GENDER, WOMEN, AND THE TOBACCO EPIDEMIC

World Health Organization

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Preface

Dr Margaret Chan, Director-General of the World Health Organization (WHO), stated in her Foreword to the 2009 WHO report on women and health*:

> *The Millennium Development Goals and other global commitments have focused primarily on the entitlements and needs of women. The current financial crisis and economic downturn make this focus even more urgent: protecting and promoting the health of women is crucial to health and development – not only for the citizens of today but also for those of future generations.*

A rise in the number of women smokers around the world will have enormous adverse effects on households' financial status and family health. While the epidemic of tobacco use among men is in slow decline in some countries, use among women in some countries is increasing. However, in India and in several other countries, women also use other forms of tobacco, such as chewing tobacco. Unless innovative and sustained initiatives are undertaken, the number of female users of tobacco is predicted to rise over the next several decades as a result of increased prevalence, as well as population growth.

This monograph is part of WHO's continued efforts to curb an epidemic of tobacco use affecting girls and women of all ages. It originated from a previous WHO monograph, *Women and the Tobacco Epidemic – Challenges for the 21st Century*, published in 2001. That monograph presented scientific papers commissioned by WHO in preparation for the 1999 WHO Conference on Tobacco and Health, Making a Difference to Tobacco and Health: Avoiding the Tobacco Epidemic in Women and Youth, held in Kobe, Japan. Since then, new data, changes in tobacco control legislation, and issues have emerged that warrant a new publication.

Much progress has been made on the issue of gender, women, and tobacco since 1999. Most significantly, the WHO Framework Convention on Tobacco Control (WHO FCTC), now endorsed by 168 signatories and with more than 170 Parties, emphasizes the need for a gender perspective. The Preamble states:

> **Alarmed** *by the increase in smoking and other forms of tobacco consumption by women and young girls worldwide and keeping in mind the need for full participation of women at all levels of policy-making and implementation and the need for gender-specific tobacco control strategies,*
>
> **Emphasizing** *the special contribution of nongovernmental organizations and other members of civil society not affiliated with the tobacco industry, including health professional bodies, women's, youth, environmental and consumer groups, and academic and health care institutions, to tobacco control efforts nationally and internationally and the vital importance of their participation in national and international tobacco control efforts,*
>
> **Recalling** *that the Convention on the Elimination of All Forms of Discrimination against Women, adopted by the United Nations General Assembly on 18 December 1979, provides that States Parties to the Convention shall take appropriate measures to eliminate discrimination against women in the field of health care.*

In addition, Article 4 of the Guiding Principles of the WHO FCTC specifically mentions gender, noting "the need to take measures to address gender-specific risks when developing tobacco control strategies".

WHO has given high priority to strengthening global action on the gender, women, and tobacco issue in its own programmes, including an operational project in Viet Nam. In the WHO Western Pacific Region, all five-year Action Plans on tobacco or health since 1990, including the 2010–2014 Plan, have emphasized the importance of preventing a rise in tobacco use among women. In 2010,

* *Women and Health: Today's Evidence, Tomorrow's Agenda.* Geneva, World Health Organization, 2009.

Gender and Tobacco with an Emphasis on Marketing to Women is the theme of the WHO campaign for World No Tobacco Day.

Progress has also been made in mobilizing non-governmental organizations (NGOs), foundations, and the scientific community in support of activities concerned with gender, women, and tobacco. For example, the International Network of Women Against Tobacco (INWAT), founded in 1990 to address issues of tobacco and women, has grown steadily and now has members in more than 80 countries. INWAT regularly distributes reports and newsletters and in 2006 published *Turning a New Leaf: Women, Tobacco and the Future. The Tobacco Atlas*, now published by the American Cancer Society and the World Lung Foundation, places a special emphasis on girls and women. A gender perspective has been integrated into many American Cancer Society tobacco projects. The CHEST Foundation, based in the United States of America, developed a Speaker's Kit on Women and Girls—an educational tool addressing the dangers of tobacco use—which has been produced in many Asian languages. World and regional conferences on tobacco and health now strive for gender equality in their committees, chairs, and speakers, and they include the topic of gender, women, and tobacco in their programmes.

The publication of this monograph is opportune. The numbers of women who use tobacco and who are exposed to second-hand smoke (SHS), especially in poor communities, are expected to increase in the coming decades, for the following reasons:

- The female population in low- and middle-income countries is predicted to increase; thus, even if smoking prevalence remains low, the absolute numbers of women smokers will increase.
- Girls' and women's spending power is increasing, so cigarettes are becoming more affordable for them.
- The social and cultural constraints that have prevented many women from smoking are weakening in some countries.
- Women-specific health education and quitting programmes are rare, especially in low- and middle-income countries.
- In countries where rates of smoking are increasing among men, women will be increasingly exposed to the hazards of SHS.
- The tobacco companies are targeting women, using well-funded, alluring marketing campaigns.

In her editorial for INWAT, Dr Gro Harlem Brundtland, the former Director-General of WHO and a lifelong anti-tobacco advocate, concluded:

> *We need a broad alliance against tobacco, calling on a wide range of partners such as women's organizations to halt the relentless increase in global tobacco consumption among women. There is a special need for gender-sensitive health education and quitting programmes. There is also a need to involve more women in senior, decision-making positions in the tobacco control movement, on editorial boards of medical journals which include tobacco issues, on WHO expert panels, and in nongovernmental organizations that deal with tobacco issues.*

In keeping with this urgent call, this monograph helps to assess the current situation, identifies gaps in research, and offers solutions that must be heeded to prevent an epidemic of the gravest order.

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A Message from Dr Margaret Chan

Director-General, WHO

We need to strongly support women's leadership in tobacco control, and we must act now. As the 2009 WHO report on women and health noted, tobacco use is one of the most serious avoidable risk factors for premature death and disease in adult women and is responsible for about 6% of female deaths worldwide. Without action to reduce smoking, deaths among women aged 20 years and over may rise from 1.5 million in 2004 to 2.5 million by 2030; almost 75% of these projected deaths will occur in low- and middle-income countries. Furthermore, second-hand smoke is a killer, and there is no safe level of exposure. In regions where the majority of smokers are men, millions of women and children suffer from exposure to second-hand smoke. Most alarming, the rates of smoking are increasing among youth and young women in several regions of the world. Where tobacco use is still relatively low among women and girls, an opportunity exists for preventing increased uptake and future premature deaths.

Let us remember that tobacco poses a threat to achieving the United Nations Millennium Development Goals (MDGs). The MDGs are about reducing poverty, as well as achieving gender equality. They recognize that poor health anchors large populations in poverty. They also acknowledge that better health allows people the opportunity to find their way out of poverty. Still, there is an alarming trend that links poverty with tobacco use. Poor families are more likely to include smokers than richer families. Poor families spend a substantial part of their total expenditures on tobacco—often more than they spend on education or health care. According to the World Bank, the use of tobacco results in economic losses of billions of dollars each year—and most of those losses occur in developing countries. Cost-effective tobacco control strategies can work. Bans on tobacco advertising, increased tobacco taxes, graphic labels on tobacco packaging, controls on smuggling and counterfeiting, and legislation to create smoke-free environments in all public places and workplaces have helped. Enforcing and enacting such measures with women's full participation is sound social and economic development policy.

WHO is committed to improving women's health and promoting women's leadership and chose Gender and Tobacco with an Emphasis on Marketing to Women as the theme of its 2010 World No Tobacco Day. As I have often said, the challenges are different for women. That is why women need special attention in health agendas. As caregivers in the home, they are an important resource. They are also susceptible to special health problems and have a heightened risk of premature mortality. Also, many women do not have adequate access to health services, even though continuity of care is essential over a life-course. Part of the solution is to empower women to leverage their resources and creativity. We have seen example after example of women who are given the right encouragement and an enabling environment making changes, not only in their own lives, but in the lives of their families and communities.

This monograph makes an important contribution to our scientific understanding of tobacco use among women. It also provides an analytical framework for promoting a gender perspective in policy-making. We have added an important new tool in the effort to scale up technical and other assistance at country level. On 27 February 2005, the WHO Framework Convention on Tobacco Control (WHO FCTC) entered into force. Currently, more than 170 Parties have ratified the Convention. Its Preamble recognizes women's leadership as key to achieving the goal of tobacco control. Most important, it supports a principle central to achieving gender equality in health—that women's right to health is a human right.


Sex appeal?
No, second-hand
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Introduction


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1. Summary and Overview

Background

In 1999, in collaboration with the Japanese Ministry of Health, Labour and Welfare, the World Health Organization (WHO) hosted a meeting in Kobe, Japan, entitled Making a Difference to Tobacco and Health: Avoiding the Tobacco Epidemic in Women and Youth. More than 500 participants from 50 countries met to consider issues related to gender equality and tobacco. The Conference proved to be a turning point in the tobacco control movement, as it brought together multiple stakeholder groups concerned with gender and tobacco. It provided a much needed forum for health scientists and other professionals to open a dialogue with leaders representing local authorities, youth, women, and human rights.

The participants at the Kobe Conference cited a number of reasons for the need to consider gender and gender equality in national and international programmes and strategies. Among the points emphasized were:

- Women and girls, particularly among the poor, are often invisible in health statistics. Information is lacking on epidemiological statistics and risks and level of health knowledge. The emphasis given to men reflects gender discrimination and the inequality underlying many tobacco control programmes.

- When women are held responsible for reproductive health, they may be blamed for their addiction to tobacco and its negative impact on their children. Much less medical attention has been paid to the negative health effects of paternal smoking on fertility and the health of the fetus. Cessation programmes for fathers are seldom provided as part of reproductive health services.

- The majority of victims of second-hand smoke (SHS) are women and children, exposed in their homes through the smoking of men. Curtailing exposure to SHS needs to be given a higher priority to protect women's and children's rights to a safe and smoke-free environment in homes and public places.

Tobacco control programmes seldom recognize women as potential leaders. Unless women are empowered they cannot fully participate in tobacco control programmes.[1]

Much of the success of the Kobe Conference was due to the persuasive power of sound evidence. With the help of a grant from Japan, WHO convened a scientific working group for one year prior to the Conference. The results of the scientific working group were first published in the 2001 WHO monograph *Women and the Tobacco Epidemic—Challenges for the 21st Century*. Nearly 10 years later, gender, women, and tobacco policies must take into account new epidemiological patterns, social and economic trends, and political challenges. For example, a landmark in international law is the WHO Framework Convention on Tobacco Control (WHO FCTC), which went into force in 2005 and has been ratified by more than 170 countries. The WHO FCTC is a multilateral evidence-based treaty that provides the legal framework for countries to reduce the supply and demand for tobacco, in addition to supporting women's rights to health as a human right.

For this monograph, an international team of scholars and experts reviewed the most current research to provide an overview of tobacco control issues related to gender, with a focus on women. Interdisciplinary teams included researchers and activists in public health, medicine, nursing, and dentistry, as well as anthropology, psychology, economics, law, journalism, and gender studies. The concerns of tobacco control policy-makers, educators, public health advocates, and economic planners, as well as youth and women leaders, are addressed. Special attention is paid to policies that affect women throughout their life-course. A gender analysis should provide information on why specific programmes are working for men and not for women. However, due to a lack of data, particularly regarding poor women and men in developing countries, it is not possible to perform a comprehensive analysis at this time. Rather, this monograph presents available research findings and data, identifies gaps to be addressed, and suggests directions for future study.

The monograph has four sections: Tobacco Use and Its Impact on Health; Why Women and Girls Use Tobacco; Quitting; and Policies and Strategies. Topics covered include determinants of starting to use tobacco, exposure to SHS, the impact of tobacco use on health, the nature

of addiction and cessation, and treatment programmes, as well as policy issues involving economic and tax measures, gender analyses, and human rights.

Tobacco Use and Its Impact on Health

Tobacco Use

What are some of the salient findings? Globally, the prevalence of smoking is higher for men (40% as of 2006) than for women (nearly 9% as of 2006), and males account for 80% of all smokers. In most countries around the world, men—being more likely than women to smoke—are also almost two times more likely to die from smoking. However, data from several industrialized and developing countries show that men's smoking rates may have peaked and are now in slow decline. Programmes should include efforts to sustain this downward trend, particularly among adolescent boys. At the same time, much more attention needs to be paid to the increasing numbers of women who use tobacco.

As noted in Chapter 3, Prevalence of Tobacco Use and Factors Influencing Initiation and Maintenance Among Women, there is wide regional variation in smoking prevalence among both males and females. In the Americas and Europe, the prevalence of female smoking is high, around 17% and 22%, respectively. The disparity between male and female smoking prevalence is greater in other regions of the world. For example, male smoking prevalence is near 37% in South-East Asia and 57% in the Western Pacific, while prevalence among women is around 4% to 5%. Globally, boys are more likely than girls to smoke. However, in half the countries surveyed by the Global Youth Tobacco Survey (GYTS), there is no sex difference in rates of youth smoking, indicating that tobacco use among girls may be increasing in some countries. If the rates of use of any form of tobacco—e.g. water pipes, cheroots, chewing tobacco, snuff—were to be included, the figures would be much higher. These disparities reflect differing social norms, cultural traditions, and socioeconomic and demographic factors.

Women who smoke tend to do so in part for different reasons than those of men smokers. The roots of tobacco uptake for women and girls often include cultural, psychosocial, and socioeconomic factors, including body image and peer pressure. In the Asian and Pacific countries where smoking has become a symbol of women's liberation, many young women are turning to tobacco as a sign of freedom. Others take up the habit because of a popular belief that smoking keeps them slim. Regardless of the reason for starting to smoke, addiction sets in quickly, as a cigarette is a carefully designed nicotine delivery system that provides sufficient nicotine to establish and maintain dependence on tobacco.

Less is known about traditional tobacco use, such as the use of khaini, mawa, or betel quid and bidis among subgroups of women. Similarly, a new trend of increased use of water pipes by women requires more attention. However, data from India suggest the need for much more research on local practices. The prevalence rates of smoking and chewing tobacco vary widely by region in India, and in many areas women are more likely to use oral tobacco products than to smoke. Reasons for starting may reflect local beliefs and cultural practices. For example, some Indian women believe that chewing tobacco can cure toothaches or can be useful during childbirth.

Studies in many countries indicate that most tobacco use begins in early adolescence. The age of starting to use tobacco has important implications. Adolescents who begin smoking at a younger age are more likely to become regular smokers and are less likely to quit than those who start later. Socioeconomic status (SES) has been implicated in the risk for onset of smoking among adolescents. In some countries, young people with more spending money have higher levels of tobacco use, in both uptake and frequency of smoking. In developing countries, the lack of health education programmes results in girls having little knowledge of the harmful effects of tobacco use. More research is needed on the gender influences leading to unequal access to health education and information by girls and boys.

Several studies in the United States of America and in Canada have found that girls have lower self-esteem than boys and that low self-esteem is associated with smoking among girls. Another significant determinant in high-income countries is the belief that smoking can reduce appetite and control body weight. Parental smoking, peer smoking, and exposure to smoking in movies can also influence tobacco use, although further research is needed in low-income countries, where differences in social

norms, family life, and culture influence behaviours. In countries where the rate of tobacco use (and particularly cigarette smoking) by women and girls is still relatively low, programmes are needed to prevent increased uptake and future premature deaths and disabilities.

Impact on Health

Chapter 4, Impact of Tobacco Use on Women's Health, concludes that women who use tobacco face virtually the same risks that men face and even greater risks for some diseases. Many women are still unaware of the full scope of risks caused by the many toxic and carcinogenic compounds in tobacco smoke: tobacco smoke contains more than 4000 chemicals, hundreds of which are toxic or carcinogenic. The reasons for both men and women failing to get accurate health information concerning sex-specific impacts of tobacco use on health need further study, followed by intervention.

Current research, largely from industrialized countries, indicates cause for alarm. Lung cancer mortality rates among women in the United States have increased approximately 800% since 1950. By 1987, lung cancer had surpassed breast cancer to become the leading cause of cancer death among women in the United States. Women who smoke have higher risks for many cancers, including cancers of the mouth, pharynx, oesophagus, larynx, bladder, pancreas, kidney, and cervix, as well as for acute myeloid leukaemia. And there is a possible link between active smoking and premenopausal breast cancer.

Smoking also affects reproductive health. Women who smoke are more likely than non-smokers to experience infertility and delays in conceiving. Maternal smoking during pregnancy increases risks of prematurity, stillbirth, and neonatal death and may cause a reduction in breast milk.

Women who smoke are at increased risk of developing potentially fatal chronic obstructive pulmonary disease (COPD), which includes chronic bronchitis and emphysema. In industrialized countries, the prevalence of COPD is now almost as high in women as it is in men. In addition, smoking is a cause of coronary heart disease (CHD) in women, for whom risk increases with the number of cigarettes smoked and the duration of smoking. The risk of CHD is even higher among women smokers who use oral contraceptives. Among postmenopausal women, current smokers have lower bone density than non-smokers and an increased risk of hip fracture.

There are many gaps in the data about the health impact of tobacco use on girls and women of all ages and throughout the life-course. Much more research is needed on the ways women—particularly in developing countries—use a variety of tobacco products, including snuff, chewing tobacco, and traditional forms of rolled tobacco. Finally, high-quality, population-based cancer incidence data are needed on health risks for women who work in the informal sectors of tobacco growing, production, and marketing.

Second-Hand Smoke

In 2004, second-hand smoke (SHS) was estimated to have caused about 600 000 premature deaths per year, (28% of which were among children). Of the 430 000 adult deaths, about 64% were among women. Although by 2008, an additional 154 million people worldwide had been covered by comprehensive smoke-free laws, nearly 90% of the world's population is not protected, and laws do not limit exposure to SHS in homes where women and children are exposed through the smoking of male family members. Second-hand tobacco smoke contributes about 1% of the total global disease burden; in the United States, the economic costs total about US$ 19.3 billion per year.[2] Chapter 5, Second-Hand Smoke, Women, and Children, sounds the alarm for those women and children who are exposed to smoke and its health hazards even though they do not use tobacco themselves. SHS jeopardizes women's health, especially in countries and cultures where many women do not have the power to negotiate smoke-free spaces, even in their own homes.

Progress has been made in improving indicators of SHS exposure, including biomarkers such as levels of cotinine in blood, urine, or saliva, which are direct measures that can be used to estimate exposure. In industrialized countries, nearly half of the children and adolescents are exposed to SHS. In China, which accounts for one third of the world's cigarette consumption, the tobacco epidemic is almost entirely a male phenomenon. A 2002 national survey reported that less than 3% of women in China smoked. However, more than half of the women of reproductive age were regularly exposed to SHS.

There is now sound scientific evidence that SHS causes illnesses and deaths among women and children. Women whose male partners smoke have increased rates of lung cancer and increased risk for CHD. Paternal smoking may have effects on sperm and may lead to postnatal health problems, including increased risk for sudden infant death syndrome (SIDS), reduced physical development, and possibly increased risk for childhood cancer. Studies from China show that paternal smoking alone can increase the incidence of lower respiratory illness in children. Maternal smoking during pregnancy reduces birth weight substantially and is a causal factor for SIDS. Exposure to SHS results in lower respiratory tract illnesses, chronic respiratory symptoms, middle-ear disease, and reduced lung function in children.

The tactics that have been used in marketing tobacco in the United States and other industrialized nations for decades now threaten women in the developing world.

Studies have found that smoke-free legislation increases cessation rates and reduces consumption. It also decreases SHS exposure and brings immediate health benefits. For example, a study in Scotland measured salivary cotinine levels in schoolchildren and found that the average concentration decreased by 30% after smoke-free legislation was put in place. Still, many governments have not taken or enforced adequate public health measures to protect women and children against exposure to SHS. Lack of enforcement is particularly relevant in developing countries where legislation prohibiting tobacco use in public places may not be strictly enforced. Since there is no safe level of exposure to SHS, the chapter's recommendations include enactment and strong enforcement of 100% smoke-free indoor workplaces and public places and smoke-free child-care settings, which would remove a major source of SHS exposure for infants and children. Special campaigns that are culturally appropriate are also needed to address the problem of SHS in the home, a major locus of exposure for women and children.

Why Women and Girls Use Tobacco

Marketing, Advertising, and Promotion

Even though the health hazards of tobacco use are known, women are becoming increasingly addicted to it. One of the powerful influences driving changing rates of tobacco use is industry advertising and sponsorship. The tobacco industry has long fostered the false idea that tobacco is linked to women's empowerment by suggesting that cigarette smoking symbolizes high fashion, freedom, and "modern" styles and values, and that it even promises weight reduction.

Chapter 6, The Marketing of Tobacco to Women: Global Perspectives, leaves little doubt that the tobacco industry considers female consumers to be a lucrative market. In the United States, 11% of total advertising and promotion expenditures in 1996 came from the tobacco industry; in 2005, US$ 13.11 billion was spent on tobacco advertising and promotions. The tactics that have been used in marketing tobacco in the United States and other industrialized nations for decades now threaten women in the developing world. In many countries recently affected by free trade agreements, the tobacco industry has targeted a flood of savvy marketing strategies towards women. Large companies sponsor events such as women's tennis tournaments and disco dances to create a public image of smoking as a promoter of health and relaxation. "Female brands", "light" cigarettes, low prices, easy availability, and free samples help these marketing strategies succeed among young women.

Tobacco companies rank among the 10 top marketers in several Asian countries. Research in Asia, including Indonesia, Sri Lanka, Viet Nam, China, India, and the Philippines, indicates that massive advertising combined with changing gender roles and women's increased earning power produces a favourable environment to advance sales. British American Tobacco (BAT), Japan Tobacco, and the China National Tobacco Corporation have substantial shares in this market. In India, where it may not be culturally "correct" for women to buy cigarettes openly, companies have offered to deliver them to the home.

Modern marketing seeks to attach symbolic meaning to brands, associating products with psychological and social

needs in a coordinated strategy that surrounds the consumer with stimuli. A cigarette brand has become the ultimate "badge product", because it is like a name badge that sends a message every time it is seen, projecting a distinctive identity. Brand images may appeal to consumers' social insecurities by appearing to propose solutions to identity problems. In addition, advertising is used to reduce fears about tobacco use and to associate products with dazzling blue skies and mountains, happiness, and healthy sports activities. Consumer culture is visual, and images of modern, Western-style women play a dominant role in developing countries. In the global consumer culture, having the right body becomes part of a woman's identity, and this ideal type is used extensively in advertisements. In the Philippines and Viet Nam, posters advertising cigarettes typically portray big-busted foreign women wearing scanty clothing. Prominent themes appealing to Asian women include weight control, stress relief, and independence. Surprisingly, women also represent 50% of the market share of brands that use images of masculinity, e.g. Marlboro and Camel.

Promotions aim for immediate action on the part of the consumer. Discount coupons may be especially effective for reaching poor women and youth, and clothing promotions create "walking billboards". Sponsorships of entertainment, sporting events, and fashion shows embed advertising within the events. In an era of globalized media, such sponsorships can reach audiences across borders and can touch millions of children, youth, and women in their homes. One study estimated that 25% of young people 12 to 17 years of age watch auto racing on television, and women constitute 39% of NASCAR's audience. Sponsorship of dance and art events, women's organizations, campaigns against domestic violence, schools, scholarships, beauty contests, and youth sports events has linked tobacco companies with social causes, as well as fun. Of particular concern has been the tobacco industry's use of film and music sponsorships, because these are known to influence tobacco initiation and uptake among children and youth. The Internet offers a still unregulated opportunity to market tobacco products to women and youth.

Addiction

Chapter 7, Addiction to Nicotine, points out that nicotine's effects on a user vary with the tobacco product and the way nicotine enters the body. Women use a variety of combustible tobacco products, including roll-your-own cigarettes, cigars, bidis, and kreteks, as well as water pipes and pipes. The nicotine content of tobacco products varies widely according to form and brand. More women than men smoke "light" or "ultra-light" cigarettes (63% vs 46%), often in the mistaken belief that "light" means "safer". In fact, "light" smokers engage in compensatory smoking, inhaling more deeply and more often in an effort to achieve the desired amount of nicotine. Further study is needed on factors driving consumer preferences for smokeless tobacco, such as chewing tobacco and the moist and dry snuff that are gaining in popularity.

Contrary to popular belief, all tobacco products can be deadly and addictive, regardless of their form or disguise. While cigarettes are the most efficient product for delivering nicotine into the body, the nicotine content in water pipes and cigars has been shown to be significantly higher than that in manufactured cigarettes. Tobacco companies have recently introduced potentially reduced-exposure products for which information on potential risks is lacking.

Nicotine affects women's physiology and mood differently from the way it affects men's. For example, rates of nicotine metabolism are significantly higher in women smokers who use oral contraceptives and those who are pregnant. Tobacco-related health risks for women include osteoporosis and increased risk of fracture, early menopause, and sexual and reproductive health problems. Nicotine replacement therapy (NRT) is useful for cessation, but women have higher sensitivity to nicotine than men have. Key barriers that may make quitting more difficult for women than for men include poverty, depression, lack of social support, and fear of weight gain. Appetite suppression is a critical aspect of the appeal of smoking for many women and girls in some socioeconomic groups. Research indicates that in some countries, girls who use tobacco tend to have relatively stronger attachments to peers and friends than do boys who smoke. The girls also tend to overestimate smoking prevalence in their environment, are less knowledgeable about nicotine and addiction, and usually have parents or friends who smoke. More research is needed on the process of initiation into smoking, transitions from experimentation to addiction, and risk and protective factors for girls and women in different cultural settings and in developing countries.

Models of addiction provide useful frameworks for designing interventions and offer a point of departure for preventing and treating addiction, taking into consideration behavioural and psychological factors, social and environmental influences, and marketing. It is important to remember that there are multiple pathways to overcoming addiction. Often overlooked are some obvious guidelines, e.g. that treatments should address women's specific concerns and that the single most effective method is to quit in the early stages of use.

Quitting

Beating Nicotine Addiction

Chapter 8, Quitting Smoking and Beating Nicotine Addiction, emphasizes the fact that most smokers and tobacco chewers are addicted tobacco customers, not satisfied consumers. Studies in Canada, the United Kingdom, Australia, and the United States show that nearly 9 out of 10 smokers say they regret smoking, with women more likely to express regret about smoking than men.

Women seem to be less successful at quitting smoking than men, although there are scant global data on this issue. Because women are more prone to depression, and depression increases the risk of relapse, this is a special concern for women. Some studies indicate that adolescent girls and women are more concerned about weight gain than men are and may resume smoking to avoid it. Also, pregnant women may prefer individual counselling over group counselling, especially if they anticipate disapproval of their smoking by others. Women-only groups may be required for intervention. The social and economic status of women smokers is also relevant, as poor, less-educated women are significantly less likely to quit.

At the moment, there does not appear to be sufficient evidence of clinically important differences between men and women to guide treatment. More research is needed on use by women of non-nicotine medications such as bupropion, varenicline, and other emerging therapies. Pregnant women should attempt cessation with non-pharmacological modalities before using NRT. There is insufficient evidence about the long-term benefit of the use of interventions to help smokers reduce but not quit tobacco use.

Determining the best way to help smokers quit requires better knowledge of their behaviour as consumers of cessation methods and services, determinants of their preferences, and the role of costs. Studies among pregnant women indicate that 82% want behavioural support, and 77% want self-help materials. In one study, two thirds of the women thought that if their partner, family, or friends quit smoking, it would be easier for them to quit. In some cultures, tobacco cessation professionals may be involved, while in others, spiritual leaders and faith healers may be consulted. All interventions need to be adapted for particular subgroups, specific cultures, and countries.

Models of behavioural change such as the Social Cognitive Theory/Social Learning Theory, Health Belief Model, and the Theory of Planned Behaviour have been applied to tobacco control with varying degrees of success. The Transtheoretical Model of intentional behaviour change is the most multidimensional of the behaviour-change theories and appears to be the most predictive. It views smokers as moving through a series of stages: precontemplation, contemplation, preparation, action, and maintenance. This stage-based approach has been used to help providers of support determine clients' readiness for change. Research supports the notion that cessation success can be predicted by the stage of change. Relapse back to tobacco use is expected after a period of abstinence and recycling through the stages.

Large numbers of tobacco users have been able to quit on their own or with minimal assistance. For those requiring assistance, combining behavioural and pharmacological treatments may increase quitting success, particularly for heavy smokers. Interventions that easily reach women at home include quit lines, Internet smoking cessation sites, and counselling. Women are especially likely to benefit from combination therapy, and psychosocial support seems to offer benefits. It is important to remember that comprehensive tobacco control measures—including bans on smoking in public places and appropriately high taxation—all contribute to higher cessation rates.

Pregnancy and Postpartum Cessation

Chapter 9, Pregnancy and Postpartum Smoking Cessation, concludes that for female users of tobacco and their partners, pregnancy represents an opportunity to

quit. The smoking cessation guidelines calling for 5 As (Ask, Advise, Assess, Assist, and Arrange for follow-up) should be used in gynaecological office practice. Emphasis should be given to the benefits of cessation *before* women become pregnant. Benefits of quitting include reduced frequency of low-birth-weight and pre-term births and of pregnancy complications, as well as improved health of the mother. A significant reduction (more than 50%) in smoking, with the associated decrease in exposure of the fetus during pregnancy, can significantly increase birth weight. For national health-care systems, cessation by women can also result in significant savings.

In the early 1990s, when the smoking prevalence among the female population in the United States was higher than 20%, the rate for women in obstetric care was estimated to be 13.6%. These figures, however, do not reflect the wide range of smoking rates among pregnant women, nor do they identify the subgroups having particularly high rates. For example, cigarette smoking is generally less prevalent among Afro-American, Hispanic, and Asian women in the United States across all age ranges, while prevalence rates are high among less-educated non-Hispanic whites.

There are multiple opportunities for intervention prior to, during, and after pregnancy, each with varying challenges. A key to success is ensuring that partners and family members support quitting during pregnancy and through the critical transition to the postpartum period. As partner smoking is probably the single most important facilitator of women's continued smoking, quitting programmes should also focus on paternal smoking. As with SHS, men have important responsibilities in helping to improve the health environment and behavioural outcomes related to women and tobacco.

Research undertaken primarily in industrialized countries has refined the approaches to effective interventions. These findings may be applicable in other settings, although further research is needed on their applicability in developing countries. For example, subgroups of pregnant women display different quitting behaviours. The non-smokers may actually include many previous users of tobacco. Indeed, information on pre-pregnancy quitting is likely to be inaccurate, as women who stop smoking prior to becoming pregnant may report themselves as never-smokers. For this group, which may relapse to smoking after pregnancy, it is important to maintain positive, tobacco-free health behaviour. In countries where access to obstetric and gynaecological care may be limited, midwives, elders, modern medical professionals, and indigenous health-care providers should be trained to promote quitting in early adulthood.

Pre-pregnancy quitters typically sustain cessation throughout the pregnancy and may be smoke-free for their entire life. Newly pregnant spontaneous quitters are often highly motivated to protect their babies. It is noteworthy that pregnant women in cultures where extended families may be heavily involved in managing the pregnancy often have lower smoking rates. However, the return to smoking for spontaneous quitters during the postpartum period may exceed 50% and may be as high as 80%. For this reason, more attention needs to be paid to relapse prevention services for women in the postpartum period.

Women who continue to smoke during pregnancy are typically less-educated, unemployed, and of lower SES. They also often live in more smoke-filled home environments. Studies in the United States, the United Kingdom, Sweden, Australia, and Canada indicate that cessation counselling in brief periods can be effective early in pregnancy. The cost–benefit ratio for an intervention that achieved a 15% smoking cessation rate, compared with the 5% cessation rate of usual practice, would be US$ 11 in savings for each US$ 1 of investment. Women who continue to smoke later in pregnancy find it particularly difficult to quit, and promoting cessation is even more difficult with women who have already had a child and smoked during the prior pregnancy.

Interventions should be based on the premise that there is no safe level of exposure to nicotine for the fetus. Health-care providers should encourage male partners who are smokers to support and not undermine a partner's cessation during pregnancy and in the postpartum period. One interesting attempt to do so was Project PANDA, which sent video and print materials tailored to the male perspective on pregnancy and child care. Cessation in light of impending fatherhood and emphasis on the dangers of SHS were also included. Evaluation indicated that 28% of the men who received the materials were not smoking at three months postpartum, compared with 14% of the control-group men. The use of NRTs should be envisaged only as a harm-reduction strategy for women who are heavy smokers and who continue to smoke during pregnancy. Additional studies are needed to evaluate pharmacotherapy options.

Pregnancy provides an opportunity for change that affects the entire family. Most of the benefits of smoking cessation during pregnancy have focused on the fetus and the child. However, programmes can also help to improve the health of mothers and fathers. Smoking cessation interventions designed to reach mothers and fathers, using gender-sensitive approaches, should be integrated in family-planning programmes and in pregnancy testing, both at home and in clinic offices.

Policies and Strategies

A Gender Framework and Gender-Sensitive Policies

A gender framework for tobacco control focuses attention on the social, cultural, and economic factors underlying tobacco use among women throughout the life-course. "Gender" is defined as the social, economic, and cultural construct of the relations between men and women, and, as such, it underlies the social construction of tobacco promotion, consumption, treatment, and health services. Gender inequality contributes to women's lack of participation in health policy decision-making. Gender inequality is embedded in institutions at many levels, from the household to macroeconomic structures. As WHO has noted, "Many of the main causes of women's morbidity and mortality—in both rich and poor countries—have their origins in societies' attitudes to women, which are reflected in the structures and systems that set policies, determine services and create opportunities".[3] Furthermore, the exclusion of girls and women of all ages on the basis of race, caste, ethnicity, religion, or disability is a serious obstacle to successfully implementing gender-sensitive tobacco control policies.

Chapter 2, A Gender Equality Framework for Tobacco Control states that a gender analysis differs from a "women and development" approach in that it acknowledges how gender roles, norms, and relations affect both women and men. Masculinities (the social construct around what being a man is) can be counterproductive or even destructive for men. For example, one reason for rising rates of tobacco use among men has been the targeted marketing that promotes smoking as macho, healthy, sexually attractive, and trend-setting. Yet men have important proactive roles in engaging in women's rights to health. As the majority of the world's smokers, men are mainly responsible for women's involuntary exposure to SHS. As more men join the gender equality movement, stronger support for women's human rights as a cornerstone for tobacco control is in sight.

Implementing the WHO FCTC through a gender perspective should be understood as part of a country's political and development agenda. If the tobacco epidemic among women and girls continues to spread, it will contribute to rising health-care costs and will use valuable resources needed for social development. It will also make achieving the United Nations Millennium Development Goals (MDGs) on improving maternal health and reducing poverty more difficult. The WHO FCTC Preamble recognizes that applying a gender equality framework to tobacco control is integral to effective implementation of its Articles. Provisions concerned with SHS, packaging and labelling, health warnings, and bans on advertising, promotion, and sponsorship, as well as improving national research, are all relevant to women's concerns.

At a theoretical level, the WHO Regional Office for South-East Asia (WHO/SEARO) model of health behaviour can be used to analyse the effects of gender inequality throughout the health system and can help map interrelationships between tobacco control and broader social, cultural, and economic processes. A gender equality framework suggests that comprehensive tobacco control requires applying a gender analysis to many sectors outside health—including finance, trade, and agriculture—all of which influence tobacco use among women. The economic costs of the death and disability of a male head of household due to tobacco use are high for poor households, and they affect women and men disproportionately.

There are a number of strategic actions that can help make a difference. Governments must improve coordination with national agencies and stakeholders for women's affairs, provide adequate financing, and apply indicators for gender equality in national planning. Gender mainstreaming of policies is more likely to succeed if gender experts are included at senior policy levels. Budgeting for gender equality requires development of sensitive, cost-effective indicators and baseline data disaggregated by age as well as by sex.

The WHO FCTC is the pre-eminent global tobacco control instrument; it contains legally binding obligations for its Parties, sets the foundation for reducing both

demand and supply of tobacco, and provides a comprehensive direction for tobacco control policy at all levels.[2] In its global tobacco reports on tobacco control, WHO launched and analysed the MPOWER package, introduced to assist in the country-level implementation of effective measures to reduce the demand for tobacco, contained in the WHO FCTC.[2,4] Although the MPOWER measures, which correspond to one or more Articles of the WHO FCTC, do not explicitly refer to a gender equality perspective, seen through a women's rights lens they can be interpreted as follows:

1. **M**onitor tobacco use *by gender* and *ensure that* prevention policies *are gender-sensitive* (Article 20 of the WHO FCTC).

2. **P**rotect *girls and women of all ages* from tobacco smoke (Article 8 of the WHO FCTC).

3. **O**ffer help to assist *women in quitting* tobacco use (Article 14 of the WHO FCTC).

4. **W**arn *women and girls* about the dangers of tobacco *through gender-sensitive information and communication strategies* (Articles 11 and 12 of the WHO FCTC).

5. **E**nforce bans on tobacco advertising, promotion, and sponsorship *by empowering women to identify and counter these influences* (Article 13 of the WHO FCTC).

6. **R**aise taxes on tobacco, *with the active participation of women leaders* (Article 6 of the WHO FCTC).

According to Chapter 10, How to Make Policies More Gender-Sensitive, the gender bias inherent in many existing health policies and tobacco control programmes must be challenged. Data from South Africa, China, Sweden, and the United Kingdom indicate varied forms of gender policies, according to Kabeer's typology of gender-related policies. Among these, gender-blind policies, which may appear to be unbiased, are often, in fact, based on information derived from men's activities and assume that all persons have the same needs and interests as men.

Tobacco control should aim to improve gender-redistributive policies that recognize women's exclusion and disadvantage in terms of access to social and economic resources, as well as decision-making. Gender-redistributive policies include provision of microcredit loans to women to help empower them and transform gender relations—measures that some health advocates believe must be taken if women's health is to improve. Tobacco control policies need to keep the goal of gender-sensitivity in mind while implementing measures to reduce consumption. The design of policies may be gender-neutral, yet the policies may affect women and men very differently. Thus, all policies, health services, and programmes must be monitored and evaluated, using gender indicators as well as conventional health indicators. Data and indicators should be disaggregated by sex where appropriate.

Economics and Taxation

Taxes that increase the price of tobacco and reduce its affordability are very effective in reducing both paternal and maternal smoking prevalence, thereby reducing the negative consequences of smoking on maternal and child health. Chapter 11, Taxation and the Economics of Tobacco Control, points out that tobacco control programmes must pay increasing attention to economic policies concerned with trade, taxation, tobacco production, and price (Article 6 of the WHO FCTC). Tobacco control is not likely to cause the estimated 33 million people engaged in tobacco farming worldwide—many of whom are women and children—to lose their jobs in the short run. Agricultural policies should therefore take into account evidence that tobacco control will have minimal negative impact on long-run economic growth, employment, or the foreign trade balance.

Rapid urbanization and changes in lifestyle and diet mean that scarce resources are now being used for treatment of noncommunicable diseases, potentially limiting the resources available for prevention. A study in the United States found that smoking-attributable neonatal costs totalled almost US$ 367 million (in 1996 dollars). The calculated annual costs to New York City related to infants' developmental delays caused by prenatal exposure to SHS amounted to US$ 99 million. In China, direct costs of smoking in 2000 were estimated to be 3.1% of national health expenditures. At the household level in Indonesia, where smoking is most common among the poor, 15% of the total expenditure of the lowest income group is on tobacco, while the poorest 20% of

households in Mexico spend nearly 11% of their income on tobacco. Productivity losses for smokers and their caregivers—including lost wages because of time off from work—represent a substantial cost to society.

The costs of SHS exposure are particularly relevant to a gender perspective on tobacco control, because women and children are the majority of the world's involuntary smokers. A study in Minnesota estimated the cost of direct medical treatment for conditions related to SHS to be US$ 228.7 million (in 2008 dollars), equivalent to US$ 62.68 per capita annually. A report from the American Society of Actuaries calculated that US$ 2.6 billion was spent for medical care for lung cancer and heart disease caused by exposure of non-smokers to SHS in the United States.

There is solid evidence that taxation of all forms of tobacco is highly effective in reducing consumption, particularly among youth and low-income groups, among which prevalence is often highest. Increases in cigarette taxes could be a powerful tool for protecting poor women in developing countries, because higher taxes are known to have a significant negative effect on maternal smoking rates. Increased taxes also help to prevent former users from re-starting and can lead current users to try to quit. Studies in the United States, the United Kingdom, and Canada have concluded that the overall price elasticity of demand ranges from –0.5 to 0.25, implying that a 10% increase in the price of cigarettes will decrease overall cigarette consumption in these countries by between 2.5% and 5.0%. Young people are found to be much more price-sensitive than adults in low-, middle-, and high-income countries, according to studies in Nepal, Ukraine, Myanmar, and the Russian Federation.

The share of taxes in the price of cigarettes varies from more than 80% to less than 30%, with many lower-income countries having the lowest tax rates. Taxes could be increased to 65–75% of the retail price of cigarettes, the level in several countries. However, tax increases need to be applied symmetrically across all types of tobacco products in a manner that equalizes the retail sales of the various types; taxes also must keep up with inflation in order for their real value not to be eroded. Concerns about tobacco taxation, such as efficiency and equity related to low-income smokers and threats of smuggling, should be addressed. Earmarking a portion of the revenue generated from tobacco taxes for tobacco control programmes reinforces the effects of the taxes on consumption.

Studies indicate that individuals from lower-income groups respond more to price changes than do persons with higher incomes, more education, and higher SES. Furthermore, evidence from many countries, including Indonesia, Malaysia, Turkey, Viet Nam, and China, shows that changing per capita income significantly affects smoking prevalence, as well as cigarette demand. One study in Turkey found that income elasticity declined with household income level. The evidence suggests that to reduce consumption by a desired amount, the percentage increase in price must be higher if income is increasing. The data on impact by gender and age are not conclusive as to whether females are more price-sensitive than males. Also, much more research is needed on the costs and impact of taxation policies related to the wide variety of smoked and smokeless tobacco products used by girls and women of all ages.

International Agreements and the International Women's Movement

Mobilization and leadership can make a difference. Chapter 13, The International Women's Movement and Anti-Tobacco Campaigns, provides an historic perspective on regional and international movements and traces women's groups' activities in reproductive health and consumer rights, as well as anti-tobacco activities.

Around the world, nongovernmental organizations (NGOs) are doing their share. The Framework Convention Alliance (FCA), a coalition of NGOs and individuals representing nearly 300 organizations from more than 100 countries, helps to organize an international social movement in support of the WHO FCTC. The FCA is exemplary in the attention it gives to monitoring gender issues in the WHO FCTC and in its good record of gender balance in its top leadership. Throughout the WHO FCTC negotiations, its women's caucus worked to ensure that women's human rights were an integral part of the treaty. Organizations of women health professionals—physicians, nurses, and scientists—in alliance with the media, have initiated community-based programmes that contribute to women's involvement in tobacco control. Groups such as the International Network of Women Against Tobacco (INWAT) and the US National Organization of Women have pioneered community-based strategies.

The Women's Environment and Development Organization, in collaboration with WHO and the Campaign for Tobacco-Free Kids, organized a meeting of their networks to plan activities on women and tobacco. Other groups, such as REDEH/CEMINA in Brazil and the Latin American Women's Health Network, have carried out public information campaigns in China, the Lao People's Democratic Republic, Thailand, Bangladesh, Saint Kitts, and Argentina, and campaigns are being planned in 20 countries.

Gender must be mainstreamed in tobacco control, fully utilizing international agreements and human rights policies. The groundwork has been laid. As Chapter 12, Women's Rights and International Agreements, points out, many tobacco-growing countries, including China, Malawi, Zimbabwe, and Indonesia, have signed the women's "bill of rights" known as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW, the most important legally binding international document on the human rights of women, has been ratified by more than 185 countries. It is unique because it addresses deep-rooted and multifaceted gender inequality, emphasizing both public- and private-sphere relations and rights, and it specifically underlines the difference between de jure and de facto equality of women. The CEDAW Committee has concluded that governments' compliance with Article 12 and General Recommendation 24 of CEDAW—both concerned with health—is central to ensuring that women have equal access to health information and services. Other Articles in CEDAW that are supportive of the WHO FCTC include Article 1, which deals with discrimination against women working in the informal sector, such as bidi workers; Article 14, which is concerned with rural women; and Article 11, on women's right to the protection of health in work conditions.

The international community can use legally binding treaties to guide implementation of important policy documents such as the Beijing Platform for Action. The follow-ups to the Fourth World Conference on Women, such as Beijing Plus Ten, the International Conference on Population and Development, and other social and economic accords, are all relevant to ensuring women's rights to health. The international women's health movement, in partnership with governments and the United Nations, has succeeded in strengthening partnerships at these forums. Tobacco control leaders should build on this momentum.

Issues for Advocacy

Although there are major gaps in data and research concerning gender, women, and tobacco, particularly in developing countries, this shortcoming should not justify inaction. Current research suggests several issues for advocacy and action. First, eliminating exposure to SHS is a high priority, because it affects the majority of women throughout their life-course. Women's empowerment is key to achieving smoke-free homes and should be included in campaigns against SHS. As a first step, women and girls need to be better informed about the hazards of SHS to themselves, as well as to fetuses, children, and family members.

Second, men have an important role in protecting women's rights to health. As the majority of the world's smokers, they are primarily responsible for women's involuntary exposure to SHS. As fathers, they can protect the health of fetuses, infants, and girls. As partners, they can encourage pregnant women who quit to stay tobacco-free. As politicians, businessmen, and media leaders, men can take greater responsibility for supporting tobacco control policies that benefit women, such as enforcing total bans on advertising and promotion of tobacco products across all media. Finally, as health planners and health-care providers, their support is critical to making health systems work better for girls and women.

Third, a couples approach to tobacco use during pregnancy and the transition to the postpartum period may be the most effective means for improving the health of the entire family, including infants. Victimization of pregnant women who use tobacco can be a major barrier to their quitting smoking. Non-reporting of tobacco use, lack of support by family members and partners, and failure of doctors to ask about paternal smoking all contribute to increased health risks for pregnant women. Assuring that reproductive health services are women-friendly is also important.

Fourth, as noted in the 2009 WHO report on *Women and Health*,[3] a life-course approach is needed to fully comprehend the impacts of tobacco on the health of girls and women of all ages. A life-course perspective can deepen understanding of the implications of exposure to tobacco smoke in childhood, through adolescence, during the reproductive years, and beyond, to old age. Such an

approach can help map out the interrelationships between social and biological determinants of women's and men's health, linking exposures even before conception to risk for chronic disease in adulthood. There has been little investigation of the later-life consequences of early-life exposures to tobacco smoke. Much more research is needed on how the age of starting to smoke regularly might affect both male and female children's growth and the subsequent risk of diseases caused by smoking.

Finally, gender-sensitive tobacco interventions that include a focus on women's rights should take place in the context of comprehensive tobacco control and as part of a development strategy to reduce poverty. For example, curbing tobacco use is essential for the achievement of the MDGs that concern improving maternal health. Furthermore, such an approach must recognize the diversity of women's and men's needs that may vary by age, ethnicity, economic status, and levels of education. Poor urban and rural women are disproportionately affected by the tobacco epidemic. In many countries, women of lower SES who also have less access to quitting resources have the highest rates of tobacco use. In developing countries, rural women working in tobacco production, manufacture, and marketing receive unequal and inadequate compensation for their labour and job insecurity. Poor families can least afford expenditures on tobacco that take away income that could be used for food, education, and health care. The social costs of the death of a male head of household due to tobacco use are high for widows, who often have unequal access to productive employment and social services.

Gains Made and Looking Ahead

WHO has taken the lead in the effort to coordinate a global strategic response to the tobacco epidemic. As already noted, the WHO FCTC is a powerful tool for change. It promotes women's participation and a gender-sensitive approach to tobacco control. Its Preamble supports women's right to participate fully in decision-making at all levels as a human right. Gender equality should be applied in the interpretation and implementation of all Articles in the WHO FCTC. The future challenge is to ensure that women leaders know their rights under the WHO FCTC and are mobilized at the grass-roots level.

Many governments and municipalities have initiated effective tobacco control measures. In 2004, Ireland became the first country in the world to implement national legislation that banned smoking in all indoor workplaces, including restaurants and bars. Uruguay and New Zealand have each implemented a national ban on smoking in all indoor workplaces, public transport, and public places; both countries also demonstrate high levels of enforcement of and compliance with the legislation. Seven mostly low- and middle-income countries implemented comprehensive smoke-free policies in 2008, covering an additional 154 million people. Panama passed a new advertising ban in 2008. Despite all these changes, nearly 90% of the world's population remains uncovered by comprehensive tobacco legislation.[2] Much more can be done by raising taxes; enforcing a ban on deceptive terms such as "low tar", "light", and "mild"; and improving health warnings to prevent initiation of tobacco use by women and girls.

In the past decade, WHO has continued to strengthen its gender policy, surveillance, resource mobilization, and human resources. A grant from Bloomberg Philanthropies, along with an additional grant from the Bill and Melinda Gates Foundation, has greatly increased resources devoted to fighting tobacco use where it is highest—in the developing world—and has given a boost to WHO's country-level work. In collaboration with the National Cancer Centre in Japan, WHO held an operational planning meeting in 2009 for gender and tobacco projects, with the aim of speeding up gender mainstreaming. Practical implementation plans were developed in Viet Nam to move from policy to action. Recommendations were made on ways to apply a gender analysis to project implementation on interventions such as gender-based health warnings; tax increases; smoke-free environments; bans on advertising, promotion, and sponsorship; and education and communications.[5]

Country-specific data disaggregated by sex have been reported in the *WHO Report on the Global Tobacco Epidemic, 2008: The MPOWER Package* and the *WHO Report on the Global Tobacco Epidemic, 2009: Implementing Smoke-Free Environments*. Other WHO activities have contributed to improving scientific evidence as a basis for policy formulation and programme implementation on gender, women, and tobacco. Important new information about gender differences in tobacco use is provided by the GYTS, which focuses on tobacco use in youth 13

to 15 years of age; the Global School Personnel Survey (GSPS), which collects information from school personnel concerning their use of tobacco; the Global Health Professions Student Survey (GHPSS), which collects data on tobacco use and cessation counselling among health-profession students; and the Global Adult Tobacco Survey (GATS), which monitors tobacco use among adults as part of the Global Tobacco Surveillance System (GTSS).

WHO has worked collaboratively with other partners, including the International Development Research Centre (IDRC), to hold scientific consultations on gender and tobacco. It also continues to work with human rights bodies, such as CEDAW, and NGOs, including the International Network of Women Against Tobacco. At the Eighth United Nations Ad Hoc Interagency Task Force on Tobacco Control meeting, representatives from United Nations agencies such as UNFPA, UNICEF, and the World Bank reviewed ways to strengthen interagency collaboration on gender, women, and tobacco. *Sifting the Evidence: Gender and Tobacco Control,* published by WHO in 2007, provides a summary policy guide and reflects WHO's concern with ensuring that the WHO FCTC process makes gender a central part of its implementation. In the WHO report *Women and Health—Today's Evidence, Tomorrow's Agenda*, the importance of tobacco control to support women's health throughout the life-course is highlighted.[3] The 2010 theme of the WHO World No Tobacco Day was Gender and Tobacco with an Emphasis on Marketing to Women. The international campaign highlighted the tobacco industry's misleading tactics in marketing tobacco products to women and girls. It also focused on women's right to smoke-free environments in the workplace and home.

Future efforts to curb the rising epidemic of tobacco use among women and girls must be built on solid evidence. However, improvements are needed in national databases, particularly in developing countries, and research targeting women and tobacco must be undertaken. Gender bias is pervasive, with the result that data concerning tobacco use or prevalence of tobacco-related diseases among girls and women throughout the life-course are often unavailable or outdated. Moreover, the data that are available may not be disaggregated to identify differences by income, ethnicity, or occupation. Considerable improvements in methodologies are needed to evaluate the impact of tobacco control policies—including trade, tax, and economic policies—on women's health. As the international community struggles to protect the public from SHS and curb rising rates of tobacco use among women and girls, a renewed commitment to women's right to health as a human right is more important than ever.

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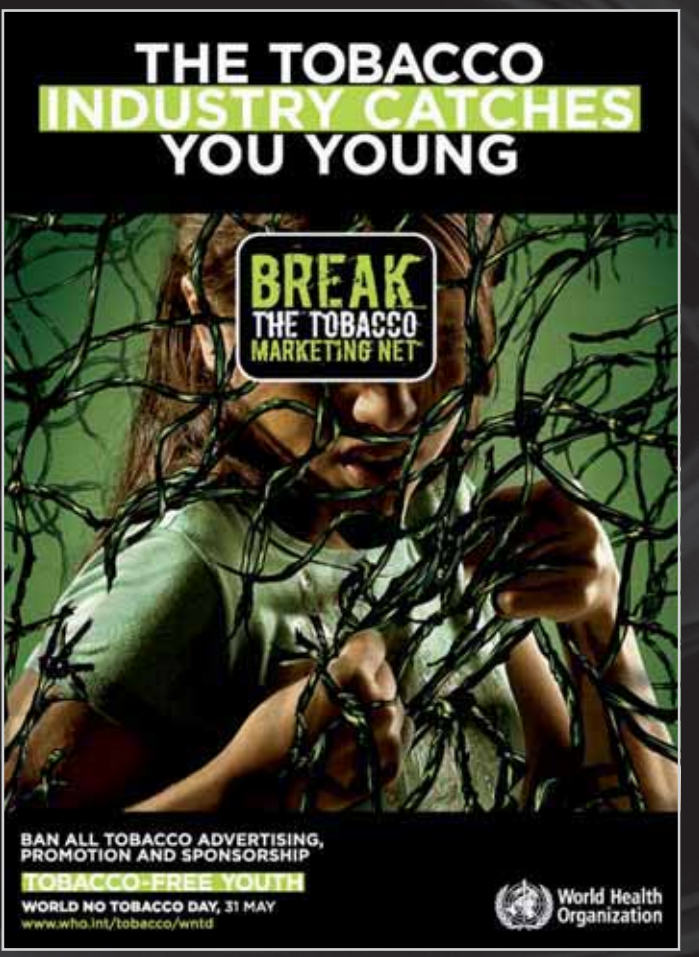
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2. A Gender Equality Framework for Tobacco Control

Introduction

The epidemiological patterns of tobacco-related diseases and deaths are largely shaped by the social and cultural meanings associated with tobacco use that drive initiation and cessation. Of these, gender is generally the least understood by policy-makers, yet the tobacco industry continues to use gender imagery as a basic marketing tool. Clearly, it is essential to clarify the concept of gender and its relevance to the design and implementation of tobacco control. Questions to consider include: Why is a gender analysis important to women and tobacco control policies? How can gender equality be mainstreamed into tobacco control policies and budgeting? Which indicators can best monitor progress?

The objectives of this chapter are to identify the scope of gender analysis—with a focus on women's rights—for tobacco control and to outline a working action-oriented framework that shows linkages to the wider context of social and economic development. Examples of how such analysis affects tobacco control laws are provided, and guidelines for translating it into institutional and financial arrangements are discussed.

In the simplest terms, "gender" is used to describe characteristics of women and men that are socially constructed, while "sex" refers to those that are biologically determined. In human society, biology is not destiny. People are born female or male but must learn to be girls and boys, then women and men. Learned behaviour makes up gender identity and helps shape gender roles. As noted in the World Health Organization (WHO) report *Women and Health,* both "sex and gender have a significant impact on the health of women and must be considered when developing appropriate strategies for health promotion.... Gender inequality, both alone and in combination with biological differences, can increase women's vulnerability or exposure to certain risks".[1] Data on the patterns of tobacco use by gender are not the same as sex-disaggregated data. It is necessary to perform gender analysis of such data to expose the social, cultural, and economic inequalities determined by the social norms, roles, and expectations of men and women.

Social relations such as gender hierarchies constantly change as old forms dissolve and are recreated.[2] This is illustrated by the impact that death and disability resulting from tobacco use has on gender roles. The disability of a male head of household puts an unequal burden on women, because of women's central role in the care economy—the sector that contributes to family welfare through provision of unpaid services such as health care, cooking, clothing, and managing the household. Women are the backbone of unpaid care work. Time-use surveys indicate that women spend twice as much time as men on unpaid care work in addition to their own paid jobs.[2] As a result, women have longer working days on average than men have. This unequal division of labour has important implications for challenges facing women during financial crises. Traditionally, the family functions as the surrogate safety net. However, when cuts in public spending on social services occur, stresses are placed on women in their roles as household managers and caregivers.

A human rights perspective that upholds women's dignity and freedom and right to health is fundamental to remedying gender inequality. As noted in the World Bank's *Global Monitoring Report, 2007: Millennium Development Goals*, gender equality does not necessarily mean equality of "outcomes" for males and females.[3] Rather, it means "equal access to the opportunities that allow people to pursue a life of their own choosing and to avoid extreme deprivation in outcomes". Equality of rights refers to gender equality under either customary or statutory law. Discrimination is apparent in the frequent invisibility of women in national tobacco control statistics, as well as the common exclusion of women in research protocols. Equality of resources means equality of opportunities that result from investments made in women's health, including investments for subgroups such as rural women. To achieve such equality, appropriate allocation of resources is required to educate women about the health hazards of tobacco use and second-hand smoke (SHS).

Men and Gender Roles

A gender equality approach differs from a "women and development" approach in that it acknowledges the ways gender roles can also affect men. The construct of

masculinity often puts men at risk of harmful health behaviours and consequences that can be destructive for them.[1] In tobacco control, the most obvious gender factor—that being born male is the strongest predictor for tobacco use—is often overlooked. Historically, in many cultures, tobacco was integrated into the fabric of a social and ritual life that was dominated by men. Indeed, tobacco use was viewed as a male prerogative in the United States and Europe until the early 20th century. One reason for rising rates of tobacco use among men has been the targeted marketing that promotes smoking as macho, healthy, sexually attractive, and trend-setting.

Integrating a gender perspective into tobacco control requires an analysis of how biological, social, economic, and cultural factors influence health risks and outcomes and lead to different needs for males and females.

Men have important roles and responsibility to help promote women's rights to health. As the majority of the world's smokers, men are primarily responsible for women's involuntary exposure to SHS. This is elaborated in the chapter in this monograph on SHS, women, and children. In some countries, including China and Viet Nam, women bear the greatest burden from exposure to men's smoking. Fathers have the ability to help protect the health of fetuses, infants, and girls. They can also encourage pregnant partners who quit smoking to stay tobacco-free. As the chapter on pregnancy and postpartum smoking cessation notes, partner smoking is the single greatest predictor of whether or not a pregnant woman will quit smoking.

However, gender norms and roles can change. An example of changing gender roles is the way in which the rising rates of tobacco use among girls and women will ultimately affect men's family responsibilities. When men die, families usually experience a downturn in economic security. However, deaths of mothers can affect the entire family's quality of life. In some areas, such as rural Africa, a woman's death means that other family members must take over caregiving roles such as child care and caring for the elderly. A woman's death also may deprive the family of basic necessities such as the provision of water and food.[2]

Recognition of the important interaction between social policy, family life, and gender roles is making headway, with men's support. The involvement of men in national campaigns for equal responsibility of men and women has proven successful in many health-related areas, including violence against women and HIV/AIDS.[4] Similarly, male United Nations officials and government leaders have supported gender, women, and tobacco activities and are strong advocates for gender equality. As businessmen and leaders, men have assumed greater responsibility for supporting tobacco control policies such as enforcing a total ban on advertising and promotion and mandating graphic warnings on tobacco products—all of which help girls and women quit smoking. Male health planners, doctors, and nurses can help ensure access to high-quality, women-friendly health services and can serve as role models for young medical students. As more men join in the gender equality movement, stronger support for women's human rights as a cornerstone for tobacco control is in sight.

The Scope of Gender Analysis and Social and Economic Development

Integrating a gender perspective into tobacco control requires an analysis of how biological, social, economic, and cultural factors influence health risks and outcomes and lead to different needs for males and females.[1] In this effort, the health sector must provide strong leadership. However, tobacco control must also involve many other sectors, because patterns of tobacco use are affected by a variety of socioeconomic and cultural trends. Policies in financial, agricultural, and trade sectors influence tobacco production, marketing, and consumption. Equally significant, tobacco use can affect social and economic development. For example, when governments must spend millions of dollars to treat tobacco-related diseases, fewer public funds are available to invest in poverty reduction. The collection of data and the conduct of research on gender-related factors should extend across all relevant

sectors.[5,6] A holistic approach can provide the scientific evidence needed to ensure that policies will be successful among both men and women and that programmes will address gender-specific issues.

What should be the scope of a gender analysis for tobacco control? Which strategies work? In many countries, the traditional public health strategy is based on the Health Belief Model, which views a person's beliefs and perceptions as the primary influence on tobacco uptake (see the chapter on quitting smoking and overcoming nicotine addiction). Public information campaigns, along with Knowledge, Attitude, and Practice surveys, are the standard tools used to change health behaviour. However, while single-strand interventions such as school health programmes have had some impact, information alone cannot always empower people to make decisions that protect their own health. Rather, a wide spectrum of interventions at multiple levels—consistently applied—is needed to reverse the tobacco epidemic.

A holistic approach is consistent with the concept developed by a team of scientists at the World Health Organization South-East Asia Regional Office (WHO/SEARO) who are concerned with broadening the scope of health behaviour research. They note that the conventional public health approach errs in focusing primarily on individuals, without reference to the social, economic, and political structures that also determine behaviour.[7] For example, to address the question of whether rural women know that tobacco leaves can cause green tobacco sickness (GTS), the conventional health education approach would be to ensure that rural women learn about health hazards and how to protect themselves. In contrast, a gender-sensitive approach would take into account the logical corollary that poor women must also be enabled to change their behaviour through economic empowerment. Unless they have money to buy protective gloves, there is little likelihood that their condition will change. While this scenario may appear obvious, the same issue of empowerment affects other situations. Any woman living in a patriarchal household knows the problems she faces in asking her husband to quit smoking in the home. Threats of domestic violence are common, yet these are seldom considered relevant to tobacco control.

A gender equality approach to tobacco control must also analyse how health cultures can influence health-promoting behaviour (see Figure 2.1). For example, a pregnant woman may be aware that smoking during pregnancy can cause low birth weight. However, she may never mention her tobacco use to a doctor for fear of being stigmatized or blamed. Similarly, the professional health culture that influences the attitudes of health-care providers can be important in determining the health behaviour of patients. The carriers of health messages must be regarded as knowledgeable, trustworthy, and, ideally, available for follow-up. They must also take responsibility for asking pregnant women whether or not they have a history of tobacco use. In many developing countries, they must also avoid the common assumption that pregnant women are tobacco-free.

The scope of a gender equality framework must be holistic and inclusive at multiple levels and must consider the social interrelationships between local health and processes.

Professional health cultures also influence traditional health practitioners such as midwives, herbalists, and shamans. It is widely recognized in developing countries that health professionals have considerable influence over self-care and the management of family health. Much more attention must be paid to actively involving them in the design of tobacco control information, education, and communication strategies.

Another weakness in conventional approaches is the tendency of health-systems analysis to focus primarily on the professional health culture—the behaviour of nurses and doctors and the delivery of information or health services—while ignoring the broader context of government policies, international trade, and socioeconomic development[7] that influences their practice. Recent trends in globalization and international trade agreements illustrate how macroeconomic policies can influence the behaviour of health-care providers, as well as patients. Free trade agreements have led to a flood of imported cigarettes and highly sophisticated marketing that targets audiences

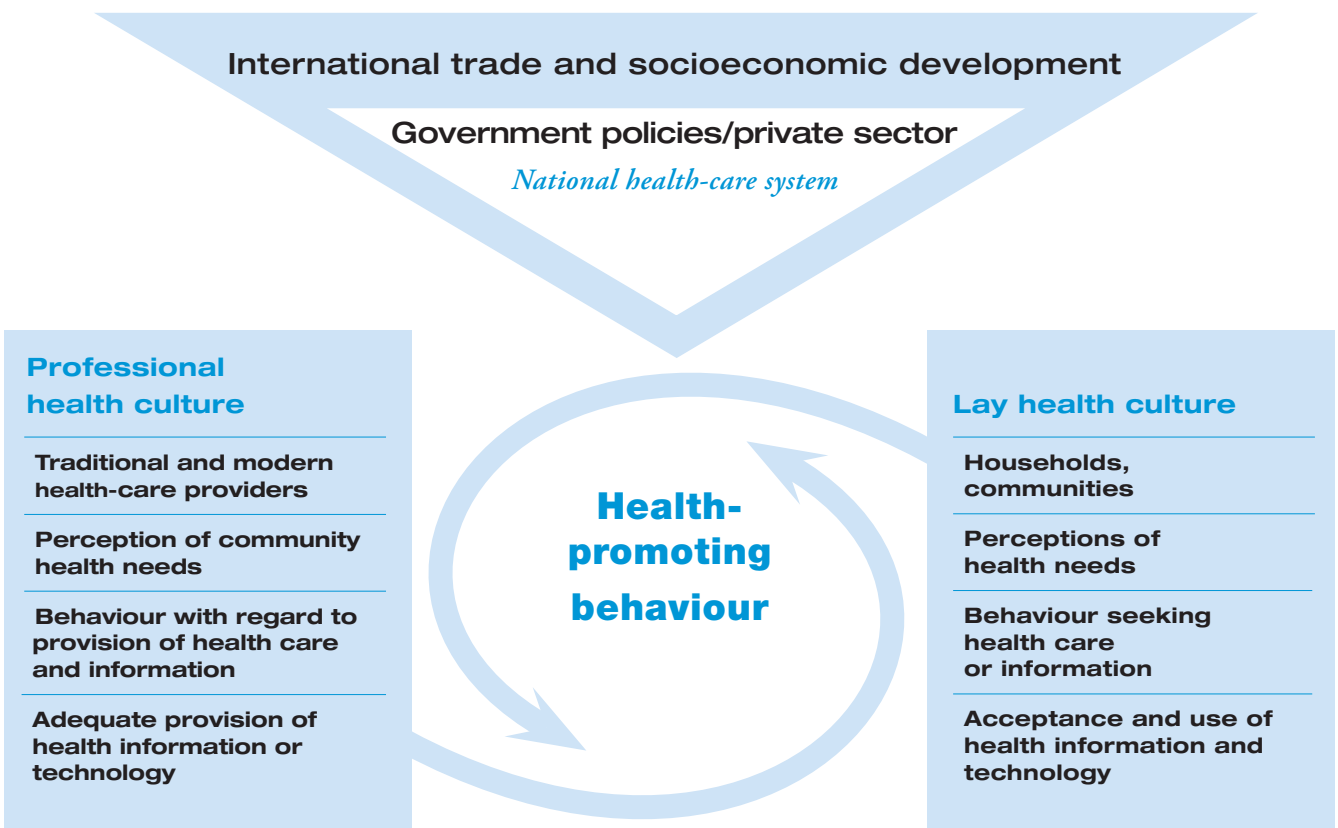
in poor developing countries. Low prices, poor enforcement of tobacco control legislation, and the absence of gender-specific tobacco control policies all contribute to the rise in tobacco use among women and girls. Doctors must increasingly treat women with tobacco-related diseases and disability, an endeavour that requires specialized knowledge about sex-specific risks. Structural adjustment programmes that require payment for health services severely curtail the frequency of visits to health centres, negatively affecting both providers and users.

The scope of a gender equality framework must therefore be holistic and inclusive at multiple levels and must consider the social interrelationships between local health systems and international processes. Figure 2.1, adapted from a WHO/SEARO model showing the importance of the social and economic environment to health-promoting behaviour,[7] illustrates this point. Lay and professional health cultures are mapped out through an historical process. Factors such as the organization of households and communities, perception of health needs, health-care-seeking behaviour, and acceptance of tobacco control messages all contribute to changing the health behaviour of women seeking health care. The professional health culture also affects the behaviour of tobacco control professionals and health workers. The perception of health needs and interventions (or the absence of services and information) contributes to the success or failure of tobacco control in reaching women.

At a structural level, tobacco control policies should take into account the fact that gender inequality is embedded in social and economic institutions, including those at the global level. As a United Nations Research Institute for Social Development report stated, "Gender inequalities are deeply entrenched in all societies, and are reproduced through a variety of practices and institutions".[2] Furthermore, the exclusion of women on the basis of race, caste, ethnicity, religion, or disability is a serious obstacle to successfully implementing gender-sensitive tobacco control policies.

The WHO FCTC is the pre-eminent global tobacco control instrument; it contains legally binding

Figure 2.1. Health-Promoting Behaviour / Spheres of Influence



Source: Adapted from *Concepts of Health Behaviour Research.* New Delhi, WHO Regional Office for South-East Asia, 1986.

obligations for its Parties, sets the foundation for reducing both demand and supply of tobacco, and provides a comprehensive direction for tobacco control policy at all levels. In its global tobacco reports on tobacco control, WHO launched and analysed the MPOWER package,[8] introduced to assist in the country-level implementation of effective measures to reduce the demand for tobacco, contained in the WHO FCTC. Although the MPOWER measures, which correspond to one or more Articles of the WHO FCTC, do not explicitly refer to a gender equality perspective, seen through a women's rights lens they can be interpreted as follows:

1. **M**onitor tobacco use *by gender* and *ensure that* prevention policies *are gender-sensitive* (Article 20 of the WHO FCTC).

2. **P**rotect *girls and women of all ages* from tobacco smoke (Article 8 of the WHO FCTC).

3. **O**ffer help to assist *women in quitting* tobacco use (Article 14 of the WHO FCTC).

4. **W**arn *women and girls* about the dangers of tobacco *through gender-sensitive information and communication strategies* (Articles 11 and 12 of the WHO FCTC).

5. **E**nforce bans on tobacco advertising, promotion, and sponsorship *by empowering women to identify and counter these influences* (Article 13 of the WHO FCTC).

6. **R**aise taxes on tobacco, *with the active participation of women leaders* (Article 6 of the WHO FCTC).

It is evident that the scope of a gender equality framework for tobacco control must be an integral part of a country's political and development agenda. Indeed, there is growing evidence that tobacco hampers sustainable development. As noted in the chapter on taxation and the economics of tobacco control, the use of tobacco results in a net loss of billions of US dollars per year. Many costs of tobacco use, including its negative impact on the environment, affect economic development. Multinational companies gain the most, while male and female tobacco farmers and women who work in tobacco production receive only a small percentage of the profits. Rural women must also cope with the possible negative impact of tobacco production on food production and the environment due to deforestation. In brief, tobacco has a negative impact on the health of economies as well as on the health of people.

The Millennium Development Goals

In 2000, the United Nations Member States pledged to dramatically decrease poverty, hunger, disease, and illiteracy within 15 years by meeting eight key targets. A global consensus was reached, involving heads of state, government representatives, and the private sector, as well as the active participation of civil society. These social and economic targets, known as the Millennium Development Goals (MDGs), do not explicitly refer to tobacco, but they are relevant to understanding how gender equality in tobacco control fits into the future of social and economic development.

Gender equality has been highlighted as a cross-cutting issue that is imperative for achieving all MDG targets.

Central to gender and tobacco concerns is the goal of promoting gender equality and empowering women (MDG 3). Gender equality has been highlighted as a cross-cutting issue that is imperative for achieving all MDG targets.[8] Furthermore, six of the eight MDGs are related to health, underscoring the fundamental role of health in poverty reduction and economic progress.[9]

The first MDG is to eradicate extreme poverty and hunger. Data from many countries show that regardless of a country's level of development, poor people are the most likely to smoke.[10] Poverty is itself a gendered issue: the majority of the more than 1 billion people in the world who live in poverty are women. Furthermore, the number of women living in poverty is increasing disproportionately to the number of men, particularly in developing countries.[3]

Tobacco and poverty are interrelated, as tobacco use diverts income from being used for food, medicine, and education, thereby increasing poverty among its users. One study estimates that a portion of the money currently spent on tobacco in Bangladesh could save 10.5 million children in the country from malnutrition. Research in other countries confirms similar findings: many poor households in Indonesia, Myanmar, and Nepal spend between 5% and 15% of their disposable income on tobacco, sometimes more than the amount spent on health care or education.[10,11]

The WHO FCTC's acknowledgement of CEDAW is important, because CEDAW is the most lucid legal blueprint of women's social, economic, and political rights, including rights to health.

Cultivation of tobacco also does not contribute to sustainable livelihoods. Approximately 5 million hectares of land around the world are used for tobacco cultivation. It has been estimated that use of this land to produce food could feed 10 to 20 million people.[10] Tobacco is increasingly being grown in developing countries and is often mistakenly perceived as a profitable cash crop. However, the net returns to local farmers are generally low, because of the declining prices paid to tobacco producers and the high costs of loans required to purchase pesticides and fertilizers. By the end of the growing season, local farmers often owe more to tobacco companies than they earn.[12] Furthermore, the calculated returns generally fail to take into account the exploitation of labour by women and children, which, although essential to tobacco farming and manufacturing, is undervalued and often unpaid.[12] Since girls' education tends to be considered unimportant in many areas of the world,[13] the production of tobacco means that MDG 2 (achieve universal primary education) is also threatened.

MDG 4 (reduce child mortality) and MDG 5 (improve maternal health) are both also linked to the impact of tobacco use. Exposure to tobacco smoke has negative health effects, but children and women, including pregnant women, often do not have the power to negotiate smoke-free spaces.[14] Furthermore, family spending on tobacco results in less money available for health care.[10] Because structural adjustment and the global financial crisis have severely increased health costs, poor women have less access to cessation methods, health information, and health services.

MDG 6 is to combat HIV/AIDS, malaria, and other diseases. Tobacco use has been associated with increasing the morbidity of existing illnesses. Gender inequality and poverty further increase vulnerability to the socio-economic impacts of HIV/AIDS, tuberculosis, and other illnesses. About 58% of Africans living with HIV/AIDS are women. They are infected at younger ages than men—on average, by 6 to 8 years.[15] There is evidence that people with subclinical tuberculosis who smoke are more likely to progress to clinical tuberculosis, which increases the likelihood that they will both infect others and die prematurely. Similarly, it has been shown that smokers infected with HIV develop full-blown AIDS in less time than non-smokers do.[10]

In addition to tobacco use, tobacco production causes diseases among agricultural workers. Nicotine absorbed through the skin during tobacco harvest and curing causes GTS. Symptoms include headache, nausea, vomiting, dizziness, and diarrhoea. The pesticides used in tobacco farming can also cause illness and may have particularly severe effects on children, because of their small size and less-mature development.[10] There is some indication that chronic exposure to pesticides can lead to birth defects in the children born to women who work in tobacco farming, although this is another area in need of further research.[12] GTS and other illnesses related to tobacco growing tend to be more common in developing countries, where the regulation of tobacco companies for the protection of farmers may be weak or poorly enforced.[16]

Tobacco production and consumption are incongruous with MDG 7 (ensure environmental sustainability). Tobacco growing requires huge amounts of fertilizer and pesticides—as many as 16 applications during a three-month growing period[12]—and the chemical runoff from the fields pollutes local waterways. Tobacco also requires curing, using wood that causes losses of 200 000 hectares of forest each year.[17] The environmental impact of tobacco

is due, in part, to the waste generated from its consumption.[18,19] The ecological stresses of tobacco production and consumption have particular implications for women, as women are often responsible for providing food and collecting water and firewood for the family. Rural women in particular suffer from the negative impact of tobacco on food production and the environment.[12]

Finally, MDG 8 (develop a global partnership for development) recognizes the need for each country to enhance and coordinate initiatives at the national level, while also calling upon industrialized and developing countries to establish partnerships in order to ensure joint progress towards each of the targets.[10] Implementation of the WHO FCTC is a prime example of the way regional and international partnerships can work together to ensure women's rights to health.

A Gender Equality Perspective on the WHO Framework Convention on Tobacco Control

The WHO FCTC is a powerful legal instrument to help stakeholders such as governments, scientists, health professionals, and community leaders achieve the highest possible standards of tobacco control. Ratified by more than 170 countries, the WHO FCTC affects more than 80% of the world's population and obliges governments to bring their national legislation into line with its agreements. The goal is to "protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke" (Article 3). The treaty offers an opportunity to strengthen tobacco control through a broad range of measures, from bans on promotion and advertising and improving package labelling to monitoring of the tobacco industry and anti-smuggling legislation. To translate the Articles into action, the WHO FCTC process requires that guidelines be developed for each Article, spelling out how laws are to be formulated, implemented, and evaluated.

Applying a gender equality framework to tobacco control is integral to achieving the goals of the WHO FCTC. The Preamble states that Parties to the treaty are "*alarmed* by the increase in smoking and other forms of tobacco consumption by women and young girls worldwide and keeping in mind the need for full participation of women at all levels of policy-making and implementation and the need for gender-specific tobacco control strategies". Under the Guiding Principles, Article 4.2d notes that strong political commitment is necessary, taking into consideration "the need to take measures to address gender-specific risks when developing tobacco control strategies".

The treaty further acknowledges that women's and girls' right to health is a human right as agreed upon in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); the International Covenant on Economic, Social and Cultural Rights; and the Convention on the Rights of the Child: "*recalling* Article 12 of the International Covenant on Economic, Social and Cultural Rights, adopted by the United Nations General Assembly on 16 December 1966, which states that it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

The WHO FCTC's acknowledgement of CEDAW is important, because CEDAW is the most lucid legal blueprint of women's social, economic, and political rights, including rights to health. Adopted in 1979 by the United Nations General Assembly, it had been ratified by 186 countries by 2009. As the chapter in this monograph on women's rights and strengthening international agreements notes, the CEDAW Committee emphasizes that lack of sex-disaggregated health data and inadequate provision of services constitute failure to fulfil a country's obligations to uphold women's health rights. CEDAW also mandates that women be active decision-makers and given chances to express their political rights equally with men. In tobacco control, this implies that women must be enabled to be leaders at international as well as community levels.

In the following, we provide an interpretation of the Articles of the WHO FCTC through a gender equality lens. This is not an exhaustive inventory; rather, it is a starting point for further research.

Article 11.1a requires Parties to ensure that the packaging and labelling of tobacco products do not promote the product by any means that are "false, misleading, deceptive or likely to create an erroneous impression about

its characteristics, health effects, hazards or emissions" and specifically lists "low tar", "light", "ultra-light", and "mild" as terms that may be prohibited. Misleading terms such as these have traditionally been targeted at women, beginning in 1927 with a Philip Morris cigarette that was advertised as being "mild as May".[20] Article 11.1b requires Parties to the WHO FCTC to place health warnings on tobacco product packaging, with optional use of pictures or pictograms. Article 11.3 states that the warnings must appear in the principal language(s) of the country.

Health warnings can be made most meaningful by ensuring that they are placed on the packaging of all tobacco products, not only cigarettes, because women in some countries use tobacco in other forms.

To maximize the effective implementation of Article 11, countries must broaden legislation beyond banning specific terms and must further prohibit colours, graphics, and other design characteristics that could imply that one tobacco product is less harmful than another. Such legislation has been introduced in Bangladesh, Slovakia, and elsewhere, and strict enforcement of the provisions is needed.[21] Health warnings can be made most meaningful by ensuring that they are placed on the packaging of all tobacco products, not only cigarettes, because women in some countries use tobacco in other forms. Further, since the majority of illiterate adults are women,[22] picture-based health warnings are an important component of gender-specific tobacco control strategies.

Article 8.2 requires Parties to adopt and implement, at the national level, effective measures that provide for "protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places" and to actively promote the adoption and implementation of such measures at other jurisdictional levels. Tobacco smoke affects women in their homes and in workplaces outside their homes, even women who are not active smokers. Further, exposure to second-hand tobacco smoke is often in addition to exposure to other pollutants that damage the lungs (e.g. fumes from cooking fuels) and thus further harms women's health.[23] By enacting and enforcing legislation that requires indoor workplaces, public transport, and indoor public places to be free of tobacco smoke, Parties to the WHO FCTC can do much to protect women's health. It is also important to educate and empower both women and men to establish smoke-free environments at home.

Under Article 13, each Party to the treaty must, in accordance with its constitution or constitutional principles, implement a comprehensive ban of tobacco advertising, promotion, and sponsorship. A country that cannot undertake a comprehensive ban because of its constitution or constitutional principles must still apply restrictions on all tobacco advertising, promotion, and sponsorship. As described above, the tobacco industry has long incorporated a gender analysis into its marketing strategies, and thus an effective tobacco control response must also take gender into account. In implementing a comprehensive ban, Parties to the WHO FCTC should seek to ban or apply restrictions on as many forms of tobacco advertising, promotion, and sponsorship as possible. Legislation and policies should specifically address marketing strategies that target women and girls.

Parties to the WHO FCTC are required under Article 20 to "develop and promote national research and to coordinate research programmes at the regional and international levels in the field of tobacco control". Research should address the determinants and consequences of tobacco consumption and exposure to tobacco smoke, as well as the identification of alternative crops. The Parties are required to establish "national, regional and global surveillance of the magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke" and to promote and strengthen training and support for all people engaged in tobacco control activities, including research and evaluation. To address gender-specific issues, research should investigate differences in the determinants and consequences of tobacco consumption and exposure to tobacco smoke for girls and women, as well as boys and men, at all ages throughout the life-course.

Article 12 of the WHO FCTC requires Parties to promote and strengthen public awareness of tobacco control issues. This means that each Party must adopt and

implement measures to promote public awareness about "the health risks of tobacco consumption and exposure to tobacco smoke", "the benefits of cessation of tobacco use and tobacco free lifestyles", and "the adverse health, economic, and environmental consequences of tobacco consumption". In addition, Article 12 requires Parties to provide public access to information on the tobacco industry that is relevant to the objectives of the WHO FCTC; adopt and implement measures that promote tobacco control training and awareness programmes to specific persons (such as health workers, media professionals, and educators); and promote awareness and participation of agencies and organizations not affiliated with the tobacco industry in developing and implementing tobacco control programmes and strategies.

Women's participation and leadership in the implementation of Article 12 are key. Health professionals and others working in tobacco control should establish reciprocal relationships with women's organizations to increase the prominence of tobacco control on women's health and women's rights agendas.[24] Counteradvertising that debunks the false claim that tobacco use enhances women's empowerment and that exposes tobacco industry marketing tactics to youth may be effective in promoting reduction of tobacco use. Finally, tobacco control activists should engage with leaders working in social justice and human rights movements to create synergy between gender equality and sustainable health development.

Mechanisms and Indicators

Implementing appropriate institutional and financial mechanisms is essential to translating principles of gender equality and human rights into action in tobacco control programmes. The following are suggested guidelines:

1. *Harmonize government sectors to work effectively with national machineries and nongovernmental organizations (NGOs) to achieve gender equality.*

Tobacco control can gain ground on gender equality through improved harmonization of policies and programmes across sectors. Unfortunately, in many countries, national resources that can be mobilized for gender equality and tobacco control are currently underutilized. For example, the expertise of national machineries for gender equality and women's affairs are seldom tapped for tobacco control, even though all countries that have signed on to the WHO FCTC and agreed to the MDGs have such institutional mechanisms. In 181 countries, these national machineries for gender equality are responsible for assuring gender mainstreaming and are mandated to implement the principles of women's rights to health as a human right, as embodied in the Beijing Platform for Action (1995). Mechanisms such as the Ministry for Women and Youth Affairs in Ghana and the Ministry for Women's Affairs and Social Development in Nigeria work intersectorally, often coordinating reports to CEDAW and the Convention on the Rights of the Child. Additional resources are being tapped in civil society. Many national machineries for gender and women's affairs have strong network partnerships among NGOs, youth groups, the media, unions, and education leaders.

2. *Use a two-pronged approach to gender mainstreaming.*

At the 2008 meeting of the United Nations Commission on the Status of Women, experts agreed that gender equality is losing ground in national programmes. Under the guise of "gender mainstreaming", gender programmes have faced serious reductions in financial resources.[25] The meeting participants recommended a two-pronged strategy that ensures a separate identity for gender equality and that also mainstreams gender equality into all legislation and fiscal policies, as well as decision-making. Such a strategy has been developed by Hivos, a prominent Dutch international NGO. In its evaluation process, programmes that appoint a junior-level or part-time gender expert are considered to be failing to abide by their gender mainstreaming policy.[26] In tobacco control, gender mainstreaming is more likely to succeed if gender experts at senior policy levels are provided with adequate resources to develop their own gender equality programmes. Such units can also act as monitoring bodies to measure the success or failure of gender mainstreaming. Setting high standards and providing adequate resources help to ensure that all programmes take gender equality guidelines seriously, that sound technical advice is provided, and that programmes are monitored and evaluated to measure results.

3. *Strengthen the data and indicators used in gender-responsive budgeting.*

Budgeting for gender equality in tobacco control requires development of sensitive, cost-effective indicators

Figure 2.2. Indicators for Gender Equality in Tobacco Programmes

1. ***The omission of women in national statistics reflects an unequal allocation of resources between men and women.***
   Are data collected on the prevalence of all forms of tobacco used by women as well as men, including cigarettes, chewing tobacco, bidis, and water pipes? Do these data reflect the needs of girls and women of all ages who face multiple exclusions based on race, caste, ethnicity, religion, or disability?

2. ***Rural women and poor urban women face particular hardships.***
   Are data and country-specific information available on women's roles in tobacco production and marketing as well as those of men?

3. ***Gender-specific strategies are needed to ensure that women are equally informed about their legal rights.***
   Are adequate steps taken to ensure that women are informed about their rights under national tobacco control legislation and under the WHO FCTC?

4. ***Communications, information, and media programmes must ensure that policies and programmes are gender-sensitive.***
   Are package warnings and/or public advertisements gender-specific and designed to reach women as well as men?

5. ***Pregnant women are often criticized if they smoke, but maternal and child health services do not provide adequate information about the dangers of tobacco and services to help avoid risk.***
   Are adequate measures being taken to inform and empower women in response to the dangers to their health and the health of their children from tobacco use and exposure to SHS during pregnancy?

6. ***Women's access to health information about occupational safety is a basic human right.***
   Are women who are involved in tobacco processing and manufacture adequately informed about the dangers of tobacco use and handling? Are precautions taken to protect them from health hazards such as tobacco dust, pesticides, and physical strain?

7. ***Maternal and child health services are often gender-biased and do not address the equal responsibility of fathers for children's health.***
   Do maternal and child health services also target fathers in campaigns to quit smoking for the sake of mothers' and children's health?

8. ***The WHO FCTC aims to ensure that women are able to voice their concerns and take leadership roles.***
   Are the Parties to the treaty ensuring the full participation of women at all levels of policy-making and implementation of programmes related to tobacco control?

9. ***Gender mainstreaming requires all programmes to state gender-specific objectives.***
   Are specific objectives concerning gender equality stated in tobacco control policies?

10. ***Resources should be allocated to ensure a separate identity for gender equality, as well as for mainstreaming.***
    Are adequate resources allocated for gender-specific interventions?

11. ***Gender expertise is needed at senior policy levels to ensure adequate technical oversight.***
    Are senior-level gender experts working at the policy level?

and baseline data. As already stated, it is necessary to monitor the social, economic, and political conditions for women as well as men, particularly for those who face multiple exclusions. Equally important is tracking the distribution of financial resources between women and men. Gender-responsive budgeting at the national level is currently being implemented in many countries, including Tunisia and Norway. In Norway, the Ministry of Children and Equality conducts annual surveys on the amounts of money spent on men and on women. Reports of these surveys are required of all line ministries (including health) and are compiled in a fiscal budget annex.[27]

Gender-responsive budgeting in tobacco control requires development of indicators for gender equality. Figure 2.2 presents examples of such indicators. This list is neither exhaustive nor conclusive; rather, it is a starting point for an important research effort.

Conclusion

Although gender-blind policies are still widespread, a comprehensive approach to tobacco control is gaining ground. The WHO FCTC sets an ambitious goal to

advance a gender as well as human rights perspective in the implementation of its Articles. At a theoretical level, the WHO/SEARO model of health behaviour can be used to analyse the effects of gender inequality throughout the health system and to help map interrelationships between tobacco control and broader social, cultural, and economic processes. A gender equality framework suggests that changes in policies must occur in many sectors outside health—including finance, trade, and agriculture—if tobacco control policies are to have an equal impact for women and for men.

An important tool for advancing tobacco control programmes is the WHO MPOWER package, but it, too, should be analysed through a gender equality lens. Governments must improve coordination with national machineries for women's affairs, provide adequate financing, and apply indicators for gender equality in national planning. There is more at stake than changes in health behaviour. The price for ignoring more than half of the world's population—i.e. women—is high. If the tobacco epidemic continues to accelerate, aggravating financial instability and undermining sustainable development, the MDGs will be in jeopardy.

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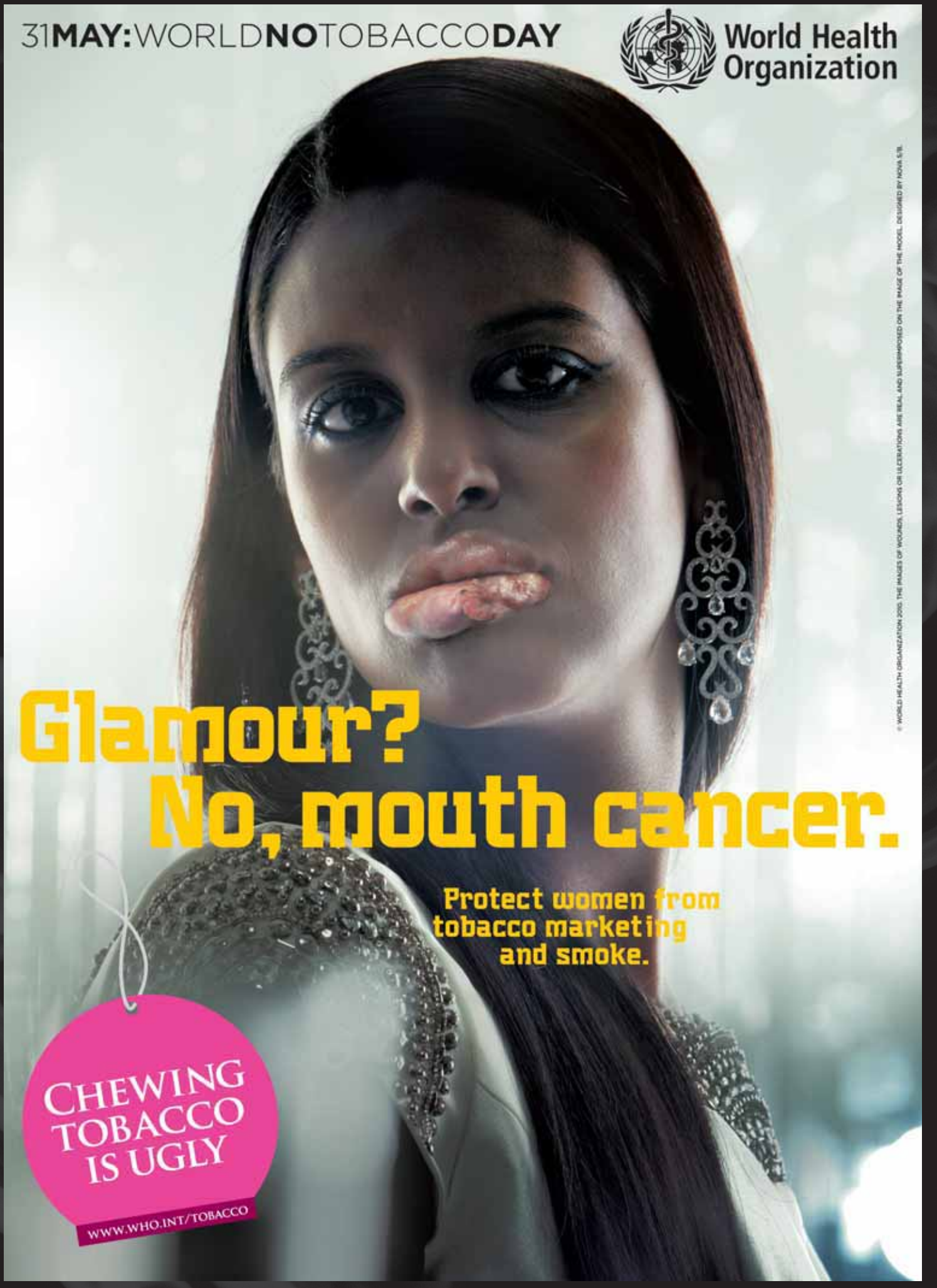
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World Health Organization
Glamour?
No, mouth cancer.
Protect women from tobacco marketing and smoke.
CHEWING TOBACCO IS UGLY
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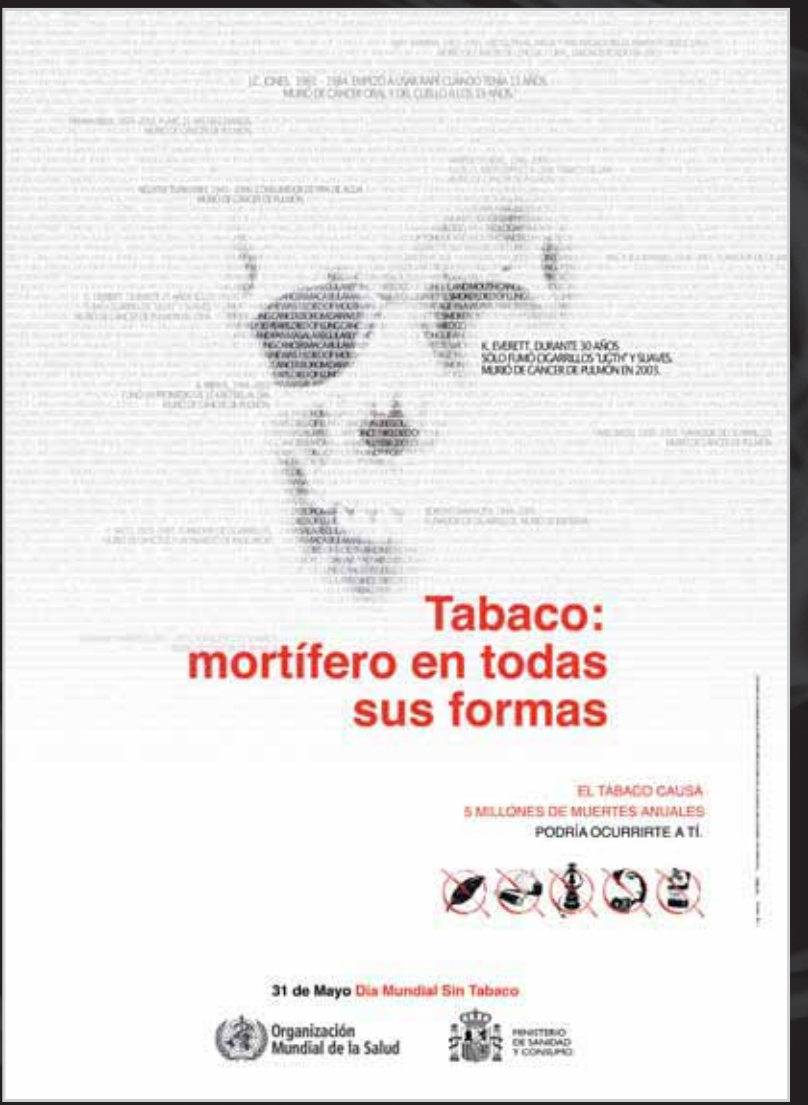
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MURIÓ DE CÁNCER DE PULMÓN EN 2003.
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