Pattern of tobacco use among the Iranian adult population: results of the national Survey of Risk Factors of Non-Communicable Diseases (SuRFNCD-2007)

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ABSTRACT

Background Previous studies report on smoking in Iran but recent national data on tobacco use (including cigarette, water-pipe and pipe) have not been reported.

Methods In 2007, 5287 Iranians aged 15–64 years were sampled from all provinces as part of a national cross-sectional survey of non-communicable disease (NCD) risk factors. Data were collected using the standardised stepwise protocol for NCD risk factor surveillance of the World Health Organization. Use of tobacco products was calculated as the sum of smoking cigarettes/cigars (smoking currently or daily any amount of factory/hand-made cigarettes or cigars), pipes (daily) and water pipes (daily).

Results Total current and daily tobacco use was 14.8% (burden 7.3 million) and 13.3% (burden 6.7 million) when extrapolated to the Iranian population aged 15–64. The prevalence of current and daily cigarette smoking was 12.5% (6.1 million; 23.4% males and 1.4% females) and 11.3% (5.6 million; 21.4 males and 1.4 females); former smokers comprised 1.7 million or 3.4% of the Iranian population (6.2% males and 0.6% females; mean cessation age 34.1). The mean age of starting to smoke was 20.5 years (24.2 males and 20.4 females). The prevalence of water-pipe smoking was 2.7% (burden 1.3 million; 3.5% males and 1.9% females). Water-pipe smokers used the water-pipe on average 3.5 times a day (2.8 males and 4.5 females).

Conclusion The prevalence of tobacco use has not escalated over the past two decades. Nonetheless, the burden is high and therefore warrants preventive public health policies.

Tobacco use is one of the major preventable causes of premature death around the world.1 Ninety per cent of all lung cancers, 70% of chronic bronchitis and emphysema and about 25% of ischaemic heart events have been attributed to cigarette smoking.2 Among 4000 chemicals detected in tobacco smoke, 60 are known or suspected to be carcinogenic.2 According to the World Health Organization, tobacco use in the 20th century resulted in 100 million deaths worldwide. Approximately 5 million deaths a year are attributed to tobacco, and this is projected to exceed one billion by the end of 21st century.3 Approximately 70% of these deaths will occur in developing countries.4 Developing nations embrace a disproportionate share of the global tobacco burden (84% of all current smokers), comprising 1.3 billion individuals.1 Recent prevalence estimates for low and middle-income countries are 49% for men and 8% for women.5 In addition, the harmful effects of passive smoking affect those people around smokers.6,7

To decrease the prevalence of tobacco use and to eliminate its related dangers, it is necessary to have a general view of the current condition. The purpose of this article is to demonstrate the extent of tobacco smoking in Iran in different strata of age, sex and residential area based on information from the third national Surveillance of Risk Factors of Non-Communicable Diseases (SuRFNCD, 2007).

METHODS

The third national SuRFNCD in Iran, designed based on the STEPwise guidelines of WHO, was conducted in May 2007 and involved 5287 Iranian citizens.6 This survey was approved by the ethics committee of the Center for Disease Management of Iran. The survey sampling was based on random clusters of 10 males and 10 females living in neighbouring households. The address of the first subject of each cluster was selected from the list of postal addresses of the Iran Post Company. The households were approached based on a predetermined plan. Sampling was continued until 20 volunteers were registered. The study population included non-institutionalised Iranian citizens aged 15–64 years. The survey sample was selected proportional to urban/rural population size of all 30 provinces of Iran. Participants were visited at their household by trained interviewers. Oral informed consent was obtained from participants.

Interviewers administered questionnaires containing six different domains: identification and demographic information, diet, physical activity, tobacco use, history of hypertension and history of diabetes. The tobacco-related questions of the STEPwise Approach to Chronic Disease Risk Factor Surveillance are built on the WHO guidelines for tobacco use surveillance documents. In brief, respondents were asked about current and daily use of any amount of any tobacco products including cigarettes, pipes and water-pipes. Tobacco use by pipe and ‘chopq’, a smoking instrument similar to a pipe, was addressed in one question. Current cigarette smoking was defined as smoking any amount of any kind of factory-made cigarettes, hand-made cigarettes or cigars at the time of the interview. The ‘current cigarette smokers’ who
smoked daily, were defined as ‘daily cigarette smokers’. Water-pipe and pipe/chopogh smokers were asked if they were daily habits. All measures considering overlaps were summed to estimate an overall prevalence of tobacco smoking. Respondents were also asked about history of daily use of any amount of cigarettes and cigars. Smoking cessation was inferred from this variable and comprised subjects who had been smoking any type of cigarettes (factory-made cigarettes, hand-made cigarettes or cigars) earlier, but they didn’t smoke at the time of the study. Finally the extent and age of initiation and abstinence of tobacco product use were recorded if indicated.

**Statistical analysis**

Complex sample survey analyses were performed by SPSS 16 for Windows. To extrapolate the results to the Iranian adult population, data were weighted directly to the 2006 population of Iran aged ≥15 years and ≤64 years, based on the 2006 national Iranian census, to match the age (10-year strata), sex and area of residence (rural/urban). Prevalence rates are presented with 95% CIs. Means of variables also are expressed with 95% CIs. ORs are reported where appropriate. All comparisons with external data were performed using 95% CIs. The burden of cigarette smoking was calculated by weighting the sample to the 15–64-year-old population of the country (Iran census 2006).

**RESULTS**

The total adult population of the country at the time of the study was about 49 million individuals aged 15–64 with 36% between 15 years and 24 years of age.

National estimate of prevalence rates of current tobacco smoking (including cigarette smoking, water-pipe and pipe) was 14.8% overall, 26.1% for men and 3.2% among women (table 1). Prevalence was highest among respondents aged 35–44 (22.4%). The prevalence of current cigarette smoking was 12.5% (95% CI 10.0% to 15.6%), which corresponds to more than 6.1 million Iranians aged 15–64 (table 2). The highest prevalence of current cigarette smoking was in individuals aged 35–44 years (19.9%). Males had much higher rates of current cigarette smoking than females (23.4% (95% CI 21.2% to 25.8%) vs 1.4% (95% CI 1.0% to 2.0%); OR=21.5 (95% CI 16.2 to 27.9)). Current cigarette smoking was found in 12.7% and 12.1% of residents in urban and rural areas, respectively (OR = 1.1 (95% CI 0.9 to 2.0)). About 90.5% of current smokers were daily smokers (11.5% of the total adult population (95% CI 9.0% to 14.1%), representing 5 570 000 Iranians). Less than 5% of respondents (3.4%; 95% CI 2.7% to 4.3%) were former smokers, representing 1 680 000 Iranians. The prevalence of former smokers was highest in those aged 55–64 (7.9%).

In all, 2.7% (95% CI 2.2 to 3.4) or 1 341 000 Iranians were daily water-pipe users and 0.3% (95% CI 0.2 to 0.5; 152 000 Iranians) smoked tobacco by chopogh or pipe (table 3). More than half of tobacco smoking women (ie, 1.9% of overall 3.2%) smoke tobacco employing water-pipe. Females do not use pipes to smoke.

On average 13.7 cigarettes were smoked per day among daily smokers (95% CI 12.1 to 15.3) (table 4). Daily-water-pipe smoking individuals smoked on average 3.5 times a day (95% CI 1.8 to 5.2). Pipe and chopogh daily tobacco smokers smoked 2.2 times a day on average (95% CI 0.8 to 3.6).

The mean age of starting to smoke was 20.4 (95% CI 19.7 to 21.0) years in males, 24.2 (95% CI 21.8 to 26.7) years in females, and 20.5 (95% CI 19.9 to 21.2) overall (table 4). The age of first smoking experience is almost the same in urban and rural areas.

**Table 1**  Estimates of current and daily tobacco smoking, Iran, 2007

<table>
<thead>
<tr>
<th>Variable</th>
<th>Subcategory</th>
<th>Population size ('000s)</th>
<th>Current use</th>
<th>Daily use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Burden</td>
<td>Prevalence (95% CI)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>15–24</td>
<td>17710</td>
<td>1608050</td>
<td>9.1% (6.8 to 11.9)</td>
</tr>
<tr>
<td></td>
<td>25–34</td>
<td>12760</td>
<td>1830350</td>
<td>14.4% (11.6 to 17.7)</td>
</tr>
<tr>
<td></td>
<td>35–44</td>
<td>9000</td>
<td>2014100</td>
<td>22.4% (17.7 to 26.4)</td>
</tr>
<tr>
<td></td>
<td>45–54</td>
<td>6270</td>
<td>1314200</td>
<td>21.6% (17.1 to 25.4)</td>
</tr>
<tr>
<td></td>
<td>55–64</td>
<td>3350</td>
<td>501600</td>
<td>15.0% (12.0 to 18.5)</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td>24840</td>
<td>648700</td>
<td>26.1% (23.8 to 28.6)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>24250</td>
<td>784000</td>
<td>3.2% (2.6 to 4.0)</td>
</tr>
<tr>
<td>Residential area</td>
<td>Urban area</td>
<td>34520</td>
<td>5031000</td>
<td>14.6% (11.8 to 17.9)</td>
</tr>
<tr>
<td></td>
<td>Rural area</td>
<td>14570</td>
<td>2240000</td>
<td>15.4% (10.1 to 22.7)</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>49090</td>
<td>7271000</td>
<td>14.8% (12.2 to 17.9)</td>
</tr>
</tbody>
</table>

RR


### Table 4: Mean estimates of smoking subpopulations, Iran, 2007

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>15–24</th>
<th>25–34</th>
<th>35–44</th>
<th>45–54</th>
<th>55–64</th>
<th>Male</th>
<th>Female</th>
<th>Rural</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age when starting to smoke</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17.2 (16.3 to 18.1)</td>
<td>19.6 (18.9 to 20.3)</td>
<td>21.7 (19.8 to 23.6)</td>
<td>22 (20.5 to 23.5)</td>
<td>23.5 (21.7 to 25.3)</td>
</tr>
<tr>
<td><strong>Number of cigarettes smoked per day</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13.1 (12.1 to 14.1)</td>
<td>11.8 (10.5 to 13.1)</td>
<td>13.6 (12.2 to 15.1)</td>
<td>16 (14.4 to 17.6)</td>
<td>15.7 (13.9 to 17.5)</td>
</tr>
<tr>
<td><strong>Age of smoking cessation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24.5 (15.5 to 33.2)</td>
<td>25.5 (23.4 to 27.6)</td>
<td>31.7 (28.9 to 34.5)</td>
<td>37.3 (34.3 to 40.3)</td>
<td>45.3 (42.2 to 48.5)</td>
</tr>
<tr>
<td><strong>No of times of use of pipe and chopogh per day</strong></td>
<td>2 (2 to 2)</td>
<td>1 (1 to 1)</td>
<td>1.7 (1 to 2.4)</td>
<td>15 (15 to 15)</td>
<td>1 (1 to 1)</td>
<td>2.2 (0.6 to 3.8)</td>
<td>2 (2 to 2)</td>
<td>2 (1 to 3.1)</td>
<td>2.3 (0.4 to 4.2)</td>
<td>2.2 (0.8 to 3.6)</td>
</tr>
<tr>
<td><strong>No of times of use of water-pipe per day</strong></td>
<td>5.3 (0.4 to 10.3)</td>
<td>2.1 (1.5 to 2.7)</td>
<td>1.9 (1.5 to 2.3)</td>
<td>3.4 (1.4 to 5.3)</td>
<td>5.2 (0.4 to 10.8)</td>
<td>2.8 (1.6 to 3.9)</td>
<td>4.5 (0.8 to 8.2)</td>
<td>2.2 (1.6 to 2.8)</td>
<td>4.5 (1.7 to 7.3)</td>
<td>3.5 (1.8 to 5.2)</td>
</tr>
</tbody>
</table>

Data are mean and 95% confidence limits in parentheses.

*Age of initiating smoking as a daily habit.
†The number of cigarettes smoked daily at the time of the study.
‡The age of quitting daily consumption of any type of cigarettes (factory-made cigarettes, hand-made cigarettes or cigars).
§The times of smoking pipe and chopogh which are full of tobacco.
What is already known on this subject?

- Developing nations experience a disproportionate share of the global tobacco burden. Estimates for low and middle-income countries are 49% for men and 8% for women. Up-to-date national estimates of the tobacco burden in Iran do not exist.

What this study adds

- The results of this study provide baseline information to monitor public health strategies for fighting tobacco abuse. The prevalence of daily smoking in Iran (24.3% in males and 2.9% in females) is not as high as in developed nations. Further, the prevalence of smoking in Iran did not increase over the past two decades. Nevertheless, because of the escalating size of the Iranian adult population, the smoking burden will likely rise in future.

CONCLUSION

Developing nations experience a disproportionate share of the global tobacco burden. The results of this study provide baseline information to monitor tobacco control strategies. The prevalence of daily smoking in Iran (24.3% in males and 2.9% in females) is not as high as in most developed nations. Furthermore, the prevalence of smoking in Iran did not increase over the past decades. Nevertheless, because of the escalating size of the Iranian adult population, the smoking burden will likely rise in future.

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Competing interests The authors declare no competing interests.

Ethics approval This study was approved by the ethics committee of the Center for Disease Management of Iran.

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REFERENCES