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Tobacco use and women's health: an opportunity in international health promotion and a case study of tobacco policy in Canada

SUMMARY

Increasing numbers of girls and women are using tobacco worldwide. As a marginalized population, women are targeted for the sale of tobacco products and social structures are organized in a manner that increases their tobacco usage. Furthermore, as a result of their anatomy and physiology, women experience greater health problems than their male counterparts when consuming the same amount of tobacco.

Tobacco usage among women must be addressed globally through the lens of health promotion. Health can be increased for women, and in turn, the entire population by taking policy measures to address the issue of tobacco usage. This paper will use Canada as an example for examining the economic and political aspects of the tobacco industry and policy changes that must be made in order to promote health.

Key words: women's health; tobacco; health promotion

INTRODUCTION

Most individuals strive for and value health. But what is health? Health promotion is a vehicle for achieving or increasing one's health. But how does health promotion achieve its aim?

As this paper will demonstrate, women's health needs are different from those of men. One such health issue is the hazards that arise for women when they use tobacco.

To tackle tobacco usage among women and the problems that it causes, specific policy measures must be taken. This paper will address the issue of tobacco usage among women by using the Canadian context and policies to examine specific measures that can be taken.

The concept of health

As early as 1948, the World Health Organization (WHO) stated, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Nearly 40 years later, at the First International Conference on Health Promotion, health promotion was defined as, "the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment" (Ottawa Charter, 1986).

The Adelaide Recommendations on Healthy Public Policy (1988), the second conference on health promotion, focused on tobacco and alcohol as areas of concentration for governments. The conference stated that tobacco and alcohol were major health hazards and urged governments to take immediate action in developing public policies. They reiterated the importance of controlling tobacco because of mounting knowledge that smoking is not just injurious to the health of the smoker but also to passive recipients, especially to infants. They urged governments not to focus on economic losses resulting from a reduction in the production and consumption of

tobacco, but to consider the price they are paying in lost human potential, which occurs through the loss of life and illnesses.

Therefore, in the quest for health, as defined by the WHO, tobacco consumption must be decreased. Health promotion acts as a process that enables individuals to take greater control over their health and decrease tobacco usage. In order to use health promotion in pursuit of increasing health, policy development and enforcement are required.

Women: a marginalized population

Gender is a malleable concept that goes beyond one's biological sex. Gender refers to the social, cultural, and economic influences that affect males and females. Gender also refers to a range of differential aspects of relations, institutional practices, and identities (Greaves, 2007).

Women warrant special attention in regards to tobacco consumption. As this paper will demonstrate, women's usage of tobacco and the effects of tobacco on women's health are different from that of men. In addition to bringing attention to tobacco and the role of policy, the Adelaide Recommendations (1988) brings to the forefront of health promotion the role that women play as "primary health promoters." They iterate that women's networks should receive more support from policy-makers. This marked the first time in international health promotion discourse that the unique needs of women were recognized.

The Public Health Agency of Canada (2001) further develops the importance of looking at women's health; they state that gender is a social construct rooted more in

culture than biology. They assert that the embodiment of gendered norms has subordinated women and, thereby, impeded their attainment of optimal health. In Canada, women will have greater exposure to the health risks of smoking than men for gender-related reasons. The Agency suggests that “gendered norms” influence health care practices and priorities. Therefore, if gender inequality and bias are addressed within and beyond the scope of health care, overall population health will improve.

From an international perspective, the WHO (2004) discusses the exploitation of women by tobacco companies. Women and girls in the developing world (a vulnerable subset within a vulnerable population) are greatly targeted by transnational tobacco companies. According to the Center for Communication, Health and the Environment (2008), the tobacco industry targets women and girls in developing countries by using seductive advertisements that exploit the notions of independence, power, emancipation, and slimness. Tobacco use among women and girls will increase even further as their economic status improves because they will have greater financial resources for purchasing tobacco.

TOBACCO: THE ADVENT, PROGRESS, AND PRESENT STATE

The European explorers to the New World discovered tobacco and in following centuries its use gained popularity throughout Europe and Asia. It was not until the late 19th century that the use of tobacco became cheap and convenient as a result of manufacturing processes for cigarettes and matches. In the 1950s concerns about the health hazards of smoking began, and the Surgeon General's report in 1964 marked a turning point in attitudes towards tobacco by concluding that cigarettes were a major cause of cancer and

several respiratory diseases. As such, the decades following the report drove tobacco regulation to become a major public policy issue (Anon., *News Batch*, 2006).

Currently, there are 1.1 billion smokers worldwide and, if these trends continue, by 2025 it is expected that this number will increase to 1.6 billion. Every 8 seconds, someone dies as a result of tobacco use, which translates into 5 million deaths each year (Martin, 2008). To put this figure into perspective, in the time it takes you to read this paper (assuming it will take approximately 40 minutes), there will have been another 300 deaths worldwide caused by smoking.

Although the developed world may seem to be at an advantage because its smoking uptake numbers are not as steep as the developing world, its death rate from smoking is nevertheless increasing (Anon., *Curbing the Epidemic: Governments and the Economics of Tobacco Control*, 1999). Canada has a tobacco-growing industry that is larger, per capita, than that of most countries including the United States (Anon., *Canadian Council for Tobacco Control*, 2009). Furthermore, as recently as 10 years ago, Canada had one of the highest levels of tobacco consumption in the industrialized world (Knaus, 1992). Currently, in Canada, 23% of adult women and 27% of adult men over the age of 18 use tobacco, which ranks as the 35th and 92nd highest numbers worldwide, respectively (Anon., *NationMaster*, 2004).

Health risks

Recent epidemiological studies indicate that death rates for smokers are two to three times higher than that of nonsmokers, at all ages. This means that half of those who smoke will eventually die as a result of their smoking. These deaths do not only occur in

old age; about half of all smokers killed by tobacco will die in middle age. Smokers who die during middle age lose an average of 20 to 25 years of life expectancy (Anon., *Health Hazards of Tobacco: Some Facts*, 1996).

Tobacco usage is a significant contributor to coronary heart disease, lung disease, and cancers, such as cancer of the mouth, throat, larynx, esophagus, pancreas, kidney, and bladder. Smoking is also the main factor associated with lung cancer. It is estimated that 80 to 90 percent of lung cancer deaths can be attributed to smoking (Anon., *Tobacco Facts*, 2008).

Evidence suggests that among youth who smoke, there are adverse changes in lipid proteins, abnormal spirometry and lung function tests, and respiratory bronchiolitis (Stevens, 2003). The adverse effects of smoking go well beyond the individuals who smoke to nonsmokers exposed to second-hand smoke (SHS). SHS contributes to heart disease, increased severity and frequency of asthma, bronchitis, chronic middle ear infection, and pneumonia (Stevens, 2003).

It is also alarming to note that one-third to one-half of all current smokers have children living in the home and that 70 percent allow for smoking inside the home. Children who are exposed to SHS in the home have more annual days of restricted activity, bed confinement, school absences, increased risk of sudden infant death syndrome, chronic middle ear infections, more cases of lower respiratory tract infections such as pneumonia and bronchitis, and increased risk and severity of asthma (Stevens, 2003).

WOMEN

Internationally, the population of smokers is set to become increasingly female.

Additionally, this population will come progressively more from economically and socially disadvantaged groups (Graham, 2009).

Intersectional theory of women's health

As Reid et al. (2007) assert, women cannot be grouped into one category and assumed to be the same merely because they are all women. They recognize that race and class play an important role and come together with gender when affecting the health of women. They state, "An intersectional analysis examines social experiences and how they intersect at multiple forms of oppression, and what happens at these intersections" (Reid, et al., 2007, pp.79-80). Therefore, it is evident that the effects of tobacco on women's health and the effects of being female on tobacco uptake must be examined from multiple perspectives, including the women's race and social class.

In a study of tobacco use among women in India, the researchers determined that women in rural areas have differing views than those in urban centres. Rural women believe that tobacco has many magical and medicinal properties: it keeps the mouth clean, gets rid of foul smells, cures toothaches, controls morning sickness, and aids in labour. They also found that women in less educated and poorer social strata have a higher use of tobacco. Additionally, these socioeconomic gradients are steeper for women than men demonstrating the importance of viewing tobacco use among women from an intersectional perspective (Anon., *Tobacco us in India: Practices, patterns and prevalence*, 2003).

According to Canadian studies, one factor in the higher rate of young women smoking than their male counterparts is their belief that smoking will help control their weight (Anon., *Tobacco Facts*, 2008). Also, according to Canadian authors Greaves and Hemsing (2009), early childhood sexual abuse is correlated with higher rates of smoking among women. In all of their analyses, childhood sexual abuse was a better predictor of tobacco use than age, income, or ethnicity. Therefore, it is clear that tobacco use among women is a multifaceted phenomenon whose inequity steams from more than gender.

Health risks specific to women

The European Multidisciplinary Conference in Thoracic Oncology (2009) states that women tend to develop cancer at an earlier age than men despite having smoked less than men. They indicate that several case-control studies suggest that women are more vulnerable than men to tobacco carcinogens. Underlying sex differences in lung anatomy and physiology leads to higher risks for cardiovascular disease among women for consuming the same amount of tobacco as their male counterparts (Greaves, 2007).

In addition to sharing all health risks (such as those stated on pages five to six of this paper) with their male counterparts and having greater vulnerability for cardiovascular disease, women have an array of other hazards when using tobacco. The risks that are uniquely linked to the female sex are in the areas of oral contraceptives, infertility, menopause and menstruation, and osteoporosis (Cornforth, 2009).

Women smokers who use oral contraceptives or other hormonal methods of birth control have a risk for blood clots, heart attacks, and strokes. This risk increases with age and female smokers over 35 should not use oral contraceptives. Women smokers

have 72% of the fertility of nonsmokers and are 3.4 times more likely to require more than a year to conceive. Women smokers experience pelvic inflammatory disease with 33% more frequency than nonsmokers. The symptoms of menopause often begin 2 to 3 years earlier for smokers. Abnormal bleeding, amenorrhea (absence of periods), and vaginal infections are common menstrual problems among smokers. Osteoporosis affects most women who age enough to experience it. However, women who smoke experience bone density loss at five to ten percent more than nonsmokers by the time menopause occurs (Cornforth, 2009).

Recently, SHS has been linked to breast cancer (Anon., *Tobacco Facts*, 2008). When women smoke during pregnancy, tobacco puts infants at risk for sudden infant death syndrome, poor lung function, asthma, and respiratory infections (Stevens, 2003). Additionally, in many countries, women are affected by men's smoking whether or not they themselves smoke. This is caused through exposure to environmental tobacco smoke, diversion of family income from food to tobacco, or premature loss of family members' earning power (Greaves, 2007).

FROM A HEALTH PROMOTION PERSPECTIVE

Personal Responsibility

The Ottawa Charter (1986) states that one of the roles of health promotion is to support personal and social development. By doing so, it can increase the individual's ability to have greater control over his/her health and make choices that enhance health. According to Godin (2007), the manner in which the Ottawa Charter has been interpreted and used in Canada was not the way it was intended. He asserts that after the Charter the emphasis

was moved away from the individual and behavioural changes to the role of socio-structural factors. The individual was progressively removed from health promotion despite meta-analyses that education is an efficient strategy for the adoption of healthy behaviour. He states that an individual cannot end his/her smoking if there is a lack of motivation. Every ex-smoker has an intention to stop smoking when he/she begins the journey to quit, but it is impossible to actually stop smoking if the person lacks motivation to change. He states that as much importance should be given to the individual as is afforded to the social environment in health promotion (2007).

Another perspective comes from the field of health psychology. Shelley Taylor (2006, p.47) discusses health behaviours, which are behaviours “undertaken by people to enhance or maintain their health.” She identifies several factors that lead a person to undertake healthy behaviours: demographics, age, values, personal control, social influence, personal goals, perceived symptoms, access to the health care system, and cognitive factors.

Taylor's analysis of changing health behaviours makes the role of the individual very clear. From the nine factors that she identifies, four factors are based solely on the individual. Regarding personal control she writes concerning the “health locus of control scale,” (2006, p.48) which measures the extent a person perceives that he/she is in control of his/her health, perceives others to be in control of his/her health, or thinks that chance is the major health determinant. Those who view health to be under their own control are more likely to practice good health habits.

Based on twin and adoption studies, Taylor suggests that there may be a genetic factor to smoking. That is, in studying twins who were separated at birth there was a high

correlation as to whether they both did or did not smoke later in life. This contradicts many of the suggested social factors and looks merely at genetic makeup. She states, "Genes that regulate dopamine functioning are likely candidates for heritable influences on cigarette smoking" (2006, p.136). Taylor's reference to both an individual's behavioural patterns and biological makeup clearly demonstrate the importance of the individual person in the variance of tobacco use.

Social Determinants

There are some factors that are highly associated with tobacco use: initiation of tobacco use, amount and kind of tobacco used, and success or failure in cessation. Educational attainment is the best predictor of smoking, with those not completing high school having the highest rates and college graduates having the lowest rates of tobacco use (Stevens, 2003).

A second highly correlated factor is socio-economic status. Tobacco use is significantly higher among individuals with low incomes. According to Health Canada, in 2001, 31.7% of individuals in the lowest income group and 26.1% of those with medium low incomes were smokers compared to 20.7%, 18.0%, and 22.3% in medium, medium high, and high income groups, respectively (McDonald, 2003).

A third factor is the social environment, which is significant in both the choice to begin smoking and the success of quitting. Individuals who are surrounded by smokers are likely to begin smoking because they are modeling others in their social environment and because tobacco is readily available (Stevens, 2003). When it comes to quitting, the

social environment and social support for cessation have a profound effect on a smoker's ability to successfully quit (McDonald, 2003).

For women, specifically, domestic pathways are important to the transmission of disadvantage from one generation to the next. Young women from advantaged backgrounds can attain education and defer parenthood to pursue careers. On the other hand, young women from disadvantaged backgrounds find that early and lone motherhood can provide a certain and rewarding path to adulthood. By foregoing education and higher income potential, these young women will commence and continue tobacco use. In turn, these mothers' tobacco use will increase their offspring's probability of smoking because childhood circumstances have an effect on smoking persistence and quitting (Graham, 2009).

Political Landscape

According to the Ottawa Charter (1986), health promotion must put health at the forefront for all levels of government. In turn, these policymakers should combine diverse approaches including legislation and taxation. This action will lead to health for individuals through social policies that foster equity and identify and remove obstacles to adopting healthy public policy in non-health sectors.

The Adelaide Recommendations (1988) takes the above concept one step further by identifying social justice and equity as prerequisites for health. The Recommendations also stresses the importance of public policy that creates a supportive environment to enable people to live healthy lives. The government must take health into account as an essential factor when formulating policy and make health choices both possible and

easier for its citizens. The Recommendations heeds governments to pay as much attention to the health of its citizens as it does to the prosperity of its economy.

In addition to knowing what factors lead to tobacco use, the factors that decrease tobacco use are also documented. In fact, a Canadian study has shown that the odds of smoking by adults and the amount smoked each day decrease as governments increase the price of cigarettes, restrictions on public smoking, and per-capita spending on health education (Anon., *The Ontario Tobacco Research Unit: Research Update*, 2002).

Although tobacco is less elastic than some other goods, studies have shown that a 10% increase in real price through taxing will decrease smoking by about four percent. Taxes are especially effective for teenagers who are price-sensitive and many of whom would not begin smoking if cigarettes were not affordable (Knaus, 1992).

However, critics of taxation state that “sin taxes” on products, such as cigarettes and alcohol, disproportionately affect low-income and minority communities. On the other hand, advocates of taxation state that, if this logic were taken to the extreme it would necessitate distributing free cigarettes to low-income communities (Knaus, 1992). There are far more effective ways to combat the financial burden of cigarettes on low-income communities that simultaneously help with the health burden associated with tobacco use. If increased taxes place a burden on low-income individuals, the government can use revenue from tobacco to aid these individuals with cessation. Therefore, these citizens can be financially more prosperous (as they no longer need to purchase tobacco) and can enjoy better physical health.

Private sector responsibility

The Jakarta Declaration (1997) urges the participation of the private sector in pursuing policies and practices that promote health. Not only is the private tobacco sector not promoting health, it is having the opposite effect as can be seen through cases in Hong Kong, the Philippines, Taiwan, India, and Asia Pacific.

Tobacco companies took advantage of the knowledge that less than two percent of women under the age of 40 in Hong Kong smoked to launch Virginia Slims. They used the fact that many women are religious in the Philippines to produce calendars that featured religious Madonna amidst cigarette packs. They took advantage of brand name awareness among girls in Taiwan to launch Yves St. Laurent gift packs containing two cartons of cigarettes. The companies used marketing tactics to appeal to fashion-conscious girls and women in India who had traditionally been nonsmokers. Tobacco company advertisements and sponsorship of sports has been widespread in Asia Pacific (Anon., *Center for communication, health and the environment*, 2008).

Modern economic theory holds that consumers are usually the best judges of how to spend their money. This principle is based on two main assumptions: the consumer makes rational and informed choices after weighing the costs and benefits of purchases and that the consumer incurs all costs from the choice. When consumers have this autonomy, society's resources are in theory allocated as efficiently as possible (Anon., *Curbing the Epidemic: Governments and the Economics of Tobacco Control*, 1999).

Smokers must perceive benefits from smoking, such as pleasure and avoidance of withdrawal, that are greater than its personal costs to continue smoking. However, there is evidence indicating that many smokers are not fully aware of the high risks of disease

and premature death that their choices entail. Also, smoking usually starts in adolescence or early adulthood where sufficient information may not have yet been given and where the capacity for sound decision-making is not high. Finally, smoking imposes costs on nonsmokers – if they bore all the costs for smoking, smokers may not have as much incentive to smoke (Anon., *Curbing the Epidemic: Governments and the Economics of Tobacco Control*, 1999).

Therefore, it is evident that consumers may not be the best judges and government intervention is necessary. In any industry where consumers cannot make fully informed decisions independently, the government should intervene to safeguard its people. The tobacco industry is no exception.

IMPORTANCE OF INTERVENTIONS FOR THE HEALTH OF WOMEN

At the 56th World Health Assembly, on May 21, 2003, the 192 Member States of the World Health Organization unanimously adopted the world's first public health treaty: The WHO Framework Convention on Tobacco Control. The treaty requires countries to impose restrictions on tobacco advertising, sponsorship, and promotion; institute new packaging and labeling of tobacco products; create clean indoor air controls; and strengthen legislation to prevent tobacco smuggling (Anon., *An International Treaty for Tobacco Control*, 2003).

The WHO emphasizes the importance of devising policies that are comprehensive and cover a wide range of interventions. They state that the elements of such a comprehensive policy include both fiscal policy and information policy. Fiscal policy should consist of the increase in price of all tobacco products beyond inflation and the

use of part of this revenue to fund tobacco control efforts. Information policy should consist of banning tobacco advertising and promotion, ensuring effective health warnings are placed on tobacco products, and investing in counter-advertising and health education. Other elements are protecting people from SHS, providing tobacco control dependence treatment, and assisting farmers to diversify away from tobacco growing. Policy must also ensure that there is adequate institutional support for tobacco control capacity building, applied research, and regular surveillance activities and program evaluation. Finally, there should be support for media debates on the need for tobacco control, the availability of policies that work, and the role of the tobacco industry in thwarting the implementation of “healthy” policies (Anon., *Tobacco Free Initiative*, 2008).

DISCUSSION: NEXT STEPS

Current gaps

In the Jakarta Declaration (1997), the Fourth International Conference of Health Promotion, the responsibility of the private sector is identified and brought to the forefront of social responsibility for health. The Declaration states that the private sector must pursue practices that avoid harming individuals' health and restrict the production and trade of harmful goods, such as tobacco, and discourage unhealthy marketing.

As the epidemiological and medical evidence builds about the dangers of tobacco, the tobacco industry has shifted its defense to economic arguments in order to influence policymakers. As such, the tobacco industry has commissioned many reports evaluating its gross economic contribution in terms of employment, earnings, exports, and taxes

paid. These studies make two incorrect assumptions: that it would be possible to eliminate all tobacco consumption and that, where tobacco consumption is reduced, money that used to be spent on tobacco would not be spent in other forms of consumption (Collins, 2004). However, in reality, there are two possible outcomes if tobacco consumption were to be reduced: the level of national savings would increase and other forms of consumption expenditure would replace tobacco expenditures.

Gaps for women

As Kelly et al. (2001) state in reference to reducing tobacco use among women, the lack of progress is the failure to implement proven strategies not a lack of knowledge. They state that tobacco-related diseases have become a women's health issue of epidemic proportion.

Gaps in Canada

In the Canadian context, cigarette production is relatively capital-intensive and foreign-owned (Anon., *Canadian Council for Tobacco Control*, 2009). Therefore, there is evidence that a reduction in tobacco expenditure could lead to higher levels of domestic employment and earnings (Collins, 2004). In 2001, over 40 billion cigarettes were sold in Canada while revenue for exports was \$140 million. This means that Canada sells far more tobacco domestically than it exports abroad (Anon., *Canadian Council for Tobacco Control*, 2009).

In other words, any monetary benefits to the Canadian economy from tobacco production are offset by the tremendous burden that tobacco-related diseases put upon the

health sector. Estimates from the 1990s suggest that smoking costs \$9.5 billion each year, including \$2.68 billion on health care costs and \$6.82 billion in lost productivity from sick days and other factors (McDonald, 2003).

Future opportunities

Having a set of clearly identified factors that are associated with tobacco use, knowing the extent of the harms caused by the use of tobacco (as previously discussed), and recognizing what factors can decrease tobacco use makes the problem of tobacco an excellent candidate for policy-oriented learning. Not only do policymakers have visibly defined factors relating to tobacco use, they also have knowledge as to the factors that decrease the problem.

In *Health Psychology* (2006), Taylor recommends five strategies in social engineering that will decrease the use of tobacco and its harms. Although her recommendations are specific to an American context, the principles are universal.

First, she writes about transferring the cost of smoking to tobacco companies through lawsuits that would force an increase in sale prices and, therefore, decrease tobacco consumption. Second, she advocates that the Food and Drug Administration can regulate access to tobacco. Third, because most smokers report that they would decrease their use of tobacco if it became prohibitively expensive, Taylor suggests heavy taxation of tobacco products. Fourth, she advocates for a ban on tobacco advertising. This suggestion is most beneficial to women, at whom most current tobacco advertising is directed. Finally, Taylor reaffirms a strategy that is commonly used in developed geographies: restricting smoking to particular places.

CONCLUSION

It is evident that tobacco use poses health threats, which are even greater amongst women. When significant resources are devoted to the implementation of strategies to decrease tobacco usage, the results are dramatic for the population overall but even greater for women (Kelly et al., 2001). At a time when more and more women are smoking globally, measures must be taken to decrease tobacco usage and increase women's health.

“Inequality between men and women is a major threat to women's health” (Greaves, 2007, p.126). As was demonstrated in this paper, health promotion is a vehicle that must be utilized to decrease the inequities in health that are created between women and men as a result of tobacco use. Health professionals in the field of health promotion can improve the health of women by advocating for policy change.

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