

Knowledge, Awareness, and Attitude among Tobacco Users about Ill Effects of Tobacco

Pratibha S. Sharma^{1*}, Sameer Priyadarshi², Kruthika S. Guttal¹, Krishna Burde¹, Kirty R. Nandimath¹

¹Department of Oral Medicine and Radiology, SDM College of Dental Sciences and Hospital, A Constituent Unit of Shri Dharmasthala Manjunatheshwara University, Dharwad, Karnataka, India.

²Department of Dentistry, Shree Narayan Medical Institute and Hospital, Saharsa, Bihar, India.

Abstract

Background: Tobacco is considered as a prime risk factor in the development of oral malignancy. It is being used widely in varied forms in South Asian countries, leading to increased mortality. Hence, it becomes necessary to increase awareness among general population about its ill effects. **Materials and Methods:** A 10 item self-administered questionnaire study was conducted on 300 outpatients attending the Department of Oral Medicine and Radiology. **Results:** Out of total 300, 89% of patients were consuming smokeless tobacco, 7% were consuming smoking form and 4% were consuming a combination of both. About 45.3% of patients had started smokeless form as a casual habit while smoking form had been started in 31.8% of patients due to peer pressure. About 67.7% of patients were aware of the oral changes that occur and 72% were aware of the fact that tobacco causes oral cancer. About 77.7% of patients wanted to quit the habit and 86% of patients were unaware of any de-addiction centers in their vicinity. **Conclusion:** Outcomes from our study outline that, regardless of the majority of the patients being aware of the adverse effects of tobacco and also expressing their desire to quit the habit, still continue its abuse. This may be attributed to their lack of knowledge and access to the centers which could guide them. Hence active initiatives and awareness drives are vital to overcome addiction.

Keywords: Attitude, Awareness, Oral cancer, Tobacco.

INTRODUCTION

The use of tobacco results in 5.4 million deaths annually and has been recognized as one of the key health issue in the world.^[1] This figure is anticipated to rise to 8.3 million in 2030, with 80% of this mortality occurring in developing nations.^[2] Data from National Family Health Survey (NFHS-3), in India, suggest that tobacco in one or more forms is used in the age range of 15–49 years in more than half of men (57%) and one-tenth (10.8%) of women.^[3] India has shown augmented use of tobacco in the duration of 7 years between the NFHS-2 and NFHS-3.^[4]

The South and South East Asian countries together with India account for the highest incidence of oral cancer.^[5] Tobacco consumption is considered as one of the prime risk factors in the development of oral premalignant and malignant disorders.^[6] The varied forms of smokeless and smoking tobacco are gutka, pan, khaini, betel quid, cigarette, and beedi. Oral premalignant alterations are typically seen in advance to oral carcinoma, which if diagnosed timely can be better managed. Yet, alarmingly increased figures of oral cancer are still diagnosed in advance stages, when the management

becomes intricate, expensive, and yields poor prognosis. Furthermore, smoking is a recognized risk factor for mortality from numerous systemic conditions, like cardiovascular diseases, respiratory diseases, and lung carcinoma.^[7] In order to decrease the morbidity and mortality occurring due to oral cancer, it is thus pivotal to increase awareness of ill effects of tobacco among general population so as to reduce the incidence of new cases.^[8] The dentist can play a key role by bringing awareness of ill effects of tobacco on health in patients, aid them in adopting healthy lifestyles, and can pilot them in tobacco de-addiction.^[9] Little to none has been surveyed about the knowledge, attitude, and awareness of ill effects of tobacco in the general population. Ample research highlight that one of the major causes for delayed detection is

Address for correspondence: Pratibha S. Sharma, Department of Oral Medicine and Radiology, SDM College of Dental Sciences and Hospital, A Constituent Unit of Shri Dharmasthala Manjunatheshwara University, Dharwad, Karnataka, India. Phone: +918890047659. E-mail: 1230pratibha@gmail.com

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the paucity of knowledge in public regarding symptoms of oral cancer and its risk factors.^[10] Consequently, the present study focuses on gauging the awareness, knowledge, and attitude of patients about ill effects of tobacco on health with any history of smokeless or smoking form of tobacco.

MATERIALS AND METHODS

A cross-sectional, questionnaire-type survey was carried out on patients reporting from in and around Dharwad district of North-Western Karnataka.

All those patients who had current habit of smokeless or smoking tobacco, visiting the Out-Patient Department of Oral Medicine and Radiology were included in the study and explained about the purpose of the study after obtaining informed consent from them. A total of 300 subjects participated in the study. Patients who were unwilling to participate were excluded from the study.

A 10 item self-administered questionnaire was used for the study. Each item was a closed-ended question with a single answer. The questionnaire items included several self-report measures developed and used over numerous studies, as well as, several self-report measures used by other investigators in other studies to measure the knowledge, attitude, and practice toward tobacco and its ill effects on oral and general health.

RESULTS

A total of 300 patients participated in this study. There were 275 males (91.7%) and 25 females (8.3%) among the study population with a mean age of 40 years and an average annual income of 14809 INR. Out of total 300, 89% of patients were consuming smokeless form of tobacco, whereas 7% were consuming smoking form and 4% were taking a combination of both. In smokeless form, a maximum of 45.3% of patients had habit of chewing betel nut and leaves and among the smoking form, a maximum (68.2%) patients had habit of smoking cigarette (Graph 1).

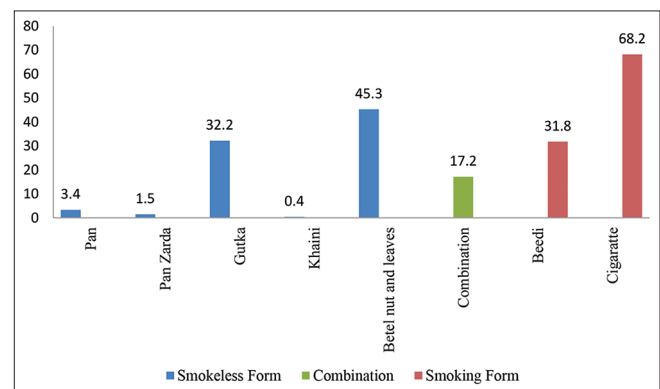
Graph 2 enumerates the study population divided on the basis of the duration of tobacco consumption. In the 5 years group, majority (43.8%) of patients were found to be consuming smokeless form of tobacco. Both, in the 5–10 years group and 10–15 years group, the combination consumption was found to be highest. In the more than 15 years group, maximum (40.9%) patients were found to be consuming smoking form of tobacco, followed closely by (36.4%) the combination type.

Graph 3 depicts the study group divided on the frequency of tobacco consumption daily. Patients who consume up to five times a day, the majority had (67.4%) habit of consuming smokeless form. In the next three groups, i.e., 5–10 years, 10–15 years and more than 15 years the majority of patients consumed smoking or combination form.

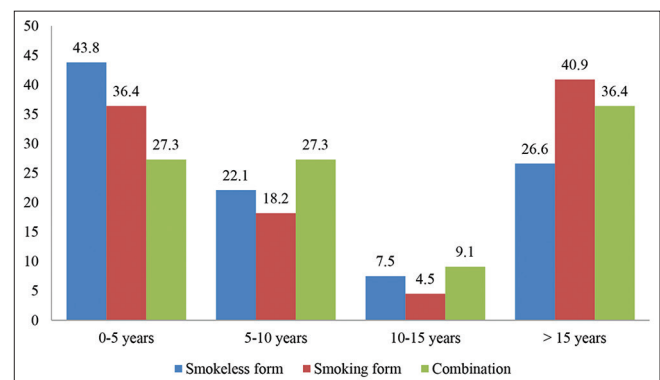
Among the patient who use only smokeless form and combination, the site of tobacco placement was found to be

highest (38.4%) for the left buccal vestibule. The next common site was the right buccal vestibule (33%), followed by (24%) patients placing all over in the mouth.

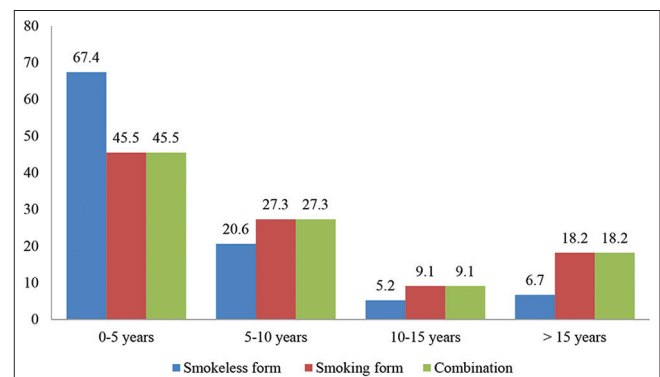
Graph 4 represents the various reasons for the initiation of tobacco consumption. The consumption of smokeless form of tobacco started as a casual habit in 45.3% of patients, due to friends' company in 22.1% and because of boredom in 15% of patients. The consumption of smoking form of tobacco started due to friends' company in 31.8% of patients. However, 27.3% of patients started consuming both as a casual habit. About 18.2% of patients each had been on combination of both due to boredom, friends' company, to relieve tension and



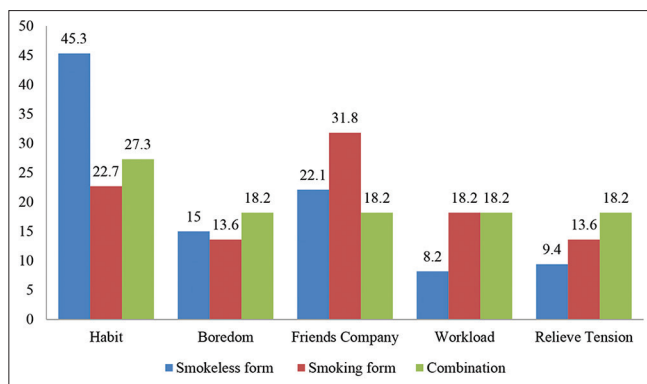
Graph 1: Indicates the type of tobacco consumed



Graph 2: Indicates study population divided on the basis of duration of tobacco consumption



Graph 3: Indicates frequency of tobacco consumption



Graph 4: Indicates various reasons for initiation of tobacco consumption

workload. Out of total study population, 67.7% of patients were found to be aware of oral changes that occur due to tobacco consumption, while 32.3% of patients were unaware about the same.

In our study, 72% of patients were found to be aware of the fact that it causes cancer. Startling high percentage of patients (78.7%) in our study read and understood the statutory warning but still continued to consume it. In our study, 88.7% of patients were found to experience no ill effects of tobacco. In our study, 77.7% of patients wanted to quit the habit however 16.3% of patients do not want to quit. Out of total 300 study samples, 86% of patients were unaware of any de-addiction centers in near vicinity.

DISCUSSION

Oral cancer continues to be a pan global obstacle to health, with major burden of disease coming from South East Asian countries including India.^[11] Tobacco is the prime preventable cause of oral cancer worldwide, resulting in excess of 5 million deaths annually.^[12] This figure is likely to surpass 8 million by 2030.^[13] Therefore a much needed assessment of knowledge, awareness and attitude of tobacco users about the ill effects of tobacco was carried out through this study.

Previous studies have established that tobacco consumption is more ubiquitous in males in comparison to females.^[14-16] Of the 300 patients in our study 91.7% of patients were male compared to a mere 8.3% female population. In developing nations like India, males are mostly the earning members of the family and tobacco habit on many occasions is acquired due to their work place environment and is also considered as a social practice.

The mean average annual income of patients in our study was approximately fourteen thousand INR indicating tobacco use being more common in the lower socioeconomic strata of society, which only leads to more enfeeblement from tobacco-related diseases.^[17] This is in coherence with a study conducted on tobacco chewers in 2016.^[18]

A majority (80%) of our study group had only completed basic education till secondary school level. This reinstates

the fact that education also plays a pivotal role in initiation of habits. Comparatively, the less privileged and less educated people have little awareness towards tobacco hazards, face higher exposure to predisposing conditions, resulting in an increased callous attitude. Hence, tobacco abuse is considered as inversely proportional to financial and education standards. These results are synchronous to a study conducted in Maharashtra.^[18]

It has been outlined in Global Adult Tobacco Survey (GATS) India, that the hazards caused by smokeless tobacco are notably higher than smoking.^[19] According to its report (2009-10) only smokeless tobacco consumers (163.7 million) far exceed than that of only smokers (42.3 million).^[20] Alike results were found in our study with 89% of patients found to be associated with chewing tobacco. The high prevalence of smokeless tobacco consumption may be attributed to its inherently inconspicuous nature of consumption which favors its use with other activities.

In our study, 72% of patients knew that tobacco consumption causes oral cancer, and 67.7% of patients were even aware of the oral changes that occur. Our results were comparable to study done by Bhatsange *et al.*,^[18] and a study done in Manipur^[20] in which 86% of patients had knowledge about ill effects of tobacco. In our study, 78.8% of patients acknowledge to have read the statutory warning on tobacco products. The continued use of tobacco despite the high percentage of awareness of its ill effects warrants the health warnings to be more impactful.

Out of total population participated in GATS India survey, 10% of them claims that decline in tobacco abuse can only be brought by banning the products.^[19]

The initiation of any habit is the most important tipping point to developing an addiction. In our study among the patients who have tobacco chewing habit, 45.3% have taken it up as a casual habit; however, among patients with a habit of smoking tobacco, 31.8% started it due to peer pressure. Majority of people consuming chewable tobacco start it casually as it is easily available to them. On the other hand, patients who mainly smoke initiate and indulge in habit by looking at their role models or under the influence of friends and relatives. In another study done in Kerala 46% of patients had started habit due to peer pressure.^[16]

Most of the patients (77.7%) in our study revealed that they do want to quit the habit. Since tobacco is one of the most addictive substances in the world, first of all, it is difficult for people to leave the habit and second, those who manage to leave are in constant environment that results in relapse. In our study 86% of patients had no knowledge of de-addiction centers available, which implies to the fact that although the centers to help guide the patient are in close vicinity, there is no knowledge among people regarding de-addiction centers and hence appropriate bodies should take measures to deliver knowledge among patients about these centers. Our results were similar to study conducted by Hussain *et al.*^[21]

Outcomes from our study outline that, regardless of majority of the patients being aware of the adverse effects of tobacco and also expressing their desire to quit the habit, continue its abuse. This may be attributed to their lack of knowledge and access to the centers which could guide them. Hence active initiatives and awareness drives are vital to overcome addiction. Path to de-addiction is partly the shared responsibility of health care providers who could counsel patients about the ill effects of tobacco and aid them in quitting the habit. Limitations of our study include the probability of recall bias, under/over reporting of tobacco use and difference in true tobacco use pattern, by the patient as the study is structured on self reporting.

CONCLUSION

From our study evaluating awareness, knowledge, and attitude of tobacco users about the ill effects of tobacco, it is evident that the need of hour is to further develop innovative ways to discourage tobacco use among public. Consequently, further studies need to be pursued to persuade patients to refrain from tobacco use. Focus now needs to shift towards patient's education so as to lessen their social and financial burden associated to unemployment. It is thus of prime importance to envision efficient educational reforms to convince the patients to discontinue tobacco use.

Ethical approval

The present study was approved by the institutional review board (IRB.No. 2017/P/OM 40).

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