Breaking the Camel's Back: Bringing Women's Human Rights to Bear on Tobacco Control

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INTRODUCTION

Tobacco is the largest single cause of premature death in the United States1 and a major cause of preventable death throughout the world.2 Globally, tobacco is now responsible for approximately four million deaths every year.3 Of these, over half a million are women—4—a yearly loss greater than the entire population of the state of Vermont.5 In the United States now, more women die annually from lung cancer than from breast cancer, and women face increased risk for a host of tobacco-related cancers, reproductive disorders, and other debilitations.6 Confronted with evidence of this magnitude, many policy makers—in the U.S. and abroad—have taken on the issue of tobacco control and decried the spread of tobacco as a global health crisis.7 Yet despite increased efforts, tobacco control has failed a major segment of its intended beneficiaries and most crucial participants: women. Until recently, tobacco policy did not seriously consider that the epidemic might have unique implications for women's health and women's rights.8 Tobacco control typically was approached without regard to gender and framed as a matter of trade, public health, or economics—never as a matter of women's human rights. As a result, women have suffered as well as the tobacco control movement itself. For instance, failure to recognize the social and economic conditions affecting women's health has meant a decontextualized approach to policy that cannot

3. Id.
4. Id.

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address the roots of the crisis. In addition, the absence of the human rights paradigm has deprived the tobacco control movement of great political and moral force; problems now described in terms of "the global burden of disease" could be far more compelling to the public and policy-makers if framed as issues of social concern, such as violations of basic human rights. Finally, tobacco control has ignored existing resources within the field of women's human rights. Women's groups around the globe already work to educate, empower, and improve the health of women and girls; such networks could prove invaluable in slowing the spread of tobacco.

This paper will suggest that the current situation calls for a new collaboration among women's advocates and tobacco control policy-makers, using the human rights paradigm to mount a more effective response to the crisis. Section I will describe the nature and history of tobacco's use among women, demonstrating the link between spread of the epidemic and women's socioeconomic conditions. Section II will suggest the meaning of human rights within tobacco policy, first defining human rights and then articulating specific violations of women's human rights in the tobacco context. Finally, Section III will argue the utility of the proposed human rights approach for all parties, suggesting that just as tobacco control needs women in order to succeed, so do women need effective tobacco control if they are to progress toward health, power, and equality.

I. WOMEN AND TOBACCO: HISTORY AND NATURE OF THE EPIDEMIC

In 1955, in the United States, only a fraction of all female deaths were attributable to smoking. Yet by 1995, just forty years later, tobacco-related deaths among women had sky-rocketed to account for nearly a third of all deaths. As women's smoking rates rose, so eventually did their rates of tobacco-related disease begin to climb, owing both to increased use of tobacco and to growing understanding of the links between tobacco and disease. In the U.S., lung cancer now kills more women annually than breast cancer; in Sweden, lung cancer is more common in women under forty-five than it is in men of the same age. Tobacco's annual death toll on women is expected to double by the year 2020, rising to one million female lives lost every year. In short, the future is clear: "As women smoke like men, they will soon die like men."
Research now confirms that women suffer most of the same harmful health effects of smoking as men, including lung, throat and other cancers, heart disease, stroke, and cardiac arrest; reduced fertility; impaired lung function; and severe nicotine addiction. Among women in the U.S., for instance, smoking is responsible for 90% of all lung cancer, which is the greatest cause of cancer death among women. Yet women’s risk of lung cancer is minor when compared to cardiovascular disease. With smoking as its greatest risk factor, coronary heart disease is responsible for twice as many female deaths as all cancers combined and is now the leading cause of death among women over fifty in many countries, including the U.S. and Britain.

There are two major issues that increase women’s tobacco-related risk above and beyond that of men. The first factor is women’s historic exclusion from research, even in the cases of some of the most common tobacco-related diseases (e.g., lung cancer, heart disease, and emphysema), which even now are understood primarily in terms of male physiology. Although medical researchers increasingly include females in their studies, the earliest evidence on tobacco’s health effects was based on male subjects. With only men to study, early researchers could not identify the ways in which tobacco-related disease might differently affect women, much less seek to provide gender-specific treatment. As a result, some of the most widely accepted medical theories (such as tobacco’s link to heart disease) have not been fully tested with respect to women’s health. For instance, some studies demonstrate a higher incidence of lung cancer in women than in men with the same level of exposure to cigarette smoke. Though this suggests that women may be more susceptible to the carcinogenic effects of cigarettes (a factor with vast implications for health and public policy), adequate resources have not been devoted to

15. Tobacco is used in a variety of forms around the world, the most common of which is cigarettes. Therefore, while this article frequently uses smoking as a shorthand reference to all tobacco use, other products merit equal consideration in tobacco policy.

16. VIEROLA, supra note 6, at 85.
17. Id. at 54-83.
18. Id. at 211-57.
19. Id. at 113-26.
20. Id. at 38-40. See also Janet Brigham, Addiction, Expert Presentation at the WHO Conference (Nov. 15, 1999).
21. VIEROLA, supra note 6, at 7.
22. Id. at 54, 56.
26. VIEROLA, supra note 6, at 54-55.
29. For instance, regulation of the contents of tobacco products might be modified in light of the differential effects on women; legislation might mandate more smoke-free public spaces in recognition of the
researching the question further. Furthermore, many of the specific conditions that place women at risk are not made the subject of medical research. Potentially important factors such as the ways in which women are exposed—i.e., through ambient smoke rather than direct inhalation—frequently have been overlooked in the study of tobacco-related disease.

The second major issue affecting women’s risk from tobacco is their vulnerability to unique medical ailments. This issue often goes unnoticed by the medical profession or, if recognized, receives little scientific attention. As a corollary to this oversight, health workers and female patients themselves are rarely aware of gender-specific tobacco-related risks, leading to poorer preventive care and treatment. Yet the list of gender-specific tobacco-related illnesses is long: cervical cancer; lowered estrogen production and early menopause; severe and accelerated osteoporosis; hypertension due to combination with oral contraceptives; reduced and irregular ovulation; complications with pregnancy and traumatic delivery; the "silent," undiagnosed heart attack; exacerbated malnutrition and anemia; and possibly increased risk of breast, uterine and ovarian cancers.

These ailments reflect two aspects of gender-specific risk: environmental and pathogenic. The first concerns the differences between women’s and men’s social contexts, linking women’s unique risk to the impact of female environments. One example of how environmental factors can impede women’s health is the relationship between tobacco smoke and cooking oil fumes, a danger that has been signaled by some research but remains unresolved. Studies in East Asia have shown that cooking oil fumes may increase lung cancer risk. However, researchers have failed to pursue the related question of cooking oil fumes combined with tobacco smoke and the possibility that the two may interact to cause a carcinogenic effect much greater than either factor alone.

This is particularly relevant in Asian countries where cooking is done almost exclusively by women and involves frequently using oils at high temperatures. Often surrounded by men who smoke heavily, women who inhale oil fumes face a high risk of tobacco-related disease, even when they themselves do not smoke. Researchers estimate that worldwide over fifty million non-smoking women each year are exposed to environmental tobacco smoke (ETS) during pregnancy, indicating that the total number of women exposed is far greater.

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33. A recent study in China found that 63% of men smoked compared to only 3.8% of women. Gonghuan Yang et al., supra note 24, at 1247. In the Asian and Pacific Region, where nearly half of the world’s cigarettes are consumed, approximately 47% of men smoke, compared to 12% of women. Discussion Paper, supra note 25, at 1.
Given the proven harmful health effects of ETS, women's high exposure is of grave concern, especially as potentially exacerbated by cooking oil fumes. Here gender inequity coincides with risk; social status may limit a woman's control over her home and inhibit objection to her spouse's smoking.

The second aspect of gender-related risk is pathogenic, meaning that tobacco as an agent of disease provokes different physical responses in women and men. For example, heightened susceptibility to osteoporosis is one of the most painful and tragic consequences of smoking for women, that is not shared by men. Nicotine has a powerful antiestrogenic effect—that is, it interferes with a woman's "active" estrogen hormone level and impedes the function of her bone-forming cells. Smoking directly inhibits estrogen, the most important hormone in preventing loss of bone mass, to the point of inducing menopause 2-4 years earlier than normal. A female smoker thus faces more than double a nonsmoker's risk of fractures in the backbone, hip, and arm; the danger multiplies with the amount and length of time that a woman smokes. Already one hip fracture in eight is attributable to smoking, and this number will rise as the pioneer female smokers, who first took up smoking in the 1950s, continue to age. Because of the specific effect of inhibiting female estrogen levels, this is a clear example of a tobacco-related illness that affects women uniquely.

Taken together, these two factors—exclusion from research and gender-specific risk (environmental and pathogenic)—greatly affect women's health. If a tobacco-related disease is unique to women, it often goes unnoticed and underresearched. Similarly, if an ailment is common to both sexes, the medical response generally is based on and geared toward the male body, ignoring significant differences between male and female physiology.

These risks are of even greater concern given the rise in female smokers. Contrary to reported trends in affluent countries like the U.S., Canada, and the United Kingdom, smoking rates are not declining among most women worldwide. Past patterns of tobacco use suggest that even very low rates of female smoking in regions such as the Asia Pacific merely reflect women's delayed uptake and forewarn a "man-made public health disaster."

All evidence indicates that tobacco swiftly will exceed its current toll of four million preventable deaths each year, 11,000 every day. By the year 2030, tobacco will kill over 10 million people annually and women will represent an increasingly large percentage of these premature deaths. As the discussion below

36. Vierola, supra note 6, at 132.
37. Id. at 128, 132.
38. Cristofides, supra note 8; Discussion Paper, supra note 25, at 4-6.
40. Id. at 128-29.
41. Brundtland, supra note 14, at 1.
42. Id.
will demonstrate, this rising mortality rate, and the social, economic, and political conditions that lead to it, is crucially connected to women's human rights.

II. TOBACCO AND HUMAN RIGHTS

A. Defining Human Rights

The term "human rights" refers to the broad array of rights, dignities, and freedoms owed to every human being, as recognized by international treaty or custom. These include many civil and political rights, such as bodily integrity, access to information, and freedom from discrimination. The term also encompasses economic, social, and cultural rights, such as the right to enjoy the highest attainable standard of health, or to enjoy the benefits of scientific progress. The discussion that follows will rely on the most broadly recognized human rights instruments: the Universal Declaration of Human Rights (Declaration); the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social, and Cultural Rights (ICESCR); and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW).

An understanding of basic human rights concepts is essential to the present discussion because women's rights (both generally and in tobacco policy specifically) are inseparable from the greater body of human rights. Though often treated as entirely distinct, women's rights are grounded in the same concepts of equality and dignity that underlie all human rights and rely on the same norms recognized by international law.

However, while human rights are universal by definition, their meaning in a particular context may be especially relevant to women. As an empirical matter, women as a group are in many cases more vulnerable to certain violations of certain rights. This is true in the case of tobacco policy, where state actions often affect women differently from men and discriminately violate women's rights. For instance, when women are denied education and freedom to travel.

48. Tobacco policy includes any state actions that affect production, availability, or use of tobacco products, as well as the social, economic, and medical implications of such action. Major components of state tobacco policy include taxation of products; regulation of product contents, labeling, and promotion; restriction of tobacco import and export; subsidization of tobacco production; monitoring of industry conduct; public health promotion; funding of scientific research; and funding of medical treatments for addiction and tobacco-related disease.
outside the home based on their gender, public health information that requires literacy is likely to reach fewer women than men. Similarly, where state-funded health research focuses exclusively on men, medical issues specific to women and girls go unidentified or receive inadequate attention. Or, when a state imposes taxes on tobacco products to lower consumption, women’s unique purchasing trends may lessen or negate the impact of the regulation, since women’s responses to price variation are not always identical to men’s.49

These and other instances of gender disparity demonstrate that tobacco policy does not take effect in a vacuum; even where state action protects the rights of men, it may simultaneously violate the human rights of many women. Admittedly, men suffer the same denial of rights in some situations. However, women in the aggregate are more vulnerable to violations in the context of tobacco control, for a variety of reasons discussed below. Thus the human rights approach to tobacco policy, though reliant on universal principles, is of unique and immediate importance to women.

The following discussion identifies and describes several violations of women’s human rights as currently effected through tobacco policy. While fundamentally indivisible, these concepts are separated for purposes of clarity and discussed as the following distinct rights: to enjoy freedom from discrimination; to seek and receive information; to participate in public affairs; to be secure in one’s life; to enjoy the highest attainable standard of health; and to obtain education, employment, and an adequate standard of living. In light of the interdependence of all human rights, some degree of overlap among these concepts is inevitable. Because this discussion seeks to explore creative legal arguments under the human rights paradigm, slight redundancy is favored over artificially categorical distinctions. Recognizing that innovation is at the heart of effective advocacy, the discussion attempts neither to isolate nor to exhaust all possible claims, but merely to demonstrate the intrinsic relevance of human rights to tobacco policy.

B. Violations of Women’s Human Rights in the Context of Tobacco Policy

1. The Right to Freedom From Discrimination

The principle of nondiscrimination is implicit in all provisions of human rights law and is explicitly guaranteed in the ICCPR, Article 2; the Universal Declaration, Article 26; and, most comprehensively, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Under this right each state must “respect and ensure to all individuals ... the rights recognized in [a given human rights instrument], without distinction of any kind, such as race, colour, sex . . . or other status.”50

49. Rowena van der Merwe, Access and Affordability, Expert Presentation at the WHO Conference (Nov. 15, 1999).
50. ICCPR, supra note 44, art. 2, para. 1 (emphasis added).
In tobacco policy, violations of the right to freedom from discrimination are readily identifiable. A primary example is where states do not equally solicit and support scientific research on tobacco's health effects among women. The principle of nondiscrimination requires states to discontinue and remedy past violations, indicating that they must analyze existing data for generalizability to diverse female groups; disaggregate all data for sex; identify and pursue priority research gaps; and design gender-sensitive tobacco prevention and cessation techniques.

The principle of nondiscrimination works also to highlight many other human rights violations committed against disadvantaged women, insofar as these women are consistently disregarded, compromised and essentialized in all aspects of policy. In fact, the principle of nondiscrimination is intricately tied to all claims for women’s rights in tobacco control. These include violations directly effected through tobacco policy as well as preexisting violations that are indirectly exposed and exploited. Freedom from discrimination is a crucial element of all women’s human rights in that it compensates for minimum standards that are often hard to articulate in the context of human rights. Thus even where standards are impossible to define and states insist that their limited resources preclude more gender-specific tobacco policy, the human right to equal treatment applies.

2. The Right to the Seek and Receive Information

One prominent violation of women’s rights within tobacco policy derives from the right to information affirmed in Article 19 of the Universal Declaration on Human Rights and Article 19 of the International Covenant on Civil and Political Rights. These provisions protect the right of each individual to “seek, receive and impart information and ideas of all kinds, regardless of frontiers....” As applied, this right pertains to any state action that controls the flow of information. In the case of tobacco policy, relevant state acts include conducting gender-specific health campaigns; effectively conveying information to disadvantaged women; improving the social conditions that enable education of women; monitoring the industry and informing women of industry conduct; training medical professionals in gender-sensitive care for women; funding women’s organizations as independent sources of information; and funding scientific research on women and tobacco. Examples of such violations discussed below are drawn from a variety of geographic contexts, both within the United States and beyond. They represent not a comprehensive review but a small sampling of ongoing violations.

51. States also should disaggregate data for age, alienage, location, and socioeconomic status, insofar as women otherwise may be essentialized and improperly treated as a uniform population. Because men generally are less subject to such reductive analysis, the state’s failure to treat women with equal consideration of diversity constitutes a distinct violation of the right to nondiscrimination.

52. Cristofides, supra note 8.

53. ICCPR, supra note 44, art. 19, para. 2.; Declaration, supra note 46, art. 19.
The right to information is central to tobacco policy, as Lucien Dhooge articulates in arguing that tobacco production and exportation violate international human rights:

In many countries, the serious consequences associated with tobacco usage are unknown.... Developing countries have failed to adopt adequate domestic control mechanisms for tobacco products that are sufficient to educate their citizens or to counteract the marketing practices of tobacco companies.... Such failures include exemption from mandatory health warnings granted to imported cigarettes... the failure of the Japanese Ministry of Health and Welfare to recognize the health hazards associated with smoking until 1987 and the relatively weak health warnings required to be carried on all cigarette packages.  

Although Dhooge’s discussion primarily concerns U.S. liability as an exporter, the argument also implicates importing nations. Under this reasoning, a state’s failure to raise awareness among its citizens, and its complicity in allowing multinational tobacco corporations to wage an “industry-wide misinformation campaign” on the health effects of their products, constitute violation of the right to receive complete and accurate information.

Current tobacco policy in many states disproportionately limits access to information by women of low status and means. One example is the absence of health campaigns tailored to women. In most countries, when public campaigns are designed as “gender neutral” they often are crafted by and for the affluent, educated, socially-integrated male. Women and girls consequently may benefit less from the standardized information flowing to the public. Health education also may directly contradict uneducated women’s perceptions of tobacco’s effects. For instance, women within a rural community may believe that “Only bidi [an indigenous cigarette widely prevalent among poor women in India] smoking can keep me physically fit. If my smoking gets disturbed I have problems with my stomach.” In the face of such strong conventional wisdom within a discrete community, information must be tailored to combat false beliefs. Yet if states do not take steps to know and target women’s smoking patterns or attitudes, the information they disseminate is unlikely to be meaningful or effective.

Similarly, states are slow to understand and address women’s broader social context as it might inform tobacco policy. Appreciation of social conditions

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55. Id. at 434.
56. Cristofides, supra note 8.
58. Id. at 31.
59. Cristofides, supra note 8 (calling for research on the attitudes and beliefs of women and girls toward smoking).
might require outreach to illiterate citizens, who are more often women than men, or women in rural populations who are confined to the home, forbidden to attend school, or denied the means of free assembly to exchange information. Also, literacy must be seen as more than the ability to read; equally crucial to tobacco prevention are media and medical literacy, meaning women's capacity to decipher misleading images in the media and to interpret health information. While the underlying causes of women's illiteracy and limited awareness are complex economic, social, and cultural forces that must be addressed directly, inadequate state response to these realities within tobacco policy constitutes an independent violation of the right to information.

This right concerns not only health education but also information about the industry itself. Release of industry documents through recent litigation has revealed years of deception and attempts to block scientific health research. In the U.S. and other countries these direct accounts of industry conduct have powerfully mobilized women against tobacco. Government suppression of these stories thus directly impedes the flow of information. Again, women are disproportionately harmed to the extent that a state does not investigate or release evidence of industry deceit targeted at women. This may happen simply because research into the industry's treatment of women is not given sufficient resources to provide results, or because a state does not see the worth of investing resources in female-specific concerns. Whatever the cause of the failure to search or disclose, the violation consists not in the underlying conditions suffered by women but in the state's failure to ensure full and accurate information to women given those conditions.

Further illustration lies in state failure to train medical professionals on crucial issues such as gender-specific screening, cessation, and follow-up strategies, thus preventing women's access to such information. In addition, where states require package warnings, they omit gender-specific risks or limit such warnings to fetal risks. Companies are permitted to market cigarettes as "light" or "low tar," creating false perceptions of a healthier cigarette. These strategies primarily target and succeed among women and girls, yet public health campaigns do little to remedy women's lack of accurate information or to

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61. Id.
66. Cristofides, supra note 8.
67. VIEROLA, supra note 6, at 77-78.
identify what would most effectively reach women with little education, little access to health care, and cultural barriers to the receipt of information.\(^6\)

Also, a disproportionate lack of state funding for women’s organizations may contribute to the suppression of information. Because public and private organizations serve a crucial role in the dissemination of information, through both direct communication and wide media participation, lack of governmental support for women’s groups inhibits women’s access to information. In addition, state neglect of women’s groups has the secondary effect of increasing the coercive power of industry money. With their support badly needed, tobacco industry giants wield tremendous influence over the work of women’s organizations and publications.\(^7\) Surveys have shown that women’s publications containing tobacco advertisements are less likely to cover the risks of smoking.\(^7\) This form of self-censorship is no less harmful than direct state censorship, since the withholding of information is the same in either case. Philip Morris has been extremely successful in using this method to ensure that women’s publications do not report the harmful effects of tobacco. At one point, after sponsoring a diverse array of women’s groups and events\(^7\) the industry proudly reported that prominent women’s groups “have assured us that, at least for the time being, tobacco is not a priority issue for them.”\(^7\) Given this coercion, it is no mystery why women’s magazines contain far more articles on breast cancer than on lung cancer, despite the rising threat of the latter.\(^7\)

Of course, the buying powers of the industry, as well as the self-censorship of women’s media, are not enforceable state violations of human rights. However, to the extent that a state disproportionately neglects women’s organizations, it may be responsible for the obstruction of information that results. For instance, deficient funding might constitute a facial violation of the right to information or, in the alternative, contradict the principle of nondiscrimination,\(^7\) based on evidence that lower funding for women’s groups, as measured against men’s, bolsters the coercive force of tobacco industry money. At a minimum, states should allocate equal resources to women’s media organizations and ideally should act proactively to create channels for women lacking political voice.

In addition, government regulation of advertising is potentially relevant to women’s right to receive information. Insofar as tobacco advertising deceives, misleads, or blatantly misinforms the public and so endangers health, the state

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69. Cristofides, supra note 8.
70. Special Report: Cigarette Advertising and Media Coverage of Smoking and Health, 312(6) N. ENG. J. MED. 384-85 (describing a 1983 Newsweek supplement on “Personal Health Care” that promised to discuss “the most important things” related to health, yet mentioned cigarettes in only four sentences, none of which explicitly identified smoking as a health hazard); See also Kaufman & Nichter, supra note 60.
71. See Special Report, supra note 70.
73. Id. (citing Philip Morris executive).
74. Id.
75. See discussion, supra Section II. B (1).
arguably has an obligation under international law to limit such marketing tactics. Where advertising equally deceives women and men, the corresponding state violation is common to both. However, where advertisements target and disproportionately deceive women, the state’s failure to act may constitute a gender-specific violation of the right to information. At very least, such situations violate women’s right to freedom from discrimination, even where state inaction does not violate an independent human right.

A final, crucial instance of the violation of women’s right to information lies in states’ failure to fund scientific research on women and tobacco. Unless a state actively investigates tobacco’s effect on women and the unique qualities of female addiction and cessation, it fails its obligation to provide women with all necessary and obtainable information about their own health. This factor can be categorized also as a violation of the right to enjoyment of the benefits of scientific progress, or the right to freedom from discrimination. However, because inadequate research constitutes an independent violation of women’s right to information, advocates should not overlook this articulation as a potential legal argument.

As others have argued, the above factors confirm that the right to information often is violated not solely by multinational corporations but through the collaboration of private industry, exporting nations, and importing nations. Despite the unique needs of women in realizing their right to seek and receive information, states regularly fail to provide gender-specific information on tobacco; increase women’s access to education; inform women of the deceptive tactics practiced by the industry; ensure gender-sensitive care and health promotion; prevent censoring of female media organizations by industry coercion; and support gender-specific research. Each of these instances—whether by act or omission—impedes the free flow of information to women and constitutes a violation of women’s human rights.

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76. Such an obligation might be located in the right to health or the right to seek and receive accurate information.

77. The tension between government protection of public health and the right to freedom of expression is admittedly complex. However, it is important to note that states are free to restrict tobacco advertising to a far greater extent than is now practiced. Unlike the right to free expression as it has been interpreted under the U.S. Constitution, see generally Sylvia Law, Addiction, Autonomy, and Advertising, 77 IOWA L. REV. 909 (1992) (discussing First Amendment aspects of advertising bans on tobacco products), the international human right to free expression is explicitly qualified by “special duties and responsibilities.” ICCPR, supra note 44, art. 19, par. 3. This qualification permits restrictions on free expression such as are necessary “[f]or the respect of the rights and reputations of others” or “[f]or the protection of . . . public health . . .” Id. Thus states should work to reconcile, but not preclude, claims of the right to free expression in light of the public interest in tobacco control.

78. See supra Section II. B (1).

79. See ICESCR, supra note 45, art. 15, par. 1(b).

80. See discussion, supra Section II. B (1).

81. See infra note 102 and accompanying text.
3. The Right to Participate in Public Affairs

An equally prominent violation of women's rights occurs in states' failure to include women in policy design and decision-making. Article 25 of the International Covenant on Civil and Political Rights provides that every citizen shall have the right "[i]o take part in the conduct of public affairs, directly or through freely chosen representatives; ... [and to] have access, on general terms of equality, to public service in his country." Although Article 25 specifically names only the right to vote and be represented, it applies to the broader context of policy and public affairs.

Tobacco policy falls squarely within the definition of public affairs. One example is the comprehensive regulation of tobacco by governments, not only in the United States but also in many countries around the world. As recently shown in its consideration by the highest court of the United States, and by continuing debate of the issue in Congress, tobacco policy is a matter of extreme political relevance. Therefore, whatever the actual content of tobacco policy, if women are not equally represented in its design and implementation, the state has violated women's right to participate in public affairs.

In addition, the content of tobacco policy is itself extremely relevant to women, making the violation especially egregious. As the factors above demonstrate, women have a unique stake in controlling the spread of tobacco and reducing its harmful effects. Although their right to participate exists independently of their specific concerns, the fact that women are so dramatically affected by tobacco policy heightens the harm of the violation. In fact, some argue that the longstanding gap between tobacco control policy makers and women's groups actually has facilitated the spread of tobacco.

This is particularly true for disadvantaged women, whose needs already tend to be overlooked and compromised in health policy. One point of concern is tobacco pricing and taxation, given that buying patterns and price response vary widely, both within and between the sexes. Analysis is further complicated by the rapidly changing roles of women and resulting shifts in earning power. Another issue is tobacco labeling and health warnings. Given women's unique physiological responses to tobacco, health policy inevitably will face conflicts of interest: if a minority of low-status women suffer damage from tobacco chemicals at far lower levels than others, should limits be fixed at the lower level, despite greater political opposition? Such conflicts cannot be resolved in

82. ICCPR, supra note 44.
84. See discussion, supra Section 1.
85. Judith Mackay, Dir., Asian Consultancy on Tobacco Control, quoted in VIEROLA, supra note 6, at 19.
86. See, e.g., Gigi Santow, Social Roles and Physical Health: The Case of Female Disadvantage in Poor Countries, 40(2) SOC. SCI. MED. 147 (1995).
87. VIEROLA, supra note 6, at 23.
88. Van der Merwe, supra note 49.
the absence of the women they affect without violating the right to political participation.

Finally, in addition to these and other specific policy issues, violation of the right to take part in public affairs denies women the symbolic and substantive benefits of leadership. As prominent participants, women demonstrate their value to society and their equal stake in guiding the community. No matter what its good intentions, or the ultimate outcome of its efforts, when a state excludes women from the development of tobacco policy, it necessarily violates their basic right to participate in public affairs.

4. The Right to Life

The right to life was recognized as fundamental at the very inception of human rights, in the Universal Declaration in 1948. It was later affirmed in the ICCPR and numerous regional human rights instruments. Although typically the right is invoked to object to arbitrary killings, state executions, or other more direct deprivation of life, the right applies with equal force to the case of tobacco, where state policy, through both its acts and its omissions, fails to protect against a known killer.

The crux of this violation lies in the fact that tobacco-related disease is one hundred percent preventable. As stated above, tobacco is currently the leading cause of premature death in the United States and in several other countries. Faced with the lethality of tobacco products, states have an obligation to combat the threat. Again, the principle of nondiscrimination suggests an additional violation of women's right to life. Not only must the state take steps to protect all people from tobacco-related death, but it must further ensure that its efforts equally benefit women. Currently, tobacco policy makers have the opportunity to avert the spread of the epidemic to women in many populations, since areas such as the Asia Pacific still show far more smoking by men than by women. But past trends in smoking suggest that the disease will erupt before long, even where smoking rates among women are now low. The potential loss of women's lives commands express response from states.

5. The Right to Health

Closely related to the right to life is the right to health, articulated in many international human rights instruments. While this is perhaps the most obvious violation of women's rights under tobacco policy, it presents one of the most difficult legal arguments for advocates, owing to its difficulty of definition and

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89. See Dhooge, supra note 54, at 414-15.
91. Amos, supra note 39.
standard setting. The right to health may be understood in several ways: as a right to health care, to minimum core standards of health, or to adequate conditions that enable a state of well-being. The right to health was recognized in Article 25 of the Universal Declaration, providing that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care." The right was further defined in Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR), which recognizes a right to "enjoyment of the highest attainable standard of physical and mental health" and obliges State Parties to take steps toward realization of the right, including "[t]he prevention, treatment and control of . . . diseases." The most comprehensive articulation of women's right to health is provided in Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women and in the General Recommendation on that article issued in February 1999 by the Committee created to oversee the Covenant. The article and recommendation articulate women's comprehensive right to health care, measured on a basis of equality between men and women. Finally, the World Health Organization sets out perhaps the most expansive definition, declaring that "[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Despite the highly aspirational nature of these terms, a right to health thus broadly defined is increasingly recognized in international law.

Equally undefined as the content of the individual right to health are states' duties. Principles of international law articulate three types of obligations under the right to health: to respect, protect, and fulfill the rights of citizens to enjoyment of the highest attainable standard of health. For each of these duties, a state violation must consist in direct infringement of the right, failure to fulfill minimum core obligations, or a pattern of discrimination that cumulatively disadvantages women.

94. ICESCR, supra note 45, para. 1, 2(c).
95. CEDAW, supra note 47.
97. See id.
101. See Chapman, supra note 92.
Even in the absence of definitive standards, numerous violations of the right to health arise in tobacco policy, all of which center on a woman’s ability effectively to promote and protect her own health. Many of these violations overlap with the rights to information and to enjoyment of the benefits of scientific progress, but however the violation is framed the ultimate problem is the same: a woman’s health is being damaged by denial of the right to make informed decisions and the means to control her own risk from tobacco.

Furthermore, many countries fail to provide women basic access to health care, including regular screening for tobacco use and gender-specific treatment of tobacco-related disease. Cessation programs are often prohibitively expensive, inaccessible, or inappropriate to women of low status. Again, violations can be measured on a basis of inequality with men or simply by reference to minimum core obligations. Significantly, in its General Recommendation on Health, the Women’s Committee stated that this type of inadequacy of health care is in and of itself a denial of women’s rights and thus establishes a violation where “... a health care system lacks services to prevent, detect and treat illnesses specific to women.” In the case of tobacco the premature death of millions of women might demonstrate an automatic violation of the state’s duty to protect. Especially given that some states have been able to reverse the rise in smoking among women and halt the spread of tobacco-related disease, the mere fact that female uptake is rising may be evidence of a violation.

In addition, as noted above, data show that many of tobacco’s female-specific health risks are deficiently researched and treated, signaling discriminatory fulfillment of the right to health. For example, the risk of nicotine-induced osteoporosis is only minimally understood by the medical profession and remains unknown to virtually all women, despite clear evidence of its devastating impact on women’s bodies. Also unknown are the effects of nicotine replacement therapy and hormone replacement therapy on pregnancy. Various reproductive cancers may be linked to tobacco use, yet research remains inconclusive. Women may suffer greater damage to their lungs than men suffer from equal or less exposure, but the causes and implications are largely unknown.

In sum, whether owing to state acts or omissions, objective
indicators of women’s health and health care imply a continuing violation of
women’s right to health through tobacco policy.\(^{111}\)

States are all the more compelled to protect women’s right to health by
evidence that females are now targeted more aggressively than ever by tobacco
companies. The industry’s desire to recruit female smokers is not new and is not,
in itself, illegal. But glimpses of the industry’s tactics make it impossible for
states to claim that they do not owe a duty to women to combat the specific
nature of their vulnerability. For instance, the industry has for many years looked
forward to exploitation of women’s social disadvantage and insecurities,
predicting that the recruitment of women “will be like opening a new gold mine
right in our front yard,” and stating that “All in all, that makes women a prime
target as far as any alert European marketing man is concerned.”\(^{112}\)

In developing the female market, the industry has divided women into
carefully “segmented markets,” such as those targeted by “Project Virile
Female,” a campaign intended to attract women with no more than a high school
education, entry level employability with high level of unemployment and part-
time work, primary aspirations “to have fun with her boyfriend and partying
with her friends,” and favorite free-time activity of spending time with her
boyfriend “doing whatever he is doing.”\(^{113}\) Such campaigns are built on
sophisticated analyses of “female image wants” so that the greatest
vulnerabilities can be used to addict women. These have included women’s
reports of “fear, even resentment of the hard choices . . . . Concrete, everyday
problems of living, working and loving as equal persons with men,” which led
the industry to note: “Key - ‘Women’s terrible need to please, to be perfect.’”\(^{114}\)

Noting that women “feel they have little influence over things affecting their
lives,” RJ Reynolds designed the following strategy:

To counteract the effects of everyday life, women will look for ways to
withdraw and recoup . . . . Also we will see more activities and products
that will provide fantasy, and self indulgences. Not only will this provide
an escape, but it will also serve as a reward . . . . Accessories will not be
limited to scarves and handbags or to high priced items, but will
encompass anything that extends an image. Women will be buying all
kinds of things that give them a lift.\(^{115}\)

\(^{111}\) See generally Chapman, supra note 92.

\(^{112}\) D. Rogers, Overseas Memo, TOBACCO REPORTER, Feb. 1982, as cited in Tobacco Explained, supra
note 68.

\(^{113}\) Women vs. Smoking Network, RJR Plans to Target Young Women With New Cigarette, Advocacy
0&start=0&if=apvidx&bool=%22RJR%20plans%20to%20target%22&docid=2025861903/1908&docnum=1&
summary=0&ssel=1 (last visited Apr. 21, 2001).

\(^{114}\) Thoughts/Notes per Betty Friedan Article, RJR Doc. # 503545602-5603, available at

\(^{115}\) Market Design Department, RJR Tobacco, Market Dynamics: YA[Young Adult] Females,
available at http://www.rjrdocs.com/imaging.jsp?SIZE=774&LOCATION=0&ALL_RECORDS=1 (last
visited June 9, 1999).
Tobacco marketers have consistently sought out the weakest points of women's conditions and offered tobacco as the solution. Tobacco's original and most effective "hook" is the image of liberation. The appeal of freedom worked first to attract women in America, and the same techniques have been applied recently in less developed countries. For example, in Sri Lanka, tobacco exporters hired women to drive jeeps and smoke "Players" cigarettes (both of which are socially unacceptable activities in Sri Lankan culture). Sri Lanka has the second-lowest female smoking rate in the entire world, but the tobacco industry is fervently attempting to undermine norms and promote acceptability for female smokers, through such events as the jeep ride and disco nights. At these free events, glamorous western models give away cigarettes and urge women to smoke them.\textsuperscript{116}

Released through recent litigation in the U.S.,\textsuperscript{117} industry documents prove that tobacco marketers seek to exploit and perpetuate all the vulnerabilities of women that result from their disempowerment in society.\textsuperscript{118} One executive noted "powerlessness" as a key factor for women, and another recorded women's exhaustion in trying to fill modern dual roles. Both saw the effects of society's denials of women's dignity and worth. And both sought to exploit these effects to addict women to tobacco. Whatever states' responsibility for the conditions that create women's disempowerment, failure to oppose industry exploitation of those conditions compounds the violations of women's rights discussed above—such as the rights to information and to freedom from discrimination—by denying women's right to health.

**6. The Rights to Education, Employment, and an Adequate Standard of Living**

I address these rights in a single section because of their interdependence in determining women's susceptibility to tobacco. The connection among them is important to recognize because it recalls the basic inseparability of all human rights, as well as the complexity of public health as the goal of tobacco control. Here, as in so many instances, women's health depends on variables far beyond physical condition and circumstance, including the more abstract ideals of empowerment and autonomy. While the role of such broad factors in women's health is beyond the scope of this discussion, their interreliance must be remembered if human rights are to be protected and if tobacco control is to achieve some measure of success.

The right to education, affirmed in Article 26 of the Universal Declaration, entitles every person to elementary and other fundamental stages of education, which shall be "directed to the full development of the human personality."\textsuperscript{119} Access to education is a significant problem among girls of low status, owing


\textsuperscript{117} See generally Ciresi et al., supra note 63.

\textsuperscript{118} See, e.g., tobacco industry documents, supra notes 114-16.

\textsuperscript{119} Declaration, supra note 46, art. 26, para. 2.
not only to family needs, economic constraints, remote location and language barriers, but also to social and cultural expectations of women. Where state-condoned practices deny a girl the right to an education, or subordinate that right to her family’s desire for a profitable marriage, the girl is deprived of knowledge, growth, employability, independence, and the full development of her “human personality.” Her denial of that single right thus impedes a web of others, including her right to seek, receive and impart information, to work and receive just and favorable remuneration; to freely pursue her economic, social and cultural development; and to achieve an adequate standard of living for herself and her family. Among adults, women unable to reach and absorb accurate information on the effects of smoking are denied the chance to control their health. Furthermore, uneducated women or those not permitted to work cannot gain economic independence, and therefore may be less able to insist on a smoke-free home or work environment. The tobacco epidemic is fueled by each of these factors and thus indicates state responsibility to address each as a violation of women’s human rights.

III. WOMEN, HUMAN RIGHTS, AND INTERNATIONAL TOBACCO CONTROL

The evidence is unequivocal that tobacco is a danger to women’s lives and health. Of what relevance, then, is the human rights approach? The answer is two-fold. First, recognizing the link between women’s tobacco use and their enjoyment of rights is simply good strategy for limiting tobacco’s harms. Because this approach places tobacco policy within the broad-based human rights framework already accepted by the international community, it avoids the limitations of any single lens onto tobacco control, such as economics or public health. Second, this approach uses the issue of tobacco control to promote women’s rights on a broader scale. Treating tobacco policy as a matter of women’s rights demonstrates that health and human rights are indivisible. Application of that principle, in turn, has far-reaching benefits for women, as evidenced in the cases of HIV and the marketing of breast-milk substitutes in Africa, described below. While there are several potential challenges to the human rights approach—the argument, for instance, that this strategy undermines women’s autonomy or instrumentalizes their rights in the service of

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120. Id.
121. ICCPR, supra note 44, art. 19.
122. Declaration, supra note 46, art. 23, para. 1, 3; ICESCR, supra note 45, art. 6, 7.
123. ICESCR, supra note 45, art. 1, para. 1.
124. Id., art. 11, para. 1.
125. Even where countries have not ratified human rights instruments, or where they have ratified the instruments but not observed their pursuant obligations, some human rights may apply nonetheless, either as customary international law or as jus cogens norms. See generally Vanessa Merton, The Utility of International Law For Protecting Women’s Health Rights, 9 PACE INT’L L. REV. 259 (1997); Cook, State Accountability for Women’s Health, supra note 100.
public health—such objections are outweighed by the long term benefits of the human rights approach.

A. Human Rights as a Strategy for Effective Tobacco Control

The spread of tobacco use among women is not random; it is the result of identifiable economic, social, and cultural factors.\textsuperscript{126} Thus, insofar as the tobacco epidemic is not a purely biomedical problem, tobacco control will require more than a purely biomedical response. The human rights approach answers this need. Integrating the rights framework into tobacco control is the only way to find an effective solution—that is, a contextual response to a contextual health crisis.

Ultimately, through acknowledging the rights implications of tobacco policy, states will have to confront the social conditions of women’s vulnerability, such as lack of education, poor access to health care, limited legal rights and inferior social status. Although some states may not feel pressured by the moral and legal weight of human rights law, this approach very likely will add political force to the public health goals of tobacco control. For example, when identified as a violation of the “right to life,”\textsuperscript{127} a state’s failure to provide health education to rural women cannot be an acceptable exercise of sovereign will. The force of international human rights law, arguably gathering momentum in recent years,\textsuperscript{128} may trump states’ claims of autonomy in refusing to improve women’s status. As populations are informed of state complicity in tobacco promotion they may be spurred to lobby governments to amend their policies under threat of political reprisal. By contrast, when tobacco control is framed purely as a matter of trade, challenges to policy carry less moral weight.\textsuperscript{129} Since political and social will are the most vital elements of success in a health movement,\textsuperscript{130} the language of human rights may be extremely valuable in convincing states to favor health over perceived profit.\textsuperscript{131}

An additional advantage of the human rights approach is that it capitalizes on existing women’s networks. Despite the clear benefits of alliance with established women’s movements, tobacco control policy makers have been slow to make connections. Through most of its history, tobacco control has acted

\textsuperscript{126} Even the most scientific inquiry could not conclusively identify all components of a woman’s decision to smoke. As discussed above, however, many significant factors in tobacco use and exposure can be identified within a woman’s social context.

\textsuperscript{127} ICCPR, supra note 44, art. 6.

\textsuperscript{128} See, e.g., Cook, supra note 100; Ruth Roemer, Health Legislation as a Tool for Public Health and Health Policy, 49(1) INT’L DIG. HEALTH LEG. 89 (1998).


\textsuperscript{130} Nathanson, supra note 10.

\textsuperscript{131} Experts now agree that the economic benefits of tobacco production are illusory. See PRABHAT JHA & FRANK CHALOUPKA, CURBING THE EPIDEMIC: GOVERNMENTS AND THE ECONOMICS OF TOBACCO CONTROL 67-78 (1999). See generally Barnum, supra note 9; Wike, supra note 129; Johnson, supra note 129.
outside (if not in conflict with) feminist movements.\textsuperscript{132} Ironically, some of the first promoters of female smoking were suffragettes, smoking proudly as they marched in the 1929 New York Easter Parade. The industry had paid the suffragettes to smoke in the parade in defiance of social norms, and the marketing strategy worked: the women's radical behavior attracted wide publicity and helped to inaugurate the cigarette as a symbol of women's liberation.\textsuperscript{133} In the seventy years since, corporations have continued to promote cigarettes as a badge of freedom,\textsuperscript{134} and their success is evident in the rise in female mortality from tobacco-related disease.\textsuperscript{135}

Only very recently have women's groups on a wide scale acknowledged the depth of tobacco's threat and its link to women's human rights.\textsuperscript{136} Increasingly, however, women from all regions with diverse agendas have come together to adopt tobacco control as a matter of women's human rights.\textsuperscript{137} These partnerships will be crucial if the movement is to succeed in limiting tobacco's impact on women.

B. Tobacco Control as Strategy for Advancement of Women's Human Rights

Beyond its value as an effective health strategy, the rights approach to tobacco control is an important political opportunity for women because it offers a unique convergence of financial, public health, and human rights interests. Ironically, it is the economic burden, not the ethical concerns, of tobacco that now motivates states to improve women's health. For example, a recent analysis by the World Bank announced that the costs of tobacco far outweigh its profits,\textsuperscript{138} amounting to a global net loss of $200 billion each year, with half of these losses occurring in developing countries.\textsuperscript{139} Through such reports, the links between wealth, social power, and health have been persuasively documented, and the power of economic self-interest increasingly coincides with the "altruism" of broader human rights goals.\textsuperscript{140} Women stand to benefit greatly from this convergence of interests. In the case of tobacco control, even those


\textsuperscript{133} Id. at 12.

\textsuperscript{134} For instance, the famous Virginia Slims slogan "You've Come a Long Way, Baby" has been replaced with the more modern "It's a Woman Thing."

\textsuperscript{135} See supra notes 11-43 and accompanying text.

\textsuperscript{136} See, e.g., Discussion Paper, supra note 25, at 18-19.

\textsuperscript{137} Charlotte Abaka, Chair of the Expert Committee on the Convention on CEDAW, stated that tobacco is a crucial emerging issue for the Committee. She argued that women must place tobacco within the broader context of feminist movements and resolved to raise the issue at the upcoming African Regional Beijing Plus Five Conference. She also suggested that CEDAW and its existing mechanisms of implementation be used to inform and assist tobacco control for women. Charlotte Abaka, Expert Presentation at the WHO Conference (Nov. 15, 1999).

\textsuperscript{138} JHA & CHALOPKOA, supra note 131, at 2, 77, 78.


states least amenable to women’s rights will want to reduce the costs of women’s use of tobacco and thus will have to confront the indivisibility of women’s health and women’s rights.

The link between health and human rights has met with success in the past, not only as an effective strategy for public health (as discussed above), but also as a tool for social change. In particular, the rights approach to women’s health has gained remarkable support in the past decade and broadened understanding of both human rights and women’s health. This synthesis, a process of connecting health to “deeply-rooted social and political structures that produce ill health and that prevent all people—women and men—from fulfilling their highest potential as human beings,” utilizes a contextual approach to health, moving beyond biomedical models of disease. Experts from a variety of fields have agreed that health by any definition cannot be divorced from the rights and freedoms of the individual.

HIV is one powerful example of this evolution. In early stages of the HIV pandemic, the World Health Organization and other policy makers did not consider HIV from the perspective of human rights. Strategies were based primarily on theories of transmission and individual risk behavior. However, as these efforts failed to curtail the epidemic, policy makers had to recognize the links between power, discrimination and the spread of HIV:

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is founded upon the same premise—that is, the recognition that a health threat like HIV/AIDS is an indivisible problem. It extends beyond the physical health of the individual and finds its sustenance and impact in the social, economic, and political conditions in which individuals live. It is for this reason that no one single UN agency, perspective, or vision has been considered sufficient, and an entity like UNAIDS has been established.

A similar shift toward rights-based health policy occurred when multinational corporations decided to market and distribute breast-milk substitutes throughout Africa. As the World Health Organization grew concerned

142. Freedman, supra note 102, at 316.
144. See generally Discussion Paper, supra note 25.
146. See Fee & Krieger, supra note 145; HIV/AIDS and Human Rights, Part I, supra note 145.
about the decline of breast-feeding in favor of artificial feeding practices, human rights advocates simultaneously noted the lack of information available to women and the inadequacies of education and health care that made poor women especially vulnerable. Advocates from the two perspectives collaborated to address this unique health problem that was integrally rooted in women’s inequity. The ultimate result was the International Code of Marketing of Breast-Milk Substitutes, adopted by the World Health Assembly in May 1981. As in the case of HIV, the foundation of human rights enabled policy makers to identify and address the greatest obstacles to well-being, by “[r]ecognizing that infant malnutrition is part of the wider problem of lack of education, poverty, and social injustice... [and] that the health of infants and young children cannot be isolated from the health and nutrition of women, their socioeconomic status and their roles as mothers...”

Just as human rights concepts guided HIV and maternal health policies, so too can this strategy lead tobacco control toward contextual models of health that benefit women’s rights beyond the tobacco issue. Because the groundwork of human rights is so basic across cultures and so fundamental to health, the vocabulary and arguments established in the context of tobacco can be used to demand social solutions for many other socially constructed problems.

One argument against using the tobacco context to promote women’s human rights is that it will instrumentalize women’s rights and treat them as merely a means to achieve more “legitimate” goals of economics or public health. As an indirect route to attaining equality for women, this reasoning suggests, tobacco policy may lessen the value of that goal in and of itself. Indeed, the link between tobacco and women’s human rights is less obvious than with other health issues, such as female genital mutilation or reproductive choice. Perhaps advocating women’s rights on this issue is so complex and attenuated as to weaken the argument in all contexts.

This argument is similar to feminist objections to the overemphasis of reproductive rights in women’s health. These voices note the reduction of women’s bodies to their reproductive function and assert that fighting for women’s rights in only a single context can obstruct progress toward women’s


151. Id. at Preamble.


153. See, e.g., Goldberg, supra note 141, at 272; Merton, supra note 125, at 260-61.
broader rights to health and empowerment. Certainly it is true that "human rights, like public health, can be wielded as a tool to promote quite particular political goals that might be substantially different from—even contrary to—the goals of women's advocates."

In the case of tobacco control, however, appeal to the human rights framework will ultimately further women's rights. As with the case of HIV, health policy makers will have to acknowledge the relevance of human rights. If nothing else, this recognition will weaken one longstanding barrier to women's equality, namely denial. State denial has effectively resisted women's equality simply by making their subordination invisible; the withholding of women's autonomy is so deeply ingrained in and reinforced by societal structures that a woman often cannot even find a voice to claim her rights. But as tobacco policy makers come to recognize the conditions of women's lives that promote tobacco use and exposure, violations of women's rights will be increasingly apparent and irrefutable. Thus, to the extent that women are instrumentalized this is an acceptable, temporary sacrifice for an overwhelmingly positive step.

Furthermore, integrating women into tobacco policy actually will benefit the discourse of women's rights, in that it humanizes women's needs. The human rights approach shifts the burden of the one onto the shoulders of the many and takes issues such as child care or health services out of the sphere of "women's rights" and into the realm of "human rights." As international law affirms, human rights are universal and indivisible; by articulating women's rights within issues that, as a whole, are not unique to women, advocates lessen the isolation and devaluation of women's rights as separate from human rights.

An additional challenge made against addressing tobacco control as an issue of women's rights is that this approach undermines women's autonomy by deeming them more "vulnerable" and in need of protective care. Such claims—voiced primarily by the tobacco industry itself—argue that the millions of people who begin and continue to smoke should be respected in their "choice of lifestyle." From this perspective international restraints on tobacco trade, marketing or sales, particularly the targeting of women as a vulnerable

154. See Freedman, supra note 102, at 336-37; see also Alice Miller, AnnJanette Rosga, & Meg Satterthwaite, Health, Human Rights and Lesbian Existence, 1 HEALTH & HUM RTS 428.
155. Freedman, supra note 102, at 336.
156. See Cook, supra note 100, at 272.
157. See, e.g., Declaration, supra note 46, Preamble; ICCPR, supra note 44, Preamble; ICESCR, supra note 45, Preamble.
158. See, e.g., Margrit Eichler, Human Rights and the New Reproductive Technologies—Individual or Collective Choices?, in HUMAN RIGHTS IN THE TWENTY-FIRST CENTURY: A GLOBAL CHALLENGE 875 (K.E. Mahoney & P. Mahoney eds., 1993) (arguing that individual benefit from new reproductive technologies is in direct conflict with the indivisible costs, in that the practice contributes to the reduction of all women to "commercialized" "reproductive actors").
159. "[W]e believe that smoking is an adult choice, and we market to adults of both sexes and races who are capable of making that choice. . . . Today we are being castigated for the same policies of inclusion and equality that have always guided our communication," William Campbell, President, Philip Morris USA, Remarks given to the Advertising Women of New York (Mar. 7, 1991) PM Document #2051020295/0336, available at http://www.who.int/inf-fs/en/fact155.html (last visited Apr. 21, 2001).
population, are paternalistic and violative of the right to autonomy. Yet a human rights analysis reveals that this position is fundamentally flawed.

The argument of autonomy incorrectly posits that tobacco’s effects are the freely chosen “personal costs” of smoking and thus the smoker’s right and responsibility.160 This premise is faulty on several grounds. First, nicotine, as it is carefully delivered through tobacco products,161 is sufficiently addictive to preclude free choice.162 Several studies have found nicotine to be as addictive as heroin and cocaine,163 and data show that almost all cigarette smokers quickly develop tolerance to nicotine. In addition, “intermittent or occasional use of cigarettes is rare, occurring with only about two percent of smokers,”164 and most tobacco users express a desire to quit but find that they cannot. These are all typical indicators of addiction.165

Second, to see tobacco uptake as a choice presumes the free flow of information. Only where a woman receives complete and accurate information on the costs and benefits of tobacco can her decision be truly autonomous. Yet the low status of many women directly interferes with their receipt of information. As discussed above, impeding factors include government suppression of information; lack of education; little or no access to comprehensive, gender-sensitive health care; exclusion from public affairs; and cultural restrictions on movement outside of the home. These denials of information preclude a claim of “free choice.”

Third, even where a woman has access to health, economic and industry-related information, the idea of a free, rational “cost-benefit analysis” is unrealistic. Rather than a self-contained, reasoned assessment of fact, a woman’s weighing of risks is strongly influenced by conditions beyond her control. She must decide from within her socioeconomic situation, possibly with a very low level of education and a high degree of coercion.166 The notion of free choice in this position is fallacious, as one prominent feminist has noted: “physical health cannot be detached from political and social concerns, posited as an objective state of biological being, and then treated as though the choices we make in pursuit of it are apolitical and compelled by some internal logic that derives

160. See generally id. For an interesting discussion of divisible and indivisible costs in the context of reproductive rights and technologies, see Eichler, supra note 158.

161. Nicotine, along with most of the 4,000 chemicals contained in cigarettes, is mixed into tiny droplets of sticky tar, making it easier and ‘smoother’ for smoke to pass the throat and enter the lungs. VIEROLA, supra note 6, at 48; Brigham, supra note 20.

162. The World Health Organization first recognized tobacco as dependence-producing in 1974. The United States Department of Health Services (DHHS) also has recognized the addictive nature of smoking at least since the Surgeon General’s report on tobacco in 1969. U.S. DEP’T. OF HEALTH AND HUMAN SERVS., FOOD AND DRUG ADMIN. NICOTINE IN CIGARETTES AND SMOKELESS TOBACCO PRODUCTS IS A DRUG AND THESE PRODUCTS ARE NICOTINE DELIVERY DEVICES UNDER THE FEDERAL FOOD, DRUG AND COSMETIC ACT, reprinted in Dhooge, supra note 54. For a discussion of the highly addictive nature of nicotine, see Law, supra note 77.

163. VIEROLA, supra note 6, at 39.


165. VIEROLA, supra note 6, at 38.

166. “Yet if people are to have real choices, the decisions that determine the context within which we must choose must not be made in our absence.” Hubbard, supra note 152, at 200.
Women's heightened vulnerability to tobacco use and exposure is not a question of weakness but of understandable response to deep and powerful structures of discrimination. The human rights analysis refutes misguided cries for women's equality in "the right to smoke." The industry itself put it best: "The assumption . . . that women, racial minorities, or the people of less developed countries are less capable than affluent white males to determine and act in their own interests and must be 'protected' by government censorship . . . is both patronizing and demonstrably inaccurate." Indeed, such groups are not intrinsically less capable but rather less empowered to act in their own interest. Autonomy is an illusion for many of the world's women and should not be falsely invoked to obstruct effective tobacco control.

Finally, tobacco control is relevant to women's rights not only because of its goals but also because of its process. By participating in the fight against tobacco, women can claim a voice in international health policy. The rights of self-determination and political participation that have been denied to low-status women may be redeemed, in part, through this fight. Effective tobacco control will call for women's leadership in local, regional and global mobilization; women's input into the design of national and international health policy; unified feminist outcry against the tobacco industry's deceptions of women and girls; and—most importantly—the direct participation of millions of individual women.

CONCLUSION

Ultimately, the fight against tobacco should stand as both cornerstone and touchstone of women's struggle for human rights. Already, tobacco claims hundreds of thousands of female lives every year, and its cost to women is likely to grow. Without integration of human rights principles, tobacco control will not succeed in reducing this threat. In addition, under current tobacco policy, many states directly violate women's rights and exploit longstanding denials of women's rights. Tobacco control policy is a chance to identify and address these violations with the support of economic and political momentum. Finally, the fight against tobacco should be a woman's fight. It is a chance to claim a voice in the public sphere, avert the loss of many lives, and integrate women's needs into the greater discourse of human rights.

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167. Freedman, supra note 102, at 323.
168. See generally Allen Brandt, Recruiting Women Smokers: The Engineering of Consent, 51(2) JAMWA (1996) (suggesting that industry marketing in the early 1900s used women's changing roles to induce public acceptance of female smoking, and arguing that such tactics can be used to engineer negative meanings for smoking and promote cessation).