International Tobacco Control Policy: The Implications of SGBA

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Introduction

Approximately 250 million women and 1 billion men smoke tobacco cigarettes daily.[1] While the smoking rate for men around the world has peaked and is slowly beginning to decline, smoking rates for women continue to climb. Moreover, the rate of smoking among the world's female population is predicted to rise from the current 12 percent to 20 percent by 2025.[2] However, these smoking statistics do not account for other types of tobacco use, such as chewing tobacco by women and men in South Asia, which may push tobacco use rates even higher in the coming years.[1]

In the 1990s, Lopez and colleagues developed a descriptive model of tobacco epidemics based on smoking prevalence rates, cigarette consumption and smoking-related mortality rates.[3] The four stages are useful because they describe the differences between women's and men's smoking rates and consumption, and illustrate that in most societies women take up smoking after men and smoke less, which in turn is reflected in delayed and lower morbidity and mortality rates from illnesses associated with tobacco use. Most high-income countries have reached stage 3 or 4, in which male smoking rates have peaked and are declining while female smoking rates have just peaked or are about to peak.[1] Low and middle-income countries tend to be in the earlier stages of the tobacco epidemic, with the result that the full impact of smoking-related illness and death has yet to become apparent and tobacco control efforts are still relatively new. Some countries, such as China and India, are of particular concern because of their large populations and early stage of the cigarette smoking epidemic.[4,5] Due to the gender differences in tobacco use identified in each stage of the

A Descriptive 4-Stage Model of Tobacco Epidemics[3]

- Stage 1: The beginning of a smoking epidemic in a population. Smoking rates are low for women and men, but cigarettes are growing increasingly popular with men. There is little evidence of any adverse health effects and smoking becomes socially acceptable.
- Stage 2: Smoking rates rise dramatically for men and reach a peak in the range of 50-80 percent, while prevalence rates among women are much lower but increasing rapidly. During this stage, smoking rates are often similar across socio-economic status or may be slightly higher among the upper classes. Negative health effects are becoming more noticeable among male smokers, causing about 10 percent of male deaths by the end of this phase.
- Stage 3: Smoking rates among women peak in this period with prevalence as high as 40-50 percent among young women. Smoking rates among men decline gradually, from 60 percent to 40 percent, but there is a dramatic increase in smoking-related mortality, particularly among men. The health effects of smoking are well-known by the general public with systematic prevention strategies in place.
- Stage 4: Smoking prevalence for women and men continue to decline slowly but more or less in parallel. Smoking-related mortality peaks early in this period for men, being as high as 40-45 percent of deaths among those in middle age. Female deaths due to smoking rise sharply due to the delayed effects of previous smoking patterns, peaking at around 20-25 percent of all deaths. Thereafter, prevalence and mortality rates steadily decline for both sexes. Policies and legislation are created for smoke free areas.

tobacco epidemic, there is a critical need for a sex- and gender-based analysis of tobacco use as well as the development of gender-sensitive international tobacco control policies.

The World Health Organization Framework Convention on Tobacco Control (FCTC), which was adopted in 2003 and came into effect in 2005, is the first international public health treaty.[6] To date, 168 countries have signed the FCTC, which is aimed at setting global standards in tobacco control. Key articles of the FCTC-as well as widespread international support-provide opportunities for recognizing and developing gendered responses. For example, Article 4 of the FCTC acknowledges the alarming increase in girl's and women's tobacco use and encourages the development of gendered tobacco control strategies and policies.

This case study is adapted from work by the British Columbia Centre of Excellence for Women's Health, in partnership with the International Network of Women Against Tobacco (INWAT), an international non-governmental organization which conducts education, research and advocacy aimed at reducing the impact of tobacco on girls and women and focuses on improving countries' inclusion of gender in their national tobacco control policies.

Sex, Gender and Tobacco

Sex and gender affect the use and effects of tobacco for women and men. For example, differences in lung anatomy, genetics and physiology between women and men potentially increase the harm associated with women's exposure to smoke.[7] Smaller airways in women may serve to concentrate the toxic chemicals in tobacco smoke while research suggests that women metabolize smoke differently than men and therefore may be more susceptible to respiratory diseases such as chronic obstructive pulmonary disease and lung cancer.[8] Further, women are at increased risk of breast cancer due to either active smoking or exposures to others' smoke, particularly if these exposures occur during adolescence.[9]

Likewise, gender affects when, how and where girls and women smoke and/or are exposed to smoke. For example, unequal power dynamics between women and men may reduce women's ability to control exposure to second-hand smoke.[10] Women may also smoke for different reasons than men, such as to organize social relationships, create an image, control emotions and as a form of social support and control.[11] Culture, class and other determinants likewise influence trends in women's smoking and differences among women. For instance, women with limited education or vocational opportunities may have to work in settings, such as restaurants, where they are more likely to be exposed to second-hand smoke. Furthermore, these biological and social factors interact and overlap. When women are exposed to second-hand smoke as a result of power inequities, their narrower airways also increase their risks of morbidity and mortality.

Other forms of tobacco use, such as chewing tobacco and bidis, also have health implications, including more oral cancers and poorer reproductive health outcomes.[15,16] As well, there are specific health risks associated with tobacco manufacturing. For example, those who work in tobacco production – most of whom are women – absorb nicotine through the skin and may develop a condition called "green sickness," which results in nausea, fatigue, headache, weakness, breathing problems and changes in blood pressure and heart rate.[17]

In many countries, although cigarette smoking rates among women may be low, second-hand smoke exposure among women is high where male smoking rates are high. In addition, due to gendered roles of care-giving and family health management, high rates of morbidity and mortality in men increase domestic demands on women and negatively influence family health and nutrition.[18] The health and economic effects of tobacco use are thus sex, gender and stage-specific. For instance, if male smoking is high, as in Stage 1-2 countries, the exposures to second-hand smoke and the nutrition- and economic-related health consequences may be greater issues for women and children, while the direct health consequences may be greater for men.

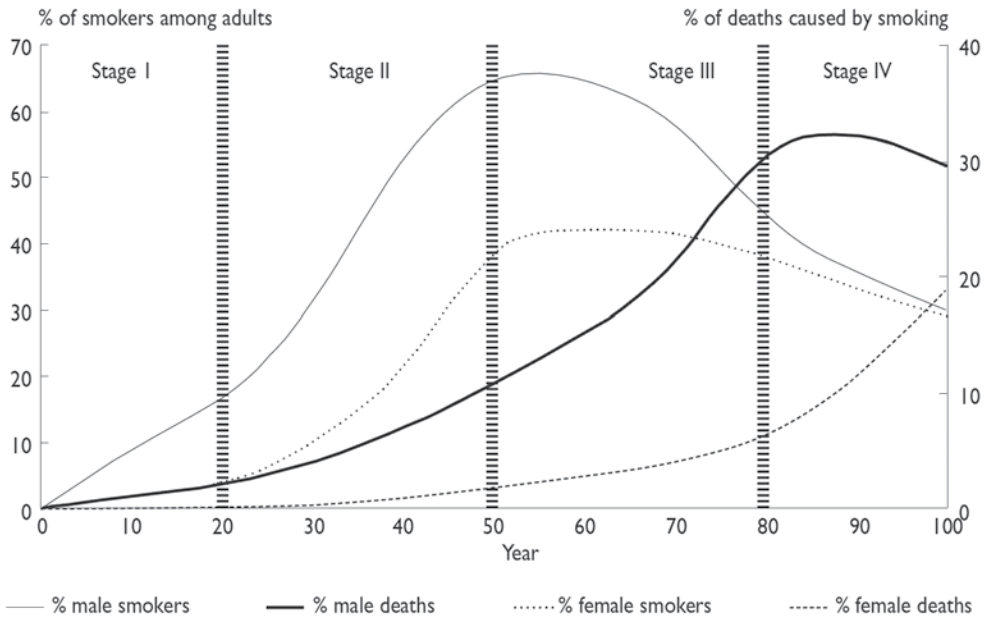
Globally, What Are the Policy Contexts for Women and Tobacco Control?

While we can see specific patterns of tobacco use in different countries – allowing us to "stage" the epidemic – it is also the case that countries find themselves in a particular stage of tobacco use because of local, historical and cultural contexts. For example, in countries in the early stages of the epidemic, such as Thailand and China, women have low smoking rates but are recognized as a potential market and are increasingly targeted by the tobacco industry.[15] In Iran, cigarette use by women has also historically been low, but women are increasingly using tobacco. In Turkey and India, there is a long cultural history of male tobacco use, but patterns of use are changing with urban, educated women increasingly taking up cigarette smoking. In Lebanon, the tobacco epidemic is at its peak with high rates of use for both women and men. South Africa and Brazil are entering the last stage of the tobacco epidemic, with tobacco restrictions being put in place and women's tobacco use having peaked. Canada and Australia are in Stage 4 of the epidemic, with smoking rates low overall, but higher among specific sub-populations of women, such as Aboriginal women. In Sweden, women actually have higher smoking rates than men, suggesting that this country is an exception to the four-stage model of tobacco epidemics or that the model itself may require adjustment. These variances demonstrate the range in stages of the tobacco epidemic and the need for contextually relevant responses.

How Should Policies be Tailored According to the Gender, Sex and Diversity Specific Contexts within Every Country?

Depending on the stage of the tobacco epidemic (see Figure 1), countries will need to enact different tobacco control initiatives. For example, in countries at earlier stages where women have not yet reached high rates of smoking, the focus should be on the prevention of tobacco use for women, the reduction of exposure and cessation for men. For countries at later stages in the epidemic, such as Canada, the United States (US) and the United Kingdom (UK), the focus should be on reducing the demand for tobacco among vulnerable sub-populations of girls and women, such as low income, pregnant, teenage and minority girls and women.[19] Tobacco control policies must also recognize the specific gender relations, cultural practices and household/relationship dynamics that exist, so that tobacco control initiatives effectively respond to the real-life conditions of tobacco use that women encounter. For example, efforts to help pregnant and post partum women reduce or stop smoking could be enhanced with greater attention to household and/or relationship dynamics and their impact on smoking exposure and reduction.[20,21]

Figure 1. A Descriptive Model of the Cigarette Epidemic in Developed Countries.[3]



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What is Being Done at the International Level to Protect and Prevent Women from Adverse Tobacco-related Health Effects?

Women's health is increasingly being identified as a human right. Calls for sex and gender analyses and approaches are increasingly common. This is an important step towards improving tobacco protection, prevention and cessation for women and girls. Examples of particular instruments that can be used to advance women and tobacco issues are the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), The Kobe Declaration and the Framework Convention on Tobacco Control (FCTC).

CEDAW, adopted in 1979 by the United Nations General Assembly, requires that measures be taken to eliminate discrimination against women in health care and that a gender perspective be included in programs and policies affecting women's health.[22] In addition, the Kobe Declaration, adopted in 1999, states that tobacco control initiatives integrate the promotion of gender equality in society and that in doing so, women must be included as leaders.[22] The FCTC, mentioned earlier, recognizes the importance of a gendered approach to tobacco control initiatives.[22] As well, the International Network of Women Against Tobacco is a global organization that works with the WHO to achieve these goals and suggest strategies for advancing tobacco control.

Conclusion

Different countries are in different stages of the tobacco epidemic. In fact, when analyzed using sex and gender and diversity lenses, there are multiple tobacco epidemics underway, reflecting, among other things, biology and physiology, historical gender relations, government policies, socioeconomic conditions and the impact of the trans-national tobacco industry. Both national and global strategies are required to respond to specific contexts, while organizing and promoting tobacco control for men and women, boys and girls that includes prevention, protection and cessation. Overall, there is a need for further sex, gender and diversity analyses within research, program and policy development processes as they relate to tobacco control. As well, there is a need to widen policy approaches to include social justice and human rights approaches, which can empower women and reduce inequalities.[15] In countries where tobacco growing and processing occur, protective labour legislation is required for women working within the tobacco industry as well as viable alternative economic options. While the FCTC officially recognizes women's vulnerability to tobacco and promotes a gendered approach, it remains to be seen how these features of the FCTC will be implemented internationally.

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