Health and Gender

Gender and Tobacco

in the Eastern Mediterranean Region

Health behaviour does not occur in a vacuum but is influenced by normative values, lay health beliefs and the surrounding environment. In most countries, tobacco use is generally more prevalent among lower-income populations and among men and boys.

What we know

In all countries of the Eastern Mediterranean Region, there is a higher prevalence of male smokers (Table 1). However, in examining the data collected during the Global Youth Survey, it can be seen that the gap in the numbers of male and female smokers is narrowing. In fact, in Somalia, female youth currently using any tobacco product has overtaken the rate for male youth use (Table 2). For adults, the highest female smoking rates are found in Lebanon at 35%, while the highest rates for men are found in Tunisia and Djibouti, at 61.9% and 57.5%, respectively. Male smoking rates are also alarmingly high in Jordan (48%), Lebanon (46%), Palestine (40.7%) and the Syrian Arab Republic (50.6%). Evidence from high-income countries shows a decrease in the gap of life expectancy between men and women,which may be due to an increase in female cigarette smoking [1]. This phenomenon is increasing in the Region as smoking among women increases, although it will take several decades to register the real impact of female smoking on female mortality rates.

Water pipe epidemic in the Eastern Mediterranean Region

There is increasing water pipe *(shisha)* use in countries of the Region, affecting both males and females.Tobacco used in water pipes has a wide variation in nicotine content; one head of unflavoured tobacco has the nicotine equivalent of 70 cigarettes while flavoured tobacco is lower in nicotine content. It is widely believed by smokers that the smoke is purified when passing through the water [2]. Compared to cigarette smokers, water pipe users display a lower interest in quitting or appreciation of the addictive nature of this habit [3]. The health dangers of water pipe usage, as opposed to cigarette smoking, are as yet little understood by the public [4,5]. A study of 416 students at the American University in Beirut found that 13% were smokers and 28.3% were current water pipe smokers [6]. Students in the Syrian Arab Republic regard the water pipe as a popular way in which to spend leisure time socializing with friends and smoke the water pipe despite a considerable recognition of its health risks [7]. Water pipe use has spread rapidly among women. In the face of a strong taboo against female smoking, adult family members appear to be more permissive towards women smoking water pipes than cigarettes.

Different motivations for tobacco use and cessation for women and men

Research suggests that men and boys perceive greater pressure than women and girls to accept the gendered stereotype that men should be rugged, robust and strong. Such concepts lead to a dangerous combination of risk-taking and lack of preventive health activities, with relevance for tobacco uptake, quitting and self-care. In many countries, smoking marks the transition to manhood and is deeply embedded in everyday male social relations.Recent findings of the Global Youth Tobacco Survey show that although young people's use of cigarettes and other tobacco products varied dramatically, young girls are smoking almost as much as young boys.The survey also noted that girls and boys are using non-cigarette tobacco products, such as water pipes, at similar rates. These findings suggest that projections of future tobacco-related deaths worldwide may have been underestimated as they are based on current patterns of tobacco use among adults, in which women are only about

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Table 1. Adult (> 15 years) smoking prevalence (%) in the Region

Country	Male	Female
Bahrain	23.5	3.1
Djibouti	57.5	4.7
Egypt	35.0	1.6
Iran, Islamic Republic of	27.2	3.4
Jordan	48.0	10.0
Kuwait	29.6	1.5
Lebanon	46.0	35.0
Morocco	15.5	1.6
Oman	15.5	1.5
Pakistan	36.0	9.0
Qatar	37.0	3.2
Saudi Arabia	22.0	0.5
Sudan	23.5	1.5
Syrian Arab Republic	50.6	9.9
Tunisia	61.9	7.7
United Arab Emirates	18.3	< 1.0
Yemen	77.0	29.0

Source: WHO Regional Office for the Eastern Mediterranean. *Tobacco control country profiles for the Eastern Mediterranean Region*, 2003 (WHO-EM/TFI/008/E/G).

Table 2. Data from the Global Youth Tobacco Survey

Country	Ever smoked cigarettes		Currently smoke cigarettes		Currently use any tobacco product	
	Male	Female	Male	Female	Male	Female
Afghanistan	35.9	14.5	10.8	0.9	15.4	5.4
Bahrain	41.5	14.1	23.1	14.1	33.5	11.9
Djibouti	23.9	9.3	14.9	4.7	23.7	12.2
Egypt	16.2	10.7	404	3.4	22.8	15.8
Iran, Islamic Republic of	26.1	6.2	406	1.5	21	9.6
Lebanon	39.9	27.1	16.1	7.4	45.5	27.7
Jordan	49.8	35.9	25	14.8	36.5	18.4
Kuwait	37.6	17.6	21.1	6.7	33.3	39.6
Morocco	19.4	5.9	6.3	1.5	17.4	9.3
Oman	31.4	6.8	16.2	1.8	27.3	8.9
Pakistan	13.9	4.1	2.5	0.5	12.8	8.0
Palestine-Gaza Strip	56.2	24.4	18.5	3.8	24.3	6.6
Palestine-West Bank	70.4	41.4	29.4	5.9	31.8	8.3
Saudi Arabia	-	-	-	-	-	-
Somalia	23.7	20.1	10.2	11.1	26.8	33.1
Sudan	30.0	10.0	14.1	2.1	20.3	12.9
Syrian Arab Republic	15.4	6.1	8.4	3.8	23.7	15.2
Tunisia	39.0	11.8	23.1	4.2	28.7	7.2
United Arab Emirates	29.5	10.9	14.3	2.9	29.7	12.6
Yemen	19.8	10.6	7.5	3.2	21.5	14.9

Source: WHO Regional Office for the Eastern Mediterranean. *Global Youth and Tobacco Survey, 2001–2004.*

one fourth as likely as men to smoke cigarettes. The influence of peers is seen as the most important factor in the initiation of smoking in developed countries. Similarly, smoking by a best friend was found to be a major factor in predicting the future use of tobacco in a study conducted in Bahrain; similar to other findings in Kuwait, Saudi Arabia and the Syrian Arab Republic and Yemen [8]. Teachers are also play important role models in the Region and it has been found that boys are more likely to smoke if they believed a favourite teacher did not disapprove of them smoking. In assessing parental smoking rates of the sample adolescent group, 59% of fathers as opposed to 1% of mothers were found to be smokers [9]. It has been found that high levels of perceived adult smoking norms increase the risk of smoking for both sexes [10]. Traditions and norms were given as major reasons for women not smoking, followed by family values, husband's views, personal conviction, economic and religious reasons [11].

More highly-educated women were more likely to have influencing motives based on health awareness [11]. As gender norms change in the Region and women become more autonomous in their behaviour, female smoking rates are likely to increase.

Studies show that girls and women are more likely to fear weight gain than boys or men, and to initiate and continue smoking for the reason of weight control. Some surveys have found that women gain more weight after quitting than men. Recent review articles agree that women and girls tend to smoke as a 'buffer' against negative feelings, while men smoke more from habit or to enhance positive sensations. There is evidence that women and men may respond somewhat differently to nicotine. Female addiction may be reinforced more by the sensory and social context of smoking, rather than by nicotine. This may help explain why some studies have found that women quit less easily than men, other explanations include lack of social support, fear of weight gain, depression and hormones.

Exploiting gender roles to promote tobacco

With sales of tobacco products falling in developed countries, tobacco companies are using more aggressive marketing techniques in the developing world where there is less awareness of the adverse health impacts of smoking. Also, the changing aspirations of women and their improved educational status provide companies with an exploitable market towards which to target tobacco campaigns [12]. Beginning in the 1950s, the tobacco industry began specifically to target both female and youth populations. "A massive potential market still exists among women and young adults, cigarette industry leaders agreed, acknowledging that recruitment of these millions of prospective smokers comprises the major objective for the immediate future and on a long-term basis as well" [13].

The tobacco industry targets women using seductive images of vitality, slimness, emancipation, sophistication and sexual allure. Liberation, autonomy and even female friendship feature in developed countries' advertising, and, increasingly in regions where female roles have begun to change. For example, in a study completed in Alexandria, Egypt, it was found that the educational status of female smokers was higher than that of male smokers. The higher the social status of women, the more likely they were to smoke, while men were more likely to smoke the lower their social status [14]. For men, smoking is portrayed as a masculine habit linked to happiness, fitness, wealth, power and sexual success. Given that disregard for danger is an idealized masculine value, advertisements show men in rough terrain undertaking risky sports.

Smoking as a symbol of financial success may also have particular appeal to young men. Adventure-style clothingfor men and youth produced by tobacco companies also

reinforces themes of rugged fitness and independence.

Billboard advertisements are one form of marketing used by tobacco companies. Exposure to cigarette advertising on billboards was surveyed during the Global Youth Tobacco Survey. In the Eastern Mediterranean Region, rural Morocco was found to have the least exposure to these billboard campaigns, and yet 45.6% of the youth surveyed reported having seen cigarette advertising on a billboard during the previous 30 days. The highest exposure was found in Kuwait, where 84% of the youth surveyed had noted cigarette advertising on billboards.

Health impacts of smoking

The health risks associated with male smoking include: male fertility problems, such as decreased sperm count, increased abnormal sperm morphology and increased rates of impotence among men. Male smokers are also 1.5 times more likely to suffer erectile dysfunction compared to non-smoking males. Male smokers also experience a threefold risk of coronary heart disease [15].

The health risks associated with female smoking include a sixfold risk of coronary heart disease, and for menopausal women increased repeat bone fractures. In relation to pregnancy and childbirth, women experience: increased rates of spontaneous abortion of chromosomally normal fetuses; increased incidence of placental abruption; placenta praevia; bleeding during pregnancy and premature rupture of the membrane; increased incidence of low-birth-weight babies, even with low levels of tobacco exposure; and increased perinatal mortality, which is up to 1.5 times the average rate [15].

The shared health risks from smoking for men and women include: increased risk of lung cancer (85%–90% of all lung cancer cases have been attributed to tobacco use), upper aerodigestive cancer; several other cancers; heart disease; stroke; chronic bronchitis and emphysema; and increased risk of development and acceleration of osteoporosis [15].

Second-hand smoke and reproductive health

A study in Alexandria, Egypt, completed in 2000, of smokers aged 15 years and older, found that only one quarter of the 1027 households were tobacco free [14].This signifies an evident risk for pregnant mothers and young children from second-hand smoke. Children of smoking mothers have more episodes of lower respiratory illness and a clear link has been established between maternal smoking and hospital admissions of children for pneumonia and bronchitis [16]. A prospective study of 868 mothers in Saudi Arabia found that exposure to passive smoking was associated with decreased birth weight and an increase in the number of infants who were small for gestational age [17]. Another study comparing the birth weight of babies born to non-smokers to smokers of water pipes found an association between low birth weight and water pipe smoking [18].

Social and economic consequences of tobacco consumption and gender

The enormous cost of tobacco-related illness at community level has gender implications. Health services will be overstretched as they attempt to meet the tobacco health burden, which may further jeopardize primary health care delivery aimed at women and children. Women are more likely to be caring for partners with smoking-related illnesses. Women also often have less disposable income than men and are more likely to spend it on their children. The diversion of scarce family resources for tobacco (most frequently by men) may significantly contribute to malnutrition and school drop-out rates with serious and negative long-term consequences.

What research is needed?

Regular data collection on tobacco use disaggregated by sex and age will permit identification of trends and health effects on men and women of all ages. The clinical ways of identifying smoking prevalence, such as self-reporting, must be improved, as women may be more reluctant to report accurately due to greater social disapproval of female smoking [19]. There is also a need for additional clinical research on the health effects of tobacco on women, especially in increased water pipe use by women in the Region. It should not be assumed that results from studies on tobacco apply to both men and women if the differences between them in relation to smoking have not been articulated and analysed in the study process.

Social research, including qualitative approaches that illuminate the impact of gender on smoking initiation, types of tobacco used, depth and frequency of inhalation, response to diagnosis and health-seeking behaviour, would help explicate health impacts and provide a sound basis for policies and programmes. This will be critical in addressing the rising rates of female smokers in the Region. It is imperative that all smokers are included in gender and tobacco research.

It would also be useful to further investigate if women are more likely to be influenced by family and siblings, while boys may be more likely to be influenced by peers in order to project their masculinity. There is a need to identify the different risks associated with the initiation of smoking among men and women in the Region. Research is also needed on the influence of religion on smoking behaviour. Specific health outcome research is needed to investigate the risks for women who smoke during pregnancy and the exposure of the fetus to environmental tobacco smoke, as well as the implications of the epidemic of water pipe smoking for men and women.

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