

INWAT  
europe

part of the  
solution?

TOBACCO CONTROL POLICIES & WOMEN

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“If you’re not part of  
the solution,  
you’re part of the  
problem.”

ELDRIDGE CLEAVER (attrib.)

## ACKNOWLEDGMENTS

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# FOREWORD

In the European Union, the prevalence of female smoking has risen sharply since the end of the Second World War. The number of female deaths caused by smoking rose from 10,000 in 1955 to 113,000 in 1995. Deaths among women from lung cancer doubled between 1973 and 1992. Given the long time lags involved, the burden of mortality and morbidity will continue to increase sharply in the new century. These trends have been described as a major failure of public health.

Analyses of population smoking patterns suggest that women and men “smoke differently”. Recognising this, the marketing and promotion strategies of the tobacco industry target women, with considerable success, in very specific ways. Meanwhile, traditional tobacco control measures aimed at reducing tobacco use, seem to have failed for many women because they have too often been designed for men. What is it that persuades women to smoke, and how do these factors differ from those which will predict smoking among men? What keeps women smoking and what cessation policies are appropriate specifically for women?

The following pages contain frameworks for developing tobacco control policies devoted to the specific needs of women. These frameworks been developed under the European pilot project of the International Network of Women Against Tobacco, which was funded in part by the Europe Against Cancer programme of the European Commission, the Swedish Institute of Public Health, and the UK Health Education Authority. They reflect the discussions of an INWAT expert seminar held in June 1999\*. This report is a summary of the fully referenced proceedings of the seminar. The immediate target nations for this work are the member states of the European Union, but special urgency attaches to the new smoking economies of southern and eastern european states where the war against women's smoking has not yet been lost. The proposals which this report offers are potentially applicable worldwide.

Patterns of tobacco use are differentiated by gender, but gender also interacts with socio-economic status and with age. In the development of the tobacco epidemic curve it is younger, advantaged women who first take up smoking, and who also lead the decline, eventually leaving the habit entrenched among disadvantaged women.

Tobacco promotion targets different types of women in different circumstances. Tobacco control, by contrast, stands accused of having paid too little regard to the circumstances in which women take up smoking and continue to smoke. In particular, complex patterns of social, material and psychological circumstances conspire to keep many women dependent on tobacco. These seem to require a broader research effort, and more comprehensive policy response, than tobacco control has yet managed to achieve.

An important agenda for the women's tobacco control movement is to join hands with other groups whose primary concern is with the status and health of women in society to persuade governments and health authorities of the need to develop gender sensitive policies. At the same time, the importance of tobacco use as a key determinant of women's health, and in some cases of health inequalities, must not be lost. Traditional tobacco control activities – restrictions on promotion, taxation policy, restrictions on smoking in public places, cessation and health promotion activities – have an important ongoing role to play, but need to be better refined to take into account the differing needs and behaviours of women and men in differing circumstances. Sections of this report are devoted to how this might be better achieved in the future.

The INWAT seminar, which had originally been held to identify a consensus on tobacco control for women, instead identified a serious lack of well-coordinated data collection in Europe. As a result, analyses of smoking patterns and their underlying determination are patchy; much evidence on the efficacy of traditional tobacco control is either incomplete, or is scattered and unavailable in a form which would be accessible to policy makers; the cost-effectiveness of alternative measures is hardly addressed; basic research into the impact of tobacco use on women's health is yet to be undertaken. The final sections of this report set out how these data deficiencies might be redressed, using the frameworks proposed in this report. In turn, INWAT hopes to continue its work of developing and promoting high quality tobacco control measures designed for the needs of women, by developing a European Centre for Women and Tobacco as a resource not just for its immediate members, but for all those working in the field of tobacco control for women.

## PART 1 Introduction and Background

### The INWAT Europe Project

- 1.1 This report has two objectives. First, it sets out a future agenda for the development of tobacco control policies designed for women. Tobacco control concerns all those measures undertaken by international agencies and NGOs, governments, health authorities and other organisations concerned with, or responsible for, health promotion, with the aim of reducing tobacco use, and thereby, the health damage caused by tobacco in society. As will become clear, this report challenges the traditional view of how tobacco control policies should be thought of and formulated, particularly with respect to actual or potential women smokers.
- 1.2 The report also explores the role which the International Network of Women Against Tobacco (INWAT) aspires to play in promoting the design and adoption of women-specific actions in tobacco control. The immediate target nations for this commentary are the member states of the European Union, since the work underlying this report derives from INWAT's Europe Project. However, its conclusions are especially relevant to the countries of Central and Eastern Europe (CEE), including the pre-accession states of the European Union, and the frameworks which it proposes are potentially applicable worldwide.
- 1.3 INWAT is a worldwide network of mainly women professionals and academics dedicated to supporting and uniting its members in actions to reduce and prevent tobacco use among women. It has 600 listed members around the world.
- Much of this report summarises the discussions and conclusions of an expert seminar staged by INWAT in June 1999. This formed a key component of its Europe Project. The aim of the INWAT Europe project is to contribute to the reduction of tobacco use among women in Europe, by means of a threefold strategy:
- developing and promoting a consensus on what should be the main elements of a women-centred tobacco control strategy for Europe
  - raising awareness of women's tobacco control issues
  - promoting communication and exchange
- 1.4 The INWAT Europe project began in 1997, with financial support from the European Commission's Europe Against Cancer programme, the Swedish Institute of Public Health and the UK Health Education Authority – now the UK Health Development Agency.
- 1.5 A 1999 European Report – “ ‘Some Like It Light’ Women and Smoking in the European Union”, Report of the ENSP Paris Conference of 1998 – had identified tobacco use as a growing health problem amongst women in Europe, trends which have been described as a major failure of public health. At the same time, analyses of population smoking patterns suggest that women and men “smoke differently”. Recognising this, tobacco promotion targets women in very specific ways, whilst traditional tobacco control seems to have failed for many women because it has been too often designed solely with men in mind. When developing appropriate health promotion policies for women we need to ask what is it that persuades women to smoke, and how these factors differ from those which will predict smoking among men? What keeps women smoking and what cessation policies are appropriate specifically for women? These questions were explored during the INWAT expert seminar, and the following pages contain research and policy frameworks within which INWAT believes that they can be answered.

### The INWAT Europe Expert Seminar

- 1.6 The INWAT expert seminar of June 1999 addressed the first of INWAT's Europe Project objectives. The seminar gathered together specialists representing many areas of expertise in tobacco control and in women's health from the social, epidemiological and biomedical analysis of the issues, to expertise gained in the implementation of cessation programmes. It also involved others who could offer guidance on how to make women and smoking a priority subject in the promotion of women's health internationally and some who were able to suggest means of overcoming cultural and language barriers to communication and exchange across Europe. A full account of the seminar proceedings can be obtained from the UK Health Development Agency.
- 1.7 There was a central question, namely, “To what extent is there a consensus on what should be the main elements of a women-centred tobacco control strategy for Europe?” and then a second issue: “How could INWAT set about developing and promoting such a consensus?”
- 1.8 A substantial part of the seminar was devoted to a discussion of traditional tobacco control measures, and their applicability to women. The traditional approach, exemplified notably by the World Health

Organization (WHO) in its book "Guidelines for Monitoring and Controlling the Tobacco Epidemic" incorporates five elements: control of tobacco advertising and promotion, fiscal (taxation) policy, health promotion and education, cessation programmes and reducing exposure to environmental tobacco smoke (ETS) – so called "passive smoking". For the most part this approach has not so far drawn on analyses of the different smoking patterns or motivations of women and men, nor has it yet proposed a differentiated policy response. In addition, the possibility that traditional tobacco control measures might have a differential impact on women and men has hardly been evaluated. The purpose of this part of the seminar was to establish whether and how it might be appropriate to apply a "gender lens" to traditional tobacco control measures.

- 1.9 However, an important addition to the debate was the inclusion of an entire morning devoted to a discussion of gender and health. INWAT was aware of the work being undertaken by other organisations, notably the WHO, and by other countries, particularly Canada and Ireland, to develop public health programmes which are sensitive to the different needs of women and men. It was recognised that lessons might need to be learned from this work, which provides a gender perspective both on how health is determined and on possible policy prescriptions. This was seen as a particularly important opportunity to understand the system of values which are being developed elsewhere in relation to the promotion of women's health, and to explore the underlying analytical structures which are being utilised by professionals working in this field which might inform the development of gender-sensitive tobacco control policies in Europe.
- 1.10 The seminar incorporated three workshops. These explored future epidemiological data needs, future research priorities across the range of tobacco control activities and in the field of biomedical research, and considered how best to promote issues and strategies in the future through effective alliance building, networking and participation in international events. The workshop on policy promotion was supported by sessions devoted to effective lobbying techniques and to an analysis of future scenarios for the tobacco industry.
- 1.11 The main findings of the seminar are summarised in the pages which follow. It was recognised at the outset that the main contribution of the seminar might be not so much to agree on the content of policy, but rather to agree on the frameworks within which the phenomenon of tobacco use among women, and an appropriate policy response, might be analysed and described within individual member states. These frameworks and their derivation are described in the opening sections, which also form the conceptual background to the later discussions about the adequacy of the current research base and prevailing tobacco control measures. The last sections consider the all important question, how to promote the policy agenda so that it is high on the priorities of politicians and policy makers. All the evidence suggests not just that action to reduce tobacco use is one of the most important of public health objectives, but that doing so represents one of the most cost-effective ways of allocating scarce health budgets.
- 1.12 Finally, this report sets out INWAT's proposed action plan in response to the seminar's findings. This follows a period of extensive consultation with INWAT members, and reflects decisions taken at two subsequent meetings of the INWAT Europe Advisory Board, which also drew on the evaluation of the first two years of the INWAT Europe Project.

## The problem of women and tobacco: analytical and research frameworks

### The tobacco epidemic: a restatement

2.1 Tobacco use is a worldwide phenomenon. In the 1990s an estimated 1100 million of the world's population were smokers, or about one third of the global population aged 15 years and over. 300 million of these smokers are to be found in developed countries. On average about 12% of the total world population of women are smokers, a percentage which is increasing rapidly. However this statistic disguises very different pictures for the developed and developing world. 24% of women in developed countries smoke, compared with 7% in the developing world. Smokers make up about 47% of the global population of men, 42% in the developed world and 48% in developing countries. The estimates by WHO regions are shown in Figure 1 alongside.

2.2 Before the twentieth century, tobacco use in northern Europe was restricted to traditional tobacco products which utilised dark tobacco cured by air or fire. These included tobacco for pipes, hand-rolled cigarettes and snuff, as well as cigars and cheroots. There is some evidence that both women and men consumed these products in the seventeenth and eighteenth centuries. However, by the nineteenth century, tobacco use in Europe had become a strongly gendered activity, with low reported use of tobacco among women until the early decades of the twentieth century.

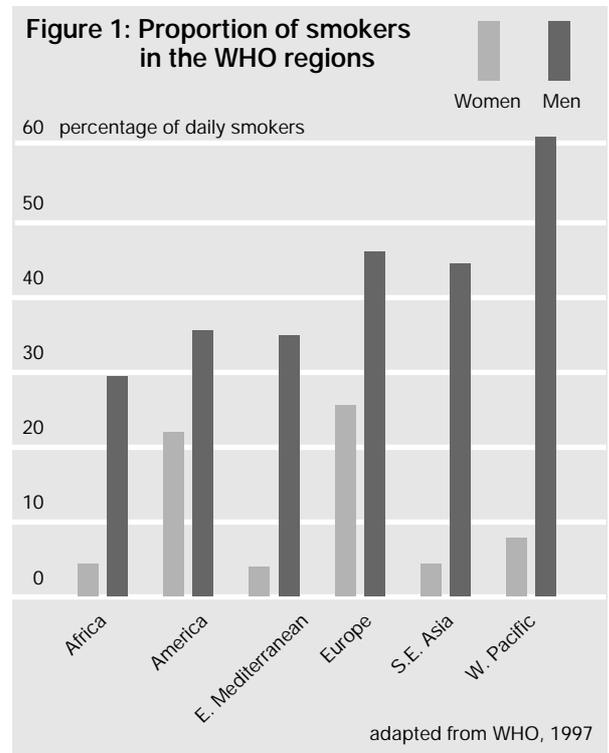
2.3 An important development was the availability of manufactured cigarettes using blond (flue-cured) tobacco. Most women who smoke use manufactured cigarettes\*, and since the early decades of the twentieth century when these were first introduced, there has been a radical change in the smoking habits of women. In the European Union the prevalence of female smoking has risen sharply since the end of the Second World War.

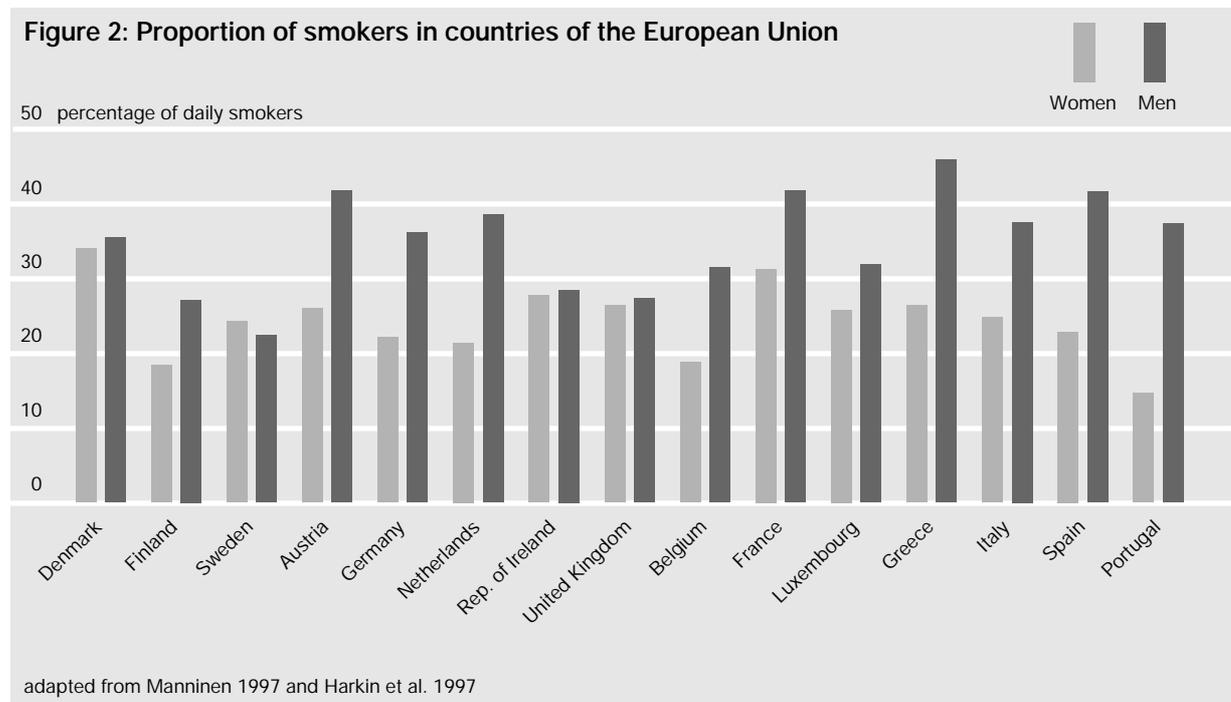
\*There are some notable national exceptions to this. For example, in Denmark women continue to smoke non-cigarette tobacco. In Sweden, use of moist snuff, placed under the upper lip is increasing. In France, data for the early 1980s suggest that dark tobacco brands were most commonly consumed by 50% of female smokers.

2.4 Manufactured cigarettes, mass produced and marketed by the transnational tobacco companies, were promoted earliest in countries which had themselves industrialised early, particularly the United Kingdom and the Netherlands, but only in Spain, for example, in the 1950s. The increase in smoking prevalence among women mimics the pattern of promotion of manufactured cigarettes, beginning earlier in northern European countries, where prevalence has now peaked, and the ratio of smoking men to women is low. Thus in the UK, Denmark, Ireland and the Netherlands, lower and relatively stable prevalence of smoking among women gave way to a rapid rise peaking at over 40%, against a backdrop of high, but declining male prevalence. A current picture of smoking practices in EU member states, differentiated by sex, is shown at Figure 2 opposite.

2.5 In French-speaking countries, the differences between male and female smoking prevalences are more marked, but this effect is particularly evident in the new smoking economies of southern Europe where women have started to smoke only relatively recently. In Greece, Italy, Portugal and Spain, the proportion of women who smoke is still low, but increasing. Surveys point to prevalence of 10% or less until the late 1960s in Italy, until the 1970s in Spain and Greece and until the 1980s in Portugal. Southern EU countries appear, therefore, to be at an earlier stage of the prevalence curve that has characterised women's smoking in northern Europe. From the point of view of primary prevention, action in these countries is particularly urgent.

2.6 The link between tobacco smoking and lung cancer was first made fifty years ago. Since then, tobacco has been reliably linked with a wide variety of diseases (see Appendix 2). It is the largest cause of preventable death and morbidity in the world.



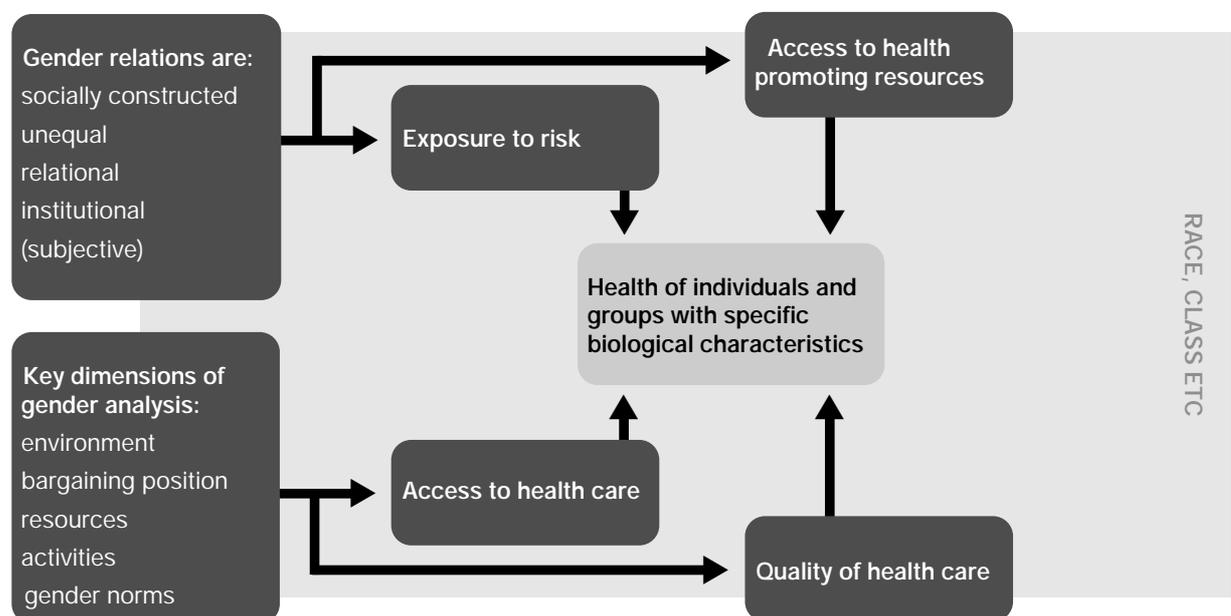


2.7 Evidence presented to the ENSP Paris Conference of 1998 indicated the growing burden of mortality associated with the increase in smoking among women in Europe. In the EU, the number of female deaths related to smoking rose from 10,000 in 1955 to 113,000 in 1995. Deaths among women from lung cancer doubled between 1973 and 1992. Given the long time lags involved, the burden of mortality and morbidity will continue to increase sharply in the new century.

### Gender and Health

2.8 The concept of "gender" does not refer to the biomedical differences between men and women, although these clearly form part of the picture, but rather to the way in which patterns of – and inequalities in – relationships and control between men and women, in various settings such as the family and in the workplace, can have an impact on patterns of health and disease among both sexes. Societies have been described as divided along a "fault line" of gender with women and men representing different actors in society, with different rewards and responsibilities. The experience of gender might lead to more or less exposure to particular kinds of risk (e.g. occupational hazards), to more or less access to the resources necessary to promote health, and to more or less access to health care. A possible structure for such an analysis is set out at Figure 3 below.

**Figure 3: Possible Structure of a Gender Analysis**



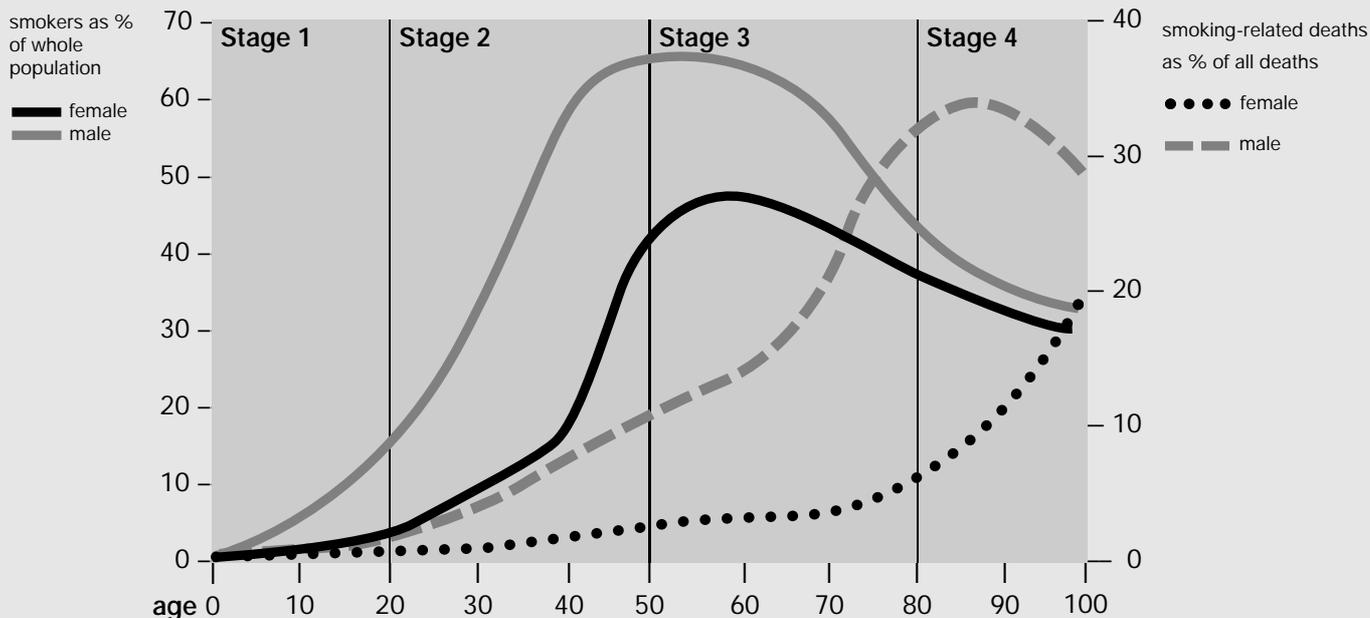
Source: Lesley Doyal

- 2.9 Most of the literature on gender and health has, at least until recently, concentrated on women, since women have been seen as particularly damaged by unequal gender relationships, although there is now increasing interest in how being male can increase exposure to health risks, for example, through the social encouragement of risk-taking behaviour.
- 2.10 Ironically, the relatively subservient position of women in the early twentieth century tended to be a protecting factor against tobacco use, since gender norms meant that it was much less acceptable for women to use tobacco. These norms reinforced the notion of women as moral guardians of society and consumption of "drugs" by women was seen as unacceptable. Women have also traditionally had less command over the economic resources with which to buy tobacco products. Men's smoking patterns, on the other hand, present a very different picture. Men have tended to have much higher levels of smoking prevalence than women, are more likely to be in tobacco promoting environments, have not faced the same social stigma and traditionally have had more resources to spend on themselves. Above all, men in many social groups have apparently felt pressure to smoke and consume alcohol in order to be part of masculine cultures. Gender norms also seem to make it less likely that men will use health promoting resources.
- 2.11 Social and economic change in many societies, particularly in the developed countries of northern America, Australasia and parts of Europe in the latter part of last century has given women better access to economic resources, whilst the stigma attached to smoking has been reduced. One presentation described this as women "appropriating" a male habit and offering a "gender challenge". In many other countries, however, the conditions which prevailed in Europe fifty years ago are the current norm.
- 2.12 Given that gender relations do have a major impact on smoking patterns, gender should be a key concern to those concerned with tobacco control. A question posed was how does the choice by men to smoke, or to continue smoking, differ from the sort of choices to smoke that are made by women. The hypothesis proposed was that, whilst some tobacco control policies (such as restrictions on tobacco promotion) are clearly of benefit to both sexes, other policies need to take gender seriously to be maximally effective. Health promotion, however, needs to be undertaken sensitively, without playing into "gender stereotyping", that is, reinforcing social roles or dual standards which restrict, rather than enhance women's choice and control over their lives.
- 2.13 An important finding of the seminar was that "gender" is not a term which translates into some European languages. Hence it is not a concept which some participants would find easy to use in their own countries without careful explanation and elaboration.

### **Sex, socio-economic status and age in tobacco use**

- 2.14 The diagram at Figure 3 suggests that gender cannot be considered independently of other determining social characteristics, including race, geopolitical status and, above all, socio-economic status. Cross-national analysis of women's smoking in the European Community is hampered by lack of research and poor quality data. However, such data as are available suggests that, whilst at any given point in time there are wide variations in prevalence of tobacco use between member states, there are also well established underlying trends in the development of smoking behaviour over time, which are differentiated socially as well as by sex and age. Cigarette smoking is first taken up by young adult men in higher socio-economic groups. Women typically take up manufactured cigarettes later, with uptake again beginning among younger women in higher socio-economic groups. The habit then spreads downwards to other social groups and, as the new recruits to smoking grow older, to older age groups.
- 2.15 In countries where tobacco consumption is declining, the trend away from cigarette smoking has also been strongly socially differentiated, with women on the higher rungs of the educational and occupational ladder turning away from smoking earlier and in larger numbers than women in less advantaged circumstances. Surveys in Spain, Italy and France report higher quit ratios among women in richer, urban areas than poorer rural areas. This socio-economic patterning of women's smoking prevalence across Europe reveals that in mature smoking economies prevalence is more likely to be associated with lower levels of educational attainment. In more recent smoking economies, such as Spain and Portugal, the reverse is true and rising smoking prevalence among women is associated with a desire for emancipation among women of higher social status. Figure 4 opposite shows the typical development of the tobacco epidemic in any country. Different countries will be found at different points in the evolution of this epidemic. Because trends in women's smoking have occurred across a period in which male smoking prevalences have been declining, women make up an increasing proportion of the declining population of smokers in northern Europe.
- 2.16 Figure 5 opposite provides an example of smoking patterns differentiated by age, in this case the results of a survey in Spain. Among subjects less than 30 years of age, the proportion of smokers is higher in women than in men, whereas in the eldest generation, men are almost 6 times as likely to be

**Figure 4: The Four Stages Of The Tobacco Epidemic**



Source: Lopez AD, Collishaw NE, Piha T. A descriptive model of the cigarette epidemic in developed countries. "Tobacco Control", 1994, 3(30):232-247.

"Typically, smoking prevalence first rises sharply among men, often reaching a maximum level where 60-70% smoke. Two to three decades later, deaths from smoking begin to rise in men. The same pattern occurs later among women, as they typically reach maximum smoking prevalence 15-20 years after men do so. About 30 years after the maximum prevalence level for men has been attained, cigarette smoking can cause up to one-third of all male deaths and an even higher proportion (40-45%) of deaths among middle-aged men."

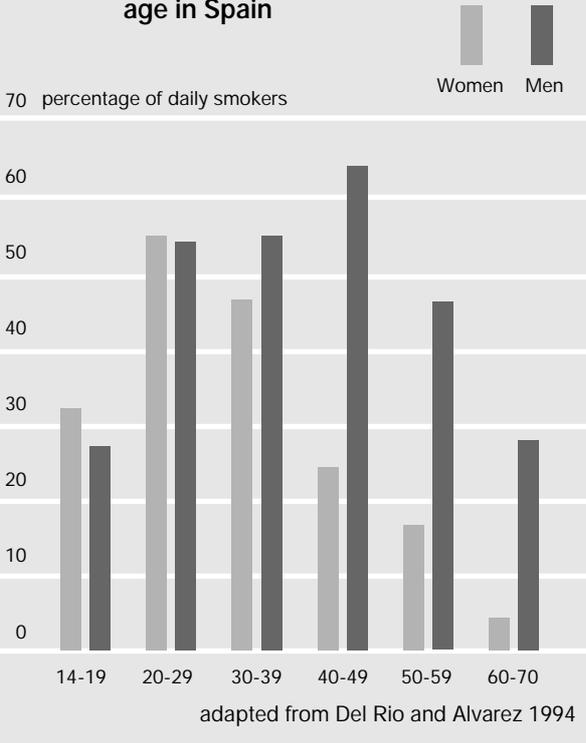
smokers as women. Age related patterns of smoking have been discovered in other European countries. For example, in the Netherlands in 1994, overall smoking prevalence among women stood at 29%. However, women aged 20-30 had a prevalence of 46% compared with 18% among women aged 50-64, differences which narrowed over time as younger cohorts aged. Surveys in France, Greece, Italy and Portugal also confirm that smoking prevalence displays a sharp age gradient.

2.17 Most data are based on prevalence surveys which ask the question "whether" not "how much". Evidence presented at the seminar also showed that tobacco consumption is itself differentiated by socio-economic status and that in countries with relatively recent increases in female smoking, women in higher socio-economic groups were more likely to smoke heavily, whilst in others, heavier smoking (more than 10 cigarettes a day) was more common among women in lower socio-economic groups. Recent UK-based evidence suggests that quitters are disproportionately drawn from the population of women smoking fewer than ten cigarettes a day.

**The role of the tobacco industry in marketing cigarettes to women**

2.18 The tobacco industry's promotion strategy, based on the development of mutual relationships with actual or prospective consumers, exploits these differing population characteristics. Current and prospective markets are finely segmented, and geared not just to the different sexes, but to different ages and to people in differing socio-economic circumstances. The INWAT seminar was

**Figure 5: Proportion of smokers according to age in Spain**



presented with many examples of how tobacco promotion exploits a desire for emancipation in some female groups, or emphasises the importance of cigarettes as a coping strategy for others. Care is taken to develop the right product for the right market segment, for example "light" cigarettes for women, or products acceptable to the palate of younger smokers which nonetheless retain enough nicotine to be addictive. Pack sizes are diversified to persuade the young or the poor that they can afford to smoke, and there is a range of products at different prices. Globally sales are increasing, and the female market is seen as potentially extremely lucrative: in this relatively young market of female smokers, girls are overtaking boys. As yet there are relatively low levels of mortality among women smokers relatively to men, and the media still project very positive images of women's smoking.

### Analytical and Research Frameworks

2.19 Figure 6 below, sets out a possible research framework within which to analyse tobacco use among women as a basis for redressing the problem of deficient data and research findings. We need to be able:

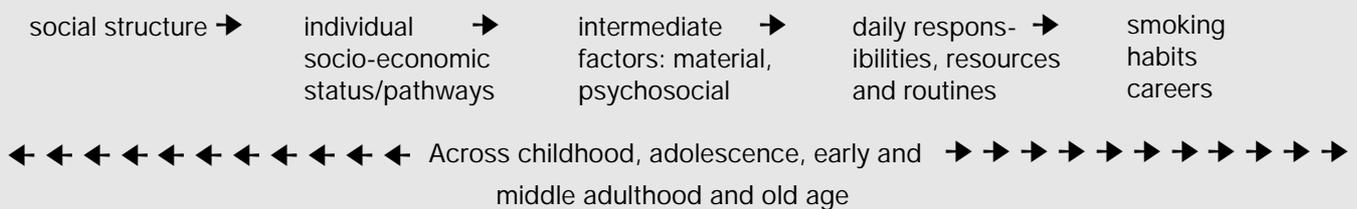
- to describe patterns of tobacco use among women of different ages and socio-economic backgrounds.
- to analyse the factors which predispose women in different circumstances to smoke, as a precursor to understanding how best to design effective prevention strategies. These factors may operate at individual, community and societal levels
- to analyse the factors which predispose women to quit smoking, as a prerequisite for designing effective cessation policies. As before, these factors, and their appropriate policy response may operate at different levels.

This would consider smoking habits and smoking careers across childhood, adolescence, early and middle adulthood and old age, in terms of the following:

#### *Prevailing social structures and changes in them*

Changes in the socio-economic grading of tobacco use among women are framed by broader socio-economic changes in women's lives. In the UK, for example, these gradients have been emerging across a time in which there has been an increase in poverty, in lone-parent families and in households without any one in work. In Spain there have been rapid rates of increase in unemployment and changes in family life as a backdrop to developing smoking patterns.

Figure 4: A Preliminary Research Framework



Source: Hilary Graham

#### *The socio-economic pathways which individuals move through over time*

2.20 There is increasing evidence that smoking careers are shaped by continuity of disadvantage from childhood through adolescence into adulthood. Snapshot data which illustrate relationships at one point in time may not give sufficient insight into how disadvantage accumulates across the life course of individuals. This indicates the need for longitudinal data.

#### *Intermediate factors: material and psycho-social*

2.21 Measures of socio-economic status use proxies such as income and education which serve as markers but may conceal more subtle processes. Multivariate analysis helps to take account of the influence of factors that are themselves interrelated, like occupation, income and education. Measures of smoking status incorporate a wide range of consumption patterns whereas more sensitive measures might reveal relationships which are currently not being identified. UK studies have shown how smoking status in adolescence is linked to class of destination. Data from the British Household Panel Study, a longitudinal survey of 5000 households launched in 1991, was analysed to map patterns of prevalence among women aged 18-49 exposed to different degrees of disadvantage. Among women in the 18-49 age group who leave school without qualifications, 46% are smokers. Within this group, of those whose current or last job was a semi-skilled or unskilled one, 50% are smokers. When the group is further narrowed down to those who, in addition to the other two

measures of disadvantage are also reliant on social housing, prevalence rises to 67%. When the additional disadvantage of living on means-tested benefits was included, the group experiencing all four measures of disadvantage had smoking prevalence of 73%. These studies suggest that cumulative exposure to disadvantage increases the risks of smoking among women. Not experiencing one of these dimensions of disadvantage, even in the presence of all the others, reduced the risks of a woman being a smoker.

### ***Daily responsibilities, resources and routines***

2.22

Qualitative investigation, using face to face interviewing, is also needed to investigate how women explain the role which tobacco use has come to play in their daily lives. The results of qualitative research suggest that young people and adults develop strategies to resist and subvert the impact of disadvantage on their wellbeing and sense of self. Health-related behaviours like cigarette smoking occupy a "pivotal, if deeply contradictory" place in these strategies. The accounts provided by women in disadvantaged circumstances suggest that smoking is structured into their daily lives and social relationships in ways that give them respite from chronic hardship, constant demands and physical exhaustion. Smoking provides anticipated breaks and cigarettes are a resource which can be quickly accessed in times of crisis.

## The Policy Response

### Objectives and a Policy Framework

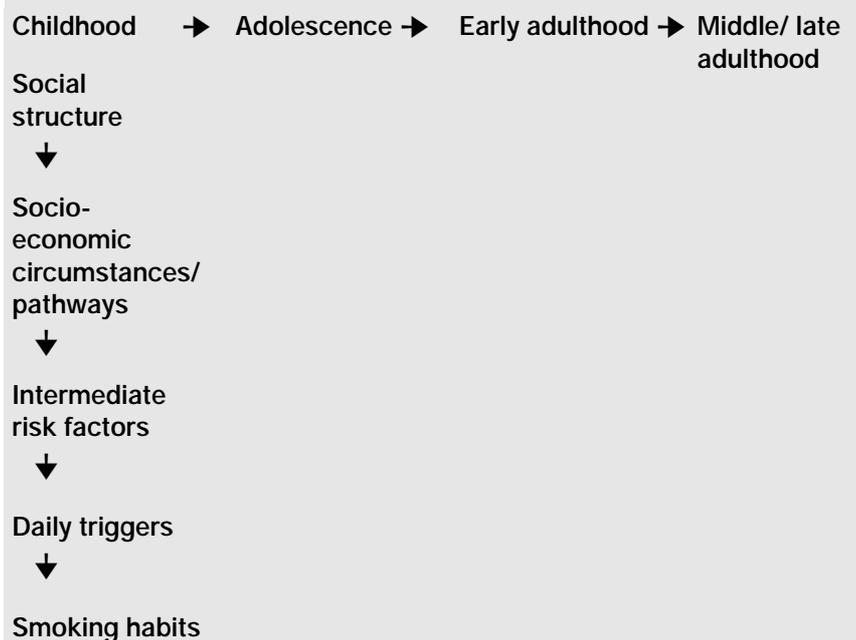
3.1 As we have seen, tobacco use in mature smoking economies is concentrated disproportionately among lower socio-economic groups. It is a major risk factor producing inequalities in health status, and in countries where the reduction of health inequalities is an important objective of policy, tobacco control measures targetted at particularly vulnerable population groups are potentially an important instrument of policy. Such an approach is not uncontroversial, however and raises two important questions: one of effectiveness and cost-effectiveness and one relating the ethics of providing a source of help to only a proportion of those who may benefit from it.

3.2 A different tension exists between those who advocate traditional prevention and cessation programmes, targetted as necessary to particular sub-groups of the population and seeking to exert leverage directly on women's smoking behaviour, and those who believe that tobacco control, will not be effective unless the underlying causes of tobacco use – which has been shown to be patterned by social circumstances – are also addressed. The seminar was presented with a possible policy framework, reproduced at

Figure 7 alongside, which provides a framework for thinking about points in women's lives where interventions could be targetted. Although inclusive of traditional tobacco control policies, it incorporates a much broader sense of what tobacco control policies might imply.

The analysis above takes the "pathways" approach identified in the research framework, from social structure, to life pathways, to individual risk factors, and daily triggers for smoking habits, as a framework for considering what an appropriate policy response might be at various points of individuals lives, from childhood and adolescence into adulthood.

Figure 7: A Preliminary Policy Framework



Source: Hilary Graham

#### ***Social Structure***

The kinds of macro-level policy priorities would be those which differentially benefit lower socio-economic groups because that is what is needed if the objective is to alter the socio-economic gradient, for example, changes in direct taxation which influence "income adequacy".

#### ***Socio-economic pathways***

Policy prescriptions are needed which hit these pathways at key intervention points, for example, interventions which target disadvantaged children and their families through additional educational resources or welfare to work.

#### ***Intermediate risk factors***

Here it is important to think about community interventions which either remove or reduce the kinds of stresses that are associated with smoking, around environmental improvements, mental health schemes and family support programmes.

#### ***Daily triggers to smoking***

Now we have reached what have been identified as community-based smoking intervention programmes. Informed by a community development approach, these seek to support locally-led initiatives which help women to take care of themselves in those periods and pressure points in their

daily lives where they are most likely to turn to cigarettes. These focus, for example, on child care, or alleviating workplace tedium, and can be characterised as “coping strategies” both of an individual and a community kind.

### **Tackling smoking habits**

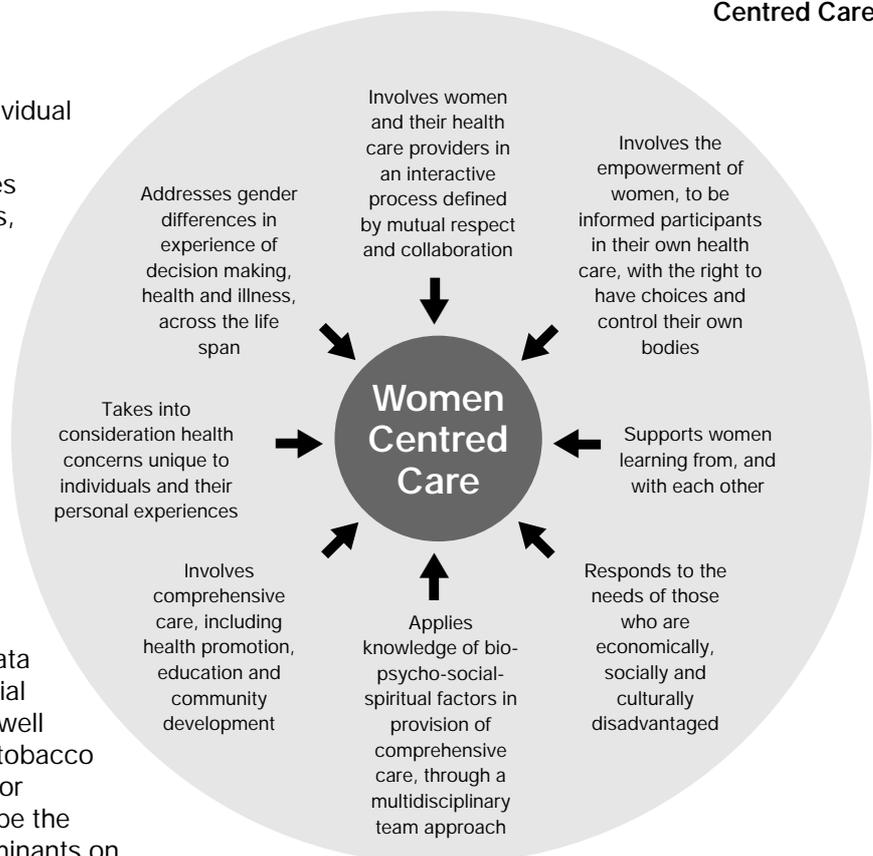
This is the traditional territory of tobacco control and smoking intervention programmes. These programmes are typically individualistic in focus and orientation. They seek to provide the (potential) smoker with the cognitive and effective skills (knowledge, motivation, self-efficacy, etc.) to resist becoming a smoker in adolescence and to break their habit in adulthood. Controlling tobacco advertising and raising taxes on tobacco products also fall under this heading.

### **A Framework of Values**

3.3 Several presentations to the INWAT seminar emphasised that the design and implementation of women-centred tobacco control policies should avoid restrictive gender stereotyping (e.g. women as moral guardians of society), should not further contribute to women's disadvantaged status and should not generate an atmosphere of blame. These values are drawn from a broad understanding of the determination of women's health. A presentation based on the Canadian experience of developing and implementing gender-sensitive health policies explored these values in relation to the design and implementation of tobacco control policies. This framework is illustrated at Figure 8 below. According to the values which it incorporates, policies should:

- be empowering and supportive
- be respectful
- be educational
- acknowledge women's individual experiences
- acknowledge women's roles as workers, partners, mothers, daughters and care givers
- be comprehensive
- be collaborative

**Figure 8: The Values of Women Centred Care**



3.4 This statement of values has a number of implications for future research, for the development of policy and for evaluation. As regards research, the approach endorses the view that there needs to be more comprehensive, qualitative data which describe the wider social context of women's lives, as well as narrow data sets defining tobacco use. It also implies the need for qualitative research to describe the interaction of all social determinants on women's tobacco use. Research priorities should be set interactively, involving women and their health care providers, rather than imposed from the top.

3.5 Policy development should also be “bottom up”, establishing priorities by reference to what is known about the social determination of women's health and the importance of integrating tobacco use with other health issues. The process of policy development must be managed in collaboration with women smokers, and in partnership with (non-tobacco) women's groups.

3.6 Evaluation needs to be much more comprehensive than at present. Evaluation must consider not just the quantitative outcomes of policy (described in terms of impact on tobacco use) but also qualitative factors, which take the importance of the process and experience of cessation into account. On this analysis, evaluation also needs to be considered in the context of a wider range of outcome measures than tobacco use and tobacco-related illness, and needs to be integrated with the evaluation of a broad range of policies, such as social housing and child care.

## **Applying a Gender Lens to Traditional Tobacco Control Policies**

- 3.7 Traditional tobacco control policies have attempted to impact directly on smoking behaviour, rather than targetting underlying social and psychological factors affecting tobacco use. Their aim has been to discourage tobacco use by preventing initiation, encouraging cessation, and reducing the quantity of cigarettes consumed. The paradigm for traditional tobacco control is set out in the WHO Guidelines, and it encompasses a number of key activities, which operate at various levels, from national through community-based and to individual interventions. The main pillars of tobacco control have been seen as: fiscal policy, control of tobacco promotion (advertising bans) controls on environmental tobacco smoke, smoking cessation programmes.
- 3.8 However, a view is gathering strength that traditional tobacco control has not worked for many women, because it has been designed for men. The INWAT expert seminar set out, therefore, to examine the hypothesis that, even within a narrow view of what tobacco control might entail, improvements to policy design could be made by taking into account the different needs and behaviour patterns of women and men.

### **Fiscal Policy**

- 3.9 Fiscal policy refers to the use of taxation as a policy instrument. Indirect taxes can be applied to tobacco products, thereby raising their price so as to act as a deterrent to consumption. The purpose of this seminar presentation was to explore how sensitive consumption is (measured principally in terms of sales, but also by reference to numbers of smokers) to changes in the price of tobacco products. The session considered what material was available to illustrate differential responses between different population groups, particularly as between socio-economic classes, women and men and adults and the young. Reference was also made to the influence of pricing on choice of cigarette brands.
- 3.10 One of the main messages of the presentation was that there is very little work in this area, and what there is is confined largely to American, British and Canadian data. Since these are all "mature" smoking economies, the results may not be representative of other situations. Another problem is that the studies often lack a strong statistical framework necessary to validate the empirical results, and that there was little comparability between the data and the approaches used. Mostly the studies do not differentiate female and male smoking levels within total sales figures.
- 3.11 Such studies as are available fall into two categories:
- studies based on adults which added gender as a variable and generated separate estimates of the responsiveness of consumption of cigarettes by women and men to changes in price (the "price elasticity of demand")
  - studies of young people, looking at different patterns of smoking among different age groups
- The results of these studies are often conflicting and tenuous. To the extent that generalisation is possible, there is some evidence that the young are sensitive to price changes. It is more questionable what the tax effects are on adult women, particularly as the evidence comes from different types of data. UK data suggests that choice of brands seems to be related to age, with higher priced brands being preferred in younger populations. The older the women, the greater the relative consumption of medium price and generic brands.
- 3.12 It would in any case be extremely difficult to have a gender specific tax on tobacco products, even if there were clear evidence that price sensitivity differed as between women and men. Similar comments apply to brand sensitivity since it would be contrary to tax harmonisation measures to apply different taxes to different brands of cigarettes. Many member states do not have in place swift mechanisms for making changes in taxation and have to legislate each time this is proposed.
- 3.13 In addition, taxation is a very blunt policy instrument, and whilst it might be effective as a population strategy, there may be gainers and losers as between different population groups. This is particularly true of the poor, where tobacco smoking is eventually concentrated. In discussion, it was agreed that not enough was known about the differential effect of indirect taxation on women and men, and low and high income consumers and it was proposed that a gender impact assessment of fiscal policy should be undertaken to ascertain what these effects are.

### **Environmental Tobacco Smoke**

- 3.14 Environmental Tobacco Smoke (ETS) consists of the sidestream smoke emitted from the smouldering end of a cigarette added to smokers' exhaled mainstream smoke. Sidestream smoke accounts for 85% of the smoke released by a cigarette and contains a high concentration of harmful chemicals. Involuntary smoking, that is, the inhalation of tobacco smoke circulating in the environment as a result of others' smoking habits is a direct, external, social disbenefit from the private actions of others, and as such has come under particular scrutiny.

- 3.15 It has been known for about ten years that in adults, inhalation of ETS (so-called "passive smoking") has been shown to be associated with increased risk of tobacco-related disease. Recent studies show that people who have never smoked have a surprisingly large risk of ischaemic heart disease if they live with a smoker – an estimated 30% greater risk, or almost half the risk of smoking 20 cigarettes per day, even though the exposure is only 1% of that of a smoker. A woman who has never smoked has an estimated 24% greater risk of lung cancer if she lives with a smoker.
- 3.16 The adverse health effects of ETS are also pronounced in children, and can result in lower respiratory tract illness, exacerbation of asthma, reduced lung function, middle ear disease, impaired cognitive functioning and childhood cancers. There is also well known evidence of the impact of maternal smoking on foetal growth, and Sudden Infant Death Syndrome. For the vast majority of children, exposure to ETS is involuntary, arising from smoking, mainly by adults, in the places where children live, work and play. More than one billion adults smoke worldwide and the WHO estimates that around 700 million (almost half) of the world's children breathe air polluted by tobacco smoke.
- 3.17 The objective of policy measures to control ETS is to guarantee that all public places, including places of work and public transit, should be smoke-free. These include schools, child care and other health facilities, places where young people gather, sports clubs, restaurants, shopping centres, public transport and all places of work. Of these, the WHO has singled out as particular targets smoking in workplaces and smoking control in health care institutions, where the importance of setting an example is also emphasised. The WHO also notes that ETS has sometimes been easier to deal with through voluntary and administrative arrangements, because employers often recognise the benefits of a smoke-free workplace. Furthermore, exposure of children to ETS occurs principally through exposure to tobacco smoke in the home, which cannot easily be the subject of legislation and requires more careful health promotion and education.
- 3.18 However, ultimately, legislation is the only guarantee of protection.

### **Developing tobacco control policies in the workplace**

- 3.19 A seminar presentation was concerned with workplace policies on ETS, and considered whether there were specific gender issues which needed to be taken into account. Three issues emerged from the discussion:
- companies with a higher percentage of women in the workforce were more likely to have smoking restrictions. It was suggested that perhaps women place more direct pressure on management to create a healthy work environment and that management is more inclined to meet this kind of request from women than they might if it came from men. It was perhaps also easier for women to accept moral norms and restrictions on behaviour which these might imply.
  - at the same time it was noted that in some companies, women made up a majority of the workforce, and there was interest in understanding the impacts of workplace smoking restrictions on a predominantly female workforce. In the past the only studied occupational factors related to men, but with now close to 70% of women in the workforce, women also face occupational hazards as yet not fully recognised or studied.
  - It seemed that the workplace could be a supportive environment in which women could be successfully encouraged to stop smoking. Unemployed women were said to be 4.5 times more likely than employed women to relapse after first quitting smoking, and outright prohibition in the workplace had been proven effective in causing female smokers to quit.
- 3.20 The main implication of the discussion was that policies are being urged in this area without being as fully informed as they might be by relevant policy-related research.

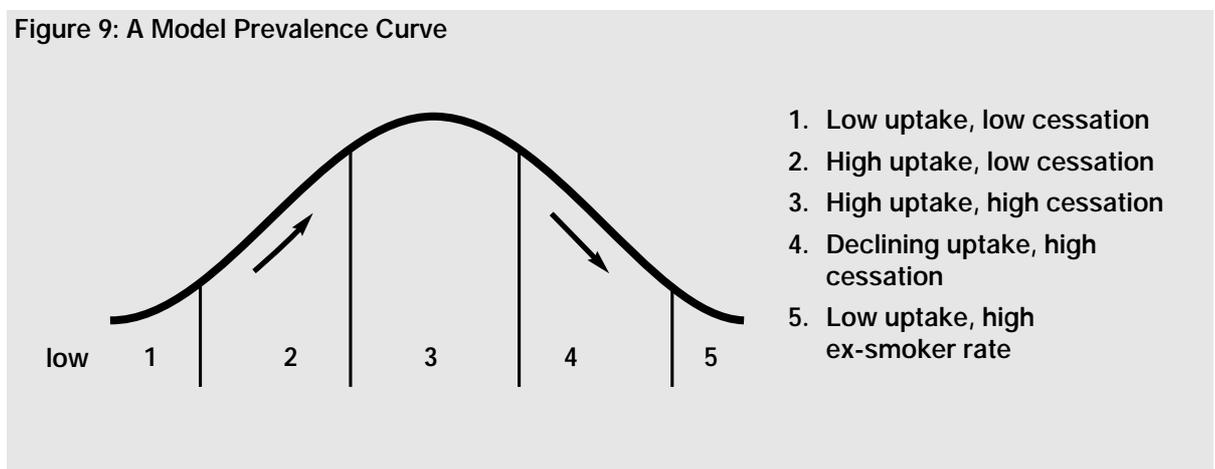
### **Cessation Programmes**

- 3.21 "Cessation" can be defined as any activity designed to help individuals quit their smoking habit. Cessation programmes have been characterised under ten types:
- self care
  - educational approaches
  - medication
  - nicotine replacement therapy (NRT)
  - hypnosis
  - acupuncture
  - physician counselling
  - risk factor prevention
  - mass media and country programmes
  - behavioural therapies

3.22 An overview presentation to the INWAT seminar addressed the strategic question “should the issue of gender be taken up in the design and implementation of cessation programmes?”. It concluded that, across the board, there was no consistent evidence to suggest that women, because they are women, have more difficulty quitting smoking. The issue was considered in relation to three main sets of data

- what national macro data demonstrate about the relative success which laws, campaigns and other macro level measures have had in discouraging smoking among women
- what evaluation data suggest about the relative difficulty women have in giving up smoking
- what the data suggest about which groups to target in order to achieve maximum health benefit from cessation campaigns.

3.23 As discussed above, tobacco use can be seen as an epidemic. Some part of a stylised model of a tobacco prevalence curve can be found in every country, in every population group, whether men, women or ethnic groups. According to this model, tobacco consumption begins, quite slowly and rises to a peak rate. Equilibrium is achieved when the number of people initiating tobacco use exactly balances those who stop or die. Then prevalence starts to decline, first due to more cessation, followed by lower initiation. A final post-tobacco stage is detectable in some groups – for example, doctors in New Zealand, of whom only 5% are estimated to smoke. In this phase, most people have either stopped smoking or have never smoked. Figure 9 illustrates this picture.



3.24 The maximum prevalences of men and women are often different, women's maximum rates tending to be lower. Women's prevalence peaks are also longer lasting, and it has sometimes been assumed that women's smoking patterns are characterised by: not as many women smoking, women consuming less, women finding it more difficult to stop

3.25 Other explanations are possible. For example, as women tend to start smoking later than men in the tobacco epidemic, differences in women's peak prevalences have also been attributed to the impact of tobacco control measures introduced earlier in the female smoking cycle than for men. These help to inhibit the increase in women's smoking.

3.26 The contention that women do not have more difficulty quitting than men was scrutinised by reference to evaluation data. Here, however, the results were inconclusive: the Commit study showed that women were less likely to be heavy smokers though showed greater signs of dependency, were more likely to feel pressure to stop, but were less likely to remain abstinent for a certain length of time. A different study, however, of intervention in primary care, suggested that men and women were equally likely to participate in each step of recommended interventions and that there was no gender difference in relapse at twelve months. In general, there was some evidence that overall a lower proportion of women were ready to stop, but that this could have something to do with where women are, relative to men, in the evolution of smoking.

3.27 Further data suggest that women have more cues to smoke, and more of the factors predicting relapse. The factors which prompt people to attempt to stop smoking are different from the factors which cause relapse. The former include: social pressure and norms, illness events such as heart attacks, demographic factors and smoking dependence. Factors in relapse are different. People who relapse tend to have other smokers in the household, have a greater tendency towards depression, are less ready to change. However, degree of dependence and withdrawal distress are not necessarily indicators of success or failure in cessation: there is no hard evidence of this, once cessation has been attempted. Regardless of level of income, cessation occurred more in families with dependent children. Cessation programmes have to find a way of dealing with weight gain because of its importance as a demotivating factor.

## Health Education and Promotion

- 3.28 Health education is one part of a comprehensive tobacco control strategy and interacts with all other activities, such as opportunistic advice from health professionals, schools' education programmes, media advocacy and other supportive policies, such as smoke-free public places. Whilst there was relatively little comment in the INWAT seminar about the gender aspects of health promotion, the lessons of evaluation of health education and promotion in the field of tobacco control have implications for developing a gender-sensitive approach in this area.
- 3.29 It is also important to recall that this is an area in which the tobacco control community is in direct competition with the tobacco industry which has highly diversified promotion strategies aimed at different segments of the female market.
- 3.30 The following sections consider the changing nature of health education campaigns, evidence for the impact of mass media on behavioural change, and factors which influence the effectiveness of mass media communications, including the importance of complementary community-based activities.
- 3.31 The traditional model of a health education campaign involved the passive delivery of health information to a mass audience. More recently, information campaigns have combined the direct delivery of messages in the media with messages delivered by alliances and task forces operating at a national and local levels, each supporting the activities of the other. Important additional ingredients in this model are:
- communications seen as an active exchange
  - emphasis on the community as a means of changing societal views as well as supporting individual change
- 3.32 The objective of information campaigns is to discourage initiation into smoking by informing the public about the risks involved, and encouraging existing smokers to quit. Indirect effects are about influencing social norms and shaping public opinion.
- 3.33 Mass media campaigns on smoking can have a significant impact on knowledge and attitudes, although the evidence for impact on individual behaviour is mixed. On balance it seems that an individual is unlikely to quit smoking in the absence of additional support, hence the conclusions that mass communication should be used in conjunction with other prevention and cessation efforts.
- 3.34 Research has consistently shown that where the content of the message, style of the message or messenger is inappropriate, the recipient responds in counterproductive ways, for example, by dismissing the message or perceiving it to be impersonal or irrelevant.
- 3.35 Empirical studies on the use of different messages (rational, emotional, educational, fear-eliciting, humorous) and appeals in anti-smoking mass media campaigns are rare, although it has been indicated that the nature of persuasive appeals is the most critical factor for success. When, as with smoking, the awareness of the problem is high and interest low, the use of emotional appeals is recommended.
- 3.36 Fear inducing messages can be very effective in bringing about behavioural change: negative messages are more likely to be remembered and processed to a deeper level. However, mechanisms must also exist for reducing the fear and anxiety aroused by such messages. These can include a range of cessation support services, such as telephone quit lines. Humour can be used to deliver hard-hitting health risk messages in a non-threatening way.
- 3.37 Provocative messages which stimulate debate can influence effectiveness. Some types of message (eg health belief messages, social influence messages) may become more effective when used in combination. Indeed, it is probable that the most effective approach will combine messages and styles, some of which may have more general appeal than others.
- 3.38 Accurate segmentation of the mass audience, namely the identification of a sub-group of a broader population, combined with carefully formulated messages, is an essential feature of an effective mass communications' strategy. For example, research amongst teenagers has shown that 11-12 year olds and 13-15 year olds require quite different approaches to anti-smoking communications. The former respond best to a rational approach using clearly stated facts. The older age group show increasing sophistication as media consumers, ambivalence, cynicism and suspicion of authoritarian figures and respond better to an indirect approach. In addition, differences in lifestyles and response to imagery which begin to develop between girls and boys in the older age group indicate a need to develop separate communication strategies for the two sexes.

- 3.39 It has been argued that the relatively low levels of effectiveness associated with mass media, compared with more intensive interventions, is offset because their mass reach makes them more cost-effective. Furthermore, interventions focused solely on high risk individuals are unlikely to eradicate the population burden of smoking-related deaths and diseases. In practice, research has shown that mass media anti-smoking campaigns can have a significant impact on low income and low educational groups (who may watch TV more intensively than other groups). The question remains, however, whether a combined approach which targets the whole population and high risk groups is more effective than a single population-based approach.

### **Incorporating community interventions**

- 3.40 There are numerous types of community interventions, but in general they seek to bring about change by influencing the individual directly through the mass media and/or indirectly through the community by creating institutional and societal change which encourages the desired change in individual behaviour. Support within the community can be achieved by specific agencies acting independently, or more typically through the establishment of multi-agency alliances which seek to deliver a programme of integrated activities. Typically they seek to achieve a reduction in the uptake of smoking by young people, increased cessation amongst adults, the promotion of policies to reduce public exposure to environmental tobacco smoke and restrictions in access to cigarettes for young people.
- 3.41 Alliances are thought to be a crucial component of health education campaigns which seek to combine mass media communications with community-based interventions. Local alliances are particularly important as they are ideally placed to provide information, support and resources that reflect the needs of the locality. This is part of an approach which argues (see above) that change is more likely to occur when people affected by a problem are involved in defining and solving it.
- 3.42 However, the evidence of impact is mixed. Many trials of community interventions have yielded disappointing results, whilst others have shown that they can have impact. Sometimes the consequences may be unintended. For example, the COMMIT programme was a community-based trial designed for heavy smokers, which appeared to have most impact on light and moderate smokers. What is needed is research that tests the effects of different kinds of community approaches.

# The Development of Gender-specific Tobacco Control Policies in Europe and the Future Role of INWAT

## Aims and Objectives

- 4.1 The INWAT Seminar explicitly addressed two questions which arose from early presentations. First, should INWAT, which had been first established to address the problem of women and smoking, widen its remit to one of gender equity. This implies a somewhat different approach. For example, one aim of gender equity might be to achieve equally low numbers of smokers among both sexes, or another might be to spend equal amounts of money on health promotion for women and men.
- 4.2 A second question was whether INWAT should widen its objectives to include all aspects of women's health, rather than just tobacco-related disease, in response to calls for an integrated approach to women's health.
- 4.3 Seminar participants were unequivocal in declining to support either proposition. The seminar had demonstrated that many aspects of research into tobacco use, and design of tobacco control, would benefit from the application of a "gender lens". It was agreed that it should remain a central objective of INWAT to support analyses and actions which took into account the distinctive needs and behaviour of women since these are not currently addressed adequately. In addition, it was important not to lose sight of the importance of tobacco use as a key risk factor in women's health status and a principal determinant of health inequalities.
- 4.4 Accordingly it was agreed that the INWAT remit, of action towards women and smoking was as relevant as ever, that INWAT should continue to promote women-specific tobacco control policies in Europe, and that it had a distinctive role to play in doing so. INWAT was unique in providing a gender perspective on tobacco control, and in also being able to offer insight's on the role of smoking in the wider determination of women's health.
- 4.5β This could be crucial in those European countries where the tobacco "war" has not yet been lost for women, namely the relatively new smoking economies of southern and eastern Europe, but ultimately also in other parts of the world

## *The development of prevention and cessation policies*

- 4.6 The expert seminar, which had originally been held to identify a consensus, had instead identified a serious lack of well-coordinated data collection and analyses of smoking patterns and their underlying determination. It had also identified how traditional tobacco control policies frequently lacked a gender perspective. Much evidence on the efficacy of traditional tobacco control was either incomplete, or available in a scattered form which would be inaccessible to policy makers. There was an urgent need to compile and collate individual case studies into meta analyses which would compare methodologies and outcomes, indicate the generalisability of results and indicate how cultural differences are important in determining results. The WHO guidelines, whilst an important framework for ongoing policy development, needed to be refined by developing a deeper understanding of what works in which circumstances.
- 4.7 It was agreed that INWAT had a prospectively important role to play in the ongoing development of prevention and cessation policies, in three specialist areas:
- collation and analysis of data
  - evaluation of ongoing tobacco control activities
  - commissioning overview studies, for wider dissemination
- 4.8 It was proposed that the oversight of these activities should be the subject of a specialist body, drawing on the best available expertise, whose remit would be:
- to scrutinise and comment on the technical quality of data collection and evaluation results
  - to liaise with other specialist national and international institutions
  - to promote relevant research and dissemination
  - to commission original research

## *Promoting Policies and Policy Development in European Countries*

- 4.9 In addition, an INWAT action agenda was identified, some of which is already underway, which would focus on three activities:
- ongoing participation in international activities and conferences, and in support of international

tobacco control initiatives, such as the Framework Convention and the EU Directive on tobacco promotion. The purpose of this activity would be twofold: to enhance and widen the consensus at international level, and to continue to draw attention to the importance of gender in designing a policy response

- developing links with other European and international networks concerned with women's status and health. This work would also have several aims: to ensure that tobacco use features prominently in discussions and in actions to improve women's health; to acknowledge the complex and multi-faceted nature of the determination of women's health, and the necessity of a broad policy response which would not necessarily be confined to traditional measures of tobacco control; to enhance the international consensus and improve the prospects for the successful promotion of policies in the priorities of policy makers; to ensure that cultural sensitivities are taken into account and to advise on the applicability of policies throughout Europe.
- effective bilateral working with member states own policy making institutions, by encouraging and exploiting effectively INWAT's extensive network of members, and facilitating their effectiveness within national policy making.

### ***Action Points***

- 4.10 Seminar workshops and discussion gave rise to a specific set of action points, to be carried out under the remit identified above. These are summarised in Appendix 1.

### ***The Future Structure and Resourcing of INWAT***

- 4.11 One of the extreme difficulties faced by the INWAT Europe project, as identified in the Evaluation Reports of the first two years, has been low, uncertain and short term levels of funding and a consequent lack of personnel with which to manage and further the aims of the project.
- 4.12 The action plan identified above calls for a four-part structure for the INWAT Europe project, for which INWAT will now actively seek funding:
- a specialist technical competence, drawing on the expertise of a carefully selected pool of specialists, overseeing the development of high quality tobacco control policies for women:
  - a directorship active in international networking, lobbying and conference participation in support of tobacco control generally, taking advantage of opportunities to promote the development of gender-specific policies and provide advice to policy makers
  - a fully-resourced secretariat devoted to informing, motivating and utilising the expertise of the INWAT membership.
  - a training function, aimed at the wider dissemination of good practice

## Appendix 1

### Summary of Conclusions and Recommendations

#### ***INWAT Mission Statement***

'INWAT Europe exists to draw attention to the importance of tobacco use as a key determinant of women's health and to promote gender sensitivity in tobacco control at all levels in Europe'

#### ***Future Work Programme***

##### **Understanding the determination of tobacco use**

INWAT should seek to establish itself as a specialist centre of advice charged with overseeing the development of high quality descriptive and evaluative data, with disseminating lessons.

There is an urgent need for better data collection, especially longitudinal data describing lifetime smoking habits among women in EU member states and beyond.

##### **Promoting the importance of the biomedical research agenda**

A range of biomedical health effects of smoking remained to be researched, including:

- the determination of nicotine dependence, eating disorders and smoking
- the impact of post-menopausal smoking on CHD
- impacts of Hormone Replacement Therapy
- sensitivity to lung disease, especially adenocarcinoma
- investigation of mechanisms linking smoking and osteoporosis
- how damage occurs in skin tissue,
- the long term implications of low body mass index,
- the impact of smoking on oocyte maturation and the "ovarian reserve" (see Appendix Two).

##### **Extending and deepening the current understanding of the effectiveness and cost-effectiveness of tobacco control policies, particularly by providing a gender perspective**

Specific gender impact assessments need to be made of tobacco control policies, with the assessments including the impact of tobacco control policies on the socio-economic patterning of tobacco use.

Assessments should be made of the impact of tobacco control policies and of broader social and economic policies which also affect the welfare of women .

Particular attention should be paid to the impact of tobacco control policies and wider social and economic policies on the socio-economic patterning of smoking uptake, maintenance and cessation among women and, therefore, to the implications for policy interventions in European countries where incidence is still rising and in countries where female prevalence has peaked and is now declining.

Fiscal policy should be the subject of a gender impact assessment.

More research is needed into the effects of generic packaging and the impact of package design on young women

More needs to be ascertained about the exposure of women and children to ETS.

There is a need to evaluate cessation programmes in pregnancy, particularly with respect to whether there is a socio-economic gradient in uptake and/or effectiveness.

There should be better evaluation of integrated programmes which combine mass media and local activities.

INWAT should push for further restrictions on smoking in public places. However, prior to this, further work needs to be undertaken to understand cultural differences and perceptions of ETS

##### **Continuing to support and develop international networks and to support their work in promoting the importance of tobacco control policies at all levels by:**

- Extending its membership base and disseminating evidence-based strategies, policies and evaluation material
- supporting other international initiatives

INWAT should continue to support and contribute to international efforts to curb the influence of the tobacco industry worldwide, notably through the International Framework Convention on Tobacco Control initiated by the WHO-TFI and recent EU directives on Advertising and Tobacco Product Regulation. Specifically:

All health impact assessment should include the dimension of gender.

INWAT should contribute to efforts to frame regulations for the EU advertising ban, particularly in view of the effectiveness of tobacco industry marketing to women in new smoking economies.

INWAT should support an EU ban on the use of terms such as "light", "mild", etc, as in the directive proposal regarding the manufacture, presentation and sale of tobacco products, and should contribute to the development of any other relevant EU legislation.

More work needs to be undertaken to understand how to promote advertising restrictions outside the EU.

Insufficient is known about the marketing and cigarette engineering data of the tobacco industry, which should be required to disclose the ingredients of cigarettes, including additives.

EU governments should be encouraged to declare that they will not support national tobacco companies in promoting business overseas.

**Extending contacts with international and national networks and organisations concerned with women and inequalities.**

INWAT should extend its range of contacts with international and national networks concerned with women issues, and seek to work with them on appropriate projects and activities.

**Future Structure of INWAT and Resourcing Needs**

INWAT should establish a scientific and technical committee which will be responsible for agreeing scientific criteria and advising on activities, including:

- networking with the scientific community, with national institutions and with European level institutions (for example the Health Monitoring Programme, and Eurostat) to promote appropriate data collection and research
- developing and promoting appropriate frameworks for undertaking research and policy development
- commissioning meta analyses of existing research
- identifying gaps in the existing research base
- commissioning original research
- disseminating effectively the messages from the research

INWAT should also seek to establish a core managerial team with high quality administrative, networking and communication skills, responsible for coordination between all levels of the INWAT organisation including that between the scientific committee, the Advisory Board and the membership and for liaising with international agencies and other networks.

## Appendix 2

### The Biomedical Research Agenda

#### *The Health Impacts of Women's Smoking*

"Some Like It Light", the Report of the European Network for Smoking Prevention (ENSP) Conference on women and tobacco held in Paris in November 1998, contains an important summary by Dr Annie Sasco of the International Agency for Research into Cancer of the health consequences of women's smoking. Key facts and conclusions of this summary are as follows:

- since the end of the Second World War the prevalence of female smoking has risen sharply in Western Europe. In order to assess properly the full burden of mortality and morbidity linked to tobacco use, one has to wait at least 25 years or more. The number of female deaths caused by smoking in the European Union rose from 10,000 in 1955, to 49,000 in 1975, to 113,000 in 1995. If women keep on increasing smoking and using other forms of tobacco they will be equally and even predominantly affected by tobacco-related morbidity and mortality during the next century.
- cancer of the lung has been the traditional marker of disease linked to tobacco, since tobacco use is by far the strongest, and almost unique, risk factor. In Europe, the total number of lung cancer deaths in men increased from 36,772 to 107,056 between 1973 and 1992, and in women, almost doubled, from 18,822 to 36,722. In countries such as the USA and Scotland, mortality from lung cancer among women has already overtaken the previously traditional cancer killer of women, namely breast cancer. In other countries, this crossing is expected to occur around the year 2020. Furthermore, there is evidence that (adjusted) death rates from lung cancer are greater in more recent than in older studies, with a greater proportionate increase in women than in men. Reasons for this trend are not clear. They may relate to an effect of earlier age of initiation. They clearly counteract the argument that "light" cigarettes are "safe".
- all urinary sites come into close contact with tobacco metabolites which exert a carcinogenic action. Cancers of the bladder, urinary tract and kidney, as well as pancreatic cancer, have also been found to be increased among women smokers.
- other cancer sites linked to tobacco use are represented by cancers of the upper aero-digestive tract. These sites comprise cancer of the oral cavity, lip, larynx, pharynx and oesophagus. However, risk of cancers of these sites is increased by interaction between smoking and alcohol. As women generally drink less alcohol than men, they are less frequently affected by these cancers.
- the role of smoking in the development of cervical cancer is controversial: a small increased risk of cancer of the cervix uteri is seen among smokers, but it is debated whether smoking is a causal or a confounding factor. However, cotinine, a marker of tobacco exposure, has been found in the cervical fluid of smokers. Furthermore, tobacco is well known for its negative impact on the immunity of subjects and therefore may play a role in the response of the individual to sexually transmitted viruses such as the human papilloma virus.
- unlike lung cancer, the aetiology of cerebrovascular disease is multi-factorial, making it more difficult to isolate the role of tobacco from other risk factors. Death rates from CHD have decreased among both smokers and never smokers, with an effect less marked in women than in men. The contrasting temporal trends between lung cancer and coronary disease reflect the change in other risk factors for CHD and not in smoking.
- in the USA chronic obstructive pulmonary disease such as emphysema and chronic bronchitis increase over time among smokers, a trend more marked in women than in men.
- smoking has been reliably linked to facial wrinkling. It affects the fertility of women, as well as men, with a longer delay for conception in smokers, an increased risk of pelvic inflammatory disease and higher risks of total infertility and ectopic pregnancy. Smoking is associated with increased risks of low birth weight babies and spontaneous abortions, as well as an increase in perinatal mortality and sudden infant death syndrome.

Despite these well-established effects, this chapter of the ENSP conference report concludes that "one should be greatly concerned by the relative scarcity of valid studies dealing specifically with women." The report notes the need for the thorough study of reasons for the relative increase in death rates from cancer, even adjusted for amount and duration of smoking, "in particular in relation to the increase in the incidence of specific histological forms of lung cancer such as adenocarcinoma, which may be partly hormonodependent". It also refers to the need to study thoroughly a specific interaction for women, namely smoking and exogenous hormonal exposures, that is, oral contraceptives and hormone replacement therapy.

## **Research Needs into the Health Effects of Women's Smoking**

Moving on from these preliminary comments, a presentation was arranged which addressed the future biomedical research agenda for women and smoking. Specifically, it was argued that in many cases where statistical association had been established between smoking and disease beyond reasonable doubt, the biological transmission mechanisms were unknown. The thesis of this presentation was not only that advice and treatment could be improved, but that prevention would be enhanced if actual and potential consumers of tobacco could be informed about the precise biological effects of smoking, as well as the heightened risk of disease.

### **Nicotine Dependence**

Not everything is socially determined, and the brains of male and female foetuses develop differently under different hormonal influences. It is not known exactly how receptors in the brain determine nicotine dependence and how this differs between men and women, leading, for example, to differential dependence for given levels of use. The phenomenon of "anxiety", which women say they use nicotine to address, may be different for women and for men. Among schizophrenics in Sweden, 90% are smokers. Similarly for eating disorders. It is not understood how nicotine produces a feeling of wellbeing when people are depriving themselves of food. The psychological experiences of "captivity" and "dependence" are likely to be very different for women, and hence the motives for giving up smoking will be different.

### **Cerebrovascular Disease**

Women suffer cerebrovascular disease later than men due to the pre-menopausal protective influence of hormones. However, women are more likely than men to die from their first myocardial infarction and have a higher mortality from coronary artery bypass graft. It is not known why this is, whether because women are more vulnerable, or receive fewer, later treatments.

Nicotine causes constriction of the arteries and in women this exacerbates a prior tendency to vasospastic disease compared with men. Pregnancy protects against this condition, but it is not known how or why. Nor is it known what mechanism and ingredients of tobacco cause thickening of the arterial walls.

Where women take hormone replacement therapy, higher doses are needed to counteract the effect of smoking. Does this increase the risk of disease?

### **Lung Disease**

It is not known why some people are more sensitive than others to lung disease. We know that if certain enzymes are missing this predisposes towards emphysema. More women contract asthma due to smoking and women have a higher mortality than men from emphysema.

Women dominate lung cancer patients under the age of 50. In addition, there is an increase in the incidence of adenocarcinoma, which may be the effect of deeper inhalation due to the use of "light" cigarettes; or could be influenced by hormonal factors.

### **Osteoporosis**

It is not known what mechanisms link smoking and osteoporosis. Menopause occurs earlier in smoking women, but it is not known what ingredients in tobacco influence the balance of hormones.

### **Smoking and Skin Condition**

It is known that smoking can have a seriously deleterious effect on the skin, a factor which ought to be persuasive in influencing young women and girls not to smoke. It is not known, however, how this damage occurs in the connective tissues, nor how the outcome is influenced by hormonal factors.

### **Long Term Effects of Low Body Mass Index**

These are completely unknown. Girls in the 1950s, now of an age when they would be beginning to contract smoking-related diseases, did not have such a low BMI as can be found now in current cohorts of young women. The long term impact of this will not be known until about 2030.

### **The Impact of Smoking Pre-Pregnancy**

It is well known that smoking can harm the foetus during pregnancy and can damage a baby afterwards. Less is known about the effect of smoking on oocyte maturation and the "ovarian reserve". Nor is it known what effects foetal nicotine dependence might have on smoking patterns later in life.

## Appendix 3

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## Appendix 4

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