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The World Health Organization
and
The Global Alliance for Women's Health
co-sponsored a panel and discussion on

**Smoking and Women's Health:
Les Liaisons Dangereuses**

AT THE
UNITED NATIONS COMMISSION ON THE
STATUS OF WOMEN
43RD SESSION

SPEAKERS

Dr. Paul Dolin, Epidemiologist, World Health Organization,
Geneva.

**"SMOKING AND WOMEN'S HEALTH: THE ADVERSE
EFFECTS"**

Nicola Christofides, Researcher, Women's Health Project,
Johannesburg.

**"GENDER ISSUES IN TOBACCO CONTROL:
HIGHLIGHTING SOME DEVELOPING COUNTRY
ISSUES"**

Garrett Mehl, Researcher, Department of International
Health, Johns Hopkins University School of Public Health,
Baltimore.

**"WOMEN AND TOBACCO SMOKING IN SRI LANKA:
PREVENTING THE INEVITABLE"**

Margaretha Haglund, head of Tobacco Control Program,
National Institute of Public Health, Stockholm: President,
International Network of Women Against Tobacco.

**"WOMEN: THE NEXT VICTIMS OF THE TOBACCO
EPIDEMIC"**

Moderator: Dr. Elaine M. Wolfson, President, Global
Alliance for Women's Health.

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Preface

Dr. Derek Yach, Project Manager, Tobacco Free Initiative

**Dr. Olive Shisana, Executive Director of Health Systems and Community Health
World Health Organization**

Tobacco use has become a major threat to the health and well being of women and girls around the world. According to our estimates, there are currently approximately 200 million female smokers in the world. In almost all countries, female deaths due to tobacco are increasing. If the prevailing trends continue, it is estimated that by the year 2030, between one and two million women will die each year from tobacco.

The two leading causes of mortality and morbidity in adult women world-wide are coronary heart disease and stroke. Smoking is well documented as a cause of these in both men and women. Unfortunately, the common view is that coronary heart disease and stroke are men's health problems, which tends to obscure their significance for women's health. Globally, fewer women smoke than men, but those who do run the same risks as men for the major smoking-related diseases and, in some cases, these risks are higher. During the past few years, evidence has shown that the health consequences of smoking may be worse for women than men. Women smokers develop lung cancer earlier than men despite starting smoking at a later age and smoking fewer cigarettes.

Even less well known is that smoking increases a women's risk of several other important diseases. Women who smoke are more likely to have an unsuccessful pregnancy resulting in early spontaneous abortion. Women who smoke are more likely to have a low birth weight baby, which increases the baby's likelihood of early morbidity or mortality. Smoking is also linked with cervical cancer and osteoporosis, leading causes of morbidity and mortality of older women.

However, there is solid evidence that once women cease to smoke, their risk of these diseases starts to diminish, and with continued non-smoking, risk can be reduced to that of a lifetime non-smoker.

In many developed countries, prevalence of smoking is increasing among adolescent girls; some recent surveys show that up to 25% of girls at high school and university smoke. In developing countries, smoking among young women is still low. Surveys from several African countries show that up to 5% of young women smoke. There is much concern that these low levels are starting to increase.

As European and North American tobacco markets are becoming more strongly regulated, and as smoking among older adults is declining, the tobacco industry is increasingly turning its attention to developing world markets. Throughout Africa, Asia, the Baltic States, and the Central Asian Republics, there has been a dramatic increase in visibility of tobacco advertising and strong marketing rivalries between companies. Women are being specifically targeted through sports, fashion and entertainment industries with heavy use of beautiful lifestyle images particularly directed to educated young women.

In confronting these present and future threats an additional problem exists: tobacco is generally not seen as a major issue for women's groups to address together. The participation and leadership of women has shifted international policy in many areas, and this should also be the case with tobacco.

WHO's Tobacco Free Initiative, in collaboration with the Department of Women's Health, has taken up Smoking in Women as a priority emerging global problem with special relevance for developing countries. The objectives of this collaborative initiative are: i) to prevent and reduce the negative health impacts of tobacco on the health and well-being of girls and women; ii) to improve understanding of the influences and determinants of tobacco use by girls and women; iii) to build capacity at country level through action research in order to design activities to address the influences and determinants of girls and women smoking; and iv) to promote gender-specific responses to the tobacco epidemic, including approaches to smoking cessation which are tailored to women's needs.

WHO is currently developing strategies to work with governments and non-governmental organizations to provide an evidence base on smoking trends among young women, to develop interventions, and to advocate that smoking is an important women's health issue that needs to be put on national and international women's health agendas.

Within this context, WHO is particularly pleased to collaborate with the Global Alliance of Women's Health in organizing this meeting, which aims to tap into the leadership provided by women and their organizations in order to raise awareness and action that will put a stop to this preventable public health disaster.

Executive Summary
by Dr. Mary K. Flowers, Senior Program Officer



The Global Alliance for Women's Health (GAWH) and WHO invited Dr. Paul Dolin from Switzerland, Nicola Christophides from South Africa, Garrett Mehl of the United States and Margaretha Haglund of Sweden, to discuss health risks for women who smoke, gender issues in tobacco control initiatives, techniques for marketing cigarettes to women in developing countries and recommendations for action. Dr. Elaine M. Wolfson, president of GAWH, was moderator.

Dr. Dolin, an epidemiologist with WHO in Geneva, reiterated the accepted health dangers that smoking poses for both men and women, including its relationship to heart disease and twelve types of cancer. He then moved on to health consequences that are gender specific to women. He cited a 1998 Norwegian study that found a strong association among smoking, Human Papilloma Virus (HPV-16) infection, and the risk of Cervical Intraepithelial Neoplasia (CIN). The study concluded that the risk of cervical cancer increases with intensity of smoking, but those with minor grades of CIN showed reductions in the size of their lesions if they had stopped or substantially reduced their smoking. Dolin believes that young women should be targeted at routine gynecological exams to raise their awareness that smoking may have a causal

relationship to cervical cancer. Dolin elaborated, "I think that discussing smoking risks during visits to gynecologists and midwives could provide strong motivation to cease smoking." He also presented evidence from recent studies in several countries that show smoking is associated with spontaneous abortions, low birth weight babies and Sudden Infant Death Syndrome (SIDS). Finally, he discussed studies in which the long-term effects of tobacco smoking appeared to be associated with osteoporosis, periodontal disease, its ensuing tooth loss, and cutaneous damage and premature aging of the skin.

Margaretha Haglund, National Institute of Public Health in Sweden and President of the International Network of Women Against Tobacco (INWAT), emphasized that with the success of anti-smoking campaigns in developed countries, transnational tobacco companies are expanding to new markets with the prime targets being women. Even the Chinese tobacco industry, a state monopoly with the fastest growing cigarette market in the world, has developed a new brand designed specifically to attract women. "Today there seems to be no limitation on the tobacco companies in their eagerness to get women hooked on tobacco, whether a state monopoly or a private company," Haglund said. To counteract this, she believes that women need to educate themselves about tobacco hazards and be more involved in anti-smoking policy formation.

Garrett Mehl, of Johns Hopkins University School of Public Health picked up Haglund's theme of the conscious effort by the tobacco companies to target women - young women in particular - to make up for the market losses in other countries. Mehl stated, "Tobacco companies are working hard to undermine these cultural norms prohibiting women from smoking." The British American Tobacco Company and its local subsidiary, the Ceylon Tobacco Company (CTC), use discos, music shows, giveaways, races, sports, contests and even high paying job offers in the tobacco industry to promote smoking. Safety campaigns for children are sponsored by this industry and the CTC logo is prominently displayed near school crossings. Mehl noted that Sri Lanka passed a general ban on cigarette advertising in January 1999, but its effect will depend on enforcement efforts.

Nicola Christofides, researcher at the Women's Health Project (WHP) in South Africa, spoke on gender issues in tobacco control, and pointed out many differences between male and female smokers. In developing countries, women start using tobacco at later ages than men and evidence indicates that it is more difficult for women to stop smoking than it is for men. Christofides reported, "Smoking rates go up among women when they have disposable income, are well-educated and are urbanized." Women are also less aware that smoking is often associated with independence and control issues for women. The WHP is currently addressing such issues by coordinating a South African Development

Commission (SADC) multi-country research initiative that is funded by WHO/TFI. WHP is developing research proposals, identifying priorities and developing protocols. The focus at the end of the research will be directed at recommendations for policy and mobilizing community action.

A lively question and answer session followed the panelists' presentations, beginning with a comment on the cigarette smoke wafting through the lobby area outside the conference room door. Several participants expressed concern that advocacy and awareness alone do not stop young women from smoking. Participants and speakers alike emphasized the need to challenge the tobacco industry on its own ground with programs that "de-link" concepts of equality, freedom and power from smoking.

Finally, in the center of this document, we have included a WHO primer on the Framework Convention on Tobacco Control (FCTC); after the presentations, GAWH recommendations for action; at the end of the document, an annex of panel participants plus a listing of members of the WHO/NGO Global Network for a Tobacco Free World.

Opening Remarks
Dr Elaine M. Wolfson, President
Global Alliance for Women's Health



Let me welcome you to today's meeting. My name is Dr. Elaine Wolfson and I am President of the Global Alliance for Women's Health and the Chair of the NGO Health Committee. The Global Alliance is very pleased to be co-sponsoring this meeting on smoking and women's health with the World Health Organization and we are very proud to have such an illustrious group of participants.

This meeting is being held at the 43rd Session of the United Nations Commission on the Status of Women (CSW). It is especially propitious because the 40 plus countries on the CSW are reviewing women's health in the context of the Beijing Platform of Action. The CSW will be reporting its agreed upon conclusions to the Economic and Social Council of the United Nations.

By holding this meeting and by circulating a formal Statement, E/CN.6/1999/NGO/7. (See Page 20), the Global Alliance for Women's Health is working for an immediate outcome - we want the member states to take note of smoking as a women's health issue and to include a provision on smoking in their final report.

Of equal importance is the NGO community. The Global Alliance for Women's Health and the World Health Organization, by cosponsoring this panel, are extending health promotion outreach to the hundreds of NGOs from all over the world who are present at United Nations headquarters at this year's CSW meetings. The immediate goal is concrete and tangible- to develop a WHO/NGO Network on smoking and women's health. To that end, members of the Global Alliance for Women's Health and the NGO Health Committee will be circulating sign up sheets.

But the long-term goal is broader and equally as far reaching. It is our intention to highlight and integrate smoking and women's health within the worldwide women's health movement. In many countries the concept has been introduced and is being promoted, but it needs far more attention. Most women's health groups are not yet working in this arena. We hope to activate many of them and to forge alliances so that we can all strengthen each other's initiatives and efforts.

Many of the participants at today's meeting have been working on smoking and women's health for a number of years now. We look forward to hearing from you today and learning from your expertise. Many others have come for information.

There will be four presentations: Dr. Paul Dolin of the World Health Organization will talk on "Smoking and Women's Health: the Adverse Effects"; Nicola Christofides of the Women's Health Project in Johannesburg, South Africa will speak on "Gender Issues and Tobacco Control: Highlighting Some Developing Country Issues"; Garrett Mehl of Johns Hopkins University School of Public Health has a presentation entitled: "Women and Tobacco Smoking in Sri Lanka: Preventing the Inevitable"; and our final speaker, Margaretha Haglund

from the National Institute of Public Health in Sweden and the International Network of Women Against Tobacco, will talk about “Women: The Next Victims of the Tobacco Epidemic”. The presentations will be followed by questions and answers. We can also continue our discussion in the immediate vicinity of this conference room, but I must warn you that this is not a smoke free zone!

"Smoking and Women's Health: The Adverse Effects"

Dr. Paul Dolin

World Health Organization



I am going to focus on the health risks of smoking for women, and summarize some of the current research. As most of you I'm sure are aware, smoking is dangerous for you. What I want to do is provide you with some facts and figures on specific diseases and also some information as to how the risks of women differ from the risks of men.

Cancer and Smoking

The best documentation on health risks and smoking is in relation to the cancers (See Figure A). This is where the bulk of the work has focused over recent decades. I have a list of the major diseases caused by smoking (See Figure B). There is no argument that smoking contributes heavily to these diseases. The medical evidence overwhelmingly demonstrates this.

FIGURE A:		
<i>MAJOR SMOKING RELATED CANCERS</i>		
Lung	Pharynx	Bladder
Renal Body	Pancreas	Myeloid Leukemia
Larynx	Esophagus	Renal pelvis
Liver	Nose	Stomach

When you smoke, you breathe the smoke into your lungs, but I've also listed here the sites all over the body where cancer can occur, because smoke or the components of smoke actually spread throughout the body (Revisit Figure A). You smoke from your mouth, then after your mouth, the smoke goes to the larynx, pharynx and esophagus, the back of the throat, the windpipe, the voice box. Smoking can cause cancers of those sites and ultimately, you breathe smoke into your lungs and you are susceptible to tumors of the lung.

From the lung, toxic by-products of smoking such as nicotine go into the blood system and circulate around through the liver into other parts of the body, increasing risk of carcinoma of the liver.

FIGURE B:
OTHER MAJOR SMOKING RELATED DISEASES

Ischaemic heart disease
 Cerebrovascular disease (stroke)
 Chronic obstructive pulmonary disease

Ultimately, the kidneys will remove the products from the blood which will go out through the urine, also increasing risk for cancers of the bladder where the urine is held. In addition there are cancers of the renal pelvis and the renal body, which are the two components of the kidney, plus a number of other sites, such as the pancreas and stomach. Many of these sites are away from the lungs, but there is excellent evidence that smoking contributes to these diseases.

FIGURE C:
HIGH GRADE CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)

<i>Norwegian study including 90 patients and 216 controls, 20-44 years of age</i>		
<i>Ever Smoke</i>	<i>HPV-16 infection</i>	<i>Risk of CIN</i>
No	No	1
No	Yes	16
Yes	Yes	65

Conclusion:
 Strong interaction between smoking and HPV-16 infection and risk of cervical neoplasia
 Olson, A. et al., Epidemiology. 1998; 9(3): 346-9

Men and women are both at risk. The more you smoke the greater your risk of these diseases. An article in The Lancet, the Journal of the British Medical Association, which came out earlier in 1999, suggests women who smoke get small cell carcinoma, a much more aggressive lung cancer, more frequently than men. In fact, men and women aren't the same in their risk. Women may have a higher mortality risk than men for some of these diseases, because they get more aggressive types of tumors. So, women who smoke like men are dying like men. It's an unfortunate situation.

FIGURE D: STUDY OF CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN) AMONG HPV-INFECTED WOMEN	
<i>Albert Einstein College of Medicine, Bronx, NY</i>	
<i>Smoking Status</i>	<i>Risk of high grade CIN</i>
Non smoker	1.0
1-10 cigarettes/day	1.5
11+ cigarettes/day	3.4
<i>Conclusion:</i> Risk of disease increases with intensity of smoking Ho, G. et al. International Journal of Cancer. 1998; 78(3): 281-5	

There are three other major diseases that smoking can cause: heart disease, stroke and chronic obstructive pulmonary disease (See Figure B). These are three of the leading causes of death amongst men and women in the world. They are three of the biggest killers and they are often smoking related. And again, men and women are at very similar risk.

Gender-Specific Diseases and Smoking

I'm now going to concentrate on diseases in which smoking may be a contributory factor which are gender related, for example cervical cancer. For cervical cancer, the main cause is the HPV-16 infection, a viral infection from the papilloma virus which causes cervical warts. There is overwhelming evidence that this is the major cause of cervical cancer. There is interesting evidence that smoking is associated with cervical cancer.

This very recent data that I have is from major international journals within the last one or two years. The first one is a study of high grade cervical intraepithelial neoplasia, (CIN) or early stage malignant tumors. This particular study comes from Norwegian women of a relatively young age: 20 to 44 (See Figure C).

For someone who does not smoke, has never smoked and has no infection, her risk for CIN is one, which I've set as a reference base. If you have the HPV infection, your risk of cervical cancer is sixteen times greater, and that is a mammoth risk. That is one of the strongest associated disease risks that exists. Women with an HPV infection who smoked increased their risk 16 to 65 which is approximately four times greater. So, according to this study, women with an HPV infection who smoked were around 65 times more likely to get early stage neoplasia than a non-smoking, non-infected woman. This is really strong evidence damning tobacco use, I believe.

Next is a study from The Albert Einstein Medical College here in New York looking at the number of cigarettes per day smoked by relatively young women

(See Figure D). This time we're just looking at women who have the HPV infection and their risk of early stage neoplasia of the cervix. For those who smoked up to ten cigarettes a day, 1.5 is the risk. One point five is a 50 percent increase in risk over women who didn't smoke. If they smoked eleven or more cigarettes a day, their risk went up to over three times greater than the women who did not smoke. The main point of the two studies is that smoking more and smoking longer both appear to increase the risk of CIN.

There are also some laboratory studies that show that nicotine, or its metabolic products of cotinine, are actually found in the cervical mucous of women who smoke. In the cervical epithelial cells, the cells lining the cervix, we can find evidence of DNA damage very specifically related to smoking. We have here more evidence that smoking predisposes to early stage cervical neoplasia (See Figure E).

Reducing Risk

What if you give up smoking? Can you reduce your risk? This is the good news: it is never too late to stop smoking . In a study published in The Lancet, women who had early stage neoplasia of the cervix were invited to quit smoking (See Figure G). It's a small study, around 75 women. Twenty eight women stopped smoking completely for six months or cut their smoking down by 75 percent or more. Of that group of women who managed to reduce or give up their smoking, 82 percent showed a marked reduction in the size of their tumor. Of women who did not cease smoking or ceased only to a small degree, only 28 percent of those showed a remission in size.

FIGURE E: <i>Smoking and Cervical Cells</i>
<i>Cervical mucus</i> Nicotine and its metabolic products (cotinine) are found in cervical mucus of women who smoke
<i>Cervical epithelial cells</i> Smoking-related DNA damage found in epithelial cells of women who smoke

<p>FIGURE F: <i>Routine gynecological screening/PAP smear cytology</i></p>
<p>An important clinical opportunity Target young women Raise awareness that their smoking may cause cervical cancer A strong motivator for cessation</p>

Eighty-two percent amongst the smokers who gave up, compared to only 28 percent amongst those who continued to smoke- this is a good indication that if you cease smoking you may get a rapid benefit. From a public health point of view, I think there is a target group here that needs to be addressed: women who are getting a pap smear or gynecological assessment. This is a very important clinical opportunity for the anti-tobacco, anti-smoking lobby to start targeting and, where awareness of smoking and the risks to women's health need to be addressed. I think that discussing smoking risks during visits to gynecologists and midwives could provide strong motivation to cease smoking.

Let's move on to a different disease, ovarian cysts, which are fairly common. According to the results of a study published in The American Journal of Epidemiology, a very prestigious medical journal, if you smoke, you may double your risk of ovarian cysts. The evidence here is a bit weaker than for cervical cancer, where I think, the evidence is more supportive. For ovarian cysts, I would say we have some evidence. It's a maybe. We need some more studies to confirm it.

<p>FIGURE G: SMOKING AND ECTOPIC PREGNANCY</p>	
<p><i>A review of published studies, 1988-96</i></p>	
<i>Smoking Status</i>	<i>Disease risk</i>
Non smoker	1.0
1-9 cigarettes/day	1.5
10-19 cigarettes/day	2.0
20+ cigarettes/day	2.5
<p><i>Dolin's Conclusion:</i> There is a large body of evidence that smoking causes ectopic pregnancy</p>	

FIGURE H:
<i>SMOKING AND SPONTANEOUS ABORTION</i>
Nicotine is a strong vasoconstrictor
-Reduction in placental blood flow
Carbon monoxide binds to hemoglobin
-Leads to decreased availability of oxygen to fetus
Cyanide depletes vitamin B ₁₂
- B ₁₂ necessary for health fetal growth and development

Pregnancy and Smoking

There have been many studies looking at smoking and ectopic pregnancy, and the data I present here are a compilation across several studies (See Figure G). I have grouped women into those who have never smoked, those who smoked one to nine cigarettes a day and those who smoked ten to nineteen or twenty plus cigarettes a day. My conclusion is that the more one smokes, the greater the risk of ectopic pregnancy. There is a huge amount of evidence on this, and I think there is a fairly good consensus that smoking can be related to the occurrence of ectopic pregnancy. Women who smoke are more likely to have a spontaneous abortion (See Figure H). There are very good reasons for this. First, nicotine is a strong vasoconstrictor, so it reduces the blood supply to the fetus through lack of blood in the placenta. Second, the carbon monoxide in the tobacco smoke, which will end up in your blood when you breathe it in, reduces the oxygen-carrying potential of hemoglobin and as result, reduces oxygen supply to the fetus. The third main mechanism is the cyanide in tobacco smoke. Tobacco smoke contains minute amounts of cyanide. If you smoke over intense periods, you may build up enough of that to cause damage to the nervous system of the fetus through depletion of vitamin B-12.

FIGURE I:	
<i>COHORT OF 210 PREGNANT WOMEN IN INDIA</i>	
<i>Smoking Status</i>	<i>Risk of Low birth weight</i>
Non smoker	1.0
Smoker (or passive exposure)	3.1
Deshmukh, J. et al. Indian Pediatrics. 1998; 35(1): 33-6	

FIGURE J: A SURVEY IN THE CANTON OF GENEVA (N= 278)	
<i>Smoking Status</i>	<i>prevalence of low birth Weight</i>
0- 4 cigarettes/day	4.9%
5+ cigarettes/day	17.2%
Bouvier, P. et al. Soz-Praventivmed. 1997; 42(2): 121-7	

Let me give you some ideas of the magnitude of risks. There is a recent study from The New England Journal of Medicine, February, 1999 (See Figure H), of 400 women who came to a clinic following spontaneous abortions and 570 women who went to the same clinic but had healthy pregnancies. The study showed that smokers were 1.8 or 80 percent more likely to have a spontaneous abortion than non-smoking pregnant women.

The same mechanism of lack of oxygen I described above, may produce a low birth weight infant. We know that low birth weight is one of the greatest predictors of an infant's death. Smoking can cause growth retardation of the fetus, causing low birth weight as well.

FIGURE K: SUDDEN INFANT DEATH SYNDROME (SIDS)
<i>Design:</i> Cotinine levels in pericardial fluid were used as an indicator of exposure
-levels >20 Ng/mL indicated heavy exposure
<i>Results:</i> a significantly higher proportion of victims of SIDS had been heavily exposed to nicotine
-25% vs. 0%
<i>Conclusions:</i> Victims of SIDS are more often and more heavily exposed to tobacco smoke doses before death than are infants who have other sudden deaths.
Milerad, J. et al. Journal of Pediatrics. 1998; 133(2): 232-6

FIGURE L: SMOKING, FETAL GROWTH RETARDATION AND SIDS	
<i>104 SIDS victims were compared to 206 controls infants</i>	
<i>Smoking Status</i>	<i>Risk of SIDS</i>
Non smoker	1.0
Smoker	4.8
10-19 cigarettes/day	2.0
20+ cigarettes/day	2.5
<i>Conclusion:</i> Most of the risk of SIDS associated with growth retardation may be accounted for by maternal smoking. Cooke, R. International Journal of Epidemiology. 1998;27(2):238-41	

A study in the Indian Pediatric Journal, 1998 found that a woman who is a smoker or who is exposed to second hand smoke is three times more likely to have a low birth weight child (See Figure I). This is not a very good situation. Again, we have some data from my own city of Geneva showing the greater the intensity of smoking the more likely a low birth weight (See Figure J).

In SIDS (Sudden Infant Death Syndrome), smoking appears to be a contributing factor. When cotinine levels in pericardial fluid are used as an indicator of exposure to cigarette smoking, study findings show that infants who die of SIDS are more often or more heavily exposed to tobacco smoke before death than infants who die of other causes (See Figures K and L).

Health, Appearance and Smoking

Finally, there are three more health risks of smoking; osteoporosis, periodontal disease and facial wrinkling, which I would like to discuss. The first two, osteoporosis and periodontal disease, can have serious health consequences, while all three have serious effects on physical appearance.

FIGURE M: SMOKING AND OSTEOPOROSIS	
<i>Smoking Status</i>	<i>Risk of Fracture</i>
Non smoker	1.0
Smoker	1.5 + (often more severe fractures)
<i>Conclusion:</i> Smoking leads to: less strong bones, mineral deficient bones, reduces blood supply, fewer bone-forming cells, less functioning bone-forming cells <i>Avoiding tobacco is essential for preventing osteoporosis</i>	

FIGURE N:	
SMOKING AND FACIAL WRINKLING	
<i>Survey of Women aged 40 through 69 years, California</i>	
<i>Smoking Status</i>	<i>Risk of moderate/severe wrinkling</i>
Non smoker	1.0
Current Smoker	3.1
10-19 cigarettes/day	2.0
20+ cigarettes/day	2.5
<i>Conclusion:</i>	
Risk of facial wrinkling is greater in cigarette smokers than in never smokers	
Ernster, V. et al. American Journal of Public Health. 1995;85(1):78-82	

Osteoporosis occurs because of estrogen loss, insufficient calcium, alcohol use, lack of exercise, and finally, smoking. Smoking leads to weaker, mineral deficient bones by reducing blood supply and the number of bone-forming cells. If the risk of bone fracture in a non-smoker is 1.0, the risk rises to 1.5 in a smoker, and the fractures are more severe (See Figure M).

In smokers, the risk of periodontal disease appears to be 2 to 3 times as high as non-smokers. Smokers not only have an increased risk of periodontal disease, but the disease is more likely to be severe, more likely to re-occur, more likely to result in tooth loss, and treatment is more likely to be difficult. As for facial wrinkling, the risk of moderate to severe wrinkling in current smokers is, in this study, more than 3 times as high as in non-smoking women between the age of 40-69 years of age (See Figure N).

As you can see, the deleterious health consequences of smoking to women are not just found to effect the respiratory system but the entire body, including the mouth, lungs, digestive organs, bones, skin, teeth and reproductive organs. Finally smoking affects the viability of the fetus and the newborn. There are no positive effects of smoking.

***"Gender Issues in Tobacco Control:
Highlighting Some Developing Country Issues"***

Nicola Christofides

Women's Health Project, Johannesburg



I would like to thank the Global Alliance and WHO for the opportunity to address you on the issues in tobacco control. I'm focusing specifically on Southern Africa for two reasons: it's where I come from, and we are starting an initiative in the region which I would like to tell you a little bit more about.

While the number of women who use tobacco in Southern Africa remains lower than that of men in the region, there has been an increase. Preventative measures to maintain healthy choices need to be taken now. However, it is essential to explore ways of maintaining low smoking rates amongst women without re-enforcing negative gender stereotypes. This is one of the most important public health interventions that can be carried out. We need to understand the factors underlying why women start using tobacco and what makes it harder for women to quit smoking. In order to do this, we must understand the gender issues that underpin both of these aspects.

Additionally, gender issues surrounding tobacco production are important and need to be explored because 73 percent of the world's tobacco is grown in developing countries. Southern Africa produces nearly 80 percent of the tobacco grown in Africa. So, tobacco production is an important issue for this region.

Very little research has been carried out looking at gender issues in tobacco control in developing countries, and Southern Africa in particular. Today, I will address what we know, hypothesize on what might be true based on what we

know from other regions, and raise a lot of questions.

I will do this through looking at:

- Patterns and trends of smoking among women in Southern Africa;
- Gender issues underlying the uptake of smoking in developing countries;
- Theories that have been developed to explain why women keep smoking and find it difficult to stop;
- Gender issues pertaining to the production of tobacco;
- The multi-country initiative in which the Women's Health Project is participating.

Patterns and Trends in South Africa

The region that I'm talking about, Southern Africa, is comprised of twelve countries. Two of the countries, Malawi and Zimbabwe, have tobacco as their main export crop. Seventy-five percent of income from export in Malawi is from tobacco, and in Zimbabwe, 25 percent of income from export is tobacco-based. South Africa is the largest consumer of cigarettes in this region.

There is very little relevant data for this region on smoking amongst women. Few surveys which look at smoking rates have been carried out for even the general population. A survey from South Africa in 1996 indicated that 17 percent of women smoke, compared to 52 percent of men. These rates have increased about one percent per year since 1992. In Swaziland two percent of women smoked in 1997, eight percent of women smoked in Zimbabwe and the rates appear to be similar for Zambia. The differential from country to country is related to the wealth of the country. Smoking rates are lower among women in countries that are poorer. This has the potential to change as wealth in these countries increases.

The proportions I listed reflect smoking rates. This is not the only form of tobacco use. Snuff is used quite frequently in South Africa and in other countries of the region either through sniffing it or placing it under the lip. There is very little data on snuff use. A study in South Africa indicated that four percent of mothers use snuff. Because this is an area where almost no research has been conducted, most of the theories I will present will be on cigarette smoking. More research must be carried out on snuff use to examine the full extent of the effects of tobacco products in this region.

Why are smoking rates amongst women lower than that of men in the region? These low rates could be attributed to socio-cultural factors such as it not being socially acceptable for women to smoke in public, religious attitudes which discourage women from tobacco use and access to income. Men often have control over economic resources, (Amos, 1996; Mackay and Croftone, 1996) while women are more likely to spend the money that they have on their families

before themselves and, therefore, have less disposable income than men. These associated factors, especially control of the income and women's free choice, are instruments of gender inequality.

In developing countries, on average, women start using tobacco later in life than men. This can be linked to an increase in status and freedom for older women. Ritual use of tobacco and marijuana by post-menopausal women is often socially acceptable. Gender differences also occur with regard to number of cigarettes smoked, as women generally smoke fewer cigarettes than men. (Mackay and Croftone, 1996; Waldron, et.al, 1988).

Why do women start smoking? There is some discussion in the literature which suggests that smoking increases with age amongst women due to aggressive advertising campaigns and changes in women's socio-economic status. Smoking rates go up among women when they have disposable income, are well educated and urbanized. Urbanization results in changing lifestyles and increases exposure to advertising. The tobacco industry tailors its marketing and product appeal to specific target groups, such as women. In the context of developing countries, there are often limited restrictions or no restrictions at all on tobacco promotion and women represent a largely untapped potential market.

The marketing strategies also indicate that the tobacco industry understands the gender inequalities, demonstrated in the way in which they market cigarettes to women by promoting liberation and equality in their advertising. There is a need to disconnect concepts of gender equality from cigarette smoking in cigarette advertising. Little is known about the interface between increased access to income and urbanization which contributes to women's initiation into tobacco use and the factors which make it difficult for women to stop smoking.

There is a complex mechanism of gender issues impacting the initiation of women into tobacco use and the cessation of use. We need to understand this mechanism better. Once women start smoking, it is often harder for them to stop than their male counterparts. This is especially true of marginalized women.

What are the underlying gender issues of this phenomenon?

- Smoking is often an outward sign of women's often lower status.

- Smoking reflects a battle to control unvoiced frustrations.

- Smoking can be a symbol of independence in the midst of perceived powerlessness.

- Smoking can become a way of coping with the burdens of work, motherhood and poverty.

- Smoking can be a leisure activity that allows time and space for women to look after themselves.

Smoking can also be a form of control and allow for decision making, which women often don't have the ability to do elsewhere. (Graham, 1987 and Stewart, et. al., 1996).

Limited access to information is another gender issue which could contribute to the difficulty in stopping smoking. In studies carried out in South Africa, women's knowledge about disease associated with smoking was less than that of men. (Reddy, et. al., 1996)

The implications for these issues suggest that in a developing country such as South Africa, where socio-cultural factors are rapidly undergoing change, there is likely to be an increase in smoking amongst women. This, combined with women's low status, could lead to a rapid rise in smoking rates especially amongst lower to middle income groups.

Women and Tobacco Production.

I would like to look quickly at some of the gender issues in tobacco production. There is very little recent literature about gender issues surrounding tobacco production in the Southern African region. What we do know is often based on cash cropping in general. Some of these gender issues are true of other crops such as sugar and so on.

Previously, women often had traditional control over domestic production; this is being replaced by men's control over the cash crop. Women also have the double burden of working in the production of tobacco while having the full responsibility of running the household, including cooking, raising children, cleaning and collecting water. Tobacco is a labor intensive crop. Gender issues that pertain to tobacco specifically include women's role in the curing process. They are often responsible for re-kindling fires used for curing tobacco which exposes them to different environmental risks. In terms of flue-cured tobacco production, women's employment tends to be seasonal. This has resulted from historical factors that are perpetuated by male managers. The reaping of tobacco is viewed as being too hard physically for women, and yet women perform these tasks when sufficient male labor is unavailable. So, tobacco production highlights the inequalities that already exist in rural areas and the burdens being placed on women.

What role do women have in tobacco control? Women could be prominent in lobbying for changes in legislation on tobacco and enforcing them through social pressure and promoting positive role models. Strategies could include assertiveness training to empower women and allowing them to protect their own health and that of their families. (Yach, 1996).

To summarize, I would like to say that gender differences exist both with regard

to trends and patterns of tobacco use and the factors that surround tobacco control. Tobacco production highlights the inequalities that exist. There are also environmental health risks due to increased exposure of women working on tobacco farms. The proposed changes to the law with regard to tobacco advertising in countries like South Africa is of particular importance if we want to maintain lower smoking rates amongst women. My presentation highlights the need for further research to assist in explaining the complex mechanisms that surround the uptake, cessation and control of tobacco use. Gender specific and gender sensitive approaches to tobacco control need to be considered, and the implementation of these should be carefully evaluated.

Research Initiative

One of the ways to fill the research gap is the multi-country, inter-disciplinary Southern African Development Community (SADC), a research initiative, which is being coordinated by the Women's Health Project. This initiative is being funded mainly by the Tobacco Free Initiative of the World Health Organization, will partner with researchers and institutions from the Southern African region. At the moment we are in the initial phase of this initiative, identifying and developing partnerships with other groups in the region. The project will run for about two years. The process will include a series of workshops to develop the research proposal, identify research priorities in this area and develop protocols. At the end of the research, a dissemination process will be undertaken which will focus on policy as well as mobilizing community action. We will also be undertaking critical review of the literature around gender issues in tobacco control that will run throughout the period.

Today I've tried to highlight the need for further research to assist in explaining the complex mechanisms that surround the uptake, cessation, and control of tobacco. Gender specific and gender sensitive approaches to tobacco control need to be considered and implementation of these should be carefully evaluated. Thank you.

References Supplied by Nicola Christofides: Amos, A. "How Women are Targeted by the Tobacco Industry". World Health Forum, (1990) 11, 416-422.
Amos, A. "Women and Smoking: A Global Issue". World Health Statistics Quarterly, (1996) 49, 127-133.
Amos, A. "Women and Smoking". British Medical Bulletin, (1996) 52: 1, 74-89.
Ettore, E. Women and Substance Use. Macmillan, London. 1992
Goldstein, S. "Women and Tobacco". In Women's Health News and Views, (1998) 27, 26.
Graham, H. "Women's Smoking and Family Health". Social Science and Medicine, (1987) 25:1, 61-78.
Harry, I.S. "Women in Agriculture in Trinidad: An Overview" in Momsen, JH

(Ed.) Women and Change in the Caribbean, Indiana University Press. 1993

Jacobson, B. "Beating the Lady-killers: Women and Smoking" (1987) in Ettore, E. Women and Substance Use. London: Macmillan. 1992

Mackay, J and Crofton, J. "Tobacco and the Developing World". British Medical Bulletin, (1996) 52: 1, 206-221.

Muller, J. 'Smoking in Pregnancy: A Needs Assessment' in Wakefield et al. "Smoking and Smoking Cessation Among Men Whose Partners are Pregnant: A Qualitative Study". Social Science and Medicine, (1987) 47:5, 657-664.

Reddy, P., Yach, D., and Meyer-Weitz, A., "Smoking Status, Knowledge of Health Effects and Attitudes Towards Tobacco Control in South Africa". South African Medical Journal, (1996) 86:11, 1389-1393.

Reid, D.J., Killoran, A.J., McNeill, A.D., and Chambers, J.S., "Choosing the Most Effective Health Promotion Options for Reducing a Nation's Smoking Prevalence". Tobacco Control, (1992) 1, 185-197.

Stewart, M., Brosky, G., Gillis, A., and Jackson, S., et al. "Disadvantaged Women and Smoking". Canadian Journal of Public Health, (1996) 87:4, 257-260.

Steyn, K., Yach, D., Stander, I., and Fourie, J.M., "Smoking in Urban Pregnant Women in South Africa". South African Medical Journal, (1997) 87:4, 460-463.

Stubbs, J. "Women and Cuban Small-holder Agriculture in Transition. In Momsen, JH (Ed.) Women and Change in the Caribbean, Indiana University Press. 1993

Vaughan, M. and Chipande, G. "Women in the Estate Sector of Malawi: The Tea and Tobacco Industries", International Labour Office, Geneva. 1986

Wakefield, M., Reid, Y., Roberts, L., Mullins, R. and Gillies P. "Smoking and Smoking Cessation Among Men Whose Partners are Pregnant: a Qualitative Study. Social Science and Medicine, (1998) 47:5, 657-664

Waldron, I., Bratelli, G. Carriker, L., Sung, W-C., Vogeli, C. and Waldman, E. "Gender Differences in Tobacco Use in Africa, Asia, the Pacific, and Latin America" Social Science and Medicine, (1988), 27:11, 1269-1275.

Yach, D. "Tobacco in Africa". World Health Forum, (1996), 17, 29-37.

***Women and Tobacco Smoking in Sri Lanka:
Preventing the Inevitable"***

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Facing an intensifying anti-tobacco climate within the United States and Europe, British American Tobacco (BAT), like other multinational tobacco corporations, has shifted its focus to the vast markets of developing countries. My presentation will highlight the small island nation of Sri Lanka, where BAT's subsidiary, Ceylon Tobacco Company (CTC) uses lavish advertising campaigns to target the country's most vulnerable groups, preying especially on the young, untapped female population.

In the first part, I will discuss tobacco promotions in Sri Lanka aimed to encourage new smokers including women and girls. In the second half, I will show you current tobacco control efforts of an NGO called LIFE whose goal is to maintain Sri Lanka's low female smoking rate.

Smoking in Sri Lanka

Sri Lanka has the second lowest female smoking rate in the world at one percent. Only the rate in Afghanistan is lower. Male smoking rates, however, are high. Of the women who smoke, there are two types: the old, who often smoke for perceived medicinal purposes, thinking that suruttu (cigars) prevent toothaches, and the trendy, high-income Western-oriented urban young girls and women.

The tobacco companies in Sri Lanka are working hard to foster a smoking lifestyle among the 99 percent of girls and women who do not smoke. Among Sri Lankan men, 55 percent smoke an average of eight cigarettes per day. Smoking affects not only the man himself but also those around him, including family members, and impacts the well being of a household both in terms of economics and health.

At the community level, women who smoke cigarettes are regarded in a very unfavorable way. These opinions are echoed in film and in media. Women who smoke are often associated with sex workers. One tobacco advertising billboard that featured a woman smoking was so violently opposed by community members and townsfolk in Kandy, Sri Lanka, that it had to be removed immediately.

Tobacco Companies Undermine Norms

Tobacco companies are working hard to undermine these cultural norms prohibiting women from smoking. In addition to the numerous bidis there are three prominent brands of cigarettes: Bristol, the most popular brand, Gold Leaf, the premium brand, and Benson & Hedges, the elite up-market brand. Gold Leaf and Benson & Hedges are marketed to women. Each of these brands are promoted by the tobacco monopoly CTC, which saturates the visual environment with various advertising and promotional materials to encourage new smokers. These include sponsorships of sporting events, music groups, night clubs and discos, in addition to using contests, prizes and free cigarette giveaways as incentives to lure new smokers. I attended one of the discos sponsored by Benson & Hedges and attempted to videotape the event but was kicked out by "bouncers" who stated that this was a private, sponsored event: "no photographers allowed".

The disco catered to an elite young crowd, the country's English speaking youth. Entrance was free for females. Upon entering the disco, women were approached by young ladies, clad in gold saris and gold platform shoes, hired by the tobacco companies. These promoters strongly encouraged women to smoke free cigarettes that they were giving out. People who purchased cigarettes were given free prizes as incentives to smoke Benson & Hedges. The aggressive promotion continued throughout the night.

Circumventing Advertising Bans

Benson & Hedges circumvents existing bans of radio advertisements by not directly mentioning the product that they are advertising on the radio, but suggesting that men and women look in the newspaper for details, which include full color photos of the available "gifts", alongside Benson & Hedges advertisements. Grocery stores are part of this Benson & Hedges promotion. Benson & Hedges hires women to stand next to the cigarette displays in larger grocery store chains to give out such premiums as radios, and key chains.

Gold Leaf, which is another prominent cigarette brand in Sri Lanka, sponsored a one month long festival based in one of the hill station resorts. CTC's presence is ubiquitous at these events, many of which presumably cater to women, such as a science competition, fancy dress competition, healthy child competition and flower show.

Throughout the country, Gold Leaf has targeted the sponsorship of milk bars where people purchase dairy products. Their sponsorship includes an orgy of Gold Leaf cigarette promotions, including sales booths, vans, banners and other advertising. Women and children commonly frequent milk bars.

Another part of a promotional campaign includes women dressed up in Gold

Leaf clothing. They assist in sales at the booths promoting the association of women and smoking. There are many reports of similarly attired women being paid to "hang out" at popular shopping malls, on university campuses and on the more exclusive train journeys distributing free cigarettes and promotional merchandise and just plain smoking. In a less blatant but equally effective form of cigarette promotion, CTC has lent a hand to foster the Sri Lankan arts.

LIFE: An NGO Against Tobacco

Fortunately, in this world of slick, expensively produced advertising and visual media, there are a number of organizations that are working to prevent women from taking up smoking. One of them is LIFE, a volunteer drug and tobacco prevention movement for boys and girls which attempts to counteract and expose the activities and promotion of CTC.

This type of NGO is sustainable. It has been in existence for nine years and has operated on a shoe string budget of less than one hundred dollars per month. Among the 250 volunteers that are associated with this organization, women are strongly represented among the volunteers and in running the organization. School aged boys and girls do not have many opportunities to socialize with one another, and LIFE offers some opportunity for them. This organization provides a healthy outlet for them to socialize in a tobacco-free environment. Operating costs are met through fund-raising activities, including car washes and canvassing, as well as through small grants from a drug prevention organization in Colombo. There are many organizations like this in Sri Lanka. They promote their message using low tech, low cost media materials. Campaigns typically include hand-painted posters and placards, brochures, megaphone enhanced specific messages and street theatre. They use numerous special days including "World No Tobacco Day", "International Woman's Day" and Valentine's Day, as well as various sports events sponsored by CTC as occasions to develop anti-smoking campaigns and promote their messages.

Protests Against Tobacco

Campaign preparation typically spans the day and night before an event, such as a cricket match or a soccer tournament. Posters are plastered around town at night to avoid conflicts with the tobacco company, who, in the past, has sent thugs to disrupt these activities and beat up the youth. In one instance LIFE targeted (unsuccessfully) the CTC Chairman and asked him not to cheat Sri Lanka youth with tobacco advertisements.

One event the group protested was the "Bristol Tour-de-Lanka" bike race sponsored by Bristol cigarettes, a brand so popular that its name is synonymous with "cigarette". The race is a gruelling event that takes place throughout the island over the course of a ten day period, drawing crowds all along the course.

LIFE volunteers launched a campaign to protest this "cancer race" when it came through their area. They made hand-painted posters emphasizing that sports and tobacco don't mix, using a one-room office loaned to them by the municipal government. They operated using donations from sympathetic townspeople, who helped them get supplies, and carried the posters on a three-wheeler taxi downtown to post them. Their posters were torn down as fast as they could paste them up, and complaints to the police met with sympathy but no action. A senior police officer had been the guest of honor at the ribbon-cutting ceremony inaugurating the race. In the end, LIFE volunteers sang and drummed tobacco-free messages in the back of a truck that they had used to go to the bike race.

LIFE also used Valentine's Day as a way to promote the ideas that women appreciate men who do not smoke, that smoke-free relationships last longer, and that girls from the village of Kandy prefer non-smoking men. International Women's Day was another opportunity to deliver the message that smoking by men harms women and children through second hand smoke. As an additional activity, LIFE staff and volunteers worked with wives of smokers in small groups counseling them on ways of contending with their husband's smoking.

At other sporting events, LIFE volunteers perform skits that demonstrate the idea that a non-smoking lifestyle is a positive one. They put up non-smoking stickers on public transport vehicles because the government doesn't have enough money to do it themselves. In addition, they also try to persuade shop keepers to remove tobacco advertising.

LIFE also takes young men and women on trips that are otherwise associated with smoking, such as an outing to a beach. They take all their own music and they plaster the side of the bus with non-smoking messages. Again, this is an opportunity for boys and girls to interact where they wouldn't otherwise have an opportunity.

The image of this underfunded voluntary organization facing the likes of a financially powerful and influential corporation is daunting. Even major government efforts such as the recent announcement of a ban on tobacco advertising as of January 1, 1999 will be effective only with strict enforcement and preemption of a surge in indirect advertising and "brand-stretching" or the marketing of music, clothing, coffee and other items under the brand names of cigarettes.

It is critical for Sri Lanka's tobacco control community to expose and undermine the legacy of years of unrestrained tobacco advertising which associates smoking with wealth and carefree living. Combined with an advertising ban, proactive measures by the government and grass roots organizations such as LIFE might

offer Sri Lankan youth, and especially young women, a reprieve from the illusory lure of a smoking lifestyle.

FRAMEWORK CONVENTION ON TOBACCO CONTROL (FCTC)

- A Primer-

THE FCTC IS NO ORDINARY CONVENTION - IT IS POTENTIALLY A PUBLIC HEALTH MOVEMENT

The spectacular rise and spread of tobacco consumption around the world is a challenge and an opportunity for the World Health Organization. The challenge comes in seeking global solutions for a problem that cuts across national boundaries, cultures, societies and socio-economic strata. The unique and massive public health impact of tobacco provides WHO with an opportunity to propose to the world a first comprehensive response to deal with the "silent epidemic", as the tobacco menace has often been called. The Tobacco Free Initiative (TFI) has begun preliminary work in this direction. On 24 May 1999, the World Health Assembly (WHA), the governing body of the World Health Organization (WHO), paved the way for multilateral negotiations to begin on a set of rules and regulations that will govern the global rise and spread of tobacco and tobacco products in the next century. The 191-member WHA unanimously backed a resolution calling for work to begin on the Framework Convention on Tobacco Control (FCTC) - a new legal instrument that could address issues as diverse as tobacco advertising and promotion, agricultural diversification, smuggling, taxes and subsidies.

1. What is the FCTC?

The Framework Convention on Tobacco Control (FCTC) will be an international legal instrument that will circumscribe the global spread of tobacco and tobacco products. This is the first time that WHO has activated Article 19 of its constitution, which allows the Organization to develop and adopt such a Convention. In fact, the FCTC negotiations and the adoption of the Convention should be seen as a process and a product in service of public health.

This instrument will be developed by WHO's 191 Member States so that their concerns are adequately reflected throughout the process. In fact, the framework convention/protocol approach will allow Member States to proceed with the process of crafting this piece of international legislation in incremental stages:

The Framework Convention will establish the legal parameters and structures of the public health tool. It's a little like laying the foundation of a building.

The Protocols will be separate agreements that will make up the substantive part of the agreement - building on the foundation.

2. How will the FCTC help international tobacco control?

The FCTC and related protocols will improve transnational tobacco control and co-operation through the following avenues:

The guiding principles of the Convention could encompass both national and transnational measures making it clear that: tobacco is an important contributor to inequity in health in all societies; as a result of the addictive nature and health damage associated with tobacco use it must be considered as a harmful commodity; the public has a right to be fully informed about the health consequences of using tobacco products; and the health sector has a leading responsibility to combat the tobacco epidemic, but success cannot be achieved without the full contribution of all sectors of society.

Under the Convention, State Parties would take appropriate measures to fulfill, through co-ordinated actions, the general objectives which they had jointly agreed to. In this respect, the FCTC could include the following general objectives: protecting children and adolescents from exposure to and use of tobacco products and their promotion; preventing and treating tobacco dependence; promoting smoke-free environments; promoting healthy tobacco-free economies, especially stopping smuggling; strengthening women's leadership role in tobacco control; enhancing the capacity of all Member States in tobacco control and improving knowledge and exchange of information at national and international levels; and protecting vulnerable communities, including indigenous peoples.

The protocols could include specific obligations to address inter alia: prices, smuggling, tax-free tobacco products, advertising/sponsorships, Internet

advertising/trade, testing methods, package design/labelling, information sharing, and agricultural diversification.

Unless national and transnational dimensions of tobacco control are addressed in tandem, even the best comprehensive national control programs can be undone. The national and global thrusts of the Convention, by the way, are interdependent.

The process of developing and adopting the FCTC and related protocols will also help to: mobilize national and global technical and financial support for tobacco control; raise awareness among several ministries likely to come into the loop of global tobacco control, as well as various sectors of society directly concerned with the public health aspects of tobacco; strengthen national legislation and action; and mobilize NGOs and other members of civil society in support of tobacco control.

In the run-up to the adoption of the FCTC, WHO and its Regional Offices will work with NGOs, media and civil society in countries to focus on tobacco in all its dimensions.

3. What will happen to economies that depend on tobacco?

The widely held perception that tobacco control will lead to loss of revenues is really a misperception! In reality, the numbers are heavily in favor of moving away from tobacco cultivation. Recent economic analyses, for example World Bank data to be published this year, as well as the publication, "The Economics of Tobacco Control: Towards an optimal policy mix", show that the social and health costs of tobacco far outweigh the direct economic benefits that may be possible because of tobacco cultivation.

The FCTC takes a long-term view of agricultural diversification. The framework-protocol approach provides for an evolutionary approach to developing an international legal regime for tobacco control, and thus all issues will not need to be addressed at the same time. Further, the need for a multilateral fund to assist those countries which will bear the highest adjustment cost needs to be established. The FCTC will probably be the first instrument seeking global support for tobacco farmers.

4. Do internationally binding conventions/treaties lead to action and tangible results?

Adopting an international agreement can make a significant difference. For example:

Production and consumption of substances that deplete the stratospheric ozone layer have declined dramatically over the last decade as a result of the Montreal Ozone Protocol.

The General Agreement on Tariffs and Trade has brought down trade barriers and promoted the expansion of international trade.

Arms control agreements have limited nuclear weapons proliferation and have led to a substantial reduction in the arsenals of the nuclear powers.

Can international agreements affect the behaviour of States? In some cases, international agreements establish meaningful enforcement mechanisms, such as the World Trade Organization's dispute settlement system. But even in the absence of such mechanisms, an international agreement can:

- establish review mechanisms that focus pressure on States by holding them up to public scrutiny;

- articulate legal rules that may be enforceable in domestic courts;

- provide supporters within national governments with additional leverage to pursue the treaty's goals.

5. What linkages will the work on the FCTC have with other regional/international agreements which could have added value to the FCTC?

Under the WHO/UNICEF project, "Building alliances and taking action to create a generation of tobacco-free children and youth, supported by the United Nations Foundation, a review of the Convention on the Rights of the Child with respect to tobacco control, is currently being conducted. Also, with respect to TFI's work on strengthening the role of women in global tobacco control, links between the FCTC and the United Nation's Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), are being considered. Links between the FCTC and other international treaties addressing issues such as smuggling will also be examined. Furthermore, all efforts will be made to build on proposed and existing regional tobacco control agreements.

"Women: The Next Victims of the Tobacco Epidemic"

Margaretha Haglund

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When the American Lola Montz had her portrait painted in a Boston Studio in 1851, her dress, hairstyle and demeanour indicated that she was a “lady”, except for the cigarette she held in her gloved hand. Used as a focal point in her portrait, the cigarette was certainly intended to provoke the viewer. I’m absolutely sure, however, that neither she nor anyone else could foresee the future symbolic value of the cigarette as a sign of emancipation for women and the tragic development that we are now facing, where women are the next wave of the tobacco epidemic.

Ladies in 1851 did not smoke, and the very notion that women and girls might be experimenting with cigarettes was certainly not confronted publicly. Instead, women during this period played a central role in battling against the cigarette. Among other things, they urged restriction of sales of cigarettes to women. A total ban on sales to women was actually not far away in the U.S. as late as 1921. But today the number of women smokers is increasing daily, not only because of the world’s fast growing population, but also because cigarette smoking is still fostered and encouraged world-wide for commercial gain.

World-Wide Patterns of Smoking

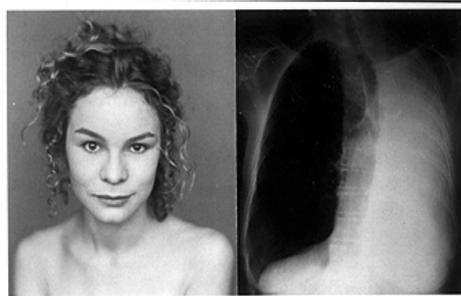
In the developed nations, there are many projections of the dire trends of smoking among women, but in developing nations we can only begin to make estimations. Currently between 2 to 10 percent of women in developing countries are smokers, compared with 25 to 30 percent in developed countries. In developing countries, where the epidemic is rising fast, especially in urban areas, there are considerable variations.

In Africa data is available from less than 30 percent of the countries, and it is estimated that about 4 percent of African women smoke.

In Latin America, there are reported variations from 3 percent to 49 percent, depending on the country.

In Asia, the prevalence of cigarette smoking is still very low among women. Only 3 percent smoke manufactured cigarettes, but in many areas of India, for example, 50-60 percent of women chew tobacco. Also, rural women smoke other tobacco products such as bidis (hand-rolled cigarettes), Kretek (bidis made with

flavored tobacco for export), and water pipes. Some smoke chutta (hand rolled cigars) through reverse smoking, with the lighted end inside the mouth.



Våldtagen av en **PRINCE**

"Raped by a Prince." An anti-smoking advertisement showing the effects of smoking by using the name of a popular cigarette brand, *Prince*.

In Asia Pacific, the overall smoking rate is 10 percent, but of course even here there are big variations from 28% in Papua New Guinea to about 10 percent in China and 5 percent in Thailand.

In the Eastern Mediterranean, smoking among women is still often considered vulgar, improper and immoral. But despite that, about 8 percent of women smoke in the Gulf Region. Finally, in Central and Eastern Europe the smoking rates are now, in most countries, similar to those in Western Europe: 20-30 percent.

I wish I could be more optimistic about the future, but from what has happened in the developed countries, we have strong reasons to believe that the smoking habits among women in developing countries will soon be similar to those among men and then follow the same upward trend. It only seems to be a question of time and the phase of development of a specific country.

For several years now, there has been a trend in developed countries towards more smoking among girls than among boys, as in my own country, Sweden. Actually, Sweden is one of the very few countries in the world where smoking now is more common among women than men. Sweden was recognized at the women's conference in Beijing as being the most emancipated country in the world, but isn't our smoking trend the ultimate backlash of equality? In contrast, in developing countries the gap between women and men is still large, and the prevalence of smoking among men is often over 50 percent.

Why does this large difference between women and men in developing countries exist? Of course, the main explanation is that the tobacco epidemic began much later among men in developing countries than in developed countries, and women have not yet caught up. But there are also other important explanations:

With some few exceptions, smoking has been, and still is, considered socially unacceptable for women.

There may also be religious constraints against smoking, as in Islamic countries.

Women have less spending power than men, and women may also be more inclined to use the money they have to buy food for the family.

Rural women may adhere to more traditional ways of using tobacco like chewing, such as in India, where as many as 80 % of women are currently living in rural areas.

Even if there are great variations between the continents, they have one thing in common: the epidemic is rising. In many of the new democracies in Central and Eastern Europe, we now have a very explosive situation. For example, in one of Sweden's neighboring countries, Lithuania, only very few women used to smoke: 10 percent until 1990. But in the last five years, the proportion of women smokers has doubled. Among younger women, the increase is almost 500 percent. In fact, this increase in Lithuania has been much faster than in Sweden, where it took almost 20 years to double female smoking levels. The number of women who smoke will also continue to increase for demographic reasons as the female population in developing countries will rise to be more than one billion by the year 2025.

If these trends are not enough to inspire us to further action, we also have the strong medical arguments which we have heard about from the first speaker, Paul Dolin. From what we have learned during the last few years, the health consequences of smoking, as with alcohol, seem to be even worse for us women than men. Women's bodies seem to be even more sensitive to tobacco than the male body. In addition, there are also those risks related to our reproductive function.

The message that has to be brought to the public now is that women who smoke like men will also die like men, and perhaps when they are even younger. Even if you can raise awareness and introduce effective actions, the burdens on society, the economy, the individual, and last but not least, her family, will continue to increase. And what is even more tragic is that we so far have only seen the tip of the iceberg! The World Health Organization's estimation of those more than one million who will be killed in 2020 by tobacco are not just faceless statistics but the girls and women of today.

Unfortunately, until very recently, there was a perception in many countries that smoking was mainly a male problem and that women seem to be more resistant to tobacco than men. In a way, this isn't very surprising. It's only in a few countries like the U.S., the U.K. and Denmark, where women have smoked for decades, that smoking-related diseases among women have become common. At present, as many as 50 percent of the total number of women who are killed by tobacco every year are in the U.S., which has only 5 percent of the world's female population. This is a fact that clearly demonstrates the magnitude of the smoking epidemic among women.

While we are hesitating to take actions, the trans-national tobacco companies are expanding to new markets, and their prime target is women. Since the 1920's, women have been heavily targeted by the tobacco industry with advertising that exploits our ideas of liberation, power and other values important to us. After the First World War, attitudes towards women smoking rapidly changed in the U.S., where it all started, and the tobacco companies turned their attention to how to recruit women for the cigarette market. They began to dream of the possibility of doubling the female share of the market. In 1928 the president of American Tobacco Company, made the following comments about the large potential female market for cigarettes: "It will be like opening a new gold mine right in our front yard". The quickest way to interest women in this product, he believed, was to zero in on women's waist lines.

The timing couldn't have been better, as slimness was, by that time, coming into fashion. The American Tobacco Company saw the potential of selling cigarettes to women as a fat-free way to satisfy hunger. I must say I can't find a more persuasive argument aimed at a target group whose members tend to like themselves better the less there is of them. The brand was, as many of you know, Lucky Strike, and the slogan was "Reach for a Lucky instead of a sweet." With the help of the father of Public Relations, Edward Bernays of American Tobacco made Lucky Strike the best selling brand for two years.

Another important event that led to decreased resistance of women to smoking occurred when ten young women marched down Fifth Avenue in New York on Easter Sunday in 1929 with their lighted "torches for freedom". The intention of the march was to challenge the social taboo that saw women who smoked in the street as having a doubtful character. After this event, there was less resistance to women smoking in the United States and the tobacco companies could go on marketing their deadly product to women.

You might think that this is in the past, but unfortunately it is not. A couple of months ago I saw a very similar example in Sri Lanka where only one percent of

women smoke. It was a modern version of the Easter Sunday walk, where the tobacco industry hired young women to drive jeeps and smoke Players cigarettes. In Sri Lanka, women don't normally drive jeeps and this event attracted the media, as you can understand.

For the tobacco industry, it's all about creating the right image of women as smokers. The industry creates needs and desires and manufactures the products as a tool to fill these needs and desires. How the strategy looks in a specific country will, of course, vary with factors such as the country where the campaign takes place, the country's culture, patterns and trends in smoking and any restrictions. Important also, of course, is the tobacco company itself. Together with their specific advertising and promotions strategies targeting women directly, the tobacco companies have also designed women's cigarettes with appealing names like Capri, Vogue, Kim and Virginia Slims.

Today, even the Chinese tobacco industry, with the fastest growing cigarette market and, at present, 30 million women smokers, has developed specific brands designed to attract women. One of these brands is Camellia, which is modeled on the American brand More. Today there seem to be no limitations on the tobacco companies in their eagerness to get women hooked on tobacco, whether a state monopoly or a private company.



**"Nobody can take the cigarette away from me, not even if I get hurt."
Caption from Eastern European cigarette advertisement.**

I must say that anger is too mild to describe my feelings when I look at this ad (above) from Lithuania, showing a woman with a black eye. The caption says: "Nobody can take cigarettes away from me, not even if I get hurt". In other words, I would rather be beaten up than do without cigarettes. So, the tobacco industry even found it appropriate to use violence against women in their marketing strategies to women. Isn't it disgusting?

The value for me of getting women to quit smoking in the U.S. or Sweden is very much neutralized if other women at the same time take up smoking in Lithuania, China, Brazil or South Africa.

The challenge is daunting and it's easy to be pessimistic. But, on the other hand, the solution is very simple. We just have to do more, and the sooner we act, the sooner we will get results. Don't forget that death and disease among women who use tobacco are all 100 percent preventable.

Of course, there is no alternative for us. The Beauty has to beat the Beast. But how? First of all, we must not let it get worse before it gets better. It's our responsibility to educate ourselves and teach others that women who smoke like men will also die like men. My **first** recommendation for action is the need to frame women's tobacco use as a major health problem and to build an international consensus around this issue. As the President of The International Network of Women Against Tobacco (INWAT), I'm very pleased to be here at this important meeting and to raise the topic of women's smoking.

This meeting is certainly a golden opportunity for further progress. Unfortunately, so far most women's organizations have not been very interested in the tobacco issue. Let us hope that this conference will signal the start of real progress in this area. I am looking forward to cooperating with all of you and also to a strong commitment on women and tobacco in the resolutions coming out of the UN Commission on the Status of Women meetings.

My **second** recommendation is to combine our tobacco control policies and measures such as the ban on tobacco promotion and tobacco advertising and price policies with a comprehensive tobacco control strategy which includes gender sensitivity in every aspect of tobacco research, cessation and prevention.

However, most current tobacco control programs today fail to address the specific needs of women. For example, the spread of more information about the health effects of tobacco use in many countries may clash with traditional forms of tobacco wisdom for many women. This could be exemplified with a quote from Jego, a bidi smoker from India who said, "Only bidi smoking can keep me physically fit. If my smoking gets disturbed I have problems with my stomach." Such attitudes really indicate that traditional tobacco control education may not be successful in some communities of women.

In order to understand the problem of women and tobacco, it is also essential to look upon tobacco as a class issue. Nowadays, in much of the developed world, women from lower classes use tobacco more than their advantaged counterparts.

But in the developing countries, the situation is often in fact the opposite. In India, for example, a woman's choice of tobacco is closely tied to her class. Middle class women are smoking cigarettes while poor women chew pan or smoke bidi.

Another example of the specific need for women-centered programs is the conflict of interest that many women in Asia and South America are facing as they are working for the tobacco companies, especially in the fields or processing plants. In Indonesia, for example tobacco manufacturers employ about 15 million people, mostly women.

My **third** and last recommendation is to increase the number and the power of women leaders in the tobacco control movement. I would welcome many more women having leadership in the tobacco control movement all over the world. Right now we are engaged in a lengthy war against tobacco related diseases. The war is being fought on many fronts. Therefore, we will need many of you to work with us. These women have also seen their living standards improved by working for the tobacco companies. As daughters and mothers, many of them have seen the harm of tobacco, but as workers and economic mainstays of their family, they must continue to work with tobacco. Any policies to move to other crops or products must therefore include the specific needs of women. At the same time, cigarettes for a woman smoker are also a financial drain to herself and her family. For example, a Philippine smoker of 20 cigarettes per day will spend 35 percent of the median household income on her habit.

So, I would like to invite all of you who are not already members to join INWAT, a network of over 600 members from 60 countries. Our main objectives are: to counter ruthless marketing and promotion of tobacco to women, to develop women-and-girl-centered prevention and cessation programs, and finally, but not least important, to promote women's leadership in tobacco control.

Tobacco control expert Judith Mackay from Hong Kong has said that the greatest single opportunity for prevention of non-communicable diseases in the world would be to prevent a rise in smoking among girls and women in China. This applies to women everywhere. Please join us and accept this challenge for better health among women. Thank you.

Questions and Answers: A Dialogue

Dr. Elaine Wolfson We will begin the question and answer period by first taking several questions, and then asking for responses from members of the panel and the audience.

Roma Stibmavy, International Chamber of Commerce My question is how can we expect to be an influence in the world when we cannot even influence the lack of air in this building? (Laughter) The United Nations put up new signs saying "smoking discouraged". Before there was a "no smoking" and a "smoking" area. So, we actually have gone backwards in our own home. At the United Nations headquarters in Vienna, they outlawed smoking in 1980, and it was all the staff who did it. It had nothing to do with anybody else. It started in one small office, and it spread to the whole building. If we cannot do it here, and if we cannot do it in Geneva, forget about the world.

Margaretha Haglund I think this is a very relevant comment. I was shocked when I came into this building because I expected it to be smoke free. But even if it's quite pessimistic, if we don't raise our voices and make this an important issue, nothing will be done.

Efua Dorkenoo, Women's Health Department, WHO, Geneva I would like to comment on smoking at the UN and WHO. First, in the World Health Organization, smoking is not allowed in the working place. Second, Dr. Brundtland takes the Tobacco Free Initiative as one of WHO's major initiatives. Third, I think that there is a vast opportunity for linking the tobacco free initiative with the grassroots women's movement around the world. And of course, in the Women's Health Department, we would like to really link this project into the grassroots women's movement in the developing world.

Dr. Paul Dolin In Geneva there is a huge amount of smoking in the UN buildings. Within my own organization, WHO, smoking is banned in the

building except, I believe, in the garage, where they have a smoking area that forces the smokers outside to a large extent. So we now have them polluting the gardens and so on with all their cigarette butts. It's not a very good situation.

I, too, was very dismayed to find that this building is full of smoke. It is very poor. I think that it is something that really does need to be addressed across the UN. The UN, in a way, is almost like a company, and our stockholders are the individual governments. I think we need to lobby our governments or the representatives to the UN agencies and say, "I came to New York and it was dreadful that smoking is allowed here". I would like you to lobby through your delegations. I think that is probably one of the ways to actually put the pressure on from the member states back to the UN itself and do it within the system.

Wolfson I think that we have to understand that there are processes and procedures, and there are different governments and jurisdictions. So it may not be the province of WHO to stop smoking at UN headquarters in New York. We can promote and WHO can promote and try to advance ideas, but we do indeed have to work within democratic processes to get them adopted. That is one of the intentions of a meeting such as ours.

Grace Iijima, International Council on Aging Some years ago I was overcome by smoke from a man who was smoking a cigar here at the UN, and I remarked on it to a guard and he said he couldn't do anything. In the last year or two, I have seen signs around that say smoking is discouraged. They don't say prohibited. But apparently discouragement isn't strong enough, and I think we have to appeal to the missions to ask them to have their people to stop smoking in public places.

Soon-Young Yoon With respect to passive smoking, do you think that there is room for a human rights argument - especially based on recent elaboration on women's right to a healthy environment - to a safe environment, to mobilize women around the passive smoking issue?

Dolin In relation to the human rights issue, I think it's a central issue that one must use to tackle this problem, and maybe that is one of the ways that hasn't been used in the past that needs to be done much stronger.

It's very true if you smoke you cannot hide the fact that you smoke. There are biological tests to detect smoking and there will be consequences in relation to one's health insurance in the future. I think that one potentially runs a risk of exclusion from coverage for certain diseases from insurance policies if you are a smoker. One must also remember that the tobacco companies are linked with a number of the health insurance companies across the world.

Dr. Bud Pletcher, Obstetrician/Gynecologist I just want to add to Paul's comments that cervical mucous was shown to be positive for the use of tobacco in patients. It's also in the urine in both men and women, so women of the world, if you're going to have life insurance examinations, make sure you don't use tobacco for at least fourteen days before you have a pap smear or you submit your urine.

Nicola Christofides What I didn't have time to talk about earlier was how our initiative in South Africa is actually going to address women through a network that already exists with grassroots women's organizations. We will use this research initiative to actually create advocacy around the issue of women and smoking amongst grassroots organizations.

About the issue of passive smoking, I know in South Africa, the new legislation that is being considered at the moment is being presented in the media as it will affect people's individual rights and the individual right to smoke. I think it needs to be reframed in terms of groups rights and about the rights of the majority of the people to move it forward and get public support around the issue of non-smoking.

Garrett Mehl Just to follow up on that, I think second hand smoking and the rights of the child should be considered, because I think that is a tactic that has perhaps not been thought of or has been thought of but not brought to the forefront. Again, there are a number of existing structures out there in developing countries that I think we can use to introduce the issue of women and smoking in general through human rights groups and through environmental groups if those exist in your countries. And, obviously, we should also use the existing network of health NGOs.

To follow, Paul also mentioned that insurance companies were affiliated with tobacco companies in some countries. In fact, the largest insurance company in Sri Lanka, Eagle Insurance, uses the logo of the tobacco company as their symbol and is owned by the tobacco company. One of the prominent girl's schools in the city of Kandy where I was based had a safety message for people to watch out crossing the roads that was sponsored by Celyon Tobacco Company. So, they are trying to associate the company with feelings of safety and health, feelings that really are not normally considered part of smoking.

One last comment: I think the movement towards tobacco free environments needs to be addressed both at the community level and at the policy level. Without these two, you can have the policy but not move public perceptions and cultural norms in that direction. If you don't change at the community level then

all you have are policies that are not being implemented. I think that is a huge issue.

Haglund I have a minor comment about passive smoking. Women are actually the main victims of passive smoking so it's a very important issue for us women. Perhaps this is something that can interest organizations better if we try to address it from this perspective because, we need to involve as many organizations as we can from many parts of the society. This is not a question only for those who represent health. It's a question for the whole society, and that has been the problem up until now: too little action and very much talk.

Dr. Debra Singh, Baha'I International, Israel In the absence of human papilloma virus, is cigarette smoking a risk factor for cervical cancer?

Dolin The answer is we're not sure. In the presence of the virus, it's highly probable that smoking is a co-cause. In the absence of it, we're not sure. There is some data saying yes, some data saying no.

Jane Zimmerman, Soro-optimist International We have members in 116 countries and we have advocated changes to laws such as banning advertising so underage people are not encouraged to buy cigarettes. But I think we're at the point now where we're finding that awareness and advocacy are not actually stopping young women from smoking, and I would like somebody to give me some advice on what the next step is, because making young women aware of the risks does not seem to be sufficient to have them stop smoking or not start. I'm wondering if there was some way we can actually look at young women and women generally who do smoke and find out what their reasons for smoking are. We should also look at women who don't take up smoking and find out why they don't and then perhaps develop a policy on that. Thank you.

Judy Norsigian, The Boston Women's Health Collective I would love to talk with you afterwards because in 30 years of working with various women's groups around the world who use our book, *Our Bodies, Ourselves*, and the literature that these groups have been producing, one of the big struggles has been that women's health advocates in most countries in the world are smokers themselves. Although none of us smoke in our organization, we have been trying to build these bridges with women who do smoke and trying to create an environment in which they can make it their agenda that other women who come after them will not. One thing I have learned and want to share is that most young women do not want to hear lectures about smoking, whether about the medical risks or anything else. But they are willing to engage in conversations where they look at the manipulation of advertising and the role it plays in hurting women's health.

I have to tell you, the most useful tool I have ever seen in the last 25 years of working on this issue, and I am a founding member of INWAT, is a new video produced about three years ago by the NOW Foundation called "Re-defining Liberation". It is a very engaging and articulate review of the deleterious health consequences of tobacco, alcohol and fashion industry advertising. It links up the whole issue of body image and the desire to be slender, but in a way that does not blame women as victims. It basically gets at the whole issue of manipulation and it encourages women to activism.

I have used this video in probably 25 different high schools and colleges just in the last two years. It is the first thing I have seen generate phone calls and letters to our office. It's a video that costs ten dollars and is available at the NOW website. We've put it at our website, [<http://www.ourbodiesourselves.org>] and we are very excited because it's a tool younger women want to use to convince other younger women not to smoke and to get active on this issue. If you're looking for a tool, I urge you all to get ahold of it.

Unidentified Woman I just wanted to say that I never dreamed twenty years ago when I started working in anti-tobacco programs in public health here in New York State, that society would change to the degree that it has. I know there are enormous frustrations, and we have a long way to go, but we should be encouraged by what has happened. People just don't smoke on commuter trains anymore. Even where there is not a law, people don't smoke in your car nor in your home. Society has changed and maybe what we need to do is look more carefully and research what has worked.

Terry Singh, Pan Pacific Southeast Asia Women's Association I must be older than a lot of people here because when I was raised, before World War II, smoking was unacceptable for women. It seemed to come with the war along with other changes in what was normal for women. We should be getting out kits that can be used at the grassroots level to really educate the girls, because just to tell people not to smoke isn't enough. If you come up and give them a kit and make them responsible for themselves like the AIDS kits which I've seen recently, they might at least have some use so that we can get started.

Linda Min, International Women's Tribune Centre I'm 23 years old and I just wanted to piggy back what you said about the growing trend of smoking amongst women and young women. I guess I could be classified as a young woman. I've grown up in the United States. But among peers I definitely see an overwhelmingly larger number of women smoking than my male peers.

My question is that, given in the United States there are so many women

smokers and so many smokers who are well educated about the effects of smoking, what are your strategies for facing that inconsistency?

Unidentified Woman There are a lot of smokers who are really interested in quitting. Did you come up with some remedies that might help them to quit smoking?

Dolin You're asking very practical, hands on questions. But certainly I think using the health argument is not a very good way of getting the message across because often they are talking about young girls who are already smoking, but the health consequences are not for another ten or twenty plus years. I think talking to a teenage girl about lung cancer, talking to her about osteoporosis, talking to her about birth outcomes, is something that is not in her current realm of experience.

One argument we could use that might catch their attention is facial wrinkling. As I noted before there is quite good evidence that if you smoke you get much more wrinkling of your face. So, potentially, this is an argument that could be used and there is a growing amount of literature on that.

In countries such as Sri Lanka, where very few women smoke, maybe you want to turn your focus around and instead of being negative, get very positive. You could say that the women in Sri Lanka are the lucky ones: they are not smoking. How can we actually positively reinforce this? It's nicer to kiss a non-smoker. It's a very positive message. So, I think that what we need to do is not only play on the negative consequences where possible, but come out with a very positive strategy somehow.

Christofides Just a couple of quick comments. I want to reiterate, that we need to "de-link", concepts of "equality" and "freedom" and "power" from smoking because that is one of the things that makes smoking attractive to young women. The fact is that the advertising companies are portraying smoking in that way. Smoking and these concepts need to be separated because it's a total misconception that has been created by tobacco advertising. Also, I think that we need to understand a lot of these underlying mechanisms in greater detail: the whys and the why nots of smoking and non-smoking. I think that is another call for more information.

Mehl Someone has mentioned that advocacy was not enough and that being aware of the risks was not enough. I think what we're contending with is a huge advertising industry, and I think by using health messages it will only resonate with a certain proportion of the population and that is a very small percentage. Beyond that, you have to use the same messages, the same types of techniques

that the advertising industry is including in the Sri Lanka situation, i.e., culturally specific messages: "Kiss a non-smoker and see the difference!" It can actually be a culturally specific message, because people in Sri Lanka perceive smoking to cause black lips. That is seen as a negative outcome of smoking among men and women; that was a message that resonated with them.

Another thing is media literacy. Actually, someone else had suggested the idea of developing media literacy and talking young women through, being able to deconstruct the messages and seeing how they are manipulated by advertising. Advertising is really promoting the image of freedom and smoking. Perhaps we should be promoting the idea of slavery to the cigarette. Anyway, I think we should use the same approaches that they use.

Haglund It's a privilege to be the last one to comment. To smoke or not to smoke is absolutely not about doing what is best for you. So far we have very few women-centered strategies in tobacco control. That is what we are campaigning for. For example, in Europe, we are going to write down a women centered approach for all Europe. I have been going through the literature and seeing what we've been doing in other countries and there are too few good projects targeting women.

You will need to have a broad variety of activities. It's about empowering women, it's about educating women, it's about involving women. I also think that you need to be sometimes brave in order to try new ways of working. I am going to tell you very briefly about one thing which perhaps some of you will not like. But I take the risk.

In my country it's the blue collar working women who smoke and it is their daughters who start to smoke. Four years ago we started to involve Miss Sweden in our activities. Even in my very emancipated country of Sweden, Miss Sweden beauty competitions are very popular. One fourth, 25 percent of the population in Sweden, watch the final of the Miss Sweden competition every year. As of four years ago, all candidates have to be smoke free. You cannot be a beauty queen in Sweden if you smoke.

We have 28 candidates touring their areas for six weeks every year. They are doing it right, and normally they meet about 30 thousand pupils every year. I can tell you that this doesn't cost us anything. It costs us energy to train them, but that is a pleasure because it's about empowering women. These girls are very much the same as other women, and they feel that they do something very good in this activity. This is a high profile campaign which attracts a lot of the media in Sweden and it's very cost effective. I will not say that you should use it in

other countries, but it's worth trying to identify partners who have these high profiles. So let's be very intensive and never give up.

***Global Alliance for Women's Health
Recommendations***
by Dr. Mary K. Flowers, Ph.D.

I. To build capacity at country level through action research in order to design activities to address the influences and determinants of girls and women smoking

Place women and tobacco use on the agendas of women's NGOs, especially women's health NGOs.

Develop and Expand anti-smoking networks of women's NGOs, such as the WHO-GAWH Tobacco Free Network and INWAT.

Develop and Implement social marketing strategies, using already influential cultural mediums (for example the use of soap operas that include themes concerning family planning), targeted at eliminating tobacco use.

Make information available to NGOs in a form that can be used to educate their members and their constituents.

Assess the impact of the mixed message sent by countries whose governments engage in anti-tobacco campaigns but at the same time support tobacco production, resist anti-tobacco legislation, benefit from tobacco taxes, and/or receive money and goods from tobacco lobbies.

Devote special attention to women in rapidly changing societies including societies in which socio-economic status is rapidly changing or traditional cultures are being altered.

Promote and Provide support for zero tolerance for smoking at home, in the workplace and in public areas.

II. To prevent and reduce the negative health impacts of tobacco on the health and wellbeing of girls and women.

Educate health care workers, whether professional or traditional (such as midwives, nurses, physicians), who deal with girls and women on the effects of tobacco on women's health.

Expand the role of these health care workers in the education of women and girls about health effects of tobacco use. These point-of-contact health care workers should actively present the issue of smoking to women and girls.

Educate pregnant women and women and girls of reproductive age specifically on the health hazards of smoking and second hand smoke to fetuses and newborns.

Educate women on the effects of secondhand smoke on themselves and their families. Devise meaningful and culturally specific ways to support non-smoking women who must deal with this in their homes and work. This is especially important because women, particularly those of the South, are frequently less well educated on the effects of smoking and second-hand smoke than their male counterparts, and younger women all over tend to discount the health effects of smoking until it is too late.

III. To promote gender-specific responses to the tobacco epidemic, including approaches to smoking cessation which are tailored to women's needs.

Develop smoking cessation programs tailored to women's needs.

Investigate how advertising affects women's use of tobacco.

Investigate how advertising can be used to discourage smoking and encourage cessation among women.

Investigate how women will be affected economically by changes in tobacco production if the anti-smoking movement is successful.

Look for any gender-specific factors which make it more likely that girls and women will take up smoking.

IV. To improve understanding of the influences and determinants of tobacco use by girls and women.

Update the literature that is available, such as WHO's excellent publication from 1992, *Women and Smoking*.

Distribute this literature in formats appropriate to the target groups.

Pursue focused research on why women find it more difficult to quit smoking than men.

Look at presenting the physical health affects of smoking, such as skin wrinkling and bad teeth, as reasons not to smoke.

- Discuss the cosmetic effects of smoking and the contrast between these and the image portrayed in advertising.
- Encourage further research of cosmetic effects and "visible" health impact.

Test response of young women and girls to the idea that tobacco advertisements manipulate them.

Find out from young women and girls who smoke why they do, and why those who don't smoke think they don't.

Investigate the relationship of societal constraints and smoking such as marginality, and feelings of control and power for women.

- Investigate the relationship between smoking and depression in women

Biographies

Meghan E. Bodkin is co-editor and designer of this publication. She is a student at Dartmouth College with a self-designed major in the Politics of Religion. Originally from Charlottesville, Virginia, Bodkin will graduate from Dartmouth in June of 2000.

Dr. Paul Dolin was an Epidemiologist for the World Health Organization in Geneva at the time of his presentation. His work focuses on causes of ill health and the burden of disease and disability. He worked in the newly created Department of Women's Health, and was most recently a medical officer for HIV/AIDS/STI Initiative. In August of 1999, Dolin moved to World Wide Epidemiology at Glaxo Wellcome R&D in England.

Nicola Christofides is a researcher at the Women's Health Project in Johannesburg, South Africa, primarily responsible for a multi-country research initiative on gender issues in tobacco control. The Women's Health Project specializes in mainstreaming gender into planning, programme design and training for managers, health workers and communities; health system research; policy development, analysis and evaluation; and advocacy.

Prior to this, Christofides worked on the Gender and Tropical Diseases Task Force at the Special Programme on Research and Training in Tropical Diseases at the World Health Organization in Geneva. Her area of interest was the participatory development of communication material on health for rural women in Africa.

Dr. Mary K. Flowers is co-editor of this publication and Senior Program Officer of GAWH. She has a Ph.D. in political science from New York University, has taught at John Jay College, CUNY and Mercy College. She has also served on the boards of several non-profit organizations and has donated her time to a number of other organizations including New York City Ballet and The Legal Aide Society.

Garrett Mehl is a researcher with the Department of International Health, and affiliated with the Institute for Global Tobacco Control at Johns Hopkins School of Public Health at the time of his presentation. As a Fulbright Scholar in Sri Lanka, Mehl oversaw a large investigation exploring lay perceptions of tobacco smoking among young men and women, assessing the impact of tobacco advertising, and learning about innovative grass roots tobacco control movements.

Mehl has training in cultural anthropology and international public health. He has worked with the World Bank and USAID. He directed the Malawi River Blindness Control Programme, and more recently he has been a part of the Centers for Disease Control and Prevention multi-site study investigating race and gender differences in teenage smoking. He has recently his doctorate and moved to a new position.

Margaretha Haglund is the Head of the Tobacco Control Programme at the National Institute of Public Health in Stockholm, Sweden. She is also the

President of the International Network of Women Against Tobacco (INWAT). She is a member of the World Health Organization Policy/Strategy Advisory Committee for the Tobacco Free Initiative project, and a member of the Swedish Network for Smoking Prevention. She is one of the two Swedish representatives in the European Network for Smoking Prevention.

Haglund is a member of the Steering Committee of the 11th World Conference on Smoking and Health (Chicago, year 2000), and she is a member of the Steering Group of the 2nd European Conference on Tobacco and Health (Las Palmas, year 1999).

Haglund has held different positions at the National Board of Health and Welfare at the Department of Health Education, Department of Health and Epidemiology in Sweden. She has focused on tobacco control since 1980.

Dr. Elaine M. Wolfson is founding president of the Global Alliance for Women's Health and an international health policy consultant. She has been studying socioeconomic and governmental parameters of women's health policy formation and implementation for over twenty years and is author, co-author, and/or editor of articles, monographs, and reports on women's health.

Wolfson received a BA from Smith College, a Ph. D. in political science from New York University and a Certificate in Business Administration and Management from the Wharton School of the University of Pennsylvania. She has taught public policy and organizational management in MPA programs at New York University, Rutgers, SUNY-Stony Brook and Baruch College of CUNY. Currently, she is an adjunct faculty member of the Division of Health Policy and Management, Columbia University School of Public Health.

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**World Federation for Mental Health/
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Dr. Paul Dolin
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Dr. Olive Shisana
World Movement of Mothers/ U.S.
Nadia Shmigel
Yale University/WHO Collaborating Center/ U.S.
Mary Palshaw
Zonta International/ U.S.
Doris Vaughn

WEB SITES to Find out More Information on Tobacco & Health News

***Action on Smoking and Health (ASH Australia)**

<http://www.ashaust.org.au>

***American Cancer Society: Official Position on the Tobacco Settlement**

<http://www.cancer.org/advocacy/tobaccoposition.html>

***American Lung Association**

<http://www.lungusa.org>

***Center for Disease Control TIPS: Tobacco Information and Prevention Source**

<http://cdc.gov/tobacco>

***Dr. Koop.com: "Tackling Tobacco"**

<http://www.drkoop.com/tobacco/>

***European Network for Smoking Prevention**

<http://www.ensp.org/>

***International Union Against Cancer**

<http://www.uicc.org>

***Kickbutt.org International Tobacco Site Center**

[http:// www.kickbutt.org/links/index.html](http://www.kickbutt.org/links/index.html)

***Medical News on Tobacco**

[http:// stic.neu.edu/News/medical.htm](http://stic.neu.edu/News/medical.htm)

***New strategies for cigarette victims**

[http:// rampages.onramp.net/~bdrake/views.html](http://rampages.onramp.net/~bdrake/views.html)

***Physicians for a Smoke-free Canada**

<http://www.smoke-free.ca>

***Proposed FDA Regulations**

[http:// ash.org/legal/fdapet.html](http://ash.org/legal/fdapet.html)

***Quit Now - Australian National Tobacco Campaign**

<http://www.quitnow.info.au>

***Quit Now - National Tobacco Campaign**

[http:// www.quitnow.info.au](http://www.quitnow.info.au)

***The Master Anti-Smoking Page**

[http:// www.smokefreekids.com/smoke.htm](http://www.smokefreekids.com/smoke.htm)

***Tobacco & Health News**

<http://www.tobacco.org/Health/healthnews.html>

***Tobacco and Kids**

<http://stic.neu.edu/News/kids.htm>

***Tobacco News on the Web - Archive**

http://www.tobacco.org/News/news_archives.html

***Tobacco Use: A Public Health Disaster**

[http:// www.who.org/programmes/psa/toh/Alert/4-96/E/ta3.htm](http://www.who.org/programmes/psa/toh/Alert/4-96/E/ta3.htm)

***WHO - Tobacco Alert April 1996**

[http:// www.who.ch/programmes/psa/toh/Alert/apr96/fulltext.html](http://www.who.ch/programmes/psa/toh/Alert/apr96/fulltext.html)

***WHO - World Health Organization**

[http:// www.who.org](http://www.who.org)

***World No-Tobacco Day (WNTD), 31 May 1999**

<http://www.who.int/toh/worldnotobacco99/teaser.htm>

Afterword
Dr. Elaine M. Wolfson, President
Global Alliance for Women's Health, USA

There is no gainsaying that smoking and women's health is emerging as a major critical global issue. In the 1990's in the United States for example, lung cancer deaths among women have been rising more rapidly than among men. Between the 1970's and 1990's US national statistics indicate that the number of lung cancer deaths have increased by about twenty percent for men and about 100 percent for women. Gender disparities in lung cancer mortality have begun to emerge in other countries as well. One recent British study concludes, "among smokers who get lung cancer, women are nearly twice as likely as men to develop the most deadly form, small - cell lung cancer."*

At this time the causes for the gender disparities are neither fully understood nor documented. To be sure, the number of women smokers in the US and the UK increased during the decades following World War II, and the development of cancer often takes decades. Nevertheless, many of the biological, cellular and hormonal studies that document associations between smoking and various

diseases and conditions, from gynecological to neo-natal from cardiovascular and pulmonary to environmental, require more study. Indeed, it is the position of the Global Alliance for Women's Health that in order to address the extremely serious issues involved in smoking and women's health, investments in medical and behavioral research on women health's in general and smoking related conditions in particular must be dramatically increased.

The information contained in the panel co-sponsored by WHO and GAWH at the 43rd session of the United Nations Commission on the Status of Women presages an array of serious public health consequences for member states globally and for women individually. The magnitude of the problem is captured by tobacco control expert, Judith Mackay from Hong Kong. Dr. Mackay has declared that "the greatest single opportunity for prevention of non-communicable diseases in the world would be to prevent a rise in smoking among girls and women in China."**

With the stakes for women throughout the world so high, the Global Alliance for Women's Health commends the World Health Organization's Women's Health Department and the WHO Tobacco Free Initiative for addressing the issue of smoking and women's health. What is more, GAWH is pleased to report that the United Nations Commission on the Status of Women has articulated its concern for smoking on women's health in its 1999 recommendations to the Economic and Social Council.

We at the Global Alliance for Women's Health through this publication and other initiatives, would like to help expand the ongoing movement for controlling tobacco. One of the major goals of this publication is to disseminate information on the dangers of smoking on women's health among non-governmental organizations (NGOs) throughout the world.

To that end the Global Alliance for Women's Health asks that all NGOs concerned with women's issues, make smoking and women's health a priority agenda item. The networks, coalitions and alliances that will follow, will provide essential links in the worldwide movement to control tobacco and will categorically advance women's health.

Dr. Elaine M. Wolfson

*As cited by Women United News, American Cancer Society, Vol. 1, Issue, 2

** See presentation by Maragretha Haglund

A Continuing Initiative

AT THE FOURTH WORLD CONFERENCE ON WOMEN IN 1995 AND THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT IN 1994, THE INTERNATIONAL WOMEN'S HEALTH MOVEMENT, IN PARTNERSHIP WITH GOVERNMENTS AND THE UN, SUCCEEDED IN PLACING A HIGH PRIORITY ON WOMEN'S HEALTH. WOMEN'S RIGHT TO HEALTH IS INCLUDED IN THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW), WHICH HAS BEEN SIGNED BY OVER 163 COUNTRIES AROUND THE WORLD. THE CEDAW COMMITTEE IDENTIFIED THAT GOVERNMENTS' COMPLIANCE WITH ARTICLE 12 CONCERNING WOMEN'S HEALTH IS CENTRAL TO THE HEALTH AND WELL-BEING OF WOMEN. IT REQUIRED STATES TO ELIMINATE DISCRIMINATION AGAINST WOMEN IN THEIR ACCESS TO HEALTH-CARE SERVICES AND TO INCLUDE IN THEIR REPORTS STATISTICAL INFORMATION DISAGGREGATED BY SEX, AGE, ETHNICITY AND GEOGRAPHIC LOCATION. STATES SHOULD ALSO REPORT ON THE ALLOCATION OF RESOURCES TO WOMEN'S HEALTH AND PLACE A GENDER PERSPECTIVE AT THE CENTRE OF ALL POLICIES AND PROGRAMMES AFFECTING WOMEN'S HEALTH.

IN JULY 1998, DR. BRUNDTLAND ESTABLISHED A CABINET PROJECT, THE TOBACCO FREE INITIATIVE (TFI), TO CO-ORDINATE AN IMPROVED GLOBAL STRATEGIC RESPONSE TO TOBACCO AS AN IMPORTANT PUBLIC HEALTH ISSUE. THE LONG-TERM MISSION OF GLOBAL TOBACCO CONTROL IS TO REDUCE SMOKING PREVALENCE AND TOBACCO CONSUMPTION IN ALL COUNTRIES, THEREBY REDUCING THE BURDEN OF DISEASE CAUSED BY TOBACCO. THE TFI GOALS INCLUDE EFFORTS TO BUILD NEW, AND STRENGTHEN EXISTING, PARTNERSHIPS FOR ACTION; ACCELERATE NATIONAL, REGIONAL AND GLOBAL STRATEGY IMPLEMENTATION; AND MOBILIZE RESOURCES TO SUPPORT REQUIRED ACTIONS. IN

PARTNERSHIP WITH EACH WHO CLUSTER, REGIONAL AND COUNTRY OFFICES, AS WELL AS NGOS, WOMEN AND YOUTH GROUPS, AND THE MEDIA, TFI, IN COLLABORATION WITH THE WOMEN'S HEALTH DEPARTMENT, WILL TAKE A LEADERSHIP ROLE IN PROMOTING EFFECTIVE POLICIES AND INTERVENTIONS.

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