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”. 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. 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. 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. 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. 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.

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

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. 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. 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.

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 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, 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.” 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

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**Figure 2.1. Health-Promoting Behaviour / Spheres of Influence**

International trade and socioeconomic development

Government policies/private sector

National health-care system

Professional health culture

- Traditional and modern health-care providers
- Perception of community health needs
- Behaviour with regard to provision of health care and information
- Adequate provision of health information or technology

Lay health culture

- Households, communities
- Perceptions of health needs
- Behaviour seeking health care or information
- Acceptance and use of health information and technology

Source: Adapted from Concepts of Health Behaviour Research. New Delhi, WHO Regional Office for South-East Asia, 1986.
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. 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 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.
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, 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. Monitor tobacco use by gender and ensure that prevention policies are gender-sensitive (Article 20 of the WHO FCTC).
2. Protect girls and women of all ages from tobacco smoke (Article 8 of the WHO FCTC).
3. Offer help to assist women in quitting tobacco use (Article 14 of the WHO FCTC).
4. Warn women and girls about the dangers of tobacco through gender-sensitive information and communication strategies (Articles 11 and 12 of the WHO FCTC).
5. Enforce bans on tobacco advertising, promotion, and sponsorship by empowering women to identify and counter these influences (Article 13 of the WHO FCTC).
6. Raise 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. Furthermore, six of the eight MDGs are related to health, underscoring the fundamental role of health in poverty reduction and economic progress.

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. 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.
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

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 period12—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.” 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. 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, 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. 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 12 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. 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. 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. 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?

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.

References

Glamour?
No, mouth cancer.

Protect women from tobacco marketing and smoke.

CHEWING TOBACCO IS UGLY

WWW.WHO.INT/TOBACCO
Tobacco Use and Its Impact on Health
Tabaco: mortífero en todas sus formas

EL TABACO CAUSA 5 MILLONES DE MUERTES ANUALES
PODRÍA OCURRIRTE A TÍ.

31 de Mayo Día Mundial Sin Tabaco