10. How to Make Policies More Gender-Sensitive

Introduction

Although tobacco control policies have been on record since the late 1800s, most of the early tobacco control legislation focused on policies banning sales of tobacco to youth. For example, an 1890 District of Columbia ordinance prohibited the sale of cigarettes to minors in the United States,[1] and in 1900, smoking by persons under 20 years of age was prohibited in Japan, where the sale of cigarettes to minors was also banned.[2] Once the epidemiological evidence on the relationship between smoking and lung cancer and other diseases emerged,[3–6] tobacco control initiatives began to focus more broadly on prevention and cessation of smoking for the public's health.

Until recently, tobacco control initiatives did not reflect the population's diversity and did not specifically address women's concerns. Diversity was lacking in policy largely because it was missing in the early epidemiological research that fuelled such policy. Because the smoking epidemic started primarily among upper-class men in industrialized countries, men were hit first by its devastating health consequences, making them prime targets for research. At the time, women were considered a minority of the smoking population and were not of great interest to clinicians. As a result, a significant opportunity was lost in early research to study ways in which smoking might affect women's health. Because of this missing research demographic, most policies were crafted without concern for the rates of smoking or tobacco-related disease among women. Fortunately, this male-centred approach has since been challenged, and new directions are being sought.

This chapter examines a policy model for understanding the relationship between gender and tobacco control with a focus on women. In addition, it highlights the tobacco control policies of four countries—China, South Africa, Sweden, and the United Kingdom—to provide four distinct case-studies that depict the incorporation (or non-incorporation) of gender into health policy. These countries were selected because they exemplify industrialized and developing countries at differing stages of tobacco control programme development with varying rates of smoking prevalence among women.

South Africa and China represent expanding markets for the tobacco industry, and women are being specifically targeted by marketing efforts. Sweden provides an interesting case-study, as it is one of the few countries in which the smoking prevalence of women is higher than that of men.[7] Finally, the United Kingdom, though similar to other industrialized countries in terms of smoking prevalence rates, provides some contrast to those countries because of its relatively late adoption of stringent tobacco control policies.

While the four countries selected as case-studies in no way represent the full diversity of political, economic, and social contexts or the diversity of tobacco control policies, they do offer insights into ways in which the content of tobacco policies can address both gender inequality and women as a group. While there are considerable gaps in national data concerning the effects of tobacco control policies on women, current evidence points to interesting trends and advocacy issues for the future. Table 10.1 presents age-standardized smoking prevalence among adult (15 years and older) males and females in the four countries.

A Framework for Gender-Sensitive Policy

Gender has long been established as a major factor in women's health, affecting the occurrence, etiology, treatment, and eventual outcome of illness. The concept of gender refers specifically to men's and women's socially determined roles and responsibilities.[8,9] It is distinct from men's and women's biological and reproductive characteristics, because it is shaped by historical, cultural, economic, and political constructs. By definition, then, gender constructs can be changed and may permeate institutions as well as influence individual actions. It is important to note that the sex-based (or biology-based) differences between men and women also impact men's and women's morbidity and mortality.[9]

As described by Greaves and Jategaonkar[10] and in the chapter on a gender equality framework in this monograph, gender has become an important factor in smoking

behaviour. Historically, men have had higher rates of smoking prevalence than women. However, data from the Global Youth Tobacco Survey (GYTS) suggest that smoking rates of adolescent females are higher than those of adolescent males in the United States, as well as in some countries in Europe and South America. The survey also indicates women's differential exposure to second-hand smoke (SHS) in households and workplaces. In some settings, women may be unable to avoid environmental tobacco smoke because of power imbalances between men and women. There is also an interaction between socio-economic status (SES) and gender, which influences the motivations for smoking initiation and smoking cessation. This interaction underlies much of the current policy debate surrounding gender-sensitive policies.[10–14]

The tobacco control policies of the four countries examined in this chapter can be classified according to their gender sensitivity. According to Kabeer,[15] whose work has shaped much of the research and action on gender equality in the development field, the first step in analysis is to look at the different ways that gender is present or absent in policies.

Gender-blindness is the ignoring of the socially determined gender roles, responsibilities, and capabilities of men and women. Gender-blind policies, though they may appear to be unbiased, are often, in fact, based on information derived from men's activities and/or the assumption that women affected by the policies have the same needs and interests as men.[16] For example, policies that target a particular population of smokers (e.g. all smokers or young smokers) may be based exclusively on men's experiences and needs.

Table 10.1. Age-Standardized Current Tobacco Smoking Prevalence of Men and Women in China, South Africa, Sweden, and the United Kingdom

	Smoking prevalence (%)	
Country	**Men**	**Women**
China	59	4
South Africa	29	9
Sweden	17	23
United Kingdom	26	24

Source: Ref. 22.

Gender-blind policies, though they may appear to be unbiased, are often, in fact, based on information derived from men's activities and/or the assumption that all persons affected by the policies have the same needs and interests as males.

In contrast to gender-blind policies, *gender-sensitive policies* take gender relations into account. Kabeer's framework describes three types of gender-sensitive policies: gender-neutral, gender-specific, and gender-redistributive. Gender-sensitive policies take into account the different social roles of men and women that lead to women and men having different needs. The three types of policies are described below.

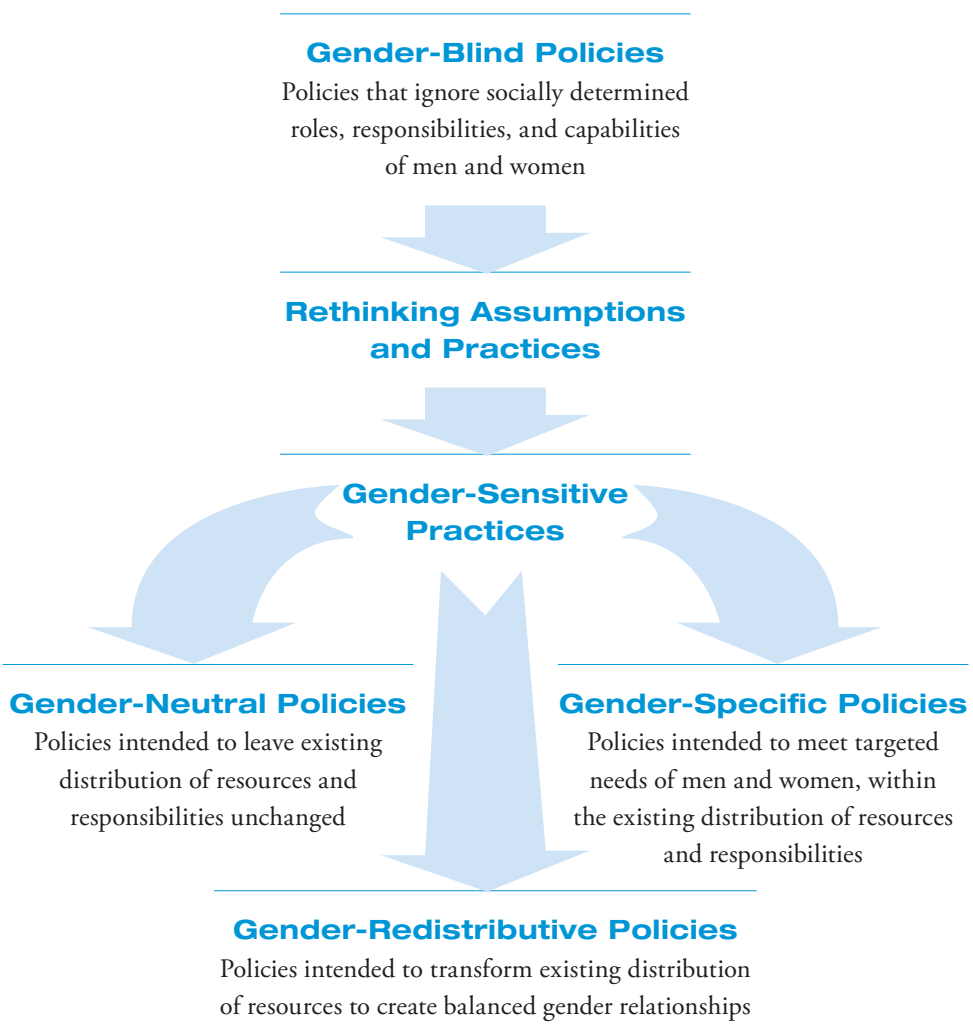
Gender-neutral policies are not aimed specifically at either men or women and are assumed to affect both sexes equally. A gender-neutral policy allocates resources to meet specific goals, such as reducing the number of young people who initiate smoking. Gender-neutral legislation could include the banning of tobacco advertising and control of SHS through regulation of smoking in public places and workplaces. Taxation of tobacco and restrictions on places where smoking is permitted may be viewed as gender-neutral policies. While these types of policies are gender-neutral by design, their impact may, in fact, be gendered.

Gender-specific policies acknowledge that women's gender-related needs have been neglected in the past and advocate on behalf of gender equality. Such policies identify specific strategies that are appropriate for women. Gender-specific tobacco control policies acknowledge the different socioeconomic and cultural factors that contribute to tobacco use among women, as compared with men. Under these policies, specific

programmes are implemented that address the needs and interests of women, while continuing to address the needs of men. For example, since health-worker interventions have proven effective in influencing clients to stop smoking, some tobacco control policies train health workers to use smoking cessation methods and messages that are specific to pregnant women. These programmes improve the health of both the women and their fetuses. Programmes that target pregnant women are by their nature gender-specific (owing to women's biological capacity for reproduction).[12]

Gender-redistributive policies recognize that because of political and economic inequality, women are often excluded or disadvantaged in terms of access to social and economic resources and involvement in decision-making. The goal of gender-redistributive policies is to rebalance the power structure to create a more balanced relationship between men and women. The policies therefore target both sexes, either simultaneously or separately. Implicit in gender-redistributive policies is the notion that they have the potential to "create supportive conditions for women to empower themselves".[17] For example, granting microcredit loans to women is a redistributive policy, as it changes the balance of financial resources between men and women in the household. Greaves and Tungohan[11] suggest that combining tobacco control with housing or child-care programmes has the potential to "transform gender relations", which is the ultimate goal of redistributive policies.

Figure 10.1. Kabeer's Framework for Gender-Sensitive Policies



Source: Adapted from March, Smyth, and Mukhopadhyay.[17]

It should be noted that in circumstances where the norm has been gender-blind policies, gender-neutral policies could represent a step forward. It is also possible that gender-redistributive policies may not be the best solution in all circumstances.[17]

Figure 10.1 presents a framework for Kabeer's gender-sensitive policies.

Ideally, tobacco control policy could lead to the transformation of gender relations in other domains. More often than not, however, tobacco policy tends to exploit existing gender relations or accommodate and reinforce them.[11] For example, tobacco control policies that specifically target women for "protection" can be viewed as paternalistic. Likewise, marketing that focuses on women's independence or liberation exploits existing gender inequalities. Programmes that target pregnant women or smoking at home in the presence of children can be viewed as accommodating and reinforcing women's traditional gender roles without doing anything to change them. Tobacco control has the potential to go beyond simply reducing women's vulnerabilities to tobacco and to move towards the achievement of greater gender equity.[11]

Gender-redistributive policies recognize that because of political and economic inequality, women are often excluded or disadvantaged in terms of access to social and economic resources and involvement in decision-making.

The WHO Framework Convention on Tobacco Control (WHO FCTC)[18,19] specifically calls for women's participation in policy-making and policy implementation. Articles 6–17 of the WHO FCTC[18] detail policy measures that should be enacted to reduce both the supply and demand of tobacco. The following discussion highlights the supply- and demand-side measures that provide the greatest opportunity for gender-sensitive policy development.

Measures Favouring Gender-Sensitive Policy Development

Price and Tax Measures

The effect of imposing taxes is indicated by price elasticity, a measure of change in consumption in response to a specified change in price. Depending on the population of smokers surveyed, the price elasticity of tobacco ranges from –0.4 to –0.8, meaning that a 10% increase in cigarette price will yield a 4% to 8% decrease in the number of cigarettes smoked.[20] Studies have shown that one of the clearest and most immediate influences on tobacco use is the price of tobacco products. Tobacco control policies that include taxation of tobacco products therefore reduce tobacco consumption.[21] This is elaborated in the chapter in this monograph on taxation and the economics of tobacco control.

Article 6 of the WHO FCTC[18] encourages Parties to adopt price and tax measures as an "effective and important means of reducing tobacco consumption by various segments of the population". The treaty is very direct in saying that this measure is intended to curtail smoking among young people who are most sensitive to price changes. Studies from the United States confirm the consistent price sensitivity of young people. The fact that young female smokers outnumber young male smokers in many industrialized countries indicates that young women are substantially affected by increases in tobacco prices.[22]

Adults are also affected by increasing cigarette prices. Although evidence is mixed as to whether adult women are more sensitive than men to changes in price, it is clear that individuals from lower socioeconomic backgrounds are more price-sensitive than their wealthier counterparts. In the United States, adolescent males are more sensitive to price than adolescent females are, while in the United Kingdom, females are more sensitive to price. In the lowest socioeconomic groups, smoking prevalence among both males and females is correlated with the price of tobacco products.[23]

Although measures to increase tobacco prices are applied equally to men and women (i.e. are gender-neutral), it is important to recognize that the consequences of such

measures are gender-specific—more women than men are affected by increasing prices, because a greater proportion of the poor are women.[24] Greaves and Tungohan[11] suggest that in addition to assistance in implementing taxes or raising prices, assistance with cessation or social support to ensure that addicted women are not doubly disadvantaged by gender and income inequalities should be included as countries implement the provisions of the WHO FCTC.

All four of the countries examined in this chapter have some form of consumer-incurred tobacco tax, but the degree to which taxation is used as a tobacco control measure varies greatly. Sweden increased taxes on tobacco in 1996 and 1997, and consumption decreased with each increase in price. Taxation was reduced in 1998, however, because of a perceived increase in smuggling (and a lack of public support for the tax increases).[25] Interestingly and somewhat unexpectedly, the overall prevalence of smoking remained similar in the years before and after the tax repeal (19.1% in 1998 and 19.3% in 1999) and continued to decrease through 2005.[26]

Limiting cigarette consumption by increasing taxation was the primary focus of South Africa's first tobacco control strategy in the 1990s.[27] In South Africa and the United Kingdom, consumption decreased with an increase in taxation that raised the real price of cigarettes.[28] However, changes in consumption were not compared across sex and age. An oversight in the taxation policy in South Africa is the exclusion of snuff, which is used primarily by rural women.

China, the largest grower of tobacco leaf in the world, has been reluctant to increase tobacco taxes for fear of damaging its own economy. At present, China has some of the world's lowest taxes on tobacco products.[22] The Chinese government has acknowledged the health risks of smoking and has discussed a variety of tobacco control options (e.g. bans on advertising) but has failed to increase tobacco taxes to reduce consumption.[29] Upon ratifying the WHO FCTC, the Chinese government issued a statement indicating that non-price measures would be its first tobacco control priority.

Protection from Exposure to Tobacco Smoke

In countries where smoking rates are high among men and low among women, such as some countries in Asia and Africa, women are more likely than men to be exposed involuntarily to tobacco smoke and to be at increased risk for a number of smoking-related diseases. This issue is described in the chapter on SHS in this monograph.

Article 8 of the WHO FCTC[18] calls upon Parties to provide protection from SHS in public transport, indoor workplaces, indoor public places, and other public areas. Some advocates question the effectiveness of restrictions on smoking in public places and workplaces in countries where women traditionally do not work outside the home. While regulations affecting public places may not appear to affect women's exposure to smoke in the home, such restrictions can create a social climate in which it is not acceptable to smoke indoors.[30,31] This can empower non-smoking women to limit smoking in their homes. Education aimed at male smokers is still needed to increase awareness of the health risks to their families from SHS.

While regulations affecting public places may not appear to affect women's exposure to smoke in the home, such restrictions can create a social climate in which it is not acceptable to smoke indoors.

In 1993, the Swedish Tobacco Act called for smoke-free workplaces, although special smoking rooms were permitted in most cases.[32] In 2004, an amendment to this act was passed whereby restaurants and bars were required to be smoke-free by 2005, with the option of building separately ventilated smoking rooms. By 2005, smoking bans were in place in health-care facilities, educational facilities, government facilities, restaurants, pubs and bars, indoor workplaces and offices, theatres, and cinemas.[32]

China's 1991 Tobacco Monopoly Act requires smoking to be banned or restricted on public transport and in transport-related public places. The 1991 Act for Protection of Minors also bans smoking in the classrooms and dormitories of middle schools, elementary schools, and kindergartens.[33] Federal legislation in China is generally very weak, by international standards, and

is not strongly enforced. Therefore, many municipalities have taken it upon themselves to introduce and monitor their own smoking bans. By 1996, more than 70 cities in China had introduced piecemeal legislation to ban smoking in places such as theatres, video halls, music venues, indoor sports stadia, reading rooms, exhibition halls, shopping malls, waiting rooms, public transport, schools, and nurseries.[34] By October 2006, 46% of Chinese cities had bans on public smoking that were more stringent than the national law.[33] Unfortunately, the rationale behind these efforts may not be reaching the general population. A 2007 study of low-income workers found that only 25% were aware of the dangers of passive smoking, despite the fact that most of the workers surveyed were subject to workplace smoking restrictions.[35] Workplace smoking has not been addressed by the Chinese government, either federally or locally, although some groups (e.g. health-care institutions) have adopted voluntary smoke-free policies. There were plans for a "smoke-free Olympics" in Beijing in 2008,[36] but reports leading up to the games indicated that legislators had created sizeable exemptions (e.g. for bars and restaurants).[37]

The United Kingdom's *Smoking Kills: A White Paper on Tobacco*[38] revealed that smoking restrictions in public places were weak in the 1990s. At the time, the United Kingdom's tobacco control policy placed greater emphasis on the individual's right to smoke than on health. However, some underground trains, buses, aboveground trains, workplaces, shops, banks, and post offices went smoke-free (despite the lack of national regulation) in response to customer demands.[31] Bans on smoking in public places changed dramatically when the Republic of Ireland went smoke-free in 2004.[39] Scientific studies quickly assuaged fears that smoking was being driven "inside the home" by demonstrating that in-home smoking rates were no different between Ireland and the United Kingdom.[40] Scotland, Wales, Northern Ireland, and England became smoke-free soon afterwards, each having a comprehensive ban in effect by 2007.[41]

South Africa's 1993 Tobacco Products Control Act (implemented in 1995) banned smoking on public transport.[42] A 1999 amendment included bans on smoking in workplaces; currently, South Africa bans smoking in all public places except bars and restaurants.[22]

Packaging and Labelling of Tobacco Products

Mandatory health warnings on cigarette packages are used to alert the public to the dangers of tobacco use. Article 11 of the WHO FCTC describes the treaty's requirements for the packaging and labelling of tobacco products.[18] Within three years of signing the WHO FCTC, Parties are required to provide health warnings that cover a minimum of 30% of tobacco-product packaging and to remove misleading package labels that imply "healthier" products (e.g. "low tar" or "light"). So-called "health-conscious" tobacco products are more likely to be adopted by women, suggesting that removal of these misleading labels will have a greater impact on women.[43] Additionally, because the majority of the world's illiterate population is female,[44] the policies created regarding tobacco packaging and labelling should include pictorial or other non-written messaging in order to be gender-sensitive.

Iceland and Canada led the world in the incorporation of pictograms into tobacco package warnings.[31] The European Union has given each of its 25 countries the option to include pictorial warnings on cigarette packages. Accordingly, the United Kingdom developed its own pictograms that went into effect in October 2008.[45] Seventeen countries have adopted pictograms, including some developing nations, such as India, Brazil, and Jordan.[45] This has great implications for women's access to health messages in these countries.

South Africa also requires health warnings on packages of cigarettes.[46] Examples include "Smoking causes lung cancer" and "Smoking is addictive". These warnings attempt to reach broad audiences.

China's first anti-tobacco law, which went into effect in January 1992, mandated the printing of tar levels and health warnings on domestic and imported cigarettes. Even the most ardent Chinese tobacco control advocates are reluctant to see graphic warning labels on cigarette packages, however, for fear that "ugly pictures would mar the packs traditionally given as presents to wedding guests".[36] Nevertheless, by signing the WHO FCTC, China agreed that by 2008, clear health warnings would occupy more than 30% of the surface of every cigarette pack sold.

Education, Communication, Training, and Public Awareness

Article 12 of the WHO FCTC[18] promotes public information, training, and education campaigns. Specifically, it imposes a legal obligation on Parties to promote access to information about the dangers of tobacco consumption and the benefits of cessation. Public awareness efforts can target specific groups, including children, young adults, and pregnant women. Because men and women cite different motivations for smoking initiation and because adolescent males and females have different predictors for initiation,[47] there is good reason to believe that prevention messages should be gender-specific. This is not to say that entire programmes must be gender-specific, but health professionals (i.e. instructors and clinicians) should understand the gender differences in smoking initiation, so that prevention efforts can be maximized. Hoving et al.[47] point to the need for continuing to teach girls skills that will build self-efficacy and allow them to resist social pressure; boys may need more messages regarding the negative consequences of smoking and may need programmes that simultaneously target other risk-taking behaviours such as alcohol consumption.

In addition to different initiation rates and rationales, other gender differences must be addressed by national education and health-worker training programmes. As Greaves and Tungohan suggest,[11] the substantially higher illiteracy rates among women in developing nations may prevent women from accessing messages about the risks of using tobacco products. They suggest that tobacco control programmes should work with organizations that promote female literacy to ensure that appropriate messages are developed and transmitted via multiple types of media.[11]

Policies in all four of our case-study countries include health promotion. Unlike anti-tobacco laws and regulations, which require small amounts of money for monitoring and evaluation, health education programmes can be very costly. The state of prevention programmes, educational efforts, and health-worker training in the four countries varies greatly, largely as a result of the financial resources available (or made available) for tobacco control.

Sweden's strong tobacco health education activities include school-based programmes about the health hazards of tobacco use and public awareness campaigns revolving around the annual World No Tobacco Day and the national non-smoking day.[7]

Before the publication of its white paper on tobacco in 1998, the UK government allocated resources to various health education agencies for anti-tobacco campaigns.[48] The white paper outlined extensive health-promotion activities, including mass media and education campaigns. The latter included the training of health workers and teachers through initiatives such as the Healthy Schools Campaign. The United Kingdom also has a highly successful national public awareness campaign to help people quit smoking—the annual UK No Smoking Day, which is now in its twenty-fifth year.[31]

In South Africa, a number of health education efforts have been undertaken to prevent smoking. In 2002, the National Council Against Smoking sponsored a "Quit & Win" campaign that awarded substantial prizes to a pool of eligible former smokers, all of whom had successfully quit smoking for at least four weeks.[49] The National Council Against Smoking also runs a tobacco/health information hotline and provides online advice regarding smoking cessation.

In 2005, cigarette sales in China generated US$ 32.5 billion in taxes and profits, yet the national government spent less than US$ 31 000 on tobacco control measures, including national public awareness campaigns.[36] Although China did participate in the 21st annual World No Tobacco Day in 2008 by asking taxi drivers to post no-smoking signs in their windows,[50] it is difficult to identify other nationally guided smoking prevention programmes.

Health promotion is a key area for the implementation of gender-sensitive policy. Unlike laws and regulations that must be gender-neutral in design and application, health promotion has the distinction of being able to purposefully target gender differences in smoking initiation rationales in order to maximize prevention efforts. For example, women are the focus of gender-specific programmes such as Scotland's Women, Low Income, and Smoking project.[38] Given the higher rates of smoking among women in Sweden, several health education programmes there also specifically target women. Sweden has published self-help manuals for different target audiences, including pregnant women, parents, young girls, and older women, which touch upon topics such as how to give up smoking

without gaining weight.[51] Since 1996, all candidates for the title of Miss Sweden have had to be non-smokers.[52] The finalists for the competition receive training from the Swedish National Institute of Public Health about how to convey anti-smoking messages to children on their tours of local schools.[53]

Some women's groups have raised objections to focusing women's anti-smoking programmes solely on pregnant women, noting that too often the motivation for such targeting has not been the reduction of smoking among women, but rather the protection of the fetus.

Tobacco Advertising, Promotion, and Sponsorship

Article 13 of the WHO FCTC mandates that Parties undertake a comprehensive ban or, in cases of constitutional limitations, a restriction of all tobacco advertising, promotion, and sponsorship.[18] Evidence suggests that in both industrialized and developing countries, advertising bans have a negative effect on tobacco consumption: decreases of approximately 6% have occurred when comprehensive advertising restrictions are in place.[54] Partial advertising restrictions have little to no effect on overall smoking consumption, because the tobacco industry quickly shifts marketing efforts to non-restricted media.[54,55] Advertising restrictions are gender-neutral in their design, but because of the specific targeting of women by the tobacco industry, the restrictions may in fact be gender-sensitive in their effect.

Tobacco advertising on Chinese television and radio and in magazines was banned in 1992, but the restriction only encouraged tobacco companies to shift marketing funds into non-restricted areas, such as sponsorship of sports, art, and music.[56] The 1996 Prevalence Survey of Smoking in China specifically highlighted the need to maintain low smoking rates among women through aggressive campaigns to counter the targeting of women by the tobacco industry.[34] However, it is not clear that any campaigns have been successful. China still permits a variety of advertising avenues that are considered highly female-targeted, including the free distribution of tobacco products by mail, promotional discounts on tobacco products, and the branding of non-tobacco products with tobacco brand names.[22] All forms of tobacco advertising will be banned in China by 2010.[36]

South Africa has never permitted the direct advertising of cigarettes on television, and it also bans tobacco advertising in local and international magazines and newspapers.[22] Industry-sponsored sports and music events, such as Rothman's soccer, circumvented the television advertising bans until 1999, when South Africa's Tobacco Control Act of 1993 was amended to include bans on all tobacco advertisements, including indirect advertising and promotional events.[42] The proposed 2008 amendment to the Tobacco Control Act further restricts advertising and increases the fines for those failing to meet the requirements of the Act.[57]

Sweden's first restrictions on tobacco advertising were introduced in the 1960s. These included the restriction of advertising in theatres, cinemas, sports arenas, and sporting events and on sports pages in magazines and newspapers. In the 1970s, tobacco companies were forbidden to use human models in their advertisements. By the end of that decade, health warnings became mandatory on advertisements for tobacco products, and the advertising of tobacco products on national television and radio was banned. Sweden, like the rest of Europe, still has not banned advertising on international television and radio. Although Sweden does not allow the free distribution of tobacco products or the branding of non-tobacco products with tobacco brand names, it does allow for promotional discounts on tobacco products.[22]

The United Kingdom originally banned the advertisement of cigarettes on television in 1964, and it banned such advertising on the radio in 1973. Successive governments wanted to follow a voluntary approach, but more recently, between 2002 and 2005, the United

Kingdom phased in an advertising and sponsorship ban. This new ban forbids billboard and press advertising and extends to the sponsorship of sports. Unlike Sweden, the United Kingdom bans promotional discounts on tobacco products.[22]

A total ban on the advertising of and sponsorship by tobacco products reduces smoking in most groups, making it a gender-neutral policy. But since it is clear from tobacco industry documents that women are being specifically targeted, enforcement of a complete ban on advertising and promotion across all tobacco products and in all media is recommended as an integral part of a comprehensive, gender-sensitive tobacco control policy.

Tobacco Dependence and Cessation Measures

Article 14 of the WHO FCTC encourages Parties to design and implement effective programmes aimed at promoting the cessation of tobacco use. While the treaty does not specifically mention the need for gender sensitivity in such programmes, current research indicates that gender-specific cessation messages, counselling services, and health-worker training may be as important as prevention activities. Although nicotine dependency is equally strong in men and women, the difficulty of smoking cessation does appear to differ by gender. Women report using cigarettes more frequently with other women, meaning that group dynamics and a desire for socialization may hinder the quitting process for women. Additionally, studies show that women report greater fears of weight gain associated with quitting and have higher rates of depression, which may create additional barriers to cessation.[58] These differences demonstrate the need for gender-specific cessation programmes that target the quitting "hurdles" unique to women.

Some women's groups have raised objections to focusing women's anti-smoking programmes solely on pregnant women, noting that too often the motivation for such targeting has not been the reduction of smoking among women, but rather the protection of the fetus. Women are thus considered only in their procreative role. As a result, programmes that aim to reduce smoking by pregnant women have sometimes been labelled as "victim blaming", and their designers have been accused of using guilt to encourage women to stop smoking. Nevertheless, programmes that seek to integrate pregnant women into larger cessation efforts are highly effective in reducing the number of women who smoke during pregnancy. In 2003, fewer than 10% of Swedish women reported smoking daily during pregnancy, a reduction of more than 50% from the level in the 1990s.[59]

The 1998 UK white paper recognized the need to provide support to prevent relapse into smoking by mothers after a baby's birth.[38] The UK policy increasingly seeks to encourage women to quit smoking during pregnancy as a way of breaking the cycle of health inequalities, since the vast majority of these women smokers are poor, young, and undereducated. The government tries to reach them through the National Health Service's Stop Smoking Services, as well as through social programmes that target infant and child health and development, such as Sure Start. Stop Smoking Services were launched countrywide in 2000 and 2001; they include a national help line, a dedicated web site, the provision of cessation prescriptions, and one-on-one counselling and support groups in local centres.[60] The annual 2004–2005 expenditure on this programme was £46.8 million, excluding the cost of prescriptions. Despite such a strong government stance on smoking cessation, the Service has been called to task for its failure to provide adequate services to underage smokers, of whom females constitute the majority. A 2003 survey found that fewer than 7% of all service providers in England accepted referrals from underage smokers,[61] indicating that beliefs about "propriety" may be overshadowing public health needs.

State funding for cessation programmes is nonexistent in China. The US$ 31 000 the Chinese government spent on tobacco control in 2005 was intended for prevention and cessation programming[36] for the country's 1.3 billion residents. The overwhelming majority of the poor are uninsured and rely on out-of-pocket payments for health care,[35] making cessation programmes somewhat of a luxury. One study of smoking cessation among lower-income Chinese workers found that of 333 former smokers, none had used nicotine replacement therapy.[35] Additionally, a study of female microelectronics workers found that the "smoking culture" of the workplace applies to women in much the same way that it applies to men, with rates of smoking increasing among blue-collar working women.[62]

Both studies indicate that much more needs to be done in China to increase support for smokers who want to quit, and there is a very specific niche for workplace cessation programmes, which have the potential to impact vulnerable women.

Currently, 55% of all tobacco leaf is grown by only three countries—China, Brazil, and India. The effects of this shift are gendered in nature, with women being most vulnerable to the health and economic harms of tobacco production.

Reducing the number of women who smoke during pregnancy is an important public health intervention, and policies targeting pregnant women are gender-sensitive. Pregnancy is a good entry point for reaching women and their partners who smoke, but support in maintaining cessation after birth should be an integral part of cessation programmes. Women need gender-sensitive programmes that focus on their entire lifespan, not solely on their reproductive lifespan. Moreover, additional strategies that target young women and non-pregnant women must be developed.

Sales of Tobacco To and By Minors

Article 16 of the WHO FCTC includes a variety of policy recommendations intended to limit youth access to tobacco. The policies include the restriction of direct sales to minors, requiring identification when making sales, and prohibition of tobacco vending machines. This Article also includes policies that are not minor-specific but do seek to limit the ease of access and appeal of cigarettes to youth. These policies restrict the sale of individual cigarettes, prohibit the distribution of free tobacco products, and ban the manufacturing of sweets and toys in the form of tobacco products (e.g. candy cigarettes). Although the policies are gender-neutral in design, their successful implementation can produce gendered results. Studies show that underage females are less likely to attempt to purchase cigarettes than their male peers are, but these same studies also show that females are more likely to be successful in such purchases if they are attempted.[10] In this example, the strong enforcement of identification laws would be gender-neutral in application but gender-sensitive in result.

South Africa's first tobacco control act, implemented in 1995, included the banning of cigarette sales to youth.[42] The 2008 amendment further elaborates on the restriction of cigarette sales to persons under 16 years of age.[57]

A UK law has restricted the supply of tobacco to young people since 1908. Under current legislation in the Children and Young Persons (Protection from Tobacco) Act of 1991, it is against the law to sell tobacco to anyone under 16 years of age.[60]

A minimum-age law was passed in Sweden in 1997, restricting tobacco purchases to persons 18 years of age and older.[63] A study comparing students before and after the law was enacted found that after enactment, all adolescents reported greater difficulty in buying tobacco near their homes, but only adolescent females reported a statistically significant decrease in tobacco purchases. Unfortunately, the proportion of adolescents who bought tobacco from friends increased during the same time period.

As of 2006, no federal law prohibited the sale of tobacco products to minors in China, although many local municipalities have addressed the issue with their own regulations.[64] The existence of local restrictions, however, does not imply widespread knowledge of them. In Wuhan province, a survey found that only 23% of parents of high-school students were aware that Wuhan had a law prohibiting the sale of cigarettes to adolescents.[65] Cigarette use by young people is considered normal in China, since children are often asked to buy cigarettes for their parents, and they are often given cigarettes as gifts on special occasions.

Support for Economically Viable Alternatives to Tobacco Production

Tobacco production has shifted primarily to lower- and middle-income countries and affects the millions of

poor women working in tobacco production. Currently, 55% of all tobacco leaf is grown by only three countries—China, Brazil, and India.[66] The effects of this shift are gendered in nature, with women being most vulnerable to the health and economic harms of tobacco production.[11,67] It is noteworthy that Article 17 of the WHO FCTC calls upon Parties to "promote, as appropriate, economically viable alternatives for tobacco workers, growers and, as the case may be, sellers".[18]

Surveys that analyse the revenue-to-cost ratio of various crops show that tobacco farming is far from the most lucrative option for Chinese farmers. Fruit, mulberries, silkworms, rice, wheat, vegetable oil, and beans all have higher revenue-to-cost ratios than tobacco, indicating that tobacco may not always produce the best economic returns for China. According to Hu et al.,[29] "this is a prime time for the Chinese government to encourage less profitable tobacco farmers to produce other crops".

As members of the European Union, Sweden and the United Kingdom operate under the jurisdiction of the Common Agriculture Policy of 2003. This policy eliminated a system of product-specific farm subsidies (e.g. subsidies provided to farmers based on the quantity of tobacco they produced) and now provides single-farm subsidies that are product-blind. The overall goal is to allow producers to adjust to a situation in which product support will be phased out. The transition from tobacco-specific subsidies to "decoupled" subsidies is gradual, and it is hoped that farmers will adjust their crop selection accordingly for maximum profit.[66]

According to a Campaign for Tobacco-Free Kids report, the world's excess tobacco production is driving many families into deep poverty.[67] Family farms that contract with tobacco companies for advance purchases of seed and fertilizer are then bound to sell their crops to those same companies for very low "market" prices—barely enough to pay off the debts they accrued prior to planting. The tobacco industry works throughout developing countries to convince farmers to grow tobacco exclusively. As a result, rates of malnutrition among children have increased in tobacco-growing regions of Kenya, for example, because families are planting tobacco instead of traditional food crops in the hope of escaping poverty.

Additionally, tobacco-leaf companies in Brazil have specifically requested that school systems shorten their terms to permit children to help their families in the field.[67] In countries where disparities in schooling and nutrition already exist between boys and girls, tobacco farms will only exaggerate the problem. In all these tobacco-producing countries, alternatives to growing tobacco have great potential for changing the educational, economic, and health prospects of women.

Given that the WHO FCTC entered into force in February 2005, the question remains as to whether countries have successfully incorporated its call for gender sensitivity into their national programmes and policies.

Conclusion

Given that the WHO FCTC entered into force in February 2005, the question remains as to whether countries have successfully incorporated its call for gender sensitivity into their national programmes and policies. Monitoring and evaluation will be the key to making such a determination. Specifically, monitoring and evaluation efforts *must* include collection of sex-disaggregated data on the initiation, maintenance, and cessation of tobacco use at the national level. Findings that reveal gender differences must then be used to inform research and to strengthen or modify existing policies and programmes.

The WHO FCTC has been a major accomplishment for international tobacco control. In the four countries examined here, ratification of the treaty has clearly brought a new commitment to tobacco control policy and programme creation and implementation. Even before these countries became Parties to the treaty, all four made progress in strengthening national legislation in many areas of tobacco control, including advertising and promotion, exposure to SHS, and information, education and communication.

The four countries offer insights into how the content of tobacco policies can ignore or address both gender inequality and women as a group. These countries have achieved varying degrees of gender sensitivity in their policies: all have a variety of gender-neutral policies (e.g. advertising bans), and all have at least some gender-specific policies. Sweden appears to have the most gender-specific policies and programmes, e.g. programmes targeting pregnant women for smoking cessation. The challenge for China will be to address smoking among vulnerable groups. In addition, the four case-studies highlight the fact that the design of policies may often be gender-neutral, while the impact of those policies may be highly gendered, affecting women more than men. Advertising bans are an excellent example of this. Although advertising restrictions are applied equally to both men and women, some measures will have a greater likelihood of decreasing smoking prevalence among women, based on gender norms, roles, and relations.

In some realms, it may be appropriate to expect gender-redistributive policies, but movement from gender-blind to gender-neutral policies and from gender-neutral to gender-specific policies may be more readily attainable and should be considered progress in the area of tobacco control.[10]

While it is not the focus of this chapter, there is clear evidence that tobacco control policies and programmes should be developed that include strong consideration of SES, in addition to gender.[68,69] Graham et al.[69] suggest that women's smoking status in developing countries is influenced by "biographies of disadvantage". Women's initiation of smoking, persistence, and cessation are influenced by childhood disadvantage, educational trajectories, and reproductive careers. Graham et al. suggest that policies regarding tobacco control need to focus on these social conditions that affect smoking status. Greaves, Vallone, and Velicer[12] suggest the use of gender-redistributive policies that link "housing, welfare, child-care, training and economic policies and programmes" to address the needs of low-SES women and girls.

Finally, in the implementation of Article 20 of the WHO FCTC related to research, surveillance, and exchange of information, there is a need for research on the development and implementation of tobacco control policies that are gender-specific with a focus on women. More case-studies related to how gender policies are financed, monitored, and evaluated will help guide policy-makers as the WHO FCTC is implemented. The active participation of gender experts in policy-related research will also enrich the knowledge concerning how tobacco control can benefit women as well as men of all ages.

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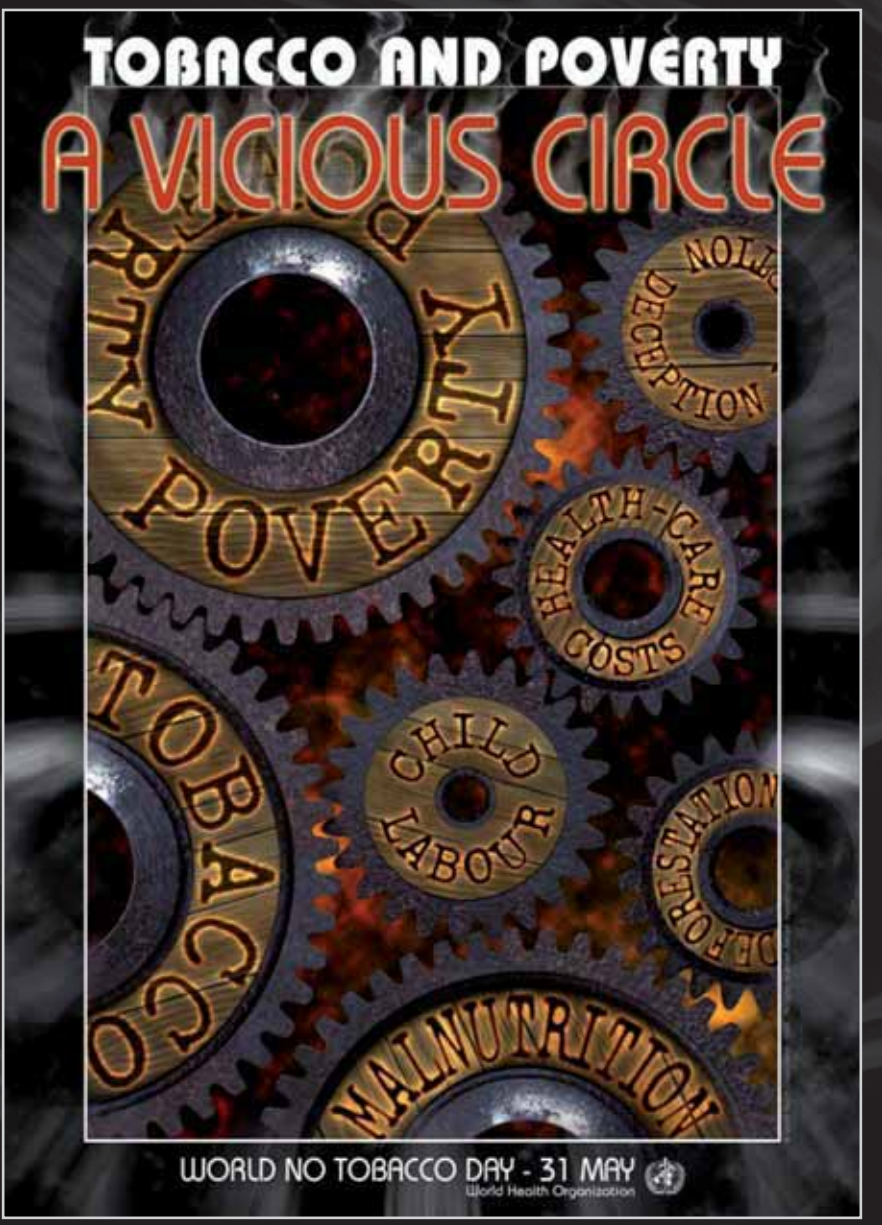
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11. Taxation and the Economics of Tobacco Control

Introduction

The relevance of economic research and analysis to tobacco control, whether directed at the general population or specifically at women, is becoming increasingly understood. The World Health Organization (WHO) 2009 report on the global tobacco epidemic noted, "While more data and analysis are needed on tobacco's costs and economic burden, it is clear that its economic impact on productivity and health care—already disproportionately felt by the poor—will worsen as tobacco use increases".[1] This chapter highlights findings and presents a gender analysis with a focus on women where data are available. Specifically, it reviews costs of tobacco use and the global evidence of the effects of taxation on the consumption of tobacco, in particular the effects of taxes on smoking. Little research on the economic aspects of tobacco has focused specifically on gender and women or the wide range of tobacco products used, including chewing tobacco, snuff, and bidis. Indeed, in some areas of the world, women and men use other tobacco products more than they use cigarettes. For example, in India, 12% of women chew tobacco, whereas only 2.4% of women smoke manufactured cigarettes.[2] Because many economic concepts, policies, and practices are relevant to a gender analysis, they are presented here to identify gaps needing to be addressed in further research.

Regardless of which subgroup is targeted, tobacco control programmes need to address the economic forces influencing tobacco production and consumption, including the role that tobacco production and sales play in employment, tax revenues, and trade balances in some countries. Tobacco control policies also need to acknowledge the health effects and other costs of tobacco use and to incorporate measures to reduce demand through higher prices. Debate continues about several aspects of the economics related to the consumption of tobacco, including concerns about the equity and efficiency of cigarette taxation.

The first section of this chapter discusses the costs of tobacco consumption. This topic is relevant to millions of women, particularly in developing countries, because tobacco use exacerbates poverty conditions and negatively affects women's roles as family providers. The costs of treating tobacco-related illnesses and the resulting loss of productivity are leading economic arguments for tobacco control policies. This is especially true for the costs related to illnesses caused by exposure to second-hand smoke (SHS)—costs that are borne by both those exposed to SHS and society in general.

The costs of treating tobacco-related illnesses and the resulting loss of productivity are leading economic arguments for tobacco control policies.

The second section covers various issues concerning taxation and price. Although taxation is a "blunt" instrument that may not have a gender-specific goal, it influences women's consumer behaviour and is an important source of revenue for governments and public health programmes.

Costs of Tobacco

Costs of Tobacco Consumption

From a policy perspective, it is important to understand how to maintain women's relatively low smoking rates in the face of greater female autonomy, higher incomes, increased female labour force participation, and increased marketing efforts by tobacco companies in low- and middle-income countries. Moreover, it is imperative to understand how to decrease women's tobacco use and the costs imposed by tobacco use in countries that have higher prevalence of female tobacco use.

As noted in the chapter on a gender equality framework, tobacco use undermines progress made in social and economic development and creates hardship for the millions of people in the world who live in poverty, the majority of whom are women. Women worldwide are

the main producers of food, while also being home-care providers and caregivers of children. Tobacco-related diseases impose serious burdens on their care responsibilities, and the costs of care compete for scarce resources needed to feed families. When mothers of young children die from tobacco-related diseases, the loss is social as well as economic. Within the household, expenditures for tobacco may reduce the resources available for necessities, including food and clothing. Tobacco use, in short, is a development issue with economic costs.

At the household level, in Indonesia, where smoking is most common among the poor, 15% of the total expenditure of the lowest income group is for tobacco, while the poorest 20% of households in Mexico spend nearly 11%.

The health costs of tobacco use fall into two broad categories: the financial consequences of tobacco use for health care, life insurance, pensions, and other collective programmes; and the health costs associated with exposure to SHS, which is also referred to as environmental tobacco smoke (ETS).[3] The indirect and intangible psychological costs of pain and suffering arising from smoking-caused disease are particularly difficult to quantify.

Estimates of the treatment costs and productivity losses associated with diseases caused by smoking provide potentially powerful evidence for implementing tobacco control. These costs are borne by individuals and society, generally consequent to the sale of an addicting product for profit. A societal perspective—including individuals, households, employers, government, and society in general—is the most comprehensive perspective. However, data limitations restrict many costing studies to specific perspectives, such as the health-care system, government, or households.

Cost estimates vary by the categories of costs included. One key distinction is between *direct* costs—including payment for tobacco products and medical care—and *indirect* costs, which include forgone earnings due to inability to work and productivity losses at the societal level. How deaths that are causally related to smoking are treated is a sensitive methodological point. If smokers die prematurely, there can be a "death benefit" in terms of saved pension costs. However, moral objections aside, these savings are counterbalanced by forgone productivity and increased costs of medical treatment while smokers are alive.

Productivity losses, including lost wages due to time off work for smokers and their caregivers and lower quality of life due to smoking-related illnesses, represent a substantial category of costs. For example, a study using household survey data from the 2005 Albania Living Standards Monitoring Survey found that after controlling for other observable factors, smokers' wages were 20% lower than those of similar non-smokers.[4]

Data from other countries also provide a basis for concern. The WHO report on the global tobacco epidemic notes that in the United States in 2008, the economic costs related to tobacco use approximated US$ 193 billion per year.[1] In China, the economic costs of smoking were estimated to be US$ 5.0 billion in 2000, equivalent to US$ 25.43 per smoker over the age of 35. Direct costs accounted for US$ 1.7 billion (34% of the total), equivalent to 3.1% of total national health spending in China. Productivity losses related to illness amounted to US$ 0.4 billion (8%), and productivity losses caused by death were US$ 2.9 billion (58%). The direct costs of smoking accounted for an estimated 3.1% of China's national health expenditures in 2000.[5]

A study conducted in the United States found that smoking-attributable neonatal costs were almost US$ 367 million (in 1996 dollars).[6] This estimate implies that a mother who smokes incurs additional neonatal costs of more than US$ 700 (in 1996 dollars). As discussed in the chapter on the impact of tobacco use on women's health, women who smoke during pregnancy are at increased risk of premature rupture of membranes, abruptio placentae, placenta previa, and pre-term delivery. Moreover, infants of mothers who smoke during pregnancy are more likely to have lower average birth weight, are more likely to be small for gestational age, and are at increased risk of

stillbirth and perinatal mortality than are the infants of non-smoking women.

As the chapter on a gender equality framework for tobacco control notes, tobacco production causes diseases among agricultural workers, many of whom are women. The diseases include acute nicotine poisoning, known as green tobacco sickness. These health ailments tend to be more common in developing countries, where regulation of tobacco companies for the protection of farmers may be weak or poorly enforced. Tobacco-related diseases in conjunction with injuries incurred while farming impose significant costs on agricultural workers. While the evidence on disease and injury costs is scant, one study conducted in Kentucky between 1992 and 1999 found that hospital costs for tobacco workers averaged US$ 403.[7] Physician fees, rehabilitation charges, and other fees related to injuries were not included in the assessment, so this estimate of the health-care cost of treating tobacco workers should be considered conservative. Much more attention needs to be paid to the costs of health care for tobacco-related diseases among women tobacco workers in developing countries.

Costs of Exposure to Second-Hand Smoke

In the chapter on SHS, the authors state that the majority of victims of SHS, particularly in developing countries, are women and children. The costs of SHS exposure are thus very relevant to a gender perspective on tobacco control. While the costs of medical treatment for smoking-related illnesses are well documented, the economic impact of SHS on health-care costs is less well understood. The 2006 US Surgeon General's report documents in detail the evidence causally linking specific medical conditions to exposure to SHS.[8] In Minnesota, the cost of direct medical treatment for conditions for which the Surgeon General's Office found sufficient evidence to conclude that there was a causal link with exposure to SHS, including lung cancer and coronary heart disease, was estimated to be US$ 228.7 million (in 2008 dollars), equivalent to US$ 44.58 per Minnesota resident.[9]

A study in China, Hong Kong Special Administrative Region, found that the total costs associated with SHS—including direct medical costs, long-term care, and productivity losses—were US$ 156 million in 1998, for a population of 6.5 million. A study in Marion County, Indiana, found that costs related to health care and premature loss of life totalled US$ 53.9 million, equivalent to US$ 62.68 per capita annually.[10]

A report from the American Society of Actuaries calculated that US$ 2.6 billion was spent on non-smokers in the United States for medical care for lung cancer and heart disease (including heart attacks) caused by exposure to SHS.

A report from the American Society of Actuaries calculated that in 2004, billions of dollars were spent on non-smokers in the United States for medical care for lung cancer and heart disease (including heart attacks) caused by exposure to SHS. The report calculated that exposure to SHS resulted in an additional US$ 3.2 billion of economic losses—including lost wages, benefits, and household services—to individuals and governments. On a per capita basis, this is equivalent to US$ 9.02 for medical care and US$ 11.10 for additional economic losses.[11,12] More research is needed on such costs related to women and men in developing countries.

As discussed in the section below on smoking and pregnancy, many studies have found that exposure of non-smoking pregnant women to SHS is associated with negative consequences,[13] including decreased average mean birth weight, which has been associated with increased costs.[14] A study in New York City calculated annual costs of US$ 99 million related to infants' developmental delays caused by prenatal exposure to SHS.[15]

Why Tax Tobacco Products?

Given the economic burden that tobacco use places on societies, policy-makers have increasingly looked to

economists to provide input into public health policies. While the taxation of tobacco products around the world is a nearly universal practice, it is not always effectively implemented.

From the public health perspective, tobacco taxation has been clearly shown to prevent non-smokers from starting, to prevent former users from re-starting, and to lead current users to try to quit.

Taxes serve different objectives and have different effects on consumption, depending on the prevalence of smoking, the behavioural impact of the tax, and pricing effects. In most countries, for a given tax increase, the price of tobacco products will rise by an amount equal to or greater than the tax increase. This pricing pattern has been attributed to the addictive nature of the product and the coordinated oligopolistic nature of the tobacco industry in many countries.[16]

One of the fundamental principles of economics is that of the downward-sloping demand curve. A demand curve that slopes downwards implies that an inverse relationship exists between the real price of a good and the amount of the good that is consumed. Some researchers once believed that because of the addictive properties of nicotine, tobacco products might be an exception to this fundamental principle. However, many econometric studies conducted over the past four decades, including several that have explicitly modelled the addictive nature of cigarettes, have shown that cigarettes are not an exception to the economic law of demand. The inverse relationship between price and consumption has important policy implications. That is, by increasing the real price of cigarettes, a cigarette tax increase has tremendous potential to be an effective policy lever for decreasing cigarette consumption.

There are several justifications for taxation of tobacco products, from the economic and public health points of view. From the public health perspective, tobacco taxation has been clearly shown to prevent non-smokers from starting, to prevent former users from re-starting, and to lead current users to try to quit. Higher taxes also reduce consumption among those who do continue to smoke. In addition, taxation generates revenues for governments, given the relatively inelastic demand for smoking (see below), which can be used to offset both the society-level costs of treating illnesses related to smoking and exposure to SHS and the loss of productivity associated with these illnesses.

Because of the inelasticity of demand, tobacco is an ideal product to tax. The taxes provide a relatively stable, predictable, and sustained source of revenue, and in general, cigarette excise taxes are inexpensive to implement and are administratively relatively easy to apply. Given the price sensitivity of demand for cigarettes, significant taxes can produce substantial public health benefits by discouraging smoking, particularly among children and the poor. Taxation can also blunt one of the most potent weapons the tobacco industry employs—differential pricing to divide and attract segments of the market that have different levels of price sensitivity.[17] However, as documented in the WHO report on the global tobacco epidemic,[1] taxes in most countries are well below the levels of those in countries that have used them as part of a comprehensive strategy for reducing tobacco use. Indeed, at least some countries adopt tax structures that tax low-price cigarettes at relatively low rates in order to keep prices low, making the cigarettes more accessible by the poor.

While the strongest rationale for using taxation as a tobacco control measure is that smoking imposes net costs on society, taxation also provides a mechanism to partially recoup these costs from smokers. In addition, the strong negative externalities associated with tobacco use, including illnesses and related medical care for conditions caused by exposure to SHS, provide a strong justification for taxation.

The Economic Perspective

Tobacco taxation is a complex topic, partly because of the variety of taxes that are possible. The most common are excise taxes, value-added or ad valorem sales taxes, import duties, and, in the case of state-owned industries, monopoly profits.

The impact of excise taxes on cigarette demand depends on the extent to which changes in the taxes are reflected in cigarette prices and the responsiveness of cigarette demand to price (the price elasticity of demand, discussed below). Excise tax increases will discourage smoking to the extent that the increases are passed on to smokers in the form of higher prices; there is substantial evidence that a tax increase often leads to a more than proportional increase in retail price.[18]

Ad valorem and specific taxes are the most common excise taxes levied by countries. Ad valorem is levied as a percentage of retail or wholesale price, whereas a specific tax is an absolute value (e.g. US$ 2, or £0.75) levied on packs (e.g. 10, 20, 25 pieces) or number of cigarettes (e.g. per 1000 pieces). In 2008, 33% of countries (60 out of 182) relied on ad valorem taxes, while 30% (55 out of 182) relied on specific excises. Some countries relied on both excises by imposing a mixture of specific and ad valorem excises (48 out of 182). There is still a significant number of countries that do not levy excise on tobacco products (19 out of 182) (WHO database, 2008).

A number of countries impose differential taxes on cigarettes and other tobacco products, based on characteristics of the cigarettes or tobacco products (e.g. price, length, packaging, type of tobacco content, content of cigarettes). In previous years, the United Kingdom imposed differential taxes on cigarettes with high tar and nicotine content.[3] A differential tax system, however, may be prone to tax avoidance: the industry may alter an aspect of a brand, such as retail price, that subsequently reclassifies the brand into a lower tax bracket. Just such a phenomenon was recently observed in Egypt, where an international brand lowered its price just enough to be reclassified into a lower tax bracket.

Excise taxes are relatively easy to collect and therefore have low administrative costs. However, specific excise taxes are susceptible to losing value; they must keep up with inflation in order for their real value not to be eroded. Thus, specific excise taxes must be regularly updated to ensure that their real value is maintained over time. In recent years, a number of countries have shifted to specific excise taxes on tobacco products. However, among 55 countries that rely solely on specific excise taxes, only two (Australia and New Zealand) have automatic inflation adjustment mechanisms in place. A failure to adjust the excise taxes led to a problem in South Africa, as discussed below. Excise taxes there did not keep pace with inflation, leading to a fall in the real price of cigarettes and a concomitant rise in consumption prior to 1991.

In contrast, the real value of an ad valorem tax is maintained when the prices of tobacco products rise in conjunction with those of other goods and services. Thus, the real value of revenues generated by ad valorem taxes stays relatively stable over time, and they are favoured by the tobacco industry, which can maintain the base price, and therefore the tax, at a relatively low level. Similar to a differential tax system, ad valorem taxes are also prone to tax avoidance, since they rely on retail or wholesale price.

Tobacco tax rates differ widely across industrialized and developing countries. The tax rates of most countries that have used taxation as part of a comprehensive approach to reducing tobacco consumption have been around 65% to 75% of the retail price of cigarettes. However, many lower-income countries still have tax rates that fall well below 50% of the price of cigarettes, and many middle-income countries have rates that fall below 25% of the price.

Smokers may engage in compensating behaviours to sustain nicotine intake as a result of tax and price increases. They may smoke longer cigarettes or cigarettes with higher tar and nicotine content; or, because cigarettes and other tobacco products may substitute for one another as a source of nicotine, they may switch to hand-rolled cigarettes, pipes, snuff, chewing tobacco, or other forms of smokeless tobacco. Thus, tax increases need to be applied symmetrically across all types of tobacco products in a manner that equalizes their retail prices, so that consumers will not turn away from relatively high-priced products towards those with relatively lower prices.

Price Elasticity

To fully understand how taxation policies work, it is necessary to understand the concept of elasticity. Economists use the price elasticity of demand to measure the responsiveness of cigarette consumption to changes in the inflation-adjusted price of cigarettes. The price elasticity of demand is defined as the percentage change in the number of cigarettes consumed that results from a 1% increase in the inflation-adjusted price of cigarettes.

The reductions in cigarette use in response to price increases reflect not only increased smoking cessation and decreased smoking initiation, but also reduced relapse among former smokers and decreased average consumption by individuals who continue to smoke despite the higher prices.

Elastic demand is defined as an elasticity that is less than –1.0, or, alternatively, whose absolute value is greater than 1.0. In other words, the change in consumption is greater, in percentage terms, than the change in price. *Inelastic demand*, on the other hand, refers to situations in which consumption does go down when the price increases, but by a relatively smaller amount—the percentage change in consumption is less than the percentage change in the price. Inelastic demand is therefore defined as having an elasticity between 0.0 and –1.0.

There is a difference between short-term elasticities and long-term elasticities. In the long term, individuals are more elastic, meaning they will reduce consumption proportionately more than in the short term.[3] Most studies, however, measure demand in the short term only. While a majority of econometric studies of the effect of price on cigarette consumption use aggregate data, a growing number of such studies, particularly in high-income countries, are using individual-level data, which enables assessment of the impact of cigarette prices on smoking in subgroups of the population, such as by age, income, and gender.

Price Elasticity Estimates

Most of the econometric studies conducted in high-income industrialized countries, such as the United States, the United Kingdom, and Canada, conclude that the overall price elasticity of demand ranges from –0.5 to –0.25, implying that a 10% increase in the price of cigarettes will decrease overall cigarette consumption in these countries by between 5.0% and 2.5%.[3] Many of these studies used individual-level data to examine the determinants of cigarette demand. Several recent studies that employed individual-level data concluded that approximately one half of the overall impact of price on demand results from decreases in smoking prevalence, and the remainder results from reductions in average cigarette consumption by smokers.

Price Elasticity and Youth

The use of individual-level data allows researchers to examine differences in the price elasticity of demand by socioeconomic and demographic characteristics. Numerous studies in the United States have used individual-level data to explore differences in the price elasticity of demand by age. As noted in the chapter on the prevalence of tobacco use and factors influencing its initiation and maintenance, tobacco use among youth is rising, and in some countries, rates are the same for boys and girls. Measuring the impact of economic policies on youth smoking is thus an important global priority. Given that most regular smokers start smoking in their youth, it is important to try to understand the influence of price on this age group. There is a growing body of evidence indicating that adolescents and young adults are substantially more price-elastic than older adults.

Although some studies, such as those of Chaloupka,[19] Wasserman et al.,[20] and Townsend et al.,[21] found either that younger people were less price-sensitive than adults or that there was no statistically significant difference between youth and adult price-responsiveness, most other studies have found youth to be much more price-sensitive than adults. Young people in industrialized countries generally have relatively low incomes, of which a high proportion is available for discretionary expenditure, so changes in relative price are likely to affect their smoking patterns. Ross and Chaloupka found, in fact, that young people's demand for smoking in the United States, with an elasticity between –0.67 and –1.02, is more elastic than adult demand and that the perceived price of cigarettes is the largest single factor affecting teen smoking.[22]

Most researchers assume that price effects on youth reflect the impact of price on smoking initiation, while the estimate for adults reflects the effects of price on smoking cessation. Although some studies examining smoking initiation found that prices had an insignificant effect on initiation by young people,[23–25] some of these studies suffered from econometric problems associated with the use of retrospective data. Studies in which missing data are imputed[26] and which use larger samples that include a number of determinants of cigarette demand (such as restrictions on smoking)[27,28] have found relatively conclusive evidence that price increases will

reduce not only the number of cigarettes smoked but also the overall prevalence of smoking among young people.

In fact, a majority of the studies that examine the economic determinants of cigarette consumption among youth and young adults have concluded that this age group is more price-responsive than adults, suggesting that excise tax increases leading to price increases would be a very effective means of reducing and discouraging cigarette smoking among adolescents. This would lead to permanent reductions in smoking in all age groups. The aforementioned studies are from the United States and the United Kingdom, high-income countries. However, a small but growing number of studies about the response to price and tax increases among youth in low- and middle-income countries have found evidence consistent with that from high-income countries on an inverse relationship between age and price-responsiveness. For example, Krasovsky et al. estimated differences in the price elasticity of cigarette demand by age and income in Ukraine[29] and found younger smokers to be more responsive to price changes than older smokers at each income level. Ross also estimated cigarette demand equations for students in Ukraine[30] and concluded that their price elasticities for smoking prevalence ranged from –0.29 to –0.51, while the estimated price elasticities for average smoking were considerably higher, from –1.42 to –1.83. Karki et al. estimated the joint demand for cigarettes and bidis by age in Nepal[31] and found that young people (15 through 24 years of age) were more than twice as responsive to price as the overall population and that price-responsiveness generally fell with age. Kyaing estimated price elasticities of smoked tobacco products in Myanmar[32] and found the price elasticity for youth and young adults to be approximately 50% greater than that for the overall population. Ross[33] estimated the price elasticity of demand for students in Moscow to be –1.15, well above the estimates provided in the limited studies of the impact of price on adult smoking in the Russian Federation.

Economic theory predicts that youth will respond more to price and tax increases than adults, and the evidence from the United States and the United Kingdom is very relevant to low- and middle-income countries, to which the tobacco epidemic is steadily shifting. In recent years, tobacco manufacturers have turned their attention to young women and girls in these countries—their largest untapped market. Given the documented effects of price increases on youth, increases in cigarette taxes can be a powerful tool for protecting young women and girls in low- and middle-income countries from the hazards of smoking.

Economic theory predicts that youth will respond more to price and tax increases than adults, and the evidence from the United States and the United Kingdom is very relevant to low- and middle-income countries, to which the tobacco epidemic is steadily shifting.

Lewit et al. suggest that young people are likely to be more price-sensitive than adults because they have been smoking for a shorter time and so can adjust more quickly to price changes than long-time smokers who are strongly addicted can.[34] Moreover, the fraction of disposable income spent on cigarettes by the young smoker is likely to be greater than that of an adult smoker. These are all important reasons for young smokers to be more affected by price increases than adults. These reasons create an important opportunity to discourage young people from taking up smoking. Because youth have higher discount rates than adults, they do not internalize risks and give less weight to future consequences from their current tobacco consumption.

Youth may also be influenced more easily than adults by bandwagon or peer-group effects.[34] That is, they are more likely to smoke if their parents, siblings, or peers smoke. Higher prices could discourage young people from smoking by the price mechanism's working through the same peer or bandwagon channel; that is, a price increase will not only reduce a youth's smoking but will also reduce peer smoking. Given evidence that individuals are far less likely to start smoking after they reach their mid-twenties, young smokers who never begin to smoke because of a price increase may well never become regular smokers. As a result, over a longer period of time, aggregate smoking and the detrimental health effects it imposes would be dramatically reduced.

Price Elasticity and Income

Some studies have used individual-level data to examine differences in the price elasticity of demand by income, socioeconomic status (SES), and education. These studies generally find that individuals who have lower income, have less education, or are of lower SES respond more to price changes than do individuals who have higher income, have more education, or are of higher SES, respectively.[19,21,35]

An inverse relationship between income and response to cigarette prices has also been found when comparing price-elasticity estimates of low- and high-income countries. A recent review of the literature suggests that the price-elasticty estimates for low- and middle-income countries are approximately double those for high-income countries.[3] That is, for low- and middle-income countries, demand is generally found to be more elastic, and estimates of the average price elasticity centre around –0.8.

Researchers found a positive relationship between income and cigarette consumption in all income groups in Turkey. Their results show that income elasticity declines with household income level.

Income Effect on Demand

When factors that increase demand (such as rising per capita income) are taken into consideration, the full expected effect of higher prices on cigarette consumption may not be achieved. Evidence from many countries (e.g. Indonesia, Malaysia, Turkey, Viet Nam, and China) shows that changing per capita income significantly affects smoking prevalence, as well as cigarette demand.[36] Onder and Yurekli found a positive and significant relationship between income and frequency of cigarette smoking in all income groups in Turkey except for the richest group.[37] Their results suggest that as income increases, the prevalence of smoking increases more for the poorest group (0.11) than for the better-off groups (fourth quartile) (0.06), but the richest households decrease their smoking as their income increases (–0.02). Similarly, Adioetomo et al.[38] and Djutahara et al.[39] estimated that a rise in incomes in Indonesia would increase the number of smokers by causing more potential smokers to decide to take up smoking. They estimated that a 10% increase in daily income would raise the current number of smoking households* from 60.2% to 60.8% and would increase the quantity of cigarettes smoked by current smokers by 6.5%.**

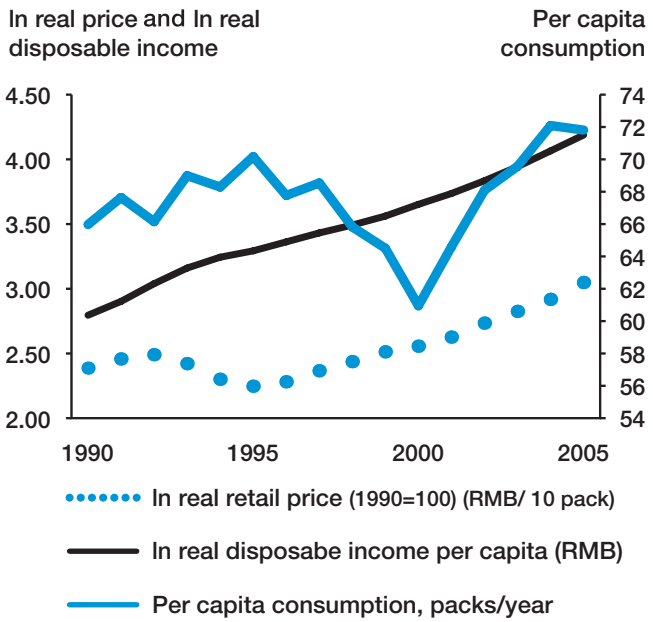
Onder and Yurekli found a positive relationship between income and cigarette consumption in all income groups in Turkey.[37] Their results show that income elasticity declines with household income level. Adioetomo et al. also found a significant and positive relationship between income and the demand for cigarettes in Indonesia.[38] The income elasticity (e) was 0.65 in Adioetomo et al., and it varied between 0.46 and 0.21 in Djutahara et al.[39] As expected, Adioetomo et al. estimated that Indonesian smokers in low-income households were more sensitive to income increases (e= 0.9) than were smokers in high-income households (e= 0.3). Adioetomo et al. estimated that a 10% increase in income would increase the quantity of cigarettes smoked by 9% in low-income households, 3% in middle-income households, and less than 1% in high-income households.

The inverse relationship between price and demand and the positive relationship between income and demand will cause a simultaneous per capita income increase and cigarette price increase to have opposing effects on cigarette demand. In order to reduce consumption by a desired amount, the percentage increase in price will need to be higher if income is increasing. If cigarette prices remain unchanged while income increases, the demand for cigarettes will rise.

* The unit of measurement was households; the data indicate whether there are smokers in the household but do not indicate who smokes. So instead of using the criterion "smokers, non-smokers", the study refers to "smoking households" (where there are smokers) and "non-smoking households" (where there are no smokers). The results show that as daily income increases by 10%, the ratio between smoking and non-smoking households increases 63%, meaning at least one member of a non-smoking household will smoke, and the household will become a smoking household.

** A 10% increase in daily income will increase the log odd ratio by 2.64% for overall household level and 7.25% for low-income households. When evaluated at the mean values of all the variables, the 10% increase in income would increase the proportion of current households' smokers from 60.2% to 60.8%, and for low-income households, from 61.1% to 62.8%.

Figure 11.1. Consumption and Price of Cigarettes in China, 1990–2005[50,51]



Source: Ref. 52. Calculated by the authors.

One of the first studies of the impact of tobacco taxes on the demand for cigarettes and other tobacco products was conducted by Chapman and Richardson in 1990.[40] Using annual data from 1973 to 1986 for Papua New Guinea, they estimated tax elasticities of demand for cigarettes and other tobacco products to be –0.71 and –0.50, respectively. These estimates are lower than the true price elasticity of demand because the tobacco taxes are less than 100% of the price of the products. If half of the price is accounted for by the tax, the estimated price elasticity of demand for cigarettes and other tobacco products would be –1.42 and –1.0, respectively, significantly higher than the consensus estimate for high-income countries.

Since the publication of Chapman and Richardson's paper, interest in tobacco tax and price effects in low- and middle-income countries has been growing. A number of studies have examined the effects of tobacco taxes and prices on the demand for tobacco in these countries, and most, but not all, have shown that the demand for tobacco products is more responsive to price and tax changes there than it is in high-income countries. Studies from China,[41–43] Viet Nam,[44] South Africa,[45,46] Zimbabwe,[47] Morocco,[48] Myanmar,[32] Bulgaria,[49] and other low- and middle-income countries have estimated tax or price effects in excess of the consensus estimate for high-income countries. Several studies have examined the differential price response by income level. For example, Sayginsoy et al. estimated cigarette demand elasticities of –1.33, –1.00, and –0.52 for low-, middle-, and high-income individuals, respectively, in Bulgaria.[49] Van Walbeek estimated price

Figure 11.2. Relationship Between Cigarette Consumption and Excise Tax Rate in South Africa, 1980–2006[1,53]

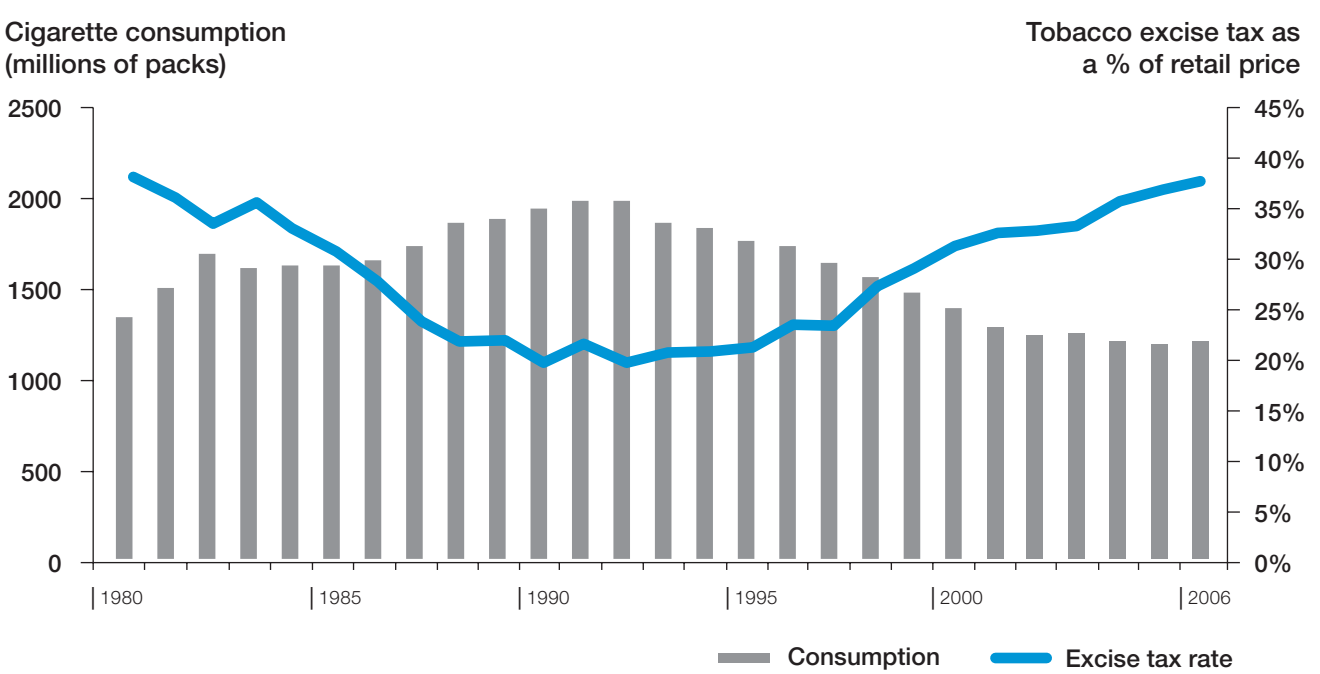
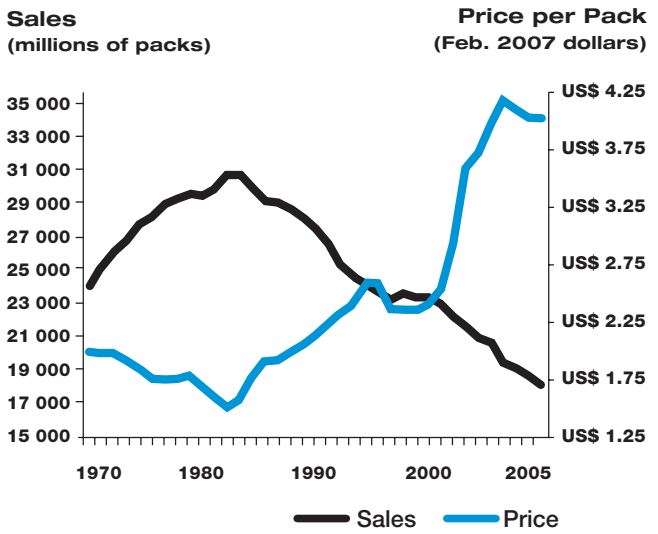


Figure 11.3. Consumption and Price of Cigarettes in the United States, 1970–2006[54]



elasticities of demand by income quartile in South Africa and found that the lowest quartile was more elastic (–1.39) than the highest quartile (–0.81).[51]

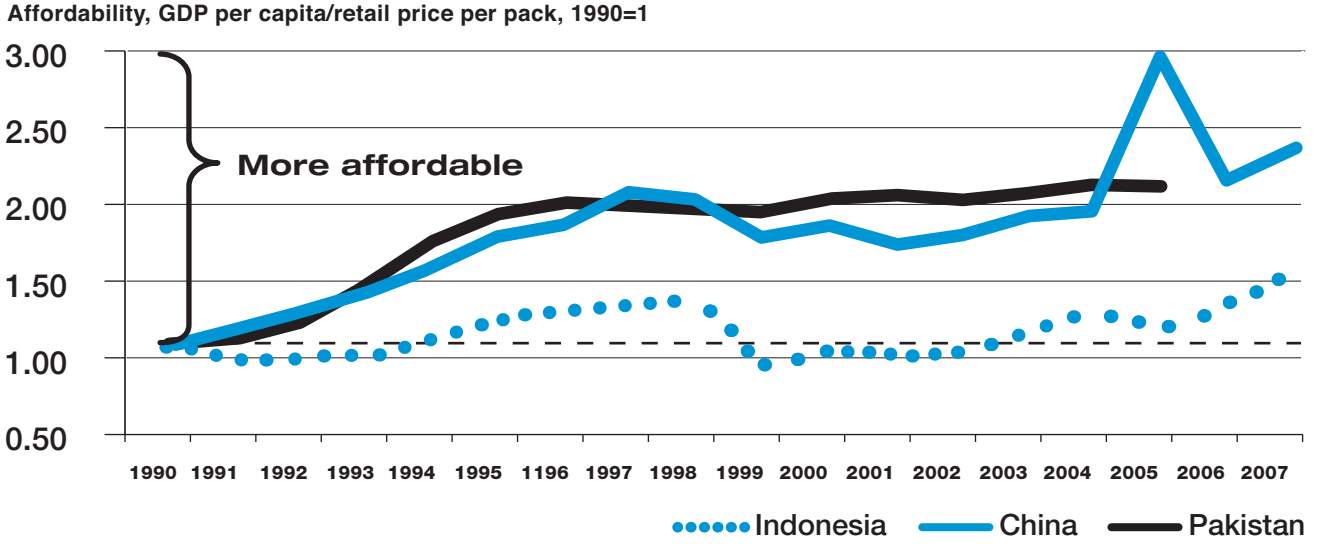
While the aforementioned studies found inverse relationships between consumption and price by using multivariate analyses that control for a host of other factors thought likely to affect cigarette demand, the inverse relationship can also be seen graphically with bivariate scatter plots. For example, Figures 11.1, 11.2, and 11.3 plot cigarette price and cigarette consumption in China, South Africa, and the United States, respectively, and show a very strong inverse relationship between consumption and price.

Price Elasticty and Gender

Of particular importance in this chapter is the relationship between cigarette prices and smoking and patterns of tobacco use among women and men. The relationship between smoking and gender is a complex one that tends to change with changes in the labour force. Demand for cigarettes may increase as more women and girls in developing countries enter the wage labour force and have more disposable income. When the increases in retail prices of cigarettes fall behind the increases in inflation and increases in income, cigarettes become more affordable, and demand increases. This is the case in many countries where the smoking epidemic is highest among men and increasing among women (see Figure 11.4).

It is clear that the epidemiological pattern needs to be analysed in relation to the differential effects of economic development and consumer patterns on women and men. As noted in the chapter on prevalence of tobacco use and factors influencing initiation and maintenance among women, there is now a significant opportunity to prevent a

Figure 11.4. Cigarette Affordability in Selected Countries



Source: WHO calculations using data from papers prepared as part of the Bloomberg Initiative to Reduce Tobacco Use (http://www.worldlungfoundation.org/publications.php).

Table 11.1. Findings of Selected Studies of the Elasticity of Demand for Smoking by Sex

Date	Study	Country	Elasticity Estimate for Females	Elasticity Estimate for Males	Comment
Studies of Prevalence and Average Smoking					
1973	Atkinson and Skegg	UK	–0.34	No significant response	Aggregate-level annual data on cigarette sales in UK for years 1951–1970
1982	Lewit and Coate	USA	No significant response	Aged 20–25, -1.4; aged 35+, -0.45	1976 Health Interview Survey
1990	Chaloupka	USA	No significant response	–0.60 long-run price elasticity	Second National Health and Nutrition Examination Survey
1994	Townsend, Roderick, and Cooper	UK	–0.61	–0.47	General Household Survey 1972–1990
1997	Lewit et al.	USA	No significant response	–1.51	Ninth-grade students from 21 North American communities, 1990–1992
1998	Farrelly and Bray	USA	–0.19	–0.26	National Health Interview Surveys 1976–1993
1999	Chaloupka and Pacula	USA	–0.595	–0.928	8th-, 10th-, and 12th- grade students, Monitoring the Future Surveys 1992–1994
2000	Hersch	USA	–0.38	–0.54	Tobacco Use Supplement to the Current Population Survey 1992–1993
2001	Farrelly and Bray	USA	–0.32	–0.18	National Health Interview Surveys 1976–1993
2001	Stephens et al.	Canada	–0.3	–0.5	National Population Health Survey
2007	Stehr	USA	–0.51	–0.26	Behavioural Risk Factor Surveillance System 1985–2000
Studies of Smoking Transitions					
2001	Tauras and Chaloupka	USA	0.34 to 0.71 price elasticity of cessation	0.27 to 0.92 price elasticity of cessation	Longitudinal component of the Monitoring the Future Surveys 1976–1995
2004	Cawley, Markowitz, and Tauras	USA	No significant response	–0.86 to –1.49 price elasticity of initiation	National Longitudinal Survey of Youth 1997 Cohort (1997–2000)
2004	Cawley, Markowitz, and Tauras	USA	No significant response	–1.20 price elasticity of initiation	Children of the National Longitudinal Survey of Youth 1979 Cohort (1988–2000)
Studies of Smoking During Pregnancy					
1999	Evans and Ringel	USA	–0.50	Not applicable	Natality Detail Files, 1989 and 1992
2001	Ringel and Evans	USA	–0.70	Not applicable	Natality Detail Files, 1989 and 1995

worldwide epidemic of tobacco use among women and girls, including in countries like China, where sex differences in prevalence and health impact are high.[1,55–57]

In the United States, men were found to be very responsive to changes in cigarette prices, with a long-run price elasticity of demand estimated to be –0.60. Women, however, were often found to be less responsive to cigarette price changes, a finding consistent with those of Lewit and Coate.

Recently published studies that estimated the price elasticity of demand by gender are summarized in Table 11.1. Most of the evidence of a differential price response by gender comes from the United States, the United Kingdom, and Canada. The results from these studies are mixed. A preponderance of those conducted in North American countries concluded that women's cigarette consumption is less responsive to changes in cigarette prices than is men's. In contrast, studies in the United Kingdom have generally found women's consumption of cigarettes to be more responsive than men's to price changes.

Studies of Prevalence and Cigarette Consumption by Smokers in the United States

One of the first US studies to examine gender-specific differences in the effects of cigarette prices on consumption was conducted by Lewit and Coate in 1982.[58] Using a split-sample methodology and data from the 1976 Health Interview Survey, Lewit and Coate found cigarette demand by females to be generally not sensitive to price. In contrast, with the exception of those 26 to 35 years of age, males were found to respond significantly to price. The price elasticities of demand for males aged 20 to 25 and over 35 were estimated to be –1.4 and –0.45, respectively. The male price coefficients were significantly larger than the male and female pooled-sample results, where the male and female price coefficients were constrained to be equal.

Chaloupka also employed a split-sample methodology to examine differences in the effects of cigarette prices on consumption by gender.[59] Using data from the Second National Health and Nutrition Examination Survey and incorporating the addictive properties of cigarette smoking, including reinforcement, tolerance, and withdrawal, Chaloupka found men to be very responsive to changes in cigarette prices, with a long-run price elasticity of demand estimated to be –0.60. Women, however, were found to be unresponsive to cigarette price changes, a finding consistent with those of Lewit and Coate.[58]

Lewit et al. examined differences in the effects of cigarette prices on smoking prevalence by gender among ninth-grade students (aged 13 to 16) in 21 North American communities in 1990 and 1992.[60] Ninth-grade boys were found to be much more responsive to changes in cigarette prices than girls were. The estimated prevalence price elasticities of demand for boys and girls were –1.51 and –0.32, respectively; however, the estimated price coefficients in the girls' equations were found not to be significantly different from zero.

Chaloupka and Pacula used data on eighth-, tenth-, and twelfth-grade students from the 1992–1994 Monitoring the Future Surveys to examine the price sensitivity of cigarette demand by sex.[61] While price was found to have a negative and significant impact on smoking prevalence rates of both young men and young women, the magnitude of the price effects was very different. The prevalence price elasticity of demand for young men was nearly twice as large (in absolute value) as that for young women: –0.928 vs –0.595.

Hersch extracted data from the 1992 and 1993 waves of the Tobacco Use Supplements to the Current Population Surveys and found that higher prices reduce cigarette demand in both men and women.[62] The estimated price elasticities of demand were similar for men and women and ranged from –0.6 to –0.4. However, when Hersch restricted the sample to individuals in the workforce, she found males to be significantly more responsive to cigarette price changes than females.

In a series of papers, Farrelly et al. pooled data from National Health Interview Surveys (NHIS) between 1976 and 1993 to investigate the cigarette-price-responsiveness of individuals with different demographic characteristics. In the first paper, Farrelly and Bray controlled for many factors thought likely to affect the demand for cigarettes, including socioeconomic and demographic characteristics, as well as year and region indicators.[35] They found that males were more responsive to changes in cigarette prices than were females. A follow-up study used the same pooled NHIS data but included state fixed effects in each model instead of region fixed effects.[63] With the state-fixed-effect specification, the authors found that women were more price-responsive than men.

The inclusion of state fixed effects eliminates time-invariant unobserved state-level heterogeneity from the model. To the extent that sentiment towards smoking within states is time-invariant during the period under investigation, the inclusion of state fixed effects in the model eliminates an omitted variable bias on the price estimates. That is, sentiment towards tobacco may be driving both changes in cigarette smoking and changes in cigarette excise taxes. Thus, not controlling for anti-tobacco sentiment may result in an omitted variable bias, producing a spurious negative relationship between price and smoking and resulting in estimated price elasticities biased away from zero. The use of state fixed effects relies on within-state variation in cigarette prices over time (as opposed to interstate differences in prices) to quantify the effect of price on consumption. For the state-fixed-effects approach to be viable, however, researchers must use multiple years of state data. One year of cross-sectional data would result in perfect multicollinearity between the state-specific prices and the dichotomous state indicators. Moreover, even if multiple years of state data are employed, there must be reasonable variation in price over time within states to avoid collinearity issues with the price variable.

Stehr used data extracted from the 1985–2000 Behavioural Risk Factor Surveillance System to investigate differences in the effects of cigarette taxes on cigarette demand by sex.[64] He included gender-specific state fixed effects in his model and concluded that women are nearly twice as responsive to cigarette taxes as men are. Specifically, the total estimated price elasticities of demand for women and for men were –0.51 and –0.26, respectively. The gender-specific state fixed effects are an attempt to control for state-specific gender gaps in smoking rate that may be correlated with cigarette taxes. If a significant correlation exists, the omission of the gender-specific state fixed effects could lead to biased price estimates.

Studies of Smoking Transitions in the United States

As noted above, many researchers examining the influence of price on smoking prevalence have assumed that the effect of price on youth is dominated by the effect on smoking initiation, while the effect on young adults and older adults is dominated by the effect on smoking cessation. Several recent studies have attempted to directly quantify the differential impact of price on smoking initiation among youths by gender and the differential impact of price on cessation among young adults. These studies have relied on longitudinal data that track individuals' smoking behaviour and other determinants over time.

Cawley, Markowitz, and Tauras investigated the determinants of youth smoking initiation, using the first four waves (1997–2000) of the National Longitudinal Survey of Youth 1997 cohort.[65] They investigated two alternative measures of smoking initiation: one that indicated a transition from non-smoker to smoking any positive quantity of cigarettes (termed "less stringent initiation"), and one (termed "more stringent initiation") that reflected the transition from non-smoker to frequent smoker, as measured by having smoked during at least 15 of the past 30 days. While controlling for smoke-free-air laws, youth-access laws, and residence in tobacco-producing states, the authors concluded that male adolescent smoking initiation was very responsive to changes in cigarette prices, with the average price elasticity of "less stringent initiation" estimated to be –0.86 and the average price elasticity of "more stringent initiation" estimated to be –1.49. Female smoking initiation was found to be not significantly related to cigarette prices but very responsive to body-weight concerns.

A follow-up paper found results very similar to those of the earlier study, despite using a longitudinal dataset that spans a longer period.[66] The authors used data from 1988 to 2000 from the Children of the National Longitudinal Survey of Youth 1979 cohort. After controlling for smoke-free-air laws and youth-access laws, they found that cigarette prices had a negative impact on smoking initia-

tion in all models that were estimated; however, the price coefficients were significantly different from zero in only the male equations. Specifically, the price elasticity of male "less stringent initiation" was estimated to be –1.20.

Tauras and Chaloupka examined gender differences in the impact of price on young adults' decisions to quit smoking,[67] using the longitudinal component of the Monitoring the Future Surveys and a semiparametric Cox regression to assess the probability that smokers would make a transition from smoking to non-smoking. They concluded that the likelihood of making a smoking cessation attempt for both men and women increases significantly as cigarette prices rise. The estimated price elasticity of smoking cessation ranged from 0.34 to 0.71 for women and from 0.27 to 0.92 for men, implying that a 10% increase in price raises the probability of making a cessation attempt by up to 7% for females and 9% for males.

While comprehensive tobacco control programmes have been found to be effective in reducing smoking in the overall population, some evidence suggests that women benefit in particular.

Previous Studies in the United Kingdom and Canada

One of the first studies to examine gender-specific differences in the effects of cigarette prices on consumption was conducted by Atkinson and Skegg in 1973.[68] Using aggregate-level annual data on cigarette sales in the United Kingdom from 1951 to 1970 and gender-specific shares of consumption, they found clear differences in the estimated price elasticity of demand: women have a total price elasticity of demand of –0.34, and men do not significantly respond to price changes.

Townsend, Roderick, and Cooper used biennial data on smoking from the general household survey for 1972–1990 in the United Kingdom and found that women respond more to price than men do.[21] They estimated the price elasticity of demand to be –0.61 for women and –0.47 for men.

Finally, Stephens et al. used data from Canada's National Population Health Survey to examine differential response to cigarette prices by gender and found cigarette prices to be positively associated with the odds of being a non-smoker for adults of both sexes; however, males responded more to the price change than did females.[69] The price elasticity for being a smoker for men was estimated to be –0.5, and for women it was estimated to be –0.3.

Policy Implications

Smoking and Pregnancy

Given the well-documented evidence that women who smoke or who are around smokers while pregnant expose their child to increasing health risks, it is important to quantify the impact of cigarette tax and price increases on consumption among pregnant women. The evidence on the impact of higher taxes on smoking during pregnancy comes from two studies conducted in the United States. Using data from the 1989 and 1992 Natality Detail Files, Evans and Ringel found that higher cigarette taxes reduce smoking prevalence rates among maternal smokers but do not decrease average consumption among those who continue to smoke.[70] They calculated a price elasticity of smoking prevalence of –0.50, implying that a 10% increase in the price of cigarettes will reduce the prevalence of maternal smoking by 5%. Moreover, they found that the tax-induced decreases in smoking improved birth outcomes. In particular, the average birth weight rose by approximately 400 g among women who quit smoking because of higher taxes.

In a follow-up study, Ringel and Evans examined the impact of taxes on smoking among different subpopulations of maternal smokers.[71] They extracted data from the 1989 and 1995 Natality Detail Files and found that for all subpopulations except women who did not report their education, tax increases had a significant negative effect on maternal smoking rates. They calculated an overall maternal participation price elasticity of –0.7. For all subgroups except those not reporting education, the price elasticity of participation

was larger (in absolute value) than the consensus general-population participation price-elasticity estimates.

The reduction in smoking rates among pregnant women in response to a tax increase not only improves birth outcomes, but also has cost implications. Lightwood, Phibbs, and Glantz estimated that smoking cessation programmes that reduce smoking rates among pregnant women before or during the first trimester of pregnancy yield significant cost savings.[14] In particular, they found that a 1% decline in smoking prevalence among pregnant women would save US$ 21 million (in 1995 dollars) in direct medical costs alone in the first year. An annual 1% decline in smoking prevalence among pregnant women would save US$ 572 million (in 1995 dollars) in direct medical costs in the first seven years.

Many studies have found that exposure of non-smoking pregnant women to SHS results in negative consequences.[13] A recent systematic review and meta-analysis concluded that SHS exposure was associated with a 33 g reduction in mean birth weight in prospective studies and a 40 g reduction in mean birth weight in retrospective studies. The review also concluded that SHS exposure increased the risk of birth weight being below 2500 g by 22%. This review has very important implications for paternal and other household smoking during pregnancy. Independent of maternal smoking, paternal and other household smoking imposes costs and negative consequences on fetal health.

Earmarked Taxes and Tobacco Control Programmes

Earmarking a portion of the revenue generated from tobacco taxes for tobacco control programmes reinforces the effect of the higher tax on consumption. Numerous studies conducted in the United States have examined the impact of comprehensive tobacco programmes on smoking and health. The Institute of Medicine reviewed these studies and concluded that multifaceted tobacco control programmes are effective in reducing tobacco use.[72] Moreover, while such programmes have been found to be effective in the overall population, some evidence suggests that women benefit in particular. A study published by the Centers for Disease Control and Prevention found that from 1988 to 1997, lung cancer rates among women in California, the state with the longest-standing tobacco control programme in the United States, decreased by 4.8%, whereas lung cancer rates increased by 13% among women in other parts of the country.[73] In addition, a report by Abt Associates found that between 1990 and 1999 in Massachusetts, the second state in the United States to create a comprehensive tobacco control programme using earmarked tobacco taxes, smoking among pregnant women declined by more than 50%, the greatest percentage decrease in any state over that time period.[74] Indeed, the 2001 Surgeon General's report on women and smoking concluded that pregnancy-specific tobacco control programmes, some of which are funded from earmarked revenues, benefit both maternal and infant health and are cost effective.

The evidence on the impact of higher cigarette taxes on smoking during pregnancy is clear: cigarette taxes reduce smoking prevalence rates among maternal smokers, and the impact of a tax increase is significantly larger on pregnant women than on the general population.

Other countries, including Canada, Finland, Denmark, Peru, Poland, Indonesia, the Republic of Korea, Malaysia, Romania, Thailand, and Nepal, as well as some US states, have earmarked tobacco taxes for tobacco-related education, counteradvertising, health care for underinsured populations, cancer research, and other health-related activities. Moreover, tax revenues are used in several Australian states and in New Zealand to fund athletic and art events previously sponsored by the tobacco industry.[3] While many finance ministries have concerns about the use of earmarked taxes for reasons relating to loss of control, rigidities in allocating general revenues, and the domino effect of other sectors also wanting hypothecated taxes, it has been argued that earmarked tobacco taxes can help reduce the loss of producer and consumer surplus from higher taxes.

Earmarked tobacco taxes can also be used to target lower-income populations that continue to smoke, and such transfers can help to reduce inequalities in health outcomes. For example, women's groups have called for more funds to be used to integrate tobacco control into reproductive health services, such as maternal and child health and family planning. These taxes could be used to subsidize cessation programmes and nicotine replacement therapies to assist and support continuing smokers. If women do have more difficulty quitting than men do, and if women in lower socioeconomic groups continue to smoke, supporting services for them through the use of earmarked taxes could help to reduce the burden of taxation falling on them and the resultant inequalities in health.

Health Implications

There is solid evidence from countries of all income levels that increased taxation of cigarettes is highly effective in reducing consumption.[75] Moreover, there is a strong economic rationale for governments' use of taxes to reduce smoking.[76] Studies of price-responsiveness by gender have primarily been conducted in high-income countries, and a majority of studies have concluded that males are slightly more price-responsive than females. The evidence on the impact of higher cigarette taxes on smoking during pregnancy is clear: cigarette taxes reduce smoking prevalence rates among maternal smokers, and the impact of a tax increase is significantly larger on pregnant women than on the general population. Finally, earmarking a portion of the revenue generated from tobacco taxes for tobacco control programmes reinforces the effect of the tax on consumption.

Given the relationship between pricing and demand and the significant health benefits accruing from cessation, tobacco control measures and taxation in particular can potentially avert millions of premature tobacco-related deaths. World Bank estimates of the health impact of control measures on global tobacco consumption are striking.[77] Under conservative assumptions, a sustained real price increase of 10% could lead to 40 million people worldwide quitting smoking and to deterring many more from taking it up. This price increase alone would avoid 10 million premature deaths, or 3% of all tobacco-related deaths. Four million of the premature deaths avoided would be in East Asia and the Pacific region.

While the public health community continues to appeal for higher tobacco taxes on the basis of social costs, few people would deny the justification of a tax increase based on health benefits. Given the empirical and other problems of the social cost argument, research on taxation may indeed be a very valuable pursuit in helping to convince policy-makers of the irrefutable health gains that can be achieved from increasing taxes on tobacco.

Government Perspective: Revenue Generation

Tobacco tax revenue has accounted for 3% to 5% of total government revenues in most industrialized countries, although its importance has been steadily declining.[3] Nevertheless, in some middle-income countries, tobacco tax revenue constitutes an important share of total government revenue. For example, in South Africa, with an estimated long-run price elasticity of –0.68 and where taxes now account for 40% of the price of cigarettes,[78] a permanent doubling of the cigarette tax would reduce demand by more than 27% in the long run (assuming the tax is fully passed on to consumers) and would increase cigarette tax revenues by nearly 50%.[3] Tobacco taxes would then account for nearly 2% of total government revenues. However, as already noted, because the government did not allow tobacco taxes to keep pace with inflation in the 1970s and 1980s, forgone excise revenue was substantial.

Revenue-generating potential will be highest where the demand for tobacco products is more inelastic or where tax as a percentage of price is relatively low. For most countries, there is still ample room to increase taxes and raise valuable tax revenue. A 10% tax increase will, on average, lead to a 7% increase in tobacco tax revenue. Therefore, even in countries where demand has been more elastic or where taxes are already a large share of price, tax increases would still lead to increases in government revenue, at least in the short run. Given the economic models of addiction and the fact that demand will be more responsive to price in the long run, a permanent change in price will have an effect on demand that will grow over time to almost double the short-run impact.[3] In addition, given the sensitivity of consumers—particularly youth—to price, permanent real increases in tobacco taxes will lead to greater reductions in prevalence and overall consumption. Therefore, increases in tobacco taxes will lead to greater tax revenue increases in the short run than in the long run.

Concerns About Tobacco Taxation

Regressivity

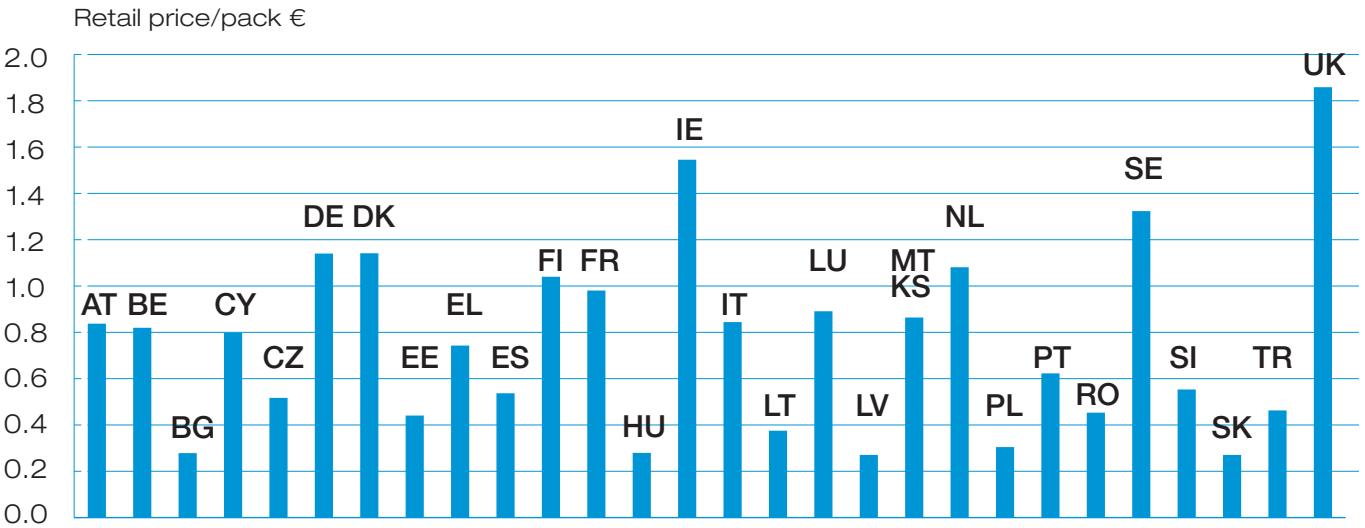
Several concerns have been expressed about using cigarette taxation as a tool for health promotion. These include policy-makers' considerations about the appropriate level of taxation and issues surrounding the efficiency and equity of taxes. Cigarette taxes impose a regressive burden on people with low incomes in places where they smoke disproportionately more than those with higher incomes. Therefore, there is a dual concern about the increasing burden of smoking-related diseases on low-income groups and the implications of price increases for low income smokers.

Tobacco taxation can violate notions of both horizontal equity (where "equals", or individuals who are identical except for their smoking behaviour, should be treated equally) and vertical equity (where rich individuals should have proportionally higher taxes because of differences in income). Vertical equity implies that individuals with the greatest ability to pay should carry the highest tax burden—in other words, marginal tax rates should be higher for the rich. Tobacco taxes clearly violate this principle in countries where poorer people smoke more than wealthy people. The disparity is worsened when income falls and tobacco taxes rise as a share of income or total expenditures. Therefore, tobacco taxes are regressive when tobacco use is more prevalent among persons with lower incomes.

However, recent evidence suggests that tobacco taxes may not be as regressive as has been feared, because rich and poor consumers do not smoke and quit at the same rates following a price increase. This has recently been shown by differences in the price elasticity of demand for different socioeconomic groups, which suggest that the regressivity normally attributed to cigarette taxation is overstated. Studies have found the price elasticity of demand to be inversely related to social class, with those in the highest social classes being less price-responsive than those in the lowest social classes.[21]

Because persons with less education, lower income, and lower SES have been found to be more price-responsive than those with more education, higher income, and higher SES, increased cigarette taxes would reduce differences in smoking among socioeconomic groups. Even though cigarette taxes may fall most heavily on lower-income smokers, increases in taxes may be progressive from a public health standpoint in that larger reductions in smoking occur among that group. The health benefits from tax-induced reductions in smoking would therefore be disproportionately larger for lower-income people. Thus, analyses that have failed to take into account the inverse relationship between elasticity and income overstate the regressive effect of tobacco taxes.

Figure 11.5. Pre-Tax Price of a Pack of Cigarettes in the European Region, 2007



Source: European Commission, excise tax data.

However, support may be needed to reduce the regressivity of tobacco taxes for persons in lower income groups who continue to smoke and their families. In low-income families, particularly in developing countries, spending on tobacco can "crowd out" expenditures on other essential household needs, including food and education.[79] Cessation therapies and nicotine replacement products and other support services could be offered to the poor, and earmarking of tax revenues could help in subsidizing these services.

Manufacturers could be required to use serial numbers on each pack to facilitate tracking, while pack-marking technology could provide further information about each link in the supply chain, such as the distributor, the wholesaler, and the exporter.

Related concerns about increased taxation include the effect it may have on cross-border shopping and smuggling and the effect it may have on the tobacco industry regarding employment and, more broadly, the macroeconomy and trade balances. These last two issues are discussed in more detail below.

The Threat of Smuggling

Differences in cigarette taxes and prices potentially lead to casual and organized smuggling and other forms of tax evasion. Worldwide, organized smuggling, which targets a significant amount of cigarettes, is the most serious illicit activity. Smugglers camouflage illicit cigarettes through trade, since the exports are free of duty from the exporting countries. Although tax differences can create a financial incentive for smugglers, this incentive already exists in the absence of taxes, because of the significant differences in pre-tax prices of cigarettes (see Figure 11.5).

The tobacco industry argues that cigarette tax increases can erode valuable tax revenues, which would be lost because of smuggling, while not reducing consumption. Sweden decreased cigarette taxes by 17% in 1998 because of a perception that smuggling led to lost cigarette tax revenues, and it saw its tax revenues fall as a result. Other countries also have chosen not to increase tobacco taxes partly out of fear of the development of a black market, given differences in tax rates across neighbouring countries.[77]

The number of studies trying to quantify the global illicit trade and examine the relationship between tobacco taxes and illicit trade is increasing. Earlier studies estimated that about 30% of internationally exported cigarettes are lost to smuggling,[3] and although the problem is acute, it has often been overstated.[80] Yurekli and Sayginsoy estimated that in 1999, 3.4% of global cigarette consumption was of illegal cigarettes,[54] whereas a study by Joossens et al. found that 11.6% of the global cigarette market is illicit.[81] Large tobacco tax increases—and significant price increases initiated by the tobacco industry—have occurred in several countries without causing dramatic increases in smuggling. Other factors, such as lack of enforcement and a general culture of corruption, may be more important contributors to the likelihood of smuggling. Many countries with high prices, including France, Norway, the United Kingdom, and Sweden, show very little evidence of smuggling, while several countries with low prices, such as Spain and Italy, have evidence of extensive smuggling.

The complicity of the tobacco industry in smuggling should also be recognized when considering the credibility of its call for reducing taxes to prevent smuggling. The tobacco industry is a clear beneficiary of smuggling, in that when smuggled cigarettes account for a high proportion of the total sold, the average price of all cigarettes, taxed and untaxed, falls, increasing sales of cigarettes overall. The tobacco industry has argued that a significant proportion of smuggled cigarettes are counterfeit cigarettes and that these counterfeit cigarettes reduce their sales.

The smuggling problem is exacerbated by the ease with which tobacco products can be transported, the huge potential profits, the informal distribution networks in many countries, the availability of tax-free and duty-free cigarettes, and the lack of enforcement in many countries.[80] Most smuggled cigarettes are well-known international

brands smuggled somewhere in transit between the country of origin and the country of destination, reappearing in the country of origin at cut-rate prices, untaxed.

Any of several easy-to-implement policies, including stronger enforcement, use of tax stamps, and greater penalties for smugglers, could significantly reduce the problem.[82] Tax stamps—which must be difficult to forge—on duty-paid packs could help enforcers ensure the legality of packs. Special packaging for duty-free packs would also help.

In addition, all parties in the supply chain could be licensed, as they are in France and Singapore, for example. Manufacturers could be required to use serial numbers on each pack to facilitate tracking, while pack-marking technology could provide further information about each link in the supply chain, such as the distributor, the wholesaler, and the exporter. Manufacturers could be required to keep better records regarding the final destination of their products. Computerized control systems would enable the tracking of individual consignments and their progress at any point in time; such a system is currently in place in Hong Kong SAR. Finally, exporters could be required to label packs with the country of final destination and a health warning in the language of that country.[77]

The threat of smuggling could lead to regional coordination, enabling successful application of tobacco tax policies across countries. Multilateral agreements that take relative tax structures into account could be valuable in applying consistent tobacco control policies across regions. For example, the WHO Framework Convention on Tobacco Control (WHO FCTC), a multilateral treaty addressing global tobacco control with more than 170 Parties, includes provisions with specific obligations regarding taxation, pricing, and controlling smuggling. Specifically, Article 6 of the WHO FCTC, *Price and tax measures to reduce the demand for tobacco,* encourages Parties to adopt price and tax measures aimed at reducing tobacco consumption and to prohibit or restrict sales and importations of duty-free tobacco products. Article 15, *Illicit trade in tobacco products,* provides binding guidance on controlling illicit trade; to augment this, the Parties to the WHO FCTC are negotiating a protocol, or additional treaty, on the elimination of illicit trade in tobacco products. The presence of these issues in the WHO FCTC, a legally binding instrument, and the commitment demonstrated by undertaking a new negotiation process for the protocol reflect the importance of coordinated action, since strong national measures taken in a single country can be undone if transnational dimensions such as smuggling are not addressed.

Impact on Employment

Although the focus of tobacco control programmes is largely on demand reduction, it is important to acknowledge that the cultivation of tobacco is important to many countries' economies. Policies regarding the supply side of tobacco production, processing, and manufacture affect millions of women workers. Much more research is needed on the economics of how gender norms and roles affect women and men differently in tobacco growing, production, and marketing. In general, rural women are the backbone of small tobacco-producing farms, performing the most labour-intensive jobs, including weeding, leaf selection, and gathering of fuel for curing. They are also the majority of bidi workers in India and, in some countries, the majority in tobacco-product manufacture.

In addition to health consequences they share with men, women face additional medical costs linked to tobacco use due to increased complications during pregnancy and low-birth-weight babies.

Tobacco is grown in more than 125 countries, and the global value of crop production is approximately US$ 25 billion. This is less than 1% of the value of agricultural production globally,[77] but in some countries the relative value is considerably higher. The Chinese government, which controls tobacco production through a state-controlled monopoly, receives about 240 billion yuan (US$ 30 billion) annually from combined profits and taxes related to production. China is the world's leading cigarette producer, manufacturing one third of the world's cigarettes. An estimated two thirds of the workers employed worldwide in

cigarette production work in just three countries—China, India, and Indonesia. Tobacco leaf exports constitute an especially large part of the economy in Zimbabwe and Malawi. In Thailand, revenue from taxation of tobacco products accounts for more than 5% of total government revenue. Economic and political concerns about threats to the industry can play a major role in the debate over tobacco control policies in these countries.

One of the main concerns raised by the tobacco industry and the general public is that tobacco control policies may increase unemployment and may negatively impact the economy. Several studies have been commissioned by the tobacco industry to produce estimates of their contribution to employment, incomes, and tax revenue in order to convince legislators that tobacco control policies will harm the broader economy and cause widespread job loss.[83–85] These studies have been criticized because they calculate the gross contribution of tobacco to employment, tax revenue, and the economy. They do not take into account the fact that if people stop spending money on tobacco, they usually will spend it on other things, thus generating alternative jobs.

Several independent studies on the overall net effect of tobacco control policies on various economies indicate a very minimal but usually positive effect in the long run.[86–89] These studies take into account the compensating effect of alternative jobs that would be generated by money not spent on tobacco.[90] Independent studies also show that in most countries and over the medium and long run, even very stringent tobacco control policies will have minimal negative impact on long-run economic growth, employment, tax revenue, and foreign trade balances as expenditure switches and reallocations in the economy take place. A country's reliance on tobacco exports and its stage of development influence its view of and openness to tobacco control measures, as, in general, a few large tobacco-producing and exporting countries stand to lose more than the majority of countries that are net importers and consumers of tobacco.[91]

The impact of a fall in consumption will vary, depending on the type of economy in the country where it occurs. The small handful of net exporting economies that are heavily dependent on tobacco for foreign-exchange earnings could experience net national job losses. However, even those agrarian economies that are dependent on tobacco production and exports will have a large enough market to ensure jobs for many years to come, despite gradually declining demand.

The overwhelming evidence suggests that the best approach is to emphasize measures that reduce demand, leaving supply to adjust to evolving changes in demand. As long as demand grows, buy-outs, price supports, subsidies, and alternative crop programmes will have minimal effect, since they will merely produce opportunities and profits for future producers of tobacco.[16] At the same time, the WHO FCTC (Articles 17 and 18) commits Party governments to supporting crop diversification, economically viable alternative activities, and sustainable livelihoods to address concerns about the effects of tobacco control on tobacco production and the environment, especially in poor developing countries.

Conclusions

This chapter provides a broad review of the economic literature on the costs of smoking and the effects of taxation, highlighting findings pertaining to women. The evidence presented on the health and economic consequences of tobacco use constitutes a robust justification for governments' use of tobacco taxes as a way to protect women's health.

Estimates of the treatment costs and productivity losses associated with diseases caused by smoking provide potentially powerful evidence for implementing tobacco control. Significant costs are also associated with SHS exposure, and the majority of victims of SHS are women and children, particularly in developing countries. Because the majority of the smokers are males, women are particularly at risk of SHS exposure at home from their partners. Moreover, since the majority of the people who work outside the home are male, women are likely to be exposed to SHS in the workplace as well. In addition to health consequences they share with men, women face additional medical costs linked to tobacco use, such as increased complications during pregnancy and low-birth-weight babies. Moreover, women face significant tobacco-related personal and economic costs, particularly in low-income countries, where they tend to have fewer resources than men.

The evidence that taxation of cigarettes is highly effective in reducing consumption is supported by more than

100 studies that examined the impact of cigarette prices on the demand for cigarettes in high-income countries. The consensus estimate from these studies is that the overall price elasticity of demand ranges from –0.25 to –0.50, implying that a 10% increase in the price of cigarettes will decrease overall cigarette consumption by between 2.5% and 5.0%. A smaller, but growing, number of studies have examined the effects of price changes in low- and middle-income countries. Recent evidence suggests that the price-elasticty estimates for these countries are approximately double those for high-income countries. That is, demand is generally found to be more elastic in low- and middle-income countries, and the average price elasticity is estimated to be about –0.8.

Economic theory predicts an inverse relationship between age and the response to changes in the price of tobacco products. A majority of the research from high-income countries confirms this prediction, finding that youth and young adults are more responsive to tobacco price changes than adults are. Some recent studies suggest that adolescents may be as much as three times as responsive to price changes as adults.

The number of studies of price-responsiveness by gender is growing. Most of these studies have been conducted in high-income, industrialized countries, and the results are mixed with respect to the influence of price. The evidence from North America generally leads to the conclusion that men's cigarette consumption is more responsive than women's to changes in price. However, recent results from the United States indicate that the magnitude of the price response by gender is sensitive to the inclusion of state fixed effects, which are designed to hold constant time-invariant state-level heterogeneity, such as smoking sentiment. Studies conducted in the United Kingdom have generally found women's consumption of cigarettes to be more responsive to price changes than men's consumption. Finally, studies from the United States have concluded that cigarette tax increases lead to significant decreases in maternal smoking rates. The price elasticity of smoking participation among pregnant women was estimated to be much larger (in absolute value) than that among the consensus general population.

Earmarking a portion of the revenue generated from tobacco taxes for tobacco control programmes reinforces the effect of the tax on consumption. Numerous studies conducted in the United States have examined the impact of comprehensive tobacco programmes on smoking and health. These studies generally conclude that comprehensive tobacco control programmes, independent of price changes, are effective in reducing tobacco use. Comprehensive tobacco control programmes have been found to be effective in reducing smoking in the overall population, and some evidence suggests that women benefit in particular, with substantial declines in lung cancer rates and in smoking among pregnant women.

Most of the objections to increased taxes and other tobacco control policies on the supply side are based on misinformation and should not be used as arguments to dissuade governments from raising taxes. These include threats of smuggling, the idea that tobacco taxes place a disproportionate burden on the poor, the fear that higher taxes will lead to reductions in revenue, and the possibility that tax increases will lead to decreased employment and macroeconomic vitality. There is little evidence to support these claims, and the threat of not doing anything to prevent the tobacco epidemic from spreading to women and children is far greater than these concerns.

While much has been learned from previous research in industrialized countries, more research is warranted. In particular, more research is required in high-income countries to disentangle the mixed results on the effects of price on smoking prevalence and average consumption by gender. Studies should focus on the impact of unobserved heterogeneity, including sentiment towards tobacco, which may be driving some of the mixed results in research to date. Moreover, additional studies are needed from high-income countries on the gender-specific impact of cigarette prices on smoking initiation and cessation and other transitions in the smoking uptake and cessation continuums. More research is warranted on the impact of comprehensive programmes, independent of cigarette prices, on female tobacco use.

The past few decades have seen a growing recognition of the effects of smoking on women in low- and middle-income countries. Much more research must be conducted on the impact of cigarette prices on demand for cigarettes by gender in these countries. Studies that examine gender differences in the impact of price on smoking prevalence, average consumption, smoking initiation, smoking cessation, and other transitions are desperately needed. Furthermore, the differential response to price by sex should be examined for other tobacco products commonly consumed by women in some countries, e.g. chewing tobacco, hookas, bidis, and

kreteks. For many of these countries, surveys will need to be conducted to collect information on tobacco consumption, SES, and demographic factors. This may not be feasible for countries with limited resources, but in countries where national health surveys are being planned, there is an opportunity for researchers to help design the surveys and collect the data needed for such analyses. Greater attention must be paid to economic research on gender with a focus on women in all their diversity, by age, ethnicity, region, occupation, and political and social status.

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12. Women's Rights and International Agreements

Introduction

Women's right to health is a human right that has been guaranteed through international agreements.[1] It includes the right to protection against second-hand smoke in the work environment and in the home; equal access to health services, including quitting and counselling programmes; protection against misleading health messages such as "light" and "mild"; and the right to full participation in political, economic, social, and cultural decision-making.

The international community can build on existing policy documents, legislative instruments, and international initiatives to develop a gender-sensitive strategy for implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC).[2] The Preamble and Guiding Principles of the WHO FCTC make reference to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child, and the International Covenant on Economic, Social and Cultural Rights. The provisions of the WHO FCTC, which address issues such as restrictions on advertising and promotion, warning labels, research, protection of minors, health information and education, smuggling, and liability and compensation, are comprehensive. Applied broadly to the general population, these measures may, of course, benefit women. However, the WHO FCTC also recognizes the importance of a gendered approach to the interpretation and implementation of policies, programmes, and research. The Preamble states that [The Parties to the 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.

The Guiding principles note that *strong political commitment is necessary to develop and support, at the national, regional and international levels, comprehensive multisectoral measures and coordinated responses, taking into consideration... the need to take measures to address gender-specific risks when developing tobacco control strategies* (Article 4, WHO FCTC).

The WHO FCTC also recognizes the importance of women's leadership, calling for emphasis on *the special contribution of nongovernmental organizations and other members of civil society not affiliated with the tobacco industry, including health professional bodies, women's, youth, environmental and consumer groups, and academic and health care institutions, to tobacco control efforts nationally and internationally and the vital importance of their participation in national and international tobacco control efforts* (Preamble, WHO FCTC).

This chapter examines how the WHO FCTC relates to other important international agreements concerning women's human rights. In particular, the issues of women, tobacco, and the WHO FCTC are analysed in the context of CEDAW.[3] In its Preamble, the WHO FCTC recalls that *the Convention on the Elimination of All Forms of Discrimination against Women, adopted by the United Nations General Assembly on 18 December 1979, provides that States Parties to that Convention shall take appropriate measures to eliminate discrimination against women in the field of health care* (Preamble, WHO FCTC).

Evolution of United Nations Agreements on Human Rights and the Convention on the Elimination of All Forms of Discrimination against Women

CEDAW is the most important legally binding international document concerning the human rights of women. It has been ratified by more than 185 countries. The importance of CEDAW and its relation to the WHO FCTC can be best understood by examining the context of its evolution. The majority of human rights agreements result from negotiations under the auspices of the United Nations. They are usually initiated in response to global concern about specific issues or tragedies such as the Second World War. In 1948, the United Nations proclaimed a Universal Declaration of Human Rights that clearly describes the "inalienable and inviolable rights of all members of the human family".[4]

This declaration marked a moral milestone in the history of the community of nations, but it lacked the force of law. Therefore, its principles have been codified in treaties, covenants, and conventions to make them legally binding on the countries and entities that became Party to them.

CEDAW is unique among existing human rights instruments because it is concerned exclusively with promoting and protecting women's human rights and because it operates from the premise that patriarchy is a global reality.

Two crucial legal instruments followed the Universal Declaration of Human Rights: the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. Together, these three documents constitute what is known as the International Bill of Human Rights. Subsequent conventions have elaborated on this bill by focusing in greater detail on specific areas.

The 1960s saw an emergence in many parts of the world of a new awareness of the patterns of discrimination against women and an increase in the number of organizations committed to combating the effects of such discrimination. Although the human rights treaties had established a comprehensive set of rights to which all persons are entitled, over the years they proved insufficient to guarantee women the enjoyment of those rights. Therefore, in 1963, the United Nations General Assembly adopted a resolution requesting that the Commission on the Status of Women prepare a draft declaration combining in a single instrument international standards that articulated the equal rights of men and women. Four years later, the Declaration on Elimination of Discrimination was adopted by the General Assembly.

In 1972, five years after the adoption of the declaration, the Commission on the Status of Women considered preparing a binding instrument that would give normative force to its provisions. Finally, in 1979, CEDAW[3] was adopted, and on 3 September 1981, just 30 days after the twentieth Party had ratified it, CEDAW entered into force. Often described as an international bill of rights for women, CEDAW was the first international document to embody the concept that rights are basic values shared by every human being, regardless of sex, race, religion, culture, or age.

CEDAW is unique among existing human rights instruments because it is concerned exclusively with promoting and protecting women's human rights and because it operates from the premise that patriarchy is a global reality. It addresses the reality of deep-rooted and multifaceted gender inequality throughout the world. It also emphasizes both public- and private-sphere relations and rights and specifically underlines the almost universal difference between de jure and de facto equality of women in the world. CEDAW focuses on elements of the social traditions, customs, and cultural practices that "legitimately" violate women's rights in many societies, identifying them as elements that help perpetuate de facto inequality. CEDAW is also clear about States Parties' use of economic conditions and factors such as structural adjustment policies and programmes, slow economic growth rates, recessionary pressures, and privatization to justify discriminatory practices against women. It operates with the understanding that the States Parties' failure to remove obstacles to women's enjoyment of all their rights is discriminatory, expanding the concept of rights by holding States Parties accountable for failure to act and for abuse of power by private parties.

The idea of introducing a complaints procedure for CEDAW came about in the early 1990s with the emergence of the international women's rights movement, which called for the strengthening of the existing United Nations human rights machinery for the advancement of women. The adoption of an optional protocol to the Convention to provide a right to petition was one of the commitments made by Member States of the United Nations at the 1993 Conference on Human Rights, in Vienna, and the 1995 Fourth World Conference on Women, in Beijing. In 1995, at its fifteenth session, the CEDAW Committee adopted a suggestion (number 7) that proposed elements for a petition and an investigation procedure for complaints. Then, at the forty-third session of the Commission on the Status of Women, delegates adopted an optional protocol to CEDAW, which entered into force in 2000.

The optional protocol introduces two procedures: a communications procedure whereby individuals or groups of individuals may submit claims of violations of rights to the committee, and an inquiry procedure whereby the committee may initiate inquiries into situations of grave or systematic violations of rights. The optional protocol, ratified by 88 Parties (as of March 2008), encourages states to implement CEDAW to avoid having complaints made against them. It provides an incentive for states to provide more-effective local remedies and to eliminate discriminatory laws and practices. Moreover, it is a major tool for women, as communications concerning violations of "any of the rights set forth in the Convention" may be submitted on behalf of an individual or group of individuals. This is critical given the obstacles many women face, such as low levels of literacy, legal illiteracy, and fear of reprisals. However, although CEDAW is widely ratified, it also has the highest number of reservations of any convention. Removal of these reservations is a major goal for both nongovernmental organizations (NGOs) and governments in the coming years.

CEDAW and Women's Health

One of the rights guaranteed under CEDAW is the right to equality in the full enjoyment of health. Article 12 requires States Parties to eliminate discrimination in all aspects of women's health care, including drug addiction and related problems. According to Article 12, "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services".

Although tobacco is not specifically mentioned in CEDAW, it is covered by Article 12 and has been interpreted by the CEDAW Committee as an issue on which governments can be held accountable. Since 1995, the CEDAW Committee has increased its efforts to hold governments accountable for accurate reporting on women and tobacco and compliance with this provision. Governments are requested to provide data on women and tobacco, along with data on drugs and alcohol. In recent years, numerous States Parties to CEDAW have improved their reporting. For example, at the forty-fourth session of the CEDAW Committee, Denmark reported a rise in lung cancer among Danish women resulting from years of tobacco use, with nearly 23% of women and 24.5% of men smoking daily. Spain also expressed concern that young women were increasingly using tobacco.

A main assumption of CEDAW is that the maintenance of health affects the very existence of human beings and is a fundamental human need. WHO studies indicate that more than 20 million lives could be saved by the provision of necessary medicines, pharmaceuticals, and health-care education and facilitation of improved lifestyles.[1] These can all be considered included under Article 12 as part of women's right to health.

The CEDAW Committee also notes that women's health should have a high priority because women are the providers of health care to their families, and their role in health care, including childbirth and child rearing, is of great significance to national social and economic development. The Committee has worked within a framework in which health care is directly concerned with issues such as population growth, development, and the environment. If malnutrition and poverty are to be overcome, the promotion of health and education and the advancement of women's status must be considered as cardinal elements. In viewing women's enjoyment of health as an intrinsic human right, States Parties are therefore obliged to address the conditions that lead to poor health, as well as women's health status.

A human rights approach to women's health is not limited to Article 12 of CEDAW.[3] Article 7 gives women the right to participate in public life and political decision-making. The effective implementation of this right involves including women in designing and implementing national health policies and programmes. Article 2 notes that states must propose a policy to guarantee women the exercise and enjoyment of human rights and fundamental freedoms, in both the private sector and the public sector. This means that women must be fully informed about their rights, a provision that can be applied to tobacco control legislation. Article 11 refers to women's right to the protection of health and safety in working conditions, a provision that is directly relevant to passive-smoke hazards. Another example is the application of the right to life. Maternal health must be protected by implementation of special proactive measures. Further, under Article 14, States Parties are obliged to take into account the specific problems faced by rural women and, in particular, to ensure that they "have access to adequate health care facilities, including information and counselling". Article

14 also guarantees rural women the right to social services and security—a right that is increasingly relevant to rural workers in the informal sector.

According to General Recommendation 24, governments have a duty to report to CEDAW on health legislation plans, cost-effective preventive measures, and policies and to provide reliable data disaggregated by sex.

Globalization has created more jobs and new employment opportunities for women, but it has also created new forms of informal and insecure employment. Citing Article 1, the Committee has often addressed the indirect discrimination faced by women in the informal sector, regularly expressing its concern about their precarious condition and demanding statistical data from States Parties. Although the data are somewhat unreliable, there is consensus that the informal sector is steadily growing in almost all developing countries.

For example, making tobacco products is one of the major informal sector activities in Malawi and Ghana. Women tobacco workers, such as those making bidis, generally have low and unstable earnings and high risks of exposure to health hazards. It is common for women who make tobacco products at home to have no access to employment benefits or social security entitlements. They often face exploitation, and because they are isolated from each other, they are less able to join in collective bargaining.

For many poor women, street vending of tobacco products—where working conditions again are precarious—is the only occupational option. Street vendors lack legal status, and they experience harassment and evictions from their selling place by local authorities or competing shopkeepers. Reports indicate that their goods are often confiscated, and arrests are common.

In addition to creating articles, the CEDAW Committee has the power to make general recommendations that interpret and update the articles. According to General Recommendation 24, governments have a duty to report to CEDAW on health legislation plans, cost-effective preventive measures, and policies and to provide reliable data disaggregated by sex on the incidence of conditions hazardous to women's health. All data must be based on ethical and scientific research. For example, collection of data on the prevalence of tobacco use by male smokers only would constitute gender discrimination, as women's health problems would remain invisible to policy-makers. As CEDAW states:

> *States parties are in the best position to report on the most critical health issues affecting women in that country. Therefore, in order to enable the Committee to evaluate whether measures to eliminate discrimination against women in the field of health care are appropriate, States parties must report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost-effectiveness of preventive and curative measures. Reports to the Committee must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture* (General Recommendation 24, Paragraph 1, CEDAW).

Under CEDAW, States Parties must also make appropriate budgetary provisions to ensure that women realize their rights to health care. Governments that do not provide these rights in relation to women and tobacco fail to fulfil their obligations under the Convention. General Recommendation 24 specifically notes:

> *The duty to fulfill rights places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care* (General Recommendation 24, Paragraph 17, CEDAW).

General Recommendation 24 also outlines the need for states to promote women's health throughout the life-course:[3]

> *States parties should implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women* (General Recommendation 24, Paragraph 29, CEDAW).

Under the optional protocol to CEDAW, alleged violations may be linked to state action or inaction or to the conduct of state officials in their public functions. Potential claims could include the absence of health warnings on tobacco products or the lack of information concerning the health hazards of tobacco use by pregnant women.

In addition to CEDAW, the following international agreements are also explicit on the issue of women's health:

- The International Covenant on Economic, Social and Cultural Rights (Article 12: 2a)[5]
- The Convention on the Rights of the Child (Article 24: 1d, 1f)[6]
- The Beijing Platform for Action (Articles 89 and 106)[1]
- The United Nations Declaration on Violence Against Women (Article 3f).[7]

When a Party ratifies or accedes to CEDAW and also adopts a policy document, the combination can be mutually reinforcing. The Beijing Platform for Action specifically identified tobacco as a women's health issue and called upon governments to take action. It states:

> *[Governments should] create awareness among women, health professionals, policy makers and the general public about the serious but preventable health hazards stemming from tobacco consumption and the need for regulatory and education measures to reduce smoking as important health promotion and disease prevention activities* (Paragraph 107o, Beijing Platform for Action).

> *[Governments should] increase financial and other support from all sources for preventive, appropriate biomedical, behavioural, epidemiological and health service research on women's health issues and for research on the social, economic and political causes of women's health problems, and their consequences, including the impact of gender and age inequalities, especially with respect to chronic and non-communicable diseases, particularly cardiovascular diseases and conditions [and] cancers* (Paragraph 109d, Beijing Platform for Action).

Most of the issues in the Twelve Critical Areas of Concern in the Beijing Platform for Action[1] are also included in CEDAW. For example, paragraph 323232 entrusts the CEDAW Committee with the responsibility of monitoring the implementation of the Platform. A government or Party that has ratified CEDAW without reservation and has also signed onto the Beijing Platform for Action is doubly committed, first at the policy level, and second, according to international law. When CEDAW was drafted, the issue of women and tobacco was not widely recognized as a women's rights issue. Today, such policy and treaty agreements can strengthen the WHO FCTC with regard to emerging health issues.

Furthermore, the concept of women's health as a human right has been promoted by United Nations World Conferences, including the Conference on Human Rights, in Vienna (1993); the International Conference on Population and Development, in Cairo (1994); and the Fourth World Women's Conference, in Beijing (1995). The four United Nations World Women's Conferences and follow-up meetings, such as Beijing Plus Ten in 2005, have also produced excellent policy documents. Policy documents, however, are not legally binding, and institutional or individual discretion may determine their implementation.

Monitoring Implementation and International Mobilization

Monitoring implementation through States Parties' reports is an important tool of CEDAW. Reporting enables a comprehensive review of national legislation, administrative rules, policies, and practices, and it ensures that States Parties regularly monitor the situation with respect to each provision of the Convention. The CEDAW Committee

has expressed concerns about the increase in tobacco use by women, the lack of gender-specific information and statistics (Uzbekistan, Kazakhstan, and the Netherlands in 2001), tobacco addiction (Ukraine in 2002), and women's occupational health, particularly in the tobacco-growing industry (the Republic of Moldova in 2006). A common recommendation is the provision of information and statistics on tobacco use by women (Suriname in 2002, Chile in 1999). At its twenty-first session, the Committee recommended that Spain undertake awareness-raising campaigns concerning the preventable health hazards of tobacco consumption and also that it assess the need for additional regulations and educational measures to prevent or reduce smoking by women. At its twenty-ninth session, it requested that France provide information on smoking as well as sex- and age-disaggregated data.

It is crucial to recognize the strategic importance of NGOs with regard to mobilizing international political will.

Article 18 of CEDAW obliges States Parties to submit reports on implementation of the Convention within one year of ratification and every four years thereafter. In these reports, states must indicate the legislative, judicial, administrative, or other measures they have adopted to implement the provisions of the Convention. Article 17 establishes the Committee on the Elimination of Discrimination against Women, an expert body with 23 members responsible for monitoring the progress made by states in implementing CEDAW. Since the adoption of the optional protocol, the Committee can also receive and consider complaints by individuals or groups of individuals from states that are Parties to the protocol.

The CEDAW Committee has adopted reporting guidelines to assist States Parties in the preparation of periodic reports. The Committee also considers the reports in public meetings in the presence of Party representatives, using a constructive dialogue that provides a non-judgemental approach aimed at assisting the States Parties. Following consideration of the reports, the Committee formulates and adopts concluding comments in a closed session. The comments outline factors and difficulties affecting the implementation of the Convention for the reporting States Parties, as well as positive aspects, principal subjects of concern, and suggestions and recommendations for enhancing implementation.

Specialized United Nations agencies and other international and national organizations make important contributions to monitoring. Article 22 specifically provides for interaction between the CEDAW Committee and specialized agencies. The Committee and the pre-session working groups invite specialized agencies and other United Nations entities to provide country-specific information on States Parties whose reports are being considered. The Committee also encourages the United Nations country teams to undertake follow-up activities to support States Parties in their implementation of the Committee's concluding comments.

It is noteworthy that at its thirty-third session, in July 2005, the CEDAW Committee provided for the first time an opportunity for a national human rights institution—the Irish Human Rights Commission—to make an oral presentation. At its thirty-fourth session, in January 2006, the Committee further discussed its interaction with such institutions and confirmed its commitment to develop modalities for improved interaction.

It is crucial to recognize the strategic importance of NGOs with regard to mobilizing international political will. Although NGOs do not have formal standing under the reporting procedure, the Committee welcomes information from them, and since its early sessions, it has invited them to follow its work and provide country-specific information on States Parties. National and international NGOs are also invited to provide the pre-session working groups with country-specific information on those States Parties whose reports are being considered. Such information may be submitted in writing prior to or at the relevant session. In addition, the Committee sets aside time at each session, usually at the start, for representatives of NGOs to speak and provide information. The pre-session working groups also provide an opportunity for NGOs to give statements, usually on the first day of a working group. The Committee further recommends that States Parties involve national NGOs in the preparation of their reports and that reports contain information on NGOs and women's associations and their participation in the implementation of CEDAW and the preparation of reports.

Conclusions

CEDAW is a dynamic document that is flexible enough to adapt to changing international circumstances and attitudes, while preserving its spirit and integrity. The CEDAW Committee endeavours to ensure that women benefit from globalization and that their increased participation in the labour market has an empowering effect on them. Likewise, the WHO FCTC can take up the challenge of improving the lives of women in the informal working sector by making them no longer invisible, unacknowledged, and excluded from protection and benefits.

CEDAW and the WHO FCTC share the common goal of ensuring women's rights to health as a human right. Together, these treaties can be used to commit governments to more gender-sensitive policies and legislation. Both hold governments accountable for commitments made in ratifying or acceding to them, provide a legal basis for interpretation of existing national laws or for amendments to them, and assist in the enactment of new legislation regarding women's health and tobacco. CEDAW can create an expanded human rights framework for women that is acceptable within their own cultures or under their own legal systems. This includes women's right to a safe and smoke-free environment, both in public places and in the home.

For a convention to be effective at both national and international levels, women need to be better informed about their rights under international agreements. CEDAW and the WHO FCTC can be widely disseminated to mobilize support among women's grass-roots organizations. It is also necessary to promote the active support and participation of other institutional actors, including legislative bodies, human rights lawyers, academic and research institutions, local community groups, NGOs, the media, and youth organizations. Other potential partners include national machineries for gender equality and the advancement of women and NGOs engaged in women's empowerment. Women have the right to life and therefore the right to be fully informed about Parties' obligations to protect their health.

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PLEASE DON'T SMOKE
IN OUR HOME

13. The International Women's Movement and Anti-Tobacco Campaigns

Introduction

For decades, the international women's movement has been mobilizing at the grass-roots level and affecting the international political agenda. Among the issues it has successfully brought to the world's attention are violence against women, consumer and environmental justice, reproductive health and sexual rights, and human rights. In recent years, the international women's movement has begun to join forces with the tobacco control movement.

The following is an historic account of women's activism in two regions where women's leadership has made a significant contribution to women's health and development. Although it deals with global trends, only two case-study regions are presented here: Asia and the Pacific, and Latin America and the Caribbean. Through an historical analysis and overview of the current situation, this chapter outlines the potential for future tobacco control actions, as well as existing social resources that promise to help prevent the rising epidemic of tobacco use among women.

A Brief History of the International Women's Movement

Women have taken strong leadership roles at the national and international levels of the women's movement throughout the world. The United Nations World Women's Conferences, which have provided opportunities to build solidarity, share visions, and articulate regional concerns, have been an important influence on the international women's movement.[1] The First United Nations World Conference on Women was held in Mexico City in 1975, the year that was designated as the International Women's Year. The Women's Tribune, consisting of about 2000 women from nongovernmental organizations (NGOs) of various countries, was held simultaneously with the United Nations Conference. The majority of the participants came from the United States and Latin America; Asian, African, and grass-roots women's groups were underrepresented. Asian women watched the heated confrontation between feminists from the industrialized northern hemisphere and the developing countries of the southern hemisphere. Issues such as women's reproductive rights were featured in debates on women and health, but otherwise, health was low on the list of priorities. In 1980, the Second United Nations World Conference on Women was held in Copenhagen, Denmark. African women were more visible at this conference, because of geographical and historical ties between Europe and Africa. The confrontation between industrialized-country and developing-country feminists was less apparent, but other political issues related to the Cold War dominated the agenda. Considered the most controversial of the global women's conferences, this one nevertheless succeeded in introducing the important Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), known as the women's bill of rights. A detailed discussion of CEDAW is found in the chapter on women's rights and international agreements.

The new strength of regional women's networks was reflected at the Third United Nations World Conference on Women, held in Nairobi, Kenya, in 1985. Women's health and the environment were not major issues at that event, but women's reproductive health was an increasingly important human rights issue, and issues of poverty and education were highlighted. In the aftermath of other United Nations conferences, including one on environment and development, the Vienna Human Rights Conference, and the International Conference on Population and Development, women's NGOs concerned with health and the environment developed stronger lobbying strategies and political agendas. This momentum culminated with the Fourth United Nations World Conference on Women, held in Beijing, China, in 1995, when representatives from the industrialized and developing countries achieved an important consensus on both environmental and women's health issues.

The Platform for Action—the blueprint for women's equality in the 21st century—was adopted by the Conference in Beijing. It included 12 critical areas of concern: poverty, education, health, violence against women, armed conflicts, economy, decision-making, mechanisms for the advancement of women, women's human rights, media, environment, and the girl-child. The Platform also contained hundreds of recommen-

dations and strategies for each area. For the first time at a United Nations Women's Conference, tobacco was recognized as a women's health issue in the general discussions and recommendations.

Founded in 1990, INWAT is a global network of more than 1700 tobacco control and women's health specialists in about 80 countries that addresses the social, cultural, health, and economic issues of tobacco as they affect women and girls.

At the parallel NGO Forum, hundreds of workshops were held on a large variety of issues, including violence against women, reproductive rights, trafficking in women, armed conflicts, feminization of poverty, and political participation. Participants at the grass-roots level shared their experiences in organizing to fight against development projects that perpetuated gender discrimination. There was also an important transformation of women's self-image, from women as victims to women as leaders and visionaries. For example, at a workshop on Asian Women's Alternatives in Action, participants from various Asian countries reported innovative and dynamic strategies and practices and showed their determination to work towards a world based on gender justice through women's empowerment. The theme of the NGO Forum, Look at the World Through Women's Eyes, reflected this newfound confidence and assertiveness.

Since that time, women's awareness of and support for tobacco control has grown. A major turning point was the gathering of nearly 500 women from 50 countries in Kobe, Japan, in November 1999, at the World Health Organization (WHO) International Conference on Tobacco and Health, Making a Difference to Tobacco and Health: Avoiding the Tobacco Epidemic in Women and Youth. Upon returning to their countries after the Conference, many women leaders carried out national campaigns and media events and joined forces with tobacco control programmes. Anti-tobacco activities led by women's groups have grown in many countries, including Malaysia, Thailand, Bangladesh, Japan, the Lao People's Democratic Republic, Turkey, Cuba, and Brazil. At the WHO public hearings held in Geneva in 2000, women leaders from the Federation of Cuban Women, REDEH/CEMINA (Brazil), the Centre for Human Environment in Ethiopia, the international Women's Environment & Development Organization (WEDO), and the Zuna Women's Operation Green (Zimbabwe) testified against the tobacco industry and showed their support for the WHO Framework Convention on Tobacco Control (WHO FCTC).[2,3]

A key resource and bridge between tobacco control and the women's health movement is the International Network of Women Against Tobacco (INWAT). Founded in 1990, INWAT is a global network of more than 1700 tobacco control and women's health specialists in about 80 countries that addresses the social, cultural, health, and economic issues of tobacco as they affect women and girls. INWAT also aims to promote women's leadership in tobacco control. Its publication *Turning a New Leaf: Women, Tobacco, and the Future* highlighted this theme, as well as the linkages between tobacco production and consumption and the status of women.

The InterAmerican Heart Foundation (IAHF) and INWAT organized a forum with a focus on women and tobacco during the First SRNT [Society for Research on Nicotine and Tobacco] Latin America & Second Iberoamerican Conference on Tobacco Control, held in Rio de Janeiro, Brazil, in 2007. The purpose of the forum was to provide a platform for debate and to share experiences and lessons learned about women and tobacco in the fields of advocacy, research, and policy.

The WHO FCTC negotiations provided an important opportunity for groups such as INWAT and the women's movement to work together to influence the final version of the treaty. During the negotiations in Geneva in October 2000, a women's caucus was begun as a subgroup of the Framework Convention Alliance (FCA). By 2008, FCA membership included almost 300 health, environmental, consumer, and human rights organizations from more than 100 countries. FCA plays a critical role in the treaty process, working collaboratively with governments, providing educational material and tobacco control expertise, monitoring the treaty implementation process,

and helping to shape the public climate that has provided momentum for international regulation of the tobacco industry. Its board has been exemplary in its gender and regional balance.

At the founding of FCA in 1999, the women's caucus acted as a coalition of NGOs to ensure effective implementation of the WHO FCTC and provided an open forum for dialogue between NGOs, government delegates, and United Nations agencies. Its specific goal was to promote networking among leaders (both women and men) concerned with gender issues and to provide technical support to government delegations.

Throughout the WHO FCTC process, the women's caucus had daily programmes that included briefings by eminent leaders such as Judith Mackay, former chairperson of the WHO Policy and Strategy Advisory Committee; Margaretha Haglund, former president of the International Network of Women Against Tobacco; and Phetsile Dlamini, Minister for Health and Social Welfare in Swaziland. The caucus organized briefings for delegates, highlighting issues such as the exploitation of feminine imagery by multinational corporations to market tobacco to women and girls. Together with the International Alliance of Women and the Campaign for Tobacco-Free Kids, the women's caucus made numerous statements during the negotiations concerning the importance of a gender perspective on political and economic policies.

Most important, the caucus was instrumental in ensuring that the WHO FCTC made reference to treaties that would strengthen a gender perspective in its interpretation. The group prepared an NGO briefing paper that evolved into the first draft of the WHO FCTC Preamble, which eventually contained key provisions on gender and human rights. Among the priorities of the caucus were women's rights as human rights issues, as encapsulated in CEDAW, the Convention on the Rights of the Child, and the Covenant on Economic, Social and Cultural Rights.

Signs of growing awareness and activity related to the WHO FCTC beyond the arena of negotiations have been evident at other international events. It is noteworthy that in 1999 and 2000, the Commission on the Status of Women, which oversees the implementation of the Platform for Action, included the topic of women and tobacco in its working documents. Similarly, at its session in 2000, the expert committee that oversees CEDAW requested that governments report on tobacco use under Article 12. During the Beijing Plus Five meeting in 2005, members of the CEDAW Committee spoke at a panel on the linkages between gender, women, and tobacco and CEDAW provisions. Also, at the United Nations Children's Summit, the World Association of Girl Guides and Girl Scouts, along with the Campaign for Tobacco-Free Kids, held events pointing out new and innovative ways for girls to become leaders in the anti-tobacco movement.

Ayako Kuno, one of the eight founding members of the Women's Group, wrote in the magazine **Women's Revolt,** *"I realized recently that most feminists smoke".*

Asian Women's Anti-Tobacco Organizations

This section describes Asian anti-tobacco organizations that, although small in membership, laid the groundwork for a stronger movement today. As taboos against women smoking in public subsided in many traditional Asian societies, well-educated, emancipated women increasingly used tobacco. Nevertheless, some health-conscious groups are prevailing in their struggle to control the tobacco epidemic among women.

The Japanese Non-Smokers' Rights Group

In 1977, around the time the Japanese Non-Smokers' Rights Group was formed, feminists in Nagoya founded the Women's Group to Eliminate Harm of Tobacco. The women's liberation movement in the early 1970s claimed the equal right to smoke, and many young feminists had started to use tobacco. However, those feminists who objected to smoking challenged this idea and insisted that both men and women should stop smoking.

Ayako Kuno, one of the eight founding members of the Women's Group, wrote in the magazine *Women's*

Revolt, "I realized recently that most feminists smoke. I felt sick of the polluted air. I myself used to look positively at women smoking because it seemed they challenged the traditional social norm based on Confucian patriarchal ideology that smoking is not women's behaviour. However, I began to question if smoking means women's liberation, because tobacco is poison and harmful to health and the environment".

The issue reappeared in 1987, when Women's Action on Smoking was formed in Tokyo by female doctors, teachers, writers, and working women who were concerned about how a male-dominated culture perpetuates women's suffering from second-hand smoke (SHS) at home and in the workplace. This group also focused its attention on rising rates of tobacco use among young women. According to Nobuko Nakano, one of the founders, the main objectives of the group were non-smokers' rights and the prevention of smoking among youth, especially girls.[4] Its members were engaged in activities to promote smoke-free education in schools, appealing to non-smokers' rights through the media and lobbying. They also established a hotline for non-smokers to address the issue of SHS in the workplace and initiated a campaign to remove tobacco vending machines. Recently, women have become more outspoken about protecting themselves and their children from SHS as a right.

In the past decade, several medical professionals in the group independently started training programmes for cessation. These programmes, carried out by women doctors, have attracted many women smokers. Also inspired by the Kobe Conference in 1999, the Japanese Nursing Association (JNA)—Japan's largest women's professional organization, with 600 000 members—campaigned to stop smoking by nurses and to make hospitals smoke-free. The rate of smoking among nurses (25.7%) was twice that of all Japanese women in 2001. JNA published booklets on quitting smoking and organized many seminars to train leaders for cessation programmes. Some progress was noteworthy: in 2006, the nurses' smoking rate dropped by 6%, although it was still high (19%). JNA is continuing its efforts to highlight nurses' important role in helping patients quit smoking and combating SHS. It is noteworthy that in other countries, such as Thailand and Brazil, nurses associations are becoming increasingly active in tobacco control and efforts to make hospitals smoke-free.

The Consumers Association of Penang

The Consumers Association of Penang (CAP), in Malaysia, an internationally recognized consumer advocacy group, started an anti-smoking campaign in 1973. Since then, it has organized numerous seminars, forums, and exhibitions and has published and distributed booklets, educational kits, posters, and stickers to inform people of the negative effects of tobacco on health, the environment, and the economy.

CAP urges women to play active roles in smoking prevention and cessation and provides concrete suggestions, including the following:

- Women health professionals can actively promote a tobacco-free lifestyle; women doctors and nurses can serve as educators and disseminators of information.
- Women in the media can reverse the social acceptability of smoking; they can promote non-smoking as an attractive and healthy lifestyle and can undo the damage done by others in the media.
- Women in politics and government can be instrumental in passing anti-smoking legislation and regulations and should advocate stricter laws.
- Women in sports should boycott sports activities sponsored by the tobacco industry, as participation in such activities implies an endorsement of smoking.

The Action on Smoking and Health Foundation of Thailand

The first project in Thailand dealing exclusively with tobacco control was the Women and Smoking Project, an NGO formed by 12 health organizations in 1986. In 1997, the Project became the Action on Smoking and Health Foundation of Thailand (ASH Thailand). Its activities include programmes designed for youth, including Smoke-Free Schools 2000. ASH Thailand cooperates closely with the National Council of Thai Women, an umbrella group that has taken strong actions against tobacco in recent years. Thai nurses have also established a national organization that works cooperatively with physicians to establish smoke-free hospitals and provide patient counselling.

A special project called "Thai Women Don't Smoke" was set up in 1995 to counter the tobacco companies' efforts to encourage women to start smoking. The project focuses on the effects of smoking on appearance and on children's health and promotes the view that smart women do not smoke. The mass media have been actively involved in the project, and ASH Thailand has worked closely with three national beauty contests: Miss Teen Thailand, Miss Thailand, and Miss Thailand World.

The Consumers Union of Korea

The Consumers Union of Korea, established in 1970, started a no-smoking campaign in 1984 to stop the spread of tobacco use among young people. The Union has 25 000 members (most of them women) and 121 member firms. Its activities and goals include:

- Demonstrations and press releases
- Street rallies on World No Tobacco Day
- Protests of tobacco-sponsored events, e.g. Marlboro concerts
- Advocating stronger warning labels
- Advocating a ban on tobacco vending machines
- The Asian Women's Health Movement.

The Asian Women's Health Movement

It is noteworthy that in the Asian region, tobacco control programmes have often worked outside the mainstream of women and health activities. This historic schism should be analysed in depth through sociological research so as to uncover more effective ways to bridge the gap in the future. Although some organizations such as the International Network of Women Against Tobacco have worked with national counterparts in the Asia region, much more work needs to be done to enlist the help of grass-roots as well as national organizations that have worked in women's reproductive health, family planning, and other public health issues—most of which currently are not advocates for tobacco control.

It is vitally important to mobilize women at the local level to participate in anti-smoking campaigns. In a number of countries, including India, Bangladesh, Nepal, the Philippines, and Malaysia, many women's organizations are committed to the advancement of women's health and are working on important health issues.[5] The groups described in this section have not focused on issues of women and tobacco to date, but it is important to encourage their participation and involvement. Most of the organizations in the Asian women's health movement are current or potential allies for tobacco control.

In a number of countries, such as India, Bangladesh, Nepal, the Philippines, and Malaysia, many women's organizations are committed to the advancement of women's health and are working on important health issues.

The Centre for Health Education, Training and Nutrition Awareness

The Centre for Health Education, Training and Nutrition Awareness (CHETNA) is an NGO based in Gujarat, India. Established in 1980 with the mission of contributing to the empowerment of disadvantaged women through health education, CHETNA (which means "awareness" in several Indian languages) has a Women and Health Programme that aims to enable women and communities to initiate, manage, and sustain comprehensive, gender-sensitive primary health care for all. Its main activity is training employees of NGOs and government in gender and health, reproductive health, emotional and mental health, ageing, and traditional health and healing practices. CHETNA uses a participatory approach, and its communications strength is its adaptation to the local social, cultural, and economic conditions of its constituents.

Buddha Bahnipati Family Welfare Project

The Buddha Bahnipati Family Welfare Project (BBP) of the Family Planning Association in Nepal formed

its first women's group in 1990. Members of BBP take a comprehensive approach to improving the overall livelihood of women. They conduct informal classes on literacy, savings and credit, animal raising, and fodder production, and they operate health camps where women can learn about gynaecology, vasectomy, and dental, eye, and general-health check-ups. The purpose of the group is to help women gain confidence, security, and dignity, as well as to improve their standards of living.

Bangladesh Women's Health Coalition

The activities of the Bangladesh Women's Health Coalition (BWHC) are based on three principles: (1) each woman should be treated with respect; (2) each woman's particular needs should be carefully discussed with her by health-care professionals; and (3) each woman should be provided with sufficient information and counselling to make her own choices about her reproductive health.

BWHC operates seven clinics that offer a choice of family-planning methods. The clinics are staffed by women paramedics recruited from the community. Doctors, nurses, and attendants also provide counselling, as BWHC considers counselling crucial to overcoming class barriers between the health professionals and their clients. BWHC also organizes training programmes for government paramedics.

Gabriela

Gabriela is a national coalition of women's organizations in various sectors of the Philippines. Its Commission on Women's Health and Reproductive Rights provides community-based health services for women, men, and children. The Commission operates a women's clinic in Metro Manila and two pilot communities; in one year, it provided approximately 1500 consultations, 1100 of which were to women. The Commission's objectives are to develop women's health initiatives and to integrate these into the overall developmental efforts of the communities. Two pilot communities have already developed their own management plans. The outstanding characteristic of Gabriela's "health service to sisters in need" is that it lets women in communities organize themselves and manage by themselves.

Asian-Pacific Resource & Research Centre for Women

The Asian-Pacific Resource & Research Centre for Women (ARROW), based in Malaysia, advocates women-centred and gender-sensitive policies and programmes for women's health based on—and evolved from—comprehensive public health care. This NGO provides practical information, resources, and research findings. Its information kit, "Towards Women-Centred Reproductive Health", is an action-oriented introduction to women-centred reproductive health and is most useful for women's health projects and movements at the grass-roots level. It can also be used to advocate for government public health policy. ARROW uses a life-course approach, covering the prenatal period, girlhood, adolescence, menopause, and old age. It also addresses critical areas of women's health that have been given little attention in Malaysia, including occupational health, emotional and mental health, and violence against women.

These networks and alliances have the potential to become essential links in the worldwide movement to control tobacco and advance women's health, but stronger connections must be made between them and the tobacco control movements. It is crucial to disseminate information on the hazards of tobacco use among women to these NGOs and to foster strong leadership skills.

The Latin American and Caribbean Women's Health Movement

As in the case of the Asian women and health movement, the feminist health movement in the Latin American and Caribbean countries was initially antagonistic to tobacco control policies, because they were viewed as attempting to obstruct women's newly found "liberties". Indeed, many women considered it their "right" to smoke in public, particularly as it had been a social taboo in the past. Similar trends can be seen in North America.

It is noteworthy that the feminist movement in Latin American and Caribbean countries began simultaneously with the growth of the movement in North America and Europe. In the late 19th and early 20th centuries, important feminist leaders in Latin American countries provided leadership and stimulated activism to improve women's status and access to education, including university education. Women's rights to health and

economic and political participation were the main areas of concern for the early activists.

Feminism in the Latin American and Caribbean region promoted women's autonomy and liberation. At the same time, the inclusion of women in traditional male activities changed women's lifestyles to include smoking. Feminist arguments used to improve women's status were adopted by tobacco companies, and the ideology of the movement was manipulated by tobacco advertising. Initially, advertisements associated tobacco with sophisticated and glamorous women. Images of women who succeeded in men's activities, such as Amelia Earhart, were also used. In the past decade, messages targeting women linked tobacco with liberty and pleasure.

Although the tobacco industry succeeded in courting many emancipated women, the beginnings of an opposition were forming. In 1984, representatives from 60 women's health groups who attended the First Regional Women and Health meeting in Colombia created the Latin American and Caribbean Women's Health Network (LACWHN). LACWHN is made up of approximately 2000 member groups; 80% of the members come from Latin America and the Caribbean, and the rest come from North America, Europe, Africa, Asia, and the Pacific. Its board of directors is composed of nine health activists from different countries in Latin America and the Caribbean, and its headquarters is in Santiago, Chile. One of its main activities is the publication of a quarterly journal, *Women's Health Journal*, and a special annual document, *Women's Health Collection*. For its first 10 years, LACWHN was coordinated by Isis International, a regional feminist NGO based in Santiago. In 1995, by agreement of its board of directors, LACWHN became an autonomous institution and currently functions as a foundation.

LACWHN disseminates and promotes research and studies on women's health issues and mobilizes groups and activists to advocate for and defend women's rights regarding these issues. Its activities are organized as campaigns around specific days designated to draw attention to particular health issues. The network also promotes activities by its members and disseminates health information to interested parties, such as women's groups, academic institutions, governmental health and social authorities, health and associated professionals, the private sector, journalists, and policy-makers.

A review of women's health campaigns promoted by LACWHN provides some perspective on women's health activities and their possible applications to tobacco control. The first LACWHN campaign focused on maternal mortality, and 28 May 1987 was declared the first Women's Health Day, a day set aside to emphasize that issue. National maternal mortality rates in the region and the difficulties of reducing them were the motivating factors for developing a campaign to influence political will and increase social support.

Since 1988, Women's Health Day has been adopted internationally and celebrated worldwide by women's health groups and other interested parties. Campaigns have been established on specific days to promote awareness of the issues of abortion (28 September), violence against women and girls (25 November), human rights (10 December), and HIV/AIDS (1 December).

LACWHN has organized regional training and the development of educational programmes for participants in women's health issues.

The campaign was initially a protest. Later, it began to incorporate proposals for change. Its visibility and impact grew, and the number of participating groups increased. In 1987, 100 groups from 45 countries participated, and today, more than 1500 groups participate in approximately 80 countries. Health workers have joined with women's health activist groups to diversify and expand participation.

Women's health groups have produced and published background papers providing data, analyses, and perspectives. Interactions between academic groups, as well as between health professionals and grass-roots women's organizations, have expanded conceptual boundaries, providing credibility and strengthening women's lobbying efforts. Interactions with United Nations agencies, international and national research/funding organizations, and governments have increased the impact of local and national actions. The media have been involved from the beginning, and recently, media attention has increased and heightened the campaign's visibility.[6]

The principal indicators on which to evaluate the campaign remain the numbers of participants and the alliances made, along with the programmes and actions established by health services. Small grants (from US$ 300 to US$ 1000 each) for women's groups have been distributed for local projects to improve grass-roots women's organizations.[7]

LACWHN has organized regional training and educational programmes for participants in women's health issues. These programmes were initiated in universities and academic units by LACWHN members associated with national women's health NGOs to disseminate scientific information on women's health from a gender perspective. In addition, scholarships for short training programmes at women's health NGOs have been provided to share successful women's health programmes and services, particularly programmes addressing sexual and reproductive health and violence against women.

One of the most important roles of global networks is lobbying and advocacy of the United Nations and other relevant international agencies.

In 1992, LACWHN organized and promoted a regional preparatory process for the International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994, through member meetings. The role of women's health activists and LAWCHN in the ICPD was crucial in the adoption of the ICPD Plan of Action by consensus.

In 1995, LACWHN developed a project to monitor implementation of the ICPD Plan of Action in several Latin American and Caribbean countries, with the cooperation of the United Nations Population Fund (UNFPA). Between 1996 and 1999, five countries in Latin America were monitored by women's health NGOs in partnership with United Nations agencies and governments. In the 1980s, democracies were reestablished in many Latin American and Caribbean countries, but inclusion of women in the participatory process was rare. The project to encourage women's participation in development through the monitoring of governmental implementation strengthened democratic procedures. This project enabled many women's health leaders and activists to develop and increase their negotiation and advocacy capacities and the tools to promote national, regional, and local women's health policies and programmes. Similar experiences in other countries of the region will increase and improve women's participation.

By 2001, the majority of LACWHN's members were based in Latin America and the Caribbean. The range of themes, activities, and goals of the groups is very broad. Some groups are activist-oriented, while others provide services and sponsor academic activities. Their actions have been influential at grass-roots, local, national, regional, and international levels.

In 1997–1998, the LACWHN database included 30 categories of thematic issues, each of which was subdivided for more specific classification of members' interests and activities. All the activities are related to women and tobacco control, but they do not necessarily give the issue prominence in their programmes. The potential, however, is apparent, as their concerns include human rights, family, mental health, women's identity, life-courses, communications, legislation, environment, religions, and economic issues.

In the Andean area, where community-based organizations are a long-standing tradition, many women's groups matured decades ago and were incorporated into the network for broader interaction with other groups.[8] In the southern hemisphere, where many countries were ruled by dictatorships until the 1980s, women's groups have developed only in the past decade.

Few of the registered groups currently pursue tobacco control activities. Their primary focus is on sexual and reproductive health issues, mental health, and the impact of medical-care policies on health-care reform. Nevertheless, great potential exists for integrating anti-tobacco campaigns into these activities. There is also potential for the dissemination of research and news related to tobacco and health through LACWHN's *Women's Health Journal*.

One reason for the lack of involvement of women's groups in tobacco control has been the perception that international, regional, and national networks, as well as

governments and United Nations agencies, have failed to invite them to participate in tobacco control activities. The frequent and fluid relations of LACWHN with United Nations agencies have been concerned with sexual and reproductive health matters, violence against women, and women's impact on the health-care reform process.

In Latin America and the Caribbean, there is considerable potential to expand the scope of women's health-care issues and to strengthen the social base for women's leadership in tobacco control. Increased awareness and the mobilization of women's health activists in the region are basic requirements for reaching women and girls. The advantage of having groups organized and connected through LACWHN is that it enables them to coordinate and promote tobacco control activities. The wide range of women's groups affiliated with LACWHN, in cooperation with the INWAT Latin and Caribbean Network, could ensure that information on the hazards of tobacco use reaches women and girls, including grass-roots and rural women.

Reaching Out to Other Women's Networks

One of the most important roles of global networks is lobbying and advocacy of the United Nations and other relevant international agencies. In addition to the women's NGOs that are actively involved in health promotion, a number of regional and international networks concerned with sustainable development and women's rights could be mobilized to participate in tobacco control.[9] A number of women's organizations have indicated a strong interest in joining the anti-tobacco movement. The Women's Global Network for Reproductive Rights has members in more than 110 countries and is a strong potential ally. Other important groups are the International Association of University Women, the Girl Guides Association, and Soroptimist International, which has almost 100 000 members in 119 countries. It is worth noting that Soroptimist has tobacco control as one of its official priorities.

As tobacco control efforts focus more on the WHO FCTC, the importance of including women lawyers and human rights organizations in these efforts has grown. One active regional network is the Asia Pacific Forum on Women, Law and Development (APWLD). This NGO was an outcome of the Third World Forum on Women, Law and Development held in Nairobi, Kenya, in 1985. The Asian participants formed APWLD as a regional organization committed to enabling women to use law as an instrument of social change for equality, justice, and development.

The breastfeeding campaigns against infant formula are also important potential allies, because their organizations have had considerable experience mobilizing at an international level and calling for conventions to deal with aggressive marketing and commercial interests. In Asia, the breastfeeding campaign was launched in the 1970s, when large numbers of babies in developing countries were dying after bottle-feeding. The women's boycott of Nestle, one of the world's largest producers of infant formula, was reportedly the largest boycott in the world up to that time. The International Baby Food Action Network (IBFAN) was founded by six individuals in 1979 and had grown to 140 groups by 1989.

Women leaders offer expertise on women's perspectives and experiences, particularly in networking and building alliances.

In addition to consumer organizations, a number of international reproductive, human rights, and sustainable-development networks continue to lobby on behalf of women's health. These organizations have expressed interest in tobacco control and have occasionally contributed as advocates. Strong international networks include the Women's Global Network for Reproductive Rights and WEDO, an international advocacy network whose aim is to achieve a healthy and peaceful planet, with social, political, economic, and environmental justice for all, through the empowerment of women in all their diversity and through their equal participation with men in decision-making, from grass-roots to global arenas. It was actively involved in the Rio Summit as well as the Kobe Conference on Women and Tobacco and has played an important role in convening a "linkage caucus" that helps integrate NGO views at various United Nations conferences.

Discussion

The greatest challenge facing women's organizations is that of galvanizing the leadership to prevent a rising epidemic of tobacco use among women, particularly young women. Women's groups involved in tobacco control programmes have argued that to be successful, such programmes must start from girls' and women's own experiences and take into account the broader context of women's lives. This is possible when women's leadership is prominent within tobacco control. Women's organizations should be involved in tobacco control for several key reasons:

- Working with women's groups helps to reach other groups, such as husbands and partners, as well as children, to influence their behaviour and reduce exposure to environmental tobacco smoke.

- Working with women's organizations can widen the political support for tobacco control, taking it beyond the health community. This may be particularly important when support is needed to introduce specific legislative or regulatory mechanisms.

- Women leaders offer expertise on women's perspectives and experiences, particularly in networking and building alliances.

However, several barriers should be recognized:

- An emphasis on emancipation and autonomy may provoke a hostile reaction to measures perceived as restrictive of individual freedom**.** Aggressive misleading advertising by tobacco companies may cause smoking to still be seen as a symbol of women's emancipation or as an important coping mechanism for women under stress. Some women's organizations are critical of traditional health education approaches aimed at changing women's smoking behaviours; they see these approaches as individualistic, victim-blaming, guilt-inducing, and disempowering.

- Funding needs have prompted some women's organizations to accept money from tobacco companies. In the United States, Philip Morris spent millions of dollars on women's causes between 1990 and 1995 and supported more than 100 women's groups in 1995.

- Many women's organizations, particularly grass-roots and community-based groups, work in a collective, non-hierarchical way. These organizations may view traditional tobacco control activities as top-down and inimical to the way they work. Information flow between national and community networks, and between international and national networks, is often limited.

Armed with a tobacco treaty—the WHO FCTC—women's health activists are promoting a comprehensive approach to women's health in which they include tobacco control activities and bring to bear important human rights treaties such as CEDAW. It is vitally important that women's leadership be enlisted at all levels in the advocacy campaign for the WHO FCTC.

Recommendations

In addition to recommendations made in other chapters, it is important to re-emphasize the importance of comprehensive tobacco control strategies such as bans on advertising and promotion of smoke-free environments, including the home.

Other measures to consider include:

1. Working closely with CEDAW and the Convention on the Rights of the Child to strengthen a gender perspective in the WHO FCTC.

2. Collaborating with women leaders working on broad social and economic issues such as the environment, human rights, labour law, religious ethics, child welfare, and fair trade laws.

3. Forming a women's watch group to monitor the WHO FCTC and the marketing practices of tobacco companies.

4. Holding regional gender, women, and tobacco conferences to strengthen regional networks against tobacco use.

5. Using new information technologies and electronic media to mobilize young women and girls in anti-tobacco campaigns.

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[The Parties to this Convention,] alarmed by the increase in smoking and other forms of tobacco consumption by women and young girls worldwide and 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,

Emphasizing the special contribution of nongovernmental organizations and other members of civil society not affiliated with the tobacco industry, including health professional bodies, women's, youth, environmental and consumer groups, and academic and health care institutions, to tobacco control efforts nationally and internationally… [have agreed...]

Preamble, WHO Framework Convention on Tobacco Control

The rates of smoking among youth and young women are increasing in several regions of the world. There are more than a billion smokers worldwide. The World Health Organization (WHO) estimates that about 9% of women and 40% of men smoke. By 2015, tobacco use is expected to cause almost three times as many deaths as HIV/AIDS and will be responsible for 10% of all deaths. The toll may be even higher when tobacco products other than cigarettes, such as khaini, mawa, and betel quid, are taken into account. In the areas where tobacco use among women and girls is still relatively low, tobacco control programmes are needed to prevent increased uptake and future premature deaths. In today's economic climate, protecting and promoting the health of women is crucial to health and development—not only for the present but also for future generations.

This monograph is intended to contribute to the scientific understanding of gender, women, and tobacco in a global effort to control the tobacco epidemic. It presents the findings of an international team of scholars and experts who reviewed the most current research and provided an overview of tobacco control issues related to gender with a focus on women. Interdisciplinary teams included researchers and activists in public health, medicine, nursing, and dentistry, as well as anthropology, psychology, economics, law, journalism, and gender studies. The concerns of tobacco control policy-makers, educators, public health advocates, and economic planners, as well as youth and women leaders, are addressed. Special attention is paid to a gender analysis of policies that affect girls and women of all ages throughout the life-course. The role and responsibility of men to protect women against second-hand smoke and as advocates for gender equality are also highlighted.

The monograph has four sections: Tobacco Use and Its Impact on Health, Why Women and Girls Use Tobacco, Quitting, and Policies and Strategies. Topics covered include determinants of starting to use tobacco, exposure to second-hand smoke, the impact of tobacco use on health, the nature of addiction and cessation, and treatment programmes, as well as policy issues involving gender analyses and human rights. The monograph also addresses the critical issues of national economic policy regarding tobacco control, international treaties, and strategies for mobilization at regional and international levels.

As the WHO Framework Convention on Tobacco Control builds momentum and the international community rallies to reduce deaths caused by tobacco, the need for timely and accurate information about tobacco and girls and women will become increasingly critical. This monograph discusses gaps in knowledge, as well as what is known. It addresses the concerns of women leaders, tobacco control policy-makers, economists, educators, health scientists, and researchers, as well as tobacco activists.

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