

Dispelling the Myths About Tobacco



**A Community Toolkit for
Reducing Tobacco Use
Among Women**



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**Office on Smoking and Health
National Center for Chronic Disease Prevention
and Health Promotion
Centers for Disease Control and Prevention
Atlanta, Ga**

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Dear Women's Health Advocates:

In March 2001, U.S. Surgeon General David Satcher and Secretary of Health and Human Services Tommy Thompson released *Women and Smoking: A Report of the Surgeon General*. This crucial report, the first in more than 20 years to focus on the issue of women and tobacco use, concludes that the single greatest preventable threat to the health, safety, and welfare of women around the world is *tobacco*.

To assist health care providers, public health professionals, teachers, faith-based and community groups, concerned citizens, and other community leaders in addressing this threat, the Centers for Disease Control and Prevention (CDC) has produced this companion toolkit. It is designed to help you lead girls and women toward the ultimate goal of happy, healthy, and smoke-free lives. The purpose of this toolkit is to apply what we have learned about why girls start smoking, what keeps women smoking, and what it takes to quit.

This toolkit includes suggestions and ideas in the form of presentations, programs, media outreach, and other activities. It is organized into tabulated sections so that you can go quickly to the parts that fit your needs, your style, or your audience, and so that you can add, delete, highlight, and edit as you learn through practice. An important highlight is a 17-minute educational video, *Women and Tobacco: Seven Deadly Myths*, narrated by Christy Turlington.

We'll also be adding toolkit updates and additional resources to our Web site, www.cdc.gov/tobacco, so please check back often to see what's new as well as to view the full Surgeon General's report and other report-related materials that we've prepared.

If you need more help, let us know. Providing us with feedback, especially by completing and returning the evaluation form at the end of this kit, will help us better serve your needs. Together, we can succeed in one of the most remarkable reform movements in history.

Sincerely,

Rosemarie Henson, MSSW, MP
Director
Office on Smoking and Health
National Center for Chronic Disease
Prevention and Health Promotion

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Contents

Video—<i>Women and Tobacco: Seven Deadly Myths</i>	
Discussion Guide for <i>Women and Tobacco: Seven Deadly Myths</i>	5
Video Posttest	9
Education and Outreach Activities	11
Community Activities	11
School Activities	14
College Campus Activities	16
Health Care Provider and Insurer Activities	18
Help With Quitting	21
You Can Quit Smoking: Consumer Guide	21
Cessation Resources	25
How to Be Heard: Making the Media Work for You	27
Media Advocacy	27
News Conferences	33
Sample Talking Points	35
Sample News Release	37
Op-Eds and Letters to the Editor	39
Proclamations and Resolutions	43
Media Campaign Resource Center (MCRC)	45
Internal Industry Documents Targeting Women	47
Searching Tobacco Industry Documents: Basic Information, Steps, and Hints	47
Excerpts About Women From Internal Industry Documents	53
More References & Resources	61
Appendix—Materials From <i>Women and Smoking: A Report of the Surgeon General</i>	
Executive Summary	
At a Glance	
Fact Sheets	
Toolkit Feedback Form	

Discussion Guide for *Women and Tobacco: Seven Deadly Myths*

*If you or someone you love smokes, listen up!
You CAN quit. And when you do, you will
know how good it feels to take control of your
health... I know because I'm one of the women
who have kicked the habit. It's one of the best
things I ever did.*

Christy Turlington

The CDC video *Women and Tobacco: Seven Deadly Myths* was produced to reach women, particularly those between the ages of 18 and 34. Its narrator, Christy Turlington, cover model, entrepreneur, and volunteer tobacco control advocate, is a well-recognized and powerful messenger. She is motivated by the loss of her father to tobacco, her own long-term addiction to cigarettes, and her personal success in finally kicking the tobacco habit for good.

Seven Deadly Myths aims to dispel some of the most powerful untruths that have captured and kept girls and women as smokers. Most of these myths have been perpetrated by tobacco advertising and promotion, but over time, smokers internalize these fictions to rationalize and defend their addiction.

You may want to begin your presentation by showing and discussing the video. It will focus your audience and give them information, ideas, motivation to quit if they smoke, and motivation to stay free from tobacco if they don't smoke. We hope that it will also encourage them to help others become and stay tobacco free.

Personalizing your presentation will make it more powerful. Not everyone in your audience may be able to relate to Christy, but every community has its own "stars" of tobacco control, including ex-smokers who can present testimonials, offer hope, serve as examples, and support those who need help to quit and stay tobacco free.

The previewing questions below can serve as a benchmark or pretest for your audience. At the end of your presentation, you can review the same questions to reinforce the learning that has occurred. You can also administer the posttest to measure how your audience has changed in terms of knowledge, awareness, attitudes, and readiness to quit.

Use the results of the evaluation and other feedback that you get to become better at convincing women to become and stay tobacco free.

Dispelling the Myths About Tobacco

I. Viewing Objectives:

After watching this video, participants will be able to

1. Discuss the myths that surround women and smoking.
2. Define some of the serious health effects of smoking on women.
3. Describe the benefits of quitting smoking.

II. Previewing Questions

Are the following statements true or false? (Answers at bottom of page 7)

1. Lung cancer, which is almost entirely caused by cigarette smoking, is responsible for more deaths among women than breast cancer.
2. As many as one-half of long-term smokers will die of causes related to tobacco.
3. Most teenagers who smoke daily do not expect to continue smoking, but most are still smoking 5 years later.
4. Women who smoke are more likely to have smaller, sicker babies, be infertile, and have more miscarriages.
5. Tobacco companies have known about the destructive health effects of tobacco and the addictive power of nicotine for at least 40 years.
6. Cigarette smoking is the leading preventable cause of death in the United States.
7. Light cigarettes have the same ingredients as regular cigarettes, including lead, ammonia, benzene, DDT, butane gas, carbon monoxide, arsenic, and polonium 210.
8. More than 50 million Americans have quit smoking.

III. Discussion Questions

Discuss the quotes from the video and answer the questions that follow.

Myth #1: It won't happen to me.

"It's not how I visualize myself dying."

"I can't get lung cancer. I'm only 24."

- ▶ Why do some young women start to smoke even though they know that smoking can damage their health?
- ▶ Why do you think people like Pam Laffin keep smoking even after smoking has begun to destroy their health?

Myth #2: It's not like I'm hurting anyone but myself.

"Smoking is a civil right worth fighting for."

"Secondhand smoke causes at least 35,000 deaths a year in nonsmokers."

- ▶ Should all Americans have the right to smoke wherever they wish, or should the public be protected from cigarette smoke?
- ▶ Do you know anyone who has been harmed by secondhand smoke?

Myth #3: I'm not hooked.

"It's not that hard to stop."

"I won't be smoking 5 years from now."

- ▶ Do you agree that most young smokers start out thinking they can quit whenever they want to? Why?
- ▶ Do you know any smokers who thought that they could stop but couldn't? Why?

Myth #4: Sure I smoke, but at least I don't do drugs, have unsafe sex, or get drunk.

"Cigarettes cause more deaths than AIDS, illegal drugs, car crashes, homicides, and suicides combined."

- ▶ Why do you think many people believe that cigarette smoking is safer than other risky types of behavior?

Myth #5: It's better to smoke; if I quit, I'll get fat.

"What's a few pounds compared with bad breath, smelly clothes, yellow teeth and nails, brittle skin, wasted money, and bad health?"

- ▶ Do you think quitting smoking is worthwhile even if it means gaining a few pounds? Why?
- ▶ Can you think of examples of how cigarette companies have promoted cigarette smoking as a glamorous symbol of freedom and independence—and thinness—for women? Do you think this strategy has been effective? Why?

Myth #6: I smoke light cigarettes, so I won't get hurt as much.

"Light cigarettes are safer."

"I switched to light cigarettes, but I just smoked more because there was less nicotine."

- ▶ Why do you think tobacco companies developed light cigarettes? Why do people buy them?
- ▶ Do you think light cigarettes help people cut down on the amount of nicotine they're getting? Do you think that they are safer? Why?

Myth #7: I've tried to quit, but I can't.

"When you quit smoking, you take control, not the cigarette."

"It's your body and your life. Don't give up giving up."

- ▶ Why do you think many people are reluctant to try to quit smoking even though they want to stop?
- ▶ Many people who quit say that it's both the best and the hardest thing they've ever done. Do you think that quitting is worth the pain? Why?

Answers to **Previewing Questions**: All true.

IV. Next Steps

For community advocates: You may want to follow-up the video presentation with community-based tobacco education activities or media interventions. Examples are included in the sections that follow.

For audience members who smoke: Discuss what additional resources the smokers in your audience will need to quit. Offer cessation tips, quit-line numbers, self-help materials, Web site addresses, and other community resources. Invite former smokers to give their own testimonials, especially hopeful stories about what quitting did for them and their families. Have smokers develop a plan by seeing their doctor, finding a quit buddy, arranging rewards for themselves, or picking a quit date. See the “Help With Quitting” section of this toolkit for more tips and information.

Video Posttest

Please answer the following questions related to the video. Check all answers that apply. When you check multiple responses, please rank them (1 = most important). If you do not smoke, please check here ___ and skip all questions except #6.

1. As a smoker, how did the video make you feel about smoking?
 - It motivated me to want to quit smoking.
 - It made me more aware of what my smoking does to nonsmokers.
 - It made me feel concern about what I have done to my body.
 - It educated me about the tobacco industry hiding the truth about addiction and health.
 - It gave me more confidence that I can quit smoking.
 - It did not help me to want to quit smoking.

2. Were you thinking about quitting smoking before you saw the video?
 - Yes No

3. Did the video help you decide to quit in the next 30 days?
 - Yes Not sure No

4. If you answered “yes” to Question 3, what information in the video helped you make a decision to quit? Check all that apply.
 - The ingredients in tobacco smoke
 - The effects of secondhand smoke on children and the unborn
 - Pamela Laffin’s story
 - Tobacco industry documents revealing its knowledge of nicotine addiction
 - Testimonials of women who have quit smoking
 - All of it
 - Other _____

5. What would be helpful to you when you decide to quit? (Check all that apply.)
 - Self-help information
 - Telephone helpline
 - Physician counseling
 - Support group
 - Nicotine gum or patch, or other medication
 - Other _____

Dispelling the Myths About Tobacco

6. What myth(s) provided new information to you about the effects of smoking?

It won't happen to me.

[*Fact:* Tobacco use kills almost one-half of all long-term smokers.]

It's not like I'm hurting anyone but me.

[*Fact:* Environmental tobacco smoke contains carcinogens and other poisons.]

I can quit anytime I want.

[*Fact:* Nicotine is as addictive as heroin.]

Sure I smoke, but at least I don't do drugs, have unsafe sex, or get drunk.

[*Fact:* Tobacco use is the single most preventable cause of death.]

It's better to smoke, because if I quit, I'll get fat.

[*Fact:* The potential weight gain is a minor health risk compared with the risks of continuing to smoke.]

I smoke light cigarettes so I won't get hurt as much.

[*Fact:* Light cigarettes are not necessarily safer.]

I've tried to quit but I can't.

[*Fact:* Using proven treatments increases your chances of staying smoke free.]

None

7. Do you feel more confident in your ability to quit smoking now than before?

Yes

Not sure

No

Education and Outreach Activities

This section includes suggestions for activities to increase awareness, attract media coverage, and focus attention on the harm perpetrated by tobacco. You can customize these activities for your own communities and media markets. Remember that all of your interventions should be part of and consistent with your comprehensive tobacco control plan that involves ensuring clean indoor air, increasing the price of tobacco, reducing the cost of tobacco cessation treatment, and establishing counteradvertising campaigns.

Community Activities

- 1. Community Presentations:** Ask to be placed on the agendas for meetings of community organizations. Prepare to use whatever time they can give you, and tailor your presentations to each audience. Ask large employers if you or a volunteer can speak to their female employees. Ask union leaders if you may address their membership. Ask elected officials to allow you to speak at town meetings. Consider parent-teacher associations, 4-H clubs, girls clubs, sororities, and sodalities. Consider inviting peers, health care providers, or community leaders to help you present. Make special efforts to reach disparate populations, especially persons with less education and lower incomes and other groups with high rates of smoking. Even if all you do is let smokers know that their community cares about them, it may help move them along in their readiness to quit. You may also be able to provide education on the benefits of smoke-free workplaces, restaurants, and public places and on reimbursement for tobacco cessation treatment. Always circulate a sign-up sheet to collect contact information about people interested in getting involved.
- 2. Cessation Assistance:** This presentation can increase awareness of the hazards of tobacco use and the benefits of quitting. It is also designed to increase smokers' readiness to quit. Be prepared to help smokers take the next step. Identify and locate community-based cessation resources, especially telephone quitlines. You might begin by contacting state and local health departments and state and local offices of the American Cancer Society, American Heart Association, and American Lung Association. Canvas organized health care systems, including hospitals, to see what cessation support they have available.
- 3. Smoke-Free Sports:** CDC has developed a variety of materials to support smoke-free education and activities through organized sports. Smoke-free coach's kits, sports posters, patches, pledges, playbooks, and other support materials are all available from the CDC Web site (www.cdc.gov/tobacco/sports_initiatives_splash.htm). Implementing smoke-free sports activities is an excellent way to combine health education with healthy habits. It also enlists coaches and players as powerful health messengers for the children on sports teams and the parents who support them.

4. **Smoke-Free Restaurants:** Survey the restaurants in your community on their smoking policies and publish the results as a brochure and in community newspapers. Let the restaurants know you are canvassing for inclusion in a “smoke-free dining directory.” Your inquiries will remind restaurateurs that the large majority of their customers do not smoke and would prefer to dine in safe and comfortable environments. Hold a media event or send out a media advisory when you release the directory. Make the directory available on the Web if you have a site. Research shows that restaurants do not lose revenue when they go smoke free; on the contrary, many increase their income by clearing the air for all customers. Reward smoke-free restaurants with awards or certificates.

5. **Celebrate the Big Days:** While we need to be ready for news opportunities when they arise, there are many recurring events that communities can use to promote tobacco control. For sample news releases for the following dates, log onto CDC’s Web site at www.cdc.gov/tobacco.
 - ▶ **New Year’s:** One of the most common New Year’s resolutions is to quit smoking. But the unpleasant symptoms of nicotine withdrawal plus greater amounts of tobacco advertising that typically appear immediately after January 1 make it hard for new ex-smokers to stay tobacco free, so support efforts during this time are especially useful. Communities can start building up to smoke-free resolutions during the slow news time right after Christmas. Try to enlist a local TV personality, sports figure, school principal, or well-known coach to discuss how she was able to quit.
 - ▶ **Kick Butts Day:** Every year in April, the National Center for Tobacco-Free Kids celebrates Kick Butts Day (www.kickbuttsday.org). Hundreds of events are coordinated with this day in every state and many foreign countries. Local events include mock funerals for the Marlboro Man, rallies at state capitols, and the release of tobacco advertising surveys. Support materials are available from the Campaign for Tobacco-Free Kids Web site (www.tobaccofreekids.org).
 - ▶ **Mother’s Day:** Mother’s Day is an excellent opportunity to focus attention on helping mothers and grandmothers quit smoking. Children provide an important reason to quit, the impetus to quit, and the support to quit.
 - ▶ **World No Tobacco Day:** Every May 31 is celebrated worldwide as World No Tobacco Day (www.worldnotobacoday.com). A rich supply of support materials for community activities is made available for this event every year from a variety of sources, including CDC (www.cdc.gov/tobacco), Campaign for Tobacco-Free Kids (www.tobaccofreekids.org), and the Pan American Health Organization (www.paho.org). This is an excellent opportunity for communities to join the worldwide tobacco control movement and partner with faraway places that face the same problems.

- ▶ **Juneteenth:** Juneteenth, which celebrates African American freedom, can also be used to promote freedom from nicotine addiction. Available materials to focus the media spotlight on this population include the 1998 Surgeon General’s Report, *Tobacco Use Among U.S. Racial/Ethnic Minority Groups*. This and other reports that localize the toll taken by tobacco are available from the CDC Web site (www.cdc.gov/tobacco).
 - ▶ **The Great American Smokeout:** The American Cancer Society’s Great American Smokeout (www.quitsmoking.com/KopyKit/reports/smokeout.htm) is celebrated on the third Thursday of November every year. The Great American Smokeout (GASO) is a great time for businesses, restaurants, and even entire communities to go smoke free—if only for a day! The “hard news” slowdown that begins around this time leaves media outlets with more time and space to focus on “soft news” issues, including lifestyle stories about ex-smokers. Find a community leader who quit on the first GASO or the most recent GASO, and broadcast the person’s success through the media.
6. **Local Spokespersons:** Create a list of experts on the issues of women and smoking who are ready to serve as local spokespersons on very short notice or for public presentations. This allows you and your media specialists to take advantage of late-breaking news, including short-lived national stories that can be kept alive through a “local angle.” CDC’s State Tobacco Activities Tracking and Evaluation (STATE) system is a good source of state-specific data on tobacco use, tobacco control laws, the health impact and costs associated with tobacco use, tobacco agriculture and manufacturing, and investments in tobacco control. To access the STATE system and other sources of state and local tobacco control data, visit www.cdc.gov/tobacco and click on “state information.”
7. **Editorial Board Meetings:** Form a small expert team to meet with the editorial board of your local newspapers. Explain the issues of women and tobacco to them. Prepare a leave-behind packet with the best and hardest-hitting information, including graphs and charts, relevant internal industry documents, and local contacts. Many of these items can be found in this toolkit. Focus your efforts on getting the paper to print an editorial—e.g., on ensuring clean indoor air in municipal buildings or on creating smoke-free day-care centers. Even if the paper does not print such a favorable editorial, the editors will have the subject of tobacco in mind. They may call you when they need more information or be more open to printing letters to the editor on this topic.

School Activities

Research has shown that well-designed, well-implemented, and comprehensive school programs to prevent tobacco use and addiction

- ▶ Have proved effective in preventing tobacco use.
- ▶ Provide prevention education during the years when the risk of becoming addicted to tobacco is greatest.
- ▶ Provide a tobacco-free environment that establishes nonuse of tobacco as a norm and offers opportunities for positive role modeling.
- ▶ Can help prevent the use of other drugs, especially if the program addresses the use of these substances.

Based on this body of research, CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* recommends that schools

1. Develop and enforce a smoke-free school policy on tobacco use.
2. Provide instruction about the short- and long-term effects of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills.
3. Provide tobacco-use prevention education in kindergarten through 12th grade, with especially intensive instruction in junior high or middle school.
4. Provide program-specific training for teachers.
5. Involve parents and families in supporting school-based programs to prevent tobacco use.
6. Assess the tobacco-use prevention program at regular intervals.
7. Support cessation efforts among students and school staff who use tobacco.

Here are some practical ideas for activities that teachers and youth group leaders can use to supplement CDC's overall guidelines:

- 1. Reviewing Magazines:** Have students review copies of popular female-targeted magazines and count and tabulate the number of tobacco ads and antitobacco ads. Students can then write up the results of their research in a news release for distribution to the media or school newspaper. They can also send the results to magazine editors, asking for the elimination of such targeted tobacco advertising.
- 2. Researching Tobacco Industry Documents:** Through the development of research skills, students can learn about the formerly secret, internal tobacco industry documents that have been made available after settlements of large lawsuits brought against tobacco companies. The documents comprise the paper trail of the tobacco industry's 40-year effort to hide the truth about the health hazards and addictiveness of tobacco, and their incredibly successful marketing efforts that have helped create the

current epidemic of tobacco-related disease among women. Students can devise search strategies to locate documents relevant to their own state or community to uncover industry plans for targeting vulnerable populations, including women and girls, and to show the industry's subversion of its own scientific studies. Because these documents are often so shocking and surprising, they are valuable as news "hooks" or "pegs" for investigative journalists and TV reporters.

- 3. Developing Media Literacy:** Media literacy refers to the ability to deconstruct and understand the real purpose and messages behind slick productions. Media literacy courses in junior high and high schools have been especially effective in helping young people critically analyze how the media normalize and glamorize unhealthy lifestyles and behaviors, including the use of tobacco and alcohol. Media Sharp, a modular media literacy training kit, and SmokeScreeners, which focuses on smoking in the movies, are available at no charge from the CDC Web site (www.cdc.gov/tobacco).
- 4. Other Activities:** Additional activity ideas, school curricula, Guidelines for School Health Programs to Prevent Tobacco Use and Addiction, and other resources are available from CDC's Division of Adolescent and School Health (DASH) at www.cdc.gov/nccdphp/dash. Materials, ideas, and other resources for school activities are also available from the National Center for Tobacco-Free Kids (www.tobaccofreekids.org) and the American Legacy Foundation (www.americanlegacy.org).

College Campus Activities

- 1. Promote Smoke-Free Campus Policies:** College campuses are institutions of higher learning and residences for young adults, many of whom are away from home for the first time. Students and faculty can work through the governing bodies of their universities to maintain a clean and healthy environment with clean air policies, including adequate signage and enforcement. Increasingly, smoke-free policies are becoming the norm, not the exception, at colleges and universities. For example, in spring 2001, Purdue University became the eighth of the Big Ten universities to forbid smoking in dormitories. Begin by surveying students. Ask if they know what secondhand smoke is and if they want to be protected from it. (Even many smokers don't want to breathe others' secondhand smoke.) Include questions about the need for services to help smokers quit. Increase awareness and solicit support through the college newspaper or local media. If a decision is made to implement smoke-free policies gradually, begin with public places such as libraries, eating areas, and classroom buildings, and continue to build support. Enlist the aid of resident assistants in the dormitories. For maximum protection, all indoor areas (including residence halls and sports arenas) should be smoke free. Sample policies are available on the CDC Web site at www.cdc.gov/tobacco.
- 2. Make Presentations to Peers:** Students can use the *Women and Tobacco: Seven Deadly Myths* video and discussion guide to make presentations to groups such as campus clubs, student organizations, sororities, campus governing bodies, and health-related classes. Use the posttest questionnaire to assess the students' understanding of the video.
- 3. Involve Campus Health Care Centers:** Encourage the student health care system to offer cessation counseling and other services. Work with health care centers to ensure that tobacco cessation treatments approved by the U.S. Food and Drug Administration (FDA) are available at a low cost or free of charge. Publicize the availability of these treatments, services, and other resources.
- 4. Remove Tobacco Products From Campus:** When approached directly, bookstore managers might agree to remove tobacco products, but if not, students have other avenues for pursuing this goal. Petitions could be circulated for signatures. Articles and letters to the editor could be placed in the campus newspaper. Remind campus merchants that tobacco sales are inconsistent with drug-free zones.
- 5. Use Virginia SLAM!:** New York singer-songwriter Leslie Nuchow's talent attracted the marketers of Virginia Slims cigarettes, who tried to purchase her reach and effectiveness with money and offers of fame. Tempted as most of us would be, Leslie maintained her moral compass and instead dedicated herself and her talents to helping young people become and stay

tobacco free by creating her own record label—Virginia SLAM! Leslie’s musical talent draws young people to her tobacco-free message, which is strong, personal, convincing, and effective. Schools, campuses, clubs, and community groups can book Leslie for concerts at a relatively small cost. For more information, log on to the CDC Web site at www.cdc.gov/tobacco. Also available from the CDC Web site is a 15-minute video entitled *SLAM!* that describes Leslie’s refusal to have her music associated with cigarette marketing (www.cdc.gov/tobacco/slam.htm).

For additional activities, information, sample policies, case studies, and other resources, visit www.bacchusgamma.org or call (303)871-0901.

Health Care Provider and Insurer Activities

- 1. Health Care Providers:** Doctors, dentists, nurses, physician assistants, midwives, and nurse practitioners are powerful messengers for becoming and staying smoke free because they
 - ▶ Have a very personal relationship with their patients.
 - ▶ See them fairly regularly.
 - ▶ Are trusted and respected.
 - ▶ Communicate with smokers in a context where health is the central issue.

Work with health professionals—directly and through their professional associations—to deliver the smoke-free message. Provide patient chart stickers that ask about tobacco use, preprinted “prescription” pads for smoking cessation, and lists of cessation resources. Order and distribute copies of the Public Health Service guideline “Treating Tobacco Use and Dependence: A Clinical Practice Guideline” and the consumer guide “You Can Quit Smoking” from www.cdc.gov/tobacco. (Click on “how to quit,” then click on “treating tobacco use. . .”)

Pregnant women are especially motivated to quit smoking for the health of their babies, and many of them do. Unfortunately, **only about one-third of new mothers who quit during pregnancy are still smoke free 1 year later.** Focus your efforts on the health providers who care for women during and after pregnancy (e.g., family practitioners, obstetricians, internists) and those who care for children (e.g., family practitioners, pediatricians). The need to protect the air of infants and children is important to communicate to parents.

- ▶ Work with local and statewide medical societies.
 - ▶ Include smoke-free messages in birthing and Lamaze classes.
 - ▶ Offer referral sources for cessation programs.
 - ▶ Place take-home cessation brochures in providers’ offices.
 - ▶ Educate providers and their patients about the dangers of secondhand smoke, especially the harm it causes infants and children. Emphasize the need for remaining smoke free.
 - ▶ Work with local Women, Infants, and Children (WIC) programs to deliver and reinforce the smoke-free message, especially around small children.
 - ▶ Distribute copies of the video *Women and Tobacco: Seven Deadly Myths* for airing in medical office waiting rooms.
- 2. Health Care Systems:** Organized health care systems have financial incentives to invest in prevention services, and smoking cessation is one of the most cost effective. Meet with the managers of your HMOs, PPOs, and employer-sponsored health care systems. Work with them to ensure that

plan members are reimbursed for cessation services and products. For additional resources to encourage health plan coverage for cessation services, see www.endsmoking.org.

- 3. Employers and Insurers.** Work with your local employers to develop smoke-free workplace policies and coverage of cessation services. Employers—whose health benefits currently cover nearly two-thirds of Americans and who have a stake in keeping employees healthy and on the job are a driving force in determining the benefits that competing health insurers offer. The CDC publication *Making Your Workplace Smokefree: A Decision Maker's Guide* (www.cdc.gov/tobacco, click on “educational materials”) offers practical and proven strategies for implementing successful policies. The article featured in *The New England Journal of Medicine* on September 3, 1998, entitled, “Use and Cost Effectiveness of Smoking-Cessation Services Under Four Insurance Plans in a Health Maintenance Organization,” by Susan J. Curry et al., supports providing coverage for tobacco dependence treatment.

Help With Quitting

The large majority of current smokers report that they would like to quit. But because nicotine is a very addictive drug, quitting and staying tobacco free is hard for most smokers. The good news is that many smokers do succeed in quitting, effective strategies exist to increase the chances of success, and numerous resources are available to help.

The following consumer guide is a document that advocates can distribute to smokers to help them quit smoking.

You Can Quit Smoking: Consumer Guide

Learn how to get help to quit smoking and improve your chances of quitting. This document explains the best ways for you to quit as well as new treatments to help. It lists new medications that can double your chances of quitting for good. It also talks about ways to avoid relapses and concerns you may have about quitting, including weight gain.

All information is based on scientific research about what will give you the best chances of quitting.

Nicotine—A Powerful Addiction: If you have tried to quit smoking, you know how hard it can be, because nicotine is a very addictive drug. For some people, it can be as addictive as heroin or cocaine.

Quitting is hard. Usually people make two or three tries, or more, before finally being able to quit. Each time you try to quit, you learn about what helps and what hinders your success.

Quitting takes hard work and a lot of effort, but you can quit smoking.

Good Reasons for Quitting: Quitting smoking is one of the most important things you will ever do:

- ▶ You will live longer and live better.
- ▶ Quitting will lower your chance of having a heart attack, stroke, or cancer.
- ▶ If you are pregnant, quitting smoking will improve your chances of having a healthy baby.
- ▶ The people you live with, especially your children, will be healthier.
- ▶ You will have extra money to spend on things other than cigarettes.

Five Keys to Quitting: Studies have shown that these five steps will help you quit and quit for good. You have the best chances of quitting if you use them together:

Dispelling the Myths About Tobacco

1. Get ready.
2. Get support.
3. Learn new skills and behaviors.
4. Get medication and use it correctly.
5. Be prepared for relapse or difficult situations.

1. Get Ready

- ▶ Set a quit date.
- ▶ Change your environment.
 1. Get rid of ALL cigarettes and ashtrays in your home, car, and place of work.
 2. Don't let people smoke in your home.
- ▶ Review your past attempts to quit. Think about what worked and what did not.
- ▶ Once you quit, don't smoke—NOT EVEN A PUFF!

2. Get Support and Encouragement

Studies have shown that you have a better chance of being successful if you have help. You can get support in many ways:

- ▶ Tell your family, friends, and coworkers that you are going to quit and want their support. Ask them not to smoke around you or leave cigarettes out.
- ▶ Talk to your health care provider (e.g., doctor, dentist, nurse, pharmacist, psychologist, or smoking cessation counselor).
- ▶ Get individual, group, or telephone counseling. The more counseling you have, the better your chances are of quitting. Programs are given at local hospitals and health centers. Call your local health department for information about programs in your area.

3. Learn New Skills and Behaviors

- ▶ Try to distract yourself from urges to smoke. Talk to someone, go for a walk, or get busy with a task.
- ▶ When you first try to quit, change your routine. Use a different route to work. Drink tea instead of coffee. Eat breakfast in a different place.
- ▶ Do something to reduce your stress. Take a bath, exercise, or read a book.
- ▶ Plan something enjoyable to do every day.
- ▶ Drink a lot of water and other fluids.

4. Get Medication and Use It Correctly

Medications can help you stop smoking and lessen the urge to smoke.

- ▶ The FDA has approved five medications to help you quit smoking:
 1. Bupropion SR—available by prescription
 2. Nicotine gum—available over the counter
 3. Nicotine inhaler—available by prescription
 4. Nicotine nasal spray—available by prescription
 5. Nicotine patch—available by prescription and over the counter
- ▶ Ask your health care provider for advice and carefully read the information on the package.
- ▶ All of these medications will increase your chances of quitting for good.
- ▶ If you are pregnant or trying to become pregnant, nursing, under age 18, smoking fewer than 10 cigarettes per day, or have a medical condition, talk to your doctor or other health care provider before taking medications.

5. Be Prepared for Relapse or Difficult Situations

Most relapses occur within the first 3 months after quitting. Don't be discouraged if you start smoking again. Remember, most people try several times before they finally quit. Here are some difficult situations to watch for:

- ▶ **Alcohol.** Avoid drinking alcohol. Drinking lowers your chances of success.
- ▶ **Other smokers.** Being around smoking can make you want to smoke.
- ▶ **Weight gain.** Many smokers will gain weight when they quit, usually less than 10 pounds. Eat a healthy diet and stay active. Don't let weight gain distract you from your main goal—quitting smoking. Some quit-smoking medications may help delay weight gain.
- ▶ **Bad mood or depression.** There are a lot of ways to improve your mood other than smoking.

If you are having problems with any of these situations, talk to your doctor or other health care provider.

Special Situations or Conditions

Studies suggest that everyone can quit smoking. Your situation or condition can give you a special reason to quit.

- ▶ **Pregnant women and new mothers:** By quitting, you protect your baby's health as well as your own.
- ▶ **Hospitalized patients:** By quitting, you reduce health problems and help healing.
- ▶ **Heart attack patients:** By quitting, you reduce your risk of a second heart attack.
- ▶ **Parents of children and adolescents:** By quitting, you protect your children and adolescents from illnesses caused by secondhand smoke.

Questions to Think About

Think about the following questions before you try to stop smoking. You may want to talk about your answers with your health care provider.

1. Why do you want to quit?
2. When you tried to quit in the past, what helped and what didn't?
3. What will be the most difficult situations for you after you quit? How will you plan to handle them?
4. Who can help you through the tough times? Your family? Friends? Your health care provider?
5. What pleasures do you get from smoking? In what ways can you still get pleasure if you quit?

Here are some questions to ask your health care provider.

1. How can you help me to be successful at quitting?
2. What medication do you think would be best for me and how should I take it?
3. What should I do if I need more help?
4. What is smoking withdrawal like? How can I get information on withdrawal?

Help Others

After you quit, become a role model. Be a quit buddy for your friend—you know what it was like to be addicted. Become a women's health advocate to prevent young people from ever becoming addicted.

For more information about quitting, log on to the CDC Web site at www.cdc.gov/tobacco or the National Women's Health Information Center site at www.4women.gov.

Cessation Resources

The information in the consumer guide was taken from *Treating Tobacco Use and Dependence*, a U.S. Public Health Service-sponsored clinical practice guideline. This guideline was developed by a nonfederal panel of experts sponsored by a consortium consisting of federal government and nonprofit organizations:

- ▶ Agency for Healthcare Research and Quality
- ▶ CDC
- ▶ National Cancer Institute
- ▶ National Heart, Lung, and Blood Institute
- ▶ National Institute on Drug Abuse
- ▶ Robert Wood Johnson Foundation
- ▶ University of Wisconsin Medical School's Center for Tobacco Research and Intervention

For information about the guideline or to get copies of this booklet, call toll free (800)358-9295, or write:

Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907

Internet Citation: *You Can Quit Smoking*. Consumer Guide, June 2000. U.S. Public Health Service. www.surgeongeneral.gov/tobacco/consquits.htm

Cessation Web Sites

Inclusion here does not imply endorsement by CDC. Note that Web sites change often.

Centers for Disease Control and Prevention
www.cdc.gov/tobacco/how2quit.htm

The National Women's Health Information Center (Office on Women's Health, U.S. Department of Health and Human Services)
www.4women.org (click on "how to quit smoking")

American Lung Association Quit Smoking Action Plan
www.lungusa.org/partner/quit/

The Great American Smokeout
www.quitsmoking.com/kopykit/reports/smokeout.htm

Dispelling the Myths About Tobacco

Mayo Clinic's Stop Smoking Planner

www.mayohealth.org/home (click on "healthy lifestyle planners," and then click on "stop smoking")

Treating Tobacco Use and Dependence: A Clinical Practice Guideline

www.cdc.gov/tobacco (click on "how to quit," then click on "treating tobacco use. . .")

Contact Information

For general information:

American Heart Association
7272 Greenville Avenue
Dallas, TX 75231
(800)AHA-USA1 (242-8721)

American Cancer Society
1599 Clifton Road, NE
Atlanta, GA 30329
(404)320-3333
(800)ACS-2345

American Lung Association
1740 Broadway, 14th Floor
New York, NY 10019
(212)315-8700
(800)LUNGUSA

National Cancer Institute
Bethesda, MD 20892
(800)4-CANCER (422-6237)

For pregnant women:

American College of Obstetricians and Gynecologists
409 12th Street, SW
Washington, DC 20024
(202)638-5577

Contact your state health department to find out if phone counselors are available in your state.

How to Be Heard: Making the Media Work for You

Countermarketing activities can promote smoking cessation and decrease the likelihood of initiation. In addition, countermarketing messages can have a powerful influence on public support for tobacco control interventions and can set a supportive climate for school and community efforts. Countermarketing attempts to oppose protobacco influences and increase prohealth messages and influences throughout a state, region, or community. Countermarketing consists of a wide range of efforts, including paid television, radio, billboard, and print counteradvertising at the state and local levels; media advocacy and other public relations techniques using such tactics as media releases, local events, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorships and promotions.

*—Best Practices for Comprehensive Tobacco Control Programs,
CDC*

Media Advocacy

Media advocacy is the strategic use of mass media to advance a social or public policy initiative. The goal is to work with mass media to generate pressure for social change. Media advocacy does not try to get individuals to make specific decisions. Rather, it uses media to change the social environment in which individuals make those decisions. Media advocacy is one part of a comprehensive tobacco control program. Used in conjunction with community activities, mass media activities have been shown to decrease tobacco initiation and increase tobacco cessation.

I. “Framing” the News

Getting a story into the news is only half the battle. How the issue is covered is just as important as whether it is covered. The way reporters shape news stories influences what viewers and readers think about the issue and its possible solutions.

- A. News Frames:** News frames are the boundaries around a news story that draw attention to specific parts of the news picture, relegate other elements to the background, and leave other aspects out entirely. Just as decisions are made whenever a snapshot is taken—some conscious, some instinctive—so journalists decide what to include in a story.
- B. Framing:** Framing is the selection process a journalist goes through when deciding what issues, ideas, images, and other elements should appear in the news story. Framing can also refer to the attitude toward or perspective on the contents of the story. This is commonly considered the “angle” of

the story. Understanding frames in this way means paying attention to symbols, metaphors, or visuals that evoke a particular meaning, image, or feeling.

- C. Defining the Problem:** How the problem is defined is crucial for supporting public health solutions. Originally, tobacco use was considered a private issue between patient and doctor. In this framework, “fault” was presumed to reside in the smoker; we “blamed the victim.” In recent years, we have shifted the way we perceive smoking from an individual medical problem to a public health issue. This shift broadens the definition of the problem, encourages the development of more environmental approaches to tobacco control, and opens the door for expanded participation in tobacco control by a wider range of groups.

II. The Public Health Perspective

The public health frame may not automatically resonate with the media. The challenge is to make information as vivid and as compelling as possible. The language must always point to the broader environment in which people are making decisions. What barriers limit their options related to health? What elements of the environment could support wise decisions not to smoke? Illustrating the answers to these questions helps journalists and their audiences understand the importance of addressing solutions that go beyond providing help for individual smokers.

- A. Assign primary responsibility.** Remember that most news consumers, unless given additional information, will assume that the person with the problem is responsible for solving it. The key to advancing effective policy solutions is to create a story that leads people to say, “That just isn’t right. Something ought to be done about that.”
- B. Present a solution.** Journalists will always ask some version of two questions: What is the problem? What is the solution you propose, or what do you want to happen? Always have a concrete solution to offer that has top priority—the one that needs to be advanced today. This means knowing what you want to say and being able to say it simply. Practice with colleagues until the answers roll off your tongue.
- C. Make a practical appeal.** Emphasize that public health solutions are based on science and desirable outcomes. Talk about how your solution will save money, enhance productivity, save lives, support business, and protect children. Give concrete examples of how policy will benefit the entire community—not only those who suffer from the problem.
- D. Develop story elements.** The challenge in trying to influence a story’s frame is that the journalists, not you, control what is covered and what is not covered in a story. But if you understand the business of news reporting and can anticipate journalists’ needs, you can offer story

elements that will make the reporter's job much easier. TV coverage typically requires compelling visual images. For a print story, use metaphors and symbols that make your story come alive in the readers' imaginations.

III. Tips for Successful Media Advocacy

- A. Prepare media bites.** Despite the complexity and depth of your issue, you must be prepared to make it come alive for news consumers in short "bites." At most, a source can expect to be heard for 15 seconds in a TV story, and a few sentences in print. Think of media bites as the headlines you would want on your story. Practice with colleagues, trying out different ways to describe the problem and convey your solution in short, pithy statements. Try to address shared values, emphasizing universal themes such as fairness, common sense, or protection of children. Talk about what is at stake. Who is affected? What will this mean for people's lives? For families? For tax-supported medical care costs?
- B. Practice creative epidemiology.** Numbers can help substantiate claims about the importance of tobacco as a public health problem. But too often, public health spokespersons use huge numbers and statistics that are overwhelming and hard to comprehend. Creative epidemiology is the practice of making large numbers interesting and compelling by placing them in a social context that provides meaning. For example, in the few minutes that it took you to read this information, seven people died from smoking-related illness.
- C. Use spokespersons.** Put journalists in touch with people who have had direct experience with tobacco-related problems. Work with your spokespersons in advance. Discuss the key points they should make and the media bites they should use so that they will feel prepared and comfortable talking to journalists.
- D. Tailor the message to your audience.** One of the most important rules for success in using all forms of media is to understand your audience. When you take account of the audience's background, experience, and the context in which your message will be received, people will pay attention. Discuss the issues in ways that will resonate with your audience's existing values and beliefs. Use creative ways to cut through the media clutter.
- E. Make use of local media.** National media get a lot of attention because they are produced on a grand scale and they reach from coast to coast. But for these same reasons, it is very difficult to access the national media. Local newspapers and radio and television stations have a much greater investment in communities, and are more open to local health stories. In addition, local media may have many hours of airtime and column inches of print space to fill. Give national or international events a local spin that

Dispelling the Myths About Tobacco

humanizes and personalizes the story. For state and local tobacco control data, including access to CDC's STATE system, visit www.cdc.gov/tobacco and click on "state information."

- F. Know why you are doing what you are doing.** Always keep the specific goal in mind. Constantly ask yourself whom you are trying to reach and what you want as a result. Let the answers to these questions guide your media plan.
- G. Be flexible.** Successful media advocacy requires that you be flexible and persistent. If your initial media contacts don't succeed, keep trying. Change approaches, change targets, or change spokespersons.

IV. Media Strategies

A media strategy is a plan for using the media to accomplish a specific goal. To be successful, your media strategy must be carefully thought out and tailored to accomplish its goal. In particular, the strategist must know

1. What the goal is, in precise and realistic terms.
2. What the message is, in clear, simple terms.
3. Who the target audience is.
4. What outlets are best to disseminate the message and reach the target audience.
5. What the audience should do after they have heard the message.
6. What assistance will be needed to accomplish the goal.

Pick a single central theme. Proceed as if the audience will only remember one line from everything that is said. Decide ahead of time what that one line should be, and lead with it. Make your total message revolve around it. Keep the theme simple and appealing.

Listed below are different ways in which you can initiate contact with the media:

- ▶ **News Release:** Used to announce an event or release information for the media to cover. Needs to be written so it can be reprinted directly or with few changes.
- ▶ **Media Advisory:** Less formal, not for direct reprinting. It may be E-mailed, faxed, hand delivered, or mailed to apprise the media of an upcoming newsworthy event.
- ▶ **Pitch Letter or Phone Call:** Used to feed an exclusive to a specific journalist who will be interested in a particular story.

When you make initial contact by E-mail, fax, or regular mail, follow-up with phone calls. Ask if the reporter has received the information you sent and if

the reporter has any questions you may answer. Keep good records of contacts with reporters and track actual coverage. Develop different interview opportunities and story angles to offer to different media outlets.

V. Media Relations

Reporters are people too, so you should form relationships with them that will be mutually beneficial. You need them, but they need you too.

Take the time to introduce yourself, your organization, and your cause to members of your local media. Let them know that you are an expert on your issue and become a continuing resource for them. Build the mutual trust and respect that are essential to all successful relationships.

Keep track of the reporters on your “beat.” Learn all you can about who makes the decisions in each media outlet and how. Newspapers have reporters, but they also have section editors, city editors, national editors, feature editors, managing editors, and publishers. Broadcast personnel include assignment editors and executive producers. The key people in each outlet are worth meeting in person. After a professional relationship with an assignment editor has been developed, it is acceptable to sound out ideas for news conferences or other media events to determine if the editor would send reporters to attend a particular event.

Reporters’ interests will not always converge with yours. They are after *stories*, not necessarily social goals. Therefore, it is your responsibility to package the information that you give them in a way that serves both your needs and theirs.

Always tell the truth and do not mislead a reporter. Information is the commodity you are brokering, but credibility is what you must use to sell it. Exaggeration is not necessary in public health, because the bare facts are sufficiently sensational, like this statistic: lung cancer deaths among women have risen 600% over the past 50 years.

VI. Media Interviews

Learn as much as you can about the audience you will reach. If the opportunity arises, assist the reporter in developing the questions to be asked. Provide background information, including useful facts and figures. Strategies to keep in mind include the following:

A. Keep language simple and direct. Don’t fall into the use of jargon or acronyms that might confuse your audience.

B. Speak in short, clear, and quotable sentences. Pretaped interviews will be edited, so points that are made in long paragraphs will be lost. Remember that media bites—the 9-second quotes that encapsulate main points—are essential in communicating through the media.

Dispelling the Myths About Tobacco

- C. Make your most important point first.** If you try leading up to it with background information, you may not get it in at all, or you may lose your audience in the meantime. Emphasize your major points by “flagging” or listing them. For example, “The most important thing to remember is. . .”, “The three crucial conclusions are. . .”
- D. Maintain control throughout the interview.** Do not feel compelled to answer a question if you don’t like it. Rather, use it as the opportunity to get your point across. Be ready to “reframe” questions that are off the mark. Turn negatives into positives.
- E. Don’t be a know-it-all.** If you don’t have the answer to a particular question, don’t fake it. Instead, use the opportunity to make one of your main points. If a question is asked to which you do not know the answer in an interview for print, offer to get the information for the reporter. Be patient, not belligerent; kind, not nasty; helpful, not argumentative. Let your expertise come across, but do not be arrogant.
- F. Dress appropriately for TV.** Wear clothes that look professional but not too formal. Solid colors are better than prints. Bright colors are fine as long as they are not overwhelming. Keep jewelry simple. Let nothing dangle that could distract from what you are saying.
- G. Don’t count on anything you say being truly off the record.** If you never want to see it in print, don’t say it.

News Conferences

Hold a news conference when you have something to say that can be enhanced visually, through charismatic spokespersons, and with timely information. (A news release may be sufficient for disseminating information to the media.) Use good audiovisual materials.

- A. Announcements:** Announce the conference with a media advisory or a news release, but hold the important information for the event itself.

- B. Place and Time:** Make sure the location you choose will accommodate the media (e.g., has a sufficient number of electrical outlets, good lighting, and enough space). The news conference should be held early in the day to give the media time to develop and edit their stories. Monday through Thursday are often the optimal days for hard news coverage. If TV and radio reporters attend the conference, plan on the camera and sound crews arriving well ahead of starting time to set up. They may want to tape some brief interviews with your speakers before the news conference begins. Allow extra time with your spokespersons before and after the conference.

- C. Spokespersons:** Feature good speakers who are issue experts or community leaders. Always ask, is this person interesting enough to watch on TV or listen to on the radio? Before the news conference, discuss the agenda with your speakers, detail the questions they might anticipate, and go over the answers they should give. Develop speaking points that communicate your main messages.

- D. Materials:** At the event, distribute media kits that include background information, biographies, and other useful materials.

Sample News Conference Agenda

When you plan a news conference, remember that speakers with different areas of expertise have different perspectives and therefore bring unique contributions to your media event. For example,

- ▶ Medical topics—including the presentation of medical research findings, impressions from clinical practice, and medical advice—are often most convincing when the information comes from a doctor, nurse, midwife, or other health care provider.
- ▶ Economic impact is often best explained by an economist.
- ▶ A business leader might best explain the impact of a proposed policy on business.
- ▶ Educational issues are often most convincingly presented by an admired educator or school principal.

The right speaker can attract media coverage and strengthen the impact and reach of an important message.

Dispelling the Myths About Tobacco

This sample news conference agenda may give you ideas for how to structure your own media events.

Sample Agenda

Time	Content	Spokesperson
9:00–9:05 a.m.	Welcoming and introductory remarks	Tobacco Control Coalition Chairwoman
9:05–9:10	The problem (discuss facts about women and tobacco use based on localized data and statistics)	Physician
9:10–9:15	The effect (put a human face on the problem through a personal story)	Tobacco-use sufferer
9:15–9:25	The solution (announce local efforts to reduce tobacco use among girls and women) Youth peer education Secondhand smoke initiatives Tobacco cessation programs	Youth advocate Smoke-free business leader Cessation facilitator
9:25–9:30	Conclusion (including wrap-up and Q&A)	Coalition chairwoman

Sample Talking Points

You can prepare bulleted talking points for your speakers. Work with your presenters ahead of time to ensure that they cover the important points you want to communicate. Below is a list of talking points that emerged from *Women and Smoking: A Report of the Surgeon General*. Tailor talking points according to the target audience, the specific messages, and the selected messengers.

Physician:

- ▶ Lung cancer—not breast cancer—is the leading cause of cancer death in women.
- ▶ Women who smoke during pregnancy have a greater risk of neonatal death, including stillbirths.
- ▶ Smoking is a major cause of cancers of the oropharynx and bladder among women and also increases women's risks for liver, colorectal, and cervical cancer, and cancers of the pancreas and kidney.
- ▶ Smoking is a major cause of coronary heart disease among women.
- ▶ Women who smoke have a higher risk for hip fracture than women who have never smoked.

Tobacco Use Sufferer:

- ▶ Ninety percent of all lung cancer deaths among women who smoke are directly related to smoking.
- ▶ Smoking is a primary cause of chronic obstructive pulmonary disease among women.
- ▶ Smoking is a major cause of coronary heart disease among women.
- ▶ The possibility of exposure to secondhand smoke limits where asthma sufferers can go.

Involved Youth:

- ▶ Youth in (locality) surveyed (stores or magazines) and found that (list finding).
- ▶ Adolescent girls who smoke have reduced rates of lung growth, and adult women who smoke experience a premature decline in lung function.
- ▶ The large majority of smokers became addicted when they were too young to buy cigarettes legally.
- ▶ Young girls are a major target of the tobacco companies; tobacco industry marketing is a factor influencing susceptibility to and initiation of smoking among girls.

Dispelling the Myths About Tobacco

Cessation Facilitator:

- ▶ More than three-fourths of women who smoke want to quit smoking completely.
- ▶ Help with quitting smoking is available locally through (**name of organization**). For more information, call (**contact number**).

Sample News Release

FOR IMMEDIATE RELEASE

Photo Opportunity

Contact:

Phone:

Date:

Smoking-Related Disease Is a Full-Blown Epidemic

Among Women in (town, city, or state name)

(**Coalition name**) will put a human face and a local focus on the toll tobacco takes on women in (**town, city, or state name**). At (**name activity or event here**), (**name of featured speaker or group**) will call on the community to prevent and reduce smoking among girls and women at (**time**) at (**location address**).

Women now account for 39% of all smoking-related deaths each year in the United States, a proportion that has more than doubled since 1965, according to *Women and Smoking: A Report of the Surgeon General*. The report concludes that the increased likelihood of lung cancer, cardiovascular disease, and reproductive health problems among female smokers makes tobacco use a serious women's health issue.

“The millions of women who die prematurely from smoking aren't strangers,” (**local leader**) said. “They are our mothers and grandmothers, our friends and neighbors. Smoking cessation can save their lives.”

“Increased marketing by tobacco companies has stalled progress in smoking cessation by women, and recent increases in smoking among teenage

Dispelling the Myths About Tobacco

girls threaten to wipe out any progress in tobacco prevention that has been made in the last few decades,” said (**expert**).

Quitting results in immediate health benefits for both light and heavy smokers, including improvements in breathing and circulation. The increased risk for coronary heart disease and stroke is substantially reduced after 1 or 2 years of not smoking.

When smokers quit, their lungs begin to heal and their risk of lung disease drops. Smoking cessation also improves quality of life and physical functioning. Science-based smoking cessation interventions are much more cost effective than many common medical interventions.

“I think that it’s important to emphasize that it’s never too soon or too late to quit smoking,” (**expert**) said.

For more information, call (**contact name and phone number**).

Op-Eds and Letters to the Editor

Most major newspapers include an op-ed section on the page opposite the editorial page. Although op-eds are often written by regular columnists (national and local), there are always opportunities for guest writers. Many papers solicit articles from individuals knowledgeable in particular fields or from local writers if they are seeking a local point of view.

Letters to the editor offer important opportunities for readers to share their opinions through the newspaper to a broad audience. Letters to the editor are among the best-read sections of the paper. After reading the editorials, most policy makers turn next to letters to the editor.

Find out how your local newspaper wants to receive op-eds and letters to the editor (i.e., in electronic or hard-copy format), what the maximum length should be, and how much lead time they need. This information is often available on the editorial page of the newspaper or from the local newspaper office. Be prepared to make your submissions on short notice when national or local news provides an opportunity.

Below are two sample letters to the editor that illustrate how you can use this media outlet.

Sample Letter to the Editor on Smoking and Pregnancy

Dear Editor:

Recently, the Surgeon General released his latest report on women and smoking, and the numbers are grim. Since the last report on women and tobacco in 1980, over 3 million women have lost their lives to cigarettes. These women are our mothers, our sisters, our grandmothers, our aunts, and our friends.

According to the new report, the consequences of tobacco use are especially devastating to pregnancy outcomes. Not only are women who smoke more susceptible to fertility problems, but the impact on the babies they carry can be deadly. Smoking during pregnancy has been associated with increased risk or spontaneous abortion, low birth weight, stillbirths, and sudden infant death syndrome (SIDS). Not only does this create a huge human tragedy, but the additional health care costs are enormous. According to the report, reducing the national prevalence of smoking during the first 3 months of pregnancy by only 1 percentage point every year would prevent 1,300 babies from being born at low birth weight and save \$21 million in direct medical costs during the first year alone.

(State's) numbers for smoking during pregnancy and neonatal outcomes can definitely be improved. **(Insert state-specific dollar amounts and smoking**

Dispelling the Myths About Tobacco

during pregnancy rates, if available.) We can save health care dollars, but more importantly, we can save lives if we encourage young girls to never start smoking and help women who want to quit.

Sincerely,
(Your name and affiliation)

Sample Letter to the Editor on the Surgeon General's Report on Women and Smoking

Dear Editor:

Recently, the Surgeon General released an important report on women and smoking. Not only does it show that lung cancer—NOT breast cancer—is now the leading cause of cancer death in women, but since the last Surgeon General's report on women and smoking in 1980, over 3 million women in the United States have died from tobacco use. Here in **(State)**, **(number of women who have died)** have died in this 21-year period.

It is not by accident that tobacco use has increased to the point of creating an epidemic among American women. The tobacco companies have developed slick advertising campaigns that glamorize smoking. A recent Federal Trade Commission report on tobacco advertising revealed that advertising expenditures have increased by more than \$2 billion since 1998, for a grand total annual expenditure of \$8.24 billion. In our state, tobacco companies spend **(get number from www.tobaccofreekids.org Web site)** to advertise their deadly and addictive products.

The Centers for Disease Control and Prevention is now providing a community toolkit to help combat the problem of tobacco use among young girls and women. This is good news because tobacco use among young girls in **(state)** has been on the increase. We must fight back.

We may not have the money that the tobacco companies have, but we have hearts that react to the pain and suffering caused by tobacco use. All of us must work together to keep children safe from tobacco use and to help those who want to quit their deadly addiction.

Sincerely,
(Your name and affiliation)

Sample Op-Ed

Christy Turlington, cover model and entrepreneur, is working with the Centers for Disease Control and Prevention (CDC) to communicate the smoke-free message to teens and young women. Watch her video-stream on

Women and Tobacco: Seven Deadly Myths at www.thriveonline.com (click on “stop smoking”).

The following example is an actual op-ed written by Christy Turlington that was printed in local newspapers across the country. Additional timely examples of op-eds are posted on the Web site of the Campaign for Tobacco-Free Kids at www.tobaccofreekids.org.

**My Message to Women: Stay Smoke Free
By Christy Turlington**

In my family, there are two people who have quit smoking—my Dad and me. For me, it took 7 years. When I finally did quit for good, I knew it was one of the biggest accomplishments of my life.

It was different for my father. He stopped smoking in December 1996, just 6 months before he died of lung cancer. He was only 64. So much has happened in our family since then that my father would have enjoyed. There have been many things I wanted to tell him, many questions I wanted to ask him. Now there’s a great deal that he and I will never share.

It’s comforting to know that when you’re gone, you live on in the hearts of those who loved you. But it’s infuriating to realize that his and so many other premature deaths were completely preventable! Tobacco use remains the leading preventable cause of death in the United States, killing more than 430,000 Americans each year—more than all who die of AIDS, alcohol or drug abuse, car crashes, murders, and suicides—combined!

For women, particularly young women and the children they care for, the health consequences of smoking grow increasingly grave. We may have come a long way in some ways, but when it comes to tobacco, women have taken many steps back.

The number one cause of cancer deaths in women is lung cancer. The rate of lung cancer in women has increased by 600% in the last 50 years.

Women who smoke have more miscarriages, are more likely to be infertile, and enter menopause earlier than nonsmokers.

Mothers who smoke have smaller and sicker babies, more stillbirths, and more neonatal deaths than mothers who do not smoke. Secondhand smoke causes 35,000 to 62,000 deaths a year from heart disease in nonsmokers. Secondhand smoke also causes asthma, lung infections, and even sudden infant death syndrome (SIDS).

More than 5 million children living today will die prematurely because of a decision they made as adolescents—the decision to smoke cigarettes.

Dispelling the Myths About Tobacco

We were warned long ago that when women started to smoke like men, they would die like men. The reality is even worse. Not only do women smokers suffer like men smokers from the increased risk of cancer, heart disease, and lung disease, but they also experience the health problems unique to menstrual and reproductive functions. Why, after all that we know, has this happened? There are two important reasons.

The first is sheer marketing power. Women started smoking in great numbers when tobacco companies targeted them to do so. “Reach for a Lucky instead of a sweet” remains one of the most successful advertising themes of all times because it made women believe that if they smoked, they would be slim and beautiful. Virginia Slims’ incredibly successful “You’ve come a long way Baby” morphed into the 1990’s as “It’s a woman thing,” and recently into the most cynical multiethnic advertising campaign, “Find your voice.”

The commercial coupling of smoking with women’s freedom, emancipation, and empowerment camouflages the second reason why so many women are suffering from tobacco use—the terrible reality of tobacco addiction. Like the large majority of smokers, I was just a kid when I started smoking—only 13. And, like almost every smoker, I started out believing that I wouldn’t get hooked. But addiction is a fact—one that the tobacco companies have long known and used to their advantage.

There is good news. Quitting is hard, but everyone can quit. More than 50 million Americans have! That’s more than those who still smoke. And, according to the new Surgeon General’s Report on women and smoking, quitting smoking begins immediately to reduce the risk of dying prematurely, no matter when that step is taken. As Dr. Virginia Ernster, Senior Scientific Editor of the report emphasizes, it’s never too late to quit smoking.

Now I know that the best contribution I can make is to help girls and women to become and to stay smoke free. That’s why I’m helping Secretary of Health and Human Services Tommy Thompson and U.S. Surgeon General David Satcher to deliver this important message about women and smoking: Don’t start and if you already do smoke, please stop. Trust me, I know this is hard. Don’t give up giving up.

Proclamations and Resolutions

Another idea for a news event is to issue a proclamation or resolution. A resolution is a request or demand for a specific action or the adoption of a certain policy. Generally, a resolution can be broken down into “whereas” clauses (which are basically translations of facts or data) and “resolved” clauses (that state the action or promise). “Whereas” clauses give the background and rationale for the resolution. They identify the problem or need for action and frame it as urgent or timely. “Resolved” clauses are the essential part of the resolution because they state clearly the action or policy called for. They come at the end of the document, and comprise the main motion for the organization.

Proclamations use “whereas” clauses in the same format; the final statement in the document is the official action taken on the basis of these clauses.

Sample Resolution

Whereas, tobacco use is the leading cause of preventable death and disease in the United States;

Whereas, according to a new report from the Surgeon General in March 2001, nearly 3 million U.S. women have died prematurely from smoking since the first Surgeon General’s report on women and smoking in 1980;

Whereas, lung cancer is the leading cause of cancer death among women;

Whereas, in (state, city, town) (number of women who have died in the last year) women have lost their lives to smoking-related disease in the last year;

Whereas, tobacco use during and after pregnancy harms the unborn child and newborn infant;

Whereas, tobacco companies are targeting women and young girls with advertising that makes smoking look attractive;

Whereas, educational and policy initiatives can greatly reduce smoking initiatives and increase cessation rates for young girls and women; now, therefore, be it

Resolved that (name of organization) supports public health efforts to offer smoking cessation assistance to women who smoke; be it further

Resolved that we will promote tobacco-free messages to our members and to the public; be it further

Dispelling the Myths About Tobacco

Resolved that, where possible, we will support policies that reduce youth access to tobacco products and that promote community awareness of the hazards of smoking and of secondhand smoke.

(Sponsoring Organization)

(Date)

Media Campaign Resource Center

Creating high-quality, effective tobacco counteradvertising can be time consuming and expensive. To save time and costs, CDC has licensed existing advertisements developed by a number of states and federal agencies. These include the California Department of Health Services, Massachusetts Department of Public Health, Arizona Department of Health Services, Tobacco-Free Florida Coalition, Kansas Health Foundation, Oral Health America, U.S. Environmental Protection Agency, FDA, and others. These ads are available through the Media Campaign Resource Center for Tobacco Control, which not only provides access to these ads but also offers help in developing an overall campaign that uses them effectively.

By providing access to existing advertising materials, the resource center allows states and organizations to save the high cost of producing new ads; resource center customers pay only talent fees and nominal charges for tagging, shipping, and processing. The resource center currently offers about 400 television spots, 200 radio spots, 125 print ads, and 100 outdoor ads. The materials are available in several different languages, and topics addressed include youth prevention, adult cessation, and protection from secondhand smoke. The resource center's Web site includes a comprehensive chart of advertising materials, information about how to order media campaign resource books and video catalogs, and other helpful information. The resource center also offers technical assistance to help with ad selection and other advertising campaign tasks.

Resource books: The Media Campaign's resource books catalog available ads and contain valuable information on developing tobacco prevention advertising campaigns. In addition, all of the television and radio spots are featured on the video catalog (VHS format). For a \$25 subscription to the resource books and video catalogs, you will also receive future resource center updates and ideas.

Technical assistance: For those who would like an expert's advice, in-depth technical assistance is available. Assistance includes help in choosing ads for the target audience, developing a media plan, negotiating with media outlets, and publicizing campaigns to other states and organizations.

Web site—www.cdc.gov/tobacco/mcrc/: To get more information about the Media Campaign Resource Center, order the resource books, and find out about promotional packages, please visit this Web site. The electronic campaign chart in the "what's new" section of the site is a downloadable Excel spreadsheet that includes information about all of the advertising materials in the resource center. The "advertising on a tight budget" section of the Web site contains lists of spots with no talent fees and lists of "in cycle" spots that are available at reduced talent fees. Reviewing these lists can help you save money.

Dispelling the Myths About Tobacco

Contact information: To order materials or request technical assistance, contact the Media Campaign Resource Center at (770)488-5705 (press 2 at the prompt), or E-mail mcrc@cdc.gov. Other inquiries can be directed to CDC's Office on Smoking and Health at (770)488-5705.

Internal Industry Documents Targeting Women

As part of its settlement agreements with a number of U.S. states, the tobacco industry was forced to disclose millions of pages of internal documents, many of which are now publicly available on the World Wide Web. These documents have provided important information, including ways in which tobacco industry marketing has targeted girls and women. The continuing challenge for people concerned about public health is how to search these documents, locate and analyze the most relevant and revealing ones, and use them for effective tobacco control.

Searching Tobacco Industry Documents: Basic Information, Steps, and Hints

CDC has created a Web site to make searching internal industry documents easier (www.cdc.gov/tobacco/industrydocs). The Web site has three main searchable components:

4B Index—A compilation of indexes developed and provided by each of the tobacco companies that were defendants in the State of Minnesota vs. Philip Morris, Inc., et al. trial. The 4B Index contains objective indexing information on the 27 million pages of documents provided during litigation.

Minnesota Select Set—A subset of approximately 380,000 pages of documents that were considered most relevant by the attorneys in Minnesota’s case against the tobacco industry. This component of the Web site provides text-searchable access to a valuable portion of the tobacco industry documents.

Guildford—British American Tobacco Documents—A subset of the Minnesota Select Set that contains approximately 7 thousand documents that attorneys for Minnesota thought related best to their trial and to the population of Minnesota. Although this is an interesting and informative cache of documents with global relevance, the selection process means that some types of documents are not represented. For instance, because Minnesota does not have a large Hispanic or African American population, few documents relating to these groups were chosen.

The Web site also contains links to all of the major document sites at www.cdc.gov/tobacco/industrydocs. On this page, you can find direct links to a number of document sites, including the following:

Brown & Williamson (the U.S. subsidiary of British American Tobacco)
www.bw.aalatg.com

Dispelling the Myths About Tobacco

Council for Tobacco Research
www.ctr-usa.org/ctr

Lorillard Tobacco Company
www.lorillarddocs.com

Minnesota Blue Cross/Blue Shield
Tobacco Litigation
www.tobacco.neu.edu/mn_trial

R.J. Reynolds Tobacco Company
www.rjrtdocs.com (when you reach the site, the URL will read
www.rjrtdocs.com/rjrtdocs/main.dms?tab=home)

Philip Morris
www.pmdocs.com

The Tobacco Institute
www.tobaccoinstitute.com

University of California ad in San Francisco's Brown & Williamson Collection
www.library.ucsf.edu/tobacco

U.S. Committee on Commerce document Web site
www.house.gov/commerce/TobaccoDocs/documents.html

Other Important Sites

www.tobaccodocuments.org

A meta-site that allows you to search multiple Web sites at once, as well as to look at various collections that researchers have compiled.

www.ash.org.uk/links/industry.html

Links to document sites and compilations of quotes from industry documents.

British American Tobacco Documents:

British American Tobacco was allowed to place its documents in a separate repository in Guildford, England, rather than placing them online. A limited subset of these documents can be found online at:

www.cctc.ca/Guildford.nsf/1_MainFrameWeb?OpenFrameSet

Getting Started

The Philip Morris site (www.pmdocs.com) is one of the easiest for beginners to use and contains a large number of useful documents. Becoming proficient with this site first will help advocates better understand the sites that are more difficult to navigate.

The best way to explain how to use the document sites is to start with an example. Let's say you want to know about Philip Morris's marketing plans in Florida. If you go to the Philip Morris document site, www.pmdocs.com, and type in the word "Florida" as your search criterion, you will find that this search returns 0 documents. This is because Philip Morris's Web site is case sensitive. Instead, type in FLORIDA (all in caps). This search returns 1,778 documents—clearly too many to look through. To narrow down your search further, add the phrase "& MARKETING" to the search criterion. (Remember to use the symbol "&" instead of the word "AND.") A search of "FLORIDA & MARKETING" returns 255 documents. This is much smaller, but still an unwieldy number. Let's say you first want to look at confidential documents regarding marketing in Florida. Add the words "& CONFIDENTIAL" to the search criteria, so that it reads "FLORIDA & MARKETING & CONFIDENTIAL." This search returns 10 documents, including memos about marketing cigarettes at Black Expos in Jacksonville, Florida (www.pmdocs.com/getallimg.asp?if=avpidx&DOCID=2042390465), and Fort Lauderdale, Florida (www.pmdocs.com/getallimg.asp?if=avpidx&DOCID=2044750345).

Bear in mind that the search engines on the sites are only able to search the indices of the documents, not the entire text. Thus, those documents that contain the term "FLORIDA" in the indices, but not in the text, will appear in a search for that term. Not all documents returned will be pertinent to your particular topic. For example, the above search will also return information on a confidential "PROJECT FLORIDA" that Philip Morris implemented in Switzerland.

Search Tips and Tactics

While searching, keep a pad of paper handy to record code names of special projects, interesting terms, employee names and titles, and other words of interest that could aid in later searches.

Keywords: Aside from specific search terms, here are some generic key words to keep in mind:

- ▶ "Memo" (written correspondence between company employees)
- ▶ "Plan" (can help you find state- or country-wide marketing plans, or overall corporate plans)
- ▶ "Letter" (written correspondence usually with people outside the company)
- ▶ "Publication" (articles published in journals or other periodicals)
- ▶ "Article" (usually a newspaper or magazine article)
- ▶ "Telex" (the industry's word for E-mail in earlier documents as well as overseas telexes. More recent documents use the term "E-mail.")

Dispelling the Myths About Tobacco

- ▶ “Confidential”—To help find the most confidential information, you can also try adding the terms “attorney work product” or just “work product” to your search criteria. Some of the most sensitive documents were given this designation in an attempt to shield them from the public.

Code names and acronyms: As you will discover when you start searching, the companies use code names and acronyms for many of their campaigns, internal studies, and research projects. Examples are names like “Project 16,” “Operation Downunder,” and “FUBYAS” (R.J. Reynolds’ acronym for “First Unbranded Young Adult Smokers,” a term used to refer to youth). These code names and acronyms can help you zero in on a particular project while excluding many extraneous documents.

Bates numbers: The courts have placed a unique “Bates number” on each page of every document. These identifying numbers are stamped on the page, usually vertically, on the lower left corner of each document. Record the Bates numbers of important documents to use as references and to make them easier to find again.

Names of employees: Note the names and titles of the employees on the documents that you find. Often, one executive is put in charge of a company’s political or marketing activities in a certain part of the country or world. Searching for documents authored by this person can reveal a cache of information about how the industry acted in certain localities. In addition, these executives usually turned in regular reports (“weekly report” or “monthly report”) to their headquarters about their division’s activities. These reports can be valuable sources of information.

Storing Documents for Later Use

The Philip Morris, Lorillard, and Tobacco Institute sites all allow you to “bookmark” documents on your computer’s hard drive. You should bookmark any documents that you think are particularly important or that you might need in the future. To do this, hit the “view all pages” button, and then in your browser click the “add bookmarks” button. If you are using Internet Explorer, it will prompt you to type an identifying phrase into the “bookmark properties.” With Netscape, you will have to go into the “edit bookmarks” section to type in the phrase. If you do not add an identifying phrase, your bookmarks will just say “image viewer” and will not reflect the contents of the document you are saving, or even the title.

Where to Go for Further Help

The search instructions posted at each site contain basic information, such as how to properly format search terms. Always read these instructions before proceeding. Consult the examples offered within them as your first step in addressing problems.

You may also be able to get assistance from other experienced researchers by joining the tobacco industry document discussion lists “doc-talk” and

“intldoc-talk” on the Web. To sign up for these lists, go to www.smokescreen.org.

Technical Requirements

Internet Connection Speed: A modem and phone line that support a 28.8 kbps baud rate should be adequate for viewing documents without being so slow as to be completely frustrating. At this speed, an average page of text should take between 5 and 7 seconds to load, while a 50-page document could take 6 to 8 minutes to load. Higher speed Internet connections (such as DSL, ISDN, satellite, or wireless services) offer faster download times but cost more and generally are only available in major urban centers. A satellite Internet connection is now available in rural localities, where access to in-ground high-speed lines does not exist. Satellite connections are more expensive, but as of now are the only option for people in remote locations. At the time of this writing, only one satellite company supplies high-speed Internet access.

Processing Speed: A minimum of 32 MB of random-access memory (RAM) is recommended for viewing documents. Upgrading the amount of RAM is relatively simple on most computers.

Software: To view the documents, you will need a recent version of a Web browser, such as Internet Explorer (www.microsoft.com/downloads/search.asp?) or Netscape Navigator (home.netscape.com/computing/download), which can be downloaded for free. You will also want a copy of Adobe Acrobat, a file-viewing program for portable document format (PDF) files that can also be downloaded for free (www.adobe.com/products/acrobat/readstep.html). The Brown & Williamson Web site requires its own unique viewer (MIF), which you can download for free at this site.

Other Frequently Asked Questions

Q. How do I find a document if I only have the Bates number?

A. If, after typing in the Bates number on the appropriate site, you get the response “no records match your search,” you’ll need to try substituting a wildcard symbol (*) for the last digit in the Bates number. If that doesn’t work, try substituting two wildcards for the last two digits of the number. The idea is to find numbers that are very close to the one you’re looking for. Some sites respond to entering the Bates number of the starting page instead of the number for the entire document.

Q. Do all the sites respond to narrowing searches by using the symbol “&”?

A. No. On some sites you have to use the word “and” to indicate the search term. Read the search directions on each site to find out whether words or symbols are used for terms like “and” or “not.”

Dispelling the Myths About Tobacco

Q. How should I search for phrases like “Philip Morris”? Do I type in “Philip Morris” or “Philip and Morris”?

- A. To find every occurrence of the company name “Philip Morris,” you would type it exactly the way the name of the company appears. To find the words exclusively where they appear together, put quotation marks around the phrase (“Philip Morris”). Likewise, if you want to find every occurrence of the two-word phrase “political strategy,” type the two words together just like that, with quotation marks around them. However, if you want to find every document with both the words “political” and “strategy” contained somewhere in the description but not necessarily together, enter as the search criteria “political & strategy.”

Q. What about my privacy? Will the tobacco companies know it’s me searching?

- A. Visiting some of the sites will result in markers (or “cookies”) being imbedded into your browser, which tells the companies where people go on the site and what they view. Currently, this information cannot be linked back to an individual, but cookies can be set up to identify the Internet service provider you are using. All browsers allow you to either block cookies or delete them after every session.

Q. Is there any way to copy the text of a document into my word processor?

- A. No, outside of retyping it verbatim. You should print documents out directly from the site while you are online. For those sites that allow you to view and print documents in PDF format, using this format will result in the best possible copy. You can also save the document to your computer in PDF format by clicking on the “save” icon. A scanner can be used to scan in the text from a printout, but the character recognition software is still somewhat crude.

Q. I’ve tried searching for a particular word or phrase but get nothing. How can I have a more productive search?

- A. Be creative. Think of every other phrase that could possibly turn up something on the subject for which you are searching. Most importantly, read what you do find carefully. The more you read, the more terms you will discover that will return a productive search. Take note of the authors’ names and the jargon and acronyms that the companies use to refer to particular regions, projects, and marketing techniques, and then start searching for documents with those words and names.

Excerpts About Women From Internal Industry Documents

From: New Ad Target: “Virile Female.” The Washington Post, February 17, 1990

“The R.J. Reynolds Tobacco Co. plans soon to introduce a brand of cigarette—Dakota—that, according to the detailed marketing strategy prepared for the company, targets young, poorly educated, white women whom the company calls ‘virile females.’ The advertising campaign focuses on a certain group of women whose favorite pastimes, according to the marketing plan, include ‘cruising,’ ‘partying’ and attending ‘hot rod shows’ and ‘tractor pulls’ with their boyfriends... They describe the preferred ‘Dakota’ smoker as a woman with no education beyond high school, whose favorite television roles are ‘Roseanne’ and ‘evening soap opera (derogatory term deleted)’ and whose chief aspiration is ‘to get married in her early 20’s and spend free time with her boyfriend doing whatever he is doing.’

“The plan also outlines future advertising options based on interviews with small groups of potential consumers. ‘Cannot be too tough...i.e., bitchy/cold (motorcycle jacket),’ the memo states. ‘Cannot be too cute, giggly. Woman cannot be too submissive (i.e., fawning at man who looks disinterested.)’”

Bates No. 515576297/6299

From: The British American Tobacco Company, The Smoking Behaviour of Women

“[One] report claimed to have made the unexpected discovery of an increased frequency of neurotic traits in women smokers, with the suggestion that men smoke as a tribal custom whereas women smoke as a symptom of insecurity.”

Report No. RD 1410 Restricted Report, December 11, 1976

From: Philip Morris “Virginia Slims Opinion Poll Public Relations Plan” October 1996

“Objectives: [To] position the Virginia Slims opinion poll as the nation’s most authoritative chronicler of women’s issues and opinions—only Virginia Slims has the history, the heritage and scope.”

Bates No. 2044417376/7386

Dispelling the Myths About Tobacco

From: R.J. Reynolds' Psychographic Profiles, April 7, 1988

General Opinions and Attitudes:

Cluster 1: Older Females

“Lowest income of all segments, they live in the past, with little vision of the future accomplishments...Because of their age, isolation, and marginal economic circumstances, they avoid risks and are relatively inactive, but derive maximum enjoyment from the few pleasures available to them, one of which is smoking. They *enjoy* smoking more than any other segment, and are *the* most active coupon redeemers of both RJR and competitive coupons.”

Cluster 4: Low-Profile Females

“They hunt for bargains, rarely buy anything on impulse, and economize whenever possible. They are active redeemers of cigarette coupons. Not well educated, they have little interest in the arts. Their households are conspicuous in the absence of VCRs. LPF smokers walk softly through life, and maintain low profiles. They concentrate their energies in domestic activities and in close-knit friendship groups. They are disproportionately homemakers.”

Cluster 5: VCR Lovers

“VCRs (73% female; 56% married) watch a lot of television. They have discovered the VCR and they know how to use it. They engage in traditional feminine indoor domestic activities, but avoid outdoor domestic chores. Their lifestyle is inactive: situated near a TV/VCR.”

Bates No. 507403273/3282

From: R.J. Reynolds Project TF—Tomorrow's Female

Rationale:

“Among the brands that currently have appreciable share among 18–34 female smokers, there are none with the exception of Virginia Slims that have a distinct female smoker product benefit.”

Name/Advertising/Packaging Development:

“An analysis of the image wants of 18–34 year old female smokers indicates that an opportunity exists for a romantic fantasy/freedom positioning.”

Bates No. 505618415

From: R.J. Reynolds Report—Florida Ideation Session: Female FUBYAS (First Usual Brand Young Adult Smokers), May 10, 1985

“Concept Framework Benefits:

1. Provide some focus to life (something tangible to do or be) as well as immediate gratification, perhaps gratification in terms of enjoyment

(e.g., Army Campaign—Be all you can be now, and experience the thrill of paratroop maneuvers at dawn.)

2. Bring it down to their level—no lofty goals, only aspirations obtainable very short term.”

Bates No. 504102889

From: Brown & Williamson Tobacco Corporation, Report Marketing, October 1982. Quotes from focus group interviews

Those who smoke “True” brand:

“Female—very hyperactive, runs around in circles but doesn’t get anything done, all activity, but no progress—flutter brained, surface value only. Frivolous. A TRUE smoker is not a true smoker.”

Those who smoke “Vantage” brand:

“Female—housewife at a bridge game, strictly a social smoker who needs a prop. Someone trying to quit. Ghosts. Very frivolous, all surface value, flaky.”

Those who smoke “Merit” brand:

“Woman on the go, pressured. Flighty woman, dumb blonde, couldn’t depend on. Friendly. Hyper.”

Those who smoke “Carlton” brand:

“A nonsmoking smoker, desperate, little old lady, trying to quit, puny, squeaky, wimp, poor taste, someone in a nursing home.”

Bates No. 670575136/5158

From: Chronological Notes On the History of Cigarette Advertising

“1929: Bernays, PR man, hired models to smoke in public and take photos, write stories, etc., organizes women to march together, smoking in public, in New York Easter Parade with ‘torches of liberty’ [cigarettes].”

“1934: Bernays works for 6 months to make GREEN the fashion color of the year. ‘Mr. Hill wanted more women to smoke Luckies but research showed green unpopular with women because clashed with clothing. Organizes ‘Green Ball’ with socialites, New York Infirmary for Women, art galleries. Works with manufacturers of accessories, dresses, textiles, etc. Sends 6,500 letters and kits to dept. stores, fashion editors, interior decorators, etc., telling them of this ‘trend.’ Gets *Harper’s Bazaar* and *Vogue* to feature green on covers on date of the Green Ball. [Bernays 1965; 1971] Silk company throws Green Fashion Luncheon with all green menu (*a la* St. Patrick’s Day). Sends media releases

Dispelling the Myths About Tobacco

with psychologist stories, suggest benefits of color green as ‘color of spring, an emblem of hope, victory (over depression) and plenty.’ [Sobel 1978] [Bernays 1965] For this ‘engineering of consent ... I drew up a comprehensive blueprint, a complete procedural outline, detailing objectives, the necessary research, strategy, themes and timing of the planned activities.’ [Bernays 1965, p. 390]”

Bates No. 2024985261-5290

From: Topline Report on Eight Focus Groups With Women Smokers About Issues Related to New Virginia Slims Kings, Henderson, NR; Kensinger, JL, Riva Market Research, 1994

“Image of Specific Brands:

It did not seem to matter if the group was ‘young’ or ‘older’ when it came to image of specific brands, so what is reported here are the key images for each brand.

Capri: Feminine/skinny/stupid/dumb ads/stuck-up bitches/rainbow/pastel box/ ‘posers’/fall out of ashtrays/older women/prissy/too small/special, low prices, orchids

Misty: Feminine/rain/grandma/cheap/bad taste/tacky/winter/state/damp/ coupons/teenagers

Doral: Generic/cheap/old people/ bad taste/ old poor men/dull/‘trailer trash’/ Jeeps/charcoal/low tar/plastic filters”

Bates No. 2057763894/3911

From: The British American Tobacco Company, The Smoking Behaviour of Women

“In terms of product design, there does not seem to be a great deal of evidence that women in general require a cigarette delivering relatively low amounts of nicotine—in fact some evidence points in the opposite direction. However, given that women are more neurotic than men, it seems reasonable to assume that they will react more strongly to smoking and health pressures...”

Report No. RD 1410 Restricted Report, December 11, 1976

From: A letter to the president of the R.J. Reynolds Company

December 9, 1988

Mr. Richard A. Kampe
President
R.J. Reynolds Tobacco Development Co.
401 N. Main Street
Winston-Salem, NC 27102

Dear Mr. Kampe,

Imagine a 5-year old child, who will be a future customer of your cigarettes in the next few years. How can your company begin to attract/tap into this next generation? As a creative strategic marketing company, Flanigan Enterprises has developed a concept that will be innovative, have a reputable advertising effect in the home, and be a new source of revenues for R.J. Reynolds.

The young children of this country have a curious desire to be instantly entertained, educated and expand their horizons. The parents of these children (yuppies with discretionary incomes) want the best for their children and are willing to pay if quality and reliability are present. These parents place a premium on high-technology and modern advances to ensure their children are keeping pace with today's dynamic, rapidly changing environment.

The concept is a simple one—Flanigan Enterprises is proposing a children's video be made to advertise the Camel product. This can be done through a series of full-cel animation (Disney style) videos directed towards the youth of today. Children love cartoons and these can be incorporated into the purchasing of cartons/packets of Camel cigarettes.

The camel symbol can be transformed into a moving, talking, animated cartoon for children. It can also include the actual footage of visiting live camels in the zoo and in their native environment. Children love to watch animals (repeatability) and this video can incorporate an education/environment theme. How often smokers are told, 'it is a bad example for children in our home to see you smoke.' Here is a positive way to enhance the image of R.J. Reynolds in the home—to engrain a positive image of the company to the children of the nonsmoker while linking the video to purchase of cigarettes...

Bates No. 513612438

Dispelling the Myths About Tobacco

From: "Going Into the Tank for Tobacco" by Albert R. Hunt. The Wall Street Journal Interactive Edition, August 2, 2001

“The unsurpassed arrogance and immorality of cigarette makers surfaced most recently when this newspaper reported that Philip Morris distributed, in the Czech Republic, an analysis of why cigarettes weren’t a drag on that country’s budget. A key argument: Cigarettes kill people and, if they’re dead, the government doesn’t have to spend money on health care, housing, and pensions.”

From: A telephone survey of 300 advertising industry executives in agencies with billings of more than \$10 million, commissioned by the New York advertising firm of Shepardson, Stern, and Kaminsky (December 1996)

In December 1996, a survey of advertising industry executives revealed the following:

1. 82% believe advertising for cigarettes and tobacco products reaches children and teenagers in significant numbers.
2. 78% believe that tobacco advertising makes smoking more appealing or socially acceptable to kids.
3. 71% believe that tobacco advertising changes behavior and increases smoking among kids.
4. 59% believe that a goal of tobacco advertising is marketing cigarettes to teenagers who do not already smoke.
6. 79% favor limitations on the style and placement of advertising for cigarette and tobacco products to minimize impact on children and teenagers.

From: "RJR Wins Fight" by David Carrig, USA Today: B1, April 18, 1996

“Charles Harper, R.J. Reynolds Chairman: ‘If children don’t like to be in a smoky room, they’ll leave.’ When asked by a shareholder about infants, who can’t leave a smoky room, Harper stated, ‘At some point, they begin to crawl.’”

From: New York Times, March 4, 1998

Geoffrey C. Bible, CEO and Chairman of the Board of Philip Morris Companies, exchange in Minnesota trial:

“A: We should not be marketing cigarettes to young people. It is certainly anomalous to the Philip Morris I know.

“Q: If we keep seeing more anomalies, sooner or later it becomes usual, doesn't it?

“A: Well, it's a large company, and we sell a lot of products.”

From: Videotaped testimony in the Minnesota lawsuit

“We did not look at the underage market even though I am holding a document in my hand that says we did.”

James Morgan, Former President and CEO of Philip Morris

More References and Resources

Women and Tobacco Information Web Sites

Inclusion here does not imply endorsement by CDC. Note that Web sites change often.

National Women's Health Information Center

Supported by the Office on Women's Health, U.S. Department of Health and Human Services, this site offers a variety of resources and information related to the Surgeon General's report and tailored to women.

www.4women.org

American Medical Women's Association

The American Medical Women's Association is an organization that functions at the local, national, and international levels to advance women in medicine and improve women's health by providing and developing leadership, advocacy, education, expertise, mentoring, and strategic alliances.

www.amwa-doc.org

The CHEST Foundation

This site offers resources, information, and advice to support the use of the Speakers Kit by the Task Force on Women & Girls, Tobacco, & Lung Cancer. The Web site includes downloadable PowerPoint presentations on tobacco tailored to health care professionals and students, women, teens, and girls.

speakerskit.chestnet.org (do not use "www" in the URL)

National Coalition for Women Against Tobacco

Founded by the American Medical Women's Association, the National Coalition for Women Against Tobacco aims to increase awareness of the dangers of tobacco use and exposure, and provide leadership in helping the global community of women and girls lead tobacco-free lives.

www.womenagainst.org

Tobacco Control Information Web Sites

Inclusion here does not imply endorsement by CDC. Note that Web sites change often.

CDC's Office on Smoking and Health

This Web site offers one-stop access to government-supported tobacco control research, data (including CDC's STATE system and other state and local data), publications (including all Surgeon General's reports), posters (including Christy Turlington's), videos (including ways to order *Women and Tobacco: Seven Deadly Myths*), fact sheets, smoke-free sports materials, and cessation resources.

www.cdc.gov/tobacco

Dispelling the Myths About Tobacco

Smokefree Soccer

This Web site, soon expanding to cover all sports, is jointly sponsored by CDC and the National Cancer Institute. It provides information and resources, including ways to order posters and other sports-related materials to disseminate the smoke-free message. It is especially oriented to serving young people and their sports coaches.

www.smokefree.gov

Action on Smoking and Health

Action on Smoking and Health (ASH) is a national nonprofit legal action and educational organization fighting for the rights of nonsmokers against the many problems of tobacco. ASH represents nonsmokers in courts and legislative bodies, and before regulatory agencies.

www.ash.org

The Truth Campaign

The Truth Campaign is dedicated to exposing the truth about tobacco. The Web site works in conjunction with the American Legacy Foundation's edgy Truth ad campaigns. It includes news, resources, and links to the tobacco industry so that visitors can "see for themselves" what the tobacco companies are doing and saying.

www.thetruth.com, www.americanlegacy.org

Americans for Non Smokers' Rights

This site includes internal industry quotes, extensive information on secondhand smoke, smoke-free advocacy resources, and a large section on youth advocacy.

www.no-smoke.org

National Health Organizations and Federal Agencies

American Heart Association

www.amhrt.org

American Lung Association

www.lungusa.org

American Cancer Society

www.cancer.org

Agency for Health Care Research and Quality

www.ahrq.gov

National Cancer Institute

www.nci.nih.gov

The Centers for Disease Control and Prevention

www.cdc.gov

Video Resources

Women and Smoking: A Fatal Attraction

Video copies of this program, which was aired on ABC on July 5, 2001, can be ordered from ABC's Web site (www.abcnewsstore.com) for \$29.95. Discounts are available for orders of 100 or more. Permission from ABC is needed to show the tape in a public venue. Please fax a letter requesting permission to Tony at (212)456-1798. Tony may also be reached by phone at (212)456-4105.

SLAM!

SLAM! is a 15-minute video developed by CDC's Office on Smoking and Health to help young people become more aware of the power and pervasiveness of cigarette advertising and to resist the influences of the tobacco industry. The video tells the story of Leslie Nuchow, a talented but unsigned young singer-songwriter who refused to have her music associated with a cigarette marketing campaign targeted toward young women. Discussion questions and teaching objectives are included with the video, which can be used as part of a comprehensive health education program; an alcohol, tobacco, or other drug program; or a current events or media literacy curriculum.

www.cdc.gov/tobacco/slam.htm

Secrets Through the Smoke

Dr. Jeffrey S. Wigand (www.jeffreywigand.com), subject of the Academy Award-nominated film *The Insider*, achieved national prominence in 1995 when he became the tobacco industry's highest ranking former executive to publicly acknowledge the devastating effects of smoking on health. In *Secrets Through the Smoke*, produced by CDC's Office on Smoking and Health, Dr. Wigand shares his experiences with the tobacco industry's manipulation of the truth.

www.cdc.gov/tobacco/educational_materials/secrets_smoke/VideoCoverR4.pdf

Appendix
Materials from *Women and Smoking:*
A Report of the Surgeon General

Executive Summary

This is the second report of the U.S. Surgeon General devoted to women and smoking. The first was published in 1980 (U.S. Department of Health and Human Services [USDHHS] 1980), 16 years after the initial landmark report on smoking and health of the Advisory Committee to the Surgeon General appeared in 1964 (U.S. Department of Health, Education, and Welfare [USDHEW] 1964). The 1964 report summarized the accumulated evidence that demonstrated that smoking was a cause of human cancer and other diseases. Most of the early evidence was based on men. For example, the report concluded, "Cigarette smoking is causally related to lung cancer in men.... The data for women, though less extensive, point in the same direction" (USDHEW 1964, p. 37). By the time of the 1980 report, the evidence clearly showed that women were also experiencing devastating health consequences from smoking and that "the first signs of an epidemic of smoking-related disease among women are now appearing" (USDHHS 1980, p. v). The evidence had solidified later among women than among men because smoking became commonplace among women about 25 years later than it had among men. However, it was still deemed necessary to include a section in the preface of the 1980 report titled "The Fallacy of Women's Immunity." In the two decades since, numerous studies have expanded the breadth and depth of what is known about the health consequences of smoking among women, about historical and contemporary patterns of smoking in demographic subgroups of the female population, about factors that affect initiation and maintenance of smoking among women (including advertising and marketing of tobacco products), and about interventions to assist women to quit smoking. The present report reviews the now massive body of evidence on women and smoking—evidence that taken together compels the Nation to make reducing and preventing smoking one of the highest contemporary priorities for women's health.

A report focused on women is greatly needed. No longer are the first signs of an epidemic of tobacco-related diseases among women being seen, as was the case when the 1980 report was written. Since 1980, hundreds of additional studies have expanded what is known about the health effects of smoking among women, and this report summarizes that knowledge.

Today the Nation is in the midst of a full-blown epidemic. Lung cancer, once rare among women, has surpassed breast cancer as the leading cause of female cancer death in the United States, now accounting for 25 percent of all cancer deaths among women. Surveys have indicated that many women do not know this fact. And lung cancer is only one of myriad serious disease risks faced by women who smoke. Although women and men who smoke share excess risks for diseases such as cancer, heart disease, and emphysema, women also experience unique smoking-related disease risks related to pregnancy, oral contraceptive use, menstrual function, and cervical cancer. These risks deserve to be highlighted and broadly recognized. Moreover, much of what is known about the health effects of exposure to environmental tobacco smoke among nonsmokers comes from studies of women, because historically men were more likely than women to smoke and because many women who did not smoke were married to smokers.

In 1965, 51.9 percent of men were smokers, whereas 33.9 percent of women were smokers. By 1979, the percentage of women who smoked had declined somewhat, to 29.9 percent. However, the decline in smoking among men to 37.5 percent was much more dramatic. The gender gap in adult smoking prevalence continued to close after the 1980 report, but since the mid-1980s, the difference has been fairly stable at about 5 percentage points. In 1998, smoking prevalence was 22.0 percent among women and 26.4 percent among men. The gender difference in smoking prevalence among teens is smaller than that among adults. Smoking prevalence increased among both girls and boys in the 1990s. In 2000, 29.7 percent of high school senior girls and 32.8 percent of high school senior boys reported having smoked within the past 30 days (University of Michigan 2000).

In recent years, some research has suggested that the impact of a given amount of smoking on lung cancer risk might be even greater among women than among men, that exposure to environmental tobacco smoke might be associated with increased risk for breast cancer, and that women might be more susceptible than men to weight gain following smoking cessation. Other research indicated that persons with specific genetic polymorphisms may be especially susceptible to the effects of smoking and exposure to

environmental tobacco smoke. These issues remain active areas of investigation, and no conclusions can be drawn about them at this time. Nonetheless, knowledge of the vast spectrum of smoking-related health effects continues to grow, as does knowledge that examination of gender-specific effects is important.

Smoking is one of the most studied of human behaviors and thousands of studies have documented its health consequences, yet certain questions and data needs exist with respect to women and smoking. For example, there is a need to better understand why smoking prevalence increased among teenage girls and young women in the 1990s despite the overwhelming data on adverse health effects; to identify interventions and policies that will prevent an epidemic of tobacco use among women whose smoking prevalence is currently low, including women in certain sociocultural groups within the United States and women in many developing countries throughout the world; to study the relationship of active smoking to diseases among women for which the evidence to date has been suggestive or inconsistent (e.g., risks for menstrual cycle irregularities, gallbladder disease, and

systemic lupus erythematosus); to increase the data on the health effects of exposure to environmental tobacco smoke on diseases unique among women; to provide additional research on whether gender differences exist in susceptibility to nicotine addiction or in the magnitude of the effects of smoking on specific disease outcomes; and to determine whether gender differences exist in the modifying effects of genetic polymorphisms on disease risks associated with smoking. Many studies of smoking behavior and of the health consequences of smoking have included both females and males but have not reported results by gender. Investigators should be encouraged to report gender-specific results in the future.

Other recent reports of the Surgeon General have been devoted to smoking and youth (USDHHS 1994), smoking and racial or ethnic minorities (USDHHS 1998), and interventions to reduce smoking (USDHHS 2000). The reader is encouraged to consult those reports for comprehensive reviews of the evidence on these topics. The present report focuses on data specific to women and girls and on comparisons of results by gender.

Major Conclusions

1. Despite all that is known of the devastating health consequences of smoking, 22.0 percent of women smoked cigarettes in 1998. Cigarette smoking became prevalent among men before women, and smoking prevalence in the United States has always been lower among women than among men. However, the once-wide gender gap in smoking prevalence narrowed until the mid-1980s and has since remained fairly constant. Smoking prevalence today is nearly three times higher among women who have only 9 to 11 years of education (32.9 percent) than among women with 16 or more years of education (11.2 percent).
2. In 2000, 29.7 percent of high school senior girls reported having smoked within the past 30 days. Smoking prevalence among white girls declined from the mid-1970s to the early 1980s, followed by a decade of little change. Smoking prevalence then increased markedly in the early 1990s, and declined somewhat in the late 1990s. The increase dampened much of the earlier progress. Among black girls, smoking prevalence declined substantially from the mid-1970s to the early 1990s, followed by some increases until the mid-1990s. Data on long-term trends in smoking prevalence among high school seniors of other racial or ethnic groups are not available.
3. Since 1980, approximately 3 million U.S. women have died prematurely from smoking-related neoplastic, cardiovascular, respiratory, and pediatric diseases, as well as cigarette-caused burns. Each year during the 1990s, U.S. women lost an estimated 2.1 million years of life due to these smoking attributable premature deaths. Additionally, women who smoke experience gender-specific health consequences, including increased risk of various adverse reproductive outcomes.

4. Lung cancer is now the leading cause of cancer death among U.S. women; it surpassed breast cancer in 1987. About 90 percent of all lung cancer deaths among women who continue to smoke are attributable to smoking.
5. Exposure to environmental tobacco smoke is a cause of lung cancer and coronary heart disease among women who are lifetime nonsmokers. Infants born to women exposed to environmental tobacco smoke during pregnancy have a small decrement in birth weight and a slightly increased risk of intrauterine growth retardation compared to infants of nonexposed women.
6. Women who stop smoking greatly reduce their risk of dying prematurely, and quitting smoking is beneficial at all ages. Although some clinical intervention studies suggest that women may have more difficulty quitting smoking than men, national survey data show that women are quitting at rates similar to or even higher than those for men. Prevention and cessation interventions are generally of similar effectiveness for women and men and, to date, few gender differences in factors related to smoking initiation and successful quitting have been identified.
7. Smoking during pregnancy remains a major public health problem despite increased knowledge of the adverse health effects of smoking during pregnancy. Although the prevalence of smoking during pregnancy has declined steadily in recent years, substantial numbers of pregnant women continue to smoke, and only about one-third of women who stop smoking during pregnancy are still abstinent one year after the delivery.
8. Tobacco industry marketing is a factor influencing susceptibility to and initiation of smoking among girls, in the United States and overseas. Myriad examples of tobacco ads and promotions targeted to women indicate that such marketing is dominated by themes of social desirability and independence. These themes are conveyed through ads featuring slim, attractive, athletic models, images very much at odds with the serious health consequences experienced by so many women who smoke.

Chapter Conclusions

Conclusions from Chapters 2–5 are presented below. Separate conclusions are not included for Chapter 1 because it is a summary of the report. Chapter 6, which presents a vision for the future, is reproduced in its entirety following the conclusions for Chapters 2–5.

Chapter 2. Patterns of Tobacco Use Among Women and Girls

1. Cigarette smoking became prevalent among women after it did among men, and smoking prevalence has always been lower among women than among men. The gender-specific difference in smoking prevalence narrowed between 1965 and 1985. Since 1985, the decline in prevalence has been comparable among women and men.
2. The prevalence of current smoking among women increased from less than 6 percent in 1924 to 34 percent in 1965, then declined to 22 to 23 percent in the late 1990s. In 1997–1998, smoking prevalence was highest among American Indian or Alaska Native women (34.5 percent), intermediate among white women (23.5 percent) and black women (21.9 percent), and lowest among Hispanic women (13.8 percent) and Asian or Pacific Islander women (11.2 percent). By educational level, smoking prevalence is nearly three times higher among women with 9 to 11 years of education (30.9 percent) than among women with 16 or more years of education (10.6 percent).
3. Much of the progress in reducing smoking prevalence among girls in the 1970s and 1980s was lost with the increase in prevalence in the 1990s: current smoking among high school senior girls was the same in 2000 as in 1998. Although smoking prevalence was higher

- among high school senior girls than among high school senior boys in the 1970s and early 1980s, prevalence has been comparable since the mid-1980s.
4. Smoking declined substantially among black girls from the mid-1970s through the early 1990s; the decline among white girls for this same period was small. As adolescents age into young adulthood, these patterns are now being reflected in the racial and ethnic differences in smoking among young women. Data are not available on long-term trends in smoking prevalence among high school seniors of other racial and ethnic groups.
 5. Smoking during pregnancy appears to have decreased from 1989 through 1998. Despite increased knowledge of the adverse health effects of smoking during pregnancy, estimates of women smoking during pregnancy range from 12 percent based on birth certificate data to as high as 22 percent based on survey data.
 6. Historically, women started to smoke at a later age than did men, but beginning with the 1960 cohort, the mean age at smoking initiation has not differed by gender.
 7. Nicotine dependence is strongly associated with the number of cigarettes smoked per day. Girls and women who smoke appear to be equally dependent on nicotine when results are stratified by number of cigarettes smoked per day. Few gender-specific differences have been found in indicators of nicotine dependence among adolescents, young adults, or adults overall.
 8. The percentage of persons who have ever smoked and who have quit smoking is somewhat lower among women (46.2 percent) than among men (50.1 percent). This finding is probably because men began to stop smoking earlier in the twentieth century than did women and because these data do not take into account that men are more likely than women to switch to or to continue to use other tobacco products when they stop smoking cigarettes. Since the late 1970s or early 1980s, the probability of attempting to quit smoking and to succeed has been equally high among women and men.
 9. Prevalence of the use of cigars, pipes, and smokeless tobacco among women is generally low, but recent data suggest that cigar smoking among women and girls is increasing.

10. Smoking prevalence among women varies markedly across countries; the percentages range from an estimated 7 percent in developing countries to 24 percent in developed countries. Thwarting further increases in tobacco use among women is one of the greatest disease prevention opportunities in the world today.

Chapter 3. Health Consequences of Tobacco Use Among Women

Total Mortality

1. Cigarette smoking plays a major role in the mortality of U.S. women.
2. The excess risk for death from all causes among current smokers compared with persons who have never smoked increases with both the number of years of smoking and the number of cigarettes smoked per day.
3. Among women who smoke, the percentage of deaths attributable to smoking has increased over the past several decades, largely because of increases in the quantity of cigarettes smoked and the duration of smoking.
4. Cohort studies with follow-up data analyzed in the 1980s show that the annual risk for death from all causes is 80 to 90 percent greater among women who smoke cigarettes than among women who never smoked. A woman's annual risk for death more than doubles among continuing smokers compared with persons who have never smoked in every age group from 45 through 74 years.
5. In 1997, approximately 165,000 U.S. women died prematurely from a smoking-related disease. Since 1980, approximately three million U.S. women have died prematurely from a smoking-related disease.
6. U.S. females lost an estimated 2.1 million years of life each year during the 1990s as a result of smoking-related deaths due to neoplastic, cardiovascular, respiratory, and pediatric diseases, as well as from burns caused by cigarettes. For every smoking attributable death, an average of 14 years of life was lost.
7. Women who stop smoking greatly reduce their risk of dying prematurely. The relative benefits of smoking cessation are greater when women stop smoking at younger ages, but smoking cessation is beneficial at all ages.

Lung Cancer

8. Cigarette smoking is the major cause of lung cancer among women. About 90 percent of all lung cancer deaths among U.S. women smokers are attributable to smoking.
9. The risk for lung cancer increases with quantity, duration, and intensity of smoking. The risk for dying of lung cancer is 20 times higher among women who smoke two or more packs of cigarettes per day than among women who do not smoke.
10. Lung cancer mortality rates among U.S. women have increased about 600 percent since 1950. In 1987, lung cancer surpassed breast cancer to become the leading cause of cancer death among U.S. women. Overall age-adjusted incidence rates for lung cancer among women appear to have peaked in the mid-1990s.
11. In the past, men who smoked appeared to have a higher relative risk for lung cancer than did women who smoked, but recent data suggest that such differences have narrowed considerably. Earlier findings largely reflect past gender-specific differences in duration and amount of cigarette smoking.
12. Former smokers have a lower risk for lung cancer than do current smokers, and risk declines with the number of years of smoking cessation.

International Trends in Female Lung Cancer

13. International lung cancer death rates among women vary dramatically. This variation reflects historical differences in the adoption of cigarette smoking by women in different countries. In 1990, lung cancer accounted for about 10 percent of all cancer deaths among women worldwide and more than 20 percent of cancer deaths among women in some developed countries.

Female Cancers

14. The totality of the evidence does not support an association between smoking and risk for breast cancer.
15. Several studies suggest that exposure to environmental tobacco smoke is associated with an increased risk for breast cancer, but this association remains uncertain.
16. Current smoking is associated with a reduced risk for endometrial cancer, but the effect is probably limited to postmenopausal disease. The

risk for this cancer among former smokers generally appears more similar to that of women who have never smoked.

17. Smoking does not appear to be associated with risk of ovarian cancer.
18. Smoking has been consistently associated with an increased risk for cervical cancer. The extent to which this association is independent of human papillomavirus infection is uncertain.
19. Smoking may be associated with an increased risk for vulvar cancer, but the extent to which the association is independent of human papillomavirus infection is uncertain.

Other Cancers

20. Smoking is a major cause of cancers of the oropharynx and bladder among women. Evidence is also strong that women who smoke have increased risks for cancers of the pancreas and kidney. For cancers of the larynx and esophagus, evidence among women is more limited but consistent with large increases in risk.
21. Women who smoke may have increased risks for liver cancer and colorectal cancer.
22. Data on smoking and cancer of the stomach among women are inconsistent.
23. Smoking may be associated with an increased risk for acute myeloid leukemia among women but does not appear to be associated with other lymphoproliferative or hematologic cancers.
24. Women who smoke may have a decreased risk for thyroid cancer.
25. Women who use smokeless tobacco have an increased risk for oral cancer.

Cardiovascular Disease

26. Smoking is a major cause of coronary heart disease among women. For women younger than 50 years, the majority of coronary heart disease is attributable to smoking. Risk increases with the number of cigarettes smoked and the duration of smoking.
27. The risk for coronary heart disease among women is substantially reduced within 1 or 2 years of smoking cessation. This immediate benefit is followed by a continuing but more gradual reduction in risk to that among non-smokers by 10 to 15 or more years after cessation.
28. Women who use oral contraceptives have a particularly elevated risk of coronary heart disease if they smoke. Currently, evidence is conflicting as

to whether the effect of hormone replacement therapy on coronary heart disease risk differs between smokers and nonsmokers.

29. Women who smoke have an increased risk for ischemic stroke and subarachnoid hemorrhage. Evidence is inconsistent concerning the association between smoking and primary intracerebral hemorrhage.
30. In most studies that include women, the increased risk for stroke associated with smoking is reversible after smoking cessation; after 5 to 15 years of abstinence, the risk approaches that of women who have never smoked.
31. Conflicting evidence exists regarding the level of the risk for stroke among women who both smoke and use either the oral contraceptives commonly prescribed in the United States today or hormone replacement therapy.
32. Smoking is a strong predictor of the progression and severity of carotid atherosclerosis among women. Smoking cessation appears to slow the rate of progression of carotid atherosclerosis.
33. Women who are current smokers have an increased risk for peripheral vascular atherosclerosis. Smoking cessation is associated with improvements in symptoms, prognosis, and survival.
34. Women who smoke have an increased risk for death from ruptured abdominal aortic aneurysm.

Chronic Obstructive Pulmonary Disease (COPD) and Lung Function

35. Cigarette smoking is a primary cause of COPD among women, and the risk increases with the amount and duration of smoking. Approximately 90 percent of mortality from COPD among women in the United States can be attributed to cigarette smoking.
36. In utero exposure to maternal smoking is associated with reduced lung function among infants, and exposure to environmental tobacco smoke during childhood and adolescence may be associated with impaired lung function among girls.
37. Adolescent girls who smoke have reduced rates of lung growth, and adult women who smoke experience a premature decline of lung function.
38. The rate of decline in lung function is slower among women who stop smoking than among women who continue to smoke.

39. Mortality rates for COPD have increased among women over the past 20 to 30 years.
40. Although data for women are limited, former smokers appear to have a lower risk for dying from COPD than do current smokers.

Sex Hormones, Thyroid Disease, and Diabetes Mellitus

41. Women who smoke have an increased risk for estrogen-deficiency disorders and a decreased risk for estrogen-dependent disorders, but circulating levels of the major endogenous estrogens are not altered among women smokers.
42. Although consistent effects of smoking on thyroid hormone levels have not been noted, cigarette smokers may have an increased risk for Graves' ophthalmopathy, a thyroid-related disease.
43. Smoking appears to affect glucose regulation and related metabolic processes, but conflicting data exist on the relationship of smoking and the development of type 2 diabetes mellitus and gestational diabetes among women.

Menstrual Function, Menopause, and Benign Gynecologic Conditions

44. Some studies suggest that cigarette smoking may alter menstrual function by increasing the risks for dysmenorrhea (painful menstruation), secondary amenorrhea (lack of menses among women who ever had menstrual periods), and menstrual irregularity.
45. Women smokers have a younger age at natural menopause than do nonsmokers and may experience more menopausal symptoms.
46. Women who smoke may have decreased risk for uterine fibroids.

Reproductive Outcomes

47. Women who smoke have increased risks for conception delay and for both primary and secondary infertility.
48. Women who smoke may have a modest increase in risks for ectopic pregnancy and spontaneous abortion.
49. Smoking during pregnancy is associated with increased risks for preterm premature rupture of membranes, abruptio placentae, and placenta previa, and with a modest increase in risk for preterm delivery.
50. Women who smoke during pregnancy have a decreased risk for preeclampsia.

51. The risk for perinatal mortality—both stillbirth and neonatal deaths—and the risk for sudden infant death syndrome (SIDS) are increased among the offspring of women who smoke during pregnancy.
52. Infants born to women who smoke during pregnancy have a lower average birth weight and are more likely to be small for gestational age than are infants born to women who do not smoke.
53. Smoking does not appear to affect the overall risk for congenital malformations.
54. Women smokers are less likely to breastfeed their infants than are women nonsmokers.
55. Women who quit smoking before or during pregnancy reduce the risk for adverse reproductive outcomes, including conception delay, infertility, preterm premature rupture of membranes, preterm delivery, and low birth weight.
64. Women who smoke have an increased risk for peptic ulcers.
65. Women who currently smoke have a decreased risk for ulcerative colitis, but former smokers have an increased risk—possibly because smoking suppresses symptoms of the disease.
66. Women who smoke appear to have an increased risk for Crohn’s disease, and smokers with Crohn’s disease have a worse prognosis than do nonsmokers.

Body Weight and Fat Distribution

56. Initiation of cigarette smoking does not appear to be associated with weight loss, but smoking does appear to attenuate weight gain over time.
57. The average weight of women who are current smokers is modestly lower than that of women who have never smoked or who are long-term former smokers.
58. Smoking cessation among women typically is associated with a weight gain of about 6 to 12 pounds in the year after they quit smoking.
59. Women smokers have a more masculine pattern of body fat distribution (i.e., a higher waist-to-hip ratio) than do women who have never smoked.

Bone Density and Fracture Risk

60. Postmenopausal women who currently smoke have lower bone density than do women who do not smoke.
61. Women who currently smoke have an increased risk for hip fracture compared with women who do not smoke.
62. The relationship among women between smoking and the risk for bone fracture at sites other than the hip is not clear.

Gastrointestinal Diseases

63. Some studies suggest that women who smoke have an increased risk for gallbladder disease (gallstones and cholecystitis), but the evidence is inconsistent.

Arthritis

67. Some but not all studies suggest that women who smoke may have a modestly elevated risk for rheumatoid arthritis.
68. Women who smoke have a modestly reduced risk for osteoarthritis of the knee; data regarding osteoarthritis of the hip are inconsistent.
69. The data on the risk of systemic lupus erythematosus among women who smoke are inconsistent.

Eye Disease

70. Women who smoke have an increased risk for cataract.
71. Women who smoke may have an increased risk for age-related macular degeneration.
72. Studies show no consistent association between smoking and open-angle glaucoma.

Human Immunodeficiency Virus (HIV) Disease

73. Limited data suggest that women smokers may be at higher risk for HIV-1 infection than nonsmokers.

Facial Wrinkling

74. Limited but consistent data suggest that women smokers have more facial wrinkling than do nonsmokers.

Depression and Other Psychiatric Disorders

75. Smokers are more likely to be depressed than are nonsmokers, a finding that may reflect an effect of smoking on the risk for depression, the use of smoking for self-medication, or the influence of common genetic or other factors on both smoking and depression. The association of smoking and depression is particularly important among women because they are more likely to be diagnosed with depression than are men.

76. The prevalence of smoking generally has been found to be higher among patients with anxiety disorders, bulimia, attention deficit disorder, and alcoholism than among individuals without these conditions; the mechanisms underlying these associations are not yet understood.
77. The prevalence of smoking is very high among patients with schizophrenia, but the mechanisms underlying this association are not yet understood.
78. Smoking may be used by some persons who would otherwise manifest psychiatric symptoms to manage those symptoms; for such persons, cessation of smoking may lead to the emergence of depression or other dysphoric mood states.

Neurologic Diseases

79. Women who smoke have a decreased risk for Parkinson's disease.
80. Data regarding the association between smoking and Alzheimer's disease are inconsistent.

Nicotine Pharmacology and Addiction

81. Nicotine pharmacology and the behavioral processes that determine nicotine addiction appear generally similar among women and men; when standardized for the number of cigarettes smoked, the blood concentration of cotinine (the main metabolite of nicotine) is similar among women and men.
82. Women's regulation of nicotine intake may be less precise than men's. Factors other than nicotine (e.g., sensory cues) may play a greater role in determining smoking behavior among women.

Environmental Tobacco Smoke (ETS) and Lung Cancer

83. Exposure to ETS is a cause of lung cancer among women who have never smoked.

ETS and Coronary Heart Disease

84. Epidemiologic and other data support a causal relationship between ETS exposure from the spouse and coronary heart disease mortality among women nonsmokers.

ETS and Reproductive Outcomes

85. Infants born to women who are exposed to ETS during pregnancy may have a small decrement in birth weight and a slightly increased risk for intrauterine growth retardation compared with infants born to women who are not exposed; both effects are quite variable across studies.
86. Studies of ETS exposure and the risks for delay in conception, spontaneous abortion, and perinatal mortality are few, and the results are inconsistent.

Chapter 4. Factors Influencing Tobacco Use Among Women

1. Girls who initiate smoking are more likely than those who do not smoke to have parents or friends who smoke. They also tend to have weaker attachments to parents and family and stronger attachments to peers and friends. They perceive smoking prevalence to be higher than it actually is, are inclined to risk taking and rebelliousness, have a weaker commitment to school or religion, have less knowledge of the adverse consequences of smoking and the addictiveness of nicotine, believe that smoking can control weight and negative moods, and have a positive image of smokers. Although the strength of the association by gender differs across studies, most of these factors are associated with an increased risk for smoking among both girls and boys.
2. Girls appear to be more affected than boys by the desire to smoke for weight control and by the perception that smoking controls negative moods; girls may also be more influenced than boys to smoke by rebelliousness or a rejection of conventional values.
3. Women who continue to smoke and those who fail at attempts to stop smoking tend to have lower education and employment levels than do women who quit smoking. They also tend to be more addicted to cigarettes, as evidenced by the smoking of a higher number of cigarettes per day, to be cognitively less ready to stop smoking, to have less social support for stopping, and to be less confident in resisting temptations to smoke.

4. Women have been extensively targeted in tobacco marketing, and tobacco companies have produced brands specifically for women, both in the United States and overseas. Myriad examples of tobacco ads and promotions targeted to women indicated that such marketing is dominated by themes of both social desirability and independence, which are conveyed through ads featuring slim, attractive, athletic models. Between 1995 and 1998, expenditures for domestic cigarette advertising and promotion increased 37.3 percent, from \$4.90 billion to \$6.73 billion.
5. Tobacco industry marketing, including product design, advertising, and promotional activities, is a factor influencing susceptibility to and initiation of smoking.
6. The dependence of the media on revenues from tobacco advertising oriented to women, coupled with tobacco company sponsorship of women's fashions and of artistic, athletic, political, and other events, has tended to stifle media coverage of the health consequences of smoking among women and to mute criticism of the tobacco industry by women public figures.
3. A higher percentage of women stop smoking during pregnancy, both spontaneously and with assistance, than at other times in their lives. Using pregnancy-specific programs can increase smoking cessation rates, which benefits infant health and is cost effective. Only about one-third of women who stop smoking during pregnancy are still abstinent one year after the delivery.
4. Women fear weight gain during smoking cessation more than do men. However, few studies have found a relationship between weight concerns and smoking cessation for either women or men. Further, actual weight gain during cessation does not predict relapse to smoking.
5. Adolescent girls are more likely than adolescent boys to respond to smoking cessation programs that include social support from the family or their peer group.
6. Among persons who smoke heavily, women are more likely than men to report being dependent on cigarettes and to have lower expectations about stopping smoking, but it is not clear if such women are less likely to quit smoking.
7. Currently, no tobacco cessation method has proved to be any more or less successful among minority women than among white women in the same study, but research on smoking cessation among women of most racial and ethnic minorities has been scarce.

Chapter 5. Efforts to Reduce Tobacco Use Among Women

1. Using evidence from studies that vary in design, sample characteristics, and intensity of the interventions studied, researchers to date have not found consistent gender-specific differences in the effectiveness of intervention programs for tobacco use. Some clinical studies have shown lower cessation rates among women than among men, but others have not. Many studies have not reported cessation results by gender.
2. Among women, biopsychosocial factors, such as pregnancy, fear of weight gain, depression, and the need for social support, appear to be associated with smoking maintenance, cessation, or relapse.
8. Women are more likely than men to affirm that they smoke less at work because of a worksite policy and are significantly more likely than men to attribute reduced amount of daily smoking to their worksite policy. Women also are more likely than men to support policies designed to prevent smoking initiation among adolescents, restrictions on youth access to tobacco products, and limits on tobacco advertising and promotion.
9. Successful interventions have been developed to prevent smoking among young people, but little systematic effort has been focused on developing and evaluating prevention interventions specifically for girls.

A Vision for the Future: What Is Needed to Reduce Smoking Among Women

This report summarizes what is known about smoking among women, including patterns and trends in smoking prevalence, factors associated with smoking initiation and maintenance, the consequences of smoking for women's health, and interventions for smoking cessation and prevention. The report also describes historical and contemporary tobacco marketing targeted to women. Evidence of the health consequences of smoking, which had emerged somewhat earlier among men because of their earlier uptake of smoking, is now overwhelming among women. Tragically, in the face of continually mounting evidence of the enormous consequences of smoking for women's health, the tobacco industry continues to heavily target women in its advertising and promotional campaigns and is now attempting to export the epidemic of smoking to women in areas of the world where the smoking prevalence among females has traditionally been low. The single overarching theme emerging from this report is that *smoking is a women's issue*. What is needed to curb the epidemic of smoking and smoking-related diseases among women in the United States and throughout the world?

Increase Awareness of the Impact of Smoking on Women's Health and Counter the Tobacco Industry's Targeting of Women

- *Increase awareness of the devastating impact of smoking on women's health.* Since 1980, when the first Surgeon General's report on women and smoking was published documenting the serious health consequences of smoking among women, the number of women affected by smoking-related diseases has increased dramatically. Smoking is now the leading known cause of preventable death and disease among women. Each year during the 1990s it accounted for more than 140,000 deaths among U.S. women. By 1987, lung cancer became the leading cause of cancer death among women, and in 2000 approximately 27,000 more women in the United States died of lung cancer (67,600) than of breast cancer (40,800). Smoking also claims women's lives

through deaths due to other types of cancer as well as to cardiovascular, pulmonary, and other diseases—all risks shared with men who smoke. In addition, women experience unique health effects due to smoking, such as those related to pregnancy. In 1997, smoking accounted for an estimated 165,000 premature deaths among U.S. women. Exposure to environmental tobacco smoke also contributes to lung cancer and heart disease deaths among women and affects the health of their infants. The media, including women's magazines and broadcast programming, can play an important role in raising women's awareness of the magnitude of the impact of smoking on their health and in prioritizing the importance of smoking relative to the myriad other health-related topics covered.

- *Expose and counter the tobacco industry's deliberate targeting of women and decry its efforts to link smoking, which is so harmful to women's health, with women's rights and progress in society.* Even in the face of amassing evidence that a large percentage of women who smoke will die early, the tobacco industry has exploited themes of liberation and success in its advertising—particularly in women's magazines—and promotions targeted to women. Through its sponsorship of women's sports, women's professional and leadership organizations, the arts, and so on, the industry has attempted to associate itself with things women most value (e.g., recent heavily advertised support from a major tobacco company for programs to curb domestic violence against women) (Levin 1999; Bischoff 2000–01). Such associations should be decried for what they are: attempts by the tobacco industry to position itself as an ally of women's causes and thereby to silence potential critics. Women should be appropriately concerned by and speak out against tobacco marketing campaigns that co-opt the language of women's empowerment, and they should recognize the irony of attempts by the tobacco industry to suggest that smoking—which leads to nicotine dependence and death among many women—is a form of independence. Such efforts on the part of women would be unnecessary if the tobacco industry would voluntarily refrain from targeting women and associating tobacco use with women's freedom and progress.

Support Women's Anti-Tobacco Advocacy Efforts and Publicize that Most Women Are Nonsmokers

- *Encourage a more vocal constituency on issues related to women and smoking.* Taking a lesson from the success of advocacy to reduce breast cancer, concerted efforts are needed to call public attention to the toll that lung cancer and other smoking-related diseases is exacting on women's health and to demand accountability on the part of the tobacco industry. Women affected by tobacco-related diseases and their families and friends can partner with women's and girls' organizations, women's magazines, female celebrities, and others—not only in an effort to raise awareness of tobacco-related disease as a women's issue, but also to call for policies and programs that deglamorize and discourage tobacco use. Some excellent but relatively small-scale efforts have already taken place in this area, but because of the magnitude of the problem, these efforts deserve much greater support.

- *Recognize that nonsmoking is by far the norm among women.* Although in recent years smoking prevalence has not declined as much as might be hoped, nearly four-fifths of U.S. women are nonsmokers. In some subgroups of the population, smoking is relatively rare (e.g., only 11.2 percent of adult women who have completed college are current smokers, and only 5.4 percent of black high school senior girls are daily smokers). Despite the positive images of women in tobacco advertisements, it is important to recognize that among adult women, those who are the most empowered, as measured by educational attainment, are the least likely to be smokers. Moreover, most women who do smoke say they would like to quit. The fact that almost all women have either rejected smoking for themselves or, if they do smoke now, wish to quit, should be promoted.

Continue to Build the Science Base on Gender-Specific Outcomes and on How to Reduce Disparities Among Women

- *Conduct further studies of the relationship between smoking and certain outcomes of importance to women's health.* For example, does exposure to environmental tobacco smoke increase the risk for breast cancer? Some case-control studies suggested that possibility, but the link remains controversial, especially because relatively little evidence exists thus far supporting an association between active

smoking and breast cancer. Any health effects of exposure to environmental tobacco smoke may be particularly important among women in developing countries, where the vast majority of women are nonsmokers but smoking prevalence among men is high. Tobacco products, particularly the cigarette brands that have been most heavily promoted to women smokers, may vary significantly in the levels of known carcinogens; however, little data exist on how much brands vary in toxicity and whether any of these possible variations may be related to the changes in lung cancer histology over the last decades. More research is needed to evaluate whether changes in the tobacco product and increased exposure to tobacco-specific nitrosamines may be related to the increased incidence rates of adenocarcinoma of the lung. More data are also needed on the effects of employment in tobacco production on women's health, including data on reproductive outcomes among women who work with tobacco during pregnancy. This topic is not covered in the present report because of a paucity of information. In general, much better data are needed on the health effects of smoking among women in the developing world. Are the effects similar to those reported in the literature to date, which is based largely on studies of women smokers in the developed world, or are they modified by differences in lifestyle and environmental factors such as diet, viral exposures, or other sources of indoor air pollution?

- *Encourage the reporting of gender-specific results from studies of factors influencing smoking behavior, smoking prevention and cessation interventions, and the health effects of tobacco use, including use of new tobacco products.* The evidence to date has suggested that more similarities than differences exist between women and men in the factors that influence smoking initiation, addiction, and smoking cessation. When differences in smoking history are taken into account, health consequences also are generally similar. These conclusions are tempered by the fact that many research studies are not reporting gender-specific results. However, some studies do report gender differences in smoking cessation and the health effects of smoking; thus, issues regarding gender differences are not entirely resolved. For example, it is still not known whether susceptibility to lung cancer is greater among women smokers than among men smokers, or whether women are more likely than men to gain weight following smoking cessation. Researchers are strongly encouraged to use existing data sets to examine results by gender and to do so in future studies.

Where these additional analyses suggest important gender differences, more research is needed to focus on the development of interventions tailored to the special needs of girls and women. As new “reduced-risk” tobacco products are marketed in the future, it will also be important to learn whether gender differences exist in the appeal and use of such products, as well as the health consequences of their use.

- **Better understand how to reduce current disparities in smoking prevalence among women of different groups, as defined by socioeconomic status, race, ethnicity, and sexual orientation.** Women with only 9 to 11 years of education are about three times as likely to be smokers as are women with a college education. American Indian or Alaska Native women are much more likely to smoke than are Hispanic women and Asian or Pacific Islander women. Limited data also suggest that lesbian women are more likely to smoke than are heterosexual women. Among teenage girls, whites are much more likely to smoke than are blacks. How can the decline in smoking among women who are less well educated be accelerated? Why are smoking rates so high among American Indian women? What contributes to the relatively low smoking prevalence among Hispanic women and Asian or Pacific Islander women, and what can be done to prevent smoking among them from rising in the future? What positive influences contributed to the vast majority of black teenage girls resisting smoking throughout the 1990s, in stark contrast to the relatively high smoking prevalence among white girls during the same period? The objective is to reduce smoking to the lowest possible level across all demographic groups. The answers to these questions will provide crucial information for intervention efforts.

- **Determine why, during most of the 1990s, smoking prevalence declined so little among women and increased so markedly among teenage girls.** This lack of progress is a major concern and threatens to prolong the epidemic of smoking-related disease among women. What are the influences that have kept smoking prevalence relatively stagnant among women and have contributed to the sharp increases in prevalence among teenage girls? Tobacco control policies are known to be effective in reducing smoking, and smoking prevalence tends to decline most where these policies are strongest. However, efforts to curb tobacco use do not operate in a vacuum, and powerful pro-tobacco influences (ranging from tobacco advertising to the use of tobacco in movies) have promoted the social acceptability of smoking and thereby

have dampened the effects of tobacco control programs. Moreover, ongoing monitoring of tobacco industry attempts to target women in this country and abroad are necessary for a comprehensive understanding of the influences that encourage women to smoke and for designing effective countermarketing campaigns. If, for example, smoking in movies by female celebrities promotes smoking, then discouraging such practices as well as engaging well-known actresses to be spokespersons on the issue of women and smoking should be a high priority.

- **Develop a research and evaluation agenda related to women and smoking.** As noted above, the impact of smoking and of exposure to environmental tobacco smoke on the risk of some disease outcomes has been inadequately studied for women. Determining whether gender-tailored interventions increase the effectiveness of various smoking prevention and cessation methods is important, as is documenting whether any gender differences exist in the effectiveness of pharmacologic treatments for tobacco cessation. A need also exists to determine which tobacco prevention and cessation interventions are most effective for specific subgroups of girls and women, especially those at highest risk for tobacco use (e.g., women with only 9 to 11 years of education, American Indian or Alaska Native women, and women with depression). The sparse data available on smoking among lesbian women suggest that prevalence exceeds that of U.S. women overall, but better data are clearly needed. Research designed to reduce disparities in smoking prevalence across all subgroups of the female population deserves high priority to help eliminate future disparities in smoking-related diseases. The components of programs and policies targeted to individual women, and those targeted to communities that produce the greatest reduction in smoking, need to be identified. Progress on these and other issues will be facilitated by the development of an agenda of research and evaluation priorities related to women and smoking.

Act Now: We Know More than Enough

- **Support efforts, at both individual and societal levels, to reduce smoking and exposure to environmental tobacco smoke among women.** Proven smoking cessation methods are available for individual smokers, including behavioral and pharmacologic approaches that benefit women and men alike. Tobacco use treatments are among the most cost-effective of preventive health interventions; they

should be part of all women's health care programs, and health insurance plans should cover such services. Efforts to maximize smoking cessation and maintenance of smoking cessation among women before, during, and after pregnancy deserve high priority, because pregnancy is a time of high motivation to quit and occurs when women have many years of potential life left. With respect to prevention, the knowledge that girls who are more academically inclined or who are more physically active are less likely to smoke suggests that supporting positive outlets for mental and physical development will contribute to reducing the tobacco epidemic as well. Because regular cigarette smoking typically is initiated early in the teenage years, effective smoking cessation and prevention programs for adolescent girls and young women are greatly needed. Societal-level efforts to reduce tobacco use and exposure to environmental tobacco smoke include media counter-advertising, increased tobacco taxes, laws to reduce youth access to tobacco products, and bans on smoking in public places.

- ***Enact comprehensive statewide tobacco control programs—because they work.*** There are known strategies for reducing the burden of smoking-related diseases, but making the investment in these proven strategies remains a challenge. Results from states such as Arizona, California, Florida, Maine, Massachusetts, and Oregon have demonstrated that smoking rates among both girls and women can be dramatically reduced. California was the first state to establish a comprehensive statewide tobacco control program in 1990, and it is now starting to observe the benefits of its sustained efforts: between 1988 and 1997, the incidence rate of lung cancer among women declined by 4.8 percent in California but increased by 13.2 percent in other regions of the United States (Centers for Disease Control and Prevention [CDC] 2000). Another recent study concluded that the California program was associated with 33,300 fewer deaths from heart disease between 1989 and 1997 among women and men combined than would have been predicted if trends like those observed in the rest of the country had continued (Fichtenberg and Glantz 2000). Enormous monetary settlement payments from state Medicaid lawsuits with the tobacco industry have provided the resources to fund major new comprehensive statewide tobacco control efforts. However, a recent report found that only six states were meeting the minimum funding recommendations from CDC's *Best Practices for Comprehensive Tobacco Control Programs* (Campaign for Tobacco Free-Kids 2001).

Stop the Epidemic of Smoking and Smoking-Related Diseases Among Women Globally

- ***Do everything possible to thwart the emerging epidemic of smoking among women in developing countries.*** Multinational policies that discourage spread of the epidemic of smoking and tobacco-related diseases among women in countries where smoking prevalence has traditionally been low should be strongly encouraged. Efforts to disassociate cigarette smoking from progress in achieving gender equity are particularly needed in the developing world (Magardie 2000). Because smoking prevalence among men is already high in many developing countries, even women who do not smoke themselves are already at risk because they are exposed to environmental tobacco smoke—and because they suffer the losses of male loved ones who are dying of tobacco-related diseases. It is urgent that what is already known about effective means of tobacco control at the societal level be disseminated as soon as possible throughout the world. A major measure of public health victory in the global war against smoking would be the arrest of smoking prevalence at its still generally low level among women in developing countries and a reversal of the now worrisome signs of increases in smoking among them. In November 1999, the World Health Organization sponsored an international conference on smoking among women and youth, which took place in Kobe, Japan. The conference resulted in the Kobe Declaration, which states that, “The tobacco epidemic is an unrelenting public health disaster that spares no society. There are already over 200 million women smokers, and tobacco companies have launched aggressive campaigns to recruit women and girls worldwide.... It is urgent that we find comprehensive solutions to the danger of tobacco use and address the epidemic among women and girls” (World Health Organization 1999b).

- ***All national governments should strongly support the World Health Organization's Framework Convention for Tobacco Control (FCTC).*** The FCTC is an international legal instrument designed to curb the global spread of tobacco use through specific protocols, currently being negotiated, that cover tobacco pricing, smuggling, advertising and sponsorship, and other activities (World Health Organization 1999a). In the words of Dr. Gro Harlem Brundtland, director-general of the WHO, “If we do not act decisively, a hundred years from now our grandchildren and their children will look back and seriously question how people claiming to be committed to public health and social justice allowed the tobacco epidemic to unfold unchecked” (Asma et al., in press).

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Women and Smoking

A Report of the Surgeon General—2001

At A Glance

The Burden:

This year alone, lung cancer will kill nearly 68,000 U.S. women. That's one in every four cancer deaths among women, and about 27,000 more deaths than from breast cancer (41,000). In 1999, approximately 165,000 women died prematurely from smoking-related diseases, like cancer and heart disease. Women also face unique health effects from smoking such as problems related to pregnancy.

The Trends:

In the 1990s, the decline in smoking rates among adult women stalled and, at the same time, rates were rising steeply among teenaged girls, blunting earlier progress. Smoking rates among women with less than a high school education are three times higher

than for college graduates. Nearly all women who smoke started as teenagers - and 30 percent of high school senior girls are still current smokers.

The Hope:

We have the solutions for preventing and reducing smoking among women. Quitting smoking has great health benefits for women of all ages. Thanks to an aggressive, sustained anti-smoking program, California has seen a decline in women's lung cancer rates while they are still rising in the rest of the country. The voice of women is needed to counter tobacco marketing campaigns that equate success for women with smoking.

“When calling attention to public health problems, we must not misuse the word ‘epidemic.’ But there is no better word to describe the 600-percent increase since 1950 in women’s death rates for lung cancer, a disease primarily caused by cigarette smoking. Clearly, smoking-related disease among women is a full-blown epidemic.”

David Satcher, M.D., Ph.D.
Surgeon General

Women and Smoking: a Report of the Surgeon General makes its overarching theme clear—smoking is a woman's issue. This report summarizes what is now known about smoking among women, including patterns and trends in smoking habits, factors associated with starting to smoke and continuing to smoke, the consequences of smoking on women's health and interventions for cessation and prevention. What the report also makes apparent is how the tobacco industry has historically and contemporarily created marketing specifically targeted at women.

Smoking is the leading known cause of preventable death and disease among women. In 2000, far more women died of lung cancer than of breast cancer. A number of things need to be acted on to curb the epidemic of smoking and smoking-related diseases among women in the United States and throughout the world.

- ▲ Increase awareness of the impact of smoking on women's health and counter the tobacco industry's targeting of women.
- ▲ Support women's anti-tobacco advocacy efforts and publicize that most women are nonsmokers.
- ▲ Continue to build the science base for understanding the health effects of smoking on women in particular.
- ▲ Act now: more than enough is already known to enable us to support efforts to stop smoking at both individual and societal levels.
- ▲ Do everything possible to stop the epidemic of smoking and smoking-related diseases among women globally.



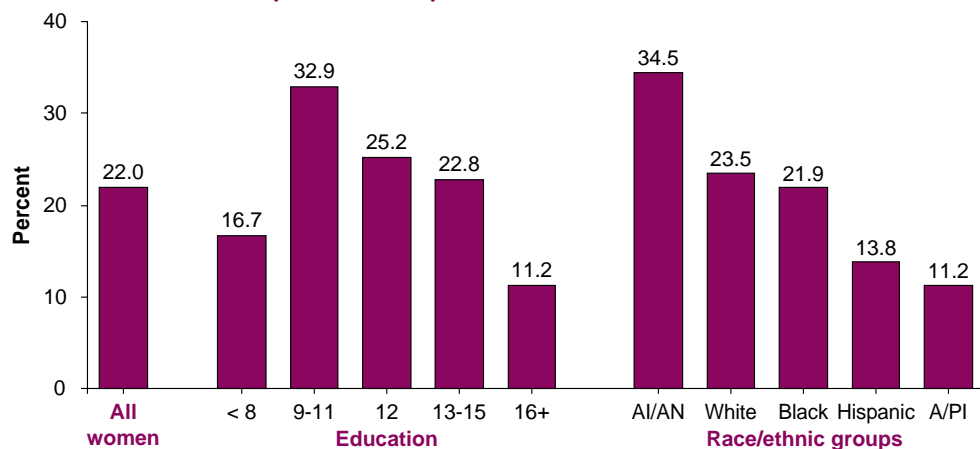
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health



Major Conclusions of the Surgeon General's Report

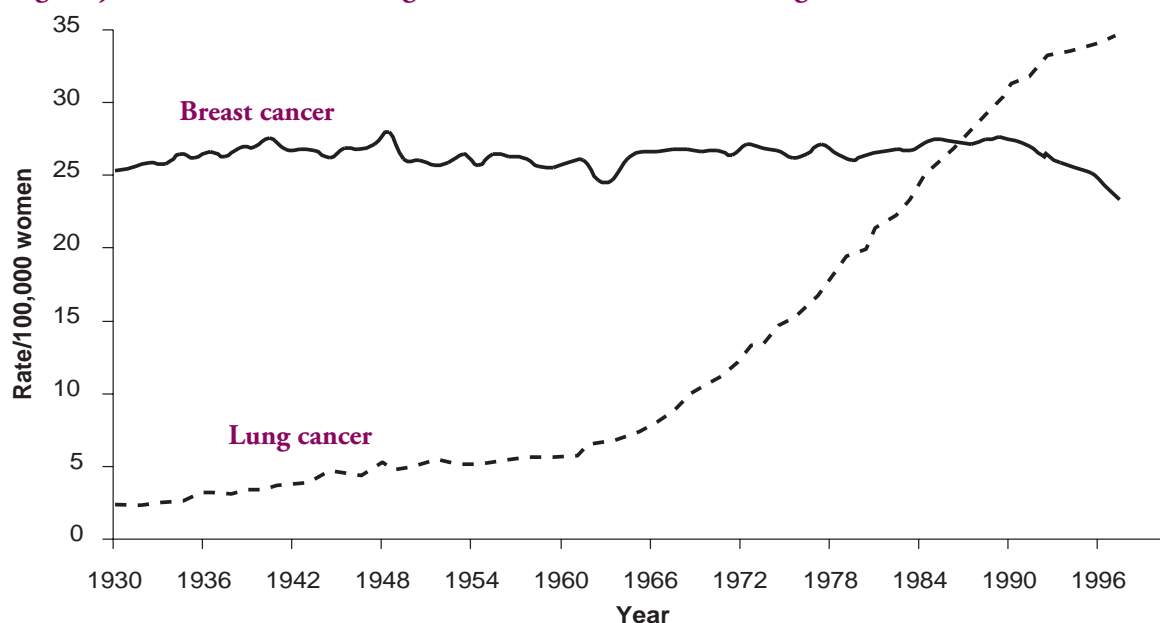
- ▲ Despite all that is known of the devastating health consequences of smoking, 22.0 percent of women smoked cigarettes in 1998. Cigarette smoking became prevalent among men before women, and smoking prevalence in the United States has always been lower among women than among men. However, the once-wide gender gap in smoking prevalence narrowed until the mid-1980s and has since remained fairly constant. Smoking prevalence today is nearly three times higher among women who have only 9 to 11 years of education (32.9 percent) than among women with 16 or more years of education (11.2 percent).
- ▲ In 2000, 29.7 percent of high school senior girls reported having smoked within the past 30 days. Smoking prevalence among white girls declined from the mid-1970s to the early 1980s, followed by a decade of little change. Smoking prevalence then increased markedly in the early 1990s, and declined somewhat in the late 1990s. The increase dampened much of the earlier progress. Among black girls, smoking prevalence declined substantially from the mid-1970s to the early 1990s, followed by some increases until the mid-1990s. Data on long-term trends in smoking prevalence among high school seniors of other racial or ethnic groups are not available.
- ▲ Since 1980, approximately 3 million U.S. women have died prematurely from smoking-related neoplastic, cardiovascular, respiratory, and pediatric diseases, as well as cigarette-caused burns. Each year during the 1990s, U.S. women lost an estimated 2.1 million years of life due to these smoking attributable premature deaths. Additionally, women who smoke experience gender-specific health consequences, including increased risk of various adverse reproductive outcomes.
- ▲ Lung cancer is now the leading cause of cancer death among U.S. women; it surpassed breast cancer in 1987. About 90 percent of all lung cancer deaths among women who continue to smoke are attributable to smoking.
- ▲ Exposure to environmental tobacco smoke is a cause of lung cancer and coronary heart disease among women who are lifetime nonsmokers. Infants born to women exposed to environmental tobacco smoke during pregnancy have a small decrement in birth weight and a slightly increased risk of intrauterine growth retardation compared to infants of nonexposed women.
- ▲ Women who stop smoking greatly reduce their risk of dying prematurely, and quitting smoking is beneficial at all ages. Although some clinical intervention studies suggest that women may have more difficulty quitting smoking than men, national survey data show that women are quitting at rates similar to or even higher than those for men. Prevention and cessation interventions are generally of similar effectiveness for women and men and, to date, few gender differences in factors related to smoking initiation and successful quitting have been identified.
- ▲ Smoking during pregnancy remains a major public health problem despite increased knowledge of the adverse health effects of smoking during pregnancy. Although the prevalence of smoking during pregnancy has declined steadily in recent years, substantial numbers of pregnant women continue to smoke, and only about one-third of women who stop smoking during pregnancy are still abstinent one year after the delivery.
- ▲ Tobacco industry marketing is a factor influencing susceptibility to and initiation of smoking among girls, in the United States and overseas. Myriad examples of tobacco ads and promotions targeted to women indicate that such marketing is dominated by themes of social desirability and independence. These themes are conveyed through ads featuring slim, attractive, athletic models, images very much at odds with the serious health consequences experienced by so many women who smoke.

Prevalence of current smoking among women aged 18 years or older, all women, by education (1998), and by race/ethnicity (1997-1998), United States.



Source: National Health Interview Survey, 1998. Source: National Health Interview Survey, 1997-1998.

Age-adjusted death rates for lung cancer and breast cancer among women, United States, 1930–1997.



Note: Death rates are age-adjusted to the 1970 population.

Sources: Parker et al. 1996; National Center for Health Statistics 1999; Ries et al. 2000; American Cancer Society, unpublished data.

Patterns of Tobacco Use Among Women and Girls

- ▲ The prevalence of current smoking among women was 22 percent in 1998. Smoking prevalence was highest among American Indian or Alaska Native women, intermediate among white women and black women, and lowest among Hispanic women and Asian or Pacific Islander women. By educational level, smoking prevalence is nearly three times higher among women with 9 to 11 years of education than among women with 16 or more years of education.
- ▲ Much of the progress in reducing smoking prevalence among girls in the 1970s and 1980s was lost with the increase in prevalence in the 1990s: current smoking among high school senior girls was the same in 2000 as in 1988. Although smoking prevalence was higher among high school senior girls than among high school senior boys in the 1970s and early 1980s, prevalence has been comparable since the mid-1980s.
- ▲ Smoking declined substantially among black girls from the mid-1970s through the early 1990s; the decline among white girls for this same period was small.
- ▲ Smoking during pregnancy appears to have decreased from 1989 through 1998. Despite increased knowledge of the adverse health effects of smoking during pregnancy, estimates of women smoking during pregnancy range from 12.9 percent to as high as 22 percent.
- ▲ Since the late 1970s or early 1980s, women are just as likely to attempt to quit and succeed as are men.
- ▲ Smoking prevalence among women varies markedly across countries; it is as low as an estimated 7 percent in developing countries to 24 percent in developed countries. Thwarting further increases in tobacco use among women is one of the greatest disease prevention opportunities in the world today.

Health Consequences of Tobacco Use Among Women

- ▲ A woman's annual risk for death more than doubles among continuing smokers compared with persons who have never smoked in all age groups from 45 through 74 years.
- ▲ The risk for lung cancer increases with quantity, duration, and intensity of smoking. The risk for dying of lung cancer is 20 times higher among women who smoke two or more packs of cigarettes per day than among women who do not smoke.
- ▲ Smoking is a major cause of cancers of the oropharynx and bladder among women. Evidence is also strong that women who smoke have increased risks for liver, colorectal, and cervical cancer, and cancers of the pancreas and kidney. For cancers of the larynx and esophagus, evidence among women is more limited but consistent with large increases in risk.
- ▲ Smoking is a major cause of coronary heart disease among women. Risk increases with the number of cigarettes smoked and the duration of smoking. Risk is substantially reduced within 1 or 2 years of smoking cessation. This immediate benefit is followed by a more gradual reduction in risk to that among nonsmokers by 10 to 15 or more years after cessation.
- ▲ Women who smoke have an increased risk for stroke and subarachnoid hemorrhage. The increased risk for stroke associated with smoking is reversible after smoking cessation; after 5 to 15 years of abstinence, the risk approaches that of women who have never smoked.
- ▲ Women who smoke have an increased risk for death from ruptured abdominal aortic aneurysm. They also have risk for peripheral vascular atherosclerosis, but cessation is associated with improvements in symptoms, prognosis, and survival. Smoking is also a strong predictor of the

progression and severity of carotid atherosclerosis among women, but smoking cessation appears to slow the rate of progression.

- ▲ Cigarette smoking is a primary cause of chronic obstructive pulmonary disease (COPD) among women, and the risk increases with the amount and duration of smoking. Approximately 90 percent of deaths from COPD among women in the United States can be attributed to cigarette smoking.
- ▲ Adolescent girls who smoke have reduced rates of lung growth, and adult women who smoke experience a premature decline of lung function.
- ▲ Women who smoke have increased risks for conception delay and for both primary and secondary infertility and may have a modest increase in risks for ectopic pregnancy and spontaneous abortion. They are younger at natural menopause than nonsmokers and may experience more menopausal symptoms.
- ▲ Women who quit smoking before or during pregnancy reduce the risk for adverse reproductive outcomes, including conception delay, infertility, pre-term premature rupture of membranes, pre-term delivery, and low birth weight.
- ▲ Postmenopausal women who currently smoke have lower bone density than do women who do not smoke. Also women who currently smoke have an increased risk for hip fracture compared with nonsmoking women.
- ▲ The association of smoking and depression is particularly important among women because they are more likely to be diagnosed with depression than are men.
- ▲ Exposure to environmental tobacco smoke is a cause of lung cancer among women who have never smoked and is associated with increased coronary heart disease risk.

Factors Influencing Tobacco Use Among Women

- ▲ Girls who initiate smoking are more likely than those who do not smoke to have parents or friends who smoke. They also tend to have weaker attachments to parents and family and stronger attachments to peers and friends. They perceive smoking prevalence to be higher than it actually is, are inclined to risk taking and rebelliousness, have a weaker commitment to school or religion, have less knowledge of the adverse consequences of smoking and the addictiveness of nicotine, believe that smoking can control weight and negative moods, and have a positive image of smokers.
- ▲ Women who continue to smoke and those who fail at

attempts to stop smoking tend to have lower education and employment levels than do women who quit smoking. They also tend to be more addicted to cigarettes, as evidenced by the smoking of a higher number of cigarettes per day, to be cognitively less ready to stop smoking, to have less social support for stopping, and to be less confident in resisting temptations to smoke.

- ▲ Women have been extensively targeted in tobacco marketing, and tobacco companies have produced brands specifically for women, both in the United States and overseas. Myriad examples of tobacco ads and promotions targeted to women indicated that such marketing is dominated by themes of both social desirability and independence, which are conveyed through ads featuring slim, attractive, athletic models. Between 1995 and 1998, expenditures for domestic cigarette advertising and promotion increased from \$4.90 billion to \$6.73 billion. Tobacco industry marketing, including product design, advertising, and promotional activities, is a factor influencing susceptibility to and initiation of smoking.
- ▲ The dependence of the media on revenues from tobacco advertising oriented to women, coupled with tobacco company sponsorship of women's fashions and of artistic, athletic, political, and other events, has tended to stifle media coverage of the health consequences of smoking among women and to mute criticism of the tobacco industry by women public figures.

Efforts to Reduce Tobacco Use Among Women

- ▲ Using evidence from studies that vary in design, sample characteristics, and intensity of the interventions studied, researchers to date have not found consistent gender-specific differences in the effectiveness of intervention programs for tobacco use.
- ▲ A higher percentage of women stop smoking during pregnancy, both spontaneously and with assistance, than at other times in their lives. Using pregnancy-specific programs can increase smoking cessation rates, which benefits infant health and is cost effective. Only about one-third of women who stop smoking during pregnancy are still abstinent one year after the delivery.
- ▲ Successful interventions have been developed to prevent smoking among young people, but little systematic effort has been focused on developing and evaluating prevention interventions specifically for girls.

For more information:

To obtain a copy of *Women and Smoking: A Report of the Surgeon General* full report or executive summary or for additional copies of this *At A Glance*, please call CDC's Office on Smoking and Health at (770) 488-5705 and press 3 to speak with an information specialist. Please note that the report, along with supporting documents, is available on-line at the Office on Smoking and Health Web site at www.cdc.gov/tobacco.



Health Consequence of Tobacco Use Among Women

MORTALITY

- Cigarette smoking plays a major role in the mortality of U.S. women. Since 1980, when the Surgeon General's Report on Women and Smoking was released, about three million women have died prematurely of smoking-related diseases.
- In 1997, about 165,000 U.S. women died of smoking-related diseases, including lung and other cancers, heart disease, stroke, and chronic lung diseases such as emphysema.
- Each year throughout the 1990s, about 2.1 million years of the potential life of U.S. women were lost prematurely because of smoking-attributable diseases. Women smokers who die of a smoking-related disease lose on average 14 years of potential life.
- Women who stop smoking greatly reduce their risk of dying prematurely. The relative benefits of smoking cessation are greater when women stop smoking at younger ages, but smoking cessation is beneficial at all ages.

LUNG CANCER

- Cigarette smoking is the major cause of lung cancer among women. About 90% of all lung cancer deaths among U.S. women smokers are attributable to smoking.
- In 1950, lung cancer accounted for only 3% of all cancer deaths among women; however, by 2000, it accounted for an estimated 25% of cancer deaths.
- Since 1950, lung cancer mortality rates for U.S. women have increased an estimated 600%. In 1987, lung cancer surpassed breast cancer to become the leading cause of cancer death among U.S. women. In 2000, about 27,000 more women died of lung cancer (about 68,000) than breast cancer (about 41,000).

OTHER CANCERS

- Smoking is a major cause of cancer of the oropharynx and bladder among women. Evidence is also strong that women who smoke have increased risk for cancer of the pancreas and kidney. For cancer of the larynx and esophagus, evidence that smoking increases the risk among women is more limited but consistent with large increases in risk.
- Women who smoke may have a higher risk for liver cancer and colorectal cancer than women who do not smoke.

- Smoking is consistently associated with an increased risk for cervical cancer. The extent to which this association is independent of human papillomavirus (tumor caused by virus) infection is uncertain.
- Several studies suggest that exposure to environmental tobacco smoke is associated with an increased risk for breast cancer; however, this association remains uncertain. More research is needed.

CARDIOVASCULAR DISEASE

- Smoking is a major cause of coronary heart disease among women. Risk increases with the number of cigarettes smoked and the duration of smoking.
- Women who smoke have an increase risk for ischemic stroke (blood clot in one of the arteries supplying the brain) and subarachnoid hemorrhage (bleeding in the area surrounding the brain).
- Women who smoke have an increased risk for peripheral vascular atherosclerosis.
- Smoking cessation reduces the excess risk of coronary heart disease, no matter at what age women stop smoking. The risk is substantially reduced within 1 or 2 years after they stop smoking.
- The increased risk for stroke associated with smoking begins to reverse after women stop smoking. About 10 to 15 years after stopping, the risk for stroke approaches that of a woman who never smoked.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) AND LUNG FUNCTION

- Cigarette smoking is the primary cause of COPD in women, and the risk increases with the amount and duration of cigarette use.
- Mortality rates for COPD have increased among women for the past 20 to 30 years. About 90% of mortality from COPD among U.S. women is attributed to smoking.
- Exposure to maternal smoking is associated with reduced lung function among infants, and exposure to environmental tobacco smoke during childhood and adolescence may be associated with impaired lung function among girls.

- Smoking by girls can reduce their rate of lung growth and the level of maximum lung function. Women who smoke may experience a premature decline of lung function.

MENSTRUAL FUNCTION

- Some studies suggest that cigarette smoking may alter menstrual function by increasing the risks for painful menstruation, secondary amenorrhea (abnormal absence of menstrual), and menstrual irregularity.
- Women smokers have natural menopause at a younger age than do nonsmokers, and they may experience more severe menopausal symptoms.

REPRODUCTIVE OUTCOMES

- Women who smoke have increased risk for conception delay and for both primary and secondary infertility.
- Women who smoke during pregnancy risk pregnancy complications, premature birth, low-birth-weight infants, stillbirth, and infant mortality.
- Women who smoke may have a modest increase in risks for ectopic pregnancy (fallopian tube or peritoneal cavity pregnancy) and spontaneous abortion.
- Studies show a link between smoking and the risk of sudden infant death syndrome (SIDS) among the offspring of women who smoke during pregnancy.

BONE DENSITY AND FRACTURE RISK

- Postmenopausal women who smoke have lower bone density than women who never smoked.
- Women who smoke have an increased risk for hip fracture than women who never smoked.

OTHER CONDITIONS

- Women who smoke may have a modestly elevated risk for rheumatoid arthritis.
- Women smokers have an increased risk for cataract, and may have an increased risk for age-related macular degeneration.
- The prevalence of smoking generally is higher for women with anxiety disorders, bulimia, depression, attention deficit disorder, and alcoholism; it is particularly high among patients with diagnosed schizophrenia. The connection between smoking and these disorders requires additional research.

HEALTH CONSEQUENCES OF ENVIRONMENTAL TOBACCO SMOKE (ETS)

- Exposure to ETS is a cause of lung cancer among women nonsmokers.
- Studies support a causal relationship between exposure to ETS and coronary heart disease mortality among women nonsmokers.
- Infants born to women who are exposed to ETS during pregnancy may have a small decrement in birth weight and a slightly increased risk for intrauterine growth retardation.



Marketing Cigarettes to Women

HISTORY OF ADVERTISING STRATEGIES

- Tobacco advertising geared toward women began in the 1920s. By the mid-1930s, cigarette advertisements targeting women were becoming so commonplace that one advertisement for the mentholated Spud brand had the caption “To read the advertisements these days, a fellow’d think the pretty girls do all the smoking.”
- As early as the 1920s, tobacco advertising geared toward women included messages such as “Reach for a Lucky instead of a sweet” to establish an association between smoking and slimness. The positioning of Lucky Strike as an aid to weight control led to a greater than 300% increase in sales for this brand in the first year of the advertising campaign.
- Through World War II, Chesterfield advertisements regularly featured glamour photographs of a Chesterfield girl of the month, usually a fashion model or a Hollywood star such as Rita Hayworth, Rosalind Russell, or Betty Grable.
- The number of women aged 18 through 25 years who began smoking increased significantly in the mid-1920s, the same time that the tobacco industry mounted the Chesterfield and Lucky Strike campaigns directed at women. The trend was most striking among women aged 18 through 21. The number of women in this age group who began smoking tripled between 1911 and 1925 and had more than tripled again by 1939.
- In 1968, Philip Morris marketed Virginia Slims cigarettes to women with an advertising strategy showing canny insight into the importance of the emerging women’s movement. The slogan “You’ve come a long way, Baby” later gave way to “It’s a woman thing” in the mid-1990s, and more recently the “Find your voice” campaign featuring women of diverse racial and ethnic backgrounds. The underlying message of these campaigns has been that smoking is related to women’s freedom, emancipation, and empowerment.
- Initiation rates among girls aged 14 through 17 years rapidly increased in parallel with the combined sales of the leading women’s-niche brands (Virginia Slims, Silva Thins, and Eve) during this period.
- In 1960, about 10% of all cigarette advertisements appeared in popular women’s magazines, and by 1985, cigarette advertisements increased by 34%.

CURRENT ADVERTISING STRATEGIES

- Women have been extensively targeted in tobacco marketing. Such marketing is dominated by themes of an association between social desirability, independence, and smoking messages conveyed through advertisements featuring slim, attractive, and athletic models. In 1999, expenditures for domestic cigarette advertising and promotion was \$8.24 billion — increasing 22.3% from the \$6.73 billion spent in 1998.
- Advertising is used in part to reduce women’s fear of the health risks from smoking by presenting information on nicotine and tar content or by using positive images (e.g., models engaged in exercise or pictures of white capped mountains against a background of clear blue skies).
- Because cigarette brands developed exclusively for women (e.g., Virginia Slims, Eve, Misty, and Capri) account for only 5% to 10% of the cigarette market, many women are also attracted to brands that appear gender neutral or overtly targeted to males.
- Research has shown that women’s magazines that accept tobacco advertising are significantly less likely to publish articles critical of smoking than are magazines that do not accept such advertising.

SPONSORSHIP/PROMOTIONS

- The tobacco industry has targeted women through innovative promotional campaigns offering discounts on common household items unrelated to tobacco. For example, Philip Morris has offered discounts on turkeys, milk, soft drinks, and laundry detergent with the purchase of tobacco products.
- Cigarette brand clothing and other giveaway accessories have been used to promote cigarette products to women and girls.
 - Virginia Slims offered a yearly engagement calendar and the V-Wear catalog featuring clothing, jewelry, and accessories coordinated with the themes and colors of the print advertising and product packaging.
 - Capri Superslims used point-of-sale displays and value-added gifts featuring items such as mugs and caps bearing the Capri label in colors coordinated with the advertisement and package.
 - Misty Slims offered color-coordinated items in multiple-pack containers, as well as address books, cigarette lighters, T-shirts, and fashion booklets.

GLOBAL ADVERTISING STRATEGIES

- Evidence suggests a pattern of international tobacco advertising that associates smoking with success, similar to that seen in the United States. This development emphasizes the enormous potential of advertising to change social norms.
- As western-styled marketing has increased, campaigns commonly have focused on women. For example, in 1989, the brand Yves Saint Laurent introduced a new elegant package designed to appeal to women in Malaysia and other Asian countries. National tobacco monopolies and companies, such as those in Indonesia and Japan, began to copy this promotional targeting of women.
- One of the most popular media for reaching women – particularly in places where tobacco advertising is banned on television – is women's magazines. Magazines can lend an air of social acceptability or stylish image to smoking. This may be particularly important in countries where smoking rates are low among women and where tobacco companies are attempting to associate smoking with Western values.
- A study of 111 women's magazines in 17 European countries in 1996-1997 found that 55% of the magazines that responded accepted cigarette advertisements, and only 4 had a policy of voluntarily refusing it. Only 31% of the magazines had published an article of one page or more on smoking and health in the previous 12 months. Magazines that accepted tobacco advertisements seem less likely to give coverage to smoking and health issues.
- One of the most common advertisement themes in developed countries is that smoking is both a passport to and a symbol of the independence and success of the modern women.
- Events and activities popular among young people are often sponsored by tobacco companies. Free tickets to films and to pop and rock concerts have been given in exchange for empty cigarette packets in Hong Kong and Taiwan. Popular U.S. female stars have allowed their names to be associated with cigarettes in other countries.
- Many countries have banned tobacco advertising and promotion. In 1998, the European Union adopted a directive to ban most tobacco advertising and sponsorship by July 30, 2006. Other countries have banned direct advertising, and still others have instituted partial restraints. Such bans are often circumvented by tobacco companies through various promotional venues such as the creation of retail stores named after cigarette brands or corporate sponsorship of sporting and other events. Moreover, national bans on tobacco advertisements may be rendered ineffective by tobacco promotion on satellite television, by cable broadcasting, or via the Internet.



Tobacco Use and Reproductive Outcomes

SMOKING AND REPRODUCTIVE OUTCOMES

- Women smokers, like men smokers, are at increased risk of cancer, cardiovascular disease, and pulmonary disease, but women smokers also experience unique risks related to menstrual and reproductive function.
 - Women who smoke have increased risk for conception delay and for primary and secondary infertility.
 - Women who smoke may have a modest increase in risks for ectopic pregnancy and spontaneous abortion.
 - Smoking during pregnancy is associated with increased risk for premature rupture of membranes, abruptio placentae (placenta separation from the uterus), and placenta previa (abnormal location of the placenta), which can cause massive hemorrhaging during delivery; smoking is also associated with a modest increase in risk for pre-term delivery.
 - Infants born to women who smoke during pregnancy have a lower average birth weight and are more likely to be small for gestational age than infants born to women who do not smoke. Low birth weight is associated with increased risk for neonatal, perinatal, and infant morbidity and mortality. The longer the mother smokes during pregnancy, the greater the effect on the infant's birth weight.
 - The risk for perinatal mortality, both stillbirths and neonatal deaths, and the risk for sudden infant death syndrome (SIDS) are higher for the offspring of women who smoke during pregnancy.
 - Women who smoke are less likely to breast-feed their infants than are women who do not.
- during pregnancy appears to have decreased from 1989 through 1998.
 - Eliminating maternal smoking may lead to a 10% reduction in all infant deaths and a 12% reduction in deaths from perinatal conditions.
 - Women who quit smoking before or during pregnancy reduce the risk for adverse reproductive outcomes, including difficulties in becoming pregnant, infertility, premature rupture of membranes, preterm delivery, and low birth weight.
 - Most relevant studies suggest that infants of women who stop smoking by the first trimester have weight and body measurements comparable with those of nonsmokers' infants. Studies also suggest that smoking in the third trimester is particularly detrimental.
 - Women are more likely to stop smoking during pregnancy, both spontaneously and with assistance, than at other times in their lives. Using pregnancy-specific programs can increase smoking cessation rates, which benefits infant health and is cost effective. However, only one-third of women who stop smoking during pregnancy are still abstinent 1 year after the delivery.
 - Programs that encourage women to stop smoking before, during, and after pregnancy – and not to take up smoking ever again – deserve high priority for two reasons: during pregnancy women are highly motivated to stop smoking, and they still have many remaining years of potential life.

ENVIRONMENTAL TOBACCO SMOKE AND REPRODUCTIVE OUTCOMES

- Infants born to women who are exposed to environmental tobacco smoke (ETS) during pregnancy may have a small decrement in birth weight and a slightly increased risk for intrauterine growth retardation than infants born to women who are not exposed to ETS.

SMOKING PREVALENCE AND SMOKING CESSATION DURING PREGNANCY

- Despite increased knowledge of the adverse health effects of smoking during pregnancy, estimates of women smoking during pregnancy range from 12% (based on birth certificate data) up to 22% (based on survey data). However, smoking



What Is Needed to Reduce Smoking Among Women

- **Increase awareness of the devastating impact of smoking on women's health. Smoking is the leading known cause of preventable death and disease among women** — In 1997, smoking accounted for about 165,000 deaths among U.S. women. In 1987, lung cancer became the leading cause of cancer death among women, and by 2000, about 27,000 more women in the United States died of lung cancer (about 68,000) than of breast cancer (about 41,000).
 - Cigarette brand variations in toxicity and whether any of these possible variations may be related to changes in lung cancer histology during the past decade.
 - Changes in tobacco products and whether increased exposure to tobacco-specific nitrosamines may be related to the increased incidence rates of adenocarcinoma (malignant glandular tumor) of the lung.
 - Health effects of smoking among women in the developing world.
- **Expose and counter the tobacco industry's deliberate targeting of women and decry its efforts to link smoking, which is so harmful to women's health, with women's rights and progress in society** — In 1999, tobacco companies spent more than \$8.24 billion – or more than \$22.6 million a day – to advertise and promote cigarettes. To sell its products, the tobacco industry exploits themes of success and independence, particularly in its advertising in women's magazines.
- **Encourage a more vocal constituency on issues related to women and smoking** — Taking a lesson from the success of advocacy to reduce breast cancer, we must make concerted efforts to call public attention to the toll of lung cancer and other smoking-related diseases on women's health. Women affected by tobacco-related diseases and their families and friends can partner with women's and girls' organizations, women's magazines, female celebrities, and others — not only in an effort to raise awareness of tobacco-related disease as a women's issue, but also to call for policies and programs that deglamorize and discourage tobacco use.
- **Recognize that nonsmoking is by far the norm among women** — Publicize that most women are nonsmokers. Nearly four-fifths of U.S. women are nonsmokers, and in some subgroup populations, smoking is relatively rare (e.g., only 11.2% of women who have completed college are current smokers, and only 5.4 % of black high school seniors girls are daily smokers). It is important to recognize that among adult women, those who are most empowered, as measured by educational attainment, are the least likely to be smokers. Moreover, most women who smoke want to quit.
- **Conduct further studies of the relationship between smoking and certain outcomes of importance to women's health** — Additional research is needed to explore these issues:
 - The link between exposure to environmental tobacco smoke and the risk of breast cancer.
 - Determining whether gender-tailored interventions increase the effectiveness of various smoking prevention and cessation methods.
- **Encourage the reporting of gender-specific results from studies of influences on smoking behavior, smoking prevention and cessation interventions, and the health effects of tobacco use, including use of new tobacco products** — Research is needed to better understand and to reduce current disparities in smoking prevalence among women of different groups as defined by socioeconomic status, race, ethnicity, and sexual orientation. Women with only 9 to 11 years of education are about three times as likely to be smokers as are women with a college education. American Indian or Alaska Native women are much more likely to smoke than are Hispanic women and Asian or Pacific Islander women. Among teenage girls, white girls are much more likely to smoke than are African-American girls.
- **Determine why, during most of the 1990s, smoking prevalence declined so little among women and increased so markedly among teenage girls** — This lack of progress is a major concern and threatens to prolong the epidemic of smoking-related diseases among women. More research is needed to determine the influences that encourage many women and girls to smoke even in the face of all that is known of the dire health consequences of smoking. If, for example, smoking in movies by female celebrities promotes smoking, then discouraging such practices as well as engaging well-known actresses to be spokespersons on the issue of women and smoking should be a high priority.
- **Develop a research and evaluation agenda related to women and smoking** — Research agendas should focus on these issues:
 - Determining whether gender-tailored interventions increase the effectiveness of various smoking prevention and cessation methods.

- Documenting whether there are gender differences in the effectiveness of pharmacologic treatments for tobacco cessation.
 - Determining which tobacco prevention and cessation interventions are most effective for specific subgroups of girls and women.
 - Designing interventions to reduce disparities in smoking prevalence across all subgroups of girls and women.
- ***Support efforts, at both individual and societal levels, to reduce smoking and exposure to environmental tobacco smoke among women*** — Tobacco-use treatments are among the most cost-effective of preventive health interventions at the individual level, and they should be part of all women's health care programs. Health insurance plans should cover such services. Societal strategies to reduce tobacco use and exposure to environmental tobacco smoke include counter-advertising, increasing tobacco taxes, enacting laws to reduce minors' access to tobacco products, and banning smoking in work sites and in public places.
 - ***Enact comprehensive, statewide tobacco control programs proven to be effective in reducing and preventing tobacco use*** — Results from states such as Arizona, California, Florida, Maine, Massachusetts, and Oregon show that science-based tobacco control programs have successfully reduced smoking rates among women and girls. California established a comprehensive statewide tobacco control program more than 10 years ago, and is now starting to observe the benefits of its sustained efforts. Between 1988 and 1997, the incidence rate of lung cancer among women declined by 4.8% in California, but increased by 13.2% in other regions of the United States.
- ***Increase efforts to stop the emerging epidemic of smoking among women in developing countries*** — Strongly encourage and support multinational policies that discourage the spread of smoking and tobacco-related diseases among women in countries where smoking prevalence has traditionally been low. It is urgent that what is already known about effective means of tobacco control at the societal level be disseminated throughout the world.
 - ***Support the World Health Organization's Framework Convention for Tobacco Control (FCTC)*** — The FCTC is an international legal instrument designed to curb the global spread of tobacco use through specific protocols – currently being negotiated – that relate to tobacco pricing, smuggling, advertising, sponsorship, and other activities.



Pattern of Tobacco Use Among Women and Girls

CIGARETTE SMOKING PREVALENCE AMONG WOMEN

- Cigarette smoking was rare among women in the early 20th century. Cigarette smoking became prevalent among women after it did among men, and smoking prevalence has always been lower among women than among men. However, the gender-specific difference in smoking prevalence narrowed between 1965 and 1985. Since 1985, the decline in prevalence among men and women has been comparable.
- Smoking prevalence decreased among women from 33.9% in 1965 to 22.0% in 1998. Most of this decline occurred from 1974 through 1990; prevalence declined very little from 1992 through 1998.
- The prevalence of current smoking is three times higher among women with 9-11 years of education (32.9%) than among women with 16 or more years of education (11.2%).
- Smoking prevalence is higher among women living below the poverty level (29.6%) than among those living at or above the poverty level (21.6%).

CIGARETTE SMOKING AMONG RACIAL/ETHNIC POPULATIONS OF WOMEN

- In 1997-1998, 34.5% of American-Indian or Alaska-Native, 23.5% of white, 21.9% of African-American, 13.8% of Hispanic, and 11.2% Asian/Pacific-Islander women were current smokers.
- Among white women and African-American women, smoking prevalence decreased from 1965 through 1998. The prevalence of current smoking was generally comparable, but from 1970 through 1985 it was higher — some years significantly so — among African-American women. In 1990, it was higher among white women.
- From 1965 through 1998, the decline in smoking prevalence among Hispanic women was significantly less than among white and African-American women.
- Among Asian-American or Pacific-Islander women, smoking prevalence decreased from 1979 through 1992, but then increased from 1995 through 1998. Prevalence changed little from 1979 through 1998 among American-Indian or Alaska-Native women.

CIGARETTE SMOKING AMONG GIRLS AND YOUNG WOMEN

- Among high school senior girls, past-month current smoking rates decreased from 39.9% in 1977 to 25.8% in 1992, but increased to 35.3% during 1997. In 2000, smoking prevalence declined again to 29.7%.
- Much of the progress in reducing smoking prevalence among girls in the 1970s and 1980s was lost with the increase in prevalence in the 1990s. Current smoking rates among high school senior girls were the same in 2000 as in 1988.
- In the late 1970s and early 1980s, the prevalence of smoking among high school seniors was higher among girls than among boys, but the decline in smoking prevalence from 1976 through 1992 was more rapid among girls than among boys. Since the mid-1980s, smoking prevalence among girls and boys has been similar.
- From 1991 to 1996, current smoking prevalence in the past 30 days increased from 13.1% to 21.1% among 8th grade girls but decreased to 14.7% in 2000. Among 10th grade girls, current smoking prevalence in the past 30 days increased from 20.7% in 1991 to 31.1% in 1997, but decreased to 23.6% in 2000.
- Aggregated data from 1976-1977 through 1991-1992 showed a dramatic decline in past-month cigarette smoking among African-American high school senior girls (from 37.5% to 7.0%) compared with the decline among white girls (from 39.9% to 31.2%). From 1991-1992 through 1997-1998, past-month smoking prevalence increased among white girls (from 31.2% to 41.0%) and African-American girls (from 7.0% to 12.0%) — but the increase was statistically significant only among white girls.
- In 1990-1994, smoking prevalence for high school senior girls was highest among American-Indians or Alaska-Natives (39.4%) and whites (33.1%) and lowest among Hispanics (19.2%), Asian-Americans or Pacific-Islanders (13.8%), and African-Americans (8.6%).
- Smoking among young women (aged 18 through 24 years) declined from 37.3% in 1965-1966 to 25.1% in 1997-1998. However, recent trends show that smoking rates in this population may be rising.
- In 1998, nearly 14 million women of reproductive age were smokers, and smoking prevalence in this group was higher (25.3%) than in the overall population of women aged 18 years or older (22.0%).

CIGARETTE SMOKING AMONG PREGNANT WOMEN

- Despite increased knowledge of the adverse health effects of smoking during pregnancy, survey data suggest that a substantial number of pregnant women and girls smoke. However, cigarette smoking during pregnancy declined from 19.5% in 1989 to 12.9% in 1998.
- Smoking prevalence during pregnancy differs by age and by race and ethnicity. In 1998, smoking prevalence during pregnancy was consistently highest among young adult women aged 18 through 24 (17.1%) and lowest among women aged 25 through 49 (10.5%).
- Smoking during pregnancy declined among women of all racial/ethnic populations. From 1989 to 1998, smoking among American-Indian or Alaska-Native pregnant women decreased from 23.0% to 20.2%; among pregnant white women from 21.7% to 16.2%; African-American pregnant women from 17.2% to 9.6%; Hispanic pregnant women from 8.0% to 4.0%; and Asian-American or Pacific-Islander pregnant women from 5.7% to 3.1%.
- In 1998, there was nearly a 12-fold difference by the educational status among pregnant women who smoked — ranging from 25.5 percent among mothers with 9-11 years of education to 2.2 percent among mothers with 16 or more years of education.

NICOTINE DEPENDENCE

- The level of nicotine dependence is strongly associated with the quantity of cigarettes smoked per day.
- When results are stratified by the number of cigarettes smoked per day, girls and women who smoke appear to be equally dependent on nicotine, as measured by first cigarette after waking, smoking for a calming and relaxing effect, withdrawal symptoms, or other measures of nicotine dependence.
- Of the women who smoke, more than three-fourths report one or more indicators of nicotine dependence, and nearly three-fourths report feeling dependent on cigarettes.

QUITTING SMOKING AND ATTEMPTS TO QUIT

- More than three-fourths (75.2%) of women want to quit smoking completely, and nearly half (46.6%) report having tried to quit during the previous year.
- In 1998, the percentage of people who had ever smoked and who had quit was lower among women (46.2%) than among men (50.9%). This finding may be because men began to stop smoking earlier in the 20th century than did women and because these data do not take into account that men are more likely than women to switch to, or to continue to use, other tobacco products when they stop smoking.
- Since the late 1970s or early 1980s, the probability of attempting to quit smoking and succeeding has been equal among women and men.

OTHER TOBACCO USE

- The use of cigars, pipes, and smokeless tobacco among women is generally low, but recent data suggest that cigar smoking among women and girls is increasing.
- A California study found that current cigar smoking among women increased five-fold from 1990 through 1996.
- The prevalence of cigar use appears to be higher among adolescent girls than among women. In 1999, past-month cigar use among high school girls younger than 18 was 9.8%.
- The prevalence of pipe smoking among women is low, and women are much less likely than men to smoke a pipe.
- The prevalence of smokeless tobacco use among girls and women is low and remains considerably lower than that among boys and men.
- For tobacco use other than cigarettes among high school girls, cigar use is the most common, bidi and kretek use are intermediate, and pipe and smokeless tobacco use are the least common.



Efforts to Reduce Tobacco Use Among Women and Girls

SMOKING CESSATION

- There are numerous effective smoking cessation methods available in the United States. The methods range from self-help materials, to intensive clinical approaches, to broad community-based programs. Minimal clinical assistance; intensive clinical assistance; and individual, group, or telephone counseling have shown few differences in effectiveness between men and women.
- Studies show no major or consistent differences between women's and men's motivation to quit, readiness to quit, general awareness of the harmful health effects of smoking, or the effectiveness of intervention programs for tobacco use.
- Based on national surveys, the probability of attempting to quit smoking and to succeed has been equally high among women and men since late 1970s or early 1980s.

SELF-HELP INTERVENTIONS

- The majority of smokers who try to stop using tobacco reported doing so on their own, even though this is the least effective method. This pattern has changed somewhat in recent years with increased use of pharmacologic aids.

MINIMAL CLINICAL INTERVENTIONS

- The likelihood of having been counseled to stop smoking was slightly higher for women (39%) than for men (35%); women report more physician visits than men, which allows more opportunity for counseling.

INTENSIVE CLINICAL INTERVENTIONS

- Intensive clinical interventions involve individual, group, or telephone counseling for multiple sessions. The most successful treatments are multi-component cognitive behavioral programs that incorporate strategies to prepare and motivate smokers to stop smoking.
- Women are somewhat more likely than men to use intensive treatment programs. Similarly, women have a stronger interest than men in smoking cessation groups that offer mutual support through a buddy system and in treatment meetings over a long period.

PHARMACOLOGIC INTERVENTIONS

- A number of effective pharmacotherapies for nicotine addiction have emerged in the past decade — nicotine gum and nicotine patch (approved for over-the-counter use), nicotine nasal spray, oral nicotine inhaler, and Bupropion (available by prescription). Two other pharmacotherapies, Clonidine

and the antidepressant Nortriptyline, have been recommended as second-line pharmacotherapies, but have not yet been approved by the Food and Drug Administration for this indication — smoking cessation.

- Pharmacologic approaches to smoking cessation raise a number of issues specific to women. Nevertheless, nicotine replacement has been shown to be more effective than placebo among women smokers and, thus, remains recommended for use.
- More research is needed to determine the effects of nicotine replacement therapy on pregnant women and their offspring.

SMOKING CESSATION ISSUES UNIQUE TO WOMEN

- Studies have identified numerous gender-related factors that should be studied as predictors for smoking cessation, as well as factors for continued smoking or relapse after quitting. These factors include hormonal influences, pregnancy, fear of weight gain, lack of social support, and depression.
- Women stop smoking more often during pregnancy — both spontaneously and with assistance — than at any other time in their lives. However, most women return to smoking after pregnancy: up to 67% are smoking again by 12 months after delivery.
- Pregnancy-specific programs benefit both maternal and infant health and are cost-effective. If the national prevalence of smoking before or during the first trimester of pregnancy were reduced by one percentage point annually, it would prevent 1,300 babies from being born at low birth weight and save \$21 million (in 1995 dollars) in direct medical costs in the first year alone. Prenatal smoking cessation interventions can be of economic benefit to healthcare insurers.
- More women than men fear weight gain if they quit smoking; however, few studies have found a relationship between weight gain concerns and smoking cessation among either women or men. Further, actual weight gain during cessation efforts does not predict relapse to smoking.

- Smoking cessation treatment and social support derived from family and friends improve cessation rates. It is inconclusive whether there are gender differences in the role of social support on long-term smoking cessation.

SMOKING CESSATION AMONG WOMEN OF LOW SOCIOECONOMIC STATUS

- Women of low socioeconomic status (SES) have lower rates of smoking cessation than do women of higher SES. Studies that analyze the effects of mass media campaigns suggest that smokers of low SES, especially women, are more likely than smokers of high SES to watch and obtain cessation information from television.
- Women of low SES enrolled in intensive cessation intervention programs (stress management, self-esteem enhancement, group support, and other activities that improve quality of life) have 20%–25% successful cessation rates. Unfortunately, only a small proportion of women of low SES appear to take advantage of these programs.

SMOKING CESSATION AMONG WOMEN FROM RACIAL AND ETHNIC POPULATIONS

- In general, African-American, Hispanic, and American-Indian or Alaska-Native women want to stop smoking at rates similar to those of white women, but there is little research on smoking cessation among women in racial/ethnic minority populations.

INCREASING THE UNIT PRICE FOR TOBACCO PRODUCTS

- There is strong scientific evidence that shows increases in state and federal excise taxes on tobacco products reduce consumption and increase the number of people who stop using tobacco. Price increases reduce consumption of tobacco products by adults, young adults, adolescents, and children.

MASS-MEDIA EDUCATION CAMPAIGNS

- Mass-media campaigns implemented in combination with other interventions, such as excise tax increases and community education programs are effective in reducing tobacco consumption and motivating tobacco product users to quit.

REDUCING THE COST OF CESSATION SERVICES TO SMOKERS

- There are a number of effective interventions to help tobacco-users in their efforts to quit, such as behavioral programs offering counseling in individual or group settings and the use of a number of pharmacotherapies, including nicotine replacement. One way to increase the use of effective treatments is to lower the cost for people who wish to use these treatments. Scientific evidence shows that interventions that reduce smokers' costs (such as programs that reduce or eliminate the insured's co-payment) increase the number of people who stop using tobacco products.
 - There is no Medicare coverage for tobacco use dependence except in a few states that will participate in a demonstration project beginning in April 2001.
 - Six states provide Medicaid coverage for counseling, and four states cover all prescription drugs and over-the-counter nicotine replacement products.
 - Under private insurance, 42% of managed care organizations (MCOs) cover counseling, 16% cover indemnity counseling, 38% cover drugs, and 25% cover indemnity drugs.



African-American Women and Smoking

SMOKING PREVALENCE AMONG AFRICAN-AMERICAN WOMEN

- In 1998, smoking prevalence was highest among American-Indian or Alaska-Native women (34.5 percent), intermediate among white women (23.5 percent) and black women (21.9 percent), and lowest among Hispanic (13.8 percent) and Asian or Pacific-Islander women (11.2 percent).
- Among black women, the prevalence of ever smoking increased from 1965 through 1985. The increase was not statistically significant; however, the subsequent decrease from 1985 through 1998 was significant.
- Several studies have looked at prevalence of smoking among women over time, which provides an opportunity to examine when persons take up smoking and how smoking diffuses through a population over time.
 - For black women, a large increase in smoking prevalence occurred in the 1920-1924 birth cohort.
 - Prevalence peaked in the 1935-1939 and 1940-1944 birth cohorts (51 percent).
 - In the 1940-1944 cohort, smoking prevalence was comparable among white women and black.
 - Among whites, blacks, and Hispanics, smoking prevalence and the proportion of women who had ever smoked declined in cohorts of women born after 1944.
- Among women who smoked in 1998, white women (14.0 percent) were more likely to be heavy smokers than were black women (4.5 percent) or Hispanic women (2.1 percent).
- Among racial and ethnic groups, a significant difference of heavy smoking by gender was observed among white non-Hispanics, black non-Hispanics, and Hispanics.
- Recent data are limited for assessing cigarette brand preference among women by race and ethnicity.
 - The National Health Interview Survey (1978-1980) showed the three most popular brands for black women were Kool (24.4 percent), Salem (19.4 percent), and Winston (10.3 percent).

— Another study from 1986 demonstrated the three most popular brands among black women were Newport (20.5 percent), Kool (20.3 percent), and Salem (19.7 percent).

- Black women may be more sensitive than white women to the dependence-producing properties of nicotine. Researchers have hypothesized that black women may smoke cigarettes with a higher nicotine content or inhale more deeply than white women.

SMOKING PREVALENCE AMONG YOUNG AFRICAN-AMERICAN WOMEN

- The prevalence of ever smoking has been shown to be lower among black and Hispanic young women than among white young women.
 - In one study, in 1997-1998 the prevalence of current smoking among young women was substantially lower among black young women (9.6 percent) than among white young women (31.6 percent).
- Young black women had a dramatic decrease in smoking prevalence from 1983-1985 (27.8 percent) through 1997-1998 (9.6 percent)

SMOKING AMONG AFRICAN-AMERICAN GIRLS

- Studies conducted in 1998 showed that white girls were more likely than black girls or Hispanic girls to have ever tried smoking.
- Survey data from 1990-1994 indicate smoking prevalence among high school senior girls was lowest among blacks (8.6 percent), intermediate among Hispanics (19.2 percent) and Asian or Pacific-Islanders (13.8 percent), and highest among American-Indian or Alaska-Natives (39.4 percent) and whites (33.1 percent).
- 1998 data show that among smokers, black girls (9.7 percent) and Hispanic girls (15.8 percent) were less likely than white girls (34.2 percent) to be heavy smokers (one-half pack or more per day).
- The process of smoking initiation may be different across racial and ethnic groups.
 - According to a school-based survey, concerns about weight and dieting may have been less important among African-American girls than among white girls.

- In another study of seventh-grade adolescents in an urban school system, African-American adolescents who knew about the weight-suppressing effect of smoking were less likely to experiment with cigarettes than were those who believed that smoking had no effect on weight.
- Studies vary on whether sibling smoking may be a factor for the initiation of smoking among younger sisters and brothers. The pattern may vary by race or ethnicity; in particular, African-American girls appeared to be less susceptible than white girls to the influence of siblings, other family members, and peers who smoked.
- Theories of smoking and drug use have suggested that persons have difficulty resisting temptations to smoke if they are anxious, hostile, irritable, or psychologically distressed. A study reported that the intense feelings of anger and irritability were related to both smoking initiation and maintenance among African-American adolescents, whereas among white adolescents these emotions were associated only with smoking initiation.

SMOKING AND PREGNANCY

- Smoking prevalence during pregnancy differs by race and ethnicity. Although the prevalence declined in all racial and ethnic groups from 1989 through 1998, the greatest decline occurred among black mothers (from 17.2 percent in 1989 to 9.6 percent in 1998) and white mothers (from 21.7 to 16.2 percent).
- A 1992 study examined the relationship between early relapse and personal characteristics, including race. Overall, 46 percent of pregnant African-American women and 28 percent of pregnant white women relapsed; 70 percent of those who relapsed resumed smoking by week 3 after childbirth.
- The high incidence to relapse during the postpartum period in the general population suggested that concern for health of the fetus is a strong deterrent to smoking during pregnancy but that women may be less aware of, or less concerned about, the risks from environmental tobacco smoke on the health of infants and children.
- The effects of smoking on birth weight appear to be similar among various racial groups in the United States. The findings from one study suggested stronger effects of smoking among black women than among white women.

HEALTH EFFECTS OF SMOKING AMONG AFRICAN-AMERICAN WOMEN

LUNG CANCER

- The overall incidence of lung cancer among black women resembles that among white women.
 - In 1997, the age-adjusted incidence per 100,000 women was 42.6 percent among blacks and 45.0 percent among whites.

- In 1996-1997 lung cancer incidence rates among women younger than age 65 years were higher among blacks than among whites. This finding suggested that the differences between incidence among black women and white women may increase in the future.
- Because of the poor survival associated with lung cancer, mortality parallels incidence for all age and ethnic groups. The five-year relative survival rates among black women and white women diagnosed with lung cancer in 1989-1996 were 13.5 and 16.6 percent, respectively.
- Few case control studies reported data on variation in smoking-associated risk by race or ethnicity.
 - In a hospital-based study, the odds for lung cancer were higher among black women than among white women at each level of tar exposure.

CORONARY HEART DISEASE (CHD)

- Despite a continuing decline since the 1960s in mortality from CHD, this condition still ranks first among the cause of death for middle-aged and older women. The effect of CHD risk among women seems to be relatively similar regardless of racial or ethnic group.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

- According to data from 1995, the steep rise in mortality from COPD among women in the U.S. continued during 1980-1992 and was similar among white women and African-American women.
- In 1992 COPD mortality was 44 percent among white women and 78 percent among African-American women.
- In 1992 the overall age-adjusted death rates were 1.67 times higher among white men than among white women, and 2.21 times higher among African-American men than among African-American women.

BODY WEIGHT AND FAT DISTRIBUTION

- Among current smokers, there tends to be a U-shaped curve for the relationship between smoking and body mass: typically, moderate smokers (approximately 10 to 20 cigarettes per day) weigh less than light smokers (less than 10 cigarettes per day), and heavy smokers (20 or more cigarettes per day) weigh more than moderate smokers. This relationship was particularly pronounced among black women in a study conducted in 1993.
- Many studies reported a positive association of smoking with a high waist-to-hip ratio (WHR) among women. WHR among black women was 2.0 percent higher among current smokers than among those who had never smoked. WHR was also higher among current smokers than among those who had never smoked, for women and men, black or white.

SMOKING CESSATION AMONG AFRICAN-AMERICAN WOMEN

- Published data shows the percentage of smokers who had quit smoking increased significantly among white women

(from 19.6 percent in 1965 to 47.4 percent in 1998) and among black women (from 14.5 percent to 34.7 percent).

- Data from the 1993 National Health Interview Survey showed that 74.9 percent of African-American women smokers would like to stop smoking.
- Overall, research has suggested that more African-American men achieve cessation than do African-American women.
- Mixed results have been observed in studies that have examined the differences in quit rates between African-American women and non-Hispanic white women.
- Much of the research that has been reported on cessation programs for African-American women has focused on pregnant women. Several approaches have been tested in prenatal smoking cessation programs for low-income women. However, results have been inconsistent.



Asian and Pacific-Islander Women and Smoking

SMOKING PREVALENCE AMONG ASIAN AND PACIFIC-ISLANDER WOMEN

- In 1998, smoking prevalence was highest among American-Indian or Alaska-Native women (34.5 percent), intermediate among white women (23.5 percent) and black women (21.9 percent), and lowest among Hispanic (13.8 percent) and Asian or Pacific-Islander women (11.2 percent).
- Among Asian-American or Pacific-Islander women, the prevalence of smoking decreased from 1979 through 1992, but then doubled from 1995 through 1998.
- Estimates from national surveys indicate that the prevalence of smoking among Asian or Pacific-Islander women is lower than that among women in other racial and ethnic groups. However, state and local surveys showed that smoking prevalence varies dramatically among ethnic subgroups.
 - In a California survey, the prevalence among Asian women was highest among women of Japanese ancestry (14.9 percent) or Korean ancestry (13.6 percent) and lowest among women of Chinese ancestry (4.7 percent).
 - In a survey of women enrolled in a prepaid health plan in California, 18.6 percent of Japanese-American women and 7.3 percent of Chinese-American women were current smokers.
 - Aggregate data from California studies in 1990 and 1991 showed that the prevalence of smoking among Asian or Pacific-Islander women aged 18 through 24 years was 22.9 percent among Japanese women, 19.9 percent among Korean women, 5.8 percent among Chinese women, and 4.0 percent among Filipino women.

SMOKING PREVALENCE AMONG ASIAN AND PACIFIC-ISLANDER GIRLS

- In 1990-1994, the smoking prevalence among Asian and Pacific-Islander high school senior girls was 13.8 percent.
- Behind Native-American and white girls, Asian girls reported the third highest prevalence of smoking intensity (one half pack or more per day) among current smokers: (4.5 percent).

SMOKING AND PREGNANCY

- Smoking during pregnancy is particularly uncommon among Asian or Pacific-Islander women born outside the United States. In 1993, twelve percent of Asian or Pacific-Islander mothers born in the United States were smokers, but only 3 percent of those born elsewhere were smokers.
- The pregnancy smoking prevalence during 1989-1998 decreased in all racial and ethnic groups. Published data from the natality statistics reported that among Asian or Pacific-Islander women, prevalence was highest among pregnant Hawaiian and part-Hawaiian woman and lower among pregnant Chinese, Filipinos, Japanese, and other Asians or Pacific-Islanders.

SMOKING CESSATION INTERVENTIONS

- Because of the small sample sizes of Asians and Pacific-Islanders who have participated in epidemiologic surveys and smoking cessation programs, little information has been available on cessation rates and associated factors. No studies of smoking cessation interventions among Asian or Pacific-Islander women have been reported.

INTERNATIONAL TOBACCO USE AMONG ASIAN OR PACIFIC-ISLANDER WOMEN

- Relatively little is known about recent trends in smoking prevalence among young women in Asian countries, where cigarette marketing targeted to women has increased markedly.
- The rise of smoking among women and children in Asia has coincided with aggressive Western-style advertising. Preliminary evidence suggests a pattern of association similar to that seen in the United States and emphasizes the enormous potential of advertising to change social norms.
- In central, south, and southeast Asia, smokeless tobacco use includes nass, naswar, khaini, mishri, gudakhu, and betelquied. The prevalence of smokeless tobacco is relatively high among women in some developing countries, where its use is considered more socially acceptable for women than smoking.



American-Indian or Alaska-Native Women and Smoking

SMOKING PREVALENCE AMONG AMERICAN-INDIAN OR ALASKA-NATIVE WOMEN

- In 1998, smoking prevalence was highest among American-Indian or Alaska-Native women (34.5 percent), intermediate among white women (23.5 percent) and black women (21.9 percent) and lowest among Hispanic women (13.8 percent) and Asian or Pacific-Islander women (11.2 percent).
- Reported smoking rates have varied widely among American-Indian tribal affiliations and by geographic location. The type of cigarettes, manner of inhaling, and numbers of cigarettes smoked vary widely. Fifty-four percent of American-Indians live in urban settings, and another large percentage live on rural reservations.
 - Data from 1994-1996 show that smoking prevalence was the highest among American-Indian or Alaska-Native women living in the northern plains (43.5 percent) and in Alaska (40.6 percent), intermediate among women living in the East (33.4 percent) and the Pacific coast (30.6 percent), and lowest among women living in the Southwest (18.6 percent).
 - Current Population Survey data for 1992-1993 showed a higher smoking prevalence among Alaska-Native women (46 percent) than among American-Indian women in the continental United States (35 percent).

- The prevalence of heavy smoking (25 or more cigarettes per day) among American-Indian or Alaska-Native women was unchanged from 1978-1980 and through 1994-1995.
- Data for the combined years 1978-1980 through the combined years 1992-1993 demonstrate that American-Indian and Alaska-Native women consistently smoked fewer cigarettes than did men.

SMOKING PREVALENCE AMONG AMERICAN-INDIAN OR ALASKA-NATIVE YOUNG WOMEN

- Published data show that among American-Indian or Alaska-Native women aged 18-34 years there has been no significant change in current smoking prevalence from 1978-1980 (53.3 percent) through 1994-1995 (48.0 percent).

SMOKING PREVALENCE AMONG-AMERICAN INDIAN OR ALASKA-NATIVE GIRLS

- The 1997 Youth Risk Behavior Survey showed that the percentage of girls who had ever tried a cigarette was substantially higher among high school students who attended

schools that were funded by the Bureau of Indian Affairs (93.5 percent) than among high school girls overall (69.3 percent).

- Data on current smoking among girls of racial and ethnic groups are limited and range in prevalence. Studies indicate that among high school aged girls, smoking prevalence for American-Indian or Alaska-Native girls ranges from 9 to 65 percent.
- Survey data from 1990-1994 indicate smoking prevalence among high school senior girls was highest among American-Indian or Alaska-Natives (39.4 percent) and whites (33.1 percent), intermediate among Hispanics (19.2 percent) and Asian or Pacific-Islanders (13.8 percent), and lowest among blacks (8.6 percent).

SMOKING AND PREGNANCY

- Smoking prevalence during pregnancy differs by age and race and ethnicity.
 - The prevalence declined in all age groups and all racial and ethnic groups from 1989 through 1998.
 - Smoking prevalence was consistently highest among women aged 18 through 24 years, lower among girls, and generally lowest among women aged 25-49 years.
 - Tobacco use during pregnancy by American-Indian or Alaska-Native mothers was higher than in any other racial or ethnic group, but the prevalence decreased from 23.0 percent in 1989 to 10.2 percent in 1998.
- The effects of smoking on birth weight appear to be similar among various racial groups in the U.S. In one study, lower average birth weight has been reported among infants of Alaska-Native smokers compared with nonsmokers of the same race or ethnicity.

SMOKING CESSATION AMONG AMERICAN-INDIAN OR ALASKA-NATIVE WOMEN

- No studies have addressed factors that may influence smoking cessation among American-Indian or Alaska-Native women specifically.
- Smoking cessation among women varies by age, race and ethnicity, level of education, and income.
 - Data from 1997-1998 show the percentage of smokers

who had quit smoking was lower among American-Indian or Alaska-Native women (37.2 percent) and Hispanic women (43.1 percent).

- Among American-Indian or Alaska-Native women, the percentage of smokers who had quit smoking varied by region of the United States.
- White female girls (27.9 percent) were more likely than black (22.5 percent), Hispanic (23.5 percent), or Alaska-Native and American-Indian (15.7 percent) girls to have been counseled by a health care provider on cigarette smoking.

SMOKELESS TOBACCO USE

- The prevalence of use of smokeless tobacco among girls and women is low and remains considerably lower than among boys and men. Use of smokeless tobacco is higher among black women and American-Indian or Alaska-Native women, women with fewer than 12 years of education, and women who live either in rural areas or in the South.
- Among girls, whites, blacks, and Hispanics are equally likely to use smokeless tobacco, but use is thought to be higher among American-Indian or Alaska-Native girls.



Hispanic Women and Smoking

SMOKING PREVALENCE AMONG HISPANIC WOMEN

- In 1998, smoking prevalence was lowest among Hispanic women (13.8 percent) and Asian or Pacific-Islander women (11.2 percent), intermediate among white women (23.5 percent) and black women (21.9 percent), and highest among American-Indian or Alaska Native-women (34.5 percent).
- Reports have shown smoking among Hispanics to be positively associated with acculturation.
- Several studies have looked at prevalence of smoking among women over time, which provides an opportunity to examine when persons take up smoking and how smoking diffuses through a population over time.
 - Prevalence was the highest in the 1920-1924 (31 percent) and 1940-1944 (29 percent) birth cohorts.
 - Smoking prevalence was lower among Hispanic women than among white women or black women.
 - The patterns of cigarette smoking among women and men became increasingly similar; however, smoking prevalence remained lower among women than men.
- Among Hispanic women, a decline in smoking prevalence was noted from 1979 through 1998. Prevalence was also significantly lower among Hispanic women than among white women or black women during this period.
- The 1995 Stanford Five-City Project found that the difference in smoking prevalence between white women and Hispanic women decreased as education increased and that smoking prevalence was the same among white women and Hispanic women who were college graduates.
- Among Hispanic women who smoked, data show that Mexican-American women (18.8 percent) were less likely to be heavy smokers (one-half pack of cigarettes or more per day) than were Puerto Rican-American women or Cuban-American women (48.6 percent). Heavy smoking among Hispanic women who smoked was highest among “other Hispanics” (17.5 percent) and Cuban-Americans (4.0 percent).
- Among racial and ethnic groups, a significant difference of heavy smoking by gender was observed among white non-Hispanics, black non-Hispanics, and Hispanics.
 - Among women who smoked in 1998, white women (14.0 percent) were more likely to be heavy smokers than were black women (4.5 percent) or Hispanic women (2.1 percent).
- National data on the cigarette brand preferences of Hispanic women are limited; however, data from the 1992-1994 Hispanic Health and Nutrition Examination Survey are notable:
 - Among Mexican-American women who smoked, 30.4 percent used Marlboro cigarettes, 15.7 percent Salem, 13.6 percent Winston, and 9.9 percent Benson & Hedges.
 - Among Puerto Rican-American women who smoked, 22.0 percent used Newport cigarettes, 20.5 percent Marlboro, 17.6 percent Winston, and 8.5 percent Kool.
 - Among Cuban-American women who smoked, 18.7 percent used Benson & Hedges cigarettes, 16.2 percent Winston, 15.6 percent Salem, and 15.4 percent Marlboro.
 - Cuban-American women (25.7 percent) were more likely than Mexican-American women (19.0 percent) or Puerto Rican-American women (9.8 percent) to choose a brand other than one of top seven brands.
- A 1984-1985 study of current smokers in New Mexico suggested that the gender gap had narrowed considerably for the use of filter-tipped cigarettes: 92.9 percent of white women and 94.6 percent of Hispanic women smoked filter-tipped cigarettes, compared to 90.0 percent of white men and 87.0 percent of Hispanic men.

SMOKING PREVALENCE AMONG YOUNG HISPANIC WOMEN

- A substantial decline in smoking prevalence occurred among young Hispanic women from 1978-1980 (29.6 percent) through 1997-1998 (17.0 percent).
- Since 1992-1993, smoking prevalence has been lower among young Hispanic women than among young Hispanic men.

SMOKING PREVALENCE AMONG HISPANIC GIRLS

- Studies show that among girls aged less than 18 years, Hispanic and black girls are less likely than white girls to have ever tried smoking.
- Hispanic girls are less likely than white girls to be current smokers.
- Survey data for 1990-1994 showed that smoking prevalence among high school senior girls was highest among American-Indians or Alaska-Natives (39.4 percent) and whites (3.1 percent), intermediate among Hispanics (19.2 percent) and Asian or Pacific-Islanders (13.8 percent), and lowest among blacks (8.6 percent).
- From 1985-1989, it was found that the prevalence of current smoking was 24.7 percent among Puerto Rican-American and Latin-American girls and 18.7 percent among Mexican-American girls.
- In 1998, among smokers, black girls (9.7 percent) and Hispanic girls (15.8 percent) were less likely than white girls (34.2 percent) to be heavy smokers (one-half pack of cigarettes or 6-15 cigarettes or more per day).
- Data from the 1999 school-based Youth Risk Behavior Survey (grades 9-12, girls aged <18 years) show that among current smokers, Hispanic girls were more likely than black girls to be trying to lose weight.

SMOKING AND PREGNANCY

- Studies targeting pregnant Hispanic women have been inconsistent.
 - In the National Pregnancy and Health Survey, conducted from October 1992 through August 1993, 24.4 percent of white women, 19.8 percent of black women, and 5.8 percent of Hispanic women reported smoking during pregnancy.
 - Smoking prevalence during pregnancy differs by age and race and ethnicity. The prevalence declined in all age groups and all racial and ethnic groups from 1989 through 1998. For pregnant Hispanic women, prevalence was highest among Puerto Rican, “other Hispanic”, and women of unknown Hispanic status. Prevalence was lower among Cuban, Mexican-American, and Central and South American women.
 - Smoking during pregnancy is particularly uncommon among Mexican-American women born outside the United States. In 1993, for example, the prevalence of smoking during pregnancy was 6 percent among Mexican mothers born in the United States, and only 2 percent among Mexican mothers born elsewhere.
- The effects of smoking on birth weight appear to be similar among various racial groups in the United States. In one study, lower than average birth weight was reported among infants of Mexican-American smokers compared with non-smokers of the same race or ethnicity.

SMOKING CESSATION

- Little work has been published on smoking cessation among Hispanic women in the United States. In general, Hispanic women want to stop smoking at rates similar to those of non-Hispanic whites, and a higher percentage of Hispanic women (79.3 percent) want to stop smoking compared to Hispanic men (68.3 percent).
- A 1998 study showed that the percentage of smokers who had quit smoking was lower among American-Indian or Alaska-Native women (37.2 percent) and Hispanic women (43.1 percent) and highest among Asian or Pacific-Islander women (62.2 percent).
- Hispanic women who smoked were less likely than white women to report having received advice to quit smoking. This difference occurred despite a comparable number of visits to a physician by Hispanic women and white women.
- Among girls, white females (27.9 percent) were more likely than black (22.5 percent), Hispanic (23.5 percent), or Alaska-Native and American-Indian (15.7 percent) females to have been counseled by a health care provider on cigarette smoking.

EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE (ETS)

- In 1982-1983, the proportion that reported ETS exposure at home ranged from 31 percent (among Puerto Rican women aged 40 through 49 years) to 62 percent (among Mexican-American girls and young women aged 12 through 19 years).
- Among both Mexican-American and Puerto Rican-Americans, adolescents had significantly higher levels of exposure in the home than did older groups.
- In a 1993 California survey, 52 percent of the Hispanic women reported a complete ban on smoking in their homes, and 21 percent a partial ban. Hispanic women and Asian or Pacific-Islander women were more likely than white women or black women to have a total ban on smoking in their home.

Toolkit Feedback Form

After reviewing the *Community Toolkit for Reducing Tobacco Use Among Women*, please provide the following feedback about the contents and the application of the *Toolkit* and drop it in the mail.

1. Under Cessation Resources, are you satisfied with the information provided for cessation?

Yes Needs improvement

2. Is there anything else for cessation that should be provided in this toolkit? (Please print clearly.)

3. Do you think that you will be able to use the cessation information in your community?

Yes No

4. If you answered yes to Question 3, check all community settings where you hope to use the toolkit.

Women's health clinics Women's clubs One-on-one counseling
 College campus Physician's office Health fairs
 Cessation clinics Church-based support groups Other _____

5. This toolkit provides lists of activities for different settings. Do you think that these activities can be applied with your

Schools?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	College campuses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Health care providers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Community?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

6. What other kinds of activities, if any, would be valuable in your community? _____

7. Working with the media is a critical part of making information available to the public. Has this toolkit provided you with enough media tools to help you work with the media in your community?

Yes No

8. If you answered "no" to question 7, what other tools would be helpful with the media in your community?

9. Several of the media tools require that you fill in the blanks with state and local information. Are you able to access local or state tobacco control data for this type of media tool?

Yes No

10. How would you rate the references and resources provided, including Web site information?

Comprehensive Adequate Needs improvement

11. Regarding the resources and Web sites provided, are you aware of any other resources or Web sites that should be included in this toolkit?

No Yes

If yes, please list _____

12. Overall, do you feel this toolkit can be useful to you in your local community?

Yes No

If no, please explain _____

Thank you very much for your help!

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