# WOMEN AND TOBACCO

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# Women and tobacco

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The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this organization, which was created in 1948, the health professions of some 170 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

By means of direct technical cooperation with its Member States, and by stimulating such cooperation among them, WHO promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of human resources for health, the coordination and development of biomedical and health services research, and the planning and implementation of health programmes.

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Progress towards better health throughout the world also demands international cooperation in such matters as establishing international standards for biological substances, pesticides and pharmaceuticals; formulating environmental health criteria; recommending international nonproprietary names for drugs; administering the International Health Regulations; revising the International Statistical Classification of Diseases and Related Health Problems; and collecting and disseminating health statistical information.

Reflecting the concerns and priorities of the Organization and its Member States, WHO publications provide authoritative information and guidance aimed at promoting and protecting health and preventing and controlling disease.

# Preface

This book represents the consolidation of a number of activities undertaken by WHO in recent years to review the available evidence on tobacco use by women and to identify the most promising strategies for tobacco control.

The events leading to the publication of this book began on 31 May 1989, the second World No-Tobacco Day, when a round-table meeting on "women and tobacco" was held at WHO headquarters in Geneva. It was subsequently agreed that the proceedings of this meeting should be edited and a paper produced on the subject. In the course of the preparation of this paper, it became clear that the subject deserved more extensive consideration. Accordingly, information on women and tobacco was gathered from a variety of countries and a draft monograph was produced. The monograph was reviewed by a group of experts who met in Geneva from 10 to 14 June 1991, following which it was revised.

This book is intended to inform all those concerned with this previously under-researched and under-publicized subject. It is primarily aimed at decision-makers and, in particular, at the staff of ministries of health, education, labour and social welfare, legislators, nongovernmental organizations and community leaders. It is also expected that this monograph will prompt the opening of new avenues of research and the more systematic documentation of issues relating to women and tobacco.

# Author and editorial advisers

## Author

Dr Claire Chollat-Traquet joined the World Health Organization in 1974; at present she is a scientist with the WHO Programme on Tobacco or Health.

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Leading experts on tobacco control have provided information and acted as advisers for this book. Their contribution is gratefully acknowledged.

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# Contents

# Chapter 1

# Women and tobacco: the issues at stake

Women smokers are numbered in millions throughout the world, and several million more are dependent on tobacco used in other ways. The number of women smokers increases daily, not only because of the world's fast-growing population, but also because smoking cigarettes is being fostered and encouraged worldwide for commercial gain and, in spite of incontrovertible evidence on the toll of death, disease, and disability that is being caused, many governments have remained ambivalent towards a problem that has implications for excise and tax revenue, health and welfare expenditure, and political expediency.

The incidence of smoking-related diseases and concomitant death rates have increased rapidly among women in many developed countries in recent years. In most countries, there are no epidemiological indications of a likely decrease in the near future and the continuing uptake of smoking in these countries gives cause to expect a continuing increase in both disease incidence and death rates. In most developing countries, cigarette smoking, so far maintained at a low level, is being fiercely promoted by the tobacco companies. As more women become dependent on tobacco, the effect will be an inexorable toll on health and well-being; and the impact will be such as to prevent the achievement of WHO's goal of health for all by the year 2000.

Tobacco use can be compared to an epidemic; it spreads within societies and from one society, and one population, to another. There follows in its wake an epidemic of smoking-related disease, albeit after a lapse in time. In the absence of tobacco, some diseases such as lung cancer might be almost nonexistent in women, and others such as ischaemic heart disease and chronic lung disease would be rarer.

Until recently, the incidence and mortality rates from smoking-related diseases had been much lower among women than

among men and suppositions that women may be more resistant to tobacco have arisen. It is now clear, however, that women are not only susceptible to the same tobacco-related diseases as men, but are also affected by other specific conditions.

In the developed countries, where smoking by women is well established, the challenge is twofold: to halt the rapid escalation in tobacco dependence that is currently occurring in many areas and to register more success in reducing the prevalence and intensity of smoking by women.

There are many areas of the world, particularly in the developing countries, where tobacco use is still at a low level and may as yet even be nonexistent among women. Here is where future disease could be effectively prevented. There is, however, a lack of knowledge on tobacco use by women in most countries and efforts to obtain more factual information are needed so that countermeasures can be developed and used more effectively.

While there is a need for further information, there is sufficient evidence for public health action on tobacco use by women not to be delayed. This monograph is thus intended to provide background information on a wide range of aspects of smoking by women and to identify the strategies available to combat the growing problem of tobacco use among women.

Chapter 2

# Women and tobacco use: patterns and trends

Tobacco is the single largest cause of premature adult death throughout the world. Over the next 30 years tobacco-related deaths among women will more than double, so that by the year 2020 well over a million adult women will die every year from tobacco-related illnesses. Currently, in the developed world, the prevalence of smoking among women is approximately 20–35%, whereas in the developing world, it is estimated at 2–10%.

In the developed countries, smoking by women was socially unacceptable for many years. However, by the mid-20th century, in most developed countries, smoking by women had increased rapidly. As the health hazards of tobacco became apparent, the prevalence of smoking among men declined in some developed countries. Prevalence rates among women did not begin to decline until later and then only in a few countries; the two rates are currently converging in several countries. Today, in many developed countries, smoking is predominantly a practice of young women, women with limited education, and women of low socioeconomic status.

In the past, cultural norms were a powerful deterrent to women's smoking in the developing world, although there have always been areas in which women have practised traditional forms of tobacco use. Currently, in the developing world, smoking is linked with a cosmopolitan and affluent life-style. With increasing urbanization and career-oriented education, and increasing spending power, many young women who aspire to this life-style have taken up smoking. There is grave concern that these aspirations, fuelled by aggressive tobacco marketing, will result in increased prevalence rates among women in developing countries, further compounding their present difficulties.

This chapter provides the statistical evidence for urging strong tobacco control efforts in both the developed and developing world to decrease the epidemic of tobacco use among women. While there is already enough evidence to justify urgent action, knowledge of the overall situation among women in developing countries is hampered by cultural reticence to admitting to tobacco use and by the scarcity of survey data. To complement tobacco control interventions more effectively and to monitor future trends, continuous surveillance will be needed.

Tobacco (*Nicotiana*, a member of the Solanaceae family) is a native plant of the Americas, where it was used for ceremonial and medicinal purposes for thousands of years by many of the indigenous populations. It is believed that the practice of smoking was also known in Asia long before Columbus visited the New World. Tobacco was one of many plants brought from North America to Europe in the 1500s by the early European explorers and the use of tobacco quickly spread through the European populations. Tobacco was also introduced to other continents as early as the 1600s by explorers and missionaries. In Europe, Portuguese men were the first users of tobacco (usually smoked in pipes), but European women also used tobacco, both in pipes and as snuff. During this period, arguments for sexual equality were already being made to gain permission and social acceptability for women's smoking.

The advent of machine-manufactured cigarettes in the late 1800s was a major factor in cigarettes becoming the dominant form of tobacco use in the early twentieth century. Colonization in many parts of the world brought about dramatic changes in agricultural patterns; colonized countries were encouraged to grow tobacco, and they continued to do so after independence because of the substantial earnings from tobacco exports, making it the most widely grown commercial non-food plant in the world. Through exploration, advertising, marketing, and widespread tobacco cultivation, cigarette use continued to spread throughout the world, and progressively became superimposed upon traditional tobacco uses.

Smoking has not always been socially acceptable for men and it has been even less so for women. In 1606, two University Decrees were issued by Cambridge University which prohibited any student or other member of the University from drinking excessively or using tobacco. During the 1800s and early 1900s, tobacco use by women and children was largely unacceptable. In most developed countries, smoking by women was considered to be vulgar, improper and even immoral, and the anti-smoking movements in several countries were often led by women or women's organizations. Opponents of tobacco believed that it exploited the poor and was immoral, unhealthy, hazardous and unfeminine; however, such attitudes began to change with the coming of women's emancipation, combined not only with their increasing employment in paid occupations but also their development of careers of their own and a decreasing dependence on men for their livelihood.

During the First World War, sending cigarettes to soldiers was deemed patriotic, which effectively put an end to the organized anti-smoking movement. As women became more emancipated in North America and Europe, through suffrage and dress reform, smoking became increasingly acceptable.

In the 1920s, women started smoking in public as a sign of emancipation and equality, although they smoked considerably fewer cigarettes than men (2.4 versus 7.2 cigarettes per day on average in the United States in 1929). Smoking became fashionable in the 1930s, particularly among women in the cities; in the United States, 18.1% of women and 52.5% of men were smokers by 1935.

During the Second World War, as women contributed to the national war effort, smoking by women became associated with going out to work, and with independence, emancipation and patriotism. Women were not only working like men, but adopting their behaviour as well. After the war, the prevalence of smoking among women was about 40% in the United Kingdom, 30% in Australia and 25% in the United States.

- In the United Kingdom, by 1950 the prevalence of smoking was 38% for women and 62% for men. Prevalence rates among women reached 45% in 1966 before starting to fall as the risks of smoking became evident (*1*).

Although some studies had been carried out in 1939 and in the 1940s (mainly in Germany and the Netherlands), there was little scientific evidence on the harmful effects of tobacco use until the 1940s. In 1950, it began to be recognized that cigarette smoking was associated with serious disease risks. A number of studies carried out in the United Kingdom and the United States showed an association between smoking and certain forms of cancer, particularly lung cancer.

Nevertheless, cigarette sales continued to increase throughout the developed world until the mid-1970s, when information campaigns against tobacco began to take effect. During the 1970s and 1980s, stagnation in the growth of the global tobacco economy due to reduced demand became evident. As profits are threatened, the tobacco industry has started massive marketing in the developing countries. Long-term expansion will be seen in developing countries because of their dependence on the substantial export earnings from tobacco and revenue from domestic use. Moreover, the public health campaigns about the hazards of tobacco use are at an early stage in many developing countries.

In some countries, the change from traditional forms of tobacco use can be seen as recently as during the last 20 years. In Bangladesh the majority of smokers used hookah in the 1970s, while the recent smokers are beginning to take up bidi smoking.

# Global overview

## Tobacco use

The foremost way in which tobacco is used throughout the world is for smoking in cigarettes, but in some developing countries, although cigarette use has increased since the 1940s, other traditional uses continue to predominate, particularly among rural and isolated communities.

Tobacco use can be classified under six principal headings: as cigarettes, bidis, cigars, pipe tobacco, snuff and for chewing. There are variants of usage within each group. Thus, for example, in addition to manufactured ("white") cigarettes, kreteks (cigarettes containing tobacco and cloves) are smoked in Indonesia, and papyrosi (cigarettes in which the conventional tip is replaced by a long paper tube) are smoked in many parts of the USSR.

The tobacco in manufactured cigarettes is cut in very thin strands, approximately 1 mm in diameter, and a form of "fine cut" tobacco is sold loose for smokers to roll their own cigarettes. Hand-rolled cigarettes usually yield more tar and nicotine, because the tobacco is stronger and the paper used is also thicker and less permeable than the wrapper of manufactured cigarettes; on the other hand, they often contain less tobacco than manufactured cigarettes.

The bidi (beedi, biri) is common throughout south-east Asia and consists of tobacco flakes or powder, loosely packed and rolled in a dried tendu or temburni leaf. The dhumti in India is similar, but the tobacco is rolled in a leaf of the jackfruit tree. Other bidi-like smoking devices may have banana leaves or even newspaper as the wrapper.

Cigars are made from cured tobacco leaves rolled and wrapped in a dried tobacco leaf and are produced in a variety of shapes and sizes. They are also known by different names in different localities: e.g. the cheroot and chutta in India; and khi yo, ya muan and tra kai in regions of Thailand. All these traditional smoking devices tend to use oriental or native varieties of tobacco and the smoke is invariably extremely strong, containing high levels of tar, nicotine and carbon monoxide.

Pipe smoking, probably the oldest recorded form of smoking, is practised in almost all countries and the shapes and names for pipes are legion. However, one variety of pipe common to almost all countries in the Eastern Mediterranean and parts of Asia is the water pipe (hookah, goza or hubble-bubble), a device in which the smoke bubbles through water before being inhaled. The hookah apparatus also has many shapes, sizes and names in different countries or areas in which it is common. Hookah tobacco shows regional variations;