

Women & Tobacco

A CASEBOOK

**CONTEXTS AND ISSUES ► STRATEGIES AND INTERVENTIONS
► ADVOCACY AND ACTION ► DIVERSITY AND EQUITY ISSUES ►
POLICY AND RESEARCH ► DISCUSSION GUIDES ► RESOURCES**



British Columbia
Centre of Excellence
for Women's Health

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A companion piece to this casebook, a guide to brief, women-centred approaches to tobacco interventions for health care providers, has been developed:

Urquhart, C., Jasiura, F., Poole, N., Nathoo, T. & Greaves, L. (2012). *Liberation! Helping Women Quit Smoking: A Brief Tobacco Intervention Guide*. Vancouver, BC: British Columbia Centre of Excellence for Women's Health.

Visit www.expectingtoquit.ca and www.coalescing-vc.org for other BCCEWH work on women and tobacco.

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Table of Contents

INTRODUCTION

Our Story / iii

Our Approach / xi

About this Casebook / xvi

I. CONTEXTS AND ISSUES

Girls, Women, and Tobacco: Global Trends / 2

Women Working in the Health Care System and Tobacco Control / 4

Women and Exposure to Secondhand Smoke / 8

Women Working in Tobacco Production / 10

Indigenous Women and Tobacco / 18

II. WORKING WITH GIRLS AND WOMEN

Women-only Group Programs for Reducing and Quitting Smoking
/ 24

Harm Reduction Support Strategies for Mothers who Smoke / 28

Women-Centred Brief Interventions by Health Care Providers / 32

Strategies for Reducing Tobacco Use with Pregnant and Postpartum
Women / 38

Women-Centred Approaches to Smoking Cessation Drugs and Nicotine
Replacement Therapies (NRTs) / 42

Girls, Women, Media, and Tobacco / 48

III. ADVOCACY AND ACTION

The International Network of Women Against Tobacco / 56

Using Shadow Reporting to Advance Women's Health and Reduce
Tobacco Use / 60

Changing Organizations: Integrating Tobacco Interventions into
Treatment for Other Addictions / 64

Sex- and Gender-based Analysis and Tobacco Policy / 68

Diversity, Equity, and Secondhand Smoke Policies / 74

DISCUSSION GUIDES

INTRODUCTION

- ▶ OUR STORY
- ▶ OUR APPROACH
- ▶ ABOUT THIS CASEBOOK



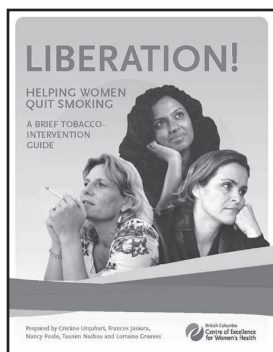
Our Story

ABOUT US

The mission of the British Columbia Centre of Excellence for Women's Health (BCCEWH) is to improve the health of women through innovative research and the development of women-centred programs, practices, and policies. We are proud to have established the first research program on girls, women, gender and tobacco in 1997, based in Vancouver, Canada. In this program, we have worked with partners in women's health across the world as well as a range of communities and populations across Canada, including Aboriginal groups, young women and girls, pregnant women, low income women, and expectant and new fathers.

Drawing upon 15 years of research, intervention design and knowledge translation at the BCCEWH, this casebook profiles a range of issues concerning girls, women and smoking for local, national and global audiences of health care and social service providers, researchers, program planners, policy makers, and women. This casebook takes on some complex issues in a practical way and provides links to resources and support for individuals and organizations working with women and tobacco related issues.





We promote a women-centred approach to the health of girls and women. This casebook is a companion document to *Liberation! Helping Women Quit Smoking: A Brief Tobacco Intervention Guide*, which details women-centred approaches to brief interventions. It moves beyond discussing the health impacts of smoking on women and shifts attention towards innovative approaches to reducing the impact of tobacco on diverse groups of girls and women in a variety of settings. In addition, it provides an overview of our legacy of work on women, girls and tobacco.

OUR WORK

As you will see, the effects of tobacco use and exposure are not uniformly experienced across global populations nor are tobacco control policies and programs. Some of the key factors affecting these patterns are sex and gender related factors, ethnicity, socioeconomic status and regional location. Our work in tobacco has consistently analysed existing and proposed tobacco control efforts with all of these factors in mind.

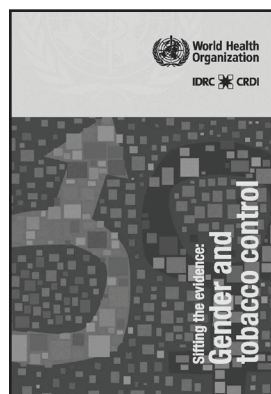
This work has taken us down many paths. We have worked at the international level, with the International Network of Women Against Tobacco (INWAT) and the World Health Organization (WHO) and in countries such as the United Kingdom, United States of America, Australia and Argentina. In addition, we have worked with a range of communities across Canada, including Aboriginal groups, young women and girls, pregnant women and

mothers, low income women and expectant and new fathers. We have worked with other researchers, health providers and policy makers, and often tried to blend all of these groups together to learn from each other and enrich our mutual understanding of the issues facing women and girls. We have addressed the impact of tobacco policies, examined the effects on different groups of women and men and made suggestions for introducing a sex, gender and diversity analysis to policy making on tobacco. As well, we have focused on programs and interventions – trying to discover, in collaboration with women and providers, what works and what doesn't, to prevent or reduce tobacco use among girls and women.

KEY ASPECTS OF OUR WORK

HELPING TO REDUCE THE SIZE AND IMPACT OF THE GLOBAL EPIDEMIC OF WOMEN'S TOBACCO USE

The overall rates of smoking are on the decline in high income countries like Canada. However, in low and middle income countries, rates of women's smoking are on the increase. Men's global smoking rates have peaked and are declining, but the true scope of the epidemic for women, globally, is yet to be seen. Hence, it has been important to clearly understand trends in girls' and women's relationship to tobacco use and tobacco production within Canada and internationally. Here, these issues are reflected in the sections on worldwide trends in women's tobacco use and the role of



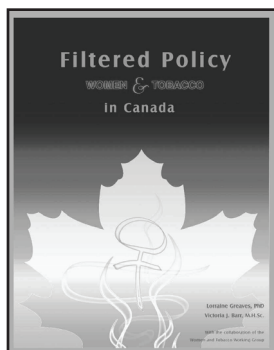
women in the cultivation, manufacturing and marketing of tobacco.

CLARIFYING AND IMPROVING THE EVIDENCE BASE

Often there is a gap in the evidence on women's health, including on the effects of tobacco. We have assessed and added to the evidence by integrating sex, gender and diversity-related factors into research, programmes and policy work in order to identify what might work for women (and men) and what policy impacts might be affected by gender inequities. We have conducted numerous systematic reviews on tobacco use in vulnerable populations, smoking during pregnancy and postpartum, workplace tobacco policies, tobacco prevention in youth, and partner support for smoking cessation during pregnancy. We have conducted qualitative research to better understand the experiences of women and their relationship with tobacco and designed interventions and tested them on various populations of women. These issues are reflected in the casebook in the sections on pregnancy and smoking, indigenous women and tobacco, group programming for low-income women, and the effects of second hand smoke.

DEVELOPING TAILORED TOBACCO INTERVENTIONS

In the 1980s, practically the only topic addressed under the “women and tobacco” banner was smoking during pregnancy. The approaches were almost exclusively centred on

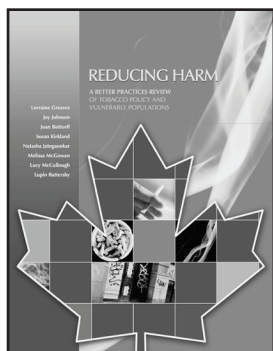


fetal health, and did not address smoking as a women's health issue. Consequently, a range of interventions focused just on the pregnancy period, and often produced temporary cessation followed by postpartum relapse. None of this was good for women's or infant and children's health. We have done two systematic reviews of smoking during pregnancy and postpartum for girls and women, and identified best practices with these groups.

We have been involved in several projects to develop and test appropriate smoking cessation interventions for diverse groups of women. We have examined the role of sex and gender in tobacco dependence treatment for women and men in drug treatment settings, and explored the efficacy, safety, and sex/gender differences in the use of varenicline as an aid to smoking cessation in a population of methadone maintained opioid dependent patients. We have studied the evidence and better practices in the tobacco research and women-centred care fields to develop a women-centred approach to tobacco dependence treatment. We have created an approach to women-centred tobacco dependence treatment based on existing evidence and meetings with key stakeholders, and have shared this approach with women and health care providers.

Ultimately, our goal is to support the development of smoking cessation and tobacco dependence treatment programs that also address other issues occurring in both women's and men's lives, recognizing a range of gender, diversity and equity issues. These

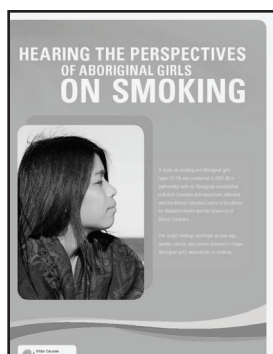




themes are explored in the sections on brief interventions for health care providers, women-specific cessation programs, developing tobacco control initiatives for diverse populations, and the development of digital media and social media resources.

UNDERSTANDING THE LINKS BETWEEN TOBACCO, TRAUMA AND WOMEN'S SUBSTANCE USE

In our work it has become clear that some sub-groups of women are more vulnerable to tobacco use and may continue smoking longer than others. In the past few years, we have conducted research on the complex relationships among tobacco use, violence and trauma and substance use issues for girls and women. Our aim is to apply this understanding in shaping practice, programs and policy to improve responses to women affected by substance use and addiction, and violence. This has required the development of partnerships with governments and service providers in trauma, addictions and mental health settings, to identify potential steps for promoting the implementation of tobacco interventions as routine care, integrated into services treating women for trauma-related, mental health and addiction problems. These issues are explored in the sections on integrating tobacco interventions into addictions treatment and using smoking cessation aids with pregnant and early parenting women who are affected by substance use and/or violence.

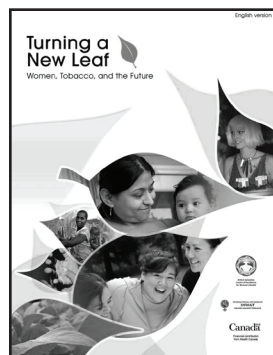


UNDERSTANDING THE EFFECTS OF TOBACCO CONTROL POLICIES

One of the most important areas of our work has been in interpreting the effects of generic tobacco policies on women, men and vulnerable subpopulations. We have looked at the differential effects of secondhand smoke (SHS) policies, and consequences of the introduction of smoking location restrictions for women and men of varied income levels. We have examined how the experience of smoking restrictions and the management of SHS is influenced by the social context (relationship with a partner, family member or stranger), space of exposure (outdoor/public or private space) and social location of individuals involved (gender, income, control of resources), and how these factors create unintended or unexpected consequences to the social and physical situations of women and men. We have examined the effects of tobacco control policies such as price and taxation, sales restrictions, and location restrictions, on vulnerable populations in Canada, including young women and men, Aboriginal peoples, and women and girls living on low incomes. These issues are explored in the sections on sex- and gender-based analysis, shadow reporting, and secondhand smoke.

LINKING TOBACCO USE AND WOMEN'S EMPOWERMENT

The work we started in 1997 in the Tobacco Research Program has mushroomed from looking at girls and women and tobacco into a more complex assessment of both biological



and social factors affecting women and men, vulnerabilities, disadvantages, income, culture and experiences such as mental illness, trauma, violence, and substance use as key issues affecting tobacco use, research, policy and programming. Overall, we have consistently addressed the theme of gender and social inequity and how these affect experiences with tobacco. The quest for women's empowerment is at the heart of many global movements towards change and this is reflected in our work on tobacco and throughout this casebook.

Our Approach

Tobacco use is a complex phenomenon, affected by a range of social, political, cultural and economic factors. However, its use and exposure has consistently been gendered. Numerous frameworks have been developed to help us understand the causes, influences, and solutions to global tobacco use. These frameworks remind us that tobacco use is more than a health issue and that addressing tobacco use and exposure, especially in girls and women, requires paying attention to all of these social, political, cultural, and economic factors. Our approach is informed by the following three key ideas.

**Without health,
women cannot prosper.
Without gender
equity, women will
continue to experience
barriers to achieving
and maintaining good
health.**

1. TOBACCO USE IS CONNECTED TO GENDER EQUITY.

There is a link between women's empowerment (as measured by economic and political participation) and smoking. As women's status increases in a country, women's use of tobacco also rises. Understanding this relationship is important so that women's tobacco use can be lowered while still ensuring that women's socioeconomic status continues to improve. While we are concerned with preserving the health of women around the world, we are equally concerned with improving women's economic, political, and social empowerment and progress. Tobacco use and gender equity

are linked. Without health, women cannot prosper. Without gender equity, women will continue to experience barriers to achieving and maintaining good health.

We advocate for and support the development of gender-transformative approaches to addressing women and tobacco. Gender-transformative approaches actively strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender equity objectives (Rottach *et al*, 2009). Often, strategies that focus on tobacco reduction in women simply rely on or reinforce women's traditional roles and responsibilities - for example, by focusing exclusively on quitting smoking during pregnancy or when around small children.

Gender-transformative approaches actively strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender equity objectives.

Gender transformation involves identifying the ways that gender discrimination, inequality or oppression operates in a particular situation and taking feasible steps toward improving these conditions – even if the result would still be considered regressive by the standards of another context or situation. Gender-transformative approaches encourage critical awareness among men and women, of gender roles and norms; promote the position of women; challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers or traditional leaders.

2. TOBACCO USE IS A WOMEN'S HEALTH ISSUE AND A HUMAN RIGHTS ISSUE.

We all have fundamental rights such as the right to health, the right to life and the right to a safe, clean environment. However, in a world of gender inequity, addressing issues related to women and tobacco is integral to the protection of the right to health. A human rights perspective fosters the view that women's right to health is addressed by upholding women's dignity and freedom.

We support approaches to tobacco control that build bridges between public health and social justice and human rights concerns.

We support approaches to tobacco control that build these bridges between public health and social justice and human rights concerns. The 'tobacco control movement' endorses a comprehensive set of strategies including a focus on prevention, cessation, marketing, cultivation, sales, exposure, and legal and human rights protections. It is critical to support initiatives like clean air and smoke-free areas, fair labour practices, and access to quit smoking programs that meet individual needs. Given women's roles in families and communities, addressing issues related to women and tobacco promotes improved health and increased freedom for everyone.

3. TOBACCO USE HAS HARMFUL SOCIAL AND HEALTH CONSEQUENCES THAT CAN BE ADDRESSED THROUGH EVIDENCE-BASED POLICIES, ADVOCACY, AND COMMUNITY ACTION.

Evidence-based and cost-effective tobacco control strategies exist. Bans on tobacco advertising, increased tobacco taxes, controls on smuggling and counterfeiting, and legislation to create smoke-free environments in all public places and workplaces are just a few of the strategies that we know can be effective.

Some of these approaches are part of the World Health Organization's Framework Convention on Tobacco Control (WHO-FCTC), the first international public health treaty in the world. The goals of the WHO-FCTC and related recommendations for addressing global tobacco use are an important starting place. If such recommendations were fully implemented, there could be a global decrease in the number of smokers by 28% over a 10-year period (Méndez *et al*, 2012).

Given women's roles in families and communities, addressing issues related to women and tobacco promotes improved health and increased freedom for everyone.

But, this could be just part of the story. Change needs to happen from the bottom up and the top down. Women and men around the world are using creativity and local knowledge to figure out what works for their communities. When it comes to women and tobacco, the answers are still being developed through advocacy and action. We hope that this casebook will support past, present, and future initiatives towards global change.

REFERENCES

Méndez, D., Alshanteety, O., Warner, K.E. (2012). The potential impact of smoking control policies on future global smoking trends. *Tobacco Control*, doi:10.1136/tobacco control-2011-050147

Rottach, E., Schuler, S.R., Hardee, K. (2009) *Gender Perspectives Improve Reproductive Health Outcomes: New Evidence*. Washington, DC: PRB for the IGWG.

About this Casebook

This casebook is intended for a range of audiences and can be used in a number of ways. Health and social service providers looking for ways to expand their practices or to gain a stronger understanding of women and tobacco issues will find an introduction to better and promising practices for working with women. Program planners and community organizations will find resources and ideas for addressing the impact of tobacco on girls and women in their individual contexts.

Students, researchers, decision makers, and policy makers new to the field of tobacco or who are interested in learning more about applying a gender analysis to tobacco control will find a range of practical examples. Indeed, anyone who is interested in expanding their understanding of smoking from a risky individualized health behaviour to a complex social, economic and cultural issue will find lots to think about here. The casebook includes examples and resources from around the world, in order to support and encourage innovation and sharing across locations and to reduce isolation in the effort to address girls, women and tobacco.

The casebook has three sections. First, we provide an introduction to key topics in the area of women and tobacco. Second, we profile some strategies for working with women - not just women who smoke, but women whose lives are affected by tobacco. Finally, we introduce a range of strategies for advocacy and action. Throughout the casebook, we have ensured that the experiences of women are included and connected to strategies and movements for change.

The “In Sum” statements and reflective “The Next Step” questions throughout the casebook are intended to encourage reflection, integration of key ideas, and support discussion.

To assist readers in bringing a sex and gender analysis to their work on tobacco-related issues, we have included brief “In Sum” statements and reflective “The Next Step” questions throughout. The casebook concludes with a series of discussion guides for different audiences. We hope that this casebook encourages dialogue that can lead to small steps to increased understanding, advocacy and change, blending the dual goals of reducing tobacco use as well as improving the status of women and girls. The discussion guides will help support individuals and organizations in moving from self-assessment and critical reflection to planning, education, and innovation.

I. CONTEXTS & ISSUES

- ▶ GIRLS, WOMEN, AND TOBACCO:
GLOBAL TRENDS
- ▶ WOMEN WORKING IN THE HEALTH
CARE SYSTEM AND TOBACCO
CONTROL
- ▶ WOMEN AND EXPOSURE TO
SECONDHAND SMOKE
- ▶ WOMEN WORKING IN TOBACCO
PRODUCTION
- ▶ INDIGENOUS WOMEN AND
TOBACCO



Girls, Women, and Tobacco: Global Trends

IN SUM

While global tobacco-use trends among men are now declining, overall tobacco use among girls and women are continuing to rise in the 21st century.

SOURCE

Eriksen, M., Mackay, J., and Ross, H. (2012). *The Tobacco Atlas. Fourth Ed.* Atlanta, GA: American Cancer Society; New York, NY: World Lung Foundation. Available from: www.TobaccoAtlas.org

RESOURCES

Greaves, N. Jategaonkar, and S. Sanchez (Eds.). *Turning a New Leaf: Women, Tobacco, and the Future.* British Columbia Centre of Excellence for Women's Health (BCCEWH) and International Network of Women Against Tobacco (INWAT). Vancouver: British Columbia Centre of Excellence for Women's Health. Available from www.bccewh.bc.ca

Samet, J.M. and Yoon, S-Y. (Eds.). (2010). *Gender, women, and the tobacco epidemic.* World Health Organization. Press: Geneva, Switzerland. Available from www.who.int

Nearly 20 percent of the world's population smokes cigarettes, including about 800 million men and 200 million women. Global rates of male smoking have peaked, while rates of women's smoking are on the rise. The World Health Organization predicts that the prevalence of smoking among women worldwide will be 20 percent by 2025 - a sharp contrast to the 12 percent of the world's women who smoke today.

In countries where women have been smoking for some time, tobacco related deaths are high. In other countries the historical gender gap between girls' and boys' tobacco use is narrowing. Successfully addressing tobacco-use trends requires interrupting the rise in women's tobacco use as well as women's exposure to secondhand smoke.

We present a few statistics below from the *Tobacco Atlas* produced by the American Cancer Society and the World Lung Foundation which provides a glimpse at patterns of tobacco use among girls and women around the world today.

- More than half of all countries have a female smoking prevalence rate of less than 10%.

- There are at least 49 countries in which ten times more men than women smoke.
- In contrast, in most of the world, the difference in smoking rates between girls and boys is small. In fact, more girls smoke than boys in at least 25 countries.
- Sweden and Nauru are the only two countries in the world where smoking prevalence is higher among women than men.
- In some countries, like Finland and Egypt, men use smokeless tobacco products (such as snuff, snus, or gutka) in much greater numbers than women because such products are perceived as masculine.
- In countries like South Africa, Thailand, and Bangladesh, women use smokeless tobacco products more than men because they are seen as a discreet way to consume tobacco.

THE NEXT STEP

1. *Globally, tobacco use is increasing for girls and young women, and in some cases surpassing rates for boys. How does this fit with your experience?*
2. *What policies and services are in place in your community/region/country that directly address girls' and women's tobacco use?*

PLACES WHERE SUBSTANTIALLY MORE GIRLS THAN BOYS SMOKE CIGARETTES

(ages 13-15, 2010)

Country	% Boys	% Girls	% More Girls
Chile (Santiago)	28.0	39.9	11.9%
Argentina	21.1	27.3	6.2%
Uruguay	16.4	22.9	6.5%
Cuba	8.7	13.1	4.4%
Brazil (Sao Paulo)	9.2	13.2	4%
Bulgaria	24.4	31.6	7.2%
Slovenia	15.2	23.0	7.8%
Sweden	5.0	13.0	8%
New Zealand	14.5	20.6	6.1%

RELATED:

- Women and Exposure to Secondhand Smoke, p. 8
- Indigenous Women and Tobacco, p. 18

Women Working in the Health Care System and Tobacco Control

IN SUM

Women health care providers can play multiple roles in tobacco control. For example, introducing gender analysis into the design and delivery of programmes; supporting the development of women-specific smoking cessation programs within their professional organizations; advocating for smoke-free hospitals; and improving health curricula to include information on gender, women and tobacco use and cessation.

Research has shown that brief counselling by health care providers on the harms of smoking and the importance of quitting is one of the most cost-effective methods of reducing tobacco use. Given the health consequences of tobacco use, few would argue that health care workers, including physicians, nurses, midwives, dentists, psychologists and pharmacists, have an important role to play in the tobacco control movement.

Historically, many health care providers have had an ambivalent relationship with tobacco use. Images of physicians and nurses have been used in advertising to support the supposed safety of cigarettes, to glamorize women working in health care, and to encourage tobacco use in health care workers. In some countries, rates of smoking in certain groups of health care providers remain higher than rates in the general population. In many countries, rates of smoking have stabilized or declined in men but are still increasing for women, a trend reflected in smoking rates in health care workers.

In the past thirty years, individual health care providers and health professional organizations have become involved in addressing tobacco use in a range of ways. As many health care professions are predominately made up



NURSE IN A SMOKING ADVERTISEMENT, 1932. Source: <http://tobacco.stanford.edu/tobacco>

of women, women are often taking a leadership role in supporting cessation efforts, developing programming, and advocacy (e.g., efforts to make hospitals smoke-free). As just one example, in 1999, the 600,000 member Japanese Nursing Association, Japan's largest women's professional organization, campaigned to stop smoking among nurses and to make hospitals smoke-free. The rate of smoking among nurses (25.7%) was twice that of all Japanese women in 2001. JNA published booklets on quitting smoking and organized many seminars to train leaders for cessation programmes. In 2006, the nurses' smoking rate had dropped by 6% to 19%.

PERCENT OF COUNTRIES WITH SMOKE-FREE HEALTH FACILITIES (2010 or latest available, World Tobacco Atlas, 2012)

Region	Percent
Americas	49%
Europe	64%
Eastern Mediterranean	59%
Western Pacific	44%
South-east Asia	100%

SOURCES

Malone, R. E. (2006). Nursing's Involvement in Tobacco Control: Historical Perspective and Vision for the Future. *Nursing Research*, 55(4S): S51–S57.

Schwarz, T. (2004). Nightingales vs. Big Tobacco. *The American Journal of Nursing*, 104(6); 27.

WHO Tobacco Free Initiative. (2005). The role of health professionals in tobacco control. World Health Organization. WHO Press: World Health Organization. Available from <http://www.paho.org/english/ad/sde/ra/bookletWNTD05.pdf>

WHO/CDC Global Health Professional Survey (GHPS). (2005). *Tobacco Use and Cessation Counseling*. Global Health Professionals Survey Pilot Study, 10 Countries, 54(20); 505-509. Available from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5420a2.htm#tab2>

RESOURCES

The NET (special issue on nurses and tobacco control), E-zine of the International Network of Women against Tobacco
September 2009-February 2010 issue

Available from: <http://archive.oxha.org/knowledge/publications/INWAT%20newsletter%20Sept%2009.pdf>

The Nightingale Nurses
www.nightingalesnurses.org
Includes sample letters to send to newspapers, tobacco companies, and magazines that include tobacco advertising.
Information about the tobacco industry and resources for nurses to help smokers quit.

Outsmart Tobacco
www.outsmarttobacco.org
The blog of nurse, Joan O'Connor, includes a range of resources that nurses can use with their clients.
Since 2008, Joan has been keeping track of every cigarette not smoked by members of her 'Tobacco Fighters and Survivors Club,' a smoking reduction and cessation group for people living with mental illness.

Tobacco Free Nurses
www.tobaccofreenurses.org

THE NIGHTINGALE NURSES

The Nightingale Nurses are a group of nurse activists who volunteer to educate nurses and the public about the tobacco industry. The Nightingales group was founded in 2004 after Ruth Malone, a nurse researcher at the University of California, San Francisco, uncovered hundreds of letters while conducting research using internal tobacco industry documents that were released in the 1990s. The letters had been sent by consumers and their grieving families from across the country to tobacco companies, asking them to stop sending coupons, catalogs, birthday cards, and other materials in the mail. The letters became one way to draw public attention to the actions of the tobacco industry and its contributions to tobacco-related disease and illness.

In 2011, the group had about 200 members. The group uses a range of strategies to challenge the tobacco industry. Since 2004, the Nightingales have attended annual shareholder meetings of tobacco companies after members have bought a company share in order to become a shareholder. At the meetings, they voice their concerns as health care providers who witness the negative effects of tobacco products and question claims of social responsibility. The first meeting attended was at Altria/Philip Morris, the largest multinational tobacco company in the world. At that meeting, one of the Nightingales asked the board members and directors for two minutes of silence to remember the people she cared for who had died due to tobacco use.

The Nightingales Nurses have also launched the RN2Q1 campaign. The campaign encourages every nurse to help at least one

person to quit tobacco every year. Other activities include targeting tobacco advertising and marketing practices.

THE NEXT STEP

1. *What have you noticed about how tobacco issues for women in particular, are treated within the health care system?*
2. *Who are (or might be) leaders in promoting action on women and tobacco in your community/region/country?*

RELATED:

- Women-centred Brief Interventions by Health Care Providers , p. 32
- Women-centred Approaches to Smoking Cessation Drugs and Nicotine Replacement Therapies, p. 42

Women and Exposure to Secondhand Smoke

IN SUM

Approximately 75% of the 600,000 non-smokers who died from secondhand smoke exposure in 2011 were women and children. Yet, women and children do not always have the power to control their exposure in homes, workplaces or communities.

SOURCES

Greaves, L.J. and Hemsing, N.J. (2009). Sex, gender, and secondhand smoke policies: implications for disadvantaged women. *American Journal of Preventive Medicine*, 37(2S): S131–S137.

Johnson, K.C., Miller, A.B., Collishaw, N.E., et al. (2011). Active smoking and secondhand smoke increase breast cancer risk: the report of the Canadian Expert Panel on Tobacco Smoke and Breast Cancer Risk. *Tobacco Control*, 20:e2.

World Health Organization. (2010). "Ch. 5 Secondhand Smoke, Women and Children." In Samet, J.M. and Yoon, S-Y., (eds) *Gender, women, and the tobacco epidemic*. (pp. 65-101). WHO Press: Geneva, Switzerland.

Secondhand smoke (SHS) is the combination of smoke from the burning end of a cigarette and the smoke exhaled by the smoker. Deaths from smoking are directly related to both active smoking and exposure to secondhand smoke. As smoking prevalence worldwide is higher among men than women, the issue of secondhand smoke has particular implications for women, particularly in countries with a high male and low female smoking prevalence. Worldwide, 75% of the approximately 600,000 nonsmokers who died in 2011 from involuntary exposure to secondhand smoke were women and children. Exposure to secondhand smoke most commonly occurs in the home, workplace, and public areas and is risky for all, but especially risky for infants, children, and pregnant women.

NUMBER OF GLOBAL DEATHS CAUSED BY SECOND HAND SMOKE IN NONSMOKERS (2004 data, World Tobacco Atlas, 2012)

	Number	Percent
Men	156,000	26%
Women	281,000	47%
Children	166,000	28%

Total might not sum due to rounding

Exposure to secondhand smoke increases the risk of lung cancer and ischemic heart disease among nonsmokers. Children exposed to SHS are at increased risk of bronchitis, asthma attacks, pneumonia, middle ear disease,

sudden infant death syndrome, and a reduction in lung function. Nonsmoking women who are exposed to SHS have a greater chance than men of developing respiratory diseases, particularly lung cancer. Exposure to SHS also increases the incidence of breast cancer in premenopausal women and increases the risk of pregnancy complications. It can also cause serious adverse fetal outcomes.

TOBACCO SMOKE AS A CAUSE OF BREAST CANCER IN YOUNG WOMEN

Breast cancer is the most common cancer in women worldwide and is the principal cause of death from cancer among women globally. The first research study demonstrating a relationship between SHS and lung cancer was published in 1981 by Takeshi Hirayama. Then, in the early 1990s, Hirayama observed that the same group of women exposed to SHS experienced an increase in the risk for breast cancer. 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 1.12–2.66)) when their husbands smoked more than 20 cigarettes per day. Unfortunately, this research was largely ignored. It wasn't until 2009 that the Canadian Expert Panel on Tobacco Smoke and Breast Cancer Risk concluded that exposure to secondhand smoke could lead to breast cancer in younger, primarily premenopausal, women. While questions remain as to the mechanisms of secondhand smoke for different groups of women, the scientific community now acknowledges that both active and passive smoking are a cause of breast cancer in women.

RESOURCES

Eriksen M, Mackay J, Ross H. (2012). *The Tobacco Atlas*. Fourth Ed. Atlanta, GA: American Cancer Society; New York, NY: World Lung Foundation. Available from: www.TobaccoAtlas.org

The Heather Crowe Campaign
<http://www.smoke-free.ca/heathercrowe/heathers-story.htm>

THE NEXT STEP

1. *What do you think could be done in your community to support women exposed to secondhand smoke in the workplace, in public transportation, or in the home?*
2. *How do you think women could be supported in increasing their ability to influence where smoking is allowed? How do you think men could be influenced to reduce women's exposure to SHS?*

RELATED:

- ▶ Girls, Women, and Tobacco: Global Trends, p. 2
- ▶ Harm Reduction Support Strategies for Mothers who Smoke, p. 28
- ▶ Sex- and Gender-based Analysis and Tobacco Policy, p. 68
- ▶ Diversity, Equity, and Secondhand Smoke Policies, p. 74

Women Working in Tobacco Production

IN SUM

The labour of women and girls is key to the global production of tobacco, from farming to processing, manufacturing, and marketing. However, women face challenging, unsafe and unrewarding conditions in these jobs.

Tobacco is the world's most widely cultivated commercial non-food crop. Yet, in 2000, just four multinational companies dominated the global tobacco market, holding 70 percent of the market share. As the international tobacco industry becomes ever more powerful and consolidated, the cheap (or often unpaid) labour of women is a key factor that ensures the large profit margins of tobacco multinationals. While the labour of women and girls is key in the global production of tobacco, from farming to processing, manufacturing, and marketing, they face challenging and often unrewarding conditions in these processes.

With increasing regulation of tobacco companies and anti-smoking measures in high income countries, these companies have slowly moved their activities to low and middle income countries. Although the global headquarters of all major tobacco companies are still in industrialized countries, since the 1960s, the bulk of tobacco production has moved from the Americas to Africa and Asia. This has not only spread tobacco use, but also contributed to food crop replacement and food insecurity, environmental degradation, deforestation and poverty.

Tobacco is grown primarily in low- and middle-income countries and occupies 3.8 million hectares of land. World tobacco production peaked in 1997 at over 9 million

WHAT IS GREEN TOBACCO SICKNESS?

Green tobacco sickness (GTS), which is a major occupational illness found among tobacco workers, is brought about by the absorption of nicotine through the skin from contact with wet tobacco leaves. Symptoms of GTS can include nausea, vomiting, weakness, headache, dizziness, abdominal cramps, difficulty in breathing, and fluctuations in blood pressure and heart rates. A study of Hispanic migrant workers in North Carolina suggests that 41 percent of workers get GTS at least once during harvest season. Furthermore, tobacco plants require large and frequent applications of pesticides, such as Aldicarb, Chlorpyrifos, and 1,3-Dichloropropene, which are highly toxic and have been associated with respiratory, nerve, skin, liver, and kidney damage. A study among indigenous Huichole Indians working on tobacco plantations in Mexico highlighted the hazards of chronic exposure to pesticides – from extreme birth defects in children born to women who have worked in the fields to incidences of deaths from aplastic anaemia, a blood disease associated with chronic exposure to organochlorine pesticides.

tonnes and has since declined by almost a quarter to 7.1 million tonnes in 2009. Tobacco is often sourced by companies through contract farming where companies lend materials and equipment to farmers but buy their harvest only if it meets certain standards. Usually, women are not the contract holders, but provide the labour for the cultivation. Women and children also work in exploitative conditions in other key aspects of the tobacco industry, including processing, bidi rolling, cigarette manufacturing and sales.

SOURCES

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<http://www.ceche.org/publications/infocus/winter2011/InFocus-winter2011.pdf>

Eriksen M, Mackay J, Ross H. (2012). *The Tobacco Atlas*. Fourth Ed. Atlanta, GA: American Cancer Society; New York, NY: World Lung Foundation. Available from: www.TobaccoAtlas.org

Fair Trade Tobacco.org: A Resource on Tobacco Industry Agriculture Exploitation
www.fairtradetobacco.org

Greaves, L., Jategaonkar, N. and Sanchez, S. (Eds.) *Turning a New Leaf: Women, Tobacco, and the Future*. British Columbia Centre of Excellence for Women's Health (BCCEWH) and International Network of Women Against Tobacco (INWAT). Vancouver: British Columbia Centre of Excellence for Women's Health. Available from www.bccewh.bc.ca

Roshni website
www.roshniindia.org

Estimates suggest that women globally perform more agricultural labour than men. “Cash” crops (such as tobacco, cotton, coffee, and tea), as differentiated from “subsistence” crops, are grown for the market and are often exported. Tobacco farming, being exceptionally labour intensive, relies heavily on the labour of women – and often, of children – who are in turn exposed to the hazards of handling and processing raw tobacco. High frequencies of tobacco farming-related illnesses, deaths, and birth defects have been observed in a growing number of communities, including higher risks of developing cancers and liver cirrhosis. Children may also experience stunted growth.

Green tobacco sickness and other farming-related illnesses are more prevalent where facilities for the safe disposal of chemicals are more scarce and where regulation of tobacco companies for the protection of farmers is lax – that is, in poorer regions and developing countries. Due to the prohibitively high costs and lack of knowledge regarding protective clothing and equipment, many workers in these regions do not use such safety measures.

Before reaching the consumer, tobacco passes through several processes in which women and girls are usually heavily involved, starting with the curing of tobacco leaves. Curing can take between 7 and 10 days per batch. Throughout, wood is fed into the tobacco barns’ furnaces, in what amounts to a 24-hour operation. There are many reports of children being kept out of school to help with curing during which time they are at risk from continuous inhalation of tobacco particles and fumes.

WHAT DOES IT FEEL LIKE TO BE A PREGNANT WOMAN FARMING TOBACCO IN KENYA?

In 2011, Mary Okioma from Women for Justice in Africa and Marty Otañez, professor of political ecology, Anthropology Department, University of Colorado, Denver collaborated with the International Labor Rights Forum to examine the role of children and pregnant women as laborers on tobacco farms. One of the project outcomes was a short video documenting the conditions of women working in the tobacco fields in Kenya. The video can be viewed at <http://www.fairtradetobacco.org>.

Below is a transcript of an interview in the video.

"I am 8 months pregnant and I cannot do hard work. When I got pregnant, I continued to work on the tobacco farm. I was able to do all the work required right from the seed beds to the field, but I am tired and cannot continue to work. Last Saturday, I picked tobacco. That is the last time I worked on the farm due to exhaustion. That evening I had sore joints. I was forced to take painkillers.

One morning in March 2010, I woke up to dig. I went to the field and I was fine, then I cut myself when I was weeding tobacco with my hoe. I told Mastermind tobacco company that I was hurt but it did not help me. I went to the hospital and I was treated. The doctor gave me a tetanus shot and I returned home. During that week I was unable to work on the farm.

When someone is pregnant, working on a tobacco farm can hurt the baby. I do not know if pesticide spray can harm a fetus.

RESOURCES

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After I harvest the tobacco I bring it into the house for tying and curing. After three days the tobacco is dry and I take it to my house where I sleep. I have to sleep with it in my house to prevent the tobacco from being stolen. The tobacco [stored in my house] emits a smell. When I smell it, I feel like I have a cold and I develop chest problems. [In 2010] the problems forced me to go to the hospital. When I got to the hospital, I told the doctor my problems. The doctor diagnosed me with asthma and treated me.

When there is work on the farm, I am forced to withdraw my children from school to help me harvest and do other jobs on the farm. The children I hire for work on the tobacco farm are 15 years old and younger. The youngest child is around 8 years old. The children work for 7 or more hours a day. If Mastermind sees the children tying tobacco, the company will not ask any questions. The company knows that children work on tobacco farms.”

In a 2002 comprehensive survey by the International Labour Organization (ILO), the scale and conditions of women's and girls' underpaid and informal labour in India's bidi (small, hand rolled cigarettes) sector were studied. While bidis are manufactured in both factory and home-based operations, women and girls often do piecemeal home-work in regions where social factors encourage females to work within the home. In India's bidi sector, approximately half of the workers carry out their work from the home, without a regular salary or wages. 81% of the household workers are female. Child workers, 93% of whom are girls, account for 11% of the total

number of workers. The work of bidi rolling, especially among home-workers, is marked by low earnings and hours so long that combining work with education is practically impossible.

Bidi buyers gain from the low status of women, using the situation to enforce low wages and refuse benefits to female workers. However, bidi rolling is one of the few income-generating opportunities for many women. The need to protect their livelihoods can complicate efforts to improve conditions. For example, in response to a recent proposal by the government of India, the Self-Employed Women's Association (SEWA) opposed the idea of increased taxes in the bidi-manufacturing sector since it employs many women, even though this tobacco control measure could ultimately improve the health of women.

Excerpt from Khafan, M. and Waverly, L. (2006). "Chapter 3. From the Fields to the Consumer." In L. Greaves, N. Jategaonkar, and S. Sanchez (Eds.) *Turning a New Leaf: Women, Tobacco, and the Future* (pp. 28-31). British Columbia Centre of Excellence for Women's Health (BCCEWH) and International Network of Women Against Tobacco (INWAT). Vancouver: British Columbia Centre of Excellence for Women's Health. For the full chapter and references, download from www.bccewh.bc.ca

THE NEXT STEP

1. Tobacco is often considered a "cash" crop as opposed to a "subsistence" crop. What role does your country play in the economics of tobacco? And what role do women have in this?
2. Tobacco farming and processing have become economically important to the livelihood of many people. What kinds of programs are needed to support shifts away from these activities towards more sustainable and ethical practices?

ECONOMIC EMPOWERMENT AND TOBACCO CONTROL INITIATIVES

The economic effects of tobacco are many and varied. For those smokers who are dependent, the costs of buying cigarettes or tobacco products becomes a large pressure on their budgets. For women and families on low incomes, tobacco dependency is even more of a financial pressure, and barrier to mobility. For women and communities in areas where tobacco is grown or manufactured there is a range of negative effects on agriculture, food supply, environment, soil degradation, labour practices and health. These issues are particularly resonant for women and families in low-income countries, but they also affect low-income women in higher income countries. In short, tobacco introduces a range of economic pressures on women and families and communities, threatening overall health through food insecurity, threatened nutrition and the need to support tobacco dependency.

In 2004, two non-governmental organizations, the Center for Communications, Health and the Environment (CECHE) in the USA and Roshni in India, launched a Tobacco Control Communications Program which ran an initiative that focused on both tobacco control and economic empowerment. CECHE's work focuses on addressing the health effects of environmental pollution while Roshni is committed to educating women and children (Roshni's motto is "Help educate a woman and you help educate a family"). Based in Chennai city, Tamil Nadu, India, Roshni works in several villages in South India, including Pattur. The purpose of the joint program was to help transition individuals in Pattur out of tobacco-related trades and

into other professions, including garment design and production.

When the program started, Pattur had a population of approximately 2500 families whose main source of income was from rolling tobacco leaves to make beedis (small, unfiltered cigarettes). Most of the village population was heavily involved in making beedis and there was a high prevalence of beedi smoking, even among young children. Program plans included the formation of self help groups, introducing micro credit schemes, non-formal education, vocational training, health and hygiene classes and camps, and income generating skills.

In 2005, 61 girls who underwent training at Roshni's tailoring school were awarded two-month apprenticeships at a nearby leather factory and started earning monthly salaries. Similarly, six boys got into workshops in the leather industry after completing a vocational course offered through the program. In the last 3 months of 2005, an additional five members from different families in Pattur quit smoking. In the first year alone, as many as 100 individuals and nine families gave up beedi production for other professions, including garment design, tailoring and embroidery, leather goods production and grocery/shop businesses. Overall, the program evaluation showed that by the end of the two year project, only 250 families earned their living through beedi rolling and smoking rates had dropped by 60%.

RELATED:

- Sex- and Gender-based Analysis and Tobacco Policy, p. 68
- Diversity, Equity, and Secondhand Smoke Policies, p. 74

Indigenous Women and Tobacco

IN SUM

In many parts of the world, the prevalence of tobacco use is higher in indigenous groups than in the general population - often two to three times higher. The design of approaches that reach and involve indigenous women in tobacco prevention and cessation tailored to their culture is critical.

In some indigenous cultures, tobacco is considered a sacred plant and was historically used in ritual ceremonies, trade, and medicine before contact with Western European culture. In North America for example, the tobacco plant, *Nicotiana rustica*, grown by some Aboriginal peoples was considered sacred. In contrast, the tobacco plant *Nicotiana tabacum* introduced by the Europeans is often considered non-sacred with its emphasis on recreational and commercial use.

In many of the traditional indigenous cultures of continental Asia, Indonesia, Papua New Guinea, South America, Africa and Australia, smokeless tobacco, such as chewing tobacco or snuff, was more commonly used than cigarettes. In Central Australia, the chewing of wild tobacco plants by Aboriginal groups remains common. One study found that over 30% of Aboriginal women who gave birth at Alice Springs Hospital regularly chewed pituri.

Not all indigenous groups have a traditional relationship with tobacco. For these groups, tobacco was introduced with colonization. In many parts of the world, tobacco took on new significance as a trade commodity in the context of colonialism and the dramatic social, economic, and political changes to the lives of indigenous groups around the world.

TOBACCO-WISE CAMPAIGN



Many tobacco cessation programs for indigenous groups explore the differences between traditional and commercial tobacco. In this campaign by Cancer Care Ontario and its partners, being “tobacco-wise” means recognizing this difference.

Source: www.tobaccowise.com

SOURCES

Aboriginal Tobacco Program
Prevention and Cancer
Control (Ontario, Canada)
www.tobaccowise.com

BC Centre of Excellence for
Women's Health
*Hearing the Perspectives of
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Study Findings*
Available from: www.coalescing-vc.org

Kohrmann, M. and
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Ratsch A, Steadman KJ
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The pituri story: a review
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Today, in many parts of the world, the prevalence of tobacco use is higher in indigenous groups than in the general population - often two to three times higher. In some areas, girls' and women's rates are higher than those of boys and men. However, tobacco control efforts must address a wide range of gender, geographic, cultural and language diversity within and across indigenous communities. Many programs and policies have failed to sufficiently involve indigenous communities in their development. Many programs are simply adapted from mainstream programs, with an educational component on traditional tobacco use. To date, most programs developed for

RESOURCES

Centre for Excellence in
Indigenous Tobacco Control
(Australia)
www.ceitc.org.au

Pearce, D., Schwartz,
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and Aboriginal People
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child-encyclopedia.
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Smoke Traders (Canada)
A documentary about the
controversial involvement
of the Mohawk Nation in
Canada with the tobacco
trade. Available from:
[ww3.tv.o.org/video/180204/
smoke-traders](http://ww3.tv.o.org/video/180204/smoke-traders)

indigenous women have focused on pregnant women, partly stemming out of concern for the developing fetus.

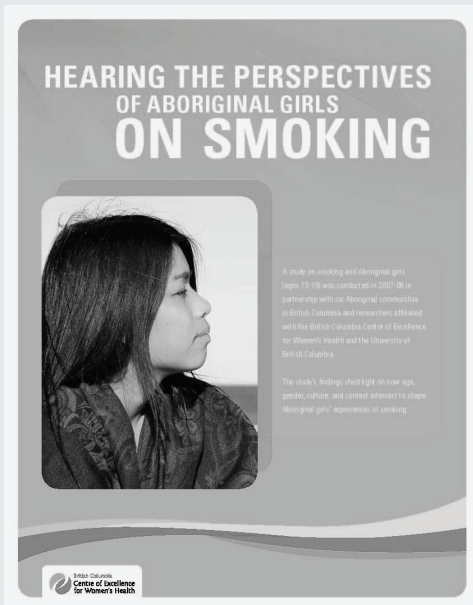
Many mainstream tobacco control efforts have had limited effect as they fail to address the social, cultural and economic circumstances of many indigenous women and girls (e.g., poverty, racism, inadequate housing). This requires policy changes that often fall outside of the traditional purview of tobacco control and health care, posing difficult challenges for tobacco control. Indigenous women and men have also been harmed by the tobacco industry through advertising that exploits and manipulates traditional cultural associations with tobacco and, more recently, through the involvement of indigenous groups in the manufacturing and sale of illegal cigarettes.

PERSPECTIVES OF ABORIGINAL GIRLS ON SMOKING

Smoking rates among Aboriginal teenaged girls are the highest of any group in British Columbia, Canada. 32% of female Aboriginal teenagers report current smoking, compared with 22% of Aboriginal male teenagers, 17% of all BC female teens, and 13% of all BC male teens. As a way of learning more about initiatives that can help to address smoking, a study on smoking and Aboriginal girls (ages 13-19) was conducted in 2007-08 in partnership with six Aboriginal communities in British Columbia.

Peer pressure, family context, experiences of colonialism and discrimination, access to cultural knowledge, gendered roles and

responsibilities, stress, and co-substance use, were some of the factors that girls identified as influencing their smoking.



THE NEXT STEP

1. *Does tobacco have any specific significance for indigenous people in your community/region/country?*
2. *Are there efforts underway to respectfully involve indigenous women in developing and delivering culturally and gender sensitive interventions in your community/region/country?*

RELATED:

► Sex- and Gender-based Analysis and Tobacco Policy, p. 68

II. WORKING WITH GIRLS AND WOMEN

- ▶ WOMEN-ONLY GROUP PROGRAMS FOR REDUCING AND QUITTING SMOKING
- ▶ HARM REDUCTION SUPPORT STRATEGIES FOR MOTHERS WHO SMOKE
- ▶ WOMEN-CENTRED BRIEF INTERVENTIONS BY HEALTH CARE PROVIDERS
- ▶ STRATEGIES FOR REDUCING TOBACCO USE WITH PREGNANT AND POSTPARTUM WOMEN
- ▶ WOMEN-CENTRED APPROACHES TO SMOKING CESSATION DRUGS AND NICOTINE REPLACEMENT THERAPIES (NRTs)
- ▶ GIRLS, WOMEN, MEDIA, AND TOBACCO



Women-only Group Programs for Reducing and Quitting Smoking

IN SUM

Over the past 20 years, program planners have recognized the importance of connecting women's tobacco use to other issues in their lives and that the process of quitting smoking can vary enormously from woman to woman.

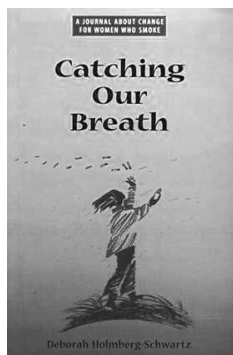
Group programming for women and peer-led group programming for women can be an effective intervention approach.

In 1988, the Women's Health Clinic, a community-based health centre in Winnipeg, Canada, started a "Women's Smoking Project." One of the outcomes of this project was the development of a group program called *Catching Our Breath*. Starting in 1989, *Catching Our Breath* support groups were facilitated in many areas of Canada. Over the course of a decade, the program evolved and adapted to different groups of women and settings.

The program took a unique approach to helping women overcome some of the problems they faced with their use of tobacco. It was based on the idea that every woman is the expert on her own life and that each woman has her own reasons for smoking and that each will have her own ways of quitting and reasons for staying smoke-free in her own time. Using this idea, the Clinic hired a woman who smoked, as the coordinator. Rather than hiring a smoking cessation 'professional', the Clinic supported the idea that 'ordinary women' can find solutions when provided with support and opportunity.

From the beginning, the program emphasized choice and options and had a wide range of goals. It was designed for women who wanted to:

- Reduce the amount they smoke
- Quit smoking
- Learn more about why they smoke
- Learn ways to relax and cope without smoking



The program included components such as: specific strategies for changing smoking behaviours, exploring self-esteem and confidence, relaxation exercises, and use of a self-help journal.

An evaluation of the group program in 1999 gives a glimpse of how the programs were implemented and the outcomes for women. In 1996, there were five groups run in a workplace setting. This consisted of an on-site program in the workplace for 10-12 weeks for 1-1.5 hours. Four groups were run in community agencies serving various populations (e.g., parents living on low income, women using mental health services) and these groups ran for eight weeks, for two hours each session.

At the end of the program, about 75% of the women who participated in the evaluation had either stopped or reduced their smoking. But the evaluation also found a range of other positive outcomes. In addition to quitting or reducing smoking, women reported increased confidence in ability to quit, increased commitment to further address their smoking, the use of behavioral modification and monitoring techniques beyond the program

SOURCES

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RESOURCES

Women's Health Clinic (Canada)
Catching Our Breath
www.womenshealthclinic.org

Urquhart, C., Jasiura, F., Poole, N., Nathoo, T. & Greaves, L. (2012). *Liberation! Helping Women Quit Smoking: A Brief Tobacco Intervention Guide*. Vancouver, BC: British Columbia Centre of Excellence for Women's Health. Available from: www.coalescing-vc.org

THE NEXT STEP

1. *In your personal or professional experience, how does quitting smoking (or other forms of tobacco) differ between men and women? What are some of the issues that may be unique to or more serious for women?*
2. *What role does group or peer support play in reducing or quitting tobacco use?*

time frame, and ongoing use of learned self-care strategies. The program also had long-term effects on relationships. At six months, over 2/3 women were still in touch with other women in the group and about 1/3 were still in touch with the group facilitator.

In addition to quitting or reducing smoking, women reported increased confidence in their ability to quit.

Group facilitators in the Catching Our Breath groups reported that they were often surprised by the diversity of approaches women took to addressing their smoking. For example, while many smoking cessation programs advise setting a “quit day,” some facilitators started to use the term “change day” for women who would prefer to take an incremental approach to quitting smoking. Confidence also emerged as a key issue - the more confident women were about not smoking in a variety of situations, the fewer cigarettes they smoked per day. Rather than focus solely on quitting smoking, facilitators worked with women to feel supported, learn about their smoking patterns, understand the health effects of smoking, and gain confidence that they can quit.

INCLUDING GROUP SUPPORT IN TOBACCO CESSATION FOR LOW-INCOME WOMEN

What does a tobacco intervention for low-income women look like? Tobacco reduction or cessation is known to be more difficult for women living in poverty due to limited options and resources for making change, poor living conditions, stresses from parenting in limited and reduced circumstances and a range of other factors. In the development of a comprehensive support intervention for low-income women who smoke in urban centres in Canada, researchers and program planners considered the specific support needs of low-income women who smoke, the social factors (e.g., gender, income) influencing their smoking behavior, and their intervention preferences.

Ultimately, the intervention included:

Group support: Weekly 2 hour sessions over 14 weeks.

Buddy system: Participants were encouraged to match with another member of the group or to identify a friend or family member who would serve as a ‘buddy’.

One-on-one support: In addition to support offered to participants within the groups, one-on-one support from a support worker was incorporated into the program. Support workers provided support focused on smoking cessation and support for stressful aspects of women’s lives such as children, health, housing, finances, and relationship problems.

Child-care and transportation costs: Many women described these as crucial to allow them to attend the program.

Other program accessibility issues: The program needed to be designed to consider literacy levels and acceptable physical locations.

RELATED:

► Harm Reduction Support Strategies for Mothers who Smoke, p. 28

► Strategies for Reducing Tobacco Use in Pregnant and Postpartum Women, p. 38

► Diversity, Equity, and Secondhand Smoke Policies, p.74

Harm Reduction Support Strategies for Mothers who Smoke

IN SUM

Helping women to reduce exposing their children to secondhand smoke can be an important first step in quitting smoking for some women and allows others to make changes at their own pace.

Since 1995, AWARE (Action on Women's Addictions — Research & Education) in Kingston, Ontario, Canada has been actively involved in issues that have an impact on the lives of low-income single mothers. One component of this involvement has been the investigation of smoking support strategies for low-income single mothers and the development of the STARSS (Start Thinking About Reducing Secondhand Smoke) program.

SOURCE

The Guide to STARSS Strategies (Start Thinking About Reducing Secondhand Smoke) A harm reduction support strategy for low-income moms who smoke. Developed and produced by Action on Women's Addictions - Research & Education (AWARE), AWARE Press, 2007.

STARSS is not a quit smoking program (although it contains strategies to support moms who make this choice). STARSS is a supportive, sensitive strategy for mothers who smoke and are interested in learning ways to protect their children from the effects of secondhand smoke. STARSS is based upon harm reduction principles and uses strengths-based and mother-centred empowerment strategies. The program's goal is to enable moms to protect their children as much as possible from secondhand smoke in the home without a focus on smoking cessation.

STARSS was developed by and for women of low socio-economic status because, over time, low income women have experienced a less steep decline in smoking rates relative to women in higher socio-economic groups. Rates of tobacco consumption among low-

income single mothers may be among the highest of any population group and consumption is inextricably linked with the social conditions of their lives, including stress, depression, and reduced family support.

Many single moms find the challenge of protecting their children from secondhand smoke to be overwhelming. For example, the message to “just take it outside” is not perceived as a realistic option by single moms with very young children who can’t be left alone.

As a result, low-income single mothers needed an approach focused on motivation and decision making, not advice about quitting smoking. Quitting smoking can be a greater struggle for single mothers. The same applies to secondhand smoke. Many single moms find the challenge of protecting their children from secondhand smoke to

be overwhelming. For example, the message to “just take it outside” is not perceived as a realistic option by single moms with very young children who can’t be left alone. The result is many moms continue to smoke around their children – and feel guilty about it. So STARSS was developed to provide a range of options (or small steps) single moms can take to protect their children from secondhand smoke.

STARSS was designed to meet the needs of women who: (1) live on a low-income (that is, they find it difficult to meet basic needs, as defined by the women themselves) (2) are single (which could mean they have a part-

RESOURCES

AWARE (Action on Women’s Addictions — Research & Education) web site.

www.aware.on.ca/starss

Available resources include:

- A guide to STARSS strategies for providers
- A journal for women to record and support their smoking reduction or cessation goals
- Reports and posters describing the STARSS program

THE NEXT STEP

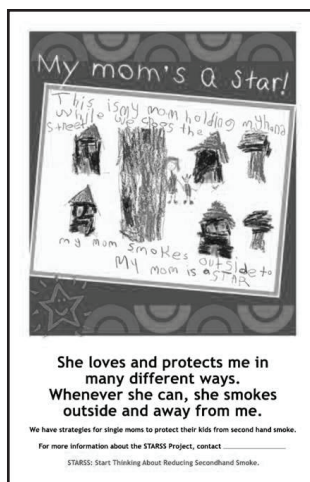
1. *What initiatives, laws, and policies are you aware of in your community to reduce the exposure of children to secondhand smoke?*
2. *Most smokers are aware of the harms of smoking and are interested in quitting smoking. How does a program like STARSS build upon these facts? Are there other harm reducing approaches that do this?*

time partner or a partner who works away from home, again as defined by the women themselves) (3) have children under the age of six living with them (4) receive support from a service provider on a regular basis. In

the program, moms learn about how to record and understand smoking patterns; what works to reduce secondhand smoke; benefits and drawbacks of both smoking and quitting smoking; how to set personal goals and work toward them; the importance of making small changes; and, how to plan ahead for setbacks.

In an evaluation of the pilot phase of STARSS, researchers followed a group of 85 women over a period of six months. Of these, 25 lived in a rural, remote community, 23 lived in a large urban centre, and 37 lived in a small urban centre. All were low-income single mothers, parenting at least one child age 0 to 6. At the end of the initial six months, the researchers found:

- 30% had a long term goal of quitting smoking and half of them achieved this at six month follow-up.
- 70% had a long term goal of protecting their children from environmental tobacco smoke and 80% of them achieved this at six month follow-up.



- 79% made at least one quit attempt during their participation in STARSS and the quit attempts lasted for 1 week to 6 months.
- All participants reduced their smoking consumption by about 50% from 12 to 25 cigarettes per day to 3 to 15 cigarettes per day.
- Availability of smoking cessation aids was rated very highly as the single most important support to help low-income single mothers quit smoking.

RELATED:

- ▶ Women and Exposure to Second Hand Smoke, p. 8
- ▶ Women-only Group Programs for Reducing and Quitting Smoking, p. 24
- ▶ Strategies for Reducing Tobacco Use in Pregnant and Postpartum Women, p. 38
- ▶ Sex- and Gender-based Analysis and Tobacco Policy, p. 68
- ▶ Diversity, Equity, and Secondhand Smoke Policies, p. 74

Women-Centred Brief Interventions by Health Care Providers

IN SUM

Research evidence shows that clinical interventions as brief as three minutes can increase quitting rates significantly among current smokers and recent quitters.

Research has clearly shown that interventions by health care providers can increase quitting rates significantly among current smokers and recent quitters. Brief interventions are tools and approaches that health care providers can incorporate into their practice that take approximately 3 - 15 minutes. Brief interventions can be provided by all health care providers but are most relevant to clinicians who see a wide variety of patients and are bound by time constraints (e.g., physicians, nurses, physician assistants, nurse practitioners, medical assistants, dentists, hygienists, respiratory therapists, mental health counselors, pharmacists, etc.).

PROPORTION OF COUNTRIES PROVIDING CESSATION SUPPORT SERVICES IN THE OFFICES OF HEALTH PROFESSIONALS (2010 data, *World Tobacco Atlas*, 2012)

Service Availability	Percent
Services available in most offices	12.8%
Services available in some offices	45.6%
Services not available	38.0%

Total might not sum due to rounding

One of the earliest and most popular brief interventions is the “5 As” model developed by the U.S. Department of Health and Human Services. This model incorporates the latest clinical guidelines for treating tobacco use and dependence and has been used in a range of settings and populations, including women of childbearing age and pregnant and postpartum women. The five A’s are ASK, ADVISE, ASSESS, ASSIST, and ARRANGE.

Ask about tobacco use - Identify and document tobacco use status of every patient at every visit.

Advise to quit - In a clear, strong and personalized manner urge every tobacco user to quit.

Assess for current tobacco use - Is the tobacco user willing to make a quit attempt at this time? For the ex-tobacco user, how recent did you quit and are there any challenges to remaining abstinent?

Assist - For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional behavioral treatment to help the patient quit. For patients not yet ready to quit, use motivational interventions designed to increase future quit attempts. For the recent quitter and any with remaining challenges, support relapse prevention.

Arrange - All those receiving the previous A’s should receive follow-up.

In recent years, brief interventions based on principles of motivational interviewing have become popular, especially as research to support this type of approach for a range of

SOURCES

Fiore MC, Jaén CR, Baker TB, et al. (2009). *Treating Tobacco Use and Dependence: 2008 Update. Quick Reference Guide for Clinicians*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. Available from: www.ahrq.gov/clinic/tobacco/tobaqrg.htm

Jategaonkar, N., et al. (2011). *Women-Centred Treatment for Tobacco Dependence and Relapse Prevention*. Vancouver, BC: British Columbia Centre of Excellence for Women’s Health. Available from: www.bccewh.bc.ca

RESOURCES

Motivational Interviewing
website
Resources for clinicians,
supervisors, program
managers and trainers
www.motivationalinterview.org

Urquhart, C., Jasiura,
F., Poole, N., Nathoo, T.
& Greaves, L. (2012).
*Liberation! Helping
Women Quit Smoking: A
Brief Tobacco Intervention
Guide*. Vancouver, BC:
British Columbia Centre of
Excellence for Women's
Health. Available from:
www.coalescing-vc.org

health issues continues to grow. In the tobacco cessation field, motivational interviewing is particularly helpful for health care providers who are interested in approaches to supporting patients who are not ready to make a quit attempt or have recently relapsed.

Motivational interviewing is an evidence-based clinical approach for encouraging patients to discuss and consider their own personal motivations and resources for making positive changes in behaviour in the interest of their health. Health care providers use a range of techniques to explore feelings, beliefs, ideas, and values regarding tobacco use in an effort to explore with the smoker, ambivalence about using tobacco. Building on this ambivalence, health care providers encourage “change talk” (e.g., reasons, ideas, needs for eliminating tobacco use) and commitment (e.g., intentions to take action to change smoking behavior, such as not smoking in the home). Research has shown that having patients use their own words to commit to change is more effective than clinicians merely providing information or telling patients that they need to quit.

While many women succeed in quitting smoking with generic or mainstream interventions to quitting smoking, many do not. As the evidence and understanding of sex- and gender-related influences on smoking and cessation behaviours continues to grow, work is being done to identify principles and practices for cessation interventions tailored for women.

The following four principles have been identified by researchers at the British Columbia Centre of Excellence for Women's Health:

1. *Women-centred care for tobacco is tailored* - A tobacco-dependence program that is tailored specifically for women supports a woman's readiness to quit and allows her to have choice and control over the intervention components, including the use of pharmacotherapy.
2. *Women-centred care for tobacco builds confidence and increases motivation* - Working with women to identify gender specific barriers and opportunities for change helps build confidence and motivation, ultimately improving their chances of meeting smoking cessation goals.
3. *Women-centred care for tobacco integrates social justice issues* - Women-centred care acknowledges other priorities such as housing, food security, and caregiving roles and how these challenges may be related to smoking behaviour.
4. *Women-centred care for tobacco is holistic and comprehensive* - Women-centred care integrates support/treatment for trauma, mental health recovery, substance use, or other important health concerns which the woman identifies; valuing women's health for its own sake.

Many women-centred approaches can be applied in primary care settings as well as in more specialized (e.g., mental health treatment) and group settings.

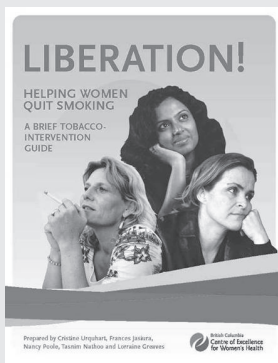
THE NEXT STEP

1. *If you are a health care provider who uses the 5 As model in your work, how can you adapt or expand the model to consider some of the unique issues that women may be facing as they address their tobacco use?*
2. *The term "Liberation" in the women-centred brief intervention guide is used to convey both the idea of women's empowerment and the benefits of being free from tobacco use. What do you think of the choice of that word?*

RELATED:

- ▶ Women Working in the Health Care System and Tobacco Control, p.4
- ▶ Strategies for Reducing Tobacco Use in Pregnant and Postpartum Women, p. 38
 - ▶ Women-centred Approaches to Smoking Cessation Drugs and Nicotine Replacement Therapies (NRTs), p. 42
 - ▶ Changing Organizations: Integrating Tobacco Interventions into Treatment for Other Addictions, p. 64

LIBERATION! A GUIDE TO WOMEN-CENTRED TOBACCO TREATMENT



Liberation! A Guide to Women-Centred Tobacco Treatment

supports health care providers to implement brief tailored tobacco interventions for women. This resource was

developed as a guide, rather than a manual, to help shift away from a prescriptive approach to smoking cessation and to emphasize the collaborative and dynamic nature of real-life clinical interactions. It is meant to support brief interventions, from 5 to 30 minutes, and can be used by practitioners in various contexts and roles. Overall, the guide provides practical ideas on ‘how’ to conduct a brief intervention with women and offers:

- Ideas to collaboratively begin the conversation & make links with other areas of a woman’s life
- Strategies for guiding the conversation towards change and connecting with core values
- Approaches for building confidence
- Ideas on how to share information without (re)traumatizing and shaming women
- Key questions to pace the conversation and avoid getting ahead of readiness
- Tools and considerations for planning and follow-up

Strategies for Reducing Tobacco Use with Pregnant and Postpartum Women

IN SUM

Close to half of pregnant women who smoke either seriously consider or take steps towards stopping during pregnancy. However, high postpartum relapse rates suggest that pregnant and postpartum women have unique smoking cessation needs.

Over the past thirty years, smoking in pregnancy has attracted increased attention in the tobacco-intervention field. Unfortunately, health interventions designed to reduce smoking during pregnancy have not been resoundingly successful. Evidence in more industrialized countries suggests that the drop in smoking over time among pregnant women has been primarily caused by an overall decline in smoking rates among women of childbearing age, not by increased rates of smoking cessation in pregnancy. One reason for this lack of success seems to be an emphasis on improving fetal health only, and reducing future health-care costs for premature and low-birth weight babies. Such interventions pay less attention to the pregnant women's overall health and to women's smoking before and after pregnancy.

Many women feel intense pressure to stop smoking when they become pregnant. This pressure comes from partners, family members, the media, etc. Pregnant women who are unable to reduce or stop smoking often feel guilty and ashamed about their smoking. While many women are able to quit smoking when they become pregnant, approximately 70 % of women resume after they give birth. For these women, reduction during pregnancy is often not truly voluntary; many have

FIVE WAYS TO CHANGE YOUR PRACTICE: SUGGESTIONS FOR HEALTH CARE PROVIDERS WHO WORK WITH PREGNANT AND POSTPARTUM GIRLS AND WOMEN

In 2010, the British Columbia Centre of Excellence for Women's Health in Vancouver, BC conducted a best practices review to examine smoking cessation interventions tested in pregnant populations. The review showed that, when it comes to prenatal care, many health care providers believe that they don't have adequate time to address smoking, or that the stress of stopping smoking may negatively affect the fetus or the mother's ability to care for her child after birth. While pregnancy can increase women's stress level, there is no evidence to suggest that quitting smoking during pregnancy increases stress or negatively impacts the health or well being of the woman or the fetus. On the contrary, there is a wealth of evidence to suggest that stopping, reducing, or quitting smoking has great health benefits for woman, fetus and baby.

The **Expecting to Quit** website includes a section called "Five Ways to Change Your Practice" for health care providers which provides an overview of brief smoking cessation interventions for pregnant and postpartum girls and women.

SOURCES

Bottorff, J. L., Carey, J., Poole, N., Greaves, L., & Urquhart, C. (2008). *Couples and smoking: What you need to know when you are pregnant*. Vancouver, BC: Jointly published by the British Columbia Centre of Excellence for Women's Health, the Institute for Healthy Living and Chronic Disease Prevention, University of British Columbia Okanagan, and NEXUS, University of British Columbia Vancouver. Available from: www.facet.ubc.ca

Greaves, L., Poole, N., Okoli, C. T. C., Hemsing, N., Qu, A., Bialystok, L., & O'Leary, R. (2011). *Expecting to Quit : A Best Practices Review of Smoking Cessation Interventions for Pregnant and Postpartum Girls and Women, 2nd edition*. Available from: www.expectingtoquit.ca

Families Controlling and Eliminating Tobacco (FACET) website Research and resources for supporting tobacco reduction for pregnant and postpartum women and new fathers. Available from: www.facet.ubc.ca

undergone what researchers refer to as "compelled tobacco reduction."

Helping pregnant women to quit or reduce smoking is different from helping other smokers. Pregnant smokers have unique cessation issues (e.g., social pressures to quit, physiological changes, brief time period to

RESOURCES

Expecting to Quit: Smoking
Cessation Interventions for
Pregnant and Postpartum
Girls and Women
www.expectingtoquit.ca

THE NEXT STEP

1. *Approaches to smoking cessation that focus on the health of the fetus, focus the motivation for quitting away from woman's own health. Yet the well-being of the fetus can be a key motivator for some women. How does this relate to high rates of relapse following pregnancy? What other strategies can be used to support women?*

2. *How do you feel about harm reduction approaches to addressing smoking during pregnancy where women are encouraged to cut down on their smoking as opposed to quitting altogether?*

make changes) compared to other women. High postpartum relapse rates demonstrate that we need to treat pregnant and postpartum women differently than other smokers. Pregnant women often appear to experience the “quitting” process, but end up returning to smoking behaviour.

During pregnancy, nicotine replacement therapies (NRTs) are not completely free of risk, but evidence suggests that NRTs are less harmful than smoking during pregnancy because both the woman and fetus receive less nicotine and no exposure to carbon monoxide and other toxic substances. For some groups of women, where other avenues to quit or reduce have not been successful, NRTs may be an option to discuss further.

Other strategies to support pregnant and postpartum women include:

- Ensuring that public health messages are framed in a sensitive, nonjudgmental way that is relevant to the social and economic circumstances of women's daily lives;
- Encouraging harm reduction among pregnant smokers by recommending and supporting: a decrease in the number of cigarettes they smoke, brief periods of cessation at any point in pregnancy and around delivery, and health-promoting behaviours such as exercising and addressing partner smoking;
- Encouraging women to continue breastfeeding even if they smoke or are using NRTs to aid their cessation.

COUPLES, SMOKING, AND COMPELLED TOBACCO REDUCTION

There is evidence that partners and family members play a powerful role in influencing whether pregnant women quit smoking and are able to maintain abstinence in the postpartum period. Compared to pregnant women who live with non-smokers, those who live with a partner who smokes are less likely to stop smoking during pregnancy and more likely to relapse during the postpartum period. However, if a partner is resistant to quitting smoking, encouraging the woman to ask her partner to quit with her may cause tension in the relationship. In other cases, the woman is pressured by her partner to quit, making her process more difficult. Considering the possible stress that smoking cessation may put on a woman's relationship (with the possibility for elevated frustration and anger), partner cessation should be considered and supported separately from the woman's own attempt to quit.

RELATED:

- ▶ Indigenous Women and Tobacco, p. 18
- ▶ Harm Reduction Support Strategies for Mothers who Smoke, p. 28
- ▶ Diversity, Equity, and Secondhand Smoke Policies, p. 74

Couples and Smoking

What You Need to Know When You are Pregnant



Women-Centred Approaches to Smoking Cessation Drugs and Nicotine Replacement Therapies (NRTs)

IN SUM

Prescription smoking cessation drugs and nicotine replacement therapies (NRTs) products can be effective tools for women who are quitting smoking, especially when combined with other women-centred approaches.

Some governments are now introducing policies related to covering the cost of smoking cessation products and nicotine replacement therapies (NRTs). The British Columbia (BC) program, introduced in September 2011, covers two types of smoking cessation aids: (1) Prescription smoking cessation drugs such as bupropion (brand name Zyban®) and varenicline (brand name Champix®) or (2) Non-prescription nicotine replacement therapy NRT gum or patches such as Thrive™ nicotine chewing gum and Habitrol® nicotine patches.

The governmental funding provided many health care centres with the opportunity to review their approaches to smoking cessation support. At the Maxxine Wright Health Centre in Surrey, BC, the multidisciplinary team of health and social service professionals began a nicotine replacement therapy demonstration project in 2011. The Maxxine Wright Health Centre (MWCHC) is a primary health clinic serving pregnant and early parenting women impacted by violence and/or substance misuse. The multidisciplinary care team provides comprehensive healthcare to women

WOMEN AND SMOKING CESSATION AIDS

There are two main types of smoking cessation aids: prescription smoking cessation drugs and nicotine replacement therapies (NRTs) products. Prescription smoking cessation drugs do not contain nicotine but work on the brain to manage withdrawal symptoms and cravings and reduce the urge to smoke. NRTs are non-prescription medications that contain nicotine. They work to reduce withdrawal symptoms by replacing the nicotine one would get through smoking. NRTs allow for the gradual reduction of nicotine, making it easier to handle withdrawal symptoms.

Research has shown that these pharmacotherapies can be effective tools in smoking cessation for women, although they are not appropriate for all women (e.g., bupropion may not be suitable for women or men with history of an eating disorder) and not all women may be interested in medication or NRTs. In general, smoking cessation outcomes improve when medications are used in combination with an effective behavioral intervention such as counseling. NRTs in any of its five different forms (patch, gum, nasal spray, inhaler, and lozenge) reliably increases long-term smoking abstinence rates and approximately doubles the chance of successfully quitting.

SOURCES

British Columbia Smoking Cessation Program
www.health.gov.bc.ca/pharmacare/stop-smoking/

Maxxine Wright Community Health Centre, Atira Women's Resource Society
www.atira.bc.ca

and children including methadone and prenatal care services, as well as support staff for social services such as housing, networking and advocacy. Many MWCHC clients are multi-barriered, facing complex issues such as gender-based violence, mental health and/or addiction concerns, poverty, food insecurity,

RESOURCES

Urquhart, C., Jasiura, F., Poole, N., Nathoo, T. & Greaves, L. (2012). *Liberation! Helping Women Quit Smoking: A Brief Tobacco Intervention Guide*. Vancouver, BC: British Columbia Centre of Excellence for Women's Health. Available from: www.coalescing-vc.org

insecure housing or homelessness, and many are marginalized from traditional healthcare services related to these barriers. Because little is known about what helps women who are facing these types of issues to quit smoking, the project was designed to learn more about how smoking cessation aids might help the clinic's clients.

Staff found that while some women were interested in hearing about the increased risk for stroke or cancer resulting from tobacco use, many were motivated to quit smoking due to a desire to save money or concerns about the physical effects of smoking such as wrinkles and yellow teeth. Staff also had to dispel myths about quitting smoking that many clients had been told. For example, several women reported that their physician had told them not to quit smoking during pregnancy as it would be stressful for the baby. Staff had to respond by providing current information while not discrediting other professionals.

Overall, staff found that there were few absolute rules about what would work best for their clients and that supporting women requiring a tailored case-by-case approach. Many women required support in breaking the “hand-to-mouth” habit; staff made straws, stir sticks, and licorice available for those women who had quit smoking and NRT inhalers for women who were reducing their tobacco use. In groups and individual counseling sessions, women were offered NRT gum as a substitute for leaving the session to go outside for a smoke break. Staff also worked with women to come up with individual solutions. For example, in

some cases, pregnant women were initially advised to take the NRT patch off at night. But, for women who were getting up to smoke in the middle of the night, they experimented with leaving it on overnight to see how that affected their overall sleep.

Building confidence and celebrating successes, no matter how small, were important. Many women were fearful that quitting smoking could lead to relapse related to quitting other substances (e.g., marijuana use or crack cocaine use). Staff had open discussions with women about the connections between stress, smoking, and poverty to help women develop awareness of the influences on their smoking and to appreciate their successes.

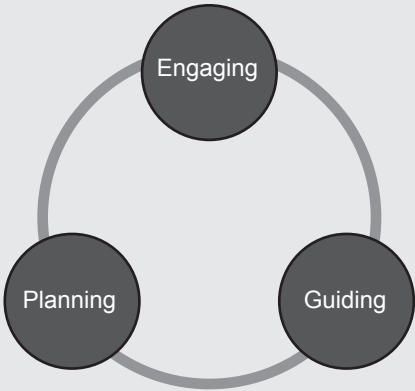
Clear and ongoing communication between staff members of the multidisciplinary team was also important. Staff worked to develop short and consistent messages about smoking and shared their findings about dosages (e.g., often important to aim higher as smoking tends to be under-reported) and effective strategies (e.g., many women preferred using NRT gum before moving towards the patch as it gave them an ‘instant fix’).

THE NEXT STEP

1. *In your personal or professional experience, what are the benefits of using smoking cessation drugs and nicotine replacement therapies as part of a quit smoking approach? Have you noticed differences in strategies and successes between men and women?*
2. *In your community, how available and accessible are smoking cessation drugs and nicotine replacement therapies? What is known about them?*

WOMEN-CENTRED TOBACCO REDUCTION AT A COMMUNITY HEALTH CENTRE

This diagram from *Liberation! Helping Women Quit Smoking: A Brief Tobacco Intervention Guide* helps health care providers translate women-centred principles to quitting smoking into practice. Health care providers at the Maxxine Wright Community Health Centre tailored this model to their community and population.



ENGAGING	
Build a relationship with her.	Listen to her needs, concerns, and strengths without judging her or assuming her priorities.
Develop a collaborative understanding of how smoking is impacting her life.	<p>Is poverty causing her stress, which leads her to smoke, which leads to increased financial stress?</p> <p>How is smoking impacting how she feels about her body?</p>
Understand and address her beliefs about smoking.	For example, some women say that their doctors told them not to quit during pregnancy due to stress on the baby; address this myth by providing accurate information

GUIDING

Understand her reasons for smoking. Ask how these needs could be met.

Does she smoke to deal with stress? Are there other ways she deals with stress? Does she have other competing priorities for change? Is she afraid she might fail if she quits?

Help her find the motivation to reduce or quit.

For example, ask: what would you do with the extra money?

PLANNING

Assess reduction or cessation strategies that work for her.

Provide her with options for strategies and ask which fit for her.
Hand to mouth habits can be hard to break, suggest having carrots or straws available to chew on.

Adjust the strategies to work for her.

If women are getting up through the night to smoke, suggest trialing leaving the patch on overnight. Keep the barriers to NRT low; the multi-day inventory may not work for her; if not then find another way to assess smoking. Consider using gum as well as the patch, to get the nicotine levels up before the patch starts to work.

Help her prevent relapse

Don't lower NRT before she is ready.
Continue to provide support by asking how her strategies are working for her.

RELATED:

► Harm Reduction Support Strategies for Mothers who Smoke, p. 28

► Women-Centred Brief Interventions by Health Care Providers, p. 32

► Changing Organizations: Integrating Tobacco Interventions into Treatment for Other Addictions, p. 64

Girls, Women, Media, and Tobacco

IN SUM

Media, including social media such as Facebook and YouTube, can be important tools for organizations working to increase awareness and take action related to women and tobacco issues.



Girls and young women have long been a key target for tobacco companies' brand development and marketing campaigns. But traditional health programming has generally been gender neutral, not doing women-specific prevention and intervention unless pressed by women's health advocates. More recently, however, technology has facilitated the tailoring of messages to a wider variety of sub populations.

Hence, more and more women's organizations, health agencies, and governments are making use of the increasing popularity of social media tools such as Facebook, Twitter, and YouTube. Using social media can be helpful in tapping into word-of-mouth networks, presenting information in multiple formats (e.g., texting, images, video), connecting different sources of information, and allowing individuals to access and use information in formats and timeframes that makes sense for them.

The image above is from the National Cancer Institute (USA) Smokefree Women Facebook page. This campaign is using both traditional and new social media strategies. On the Women.Smokefree.gov website, women can learn more about quitting and download resources, including self-help tools. The website links to Twitter which provides daily tips and encouragement to women who are in the process of quitting and trying to stay quit. On Facebook women can share stories, connect with other women, and offer/receive tips & encouragement. Videos on YouTube allow women to learn more about specific issues and to hear about the successes and challenges that other women have experienced. Links to other smoking cessation programs in the community or on-line are easy to find.

While media, especially social networking sites, can be a powerful tool in engaging girls and young women to not smoke or quit smoking, it has also been a powerful tool for the tobacco industry. Over the past century, the tobacco industry has developed some of the most aggressive and sophisticated marketing campaigns based on extensive research of girls' and women's attitudes, beliefs, and the social pressures they experience.

Media literacy education is designed to provide people with tools for understanding how mass media affects their perceptions, values and actions. Media literacy education helps individuals to critically analyze messages, to learn about different forms of media, and to develop skills in creating their own media messages.

SOURCES

Expecting to Quit: Smoking Cessation Interventions for Pregnant and Postpartum Girls and Women
www.expectingtoquit.ca

The Nightingale Nurses
www.nightingalesnurses.org

Smokefree Women
National Cancer Institute (USA)
Women.Smokefree.gov

RESOURCES

American Cancer Society
Cancer Action Network,
American Heart Association,
American Lung Association,
Robert Wood Johnson
Foundation and Campaign
for Tobacco-Free Kids.
(2009). *Deadly in Pink:
Big Tobacco Steps Up Its
Targeting of Women and
Girls*. Washington, D.C.:
The Campaign for Tobacco-
Free Kids. Available from:
www.tobaccofreekids.org

Digital Engagement Toolkit
Substance Abuse &
Mental Health Services
Administration (United
States)
Available from: [www.
samhsa.gov/socialmedia/
toolkit.aspx](http://www.samhsa.gov/socialmedia/toolkit.aspx)

Media Smarts
Resources for teachers on
media literacy, including a
*Gender and Tobacco lesson
plan*
<http://mediasmarts.ca>

Smoke Free Movies
Developed by Stanton A.
Glantz, at the University of
California, San Francisco,
this organization works to
reduce youth exposure to
smoking in movies. Includes
a Screen Out! campaign kit.
[www.smokefreemovies.
ucsf.edu](http://www.smokefreemovies.ucsf.edu)

When it comes to tobacco use, media literacy focuses on issues such as: how does tobacco advertising glamorize smoking? What kinds of characters smoke in movies? Who is providing information about health benefits and risks? Who owns the media and how is it funded? Why does the tobacco industry have different messages for girls than boys? What are the ethics of the tobacco industry in addressing the effects of their products?

DIGITAL STORYTELLING: “I HAVE A SECRET”

Digital storytelling is the practice of using computers and other types of technology like cameras, smartphones and scanners to create and tell stories. In 2012, the BC Centre of Excellence for Women’s Health asked a group of women to share their experiences and thoughts about smoking and pregnancy during a digital storytelling workshop. The workshop allowed women to develop new skills, meet other women and hear about their experiences with smoking, and to create a story that could be shared with other women, friends, family, and health care providers. One of the participants, a nurse, described her struggles with being both a smoker and a health care provider. A transcript of her story is below; the video can be viewed at: www.expectingtoquit.ca

“I have a secret. But first let me introduce myself. I am the mother of a beautiful baby boy. At the age of 30, I feel confident enough to say that I’m a good mother. Working as a nurse in the hospital, I felt enormous pressure to be a perfect expectant mother. When I was a baby, it wasn’t uncommon for expectant mothers to smoke.

Most of the women in my family smoked throughout their pregnancy and didn't feel ashamed - it was normal. Smoking has such a firm grasp on my family that we can't help but laugh in spite of the large thick and dark cloud of smoke that hangs over us when we're together. "The Smokers go for a walk." I felt shame as a smoker even before I became pregnant. That's my secret. I was unable to quit smoking when I was pregnant. The shame I felt during this time was compounded by the feeling that I was the only mother in the world not strong enough to quit. It really tore me down. Even with the biggest motivating factor, a baby growing inside me, I just couldn't stop. When I told my doctor how consumed with guilt over smoking while pregnant, he said "There's no point in going crazy and smoking." Now that my baby's born, I still struggle with smoking but I feel optimistic that I will be smoke-free sooner than later. I still go to drastic measures to hide the fact that I smoke, but I wanted to share my story in case another woman would feel less alone."

Videos, lectures, study guides, handouts, and resources for change by Jean Kilbourne. Videos include: *Killing Us Softly: Advertising's Image of Women*, *Deadly Persuasion: The Advertising of Alcohol & Tobacco*, and *Pack of Lies: The Advertising of Tobacco* www.jeankilbourne.com

US Centers for Disease Control and Prevention. (2011). The Health Communicator's Social Media Toolkit. Developed by the Electronic Media Branch, Division of News and Electronic Media, Office of the Associate Director of Communication at the Centers for Disease Control and Prevention (CDC). Available from: www.cdc.gov/healthcommunication/ToolsTemplates/SocialMediaToolkit_BM.pdf



THE NEXT STEP

1. How do you personally and/or professionally use social media? From your perspective, what are the advantages and disadvantages of using social media to address issues related to women and tobacco?
2. Tobacco advertisers target girls and young women through gendered and stereotyped concerns about appearance and a desire to connect with others. Do you think media literacy skills are sufficient to counteract these messages? What else might be needed?

BOYCOTT GLAMOUR - LETTER TO GLAMOUR MAGAZINE

The Nightingale Nurses encourage the public to boycott magazines that advertise tobacco products and/or write to the magazine and ask them to stop accepting tobacco advertisements that harm their readers. Below is a letter directed to the popular women's magazine, Glamour.

Dear Cindy Levine and Condé Nast Publishing,

We write to ask you to act responsibly in proportion to your influence on women's lives by making the decision to refuse acceptance of tobacco advertising, and letting your readers know why you have done so.

Tobacco products kill more than 1.5 million women worldwide each year, and in the United States, lung cancer (virtually all caused by tobacco smoking or secondhand smoke exposure) has long outpaced breast cancer as the leading cancer killer of women.

Magazines such as Glamour, which have enormous influence on young women's ideas about fitness, health, fashion and image, could play an important role in ending this entirely preventable epidemic of suffering and premature death.

Conversely, continuing to accept advertising for tobacco products undermines your reputation as a publication that encourages healthy lifestyles among women. The content you routinely feature, such as the promotion of a healthy body image and the value of disease prevention and screening for breast cancer and heart disease, is fundamentally incongruent with tobacco advertising.

It is contradictory and irresponsible to deliver

such health-positive messages to women alongside fold-out, 8 X 11 advertisements for the single most deadly consumer product ever made, a product that would not be allowed on the market were it invented tomorrow. Such incongruity creates mixed messages, actually creating perverse and deceptive links between healthy content and tobacco products.

Ending tobacco advertising would send a strong message to your readers and the public that you “walk the walk” of caring about women’s health. The time is long past for responsible organizations to cease furthering the agenda of an industry that has undermined public health efforts at all levels and continues to do so in the most aggressive manner, as the World Health Organization has documented.

As a women’s magazine with a global readership, you have a crucial role in changing the course of the tobacco epidemic. We ask that you stand up to tobacco industry advertising to women. We know from many years of research and advocacy that eliminating advertisements for tobacco is the most important step in saving the millions of lives lost each year to tobacco.

Eliminating advertisements for tobacco, and telling your readers why you have done so offers a wonderful opportunity for Glamour to demonstrate its commitment to women’s health. We commit to publicizing such a decision widely through our organizational networks.

We look forward to your positive response.

Sincerely,

Nightingales Nurses

Source: www.nightingalesnurses.org

RELATED:

- Women Working in the Health Care System and Tobacco Control, p.4
- Sex- and Gender-based Analysis and Tobacco Policy, p. 68

III. ADVOCACY & ACTION

- ▶ THE INTERNATIONAL NETWORK OF WOMEN AGAINST TOBACCO
- ▶ USING SHADOW REPORTING TO ADVANCE WOMEN'S HEALTH AND REDUCE TOBACCO USE
- ▶ CHANGING ORGANIZATIONS: INTEGRATING TOBACCO INTERVENTIONS INTO TREATMENT FOR OTHER ADDICTIONS
- ▶ SEX- AND GENDER-BASED ANALYSIS AND TOBACCO POLICY
- ▶ DIVERSITY, EQUITY, AND SECOND HAND SMOKE POLICIES



The International Network of Women Against Tobacco

IN SUM

Advocating for a reduction in tobacco use by women and girls, as well as for improvements in women's health and status are the dual goals of the International Network of Women Against Tobacco (INWAT).

The International Network of Women Against Tobacco (INWAT) was established in 1990 by a group of concerned women to bring international attention to the issues surrounding girls, women and tobacco use. The inaugural group met in Perth, Australia at the 7th World Conference on Tobacco or Health to set down the objectives of INWAT.

This action was necessary to redress the ongoing exclusion of women and tobacco issues from the World Conference agenda. Reflecting the tobacco control movement at the time, there was scant attention paid to women and tobacco, other than the singular and medicalized interest in smoking during pregnancy.

Advocating for a reduction in tobacco use by women and girls, as well as for improvements in women's health and status are the dual goals of INWAT. The group does this through maintaining a network of members, doing research and projects to highlight new issues of concern, and communicating with mainstream tobacco control organizations about the issues of gender and equity.

SOURCE

International Network of Women Against Tobacco
www.inwat.org

Feminist critics highlighted tobacco marketing and the sexism of tobacco control then focused on a male model of smoking and treatment. Bobbie Jacobson, Hilary Graham and Lorraine

Greaves addressed these issues in the books, *The Ladykillers* (1981) and *Beating the Ladykillers* (1986), *When Life's A Drag* (1999) and *Smoke Screen: Women's Smoking and Social Control* (1996).



These books were hard hitting – not only describing the gendered issues of tobacco marketing and the sexist focus on pregnancy and smoking, but also highlighting the importance of equity, the social determinants of women's health and the impact and links of violence and trauma to women's smoking.

These books heralded the key issues of the 21st Century for tobacco control. Globally, male smoking rates have peaked and yet female rates are still on the incline. The use of tobacco is declining overall among high-income countries and moving to low-income countries. When tobacco companies moved their growing and marketing to low-income countries, the links between poverty and tobacco use became even more stark and the challenge of integrating gender and equity into tobacco control had to be faced head-on by global organizations. At the same time, the remaining groups of smokers in high-income countries were those least privileged, dealing with a range of social and economic issues.

INWAT emerged in 1990 to define a wider view of women's tobacco use and exposure, but its goals are even more relevant today. It

RESOURCES

The NET - E-Zine of the International Network of Women Against Tobacco
www.inwat.org

INWAT Europe
www.facebook.com/pages/INWAT-Europe-International-Network-of-Women-Against-Tobacco/254091551276926

THE NEXT STEP

1. *In your community, do women have a role in developing and implementing tobacco control initiatives? How might women's leadership in the tobacco control movement be better promoted?*
2. *Do tobacco control initiatives in your community emphasize women's empowerment? How would existing initiatives need to be adapted to include this focus? What would be some of the benefits and challenges of doing so?*

RELATED:

- Sex- and Gender-based Analysis and Tobacco Policy, p. 68

has almost 2000 members in its global network and has spawned vibrant regional networks in Europe, South America and Australasia.

Over the years INWAT has influenced the scientific agenda of the World Conferences, worked closely with international bodies such as the World Health Organization, International Union Against Cancer, as well as the InterAmerican Heart Foundation and countless country based organizations across the globe.

It has produced several important reports on world tobacco policies, gender and the Framework Convention on Tobacco Control, women and secondhand smoke, advocacy and science, and produces a magazine on women and tobacco issues 3 times per year (the NET). All of these reports are housed on the website inwat.org.

In addition, INWAT has created awards for individuals who have made significant efforts to change the situation for women, girls and tobacco, and has awarded these at several World Conferences.

Developing and naming a gendered and equitable approach to understanding of tobacco use and exposure, and creating new leadership to carry these goals forward is the *raison d'être* of INWAT. The issues that INWAT stands for are now forming the agenda for the global tobacco control movement. The overarching aim of interrupting the arc of the tobacco epidemic for women as it spreads across the world remains as critical as ever.

Using Shadow Reporting to Advance Women's Health and Reduce Tobacco Use

IN SUM

There are numerous legal tools available to advance women's health, human rights and reduce tobacco use. The WHO-FCTC (Framework Convention on Tobacco Control) is an international public health treaty that identifies gender as a key element in its Preamble. Shadow reports help make the connections between tobacco control and human rights and can be a tool for civil society organizations to advocate at national and international levels.

The Framework Convention on Tobacco Control (FCTC) is the world's first international public health treaty, adopted in May 2003, by the member countries of the World Health Organization (WHO). Argentina signed the FCTC on September 25, 2003. By 2012, Argentina, the second largest producer of tobacco in the region, was one of the few countries in the world and the only one in South America that had yet to ratify the FCTC. Rates of smoking for women in Argentina are approximately 22%. It's estimated that tobacco use causes 40,000 deaths annually in Argentina; policies recommended by the FCTC could save 16,000 lives.

In July 2010, a diverse group of national and international women's and civil society organizations submitted a 'shadow report' to the United Nations Committee on the Convention on the Elimination of Discrimination against Women (CEDAW) in response to the sixth periodic report submitted by the Argentine government. These organizations included:

- The O'Neill Institute for National and Global Health Law
- The Campaign for Tobacco-Free Kids
- Argentina Smoke-Free Alliance (ALIAR)

WHAT IS SHADOW REPORTING?

Shadow reports are submissions to treaty monitoring bodies to successfully lobby various UN bodies, including treaty-monitoring bodies (such as the Committee on the Elimination of Discrimination Against Women) or thematic groups (such as the Special Rapporteur on Violence Against Women), charter-based bodies (such as the Commission on the Status of Women) and the High Commissioner for Human Rights. They often address omissions, deficiencies, or inaccuracies in official government reports. The shadow reporting process plays a critical role in holding governments accountable to their international human rights obligations.

SOURCES

The O'Neill Institute for National and Global Health Law, Fundación Interamericana del Corazón Argentina, et al. (2010). *Challenges in the Prevention and Reduction of Women's Tobacco Use in Argentina: Shadow Report To The Sixth Periodic Report By The Government Of Argentina*. www.law.georgetown.edu/oneillinstitute/documents/2010-07_Argentina_Shadow_Report.pdf

Mejia, R., Schoj, V., Barnoya, J., Flores, M. L., & Pérez-Stable, E. J. (2008). Tobacco industry strategies to obstruct the FCTC in Argentina. *CVD Prevention and Control*, 3, 172-179.

World Health Organization. (2012). World Health Statistics 2012. Available from: www.who.int

FIC – Argentina: Fundación Interamericana del Corazón Argentina [Argentine Interamerican Heart Foundation]

- Fundación Cardiológica Argentina [Cardiology Foundation Argentina]
- Center for the Study of State and Society
- Foundation for Women's Study and Research (FEIM)
- Argentine Cardiology Society (SAC)
- The Foundation for the Development of Sustainable Policy (FUNDEPS)

The report, “Challenges in the Prevention and Reduction of Women's Tobacco Use in Argentina,” described how Argentina could improve its tobacco control policies and highlighted the negative health impacts of tobacco use in women. After its official review, the CEDAW Committee released its

RESOURCES

A guide to tobacco-related shadow reporting before United Nations human rights bodies. O'Neill Institute for National and Global Health Law at Georgetown University and Fundación InterAmericana del Corazón - Argentina (FIC Argentina). Available in English and Spanish. www.oneillinstitute.org

Framework Convention Alliance Shadow Reporting Campaign. <http://fctc.org>

O'Neill Institute for National and Global Health Law. (2010). *Shadow Report to the Periodic Report by the Arab Republic of Egypt to the United Nations Committee on the Elimination of all Forms of Discrimination Against Women. Women and Tobacco in Egypt: Preventing and Reducing The Effects of Tobacco Consumption through Information, Implementation and Non-Discrimination.* http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/ONeillInstitute_Egypt45.pdf

Marcet Champagne, B., Sebríé, E., & Schoj, V. (2010). The role of organized civil society in tobacco control in Latin America and the Caribbean. *Salud Publica Mex*, 52(suppl 2), S330-S339.

concluding observations, which encouraged the Argentine government to ratify and implement the FCTC. This report was important in making links between tobacco, gender, and human rights. It was also one of the first times the CEDAW Committee had made a specific recommendation on implementing tobacco control measures.

In fall of 2012, at the 4th session of the United Nations Human Rights Council in Geneva, Argentina underwent the Universal Periodic Review (UPR). Once again, the government was given the recommendation to ratify the FCTC. Shadow reports, which connect tobacco issues to women's and human rights, is one way to continue to pressure and hold accountable national governments for women's right to health.

KEY TREATIES & DECLARATIONS RELEVANT TO WOMEN AND TOBACCO

Framework Convention on Tobacco Control (FCTC)

The FCTC is the world's first international public health treaty, adopted in May 2003 by the member countries of the World Health Organization. The FCTC aims to reduce the toll of tobacco on the lives of women and men around the globe, and recognizes the importance of a gendered approach to tobacco programming, policy and research. The FCTC explicitly mentions women in the preamble and expresses concern about the potential global rise in women's tobacco use. By April 2006, 168 countries had signed the FCTC and 126 had ratified the treaty.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

CEDAW, often described as an international bill of human rights for women, was adopted in 1979 by the United Nations (UN) General Assembly. In article 12, CEDAW requires that all appropriate measures must be taken to eliminate discrimination against women in the field of health care. Furthermore, the general recommendations of CEDAW state that a gender perspective should be integrated into all policies and programs affecting women's health and that women should be involved in the planning, implementation and evaluation of such policies and programs.

The Kobe Declaration

The Kobe Declaration was adopted in 1999 at an international conference on women and tobacco hosted by the World Health Organization (WHO) in Kobe, Japan. This declaration states that tobacco control strategies must integrate the promotion of gender equality in society and that women's leadership is essential to the success of these strategies. The Kobe Declaration further demands that the Framework Convention on Tobacco Control (FCTC) include gender-specific concerns and perspectives.

THE NEXT STEP

1. *How do shadow reports connect tobacco issues to human rights?*
2. *Has the country you live in ratified the WHO Framework Convention on Tobacco Control (FCTC)?*
3. *Can you identify allies for advancing women's health, human rights and tobacco reduction? Do you see any movements towards change resulting from global pressures and initiatives?*

RELATED:

► Sex- and Gender-based Analysis and Tobacco Policy, p. 68

Changing Organizations: Integrating Tobacco Interventions into Treatment for Other Addictions

IN SUM

Tobacco use is frequently considered separately from other types of substance use even though there are documented advantages to addressing the two together. When treating women's tobacco dependency in concert with other addictions, it is important to consider women's experiences of gender-based violence.

Studies have found that approximately 80% of women in treatment for other substance use problems also smoke cigarettes. Yet despite these very high rates of tobacco use among women (and men) with other substance use issues, the addictions treatment field has historically not addressed tobacco use.

But this is changing. Increasingly tobacco is being considered in the planning and provision of addictions treatment. The Aurora Centre, a substance use treatment centre for women in Vancouver, Canada began a process of addressing tobacco in 1996, and began treating tobacco addiction in the context of treatment for other substances in 2006.

For the first 20 years of its operations, both program participants and staff of the Aurora Centre smoked indoors with few restrictions. In 1991, a staff member expressed concerns about her health due to exposure to secondhand smoke and a policy requiring individuals to smoke outdoors was put in place. In 1997, the Aurora Centre staff began to draw attention to tobacco by adding it to the list of drugs

SMOKING AND EXPERIENCES OF VIOLENCE AND TRAUMA: WHAT ARE THE CONNECTIONS?

Women and girls with substance use problems, mental illness or experience of violence and trauma are much more likely to be smokers than the general population. Not only are women with violence-related/traumatic experiences likely to be smokers, but they are frequently heavy smokers. Sex and gender-related factors contribute to these relationships. Women and men vary in their smoking motivation, symptoms of tobacco dependence, and cessation attempts. Women and girls are more likely to be victims of incest, interpersonal violence and sexual assault. As well, women smokers with post-traumatic stress disorder (PTSD) have been found to smoke in response to different symptoms than men with PTSD. Women smokers with violence and trauma histories attach deep meanings to smoking including emotional dependency and identity formation, making cessation difficult.

These connections between violence, tobacco use, and women's lives are important to consider in designing programs and targeting resources, as they have varied impacts on cessation processes and the success of interventions. They also require the design of tobacco programs that are integrated with violence and mental health services, and offered in a range of locations.

SOURCES

Greaves, L (1996). *Smoke Screen: Women's Smoking and Social Control*.

Fernwood Books, Halifax, Zed Books UK, Scarlet Press, USA.

Malmö, G. (2007). Addressing Tobacco Dependency in Women's Substance Use Treatment. In Poole, N., & Greaves, L. (Eds.). *Highs and Lows: Canadian Perspectives on Women and Substance Use*. (pp. 323-331). Toronto, ON: Centre for Addiction and Mental Health.

Poole, N., Greaves, L. and Cormier, R. A. (2003). Integrating Treatment for Tobacco and Other Addictions at the Aurora Centre of the British Columbia Women's Hospital and Health Centre. *Canadian Journal of Nursing Research*, 35(1): 123-134.

that clients might consider a problem upon entering the program. Indeed, in 2001, 76% of women entering treatment were smokers and 43% identified nicotine as one of their top three problem drugs. Only alcohol and cocaine were cited more frequently. The

RESOURCES

Coalescing on Women and Substance Use: Violence trauma and substance use section
www.coalescing-vc.org

Coalescing on Women and Substance Use: Women-centred tobacco treatment section, information sheet on "Integrating Tobacco Cessation Interventions into Mental Health, Substance Use and Anti-Violence Services"
www.coalescing-vc.org

Poole, N. and Lyon, J. (2012). Integrating treatment of tobacco with other substances in a trauma-informed way. In Poole, N., & Greaves, L. (Eds.). *Becoming Trauma Informed*. Toronto, ON: Centre for Addiction and Mental Health.

majority of treatment participants who were smokers also indicated interest in the Aurora Centre helping them with smoking cessation.

The full scale integration of tobacco into this women-centred treatment program had several stages including: introducing tobacco awareness sessions within treatment; piloting tobacco reduction/cessation programming for women post-treatment; and finally becoming smoke free, treating tobacco as an addiction of concern comparable to other addictions.

For several years, the Aurora Centre offered awareness sessions about smoking and its effect on women's lives and introduced harm reduction and coping strategies. After the first year of these sessions, the evaluation showed that by the end of treatment, 62% of participants were smoking less and 43% planned to quit within 6 months of completing treatment. For those contacted three months after treatment, 28% reported they had reduced their smoking levels and 9% reported having quit smoking.

Finally the Aurora Centre became smoke free, requiring women not to smoke for the duration of treatment, providing nicotine replacement therapies, and working with them on short and long term cessation strategies. Throughout the process of organizational change, the treatment providers at the Aurora Centre increasingly addressed the links between women's experience of violence and trauma, smoking, and other substance use.

WHY HAS THERE HISTORICALLY BEEN RESISTANCE TO THE IDEA OF TOBACCO AS A “PROBLEM DRUG” IN ADDICTIONS PROGRAMS?

While there is widespread agreement about the harms of cigarette smoking, tobacco has frequently been considered separately from other types of substance use. Some of the reasons for this include:

- A misperception that addressing cigarette smoking will interfere with and have a negative impact on treatment for other addictions
- Resistance by staff members in addictions programs who may be smokers themselves
- The misperception that tobacco dependence is not as serious as other drug dependencies
- The function of tobacco use for women facilitates the suppression of anger and other negative emotions, rendering the dependence on tobacco less of a problem to society

THE NEXT STEP

1. *Tobacco is the single greatest preventable cause of death in the world. Why do you think we do not have a wider range of treatment options for tobacco dependency?*
2. *What opportunities are there for integrating tobacco cessation interventions for women with interpersonal violence?*

RELATED:

► Women-centred Approaches to Smoking Cessation Drugs and Nicotine Replacement Therapies (NRTs), p.42

Sex- and Gender-based Analysis and Tobacco Policy

IN SUM

Sex- and gender-based analysis is a tool that can help develop more effective tobacco control policies by tailoring tobacco control to women's and men's circumstances.

Sex- and gender-based analysis (SGBA) is an analytical tool that systematically integrates a gender perspective into the development of policies, programs and legislation, as well as planning and decision-making processes. It helps to identify and clarify the differences between women and men, boys and girls, and demonstrates how these differences might affect access to and use of tobacco, responses to policies and programs and social and economic issues affecting health.

SGBA rests on the understanding that both biology (sex) and the social experience of being a man or a woman (gender) affect people's lives and their health. We know that male and female bodies have different functions in reproduction, but sex differences in the size of the coronary arteries or lung capacity, or different disease processes may also explain women's and men's different responses to tobacco use and exposure.

As well, the roles and expectations attached to being male or female also affect one's chances of education, income level, labour force participation, care giving roles and experiences of violence and opportunity for health. Taking into consideration these biological and social differences between women and men,

WHY IS SEX- AND GENDER-BASED ANALYSIS (SGBA) IMPORTANT?

The SGBA process is critical in planning health programs, developing health policies and conducting research so that the needs and issues affecting women and tobacco are taken into account. SGBA supports the analyses of health inequities arising from gender relations and the interaction of gender with other social factors such as income, race and ethnicity and can contribute to designing health system responses.

and analyzing how they relate to tobacco use, exposure, marketing or production is critically important.

Rather than assuming that “one size fits all,” SGBA reminds us to ask questions about similarities and differences between and among women and men, such as: Do women and men have the same susceptibility to lung disease from smoking? Do tobacco control policies and programs work the same way for different groups of women? By introducing such questions, SGBA can help lead to positive changes in how programs are offered or how resources are allocated.

Sex and gender affect the use and effects of tobacco for women and men. For example, differences in lung anatomy, genetics and physiology between women and men potentially increase the harm associated with women’s exposure to smoke. Smaller airways in women may serve to concentrate the toxic chemicals in tobacco smoke while research

SOURCES

Clow, B., Pederson, A., and Bernier, J. (2009). *Rising to the Challenge: Sex- and gender-based analysis for health planning, policy, and research in Canada*. Atlantic Centre of Excellence for Women’s Health. Halifax, Nova Scotia. Chapters 1 and 7 (pp. 1-3 and pp.146-151). Available from <http://sgba-resource.ca>

Greaves, L., Jategaonkar, N. and Sanchez, S. (Eds.) *Turning a New Leaf: Women, Tobacco, and the Future*. British Columbia Centre of Excellence for Women’s Health (BCCEWH) and International Network of Women Against Tobacco (INWAT). Vancouver: British Columbia Centre of Excellence for Women’s Health. Available from www.bccewh.bc.ca

Greaves, L. and Tungohan, E. (2007). Engendering tobacco control: using an international public health treaty to reduce smoking and empower women. *Tobacco Control*, 16:148–150. doi: 10.1136/tc.2006.016337

suggests that women metabolize smoke differently than men and therefore may be more susceptible to respiratory diseases such as chronic obstructive pulmonary disease and lung cancer. Further, women are at increased risk of breast cancer due to either active smoking or exposure to others' smoke, particularly if this exposure occurs during adolescence.

Likewise, gender affects when, how and where girls and women smoke and/or are exposed to smoke. Unequal power dynamics between women and men may reduce women's ability to control exposure to secondhand smoke in home or work settings. Women may also smoke for particular reasons, such as to organize social relationships, create an image, control emotions and as a form of social support and control. Culture, class and other determinants, likewise, influence trends in women's smoking and differences among women. For instance, women with limited education or vocational opportunities may have to work in settings, such as restaurants, where they are more likely to be exposed to secondhand smoke. In addition, these biological and social factors interact and overlap. When women are exposed to secondhand smoke as a result of power inequities, their narrower airways again increase their risks of morbidity and mortality.

Other forms of tobacco use, such as chewing tobacco and beedis, also have health implications, including more oral cancers and poorer reproductive health outcomes. There are specific health risks associated with tobacco manufacturing and women who

work in tobacco production absorb nicotine through the skin and can develop a condition called “green sickness,” which results in nausea, fatigue, headache, weakness, breathing problems and changes in blood pressure and heart rate.

In many countries, although cigarette smoking rates among women may still be low, secondhand smoke exposure among women is high where male smoking rates are high. In addition, due to gendered roles of care-giving and family health management, high rates of tobacco dependence, morbidity and mortality in men increase domestic demands on women, reduce family income and negatively influence family health and nutrition. The health and economic effects of tobacco use are thus sex- and gender-specific.

THE WORLD HEALTH ORGANIZATION'S FRAMEWORK CONVENTION ON TOBACCO CONTROL (FCTC) AND SEX- AND GENDER-BASED ANALYSIS

The Preamble of the WHO FCTC indicates “[alarm] by the increase in smoking and other forms of tobacco consumption by women and young girls worldwide and [emphasizes the need for Parties to] 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 measures”.

Below are some examples of selected FCTC Articles with considerations for the development of gender-specific tobacco policies as well as overall strategies for empowering women.

RESOURCES

Christofides N (2001). 'Policies and strategies: how to make policies more gender-sensitive.' In: Samet JM, Yoon SY, eds. *Women and the tobacco epidemic: challenges for the 21st century*. Geneva, World Health Organization www.who.int/tobacco/media/en/WomenMonograph.pdf

Gender Analysis in Health: A Review of Selected Tools (2002)
World Health Organization
www.who.int/gender/documents/en/Gender_analysis.pdf

Greaves, L. (2007). *Sifting the evidence: gender and tobacco control*. World Health Organization: Department of Gender, Women and Health and Tobacco Free Initiative. Available from www.who.int.

SGBA e-Learning Resource
<http://sgba-resource.ca>
Free tutorials on the core concepts and process of sex- and gender-based analysis

THE NEXT STEP

1. *What tobacco-related initiatives are happening in your community or country? Do they take a gender-informed approach?*
2. *How does tobacco use by men affect women? How does tobacco use by women affect men?*

Article 6 endorses price and taxation measures. The gendered effects of taxation and price are mixed according to research from developed countries. Although low-income groups exhibit greater price elasticity than higher income groups, tobacco taxes impose a “regressive burden” on lower-income taxpayers. 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 inequities experienced by low-income women.

Article 12 encourages public education and information campaigns on tobacco. Such endeavours may need tailoring when the majority of illiterate people globally are women, often without formal education. 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. Female educational empowerment may assist in reducing tobacco use.

Article 13 endorses legislation controlling tobacco advertisement, promotion and sponsorship. The tobacco industry spends US\$4.6 billion annually on marketing to women and children, and has used a gender and diversity approach for decades. Campaigns promoting cigarettes 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 ethnocultural 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.

Article 16 encourages the promotion of economically viable alternatives for tobacco workers, growers and individual sellers. Women are less likely than men to be land owners and named in agreements with tobacco companies, but are encumbered with intensive tobacco farming responsibilities. Children from tobacco estates usually cannot attend school. Because girls' education is undervalued in low- and middle-income countries, girls from tobacco estates are further disadvantaged.

RELATED:

- ▶ Girls, Women, Media, and Tobacco, p. 48
- ▶ Using Shadow Reporting to Advance Women's Health and Reduce Tobacco Use, p. 58
- ▶ Sex- and Gender-based Analysis and Tobacco Policy, p. 68
- ▶ Diversity, Equity, and Secondhand Smoke Policies, p. 74

Diversity, Equity, and Secondhand Smoke Policies

IN SUM

Many countries have taken steps towards implementing secondhand smoke policies with many successful outcomes. However, these policies do not affect all groups of women equally and may have unintended consequences.

A range of diverse factors, such as ethnicity, sexual orientation, income level and culture, interact with gender and need to be considered in planning tobacco initiatives. Generic tobacco control approaches can often be strengthened by considering the specific needs of various communities and populations. Other initiatives tailored for specific groups of women and men may be needed to ensure that all groups within a population equally experience the benefits of tobacco prevention and control policies.

Many countries have begun to implement policies that prohibit or restrict smoking in outdoor areas (such as beaches, parks, and campuses), in public places (such as restaurants and bars) and workplaces. On 29 March 2004, Ireland became the first country to implement legislation to make 100% of enclosed workplaces, including restaurants and bars, smokefree. Since then, several countries, including the United Kingdom, New Zealand, Uruguay, Bermuda, Bhutan, and the Islamic Republic of Iran, have enacted 100% smoke-free laws. Other jurisdictions around the world have enacted similar legislation at the local or regional levels.

Currently, more than 170 countries have ratified the World Health Organization's



Framework
Convention on
Tobacco Control
(WHO-FCTC),
which requires
them to protect
all people from
exposure to tobacco
smoke in most
public places and
on public transport.

Some laws prohibit smoking in many or most public places but allow for smoking rooms or make exceptions, while others prohibit smoking in all enclosed public places, with no exceptions.

In general, public support is high for smoking bans in public places, including crowded outdoor areas. In regions where smoking bans have been mandated by law, employees, customers, and business owners report high compliance and satisfaction with the results, and compliance with smoke-free regulations increases over time. A 2010 Cochrane literature review assessed 31 studies measuring exposure to secondhand smoke after smoking bans, with 19 studies including biomarkers. The review concluded that there is “consistent evidence that smoking bans reduced exposure to secondhand smoke in work places, restaurants, pubs, and public places.”

However, research suggests that not all men and women experience the effects of these policies equally and that there might be unintended consequences to secondhand smoke policies. Current challenges are how to

SOURCES

Eriksen, M., Mackay, J., Ross, H. (2012). *The Tobacco Atlas*. Fourth Ed. Atlanta, GA: American Cancer Society; New York, NY: World Lung Foundation. Available from: www.TobaccoAtlas.org

Greaves, L. and Hemsing, N. (2009). Sex, Gender, and Secondhand Smoke Policies: Implications for Disadvantaged Women. *American Journal of Preventive Medicine*, 37(2S): S131-S137

Hemsing, N., Greaves, L., Poole, N., and Botorff, J. (2012). Reshuffling and Relocating: The Gendered and Income-Related Differential Effects of Restricting Smoking Locations. *Journal of Environmental and Public Health*, doi:10.1155/2012/907832

National Networks for Tobacco Control and Prevention (USA) www.tobaccopreventionnetworks.org

Network for LGBT Health Equity. (2012). *MPOWERED: Best and Promising Practices for LGBT Tobacco Prevention and Control*. The Fenway Institute: Boston, MA. Available from: <http://lgbthealthequity.wordpress.com/>

Tobacco Research Network on Disparities (TReND) <http://tobaccodisparities.org>

RESOURCES

Callinan, J.E., Clarke, A., Doherty K., and Kelleher, C. (2010). Legislative smoking bans for reducing secondhand smoke exposure, smoking prevalence and tobacco consumption. *Cochrane Database of Systematic Reviews* 2010, Issue 4. Art. No.: CD005992. DOI: 10.1002/14651858.CD005992.pub2.

Eriksen, M., Mackay J., Ross, H. (2012). *The Tobacco Atlas*. Fourth Ed. Atlanta, GA: American Cancer Society; New York, NY: World Lung Foundation. Available from: www.TobaccoAtlas.org

Greaves, L., Kalaw, C., and Bottorff, J.L. (2007). Case studies in power and control related to tobacco use during pregnancy. *Women's Health Issues*, 17(5): 325-332.

The Network for LGBT Health Equity
<http://lgbthealthequity.wordpress.com>

decrease smoking in the home, and how to regulate smoking in multifamily homes and in vehicles with small children. Because the home is generally considered outside the realm of government regulation, and in many cultures it may not be acceptable for a woman to ask her partner or another male to refrain from smoking in the home, many public health and tobacco control organizations have begun to implement educational campaigns to reduce secondhand smoke (SHS) exposure in the home. However, this also requires addressing overall gender inequalities within the domestic sphere.

Women may also face specific vulnerabilities due to the gendered and classed nature of work and the type of jobs women are more likely to occupy. For example, low-income women working primarily in office and retail environments may experience a pro-smoking environment (including more opportunities for smoke breaks and the presence of other coworkers who smoke).

SHS policies may have unintended consequences as they contribute to 'denormalizing' tobacco. In certain contexts, women and men smokers may eventually be denied housing, may be discriminated against in the workplace or may avoid seeking health care due to shame associated with being a smoker. Low-income women may face additional challenges. For example, low-income women living in high density areas may have limited access to safe outdoor spaces for smoking. The implementation of

SHS policies can also contribute to conflict or tension between partners or within households, particularly during pregnancy and postpartum.

DIVERSITY ANALYSES: TAILORING TOBACCO PREVENTION AND CONTROL FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) COMMUNITIES

Because lesbian, gay, bisexual, and transgender (LGBT) people smoke at rates from 35% to almost 200% higher than the general population, tailored tobacco interventions are likely to be more successful when used alone or in tandem with mainstream or traditional approaches.

The TReND network in the USA was a multi-year project that addressed many of these issues and commissioned research and projects to develop evidence, new research methods, develop initiatives and appropriate policy and messaging for a variety of groups experiencing disparities in tobacco use and exposure.

An example of creating specific networks to address a subpopulation is the work of the Network for LGBT Health Equity, a community-driven network of advocates and professionals based in the United States. In 2012, The Network for LGBT Health Equity released MPOWERED: Best and Promising Practices for LGBT Tobacco Prevention and Control. Building upon the MPOWER best practices model for tobacco control developed by the World Health Organization, the Network brought together research and evidence related to key challenges in tobacco control for LGBT people.

The Network is one of six networks funded

THE NEXT STEP

1. *Has the country you live in ratified the WHO Framework Convention on Tobacco Control (FCTC)? What secondhand smoke policies have been developed? What have been some of the challenges of implementing these policies?*
2. *In your community, which groups or populations of women have significantly higher tobacco use rates than the general population or from women in general? What do you think are some of the reasons for these differences?*

RELATED:

- ▶ Women and Exposure to Secondhand Smoke, p. 8
 - ▶ Harm Reduction Support Strategies for Mothers who Smoke, p.28
 - ▶ Sex- and Gender-based Analysis and Tobacco Policy, p. 68

by the Centers for Disease Control to address tobacco issues in groups that experience significant tobacco related disparities, e.g., they experience increased targeting by the tobacco industry and rates of tobacco use that vary substantially. In addition to the LGBT population, this initiative works with African American, American Indian/Alaska Native, Asian American, Native Hawaiian and Pacific Islander, Hispanic/Latino, and Low Socio-economic populations.

DISCUSSION GUIDES

- ▶ HEALTH PLANNERS, POLICY MAKERS, AND RESEARCHERS
- ▶ MATERNAL AND CHILD HEALTH PROGRAMS
- ▶ ANTI-VIOLENCE ORGANIZATIONS AND OTHER WOMEN-SERVING ORGANIZATIONS
- ▶ MENTAL HEALTH AND ADDICTIONS PROGRAMS
- ▶ HEALTH AND SOCIAL SERVICE PROVIDERS
- ▶ WOMEN WHO ARE QUITTING OR REDUCING THEIR SMOKING (OR ARE THINKING ABOUT IT)



These discussion guides explore different areas of practice, programming, and policy development related to women and tobacco. They are designed to stimulate further conversation on addressing the harms of tobacco in prevention, treatment, service system planning and policy making. Each guide begins by asking individuals to reflect on their current practices, policies and approaches to a range of issues related to women and tobacco. The questions then shift to supporting individuals in considering the impact of tobacco in their field/work and community and to explore strategies and approaches that can be used to address the harms of tobacco.

I. DISCUSSION GUIDE FOR HEALTH PLANNERS, POLICY MAKERS, AND RESEARCHERS

Suggested Reading

- Girls, Women, and Tobacco: Global Trends
- Women and Exposure to Secondhand Smoke
- Women-Centred Brief Interventions by Health Care Providers
- Strategies for Reducing Tobacco Use in Pregnant and Postpartum Women
- Girls, Women, Media, and Tobacco
- Sex- and Gender-based Analysis and Tobacco Policy
- Diversity, Equity, and Secondhand Smoke Policies

Overall, tobacco use is increasing for girls and young women, and in some cases surpassing rates for boys. How does this fit with your experience? Why is it important to know this type of information?

What tobacco-related initiatives are happening in your community or country? Do they take a gender-informed approach? What is working? What are areas that could be developed?

What have you noticed about how tobacco issues, in general, and for women, in particular, are treated within the health and social service system?

What can you do in your role to shift perceptions and awareness of issues related to women and tobacco?

What can be done to support women exposed to secondhand smoke in the workplace, in public transportation, or in the home?

How are women who smoke or women exposed to secondhand smoke involved in influencing program development specific to your service? What about women overall?

II. DISCUSSION GUIDE FOR MATERNAL AND CHILD HEALTH PROGRAMS

Suggested Reading

- Women Working in the Health Care System and Tobacco Control
- Women and Exposure to Secondhand Smoke
- Indigenous Women and Tobacco
- Harm Reduction Support Strategies for Mothers who Smoke
- Women-Centred Brief Interventions by Health Care Providers
- Strategies for Reducing Tobacco Use with Pregnant and Postpartum Women
- Women-centred Approaches to Smoking Cessation Drugs and Nicotine Replacement Therapies (NRTs)

Overall, interventions to address tobacco use with pregnant women have not been resoundingly successful. How does this fit in with your experience? What are some alternate approaches to addressing tobacco use in the perinatal period that might work in your context?

What tobacco-related initiatives are happening in your community or country? Do they take a gender-informed approach? What is working? What are areas that could be developed? How can your program/agency become better connected or involved with these initiatives?

What can you do in your role to shift perceptions and awareness of issues related to women and tobacco?

How is your program/agency linking with other programs/agencies in a position to support women's health and reduce harms related to tobacco?

What can be done to support women exposed to secondhand smoke in the workplace, in public transportation, or in the home?

What opportunities are there for staff education for learning practice skills such as motivational interviewing? How does your work environment support ongoing learning and sustainability?

How are women who smoke or women exposed to secondhand smoke involved in influencing program development specific to your service? What about women overall?

Tobacco advertisers target girls and young women through concerns about appearance and a desire to connect with others. What can be done in your service or program to reduce media influence and strengthen protective factors for girls and young women?

III. DISCUSSION GUIDE FOR ANTI-VIOLENCE ORGANIZATIONS AND OTHER WOMEN-SERVING ORGANIZATIONS

Suggested Reading

- Women and Exposure to Secondhand Smoke
- Indigenous Women and Tobacco
- Girls, Women, Media, and Tobacco
- Using Shadow Reporting to Advance Women's Health and Reduce Tobacco Use
- Changing Organizations: Integrating Tobacco Interventions into Treatment for Other Addictions
- The International Network of Women Against Tobacco

What is your smoking story?

How is your program/agency linking with other programs/agencies in a position to support women's health and reduce harms related to tobacco?

What tobacco-related initiatives are happening in your community or country? Do they take a gender-informed approach? What is working? What are areas that could be developed? How can your program/agency become better connected or involved with these initiatives?

What opportunities are there for staff education for learning practice skills such as motivational interviewing? How does your work environment support ongoing learning and sustainability?

Tobacco advertisers target girls and young women through concerns about appearance and a desire to connect with others. What can be done in your service or program to reduce media influence and strengthen protective factors for girls and young women?

What can you do in your role to shift perceptions and awareness of issues related to women and tobacco?

When you think about how attitudes and beliefs towards tobacco have changed in your lifetime, what do you think has been effective in contributing to these changes?

IV. DISCUSSION GUIDE FOR MENTAL HEALTH AND ADDICTIONS PROGRAMS

Suggested Reading

- Women Working in the Health Care System and Tobacco Control
- Women-Centred Brief Interventions by Health Care Providers
- Changing Organizations: Integrating Tobacco Interventions into Treatment for Other Addictions

What is your smoking story?

What have you noticed about how tobacco issues, in general, and for women, in particular, are treated within the health and social service system?

When you think about how attitudes and beliefs towards tobacco have changed in your lifetime, what do you think has been effective in contributing to these changes?

Overall, tobacco use is increasing for girls and young women, and in some cases surpassing rates for boys. How does this fit in with your experience? Why is it important to know this type of information?

What can you do in your role to shift perceptions and awareness of issues related to women and tobacco?

How is your program/agency linking with other programs/agencies in a position to support women's health and reduce harms related to tobacco?

What opportunities are there for staff education for learning practice skills such as motivational interviewing? How does your work environment support ongoing learning and sustainability?

V. DISCUSSION GUIDE FOR HEALTH AND SOCIAL SERVICE PROVIDERS

Suggested Reading

- Girls, Women, and Tobacco: Global Trends
- Women Working in the Health Care System and Tobacco Control
- Women-Centred Brief Interventions by Health Care Providers
- Strategies for Reducing Tobacco Use with Pregnant and Postpartum Women
- Women-centred Approaches to Smoking Cessation Drugs and Nicotine Replacement Therapies (NRTs)

What is your smoking story?

What have you noticed about how tobacco issues, in general, and for women, in particular, are treated within the health and social service system?

How is your program/agency linking with other programs/agencies in a position to support women's health and reduce harms related to tobacco?

What can you do in your role to shift perceptions and awareness of issues related to women and tobacco?

What can be done to support women exposed to secondhand smoke in the workplace, in public transportation, or in the home?

What opportunities are there for staff education for learning practice skills such as motivational interviewing? How does your work environment support ongoing learning and sustainability?

When you think about how attitudes and beliefs towards tobacco have changed in your lifetime, what do you think has been effective in contributing to these changes?

VI. DISCUSSION GUIDE FOR WOMEN WHO ARE QUITTING OR REDUCING THEIR SMOKING (OR ARE THINKING ABOUT IT)

Suggested Reading

- Indigenous Women and Tobacco
- Women-only Group Programs for Reducing and Quitting Smoking
- Harm Reduction Support Strategies for Mothers who Smoke
- Girls, Women, Media, and Tobacco

What is your smoking story?

What approaches to reducing or quitting smoking have been effective for you in the past? Do you believe that women-specific programs or approaches to quitting smoking have been or could be effective for you?

Many women say that social support is important in helping them to succeed in stopping tobacco use. What kind of support is available to you (partner, parent, sibling, friend, health care provider, community agency, other women who are quitting smoking, on-line resources or support groups)? What other kinds of support would be helpful?

Often, the tobacco industry equates smoking with women's freedom and empowerment. What do you think about this?

How do you think your own smoking has been affected by broader social, political, and economic forces? How do you think these forces might affect your own approach to quitting or reducing smoking?

The 'tobacco control movement' includes a breadth of strategies ranging from initiatives like clean air and smoke-free areas, fair labour practices, and access to quit smoking programs that meet individual needs. Which policies and global movements for change do you believe are making a difference? Which ones are not?