Women and Tobacco: International Issues

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Most women live in the developing world, and of these, between 2% and 10% smoke cigarettes, although in some regions women more commonly chew tobacco. There can be no complacency about the lower level of tobacco use among women; it does not reflect health awareness, but rather social traditions and women’s low economic resources. The number of women smokers will inevitably increase: the female population in developing countries will rise from the present 2.1 to 3.5 billion by 2025, women’s spending power is increasing, the tobacco companies are targeting women n governments may be less aware of the harmfulness of smoking and are preoccupied with other health issues, and woman-specific health education and quitting programs are rare. Tobacco-related health problems have hitherto been masked by women’s shorter life expectancy, but rural women who become sick from tobacco-related diseases have extremely limited access to health care. In addition, tobacco inflicts a particularly heavy economic burden on women in developing countries. Women’s health organizations in Western countries have a special responsibility in addressing, reducing, and preventing further expansion of the global tobacco epidemic among women.

The tobacco epidemic began later among women than men in developing countries and later than among women in developed countries. Currently, between 2% and 10% of these women smoke cigarettes, compared to 25% to 30% of women in developed countries. There are considerable variations, however, and underreporting of smoking may be significant where it is culturally less acceptable.

Several explanations have been offered for lower tobacco consumption among women in developing countries: Girls start smoking later than boys and smoke fewer cigarettes (as in developed countries). With some exceptions, (areas of India, Nepal, Papua New Guinea, northern Thailand) smoking has been considered socially unacceptable for women. There may be religious constraints against smoking as in Islamic countries. Women have less spending power than men. Women may be more inclined to use available money to buy food for their families. Rural women may adhere to traditional ways of smoking, such as hubble-bubble pipes or, in central Asia and parts of the Middle East, chew tobacco.

Regional Cameos

Africa. Data are available from only 25% (12 out of 52) of African countries. Some of these studies, as in Ethiopia, were conducted in the 1970s, and most were undertaken on a select group, such as students or urban dwellers. Smoking rates vary, but overall it is estimated that about 10% of African women smoke. Studies from the few countries where more than one survey has been undertaken show a rising trend, especially in urban areas. In Mauritius, for example, female:male smoking ratio has changed from 1:7 in 1960 to 1:3.5 in 1987.

Latin America. The 1992 US Surgeon General’s Report Smoking and Health in the Americas collated data from 150 surveys in Latin America and the Caribbean. Lack of standard sampling resulted in variable prevalence rates of between 3% and 49%, but overall, smoking is lower among women than among men.

Central (South) Asia. The prevalence of cigarette smoking is very low among women. Only 3% of women smoke manufactured cigarettes, but 50% to 60% of women chew tobacco in many areas of India, and rural women smoke the kretek, dhumti, khi yo, ya muan, chilum, and water pipe, and “reverse smoke” bidis and chutta, with the lighted end inside the mouth.

Asia-Pacific. Although the overall smoking rate is estimated to be less than 10%, there are wide variations. For example, 80% of women in Papua New Guinea smoke, and rates are also high among women in the Pacific Islands. Only 7% of women in China smoke, and less than 5% in Hong Kong. Malaysia, Singapore, and Thailand. Tobacco chewing is uncommon.

Eastern Mediterranean. Smoking in women is often considered vulgar, improper, even immoral. Only 2% of Egyptian women smoke compared with 33% of men. In the Gulf region, about 8% of women smoke in contrast to 33% of men.

Central and Eastern Europe. According to the World Health Organization (WHO), prevalence rates in some countries (Czechoslovakia, Hungary, Poland, and Yugoslavia) are similar to those of western Europe—about 20% to 30%. In Rumania and Russia, where it is less acceptable for women to smoke in public places, the rates are much lower (1% to 13%).

Consequences of Smoking for Women in Developing Countries

Health Hazards. As the tobacco epidemic among women in developing countries is at an early stage, the health consequences are not yet very evident. Also, tobacco-related health problems have hitherto been masked by women’s average shorter life expectancy—currently 65 years, still 13 years shorter than for women in developed countries. Annual tobacco-related deaths are currently estimated at 3 million, 2.5 million in developed and 0.5 million in developing countries. About half a million of these 3 million deaths occur in women, mostly in developed countries. In almost all countries, female deaths due to smoking are increasing and will more than double over the next 30 years, so that by the...
year 2020 more than a million women will die every year from tobacco-related diseases. Women are at particular risk from passive smoking, as a high percentage (50% to 60%) of men in developing countries smoke, and extended families live in close proximity.

When rural women become ill from tobacco-related illnesses, 80% of them have no, or extremely limited, access to health care. In developed countries there is one doctor for every few hundred people. In the poorest countries, more than 20,000 people have to share one doctor. Even this figure masks inequalities within a developing country, where 80% of the doctors work in the urban areas, and the rural poor are often left without any medical care. In most of South America, for example, 80% to 90% of the urban population has access to health care in contrast to less than 40% of the rural population.

Risks of smoking to mother and fetus increase where maternal health is poor and where access to health care is limited. Half a million women still die each year in childbirth, 99% (all but 4,000) in poor countries. Problems associated with smoking and oral contraceptive use are also compounded by lack of access to health care and information. The decrease in fertility associated with smoking may affect a woman’s marital status in countries where large families (and the birth of sons) are important. No studies on the effects of smoking on the menopause can be traced in developing countries, although in general women stay physically active and may therefore be less at risk of osteoporotic fractures.

**Economic Impact.** The money that a woman (or her husband) spends on cigarettes can be a financial drain on herself and her family. Philippine smokers of 20 cigarettes a day can spend 35% of median household income on their habits. One report commented that a “Filipino spends more on alcohol and cigarettes than on his medical needs and the education of his children” (Business World, May 11, 1989). It is estimated that $6.9 billion is spent on cigarettes each year in China, a sum that would buy 71 million tons of grain, 11 millions tons of edible oil, several millions tons of pork, or 7.5 millions tons of eggs (China Daily, April 15, 1992:4).

Governments in developing countries fund only 40% of health expenditures, compared to 58% in developed countries, leading to economic hardship for the family. If a husband dies from smoking, women (wife, mother) and children can be left in poverty. If the woman dies, the children can be left destitute. The national costs of smoking indirectly affect women—the costs of death and disease, lost productivity and absenteeism, fires, costs of the misuse of land that could be used to grow food, loss of foreign exchange spent importing tobacco (with two-thirds of developing countries spending more on importing tobacco than exporting it), even the costs of removing smokers’ litter.

**Starting and Continuing to Smoke**

Studies show that girls in the developing world start smoking for much the same reasons as do girls in developed countries. One study on high school students in ten schools in Indonesia showed that although knowledge of the harm of cigarettes is similar among youthful smokers and nonsmokers, they differ in their perception of the social image of smoking. Studies in China highlight the lack of knowledge on the dangers of smoking. In Hong Kong, only one-third of girls who smoked were aware of the association between smoking and cardiovascular disease. Other likely reasons for increasing tobacco use among all populations, including women, are the affordability of cigarettes, the accessibility of tobacco, and lack of restrictions on tobacco advertising and other promotion.

As smoking decreases in the West, the tobacco industry is aggressively targeting women and girls with expensive and seductive advertising that blatantly exploits ideas of independence, power, emancipation, and slimness. Although the tobacco industry argues that cigarette advertising only encourages brand switching, the launching of Virginia Slims in Hong Kong provided a good example of an attempt to create a market, as less than 2% of women under the age of 40 were smokers. The tobacco companies sponsor tours by female pop stars, such as Paula Abdul, to developing regions and even produce yearly calendars in the Philippines (a strongly Catholic country) featuring (the religious) Madonna amidst packets of cigarettes. A US comprehensive study showed that tobacco advertising revenue prevents the media from reporting the risks of smoking; this is of particular concern in developing countries, where awareness of the harmfulness of smoking is low, sometimes even nonexistent.

The US government has threatened Asian countries with trade sanctions that would force them to open their markets and allow US tobacco companies to advertise, leading to the replacement of a simple rural industry by powerful, sophisticated transnational companies. Evidence indicates that this is leading to a sharp increase in market share of foreign cigarettes and also to increased smoking among youth (China Post, November 14, 1992:16).

**Tobacco Reduction Strategies**

WHO has recommended that prevalence of tobacco use, attitudinal surveys, mortality and morbidity be monitored separately for men and women in order to identify risk groups and plan appropriate, possibly separate, interventions. Health education programs often start only in secondary schools and rarely include any gender focus. Most health education concentrates on “death and dying” messages related to cancer and other medical problems. This may be effective in persuading middle-age smokers to quit, but seems to be less effective in preventing youth from taking up the habit.

Tobacco control policies and measures, such as bans on tobacco promotion, tobacco price policies, sales restriction, health warnings, the creation of smoke-free areas, and health education generally lag far behind those of developed countries. Men are perceived to be the ones with the immediate problem, so most health education programs are directed at them. Woman-specific campaigns are rare and principally concen-
The Role of the Tobacco Control Movement in Preventing and Reducing Smoking among Women

The Role of the Health Professional.

Studies on 9,326 medical students from 43 countries found low smoking prevalence rates among women in Africa, the Middle East, and Asia, reflecting smoking rates in the general population. The authors reported sweeping ignorance of the causal role of smoking in specific diseases and widespread defects in knowledge of the doctor’s role in quitting advice or understanding of national measures.27 Health professionals in universities and nursing colleges should ensure that medical information, advice on quitting, and advocacy is included in the curricula. At a minimum, health professionals can write letters to the press, politicians, government, and decision-makers; participate in public rallies; appear on the media; and give talks to schools.

There are no cancer or heart societies in many countries, but where they exist, they should make firm public statements on smoking, act as government advisors, make their premises and conferences smoke free, and dedicate funds and personnel to supporting tobacco control action.

Women in Leadership Positions. There are very few women in senior, decision-making positions in the tobacco control movement. There are few women on editorial boards of most medical journals, on the WHO Expert Advisory Panel on Tobacco or Health, or in senior roles in most of the nongovernmental organizations that deal with tobacco issues. At the 1994 9th World Conference on Tobacco or Health in Paris, women made up a minority of committee members, and there were six men but not a single woman on the stage at the closing ceremony. As long as women are so severely underrepresented, the issue of women and smoking will not achieve its appropriate prominence and action. In 1990, the International Network of Women Against Tobacco (INWAT) was formed by women from about 60 countries to promote women to decision-making positions, as well as to counter targeted marketing and promotion, and to assist in the development of women-centred tobacco prevention and cessation programs.

The Future

There can be no complacency about the lower level of tobacco use among women; it does not reflect health awareness, but rather social traditions and women’s low economic resources. The number of women who smoke will increase if only for demographic reasons, as the female population in developing countries increases. As women’s economic situation improves, cigarettes will become more affordable for girls and women if regulatory measures are not taken to increase tobacco prices. Also, as life expectancy increases, the effects of the tobacco-related epidemic will become more obvious. The historic pattern from developed countries is that the female epidemic follows the male epidemic after a lag of several decades. There are already strong indications this is happening in developing countries.

Recommendations for Reducing Smoking among Women

The strategy to reduce tobacco use among women globally can be summarized by an approach that:28

1) Recognizes that research is urgently needed to identify profiles of female tobacco users in developing countries. Until this is done, health educators cannot plan appropriate programs.

2) Includes gender sensitivity in every aspect of tobacco research, prevention, and cessation.

3) Counter the companies’ marketing and promotional strategies.

4) Designs gender-specific, positive, health education and quitting programs.

5) Involves girls and women’s groups and publications.

6) Works toward legislative change, specifically related to smoking reduction but also to improving and equalizing women’s social, work, and financial situations.

7) Actively promotes and recruits women’s participation in the senior decision-making processes of tobacco control.

8) Advocates a national coordinating body focusing on women and smoking.

9) Actively seeks to avoid global transfer of the problem to developing countries.

The greatest public health opportunity to prevent noncommunicable diseases worldwide is to prevent a rise in smoking among women in developing countries.

The Role of Developed Countries

Health organizations in the United States and other developed countries have a special responsibility to continue and expand the following roles:

1) The exemplar role. Despite having only 4% of the world’s population, the United States has a worldwide presence and can effectively export the message that smoking rates can be, and have been, reduced.

2) The political role. Stressing the importance of political will to reduce the epidemic.

3) The sharing role. Sharing experience, expertise, and funds; the essential elements of a national tobacco control policy are similar throughout the world.

4) The supportive role. Supporting tobacco control measures in developing countries and lobbying the US government to ensure that trade sanctions are not used to force developing countries to advertise Western cigarettes.

Ten years ago, virtually no developing country had implemented significant tobacco control measures. Now, with assistance from colleagues in the United States and other Western countries, all countries in the Asia Pacific region, for example, have introduced health education on smoking. Most developing countries have a national tobacco control coordinating agency, and many have enacted legislative measures. Although the female tobacco epidemic will get much worse before it begins to improve, measures are beginning to be put into place that will eventually reduce this global epidemic.

References

2. Egebeleye OO, Femi-Pearse D. Incidence and variables contributing to the onset of cigarette smoking among secondary school children and medical students in Lagos, Nigeria. Br J Prev
17. Findings of Research into the Behaviour and Attitudes of Junior High School Pupils Aged 10-16 Years in 10 Schools towards Smoking by SRI Indonesia Heart Foundation; 1990.