Testimony
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The Impact of Smoking on Women's Health

Statement of

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Good morning, and thank you for inviting me to participate in this panel. My name is Cristina Beato and I am the Deputy Assistant Secretary for Health. Before joining the Department of Health and Human Services (DHHS), I served as the Associate Dean for Clinical Affairs and Medical Director at the University of New Mexico Health Sciences Center.

President Bush and Secretary Thompson have made women's health, prevention, and eliminating health disparities a top priority. As the 2001 Surgeon General's Report on Women and Smoking indicated, smoking-related diseases have truly become a women's health issue. Women who smoke are subject to all the same risks as men, including cancer, cardiovascular disease and chronic obstructive pulmonary disease. In addition, women are also at risk of infertility, adverse reproductive outcomes, altered menstrual function, lower bone density and increased fracture risk. Lung cancer surpassed breast cancer as the leading cancer death among women in 1987. However, we know what works to prevent initiation and promote cessation of smoking, and if we work together, we can achieve the Administration's goals of reducing prevalence of smoking among women to 12 percent or less, and among girls to 16 percent or less.

We have seen some success. The prevalence rate of smoking among women has declined since it peaked at 33.9 percent in 1965. By 2000, smoking prevalence among women was at 21 percent. Most of the decline occurred from 1974 to 1990. While the decline slowed in the early 1990s, rates have begun to decline more rapidly again in recent years. Smoking prevalence is higher among women living below the poverty level - nearly 30 percent - as compared to those above the poverty line- 20 percent. Education level among women plays a key role: among women with 9 to 11 years of education there is 31 percent prevalence; among women with over 16 years of education there is 8 percent prevalence. Prevalence rates among racial and ethnic populations adds another dimension to our need to better understand women and smoking. In 2000, 42 percent of American Indian or Alaska Native women, 22 percent of Caucasian women, 21 percent of African American women, 13 percent of Hispanic women and 8 percent of Asian/Pacific Islander women were current smokers. The prevalence rates among women are still much too high, but through our expertise, programs and funding we are continuing to work on lowering these prevalence rates.

The Surgeon General's Report on Women and Smoking includes a number of practical recommendations that will move us toward these goals. Today I would like to share with you some of the on-going and planned activities at the national and state levels that are designed to implement these recommendations.

Addressing the burden of tobacco within specific populations is essential if we are to achieve the President's and the Secretary's goals, and eliminate the disparities that exist in tobacco use and tobacco-related diseases. This is one of the reasons why the Surgeon General recommended expansion of the diverse constituency that is working on tobacco issues. Women of all ages, races, and ethnic backgrounds are affected by tobacco. To this end, DHHS has engaged in collaborations with a number of non-profit organizations through the Centers for Disease Control and Prevention's (CDC) National Networks Program. CDC funds, to name a few, the Association of Asian Pacific Community Health Organizations (AAPCHO); BACCHUS and GAMMA Peer Education Network; Employee & Family Resources; The Health Education Council; The Latino Council on Alcohol and Tobacco (LCAT); and the National Hispanic Leadership Network for Tobacco Control. These networks represent eight priority populations to prevent and reduce the use of tobacco and exposure to second-hand smoke. These non-profit organizations reach women and girls, and one organization focuses exclusively on women. In addition, CDC funds seven tribal-serving organizations: Aberdeen Area Tribal Chairmen's Health Board (AATCHB); Alaska Native Health Board (ANHB); California Rural Indian Health Board (CRIHB); Intertribal Council of Arizona (ITCA); Muskogee Creek Nation Northwest Portland Area Indian Health Board (NWPAIHB); and the Inter-tribal Council of Michigan. They have been funded to begin to build capacity in the Native American/Alaska Native community, where the prevalence of tobacco use among women is the highest.

The Surgeon General's Report on Women and Smoking states that success in reducing tobacco use will require implementation of programs that focus on prevention and cessation. Women who stop smoking greatly reduce their risk of dying prematurely, and quitting smoking is beneficial at all ages. The recommendations of the Task Force on Community Preventive Services provide a solid scientific foundation upon which to build our efforts to promote cessation among women. The *Guide to Community Preventive Services* was produced by the independent non-governmental Task Force on Community Preventive Services and staffed by the CDC. The *Guide* recommends several interventions to encourage tobacco use cessation: provider reminder systems alone or in combination with provider education programs, and cessation quitline services are some of the recommended interventions. We know that women are more likely than men to be willing to access assistance when they try to quit, and that using assistance increases the likelihood of success. Therefore, the Department and its partners are working to improve the availability of cessation treatments to all women who smoke. Some states have developed quitlines that are designed to increase access to and reduce the cost of cessation treatments. States also are taking steps to ensure that an increasing number of women have access to these services. Research has demonstrated that behavioral counseling is effective alone and can enhance the efficacy of pharmaceutical treatment; however, rates of utilization of most counseling options have been very low. Experience has shown that smokers are more likely to use a telephone quitline than to attend cessation classes. Telephone counseling is attractive because it is more accessible and private. Telephone counseling has also been shown to reduce ethnic disparities in the use of smoking cessation services. In California, both African American and Hispanic smokers are active participants in the statewide quitline, with the

latter especially encouraged by the availability of Spanish language services and materials.

The California Smokers' Helpline was initiated in 1991. The California Smokers' Helpline is available in six languages (English, Spanish, Mandarin, Cantonese, Vietnamese and Korean) and has a TTY line for the hearing impaired. Protocols are tailored to adults, teens or pregnant callers. The Helpline currently serves about 45,000 callers per year, of whom 34 percent are ethnic minorities. The quitline's protocol has demonstrated its effectiveness through a large randomized trial that indicated that overall the quitline doubled cessation rates. Smokers who received multiple telephone counseling sessions had a higher one-year quit rate than those who received only one session. Other studies have confirmed these results.

Smoking can affect women's ability to get pregnant, increasing their risk of conception delay and infertility. The good news is that smoking among pregnant women has declined from 19 percent in 1989 to 13 percent in 1998. Sadly, that 13 percent means too many pregnant women and girls continue to smoke. Infants born to women who smoke during pregnancy have a lower average birth weight. Women smokers also are less likely to breastfeed their infants. Eliminating maternal smoking may lead to a 10 percent reduction in all infant deaths and a 12 percent reduction in deaths from perinatal conditions. Furthermore, because women are more likely to stop smoking during pregnancy than at other times in their lives, it is vital that we seize this opportunity to reach out to women during pregnancy to assist them in quitting for good.

It is also important to recognize that direct smoking is not the only way in which women are exposed to the dangers of tobacco. The Surgeon General's Report on Women and Smoking concludes that significant, prolonged exposure to environmental tobacco smoke (ETS) is a factor in lung cancer and coronary heart disease among women who are lifetime nonsmokers . Furthermore, infants born to nonsmoking women exposed to ETS during pregnancy have a small decrease in birth weight and a slight increase of intrauterine growth retardation compared to infants of nonexposed women. Some women continue to be exposed to a completely preventable health hazard.

The age of initiation of smoking is an important indicator of smoking behavior. Smoking initiated at an earlier age increases the risk of smoking-related illness or death. The risks associated with smoking at an early age make it imperative that we focus on young girls and make sure they never start smoking.

Comprehensive programming at the state level plays an important role in reducing smoking among women. CDC's "Best Practices for Comprehensive Tobacco Control Programs" provides an evidence-based analysis that can help states determine funding priorities, plan, and execute effective comprehensive tobacco control and prevention programs. Following the start of the statewide tobacco control program in 1989, lung cancer rates among women in California have declined even though they are still increasing for the rest of the country. This decline underscores the importance of investing in tobacco control at the state level. Other states are seeing dramatic results as well. For example, in Massachusetts, rates of smoking during pregnancy have dropped sharply, from a prevalence of 25 percent in 1990 to 13 percent in 1996. Most of the decline occurred after 1992, when the Massachusetts Tobacco Control Program was implemented with funds from an increase of the tobacco excise tax. In comparison, nationwide prevalence of smoking during pregnancy declined much more slowly during the same period. With the support of a dedicated excise tax, Arizona was able to begin funding a comprehensive tobacco control program in 1996 that includes all nine *Best Practices* components. Between 1996 and 1999, smoking prevalence declined significantly in Arizona among all groups including women, Hispanics, and people with low income and low education. Other states are now beginning the process of developing comprehensive tobacco control programs and, as a result, interesting and innovative state-level efforts are beginning to proliferate. I will highlight some of these state-level programs, as I discuss some of the other recommendations in the Surgeon General's Report.

Several of the Report's recommendations focus on increasing awareness of the health effects of tobacco on women and on boosting knowledge that non-smoking is the norm among women. Without increasing this type of awareness, we are unlikely to see expanded efforts that address this growing epidemic at either the individual or the societal levels. In response, DHHS has collaborated with the internet-based services providers Oxygen Network and Thrive Online to develop *Women and Smoking: 7 Deadly Myths*. This 17-minute educational video premiered in 2001 on Thrive Online and is now available on video. This past fall we released a tool kit that we developed that will accompany the *7 Deadly Myths* video. The tool kit contains materials and ideas to help women's organizations spread the message about women and smoking in a variety of ways. The video, along with the tool kit, has helped women better understand the common myths about smoking and empowers women to stay smoke free.

At the state and local levels, activities designed to promote awareness are increasing. For example, the Wisconsin Tobacco Control Board, drawing on revenue from Wisconsin's settlement with the tobacco industry, funds the Wisconsin Women's Health Foundation to implement the "First Breath" program, which offers counseling to pregnant women at regional Prenatal Care Coordination and the Department of Agriculture's Women, Infants and Children (WIC) sites. The program also includes educational materials, information about how to use the state telephone quitline, and opportunities to join local support groups. Program sites have been established in all regions of Wisconsin, including two tribal clinics. These initiatives are implemented on a pilot basis.

In Washington state, the state tobacco prevention program plans to provide training to Maternity Support Services and WIC staff on providing a brief cessation intervention to pregnant women, including information on reduction of exposure to secondhand smoke and motivational interviewing. The program plans to implement the Tobacco Cessation During Pregnancy performance indicator for all Maternity Support Services staff to ensure that

all women enrolled in the Medicaid Maternity Support Services program receive counseling on smoking cessation and on reduction of exposure to secondhand smoke.

DHHS continues to be a leader in tobacco counter marketing efforts, and is pleased to have enlisted the aid of numerous celebrities in our counter marketing initiatives. This year we unveiled a new poster campaign featuring celebrity spokes-model Christy Turlington. The poster, entitled, "Smoking Is Ugly," illustrates that lung cancer kills more women than breast, uterine, and ovarian cancers combined. We are also proud of our forthcoming television public service campaign featuring TV star Esai Morales *of NYPD Blue*. This new initiative, which will be launched later this month, will be aimed at decreasing tobacco use in the Hispanic community. Furthermore, Secretary Thompson has urged the entertainment industry to expand its role in discouraging women and girls from smoking:. In a speech before the National Council for Families and Television in January of this year, the Secretary stated, "We need help in reaching our young women with a very simple message: Smoking is not glamorous. Smoking is deadly. We as a society must not glorify smoking. Ever. The televison industry and the federal government can be powerful partners in delivering that messages to women and girls throughout America and around the world."

In conclusion, there are some exciting innovations in tobacco prevention and cessation that have already begun to reap results. However, many challenges remain. Nowhere is this more clear than in the area of research. The National Institutes of Health, and in particular the National Cancer Institute, is leading the research effort for the Department. To move the research effort forward, NCI is working with both public and private partners to set priorities and promote action on effective intervention strategies. These efforts include the Transdiciplinary Tobacco Use Research Centers which are public-private collaborations at seven sites around the country to understand the biological, behavioral and cultural factors that explain why women smoke and how to help them quit. In addition we will 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 new products. The Surgeon General's report reviewed some of the literature on women and smoking, but there is still much more that we need to know.

As the science advances I think it is critical that we continue to address this preventable women's health issue. President Bush, Secretary Thompson, and DHHS with all of our partners can be successful in meeting the challenges ahead. We appreciate your interest in this issue and look forward to working with you. I would be happy to answer any questions.