

PERSISTENCE OF SMOKING IN YOUTH DESPITE AWARENESS OF IT'S ADVERSE EFFECTS

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Abstract

Smoking is highly addictive. Nicotine is the drug primarily responsible for a person's addiction to tobacco products, including cigarettes. The addiction to cigarettes and other tobacco products that nicotine causes is similar to the addiction produced by using drugs such as heroin and cocaine. Cigarette smoking is one of the leading causes of death. This article is targeted at discovering the prevalence of smoking despite numerous awareness campaigns and laws of its contraindications.

Keywords: Cigarette smoking, second hand smoke, lung cancer, heart diseases, effective prevention techniques, smoke free places, electronic nicotine delivery systems, Heated tobacco products

Introduction

Cigarette smoking is the single biggest avoidable cause of death and disability in developed countries. Smoking is now increasing rapidly throughout the developing world and is one of the biggest threats to current and future world health. For most smokers, quitting smoking is the single most important thing they can do to improve their health. Encouraging smoking cessation is one of the most effective and cost-effective things that doctors and other health professionals can do to improve health and prolong their patients' lives. [1]

Cigarette smoking first became a mass phenomenon in the United Kingdom and other more affluent countries in the early 20th century after the introduction of cheap, mass produced, manufactured cigarettes. Typically, a "smoking epidemic" in a population develops in four stages: a rise and then decline in smoking prevalence, followed two to three decades later by a similar trend in smoking related diseases. Usually, the uptake and consequent adverse effects of smoking occur earlier and to a greater degree among men. Some of the increases in health risk associated with smoking are greater among younger smokers. The risk of heart attack among smokers, for example, is at least double over the age of 60 years, but those aged under 50 have a more than fivefold increase in risk. Smokers are also at greater risk of many other non-fatal diseases, including osteoporosis, periodontal disease, impotence, male infertility, and cataracts. Smoking in pregnancy is associated with increased rates of fetal and perinatal death and reduced birth weight for gestational age. Passive smoking after birth is associated with cot death and respiratory disease in childhood and lung cancer, heart disease, and stroke in adults. Stopping smoking has substantial immediate and long term health benefits for smokers of all ages. The excess risk of death from smoking falls

soon after cessation and continues to do so for at least 10-15 years. Former smokers live longer than continuing smokers, no matter what age they stop smoking, though the impact of quitting on mortality is greatest at younger ages. For smokers who stop before age 35, survival is about the same as that for non-smokers.

The rate and extent of reduction of risk varies between diseases—for lung cancer the risk falls over 10 years to about 30%-50% that of continuing smokers, but the risk remains raised even after 20 years of abstinence. There is benefit from quitting at all ages, but stopping before age 30 removes 90% of the lifelong risk of lung cancer. The excess risk of oral and esophageal cancer caused by smoking is halved within five years of cessation.

The risk of heart disease decreases much more quickly after quitting smoking. Within a year the excess mortality due to smoking is halved, and within 15 years the absolute risk is almost the same as in people who have never smoked. In a meta-analysis by Wilson and colleagues in 2000, the odds ratio for death for smokers who stopped smoking after myocardial infarction was 0.54, a far higher protective effect than the 0.75-0.88 odds ratio for death achieved by the conventional standard treatments for myocardial infarction, including thrombolysis, aspirin, β blockers, and statins. Smoking cessation also reduces the risk of death after a stroke and of death from pneumonia and influenza. Smoking is associated with an accelerated rate of decline in lung function with age. Cessation results in a small increase in lung function and reverses the effect on subsequent rate of decline, which reverts to that in non-smokers. Thus, early cessation is especially important in susceptible individuals to prevent or delay the onset of chronic obstructive pulmonary disease. In patients with this disease, mortality and symptoms are reduced in former smokers compared with continuing smokers. Recent evidence shows that the benefits occur even in older patients with severe chronic obstructive pulmonary disease.

According to WHO¹, some of the key measures to reduce the demand for tobacco are: Implementing smoke-free laws that protect people from exposure to second-hand smoke, which is also a major health risk. Displaying large pictorial or graphic health warnings on tobacco products and plain packaging to inform people about the dangers of tobacco use and discourage them from starting or continuing to use tobacco. Increasing taxes on tobacco products to make them less affordable and reduce consumption, especially among young people and low-income groups. [6,7]

Providing cessation services and support to help people quit tobacco use, such as counseling, medication, quit lines and mobile applications.

Educating and raising awareness among the public, especially young people, about the health risks and social costs of tobacco use and the benefits of quitting. Enforcing bans on tobacco advertising, promotion and sponsorship to prevent the tobacco industry from influencing people's attitudes and behaviors towards tobacco use. These measures are in line with the WHO Framework Convention on Tobacco Control (WHO FCTC), which is a global treaty that aims to protect present and future generations from the devastating consequences of tobacco consumption and exposure¹. The treaty has been ratified by 182 countries as of 2021. The WHO also provides guidance and technical assistance to countries to implement the treaty and monitor its progress. At a population level, the importance of smoking cessation is paramount. It has estimated that current cigarette smoking will cause about 450 million deaths worldwide in the next 50 years. Reducing current smoking by 50% would prevent 20-30 million premature deaths in the first quarter of this century and about 150 million in the



second quarter. Preventing young people from starting smoking would have a more delayed but ultimately even greater impact on mortality. [4,9,10]

Effective prevention of cigarette smoking and help for those wishing to quit can therefore yield enormous health benefits for populations and individuals. Promoting and supporting smoking cessation should be an important health policy priority in all countries and for healthcare professionals in all clinical settings. However, this has not so far generally been reflected at a policy level or in the practice of individual healthcare professionals

Second-hand tobacco smoke is the smoke emitted from the burning end of a cigarette or from other smoked tobacco products (such as bidis and water-pipes) and the smoke exhaled by the smoker. More than 4000 chemicals have been identified in tobacco smoke and there is no safe level of exposure to second-hand tobacco smoke. Based on the scientific evidence, the Conference of the Parties to the WHO Framework Convention of Tobacco Control (WHO FCTC) has concluded that 100% smoke-free environments are the only proven way to adequately protect the health of people from the harmful effects of second-hand tobacco smoke. Smoke-free laws protect the health of non-smokers and are popular, as they do not harm business and they encourage smokers to quit. [3,5]

Quitting tobacco: when tobacco users become aware of the dangers of tobacco, most want to quit. However, nicotine contained on tobacco products is highly addictive and without cessation support only 4% of users who attempt to quit tobacco use will succeed. Professional support and proven cessation medications can more than double a tobacco user's chance of successful quitting.

HTPs are, like all other tobacco products, inherently toxic and contain carcinogens. They should be treated like any other tobacco product when it comes to setting policies. HTPs produce aerosols containing nicotine and toxic chemicals upon heating of the tobacco, or activation of a device containing the tobacco. HTPs have been promoted as reduced harm products or products that can help people quit conventional tobacco smoking. HTPs expose users to toxic emissions, many of which cause cancer and currently there is not enough evidence to suggest that they are less harmful than conventional cigarettes. There is also insufficient evidence at present on the effects of second-hand emissions produced by HTPs, though the emissions from these products contain harmful and potentially harmful chemicals.

E-cigarettes: the devices known as electronic nicotine delivery systems (ENDS) and electronic non-nicotine delivery systems (ENNDS) heat a liquid to produce an aerosol that the user then inhales. Children and teenagers should avoid using e-cigarettes since nicotine is very addictive and young people's brains continue to grow until they are in their mid-20s. WHO recommends that the products be regulated in accordance with 4 key objectives: prevent non-smokers, minors, and vulnerable groups from beginning to use ENDS/ENNDS; minimize health risks for ENDS/ENNDS users and protect non-users from exposure to their emissions; prevent the making of unproven health claims about ENDS/ENNDS; and protect tobacco control from all commercial and other vested interests related to ENDS. When adolescents vape, they inhale a heated aerosol that often contains nicotine using a device like an e-cigarette.[2,3,4]

Material and methods

This study was conducted through an online questionnaire made using Google forms. The respondents were kept anonymous to preserve the authenticity of the data. The pie-charts



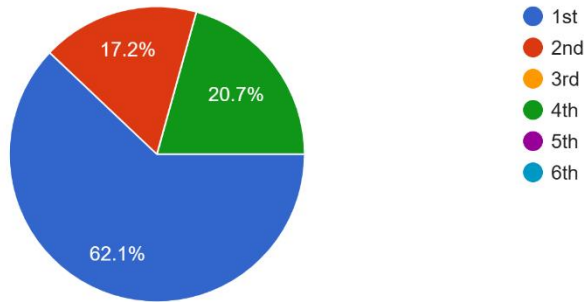
below exhibit the results gathered. The target respondents are the young students of Tashkent Medical Academy.

Result

The survey was conducted online through google forms and a total of 30 responses were recorded. Of those, students of first course (62.1%), second course (17.2%), and third course (20.7%) participated.

What course are you in?

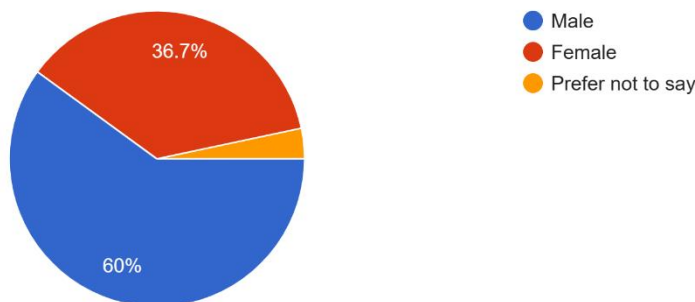
29 responses



60% of the participants were male and 36.7% were female.

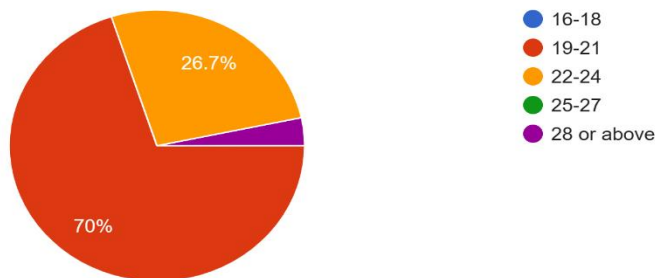
Please specify your gender?

30 responses



What is your age group?

30 responses

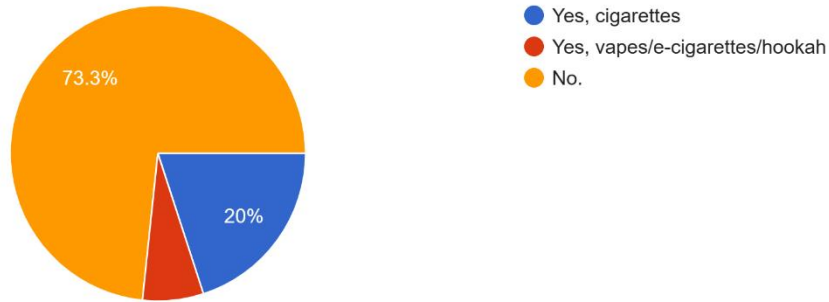


Most of the respondents are 19-24 age group.



Do you smoke?

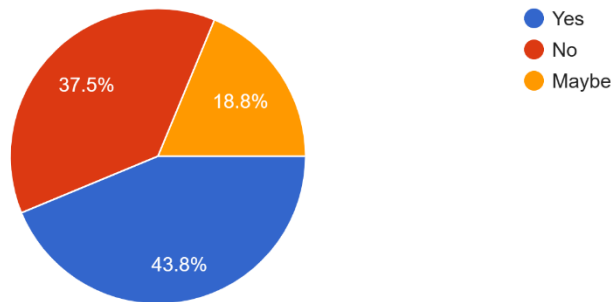
30 responses



Majority(73.3%) of the respondents do not smoke while 20% smoke cigarettes, some (6.5%) engage in vaping.

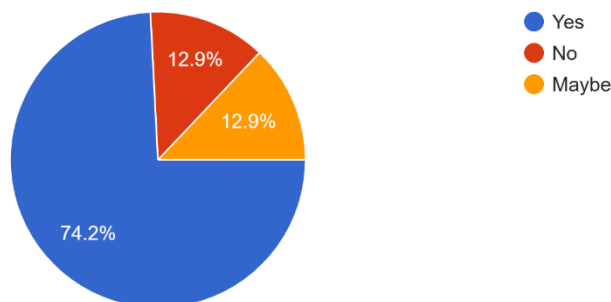
If yes, do you want to quit smoking?

16 responses



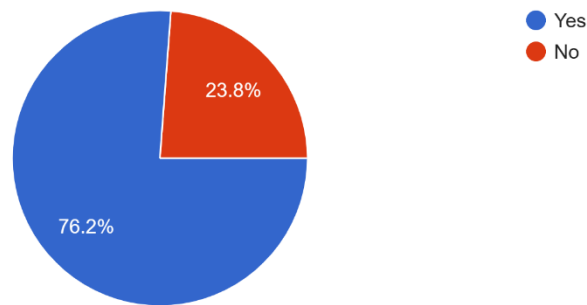
Do you have an idea of the adverse health effects of cigarettes/vapes etc.?

31 responses



Were you aware of the dangers of smoking when you started smoking?

21 responses



Conclusion

Majority of the students knew the adverse health effects of smoking yet the still choose to smoke, almost half of the respondents want to quit smoking while some do not and the others are undecided.

This study may not be completely accurate as students may have randomly marked or intentionally marked fallacious answers to refrain from disclosing their personal details despite the form being completely anonymous.

Acknowledgements

We need to educate our youth better about the pitfalls of smoking.

We need to make improved programmes for helping smokers quit early on before health complications arise.

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