

Acknowledgments

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Executive Summary

Tobacco use remains the number one preventable cause of death and disease in Canada. Smoking among Canadians is responsible for at least one-quarter of all deaths of adults between the ages of 35 and 84 (Collishaw & Leahy, 1988), outweighing suicide, motor vehicle crashes, AIDS and murder combined (Ellison et al., 1999). One out of two smokers will eventually die from smoking-related causes (World Health Organization, 1995a). Lung cancer, a key smoking-related disease, now exceeds breast cancer as the leading cause of cancer death among women (National Cancer Institute, 1998). The risk of cardiovascular disease, the leading cause of death among women, is doubled as a result of smoking.

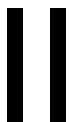
Women and girls have particular, and in some cases larger, health effects from smoking and exposure to smoke. The full effect of smoking on females is not fully understood, due to large gaps in the biomedical research on women and tobacco. Smoking among Canadian girls and young women is on the rise and is higher than boys' rates of the same age. In addition, women who are Aboriginal, Francophone, or of low income are at additional risk for high smoking rates.

This paper describes these issues and trends, and identifies the elements of gender and sex that affect women and tobacco use in Canada. In particular, analyses of income adequacy, child care responsibilities and the nature of women's work are critical to understanding the gendered effects of policy. The regulatory policy responses to tobacco are examined and a gender analysis applied to several selected examples, including packaging and restrictions on smoking.

The differences between the traditional tobacco control approach and an integrated and comprehensive tobacco policy response are examined. While the former is focused on macro measures designed to reduce rates of smoking across the population, the latter uses broad policy measures reflecting all the determinants of health to reduce inequalities. In both cases, integrating sex, gender and women's health issues into tobacco policy research and the development of tobacco

policy in Canada is seen as essential. This would result in women-centred tobacco policy reflecting the context of women's lives and the full impact of both tobacco use and tobacco policy.

Globally, the rates of women's smoking are on the rise. The World Health Organization estimates that the number of women smoking will triple over the next generation to 500 million (Amos & Haglund, 2000). The Kobe declaration, resulting from the 1999 International Conference on Tobacco and Health, states that there is an "urgent need" for the development of "effective gender-specific tobacco control strategies and to allocate sufficient funds for tobacco control programmes that reach poor women and girls". In this era of international concern, this paper suggests similar improvements in Canadian tobacco policy.



Key Recommendations

Following are the key recommendations; a full set of recommendations appears on page 56.

- ☺ Develop an ethical framework for assessing the impact of tobacco policy that takes gender, sex and inequality into account.
- ☺ Develop tobacco policy processes at federal and provincial levels that require the routine use of a gender analysis, are inclusive, and result in women-centred policy.
- ☺ Develop and publicize a new policy framework that includes both the traditional targeted tobacco control approach and an integrated and comprehensive approach, highlighting the best elements in both.
- ☺ Conduct a comprehensive gender impact assessment of current tobacco policy, with particular emphasis on taxation and fiscal measures.
- ☺ Develop gender-sensitive (and blame-free) campaigns aimed at reducing environmental tobacco smoke (ETS) around children.
- ☺ Develop package labels that address the social determinants of health, and provide women-centred cessation advice.
- ☺ Integrate sex and gender into all tobacco-related research (biomedical, clinical, health services, social and cultural, and policy).
- ☺ Improve data collection and survey techniques to establish accurate sex-disaggregated prevalence rates among Aboriginal people, children under age 15 and Francophones.
- ☺ Involve women and women smokers in developing gender specific tobacco control strategies and tobacco control programs that reach poor and low literacy women and girls.
- ☺ Implement the bilateral initiatives regarding tobacco use agreed upon at the Canada-United States Women's Health forum in 1996.



Introduction

This paper assesses the gendered differences in tobacco use in Canada at the end of the 20th century and potential differential impacts of regulatory legislation and policy on women and men. This initiative is congruent with a European initiative currently underway, which addresses the interaction of gender and tobacco policy (see, INWAT, 1999), and the upcoming release of the Surgeon General's Report on Women and Tobacco in the United States. It is an example of applying a "gender lens" to policy, following the directives of the federal government and several provincial governments in Canada. These studies are undertaken to contribute to the development of more effective, efficient and ethical tobacco control strategies that take gender, sex and inequality into account.

While focussed research on sex and gender differences and tobacco use has been underway for well over ten years in Canada, there is little known about the gendered effects and/or consequences of tobacco policy. In this project, a review of the literature and a scan of tobacco legislation and regulation across Canada form the basis for a gender analysis of some selected key elements of tobacco control policy.

Recommendations for further research on gender and tobacco policy and suggestions for the development of women-centred tobacco policies are made. Of necessity, much of this analysis is speculative regarding the differential impacts of policy. Clearly, a more complete picture needs to be drawn through both primary research and full integration of systematic and ongoing gender analyses into tobacco policy development and evaluation.

A central dilemma emerges in discussing gender and tobacco policy. On the one hand, the traditional targeted tobacco control approach (focussing on the pillars of fiscal policy, regulation, health promotion, prevention and cessation) has as its primary aim the reduction or elimination of the use of tobacco across the entire population. On the other hand, an integrated and comprehensive policy approach (using a blend of tobacco, social and economic policy), has as its primary aim

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the reduction of inequalities in health which, in turn, will have an influence on the reduction of tobacco use. While both of these approaches are used in responding to women's tobacco use in Canada, the targeted tobacco control approach is more established. With the growing commitment to population health in the 1990s, an increased attention to inequalities of health and the effects of gender on health has been required.

Following the traditional approach, the questions of concern to women's and girls' health are: How can such policies be made gender-sensitive and women-centred? How can they be developed and evaluated with differences between men and women in mind? How can differential consequences of policy be assessed and mitigated?

Following the integrated and comprehensive inequalities of health approach, the relevant questions for female health status are: How do the social determinants interact in affecting tobacco use among girls, women and female members of other high risk groups, such as Aboriginals and Francophones? How can related economic, health and social policy be tailored to serve the goal of reducing female tobacco use? How can tobacco policy avoid increasing inequality?

While these approaches inevitably lead to different policy results, and in some cases conflicting policy plans and positions, both are relevant and important for women's health. The traditional tobacco control approach benefits girls and women as members of the general population by reducing the use of tobacco and the exposure to smoking. The inequalities of health approach promises to benefit women's overall health and socioeconomic position, not just reduce tobacco use and its related illnesses.

It may be prudent to identify elements of both of these approaches and their areas of convergence in order to more comprehensively address the issue of female tobacco use in Canada. In other words, to fulfill the goal of developing women-centred, efficient, effective and ethical tobacco policy, both approaches must be mined for their best elements, and areas of conflict mediated and merged.

A. Methodology – Women and Tobacco

This analysis was done by a research team at the British Columbia Centre of Excellence for Women's Health in Vancouver, Canada in consultation with members of the Women and Tobacco Working Group. It includes a secondary analysis of data from the National Population

Health Survey (Statistics Canada, 1999), and other national data concerning gender and health. Interim results were presented on June 5, 1999 at the INWAT Europe Expert Seminar on Women and Tobacco in London, England.

To collect relevant and timely literature for this investigation, publications were identified using computerized searches of more than 15 different electronic databases, including MEDLINE, HEALTHSTAR, CINAHL, and Sociological Abstracts (see Appendix 1 for full list). This search was limited to research reports published from 1991 to the present.

Comprehensive Internet searches were also conducted using the same keywords. Websites from national, provincial and some municipal governments were carefully examined to collect information regarding tobacco control policy and legislation. As well, databases from the National Clearinghouse for Tobacco and Health, Health Canada, the Centers for Disease Control & Prevention, the Ontario Tobacco Research Unit and others were regularly accessed to provide the research team with up-to-date information. Special searches were made for reports or documents that

may not have been published in the peer-reviewed literature.

Further information for this analysis was gathered from informal interviews with key policy and research staff in the area of Women and Tobacco Control. These interviews were used to guide the investigation and highlight potential sources of unique information. Please see Appendix 2 for a list of interviewees.

IV

Sex, Gender and Tobacco Policy

A. The Context of Tobacco Use

Tobacco use does not occur in a vacuum. It is deeply affected by our social, cultural and economic environments. It is a product of historical trends, consumer and advertising patterns, and government and industrial interventions. As research is beginning to demonstrate, smokers of both sexes, all ages, socioeconomic levels and ethnicities act differently with regard to tobacco use. Further, these patterns change and evolve over time.

A useful framework for understanding the complexities and patterns of tobacco use is a determinants of health approach. This includes social as well as biological aspects of human experience. Health Canada has identified the following determinants as having significant impacts on health:

- income and social status
- social support networks
- culture
- healthy child development
- physical environments
- personal health practices and coping skills
- health services
- gender
- biology and genetic endowment
- employment
- education
- social environments

While these elements are difficult to disentangle, **gender is a determinant that cross cuts all populations** and works in concert with other social and biological determinants to affect smoking behaviour. This is integral to understanding the riddle of girls' and women's smoking behaviour in contemporary Canada.

Secondly, as more knowledge concerning biological differences in response to tobacco use becomes available, it is clear that genetics and sex-specific physiological characteristics play a part in determining

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the health effects of smoking. Consequently, research, policy and program recommendations in biomedical areas must acknowledge the influence and effects of sex, as well as gender.

As noted, a key challenge for a renewed tobacco control strategy is to combine macro public health policies with more focused policy initiatives that are effective and pertinent for sub-groups of populations. In particular, sex and gender specificity is increasingly important to fill in knowledge gaps regarding tobacco use, and to identify differential behaviours and responses regarding tobacco use.

B. Sex, Gender and Women's Tobacco Use

It is always important in studying women's health to identify the impact of sex (the biological differences between men and women) and gender (the social and cultural differences experienced by women and men) as separate variables (Greaves et al., 1999). Further, in the pursuit of new knowledge about the health of both women and men, it is necessary to consider the interaction between sex and gender and the impact on health status and the delivery of health care.

Gender influences what we do and how we are regarded. It influences

our identity formation and others' responses to us. Gender-based social roles define the nature and type of activities pursued by women and men. Gender is a powerful factor in all aspects of social life: in the workforce, in the family, in cultural and political relations, and in the ways people relate to their environments (Kitts & Hatcher Roberts, 1996). It can also affect the interpretation of biological symptoms, of disease patterns and of individuals' sense of self-care. In short, gender is an important and powerful determinant of a complex behaviour like smoking.

Sex is also a powerful and under-researched factor in understanding the response to tobacco use. Many areas of biomedical research are in need of development to fully determine the extent of sex differences in tobacco-related diseases in particular.¹ A landmark report on women and smoking in Europe states, regarding the health consequences of smoking: "One should be greatly concerned by the relative scarcity of valid studies dealing specifically with women." Indeed, it is now felt that women are at least "equally and even more affected by (tobacco) than men" (Sasco, 1999, 9).

Specific areas of biomedical research that need more sex-differentiated knowledge include: the effects

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of nicotine dependence, effects of nicotine on vascular disease and hardening of the female arterial wall and disease patterns of lung cancer, emphysema and asthma. There are outstanding questions regarding the connections of smoking to osteoporosis, breast and cervical cancer, its influence on connective tissues, ovarian development and its interaction with low body mass index and hormones (INWAT, 1999, 37-38). These needs are in addition to the longer standing recognition of smoking's effects on the female reproductive system, menopause, pregnancy, breastfeeding and fetal health.

In short, gender affects our behaviours regarding smoking, our cultural and social experiences of tobacco advertising, our smoking behaviours and interpretations of smoking. Our biology affects, in ways not at all well understood, how women and girls react to tobacco consumption or exposure to environmental tobacco smoke (ETS). Both of these affect women's health status, and both need recognition in research and policy initiatives.

Gendered differences in smoking rates vary across the world, reflecting different stages of the smoking epidemic in different countries (Amos, 1996; Chollat-Traquet, 1992). For instance, in many developing

countries, rates of male tobacco use are at relatively low levels, but increasing rapidly, while female rates remain at even lower levels than those of men. In industrialized countries like the United Kingdom and Canada, however, smoking prevalence is thought to have already peaked, and is decreasing slowly in both sexes. In the middle range are countries such as France or Spain, where women have started smoking much later than men, and their rates have yet to peak.

Generally, women's prevalence rates have historically not reached the heights of male prevalence rates that have preceded them. However, women's peak rates are also quite long lived. This pattern may indicate that women smoke "differently" than men and find it harder to quit, or that women's peak smoking rates are reflecting positive effects of tobacco control measures (INWAT, 1999, 19). In either case, rates of new smoking among girls is the key aspect to watch, as these smokers will age and eventually replace, or even increase, the proportion of women smokers in the population.

C. Trends of Tobacco Use in Women and Girls

1. Overall Female Rates

In Canada, overall smoking prevalence rates have decreased from

30% to 25% between 1990 and 1999 (Health Canada, 1999, Feb - June, CTUMS, Wave 1). Currently, 27% of men and 23% of women reported smoking in the Canadian Tobacco Use Monitoring Survey in 1999.

However, for the first time in Canada, more teen girls (29%) than teen boys (28%) are smokers (age 15-19). Further, these girls smoke as many cigarettes per day as the teenage boys (approximately 13), and this consumption level is on the increase (Health Canada, 1999, Feb - June, CTUMS, Wave 1). Both of these trends are new developments, and are cause for alarm and close analysis. In addition, girls begin to smoke at an earlier age than boys, which may mean that years of exposure to smoking may be longer. If these teen girls continue to smoke and these trends continue among those that follow, the future rates of female smoking will eventually top male rates in older age cohorts.

Female smoking-related deaths are also rising faster than those of their male counterparts. While this is assumed to be due to the time lag of developing smoking-related diseases from onset of smoking (about 25 years), it may also be connected to not yet understood sex differences in the development

of smoking-related diseases that could directly affect morbidity and mortality rates.² Should the latter be true, we may expect soaring mortality and morbidity rates among women smokers in the next generation. This difference in male and female death rates is expected to shrink as smoking rates between the sexes become more equal. The number of deaths due to smoking-related illnesses increased by approximately 8% from 1991 to and 1996; 64% of these were women (Makomaski Illing & Kaiserman, 1999). The increase in women's deaths due to smoking-related illnesses is expected to continue, and may reach, or even exceed, male levels (Makomaski, Illing & Kaiserman, 1999).

Following a pattern of the previous two decades, the overall male rate of smoking in Canada has decreased much more dramatically and quickly than the overall female rate (see Table 1). This differential decline may be related to the stage of the epidemic among women, or it may indicate different responses to tobacco policies and programs that have been initiated over the last twenty years. In addition, there are regional and cultural differences in smoking prevalence among Canadians, that indicate higher levels among Aboriginal people and Francophones, particularly in Quebec.

2. Aboriginal Women's Rates

Aboriginal people report the highest rates of smoking in Canada. Smoking prevalence among this group is about double that of the Canadian population as a whole. Similarly, Aboriginal women's rates are over double the rates of the general female population (see Table 2). Unfortunately, it appears that the problem may only get worse: In 1997, adult Aboriginal smoking rates were highest among young people aged 20 to 24 (72%) and 25 to 29 (71%) (Reading, 1999).³ In addition, the average age of smok-

ing initiation is the lowest (age 10) for Aboriginal smokers.

It is difficult to find sex-specific information that describes smoking among Aboriginal people. However, the following trend information is available regarding overall (both men and women) smoking rates: In 1997, the cigarette smoking rate among First Nations and Inuit peoples was 62% (Reading, J. *First Nations and Inuit Regional Health Survey: National Report*. 1999). This rate is unchanged from 1991 (Statistics Canada, 1995a).

TABLE 1

MALE (Age 15+) AND FEMALE (Age 15+) SMOKING PREVALENCE RATES: 1981-1997

Year	Male	Female
1981	43.7	35.1
1986	34.6	30.3
1991	32.2	30.0
1996/97	31.5	26.3

1981-1991 data – Health Canada. (1999, January 19).
Smoking Statistics in Canada for the Past 16 Years.

1996/97 data – Statistics Canada. (1999). *National
Population Health Survey – Cycle 2, 1996/97*.

These statistics reflect the poor overall health status of many Aboriginal people in Canada. Life expectancy is significantly lower among Aboriginal peoples, and the prevalence of all major chronic diseases, including diabetes, cardiovascular disease and cancer is significantly higher (Federal, Provincial and Territorial Advisory Committee on Population Health (ACPH), 1999). For reasons not yet fully understood, lung cancer rates among Inuit women are five times the national average (NST Cancer Registry, in Wilkin, 1998).

Reading (1996) points to the lack of success that cessation programs and strategies have had in Aboriginal communities. He suggests that

cessation programs include a consideration of cultural values and be designed and delivered from within the Aboriginal community. New or revised programs and policy must also be in the context of traditional spiritual and ceremonial uses of tobacco. Additionally, comprehensive evaluation of different approaches to tobacco use prevention and cessation in Aboriginal communities is necessary (Bulterys et al., 1990).

3. Francophone Women's Rates

As the 1996 report, *Francophone Women's Tobacco Use in Canada* (Health Canada, 1996a) states, there is a lack of detailed information on population sub-groups in Canada, including Francophone women. The

TABLE 2

ABORIGINAL WOMEN'S SMOKING RATES - 1991

Year	Aboriginal Women (Age 15+)
1991	57.0

1991 data – Stephens, T. (1994). *Smoking Among Aboriginal People in Canada, 1991*. Ottawa, Minister of Supply and Services Canada.

Prevalence rate defined as "current smoker" (includes "occasional" and "daily" smokers)

rates among Francophone women have changed little over the past 10 years (see Table 3). While provincial differences in prevalence rates are available, it is difficult to describe Francophone women's tobacco use in all parts of the country.

Provincially, Quebec has the highest prevalence of smoking among people aged 15 and over (Statistics Canada, 1999). This province has consistently had the highest percentage of smokers since 1981. In 1996/97, the prevalence rate was 33.9% – much higher than B.C., which had a rate of 25.5% (Statistics Canada, 1999). There is little research, however, that examines the reasons for this interprovincial discrepancy, and how prevalence rates may relate to Quebec

Francophone culture. In addition, it is currently impossible to fully describe the smoking behaviour of Francophone women in different regions of Canada.

Even when tobacco use among Francophone women and men has been adequately described, policies and programs developed for this population must account for its heterogeneity. Cultural, linguistic, and regional factors interact with gender to make groups of Francophone women smokers in different parts of the country unique. Cultural sensitivity means that aspects of language, daily practices and attitudes must be accurately reflected in policy and program design and dissemination.

TABLE 3

FRANCOPHONE WOMEN'S SMOKING RATES (1985-1995)

Year	Francophone Women (Age 15+)
1985	38.2
1995	34.7

1985 data – General Social Survey, 1985 as reported in Letourneau, G. (1988). Francophones and Smoking. Ottawa: Health and Welfare Canada.

1995 data – Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health. (1999). Canadian Profile: Alcohol, Tobacco and Other Drugs. Toronto: Centre for Addiction and Mental Health.

4. Adolescent Girls' Rates

While a general increase in youth smoking rates has occurred during the 1990s, girls' smoking rates topped boys' rates for the first time in history – an alarming development in tobacco use trends in Canada. Young women's smoking has increased from 23.5% in 1989 to 31% in less than a decade (1989-1997) (see Table 4) while young men's smoking rates increased from 21.6% to 27.2% in the same period (Statistics Canada, 1999-NPHS). Although young women have historically been lighter and less regular smokers than young

men, they experiment with smoking at a younger age than do their male peers (Hachey, 1998).

Young women and men have reported different reasons for starting and continuing to smoke. For example, girls more often cite curiosity as a reason for initiation, and some young women report starting to smoke in an effort to deal with stress. This continues to be a motivator in continuing to smoke, especially among disadvantaged girls (Hachey, 1998). Finally, young women appear to be more influenced by the tobacco use of family and friends than are boys (Hachey, 1998).

TABLE 4

ADOLESCENT GIRLS' SMOKING RATES 1981-1997

Year	Adolescent Girls (Aged 15-19)
1981	41.7
1986	27.0
1991	25.6
1996/97	31.0

1981-1991 data – Health Canada. (1999, January 19). *Smoking in Canada During the Past 16 Years*.

1996/97 data – Statistics Canada. (1999). *National Population Health Survey – Cycle 2, 1996/97*.

The different social contexts of girls, characterized by an increased tendency to conform in friendship groups and higher levels of anxiety and insecurity about friendships, may facilitate the initiation of smoking.

This greater influence of others' behaviour may be because young women often have smaller and more close-knit friendship groups than young men (Hachey, 1998; van Roosmalen & McDaniel, 1992). The different social contexts of girls, characterized by an increased tendency to conform in friendship groups and higher levels of anxiety and insecurity about friendships, may facilitate the initiation of smoking (van Roosmalen & McDaniel, 1992). Of course, any new programs and policies will need to take these differing social contexts into account.

While boys may smoke to look "tough", girls smoke to make friends, to be part of a group or to give themselves an image. Girls (more than boys) also use cigarettes as a way of rebelling against their parents, school or society in general (Health Canada, 1996c). The vulnerability of these youth may encourage them to seek acceptance through peer group affiliation, which may be characterized by anti-societal values and a variety of health-risk behaviours (King et al., 1996).

This increase in the risky behaviours among young women coincides with higher levels of stress reported by girls in high schools across Canada. For example, girls

are more likely than boys to be concerned about their appearance, to have headaches, backaches and stomach aches, to lack confidence, and to suffer periods of depression (Health Canada, 2000). Increases in smoking prevalence, then, may simply reflect a deterioration in health among adolescent girls.

As girls compare themselves to the idealized images of women portrayed in the media, they may develop a negative body image, and seek ways to manage their weight. Not surprisingly, many girls refer to tobacco's ability to help with this struggle as a reason for smoking (Health Canada, 1996c). A recent study found a clear association between smoking and anxieties about body weight and shape among adolescent women in Ottawa and London, England (Crisp et al., 1998). These researchers suggest that programs designed to prevent or reduce smoking among youth address these underlying issues of concern with weight gain common in girls. As well, it is important to view concerns with body image and weight loss in the broader context of other health behaviours, including alcohol use (French, 1995). In both research and policy development, health-related behaviours among adolescent girls cannot be examined in isolation.

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Young women today also face pressures of gender inequities that may influence their use of tobacco. As girls become more aware of the limits on their futures⁴ and cultural pressures on how they can behave, they feel less control over their lives and turn to smoking as a way to cope (Health Canada, 1996c; Greaves, 1996, 112-13). For instance, young women with low self-esteem and who are struggling academically are more likely to take up smoking (Amos, 1996; Health Canada, 1998; King et al., 1996). At an individual level, the use of smoking to bolster self-confidence among these young women may come from the widespread belief that tobacco can help calm nerves, control moods and alleviate stress.

Of most concern, however, is the tendency for girls to demonstrate a stronger intention to continue to smoke, even at relatively early stages in their smoking “careers” (van Roosmalen & McDaniel, 1992). This stance remains despite an awareness of the deleterious health effects associated with cigarette smoking. Clearly, this finding demonstrates that new or revised policies and programs face significant challenges, as these young women carry their attitudes and beliefs into adulthood.

5. Low-Income Women’s Rates

In Canada and other industrialized countries, smoking is increasingly associated with social and economic disadvantage (Amos, 1996; Graham & Hunt, 1994). Specifically, smoking prevalence is associated with low incomes, low levels of education, and unemployment. This trend may continue; adolescent girls who smoke are more likely to be underachievers at school, have low academic goals, and be less interested in continuing their education than are non-smokers (Fried, 1994).

Rates of smoking also vary significantly by income adequacy⁵ and educational level in Canada. In fact, the highest rates of tobacco use are found at the lowest income levels. At the lowest income adequacy level, smoking prevalence stands at approximately 35% for women and 41% for men. In contrast, smoking prevalence at the highest income adequacy level is 18% for women and 22% for men (Statistics Canada, 1999). Similarly, about one in three Canadians with less than secondary school education were current smokers, compared with fewer than one in four of those with post-secondary education (Statistics Canada, 1999).

For women, the factors associated with high smoking prevalence include unemployment, low-income

or service-sector jobs, lone parent status, low levels of education, isolation and lack of social support, dual responsibilities of work and family, family violence, stress, and low self-esteem (Hachey, 1998). The association between poverty and smoking status among women may endure throughout the life span; Hilary Graham and colleagues in the United Kingdom have found that both adult and adolescent socioeconomic status have significant and independent associations with smoking status among women (Graham & Der, 1999). Again, these data highlight the complexity of the relationship between smoking, gender and economic circumstances.

Marsh and McKay (1994) see the very high levels of smoking among persons with low income as a response to poverty. Research on smoking cessation demonstrates that people often give up smoking for optimistic reasons: they want to improve their health, present themselves in a better light, etc. But low-income families may have little reason to be optimistic, and their every day lives may be focussed on survival, precluding consideration of issues like long-term health (Marsh & McKay, 1994).

However, poverty may not just influence the smoking behaviour of individuals. Poor housing, high

crime rates and crowded conditions of deprived areas may also have an overall detrimental effect on health. In a study by Reijneveld (1998), living in a deprived area or community was associated with smoking. Much more research of this type is needed before we can begin to understand the effects of the social and physical environments on smoking behaviour. However, even these preliminary results demonstrate that tobacco use occurs in a social context (most often one of poverty) that cannot be ignored. Policies or programs that assume that smoking is a behaviour that is controlled only by the individual will be limited in their success.

6. Gender Differences, Smoking and Cessation

Adult male and female smokers report smoking for different reasons and under different circumstances. A number of recent qualitative studies with female smokers suggest that women smoke to cope with the stress in their lives caused by gender inequalities of economics, multiple roles and violence toward women (Health Canada, 1998; Greaves, 1996; Graham, 1993; Jacobson, 1986).

The tobacco industry has long exploited these gender differences by promoting some “women only”

brands that suggest that smoking is glamorous, liberating and relaxing. Smoking is depicted as “part of a positive and exciting lifestyle, and as a way to reconcile perceived contradictions of womanhood, such as the pressure to be thin and the desire for more independence and control over their lives” (Hachey, 1998). In these ads, the contradiction between personal control and the addictive nature of tobacco is ignored.

Women with multiple disadvantages (including poverty, unemployment and ethnic minority status) have described cigarettes as one small “luxury” in their lives. This form of leisure activity creates structure in the day, allows an opportunity to relax and put both physical and emotional distance between themselves and the responsibilities of child care and household work (Payne, 1991; Graham, 1993; Greaves, 1996). Although recognizing that tobacco use may damage their own health, these women refer to smoking as less damaging to their children than “letting off steam” in some other way (Amos, 1996).

Much more can be learned about how and why men and women, and boys and girls smoke, to determine the actual impact of gender. This initial overview highlights the complex relationship that

exists between smoking, gender, age, minority status and material disadvantage for women.

Fewer men and women in lower income adequacy or education levels have considered quitting smoking. Again, smoking behaviour and economic circumstances are intertwined. At the lowest income adequacy level, 44.1% of women and 40.5% of men have considered quitting, in contrast to the highest income adequacy level, where 52% of women and 62.2% of men have considered quitting (Statistics Canada, 1999).

Many studies that have tested the effectiveness of clinics and programs designed to assist smokers in quitting have shown that women have had less success in smoking cessation than have men. However, this result cannot be generalized to all women, since the vast majority of smokers who quit successfully do so independently, without the use of an established program (Greaves, 1991; Amos, 1996). At the same time, there is some evidence that, for women, the cessation process is different than it is for men. For instance, women tend to report less confidence in their abilities to quit, perceive more barriers to abstinence, and anticipate negative consequences related to quitting (Fried,

The current challenge is to develop additional effective policy tools to affect tobacco use among individuals or specific populations in high-priority groups such as youth, women, Francophones, Aboriginals and those in lower socioeconomic classes.

1994). Fear of weight gain is a particularly salient deterrent to cessation among women.

Nicotine replacement approaches may also be experienced differently by the sexes. Recent studies suggest that men and women differ in the degree to which nicotine is reinforcing, as well as in the magnitude of some effects of nicotine intake (Perkins, 1999). Clearly, these and other sex differences in the smoking cessation process suggest that a “one-size-fits-all” approach will not be effective.

In conclusion, research has demonstrated that women and men, and girls and boys, smoke for different reasons, in different social and economic contexts, are represented differently in advertising, and exhibit different patterns of consumption and cessation. In Canadian society, smoking used to be a predominantly male behaviour. However, the gender gap in adult prevalence is now virtually invisible. Among young people it is becoming reversed, as smoking rates among teenaged girls exceed that of teenaged boys. Smoking was initially linked to higher socioeconomic class but is now predominantly linked to lower socioeconomic class. As the current cohort of girls grows up and struggles with nicotine addiction, researchers and policy makers will

need to appreciate the elements of tobacco use that are linked to gender and class.

D. Policy Responses

1. Traditional Tobacco Control Policy

Within tobacco control policy in Canada and elsewhere, the dominant approach to reducing tobacco use has been to establish macro, broad based strategies that have a wide impact on changing smoking behaviour across the population. Approaches such as increasing tobacco taxation, limiting sales to minors, developing health promotion and prevention, and instituting smoking restrictions are examples. Such efforts are widely used, well supported and popular policy approaches in countries across the world, in line with their stage of the tobacco epidemic.

Historically the Canadian policy response has focused on reducing overall prevalence and consumption of tobacco in the Canadian population. The current challenge is to develop additional effective policy tools to affect tobacco use among individuals or specific populations in high-priority groups such as youth, women, Francophones, Aboriginals and those in lower socioeconomic classes. Tobacco use is a complex behaviour that reflects a myriad of determinants in its patterns of initia-

tion, maintenance and cessation. Similarly, the effects of tobacco policy on groups within the population are potentially affected and differentiated by determinants such as gender, socioeconomic class, income, ethnicity and culture.

Since 1985, there has been a Steering Committee to guide and consult on the National Strategy to Reduce Tobacco Use in Canada (NSRTU), consisting of federal and provincial governments, non-governmental organizations and national health organizations. In 1999, it released an updated National Strategy, *New Directions for Tobacco Control in Canada* (Steering Committee, 1999). It correctly identifies that the rising smoking rates among young women are a cause for “particular concern” (Steering Committee, 1999, 6). However, gender is not listed as a determinant of smoking (p. 9), and there is no sex-disaggregated data or gender analysis underpinning the Strategy. In addition, while the Strategy suggests that action plans should address gender-sensitive issues, the only group of women mentioned under the Priorities for Action is pregnant women (p. 16).

Among the goals in the Tobacco Strategy is “denormalization” of smoking. This refers to the process of changing the idea that smoking

is a behaviour that is acceptable. Interestingly, the two first denormalization goals in the Strategy both directly affect women:

- working to discourage smoking in enclosed public or private spaces where others could be affected by secondhand smoke, including children in the home, and
- working to discourage smoking by and around pregnant women (p.24).

Given that one of the goals of denormalization is to create enough social unacceptability to “attract adverse attention” (p. 26), it is clear that if the updated NSRTU Strategy is successful women smokers could be the focus of considerable social monitoring and policing.

The NSRTU *New Directions* document recognizes that the “momentum toward reducing the prevalence of tobacco use has stalled” (p. 8), primarily because quitters are being replaced by new adolescent smokers. It also recognizes the seriousness of the trend of young girls initiating smoking, but unfortunately does not seize the logical opportunity to tune its goals by applying a gender analysis.

2. Integrated and Comprehensive Tobacco Policy

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sive health determinants perspective is applied to tobacco use, however, it becomes immediately evident that tobacco control policies must be applied in concert with other social, economic and health policies in order to have optimum effect with groups of smokers most prone to smoking. Such an approach is inevitably focused on all aspects of life that affect health, and often turns up inequalities of health.

Hilary Graham (INWAT, 1999) suggests that a comprehensive policy framework would identify and integrate all policies influencing smoking behaviour from daily triggers to widespread social system influences, and would analyze the differential policy effects over the life cycle.

Such integration could result in more sensitive and ethical policy, account for both intended and unintended consequences, and improve overall health and welfare of the priority populations. Without this fine-tuning, tobacco control policy will not fully and evenly achieve its goal of reducing smoking rates and improving the health of Canadians.

Policy refers to several aspects of tobacco control. The focus of this report is the regulation and legislation that serves to prevent tobacco use, support its cessation or protect

the population from harmful second-hand smoke. However, policy also directs less formal strategies that direct decisions regarding tobacco control. For instance, allocating funds and resources to school-based prevention initiatives is a policy decision, or offering workplace cessation programs to staff is a policy decision. All aspects of policy, formal and informal, public, private and institutional, are important.

3. Tobacco Policy Research

The health research environment in Canada is undergoing rapid change as the 21st century begins. In February 1999, the federal government announced the creation of the Canadian Institutes for Health Research (CIHR), along with a wide and integrated mandate and increased funding. The mandate of the CIHR will particularly support research that crosses the quadrants of research – biomedical, applied clinical, health services and systems and social and cultural dimensions and population health. Integrating these areas of research will serve the problem of tobacco use very well. By its very nature the problem of tobacco use cross cuts all of these quadrants, and integrating tobacco research efforts in this way will enhance the development of knowledge in this field. The CIHR is also expected to integrate sex

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and gender into all health research it funds. This will further assist in understanding all of the issues facing women and girls in tobacco in Canada.

Other partnerships offer routes to integration. In 2000, the Social Sciences and Humanities Research Council (SSHRC) and the Canadian Tobacco Research Initiative (CTRI) are co-funding a research program in tobacco policy. At a recent workshop held by the CTRI, a tobacco policy research definition was developed that identifies the stages and content of tobacco policy research.⁶ It is useful in its clear articulation of the breadth of the policy process, and its private and public dimensions. The process of developing health policy, let alone tobacco policy is ambiguous to many stakeholders, and is clearly a process that has idiosyncratic aspects.

However, policy-relevant research is an emerging area in health, and is welcomed by many stakeholders as a route to evidence-based decision making. It is also welcomed by many health and social justice advocacy groups. Women's health advocates in Canada are key supporters of policy-relevant research, especially that which is inclusive of all stakeholders, including women and community groups. Emphasizing the process as well

as content of policy and including a wider slate of stakeholders are of particular relevance to women and tobacco use in Canada.

At a time when tobacco use among girls is not abating, tobacco control policy must become more tailored, not less. Equally important, at a time when biomedical knowledge surrounding tobacco-related diseases indicates huge gaps and differences in the responses of females to tobacco compared to males, it is important to develop focused goals and methods of addressing sex, gender and women's tobacco use. If such policy is going to succeed in reducing female tobacco consumption in contemporary Canada, it must reflect knowledge of the complexity of tobacco use as it is influenced by a variety of factors, including sex, gender, class and ethnicity.

The CTRI tobacco policy research program also proposes funding criteria for research that could reflect these elements (Best, 1999 Dec., 4). These criteria stress relevance, flexibility, quality, impact and theoretical rationale. Most relevant, however, is the criterion requiring sensitivity to the social, political, economic and cultural environments surrounding tobacco use.

A gender-based analysis ensures that tobacco policy is undertaken with an appreciation of men's and women's different social realities, life expectations and economic circumstances.

4. Gender Analysis and Tobacco Policy

In 1995, the federal government adopted a policy⁷ requiring federal departments and agencies to conduct gender-based analyses of future policies and legislation, where appropriate. Tools⁸ are available (and continue to be developed) to help policy makers do such analyses. In addition, the Women's Health Strategy issued in 1999 by Health Canada clearly requires that all health policies integrate sex and gender into policies and programs (1999 March 21). Applying such gender analyses and lenses to the tobacco policy development process would address both the process and content of control policies, to reflect gendered differences in smoking behaviour and responses to tobacco.⁹

A gender-based analysis ensures that tobacco policy is undertaken with an appreciation of men's and women's different social realities, life expectations and economic circumstances. Both the process of policy development and its evaluation would not be separated from the social context in which it occurs, nor from an assessment of the differential effects on Canadian women and men.

Although the requirement for gender analyses in policy development is

clear, it is not always evident how policies have been developed using this filter. Some key elements of the gender analysis process are sometimes evident in Canadian tobacco policy development, notably the collection and examination of sex-disaggregated quantitative data regarding tobacco. Also, there is a growing appreciation for qualitative data in Canada (and other industrialized countries) as we experience this stage of the tobacco epidemic. Further, the emphasis on women and girls in both the Tobacco Demand Reduction Strategy (TDRS) (http://www.hc-sc.gc.ca/iacbdgiac/nhrdp/abstracts/tobacco_strategy.htm) and the Canada-U.S.A. Women's Health Forum in 1996 (<http://www.hc-sc.gc.ca/canusa>) is an example of a gendered analysis at work.

Within the Women's Health Strategy issued by Health Canada in March 1999, there are two tobacco-related goals emerging from the 1996 Women's Health Forum. One identifies a joint USA-Canada "Program of Cooperation on Smoking Cessation Among Young Women and Adolescent Girls." A second goal was to identify "best practices" in smoking prevention and cessation for girls and young women. These initiatives have not yet begun.

Much more development of a gender

analysis is needed to question some basic assumptions of tobacco policy development, evaluation and effect. In addition, more understanding of the inter-relationships among economic and social sectors in Canadian society and how these relate to gender is needed. The federal government identifies values clarification as an integral step, and consciously asks how the values of decision-makers, the “system”, and those of society limit the range of policy options suggested. In this context, the ethical implications of tobacco policy initiatives can be clarified.

First, though, gender and sex must be integrated into the agenda of the national strategy for tobacco reduction, and be considered an integrated element of analysis, as opposed to an additional or “special” interest. Then, the issues would turn up in all policy development processes, evaluation and impact assessments. This does not yet occur in Canada. Fully integrated gender analyses constitute gender mainstreaming, the systematic inclusion of a gender analysis into all activities of policy development and evaluation.

Specific gendered elements of economic and social life in Canada could be integrated into an overall tobacco control policy. Three important and

interactive elements are income, work (paid and unpaid) and child care responsibilities.

Women are usually poorer than, and often economically dependent on, men (Kitts & Hatcher Roberts, 1996). In Canada, women earn 70% of what men do for full-year, full-time work (Statistics Canada, 1998, May 12), in part reflecting occupational location. According to the 1996 Census, women are concentrated in a limited range of occupations, including the sectors of health, teaching, clerical and the service industry and still hold the majority of the lowest paying jobs. Women dominate in all but five of the 25 occupations at the bottom of the earning scale (Statistics Canada, 1998, May 12), and are over-represented in part-time, temporary and contracted jobs (Krahn, 1995). A 1998 survey indicated that approximately 30% of adult women working part-time were doing so involuntarily, and an additional 20% worked part-time so they could care for their children (Statistics Canada, 1999, January 27).

The presence of children is a major factor in the earnings differential between women and men (Statistics Canada, 1995b). In most Canadian families, the responsibility for child care falls disproportionately on women, reducing time available

for paid work in the labour force. This results in a direct economic impact on women in terms of income, promotions and career opportunities. The 1996 Census showed that among employed women in two-parent families with a child under the age of six, 50% of women reported spending at least 30 hours per week on child care, while only 25% of men reported similar levels (Statistics Canada, 1998, March 17).

It is easy to see how the mixture of paid and unpaid work, child care and low income can affect physical health and emotional well-being. This mixture of circumstances is acute in women-led lone-parent families, the number of which is increasing in Canada. Approximately four in five lone parents are women, and many of them – 48% in 1995 – live below the Low Income Cut-Off (LICO) set by Statistics Canada (Statistics Canada, 1998, May 12). In 1993, the average income of lone-parent families headed by women was \$12,100 less than lone-parent families headed by men (Statistics Canada, 1995b).

Even when the household income is stable, many women, especially those who experience economic control and/or physical violence from a male partner, have little or no access to the family income. In

a 1993 survey, 10% of women with male partners stated that they had been denied access to the family's income. In some cases, women were not told what the family income was (Rodgers, 1994).

These are examples of gendered social and economic elements of life that determine health status, health practices, behaviour (including smoking), and responses to policy and program. Gender mainstreaming in tobacco policy development would identify and acknowledge such elements, and include them in design, implementation, evaluation and impact assessment of policy.

V

Tobacco Legislation, Regulation and Gender – Key Elements¹⁰

Tobacco control is well established in Canada, and is considered progressive by international standards. In general, the national strategy to reduce tobacco use is concerned with legislative and regulatory issues, and wide ranging prevention/cessation and education initiatives, utilizing both community and research capacity to reach these goals. These initiatives are generally broad and “blunt”, in the sense that they are not refined or focused on particular groups of smokers with a view to either sharpening or sensitizing them, but are intended to have as wide an impact as possible on prevalence and consumption trends.

The federal government and most provinces and territories have passed legislation to restrict smoking and/or to control the sale, promotion and packaging of tobacco products. In general, these policies are directed toward reducing or limiting the use of tobacco.¹¹ While it is clear that the circumstances surrounding smoking and the reasons for tobacco use are not the same for all Canadians, traditional tobacco control policy rarely overtly and consciously considers the consequences of broad based initiatives.

It is sometimes argued that blunt policies that reduce overall consumption (such as smoking bans or taxation increases) improve the health of *all* Canadians, including the groups most likely to smoke (such as young people, or low-income women) and therefore are appropriate measures. While true, this approach overlooks analyzing the consequences of tobacco control policy, whether intended or unintended, which would ensure that the effects are positive, ethical and not creating or contributing to other negative patterns or circumstances in smokers' lives. To more effectively reach their goals, while at the same time *not* contributing to gender and other social and economic inequalities, these policies need to be analyzed in the context of the reality of women's lives. The following discussion examines some of the current legislative and regulatory initiatives in Canada, and presents some selected ways in which they may differentially impact upon women and girls.

The industry artfully exploits the contradictory elements of women's smoking by offering freedom and escape alongside control, while nicotine addiction is the ultimate controlling element.

A. Restrictions on Promotion, Packaging and Products

It is well understood that aspects of the promotion of tobacco have an impact on initiation of smoking among young people and that advertising and sponsorship have an influence on public acceptance of tobacco. The promotion of cigarettes is designed to encourage smokers to switch brands, keep smokers from quitting, recruit new smokers, and encourage current tobacco users to smoke more cigarettes (Physicians for a Smoke-Free Canada, 1997). Because the taste and price of cigarettes vary little in Canada, tobacco companies must rely on the promotion of brand images to attract new customers. Through advertising, sponsorship and other forms of promotion, tobacco companies convey that:

- Smoking is a rite of passage to adulthood
- Smoking is relaxing in social situations
- Smoking is socially normal, and
- Smoking is safe and healthful (Canadian Council on Smoking and Health, 1997).

For girls and women, the messages have additional impact. There are campaigns surrounding "light" cigarettes that infer less harmful

product, more feminine imagery and resonate with weight control issues. These "light" cigarettes are often popular with older, female smokers who are concerned with their health¹², and are thought to act as a deterrent to cessation (Kozlowski et al., 1998).¹³ Also, messages on tobacco products directed at women address "freedom" and liberation, as well as stress-related "escape" and "take a break" themes.

These elements in female-directed advertising speak to the key gendered social determinants mentioned earlier: child care, workload and income. In addition, these industry messages directed at women correctly identify and reflect the links between identity formation and smoking derived from qualitative research with women (see, Greaves, 1996; Greaves, 1993-95; Graham, 1993; Greaves, 1995). The industry artfully exploits the contradictory elements of women's smoking by offering freedom and escape alongside control, while nicotine addiction is the ultimate controlling element.

In Canada, tobacco advertising has been tightly restricted by the federal *Tobacco Act* since 1997. However, the marketing of tobacco products is still evident in news stories and in television and movies, paid advertising in newspapers and magazines,

on the World Wide Web, and through sponsorship for festivals and sporting events (Physicians for a Smoke-Free Canada, 1997). For Canadian women and girls additional exposure is guaranteed through reading women's magazines, the majority of which are American sourced and have no restrictions on tobacco advertising within them (see, Greaves, 1995, and Greaves, 1993 – 95, for the technical reports on content analysis of women's magazines in Canada).

Sponsorships and promotions directed at women are the new front for tobacco industry marketers. Instead of directly marketing tobacco to women, a practice more and more restricted, tobacco companies are using ingenious approaches such as custom publishing (Kuczynski, 1999) and special "awards" constructed to recognize women's achievements. In custom publishing, tobacco companies such as RJReynolds, Brown and Williamson and Philip Morris team up with major publishers such as Time Inc., Hearst Publishing and EMAP Peterson to produce stylish niche magazines. These magazines are strictly controlled and designed to further the images and products of tobacco companies. RJReynolds, for example, publishes *CML: The Camel Quarterly*. An internal memo dated

July 8, 1998, clearly laid out the objective of this publishing venture:

"To prepare for a regulated environment by filling a communication gap among 21-34 year old adult smokers when key pubs may no longer contain tobacco advertising in colour" (Kuczynski, 1999).

In Canada, the Women of Originality Awards program was created by Vantage cigarettes in 1998. Several entertainers such as Jann Arden, Mary Walsh and Kate and Anna McGarrigle have accepted these awards along with sizeable donations for charities of their choices. Similarly, the Matinee Foundation has given awards to young accomplished fashion designers for several years, and advertises its program widely in bus shelters, billboards and magazines.

To counteract tobacco company marketing efforts, the federal Act and other provincial and municipal legislation aim to restrict youth access to cigarettes and limit inducements to smoke, protect the health of Canadians from diseases caused by tobacco use, and enhance public awareness of the health hazards associated with tobacco use. These restrictions, however, do not affect all Canadians uniformly. As we have seen, the economic, social and cultural conditions under which men and women smoke differ. Similarly, the

conditions under which girls and boys (and men and women) are targeted by tobacco companies differ. The conditions under which legislation and regulation is experienced are also distinct.

The 1997 *Tobacco Act* prohibits tobacco product promotion at events that are associated with young persons or that are associated with “a way of life that includes glamour, recreation, excitement, vitality, risk or daring”. Some provinces also limit the use of logos on non-tobacco products (e.g., clothing), as well as restricting where advertisements can be placed. In addition, legislation such as British Columbia’s 1996 *Tobacco Sales Act* stipulates that advertising must not mislead consumers regarding the composition or toxicity of tobacco products.

Several provincial jurisdictions place restrictions on the promotion and packaging of tobacco products, but British Columbia and Quebec are the only two provinces that have introduced product standards to date. Some provinces prohibit certain types of tobacco advertising, including the use of slogans, fictional persons, characters and animals. Quebec’s 1998 *Tobacco Act* also prohibits advertising that directly or indirectly associates the use of tobacco with a particular lifestyle.

Most provinces have mandated

the minimum number of cigarettes (usually 15 or 20) that must be present in a package. Four provinces (British Columbia, Manitoba, Ontario and Quebec) have regulated the health warnings to be included in packaging and that government-written information regarding the hazards of tobacco use must be included in the package. As well, four provinces have enabling authority to require plain packaging of tobacco products. A related regulatory area regarding tobacco manufacturing and distribution requires regular reports of cigarette sales, by brand and province. Quebec and British Columbia both have more detailed regulatory and legislative strategies that affect the manufacturers.¹⁴

Closer examination of two strategies of restricting promotion, packaging and products is warranted to illustrate potential differentiated effects of regulation. First, health warnings on packages will be examined for their gendered implications.

1. Warnings and Packages

Health warnings located on cigarette packaging are considered important resources for information about the health risks of tobacco use. Most (if not all) smokers have seen these messages and they are easily recalled (Tandemar Research Inc., 1996). In fact, a recent study sug-

gested that, as a source of information, cigarette packaging ranks second only to television (Tandemar Research Inc., 1996). It is unclear, however, just how much these health warnings encourage smokers to quit, or discourage teens from beginning to smoke. As well, health messages that are seen as old or repetitive may cease to be effective, as smokers fail to read them (Environics Research Group Limited, 1999).

The *Tobacco Act* gives the federal government the power to require cigarette companies to put health warnings on the packages of cigarettes they sell. In January 1999, the federal Health Minister proposed new regulations on tobacco package labeling and promotion. These included the use of new health messages designed to target young people, as well as new provisions to make health messages on cigarette packages more prominent and visible to consumers. In January 2000, the Health Minister released the proposed content of several new health warnings to be placed on cigarette packages.

Several health warnings included on cigarette packaging are intended to facilitate quitting among smokers. Images depicting the health consequences of smoking on the body

are featured. Others are concerned with the harmful effects of tobacco on pregnancy and children, such as “Tobacco smoke can harm your children” and “Smoking during pregnancy can harm your baby”. The latter category of warnings is of particular concern to women smokers.

There is no doubt that developing an appropriate focus on pregnancy and small children is a difficult area in tobacco control. On the one hand, it is crucial to transmit the health knowledge concerning pregnancy, babies and children to women and men in the population. On the other hand, there is a long history of critique and research on the potential effects of this focus on women smokers and their advocates.

This approach has historically been seen as objectifying (see for example, Jacobson, 1981 and 1986). Presenting smoking cessation as purely a benefit to others (fetus, infant or child) reflects a lack of concern with the smoker’s own health, and a reduction of the woman to a vessel and/or caretaker. Many of the earliest initiatives (in the 1970s and 1980s) on women and tobacco were composed entirely of pregnancy-related programming. This exclusive or predominant conceptualization of “women and tobacco” contributed to the develop-

Policies that include the provision of health warnings on cigarette packaging need to look at smoking cessation in a more holistic way in order to offer support, rather than blame, to women.

ment of tobacco reduction programs for pregnant women, but more importantly, contributed to a limited and distorted understanding of women and tobacco that was damaging for individuals and groups.

For the women smokers, an inevitable response is guilt – guilt that may lead to increased stress and smoking consumption among some women (Health Canada, 1998). In addition, self-esteem may decline, making any cessation attempts even more difficult. In general, messages such as this may result in making women feel guilty, ashamed or judged. Certainly, for those pregnant women who continue to smoke, there is increasing public scrutiny.¹⁵

This approach led to programming that encouraged smoking cessation early in pregnancy, in order to bring immediate benefit to the fetus and newborn. The predominance of this focus did not help to develop a focus on women's health. Unfortunately, approximately 60% of women who quit smoking for all or part of their pregnancy start smoking again before their babies reach six months of age (Health Canada, 1997b).

Clearly, this result illustrates that the pregnant women were motivated to quit smoking for "others", and not for their own health. As some practitioners involved with programs associated with the Tobacco Demand

Reduction Strategy (TDRS) pointed out, targeting pregnant women, and disadvantaged pregnant women in particular, with a smoking cessation message can be experienced by these women as a form of victim blaming (Health Canada, 1997b). Given the increasingly negative reaction society has to pregnant women smoking, facilitating these messages, without including adequate supports, may only induce guilt. In short, focussing on pregnancy, while important, effectively decontextualizes tobacco use from the determinants influencing it.

Policies that include the provision of health warnings on cigarette packaging need to look at smoking cessation in a more holistic way in order to offer support, rather than blame, to women. As research on disadvantaged women and tobacco use demonstrates, smoking is just one of the many issues mothers and mothers-to-be must face. The complete context of these women's lives must be acknowledged to help them deal with tobacco.

Not only would this approach be more respectful and constructive for women who smoke, but it would also contribute to a more productive understanding of pregnancy and smoking in society at large. Damage from the initial medicalized approach taken to women and tobacco that

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resulted in the focus on pregnancy has taken some time to rectify. The women's health movement and women's groups were alienated during the 1980s and early 1990s as a result of this approach.¹⁶ During the 1990s, efforts to utilize legal frameworks to further pressure women smokers regarding custody, child care, and child abuse and neglect have been even further frightening and alienating for both individual women smokers and their advocates (see Greaves, 1996, 130-132).

We need not slow down the process of new warnings, but develop additional ones to take these issues into account. Messages that acknowledge the complexity and context of women's smoking, particularly when pregnant, would be a more useful and gender-sensitive addition to the health warnings package. Also, messages that encourage both smoking and non-smoking partners of pregnant women would be more helpful in both the short and long terms (Health Canada, 1997b). It may be that the warnings are most effective with those who have yet to have children (aged 15-24), rather than with current parents (Environics Research Group Limited, 1999). Certainly, the best time for intervening on pregnancy and smoking is always pre-pregnancy.

In general, Canadians approve of health warnings on cigarette packages (Environics Research Group Limited, 1999), and indeed want them even larger and more graphic than they currently are. The challenge in devising health warnings is to convey both the social context of tobacco smoking as well as the health damage it creates. At the moment, the emphasis in package warnings is on the latter. Creating package warnings that address the social determinants and social context of smoking in an understanding manner is a key element in devising sensitive tobacco policy.

2. Tobacco Sponsorships and Advertising

A second example of legislation regarding promotion is in the area of advertising and sponsorship. Since 1997, the *Tobacco Act* has severely restricted direct advertising of tobacco products in magazines, newspapers, radio and television. However, as noted above, Canadians have access and high utilization of media produced in the United States and other parts of the world where such advertising is allowed. Both magazines and movies are particularly important media vehicles in this regard. Not only do these portrayals serve as exemplars of behaviour, but they convey a widespread sense of social and cultural approval.

Tobacco promoters have successfully targeted the female market since 1928, with a renewed emphasis in the last 20 years. These recent efforts at promotion have coincided with a decrease in smoking prevalence among men in Canada. Girls and women, then, represented an opportunity for market expansion through promotion and marketing.

A recent analysis of tobacco advertising in a variety of media channels indicated that current tobacco advertising directed towards women deals with many of the worries and concerns of contemporary female smokers. For instance, the health concerns around smoking were addressed by the presentation of advertisements for “light”, low-tar cigarettes. Stress and anxiety were dealt with in ads that promoted relaxation, and support was expressed for smokers in this era of increased restrictions on tobacco use (Greaves, 1995).

As restrictions on tobacco advertising have been increased over the last 10 years, direct brand advertising of cigarettes in Canada has been replaced with more indirect advertising, including sponsorship and other types of promotions (Nielsen Government Services, 1995). Young people have been found to misinterpret advertising of tobacco-company sponsored events as advertis-

ing for tobacco products (Rootman & Flay, 1995). Given this type of evidence, there has been recent movement to restrict the promotion of tobacco through sponsorship of sport and entertainment events.

For sponsorships with “lifestyle” or youth appeal, advertisements using tobacco brand names have been restricted since 1998 to publications with a mainly adult readership, as well as to places where only adults are allowed by law.¹⁷ Since the early 1990s, following the advertising restrictions in Canada, Canadian magazines and newspapers have begun to carry tobacco company sponsorship ads (such as Matinee Foundation), which are directly targeted to women and girls. Tobacco companies still spend \$42 million per year in Canada on promotions and sponsorships of sports, arts and cultural events.

But as governments cut back on supporting grants to arts organizations, the pressure to accept such support from tobacco companies will increase. While some organizations have already found alternative sponsors, the history of sponsorships for women’s organizations and events has been difficult. Certain sports, such as women’s tennis, have historically benefited greatly from tobacco monies. In the U.S., both women’s and minority organiza-

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tions have been both grateful for and trapped by tobacco support, given the difficulties in finding alternate sources of funding.

The sponsorship issue is fraught with conflict, as many organizations struggle to convert their funding bases to non-tobacco sources. Traditionally, support for women's sport and for female-specific arts and cultural events has been harder to come by than for generic events or male sport. Societal-level gendered inequities are crucial in this debate. How do women's sports and women-specific events acquire new monies? How do they fare in relation to generic events or male sport? What mechanisms may be required to create gender-sensitive and women-positive sponsorship transitions?

B. Restrictions on Sales

The federal *Tobacco Act* requires that retailers post signs that inform the public that the sale or giving of tobacco products to youth under the age of 18 is prohibited. Nine out of ten provinces have legislation placing restrictions on retail sales, requiring that buyers be at least 18 years of age and be able to produce photo ID. Saskatchewan prohibits the possession, though not the purchase, of tobacco by minors.

Beyond this, five provinces also

require health warning signs to be posted at point-of-sale. Three provinces prohibit tobacco sales in pharmacies and/or health care facilities. Most provinces use federal legislation that prohibits self-service displays of tobacco products, as well as vending machines, except in bars or taverns with separate security mechanisms. Quebec also prohibits face-to-face sales of tobacco and sales on school grounds.

A significant portion of provincial tobacco control strategies is focused on enforcement of sales-to-minors legislation. Effective enforcement is considered vital, according to the U.S. Centers for Disease Control and Prevention's (1999) Best Practices guidelines, not just to restrict access but to build public understanding and support for such restrictions. The CDC suggests a system of licenses and penalties for retailers, and recommends an education program for retailers about tobacco and youth.

There has been little study to date of gender differences in teen access to tobacco. Some research, however, suggests that teenage girls have easier access to tobacco than do teenage boys (Hachey, 1998). These young women may be more likely to be sold cigarettes in retail locations. A gendered impact analysis of sales-

to-minors legislation is needed to provide more information on if and/or how girls and boys are affected differently by sales restrictions. This type of research is needed to ascertain whether and how current policy can be changed to more effectively limit girls' access to tobacco products.

Such knowledge would also have an effect on public attitudes and form part of public and retailer education about sales restrictions and their purpose. A lack of cross-community support, combined with budgetary threats and political pressure, has been found to be one of the key barriers to successful enforcement of sales-to-minors legislation (DiFranza & Rigotti, 1999).

However, enforcing sales-to-minors legislation has its limits in reaching the goal of restricting access to tobacco. Recent surveys have indicated that most young people access tobacco products through social sources rather than retail outlets. Key questions remain about gendered differences in acquiring tobacco through social sources: Do girls have more or less social access than boys? Do girls provide social access to boys, or vice versa?

C. Restrictions on Smoking

Tobacco smoking legislation and regulation differentially impact

women in two distinct ways. For all women (non-smokers and smokers), there is a differential exposure to secondhand smoke, dependent upon occupational location and control over environments. For women who smoke, there is the added issue of control over private or public space, and how it may impact their smoking behaviour. Policies that restrict smoking affect all of the population, and certainly all women, but potentially in more than one way. It is important to keep in mind the key social determinants that interact with gender regarding tobacco: income adequacy, work, and child care responsibility.

Responses to restrictions on smoking are affected by occupational location, the presence of children, and possibly income adequacy. Policies that restrict smoking may need to acknowledge these differences in order to be gender- and class-sensitive. There are clear health costs to women who are exposed to secondhand smoke. Of particular clarity is the effect of living with a smoker over a period of time. It is of importance to recognize the interpersonal and power dynamics within households, particularly between women and men. Generally, it cannot be assumed that women will have control over family air space, particularly if the male partner is the smoker.

Two issues are highlighted that focus on smoking in the home and in the workplace/public places, framing the discussion of gender and smoking restriction policies.

1. Protection of Children and Environmental Tobacco Smoke in the Home

The health effects of Environmental Tobacco Smoke (ETS) have led to the allocation of vast resources in an effort to convince parents to avoid smoking around their children. The concern is real and valid; exposure to ETS is associated with infections of the lower respiratory tract, reduced lung function and heart disease (Physicians for a Smoke-Free Canada, 1999a). Young children are especially vulnerable to the effects of ETS in the home because they breathe more air relative to their body weight, they are less able to complain, and they are unable to remove themselves from the exposure.

A recent secondary analysis of the National Population Health Survey estimates that 85% of children who live with a daily smoker are regularly exposed to ETS (Physicians for a Smoke-Free Canada, 1999b). The use of such data has led many policy makers and health professionals to suggest that governments educate parents about the dangers of smoking around their children

(e.g., WHO, 1999). Of course, it is difficult to address this issue with legislation or regulations that aim to protect children. Instead, the focus has been on increasing awareness of the dangers of ETS, saying that “the best protection for children would result if the smokers in their homes would quit” (Physicians for a Smoke-Free Canada, 1999b, 3).

The designers of this strategy have failed to acknowledge the effects of gender on this issue. It is mothers, not fathers, who spend the most time with young children in the home. Not surprisingly, a recent review done by the World Health Organization (1999) showed that maternal smoking has a greater impact on children’s ETS exposure than paternal smoking.

At the same time, a clear relationship between socioeconomic status and ETS exposure has been established: among all Canadian children under the age of 12, ETS exposure is greatest in disadvantaged households. This includes lone-parent households (48%), low-income households (51%), and those families receiving most of their income from social assistance (53-63%) (Physicians for a Smoke-Free Canada, 1999b). In contrast, exposure to ETS is lowest for children living with both parents in upper-income families. There is often no recognition that most lone-parent,

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low-income families are headed by women.

The problem is oversimplified by failing to acknowledge both the gender and economic aspects of the issue. Instead, responsibility is placed on individual parents (mostly women) to rectify the situation, even in light of data that suggests that class and gender have played a role in its development. Rather than assisting parents with the struggle to raise children in poverty, this view blames parents (mostly mothers) for harming their children, and assumes parents are doing so because they lack the will or intelligence to know any better. In fact, the knowledge of the health risks of ETS is fairly widespread – 86% of Canadians 12 years and older surveyed in the 1996/97 National Population Health Survey were aware of some risk (Health Canada, 1998).

By portraying this issue in a way that fails to acknowledge its complexity and using standard health promotion strategies to only increase awareness, policy makers and program planners run the risk of increasing the guilt that smoking mothers feel. When parents are told to “protect” their children from ETS exposure, they are receiving the message that they are bad parents if they smoke in front of their kids. Such guilt-producing messages

can serve to increase the stress that women smokers who are responsible for child care already feel. This increased stress will not help women decrease their tobacco use, in light of the struggle to meet every day needs.

Legislation designed to protect children from Environmental Tobacco Smoke may implicitly blame smoking mothers (especially lone parents) who may have limited options and choices. Secondly, it may expose mothers who smoke to increased public scrutiny and potential litigation, particularly in areas of child neglect and custody. The potential of this strategy to alienate women and women’s advocates was plain in the 1995 Workshop on Women and Tobacco in Ottawa. At this event, perspectives collided between prioritizing child exposure to ETS on the one hand, and contextualizing and understanding women’s smoking on the other. This remains a good example of where a broad based tobacco control approach could benefit from gender sensitization, and information regarding the context of women’s smoking could serve to successfully contextualize ETS strategies.

2. Smoking in the Workplace/ Public Places

Regulations that act to restrict smoking in the workplace may also

affect women and men differently, mainly due to occupational segregation. Many workplaces in the service industry, such as restaurants and bars, may be exempt from these laws. Since women are more often employed in these workplaces, these exemptions put more women at risk from the detrimental health effects of secondhand smoke. In addition, women in these occupations are more likely to be in low status positions in their workplaces, with little opportunity to advocate for smoking restrictions.

Provincially, British Columbia has the most stringent regulations regarding restrictions on smoking, set by their Occupational Health and Safety Regulation guidelines. These regulations state that the employer must control exposure of workers to Environmental Tobacco Smoke (ETS) by prohibiting smoking in the workplace or restricting smoking to designated smoking areas, as defined by strict structural and ventilation rules. Restaurants, bars, game rooms and long-term residential care facilities were exempt from these regulations, but that exemption expired on January 1, 2000. Recently, correctional centres have become smoke-free in the Province of British Columbia in order to protect staff from ETS.

Six other provinces have legislation

prohibiting or restricting smoking in public areas or workplaces. Quebec, for instance, has prohibited smoking in restaurants by 2008. Six provinces have policies restricting smoking in government workplaces, but, beyond B.C., only Quebec, Ontario and Newfoundland have regulations restricting or prohibiting smoking in private sector workplaces. There are, however, several exemptions to these regulations – in most cases, restaurants, bars and other public entertainment facilities are exempt from these laws. Ontario's 1990 *Smoking in the Workplace Act* also provides protection for employees who attempt to enforce the Act in their workplaces.

There is another element to workplace and public place legislation. Eight provinces allow municipalities to pass bylaws to control the use of tobacco. If there is conflict between a municipal and a provincial regulation, the strictest policy will most often prevail. The focus of most of these bylaws is the regulation and control of smoking in public places – most notably restaurants and bars. Recently some municipal jurisdictions, such as Toronto and Victoria, have introduced legislation that bans smoking in all public places, including restaurants, bars and long-term health care facilities.

Public reaction to municipal legislation has varied considerably, as

smokers come to terms with the new restrictions on their behaviour. Much negative reaction stems from the prediction that local business owners may suffer financial hardship as a result of restrictive legislation, despite evidence to the contrary. Researchers in New York, California, Arizona and Massachusetts conclude that smoke-free ordinances do not adversely affect tourist business (Glantz & Charlesworth, 1999), restaurant patronage (Biener & Siegel, 1997), restaurant and bar sales (Hyland & Cummings, 1999a; Sciacca & Ratliff, 1998; Glantz & Smith, 1997), or service sector employment (Hyland & Cummings, 1999b). While beyond the scope of this paper to detail the range of municipal bylaws in Canada, three jurisdictions have been selected that reflect the diversity that currently exists across the country:

Victoria, B.C.

Citing the health hazards of Environmental Tobacco Smoke (ETS), and the difficulty of defining a “safe” level of exposure to secondhand smoke, the Capital Regional District (which includes the city of Victoria) imposed a new bylaw as of January 1, 1999. This new legislation imposed a total ban on smoking in all restaurants, bars, pubs, lounges, clubs, bowling alleys, bingo halls and casinos. This move eliminated the exceptions to

the previous 1992 legislation that declared all workplaces and public premises in the area to be 100% smoke-free.

Icepik, Nunavut

Operating under old Northwest Territories legislation, the hamlet of Icepik restricts smoking in “places of public assembly”, including schools, churches and entertainment facilities, but continues to allow it in restaurant smoking areas. Non-smoking areas must be allocated as a certain percentage of all restaurant seating space, but no ventilation requirements for these buildings are specified.

Toronto, Ontario

In March, 1999, Toronto’s Medical Officer of Health recommended that workplaces in that jurisdiction be smoke-free, except in fully enclosed, separately ventilated smoking rooms. As well, she recommended that public places, including restaurants, bars and casinos have closed smoking in 25% of their space until April 30, 2001, when they will become smoke-free (Basrur, 1999). The proposed changes to smoking regulations in Toronto have been undertaken with public consultation. In one such survey, the majority of respondents (60.9%) were in favour of increasing non-smoking space in public places by a certain percentage each year until they become

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100% smoke-free. There was less support for increasing restrictions in bars than in restaurants (Smaller World Communications, 1998).

Finally, many restrictive bylaws cover more and more public space. Areas such as malls and zones surrounding public buildings are increasingly regulated. Low-income men and women generally have fewer recreational options and may control less private space than those with more resources. Low-income women may therefore frequent public places more often than other smokers. Once again, this affects women in two ways: when smoking is not prohibited in public places, women are left exposed to secondhand smoke at a greater rate than their higher-income counterparts, male or female. In contrast, when smoking in public places is prohibited, low-income women are forced to smoke exclusively in their own homes (or in unhealthy, unsafe locations), or to refrain from smoking.

D. Taxation and Pricing

Restricting access to cigarettes, achieved through price increases, generally results in lower levels of tobacco consumption. Trends over the last three decades reflect increases when the price of cigarettes was lower during the early 1970s and late 1980s. Consumption decreased when prices increased in

the mid-1970s and the early 1980s and 1990s (Townsend, 1996).

The degree to which changes in the price of tobacco products influence consumption is the subject of considerable controversy. The effect of increased taxation and price increases on tobacco consumption is far from a simple story. While smoking rates decline when tobacco taxes increase, it is impossible to determine how much of the drop in consumption is due to higher prices and how much is attributable to other factors. Tobacco programs and other types of policies aimed at reducing smoking, such as health education and other policies applied at the local, provincial, and federal levels may contribute to these declines.

The gendered effect of fiscal policy regarding tobacco taxation and pricing is also unclear. Sales figures to measure overall consumption are not gendered, thereby depriving us of a key source of data for analysis. In countries such as the UK, where there are larger variations in price per pack of cigarettes, it is known that adult women will switch to cheaper, generic brand cigarettes, while younger people will stick to the higher priced brands.

In general though, the differentiated impact of taxation and pricing policies on both women and youth is not yet fully understood. A recent Europe

Expert Seminar on women and tobacco policy concluded that “insufficient (information) was known about the impact of fiscal policy on women, particularly poorer women” (INWAT, 1999, 6). A key recommendation of this Expert Report is that a gender-impact assessment of tobacco taxation policy and pricing is of high priority.

In 1994, due to fears of increases in smuggling, provincial cigarette taxes were reduced, cutting the price of cigarettes by as much as one half in much of Canada. Currently, cigarette taxes in Canadian provinces range from \$4.70 per carton in Ontario, to \$22.00 per carton in British Columbia and Newfoundland (Finance Canada, personal communication to J. Wu, June 28, 1999). This discrepancy has led to recommendations for as much as a \$10 tax increase (per carton) in “low-tax” provinces.

Brand pricing and pricing across each province in Canada is not regulated. With the exception of the *Federal Tobacco Act* S29,¹⁸ there are no restrictions on pricing or discounts. The apparent uniformity in tobacco prices in Canada seems to be based on the small number of tobacco manufacturers that supply tobacco products to retailers.

The effect of such taxation policy on smoking rates is often measured

with an indicator called price elasticity, which can be measured in relation to either consumption levels (numbers of cigarettes consumed), or to prevalence rates (reduction in the rate of smoking in the population).¹⁹ Estimates of tobacco consumption elasticity vary considerably due to the techniques used to both collect and analyze the data (Wasserman et al., 1991). These estimates range from -0.2 to -0.75 (Brown, 1998). Recently, the Centers for Disease Control and Prevention in the United States have estimated a prevalence price elasticity of -0.15 and a consumption price elasticity of -0.10 (Centers for Disease Control and Prevention, 1998). Similar Canadian data are not available at this time.

As Townsend, Roderick and Cooper (1994) have demonstrated, price elasticities vary not only by age and socioeconomic group, but also by gender. Women in the lowest income groups have been found to show a significant price elasticity when looking at smoking prevalence. However, tobacco consumption price elasticity was not highly significant in this study, demonstrating that tobacco prices may affect smoking prevalence and tobacco consumption in different ways among women. Higher prices, then, may simply lead to increased expenditures on cigarettes for those who continue to smoke because

those women do not reduce consumption.

As smoking prevalence rates in Canada are inversely related to socioeconomic class, tobacco tax increases can be considered regressive²⁰ in nature. As a proportion of income, price increases in the cost of tobacco impact most heavily on those in our society with lower incomes. The effect of tobacco tax increases on smoking prevalence and consumption in lower income groups continues to be a matter of debate.

Some researchers and policy makers maintain that the response to price increases among people in disadvantaged circumstances tends to be particularly high (e.g., Townsend 1996). Many have pointed to the relatively high price elasticity among lower income populations. For instance, Farrelly and Bray (1998) reported that lower income populations were more likely to reduce their tobacco consumption or quit altogether than those people with higher incomes. If this relationship is airtight, then raising prices through increased taxation would be expected to narrow the differentials in smoking prevalence and consumption between social and economic groups.

Others, however, contend that those who can least afford to smoke have

responded least to increased tobacco taxes. For instance, Marsh (1997) points to data in the United Kingdom that suggest that while tax hikes may depress tobacco consumption across the income range, they appear to have little effect on smoking prevalence in the lower income groups. Canadian data analysing the effects of tax changes on poor smokers between 1978 and 1994 were analyzed by Hamilton (1997). She concluded that there is a “direct negative correlation between smoking expenditures and purchases of essential items, such as food, clothing, shelter and health-care” (p.1). The author estimates that the reduction of smoking in low-income smokers due to tax increases will be only half the magnitude of higher income Canadians (p.1).

Young smokers, especially teens, have been identified as a group that may potentially be very sensitive to price and tax increases. These data, however, are also far from conclusive; contradictory evidence suggests that teens’ relatively low monthly expenditures on tobacco products may allow them to be less price-sensitive than other populations (California Budget Project, 1998).

1. Taxation and Low-Income Women

Because smoking prevalence is highest among people in low socioeconomic circumstances, and

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women are disproportionately poor, the impact of taxation increases is inevitably gendered. Low-income women will tend to spend a disproportionately large share of their income on cigarettes. Smoking not only harms health; it also reduces the economic resources available to women and their families.

When the key social determinants discussed earlier combine their effect (income adequacy, child care responsibilities and work), the hardships experienced by low-income women with children make these women much more likely to smoke compared with better off families. For those smokers in this group unable to reduce their tobacco consumption, an increase in the price of cigarettes due to tax hikes can lead to what Chollat-Traquet (1992) calls a “downward spiral”. As the financial burden gets heavier on groups such as female single parents, disadvantage and hardship build, and the overall quality of life decreases.

Marsh (1997) tries to explain this situation by indicating the difficulty that people with low income may have with quitting smoking. The challenge for this group may lie in inequalities experienced by those with low income, and its relation to optimism. As Marsh points out,

many smokers quit for optimistic reasons – they want to feel better, look better, gain social approval or avoid illness. For those with middle to high incomes, it is easy to see where this optimism comes from. But women living in poor quality housing, with few qualifications and low-paid work have less reason to value their future. Giving up their “only luxury” (Graham, 1987) may feel impossible. The “downward spiral” involves poverty, smoking, inequality and pessimism. This discourages cessation, and the economic cost of smoking deepens hardship (Marsh, 1997).

If low-income women continue to smoke after a tax increase, the ability of their families to acquire essentials such as food, clothing and other basics is diminished. Again, data from the United Kingdom suggest that mothers on low incomes may regard tobacco as an essential expense, and reduce their food budget if the price of cigarettes goes up. This situation, of course, causes hardship and threatens health and nutrition not only for the smoking mother, but also for her children. In one qualitative study, two lone mothers reflected on their spending habits, should the price of cigarettes go up:

“I’d try to cut down to save money, but cigarettes are my one luxury and at the moment they feel a bit like a necessity.”

“I think smoking stops me getting so irritable. I can cope with things better. If I was economizing, I’d cut down on cigarettes but wouldn’t give up. I’d stop eating ... Food just isn’t that important to me but having a cigarette is the only thing I do just for myself.”

(quoted in Action on Smoking & Health, 1993).

The heavy taxation of tobacco products, then, hits hardest on those who can least afford it, and redistributes resources to more affluent segments of society. Van Doren (1998) calls this “theft ... dressed up in good intentions” (p. 3). He asks “if a politician proposed a tax that disproportionately took money from poor and minority citizens, how would most people react?” (Van Doren, 1998, 1). While tobacco tax increases are a legitimate and central element of the traditional tobacco control portfolio, an integrated, comprehensive tobacco strategy would definitely highlight the latent consequences of tax increases which are not usually named.

Ethically, the latent consequences of taxation and the gendered and class-related effects of price increases must be factored into the policy development process and ameliorated using other means. Free cessation programming and

therapies for low-income people are examples of such measures. At a systems level, the capturing of tobacco tax money to directly fund health promotion initiatives is another measure that has been used in other jurisdictions to respond to the consequences of tobacco taxation.

VI

Policy and Research Issues

A. Gaps in Sex, Gender and Tobacco Policy

It is clear that contemporary tobacco use in Canada is a complex behaviour influenced by a variety of social, cultural and economic factors, including gender, ethnicity, socioeconomic status and age. To meet the challenges inherent in reducing or eliminating tobacco use in current smokers and preventing uptake of tobacco use by girls and boys, it will be necessary to merge and mediate the two policy approaches outlined in the Introduction. The strengths of the traditional tobacco control strategy are in the broad based nature of its aims and methods, and its pan-population impact. The strengths of the integrated and comprehensive tobacco strategy lie in its focus on reducing inequality of health, a key component of tobacco use.

There are three preliminary linked policy/research issues that require more attention to fully inform a productive future tobacco strategy to address sex, gender and women's tobacco use in Canada. These include gender mainstreaming, improving data collection, and using a wider set of disciplines and methodologies.

1. Gender Mainstreaming

First, a gender analysis (or "lens") applied to all tobacco-related research or policy development is needed. The most effective application of a gender analysis is often to "mainstream" the approach into existing mechanisms and processes for deriving policy and research agenda.

This integration into the research protocol or policy development process as it is being designed, naturally leads to process and analysis being measured against gender analysis principles.

The results of applying a gender analysis to both the research and policy development processes allow identification of the plethora of sex- and gender-related factors that may affect the research agenda and the potential policy impact. For instance, sex-related issues impact on what research is needed for girls' and women's health. Gender-related factors impact on issues such as how women and men interpret

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the social world, and the place of smoking in their lives. Gender also affects the nature of the impact of policies, such as those discussed in Section 3, above. In addition, it affects the ability of individuals and groups to absorb health education or respond to prevention or cessation programming.

2. Improving Data Collection

Second, there are data gaps which need to be filled in order to inform the research and policy decision making processes, and to develop the basis for programs and protocols at the community and institutional level. Sex-disaggregated data are essential for evidence-based decision making. The existing lack of such data regarding smoking hinders analysis and delays progress in the fight to reduce tobacco use.

In addition, data collection to address gender should address differential female and male roles, responsibilities, knowledge bases, positions and status in society, attitudes and perception, access to and use of resources, participation in decision-making, and social codes and attitudes governing female and male behaviour (Kitts & Hatcher Roberts, 1996).

Specific gendered data collection in tobacco control should focus on

consumption, prevalence rates in sub-groups, tobacco-purchasing behaviours, personal and family spending patterns of smokers, responses to advertising and sponsorship, and price increases.²¹ Health system data sets and surveillance mechanisms should collect more data on sex-disaggregated tobacco-related health care utilization. These data need to be turned into useful health information for planners, policy makers, communities and individuals. In the biomedical area, much more data are required to explain the mechanisms underlying gender-related physiological susceptibilities to the adverse effects of tobacco use on health (Pope, Ashley & Ferrence, 1999).

3. Interdisciplinarity and Mixed Methodologies

Finally, methodological improvements in both research and policy development are warranted to address the issues of sex, gender and women's tobacco use. Interdisciplinary research will ensure that a sex and gender perspective is incorporated into developing research questions, design and analysis. In particular, combining researchers with medical/health and social science backgrounds is useful in filtering out the influences of biology and society on female tobacco use and its effects. Initiating more policy-relevant action

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research in communities and involving community organizations in meaningful ways are crucial to understanding the complexities of tobacco use in Canadian women.

Similarly, the methods and procedures used in developing and evaluating policy initiatives can be improved to better reflect the context issues of tobacco policy, and to understand its differential impacts. Engaging women and girls, particularly from the high-prevalence groups (young women, Francophones and Aboriginals) in the policy development process will help to ensure its effectiveness, appropriateness and desired impact.

These three shifts will affect both research and policy. Developing women-centred tobacco policy is inextricably linked to research, and often vice versa. The overall goal of doing gender analyses on tobacco policy is to develop sensitive, effective and ethical policy, that accurately reflects the sex and gender differences in smoking behaviour and responses to tobacco.

B. Developing Women-Centred Tobacco Policy

Women-centred policy is a term for policy that not only accurately reflects sex and gender, but also is developed with and for women. It is a natural evolution of models

of women-centred care²² in the health delivery system which have been developed to respond to women's needs more adequately.

Women-centred policy can be created by extending the principles of women-centred care to policy development and evaluation. Women-centred policy would view women as experts on their own lives, take into account life stresses and barriers to change, and allow for a range of successful outcomes. It integrates policy with other concerns of women's lives. Women and girls need to be considered stakeholders in the policy development process, and could be actively involved on decision-making bodies where the fundamental planning for tobacco control policy occurs.

Policy makers, key professionals, and the public need to be more aware of the specific threat that tobacco use poses to women's health. Single et al. (1999) estimated that in 1992, 176,679 years of life were lost among Canadian women because of smoking. If tobacco use among adolescent women maintains its current trend, the health of future generations of women will continue to deteriorate. It is essential that the issue of women and smoking be placed high on the health agenda of all stakeholders.

The improvement of social and economic conditions through effective policy and legislation could have a profound effect on both the tobacco use and the overall health of women and girls in Canada.

C. Integrating Tobacco with Other Health and Social Justice Policies

Women-centred policy planning brings with it a recognition that tobacco use is not divorced from its social context, and, to be effective, tobacco policy must reflect the impact of health determinants. Integrated policy solutions to tobacco cessation and prevention must mix individual change strategies within a context (e.g., reflecting low income, violence, discrimination, harassment, caregiving responsibilities, etc.).

This also means integrating traditional health sector policy with policies regarding unemployment, low income, single parenthood, lone parent status, low levels of education, isolation and lack of social support, dual responsibilities of work and family, family violence and stress. Combined action at the international, national, regional, and community levels will be needed.

Policies would then be reflective of the systemic changes needed to affect women's tobacco use (and its cessation). The improvement of social and economic conditions through effective policy and legislation could have a profound effect on both the tobacco use and the overall health of women and girls in Canada. If disadvantaged women are to be

encouraged and empowered to take control of their lives, it will be necessary to adopt strategies that address not only their smoking, but also the range of circumstances that contribute to tobacco use. Finally, policies aimed at augmenting the economic opportunities of women living in poverty will ultimately improve not only the health of women, but also that of other household members, particularly their children.

Tobacco control individuals and organizations could develop strong partnerships with other groups and institutions sharing similar values and goals around women's health, regardless of whether their work focuses on tobacco use. New policy development will need to involve organizations that reach women in different ways, such as youth organizations, community groups, churches and workplaces. Support for these organizations is vital to the process of policy change (Stein, 1997).

Any new policies should be developed in collaboration (not merely in consultation) with disadvantaged women and youth, both smokers and non-smokers. In the case of regional or organizational policy development, the entire process may be driven by the needs of women, using a community development approach. Such an approach

The battle against tobacco use in Canada will increasingly depend on knowing the population of smokers and appreciating its diversity.

involves “working with and not for, acting with and not on, doing with and not to” (Stein, 1997, 272). Initiatives that facilitate the active involvement of women in addressing health and tobacco issues will need to be supported to achieve complete integration of policy.

1. Gearing Tobacco Policy and Programming to the Needs of Specific Groups of Women

Women-centred policy is also reflective of diversity and the different health and social needs attached to specific groups. Policy and programming must be appropriately designed for women in various life stages, cultural groups and socio-economic circumstances. For instance, programs and policies for Francophones need to recognize that French culture has been less questioning of smoking and emphasizes freedom of lifestyle choice over health issues (Health Canada, 1998). It is vital that economic, physical and cultural accessibility be ensured for all materials designed for the general public. This will mean gearing educational and programming materials to the language and customs of specific communities, as they vary by ethnicity, age and geographic region.

The battle against tobacco use in Canada will increasingly depend on knowing the population of smokers

and appreciating its diversity. The high rates of smoking among some population sub-groups clearly indicate the need for special attention. Aboriginal women, Francophone women, adolescent girls and low-income women comprise four groups in Canada that deserve special mention.

Without this knowledge, it will be difficult to tell how current policies affect men and women in the context of their lives. Additionally, without adequate data collection systems that track smoking rates that reflect diversity related to geographic region, culture, language and age, it will be impossible to examine the effects of new policy on these population sub-groups.

For instance, very little is known about gender differences in the effects on adolescents of regulations restricting the sale of cigarettes to minors, smoke-free indoor air regulations, warning labels, and health education campaigns (Cohen et al., 1996). At a time when trends suggest that smoking among young women may be the precursor of an alarming future problem of adult women smokers in Canada, this type of specific research is vital. To more effectively deter young girls (and boys) from initiating tobacco use, we will need to know much more about the ways gender and youth

culture interact to influence uptake.

Questions remain about tobacco use among Aboriginal girls and women in Canada. It is clear that an integrated, comprehensive tobacco policy is essential to better reflect the specific needs and circumstances of this group. Questions also exist regarding the future impact of tobacco control policy – for example, how will a move toward self-governance affect tobacco control policy development? Do tobacco policies impact urban and rural First Nations women differently?

2. The Links to Comprehensive Research

To be effective, policy must be informed by research. Throughout this report, many areas requiring knowledge development have been identified to more fully understand women's smoking. Both quantitative and qualitative research are required, and both kinds of research results utilized to develop effective policy.

Surveillance data is inadequate, and there are difficulties in linking data between provinces and collating at a national level. Translating surveillance information into program and policy action is needed.

3. Improved Quantitative Data

At the moment, gaps exist in the

types of information currently gathered in Canada. At this point it is difficult to fully identify trends in smoking rates as they vary by gender, race and ethnicity. There is little information available regarding how disability and sexual orientation²³ may be related to smoking patterns and prevalence. Of course, each of these factors may be studied as they interact with aspects of sex and gender, either within individuals or populations. Particular attention will need to be paid to measuring those variables that identify social and economic determinants of health. The gaps in knowledge on the sex-related biological effects of tobacco use and exposure are considerable. In fact, as current research projects release findings, the biomedical research agenda on girls' and women's smoking lengthens. New frontiers in understanding the sex-related physiological responses to tobacco are constantly being drawn.

4. Qualitative Data and Participatory Methodologies

Qualitative research also provides distinct and important knowledge on tobacco use, such as sharper insights into how and why people smoke, and how they are affected by policies, regulation or legislation. For tobacco control policy to more effectively reach its goals, it is necessary to know more than

smoking prevalence rates and consumption patterns. For example, what role does smoking play in the lives of women and girls? How can health promotion (and, specifically, tobacco control policy) best reflect these realities?

To obtain this information, we need multidisciplinary research which includes participatory and qualitative research methods that are planned and implemented with the active participation of women in communities. To fully understand the impact of gender on women, such research must also focus on establishing qualitative data on men and boys as a point of comparison. Then, necessary gender sensitivity in programming, policy and protocol can be implemented in responding to tobacco use in women and girls.

5. Enhanced Knowledge of the Cessation Process

Ultimately, a key part of the effort to reduce the use of tobacco focuses on encouraging cessation. The gender-related factors associated with achieving and maintaining cessation have not yet been comprehensively studied. More research is needed to gain a better understanding of the barriers and supports to cessation among women and girls, particularly as they relate to poverty. For instance, how can family members, partners and health

professionals best support low-income women during a cessation attempt? How is food security related to increased cigarette taxes, and how can programming best reduce the hardship that low-income women (and their families) face? What is the place of harm reduction in tobacco cessation for women? This kind of new information will allow the design of more appropriate and effective programming and policy.

VII

Future Directions in Gender and Tobacco Policy

As we enter the 21st century, it is clear that the progress toward reducing smoking rates among women and girls has stalled in Canada, especially if smoking among adolescent women continues on its current trajectory. The costs connected to smoking will become increasingly pertinent to women and women's health, as projected increases in tobacco-related female morbidity and mortality come to pass in the next 20 years.

A. Inequality and Smoking

Smoking is not evenly distributed across Canadian society – it is concentrated in those groups who struggle financially and live in disadvantaged communities. Specific gendered factors affecting tobacco use are income adequacy, work, and child care responsibility. The connections between women's smoking and social, economic and political disadvantage form the undercarriage of this major health issue for women.

Some recent Canadian reports have identified these connections and made recommendations for a framework of action. One of the three main "priorities for action" put forward by the Federal, Provincial and Territorial ACPH, is improving the health of Canadians by reducing economic and social inequities.²⁴ Despite this, the recently released *Toward a Healthy Future: Second Report on the Health of Canadians* (Federal, Provincial and Territorial ACPH, 1999), discusses tobacco use under "personal health practices", a particularly limited and misleading description of tobacco use which ignores its social, economic and political context.

The 1995 report *Women and Tobacco: A Framework for Action* (Horne, 1995) clearly presented the complexity of tobacco use by placing the issue within the context of social, economic and cultural inequities based on gender. This report provided a series of recommendations that helped to shape the federal Tobacco Demand Reduction Strategy. While the TDRS developed considerable new knowledge on women and tobacco as reflected in *Women and Tobacco: Lessons Learned*

(Health Canada, 1998), little has been done in Canada since this time.

B. Need for a Gender Analysis

More recently, the National Strategy to Reduce Tobacco Use in Canada (Steering Committee, 1999) has published *New Directions for Tobacco Control in Canada*. It does not refer to gender as an important determinant of smoking behaviour, nor do its recommendations address the special needs of women (other than pregnant women).

These directions are surprising, given that the rate of smoking among girls 12-17 is higher than that of young men the same age (Health Canada, 1999, January). As these trends continue, it will become more vital, accurate and ethical to develop policies that take gender and class into account. Tobacco companies have long focussed on women (and men) in advertising and promotion, but it has taken tobacco control personnel several decades to understand and accept that gender has a distinct place in analysing and responding to smoking. There is no doubt that exploring qualitative data and investigating subjectivity in tobacco use can complicate policy making. It is challenging to maintain a focus solely on pan-population traditional tobacco control strategies in the face of more comprehensive data

surrounding tobacco use.

Research has only just begun to reveal the role that smoking plays in women's lives. More work will be needed to develop a broader understanding of how policies and programs affect women and men differently, in both positive and negative ways. Hopefully, such research will be done in a way that respects and empowers women. This positive approach will be particularly important for Aboriginal and young women, who face unique challenges.

The redefinition of tobacco policy as an integrated, comprehensive strategy, rather than one strictly focused on reducing consumption and prevalence, will require the involvement of experts (including smokers) from a variety of disciplines, including sociology, psychology, health promotion, medicine and epidemiology. Alliances will be required to go beyond the traditional health sector, to break through a "control" paradigm and into an "opportunity for health"²⁵ model. Achieving integration of policy will require collaboration between (at least) finance, health, justice, housing, education, social services and recreation.

Programming or policy change designed to improve health by reducing inequities in income distri-

At base is an ethical stand that recognizes tobacco use as a key indicator of social and health inequality, and considerably more than a “lifestyle choice”.

bution and education will require new or additional measures of effectiveness. While policy that improves the socioeconomic circumstances of those most needy in our society (especially women) will have at least an indirect influence on smoking prevalence, it may take some time to see those effects.

Often, evaluation of the tobacco control strategy has focussed on smoking prevalence rates and tobacco consumption patterns. Using these indicators alone, it is difficult to identify other effects of policy and legislation, media campaigns and education programs. The inclusion of social determinant indicators will move the evaluation of tobacco control beyond tobacco usage statistics. Instead, evaluation will include the examination of other aspects of health, including other health behaviours, perceptions of stress, and poverty rates. Evaluation would assess the impact of tobacco tax increases on both smoking behaviour and the economic well-being of women living on low incomes. In these ways, the weight of the analysis of tobacco use is lifted from the individual smoker's shoulders, and placed on the structural constraints of people's lives.

At base is an ethical stand that recognizes tobacco use as a key indicator of social and health in-

equality, and considerably more than a “lifestyle choice”. With this in mind, tobacco policy must be appropriate, effective and conscious of all of its consequences. Asking women not to smoke without examining the pressures that lead to the desire for a cigarette is problematic. Instilling guilt in mothers or using the legal system to persecute them in the process of reducing child exposure to ETS is both insensitive and revictimizing. Increasing taxes on tobacco without understanding the effects on low-income families is unethical and irresponsible. In the final analysis, it is not acceptable to pressure women smokers to quit if an appropriate social exchange is not offered. Sharing responsibility for tobacco use is sharing responsibility for health.

VIII

Recommendations

Below is the full list of recommendations aimed at improving or assessing the impact of tobacco policy on women and girls, grouped according to the categories used in *New Directions for Tobacco Control in Canada*, issued in 1999 by the National Strategy to Reduce Tobacco Use. These recommendations are derived from the analysis underpinning this paper, and relate to issues discussed in the text.

A. Policy and Legislation

- ☺ Develop tobacco policy processes at federal and provincial levels that require the routine use of a gender analysis, have an inclusive participatory policy making element, and result in women-centred policy.
- ☺ Develop a women-centred policy planning framework that incorporates social context and determinants of health, (reflecting low income, violence, discrimination, harassment, caregiving responsibilities, etc.).
- ☺ Develop and publicize a new policy framework that includes both the traditional targeted tobacco control approach and an integrated and comprehensive approach, highlighting the best elements in both.
- ☺ Develop policy and programs that reflects women's various life stages, cultures, socioeconomic circumstances, customs, sexual orientation and abilities, based on ongoing qualitative and quantitative research.
- ☺ Conduct a comprehensive gender-impact assessment of current tobacco policy, with particular emphasis on taxation and fiscal measures.
- ☺ Invest tobacco tax revenue in health promotion efforts that address the key social determinants of smoking and health.
- ☺ Utilize tobacco tax revenue to support free cessation therapies and programs for low-income smokers.

- ☺ Enhance welfare benefits and social assistance rates for low-income families in line with rises in tobacco tax and prices.
- ☺ Identify a range of policy initiatives (including those in non-health areas) that could reduce the inequality of health and integrate them into the national tobacco control strategy.

B. Public Education

- ☺ Ensure that young girls are taught media literacy and develop a clear understanding of the strategies of tobacco marketers.
- ☺ Develop gender-sensitive (and blame-free) campaigns aimed at reducing ETS around children that recognize the child care and homemaking roles of women.
- ☺ Create and publicize a women-centred “denormalization” strategy that respects and acknowledges women’s experiences, status and roles.
- ☺ Invest resources in gender-specific programs directed at girls and youth at risk of tobacco use and related behaviours and issues,

via recreation, education, mentoring, peer counselling and tutoring, etc.

- ☺ Develop a broad based media strategy to enhance understanding of women and girls who smoke, focusing on the elements of social and economic life that affect health inequalities and hence, tobacco use.

C. Industry Accountability and Product Control

- ☺ Introduce legislation to curtail the indirect sponsorship efforts of tobacco companies.
- ☺ Increase enforcement of sales-to-minors legislation.
- ☺ Develop package labels that address the social determinants of health.
- ☺ Develop package labels that address the role of smoking in women’s and girls’ lives.
- ☺ Expand package information regarding gender-specific cessation tips.
- ☺ Develop package information that acknowledges the difficulties and complexities of cessation for pregnant women, and provides women-centred advice and assistance.

D. Research

- ☉ Integrate sex and gender into all tobacco-related research across biomedical, clinical, health services and social and cultural determinants areas.
- ☉ Develop funded research programs on the sex-differentiated (biological) effects of tobacco use on girls and women.
- ☉ Develop funded research programs on the influence of gender on tobacco use, social response to smoking, impact of cessation programs, and the delivery of health promotion.
- ☉ Integrate a sex- and gender-specific research agenda into all tobacco-related research activity at the Canadian Institutes for Health Research and the Canadian Tobacco Research Institute, and influence other relevant research programs such as the National Cancer Institute and the Heart and Stroke Foundation.
- ☉ Develop an evaluation/research framework for analysing the effects of tobacco policies on girls and women, integrating the impact of low-income status, Francophone or Aboriginal status and age.
- ☉ Evaluate traditional spiritual and ceremonial tobacco use and integrate into developing prevention and cessation in Aboriginal communities.
- ☉ Improve data collection and survey techniques to establish accurate sex-disaggregated prevalence rates among Inuit, First Nations and Metis.
- ☉ Investigate and analyse interprovincial prevalence rates of tobacco use among Francophone women.
- ☉ Develop biomedical research capacity to include sex- and gender-specific studies that reflect how physiological characteristics play a part in determining the disease patterns related to smoking and the health effects of smoking or exposure to environmental tobacco smoke.
- ☉ Enhance the surveillance system in Canada to lower the age of surveillance on tobacco use to age 10 (it is currently 15), and to include tobacco use in the territories.

- ☺ Conduct a gendered impact analysis of sales-to-minors legislation to provide more information on if and how girls and boys are affected differently by sales restrictions.
- ☺ Conduct further research on the links between childhood cancers and environmental tobacco smoke in the home.
- ☺ Conduct further research on the links between breast cancer and tobacco use or exposure to ETS.
- ☺ Evaluate and analyse the experiences of pregnant women as the objects of increased public scrutiny vis-a-vis the “denormalization” strategy (outlined by the Steering committee of the National Strategy to Reduce Tobacco Use).

E. Building and Supporting Capacity for Action

- ☺ Develop an ethical framework for assessing the impact of tobacco policy in Canada that takes gender, sex and inequality into account.
- ☺ Involve women and women smokers in developing gender-specific tobacco

control strategies and tobacco control programs that reach poor and low-literacy women and girls.

- ☺ Develop a capacity-building process to include all sectors and women’s organizations in the process of tobacco policy development.
- ☺ In collaboration with women, women smokers and women’s organizations, identify the barriers and supports to cessation among women and girls, particularly as they relate to poverty.
- ☺ Share Canada’s capacity for gender analysis of tobacco policy with international bodies, such as the United Nations, World Health Organization, Pan American Health Organization and the International Network of Women Against Tobacco.
- ☺ Implement the bilateral initiatives regarding tobacco use agreed upon at the Canada-United States Women’s Health Forum in 1996.

Appendix 1

Literature Search and Scan of Legislation

Literature Search

Searches for the following terms:

- wome?n? or girl* or female
- tobacco* or smok* or cigar*
- law or legislati* or regulat* or ordinance or bylaw or polic*
- feminis* or gender*
- critiqu* or critic* or analy*
- tobacco control, tobacco policy, health policy, public policy

Searches on the following databases and websites:

Academic Databases

Books in Print

Books Out of Print

NASW Clinical Register

Contemporary Women's Issues

PAIS International

PAIS Periodicals/Publishers

sociofile

Sociological Abstracts

Social Work Abstracts

National Library of Medicine

Medscape

Medline

EBSCOhost

HSSI

MLOG

RGAB

CINAHL

Government of Canada Depository
Services Program

University of British Columbia

University of Western Ontario

National Library of Canada

Outlook Online Internet Catalogue
of BC's Public, College and Institute
Libraries

Tobacco Databases/Websites

Alberta Alcohol And Drug Abuse
Commission [http://www.gov.ab.ca/
aadac/aadac/policy_tobacco.htm](http://www.gov.ab.ca/aadac/aadac/policy_tobacco.htm)

ASH US – Action on Smoking and
Health <http://ash.org>

ASH Canada <http://www.ash.ca>

ASH UK <http://www.ash.org.uk>

AIRSPACE Non-Smokers' Rights
Society <http://seercom.com/airspace>

Alberta Tobacco Control Centre
<http://www.tobaccocentre.ab.ca>

Canadian Council for Tobacco
Control (CCTC) <http://www.cctc.ca>

CCTC's National Clearinghouse
on Tobacco and Health [http://www.
cctc.ca/ncth](http://www.cctc.ca/ncth)

Canadian Centre on Substance
Abuse <http://www.ccsa.ca>

Council for a Tobacco-Free Ontario
<http://www.opc.on.ca/ctfo>

NO PATSY – National Organization
of People Attacking Tobacco Sales to
Youth [http://www.healthwatcher.net/
nopatsy.html](http://www.healthwatcher.net/nopatsy.html)

Ontario Campaign for Action on
Tobacco <http://www.ocat.org>

Ontario Ministry of Health [http://www.
gov.on.ca/health](http://www.gov.on.ca/health)

Ontario Tobacco Research Unit
<http://www.arf.org/otru>

PEI Health and Social Services
<http://www.gov.pe.ca/hss/index.php3>

Saskatchewan Health, Health
Promotion's Second Hand Tobacco
Smoke [http://www.gov.sk.ca/health/
promotion/secondhand/toc.htm](http://www.gov.sk.ca/health/promotion/secondhand/toc.htm)

Physicians for a Smoke-Free
Canada <http://www.smoke-free.ca>

Senator Colin Kenny's Personal Web
Site [http://sen.parl.gc.ca/ckenny/
sssssmok.htm](http://sen.parl.gc.ca/ckenny/sssssmok.htm)

Substance Abuse Network of Ontario <http://sano.arf.org>

Tobacco-Free Times <http://www.commit.org/commit/tft>

Tobacco News Online (scanned daily)

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

WHO –World Health Organization's Tobacco Free Initiative <http://www.who.int/toh>

PAHO – Pan American Health Organization's Prevention and Control of Tobacco Use <http://www.paho.org/english/hpp>

The European Commission – European initiatives for smoking prevention <http://europa.eu.int/comm/dg05/phealth/tobacco/tobacco.htm>

INWAT – International Network of Women Against Tobacco <http://www.inwat.org>

Tobacco Control: An International Journal <http://www.bmjpg.com/data/tob.htm>

Tobacco Control Supersite <http://www.health.usyd.edu.au/tobacco>

Victorian Health and Smoking Program (Quit Victoria) <http://www.peg.apc.org/~vshp>

American Public Health Associa-

tion's Alcohol, Tobacco and Other Drugs Section <http://www2.edc.org/capt/apha>

Society for Research on Nicotine and Tobacco <http://www.srnt.org>

Smoke Screen Action Network <http://www.smokescreen.org/login/vhome.cfm>

The State Tobacco Information Center <http://stic.neu.edu>

Tobacco Control Resource Center <http://www.tobacco.neu.edu>

American Psychological Association's The Addiction Newsletter http://www.kumc.edu/addictions_newsletter

The QuitNet <http://www.quitnet.org>

Tobacco Control Archives <http://www.library.ucsf.edu/tobacco>

The Tobacco Institute <http://www.tobaccoinstitute.com>

Tobacco BBS <http://www.tobacco.org>

International Union Against Cancer's GLOBALink Tobacco Control Network <http://www.globalink.org/globdemo>

Anti-Control Databases/Websites

American Smokers Alliance <http://www.smokers.org>

IMASCO <http://www.imasco.com>

National Smokers Alliance <http://www.speakup.org>

Forces - Fight Ordinances and Restrictions to Control and Eliminate Smoking <http://www.forces.org>

Government Databases/Websites

BC Ministry of Health and Ministry Responsible for Seniors' BC Tobacco Facts <http://www.tobaccofacts.org>

Health Canada's Office of Tobacco Reduction Programs <http://www.hc-sc.gc.ca/hppb/tobaccoreduction>

Health Canada's Office of Tobacco Control <http://www.hc-sc.gc.ca/ehp/ehd/tobacco>

Statistics Canada <http://www.statcan.ca/start.html>

Manitoba Health <http://www.gov.mb.ca/health>

New Brunswick Health and Community Services, Public Health and Medical Services, Comprehensive Tobacco Reduction Strategy http://www.gov.nb.ca/hcs-ssc/english/services/public_health/tobacco

NWT Department of Health and Social Services <http://www.hlthss.gov.nt.ca>

Nova Scotia Department of Health, Smoke-Free Places http://www.gov.ns.ca/health/smoke_free

Commit to a Healthier Brant <http://www.commit.org/commit>

Gouvernement du Québec, Ministère de la Santé et des Services sociaux <http://www.msss.gouv.qc.ca/fr/orientat/priospub/tabac>

U.S. Centers for Disease Control and Prevention's Tobacco Information and Prevention Source <http://www.cdc.gov/nccdphp/osh/tobacco>

U.S. Centers for Disease Control and Prevention's Smoking and Health Database <http://www.cdc.gov/nccdphp/osh/search>

U.S. Food and Drug Administration's Children and Tobacco Regulations and Information <http://www.fda.gov/opacom/campaigns/tobacco>

The U.S. House of Representatives Committee on Commerce's Tobacco Documents <http://www.house.gov/commerce/TobaccoDocs/documents.html>

Florida's Office of Tobacco Control's Florida Online Tobacco Education Resources <http://www.state.fl.us/tobacco>

The Massachusetts Tobacco Education Clearinghouse <http://www.jsi.com/health/mtec/home.htm>

Arizona Program for Nicotine and Tobacco Research's NicNet <http://www.nicnet.org>

Utah Tobacco Prevention and Control Program <http://hlunix.hl.state.ut.us/cfhs/tpcp>

Australian Department of Health and Aged Care, Population Health Division <http://www.health.gov.au/pubhlth/strateg/drugs/tobacco>

Miscellaneous Databases/Websites

Canadian Cancer Society
<http://www.cancer.ca>

Heart and Stroke Foundation
http://www.hsf.ca/main_e.htm

The Lung Association
<http://www.lung.ca>

Canadian Centre on Substance Abuse <http://www.ccsa.ca>

Centre for Health Promotion at the University of Toronto
<http://www.utoronto.ca/chp>

Canadian Health Network <http://www.canadian-health-network.ca>

Prevention Source BC <http://www.preventionsource.bc.ca>

Tobacco Use in BC <http://www.hlth.gov.bc.ca/tobacrs>

QuitSmokingSupport.com <http://www.quitsmokingsupport.com/intro.htm>

Scan of Legislation

Jurisdictions:

Canada

federal

provincial and territorial

samples of municipal

USA

federal

samples of state

samples of municipal, institutional

United Kingdom

samples of federal, regional

Australia

federal

state and territorial

Appendix 2

Key Informants

Madeline Boscoe
Advocacy Coordinator
Women's Health Clinic
Winnipeg, Manitoba

Elinor Wilson
Director, External Relations
Heart & Stroke Foundation
of Canada
Ottawa, Ontario

Cheryl Moyer
Director, Tobacco Reduction
Canadian Cancer Society
Toronto, Ontario

Nancy Hoddinott
Tobacco Control Unit
Nova Scotia Department
of Health
Halifax, Nova Scotia

Roberta Ferrence
Director
Ontario Tobacco
Research Unit
Centre for Addition
and Mental Health
Toronto, Ontario

Linda Brigden
Senior Program Officer
Research for International
Tobacco Control
International Development
Research Centre
Ottawa, Ontario

Through e-mail discussion:

Mary Jane Ashley
**Department of Public Health
Sciences**
University of Toronto

Endnotes

¹Some examples of the many biomedical issues under investigation include the following: a possible relationship between breast cancer and passive smoking as adolescents; understanding genetic markers affecting the risk of developing lung cancer in women smokers and passive smokers, (lung cancer is more prevalent among women than men); and sex-differentiated patterns of withdrawal and responses to nicotine replacement therapy.

²For example, recent research indicates the mechanisms underlying women's susceptibility to developing smoking-related lung cancer are different than for men, possibly due to genetic and chromosomal differences (S. Shriver, 2000).

³These prevalence rates are among the highest in the world, and mirror similarly high rates among indigenous populations in other countries.

⁴Issues such as male/female wage gaps, dual and triple workloads, "glass ceiling" issues, and inadequate child care services.

⁵An indicator of socioeconomic status derived by Statistics Canada, income adequacy is a measure of income that takes into account both household income from all sources, and household size.

⁶Tobacco policy research aims to understand, stimulate, inform, support, direct and/or evaluate tobacco policy making which will reduce tobacco use in Canada. It includes: the full policy process from agenda setting, through development and implementation, to enforcement, evaluation and refinement; all areas in which policy might be used to influence tobacco use, including fiscal, legislative, regulatory, and educational policies; public and private policy at all levels of government/locale; both supply and demand issues relevant to tobacco use reduction. (Best, 1999, CTRI Tobacco Policy Research Program Workshop report, p. 4)

⁷"The federal government is committed to ensuring that all future legislation and policies include, where appropriate, an analysis of the potential

for different impacts on women and men.” Status of Women Canada (SWC), 1995.

⁸e.g., Women's Bureau (1997) *Gender-Based Analysis Guide*; BC Ministry of Women's Equality (1998) *Gender Lens: A Guide to Gender-Inclusive Policy and Program Development*; Status of Women Canada (1998) *Gender-based Analysis: A Guide for Policy Making*.

⁹Gender-based analysis of policy is a “a process that assesses the differential impact of proposed and/or existing policies, programs, and legislation on women and men” (Status of Women Canada, 1998, p. 4). Its origins in government machinery, both in Canada and elsewhere, were to address and acknowledge historical and social differences and disadvantages experienced by women and girls.

¹⁰With the exception of the subsection on Taxation and Pricing, and information on the three territories, data informing this scan of regulation and legislation were obtained from Alberta Tobacco Control Centre (October 1998). *Analysis of Provincial Tobacco Control Legislation in Canada*. Alberta: Alberta Tobacco Reduction Alliance. Also, please see a recently established website of the National Clearinghouse of Tobacco and Health for up-to-date information

on tobacco legislation in Canada: www.cctc.ca/ncth/docs/legislation

¹¹However, two provinces (British Columbia and Quebec) have also passed legislation to place direct restrictions on tobacco manufacturers and distributors. B.C. and Quebec currently have the most comprehensive tobacco control legislation in Canada.

¹²In the European Union in 1995, 60% of female smokers over age 45 smoked “light” cigarettes, believing they were safer (Joossens & Sasco, 1999).

¹³In addition, “light” cigarettes are thought to contribute to adenocarcinoma (a deep lung cancer which is rising in women, and possibly linked to both hormones and the deep inhalation practiced with “light” cigarettes).

¹⁴Quebec requires the reporting of the funds invested by tobacco companies in the promotion and marketing of their products. B.C. enacted legislation (the 1998 *Tobacco Sales Amendment Act*) requiring the disclosure of tobacco product ingredients and additives, of tobacco smoke emissions, and of the health hazards that may arise from exposure to tobacco or tobacco smoke. British Columbia also requires licensing for manufacturers, the fees from which are used for the

development of a comprehensive tobacco reduction strategy. In its regulation of “product standards”, Quebec is able to restrict the use of certain substances or manufacturing processes in tobacco products sold in that province. British Columbia’s Testing and Disclosure Regulation requires that every tobacco manufacturer submit quarterly reports which identify all ingredients and additives in those cigarettes sold in B.C. Only B.C. has legislation to facilitate tobacco product liability lawsuits. In addition, B.C. and Ontario are the only jurisdictions that have expressed any intention to file government medicare cost recovery lawsuits to date.

¹⁵While increased public scrutiny is seen as a contribution toward denormalization in the National Strategy’s document, *New Directions for Tobacco Control in Canada*, (Steering Committee, 1999) there is no discussion about the experience of being the object of that scrutiny.

¹⁶This is possible again under the pressures of suggestions for interventions on ETS (environmental tobacco smoke) that often unduly focus on women smokers in an insensitive way.

¹⁷Health Canada also has the power to regulate sponsorship advertisements that could require certain text

or graphics-based health warnings, restrict the use of human figures or define allowable “sites” for promotional signs.

¹⁸29. No manufacturer or retailer shall

- (a) offer or provide any consideration, direct or indirect, for the purchase of a tobacco product, including a gift to a purchaser or a third party, bonus, premium, cash rebate or right to participate in a game, lottery or contest;
- (b) furnish a tobacco product without monetary consideration or in consideration of the purchase of a product or service or the performance of a service; or
- (c) furnish an accessory that bears a tobacco product-related brand element without monetary consideration or in consideration of the purchase of a product or service or the performance of a service.

¹⁹For example, the price elasticity of demand for cigarettes is the expected per cent decrease in the quantity of cigarettes consumed in response to a given per cent increase in the price of cigarettes. A price elasticity of -0.5 would indicate that for a 10% increase in the price of cigarettes, consumption would be expected to decrease 5%.

²⁰Having said this, some argue that

these taxes are actually progressive as poor smokers exhibit more price responsiveness to price increases and therefore will reduce consumption and suffer less illness as a result (see Warner, 2000).

²¹A partial solution to this problem is being addressed by the “Searchable Database of Questionnaire Items from Population Surveys of Tobacco Use in Canada” (<http://www.arf.org/otru/downloads.html>) (Ontario Tobacco Research Unit). The database contains over one thousand questions, and is intended to provide researchers and program evaluators with reliable and valid survey questions that will allow comparisons with other jurisdictions. The questions were gathered from 55 national, provincial and local surveys conducted between 1977 and 1998.

²²Women-centred care addresses gender, involves women in their own care, offers learning opportunities, uses a holistic framework of biopsychosocial-spiritual elements, addresses social, economic and cultural disadvantages, and includes health promotion.

²³Some U.S. data are available on links between sexual orientation and smoking. For lesbians, California Lavender Smokefree Project (funded by tobacco tax) reports 25-40% of adult lesbians smoke,

compared to 22.5% of women in the general U.S. population (San Francisco Bay Times, Dec. 23, 1999, p. 14).

²⁴Specific recommendations include increasing employment opportunities for those with low incomes (including women and Aboriginal people), recognizing the importance of recreational and social services, and ensuring that, in the long-term, all Canadian families have their essential needs for shelter, privacy and security met (Federal, Provincial and Territorial ACPH, 1999).

²⁵Thanks to Professor Lesley Doyal, University of Bristol, for this phrase reflecting the challenge of reducing health inequalities for women. (Personal communication, 1999).

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