INTERNATIONAL NETWORK OF WOMEN AGAINST TOBACCO

Global Bridges: A New Approach to Tobacco Dependence Treatment

Katherine Kemper, Executive Director, Global Bridges

When the Framework Convention entered into force in early 2005, Article 14 received relatively little attention. In many places it was assumed that the population "wasn't ready" for treatment, since the smokers there had no reason to want to stop. Nearly nine years later, broad implementation of tobacco control policies is creating a new demand for treatment, as tobacco use becomes increasingly denormalized and restricted. This summer, the World Health Organisation Tobacco Free Initiative launched a comprehensive suite of training materials on tobacco dependence treatment, pursuing a systems approach to ensure that healthcare professionals, policymakers, and health systems managers all have appropriate information. "As countries implement more tobacco control policies, there is an ethical imperative to provide support for people who seek help to stop smoking" says Dr. Adriana Blanco, regional advisor with the Pan American Health Organisation.

Many people believe treatment is all about drugs; this raises concerns in areas where pharmacologic treatment is unavailable, or expensive to the individual. In fact, healthcare providers can make an enormous impact even

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President's Corner

Quitting Tobacco Use: Women Are Different

Women's right to health is a fundamental human right. Few people would disagree with the statement but unfortunately it is not always reflected in health policies, laws and programmes nor is it necessarily implemented on the ground. In the words of the poet T S Eliot, "Between the idea and the reality... Falls the Shadow."

The 'shadow', or the gap between what is said about women's health and what is done about women's health, is as starkly apparent in tobacco control as it is in other dimensions of women's health. For this reason, it is imperative not only that we bring a gender and inequality lens to tobacco use but also that we support women's leadership in tobacco control. This is one of the central tenets of INWAT's work.

Within the realm of tobacco control, cessation or tobacco dependence treatment (TDT) for women is a high-priority issue. According to figures from WHO, without action to reduce smoking, deaths among women aged 20 years and over may rise from 1.5 million in 2004 to 2.5 million by 2030, with almost 75% of the projected deaths occurring in low- and middle-income countries. And if this were not alarming enough, there is now evidence that the rates of smoking among girls and young women is increasing in several regions of the world.

The best way to prevent this pending disaster would be to make sure those girls and women don't become addicted to tobacco in the first place. But it is also essential that we make every effort to assist current tobacco users to quit, especially because adult women are role models to their daughters and sisters. Accordingly, we have dedicated the issue of the NET to cessation and tobacco treatment dependence.

Our feature article, by Katie Kemper, provides information about an exciting new approach to TDT called Global Bridges. This initiative, operating out of the renowned Mayo Clinic in the United States, is currently working across the globe to advance evidence-based tobacco dependence treatment and to support healthcare providers to assist tobacco users to quit.

And there is clearly much work to be done on TDT. Martin Raw's article highlights the key findings of a recent survey of 166 countries, which indicate that fewer than half of the countries surveyed had TDT guidelines or strategies in place and only 22% had treatment budgets.

Moving from the global picture to country specific scenarios for treatment, we have articles that focus on Spain, India, China, Nigeria and the Czech Republic. A common theme in all of these countries indicate that healthcare professionals, and particularly nurses, have a key role to play in TDT and, alarmingly that many healthcare professions continue to use tobacco themselves.

We are including an article on the controversial subject of e-cigarettes. Often touted as a device for reducing tobacco use, Patti White and Martina Potschke-Langer examine the current status of the evidence and focus on whether e-cigarettes might help or hinder women and girls in their attempt to quit tobacco use.

Finally, we have two articles from Canada, specifically from the British Columbia Centre for Excellence in Women's Health, that deal with the content and delivery of TDT initiatives. Firstly, Nancy Poole alerts us to the fact that women who have experienced trauma and violence have higher rates of smoking than the general population. She argues that as we try to help women tobacco users who have experienced trauma and violence we need to change the ways in which we interact with them in order to avoid causing further trauma. And secondly, Lorraine Greaves, the immediate past president of INWAT, shares with us a new guide called Liberation! The guide provides practical ideas on how to talk with women about quitting smoking in ways that build confidence and show real understanding of the difficulties of quitting. It also contains tools and resources for discussion, planning and support before and during interventions.

I hope that you will find this ì̀ssue of the NET useful. Do share your reactions to the articles with us and feel free also to make suggestions for themes or articles for future editions of the NET. You'll find us at INWAT.org. We look forward to hearing from you.

The struggle to curb the epidemic of tobacco use, particularly among women and girls, continues. We are a vital part of it!

Patricia Lambert, President INWAT

without the use of pharmaceuticals. Even brief advice from a doctor about stopping smoking increases the likelihood that someone who smokes will successfully quit and remain a nonsmoker 12 months later (Stead LF, Cochrane review). More intensive advice and providing follow-up support can increase the success rate. As respected members of the community, healthcare professionals can also be highly effective advocates. Bringing these influencers into the war against tobacco is to everyone's benefit.

Global Bridges: Healthcare Alliance for Tobacco Dependence Treatment was founded in 2010 with an unrestricted grant from the Pfizer Medical Education Group. Our mission is to mobilize a global network of healthcare providers and organizations dedicated to advancing evidence-based tobacco dependence treatment and effective tobacco control policy. Global Bridges is hosted and managed at Mayo Clinic, in Rochester, MN, USA in partnership with the American Cancer Society. The Executive Committee includes Chairman Richard D. Hurt, M.D. along with Directors J. Taylor Hays, M.D. and Scott Leischow, Ph.D. and Executive Director Katherine Kemper, M.B.A. (all of Mayo Clinic) and Director Thomas J. Glynn, Ph.D. of the American Cancer Society. Training sessions and other program work is conducted by regional partners in four WHO regions:

- AFRICA REGION: University of Pretoria; Regional Director Lekan Ayo-Yusuf BDS MPH PhD
- AMERICAS REGION: InterAmerican Heart Foundation; Regional Director Gustavo Zabert MD, IAHF Executive Director Beatriz Champagne PhD (INWAT Board member)
- EASTERN MEDITERRANEAN REGION: King Hussein Cancer Center; Regional Director Feras Hawari MD
- EUROPE REGION: NATIONAL CENTRE FOR SMOKING CESSATION TRAINING (UK); Regional Directors Andy McEwen PhD and Emma Croghan RGN

Each regional partner has developed a customized 2-3 day training curriculum for healthcare professionals in their region, aligned with competencies developed by the Association for Treatment of Tobacco Use and Dependence. The regional leadership ensures that training curricula are culturally appropriate and that learning is shared between countries. To date 2000 people from 56 countries have been trained; these healthcare providers will see an estimated 221,000 tobacco-dependent patients in 2013. To facilitate communication among the network, Global Bridges maintains a multilingual website www.globalbridges.org which now has over 1200 registered members. Working with our regional partners and with instructional design experts at the University of Toronto Centre for Addiction and Mental Health, Global Bridges is developing an internet-delivered curriculum in Arabic and Spanish. Using the internet in languages where scarce resources currently exist will significantly broaden the reach of Global Bridges' training.

One particular area where Global Bridges can have an impact is in supporting the work of the nursing community. Globally there are over 19 million nurses and midwives (WHO, 2011). As frontline, respected, and trained health professionals, nurses are ideally placed to help patients quit smoking. There is an extensive evidence-base for treatment and nurse smoking cessation interventions are effective (Rice & Stead, 2008). Unfortunately tobacco dependence treatment is not embedded in the practice of most nurses or included in most nursing curricula (Chan et al, 2007; Sarna et al, 2009a; Sarna et al, 2009b). Some organizations have position statements about nurses and tobacco control but advocacy is needed to action these. Through an agreement with Tobacco Control Nurses International, Global Bridges created a resource space on our website specifically for nurses. This is maintained and populated by the Grace Wong and Lynn Stevenson at the Auckland (NZ) University of Technology for the benefit of our 380+ nurse members. Wong said: "The potential for nurse support for smokers to quit is enormous but as yet untapped in most countries. National nurse leaders are enthusiastic about advancing nurse smoking cessation action. Six hundred visited our stand at the recent International Congress of Nurses in Melbourne, Australia."

The Global Bridges team is excited about the opportunities to expand evidence-based tobacco dependence treatment around the world and support advocacy among healthcare professionals. We'd love to get input from INWAT members – please post a comment on our website!

References

1. Stead, L.F., Bergson, G., & Lancaster, T (2008). Physician Advice for Smoking Cessation. Cochrane Database of Systematic Reviews 2008, Issue 2. Art. No.: CD000165.
2. World Health Organisation (2011). World Health Statistics 2011. World Health Organisation, Geneva.
3. Rice, V.H., & Stead, L.F. (2008). Nursing interventions for smoking cessation. Cochrane Database Syst Rev (1), CD001188.
4. Chan, S.S., Sarna, L., Wong, D.C., & Lam, T.H. (2007). Nurses' tobacco-related knowledge, attitudes, and practice in four major cities in China. J Nurs Scholarsh, 39 (1), 46-53.
5. Sarna, L., Bialous, S.A., Wells, M., Kotlerman, J., Wewers, M.E., & Froelicher, E.S. (2009a). Frequency of nurses' smoking cessation interventions: report from a national survey. J Clin Nurs, 18 (14), 2066-2077.
6. Sarna, L., Bialous, S.A., Rice, V.H., & Wewers, M.E. (2009b). Promoting tobacco dependence treatment in nursing education Drug Alcohol Rev, 28 (5), 507-516.

The Tobacco Products Directive: is Europe ready to go for it?

Elizabeth Tamang, Chair INWAT Europe

A Directive is a legislative act of the European Union (EU) which sets the rules for EU Member States to achieve a particular result. National authorities have to adapt their laws to meet these goals. When adopted, a Directive gives Member States a timetable for its implementation after which it becomes binding. The European Commission, the executive arm of the EU, prepares the draft of the Directive after consultation with its own and national experts, presents it to the Parliament and the Council of Ministers initially for evaluation and comment, then subsequently for approval or rejection.

Ten years after its adoption, it has become necessary to update and complete the current Tobacco Products Directive (TPD). The new proposal responds to requests from the European Parliament and the Council of Ministers as well as the Commission's own report on the Application of the Tobacco Products Directive of 2007 and 2009, which identified potential areas for improvement.[1]

The EU Commission has estimated that in five years the revised and properly implemented TPD will reduce the number of smokers by 2.4 million, create a net gain of 2234 jobs, produce a net benefit to the economy of €4 billion, €506 million in annual reductions in healthcare costs, and save 16.8 million life-years.[2]

As part of the preparatory work on the revision of the current Directive, the Commission's Directorate General for Health & Consumers (DG SANCO) held an extensive consultation of stakeholders including a public consultation in September 2010 which generated 85,000 online responses and 300 letters.[3] Almost two-thirds of the responses came from only two countries: Italy (31,336) and Poland (23,711), most probably due to the petition campaigns supported by the tobacco industry and its allies. One such campaign was organised by a group representing over 75% of Italian tobacconists. This action was followed by submissions of personal signatures by over 30 000 tobacconists across Italy.[4, 5]

In December 2012 the European Commission finally adopted its proposal to revise the Tobacco Products Directive. The proposed legislation consists of new and strengthened rules on how tobacco products can be manufactured, presented, and sold. This proposal will be discussed in the European Parliament and in the Council of Ministers. It is expected to be adopted in 2014. It would come into effect from 2015-2016.

INWAT Europe has written letters to MEPs and Ministers of Health in support of the TPD underlining the importance of the following parts in relation to protecting girls and women.[6]

- **The ban on slim packs including slim cigarettes–** Research on the impact of pack design on young women, including brand descriptors such as "slim", as well as skinny packs and 'feminine' colors, has found that such packs are more misleading about health risks and more appealing to young women.
- **75 % pictorial health warnings–** A review of the evidence has found that picture health warnings covering 75% or more of the pack are significantly more effective than warnings covering 50% or less.
- **Removal of tar nicotine and carbon monoxide levels from packs–** Quantitative information on these levels is misleading as it encourages consumers, including many women, to think that some products are safer or less risky than others.
- **Banning characterizing flavors–** These flavors such as chocolate, mint, vanilla, peach and grape make it easier to inhale, particularly for young people.
- **E-cigarettes–** They should be regulated as pharmaceutical products.

However the tobacco industry and its allies continue to attempt to block and obstruct the proposal and are fighting Member States' attempts to reduce smoking prevalence.[7]

On 8 October, the European Parliament, voted for the first time on the proposals, rejecting the proposal for 75% pictorial **health warnings in favour of 65%** but minimum dimensions of the health warnings means that **'lipstick packs'** will no longer be legal. There was no approval of regulation of **e-cigarettes**. The European Parliament approved of a **ban on flavours**, but permitting a four-year delay on menthol. Following this vote, there must now be negotiations between the Parliament, the Council of Health Ministers and the Commission to see if a new proposal can be made. The European institutions remain under time pressure to complete the legislative process in the next weeks; otherwise its adoption will fall dangerously close to the European Parliament's elections later this year, putting the hard-fought political process back to the start.

The EU and its Member States must recognize the irreconcilable conflict of interest between the tobacco industry and public health. Being Parties to the WHO FCTC, they are required to ensure that the commercial and vested interests of the tobacco industry do not undermine tobacco control policies.

1. http://ec.europa.eu/health/tobacco/products/revision/
2. http://ec.europa.eu/health/tobacco/key_documents/index_en.htm#anchor0

3. http://ec.europa.eu/health/tobacco/consultations/tobacco_cons_01_en.htm
4. Report on the public consultation on the possible revision of the Tobacco Products Directive (2001/37/EC), July 2011,
5. http://www.tobaccotactics.org/index.php/TPD:_Delaying_the_Process_of_Consultation
6. World Health Organization Europe (2010) Empower Women: Combating Tobacco Industry Marketing in the European Region, Copenhagen
7. http://www.nothankeu.com/tpd.php

Tobacco dependence treatment around the world

Martin Raw, Special Lecturer, UK Centre for Tobacco Control Studies, University of Nottingham

During 2012 our team, based at the universities of Nottingham, King's College London and Harvard, conducted a survey of tobacco dependence treatment services and treatment guidelines in Parties to the FCTC. We received responses from 121 of the 166 countries surveyed, a response rate of 73%. The response rate was high in all WHO regions and all World Bank income groups, the lowest being 65% and the highest 83%.

The key findings on basic infrastructure were that fewer than half of the countries surveyed had national treatment guidelines (44%), a government official responsible for tobacco dependence treatment (41%), an official national treatment strategy (44%), a clearly identified treatment budget (22%), mandated the recording of tobacco use in medical notes, or provided tobacco cessation support for health workers (46%); 56% encouraged brief advice in existing health care services.

The key findings on the provision of cessation support were that 36% of countries had quitlines, 17% had a network of specialised treatment support covering the whole country (32% had no specialised treatment facilities at all), the most readily available medications (according to manufacturer data) were available in just over half of countries – varenicline in 52%, NRT in 51%, bupropion in 17% and cytisine in 10%. Perhaps not surprisingly there were large differences in rated affordability of medications according to World Bank income level, with affordability being highest in high income countries. The only medication rated as being easily affordable everywhere it was available, was cytisine (in Eastern Europe a one month course costs approximately US$15). Respondents in almost one third (30%) of countries indicated that tobacco users could easily get help in a general/family practice setting, while 17% said the same for pharmacists, 7% for dentists, 18% for hospitals and 23% from the internet; in no other setting did the figure exceed 25%.

In the case of almost all aspects of provision of cessation support, there was a steep gradient by income level, with much lower levels of provision in lower income countries.

We also conducted a similar survey in 2007 and although the results cannot be directly compared because the samples were so different, it does not look as if there has been significant improvement in the provision of cessation support over these five years. The (not very surprising) finding that countries with higher income provide more support, should remind us that the FCTC Article 14 guidelines strongly stress prioritising the development of broad reach low cost interventions. The relatively poor integration of brief advice throughout the healthcare system is disappointing, as is the very low proportion of countries that mandate the recording of tobacco use in medical notes. Low cost measures like these last two should be standard in all countries.

The research team was: Hemba Pine-Abata, Ann McNeill, Martin Raw, Rachael Murray, Nancy Rigotti, Asaf Bitton; the papers are now available online to Addiction subscribers: (1) Piné-Abata H, McNeill A, Raw M, Bitton A, Rigotti N, Murray R. A survey of tobacco dependence treatment guidelines in 121 countries. Addiction 2013, in press; (2) Piné-Abata H, McNeill A, Murray R, Bitton A, Rigotti N, Raw M. A survey of tobacco dependence treatment services in 121 countries. Addiction 2013, in press.

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Nigerian women and tobacco use

Kemi Odukoya, Lecturer, Department of community health and primary care, College of Medicine, University of Lagos, Nigeria.

Nigeria is the most populous country in Africa, with over 160 million people. Tobacco use is reported to be relatively low among Nigerian women - less than one percent. These apparently low rates provide a huge potential for the tobacco industry to increase its market share among women in Africa.

Despite the low rates of use reported among Nigerian women, there is a disparity in prevalence by sub-groups such as young girls and female sex workers. The rates reported among young girls (13-15 year olds) in some selected states in Nigeria appear to be higher than that of their older counterparts. Almost 10% of young girls in some of the sites had ever smoked, and half of these were current smokers. The number of girls reported to be likely to start smoking within the next year was higher than that among boys, despite the fact that overall, boys smoked more than girls. Also of concern is the high rate of use of other tobacco products, such as hand-rolled, snuff and traditional local products (18% among some girls). Among female sex workers in Lagos State, a study reported that rates of cigarette smoking were 200 times that of women and twice that of men in the general population.

The protection of women and girls from exposure to second hand smoke (SHS) is particularly important in a country like Nigeria, where though the majority of the women are non-smokers but significant proportions are exposed to the danger of tobacco smoke. A quarter of the girls in one of the states surveyed in the 2008 Global Youth Tobacco Survey were exposed to SHS at home and almost half was exposed in public places.

Lastly, and importantly, is the influence of the tobacco industry marketing on smoking initiation. Industry marketing strategies with themes of body image, fashion, and independence used in industrialized nations may increase the appeal of cigarettes and threaten women in the developing countries like Nigeria.

Nigeria signed the Framework Convention for Tobacco Control (FCTC) in 2004 and ratified in 2005. Since then, attempts to pass the Nigeria Tobacco Control Bill (NTCB) have been challenging despite several efforts by tobacco control advocates. Highlights of the NTCB include:

- Setting up of the National Tobacco Control Committee
- Instituting smoke-free public places
- Ban on sales to and by minors
- Tobacco health warnings (at least 50% of the pack, and pictures may be prescribed by the Health Minister)
- Ban on promotion of tobacco products
- Enforcement by newly-empowered officers

The passage of the NTCB would be a major leap for tobacco control in Nigeria, helping to protect Nigerians, particularly women and girls. Efforts must be intensified to prevent the uptake of smoking among women in Nigeria and to provide programs and services to help current female smokers quit, as few or no tobacco cessation services currently exist.

Treatment for tobacco dependence: Do Indian women and girls have a fair deal?

Jagdish Kaur, Chief Medical Officer (NCDs), Ministry of Health & Family Welfare, India

India is the world's second largest consumer of tobacco, with more than one third (35%) of adults (aged 15 years and above) consuming tobacco in some form or the other. While 21% adults use only smokeless tobacco, 9% only smoke and 5% smoke as well as use smokeless tobacco. The prevalence of overall tobacco use among males is 48% and among females is 20%.[1]

According to the Global Youth Tobacco Survey (GYTS 2009) India, 14.6% school children, aged 13-15 years used tobacco. Out of these 19% were boys and 8.3% were girls. It is interesting to note that more than two thirds of the current smokers wanted to stop smoking.[2]

The Global Adult Tobacco Survey (GATS) India revealed that among 47% of smokers who had visited a healthcare provider in the past 12 months, only 53% were asked by the healthcare providers about the smoking habits and only 46% were advised to stop smoking. A higher proportion of male smokers (54%) were asked about smoking status

than female smokers (46%). In case of smokeless tobacco users, 34% were asked about their tobacco use habit and 27% were advised to stop such use. As many as five out of ten smokers wanted to quit and users of smokeless tobacco planned to quit or at least had thought about quitting, however compared to men, a smaller proportion of women wanted to quit. [1]

Because of high socio-cultural acceptance in many parts of the country, women mainly use smokeless tobacco products. Different locally produced tobacco products are in use among women in various states. Women also use tobacco products as dentifrice to clean their teeth. There are various myths attached to usefulness of tobacco for labour pain and other common ailments. It is also documented that girls have more difficulty with stopping smoking, experiencing stronger effects on behavior and more negative emotions during attempts to quit.[3]

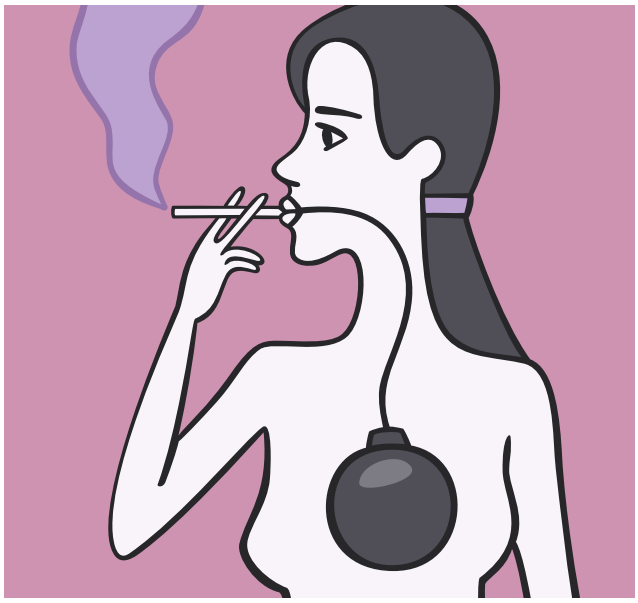
Existing tobacco cessation services in India, both in the public and private sector are grossly inadequate. Moreover, the undergraduate medical curriculum does not adequately address the treatment of tobacco dependence.[4] A study based on tobacco cessation clinics in India reported that the outcome of pharmacotherapy and behavioral counseling interventions at the end of six weeks was poorer among women compared to men.[5]

The main challenges concerning treatment of tobacco dependence among women and girls can be identified as high socio-cultural acceptance of tobacco use, prevailing myths about some health benefits of tobacco, high use of smokeless tobacco products especially among women of low socio-economic class and lower levels of literacy, low awareness regarding harmful effects of tobacco use, limited access to health care services, limited facilities and lack of health professionals trained for tobacco dependence treatment, the attitude of health care professionals and lack of access to information related to harmful effects of tobacco use and treatment facilities.

More research into the gender perspective of tobacco use and tobacco dependence treatment in India is needed to improve the access and use of tobacco dependence treatment facilities by women and girls.

References

1. Ministry of Health & Family Welfare, Government of India and International Institute of Population Sciences, Mumbai. Global Adult Tobacco Survey; 2009-10.
2. Global Youth Tobacco Survey, India. 2009. Fact sheet.
3. Menon I, Parkash H. Women and tobacco: A total misfit or mis-unfit. Indian Journal of Dental Research 2012;23:537-541
4. Jagdish Kaur, S K Sinha, R K Srivastava. Integration of tobacco cessation in general medical practice: need of the hour. Journal of the Indian Medical Association; vol. 109, number 12, December, 2011:925-928
5. Cherian Varghese et al. Initiating tobacco cessation services in India: challenges and opportunities. WHO South-East Asia Journal of Public Health 2012;1 (2):159-168



Getting healthcare professionals to quit: are there gender issues?

Eva Kralikova, Institute of Hygiene and Epidemiology, First Faculty of Medicine, Charles University, and the General University Hospital, Prague

Healthcare professionals should be non-smoking role models for their patients as well as in their social environments, only then they can credibly recommend that their patients quit smoking.

According to WHO M-POWER, four main categories of healthcare workers should be involved in tobacco control and cessation: doctors, nurses, dentists and pharmacists.

In the Czech Republic, we cannot avoid the gender issue in this field since almost 100 % of the 90,000 nurses in the country are female. Even the word nurse is female and is a synonym for sister in Czech ("health sister"). While smoking prevalence (age 15+) is about 29% (33% men, 25% women)[1], among the 40,000 doctors and dentists it is about half that: 16% in total – 20% male and 12% female.[2] But about 40% of nurses smoke, twice the rate of women in the population.[3] Also, nurses compose the majority of smoking health professionals in absolute numbers; there are about 6,500 smoking doctors compared to about 36,000 smoking nurses!

While in most countries nurses smoke more than doctors and sometimes more than the female population, the reason is not clear – maybe stress or sharing a cigarette with a nice young doctor? But doctors, even young and nice, tend to stop.

A few hospitals in the Czech Republic are involved in the Smoke-Free Hospitals network (www.ensh.org); at these hospitals special attention is paid to smoking cessation for the hospital staff, who are able to attend the local Centre for Tobacco-Dependence and where nurses are trained in a brief intervention. Currently all indoor hospital spaces are required by law to be smoke-free (with exception of closed psychiatric and detox wards), so smokers have to go outside to smoke, but the law is not well implemented. Also, since no medication for smoking cessation is provided, it is hard to require abstinence in dependent patients.

Hopefully international collaboration, a smoke-free nursing standard and the spread of information about the impact of smoking may help to lower number of smokers among Czech health professionals.

References

1. Sovinova, H., Sadilek, P., Csemy, L.: Smoking prevalence development in the Czech adult population, citizen's opinions to smoking (1997-2011) (in Czech), SZU, Prague, 2011, available at http://www.szu.cz/31-kveten-svetovy-den-bez-tabawho?highlightWords=koreni
2. Sovinova, H., Sadilek, P., Csemy, L.: Physicians and smoking (in Czech), SZU, Prague, 2011 available at http://www.szu.cz/31-kveten-svetovy-den-bez-tabaku-who?highlightWords=koreni
3. Kralikova, E.: personal data, not published

Women and Tobacco: Experiences from Spain

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According to 2012 data, the prevalence of smoking among Spanish women is 20%. However after analyzing by age, we see that 28% of women aged 25-55 years smoke, including 30% of those 45-54 years old[1]. This is very similar to Catalonia where women's prevalence has been stable at 23 - 24% since 2006[2].

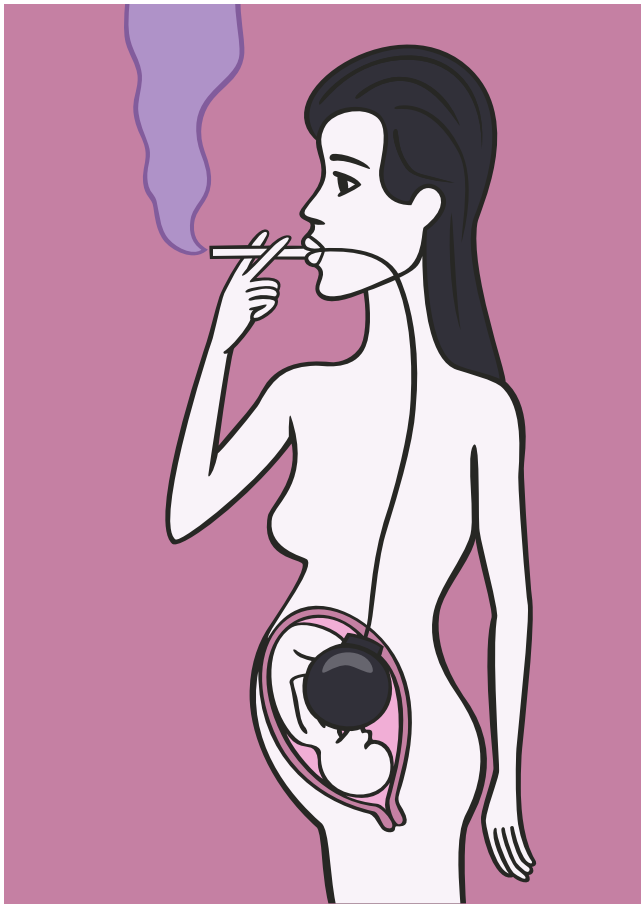
Recent estimates indicate that in Spain, like in other European countries, lung cancer is increasing among women and that in the near future (2015) mortality due to the disease will exceed that of breast cancer, as has been the case in other developed countries[3]. Recent studies have also shown that only 41% of Spanish pregnant smokers quit and that prevalence at the time of delivery is still 18%.[4]

Because there are differences by sex in the factors related to the onset of smoking, it has been suggested that the process of quitting could also be different.[5] The treatment recommended as most effective for both men and women combines cessation medications with psychological treatment[6]. This Guideline also recommends that treatments be adapted to the smoker's characteristics. Therefore, the treatments which include some strategy to address women's difficulties or special needs, like weight or stress control, can achieve similar results as the ones for men.[5]

The Smoke Free Pregnancy Programme has been implemented in Catalonia since 2006.[7] It is based on a structured intervention delivered by maternal and child health professionals and includes support material for both professionals and pregnant women. A programme evaluation based on a cohort study has been carried out on 493 pregnant smokers attending 18 sexual and reproductive health centres at conception, diagnosis, third trimester, as well as six and twelve months after birth. Information collected included: socio-demographic status, consumption, partners' consumption, passive smoking and intention to quit. Some 14.8% of pregnant smokers quit at the first visit, 39.5% in the third trimester and 29% at six and twelve months after birth. At the first visit, women smoked an average of 14 cigarettes a day, which was reduced to four at the third trimester, but went back to eight at six and twelve months after birth.

These results make it clear that pregnancy is a trigger to quitting smoking. After a follow-up nine months after birth, the evaluation showed that the programme to help women quit smoking during pregnancy was effective. One in four smokers was abstinent a year after the birth but it remains necessary to reinforce interventions in neonatal and paediatric stages[7].

In Spain, as well as countries where smoking prevalence remains high among women, it is necessary to develop prevention and treatment programs with a gender perspective to curb the consequences of tobacco on the health of women.[8] These programs must include the entire life situation of women and not just focus on pregnancy.[9]



References

1. Encuesta Nacional de Salud. Ministerio de Sanidad, Consumo e Igualdad. http://www.msssi.gob.es/estadEstudios/estadisticas/encuestaNacional/encuestaNac2011/PresentacionENSE2012.pdf
2. ESCAc 2012. Departament de Salut. Generalitat de Catalunya
3. Malvezzi M, Bertuccio P, Levi F, La Vecchia C, Negri E. European cancer mortality predictions for the year 2013. Annals of Oncology 00: 1–9, 2013. doi:10.1093/annonc/mdt010

4. Jiménez-Muro A, Nerín I, Samper P, Marqueta A, Beamonte A, Gargallo P, Oros D, Rodríguez G. A proactive smoking cessation intervention in postpartum women. Midwifery. 2013;29(3):240-5.
5. Marqueta A, Nerín I, Jiménez-Muro A, Gargallo P, Beamonte A. Predictors of outcome of a smoking cessation treatment by gender]. Gac Sanit. 2013; 27(1):26-31
6. Fiore MC, Jaen CR, Baker TB, et al. Treating tobacco use and dependence: 2008 update. Rockville (MD): U. S. Department of Health and Human Services, Public Health Service; 2008, 257 p.
7. Jané M, Tomas Z, Vidal MJ, Alcaraz L, Martínez C, et al. Smoke Free Pregnancy Programme in Catalonia. Child Health Research, the key to a Healthier European Society, Dublin, may 2013
8. Jané Checa M, Martínez Bueno C. Tabaquismo y Salud reproductiva en las mujeres. En: Nerín de la Puerta I, Jané Checa M. Libro blanco sobre Mujeres y Tabaco: un abordaje con perspectiva de género. Zaragoza: Comité Nacional de Prevención y Control del Tabaquismo y Ministerio de Sanidad y Consumo, 2007. Accesible http://www.cnpt.es/documentacion/publicaciones/baaebc07f002a5b7cb82c5908bcca3bbc61a77466ce08c98c76dcdff8ed873a6.pdf
9. Nerín I, Jané M. Políticas de género de ámbito global en el control y la prevención del tabaquismo. Salud Pública Mex. 2010; 52:304–14.

No One Formula: Cessation for Women

Lorraine Greaves, Past President INWAT
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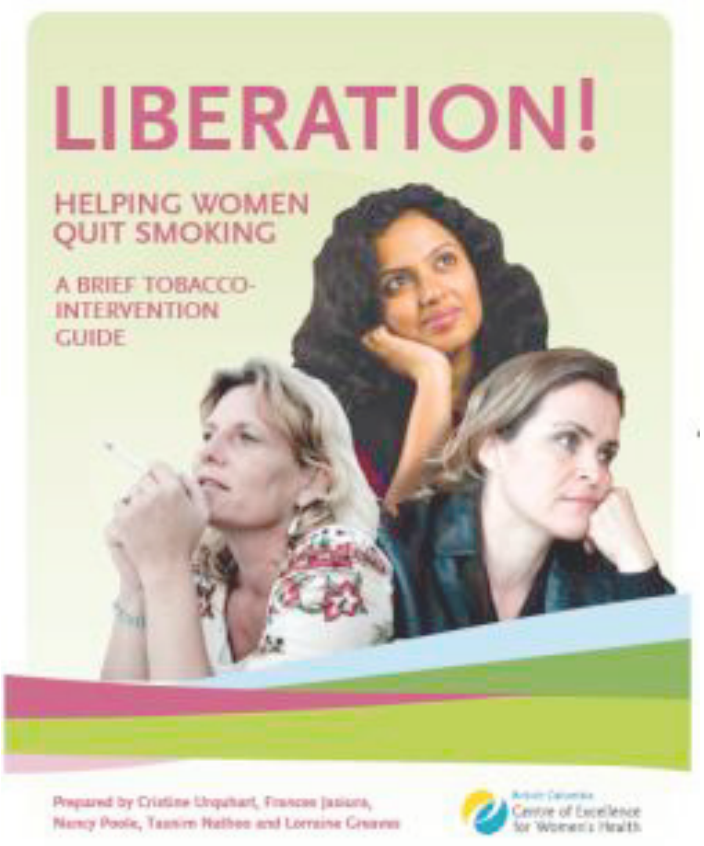
Liberation: Helping Women Quit Smoking A Brief Tobacco-Intervention Guide

By Cristine Urquhart, Frances Jasiura, Nancy Poole, Tasnim Nathoo and Lorraine Greaves

Usually, cessation guides are aimed at smokers. Traditionally, there has been a lot of emphasis on creating behavioural change among women who smoke and little attention to creating changes among health care providers or others who are trying to help.

The Liberation guide fills that gap. It is aimed at providers and focused on skill building to engage women in supportive ways in a conversation about smoking. This



guide is not prescriptive, rigid or pushing external goals and motivations; rather, it recognizes the individual processes that women have, their social contexts and priorities, and the range of pressures and determinants that make quitting smoking difficult.

Much of the current focus on cessation interventions for women is on those who are ready, willing and able to make changes. However, often women are not ready and able to quit, or have tried to quit smoking before with limited success. There is often a lack of emphasis on how to prepare women to quit and support them within the larger context of their lives. Also, there is insufficient focus on how to share tobacco-related health information and start the conversation about quitting with women.

The Liberation guide is based on a few principles, such as being women-centered, reflective of women's circumstances, motivational, integrating a social justice perspective and trauma-informed. Trauma-informed means that there is an awareness of past and present trauma and violence that is built into the materials and the interactions with women, whether or not they disclose. The guide offers concrete tips and scripts for the provider to support the shift from a prescriptive approach to emphasizing the collaborative and dynamic nature of real-life clinical interactions. It is intended to support brief interventions,

from 5 to 30 minutes, and can be used by practitioners of any kind in various contexts and roles.

The conversations providers have with a woman will vary, depending on her level of readiness to quit. A woman who knows she needs to make a change but does not have the confidence to do it, has different needs than a woman who knows how important it is to stop smoking, has had some success in the past, and is now ready to try again. These nuances are taken into account.

But most of all, the Liberation guide aims to shift providers out of rigid approaches and into authentic, supportive conversations with women that will resonate long after the brief intervention.

You can learn more about how to use these principles and techniques in your practice by reading the whole guide. It is available at: www.coalescing-vc.org along with many other resources on tobacco and other substance use among women and girls.

The Liberation Guide was developed by the British Columbia Centre of Excellence for Women's Health after a wide review of evidence on women's cessation, focus groups with women and providers, and testing in settings such as drop-in centers serving pregnant women and new mothers. The BCCEWH has had a dedicated research program on women, girls and tobacco since 1997. www.bccewh.ca

Training Female Doctors in China

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China is the world's largest consumer of tobacco with nearly 301 million smokers, including about 53% of men but only 2% of women[1]. An estimated 740 million nonsmokers are exposed to secondhand smoke in China.[1] Secondhand smoke exposure is an important risk to the health of Chinese people, especially for women and children. Although the percent of women smokers in China is small, there are more than 10 million female smokers in China, and the number is increasing. Helping women quit will be very important in tobacco control in China. The good news is that the number of Chinese doctors committed to helping smokers quit is increasing, and most of them are females.

The WHO Collaborating Center set up the first smoking cessation clinic in China at Beijing Chao-Yang Hospital in 1996, where all of the doctors were female. The WHO Collaborating Center also set up the first quitline in China in 2004 and extended it to a national quitline in 2009. All of the quitline counselors were female.

Moreover, in collaboration with the Nicotine Dependence Center of Mayo Clinic, the WHO Collaborating Center for Tobacco or Health held three National Nicotine Dependence Conferences in 2006, 2007 and 2009; more than 400 medical professionals around China attended these conferences. The Center also developed the first China Clinical Smoking Cessation Guideline in 2007 and updated it in 2009. To improve the knowledge and skill of smoking cessation practices among Chinese physicians, the WHO Collaborating Center, supported by the Ministry of Health, carried out a smoking cessation training course for doctors from 2010.[2] This was based on the UK Smoking Cessation Training Program for a three-day course and material covered in the National Health Service Centre for Smoking Cessation and Training Stage 1.[3] It also included sessions addressing issues specific for China. Training was provided on how to deal with typical and difficult situations in the process of providing cessation services, how to overcome barriers to effective use of smoking cessation medications, and how to solve some practical issues in running a smokers clinic in China. From 2010 to 2012, ninety-nine physicians took part in the training course. Among those participants, 54 were female physicians, who came from 46 hospitals in 33 cities representing 22 provinces and 5 autonomous regions. Participants' knowledge, skills and self-efficacy across different domains significantly improved after the three-day training course. Sixty-eight participants received certification as a "smoking cessation specialist", including 46 female physicians (about 68%).

After the trainings, the female physicians became more committed to tobacco control in their hospitals. They disseminate information about the health hazards of smoking and secondhand smoke, especially to women and parents, and help smokers to quit and nonsmokers to avoid secondhand smoke. At least 35 hospitals have established smoking cessation clinics, and these clinics run well.

Evidence-based clinical interventions for smoking cessation are effective in reducing smoking rates among patients who use tobacco.[4] The new course was developed to disseminate such interventions in China, where up to now such resources were lacking. Having evidence that such courses can meet their objectives, at least in the short term, provides an important reassurance and encouragement for such work. Rolling out training for health care professionals on smoking cessation will be

essential if China is to cater to the large number of patients who can benefit from smoking cessation treatments.

References

1. Li Q, Hsia J, Yang G. (2011) Prevalence of smoking in China in 2010. N Engl J Med, 364: 2469-2470.
2. Zhang CM, Xiao D, West R, et al. (2012) Evaluation of 3-day smoking cessation training course for doctors from 38 cities in China. Chin Med J (Engl). 125: 1338-40.
3. UK National Health Service Center for Smoking Cessation and Training. NCSCT Stage 1 Training & Assessment Programme (knowledge). (Accessed January 30, 2012 at http:/www.ncsct.org/training
4. The 2008 PHS Guideline Update Panel, Liaisons, and staff. Treating tobacco use and dependence: 2008 update. Rockville, MD: US Department of Health and Human Services; 2008. 39-60. (Accessed January 30, 2012 at http://www.ahrq.gov/path/tobacco.htm#clinic).

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Tobacco Dependence Treatment for Women in East Mediterranean Region

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Although the gap between the rates of tobacco use in males and females (30% and 4% respectively) is still larger than that in the western world[1], the prevalence of tobacco use among women in the East Mediterranean Region (EMR) is on the rise. The Global Youth Tobacco Survey showed that tobacco use is also increasing among girls (cigarettes 2%, other tobacco products 9%).[2] A key reason for this is that girls and women start and continue to smoke in order to control their body weight.[3]

There is also a shift in tobacco use from cigarettes to other tobacco products, namely waterpipe (Sheisha). Waterpipe smoking is now perceived to be less addictive and less harmful than cigarette smoking[4], more socially acceptable with a modern social image.[5]

Being a mother, teacher or homemaker creates a greater need for girls and women to be treated for their tobacco addiction. But the Tobacco Dependence Treatment (TDT) programs available in the area are neither well-structured nor widely available in a majority of EMR countries, and stop smoking medications are not easily available. Moreover, the cost of treatment is high, and the health care systems do not appreciate the benefit of investing in the service. The programs available are being offered similarly to all sectors of the community; there are no dedicated centers or clinics to provide a unique service to this vulnerable group of smokers. Consequently, TDT programs delivery and effectiveness have not been studied in depth among females.

The main approaches or key points that encourage girls and women to quit are those with social and cultural value, such as; fertility, delivery of a healthy baby, as well as beauty and appearance. The prevention of osteoporosis, heart disease and cancer rate a lower level of importance to those smokers. Another crucial point that should always be considered is the stigma; females in the eastern Mediterranean are embarrassed to unveil their tobacco use and their need for treatment.

It is vital to develop culturally sensitive and gender-specific programs to prevent initiation and maintenance of tobacco use among females, and to utilize proficiently the available treatment programs for those who continue to smoke. Moreover, there is a need to adopt TDT guidelines specific for females, and to establish services in health care centers (e.g. Mother and Child Health care centers) where women feel more comfortable discussing their health needs and issues.

References

1. World Health Organization, (2010), “Gender, Women, and the Tobacco Epidemic: 3. Prevalence of Tobacco Use and Factors Influencing Initiation and Maintenance Among Women”
2. Centers for Disease Control and Prevention, Global Youth Tobacco Survey, Global Tobacco Use Among Girls: http://www.cdc.gov/features/dstobacco_use_girls/
3. World Health Organization, “Gender and Tobacco in the East Mediterranean Region”, Women in Health and Development, Regional Office for the Eastern Mediterranean. http://www.emro.who.int/whd
4. Amin TT, et al.(2010) Harm perception, attitudes and predictors of waterpipe (shisha) smoking among secondary school adolescents in Al-Hassa, Saudi Arabia. Asian Pac J Cancer Prev.; 11(2):293-301.
5. Khalil J. et al, (2013), Women and waterpipe tobacco smoking in the eastern Mediterranean region: allure or offensiveness. Women Health, Jan; 53(1):100-16. doi: 10.1080/03630242.2012.753978.

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The Need for Gender-Relevant Tobacco Cessation Programs: Preliminary Findings among Brazilian Women in Tobacco Producing State

Isabel C. Scarinci, University of Alabama at Birmingham

An understanding of women and tobacco-related issues, as well as the need for gender-relevant smoking cessation efforts, have been highlighted as priorities in landmark guiding documents (e.g., WHO FCTC). In order to address women and tobacco-related issues we have established a Network for Tobacco Control among Women in Paraná, Brazil with the purpose of building and sustaining community and institutional capacity to promote gender-relevant tobacco control efforts among women.

One of the initial goals of the network was to better understand the prevalence of tobacco use among women as well as the particularities in the different regions within this tobacco growing state. In order to facilitate comparisons with the national data, we conducted the Global Adult Tobacco Survey (GATS) among adult women in all regions of the state (seven representative towns) using the same methodology as the national survey (i.e., cluster sampling, door-to-door). Although the overall prevalence of cigarette smoking in Paraná was consistent with national data, it varied greatly across towns (10% in Cascavel to 19.1% in Irati - a town that relies heavily on tobacco growing). Over 70% of women reported smoking £ 10 cigarettes/day.[1]

	National GATS – Women[2]	Paraná – Women
Current cigarette smokers Daily	13.1% 11.5%	13.4% 12.3%
Current use of other forms of smoked tobacco products	.7%	1.7% (1.5% hand-rolled cigarettes, .2% narguile)
Current use of smokeless tobacco products	.3%	.1%
Quit attempt in the last 12 months	49.5%	49%
Current smokers seen by a health care professional in the past year	58.8%	58.4%
Current smokers who were asked by a health care professional about their smoking status*	71%	76.5% (range 7 towns: 66.7% – 82.4%
Current smokers who were advised to quit by a health care professional - overall **, *** Within the public health system **	57.1%	83.1% (range 7 towns: 68.8% – 100%) 65.7%

* Only includes current smokers who reported seeing a health care professional in the past 12 months,** Only includes current smokers who reported seeing a health care professional in the past 12 months and that they were about their smoking status, *** "Overall" - encompasses the private and public health care system

In a qualitative study among adult women in Curitiba (capital of the State of Paraná), we identified gender-specific issues associated with both starting and quitting smoking. We found the most salient negative factors associated with cessation were: stress/anxiety-relieving benefits, weight control, access/low-cost of cigarettes, being around smokers, and the belief that engaging in other healthy behaviors such as healthy eating would protect them from the hazards of smoking. Positive factors for quitting included: smoking restrictions at home and the workplace, and concerns about appearance. Current and former smokers did not to rely on treatment programs or aids to stop smoking or believe in their effectiveness, and they reported never having received assistance from their health care providers to quit smoking.[3]

Based on these findings, we are currently conducting a group randomized controlled trial to assess the efficacy of a theory-based, culturally- and gender-relevant Community Health Worker intervention for Brazilian women "light smokers" that will augment the smoking cessation offered through the public health system.

This work has been support by NIH grants (R01DA024875, R01Tw009272), and a grant from the Research for International Tobacco Control (RITC).

Continued on page 14 with references

References *for page 13*

1. Scarinci IC, Bittencourt L, Person S, Cruz RC, Moysés ST (2012). Prevalence of tobacco use and associated factors among women in Paraná state, Brazil. Cadernos de Saúde Pública, 28, 1450-8.
2. Instituto Nacional do Câncer /Organização Pan-Americana da Saúde (2011). Pesquisa Especial de Tabagismo – PETab: Relatório Brasil. Rio de Janeiro, INCA.
3. Scarinci IC, Silveira AF, dos Santos DF, Beech BM (2007). Sociocultural factors associated with cigarette smoking among Brazilian worksites: a qualitative study. Health Promotion International, 22, 146-54.

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Trauma informed support for women who smoke

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BC Centre of Excellence for Women's Health

Women with trauma- and violence-related concerns have higher rates of smoking than the general population (See text box). Women with these experiences are frequently heavy smokers and may find it more difficult to quit. These high smoking rates for women with trauma and violence concerns suggest two needs:

- All those who work with women on smoking cessation need an understanding of the links between trauma and violence and smoking to provide women with information and practical support
- Practitioners providing treatment and support on violence and trauma issues with women need to integrate support for smoking cessation.

How to achieve such integrated practice on smoking, violence and trauma?

It is helpful for women to understand how their smoking may be related to past experiences or current symptoms of trauma through discussing these links with service providers, and getting insights into trauma symptoms and avenues for healing.

As many women see smoking as a way of coping with emotional distress, it is helpful to teach women new coping skills for managing stress and/or helping to regulate emotions.

Practitioners need to learn more about the connections between substance use, mental health and addictions for women. Research is growing quickly in this area and innovative programming and policies are being developed that incorporate principles of women-centered care, trauma- informed practice, and harm reduction activities.

Visit the *Coalescing on Women and Substance Use* website from the BC Centre of Excellence for Women's Health at http://www.coalescing-vc.org for information on trauma informed practice and on women centre approaches to

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Smoking Violence and Trauma Links

De Von Figueroa-Mosley and colleagues (2004) found women survivors of childhood sexual abuse are 3.8 times more likely to be current smokers.

The smoking rates for women with posttraumatic stress disorder (PTSD) range from 39.2% (Helstrom, Bell, and Pineles 2009), and 40%-45% (Fu et al. 2007), to 53.6% for women with trauma related to sexual assault (Amstadter et al. 2009), and 58% for severely battered women (Weaver and Etzel 2003).

Women with a history of intimate partner violence were almost four times more likely than women smokers without trauma to consume a pack or more of cigarettes a day (Loxton et al. 2006; Weaver & Etzel, 2003)

29% of women smokers in treatment for trauma reported heavy smoking of a pack or more daily (Helstrom, Bell, and Pineles 2009).

tobacco cessation. A brochure entitled *Women: What do these signs have in common? Recognizing the effects of abuse-related trauma* is available for download from http://www.camh.net

Practitioners need to link up with trauma services and address trauma either before or along with smoking and other addictions, as well as be prepared to answer questions or provide information about available services to women who indicate that they might be ready or interested in formal treatment for trauma.

Trauma informed support is about changing the nature of our interactions with women so that we do not cause further trauma even as we are trying to help with smoking cessation. It is about helping women develop understanding and compassion for the strategies they have used to cope with symptoms, while at the same time helping them learn new skills and strategies. Trauma informed practice is being employed in a wide range of settings including tobacco and other addictions treatment settings.[9] Trauma-informed approaches with their emphasis on choice, collaboration and connection are highly relevant to our work with women on tobacco, given the high proportion of women smokers who have experienced violence and trauma.

REFERENCES

1. Amstadter, A. B., Resnick, H. S., Nugent, N. R., Acierno, R., Rheingold, A. A., Minhinnett, R., et al. (2009). Longitudinal trajectories of cigarette smoking following rape. *Journal of Traumatic Stress, 22*(2), 113-121.
2. Davis, T. M., Bush, K. R., Kivlahan, D. R., Dobie, D. J., & Bradley, K. A. (2003). Screening for substance abuse and psychiatric disorders among women patients in a VA health care system. *Psychiatric Services, 54*(2), 214-218.
3. De Von Figueroa-Moseley, C., Landrine, H., & Klonoff, E. A. (2004). Sexual abuse and smoking among college student women. *Addictive Behaviors, 29*(2), 245-251.
4. Dennis, M. F., Clancy, C. P., & Beckham, J. C. (2007). Gender differences in immediate antecedents of ad lib cigarette smoking in smokers with and without Posttraumatic Stress Disorder: A preliminary report. *Journal of Psychoactive Drugs, 39*(4), 479-485.
5. Fu, S. S., McFall, M., Saxon, A. J., Beckham, J. C., Carmody, T. P., Baker, D. G., et al. (2007). Post-traumatic stress disorder and smoking: A systematic review. *Nicotine and Tobacco Research, 9(*11), 1071-1084.
6. Helstrom, A., Bell, M., & Pineles, S. (2009). Feeling better and smoking less: The relationship between trauma symptoms and smoking over time. *Cognitive Therapy and Research, 33*(2), 235-240.
7. Loxton, D., Schofield, M., Hussain, R., & Mishra, G. (2006). History of domestic violence and physical health in midlife. *Violence Against Women, 12(*8), 715-731.
8. Poole, N., & Lyon, J. (2012). Integrating treatment of tobacco and other substances in a trauma-informed way. In N. Poole & L. Greaves (Eds.), *Becoming Trauma Informed* (pp. 339-350). Toronto, ON: Centre for Addiction and Mental Health
9. Weaver, T. L., & Etzel, J. C. (2003). Smoking patterns, symptoms of PTSD and depression: Preliminary findings from a sample of severely battered women. *Addictive Behaviors, 28*(9), 1665-1679.

Cutting out smoking: are e-cigarettes a help or a hindrance to women and girls?

Patti White, UK, Martina Pötschke-Langer, German Cancer Research Center

One of the biggest current controversies in the tobacco control world is about tobacco harm reduction and use of electronic cigarettes. Are they safe? Will they tempt current nonsmokers, especially children, into smoking? Can they help people cut down or even stop smoking completely? In countries with smoke free legislation, will they undermine the de-normalization of smoking? How should they be regulated, if at all?

Many e-cigarettes, also called electronic nicotine delivery systems (ENDS), are designed to look and feel like cigarettes. Reports from high income countries indicate that the use of such products has increased rapidly over the last few years. For example, according to surveys commissioned by ASH in London, use of e-cigarettes by British adult smokers more than doubled from 3% in 2010 to 7% in 2012.[1] Use in is very low among 11-18 year olds, but elsewhere in Europe, teen use is much higher, as it is in the United States.[2]

There are about 250 different products on the market, some of which are made in countries where they have not been subject to safety regulations, prompting worries about their hazards. There have been reports of e-cigarettes or their battery rechargers exploding, their cartridges leaking or of inconsistent quality in different samples of the same brand. Of deeper concern is the long term effect of the various liquids used.[2]

One key element in the discussion has been whether these products can help people stop smoking. Anecdotally, many smokers report using e-cigarettes to cut down or stop smoking and a recently reported study from New Zealand showed that e-cigarettes were at least as effective as nicotine patches in helping smokers to quit.[3] Although there is testimonial from smokers, surveys and uncontrolled clinical trials, there is a real need to carry out controlled trials and population level cohort studies to determine the value of alternative delivery of nicotine to eliminate smoking cigarettes.

Discussions of how to regulate e-cigarettes have been going on in Europe, especially because it has been considered by the European Union (see Elizabeth Tamang's article on page 4). A UK government agency that regulates medicines and medicinal products announced, after a three-year study, that it would require e-cigarettes and

other nicotine containing products to be licensed as medicines. Those who welcomed the move pointed out that these products would be safe, effective and quality assured. Those against regulation in this way say requiring a medicines license is inappropriate, stifling innovation and causing an economic burden that will encourage the sale of independent businesses to 'cash-rich' companies, like the tobacco industry.

1. Dockrell M et al. (2013) E-cigarettes: prevalence and attitudes in Great Britain. Nicotine Tob Res. 15(10):1737-44. 2013 Oct; doi: 10.1093/ntr/ntt057. Epub 2013 May 23
2. German Cancer Research Center (2013) Electronic cigarettes – an overview. Red series: Tobacco prevention and tobacco control, Vol. 19. German Cancer Research Center, Heidelberg. http://www.dkfz.de/de/tabakkontrolle/download/Publikationen/RoteReihe/Band_19_e-cigarettes_an_overview.pdf
3. Bullen C et al. Electronic cigarettes for smoking cessation: a randomised control trial. The Lancet, Early Online Publication, 9 September 2013 doi: 10.1016/S0140-6736(13)61842-5

Low income Indian women: quitting smokeless tobacco use

Mira Aghi - INWAT Regional Representative South and South-east Asia

Smokeless tobacco is 'Class A carcinogen' and is known to contain over 20 potential cancer-causing agents. Areca nut, an ingredient in some popular smokeless tobacco products in India, including Gutkha and Mawa, confers taste as well as harmful constituents. The high incidence of oral cancer in India is due to smokeless tobacco and women tobacco users are more likely to use it (18.4%) than to smoke (2.9%) (1).

Although guidelines exist for health care professionals to counsel tobacco users on quitting, (2) most practitioners have not yet received training on how to do this. Also in India unskilled workers, especially women, rarely visit health care providers. Hence there is a need outside of the health care system to reach people in low income groups with tobacco cessation advice and counseling. A small study demonstrated how among certain populations intensive, small group session on quitting tobacco have been found effective (3).

Group counseling has been found to be especially appropriate as it is the least threatening in India because of the large socio-economic and cultural gap between the counselor and the clients. Face- to- face support provides opportunities for the counselor to assist the client in building problem-solving skills. The counseling concepts and methods used in this intervention fit well into behavior change communication which is evolved and developed by involving the user.

This study was among eight women aged 22 to 37 years; all were married and were daily users of smokeless tobacco. They used basic ingredients like tobacco, lime and areca nut which they mixed in the palm of one hand with thumb of the other. One woman chewed *paan* (betel quid). All the women had started using tobacco around 10 to 14 years of age. This intervention consisted of initial 11-day workshop and two follow-up sessions. The workshop was carried out using a class-room approach and the duration of each session varied from 35 to 50 minutes depending upon the queries of the clients and the counselor's responses. On the first three days of the quit attempt the counselor met the subjects three times--morning, afternoon and evening. Sessions included lectures on the hazards of using tobacco, planning sessions, discussions of withdrawal and how to deal with it and neck and shoulder exercises along with deep breathing.

At the end of the study, four out of eight women had stopped completely and the other four were contemplating stopping. The total abstainers had started to help other women quit the use of tobacco.

References

1. Perkin D, Bray F, Ferlay J, Pisani P. (2002) Global cancer statistics: CA Cancer
2. Ministry of Health and Welfare. (2010) Global Adult Tobacco-Survey, India 2009-2010. New Delhi: MOHFW, Government of India and Mumbai: International Institute for Population Sciences; 2010---{cited 2012-March 2}. Available from: www.who.int/LinkFiles/Regional_Tobacco_Surveillance_System_GATS_India.Pdf
3. Aghi M, Gupta P, Bhosle R et al. (1992) Communication Strategies for Intervening in Tobacco Habits of Rural Population in India. In: Gupta P, Hamner J, Murti P, (eds.). Control of Tobacco-related Cancers and Other Diseases. Proceedings of an International Symposium: 1990 Jan 15-19: Bombay, India Bombay: Oxford University Press; p.303-306

Tobacco Control Nurses International - Nurses for a Tobacco Free World

Jennifer Percival, Royal College of Nursing UK

Nurses, one of the largest groups of health care professionals worldwide, have often been 'invisible' in the tobacco control movement but now they are being supported to take action against tobacco and help users to quit.

A new web space www.globalnurses.org dedicated to providing information, key to increasing the nursing professions knowledge and skills in this topic area, has been provided by Global Bridges, an international alliance of healthcare professionals hosted by the Mayo Clinic.

The people who have shaped the development of **Tobacco Control Nurses International (TCNI)** web space are longstanding nurse advocates, researchers and educators; and include Linda Sarna, (USA) Stella Bialous, (USA) Ruth Malone, (USA) Sophia Chan, (Hong King) Deborah Ritchie, (Scotland) Grace Wong, (New Zealand) Jennifer Percival (UK) and Mona Wahlgren. (Sweden)

The goal of the TCNI is to promote the visibility of nurses' involvement in tobacco control and facilitate professional collaboration and leadership to curb the tobacco epidemic. Using the website as a communication tool, nurses working

in different parts of the world can engage and support each other to initiate tobacco control policies.

The website will enable members to share information, get access to resources, how-to stop smoking guides, and connect with members in other regions. Developing the website is the just the beginning, and as the TCNI gains momentum, it is hoped that many more nurses' will become active, powerful and visible participants in the international tobacco control movement.

The TCNI hosted a stand at the International Council of Nurses (ICN) Congress to tell delegates about why nurses need to be part of the tobacco control movement and the support offered by the website. Many new members signed up during the meeting. Once signed up, members get access to the library of nurse-specific research papers, other nurse members and examples of good practice from around the globe.

The support of tobacco control advocates is required to increase the numbers of nurses recruited.

Please help by passing the information about the new website to all your colleagues in the nursing profession and actively encourage them to register. It's a simple, easy process to become a member of the TCNI and will make a difference. Please pass the word on.

Register at http://www.globalnurses.org

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