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Gender and tobacco control:

A policy brief

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Gender and tobacco control: A policy brief

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Tobacco Free Initiative (TFI)

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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 conclu-

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).