Int J Public Health 52 (2007) 263–264
1661-8556/07/050263-2
DOI 10.1007/s00038-007-0221-6
© Birkhäuser Verlag, Basel, 2007

As if cigarettes were not enough, here comes narghile

A commentary on an article by Yunis et al. in IJPH 52/4

Ali H. Mokdad, Charles W. Warren

Dr. Ali H. Mokdad is working at the Division of Adult and Community Health, Dr. Charles W. Warren is working at the Office of Smoking and Health of the Centers for Disease Control and Prevention, Atlanta, USA.

It is time to take stronger action against the global epidemic of tobacco-related disease. Tobacco use is one of the major preventable causes of premature death and disease in the world. A disproportionate share of the global tobacco burden falls on developing countries, where 84% of 1.3 billion current smokers live (Jha & Chaloupka 2000). In the previous issue of IJPH, the paper by Yunis et al. (2007) focused on narghile, a form of tobacco use that is gaining popularity in many Arab countries as well as around the world (Soweid 2005).

Yunis et al. (2007) examined the narghile-related behavior among 4660 pregnant women in Beirut, Lebanon. They reported that about 14% of women in their study smoked either cigarettes or narghile on a regular basis. The authors reported that high education, adequate prenatal care, and mild smoking at baseline were the main determinants for cigarette smoking cessation during pregnancy. On the other hand, the successful quitters for narghile were nulliparous women. Although the study may not have all the variables needed to fully understand the main contributors to cessation during pregnancy, it is a step in the right direction. The findings from this study are not however representative of Lebanon. The women in this study live in an urban area and have better access to medical care; thus, it is very likely that the rates of smoking among pregnant women are higher elsewhere in Lebanon and the chances of cessation during pregnancy lower.

We think the broader importance of the paper by Yunis et al. (2007) is bringing the attention to the use of narghile. In many countries, including Lebanon, narghile is emerging as the preferred form of tobacco to use among women and young people. Moreover, it is easily accessible since many outlets are now offering deliveries. Indeed, in Lebanon, you can order a narghile with any flavor by telephone and it will be delivered shortly to your location. This signals important new challenges for international tobacco control. First, the World Health Organization Framework Convention on Tobacco Control (WHO FCTC (WHO 2003)), the world's first public health treaty on tobacco control, urges countries to develop action plans for public policies, such as bans on direct and indirect tobacco advertising, tobacco tax and price increases, promoting smoke-free public places and workplaces, and placing health messages on tobacco packaging. The emergence of narghile suggests these national action plans must be broad in focus, including many forms of tobacco and reach men, women and youth (boys and girls). Second, for decades the tobacco industry has targeted females and continues to expand this market (Hochberg 2007; CTFK 2007). The tobacco industry targets women through advertisements showing smoking associated with independence, stylishness, weight control, sophistication, and power. The tobacco industry markets cigarettes (such as Virginia Slims, Capri, Misty, and Camel No. 9) directly to women using feminine images. In addition, gender neutral brands such as Marlboro are marketed to women using independent and "fun-loving" imagery. Soweid (2005) has found similar advertising of narghile aimed at youth and women. National tobacco control programs must expand their efforts to confront these new forms of advertising. Third, cultural traditions and social influences may be changing; thus, making smoking among women and young girls more acceptable both at home and in public. This suggests tobacco control programs should focus on cessation for adult men and on prevention for women and youth (boys and girls).

The irony in all of this is that the Governments of the region provide curative medical care to all the population. For example, in Lebanon the Ministry of Health will pay for medical care regarding heart, cancer, dialysis, and recently mental health. This costs an estimated 13 % of the GDP in Lebanon. There is no doubt that the cost will increase given

© Birkhäuser Verlag, Basel, 2007

that preventive services are non-existent and the increase in risk factors of globalization (obesity, physical inactivity, and the rise in smoking). Lebanon cannot afford that, in fact, no country can.

Results of the study by Yunis et al. (2007) show risky patterns of narghile smoking among pregnant women in Beirut, Lebanon. Moreover, their literature review and discussion shows a rising burden of narghile and smoking in the Middle East. These findings suggest that countries must develop, implement and evaluate interventions shown to decrease tobacco use in their population (including increasing excise taxes, media campaigns, school programs in conjunction with community interventions, and community interventions that decrease minors' access to tobacco). These programs must be broad-based, focused on adults (men and women) and youth (boys and girls), and have components directed toward prevention and cessation. If effective programs are not developed and implemented soon future morbidity and mortality attributed to tobacco will surely increase. The WHO FCTC provides a useful framework for implementing such a comprehensive approach; national tobacco control programs must take advantage of all possible resources to achieve an effective program.

As a society, we are faced with a simple choice: Do we continue to turn a blind eye while a large segment of our population, including women of childbearing age, smoke tobacco, thereby placing themselves and others through second hand smoking, including their unborn children, at high risk of morbidity and mortality, or do we take decisive action by implementing evidence-based prevention strategies that can ultimately help us change social norms and reduce harms? The health and well-being of our generation and future generations rest on our decision.

Ali H. Mokdad
Charles W. Warren

The findings and conclusions in this article are those of the authors and do not represent the views of the Center for Disease Control and Prevention.

References

Campaign for Tobacco-Free Kids CTFK (2007). Tobacco Industry Targeting of Women and girls. CTFK Factsheet, May 7, 2007.

Jha P, Chaloupka FJ (2000). Tobacco Control in Developing Countries. Oxford: Oxford University Press.

Hochberg A (2007). Critics fume over marketing of "Camel No. 9". NPR, March 16, 2007. www.npr.org/templates/story/story.php?storyId=8909745.

Soweid RA (2005). Lebanon: Water pipe line to youth. Tobacco Control *14*: 363–4.

World Health Organization (2003). *WHO Framework Convention on Tobacco Control*. Geneva: World Health Organization.

Yunis K, Beydoun H, Nakad P, Khogali M, Shatila F, Tamim H (2007). Patterns and predictors of tobacco smoking cessation: A hospital-based study of pregnant women in Lebanon. Int J Public Health *52(4)*: 223–37.

Address for correspondence

Ali H. Mokdad
4770 Buford Highway, NE
MS K66
Atlanta, Georgia 30341 USA
e-mail: ahm1@cdc.gov

To access this journal online:
http://www.birkhauser.ch/IJPH