Women and Healthy Living in Canada

Fact Sheet Number 3 Fall 2012

SMOKING TOBACCO

Smoking rates are decreasing in Canada but there are groups of women where smoking rates are higher, including women living with low income and Aboriginal women.

RETHINKING WOMEN AND HEALTHY LIVING IN CANADA

Rethinking Women and Healthy Living in Canada: Challenging the Discourse, Evidence and Practice examines the sex, gender, diversity and equity dimensions of healthy living among women in Canada by conducting sex- and gender-based analyses of the healthy living discourse, key healthy living topics and selected healthy living strategies.

Fact sheets on women and healthy living have been prepared on physical activity, sedentary behaviour, self-injury, food insecurity, sodium, tobacco, alcohol, sexual behaviour and condom use.

Learn more at www.womenshealthdata.ca

In 2011, 17.9% of women reported current smoking in Canada [1]. Overall smoking rates are decreasing but there are groups of women were smoking rates are higher including young women, women living with low income, single mothers, Aboriginal women [2] and women who have survived sexual and physical abuse [3].

Women are also exposed to other people's tobacco use. In 2010, 5% of non-smoking girls and women (aged 12 years and older) reported being exposed to second-hand smoke at home and 15% in vehicles and/or public places [1].

Sex- and gender-based analysis

Sex–and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

1. ***Sex*** refers to the biological characteristics that distinguish male from female bodies. Sex differences include different chromosomal patterns, reproductive organs, hormones and proportions of fat to muscle.

2. ***Gender*** refers to socially constructed roles, relationships, attitudes, behaviours, relative power, etc., that shape and describe what it means to be male or to be female in a society.

3. ***Diversity*** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.

4. ***Equity*** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [4].

Sex issues

Research suggests that girls and women may be particularly vulnerable to the effects of smoking and exposure to second-hand smoke. Women who smoke are at risk of developing heart disease, chronic obstructive pulmonary disease, cervical cancer, lung cancer, and breast cancer [2, 5]. Smoking may also have detrimental effects on women's reproductive function including decreased fertility and early menopause [6].

There are delayed sex-specific effects of second-hand smoke that may put girls and women at particular risk of certain health outcomes such as breast cancer [5, 7] .

Smoking during pregnancy can result in health risks for both the women and the fetus, including increased risk of preterm delivery, spontaneous abortion, growth restrictions for the fetus and could potentially increase the risk of long-term behavioural and psychiatric disorders for the child [8].

It has also been suggested that women metabolize nicotine differently than men [9] and that nicotine replacement therapy may be less effective for women [7, 10].

Gender issues

Several gender-related factors can influence women's smoking behaviour and exposure to second-hand smoke, including unequal power and income differences. For example, some women may not feel comfortable, or have the power, to implement smoke-free policies in the home or in the car if their partner smokes. Women are also more likely to work in the service-industry or in private homes where they may be exposed to second-hand smoke [11]. Fear of weight gain is a barrier for many women to stop smoking, as women encounter tobacco marketing which brand cigarettes as a means to achieve cultural ideals of thinness [12].

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Diversity issues

Smoking rates in Canada tend to vary depending on where women live, their income and education level, by age and Aboriginal identity. Results from the Canadian Community Health Survey (CCHS) 2009/2010, suggest that daily smoking rates are higher among women with low income and low levels of education. Young women are also more likely to smoke and rates tend to decrease with age. The largest proportion of daily and occasional smokers can be found in the three territories (Yukon, Nunavut and the Northwest Territories) and it has been estimated that smoking rates in the Aboriginal population could be more than twice as high as in most Canadian provinces [13].

Equity issues

Female smokers in Canada often occupy marginalized social positions in relation to socioeconomic status, Aboriginal status, sexual orientation and/or experiences of trauma or mental illness. Although smoke-free policies have been effective in reducing smoking rates in the general population, these declines have not been equitable across population subgroups [7] and it has been suggested that smoke-free policies may contribute to inequities. For example, the 'denormalization' of tobacco use may result in smokers having difficulty finding housing and they may be discriminated against at work. Feelings of shame may also prevent smokers from seeking health care and accessing smoking cessation services [14]. Some argue that smoke-free policies have had particularly limited impact on girls and women with low socio-economic status [7].

Pregnant women may also be particularly vulnerable as the social stigma attached to smoking during pregnancy may cause additional delays in treatment and prevent many women from seeking cessation assistance.

Critique

Smoke-free policies have been largely gender-blind [7] and have not considered socio-economic disparities [15] despite that fact that the large majority of female smokers occupy marginalized social positions and often have low income. Smoke-free policies should therefore adopt a health and social justice approach to reduce inequity, and it has been suggested that smoke-free policies should be accompanied with cessation programs [11]. There are currently no detailed, large-scale surveys or surveillance initiatives focusing specifically on Canadian women's tobacco patterns and more research is needed to accurately understand why women start and continue to smoke, in light of evidence of the harmful health effects.

FOR MORE INFORMATION

BC Centre of Excellence for Women's Health:
www.bccewh.bc.ca

Atlantic Centre of Excellence for Women's Health:
www.acewh.dal.ca

Prairie Women's Health Centre of Excellence:
www.pwhce.ca

The Source:
www.womenshealthdata.ca

La Source:
www.lasourcesantedesfemmes.ca

SGBA e-learning resource:
www.sgba-resource.ca

References

[1] Statistics Canada. Health Trends. http://www12.statcan.gc.ca/health-sante/82-213/index.cfm?Lang=eng

[2] Poole N & Greaves L (eds). (2007). Highs and Lows: Canadian Perspectives on Women and Substance Use. Toronto: Centre for Addiction and Mental Health.

[3] Nichols HB & Harlow BL. (2004). Childhood abuse and risk of smoking onset. Journal of Epidemiology and Community Health, 58(5):402-6.

[4] Atlantic Centre of Excellence for Women's Health, British Columbia Centre of Excellence for Women's Health & Prairie Women's Health Centre of Excellence. SGBA e-Learning Resource: Rising to the Challenge. http://sgba-resource.ca/en/

[5] Johnson KC, Miller AB, Collishaw NE, Palmer JR, Hammond SK, Salmon AG, et al. (2011). Active smoking and secondhand smoke increase breast cancer risk: the report of the Canadian expert panel on tobacco smoke and breast cancer risk. Tobacco Control, 20(1):e2.

[6] Health Canada. Health Concerns - Smoking and Your Body. http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/body-corps/preg-gros-eng.php

[7] Amos A, Greaves L, Nichter M & Bloch M. (2012). Women and tobacco: a call for including gender in tobacco control research, policy and practice. Tobacco Control, 21(2):236-43.

[8] Shea AK & Steiner M. (2008). Cigarette smoking during pregnancy. Nicotine & Tobacco Research, 10(2):267-78.

[9] Brady KT & Randall CL. (1999). Gender differences in substance use disorders. Psychiatric Clinics of North America, 22(2):241-52.

[10] Cepeda-Benito A, Reynoso JT & Erath S. (2004). Meta-analysis of the efficacy of nicotine replacement therapy for smoking cessation: differences between men and women. Journal of Consulting and Clinical Psychology, 72(4):712-22.

[11] Greaves L & Hemsing N. (2009). Sex, gender, and secondhand smoke policies: implications for disadvantaged women. American Journal of Preventive Medicine, 37(2 Suppl):S131-7.

[12] Sarna L & Bialous SA. (2004). Why tobacco is a women's health issue. Nursing Clinics of North America, 39:165-80.

[13] Statistics Canada. 2009/2010. Canadian Community Health Survey (CCHS) (master file) Statistics Canada (producer). Using remote access program of Health Division, Statistics Canada (distributor).

[14] Bell K, Salmon A, Bowers M, Bell J & McCullough L. (2010). Smoking, stigma and tobacco 'denormalization': further reflections on the use of stigma as a public health tool. A commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health Special Issue (67: 3). Social Science & Medicine, 70(6):795-9.

[15] Reid JL, Hammond D & Driezen P. (2010). Socio-economic status and smoking in Canada, 1999-2006: Has there been any progress on disparities in tobacco use? Canadian Journal of Public Health,101(1):73-8.

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