



Women and tobacco

In 1994, roughly three out of ten (29%) Canadian women were smoking on a daily or occasional basis. Smoking prevalence is higher among women living in Quebec (38%), young adult women aged 20 to 24 (38%) and young women with lower incomes (47%).¹ This overall prevalence rate has not changed significantly since 1991.



Inside: KEY LESSONS

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Women's tobacco use has devastating consequences. Smoking is the leading preventable cause of premature death among Canadian women. Of these smoking-related deaths, lung cancer, ischemic heart disease, stroke and chronic obstructive lung disease are the leading causes. Smoking reduces the number of years a woman can expect to live – the reduction in life expectancy for a 35-year-old Canadian woman who smokes is estimated to be more than five years.²

When the federal government initiated the Tobacco Demand Reduction Strategy (TDRS) in early 1994, it was clear that addressing women's tobacco use was a priority. As a result, a number of projects were initiated to enhance our understanding of the issue and to increase the level of action to reduce women's tobacco use.

¹ Health Canada. *Survey on Smoking in Canada, Cycle 1, August 1994. #7. Profile of Women.*

² Pope, M., Ashley, M.J. & Ferrence, R. *Tobacco and Women's Health.* March 1997.

information

Background: Information about tobacco control in Canada and this document.

1 About the Tobacco Demand Reduction Strategy.

In February 1994, the federal government launched a comprehensive, three-year initiative to counteract tobacco use in Canada, the Tobacco Demand Reduction Strategy (TDRS). The TDRS was developed to be consistent with the work and directions of the National Strategy to Reduce Tobacco Use (NSRTU), launched in 1987.

The goals of the TDRS were:

- to help non-smokers stay smoke free;
- to encourage and help those who want to quit smoking to do so; and
- to protect the health and rights of non-smokers.

2 About the Summary Series – Lessons Learned from the TDRS.

This is one in a series of five summaries that present the lessons learned from the Tobacco Demand Reduction Strategy. Other topics include Youth, Aboriginal Peoples, Francophones and Prenatal and Postpartum Women. The summaries are intended to assist health professionals and policy makers in shaping future action on tobacco reduction. Each summary identifies key lessons that have been drawn from the work completed on the topic and profiles a few of the many community-based projects and local and national resources developed under the TDRS. Descriptions of these projects and resources appear throughout the summaries.

Codes such as "A4" and "W10" refer to complete references for TDRS resources which are listed at the end of the summary.

3 About the Tobacco Control Initiative.

The Tobacco Control Initiative (TCI), which was announced in November, 1996, is a \$100 million commitment by the federal government over five years, beginning in 1997/98. The four key elements of this comprehensive strategy are legislation and regulations, enforcement, research, and public education.

Building upon the lessons learned and the results achieved under TDRS and other tobacco strategies, the Public Education Component of the TCI aims to improve the overall health and quality of life of Canadians, particularly young Canadians, through:

- the identification and dissemination of best practices;
- training and consultation to enhance the capacity of communities to deliver effective tobacco reduction programs; and
- building public concern about tobacco and the tobacco industry.

In partnership with the provinces, territories, health, community and youth-oriented organizations, the TCI will expand prevention, protection and cessation efforts which began under the TDRS.

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The opinions expressed in this document are those of the authors and do not necessarily reflect the official position of Health Canada.

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*Our mission is to help the people of Canada
to maintain and improve their health.
– Health Canada*

4 About This Summary – Women and Tobacco.

At the outset of the TDRS, there was a lack of information about women's smoking behaviour and few gender specific approaches to helping women become and remain smoke free. The TDRS included several major research and public education activities to address these gaps. Synthesis work conducted throughout 1997 pulled together the conclusions

and insight of all TDRS projects and activities related to women. The resulting lessons are organized into six major topics presented in this summary.

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Lesson One: Gender differences in smoking behaviour.

1 Young females (ages 13 or 14) are more likely to smoke than males the same age. More females than males in this age group are non-daily smokers.

Among children aged 10 to 12 at the time of the 1994 *Youth Smoking Survey*, smoking prevalence was low – 2% for females and 3% for males (Y3).

Female smoking prevalence began to exceed male prevalence in the 13 to 14 year-old age group: 14% of females were

current smokers, compared to 12% of males. This gender difference was due entirely to a higher prevalence of non-daily smoking among females – 9% vs. 7% for males.

2 Age 15 to 17 is the age group where female smoking prevalence most exceeds male prevalence. More females than males in this age group are daily smokers.

In the age group 15 to 17, 22% of females smoke, compared to 18% of males (Y3).

This difference is due to a higher prevalence of daily smoking among females – 17% vs. 13% for males.

3 At ages 18 or 19, gender differences in smoking prevalence are reversed as male smoking prevalence begins to exceed female prevalence.

Among 18- and 19-year-olds, male smoking prevalence is higher than female smoking prevalence (31% vs. 27%), though prevalence for both males and females rise compared to the younger age groups.



4 Overall, females experiment with smoking at a younger age than males.

The period before age 15, especially ages 13 or 14, is a critical time for the adoption of smoking. Among 13- and 14-year-olds, 15% of females were “beginning smokers,” compared with 9% of males. Among smokers who were aged 15 to 19 at the time of the *Youth Smoking Survey, 1994*, 29% of females had smoked their first cigarette by age 12. Among males, 29% had smoked their first cigarette by age 13. An additional 47% of females and 33% of males had tried smoking by age 15 (Y3). It should be noted that these data are subject to error in that they are based on recall of those aged 15 to 19 about when they first tried smoking. However, the general pattern reported by this age group is consistent with the pattern of a higher prevalence of experimentation among young females than young males. Focus group research (G1) has shown similar findings. The average age of first smoking experience was 12 or 13 for females and 14 years or older for males.



5 At all ages, male youth smoke more cigarettes per day than females the same age. For teens, the differences in daily smoking are greatest among 13- and 14-year-olds.

Among teens aged 13 and 14, females smoke 9.0 cigarettes per day on average, compared to 13.2 for males. This is a difference of about four cigarettes per day. This gender gap closes to about 2.5 cigarettes per day – 15.1 for males vs. 12.7 for females – among 18- and 19-year-olds (Y3).

6 The *Survey on Smoking in Canada* found that female smoking prevalence is less than male prevalence for all age groups 20 or over.

The *Survey of Smoking in Canada (SOSIC)* (S8) collected information on a sample of roughly 15,800 Canadians over the age of 15. The information was collected in four cycles that were three months apart. The survey measured levels and changes in cigarette smoking behaviour over the course of one year.

In its first cycle, the survey found that smoking prevalence for Canadians over age 15 was 29% for females and 32% for males. Male smoking prevalence rates were higher than female rates in all age groups with the exception of those aged 15 to 19 years, where 29% of young women smoked compared to 26% of young men.

7 The *Survey on Smoking in Canada* found regional and cultural variations in gender differences in smoking behaviour.

Information collected during the fourth SOSIC (S8) cycle found less gender discrepancy in smoking prevalence among Francophones (36% of males, 35% of females) compared to Anglophones (28% of males, 24% of females). Overall, Francophone smoking rates were higher than Anglophone rates (35% vs. 26%).

More women smoked in Quebec than in any other region and more of them smoked every day. British Columbia had the lowest smoking prevalence rate among women.

Gender differences in prevalence rates were most pronounced in Prince Edward Island where 49% of men and 29% of women over the age of 15 were smokers (Cycle 1).

8 Among all Canadian smokers aged 20 or over, males smoke more cigarettes per day than females.

Among adult smokers, gender differences in amount smoked per day are small for most age groups, except among those aged 45 to 64 (S8). For ages 20 to 24, males average 16.3 cigarettes per day; females 13.3. Similarly, for ages 25 to 44, males smoked an average of 17.1 cigarettes per day, compared to 14.6 for females. There was a larger difference in the amount smoked per day for ages 45 to 64. Males on average smoked 21.4 cigarettes per day, compared to 14.5 per day for females. For ages 65 and over, gender differences in amount smoked were small – 16.2 for males and 15.1 for females.

The number of cigarettes smoked per day declined among women (from 19 to 17) between 1981 and 1994 while it remained consistent at 21 cigarettes per day among men (S8).

9 More females than males quit smoking during the one-year time frame of the *Survey on Smoking in Canada*, particularly among 20 to 24 year-olds.

Among females who were smokers at Cycle 1 (spring 1994), 18% had quit smoking by Cycle 4 (winter 1995). Among males, 14% quit between Cycles 1 and 4.

The decline in female smoking was most evident in the 20 to 24 age group. In Cycle 1, 38% of females and 41% of males smoked. By Cycle 4, 31% of females and 37% of males in this age group were smoking, a decline of 7% and 4% respectively.

About half (54%) of all quitters, both men and women, cited present or future health concerns as their reasons for quitting. About 25% said that the cost of cigarettes was a factor (S8).



Check

YOUR FACTS!

Sometimes it pays to start over! The Halifax Regional Drug Prevention Network wanted to provide factual, up-to-date information on physical health risks, emotional health and ways of quitting for women who currently smoke (C5). Not satisfied with the number of sources cited and the contradictory figures presented in

many of the existing pieces, the Network ambitiously chose to research and write their own information pieces.

The Network has produced a series of 15 women's health information sheets covering the relationship between smoking and breastfeeding, cervical cancer,

menopause and osteoporosis, and weight control. The sheets also cover specific aspects of quitting smoking such as nicotine replacement therapy and coping with relapse. The sheets go to great lengths to incorporate the concept of harm reduction rather than taking a straightforward "quit or else" tone.

Lesson Two: Why young women start smoking.

1 The most common reasons teenage girls give for why people their age start smoking are “their friends smoke (peer pressure)” and “curiosity/just try it.”

The *Youth Smoking Survey, 1994* asked young people to indicate why they thought that young people started smoking. The above reasons were most commonly given by both females and males (Y3). The latter reason was given more often by females than males in the 10 to 14 age group.

2 Some teenage girls and young women start smoking to deal with stress and then maintain their smoking habit as a coping tool.

Some young women smoke to deal with gender-related stress (D1). Some research has shown that there is a relationship between stress and smoking initiation among teenage girls (A9, D1). Stress also contributes to the continuation of smoking, particularly for disadvantaged teens.

Women who quit school or who are struggling academically are more likely to smoke (R4). Also, a qualitative study of university women showed that women found smoking a helpful strategy for dealing with stress in their lives (C1).

3 Some research has found that young females are more influenced by the smoking behaviour of family and friends than young males.

As with much previous research into smoking initiation, the *Youth Smoking Survey, 1994* (Y3) found that the smoking behaviour of family and friends were key influences on decisions to start smoking among youth. Some evidence suggests that family influences may be stronger for young women than for young men, particularly when mothers smoke (A9, G1, W2). The *Youth Smoking Survey, 1994* found that females are more likely than males to be current smokers if both parents smoke or if only the mother smokes. Males are more likely to smoke than females if only the father smokes (Y3). Also, sibling smoking has been found to be related to smoking onset for females only (G1).

In terms of friends' smoking, some researchers have suggested that the greater influence for females may be due to girls having smaller and more close-knit friendship groups than boys (W2). However, the evidence of gender differences in degree of peer influence on smoking is not conclusive. The *Youth Smoking Survey, 1994* found no gender differences in the relationship between number of friends who smoke and smoking behaviour (Y3).

4 Advertising, sponsorship and the popular media depict smoking as part of a positive and exciting lifestyle, and as a way to reconcile perceived contradictions of womanhood. Media literacy is essential for counter-ing these pressures.

Tobacco advertising seems to equate beauty with thinness and implies that smoking “thin” or “light” cigarettes can help young women achieve this “ideal.” Smoking is also portrayed as a way to relax, cope with stress, get time for oneself, and as a solution to any tensions between a young woman's desire for independence and control and her desire to be attractive (i.e. thin). The contradiction between personal control and the addictive nature of tobacco is ignored (D1, M1, R4, W1, W2).

Although tobacco advertising in Canadian magazines has been restricted in recent years, young women who read American magazines continue to see tobacco advertising. Some tobacco sponsorship reaches females directly, such as sponsorship of women's sports, arts and fashion events (M1).

In the popular media, films show people using tobacco for both socializing and stress release, implying that tobacco use is appropriate in both positive and negative situations. Information about smoking as a health issue is rare in women's magazines, even though such magazines carry many other health articles (M1). As advertising revenue from tobacco companies increases, magazines' editorial coverage of the dangers

of smoking decreases (W2). Newspapers have covered health issues related to smoking. French-language newspapers take a smokers' rights position against the anti-tobacco lobby more often than English newspapers (M1).

5 The role of weight control in smoking initiation is inconclusive. Weight concerns are more likely to influence continuation of smoking and concerns about quitting.

Research findings regarding the relationship between smoking initiation and weight control concerns have been inconclusive.

Some studies have suggested that such concerns may encourage smoking while others have found no relationship (C1, G1, W1, W2). Thinking about body weight, eating a lot, attempting to lose weight, and having eating disorder symptoms have been associated with smoking in teenage females but not teenage males (G1). However, this does not mean that such concerns cause women to start smoking. Also, young women are reluctant to acknowledge that they smoke to control weight, and some only recognize that they have done this after they quit (C1).



three Lesson Three: Preventing tobacco use by young women.

1 Young women need positive alternatives to smoking as well as ways to develop a sense of control over their lives.

Awareness of health risks is not sufficient to prevent teens from smoking. Skill and confidence-building strategies and resources are also needed. For example, *Stop Smoking Before It Starts* (S6), an information kit for teachers, parents, organizations and peers working with teenage girls, builds awareness of smoking prevalence, health and social consequences of smoking and reasons why girls smoke. It also includes skill-building strategies to resist smoking, positive alternatives to smoking (e.g. physical activity, healthy eating and stress management) and ways to create supportive environments that encourage healthy lifestyles.

Physical activity may be a particularly attractive positive alternative to smoking. Physical activity can help young women manage stress, maintain a healthy weight, make social connections and achieve status (in the case of sports teams or clubs), and develop feelings of strength and power rather than passivity. Also, decreased physical activity and smoking initiation seem to be linked (A9, D1).

In addition to developing individual behaviour strategies for taking more control of one's life and health, it is important that girls and young women develop a critical analysis of gender issues (C7, G1). For example, if young women experiencing harassment learn to recognize that males use harassment as a form of power over

females, they will be less likely to believe that harassment is their fault, and less likely to use smoking as a way of coping with the resulting negative feelings.

Peer discussions and connections to supportive adults and community groups, such as organizations that work with youth and/or women, may be particularly useful for skill building and increasing awareness of gender issues. Such connections can help teenage girls recognize that they are not alone in experiencing life stresses and pressures.

2 Media literacy helps girls and young women become more critical of tobacco company messages.

Being media literate is to understand the ways the mass media influence the perceptions, values and behaviours that affect health and well-being. Girls and young women who are media literate are in a position to take a critical view of messages that support and encourage smoking. The recently developed kit *Back Talk: Media Wise and Feeling Good* (B2) addresses media influences, body image and smoking.



3 School-based prevention programs should start in elementary school, continue throughout secondary school, and be integrated with policies to discourage youth smoking.

Most school-based prevention programs use the social influences model as a foundation and are typically offered to students in Grades 6 to 8. The assumption behind the social influences approach is that peers, parents and media influence children and adolescents to use tobacco. If young people can perceive and resist those social influences toward tobacco use, they will be able to resist future pressures to smoke. Typical program components include personal consequences of tobacco use, decision making, problem solving, stress management and corrections of misconceptions about tobacco use prevalence. Extensive student participation (e.g. role playing) is used to develop skills and confidence to resist social pressure to use tobacco.

A national survey of prevention programs (S2) conducted just prior to the TDRS cited studies that concluded that prevention programs based on the social influences approach have had some success in reducing youth smoking rates, but the effects fade during the secondary school years and gaps exist in program content. Subsequent work conducted under the TDRS, most notably the development and dissemination of the prevention program *Improving the Odds* (I2), supplemented existing school-based prevention programs.



Filling the Gaps

IN SCHOOL-BASED PREVENTION PROGRAMS

Improving the Odds (I2) is unique among prevention programs because it has been designed to fit in with existing school-based programs, not duplicate or replace them. Covering topics such as the role of the tobacco industry, women and smoking, media awareness and trends in tobacco use, *Improving the Odds* supplements smoking prevention resources in Grades 5 to 8. The complete resource has been designed for teachers, volunteers and

in-class health educators, and includes two options for training: a self-directed training module and a Workshop Facilitator's Guide. The resource also includes a CD-ROM for student use with information and interactive exercises.

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4 Policies can be implemented that make it more difficult to use smoking as a routine aspect of peer group socializing.

School smoking restrictions are becoming more common (S5). These make smoking among peers less visible and limit opportunities to smoke as a social activity during school time, provided that restrictions cover school grounds as well as buildings and are consistently enforced. To the extent that teenage girls may be more influenced by peer smoking than boys, restricting opportunities for peers to smoke together during school hours may be an especially useful prevention strategy for young females.

Policies that restrict smoking need to extend beyond the boundaries of schools, to other places where teenagers spend their

free time, such as malls and recreational facilities.

School programs that are implemented in concert with community-wide environmental approaches are more effective than school programs alone (S2). Other policies that discourage smoking and make non-smoking a community norm (e.g. increased price through taxation, strict enforcement of sales to minors legislation, plain packaging of cigarettes, mass media messages, smoking restrictions in public places) are also important. Some research has shown that teenage girls may have easier access to tobacco than teenage boys in that they are more likely to be sold cigarettes than underage males (M4). Females are also more likely than males to purchase single

cigarettes (Y3). Many tobacco control advocates have recommended tax increases on tobacco products to make them less affordable to young people.

It has been suggested that plain packaging may decrease smoking among teens by decreasing the linkages between brands and images (P10). This may make smoking less desirable as a way of asserting one's "image" within a peer group.

5 Programming for certain priority groups of teenage girls needs to take cultural differences into account.

For instance, programs for Aboriginal girls need to recognize the spiritual and ceremonial uses of tobacco, high smoking rates in Aboriginal communities, lower tobacco prices on reserves, and preference for family and community involvement in programming. Prevention programs need to start very young as the age of smoking onset in Aboriginal communities is younger than in many other groups.

Programs for Francophone girls need to recognize that the French culture has been less questioning of smoking and emphasizes freedom of lifestyle choice over health issues. Thus, Francophone girls are exposed to a higher prevalence of smoking than in the general population. Also, French media are less critical of smoking than English media (M1).

Research and development carried out as part of the TDRS has led to an increase in the number of linguistically and culturally appropriate tobacco control programs.



Lesson Four: Effective ways of helping women of all ages to quit smoking.

1 TDRS research has raised awareness of how women's smoking behaviour occurs within a broader social context of gender inequality.

Factors often associated with high smoking prevalence include unemployment, low income or service-sector jobs, lone-parent status, low levels of education, isolation and lack of social support, dual responsibilities of work and family, family violence, stress and low self-esteem. Women with multiple disadvantages and/or other addictions are more likely to smoke (H3). Woman-centred approaches to tobacco reduction recognize that individual "lifestyle" behaviours such as smoking occur in this broader social context (H3, W2). Though social disadvantage affects men's smoking as well, the specific experiences of disadvantage often differ by gender (e.g. women are more likely to be low-income single parents or informal caregivers). These differences and the different types of stresses they entail need to be recognized in programming.

2 Feelings of confidence, control and self-worth play a large role for women in trying to quit smoking and succeeding in making a change.

Though feelings of confidence, control and self-worth are important to anyone trying to quit smoking, such feelings may be especially important to women in disadvantaged circumstances who often feel a lack control over their lives and may

view smoking as something that is within their control. Smoking may provide them with feelings of independence and choice. When women decide that they can gain more control over their life by quitting smoking, but are then unable to reach that goal, their failed cessation attempts can undermine feelings of control and self-esteem (H3). In order for women to change their smoking behaviour, they must feel confident that they can achieve success and feel in control.

Programs that allow for a range of goals, such as cutting back on the amount smoked, gaining the skills to be able to quit or quitting completely, and programs that tailor interventions to the circumstances of women, allow them to build feelings of confidence and self-worth as they experience success on their own terms. For example, the recent evaluation of *Catching Our Breath* (C7) in Winnipeg found that women felt confident and successful as they reduced the number of cigarettes they smoked per day, and that most women who reduced smoking during the course of the program wanted to continue to progress toward eventually quitting. The evaluation also found that the more confident women were about not smoking in a variety of situations, the fewer cigarettes they smoked per day.

There is some evidence that women perceive more barriers associated with quitting, anticipate more negative consequences of quitting and interpret their unsuccessful quit attempts more harshly than men (D1,

W2). Also, women seem to metabolize nicotine more slowly than men, so equal amounts of nicotine result in a higher dose per body weight for women. This may be why women report more severe withdrawal symptoms. The more convinced women are of their addiction, the less confident they are in quitting. Some women are more likely than others to believe they are strongly addicted to nicotine (e.g. women with disabilities) (R2). However, there is little difference between women and men in actual quitting behaviour, though women are slightly more likely to seek help in quitting than men (W1). It is essential that the help women receive includes strategies to build confidence in making changes and to cope with withdrawal.



3 Applying the Stages of Change model can increase the confidence and skills of women who are in the process of quitting smoking. Recognition of multiple definitions of success is an important part of woman-centred programming.

The Stages of Change model views smoking cessation as a process or series of steps rather than a single event when a smoker actually quits. The model identifies five stages of behaviour change as a smoker gets ready to quit: not thinking about quitting, thinking about and deciding to quit, getting ready to quit, quitting, and staying quit. The model acknowledges the frequency with which relapse can occur in any of the stages and that relapse needs to be seen as a natural occurrence that is to be expected when a smoker is trying to quit.

The Stages of Change model has many definitions of success within a program. For example, moving from one stage to another is a success, as is becoming more aware of individual reasons for and patterns of smoking, as is making a change in one's smoking behaviour.

Applying the Stages of Change model to smoking cessation programs precedes the TDRS. Some pre-TDRS woman-centred programs such as *Catching Our Breath* and *Stop Smoking for Women* have long recognized that quitting smoking is a process rather than an "all or none" event and have been accepting of differential program goals (cessation, reduction, learning). However, under the TDRS, existing programs were modified, updated and/or disseminated

nationally (S7) and new programs were developed for specific populations of smokers (C2).

An important outcome of expanding the use of cessation programs based on the Stages of Change model is that it makes the programs more attractive to a broader range of smokers. Support is no longer just for smokers who feel ready to quit soon, it is also available for smokers who would just like to talk about smoking before making any decisions.

Allowing for multiple definitions of success according to each woman's degree of readiness or stage of change can foster a sense of success as women achieve goals that are realistic for them. Feelings of success along the way contribute to confidence and self-esteem.

4 Knowledge of health risks is not enough to motivate women to quit smoking.

According to the *Survey on Smoking in Canada*, women of all ages were more likely than men to know the health risks of smoking, and young women (age 15–24) were most likely to say an occasional cigarette can be harmful (S8). Women also were more likely to think that displaying lists of toxic ingredients on cigarette packages would be effective in discouraging smoking (P10).

The survey (S8) also found that more women than men were in the first stage of change (not even thinking about quitting),

59% of women compared to 50% of men. At this stage, increasing awareness of the negative factors associated with smoking is critical to help women move from not thinking about quitting to considering it.

Most women were knowledgeable about health risks but did not see the need to quit unless they actually had a smoking-related disease – 31% of women said that getting a smoking-related illness or a potentially fatal disease would get them to quit (S8). Another 16% said that nothing would get them to quit. Being pregnant or having children was mentioned by 24% of 20- to 24-year-olds and 13% of 25- to 44-year-olds as reasons for quitting. Other TDRS research found that various ethno-cultural groups and disadvantaged women felt that actual development of health problems would influence decisions to quit more than knowledge of health risks (C10, H3, R2). In other words, women were saying that certain physical conditions (illness, pregnancy) would have to *happen to them personally* to make them quit.

However, there are some inconsistencies in research findings on the effects of health risk knowledge on smoking behaviour. Though the national survey data (S8) found that knowledge alone did not motivate women to want to quit smoking, another study (H3) found that the more that disadvantaged women saw smoking as harmful to their health, the more likely they were to try to cut down. These findings suggest some degree of influence of health knowledge on behaviour change.

5 Information on the immediate effects of smoking may be more effective in motivating women to quit than long-term health risk information. This may be especially true for young women.

In some TDRS research (C1, H3, W1), women (especially young women) reported that immediate health effects are more motivating than long-term effects in getting women to quit smoking. Particularly important were aesthetic factors like odour (of breath and clothing) and discolouration of fingers. However, those who develop anti-tobacco messages must be careful not to reinforce the notion that females should be primarily concerned about their appearance and/or the approval of others.

One immediate effect of smoking that may concern many pregnant women is the effect of smoking on the fetus. Women often use pregnancy as a motivator to quit or reduce smoking (H3, W1). However, many women take up smoking again after the baby is born. This suggests that women may be changing their smoking habits to protect the fetus, rather than for their own benefit. It is important that a woman's health be viewed as an important issue in its own right, not only because a baby is involved (W2). Also, if a woman quits smoking for herself, whether for health or other reasons, it will be easier to maintain her success, which in the long run will be beneficial for both herself and her family.

6 While they recognize the risks, women perceive benefits from continuing to smoke, including stress management and weight control.

Some female smokers report benefits such as relaxation, stress reduction and weight control (H1, W1). In the *Survey on Smoking in Canada*, "to relax" was the most frequent reason given by women for resuming smoking after a quit attempt. Among women who reported high stress in their lives, 45% smoked, compared with 32% of women who reported very low stress levels (S8).

Some research has shown that women are more likely than men to use smoking to cope with stress and to relapse in stressful situations after a quit attempt (D1, W1). These stresses are often related to gender inequality, economic inequality, multiple roles and violence against women (D1, B3, W2). Both individual stress management

Double

RESOURCES

Double

RESULTS

A comprehensive approach to women's tobacco use includes preventing adolescent girls from starting to smoke and helping women to stop smoking. Health Canada has produced two resources to guide community organizations through both prevention and cessation efforts.

Stop Smoking Before It Starts (S6) is a thorough information source that introduces organizations to the issues surrounding prevention efforts. *Getting Smoke-Free* (G2) helps organizations wade through the many available cessation resources to decide what will work in their community.

Both resources include references to existing programs and a series of materials for women in their communities.

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techniques and an analysis of external causes of stress in women's lives would be useful components of cessation programs for women.

Women with multiple disadvantages (especially poverty and unemployment) may see their cigarettes as one small "luxury" in their lives. Single women with young children sometimes view smoking as a way of getting time to relax (W2).

Women are more likely than men to believe they will gain weight after quitting (D1). In order to encourage women of all ages to quit smoking, it is essential to help women find other ways to achieve the perceived benefits of smoking. In the case of weight control, it is important to assist women to learn to critique popular images of female attractiveness and to accept their own bodies. Women also benefit from information on healthy eating and active living to help them to maintain healthy body weights.

Programs that are woman-centred (e.g. *Catching Our Breath* (C7), *Stop Smoking* (S7) and the recently developed *Health in Perspective* (H1) for girls aged 10 to 15 years) already address stress and weight control. Other programs and resource materials could incorporate some of these issues by recognizing the benefits women perceive from smoking while encouraging critical analysis and positive alternatives.



It Works AND YOU CAN Order It!

When a small group of community health centres in Ontario developed a group-based smoking cessation program for women in the early nineties, they had no idea how far it would go. *Stop Smoking: A Program for Women* (S7) takes a holistic approach to women's smoking, looking at all the life circumstances of individual women, and includes cutting down as a goal along with quitting completely.

Initially successful and widely adopted in Ontario, the TDRS provided funding for the project to be updated and evaluated. The evaluation found that the program helped 57% of French-speaking participants and 71% of English-speaking participants

to reduce the number of cigarettes smoked at the quitting stage of the program. Another 26% of French-speaking participants and 14% of English-speaking participants quit altogether. Six months after the program had ended, 54% of English-speaking participants and 83% of the French-speaking participants had maintained the changes in their smoking behaviour. The program also increases participants' self-esteem, sense of personal control, and helps reduce stress levels.

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7 Adult education principles are more likely to be seen as acceptable and relevant by women than “top-down” advice.

Drawing out women's own beliefs and solutions is consistent with principles of personal empowerment and adult education. Messages to promote increased awareness of the negative consequences of smoking may be best achieved by asking women what they believe are the drawbacks of smoking. Asking women what they could do for themselves to improve their health would allow women to raise the issue of quitting smoking on their own, rather than having a health professional imposing the agenda. When smoking is addressed as part of routine service delivery rather than being singled out as a problem, advice about stopping may be more acceptable. Given

the guilt many women feel about smoking (C1), there may be discomfort with anything that seems like “preaching” from professionals.

Messages encouraging women to quit smoking should not make women feel guilty or ashamed. Some TDRS projects found that fear-based messages may increase guilt, stress and smoking (B3, H3). “Shaming and blaming” strategies decrease self-esteem. Although some smokers may find negative messages motivating, positive messages might be more effective in reaching smokers more resistant to change, such as those who have not begun to seriously consider quitting smoking. These messages, combined with participatory adult education approaches, form a positive strategy for smoking reduction.



Making A GOOD THING Better

The Women's Health Clinic in Winnipeg received a lot of positive feedback about *Catching Our Breath*, its group cessation program for women. With TDRS funding, the Clinic adapted the program for two specific groups of women: women in the workplace and women who have difficulty accessing existing cessation programs due to barriers such as low literacy or poverty. The result, *Catching*

Our Breath (C7), offers an effective woman-centred approach which is accessible and relevant to a wide range of women.

The project also provides a good example of a program evaluation that recognizes the limitations of measuring only cessation rates. *Catching Our Breath* is effective in raising participants' awareness of their reasons for smoking, increasing their commitment to quitting, and increasing their

confidence in not smoking in a variety of challenging situations. Most participants reduced the amount they smoked and fewer women were smoking daily. Cessation was more common among workplace groups than community groups.

The Women's Health Clinic
3rd Floor, 419 Graham Avenue
Winnipeg, MN R3C 0M3
Phone: 204-947-1517

8 Social support is important to women who are trying to quit smoking.

Women appear to prefer a greater degree of social support when quitting than men (H3, R2, R4, W1, W2). This support can take a number of forms. Some women join group-based cessation programs. Group programs led by peers with previous smoking experience may be especially valuable. Such groups allow women to benefit from others' experiences, share support and practical solutions and build support networks.

Not all women wish to join group programs. Some prefer individual assistance from a

health professional. However, advice from health professionals can be a barrier to cessation if it is insensitive or judgmental. Some women quit on their own but desire the support of a partner, family and/or friends. For example, women most likely to quit smoking are those with a non-smoking partner (H3).

Support for women also entails making both group programs and individualized assistance accessible. Accessibility means addressing financial, situational, physical, educational (e.g. literacy) and emotional barriers.

9 Most young female smokers (14 or under) have tried to quit in the past and have the smoking-related characteristics that facilitate cessation. Cessation support needs to be available for smokers in this age group.

Non-daily smokers and those who smoke fewer cigarettes per day are more likely to quit for longer periods of time. As young females (14 or under) are more often non-daily (occasional) smokers and smoke fewer cigarettes per day, habitual smoking behaviour patterns and physical addiction to nicotine may be less entrenched. Also, the younger the smoker, the greater the interest in quitting. Most smokers try to quit within two years of their first cigarette. A higher percentage of 10- to 14-year-old females (88%) have tried to quit than males (79%) the same age (Y3). Therefore, smoking cessation interventions, such as *Quit 4 Life* (Q1), should be offered at a young age.



10 There are gaps in programming for certain priority groups of women.

There is little in terms of cessation programs or resources for teenage girls who have left school and/or home. Smoking is often the norm for these women. The recently prepared *Youth and Tobacco* summary has made a number of suggestions for programming for this group, including the integration of smoking reduction into broader programs serving priority teens (e.g. job training, outreach, parenting programs, residential youth programs), flexibility regarding attendance, emphasis on

immediate effects of smoking, focus on multiple health behaviours and presence of non-smoking environments. As well, prevention needs to begin during the early school years before teens may drop out of school.

Cultural sensitivity is important in programming for Aboriginal, Francophone and ethnocultural groups. Aboriginal women and Francophone women have higher rates of smoking than the population of Canadian women as a whole, and there is more acceptance of smoking within their communities. They may experience more pressure to continue to smoke and less support for quitting.

Women from ethnocultural groups who have recently immigrated to Canada generally have lower than average smoking rates than other women. Those women who do smoke often face severe disapproval within their own cultural circles.

Women living in rural communities are often not well served by cessation/reduction programs (R8). Social isolation, economic uncertainty (and associated stresses), as well as a belief in handling one's problems privately or at home, are issues that need to be considered in developing relevant programs for rural women. Program providers need to involve rural women in all aspects



of programming and be sensitive to community norms in order to make sure programs are relevant. There may be potential to reach more women through distance education techniques (e.g. Internet, teleconferencing). However, many disadvantaged women will not have access to these, and there is the risk that such technologies will be seen as tools of “outside experts” supplanting local resource persons who may have more credibility in the community.

The Real

MEANING OF PARTICIPATION

We've all heard it said that the most meaningful and effective programs are developed by the people who use them. The Crabtree Corner YWCA Women and Tobacco Pilot Project (C8) in Vancouver can teach us about meaningful participation. Through patient and consistent word-of-mouth recruitment, the project coordinator recruited 10 women to form a steering committee to learn about and conduct action research so that they could develop a program to reduce women's tobacco use. Eventually, the women on the steering committee became the facilitators of a group program that was modelled on their own experience in learning about tobacco.

Was the approach successful? The 10 women on the steering committee all quit or substantially reduced their smoking and all of them made their homes smoke free. The program they developed ran at full capacity for the duration of the project and had a waiting list at all times. While the program itself is not documented, the evaluation report describes the process of conducting participatory action research and includes a tool developed by the project coordinator to help the steering committee overcome its hesitancy to move from research to program planning.

What

A DIFFERENCE A DRIVE

Makes

We've all seen the statistics that say the majority of smokers quit “on their own.” Does this mean that group programs are not useful? Absolutely not! Several TDRS projects in Ontario used *Stop Smoking: A Program for Women* (S7) to offer group cessation and reduction support to women in their communities. These groups were well attended and, in some cases, even had a waiting list.

What made the difference? These projects went to great lengths to make it possible for women to attend by providing transportation – taxi fare, bus fare or personal rides – and child care either on-site or in the women's homes. The lesson? Many lower income women are prevented from attending cessation groups by financial and situational barriers. Programs that try to overcome some of these external barriers are appreciated and well attended by women.

Lesson Five: How tobacco-related policy issues affect women.

1 Women are more likely than men to be employed in workplaces where there are few smoking restrictions.

Small firms and service sector workplaces (e.g. food and beverage, hairdressing, child care), where women are more likely to be employed, are less likely to have smoking policies than larger workplaces (W3). Also, women in low status jobs with little control over decision making are more likely to be smokers.

As well, non-smoking women are often exposed to environmental tobacco smoke (ETS) in their place of work (W2).

Restaurants and bars have particularly high concentrations of ETS. Women who are in low-status positions within their workplaces may have difficulty advocating for smoking restrictions within their workplaces (W2).

However, in the total population of employed women (across all workplace sectors, large and small), half experience smoking restrictions where they work, compared with only one third of men (S8). When workplace smoking is restricted, the desire to smoke and actual amount smoked declines, and women become more interested in cessation (H3, R4, W1).

2 Tobacco control policies need to incorporate a gender analysis.

Although woman-centred approaches have been incorporated primarily into programming at this point (with varying degrees of emphasis), the approach also needs to be considered during policy formulation.

For example, the need to study the impact of tobacco tax increases on both the smoking behaviour and economic well-being of women living on low incomes has been raised by some researchers. One major TDRS study showed that even when they had little money, women continued to spend money on cigarettes (H3). This has implications for tobacco taxation policies designed to reduce smoking (especially among youth) by making it more costly. On the other hand, some women use higher cost as an incentive to quit or reduce smoking (R4, W1). There is no consensus at this point on how best to balance prevention of smoking onset through higher prices with financial hardship to low-income smokers (W2).

As previously mentioned, prevention approaches for youth need to be comprehensive and to include policy as well as program-based initiatives. There has been some research into gender differences in policy impacts. For example, young females appear to have an easier time buying cigarettes under age than young males.

With tax increases, females seem to be affected more in terms of the amount smoked and males more in terms of smoking prevalence. However, research into gender differences in policy impacts is still scarce and is primarily descriptive.

3 Almost 40% of the population live in homes where one or more people smoke. More women smoke in the home than men. Innovative, non-judgmental strategies to promote smoke-free homes can reduce non-smokers' exposure to ETS.

Women are more likely to smoke in the home than men (60% of women who smoke vs. 48% of men who smoke) (S8). This has implications for ETS exposure and influences teen smoking behaviour (especially for girls). The challenge will be to encourage smoke-free homes without inducing guilt among smoking mothers, many of whom may be smoking to cope with various life circumstances.

Through the TDRS, some educational materials have been developed to encourage smoke-free homes. One well-known example developed in Ontario is *Take It Outside* (T1). Programs that promote smoke-free homes provide strategies for smokers to separate their children and other non-smokers from ETS, without being judgmental about their smoking behaviour.

4 Policies that affect women's health go beyond those that deal only with tobacco control.

A woman-centred approach to policy would also consider policies beyond those specific to tobacco, such as policies dealing with income support, equity, child care, violence, harassment and human rights. Given that some researchers have drawn links between smoking and women's social conditions (D1, H3, W2), policies in the realm of "social determinants of health" as well as tobacco-specific policies need to be analyzed for their potential impact on women. A recent paper on women and smoking cessation (W1) concluded that tobacco control policies (e.g. increased



taxation) need to go hand-in-hand with other measures to support health, housing, employment and day care, and that impacts of such policies on women's social conditions should be tracked (e.g. any increased use of food banks by women following tobacco taxation increases.)

Promoting Partnerships AND ACTION ON Women and Tobacco

Many health and community organizations are interested in taking some form of action on tobacco. *Bridging the Visions* (B4) provides these organizations with information and support so that they can join forces to maximize their efforts in helping women to live smoke-free lives.

Bridging the Visions provides information on taking a health determinants and woman-

centred approach to health promotion activities intended to reduce tobacco use. It inspires organizations to put women and tobacco on their agenda and to work collaboratively with others in the process.

Canadian Cancer Society
10 Alcorn Avenue, Toronto, ON M4V 3B1
Phone: 416-961-7223

Website: www.cancer.ca/tobacco

Closing the Gap FOR WOMEN WITH Disabilities

Until now, little attention has been paid to tobacco use by women with disabilities. Few cessation programs for women have taken accessibility issues (e.g. the type of materials used and the location of the program) into account. By developing *A Way Out: Women with Disabilities and Smoking* (A5), DAWN Canada has taken an important step toward closing the gap in cessation support for disabled women.

A Way Out was written by and for women with disabilities. It incorporates many of the insights and techniques of other reduction or cessation programs and applies them to real-life situations experienced by women with disabilities.

Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366
Website: www.hc-sc.gc.ca/hppb/tobacco/reduction

Lesson Six: Encouraging community action on women's tobacco use.

1 There appears to be a growing awareness of the importance of a woman-centred approach to tobacco programming.

Some of the background papers prepared in the early stages of the TDRS (D1, H3, W2), as well as some pre-TDRS work, focused on a woman-centred approach to tobacco reduction. This approach draws from feminist as well as “mainstream” cognitive-behavioural approaches to programming and policy making, integrating effective individual change strategies with an analysis of the social context of many women's lives (e.g. low income, violence, discrimination, harassment, caregiving responsibilities).

A woman-centred approach views women as experts on their own lives, recognizes that individual “lifestyle” behaviours occur within a broader social context, addresses life stresses and barriers to change, allows for a range of successful outcomes (e.g. reduction as well as cessation, depending on women's present needs and goals), integrates tobacco reduction with other concerns in women's lives, and recognizes the importance many women place on social support (D1, H3, W2). A woman-centred approach recognizes barriers women experience in making changes and it addresses these barriers to ensure that programs are accessible to women (R2).

2 Many community organizations that work with women are beginning to integrate tobacco cessation/reduction into their work.

A survey of women's organizations across Canada (B3) found that most were not aware of existing tobacco programs. TDRS resources such as *Bridging the Visions* and *Getting Smoke Free* (B4, G2) are now available to guide groups in taking action on women's tobacco reduction in organizations and communities. Organizations are becoming more aware of the links between smoking and other determinants of health, and of the potential for enhancing women's feelings of personal empowerment through smoking cessation or reduction. Tobacco control organizations and women's organizations are working together more than they were prior to the TDRS, and many community coalitions on tobacco and health were formed during the TDRS.

Women's organizations are uniquely positioned to assist women in changing their smoking behaviour. They reach many priority populations that traditional cessation providers do not reach effectively. They are well respected and accessible to women, and focus on issues of self-esteem and equality – issues that influence smoking. Tobacco issues can and have been integrated effectively into programs in women's shelters and prenatal, parenting and nutrition programs. Health professionals can reach women about smoking issues as part of routine health care.

3 Efforts will be needed to ensure effective dissemination, sustainability and evaluation of woman-centred programs over time.

Though several initiatives developed during the TDRS have a woman-centred focus, there is an ongoing need for dissemination of effective programs and resources, and training for people who wish to implement them. Community development must lead to interventions (program and policy) that will more specifically influence attitudes and behaviours regarding tobacco use. Evaluations need to examine collective and interactive impacts of a number of initiatives on specific groups of women over time, rather than simply focus on individual programs.

For more information

ON TOBACCO CONTROL:

Health Canada's website:
www.hc-sc.gc.ca/hppb/tobaccoreduction

Canadian Council for Tobacco Control's website: www.cctc.ca

Quit 4 Life website:
www.quit4life.com

TDRS

DOCUMENT CODES

The TDRS, in association with a range of partners, produced hundreds of reports, resources and papers. This section provides a brief description of each resource referenced in the summary. Information for finding out more about the project or ordering a resource is included, when available. Other items may be borrowed through interlibrary loan from the Departmental Library, Dept. of Health Canada. Please contact your public or institutional library to make arrangements for any such loans. The majority of the projects were conducted under the TDRS. Documents from projects that were initiated prior to the TDRS are denoted by an asterisk (*).

- A5 A Way Out: Women with Disabilities and Smoking. 1997, English and French.
- Resource consists of a self-help workbook for disabled women who want to stop smoking. The quitting process described is based on the five Stages of Change model. Available in hard copy, computer diskette, audiotape and Braille.
- Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366
Website: www.hc-sc.gc.ca/hppb/tobaccoreduction
- A9 A Literature Review on Tobacco Sponsorship. 1996, English.
- An overview of the types of sponsorship activities engaged in by the tobacco industry; international and Canadian legislation to control sponsorship and the lessons learned on an international basis; tobacco industry responses to advertising bans; and non-legislative policies, programs and approaches to limiting sponsorship.
- B2 Back Talk: Media Wise and Feeling Good. 1996, English and French.
- A kit designed to teach young women aged 12 to 15 years how the media and advertising may influence beliefs and behaviour about self-image and tobacco use and affect a woman's health. The kit consists of three resources, including a guide, a set of fact sheets and a book of activity sheets.
- Website: www.hc-sc.gc.ca/hppb/tobaccoreduction
- B3 Breathing Space: A Needs Assessment and Feasibility Study for a National Women and Tobacco Project. No date, English and French.
- Needs assessment report based on interviews with six women in each of nine regions. Recommends ways of integrating tobacco into existing programs and the tools needed.
- Website: www.hc-sc.gc.ca/hppb/tobaccoreduction
- B4 Bridging the Visions: A Guide to Shared Action About Women and Tobacco. 1996, English and French.
- A guide for community organizations that want to form partnerships with other organizations to take action on tobacco reduction. Addresses women's groups that may not have a specific focus on tobacco.
- Canadian Cancer Society
10 Alcorn Avenue, Toronto, ON M4V 3B1
Phone: 416-961-7223
Website: www.cancer.ca/tobacco
- C1 Cigarette Smoking and Young Women's Presentation of Self. 1996, English and French.
- Research report, based on a literature review and in-depth interviews with 30 female university students, that examines the role and the impact of smoking behaviours in the self-presentation behaviours of young women. The study includes examples of cigarette package warning labels that address presentation-of-self issues.
- Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366
Website: www.hc-sc.gc.ca/hppb/tobaccoreduction
- C2 Close Up: A Resource Package for Nurses Who Smoke or Have Recently Become Smoke-Free. 1996, English.
- A self-help cessation guide for nurses who smoke that is based on the five Stages of Change model.
- Manitoba Nursing Research Institute, Faculty of Nursing
University of Manitoba, Winnipeg, MB R3T 2N2
Phone: 204-474-9080 Fax: 204-275-5464
Website: www.umanitoba.ca/faculties/nursing/mnri/closeup
- C5 Communities for Youth/Women and Tobacco. 1997 English.
- The Drug Prevention Network conducted individual tobacco reduction projects with adolescent girls, women and seniors. Each project used a different approach, including developing a support program, offering cessation programs and writing fact sheets. A final evaluation report was written.

- C7 **Catching Our Breath.** 1997, English.
An updated version of a two-part smoking cessation and reduction resource for low-income women, adapted to be appropriate for women in the workplace. Includes a group facilitator's guide and a change journal for participants.
The Women's Health Clinic
419 Graham Avenue, 3rd Floor, Winnipeg, MB R3C 0M3
Phone: 204-947-1517
- C8 **Crabtree Corner Women and Tobacco Pilot Project.** 1997, English.
A women's centre developed a smoking reduction program in partnership with the women who used the centre's services. The program provided education workshops, peer support and access to resources. An evaluation report was prepared.
- C10 **Cultural Factors in Tobacco Use Among Ethnic Groups in Canada.** 1996, English.
Focus groups and a telephone survey were conducted with specific immigrant linguistic and cultural groups to identify the need for anti-smoking programs for immigrants. The research showed changes in smoking behaviours around the time of immigrating to Canada and that new arrivals are less likely to be aware of the effects of smoking and ETS.
- D1 **Delivering Gender Sensitive Tobacco Reduction Programs: Issues and Approaches.** 1995, English.
A resource book to enhance knowledge of the unique needs and approaches for the development and delivery of effective tobacco prevention and cessation programs and resources for diverse groups of women. Includes examples of health initiatives that have taken a gender-sensitive approach.
- G1 **Gender Differences in Smoking Uptake and Tobacco Use Among Adolescents.** No date, English and French.
A literature review of gender differences in the predictors of smoking acquisition by adolescents, plus a focus group study consisting of 12 groups and 112 participants was conducted to gain a better understanding of the role gender plays in the acquisition of smoking among adolescents.
- G2 **Getting Smoke Free.** No date, English and French.
A resource book for community organizations containing information on facts and programs related to smoking reduction and cessation for women. Provides resource materials both for service providers and their clients.
Website: www.hc-sc.gc.ca/hppb/tobaccoreduction
- H1 **Health in Perspective (HIP).** 1996, English and French.
A peer-led program that teaches smoke-free lifestyle skills to adolescent girls in health, recreational and active living settings. Materials include a Facilitator's Guide and a Peer Leader's Guide.
Canadian Intramural Recreation Association
212B – 1600 James Naismith Drive, Ottawa, ON K1B 5N4
Phone: 613-748-5639 Fax: 613-742-5467
- H3 **High Priority Women Project.** 1995, English.
A comprehensive needs assessment with priority women and agencies outside traditional tobacco control organizations. The purpose of the project was to assess the nature and extent of the tobacco problem within the priority groups in order to provide smoking reduction and cessation support through existing or new programs and resources. A series of reports were developed from the study.
- I2 **Improving the Odds.** 1996, English and French.
A resource designed to supplement school-based smoking prevention programs for Grades 5 to 8. Topics covered include the role of the tobacco industry, media awareness, and women and smoking. Materials include an Educator's Resource Guide, a Workshop Facilitator's Guide and a CD-ROM for student use.
Canadian Cancer Society
200–10 Alcorn Avenue, Toronto, ON M4B 3B1
Phone: 416-961-7223 Fax: 416-961-5189

- M1 Mixed Messages: Women, Tobacco and the Media. 1996, English and French.
A research project on the presentation of smoking and tobacco use and the portrayal of girls and women in four media – women's magazines, newspapers, films and television – in English and French Canada.
Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366
- M4 Measurement of Retailer Compliance with Respect to Tobacco Sales to Minors Legislation. 1996, English and French.
Study of the extent to which various tobacco retailers are in compliance with legislation that restricts tobacco sales to minors and limits tobacco advertising.
Website: www.hc-sc.gc.ca/ehp/ehd/tobacco/research/index.htm
- P10 Public Attitudes Toward Toxic Constituent Labelling on Cigarette Packages. 1996, English.
Describes the results of a qualitative study consisting of 18 focus groups. Discusses labelling of tobacco products, smokers' awareness of health risks from smoking and the effects of ETS, sources of information of the effects of smoking, and awareness of toxic constituents in cigarettes.
Website: www.hc-sc.gc.ca/ehp/ehd/tobacco/research/index.htm
- Q1 Quit 4 Life.* 1993, 1995, 1996, English and French.
Self-help or group format cessation resource for adolescents. Resources include CD format kit for teens and Facilitator's Guide for group format. Additional support is available from the Quit 4 Life website.
Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366
Website: www.quit4life.com
- R2 Relief... At What Cost? Women with Disabilities and Substance Use/Misuse. 1996, English.
Summary document of a needs assessment report on the issues related to the use of tobacco, alcohol and other drugs by women with disabilities. Twelve focus groups were held across Canada. An extensive report, *Lessons from the Research*, was produced.
- R4 Research in the Areas of Social Sciences and Health Dealing with High Priority Adolescent Women. 1995, English and French.
Summarizes the literature concerning cigarette smoking among adolescent women aged 14 to 19 years who have left high school before graduation and are no longer living with their family. Identifies existing smoking prevention and cessation programs for the target group and describes key components of a prevention and cessation strategy that could reach high priority adolescent women.
- R8 Rural Women and Substance Use Problems. 1996, English and French.
Research report to identify key components of effective tobacco, alcohol and other drugs prevention and treatment programs for women in rural communities. Includes a literature review, results of key informant interviews and a description of effective programs and resources.
- S2 School Smoking Prevention Programs: A National Survey.* 1994, Reprinted 1996. English and French.
Examines the extent to which smoking prevention programs are offered in Canadian schools, assesses the extent to which efficacy criteria are met by existing programs and identifies program gaps that need to be addressed.
Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366
- S5 Smoking Policies in Schools, Daycares, Health Care Institutions, and Commercial Settings. 1995, English and French.
A set of four summary fact sheets describing the extent to which various public settings have adopted policies that restrict smoking and identifying key issues surrounding the implementation of these policies. Summarizes the findings of larger survey.
Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366

- S6 Stop Smoking Before It Starts. 1996, English and French.
An information kit for community groups consisting of eight modules for providers and supporting materials for adolescent girls.
Website: www.hc-sc.gc.ca/hppb/tobaccoreduction
- S7 Stop Smoking: A Program for Women.* 1996, English and French.
An existing smoking reduction and cessation group support program for women was adapted to include the five Stages of Change model and evaluated with English and French groups across the country in order to extend the reach of the program. Available resources include a Facilitator's Guide, participant materials, a promotional video and evaluation report.
Canadian Public Health Association
1565 Carling Avenue, Suite 400, Ottawa, ON K1Z 8R1
Phone: 613-725-3769 Fax: 613-725-9826
- S8 Survey of Smoking in Canada, Cycles 1-4. 1995, English and French.
Modified longitudinal national survey that collected information on roughly 15,800 Canadians 15 years of age and older at four intervals during a one year time frame.
Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366
- T1 Take It Outside. 1996, English and French.
A media campaign to encourage physicians to be more active in promoting smoke-free spaces for children, increase media awareness, increase parental knowledge and motivate parents to have smoke-free homes. Campaign included print ads, transit ads for buses and TV spots.
Physicians for a Smoke-Free Canada
P.O. Box 4849, Station E, Ottawa, ON K1S 5J1
Phone: 613-233-4878 Fax: 613-567-2730
Website: www.smoke-free.ca
- W1 Women and Smoking Cessation. 1996, English and French.
Literature review on cessation, secondary analysis of national survey data on smoking patterns, a report of five focus groups with a total of 25 women.
Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366
Website: www.hc-sc.gc.ca/hppb/tobaccoreduction
- W2 Women and Tobacco. A Framework for Action. 1995, English and French.
Summary document on tobacco control issues related to women prepared as background for a national meeting. The document includes an overview of research findings on women and tobacco, available programs and resources, public policy issues, social marketing strategies and information on age groups and high-priority groups.
Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366
- W3 Workplace Smoking: Trends, Issues and Strategies. 1996, English and French.
This paper reviews the current state of knowledge about the exposure of non-smokers to ETS in the workplace. The paper's main objective is to provide information and analysis for planning actions to further reduce ETS exposure in the workplace. Arguing that more concerted action in the workplace is essential, the paper discusses the factors that will both inhibit and facilitate achieving this goal.
Website: www.hc-sc.gc.ca/hppb/tobaccoreduction
- Y3 Youth Smoking Survey, 1994 (Technical Report). 1996, English and French.
Research based on interviews with 23,761 youth aged 10 to 19 years. Results available on computer diskette, large print, audio cassette and Braille on request. Summary Fact Sheets also available.
Publications Unit, Health Canada
Phone: 613-954-5995 Fax: 613-941-5366
Website: www.hc-sc.gc.ca/ehp/ehd/tobacco/research/index.htm