Spring 2003

THE NET

International Network of Women Against Tobacco
A Program of the American Cancer Society

From the President, Margaretha Haglund

Finally spring is in the air and after an extremely cold winter in Sweden it is a pleasant change for your Swedish President! For those living in warmer parts of the world you might not understand how tough our Scandinavian winters are: so very chilly and dark for several months. Hopefully, the warmer weather will energize us for the challenging times we are now facing. Even if we are fighting daily against the real weapon of mass destruction, tobacco, I do not believe that war is a solution of disarmament of any product. Dear sisters, I must say that all my years working in the global tobacco-control movement, and frequently meeting colleagues from all over the globe, has made me even more of the pacifist I am today.

As a contrast allow me to focus on outstanding global co-operation and perhaps the most important milestone for progress in combating the tobacco epidemic so far, the adoption of the groundbreaking health treaty to control tobacco supply and consumption, the WHO, Framework Convention on Tobacco Control. The decision on March 1st concluded four years of negotiations and I have been privileged to represent my government at all six rounds of these negotiations. Of course, it has not been an easy task, as all of us who devote our lives to tobacco control wanted to have more, but all-in-all, I strongly believe that the FCTC will have a great impact on tobacco use and health for decades to come.

Actually, in the preamble the text explicitly recognizes the main priorities of INWAT such as the need for full participation of women at all levels of policy-making and implementation and the need for gender-specific tobacco control strategies. This recognition is an important step forward for our organization. In this context, I would like to focus on two remarkable women who have been instrumental in achieving the FCTC, the world's first health treaty. First, our member Ruth Roemer, who together with Allyn Taylor, drafted the following resolution to the 9th World Conference on Tobacco and Health in Paris in 1994: "National Governments, Ministers of Health Organizations should immediately initiate action to prepare and achieve an International Convention on Tobacco Control to be adopted by the United Nations as an aid to enforcement of the International Strategy for Tobacco Control adopted by the Ninth World Conference on Tobacco and Health".

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Special Issue Focus: Australia

2003 Membership Directories

While we would like every INWAT member to receive a copy of the Membership Directory, many of the ones we mail are returned to us as undeliverable. Since this is very costly, this year, INWAT Membership Directories will be sent only to those members who request them.

To request a copy of the 2003 INWAT Membership Directory (which will be available in August), please contact Bonnie Kantor, by email at bonnie@inwat.org or by fax at 1-732-549-9056. If email and fax are unavailable, send a note to Pressing Issues, P.O. Box 224, Metuchen, NJ 08840 USA. Be sure to include your current mailing address when you request your copy. Thanks for your cooperation.

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Why the Tobacco Treaty Matters

by Soon-Young Yoon, International Alliance of Women

On March 2, 2003, in Geneva, the nations of the world completed negotiations on the World Health Organization Framework Convention on Tobacco Control (FCTC). As many INWAT members know, a global treaty on tobacco is timely-particularly in developing countries. Every six seconds, someone dies of a tobacco related disease and in the future, nearly 70 percent of these deaths are expected to be in poor, developing countries. Furthermore, rates of female smoking, particularly among young women, are on the rise. Unless gender-specific policies are integrated into national programs, women and girls will remain invisible to planners.

Women's groups have done their part to strengthen the treaty. Throughout the negotiations, a women's caucus of the NGO Framework Alliance worked hard to ensure that gender equality and women's leadership featured prominently. Representing women's groups in countries such as Brazil, India, China, Switzerland, Bangladesh, Sweden, South Africa, Canada and the USA, this diligent group held briefings for delegates on gender and tobacco and actively participated in lobby efforts. At the sixth Intergovernmental Negotiating Body meeting, the International Alliance of Women and WHO organized a panel on gender research. Martha Morrow from Australia introduced a new "WHO Fact Sheet on Gender and Tobacco" and experts from South Africa, Australia, China and the US highlighted priority areas of research such as the need for epidemiological surveillance by sex and age. Panelists agreed that unless drastic improvements are made in national surveys, it will be difficult to monitor the impact of the FCTC on women and girls.

The Women's Caucus

The Convention has two provisions in the Preamble specifically related to women. It states: "Strong political commitment is necessary to develop and support, at the national, regional and international levels, comprehensive multisectoral measures and coordinated responses, taking into consideration...the need to take measures to address gender-specific risks when developing tobacco control strategies."

It also notes that governments should act "keeping in mind the need for full participation of women at all levels of policy-making and implementation and the need for gender-specific tobacco control strategies."

Key articles that affect women call upon governments to:

- ☐ Enact a comprehensive ban on advertising, marketing and promotion unless constitutional barriers exist.
- ☐ Implement warnings of at least 30% or more of the principal display areas of the pack.
- ☐ Ban misleading descriptors such as "light" and "mild" on packs.
- ☐ Raise tobacco taxes significantly.
- ☐ Provide smoke-free air in public spaces and workplaces.
- ☐ Consider using litigation to hold the tobacco industry liable for its wrong-doings.

These are strong and clear statements that women's rights to health as a human right must be defended. The treaty goes to the World Health Assembly for adoption in May. When 40 nations have ratified the treaty, it will go into force. That is when the real work begins. With some governments still reluctant to endorse key provisions, it is important for women's groups to pressure governments to enforce this new public health treaty once commitments are made. For more information, see the WHO website (http://www5.who.int/tobacco) and the Framework Alliance website (http://www.fctc.org).

Dissemination of Interventions for Pregnant Smokers

by Lisa Trotter, Meg Montague and Jane Martin

Special Issue Focus: Australia

Introduction

This article gives some background to the current approach used in relation to smoking cessation among pregnant women in Australia. It also details some of the work currently underway in the state of Victoria to promote smoking cessation during pregnancy through the development of routine antenatal care guidelines.

Current Practice

The need to identify and assist pregnant smokers as part of routine care has been identified by the Australian National Tobacco strategy and a national consensus conference on smoking and pregnancy.[1, 2]

Lumley concludes in the Cochrane review that:[3] "Attention to smoking behavior together with support for smoking cessation and relapse prevention needs to be as routine a part of antenatal care as the measurement of blood pressure."

However, this is far from the current situation. Identifying smokers and providing advice is not a routine part of antenatal care[4] in Australia, and many health practitioners do not perceive this to be part of their role. In an observational study of General Practitioners (GPs), it was found that GPs only detected about half (48%) of the smokers presenting for antenatal care. This is consistent with the findings of a review by Walsh et al. of the international literature—usually less than half of pregnant smokers recall receiving advice[5].

In a study conducted by Walsh et al. medical and nursing directors were asked if they thought it was essential or desirable to give smoking advice at the first ante-natal visit.[6] As can be seen in Table 1, a large percentage of these staff, particularly medical directors, do not think that it is essential.

Table 1: Percentage of Australian clinical directors rating advice at first antenatal visit

	Smoking advice	
Health professional	**Essential**	**Desirable**
Nursing directors (n=106)	79%	20%
Medical directors (n=83)	57%	42%

In this study, Walsh also asked if they recommended cutting down rather than quitting: 30% said that they did.

Barriers

There are a range of reasons why encouragement of smoking cessation for pregnant women is not a routine part of antenatal care. Walsh et al. found that the main barriers that health providers perceive to encouraging smoking cessation are lack of training, time, staff, confidence, teamwork and pessimism about the effectiveness of their intervention.[7] If priority is given to reducing maternal smoking, all these barriers can be addressed with the development of practice guidelines and staff training.

Best Practice

Based on an evaluation of antenatal smoking intervention trials, Dolan-Mullen et al recommends the use of more intensive interventions with multiple contacts and multiple formats such as brief personal counselling, with supporting written materials and follow-up contacts.[8] Group sessions for smoking cessation are poorly accepted.[9]

However, smoking cessation interventions which are effective in some settings may not be in other settings with a different patient population (Windsor self-help manual).[10] Interventions need to be developed or adapted in the setting with patients similar to those likely to use the intervention and full involvement of staff who might be involved in the intervention. Smoking cessation interventions should also involve fathers and other family members.[11]

Type of intervention

- Multiple contacts, multiple formats, follow-up
- Materials tailored to pregnancy
- One-on-one, not group sessions

A minimum protocol that should be expected from practitioners consulted is the identification of smoking status, provision of health effects advice and brief intervention or referral. Some practitioners may want to deliver a more comprehensive intervention. This would need to be done at the first visit (12 weeks) with follow up at later visits. Smoking status and interventions provided should be recorded in patient records and audited.

Minimum protocol

- Identification of smoking status
- Provision of health effects advice
- Delivery of brief intervention or referral

Clinical practice guidelines for treating tobacco use and dependence have been published in the JAMA.[12] The guidelines were developed by an independent panel of 18 scientists, clinicians and consumers. Approximately 6,000 peer-reviewed articles were reviewed and a consensus consultation process with experts was conducted. They propose a 5-step model for brief intervention. This model has also been adapted specifically for pregnant smokers in Canada.[13]

Model for Guidelines: The "5-As"

1. Ask–systematically identify all tobacco users at every visit
2. Advise–strongly advise all tobacco users to quit
3. Assess–determine willingness to make a quit attempt
4. Assist–aid the patient in quitting
5. Arrange–schedule follow-up contact

These guidelines need to be adapted to suit pregnant smokers. For example, it is important that recent quitters are also identified. Also, pregnant women are more reluctant to admit to smoking, so special consideration needs to be given to the types of questions asked. Research conducted by Dolan-Mullen et al. shows that pregnant women are more likely to disclose their smoking if the question format is changed from 'yes'/'no' options to include 'I used to smoke' and 'I have cut down.'[14] Existing services to assist smoking cessation such as Quitline could be offered at the 'Assist' step.

Adaption Of Guidelines In Victoria

The adaptation of the guidelines occurred recently in Victoria as part of the Three Centres Consensus Guidelines on Antenatal

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Campaign to Target Young Female Smokers

by Denise Sullivan and Jane Martin

Smoking-related disease among women in Australia has reached epidemic levels with an almost 500% increase since 1950 in the death rate among women from lung cancer.

Current figures suggest that within the next decade smoking will be more common among women than men and that lung cancer will overtake breast cancer as the leading cause of cancer death for Australian women in the near future. In 2000, lung cancer surpassed breast cancer as the most common cause of cancer death in West Australian women for the first time, and it is expected to occur in Victoria in 2006.

In February, the Western Australian Cancer Foundation launched a new campaign aimed at making women aware of the specific health risks they face as a result of smoking and the urgency to quit or never start. This was also adopted by Quit Victoria and launched at the end of March. The focus of the campaign is young women aged 18 to 29, and has been developed by Make Smoking History at the Cancer Foundation.

The centerpiece of the young women and smoking campaign is a series of television advertisements featuring a West Australian woman, Jenny, a 42-year-old who has terminal lung cancer after many years as a smoker. Jenny has three sons aged 21, 19 and four.

Make Smoking History Director, Denise Sullivan said Jenny had decided to tell her story so young women would be left with no doubt that their smoking was placing them at risk of serious harm.

"We believe that Jenny's heartbreaking personal story and the strength of the message she has to share will motivate young women to quit smoking or not take it up in the first place," Ms Sullivan said.

"Despite all of the information and knowledge we have about the harm that smoking causes, 24 per cent of Australian women aged 20 to 29 are daily smokers, compared to 20 per cent of all Australians.

"Without campaigns such as this, Jenny's story will be repeated across the country time and time again as women lose their lives to disease that could have been prevented," Ms Sullivan said.

Tobacco smoking continues to be the single largest cause of preventable death and disease in Australia. Around 6,000 Australian women die prematurely each year due to tobacco-related illness.

In officially launching the new campaign, Dr Rosanna Capolingua, tobacco control spokesperson for the West Australian branch of the Australian Medical Association, said women needed to be aware of the specific health issues they may face as a result of smoking cigarettes.

"Many may already know that their smoking puts them at greater risk of lung cancer but young women may not be aware that smoking also places them at increased risk of cervical cancer, reduced fertility, menstrual problems, difficulties with pregnancy and childbirth and earlier menopause.

"There is also recent research which indicates that women are more susceptible to lung cancer than men. Scientists are yet to identify whether this is due to genetic or biological factors," Dr Capolingua said.

There was also a worrying trend of increased rates of lung cancer in women.

"While the rate of lung cancer in men has been in steady decline, it is on the increase in women. In the decade 1989

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Research Behind the Campaign

Qualitative research was commissioned to inform the development of the advertisements. Six focus groups were run with women aged 18-29, four with regular and occasional smokers and two with ex-smokers. The key findings are outlined below:

Smoking Behaviors

The research found that women most commonly smoked in social situations, this was also a factor influencing initiation and continuation of young women's smoking. Other cues for smoking included while driving, during stressful situations or when alone. This indicates that young women use cigarettes to manage their mood. Most women felt unhappy about how often and how much they smoked.

Advantages and Disadvantages of Smoking

Smokers focussed on the negatives of their behavior before mentioning any positives. They identified short-term effects, social isolation and cost of smoking. The key reasons women smoked were to alleviate boredom, relax and to help them feel more comfortable in social situations.

Awareness of Health Effects

Young women were aware of the health effects, but not in any depth. They had a low awareness of sex-specific health effects. They also had a number of misconceptions about the harm caused by smoking and how to reduce risk. In particular, a number of young women believed that mild cigarettes were either less harmful of less addictive than regular cigarettes. Most participants believed they would quit before it was too late, for example when they turned thirty, or when they became pregnant.

Attitudes and Experiences Around Quitting

Most participants had tried to quit previously because of the influence of family and friends, experiencing the short-term health effects and the cost of cigarettes. Social situations, experiencing cravings and stress all influenced relapse. Young women believed that willpower and the support of family and friends were the most important facilitators to quitting. Many also felt that they would need to avoid friends who smoked in order to successfully quit.

INWAT Elections

INWAT officers will be elected at the World Conference on Tobacco or Health in Helsinki in August, 2003. A ballot is enclosed with this issue.

To vote, return the ballot NO LATER THAN July 7, 2003.

You can return your ballot

by email to bonnie@inwat.org

by fax to 1-732-549-9056

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Lone Mothers in Australia

Lone mothers constitute 17% of families with dependent children and are the fastest growing demographic group in Australia. Lone parents are one of the most disadvantaged groups in the community with between 40-60% living below the poverty line compared with 14% of all couples with children.

In 1995, the prevalence of smoking by lone mothers was 46% which is more than three times the prevalence among mothers with partners, and twice that of women living alone. Children of lone mothers and with parents who smoke are more likely to become smokers themselves, thereby perpetuating disadvantage.

High smoking prevalence among lone mothers in Australia is not entirely explained by low SES. Furthermore, the effect is not simply due to living alone, or not having a partner. Social isolation, loneliness, limited time spent in smokefree environments and the monotony of daily life may also contribute to continued smoking among these women.

Smoking imposes a significant financial burden on this group and quitting would considerably add to the quality of life for this group. It is important to provide behavioral programs that aim directly at preventing uptake and assisting in cessation of smoking. However, policies affecting upstream factors can also be effective in reducing smoking prevalence in this group. These include increasing social security payments, policies to provide gainful employment for those who are able to work along with training, childcare and transport. Some of these may also help to address the feelings of isolation and loneliness that may account for continued smoking in these groups. Participation and membership of community groups may also provide social contact lacking for many in this population.

Siahpush M, Borland R & Scollo R. Prevalence and correlates of smoking among lone mothers in Australia. *Aust NZ J Public Health*. 2002; 26:132-135.

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to 1999 the incidence of lung cancer in men in WA decreased by 20 per cent and increased by three per cent in women.

"This reflects the changes in smoking patterns over time and how successful the tobacco companies have been in promoting their deadly product to women.

"Strategies such as sponsoring fashion events and hosting glamorous parties attended by celebrities and models and product placement in Hollywood movies have all been part of the industry's marketing ploy to make smoking attractive and appealing to this sector of the population," Dr Capolingua said.

Ms Sullivan said young women should make a positive commitment to their personal health, self-confidence and quality of life through quitting smoking.

"There was a time when cigarette smoking was a symbol of independence and freedom for women. It is now a symbol of dependence, addiction and sickness. It is also a symbol of loss as more and more families lose a woman they love to disease caused by smoking."

The campaign will be run in other states and territories, later in the year. Quit Victoria has developed a complimentary advertisement to encourage female smokers to call the Quitline for information from trained advisors for the cost of a local phone call. Both the advertisements can be viewed on the Quit Victoria website along with some background information at www.quit.org.au

Quit Victoria has also developed an advertisement targeting pregnant women with the aim of encouraging them to call the Quitline and this will go to air later in the year.

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Find INWAT on the web at www.inwat.org

Our very well-visited website has back issues of *The Net*, as well as English and French versions of INWAT-Europe's newsletter, in PDF format. All you need is Adobe Acrobat to view or print it.

From the President *continued from page 1*

Second, the Director General of WHO Dr Gro Harlem Bruntland, for her outstanding, courageous leadership. Both of these remarkable women should absolutely be qualified for the Luther Terry Awards. As a member of selection Committee of the Awards I really hope that we will be able to get some female winners this year! Last, but not least, I would also like to thank all our members who have worked so hard to achieve the FCTC by raising awareness both in their own countries and on the international arena. I am so proud of being your president!

Let us now keep our fingers crossed for a positive outcome in May at the World Health Assembly. A key country for progress is Germany who is now against the advertising article. If there will not be a change in opinion of the German government it will prevent all the other EU countries, and the accession countries, from signing and ratifying the FCTC. Actually, the impact will be even greater as certainly countries like Canada, Australia and New Zealand will hesitate to join as long as the EU is outside the FCTC. Please use all your contacts to influence Germany!

Another interesting activity that has happened this year, and one I strongly believe will strengthen INWAT priorities, was a research conference on women and cancer that I was fortunate enough to be invited to. So please allow me to take this opportunity to thank the organizers of the meeting on Women, Tobacco and Cancer, an agenda for the 21st Century, held in Houston, Texas, February 3-5 2003, and in particular our North American regional representative, Michele Bloch, for her hard work in the preparation and accomplishment of the conference. The purpose of the Houston meeting was to identify and prioritize research needs for a better understanding of cancer-related biological effects of women's tobacco use and ETS exposure and to develop better intervention activities in these areas. A report about the conference will be distributed at the World Conference in Helsinki.

By the way it is now only four months until this year's big event in tobacco control, the 12th World Conference on Tobacco and Health in Helsinki, August 3rd-8th. As usual, we are working to have the best gender balance of women and men speakers and chairs. Our goal, as you might remember, is 50-50 representation! Many things are still in a preliminary stage as far as dates and times for the different events but just to give you a glimpse of INWAT activities, I have the pleasure to tell you that the organizers have approved the following five INWAT workshops which are in a series of workshops exploring different aspects of women smoking and tobacco control.

The five workshops are:

- Gender Analysis and Tobacco Control -making research, policy and practice more gender sensitive organized by Amanda Amos from Scotland
- Women, smoking and inequalities, organized by Patti White from England
- Global seduction - the latest trends in marketing to women, organized by Martina Poetske Langer from Germany
- The gender issue between evidence and experience. How to stop the epidemic in midcycle by making women quit successfully, organized by Trudi Prince from the Netherlands
- Women, Tobacco Control & Sustainable Development in Africa organized by Nicola Christofides from South Africa.

Each workshop will draw on perspectives and experiences from developed and developing countries at different stages of tobacco epidemic in women. Finally there will also be a presentation by Amanda Amos on INWAT Europe and the lessons from that project.

The members' meeting is preliminarily scheduled for Wednesday, August 6th, from12-1.30 pm. There will also be an INWAT press conference on Tuesday, August 5th from 1-1.30 pm but so far the theme is not set.

It is also time for the election of the INWAT Board Members. A ballot is enclosed with this issue. Please use your right to take part in the democratic process. It is only with your active involvement that INWAT will develop further.

I am very much looking forward meeting many of you in Helsinki in August and please let us hope that the sun will shine from a blue sky in Helsinki in the beginning of August. The weather can be very surprising in Scandinavia so don't bring your lightest summer clothes and I am sure you will all love the beautiful city of Helsinki.

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Care. Smoking cessation was one of the eight key areas. The Cancer Council Victoria and Quit Victoria offered to assist with the development of the guidelines for smoking cessation.[15]

The guidelines are brief, but capture the essence of what the evidence indicates is likely to reduce morbidity and mortality caused by maternal smoking. The over-arching guideline is to offer smoking interventions to all women who smoke or have recently quit and it is suggested that this be done by following a 5-step model. These steps are to:

- First: ask all women about their smoking. It recommended that a multiple choice format be used.
- Second, advise all women who smoke or have recently quit about the health risks to their babies and themselves of smoking and to quit. Need to explain that LBW means a sick baby.
- Third, assess the woman's willingness to quit. Must be their decision and not a result of pressure from family/friends/hospital.
- And, according to their willingness, provide assistance. The guidelines suggest that take-home material is given - tailored for pregnant smokers, a quit date is set, support to stay quit, information for the partner. The assistance may be given by a health professional or referred.
- The final step is to follow up by asking about smoking again and giving appropriate support and encouragement. This is best done soon after the quit date.

For the guidelines to be of any value, they have to be used as part of routine care and staff need to be trained and their practice monitored. The three hospitals that produced the guidelines have begun to develop manuals, training and systems for monitoring use of guidelines. Quit Victoria has assisted with this by offering a training course and creating a flow chart for easy reference.

At the same time as the Guidelines were being written in 2000, a separate project was initiated. The Royal Women's Hospital in Melbourne, Victoria which set out to develop a set of performance indicators for measuring maternity care[16]. Nine indicators were identified by the Performance Indicators project and included an indicator of the delivery of smoking cessation interventions. The indicator was based on a search and appraisal of the literature and a statewide consultation with consumers and providers.

Consumers selected the smoking indicator in consultations whereas providers did not support the inclusion of this indicator because of perceived difficulty in data collection. The project team, nevertheless, endorsed the inclusion of the smoking cessation performance indicator on the basis of its public health importance and an understanding that there is considerably more room for improvement in this area. The indicator is measured by "The proportion of women offered appropriate interventions in relation to smoking". The smoking indicator was trialed at six hospitals and involving the establishment of new data recording systems, protocols and assessment tools for the smoking indicator. As part of the implementation of the smoking cessation performance indicator throughout Victoria, Quit has been contracted by Victorian Department of Human Services to conduct Train the Trainer sessions in each geographic region.

Conclusions

All performance indicators used to measure maternity care in Victorian hospital settings should include the delivery of smoking cessation interventions. Smoking cessation should be a routine part of antenatal care in all Victorian hospitals. To achieve this smoking cessation guidelines must be routinely incorporated.

One of the issues with the implementation of guidelines will be to resource clinicians in antenatal care so that they can be more effective in providing smoking cessation interventions and, at the same time as providing them with the knowledge, to resource and refer women as necessary.

Training of all relevant staff in the provision of smoking cessation interventions during pregnancy is essential to the success of the intervention. Quit has developed training to provide this expertise.

A telephone counselling intervention for pregnant women has been developed by the Quitline and found to be feasible, acceptable and probably effective. This expertise among counselors is continuing to be developed. This service should be promoted as a referral service by maternity care staff and provided widely throughout Victoria.

Relapse prevention strategies targeting those women in the post partum period who quit spontaneously when they became pregnant, should be developed and implemented. The Quitline call-back service has been evaluated as an intervention that is effective with this group.

The feasibility of reducing consumption as an outcome, once all avenues for promoting cessation have been exhausted, should be investigated.

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INWAT Workshops at the 12th World Conference on Tobacco or Health

Several workshops,.organized by INWAT, will be presented at the 12th World Conference on Tobacco or Health in Helsinki this August. Each will explore different aspects of women, smoking and tobacco control and will draw on perspectives and experiences from countries at different stages in the tobacco epidemic in women, including both developed and developing countries. These are brief descriptions:

Gender Analysis and Tobacco Control: making research, policy and practice more gender sensitive

The workshop will explore how tobacco control through adopting a gendered analysis of research policy and practice, can develop effective gender sensitive approaches. The workshop will take a global perspective and will include presentations from experts in gender analysis as applied to tobacco control from countries at different stages in the epidemic such as Canada, Germany and South Africa. Some of the questions that will be addressed include:

- What is gender based analysis?
- How can it be applied to research, policy and practice in tobacco control?
- What have such analyses revealed about the extent to which these fields are gender sensitive?
- How might gender based analysis be used constructively to develop more gender sensitive approaches?

Women, inequalities and smoking

The workshop will explore some of the questions that will be addressed include:

- What do we mean by health inequality and how is it measured in different countries (e.g. disadvantage, social exclusion/inclusion, low income, poverty)?
- What different perspectives do we take? (e.g. gender, age, life-course, ethnicity)?
- How good is our knowledge base on patterns, trends and determinants in different countries and at different stages of development?
- What does gender analysis bring to this discussion?
- Which countries are developing programs and policies to address inequalities and smoking?

Women, Tobacco Control & Sustainable Development in Africa

The workshop will present findings from studies conducted in 6 African countries in order to share experiences and research on tobacco control in Africa. Topics include:

- Tobacco use (smoking & smokeless) amongst women in Nigeria and Malawi
- Gender Issues in tobacco farming studies from Kenya and Uganda
- Gender issues in the Informal trading of tobacco products in Uganda and South Africa

Global seduction of women: the latest trends in marketing to women

The tobacco companies have openly identified women and girls as a key group for their further expansions. Since the 1920's the tobacco companies have been bombarding women with their seducing messages. This is reflected in advertising and promotional strategies, the development of brands designed to appeal women and the abuse of women's media.

The workshop will describe examples of cigarette marketing strategies addressed to women and girls from different parts of the world as well as to describe the overall tactics of the cigarette industry.

The gender issue between evidence and experience: How to stop the epidemic in midcycle by making women quit successfully

The workshop will bring together evidence-based and experience-based data in order to create a window of opportunity for developing gender-based interventions within a socio-cultural framework. Such interventions will increase the success rate of quit attempts among women. It will give the participants the opportunity to look at the four stages of the epidemic and draw the parameters for the effectiveness of interventions in their own countries, with regard to these. Thus the workshop will create insight on both a macro and global level, and on a micro and individual level.

12th World Conference on Tobacco or Health
August 3-8 2003 in Helsinki, Finland

For more information, go to the Conference website: www.wctoh2003.org

Can I view the program before the conference?

The program will be published on the conference website in June 2003.

How much does it cost to register for the conference?

	From 2 April to 2 August	On-site
Delegate	590	620
Graduate student	300	350
One day rate*	250	300
Accompanying person	150	200

**Social programs are not included in the one day rate.*