INTERNATIONAL NETWORK OF WOMEN AGAINST TOBACCO

Women's Leadership in Health Professions

Nursing Network gets active in Thailand

By: Pongsri Srimoragot

The Nurses' Network Against Tobacco and Substance Abuse of Thailand, located at the Faculty of Nursing, Mahidol University, are members of INWAT. The Network has coordinated a number of tobacco activities in the past few months and has more planned for the future.

The first activity was a tobacco control research exhibition at the Thailand Research Expo in September, 2006 in Bangkok. This event, sponsored by the National Research Council of Thailand, disseminated tobacco control reports that reflected the experience of the nursing profession. The exhibition provided an opportunity for nursing researchers who are members of the Network to educate the public about the harmful effects of both tobacco smoking and secondhand smoke.

The second event was an initiative about secondhand smoke jointly sponsored with ASH Thailand, the Health Professional Alliance Against Tobacco and the Ministry of Public Health in October, 2006. Members of the Network shared information about the hazards of tobacco and screened smokers and non-smokers at a mobile tobacco cessation counseling clinic.

The most recent undertaking was a secondhand smoke campaign called, "Smoke free home," which was conducted in partnership with ASH Thailand, the Health Professional Alliance Against Tobacco and the Ministry of Public Health in December, 2006 during the celebration of the birthday of the King of Thailand. This event featured a mobile smoking cessation counseling clinic and also provided medical screening and many other kinds of health advice for the public.

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President's Corner

By: Lorraine Greaves

Over the next few decades, the tobacco epidemic is expected to spread widely among girls and women across the globe. By 2025, it is estimated that 20% of the world's women will be smokers, in contrast to 12% at the moment. Much of this growth will take place in countries such as India and China, where large populations represent huge markets for the industry.

INWAT is the leader in drawing attention to the issue of women and tobacco and, along with our allies, is taking on the huge challenge of reducing its impact. Fortunately, our allies are steadily increasing in number and activity as the stories in this issue of the NET illustrate. This issue features activists and health professionals around the world who are doing innovative and exciting work to reduce the toll of tobacco on women and girls.

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You will read about the exciting work of nurses, physicians, midwives and dental hygienists, as well as groups such as the International Alliance of Women, the National Lung Cancer Partnership (USA) and the Framework Convention Alliance. A feature on oral smokeless tobacco use (snuff) among women in Sweden emphasizes how the tobacco industry continues to relentlessly target women in new ways.

Since 1990, when INWAT was born in Perth, Australia, we have steadily increased our membership and activity. We have seen INWAT spawn new networks, and gain recognition for our work from a wide range of sources outside of our organization.

The themes that INWAT stands for are also more often emerging in the wider tobacco control movement. At the World Conference on Tobacco or Health in 2006 in Washington, DC, issues of gender, women and inequality garnered a lot of attention. Many speakers indicated that the key issues in their region were linked to inequities of various kinds, and that these perspectives are critical in dealing with the epidemic.

At the conference, INWAT released its newest report, *Turning A New Leaf: Women, Tobacco and the Future*, bringing the latest statistics and trends on women and tobacco to the world's attention in English and French (and soon in Spanish). Media outlets from Jamaica to India to the USA covered the report and gave INWAT wide exposure and prominence. This report is the first in the world to argue that improving the status of women goes hand in hand with reducing and preventing women's tobacco use. This notion flies in the face of some common understandings of the symbolism and impact of tobacco use for women.

In the past year alone, there have been important meetings in Turkey, Morocco, Bulgaria and Argentina, all of which have included a focus on advancing women and tobacco issues. We have a new emerging Ibero-American network on women and tobacco, strengthening our presence in several Spanish-speaking countries and providing an exciting new voice for INWAT. We are preparing for the upcoming Society for Research on Nicotine and Tobacco (SRNT) conference in Rio de Janeiro in September 2007.

INWAT is also a source of information and assistance in creating change for women and tobacco. The second Conference of the Parties to the FCTC is meeting in Bangkok, Thailand in June 2007. INWAT will be there to play a role in highlighting the importance of gender in enacting the Articles in the FCTC, the world's first public health treaty.

Less visibly, INWAT is developing proposals for research, advocacy projects and new interventions on women and tobacco, and being a willing partner when other organizations seek funding for their initiatives in women and tobacco. We are particularly interested in convincing policy makers and service providers to integrate gender considerations into all of their planning and activities.

We are attracting much appreciated support. We recently received a generous donation from the International Women´s Health Coalition, based in New York. This fund will allow us to continue our work in creating better and more extensive communications with our members and the general public. Our website is being enhanced, and the work of our many members is being featured in presentations and reports available to all.

There is strength in numbers. INWAT is no longer a unitary, solitary voice in trying to reduce and prevent tobacco use among girls and women. Instead, INWAT is a guide, a source, a catalyst and a facilitator. The true measure of INWAT's success is how many others become interested in the issue of women and tobacco, and how many activities and alliances are inspired by our network, our members, our resources and our points of view.

The current issue focuses mainly on health professionals, but they represent only one of our groups of allies across the world. If you are not an active member of INWAT, consider becoming an ally yourself. If you or your organization is concerned about women, women's health, social justice, globalization, environmental issues or gender equity, INWAT is an ally of yours. Please join us!

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Swedish Nurses against Tobacco

Advancing tobacco control since the 1990s

By: Ann Post

Civil society groups such as Swedish Nurses against Tobacco have played a key part in advancing tobacco control over the years in Sweden. Founded fifteen years ago, the NGO has contributed to Sweden's impressive range of tobacco control activities by providing a unique care perspective and advocacy via its widespread network.

It all started on a spring day in May of 1992 as a group of seven dedicated nurses with strong involvement in tobacco issues.

The organization has since then grown to 800 members. Regional representatives based in every Swedish county coordinate local activities. This NGO demonstrates the dedication of nurses and midwives to incorporate tobacco treatment and prevention into their overall work.

Why should nurses create a network against tobacco?

A brochure developed by Swedish Nurses against Tobacco that outlines steps on creating such a network can be ordered free of charge by emailing professionals@globalink.org or downloaded via the website www.nursesagainsttobacco.org

Some of the key past activities that have made an impact on the progress of tobacco control in Sweden include demonstrating at key political events and generating media attention to further advance tobacco control legislation in Sweden. At the international level, Swedish Nurses against Tobacco led the first European Conference of Nurses against Tobacco in order to link with similar networks in other countries and to inspire such organizations to motivate change in their countries.

Today tobacco use is most prevalent among those with the least amount of education and the long-time unemployed. As a response to this, Swedish Nurses against Tobacco are now working on integrating tobacco cessation techniques and policy into the national health care system. This activity can improve health outcomes among smokers who are hard-to-reach and who have complex conditions.

Nurses are key in developing comprehensive tobacco control activities.

Coming Soon: Swedish Nurses against Tobacco, in partnership with the Swedish Association of Health Professionals, will present a seminar to share experiences of their role in advancing tobacco control in Sweden at the International Council of Nurses Conference on 27 May – 1 June 2007 in Yokohama, Japan: www.icn.ch Their seminar will take place from 13:00-14:20 on World No Tobacco Day (May 31). For more information contact Ann Post: ann.post@sll.se

In 2000, Swedish Nurses against Tobacco led the first European Nurses and Midwives Conference.

If Not Us, Then Who?

By: Cory Kalat

As women, we are much more capable than we think. I believe that we are capable of assuming leadership roles in the fights against tobacco dependence and for tobacco recovery.

I have been tobacco-free for 10+years. I also serve as a counselor specializing in women's tobacco dependence. My personal/professional missions are to help other women to become tobacco-free.

At first, I wondered what I could really do. I am simply one woman. I am in private practice and not a part of an agency. That voice in my head said "You are only one person – there probably isn't anything you can do." And then the other voice in my head – that rebel – the one who won't be told that she cannot do something – spoke up and said "Hmmm…can't do anything?! Watch me!"

My invitation to women worldwide is this: OPPORTUNITY. Look for and make opportunities to help spread the message that we can overcome tobacco.

The following is a partial list of the things that this solo practitioner has done. This is not about vanity – it is an invitation to other women to look inside for your own unique talents and trust that your inner wisdom and the universe will support your efforts. Perhaps you will consider similar endeavors, or maybe these ideas will spark new and innovative ideas of your own:

- Gave presentations to other addictions counselors on tobacco dependence and recovery. In my geographic area, tobacco is not taken seriously as a drug. Treatment providers help women become clean and sober, but many later die from tobacco-related illnesses.

- Set up a website (www.crkalat.com) as an information source on women and tobacco, including links to other websites.

- Said yes to being of service to others. I recently sent an email request to a company. After seeing from my auto-signature that I specialize in tobacco dependence treatment, the president of the company asked me to review their in-process pamphlet on tobacco dependence. We must lead with our hands, not with our business cards!

- Spoke out (workshops, seminars, presentations) about tobacco industry tactics aimed at encouraging women and girls to smoke. This included my informal survey of girls' and women's magazines and noted that the magazines with tobacco ads also included ads for alcohol and birth control.

- Offered free screenings to tobacco-dependent women and provide printed materials and lists of resources for help and support. The screenings were tied to World No Tobacco Day and the Great American Smoke Out.

- Provided printed material and information to other health care providers. I recently mailed information to respiratory care doctors, gynecologists and dentists in my area. Included were printed materials for the doctors, staff and patients on the importance of addressing tobacco use among women.

- Developed a specialized one-on-one counseling program (The Quit Smoking Program Just-4-Women) that focuses on the 3 P's of tobacco recovery: Tobacco recovery as a PRIORITY, the importance of PLANNING for quitting smoking, and PREVENTION of relapse.

- Developed a symbol for lung cancer awareness for women. In 1987, lung cancer surpassed breast cancer as the top cancer killer among U.S. women. We have a pink ribbon to symbolize breast cancer awareness, but no symbol for lung cancer awareness. This upset me, so I developed one and it is proudly displayed in my office.

- Joined with other women (INWAT) in the fight for tobacco recovery. I have also become active in other tobacco-related organizations with the intention to help raise awareness about issues specific to women and tobacco.

If we don't step up, become involved and take active leadership roles in the battle against tobacco and women, who will? Instead of spending our energy frustrated with the problem, we can instead use that energy to become part of the solution. I hope you will join me!

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Dental Hygiene and Tobacco Interventions:

A Natural Symbiosis

By: Jackie Fried

With over 120,000 practicing members, the American Dental Hygienists' Association (ADHA) is the largest professional organization in the United States that solely represents the interests of the dental hygiene profession. The professional's commitment to disease prevention and health promotion is integral to the mission of the ADHA. Dental hygiene is the key preventive arm of dentistry; dental hygienists are holistic health care providers who address both the oral and systemic well being of their patients. As such, they are important figures in the war against tobacco. Typically, patients see their dental hygienists and dentists more often than they see their physicians. It has been reported that 75% of the American public seeks some type of dental care in a given year.

Dental hygienists are in the front lines for screening patients for tobacco use and noting any changes in the oral cavity that may be due to tobacco use. As health educators and motivators, dental hygienists are well positioned to intervene with tobacco-using patients. During what has been dubbed as the "teachable moment", dental hygienists show their patients the effects of tobacco use in their own mouths. The reality check serves as a strong motivator for cessation since the patient must own the problem, at least visually. The oral effects of tobacco use range from the aesthetic (e.g., halitosis, tooth staining) to the life-threatening (e.g., head and neck cancers.)

Although not by design, dental hygiene is historically a female dominated profession. Consequently, a large but often overlooked cadre of female health care professionals is committed to and engaged in helping their patients abstain from tobacco use. A history of how this involvement has grown is provided below.

In September of 2003, the American Dental Hygienists' Association established a14-member Tobacco Task Force to move forward the initiative of increasing dental hygiene's involvement in tobacco interventions. Members of this task force possessed leadership skills and expertise in research, education and clinical activity related to tobacco interventions. The Task Force met initially under the auspices of the Smoking Cessation Leadership Center (SCLC) of the University of California, San Francisco. This Center is funded through the Robert Wood Johnson Foundation. The American Dental Hygienists' Association was awarded a grant through the Center to enhance the role of the dental hygienist in screening patients for tobacco use. In 2001, it was reported that only 20% of clinical dental hygienists were screening their patients for tobacco use. The ADHA, through grant-funded activities, hoped to increase that number to 50% by 2006.

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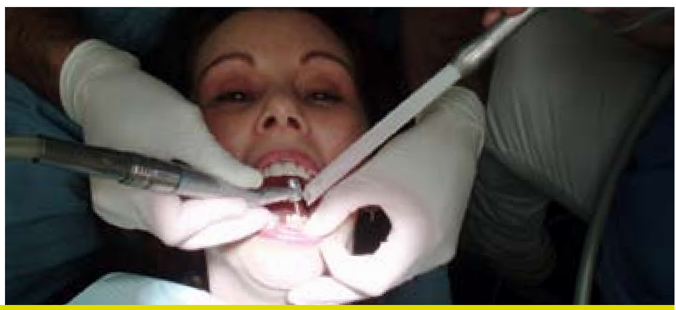
To achieve that goal, the ADHA instituted many creative measures. To create a centralized focus, the ADHA hired a Project Director who developed a nationwide network of state Smoking Cessation Initiative (SCI) liaisons. State liaisons work at the grassroots level as a resource person and create awareness among the membership. In addition, a user-friendly and information rich website was developed. The website, www.askadviserefer.org, includes PowerPoint presentations for speakers, scripts to guide providers when intervening with patients, links to relevant tobacco related websites, a discussion board for sharing information and posted briefs that relay tobacco-related news and commentary. The website has attracted many users from all walks of health care.

The Project Coordinator for the tobacco grant has visited each of the states in the Union and has delivered comprehensive and dynamic presentations on the importance and necessity for dental hygienists to actively engage in tobacco use prevention and cessation. The ADHA has been funded by the Smoking Cessation Leadership Center for an unprecedented fourth year. The infrastructure of the national initiative, the extensive state network and the unique intervention protocol created by the ADHA has won the organization kudos from many health professionals and experts in the area of tobacco prevention and cessation.

Presently, too few people understand the relationships between tobacco use and oral health, and oral and systemic disease. Tobacco use is the key environmental risk factor for periodontal disease, an infection of the gums and bone that support the teeth. Tooth loss which can result from periodontal disease may lead to compromised nutrition, a diminished ability to communicate and lowered self-esteem. Current research also suggests links between periodontal disease and heart disease, preterm low birth weight babies and diabetes. Periodontal disease may also exacerbate jawbone loss associated with osteoporosis.

It is clear that the oral disease related to tobacco use can impact overall well being. Dental hygienist have taken the initiative to be in the forefront for screening patients for tobacco use, performing oral cancer examinations, showing patients the clinical effects of tobacco use and educating them about the ramifications of tobacco use both orally and systemically. Incorporating tobacco interventions into the practice of dental hygiene enhances the provider's role and provides an opportunity for greater professional satisfaction and the chance to save someone's life.



Making a difference in the lives of lung cancer patients

The National Lung Cancer Partnership, formerly Women Against Lung Cancer, is a non-profit organization of leading physicians, researchers, patient advocates and lung cancer survivors dedicated to decreasing deaths due to lung cancer, and to helping patients live longer and better, through research, awareness and advocacy.

The National Lung Cancer Partnership is working to make a difference in the lives of lung cancer patients. We award grants to drive forward research that will increase the understanding of how lung cancer starts and progresses, and how to better detect and treat it. Ample lines of research show that there are significant biological differences in how women's and men's bodies react to lung cancer. One key focus of the Partnership is to understand how sex and gender differences contribute to lung cancer risk, biology and response to treatment. Approximately 15-20,000 patients diagnosed with lung cancer in the US each year have never smoked. A disproportionate number of these patients are women.[1-3] Some of the newest drugs developed to treat non-small cell lung cancer, which most commonly occurs in non-smokers, are more likely to work in women.[4-5] Many lines of evidence suggest that women may be more sensitive than men to the cancer-causing effects of chemicals in cigarettes.[1, 7-12] Conversely, women typically respond to lung cancer treatments better than men, and therefore have a slight survival advantage.[3-5, 12-13] Even the specific types of lung cancer that affect women can differ from men. For example, women are more likely than men to get a sub-type of lung cancer called bronchioloalveolar carcinoma.[6]

The Partnership conducts educational outreach to physicians, allied health professionals, and patients and their families through our Annual Meeting, lung cancer awareness displays, website and other print materials. We are currently developing a patient education handbook and a video on clinical trials.

The National Lung Cancer Partnership also hosts lung cancer awareness and fundraising events. In 2006, the Partnership launched the Free to Breathe 5K race series in Philadelphia, Pennsylvania. The Free to Breathe races will be expanding across the nation this year.

For more information about our organization, our programs and events, please visit our website at www.NationalLungCancerPartnership.org.

1. Zang, E.A. and E.L. Wynder, *Differences in lung cancer risk between men and women: examination of the evidence*. J Natl Cancer Inst, 1996. **88**(3-4): p. 183-92.
2. Radzikowska, E. and P. Glaz, *Lung cancer--differences of incidence between the sexes*. Pneumonol Alergol Pol, 2000. **68**(9-10): p. 417-24.
3. de Perrot, M., et al., *Sex differences in presentation, management, and prognosis of patients with non-small cell lung carcinoma*. J Thorac Cardiovasc Surg, 2000. **119**(1): p. 21-6.
4. Kris, M.G., et al., *Efficacy of gefitinib, an inhibitor of the epidermal growth factor receptor tyrosine kinase, in symptomatic patients with non-small cell lung cancer: a randomized trial*. JAMA, 2003. **290**(16): p. 2149-58.
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7. Tang, D.L., et al., *Associations between both genetic and environmental biomarkers and lung cancer: evidence of a greater risk of lung cancer in women smokers*. Carcinogenesis, 1998. **19**(11): p. 1949-53.
8. Henschke, C.I. and O.S. Miettinen, *Women's susceptibility to tobacco carcinogens*. Lung Cancer, 2004. **43**(1): p. 1-5.
9. Nordlund, L.A., J.M. Carstensen, and G. Pershagen, *Are male and female smokers at equal risk of smoking-related cancer: evidence from a Swedish prospective study*. Scand J Public Health, 1999. **27**(1): p. 56-62.
10. Harris, R.E., et al., *Race and sex differences in lung cancer risk associated with cigarette smoking*. Int J Epidemiol, 1993. **22**(4): p. 592-9.
11. Risch, H.A., et al., *Are female smokers at higher risk for lung cancer than male smokers? A case-control analysis by histologic type*. Am J Epidemiol, 1993. **138**(5): p. 281-93.
12. International Early Lung Cancer Action Program Investigators, *Women's susceptibility to tobacco carcinogens and survival after diagnosis of lung cancer*. JAMA, 2006. **296**(2):180-4.
13. Alexiou, C., et al., *Do women live longer following lung resection for carcinoma?* Eur J Cardiothorac Surg, 2002. **21**(2): p. 319-25.

Not a definition of equality

By: Sara Sanchez, Margaretha Haglund and Gunilla Bolinder

Oral smokeless tobacco (OST) use - a tradition among men in Sweden since the 1900s - began to fade during World War II but made a comeback in the 1970s as the producer, Swedish Match, was not prepared to let this "noble old Swedish tradition" disappear. Swedish OST is a form of moist tobacco which has a damp consistency, in contrast to the dry snuff used in may other countries. Increased marketing efforts and innovative product packaging in the form of sachets or "teabags" that came on the market in the 1970s continue to be used today.[1] As the male market becomes saturated, tobacco companies aim their arrow at another target – young girls and women. Although the use of OST among women has never been as popular as among men, the present day's appealing package design, small portions, and significantly cheaper prices when compared to cigarettes is appealing to an increasing number of young girls.

Slick tobacco industry messages

The new marketing direction and flavour-full product development is clear in Swedish Match's 2005 Annual Report.[2] *"The recruitment of new consumers in recent years has not only meant increased volumes for snuff producers but has also increased the need for product renewal and innovation."* Although women are not referred to in print, a photograph of a small pink purse containing a discrete package of OST speaks loud and clear. In addition to boasting about the profit made, the company states that in 2005 several new flavours were launched, 240 million cans were sold in Scandinavia to both *"men and women"* and *"further market expansion in new and existing geographies"* is the right direction. Simply scanning the annual report, there are many pictures of young female executives - except on those pages which feature Swedish Match's own management, who all appear to be men. And because it is a shareholder's report, the company does not write a single word about the adverse health effects, they just repeat the same mantra, "the product is less harmful than cigarettes".

Although not blatantly named as a target market in the annual report, advertisements which decorate the report demonstrate that Swedish Match is making efforts to engage female customers.

The life-threatening health effects of Oral Smokeless Tobacco

Advocates of tobacco harm- reduction argue that OST can prevent lung cancer and other respiratory disease among smokers. Yet the perspective must be broader as there do exist debilitating diseases caused by OST. It is known conclusively that Swedish-type OST doubles the risk of "the metabolic syndrome" which is attributed to the oneset of type II diabetes and the risk of dying when having an acute myocardial infarction. It increases the risk of vascular spasm and angina pectoris and the risk of complications after surgical treatment.[3]

1. Nordgren, P. European Network for Smoking Prevention (ENSP) Status Report on Oral Tobacco; 2002
2. Swedish Match Annual Report 2005. English Version.
3. The Health Effects of Swedish Oral Smokeless Tobacco. November 2005. National Institute of Public Health.

OST is associated with a higher incidence of hypertension, hyperlipidemia and insulin resistance.[4] The product also influences oral health and causes irreversible retraction of the gum tissue, and a "snuff-lesion" in the soft tissue.[3] During pregnancy the use of OST increases the risk of premature birth, lower birth weight, toxemia, sudden infant death syndrome[5] and later attention deficit disorders.[6] The child may also be born with an already established nicotine addiction. Breast feeding mothers pass high amounts of nicotine to their babies.[7] The International Agency for Research on Cancer (IARC), has evaluated all smokeless tobacco products and conclusively labelled them "carcinogenic" as OST also increases the risk of pancreatic cancer.[3] Finally, OST is as least as addictive as smoking, and for many users leads to even more craving due to its continuous nicotine supply.

Prevalence rates

Prevalence of OST use remains significantly higher among men than women (Table 1). Among women, OST use has traditionally been almost non-existent: 0.6 per cent of adult women were daily snus users in 1988-89, compared to 4% in 2006. Yet, since 2004 there has been no significant increase. Looking at the overall nicotine addiction, there is a much higher proportion of men dependent on tobacco products compared to women in Sweden. On a global scale, Swedish male tobacco use prevalence does not compare favourably to that of other countries because of this overall tobacco addiction. The smoking cessation trends demonstrate that women are quitting without an increase in the use of OST while men continue to stay addicted to tobacco. When concluding that OST assists in smoking cessation, it should be clearly emphasised that this has thus far been limited to men.[8]

4. Norberg M, Stenlund H, Lindahl B, Boman K and Weinehall L. Contribution of Swedish moist snuff to the metabolic syndrome: A wolf in sheep's clothing? *Scandinavian Journal of Public Health* 2006:1-8.
5. England LJ, Levine RJ, Klebanoff MA, Yu KF, Cnattingius S. *Am J Obstet Gynecol* 2003; 189(4) 939-43.
6. Kotimaa AJ et al. Maternal smoking and hyperactivity in 8 year old children. *J Am Acad Child Adolesc Pschiatry* 2003; 42(7):826-33.
7. Dahlström A, Ebersjo C, Lundell B. Nicotine exposure in breastfed infants. *Acta Pediatr* 2004; 93 (6):810-16.

Oral smokeless tobacco is the cheapest form of nicotine in Sweden

Although taxes increased in 2007, a lack of adequate taxes on oral smokeless tobacco compared to cigarettes and the expense of buying nicotine replacement therapy at a pharmacy, give oral smokeless tobacco an advantage as the cheapest and most accessible way to get a nicotine fix. Table 2 compares OST's affordability to other nicotine products by price per mg of nicotine. This affordability gives OST an unfair advantage over nicotine replacement therapy (NRT) and from a public health perspective, may actually dissuade smokers from making a clean break from nicotine addiction. Moreover, there are numerous cases where the smoker starts to using both tobacco products. OST is in no way a clean form of nicotine, as is NRT, nor is it a recommended cessation aid by any Swedish Cessation Guideline.

Working through loopholes

Sweden has been commended for its long-standing comprehensive ban on tobacco advertising. Yet, promotion of OST leaks through loopholes and holds a prominent advertising position at point of purchase. For example. a brand named "Skruf" ran a well-designed ad in the centrefold of Metro, a newspaper distributed free of charge on public transport in Stockholm and other cities in Sweden. A picture of stylish young women with a package of OST in her turquoise purse was used to advertise a job as a marketing manager. Swedish Match frequently runs ads for its nicotine-free version of OST which consequently brands its logo and package design for many potential shoppers.

Table 1 Smoking, oral smokeless tobacco and total tobacco use rates (daily use)

	Smoking	OST	All Tobacco Products
Women age 18-84 (2006)[9]	15%	4%	19%
Men age 18-84 (2006)[9]	13%	21%	33%
Young Women age 15[10]			
2002	15%	1%	16%
2003	13%	2%	
2004	13%	3%	
Young Men age 15[10]			Information unavailable
2002	9%	17%	
2003	7%	16%	
2004	5%	15%	
Pregnant Women week 8-12 (2003)[11]	10%	1.4%	Information unavailable

Ads for tobacco are banned in Sweden except at point of purchase.
This half page ad made its way in to a well-read free daily newspaper as it also promoted a job ad.

Package design and product flavour development

OST products designed for young women typically include small packages and fruity or fresh flavours. Historically, all OST had a standard taste and higher nicotine content and was available as loose tobacco which caused many new starters to nearly vomit on the first try. Today new users can start with a softer variant, in a wide range of flavours available in small-size sachets or 'teabags' to become hooked. This same marketing technique using flavours is also seen in alcohol product development where young women are successfully lured to start drinking by a flavoured vodka or rum.

8. Ramström, LR and Foulds J. Role of snus in initiation and cessation of tobacco smoking in Sweden. *Tobacco Control* 2006;15:210-214.
9. Hälsa på lika vilkor (HLV), National Institute of Public Health 2006
10. Skolelevers drogvanor, CAN 2005
11. Medicinska födelseregistret, EpC/Socialstyrelsen 2003
12. 2007 Budget Projections of the Swedish Government. Taken from an article posted on Tobaksfakta.org
13. www.apoteket.se – Swedish Pharmacy Monopoly – September 20, 2006

Table 2 Price Chart – Nicotine Product Price Chart in Euros

Product	Approximate price per mg nicotine in Sweden Kronor and Euros	Remark
Cigarettes (0,8 mg nicotine cigarettes)	2.40 SEK (0.26€)[12]	Medium strong cigarettes
OST (8 mg nic/g tobacco) loose and portion	0.25 SEK – 0.45 SEK (0.03€- 0.05€)[12]	given only 1/3 of the nicotine content is absorbed
Gum (2 mg and 4 mg)	0.80 SEK – 1.30 SEK (0.09€- 0.14€)[13]	
Patch brands (5 mg and 15 mg)	3.50 – 1.20 SEK (0.39€- 0.13€)[13]	All patches same price

Women can lose on a "OST as harm reduction" slippery slope

The Swedish Match branded "Swedish Experience" continues to be promoted within the public health sector on the false pretence that a) never mentions Sweden's long-standing tobacco control tradition since the 1960s and b) focuses on the small percentage of men smokers that have substituted smoking for snus. Last, but not least, harm reduction models simply compare smoking to OST use whereas the health risks of OST should always be compared with no use of tobacco. Almost anything that is compared with smoking will appear less harmful.

An NGO, A Non Smoking Generation, launched a social marketing campaign in the spring of 2005 to deter youth from using OST.

14. Andersson G, Björnberg G, Curvall M. J *Oral Pathol Med* 1994; 23:161-67

A look through the gender lens also shows that for the present OST harm reduction hopes are limited to men and that the number that have become free from tobacco is negligible, since 33% continue to be addicted to nicotine.[9] For women, promotion of OST as a form of cessation risks repeating the light cigarette catastrophe – continued dependence on a product which is mistakenly thought to be a better "choice". Furthermore, the Framework Convention on Tobacco Control (FCTC) states that all tobacco use should be taken into account when creating policy to eliminate its use around the world.

Addiction to OST is hard to kick

OST cessation is an area that is not often mentioned. The average daily OST user has tobacco in his mouth for 13 hours a day.[14] OST often also contains higher concentrations of nicotine than do cigarettes which can make users even more dependent. According to testimonials by tobacco cessation counsellors in Sweden, OST users also have a difficult time quitting their tobacco dependence.

Conclusion: Investing in tobacco control is the only solution

As repeatedly stated, the cure for the tobacco epidemic is sustained funding in tobacco control to advance implementation of a comprehensive program. Looking beyond Sweden at countries such as USA California, Canada, Thailand and New Zealand, long running comprehensive programming with adequate funding is the key to significantly reducing tobacco use rates to a minimum without the use of OST as a prerequisite. A multifaceted approach which encompasses tighter tobacco control laws, tobacco cessation that is gender-specific and effective social marketing messages to discourage use of all tobacco products are keys to success.

In Sweden, efforts are being made to alert women to the marketing tactics of the tobacco industry to prevent them from being seduced again as in the 1960s when cigarettes were promoted to women in Sweden. For example, A Non Smoking Generation (an NGO) has launched social marketing campaigns to draw attention to the fact that women are being encouraged to use oral smokeless tobacco within the realm of a comprehensive tobacco control program.

Looking at the evidence from a gender perspective, it is our recommendation that investment in tobacco control without the introduction of new tobacco products in societies, including in Sweden, be the direction taken by countries. The only life saved by oral smokeless tobacco is the tobacco industry's life.

Margaretha Haglund is the Director of the Tobacco Control Program at the National Institute of Public Health, Gunilla Bolinder is a medical doctor, PhD and Director of Education at Karolinska University Hospital and Sara Sanchez is the International Project Coordinator for Health Professionals against Tobacco, Sweden.

The International Alliance of Women participates in a WHO expert group meeting on Secondhand Smoke (1-3 November, Dublin, Ireland)

By: Soon-Young Yoon

The right to protection against secondhand smoke is based on a fundamental human right to life. That was a key issue discussed by a WHO expert group on secondhand smoke that met in Dublin, Ireland from 1 to 3 November. The purpose of the meeting was to develop guidelines for the implementation of Article 8 of the WHO Framework Convention on Tobacco Control, ratified by more than 140 countries. The International Alliance of Women (IAW), a member of the Framework Convention Alliance (FCA) participated in the working group that drafted definitions.

Ireland, the first country to pass a comprehensive indoor smoking ban, emphasized the importance of partnerships with labour union leaders in their successful campaign on smoke-free legislation. Uruguay's creative public information strategy thanked smokers for their cooperation in safeguarding non-smokers' health. The IAW representative, Soon-Young Yoon, noted that "the majority of the world's secondhand smoke victims are women and children. Yet few women are aware that exposure to SHS contributes to coronary heart disease and lung cancer and that it puts them at increased risk for breast cancer."

This is just one example of how a women's organization can advocate for critical health issues that affect women. Much more effort needs to be put into reaching women leaders outside the orbit of health professional and anti-tobacco NGOs. The IAW has raised the issue of secondhand smoke at the UN Commission on the Status of Women and hopes to expand its activities to reach NGOs working with girls' health.

For more information contact Soon-Young Yoon: SYNGO1@aol.com. For more information on the WHO expert group meeting or the WHO-FCTC consult the WHO website: http://www.who.int/tobacco/en/.

WHO Director General Makes the Health of Women and Africans Her Top Priorities

On January 4th, Dr. Margaret F. C. Chan took office as the Director General of the World Health Organization. Her two primary goals are to improve the health of Africans and of women throughout the world.

"Women face risks during pregnancy and childbirth that make them particularly vulnerable to health problems," said Dr. Chan, 59, a former Hong Kong health chief. "On the positive side, they can be powerful agents of change for better health."

"Women do much more than have babies," Dr. Chan said in a statement on the WHO website. She also added that women were a rising influence in the work force and in their communities – particularly since so many teachers and health care workers are women.

When she was elected, she noted that "the people of Africa carry an enormous and disproportionate burden of ill health and premature death." When taking office she told her staff that "poor health and poverty are closely tied, as are better health and the prospects for development."

Efforts are needed to strengthen the weak national health systems that are Africa's biggest public health challenge, Dr. Chan said. She cautioned that poor countries did not want to be told what to do, preferring to come up with plans that met their own needs.

Dr. Chan, who earned her medical degree from the University of Western Ontario in Canada, cited a list of chronic diseases and other problems that were creating new challenges for poor countries. Among them are violence, injuries, heart disease, stroke, cancer, diabetes, kidney disease and mental illness.

Source of Information: NY Times Article dated January 5, 2007 by Lawrence K. Altman

The Framework Convention Alliance FCTC Monitor:

Representing the Voice of Civil Society

By: *Natasha Jategaonkar*

In 2003, member states of the World Health Organization (WHO) voted unanimously to adopt the Framework Convention on Tobacco Control (FCTC). This historic document, the culmination of four years of negotiations, is the first international legal instrument designed to promote national action and global cooperation to counter the worldwide spread of the tobacco epidemic. The FCTC entered into force in February 2005.

According to Article 21 of the FCTC, each Party to the Treaty has an obligation to submit periodic reports on its implementation of the provisions of the FCTC. Parties have agreed to a reporting system that facilitates learning from each other's experiences in implementing the treaty, but does not monitor compliance. Thus, the Framework Convention Alliance (FCA) has developed a "shadow" mechanism whose mission is to monitor the implementation of the FCTC.

The Framework Convention Alliance (FCA) represents the voice of civil society and engages in efforts around the world to ensure effective implementation of the FCTC. The main instrument of the FCA's shadow reporting is the FCA FCTC Monitor, a web-based data collection tool developed by the Johns Hopkins Bloomberg School of Public Health, with assistance from international experts. The Monitor, currently in its first year, will provide a baseline of information that will allow comparisons among countries and over time. Data collection is being conducted in each participating nation by members of civil society and non-governmental organizations (NGOs). The aim for this first year of data collection is to include the first 41 countries to ratify the FCTC, and expand to a greater number of countries in subsequent years.

The Monitor includes assessments of tobacco policy information as well as other factors that may influence implementation of FCTC articles. Data collected from countries around the world will be compiled to produce The FCA Monitor Report, which, based on NGO input, will identify specific gaps and successes of FCTC implementation and offer recommendations as to how those gaps can be addressed. The report will serve as an advocacy tool and will be distributed widely in order to encourage greater compliance with FCTC commitments.

Opportunities for monitoring gender issues

One of the unique features about the Monitor data collection instrument is that it accommodates both quantitative and qualitative data. In other words, data collectors are asked to provide numeric data and rank policy implementation progress in categories such as "High, Moderate or Low"; but are also asked to expand on their answers by describing the unique context of the situation in their respective countries in their own words. Hence, data collectors have an opportunity to provide information about women, youth, indigenous communities and other groups who may have specific vulnerabilities to tobacco.

For example, Section 4 of the Monitor asks questions that pertain to FCTC Article 8 (Protection from exposure to tobacco smoke). In countries where smoking rates are high among men, but not yet among women, protection from secondhand smoke becomes an important women's health concern. The FCA Monitor collects data regarding smoking restriction legislation in specific indoor public places such as health care facilities, restaurants, and government workplaces, as well as sanctions for violations. Many of these indoor smoking restrictions affect women and men differently. For example, if women are more likely to be employed in the hospitality industry, then a policy that bans smoking in government buildings but not restaurants may afford less protection from secondhand smoke to women in their workplaces.

Section 5 of the Monitor inquires about issues related to FCTC Article 11 (Packaging and labeling of tobacco products). In particular, this section focuses on legislation that bans the use of misleading or deceptive terms that could minimize the perceived hazards of smoking, as well as legislation that requires health warnings on tobacco product packaging.

Misleading terms such as "light", "mild" or "low tar" have traditionally been targeted at women, and it is likely that future attempts to create an erroneous impression of the health effects of tobacco use may also be directed toward women. Regarding requirements for health warnings, the Monitor records whether or not the legislation stipulates that the warnings be placed on *all* tobacco product packaging – not just cigarettes. This item, too, has important implications for women, as in many countries, women are more likely to be using tobacco in a form other than cigarettes and suffering serious health effects such as oral cancers.

The Monitor also goes beyond the articles of the FCTC in Section 10, to ask about other key tobacco control activities being conducted around the world. Questions in this section inquire about both government and civil society efforts in tobacco control policy and programming. These questions provide an opportunity to highlight advocacy work being carried out by women's groups either within the tobacco control movement or as part of a broader women's health agenda.

The Monitor aims to monitor implementation of the FCTC. However, the FCTC itself states in Article 2 that "Parties are encouraged to implement measures beyond those required by this Convention and its protocols"[1]; in other words, the FCTC sets a "floor" but not a "ceiling" for tobacco control efforts.[2] In order for the FCTC to be most effective within the individual countries that have ratified it, all of our activities connected with its implementation – including monitoring – must reflect the unique needs of women and other communities within our own local contexts.

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Natasha Jategaonkar MSc is the Project Manager for the Framework Convention Alliance (FCA) FCTC Monitor. She is coordinating the data collection and analysis process for this project, and will be leading the production of a final report based on the information gathered. Natasha previously worked with the British Columbia Centre of Excellence for Women's Health (Canada) for three years and collaborated with INWAT on the report *Turning a New Leaf: Women, Tobacco, and the Future*.

For women smokers in Hong Kong

Providing a gender specific smoking cessation program

By: *Sophia Chan, EMY Wong GM Leung and TH Lam*

Smoking is the biggest preventable cause of death in Hong Kong; it kills about 6,000 people per year, accounting for about one fifth of all deaths and about 9% among all women.[1] In Hong Kong, the number of female daily cigarette smokers rose from 102,600 (3.5%) in 2000 to 107,800 (3.6%) in 2002.[5] Significant increases in daily cigarette smokers among women aged 20-29 and 30-39 years were observed where the prevalence of daily cigarette smokers among women aged 20-29 years has increased from 4.7% in 2000 to 6.2% in 2002 and for women aged 30-39 years from 3.4% to 4.3% respectively.[5] Greater female autonomy and changes in women's roles may put women and girls at risk of smoking. As the health effects of smoking only become fully evident 40-50 years after the widespread uptake of smoking, the full global impact of smoking on women's health will not be seen for some decades. It is estimated that over the next 30 years, tobacco-attributable deaths among women will more than double.[6]

In Hong Kong, almost all female smokers (99.5%) had not tried smoking cessation service provided by government or other organizations, although around 50% of them aware of the service.[5] However, we observed that there is an urgent need of gender-specific smoking cessation service for female smokers in Hong Kong as around 20% of the attendees of the Smoking Cessation Health Centre (SCHC) were female smokers.[7] The SCHC data also showed that women perceived more difficulties and have lower confidence in quitting than their male counterparts.[8] In addition, female smokers had a slightly lower quit rate (21.9%) than male smokers (28.4%).[8]

Previous studies showed no consistent differences between men's and women's motivation to quit, readiness to quit, awareness of harmful effects, or effectiveness of interventions[9], however, other studies have suggested that women may find it more difficult to quit smoking than men.[3] The reasons are not well understood, but it is likely due to a combination of biological, psychological and social factors.[10] In addition, the association of smoking with impaired quality of life is more marked in females than in males.[11] Hence, gender-specific health education and quitting program targeting smoking cessation issues such as hormonal influences, pregnancy, fear of weight gain, lack of social support and depression, is urgently needed.

The University of Hong Kong collaborated with community women's organizations to form a 'Women Against Tobacco Taskforce (WATT)' to increase the public's awareness of health risks specific to women from smoking, and promote smoking cessation among female smokers in Hong Kong. We also devised a training programme for staff and volunteers of the WATT organizations so that they could provide gender specific smoking cessation advice to woman smokers, and refer smokers who

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need intensive intervention to our trained nurse counselor, who will then provide face-to-face and/or telephone counselling.

A total of 32 female staff and volunteers from WATT participated in four focus group interviews which explored their perception of woman smoking in Hong Kong, adequacy of existing smoking cessation services for females, and their learning needs in providing smoking cessation counseling. Data were transcribed and analyzed using thematic content analysis. The mean age of the participants was 47 years and 20% and 56% had attained primary and secondary education respectively. Participants were non-smokers, perceived an increasing trend of female youth smoking, and were not aware of any gender specific smoking cessation services in Hong Kong. Learning needs identified included knowledge on smoking and woman's health, skills to assess smoking status, and specific ways to motivate woman to quit smoking. This preliminary analysis indicated the need to provide gender specific interventions for woman smokers in Hong Kong. The identified learning needs can guide the design and delivery of a woman smoking cessation program for the staff and volunteers of WATT, as well as the gender-specific smoking cessation program for women smokers in Hong Kong.

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Acknowledgement: Health Care and Promotion Fund

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女性反吸煙工作組

Women Against Tobacco Taskforce (WATT)

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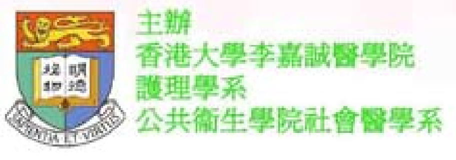

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Women and Tobacco highlighted at numerous recent conferences

Since the 13th World Conference on Tobacco or Health in July 2006, there have been several congresses and conferences at the country or regional level which have examined the issue of women and tobacco. Highlighting just four of these conferences which took place in Argentina, Turkey, Morocco and Bulgaria we see that the issue of women's tobacco use and role in tobacco production is gathering increasing attention.

17 - 19 November, 2006, First Argentinean Congress on Tobacco or Health Olavarria, Argentina

The first Argentinean Congress on Tobacco or Health was organized by the Argentine Union against Tobacco (UATA) and the Secretary of Public Health of the city of Olavarria. The event was a great opportunity to unite politicians and the public against the tobacco pandemic.

The issue of women and tobacco had an important place in the Congress with many women speakers in the main sessions. A roundtable discussion about the tobacco industry's efforts to target women as potential customers was coordinated by Dr. Mario Bruno and Dr. Enrique Colombo.

INWAT members from Argentina, Uruguay and Chile had an opportunity to meet during the Congress to discuss the development of a regional network on women and tobacco and future activities in the region.

Attendees at the women and tobacco meeting.

The Congress concluded with a Declaration that emphasizes the necessity to create tobacco control strategies at the municipal, provincial and national levels.

Gabriela Reguira is the Secretary for the International Network of Women Against Tobacco and one of the founding leaders of the recent Women and Tobacco Movement in Latin America.

Latin American women against tobacco group.

20 - 24 November, 2006, Third National Tobacco or Health Congress Ankara, Turkey

On 21 November Celal Karlikava proposed that Turkey implement a "Smokefree Women's Day" to remember the importance of the influence of tobacco on women's lives. The Congress agreed to dedicate special attention to the important issues of women's tobacco use in Turkey. For more information or to read the final conference declaration, visit: http://www.tutunsuzyasam.org/dosya/SonucBildirgesi.doc

Celal Karlikaya, MD is Associate Professor at Trakya University Faculty of Medicine Dep Chest Diseases and was the leader of the first tobacco litigation of Turkey in 2000 published in http://tc.bmjjournals.com/cgi/content/full/15/2/78.

20 - 22 November, 2006, European Network for Smoking Prevention Annual General Meeting Sofia, Bulgaria

INWAT-Europe had strong representation at the Annual General Meeting for the European Network for Smoking Prevention (ENSP). Elizabeth Tamang, a member of the INWAT-Europe Advisory Board chaired the meeting as the President of ENSP. The meeting covered tobacco control research in Europe, secondhand smoke, sales to minors, price and taxes and advertising bans. INWAT-Europe drew attention to the report from an expert seminar on women and secondhand smoke in addition to raising the issue of women's health throughout the meeting's seminars.

Carolyn Dresler *right* (formally of IARC) and new recruit Maria Karekla of the Centre for Therapy Training and Research in Cyprus by the INWAT-Europe display.

7-10 December, 2006, 1st African Conference on Tobacco or Health Casablanca, Morocco

Women and tobacco experts Karen Slama, Annie Sasco and Mira Aghi were among the speakers invited to discuss women and tobacco issues in this African setting. There is much diversity of type of tobacco use and prevalence among the women on this continent. From narghile (water pipe) smoking ín Morocco to inhaling oral tobacco in South Africa, tobacco use is increasing the burden of infectious diseases, including tuberculosis, HIV/AIDS and pneumonia in addition to the toll of chronic disease, Under the leadership of Prof Mohamed Bartal MD , president of AMAPES STOP TABAC in Casablanca, this first conference brought together tobacco control advocates from 29 countries.

Mira Aghi, INWAT South East Asia Regional Representative, provided a broad overview on global consumption of tobacco from a gender perspective including information from the Global Youth Tobacco Survey. She also described the various factors that influence young people's decisions to start and continue using tobacco including self-image, self-esteem, peer influences, disposable income and media influence. Mira Aghi cited treaties, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), to highlight the global agreement that women have a fundamental right to health.

To read the Casablanca Declaration on tobacco control visit: http://www.ingcat.org/linked%20files/Casablanca_Declaration.doc

West Midlands Stop Smoking in Pregnancy Network

By: Carmel O'Gorman

When I was appointed as the Midwifery Lead for Smoking and Pregnancy at Good Hope Hospital in Birmingham, England in 2002, I felt enthusiastic about making a difference and improving the health of women, babies and families. Yet life at the 'cutting edge' of this work quickly saw these well documented patterns emerge: women who smoke in pregnancy experience less support and fewer financial resources, more family problems, less residential stability and more psychological and emotional problems. Often smoking is used to relieve stress. In addition to their multiple disadvantages, many are typically highly nicotine dependent and live with another smoker.

My first year in post was a challenging time and increasingly I felt the need for communication and support from others working with this difficult client group. This work creates particular stresses; having to cope with the lack of understanding by some staff members about nicotine addiction and why pregnant women smoke; having to smile when yet another person tells you how easy it was to give up smoking when they were pregnant and why don't these women just give up? With the support of colleagues, I established the network in September 2003.

The United Kingdom is unique in that local, intensive support for giving up smoking is available through our National Health Service (NHS) at no cost to the patient. There has been an annual increase in the number of pregnant women using local NHS Stop Smoking Services since 2001/02. Generally, local services offer pregnant women flexible home visits, intensive, multi-session and one-to-one support delivered by well trained, dedicated and capable staff.

Initially our 'network' was six NHS Stop Smoking Advisors who chose to get together informally in order to share experiences. We all worked in the West Midlands, a region of about five million people in the heart of England. Aside from working directly with pregnant women, we were a diverse group; varying in age, experience and professional background. The network's strength is its multidisciplinary nature, members being midwives, health visitors (community nurses), practice nurses and health psychologists.

With only six founder members, the meeting structure was very informal. This informality remains a popular element of meetings. Stop Smoking Advisors visit women at home so they very often work in isolation and with varying levels of support. Establishing contacts with others in the field was vital. The network allows us to share best practice, innovations, information, resources and experience. The knowledge that we are part of a group working toward the same goals is empowering.

Each time we met the geographical net widened, and it now covers 19 NHS Stop Smoking Services. Due to the network's rapidly increasing size and lean infrastructure, it was difficult for me to coordinate the network effectively and do my 'day job', so in November 2005 I started a 12 month secondment that enabled me to spend one day each week as network coordinator. The extra time allowed me to organise sub-groups to develop patient notes, information leaflets, a regional register to record basic data about NRT use in pregnancy and regional recommendations for core services for pregnant women. We also now have an administrative central point and an infrastructure consisting of: bimonthly meetings, minutes, a website, regular email updates to named contacts. A milestone was when we held a national smoking and pregnancy conference in 2005.

This activity raised the network's profile with regional stakeholders who now support and 'champion' our network. However, my secondment has now ended, making the development of the network a constant challenge. But the need for high level support is still there. The latest UK figures reveal that the highest levels of smoking during pregnancy are still found among young and socially disadvantaged mothers. These are the only two groups whose prevalence has increased over the last five years. Closer to home, the West Midlands has high rates of smoking in pregnancy (in 2006 some 18% of pregnant women in the West Midlands were recorded as "current smokers" around the time of their baby's birth) and the highest infant mortality rates of any English region. Helping parents to stop smoking and remain smoke free for life is a regional priority, demonstrating the importance of the network's continued existence.

Is the network beneficial? The members used these words to describe our meetings: therapeutic, effective, vital, inspiring, informative, feedback, empowering, knowledgeable, supportive, useful, encouraging, friendly, disseminating and unique. My favourite is 'support for the supporters'.

I am appreciative of the on-going management support from both my employing organisations, without which these achievements would not have been possible.

I would like to get more involved with INWAT. If anyone from the West Midlands would like to be involved in starting a regional network of INWAT please contact me.

For more information contact Carmel O'Gorman at carmel o'gorman@goodhope.nhs.uk Midwifery Lead Smoking and Pregnancy / Network coordinator and founder member Good Hope Hospital NHS Trust and Birmingham East and North Primary Care Trust.

The Mater Hospital's Smoking Cessation clinic

By: Trish Keogh - Hodgett

I have been running the Mater Hospital's smoking cessation clinic in Belfast, UK since 1996. The clinic operates as a smoking cessation and relapse prevention centre. Clients struggle through their nicotine addictions and sometimes drop out and come back to the counselling. Our patients are referred to the clinic by health professional staff working both inside and outside the hospital.

The age ranges of those attending are between 18 and 80+years with a mixture of females and males, with various conditions including chronic obstructive pulmonary disease (COPD), psychiatric conditions and vascular disease. Occasionally pregnant women attend. The clinic also has a support group which runs one hour each week.

We also offer stop smoking support to hospital employees with one to one counselling and nicotine replacement therapy, if needed. The employees who attend the initial assessment are followed up at one and four weeks and at one year.

For more information contact Trish Keogh – Hodgett, Health Promotion Trish.Keogh-Hodgett@mater.n-i.nhs.uk.

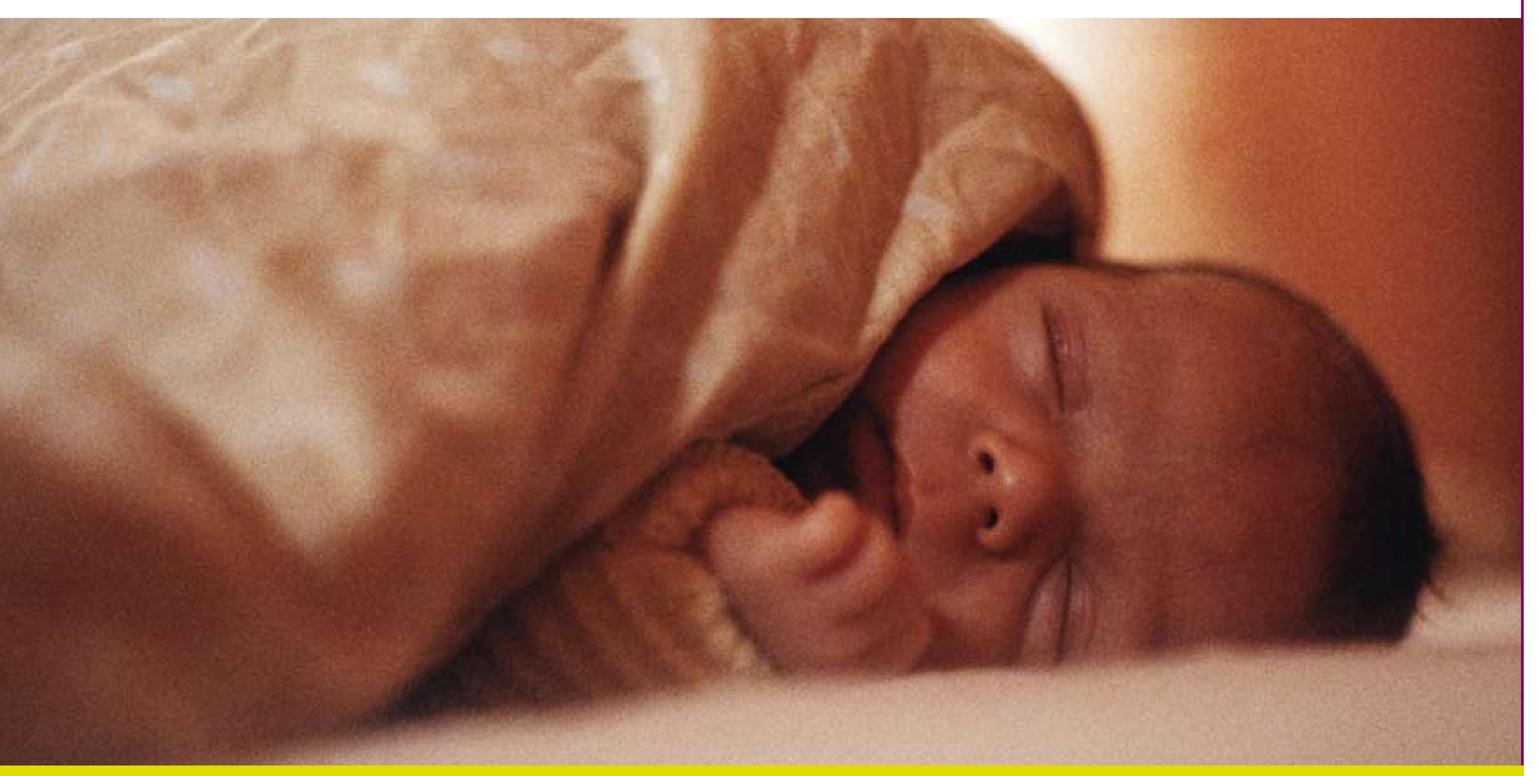
Tuberculosis, Smoking and Women*

By: Dr. Tjandra Yoga Aditama

A new book *Tuberculosis, Smoking & Women* was launched on 22nd of December, which is Mother's Day in Indonesia during a "National Seminar on Women and Health" officially opened by the First Lady and by the Indonesian Minister for Women's Affairs. This book is just one of the efforts in Indonesia to combat tobacco problems among women in this country. The publishing of this book was fully supported by National Health Insurance Organization ("ASKES"). In the Indonesia 65.2% of males and 4.5% of females currently smoke. The 2006 Global Youth Tobacco Survey demonstrated that 24.5% of boys and 2.3% of girls currently smoke cigarettes.

For more information contact: Dr Tjandra Yoga Aditama aditama@globalink.org Pulmonology & Respiratory Medicine Department, Faculty of Medicine University of Indonesia / Persahabatan Hospital, Indonesian Smoking Control Foundation.

**The publication is only available in Indonesian*



South East Asia Acts Against Tobacco

By: *Majari Peiris – INWAT Columnist*

Indonesia

Dr. Tijandra Yoga of the Indonesian Smoking Control Foundation has sent details of several tobacco control projects in the country.

A tabloid paper, "Info Kecantikan", which reports on beauty, interviewed representatives of the Foundation about the impact of smoking on women. This is the first time that a tabloid paper which focuses women's beauty had published a story on women and tobacco.

The Indonesian Smoking Control Foundation has also been invited to make a presentation on tobacco and health in Balongan West Java by the Indonesia National Oil & Gas Company. This is an important area for the chemical and petro-chemical industries. It is due to become a smoke free area in early 2007. Some people have commented that smoke free status is long overdue, and that similar areas in Indonesia should also eliminate public smoking.

Following representations from the Indonesian Smoking Control Foundation and the Indonesian Association of Public Health, Cirebon City has just been a declared a smoke free city .

Bangalore

In Bangalore, beedi manufacturing is a home-based industry providing a major source of employment for many illiterate women. Beedis are an indigenous hand-rolled cigarette of tobacco rolled in a tendu leaf and tied with a string. In Dakshina Kannada and Udupi, there are about 600,000 – 700,000 women employed in the rolling of beedis. However the industry is now going through a downturn and it claims that this is due to increased awareness about health.

Many of the women working in the industry are subject to health problems caused by the heavy tobacco dust in the work environment. Researchers have found that many workers suffer from chest congestion and there may be a cancer risk from inhaling the dust. The conditions also cause eye strain and many beedi rollers suffer from backaches caused by sitting in one position for a long time.

These problems are likely to intensify as the industry faces increased competition from Indian and foreign cheap brands.

Thailand

The end of 2006 saw a flurry of tobacco control activity in Thailand. The National Research Council of Thailand held the Tobacco Control Research Exhibition at Central Plaza, Ladprew, Bangkok, to publicise the risks of smoking and passive smoking.

A demonstration against environmental tobacco smoke in offices and public places was held in Siam Square Soi, by the Nurses' Network against Tobacco and Substance Abuse, ASH Thailand, the Health Professional Alliance Against Tobacco and the Ministry of Public Health. Nurses were able to speak to members of the public about the health risks of smoking and screening tests for smokers and to arrange mobile counseling clinics for smokers wanting to quit.

Hong Kong

With the enactment of a ban on public smoking, a European company that helps smokers to give up cigarettes has announced plans to open its first office in the special administrative region, *The Shanghai Daily* of Hong Kong, reported.

The company's Managing Director said that although Hong Kong was leading the way on tobacco control in Asia, there seemed to be a very few services available to help smokers quit. This is the company's first Asian operation and it will become the centre for the region.

Malaysia

A letter campaign to petition the Malaysian Government to cancel a trade exposition in Kuala Lumpur was organised locally and through Globalink by the Malaysian Council for Tobacco Control (MCTC). Thousands of executives from all fields of the international tobacco industry were expected to attend the exposition. Although it went ahead on this occasion, despite the protest and petition, the Prime Minister's department wrote to the MCTC to say that such event would not be held in Malaysia ever again.

Sri Lanka

Sri Lanka has taken a great stride forwards on tobacco control by implementing the tobacco control law, with effect from December 2006. The law includes of the following provisions:

- Prohibition of the sale of any tobacco product to persons under twenty one years of age;
- Prohibition of the installation of vending machines for dispensing tobacco products;
- Prohibition on the sale of tobacco products without health warning and indication of the tar, nicotine levels; prohibition of tobacco advertisements; prohibition of sponsorships and free distribution and of tobacco products;
- Prohibition of the manufacture or sale of tobacco products which are specifically proscribed.

Much of the credit for these new regulations should go to the Director of the Non-communicable Disease Programme of the Health Ministry and the Health Minister, who have shown their personal attention and dedication towards this worthy cause.

A Warm Welcome to Two New Board Members

The Regional Representative for Africa

Patricia Lambert is a South African lawyer and activist. From 1997 until 2005, she worked as a legal adviser to the South African government. Before that she was involved in the theatre and in education. It was her legal background that brought Patricia into the realm of tobacco control. In 1999, she began to work on the implementation of South Africa's domestic tobacco control law – the first comprehensive tobacco control measures adopted by an African country. In 2000, she was appointed to head the South African negotiating team for the WHO *Framework Convention on Tobacco Control* (FCTC). In that role she participated in all six of the Negotiating Body meetings in Geneva and in five African FCTC meetings. She chaired one of the Intergovernmental Working Group meetings that made recommendations on the rules of procedure and governance of the Conference of the Parties to the FCTC and participated in the first meeting of the Conference of the Parties in February 2006. Patricia has also advised several African country governments on tobacco control policies and legislation. Currently, Patricia is heading the new International Legal Consortium, established at the Campaign for Tobacco-Free Kids in Washington D.C. as part of the Michael Bloomberg international tobacco control initiative.

Email: plambert@tobaccofreekids.org

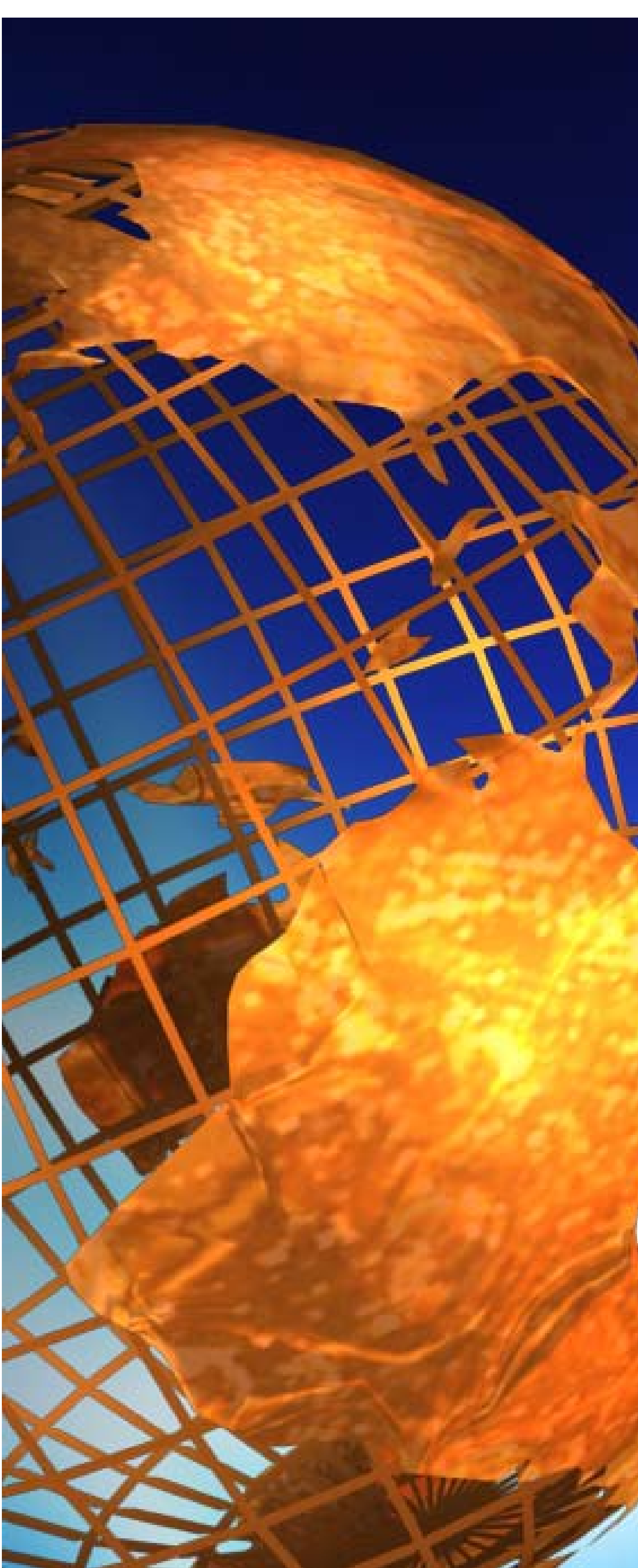
Regional Representative for Asia Pacific

Sophia Chan, PhD, MEd, RN, RSCN is currently Head of the Department of Nursing Studies and Assistant Dean of the Li Ka Shing Faculty of Medicine at the University of Hong Kong.

Having trained in and practised paediatric nursing in Hong Kong and London, Sophia subsequently specialised in health promotion with a particular focus on the management of tobacco dependency. She read for her Master's at the University of Manchester and completed doctoral studies at the University of Hong Kong, and now reading for a Master of Public Health at the Harvard School of Public Health.

Sophia's research portfolio explores comparative ethno-cultural differences between Chinese and other smokers through the synthesis of epidemiological and social science methodologies. It also examines the differences in professional roles among health and social care workers who work to help smokers quit.

On the service side, Sophia pioneered the first smoking cessation counselling programme (both clinic-based and via telephone quitlines) in Hong Kong and has been training medical, nursing, pharmacy, and social work professionals in tobacco dependency treatment interventions throughout China. Most recently, she developed a Women Against Tobacco Taskforce (WATT) in Hong Kong to help women smokers quit, and also developed the first Youth Quitline in Hong Kong in 2005.



The production of INWAT e-zine is financed by STIVORO in the Netherlands

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Design and layout by:
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