8%) patients were 61- 70 years of age and 1 (0.2%) patient was >71 years of age. Association of Age in Group with No Relatives was not statistically significant (p=0.3025). In Without, 17 (3.1%) patients were Female and 529 (96.9%) patients were Male. In With, 17 (3.5%) patients were Female and 473 (96.5%) patients were Male. Association of Sex with No Relatives was not statistically significant (p=0.7482). In our study, 48 (4.6%) patients were ≤20 years of age, 250 (24.1%) patients were 21 -30 years of age, 266 (25.7%) patients were 31- 40 years of age, 270 (26.1%) patients were 41-50 years of age, 154 (14.9%) patients were 51-60 years of age, 42 (4.1%) patients were 61- 70 years of age and 6 (0.6%) patients were 61- 70 years of age. The value of z is 17.0683. The value of p is < .00001. The result is significant at p<.05. In our study, 34 (3.3%) patients were Female and 1002 (96.7%) patients were male. The value of z is 42.5315. The value of p is <.00001. The result is significant at p<.05. The present study was a Observational Descriptive Study. This Study was conducted from January 2020-December 2023. Total 1036 patients were included in this study. Sharma[9] showed we evaluated the families of 65 tobacco users (Group 1) who visited an Ayurvedic post-graduate hospital's outpatient clinic with cough complaints and compared them to age and gender-matched non-tobacco users (Group 2). In our study, out of 1036 patients most of the patients were 41-50 years old [270 (26.1%)]. Which was statistically significant (p<.00001), (z=17.0683). Sharma[9] found that Group I included 50 patients with CAD, while Group II included 50 healthy controls of the same age and gender. The cases and controls had an average age of 44.2±16.3 years. The cases had 12 girls (24%), while the controls had 38 males (76%). We found that, male population was higher [1002 (96.7%)] than the female population [34(3.3%)]. Male: Female ratio was 29:1 but this was not statistically significant (p=0.4444). Guo[10] observed that this study discovers that high nicotine dependence in smoking fathers is linked to risky behaviors and demographics such as prolonged smoking periods and frequent alcohol usage. We discovered that a lesser number of patients had a relative father [402 (38.8%)]. It was statistically significant (p< .00001), (z=10.1935) We discovered that the lowest percentage of patients had a relative brother. [76 (7.3%)] and it was statistically significant (p< .00001), (z=38.8407). We found that, significantly lower of patients had Relative Others [67 (6.5%)]. (p< .00001), (z=39.6316) We found that, a greater number of patients had No Relatives [409 (47.3%)]. It was statistically significant (p=.0139), (z=2.4605).

CONCLUSION

We concluded that family and relatives play an important influence in influencing people's tobacco use and cessation. Strong familial support can considerably drive tobacco users to stop, as emotional connections and shared beliefs frequently lead to healthier lifestyle choices. In contrast, family members who use tobacco can mistakenly mainstream the behaviors, making it more difficult for others to quit the cycle. Particularly fathers were seen to occupy the largest number of close people who used tobacco and they can have a very strong influence on sons regarding their tobacco use attitudes. Open communication, education on the dangers of tobacco and collective participation in healthier activities can all contribute to a less smoke-friendly society. Finally, families may play an important role in raising awareness and offering assistance, making them valuable partners in the fight against tobacco addiction.

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