English version

Turning a New Leaf

Women, Tobacco, and the Future

British Columbia Centre of Excellence for Women's Health

INTERNATIONAL NETWORK OF INWAT WOMEN AGAINST TOBACCO

Canada

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Turning a New Leaf:
Women, Tobacco, and the Future

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Foreword

A message from Dr. Yumiko Mochizuki-Kobayashi
Director, Tobacco Free Initiative
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The use of tobacco among women is sharply rising globally whereas for men it is in decline. Even though current overall prevalence is about four times higher among men than women globally (48% vs 12%), this situation is quickly changing. Recent studies show that young girls are smoking in most countries almost as much as young boys, and in some, their prevalence is already higher. It is also alarming that there is an increasing prevalence of other forms of tobacco use, such as spit tobacco, bidis, and water pipes.

The Tobacco Free Initiative (TFI) of the World Health Organization (WHO) continues to lead the efforts towards reversing the negative impact that tobacco use has on health, economies, and countries. TFI is committed to supporting women's issues and equality in the context of tobacco control. This includes incorporating a gender perspective into research, programming, and policy development, particularly during the implementation of the WHO Framework Convention on Tobacco Control (FCTC).

The WHO FCTC, a legally binding instrument for its signatory countries around the world, has in its preamble that "The Parties to this Convention [are]... *alarmed* by the increase in smoking and other forms of tobacco consumption by women and young girls worldwide and are keeping in mind the need for full participation of women at all levels of policy-making and implementation and the need for gender-specific tobacco control strategies." Furthermore, Article 4.2d states that there is a need to take measures to address gender-specific risks when developing tobacco control strategies. The effective implementation of the WHO FCTC provides a basis for comprehensive, gendered tobacco control in national, regional, and global initiatives.

This report, *Turning a New Leaf: Women, Tobacco, and the Future*, provides a much-needed picture of women's tobacco use in different social contexts, identifies the health effects of tobacco, and describes women's role in tobacco production and marketing. It also provides direction on assessing and addressing the gendered issues of tobacco control in policy, programming, and research in order to reduce the devastating effects of tobacco on women.

We have come a long way in recent years in paying attention to issues involving women and tobacco, but not yet far enough. Only with a concerted international effort to include a gender perspective in tobacco control can we address women's tobacco use and take into account women's role in tobacco production and marketing. In this way, tobacco use rates among women can be curbed, millions of women's lives saved, and a debilitating 21st century epidemic prevented. This is the challenge for the future.

A Message from the British Columbia Centre of Excellence for Women's Health

Canada has long been considered a leader in tobacco control and for good reason—the rates of tobacco use have reduced dramatically in Canada over the past 40 years. Bringing women's concerns and gender issues to tobacco control has featured in the Canadian effort since 1987, when the first edition of the *Background Paper on Women and Tobacco* was released. Since that time, there has been an increased awareness of how women are affected by tobacco use and policy, and how the application of Canada's gender-based analysis policy (GBA) can assist in improving actions and responses to women and tobacco.

Since 1996, the British Columbia Centre of Excellence for Women's Health (BCCEWH) has had a robust research and knowledge transfer program related to women, girls, and tobacco. The BCCEWH has worked in conjunction with many partners in Canada and around the world to advance the research, practices, and policy responses for girls and women. We have promoted women-centred programming, policy, and research and focused on enhancing women's role and status in society along with tobacco-free lives.

As Executive Director of the BCCEWH, I have had the privilege of representing these issues around the world. As one of the founders of the International Network of Women Against Tobacco (INWAT) in 1990, I am doubly pleased to be presenting *Turning a New Leaf: Women, Tobacco, and the Future*. Together with committed advocates, researchers, and policy-makers worldwide, I am convinced that we can prevent or reduce the toll of tobacco on the world's women in the 21st century.

Lorraine Greaves
Executive Director, British Columbia Centre of Excellence for Women's Health, Canada
President-elect, INWAT 2006

A Message from the President of the International Network of Women Against Tobacco

The International Network of Women Against Tobacco (INWAT) is pleased to have partnered with the British Columbia Centre of Excellence for Women's Health in the development of this publication. *Turning a New Leaf: Women, Tobacco, and the Future* raises very timely and pertinent issues for the 21st century and is intended for both the women's health and tobacco control movements.

Several INWAT members have contributed to this publication by sharing their expertise and perspectives from around the world and have reviewed its content. The report brings to light the unique tobacco control challenges facing us today and provides a basis on which to develop effective gender-based policy, programming, and research to increase women's equality in societies. INWAT joins hands with groups whose primary concern is with the status and health of women in society to meet these challenges.

INWAT was founded in 1990 and acts to eliminate tobacco use and exposure to second-hand smoke among girls and women. An important challenge for INWAT is to assist in developing and promoting high-quality tobacco control measures designed for women.

It is now, more than ever, critical that our global networks support actions to decrease tobacco consumption among women and girls, ban exploitative marketing practices, regulate safe and equitable production practices, and protect women from exposure to second-hand smoke. It is equally important to push for equality and enhanced women's rights — living free of tobacco is one of those.

Margaretha Haglund
Director, Tobacco Control, National Institute of Public Health, Sweden
President of INWAT 1997 - 2006

Introduction
Turning a New Leaf: Women, Tobacco, and the Future

Lorraine Greaves, Natasha Jategaonkar, and Sara Sanchez

Current Trends

Tobacco use is increasing its hold and impact on women and girls across the globe. In the 21st century, it threatens to undermine not only women's physical and mental health but also their economic and social progress. This report describes the urgent issues surrounding tobacco use and production that affect women around the world and offers direction for preventing and reducing the impact of tobacco among girls, women, and their communities. Preventing the full expansion of the tobacco epidemic among the world's women will be a critical factor in improving the status of women.

While global tobacco-use trends among men are now in a slow decline, the epidemic among women will not reach its peak until well into this century.[1] The World Health Organization predicts that the prevalence of smoking among women worldwide will be 20 percent by 2025[2] a sharp contrast to the 12 percent of the world's women who smoke today.[3] Yet, even if smoking rates remain unchanged, the *number* of female smokers will increase simply because the number of women in developing countries will increase by an estimated 1 billion from the current 2.5 to 3.5 billion by 2025.[1]

For a number of decades, the tobacco industry has sold tobacco by exploiting women's need for liberty and independence. This approach has been, and continues to be, the basis of many advertising and marketing campaigns, and has served to change cultural beliefs about women and smoking. Its message has been tragically ironic—although smoking has been linked to independence and pleasure, cigarette smoking has had the opposite effect of diminishing both women's health and material wealth, while also diminishing their independence and quality of life.

It was over eight decades ago, in 1924, that Philip Morris introduced a so-called women's cigarette that they described being "mild as May." Forty years later, the United States Surgeon General reported that there were "probable" linkages between tobacco use and cancer for women and "definite" linkages between tobacco use and cancer for men.[4] By this time, there were also emerging concerns about the effects of smoking during pregnancy, although most of these focused primarily on the health of the fetus, not on the health of women.[5]

In more recent history, other tobacco-related issues began to emerge. By the early 1980s, the immense toll of second-hand smoke on women started to become more apparent when research in Japan documented the perils of exposure for women who lived with smokers.[6] In the meantime, the gradual movement of tobacco farming and processing from the Americas to Africa and Asia had an increasing and negative impact on women's lives, whether they were smokers or not. Women and their families lost valuable food production capacity and were exposed to various exploitative labour practices of tobacco producers.

It took these events *and* women's advocacy before the scientific community and the public took notice of the issues linked to girls, women, and smoking. In 1983, women were a group of "special concern" at the Fifth World Conference on Smoking and Health in Winnipeg, Canada. By 1989, the World Health Organization's "World No Tobacco Day" took on the theme of "Women and Tobacco" and a year later, in 1990, the International Network of Women Against Tobacco (INWAT) was formed in Perth, Australia, to develop leadership, advocacy, and education on the issues of women and tobacco. In 1992, the first international conference on women and tobacco was held in Northern Ireland. Later, in 1999, Japan hosted the first World Health Organization (WHO) International Conference on Tobacco and Health, with the theme "Making a Difference to Tobacco and Health: Avoiding the Tobacco Epidemic in Women and Youth," which gave rise to the Kobe Declaration.

In related moves, the Global Youth Tobacco Survey (GYTS), developed by WHO and the US Centers for Disease Control and Prevention (CDC), was launched in 1999 to gather data on smoking by girls and boys. In 2000, eight Millennium Development Goals (MDGs) were adopted by United Nations (UN) member states. Two of these specifically focus on improving the status of women, and the WHO has applied these goals to tobacco control.

This early work culminated in May 2003 when the member countries of WHO adopted the Framework Convention on Tobacco Control (FCTC), a historic tobacco control treaty, which came into force with ratifications in 40 countries in February 2005. This international public health treaty recognizes the importance of a gendered approach to tobacco programming, policy, and research and expresses concern about the potential global rise in tobacco use among women.

Health, Wealth, and Equality

This report is concerned with preserving the health of women worldwide. However, it is equally concerned with improving women's economic, political, and social empowerment and progress. These issues are inextricably linked—without health, women cannot prosper. Without equality, women are at a disadvantage in achieving and maintaining good health.

Indeed, the women and girls experiencing health inequities in developed countries are also most likely to be among the remaining smokers, and smokers in developed countries are those most likely to be disadvantaged or marginalized. Because access to power and resources is gendered, there are numerous female populations that are a priority for tobacco control.

In countries with fewer resources and capacity, where women are often just beginning to smoke or increase their

smoking rates, tobacco use will impair their long-term health. In these countries, where most of the global growth in women's tobacco use is occurring, the irony of the marketers' messages linking smoking to independence has yet to be fully exposed. Hence *Turning a New Leaf: Women, Tobacco, and the Future* addresses the issues of women, gender, tobacco use, tobacco production, and legislation, and draws important links between tobacco use, production, and women's struggle for equality.

Chapter 1 describes current trends and contexts with respect to the status of women and women's tobacco use in the world, and highlights selected countries as examples. A feature of the global context is the FCTC, the first international public health treaty. Chapter 1 presents some examples of countries where there are still very low rates of women's smoking, which indicate the potential size of the women's tobacco-use epidemic. We also present examples of countries where women's tobacco-use rates are still climbing, and either matching men's rates or, in some cases, even surpassing them. Finally, there are examples of countries where tobacco use is declining overall, but specific groups of women are still very much at risk for starting or continuing to smoke. These varied examples illustrate the issues specific to girls and women in all stages of the tobacco epidemic.

Chapter 2 summarizes existing knowledge about the impact of tobacco use on women's health, with attention to emerging findings about how these effects differ between women and men. Over several decades, scientific research has established many links between smoking and health and it is constantly exploring more. For example, emerging links between smoking, second-hand smoke, and breast cancer are under considerable scrutiny. In the developing world, the cumulative effects of cooking fuel emissions, second-hand smoke, air pollution, *and* smoking on women's lung health is an urgent issue. Research into genetics offers new understanding of female susceptibilities to tobacco and second-hand smoke as well sex-specific, tobacco-related disease trajectories in women.

Chapter 3 examines the production and promotion of tobacco products and illustrates their impact on girls' and women's lives from the tobacco field to the female consumer. Serious threats to women's equality are evident as tobacco companies shift their gaze to the low- and middle-income countries for market development as well as tobacco cultivation and production. Exploitation of women's and children's labour and low economic rewards go hand in hand with poor and unsafe working conditions. Loss of food production to tobacco cultivation is not only an economic threat but also undermines nutrition and health for women and their families. Since men generally pick up smoking first, women and children suffer from second-hand smoke and food insecurity resulting from diminished family incomes.

Key Treaties & Declarations Relevant to Women and Tobacco

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

CEDAW, often described as an international bill of human rights for women, was adopted in 1979 by the United Nations (UN) General Assembly. In article 12, CEDAW requires that all appropriate measures must be taken to eliminate discrimination against women in the field of health care. Furthermore, the general recommendations of CEDAW state that a gender perspective should be integrated into all policies and programs affecting women's health and that women should be involved in the planning, implementation, and evaluation of such policies and programs.

The Kobe Declaration

The Kobe Declaration was adopted in 1999 at an international conference on women and tobacco hosted by the World Health Organization (WHO) in Kobe, Japan. This declaration states that tobacco control strategies must integrate the promotion of gender equality in society and that women's leadership is essential to the success of these strategies. The Kobe Declaration further demands that the Framework Convention on Tobacco Control (FCTC) include gender-specific concerns and perspectives.

Framework Convention on Tobacco Control (FCTC)

The FCTC is the world's first international public health treaty, adopted in May 2003 by the member countries of the World Health Organization (WHO). The FCTC aims to reduce the toll of tobacco on the lives of women and men around the globe, and recognizes the importance of a gendered approach to tobacco programming, policy, and research. The FCTC explicitly mentions women in the preamble and expresses concern about the potential global rise in women's tobacco use. By April 2006, 168 countries had signed the FCTC and 126 had ratified the treaty.

Chapters 4 and 5 offer a way forward, outlining future action, policy, research, and advocacy. **Chapter 4** highlights the links between human rights, women's rights, and tobacco by considering health as a human right in the context of existing treaties and laws. The FCTC has the potential to be an important treaty for women, particularly if the application of its articles is gendered and women-specific. Similarly, established treaties outlining goals and agreements for women's advancement such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) can be utilized to achieve lowered exposures to tobacco and improved opportunities for health in the context of women's equality.

Finally, **chapter 5** provides examples of gendered and women-specific approaches to tobacco control in policy, programs, and research. Many of these activities will benefit from more research and evaluation, and better sex- and gender-sensitive surveillance and data collection programs. Fortunately, there are emerging examples of innovation and advocacy taking place in countries at all stages of the tobacco epidemic. The challenge is to link these and future initiatives to tobacco production as well as consumption, and to ensure that these responses are truly progressive when measured against the goal of increasing equity for women and girls.

Solving the problems associated with women and tobacco will take inspiration and innovation. It will also demand a commitment to improving the status of women, and taking an interest in educating and empowering girls in countries around the world. Tobacco marketers have been falsely holding up empowerment and liberation as women's reward for smoking – it is high time that women's actual empowerment reduces the spread of tobacco.

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Chapter 1. Tobacco or Equality?

Lorraine Greaves, Natasha Jategaonkar, and Sara Sanchez

The Toll of Tobacco on Women

In the year 2000, 990,000 women worldwide died from tobacco use.[1] This constitutes a loss of almost 2720 women per day. At present, this mortality is concentrated in developed nations but if current trends continue, the proportion of deaths from tobacco use in the developing world will increase significantly over the next few decades.[2] The World Health Organization (WHO) and many others identify tobacco use as one of the top ten leading threats to global health.

Approximately 250 million women and almost 1 billion men are daily smokers.[3] The rates for men have peaked and are now in slow decline, but the rates for girls and women are still rising. Researchers predict that while 12 percent of the female population currently smokes, this number will rise to 20 percent by 2025.[4] And this does not account for other forms of tobacco use such as chewing tobacco, water pipes, bidis, chutta, betel nut, and snus or snuff, all of which are used by women in gendered and region-specific patterns. (Chapter 2 discusses these other tobacco uses in more detail.)

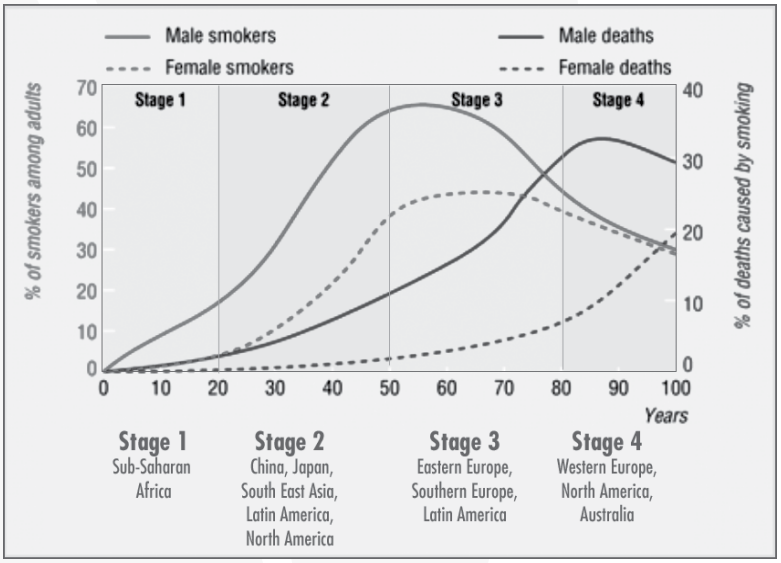

Figure 1. Stages of worldwide tobacco epidemic. [5] Reproduced with permission from the BMJ Publishing Group. *Tobacco Control*, 1994, 3, 242-247.

Tobacco-use patterns in countries around the world have been characterized according to four stages of a worldwide tobacco epidemic (see Figure 1).[5] The stages in this framework account for the gendered patterns of cigarette smoking throughout the last century. For a country in Stage 1, smoking rates are low for both women and men (i.e., on the order of 10% or less), but cigarettes are increasing in popularity among men. Stage-2 countries experience a sharp increase in the prevalence of cigarette smoking among men, while women gradually begin smoking as well. In Stage 3, men's rates of smoking have peaked and are beginning to decline, and women's smoking will also begin to decrease, but at a much slower rate. In the fourth stage, the decline in women's and men's smoking rates continues, but the mortality due to tobacco is still generally increasing among women, due to the delay of many of tobacco's health effects.

The response to tobacco will also vary depending on what stage the country finds itself in. Some countries, currently in Stage 1, have very low smoking rates among both women and men, and so tobacco use among women is not yet perceived as a problem. Other countries, having advanced through the stages of the epidemic to Stage 4, are often working on how to tailor smoking prevention and cessation interventions to specific gendered and diverse subpopulations where tobacco use remains high. In between, Stage-2 and -3 countries are grappling with rising rates of tobacco use, and struggling to develop effective tobacco control infrastructure as well as adequate health services for those with tobacco-related disease. While this is the broad picture, there are many examples of subpopulations within a country that exhibit tobacco use characteristics that differ from the country as a whole. Regardless of which stage categorizes a country in the smoking epidemic, they all have one thing in common: none has responded sufficiently to the gendered nature of the tobacco epidemic.

Using this model, it is clear that there is a second layer to this pattern of stages in the tobacco epidemic – while women's uptake of smoking follows that of men's, developing countries are following the patterns of developed countries. To ensure this pattern in the adoption of smoking, the tobacco industry has sold a message of modernity, implying that a modern Westernized society is the epitome of desire and that smoking symbolizes its style and values. This has resulted in the global spread of tobacco use and cultivation to many developing countries. Following their success in the developed world, advertisements directed towards women in developing countries press even more specific messages, falsely linking cigarette smoking with empowerment, beauty, and success.

Herstory of Women & Tobacco

1851 First known portrait of a woman (Lola Montez) posing with a cigarette.[1]

1919 First time a woman is depicted smoking in an advertisement (USA).[2]

The Status of Women

There remains a dangerous, wide-spread perception that tobacco is a symbol of equality and independence. Unfortunately, there is a related prevalent presumption in the minds of tobacco marketers that increased equality for women will encourage the uptake of smoking. Although tobacco advertising strives to make this connection, we know these messages to be false. Increased income and education may coincide with the initial uptake of tobacco use among women, but we now know that tobacco use ultimately becomes associated with disadvantage among women.

The status of women varies significantly from country to country. In the year 2000, the United Nations (UN) member states pledged to reach eight important Millennium Development Goals by the year 2015. A key goal is to "promote gender equality and empower women" via indicators such as the ratio of girls to boys in all levels of education, the proportion of paying jobs held by women, and the proportion of parliamentary seats held by women.[6,7]

According to a 2005 UN report, regions around the world show huge variations in their progress in meeting this goal.[7] For example, in some areas, such as sub-Saharan Africa and Southern Asia, girls' enrolment in primary schools is much lower than boys', women do not hold an equal share of paid employment, and the representation of women in national parliaments is low. These regions are in danger of not meeting the targets by 2015 if the current trends persist.

Conversely, in the Commonwealth of Independent States (CIS), Asia and Europe, parity in primary school enrolment has been achieved and women hold a large share of paid employment, although the average representation of women in national parliaments is still very low. Around the world, there is a range in countries' actions to ensure women's participation in national decision making. For example, South Africa, Eritrea, and Uganda have passed provisions that reserve parliamentary seats for women. Jordan and Tunisia have established quotas for women in parliament. Improving the status of women is the goal of all of these measures.

A report from the World Economic Forum identified and quantified the "global gender gap" in 58 countries according to five key measurement criteria: economic participation, economic opportunity, political empowerment, educational attainment, and health and well-being.[8] They conclude that, while no country has yet achieved equality, some countries have considerably smaller gender gaps than others. While the forum clearly includes health and well-being as a key indicator of gender equality, they note that it is a particularly difficult area to both measure and improve. In closing the gender gap, improvement in health and well-being has to critically coincide with other social and economic factors.

The Canadian International Development Agency (CIDA) argues that when the status of women improves, so does their health.[9] But when women are exposed to tobacco, health prospects will invariably diminish. While there has been some correlation between equality-seeking and the initiation of tobacco use among women, it is clear that the long-term consequences of tobacco use lead to poorer women's health, which will in turn compromise women's prospects for economic health and gender equity. There are evident and compelling reasons to think that prospects for global improvements in the status of women are directly related to health, as CIDA argues.

Tobacco industry marketing, such as the pivotal Virginia Slims "You've come a long way, baby" campaign launched in 1968, plus the later version called "Find your voice" in 1997, has created a particularly dangerous perception that women's cigarette smoking is linked to women's equality for women everywhere. We now know that nothing could be further from the truth. The first campaign was aimed at mainstream American women, while the second campaign has found diverse audiences around the globe.

In the 21st century we can address the female tobacco epidemic with the benefit of hindsight from experiences in the developed world. We can project the scope and size of female tobacco use, and its consequent costs. We also have seen those experiencing the most inequality as most likely to remain smokers. Making the links between women's tobacco use and women's equality is crucial for circumventing the future loss of women to tobacco worldwide.

In this chapter we discuss the rise and spread of the tobacco epidemic. The varied challenges faced by many countries include collecting adequate data to establish current women's and men's smoking rates, dealing with traditional and cultural forms of tobacco use in addition to cigarette smoking, as well as tailoring programs and policies so that prevention and cessation strategies are accessible to women who need them most. Whether the countries are grappling with the serious impact of girls' and women's tobacco use and struggling to prevent its rise, or strategizing to hasten its reduction, women's smoking may finally be getting long-overdue attention.

Countries representing diverse geographic areas, all stages of the tobacco epidemic, and varying levels of equity

1921 First legislative bill passes to prevent women from smoking in an American region: District of Columbia.[3]

1924 Philip Morris introduces Marlboro as a women's cigarette that is supposedly as "mild as May."[4]

for women serve as case studies here. In countries at the early stages of the epidemic, such as Ghana, Thailand, and China, women currently have low smoking rates but are viewed as a huge potential "market" for cigarette consumption. In Iran, where women's smoking rates have traditionally been low, girls and young women are consuming cigarettes in increasing proportions and there is considerable cause for concern. India and Turkey are both nations with a long cultural history of tobacco use, but these days more urban, educated women are turning to cigarette smoking.

As a country at the height of its tobacco epidemic, Lebanon has high smoking rates among both women and men, but many health activists hope that comprehensive tobacco control policy can reverse this trend. South Africa and Brazil are just entering the latter stages of the epidemic, where tobacco restrictions are in place and women's smoking rates appear to have peaked. Australia and Canada represent Stage 4 of the epidemic, where smoking rates are low overall but significantly higher in specific subpopulations of women, while Sweden is among a small group of nations where women actually have higher rates of smoking than men.

The countries are presented here with two themes in mind. What is the picture of women's and girls' tobacco use, and how are women and girls positioned in each country? Understanding both elements prepares us for staging responses to prevent or reduce women's tobacco use, while enhancing the status of women.

Ghana – Eyes on the Next Generation of Women

Sara Sanchez

Ghana is in the early stages of the tobacco epidemic. Although overall cigarette smoking rates are still low— 4 percent among women and 10.8 percent among men,[10] the youth rates reported by the Global Youth Tobacco Survey are alarming: 18.8 percent of girls and 19.5 percent of boys report that they currently use a tobacco product.[11] The high prevalence of tobacco use among the young may indicate that cigarette smoking is set to rise in Ghana. British American Tobacco (BAT) Ghana has the highest cigarette share, dominating 99.4 percent of the market,[10] but it masks its financial gains under some social responsibility measures such as contributing to combat the country's AIDS crisis and restoring forests.[12] Although less than 0.5 percent of agricultural land is devoted to tobacco growing, Ghana produced 2600 metric tonnes of tobacco leaves in 2000.[10] Because Ghana is a party to the WHO FCTC, having ratified the treaty on 29 November 2004,[13] the country has an opportunity to stem the rising tide of tobacco use among young people.

Women in Ghana still lag behind men in educational attainment and training, although efforts have been made to enhance women's opportunities. More than half of all women over the age of 15 (54.3%) have never been to school or are illiterate[14] and the national literacy rate is 67.1 percent among women.[15] However, the gap between the proportion of boys and girls at the secondary education level is narrowing and now stands at 15 percent.[16] Training programs for girls are increasing yet continue to focus on traditional women's jobs such as catering and sewing.[14] Among economically active women, 85.5 percent are employed in the informal sector.[16] Agriculture is a significant contributor to Ghana's GDP and women contribute between 55 and 60 percent of the total agricultural production.[16]

Although women occupy some positions in Ghana's parliament, the ratio of women to men remains quite low: between 2000 and 2004, roughly 1 in 10 members of parliament and cabinet ministers were women and no woman held a position as regional minister.[17]

China – Will Women Hold up Half the Market?

Judith Mackay

"Women hold up half the sky" is the famous saying of Chairman Mao Tse-tung (1893 -1976). In China women make up 48.5 percent of the population or 600 million people.[18] Women represent 45 percent of all employed people;[18,19] however, in terms of leadership positions, there are no women members of the senate or upper house and women make up only 21 percent of the lower house.[20] Literacy rates for the general population of women and men are high, at 87 percent and 95 percent respectively (in the four years between 2000 and 2004).[21,22] However, among those over the age of 24, almost one-third of women (32%) are illiterate or semi-literate, compared with 13 percent of men.[18]

As women in China gain independence and spending power, there is a real danger that cigarettes will come to symbolize women's demand for greater equality.[23] Less than 10 years ago, women smoked only in private whereas today it is more common to see women smoke in public. Preventing a rise of smoking among millions of Chinese women is a significant challenge because China is the most important country in the world in the tobacco epidemic.

Herstory of Women & Tobacco

1925 The American Tobacco company markets to women with "Reach for a Lucky instead of a sweet" campaign.[5]

1942 The Federation of German Women launch a campaign that results in a prohibition of sales of cigarettes to women in restaurants and cafes.[6]

1955 Filtered cigarettes first introduced.

One in every three cigarettes smoked globally is smoked in China. Because there are 600 million girls and women in China, even a 1 percent change in tobacco prevalence translates into very large numbers of users. However, to date, the epidemic in China has been, and still is, almost entirely confined to men. The latest national survey in 2002 shows current smoking prevalence among females aged 15 and over at 2.6 percent,[24] down from 7 percent in the first survey in 1984,[25] and 3.8 percent in 1996.[26] The smoking rate is higher for urban women than for rural women. The average consumption of cigarettes in China is 10 cigarettes per person per day (and virtually all tobacco consumed in China is in the form of manufactured cigarettes). Despite these trends, the smoking rate in some groups is increasing, especially for example, in 15 to 24 year olds of both sexes. Further, an estimated 54.6 percent of women are exposed to environmental tobacco smoke, with 90 percent of these women exposed to smoking by family members.[27]

Apart from the promotional campaigns aimed at women by the transnational tobacco companies, there has been similar advertising and sponsorship by the Chinese tobacco industry.[28] For example, the "Zhonghua Cup" International Female Fashion Design Contest was sponsored by the Shanghai Tobacco (Group) Company in 2000.[29]

Although all surveys report sex-disaggregated data, tobacco control (including health education and quitting advice) in mainland China has not been gender specific. Male smoking is seen as the overwhelming problem — almost 60 percent of men are currently smokers. Most disconcerting is that three quarters of all male and female smokers report they that have no intention to quit smoking.[30] China (including Hong Kong and Macau) ratified the WHO Framework Convention on Tobacco Control on 11 October 2005, and is among the first 100 parties to the treaty.

Thailand – Will Women's Low Smoking Rates Be Maintained?

Bungon Ritthiphakdee

Thai women play a vital role in the social and economic development of the country. According to the Thai constitution, women have rights in all areas accorded to Thai citizens, particularly the right to education and the right to engage in the paid labour force. The national statistical office reported that in 1992, out of 32.9 million people in the labour force, 15.2 million (46.1%) were women, and 54.4 percent of government officials were women.[31] The number of women in the labour force has been increasing rapidly in the last 20 years.

Fortunately for Thai women, they are not as well represented among smokers. Only 5 percent of the 9.6 million regular smokers are women.[32] The smoking rate among women is very low, with the national average for adult women at less than 2.1 percent, compared to 37 percent for Thai men.[33] In Northern Thailand, the country's main tobacco plantation area, the smoking rate among women is highest (6%), particularly among elderly women, who smoke hand-rolled cigarettes.[34] Not surprisingly, the higher rate of smoking in the North is reflected by higher rates of lung cancer, which is the most common form of cancer in Northern Thai women.

Smoking prevalence in Thailand seems to be on the decline as a result of comprehensive tobacco control policy and programming. Thailand was one of the first 40 countries to ratify the FCTC and has implemented most of the WHO's recommendations. In 1988, 53 percent of men smoked compared to 4.8 percent of women, but by 2004 the rates were 37 percent and 2.1 percent respectively.[35] Despite these trends, however, smoking among young women has been increasing in the past three years. The upward trend was first seen in a 1997 study which showed that nearly 5 percent of female high school and vocational students were smokers,[36] which is double the national smoking rate for women. Although by tradition smoking is not seen as socially acceptable for Thai women, this increase may be associated with the increased prominence of foreign brands because nearly 70 percent of these young women indicated a preference for Marlboro.[36] Thailand has been pegged by the tobacco industry as a fertile ground for future sales due to the country's economic growth. In its bid to open Asian tobacco markets using US trade law, the tobacco industry has targeted Thailand among other countries.

Iran – Girls' and Young Women's Smoking on the Rise

Hassan Azaripour Masooleh

The latest national survey in Iran in 1999 showed that 1.7 percent of women aged 15 and over were smokers, and that the prevalence of water-pipe use was 3.7 percent, with no difference between males and females.[37] But unfortunately, more recent surveys show that smoking prevalence is increasing among educated young women and girls.[38,39] This is of particular concern because of Iran's female

1964 First time a US Surgeon General's report is disseminated, showing "definite" linkages between tobacco use and cancer for men, and "probable" linkages between tobacco use and cancer for women.[7]

1968 Launch of Virginia Slims, a brand of cigarettes created specifically for women, which links its marketing tactics to feminist/liberation ethics, as shown by its first slogan, "you've come a long way, baby."[8]

1969 Tobacco industry documents focus on women "Smoking and Baby Weight."

population, the majority (more than 70%) are young—aged 29 or below.[37]

A study of smoking prevalence among college students in Tehran in 1999 showed that 26.9 percent of women students have experimented with cigarettes but only 1 percent of them were current smokers.[40] However, a separate survey carried out in the same year showed that 5 percent of women students were smokers. Furthermore, this study showed that smoking prevalence was dramatically increasing from the first year through the last year of university study (2.7% versus 7.8%, respectively). The age of smoking initiation was 16 for first-year students and 20 for students in their final year.[38]

The 2002 Global Youth Tobacco Survey supported these trends. It showed a dramatic change in smoking prevalence among the young in Iran. Among girls aged 13 to 15, 9.8 percent used tobacco products compared to 21 percent of boys the same age. Cigarettes are smoked by 1.3 percent of girls and 4.8 percent of boys whereas 9.5 percent of girls and 18.9 percent of boys use other types of tobacco products, mainly water pipes. There are also alarming indications that 9.7 percent of girls who have never smoked at the time of the survey are susceptible to initiating smoking within the next year. Less than 30 percent of girls had been taught about the dangers of smoking, and more than half of the girls who were currently smoking thought that it made them look more attractive.[39]

Transnational tobacco industries are utilizing Iranian traditions in order to introduce their products to Iranian youth. Water pipes have traditionally been used by older women in southern parts of Iran, but they are now commonplace in modern coffee shops frequented by young girls and boys. Iran might well face an overwhelming tobacco epidemic among youth in the near future. Fortunately, the country has taken steps to address this impending problem, including ratifying the WHO FCTC on 6 November 2005 and a national tobacco control law in 2006.

Iran has a small number of women engaged in government bodies, including 4.4 percent of Islamic parliament delegates who are women.[40] However, literacy rates stand at about 81.8 percent among urban women and 65.4 percent among rural women.[41] According to the latest reports, about 60 percent of university students in Iran are now women.[40] Ten and a half percent of urban women and 19.5 percent of rural women are employed in the workforce.[42] In terms of access to health care, the majority of women in Iran make use of family planning programs and receive at least two prenatal care visits during pregnancy.[43]

India – While Traditional Tobacco Persists, Cigarettes Flare up among Urban Women

Mira Aghi

Women were created equal to men according to India's ancient mythologies. Manu, the great lawgiver, said that "where women are honoured there reside the gods," which may be why wives are referred to as *Ardhangani*, a Sanskrit word that means one-half of a body. This implies that in a married couple, the woman is equivalent to the man, since they each form one half of a single entity.

Sadly, the position of women in India deteriorated due to historical reasons. Today, in contemporary India, 54 percent of the women are literate;[44] over 1 million women are elected into local government bodies.[45] While there has been an upsurge in awareness about women's rights since the days of Mahatma Gandhi, Indian society is still very much a mix of progressive and regressive attitudes towards women.

Indian women's tobacco-consuming practices reflect this mix of attitudes. When the aspirations of some independent and ambitious women resonated with what the tobacco companies were promoting, they started smoking cigarettes. At the same time, many poor, uneducated, and over-burdened women found solace in something that they could call their own, namely the pouch containing their paraphernalia for chewing tobacco (tobacco, areca nut, lime, etc.).

Results from two national surveys show the overall prevalence of tobacco use among women as 10.3 percent and 13 percent.[46,47] The estimates of the prevalence of regular smoking among women in India range from 2.4 percent to 2.6 percent. Women make up between 8.6 percent and 12 percent of regular smokeless tobacco users. Tobacco is used in a wide variety of ways including smoking, chewing, applying, sucking, and gargling. Hence, a wide variety of tobacco products are available, some commercially manufactured and others that can be made by the user herself. Although the prevalence of cigarette smoking is currently low among women, it is set to increase due to aggressive marketing and globalization. The prevalence of smoking is higher among rural women, who smoke bidis.

Among urban women in India, smoking is often seen as a symbol of emancipation and modernity. But on the whole, women mostly use smokeless tobacco, which is less associated with the stigma attached to smoking. Tobacco use in pregnant women is similar to that among non-pregnant women of the same age.[48]

Herstory of Women & Tobacco

1971 Eve Cigarettes are first manufactured by Liggett to compete with Virginia Slims. "Eve" uses marketing tactics that associate cigarette smoking with lady-like behaviour as demonstrated by its slogan, "a beautiful cigarette for a beautiful lady."

1977 The Health Education Campaign (HEC) in the UK begins its first nationwide smoking cessation campaign for women.[9]

India ratified the FCTC on 5 February 2004 and introduced comprehensive tobacco control legislation on 18 May 2003. In addition to its very robust legislation, the Ministry of Health is also working towards banning smoking in films, which could provide global leadership in this area. However, a national effort to educate women on the ill effects of tobacco use is lacking. In fact, many women in rural areas believe that tobacco has numerous magical and medicinal properties, from keeping the mouth clean and curing toothache to controlling morning sickness and easing labour pains.

Turkey – Cigarette Use Soars Past Water-pipe Use

Elif Dagli

Traditionally, only men in Turkey used to smoke; it was quite unacceptable for a woman to be seen with a cigarette. But Turkey has experienced a rapid rise in women's smoking rates over the past two decades. In 1988, the prevalence of women's smoking was 24 percent,[49] but since then, rapid urbanization and multinational tobacco industry activities have led to an increase in the popularity of smoking cigarettes, particularly among educated, urban women of higher socioeconomic status. The rate among women is now similar to that among men, with 30 to 50 percent of health professionals and teachers smoking.[50] A recent survey reports smoking rates of 30 to 37 percent among mothers up to 49 years of age and 15 percent among mothers over the age of 50. Cigarettes are the most widely used tobacco product, in spite of the eruption of water-pipe cafes.[51]

The Turkish tobacco monopoly, which never advertised, did not achieve huge market expansion. However, with the introduction of a liberal market economy in the 1980s, Turkey experienced the aggressive marketing strategies of the multinational tobacco industry and lost a substantial proportion of its market in the country and abroad.[52]

Although women in Turkey have a longer life expectancy than men, they are clearly disadvantaged compared to men with respect to per capita income and education. There is also a gap in literacy between males and females (91.3% and 76.1%, respectively), but this is rapidly narrowing. Women were given the right to vote in 1933, and at that time obtained 4.5 percent of the total seats in the legislative assembly. Despite the fact that a woman was elected prime minister in 1996, at present women are seriously underrepresented in the Turkish parliament at 4.4 percent.[53]

Approximately 27 percent of the economically active population is made up of women, who are well represented in professional occupations. For example, 29 percent of lawyers, 32 percent of university academic posts, 39 percent of architects, and 70 percent of graduating physicians were women in 1995. Turkey has ratified the convention on Payment of Equal Wages to Women and Men Workers for Work of Same Value.[54] The unemployment rate is 6.1 percent among women,[55] and there are no specific legal provisions regarding employment and gender discrimination.

In terms of women's health, Turkey has social security coverage and free access to health services for women who are generating income in the formal sector or are dependent on a relative in that sector. However, nearly half of urban women in Turkey are working in the informal sector and so are not covered by social security.[56]

Lebanon – At the Height of Women's Smoking

Simone Elias Abou-Jaoudeh

In contrast to other Arab countries, the prevalence of cigarette smoking in Lebanon is high among both women and men.[57] Lebanon has experienced widespread cigarette smoking since the beginning of the 20th century as well as the reappearance of narghile or water-pipe tobacco use as a modern trend for both women and youth.[58] A 1999 study of adults in a suburb of Beirut found that 31 percent of women and 42 percent of men smoke cigarettes, while another 34 percent of women and 27 percent of men smoke narghile.[59] A separate study reported that 20 percent of women smoke during pregnancy.[56]

The high prevalence of smoking is not limited to adults. In 2001, a survey of university students indicated that more men (61.7%) smoked cigarettes than women (41.9%).[61] Narghile use seems to be rapidly on the rise among university students: 43 percent of students entering university reported having used tobacco in 2002,[62] compared to 30 percent four years earlier.[63]

Data from school students collected through the Global Youth Tobacco Survey (GYTS) clearly indicate an increasing preference for other tobacco types, typically narghile. Cigarette smoking seems to have decreased slightly, from 7.4 percent of girls and 16.1 percent of boys in 2001[62] to 6.7 percent of girls and 14.8 percent of boys in 2005.[64] In contrast, 38 percent of girls and 51 percent of boys reported currently using some other form of tobacco (mainly narghile) in 2001,[62] which increased to 54.7 percent of girls and

1980 First US Surgeon General's report on women entitled, "The Health Consequences of Smoking on Women."[10]

1981 Takeshi Hirayama publishes "Non-smoking Wives of Heavy Smokers Have Higher Rates of Cancer: A Study from Japan," which is the first study documenting the perils of second-hand smoke.[11]

64.1 percent of boys in 2005.[64] There is some promise that these high rates can be reversed, especially with the recent ratification by Lebanon of the WHO FCTC on 7 December 2005.

Lebanon's social and political climate reflects some contradictions in indicators of gender equality. For example, women in Lebanon obtained the right to vote in 1953, and in March 1993, Lebanon ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) with reservations regarding conflicts with religious law. In addition, Lebanon has made significant progress towards achieving gender equality in educational attainment.[65]

Despite this progress, Lebanese women still do not have the same economic and political opportunities as men. Women constitute only 29 percent of the labour force. In addition, Lebanese women's access to national decision making and their participation in political life remains weak. The presence of women decreases at higher levels of the administrative decision-making positions — women's share in high-ranking positions does not exceed 6.1 percent.[66] Parliamentary seats held by women have not exceeded 6 out of 128 and, as of 2005, there has been only one female minister.

Tobacco use remains a threat to young women in Lebanon. As women's ability to participate with men in some aspects of life remains limited, multinationals will no doubt continue to play on the contradictions of gender equality in Lebanon.

South Africa – A Decline in Women's Smoking

Priscilla Reddy

The Global Youth Tobacco Survey (GYTS) in 1999 and 2002 reported the prevalence of girls' cigarette smoking at 17.5 percent and 21.6 percent, respectively. Exposure to tobacco advertising increased from 40.2 percent in 1999 to 65.5 percent in 2002.[67] These alarming trends may threaten past progress in preventing and reducing tobacco use in South Africa.

The 1998 South Africa Demographic and Health Survey reported a smoking prevalence of 11 percent among women and 42 percent among men.[68] There were distinct differences in the rates for Coloured women (39%) compared to Black women (6.4%). However, the smoking rate in South Africa declined steadily in the 1990s.[69] Tobacco control initiatives undertaken during this period continue to protect women and men from advertising and from second-hand smoke; meanwhile, tailored interventions should help to maintain the low prevalence rates of smoking among Black women.

A recent study of Black women in Cape Town showed that those who smoked cigarettes were older and less educated than those who did not. The majority (72%) of the respondents (tobacco users included) agreed that smoking among women was perceived as taboo, disgraceful, and shameful. The type of tobacco product used by women in South Africa seems to vary by age. Older women use snuff as a means of pain relief and they lack knowledge related to the health hazards of smoking.[70] Another study found that the majority of women were conscious of the harm caused by cigarette smoking but they also believed that it provided a means to lose weight.[70]

In general, female representation in African parliaments/governments is less than 8 percent — although women are nominated, they are not successfully elected.[71] In contrast, approximately 32 percent of the elected members of parliament in South Africa are women.[72] Although South Africa elected its first female deputy president in 2005, women are still not adequately represented in regional and local structures.[73]

In terms of health care, many South Africans have benefited from the recent building and upgrading of health clinics, the reallocation of financial resources, and the introduction of free health care. However, for women who reside on the outskirts of cities or in rural areas, access to health care for them and their families continues to be a huge obstacle.[74]

Brazil – Tobacco Crops Flourish but Consumption Falters

Tania Cavalcante

Brazil is second in the world in tobacco production and is the world leader in tobacco export. Women are very involved in tobacco growing— the cultivation and production often take place in a network of farming families integrated within the tobacco production chain, all of which is dominated by transnational companies. An estimated 200,000 families grow tobacco in the south part of Brazil.[75,76]

Despite the number of people involved in tobacco production, the smoking prevalence among Brazilian adults decreased significantly between 1989 and 2003. Among men, smoking decreased from 36 percent to 22.7 percent and among women, from 24 percent to 16 percent.[77,78] Among a sample of adolescents surveyed in 12 major cities of Brazil, the smoking prevalence varies from 11 percent to

Herstory of Women & Tobacco

1984 Rose Cipollone becomes the first woman to file a lawsuit against three major tobacco companies: Ligget Group, Lorillard, and Philip Morris.

1985 In the USA, lung cancer surpasses breast cancer as number-one killer of women.[12]

27 percent among boys and from 9 percent to 24 percent among girls.[79] Smoking rates are higher among the low-educational-level groups.

Since 1987, the Brazilian Ministry of Health, through its Instituto Nacional de Câncer, has coordinated a national tobacco control program and has built a network involving the health offices of 26 states, the Federal District, and nearly 4,000 municipalities, along with representatives from non-governmental organizations. This network has been developing countrywide educational activities to promote smoke-free environments and smoking cessation, thus fostering a positive environment to advance tobacco control legislation.

For example, in 2000, new restrictions on tobacco promotion forced the removal of sophisticated tobacco advertisements — many of them targeting women — from TV, magazines, and other mass media. In 2002, a federal law made obligatory the insertion of heath warnings with pictures on the packages of tobacco products. Some of these warnings address gender issues. Further pushed by FCTC negotiation, the government of Brazil has enhanced their approach to tobacco control by creating an inter-ministerial national commission to plan the implementation of FCTC provisions and to build a tobacco control plan that addresses gendered aspects of tobacco use.

This is all taking place in a country still marked by gender inequalities. Although 67.2 percent of men and 44.5 percent of women are economically active, the average income of women is only 69.6 percent of men's.[80] The inequity reflects the fact that women in the labour market are strongly concentrated in less-qualified and low-paying jobs.[80] More than 50 percent of Brazilian women live in rural areas in precarious economic circumstances.

In the family, women are normally considered "husband helpers" and their access to public credit for agricultural activities is still unequal.[80] To tackle these gender inequalities, the Brazilian government created a Secretariat for Special Policies for Women[81] and formalized a national plan to address these issues. A recent law determines a quota for women's participation in the legislative arena and has been impelling women's participation in policy.

Australia – Disadvantaged Women at Higher Risk for Smoking

Jane Martin

Australia has actively implemented a number of tobacco control policies over the last thirty years that have worked to reduce smoking prevalence, particularly among adults.[82] But, in keeping with the pattern described in the four-stage model of the tobacco epidemic, the rate of decline in smoking prevalence among women has occurred at a slower rate than among men.

Smoking prevalence among Australian women peaked at 33 percent in the mid 1970s and since then has been in decline, reaching 17.5 percent in 2004 compared with rates among men of 20.6 percent.[83-85] Both women and men in the 20- to 29-year-old age group have the highest prevalence where 25.5 percent of women smoke.[85]

However, these trends are not the same for all Australians. Indigenous Australians have substantially higher smoking rates than the population at large. In 2002, 47 percent of all indigenous women were smokers, the rate for indigenous men was 51 percent, and rates were highest in the 25- to 44-year-old age groups.[86] Pregnant women from indigenous communities are reported as having smoking rates of around 50 percent.[87]

Single-parent families are the fastest growing family structure in Australia, with more than 80 percent of such families led by women.[88,89] Single motherhood is closely associated with disadvantage, including the overall prevalence of smoking by lone mothers which is around 46 percent, with those aged 18 to 29 having the higher prevalence at 59 percent. Australian research has found lone motherhood to be an independent predictor of smoking.[90] The tobacco industry has actively targeted women through marketing schemes involving gifts, fashion events, the Internet, and collaborations with companies selling female-oriented products. For example, a Philip Morris menthol brand named Alpine is smoked almost exclusively by women and has been the cornerstone of a sophisticated covert marketing campaign, using models and make-up products to promote the brand, in an environment where marketing of tobacco is otherwise banned.[91,92]

Australia signed the WHO's FCTC in December 2003 and ratified it in October 2004.[93] All Australian jurisdictions, except the Northern Territory, have passed legislation to ban smoking indoors in hotels, bars, restaurants, and workplaces.[94] Fourteen graphic picture warnings covering 90 percent of the back and 30 percent of the front of each package appeared on tobacco products starting in March 2006.[95] In 2005, tobacco companies removed the terms "light" and "mild" from packaging (terms that have been particularly aimed at women).[96]

The percentage of women in the labour force continues to grow and is at 56 percent, accounting for 45

1987 Capri cigarettes are first manufactured. They are created specifically for women, boasting of "slimmer" cigarettes.[13]

1989 WHO World "No Tobacco" Day. First WNTD theme on "Women and Tobacco."

percent of the overall labour force.[97] Women account for the majority of casual and part-time workers, making up 71 percent of part-time employees in 2005.[98] Yet women in full-time work earn, on average, 84 percent the earnings of men. In the top 200 companies listed on the Australian Stock Exchange in 2004, only four of the CEOs were women.[97]

Sweden – More Women Smoke than Men

Margaretha Haglund

Sweden is one of five countries in the world where smoking is more prevalent among women than men. But women are now quitting at the same rate as men, and in some age groups, even faster than men. As a result of comprehensive gender-sensitive tobacco control activities, Sweden now has smoking rates of 17 percent among women and 13 percent among men, the lowest in Europe.[99]

Women make up more than half of the 9 million people living in Sweden and almost half of the labour force. The proportion of women aged 20 to 64 in the labour force increased from 60 percent in 1970 to almost 80 percent today. Women's representation in parliament more than doubled since 1973 to 45 percent in 2002.[100] According to the 2005 World Economic Forum report, which measured the global gender gap, no country has achieved equality between genders – but Sweden was doing better than the other 57 countries listed. Sweden gained points due to accessible and affordable health care, long maternity leaves, and high educational attainment among women.[100]

Progress toward greater economic and social equality in Sweden started in the 1930s and accelerated after World War II. Yet in many ways, this apparent equality was superficial because women were recruited mainly to occupations and sectors reflecting traditional gender roles, such as child care and nursing. And during this time, the tobacco industry portrayed smoking as a symbol of women's liberation and gender equality.[101]

The first smoking prevalence data is from 1946 which demonstrated that 9 percent of women and nearly 50 percent of men smoked at that time. After a big increase, particularly in the 1960s, women's smoking began to decline by the end of the 1970s. Today a typical smoker is a woman between the ages of 45 and 64 or a single mother.[102]

Besides smoking, snus (a form of oral smokeless tobacco) is common in Sweden, more so among men than women. Today, 22 percent of men and 4 percent of women use snus. However, the tobacco industry is making a big effort to increase the market share among women.[103]

While tobacco control policies such as high prices, bans on advertising and promotion, and smoke-free workplaces including bars and restaurants have been effective,[104] experience from Sweden indicates that a variety of gender-sensitive measures are also needed in order to influence tobacco use. It also seems that women, compared to men, are more responsive to messages about the dangers of passive smoking and more inclined to make use of services that are available to help them quit tobacco. For example, women make up a great majority of those who call the quit-smoking helpline.[105] Sweden ratified the WHO FCTC on 7 July 2005 and was among the first 100 parties to the treaty.

Canada – Overall Decline Masks Priority Populations of Women

Natasha Jategaonkar

The prevalence of smoking among Canadian adults aged 15 years and older has declined to approximately 17 percent among women and 22 percent among men. The current rates reflect a significant drop in the prevalence of smoking in all age groups in the past 20 years.[106] The decrease has been largely attributed to the implementation of several population-based tobacco control policies such as sales restrictions, increased price and taxation, and efforts to "denormalize" cigarette smoking. While the overall reduction seem promising, these statistics hide the fact that specific subpopulations of women and men still have smoking rates that persist at high levels.

Current Canadian smokers often occupy a disadvantaged or marginalized social position related to age, socioeconomic status, Aboriginal status, sexual orientation, and/or experiences such as trauma, mental illness, and use of other substances. Gender is a key determinant of health, and acts in concert with these elements to influence smoking status. For example, Canadians living on a low income are more likely to be smokers. In 1996-97, approximately 35 percent of women and 41 percent of men at the lowest income level were smokers. In contrast, at the highest income level, smoking prevalence was 18 percent for women and 22 percent for men.[107] On average, women in Canada earn a lower salary than men and are more likely to be living below the low-income cutoff.[108] Aboriginal youth also smoke at high rates. In the province of British Columbia, for example, levels of tobacco use among Aboriginal adolescent females are the highest among any ethnocultural-gender group in the province.[109]

Herstory of Women & Tobacco

1990 International Network of Women against Tobacco (INWAT) is formed.

1991 WHO publishes "Women and Tobacco."

1990 A brand of cigarettes specifically targeting women, MS Filters, is first distributed in India.[14]

In all of these subpopulations, attention to specific women's issues is warranted. For example, it is often considered a woman's responsibility to provide child care and nutritious meals and to maintain smoke-free spaces for children. This can be difficult where space, money, and resources might not be under her control. It also places different demands on women smokers compared to men when these responsibilities are present, particularly for lone mothers. Lone mothers in Canada are much more likely to smoke than partnered mothers, with one report of a smoking prevalence of 52.8%.[110] Young mothers, that is, those age 15 to 24 years, are more likely to smoke during pregnancy than mothers age 25 years and older (21% and 7%, respectively).[111]

Status of Women Canada is a federal government agency established to promote gender equality. Its work focuses on improving women's well-being and advancing women's human rights. In one of its recent documents, Status of Women Canada identified child care, violence against women, and wage inequity as the top three issues that need to be addressed to improve the lives of girls and women in Canada.[112]

Health Canada, the federal department with the mandate of helping Canadians maintain and improve their health, has developed a women's health strategy that conforms with the international documents Convention on the Elimination of All Forms of Discrimination Against Women and Beijing Platform for Action, as well as the Federal Plan for Gender Equality.[113] Training on gender-based analysis (GBA), a tool for policy-makers, program providers, and researchers, is provided by federal government agencies. Canada signed the FCTC on 15 July 2003, and ratified it on 26 November 2004.

Conclusion

The country profiles described here are just a small representation of the many complex issues that are at the intersection of controlling tobacco and improving the status of girls and women. While the priority concerns vary from one country to another depending on which stage of the tobacco epidemic the country finds itself facing, or which regional trends are present, in all countries it is critical to recognize and respond to the impact of tobacco on women's lives, and to develop women-sensitive mechanisms and policies that empower women to live free of tobacco.

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2003 Agreement reached over terms for the Framework Convention on Tobacco Control (FCTC).[16]

2005 INWAT celebrates 15 years of existence.

2003 The second INWAT award is given to Ruth Roemer, one of the primary architects of the Framework Convention on Tobacco Control.

Chapter 2. Tobacco Kills Women: What We Know about Adverse Health Effects

Michele Bloch

For many years, the impact of cigarette smoking on women's health was not fully understood because the full effects of tobacco use on a population require several decades to become evident. Reflecting the gendered trends in smoking uptake, the impact on men's health was first recognized, so men's health issues became the benchmark for assessing the effects of tobacco use. However, as we continue to learn about the female-specific effects of smoking, we now have new insight into the negative effects of smoking on nearly every system of a woman's body.

Cigarettes have changed significantly over the years, but the disease risks from smoking have not.[1] In the 1950s, cigarette manufacturers added filters; beginning in the late 1960s, they began marketing cigarettes with lower machine-measured yields of tar and nicotine (so-called light or low-tar cigarettes). Advertisements for these new brands were intended to reassure smokers concerned about health risks and to delay them from quitting. Many women took up these new brands in the hopes of reducing their risk, only to find much later that their exposure to hazardous compounds, and so their risk of disease, remained essentially unchanged.

Although it is known that tobacco harms health, we still need a better understanding of how the health impact of tobacco use and exposure to second-hand smoke differs between men and women and whether these differences are due to different patterns of tobacco use or to underlying biological differences. We also need a better understanding of the specific harms of bidis, water pipes, and smokeless tobacco products for women. A better understanding of gender differences will help us to understand how continued smoking affects the progression and treatment of diseases caused by tobacco.

One thing is certain, and it's good news for women who use tobacco products: quitting smoking saves lives. While the health benefits are greatest for those who quit at younger ages, every woman who quits can expect to see major and immediate improvements in her health. And every year, we know more about how to help women be successful in quitting for good. This chapter explores the impact of tobacco use and second-hand smoke exposure on women's health and the specific health benefits of quitting.

Cigarette Smoking and Its Overall Impact on Health

Cigarette smoking significantly shortens a woman's lifespan and women who smoke are far more likely to die prematurely than those who do not. Scientists have estimated that about one-half of all smokers, especially those who began as teenagers, can expect to die from their tobacco use, and that one in four smokers can expect to die in middle age.[2] The risk of death increases with both the number of years of smoking and the number of cigarettes smoked per day.

Numerous studies show that both women and men who smoke tend to rate their health status as lower than do non-smokers.[3] Smokers miss more work days, are more likely to be hospitalized, and have higher medical expenses than non-smokers.[4]

Cancer

Because of the dozens of carcinogens (cancer-causing chemicals) found in cigarette smoke, smoking can cause cancer in many parts of the body. However, the highest cancer risk is found in those parts of the body that have the most extended and intense exposure to smoke, such as the lungs, throat, and mouth.

Lung cancer is the most common cancer caused by smoking and is the most common cause of cancer death among men worldwide. While breast cancer is the leading cause of cancer death among women around the world, in a growing number of developed countries, lung cancer is surpassing breast cancer as the leading cause of cancer death.[5] In most developing nations, women's rates of lung cancer are currently low, but they are expected to increase as women's smoking continues to rise. In contrast to many other types of cancers, lung cancer is rarely curable. In the USA, five years after diagnosis, nearly 90 percent of women with breast cancer are alive, whereas nearly 85 percent of women with lung cancer have died.[6]

There remain questions about how lung cancer differs between men and women. For many years, men and women tended to develop different histological types of lung cancer: squamous cell carcinoma in men, adenocarcinoma in women. This difference was attributed, in part, to the introduction of filter-tipped and lower-yield cigarettes, which make it easier to inhale smoke deep into the lungs where adenocarcinomas develop. Such changes in cigarettes coincided with an increase in smoking among women. Today, adenocarcinoma is the most common histologic type of lung cancer found in both men and women, probably reflecting similarities in the types of cigarettes men and women smoke.[7] Some research suggests that women may be diagnosed with lung cancer at an earlier age than men; other studies find women have better survival than men, for the same stage of diagnosis.[8] Clearly, a better understanding of sex and gender differences in lung cancer incidence and outcome will contribute to better prevention and treatment.

In addition to lung cancer, smoking also increases a woman's risk of cancer of the mouth, throat, voice box (larynx), esophagus, stomach, pancreas, bladder, kidney, cervix, and uterus. As the recent report of the California Air Resources Board has found, the data also "provide support for a causal association between active smoking

and elevated breast cancer risk."[9] Lung cancer risk declines steadily with cessation; by 10 to 15 years after quitting, a woman's risk is close to that of a non-smoker. The risk of other cancers also declines substantially after smoking cessation.[10]

Lung Health

Inhaling large quantities of smoke into lungs on a regular basis damages lung tissue, can impair lung growth and function, and leads to both acute and chronic lung diseases. Infants whose mothers smoked have reduced lung function, teenage girls who smoke have poorer lung growth, and adult women who smoke have an earlier decline in lung function than those who do not smoke.

Smoking is a major cause of both emphysema and chronic bronchitis, which are Chronic Obstructive Pulmonary Diseases (COPD). Both are serious illnesses that frequently lead to death or disability. Smoking also increases the risk of developing serious acute lower respiratory illnesses, such as pneumonia and bronchitis, and it worsens asthma.

In many parts of the developing world, smoking also adds to other lung burdens, such as the heavily polluted air of many large cities, and indoor exposure to gases from cooking and heating with solid fuels such as coal, wood, and agricultural residues.[11] Recently, scientists have linked smoking to an increased incidence of clinical tuberculosis, an important cause of death in many parts of the world.[12]

Cardiovascular Health

In all developed countries, and increasingly in developing countries, disease of the heart and blood vessels is a major cause of death for women. Cigarette smoking dramatically increases the risk of atherosclerosis (hardening of the arteries) and heart disease. The risks are greater for women who are heavier smokers and those who have smoked the longest. Even women who smoke as few as one to four cigarettes per day have twice the risk of heart disease as women who have never smoked.[3] Women who smoke and simultaneously take oral contraceptives ("the pill") increase their risk of heart disease even further. Cigarette smoking can also cause stroke, an important cause of death and disability in women. A US-based study found that, in women under the age of 65, smoking accounted for more than half (55%) of all deaths from stroke.[13] A woman who quits smoking will have decreased her risk of coronary heart disease by 50 percent within one or two years.[14]

Reproductive Health, Menses, and Menopause

Cigarette smoking has a significant impact on women's hormonal patterns—some studies show that women who smoke have a greater risk for painful menstruation (dysmenorrhea) and irregular menstrual periods. Additionally, cigarette smoking can cause reduced fertility in women and also reduces women's reproductive choices, as women who smoke are typically counselled against using oral contraceptives.[15,16]

Smoking is an important cause of poor pregnancy outcome. Women who smoke during pregnancy increase their risk of delivering early (preterm delivery, i.e., less than 37 weeks gestation) and of delivering a low-birth-weight baby; both of these conditions place the infant at greater risk of disability and death. Smoking during pregnancy also increases the risk of ectopic pregnancy, miscarriage, stillbirth, and Sudden Infant Death Syndrome (SIDS, cot/crib death). Women smokers are less likely to start breastfeeding, tend to wean their babies earlier, and have less milk production than non-smokers. Women who quit smoking either before pregnancy or very early in pregnancy can protect their fetus from many of these adverse health effects.[3]

Menopause occurs one to two years earlier in women who smoke, which means these women spend fewer years with the protective effects of ovarian hormones. Additionally, women who smoke may experience more menopausal symptoms (e.g., "hot flashes") compared with those who do not.[15]

Addiction, Mental Health, and Substance Abuse Disorders

Tobacco products are addictive because they contain nicotine, which "activates" the brain circuitry that regulates feelings of pleasure.[17] Cigarettes and other smoked forms of tobacco are particularly efficient at delivering nicotine to the brain. The brain actions of nicotine are similar to those of other addictive drugs, such as cocaine and heroin. Tobacco dependence also involves sensory and environmental factors, such as the smell and taste of smoke, and other cues that remind the person of smoking; research suggests these factors may be more important for women than for men.[3] Additionally, women are likely to say that they smoke to "cope" – to relieve stress, anger, anxiety, boredom, or feelings of unhappiness.[18]

Mental health disorders – including depression, anxiety, and schizophrenia – and substance abuse are common in both developed and developing nations, and women with these conditions are significantly more likely to smoke than those without such conditions.[19-21] Depression and anxiety disorders are about twice as common among women as among men.[22] This makes the association of smoking with mental health disorders a critical issue for women's health. Importantly, scientists are still studying the reason that smoking is more common among women with some mental health disorders. For example, some studies suggest that cigarette smoking may contribute to the development of certain anxiety disorders.[23] Other studies have shown that mental health disorders are a risk factor for becoming a smoker, and that early mental health treatment can reduce the risk of becoming a smoker.[24]

Other Important Health Effects of Tobacco Use

Many women know that tobacco use is harmful, but few know the enormous range of health conditions and the degree of risk that smokers face. For example, in older women, smoking can lower bone density and increase the risk of hip fracture. Because smoking exposes the mouth to tobacco smoke, it can cause periodontitis (inflammation of the mouth tissues) that can lead to gum disease and tooth loss.[13] Research also suggests that smoking contributes to cataracts and age-related macular degeneration, both important causes of visual loss and blindness.[3]

Economic Costs to Women and Their Families

Tobacco use can harm women in other ways because spending on tobacco products diminishes families' economic resources. Household spending on tobacco products means less money to purchase food, education, housing, health care, and other valuable commodities and services. Diseases caused by tobacco can lead to increased health care costs for the family, or even the premature death of a family member whose earnings are needed to maintain the family. The economic consequences of tobacco for women are especially of concern in poor nations, where families often live close to the margin of survival.

Health Risks of Second-hand Smoke

Numerous studies now show that adults and children who do not smoke but who are exposed to the smoke of others can suffer real harm. Second-hand smoke, which is also called environmental tobacco smoke (ETS), passive smoking, and involuntary smoking, is now known to cause lung cancer and heart disease in adults, as well as serious illnesses in infants and children. Indeed, many of the early studies on second-hand smoke measured the health hazard of a husband's smoking on his non-smoking spouse. The recent report of the California Air Resources Board found that second-hand smoke increases the incidence of breast cancer in non-smoking pre-menopausal women.[9]

Health Risks of Other Tobacco Products

As described in chapter 1, forms of tobacco other than cigarettes are commonly used by women around the world. For example, bidis are small, thin, hand-rolled cigarettes that consist of tobacco wrapped in the leaf of the tendu or temburni plant, sometimes with added flavours. Studies from India have shown that their health effects are similar to cigarettes: bidis are linked to an increased risk of cancers of the lung, mouth, stomach and esophagus, as well as heart disease, and chronic bronchitis.[25,26]

Water pipes are devices that burn tobacco and then pass the tobacco smoke through water before it is inhaled by the user; these devices have various names, depending upon the region, such as hookah, shisha, narghile, and others. Water-pipe smoke appears to contain at least some of the toxic compounds present in cigarette smoke, including carbon monoxide, nicotine, heavy metals, and other constituents. Preliminary evidence links water-pipe smoking to many of the serious health hazards identified with cigarette smoking, including cancer, pulmonary disease, heart disease, and complications of pregnancy.[27]

Smokeless tobacco (sometimes called snuff) is sold in many forms and contains nicotine, carcinogens, and other harmful chemicals; it is addictive and can cause oral cancer. Studies from India found that smokeless tobacco use during pregnancy reduces fetal birth weight and doubles the risk of stillbirth.[28,29]

Quitting is Lifesaving!

Every woman who uses tobacco threatens her health and, sometimes, the health of her family and friends. Quitting is never easy, but around the world, tens of millions of women have succeeded. Helping women to quit is especially important in developing world nations, where quitting is still uncommon.[30] The World Health Organization (WHO) has highlighted the importance of cessation, noting that it is the only intervention with the potential to reduce global mortality in the short and medium term. The WHO notes that many tobacco users will need support in quitting and that it is necessary both to help individual smokers change their behaviour and to address environmental factors that promote and support tobacco use.[31]

Conclusion

Around the world, tobacco products are one of the most important threats to women's health. As a result of decades of widespread use of cigarettes by women in the developed world, we have a clear understanding of the devastating health consequences of cigarette smoking for women. Our knowledge of the health hazards of other tobacco products for women is less well defined, but enough is known to state with certainty that all tobacco products are hazardous. Particularly in the developing world, tobacco use has the potential to do enormous additional harm to the health of women whose health is already compromised because of existing disease, malnutrition, poverty, and other inequalities.

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Chapter 3. From the Fields to the Consumer

Mehreen Khalfan and Linda Waverley

Tobacco use and smoking, including passive smoking, are now recognized as one of the most significant causes of preventable death in the world.[1] However, the negative effects of tobacco on women, girls, and societies are not due only to consumption; they begin from the cultivation stage, are exacerbated by gender inequalities, and have an impact upon health, education, labour, and food security, as well as on economic and ecological poverty. In this chapter, a gender-based analysis is applied to the dynamics of tobacco cultivation, processing, and marketing to illustrate how gender inequality intensifies the negative effects of tobacco for women.

Tobacco is the world's most widely cultivated commercial non-food crop, yet in 2000, just four multinational companies dominated the global tobacco market, holding 70 percent of the market share.[2] As the international tobacco industry becomes ever more powerful and consolidated, the cheap (or often unpaid) labour of women is a key factor that ensures the large profit margins of tobacco multinationals.

With increasing regulation of tobacco companies and anti-smoking measures in developed countries, these companies are further focusing their activities in the developing world. Although the global headquarters of all major tobacco companies are still in industrialized countries, since the 1960s, the bulk of tobacco production has moved from the Americas to Africa and Asia.[3] Tobacco is now grown in approximately 80 developing countries, which by 1996 produced over four-fifths of the global crop.[4] Increasingly, tobacco is sourced by companies through contract-farming arrangements in which the companies lend materials and equipment to the farmers but then agree to buy their harvest only if it meets certain standards.[5] Other key activities are also being outsourced to developing countries, including processing and cigarette manufacturing.[3]

The labour of women and girls is key in the global production of tobacco, from farming to processing, manufacturing, and marketing. Women face challenging and often unrewarding conditions in these processes.

Women Working in Tobacco Cultivation

Clear links have been shown between tobacco farming and ill health, poverty, and natural resource degradation, all of which affect girls and women in particular ways.

Health and Safety Hazards of Tobacco Cultivation

Estimates suggest that women globally perform more agricultural labour than men and, although they remain primarily responsible for food crop production and household labour, they are playing increasingly important roles in cash cropping.[6] "Cash" crops (such as tobacco, cotton, coffee, and tea), as differentiated from "subsistence" crops, are grown for the market and are often exported. Tobacco farming, being exceptionally labour-intensive, relies heavily on the labour of women – and often, of children – who are in turn exposed to the hazards of handling and processing raw tobacco. High frequencies of tobacco-farming-related illnesses, deaths, and birth defects have been observed in a growing number of communities, including higher risks of developing cancers and liver cirrhosis.[7,8] Children may also experience stunted growth.[9]

Many of the dangers of tobacco farming befall particularly the poor and more vulnerable women and girls, as farmers, child workers, and migrant workers – groups that generally fall under the radar of mechanisms that create incentives for companies to display corporate social responsibility.

Green tobacco sickness (GTS), which is a major occupational illness found among tobacco workers, is brought about by the absorption of nicotine through the skin from contact with wet tobacco leaves. Symptoms of GTS can include nausea, vomiting, weakness, headache, dizziness, abdominal cramps, difficulty in breathing, and fluctuations in blood pressure and heart rates.[7] A recent study of Hispanic migrant workers in North Carolina suggests that 41 percent of workers get GTS at least once during harvest season.[7] Furthermore, tobacco plants require large and frequent applications of pesticides, such as Aldicarb, Chlorpyrifos, and 1,3-Dichloropropene,[7] which are highly toxic and have been associated with respiratory, nerve, skin, liver, and kidney damage.[9] A study among indigenous Huichole Indians working on tobacco plantations in Mexico highlighted the hazards of chronic exposure to pesticides – from extreme birth defects in children born to women who have worked in the fields to incidences of deaths from aplastic anaemia, a blood disease associated with chronic exposure to organochlorine pesticides.[7]

GTS and other farming-related illnesses are more prevalent where facilities for the safe disposal of chemicals are more scarce and where regulation of tobacco companies for the protection of farmers is lax – that is, in poorer regions and developing countries. Due to the

prohibitively high costs and lack of knowledge regarding protective clothing and equipment, many workers in these regions do not use such safety measures.[8]

Tobacco Farming Increases Poverty and Vulnerability

Despite its often being promoted as a profitable cash crop, tobacco offers net returns that are smaller than for many other crops,[7] and prices paid to producers continue to decline due to global oversupply – between 1985 and 2000, the real price for tobacco fell by 37 percent.[10] The undervaluation of family labour – that of women and children on family farms – is part of this illusory perception of tobacco as lucrative. An economic study of tobacco cultivation in Bangladesh revealed that "almost 50% of the total economic cost of labour is attributable to household labour. When the imputed value of this is taken into account, tobacco loses much of its profitability."[11] The low returns to farmers are also partly due to the costs of loans for the high volumes of pesticide, herbicide, and fertilizer required. Farmers consequently often find themselves in debt to tobacco companies or unable to get a decent price for their harvests.[12] For example, in Brazil in 1998, approximately 35 percent of tobacco growers finished the harvest owing more money to the tobacco companies than they earned.[7]

Perhaps the most hidden level at which women and girls are affected by tobacco is within households in tobacco-growing communities. Their labour, though essential, is often unpaid. In many countries where women do not have equal rights to access and own land, customary law means that men are more likely to control farmland as well as family labour.[13] Cash crops such as tobacco are frequently seen as the domain of men, who receive the payments for harvests. It is well established, however, that not all income generated by family labour is necessarily pooled or used to benefit all family members, and that women and children may not benefit equally from so-called household income when it is paid to men.[14] Despite this, *households* often continue to be emphasized by policy-makers and planners as the units of production, with the assumption that, particularly on family farms, "men are the primary agriculturalists, assisted by women and children."[14] Some state policies have explicitly considered "good" farmers to be men with several wives who could control a large amount of family labour,[15] and in some countries, companies that contract out production typically refuse to sign contracts with single men.[5] Underpaid or unpaid family labour ensures a cheap, large supply of labour-intensive commodities for the contractor where the contracting arrangement exploits unpaid household work through the gendered division of labour.[16]

Another level at which unequal power relations play out is between farmers and the tobacco industry. For instance, the price that farmers receive for the tobacco crop depends on quality assessments by the tobacco company *itself*. Because a single company normally controls the tobacco market for an entire region, farmers generally have little bargaining power and must tolerate inadequate prices and arbitrary changes to quality standards.[12] Furthermore, farmers have no insurance against damages or poor growing conditions, which can mean a low price or no payment at all.[17] By contrast, contracting or sourcing tobacco in the developing world, especially where land and labour are plentiful, is especially advantageous for multinationals who bear neither the risks posed by cultivation, climate, or accidents, nor the responsibility of providing fair recompense for labour.

Tobacco Causes Ecological Poverty

Tobacco farming has also been linked to considerable environmental degradation. Some of the identified side effects of the fertilizers, herbicides, and pesticides that are used include waterway pollution and biodiversity destruction due to chemical runoff.[8] In addition, vast amounts of manufacturing and chemical waste are created by tobacco processing.[8] Further compounding the unsustainability of tobacco production are the associated declines in soil fertility and radically accelerated deforestation. Raw tobacco is normally dried or cured by wood-firing in a barn in a process that globally causes losses of 200,000 hectares of forest a year, with annual tobacco-related deforestation ranging from 16 percent in Zimbabwe to 45 percent in The Republic of Korea and 30 percent in Brazil.[3,11] Despite company claims that tree-planting programs are in place, deforestation remains prevalent in tobacco-growing regions. Even when reforestation does occur, tobacco companies generally replace the cut native species of trees with homogeneous plantations of fast-growing trees – normally eucalyptus, a tree remarkable for the stress it puts on water tables and soil fertility[8] – which further compromises biodiversity and environmental sustainability.

The stresses on soil fertility, water, and forests have particular implications for women who, in many regions, are traditionally responsible for providing food and collecting water and firewood. Women who are faced with deforestation and contaminated water and soil increasingly have to walk farther and work longer and harder to fulfill household labour responsibilities.[7]

Broader Implications of Tobacco Production

Not coincidentally, regions in which cultivated tobacco occupies a significant amount of land are also often pockets of poverty.[12] Around the world, 5.3 million hectares of land are under tobacco cultivation – land that could otherwise feed 10 to 20 million people.[9] Tobacco is a significant product in several countries that have been experiencing chronic food insecurity and that rely on imports of essential food sources, including Malawi and Zimbabwe.

Furthermore, there is an inverse relationship between income and tobacco consumption; the poor generally spend a large proportion of their incomes on tobacco.[12] The power of addiction is so great that nutrition and education can be neglected. In a study of the economic impact of tobacco in Bangladesh, it was shown that money spent on tobacco could save over 350 children under age 5 every day from death by malnutrition, if that money were redirected to food.[18]

Tobacco cultivation and consumption have evident detrimental effects on development and poverty levels that impact women and girls in particular ways, whether considered in terms of purely economic or sustainable development gains. When the losses of health and labour productivity, food security, children's education, deforestation, and environmental degradation are taken into account, we see the true cost of growing tobacco. As with tobacco consumption, many of the costs of tobacco cultivation are "absorbed" not by the tobacco industry, but by people and societies.

Processing and Manufacturing

Before reaching the consumer, tobacco passes through several processes in which women and girls are usually heavily involved, starting with the curing of tobacco leaves. Curing can take between 7 and 10 days per batch; throughout, wood is fed into the tobacco barns' furnaces, in what amounts to a 24-hour operation.[4] There are many reports of children being kept out of school to help with curing,[7,11] during which time they are at risk from continuous inhalation of tobacco particles and fumes.

In a recent comprehensive survey by the International Labour Organisation (ILO), the scale and conditions of women's and girls' underpaid and informal labour in India's bidi sector were studied. While bidis are manufactured in both factory and home-based operations,[19] women and girls often do piecemeal home-work in regions where social factors encourage females to work within the home.[20]

In India's bidi sector, approximately half of the workers carry out their work from the household, without a regular salary or wages. Eighty-one percent of the household workers are female. Child workers, 93 percent of whom are girls, account for 11 percent of the total number of workers.[19] The work of bidi rolling, especially among home-workers, is marked by low earnings and hours so long that the combination of work with education is practically impossible.[12] Bidi buyers gain from the low status of women, using the situation to enforce low wages and refuse benefits to female workers.[20] However, bidi rolling is one of the few income-generating opportunities for many women. The need to protect their livelihoods can complicate efforts to improve conditions. For example, in response to a recent proposal by the government of India, the Self-Employed Women's Association (SEWA) opposed the idea of increased taxes in the bidi-manufacturing sector since it employs many women, even though this tobacco control measure could ultimately improve the health of women.[21]

The most common health concerns among home-based bidi workers are caused first by inhalation of tobacco and, second, by work that requires sitting in one position for hours at a time. These include respiratory problems in particular, such as asthma and tuberculosis, back and eye strain, headaches, spondilitis, swelling of the lower limbs, digestive problems, as well as problems relating to menstruation and pregnancy, including miscarriages.[19] In factories, children's labour is much cheaper than that of adults, and due to prevailing poverty, this ensures that anti-child labour laws are not fully implemented. Women are also often paid less than men in factories.[22] In sum, it appears that in many tobacco-processing activities, as with cultivation, *informal* or *undervalued* female labour is key to lowering the costs to and responsibilities of the tobacco industry.

Paradoxically, at the more visible executive level, tobacco companies attempt to present themselves as enhancing equality by placing more women in key positions at corporate headquarters. British American Tobacco topped the list in a prominent "Where women want to work" UK website[23] and Philip Morris International states that they are striving to allow more women into senior management positions.[24]

Marketing

Tobacco companies have refined their marketing tactics over time, developing the brand recognition and physical appeal of their products to niche groups differentiated by class, gender, purchasing power, and ethnicity. Although tobacco companies are focusing more than ever on expanding their markets in developing countries, they also continue marketing to specific groups in industrialized countries. Their use of lifestyle marketing – which hinges on the consumer's aspirations towards social status and other (normally sharply gender-defined) desirable qualities – has been adept.

For decades, female consumers have been a prime target of tobacco advertising, spurring the development of many so-called women's brands promoted as being "slim," "light," or low-tar/low-smoke, although these are no safer than regular cigarettes. Marketing to women has often reinforced a link between smoking and weight control, a belief that is increasingly held in developing countries. Kaufman and Nichter remark of this trend that "in the global consumer culture, having the right body becomes central to a woman's identity. By using women's bodies as a way to sell cigarettes, the tobacco industry reinforces a strong association between the two."[25]

It is notable that women's bodies are used in advertising that targets *both* men and women; in either case, the tactic is used to link smoking with expectations regarding gender roles. For men, the placement of women in advertising normally denotes admiration of the male

smoker, and thus attempts to establish smoking as a symbol of sexual success, power, masculinity, and status. In Hanoi, for example, young and attractive women are routinely hired to pass out free samples on the street, while in South Asia, women do the same in nightclubs and shopping malls.[25] Using women's bodies as a marketing strategy directed towards men is not limited to the developing world; Benson and Hedges hire "Gold Club Girls" to distribute their tobacco products at private functions — the only difference is the setting: street promotion versus indoor events.[23]

Similarly, advertising targeted to women links smoking with images of women whose attributes are considered worthy of attainment, such as western modernity, beauty, and glamour. Messages of emancipation and individualism are standard in advertising to women.

Furthermore, tobacco advertising often makes overt links with images of health and vitality that downplay dangers to health and ironically obscure the disempowering effects of tobacco consumption with messages of empowerment and upward mobility. Faced with increasing controls on advertising, tobacco companies are focusing extra resources on alternative means of marketing, such as sponsorship of concerts, sporting events, sports teams and athletes, and even high-profile talent contests and fashion shows.[9] "Product placement" of cigarettes in films has been practised for decades, with scenes often constructed to positively associate smoking as a response to certain emotional moments, from anger and stress to the bonding of a group of friends.

The expansion of tobacco production and manufacturing in developing countries and the ever-changing tenor of tobacco marketing globally impacts women and girls in particular ways, and should be addressed through targeted treaties, research, and policy interventions, as detailed in the next chapters.

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Chapter 4. Women's Health Is a Human Right, Tobacco Is Not

Patricia Lambert

The toll of tobacco use and production on women around the world is significant. Without effective interventions, the tobacco use rates among women may explode in the 21st century. In addition to improving tobacco control, and making it gender sensitive, ongoing work establishing treaties and improving rights for women is required. One of these approaches involves articulating human rights, women's rights, and rights to health, and enshrining these principles in binding treaties for the benefit of women.

On 22 April 1946, two years before the Universal Declaration of Human Rights was adopted by the General Assembly of the United Nations,[1] the World Health Organization (WHO), the United Nations agency specialized for health, declared in its constitution that the enjoyment of the highest attainable standard of health is the basic right of every human being. Health is defined in the WHO's constitution as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[2]

New Impetus for Health As a Human Right

It was not until May 2000, 54 years later, that the committee for the International Covenant on Economic, Social and Cultural Rights (ICESCR)[3] clarified the nature and content of the right to health by issuing general comment 14. In it the committee interprets the right to health as an inclusive right, extending not only to appropriate health care, but also to the underlying determinants of health, such as "healthy occupational and environmental conditions and access to health-related education and information." It recognizes that the right to health is closely related to, and dependent on, several other human rights, including the right to the enjoyment of "the benefits of scientific progress and its applications."[4]

Moreover, it emphasizes women's health: paragraph 20 recommends that parties integrate a gender perspective, including the disaggregation of health and socioeconomic data according to sex, into their health-related policies, planning, programs, and research, in order to promote better health for both women and men; and paragraph 21 recommends that, in order to eliminate discrimination against women, strategies for promoting women's right to health throughout their lifespan must be developed.[4]

Health As a Human Right for Women

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted in 1979 by the UN General Assembly, is often described as an international bill of human rights for women.[5] The CEDAW has been ratified by 181 countries. This represents over 90 percent of the members of the UN.

The CEDAW, in article 12, requires parties to eliminate discrimination against women in all aspects of health care. Although tobacco is not specifically mentioned in the CEDAW (because it was not raised during the negotiations as a special health issue), tobacco control efforts and evidence-based public health measures have progressed at an astonishing rate since then. Just 17 years after negotiations for the CEDAW were completed, at the Fourth World Conference on Women in Beijing in 1995, tobacco use by women was seen as a major health issue. As a consequence, it is specifically mentioned in paragraphs 100 and 107 of the Beijing Platform for Action, the international agenda for women's empowerment adopted by the conference.[6] The CEDAW committee, which is tasked with implementing both the convention and the Beijing Platform for Action, has, since 1995, increased its efforts to hold parties to the convention accountable for accurate reporting on women and tobacco control, in compliance with article 12.[7]

In addition to the all-encompassing provisions of article 12, two other articles in the CEDAW are particularly significant for women's health: article 7 gives women the right to participate in public life and decision making and article 11 deals with safe working conditions for women.

How Does a Rights-based Approach to Health Affect Tobacco Control?

In terms of the World Health Organization (WHO) guidelines, using a rights-based approach to health means, at the very least, that we should use human rights as a framework for health development; assess and address the human rights implications of any health policy, program, or piece of legislation; and make human rights an integral dimension of the design, implementation, monitoring, and evaluation of health-related policies and programs in all spheres, including political, economic, and social. According to the WHO, every country in the world is now party to at least one human rights treaty that addresses health-related issues.[8]

Read together, the constitution of the WHO, general comment 14, and the relevant provisions of the CEDAW argue for the idea (on a firm legal footing) that tobacco control cannot consist merely of treatment for tobacco-related disease and infirmity but must also include all other aspects of tobacco control that can contribute to the achievement of a state of complete physical, mental, and social well-being. Tobacco control is therefore not only a matter of public health but also a matter of fundamental human rights.

Applying a gender lens to this makes it clear that, in relation to women and tobacco control (among other things), women have a right to participate actively and directly in the design and implementation of tobacco control policies, programs, and legislation. Women have a right to gender-specific protection from: exposure to tobacco smoke at home and in the workplace; advertising, promotion, and

sponsorship of tobacco products; misleading information about tobacco products; and the harmful effects of tobacco production and processing. Women also have a right to gender-sensitive and proactive education, training, and public awareness about tobacco and public health.

The Millennium Development Goals,[9] though not a legally binding treaty, represent a unique international effort to outline eight very ambitious goals for world peace and prosperity — they are to be achieved by 2015. Drafted by the 191 member states of the UN in New York from 6 to 8 of September 2000, two of the goals directly mention women and all eight goals relate to tobacco control, as outlined in the WHO's recent publication on tobacco control and the Millennium Development Goals.[10]

The Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control (FCTC)[11] is the foundation for an international strategy to deal with the growing global epidemic of tobacco-related disease and death. The objective of the convention, as reflected in article 3, is "to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke."

Negotiations for the FCTC began in October 2000 under the auspices of the WHO. It is the first time that the WHO has used international law and its international legal powers to deal with a global public health problem. The intergovernmental negotiating body that drew up the convention met six times between October 2000 and early March 2003. The FCTC was forwarded to the 192 member countries of the World Health Assembly in May 2003 for approval, which was unanimous. The FCTC entered into force on 27 February 2005. It is the world's first convention dealing with a public health issue.

The person who initiated the drive towards the negotiation and adoption of the FCTC, Dr. Gro Harlem Brundtland, then the director-general of the WHO, addressed the 59th Commission on Human Rights in March 2003 shortly after the negotiations were completed. In her speech, she called the FCTC, "a vital new mechanism to protect and promote the individual's right to health." She said that health as a human right had been neglected and that human rights should be seen, not merely as an inspirational framework, but as useful tools for analysis and action on public health issues.[12]

The first meeting of the conference of the parties to the FCTC took place in Geneva in February 2006. By then, 124 countries had become parties to the convention. Together, these countries represent roughly 70 percent of the people in the world. The FCTC aims to create international harmonization of tobacco control measures. But regarding this harmonization, article 2 makes it clear that the FCTC should not prevent parties from adopting national tobacco control measures that are stricter than those that appear in the FCTC. In other words, in relation to tobacco control, the FCTC is the "floor" and not the "ceiling."

The FCTC already contains several substantive provisions of international law on tobacco control, like requirements for the packaging and labelling of tobacco products (article 11) and a comprehensive ban on tobacco advertising promotion and sponsorship (article 13). In addition, like other framework conventions, the FCTC clearly establishes an ongoing process to further develop the basic legal provisions contained in the convention through the negotiation of protocols on specific issues connected to global tobacco control (article 33). As decided by the first conference of the parties to the FCTC in February 2006, protocols currently being developed include one on illicit trade in tobacco products (article 15) and one on cross-border advertising, promotion, and sponsorship (article 13.8).

Future protocols might include issues like duty-free sales of tobacco products, industry liability for the harm caused by its products, or women and tobacco control. All protocols would, in effect, be new treaties. Only parties to the FCTC can become parties to any of its protocols. Each protocol will apply only to those countries that agree to be bound by it through ratification, acceptance, approval, formal confirmation, or accession. Effective national legislation and the FCTC place strong curbs on the activities of the tobacco industry. Because the industry has persistently attempted to interfere in both, and will continue to do so, all countries should be vigilant and pro-active in this regard.

In its preamble, the FCTC specifically incorporates provisions from the CEDAW, ICESCR, and the Convention on the Rights of the Child. These international treaties are mutually reinforcing for the parties that have committed to them. In concert, they can be used both to strengthen tobacco control policies, laws, and activities, and to provide a basis for monitoring and evaluating them.

The FCTC and Gender

In addition to incorporating provisions from CEDAW, the FCTC asserts its own clear gender perspective. In the preamble it expresses alarm at the increase in tobacco consumption by women and girls; reinforces the need for women to participate in tobacco control policy-making and implementation at all levels; calls for gender-specific tobacco control strategies; and emphasizes the special contribution that nongovernmental organizations, including women's groups, make to national and international tobacco control efforts. Among the guiding principles is a reference to the legitimate expectation that gender-specific risks be addressed when developing tobacco control strategies. The preamble and the guiding principles underpin the FCTC and must be read into all its substantive provisions.

The FCTC and Development

The FCTC contains a clear development perspective. It expresses concern about the increase in tobacco consumption among indigenous peoples, in developing countries, and in

countries with economies in transition; it also identifies the burden that tobacco consumption places on families, on the poor, and on national health systems. This is noteworthy not only for development but also for women, particularly poor women, since they support and sustain many indigenous families as well as families in the developing world and countries with economies in transition. The FCTC also acknowledges that, in order to implement tobacco control measures, parties from developing countries and countries with economies in transition will need financial and technical assistance. This is identified as a major task to be undertaken by the secretariat of the conference of the parties.

The Substantive Provisions of the FCTC from a Gendered Perspective

In its preamble, the FCTC acknowledges the special contribution that members of civil society, including women's groups, have already made to tobacco control efforts nationally and internationally and emphasizes the vital importance of their continued participation in tobacco control efforts. What follows is a gendered perspective on some of the key articles of the convention, with brief examples of how women and women's groups can become actively involved in implementing effective gendered tobacco control.[13,14]

Article 6: Price and tax measures to reduce the demand for tobacco

The price of tobacco products, including the degree to which they are taxed, plays an important role in reducing consumption. The more expensive tobacco products are, the less likely people (especially young people) are to buy them. It is important that women, and in particular policy-makers and lawmakers, as well as women's organizations, understand clearly how the taxation and pricing systems work in their countries. With this knowledge, pressure can be put on government officials to raise taxes and hopefully, to apply the taxes raised from tobacco products to specific tobacco control activities that would benefit women and other disadvantaged groups.

Article 8: Protection from exposure to tobacco smoke

Science indicates that exposure to environmental tobacco smoke increases the risk of lung cancer, particularly among non-smokers. This affects women in their homes as well as in the places where they work outside their homes. Because women frequently do not have the power to negotiate their homes and workplaces to be smoke-free spaces, many women, especially those involved in the hospitality industry, are exposed to tobacco smoke with dire consequences for their health. It is therefore not only crucial for women to know that they are at risk — it is also important for them to know how employment law works in their countries, and how they can use the law to protect themselves in the workplace.

For example, a Canadian woman, the late Heather Crowe, who had never smoked, developed lung cancer as a result of her exposure to tobacco smoke while working as a waitress for many years. She applied to the Ontario Workplace Safety and Insurance Board (WSIB) in 2002 for compensation for her medical expenses as well as for her disability and other impairments. Not only was her claim successful but the board also awarded her some loss-of-earnings benefit.[15] This case highlights the fact that it can be extremely helpful to bring tobacco-related employment law cases to the attention of organizations that can help women to fund prosecutions in order to protect themselves, their jobs, and their livelihoods.

Article 11: Packaging and labelling of tobacco products

The treaty obliges parties to adopt and implement large, clear, visible, and rotating health warnings and messages on tobacco products. These should occupy at least 30 percent of the package display area and may be in the form of pictures. In addition, the treaty prohibits the use of misleading descriptors like light, mild, or low tar — false descriptors that were specifically targeted at women and that have lured many into the mistaken belief that they are using safer tobacco products. Taken together, these FCTC provisions could play a significant role in ensuring that women and girls do not start using tobacco products or that they quit. Pictorial messages can have a dramatic impact, particularly in developing countries where levels of literacy among women are a cause for concern.

Article 12: Education, communication, training, and public awareness

The importance of education, training, and public awareness about the dangers of tobacco products, as well as about the deceptions that the tobacco industry engages in, are an essential aspect of tobacco control activities that can be led by governments and civil society. It is vital that women are directly involved in crafting this information, including counter-advertising, especially when it is targeted at women and girls.

Article 13: Tobacco advertising, promotion, and sponsorship

The tobacco industry has targeted its exploitative advertising campaigns at women from different socioeconomic backgrounds in different ways. The comprehensive ban on advertising, promotion, and sponsorship contained in the FCTC (or restrictions, where, for constitutional reasons, countries cannot apply bans) will protect women from this kind of advertising by the tobacco industry.

Article 14: Demand reduction measures concerning tobacco dependence and cessation

Women as individuals, along with women's health groups and women's groups, need to become directly involved in efforts to provide and sustain activities to help women to quit using tobacco products. It is vital that women's special needs and circumstances are consciously considered in the design and implementation of cessation programs.

Article 16: Sales to and by minors

Women can play an important role in preventing the sale of tobacco products to and by girls who are minors. A sound knowledge base will be essential to understand why girls smoke and the circumstances in which girls sell tobacco products, especially in developing countries, in order to implement this article from a gender perspective.

Article 17: Provision of support for economically viable alternative activities

In developing countries particularly, women are often involved in large numbers in the growing of tobacco as well as the production and sale of tobacco products. These women will require financial and technical support in order to begin to adopt economically viable alternatives to tobacco crops.

Article 18: Protection of the environment and the health of persons

Women and girls in the developing world who are involved in tobacco growing are exposed to chemicals that are injurious to their own health and to the environment. It is crucial that these women and girls are made aware of the dangers involved in tobacco growing and production, and that they are provided with assistance to counter their exposure to chemicals and other pollutants.

Article 19: Liability

The FCTC encourages parties to take steps, including litigation, to hold tobacco corporations responsible for their harmful actions and practices, as well as for the harmful nature of their products. Women and women's groups should identify possibilities for litigation against the tobacco industry, should encourage women (in appropriate cases) to become litigants, and should source the necessary financial support.

Articles 20 – 22: Scientific and technical cooperation and communication of information

It is vitally important that research into tobacco use and tobacco control reflects the perspectives and problems of women, including women in indigenous communities and in the developing world. It is also necessary that all reports that are made to the conference of the parties in compliance with the convention be properly gendered.

The Way Forward

The FCTC is the key human rights instrument for effective tobacco control nationally and internationally. However, in order for the provisions of the FCTC to have a truly noticeable effect on the lives of people, including women around the world, governments and members of civil society alike will have to promote them actively. For the FCTC to fulfill its promise for women, the full and meaningful participation of women in this process is essential. Women and women's groups, at all levels and in all spheres in society, should know their health rights in relation to tobacco. In addition, they may need to create the necessary infrastructure to ensure that their rights, as well as their responsibilities, can be exercised in the places where they live and work. We cannot afford to be complacent. We can, and must, use the FCTC to enforce our right to health as we move towards a tobacco-free world.

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Chapter 5. Moving Forward: Women, Tobacco, and the Future

Lorraine Greaves and Natasha Jategaonkar

The challenge of preventing or reducing the tobacco epidemic among girls and women in the 21st century is great. Health, equity, and tobacco use are interrelated for women. As we address these linked challenges of improving women's health, and reducing the impact of tobacco, we must be equally concerned with improving the status of women and girls. As we have seen, in some countries, women feature among the populations most vulnerable to continued tobacco use. In other countries where women have not started smoking, women are seen by tobacco companies as a huge, untapped market and so constitute a large group of potential tobacco users. While men's tobacco-use rates globally have peaked and are waning,[1] the possibility of women's tobacco use rates exploding is a significant threat to women's physical, mental, and economic health. To prevent or reduce this risk, we urgently require a coordinated effort, addressing both tobacco control and women's equality.

We have also seen the dramatic shift of tobacco production from developed countries to developing countries. This has introduced additional health threats, as well as economic and environmental pressures to women, families, and communities. Women and girls in particular form a significant part of an exploited labour force and suffer from diminished family income and nutrition when tobacco production and use are introduced to their communities.

Fortunately, there are opportunities that will enable us to better address women and tobacco in the future. The Framework Convention on Tobacco Control (FCTC), in conjunction with the Kobe Declaration and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), offer new platforms for designing a women- and gender-sensitive approach to tobacco control, embedded in a global plan for improving the status of women. These three initiatives all emphasize the importance of gender in achieving their goals, and the specific importance of ensuring improvements in women's health and equity. A key challenge for both civil society and international and national governments is to act in concert to more effectively link these forward-looking treaties and declarations.

Both comprehensive tobacco control policies and progressive, as well as equity-seeking social and economic policies will be required. While the tobacco industry has been quick to understand and exploit the implications of gender for tobacco marketing, tobacco control efforts have been slow to adopt gender-based and women-sensitive approaches to policy, programs, and research in tobacco reduction. Similarly, broad social and economic policies have lagged behind in assuring that women and girls have equal access to resources and power worldwide. Recent experiences of countries in Stage 4 of the tobacco epidemic clearly link inequity with vulnerability to tobacco use for women and girls.

Comprehensive tobacco control efforts have always attempted to stem the impact of tobacco from multiple angles: preventing and reducing tobacco use, assisting with cessation for those who do smoke, changing attitudes and practices that affect use, restricting smoking, and regulating advertising and marketing linked to tobacco use and promotion. However, in order to prevent the growth of the tobacco epidemic among girls and women in the 21st century, the application of these principles must become more nuanced and gendered to reach the women most at risk. Furthermore, it will be necessary to go beyond the realm of traditional tobacco control and link to human rights and women's rights priorities in order to effect change.

There are long-standing challenges to tobacco control, including issues such as advertising and production strategies as well as the globalization of trade, marketing, and communications. Chapter 4 described how we can use several treaties – which were not available decades ago when the tobacco epidemic first affected women in the developed world — to ensure rights to health for women, and to improve women's and girls' status in every country. Specifically, the FCTC expresses concerns about gender and women and promotes actions on tobacco control that promise to respect gender issues and work to actively

Uruguay: Women in Tobacco Control Fight Back

Maria Inés Roca

The tobacco epidemic has reached women in Uruguay, where 27 percent of women smoke[31] and young girls aged 13 to 17 have a higher smoking prevalence than boys of the same age group (34.3 % vs 25.2 %).[32] Women's lung cancer rates have doubled between 1990 and 2000, from 3 percent to 6 percent, and they continue to increase.[33] In spite of these alarming trends, women have played a critical role in the Uruguayan tobacco control movement, particularly in the Passive Smokers Association (Fumadores Pasivos Uruguayos or FPU) but also in health care and patients' organizations. Women's increased participation in tobacco control has given more strength to the movement by non-governmental organizations.

The main objectives of the FPU for the year 2006 are: 1) to help establish Uruguay as the first smoke-free country in the Americas (achieved on 1 March 2006) ; 2) to conduct a national meeting on women and the tobacco epidemic as a tool for increasing women's awareness and launching the Uruguayan Women and Tobacco Control Network; and 3) to enact strong enforcement of the FCTC. There is no doubt: tobacco is a matter for Uruguayan women and we will fight it!

prevent the gendered epidemic of tobacco use. Working under these frameworks, it will also be necessary to create effective policies and programs for women and girls.

Gender-based analysis (GBA) is a tool that helps to systematically ask questions of all elements of research, policy and programming, whether in tobacco control or any other field.[2,3,4] In applying GBA to tobacco control efforts, we should ask: Do the policies and programs benefit women, affect different groups of women differently, have unintended consequences for women, or have other effects on the status of women and girls? Are the programs and policies designed with males in mind only, not females? Are the tobacco control efforts based on data that reflect women and men, diverse groups, and girls and boys? These kinds of questions are intrinsic to gender-based analysis and will help us to tailor our tobacco control efforts in programming, policy, and research to be more effective and appropriate for girls and women.

Programming: How Can We Lower the Demand for Tobacco?

There are many and varied ways to reduce the demand for tobacco among women and men. Programming approaches include mass media campaigns, smoking cessation telephone counselling lines (or "quitlines"), and specialized supports integrated into schools and workplaces, all designed to prevent smoking uptake and/or decrease tobacco dependence. Depending on the stage of the tobacco epidemic, countries have varied programming in place.

In countries at earlier stages, where women have still not reached high rates of smoking and still smoke less than men, the focus of programming is on preventing uptake more generally, and making sure that role models such as physicians, nurses, and teachers reduce tobacco use (see the example from Japan). Health education campaigns transmit information about smoking to girls and women (see the example from Mauritius), introduce the message about the dangers of smoking during pregnancy, and concurrently try to develop advocacy in voluntary groups and policy change in government departments (see the example from Uruguay).

For countries that are at later stages of the epidemic, such as the UK and the USA, overall tobacco use rates have peaked. The focus now is on reducing the demand among vulnerable subgroups of the populations by supporting targeted prevention and cessation among low-income girls and women, pregnant smokers, teen girls, and specific ethnic or cultural groups. Tailored approaches include approaches such as designing culturally relevant programs for specific communities[5] or providing free or subsidized nicotine-replacement therapy for women living on low incomes.[6] Such targeted strategies are integrated with existing broad programming for the general population.

The key challenge is to make sure that prevention and cessation programs for women succeed in reducing tobacco use without compromising the goals of achieving equity and empowerment. How can our approaches transform gender relations and improve women's status, not exploit women's aspirations?[7] Media messages and counter-advertising must embrace positive messages of freedom and liberation from tobacco to prevent tobacco companies from continuing to own the message that smoking equals liberation.

Where tobacco production involves increasing numbers of women and girls, programming must go beyond the issues of consumption to address the needs and concerns of women involved in its cultivation, manufacture, and marketing. In these settings, information campaigns through various media such as radio and posters are important for getting messages directly to women about occupational safety and the potential health consequences of tobacco farming and processing. In addition, information about the tobacco industry, workers' rights to safe work, equitable pay, and non-exploitive working conditions is critical for protecting girls and women from the detrimental effects of working in tobacco. These community- and home-based information and education interventions must be targeted to women (and mothers in particular), as well as their families and other vulnerable groups, in appropriate formats.

Japan: Setting an Example by Tackling Nurses' Smoking

Yumiko Mochizuki-Kobayashi

Traditionally, Japan has had very low rates of smoking among women, yet in some subgroups tobacco use is high. For example, the smoking prevalence among nurses is presently almost double the rate for the average woman. Because the majority of nurses in Japan are women, their smoking rates are alarming, especially since, as health care professionals, they serve as role models to their patients and communities. To address these high rates, the Japan Nursing Association launched a nation-wide campaign to take action in four ways: first to advocate for health policy including tobacco control in society at large; second to assist nurses to become smoke-free; third to establish smoke-free health premises; and fourth to educate nursing students on smoking prevention and cessation. This is just one example that can be repeated in other parts of the world where tobacco use is high among women-dominated professions. And while a single profession's sincere commitment to tobacco control improves the lives of its members, it can also mobilize the rest of society toward achieving stronger tobacco control policy.

Policy: How Can Policies Help Limit the Spread of Tobacco Use Among Girls and Women *and* Improve Their Lives?

Comprehensive tobacco policies are a key component in preventing and decreasing women's tobacco use. Comprehensive tobacco policies include price controls and taxation of tobacco products, packaging regulations, advertising bans, limiting depictions of smoking in mass media, smoking location restrictions, and sales legislation, among other strategies that have been shown to be very effective at the population level. The level of implementation of such policies will vary from one country to the next around the world, depending on the stage of the tobacco epidemic.

However, regardless of which elements are in place, there has been little acknowledgement of how tobacco control policies may affect women and men differently, and how the effects may also vary among diverse groups of women. The available evidence indicates that there are differences that we can take into account, but we must also work hard to include this question in all further policy development and analysis (see the example from Europe). Incorporating gender- and diversity-based analyses (GBA) in these processes has helped to identify priority areas in Stage-4 countries and could foreshorten the tobacco epidemic among women and girls in earlier-stage countries.

Mauritius: Spreading the Word about Women and Tobacco

Véronique Leclezio

On World Health Day in 2005, a brochure and flyer about women and tobacco issues were launched at a press conference. Thousands of copies were widely disseminated by the Ministry of Women and by non-governmental organizations (NGOs). In a joint program of ViSa Mauritius (an NGO dedicated to tobacco control) and the Mauritian branch of the Soroptimist International Ipsae (which runs a nursery for disadvantaged children), these materials were distributed to schools, youth health centres, community centres, and to the broader public following tobacco control lectures by ViSa.

This initiative was timely because smoking among women in Mauritius is still in its early stages. Culturally, most Mauritian women do not smoke. However, the most recent non-communicable disease survey in Mauritius in 2004 shows that smoking among women rose from 3 percent to 5.1 percent between 1998 and 2004, while the percentage of smoking among men fell significantly during the same period. The smoking rate among Mauritian women is expected to rise rapidly without further initiatives that address these specific issues.

Applying a full gender analysis requires that all aspects of women's lives, including both the biological and psychosocial, are taken into account. These diversities of experience clearly contribute to initiation, maintenance, and cessation of smoking while creating differential responses to tobacco interventions and policies.[8,9] For example, European research indicates that multiple disadvantages accumulate to influence both smoking initiation and cessation.[10] Vulnerability due to income, education, or other social and biological factors will interact with gender inequalities to result in further challenges for women.

In Germany, for example, smoking cessation has been slowest among groups who are simultaneously experiencing low income, low education, and low labour force participation.[11] Women with mental health diagnoses are also vulnerable to tobacco use, especially when they combine nicotine with other drugs, and/or use nicotine to calibrate their own biochemical states.[12,13,14] Children of women smokers are more likely to become smokers themselves due to biological predispositions that are established during fetal development if their mothers smoked during pregnancy[15,16] and due to the effects of role modelling.[17,18]

Sales restrictions. Considering sex, gender, and diversity issues in responses to FCTC recommendations, such as sales to minors regulations (article 16) and taxation (article 6), illustrates questions that must be addressed in order for comprehensive tobacco control policies to be most effective. Restrictions on the sales of tobacco to youth can be effective in discouraging sales of cigarettes and other products to children, particularly when these restrictions are regularly enforced. However, numerous factors influence whether or not a child's attempt to purchase tobacco will be successful. Understanding the diverse issues that impact the interaction between merchant and buyer will be helpful in policy development in countries where sales to minors and/or sales by minors are not yet regulated.

For example, evidence from the USA suggests that both the gender and ethnicity of the teenager and the gender of the merchant may play a role in whether or not tobacco is sold to someone who is underage. One study suggests that female merchants are less likely to sell cigarettes to youth than male merchants. Underage girls are more likely to be successful in purchasing cigarettes than boys.[19] A 1997 study by Klonoff and others in the USA found that Latino teenagers were significantly more likely to successfully purchase cigarettes compared to white teenagers, and Latina girls were four times more successful than Latino boys.[19] It is important to note, however, that many children and teenagers will not go into stores in order to acquire cigarettes and other tobacco products. Evidence from Stage-4 countries suggests that girls in particular are more likely to obtain cigarettes from friends and family members and are less likely to attempt to buy them.[20,21]

Taxation and pricing policies. Tax increases, when combined with other control strategies, have been credited with significantly reducing tobacco consumption. Among studies in Stage-4 countries that have examined

taxation or price increase as a tobacco control measure, the evidence indicates that financial disincentives are an effective strategy to substantially reduce smoking among the general population and also among people living on low income, although conflicting results from different countries have made it unclear if (and how) women may differ from men in their response to such strategies.[22-27] Ethnic diversity within a population also matters, although the reasons for this are unclear.[28]

Occupational and environmental protection policies. Where women are increasingly engaged in tobacco production, other forms of policy development need attention. Stronger regulation of tobacco companies on issues related to both environmental protection and occupational safety for farm families, especially women and children, is urgently required to deal with the effects of industry work detailed in chapter 3. Environmental degradation, loss of food crops and nutritional security, and the effects of pesticides and agricultural practices all affect women and girls in ways that may be sex and gender specific and therefore need specific policy responses. For example, policies could require training and information for farm families on sex-specific occupational safety issues and information on the health consequences of tobacco farming and processing. In addition, governments and NGOs may want to press for more crop diversification programs and research.

Research: What Do We Need to Know to Reduce the Impact of Tobacco Use Among Girls and Women Around the World?

There is a lot that we do not yet know about gendered tobacco use and health. In particular, we have a clear need for better data collection and ongoing surveillance, as well as more informed and innovative research questions. Tobacco control, like many health practices, has tended to develop programming and policies prior to fully developing research.[29] This has been in response to the needs presented by both individuals and countries as the tobacco epidemic has spread. At this point, however, we have an opportunity to think more broadly about the intersections of tobacco use and inequalities, in a variety of different situations around the globe. For example, we have many unanswered questions about particular disadvantages and their effects on girls' and women's tobacco use and their responses to policies and programs (see the example from the USA). We all have to make sure that each emerging policy and program incorporates gender concerns in its development.

Considerable work is needed to address gaps in research on sex differences and gender influences in tobacco use and control. Decades of study addressing tobacco use as a male health issue have led to the acquisition of scientific knowledge relevant to men and male-sensitive prevention, interventions, and policies that were often presented and applied generically.

Furthermore, beyond tobacco consumption, data are needed to measure the extent of labour provided by women in farming families, and the broader implications of women's labour in tobacco fields and children's labour (particularly by girls) in tobacco cultivation and processing. In addition, qualitative research is required to complement these data to illuminate the various gender-specific issues for girls and women in the tobacco production and cultivation labour force. These accounts will add texture and detail to highlight the issues of exploitation and inequality that girls and women face.

USA: Addressing the Impact of Tobacco Policy on Disadvantaged Women and Girls

Deborah McLellan

The Tobacco Research Network on Disparities (TReND) in the United States was established in 2004 by the National Cancer Institute and American Legacy Foundation to eliminate tobacco-related health disparities through transdisciplinary research that advances science, translates knowledge into practice, and informs public policy. Recognizing the effects of class and gender, TReND is supporting a project that explores the impacts of tobacco control policy on low socioeconomic status (SES) women and girls. Very few empirical papers have examined the effects of tobacco control policies on low SES women and girls. In response to a call for abstracts, researchers presented new qualitative and quantitative findings at the September 2005 meeting entitled, "Tobacco Control Policies: Do They Make a Difference for Low SES Women and Girls?" Papers from the meeting will be published in a special issue of the *Journal of Epidemiology and Community Health* in 2006. In addition, a research report will be published during 2006. Strategies to disseminate these findings are also being developed.

This project is the first national research effort of its kind in the US to focus on this topic. We anticipate that the publication of the special journal issue and research report will stimulate additional research and collaborations, thus augmenting the available scientific evidence, and ultimately helping to develop effective strategies to reduce smoking among low SES populations of women.

There are opportunities for research to support the FCTC and other treaties that can be developed concurrently in all regions of the world. One is the re-analysis or secondary analysis of large data sets to identify the sex-differentiated knowledge on tobacco use and production that may already exist but not be recognized or published. A second is the development of a fully informed research agenda that accounts for not only sex differences and gender influences

but also the interaction of sex and gender as it affects tobacco use and responses to interventions. But to complete this picture and account for all of women's circumstances, we must mainstream attention to diversity into all future research, both within and between countries and regions.

If a global tobacco research agenda is developed that is sensitive to gender, it will assist in shortening the tobacco epidemic in low- and middle-income countries. Given the historical and ongoing sex-, gender-, and diversity-sensitive research carried out by the tobacco transnationals, it is imperative that all further research in tobacco be similarly designed. Although the developed world erred in not addressing the sex and gender differences in tobacco use until well into the epidemic, the low- and middle-income countries now have an opportunity, with the advantage of this hindsight, to take a much more effective approach.

Research at the local and community level is also required. In many countries, basic information about community use and attitudes will be very important in detecting early trends of girls' and women's smoking or other tobacco use. Increasing women's engagement in this research will build awareness, skills, and capacity for improving women's health via tobacco prevention and control.

However, it will be just as important to track the indicators of women's progress and empowerment. The tracking of progress towards the Millennium Development Goals is a key source of ongoing statistics, as are many global and national databases on women's education, labour force participation, and the policy environments affecting women. Tying together these issues in future research is the key to defining successful interventions, media messages, policies, and programs to reduce women's and girls' tobacco use globally, while ensuring their progress, equality, and empowerment.

Conclusions

What will "Turning a New Leaf" on women and tobacco require? A concerted effort is urgently needed to prevent or reduce the extent of the tobacco epidemic among women around the world. This objective cannot be met in isolation, or through unlinked steps and programs. Rather, it will require improvements in girls' and women's status, relevant equity-based innovations in programs and policy across health, social, and economic sectors, as well as truly comprehensive tobacco policies.

The Framework Convention on Tobacco Control is a critical tool for achieving these goals. Its clear commitment to gender and women's and girls' issues establishes a basis for action in the 21st century. While article 4 of the FCTC states that gender must be threaded throughout the treaty and its application, it is still difficult to assess what this will really mean. Will the states that ratify the FCTC know how to apply its articles within a women-centred framework, respecting both sex and gender issues? We have emerging evidence that women and girls are affected differently by many of the issues in the articles in the FCTC. Despite the need for more evidence, we can still use the evidence we have to move forward with greater sensitivity and tailor our efforts according to gender.

Some countries are already moving toward gender-sensitive policies. For example, the Canadian federal government already requires a gender-based analysis in all of its policy and programming.[30] In any country, policy-makers and evaluators require ongoing training to make this analysis work, but instituting a progressive GBA policy at the national, or even international level through the WHO, is an important and essential step toward turning a new leaf in tobacco. These policies create opportunities for training and sensitization about gender and women's issues, while ensuring better quality policies and programs to address tobacco control for girls and women.

Europe: Seeking Gendered Policies

Patti White

Although trends in women's smoking are not uniform across Europe, most European countries are united in their failure to develop tobacco control policies that address the needs of women smokers. The European branch of the International Network of Women Against Tobacco (INWAT) has undertaken three projects to make recommendations to policy-makers and tobacco control advocates to address these shortcomings. In 1999, a seminar in London examined this issue and found that a fundamental lack of data, including basic biomedical research into the impact of tobacco on women's health, made formulating gender-sensitive, evidence-based policy difficult. The resulting report, *Part of the Solution? Tobacco Control Policies and Women*[34] set out a framework for developing tobacco control strategies appropriate for women. Another outcome of that seminar was a growing concern that smoking across Europe is increasingly concentrated in lower socioeconomic groups. A seminar held in Berlin in 2002 therefore considered the gender implications of specific tobacco control policies. The report, *Searching for the Solution: Women, Smoking and Inequalities in Europe*,[35] distills key issues such as smoke-free public and private places, taxation and price, mass media and community interventions, marketing, cessation support, and alliance building and makes recommendations on research and on tailoring policies to make them gender sensitive. A seminar in Barcelona in 2005 examined the issue of gender and smoke-free policies in public places at the European level as well as second-hand smoke exposure in the home. The INWAT-Europe advisory board continues to advocate to decision makers on the most pertinent issues regarding women and tobacco in Europe.

Making tobacco control policies more responsive to women is crucial, but preventing or reducing the scale and impact of the tobacco epidemic in the 21st century will involve more than the traditional set of tobacco control policies. We know that women benefit from a range of policy initiatives and programs that enhance their economic and social status along with their health. It seems likely that these improvements will also strengthen their resistance to tobacco or enable their cessation of its use.

For women smokers, social, housing, and economic policies can ensure a reduction in vulnerability to smoking due to stress, double or triple workloads, or lone motherhood. Ensuring adequate incomes for women, and enough support for child and dependent care, are also important to ensure health for women and reduce their vulnerability to tobacco use. For girls, staying in (or getting to) school, along with positive role models and access to health-promoting activities such as sport and physical activity, also work against tobacco use. Although these issues have often been regarded as outside of the domain of tobacco control, this is far from true anymore. A key challenge for women's health is to widen the efforts of the tobacco control movement to include social justice and human rights perspectives. A key challenge for tobacco control is to engage with the women's health movement in respecting the goal of women's empowerment.

For women working in tobacco production, protective labour legislation is urgently needed to promote occupational health. But better yet, women need alternatives for economic survival that are healthier and more productive than working in tobacco production, being manipulated and objectified in tobacco marketing, or working in the tobacco-marketing industry.

Tobacco control for women and girls is at a crossroads. How will we use the Framework Convention on Tobacco Control to ensure that gender equity is advanced while tobacco use is reduced, and that existing unequal gender relations are not exploited? How can we ensure the advancement of women and girls along with the eradication of tobacco from our world? This is the challenge for the 21st century.

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Chapter 6. Recommendations

Research Recommendations

Given the lack of information on the variety of ways women are affected by tobacco, there is a need to:

1. Establish or expand existing surveillance data differentiating female and male tobacco use rates.
2. Expand reporting on indicators for the status of women and disease outcomes.
3. Develop a more accurate understanding of the status of women in relation to tobacco use.
4. Conduct further research on sex, gender, and health effects of tobacco products other than cigarettes.
5. Develop better measures of exposure to second-hand smoke that are sex- and gender-sensitive.
6. Develop a more accurate understanding of the additive effects of multiple exposures to cigarette smoke and other risk factors in causing respiratory and other health outcomes for women.
7. Develop a more accurate understanding of women's and girls' roles in tobacco-farming families and the implications on health, education, economics, and food security.
8. Set standards for and conduct gender-based analyses of program and policy development along with the implementation of the FCTC.
9. Build capacity and engage women and girls in conducting tobacco research.

Policy Recommendations

In order to create a comprehensive infrastructure for decreasing tobacco and improving the status of women, there is a need to:

1. Sign, ratify, and implement the FCTC. This convention includes comprehensive provisions to tighten tobacco control, under the auspice of the legally binding preamble that identifies specific concerns about women and girls.
2. Promote gender-sensitive policy to benefit health, including smoke-free public places and bans on sales of cigarettes to and by minors.
3. Promote policy that upholds equality by introducing stronger regulation of tobacco companies on issues related to environmental protection and occupational safety for farm women and their families.
4. Design and promote empowering counter-messaging and advertising for improving women's health.
5. Promote comprehensive tobacco policy frameworks for women that include social, child care, and economic policies as well as health policies.

Programming Recommendations

Programming, based at the community or country level, is often the most visible component of a comprehensive strategy. There is a need to:

1. Tailor programs to the specific contexts in which tobacco use occurs, taking into account the gender and equality issues.
2. Create women-centred programs for addressing tobacco use during pregnancy and postpartum.
3. Implement tobacco prevention and cessation strategies that are gender specific and age specific.
4. Provide information and training to farm women on occupational safety and the potential health consequences of tobacco farming.
5. Engage women in designing and delivering services and programs.
6. Create opportunities for leadership and mentorship among women and girls.

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The British Columbia Centre of Excellence for Women's Health is committed to improving the health of women through collaborative research and the translation of research into innovative clinical practice, programs, and policies. The BCCEWH is particularly interested in improving the health of women and girls who are marginalized due to factors such as socioeconomic status, race, culture, age, sexual orientation, geography, disability, and addiction.
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The International Network of Women Against Tobacco (INWAT) is a global network dedicated to achieving improved health and greater equality by addressing the complex social, cultural, health, and economic issues of tobacco as they affect women and girls. The network functions to connect women and men working on women and tobacco issues to conduct research, education, and collaborative activities, and to share information.
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Le Centre d'excellence pour la santé des femmes de Colombie-Britannique s'est donné pour tâche d'améliorer la santé des femmes au moyen de la recherche coopérative et du transfert des résultats de la recherche dans des pratiques cliniques, des programmes et des politiques innovateurs. Le CESFCB s'intéresse particulièrement à l'amélioration de la santé des femmes et des jeunes filles marginalisées en raison de facteurs comme la situation socio-économique, la race, la culture, l'âge, l'orientation sexuelle, la géographie, la présence d'un handicap et l'accoutumance.
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L'International Network of Women Against Tobacco (INWAT) est un réseau mondial voué à améliorer la santé et à promouvoir l'égalité des femmes. Pour ce faire, il s'attaque spécifiquement à des questions complexes d'ordre social, culturel, économique et de santé liées au tabac qui touchent les femmes et les jeunes filles. Le réseau sert à relier des femmes et des hommes qui travaillent sur des questions relatives aux femmes et au tabac pour mener des recherches, des activités de sensibilisation et de collaboration de même que pour partager des renseignements.
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