aimed at hindering local, national or international tobacco control efforts and to demand from the authorities the adoption of policies that prioritize the health and quality of life of their people over the industry's profits. In addition, health professionals need to take a stand against the pervasive and negative influence of tobacco industry money in many aspects of our society. It is not easy to keep away from the tobacco industry sphere. The presence of their resources, products or influence is not always that visible. Health professionals should have a greater awareness of this influence than the rest of the population. Banning the sale and consumption of tobacco products on their premises; refusing to accept funding from the tobacco industry for their projects or research; and possibly having a declaration of interest for their associations, members and partners that regulates interaction with the tobacco industry are ways of raising awareness and keeping away from this undesirable influence. All of the above points are listed under the code of practice approved and adopted during the Geneva meeting.

In addition, by developing alliances with health professionals in other areas, the awareness of the tobacco industry's influence can grow and be countered more efficiently. This is why it is so important that all health professionals be involved in tobacco control, and not only those that encounter the more obvious consequences of tobacco use. The actions of health professionals who are interested in setting an example as well as changing policy and public opinion should go beyond their strictly clinical or individual patient duties.

Such was the approach taken by the Canadian Medical Association (CMA) in August 2004 when it called on the Canada Pension Plan to end its investment in tobacco industry stock, stating that it undermines public-health efforts. The association received the support of Canada's Health Minister, who said he was shocked and angered to learn that almost CAD$ 95 million in pension contributions had been invested in the tobacco industry.[XXIII]

A similar approach was taken by a group of students in Edinburgh, who initiated a campaign in November 2004 to persuade Edinburgh University to divest itself of tobacco industry stock, arguing that there was a conflict between the university's medical research and its shares in companies such as British American Tobacco.[XXIV]

BARRIERS TO HEALTH PROFESSIONAL INVOLVEMENT IN TOBACCO CONTROL

Some barriers to the full involvement of health professionals in tobacco control do persist:

1) Lack of knowledge and skills about tobacco and tobacco control:

Health professionals' curricula lack, in general, appropriate content and practice on tobacco-related matters, from prevention to cessation and policy. Although some general aspects of harms to health might be covered, the full extent of the tobacco epidemic, the breadth and depth of the problem might be overlooked. Given that tobacco is one of the most significant causes of preventable illness and death in the world, health professional schools may need to reassess the time they dedicate to this issue (Article 6 of the code of practice).

2) Lack of organizational leadership:

In many parts of the world, health professional organizations have not yet joined and lent their voice to tobacco control efforts. Many remain unaware of the epidemiological aspects of tobacco use and its impact in the world's health. This is slowly changing, with some international-level organizations taking action, and some national organizations becoming more involved in all aspects of tobacco control. But much remains to be done for all health professionals to be able

to accept that tobacco control is part of every health professional's practice.

3) Continued tobacco consumption among health professionals:

In many parts of the world health professionals continue to use tobacco, often at a rate similar to – if not higher than – that of the general public. The latest available data from the Tobacco Atlas on line show that in China, for example, there is a smoking prevalence of 61.3% for male physicians, while in general, 66.9% of the male population smokes. However, for women, the prevalence among physicians is nearly three times that of the general female population (12.2% vs 4.2%). In Russia, the prevalence for female physicians is also higher (13%) than for the general female population (9.7%), which shows the epidemic's expansion among women. In Spain, the prevalence of smoking among female physicians is high, and among female nurses it is higher than that of the general female population.[XXVI] It is common knowledge that health professionals who consume tobacco themselves are often less likely to engage in tobacco control than their non-tobacco-using counterparts. Health professional schools and organizations need to make an effort to provide support for members who want to quit using tobacco. In fact, a 2003 survey of several countries showed that nurse and physician smoking rates respond to the levels of tobacco control activity in a country. In countries where tobacco use prevalence is declining, smoking among health professionals is also declining. In countries where tobacco prevalence is rising or stable, prevalence among health professionals, mainly women, is also rising.[XXVIII]

Nurses are a group of health professionals with a traditionally high smoking prevalence.

Global Health Professional Tobacco Survey

While health professionals, including physicians, pharmacists, nurses and dentists play a major role in tobacco control, tobacco consumption in this group is often high. Many countries have requested technical assistance in monitoring tobacco use among health professionals. In collaboration with WHO, the Centers for Disease Control and Prevention (CDC) is conducting a pilot survey to monitor tobacco-related issues among different health professionals. Since the survey follows the same methodology of established global tobacco surveys such as the Global Youth Tobacco Survey (GYTS) and the Global School Personnel Survey (GSPS), health professional students in the third year of dentistry, medicine, nursing and pharmacy have been chosen to participate in the pilot. The rationale is based on previous experience and cost effectiveness of school-based and self-administered data collection from students of the Global Youth Tobacco Survey. The study also includes questions on knowledge of and attitudes towards tobacco control and education/training on tobacco-related issues. The study has a two-fold objective: first, it would serve as a global surveillance system for adult tobacco consumption and other tobacco-related issues, taking this group of the population as a proxy, and second, it would monitor tobacco consumption patterns among health professionals. In that respect, the study would identify the elements needed to achieve a reduction in their consumption and it would help them implement tobacco control measures and act as advocates for tobacco control in their respective countries. The GHPS is being pilot-tested in each of the six WHO regions. The sites included in the pilot are: Albania, Argentina, Bangladesh, Bosnia and Herzegovina, Croatia, Egypt, India, the Philippines and Uganda. The results are expected in the next few months. Apart from providing us with preliminary data, the pilot survey results will help in evaluating how appropriate the methodology is and will assist in the design of the global survey.

The Tobacco Free Nurses Initiative was created in the United States to help nurses' patients to quit smoking as well as help other nurses to do the same. They describe themselves as "…nurses who want to benefit nurses and patients, and promote a tobacco-free society".[XXIX] It is an example of the kind of initiatives needed to help health professionals to quit tobacco use themselves.