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Robin Appleberry

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Recent Developments

"It's a Woman Thing": Sex, Status, and Human Rights in the Tobacco Epidemic

Robin Appleberry†

INTRODUCTION

Although the tobacco industry has been the subject of countless headlines in recent years, few voices describe the subject as an issue of human rights, much less one of women’s rights. The vocabulary of human rights commonly is limited to torture, detention, or brutal physical violation. At the same time, tobacco policy is considered a matter of trade, economics, or public health, but rarely a question of fundamental dignities. As a result, the spread of tobacco has been checked only by those measures that money, politics, and medicine endorse. Success, thus far, has been less than overwhelming.

Against this backdrop I contend that the tobacco epidemic is intimately linked to human rights and must be seized as a crucial issue of women’s rights. Relying on evidence of tobacco’s devastating impact—physical, social, and mental—on women’s health, I suggest that the intersection of sex, status, and power has placed the world’s poorest women in a position of unique and intolerable risk. In recognition of this crisis, I argue that women in all countries should challenge government tobacco policies on the grounds that they violate women’s fundamental human rights. While I do not now attempt a comprehensive legal analysis, I discuss the theoretical groundwork and likely benefits of a human rights approach. Also, because I recognize the practical and ideological difficulties of a human rights framework, I discuss potential challenges to this approach. Whatever the unlikelihood of my argument, I hope ultimately to prove that tobacco policy is of singular importance to the
rights of all women. Much more than an issue of physical health, the fight against tobacco offers women an invaluable means of empowerment and a window onto women’s human rights in their deepest meaning.

I. DEFINING HUMAN RIGHTS

For purposes of this article, 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. Although human rights law derives from numerous regional and international sources, many of which contain unique provisions, my discussion draws primarily on the most broadly recognized human rights instruments: 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), all adopted under the auspices of the United Nations since its formation in 1945.

II. WOMEN AND TOBACCO

A. History and Onset of the Epidemic

In 1955, in the United States, only a fraction of all female deaths were attributable to smoking. Compared to the rates among men, this meant that for every female death from tobacco a significantly larger

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4. See, e.g., The African Charter on Human and Peoples’ Rights art. 27, reprinted in Twenty-Five Human Rights Documents, supra note 1, at 119, 123 (recognizing particular duties owed by every individual African to the family, the state, and the common interest of the community).
5. See Twenty-Five Human Rights Documents, supra note 1, at 17.
6. See id. at 10.
7. See id. at 48.
8. See id. at 6.
percentage of men died from the same causes. Yet forty years later, in 1995, the proportion of female deaths owing to tobacco had grown to nearly a third. And as women’s smoking rates rose, so too did their rates of death and disease begin to climb. Globally, tobacco now kills over half a million women each year and female deaths are expected to double by the year 2020 as tobacco’s effects trace women’s delayed uptake. In short, it is now clear: women who smoke like men die like men.

Research now confirms that women suffer the same harmful health effects of smoking as men, including lung, throat, and other cancers; heart disease, stroke, sudden death, and heart attack; impaired fertility; impaired lung function; and severe nicotine addiction. In the United States, for instance, smoking is responsible for ninety percent of all lung cancer in women, a disease that (unbeknownst to many women and the physicians who treat them) has surpassed breast cancer as the primary cause of cancer death among women. However, even lung cancer is overshadowed by the risk of cardiovascular disease. With smoking as its greatest risk factor, coronary heart disease and stroke are responsible for twice as many female deaths as all cancers combined, and coronary artery disease is now the leading cause of death among women over fifty in many countries, including the United States and Britain.

Furthermore, women’s vulnerability is compounded by gender-specific risks and historic and continuing underinclusion in health research. Although research increasingly includes diverse female populations, much of the earliest evidence on tobacco’s effects was based on male models. As a result, issues of crucial importance to women’s health

10. See id.
11. See id.
13. See Gro Harlem Brundtland, Opening Address, in Kobe Conference, supra note 9.
14. See Vierola, supra note 12, at 85.
15. See id. at 54-83.
16. See id. at 211-57.
17. See id. at 113-26.
18. See id. at 38-40.
19. See id. at 85.
20. See id. at 56-57.
21. See id. at 7.
22. See id. at 7, 10, 54, 56.
25. See, e.g., Vierola, supra note 12, at 54; Amos, supra note 23, at 129.
remain unexplored and poorly understood. For instance, some studies demonstrate a higher incidence of lung cancer in women than in men with the same level of exposure to smoke. Though this indicates that women may be more susceptible to the carcinogenic effects of tobacco, (a factor with vast implications for health and public policy), adequate resources have not been devoted to resolving the question. Even with this insufficiency of research, the list of gender-specific afflictions is long:

- Cervical cancer
- Lowered estrogen production, leading to:
  - Early menopause
  - Osteoporosis
  - Increased risk of heart attack
  - Possible increased risk of breast cancer
  - Dysmenorrhea
- Hypertension due to combination with oral contraceptives, leading to:
  - High risk of stroke
  - High risk of heart attack
  - Irregular or discontinued menstruation
- Complications in pregnancy, increasing the risk of:
  - Physical trauma or death during pregnancy or delivery
  - Emergency surgery during delivery
  - Bacterial infection due to premature labor
  - Ectopic pregnancy, risking trauma or death
- Impaired fertility
  - Reduced and irregular egg production
  - Spontaneous miscarriage
  - Accelerated egg degeneration within the ovary
  - High risk of fetal harm or death
  - Lowered milk production and infant refusal of milk
- Exacerbated malnutrition and anemia
- Accumulation of heavy metals and chemicals in ovaries, increasing risk of ovarian cysts

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26. See, e.g., VIEROLA, supra note 12, at 88, 211, 213; Amos, supra note 23, at 129.
28. See VIEROLA, supra note 12, at 90.
29. For instance, regulation of the contents of tobacco products might be modified in light of their differential effects on women; legislation might mandate more smoke-free public spaces in recognition of women's greater risk from environmental tobacco smoke (ETS); or product labeling might include mandatory gender-specific warnings of increased harmful effects.
30. See VIEROLA, supra note 12.
Many dangers have been identified in women only to go without adequate study, thus impeding effective prevention and treatment. One example concerns the synergistic effects of tobacco smoke and cooking oil fumes, a combination that is thought to increase the carcinogenic effect of cigarette smoke. This is particularly relevant in Asian countries where cooking is done almost exclusively by women and involves frequent use of oils at high temperatures. Compounded by the prevalence of male smoking in many such countries, women’s risk of tobacco-related disease may be high even where women themselves do not smoke. Researchers estimate that worldwide over 50 million nonsmoking women each year are exposed to environmental tobacco smoke (ETS) during pregnancy, indicating that the total number of women exposed is far greater. Here gender inequity coincides with risk; status may limit a woman’s control over her home and preclude objection to a spouse’s smoking. Given the proven harmful effects of ETS, women’s disproportionately high exposure is of grave concern, especially as it may be exacerbated by cooking fumes and other unknown factors.

Another dramatic example of tobacco’s impact is the increased risk of osteoporosis for women who smoke. When I speak to friends and colleagues about tobacco and women, most are quick to mention the risk of lung cancer, the added risks of stroke when combined with oral contraceptives, and, most frequently, the danger of harm to the fetus of a pregnant smoker. None whom I have encountered—including experienced physicians—has mentioned osteoporosis. Yet for women, heightened susceptibility to osteoporosis is one of the most painful and tragic consequences of smoking. Due to nicotine’s interference with natural estrogen levels, a female smoker suffers accelerated loss of bone tissue and may reach menopause two to four years earlier than normal. She faces more than

31. See, e.g., Discussion Paper, supra note 27, at 2; VIEROLA, supra note 12, at 88 (discussing the clear but unexplained connection between smoking and cervical cancer), 89 (noting doctors’ failure to warn women about the smoking-related dangers of cervical cancer), 211, 213 (noting the need for further research on the connection between women’s exposure to environmental tobacco smoke (ETS) and low birth weight of their children).
33. A recent study in China found that 63% of men smoked compared to only 3.8% of women. See Yang et al., supra note 24, at 1247. In the Asia and Pacific Region, where nearly half of the world’s cigarettes are consumed, approximately 47% of men smoke, compared to 12% of women. See Discussion Paper, supra note 27, at 4.
34. See, e.g., Saundra Hunter, Cessation II, in Kobe Conference, supra note 9.
36. See VIEROLA, supra note 12, at 213-14.
twice the nonsmoker’s risk of fractures in the backbone, hip, and arm and her danger multiplies with the duration and frequency of her smoking.\(^3\) Already, one hip fracture in eight is caused by smoking, a percentage expected to rise as the “pioneer” female smokers age.\(^3\)

These numbers and stories prove that tobacco products dramatically harm the health and well-being of women, who are now more vulnerable to the epidemic than ever before.\(^3\) Despite promising trends in some affluent countries, such as the United States, Canada, and the United Kingdom, smoking rates are not declining among most women worldwide.\(^4\) In fact, history suggests that current low rates in regions such as Asia merely reflect the lag between men’s and women’s uptake and forewarn a “man-made public health disaster.”\(^4\) Tobacco in its many forms—most prominently the cigarette, a “nicotine delivery device”\(^4\) composed of over 4,000 chemicals, at least 40 of which are known to cause cancer—swiftly will exceed its current toll of four million preventable deaths per year, 11,000 every day.\(^4\) By the year 2030 tobacco will kill over 10 million people annually\(^4\) and women can expect every measure of equality in this loss.

B. Smoking and Status: Migration of the Epidemic

In addition to its shifts across gender lines, the tobacco epidemic is migrating across class, further revealing the connection between status and health. For instance, just as affluent, well-educated women often are the first to take up smoking, so also are they the first women to quit.\(^4\) By contrast, the highest rates of female smoking are among disadvantaged ethnic minorities, such as the Inuit women in Canada and the Maori women in New Zealand.\(^4\) Although prevention and cessation programs

\(^{37}\) See id. at 127-45.
\(^{38}\) See id.
\(^{39}\) See, e.g., Amos, supra note 23, at 128 (laying out a four-stage model of global smoking trends that shows increasing rate among women).
\(^{40}\) See id.
\(^{41}\) See Amos, supra note 23, at 128-29; Brundtland, supra note 13.
\(^{43}\) See VIEROLA, supra note 12, at 48.
\(^{44}\) See Brundtland, supra note 13.
\(^{45}\) See Discussion Paper, supra note 27, at 1.
\(^{46}\) See Amos, supra note 23, at 128.
\(^{47}\) See id. at 129; see also Cesar Chelala, Tobacco Corporations Step Up Invasion of Developing Countries, 351 THE LANCET 889 (1998) (describing the effects on developing countries of promotional campaigns by U.S. tobacco companies).
increasingly recognize women's unique needs, such programs do not equally benefit women of low status whose limited rights, freedoms, and economic independence already impede good health. Thus, in developed countries where smoking among women is declining, the typical female smoker now has little education, holds a low status job or none at all, lives on a low income, and experiences high levels of deprivation.

Increasingly, those likely to bear the heaviest burden of tobacco are women living in extreme poverty and disadvantage. Here the link between tobacco policy and human rights becomes undeniably clear: it cannot be by chance that women and girls with poor education, few resources, and no political voice face drastic rises in smoking while affluent, well-educated women are showing declines. Women's advocates must recognize that the tobacco crisis has not been eliminated but merely transferred onto the most disadvantaged members of the global population.

III. THE HUMAN RIGHTS FRAMEWORK

The primary benefit of a human rights analysis is that it implies some degree of government accountability. By framing national tobacco policies as rights violations, advocates force governments to take responsibility for their effect on women's health. Although the legal claim is novel and difficult to prove, I suggest that tobacco's threat to women is in many ways the direct result of government action. Thus tobacco policy—in and of itself—constitutes a violation of women's rights, and where government action clearly violates human rights, international law may impose an affirmative duty to meet women's needs.

My second claim is less direct: I argue that a human rights analysis of tobacco policy is valuable as a means to address broad abuses of women's rights. The tobacco epidemic itself brings to light ongoing policies that impede women's education, economic opportunity, political power, and personal liberty. Because such violations heighten women's susceptibility to addiction and disease, the connection between health and state-sanctioned rights can be explicitly drawn and brought to bear on state policy. Of course, many areas of public policy reveal the same violations

48. See Discussion Paper, supra note 27, at 15; see also Gigi Santow, Social Roles and Physical Health: The Case of Female Disadvantage in Poor Countries, 40 SOC. SCI. MED. 147 (1995).
49. See Discussion Paper, supra note 27, at 11.
50. See Amos, supra note 23, at 129.
51. See id.
52. Of course, smoking rates vary between and among populations. These patterns are not uniformly true but a statement of overall trends. See, e.g., Amos, supra note 23.
53. See generally Santow, supra note 48 (arguing that women's cultural and social roles impair their health and that of their children and affect their use of health services); W.M. Kabira et al., The Effect of Women's Role on Health: The Paradox, 58 INT'L J. GYNECOLOGY & OBSTETRICS 23 (1997) (discussing the impact of African patriarchal social structures on women's health and health systems).
of women’s rights. So to the extent that my argument rests on this second claim, I face a threshold question: why should women invoke human rights in the unlikely (and potentially problematic) context of tobacco control? If advocates aim to challenge the conditions of women’s disempowerment, why tobacco, why now, and why human rights?

A. A Convergence of Interests: Rights, Public Health, and Economics

First, tobacco policy is a unique political opportunity in that it reflects a convergence of financial, public health, and human rights interests. Ironically, it is the economic burden, not the ethics, of tobacco that now gives states a powerful incentive to improve women’s health. Recent analysis by the World Bank concluded that the costs of tobacco far outweigh its profits,54 amounting to a global net loss of $200 billion each year, with half of these losses occurring in developing countries.55 At last the connection between health, rights, and money has been documented and the goals of human rights and economics can become increasingly aligned.56 As a result of this convergence, it is likely that even those states least amenable to women’s rights eventually will want to reduce tobacco use among women. Furthermore, policy makers will have to confront the cumbersome truth that improving health requires improving women’s status. The power of economics now dictates a concern for health, and health in turn dictates the recognition of women’s rights.57

The synthesis of health and human rights is not untried as a tool for social change. This approach to women’s health in particular has gained remarkable support in the past decade and has broadened understanding of both human rights and health.58 By linking 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,”59 this approach adopts a contextual model of health.60 Increasingly, experts from a variety of fields agree that health by any

60. See id. at 326.
definition cannot be divorced from the rights and freedoms of the individual.  

Human Immunodeficiency Virus (HIV) is one powerful example of this evolution. In early stages of the HIV pandemic, the World Health Organization (WHO) 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, finding 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.”

Just as economic and human rights goals have aligned to guide HIV policy, so too can this framework move tobacco control from a narrow biomedical approach to a contextual understanding. As states and private actors publicly resolve to promote good health, the human rights paradigm can supply the vocabulary and theoretical grounds to demand solutions for socially constructed problems.

B. The Problem of Instrumentalism

One objection to addressing women’s rights through tobacco policy is that practical arguments such as economics or public health serve to instrumentalize women. Under this view, tobacco policy is an indirect and thus harmful means for pursuing women’s rights. Indeed, the connection between tobacco and women’s human rights is less obvious than that of other health issues, such as female genital cutting or reproductive choice. Perhaps the focus on tobacco control will frame women’s rights

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61. See generally Discussion Paper, supra note 27 (discussing the international cultural, social, and health implications of tobacco smoking by women and children).


63. See Fee & Krieger, supra note 62; Symposium on AIDS Part I, supra note 62.


65. See Freedman, supra note 59 (arguing the utility of human rights in holding violators accountable and in defining standards; discussing the need for contextual understanding and treatment of the ill health that develops alongside poverty, racism, and discrimination); see also Ruth Hubbard, Abortion and Disability: Who Should and Who Should Not Inhabit the World?, in THE DISABILITY STUDIES READER 187, 200 (Lennard J. Davis ed., 1997) (recognizing the social factors that determine women’s choices in reproduction and circumscribe women’s human rights).

as a means to an end and cast women as dangerous “vectors of disease.” In fact, this argument is not unlike feminist objections to the overemphasis of reproductive rights in women’s health. Many voices within health policy assert that the exclusive focus on women’s reproductive health obstructs progress toward a broader right to health. Certainly it is true that the rhetoric of human rights, like any political tool, can be wielded to hinder women’s interests as well as promote them.

However, in the case of tobacco control, I believe that a human rights framework will only advance women’s rights. As in the case of HIV, health policy makers will have no choice but to acknowledge the link between women’s health risks and their social status. If nothing else, this recognition will be a small challenge to the barrier that obstructs women’s equality. Currently, the strength of this barrier is its ability to make women’s subordination invisible, such that refusal of a woman’s autonomy is so deeply entrenched in society that she cannot even claim her societal rights. I believe that as tobacco policy makers come to know the conditions of women’s tobacco addiction and disease, violations of women’s rights will emerge as undeniable. To the extent, then, that women temporarily are instrumentalized, this is an acceptable sacrifice in favor of eventual progress.

Furthermore, the human rights approach to tobacco control will benefit the ongoing discourse of women’s rights, in that it humanizes women’s needs. This analysis shifts the burden of the one onto the shoulders of the many; it moves such issues as health care from the realm of “women’s rights” to the realm of “human rights.” As international law affirms, human rights are universal and indivisible: what a poor woman suffers, every rich man suffers, since oppression of the few undermines the dignity of all. To recognize this will mean a great step forward in the fight for women’s rights.

C. Legal and Political Pressure

One practical advantage of the human rights approach is that it generates legal and political pressure. For example, when framed as a viola-

67. See Symposium, Special Focus: Women’s Health and Human Right, supra note 58.
68. See Freedman, supra note 59.
69. See id. at 337.
70. See Rebecca Cook, State Accountability for Women’s Health, 49(1) INT’L DIG. OF HEALTH LEGIS. 265, 272 (1998).
71. See Universal Declaration of Human Rights, G.A. Res. 217A(III), U.N. GAOR, Dec. 10, 1948 reprinted in TWENTY-FIVE HUMAN RIGHTS DOCUMENTS, supra note 1, at 6; see also ICCPR, supra note 2; ICESCR, supra note 3.
72. See, e.g., Margrit Eichler, Human Rights and the New Reproductive Technologies—Individual or Collective Choices?, in HUMAN RIGHTS IN THE TWENTY-FIRST CENTURY 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”).
tion of the "right to life," a state's failure to provide health education to rural women cannot be dismissed as an exercise of sovereign will. The force of international human rights law, arguably gathering momentum in recent years, can "trump" the reluctance of individual states to improve women's status. Politically, the language of human rights adds vital force to women's claims. As citizens are informed of state complicity in tobacco promotion they will have the motivation to force governments to choose: amend state policies or face being branded as violators of fundamental rights. By contrast, when governments frame tobacco control purely as a matter of trade, advocates have fewer tools to challenge policy. Since political and social will are the most vital elements of success in a health movement, the language of human rights is extremely valuable in convincing states to favor health over perceived profit.

D. The Problem of Autonomy

An additional benefit of the human rights paradigm is that it effectively refutes claims of the right to autonomy and accusations of paternalism. Such claims—voiced primarily by the tobacco industry itself—argue that the decision of millions of people to begin and continue to smoke should be respected as a "choice of lifestyle." From this perspective, international restraints on tobacco trade, marketing, or sales, particularly those that target women as a vulnerable population, are paternalistic and violative of the right to autonomy. A human rights analysis reveals that this position is fundamentally flawed.

The argument from autonomy posits that tobacco's effects are the freely chosen "personal costs" of smoking and thus the smoker's right

73. See ICCPR, supra note 2.
74. See, e.g., Cook, supra note 70, at 265; Ruth Roemer, Health Legislation as a Tool for Public Health and Health Policy, 49(1) INT'L DIG. HEALTH LEGIS. 89 (1998).
77. Experts now agree that the economic benefits of tobacco production are illusory. See JHA & CHALOUPIKA, supra note 54; Barnum, supra note 54.
78. See, e.g., Wike, supra note 75; Johnson, supra note 75.
79. "[W]e believe 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, Phillip Morris USA, Address before the Advertising Women of New York (March 7, 1991) in Phillip Morris Document #2051020295-336, at 326-328 (visited Feb. 12, 2000) <http://www.tobaccoarchive.com/docarch.html>.
80. See id.
and responsibility.\textsuperscript{81} This premise is faulty on several grounds. First, nicotine delivered to the brain through carefully designed tobacco products\textsuperscript{82} is sufficiently addictive to preclude free choice.\textsuperscript{83} Several studies have found nicotine to be as addictive as heroin and cocaine\textsuperscript{84} 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.”\textsuperscript{85} Most tobacco users express a desire to quit but find that they cannot—a typical indicator of addiction.\textsuperscript{86}

Second, to see tobacco use 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. Impeding factors include government suppression of information, lack of education, low or no access to comprehensive, gender-sensitive health care, exclusion from public affairs, and cultural restrictions on movement outside of the home. These restrictions on information invalidate the “free choice” objection to tobacco control and confirm that targeting disadvantaged women is neither paternalistic nor unwarranted.

Third, even where a woman has access to economic, social, and political 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, her level of education, and her subjection to coercion.\textsuperscript{87} The notion of free choice in this position is fallacious, as one prominent feminist has noted: “[P]hysical health cannot be detached from political and social concerns, posited as an objective state of biological being, and then treated as

\textsuperscript{81} See generally \textit{id}.

\textsuperscript{82} Nicotine, as with most of the 4,000 chemicals contained in cigarettes, is mixed into droplets of tar in order to make the smoke ‘smoother’ as it passes through the throat and enters the lungs. \textit{See VIEGOLA, supra} note 12, at 48; \textit{see also} Jane Brigham, Kobe Conference, \textit{supra} note 9.

\textsuperscript{83} The World Health Organization first recognized tobacco as dependence-producing in 1974. The United States Department of Health and Human Services (DHHS) also has recognized the addictive nature of smoking since at least 1969, the time of the Surgeon General’s first conclusive report on the harms of tobacco. \textit{See 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, supra} note 42. For more detailed discussion of the highly addictive nature of nicotine, \textit{see Sylvia Law, Addiction, Autonomy, and Advertising, 77 Iowa L. Rev. 909 (1992).}

\textsuperscript{84} \textit{See VIEGOLA, supra} note 12, at 39.

\textsuperscript{85} Law, \textit{supra} note 83, at 948.

\textsuperscript{86} \textit{See VIEGOLA, supra} note 12, at 38. \textit{But see Yang supra} note 24 (reporting a low desire to quit among Chinese men in the Mindhang District despite high awareness of the health hazards). Disparities in desire to quit may be due in part to cultural perceptions of the habit, reinforcing the conclusion that tobacco use is influenced by the effects of state policy.

\textsuperscript{87} “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, \textit{supra} note 65, at 200.
though the choices we make in pursuit of it are apolitical and compelled by some internal logic that derives solely from health itself.88

Human rights theory rejects the autonomy argument by proving that women’s heightened vulnerability is not a question of weakness but of coerced response to deep and powerful structures of discrimination.89 By revealing how coercive it is for a woman to be ignored and demeaned by her family and community, excluded from public affairs, and refused the benefits of good nutrition, clean water, and fair-wage employment, the human rights approach dispels the myth of “personal choice” and refutes misguided cries for 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.”90 Indeed, such groups are not intrinsically less capable but rather less empowered to act in their own interests. Autonomy is an illusion for many of the world’s women and such claims should not be allowed to obstruct effective tobacco control.

E. The Strength of Alliance

An additional advantage of the human rights framework is that it enables advocates to build on existing women’s networks. Although the benefits of alliance among women’s interest groups are clear, the tobacco control movement has been slow to seek a feminist coalition. Through most of its history, tobacco policy makers have acted outside (if not in conflict with) feminist movements.91 Ironically, some of the first promoters of female smoking were suffragettes, marching proudly with cigarettes in hand through the 1929 New York Easter Parade.92 The suffragettes were hired to smoke in the parade in defiance of social norms discouraging female smoking; their radical behavior attracted wide publicity and helped to inaugurate the cigarette as a symbol of women’s liberation.93 Women won the right to vote and held their victory dear; they also forged what would be a long term alliance with the tobacco industry. Only very recently have women’s groups on a wide scale acknowledged the depth of tobacco’s threat and its bearing on women’s rights.94 In-

88. Freedman, supra note 59.
89. See Allen Brandt, Recruiting Women Smokers: The Engineering of Consent, in 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).
90. Phillip Morris Document, #2503017371/7391, supra note 79.
91. See VIEROLA, supra note 12, at 10-15.
92. See id. at 12.
93. See id.
94. See, e.g., Discussion Paper, supra note 27.
Increasingly, however, women from all regions with a wide array of agendas have come together to adopt tobacco control as a matter of women's human rights. These partnerships will be crucial if the movement is to leave no woman behind in its efforts.

F. A Process of Empowerment

Finally, tobacco control should be taken up not only as a goal for women's rights but as a project of empowerment. By participating in the fight against tobacco women claim a voice in international health policy. The rights of self-determination and political participation that so frequently are denied to low-status women can be redeemed, in part, through this fight. This will call for women's leadership in local, regional and global mobilization, input into the design of national and international health policy, active participation in negotiating an international treaty on tobacco control, unified feminist outcry against the tobacco industry's deceptions and manipulations, and—most important—the direct participation of millions of individual women.

IV. CONCLUSION

The fight against tobacco is a woman's fight. This is so—first and foremost—simply because millions of women will die from tobacco-related disease in our lifetimes. It is also true because the direction of the epidemic is no accident; the unique vulnerability of disadvantaged women is due, in large part, to states' tobacco policies that directly violate women's rights. Finally, tobacco control offers a means for women to challenge the broader conditions of their disempowerment. It is a chance for women to claim their fundamental rights to dignity, self-determination, and equal opportunity, backed by a rare alignment of economic and public health interests.

I have tried to demonstrate the intimate link between women's human rights and the tobacco epidemic. I have argued for women to take up the fight against tobacco and to rely on the law of international human rights in doing so. As the logical extension of my argument, it remains to identify specific provisions of international law and to articulate their meaning in the context of tobacco policy. While I leave this analysis to a later discussion, it bears noting such an argument must draw on the full spectrum of human rights. The tobacco epidemic cannot be explained by

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95. Recently, Charlotte Abaka, Chair of the Expert Committee on the Women's Convention (CEDAW), stated that tobacco control 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. See Kobe Conference, supra note 9.
any single factor and the interwoven meanings of all human rights are undeniably at stake in tobacco policy: the right to participation in public life and political decision-making,96 the right to freedom from discrimination on the basis of sex,97 the rights to self-determination, bodily integrity and dignity,98 and the right to economic development and the benefits of scientific progress.99 These rights are being violated in precisely those countries and populations where the tobacco epidemic is poised to take hold. Though it stands as a tragic demonstration of the broad denial of women's human rights, the tobacco epidemic offers—precisely because of its complexity—a chance to deepen the meaning of women's health and to advance the discourse of human rights to the benefit of all.

96. See ICCPR, supra note 2.
97. See CEDAW, supra note 7; ICESCR, supra note 3; ICCPR, supra note 2.
98. See ICESCR supra note 3; ICCPR, supra note 2; Universal Declaration of Human Rights, supra note 71.
99. See ICESCR, supra note 3.