World Health Organization
REGIONAL OFFICE FOR Europe

THROUGH A GENDER LENS

WOMEN AND TOBACCO IN THE WHO EUROPEAN REGION

Abstract

This report provides a brief summary of some of the challenges, old and new, that women and girls face in the context of the tobacco epidemic in the WHO European Region, outlining the gendered nature of tobacco use and exposure and how the tobacco industry continues to target them through gendered messaging. It also provides recommendations for approaches and policy interventions that take a gender lens to tobacco control. The WHO Framework Convention on Tobacco Control (WHO FCTC) strongly underpins gender equality and highlights the importance of addressing gender-specific risks. This report seeks to reinforce these aspects of the WHO FCTC, supplement tobacco-control reports published by the WHO Regional Office for Europe, and follow up on the recommendations of the WHO European strategy for women's health and well-being by promoting gender-responsive tobacco-control policy.

Keywords

TOBACCO

WOMEN

GENDER-RESPONSIVE TOBACCO CONTROL

WHO FCTC

WHO EUROPEAN REGION

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Acknowledgements

Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSR	corporate social responsibility
CVD	cardiovascular disease
ENDS	electronic nicotine delivery systems
ENNDS	electronic non-nicotine delivery systems
EU	European Union
GRASS	WHO gender-responsive assessment scale
HTP	heated tobacco product
LGBTQ	lesbian, gay, bisexual, transgender and queer (or questioning)
NCD	noncommunicable disease
NGO	nongovernmental organization
RYO	roll-your-own (tobacco product)
SHS	second-hand smoke
TAPS	tobacco advertising, promotion and sponsorship
WHO FCTC	WHO Framework Convention on Tobacco Control

Glossary

Gender is a culturally and historically formed social construct; it refers to norms, roles, attributes and relationships that a given society accepts for men and women. When individuals or groups do not fit the established gender norms, they often face stigma, discriminatory practices or social exclusion, all of which adversely affect health. As gender is socially situated, it is closely calibrated to political and economic relations that govern value in a society *(1)*.

Gender equality is the absence of discrimination in opportunities, rights, responsibilities, the allocation of resources and benefits, and access to services on the basis of a person's sex *(2)*.

Sex refers to a person's biological makeup. Most people are born biologically female or male and are then socialized into gendered norms and behaviours *(2)*.

Sex-disaggregated data refers to data collected and tabulated separately for women and men. Gender statistics and gender-sensitive data, however, go beyond sex disaggregation and allow for the integration of gender roles, relations and inequalities into statistics *(3)*.

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3. Glossary of terms. In: Gender statistical manual. Integrating a gender perspective into statistics [website]. New York (NY): United Nations Statistics Division; 2015 (https://unstats.un.org/unsd/genderstatmanual/Glossary.ashx).

Introduction

Tobacco-control advocates have been warning of the increasing prevalence of smoking among women in the WHO European Region for decades. Although tobacco use among women is decreasing overall, it is dropping at a much slower rate than in men, and is increasing in some areas of the European Region. Bold steps forward have been made in tackling the tobacco epidemic in recent years, but much work remains to be done, with the relatively high numbers of women and girls who smoke presenting a serious cause for concern. As gender mainstreaming is increasingly recognized as being important to policy development, tobacco control is well placed to build on progress already made.

To address the enormous health, economic, environmental, social and developmental burdens caused by tobacco, the United Nations and WHO have agreed on a number of policy frameworks, such as the WHO Framework Convention on Tobacco Control (WHO FCTC) (1), the United Nations Political Declaration on the Prevention and Control of Noncommunicable Diseases (2), the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases (document A/RES/66/2, endorsed by the Sixty-sixth World Health Assembly in resolution WHA66.10) (3) and the United Nations Sustainable Development goals (4).

The global noncommunicable diseases (NCD) action plan includes a target for reducing the global prevalence of tobacco use (smoked and smokeless tobacco) by 30% by the year 2025 relative to 2010. This was set in recognition of the high proportion of premature deaths from NCDs caused by tobacco use. According to WHO estimates, the WHO European Region currently is tracking towards an 18% relative reduction in the average prevalence rate. It is also the only WHO region not expected to reach the female 30% relative reduction target by 2025 (by a staggering 3.8%) (5). Substantial and robust public health interventions are required to reduce tobacco-use rates across the European Region in all population groups, achieve global, regional and national targets, and save millions of people from tobacco-related diseases and death.

Until recently, tobacco-control policies paid little to no attention to gender and its role in smoking initiation, maintenance and quitting, while the tobacco industry used sophisticated gender-based strategies to reach different population groups, including use of hypermasculine figures to advertise to men, and either feminizing smoking or promoting it as a symbol of emancipation, equality and liberation when advertising to women (6,7). Numerous calls for gender-sensitive policies relating to action on women and tobacco have been made to raise awareness of the issue, emphasizing the need to better understand the impact of tobacco on women's health and economic well-being (8).

This report provides a brief summary of some of the challenges, old and new, that women and girls face in the context of the tobacco epidemic in the European Region, outlining the gendered nature of tobacco use and exposure and how the tobacco industry continues to target them through gendered messaging. It also provides recommendations for approaches and policy interventions that take a gender lens to tobacco control. The WHO FCTC strongly underpins gender equality and highlights the importance of addressing gender-specific risks. This report seeks to reinforce these aspects of the WHO FCTC, supplement tobacco-control reports published by the WHO Regional Office for Europe, and follow up on the recommendations of the WHO European strategy for women's health and well-being (9) by promoting gender-responsive tobacco-control policy.

Why women?

In 2018, tobacco-use prevalence for women in the WHO European Region was the highest in the world, at 19% (or 67 million women) (*5*). While this number had declined from around 77 million (23%) in 2000, it is expected to sit at around 63 million (18%) in 2025. Compared to the global rate of tobacco use among women in 2018 (9%), the rate in the European Region is very high, with rates above 20% in 24 countries (*5*). Tobacco use among men in the European Region is decreasing (from 46% in 2000 to 34% in 2018), but women's rates trace a less clear downwards trajectory and, in some parts of the Region, specifically countries that traditionally had a low prevalence of tobacco use among women, the prevalence of tobacco use is on the rise (*10*).

At global scale, 12% of all deaths among adults aged 30 years and above could be attributed to tobacco, with figures for women standing at 7% and for men 16%. Tobacco use in Europe significantly increases the probability of dying prematurely from a number of NCDs such as cardiovascular disease (CVD), cancer and respiratory disease, accounting for 6%, 10% and 37% of deaths in women respectively (*10*) (Fig. 1).

The picture is similarly challenging among girls, with prevalence high on a global scale. WHO estimates that 12% of girls aged 13–15 in the European Region are current tobacco users, which is 1.5 times the global average of 8% (*5*).

Fig. 1. Tobacco health-effects targets, mortality rates[a] and estimated attributable fraction for key diseases due to smoking in European countries

Females

NCDs: (7%)
CVDs: 253.8 (6%)
Stroke: 67.8 (5%)
Heart attack: 107.0 (6%)
Other CVDs: 9%

Malignant neoplasms: 11.58 (10%)
Trachea, bronchus and lung cancer: 15.5 (62%)
All other malignant cancers: 4%

Respiratory diseases: 32.7 (37%)
Chronic obstructive respiratory disease: 16.9 (54%)
Other respiratory diseases: 14%

Communicable disease: 8.5 (12%)
Tuberculosis: 1.4 (5%)
Lower respiratory diseases: 18%

ALL CAUSES: 553.6 (7%)

Males

NCDs: (28%)
CVDs: 396.4 (25%)
Stroke: 89.4 (21%)
Heart attack: 193.5 (26%)
Other CVDs: 27%

Malignant neoplasms: 201.8 (41%)
Trachea, bronchus and lung cancer: 53.3 (92%)
All other malignant cancers: 22%

Respiratory diseases: 67.5 (63%)
Chronic obstructive respiratory disease: 39.8 (79%)
Other respiratory diseases: 28%

Communicable diseases :16.6 (23%)
Tuberculosis: 5.4 (30%)
Lower respiratory diseases: 30%

ALL CAUSES: 932.5 (25%)

[a] Age-adjusted mortality rate per 100 000 population (attributable mortality fraction, %).
Sources: WHO *(11)*; WHO Regional office for Europe *(12)*.

The Lopez Curve

The Lopez Curve maps the four stages of the tobacco epidemic (*13*) (Fig. 2). It indicates that female smoking tends to occur later than male smoking. Typically, there is a 30-year gap between peak tobacco use and peak tobacco-related mortality. As women's uptake of tobacco occurs later, the surge in related female deaths will also occur later than for male deaths. This renders projected increases in female smoking an alarming reality for public health.

Mortality rates for lung cancer in females were higher than that for breast cancer in a third of European Region countries in 2018 (*14*), and despite the common perception that CVD is a men's issue, it is the European Region's biggest killer of women, alongside cancer (*15*).

Fig. 2. Four stages of the tobacco epidemic

| | Stage 1 | Stage 2 | Stage 3 | Stage 4 |

Percentage of smokers among adults

Percentage of deaths caused by smoking

— Percentage of male smokers   — Percentage of female smokers   •••• Percentage of male deaths   •••• Percentage of female deaths

Source: Lopez et al. *(13).* Reproduced from Tobacco Control, Lopez AD, Collishaw NE, Piha T, A descriptive model of the cigarette epidemic in developed countries, 242–7, © 1994, with permission from BMJ Publishing Group Ltd.

Reproductive health

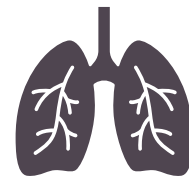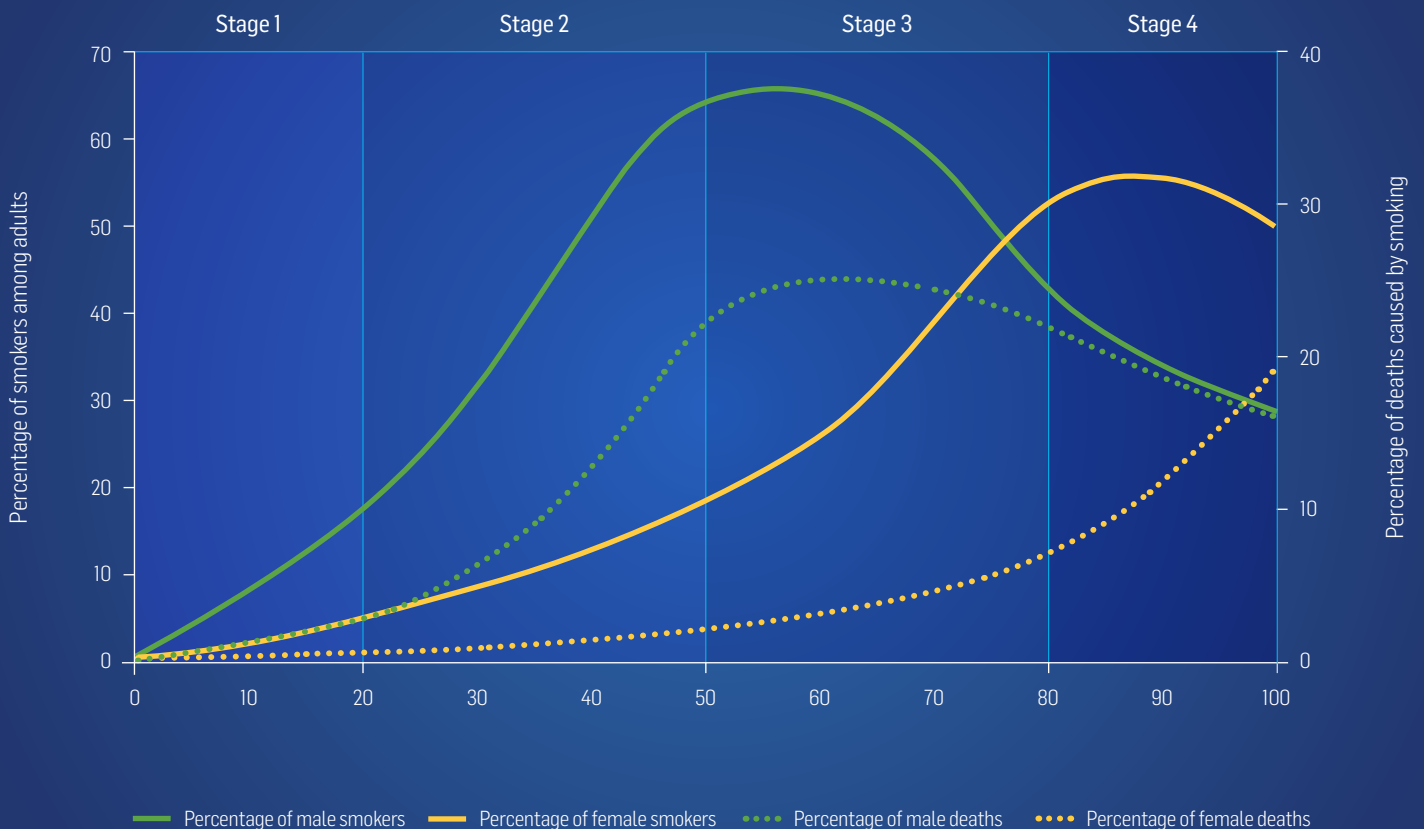Women not only experience similar negative health effects of tobacco as men, but also face additional health risks related to reproduction (*16*). Smoking and exposure to second-hand smoke (SHS) while pregnant put the unborn child at risk from SHS, which can cause serious developmental harm. Despite these risks, smoking during pregnancy remains the leading cause of poor pregnancy outcome and prenatal death in the European Region (*17*). Globally, 52.9% of women who smoke daily continue doing so during pregnancy; the European Region has the highest rates in the world of smoking during pregnancy, with prevalence at 8.1% (*18*).

The rates of smoking in pregnant women are strongly associated with social determinants of health, particularly age and socioeconomic status. Young women, those in the lowest socioeconomic groups, and those with manual occupations and low levels of education are more likely to smoke during pregnancy (*19,20*).

Pregnant women also remain at risk of SHS exposure, often as a result of partners' smoking, and smoking by others inside their homes, in their workplaces, in public places and on public transport.
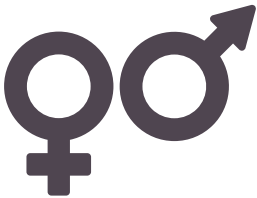
Gender as a social determinant of health

Gender is a fundamental determinant of women's and men's health and must be taken into account in tobacco-control efforts. It is crucial to take a tailored approach to tobacco control that engages with the challenges faced specifically by women, including gender norms and roles, access to resources, gender biases in health-system responses and gendered marketing, for policy to be effective. Gender influences everyone's susceptibility to different health conditions and diseases and affects their enjoyment of good mental and physical health and their well-being. It also has a bearing on people's access to, and uptake of, health services and on the health outcomes they experience throughout the life-course (*21*). Research indicates that certain health-related risk behaviours are more common among marginalized groups such as lesbian, gay, bisexual, transgender and queer (or questioning) (LGBTQ) people than among heterosexuals and cis[1] people (*22,23*). The strongest evidence of a higher risk among LGBTQ people relates to the use of alcohol and drugs and to tobacco-smoking.
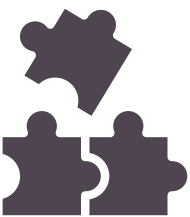
Intersectional approaches to gender

Intersectionality is a framework that addresses multiple discriminations and inequalities to identify the impact of intersecting identities on access to resources, opportunities and rights. Intersectional approaches to gender recognize that "women" is not simply one homogenous category, but that women's experiences vary according to other aspects of their identity, including (but not limited to) race, socioeconomic status, education, age, sexual orientation, gender identity and religion. These factors intersect with gender as social determinants of health. This is fundamental to tobacco control, as inequities in smoking behaviours are recognized

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1   Cis is used to describe anyone whose gender identity matches the sex they were assigned at birth.

not only between countries and age groups, but are also known to occur based on education level, sex, occupation, race, housing tenure and other measures of wealth (*24*). The absence of intersectionality in policy and research, such as a lack of disaggregation of data beyond age and sex, limits the capacity of policy-makers to take appropriate action to prevent increasing numbers of women using tobacco and could also contribute to further marginalization of some groups.

It is important to note that intersectionality in tobacco control is not just about optimizing accuracy in data, but is also about protecting human rights. The WHO FCTC refers in its preamble to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which provides that "States Parties to that Convention shall take appropriate measures to eliminate discrimination against women in the field of health care"(*1,25*). Marginalized women need their rights to health and equality to be redressed; this is as much the case in Europe as in any other part of the world. Tailoring tobacco-control efforts to the needs of these groups is key to achieving both, ensuring the right to a healthy life is extended to all women, regardless of social or economic background. A human-rights approach will not only broaden the coalition of stakeholders involved in tobacco-control activities, but will also provide advanced reporting mechanisms through human-rights treaties (*26*).

The impact of tobacco-control policies on women and girls
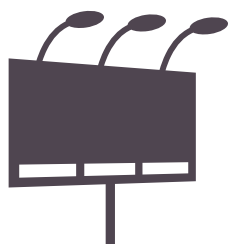
Tobacco advertisement, promotion and sponsorship

The tobacco industry has been using gendered advertising techniques for over a century to target women and men as high-potential markets. Their methods specifically aimed at women are not dissimilar to those used by the (traditionally women-focused) beauty industry. One tactic has involved coopting women's empowerment movements to position smoking as an act of rebellion or rejection of traditional femininity, portraying cigarettes as symbols of emancipation and equality with men. As the feminist movement has grown across the European Region, Big Tobacco has piggybacked on its progress for profit. Simultaneously, the industry has reinforced established gender norms to reach women, depicting smoking as an expression of beauty or status. Notably, the industry has benefited from harmful gendered ideals of thinness and promoted an alignment between smoking and being slim (*27*).

Full implementation of the WHO FCTC's ban on tobacco advertising, promotion and sponsorship (TAPS) (Article 13) is one of the key elements for addressing women's tobacco use, but as of 2019, only seven countries in the European Region had implemented Article 13 in its totality (*28*). Today, most European countries have banned advertising on national television and radio, in print media, on billboards and on the Internet, but other forms of TAPS, including tobacco point-of-sale displays, brand stretching and sharing and showing tobacco products in films and on television, are less regulated (*28*).

Product placement in film and on television

As its access to traditional advertising has increasingly been restricted, the tobacco industry has moved to using other forms, such as promoting tobacco use via film and television. Tobacco sponsorship, product placement in arts and cinema and certain forms of online exposure to tobacco products are often covert and informal in nature (*29*), making it difficult for tobacco-control measures to combat. The role of these forms of advertising in shaping culture and normalizing tobacco use is profound.

Evidence shows that people with higher levels of exposure to tobacco in films are twice as likely to begin smoking compared with those who are less exposed to such imagery (*30,31*). Studies from the United States of America show that around a third of smoking initiation among young people can be attributed to exposure to smoking in films (*32,33*). This is alarming, as 79% of the television shows considered to be most popular among young people aged 15–24 depict smoking prominently; tobacco imagery is increasing on the small screen and in content streamed online (*30*). Popular television drama series such as "Stranger Things", "Walking Dead" and

"Orange is the New Black" frequently depict their main characters using tobacco – these shows featured 180, 94 and 45 tobacco incidents respectively in their 2016 seasons. The main characters are often seen smoking in stressful situations and within the context of rebellious behaviour or conversation (*30*).

Portrayals of tobacco smoking in film, on television and in magazines popular among women are well documented (*34,35*). Female characters who smoke are often shown as glamorous, fashionable, cool and of high social status. Tobacco use viewed by girls and women though these media often promotes unduly positive smoking messages and appeal to the gender-normative values of femininity.

This form of promotion is especially concerning, as it allows the tobacco industry to shape women's perceptions of tobacco in a context that does not appear to the viewer to be an *advert* in the traditional sense. It also serves to normalize smoking, potentially portraying it as more prevalent than it is in reality.

Online exposure

Consumers increasingly are being exposed to advertising and promotion online, especially on social media. The tobacco industry is making use of these platforms to bypass restrictions on traditional advertising. Marketing of tobacco on the Internet is explicitly banned by European Commission regulations, although approaches to regulation of online advertising in the WHO European Region more generally are uneven. Finland, for example, has a negative list banning specific forms of advertising, while France has a positive list defining what can be advertised, which leaves fewer loopholes for exploitation (*36*).

Potential gender differences in Internet usage, such as preferences for gaming rather than social media or online shopping, are also important to comprehend, as Internet usage in large part determines exposure to advertising (Box 1). More research is required to understand how gender interacts with online behaviour.

HOW IT WORKS

Box 1.

Given that Internet users are inundated with content, the promotional goal in online advertising is to retain the viewer's attention. Even those who consider themselves to be relatively tech-savvy are being manipulated psychologically in surreptitious ways to hold their attention.

The complex mechanisms by which online advertising targets consumers are rigorously described in the WHO Regional Office for Europe publication *Monitoring and restricting digital marketing of unhealthy products to children* (*36*). In brief, it shows that brands interact with consumers via advertising media agencies that bid for advertising space on online platforms in real time. Because this multi-step process (requesting content, choosing content, and deciding to whom it will go and at what prices) is almost instantaneous, it is impossible for any organization involved in the process (the publisher, media agency or brand) to know which ads an individual user actually sees on their device. This reveals a need both to regulate advertising and to conduct further study into the ways algorithms and advertising systems detect and target women and girls specifically.

Social media influencers

Influencer promotion is a huge, rapidly growing marketing industry (*37*), with multiple countries in the European Region ranking among those with the highest number of influencer posts globally (*38*). Influencers refers to individuals with a large social media following who are remunerated for promoting a product on their personal social media profiles. Most commonly, influencers will share images of themselves posing casually with the product, appearing as keen users and often with accompanying brand-related hashtags. They are also invited to brand events and often are expected to publicize this on their social media pages, gaining exposure for the brand.

The tobacco industry has made extensive use of this new form of promotion within the European Region, employing influencers such as female fashion bloggers, hosting events with promotional messaging and, alarmingly, instructing influencers to conceal health warnings on tobacco packaging in their images (*39*). New studies exploring the promotion of novel tobacco products by influencers have emerged, showing how these products are used in a way that makes them seem integral to celebrity culture and a healthy lifestyle (*40*). This is a rapidly growing industry, with Instagram influencer posts doubling from 2016 to 2017 (*38*) and growing by over 39% in 2018 (*41*). Spending on this form of advertising is predicted to reach up to US$ 15 billion by 2022 (*42*).

Promotion of this kind has a notably gendered reach. Traditionally, influencer marketing has been utilized mostly by industries targeting women, such as the fashion and beauty industries. It is no surprise, then, that women appear to make up 85% of influencers, and that the predominant influencer age group is 25–34 (*38,41*). A recent study of Instagram "selfies" with tobacco-related hashtags found that young women were the main group sharing photos of themselves alone using tobacco products (*43*).

Influencer marketing enables tobacco companies to reach various groups of users, including those who are underage and users in countries where promotion is banned, because there is no way to control which accounts access the content and because of the transnational nature of social media interaction. Tobacco companies' hashtags have already achieved hundreds of millions of views globally through these promotional activities (*39*) (Fig. 3).
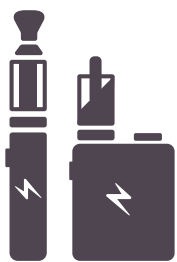
Marketing of new and emerging products

The tobacco-product landscape and patterns of tobacco use have changed substantially in recent years. New portfolios of nicotine and tobacco products and their advertisement have generated concern among the public health community and regulators. There are three distinct categories of these products: electronic nicotine delivery systems (ENDS), electronic non-nicotine delivery systems (ENNDS), also known as e-cigarettes, and heated tobacco products (HTPs) (*45*).

E-cigarettes are often promoted as "reduced-risk", "smoke-free" and "socially acceptable" consumer products. Their long-term health effects have not been established and the products are not yet regulated in most countries, allowing tobacco and related industries to continue to work around tobacco advertising bans and promote use of these new products in smoke-free environments (*46*).
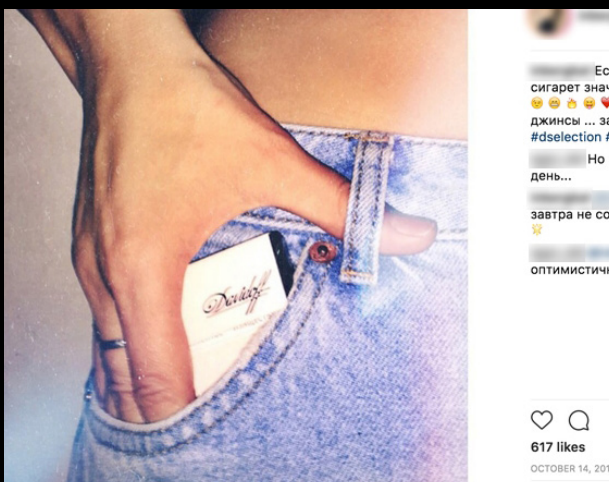
Tobacco and related industries advertise and promote their new products through traditional outlets, such as television, radio and print media, and means, including through the Internet, in retail and at recreational venues and events (*47*). Studies show that e-cigarette advertisements in magazines that primarily target young women portray users having fun with friends and being cool (*48*). Marketing of e-cigarettes and HTPs on social media position these products as socially attractive and associate their use with having a good time, relaxation, exclusivity, partying, freedom and sex appeal, themes that may be considered important to young people, especially young women (*47,49,50*).

Social-positioning techniques and marketing tactics employed by the industry effectively target adolescents and young adults and have the potential ultimately to promote smoking and sustain nicotine addiction in young people globally.

Funding women's groups

The tobacco industry has tried to align itself with women's advocacy groups over the years, most significantly by offering funding. This represents an attempt to improve their corporate image among women and fulfil corporate social responsibility (CSR) measures. Maintaining an image as a socially responsible organization is important for tobacco companies, as unfavourable public opinion can create support for tobacco-control measures (*51*).

The areas in which tobacco companies have repeatedly invested include supporting women's organizations working on domestic violence (*26,27*), sponsoring academic careers (*52*) and building support among more credible groups, including local communities, nongovernmental organizations (NGOs) and artistic/athletic organizations (*53*).

The industry has also attempted to stir up opposition to tobacco-control efforts by encouraging social class-based objections to tobacco taxes among working-class women via sponsorship initiatives (*54*). It has funded women's groups to advance their agenda, change perceptions of the industry among populations and divert attention from, and promote criticism of, tobacco-control messages.

Examples of marketing strategies described above show that tobacco companies employ a variety of tools to continue advertising their products to girls and women, despite strengthened efforts by countries to regulate these and other promotional activities. They also emphasize that a comprehensive approach to, and proper enforcement of, TAPS bans, including building awareness on why NGOs, community groups and influential groups/individuals must stay vigilant to offers of funding from the tobacco industry, are needed to protect the health of different population groups, particularly women and girls.

Packaging and product design

The tobacco industry consistently uses design strategies to attract more women and girls to their products, drawing on gender norms of femininity through colours, images, and sizes and shapes of packaging (such as creating pink packs and packs that mimic cosmetics packaging). Package design provides a key communication channel between tobacco companies and consumers and may be used more aggressively as a marketing tool in countries where other forms of advertising have been outlawed. It therefore is vital to remove this promotional opportunity.

Studies suggest that packaging can influence perceptions of the risks of smoking. Some have found that women and girls viewed so-called super-slim and lipstick-style cigarette packs as being less harmful (*55*), and available evidence suggests that terms such as "light" and "mild" mislead women in the same way (*8*). CEDAW has called for a ban on such terms (*26*). Other studies have shown that young people draw a correlation between the colour of packaging and the strength/harmfulness of the cigarettes, with lighter-coloured packets being perceived as less dangerous (*56*). Most countries in the WHO European Region (96%) prohibit use of deceitful terms, including "light", "ultra-light" and "mild", on cigarette packages. Figurative and other signs, including colours or numbers, are banned in 72% of the countries (*28*).

Such misleading marketing tactics continue, however, with the tobacco and related industries advocating for the harm-reduction approach through their new products, including e-cigarettes and HTPs. With their sleek, minimalist and stylish designs, e-cigarettes and HTPs are promoted as modern, high-tech and high-end lifestyle products. The design features also allow products to be deceptive, resembling USB flash drives and making them easy to conceal in a young person's hand (*46*).

Health warnings on packaging

The European Commission adopted a library of 42 pictorial health warnings for use by European Union (EU) Member States in May 2005. An examination of women's representation in these images by the International Network of Women against Tobacco – Europe found that when the most severe health risks of smoking were portrayed, a man was always featured, whereas when cosmetic risks (such as wrinkles) were highlighted, a woman was featured (*57*). The 42 images used by EU Member States were revised in 2014, resulting in female-presenting people appearing in 31% and male-presenting people in 40% of warnings, with clear differentiation in the portrayals (Fig. 4). Some of the portrayals appear to draw on gender stereotypes and gender-unequal messaging, with women most likely to receive warnings regarding reproduction and maternity and men never being shown as a loved one or carer.

The WHO European Region has made strong advances at global scale with implementation of health warnings. The number of countries having large health warnings on cigarette packages in the Region increased from three in 2007 to 38 in 2018 (*59*). More than 80% of the countries require graphic images to be used on packages and nine have passed legislation on plain packaging, with some already having implemented this measure (*28*). The 27 Member States of the EU and five Member States of the Eurasian Economic Union are strong contributors to this progress, as all of them have incorporated the requirements for large graphic health

Fig. 4. Analysis of the library of pictorial health warnings used by the European Commission

REPRESENTATION IN PORTRAYALS **OF MOST SERIOUS OR FATAL RISKS OF SMOKING**

11%

89%

- Male-presenting
- Female-presenting

MALE-PRESENTING IMAGES

19%

81%
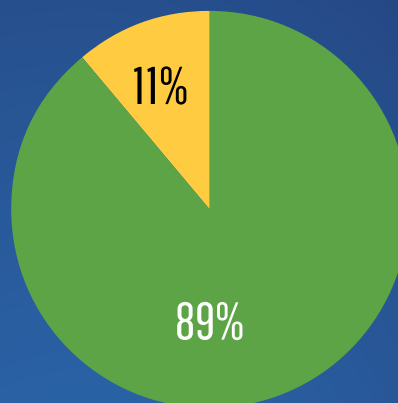
- Visibly in ill health themselves
- Loved one or carer
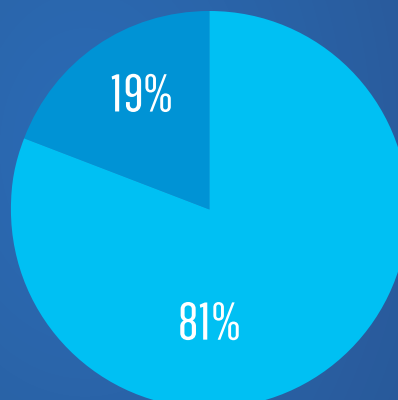
FEMALE-PRESENTING IMAGES

38%

31%

31%

- Visibly in ill health themselves
- Loved one or carer
- Harming child, unborn child or fertility
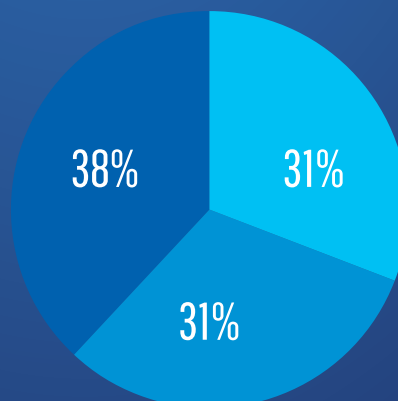
Source: European Commission (*58*).

warnings required by Directive 2014/40/EU (*60*) and the Technical Regulations for Tobacco Products (TR TC 035/2014) (*61*) respectively.

Further consideration should be given to incorporating gender-equal messaging in graphics to ensure that health information reaches all target groups effectively.

Flavoured tobacco

Many added ingredients are used by the tobacco industry to make tobacco products more appealing to potential and existing users (*62*). They can mask the harshness of tobacco, mimic flavours of candy, gum and fruits, and create the impression that products have health benefits or increase the consumer's vitality (*63*). Ingredients include flavours and flavour capsules that are known to be more appealing to women as embellishments (*64*).

Studies show that age and gender are the predictors of flavoured tobacco and nicotine product use, with these products being most popular with young people and women (*65–75*). Menthol and flavourings may be used to soften the strong earthy flavour of tobacco and attract new young smokers who are prone to experimentation and risk-taking behaviours, facilitating progression to regular use. To date, researchers have identified that over 15 000 e-cigarette flavours are available, including those proven to appeal to young people (such as cotton candy and gummy bear) (*46*). Studies show that young people consider appealing flavours to be the main reason for starting to use e-cigarettes (*47*). Restricting access to flavoured tobacco and nicotine products therefore may help to slow the tobacco epidemic, particularly among groups like young people and women (*66*).

The WHO FCTC recommends regulation of flavours that make smoking more palatable (*68*). Turkey was the first country in the European Region successfully to introduce a ban on flavoured cigarettes, including menthol[2] (*69*). Other countries of the European Region have also taken actions to regulate these products, largely due to strong legislation from the EU (Box 2, and see Box 3 for an example from Finland). In total, 29 countries of the European Region have banned menthol cigarettes and rolling tobacco, and 30 have banned cigarettes and rolling tobacco that contain other flavourings (WHO, unpublished data, 2019).

More work nevertheless must be done in this area if smoking initiation rates are to be reduced in girls, who are most vulnerable to these forms of tobacco use. This is also true of smokeless tobacco, which is particularly popular with young people. Only seven countries in the European Region have taken steps to ban menthol in these forms of tobacco products (WHO, unpublished data, 2019).

EU-WIDE BAN ON THE SALE OF FLAVOURED CIGARETTES

An EU-wide ban on the sale of flavoured cigarettes, including menthol, was introduced in May 2016 under Directive 2014/40/EU (*60*) of the European Parliament. While retailers were allowed a year to sell stocks of other flavours, the phase-out period for menthol was extended for a further three years and went into effect on 20 May 2020 (*70,71*). There was

Box 2.

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2   Legislation was adopted in 2015 and will be implemented fully in 2020.

no sell-through period for menthol cigarettes, meaning that retailers had to have sold their remaining stock by the due date.

The ban applies to menthol cigarettes, capsules, click ons, click & roll, dual menthol cigarettes or roll-your-own (RYO) products that come in the same packaging. The directive does not include in the ban mentholated papers and filters sold separately from RYO tobacco products or tobacco products such as cigars, cigarillos and pipe tobacco (*60*), nor does the ban apply to HTPs or e-cigarette products.

A 2014 leaked tobacco-company document indicated that the company opposed flavour bans and saw the European menthol ban as a threat to its business (*70*). Tobacco companies have taken action to circumvent and undermine the menthol ban through various methods, including lobbying the European Commission to further postpone the ban, developing new products, and encouraging users to switch to vaping or other alternatives that the directive does not affect[3] (*70,71*).

Box 3.

FINLAND'S BAN ON CHARACTERIZING FLAVOURS AND AROMAS USED IN E-CIGARETTE LIQUIDS

The Finnish Tobacco Act (*72*) was broadened in 2016 to cover not only tobacco, but also all nicotine products, including e-cigarettes. Finland introduced pioneering e-cigarette regulations that banned use of flavourings, set minimum-age limits for buyers, provided import restrictions, banned the use of e-cigarettes in non-smoking areas and prohibited marketing, displaying and distance-selling. Following these revisions to the Tobacco Act, liquids used in e-cigarettes are available exclusively in tobacco flavour in Finland (*73*).

The e-cigarette industry made numerous attempts to undermine the new legal provisions, including lodging appeals in 2018 and 2019 against the flavour ban on products in vape shops and employing marketing ads on buses, with the latter being swiftly prohibited by the national enforcement authority (*74*).

Through a combination of swift action and stringent regulation, Finland achieved further declines in smoking prevalence (from 15% in 2016 (*75*) to 14% in 2018 (*76*)) without seeing a contingent rise in daily e-cigarette use (less than 1% in 2018 (*28*)).

The country has set an ambitious goal of bringing both tobacco and nicotine products below a prevalence rate of 5% within the next decade. The Tobacco Act will be revised again in 2020 to ensure that tobacco control remains ahead of the industry and that protections are in place for all population groups, including young people and women (*74*).

Education, communication and public awareness

A key element of any comprehensive tobacco-control policy is communication of the dangers of tobacco use and SHS and the benefits of quitting. Well designed, hard-hitting anti-tobacco mass media campaigns can reduce tobacco use, and there is strong evidence that mass media campaigns increase quit attempts, lower initiation rates among young people and reduce SHS exposure (*28*).

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3   HTPs, menthol or flavoured e-liquid flavours, as well as other tobacco-free nicotine products, are exempted from this decision.

Governments sometimes neglect public education campaigns as they can be costly, especially if broadcast on television. As of 2018, the proportion of European countries conducting anti-tobacco national campaigns that were aired on television and/or radio and lasted at least three weeks was only 30% (or 16 countries) (28). Anti-tobacco mass media campaigns do not have to be expensive, especially if advertising is adapted from content that has been used successfully in other countries and costs are transferred to the tobacco industry, or tobacco tax revenues or similar mechanisms are dedicated to mass media campaigns. Another option to cut costs is to obtain free or low-cost television and radio time from broadcasters: in Turkey, free air time (90 minutes per month) for anti-tobacco mass media campaigns is mandated by law (77,78). Emerging communication tools such as social and digital media may also be considered for use with many key populations, including young people. Evidence shows that the costs of social media campaigns are less, while users help to increase the dissemination of messages and, through this, reach and mobilize large population groups to advocate for tobacco-control policies (77).

Public health campaigns with a focus on preventing smoking among young people must be gender-sensitive, as the reasons for starting smoking differ between boys and girls. Girls appear to be more affected by a positive image of smoking, desire to control weight and perception that smoking negates negative mood (27). Children should be taught through education on tobacco use in schools to identify and deconstruct gendered messaging in tobacco marketing and challenge narratives of smoking as "cool" or "empowering" for girls. In 2018, only eight countries in the European Region had implemented education programmes specifically designed for underage girls and young women, and only 10 had implemented programmes specifically designed for women (79) (down from 15 countries in 2016 and 17 in 2014).

Tailored public health campaigns present an opportunity to reach women with positive health messages, but attempts to influence women and girls often employ gender-unequal messaging, such as drawing on women's beauty expectations or comparing smoking to sexual violence (80,81). This ultimately reinforces harmful stereotypes that are bad for health and alienates potential civil society allies such as women's groups.

Box 4 describes an innovative campaign with a clearly defined target group in Australia.

"SMOKE FREE, STILL FIERCE" CAMPAIGN, NEW SOUTH WALES, AUSTRALIA

Box 4.

This campaign, launched in May 2016, was supported by the Cancer Institute of New South Wales partnered with ACON, an LGBTI[a] health organization. It was aimed at lesbian, bisexual and queer women based on evidence that they are significantly more likely to smoke than heterosexual women, despite many reporting a desire to quit (82). The campaign platformed real women who discussed their difficult but successful journeys to quitting. The case studies provided smokers with someone they could relate to, and the focus on real women's success enabled a tone of positivity and empowerment, rather than one of shame or fear.

This example demonstrates the value of engaging directly with advocacy groups. They are best placed to understand the needs and experiences of the marginalized groups they represent and are likely to have an extended reach.

[a] The I in LGBTI stands for intersex.

Smoke-free policies

Globally, around 1.2 million people die from SHS exposure every year (*83*). According to WHO estimates, women constituted 64% of all SHS-related deaths in 2010 (*84*). Even in countries where few women use tobacco, they suffer the risks of breathing SHS (*16*). Men smoke in greater proportions across the Region, meaning women often are subjected to SHS in the home while carrying out domestic tasks, entertaining or even sleeping. This partially is explained by their disproportionate contribution to domestic labour, with many women in the European Region staying home full-time. The average labour-force participation for women in European Region countries in 2018 was 50.8% against 66.9% for men, and only 30 countries had women's labour-force participation of over 50% (*85*). The likelihood of women working in this private domain puts them at a disadvantage in terms of regulated protection from SHS exposure. Traditional gendered hierarchies in the home could also play a role here, with women more likely to lack negotiating power to establish a smoke-free home.

Exposure to SHS results in health effects such as eye irritation, breathing problems, and increased risk of heart disease, stroke, and breast and lung cancer, especially in young women (*8,27*). Those exposed to SHS tend to engage more often in tobacco use. This is of particular relevance for exposure among children in the European Region, some of whom start smoking as early as 11 years (*10*); 12.6% of adolescents aged 13–15 years in the Region, amounting to 3.9 million young people, already are using tobacco, signalling a matter of great concern. Studies show that young people living in homes with restrictive smoking rules are less likely to experiment with cigarette-smoking and take up smoking later in life. Permissive home-smoking policies are more strongly related to regular smoking in girls than boys (*86*).

Smoke-free policies in workplaces benefit both women and men, with countries introducing comprehensive smoke-free workplace legislation reporting an equal reduction in tobacco-smoking in men and women (*26*).
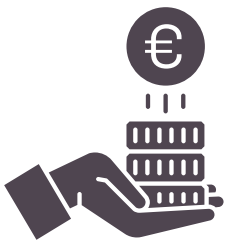
Price and taxation

Evidence from countries of all income levels shows that price increases on cigarettes are highly effective in reducing smoking prevalence and consumption in young people and adults. Higher prices on tobacco products encourage cessation and prevent initiation of tobacco use, with children and adolescents being more sensitive to price increases than adults (*87,88*). These findings suggest that tax increases (leading to price increases) are an effective means of reducing and discouraging tobacco use among children and young people.

The relationship between tobacco prices and patterns of tobacco use by gender are complex, and the evidence from systematic reviews suggests a mixed picture. Some studies show that women's consumption of cigarettes is less responsive to changes in cigarette prices than men's, while others conclude the opposite (*89*).

Some studies have also looked at the impact of cigarette tax and price increases on consumption among pregnant women and found that higher cigarette taxes lead to significant decreases in maternal smoking rates. Increased prices do not decrease average consumption among those who continue to smoke, however (*89*).

The number of studies of price–responsiveness of various demographic and socioeconomic characteristics is growing, and there are clear indications that price is

likely to be effective in reducing smoking rates among young people. More research is needed, however, to understand the impact of taxation on smoking prevalence by gender and its potential relationship to women's economic disadvantage.

Cessation support

Access and biases within health research and health care

Globally, women experience gender-based barriers in terms of access to appropriate high-quality treatment. Systemic biases mean women are less likely to receive the most appropriate and safest medicine. Health professionals are not equipped to deliver the most tailored, gender-sensitive care to women, compromising the quality of treatment for tobacco-related illness and cessation programmes.

Women are underrepresented in clinical trials (*15*) and in smoking-cessation drug trials (*90*). This results in them being "1.5 times more likely to develop adverse reactions to medication due to differences in female and male responses" (*15*), which could signify a lack of focus on women at trial stage.

In terms of health outcomes, women experiencing tobacco-related morbidities such as CVD are likely to receive poorer standards of care because of gender biases. CVD has become the biggest killer of women in the European Region, but the women's health strategy notes a bias within the health system in that CVD continues to be seen as a men's issue (*9*). A review of clinical trials in Europe focusing on CVD and risk factors showed a disproportionately low number of women enrolled in studies (fewer than 35% on average) and that few trials disaggregate results by sex (*15*).

Another issue of concern is that social power relations and inequalities are still present in patients' interactions with health professionals, with women's reported symptoms potentially being taken less seriously. Studies have found that women are asked fewer questions and given fewer examinations and diagnostic tests (*91*). One study found women of "diverse race and ethnicity" who were being treated for CVD were less likely than men to receive high-quality care (*26,92*), exemplifying the heightened disadvantage of women marginalized on multiple measures.

Gender disparities in tobacco cessation

Sex-disaggregated data on the specifics of health-care-seeking behaviour show that women tend to have higher rates of health-care utilization (*26*). This is also true for tobacco cessation, with women and men taking different approaches. Higher utilization of quitline services among women has been reported in several countries, including Romania and Sweden (*27*). Women are more willing to seek advice and assistance to quit tobacco, but often face problems with access to services due to lack of transport, childcare commitments and cultural barriers, including stigma (*57*).

Gender differences are also noted in the ability of men and women to stop smoking, with some studies showing that in any given quit attempt, women have lower success rates than men (*93*). The lowest quit rates have been observed in young women, those who live in deprived areas and/or those from ethnic minorities (*8*).

Smoking-cessation programmes developed for women tend to focus specifically on smoking during pregnancy. While this is important, there is a need to develop broader programmes to support women in stopping smoking throughout their lives (*57*). Programmes focused on expectant fathers that emphasize positive aspects of masculinity and increase quitting rates among men are also needed to support mothers' health (*26,94*).
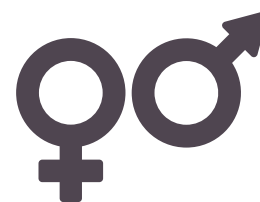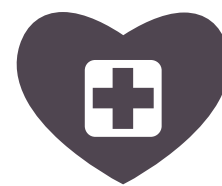
Gender-responsive tobacco control

The first two chapters described briefly why more attention should be given to incorporating gender considerations into tobacco control, reflecting high rates of tobacco use in women and girls in WHO European Region countries, continuous utilization of gender stereotypes by the tobacco industry in its marketing campaigns, and the impact of tobacco-control interventions on women and girls. This chapter lays out a gender-responsive approach that could be implemented to tackle the high prevalence of tobacco use in women in the European Region and describes clear policy options for gender-responsive tobacco control aligned with the WHO FCTC guidelines, including actions to reduce exposure, increase participatory processes and improve the design of health-system responses.

WHO gender-responsive assessment scale

Health policies (like health promotion initiatives) often use gendered norms and stereotypes, such as women primarily being concerned with body image, to convey key health messages. Anti-tobacco campaigns, for example, are known for building links between consumption, weight and appearance when they target women with health messages. This may have a direct effect on the target audience, but may also perpetuate gender stereotypes that are harmful to health (*95*).

The links between gender and other social and economic determinants of individual behaviour can be missed in public health campaigns. Campaigns targeting smoking during pregnancy, for example, may place the sole responsibility on women, take a judgemental approach or ignore socioeconomic status (*95*).

The WHO gender-responsive assessment scale (known as the GRASS tool) (Fig. 5) was designed as a mechanism to assess the gendered implications of health policies and initiatives. They can range from "gender unequal", reinforcing harmful gender relations, to "gender transformative", fostering gender equality as an objective, actively combating harmful gender norms, roles and relations, and addressing inequalities at their root cause. The use of the GRASS tool during the development of tobacco-control policies and initiatives can lead to better health outcomes for all population groups.

Options for gender-responsive tobacco control

The WHO FCTC has the potential to protect women and all groups from the harms of tobacco, with one of its guiding principles (outlined in Article 4.2(d)) being "the need to take measures to address gender-specific risks when developing tobacco control strategies" (*1*). This potential of the WHO FCTC can be realized fully if gender is mainstreamed as a concern at every level of policy-making. A better understanding of the relationships between gender, tobacco and health, and of the evidence on effective gender-responsive interventions, can enable countries to strengthen their tobacco-control efforts, improve gender equity and reduce the health impacts of tobacco on all population groups.

Fig. 5. WHO gender-responsive assessment scale

Gender transformative

Aims at transforming harmful gender norms, roles and relations

Gender specific

Considers women's and men's specific needs

Gender sensitive

Acknowledges but does not address inequalities

Gender blind

Ignores gender norms

Gender unequal

Perpetuates inequalities

GENDER-RESPONSIVE POLICY

CONSIDERS GENDER, NORMS, ROLES AND RELATIONS

TAKES ACTIVE MEASURES TO REDUCE HARMFUL EFFECTS

Source: WHO (*96*).

Evidence increasingly demonstrates that gender characteristics play a significant role in people initiating, maintaining and quitting tobacco use (*97*). Effective and equitable implementation of the WHO FCTC therefore requires that these differences be addressed through intersectional approaches.

Gender-sensitive policies and measures that countries may consider implementing, including those highlighted in recent publications and WHO FCTC Conference of the Parties decisions, are outlined in Table 1.

Table 1. Examples of potential actions

PRIORITY AREA	EXAMPLES OF RELEVANT TOBACCO-CONTROL POLICY ACTIONS
TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP	- Fully implement the WHO FCTC recommendations on advertising, promotion and sponsorship of all tobacco products, ensuring TAPS legislation covers all types of media, and analyse the impact of these policies by sex and gender (*26,98*) - Consider banning or restricting TAPS of novel and emerging products, including ENDS/ENNDS (*99*) - Empower women, girls, boys, men and other gender groups to identify and counter influences from tobacco advertising, promotion and sponsorship (*97*) - Introduce strong gender-sensitive health warnings on all TAPS notices (*57*) - Continue research into, and monitoring and reporting of, gender-specific tactics used by the tobacco industry in its marketing activities (*57*) - Urge social media influencers and celebrities to reject any financial support and sponsorship from tobacco companies, and explore involving influencers across the European Region in promotion of anti-tobacco messaging to women, girls and underage users, given the success of the influencer industry and its access to these demographic groups (*100,101*) - Prohibit any contributions from tobacco companies for "socially responsible causes" (*102*) - Develop relationships with women's groups by supporting their wider aims; such alliances would raise awareness around tobacco CSR tactics and the importance of boycotting tobacco money, and enable greater reach to vulnerable women (*26*)
PRODUCT DESIGN	- Prohibit use of flavours and other ingredients that make tobacco products (*68,98*) and novel products such as ENDS/ENNDS (*99*) more attractive to existing and potential users, including children and women
PACKAGING AND LABELLING	- Implement WHO FCTC recommendations on the packaging and labelling of tobacco products and promote the introduction of standardized plain packaging across the European Region to circumvent targeting of women by the tobacco industry through targeted packaging (*103*) - Implement health warnings about potential health risks deriving from the use of novel tobacco products; health warnings may additionally inform the public about the addictive nature of nicotine in ENDS (*99*) - Develop and implement textual and pictorial health warnings that reflect gender-specific patterns of tobacco uptake and cessation, ensuring a gender balance of identities represented (*97*) - Undertake premarketing testing to assess the effectiveness of health warnings on packages on the intended groups (*57*)

Table 1. contd

PACKAGING AND LABELLING

- Consider developing graphic health warnings for packages of all tobacco and nicotine products depicting severe health risks and featuring women of different ages and backgrounds (*57*)
- Ensure warnings targeting women move away from a disproportionate focus on maternity to reach women at every stage of the life-course and appeal to their many other health concerns (*6*)
- Provide information on available cessation support (such as a quitline number or website address) on the packages of tobacco products (*103*)
- Ban single-stick and 10-packs of cigarettes sales to discourage minors, low-income and first-time smokers (*103*)

EDUCATION, COMMUNICATION AND PUBLIC AWARENESS

- Warn women and girls, boys and men about the dangers of tobacco and exposure to SHS through gender-sensitive information and communication (*97*)
- Ensure that policies and programmes for education and awareness integrate a gender perspective, promote positive gender norms and avoid drawing on stereotypes, are developed with the participation of all affected population groups, and are evaluated for their impact on reducing smoking uptake and promoting smoking cessation among different population groups (*26*)
- Involve women and gender experts at every stage of the process, from design of the communication campaign to its delivery (*57*)
- Use new digital media, especially those targeting girls and young women, to raise awareness and educate about the dangers of tobacco (*57*)
- Use school-based health programmes that focus on skills-training approaches effective in reducing the onset of tobacco use to educate children and adolescents (*104*)
- Avoid treating women as one homogenous group, but rather acknowledge how womanhood intersects with other aspects of identity, tailoring health campaigns to reach out to women suffering multiple marginalization
- Provide platforms and visibility for women from marginalized groups who have smoked and successfully quit
- Promote influential women who have quit smoking as positive role models, thereby reversing the tactics of the tobacco industry on use of influencers
- Partner with women's and LGBTQ groups for extended reach and greater insight into the needs and experiences of campaign target audiences
- Develop powerful health education messages portraying freedom from tobacco as a woman's right and encouraging women to take control of their own health (*57*)

SMOKE-FREE POLICIES

- Adopt and implement comprehensive smoke-free laws in line with WHO FCTC recommendations, and consider widening the scope of smoke-free legislation through prohibition of the use of novel and emerging nicotine and tobacco products in places where smoking is banned (*1,97*)
- Empower individuals, particularly women, through gender-sensitive education efforts to create smoke-free environments (*97*)
- Consider further strengthening efforts to protect children, adolescents and women through prohibiting smoking in outdoor public places, such as playgrounds, sport arenas and parks, and in private vehicles and dwellings
- Strengthen collaboration with women's empowerment groups to increase awareness and take stronger action on smoking and SHS exposure

Table 1. contd

TOBACCO TAXATION

- Increase the price and level of taxation in line with WHO FCTC guidelines, as this will have the greatest population-level impact (*26*)
- Tax ENDS/ENNDS at a level that makes the devices and e-liquids unaffordable to minors to deter use in this age group (*99*)
- Raise taxes on tobacco with the active participation of women leaders, and earmark revenue to specific tobacco-control activities benefitting women, adolescent girls, boys, men and other groups (*97*)

TOBACCO CESSATION AND GENDER-RESPONSIVE HEALTH SERVICES
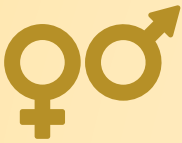
- Ensure that cost-covered nationwide support, such as brief advice and toll-free quitline services, are available to all (*105*)
- Train health professionals and community organizers in gender-specific treatment of tobacco dependence (*97*)
- Integrate a gender perspective in tobacco-cessation programmes and evaluate their impact (*26*)
- Identify and address the different barriers to men and women gaining access to smoking-cessation support, including pharmacotherapies and services (*57*)
- Tailor cessation services and materials promoting quitting to address women's reasons for smoking and concerns about stopping (*57,106*)
- Address the different reasons and concerns of men; examples that might differ between women and men are weight concerns, dealing with stress and peer pressure to continue smoking
- Encourage antenatal and postnatal care providers to ask about a partner's tobacco use and train them in offering judgement-free guidance on available cessation support to reduce exposure to SHS in the household (*26*)
- Ensure that tobacco-control messages in maternal health programmes focus on the health of the child before and after birth and on health benefits for the mother to support long-term quitting (*57*)
- Review women's representation in trials for tobacco-cessation drugs and nicotine replacement therapy within the European Region to ensure drugs are tested adequately on women as well as men
- Promote sex- and gender-based analysis tools to aid health researchers in tobacco control (*107*)
- Ensure that national plans on universal health coverage include evidence on tobacco and gender (*26*)
- Embed gender awareness into medical training, equipping staff to appreciate bias, social power dynamics between patient and doctor, and limitations of treatments due to, for example, underrepresentation of women in drug trials (*9*)
- Promote gender-responsive health systems that are available, accessible and effective for all population groups, and deliver quality tobacco-cessation services for all (*26*)
- Promote women-centred and gender-sensitive interventions for prevention and management of tobacco use and exposure to SHS in pregnancy that are grounded in human rights (*26*)

POLICY AND PROGRAMME FORMULATION, IMPLEMENTATION AND EVALUATION

- Recognize the role of gender in tobacco exposure and use, health outcomes, health-care use and treatment pathways, and develop and implement gender-responsive policies and programmes to reduce tobacco use and improve health outcomes in all population groups (*26*)
- Make use of gender and other identity-based indicators in the collection of tobacco-use data and increase both qualitative and quantitative research to better understand gender differences in tobacco use, dependence and cessation (*97*)

Table 1. contd

GENDER-RESPONSIVE PARTICIPATION	- Ensure women are involved in tobacco-control policy-making and implementation, including in the development of programmes for education and public awareness (*26*)
	- Ensure greater coordination between ministries of health and gender equality bodies in the context of tobacco control (*26*)
	- Mobilize leaders from different levels of government in gender equality in support of national tobacco-control legislation (*26*)
	- Ensure greater communication between tobacco-control advocates, stakeholders and the public; an informed public can act as the vanguard against the uptick in women's smoking, and women's groups are critical allies and communicators of tobacco-control messages (*26*)
	- Provide financial support for women's empowerment and community-development programmes to ensure that tobacco-control aims and objectives are incorporated (*26*)

Table 1 outlines some ideas about action that could and should be taken by countries if they want to ensure that rates of tobacco use among girls and women decrease over time. To revert the currently observed slow progress in reducing tobacco use in these population groups, it is necessary to address issues through a gender lens and make sure that national tobacco-control policies are in line with the WHO FCTC and are both intersectional and gender-responsive.

Further opportunities for organizations and governments to integrate gender into policies and actions are presented through promotion of approaches to tobacco control that build bridges among public health, human-rights concerns and national sustainable development plans. These provide instruments and arguments to support tobacco-control measures, including collaboration of a broader coalition of stakeholders (governments, international organizations, civil society, women's empowerment and community-development programmes, academia and the corporate sector) concerned with, and advocating for, gender equity in health and development that so far have been underutilized (*10,26*).

Conclusion

Unless drastic interventions are made in relation to tobacco use among women and girls, the European Region will face a crisis. If the health of women is to be protected, it is not enough to add gender as an afterthought – it must be an integral factor throughout the health-policy process. Gender is not biologically determined. It is a construct that determines rights, power relations, vulnerabilities, health-seeking behaviours and health outcomes. The tobacco-control community must put it at the heart of action.

Policies and programmes should be revised to ensure they are gender-transformative rather than gender-unequal and should incorporate intersectional approaches to demarginalize groups of women who may be left behind in tobacco control. Tobacco-control policy-makers must acknowledge their own roles in creating and challenging gender stereotypes, both in the classroom and on the billboard. In a similar vein, sex-disaggregated and gender-sensitive data must be the norm in research to facilitate extrapolation of gender-specific trends.

With TAPS moving increasingly online and the industry developing innovative products and procedures to ensnare women into tobacco dependency, urgent, creative action is required. Further research and subsequent regulation must take place in the online sphere. Tobacco promotion and sponsorship should be banned across the European Region, and tobacco control must equip itself to tackle the threat posed by online and social media advertising.

Women's groups should be engaged and empowered in all processes of tobacco-control policy-making, design and implementation. This not only offers a means to protect such groups from nefarious industry intervention and CSR, but also builds targeted policy and stronger alliances among civil society and tobacco control.

Health systems across the European Region must take on a gender-transformative agenda, with staff receiving adequate training. Bias against, and exclusion of, women's needs within health research should be addressed to enable the European Region to combat the surge in female tobacco-related deaths.

Addressing women's tobacco use in the European Region is about leapfrogging – getting ahead of the tobacco epidemic in an effort to surpass the acceleration in women's tobacco use across the European Region and avoid a surge in female mortality. This is especially the case for countries in which women's smoking remains relatively low.

The power to take on the industry and protect the lives of women and girls is in policy-makers' hands. The only question remaining is if the will exists to implement these next steps to reduce tobacco-use prevalence in women further – and for good – in all countries of the WHO European Region.

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