Policies and Strategies
HEALTH PROFESSIONALS AGAINST TOBACCO

ACTION AND ANSWERS

World No Tobacco Day - 31 May

HEALTH PROFESSIONALS AGAINST TOBACCO

The Health Professionals Code of Practice on Tobacco Control was developed by representatives from international health professional regulatory bodies and endorsed by 482 national experts from the potential six health professional and their organizations to support tobacco control and public health goals, including support for the WHO FCTC process.

www.who.int/tobacco/health_professionals
10. How to Make Policies More Gender-Sensitive

Introduction

Although tobacco control policies have been on record since the late 1800s, most of the early tobacco control legislation focused on policies banning sales of tobacco to youth. For example, an 1890 District of Columbia ordinance prohibited the sale of cigarettes to minors in the United States; and in 1900, smoking by persons under 20 years of age was prohibited in Japan, where the sale of cigarettes to minors was also banned. Once the epidemiological evidence on the relationship between smoking and lung cancer and other diseases emerged, tobacco control initiatives began to focus more broadly on prevention and cessation of smoking for the public’s health.

Until recently, tobacco control initiatives did not reflect the population’s diversity and did not specifically address women’s concerns. Diversity was lacking in policy largely because it was missing in the early epidemiological research that fuelled such policy. Because the smoking epidemic started primarily among upper-class men in industrialized countries, men were hit first by its devastating health consequences, making them prime targets for research. At the time, women were considered a minority of the smoking population and were not of great interest to clinicians. As a result, a significant opportunity was lost in early research to study ways in which smoking might affect women’s health. Because of this missing research demographic, most policies were crafted without concern for the rates of smoking or tobacco-related disease among women. Fortunately, this male-centred approach has since been challenged, and new directions are being sought.

This chapter examines a policy model for understanding the relationship between gender and tobacco control with a focus on women. In addition, it highlights the tobacco control policies of four countries—China, South Africa, Sweden, and the United Kingdom—to provide four distinct case-studies that depict the incorporation (or non-incorporation) of gender into health policy. These countries were selected because they exemplify industrialized and developing countries at differing stages of tobacco control programme development with varying rates of smoking prevalence among women.

South Africa and China represent expanding markets for the tobacco industry, and women are being specifically targeted by marketing efforts. Sweden provides an interesting case-study, as it is one of the few countries in which the smoking prevalence of women is higher than that of men. Finally, the United Kingdom, though similar to other industrialized countries in terms of smoking prevalence rates, provides some contrast to those countries because of its relatively late adoption of stringent tobacco control policies.

While the four countries selected as case-studies in no way represent the full diversity of political, economic, and social contexts or the diversity of tobacco control policies, they do offer insights into ways in which the content of tobacco policies can address both gender inequality and women as a group. While there are considerable gaps in national data concerning the effects of tobacco control policies on women, current evidence points to interesting trends and advocacy issues for the future. Table 10.1 presents age-standardized smoking prevalence among adult (15 years and older) males and females in the four countries.

A Framework for Gender-Sensitive Policy

Gender has long been established as a major factor in women’s health, affecting the occurrence, etiology, treatment, and eventual outcome of illness. The concept of gender refers specifically to men’s and women’s socially determined roles and responsibilities. It is distinct from men’s and women’s biological and reproductive characteristics, because it is shaped by historical, cultural, economic, and political constructs. By definition, then, gender constructs can be changed and may permeate institutions as well as influence individual actions. It is important to note that the sex-based (or biology-based) differences between men and women also impact men’s and women’s morbidity and mortality.

As described by Greaves and Jategaonkar and in the chapter on a gender equality framework in this monograph, gender has become an important factor in smoking
behaviour. Historically, men have had higher rates of smoking prevalence than women. However, data from the Global Youth Tobacco Survey (GYTS) suggest that smoking rates of adolescent females are higher than those of adolescent males in the United States, as well as in some countries in Europe and South America. The survey also indicates women’s differential exposure to second-hand smoke (SHS) in households and workplaces. In some settings, women may be unable to avoid environmental tobacco smoke because of power imbalances between men and women. There is also an interaction between socio-economic status (SES) and gender, which influences the motivations for smoking initiation and smoking cessation. This interaction underlies much of the current policy debate surrounding gender-sensitive policies.10–14

The tobacco control policies of the four countries examined in this chapter can be classified according to their gender sensitivity. According to Kabeer,15 whose work has shaped much of the research and action on gender equality in the development field, the first step in analysis is to look at the different ways that gender is present or absent in policies.

Gender-blindness is the ignoring of the socially determined gender roles, responsibilities, and capabilities of men and women. Gender-blind policies, though they may appear to be unbiased, are often, in fact, based on information derived from men’s activities and/or the assumption that all persons affected by the policies have the same needs and interests as men.16 For example, policies that target a particular population of smokers (e.g. all smokers or young smokers) may be based exclusively on men’s experiences and needs.

**Gender-blind policies, though they may appear to be unbiased, are often, in fact, based on information derived from men’s activities and/or the assumption that all persons affected by the policies have the same needs and interests as males.**

In contrast to gender-blind policies, gender-sensitive policies take gender relations into account. Kabeer’s framework describes three types of gender-sensitive policies: gender-neutral, gender-specific, and gender-redistributive. Gender-sensitive policies take into account the different social roles of men and women that lead to women and men having different needs. The three types of policies are described below.

**Gender-neutral policies** are not aimed specifically at either men or women and are assumed to affect both sexes equally. A gender-neutral policy allocates resources to meet specific goals, such as reducing the number of young people who initiate smoking. Gender-neutral legislation could include the banning of tobacco advertising and control of SHS through regulation of smoking in public places and workplaces. Taxation of tobacco and restrictions on places where smoking is permitted may be viewed as gender-neutral policies. While these types of policies are gender-neutral by design, their impact may, in fact, be gendered.

**Gender-specific policies** acknowledge that women’s gender-related needs have been neglected in the past and advocate on behalf of gender equality. Such policies identify specific strategies that are appropriate for women. Gender-specific tobacco control policies acknowledge the different socioeconomic and cultural factors that contribute to tobacco use among women, as compared with men. Under these policies, specific

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**Table 10.1. Age-Standardized Current Tobacco Smoking Prevalence of Men and Women in China, South Africa, Sweden, and the United Kingdom**

<table>
<thead>
<tr>
<th>Country</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>59</td>
<td>4</td>
</tr>
<tr>
<td>South Africa</td>
<td>29</td>
<td>9</td>
</tr>
<tr>
<td>Sweden</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>26</td>
<td>24</td>
</tr>
</tbody>
</table>

Source: Ref. 22.
programmes are implemented that address the needs and interests of women, while continuing to address the needs of men. For example, since health-worker interventions have proven effective in influencing clients to stop smoking, some tobacco control policies train health workers to use smoking cessation methods and messages that are specific to pregnant women. These programmes improve the health of both the women and their fetuses. Programmes that target pregnant women are by their nature gender-specific (owing to women’s biological capacity for reproduction).12

Gender-redistributive policies recognize that because of political and economic inequality, women are often excluded or disadvantaged in terms of access to social and economic resources and involvement in decision-making. The goal of gender-redistributive policies is to rebalance the power structure to create a more balanced relationship between men and women. The policies therefore target both sexes, either simultaneously or separately. Implicit in gender-redistributive policies is the notion that they have the potential to “create supportive conditions for women to empower themselves”.17 For example, granting microcredit loans to women is a redistributive policy, as it changes the balance of financial resources between men and women in the household. Greaves and Tungohan11 suggest that combining tobacco control with housing or child-care programmes has the potential to “transform gender relations”, which is the ultimate goal of redistributive policies.

Figure 10.1. Kabeer’s Framework for Gender-Sensitive Policies

Source: Adapted from March, Smyth, and Mukhopadhyay.17
It should be noted that in circumstances where the norm has been gender-blind policies, gender-neutral policies could represent a step forward. It is also possible that gender-redistributive policies may not be the best solution in all circumstances.\textsuperscript{17}

Figure 10.1 presents a framework for Kabeer’s gender-sensitive policies.

Ideally, tobacco control policy could lead to the transformation of gender relations in other domains. More often than not, however, tobacco policy tends to exploit existing gender relations or accommodate and reinforce them.\textsuperscript{11} For example, tobacco control policies that specifically target women for “protection” can be viewed as paternalistic. Likewise, marketing that focuses on women’s independence or liberation exploits existing gender inequalities. Programmes that target pregnant women or smoking at home in the presence of children can be viewed as accommodating and reinforcing women’s traditional gender roles without doing anything to change them. Tobacco control has the potential to go beyond simply reducing women’s vulnerabilities to tobacco and to move towards the achievement of greater gender equity.\textsuperscript{11}

**Gender-redistributive policies**

recognize that because of political and economic inequality, women are often excluded or disadvantaged in terms of access to social and economic resources and involvement in decision-making.

The WHO Framework Convention on Tobacco Control (WHO FCTC)\textsuperscript{18,19} specifically calls for women’s participation in policy-making and policy implementation. Articles 6–17 of the WHO FCTC\textsuperscript{19} detail policy measures that should be enacted to reduce both the supply and demand of tobacco. The following discussion highlights the supply- and demand-side measures that provide the greatest opportunity for gender-sensitive policy development.

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**Measures Favouring Gender-Sensitive Policy Development**

**Price and Tax Measures**

The effect of imposing taxes is indicated by price elasticity, a measure of change in consumption in response to a specified change in price. Depending on the population of smokers surveyed, the price elasticity of tobacco ranges from $-0.4$ to $-0.8$, meaning that a 10% increase in cigarette price will yield a 4% to 8% decrease in the number of cigarettes smoked.\textsuperscript{20} Studies have shown that one of the clearest and most immediate influences on tobacco use is the price of tobacco products. Tobacco control policies that include taxation of tobacco products therefore reduce tobacco consumption.\textsuperscript{21} This is elaborated in the chapter in this monograph on taxation and the economics of tobacco control.

Article 6 of the WHO FCTC\textsuperscript{19} encourages Parties to adopt price and tax measures as an “effective and important means of reducing tobacco consumption by various segments of the population”. The treaty is very direct in saying that this measure is intended to curtail smoking among young people who are most sensitive to price changes. Studies from the United States confirm the consistent price sensitivity of young people. The fact that young female smokers outnumber young male smokers in many industrialized countries indicates that young women are substantially affected by increases in tobacco prices.\textsuperscript{22}

Adults are also affected by increasing cigarette prices. Although evidence is mixed as to whether adult women are more sensitive than men to changes in price, it is clear that individuals from lower socioeconomic backgrounds are more price-sensitive than their wealthier counterparts. In the United States, adolescent males are more sensitive to price than adolescent females are, while in the United Kingdom, females are more sensitive to price. In the lowest socioeconomic groups, smoking prevalence among both males and females is correlated with the price of tobacco products.\textsuperscript{23}

Although measures to increase tobacco prices are applied equally to men and women (i.e. are gender-neutral), it is important to recognize that the consequences of such
measures are gender-specific—more women than men are affected by increasing prices, because a greater proportion of the poor are women. Greaves and Tungohan suggest that in addition to assistance in implementing taxes or raising prices, assistance with cessation or social support to ensure that addicted women are not doubly disadvantaged by gender and income inequalities should be included as countries implement the provisions of the WHO FCTC.

All four of the countries examined in this chapter have some form of consumer-incurred tobacco tax, but the degree to which taxation is used as a tobacco control measure varies greatly. Sweden increased taxes on tobacco in 1996 and 1997, and consumption decreased with each increase in price. Taxation was reduced in 1998, however, because of a perceived increase in smuggling (and a lack of public support for the tax increases). Interestingly and somewhat unexpectedly, the overall prevalence of smoking remained similar in the years before and after the tax repeal (19.1% in 1998 and 19.3% in 1999) and continued to decrease through 2005.

Limiting cigarette consumption by increasing taxation was the primary focus of South Africa’s first tobacco control strategy in the 1990s. In South Africa and the United Kingdom, consumption decreased with an increase in taxation that raised the real price of cigarettes. However, changes in consumption were not compared across sex and age. An oversight in the taxation policy in South Africa is the exclusion of snuff, which is used primarily by rural women.

China, the largest grower of tobacco leaf in the world, has been reluctant to increase tobacco taxes for fear of damaging its own economy. At present, China has some of the world’s lowest taxes on tobacco products. The Chinese government has acknowledged the health risks of smoking and has discussed a variety of tobacco control options (e.g. bans on advertising) but has failed to increase tobacco taxes to reduce consumption. Upon ratifying the WHO FCTC, the Chinese government issued a statement indicating that non-price measures would be its first tobacco control priority.

Protection from Exposure to Tobacco Smoke

In countries where smoking rates are high among men and low among women, such as some countries in Asia and Africa, women are more likely than men to be exposed involuntarily to tobacco smoke and to be at increased risk for a number of smoking-related diseases. This issue is described in the chapter on SHS in this monograph.

Article 8 of the WHO FCTC calls upon Parties to provide protection from SHS in public transport, indoor workplaces, indoor public places, and other public areas. Some advocates question the effectiveness of restrictions on smoking in public places and workplaces in countries where women traditionally do not work outside the home. While regulations affecting public places may not appear to affect women’s exposure to smoke in the home, such restrictions can create a social climate in which it is not acceptable to smoke indoors. This can empower non-smoking women to limit smoking in their homes. Education aimed at male smokers is still needed to increase awareness of the health risks to their families from SHS.

While regulations affecting public places may not appear to affect women’s exposure to smoke in the home, such restrictions can create a social climate in which it is not acceptable to smoke indoors.

In 1993, the Swedish Tobacco Act called for smoke-free workplaces, although special smoking rooms were permitted in most cases. In 2004, an amendment to this act was passed whereby restaurants and bars were required to be smoke-free by 2005, with the option of building separately ventilated smoking rooms. By 2005, smoking bans were in place in health-care facilities, educational facilities, government facilities, restaurants, pubs and bars, indoor workplaces and offices, theatres, and cinemas.

China’s 1991 Tobacco Monopoly Act requires smoking to be banned or restricted on public transport and in transport-related public places. The 1991 Act for Protection of Minors also bans smoking in the classrooms and dormitories of middle schools, elementary schools, and kindergartens. Federal legislation in China is generally very weak, by international standards, and
is not strongly enforced. Therefore, many municipalities have taken it upon themselves to introduce and monitor their own smoking bans. By 1996, more than 70 cities in China had introduced piecemeal legislation to ban smoking in places such as theatres, video halls, music venues, indoor sports stadia, reading rooms, exhibition halls, shopping malls, waiting rooms, public transport, schools, and nurseries. By October 2006, 46% of Chinese cities had bans on public smoking that were more stringent than the national law. Unfortunately, the rationale behind these efforts may not be reaching the general population. A 2007 study of low-income workers found that only 25% were aware of the dangers of passive smoking, despite the fact that most of the workers surveyed were subject to workplace smoking restrictions.

Workplace smoking has not been addressed by the Chinese government, either federally or locally, although some groups (e.g. health-care institutions) have adopted voluntary smoke-free policies. There were plans for a “smoke-free Olympics” in Beijing in 2008, but reports leading up to the games indicated that legislators had created sizeable exemptions (e.g. for bars and restaurants).

The United Kingdom’s *Smoking Kills: A White Paper on Tobacco* revealed that smoking restrictions in public places were weak in the 1990s. At the time, the United Kingdom’s tobacco control policy placed greater emphasis on the individual’s right to smoke than on health. However, some underground trains, buses, above-ground trains, workplaces, shops, banks, and post offices went smoke-free (despite the lack of national regulation) in response to customer demands. Bans on smoking in public places changed dramatically when the Republic of Ireland went smoke-free in 2004. Scientific studies quickly assuaged fears that smoking was being driven “inside the home” by demonstrating that in-home smoking rates were no different between Ireland and the United Kingdom. Seventeen countries have adopted pictograms, including some developing nations, such as India, Brazil, and Jordan. This has great implications for women’s access to health messages in these countries.

South Africa also requires health warnings on packages of cigarettes. Examples include “Smoking causes lung cancer” and “Smoking is addictive”. These warnings attempt to reach broad audiences.

China’s first anti-tobacco law, which went into effect in January 1992, mandated the printing of tar levels and health warnings on domestic and imported cigarettes. Even the most ardent Chinese tobacco control advocates are reluctant to see graphic warning labels on cigarette packages, however, for fear that “ugly pictures would mar the packs traditionally given as presents to wedding guests”. Nevertheless, by signing the WHO FCTC, China agreed that by 2008, clear health warnings would occupy more than 30% of the surface of every cigarette pack sold.

### Packaging and Labelling of Tobacco Products

Mandatory health warnings on cigarette packages are used to alert the public to the dangers of tobacco use. Article 11 of the WHO FCTC describes the treaty’s requirements for the packaging and labelling of tobacco products. Within three years of signing the WHO FCTC, Parties are required to provide health warnings that cover a minimum of 30% of tobacco-product packaging and to remove misleading package labels that imply “healthier” products (e.g. “low tar” or “light”). So-called “health-conscious” tobacco products are more likely to be adopted by women, suggesting that removal of these misleading labels will have a greater impact on women. Additionally, because the majority of the world’s illiterate population is female, the policies created regarding tobacco packaging and labelling should include pictorial or other non-written messaging in order to be gender-sensitive.

Iceland and Canada led the world in the incorporation of pictograms into tobacco package warnings. The European Union has given each of its 25 countries the option to include pictorial warnings on cigarette packages. Accordingly, the United Kingdom developed its own pictograms that went into effect in October 2008. Seventeen countries have adopted pictograms, including some developing nations, such as India, Brazil, and Jordan. This has great implications for women’s access to health messages in these countries.

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**Education, Communication, Training, and Public Awareness**

Article 12 of the WHO FCTC promotes public information, training, and education campaigns. Specifically, it imposes a legal obligation on Parties to promote access to information about the dangers of tobacco consumption and the benefits of cessation. Public awareness efforts can target specific groups, including children, young adults, and pregnant women. Because men and women cite different motivations for smoking initiation and because adolescent males and females have different predictors for initiation, there is good reason to believe that prevention messages should be gender-specific. This is not to say that entire programmes must be gender-specific, but health professionals (i.e. instructors and clinicians) should understand the gender differences in smoking initiation, so that prevention efforts can be maximized. Hoving et al. point to the need for continuing to teach girls skills that will build self-efficacy and allow them to resist social pressure; boys may need more messages regarding the negative consequences of smoking and may need programmes that simultaneously target other risk-taking behaviours such as alcohol consumption.

In addition to different initiation rates and rationales, other gender differences must be addressed by national education and health-worker training programmes. As Greaves and Tungohan suggest, the substantially higher illiteracy rates among women in developing nations may prevent women from accessing messages about the risks of using tobacco products. They suggest that tobacco control programmes should work with organizations that promote female literacy to ensure that appropriate messages are developed and transmitted via multiple types of media.

Policies in all four of our case-study countries include health promotion. Unlike anti-tobacco laws and regulations, which require small amounts of money for monitoring and evaluation, health education programmes can be very costly. The state of prevention programmes, educational efforts, and health-worker training in the four countries varies greatly, largely as a result of the financial resources available (or made available) for tobacco control.

Sweden’s strong tobacco health education activities include school-based programmes about the health hazards of tobacco use and public awareness campaigns revolving around the annual World No Tobacco Day and the national non-smoking day.

Before the publication of its white paper on tobacco in 1998, the UK government allocated resources to various health education agencies for anti-tobacco campaigns. The white paper outlined extensive health-promotion activities, including mass media and education campaigns. The latter included the training of health workers and teachers through initiatives such as the Healthy Schools Campaign. The United Kingdom also has a highly successful national public awareness campaign to help people quit smoking—the annual UK No Smoking Day, which is now in its twenty-fifth year.

In South Africa, a number of health education efforts have been undertaken to prevent smoking. In 2002, the National Council Against Smoking sponsored a “Quit & Win” campaign that awarded substantial prizes to a pool of eligible former smokers, all of whom had successfully quit smoking for at least four weeks. The National Council Against Smoking also runs a tobacco/health information hotline and provides online advice regarding smoking cessation.

In 2005, cigarette sales in China generated US$ 32.5 billion in taxes and profits, yet the national government spent less than US$ 31 000 on tobacco control measures, including national public awareness campaigns. Although China did participate in the 21st annual World No ‘Tobacco Day in 2008 by asking taxi drivers to post no-smoking signs in their windows, it is difficult to identify other nationally guided smoking prevention programmes.

Health promotion is a key area for the implementation of gender-sensitive policy. Unlike laws and regulations that must be gender-neutral in design and application, health promotion has the distinction of being able to purposefully target gender differences in smoking initiation rationales in order to maximize prevention efforts. For example, women are the focus of gender-specific programmes such as Scotland’s Women, Low Income, and Smoking project. Given the higher rates of smoking among women in Sweden, several health education programmes there also specifically target women. Sweden has published self-help manuals for different target audiences, including pregnant women, parents, young girls, and older women, which touch upon topics such as how to give up smoking.
without gaining weight. Since 1996, all candidates for the title of Miss Sweden have had to be non-smokers. The finalists for the competition receive training from the Swedish National Institute of Public Health about how to convey anti-smoking messages to children on their tours of local schools.

Some women’s groups have raised objections to focusing women’s anti-smoking programmes solely on pregnant women, noting that too often the motivation for such targeting has not been the reduction of smoking among women, but rather the protection of the fetus.

Tobacco Advertising, Promotion, and Sponsorship

Article 13 of the WHO FCTC mandates that Parties undertake a comprehensive ban or, in cases of constitutional limitations, a restriction of all tobacco advertising, promotion, and sponsorship. Evidence suggests that in both industrialized and developing countries, advertising bans have a negative effect on tobacco consumption: decreases of approximately 6% have occurred when comprehensive advertising restrictions are in place. Partial advertising restrictions have little to no effect on overall smoking consumption, because the tobacco industry quickly shifts marketing efforts to non-restricted media. Advertising restrictions are gender-neutral in their design, but because of the specific targeting of women by the tobacco industry, the restrictions may in fact be gender-sensitive in their effect.

Tobacco advertising on Chinese television and radio and in magazines was banned in 1992, but the restriction only encouraged tobacco companies to shift marketing funds into non-restricted areas, such as sponsorship of sports, art, and music. The 1996 Prevalence Survey of Smoking in China specifically highlighted the need to maintain low smoking rates among women through aggressive campaigns to counter the targeting of women by the tobacco industry. However, it is not clear that any campaigns have been successful. China still permits a variety of advertising avenues that are considered highly female-targeted, including the free distribution of tobacco products by mail, promotional discounts on tobacco products, and the branding of non-tobacco products with tobacco brand names. All forms of tobacco advertising will be banned in China by 2010.

South Africa has never permitted the direct advertising of cigarettes on television, and it also bans tobacco advertising in local and international magazines and newspapers. Industry-sponsored sports and music events, such as Rothman’s soccer, circumvented the television advertising bans until 1999, when South Africa’s Tobacco Control Act of 1993 was amended to include bans on all tobacco advertisements, including indirect advertising and promotional events. The proposed 2008 amendment to the Tobacco Control Act further restricts advertising and increases the fines for those failing to meet the requirements of the Act.

Sweden’s first restrictions on tobacco advertising were introduced in the 1960s. These included the restriction of advertising in theatres, cinemas, sports arenas, and sporting events and on sports pages in magazines and newspapers. In the 1970s, tobacco companies were forbidden to use human models in their advertisements. By the end of that decade, health warnings became mandatory on advertisements for tobacco products, and the advertising of tobacco products on national television and radio was banned. Sweden, like the rest of Europe, still has not banned advertising on international television and radio. Although Sweden does not allow the free distribution of tobacco products or the branding of non-tobacco products with tobacco brand names, it does allow for promotional discounts on tobacco products.

The United Kingdom originally banned the advertisement of cigarettes on television in 1964, and it banned such advertising on the radio in 1973. Successive governments wanted to follow a voluntary approach, but more recently, between 2002 and 2005, the United
Kingdom phased in an advertising and sponsorship ban. This new ban forbids billboard and press advertising and extends to the sponsorship of sports. Unlike Sweden, the United Kingdom bans promotional discounts on tobacco products.\textsuperscript{22}

A total ban on the advertising of and sponsorship by tobacco products reduces smoking in most groups, making it a gender-neutral policy. But since it is clear from tobacco industry documents that women are being specifically targeted, enforcement of a complete ban on advertising and promotion across all tobacco products and in all media is recommended as an integral part of a comprehensive, gender-sensitive tobacco control policy.

\textit{Tobacco Dependence and Cessation Measures}

Article 14 of the WHO FCTC encourages Parties to design and implement effective programmes aimed at promoting the cessation of tobacco use. While the treaty does not specifically mention the need for gender sensitivity in such programmes, current research indicates that gender-specific cessation messages, counselling services, and health-worker training may be as important as prevention activities. Although nicotine dependency is equally strong in men and women, the difficulty of smoking cessation does appear to differ by gender. Women report using cigarettes more frequently with other women, meaning that group dynamics and a desire for socialization may hinder the quitting process for women. Additionally, studies show that women report greater fears of weight gain associated with quitting and have higher rates of depression, which may create additional barriers to cessation.\textsuperscript{58} These differences demonstrate the need for gender-specific cessation programmes that target the quitting “hurdles” unique to women.

Some women’s groups have raised objections to focusing women’s anti-smoking programmes solely on pregnant women, noting that too often the motivation for such targeting has not been the reduction of smoking among women, but rather the protection of the fetus. Women are thus considered only in their procreative role. As a result, programmes that aim to reduce smoking by pregnant women have sometimes been labelled as “victim blaming”, and their designers have been accused of using guilt to encourage women to stop smoking. Nevertheless, programmes that seek to integrate pregnant women into larger cessation efforts are highly effective in reducing the number of women who smoke during pregnancy. In 2003, fewer than 10\% of Swedish women reported smoking daily during pregnancy, a reduction of more than 50\% from the level in the 1990s.\textsuperscript{59}

The 1998 UK white paper recognized the need to provide support to prevent relapse into smoking by mothers after a baby’s birth.\textsuperscript{58} The UK policy increasingly seeks to encourage women to quit smoking during pregnancy as a way of breaking the cycle of health inequalities, since the vast majority of these women smokers are poor, young, and undereducated. The government tries to reach them through the National Health Service’s Stop Smoking Services, as well as through social programmes that target infant and child health and development, such as Sure Start. Stop Smoking Services were launched countrywide in 2000 and 2001; they include a national help line, a dedicated web site, the provision of cessation prescriptions, and one-on-one counselling and support groups in local centres.\textsuperscript{60} The annual 2004–2005 expenditure on this programme was £46.8 million, excluding the cost of prescriptions. Despite such a strong government stance on smoking cessation, the Service has been called to task for its failure to provide adequate services to underage smokers, of whom females constitute the majority. A 2003 survey found that fewer than 7\% of all service providers in England accepted referrals from underage smokers,\textsuperscript{61} indicating that beliefs about “propriety” may be overshadowing public health needs.

State funding for cessation programmes is nonexistent in China. The US$ 31 000 the Chinese government spent on tobacco control in 2005 was intended for prevention and cessation programming\textsuperscript{36} for the country’s 1.3 billion residents. The overwhelming majority of the poor are uninsured and rely on out-of-pocket payments for health care,\textsuperscript{35} making cessation programmes somewhat of a luxury. One study of smoking cessation among lower-income Chinese workers found that of 333 former smokers, none had used nicotine replacement therapy.\textsuperscript{35} Additionally, a study of female microelectronics workers found that the “smoking culture” of the workplace applies to women in much the same way that it applies to men, with rates of smoking increasing among blue-collar working women.\textsuperscript{62}
Both studies indicate that much more needs to be done in China to increase support for smokers who want to quit, and there is a very specific niche for workplace cessation programmes, which have the potential to impact vulnerable women.

**Currently, 55% of all tobacco leaf is grown by only three countries—China, Brazil, and India. The effects of this shift are gendered in nature, with women being most vulnerable to the health and economic harms of tobacco production.**

Reducing the number of women who smoke during pregnancy is an important public health intervention, and policies targeting pregnant women are gender-sensitive. Pregnancy is a good entry point for reaching women and their partners who smoke, but support in maintaining cessation after birth should be an integral part of cessation programmes. Women need gender-sensitive programmes that focus on their entire lifespan, not solely on their reproductive lifespan. Moreover, additional strategies that target young women and non-pregnant women must be developed.

**Sales of Tobacco To and By Minors**

Article 16 of the WHO FCTC includes a variety of policy recommendations intended to limit youth access to tobacco. The policies include the restriction of direct sales to minors, requiring identification when making sales, and prohibition of tobacco vending machines. This Article also includes policies that are not minor-specific but do seek to limit the ease of access and appeal of cigarettes to youth. These policies restrict the sale of individual cigarettes, prohibit the distribution of free tobacco products, and ban the manufacturing of sweets and toys in the form of tobacco products (e.g. candy cigarettes). Although the policies are gender-neutral in design, their successful implementation can produce gendered results. Studies show that underage females are less likely to attempt to purchase cigarettes than their male peers are, but these same studies also show that females are more likely to be successful in such purchases if they are attempted. In this example, the strong enforcement of identification laws would be gender-neutral in application but gender-sensitive in result.

South Africa's first tobacco control act, implemented in 1995, included the banning of cigarette sales to youth. The 2008 amendment further elaborates on the restriction of cigarette sales to persons under 16 years of age.

A UK law has restricted the supply of tobacco to young people since 1908. Under current legislation in the Children and Young Persons (Protection from Tobacco) Act of 1991, it is against the law to sell tobacco to anyone under 16 years of age.

A minimum-age law was passed in Sweden in 1997, restricting tobacco purchases to persons 18 years of age and older. A study comparing students before and after the law was enacted found that after enactment, all adolescents reported greater difficulty in buying tobacco near their homes, but only adolescent females reported a statistically significant decrease in tobacco purchases. Unfortunately, the proportion of adolescents who bought tobacco from friends increased during the same time period.

As of 2006, no federal law prohibited the sale of tobacco products to minors in China, although many local municipalities have addressed the issue with their own regulations. The existence of local restrictions, however, does not imply widespread knowledge of them. In Wuhan province, a survey found that only 23% of parents of high-school students were aware that Wuhan had a law prohibiting the sale of cigarettes to adolescents. Cigarette use by young people is considered normal in China, since children are often asked to buy cigarettes for their parents, and they are often given cigarettes as gifts on special occasions.

**Support for Economically Viable Alternatives to Tobacco Production**

Tobacco production has shifted primarily to lower- and middle-income countries and affects the millions of
poor women working in tobacco production. Currently, 55% of all tobacco leaf is grown by only three countries—China, Brazil, and India. The effects of this shift are gendered in nature, with women being most vulnerable to the health and economic harms of tobacco production. It is noteworthy that Article 17 of the WHO FCTC calls upon Parties to “promote, as appropriate, economically viable alternatives for tobacco workers, growers and, as the case may be, sellers”.

Surveys that analyse the revenue-to-cost ratio of various crops show that tobacco farming is far from the most lucrative option for Chinese farmers. Fruit, mulberries, silkworms, rice, wheat, vegetable oil, and beans all have higher revenue-to-cost ratios than tobacco, indicating that tobacco may not always produce the best economic returns for China. According to Hu et al, “this is a prime time for the Chinese government to encourage less profitable tobacco farmers to produce other crops”.

As members of the European Union, Sweden and the United Kingdom operate under the jurisdiction of the Common Agriculture Policy of 2003. This policy eliminated a system of product-specific farm subsidies (e.g. subsidies provided to farmers based on the quantity of tobacco they produced) and now provides single-farm subsidies that are product-blind. The overall goal is to allow producers to adjust to a situation in which product support will be phased out. The transition from tobacco-specific subsidies to “decoupled” subsidies is gradual, and it is hoped that farmers will adjust their crop selection accordingly for maximum profit.

According to a Campaign for Tobacco-Free Kids report, the world’s excess tobacco production is driving many families into deep poverty. Family farms that contract with tobacco companies for advance purchases of seed and fertilizer are then bound to sell their crops to those same companies for very low “market” prices—barely enough to pay off the debts they accrued prior to planting. The tobacco industry works throughout developing countries to convince farmers to grow tobacco exclusively. As a result, rates of malnutrition among children have increased in tobacco-growing regions of Kenya, for example, because families are planting tobacco instead of traditional food crops in the hope of escaping poverty.

Additionally, tobacco-leaf companies in Brazil have specifically requested that school systems shorten their terms to permit children to help their families in the field. In countries where disparities in schooling and nutrition already exist between boys and girls, tobacco farms will only exaggerate the problem. In all these tobacco-producing countries, alternatives to growing tobacco have great potential for changing the educational, economic, and health prospects of women.

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### Conclusion

Given that the WHO FCTC entered into force in February 2005, the question remains as to whether countries have successfully incorporated its call for gender sensitivity into their national programmes and policies. Monitoring and evaluation will be the key to making such a determination. Specifically, monitoring and evaluation efforts must include collection of sex-disaggregated data on the initiation, maintenance, and cessation of tobacco use at the national level. Findings that reveal gender differences must then be used to inform research and to strengthen or modify existing policies and programmes.

The WHO FCTC has been a major accomplishment for international tobacco control. In the four countries examined here, ratification of the treaty has clearly brought a new commitment to tobacco control policy and programme creation and implementation. Even before these countries became Parties to the treaty, all four made progress in strengthening national legislation in many areas of tobacco control, including advertising and promotion, exposure to SHS, and information, education and communication.
The four countries offer insights into how the content of tobacco policies can ignore or address both gender inequality and women as a group. These countries have achieved varying degrees of gender sensitivity in their policies: all have a variety of gender-neutral policies (e.g., advertising bans), and all have at least some gender-specific policies. Sweden appears to have the most gender-specific policies and programmes, e.g. programmes targeting pregnant women for smoking cessation. The challenge for China will be to address smoking among vulnerable groups. In addition, the four case-studies highlight the fact that the design of policies may often be gender-neutral, while the impact of those policies may be highly gendered, affecting women more than men. Advertising bans are an excellent example of this. Although advertising restrictions are applied equally to both men and women, some measures will have a greater likelihood of decreasing smoking prevalence among women, based on gender norms, roles, and relations.

In some realms, it may be appropriate to expect gender-redistributive policies, but movement from gender-blind to gender-neutral policies and from gender-neutral to gender-specific policies may be more readily attainable and should be considered progress in the area of tobacco control.

While it is not the focus of this chapter, there is clear evidence that tobacco control policies and programmes should be developed that include strong consideration of SES, in addition to gender. Graham et al. suggest that women's smoking status in developing countries is influenced by “biographies of disadvantage”. Women's initiation of smoking, persistence, and cessation are influenced by childhood disadvantage, educational trajectories, and reproductive careers. Graham et al. suggest that policies regarding tobacco control need to focus on these social conditions that affect smoking status. Greaves, Vallone, and Velicer suggest the use of gender-redistributive policies that link “housing, welfare, child-care, training and economic policies and programmes” to address the needs of low-SES women and girls.

Finally, in the implementation of Article 20 of the WHO FCTC related to research, surveillance, and exchange of information, there is a need for research on the development and implementation of tobacco control policies that are gender-specific with a focus on women. More case-studies related to how gender policies are financed, monitored, and evaluated will help guide policy-makers as the WHO FCTC is implemented. The active participation of gender experts in policy-related research will also enrich the knowledge concerning how tobacco control can benefit women as well as men of all ages.

References

Tobacco and Poverty
A Vicious Circle

World No Tobacco Day - 31 May
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