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TOBACCO AND USE YOUTH: A REVIEW

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1. INTRODUCTION

Smoking is a global epidemic among young people. For adults, it poses a serious threat to the health of young adults and young adults in the United States and has important public health and economic implications for this nation going forward. Perry et al. 199; Kessler 1995). The impact of smoking and other tobacco use on chronic disease, which accounts for 75% of US healthcare spending (Anderson 2010), is well documented and undeniable. Although much progress has been made since the Directorate General's report on smoking and health in 1964 (U.S. Department of Health, Education and Welfare [USDHEW] 1964), nearly one in four High school student currently smoking. Most young people who smoke become adult smokers. Half of adult smokers die prematurely from tobacco-related diseases (Fagerström 2002; Doll et al. 200). Despite thousands of programs aimed at reducing youth smoking and hundreds of thousands of media articles about the dangers of smoking, generation after generation continues to use this deadly product, and family after family continues to suffer the devastating consequences. However, a solid scientific basis exists regarding the social, biological and environmental factors that lead to youth tobacco use, the physiology of the progression from experimentation to tobacco addiction, the effects of other health effects of tobacco use, the epidemiology of tobacco use among adolescents and young adults, and evidence of tobacco-focused interventions that have been shown to reduce both and smoking prevalence among adolescents. These are precisely the questions examined in this report, intended to support the application of this solid scientific basis.

Almost all tobacco use begins in childhood and adolescence (U.S. Department of Health and Human Services [USDHHS] 199). A total of 88% of adults who smoke daily said they had started smoking by age 18 (see Chapter 3, "Epidemiology of youth smoking in the United States and around the world"). It is a life stage that is vulnerable to social influences (Steinberg 200), such as those provided by the marketing of tobacco products and the smoking pattern of attractivenesses. , such as in film (Dalton et al. 2009), which has a particularly strong effect on young people. This is also a time of life when susceptibility to normative influences is increasing: because smoking in public places is less acceptable and there are fewer people using tobacco in society or regularly. More often, consumption in young people decreases (Alesci et al. 2003). So as adults, we help protect our children.

Tobacco is the only legal consumer product in the world that causes premature death for half of long-term users (Fagerström 2002; Doll et al. 200). As this epidemic continues to wreak havoc in the United States, it is also increasing in low- and middle-income countries that are less able to cope with the economic and health consequences (Peto et al. and Lopez 2001; Reddy and 2006). It's time to end this epidemic. To do this, primary prevention is needed, which we must focus on young people and young adults. As mentioned in this report, we now have a proven set of tools and policies that can significantly reduce youth initiation and use of tobacco products.

2. REPORT OF THE GENERAL SURGEON IN 1994

This Surgeon General report on tobacco is the second report focusing solely on youth since these reports began in 1964. Its primary purpose is to update the science of youth smoking since from Surgeon General's first comprehensive report on youth tobacco use, Prevention of Tobacco Use Among Young People, published in 1994 (USDHHS 1994). This report concludes that although young people may not smoke until the age of 18, most will never start smoking. The report documented the course of addiction in young people, and the symptoms of addiction in young people were similar to those in adults. Tobacco is also considered a gateway drug for young people, as its use often precedes and increases the risk of illicit drug use. Tobacco advertising and promotional activities are found to be an effective way to increase the risk of smoking among adolescents, while community efforts are found to be effective in reducing youth smoking. Year. All of these findings are still important, relevant, and accurate, as documented in this report, but there has been substantial research since 1999 that broadens our knowledge of the use of Tobacco use in adolescents, prevention and motivation for smoking cessation in adolescents. Therefore, there is an urgent need for current reporting.

3. DEVELOPING TOBACCO CONTROL SINCE 1994

Many legal and scientific developments have altered the tobacco control environment and thus influence youth smoking. States and the US Department of Justice have filed lawsuits against tobacco manufacturers, with the result that many tobacco industry internal documents have been made public and have been analyzed and included in control science. Cigarette. In addition, the 1998 Master Settlement Agreement with tobacco companies resulted in the elimination of billboard advertising and on public transport as well as print advertising directed at minors. age and limitations on the use of brand sponsorship (National Association of Bar Associations [NAAG] 1998). The settlement also created the American Legacy Foundation, which conducts a national anti-smoking campaign aimed at young people. In 2009, the United States Congress passed legislation giving the U.S. Food and Drug Administration the power to regulate tobacco products to promote public health (the Tobacco Control and Prevention Act). Family Tobacco Control 2009). Some tobacco companies are currently subject to regulations that limit their ability to market to young people. In addition, they must reimburse state governments (through some state agreements and Master Settlement Agreements) for certain health care costs. Partly as a result of these changes, adult and youth smoking has decreased under the Master Settlement, documented in this report.

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Youth This report focuses on "young people".

Overall, the work reviewed the health consequences, epidemiology, etiology, reduction and prevention of smoking in adolescents (11 to 1 years), adolescents (15 to 17 years) and youth. (18-25 years old) age group. Where possible, we have attempted to specify the age group to which a particular analysis, study or finding applies. However, since hundreds of articles, books, and reports have been reviewed, there is bound to be a contradiction in the terminology used. “Adolescents,” “children” and “adolescents” are used interchangeably in this report. In general, this group includes people between the ages of 11 and 17, although the term "children" is a more general term that includes people under the age of 11. In general, people between the ages of 18 and 25 are considered to be young adults (although, from a developmental perspective, the period 18 to 20 is often referred to as late adolescence), and those aged 26 and up. up is considered an adult. In addition, it is important to note that the report focuses on smoking or smokeless tobacco use among young people. The report does not take into account youth exposure to secondhand smoke, also known as involuntary or passive smoking, discussed in the 2006 report by Surgeon General (USDHHS 2006). In addition, the report does not include research on children under 11 years of age; There is little evidence for tobacco use in the United States for children under 11 years of age, and while there may be some predictors of later tobacco use in these younger years, the study Research on tobacco use among active youth smokers has focused on those 11 years of age and older.

Smoke Use

Although smoking is the most common form of tobacco use in the United States, this report also focuses on other forms, such as smokeless tobacco use (including chewing tobacco and snuff).) and smoke a non-tobacco product, such as a pipe, cigar, or bidi (tobacco wrapped in veins). Since youth use of one form of tobacco has been linked to use of other tobacco products, monitoring all forms of tobacco use in this age group is particularly important. The term "tobacco use" in this report refers to the use of any tobacco product. When the word "smoking" is used alone, it refers to tobacco.

Prepare report

This surgeon general report was prepared by the Office of Smoking and Health (OSH), the National Center for Chronic Disease Prevention and Health Promotion, the Centers for Disease Control and Prevention (Centers for Disease Control and Prevention). CDC), USDHHS. In 2008, 18 independent external scientists reviewed the 1994 report and suggested areas for addition and updating. These scientists also recommend chapter editors and a senior science editor who are contacted by OSH. Each chapter editor nominated external scientists who could contribute, and 33 content experts prepared the preliminary sections. Section manuscripts have been grouped into chapters by chapter editors and then reviewed by a senior science editor, with technical editing by CDC. Chapters were sent exclusively to

The 3 reviewers who are experts in the fields covered and who have evaluated the chapters for scientific accuracy and completeness. The entire manuscript was then sent to more than 25 leading outside scientists, who reviewed the entire document's scientificity. After each review cycle, the drafts were revised by the Chapter and the Senior Scientific Editor based on expert feedback. The report was subsequently reviewed by various agencies within USDHHS. Publication delays prevent inclusion of all recently published articles and data, so some newer publications may not be cited in this report.

Surgeon General's report,

The Health Consequences of Smoking, a four-level hierarchy has been used to assess the research data on associations discussed in these reports (USDHHS 2006). Overall, this review was performed by the chapter compilers and then revised, as appropriate, by peer reviewers, senior scientists, and science editors. For a relationship to be considered sufficient to be described as causal, numerous studies over time have provided supporting evidence for each criterion.

When causality is presented in the chapter conclusion of this report, these four levels are used to describe the strength of the evidence for the association, from causal (1) to non-causal . In the report, other terms are used to discuss the evidence to date (i.e., mixed, limited, and equivalent evidence), which often represents insufficient data to draw

5. CONCLUSIONS

On smoking and health (USDHEW 196), major conclusions concerning the conditions and diseases caused by cigarette smoking and the use of smokeless tobacco have been based on explicit criteria for causal inference (USDHHS 2006). Although a number of different criteria have been proposed for causal inference since the 1960s, this report focuses on the five commonly accepted criteria that were used in the original 196 report and that are discussed in greater detail in the 2006 report on the health consequences of smoking (USDHHS 2006). The five criteria refer to the examination of the association between two variables, such as a risk factor (e.g., smoking) and an outcome (e.g., lung cancer). Causal inference between these variables is based on (1) the consistency of the association across multiple studies; this is the persistent finding of an association in different persons, places, circumstances, and times; (2) the degree of the strength of association, that is, the magnitude and statistical significance of the association in multiple studies; (3) the specificity of the association to clearly demonstrate that tobacco use is robustly associated with the condition, even if tobacco use has multiple effects and multiple causes exist for the condition; () the temporal relationship of the association so that tobacco use precedes disease onset; and (5) the coherence of the association, that is, the argument that the association makes scientific sense, given data from other sources and understanding of biological and psychosocial mechanisms (USDHHS 2006). Since the 2006

However, relationship evaluation is not normally used to present all of the report's findings. Key findings are written into important summaries that can be easily understood by those who read the report. Some of the findings, especially those in Chapter 3 (Epidemiology), provide observations and data regarding tobacco use in young people and are not generally a test of tobacco use. causality. For the conclusions written according to the hierarchy above, this report conducted a thorough and extensive review of the literature, based on accepted criteria of causality (USDHHS 2004). Qualifying evidence such as Level 1 or Level 2 has been prioritized in the conclusion of the chapter

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