

**Gender Impact Assessment
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Women and Tobacco

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1. Introduction

Tobacco use is the single most preventable cause of ill health and death in Victoria¹ and Australia². It is responsible for 7 percent of the total disease burden in women, and 12 percent in men³. Around 80 percent of total drug-abuse-related health care costs in Australia can be attributed to tobacco⁴.

Approximately 17 percent of Victorian women are current smokers⁵, which is slightly less than the national rate of 20 percent⁶. The prevalence of smoking in Victorian women is highest in the 18-24 year age group, at 22 percent⁵. Over the past few decades, women and men's smoking behaviour has become more similar. Female smoking rates are generally lower than those for males but this gap has reduced over time⁷.

Overall, female smoking rates have declined after a sharp spike in the 1980s⁷. Much of this is credited to increased public awareness about the danger of smoking and greater restrictions on tobacco through related laws and regulations⁶.

Despite the overall declining rates of tobacco use, tobacco experimentation and uptake among Victorian adolescents remain high. Of girls aged 17 years, 51 percent have ever smoked and 15 percent are current smokers⁸. Adolescent girls are experimenting with smoking at a slightly higher rate than boys, and are more likely to continue smoking⁸.

When considering the current rates of adolescent female smoking uptake, along with findings that women are less likely to succeed in quitting than men - it is possible that we could see a higher smoking prevalence in women than in men, and tobacco-related morbidity and mortality in females could eventually surpass that of males³.

Given the significant investment in tobacco cessation programs in Australia, this paper aims to inform a gender sensitive approach to policy and program development. It does this through an exploration of the effects of tobacco on women, the gendered approach of advertising and marketing, and factors associated with smoking and cessation commonly experienced by women. This is followed by discussion of tobacco related policy, health promotion and intervention programs and their impact on female smoking. The last section outlines a set of recommendations based on the analysis of research evidence and policy.

2. The effects of smoking on women

Common health problems associated with smoking include various forms of cancers, heart disease, stroke, chronic bronchitis and emphysema⁹. Adding to this, smoking also has negative impacts that are unique to women, and is increasingly recognised as a women's health issue¹⁰.

While not all lung cancer sufferers smoke, lung cancer is one of the most serious illnesses commonly caused by smoking¹¹. Because of the increase in women's smoking rates during the 1960s-80s, women's lung cancer rates have risen dramatically in recent years¹². Australian data shows that between 1982 and 2007 the incidence of lung cancer has continued to rise among women while it has fallen among men¹³. Lung cancer has now become the fifth most diagnosed form of cancer in Australian women¹³. In Victoria, it is the

sixth leading contributor of disability adjusted life years (DALYs) in women aged 35-64 years¹.

Women smokers are more prone to lung cancer than men as women are more likely to carry the genetic mutations associated with an increased risk of lung cancer^{9, 14-15}. Women can also develop lung cancer from lower levels of smoking, and are more at risk of contracting more aggressive small cell lung cancer⁹. Other reasons cited for women's higher risks include their greater use of low-tar cigarettes which encourages deeper inhalation, and faster smoking in response to limited time for breaks in the workplace⁹.

In addition to lung cancer, women who smoke are at increased risk of numerous other health issues. Female smokers have increased risk of ectopic pregnancy and spontaneous abortion¹⁴, premature labour, delivering infants with low birth weight, cervical cancer, early menopause, osteoporosis and other conditions associated with bone density, along with an increased risk of cardiovascular disease and stroke, particularly while using oral contraceptives^{12,16}. Furthermore, when considering the lag of time between smoking and the serious ill-effects on health, we are yet to see the full effects of smoking on women's health¹⁴.

3. Tobacco advertising and marketing

Litigation against tobacco companies in the USA during the 1970s and 80s saw internal documents on tobacco market research released to the public, revealing a highly sophisticated understanding of gender and diversity¹⁷. Tobacco companies have employed gender sensitive research and advertising since the 1950s. They have recognised the changing values of what it means to be a woman throughout the ages along with women's changing priorities throughout the life course. Furthermore, the industry does not see women as a homogenous group, and conducts profiling according to women's age and economic background. The industry utilises this knowledge in creating targeted campaigns which have proven to be very successful. The following section outlines the key components of the tobacco industry's gender sensitive campaigns.

3.1 Recognising women's changing values, roles and movements

During the first half of the 20th century, tobacco had the image of being dirty and masculine¹⁸. However, as more women entered the job market in the post-war era, the tobacco companies became aware that women were an untapped consumer market¹⁶. This marked the beginning of the industry's significant investment in market research.

Between the 1950s and 60s, cigarettes were marketed towards middle and upper class women who were seen as having the power to purchase. Cigarettes were presented as sophisticated, sociable, stylish, appetite suppressing fashion accessories¹⁶. Cigarettes were sold in feminine and stylish packaging. Glamorous models were used to normalise smoking among women¹².

The 1970s saw increased public awareness about the health consequences of tobacco, along with a decline in smoking prevalence among women and men with tertiary education¹⁹⁻²⁰. Tobacco companies then shifted their focus towards working class women and men¹⁹⁻²⁰. Working class women in particular were recognised as the main potential market^{12, 16, 18}. As

more and more women entered the workforce, they were being lured to spend their income on cigarettes^{12, 16}.

The tobacco industry successfully exploited the growth of feminist consciousness by portraying women's tobacco use as a marker of equality and emancipation^{12, 19}. Tobacco marketing began to advertise cigarettes as a symbol of independence¹⁹, self reliance, stress management, social progress, popularity, and personal attractiveness¹⁴. In the USA, tobacco company Philip Morris produced the famous campaign '*You've come a long way, baby*' for Virginia Slims cigarettes which saw a staggering increase in the sales among working women²¹. By the 1990s however, the sales of Virginia Slims dropped as the new generation of women no longer saw themselves as a part of the feminist movement²¹. After conducting more market research, it was revealed that young women (particularly in the target group of having lower education and lower socioeconomic status) valued individual success such as wealth and a good job²¹. The company then introduced Virginia Slims Kings with the image of strong, confident, successful women who are also attractive, sexy and fun-loving in a bid to reclaim the territory of the young female market²¹.

3.2 Understanding women's life course

For the tobacco industry, women are not a homogenous group²². The industry alters product design to target groups based on age and demographic diversity²². Advertisements are then developed to reflect the needs encountered at different stages in women's lives¹⁷.

Internal reports from tobacco companies reveal that the tobacco industry deliberately targets young people, with one report mentioning that only 5 percent of smokers started smoking after they turned 24²⁰.

A tobacco industry document from the 1980s outlined strategies to target females aged 18-24 years without tertiary education²⁰. These women were profiled as light, social smokers who report positive effects of smoking as assisting with socialising, being accepted into social groups and a perceived increase in sexiness²³. These women were at the beginning of their smoking habit, and were seen as an ideal group to target²³.

The tobacco industry attempted to entice these women to continue smoking by presenting images of young, slender, beautiful women who appear to enjoy smoking among their friends, suggesting the social benefits of smoking²³. Cigarette brands for younger women also often promote self confidence, freedom and friendship^{17, 20, 24}.

By the time women are committed smokers in their 30s to 50s, smoking presents a sanctuary from everyday responsibilities¹⁷. Brands for older women promote needs for pleasure, relaxation and escape from everyday stress¹⁷, such as Holiday and Long Beach brand cigarettes which both feature illustrations of a beach scene on the packet.

3.3 Addressing concerns: light and menthol cigarettes

Female smokers often report feeling self conscious about the smell of tobacco and the health impacts of smoking¹⁶. Tobacco companies have addressed these issues by introducing the 'mild' or 'light' brands of tobacco to encourage women to start smoking and to keep smoking rather than quitting¹⁶. 'Light' when added to a product name is particularly appealing to

women and the promotion of light cigarettes has proven to be even more successful than the development of female-focused cigarette brands¹⁶. However, it has been found that light cigarettes have the same amount of nicotine and tar as regular cigarettes, and in some cases, even more so¹⁶.

Flavoured cigarettes are also used to attract female smokers. Menthol cigarettes are often marketed in association with messages of refreshing taste, youthfulness and fun, medicinal benefits, and a feminine aura²⁵. Many popular cigarettes aimed at women include menthol additives²⁵. The popularity of this type of cigarette is especially concerning because individuals who smoke menthol cigarettes are more likely to inhale deeper, increasing exposure to nicotine and tobacco smoke²⁵.

4. Factors associated with smoking

The most disadvantaged people in industrialised countries are among the most committed smokers²⁶. In developed countries, groups who exhibit higher levels of smoking include people with low socio-economic status, Indigenous peoples, those with mental health issues, same-sex attracted women and young mothers²⁶. These patterns are often gendered in the way that poverty and equity are gendered, with women having lower incomes, more childcare responsibilities and less power in relation to men²⁶.

Women smoke to reduce stress, negative mood and body weight more than men, and the association between smoking and depression is stronger among women²². The following section discusses the key factors associated with smoking in women.

4.1 Youth

Adolescence is the life stage where people are most likely to take up smoking. Despite strong public health efforts to discourage smoking³, and the legal cigarette purchasing age being 18, a significant proportion of young people continue to experiment with tobacco and become daily smokers²⁷.

Over 80 percent of women smokers start smoking by the age of 20²⁸. On average, Australian women who have ever smoked had their first cigarette at 16.5 years²⁹. A government survey of young Victorians found of girls aged 13, 14 percent have tried smoking a cigarette, and 2 percent are current smokers⁸. Among girls aged 14, these numbers jump to 25 percent who have ever smoked, with 9 percent current smokers⁸.

In Australia, tobacco experimentation has increased among adolescent girls³. Victorian data also reveals that experimental rates among girls aged 15-17 years are particularly high, with around one in two girls having tried smoking⁸. These rates are slightly higher than their male peers⁸.

Adolescent girls are also showing increasing rates in their progression from experimentation to committed smoking³. Victorian girls aged 12-17 years who reported that they had smoked in the past seven days smoked an average of 22 cigarettes in the past week⁸.

Evidence shows that the younger people are when they start to smoke, the more likely they are to become heavy users of cigarettes³⁰, and the less likely they are to quit^{24, 31}. Young female smokers are also among the most resistant to health warnings as chronic health conditions are of a distant concern³².

4.2 Peer pressure

Many young women express that smoking is a means of enhancing their social identity and status³³. Women who start smoking because their friends smoke, or to look 'cool' are more likely to start smoking at a younger age²⁸. While a gender breakdown is not available, 30 percent of Victorians aged 12-15 years who have smoked, believe smokers are more popular than non-smokers³¹. Young people see cigarettes as 'cool' because it is seen as a rebellious and dangerous behaviour. Smoking has come to symbolise a sense of danger, adventure, and social desirability among many young women^{24,33}.

Friends were the primary factor influencing ever smoking, especially among young women^{28, 34}. In a large scale survey, women reported that they started smoking because their friends smoked (62 percent), and to look 'cool' (26 percent)²⁸. In another study young women also reported fear of rejection from their peer group if they did not smoke²⁴.

The ladder to popularity among teens is influenced by gender. While sport is often a way for boys to reach a level of popularity, girls can see attractiveness as the main means of reaching popularity and smoking is perceived as an attractive and dangerous behaviour³³. An Irish study found that young girls were more likely than boys to point out the link between smoking and romance, and saw smoking as a behaviour that the opposite sex find attractive³⁵.

Most young women are aware of the negative health consequences associated with smoking³⁶. They see smoking as a 'risky' behaviour, its health consequences are remote and long term possibilities, with the immediate gains of social belonging being seen as more important^{31, 36}.

4.3 Fear of weight gain

Concerns about body image and self-esteem, together with weight management are influential reasons for smoking among girls and women³⁷, but less so for boys and men^{38,39}. Girls can also be swayed by celebrities and models who smoke to stay thin⁴⁰.

Smoking is associated with weight control as it suppresses appetite⁴⁰. After quitting, people not only lose the use of an appetite suppressant, their sense of taste also improves, making food more appetising⁴⁰.

4.4 Low socio-economic status

Smoking is linked with socioeconomic status (SES)^{6,16}. In developed countries, the prevalence of smoking has declined among people in the higher-income bracket but has remained static among the those with the lowest income¹⁶. Around 14 percent of Victorian professionals are current smokers, while 25 percent of non-professionals smoke⁴¹. People who earn less than \$20,000 per year make up the largest group of Victorian smokers at 33 percent⁴¹.

In Australia, smoking rates have risen among women with low SES¹⁶. According to the Australian Bureau of Statistics, 28 percent of women living in the most disadvantaged areas reported being daily smokers, compared to 11 percent of women living in the most advantaged areas⁶. Explanations cited in literature focus on the fact that women with low SES are more likely to be exposed to factors that promote smoking, such as poor mental health (related to financial problems and poor work conditions), limited access to information (related to lower education), and peer pressure (related to having more friends who smoke and using alcohol or drugs more frequently)³⁴.

4.4 Young motherhood and sole parenting

The relationship between motherhood and smoking is complex. While on the whole, motherhood is associated with smoking cessation, this is only significant for women in their mid 20s and older³⁴.

Among younger mothers – particularly those with low SES, becoming a parent does not correlate with quitting³⁴. Young women who adopt adult roles such as parenting and employment early on may smoke to cope with the stresses associated with becoming a parent early in life or being a sole parent³⁴ and may have fewer resources available to help them quit^{7, 23}. A New Zealand study found that women who had their first child before the age of 21 years were 60 percent more likely to be daily smokers, and were also less likely to quit smoking⁴².

Sole parenthood is also associated with smoking. In Victoria, 28 percent of sole parents are current smokers, the majority of whom are women⁴¹. In the United Kingdom, single mothers on low income have a higher prevalence of tobacco consumption compared to other women¹⁶.

4.5 Stress

Stress has been identified as a major reason for smoking among women³⁸. It has been reported that women and girls tend to smoke as a ‘buffer’ against negative feelings, while men smoke more from habit or to enhance positive sensation⁹. Women who start smoking to manage stress or to feel less depressed are more likely to start smoking at an older age than those who do so due to peer pressure²⁸.

Women smokers report high levels of physical and psychological demand in their employment and home life⁴³. In Australia and many other developed countries, women have been increasingly engaged in the paid labour force, but their hours spent in household work and childcare continue to be significantly higher than for men³⁸. Thus, many women experience ‘double or triple workdays’ and experience more stress as a result of these duties³⁸. Women, particularly middle-aged women frequently explain that they use cigarettes as a coping mechanism when facing difficult life events and feelings such as sadness, loneliness, stress, anxiety and depression³⁵.

Studies among low-income mothers found smoking was used as a ‘time-out’ from the demands of caring for young children^{9, 18}. In an Australian study, women describe a number

of psychological benefits of smoking, including emotional management and providing a source of predictability and control⁴⁴.

4.6 Depression and other mental illness

In Australia, women who are depressed are twice as likely to be smokers than women who are not depressed⁴⁵. Smoking is also associated with a range of other mental disorders including schizophrenia⁴⁶ and anxiety disorders⁴⁷. Women with mental illness are more likely to smoke than women without mental illness, and tend to face more challenges when trying to quit smoking⁴⁸.

Depression constitutes a major women's public health problem as it takes a large toll in terms of lost productivity and diminished quality of life⁴⁹. Taking into account that depression also increases the likelihood of smoking and greater difficulty in quitting, the health consequences associated with this mental illness are magnified⁴⁹. A relationship between smoking and depression has been repeatedly demonstrated in numerous clinical studies and population-based surveys⁴⁹. However, it is not known whether depression is a cause or an effect of smoking, or whether common factors predispose people to both⁹.

In a Canadian study which compared the gender difference in tobacco use in relation to depression found a higher correlation between smoking and depression among women compared to men⁵⁰. It was also found that women were more likely to find the act of smoking itself 'comforting' and 'relaxing', while men were more driven by the physiological effects of nicotine⁵⁰. This may help to explain why nicotine replacement therapy tends to be less successful in women⁵⁰.

4.7 Violence and trauma

In many cases, smoking is used as a coping device for women who have experienced violence and/or trauma. Sexual abuse, being a victim of violence, and other traumatic events are associated with higher rates of smoking among women⁴⁸. Tobacco use contributes to 14 percent of the total burden of disease associated with intimate partner violence among Victorian women⁵¹. A survey of American secondary school students also found that girls who had experienced depression and/or family violence were more likely to smoke compared to boys with similar backgrounds⁹.

4.8 Poor physical health

Smokers generally report other poor health practices. Evidence demonstrates a correlation between high-risk alcohol consumption and the use of illicit drugs with women's smoking uptake^{6,52} and relapses after quitting³⁴. Poor diet including lower daily fruit and vegetable intake⁶ and lower participation in physical activity are also linked to smoking³⁴.

Additionally, smoking appears to change the distribution of fat in women³⁷. Women who smoke tend to put on more fat around their waist compared to women who do not smoke³⁷. Fat in this area is associated with risks such as stroke, heart disease, type 2 diabetes and a general increased death rate³⁷.

4.9 Indigenous status

The high level of tobacco use among Indigenous Australians is linked to dispossession and family removal, along with lower socio-economic status, racism, discrimination and violence⁵³. When combined with high rates of poor mental health and poor physical health, it is not surprising that Indigenous women are twice as likely than non-Indigenous women to smoke^{7, 54}. Approximately 43 percent of Indigenous women are current daily smokers⁵⁵. Indigenous women in Victoria are around five times more likely to smoke during pregnancy than non-Aboriginal women⁵³.

Indigenous women share the barriers to quitting faced by other women who experience multiple social disadvantages, with the addition of limited access to health services, language barriers, racism and reduced cultural safety⁷.

The body of literature on smoking cessation programs aimed at Indigenous women is mostly limited to pregnant Indigenous women. Quitting smoking may be a lower priority for pregnant Indigenous women because of the many other health and social issues that affect them⁵³. Smoking becomes a way to cope with the many stressors in their lives⁵³.

Many pregnant women living in Indigenous communities find it difficult to quit because of the high numbers of smokers all around them, and the strong social norms supporting smoking in Indigenous communities⁷.

Smoking cessation programs that focus on communities or whole populations are more likely to be successful in the Indigenous context⁵³. Indigenous women could also benefit from programs that address social disadvantages⁵³.

4.10 Samesex attraction

Samesex attracted women report higher tobacco use than heterosexual women⁵⁶. The Australian Longitudinal Study of Women's Health found a significant difference in tobacco use between young women depending on sexual orientation⁵⁷. Around 46 percent of women aged 22-27 years who identified themselves as 'bisexual or lesbian' were current smokers compared to 35 percent of those who identified themselves as 'exclusively heterosexual'⁵⁷.

Evidence shows a link between tobacco use among samesex attracted women and emotional distress stemming from social discrimination and homophobic abuse^{56, 58}. Greater tobacco use among the samesex attracted peer group is also found to be an influential factor for higher tobacco use among samesex attracted women⁵⁶.

Programs which provide samesex attracted young people with emotional support and address homophobic attitudes in the community have been shown to improve young people's mental health and reduce their use of tobacco and other drugs⁵⁸.

5. Smoking cessation

Many female smokers report that while smoking may have been initiated as a way of controlling their environments and lives, it ends up controlling them⁴⁴. An international survey (Canada, United Kingdom, United States of America, and Australia) found that the majority of

female smokers feel guilt and regret about smoking, and wished they had never begun smoking⁵⁹.

In Victoria, 20 percent of women have quit smoking⁵, and many more are in the process of quitting or relapsing. Many women perceive smoking cessation to be a daunting task and many have several relapses in their attempts to quit⁵⁹.

Women who have chosen to quit smoking stated a general health concern to be the primary reason for cessation (80%)¹⁴. The expense of cigarettes was another major factor quoted for cessation (42%), along with pressure from family and friends (38%)¹⁴.

Marriage and parenthood modify smoking behaviour for many women⁶⁰. A 10-year longitudinal study of Australian women found that getting married and being in a long term relationship is linked to quitting³⁴. For women who have been social smokers in their teens and in their early adulthood, cessation signifies a transition away from the 'partying single stage of life' towards maturing into adulthood⁶⁰. As women consider their future health and plans for having children, they become more concerned about the addictive nature of cigarettes and their capacity to quit⁶⁰.

5.1 Barriers to cessation and reasons for relapsing

Research has found that women may find it more difficult to quit smoking than men and have a higher number of relapses^{19,61}. Common barriers women face when quitting smoking are:

- *The association between smoking and stress relief.* Stress related to financial problems is linked to women's continued smoking and relapsing, more so than for men⁶². A survey of North American women found the biggest perceived barrier to cessation is stress (63 percent)¹⁴.
- *Concerns about weight-gain post cessation which lessens the desire to quit*^{19,63}. In the same North American survey, fear of weight gain was listed as the second major concern at 41 percent¹⁴.
- *Partner smoking, creating a difficult environment for quitting*⁶⁴.
- *Side effects in using nicotine replacement therapy.* Women who quit smoking often express unbearable cravings for nicotine¹⁴ which can be combated by nicotine replacement products. However, women report more side effects from using nicotine replacement products than men⁶⁵.

6. Public health prevention and cessation strategies

Women and men exhibit numerous differences in behaviour, illness and disease associated with smoking^{66,61}. These differences also extend to their responses to health promotion and cessation strategies⁶¹. This section discusses some common strategies and their impact on women.

6.1 Presenting an alternative norm

Given that the tobacco industry has found audience segmentation to be a useful approach in encouraging women to smoke, it makes sense that the same approach may be used to develop effective initiatives that encourage women to stop smoking²³.

Tobacco companies have been very successful in equating images of independence, vigour and happiness with smoking⁶⁷. Similarly, cessation efforts can focus on fostering self-confidence as a tool for cessation²³, such as the Feeling Good Campaign (<http://www.feelinggood.com.au/>) delivered by the Queensland Government and Quitline. It was designed specifically for young women and contains gender sensitive information about tips on dealing with common barriers for cessation such as weight gain, peer pressure and stress. It features images of beautiful, popular and healthy young women who are ex or non-smokers. These images offer young girls an alternative norm of popularity and attractiveness derived from the refusal to smoke.

Due to the recent adoption of these strategies, we are yet to see an evaluation of their impact on young women's attitude to smoking, uptake and cessation.

6.2 Gradual cessation

Although all committed smokers are addicted to nicotine, research suggests that female smoking behaviour is largely reinforced by 'non-nicotine factors' such as hand-mouth activity, social pressure and comfort²².

Related to these factors, women find it difficult to quit 'cold turkey' and are more likely to experience relapses than men when they use this method⁶⁸. Therefore, women may benefit from gradual smoking reduction⁶⁸ along with the introduction of alternative ways to cope with stress and socialise.

6.3 Exercise

Exercise such as aerobics⁶⁹, yoga and running improve mood and are linked to decreased smoking among female smokers^{34,70}. Women receiving physical activity counselling report less tension, anxiety, stress, irritability and restlessness during the first weeks of smoking cessation⁷⁰. Moderate to high levels of physical activity are positively associated with remaining an ex-smoker³⁴. Therefore, women may benefit from programs that encourage them to quit smoking and become more physically active rather than encouraging cessation alone.

6.4 Programs for pregnant women

Pregnant women are among the most targeted people for cessation intervention strategies for three reasons. First is the notion of protecting the health of the unborn child. The second reason is that pregnant women present a convenient population group for an intervention point as most make regular visits to antenatal care. The third reason is based on the evidence that pregnancy is a key motivator for women in giving up smoking¹⁹, with 74 percent of pregnant smokers expressing desire to stop smoking⁷¹. A Cochrane review of 72 trials found that smoking cessation intervention in pregnancy reduces the proportion of women who continue to smoke in late pregnancy⁵⁴. However, little attention has been placed

on the social factors that influence these women's smoking behaviour. This section examines some of the challenges around pregnancy-based intervention strategies.

A difficulty with delivering smoking cessation messages during pregnancy is the primary focus on the wellbeing of the unborn child. While this is an important message, it is liable to foster the low self-regard that often contributes to women's smoking in the first place^{19, 71}. Not surprisingly, there is a high rate of relapse among women post-partum^{19, 71}, particularly in those with low SES⁷².

Another barrier to delivering smoking cessation programs to women in antenatal settings relates to women's unwillingness to disclose their continued smoking to health practitioners⁷³. United States based research found that women were hiding their smoking behaviour during pregnancy due to the stigma attached⁷³. Most pregnant smokers were well aware of the health impact of smoking during pregnancy but were unable to quit⁷³. This resulted in increased feeling of shame and guilt, leading to secrecy about their smoking practice⁷³. This evidence suggests that intervention programs need to acknowledge and assist with the social reasons for smoking beyond the rationale of the health of the foetus⁷².

Pregnant women also find quitting especially difficult when their partners continue to smoke⁷¹. Evidence shows that pregnant smokers are more likely to have partners and family members who smoke⁷¹. Many pregnant smokers state that their partners are generally supportive of them giving up smoking, although most of the time, the support does not extend to the partners giving up smoking themselves⁷¹.

Smoking cessation interventions that focus exclusively on the pregnancy may be missing opportunities to help women and their partners to quit permanently. Men often report feeling coerced into receiving advice simply because of their partner's pregnancy⁷¹.

While pregnant women receive advice during their antenatal care appointment, their partners may have more difficulty quitting without also having access to professional support⁷¹. Findings also show that partners of pregnant women are unwilling to participate in smoking cessation programs provided in antenatal settings⁷¹. It has been suggested that health promotion programs delivered outside antenatal settings and specially designed for couples are more likely to achieve changes in behaviour and risk factors by building on the social support that stems from involving both partners⁷¹.

7. Policy context

Over the past three decades, anti-smoking laws and regulations have become increasingly tough, and this has led to a decline in smoking prevalence among the general population¹¹. However, some groups of women have shown resistance to these strategies¹¹. This section examines key initiatives by the government and implications for women.

7.1 Ban on tobacco advertising

Since the 1970s, Federal and State governments have progressively tightened laws around tobacco advertising. The *Tobacco Advertising Prohibition Act 1992*⁷⁴ enforces a total ban on cigarette advertising in the popular media, on billboards, on public transport, and at popular

events. The Act also prohibits co-packaging of cigarettes with other products. Recently, the Victorian Government announced further advertising restrictions on the display of cigarettes at the point of sale which will become effective on 1 January 2011⁷⁵.

It is well documented that restrictions on advertising are associated with a reduction in smoking prevalence. In Australia, when the total tobacco advertising ban was introduced, smoking rates were at 22 percent¹⁷. Three years later, they had dropped to 19.5 percent¹⁷.

Despite heavy advertising bans however, smoking continues to be promoted through covert and indirect ways¹⁰. In Australia, cigarette promotion now occurs through a number of avenues including the internet³¹; small circulation magazines; broadcasts of international sporting events; and the portrayal of smoking in movies, television, music lyrics and videos, video games, fashion magazines¹⁰ and fashion shows¹². A study that examined films from the 1960s to the 1990s found that there has been an increase in the number of films depicting women smoking, while there has been a decrease in films depicting men smoking¹⁰. This continuation of covert advertising means that tobacco advertising is still reaching women and girls.

7.2 Graphic anti-smoking campaigns

Anti-smoking ads have been shown in Australia since 1985 with mixed success. In the 1990s as part of the *National Tobacco Control Strategy*⁷⁶, advertising campaigns incorporated a series of graphic advertisements warning people of the negative health effects of smoking.

There is conflicting evidence around the effectiveness of graphic anti-smoking campaigns on adolescent females. One qualitative Australian study found that graphic anti-smoking advertisement campaigns have little influence on young women smokers who are well aware of the health risks³⁶. Other studies have found that graphic adverts have been effective in reducing the appeal of smoking and encouraging quitting among young people^{77,78}. However, reports were not sex-disaggregated, making it difficult to identify any possible difference in the impact on girls and boys.

It is well known that young women take up smoking despite an awareness of the health consequences³. Therefore, further gender sensitive research is required to determine the most effective prevention strategies for young women.

7.3 Ban on smoking in public spaces

In 1987, the Victorian Parliament passed the *Tobacco Act*⁷⁹. Since then reforms to the Act and its supporting regulations have been rolled out, banning smoking in public spaces. Venues under the Act include shopping centres, restaurants, dining areas, gambling areas and some bar areas. In March 2006, most Victorian workplaces became smoke-free, except for licensed premises which became smoke-free on 1 July 2007^{31,80}. Smoking is still permitted in outdoor dining or drinking areas unless the area has a roof in place and walls that cover more than 75 percent of the total notional wall area. However, there is now a call by the Australian Medical Association for Victoria to ban smoking in all public outdoor dining venues⁸¹. This ban is already in place in Queensland and Western Australia.

Because addiction is not the primary motive for smoking among the majority of young women, public policies aimed at limiting opportunities to smoke such as banning smoking in bars and restaurants may be particularly effective in deterring young women from smoking⁶⁰. Policies that provide smoke-free environments in social establishments may greatly assist with cessation efforts⁶⁰.

Prevention strategies should build on understanding the social and environmental factors that make cigarettes smoking attractive option for young women, particularly in social, education and occupational settings⁶⁰. Targeted interventions in vocational training settings and non-professional occupational settings could help to prevent the escalation to daily smoking and promote cessation⁶⁰.

7.4 Plain packaging

In April 2010, the Federal Government announced plans to introduce plain packaging for tobacco products from January 2012. Australia is the first country in the world to take up this measure which is recommended in health promotion literature⁸².

The Government faces strong resistance to this initiative from the tobacco industry. This is because the cigarette pack has become the primary vehicle for cigarette promotion since the enforcement of advertising restrictions¹⁰. Packaging of cigarettes has become an important marketing strategy because it attracts attention to the product makes cigarettes more appealing and helps to make the sale¹⁰. Cigarettes designed for women tend to be light in colour and come in slim, long packs to make the products appear more 'feminine'¹⁰

What distinguishes cigarette packaging from most other packaged products is that rather than discarding the packaging after opening, smokers generally keep their pack close to them for easy accessibility¹⁰. The social visibility of the cigarette packs means that they have come to be known as badge products, where the smoker is associated with the branded image¹⁰.

7.5 Increasing price

The cigarette price in Australia has steadily increased over recent years due to a number of tax increases. As a result of these taxes, between 1988 and 2006, an average pack of cigarettes more than quadrupled in price⁸³. The price rise of cigarettes has exceeded the rise of other consumer products, and has risen at a rate that exceeds increases in average earnings⁸³. In 1984, a week's supply of cigarettes would cost a pack-a-day smoker on an average Australian income just over an hour's pay⁸³. By 2007, a worker needed to spend three hours of their pay on the same supply⁸³.

It has been found that increasing the cigarette price is associated with a reduction in smoking, particularly among low-income groups⁸⁴. However, while there is the potential to reduce consumption, this may also result in increased financial hardship, particularly for heavily addicted smokers.

8. Recommendations

Tobacco use among women and girls has the potential to undermine their physical health as well as their economic and social wellness⁴⁴. This issue therefore requires ongoing action by government as well as the public health and community sectors, including a targeted approach that recognises the relationship between smoking and gender.

1. Gender sensitive research

Evidence shows that gender plays an important role in the issue of smoking. Therefore, research into the factors that influence girls and women to smoke is required to inform programs that address the needs and interests of women. Gender sensitive research practice is achieved through:

- A systematic and consistent reporting of sex-disaggregated data. This is critical in gauging how women and men behave and are impacted differently.
- A gender analysis of evidence. This leads to policies and intervention programs that are targeted to the varying needs and concerns of women and men, so that outcomes can be improved for both.

2. Gender sensitive prevention strategies

Targeted prevention strategies should build on understanding the social and environmental factors that make cigarette smoking an attractive option for women in young adulthood.

3. Gender sensitive evaluation

A gender analysis should be conducted in the evaluation of all prevention strategies, whether or not they were targeted specifically towards women or men.

4. Gender sensitive cessation strategies

To optimise cessation efforts among women who are long-term smokers, a multi-faceted approach is required. These measures include:

- Expanding programs that target pregnant women, to also include their partners, with emphasis beyond the health of the foetus.
- Provision of cessation treatments that are affordable, effective and sensitive to the needs of women.
- Provision of cessation approaches that are sensitive to the stressors that undermine women's smoking cessation efforts. Focus should also be made on countering messages from the tobacco industry, including that smoking can relieve stress.

5. Ban smoking in public outdoor drinking and dining areas in Victoria

To decrease women's social smoking opportunities, the ban on smoking in public spaces should be extended to include outdoor spaces such as beer gardens and alfresco dining areas.

9. Conclusion

The health impacts of smoking are serious and well-documented. This paper has highlighted the multiple ways that gender differences and gender inequities influence smoking uptake, behaviours and cessation for women. Strategies to prevent and address women's smoking can be strengthened by addressing factors such as stress, peer pressure, fear of weight gain and social disadvantage.

The tobacco industry has long employed gender sensitive research and has targeted their advertising and marketing accordingly. The public health sector and governments have been slow to recognise the need for such an approach. A number of prevention and intervention strategies are now in place and they are making an impact. In order to optimise their effectiveness, policy and health promotion measures must address the relationship between gender and smoking and tailor their responses to meet the needs and concerns of women and girls.

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