World Health Organization

IDRC CRDI

Gender and tobacco control:

A policy brief

WHO Library Cataloguing-in-Publication Data:

Gender and tobacco control: a policy brief.

1.Smoking - adverse effects. 2.Smoking - prevention and control. 3.Public policy. 4.Sex factors. I.World Health Organization. II.Research for International Tobacco Control. III.Title.

ISBN 978 92 4 159577 3 **(NLM classification: QV 137)**

Printed in Switzerland

Gender and tobacco control: A policy brief

Department of Gender, Women and Health (GWH)

Tobacco Free Initiative (TFI)

Acknowledgements

This policy brief was developed by WHO with the support of Research for International Tobacco Control (RITC) and further elaborates on the deliberations of the WHO/RITC meeting on the development of policy recommendations for gender-responsive tobacco control, 28-30 November 2005, held at the International Development Research Center (IDRC), Ottawa, Canada. The development of the brief was guided in WHO by Dr Adepeju Olukoya of the Department of Gender, Women & Health, Ms Annemieke Brands, formerly of the Tobacco Free Initiative, and Dr Armando Peruga of the Tobacco Free Initiative (all of WHO headquarters, Geneva).

WHO would like to thank Dr Lorraine Greaves, the Executive Director of the British Columbia Centre of Excellence for Women's Health (BCCEWH) Vancouver, Canada, the principal writer. The research assistance provided to Dr Greaves by Ms Natasha Jategaonkar, Ms Lucy McCullough, Ms Pamela Verma and Ms Ethel Tungohan, all of BCCEWH, is also gratefully acknowledged. Gratitude is further extended to Ms Shelly Abdool of the Department of Gender, Women & Health, WHO, Geneva, who reviewed various drafts of the brief.

We wish to thank Teresa Lander for editorial support, Mr Bernard Sauser-Hall (EKZE) for the layout and design, and Mrs MiriamJoy Aryee-Quansah for additional assistance. We also would like to thank Ms Carla Salas-Rojas of the Department of Gender, Women & Health and Dr Luminita Sanda, Ms Smita Trivedi and Ms Gemma Vestal of the Tobacco Free Inititiative for their technical support in the finalization of this brief.

The examples provided in this publication include experiences of organizations beyond WHO. This publication does not provide official WHO guidance, nor does it endorse one approach over another. Rather, the document presents various examples of innovative approaches for gender-responsive tobacco control.

Contents

Summary of recommendations

1. Incorporate gender into tobacco control measures

1.1. Make tobacco products less affordable by raising prices through tobacco tax measures and apply the revenue raised to specific tobacco control activities benefiting women, young people and disadvantaged groups

1.2. Enact and enforce legislation requiring all indoor workplaces and public places to be 100% smoke-free environments. Gender-sensitive education efforts must empower individuals to claim smoke-free environments

1.3. Enforce a comprehensive ban on advertising, promotion and sponsorship to protect males and females of all ages from being targeted by the tobacco industry

1.4. Implement large, visible, and regularly changing health warnings and messages on tobacco product packages. Specific textual and pictorial health warnings for men and for women should reflect sex and gendered effects and patterns of tobacco uptake and cessation

1.5. Increase availability and access to treatment services for tobacco dependence and train health professionals in these services to take into account sex and gender specificities when treating tobacco dependence

1.6. Use gendered education and communication approaches to increase public awareness and support for approval and enforcement of effective tobacco control policies

2. Develop a gender-responsive infrastructure for tobacco control

2.1. Collect and analyse sex-specific and gender-specific information on tobacco use and the effectiveness of tobacco control measures

2.2. Integrate gender analysis into tobacco control planning

Introduction

The most cost-effective ways of reducing tobacco consumption in low-income, middle-income and high-income countries are price increases through tobacco taxes and the creation of smoke-free environments. Other non-price measures, such as comprehensive bans on tobacco advertising, sponsorship and promotion, strong warning labels and wide dissemination of information in support of these key policy interventions, are also effective.

There have been few consistent analyses of the gender-specific and diversity-specific effects of tobacco policies, but emerging data indicate that such generic tobacco control measures may not be equally or similarly effective in respect to the two sexes and the various subgroups in a country's population. Therefore, in order to address the specific needs of men and women of all ages more effectively, a gendered perspective must be included in tobacco control measures.

Indeed, for almost a century the tobacco industry has capitalized on gender norms and differences to enhance product development and marketing techniques and broaden its market, with negative effects on the health of women and men. Age, ethnicity and class have also played a key role in the design and dissemination of tobacco marketing strategies. It is therefore important that tobacco control policies recognize and take into account gender norms, differences and responses to tobacco, in order to counteract these pressures, reduce tobacco use and improve the health of men and women worldwide.

Tobacco kills men and women. However, there are sex-specific differences

The main consequences of smoking are heart disease and stroke, chest and lung diseases (including lung cancer) and several other cancers.

Generally, both sexes fall victim to the morbidity and mortality associated with these diseases, but there is growing evidence that these diseases and effects also have sex-specific elements. For example, women get lung cancers at a lower exposure than men; adenocarcinomas are more prevalent among women smokers than men, and may result from gendered smoking behaviours (inhaling more deeply) and/or gendered products ("light" cigarettes) that were designed for women (Payne, 2001; INWAT, 1999; Samet & Yoon, 2001; INWAT, 1994; Joossens & Sasco, 1999). The effects of tobacco use on the trajectory of lung health, evidenced by diseases such as cancer and chronic obstructive pulmonary disease, are sex-differentiated, with women experiencing a different and faster development of lung disease, starting in adolescence.

There are sex-specific effects on both male and female reproductive systems and capabilities. Both the ingestion of nicotine and the chronic vascular damage caused by smoking appear to contribute to erectile dysfunction in men. Similarly, research has investigated links between sperm quality and smoking, but has yet to pinpoint the actual effect of smoking compared with, or in the context of, occupational exposures or other confounders (United States Surgeon General, 2004:534). The effects of smoking during pregnancy are numerous and well documented, and include difficulties with labour, delivery and breastfeeding, low-birth-weight infants and possible long-term effects on child

behaviour and a propensity to nicotine addiction in later life (United States Surgeon General, 2004, Chapter 5; United States Surgeon General, 2001:277-307). Additional female health conditions affected by tobacco use include cervical cancer and bone disease and enhanced mortality from breast cancer for women who smoke (Fentiman et al., 2005).

Specific effects of smoking on male and female children and adolescents are less well documented. There is evidence that smoking has an effect on children whose bodies are still growing, and may have an effect on the later development of diseases such as breast cancer in women (Band et al., 2002).

Smoking affects not only the health of smokers, but also the health of those around them who are exposed to secondhand smoke, such as their children, spouses and other relatives at home and their co-workers in the workplace. Exposure to secondhand tobacco smoke causes serious and fatal diseases in adults and children. Several recent reports, including the 2004 monograph from the International Agency for Research on Cancer (IARC, 2004), the 2005 report from the California Environmental Protection Agency in the United States (California Environmental Protection Agency, 2005), and the 2006 report of the United States Surgeon General (United States Surgeon General, 2006) have synthesized this evidence and reached clear and firm conclusions with regard to the adverse consequences of exposure to secondhand smoke.

There are sex-specific issues in exposure to secondhand smoke. For example, it contributes to lower fertility in women and men, and pregnant women suffer added morbidity for themselves and their newborns when exposed to secondhand smoke. Also, research suggests that exposure to secondhand smoke increases the risk of breast cancer in young premenopausal nonsmoking women (California Environmental Protection Agency, 2005). Male never-smoking spouses of smokers have a higher risk of developing lung cancer, compared with female never-smoking spouses (California Environmental Protection Agency, 2005).

Tobacco kills 5.4 million people a year: that figure will rise to 8.3 million by 2030

There are an estimated 1.3 billion adult smokers (over 15 years old) among the world's six billion people (Guindon & Boisclair, 2003). If the prevalence of tobacco use remains constant, the number of smokers will rise to 1.7 billion between 2020 and 2025 (Guindon & Boisclair, 2003). Four-fifths of current smokers live in low-income or middle-income countries.

Half of all long-term smokers will eventually be killed by tobacco, and half of these deaths will occur in middle age, between the ages of 45 and 54 years-WHO, 2003a (Guindon & Boisclair, 2003). More than five million people die every year as a consequence of tobacco smoking, with three quarters of all deaths currently occurring among men (Mathers & Loncar, 2006). Based on current trends, mortality will increase to 8.3 million a year by 2030 (Mathers & Loncar, 2006), and 80% of these deaths will occur in low and middle income countries (Mathers & Loncar, 2006).

More males than females smoke. However, tens of millions of women currently smoke and this number is growing rapidly

There are important sex and gender differences in tobacco use, with global prevalence among males about four times higher than among females - 48% versus 10% (Guindon & Boisclair, 2003). There may be considerable female smoking that is underreported, or unreported, because of gender norms that stigmatize smoking by

women. Male-female differences in use are highest in the Western Pacific Region and lowest in the Americas and the European Region, where about one quarter of women smoke (Corrao et al., 2000). The most recent data for China show a dramatic gender gap (63% among men and 3.8% among women) (Yang et al., 1999).

Typically, the smoking epidemic starts among men and higher-income groups, and later affects women and low-income groups in most populations (World Bank, 1999). However, global male rates have peaked and have stabilized or are in slow decline, while the prevalence of tobacco use among women is increasing (Mackay, 2001). In fact, the historical gender differences in uptake and prevalence are shrinking because of the increased prevalence of smoking among girls. Recent findings of the Global Youth Tobacco Survey, the largest global survey of adolescents aged 13 to 15 and tobacco use, show that almost as many young girls are smoking as young boys in many parts of the world. This is an indicator of the increasing global epidemic among women that will not peak until well into the 21st century. The prediction is that by 2025, 20% of the female population will be smokers, up from 12% in 2005.

Even so, despite low prevalence in some countries, the large population base of countries like China and India means that tens of millions of women are already smokers. And, although the global prevalence of male tobacco use is not increasing, smoking rates among men and boys remain alarming, particularly in countries which are still in the early stages of the tobacco epidemic. In addition, available data do not generally consider other forms of tobacco use, which also often display gendered and region-specific patterns within countries and cause largely unaccounted morbidity and mortality among both women and men.

Incorporating gender into tobacco control measures

Tobacco control is best accomplished through a comprehensive approach that includes a number of measures aimed at preventing or reducing the use of tobacco in a population or country. These measures are reflected in the substantive articles of the WHO Framework Convention on Tobacco Control (WHO, 2003b). However, a practical approach needs to prioritize some core measures. The following recommendations reflect a core set of policy measures that governmental and nongovernmental organizations should consider applying.

Gender issues have an impact on all of these measures, and on how individuals and groups respond to tobacco control policies. Hence, it is important to understand that core tobacco control policies ought not to be mounted as "stand-alone" initiatives, but rather need to be coordinated, making sure that gender and diversity are taken into account and that each policy measure complements the others.

Make tobacco products less affordable by raising prices through tobacco tax measures and apply the revenue raised to specific tobacco control activities benefiting women, young people and disadvantaged groups

The more expensive tobacco products are, the less likely people (young people in particular) are to buy them. Generally, both women and men of low socioeconomic status are likely to quit

smoking as a result of price measures. However, the results of studies investigating whether one gender is more price-responsive than the other have been mixed, with results in the United Kingdom and the United States of America showing that women are more price-responsive than men (Farrelly et al., 2001; Borren & Sutton, 1992) and results in Canada showing equal receptiveness to price measures among women and men (Stephens et al., 2001).

Governments should raise taxes and, preferably, apply part of the revenue raised from tobacco taxes to specific tobacco control activities that would benefit women, young people and other disadvantaged groups (Lambert, 2006). Although tax and price increases indisputably reduce tobacco use in the population, some individuals try to compensate for such increases by obtaining cheaper cigarettes or other tobacco products, or by depleting household income to maintain their level of addiction. Women, men, nongovernmental organizations and anti-poverty organizations, as well as policy-makers and lawmakers, must understand how taxation and pricing systems work in their countries to implement specific effective tax and price policy measures that adequately address compensatory behaviours.

Enact and enforce legislation requiring all indoor workplaces and public places to be 100% smoke-free environments and implement educational strategies to reduce secondhand smoke exposure in the home for effective protection of men and women from exposure to tobacco smoke. Gender-sensitive education efforts must empower individuals to claim smoke-free environments at home

Exposure to secondhand smoke is widespread in most countries, even in health care settings and among health professionals. The number of men and women exposed to secondhand smoke in workplaces reflects the rates of labour force participation among men and women. Although the active labour force is male-dominated in many countries, there are sectors with a predominance of female workers: for example, the majority of health care workers and unpaid caregivers are female. Despite the lack of sex-disaggregated data in most countries, approximately 44% of all students aged 13 to 15 worldwide are exposed to secondhand smoke at home, and 56% are exposed to secondhand smoke in public, according to the Global Tobacco Youth Survey (Global Tobacco Youth Survey Collaborating Group, 2003).

The only way to protect men and women effectively from exposure to tobacco smoke in public and in workplaces is to enact and enforce legislation requiring all indoor workplaces and public places to be 100% smoke-free. Smoke-free environments achieve the goal of protecting nonsmokers from exposure to tobacco smoke, while simultaneously having a positive impact on two other major tobacco control goals established by public health organizations: reducing smoking initiation and increasing smoking cessation.

Education is an effective strategy in promoting protection from secondhand smoke in settings for which legislation is neither feasible nor advisable, such as the home (WHO, 1999; Thompson et al., 2006). The home is often the setting where the highest exposure to secondhand smoke occurs for children and for adults, especially women who do not work outside the home. While it is not required by any of the laws creating smoke-free environments, more people voluntarily make their homes smoke-free when workplace and public place laws are implemented (Borland et al., 1999). More specifically, smoke-free homes protect children and other family members from secondhand smoke and further increase the likelihood that the smokers will successfully quit smoking. Smoke-free homes are also associated with reduced tobacco use among adolescents (Wakefield et al., 2000).

Education to promote smoke-free homes can be part of campaigns to build public support for smoke-free legislation, which have included messages informing smokers, particularly those who are also parents, of the impact of exposure to secondhand smoke in the home and have urged them to make their homes smoke-free. To complement mass media campaigns, health warnings on tobacco packages are a very cost-effective public education medium that is guaranteed to reach all smokers.

Education efforts should take into account the fact that gender roles not only affect exposure to secondhand smoke, but also the power to claim the right to health. Occupations that men and women typically hold in a society will often determine how much exposure they will experience and whether or not they can easily avoid it. In domestic settings, women and children are especially vulnerable to exposure to secondhand smoke in countries with high rates of male smoking, and typically have less power in negotiating smoke-free homes and cars. Specific skill-building programmes and advice can be

offered to enhance women's and children's power to achieve smoke-free private spaces. Nongovernmental organizations, including trade unions, staff associations and women's groups, can help by providing information and education on secondhand smoke, and advising their members and the public on how to negotiate smoke-free homes successfully.

Enforce a comprehensive ban on advertising, promotion and sponsorship to protect males and females of all ages from being targeted by the tobacco industry

Decades of history and experience with the tobacco industry's promotion practices clearly indicate that the industry has taken gender roles and norms into consideration in its market research for almost a century. This has resulted in "male" brands and "female" brands, supported by tailored marketing campaigns and imagery that are also often aimed at children and youth. Gender-specific product development and promotion included "light" and "slim" cigarettes directed at girls and women and manufactured with female physiologies in mind (Joossens & Sasco, 1999). Gendered and diversity-based advertising and promotion continue to occur as the industry focuses on women and

men in countries where tobacco markets are emerging and tobacco use is on the increase, especially among women.

Even in countries with comprehensive bans, sponsorship by the tobacco industry often continues. Usually this has a gendered component, as the tobacco industry continues to seek other means of supporting its target markets and increasing product exposure. Examples include the tobacco industry's sponsorship of events like fashion shows, talent contests, concerts, etc. and cigarette product placement in television shows, plays and movies (Esson & Leeder, 2004), many of which are aimed at specific audiences.

Only the enforcement of a comprehensive ban on advertising, promotion and sponsorship, as advocated in the WHO Framework Convention on Tobacco Control, will help to protect males and females of all ages. However, governments and nongovernmental organizations should continue to educate the population about the gender-specific marketing tactics which the tobacco industry employs, to show how gender identity and gendered roles are manipulated by the tobacco industry.

Implement large, visible, and regularly changing health warnings and messages on tobacco product packages. Specific textual and pictorial health warnings for men and for women should reflect sex and gendered effects and patterns of tobacco uptake and cessation

Descriptors like "light," "mild," or "low-tar" are often specifically targeted at women, and can foster the belief that they are consuming safer tobacco products. For example, half of all women smokers in the European Union smoke "light" cigarettes, as opposed to 33% of male smokers (Joossens & Sasco, 1999). Similarly, 66% of female smokers in Canada, compared with 57% of male smokers, use "light" cigarettes. Misleading information on the health consequences of "light" cigarette usage particularly affects girls and women (CTUMS, 2002).

The WHO Framework Convention on Tobacco Control prohibits such misleading terms and descriptors and also requires States Parties to adopt and implement large, clear, visible, regularly changing (rotating) health warnings and messages on tobacco products within a period of three years after entry into force of the Convention for that Party. These should ideally occupy 50% or more of the principal display area of the package and may be in the form of pictures and/or text.

Specific textual and pictorial health warnings for men and for women reflecting sex and gendered effects and patterns of tobacco uptake and cessation are in place in some countries and could be expanded. Together, these measures could play a significant role in reducing predicted future smoking rates among women and girls by making sure that they do not start using tobacco products or that they quit. Pictorial messages may have a particular impact on girls and women, as global illiteracy rates are higher for women than men.

Increase availability and access to treatment services for tobacco dependence and train health professionals in these services to take into account sex and gender specificities when treating tobacco dependence

Tobacco use affects both men and women by creating a dependence on nicotine. However, smoking in women is reinforced by less nicotine than in men (Perkins et al., 1991). Recent genetic research indicates that there are sex differences in the metabolism of nicotine, which may play a role in the trajectory of addiction, maintenance patterns and the responses to cessation interventions (United States Surgeon General, 2000).

Men and women approach cessation in different ways. Although the evidence on sex and gender related factors on cessation is far from complete, it is known that biopsychosocial factors are important for women, such as hormonal cycles, pregnancy, fear of weight gain, social support needs, identity issues and depression, and that these are linked with maintenance and cessation patterns. Women may be less confident than men in their ability to quit, and generally have fewer successful smoking cessation attempts and more relapses than men (Samet & Yoon, 2001:122). Numerous studies have established that women have more difficulty in quitting than men (Osler et al., 1999), more difficulty in remaining abstinent after quitting (Perkins et al., 1991) and that nicotine replacement therapy may be less efficacious among women than men (Samet & Yoon, 2001). The reasons are largely unclear (Wetter et al., 1999) but may reflect psychosocial factors such as lone motherhood and the related burden of care of low income women (Graham & Der, 1999), concerns about weight gain or body image or low education (Osler et al., 1999).

Hence, in order to increase access to appropriate smoking cessation and prevention programmes, gendered cessation programmes need to be developed. They should be integrated into existing primary health care, maternal and child health care or reproductive health services to increase access. Since women are usually more likely to use health services, they are more likely than men to be exposed to health information and tobacco use prevention and cessation services. These programmes should address different patterns and reasons for smoking in women, men, boys and girls as well as different cessation issues and patterns.

Health professionals also need training that highlights sex and gender-specific reasons and patterns for male and female smoking uptake and the different challenges faced by both women and men in cessation. For example, adolescents, especially adolescent girls, are more likely to smoke as a result of low self-esteem and the need for peer approval (Wagner & Atkins, 2000). Adolescent girls also report smoking for stress reduction and relaxation (Nichter et al., 1997). Adolescent boys of multiethnic origin report that their peers exert strong messages to initiate smoking (Alexander et al., 1999). Tobacco control programming that incorporates a gendered approach to analysing meanings and reasons for smoking will better address adolescents' needs.

Use gendered education and communication approaches to increase public awareness and support for approval and enforcement of effective tobacco control policies

Women and men need to be informed about the dangers of tobacco products, the deceptive behaviour of the tobacco industry and the most effective measures to reduce smoking. However, tobacco control messages should be sensitive to gender and culture. Cultural norms regarding gendered behaviour affect both smoking behaviour and cessation patterns, sometimes reflecting or leading to unequal access to tobacco control information or education. For example, smoking may be deemed the behaviour of "aberrant" women in some cultures, or may simply be an activity that women are "not supposed" to do, making some women reluctant or afraid to be involved in tobacco control education or preventing the development of, or access to, information or services.

When this is the case, rather than having general tobacco control messages, it is important to develop gender-specific education and deliver it in gendered settings in order to maximize

access to information, engagement with the material and its effectiveness. Involving both men and women in the development of information and education materials, including counter-advertising, is particularly important for ensuring the relevance of the materials.

Tobacco education and information programmes and materials should be empowering, blame-free and stigma-reducing. In particular, improved approaches are needed for programmes that focus on maternal health. Tobacco control messages in maternal health programmes have traditionally centred on the health of the fetus or child rather than the health of the woman, compelling pregnant women to quit smoking through guilt, failing to ensure they also quit for their own health, and contributing to high rates of postpartum relapse.

Developing a gender-responsive infrastructure for tobacco control

Collect and analyse sex-specific and gender-specific information on tobacco use and the effectiveness of tobacco control measures

A national tobacco control programme must ensure that the situational analysis determines the specific risks and needs of girls, boys, men and women in tobacco use or production. Such a gender and diversity analysis should be repeated on a regular basis (every 2-3 years) and could measure different patterns of use as well as differential responses to policies (such as tax, price or smoking bans) and programmes (such as prevention or cessation efforts).

Countries can establish sex-specific and gender-specific indicators in tobacco control that measure the effects of their programmes and policies. These research and evaluation mechanisms also need to evaluate the specific effectiveness of control measures for women and men and in diverse subpopulations. This type of scientific approach will help to create a research and evaluation agenda that accounts not only for sex differences and gender influences, but also for the interaction of sex and gender as it affects tobacco use and responses to policies and programmes. Further, groups who are at the highest risk for tobacco use, or the least responsive to tobacco control, including pregnant smokers or young girls and boys, can be identified earlier and remedies created or adapted for them.

Integrate gender analysis into tobacco control planning

Building a national plan of action for tobacco control and establishing the infrastructure and capacity to implement the plan of action are key steps in tobacco control. These actions provide opportunities to involve both women and men in integrating gender analysis into planning to ensure the development and promotion of gendered tobacco control policies and programmes.

Specific indicators of progress must include the gender-responsiveness of the process itself (e.g. proportion of women involved in the planning process for ratification and implementation of the WHO Framework Convention on Tobacco Control or proportion of women represented on the national planning committee).

Plans and programmes should address the specific risks and needs of girls, boys, women and men. Public information and advocacy programmes can be made gender-responsive. Effective gender-responsive social marketing and communication campaigns can be developed to ensure a critical mass of public supporters of tobacco control. A core group of champions can be encouraged to sustain a gendered approach. In order to optimally address the specific risks and needs of men and women of all ages, representatives of women's and youth groups, health professionals and ministries that work on women's affairs should be involved in developing capacity for gender analysis in tobacco control.

In its Preamble, the WHO Framework Convention on Tobacco Control highlights the importance of incorporating gender and diversity concerns in tobacco control, and acknowledges the special contribution that members of civil society, including women's groups, have already made and should continue to make to tobacco control efforts nationally and internationally. The Framework Convention further recognizes the importance of the Convention on the Elimination of All Forms of Discrimination Against Women, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child.

Source: WHO Framework Convention on Tobacco Control. Geneva

Conclusion

Historical trends and rapidly accumulating evidence indicate that tobacco use and tobacco control affect women and men (of all ages) differently. Given the predictions for the 21st century, greater attention must be placed on the growing prevalence and consumption of tobacco among girls, boys and women, along with the continuing consumption of tobacco by men. The future of tobacco control rests on successfully enacting comprehensive tobacco control measures, as outlined in the WHO Framework Convention on Tobacco Control, on integrating gender and diversity concerns early on in the implementation of its substantive articles, and on the establishment of a gender-responsive infrastructure for tobacco control.

Selected resources

Alexander CS et al. (1999). Taking a first puff: cigarette smoking experiences among ethnically diverse adolescents. *Ethnicity and Health,* 4, 245-257.

Band PR et al. (2002). Carcinogenic and endocrine disrupting effects of cigarette smoke and risk of breast cancer. *Lancet*, 360(9339):1044-49.

Borland R et al. (1999). Trends in environmental tobacco smoke restrictions in the home in Victoria, Australia. *Tobacco Control*, 8:266-271.

Borren P, Sutton M (1992). Are increases in cigarette taxation regressive? *Health Economics*, 1(4):245-253.

Brands A, Yach D (2002). *Women and the rapid rise of noncommunicable diseases* (NMH Reader No.1). Geneva, World Health Organization.

California Environmental Protection Agency: Air Resources Board (2005). *Proposed identification of environmental tobacco smoke as a toxic air contaminant. Part B: Health effects*. Sacramento, Office of Environmental Health Hazard Assessment (http://repositories.cdlib.org/tc/surveys/CALEPA2005, accessed 14 June 2007).

Castrucci et al. (2002). Adolescent acquisition of cigarettes through non-commercial sources. *Journal of Adolescent Health*, 31(4):322-326.

Corrao MA et al., eds. (2000). *Tobacco control country profiles*, Atlanta, GA, American Cancer Society.

CTUMS (2002). *Canadian Tobacco Use Monitoring Survey, February-December 2002* (http://dsp-psd.pwgsc.gc.ca/Collection/H12-35-2002-1E.pdf, accessed 15 June 2007).

Esson KM, Leeder SR (2004). *The Millennium Development Goals and tobacco control: an opportunity for global partnership*. Geneva, WHO Tobacco Free Initiative (http://who.int/tobacco/publications/mdg_final_for_web.pdf, accessed 14 June 2007).

Farrelly MC et al. (2001). Response by adults to increases in cigarette prices by sociodemographic characteristics. *Southern Economic Journal*, 68(1):156-165.

Fentiman IS, Allen DS, Hamed H (2005). Smoking and prognosis in women with breast cancer. *International Journal of Clinical Practice*, 59(9):1051-54.

Global Youth Tobacco Survey Collaborating Group (2003). Differences in worldwide tobacco use by gender: findings from the Global Youth Tobacco Survey. *Journal of School Health*, 73(6):207.

Graham H, Der G (1999). Patterns and predictors of tobacco consumption among women. *Health Education Research*, 14(5):611-618.

Greaves L, Jategaonkar N (2006). Tobacco policies and vulnerable girls and women: toward a framework for gender-sensitive policy development. *Journal of Epidemiology and Community Health* 60:57-65.

Greaves L, Jategaonkar N, Sanchez S, eds. (2006). *Turning a new leaf: women, tobacco, and the future.* Vancouver, British Columbia Centre of Excellence for Women's Health.

Greaves L, Vallone D, Velicer W, eds. (2006). How do tobacco policies affect low socioeconomic status girls and women? *Journal of Epidemiology & Community Health* Vol. 60 (Suppl.).

Greaves L et al. (2006). What are the effects of tobacco policies on vulnerable populations? A better practices review. *Canadian Journal of Public Health,* 97(4): 310-315.

Guindon GE, Boisclair D (2003). Past, current and future trends in tobacco use. (http://www1.worldbank.org/tobacco/pdf/Guindon-Past,%20current-%20whole.pdf).

IARC (2004). *The herstories project* (IARC Monographs on the Evaluation of Carcinogenic Risks to Humans, Vol. 83). Lyons, International Agency for Research on Cancer.

INWAT (1994). *The herstories project*. New York, International Network of Women Against Tobacco.

INWAT (1999). *Kobe Declaration*. New York, International Network of Women against Tobacco (http://www.inwat.org/inwatkobe.htm, accessed 16 June 2007).

INWAT Europe (1999). *Part of the solution? Tobacco control policies and women*. London, International Network of Women Against Tobacco (http://www.inwat.org/pdf/PARTOFTHESOLUTION.pdf, accessed 16 June 2007).

Joossens L, Sasco A (1999). *Some like it "light": women and smoking in the European Union*. Brussels, European Network for Smoking Prevention.

Lambert P (2006). Women's health is a human right, tobacco is not. In: Greaves L, Jategaonkar N, Sanchez S, eds. *Turning a new leaf: women, tobacco and the future.* Vancouver, British Columbia Centre of Excellence for Women's Health: Chapter 4.

Mackay J (2001). Preface. In: Samet JM, Yoon SY, eds. *Women and the tobacco epidemic: challenges for the 21st century.* Geneva, World Health Organization.

Mackay J, Eriksen M (2002). *The tobacco atlas*. Geneva, World Health Organization (www.who.int/tobacco/resources/publications/tobacco_atlas/en/, accessed 21 June 2007).

Mathers CD, Loncar D (2006). Projections of global mortality and burden of disease from 2002 to 2030. *Public Library of Science Medicine*, 3(11): e442 doi:10.1371/journal.pmed.0030442 (http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0030442, accessed 27 June 2007).

National Cancer Institute (2004). *Women, tobacco, and cancer: an agenda for the 21st century*. Bethesda, MD, United States Department of Health and Human Services.

Nichter M et al. (1997). Smoking experimentation and initiation among adolescent girls: qualitative and quantitative findings. *Tobacco Control,* 6(4):285-295.

Osler M et al. (1999). Gender and determinants of smoking cessation: a longitudinal study. *Preventive Medicine*, 29(1):57-62.

Payne S (2001). "Smoke like a man, die like a man"?: a review of the relationship between gender, sex and lung cancer. *Social Science & Medicine*, 53:1067-80.

Perkins KA, Donny E, Caggiula A (1991). Sex differences in nicotine effects and self-administration: human and animal evidence. *Nicotine & Tobacco Research*, 1:301-315.

Quit Smoking Support (2007). *Global smoking deaths approach 5 million* (http://www.quitsmokingsupport.com/global.htm, accessed 14 June 2007).

Samet JM, Yoon SY, eds. (2001). *Women and the tobacco epidemic: challenges for the 21st century*. Geneva, World Health Organization

Stephens T et al. (2001). Comprehensive tobacco control policies and the smoking behaviour of Canadian adults. *Tobacco Control*, 10(4):317-322.

Thompson G, Wilson N, Howden-Chapman P (2006). Population level policy options for increasing the prevalence of smokefree homes. *Journal of Epidemiology & Community Health*, 60:298-304.

United States Surgeon General (2000). *Reducing tobacco use: a report of the Surgeon General*. Atlanta, GA, Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

United States Surgeon General (2001). *Women and smoking: a report of the Surgeon General*. Rockville, MD, United States Department of Health and Human Services, Office of the Surgeon General.

United States Surgeon General (2004). *The health consequences of smoking: a report of the Surgeon General*. Rockville, MD, United States Department of Health and Human Services, Office of the Surgeon General.

United States Surgeon General (2006). *The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General*. Rockville, MD, United States Department of Health and Human Services, Office of the Surgeon General.

Wagner E, Atkins J (2000). Smoking among teenage girls. *Journal of Child and Adolescent Substance Abuse*, 9(4):93-110.

Wakefield MA et al. (2000). Effect of restrictions on smoking at home, at school, and in public places on teenage smoking: cross sectional study. *British Medical Journal*, 321(7257):333-337.

Wetter DW et al. (1999). Gender differences in response to nicotine replacement therapy: objective and subjective indexes of tobacco withdrawal. *Experimental & Clinical Psychopharmacology*, 7(2):135-144.

WHO (1999). *International consultation on environmental tobacco smoke and child health, 11-14 January 1999*. (document WHO/NCD/TFI/99.10). Geneva, World Health Organization.

WHO (2002). *Integrating gender perspectives in the work of WHO: WHO Gender Policy*. Geneva, World Health Organization (www.who.int/gender/documents/engpolicy.pdf, accessed 16 June 2007).

WHO (2003a). *Gender, health and tobacco*. Geneva, WHO, Department of Gender and Women's Health (www.who.int/gender/other_health/Gender_Tobacco_2.pdf, accessed 14 June 2007).

WHO (2003b). *WHO Framework Convention on Tobacco Control*. Geneva, World Health Organization Tobacco Free Initiative (www.who.int/tobacco/framework/en/, accessed 14 June 2007).

WHO (2004a). *Building blocks for tobacco control*. Geneva, World Health Organization.

WHO (2004b). *Tobacco and poverty: a vicious circle*. Geneva, World Health Organization.

WHO (2005). *Gender, women and health: incorporating a gender perspective into the mainstream of WHO's policies and programmes. Report by the Secretariat*. Geneva, World Health Organization (www.who.int/gb/ebwha/pdf_files/EB116/B116_13-en.pdf, accessed 16 June 2007).

World Bank (1999). *Curbing the epidemic: governments and the economics of tobacco control* (Development in Practice Series). Washington, DC.

Yang G et al. (1999). Smoking in China: findings of the 1996 National Prevalence Survey. *Journal of the American Medical Association*, 282(13):1247-53.

For further information, kindly contact GWH and TFI as follows:

Department of Gender, Women and Health (GWH)
World Health Organization
20, Avenue Appia
CH-1211 Geneva 27
Switzerland
Fax: + 41 22 791 1585
http://www.who.int/gender/en/

Tobacco Free Initiative (TFI)
World Health Organization
20, Avenue Appia
CH-1211 Geneva 27
Switzerland
Fax: + 41 22 791 48 32
http://www.who.int/tobacco/en/

Gender and tobacco control: A policy brief

Today, 250 million women worldwide – 12% of the female population – are daily smokers. If current trends continue, that percentage will rise to 20% of all women by 2025. Global smoking rates are stable or in slow decline among men. However, rates are still increasing among women, and in low-income and middle-income countries men's and women's smoking rates are converging. How can tobacco control policies in a range of countries take into account the specific characteristics and needs of women and girls, men and boys?

This policy brief, aimed at national and international policy-makers and nongovernmental organizations, shows how a gender-sensitive approach can be incorporated into tobacco control policies, making existing instruments such as the WHO Framework Convention on Tobacco Control more effective. The developed world did not address gender differences in tobacco use until the epidemic was well advanced. Low-income and middle-income countries have the opportunity, with the advantage of this hindsight and the support of the WHO Framework Convention, to adopt a much more effective approach.

World Health Organization

Department of Gender, Women and Health (GWH)

http://www.who.int/gender/en/

Tobacco Free Initiative (TFI)

http://www.who.int/tobacco/en/

IDRC CRDI

International Development Research Centre

Centre de recherches pour le développement international

ISBN 9 789241 595773