INTERNATIONAL NETWORK OF WOMEN AGAINST TOBACCO

At the 13th World Conference on Tobacco or Health

Tobacco Smoke as a Cause of Breast Cancer in Young Women

By: Kenneth C. Johnson, PhD

History

In 1981, Takeshi Hirayama published the first study demonstrating a relationship between secondhand smoke (SHS)[A] and lung cancer.[1] Almost simultaneously, Trichopoulos and co-workers published a study from Greece.[2] Both studies found an increased lung cancer risk for women who never smoked and whose husbands smoked. Within five years, 10 more studies of exposure to SHS and lung cancer were published. In 1986, three expert panels - the U.S. Surgeon General, the National Research Council in the U.S. and the International Agency for Research on Cancer (IARC) - independently reviewed the evidence and concluded that SHS caused lung cancer.[3] In the two decades since then, more than 35 additional studies and several meta-analyses have confirmed the 1986 conclusions.[3]

What went less noticed was Hirayama's observation in the early 1990s that the same cohort of women exposed to SHS experienced an increase in the risk for breast cancer.[4] The breast cancer risk associated with SHS, was, in fact, larger than for lung cancer: women who had never smoked, but who lived with a smoker, had a 32% increase in risk of breast cancer mortality overall (relative risk 1.32), and a 73% increase in risk (relative risk of 1.73 (90 confidence interval (CI) 1.12–2.66)) when their husbands smoked more than 20 cigarettes per day.[4]

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(A) Secondhand smoke is also commonly referred to as passive smoking, involuntary smoking and environmental tobacco smoke (ETS).

By: Lorraine Greaves

President's Corner

This issue of the NET, INWAT's e-magazine, focuses on secondhand smoke (SHS) and its effects on women and girls, as well as the effects of various policy initiatives aimed at reducing exposure to secondhand smoke. Secondhand smoke is an old issue for women. Long before women smoked cigarettes in any great numbers, they were often exposed to men's smoking, in the home, in public or in workplaces. Indeed, one of the first studies of secondhand smoke, conducted in 1981, concerned the effects on the wives of Japanese men who smoked, and it illustrated how destructive long-term exposure to secondhand smoke can be.

Since the time of that study, women themselves have taken up smoking in greater numbers, and the science and advocacy concerning SHS have also increased.

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Now, the drive for smoke-free spaces is driven by a desire to protect the health of smokers and non-smokers alike by eliminating exposure to SHS. Hence, policies and campaigns aimed at educating the public about the dangers of SHS, as well as at limiting exposure to SHS, are firmly on the agenda of the tobacco control movement.

How do these trends affect women? This issue of the NET explores several angles on SHS illustrating how girls and women are particularly affected by exposure to SHS and by the drive to reduce SHS. First, women's health is compromised by exposures to SHS over which they may have no control. Recent research indicates that this can start in childhood, when girls may be exposed to SHS in the home, and end up in later life with female specific health effects such as higher rates of breast cancer. Ken Johnson's article relates the latest research on this topic - sobering information for all of us interested in the health of girls and women.

Second, there is the issue of how women may be exposed to SHS in public, at work and at home. Typically, women are less empowered than men in these settings, due to lower economic and social status, and thus have less power to affect their environments. This issue is advanced by Soon-Young Yoon and Heather Wipfli, who write about women's empowerment in addressing SHS and exposure to SHS by women and children across the globe.

Finally, there is the complex issue of how the smoke that women exhale may affect their own children or, when pregnant, their fetuses. Responding to this issue is exceedingly complex, given the long history of tobacco control activity that has singularly focused on women smokers as dangers to child and fetal health, often to the exclusion of any interest in the health of women themselves. This approach - seeing women and women smokers primarily as vessels and not individuals with needs - has affected the response of the broader women's health movement to tobacco control, often making it critical of typical tobacco control efforts.

Nonetheless, once SHS reduction policies are in place, the ongoing question is how are girls and women affected by them, and specifically, how are different groups of girls and women affected by them? In 2006, the Journal of Epidemiology and Community Health, in partnership with the U.S. Tobacco Research Network on Disparities (TReND), published a special issue on how girls and women of low socioeconomic status were affected by tobacco policies (September, 2006, Vol 60, Suppl 11). Research in this special issue illustrated how home-based policies are associated with a reduction in women's smoking and SHS exposure. Other contributors illustrate the gendered complexities of the effects of work-based policies. More information such as this is urgently required to fully understand the gendered effects, both positive and negative, of SHS policies, as well as other tobacco policies, on women..

At the core of applying a gender-based analysis to tobacco control is the question of how both the biological and social characteristics and experiences of girls and women affect their responses to programs and policies. Recently, INWAT was a partner in presenting a briefing at the Second Conference of the Parties (COP2) meeting held in Thailand in June and July 2007 to assess the progress of the World Health Organization's (WHO) Framework Convention on Tobacco Control (FCTC).

At this important meeting, further described in this issue of the NET, the Parties to the Treaty reached agreement to develop gendered indicators of tobacco control in the reporting mechanism, as a way of measuring the particular impacts of the WHO-FCTC on women and men. This approach, embedding gender in the assessment tools of the FCTC, as well as applying gender analysis more broadly in country-specific activities in tobacco control, is one of INWAT's key ongoing goals. We are currently in partnership with the British Columbia Centre of Excellence for Women's Health in Vancouver on a project developing such mechanisms in Argentina, and we hope to extend this work to other countries in the future. Indeed, this is the central question that INWAT pursues in concert with its partners, in order to bring about more effective and women-sensitive tobacco policies and programs across the world.

How can all of this information and activity be used to reduce the effects of SHS on women? By increasing the gender-sensitivity of tobacco control, and specifically addressing women's characteristics and contexts in assessing its effects, we will have taken the first step. In particular, INWAT's challenge is to advance both tobacco reduction and the empowerment of women at the same time. This issue is critical for the global tobacco control movement, and is addressed in Sara Sanchez' description of a recent journal article assessing the potential of the WHO-FCTC to do just that.

In short, reducing exposure to SHS is but one small part of tobacco control, women's health and women's empowerment. However, it is, as you will read, a particularly instructive example of how women's power, women's biology and women's smoking status interact to create a challenge for all of us interested in reducing the toll that tobacco takes on women around the world.

Tobacco Smoke as a Cause of Breast Cancer in Young Women continued from page 1

This finding was largely ignored because it was "already known" that active smoking did not cause breast cancer. As discussed below, the many studies that led to this negative conclusion about active smoking were based on studies that had only collected data on active smoking without considering the concurrent effects of SHS. In 1986, a U.S. study by Dale Sandler and colleagues,[5] and in 1994 a British study by Smith and colleagues,[6] also reported an SHS-breast cancer link.

In 1996, Alfredo Morabia in Switzerland published results of the first study designed specifically to study SHS, active smoking and breast cancer, and found more than a doubling of breast cancer risk associated with SHS and with active smoking.[7] In 1998, A. Judson Wells published a letter in the American Journal of Epidemiology summarizing the positive results for passive and active smoking and breast cancer from the four studies, and advocated for more studies of breast cancer where smokers and passively exposed never-smokers were compared to non-passively exposed never-smokers.[8] By 2005, 16 more studies of SHS and breast cancer had been published (one from Europe, six from Asia and nine from North America).[9] As is always the case, the studies' results varied, with several reporting a doubling of breast cancer risk among women who never smoked but who were regularly exposed to SHS.[9]

Summarizing the Evidence – Refining Understanding of SHS Risk

A meta-analysis of the 20 studies available by 2005 found that the risk of breast cancer due to SHS was concentrated in premenopausal/women under age 50: the summary risk estimate was a 68% increase in risk for the 14 studies that had evaluated risk in premenopausal/younger women, i.e. a relative risk of 1.68 (95% CI 1.33-2.12).[9] Furthermore, studies that did the best job of collecting SHS exposure histories (collection of lifetime data on childhood, adult residential and workplace SHS exposure), and so would be expected to provide the most reliable estimates of risk, found more than a doubling of premenopausal risk associated with SHS: RR 2.18 (95% CI 1.68-2.84).[9] Figure 1 summarizes that evidence, separating out the studies by study type – case-control or cohort - and by the completeness of the SHS exposure assessment.

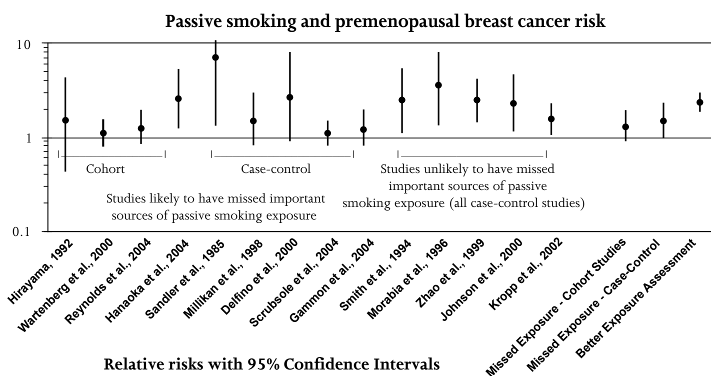

FIGURE 1. Meta-analysis of secondhand smoke and breast cancer risk in younger, primarily premenopausal women who never smoked [9]

Figure 1 note: For Reynolds et al., 2004, new risk estimate from Reynolds et al. letter (2006)[10] presented for women exposed in childhood and adulthood (risk for all exposed women not reported).

In 2004, IARC had reported the SHS-breast cancer link was inconclusive but had included only evidence up to 2002 and no numerical summary of the evidence.[11] The California Environmental Protection Agency (CalEPA) recently published a thorough, systematic review of the health consequences associated with SHS, including a detailed evaluation of the evidence for an SHS-breast cancer link.[12] The California EPA replicated the meta-analysis by Johnson and had essentially the same results: a 68% increase in premenopausal risk for the 14 studies reporting on premenopausal breast cancer, and more than a doubling of premenopausal risk for the five studies with more complete measures of SHS exposure.

The California EPA considered not only the epidemiological evidence, but also toxicological and breast biology evidence, and became the first major scientific agency to conclude that passive smoking caused breast cancer in younger, primarily premenopausal women. The California EPA considered the risk associated with SHS for post-menopausal women was inconclusive.

In 2006, the U.S. Surgeon General also published a major report on the health consequences of SHS and provided a detailed analysis of the SHS-breast cancer link.[3] One additional new study was examined and the SHS-breast cancer data were analyzed in slightly different ways. The summary risk estimates from the Surgeon General were similar to those produced by the California EPA (see Table 1.) The Surgeon General came to the conclusion that "The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke and breast cancer."[3]

Table 1. Pooled risk estimates of breast cancer risk associated with secondhand smoke

	California EPA Report 2005 [12]		Surgeon General's Report 2006 [3]	
Exposure	**n**	**Relative Risk (95% CI)**	**N**	**Relative Risk (95% CI)**
All studies	19	1.25 (1.08-1.44)	21	1.20 (1.08-1.35)
Premenopausal or Women < 50 (California EPA) Premenopausal (Surgeon General)	14	1.68 (1.31-2.15)	11	1.64 (1.25-2.14)
Premenopausal – Studies with lifetime exposure assessment	5	2.20 (1.69-2.87)	6	1.85 (1.19-2.87)

Causal or Suggestive? The Debate over the Evidence

Given that the California EPA and U.S. Surgeon General reached essentially the same conclusions about the magnitude of the risk of breast cancer associated with SHS, why did they reach a different conclusion on causality? The answer lies primarily in how they interpreted the evidence on active smoking.

The U.S. Surgeon General's Report states at the beginning of its breast cancer section that because a very large meta-analysis of active smoking and breast cancer did not find an increased risk, it is difficult to accept an SHS risk.[3] Unfortunately this pooled analysis only included smoking status (ever/never) and smoker (current/ex), so no analysis was possible on the intensity of smoking, duration of smoking or timing of smoking (before pregnancy in particular). Most important, this analysis did not control for SHS and premenopausal breast cancer was not targeted for thorough analysis. These limitations seriously biased the study against detecting a real effect of active smoking on breast cancer risk in premenopausal women.

In contrast to the U.S. Surgeon General's Report, which did not examine in detail the active smoking literature after 2002, the California EPA's assessment included evaluation of 19 studies on active smoking and breast cancer published between 1996 and 2005 in a 39-page appendix to its report on passive smoking. Unlike the earlier studies that led to the conclusion that there was no association between active smoking and breast cancer, there were several newer studies of active smoking that carefully controlled for SHS exposure. For women who had smoked, the breast cancer risk estimate was 1.46 (95% CI 1.1.15-1.85) compared to non-smoking women not exposed to SHS. For the studies with the best assessment of SHS, the active smoking risk was more than double (relative risk 2.08 (95% CI 1.44-3.01)).[9] Furthermore, the California EPA reported on six recent prospective cohort studies that each found statistically-significant increased breast cancer risks associated with at least some measure of active smoking.[11]

In general, epidemiologists consider cohort studies better than case-control studies because one avoids the potential of bias in the recall of exposure. Three large North American cohort studies have not observed increases in breast cancer risk with SHS exposure. However, these cohort studies (and the case-control studies with poorer exposure assessments) could not adequately identify all women who had been regularly exposed to SHS. For example, in the main analysis of the Cancer Prevention Study-II American cohort study,[14] SHS exposure information included a history of spousal smoking, but assessment of workplace and other household exposure was limited to the exposure in the single year - 1982. The study did not collect information on the history of workplace, childhood or non-husband residential SHS exposure for the women. In a North American study, missing these passive exposures is likely to result in important misclassification of exposure status.[15] In the dose-response analysis, only 50% of women were categorized as exposed to passive smoking.[14] Other studies that examined major sources of SHS exposure, including residential, workplace and sometimes social exposure, have found 80% to 95% of the women who were never-smokers reporting having had regular exposure to SHS during some periods of their lives.[16;17] The Nurses Cohort Study, the second large North American cohort study only collected current exposure in 1982 in their evaluation of nurses workplace SHS exposure,[18] and the third study on California teachers has only reported on residential exposure to date.[19] This kind of exposure misclassification can seriously dilute risk estimates, making it more difficult to detect an effect of SHS when it exists.[20]

Environmental Health Perspectives recently published an article, available online, on the debate over the strength of the evidence for SHS and breast cancer risk. (http://www.ehponline.org/docs/2007/115-3/focus-abs.html) It provides perspectives from a number of involved researchers.

(B) Case-control and cohort studies are the two major types of epidemiologic studies that have been used to study second-hand smoke and health. In cohort studies, exposure information is determined for a large group of individuals. The group is then followed for a period of time until some members of the cohort develop the disease(s) of interest to the researchers. In case-control studies exposure information is collected from a group of individuals diagnosed with a disease and a group of similar individuals who have not developed the disease- hence cases and controls.[13]

Large Public Health Impact of Passive and Active Smoking on Breast Cancer

The public health impact of a risk factor relates to how common an exposure is in a population, how common the disease of interest is in a population and the amount of risk increase that the factor causes. In North America, all three effects combine to produce an important impact on breast cancer risk of exposure to SHS and active smoking. Breast cancer is the most commonly diagnosed cancer among women in North America. A large majority of women currently 35 to 70 years old have had regular long-term exposure to secondhand smoke. In a population-based study done across Canada between 1994 and 1997 of 5,000 women primarily 35 to 74, we collected lifetime histories of SHS exposure at home and at work as part of residential and occupational history taking.[16] We found that just over 50% of the women reported smoking - 25% were ex-smokers, 25% were still smoking. Among the remaining 50% of women, over 40% had had regular long–term exposure to SHS at home or at work. 15 In total, over 90% of the women were actively or passively exposed to tobacco smoke. Among the passive smokers, either their parents had smoked, their spouse had smoked or they had worked where smoking had been allowed. The non-smoking women with regular exposure to SHS reported an average of more than 15 years of living or working with smokers.

We have estimated attributable risks for active and passive smoking and breast cancer for Canada and the United States based on the risk estimates from the California EPA report. Because such a large proportion of women never-smokers in Canada and the United States have had

long-term regular exposure to SHS as children, spouses and/or as employees during some period in their lives, the impact on breast cancer risk is substantial. Furthermore, a substantial percentage of women have smoked. As a result, our estimates suggest that just under 40% of premenopausal breast cancer in North America may be attributable to active and passive smoking. (Wells AJ, Collishaw NE and Johnson K, Estimated breast cancer incidence and mortality attributable to active and passive smoking in Canada and the United States. Manuscript submitted, under review).

Conclusions

The California Environmental Protection Agency has concluded that SHS causes breast cancer in younger, primarily premenopausal women, and the U.S. Surgeon General has concluded that the evidence suggests a causal relationship. Current evidence strongly indicates that active smoking and passive smoking each can result in a doubling of breast cancer in younger/premenopausal women. Avoidance by women of regular exposure to both second-hand smoke and active smoking is an important precautionary measure in the fight to reduce the toll of breast cancer.

"The opinions expressed in this report are those of the author and do not necessarily represent the position of the Government of Canada, including the Public Health Agency of Canada or Health Canada."

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Smoke-Free Environments

A Global Theme For World No Tobacco Day And Beyond

By: Manjari Peiris

Tobacco use is the second major cause of death in the world. It is well known that half the people who smoke regularly today – about 650 million people – will eventually die from their tobacco use. Equally alarming is the fact that hundreds of thousands of people who have never smoked die each year from diseases caused by breathing secondhand smoke (SHS).

Health risks are greater for many sub-groups. The fetuses of pregnant women are at high risk, as well as children whose parents smoke. Although overall health effects are not as great for non-smokers as for smokers, a similar range of diseases can result from SHS exposure, including cancers, heart disease and stroke, and respiratory conditions such as asthma.

Because of these risks, there have been major efforts in many countries to protect non-smokers from being exposed to cigarette smoke. Through legislation and persuasion, more and more transportation systems, public places, workplaces and homes are becoming smoke-free. These laws and policies also create a climate that motivates smokers to quit.

Dismantling tobacco industry myths

The tobacco industry has known for decades that policies to protect people from secondhand tobacco smoke represent a serious threat to its business as witnessed by these statements:

"*… the most dangerous development to the viability of the tobacco industry that has yet occurred.*"

"If smokers can't smoke on the way to work, at work, in stores, banks, restaurants, malls and other public places, they are going to smoke less..."

Here are some of the most often used and widely spread tobacco industry myths about smoking bans, and the arguments – based on scientific evidence – to counter them.

MYTH: It is about rights and freedoms

Smoking bans are not about infringing rights. They are about protecting people's health. It is worth remembering that most people do not smoke, and most smokers want to quit. The right of a person to breathe air free of poisons takes precedence over the right of smokers to smoke in public places and endanger the health of others. This is not about accommodation or the freedom to use a legal product. It is about where to smoke to avoid endangering the health of others.

MYTH: Business will suffer

Independent studies in Canada, Ireland, Italy, Norway and U.S. cities, like El Paso, Texas and New York, show that, on average, business remains at the same level or even increases after smoking bans.

Even though not a single independent and rigorous study has proved that smoking bans result in negative results for the economy, the tobacco companies will try to convince business owners and policy makers of the opposite, supporting their allegations with biased studies that lack rigor and campaigning through front groups to delay or discourage smoke-free legislation.

MYTH: Smoke-free environments (SFE) will never work

SFE are widely supported by smokers and non-smokers and, if properly enforced, are the most effective way of protecting people from exposure to secondhand smoke. They also support smokers who wish to quit, making it easier for them to stop and stay stopped.

Evidence from countries, including Ireland, New Zealand, Norway and Scotland, as well as U.S. cities, like San Francisco, El Paso, Boston and New York, show that SFE work, are supported by the public, and levels of compliance can be close to 100% when good enforcement mechanisms are in place.

MYTH: Ventilation systems protect non-smokers from exposure to SHS

The industry has promoted the use of expensive ventilation systems in an attempt to accommodate smokers and non-smokers in the same indoor enclosed spaces. This is a tactic to avoid the

Sources of information for this article have been derived from the WHO World No Tobacco Day 2007 material.

establishment of strict bans. However, ventilation is not only very expensive, it does not work: only 100% smoke-free environments protect the public from exposure to SHS.

MYTH: Voluntary agreements offer "courtesy of choice" to accommodate smokers and non-smokers

Voluntary agreements that urge tolerance from non-smokers are not effective in protecting the public from the harms of SHS, and represent a barrier to the establishment of effective protective measures.

The "courtesy of choice," where smokers and non-smokers live in harmony, has been one of the tobacco industry's strongest marketing campaigns. The tobacco industry claims that this approach promotes tolerance and allows the accommodation of smokers and non-smokers in the same spaces. In Finland, Ireland, New Zealand, Uruguay and California, policy makers concluded that voluntary measures did not adequately protect public health and, therefore, have enacted smoke-free legislation.

MYTH: Secondhand tobacco smoke is just a nuisance

It is not a nuisance. It is a health hazard. Worldwide, secondhand smoke causes at least 200,000 deaths a year in workplaces alone (14% of all work-related deaths caused by disease) and 2.8% of all lung cancer. Many of these victims work in the restaurant, entertainment and service sectors; however, the problem can exist in any occupation.

Rigorous research leaves no doubt

There is no doubt: breathing SHS is very harmful. It causes cancer, as well as many serious respiratory and cardiovascular diseases in children and adults, often leading to death. There is no safe level of human exposure to secondhand tobacco smoke.

These are the indisputable conclusions reached by international and national health authorities, backed by extensive rigorously reviewed and published research results, over many years. These three recent major publications verify these statements:

- 2004 IARC Monograph 83: Tobacco Smoke and Involuntary Smoking.
- 2005 California Environmental Protection Agency Environmental Health Hazard Assessment of Environmental Tobacco Smoke.
- 2006 U.S. Surgeon General's Report on The Health Consequences of Involuntary Exposure to Tobacco Smoke.

100% smoke-free is the only answer

Neither ventilation nor filtration, alone or in combination, can reduce exposure levels of tobacco smoke indoors to levels that are considered acceptable, even in terms of odor, much less health effects. The evidence demands an immediate, decisive response, to protect the health of all people.

Smoke-free environments cost little and they work!

Smoke-free is becoming the norm: Join the trend to make the world smoke-free! This year's World No Tobacco Day focuses on 100% SMOKE-FREE ENVIRONMENTS as the only effective measure to protect the public – including people at their workplaces – from exposure to secondhand smoke. In a growing number of countries, the norm has already changed: FROM smoking being allowed practically everywhere TO places being 100% smoke-free.

7 Reasons to opt for smoke-free environments

1. Secondhand tobacco smoke kills and causes serious illnesses.
2. Only 100% smoke-free environments fully protect workers and the public from the serious harmful effects of tobacco smoke.
3. The right to clean air, free from tobacco smoke, is a human right.
4. Most people in the world are non-smokers and have a right not to be exposed to other people's smoke.
5. Surveys show that smoking bans are widely supported by both smokers and non-smokers.
6. Smoke-free environments provide smokers who want to quit with a supportive environment where they can cut down or stop smoking altogether.
7. Smoke-free environments help prevent people – especially the young – from starting to smoke.

Engendering tobacco control

By: Sara Sanchez

The following article reflects on a recently published paper by Lorraine Greaves (INWAT President) and Ethel Tungohan, "Engendering tobacco control: using an international public health treaty to reduce smoking and empower women". *Tobacco Control* 2007;16; 148-150.

As we have read elsewhere in this issue of the NET, the World Health Organization's (WHO's) Framework Convention on Tobacco Control (FCTC) has the potential to integrate gender and diversity into all future tobacco control efforts. The FCTC incorporates gender concerns in its preamble and, in Article 4, suggests that countries "address gender-specific risks when developing tobacco control strategies" at national, regional and international levels. This is particularly important for women as 12% of the world's female population currently smokes regularly, estimated to rise to 20% by 2025. Meanwhile, global male smoking rates have reached their peak and are slowly waning.

In their recent article, Greaves and Tungohan remind us that the WHO also has a gender policy, which recommends integrating gender concerns in all of its activities. However, experience with applying a gender policy suggests that gender relations and power differences can be exploited, accommodated or transformed, each with very different effects. As the article says; "For example, tobacco control efforts could exploit women's inequality, maintain paternalism and "protect" women from tobacco use using strong proscriptions against its use by women. Simplistic messages that link increased smoking to women's liberation feed this approach."

On the other extreme, strategies to actively transform gender relations would use tobacco control efforts to change women's status for the better, by promoting critical analysis and seeking to reduce inequities between women and men along with tobacco reduction. For example, the authors suggest that linking tobacco control with policies such as housing or child care, engaging smokers in planning, confronting the stigmatization of smokers or providing media literacy to enable girls to decode tobacco advertising are examples reflecting this approach.

In between, tobacco control could merely accommodate the existing gendered roles of women, such as endorsing and emphasizing the roles of mothers and care givers that women fill. The tobacco control movement has had a long history of doing only this, an unfortunate limitation that has served to reinforce women's traditional roles and not necessarily enhance opportunities for women.

Greaves and Tungohan go on to examine several of the FCTC Articles and make recommendations for transforming actions that go beyond simple gender-specific policies. For example, Article 6 endorses price and taxation measures, but the gendered effects of taxation and price are mixed, according to research from developed countries where some studies suggest women are more responsive to price increases and other studies find no differences between men and women. Thus, as the FCTC presses for price increases, supplementing these policies with free cessation aids or social support may be necessary to decrease the greater poverty-related inequalities experienced by low-income women.

In another example, Article 12 encourages public education and information campaigns on tobacco. Such endeavors may need tailoring when the majority of illiterate people globally are women. Tobacco control could work closely with women's education and literacy programmes to include rights-based messaging and be more accessible through targeted campaigns using diverse forms of media. More generally, female educational empowerment may assist in reducing tobacco use.

Article 13 endorses legislation controlling tobacco advertising, promotion and sponsorship. Campaigns promoting cigarette use to attain "western" ideals have led to an upsurge in smoking rates in low and middle income countries. Special products and brands have been developed for women, working class people and various ethno-cultural groups. Exposing these efforts within an analysis of globalisation and exploitation will generate wider support for tobacco control across a range of movements, and empower individuals and populations to confront industry tactics, become empowered and resist tobacco.

There are transformative goals associated with tobacco production as well, according to Greaves and Tungohan. Article 16 encourages the promotion of economically viable alternatives for tobacco workers, growers and individual sellers. However, women are less likely than men to be landowners and named in agreements with tobacco companies, but are encumbered with intensive tobacco farming responsibilities. Hence, they suggest that provisions curtailing and controlling tobacco production reflective of gender and diversity concerns should be consciously explored. For example, providing women with educational and employment alternatives to tobacco production will free them from harmful labour conditions and consequently give working women more power.

In summary, the authors call for the enactment of the FCTC in such as way as to assist in increasing women's empowerment along with tobacco reduction and control. In order to do this, the FCTC signatories and supporters should consciously adopt strategies that will transform gender relations, not continue to exploit or accommodate prevailing gender inequalities by failing to examine gender inequities, different responses to tobacco policies, or indeed, sex and gender differences in response to tobacco use and cessation.

For Pregnant Women in Argentina

Development of a smoking cessation program

By: Mariela Alderete

Argentina has one of the world's highest smoking rates among women of reproductive age: 27.7 percent, a serious problem since smoking is a major risk factor in pregnancy. Nearly 18 percent of pregnant Argentine women smoke, according to a 2001 survey done by INDEC (the National Institute for Surveys and Statistics). In 2005, Bozan et al., arrived at the same percentages in a survey done in Buenos Aires. These data are probably underestimates because they are based on self-reporting. It is well known that non-disclosure rates vary widely: 4 to 45 percent, especially when survey subjects perceive smoking as reprehensible. Cessation intervention has been proven useful during pregnancy, but first it is necessary to effectively identify pregnant smokers.

Tobacco use during pregnancy affects both the fetus and the expectant mother, and the adverse results are well documented. Maternal mortality is increased due to various pregnancy complications. Ectopic pregnancies are more frequent than in non-smokers, and there is a greater risk of premature rupture of membranes, abruptio placentae and placenta previa. Other complications include low birth weight, preterm births, perinatal mortality, spontaneous abortion, restricted fetal growth and sudden infant death. Ten percent of all fetal deaths are associated with smoking during pregnancy. Additionally, breast feeding is less common among smokers and milk production is lessened.

However, for health systems around the globe, pregnancy represents an opportunity to treat smoking since the expectant mother receives several routine consultations and is concerned about a healthy lifestyle. In the Tobacco Cessation Clinic at the Hospital Italiano de Buenos Aires, we work with both general and specific populations. In the last year, we have been developing a program targeting pregnant women: those who quit smoking and women who continue to smoke during their pregnancies.

As an important initial step, we needed an appropriate tool to correctly diagnose smoking status. A simple multiple choice instrument with five closed option questions was developed and tested by Patricia Dollan Mullen in 1991. Its use improved disclosure by 40 percent, with results closely correlated with biochemical validation, and it is recommended by the U.S. Public Health Service Guide. As this tool is not available in our country yet, we decided to validate this questionnaire in Spanish, with the permission of the author. We also obtained a competative grant, Carrillo Oñativia 2007, from the National Ministry of Health for its development.

The validation process included linguistic and psychometric phases. The questionnaire was translated into Spanish and then translated back into English. The first Spanish version was evaluated by experts and modified. This version is now being administered to 30 women, between 18 and 45 years of age. Sixty percent of them have no more than primary level education. This phase includes an in-depth interview in which we evaluate understanding, acceptance and relevance. After the first phase is completed, we will conduct the reliability test. In order to determine validity, carbon monoxide in exhaled air will be used as the gold standard. This phase will include only pregnant women, older than 18, at their first obstetric consultation.

As with other diseases, it is not possible to offer any treatment without a correct diagnosis. For pregnant smokers, such a diagnosis requires a sensitive tool, easily used in a medical office setting. Hopefully, the questionnaire, if free of colloquial language, will be useful in other Spanish-speaking settings. We expect it will enable us to assess pregnant smokers and offer cessation interventions to every woman at risk.

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Second hand smoke and legislation in private homes.

By: Trudy Prins

'A man's home is his castle', is a popular saying, hailing back to the Middle Ages. It was this saying that springs to my mind when legislation on smoking in private homes is discussed. In medieval days people lived as vassals in castles or on castle land. The castle was an economic and social community with its own culture, adhering to its own rules. The vassals had sworn homage to the Lord of the Manor, and in return he provided safety and sustenance for all. The Lord of the Manor was employer, exchequer, legislator, and judge. He decided what people worked at, and dictated the terms of employment. He set the rules people had to abide by, and decided on forms of punishment if those rules were broken.

Although the socio-political structure of the castle no longer exists, many of its relics can still be found in legislative systems, in social relationships, and in our way of thinking. Many still find it unacceptable for anyone other than themselves to dictate the rules in their homes. Many find it unacceptable for anyone to overrule us on our own turf. Between our four walls we like to think we are sovereign, and those we receive as guests can count on our hospitality, but only within the framework of our private rules. We even use a similar (misguided) argument to persuade our adolescent children to behave: 'as long as you live in my house, you live by my rules'.

Whenever legislation is proposed that extends to, or is valid in the privacy of our own home, loud protests are often uttered. Statements such as "The government should not behave as our nanny" or "We have a right to be treated as grownups, able to decide in our own homes what is best for those living under our roofs", are often heard. Governments and politicians are sensitive to these protestations. Legislators sometimes hesitate to enter into home territory. But, in spite of that hesitation, they very often do.

The legislator enters our private premises in two very important circumstances: to prevent our conduct from having a negative affect on the world outside it and to prevent it from being directly harmful to others. Thus, we have environmental legislation, for example, with building regulations for our houses, regulation for the level of noise we are allowed to produce or how near to the neighbour's garden we can plant our trees. Also, we cannot inflict bodily harm on anyone, nor terrorize anyone, nor keep anyone prisoner in our home. If we break environmental laws we get fined, if we abuse our spouses, or children, or guests we can go to jail.

When second hand smoking legislation is brought up, the private home is often a 'no-go' area.. However, there is an excellent argument in favour of legislation in private homes: no one is, or should be allowed to practice conduct that is harmful, and possibly lethal to others. The quality of a constitutional state depends on its willingness and readiness to protect the health and wellbeing of its citizens, regardless of their location. In medieval times people swore homage to the Lord of the Manor and received his protection in return. In a more democratic millennium, states are given the responsibility to enhance and secure everyone's wellbeing. In many realms, the notion that 'a man's home is his castle', and by extension, independent of state involvement, is long out of date.

This is an opinion piece and comments are welcome by emailing: info@inwat.org
Some editorial changes were made without prior knowledge of the author.

Women's empowerment is at the heart of addressing SHS

By: Soon-Young Yoon
International Alliance of Women
Vice-chair, NGO Committee on the Status of Women/NY

The International Alliance of Women (IAW) and INWAT focused on secondhand smoke (SHS) in their joint report to the 37th session of the Committee on the Elimination of All Forms of Discrimination Against Women that was held in New York earlier this year. The report stated that millions of women workers, including those with jobs in tourism, the service sector, restaurants and Tobacco Control production, are not guaranteed the basic right to health because of exposure to SHS. This is a major concern where smoking prevalence rates for men is high such as in Vietnam (50.7%), Namibia (65%), Nicaragua (51%) and Peru (52.5%) while rates for women are below 35% (see Tobacco Control Country Profile 2003, the American Cancer Society et al., Atlanta 2003).

These statistics speak for themselves. The issue of SHS has the potential to capture women's attention because millions of women are involuntarily exposed. Why, then, don't women's groups rush to support tobacco control? Why is there still a wide gap between tobacco control and the international human rights movement? A hint comes from a recent conversation I had with Thanpuying Sumalee Chatikavanji, President of Thai Women Watch-one of Thailand's strongest defenders of women's human rights. She said, "Since most Thai women don't smoke, tobacco isn't our priority issue." Similar reactions are common among other women's groups, including those involved in reproductive rights, the majority of which overlook the impact of tobacco on women's health. It is time to address this issue head-on. A narrow focus on reducing tobacco use has a slim chance of capturing the attention of most women's rights leaders. Rather, an approach to SHS that is based on women's empowerment has the greatest chance of reaching women because it addresses health problems as women perceive them.

In her recent address to the WHO World Health Assembly, Dr. Margaret Chan, Director-General of the WHO, identified key elements for programs on women's health that could help tobacco control projects reach advocates for gender equality and women's health rights. She stated that if women are to be agents of change, they need economic capital to earn respect. Women's human right to health cannot become a reality until women are enabled to claim their rights. These poignant statements point us in the right direction. The question is: Where can one begin?

For health advocates seeking partners, national organizations that address gender equality are a rich source. Since the 1975 UN women's conference in Mexico, such entities have established themselves as the lead government agencies responsible for monitoring women's economic and social development, including their right to health. For example, the Ministry for Women and Youth Affairs in Ghana and the Ministry for Women's Affairs and Social Development in Nigeria have considerable experience in incorporating gender into all national policies. Furthermore, these government agencies coordinate efforts to comply with human rights treaties such as the Convention on the Elimination of all Forms of Discrimination Against Women and the Convention on the Rights of the Child. Yet few are given leadership roles in policy-making for the WHO Framework Convention on Tobacco Control.

Another important reason to work with national women's machineries is that they are often the center of powerful national NGO networks. Most national gender equality agencies have developed extensive partnerships with youth groups, the media, labor unions and education leaders-precisely the constituencies that tobacco control programmes need to reach. Creating partnerships with these government bodies is a strategic opportunity that merits attention now.

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Smoke-free environments – A growing global trend

But how do they affect women?

By: Deborah McLellan and Victoria Almquist

A recent report from the U.S. Centers for Disease Control and Prevention (CDC)[1] shows a dramatic increase in the number of households in the U.S. that do not allow smoking in the home. The report showed that almost 75% of U.S. homes are smoke-free, up from only 43% a decade ago. And the results are better in homes where no smokers live – 84% of those households ban smoking, while only 32% of homes with smokers have such a prohibition.

Having a smoke-free home is an important indicator of whether or not young people will become smokers. Another CDC study released concurrently with the one on smoke-free homes[2] indicates that, worldwide, non-smoking teens (13-15 years old) exposed to secondhand smoke in their homes were up to two times more likely to become smokers themselves. This study also showed a significant difference in these young people's exposure to secondhand smoke based on where they lived. Non-smoking teens in Europe were over three times more likely (72% to 23%) to be exposed to secondhand smoke in their homes than teens in Africa.

Since the data in the CDC survey on smoke-free homes in the U.S. were from 2003, it is likely that the number of households that ban smoking has increased because of the growing number of states that have passed smoke-free laws in recent years. Currently, 22 states, the District of Columbia and Puerto Rico have passed comprehensive smoke-free laws that include restaurants and bars, while four other states have similar laws that exempt bars. And many countries have passed nationwide smoke-free laws, including Bermuda, Bhutan, England, France (effective 2008), Iceland, Ireland, Italy, Lithuania, New Zealand, Northern Ireland, Norway, Scotland, Sweden, Uruguay and Wales.

Although smoke-free laws are passed primarily to protect nonsmokers from tobacco smoke, they have also been shown overall to reduce smoking and may even encourage people to quit entirely. What is less well known is whether there are differential effects of smoke-free laws on women.

U.S. researchers have recently looked at whether protection from secondhand smoke in the home is similar across all populations of women. Using data from the Tobacco Use Supplement of the Current Population Survey, Shopland et al.[3] found that women who were service or blue-collar workers were less likely than white-collar workers to have a smoke free home. Using the same survey (but different years), Shavers et al.[4] found that smoke-free homes were most common among women in the highest socioeconomic status groups and least evident among women at or below poverty level. This pattern was particularly strong for white and African American women. Interestingly, both authors found that smoke-free homes seemed to have a stronger effect on current smoking and quitting than did worksite smoke-free policies among the women surveyed.

While smoke-free public and private places provide important protections against exposure from secondhand smoke, it is important to know whether women are enjoying those protections, and if not, to understand why not.

As more and more public places worldwide become smoke-free, smoking rates will decline and there will be less exposure to secondhand smoke for everyone. Having a smoke-free home – even if adult household members smoke – creates a healthier environment for everyone, especially children, and encourages smokers to quit.

(1) U.S. Centers for Disease Control (CDC), "State-Specific Prevlaence of Smoke-Free Home Rules – United States, 1992-2003," MMWR, 56(20): 501-504, May 25, 2007.

(2) CDC, "Exposure to Secondhand Smoke Among Students Aged 13-15Years–Worldwide,2000-2007,"MMWR,56(20):497-500, May 25, 2007.

(3) Shopland DR, Anderson CM, Burns DM. Association between home smoking restrictions and changes in smoking behavior among employed women. Journal of Epidemiology and Community Health 2006;60 (Suppl II):ii44-ii50.

(4) Shavers VL, Fagan P, Alexander LAJ, Clayton R, Doucet J, and Baezconde-Garbanati L. Workplace and home smoking restrictions and racial/ethnic variation in the prevalence and intensity of current cigarette smoking among women by poverty status, TUS-CPS 1998-1999 and 2001-2002. Journal of Epidemiology and Community Health 2006;60 (Suppl II):ii34-ii43.

30 June – 6 July 2007

Women and Gender: An important issue at the COP2 in Bangkok

By: Sara Sanchez

The second Conference of the Parties (COP) to the WHO Framework Convention on Tobacco Control (FCTC) took place in Bangkok, Thailand from 30 June to 6 July 2007. The 145 Parties gathered to discuss and decide on protocols and guidelines to advance the FCTC.

During the opening of the Conference of the Parties, Soon-Young Yoon made a statement on behalf of the International Alliance of Women and INWAT regarding the visibility of gender in all Articles of the FCTC, with a particular emphasis on women's leadership to ensure gender balance of national tobacco control boards. The statement also recommended including an expert on gender and tobacco to the Conference of the Parties subsidiary body that monitors government reports..

On Thursday, 5 June 2007 INWAT, the International Alliance of Women and the Framework Convention Alliance (FCA) held a dinner briefing for government delegates that was attended by over 60 people. The briefing was entitled, Women, Gender and the FCTC Articles - Where Now?, and was sponsored by the governments of Sweden, South Africa and Canada, and supported by the government of India.

Following the opening remarks by Bungon Ritthiphaktee of the Southeast Asia Tobacco Control Alliance and Laurent Hubert of the FCA, presentations covered topics including utilizing the FCTC preamble as a policy tool, a gender analysis of the FCTC articles, and the WHO's work advancing the issue of gender within tobacco control with a launch of the upcoming report, *Sifting the Evidence: Gender and Tobacco Control*. Country examples from Canada and Thailand were featured to illustrate Health Canada's gender analysis strategy and action by Thai nurses to advance tobacco control. The final presentation reviewed how delegates can move forward with policy-related projects including obtaining adequate sources of funding. The presentations are available at www.inwat.org

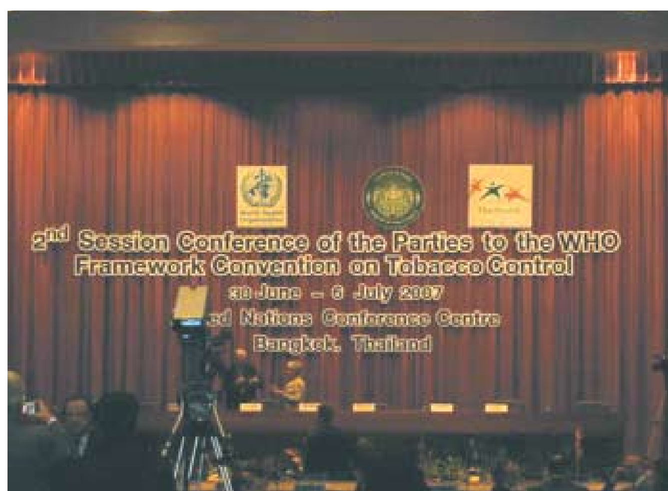
One of the major decisions made by the Conference of the Parties was to mandate the Secretariat to address the "development of indicators to measure gender-sensitive policies" in the reporting and exchange of information by the Parties. This is a positive step forward and will describe the gendered ways tobacco consumption, production and exposure to secondhand smoke take place, as well as reporting on the policies and actions taken to address these gender-specific challenges. These indicators will be valuable tools and improve upon current reporting where only a few country reports produce sex-disaggregated data.

Other decisions made by the Conference of the Parties included:

- Adopting strong Guidelines for Article 8 - protection from secondhand smoke;
- Setting up an international body to start negotiating a protocol on illicit trade for adoption at the fourth COP in 2010;
- Developing guidelines for Article 11 (packaging and labeling) and Article 13 (advertising, promotion and sponsorship) with the goal to adopt these guidelines at the third COP in 2008;
- Starting work on guidelines for Article 5.3 (protection from tobacco industry interference), Article 12 (education, communication, training and public awareness) and Article 14 (cessation); and
- Continuing work for Articles 9 and 10 (product testing, measurement and disclosure) and 17 (economically viable alternative activities).

The third Conference of the Parties will take place in South Africa in 2008. If this next COP is anything like COP 2, gender-perspectives in tobacco control will continue to have a presence due to INWAT's efforts as well as the voices of those delegates and NGOs that advocate for these kinds of changes.

For more information, email: Sara Sanchez sara@inwat.org. The WHO COP papers are at http://www.who.int/gb/fctc/E/E_cop2.htm.



From the shopping mall to a city-wide legislation in Bahía Blanca, Argentina

By: Gabriela Regueira

On 9 April 2007, Bahia Blanca, Argentina became 100% smoke-free, after an intense debate between local legislators, tobacco control specialists, and representatives of the bar and restaurant industry.

The beginning

The process began in 2005 when the Bahia Blanca Shopping Plaza started a campaign in favor of smoke-free places with the help of a program supported by the National Health Ministry.

At that time, there was high employee and public acceptance for making the mall smoke-free. For 68.7% of the workers it was very important to have a smoke-free workplace and 54.1% of the customers were in favor of having smoke-free public places. Only 3.8% of customers said they would not go to the shopping mall anymore if it became smoke-free.

Some local business owners were concerned that the regulation would adversely affect their income - 64.1% believed customers would visit the mall less frequently if the shopping center were smoke-free, and 50.7% thought that it would result in a decrease in sales.

But based on the public opinion and recognizing the hazards of secondhand smoke, the Board of Directors decided to go for a smoke-free city.

The debate

In September 2006, the Bahia Blanca Shopping Plaza experience convinced local legislators to start a legal effort to protect employees and the public from the health effects of exposure to secondhand smoke.

The most important aspect of this effort has been the discussion of other smoke-free efforts by the Bars and Restaurants Association and some local legislators, aided by the knowledge and expertise of tobacco control specialists.

The main arguments put forth against smoke-free regulation were job losses, smoker's rights, the economic impact on bar revenues, and the difficulty of enforcing the legislation. The Bars and Restaurants Association proposed providing designated smoking rooms and ventilation as the best way to protect businesses and employee and public health.

The new law

This debate resulted in Ordinance N°14.254 that prohibits smoking in all enclosed public places. The ordinance prohibits smoking in workplaces, public places, on public transportation and in bars and restaurants. Smoking rooms are not allowed.

The implementation of the law will occur in three phases. On 1 April 2007, all educational facilities, libraries and museums, supermarkets, banks, gyms, state facilities, health centers implemented the law, followed on 1 June by convention centers and offices, and on 1 September, smoking will be prohibited in restaurants, shopping centers, bars, cafes, cabarets, pubs, game rooms and others similar venues.

This smoking prohibition is for employees and customers

The ordinance upholds the rights of non-smokers and, in interpreting its provisions, the rights of non-smoking members of the public and workers shall prevail. Questions about whether smoking is permitted in a given situation shall be resolved in favor of protecting non-smokers.

This ordinance also:

- Provides for an educational campaign that focuses on the hazards of secondhand smoke, the benefits of 100 percent smoke-free places and the importance of helping smokers quit.

- Creates a special Tobacco Commission that will develop a program to explain the requirements of the ordinance and to help business owners comply with it. No representatives of the tobacco industry will be on this Commission.

- Requires that No Smoking signs be clearly posted by the owner in every building or other area where smoking is prohibited. All ashtrays and other smoking paraphernalia shall be removed.

- Orders that any person or owner of any enclosed public place where smoking is prohibited shall be guilty of an infraction if they violate any provision of this ordinance,.

For more information visit:
Campaign at Bahia Blanca Plaza Shopping (Spanish)
http://www.bahiablancaplazashopping.com/airepuro-inicio.asp

Chile: Sexist Ads Defy Tough New Tobacco Control Legislation

By: Lezak Shallat, Santiago-based journalist

December 2006 - Chile's new law makes all the right moves, but it hasn't kept the Chiletabacos, the BAT affiliate that sells nine out of ten cigarettes smoked here, from targeting youth.

In force as of August 2006, the new legislation introduced curbs on the sale and advertising of cigarettes to youth, banning sales to minors and near schools, and stopping the standard marketing ploy of giving away cigarettes at events for teens.

The tobacco company's marketing squads have been quick to react. Gone are the anorexic under-age models lighting up at the beach; Kent, Pall Mall and other cigarette brands now promote cigarette packs as finely designed objects d'art and with hip silhouettes of dancing couples that look like party invitations.

But the absence of babes in bikinis hasn't put an end to sexism in advertising aimed at young smokers. A billboard in the subway, for example, proclaims the "Party Law No. 234: 'When women say 'no', they mean 'maybe'. When they say 'maybe', watch out.'"[1]

Celia Higueras, a 20-year-old college student, finds the ad's sexist overtones "denigrating" because "it implies that when a woman says 'no', she doesn't mean it." Making light of tolerance for violence against women in a sales pitch for cigarettes is salacious, disturbing and menacing, she feels.

The good news comes on the other side of the pack that, as of October 2006, bears an unequivocal message: ESTOS CIGARILLOS TE ESTAN MATANDO. ("THESE CIGARETTES ARE KILLING YOU") 'The warning is accompanied by a photo of don Miguel. Miguel Garcia, the elderly ex smoker whose image is becoming as iconic as the Marlboro Man

Reaction from teens and young adults to the new health warnings can be gauged from Zona de Contacto, [2] the online youth magazine of El Mercurio, Chile's most influential (and pro-tobacco industry) newspaper. "I see you even more than I see my own father," complains reporter Arturo Galarce, who posts a collection of caricatures and diatribes against don Miguel Garcia. Its blog gave birth to the don Miguel fan club, which began as a joke among heavy-smoking youths from one of Santiago's outlying neighborhoods.

"To me, it looks like PR whitewash aimed at young people," comments Higueras. "I hope Chiletabacos doesn't get any ideas."

"Celia Higueras shows her reaction to the campaign"

Before the new law, which curbs promotional activities by the industry, Chiletabacos fancied itself a patron of the literary arts, organizing tertulia soirees intellectual gatherings with prominent literati in Santiago and sponsoring a prestigious annual short story competition in the country's hippest women's magazine.

Keeping close tabs on Chiletabacos efforts to sidestep and outrun the new national controls on advertising, sales and secondhand smoke is the blog Mundo Saludable [3], compiled by a health journalist who was fired by El Mercurio in 2005 for reporting the obvious - that, as the new law approached, Chiletabacos was conducting a massive advertising blitz aimed at youth, wall-papering Santiago streets and subways, especially near schools, universities and, in the summer, beaches.

Chile, with teen smoking rates of nearly 40%, leads Latin America in the number of young smokers.[4] This country of 16 million ranks fourth in the world for smoking prevalence among women. [5]

» continued on page 16

Chile: Sexist Ads Defy Tough New Tobacco Control Legislation continued from page 15

Notes

1. caption Pall Mall Muevete Non Stop billboard: Ley de Carrete No. 234: CUANDO LAS MUJERES DICEN QUE NO, QUIEREN DECIR TAL VEZ Y CUANDO DICEN TAL VEZ, PREPARATE.
2. Zona de Contacto http://www.zona.cl/monitor/
3. Mundo Saludable http://www.victorhugoduran.blogspot.com/
4. Global Youth Tobacco Survey: Results in the Americas "Nearly 40% of the young people surveyed smoke regularly in Chile, which is the country with the highest prevalence of smoking among adolescents 13 to 15 years old." http://www.paho.org/english/sha/be_v23n2-GYTS.htm
5. MacKay, et al. Tobacco Atlas 2006

Nurses active at shareholders' meetings across the USA

By: Ruth Malone, RN, Ph.D.

EAST HANOVER, NJ, WINSTON-SALEM, NC, and NEW YORK, NY: U.S. nurse activists, including nurses from California, North Dakota, West Virginia, Pennsylvania, New York, and Kentucky recently attended three separate corporate shareholder meetings, calling attention to the suffering caused by continued promotion of tobacco products. For the fourth consecutive year, nurses attended tobacco company meetings, this year including both Altria/Philip Morris (April 26) and Reynolds American (May 11). The nurses called for the companies to end active promotion of cigarettes and spoke out about the suffering caused by tobacco products.

This year, nurses for the first time also attended the Annual General Meeting of shareholders for General Electric (GE), parent company of Universal Pictures, where they urged the company to get tobacco out of kids'-rated movies or adopt an effective rating system. At the GE meeting April 25, nurses from California and Kentucky spoke of the tobacco-caused suffering that nurses witness and asked if the company was aware that 71% of Universal Studios films made for children depicted smoking. After the meeting, they were approached by other shareholders who thanked them for their comments.

At the Altria/Philip Morris meeting, one regular shareholder objected that the nurses were not major shareholders, calling health activists at the meeting "the lunatic fringe." Nurses spoke in support of several shareholder-initiated resolutions, including one calling for the company to work toward getting out of the tobacco business. "No matter how much money is being made, there will come a time when the world will see what is being done here and will wonder how this corporate slaughter was tolerated for so long," observed INWAT member and Nightingales founder Ruth Malone, RN, professor of nursing at the University of California, San Francisco, when referring to the nearly 5 million deaths worldwide caused by tobacco yearly. The measure was, like other shareholder-initiated proposals, defeated.

At the Reynolds American meeting in Winston-Salem, NC, nurses challenged the company's new cigarette, Camel No. 9, which targets a new generation of young women, pointing out that lung cancer kills more women than breast cancer. "As nurses, our job is to promote health, prevent disease, and protect life." said Lisa Greathouse Maggio, a nurse from Kentucky. "Your job is to make money and promote a deadly product that when used as directed will cause death and disease. We care for these people, we see their suffering, we sometimes see them die. And we see their families devastated by this suffering and death." The CEO of Reynolds American, Susan Ivey, responded by saying "Thank you for your comments."

L to R: Kelly Schmidt, ND; Liana Hain, CA; activist colleague Carol McGruder, CA; Jill Jarvie, CA; Bill Randall, CA; Ruth Malone, CA; Terese Doan Nguyen, CA; Patricia Bax, NY

The nurses, all members of the Nightingales (www.nightingalesnurses.org), a nursing group with members and supporters in more than 28 states and Canada, focus on highlighting the role of the tobacco industry in contributing to the epidemic of tobacco-caused disease, disability and premature death.

For more information contact Ruth Malone at: ruth.malone@ucsf.edu Nurses interested in joining the Nightingales Nurses should visit www.nightingalesnurses.org

Project Led by Association of Women Against Tobacco in Bulgaria

By: L. Tsoneva-Pentcheva, M. Vakarelova, E. Dincheva, M. Gavrailova, J. Tomova, L. Moskova

Smoking rates in Bulgaria are high and continuing to rise. Although comprehensive data on smoking during pregnancy are not available, rates among young women, their partners and parents of young children are still quite high. This is despite an increasing awareness of the harmful effects of smoking during pregnancy and the negative health consequences of passive smoking in early childhood.

Motivational interviewing

From 2005 to 2006, six European countries, Belgium, Bulgaria, Germany, Greece, Ireland and Portugal, participated in the third phase of the ENSP Project, European Action on Smoking Cessation in Pregnancy (EUROscip). The Association of Women Against Tobacco represented Bulgaria in the project. Activities included measuring prevalence rates among pregnant women, developing and distributing two information brochures, training midwifery students in "motivational interviewing" and producing and disseminating a DVD on motivational interviewing.

Prevalence Rates among Pregnant Women

The purpose of the study was to determine smoking prevalence at different points during pregnancy. The study took place at the same time and used the same methodology in all the participating countries.

In Bulgaria, 199 pregnant women were asked retrospectively about their smoking status and exposure to secondhand smoke at home and at work. Most of the women interviewed (54.3%) had a history of smoking - 47.2% were ex-smokers and 7% were current smokers.

A third of the pregnant women surveyed reported smoking at the beginning of their pregnancy. Pregnancy emerged as a strong motivation to quit or at least to reduce smoking. About half (46.8%) reported quitting at the time they found that they were pregnant and a further 8.5% stopped smoking during the pregnancy. Those who continued to smoke reported reducing the number of cigarettes smoked per day from 20 (median) to 2 (median).

Those who continued to smoke were also most commonly exposed to secondhand smoke either at home or at their work or both places. The never smokers reported being less exposed to secondhand smoke.

Information Brochures

Two brochures were designed that had two pages that were common in all participating countries and two pages that dealt with specific topics for the individual country. Each brochure had a specific target.

The first aimed to prevent relapse including during postpartum by explaining the effect of smoking during pregnancy and infancy on the babies and children as well as the effects of secondhand smoke. Advice on how to quit was presented in steps aligned with the consecutive weeks of pregnancy in addition to appropriate contact information.

The second brochure was devoted to fathers. Special attention was given to the support of the pregnant women and her partner in order to be smoke-free during pregnancy and after birth. The problem of breastfeeding and smoking was discussed.

Motivational Interviewing

From November 2005–April 2006, 100 midwifery students attending the Medical College in Sofia were trained in motivational interviewing (MI) free of charge. In contrast to the conventional method, the MI approach focuses on the patient and recognizes the patient's autonomy. By providing the MI training, the Association Women Against Tobacco – Bulgaria acted as pioneers in providing midwives with new techniques designed to aid smoking cessation among pregnant women.

Motivational Interviewing DVD

In each participating country 400 DVDs were produced demonstrating how to carry out MI for smoking cessation with pregnant women. The Association distributed the DVDs free of charge to the health specialists who provide care to pregnant women in Bulgaria.

For more information you may visit the web site of the Association Women Against Tobacco – Bulgaria at: http://www.geocities.com/wat_bg/WAT_BG or email: lilitsoneva@e-card.bg

Results from 32 Countries

Secondhand Smoke Exposure Among Women and Children

By: Heather Wipfli, MA[1], Erika Avila-Tang[1], Ana Navas-Acien[2], Georgiana Onicescu[1],Sungrol-Kim[2], and Patrick Breysse[2], Jonathan Samet, MS, MD[1]

Exposure to secondhand smoke (SHS) increases the risk of many illnesses and premature death in children and adults. Since most smokers around the world are men, women and children constitute the bulk of the population exposed to SHS. This study characterized levels of SHS in homes with smokers in order to create an international profile of SHS exposure among women and children. This information can be used to support smoke-free policies and programs in these countries and provides base-line levels for monitoring the impact of tobacco control policies and programs on voluntary efforts to reduce SHS in the home.

The study was carried out in 32 countries in 3 major regions (Asia, Eastern Europe, and Latin America). In each country a convenience sample of 40 homes with at least one male smoker and a child under 11 years of age was selected. Using passive sampling, air nicotine was measured in the homes, and hair nicotine was measured to determine the personal exposure of adult non-smoking women and children under 11.

Nicotine was detected in the air of most homes sampled (83%). These levels increased with the number of smokers in the home. The final results show great variability between regions -- the highest levels of nicotine in the air were observed in homes in Eastern Europe, followed by Latin America and Asia. The average levels of exposure found in homes in Eastern and Southern Europe were comparable to levels often found in bars and restaurants.

Women and children living with smokers had higher levels of hair nicotine than those living with non-smokers and these levels increased with the number of smokers in the home. Children of smokers who indicated that they always smoked around their children had hair nicotine concentrations 70% higher than the children of smokers who reported that they never smoked around their children. No clear geographical pattern was observed for nicotine detected in the hair of women and children. We also observed that, with a few exceptions, children's hair nicotine levels were higher than those of women by country.

The study findings show that the health of women and children is placed at rsk by exposure to SHS in their homes, and reinforce the need to develop programs and policies that protect women and children from such exposure.

(1) The Johns Hopkins Bloomberg School of Public Health, Department of Epidemiology, Institute for Global Tobacco Control, 615 North Wolfe Street, Baltimore, MD 21044,

(2) Johns Hopkins Bloomberg School of Public Health, Department of Environmental Health Sciences, 615 North Wolfe Street, Baltimore, MD 21205

Characteristics of Women smokers in Ibadan, Nigeria:

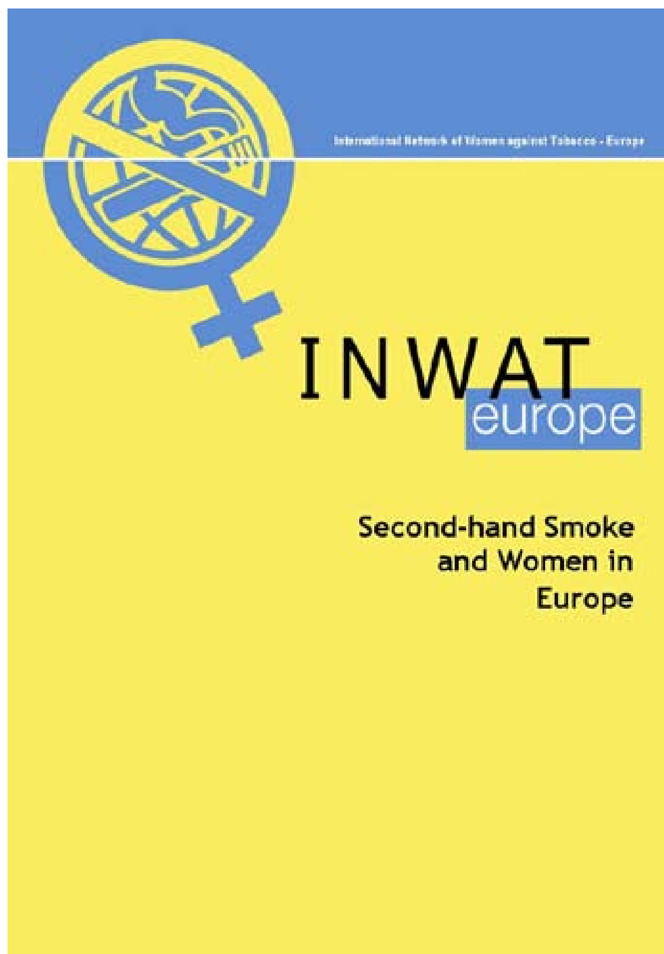
Young Women's Exposure to Secondhand Smoke

With the support of funding from the European Commission, INWAT-Europe and the European Network for Smoking Prevention (ENSP) are starting a project on young women's exposure to secondhand smoke in Europe.

Women have the highest exposure to secondhand smoke and are also the ones who pay the highest price. Lung cancer death rates in the EU are nearly three times higher for female non-smokers compared to male non-smokers. It has been estimated that over 75% of secondhand smoke-related deaths occur among women. Secondhand smoke is also an important issue for young people, not just in terms of the direct adverse health risks, but also the impact that exposure to smokers has on their perception of the social acceptability of smoking and therefore their likelihood of becoming a smoker.

The project will start by reviewing the literature and reports from European countries on secondhand smoke exposure and health effects related to women, particularly young women. Thereafter there will be an assessment of the major sources and settings for exposure related to young women and the variations between countries and groups. This will involve looking at case studies and interviewing experts in this area. The final result of the project will be a policy paper that will outline initiatives that are in place today to protect young women from second-hand smoke and set out recommendations for future action in Europe. The project runs between August 2007 and May 2008.

For more information about this project,contact: Sara Sanchez sara@inwat.org or Mariann Skar mariann.skar@ensp.org



New WHO Publication – Available Soon at www.who.int

WORLD LUNG FOUNDATION
Dedicated to lung health worldwide

World Lung Foundation announces enhanced Lung Health Image Library

By: Marta Schaaf

In honor of World No Tobacco Day, the World Lung Foundation has strengthened the anti-tobacco component of the Lung Health Image Library (LHIL) with new, powerful images illustrating tobacco consumption and related policy concerns. Moreover, the Library Resource page now has an expanded list of linked resources, including downloadable examples of print and television anti-smoking campaigns, many of which convey the need to legislate 100% smoke-free indoor places.

Hundreds of thousands of people who never smoke will die from the effects of secondhand smoke. Increasing the number and size of smoke-free zones is important to decreasing the number of tobacco-related deaths. Secondhand smoke can cause or worsen other lung health illnesses. It can lead to new cases of asthma and exacerbate existing asthma. A study from the United States found that maternal smoking was responsible for 380,000 excess cases of childhood asthma or lower respiratory tract illnesses.

The new images, which are available free of charge, graphically illustrate important policy issues, such as the need for smoke-free areas, and can be used to raise public awareness and educate policy-makers. You can browse the new images and download them to enhance anti-tobacco advocacy and education campaigns by searching under 'tobacco' at www.worldlungfoundation.org/library.

The World Lung Foundation is also sponsoring a photo contest to further expand the library. You can win a digital camera for documenting lung health programs and issues relating to tuberculosis, asthma, tobacco use and child lung health. Read the contest rules here (hyperlink http://www.worldlungfoundation.org/news_photo_contest.html)

The World Lung Foundation (WLF) is a global organization with headquarters in lower Manhattan's financial district. WLF's mission is to improve the lives of individuals across the world by strengthening community ability to prevent and manage lung disease. The organization sponsors lung health projects in countries with the highest incidence of lung disease including tuberculosis, HIV/AIDS, child lung health, asthma and tobacco related disease.

For more information email: foundation@worldlungfoundation.org

Sources:
WHO Tobacco Free Initiative, American Journal of Epidemiology

An example of a photo that can be downloaded from the image library

"Work smoke-free countries"!

Countries that have comprehensive smoke-free workplace laws that include restaurants and bars:

Ireland, Italy, Scotland, England, Northern Ireland, Wales, Jersey, British Virgin Islands, Norway, Sweden, Finland, France, Iceland, New Zealand, Bermuda, Uganda, Malta, Uruguay, Hong Kong, and Bhutan

(As of June 21, 2007)

Judith Mackay Honoured as one of The Time 100

World's most influential people

On 4 May, 2007, Judith Mackay, one of INWAT's founding members and winner of the 2006 INWAT Award for Lifetime Achievement, was honored as one of Time magazine's '100 Most Influential People'.

From the TIME article by Jeffrey Wigand

When looking at the actions of Judith Mackay, it is clear that she is moved by a profound desire to do good for others and that this desire has defined the course of her life. It led her to become first a practicing physician and then, since 1984, a tireless tobacco-control advocate. Realizing that eliminating ignorance can be more effective in mitigating disease than merely prescribing medicine, Mackay, 63, a British-born doctor who has lived in Hong Kong for the past 40 years, began to arm others, particularly those in Asia, where smoking rates are still high, with information about the health risks of tobacco use. As senior policy adviser to the World Health Organization, she is a chief architect of the 2003 Framework Convention on Tobacco Control, which recognizes tobacco use as a global problem that all governments have a moral duty to address. And her book The Tobacco Atlas educates legislators and other officials so that they can, in turn, provide their citizens with knowledge that will enable them to lead happy, healthy lives and their societies to flourish.

Some details and photos are available on the World Lung Foundation website: http://w/news_time_100.html

Tobacco control movement loses renowned legal expert

Judith Wilkenfeld, who made her mark as an attorney specializing in tobacco policy, died of pancreatic cancer on May 24 at her home in Washington, DC. She had battled the disease with dignity and courage for over 2 years.

Judy took on the tobacco industry as legal counsel for the United States Federal Trade Commission (FTC). She led the FTC's 1985 case against Brown & Williamson Tobacco, a lawsuit that began the process of uncovering the decades of deceit and product manipulation by the tobacco industry, and played a key role in ending the reign of Joe Camel when the FTC decided to sue R.J. Reynolds over the use of the cartoon character in its advertising. Judy also served as a special advisor for tobacco policy at the U.S Food and Drug Administration.

For the past eight years, she had worked at the Campaign for Tobacco-Free Kids directing international tobacco control efforts, and was a leader among the NGOs involved in the negotiation of the international Framework Convention on Tobacco Control. Her commitment to tobacco policy and her legal insight and expertise will be missed by the tobacco control communities in the United States and around the world.

Members' Activities

Nurses Association of Thailand

By: Ponsgri Sim

Thailand: The Nurses Association of Thailand joined the Thai Nurses Profession for Smoke-Free Society and the Nurses' Network Against Tobacco and Substance Abuse of Thailand to cerebrate the International Nurses day on May 7, 2007. This event launched the campaign for smoke-free nursing environments as one component to promote better nursing practice to improve the quality of patient care. More than 500 Thai nurses and nursing students participated in the campaign. In addition, nurses from Bangkok Metropolitan Community Health Center opened the mobile clinic for health education and consultation. These events were echoed by nurses working in each of the four regions of Thailand.

FACT - Frauen aktiv contra Tabak e.V.

By: Sibylle Fleitmann

Germany: Women against Tobacco in Germany has participated in the campaign for a smoke-free environment in Germany, particularly on the issue of smoke-free bars and restaurants and the health of women employees. Approximately 7 in 10 of those working in the catering industry in Germany are women and of those, 70% are under the age of 30.

FACT has participated through the following activities:

- 13 October 2006: Letter writing campaign to all national parliamentarians
- 20 February 2007: Letter writing campaign to all 16 regional health ministers of the Länder (states).
- 23 February 2007: Participation in a demonstration in Hannover at the national meeting of regional health ministers to discuss legislation on smoke-free public places, including bars and restaurants
- 19 July 2007: Letter writing campaign to all 16 regional prime ministers of the Länder
- 18. May 2007 : Position paper and participation in a Parliamentary hearing on legislation banning smoking in restaurants and bars in the Region of North Rhine Westfalia (18 million inhabitants)

For more information contact Sibylle Fleitmann, s.fleitmann@gmx.de

8e Virtual Congress of Psychiatry

From February 1 to 28, 2007, the 8e Virtual Congress of Psychiatry "Interpsiquis", organized by Psiquiatria.com and co-sponsored by the World Psychiatric Association, took place online.

Psiquaitria.com is the first specialized website on psychiatry for Spanish language professionals in more than 60 countries. Currently there are more than 176,000 subscribers who periodically receive a newsletter with a selection of the most important news of the sector.

As part of this Virtual Congress, INWAT conducted a roundtable called "Women and tobacco in Ibero- America: Challenges in the new millennium" with the collaboration of Dolores Marín Tuya (Spain), Pepa Pont Martínez (Spain), Sara Sanchez (Sweden), Miriam Otero Requeijo (Spain) and Sandra Braun (Argentina).

The main issues discussed were: why women smoke, tobacco industry strategies to target women, smoking cessation from a gender perspective, publication of Turning a New Leaf: Women, Tobacco, and the Future, and INWAT activities in the region.

For more information about women and tobacco initiatives in the IberAmerican Region contact: Gabriela Regueira at: gabrielaregueira@yahoo.com.ar

USA: Update on Women and Tobacco Information from TFK

By:Victoria Almquist

The Campaign for Tobacco-Free Kids has just updated their website to include information on women and tobacco. Among the materials which can be downloaded free of charge, is a report on women and smoking with a focus on the Camel No. 9 campaign which includes pictures of advertising and marketing materials.

Camel No. 9 is the new cigarette brand from RJ Reynolds that, based on marketing materials, appears to be targeted at women. There is a striking similarity between the typeface used for the cigarette brand and that used for Chanel No. 5.

The report includes a link to a strong editorial from The Oregonian, which is the result of work by: Tabithia Engle of the Tobacco-Free Coalition of Oregon and Kylie Meiner of the Multnomah (Oregon) Health Department.

Other information includes updated charts showing cancer death and cardiovascular disease rates among women and links to Turning a New Leaf and resources to help women smokers quit.

Visit: www.tobaccofreekids.org/reports/women

Correction

The photos published in the page 16 of the March 2007- August 2007 issue of the Net, were from the main session and attendees at the First Argentinean Congress on Tobacco or Health, not from the Women and Tobacco Meeting.

Upcoming Conferences

First SRNT Latin America and 2nd Iberoamerican Conference on Tobacco Control

Under the theme strengthening tobacco control in the era of the FCTC, this conference is the first of its kind in the Latin American region. INWAT members from Latin America have coordinated a full day session to take place on the 5th of September.

Rio de Janeiro, Brazil

5-7 September 2007

www.srntrio07.com.br

Towards a Smokefree Society

Results from Scotland's and other countries' experiences in passing smoke-free laws. The conference is being organized by NHS Health Scotland, in partnership with the WHO-EURO and the European Commission. There will be an INWAT fringe meeting.

Edinburgh, Scotland

10-11 September 2007

www.smokefreeconference07.com

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Learning from the Experts

Training World Leaders in the Fight Against Tobacco

Free Online Tobacco Control Training from the Johns Hopkins Bloomberg School of Public Health

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5th National Conference on Tobacco or Health, Canada

Edmonton, Alberta, Canada

1-3 October 2007

www.ncth.ca

4th European Conference on Tobacco or Health

INWAT-Europe will be presenting during a plenary on Women and Tobacco.

Basel, Switzerland

11-13 October 2007

www.ectoh07.org

National Conference on Prevention and Treatment of Tobacco, Spain

Current work about women and tobacco control in Spain will be featured.

Castellón, Spain

25-27 October 2007

www.cnpt2007.org

World Conference on Tobacco or Health

The 14th World Conference will take place in India.

8-12 February 2009

www.14wctoh.org

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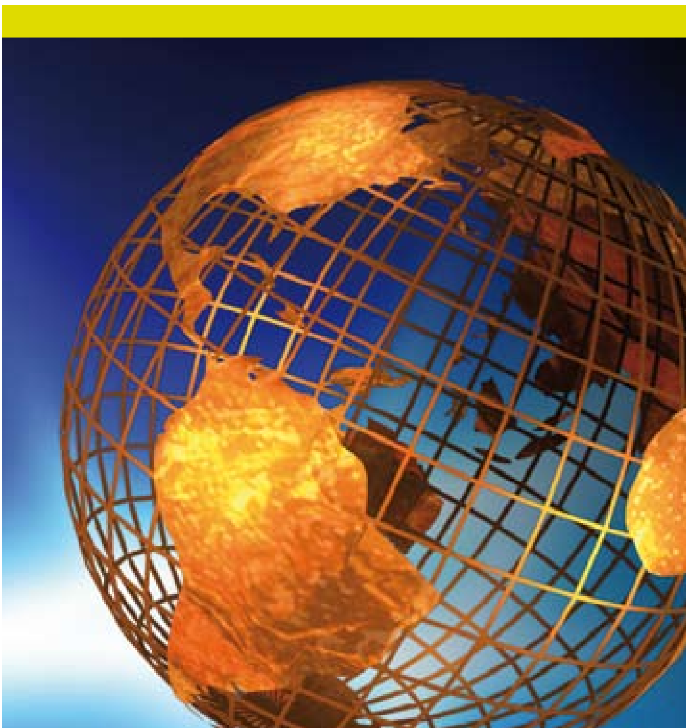

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