Gender-Responsive Tobacco Control: Evidence and Options for Policies and Programmes
Report Summary

Sarah Hawkes[1], Kent Buse[2], Soon-Young Yoon[3] | October 2018

Big Tobacco 'gets' gender when it comes to market segmentation, marketing & promotion; it is high time that the public health community catches up and becomes more gender-responsive

Gender is a social construct referring to the roles, behaviours, activities, attributes and opportunities that any society considers appropriate for women, men, girls, boys and people with non-binary identities. Gender interacts with, but is distinct from, biological sex.

Who uses tobacco and why? Studies of the distribution of tobacco use globally finds broad patterns and trends among and between populations. These patterns may help us understand who becomes a smoker/tobacco user, and may also identify effective entry points for tobacco control programmes.
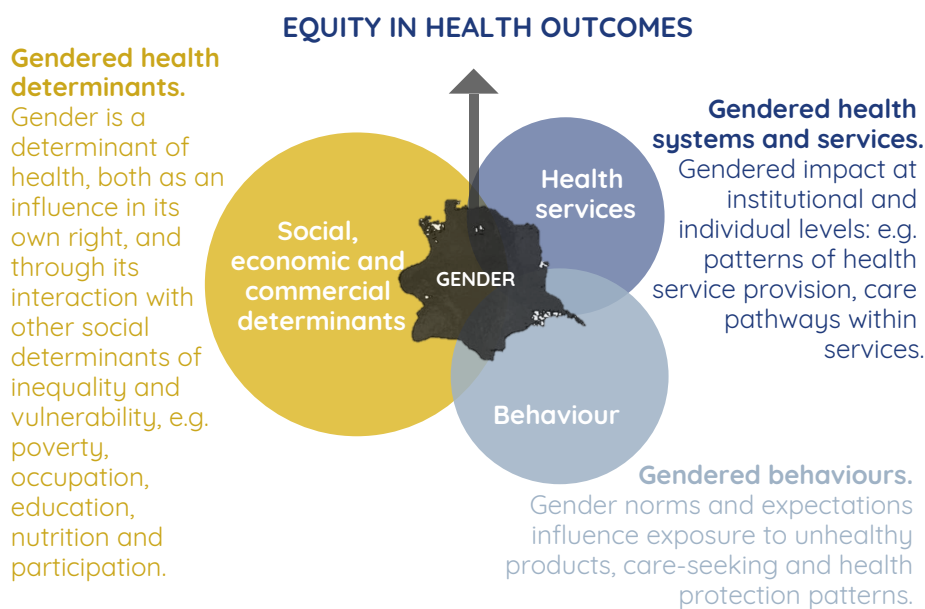
We know, for example, that tobacco use is associated with broad social and structural determinants – social class, education, geographical location, occupation, etc. Among these, one of the most important drivers of tobacco use is gender. Gender norms can determine the acceptability of tobacco use by men and women in different societies, and these norms are exploited in advertising and marketing campaigns which target men and women differently.

The impact of gender norms can be seen in the substantially different rates of tobacco use among men and women in all countries. To date, however, the response by public health programmes to this all-pervasive driver of tobacco use has been largely gender-blind.

Gender and Health: everyone's business?

Gender is an important determinant of health inequities in three interlinked domains: the intersection of gender and other social determinants of health; the impact of gender on health behaviours (protective or risky); and the gendered nature of health system responses (see Figure 1).

Figure 1: Framework for understanding pathways through which gender acts on health

EQUITY IN HEALTH OUTCOMES

Gendered health determinants. Gender is a determinant of health, both as an influence in its own right, and through its interaction with other social determinants of inequality and vulnerability, e.g. poverty, occupation, education, nutrition and participation.

Gendered health systems and services. Gendered impact at institutional and individual levels: e.g. patterns of health service provision, care pathways within services.

Social, economic and commercial determinants

Health services

GENDER

Behaviour

Gendered behaviours. Gender norms and expectations influence exposure to unhealthy products, care-seeking and health protection patterns.

All three domains have relevance for tobacco control:

- tobacco exposure is distributed unequally across different sections of society, and gender interacts with social class, occupation, age, geographical location, sexuality, etc. to reproduce and reinforce levels of exposure and risk;

- gender norms including notions of masculinity and changing notions of femininity influence whether or not people smoke, and whether they will seek care for any illness arising from their tobacco use;

- health system responses (access to care; quality of care received; gender of care-givers) are influenced by the gender of both patients, providers (and policy makers too).

Despite this, a large proportion of tobacco control research, and many tobacco control policies and programmes are gender-blind – thus missing key determinants of risk, and of effective interventions.

Box 1: Evidence from Tobacco industry on understanding and exploiting gender norms

1
Report by advertising company M&C Saatchi to tobacco company, advising on package design:

"Creativity: A very female value; it indicates that these people, although not necessarily artistic, enjoy creating things. All of this would indicate that Lambert & Butler consumers would be very heavily affected by advertising, pack design, PR and Sponsorship."

Salamander: Progress Report and Recommendations by M&C Saatchi Agency, 16 May 1995. URL:http://www.tobaccopapers.com/PDFs/0500-0599/0558.pdf

2
A Brown and Williamson memo for an advertising campaign to target a new brand of cigarettes to American men contains the following advice:

"Target: male America.

1. "Outdoorsman" – focus on blue-collar male(s) enjoying weekend or vacation outdoor activities (hunting, fishing).

2. "Exhilaration of freedom" – focus on young adult male(s) enjoying spontaneous thrill of at least temporary freedom without obligations. Th[is] secondary appeal is to a better educated, white-collar American male…for whom the idyllic escapist…pursuit …. [is] singularly male."

Young Adult Male Creative, Paul Wessel B&W; Document Date 1987; Bates Number 621709305/9309 Collection Brown & Williamson URL: http://legacy.library.ucsf.edu/tid/kff70f00

Figure 2: Percentage of young smokers (15-24 years) who are male and female, all WHO Regions

| | 83% male | 98% male | 94% male | 94% male | 91% male | 67% male | 67% male |
| Globally | SEARO | WPRO | EMRO | AFRO | EURO | AMRO |

● Male ● Female
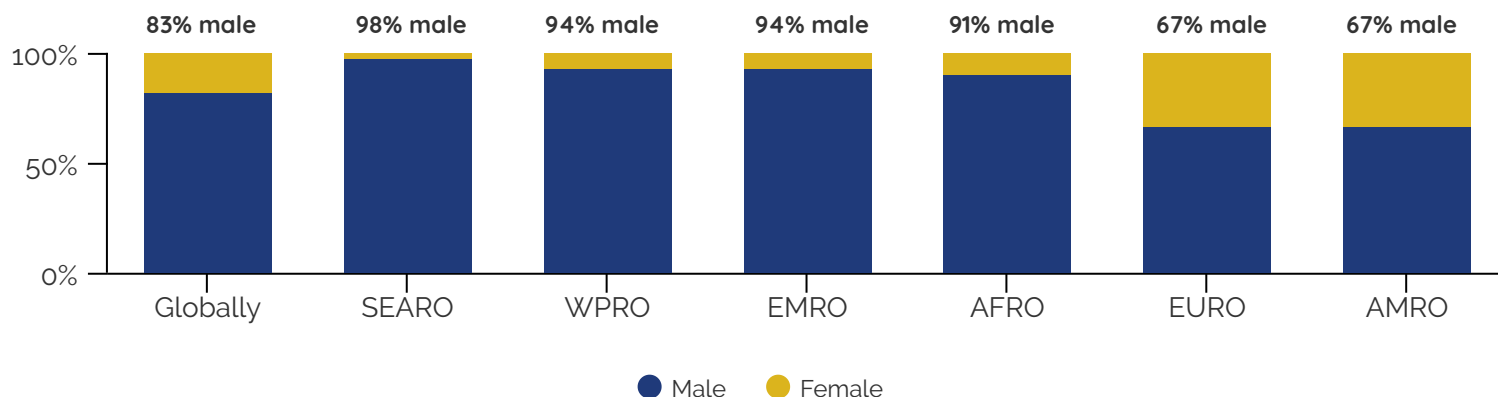
Figure 3: Percentage of smokers (25-69 years) who are male and female, all WHO Regions

| | 86% male | 94% male | 94% male | 94% male | 89% male | 67% male | 67% male |
| Globally | SEARO | WPRO | EMRO | AFRO | EURO | AMRO |
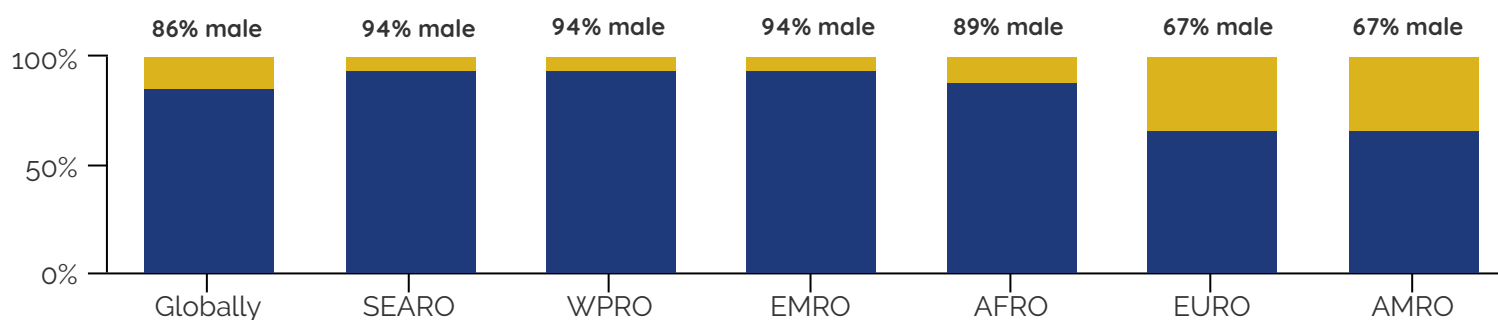
Data source: WHO global report on trends in prevalence of tobacco smoking 2000–2025, second edition. Geneva: World Health Organization; 2018.

Evidence of the impact of gender on tobacco use and associated health outcomes

Most smokers in the world are men, and rates of use of smokeless tobacco products are higher in men than women – consequently, morbidity and mortality rates due to tobacco are higher in men than women. Illness arising from exposure to second-hand smoke, however, is mainly suffered by women. Rates of tobacco use are strongly influenced by gender norms – and these start at a young age. Globally, 83% of young (15-24 years) smokers are male, but this varies by WHO Region (see Figure 2).

These differences persist across the life-span: among adults aged 25-69 years, 86% of smokers are male, again with regional variation (see Figure 3).

Why do we see these vast differences in smoking rates between men and women? Gender, as noted, is a social construction, and the 'acceptability', or even the expectation of who smokes, is a social norm driven by gender. This is well understood by the tobacco industry which has spent years seeking to understand market segmentation based on gender so as to enhance smoking initiation and maintenance through marketing, promotion and sustainability of different brands to different populations of consumers (see Box 1). Industry archives show attention paid to gender norms which have then been manipulated and

exploited by industry and successfully used to position tobacco as being associated with positive notions of masculinity, as well as ideas of independence from restrictive gender norms and options for weight control among women and girls.

The efforts of the tobacco industry to capitalise on and exploit gender norms have remained largely unchallenged in public health-focused tobacco control: the word 'gender' did not come into use in global health until the early 1990s (at least 10 years after the tobacco industry was exploiting gender norms in its advertising campaigns). Still today, tobacco research predominantly measures impact disaggregated by [biological] sex with no associated gender analysis; evaluation of interventions provides sex-disaggregated data but these are rarely analysed by gender; and design and delivery of policies and programmes remain mostly gender-unresponsive.

Tobacco control programmes must become more gender-responsive. The recently commissioned background paper on Gender and Tobacco provides a summary of the literature on both the relationships between tobacco, gender and health, as well as evidence on effective interventions.

Strategic action areas and priority collaborations for gender-responsive tobacco control

1 Promote policy and programme formulation, implementation and evaluation that incorporates a gender-lens
- Recognise that gender is a social construct that determines health outcomes in everyone. Gender-responsive policies and programmes can improve health for everyone.
- Strengthen capacity for gender analysis of policies, programmes and data for monitoring and evaluation.

2 Implement, monitor and evaluate gender-responsive actions to reduce exposure
- Increase price and levels of taxation to achieve the greatest population level impact
- Ensure tobacco education, information and cessation campaigns incorporate gender responsive messages.
- Analyse the impact of tobacco advertising (across all media, promotion and sponsorship routes) by sex and gender.

3 Implement, monitor and evaluate gender-responsive actions to reduce supply
- Promote a transition to sustainable livelihoods for all those involved in tobacco growing and production – including women and girls.
- Uphold and enhance bans on promotion and sales to minors, particularly in the face of industry tactics to exploit gender norms among young people.

4 Enable and support gender-responsive participatory processes
- Ensure that policies and programmes for education and public awareness are developed with the participation of all affected communities and their representatives – men, women, adolescents, LGBT people, people in specific occupations, etc.
- Collaborate with gender equality and womens' empowerment programmes to leverage mutual goals.
- Mobilise political and civic leaders in gender equality in support of tobacco control.
- Support adequate financial provision to women's empowerment and community-development programmes to incorporate tobacco control actions.

5 Strengthen gender responsive health care services
- Incorporate evidence on gender and tobacco control into plans for universal health coverage. Promote gender-responsive health systems that deliver quality care for everyone.
- Strengthen health worker training to understand and respond to the impact of gender on health outcomes.
- Implement WHO recommendations for prevention and management of tobacco use and second-hand smoke exposure in pregnancy.
- Promote gender equality within health systems to ensure that the burden of care (clinical, social) is equally distributed and fairly remunerated.

[1] **Sarah Hawkes**, Professor of Global Public Health, University College London, and co-Director Global Health 50/50

[2] **Kent Buse**, Chief, Strategic Policy Directions, UNAIDS, and co-Director Global Health 50/50

[3] **Soon-Young Yoon**, UN representative, the International Alliance of Women

International Alliance of Women
Alliance Internationale des Femmes

GLOBAL HEALTH 5050
TOWARDS GENDER EQUALITY IN GLOBAL HEALTH

UCL
INSTITUTE FOR GLOBAL HEALTH