



Key points:

- tobacco affects men and women differently
- women are more likely than men to be affected by health inequalities
- smoking prevalence is higher in teenage girls than in teenage boys
- support for cessation needs to extend beyond reproductive health
- maternal smoking affects children too
- tobacco use amongst women in the developing world continues to rise.

Tobacco affects men and women differently and women need a tailored support to quit smoking. Also, lower levels of education and employment are linked with lower quit success, especially among women¹. Cessation services and prevention programmes should address the changing needs of women throughout their lives and recognise that they are more vulnerable to health and social inequalities.

Prevalence in Scotland

In Scotland, 27.2% of the adult population smokes; 28.1% of men compared with 26.5% of women². However the gender disparity is reversed in 15 year olds who are regular smokers, 18% of girls compared with 12% of boys, and 13 year olds - 5% of girls and 3% of boys³.

Within Scotland, the smoking prevalence of women in the first trimester of pregnancy is 22.7%⁴.

Tobacco and women's health⁵

Like men, women smokers can suffer from tobacco-related health problems such as lung cancer, cancer of the mouth, throat, larynx, oesophagus, stomach, pancreas, bladder, kidney along with heart disease, chronic obstructive pulmonary diseases, stroke, infertility and many other illnesses. Research also suggests that smoking dose for dose, women have a significantly higher risk of developing smoking-related illnesses such as lung cancer and myocardial infarction than men. Women who smoke are also more likely to have:

- fertility problems
- altered menstrual function and menopause at a younger age
- an increased risk of cervical cancer
- an increased risk of breast cancer
- lower bone density (among post menopausal women).

Women in some minority ethnic groups smoke cigarettes but may also use a

variety of oral tobacco products which can pose additional health risks. See *ASH Scotland: Tobacco use and minority ethnic groups (May 2008)*.

Complications during and after pregnancy include:

- miscarriage
- premature rupture of membranes
- abruptio placentae
- premature labour
- lower birth weight
- stillbirth
- sudden infant death syndrome (SIDS)
- delayed milk production.

Women are more likely to be diagnosed with depression than are men and there is a strong association between smoking and depression⁶.

Smoking among women who are caregivers also causes a wide variety of adverse health effects in their children including lower respiratory tract infections, asthma, middle ear infections, decreased auditory processing and has been linked with maths, language and behavioural problems⁷.

Women and second-hand smoke

Exposure to environmental tobacco smoke is a cause of lung cancer and coronary heart disease among women who are lifetime non-smokers.⁸ Second-hand smoke has also been reported as increasing the incidence of breast cancer in non-smoking pre-menopausal women⁹. Second-hand smoke exposure is most common in disadvantaged homes where women are less likely to have childcare options or opportunities outside home.

Why do women start smoking?

Historically, the tobacco industry has used gender analysis to sell more cigarettes; from associating smoking with freedom and women's suffrage in the 1920s to co-opting the slogans and aspirational images of women's liberation in the 60s and 70s. Brands targeting women were once described as slimmer, lighter or milder and still have packaging designed to maximise their feminine appeal. In the twentieth century women's tobacco use increased alongside social and economic independence and this pattern seems set to be repeated with the women of the developing world in the twenty-first century. Whereas men's smoking rates have peaked and started a slow decline¹⁰ it is predicted that by 2025, 20% of the world's women will smoke (currently 12%)¹¹. The international challenge will be to keep gender on the tobacco control agenda in developing countries and to ensure that women have access to tailored tobacco control interventions and quality healthcare.

Teenage girls may start smoking to avoid weight gain, to identify themselves as independent, or in response to peer pressure and perceived 'social norms'. Media images perhaps suggest that being slightly overweight is worse than

smoking and reinforce the belief that cigarette smoking suppresses appetite. Also, parents who smoke are more likely than those who do not to have children who smoke.

High smoking rates are known to be related to lower socioeconomic status. Although smoking rates have declined in the population as a whole, recent socioeconomic inequalities in smoking have been widening¹². (See *ASH Scotland: Tobacco and social deprivation*)

Supporting women to stop smoking

The most successful treatments are multi-component cognitive behavioural programmes which incorporate strategies to prepare and motivate smokers to stop smoking¹³. Women are more likely than men to use intensive treatment programmes. Similarly, women have a stronger interest than men in smoking cessation groups that offer mutual support through a buddy system and in treatment meetings over a long period. To reduce the number of women who start smoking, and to meet the needs of those who want to stop, it will be necessary to have the following:

- a gendered analysis of what works in smoking prevention and cessation
- media campaigns which 'denormalise' smoking
- targeted awareness-raising about the health risks of smoking and second-hand smoke
- tailored smoking treatment services for women and women with socioeconomic inequalities.

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- ¹ Levy DT, Mumford EA, Compton C. Tobacco control policies and smoking in a population of low education women, 1992–2002. *J Epidemiol Community Health* 2006;60 (Suppl 2) :ii20–6. Available from: http://jech.bmj.com/cgi/content/abstract/60/suppl_2/ii20?ijkey=de4286012c70216198b8ccfd82451ea683f72&keytype=tf_ipsecsha [accessed 24 April 2008]
- ² NHS Health Scotland, ISD Scotland and ASH Scotland. (May 2007) *An Atlas of Tobacco Smoking in Scotland*. Edinburgh: NHS Health Scotland.
- ³ BMRB Social Research. (2007) *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) - National Report 2006*. Online. Available at: www.drugmisuse.isdscotland.org/publications/abstracts/salsus_national06.htm [Accessed 1/2/08]
- ⁴ ISD Scotland. (2 November 2006) *Smoking at booking (revised) - Scotland*. Online. Available at: www.isdscotland.org/isd/files/mat_bb_Smoking%20at%20Booking_revised.xls [accessed 1/2/08]
- ⁵ Adapted from Richmond R. You've come a long way baby: Women and the tobacco epidemic. *Addiction*.2003 May;98(5):553-7. 2. Available online at: <http://www.blackwell-synergy.com/doi/pdf/10.1046/j.1360-0443.2003.00342.x> [accessed 30 April 2008]
- ⁶ 2001 US Surgeon General's Report—Women and Smoking At A Glance. Online: www.cdc.gov/tobacco/data_statistics/sgr/sgr_2001/ata glance.htm [accessed 30.4.08]
- ⁷ Hofhuis et al. Adverse health effects of prenatal and postnatal tobacco smoke exposure on children. *Archives of Disease in Childhood*. .2003; 88: 1086-1090. Available online: <http://adc.bmj.com/cgi/content/full/88/12/1086> [accessed 1.5.08]
- ⁸ Ibid
- ⁹ State of California Air Resources Board. Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant. Online: www.arb.ca.gov/regact/ets2006/uid.pdf [accessed 30.4.08]
- ¹⁰ Mackay, Eriksen, Shafey. *The Tobacco Atlas*, 2nd ed. American Cancer Society, 2006.
- ¹¹ Greaves, Jategaonkar, Sanchez. *Turning a New Leaf: Women, Tobacco, and the Future*. British Columbia Centre of Excellence for Women's Health, 2006.
- ¹² Gilman SE, Abrams DB, Buka SL. Socioeconomic status over the life course and stages of cigarette use: initiation, regular use, and cessation. *J Epidemiol Community Health* 2003;**57** (10) :802–8
- ¹³ 2001 US Surgeon General's Report—Women and Smoking At A Glance. Online: www.cdc.gov/tobacco/data_statistics/sgr/sgr_2001/ata glance.htm [accessed 30.4.08]

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