Introduction
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1. Summary and Overview

Background

In 1999, in collaboration with the Japanese Ministry of Health, Labour and Welfare, the World Health Organization (WHO) hosted a meeting in Kobe, Japan, entitled Making a Difference to Tobacco and Health: Avoiding the Tobacco Epidemic in Women and Youth. More than 500 participants from 50 countries met to consider issues related to gender equality and tobacco. The Conference proved to be a turning point in the tobacco control movement, as it brought together multiple stakeholder groups concerned with gender and tobacco. It provided a much needed forum for health scientists and other professionals to open a dialogue with leaders representing local authorities, youth, women, and human rights.

The participants at the Kobe Conference cited a number of reasons for the need to consider gender and gender equality in national and international programmes and strategies. Among the points emphasized were:

- Women and girls, particularly among the poor, are often invisible in health statistics. Information is lacking on epidemiological statistics and risks and level of health knowledge. The emphasis given to men reflects gender discrimination and the inequality underlying many tobacco control programmes.

- When women are held responsible for reproductive health, they may be blamed for their addiction to tobacco and its negative impact on their children. Much less medical attention has been paid to the negative health effects of paternal smoking on fertility and the health of the fetus. Cessation programmes for fathers are seldom provided as part of reproductive health services.

- The majority of victims of second-hand smoke (SHS) are women and children, exposed in their homes through the smoking of men. Curtailing exposure to SHS needs to be given a higher priority to protect women's and children's rights to a safe and smoke-free environment in homes and public places.

Tobacco control programmes seldom recognize women as potential leaders. Unless women are empowered they cannot fully participate in tobacco control programmes.

Much of the success of the Kobe Conference was due to the persuasive power of sound evidence. With the help of a grant from Japan, WHO convened a scientific working group for one year prior to the Conference. The results of the scientific working group were first published in the 2001 WHO monograph Women and the Tobacco Epidemic—Challenges for the 21st Century. Nearly 10 years later, gender, women, and tobacco policies must take into account new epidemiological patterns, social and economic trends, and political challenges. For example, a landmark in international law is the WHO Framework Convention on Tobacco Control (WHO FCTC), which went into force in 2005 and has been ratified by more than 170 countries. The WHO FCTC is a multilateral evidence-based treaty that provides the legal framework for countries to reduce the supply and demand for tobacco, in addition to supporting women's rights to health as a human right.

For this monograph, an international team of scholars and experts reviewed the most current research to provide an overview of tobacco control issues related to gender, with a focus on women. Interdisciplinary teams included researchers and activists in public health, medicine, nursing, and dentistry, as well as anthropology, psychology, economics, law, journalism, and gender studies. The concerns of tobacco control policy-makers, educators, public health advocates, and economic planners, as well as youth and women leaders, are addressed. Special attention is paid to policies that affect women throughout their life-course. A gender analysis should provide information on why specific programmes are working for men and not for women. However, due to a lack of data, particularly regarding poor women and men in developing countries, it is not possible to perform a comprehensive analysis at this time. Rather, this monograph presents available research findings and data, identifies gaps to be addressed, and suggests directions for future study.

The monograph has four sections: Tobacco Use and Its Impact on Health; Why Women and Girls Use Tobacco; Quitting; and Policies and Strategies. Topics covered include determinants of starting to use tobacco, exposure to SHS, the impact of tobacco use on health, the nature
of addiction and cessation, and treatment programmes, as well as policy issues involving economic and tax measures, gender analyses, and human rights.

**Tobacco Use and Its Impact on Health**

**Tobacco Use**

What are some of the salient findings? Globally, the prevalence of smoking is higher for men (40% as of 2006) than for women (nearly 9% as of 2006), and males account for 80% of all smokers. In most countries around the world, men—being more likely than women to smoke—are also almost two times more likely to die from smoking. However, data from several industrialized and developing countries show that men’s smoking rates may have peaked and are now in slow decline. Programmes should include efforts to sustain this downward trend, particularly among adolescent boys. At the same time, much more attention needs to be paid to the increasing numbers of women who use tobacco.

As noted in Chapter 3, Prevalence of Tobacco Use and Factors Influencing Initiation and Maintenance Among Women, there is wide regional variation in smoking prevalence among both males and females. In the Americas and Europe, the prevalence of female smoking is high, around 17% and 22%, respectively. The disparity between male and female smoking prevalence is greater in other regions of the world. For example, male smoking prevalence is near 37% in South-East Asia and 57% in the Western Pacific, while prevalence among women is around 4% to 5%. Globally, boys are more likely than girls to smoke. However, in half the countries surveyed by the Global Youth Tobacco Survey (GYTS), there is no sex difference in rates of youth smoking, indicating that tobacco use among girls may be increasing in some countries. If the rates of use of any form of tobacco—e.g. water pipes, cheroots, chewing tobacco, snuff—were to be included, the figures would be much higher. These disparities reflect differing social norms, cultural traditions, and socioeconomic and demographic factors.

Women who smoke tend to do so in part for different reasons than those of men smokers. The roots of tobacco uptake for women and girls often include cultural, psychosocial, and socioeconomic factors, including body image and peer pressure. In the Asian and Pacific countries where smoking has become a symbol of women’s liberation, many young women are turning to tobacco as a sign of freedom. Others take up the habit because of a popular belief that smoking keeps them slim. Regardless of the reason for starting to smoke, addiction sets in quickly, as a cigarette is a carefully designed nicotine delivery system that provides sufficient nicotine to establish and maintain dependence on tobacco.

Less is known about traditional tobacco use, such as the use of khaini, mawa, or betel quid and bidis among subgroups of women. Similarly, a new trend of increased use of water pipes by women requires more attention. However, data from India suggest the need for much more research on local practices. The prevalence rates of smoking and chewing tobacco vary widely by region in India, and in many areas women are more likely to use oral tobacco products than to smoke. Reasons for starting may reflect local beliefs and cultural practices. For example, some Indian women believe that chewing tobacco can cure toothaches or can be useful during childbirth.

Studies in many countries indicate that most tobacco use begins in early adolescence. The age of starting to use tobacco has important implications. Adolescents who begin smoking at a younger age are more likely to become regular smokers and are less likely to quit than those who start later. Socioeconomic status (SES) has been implicated in the risk for onset of smoking among adolescents. In some countries, young people with more spending money have higher levels of tobacco use, in both uptake and frequency of smoking. In developing countries, the lack of health education programmes results in girls having little knowledge of the harmful effects of tobacco use. More research is needed on the gender influences leading to unequal access to health education and information by girls and boys.

Several studies in the United States of America and in Canada have found that girls have lower self-esteem than boys and that low self-esteem is associated with smoking among girls. Another significant determinant in high-income countries is the belief that smoking can reduce appetite and control body weight. Parental smoking, peer smoking, and exposure to smoking in movies can also influence tobacco use, although further research is needed in low-income countries, where differences in social
norms, family life, and culture influence behaviours. In countries where the rate of tobacco use (and particularly cigarette smoking) by women and girls is still relatively low, programmes are needed to prevent increased uptake and future premature deaths and disabilities.

**Impact on Health**

Chapter 4, *Impact of Tobacco Use on Women’s Health*, concludes that women who use tobacco face virtually the same risks that men face and even greater risks for some diseases. Many women are still unaware of the full scope of risks caused by the many toxic and carcinogenic compounds in tobacco smoke: tobacco smoke contains more than 4000 chemicals, hundreds of which are toxic or carcinogenic. The reasons for both men and women failing to get accurate health information concerning sex-specific impacts of tobacco use on health need further study, followed by intervention.

Current research, largely from industrialized countries, indicates cause for alarm. Lung cancer mortality rates among women in the United States have increased approximately 800% since 1950. By 1987, lung cancer had surpassed breast cancer to become the leading cause of cancer death among women in the United States. Women who smoke have higher risks for many cancers, including cancers of the mouth, pharynx, oesophagus, larynx, bladder, pancreas, kidney, and cervix, as well as for acute myeloid leukaemia. And there is a possible link between active smoking and premenopausal breast cancer.

Smoking also affects reproductive health. Women who smoke are more likely than non-smokers to experience infertility and delays in conceiving. Maternal smoking during pregnancy increases risks of prematurity, stillbirth, and neonatal death and may cause a reduction in breast milk.

Women who smoke are at increased risk of developing potentially fatal chronic obstructive pulmonary disease (COPD), which includes chronic bronchitis and emphysema. In industrialized countries, the prevalence of COPD is now almost as high in women as it is in men. In addition, smoking is a cause of coronary heart disease (CHD) in women, for whom risk increases with the number of cigarettes smoked and the duration of smoking. The risk of CHD is even higher among women smokers who use oral contraceptives. Among postmenopausal women, current smokers have lower bone density than non-smokers and an increased risk of hip fracture.

There are many gaps in the data about the health impact of tobacco use on girls and women of all ages and throughout the life-course. Much more research is needed on the ways women—particularly in developing countries—use a variety of tobacco products, including snuff, chewing tobacco, and traditional forms of rolled tobacco. Finally, high-quality, population-based cancer incidence data are needed on health risks for women who work in the informal sectors of tobacco growing, production, and marketing.

**Second-Hand Smoke**

In 2004, second-hand smoke (SHS) was estimated to have caused about 600,000 premature deaths per year, (28% of which were among children). Of the 430,000 adult deaths, about 64% were among women. Although by 2008, an additional 154 million people worldwide had been covered by comprehensive smoke-free laws, nearly 90% of the world’s population is not protected, and laws do not limit exposure to SHS in homes where women and children are exposed through the smoking of male family members. Second-hand tobacco smoke contributes about 1% of the total global disease burden; in the United States, the economic costs total about US$ 19.3 billion per year. Chapter 5, *Second-Hand Smoke, Women, and Children*, sounds the alarm for those women and children who are exposed to smoke and its health hazards even though they do not use tobacco themselves. SHS jeopardizes women’s health, especially in countries and cultures where many women do not have the power to negotiate smoke-free spaces, even in their own homes.

Progress has been made in improving indicators of SHS exposure, including biomarkers such as levels of cotinine in blood, urine, or saliva, which are direct measures that can be used to estimate exposure. In industrialized countries, nearly half of the children and adolescents are exposed to SHS. In China, which accounts for one third of the world’s cigarette consumption, the tobacco epidemic is almost entirely a male phenomenon. A 2002 national survey reported that less than 3% of women in China smoked. However, more than half of the women of reproductive age were regularly exposed to SHS.
There is now sound scientific evidence that SHS causes illnesses and deaths among women and children. Women whose male partners smoke have increased rates of lung cancer and increased risk for CHD. Paternal smoking may have effects on sperm and may lead to postnatal health problems, including increased risk for sudden infant death syndrome (SIDS), reduced physical development, and possibly increased risk for childhood cancer. Studies from China show that paternal smoking alone can increase the incidence of lower respiratory illness in children. Maternal smoking during pregnancy reduces birth weight substantially and is a causal factor for SIDS. Exposure to SHS results in lower respiratory tract illnesses, chronic respiratory symptoms, middle-ear disease, and reduced lung function in children.

The tactics that have been used in marketing tobacco in the United States and other industrialized nations for decades now threaten women in the developing world.

Studies have found that smoke-free legislation increases cessation rates and reduces consumption. It also decreases SHS exposure and brings immediate health benefits. For example, a study in Scotland measured salivary cotinine levels in schoolchildren and found that the average concentration decreased by 30% after smoke-free legislation was put in place. Still, many governments have not taken or enforced adequate public health measures to protect women and children against exposure to SHS. Lack of enforcement is particularly relevant in developing countries where legislation prohibiting tobacco use in public places may not be strictly enforced. Since there is no safe level of exposure to SHS, the chapter's recommendations include enactment and strong enforcement of 100% smoke-free indoor workplaces and public places and smoke-free childcare settings, which would remove a major source of SHS exposure for infants and children. Special campaigns that are culturally appropriate are also needed to address the problem of SHS in the home, a major locus of exposure for women and children.

Why Women and Girls Use Tobacco

Marketing, Advertising, and Promotion

Even though the health hazards of tobacco use are known, women are becoming increasingly addicted to it. One of the powerful influences driving changing rates of tobacco use is industry advertising and sponsorship. The tobacco industry has long fostered the false idea that tobacco is linked to women's empowerment by suggesting that cigarette smoking symbolizes high fashion, freedom, and "modern" styles and values, and that it even promises weight reduction.

Chapter 6, The Marketing of Tobacco to Women: Global Perspectives, leaves little doubt that the tobacco industry considers female consumers to be a lucrative market. In the United States, 11% of total advertising and promotion expenditures in 1996 came from the tobacco industry; in 2005, US$ 13.11 billion was spent on tobacco advertising and promotions. The tactics that have been used in marketing tobacco in the United States and other industrialized nations for decades now threaten women in the developing world. In many countries recently affected by free trade agreements, the tobacco industry has targeted a flood of savvy marketing strategies towards women. Large companies sponsor events such as women's tennis tournaments and disco dances to create a public image of smoking as a promoter of health and relaxation. "Female brands", "light" cigarettes, low prices, easy availability, and free samples help these marketing strategies succeed among young women.

Tobacco companies rank among the 10 top marketers in several Asian countries. Research in Asia, including Indonesia, Sri Lanka, Viet Nam, China, India, and the Philippines, indicates that massive advertising combined with changing gender roles and women's increased earning power produces a favourable environment to advance sales. British American Tobacco (BAT), Japan Tobacco, and the China National Tobacco Corporation have substantial shares in this market. In India, where it may not be culturally "correct" for women to buy cigarettes openly, companies have offered to deliver them to the home.

Modern marketing seeks to attach symbolic meaning to brands, associating products with psychological and social
needs in a coordinated strategy that surrounds the consumer with stimuli. A cigarette brand has become the ultimate “badge product”, because it is like a name badge that sends a message every time it is seen, projecting a distinctive identity. Brand images may appeal to consumers' social insecurities by appearing to propose solutions to identity problems. In addition, advertising is used to reduce fears about tobacco use and to associate products with dazzling blue skies and mountains, happiness, and healthy sports activities. Consumer culture is visual, and images of modern, Western-style women play a dominant role in developing countries. In the global consumer culture, having the right body becomes part of a woman's identity, and this ideal type is used extensively in advertisements. In the Philippines and Viet Nam, posters advertising cigarettes typically portray big-busted foreign women wearing scanty clothing. Prominent themes appealing to Asian women include weight control, stress relief, and independence. Surprisingly, women also represent 50% of the market share of brands that use images of masculinity, e.g. Marlboro and Camel.

Promotions aim for immediate action on the part of the consumer. Discount coupons may be especially effective for reaching poor women and youth, and clothing promotions create “walking billboards”. Sponsorships of entertainment, sporting events, and fashion shows embed advertising within the events. In an era of globalized media, such sponsorships can reach audiences across borders and can touch millions of children, youth, and women in their homes. One study estimated that 25% of young people 12 to 17 years of age watch auto racing on television, and women constitute 39% of NASCAR's audience. Sponsorship of dance and art events, women's organizations, campaigns against domestic violence, schools, scholarships, beauty contests, and youth sports events has linked tobacco companies with social causes, as well as fun. Of particular concern has been the tobacco industry's use of film and music sponsorships, because these are known to influence tobacco initiation and uptake among children and youth. The Internet offers a still unregulated opportunity to market tobacco products to women and youth.

Addiction

Chapter 7, Addiction to Nicotine, points out that nicotine's effects on a user vary with the tobacco product and the way nicotine enters the body. Women use a variety of combustible tobacco products, including roll-your-own cigarettes, cigars, bidis, and kreteks, as well as water pipes and pipes. The nicotine content of tobacco products varies widely according to form and brand. More women than men smoke “light” or “ultra-light” cigarettes (63% vs 46%), often in the mistaken belief that “light” means “safer”. In fact, “light” smokers engage in compensatory smoking, inhaling more deeply and more often in an effort to achieve the desired amount of nicotine. Further study is needed on factors driving consumer preferences for smokeless tobacco, such as chewing tobacco and the moist and dry snuff that are gaining in popularity.

Contrary to popular belief, all tobacco products can be deadly and addictive, regardless of their form or disguise. While cigarettes are the most efficient product for delivering nicotine into the body, the nicotine content in water pipes and cigars has been shown to be significantly higher than that in manufactured cigarettes. Tobacco companies have recently introduced potentially reduced-exposure products for which information on potential risks is lacking.

Nicotine affects women's physiology and mood differently from the way it affects men's. For example, rates of nicotine metabolism are significantly higher in women smokers who use oral contraceptives and those who are pregnant. Tobacco-related health risks for women include osteoporosis and increased risk of fracture, early menopause, and sexual and reproductive health problems. Nicotine replacement therapy (NRT) is useful for cessation, but women have higher sensitivity to nicotine than men have. Key barriers that may make quitting more difficult for women than for men include poverty, depression, lack of social support, and fear of weight gain. Appetite suppression is a critical aspect of the appeal of smoking for many women and girls in some socioeconomic groups. Research indicates that in some countries, girls who use tobacco tend to have relatively stronger attachments to peers and friends than do boys who smoke. The girls also tend to overestimate smoking prevalence in their environment, are less knowledgeable about nicotine and addiction, and usually have parents or friends who smoke. More research is needed on the process of initiation into smoking, transitions from experimentation to addiction, and risk and protective factors for girls and women in different cultural settings and in developing countries.
Models of addiction provide useful frameworks for designing interventions and offer a point of departure for preventing and treating addiction, taking into consideration behavioural and psychological factors, social and environmental influences, and marketing. It is important to remember that there are multiple pathways to overcoming addiction. Often overlooked are some obvious guidelines, e.g. that treatments should address women’s specific concerns and that the single most effective method is to quit in the early stages of use.

Quitting

Beating Nicotine Addiction

Chapter 8, Quitting Smoking and Beating Nicotine Addiction, emphasizes the fact that most smokers and tobacco chewers are addicted tobacco customers, not satisfied consumers. Studies in Canada, the United Kingdom, Australia, and the United States show that nearly 9 out of 10 smokers say they regret smoking, with women more likely to express regret about smoking than men.

Women seem to be less successful at quitting smoking than men, although there are scant global data on this issue. Because women are more prone to depression, and depression increases the risk of relapse, this is a special concern for women. Some studies indicate that adolescent girls and women are more concerned about weight gain than men are and may resume smoking to avoid it. Also, pregnant women may prefer individual counselling over group counselling, especially if they anticipate disapproval of their smoking by others. Women-only groups may be required for intervention. The social and economic status of women smokers is also relevant, as poor, less-educated women are significantly less likely to quit.

At the moment, there does not appear to be sufficient evidence of clinically important differences between men and women to guide treatment. More research is needed on use by women of non-nicotine medications such as bupropion, varenicline, and other emerging therapies. Pregnant women should attempt cessation with non-pharmacological modalities before using NRT. There is insufficient evidence about the long-term benefit of the use of interventions to help smokers reduce but not quit tobacco use.

Determining the best way to help smokers quit requires better knowledge of their behaviour as consumers of cessation methods and services, determinants of their preferences, and the role of costs. Studies among pregnant women indicate that 82% want behavioural support, and 77% want self-help materials. In one study, two thirds of the women thought that if their partner, family, or friends quit smoking, it would be easier for them to quit. In some cultures, tobacco cessation professionals may be involved, while in others, spiritual leaders and faith healers may be consulted. All interventions need to be adapted for particular subgroups, specific cultures, and countries.

Models of behavioural change such as the Social Cognitive Theory/Social Learning Theory, Health Belief Model, and the Theory of Planned Behaviour have been applied to tobacco control with varying degrees of success. The Transtheoretical Model of intentional behaviour change is the most multidimensional of the behaviour-change theories and appears to be the most predictive. It views smokers as moving through a series of stages: precontemplation, contemplation, preparation, action, and maintenance. This stage-based approach has been used to help providers of support determine clients’ readiness for change. Research supports the notion that cessation success can be predicted by the stage of change. Relapse back to tobacco use is expected after a period of abstinence and recycling through the stages.

Large numbers of tobacco users have been able to quit on their own or with minimal assistance. For those requiring assistance, combining behavioural and pharmacological treatments may increase quitting success, particularly for heavy smokers. Interventions that easily reach women at home include quit lines, Internet smoking cessation sites, and counselling. Women are especially likely to benefit from combination therapy, and psychosocial support seems to offer benefits. It is important to remember that comprehensive tobacco control measures—including bans on smoking in public places and appropriately high taxation—all contribute to higher cessation rates.

Pregnancy and Postpartum Cessation

Chapter 9, Pregnancy and Postpartum Smoking Cessation, concludes that for female users of tobacco and their partners, pregnancy represents an opportunity to
quit. The smoking cessation guidelines calling for 5 As (Ask, Advise, Assess, Assist, and Arrange for follow-up) should be used in gynaecological office practice. Emphasis should be given to the benefits of cessation before women become pregnant. Benefits of quitting include reduced frequency of low-birth-weight and pre-term births and of pregnancy complications, as well as improved health of the mother. A significant reduction (more than 50%) in smoking, with the associated decrease in exposure of the fetus during pregnancy, can significantly increase birth weight. For national health-care systems, cessation by women can also result in significant savings.

In the early 1990s, when the smoking prevalence among the female population in the United States was higher than 20%, the rate for women in obstetric care was estimated to be 13.6%. These figures, however, do not reflect the wide range of smoking rates among pregnant women, nor do they identify the subgroups having particularly high rates. For example, cigarette smoking is generally less prevalent among Afro-American, Hispanic, and Asian women in the United States across all age ranges, while prevalence rates are high among less-educated non-Hispanic whites.

There are multiple opportunities for intervention prior to, during, and after pregnancy, each with varying challenges. A key to success is ensuring that partners and family members support quitting during pregnancy and through the critical transition to the postpartum period. As partner smoking is probably the single most important facilitator of women's continued smoking, quitting programmes should also focus on paternal smoking. As with SHS, men have important responsibilities in helping to improve the health environment and behavioural outcomes related to women and tobacco.

Research undertaken primarily in industrialized countries has refined the approaches to effective interventions. These findings may be applicable in other settings, although further research is needed on their applicability in developing countries. For example, subgroups of pregnant women display different quitting behaviours. The non-smokers may actually include many previous users of tobacco. Indeed, information on pre-pregnancy quitting is likely to be inaccurate, as women who stop smoking prior to becoming pregnant may report themselves as never-smokers. For this group, which may relapse to smoking after pregnancy, it is important to maintain positive, tobacco-free health behaviour. In countries where access to obstetric and gynaecological care may be limited, midwives, elders, modern medical professionals, and indigenous health-care providers should be trained to promote quitting in early adulthood.

Pre-pregnancy quitters typically sustain cessation throughout the pregnancy and may be smoke-free for their entire life. Newly pregnant spontaneous quitters are often highly motivated to protect their babies. It is noteworthy that pregnant women in cultures where extended families may be heavily involved in managing the pregnancy often have lower smoking rates. However, the return to smoking for spontaneous quitters during the postpartum period may exceed 50% and may be as high as 80%. For this reason, more attention needs to be paid to relapse prevention services for women in the postpartum period.

Women who continue to smoke during pregnancy are typically less-educated, unemployed, and of lower SES. They also often live in more smoke-filled home environments. Studies in the United States, the United Kingdom, Sweden, Australia, and Canada indicate that cessation counselling in brief periods can be effective early in pregnancy. The cost–benefit ratio for an intervention that achieved a 15% smoking cessation rate, compared with the 5% cessation rate of usual practice, would be US$ 11 in savings for each US$ 1 of investment. Women who continue to smoke later in pregnancy find it particularly difficult to quit, and promoting cessation is even more difficult with women who have already had a child and smoked during the prior pregnancy.

Interventions should be based on the premise that there is no safe level of exposure to nicotine for the fetus. Health-care providers should encourage male partners who are smokers to support and not undermine a partner's cessation during pregnancy and in the postpartum period. One interesting attempt to do so was Project PANDA, which sent video and print materials tailored to the male perspective on pregnancy and child care. Cessation in light of impending fatherhood and emphasis on the dangers of SHS were also included. Evaluation indicated that 28% of the men who received the materials were not smoking at three months postpartum, compared with 14% of the control-group men. The use of NRTs should be envisaged only as a harm-reduction strategy for women who are heavy smokers and who continue to smoke during pregnancy. Additional studies are needed to evaluate pharmacotherapy options.
Pregnancy provides an opportunity for change that affects the entire family. Most of the benefits of smoking cessation during pregnancy have focused on the fetus and the child. However, programmes can also help to improve the health of mothers and fathers. Smoking cessation interventions designed to reach mothers and fathers, using gender-sensitive approaches, should be integrated in family-planning programmes and in pregnancy testing, both at home and in clinic offices.

**Policies and Strategies**

**A Gender Framework and Gender-Sensitive Policies**

A gender framework for tobacco control focuses attention on the social, cultural, and economic factors underlying tobacco use among women throughout the life-course. “Gender” is defined as the social, economic, and cultural construct of the relations between men and women, and, as such, it underlies the social construction of tobacco promotion, consumption, treatment, and health services. Gender inequality contributes to women’s lack of participation in health policy decision-making. Gender inequality is embedded in institutions at many levels, from the household to macroeconomic structures. As WHO has noted, “Many of the main causes of women’s morbidity and mortality—in both rich and poor countries—have their origins in societies’ attitudes to women, which are reflected in the structures and systems that set policies, determine services and create opportunities.”

Furthermore, the exclusion of girls and women of all ages on the basis of race, caste, ethnicity, religion, or disability is a serious obstacle to successfully implementing gender-sensitive tobacco control policies.

Chapter 2, *A Gender Equality Framework for Tobacco Control* states that a gender analysis differs from a “women and development” approach in that it acknowledges how gender roles, norms, and relations affect both women and men. Masculinities (the social construct around what being a man is) can be counterproductive or even destructive for men. For example, one reason for rising rates of tobacco use among men has been the targeted marketing that promotes smoking as macho, healthy, sexually attractive, and trend-setting. Yet men have important proactive roles in engaging in women’s rights to health. As the majority of the world’s smokers, men are mainly responsible for women’s involuntary exposure to SHS. As more men join the gender equality movement, stronger support for women’s human rights as a cornerstone for tobacco control is in sight.

Implementing the WHO FCTC through a gender perspective should be understood as part of a country’s political and development agenda. If the tobacco epidemic among women and girls continues to spread, it will contribute to rising health-care costs and will use valuable resources needed for social development. It will also make achieving the United Nations Millennium Development Goals (MDGs) on improving maternal health and reducing poverty more difficult. The WHO FCTC Preamble recognizes that applying a gender equality framework to tobacco control is integral to effective implementation of its Articles. Provisions concerned with SHS, packaging and labelling, health warnings, and bans on advertising, promotion, and sponsorship, as well as improving national research, are all relevant to women’s concerns.

At a theoretical level, the WHO Regional Office for South-East Asia (WHO/SEARO) model of health behaviour can be used to analyse the effects of gender inequality throughout the health system and can help map interrelationships between tobacco control and broader social, cultural, and economic processes. A gender equality framework suggests that comprehensive tobacco control requires applying a gender analysis to many sectors outside health—including finance, trade, and agriculture—all of which influence tobacco use among women. The economic costs of the death and disability of a male head of household due to tobacco use are high for poor households, and they affect women and men disproportionately.

There are a number of strategic actions that can help make a difference. Governments must improve coordination with national agencies and stakeholders for women’s affairs, provide adequate financing, and apply indicators for gender equality in national planning. Gender mainstreaming of policies is more likely to succeed if gender experts are included at senior policy levels. Budgeting for gender equality requires development of sensitive, cost-effective indicators and baseline data disaggregated by age as well as by sex.

The WHO FCTC is the pre-eminent global tobacco control instrument; it contains legally binding obligations for its Parties, sets the foundation for reducing both...
demand and supply of tobacco, and provides a comprehensive direction for tobacco control policy at all levels.\textsuperscript{2} In its global tobacco reports on tobacco control, WHO launched and analysed the MPOWER package, introduced to assist in the country-level implementation of effective measures to reduce the demand for tobacco, contained in the WHO FCTC.\textsuperscript{2,4} Although the MPOWER measures, which correspond to one or more Articles of the WHO FCTC, do not explicitly refer to a gender equality perspective, seen through a women’s rights lens they can be interpreted as follows:

1. **Monitor** tobacco use by gender and **ensure that** prevention policies are gender-sensitive (Article 20 of the WHO FCTC).

2. **Protect** girls and women of all ages from tobacco smoke (Article 8 of the WHO FCTC).

3. **Offer** help to assist women in quitting tobacco use (Article 14 of the WHO FCTC).

4. **Warn** women and girls about the dangers of tobacco through gender-sensitive information and communication strategies (Articles 11 and 12 of the WHO FCTC).

5. **Enforce** bans on tobacco advertising, promotion, and sponsorship by empowering women to identify and counter these influences (Article 13 of the WHO FCTC).

6. **Raise** taxes on tobacco, with the active participation of women leaders (Article 6 of the WHO FCTC).

According to Chapter 10, How to Make Policies More Gender-Sensitive, the gender bias inherent in many existing health policies and tobacco control programmes must be challenged. Data from South Africa, China, Sweden, and the United Kingdom indicate varied forms of gender policies, according to Kabeer’s typology of gender-related policies. Among these, gender-blind policies, which may appear to be unbiased, are often, in fact, based on information derived from men’s activities and assume that all persons have the same needs and interests as men.

Tobacco control should aim to improve gender-redistributive policies that recognize women’s exclusion and disadvantage in terms of access to social and economic resources, as well as decision-making. Gender-redistributive policies include provision of microcredit loans to women to help empower them and transform gender relations—measures that some health advocates believe must be taken if women’s health is to improve. Tobacco control policies need to keep the goal of gender-sensitivity in mind while implementing measures to reduce consumption. The design of policies may be gender-neutral, yet the policies may affect women and men very differently. Thus, all policies, health services, and programmes must be monitored and evaluated, using gender indicators as well as conventional health indicators. Data and indicators should be disaggregated by sex where appropriate.

**Economics and Taxation**

Taxes that increase the price of tobacco and reduce its affordability are very effective in reducing both paternal and maternal smoking prevalence, thereby reducing the negative consequences of smoking on maternal and child health. Chapter 11, Taxation and the Economics of Tobacco Control, points out that tobacco control programmes must pay increasing attention to economic policies concerned with trade, taxation, tobacco production, and price (Article 6 of the WHO FCTC). Tobacco control is not likely to cause the estimated 33 million people engaged in tobacco farming worldwide—many of whom are women and children—to lose their jobs in the short run. Agricultural policies should therefore take into account evidence that tobacco control will have minimal negative impact on long-run economic growth, employment, or the foreign trade balance.

Rapid urbanization and changes in lifestyle and diet mean that scarce resources are now being used for treatment of noncommunicable diseases, potentially limiting the resources available for prevention. A study in the United States found that smoking-attributable neonatal costs totalled almost US$ 367 million (in 1996 dollars). The calculated annual costs to New York City related to infants’ developmental delays caused by prenatal exposure to SHS amounted to US$ 99 million. In China, direct costs of smoking in 2000 were estimated to be 3.1% of national health expenditures. At the household level in Indonesia, where smoking is most common among the poor, 15% of the total expenditure of the lowest income group is on tobacco, while the poorest 20% of
households in Mexico spend nearly 11% of their income on tobacco. Productivity losses for smokers and their caregivers—including lost wages because of time off from work—represent a substantial cost to society.

The costs of SHS exposure are particularly relevant to a gender perspective on tobacco control, because women and children are the majority of the world’s involuntary smokers. A study in Minnesota estimated the cost of direct medical treatment for conditions related to SHS to be US$ 228.7 million (in 2008 dollars), equivalent to US$ 62.68 per capita annually. A report from the American Society of Actuaries calculated that US$ 2.6 billion was spent for medical care for lung cancer and heart disease caused by exposure of non-smokers to SHS in the United States.

There is solid evidence that taxation of all forms of tobacco is highly effective in reducing consumption, particularly among youth and low-income groups, among which prevalence is often highest. Increases in cigarette taxes could be a powerful tool for protecting poor women in developing countries, because higher taxes are known to have a significant negative effect on maternal smoking rates. Increased taxes also help to prevent former users from re-starting and can lead current users to try to quit. Studies in the United States, the United Kingdom, and Canada have concluded that the overall price elasticity of demand ranges from –0.5 to 0.25, implying that a 10% increase in the price of cigarettes will decrease overall cigarette consumption in these countries by between 2.5% and 5.0%. Young people are found to be much more price-sensitive than adults in low-, middle-, and high-income countries, according to studies in Nepal, Ukraine, Myanmar, and the Russian Federation.

The share of taxes in the price of cigarettes varies from more than 80% to less than 30%, with many lower-income countries having the lowest tax rates. Taxes could be increased to 65–75% of the retail price of cigarettes, the level in several countries. However, tax increases need to be applied symmetrically across all types of tobacco products in a manner that equalizes the retail sales of the various types; taxes also must keep up with inflation in order for their real value not to be eroded. Concerns about tobacco taxation, such as efficiency and equity related to low-income smokers and threats of smuggling, should be addressed. Earmarking a portion of the revenue generated from tobacco taxes for tobacco control programmes reinforces the effects of the taxes on consumption.

Studies indicate that individuals from lower-income groups respond more to price changes than do persons with higher incomes, more education, and higher SES. Furthermore, evidence from many countries, including Indonesia, Malaysia, Turkey, Viet Nam, and China, shows that changing per capita income significantly affects smoking prevalence, as well as cigarette demand. One study in Turkey found that income elasticity declined with household income level. The evidence suggests that to reduce consumption by a desired amount, the percentage increase in price must be higher if income is increasing. The data on impact by gender and age are not conclusive as to whether females are more price-sensitive than males. Also, much more research is needed on the costs and impact of taxation policies related to the wide variety of smoked and smokeless tobacco products used by girls and women of all ages.

**International Agreements and the International Women’s Movement**

Mobilization and leadership can make a difference. Chapter 13, The International Women’s Movement and Anti-Tobacco Campaigns, provides an historic perspective on regional and international movements and traces women’s groups’ activities in reproductive health and consumer rights, as well as anti-tobacco activities.

Around the world, nongovernmental organizations (NGOs) are doing their share. The Framework Convention Alliance (FCA), a coalition of NGOs and individuals representing nearly 300 organizations from more than 100 countries, helps to organize an international social movement in support of the WHO FCTC. The FCA is exemplary in the attention it gives to monitoring gender issues in the WHO FCTC and in its good record of gender balance in its top leadership. Throughout the WHO FCTC negotiations, its women’s caucus worked to ensure that women’s human rights were an integral part of the treaty. Organizations of women health professionals—physicians, nurses, and scientists—in alliance with the media, have initiated community-based programmes that contribute to women’s involvement in tobacco control. Groups such as the International Network of Women Against Tobacco (INWAT) and the US National Organization of Women have pioneered community-based strategies.
The Women’s Environment and Development Organization, in collaboration with WHO and the Campaign for Tobacco-Free Kids, organized a meeting of their networks to plan activities on women and tobacco. Other groups, such as REDEH/CEMINA in Brazil and the Latin American Women’s Health Network, have carried out public information campaigns in China, the Lao People’s Democratic Republic, Thailand, Bangladesh, Saint Kitts, and Argentina, and campaigns are being planned in 20 countries.

Gender must be mainstreamed in tobacco control, fully utilizing international agreements and human rights policies. The groundwork has been laid. As Chapter 12, Women’s Rights and International Agreements, points out, many tobacco-growing countries, including China, Malawi, Zimbabwe, and Indonesia, have signed the women’s “bill of rights” known as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW, the most important legally binding international document on the human rights of women, has been ratified by more than 185 countries. It is unique because it addresses deep-rooted and multifaceted gender inequality, emphasizing both public- and private-sphere relations and rights, and it specifically underlines the difference between de jure and de facto equality of women. The CEDAW Committee has concluded that governments’ compliance with Article 12 and General Recommendation 24 of CEDAW—both concerned with health—is central to ensuring that women have equal access to health information and services. Other Articles in CEDAW that are supportive of the WHO FCTC include Article 1, which deals with discrimination against women working in the informal sector, such as bidi workers; Article 14, which is concerned with rural women; and Article 11, on women’s right to the protection of health in work conditions.

The international community can use legally binding treaties to guide implementation of important policy documents such as the Beijing Platform for Action. The follow-ups to the Fourth World Conference on Women, such as Beijing Plus Ten, the International Conference on Population and Development, and other social and economic accords, are all relevant to ensuring women’s rights to health. The international women’s health movement, in partnership with governments and the United Nations, has succeeded in strengthening partnerships at these forums. Tobacco control leaders should build on this momentum.

**Issues for Advocacy**

Although there are major gaps in data and research concerning gender, women, and tobacco, particularly in developing countries, this shortcoming should not justify inaction. Current research suggests several issues for advocacy and action. First, eliminating exposure to SHS is a high priority, because it affects the majority of women throughout their life-course. Women’s empowerment is key to achieving smoke-free homes and should be included in campaigns against SHS. As a first step, women and girls need to be better informed about the hazards of SHS to themselves, as well as to fetuses, children, and family members.

Second, men have an important role in protecting women’s rights to health. As the majority of the world’s smokers, they are primarily responsible for women’s involuntary exposure to SHS. As fathers, they can protect the health of fetuses, infants, and girls. As partners, they can encourage pregnant women who quit to stay tobacco-free. As politicians, businessmen, and media leaders, men can take greater responsibility for supporting tobacco control policies that benefit women, such as enforcing total bans on advertising and promotion of tobacco products across all media. Finally, as health planners and health-care providers, their support is critical to making health systems work better for girls and women.

Third, a couples approach to tobacco use during pregnancy and the transition to the postpartum period may be the most effective means for improving the health of the entire family, including infants. Victimization of pregnant women who use tobacco can be a major barrier to their quitting smoking. Non-reporting of tobacco use, lack of support by family members and partners, and failure of doctors to ask about paternal smoking all contribute to increased health risks for pregnant women. Assuring that reproductive health services are women-friendly is also important.

Fourth, as noted in the 2009 WHO report on Women and Health, a life-course approach is needed to fully comprehend the impacts of tobacco on the health of girls and women of all ages. A life-course perspective can deepen understanding of the implications of exposure to tobacco smoke in childhood, through adolescence, during the reproductive years, and beyond, to old age. Such an
approach can help map out the interrelationships between social and biological determinants of women’s and men’s health, linking exposures even before conception to risk for chronic disease in adulthood. There has been little investigation of the later-life consequences of early-life exposures to tobacco smoke. Much more research is needed on how the age of starting to smoke regularly might affect both male and female children’s growth and the subsequent risk of diseases caused by smoking.

Finally, gender-sensitive tobacco interventions that include a focus on women’s rights should take place in the context of comprehensive tobacco control and as part of a development strategy to reduce poverty. For example, curbing tobacco use is essential for the achievement of the MDGs that concern improving maternal health. Furthermore, such an approach must recognize the diversity of women’s and men’s needs that may vary by age, ethnicity, economic status, and levels of education. Poor urban and rural women are disproportionately affected by the tobacco epidemic. In many countries, women of lower SES who also have less access to quitting resources have the highest rates of tobacco use. In developing countries, rural women working in tobacco production, manufacture, and marketing receive unequal and inadequate compensation for their labour and job insecurity. Poor families can least afford expenditures on tobacco that take away income that could be used for food, education, and health care. The social costs of the death of a male head of household due to tobacco use are high for widows, who often have unequal access to productive employment and social services.

Gains Made and Looking Ahead

WHO has taken the lead in the effort to coordinate a global strategic response to the tobacco epidemic. As already noted, the WHO FCTC is a powerful tool for change. It promotes women’s participation and a gender-sensitive approach to tobacco control. Its Preamble supports women’s right to participate fully in decision-making at all levels as a human right. Gender equality should be applied in the interpretation and implementation of all Articles in the WHO FCTC. The future challenge is to ensure that women leaders know their rights under the WHO FCTC and are mobilized at the grass-roots level.

Many governments and municipalities have initiated effective tobacco control measures. In 2004, Ireland became the first country in the world to implement national legislation that banned smoking in all indoor workplaces, including restaurants and bars. Uruguay and New Zealand have each implemented a national ban on smoking in all indoor workplaces, public transport, and public places; both countries also demonstrate high levels of enforcement of and compliance with the legislation. Seven mostly low- and middle-income countries implemented comprehensive smoke-free policies in 2008, covering an additional 154 million people. Panama passed a new advertising ban in 2008. Despite all these changes, nearly 90% of the world’s population remains uncovered by comprehensive tobacco legislation. Much more can be done by raising taxes; enforcing a ban on deceptive terms such as “low tar”, “light”, and “mild”; and improving health warnings to prevent initiation of tobacco use by women and girls.

In the past decade, WHO has continued to strengthen its gender policy, surveillance, resource mobilization, and human resources. A grant from Bloomberg Philanthropies, along with an additional grant from the Bill and Melinda Gates Foundation, has greatly increased resources devoted to fighting tobacco use where it is highest—in the developing world—and has given a boost to WHO’s country-level work. In collaboration with the National Cancer Centre in Japan, WHO held an operational planning meeting in 2009 for gender and tobacco projects, with the aim of speeding up gender mainstreaming. Practical implementation plans were developed in Viet Nam to move from policy to action. Recommendations were made on ways to apply a gender analysis to project implementation on interventions such as gender-based health warnings; tax increases; smoke-free environments; bans on advertising, promotion, and sponsorship; and education and communications.

Country-specific data disaggregated by sex have been reported in the WHO Report on the Global Tobacco Epidemic, 2008: The MPower Package and the WHO Report on the Global Tobacco Epidemic, 2009: Implementing Smoke-Free Environments. Other WHO activities have contributed to improving scientific evidence as a basis for policy formulation and programme implementation on gender, women, and tobacco. Important new information about gender differences in tobacco use is provided by the GYTS, which focuses on tobacco use in youth 13
to 15 years of age; the Global School Personnel Survey (GSPPS), which collects information from school personnel concerning their use of tobacco; the Global Health Professions Student Survey (GHPSS), which collects data on tobacco use and cessation counselling among health-profession students; and the Global Adult Tobacco Survey (GATS), which monitors tobacco use among adults as part of the Global Tobacco Surveillance System (GTSS).

WHO has worked collaboratively with other partners, including the International Development Research Centre (IDRC), to hold scientific consultations on gender and tobacco. It also continues to work with human rights bodies, such as CEDAW, and NGOs, including the International Network of Women Against Tobacco. At the Eighth United Nations Ad Hoc Interagency Task Force on Tobacco Control meeting, representatives from United Nations agencies such as UNFPA, UNICEF, and the World Bank reviewed ways to strengthen interagency collaboration on gender, women, and tobacco. Sifting the Evidence: Gender and Tobacco Control, published by WHO in 2007, provides a summary policy guide and reflects WHO’s concern with ensuring that the WHO FCTC process makes gender a central part of its implementation. In the WHO report Women and Health—Today’s Evidence, Tomorrow’s Agenda, the importance of tobacco control to support women’s health throughout the life-course is highlighted. The 2010 theme of the WHO World No Tobacco Day was Gender and Tobacco with an Emphasis on Marketing to Women. The international campaign highlighted the tobacco industry’s misleading tactics in marketing tobacco products to women and girls. It also focused on women’s right to smoke-free environments in the workplace and home.

Future efforts to curb the rising epidemic of tobacco use among women and girls must be built on solid evidence. However, improvements are needed in national databases, particularly in developing countries, and research targeting women and tobacco must be undertaken. Gender bias is pervasive, with the result that data concerning tobacco use or prevalence of tobacco-related diseases among girls and women throughout the life-course are often unavailable or outdated. Moreover, the data that are available may not be disaggregated to identify differences by income, ethnicity, or occupation. Considerable improvements in methodologies are needed to evaluate the impact of tobacco control policies—including trade, tax, and economic policies—on women’s health. As the international community struggles to protect the public from SHS and curb rising rates of tobacco use among women and girls, a renewed commitment to women’s right to health as a human right is more important than ever.

References

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