

SOME LIKE IT “LIGHT”

Women and smoking in the European Union

European report

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European Network for Smoking Prevention

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SOME LIKE IT “LIGHT”
Women and smoking in the European Union

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Understanding the past, changing the future”
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Introduction

In recent years various initiatives have been taken to raise awareness of increased smoking by women. In 1991, the first European report on women and tobacco, "Is she still a smoker?", was published by BASP in the framework of the Europe Against Cancer programme. In 1992, the first international conference on women and smoking was organised jointly by UICC, The Ulster Cancer Foundation and the Health Promotion Agency of Northern Ireland. The 1994 Eurobarometer survey "Smoking in the European Union" reported on different smoking rates between men and women. The 1996 European Commission's report on the "State of Women's Health in Europe" underlined again the importance of smoking as a risk factor for women's health throughout Europe. Since 1997, the Europe Against Cancer programme has co-funded the European branch of the International Network of Women against Tobacco (INWAT) with the aim of raising awareness of the growing epidemic in Europe.

Following these initiatives, this project of the European Network for Smoking Prevention - including both a European conference organised in Paris on 23-24 November 1998 as well as this report - aims to trigger action. The Paris conference "Tobacco and Women: understanding the past, changing the future" focused on the theme of women as individuals with personal needs in today's society. It stressed economic and social issues and their influence on women's attitudes to smoking as well as the necessity for society as a whole to act to reduce smoking among women.

This European status report was designed to support the conference findings (the conference statement is attached to the report). It provides information on the health consequences of women's smoking. A chapter with the latest statistical data available in Europe gives an insight in smoking rates of women (using comparison of smoking rates of men and young people). A detailed analysis of 'light' cigarettes considers their threat to public health. Fear of weight gain is examined as an important barrier to quitting. Practical examples of gender specific programmes targeting women have been integrated into the report to illustrate some of the actions already taken.

The report is available in Finnish, French, Danish, Dutch, English, German, Greek, Italian, Portuguese, Spanish, and Swedish and can be obtained by writing to the European Network for Smoking Prevention.

Sibylle Fleitmann
Secretary General
European Network for Smoking Prevention

Executive Summary

- The number of female deaths caused by smoking in the European Union rose from 10 000 in 1955, to 49 000 in 1975, to 113 000 in 1995. If current smoking patterns persist, the number of deaths will continue to increase sharply in the next century. It is clear that if women smoke like men, they will bear as heavy, or perhaps even heavier, a health burden.
- Lung cancer is rising more rapidly among women than among men in the European Union. The total number of lung cancer deaths among men rose from 107 056 to 140 782 between 1973 and 1992 while deaths among women approximately doubled, from 18 822 to 36 772, during the same period.
- There is growing evidence that, other things being equal, such as amount and duration of smoking, women may be more vulnerable to lung cancer than are men.
- Since the end of the Second World War the prevalence of female smoking has risen sharply in Western Europe. Growing social acceptance of women's smoking has contributed to increased smoking initiation among women. As a result, the gap between the proportions of smokers among men and women has been reduced in all E.U. countries.
- Proportions of smokers by gender differ only slightly in the Scandinavian countries (Sweden and Denmark), the UK, Ireland and the Netherlands. The difference between male and female smoking prevalence has been reduced in the middle European countries such as Belgium, France, Luxembourg, former West-Germany and Austria. In South European countries (Italy, Spain, Greece and Portugal) and former East-Germany, there is still a significant gap between smoking habits among men and women, yet the gap is narrowing.
- From a public health perspective, three smoking prevalence trends are particularly alarming:
 - Prevalence of women's smoking is still increasing in six EU countries (Portugal, Spain, Italy, Greece, Luxembourg and Austria) mainly due to the rising level of smoking among younger women.
 - In most countries the uptake of smoking among youngsters is increasing.
 - In most countries girls are smoking slightly more than boys.If these trends continue, it is possible that in the near future more women than men will smoke in the adult population.
- Women smoke different tobacco products than men, generally preferring manufactured rather than handrolled, filter-tipped, low tar, and blond tobacco cigarette brands. Women generally do not smoke cigars or pipes nor do they use oral snuff.

- The success of 'light' cigarettes has been overwhelming. In 1995, there were 60 million male and 42 million female smokers in the European Union. Some 48% of all women cigarette smokers – about 20 million - smoke light cigarettes.
- Smokers of 'light' brands tend to be older and more concerned with their health. In the European Union in 1995, 60% of female smokers aged 45 to 64 smoked light cigarettes.
- Several surveys have indicated that some smokers switch to light cigarettes in the belief that these cigarettes are safer. The health risks, however, from smoking low tar brands may be as high as for regular cigarettes.
- It is impossible to know exactly how many smokers would have stopped if they had known that light cigarettes are not safer. But if 10-20% of female light smokers had quit entirely instead of smoking low tar cigarettes, there would now be 2-4 million fewer women smokers in the European Union.
- Light cigarettes are misleading consumers, preventing smokers from quitting, and posing a serious threat to public health. Producers should be prevented from giving these brands a new, trendy and feminine image, from making unproved health claims (such as light and mild) and from falsely advocating "safer" cigarettes. There is no such thing as a safe tobacco product. The only way to avoid smoking related problems is not to smoke at all.

CHAPTER 1 - WOMEN'S SMOKING: HEALTH CONSEQUENCES

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For a long time, diseases linked to tobacco use were seen as a male attribute and the tobacco industry, always prompt at taking advantages of figures which at first appear favorable to them, let women believe for a while that they were immune to the effects of tobacco use. Whereas this type of argument was prevalent in the 50s and 60s, exactly the same strategy is now seen for the developing countries.

In order to assess properly the full burden of mortality and morbidity linked to tobacco use, one has to wait at least 25 years or more. This explains why although the deleterious effects of smoking have been suspected since last century or even before, it is only recently that the magnitude of the negative impact of tobacco on health has become clearer (Doll et al, 1994). During the second half of our century, hundreds of studies became available allowing us to estimate correctly the full burden of tobacco-related morbidity and mortality. Yet one should be greatly concerned by the relative scarcity of valid studies dealing specifically with women.

In the present document, we will describe the current state of knowledge on health effects of tobacco use in women and from this assessment derive recommendations on actions to be undertaken in order to promote health in the population at large.

A few years back, if one evaluated at 3 million the number of yearly tobacco-related deaths, “only” 500 000 occurred in women, most of them in the western world. Such a statistic does not give us any reason for reassurance, as this low proportion of deaths in women among all deaths is the mere reflection of what the prevailing tobacco use patterns were in the world twenty to thirty years ago. If women keep on increasing smoking and using other forms of tobacco they will be equally and even predominantly affected by tobacco-related morbidity and mortality during the next century. This dark prediction is firmly grounded on a simple fact: if women are equally exposed to tobacco as men were, they are going to be equally and even more affected by it than men. So any comparison of rates of disease between the two sexes always has to be seen in the light of careful exposure considerations.

Cancer:

Cancers only represent part of the global disease burden.

Cancer of the lung has been the traditional marker of disease linked to tobacco, both for historical and scientific reasons. Currently about 1.2 million lung cancer deaths

occur in the world each year, making cancer of the lung the most frequent cancer mortality worldwide. Of these, about 282 000 cases occur in women (World Health Report, 1998). The variation in age adjusted (to the world population standard) incidence rates of lung cancer in women goes from a low of 0.33 in Barshi, Paranda and Bhum in India to a high of 72.9 per 100 000 woman-years in the Maori population of New Zealand (Parkin et al, 1997). Countries with a current high incidence of lung cancer in women include those of North America, Northern Europe and Australia, whereas intermediate rates are seen in other parts of Europe and low rates in Asia and Africa.

In Europe, it is particularly striking to look at the evolution over time of lung cancer in women as compared to men. If one for example considers the total number of lung cancer deaths in 1973 and in 1992, the figure has only slightly increased among men from 107 056 to 140 782 deaths, whereas the number has approximately doubled among women, from 18 822 to 36 772 (WHO, 1998). The national figures are given in table 1. All countries, without any exception have seen an increase in figures for women, whereas some decrease is seen from men in Austria, Finland and the United Kingdom. Yet, important disparities still persist in Europe. Table 2 gives the incidence rate of lung cancer in Europe. It is clear that the highest rates are seen in the English speaking and Nordic countries whereas French speaking and Southern countries have much lower rates.

Unfortunately, this currently rather mild picture is not going to remain so. Time trends clearly indicate that in most countries of the world, rates of lung cancer are dramatically increasing. Already, in a country like the USA or Scotland, the mortality from lung cancer has overcome what was previously the traditional cancer killer of women, namely cancer of the breast. In other countries, such a crossing of cancer mortality rates is expected to occur around the year 2020 and even in low rate countries, increases are being seen. In places with a long history of smoking, such as the USA, it is interesting and at the same time very worrying to note that among smokers, even after adjustment for current amount and duration of smoking, the death rates from lung cancer are greater in more recent studies than in older ones. For example, in the prospective cohort studies called Cancer Prevention Studies (CPS I and II) the death rates from lung cancer augmented from CPS-I conducted in 1959-65 to CPS-II in 1982-88, with a greater proportionate increase in women than in men (Thun and Heath, 1997). Possible reasons for such a trend are not clear. They may relate to an effect of earlier age at initiation of smoking and clearly counteract the argument of the "safe" aspect of using light rather than regular cigarettes. Also coming mostly from the USA is evidence indicating that other things being equal (amount and duration of smoking) women may be more sensitive than men to lung cancer. Although the cohort or time period effect previously described cannot be easily disentangled from other potential explanations such as an earlier age at initiation of smoking or a different tobacco composition, this aspect will need to be studied thoroughly in the years to come, in particular in relation to the increase in the incidence of specific histological forms of lung cancer such as adenocarcinoma (Thun et al, 1997) which may be partly hormonodependent.

Other cancers linked to tobacco use (Sasco, 1991) have also been found to be increased among women smokers. This applies to cancer of the bladder, urinary pelvis and kidney; as well as pancreatic cancer. Clearly, all urinary sites come into close contact with tobacco metabolites which exert a carcinogenic action.

Other cancer sites causally linked to tobacco use are represented by cancers of the upper aero-digestive tract. These sites comprise cancer of the oral cavity, lip, larynx, pharynx and oesophagus. A second point to make about these cancers is the notion of an interaction between tobacco and alcohol, with a potentiation of risk when both exposures are combined. As in general, women drink less alcohol than men, they are less frequently affected by these cancers and the male to female ratio is generally higher than the one for lung cancer. Again, the more women will smoke in the future and the higher their risk will be of developing all tobacco-related cancers. If their alcohol consumption also increases, the multiplicative effect often described in men will also be seen in women.

The situation for the classical cancers of women deserves special attention. An increased risk of cancer of the cervix uteri is seen among smokers. The relative risk is small and has been the object of continued controversy. It has long been argued that any increased risk of cervical cancer among women smokers was the result of confounding by sexual activity. Women smokers were deemed to have more sexual partners than non smokers and therefore a greater likelihood of contracting sexually transmitted diseases. As cervical cancer is linked to infection by the papilloma virus (IARC, 1995), smoking is, by some, only considered as a confounder and not a causal factor. Still, others will advance arguments in favor of at least a facilitating role of smoking in the development of cervical cancer. These include the fact that cotinine, a marker of tobacco exposure, has been found in the cervical fluid of smokers and even of women passively exposed to tobacco smoke. The second argument is that tobacco is well known for its negative impact on the immunity of subjects and therefore may play a role in the response of the individual to sexually transmitted viruses. Although the causal role of smoking in the occurrence of cervical cancer cannot be fully demonstrated, it cannot be completely discarded.

Even more controversial is the role of smoking in the occurrence of breast cancer. For a long time, smoking has been considered as slightly protective against breast cancer and the rationale for such an effect was that tobacco behaves as an anti-oestrogen in women. This effect is linked to an earlier age at menopause of smokers as compared to non smokers and an increased risk of osteoporosis. Yet, more recent studies did not find such a protective effect and some even found an increased risk of breast cancer among smokers in relation to a specific N acetylation phenotype. For cancer of the ovary, the data are yet too limited to get to any conclusive answer. The last cancer to be considered is endometrial cancer. Again due to the antioestrogenic effect of tobacco, smokers have a slightly reduced risk of cancer of the corpus uteri.

Cardiovascular diseases:

In women, as in men, tobacco use is linked to coronary heart disease, in particular myocardial infarction, chronic heart disease, peripheral vascular disease and finally cerebrovascular diseases. In contrast to the situation of lung cancer, where by far the strongest, and almost unique, risk factor is tobacco use, the etiology of cardiocerebrovascular diseases is multifactorial and this makes it much more difficult to isolate the role of tobacco from other risk factors. The nature of the disease explains why most of the studies have been done for a variety of reasons in countries at high risk of the disease. In contrast to what was said previously for lung cancer in the USA and the evolution over time of the association with smoking, the death rates of coronary heart disease have decreased among both smokers and never smokers, with an effect less marked in women than in men (Thun and Heath, 1997). These contrasting temporal trends between lung cancer and coronary disease reflect for the latter the change in other risk factors and not in smoking.

For women, a specific interaction has to be studied thoroughly, namely smoking and exogenous hormonal exposures, in particular oral contraceptives (OC).

National figures for deaths from diseases of the circulatory system are given in table 4, with ischaemic heart disease in table 5 and cerebrovascular disease in table 6.

Pulmonary diseases:

Chronic obstructive pulmonary diseases (COPD) such as emphysema and chronic bronchitis are linked to tobacco use. These diseases may not be immediately fatal but they are extremely debilitating. For COPD again, we see trends similar to the ones observed for lung cancer. In the USA, we see over time an increase in the incidence of these diseases in smokers, more marked in women than in men (Thun and Heath, 1997).

National figures for deaths from bronchitis, emphysema and asthma are given in table 7.

Some other health effects:

Smoking has been reliably linked to facial wrinkling and the general aspect of the skin. Through a negative effect on the microcirculation of the skin, more tissue damage accumulates more rapidly in smokers than in non smokers. Effects such as these, or yellow fingers and teeth, malodorous smell may not appeal to young girls and therefore can be used as an additional argument for not initiating smoking.

In older women, the effects on the age of menopause and on osteoporosis with its associated fractures should be outlined.

Effects on reproductive health:

Smoking affects the fertility of women, as well as men, with a longer delay for conception in smokers as compared to non-smokers. In more extreme cases, in vitro fertilization is less successful in smokers as compared to non smokers. Also potentially interfering with fertility, smoking is associated with an increased risk of pelvic inflammatory disease, even after adjustment for other risk factors and potential

confounders, leading in turn to higher risks of total infertility and ectopic pregnancy. Once the woman becomes pregnant, increased risks of low birth weight are associated with smoking, as is also the case for spontaneous abortions.

Tobacco use has been reliably associated with an increase in perinatal mortality, as well as with sudden infant death syndrome. A negative impact on children's health extends beyond the neonatal period, with more frequent and more severe infections among passively exposed children, both for diseases of the ear, nose and throat and of the pulmonary system. Asthma is also more severe among these children who may suffer from a slower general development.

Conclusion:

An estimate of the total number of deaths linked to tobacco has recently been produced by Peto et al for Europe (table 3). It clearly shows the very rapid increase in mortality among women. Therefore, a very clear and simple public health message follows: in order to have a healthy population, it is crucial that the world becomes tobacco free. Women have naturally, as givers of life and providers of care, the major role to play. The future of human kind lies in their hands. Given their pivotal role in the family, they will be the actors of a holistic approach to health promotion, encouraging healthy life style and avoidance of recognized carcinogens (Sasco, 1995), such as tobacco. If women could also assume more leadership in society, the success towards this goal would be greatly enhanced.

Table 1: Number of lung cancer deaths among women and men in Europe in 1973 and 1992 (from WHO, 1998)

	Women		Men	
	1973	1992	1973	1992
Austria	511	806	2 724	2 375
Belgium	505	927	4 624	5 669
Denmark	375	1 119	1 646	2 057
Finland	132	379	1 647	1 605
France	1 728	3 055	11 500	19 580
Germany	3 682	7 364	25 106	27 882
Greece	427	704	2 326	4 138
Ireland	223	511	838	1 048
Italy	2 240	4 882	14 225	25 876
Luxembourg	11	35	166	171
Netherlands	372	1 415	5 582	7 097
Portugal	196	420	705	1 858
Spain	1 018	1 397	4 946	13 644
Sweden	441	958	1 558	1 841
United Kingdom	6 961	12 800	29 463	25 941
Total	18 822	36 772	107 056	140 782

Table 2: Lung cancer incidence rate* for women in Europe (from IARC, 1997)

Austria	11.3	Italy	8.1
Belgium	8.2	Luxembourg	9.5
Denmark	25.2	Netherlands	13.0
Finland	8.2	Portugal	5.0
France	5.5	Spain	4.0
Germany	8.5	Sweden	10.9
Greece	7.8	United Kingdom	23.5
Ireland	20.2		

*age standardized (world population)

expressed in number of new cases per 100 000 women-years

Table 3: Number of deaths attributed to smoking among women in 1955, 1975, 1995 in Europe (from Peto et al, 1998)

Year	1955	1975	1995
Austria	400	1 400	2 100
Belgium	-	1 000	2 000
Denmark	-	1 300	4 900
Finland	100	100	800
France	-	-	3 500
Germany	1 000	7 100	23 100
Greece	500	1 300	1 400
Ireland	300	1 300	2 400
Italy	-	4 700	11 800
Luxembourg	-	3	111
Netherlands	-	100	5 100
Portugal	-	-	-
Spain	-	-	-
Sweden	-	900	2 800
United Kingdom	8 100	30 000	53 000
Total	10 400	49 203	113 011

Table 4: Number of deaths from diseases of the circulatory system among women and men in Europe in 1973 and 1992 (from WHO, 1998)

	Women		Men	
	1973	1992	1973	1992
Austria	24948	34289	19972	26148
Belgium *	24525	26486	25719	24077
Denmark	11550	13325	13824	12794
Finland	11116	19349	12081	19159
France	110071	114758	96721	104409
Germany	251322	347386	211703	269533
Greece	15058	29859	13868	31177
Ireland	8051	9732	9401	11966
Italy	133595	159508	121600	150159
Luxembourg	902	935	1000	751
Netherlands	22869	35418	26832	37246
Portugal	20058	27694	17502	25902
Spain	68308	86949	60196	81009
Sweden	20798	34621	25212	38053
United Kingdom	178922	227519	168325	229834
Total	902093	1167828	823956	1062217

*1973 and 1991

Table 5: Number of deaths from ischaemic heart disease among women and men in Europe in 1973 and 1992 (from WHO, 1998)

	Women		Men	
	1973	1992	1973	1992
Austria	8813	8564	8770	8092
Belgium *	6957	5112	10648	6316
Denmark	6752	6553	9531	7801
Finland	4426	6623	7434	7568
France	19791	21797	26075	26297
Germany	64242	92096	82291	87583
Greece	2571	4647	4508	7757
Ireland	3313	3150	5263	4575
Italy	37841	31809	44267	40352
Luxembourg	132	217	279	296
Netherlands	9010	9026	15090	12068
Portugal	3599	4120	4274	5254
Spain	9349	14774	13921	20531
Sweden	12680	10964	18086	14059
United Kingdom	74995	76366	100551	90390
Total	264471	295818	350988	338939

*1973 and 1991

Table 6: Number of deaths from cerebrovascular disease among women and men in Europe in 1973 and 1992 (from WHO, 1998)

	Women		Men	
	1973	1992	1973	1992
Austria	8593	6681	5644	3950
Belgium *	8552	6098	6801	3886
Denmark	2628	3299	2370	2359
Finland	3078	3621	2290	2222
France	43600	27309	33007	18908
Germany	71532	68619	49679	38012
Greece	7270	10705	5156	7580
Ireland	2585	1708	2170	1263
Italy	39323	42503	33890	30696
Luxembourg	224	342	240	204
Netherlands	6847	7926	5711	5000
Portugal	11869	13202	9432	10678
Spain	27832	24837	21138	17244
Sweden	4962	6034	4221	4293
United Kingdom	57113	47373	36272	28474
Total	296008	270257	218021	174769

*1973 and 1991

Table 7: Number of deaths from bronchitis, emphysema and asthma among women and men in Europe in 1973 and 1992 (from WHO, 1998)

	Women		Men	
	1973	1992	1973	1992
Austria	655	732	1159	1039
Belgium *	737	525	2218	1094
Denmark	364	1130	1009	1462
Finland	178	265	838	744
France	2259	3912	4377	4378
Germany	9644	8166	24035	13916
Greece	1023	166	1479	244
Ireland	587	192	1189	296
Italy	6625	5873	13288	12118
Luxembourg	28	39	97	47
Netherlands	719	729	2423	1936
Portugal	1131	469	1820	803
Spain	4377	1362	7239	2296
Sweden	457	583	852	918
United Kingdom	8116	3518	22842	5042
Total	36900	27661	84865	46333

*1973 and 1991

Box 1 Intervention strategies during Pregnancy

Smoking during pregnancy is a concern in many countries. The proceedings of the Bremen conference (May 1998) will provide more detailed information on the intervention strategies during pregnancy. The main conclusion of the Bremen conference was that « it is important to situate campaigns for pregnant women within the global frame of smoking prevention. There is need for a co-ordinated chain of interventions from teen age to after delivery ». Based on the existing literature some preliminary lessons can be drawn.

More young smoking women mean more smoking pregnant women

Only a small proportion of the women who become pregnant succeed in giving up smoking immediately or during pregnancy. High smoking prevalence among young women results almost automatically in a high percentage of pregnant smokers. In the UK, recent research has indicated that increasing numbers of women are smoking during pregnancy. Between 1992 and 1996 the proportion of women who smoked during pregnancy increased from 27% to 32%. This may partly reflect the fact that there has been a rise in the number of younger women smoking. In 1992, 40% of pregnant women said they smoked in the months before they became pregnant, by 1996 the figure had crept up to 46%. (HEA, 1997)

The opposite is also true: fewer young women smokers means fewer pregnant smokers. In Sweden, the percentage of pregnant women who smoked decreased from 31% in 1983 to 15% in 1997. During the same period the percentage of daily smokers among women in the age group 25-44 also decreased from 37% to 25%. (Haglund, 1998)

Avoid relapse

Of those who give up smoking during pregnancy, many relapse after the baby is born. For many the main reason for quitting is their unborn child and after delivery many women lose their motivation to remain a non smoker. One study found that 56% of the women who stopped smoking during pregnancy relapsed within a month of birth of the baby (McBride et al, 1990).

In order to prevent relapse, simple interventions after delivery may help. In a study done in Stockholm, the relapse rate was 20% after eight months if the child's nurse had had an early supportive discussion about smoking with those mothers who had quit smoking during pregnancy. 'Early' means that the discussion took place within a maximum four weeks after the baby was born. The aim of the intervention was to explore new motives of staying smoke-free after the baby was born. (Haglund, 1998)

Lower socio-economic groups

In the UK, smoking among younger pregnant women in unskilled manual households is high – and rising. Twice as many pregnant women in the lower social groups smoke as in the higher social groups (HEA, 1997). In Belgium, the gap among social groups is even more important. Pregnant women in the highest socio-economic groups smoke five times less than women in the lowest socio-economic groups - 7% and 35% respectively in 1995 (Test Aankoop, 1996)

It is difficult to expect all pregnant women to quit without considering the global context of low income and poverty.

For more information on intervention strategies during pregnancy contact: Peter Lang, Bremen Institute for Prevention Research and Social Medicine, PO Box 106767, D-28067 Bremen Germany

Box 2 Put smoking out of fashion

The project « Put smoking out of fashion » of the UK Health Education Authority does not target women directly, but aims to reach people in the fashion industry, which has a major impact on women.

“Put smoking out of fashion” was launched in December 1994 with two main goals

1. to encourage the fashion industry to recognise the influence it has over teenagers when using smoking images and to take responsibility for it;
2. to raise the debate on this issue within the media.

In 1996 a nationwide competition was organised encouraging fashion, photography and design students to come up with “ Put smoking out of fashion” images . The final judging took place at London’s Fashion Café and the winning design was used for a postcard for widespread dissemination across the country.

Research was commissioned to gauge the extent to which tobacco products were used on the fashion pages of magazines and their impact on teenagers. This report was released in 1997. In 1998 the campaign concentrated on the industry itself. The aim was to encourage as many fashion industry contacts as possible to sign up to the following declaration:

« Fashion is a very influential industry. We believe that the fashion industry should use this position of power to take a stand against the use of cigarettes as props and the glamourisation of smoking in fashion photography. We support ‘ Put smoking out of fashion ’».

The aim was to incorporate the signatures in a one-off garment designed and produced by a well known designer.

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CHAPTER 2 -TRENDS OF SMOKING PREVALENCE IN THE EUROPEAN UNION

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Dr Annie Sasco described the spread of smoking in a population as an epidemic curve. In all societies men of the higher social classes are the first to acquire the habit. They are followed a couple decades later by men of other social classes. Usually, it is only after the habit is already quite widespread in the community of men that women start using tobacco, again first in the higher social classes and then in all groups. (Sasco, 1998)

Growing social acceptance of women's smoking contributed to rising smoking rates among women. Increased social acceptance of women's smoking was part of a general liberalisation of norms in women's behaviour, reflecting increasing equality between the sexes. (Waldron, 1991) Since the end of the Second World War the percentage of women adult smokers has risen sharply in Western Europe. In some EU countries the proportion of smokers among men and women are very similar and in all EU countries the gap between men and women has been reduced.

However, women do not smoke in the same way as men do. Women smoke fewer cigarettes per smoker than men (table 8), prefer to smoke manufactured cigarettes instead of roll-your-own cigarettes, prefer filter-tipped, low tar and blond tobacco cigarette brands, (table 9) and generally do not smoke cigars and pipes. In younger women, these differences become subtle.

TABLE 8 – CONSUMPTION OF CIGARETTES ACCORDING TO SEX AND AGE IN THE EUROPEAN UNION IN 1995 (%)			
Men – Age	< 10 cigarettes	10-24 cigarettes	>24 cigarettes
15-24	36 %	57 %	7 %
25-39	20 %	60 %	20 %
40-54	16 %	59 %	25 %
55+	22 %	59 %	19 %
Women - Age			
15-24	45 %	49 %	6 %
25-39	29 %	62 %	9 %
40-54	25 %	60 %	15 %
55+	35 %	55 %	11 %

Source: Commission of the European Communities, Eurobarometer 43.0 (1995)

TABLE 9 – DESCRIPTION OF CIGARETTE SMOKERS IN THE EUROPEAN COMMUNITY BY SEX (1988)		
Type of cigarettes smoked	Men	Women
Blond tobacco rolled	7 %	7 %
Black tobacco rolled	6 %	1 %
Non-filter blond	5 %	3 %
Filter blond	58 %	74 %
Non-filter black	7 %	3 %
Filter-black	14 %	8 %
Menthol	1 %	2 %
Other	1 %	1 %
No reply	1 %	1 %
TOTAL	100 %	100%

Source: Commission of the European Communities, Europeans and cancer prevention, 1988

The wide variety of countries, cultures and languages makes it difficult to describe a clear overall picture of smoking in Europe. The problems are even more complex with respect to attitudes and knowledge about tobacco. Very few comparable data are available for Europe. The most comparable data sets stem from smoking prevalence surveys carried out by the Commission of the European Communities and some WHO Collaborative Studies. Those data can be completed with national surveys from most Western and Northern European countries. Unfortunately, the European Union data have been available only since 1987. (Piha, 1994)

On the basis of the available data, the following observations can be made about smoking in the European Union. The gap in the smoking rate between women and men has become small. There is a slow decrease or stabilisation of female smoking prevalence in most EU countries, but an increase in smoking prevalence among young women in Southern European countries. Rates for smoking initiation are similar among young men and young women. In most countries smoking among youngsters is not declining.

In almost all countries, smoking behaviour is measured through sample surveys of the population. The results of these surveys are often difficult to compare, as they differ in several ways: definition of smoking (regular, occasional, or daily smoking - cigarette or tobacco smoking); population sample (different age groups - size of the sample); interview methods, etc. The main conclusion of a study of Statistics Sweden (1996) on tobacco consumption in the 15 EU countries was that sources of data and produced statistics are far from harmonised.

Comparable data are provided in the WHO-sponsored Health Behaviour in School-Aged Children (HBSC) Study for some countries in the European Region. Data from the 1993/1994 phase of the study show that the percentage of 15-year-old girls who smoke at least once a week ranges from 24% in Denmark to 31% in Austria. A higher prevalence for smoking among girls than among 15-year-old boys was recorded in

1993/94 for Austria, Denmark, the French region Nancy and Toulouse, the German region of Nordrhein Westfalen, Northern Ireland, Spain, Scotland, Sweden and Wales. In the Flemish and French speaking communities of Belgium and in Finland smoking prevalence for boys remained higher than for girls.(table 10)

COUNTRIES	BOYS		GIRLS	
	1989-1990	1993-1994	1989-1990	1993-1994
Austria	23*	29	20	31*
Belgium (Flemish-speaking)	15	32*	17*	18
Belgium (French-speaking)		23*		21
Denmark		14		24*
Finland	33*	30*	32	26
France (Nancy and Toulouse)		23		25*
Germany (Nordrhein Westfalen)		21		29*
Northern Ireland		23		25*
Spain	18	20	27*	27*
Sweden	15	15	20*	19*
Scotland	16	21	18*	26*
Wales	14	18	22*	27*

Source : The health of youth. A report of the 1993-1994 survey results of Health Behaviour in School-Aged Children.

* means a higher gender specific percentage of smoking prevalence. For instance in Austria the smoking prevalence among boys was higher than girls in 1989-1990, but in 1993-1994 the smoking prevalence among girls was higher than boys.

Comparable data are also available from the Commission of the European Communities. Between Spring 1987 and Spring 1995, the Commission of the European Communities carried out 12 public opinion surveys on smoking. The surveys were based on interviews involving representative samples of the adult population (aged 15 and over) in the 12 Member States of the Community (Belgium, Denmark, Germany, Greece, Spain, France, Ireland, Italy, Luxembourg, the Netherlands, Portugal and United Kingdom). In each survey a total 12.500 persons were interviewed at home by professional interviewers, accounting for 1.000 persons per country, except in Luxembourg (300), United Kingdom (1.300, taking Northern Ireland into account), and Germany (1 500, following unification).

These surveys show a slight decrease in the percentage of smokers in the European Union in the period 1987-1995 from 29% to 27% among women and from 46% to 39% among men. (Table 11)

TABLE 11 – PERCENTAGE OF SMOKERS IN THE EUROPEAN COMMUNITY (12)

Period	Men %	Women %	Total %	M-W %
Spring 1987	46	29	37	17
Spring 1988	44	28	36	16
Autumn 1988	43	28	36	15
Spring 1989	43	28	35	15
Autumn 1989	45	29	36	16
Spring 1990	41	26	33	15
Autumn 1990	44	28	36	16
Autumn 1991	42	28	35	16
Spring 1992	43	28	34	15
Autumn 1992	43	28	35	15
Spring 1994	42	28	34	14
Spring 1995	39	27	33	12

Source : Commission of the European Communities

Data from the various countries in the European Union present a highly varied picture of smoking prevalence. According to the EU surveys, smoking prevalence among women is increasing in Greece and Portugal due to rising smoking figures for younger women. Overall smoking prevalence was low in Portugal in 1995 : 26 %. This was due to the low initial smoking prevalence among women. In the period 1987-95, smoking prevalence in Portugal among women increased from 12 % to 15 %. Smoking became more popular with the younger age group. According to the combined data for female smoking in the period 1989-92, about one in five in the 15-39 year old group, and 1 in 18 in the 40-54 year old group were smoking compared with 2% of those women aged 55 and over.

TABLE 12 –SMOKING PREVALENCE AMONG WOMEN 55 YEARS AND OVER IN 1989-1992

Portugal	2 %
Spain	5%
France	10%
Germany	12%
Greece	14%
Luxembourg	14%
Belgium	15%
Italy	16%
Netherlands	20%
UK	22%
Ireland	25 %
Denmark	37 %

Source: Commission of the European Communities

TABLE 13 - PERCENTAGE OF SMOKERS BY SEX AND COUNTRY SINCE 1987								
	Men				Women			
Period	87-88	89-90	91-92	94-95	87-88	89-90	91-92	94-95
B	45	41	41	41	29	28	24	28
DK	46	48	48	44	44	45	42	44
D West	43	44	39	40	28	27	26	24
D East	*	48	42	44	*	22	26	20
GR	62	54	55	49	25	26	25	28
E	52	51	48	44	27	28	27	26
F	45	45	49	44	29	28	32	31
IRL	38	40	35	36	32	31	31	27
IT	40	38	38	38	27	26	26	26
LUX	37	36	40	34	31	23	26	28
NL	49	45	46	45	39	34	33	36
P	46	43	40	38	12	11	12	15
UK	40	37	35	36	31	30	29	30
EC 12	44	43	42	40	28	28	28	27

Source: Commission of the European Communities

The advantage of the EU surveys is that they are comparable and standardised. Their disadvantage is their small size (an average of 500 men and 500 women per country). Smoking prevalence surveys are also done at national level, although with different definitions, methodology and age population. The sample size of these surveys is in general much larger (in Germany for instance 340.000 persons) and because of this, more reliable. An overview of the latest available survey on smoking prevalence in the 15 EU countries is given in table 14.

We classified the EU countries according to their differences in smoking among men and women:

- The proportion of smokers for both sexes is similar in the Scandinavian countries (Sweden and Denmark), the UK, Ireland and the Netherlands.
- The gap between sexes is significant, but becomes smaller in the middle European Countries such as Belgium, France, Luxembourg, former West-Germany and Austria.
- In South European countries (Italy, Spain, Greece and Portugal) and former East-Germany, there is an significant gap between smoking rates among men and women. The difference is becoming smaller due to the rising level of smoking among younger women.

TABLE 14 - PERCENTAGE OF SMOKERS IN THE 15 EU-COUNTRIES IN THE NINETIES (LATEST AVAILABLE YEAR) ACCORDING TO SEX

	MAN	WOMEN	DIFFERENCE	YEAR	PRODUCTS
<u>SIMILAR RATES</u>					
Sweden	17	22	- 5	1997	all products
United Kingdom	29	28	1	1996	cigarettes
Ireland	29	28	1	1993-94	cigarettes
Denmark	37	31	6	1997	all products
Netherlands	37	31	7	1997	all products
<u>DIFFERENT RATES</u>					
Belgium	31	22	9	1997	all products
Finland	30	20	10	1998	all products
France	40	30	10	1997	all products
Luxembourg	39	27	12	1998	all products
West Germany	35	22	13	1995	all products
Austria	40	25	15	1995	all products
<u>IMPORTANT GAPS</u>					
Italy	35	18	17	1996	cigarettes
East Germany	37	19	18	1995	all products
Spain	45	27	18	1997	all products
Greece	49	28	23	1994-95	all products
Portugal	38	15	23	1994-95	all products

Source : Various national surveys and Eurobarometer surveys for Austria, Portugal and Greece.

A short description of the trends of female smoking in each country now follows:

Sweden

a) The trend :

- **WOMEN:** In 1946 only 9 % of women were daily smokers, in 1963, 23 %, in 1980, 29 %, in 1990, 26 % and in 1997, 22%. Smoking rates increased between the end of the Second World War and 1980, but have been decreasing very slowly in the last 15 years.
- **MEN:** During the same period smoking prevalence among men decreased from 49 % in 1946, 50 % in 1963, 36 % in 1980, 26 % in 1990 and 17 % in 1997. Smoking prevalence among men in Sweden is probably the lowest in Europe.

Year	Men	Women
1946	50	9
1963	49	23
1980	36	33
1990	26	26
1996	21	22
1997	17	22

Source: National Institute of Public Health

YOUNGSTERS: There are now fewer young people smoking in Sweden than in 1980, but during that period there have been consistently more young female than young male smokers. In 1997 only 12% of the 16-25 year old men smoked compared with 19% of the young women of the same age group.

year	men	women
1980	28	37
1985	23	30
1990	14	22
1995	14	21
1996	16	23
1997	12	19

Source : National Institute of Public Health

b) Main Characteristic :

- Sweden is now one of the few countries in the world where women smoke more than men, certainly among the youngest age groups.
- A unique feature of tobacco use in Sweden is the use of oral moist snuff, mainly among men. In 1997 there were 20% daily “snus” users among adult men but less than 1% daily “snus” users among women.
- The high level of oral snuff among men is not the cause of the low level of smoking among men in Sweden. In 1980 the percentage of daily smokers among men was 36% and the percentage of daily “snus” users was 17%. In the period 1980-1997 the percentage of smokers dropped sharply from 36% to 17%, while the percentage of daily users of oral moist snuff increased slightly from 17% to 20%.
- The decline of smoking in 1997 is the result of a huge tax increase, which was recinded in August 1998. It is probable that smoking statistics will show an increase in the second half of 1998 and in 1999 in Sweden.

United Kingdom

a) The trend :

- **WOMEN:** The percentage of women smoking cigarettes in the UK was probably among the highest in Europe after the Second World War: in 1948, 41 % of women were cigarette smokers. A lower proportion of women than men smoked cigarettes in 1948, but prevalence increased gradually, peaking around 44% in the late 1960s. Prevalence for women started falling steadily thereafter, but less steeply than among men, to 26% in 1994. The most recent figure, 28 % in 1996, marks a halt in a downward trend.(Callum, 1998)
- **MEN:** Cigarette smoking among men has been falling gradually since the late 1940s, though most steadily and steeply during the 1970s and 1980s. In 1948 nearly two in three men smoked cigarettes. By the early 1970s the figure had fallen to just over one in two and by 1996 to 29 %.(Callum,1998)

year	Men	women
1948	65	41
1960	62	41
1970	56	42
1980	42	37
1990	31	29
1996	29	28

Source : Tobacco Advisory Council and General Household Survey

YOUNGSTERS : Smoking among young adults seems to be on the rise. Between 1994 and 1996 there was a 5% increase in the number of 16-24 year old women smokers, and a rise of 2% among 16-24 year old men. At a time when prevalence among other age groups remained around 26%, smoking among 16-24 year olds stands at 33% (34% of men and 33% of women). The trends in smoking among those aged 11-15 years project further increases in prevalence among young adults. Ever since 1986 girls aged 11-15 have been more likely than boys to smoke cigarettes.

TABLE 18 – PERCENTAGE AGED 11-15 YEARS WHO SMOKE CIGARETTES IN ENGLAND		
year	Boys	girls
1986	7	12
1990	9	11
1994	10	13
1996	11	15

Source : Smoking among secondary school children

b) Main characteristic :

- A key feature of the recent history of the UK smoking epidemic is the large social class differential. About 45% of women in manual classes were smokers in 1973, and just under 40% of those in non-manual classes, falling to 31% and 21% respectively by 1994. Among men the trend is similar as the percentage of smokers of the manual class are also much higher than the proportion of the non-manual class. Although sex differentials in smoking within social class have practically disappeared, social class has become an important differentiating factor in smoking behaviour.(Callum, 1998)
- Graham (1989) identified a problem which she linked to the feminisation of poverty. Changes in family forms, especially the growth of lone parenthood, and changes in the labour market had isolated many women from the mainstream of improving family circumstances during the 1980s. The number of lone parent families in Britain has increased threefold in 25 years. According to Dorsett and Marsh (1998), smoking has become more and more concentrated among Britain's poorest families: those who smoke can afford it least. The poorest group - Britain's 1.7 million lone parent families - smoke most. In a world where a quarter of young women smoke, more than half of all lone parents (almost all women) smoke regularly.
- After the Second World War the UK had the highest proportion of female smokers in Europe. The number of deaths attributed to smoking among women in European Union in 1995 was also the highest in the UK: 113 000 deaths in the European Union of which 53 000 were in the UK alone.

Ireland

- **WOMEN:** The situation is similar to the UK with high proportions of women constant: from 60% in 1960, to 49% in 1970, 39% in 1980 and 29% in smokers since the post-war period: in 1960, 40 % of Irish women were smokers. Prevalence decreased gradually to 37 % in 1970, 32 % in 1980 and 28% in 1993/94. However, no real progress was made in the period 1987-1994 as smoking prevalence fluctuated between 27 and 30%.
- **MEN:** During the last 40 years the decrease of cigarette smoking among men has been 1993/94.

Year	Men	Women
1960	60	40
1970	49	37
1980	39	32
1990	31	29
1993/94	29	28

Source : National Media Research Survey

b) Main characteristic :

- The decline of smoking has been less evident among women than among men and has resulted in equivalent prevalence rates in 1993/94.

Denmark

a) The trend :

- **WOMEN:** In 1970 almost half of Danish women (47%) smoked. This proportion decreased very slowly in the 1970s and 1980s, but more rapidly in the 1990s. In 1980, 44% were smokers, 40% in 1990 and 33% in 1997.
- **MEN:** In 1970 two thirds of men smoked, in 1990 almost half and in 1997, 37%.

year	men	women
1970	68	47
1980	57	44
1990	47	40
1997	37	33

Source : Danish Council on Smoking and Health

b) Main characteristic :

- Denmark has been known as a country with one of the highest female smoking prevalence rates in the world; this has resulted in high female lung cancer rates. In recent years smoking prevalence among women has declined in Denmark, but it still remains high: one out of three Danish women smokes daily.

Netherlands

a) The trend :

- WOMEN: Around 30% of women smoked in the 1960s, around 40% in the 1970s and smoking prevalence fluctuated around 30% in the period 1988-1997.
- MEN: Nine out of ten men smoked in 1958, three out of four in 1970 and one out of two in 1980. In the period 1988-1997, smoking prevalence among men fluctuated around 37-39%.

Year	men	women
1958	90	29
1970	75	42
1980	52	34
1990	39	31
1997	37	30

Source : Stivoro Dutch Foundation on Health and Smoking

YOUNGSTERS : No major progress has been made during the last 15 years in the Netherlands to reduce the number of young smokers. In 1997 one out of four 15 to 19 year olds were smokers (26% of boys and 25% of girls).

year	men	women
1980	30	31
1985	22	23
1990	21	21
1995	25	21
1996	26	23
1997	26	25

Source : Stivoro Dutch Foundation on Health and Smoking

b) Main characteristic :

From 1958 to 1988 the overall proportion of smokers (men and women combined) decreased steeply - from 60% smokers in 1958 to 33% in 1988. During the same period the difference in smoking rates between men and women was greatly reduced. From 1988 to 1997 there were no further declines in smoking and the percentage of smokers remained at 33% in 1997. Tobacco smoking remains high, because the Dutch not only smoke manufactured cigarettes but also hand rolled cigarettes. Some 68% of all men smokers and 49% of all women smokers smoked rolling tobacco in 1996.

Belgium

a) The trend :

- WOMEN: Smoking prevalence among women was 23% in 1963, 28% in 1982, 26% in 1990 and 22% in 1997.
- MEN: Smoking prevalence among men was 70% in 1963, 53% in 1982, 38% in 1990 and 31% in 1997. Overall smoking prevalence for both sexes fluctuated around 26% in the period 1992-1997.

year	men	women
1963	70	23
1982	53	28
1990	38	26
1997	31	22

Source : Readers Digest (1963) and CRIOC Centre for Research and Information of the Consumer Organisations

YOUNGSTERS : Smoking among youngsters declined in the 1980s, but has been rising in the 1990s in the both the Flemish and the French speaking communities of the country.

Year	Boys		Girls	
	15-16	17-18	15-16	17-18
1990	11	25	8	13
1994	21	32	12	17
1996	23	35	17	26
1998	21	31	20	30

Source : Maes L, Van de Mierop E, HBSC-Study Flanders

b) Main characteristic:

- Smoking declined strongly in the 1970s and the 1980s, but has not fallen since 1992. Men (who also smoke hand rolled cigarettes) smoke more than women, but the gap in prevalence between the sexes has been reduced. In Flanders, daily smoking by 15-18 year old girls more than doubled in the period 1990-1998.

Finland

a) The trend :

- **WOMEN:** In 1978, 18% of women were daily smokers and in 1998, 20%. Since 1980 the percentage of daily smokers has been fluctuating around 20%.
- **MEN:** Smoking prevalence among men has decreased from 36% in 1978 to 30 % in 1998.

TABLE 25 – SMOKING PREVALENCE IN FINLAND		
year	men	Women
1978	36	18
1990	33	20
1998	30	20

Source : National Public Health Institute

YOUNGSTERS : During the last 20 years smoking among young people has declined: prevalence of smoking among 15-24 year old men decreased from 35 % in 1978 to 25 % in 1998 and among women of the same age group from 25 % in 1978 to 23 % in 1998.

TABLE 26 – DAILY SMOKERS AMONG 15-24 YEARS IN FINLAND		
year	men	women
1978/79	35	25
1983/85	26	19
1989/90	29	24
1993/94	26	22
1998	25	23

Source : National Public Health Institute

b) Main Characteristic :

- The proportion of divorced or separated men and women who smoke is high in Finland: in 1998, 48 % of divorced men and 35% of divorced women smoked, compared with 29% of married men and 18% of married women. Unemployment also has a negative impact: 47% of unemployed men smoke compared with 32% of unemployed women.

France

a) The trend :

- **WOMEN:** In 1976, 28% of French women smoked, in 1980, 24%, in 1992, 33% and in 1997, 27%.
- **MEN:** In 1976, 59% of men smoked, in 1980, 48%, in 1992 still 48% and in 1997, 39%.

Year	men	Women
1976	59	28
1980	48	24
1992	48	33
1997	39	27

Source : Comité français d'Education pour la Santé

YOUNGSTERS : Overall smoking prevalence among teenagers (12-18 years) decreased from 43% in 1977 to 25% in 1997. During these 20 years there were only small differences between the smoking proportions for boys and girls.

Year	Boys	girls
1997	48	43
1984	37	42
1990	39	32
1994	31	30
1997	24	26

Source : Comité français d'Education pour la Santé

b) Main characteristic :

- Smoking prevalence in France rose steadily after the Second World War, but has decreased since 1991, after the introduction of a comprehensive smoking prevention policy. This includes a total ban on advertising, price increases and the restriction of smoking in public places.
- Registered per capita sales of manufactured cigarettes (aged 15 and above) increased from 1790 in 1970 to 2128 in 1991 (+16 %). In the period 1992-1996, per capita sales of manufactured cigarettes decreased from 2097 to 1834 (-14 %). Without the French anti-tobacco law, the percentage of smokers among women would probably have increased or at least been constant.

Luxembourg

a) The trend :

- **WOMEN** : Smoking proportions among women increased slowly from 25% in 1987, 26% in 1993 to 27% in 1998.
- **MEN** : Smoking proportions among men fell from 41% in 1987 to 32% in 1993, but increased to 39% in 1998.

TABLE 29– SMOKING PREVALENCE IN LUXEMBOURG		
Year	men	women
1987	41	25
1993	32	26
1998	39	27

Source : Ligue Luxembourgeoise contre le Cancer

YOUNGSTERS : there has been a slight increase of the percentage of smokers among 11 to 18 year old youngsters: 17% in 1990 and 19% in 1998. Girls are smoking more (14% in 1990 and 19% in 1998) and by 1998, had smoking prevalence rates comparable to boys'.

TABLE 30– SMOKING PREVALENCE AMONG 11-18 YEARS IN LUXEMBOURG		
Year	boys	girls
1990	18	14
1998	19	19

Source : Ligue Luxembourgeoise contre le Cancer

b) Main characteristic :

- Taking into account the high standard of living and the low price of tobacco, smoking prevalence is not decreasing in Luxembourg. In 1998 the proportion of foreign residents who smoked (40%) was higher than that of Luxembourg nationals (30%).

Germany

a) The trend :

Due to the 1990 reunification of Germany, there are no long-term comparable national data for the whole country.

- **WOMEN** : In the former West-Germany the prevalence of smoking among women has remained stable for some years: 21,4% in 1989, 22% in 1992 and still 22% in 1995. In the former East-Germany smoking prevalence among women was 19,5% in 1992 and 19,4% in 1995.
- **MEN** : In the former West-Germany the percentage of smokers has decreased slightly: 36,2% in 1989, 36,3% in 1992 and 35,3% in 1995. In the former East-Germany the percentage of smokers decreased from 39,4% in 1992 to 37,2% in 1995.

TABLE 31 - SMOKING PREVALENCE IN FORMER EAST AND WEST GERMANY

Year	West G men	West G women	East G men	East G women
1989	36,2	21,4	-	-
1992	36,3	22	39,4	19,5
1995	35,3	22	37,2	19,4

Source: Statistisches Bundesamt

YOUNGSTERS : In the former West-Germany the percentage of smokers among 12-25 year olds decreased from 51% in 1973 to 40% in 1997. In the period 1993-1997, however, there was an increase of the proportion of smokers among 12-17 year olds from 21% to 26%.

In the former East Germany there was sharp increase of the smoking prevalence among youngsters in the period 1993-1997. The percentage of smokers among young women increased from 27% to 47%.

TABLE 32 - SMOKING PREVALENCE AMONG 12-25 YEARS IN FORMER EAST AND WEST GERMANY IN 1993-1997

Year	West G men	West G women	East G men	East G women
1993	41	36	38	27
1997	43	38	45	47

Source: Bundeszentrale für gesundheitliche Aufklärung

b) Main characteristic :

- The tobacco industry is a major player in the national economy and is able to influence strongly government policy. No real progress has been made in Germany to reduce smoking due to the absence of a comprehensive tobacco control policy.
- The sharp increase of the smoking prevalence among young women in the former East Germany in the period 1993-1997 is alarming.

Austria

a) The trend :

- **WOMEN** : According to Östat-surveys the prevalence of daily smoking among women increased from 10% in 1972 to 23% in 1991. A 1992 survey indicated the percentage of women smokers was 27% and in the Eurobarometer survey of 1995 the percentage of women smokers was 25%.
- **MEN** : According to Östat-surveys the prevalence of daily smoking among men was 36% in 1972, 34% in 1979, 33% in 1986 and 37% in 1991. A 1992 survey indicated that the percentage of men smokers was 42 % and in the Eurobarometer survey of 1995 the percentage of men smokers was 40%.

year	men	women
1972	36	10
1979	34	14
1986	33	17
1991	37	23

Source : Östat

YOUNGSTERS : The percentage of teenage smokers (aged 16-19) increased in the period 1979-1991. It increased among girls from 20% to 28% and among boys from 34% to 37%.

year	boys	girls
1979	34	20
1986	30	21
1991	37	28

Source : Östat

b) Main characteristic :

- In the 1970s and 1980s smoking prevalence among young women increased in Austria with the proportion of women smokers doubling over a period of 20 years. As in Germany, tobacco control is not a priority for government policy.

Italy

a) The trend :

- WOMEN : In the period 1980-1996, smoking prevalence among women was constant and fluctuated around 16% to 18%.
- MEN : Smoking prevalence among men decreased from 54% in 1980 to 35% in 1996.

year	men	women
1980	54	17
1987	41	17
1993	35	16
1995	34	17
1996	35	18

Source : ISTAT

YOUNGSTERS : Smoking prevalence among young women remained constant in the period 1993-1995, but increased slightly in 1996.

year	15-17	18-19	20-24
1993	4,6	12,7	18,0
1994	4,1	11,0	17,8
1995	4,3	12,3	17,9
1996	6,7	14,7	19,1

Source : Istat

b) Main characteristic :

- In comparison to survey-data for 1957-75, two population-based surveys conducted by the DOXA Institute in 1987 and 1990 show a long-term decline in reported smoking prevalence in Italian men, but a substantial increase in smoking among women (La Vecchia C et al, 1993). According to data from Istat, smoking prevalence among women remains rather low in Italy, but increased slightly in 1996, mainly among young women.

Spain

a) **The trend** :

- WOMEN : Smoking among women increased from 17% in 1978 to 27% in 1995 and remained at 27% in 1997.
- MEN : Smoking among men decreased from 65% in 1978 to 45% in 1997.

year	men	women
1978	65	17
1987	55	23
1993	48	25
1995	48	27
1997	45	27

Source : Spanish Ministry of Health

YOUNGSTERS : Smoking prevalence among young people in the 18-24 age group remains high and reached 50% for men and 45% for women in 1993. In the oldest age groups, however, very few women smoke.

Age group	men	women
16-17	29	27
18-24	50	45
25-44	61	39
45-64	47	11
65-74	27	2
+74	21	2

Source : Spanish Ministry of Health

b) **Main characteristic** :

- The major problem in Spain is the growing number of women who smoke. This is due to various factors, one of them being the advertising campaigns targeting young people. Spanish youth are very influenced by the American and North European lifestyle and associate smoking with women's liberation - a very sensitive issue in Spain where women only recently aspired to these «freedoms». Low prices and an absence of adequate tobacco control policies have resulted in a slower decline in smoking rates compared to other European countries.

Greece

a) The trend :

- WOMEN : According to surveys carried out by The Commission of the European Communities, the percentage of female smokers has increased from 25% in 1987-88 to 28% in 1994-95.
- MEN : Smoking prevalence among men decreased from 62% in 1987-88 to 49% in 1994-95.

year	men	women
1987-88	62	25
1989-90	54	26
1991-92	55	25
1994-95	49	28

Source : Commission of the European Communities

b) Main characteristic :

- Overall prevalence is high, particularly among men, and this is further combined with high per capita consumption. The European surveys carried out by the Commission of the European Communities show a far higher percentage of heavy smokers in Greece than in other EU countries. As in other South European countries, smoking prevalence among women is increasing in Greece.

Portugal

a) The trend :

- **WOMEN** : In the 1970s very few Portuguese women smoked. Only the younger and the well educated started to smoke. In 1995 the percentage of women smokers was still low (15%), but steadily increasing.
- **MEN** : Smoking prevalence among men decreased from 46% in 1987-88 to 38% in 1994-95.

TABLE 40 – PERCENTAGE OF SMOKERS IN PORTUGAL		
year	Men	women
1987-88	46	12
1989-90	43	11
1991-92	40	12
1994-95	38	15

Source : Commission of the European Communities

YOUNGSTERS : The increase in the prevalence of smoking among the female population is also observed among adolescents where the percentage of female daily smokers more than doubled between 1977 and 1988, from 14% to 31%.

TABLE 41 – PERCENTAGE OF DAILY ADOLESCENT SMOKERS (15-24 YEARS OLD) IN PORTUGAL		
Year	Men	Women
1977	55	14
1984	40	17
1988	45	31

Source : Conselho de Prevenção do Tabagismo

b) Main characteristic :

- The low, but increasing prevalence among women is the main characteristic of smoking in Portugal. Portuguese women started to smoke only in the 1980s, but there is a danger that the Portuguese will follow the general trend of other South European countries and experience a sharp rise in smoking among women.

Box 3 The women, low income and smoking project

One of the few projects taking a look at poverty and smoking has been the ASH Scotland «Women, low income and smoking project», which began in April 1996 with four objectives:

1. To set up a database of information and contacts on community based projects working on women, low income and smoking;
2. To provide funding to community groups in developing, implementing and evaluating innovative projects on women, low income and smoking;
3. To explore different ways of evaluating such initiatives and to develop expertise in this new area;
4. To disseminate the results of the project.

The project was not finished at the time of writing, but the findings will have been presented at a national conference and a report published in the spring of 1999. The experience so far indicates that community based work in tobacco control, and health promotion more generally, requires considerable support, not only in terms of long term funding but also of appropriate advice, expertise and resources (Gaunt-Richardson et al, 1998)

For more information contact Paula Gaunt-Richardson, ASH Scotland, 8 Frederick Street, Edinburgh.

Box 4 Miss Sweden - Smoke free

In 1995, the organisers of the «Miss Sweden» contest started working with the National Institute of Public Health. The aim was to add more serious aspects to the events, which had previously been seen as a superficial, commercial «beauty contest».

Since 1996 all 28 Miss Sweden candidates have received a one week education programme on tobacco control, must be non-smokers and have to tour their own local schools with the smoke-free message for a minimum of 4-6 weeks.

In 1996-1998, 60.000 pupils in grades 4 – 6 had met a Miss Sweden candidate.

The Miss Sweden finalists become positive role-models and get high media coverage. For example, the media coverage in February and March 1996 included: 65 local newspaper articles, 30 local radio programmes and 10 local TV programmes.

Every year the Miss Sweden final is watched by almost 2 million people, many of whom are teenage girls.

For more information contact Margaretha Haglund, National Institute for Public Health, Olaf Palmes Gata 17, S-10352 Stockholm, Sweden.

Box 5 Smoking cessation for women

Based on the experience in Austria and France, a number of smoking cessation programmes cater specifically for women's needs. Women who want to stop smoking may have some specific female concerns, such as menopause, oral contraceptives, pregnancy and osteoporosis, and will more easily speak about it when they are in a women-only group. Women are also more concerned about weight gain and tend to relapse in situations involving negative emotions, such as conflicts or stress.

There are many opportunities to offer smoking cessation therapies to women. One example is the Austrian Female Health Centre, which is connected with a gynaecological hospital. The centre offers assistance for women, based on general techniques of smoking cessation such as pharmacological and behavioural treatment, combined with specific approaches for women such as « lifestyle management », nutrition counselling and weight control, and stress management within additional supportive groups of about 10 to 12 women. (Rieder et al, 1993)

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CHAPTER 3 - SOME LIKE IT LIGHT.

“The promotion of light cigarettes has kept many people smoking who otherwise would have made a concerted effort to stop. It is contended that low-tar, low-nicotine cigarettes encourage young people and women to start smoking and may influence smokers to continue in the belief that the product offers some protection. The net effect of the introduction and mass marketing of these brands, may have been and may continue to be an increased number of smoking attributable deaths”.

(Warner et al , 1997)

In his keynote speech at the World Tobacco symposium in Prague in October 1997, William Ryan, CEO of Rothmans International, told delegates that the tobacco industry had a bright future. « The fact is that the world profitability of the tobacco industry continues to grow substantially at a constant rate that would be the envy of most other global industries. World-wide volumes are still increasing and can be expected to continue to do so, particularly given the positive trends in the incidence of women smoking,... »

Tobacco manufacturers encouraged women to adopt smoking with promises of glamour and attractiveness, and reassurance that smoking was not only an appropriate but a desirable female behaviour.(Winstanley et al , 1995) Women’s magazines with their large readership are one of the main ways that the tobacco industry tries to target its advertising at women. Based on research of women magazines in all EU countries, Amanda Amos and colleagues found that by publishing tobacco advertisements, women’s magazines provide tobacco companies with a direct way of targeting women and lend these advertisements, and thereby smoking, a spurious credibility as they trade off the image of the magazine. These advertisements variously associated smoking with glamour, sophistication, fun, romance, sexual attractiveness, sport, sociability, relaxation, youth, emancipation, femininity, rebellion, risk taking and being slim. (Amos et al 1998)

Along with specific campaigns, « women’s » cigarettes have been designed and marketed to target women, with appealing brand names such as Capri, Vogue, Kim, Virginia Slims. These cigarettes are so feminine that they are universally identified as « women’s » cigarettes, and smoked only by women. (Karaoglou, Naett 1991)

Even the Chinese tobacco industry has developed specific women’s brands with the 30 million smokers among Chinese women in mind. One of these brands, Camellia, is modelled on the American brand, More, and is quite popular among Chinese smokers, especially women smokers. In an article of the trade journal « World Tobacco » the approach by the Chinese industry was praised by some sociologists who said that it was realistic to accept that at least the new products were less harmful than were other domestic products offered on the market. (World Tobacco July 1998)

While the impact of these women’s brands should not be overestimated, as their market share in most countries remains limited, the misleading and successful character of the ‘ light cigarette’ promotion strategy cannot be underestimated.

The success of light cigarettes in the European Union is overwhelming, especially among middle-aged women: 60% of women cigarette smokers aged 45 to 64 years old smoked light cigarettes in 1995. In seven EU countries more than half of all female cigarette smokers smoked light cigarettes. (Sweden, Austria, Italy, Denmark, Ireland, Finland and France) In Sweden as many as three out of four smokers among women smoked light cigarettes.

TABLE 42 - THE PERCENTAGE OF SMOKERS OF LIGHT CIGARETTES IN THE EUROPEAN UNION ACCORDING TO SEX AND AGE IN 1995		
AGE	MEN	WOMEN
15-24	29	36
25-44	29	48
45-64	33	60
65+	46	57
Total	31	48

Source: Commission of the European Communities

TABLE 43 - PERCENTAGE OF SMOKERS OF LIGHT CIGARETTES IN THE EUROPEAN UNION ACCORDING TO COUNTRY AND SEX (1995)			
Country	Men	Women	Total
Sweden	46	74	62
Austria	55	72	62
Italy	49	63	55
Denmark	43	64	54
Ireland	39	61	49
Finland	36	58	46
France	34	52	42
U.K.	32	48	40
Belgium	34	46	39
EU 15	31	48	38
Luxembourg	42	35	38
East Germany	32	44	36
Greece	30	35	32
Germany	24	45	32
West Germany	21	45	31
Portugal	28	30	29
Netherlands	14	33	23
Spain	12	25	17

Source: Commission of the European Communities - Eurobarometer 43.0 (1995)

Light cigarettes are not safer

In the 1981 Report of the (U.S.) Surgeon General, « The Changing Cigarette », one of the major conclusions was that smoking cigarettes with lower yields of tar and nicotine reduces the risk of lung cancer and, to some extent, improves the smoker's chance for longer life, provided there is no compensatory increase in the amount smoked. However, the benefits are minimal in comparison with giving up cigarettes entirely.

The tar yield testing and control policy was based on the concept that less tar would lead to less carcinogenic activity of tobacco smoke. The concept of tar bears careful re-examination, especially in the light of new cigarette technologies. All tars are not created equal.(Slade et al, 1998) The results on West-German cigarettes indicate for instance that there is no correlation between tobacco-specific nitrosamines and tar deliveries in the main stream smoke .(Spiegelhalder and al, 1989) Low tar cigarettes do not automatically mean low carcinogenic cigarettes. Two recent studies based on research in the USA and Switzerland show that low tar cigarettes are not only not safer, but may have contributed to an increase of a type of lung cancer (adenocarcinoma) which occurs deep in the lung.(Levi et al , 1997, Stellman et al, 1997) The reason is that smokers of these cigarettes inhale more deeply and are more exposed to disproportionately higher amounts of certain carcinogenic constituents, such as N-nitrosamines.

It has been shown, for example, that smokers who switch to cigarettes with lower nicotine yields « compensate » by smoking the lower-nicotine cigarette more intensely and that the published nicotine and tar yields on the cigarette packs are not a good predictor of nicotine and tar absorbed by smokers. (FDA,1995) As a result, the actual tar exposure, and hence health risk, from smoking low tar brands may be almost the same as for conventional cigarettes. (Jarvis et al, 1998) However, only 10% of all smokers in a recent American survey knew that one light cigarette could give the same amount of tar as one regular cigarette . (Kozlowski et al, 1998) Many smokers do not stop, in the belief that light cigarettes offer some health protection.

What the industry knew

Internal industry documents released through litigation in the US and Canada reveal that for decades the industry knew and internally acknowledged that nicotine is an addictive drug and that « health-conscious » smokers could be captured by low-tar, low-nicotine products which offer consumers false reassurance. (Hurt et al, 1998)

Below are some extracts of internal tobacco industry documents:

Lorillard 1976 : « People believe that cigarettes low in tar and nicotine have different tobacco ingredients and different kinds of filters than other cigarettes...Those who smoke low tar and nicotine cigarettes generally do so because they believe such cigarettes are ‘ better for you’.»

Imperial Tobacco, Canada: « The results ... provide strong confirmation to the conclusion that smokers of ultra mild and ultra light choose their brands for health reasons. ..The present findings are consistent with the hypothesis that the advertisement of certain cigarettes as mild and extra light has induced many Canadians to continue to smoke and not to quit. »

1971 Matinée marketing plans: « To capitalise on present smoker awareness of Matinée as a low Tar&Nicotine cigarette and exploit this in a positive manner in relation to smoking and health considerations.The image of Matinée among non-users as being for women, for middle-aged smokers, as having little taste and as being safest for health reasons remains constant. »

BAT 1971: « Manufacturers are concentrating on the low tar and nicotine segment in order to create brands... which aims, in one way or another, to reassure the consumer that these brands are relatively more « healthy » than orthodox blended cigarettes. »

Philip Morris 1975: « Marlboro light cigarettes were not smoked like regular Marlboros. In effect, the Marlboro 85 smokers in this study did not achieve any reduction in smoke intake by smoking a cigarette (Marlboro lights). »

Light cigarettes: a women's product

«Light» is a powerful word. Added to a food label, light appeals to the diet conscious. Added to a cigarette brand name, light can be marketed to health-conscious smokers looking for safer products. (Kozlowski et al, 1998)

It comes as no surprise that light cigarettes are popular primarily among women, as women in general buy more light products than men. For example, the appeal of ‘light’ products for women can be seen in the food sector. (Paul et al, 1995). Light is a notion, which appeals to women. The promotion of light cigarettes has proven to be a more successful strategy than the development of women-only cigarette brands, whose market share has remained limited.

The example of Marlboro may illustrate this. Australian research on Marlboro for Philip Morris (1990) suggested that Marlboro represented the traditional masculine values. Despite Marlboro’s masculine image, the brand was also attractive to women. When, for instance, high school women in Senegal were asked to describe the Marlboro cowboy in one word, they wrote « sexy », « gentleman » and adventure. (White, 1998) In several surveys in developed countries around the world an equal number of both sexes were seen to smoke Marlboro. But the attractiveness of Marlboro for women could still be improved.

According to Philip Morris internal documents (1995), qualitative research has confirmed that «Lights» are perceived to be more feminine. The same internal document stipulates that the typical Marlboro woman has a positive and trendy image and is considered independent and fun-loving. More recent findings from the Marlboro agency briefing in Belgium (1994) describe the perception of the regular Marlboro world as « adventure, freedom, masculinity, America, universal, trendy and youth. » Masculinity is one of the important characteristics of the Marlboro scenery. According to the same survey the smoker profile of Marlboro Lights can be described as «cultured, young, refined, active, trendy, upscale, ex-red smoker, health conscious.» Group discussions among female Marlboro light smokers revealed that Marlboro Lights may share some product characteristics or some general “corporate quality” imagery with Reds, by no means did it share Reds’ machismo: “Marlboro is men, but Lights is different. It’s neutral”.

In others words, adding the notion light to the classical Marlboro red advertising campaign, made the marketing approach more refined, less masculine and more appealing to women. Health conscious women could remain Marlboro smokers! Marlboro has been one of the most successful advertising campaigns of the century and with the launch of Marlboro Lights, sales continued to rise in the 1990s. In Germany, Marlboro Lights has a market share of 10,5%, in Belgium 8,6%, in Italy 6,5% and in France 5,5%. The market share of Marlboro Lights is greater among women than among men. In Belgium for instance, 11% of female cigarette smokers were smoking Marlboro Lights in 1997, compared with 6% of male cigarette smokers.

TABLE 44 - MARKET SHARE OF MARLBORO IN SOME EUROPEAN COUNTRIES IN 1977 AND 1997		
	1977	1997
Greece	1 %	16 %(1995)
Netherlands	1 %	31 %
France	2 %	20 % (of which 5,5% Lights)
Belgium	2 %	25 % (of which 8,6% Lights)
Germany	7 %	33 % (of which 10,5 % Lights)
Italy	8 %	20 % (of which 6,5 % Lights)

Source : Maxwell Reports and Centre for Information on the Media

Not only Marlboro Lights, but all low tar cigarettes are more popular among women. According to research in the UK (General Household Survey, 1996), in the

Netherlands (Stivoro, 1998) and in the European Union (Eurobarometer 43.0 1995), low-tar smokers are more likely to be older, women and middle class.

Smoking prevalence of those who smoke light cigarettes is lowest in the youngest age-groups, which is an indication that light cigarettes are less important for the uptake of smoking, but more important as a substitute for quitting. In the UK, for instance, 23% of 16-19 year old women smoke low tar cigarettes, compared to 40% of women aged 50 years and over. In the Netherlands 18% of 15-19 year old women smoke light cigarettes compared to 28% of women aged 50 years and over. In the European Union, finally, the percentage of female light smokers in the 15-24 year old age-group is 36%, which is again much lower than the 60% light smokers in the age group of 45-64 year olds.

According to research in the UK, people switch to low-tar cigarettes as they progress in their smoking careers and become more concerned about health (Jarvis et al, 1989). These findings were confirmed in the European survey: most light smokers (69%) are switchers who previously smoked a regular brand. Switching can be seen as the behaviour of an older person who has become concerned with his/her own health, but who is not yet willing to stop smoking but believes that low tar cigarettes are a safe alternative. Worryingly, according to the European survey, 15% of those who switched to low tar cigarettes declared that they were smoking more.

Light cigarettes deter smoking cessation

Tobacco industry documents indicate that the promotion of light cigarettes was intended to reassure their customers and prevent health-conscious smokers from stopping smoking. Increased consumer demand for lower yield cigarettes is probably attributable to consumer beliefs that lower yield are less hazardous. The impression may have resulted in part from cigarette advertising implying that low-tar brands are less hazardous or are safe.(Davis,1987)

More research findings indicate that this policy is successful and that smokers' misconceptions of light and ultra-light cigarettes may keep them smoking.(Kozlowski et al, 1998)

A summary of these findings:

- In a national sample in the USA among 578 light and ultra-light smokers, one in three ultra-light smokers indicated that they were at least somewhat likely to quit smoking if they learned that one ultra-light is equivalent to one regular cigarette. In the sample of light smokers, one in four indicated that they would be at least somewhat likely to quit smoking if they learned that one light cigarette is equivalent to one regular cigarette.(Kozlowski et al, 1998)
- In 1984 the National Centre for Health Statistics asked current smokers, « Have you ever switched to a low tar and nicotine cigarette just to reduce your health risk? » About 44% of current smokers answered that they had switched for that reason. The same survey asked participants to identify techniques they had used in

their efforts to quit smoking. Among participants who had switched brands, 38% said they had switched to lower tar and nicotine cigarette brands as a quitting strategy. Low-tar smokers were also more likely, compared with high-tar smokers to believe that their cigarettes are safer. (Giovino et al, 1995)

- A Dutch study of 318 pregnant women who smoked when they were around 13 weeks pregnant indicates that low tar cigarettes prevent health-conscious smokers from attempting to give up. In the early stages of pregnancy (at the first interview of the study), only 2,5% of the subjects smoked light cigarettes. Six weeks after the first interview the percentage who said they smoked only light cigarettes had increased to 29,5% but this proportion declined again to 14,1% six weeks after delivery. (Bakker et al ,1998)
- In a French follow-up study intended to encourage smoking cessation, one out of four pregnant women who did not stop smoking during pregnancy claimed to have switched to low tar cigarettes during the pregnancy.(CNCT,1997)

In 1995 there were 60 million male smokers and 42 million female smokers in the European Union. Some 48% of all female cigarette smokers – about 20 million women - smoked light cigarettes. Several surveys indicate that switching to light cigarettes is often considered to be a healthier choice by smokers who believe that these cigarettes are safer. Most « light » smokers are unaware that low tar cigarettes may have the same amount of carcinogenic substances as regular cigarettes. Light smokers are also older, more concerned with health problems, but not yet willing to stop smoking. They seem reassured that light cigarettes offer some health protection and serve as a substitute for quitting. Some ‘light’ smokers say they would be more likely to quit if they learned that one light is equivalent to one regular cigarette. It is impossible to know exactly how many current smokers would have stopped if they had understood that light cigarettes were not safer. But if we estimate 10 to 20% of female ‘light’ smokers would have stopped smoking instead of smoking low tar cigarettes, there would be two to four million fewer women smokers in the European Union today.

The tobacco industry profits from the promotion of light cigarettes in several ways:

**first, they provide their brands with a new, trendy and feminine image;
secondly, they prevent many smokers from quitting, especially women
and; thirdly, some of those who switch to low tar brands admit to smoking more,
which means still more sales for the industry.**

Box 6 Gender specific school-based smoking prevention programmes

At which age should gender specific smoking prevention interventions start and on what should they be based?

Two studies looked at the gender differences of two school-based prevention programmes.

A first study examined the effects of a smoking prevention intervention in primary schools in Northern Germany and Southern Denmark in 1997. The programme included 20 sessions and was based on the life skills approach. In a control-group-design with repeated measurement an experimental group of 526 pupils underwent the programme, and a control group of 424 pupils did not. The mean age of the pupils was 9.2 years.

Gender differences were found on

- attitudes towards smoking (data showed that girls had a more negative attitude towards smoking than boys)
- negative expectations of smoking (the boys showed more negative expectations of smoking than the girls.)

A second survey was carried out in Austria, Denmark, Germany and Luxembourg in 1998. The main emphasis of the study was on the examination of smoking habits, perceived social norms, knowledge, behavioural intentions towards smoking and a number of motivational and attitudinal factors concerning smoking. Some 1.881 pupils with a mean age of 11.4 years filled in the questionnaires.

Gender specific differences were found on all investigated variables:

- smoking behaviour
- smoking intention
- attitudes towards smoking
- negative expectations of smoking
- body awareness.

Data showed that even though fewer girls reported actual smoking behaviour than boys, the girls seem to be more at risk of starting to smoke in the future.

Results of the two studies indicate that

1. Smoking prevention should start in primary schools.
2. Gender specific programmes are not necessary in primary schools.
3. Gender specific components should be integrated in prevention programmes in secondary schools.

For more information on these studies contact: Dr Reiner Hanewinkel, IFT-Nord, Institute for Therapy and Health Research, Duesternbrooker Weg 2, D-24105 Kiel Germany.

For more information on youth programmes contact: Ms Meri Paavola, European Network on Young People and Tobacco, KTL, National Public Health Institute, Mannerheimintie 166, Fin-00300 Helsinki Finland

CHAPTER 4 - SOME FEAR WEIGHT GAIN

Research indicates that smoking may play a role in regulating weight. The 1988 U.S. Surgeon General's Report summarised the available data:

« In summary, there is substantial evidence of an inverse relationship between cigarette smoking and body weight. Of 71 studies reported since 1970, 62 (87%) collectively indicate that smokers weigh less than non smokers and that people who quit smoking gain weight. »

The 1990 Surgeon General's Report on cessation stipulated, however:

« The health benefits of smoking cessation far exceed any risks from the average 2.3 kg weight gain or any adverse psychological effects that may follow quitting. »

Weight gain after cessation of smoking may occur for some or all of the following reasons:

- loss of effects of nicotine
- loss of smoking behaviour
- increased energy intake, especially sweet foods
- reduced energy expenditure

There seems to be considerable variation in post-cessation weight gain: heavy smokers and weight-conscious women are among the most vulnerable. (Currister, 1995)

Numerous studies show that smokers keep weight down and that weight control is a significant motivation to continue smoking. (Pomerleau et al 1993) A recent study of teenage girls in London and Ottawa concluded that anxiety about body and shape regulation, the feeling of being too fat, and the fear of losing control of eating, may be important forces at work in sustaining cigarette smoking among teenage girls, who often believe that it will help them in their goal of weight control and weight loss. (Crisp et al, 1998)

Women are more concerned with weight than men. Young women are very concerned about their body image and perceive themselves easily as being overweight. In an European survey (1991) two thirds of the women aged 18-19 years old kept a check on their weight.

**TABLE 45 – PERCENTAGE
OF WOMEN WHO KEEP A
CHECK ON THEIR WEIGHT
IN THE EUROPEAN
COMMUNITY ACCORDING
TO AGE (1991)**

Age	%
18-19	67
20-24	57
25-39	55
40-54	59
55-69	55
+70	46

Source: Commission des Communautés Européennes, “Les femmes européennes et la nutrition”, 1991

Results of the 1993-94 survey of Health Behaviour in School-aged Children showed that the proportion of girls dieting, or who felt that they should be on a diet, was for two or three times higher than for boys in each survey country.

There is evidence suggesting that weight control and dieting are major obsessions among adolescent girls. For these girls, being slim gives self-confidence and is fashionable.(Chollat-Traquet, 1992)

**TABLE 46- PERCENTAGE OF
YOUNGSTERS (15 YEARS) IN 1993-94
WHO FELT THAT THEY SHOULD LOSE
WEIGHT OR FOLLOW A DIET.**

Countries	Girls	Boys
Belgium (fr.)	58 %	26 %
Wales	54 %	20 %
Spain	51 %	28 %
Belgium (fl)	50 %	18 %
Sweden	49 %	17 %
Scotland	53%	22%
Austria	51%	20%
Nordrhein Westfalen	51%	20%
Nancy and Toulouse	50%	16%

N-Ireland	50%	16%
Denmark	45%	21%
Finland	37 %	18 %

Source: Health behaviour in school-aged children

A distinction has to be made between overweight and the fear of being overweight: the latter is not always justified. According to a survey among 1198 students in Belgium, 46% of the girls felt that they were overweight while in reality they were not according to the International recognised Body Mass Index (Test Gezondheid, 1998)

However, obesity can not be disregarded as a problem: WHO Monica data across Europe indicate that the prevalence of obesity has increased by about 10%-40% in the majority of European countries. The most dramatic increase has been observed in England, where it has more than doubled during the period 1980-1995.

The two main contributors to obesity are a sedentary lifestyle and a high fat diet. People are not eating more, but are eating more fat and have a more sedentary lifestyle, a trend which may continue in the near future.

TABLE 47 - TRENDS IN OBESITY IN SELECTED EUROPEAN COUNTRIES			
COUNTRY	YEAR	PREVALENCE OF OBESITY MEN	PREVALENCE OF OBESITY WOMEN
England	1980	6.0	8.0
	1995	15.0	16.5
Finland	1978/9	10.0	10.0
	1991/3	14.0	11.0
Former East Germany	1985	13.7	22.2
	1992	20.5	26.8
Netherlands	1987	6.0	8.5
	1995	8.4	8.3
Sweden	1980/1	4.9	8.7
	1988/9	5.3	9.1

Source: WHO Monica

The prevalence of obesity is increasing in several European countries, both among men and women. Research indicates that smoking may play a role in regulating weight. Women are more concerned with weight than men. Young women are very concerned about their body image and perceive themselves easily as being overweight. The fear of being overweight, however, is even more common than the problem itself. There is evidence suggesting that the fear of weight gain may keep women from quitting smoking and there are indications that weight control considerations influence young women who take up smoking. Advice on weight management should be part of the smoking cessation treatment programmes for women (Rieder et al, 1993)

Any smoking prevention programme for teenage women should include attention to weight gain and consequent pursuit of thinness (Crisp et al, 1998)

Box 7 Stress reduction and smoking cessation among low income women

Stress and smoking are linked, especially among women, where smoking provides a release for tensions which may not be allowed other expression (aggression, anger, refusal, selfishness), given cultural expectations and roles. For women, meeting these expectations and living out their culturally ascribed roles may also cause stress to which smoking is a response. In this respect smoking may be seen as a coping mechanism with a positive impact on self esteem : it allows a woman to achieve culturally imposed ideals of feminine behaviour (as wives, mothers, daughters).

For the women who followed the educational programme known as 'Stressbusters' there were a diverse range of outcomes. Broadly speaking these can be divided into two categories: those relating to personal development and those relating directly to behaviour change. The women themselves placed great value on the personal development outcomes, seeing any behavioural change as following from their self-development. Areas in which they noted changes were in feelings of self confidence and self worth; feelings of being in control of their lives; ability to act assertively; and in improved communication and family relationships.

One quotation illustrates this: "The self respect and the self awareness thing, and to do with me, that I am important, has been a big help, ... I feel confident enough in myself to go and sort things out."

In relation to health behaviours, the women mentioned some improvements in healthy eating and weight control, taking regular exercise, and reduction of smoking levels, however, these were self-reported and unconfirmed by any other means. The significant factors in achieving these outcomes related to the educational process which the 'Stressbusters' programme followed. This emphasised sharing personal experience and drawing out lessons from this experience. This was then related in a very direct and personal way to theories which helped the women to understand stress and its effects. This learning was of a very personal nature and therefore held great meaning, and affected their motivation to act. The fact that they were encouraged to make very small changes to begin with, almost guaranteeing success was also important, as this reinforced their gains in self confidence.

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Tobacco and Women:

Understanding the past, changing the future

23-24 November 1998 Paris

Conference statement

The Conference « Women and Tobacco : understanding the past, changing the future » was held in Paris on 23-24 November 1998. The Conference was arranged by ENSP, European Network for Smoking Prevention, in the framework of the Europe Against Cancer program. More than 270 delegates from 25 countries attended. The participants represented governmental authorities as well as non governmental from international to local levels.

The Conference delegates agreed upon the following statement :

Tobacco use of women is one of the most serious issues for Europe as well as for the rest of the world. Three smoking trends are particularly alarming :

1. The percentage of women smokers is still increasing in six EU countries (Portugal, Spain, Italy, Greece, Luxembourg and Austria) mainly due to the rising level of smoking among younger women.
2. In most countries, the uptake of smoking among youngsters is increasing.
3. In most countries, girls are smoking slightly more than boys. In other words, in the youngest age group, women are smoking more than men.

Of particular concern is the fast growing epidemic in the former socialist countries. If this trend continues, it is possible that in the near future more women than men will smoke among the adult population hence intensifying an already major public health problem.

Tobacco is embedded within the social, political and cultural context of women's lives in Europe today. The higher concentration of smoking among lower income and educational groups is of great concern considering their health is already disadvantaged. In addition, tobacco addiction in women has the potential to compromise the emancipation of women.

Between 1975 and 1995 the number of deaths among women attributed to smoking in the European Union increased from 49 000 to 113 000. Across Europe at least double this number of women die every year because of smoking. In addition to the risk of coronary heart disease, cancer and pulmonary diseases, women face the risk of specific gender-related conditions including cervical cancer, osteoporosis, low birth rate and negative effects on reproduction. These include reduced fertility, increased risk of ectopic pregnancy and low birth weight of the child. If women smoke like men they will die like men.

Paris, November 24th 1998