Tobacco: A Menace to Women's Health

There are currently more than a billion smokers in the world. The World Health Organisation (WHO) estimates that there are four million deaths a year from tobacco, a figure expected to rise to about 10 million by 2030. By that date, 70 percent of those deaths will occur in developing countries. Although some trends are encouraging, such as the declining consumption of tobacco by men in developed countries, smoking is sharply increasing among men in low- and middle-income countries. Currently, smokers in Asia consume nearly half of the world's cigarettes.

In the 1990s, about 12 percent of women smoked in the Asia and Pacific region compared to 47 percent of men. However, the rates for women are rising rapidly. In the regions of America and Europe, the prevalence of smoking for women is the highest at over 20 percent but as high as 30 percent in countries such as Denmark, Norway, the Czech Republic, Fiji, Israel and the Russian Federation. In several countries, it is already the single most important preventable cause of premature deaths in women, accounting for a third of all deaths in women between ages 35 and 69.

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In industrialised countries including Denmark, Germany and the United Sates, more young women aged 14 to 19 years now smoke compared to young men. The same is true for many Asia and Pacific countries where smoking is a symbol of women's liberation and freedom from traditional gender roles. Moreover, there is popular belief among young women that smoking keeps them slim.

There is even greater cause for alarm because statistics on cigarette consumption do not reflect the widespread use among rural women. For example, in Kerala, India, 22 percent of rural women chew tobacco in *pan* (betel leaf). They also smoke *bidis* (small indigenous cigarettes) and *hookahs* in the Bihar region and parts of Punjab and Harayana. Rural Indian women in Goa rub and plug burnt powdered tobacco inside their mouths.

Health risks for women and girls who use tobacco

Women who use tobacco face virtually the same risks as men and, in some cases, even more. In the U.S., lung cancer has surpassed breast cancer to become the leading cause of cancer mortality among women. Worldwide, lung cancer currently accounts for over 10 percent of cancer deaths in women. Furthermore, women may be more susceptible to the effects of tobacco carcinogens than males. Some studies have shown women smoking the same number of cigarettes as men have higher rates of lung cancer.

Smoking is also one of the major causes of coronary heart disease (CHD) in women, accounting for perhaps the majority cases in women under age 50, and the risk increases with the number of cigarettes smoked and duration of smoking. The risk of CHD increases among women smokers who

use oral contraceptives. Among postmenopausal women, current smokers have lower bone density than non-smokers and they have an increased risk of hip fracture.

Health risks vary according to what kind of tobacco product is used. Unfortunately, many young women experiment with pipes, cigars, smokeless tobacco and roll-your-own cigarettes. All are hazardous to their health. For example, the late-life lung cancer death rates for those who smoke about five cigars a day and inhale moderately approximate lung cancer death rates for cigarette smokers who start smoking at age 18 and smoke one pack a day through their lives. Lung cancer death rates among cigar users who do not inhale cigar smoke are higher than the rates for those who never smoke.

Despite the many known health risks, smokeless tobacco use has been high among women in south Asia where 10 to 50 percent of women of reproductive age are users. In industrialised countries, it is currently more a male habit. However, in Sweden and the United States, smokeless tobacco use has increased dramatically over the last decade among young people. For example, in 1995, about 25 percent of white high school males across the U.S. reported regular use of smokeless tobacco. Nicotine in blood levels from daily use approximate those of daily cigarette consumption.

As cigarette taxes rise, some individuals turn to rolling their own cigarettes, either by hand or with a small rolling machine as a cost-saving effort. A 1998 report by Darrall & Figgins showed that more than 20 percent of United Kingdom smokers use roll-your-own products, accounting for some 3,050 tons sold in 1994. Evidence exists that hand-rolled cigarettes increase the risk of esophageal cancer, as well as cancer of the mouth, pharynx, and larynx.

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Smoking and reproductive health

Adolescent girls and women who smoke when pregnant are in double jeopardy. Epidemiological studies indicate that maternal smoking accounts for the majority of sudden infant death syndrome (SIDS) cases. The relationship of smoking and SIDS is stronger than that seen with any other drug of abuse. When both the father and mother smoke, there is a greater risk of asthma, bronchitis, colds, ear infections and pneumonia in the children. However, if all pregnant women stopped smoking in the U.S., the number of foetal and infant deaths would be reduced each year by approximately 10 percent.

A clear, strong dose-response relationship exists between the number of cigarettes smoked during pregnancy and low birth weight. A review of five studies representing 113,000 births in the United States, Canada, and Wales found that 21 percent of low birth weights was attributed to maternal cigarette smoking. Chewing tobacco during pregnancy has a similar effect. Maternal smoking is also associated with a higher risk of miscarriages and infertility. In one study, the odds of spontaneous abortion increased by 46 percent for the first 10 cigarettes smoked per day and 61 percent for the first 20 cigarettes smoked. Smokers were 3.4 times more likely than non-smokers to take longer than one year to conceive.

Tobacco use also affects men's reproductive health. Paternal tobacco exposure during the pre-conceptual period may induce male germ cell mutations. There is clear evidence that many agents can directly induce mutations in male animals, resulting in adverse developmental outcomes, such as reduced birth weight and growth retardation in their offspring.

Are "light" cigarettes healthier?

Cigarettes advertised as "light," "low smoke," and "less smell" attempt to diffuse the harmful and addictive effects of tobacco, and to reassure present and potential smokers that they can engage in "healthy smoking." In many countries in the developed and developing world, "lights" and "low smoke" cigarettes are the preferred brand of women who may believe that they are healthier products. The tobacco industry has exploited this belief and promoted the image of cigarettes as having low risks.

The truth is that a cigarette

is a carefully designed nicotine delivery system. Its dosage has been modified to provide an amount of nicotine sufficient to establish and maintain dependence on tobacco. Researchers have repeatedly found, over two decades, that when smokers switch to a lower-yield cigarette, they compensate by increasing their puff volume and otherwise changing their smoking parameters such as inhaling more deeply or holding the smoke for a longer period of time. Smokers of low-yield cigarettes do not consume less nicotine than other smokers.

On the contrary, recent research has suggested that they may actually be increasing their health risk, since some forms of cancer are more common among those who smoke lower-yield, "light" cigarettes. Much more research is needed on how different tar levels affect women's health.

Environmental Tobacco Smoke

Since smoking has been primarily a custom and addiction of men, that leaves women and children as the majority of the world's passive or involuntary smokers. Of the world's adults, approximately 1.1 billion—a third—are estimated to be smokers, making involuntary inhalation of tobacco smoke almost unavoidable. This can affect children even before they are born. Among approximately 130 million births a year, the number of infants passively exposed during pregnancy is estimated to be over 50 million.

There is no doubt that passive smoke is a killer. In 1981, reports were published from

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Japan and Greece that indicated increased lung cancer risk in non-smoking women married to cigarette smokers. Since then, definitive conclusions on the health effects of ETS exposure have been reached by many governmental entities, such as the Surgeon General in the United Sates, and by the World Health Organisation. There is consensus among the reports: ETS exposure causes respiratory infections in children, and lung cancer and coronary heart disease in adults. In children, ETS increases the risk of common diseases including childhood asthma, lower respiratory infections, and chronic ear disease. Exposure to parents' smoking increases risk for these diseases by as much as 50 to 100 percent.

Environmental tobacco smoke as an air pollution problem

Smoke is a serious source of indoor air pollution. More than 4,000 dangerous substances are found in tobacco smoke, and in one study, nicotine was found in cervical cancer tissues as well as in kidneys and other parts of the body. Prolonged exposure has been associated with acute and chronic health effects with a 20 to 30 percent increased risk of lung cancer if a non-smoking woman is married to a man who smokes. Studies with biomarkers (*A biomarker is a physiological substance, such as human chorionic gonadotropin or alpha-fetoprotein, that when present in abnormal amounts in the serum may indicate the presence of disease, as that caused by a malignancy; a specific physical trait used to measure or indicate the effects or progress of a disease or condition. Source: www.dictionary.com),* particularly the nicotine-metabolite cotinine, show that non-smokers, including children, have measured levels of components of ETS in their bodies from involuntary exposures.

Since the home is a predominant location for smoking, women and children are exposed to tobacco smoke as they carry out their daily lives—doing tasks at home, eating, entertaining, and even sleeping. Exposures at work, at school, and in transport may add to these exposures at home, and consequently, in many countries, women and children cannot avoid inhaling tobacco smoke. At present most countries have legislation banning smoking in public places or workplaces, but for some, the ban covers very

limited locations. Implementation of laws and regulations in some areas is ineffective. Substantial reductions in exposures for women and children in many countries may not be achieved without persuading parents, particularly fathers, not to smoke in the home.

Reducing ETS exposure

In order to protect the next generation of its citizens, each country and its health authorities must assume a primary responsibility to protect their citizens through effective tobacco control programmes. They should also enthusiastically support the WHO Tobacco Free Initiative and adopt the Framework Convention on Tobacco Control (FCTC). The focus of each member state must be on a wide-range of policy and programme activities. All countries should embrace the principle of protecting mothers, infants and children. Support for this framework would translate into an examination of existing policies within health agencies and within the public and private sector that provides services to mothers, parents, and infants.

Maternity care programmes also have a clear responsibility to provide efficient and effective methods to pregnant women to help them quit smoking. Increased attention is also needed to assist maternal and child health programmes to plan, manage, and evaluate smoking cessation programmes for pregnant smokers. The typical informational content and methods of prenatal care education related to smoking need to be significantly revised. It should include specific smoking cessation and maintenance methods to help the pregnant woman to become and remain a non-smoker.

To reduce ETS exposure of women and children, exposures need to be restricted in the key environments where time is spent. Obviously, smoking in the home is a critical source of exposure and a key target for control, and parents, particularly fathers in Asian countries, should be targeted for intervention. Homes should be smoke-free, which can be easily accomplished by changing smoking behaviours so parents stop smoking or smoke outdoors. Persons in contact with children, including workers in nurseries or day care centres and teachers, also need to be persuaded not to smoke around children. Day care centres and schools should be smoke-free. To protect working women, consideration also needs to be given to smoking in public places and the workplace.

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Addiction

Impact on young people

Although differences exist by gender, ethnicity, religion and age, there are some common factors that influence young people to start using tobacco. These are:

a) Socio-cultural, which refers to social acceptability and is expressed in the form of parental influence and peer pressure
b) Personal, which includes self-esteem, self-image, disposable income and knowledge, and
c) Environmental and economic factors like advertising and promotion, product development and marketing, access and availability, price and indoor smoke-free rules.

Most smoking starts early in life when children and teenagers may know less about the health effects of tobacco use. Young people typically underestimate the risk of becoming addicted to nicotine, and therefore grossly underestimate future costs from smoking. Even teenagers who have been told the risks of smoking may have a limited capacity to use the information wisely.

Young people try to smoke for several reasons, including using tobacco to create an identity and to appear more adult and sophisticated. They may also seek approval and acceptance by friends who smoke and want to avoid peer group disapproval. Role models who smoke are frequently seen as sociable and sexually attractive. Furthermore, adolescence is usually a period of rebellion and smoking is one of the risk-taking behaviours that may appeal to young girls. Smoking is often associated with alcohol and drug use as well as with sexual activity in female teenagers.

Being raised in a home where parents smoke may desensitise children to smoke. Parents who smoke may also facilitate their children's smoking by giving children easier

access to cigarettes or even asking them to buy tobacco products in the market. Finally, parents who smoke may be less likely to oppose their children's smoking, once peer influence prompts children to experiment.

Do girls start for different reasons? In truth, much more research is needed about the differences between why girls and boys start using tobacco. One disturbing fact is that in many countries the reasons for girls to start smoking are related to body image and a belief that smoking keeps you slim. In one study of Asian women, almost 40 percent of the respondents believed that smoking would help control body weight.

Gender differences are found in other countries as well. In one study, Indian girls noted that boys smoked to impress girls, and that some male college students believed that "a cigarette in hand makes you a man." As one girl explained, "Boys feel great if they're smoking." When asked what image young male smokers project, responses were largely positive: being modern, macho, confident, and fashion-minded. These depictions mirrored the images of men in popular cigarette advertisements in the cinema. Although many of these young women actually disliked smoking, the majority thought it would be inappropriate to disclose these feelings to a male.

As in much of Asia, smoking among women in Vietnam and China was traditionally considered to be "unfeminine" and a sign of promiscuity. However, all that is changing as young women seek ways to show their emancipation and rebellion against such values. In Vietnam, where over 70 percent of men smoke compared to 4 percent of women, there is an association between smoking and masculinity.

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Tobacco advertising and promotion

Advertising works to help recruit new users of tobacco every day. A U.S. study of junior high school students that examined their exposure to tobacco advertising in magazines found that adolescents with high exposure were more likely to be smokers than students with low exposures to advertising. Another study that reviewed 20 years of cigarette advertising found that whenever the advertising of a brand increased, teen smoking of that brand was three times more likely to increase than adult smoking.

The proliferation of seductive tobacco advertising worldwide also serves to normalise smoking and may lead women and girls to believe that smoking is a commonplace and socially desirable behaviour among females. Typically, women's brands in the developing world feature thin, beautiful Western models. Such models lend a sense of foreignness to the cigarette and can serve as symbols of prestige, quality and modernity.

To sell such images, in the United States, tobacco companies spend in excess of five billion dollars a year on marketing and promotion. Japan will account for 56 percent of Asia and Pacific spending in 1999. Faced with shrinking markets in the developed world, transnational tobacco companies have increasingly turned their focus to the developing world, with aggressive marketing campaigns aimed at women and girls.

Selling tobacco products to women, including in the Asian and Pacific countries, currently represents the single largest product marketing opportunity in the world. While marketing tobacco to women in the developing world is a relatively recent phenomenon, the industry benefits from 80 years of experience enticing women to smoke in the developed countries. Body image, fashion, and independence are themes that resound in marketing strategies and popular media. The tactics used in marketing tobacco in the United Sates and other developed nations now threaten women in the developing world.

Despite the financial crises occurring throughout Asia, transnational tobacco companies have continued to identify positive aspects of the Asian market. A recent editorial in *Tobacco Reporter* exemplifies this optimism, "The situation does not fundamentally change the underlying strengths of the

market. Rising per-capita consumption, a growing population and an increasing acceptance of women smoking continue to generate new demand." Changing gender roles combined with increases in women's earning power may lead to increased resources being directed toward tobacco consumption.

The Framework Convention on Tobacco Control (FCTC) and other UN conventions that affect women and children

The issue of women, tobacco and the Framework Convention on Tobacco Control (FCTC) should be seen in the context of other UN agreements affecting women's and children's rights to health. These can be called upon to strengthen conventions that address specific issues. The first of these was the United Nations Agreements on Human Rights.

A major complement to the FCTC that addresses women and tobacco issues should be the Convention on the Rights of the Child (CRC) and the Convention to Eliminate All Forms of Discrimination against Women (CEDAW).

Celebrating its 20th anniversary, CEDAW has been ratified by 163 states. As one of the oldest and most influential conventions related to women's rights, its history, effects on national policy and impact on women's status is important to analyse. The convention is unique among the existing human rights instruments in that it is exclusively concerned with promoting and protecting women's human rights on a wide range of a deep-rooted and multifaceted gender inequality, which exists worldwide. It also emphasises both public and private sphere relations and rights and specifically underlines the almost universal difference between *de jure* and *de facto* equality of women in the world.

Article 12 of the Convention requires state parties to eliminate discrimination against women in all aspects of their health care, including drug addiction and related problems. A main assumption of CEDAW is that the maintenance of health affects the very existence of human beings and is a fundamental need that forms the basis for securing human rights.

Role of a convention on women and tobacco

The Framework Convention on Tobacco Control will establish the legal parameters and structures of public health for women in dealing with tobacco smoking control. The FCTC will make it clear that tobacco is an essential contributor to inequality in health in all societies of the globe.

A convention like the FCTC is important because no government is legally accountable to the implementation of a policy. That is, a policy is not legally binding so that institutional or individual discretion may determine its implementation. At the international level, the Beijing Platform for Action has wonderful programmes, but it is basically a policy document for which governments are not legally accountable. Only the state parties who have signed onto international conventions such as the Human Rights Convention are legally bound.

In truth, documents and conventions are complementary. For example, most of the issues in the Twelve Critical Areas of Concern such as women's health that the Beijing Platform for Action deals with are also addressed in the Convention to Eliminate All Forms of Discrimination against Women. Paragraph 232 makes the CEDAW Committee one of the monitors of the implementation of the Beijing Platform for Action. Thus, when a state party agrees to CEDAW and also adopts a policy document, as was done in Beijing, the combination is very powerful.

Through aggressive marketing campaigns, women are enticed to smoke.

Another reason to combine the two is because there are

areas where the Beijing Platform for Action is more extensive in certain things. When the CEDAW was drafted in 1979, women and tobacco was not an issue. Similarly, violence against women was not very visible. Fortunately, the Committee has elaborated on various articles and other state party reports have come out with general recommendations on issues such as violence against women that has jurisprudence. Some people have used the general recommendation to challenge issues of violation before the court. Similarly, CEDAW, as well as the Beijing Platform, can be effectively combined with a Framework Convention on Tobacco Control that includes women.

Ensuring success for the tobacco convention

For a convention to be very effective both at the national and international levels, both the power of information in all its various forms and the power of numbers must be used. People have to be conversant with the text of the convention and also use the media to raise public awareness and international support. The power of numbers is seen in placing the convention's strategy within the context of the women's movement at the national, regional and international level.

Although situations vary enormously by country and sometimes even within a country, women have used the convention as a tool to encourage change in institutional structures at the national level. In other words, in using an international legal instrument that had been agreed upon by governments in the global arena to challenge governments to correct unjust situations at the national level, women "take the global and make it local." In this "top-down, bottom-up" approach of using international conventions, the entire national law and legislation within that country and under jurisdiction must be changed, or new ones enacted to conform to the principles in the convention. In addition, in ratifying a convention, a state agrees to international monitoring and/or reporting as to its compliance. In the case of CEDAW, compliance is very high.

Role of women's NGOs

NGOs such as the International Network of Women against Tobacco (INWAT) and the U.S. National Organisation of Women have pioneered community-based strategies. NOW distributes a video teaching module that redefines women's liberation and alerts women to their rights to health. Other groups like the Latin American women's health network have provided health information on lung cancer and smoking through their newsletters. Around the world, many health professional organisations of women physicians, nurses and scientists allied with the media have initiated community-based programmes that have contributed to women's involvement in tobacco control.

In all regions, numerous examples of women's mobilisation exist that can be directed toward tobacco control. Historically the feminist movement started in Latin American countries simultaneously with its development in the North. In the late nineteenth and early twentieth centuries, feminist leaders had already emerged in Latin American countries. Their leadership and activism improved women's status and allowed women's access to education including universities. The women's rights to health, education, labour and political participation were the main areas of concern for those feminists activists. They were pioneers in health, education and policy-making activities.

Specific examples are regional women and health networks. In 1984, in Colombia, representatives from 60 women's health groups attending the First Regional Women and Health meeting created the Latin American and the Caribbean Women's Health Network (LACWHN). During its first 10 years, the Network was coordinated by Isis International-Santiago, a regional feminist NGO based in Santiago, Chile. In 1995, by agreement of its board of directors, LACWHN became an autonomous institution and functioned currently as a foundation. The network is made up of approximately 2,000 member groups, principally from Latin America and the Caribbean (approximately 80 percent) as well as from North America, Europe, Africa, Asia and the Pacific.

Source: Avoiding the Tobacco Epidemic in Women and Youth, WHO Discussion Paper, 1999