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STATUS OF CIGARETTES SMOKING AND
ALCOHOL CONSUMPTION AMONG FOREIGN
STUDENTS, STUDYING IN FIRAT UNIVERSITY

MASTER'S THESIS
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ELAZIĞ-2020

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ETHICAL DECLARATION

I have done this thesis with my studies, I have not been against ethics at all stages, from the planning of the studies, and to the acquisition of the findings and the writing stages, and that, I have obtained all the information and data in this thesis in academic and ethical rules. I hereby declare that all information and comments on this research study are referred to my data obtained.

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ACKNOWLEDGEMENT

Glory be to God Almighty forgiven me all the strength and capacity for completion not in the course of this thesis but the entire programme. With greatness joy and happiness, I wish to express my gratitude to my parents whose give me support, encouragement, suggestion toward my study. My special appreciation goes to my supervisor Prof. Dr. Edibe PİRİNÇCİ who took her time to go through my thesis work and give necessary correction throughout the work, may Allah reward her abundantly.

My sincere praise go to head of my department of public health Prof. Dr. A. Ferdane OĞUZÖNCÜL and teachers who took me some courses especially Dr. Öğr. Üyesi Ahmet Tevfik OZAN, Prof. S. Erhan DEVECİ, towards the time of the study, my sincere thanks also goes to the entire members of the staff for their support and encouragement, thanks to you all.

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ABBREVIATIONS

ABV	: The Alcohol by Volume
AZGP	: Zinc-alpha-Zinc-2-glycoprotein
BAC	: Blood Alcohol Concentration
BMI	: Body Mass Index
CI	: Confidence Interval
C_nH_{2n+1}OH	: General Formula –OH
COPD	: Chronic Obstructive Pulmonary Disease
DNA	: Deoxyribonucleic Acid
EMRO	: Eastern Mediterranean Region Organisation
FNDT	: Fagerstrom Nicotine Dependence Test
IARC	: International Agency for Research on Cancer
IUPAC	: International Union of Pure and Applied Chemistry
MPOWER	: Measure Power
OR	: Odds Ratio
PVA	: polyvinyl Acetate
USDA	: United States Department of Agriculture
WHO	: World Health Organisation

1. ÖZET

FIRAT ÜNİVERSİTESİNDE ÖĞRENİM GÖREN YABANCI UYRUKLU ÖĞRENCİLERİN SİĞARA VE ALKOL KULLANMA DURUMU

Sigara ve alkol dünyada yaygın olarak tüketilmektedir. Sigara ve alkol tüketiminin ciddi sosyal ve sağlık etkileri vardır. Bu çalışma Elazığ Fırat Üniversitesinde öğrenim gören yabancı uyruklu öğrenciler arasında sigara ve alkol kullanım sıklığını saptamak ve etkileyen faktörleri bilmek amacıyla yapılmıştır. Kesitsel tipte olan bu çalışmanın evrenini Fırat Üniversitesinde yabancı uyruklu öğrenim gören tüm öğrenciler, örnekleme ise bu evrenden seçilen 337 öğrenci oluşturmuştur. Araştırmanın verileri; sosyo-demografik özellikler, sigara ve alkol kullanımı ile ilgili sorular ve Fagerström nikotin bağımlılık testi içeren bir anket formu kullanılmıştır. Elde edilen veriler SPSS paket programına kaydedilip, istatistiksel analizde yüzde, ortalama, Ki-kare ve Fisher's Exact Test kullanılmıştır. Araştırma kapsamına alınan öğrencilerin %82.8'i erkek olup yaş ortalamaları 23.61 ± 4.68 yıldır. Öğrencilerin %36.5'i sigarayı en az bir kez denemiş olup, %31.8'i ise halen sigara içmektedir. Araştırmaya katılan öğrencilerin %13.4'ü ise alkol kullanmaktadır. Öğrencilerde eğitim durumu yükseldikçe sigara içme oranı azalmaktadır ($p < 0.05$). Alkol kullananlarda, nargile içenlerde sigara içme oranı anlamlı olarak artarken ($p < 0.05$), yaş, cinsiyet, bölüm ile sigara içme arasında anlamlı bir ilişki saptanmamıştır ($p > 0.05$). Yaş ilerledikçe, eğitim düzeyi yükseldikçe alkol içme oranı da azalmaktadır ($p < 0.05$). Öğrencilerde cinsiyet ve ülkelerine göre alkol kullanma durumu ile arasında anlamlı bir ilişki bulunmamıştır ($p > 0.05$). Müslüman öğrencilerde alkol içme

oranı düşüktür ($p<0.05$). Bu konuda uygun maliyetle ailelere, öğretmenlere ve toplumu da içine alacak şekilde, eğitimler yapılması ve üniversite kampüsünde içme yasaklarının oluşması ve spor alanlarının artırılması önerilebilir.

Anahtar Kelimeler: *Sigara, alkol, yabancı uyruklu öğrenciler, Fırat Üniversitesi*

2. ABSTRACT

STATUS OF CIGARETTES SMOKING AND ALCOHOL CONSUMPTION AMONG FOREIGN STUDENTS, STUDYING IN FIRAT UNIVERSITY

Cigarette smoking and alcohol consumption are the most common serious social practices which have profound health effect. This research was aimed to determine the status of cigarettes smoking, alcohol consumption and related factors among foreign student study at Firat University. The universe of this cross-sectional study was composed of all foreign students studying at Firat University, and 337 students selected from this universe. The data of the research; A questionnaire including socio-demographic characteristics, questions about smoking and alcohol use and Fagerström nicotine addiction test was used. The data obtained were recorded in the SPSS package program and percent, average, Chi-square and Fisher's Exact Test were used for statistical analysis. 82.8% of the students included in the study are male and their average age is 23.61 ± 4.68 years. 36.5% of students have tried smoking at least once, while 31.8% still smoke. 13.4% of the students participating in the research use alcohol. As the educational status of students increases, smoking rate decreases ($p < 0.05$). While the rate of smoking increased significantly in alcohol users and hookah smokers ($p < 0.05$), there was no significant relationship between age, gender, department and smoking ($p > 0.05$). As the age progresses and the level of education increases, the alcohol drinking rate decreases ($p < 0.05$). No significant relationship was found between students and their alcohol use status by gender and country ($p > 0.05$). Alcohol drinking rate is low in Muslim students ($p < 0.05$), from this result,

the rate of smoking and alcohol use is high among foreign students at Firat University. It may be suggested; to conduct trainings on this subject, the cost-effective reducing rate involve the participation of families, teachers and other stakeholders to deliver health education about the health risks associated with smoking and alcohol consumption, restrict the accessibility and advertising. Potential interventions could include campus-wide smoking and drinking bans, increased social/sports entertainment, are highly recommended.

Keywords: *Cigarette, alcohol, foreign students, Firat University*

3. INTRODUCTION

3.1 Cigarette Description

3.1.1 Definition

A cigarette is a narrow cylinder containing psychoactive fabric, normally tobacco, this is rolled into thin paper for smoking, most cigarettes comprise a reconstituted tobacco product called a sheet, which consists recycled tobacco, stems, stalks, scraps, collected dust, and floor sweepings, to which are brought glue, chemicals compounds and fillers; the product is then sprayed with nicotine that was extracted from the tobacco scraps, and fashioned into curls (1).

The cigarette is ignited at one end, causing it to smoulder; the ensuing smoke is orally inhaled thru the opposite end. Most modern cigarettes are filtered, although this does not make them to more secure. Cigarette smoking and alcohol consumption are the maximum common social practices that have profound effects on health. More frequently than no longer, most of the people who smoke cigarettes besides take pleasure in alcohol consumption. Cigarette smoking and alcohol consumption practices have many serious social and health effects. Alcohol is claimed to potentiate or act synergistically with cigarette smoking in oral cancer and precancerous aetiology (2). Cigarette manufacturers have defined cigarettes as a drug administration system for the transport of nicotine in a suitable and attractive form (3). Cigarettes are addictive (due to nicotine) and motive cancer, chronic obstructive pulmonary disease, coronary heart disease, and different health troubles. The term cigarette, as commonly used, refers to a tobacco cigarette but is sometimes used to refer to different substances, such as

cannabis or hashish cigarette. A cigarette is distinguished from a cigar by way of its usually smaller size, use of processed leaf, and paper wrapping, which is typically white. Cigar wrappers are normally composed of tobacco leaf or paper dipped in tobacco extract. Smoking rate have generally declined in the developed world, but retain to rise in a few developing nations (4). Cigarette smoking causes health harms and loss of life. Nicotine is likewise noticeably addictive. Approximately half of the cigarette smokers die of tobacco-associated disease and lose on average 14 years of life. Cigarette use by pregnant woman has also been proven to cause birth defects, including low birth weight, fetal abnormalities, and untimely birth (5,6). Second-hand smoke from cigarettes causes several equal health troubles as smoking, such as most cancers (7). Which has led to law and policy that has prohibited smoking in many offices and public area.

3.2 Tobacco and Its History

The earliest forms of cigarettes had been similar to their predecessor, the cigar. Cigarettes appear to have had antecedents in Mexico and Central America around the 9th century in the form of reeds and smoking tubes. The Maya, and later the Aztecs, smoked tobacco and other psychoactive drugs in religious rituals and frequently depicted priests and deities smoking on pottery and temple engravings. The cigarette and the cigar had been the most common methods of smoking in the Caribbean, Mexico, and Central and South America until recent times (8). The North American, Central American, and South American cigarette used various plant wrappers; when it was brought back to Spain, maize wrappers had been introduced, and by the 17th century, excellent paper.

The ensuing product became known as *appellate* and is documented in Goya's artwork *La Angeles Cometa*, *a Merienda en el Manzanares*, and *El Juego de la pelota a pala* (18th century) by 1830, the cigarette had crossed into France, wherein it received the name cigarette; and in 1845, the French state tobacco monopoly commenced production them (9). The French word was adopted by the English within 1840s, (10). A few American reformers promoted the spelling cigarette (11). However, this was never widespread and is now largely abandoned (12). The first patented cigarette-making machine was invented by Juan Nepomuceno Adorno of Mexico in 1847, (13). But, production climbed markedly when another cigarette-making machine was developed in the 1880s by James Albert Bonsack, which vastly multiplied the productivity of cigarette companies, which went from making about 40,000 hand-rolled cigarettes every day to around 4 million (14,15).

3.3 General Component of Cigarettes

1. Mainstream smoke
2. Filtration material
3. Adhesives
4. Ventilation holes
5. Ink
6. Adhesive
7. Sidestream smoke
8. Filter
9. Tipping Paper

10. Tobacco and ingredients

11. Paper

12. Burning point and ashes

Modern-day commercially manufactured cigarettes are seemingly simple items consisting specifically of a tobacco combo, paper, polyvinyl acetate (PVA) glue to bond the outer layer of paper together, and regularly additionally a cellulose acetate-based filter out (16). While the assemble the cigarettes is straightforward, much focus is given to the creation of each components, in particular, the tobacco blend. A key component that makes cigarettes more addictive is the inclusion of reconstituted tobacco, which has additives to make nicotine more volatile as the cigarette burns (17).

3.4 Harmful Chemical Substances in Cigarettes

Cigarette smoke includes over 7,000 chemical substances, which include arsenic, formaldehyde, cyanide, lead, nicotine, carbon monoxide, acrolein, and other poisonous substances (18). Over 70 of those are carcinogenic (19). Cigarettes are a frequent source of deadly fires in private homes, which prompted both the European Union and the United States to require cigarettes to be fire-preferred compliant (20).

3.5 Epidemiology of Cigarettes Smoking to the World

Smoking has grown to become less but remains a large public health problems globally. Worldwide, smoking rates fell from 41% in 1980 to 31% in 2012, even though the actual number of smokers expanded because of the population growth (21). In 2017, 5.4 trillion cigarettes have been produced globally and were smoked by using almost 1 billion humans. Smoking rates have levelled off or declined in most contries but is increase in a some low-income countries. The significant reduction in smoking rates in the United States, United Kingdom, Australia, Brazil, and other countries that implemented strong tobacco control programs have been offsets by the increasing consumption in lows and middle-income countries, especially China.

The Chinese marketplace now consumes greater cigarettes than all other lows and middle-income countries in general. Different regions are increasingly playing larger roles in the developing worldwide smoking epidemic. The WHO Eastern Mediterranean Region (EMRO) now has the highest growth rate in the cigarette market, with more than a one-third increase in cigarette intake since 2000. Due to its recent dynamic economic improvement and continued population growth, Africa presents the greatest risk in terms of future growth in tobacco use. Within countries, styles of cigarette intake can also vary widely. For instance, in most of the international locations where few woman smoke, smoking rates are often excessive in men (e.g., in Asia). By contrast, in most developed international locations, female smoking rates are normally only a few percentage points below those of males.

In many high and middle-income countries, decrease in socioeconomic status is a strong predictor of smoking. Smoking rates in the United States have dropped by more than half from 1965 to 2016, falling from 42% to 15.5% US adults (22). Australia is reducing their universal smoking intake faster than most of the developed world, in part due to the landmark Plain Packaging Act, which standardized the appearance of cigarette packs. Other countries have considered comparable measures. In New Zealand, a bill has been presented to parliament in which the government's associate health minister stated: "takes away the final method of promoting tobacco as a proper product." (23).

Table 1: Shown the Smoking Prevalence by Sex ages 15 or older, 2016, (24).

Region	Per cent of smoking (%)	
	Men	Women
Africa	18%	2%
Americas	21%	12%
Eastern Mediterranean	34%	2%
Europe	38%	21%
Southeast Asia	32%	2%
Western Pacific	46%	3%

Table 2: Shown the Leading Consumers of Cigarettes 2016, (25).

Country	Population (millions)	Cigarettes consumed (billions)	Cigarettes consumed (per capital)
China	1,386	2,351	2,043
Indonesia	264	316	1,675
Russia	145	278	2,295
United States	327	266	1,017
Japan	127	174	1,583

3.6 Epidemiology of Smoking in Turkey

Turkey protects its population with five tobacco control measures, known as “MPOWER” regulations (26,27). Turkey's smoking prevalence among individuals aged older than 15 years was 44.5% in 1988; however, after anti-tobacco regulations have been applied, that rate reduced to 33.6% in 1993. In 2004, Turkey signed the Framework Convention on Tobacco control with the WHO, and, by 2008, the smoking charge for that populace reduced barely to 31.2%, (28). A recent study explained that, regardless of the strict anti-tobacco policies and reduced legal tobacco product sales, as of 2006, the Turkish current smoking rate had plateaued after a 20-12 months decline. However, this still leaves Turkey with a higher smoking rate than other countries, such as United States (29). According to the last Global Adult Tobacco Survey, that rate finally decreased to 27.1% in

2012, and the MPOWER policies are the main factors in that result (28). Among the research that isolated university students' smoking rates, the situations had been just like the general population. After the implementation of MPOWER policies, researchers also observed a decrease in smoking incidence among university students from 2005–2006 to 2012–2013: 26.9% to 18.5%, (30). In general, the smoking rates in Turkey vary nationwide according to socioeconomic status. A national study determined no difference before and after the tobacco control rules in the poorest population, while the smoking rate did decrease among the richest population (31). The continuing levels of smoking rate in the poorest population, despite decreased legal cigarette sales, were attributed to unlawful tobacco use, both as cigarettes or in other forms (27). In the recent study, Turkey's ordinary illicit cigarette use became decided to be around 12%, most commonly observed in the eastern part of the country (32). Therefore, incidence research should be carried out periodically and should evaluate regional data. Teens are the primary goal for tobacco companies, and the age of beginning to smoke is reducing in developing countries.

Smoking for the first time before the age of 18 years contributes to existence-long smoking, and, for the one's smokers, quitting is harder. Universities are a key reflection of the overall records on the younger population's smoking behaviours. Generally, university foreign students traditionally leave their houses and move to another country to begin residing with their peers; consequently, reduced family strain and control allows university students more freedom to make their own decisions. Consequently, university life itself can be a risk factor for both the initiation and increase in smoking behaviour. Accordingly,

research that examines first- and last-year university students smoking levels (33,34). The studies that observe Turkish college students prospectively discovered an increased smoking rate during university lifestyles (35). Preventative measures during the period are important, such as campus-wide smoking bans, educational symposiums about the harms of tobacco, and other measures that can be known to negatively impact smoking rate (36,37).

The factors associated with smoking among University students had been evaluated by previous national and international studies. The primary factors associated with students smoking status include socioeconomic statuses, family/friends' smoking behaviour, alcohol use, sex, faculty, year of education, and residing with friends (38). However, various geographical regions have different risk factors because of their cultural-sociological differences; therefore, there is a need to conduct a research to evaluate distinct regions' statuses. Our setting for this study was a university positioned in the eastern region of Turkey. It does not have any smoking bans on campus, and the students are mostly from the eastern and northeastern parts of the country. Students were mostly from low-and middle-income families. As mentioned above, these areas of the country have the highest illicit tobacco use in Turkey, both thin-paper rolled cigars and cigarettes. Further, the city where the university is located shares a border with Greece, Georgia and Bulgaria, and is involved in that country's illicit tobacco transport (39).

3.7 The harmful Effect of Smoking

Cigarette smoke has nicotine certainly as one of its primary constituents. This chemical is very addictive. When expectant mom uses a cigarette, there is an increase risk of giving birth to children with birth defects, which encompass intellectual and physical disabilities (40). In cigarette smokers, there is increase risk in developing oral and lung most cancers. People who smoke additionally suffer from other situations like bronchitis and emphysema. Second-hand cigarette smoke is similarly dangerous. Prolonged exposure results in lung cancer or even heart problems. Smoking is a primary cause of mortality and morbidity among the developed countries. Approximately four (4) million people who smoke die annually from smoking-related diseases (41). Cigarettes are the most commonly used form of tobacco and one of the predominant causes of preventable diseases globally (42). Turkey's fight against tobacco depends on following the evidence-based tobacco control measures and guidelines that have been identified as effective by the world health organisation WHO (43).

3.8 Withdrawal Symptoms

The effects of abstinence from tobacco, Hughes concluded, weight gain, "anger, anxiety, depression, difficulty concentrating, impatience, insomnia, and restlessness are valid withdrawal symptoms that peak within the first week and last 2–4 weeks (44). In contrast, constipation, cough, dizziness, increased dreaming, and mouth ulcers may or may not be symptoms of withdrawal, while drowsiness, fatigue, and certain physical symptoms (dry mouth, flu symptoms, headaches, heart racing, skin rash, sweating, tremor) were not symptoms of withdrawal (45).

3.8.1 Weight Gain

Giving up smoking is associated with an average weight gain of 4-5 kilograms (8.8-11.0 lb) after 12 months, most of which occurs within the first three months of quitting (46). The possible causes of weight gain include:

- Smoking over-expresses the gene AZGP1 that stimulates lipolysis, so smoking cessation may decrease lipolysis (46).
- Smoking suppresses appetite, which may be caused by nicotine's effect on central autonomic neurons (e.g., via regulation of melanin-concentrating hormone neurons in the hypothalamus), (47).
- Heavy smokers are reported to burn 200 calories per day more than non-smokers eating the same diet (48).
- Possible reasons for this phenomenon include nicotine's ability to increase energy metabolism or nicotine's effect on peripheral neurons (47).

The 2008 Guideline suggests that sustained-release bupropion, nicotine gum, and nicotine lozenge be used to delay weight gain after quitting. A 2012 Cochrane review concluded that there is not sufficient evidence to recommend a particular program for preventing weight gain (49).

3.8.2 Depression

Like other physically addictive drugs, nicotine addiction causes a down-regulation of the production of dopamine and other stimulatory neurotransmitters as the brain attempts to compensate for the artificial stimulation caused by smoking. Therefore, when people stop smoking, depressive symptoms such as

suicidal tendencies or actual depression may result (50). Although a comparing smoker, who had stopped for 3 months with continuing smokers found that stopping smoking did not appear to increase anxiety or depression (51). This side effect of smoking cessation may be particularly common in women, as depression is more common among women than among men (52).

3.8.3 Anxiety

A recent study by The British Journal of Psychiatry has found that smokers who successfully quit feel less anxious afterwards with the effect being greater among those who had mood and anxiety disorders than those that smoked for pleasure (53).

Table 3: Shown the Effects of Smoking in Human Health at Duration of Nicotine Withdrawal Symptoms (43).

Craving for tobacco	3 to 8 weeks
Dizziness	Few days
Insomnia	1 to 2 weeks
Headaches	1 to 2 weeks
Chest discomfort	1 to 2 weeks
Constipation	1 to 2 weeks
Irritability	2 to 4 weeks
Fatigue	2 to 4 weeks
Cough or nasal drip	Few weeks
Lack of concentration	Few weeks
Hunger	Up to several weeks

3.9 Smoking Cessation treatment and Cessation Aid

Smoking Cessation (also known as quitting smoking or quitting) is the technique of discontinuing tobacco smoking. Tobacco smoke consists of nicotine that is addictive and can cause dependence. Nicotine withdrawal regularly makes the method of quitting tough. Nicotine withdrawal often makes the process of quitting hard (54,55). In the US, about 70% of people who smoke would like to quit smoking, and 50% report having made a quit attempt in the past 12 months,

a preventable cause of dying global. Tobacco cessation significantly reduces the risk of dying from tobacco-related disease such as coronary heart disease, chronic obstructive pulmonary disease (COPD) and lung cancer (56,57). Due to its link to many chronic diseases, cigarette smoking has been limited in lots of public areas. Many exclusive strategies can be used for smoking cessation, which includes unexpectedly quitting without help (cold turkey), cutting down then quitting, behavioural counselling, and medicines that including bupropion, cytisine, nicotine replacement therapy, or varenicline. Most people who smoke try to quit, to do so without assistance.

However, only 3-6% of quit attempt without assistance are successful long-term (58). Behavioural counselling and medications each increase the charge of successfully quitting smoking, and a combinatio of behavioural counselling with medication such as bupropion is more effective than either intervention alone (59). A meta-analysis from 2018, carried out on 61 randomized controlled trials, confirmed among people who give up smoking with a cessation therapy (and some behavioural assist), compare 20% who did not take a 12 medication (60). In nicotine-dependent people who smoke, quitting smoking can result in signs and symptoms of nicotine withdrawal such as nicotine cravings, anxiety, irritability, depression, and weight gain. Professional smoking cessation help methods generally try to address nicotine withdrawal symptoms to help the person risk free of nicotine addiction (43).

Fig 1. Shown the Health Benefits of Stopping Smoking



Survival from age 35 of non-smokers, cigarette smokers and ex-smokers who stopped smoking between 25 and 34 years old (61). The ex-smokers line follows closely the non-smoker's line. Many of tobacco's detrimental health effects can be reduced or largely removed through smoking cessation. The health benefits over time of stopping smoking include:

- Within 20 minutes after quitting, blood pressure and heart rate decrease.
- Within 12 hours, carbon monoxide levels in the blood decrease to normal.
- Within 48 hours, nerve endings and sense of smell and taste both start recovering.
- Within 3 months, circulation and lung function improve
- Within 9 months, there are decreases in cough and shortness of breath.

- Within 1 year, the risk of coronary heart disease is cut in half.
- Within 5 years, the risk of stroke falls to the same as a non-smoker, and the risks of many cancers (mouth, throat, oesophagus, bladder, cervix) decrease significantly.
- Within 10 years, the risk of dying from lung cancer is cut in half, and the risks of larynx and pancreas cancers decrease.
- Within 15 years, the risk of coronary heart disease drops to the level of a non-smoker lowered risk for developing chronic obstructive pulmonary disease (COPD).

A randomized trial from the U.S. and Canada discovered that a smoking cessation program lasting 10 weeks decreased mortality from all causes over 14 years later. (62)

3.10 Alcohol Description

3.10.1 Definition

An alcoholic drink (or alcoholic beverage) is a drink that contains ethanol, a form of alcohol produced with the aid of fermentation of grains, fruits, or other sources of sugar. The consumption of alcohol performs a vital social function in many cultures. Most countries have legal guidelines regulating the manufacturing, sale, and intake of alcoholic beverages. Some countries ban such activities completely, but alcoholic drinks are legal in most parts of the world. The global alcohol drink industry handed \$1 trillion in 2018, (63). Alcohol is a depressant, which in low doses causes euphoria, reduces anxiety, and improves sociability.

In higher doses, it causes drunkenness, stupor, unconsciousness or death. Long-term use can result in alcohol abuse, most cancers, physical dependence, and alcoholism. Alcohol is one of the most extensively used recreational drugs in the world, with about 33% of people being contemporary drinkers. As of 2016, women on average drink 0.7 drinks and adult males 1.7 beverages a day (64). In 2015, amongst individuals, 86% of adults had fed on alcohol in some unspecified time in the future, 70% had under the influence of alcohol it inside the remaining 12 months, and fifty-six% in the last month (65). Alcoholic drinks are normally divided into 3 lessons beers, wines, and spirits and typically, their alcohol content is among 3% and 50%. Discovery of late stone age jugs indicates that deliberately fermented drinks existed at the least as early because the Neolithic length (ca. 10,000 BC), (66,67).

Alcohol has been used for quite a long term for numerous reasons which include dietary, hygienic, medicinal, religious and recreational purposes or even in performing cultural ceremonies. Abuse of alcohol has negative results on health consisting of acute respiration failure, liver cancer and in the end now and then death. Because it impairs judgment in humans, it's been implicated in diverse anti-social and irresponsible behaviours. Such be behaviours encompass crime, irresponsible sexual behaviours, under the influence of alcohol-driving and even rowdy behaviours. Alcohol intake among university students has a profound effect on their psychosocial aspects. it's been connected to a decline in schooling standards, besides bad behaviour (68). In chemistry, alcohols are natural compounds that bring at the least one hydroxyl practical organization (C-OH) certain to their aliphatic substructure (69).

The term alcohol, originally referred to the primary alcohol ethanol (ethyl alcohol), which is used as a drug and is the principal alcohol found in alcoholic beverages. An important class of alcohols, of which methanol and ethanol are the simplest member, consists of all compounds for which the general formula is $C_nH_{2n+1}OH$. Simple mono alcohols that are the subject of this article consist of primary (RCH_2OH), secondary (R_2CHOH), and tertiary (R_3COH) alcohols. The suffix -ol seems in the IUPAC chemical call of all substances where the hydroxyl group is the functional group with the highest priority. While a higher priority group is present in the compound, the prefix hydroxy- is used in its IUPAC name. The suffix -ol in non-IUPAC names (which includes paracetamol or LDL cholesterol) also typically shows that the substance is an alcohol. but, many substances that incorporate with hydroxyl functional groups (mainly sugars, such as glucose and sucrose) have names which include neither the suffix -ol, nor the prefix hydroxy-.

3.11 History of Alcohol

Alcohol distillation likely originated in India. During 2000 BCE, people of India used an alcoholic drink known as Sura (70). Alcohol distillation was known to Islamic chemists as early because of the 8th century (71,72). The Arab chemist, al-Kindi, unambiguously described the distillation of wine in a treatise titled as "The Book of the chemistry of Perfume and Distillations" (73). 20th century: The process of distillation spread from the Middle East to Italy (74). Where distilled alcoholic liquids were recorded in the mid-12th century; In China, archaeological proof indicates that the actual distillation of alcohol began during 12th century

(75). 14th century: In India, the actual distillation of alcohol was delivered from the Middle East, and was in wide use in the Delhi Sultanate by the 14th century (74). By the early 14th century, distilled alcoholic liquids had spread throughout the European continent (75). The Persian doctor, alchemist polymath and philosopher Rhazes (854 CE - 925 CE) is credited with the discovery of ethanol (76,77).

3.11.1 Alcohol Concentrations

The concentration of alcohol in a beverage is usually stated as the percentage of alcohol by volume (ABV, the number of millilitres (ml) of pure ethanol in 100 ml of the beverage) or as proof. In the United States, the proof is twice the percentage of alcohol by volume at 60 degrees Fahrenheit (e.g. 80 proof = 40% ABV). Degrees proof were formerly used in the United Kingdom, where 100 degrees' proof was equivalent to 57.1% ABV. Historically, this was the most dilute spirit that would sustain the combustion of gunpowder. Ordinary distillation cannot produce alcohol of more than 95.6% by weight, which is about 97.2% ABV (194.4 proof) because at that point alcohol is an azeotrope with water. A spirit, which contains a very high level of alcohol and does not contain any added flavouring, is commonly called a neutral spirit. Generally, any distilled alcoholic beverage of 170 US proof or higher is considered a neutral spirit (78). Most yeasts cannot reproduce when the concentration of alcohol is higher than about 18%, so that is the practical limit for the strength of fermented drinks such as wine, beer, and sake. However, some strains of yeast have been developed that can reproduce in solutions of up to 25% ABV, (79).

Table 4: Shown the Alcohol by Volume ABV (78).

Typical ABV ranges	
Beers	Typically 5% (range is from 3–15%)
Wines	Typically 13.5% (range is from 8%–17%)
Fortified wines	15–22%
Spirits	Typically 30%-40% (range is from 15% to, in some rare cases, up to 98%)
Fruit juices	< 0.1%
Cider, wine coolers	4%–8%

3.12 Etiology

3.12.1 Nomenclature

The word "alcohol" is from the Arabic kohl (Arabic: **لحكلا** romanized al - Kuhl), a powder used as an eyeliner (80). Douglas Harpe 2018 Alcohol was originally used for the very fine powder produced by the sublimation of the natural mineral stibnite to form antimony trisulfide Sb_2S_3 . It was considered to be the essence or "spirit" of this mineral. It was used as an antiseptic, eyeliner, and cosmetics. The meaning of alcohol was extended to distilled substances in general and then narrowed to ethanol when "spirits" was a synonym for hard liquor (81). Bartholomew Traheron, in his 1543 translation of John of Vigo, introduces the

word as a term used by "barbarous" (Moorish) authors for fine powder.

Vigo wrote: the barbarous actors use alcohol, or (as fynde sometimes his written) alcohol, for finest Poudre. The word's meaning became restricted to "spirit of wine" (the chemical is known today as ethanol) in the 18th century and was extended to the class of substances so-called as "alcohols" in modern chemistry after 1850, (82). The term ethanol was invented in 1892, combining the word ethane with the "-ol" ending of "alcohol" (83).

3.12.2 Systematic Names

International Union of Pure and Applied Chemistry (IUPAC) nomenclature is used in scientific publications and where precise identification of the substance is important, especially in cases where the relative complexity of the molecule does not make such a systematic name unwieldy. In naming simple alcohols, the name of the alkane chain loses the terminal e and adds the suffix -ol, e.g., as in "ethanol" from the alkane chain name "ethane" (84). When necessary, the position of the hydroxyl group is indicated by a number between the alkane name and the -ol: propane-1-ol for CH

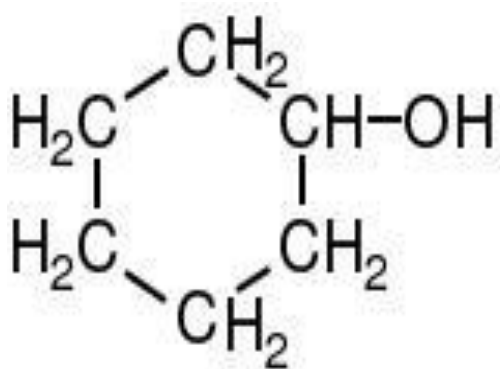


Fig 2. Shown the Position of Hydroxyl Group (85).

3.12.3 Common Names

In other less formal contexts, an alcohol is frequently referred to the name of the corresponding alkyl group followed by the phrase "alcohol", e.g., methyl alcohol, ethyl alcohol. Propyl alcohol may be n-propyl alcohol or isopropyl alcohol, depending on whether the hydroxyl group is bonded to the end or centre carbon at the straight propane chain. As described under systematic naming, if another group on the molecule takes priority, the alcohol moiety is frequently indicated using the "hydroxy-" prefix (86).

3.12.4 Physical Properties

In well-known, the hydroxyl group makes alcohols polar. Those groups can form hydrogen bonds to one another and most other compounds. Attributable to the presence of the polar OH alcohols are more water-soluble than simple hydrocarbons. Methanol, ethanol, and propanol are miscible in water. Butanol, with a 4-carbon chain, is moderately soluble. Because of hydrogen bonding, alcohols tend to have higher boiling points than comparable hydrocarbons and ethers (86) the boiling point of the alcohol ethanol is 78.29 °C, in comparison to 69 °C for the hydrocarbon hexane, and 34.6 °C for diethyl ether.

3.12.5 Occurrence in Nature

Simple alcohols are found extensively in nature. Ethanol is most prominent due to the fact that it's the product of fermentation, a major energy-producing pathway. The other simple alcohols are formed in simplest trace quantities. More complex alcohols are pervasive, as manifested in sugars, some amino acids, and

fatty acids (87). Alcohol abuse, that is the immoderate and/or unhealthy consumption of alcoholic beverages, has emerged as a prime hindrance to the health, social and economic development of the people in a world. The Alcoholic drink control Act 2010 (88), was developed due to numerous alcohol abuse patterns noticed among which include:

- a) Increase in the number of alcoholic drinks selling outlets mainly in urban residential areas, in or close to learning institution, in supermarkets and convenience stores, and rural villages;
- b) Easy accessibility to and excessive intake of alcohol even using individuals below 18 years; c) increase in adulterated alcoholic drinks and illicit brews main to deaths and injury;
- d) Aggressive advertising, promotion of alcoholic drinks especially with messages targeting young people and sponsorship of events for a person below the age of 18 years by the alcoholic drinks industry.

Alcohol has been noted to have ill-health consequences including malnutrition including thiamine deficiency main to Korsakoff's syndrome; heart diseases like increases in the risk of heart attacks in women who get drunk as mentioned in Science Daily in 2005. It was reported by the National Health Services in the year 2008 that excessive alcohol consumption has been also noted to result in dementia (89). Several types of cancers such as mouth cancers, pharyngeal cancers, oesophageal cancers, laryngeal cancer, breast cancers, bowel cancer and even liver cancers secondary to liver cirrhosis are linked to alcohol consumption as

suggested by cancer research. Rodgers et al mentioned that normal heavy alcohol consumers are more likely to be afflicted by obesity and strokes (90).

3.13 Health Effects of Alcohol

3.13.1 Short-term Effects of Alcohol Consumption

Wine, beer, distilled spirits and other alcoholic drinks contain ethyl alcohol and alcohol consumption has short-term psychological and physiological effects on the user. Different concentrations of alcohol in the human body have different effects on a person. The effects of alcohol depend on the amount an individual has drunk, the percentage of alcohol in the wine, beer or spirits and the timespan that the consumption took place, the amount of food eaten and whether an individual has taken other prescription, over-the-counter or street drugs, among other factors. Alcohol in alcohol carbonated is absorbed faster than alcohol in non-carbonated drinks (91). Drinking enough to cause a blood alcohol concentration (BAC) of 0.03–0.12% typically causes an overall improvement in mood and possible euphoria, increased self-confidence and sociability, decreased anxiety, a flushed, red appearance in the face and impaired judgment and fine muscle coordination. A BAC of 0.09% to 0.25% causes lethargy, sedation, balance problems and blurred vision. A BAC from 0.18% to 0.30% causes profound confusion, impaired speech (e.g., slurred speech), staggering, dizziness and vomiting. A BAC from 0.25% to 0.40% causes stupor, unconsciousness, anterograde amnesia, vomiting (death may occur due to inhalation of vomit (pulmonary aspiration while unconscious) and respiratory depression (potentially life-threatening)).

A BAC from 0.35% to 0.80% causes a coma (unconsciousness), life-threatening respiratory depression and possibly fatal alcohol poisoning. Alcohol is eliminated by enzymes in the liver at a rate of ca. 15 mg per dL of blood per hour (mg/dL/h), (92). For a 100 kg man, this corresponds to ca. 15 mL per hour, which is the pure alcohol content of a typical 300 mL small beer bottle (93). The rate of elimination depends linearly on body weight and follows zero-order kinetics, but can be doubled by repeated exposure (habitual drinking). Drinking while driving, operating aircraft, watercraft or heavy machinery increases the risk of an accident and is often a separately defined felony punishable by jail, license suspension, fines or compulsory treatment.

3.13.2 Long-term Effects of Alcohol Consumption

Both alcoholic and non-alcoholic red wine may boost heart health (94). Alcohol is the main active ingredient of wine, beer and distilled spirits. Drinking small quantities of alcohol (less than one drink in women and two in men per day) is associated with a decreased risk of heart disease, stroke, diabetes mellitus, and early death. Drinking more than this amount, however, increases the risk of heart disease, high blood pressure, arterial fibrillation, and stroke. The risk is greater in younger people due to binge drinking, which may result in violence or accidents (95). About 3.3 million deaths (5.9% of all global deaths) are believed to be due to alcohol each year. Alcoholism reduces a person's life expectancy by around ten years and alcohol use is the third leading cause of early death in the United States. Even moderate alcohol consumption increases cancer risk in individuals (96). No professional medical association recommends that people who are non-drinkers

should start drinking wine (97). Another long-term effect of alcohol usage, when also used with tobacco products, is alcohol acting as a solvent, which allows harmful chemicals in tobacco to get inside the cells that line the digestive tract. Alcohol slows these cells' healing ability to repair the damage to their DNA caused by the harmful chemicals in tobacco. Alcohol contributes to cancer in this process (98). While lower quality evidence suggests a cardioprotective effect, no controlled studies have been completed on the effect of alcohol on the risk of developing heart disease or stroke. Excessive consumption of alcohol can cause liver cirrhosis and alcoholism (99). The American Heart Association cautions people NOT to start drinking ... if they do not already drink alcohol. Consult your doctor on the benefits and risks of consuming alcohol in moderation (100). Alcoholic drinks are classified by the International Agency for Research on Cancer (IARC) as a Group 1 carcinogen (carcinogenic to humans). IARC classifies alcoholic drink consumption as a cause of female breast, colorectum, larynx, liver, oesophagus, oral cavity, and pharynx cancers; and as a probable cause of pancreatic cancer (101).

3.13.2.1 Congeners

In the alcoholic drinks industry, congeners are materials produced at some point of fermentation. these materials include small amounts of chemicals such as from time to time desired different alcohols, like propanol and 3-methyl-1-butanol, however also compounds that are never preferred including acetone, acetaldehyde and glycols. Congeners are responsible for a maximum of the flavour and aroma of distilled alcoholic drinks and contribute to the flavour of

non-distilled drinks (102). It has been cautioned that these materials contribute to the signs and symptoms of a hangover (103). Tannins are congeners found in wine in the presence of phenolic compounds. Wine tannins add bitterness, have a drying sensation, flavour herbaceous and are often described as astringent. Wine tannins upload balance, complexity, shape and make a glass of wine last longer, so they play an important role within the improvement of wine (104).

3.13.2.2 Food Energy

Alcoholic drinks are a source of food energy. The United States Department of Agriculture (USDA) uses a figure of 6.93 kilocalories (29.0 kJ) per gram of alcohol (5.47 kcal or 22.9 kJ per ml.) for calculating food energy (105). In addition to alcohol, many alcoholic drinks contain carbohydrates. For example, in 12 United States (US) fl oz (355 ml) of 5% Alcohol by volume (ABV) beer, along with approximately 18 ml of alcohol (96 kilocalories or 400 kilojoules), there are usually 10–15 g of carbohydrates (about 40–60 kcal or 170–250 kJ). Excessive daily calorie intake may contribute to an increase in body weight and "beer belly". In addition to the direct effect of its caloric content, alcohol is also known to potentiate the insulin response of the human body to glucose, which, in essence, "instructs" the body to convert consumed carbohydrates into fat and to suppress carbohydrate and fat oxidation. Ethanol is directly processed in the liver to acetyl CoA, the same intermediate product as in glucose metabolism. Because ethanol is mostly metabolized and consumed by the liver, chronic excessive use can lead to fatty liver. This leads to chronic inflammation of the liver and eventually alcohol liver disease (105).

3.14 Important or Reasons for Alcohol Used

An alcoholic beverage commonly served earlier than a meal to stimulate the appetite (106). While a digestif is any alcoholic beverage served after a meal for the said reason for enhancing digestion. Fortified wine, liqueurs, and dry champagne are common aperitifs. Due to the fact aperitifs are served before dining, they're usually dry rather than sweet. One example is Cinzano, a brand of vermouth. Digestifs include brandy, fortified wines and herb-infused spirits. Reduction of red wine for a sauce by cooking it on a stovetop. it is referred to as a reduction because the heat boils off some of the water and most of the more volatile alcohol, leaving a more concentrated, wine-flavoured sauce. Pure ethanol tastes sour to human beings; some people also describe it as sweet (107).

However, ethanol is also a moderately good solvent for many fatty substances and essential oils. This facilitates the usage of flavouring and colouring compounds in alcoholic liquids as a taste mask, particularly in a distilled drink. Some flavours may be naturally present in the beverage's raw material. Beer and wine may also be flavoured before fermentation, and spirits may be flavoured before, during, or after distillation. Sometimes flavour is acquired using permitting the beverage to stand for months or years in oak barrels, usually made of American or French oak. Some brands of spirits may also have fruit or herbs inserted into the bottle at the time of bottling (108). Wine is important in delicacies not only for its value as an accompanying beverage, however as a flavouring agent, mostly in inventory braising, since its acidity lends balance to rich savoury or sweet dishes. Wine sauce is an example of a culinary sauce that makes use of wine as a primary ingredient (109).

Natural wines can also exhibit a broad range of alcohol content, from below 9% to above 16% ABV, with most wines being in the 12.5–14.5% range (110) Fortified wines (usually with brandy) might also comprise 20% alcohol or more.

However, the purpose of this study is that most of the foreign students at Fırat University are away from family control and think that alcohol and cigarette smoking will make them feel like adults and free themselves. Besides, smoking and alcohol may become attractive in the face of hardship. With that cross-purpose in courage me to determine the status of cigarette and alcohol use among foreign students studying in Fırat University Elazığ, Turkey. Also, this study conducted was to clarify the actual factors associated with cigarettes smoking among the students.

4. MATERIALS AND METHODS

4.1 Setting and Study Design

The universe of the descriptive and cross-sectional study of this research work consists of all foreign students, studying at Firat University (N=1725). Adolescents and young adults foreigners both undergraduate and postgraduate recruited from all faculties in the university from the various course programs who reside at its main campus, hostels and out the campus.

Firat University is a public university in Elazig, it was established initially as a high technical school, was opened in Elazig in 1967, and the university founded in 1975 to promote economic development in the state and country in general, the university has 12 faculties and a total of 1460+ number of staff both academic and non-academic. It has a student population of 31,000+ enrolled in full time and part-time programmes at both undergraduate and postgraduate levels (111). Being a University based in Elazig, a greater proportion of the students are indigenes from Elazig and a few from other States.

When deciding on the sample size, the formula $n = Nt^2pq / d^2(N-1) + t^2pq$ was used and the probability of occurrence considered as $p = 50\%$, $t = 1.96$ and $d = 0.05$ (95% confidence interval), (112). At the time of the study, there were (1725) foreign students enrolled in Firat University. List of all foreign students received. Students who were sampled were selected from the list using the systematic sampling method. The foreign students have answered questionnaire forms. After

excluding any incomplete and unsound responses, we utilized data from (337) who volunteered to participate in the study they filled the questionnaire were included in the study and the research was approved by the Ethical Committee of Firat University.

In this formula (the values used in the study are given in parentheses);

N: Number of individuals in the universe (1725)

n: Number of individuals to be sampled (337)

p: Incidence (probability) of the investigated event

q: Incidence (probability) of the event

t: The theoretical value found from the tablet at a certain degree of freedom and the level of error detected (1.96)

d: Indicates the desired $\pm$ deviation according to the frequency of occurrence.

4.2 Data Collection

Data collection was carried out through the administration of questionnaires, and I was made a pre-tested before actual data collection is started for getting valid data. The questionnaire consisted of three parts. In the first part of the questionnaire, there are socio-demographic data, in the second part of the questions about smoking, in the third part of the questions about drinking. Besides, Fagerstrom Nicotine Addiction Test was given in the questionnaire form along with smoking characteristics (113).

The Fagerstrom Nicotine Dependence Test, which was administered to smoking students only, was developed by Fagerstrom to determine the level of physical dependence on smoking and that consists of six questions. The questions are closed-ended, as the level of dependence on smoking increases, the score obtained from the test increases. The validity and reliability study of the test in the Turkish language was conducted in 2004 by Uysal et al. and its reliability was found to be moderate ($\alpha = 0.56$), (114). Dependency level is “very low” at (0-2 points), “low” (3-4 points), “moderate” (5 points), “high” (6-7 points) and “very high” (8-10 points), is a test that determines.

In our study, those with a score higher than six were considered as “high” and “very high” risk groups for nicotine addiction. The sample selection was done conventionally, after introductions and consent seeking from the individual students, the questionnaires were handed out to respondents. After they finish filling, I collected and checked to confirm the completeness. The criteria for inclusion in the research work included all foreign Students present in the university during the research period and those students who consenting to continue their education at Firat University, that are foreign nationals. And the exclusion criteria as those that do not accept the interview, 2 or 3 times and can not be reached. The questionnaire was prepared both in English and Turkish and the necessary corrections were made to 20 students in the university. While filling the questionnaire, the height and weight measurements of the individuals not be made and I evaluated according to the information given by the participants. Body Mass Index (BMI) of the participants was evaluated by the World Health Organization, by considering BMI as <18.5 weak, $\geq 18.5 - <24.9$,

normal, ≥ 25.0 - < 29.9 slightly obese, and ≥ 30.0 obese (115). Necessary explanations were made about the survey questions to ensure that they answer the survey questions successful.

4.3 Statistical Analyses

The data analysis was carried out in a computerized manner using SPSS vision 23.0-package program for statistical analysis. “Chi-square-test” and “Logistic regression” was considered. The quantitative data were analyzed using frequency tables and percentages. Whereby “Means are given with standard deviation” for selected variables was also computed. The results were evaluated at a 95% confidence interval and statistical significance at $p < 0.05$ level, in which a p-value of less than 0.05 was accepted as being statistically significant (112).

5. RESULT

The overall result of the quantitative study is three hundred and thirty-seven 337 students' data were evaluated: 17.2 %; (n=58) were female and 82.8%; (n=279) were male. Students' mean age was 23.61 ± 4.68 years, all detailed of the demographical characteristics of the study population are shown in Table 5. The smoking rate of smokers who tried to smoke was 36.5% (n=123), but the currently smokers was 31.8%; (n=107) whereby 68.2%; (n=230) are non-smokers, comparison of categorical demographic characteristics according to smoking status showed that the smoking rate percentage was higher in the following populations: male smokers are 82.2%; (n=88) and female are 17.8%; (n=19) from the population, students from substrain Africa 48.6%; (n=52) compare with students from middle east/north Africa 51.4%; (n=55) being a Muslim 68.2%; (n=73) compare to christen/ART 31.8%; (n=34) high in students from communication department 15.9%; (n=17) compared to all 16 departments 84.1%; (n=90) and it is higher in Under-graduate students 82.2%; (n=88) compared to Post-graduate student 17.8%; (n=19) students living alone and with friends 97.2%; (n=104) compare with students living with the family 2.8%; (n=3) having all close friends who smoked 69.8%; (n=36) compared to whose does not have 30.3%; (n=71) those who their fathers' smoked 54.2%; (n=58) to those who are not 45.8%; (n=49) alcohol consumers 73.3%; (n=33) compared to non-users 26.7%; (n=12) Table 6.

Table 5: Shown the status of cigarettes smoking among the students in a study population.

Variables	Frequency (n=337)	Per cent (%)
Do you ever tried to smoke		
Yes	123	36.5
No	214	63.5
Cigarette smokers		
Yes	107	31.8
No	230	68.2
Gender		
Male	279	82.8
Female	58	17.2
How you smoke		
Non-smokers	230	68.2
Everyday	86	25.6
Occasionally	21	6.2
Does your best friend's smoke		
Yes	53	15.7
No	284	84.3
Does your father's smoke		
Yes	73	21.7
No	264	78.3
Ever tried to smoke a hookah		
Yes	81	24.0
No	256	76.0
Ever tried to quit smoking		
Non-smokers	230	68.2
Yes	43	12.8
No	64	19.0

Table 6: Shown the distribution of some characteristics of the students according to smoking status.

Variables	Total (n=337) (%)	Cigarettes Smoked (%)		Test Statistics P
		Yes	No	
	n %	n %	n %	
Gender				
Male	279{82.8}	88{31.5}	191{68.5}	$\chi^2 = 0.033$ p = 0.856
Female	58{17.2}	19{32.8}	39{67.2}	
Age group				
≤ 22	194{57.6}	68{35.1}	126{64.9}	$\chi^2 = 2.299$ p = 0.129
≥ 23	143{42.4}	39{27.3}	104{72.7}	
Region/Country				
Subsarian Africa	229{68.0}	52{22.7}	177{77.3}	$\chi^2 = 26.968$ p<0.001
Middle East/North Africa	108{32.0}	55{50.9}	53{49.1}	
Religion				
Muslim	276{81.9}	73{26.4}	203{73.6}	$\chi^2 = 19.776$ p<0.001
Christian/ART	61{18.1}	34{55.7}	27{44.3}	
Department				
Communication	295{87.5}	17{40.5}	25{59.5}	$\chi^2 = 1.686$ p = 0.194
Other Department	42{12.5}	90{30.5}	205{69.5}	
Educational status				
Post-Graduate	83{24.6}	19{22.9}	64{77.1}	$\chi^2 = 3.988$ p<0.046
Under-Graduate	254{75.4}	88{34.6}	166{65.4}	
Living with				
Alone/Friends	329{97.6}	104{31.6}	225{68.4}	$\chi^2 = 0.125$ p = 0.724
Family	8{2.4}	3{37.5}	5{62.5}	
Your best friend smoke				
Yes	53{15.7}	36{67.9}	17{32.1}	$\chi^2 = 37.977$ p<0.001
No	284{84.3}	71{25.0}	213{75.0}	
Your father's smoke				
Yes	73{21.7}	58{79.5}	15{20.5}	$\chi^2 = 97.849$ p<0.001
No	264{78.3}	49{18.4}	215{81.4}	
Ever tried to smoke a hookah				
Yes	81{24.0}	56{69.1}	25{30.9}	$\chi^2 = 68.773$ p<0.001
No	256{76.0}	51{19.9}	205{80.1}	

Drink Alcohol				
Yes	45{13.4}	33{73.3}	12{26.7}	$\chi^2 = 41.441$ P<0.001
No	292{86.6}	74{25.3}	218{74.7}	

The difference in gender had a $p > 0.856$, meaning that gender deference does not have any significant value concerning cigarettes smoking among the student. Age group $p < 0.129$, mean that the age of the student have no significant association with cigarettes smoking. Country or region $p < 0.001$, mean there is a statistically significant association with smoking cigarettes. Religions are statistically significantly associated with smoking had a $p < 0.001$. Associated with departments and cigarette smoke $p < 0.194$, meaning that there is no significant difference between each department and cigarettes smoking. Furthermore, the cigarettes smoking association showed no statistical significance for the student from under-graduate and post-graduate and had a $p < 0.046$, and living with a friend showed no significant association indicated $p > 0.724$, Table 6. Moreover, the students who're their friend smoke contributed more to associate with smoking cigarettes and $p < 0.001$, meaning that there is a statistically significant association with smoking cigarettes. For the student whose their father smoke, required a $p < 0.001$, meanwhile there is a statistical association to contribute to smoking cigarettes for the respondent. Finally, The students whose drink alcohol are statistically significant association with smoking cigarettes had a $p < 0.001$.

Table 7: Shown the reason for cigarettes smoking among the student in the study population.

Reason for your smoking Variable*	Frequency (n = 107)	Per cent (%)
Engagement	106	99.1
Stress on the way	98	91.5
Pleasure, joy	104	97.2
Family issues	22	20.5
Loneliness	87	81.3

*One person answer more than one

Table 8: Shown the distribution of students who express that they are currently using cigarettes according to the level of addiction.

Fagerström Nicotine Addiction Test	Frequency (n = 107)	Per cent (%)
How many cigarettes do you smoke per day?		
10 or less	57	53.3
11-20	11	10.3
21-30	29	27.1
31 or more	10	9.3
How soon after you wake do you smoke your first cigarette?		
After 60 minutes (1 hour)	75	70.1
After 31-60 minutes	15	14.1
After 6-30 minutes	8	7.4
Within 5 minutes	9	8.4
Do you find it difficult to refrain from smoking in a place where it's forbidden?		
Yes	10	9.3
No	97	90.7
Which cigarette would you hate most to give up?		
The first one in the morning	53	49.5
All others	54	50.5
Do you smoke more frequently during the first hours after waking than during the rest of the day?		
Yes	71	66.4
No	36	33.6
Do you smoke even if you are sick in bed most of the day?		
Yes	6	5.6
No	101	94.4

Table 9: Shown the rate of nicotine of students according to the level of addiction Fagerstrom Test.

Nicotine according to the level of addiction Fagerstrom Test	Frequency (n = 107)	Per cent (%)
Very low	84	78.5
Low	15	14.1
Moderate	4	3.7
High	3	2.8
Very high	1	0.9

Table 10: Shown the rate of nicotine of students according to the level of addiction Fagerstrom Test by gender.

Nicotine according to the level of addiction Fagerstrom Test	Gender (n = 107)			
	Male		Female	
	n	%	n	%
Very low	71	80.7	13	68.4
Low	13	14.8	2	10.5
Moderate	3	3.4	1	5.3
High	0	0.0	3	15.8
Very high	1	1.1	0	0.0

In Table 8, explained the distribution of 107 students who affirms that they are currently using cigarettes according to the level of addiction. The students that smoked sticks of cigarettes 10 or less in a day are 53.3%; (n=57) was the most frequent answer, the number of cigarettes smoking by the student may contribute for enhancing the smoking, those who's smoked 21-30 are 27.1%; (n=29) in a day, then who's smoked 11-20 sticks of cigarettes 10.3%; (n=11) barely one is who's smoked sticks of cigarettes 31 or higher 9.3%; (n=10) daily. The overall number of sticks of cigarettes smoked in a whole population study about 1,790 sticks in a day by taking an average.

The mean Fagerstrom test score among student's smokers was 1.6825 ± 0.4662 , non-smokers are 68.2%; (n=230), and the rate of nicotine according to the level of addiction showed that about seventy-nine per cent 78.5%; (n=84) of respondents who are smoked cigarettes, dependency level showed a very low, Table 9, as 10 or fewer sticks of cigarettes are the most frequent answer in Table 8 and almost thirteen per cent 12.8%; (n=43) said they have tried to quit smoking from above Table 1. 70.1%; (n=75) smoked their first cigarettes after 60minutes (1hour) and 50.5%; (n=54) of smokers feel liked hate to give up smoking cigarettes in all other the day, and about 94.4%; (n=101) don't care to smoke in sicked bed.

Table 11: Shown the status of alcohol consumption among the students in a study population.

Variables	Frequency (n=337)	Per cent (%)
Do you ever tried to drink		
Yes	45	13.4
No	292	86.6
Currently drink alcohol		
Yes	45	13.4
No	292	86.6
At age start drink		
Non-drink	292	86.6
≤ 19 years	32	9.5
≥ 20 years	13	3.9
How you drink		
Non-drinker	292	86.6
Everyday	8	2.4
Occasionally	37	11.0
Number of alcohol bottle usually drink weekly		
Non-drink	292	86.6
10 or less	38	11.3
11-20	3	0.9
21-30	4	1.2
Ever tried to release alcohol		
Non-drink	292	86.6
Yes	11	3.3
No	34	10.1
Does your best friend drink alcohol		
Yes	65	19.3
No	272	80.7

However, on alcohol respondents, there were so many differences between male and female students who accepted and refused alcohol. The description comparison showed the averages of 86.6%; (n=292) of the students have never drunk alcohol, where consumers are 13.4%; (n=45), about 81.9%; (n=276) are Muslims and 18.1%; (n=61) are Christian/ART. Comparison of categorical demographic characteristics regarding the frequency of alcohol use were observed gender differences shown the male students consume larger amounts of alcohol than females, about 14.7%; (n=41) from the alcohol consumers are male while 6.9%; (n=4) are female Table 12.

Table 12: Shown the distribution of some characteristics of the students according to alcohol status.

Variables	Total % (n=337)	Alcohol consumption (%)		Test Statistics p
		Yes	No	
	n %	n %	n %	
Gender				
Male	279{82.8}	41{14.7}	238{85.3}	$\chi^2 = 2.524$ p = 0.112
Female	58{17.2}	4{6.9}	54{93.1}	
Age group				
≤ 22 years	194{57.6}	37{19.1}	157{80.9}	$\chi^2 = 12.294$ p<0.001
> 23 years	143{42.4}	8{5.6}	135{94.4}	
Region/Country				
Subsarian Africa	229{68.0}	31{13.5}	198{86.5}	$\chi^2 = 0.210$ p = 0.885
Middle East/North Africa	108{32.0}	14{13.0}	94{87.0}	
Religion				
Muslim	276{81.9}	12{4.3}	264{95.7}	$\chi^2 = 106.873$ p<0.001
Christian/ART	61{18.1}	33{54.1}	28{45.9}	
Educational status				
Post-Graduate	83{24.6}	3{3.6}	80{96.4}	$\chi^2 = 9.027$ p=0.003
Under-Graduate	254{75.4}	42{16.5}	212{83.5}	
Department				
Other Department	42{12.5}	24{8.1}	271{91.9}	$\chi^2 = 55.692$ p<0.001
Communication	295{87.5}	21{50.0}	21{50.0}	
Living with				
Alone/Friends	329{97.6}	45{13.7}	284{86.3}	$\chi^2 = 1.263$ p = 0.261
Family	8{2.4}	0{0.0}	8{100.0}	
BMI group				
Weak	40{11.8}	1{2.5}	39{97.5}	$\chi^2 = 17.618$ p<0.001
Normal	159{47.2}	34{21.4}	125{78.6}	
Slightly Obese	133{39.5}	10{7.5}	123{92.5}	
Obese	5{1.5}	0{0.0}	5{100.0}	

Comparison of continuous variables according to alcohol status shown there is no significant value in gender with reference of alcohol used ($\chi^2 = 2.524$; $p > 0.112$) respectively, Table 12 shows the frequency of excessive drinking by gender. The mean perception score of age group was statistically significant between the frequency of alcohol use had about ($\chi^2 = 12.294$; $p < 0.001$). Country/region showed no statistical significant association with alcohol used had a ($\chi^2 = 0.21$; $p > 0.885$). The religion and alcohol consumption indicated ($\chi^2 = 106.873$; $p < 0.001$), means that there is a significant difference between religion status and alcohol abuse, Table 12.

Furthermore, on the association of the grade of study post-graduate against under-graduate and alcohol abuse showed ($\chi^2 = 9.0271$; $p < 0.003$) respectively, meaning that there is a significant difference between a grade of study and alcohol abuse, the under-graduate has an association with prevalence of alcohol abuse than post-graduate students. The significant correlation was found between the frequency of the communication department against all other departments and alcohol used ($\chi^2 = 55.692$; $p < 0.001$), respectively, Table 12.

Moreover, on the association of living arrangements and alcohol drink showed no significant association at ($\chi^2 = 1.263$; $p > 0.261$), and the body mass index (BMI) are statistically significant between the BMI group and frequency of alcohol use, ($\chi^2 = 17.618$; $p < 0.001$) respectively, Table 12.

Table 13: Shown the reason for alcohol drinking among the student in the study population.

Reason for your drinking Variable*	Frequence (n=45)	Per cent (%)
Engagement	29	64.4
Stress on the way	18	40.0
Pleasure, joy	29	64.4
Family issues	2	4.4
Loneliness	9	20.0

*One person answer more than one

Table 14: Shown the living healthcare status of students in the study population.

Variables	Frequency (n=337)	Per cent (%)
For how long have you been in Turkey		
≤ 18 month	316	93.8
≥ 19 month or more	21	6.2
Having health issues since coming to Turkey		
Yes	115	34.1
No	222	65.9
Any provisional health care in the university		
Unknown	78	23.1
Yes	173	51.3
No	86	25.6
Is access to healthcare easy in the university		
Unknown	89	26.4
Yes	33	9.8
No	215	63.8
Satisfied with the university students healthcare system		
Unknown	56	16.6
Missing	8	2.4
Yes	20	5.9
No	253	75.1
Do you think an improvement in the student healthcare system		
Unknown	3	0.9
Yes	319	94.6
No	15	4.5
Improvement of healthcare suggestions		
Unknown	17	5.0
Insurance to cover all expensive	126	37.5
Providing a translator	144	42.7
School I.D should be enough	50	14.8

Table 15: Shown the factors associated with cigarettes smoking among the students in binary logistic regression analysis.

Variables	OR	CI - 95%	P-Value
Region/Country			
Subsarian Africa.	1		
The Middle East/North Africa*	6.411	2.923-14.064	p<0.001
Religions			
Muslim	1		
Christian/ART*	13.673	4.998-37.404	p<0.001
Educational status			
Post-Graduate*	1		
Under-Graduate	1.498	0.536-4.183	p=0.441
Does your best friend's smoke			
Yes*	1		
No	0.499	0.197-1.266	p=0.143
Does your father's smoke			
Yes*	1		
No	0.76	0.033-0.175	p<0.001
Does tried to smoke a hookah			
Yes*	1		
No	0.267	0.118-0.607	p<0.002
Drink Alcohol			
Yes*	1		
No	0.123	0.061-0.251	p<0.001

Binary logistic regression analysis revealed factors associated with cigarette smoking status, in Table 15, the effect of these variables it was seen; The region/country odds ratio (OR): 6.411; 95% confidence interval (CI): 2.923-14.064; with the ($p < 0.000$); The religions OR: (13.673); 95%CI: (4.998-37.404); with the ($p < 0.000$); Post/undergraduate OR: (1.498); 95%CI: (0.536-4.183); with the ($p = 0.441$); Having a best friend who smoked OR: (0.499); 95%CI: (0.197-1.266); ($p = 0.143$); Does whose thier father's smoked OR: (0.76); 95%CI: (0.033-0.175); with the ($p < 0.000$); Does who's tried to smoke hookah OR: (0.267); 95%CI: (0.118-0.607); with the ($p < 0.002$); Alcohol consumption OR: (0.123); 95%CI: (0.061-0.251); ($p < 0.000$); Were are positive factors associated with cigarette smoking, and all variable are statistically significantly associated with cigarettes smoking, when the effect of these variables the key odds ratio (OR < 0.05 ;) in any variable, hence (OR ≥ 0.05 ;) considered as a low and can not be associated or influence cigarettes smoking by the population study.

Most of the respondents in the smoker's group in verbal conversation believed that smoking had more beneficial effects compared to harmful effects and that informed their choice to smoke. The responses include: "Smoking makes you high, it relieves you of any stressful circumstance or problem you may be passing through and without thinking any dangerous effect associated with it. If you do not smoke then how can you calm down with all these problems surrounding us? How do we feed? Where do we find a job to do? They say smoking is not good but it helps a person to calm down, I have more friends now that I smoke and smoking makes me happier afterwards. Respondents in the nonsmoking group thought that smoking had no beneficial effect but rather a lot

of harmful effects. Responses include: "Smoking affects the lungs, heart, and chest pain. Those who smoke more are affected the most". "Smokers' liver becomes bad, they vomit blood and may die from it. The effects occur faster among frequent smokers". A respondent from those who are stop smoking group thought that "Smoking at best gives only a temporal feeling of relieve because I have tried it before but on the long draught, there is no benefit except to make you continue to look for more money to buy more cigarettes. It can make you become a thief and it is addictive. It was God that delivered me". "I am told one can develop a chronic cough and other diseases so how can it be beneficial". "Smoking is dangerous and all smokers die earlier so therefore smoking is harmful".

6. DISCUSSION

Cigarette smoking and alcohol consumption are a serious public health problem among adolescents in the environment. This study investigated the status of cigarette smoking, alcohol consumption and the associated factors that would affect smoking behaviour among the foreign students of Firat University, which involved 337 out of school foreign student's adolescents in the university, the lifetime status of cigarette smoking is 31.8% and alcohol consumption is 13.4%. Male smokers are 82.2% and 17.8% are female, hence male drunker is 14.7% and female drunker are 6.9%, respectively from the population. This figure is comparable to that found according to data from the 2012 Global Adult Tobacco Survey in Turkey's smoking rate was 41.5% among men and 13.1% among women this was similar to our results (116). According to the same survey, among those aged ≤ 25 years, the smoking rate was 33.0% in boys/men and 7.4% in girls/women. So it is vital to monitor the younger population's smoking status periodically, the status smoking of the foreign student's situation was the first to evaluate in Firat University; that was not possible to make a comparison against the smoking or alcoholic status of the university students in previous years. but we considered the general frequency of the smoking rate among students of Firat University was 25.8%, hence 15.4% of the smokers were smoking at least once a day (117). However, it is possible to estimate or predict general trends when comparing against other universities' results in recent years. Previous studies conducted among Turkish students revealed that living in urban areas was a risk factor for smoking habits.

Some studies showed that increasing the cigarette tax discourages individuals from smoking (118). Therefore, Turkey has followed MPOWER policies and increased the cost of cigarettes (119). However, in eastern regions of the country high smoking rate (illicit cigarettes) and other types of tobacco products are prominent (120). The high smoking rate in our study population can be further attributed to the ease of several cigarettes smoking. In previous studies, it was shown that smoking bans on university campuses decreased the smoking rate (121). the university in the current study had no such ban. The lack of improvement of social and sport entertainment opportunities at the university may have also affected students' smoking rates by contributing to students' boredom. Therefore, to decrease smoking among this population and other university students, preventions such as smoking bans and offering student entertainment may be feasible and effective solutions.

According to the 2012 Global Adult Tobacco Survey, the mean age for starting smoking was 19 years; however, novel data shows that this age is decreasing 16 years on average (122). Future studies would benefit from examining smoking rates per sex instead of overall rates. In our study and others, alcohol consumption was associated with an increased risk of smoking (123). Studies have shown that alcohol use is a risk factor for early initiation of cigarette smoking and the continuation of smoking (124). Foreign students in the communication department had a higher smoking rate compare to all fourteen departments. The association between low academic success and smoking behaviour has been previously studied, and low academic performance was found to be a predictor for smoking (125). This strongest association was between

smoking and having both close friends and parents who smoke, which reflects prior results (126). In a recent study, the influence of parental smoking seems less clear, believing that living with families was shown to be a predictive factor for never smoking among students (127).

Moreover, when considering alcohol use, this age group (19–25 years) corresponds to the time of first use of alcohol in our study. Clinical studies done in clinical alcohol-dependent patients showed that the mean age of first use of alcohol changed between 19 and 25 in Turkey (128,129). In a general survey done by the Association of Turkish Psychologists, the lifetime prevalence of alcohol use was found as 38.7% among 19–25-year-old males and it was 16.0% in female population at the same age group (130). And the per cent it would correspond to the alcohol consumption in our study. The alcohol consumption by university students in Turkey still has not reached the levels reported in Europe and the United States. Prevalence of any more than drinking on special occasions among university students changed from 42% to 95% in West Europe and from 52% to 75% in Eastern European countries (131). In the previous study, according to Dowson et al, the prevalence of drinking more than once during my lifetime was 50.6% and the prevalence of drinking in the past year changed between 64% and 80% in a sample of American college students (132). Several studies done in various regions of Turkey indicated that over the last 15 years' prevalence rates of lifetime use of alcohol among university students changed between 36% and 82%, (133). Ogel et al. 2003 found a prevalence rate of alcohol use as 53.6% in Istanbul University adolescents between 18–25 years of age (134).

In a conclusion of this research;

- 82.8% of the students included in the study are male and their average age is 23.61 ± 4.68 years.
- 36.5% of foreign students stated that they tried smoking, and 31.8% still smoke.
- 25.6% of them smoke every day. 6.2% drink occasionally, but not every day.
- The frequency of smoking hookah is 24.0%.
- The frequency of foreign students drinking alcoholic beverages is 13.4%.
- According to the Fagestrome Nicotine Addiction Test of smoking 78% of them were found to be very little dependent.
- There was no significant difference in the rate of smoking among men and women by sex.
- As the educational status of students increases, smoking rate decreases ($p < 0.05$).
- The rate of smoking increased significantly in alcohol users and hookah smokers ($p < 0.05$).
- Smoking rate in Muslims is significantly lower compared to other religions ($p < 0.05$).
- There was no significant relationship between age, gender, department and smoking ($p > 0.05$).
- The first reason for smoking and drinking alcohol is engagement and pleasure/joy as a second.
- As the age progresses alcohol drinking rate decreases ($p < 0.05$).

- The level of education increases, alcohol drinking rate decreases ($p < 0.05$).
- No significant relationship was found between students and their alcohol use status by gender and country ($p > 0.05$).
- The rate of smoking is significantly lower in muslim according to their religion ($p < 0.05$).
- Alcohol use in muslims is significantly lower compared to other religions ($p < 0.05$)

Finally, I suggested that;

- Preventive efforts should aim in providing alternative ways of socialization other than smoking or alcohol use behaviour for university students. This can be achieved by supporting university student's life through activities preventions such as:
- Offering students social/sports entertainment and supporting various student clubs of specific purposes such as arts and other intellectual activities, it capable and effective solutions to decrease smoking among this population and other university students.
- Potential interventions could include campus-wide smoking bans, on the university, campuses it will decrease the smoking rate, hence the University in the current study had no such ban.
- Teachers and other stakeholders to deliver health education about the health risks associated with smoking and alcohol consumption.
- Restrict accessibility, such as advertising of substances like alcohol, cigarettes, are highly recommended.

- It is essential, government to review tobacco control policies to determine how effective they are for university students because smoking and drinking the resultant may be related to not only the social life but also it is, affect the students' academic success of the students.

6.3 Strengths and Limitations

This study was unique in several ways that make it valuable to the literature on Turkish smoking habits, particularly among youths. Our sample size makes it possible to generalize the results among university foreign students in the region more easily. Similarly, we evaluated both from deference department a gap in data that required bridging. The location also allowed for data from a region that plays a role in the illicit transport of tobacco products into Turkey. Furthermore, there have not been any studies on university students' status of smoking behaviour, meaning that our study adds new information to the data pool for this population. However, there are some limitations, including a lack of proof of illicit tobacco use and the cross-sectional design, which eliminates any temporal association. More studies from diverse regions in Turkey using both qualitative and quantitative measures are needed.

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8. ATTACHMENTS

ATTACHED NO: 1

SURVEY FORM SHOWED THE STATUS OF CIGARETTES SMOKING AND ALCOHOL CONSUMPTION AMONG FOREIGN STUDENTS, STUDYING IN FIRAT UNIVERSITY

Dear participants;

The answers you give to the questions will shed light on our study and will be very useful for a better understanding of this issue. Participation in this study is purely voluntary and the data will not be used for other scientific purposes. Participants will not specify their first and last name. You do not assume any monetary responsibility for this investigation and you will not be paid.

Please tick where applicable [-]

1- What is your gender? [] Male [] Female

2- What is your department? _____

3- What is your country? _____

4- What is your complexion? _____

5- What class level are you? [] Undergraduate [] Postgraduate

6- How old are you? (in years) _____

7- What is your ethnicity/tribe/culture? _____

8- What is your religion? [] ATR [] Christianity [] Islam

9- With whom do you live? Alone [] With family [] With friends []

Others, please specify _____ Declined to answer []

10- Do you usually participate in physical activities, such as walking, skateboarding, dancing, swimming, football or playing basketball? Yes [] or No []

11- If Yes in 10 above, what is your height _____ and weigh, kg _____

12- Do you usually get 8 or more hours of sleep every night? Yes [] or No []

13- Do you smoke? Yes [] or No []

14- If No, go to question 25, if Yes, how old are you trying? _____ in years.

15- How you smoke now?

1) Every day (at least one or more per day) []

2) I do not smoke every day but occasionally []

3) I was smoked, I stopped []

16- How soon after you wake do you smoke your first cigarette?

1) After 60 minutes []

2) After 31-60 minutes []

3) After 6-30 minutes []

4) Within 5 minutes []

5) Other: please specify _____

17- Do you find it difficult to refrain from smoking in a place where it's forbidden? E.g. Mosque, Church, Library, etc. Yes [] or No []

18- Which cigarette would you hate most to give up?

1) The first one in the morning []

2) All others []

19- How many cigarettes do you smoke per day?

1) 10 or less []

- 2) 11-20 []
- 3) 21-30 []
- 4) 31 or more []

20- Do you smoke more frequently during the first hours after waking than during the rest of the day? Yes [] or No []

21- Do you smoke even if you are sick in bed most of the day? Yes [] or No []

22- Have you ever tried to quit smoking? Yes [] or No []

23- If yes in 22, how many times? (in numbers) _____

24- What is your reason for smoking? Marking more than one option.

- 1) Engagement []
- 2) Stress on the way []
- 3) Pleasure, joy []
- 4) Family issues []
- 5) Loneliness []
- 6) Habit []
- 7) Increases my attention []
- 8) Other: please specify _____

25- Does your father smoke? Yes [] or No []

26- Does your mother smoke? Yes [] or No []

27- Does your best friend smoke? Yes [] or No []

28- Have you ever smoked a shisha (hookah)? Yes [] or No []

29- Have you ever tried to drink alcohol? Yes [] or No []

30- If yes, how old you tried? (in years) _____

31- Do you drink alcohol? Yes [] or No [] If No, go to question 38.

32- For how long did you start consuming alcohol? (in years) _____

33- Do you drink now?

- 1) Every day (at least one or more per day)
- 2) I do not drink every day but occasionally.
- 3) I was drunker, I stopped
- 4) I don't drink alcohol.

34- How many bottles of alcohol do you drink in a week?

- 1) 10 or less []
- 2) 11-20 []
- 3) 21-30 []
- 4) 31 or more []

35- What is your reason for drinking alcohol? Marking more than one option.

- 1) Engagement []
- 2) Stress on the way []
- 3) Pleasure, joy []
- 4) Family issues []
- 5) Loneliness []
- 6) Habit []
- 7) Increases my attention []
- 8) Other: please specify _____

36- Have you tried to release the alcohol? Yes [] or No []

37- If yes, how many times?

- 1) 0-2 []

- 2) 3-4 []
- 3) 5 []
- 4) 6-7 []
- 5) 8-10 []

38- Does your best friend drink alcohol? Yes [] or No []

39- Alcoholic consumption, are not being subjected to violence? (Marking more than one option).

- 1) Alone []
- 2) With family []
- 3) With friends []
- 4) Declined to answer []
- 5) Others, please specify _____

40- For how long have been in Turkey? Please specify _____

41- Do you ever have any health issue since coming to Turkey? Yes [] or No []

42- If yes in 39, how do you manage with the situation? Please specify _____

43- Are you having any health problem at the moment? Yes [] or No []

44- Is there any provision for health care in the university? Yes [] or No []

45- Is access to health care easy in the university? Yes [] or No []

46- Is the health care system helpful for you? Yes [] or No []

47- Are you satisfied with the university student health care system? Yes [] or No []

48- Do you think an improvement in the university student health care system is necessary? Yes [] or No []

49- If yes, you have any suggestions for the improvement of the health care system to make it easier for a foreigner?

- Thank you for participating in completing the research questionnaire.

Bukhari Abubakar ADAM

ATTACHED NO: 2

ATTACHED NO: 3



FIRAT ÜNİVERSİTESİ REKTÖRLÜĞÜ

Tıp Fakültesi Dekanlığı



Sayı :11731200/100/
Konu :İzin Talebi

HALK SAĞLIĞI ANABİLİM DALINA

İlgi :15/08/2019 tarihli, 342999 sayılı ve "İzin Talebi" konulu yazı

Rektörlük Makamının "İzin Talebi" konulu ilgi yazısı ekte gönderilmiştir.

Bilgileriniz ile gereğini rica ederim.

e-imzalıdır.
Prof. Dr. Ahmet KAZEZ
Dekan

ATTACHED NO: 4



FIRAT ÜNİVERSİTESİ REKTÖRLÜĞÜ

Genel Sekreterlik



Sayı :11611387/100/
Konu :İzin Talebi

TIP FAKÜLTESİNE

İlgi :07/08/2019 tarihli, 342315 sayılı ve "Eğitim - Öğretim İşleri (Araştırma İzni Hk.)" konulu yazı

Fakülteniz Halk Sağlığı Anabilim Dalı öğretim üyesi Prof. Dr. Edibe PİRİNÇCİ danışmanlığında, yüksek lisans öğrencisi Abubakar Adam Bukhari tarafından yürütülen, "Firat Üniversitesi'nde Öğrenim Gören Yabancı Uyruklu Öğrencilerin Sigara ve Alkol Kullanma Durumu" konulu çalışmasını uygulama izin talebi Rektörlüğümüz tarafından uygun bulunmuştur.

Bilgileriniz ile gereğini rica ederim.

e-imzalıdır.
Prof. Dr. Kutbeddin DEMİRDAĞ
Rektör

I am **Bukhari Abubakar ADAM**; I was born in Nigeria, Kano State, Yakasai Municipal, dated on 28th - July 1988. I have attended Kano State Polytechnic and the University of Maiduguri, which I got my Certificate in Microbiology and Public Health. Since before I joined the Firat University I was involved in the tour for research and orienting people's issues regards to heath, disease self prevention and epidemiological disease control and also studies related and strategies in many states in Nigeria.

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