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**LATINO
COUNCIL ON
ALCOHOL &
TOBACCO**

LCAT

Latino Council on Alcohol and Tobacco

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◆ LCAT NEWS ◆

Volume 11, Issue 3

Summer 1997

Don't repeal the beer tax!

LCAT joins CSPI and NCADD in protest of bill to lower beer taxes. On May 15, LCAT, along with the Center for Science in the Public Interest (CSPI) and the National Council on Alcoholism and Drug Dependence (NCADD), participated in a protest against HR 158, legislation that would reduce federal excise taxes on beer.

In 1991, the tax on a 31-gallon barrel of beer was \$18, which amounts to roughly 5 cents per 12-ounce serving, or 32 cents per six-pack. Had the tax, which was originally imposed in the 1950's, kept up with inflation, today the tax on the same barrel of beer would be approximately \$49, or 84 cents per six-pack.

In 1996, beer taxes contributed more than \$3.3 billion to the U.S. Treasury, only a small fraction of the enormous economic societal costs generated by excessive beer consumption. Adjusting the tax rate for inflation and requiring automatic inflation adjustments in the future would provide billions more dollars to the treasury and help reduce the cost of alcohol problems, particularly among young people.

At the May 15 protest all members of Congress received empty beer bottles

The American people strongly support excise tax increases

⇒ **87% FAVORED A 50 CENT TAX INCREASE ON A SIX-PACK OF BEER (WSJ/NBC-TV NEWS POLL,**



3/12/93)
⇒ **77% SUPPORTED THE SAME BEER TAX INCREASE IN A 4/93 WASHINGTON POST/ABC NEWS POLL.**
⇒ **ONE MONTH LATER (5/93), A GALLUP POLL FOUND AN ALCOHOL TAX INCREASE TO BE THE MOST POPULAR OPTION AMONG A RANGE OF TAX INCREASES, AT 75% APPROVAL.**

bearing labels proclaiming "A child's life is worth more than cheaper beer." The results of a study showing that an increase of the tax would save 600 young lives each year was released at the protest. The tax increase would also decrease school dropouts, crime, unwanted pregnancies, accidental deaths, and numerous other injuries and social and economic costs to society. Other studies have previously shown that lowering the beer tax would increase the frequency of drinking among youth.

While teenagers distributed the beer bottles in the background, representatives from CSPI and NCADD spoke to members of the press. Latino and African American teenagers that supported LCAT's work were interviewed by *Bill Moyer's Journal* on their personal experiences with alcohol and underage drinking. The teens interviewed felt that higher prices would reduce consumption and violence in their neighborhoods and schools.

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Alcohol Tax Equalization

Rep. Eleanor Holmes Norton reintroduces "Alcohol Tax Equalization Act of 1997". Concerned that the July 4th celebration would once again result in accidents, violence and other dire consequences for those young and old who insist on celebrating by consuming too much alcohol, Rep. Holmes Norton on June 24th reintroduced a bill that would raise beer and wine taxes to the same level as the tax on hard liquor. She said: "Beer is what America, and especially young America, drinks. In 1995, 60.3% of all alcohol sold was beer and 11.4% was wine. Only 28.4 % was hard liquor. America is getting drunk on beer and wine. It is time for the taxes on beer and wine to reflect their alcohol content. A can of beer, a 5 ounce of wine, a wine cooler and a shot of vodka are the same thing." Alcohol equivalence is a reality. A drink, is a drink, is a drink! Taxes have not reflected this. Beer and wine taxes are almost half of those imposed on liquor. This bill will increase taxes on beer and wine and will discourage teens from drinking. If you want a copy of this bill call (202) 225-3002.

FCC Deadlocked on Hard Liquor Ads on TV

On July 9th, the Federal Communications Commission (FCC) voted 2-2 on whether to investigate liquor advertising on TV and radio. Despite Reed Hundt's efforts to have an investigation take place, Commissioners Quello and Chong did not budge from their previously stated position. Quello argued that the FCC should wait until the FTC comes out with a "report" on

their investigation on deceptive TV advertising, even though a "report" may not be forthcoming for some time. He also argued that the key members of Congress in charge of the pertinent committees stated that they don't consider this an FCC matter. For Quello, the less you do, the better. Yet, the less the FCC does, the more it risks harming our country's children. According to a survey conducted by the alcohol industry, 73% of the public believes alcohol advertisements are a major contributor to underage drinking. Over 50 percent of teen mothers conceive under the influence of alcohol, and 60 percent of young violent crime victims are found to have alcohol in their system. When will we finally wake up and demand regulation? Latino and minority groups are encouraged to monitor both Spanish and English local radio stations and TV cable channels to determine the content, time, frequency and actual lyrics of the ads. LCAT intends to submit a petition to the FCC for a Notice of Inquiry on advertising in Spanish and/or directed at Spanish-speaking audiences. *Please tape the radio and TV messages. We need this data to request special counter-advertising messages down the road. Seagram's, Allied Dome (Kahlua) and International Distillers (Heublein) have been advertising on TV. Keep an eye on BET, Univision and Telemundo. Those of you who listen to Spanish radio, please listen for these ads. Let's keep up the pressure, by providing data on occurrence. If you want more information call CSPI at (202) 332-9110 or NCADD at (202) 737-8122.*

Hard liquor ads may be trickling onto cable and ethnic networks, as well as radio stations. Please tape them and send them to LCAT.

TOBACCO SETTLEMENT DISCUSSIONS GET SENT UP TO THE WHITE HOUSE!

The Settlement does address important issues that will improve public health. It doesn't address other vital issues for minority communities. We need to be at the table making recommendations not just saying No. As we oppose we can propose.

July 11, 1997. After the hoopla and celebration by the Attorneys General the day of the "Global Tobacco Settlement" announcement and after the closing meeting of the Koop/Kessler Committee deliberations, the talks move to the White House. From news accounts and reliable sources inside the White House, all the players will be asked to say their piece about the Settlement and the "Blueprint for Tobacco Control" (Koop/Kessler). LCAT has requested a meeting not just to present LCAT's point of view, but to give the opportunity to minority representatives from the Tobacco Control Networks of California, American Indian, Asian and African American groups nationwide to have a chance to express themselves directly at the White House. Our moment will come the week of July 21st. If it doesn't, we will complain.

LCAT's position is:

1) From the beginning of this process, minority communities were not represented in the Settlement negotiations and underrepresented on the Koop/Kessler Committee. Therefore, minorities have been excluded from the process, just as they have been excluded from most national tobacco control and policy activities in the past. In such states as California, state-assigned funds have made a difference since prevention programs have been designed and implemented by and for

minorities.

2) Minorities have been specifically targeted by the tobacco companies since before the early 1960's and have received a double dose of advertising (i.e. in Spanish and English). The minority leadership has been effectively silenced by sponsorships of conferences, civil rights, political and social organizations, as well as the arts and sports, where groups have received "philanthropic" support. The minority political leadership has received Tobacco PAC funds, as have most politicians, and, therefore, has not confronted the tobacco companies.

3) Congress and local legislatures still are essentially pro-tobacco, even though some states have raised taxes on tobacco and banned vending machines and billboards advertising tobacco. This Congress' \$0.20 tax increase in the child health bill is still in trouble, even though the initial proposal was for a \$1 increase, then fell to \$0.43 and finally settled at \$0.20. And is still in trouble.

4) Appropriations for the FDA's tobacco rule, proposed at \$34 million, have already been cut to \$15 million at the Subcommittee level and it is still uncertain whether that whole amount will come out of the budget reconciliation process. The Administration's Tobacco Rule was good, but if Congress doesn't appropriate funds for its implementation, it

The Tobacco Settlement continued....

will simply stay on the books and not spring into meaningful campaigns to request ID. The other provisions to limit advertising that would really curb tobacco use among children is still pending in the 4th District Court. FDA financing requirements and Congressional reaction to them gives public health advocates a "read" on what can happen if we rely solely on funding from Congress for greater public health campaigns. For years, Surgeon Generals have talked about the public health consequences of smoking, yet the budgets requested or allotted for tobacco control have not mirrored these concerns. Minorities have not been active, and we should admit this.

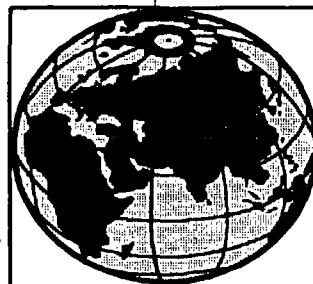
5) LCAT has no expertise to comment on the effectiveness or impact of litigation on the industry or the public health community as a whole, only that ETS rules may be strengthened. Minorities have traditionally not been a party to litigation either individually or through class action. As we understand it, some Attorneys General have been successful in obtaining compensation for state expenditures on tobacco-related illnesses and the settlement does pay for 40 AG suits. There are more AG cases in the pipeline that may hurt the tobacco companies, such as the Minnesota case. The Liggett Settlement and others have brought to light documents that show the insidious lies and deceptions of the industry. And the Minnesota AG attests to have many more documents that, when they see the light of day, could improve chances for litigation. The litigation process, if continued successfully, could in time break the financial stability of the industry and that has been

one of the reasons why they went for the settlement. But this could be a long and treacherous road, with some results for individuals and class action cases. But what does all of this really mean in terms of public health gains?

6) The Settlement does effectively address issues of youth access, advertising and marketing, and if modified fairly, with specific funds assigned to cover specific minority concerns, could in the future curb smoking addiction in America.

BUT it doesn't fully address other important issues such as :

- The FDA's ability to regulate nicotine and tobacco products, including company oversight and its impact on black market. It should incorporate cigars in the definition of tobacco products.
- The inability to file class action suits against tobacco in the past and the future—the poor and minorities will likely not be able to file individual suits.
- Inadequate penalties for failing to reduce children's use, and remedies not specifically targeted at ethnic minority groups.
- High tobacco prices will be a burden to the poor, women and minority adults who are hooked, affecting their ability to buy basic items. The poor will pay for settlement costs.
- A black market will be created that will likely take hold in minority inner city communities.
- It doesn't deal with the need for international tobacco control activities, thereby putting the world's children at risk. Minority immigrant populations are particularly affected. The percentage of the world's cigarette consumption in 1995 indicates that 91% is consumed outside the US and only 9% inside the US market.



World Cigarette Consumption:

32% People's Rep. of China
 12% Europe
 9% United States
 6% Japan
 13% Other Asian countries
 28% Other countries
The Washington Post, 7/7/97

(For a complete analysis of LCAT's concerns with the tobacco settlement, please contact us at 202-371-1186).

The Settlement is a politically "realistic" option and may provide a viable solution for tobacco control at this political time; but has serious consequences and omissions. In order for LCAT to support it a legislative package based on the settlement, it must deal effectively with the issues mentioned above and consider inserting the following recommendations:

Domestically:

- FDA should have full authority to regulate nicotine and all ingredients in tobacco products.
- Cigars and all tobacco products should be regulated.
- Tobacco company penalties for not curbing youth cigarette use should be raised considerably per percentage point and determined by ethnic/racial and gender-specific statistics. If the percentage of young white smokers decreases, so should the percentages of all ethnic minorities and genders. These penalties should not be tax deductible.
- Cessation programs need to be promoted and targeted at specific ethnic/racial groups, for adults and adolescents. Funds should be available to purchase nicotine patches, gum and other products and/or make these products affordable to low income smokers. Funds should be allotted according to the ethnic and gender composition of each state, to minority entities to design and implement continuous, culturally sensitive and language appropriate cessation education and counseling programs.
- Public education and prevention campaigns should be in the appropriate language and have culturally sensitive and gender sensitive messages. Multimedia campaigns should be funded through minority-owned advertising agencies, newspapers, magazines, radio and television stations that focus on each of the ethnic minority populations. These funds should be appropriated according to potential viewership and/or readership at the community level. American Indian publications should be funded in order to incorporate appropriate messages.
- The Scientific Advisory Panel should fund research to determine how minority communities will be affected by all provisions of the agreement, including: youth access, marketing, advertising,

sponsorship, cessation, public education, addiction rates and consequences of various brands and types of tobacco products (Cubans and cigars, African-Americans and mentholated cigarettes, American Indians and smokeless tobacco, etc.) and recommendations and funds should be correspondingly allocated.

- A specific percentage of the \$ 75 million assigned to compensate for loss of sponsorship by the tobacco industry to minority cultural, political, social, economic, arts, sports, education and health national and community groups should be provided for minority lead and related groups. Minorities should determine process of allocation of resources.
- The Koop/Kessler recommendations on compensation to small tobacco farmers should be incorporated into the Settlement.
- The exception of "adult only" facilities in the Settlement should be revisited, taking into consideration that places such as casinos, nightclubs, liquor stores, bars, etc., are disproportionately located in minority communities. Adult only facilities could include bingo salons, lottery outlets, etc., but before making this determination feedback should be obtained from minority leaders.

Internationally:

- HHS should assign a yearly portion of the \$50 million it will receive to international control activities. This should be done through the World Health Organization. A portion should specifically be earmarked for PAHO's inter-agency Tobacco Control Task Force. Funds should be used to standardize tobacco control worldwide, restricting advertising, promotion and sponsorship.
- US tar and nicotine levels and non-tobacco ingredient regulations should apply worldwide to US owned companies, including its subsidiaries.
- All US exported cigarettes should have warnings in language of port of entry.
- Add other Koop/Kessler provisions, such as restrictions on government promoting tobacco abroad.

Beer Sting in Washington, DC

LCAT participated in CSPI's sting on Washington DC beer retailers. On May 19, the Center for Science in the Public Interest (CSPI) released the results of a sting operation performed with LCAT's support to show the ineffectiveness of the beer industry's national "We ID" campaign. The "We ID" campaign distributed stickers to retailers who sell beer to promote age checks. To prove that young people without proof of age have little trouble buying beer, CSPI had adults who look under 21 attempt to purchase beer at retailers in the area. Unfortunately, the sting proved successful—62.5% of the time the purchaser was able to buy beer without using any proof of age. "Kids don't need fake IDs in DC," said George Hacker, Director of CSPI's Alcohol Policies Project, "many retailers just don't check." Representatives from the Latin American Youth Center and 'Cause Children Count Coalition also shared their views at the press conference, whose audience included representatives from FOX News, News 7, ABC, and reporters from the *Washington Post* and *Washington Times*. Copies of the press release and study conducted are available at CSPI (202) 332-9110, ext. 341.

The "We ID" campaign doesn't work. 62.5% of the time kids can purchase beer without being asked for ID!

SMOKING CESSATION

LCAT, 'Cause Children Count Coalition and LAYC co-sponsor their first training for Latino Smoking Cessation Facilitators. A group of 18 enthusiastic and dedicated young people (most under 21) met in May and June for five sessions to become smoking cessation facilitators. Representatives of the Latin American Youth Center (LAYC), the PTA of Bell Multi-Cultural School, Americorps and neighborhood students took the course that was held at LAYC's offices. Roberto Noriega of the Tobacco Control Department of DC's Health Department held the bilingual workshop. He distributed a training manual in Spanish and provided materials in both languages. In order to teach by observation, sessions included five people who wanted to quit smoking, and the facilitators who wanted to become cessation facilitators observed the process. Three of the smokers quit through this workshop. If you want to learn more about follow up activities in the Latino community, please contact Dr. Carmen Duran at LAYC (202) 265-9225. Cessation programs for youth start in the fall.

FDA makes ID poster available in Spanish.

The Food and Drug Administration (FDA) is printing 10,000 posters in Spanish to allow national and community groups to distribute them to retailers across the country. The attached poster is a small, black and white version of the color poster. If you would like to receive copies of the color poster please contact the following number: **1-888-FDA4KIDS**. Retailer brochures in English are available in the tobacco section of the FDA's web site, www.fda.gov. Please feel free to copy and post the attached mini-poster. HHS will hold a National Hispanic Health Symposium, "Building a Healthy Nation", Sept. 11-13, 1997, in Los Angeles. Call (202) 797-4313 for more information.

¿Cuál de Las Dos Tiene 16 Años?



Lena



Anita

Photograph by Roda Bae

La venta de cigarrillos o tabaco para mascar, a cualquier persona menor de 18 años de edad es ilegal.*

Para eliminar las dudas, los comerciantes deben verificar la edad de los compradores menores de 27 años.

Si usted tiene menos de 27 años favor de mostrar su tarjeta de identidad con su fotografía. Solamente toma un momento. Si usted tiene menos de 18 años, ningún comerciante puede venderle productos de tabaco.

Lena tiene 16 años. Anita tiene 25 años.

*La edad mínima es más alta en algunos estados.



ADMINISTRACION
DE DROGAS Y ALIMENTOS

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*Committed to combat-
ing alcohol & to-
bacco related harm
and their underlying
causes in the Latino
Community.*

In This Issue...

Don't Repeal Beer Tax, FCC on Hard Liquor Ads, Tobacco Settlement.....

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◆ LCAT NEWS ◆

Volume II, Issue 2 Special Tobacco Issue

Spring 1997

The Latino Council on Alcohol and Tobacco (LCAT) is dedicating this issue to tobacco control. We will be sending our members an update of recent activities and alcohol policy developments in our Summer issue.

DID YOU

KNOW THAT?

- ◆ 19.5 % of Latino adults (24.3% of men and 15.2% of women), are currently smokers.
- ◆ A 1990 survey showed that, among Latinos living in the US, Cuban (64.1%), and Puerto Rican (52.3%) men were most likely to be heavy smokers, (1+ pack(s) per day), compared to 33.8% of Mexican American male smokers.

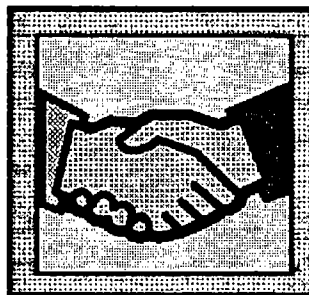
Campaign for Tobacco-Free Kids. 1997

Tobacco Settlement? Maybe. Will it blow up in smoke and/or protect public health interests? Who is or should be at the table?

Spring 1997 will be remembered by many tobacco control advocates as a series of rounds in a boxing match against the tobacco giants. Sometimes tobacco winning, sometimes losing, but mostly as a tough fight whose outcome may be ultimately decided by a technical knockout, or called off in favor of a negotiated settlement. Who are the fighters? Attorneys general, plaintiffs' lawyers, tobacco CEOs, smokers that are dying prematurely and some longtime tobacco control advocates are in the ring.

Will a "Deal" protect the health and interest of all Americans?

But, if there is a settlement, who represents the public health community at the negotiating table? Will it be better to fight to the 10th round or settle? If tobacco advocates are at the table, can they be free to walk out? The giants have duped us in the past, will they get what they want at the expense of public health? What is best for the health of the nation? What is best for the public health con-



cerns of the whole world: fight or settle? Who should be at the negotiation's table representing public health interest at large? At this moment, it appears that Matt Myers of the Campaign for

Tobacco-Free Kids

will be doing the punching, some others joining in as it evolves. But can one or two advocates really represent all sectors of the tobacco control movement? Who is representing the point of view of communities of color? Why should these negotiations be done in a secretive and selective manner? Why should we be left out?

Round one: Dr. David Kessler, as Commissioner of the Food and Drug Adminis-

tration (FDA), was able to push an FDA Tobacco Rule that gave the FDA the authority over nicotine since FDA proved it was a drug, and cigarettes were devices that delivered this addictive drug to the public. The FDA demonstrated that tobacco companies tampered with tobacco in order to increase the levels of nicotine delivered through cigarettes. The FDA also proved that many of the "additives" were specifically selected because they increased the nicotine "punch" for smokers. Lastly, the FDA made a strong case for regulating the sale, distribution, advertising and promotion of cigarettes since these were luring children into becoming addicts before the age of 18. President Clinton supported Dr. Kessler and the final rule was approved. On February 28th, 1997, in most states, sales clerks started asking for photo ID's for those under 27 years of age before selling them cigarettes; no cigarette sales to anyone under 18 or higher in some states.

Round two: The Liggett Settlement brought to light docu-

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Tobacco Settlement? Maybe. Will it protect the gains achieved..

ments that proved that tobacco companies knew that nicotine was addictive and that they were deliberately targeting youth and minorities. Liggett broke the code of silence forcing tobacco executives around the country to admit that they purposefully produce, promote, advertise, and sell an addictive drug that damages vital organs and ultimately is responsible for a smoker's death.

Round three: The tobacco companies sued the federal government claiming the FDA has no jurisdiction over nicotine or over the advertising of these products. North Carolina Judge Osteen's decision was a surprising victory for tobacco control since it sustained the FDA's jurisdiction over nicotine, as a "drug" or as a "device," but a setback since it ruled that the FDA cannot rule over advertising to children. The decision will be appealed by the tobacco companies and the government alike. If the decision is upheld, Judge Osteen's ruling would give great power to the FDA and this gain cannot be watered down or blown away in any "settlement" negotiation.

Round four: Before round three was decided, pressure mounted against the two largest cigarette makers Philip Morris Cos. and RJR Nabisco Holdings Corp. representing themselves as well as major US tobacco companies, Loews Corp's Lorillard and B.A.T.

Industries PLC's Brown & Williamson's unit, who made an unexpected move by seeking a deal. They are besieged by current mounting liability lawsuits and a black cloud over their future profits; they want to pay now, and ensure their future profitability. In addition, the non-smoker's rights movement has successfully promoted ordinances prohibiting smoking in public and some commercial spaces. After recent insider document disclosures made it evident that tobacco companies knew of the dangers of their addictive products and deliberately marketed them to teenagers. (Tobacco executive's 1994 Congressional testimony is a joke.) Tobacco wants to pay now and be free from future liability. But as the "settlement" talks get underway, the tobacco companies seem to be backing away from requiring "immunity" for their "\$300 billion fund" to settle all smoking-related claims brought by individuals and states in exchange for complete legal protection. Finally we are heading a resounding "NO" to blanket immunity! But will this hold through the round of negotiations starting in May in Dallas? Some think that there is only a 50-50 chance the negotiations will proceed. Others believe that since the tobacco companies are on the run (even if they "win" some individual cases) settlement is a give away.

Round five: Technical Knockout or Settlement. Negotiations are going on

and maybe they will result in a settlement whether the public health community agrees with it or not. And/or whether communities of color as a whole or representatives of individual constituencies are at the table or not. Some newspaper articles, editorials and OpEds question whether the Campaign for Tobacco-Free Kids has the "authority" to negotiate for the public health community and/or whether the attorneys general interested in recuperating funds immediately are the best suited to negotiate the future. What is necessary is to carry out an open discussion as to what is best for the nation's children, the world's children and public health in general.

LCAT believes that a settlement at this point of the game is premature. Negotiations are going on, whether we like it or not. Latinos and other minorities should make their positions known to the attorneys general, the Campaign for Tobacco-Free Kids (see article), the major groups, and the general public. We don't want to be sold out; we insist that minority concerns be heard and taken into account. Communities of Color will not stop fighting until our communities are not targeted by tobacco and the world's children are protected and free from all worldwide marketing strategies and sales.

Communities of Color take a position on the Settlement ...continues page 3

Members of NAAAPI, African American, Asian, American Indian and Latino organizations as members of Communities of Color in the US are concerned about the content and form of negotiations currently underway between the tobacco industry and attorneys general and lawyers for victims of tobacco. Our major concerns are in three areas:

1. As African-Americans, Asian Americans/Pacific Islanders, Latinos/

Hispanics, Native Americans and Alaskan Natives, we understand that tobacco use and abuse has impacted each of our communities differently and that the tobacco industry has deliberately targeted our communities in various ways. Since people of color are not included "at the table" in these negotiations and discussions, we are concerned that the issues currently being brokered do not fully address our concerns as racial groups, ethnicities and tribal nations. Our fear is

a settlement that is negotiated without our voices as part of the discussion will continue to leave our communities vulnerable to the ravages of tobacco.

2. With respect to the issues being negotiated by the Attorneys General, the major reason for the litigation is that public monies are being spent on health services to persons with illnesses caused by tobacco.

Campaign for Tobacco-Free Kids at the table.

On April 24th, 1997, the National Center for Tobacco-Free Kids sent a Dear Colleague letter. What follows is a partial presentation of what it says. "As you know, discussions are taking place among representatives of the tobacco industry, state attorneys general, plaintiffs' lawyers and others. We have been involved, not as an official representative of any other organization, but to represent a set of public health principles. Because of your commitment to protecting children from tobacco addiction, and all that is at stake, we want to explain the principles that have been central to the discussions thus far, and will remain so. These principles were developed in conjunction with several leading public health organizations including American Cancer Society, American Heart Association, American Medical Association, American Lung Association, American Academy of Pediatrics, and the American Academy of Family Physicians. We believe strongly that there must be no compromise with the tobacco industry that fails to meet these fundamental goals:

"We believe strongly that there must be no compromise...that fails to meet these fundamental goals:"

far, and will remain so. These principles were developed in conjunction with several leading public health organizations including American Cancer Society, American Heart Association, American Medical Association, American Lung Association, American Academy of Pediatrics, and the American Academy of Family Physicians. We believe strongly that there must be no compromise with the tobacco industry that fails to meet these fundamental goals:

1. Regulatory Authority; The FDA must have the authority to regulate the manufacture, sale, labeling, distribution, and marketing of tobacco products.

2. Minimum Standard: The current FDA requirements governing youth access and tobacco marketing are essential minimum components of any public policy initiative. The agency's ability to augment these requirements should not be curtailed.

3. Public Education: A well funded, effective sustained public education campaign that is protected from political pressure is critical to reducing tobacco use.

4. Preemption: Congress should not preempt state or local laws that are stronger than federal laws, nor should the FDA be preempted from revising the form, content, and placement of the warnings on cigarette packs.

5. Public Disclosure: The tobacco industry must disclose its research and studies about the effects of its products, including nicotine on the human body and the marketing of tobacco to children.

6. Rights of Victims: The rights of victims of the To-

bacco industry to seek compensation for the injuries they have suffered should not be abridged and the tobacco industry should not be immunized from accountability for its wrongdoing. We are aware that any discussion with the tobacco industry involves risks. Our participation represents our view that while we are rightly skeptical, we are prepared to explore any alternative that truly will accomplish our public health goals." ... "We believe that our presence ..strengthens the position of those who share the common desire to protect public health.." signed: Matt Myers and William Novelli.

Since the date of this letter, the Campaign has modified these principles and has obtained further feedback from many of the tobacco control and advocacy groups nationally and from across the nation. These modified basic principles were printed in an advertisement in The Washington Post.

If you have any questions and or comments, contact the Campaign for Tobacco-Free Kids at (202)296-5469 or (202)296-5427 fax, or 1-800-824-KIDS.

Communities of Color take a position on the Settlement. page 4

A disproportionate number of these individuals are low-income and from our racial, ethnic and tribal communities. We are concerned that a monetary settlement—even one in the range of \$ 300 billion over 25 years—will only shift the burden of payment from the general public to individual smokers as tobacco companies raise prices on their addictive products to

pay the settlement costs. This represents regressivity as its worse and has the potential to victimize low-income smokers, while allowing the investors in tobacco to realize enormous financial rewards by "immunizing" tobacco companies from the costs of further litigation.

3. In some news stories, there have been references to a pro-

posed "global" settlement. The only thing that is "global" is that these negotiations give the tobacco industry a way to effectively rid itself of liabilities in the United States, while at the same time, tobacco companies can continue to market their addictive products in other parts of the world—especially in Latin America, Africa, Asia and the

6th Biennial Symposium on Minorities, the Medically Underserved and Cancer

More than 900 cancer minority professionals, researchers, survivors and students met in Washington DC from April 22 to April 27 to share their professional knowledge and human concerns about cancer and its toll on minority communities. The Intercultural Cancer Council, in association with Baylor College of Medicine and scores of foundations, organizations and non-profit organizations organized a very successful meeting. The planned goals stated by the organizers were:

- 1) Exchange the latest scientific and treatment information and to share strategies for reducing the disproportionate incidence of cancer morbidity and mortality among minorities and the medically underserved in the US;
- 2) Enhance the competency of health care providers, laypersons and survivors in the areas of primary and secondary cancer prevention, early detection and treatment; and
- 3) Promote culturally competent cancer care and services and ethnically balanced research, especially clinical trials. Presymposium workshops included the following topics: Survivorship: from the moment of diagnosis; Achieving culturally-competent health care delivery; and Achieving Ethnically Balanced Clinical Trials.

One of the main speakers at the opening ceremony was Dr. Richard D. Klausner, who spoke about The Role of the National Cancer Institute; the keynote address was delivered by The Honorable Louis Stokes, Congressman from Ohio.

The current status of cancer research was discussed as well as: liver, leukemia, lymphoma, prostate, colorectal, lung, gynecological and breast cancer research.

At the public policy luncheon the Honorable Kevin L. Thurm, Deputy Secretary of DHHS gave the overall perspective. FDA Associate Commissioner Sharon Natanblut, presented the FDA Tobacco Rule, its origins and current battle for implementation. Dr. Joseph Simone discussed the National Cancer Policy Board and Dr. Valeria Setlow presented the perspective from the Institute of Medicine NIH Review.

Selected abstracts for oral presentation were on basic, clinical and behavioral research and community-based program research and evaluation. These sessions allowed participants the opportunity to interact with the speakers on special topics of interest.

Dr. John Alderete presented the Hispanic perspective at the Con-

gressional Briefing receiving a standing ovation, for his moving speech about the real conditions of Latinos in America. Attendance by House/Senate members was scarce. Minority researchers and activists have to make a case about the needs and realities of minority communities affected by cancer, or else Congress won't respond to our needs.

LCAT with support from www.smokescreen.org made communicating directly with Congress an easy and effective system. Letters in support of the FDA were sent via fax through the WWW site. LCAT's interns, Aldo Tinoco, 2nd year Medical Student at Georgetown University and Gina Engler, pre-med student at Howard University, circulated petitions in support of the Hatch-Kennedy bill that would raise tobacco taxes to pay for medically uninsured children. Advocacy is a vital part of community action.

If you want to get involved in tobacco control through the Web, sign on to site: www.smokescreen.org, which is the easiest way to express your tobacco concerns.

Cancer affects minorities disproportionately. Minority health professionals are working to make a difference at the local, state and national levels.

Communities of Color take a position on the Settlement..page 5

Islands of the Pacific. As people of color we have links to our brothers and sisters worldwide. We do not view an increased international trafficking of tobacco addiction as a legitimate trade off in return for tougher actions on advertising and marketing to youth in the United States. All youth are important and all youth must be protected from tobacco marketing practices, here and abroad.

These are our specific concerns, but beyond the specifics loom the large issue of principle. As communities of color, we believe strongly in the processes of consensus, inclusion, openness, and fairness. These back room negotiations toward a possible "settlement" have an air of secrecy and deception—which is in keeping with the history of the tobacco industry in this country. We oppose the clandestine nature of these discus-

sions. We are not asking that a few representatives of our communities be allowed to enter these closed meetings. Instead, we are joining our voices together with others to ask that all secret negotiations designed to cut a "deal" with the tobacco industry end immediately. These issues must be brought into the light of public disclosure and debate so that all those

LCAT's core principles on Tobacco Control

The Campaign for Tobacco-Free Kids and members of the larger tobacco control advocacy groups, drafted some core principles, that LCAT has modified. The modifications are in bold capital letters. LCAT also used ASTHO's clause on international concerns.

Core Principles for Considerations of the Resolution of Current Outstanding Tobacco Issues

Any resolution of the current outstanding tobacco issues —whether in the Courts, in Congress, or elsewhere —should be guided by a number of clearly enunciated principles. They include:

- **Regulatory Authority:** The FDA must have the authority to regulate the manufacture, sale, labeling, distribution and marketing of tobacco products.
- **Minimum Standard:** The current FDA requirements governing youth access and tobacco marketing are essential minimum components of any public policy initiative. The agency's ability to augment these requirements should not be curtailed.
- **The rights of victims** of the tobacco industry to seek compensation for the injuries they have suffered should not be abridged and the tobacco industry should not be immunized from accountability for its wrongdoing. **ADEQUATE MECHANISMS MUST BE IN PLACE TO SUPPORT VICTIMS WHO BECAUSE OF ECONOMIC CONSTRAINTS CANNOT PURSUE COMPENSATION.**
- **Public education and tobacco control:** a well funded, **INCLUSIVE**, effective sustained public education and tobacco control **AND CESSATION** campaign that is protected from political pressure is critical to reducing tobacco use.
- **Preemption:** Congress should not preempt state or local laws that are stronger than federal laws, nor should the FDA be preempted from revising the form, **PACKAGING**, content, and placement of the warnings on cigarette packs.
- **Public Disclosure:** The tobacco industry must disclose its research and studies about the effects of its products, including nicotine, **AND OTHER INGREDIENTS**, on the human body and the marketing of tobacco to children, **WOMEN AND MINORITIES.**
- **INTERNATIONAL SALES AND PROMOTION: CHILDREN IN EVERY NATION MUST BE PROTECTED FROM THE PROMOTION AND UNREGULATED SALE OF TOBACCO PRODUCTS. INTERNATIONAL STANDARDS FOR RESPONSIBLE PUBLIC HEALTH AND BUSINESS PRACTICES MUST BE ESTABLISHED TO PREVENT CHILDHOOD NICOTINE ADDICTION. (This is ASTHO's clause.)**

In addition to these principles, it is vital to recognize that there are other issues which are key components of any overall comprehensive tobacco control plan, including items such as increased tobacco taxes and protection of non-smokers from environmental tobacco smoke.

Please circulate these "Principles" and provide LCAT with feedback so that your concerns are also addressed. (202)371-1186

Communities of Color take a position on the Settlement

who are touched by tobacco can have their concerns acknowledged and addressed. We urge the public to speak out on this important issue and let all those who are part of these secret meetings —especially the individuals who are elected public officials— know how the public feels. As people of color, we will continue to raise our voices and to express our concerns. No one else can speak for us on the critical matter of the abusive sales and marketing of tobacco

in all communities — especially in communities of color.

This statement was circulated among leaders and advocates of communities of color nationwide for their input and consideration. If you would like to make a contribution to this statement and/or have any comments or desire more information about what you can do about this matter, please call (215) 477-4113 or fax your comments to (215) 477-5535.

LCAT urges action on the part of our community leaders to make the concerns stated above known to public officials and the public in general.

Communities of Color must protect their own children and the children of the world from the ravages of tobacco addiction and the greed of tobacco companies. ###

Latino Council on Alcohol and Tobacco

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*Committed to combat-
ing alcohol & to-
bacco related harm
and their underlying
causes in the Latino
Community.*

In This Issue...

Tobacco Settlement, Communities of Color take a stand, Campaign for Tobacco....

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Please fax to LCAT at (202) 371-0243.

Analysis of Minority Issues in the Tobacco Settlement

Latino Council on Alcohol and Tobacco

FIRST DRAFT

July 16, 1997

TOBACCO SETTLEMENT

MINORITY ISSUES

Italics denote correlating observations between the following minority issues and the Draft Final Report of the Advisory Committee on Tobacco Public Policy and Public Health, co-chaired by Dr. C. Everett Koop and Dr. David A. Kessler.

TITLE I: REFORMATION OF THE TOBACCO INDUSTRY

A. Restrictions on Marketing and Advertising

Prohibit the use of non-tobacco brand names of tobacco products except for tobacco products in existence as of January 1, 1995.

Restrict tobacco product advertising to FDA specified media.

Restrict permissible tobacco product advertising to black text on a white background except for advertising in adult-only facilities and in adult publications.

Require cigarette and smokeless tobacco product advertisements to carry the FDA-mandated statement of intended use ("Nicotine Delivery Device").

Ban all non-tobacco merchandise, including caps, jackets or bags bearing the name, logo or selling of a tobacco brand.

Ban offers of non-tobacco items or gifts based on proof of purchase of tobacco products.

Ban sponsorships, including concerts and sporting events, in the name, logo or selling message of a tobacco brand.

Ban the use of human images and cartoon characters, thereby eliminating Joe Camel and the Marlboro Man in all tobacco advertising and on tobacco product packages.

Ban all outdoor tobacco product advertising, including in enclosed stadiums as well as brand advertising

The restrictions seem to offer effective measures which may significantly decrease and prevent children from smoking. They will ban human images and cartoon characters in advertising, prohibit direct and indirect payments to "glamorize" tobacco use in media appealing to minors, and ban all non-tobacco merchandise bearing the name, logo or message of a tobacco brand.

There will be a loss of income for minority message advertisers. Provisions need to be made so that "counter-advertisements" must be bought from "minority" companies if it involves minority/and or targeted advertisements.

Minority store owners will likely lose income due to these provisions since "in-store" promotions will be lost. They will react negatively to the regulations.

The provision that bans sponsorships

directed outside from a retail establishment.

Prohibit tobacco product advertising on the internet unless designed to be inaccessible in or from the United States.

Establish nationwide restrictions in non adult-only facilities on point of sale advertising to minimize the impact of such advertising on minors.

Ban direct and indirect payments for tobacco product placement in movies, television programs and video games.

Prohibit direct and indirect payments to "glamorize" tobacco use in media appealing to minors, including recorded and live music performances.

Without limiting the FDA's normal rule-making authority in this area, require that words currently used as product descriptors (e.g., "light" or "low tar") be accompanied by a mandatory disclaimer in advertisements of brand styles (e.g., "Brand X not shown to be less hazardous than other cigarettes").

B. Warnings, Labeling and Packaging

The settlement mandates that new rotating warnings be introduced concurrently into the distribution chain on all tobacco product packages and cartons, as well as in advertisements.

The FDA would be required to test, report, and disclose tobacco smoke constituents, including tar, nicotine and carbon monoxide.

C. Restrictions on Access to Tobacco Products

The legislation would build upon the FDA Rule by

is very important for the minority community. (See Title VII, A. (5), [page 8] for replacement funds to minority groups.)

This is a gain for all communities.

There are no provisions which specify types of advertising in communities of color. This is needed because of wording that exempts "adults-only facilities" from restrictions in the settlement (liquor stores, bars, casinos, etc.), are disproportionately located in minority communities. (Since children enter liquor stores, they could be "singled out" as places where children should not be allowed.

There must be a disclosure of all information related to marketing, including opinion and behavioral research; the targeting of children, women and racial and ethnic minorities.

This is a very important provision that we support.

This is also a gain for minority communities

This is a good provision

Some minority groups believe that these warnings need to be distributed in languages which reach ethnic population groups (i.e., Spanish, Chinese, Korean and other frequently spoken Asian languages). There is no consideration of this in the settlement. These warnings should be placed on cigarettes made for domestic use as well as export purposes.

This is an important provision.

Minority communities may be disproportionately

banning the sale of tobacco through vending machines and banning self-service displays of tobacco products except in adult-only facilities.

affected due to the "adult only facilities" wording. Furthermore, small shop owners may face a decrease in revenue if tobacco products and products associated with tobacco may no longer be sold there.

"Tobacco Shops" in Native American reservations will be disproportionately affected by the agreement. Provisions need to be made to compensate for the loss of revenue from the reservations as well as to protect Native Americans' right to use tobacco for traditional and religious means, while at the same time discouraging abuse of manufactured addictive tobacco.

D. Licensing of Retail Tobacco Product Sellers

Any entity that sells tobacco directly to consumers, whether manufacturer, wholesaler, importer, distributor or retailer, would require a license.

Small retail owners will have to sacrifice financially in order to comply with license requirements.

More funds and/or personnel will be needed to ensure compliance with this licensing regulation. Density of these establishments needs to be considered when assigning those funds. Inner cities have more small "mom & pop" stores, requiring more compliance checks.

LCAT thinks this will benefit minority communities since they will be able to address merchants who break the law. It may even have a positive "spill over" effect on curtailing the sale of alcoholic beverages to underage kids, making ID card checking the norm.

E. Regulation of Tobacco Product Development and Manufacturing

Tobacco products will continue to be categorized as a drug, and the FDA will have permit to require product modification including nicotine content. The FDA would have to approve all health claims made by tobacco manufacturers of reduced risk products. Manufacturers will be required to notify the FDA of any technology they develop or acquire that reduces the risk of tobacco products. The FDA will also have the authority to hold tobacco manufacturers to performance standards to promote the production of "reduced risk" tobacco products, including the gradual reduction, but not elimination of nicotine yields and the possible elimination of other constituents or other harmful components of the tobacco product over a twelve year period based on the finding that the modification: (a) will result in a significant reduction of the health risks associated with such products to consumers thereof, (b) is technologically feasible, and (c) will not result in the creation of a black market.

The FDA should have full protection to have the authority to regulate nicotine and eliminate any clauses that may directly or indirectly interfere with this authority.

"Reduced risk" products need to be made affordable in order to treat nicotine addiction in poor communities.

The "performance standards" provision has caused concern from some tobacco control advocates because of the supposed of other restrictions it places on the FDA. However, it is important that nicotine be gradually reduced, due to the potential creation of a black market upon the immediate elimination of nicotine yields, and its potentially immediate and harmful effects on minority communities.

Legislation would also subject tobacco product manufacturers to good manufacturing practice standards including the implementation of a quality control system, inspection of tobacco product materials, requirements for proper handling of finished product, and tolerances for pesticide chemical residues in or on commodities in the possession of the manufacturer. The Act would also ensure that previously non-public or confidential documents from the files of the tobacco industry are disclosed to FDA, private litigants, and the public.

According to the settlement, tobacco jurisdiction does not specifically cover cigars. Cigar use is on rise among young people and in minority communities, and are sometimes used as "blunts" (to smoke marijuana, crack, PCP). The same regulations required for cigarette content should also apply for cigars, not just "short" or blunt cigarillos, "fine cut" or "roll your own" tobacco products.

In terms of nicotine regulation, the addictive nature of cigarettes and other tobacco products requires further research before final regulation. The creation of a "Scientific Advisory Panel is very important, so a determination is made of what are the dangers of use and abuse among adults of various ethnic, racial and gender groups. American Indian communities are particularly affected, as are Cuban-Americans who have used tobacco in a traditional as well as cultural way for centuries. Members of these communities need to be consulted and special provisions need to be made in order to research all communities of color.

Both prevention and treatment research needs to be conducted for each minority sub-group, since the patterns of use/abuse differ.

The new required practicing standards may adversely affect small tobacco farmers (Cuban American Floridians), who would have to make costly changes in order to meet new regulations. Thus, an economic assistance and development fund should be established (and funded by the tobacco industry) to assist tobacco farmers and their communities in developing alternatives to tobacco farming. Economic conversion funds should also be provided to assist tobacco manufacturing workers and related non-farm workers.

F. Non-Tobacco Ingredients

Under the legislation, tobacco companies would be required to provide the FDA on a confidential basis a list of all ingredients, substances, and other compounds which are added by the manufacturer to tobacco, paper or filter of the tobacco product by brand and by quantity in each brand, as well as scientific assessment proving the safety of each ingredient.

This provision benefits all communities.

G. Compliance and Corporate Culture

The Act will provide for means to ensure that the industry will not only comply with the letter of the law

but will also have powerful incentives to prevent underage usage of tobacco products and to strive to develop and market less hazardous tobacco products.

H. Effective Dates

Different requirements will become effective at separate intervals after the Act is signed by the President.

TITLE II: "LOOK BACK" PROVISIONS/STATE ENFORCEMENT INCENTIVES

In order to achieve dramatic results from the proposed legislation, the "look-back" provision sets targets for reducing current levels of underage tobacco use. For example, underage use of cigarette products must decline by at least 30% from estimated levels over the last decade by the fifth year after the legislation takes effect, by at least 50% from estimated levels over the last decade by the seventh year after the legislation takes effect, by at least 60% from estimated levels over the last decade by the tenth year after the legislation takes effect, and remain at such reduced levels or below thereafter.

If a target has not been met, FDA will impose a mandatory surcharge on the relevant industry based upon an approximation of the present value of the profit the industry would earn over the lives of all underage users in excess of the target, capped at \$2 billion.

The "look-back" provision should focus on specific ethnic and gender groups. Because certain populations experience higher rates of nicotine addiction, they should be targeted for greater assistance and expect substantial results. Teen rates for whites are greater than that of Latinos or African Americans. Thereby, cigarette companies can increase sales to the Latino and African American community while conceivably remaining within the concessions proposed by the settlement.

According to the settlement, cigarette companies will save on advertising. Thus, they will retain a large amount of money. This fact should be taken into account when determining penalties. For example, the Greenlining Institute recommends that the annual penalty for failing to meet the smoking reduction goals be raised from \$80 million to \$400 million per percentage point, and making such penalties non-tax deductible (Such information about reduction requirements, the surcharge, use of the surcharge, and abatement procedures are found in Appendix V of the settlement.)

TITLE III: PENALTIES AND ENFORCEMENT; CONSENT DECREES; NON-PARTICIPATING COMPANIES

A. Penalties and Enforcement

The legislation would be enforceable by the federal government and several states. The industry faces civil penalties of up to \$10 million per violation for any violations of the obligations to disclose to the FDA research about tobacco-product health effects and information regarding the toxicity of non-tobacco ingredients and constituents used in their products.

B. Consent Decrees

Certain terms of the agreement will also be reiterated in consent decrees between the tobacco

industry and the states that will not take effect until after enactment of the Act. The consent decrees will not contain provisions as to: (1) product design, performance or modification; (2) manufacturing standards and good manufacturing practices; (3) testing and regulation with respect to toxicity and ingredients approval; and (4) the national FDA "look back" provisions.

C. Non-participating companies

Non-participating manufacturers would receive none of the civil liability protections described in Title VIII. Their product would be subject to a user fee equal to the portion of the payments by participating manufacturers allocated to fund public health programs and federal and state enforcement of the access restrictions. Non-participating manufacturers will also be required to place 150% of its share of the annual payment required of participating manufacturers. Furthermore, the exemption from civil liability applicable to distributors and retailers of the products of participating manufacturers will not apply to distributors and retailers who handle tobacco products of non-participating manufacturers.

Small specialty manufacturers may be affected by these provisions. LCAT does not have data if/or minority companies or Native American Indian reservations would be affected.

TITLE IV: NATIONWIDE STANDARDS TO MINIMIZE INVOLUNTARY EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE

Smoking in "public facilities" would be restricted to ventilated areas with systems that exhaust the air directly to the outside, maintain the smoking area at "negative pressure" compared to adjoining areas, and do not recirculate the air inside the public facility. The legislation would exempt restaurants (but not "fast food" restaurants) and bars, private clubs, casinos, bingo parlors, tobacco merchants and prisons. Regulations to enforce the standards would be paid out of the Industry Payments. The legislation would not preempt or otherwise affect any other state or local law or regulation that restricts smoking in public facilities in an equal or stricter manner.

As aforementioned, facilities such as restaurants, bars and casinos are disproportionately located in minority communities. Additional efforts should be undertaken to determine the additional risks that environmental smoke places on those who work in these areas.

The prison population is largely minority and is affected by second hand smoke. Effective cessation programs should be instituted in conjunction with mandatory "smoke free zones" in our nation's prisons.

TITLE V: SCOPE AND EFFECT

A. Scope of FDA Authority

Applies to all product sold in U.S. commerce; covers new entrants, imports, U.S. duty free, etc.

B. State Authority

This is the most controversial provision in the entire settlement. In 1995, the United States' market only accounts for 9% of the world's tobacco consumption, while China consumes 32% of all cigarettes produced,

States, Indian tribes, military facilities, other federal agencies, and local governments preserve their legal authority to enact measures that further restrict or eliminate employee and general public exposure to smoking in workplaces and in other public and private places and facilities, and to further regulate, restrict or eliminate the sale or distribution of tobacco products, and to impose state or local taxes on such products.

Federal law currently provides for national uniformity of warning labels, packaging, labeling, other advertising requirements, and manufacturing requirements.

Japan 6%, Europe 12%, other Asian countries 13%, while other countries account for the remaining 28%.* Therefore, the large U.S. tobacco magnates, who are gaining even greater control over the world market, will continue to practice misleading advertising claims, control their own nicotine levels, and peddle their deadly product to the vast majority of their current customers. As a result, the settlement fails to damage "big tobacco" or even protect the millions of children around the globe who are confronted with these deadly products every day.

This is especially an affront to the minority community because of the large rise in cigarette addiction in Asia, Africa, and Latin America. Minority tobacco control advocates are deeply concerned with "double targeting" conducted by American companies in both the United States and their country of origin.

The mandate is that no cigarette shall be sold in the United States which exceeds a 12 mg "tar" yield, this should apply to all cigarettes manufactured by U.S. companies and sold abroad. All U.S. cigarettes sold abroad should conform to U.S. standards and regulations in packaging, warnings and content, including "tar" and nicotine yields.

These are "American" products.

Koop/Kessler proposes:

The U.S. should actively promote tobacco control worldwide.

The U.S. should actively promote the global adoption of U.S. domestic tobacco control policies through all international activities.

The U.S. should support the development and implementation of tobacco control activities by the World Health Organization and UNICEF, including the Framework Tobacco Control Convention.

The U.S. should support bilateral and multilateral treaties making the Framework Convention legally binding to all countries.

The U.S. should remove tobacco products from Section 301 of the 1974 Trade Act and should

* Swoboda, Frank and Martha M. Hamilton. "Two on Top of the World". The Washington Post. 7 July 1997. Washington Business, p. 10

prohibit Federal agency interference in international or national control activities.

The U.S. should support international research efforts to determine the most effective means of preventing the initiation of tobacco use and of smoking cessation.

The U.S. should provide financial support for WHO and UNICEF efforts to control tobacco use.

International exchange and scientific conferences on nicotine and other components of tobacco products should be convened among industry researchers and public researchers (such as those from the FDA, CDC, NIH, and WHO).

LCAT believes that international regulation of tobacco will benefit our nation's minorities as well as humanity as a whole. LCAT further suggests that tobacco companies should contribute 10% of their international tobacco sales profits to the World Health Organization or other agreed upon international agencies for tobacco-control programs.

TITLE VI: PROGRAMS/ FUNDING

A. Up Front Commitment-- Lump Sum Cash Payment -- \$10 billion.

B. Base Annual Payments-- 25 year total face value is \$358.5 billion.

C. Applicability-- Applicable to all sellers of tobacco Products.

D. Tax Treatment-- All payments pursuant to this Agreement shall be deemed ordinary and necessary business expenses to the year of payment.

There is a concern (as outlined by a statement by Communities of Color in the United States on private negotiations toward a proposed "settlement" with the tobacco industry) that "...a large monetary settlement will only shift the burden of payment from the general public to individual smokers. This has the potential to victimize low-income smokers disproportionately..."

Therefore, necessary action must be taken to ensure that a significant rise in the price of cigarettes be balanced with effective and available cessation plans. *If an effective cessation plan can be maintained, a large tax should be enacted, as it has been shown that a price increase in cigarettes deters youth smoking.* Yet, if a successful cessation plan cannot be maintained, there will be a dangerous potential for a "black market", which, according to the Onyx Group, "is a real possibility for low-income, Black communities". The same is true for Latin, Asian and American Indian communities.

TITLE VII: PUBLIC HEALTH FUNDS FROM TOBACCO SETTLEMENT

As Recommended By the Attorneys General For Consideration By the President and the Congress

Based on the premise of \$1 billion for the first year and gradually increasing to \$1.5 billion thereafter, adjusted for inflation after the first year.

Based on the premise of \$1 billion for smoking cessation for the first 4 years and \$1.5 billion thereafter, adjusted for inflation.

This is a much-needed provision. Cessation programs have historically been ineffective in treating minority smokers. *Culturally-appropriate plans need to be implemented in order for successful treatment.* Specific funds for affordable nicotine patches, nicotine gum, and counseling should be included.

A. Allocation of Grant Moneys Among Programs-

The use of moneys under this section shall be limited to programs established under this section, shall be adjusted for inflation annually from the effective date, and shall be allocated among such programs as follows:

(1) \$125,000,000 for the first three years and \$225,000,000 annually thereafter to the Secretary of HHS to accomplish the purposes described in Paragraph (B) of this Section.

(2) \$300,000,000 annually for the FDA to carry out its obligations under the Act and to enforce the terms of this Act, including for grants to the states to assist in the enforcement of the Provisions of the Act.

Once again, the FDA must be granted full authority to regulate nicotine levels in cigarettes as a result of the settlement. FDA should be adequately funded to carry out its regulatory, enforcement, public education, and research activities.

(3) \$75,000,000 for the first two years, \$100,000,000 in the third year, and \$125,000,000 annually thereafter to fund state and local tobacco control community based efforts Modeled on the ASSIST program, designed to encourage community involvement in reducing tobacco use and the enactment and implementation of policies designed to reduce the use of tobacco products

Steps must be taken to ensure that minority community needs be uniquely serviced.

(4) \$100,000,000 annually to fund the research and development of methods to discourage individuals from starting to use tobacco and how to help individuals quit using tobacco.

Research work should be focused in the area of specific cessation programs for minority smokers, due to different trends in choice of brand (e.g. black smokers tend to smoke menthol cigarettes, Latinos smoke cigars, etc.).

The FDA should have the ability to test nicotine levels by brand, based on the best science.

(5) Beginning in the second year, \$75,000,000 annually for a period of ten years to compensate events, teams or such events who lose sponsorship by the tobacco industry

A specific percentage of the \$75 million assigned to compensate for loss of entries in sponsorship by the tobacco industry to minority cultural,

as a result of this Act, or who currently receive tobacco industry funding to sponsor events and elect to replace that funding, provided that the event, team, or entry is otherwise unable to replace its tobacco industry sponsorship during those given years. Funds used for this purpose shall be used as follows: 50% to supplement funding of the multimedia campaigns in paragraph (1) of this subsection; 25% to supplement the funding of the enforcement provisions of paragraph (2) of this subsection; and 25% to supplement the funding of community action programs in paragraph (3) of this subsection.

B. Establishment of Programs by the Secretary-

The Secretary shall establish programs to accomplish the following purposes-

(1) The reduction of tobacco product usage, both by seeking to discourage the initiation of tobacco use by persons under 18 and by encouraging current tobacco users to quit through media-based and non-media based education, prevention and cessation campaigns. The Secretary may make grants to health departments to assist in carrying out the purposes of this provision.

(2) The research, development and public dissemination of technologies and methods to reduce the risk of dependence and injury from tobacco product usage and exposure.

(3) The identification, testing and evaluation of the health effects of both tobacco and non-tobacco constituents of tobacco products.

(4) The promulgation of such other rules and regulations as are necessary and proper to carry out the provisions of this Act, as well as the development of such other programs as the Secretary determines are consistent with the goals of the Act.

political, social, economic, arts, sports, education and health national and community groups should be provided for minority-led and related groups.

Cessation programs need to be promoted and targeted at specific ethnic/racial groups. Funds should be available to purchase nicotine patches, gum, and other products and/or make these products state affordable to low income smokers. *It should encourage maximum overall reduction in disease.* Funds should be allotted according to the ethnic and gender composition of each state, for use by minority entities to design and implement continuous, culturally sensitive and language appropriate cessation education and counseling programs.

Public education and prevention campaigns should be in the appropriate language and have culturally sensitive and gender sensitive messages. Multimedia campaigns should be funded through minority-owned advertising agencies, newspapers, magazines, radio and television stations that focus on each of the ethnic minority populations. These funds should be appropriated according to the potential viewership and or readership at the community level. American Indian publications should be funded in order to incorporate appropriate messages.

This should be by ethnic groups, since more African Americans smoke menthol cigarettes, more Cuban-Americans smoke cigars, etc. The effects are different, the illness and propensities to diabetes, high blood pressure, etc. are different by ethnic background.

C. Public Education Campaign- \$500,000,000 shall be spent annually in such multimedia campaigns designed to discourage and de-glamorize the use of tobacco products. To carry out such efforts, an independent non-profit organization with a Board of prestigious individuals and leaders of major public health organizations shall be created to contract or make grants to non-profit private entities unaffiliated with tobacco manufacturers or importers, who have a demonstrated record of working effectively to reduce tobacco product use and expertise in multimedia communications campaigns. The independent body shall be authorized to contract with state health departments, where appropriate, to run campaigns for their states and communities. In creating the program the independent body shall also take into account the needs of particular populations. The goal shall be the reduction of tobacco product usage, both by seeking to discourage the initiation of tobacco use by persons under the age of 18 and by encouraging current tobacco users to quit.

See Section B (2), above, for minority stance on Public Education Campaign.

D. Tobacco Use Cessation- For the first 4 years, \$1 billion, and thereafter, \$1.5 billion of the total amount paid by the tobacco industry shall be paid into a Trust Fund to be used to assist individuals who want to quit using tobacco. Within 12 months the Secretary shall promulgate regulations to govern (1) the establishment of criteria and a procedure for the approval of cessation programs and devices for which payment may be made under the program, (2) the eligibility requirements for individuals seeking to use moneys from the trust to fund the tobacco cessation efforts, and (3) the procedures to govern the tobacco cessation program.

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Women and all members of minority communities must be specifically represented on the commission.

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A. General - Current Attorney General actions (or similar actions brought by or on behalf of any governmental entity), *parens patriae* and class actions are legislatively settled. No future prosecution of such actions. All "addiction" and dependence claims are settled and all other personal injury claims are reserved. As to signatory states, pending Congressional enactment, no stay applications will be made in pending actions, based upon the fact of this resolution, without mutual consent of the parties.

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TITLE X: BOARD APPROVAL

The terms of this resolution are subject to approval by the Boards of Directors of the participating tobacco companies.

This analysis was written by Jeannette Noltenius and John Walker of the Latino Council on Alcohol and Tobacco.

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Analysis of Minority Issues in the Tobacco Settlement

Latino Council on Alcohol and Tobacco

FIRST DRAFT
July 16, 1997

TOBACCO SETTLEMENT

MINORITY ISSUES

Italics denote correlating observations between the following minority issues and the Draft Final Report of the Advisory Committee on Tobacco Public Policy and Public Health, co-chaired by Dr. C. Everett Koop and Dr. David A. Kessler.

TITLE I: REFORMATION OF THE TOBACCO INDUSTRY

A. Restrictions on Marketing and Advertising

Prohibit the use of non-tobacco brand names of tobacco products except for tobacco products in existence as of January 1, 1995.

Restrict tobacco product advertising to FDA specified media.

Restrict permissible tobacco product advertising to black text on a white background except for advertising in adult-only facilities and in adult publications.

Require cigarette and smokeless tobacco product advertisements to carry the FDA-mandated statement of intended use ("Nicotine Delivery Device").

Ban all non-tobacco merchandise, including caps, jackets or bags bearing the name, logo or selling of a tobacco brand.

Ban offers of non-tobacco items or gifts based on proof of purchase of tobacco products.

Ban sponsorships, including concerts and sporting events, in the name, logo or selling message of a tobacco brand.

Ban the use of human images and cartoon characters, thereby eliminating Joe Camel and the Marlboro Man in all tobacco advertising and on tobacco product packages.

Ban all outdoor tobacco product advertising, including in enclosed stadiums as well as brand advertising

The restrictions seem to offer effective measures which may significantly decrease and prevent children from smoking. They will ban human images and cartoon characters in advertising, prohibit direct and indirect payments to "glamorize" tobacco use in media appealing to minors, and ban all non-tobacco merchandise bearing the name, logo or message of a tobacco brand.

There will be a loss of income for minority message advertisers. Provisions need to be made so that "counter-advertisements" must be bought from "minority" companies if it involves minority/and or targeted advertisements.

Minority store owners will likely lose income due to these provisions since "in-store" promotions will be lost. They will react negatively to the regulations.

The provision that bans sponsorships

directed outside from a retail establishment.

Prohibit tobacco product advertising on the internet unless designed to be inaccessible in or from the United States.

Establish nationwide restrictions in non adult-only facilities on point of sale advertising to minimize the impact of such advertising on minors.

Ban direct and indirect payments for tobacco product placement in movies, television programs and video games.

Prohibit direct and indirect payments to “glamorize” tobacco use in media appealing to minors, including recorded and live music performances.

Without limiting the FDA’s normal rule-making authority in this area, require that words currently used as product descriptors (e.g., “light” or “low tar”) be accompanied by a mandatory disclaimer in advertisements of brand styles (e.g., “Brand X not shown to be less hazardous than other cigarettes”).

B. Warnings, Labeling and Packaging

The settlement mandates that new rotating warnings be introduced concurrently into the distribution chain on all tobacco product packages and cartons, as well as in advertisements.

The FDA would be required to test, report, and disclose tobacco smoke constituents, including tar, nicotine and carbon monoxide.

C. Restrictions on Access to Tobacco Products

The legislation would build upon the FDA Rule by

is very important for the minority community. (See Title VII, A, (5), [page 8] for replacement funds to minority groups.)

This is a gain for all communities.

There are no provisions which specify types of advertising in communities of color. This is needed because of wording that exempts “adults-only facilities” from restrictions in the settlement (liquor stores, bars, casinos, etc.), are disproportionately located in minority communities. (Since children enter liquor stores, they could be “singled out” as places where children should not be allowed.

There must be a disclosure of all information related to marketing, including opinion and behavioral research; the targeting of children, women and racial and ethnic minorities.

This is a very important provision that we support.

This is also a gain for minority communities

This is a good provision

Some minority groups believe that these warnings need to be distributed in languages which reach ethnic population groups (i.e., Spanish, Chinese, Korean and other frequently spoken Asian languages). There is no consideration of this in the settlement. These warnings should be placed on cigarettes made for domestic use as well as export purposes.

This is an important provision.

Minority communities may be disproportionately

banning the sale of tobacco through vending machines and banning self-service displays of tobacco products except in adult-only facilities.

affected due to the “adult only facilities” wording. Furthermore, small shop owners may face a decrease in revenue if tobacco products and products associated with tobacco may no longer be sold there.

“Tobacco Shops” in Native American reservations will be disproportionately affected by the agreement. Provisions need to be made to compensate for the loss of revenue from the reservations as well as to protect Native Americans’ right to use tobacco for traditional and religious means, while at the same time discouraging abuse of manufactured addictive tobacco.

D. Licensing of Retail Tobacco Product Sellers

Any entity that sells tobacco directly to consumers, whether manufacturer, wholesaler, importer, distributor or retailer, would require a license.

Small retail owners will have to sacrifice financially in order to comply with license requirements.

More funds and/or personnel will be needed to ensure compliance with this licensing regulation. Density of these establishments needs to be considered when assigning those funds. Inner cities have more small “mom & pop” stores, requiring more compliance checks.

LCAT thinks this will benefit minority communities since they will be able to address merchants who break the law. It may even have a positive “spill over” effect on curtailing the sale of alcoholic beverages to underage kids, making ID card checking the norm.

E. Regulation of Tobacco Product Development and Manufacturing

Tobacco products will continue to be categorized as a drug, and the FDA will have permit to require product modification including nicotine content. The FDA would have to approve all health claims made by tobacco manufacturers of reduced risk products. Manufacturers will be required to notify the FDA of any technology they develop or acquire that reduces the risk of tobacco products. The FDA will also have the authority to hold tobacco manufacturers to performance standards to promote the production of “reduced risk” tobacco products, including the gradual reduction, but not elimination of nicotine yields and the possible elimination of other constituents or other harmful components of the tobacco product over a twelve year period based on the finding that the modification: (a) will result in a significant reduction of the health risks associated with such products to consumers thereof, (b) is technologically feasible, and (c) will not result in the creation of a black market.

The FDA should have full protection to have the authority to regulate nicotine and eliminate any clauses that may directly or indirectly interfere with this authority.

“Reduced risk” products need to be made affordable in order to treat nicotine addiction in poor communities.

The “performance standards” provision has caused concern from some tobacco control advocates because of the supposed of other restrictions it places on the FDA. However, it is important that nicotine be gradually reduced, due to the potential creation of a black market upon the immediate elimination of nicotine yields, and its potentially immediate and harmful effects on minority communities.

Legislation would also subject tobacco product manufacturers to good manufacturing practice standards including the implementation of a quality control system, inspection of tobacco product materials, requirements for proper handling of finished product, and tolerances for pesticide chemical residues in or on commodities in the possession of the manufacturer. The Act would also ensure that previously non-public or confidential documents from the files of the tobacco industry are disclosed to FDA, private litigants, and the public.

According to the settlement, tobacco jurisdiction does not specifically cover cigars. Cigar use is on rise among young people and in minority communities, and are sometimes used as "blunts" (to smoke marijuana, crack, PCP). The same regulations required for cigarette content should also apply for cigars, not just "short" or blunt cigarillos, "fine cut" or "roll your own" tobacco products.

In terms of nicotine regulation, the addictive nature of cigarettes and other tobacco products requires further research before final regulation. The creation of a "Scientific Advisory Panel is very important, so a determination is made of what are the dangers of use and abuse among adults of various ethnic, racial and gender groups. American Indian communities are particularly affected, as are Cuban-Americans who have used tobacco in a traditional as well as cultural way for centuries. Members of these communities need to be consulted and special provisions need to be made in order to research all communities of color.

Both prevention and treatment research needs to be conducted for each minority sub-group, since the patterns of use/abuse differ.

The new required practicing standards may adversely affect small tobacco farmers (Cuban American Floridians), who would have to make costly changes in order to meet new regulations. Thus, an economic assistance and development fund should be established (and funded by the tobacco industry) to assist tobacco farmers and their communities in developing alternatives to tobacco farming. Economic conversion funds should also be provided to assist tobacco manufacturing workers and related non-farm workers.

F. Non-Tobacco Ingredients

Under the legislation, tobacco companies would be required to provide the FDA on a confidential basis a list of all ingredients, substances, and other compounds which are added by the manufacturer to tobacco, paper or filter of the tobacco product by brand and by quantity in each brand, as well as scientific assessment proving the safety of each ingredient.

This provision benefits all communities.

G. Compliance and Corporate Culture

The Act will provide for means to ensure that the industry will not only comply with the letter of the law

but will also have powerful incentives to prevent underage usage of tobacco products and to strive to develop and market less hazardous tobacco products.

H. Effective Dates

Different requirements will become effective at separate intervals after the Act is signed by the President.

TITLE II: "LOOK BACK" PROVISIONS/STATE ENFORCEMENT INCENTIVES

In order to achieve dramatic results from the proposed legislation, the "look-back" provision sets targets for reducing current levels of underage tobacco use. For example, underage use of cigarette products must decline by at least 30% from estimated levels over the last decade by the fifth year after the legislation takes effect, by at least 50% from estimated levels over the last decade by the seventh year after the legislation takes effect, by at least 60% from estimated levels over the last decade by the tenth year after the legislation takes effect, and remain at such reduced levels or below thereafter.

If a target has not been met, FDA will impose a mandatory surcharge on the relevant industry based upon an approximation of the present value of the profit the industry would earn over the lives of all underage users in excess of the target, capped at \$2 billion.

The "look-back" provision should focus on specific ethnic and gender groups. Because certain populations experience higher rates of nicotine addiction, they should be targeted for greater assistance and expect substantial results. Teen rates for whites are greater than that of Latinos or African Americans. Thereby, cigarette companies can increase sales to the Latino and African American community while conceivably remaining within the concessions proposed by the settlement.

According to the settlement, cigarette companies will save on advertising. Thus, they will retain a large amount of money. This fact should be taken into account when determining penalties. For example, the Greenlining Institute recommends that the annual penalty for failing to meet the smoking reduction goals be raised from \$80 million to \$400 million per percentage point, and making such penalties non-tax deductible (Such information about reduction requirements, the surcharge, use of the surcharge, and abatement procedures are found in Appendix V of the settlement.)

TITLE III: PENALTIES AND ENFORCEMENT; CONSENT DECREES; NON-PARTICIPATING COMPANIES

A. Penalties and Enforcement

The legislation would be enforceable by the federal government and several states. The industry faces civil penalties of up to \$10 million per violation for any violations of the obligations to disclose to the FDA research about tobacco-product health effects and information regarding the toxicity of non-tobacco ingredients and constituents used in their products.

B. Consent Decrees

Certain terms of the agreement will also be reiterated in consent decrees between the tobacco

industry and the states that will not take effect until after enactment of the Act. The consent decrees will not contain provisions as to: (1) product design, performance or modification; (2) manufacturing standards and good manufacturing practices; (3) testing and regulation with respect to toxicity and ingredients approval; and (4) the national FDA "look back" provisions.

C. Non-participating companies

Non-participating manufacturers would receive none of the civil liability protections described in Title VIII. Their product would be subject to a user fee equal to the portion of the payments by participating manufacturers allocated to fund public health programs and federal and state enforcement of the access restrictions. Non-participating manufacturers will also be required to place 150% of its share of the annual payment required of participating manufacturers. Furthermore, the exemption from civil liability applicable to distributors and retailers of the products of participating manufacturers will not apply to distributors and retailers who handle tobacco products of non-participating manufacturers.

Small specialty manufacturers may be affected by these provisions. LCAT does not have data if/or minority companies or Native American Indian reservations would be affected.

TITLE IV: NATIONWIDE STANDARDS TO MINIMIZE INVOLUNTARY EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE

Smoking in "public facilities" would be restricted to ventilated areas with systems that exhaust the air directly to the outside, maintain the smoking area at "negative pressure" compared to adjoining areas, and do not recirculate the air inside the public facility. The legislation would exempt restaurants (but not "fast food" restaurants) and bars, private clubs, casinos, bingo parlors, tobacco merchants and prisons. Regulations to enforce the standards would be paid out of the Industry Payments. The legislation would not preempt or otherwise affect any other state or local law or regulation that restricts smoking in public facilities in an equal or stricter manner.

As aforementioned, facilities such as restaurants, bars and casinos are disproportionately located in minority communities. Additional efforts should be undertaken to determine the additional risks that environmental smoke places on those who work in these areas.

The prison population is largely minority and is affected by second hand smoke. Effective cessation programs should be instituted in conjunction with mandatory "smoke free zones" in our nation's prisons.

TITLE V: SCOPE AND EFFECT

A. Scope of FDA Authority

Applies to all product sold in U.S. commerce; covers new entrants, imports, U.S. duty free, etc.

B. State Authority

This is the most controversial provision in the entire settlement. In 1995, the United States' market only accounts for 9% of the world's tobacco consumption, while China consumes 32% of all cigarettes produced,

States, Indian tribes, military facilities, other federal agencies, and local governments preserve their legal authority to enact measures that further restrict or eliminate employee and general public exposure to smoking in workplaces and in other public and private places and facilities, and to further regulate, restrict or eliminate the sale or distribution of tobacco products, and to impose state or local taxes on such products.

Federal law currently provides for national uniformity of warning labels, packaging, labeling, other advertising requirements, and manufacturing requirements.

Japan 6%, Europe 12%, other Asian countries 13%, while other countries account for the remaining 28%.* Therefore, the large U.S. tobacco magnates, who are gaining even greater control over the world market, will continue to practice misleading advertising claims, control their own nicotine levels, and peddle their deadly product to the vast majority of their current customers. As a result, the settlement fails to damage "big tobacco" or even protect the millions of children around the globe who are confronted with these deadly products every day.

This is especially an affront to the minority community because of the large rise in cigarette addiction in Asia, Africa, and Latin America. Minority tobacco control advocates are deeply concerned with "double targeting" conducted by American companies in both the United States and their country of origin.

The mandate is that no cigarette shall be sold in the United States which exceeds a 12 mg "tar" yield, this should apply to all cigarettes manufactured by U.S. companies and sold abroad. All U.S. cigarettes sold abroad should conform to U.S. standards and regulations in packaging, warnings and content, including "tar" and nicotine yields.

These are "American" products.

Koop/Kessler proposes:

The U.S. should actively promote tobacco control worldwide.

The U.S. should actively promote the global adoption of U.S. domestic tobacco control policies through all international activities.

The U.S. should support the development and implementation of tobacco control activities by the World Health Organization and UNICEF, including the Framework Tobacco Control Convention.

The U.S. should support bilateral and multilateral treaties making the Framework Convention legally binding to all countries.

The U.S. should remove tobacco products from Section 301 of the 1974 Trade Act and should

* Swoboda, Frank and Martha M. Hamilton. "Two on Top of the World". The Washington Post. 7 July 1997. Washington Business, p. 10

prohibit Federal agency interference in international or national control activities.

The U.S. should support international research efforts to determine the most effective means of preventing the initiation of tobacco use and of smoking cessation.

The U.S. should provide financial support for WHO and UNICEF efforts to control tobacco use.

International exchange and scientific conferences on nicotine and other components of tobacco products should be convened among industry researchers and public researchers (such as those from the FDA, CDC, NIH, and WHO).

LCAT believes that international regulation of tobacco will benefit our nation's minorities as well as humanity as a whole. LCAT further suggests that tobacco companies should contribute 10% of their international tobacco sales profits to the World Health Organization or other agreed upon international agencies for tobacco-control programs.

TITLE VI: PROGRAMS/ FUNDING

A. Up Front Commitment-- Lump Sum Cash Payment -- \$10 billion.

B. Base Annual Payments-- 25 year total face value is \$358.5 billion.

C. Applicability-- Applicable to all sellers of tobacco Products.

D. Tax Treatment-- All payments pursuant to this Agreement shall be deemed ordinary and necessary business expenses to the year of payment.

There is a concern (as outlined by a statement by Communities of Color in the United States on private negotiations toward a proposed "settlement" with the tobacco industry) that "...a large monetary settlement will only shift the burden of payment from the general public to individual smokers. This has the potential to victimize low-income smokers disproportionately..."

Therefore, necessary action must be taken to ensure that a significant rise in the price of cigarettes be balanced with effective and available cessation plans. *If an effective cessation plan can be maintained, a large tax should be enacted, as it has been shown that a price increase in cigarettes deters youth smoking.* Yet, if a successful cessation plan cannot be maintained, there will be a dangerous potential for a "black market", which, according to the Onyx Group, "is a real possibility for low-income, Black communities". The same is true for Latin, Asian and American Indian communities.

TITLE VII: PUBLIC HEALTH FUNDS FROM TOBACCO SETTLEMENT

As Recommended By the Attorneys General For Consideration By the President and the Congress

Based on the premise of \$1 billion for the first year and gradually increasing to \$1.5 billion thereafter, adjusted for inflation after the first year.

Based on the premise of \$1 billion for smoking cessation for the first 4 years and \$1.5 billion thereafter, adjusted for inflation.

This is a much-needed provision. Cessation programs have historically been ineffective in treating minority smokers. *Culturally-appropriate plans need to be implemented in order for successful treatment.* Specific funds for affordable nicotine patches, nicotine gum, and counseling should be included.

A. Allocation of Grant Moneys Among Programs-

The use of moneys under this section shall be limited to programs established under this section, shall be adjusted for inflation annually from the effective date, and shall be allocated among such programs as follows:

(1) \$125,000,000 for the first three years and \$225,000,000 annually thereafter to the Secretary of HHS to accomplish the purposes described in Paragraph (B) of this Section.

(2) \$300,000,000 annually for the FDA to carry out its obligations under the Act and to enforce the terms of this Act, including for grants to the states to assist in the enforcement of the Provisions of the Act.

Once again, the FDA must be granted full authority to regulate nicotine levels in cigarettes as a result of the settlement. FDA should be adequately funded to carry out its regulatory, enforcement, public education, and research activities.

(3) \$75,000,000 for the first two years, \$100,000,000 in the third year, and \$125,000,000 annually thereafter to fund state and local tobacco control community based efforts Modeled on the ASSIST program, designed to encourage community involvement in reducing tobacco use and the enactment and implementation of policies designed to reduce the use of tobacco products

Steps must be taken to ensure that minority community needs be uniquely serviced.

(4) \$100,000,000 annually to fund the research and development of methods to discourage individuals from starting to use tobacco and how to help individuals quit using tobacco.

Research work should be focused in the area of specific cessation programs for minority smokers, due to different trends in choice of brand (e.g. black smokers tend to smoke menthol cigarettes, Latinos smoke cigars, etc.).

The FDA should have the ability to test nicotine levels by brand, based on the best science.

(5) Beginning in the second year, \$75,000,000 annually for a period of ten years to compensate events, teams or such events who lose sponsorship by the tobacco industry

A specific percentage of the \$75 million assigned to compensate for loss of entries in sponsorship by the tobacco industry to minority cultural,

as a result of this Act, or who currently receive tobacco industry funding to sponsor events and elect to replace that funding, provided that the event, team, or entry is otherwise unable to replace its tobacco industry sponsorship during those given years. Funds used for this purpose shall be used as follows: 50% to supplement funding of the multimedia campaigns in paragraph (1) of this subsection; 25% to supplement the funding of the enforcement provisions of paragraph (2) of this subsection; and 25% to supplement the funding of community action programs in paragraph (3) of this subsection.

B. Establishment of Programs by the Secretary-

The Secretary shall establish programs to accomplish the following purposes-

(1) The reduction of tobacco product usage, both by seeking to discourage the initiation of tobacco use by persons under 18 and by encouraging current tobacco users to quit through media-based and non-media based education, prevention and cessation campaigns. The Secretary may make grants to health departments to assist in carrying out the purposes of this provision.

(2) The research, development and public dissemination of technologies and methods to reduce the risk of dependence and injury from tobacco product usage and exposure.

(3) The identification, testing and evaluation of the health effects of both tobacco and non-tobacco constituents of tobacco products.

(4) The promulgation of such other rules and regulations as are necessary and proper to carry out the provisions of this Act, as well as the development of such other programs as the Secretary determines are consistent with the goals of the Act.

political, social, economic, arts, sports, education and health national and community groups should be provided for minority-led and related groups.

Cessation programs need to be promoted and targeted at specific ethnic/racial groups. Funds should be available to purchase nicotine patches, gum, and other products and/or make these products state affordable to low income smokers. *It should encourage maximum overall reduction in disease.* Funds should be allotted according to the ethnic and gender composition of each state, for use by minority entities to design and implement continuous, culturally sensitive and language appropriate cessation education and counseling programs.

Public education and prevention campaigns should be in the appropriate language and have culturally sensitive and gender sensitive messages. Multimedia campaigns should be funded through minority-owned advertising agencies, newspapers, magazines, radio and television stations that focus on each of the ethnic minority populations. These funds should be appropriated according to the potential viewership and or readership at the community level. American Indian publications should be funded in order to incorporate appropriate messages.

This should be by ethnic groups, since more African Americans smoke menthol cigarettes, more Cuban-Americans smoke cigars, etc. The effects are different, the illness and propensities to diabetes, high blood pressure, etc. are different by ethnic background.

C. Public Education Campaign- \$500,000,000 shall be spent annually in such multimedia campaigns designed to discourage and de-glamorize the use of tobacco products. To carry out such efforts, an independent non-profit organization with a Board of prestigious individuals and leaders of major public health organizations shall be created to contract or make grants to non-profit private entities unaffiliated with tobacco manufacturers or importers, who have a demonstrated record of working effectively to reduce tobacco product use and expertise in multimedia communications campaigns. The independent body shall be authorized to contract with state health departments, where appropriate, to run campaigns for their states and communities. In creating the program the independent body shall also take into account the needs of particular populations. The goal shall be the reduction of tobacco product usage, both by seeking to discourage the initiation of tobacco use by persons under the age of 18 and by encouraging current tobacco users to quit.

See Section B (2), above, for minority stance on Public Education Campaign.

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LATINO COUNCIL ON ALCOHOL AND TOBACCO

**COMMITTED TO
COMBATING ALCOHOL
& TOBACCO RELATED
HARM AND THEIR
UNDERLYING CAUSES
IN THE LATINO
COMMUNITY**

Serious health problems are now confronting the Latino community because it is a target of intense advertising and promotion for alcohol and tobacco products.

THE FACTS ABOUT THE THREAT ARE*:

- The Latino community suffers widespread problems of ill health, poverty, unemployment and illiteracy--problems that are exacerbated by alcohol abuse and cigarette smoking.
- Alcohol use and cigarette smoking account for a high percentage of health problems in the Latino community, ranging from birth defects and cancer to hypertension and heart disease.
- Alcohol use and cigarette smoking contribute to a wide range of social and safety problems, including fires, auto fatalities, industrial and other accidents, and violent crime.
- Among certain sub-groups in the Latino community, drunkenness is three times more common and the alcohol-related death rate is twice that of blacks or whites
- Alcohol problems in the community are reinforced by pervasive promotional campaigns. Latino receive a double dose of such promotion, with Spanish-language newspapers, magazines and radio/TV media added to the English-language alcohol advertising they are subjected to.

- Alcoholic beverage producers sponsor many Latino community events, music groups and civic association, making it difficult for many Latino organizations to combat alcohol-related problems.
- Tobacco companies are also heavy advertisers in the Latino community and frequent sponsors of community activities, and cigarette smoking as well as lung cancer are on the increase.

***Maxwell, Bruce & Michael Jacobson, *Marketing Disease to Hispanics*, (1989), Washington, DC, Center for Science in the Public Interest.**

LCAT is a national organization dedicated to reducing the enormous harm caused by alcohol and tobacco in the Latino community. LCAT is an independent, non-profit group that does not accept support from alcohol or tobacco industries. LCAT advocates prevention measures ranging from education to legislation to promote better health among children and adults. In meeting these objectives, LCAT will publish a newsletter, testify at legislative hearings, write and publish articles, and serve as a resource agency for journalists and others.

**JOIN THE LATINO COUNCIL
ON ALCOHOL AND TOBACCO**

Name: _____

Title: _____

Organization: _____

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Circle materials you would like to receive:
Newsletters, Action Alerts, Articles,
Campaign and Educational Materials.
First year, free of charge.
Second year: \$30.00 membership fee.

Send to:
Jeannette Noltenius, Ph.D.
Executive Director
Latino Council on Alcohol and Tobacco
1015 15th Street, NW, Suite 409
Washington, DC 20005
Tel: (202) 371-1186
Fax: (202) 371-0243
Email: lcat@erols.com



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Robert L. Gnaizda, Policy Director & General Counsel
Anthony Reese, Associate Director
Helen Lie, Academy Director

August 1, 1997

Dr. Jeannette Noltenius
Executive Director
Latino Council on Alcohol and Tobacco
1015 15th Street, NW, Suite 409
Washington, D.C. 20005

Dear Dr. Noltenius:

The Greenlining Institute and Latino Issues Forum greatly appreciate your ability to communicate the concerns of minority communities regarding the proposed tobacco settlement.

We would also like to authorize you to represent both Greenlining in Latino Issues Forum in your upcoming discussions, and wish you great success in your attempt to increase awareness of the concerns of minority communities.

Please convey to the White House and the Cabinet that Greenlining and Latino Issues Forum fully support your position, and will be working closely with you on this issue in the future.

We are pleased to have such an able representative.

Sincerely,

Robert Gnaizda
General Counsel and Policy Director
The Greenlining Institute

Latino Council on Alcohol and Tobacco

JEANNETTE NOLTENIUS, Ph.D.
EXECUTIVE DIRECTOR

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Basic Facts about the Proposed Tobacco Settlement

I. Background

On Friday, June 20, 40 state attorneys general and representatives of the tobacco industry announced a settlement concluding three months of negotiations. Under the terms of the agreement, the industry would pay \$368.5 billion over the next 25 years, to be divided among the states whose attorneys general sued the industry, public health groups, and a new fund to pay for damage claims and treatment costs for ill smokers. The 68-page proposed tobacco settlement contains a variety of provisions¹:

- **Youth Smoking:** The settlement requires the tobacco industry to take steps to reduce teenage smoking by 30% in five years, 50% in seven years, and 60% in 10 years, or pay a maximum of \$2 billion in fines per year. The fines are tax-deductible. If the industry can show that it has taken "all reasonably available measures" to meet these goals, then it may recover as much as 75% of the fines.
- **Advertising:** The settlement bans billboards, vending machines, sports promotions, and all ads containing either people or cartoon characters.
- **Government Regulation:** The settlement gives Food and Drug Administration (FDA) the power to regulate nicotine (although in order to retain this authority, the FDA must prove that any measures it may take to reduce the nicotine content of cigarettes will not result in the creation of a black market).
- **Legal Issues:** The settlement protects the tobacco industry from all class-action and states' lawsuits. In addition, it protects the industry from paying punitive damages for past conduct.

II. Basic Facts

Teenage smoking is a particularly important issue in the anti-smoking campaign, since studies show that tobacco use as a minor is likely to

¹ See "Text of Attorney General/Tobacco Industry Settlement," at <http://ash.org>.

lead to regular tobacco use as an adult. The Centers for Disease Control and Prevention (CDC) reports that 62% of adult regular smokers started smoking at 16 years of age; 90% had started by the age of 18.² Studies from the CDC also show that California's teenage smoking rate (22.2%) is 12.6 percentage points lower than the national average (34.8%), and that the teenage smoking rate for African Americans and Latinos is lower than the rate for white teenagers.³

a. Teen Smoking by State

- National Average: 34.8% of U.S. high school students currently smoke⁴ (34.3% of females and 35.4% of males); 16.1% are frequent smokers⁵
- California: 22.2% of Californian high school students currently smoke (21.7% of females and 23.0% of males); 7.1% are frequent smokers⁶
- Los Angeles: 26.6% of Los Angeles high school students currently smoke (24.3% of females and 29.0% of males); 6.8% are frequent smokers
- San Francisco: 19.6% of San Francisco high school students currently smoke (18.9% of females and 20.3% of males); 6.8% are frequent smokers

b. Teen Smoking by Race

- Whites: 38.3% of white high school students currently smoke (39.8% of white females and 37.0% of white males); 19.5% are frequent smokers
- Blacks: 19.2% of black high school students currently smoke (12.2% of black females and 27.8% of black males); 4.5% are frequent smokers
- Hispanics: 34.0% of Hispanic high school students currently smoke (32.9% of Hispanic females and 34.9% of Hispanic males); 10.0% are frequent smokers

III. The Greenlining Institute and Latino Issues Forum Proposal

In the letter sent to California Attorney General Daniel Lungren on June 26, The Greenlining Institute and the Latino Issues Forum (LIF) strongly urged that Lungren fight for the following modifications to the proposed settlement:

² Smokefree Campaign, "Children and Tobacco: The Facts," at <http://www.smokefree.com/>.

³ CDC, *Morbidity and Mortality Weekly Report*, 27 September 1996 (45, SS-4) 44-46.

⁴ I.e., smoke at least one day per month.

⁵ I.e., smoke at least 20 days per month.

⁶ Survey did not include Los Angeles.

- **Setting Separate Goals for Each State:** Under the proposed settlement, the tobacco industry must reduce the national teenage smoking rate. Such an across-the-board national target would allow tobacco companies to actually *increase* sales in states such as California while avoiding the penalties described in the settlement.
- **Setting Separate Goals for Each Minority Group:** Similarly, the national target would allow tobacco companies to increase sales among Latino or African American teenagers, whose smoking rates are significantly lower than those of white teenagers.
- **Raising the Penalty:** The annual penalty for failing to meet the smoking reduction goals, under the terms of the current agreement, is \$80 million per percentage point. Greenlining and LIF propose that the penalty be raised to \$400 million per percentage point, and that the penalties be made non-tax deductible.
- **Raising the Cigarette Tax:** In order to deter teenage smoking, Greenlining and LIF propose that the federal cigarette tax be raised by \$1.⁷ The proceeds from this tax would go toward funding universal health coverage for children.
- **Protecting FDA Authority:** Greenlining and LIF support the views of the advisory committee headed by former Surgeon General C. Everett Koop and former FDA Commissioner David A. Kessler, who seek to remove the provision of the settlement that removes FDA authority if a black market in cigarettes is created.
- **Removing Legal Barriers:** Greenlining and LIF maintain that individuals should continue to hold their right to file class action suits and to seek punitive damages against the tobacco companies.
- **Limiting Lawyer's Fees:** Greenlining and LIF seek to cap legal fees for the plaintiffs' lawyers at \$1 billion, and use the rest of the anticipated legal fees of up to \$18 billion to fund child health coverage and to fund local advocacy groups protecting the public interest.

⁷ Raising the price of cigarettes has proven to be one of the most effective deterrents to teenage smoking. In California and Massachusetts, both of which raised the tax on cigarettes by \$.25 per pack in the early 1990s, per capita cigarette consumption fell by 15.8 and 19.7 percent, respectively, between 1992 and 1996. See Paul Raeburn, "An Unhealthy Deal with Big Tobacco," *Business Week*, 7 July 1997, 38.

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Press Release

Thursday, June 26, 1997

ATTORNEY GENERAL FAILS TO PROTECT MOST VULNERABLE IN TOBACCO SETTLEMENT

Contact: *Guillermo Rodriguez at 415.284.7225, John Gamboa at 415.284.7205, or Leondra Kruger at 415.547.7555, or call 415.284.7200*

The Greenlining Institute, a multi-ethnic public policy and advocacy center, and Latino Issues Forum, California's largest Latino public policy think tank, today sent a strong letter (see four-page letter attached) to Attorney General Daniel Lungren criticizing his absentee role in the proposed \$368.5 billion tobacco settlement.

Despite the fact that California is the state most affected by tobacco and tobacco-related illnesses, the settlement's national targets for reduction in teen smoking make it possible for the tobacco industry to actually *increase* sales to California teenagers and still meet the provisions of the agreement.

In addition, the across-the-board national targets fail to adequately address the issue of smoking among African American and Latino teenagers, allowing tobacco companies to compensate for lost revenue by increasing sales in minority communities.

Finally, the actual penalties for failing to meet these goals, after tax deductions and rebates, amounts to as little as \$12 million per year for the entire industry.

The two multi-ethnic organizations also urged Lungren to fight for a \$1 per pack tax on cigarettes in order to decrease teenage smoking, the proceeds of which would go toward funding universal health coverage for children.

Former California Secretary of Health and Welfare Mario Obledo said, "Dan Lungren has fumbled this deal from the beginning, compromising the health of California's teenagers."

The Greenlining Institute's members include the Latin, Black, and Asian Business Associations, the two largest African American churches in California, and the state's largest Hispanic immigrant group. Greenlining is responsible for seven low-income economic development agreements with financial institutions, including Bank of America, Wells Fargo, Union Bank, Home Savings, and Merrill Lynch, totaling \$213 billion.

The Greenlining Institute

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June 26, 1997

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World Institute on Disability

The Honorable Daniel Lungren
Attorney General of the
State of California
1300 "T" Street
Sacramento, CA 94244-2550

Protecting the Most Vulnerable in the Tobacco Settlement

Dear Attorney General Lungren:

We wish to raise with you, as our state's legal representative in the tobacco settlement, a series of fundamental concerns affecting California and minority groups.

Greenlining Institute is a multi-ethnic public policy and advocacy center that has reached multi-billion dollar low-income economic development agreements with Bank of America, Wells Fargo, Union Bank, Home Savings, and other financial institutions totaling \$213 billion. (*Partial list attached as Exhibit A.*) Latino Issues Forum is California's largest statewide Latino public policy think tank and focuses on health issues affecting minority youth.

In summary, our primary concern is that self-interested parties negotiated this settlement while ignoring the adverse impact of the settlement on California's youth, particularly minorities, who represent the majority (56.3 percent) of all Californians under the age of 18.

As the Tobacco Industry is well aware, teenage Latino and African American smoking rates are presently below the rate for white teenagers. Therefore, an across-the-board national target for percentage decreases in teen smoking would allow the tobacco companies to actually increase sales within the Latino or African American community.

A) Specific Concerns

At our anticipated meeting with you, which we hope will occur within ten days, we wish to raise the following:

1. Setting separate teenage smoking reduction goals for each state with a population of 1 million or more;
2. Setting separate goals for each major minority group to avoid the targeting of minorities who presently smoke at or below the average rate;
3. Raising the annual penalty for failing to meet the smoking reduction goals from \$80 million to \$400 million per percentage point, and making such penalties non-tax deductible. *(In addition, to ensure the effectiveness of these goals, there must be strict liability not a mere good faith effort that permits for a 75 percent reduction in the penalty);*
4. Ensuring that Congress raises the federal tax on cigarettes by \$1 per pack since studies have determined that price increases are the most effective deterrent to smoking, particularly among low-income youth;
5. Fully protecting the FDA's authority to regulate nicotine and eliminate any clauses that may directly or indirectly interfere with this authority; this includes fully supporting the views on necessary FDA authority urged by Messrs. Kessler and Koop;
6. Ensuring that the youth of today and tomorrow maintain their full statutory and constitutional rights to file class actions and recover punitive damages from the Tobacco Industry; and
7. Limiting total legal fees for all plaintiff lawyers to \$1 billion with the remainder of the anticipated legal fees of up to \$18 billion allocated to child health care and funding local advocacy groups to ensure that the long-term public interest is protected.

B) Answers Required for Evaluation

1. Have an actuary provide you with the real value of the so-called \$368 billion settlement in 1997 dollars. The real value is likely to be barely above \$150 billion dollars, minus 40 percent paid by the taxpayers. And, after a deduction of \$7 billion dollars per year in reduced industry advertising and legal expenses, the net cost to the industry could be zero, particularly if the industry raises the price per pack by \$.50, as reported in *The New York Times*.
2. Secure specific and detailed information as to the proposed legal fees of all of the plaintiffs' lawyers and urge a cap of \$1 billion. And because President Clinton will play a decisive role in ratifying this settlement, the anticipated legal fees of his brother-in-law (*Hugh Rodham, Jr.*) who was brought into the case late in the game and who lacks unique legal skills, should be closely scrutinized.
3. Determine the exact number and percentage of minorities who were part of the Attorney General, trial lawyer and other so-called public interest negotiating

team, since California's 17 million minorities are likely to pay the heaviest price in this settlement.

4. Secure from the industry within ten days the exact percentages of teenage smokers by state, by state and minority group, by state and gender, and by minority group and gender.
5. Provide an independent expert's analysis of the anticipated multi-billion dollar increase in value of tobacco industry stocks as a result of this settlement, including the value to the top five officers at each of the tobacco companies.
(Please see the SEC 10-Ks for precise stock holdings, including options.)

C) Data on Minority Concerns

These issues will have a vital impact on California, since some 56.3 percent of all California's youth (ages 1 to 18) are minorities, including 37.9 percent who are Latino. And it is anticipated that within 25 years (by the termination of this agreement) the percentage of minorities aged 1 to 18 in California be substantially larger.

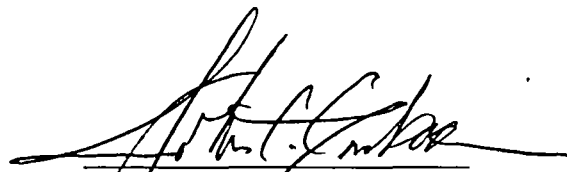
D) Personal Meeting

We will be meeting with San Francisco City Attorney Louise Renne on July 2. We look forward to meeting with you by July 8 in order to ensure that California's interests are fully considered.

Sincerely,



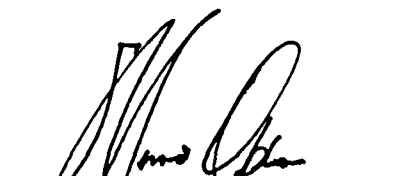
Guillermo Rodriguez, Jr.
Executive Director
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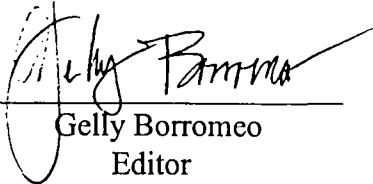
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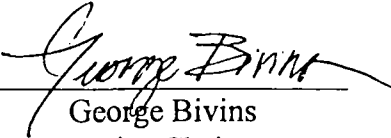
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Former California Secretary of
Health and Welfare and
Former National President
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Vice Chair
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Ortensia Lopez
Executive Officer
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Analysis of Minority Issues in the Tobacco Settlement

Latino Council on Alcohol and Tobacco

FIRST DRAFT

July 16, 1997

TOBACCO SETTLEMENT

MINORITY ISSUES

Italics denote correlating observations between the following minority issues and the Draft Final Report of the Advisory Committee on Tobacco Public Policy and Public Health, co-chaired by Dr. C. Everett Koop and Dr. David A. Kessler.

TITLE I: REFORMATION OF THE TOBACCO INDUSTRY

A. Restrictions on Marketing and Advertising

Prohibit the use of non-tobacco brand names of tobacco products except for tobacco products in existence as of January 1, 1995.

Restrict tobacco product advertising to FDA specified media.

Restrict permissible tobacco product advertising to black text on a white background except for advertising in adult-only facilities and in adult publications.

Require cigarette and smokeless tobacco product advertisements to carry the FDA-mandated statement of intended use ("Nicotine Delivery Device").

Ban all non-tobacco merchandise, including caps, jackets or bags bearing the name, logo or selling of a tobacco brand.

Ban offers of non-tobacco items or gifts based on proof of purchase of tobacco products.

Ban sponsorships, including concerts and sporting events, in the name, logo or selling message of a tobacco brand.

Ban the use of human images and cartoon characters, thereby eliminating Joe Camel and the Marlboro Man in all tobacco advertising and on tobacco product packages.

Ban all outdoor tobacco product advertising, including in enclosed stadiums as well as brand advertising

The restrictions seem to offer effective measures which may significantly decrease and prevent children from smoking. They will ban human images and cartoon characters in advertising, prohibit direct and indirect payments to "glamorize" tobacco use in media appealing to minors, and ban all non-tobacco merchandise bearing the name, logo or message of a tobacco brand.

There will be a loss of income for minority message advertisers. Provisions need to be made so that "counter-advertisements" must be bought from "minority" companies if it involves minority/and or targeted advertisements.

Minority store owners will likely lose income due to these provisions since "in-store" promotions will be lost. They will react negatively to the regulations.

The provision that bans sponsorships

directed outside from a retail establishment.

Prohibit tobacco product advertising on the internet unless designed to be inaccessible in or from the United States.

Establish nationwide restrictions in non adult-only facilities on point of sale advertising to minimize the impact of such advertising on minors.

Ban direct and indirect payments for tobacco product placement in movies, television programs and video games.

Prohibit direct and indirect payments to “glamorize” tobacco use in media appealing to minors, including recorded and live music performances.

Without limiting the FDA’s normal rule-making authority in this area, require that words currently used as product descriptors (e.g., “light” or “low tar”) be accompanied by a mandatory disclaimer in advertisements of brand styles (e.g., “Brand X not shown to be less hazardous than other cigarettes”).

B. Warnings, Labeling and Packaging

The settlement mandates that new rotating warnings be introduced concurrently into the distribution chain on all tobacco product packages and cartons, as well as in advertisements.

The FDA would be required to test, report, and disclose tobacco smoke constituents, including tar, nicotine and carbon monoxide.

C. Restrictions on Access to Tobacco Products

The legislation would build upon the FDA Rule by

is very important for the minority community. (See Title VII, A. (5). [page 8] for replacement funds to minority groups.)

This is a gain for all communities.

There are no provisions which specify types of advertising in communities of color. This is needed because of wording that exempts “adults-only facilities” from restrictions in the settlement (liquor stores, bars, casinos, etc.), are disproportionately located in minority communities. (Since children enter liquor stores, they could be “singled out” as places where children should not be allowed.

There must be a disclosure of all information related to marketing, including opinion and behavioral research; the targeting of children, women and racial and ethnic minorities.

This is a very important provision that we support.

This is also a gain for minority communities

This is a good provision

Some minority groups believe that these warnings need to be distributed in languages which reach ethnic population groups (i.e., Spanish, Chinese, Korean and other frequently spoken Asian languages). There is no consideration of this in the settlement. These warnings should be placed on cigarettes made for domestic use as well as export purposes.

This is an important provision.

Minority communities may be disproportionately

banning the sale of tobacco through vending machines and banning self-service displays of tobacco products except in adult-only facilities.

affected due to the “adult only facilities” wording. Furthermore, small shop owners may face a decrease in revenue if tobacco products and products associated with tobacco may no longer be sold there.

“Tobacco Shops” in Native American reservations will be disproportionately affected by the agreement. Provisions need to be made to compensate for the loss of revenue from the reservations as well as to protect Native Americans’ right to use tobacco for traditional and religious means, while at the same time discouraging abuse of manufactured addictive tobacco.

D. Licensing of Retail Tobacco Product Sellers

Any entity that sells tobacco directly to consumers, whether manufacturer, wholesaler, importer, distributor or retailer, would require a license.

Small retail owners will have to sacrifice financially in order to comply with license requirements.

More funds and/or personnel will be needed to ensure compliance with this licensing regulation. Density of these establishments needs to be considered when assigning those funds. Inner cities have more small “mom & pop” stores, requiring more compliance checks.

LCAT thinks this will benefit minority communities since they will be able to address merchants who break the law. It may even have a positive “spill over” effect on curtailing the sale of alcoholic beverages to underage kids, making ID card checking the norm.

E. Regulation of Tobacco Product Development and Manufacturing

Tobacco products will continue to be categorized as a drug, and the FDA will have permit to require product modification including nicotine content. The FDA would have to approve all health claims made by tobacco manufacturers of reduced risk products. Manufacturers will be required to notify the FDA of any technology they develop or acquire that reduces the risk of tobacco products. The FDA will also have the authority to hold tobacco manufacturers to performance standards to promote the production of “reduced risk” tobacco products, including the gradual reduction, but not elimination of nicotine yields and the possible elimination of other constituents or other harmful components of the tobacco product over a twelve year period based on the finding that the modification: (a) will result in a significant reduction of the health risks associated with such products to consumers thereof, (b) is technologically feasible, and (c) will not result in the creation of a black market.

The FDA should have full protection to have the authority to regulate nicotine and eliminate any clauses that may directly or indirectly interfere with this authority.

“Reduced risk” products need to be made affordable in order to treat nicotine addiction in poor communities.

The “performance standards” provision has caused concern from some tobacco control advocates because of the supposed of other restrictions it places on the FDA. However, it is important that nicotine be gradually reduced, due to the potential creation of a black market upon the immediate elimination of nicotine yields, and its potentially immediate and harmful effects on minority communities.

Legislation would also subject tobacco product manufacturers to good manufacturing practice standards including the implementation of a quality control system, inspection of tobacco product materials, requirements for proper handling of finished product, and tolerances for pesticide chemical residues in or on commodities in the possession of the manufacturer. The Act would also ensure that previously non-public or confidential documents from the files of the tobacco industry are disclosed to FDA, private litigants, and the public.

According to the settlement, tobacco jurisdiction does not specifically cover cigars. Cigar use is on rise among young people and in minority communities, and are sometimes used as "blunts" (to smoke marijuana, crack, PCP). The same regulations required for cigarette content should also apply for cigars, not just "short" or blunt cigarillos, "fine cut" or "roll your own" tobacco products.

In terms of nicotine regulation, the addictive nature of cigarettes and other tobacco products requires further research before final regulation. The creation of a "Scientific Advisory Panel is very important, so a determination is made of what are the dangers of use and abuse among adults of various ethnic, racial and gender groups. American Indian communities are particularly affected, as are Cuban-Americans who have used tobacco in a traditional as well as cultural way for centuries. Members of these communities need to be consulted and special provisions need to be made in order to research all communities of color.

Both prevention and treatment research needs to be conducted for each minority sub-group, since the patterns of use/abuse differ.

The new required practicing standards may adversely affect small tobacco farmers (Cuban American Floridians), who would have to make costly changes in order to meet new regulations. Thus, an economic assistance and development fund should be established (and funded by the tobacco industry) to assist tobacco farmers and their communities in developing alternatives to tobacco farming. Economic conversion funds should also be provided to assist tobacco manufacturing workers and related non-farm workers.

F. Non-Tobacco Ingredients

Under the legislation, tobacco companies would be required to provide the FDA on a confidential basis a list of all ingredients, substances, and other compounds which are added by the manufacturer to tobacco, paper or filter of the tobacco product by brand and by quantity in each brand, as well as scientific assessment proving the safety of each ingredient.

This provision benefits all communities.

G. Compliance and Corporate Culture

The Act will provide for means to ensure that the industry will not only comply with the letter of the law

but will also have powerful incentives to prevent underage usage of tobacco products and to strive to develop and market less hazardous tobacco products.

H. Effective Dates

Different requirements will become effective at separate intervals after the Act is signed by the President.

TITLE II: "LOOK BACK" PROVISIONS/STATE ENFORCEMENT INCENTIVES

In order to achieve dramatic results from the proposed legislation, the "look-back" provision sets targets for reducing current levels of underage tobacco use. For example, underage use of cigarette products must decline by at least 30% from estimated levels over the last decade by the fifth year after the legislation takes effect, by at least 50% from estimated levels over the last decade by the seventh year after the legislation takes effect, by at least 60% from estimated levels over the last decade by the tenth year after the legislation takes effect, and remain at such reduced levels or below thereafter.

If a target has not been met, FDA will impose a mandatory surcharge on the relevant industry based upon an approximation of the present value of the profit the industry would earn over the lives of all underage users in excess of the target, capped at \$2 billion.

The "look-back" provision should focus on specific ethnic and gender groups. Because certain populations experience higher rates of nicotine addiction, they should be targeted for greater assistance and expect substantial results. Teen rates for whites are greater than that of Latinos or African Americans. Thereby, cigarette companies can increase sales to the Latino and African American community while conceivably remaining within the concessions proposed by the settlement.

According to the settlement, cigarette companies will save on advertising. Thus, they will retain a large amount of money. This fact should be taken into account when determining penalties. For example, the Greenlining Institute recommends that the annual penalty for failing to meet the smoking reduction goals be raised from \$80 million to \$400 million per percentage point, and making such penalties non-tax deductible (Such information about reduction requirements, the surcharge, use of the surcharge, and abatement procedures are found in Appendix V of the settlement.)

TITLE III: PENALTIES AND ENFORCEMENT; CONSENT DECREES; NON-PARTICIPATING COMPANIES

A. Penalties and Enforcement

The legislation would be enforceable by the federal government and several states. The industry faces civil penalties of up to \$10 million per violation for any violations of the obligations to disclose to the FDA research about tobacco-product health effects and information regarding the toxicity of non-tobacco ingredients and constituents used in their products.

B. Consent Decrees

Certain terms of the agreement will also be reiterated in consent decrees between the tobacco

industry and the states that will not take effect until after enactment of the Act. The consent decrees will not contain provisions as to: (1) product design, performance or modification; (2) manufacturing standards and good manufacturing practices; (3) testing and regulation with respect to toxicity and ingredients approval; and (4) the national FDA "look back" provisions.

C. Non-participating companies

Non-participating manufacturers would receive none of receive none of the civil liability protections described in Title VIII. Their product would be subject to a user fee equal to the portion of the payments by participating manufacturers allocated to fund public health programs and federal and state enforcement of the access restrictions. Non-participating manufacturers will also be required to place 150% of its share of the annual payment required of participating manufacturers. Furthermore, the exemption from civil liability applicable to distributors and retailers of the products of participating manufacturers will not apply to distributors and retailers who handle tobacco products of non-participating manufacturers.

Small specialty manufacturers may be affected by these provisions. LCAT does not have data if/or minority companies or Native American Indian reservations would be affected.

TITLE IV: NATIONWIDE STANDARDS TO MINIMIZE INVOLUNTARY EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE

Smoking in "public facilities" would be restricted to ventilated areas with systems that exhaust the air directly to the outside, maintain the smoking area at "negative pressure" compared to adjoining areas, and do not recirculate the air inside the public facility. The legislation would exempt restaurants (but not "fast food" restaurants) and bars, private clubs, casinos, bingo parlors, tobacco merchants and prisons. Regulations to enforce the standards would be paid out of the Industry Payments. The legislation would not preempt or otherwise affect any other state or local law or regulation that restricts smoking in public facilities in an equal or stricter manner.

As aforementioned, facilities such as restaurants, bars and casinos are disproportionately located in minority communities. Additional efforts should be undertaken to determine the additional risks that environmental smoke places on those who work in these areas.

The prison population is largely minority and is affected by second hand smoke. Effective cessation programs should be instituted in conjunction with mandatory "smoke free zones" in our nation's prisons.

TITLE V: SCOPE AND EFFECT

A. Scope of FDA Authority

Applies to all product sold in U.S. commerce; covers new entrants, imports, U.S. duty free, etc.

B. State Authority

This is the most controversial provision in the entire settlement. In 1995, the United States' market only accounts for 9% of the world's tobacco consumption, while China consumes 32% of all cigarettes produced,

States, Indian tribes, military facilities, other federal agencies, and local governments preserve their legal authority to enact measures that further restrict or eliminate employee and general public exposure to smoking in workplaces and in other public and private places and facilities, and to further regulate, restrict or eliminate the sale or distribution of tobacco products, and to impose state or local taxes on such products.

Federal law currently provides for national uniformity of warning labels, packaging, labeling, other advertising requirements, and manufacturing requirements.

Japan 6%, Europe 12%, other Asian countries 13%, while other countries account for the remaining 28%.* Therefore, the large U.S. tobacco magnates, who are gaining even greater control over the world market, will continue to practice misleading advertising claims, control their own nicotine levels, and peddle their deadly product to the vast majority of their current customers. As a result, the settlement fails to damage "big tobacco" or even protect the millions of children around the globe who are confronted with these deadly products every day.

This is especially an affront to the minority community because of the large rise in cigarette addiction in Asia, Africa, and Latin America. Minority tobacco control advocates are deeply concerned with "double targeting" conducted by American companies in both the United States and their country of origin.

The mandate is that no cigarette shall be sold in the United States which exceeds a 12 mg "tar" yield, this should apply to all cigarettes manufactured by U.S. companies and sold abroad. All U.S. cigarettes sold abroad should conform to U.S. standards and regulations in packaging, warnings and content, including "tar" and nicotine yields.

These are "American" products.

Koop/Kessler proposes:

The U.S. should actively promote tobacco control worldwide.

The U.S. should actively promote the global adoption of U.S. domestic tobacco control policies through all international activities.

The U.S. should support the development and implementation of tobacco control activities by the World Health Organization and UNICEF, including the Framework Tobacco Control Convention.

The U.S. should support bilateral and multilateral treaties making the Framework Convention legally binding to all countries.

The U.S. should remove tobacco products from Section 301 of the 1974 Trade Act and should

* Swoboda, Frank and Martha M. Hamilton. "Two on Top of the World". The Washington Post. 7 July 1997. Washington Business, p. 10

prohibit Federal agency interference in international or national control activities.

The U.S. should support international research efforts to determine the most effective means of preventing the initiation of tobacco use and of smoking cessation.

The U.S. should provide financial support for WHO and UNICEF efforts to control tobacco use.

International exchange and scientific conferences on nicotine and other components of tobacco products should be convened among industry researchers and public researchers (such as those from the FDA, CDC, NIH, and WHO).

LCAT believes that international regulation of tobacco will benefit our nation's minorities as well as humanity as a whole. LCAT further suggests that tobacco companies should contribute 10% of their international tobacco sales profits to the World Health Organization or other agreed upon international agencies for tobacco-control programs.

TITLE VI: PROGRAMS/ FUNDING

A. Up Front Commitment-- Lump Sum Cash Payment -- \$10 billion.

B. Base Annual Payments-- 25 year total face value is \$358.5 billion.

C. Applicability-- Applicable to all sellers of tobacco Products.

D. Tax Treatment-- All payments pursuant to this Agreement shall be deemed ordinary and necessary business expenses to the year of payment.

There is a concern (as outlined by a statement by Communities of Color in the United States on private negotiations toward a proposed "settlement" with the tobacco industry) that "...a large monetary settlement will only shift the burden of payment from the general public to individual smokers. This has the potential to victimize low-income smokers disproportionately..."

Therefore, necessary action must be taken to ensure that a significant rise in the price of cigarettes be balanced with effective and available cessation plans. *If an effective cessation plan can be maintained, a large tax should be enacted, as it has been shown that a price increase in cigarettes deters youth smoking.* Yet, if a successful cessation plan cannot be maintained, there will be a dangerous potential for a "black market", which, according to the Onyx Group, "is a real possibility for low-income, Black communities". The same is true for Latin, Asian and American Indian communities.

TITLE VII: PUBLIC HEALTH FUNDS FROM TOBACCO SETTLEMENT

As Recommended By the Attorneys General For Consideration By the President and the Congress

Based on the premise of \$1 billion for the first year and gradually increasing to \$1.5 billion thereafter, adjusted for inflation after the first year.

Based on the premise of \$1 billion for smoking cessation for the first 4 years and \$1.5 billion thereafter, adjusted for inflation.

This is a much-needed provision. Cessation programs have historically been ineffective in treating minority smokers. *Culturally-appropriate plans need to be implemented in order for successful treatment.* Specific funds for affordable nicotine patches, nicotine gum, and counseling should be included.

A. Allocation of Grant Moneys Among Programs-

The use of moneys under this section shall be limited to programs established under this section, shall be adjusted for inflation annually from the effective date, and shall be allocated among such programs as follows:

(1) \$125,000,000 for the first three years and \$225,000,000 annually thereafter to the Secretary of HHS to accomplish the purposes described in Paragraph (B) of this Section.

(2) \$300,000,000 annually for the FDA to carry out its obligations under the Act and to enforce the terms of this Act, including for grants to the states to assist in the enforcement of the Provisions of the Act.

Once again, the FDA must be granted full authority to regulate nicotine levels in cigarettes as a result of the settlement. FDA should be adequately funded to carry out its regulatory, enforcement, public education, and research activities.

(3) \$75,000,000 for the first two years, \$100,000,000 in the third year, and \$125,000,000 annually thereafter to fund state and local tobacco control community based efforts Modeled on the ASSIST program, designed to encourage community involvement in reducing tobacco use and the enactment and implementation of policies designed to reduce the use of tobacco products

Steps must be taken to ensure that minority community needs be uniquely serviced.

(4) \$100,000,000 annually to fund the research and development of methods to discourage individuals from starting to use tobacco and how to help individuals quit using tobacco.

Research work should be focused in the area of specific cessation programs for minority smokers, due to different trends in choice of brand (e.g. black smokers tend to smoke menthol cigarettes, Latinos smoke cigars, etc.).

The FDA should have the ability to test nicotine levels by brand, based on the best science.

(5) Beginning in the second year, \$75,000,000 annually for a period of ten years to compensate events, teams or such events who lose sponsorship by the tobacco industry

A specific percentage of the \$75 million assigned to compensate for loss of entries in sponsorship by the tobacco industry to minority cultural,

as a result of this Act, or who currently receive tobacco industry funding to sponsor events and elect to replace that funding, provided that the event, team, or entry is otherwise unable to replace its tobacco industry sponsorship during those given years. Funds used for this purpose shall be used as follows: 50% to supplement funding of the multimedia campaigns in paragraph (1) of this subsection; 25% to supplement the funding of the enforcement provisions of paragraph (2) of this subsection; and 25% to supplement the funding of community action programs in paragraph (3) of this subsection.

B. Establishment of Programs by the Secretary-

The Secretary shall establish programs to accomplish the following purposes-

(1) The reduction of tobacco product usage, both by seeking to discourage the initiation of tobacco use by persons under 18 and by encouraging current tobacco users to quit through media-based and non-media based education, prevention and cessation campaigns. The Secretary may make grants to health departments to assist in carrying out the purposes of this provision.

(2) The research, development and public dissemination of technologies and methods to reduce the risk of dependence and injury from tobacco product usage and exposure.

(3) The identification, testing and evaluation of the health effects of both tobacco and non-tobacco constituents of tobacco products.

(4) The promulgation of such other rules and regulations as are necessary and proper to carry out the provisions of this Act, as well as the development of such other programs as the Secretary determines are consistent with the goals of the Act.

political, social, economic, arts, sports, education and health national and community groups should be provided for minority-led and related groups.

Cessation programs need to be promoted and targeted at specific ethnic/racial groups. Funds should be available to purchase nicotine patches, gum, and other products and/or make these products state affordable to low income smokers. *It should encourage maximum overall reduction in disease.* Funds should be allotted according to the ethnic and gender composition of each state, for use by minority entities to design and implement continuous, culturally sensitive and language appropriate cessation education and counseling programs.

Public education and prevention campaigns should be in the appropriate language and have culturally sensitive and gender sensitive messages. Multimedia campaigns should be funded through minority-owned advertising agencies, newspapers, magazines, radio and television stations that focus on each of the ethnic minority populations. These funds should be appropriated according to the potential viewership and or readership at the community level. American Indian publications should be funded in order to incorporate appropriate messages.

This should be by ethnic groups, since more African Americans smoke menthol cigarettes, more Cuban-Americans smoke cigars, etc. The effects are different, the illness and propensities to diabetes, high blood pressure, etc. are different by ethnic background.

C. Public Education Campaign- \$500,000,000 shall be spent annually in such multimedia campaigns designed to discourage and de-glamorize the use of tobacco products. To carry out such efforts, an independent non-profit organization with a Board of prestigious individuals and leaders of major public health organizations shall be created to contract or make grants to non-profit private entities unaffiliated with tobacco manufacturers or importers, who have a demonstrated record of working effectively to reduce tobacco product use and expertise in multimedia communications campaigns. The independent body shall be authorized to contract with state health departments, where appropriate, to run campaigns for their states and communities. In creating the program the independent body shall also take into account the needs of particular populations. The goal shall be the reduction of tobacco product usage, both by seeking to discourage the initiation of tobacco use by persons under the age of 18 and by encouraging current tobacco users to quit.

See Section B (2), above, for minority stance on Public Education Campaign.

D. Tobacco Use Cessation- For the first 4 years, \$1 billion, and thereafter, \$1.5 billion of the total amount paid by the tobacco industry shall be paid into a Trust Fund to be used to assist individuals who want to quit using tobacco. Within 12 months the Secretary shall promulgate regulations to govern (1) the establishment of criteria and a procedure for the approval of cessation programs and devices for which payment may be made under the program, (2) the eligibility requirements for individuals seeking to use moneys from the trust to fund the tobacco cessation efforts, and (3) the procedures to govern the tobacco cessation program.

The goal of the tobacco cessation program shall be to enable the most tobacco users possible to receive assistance in their effort to quit using tobacco by providing financial assistance and identifying the programs, techniques, and devices that have been shown to be safe and effective. Benefits to individuals should not be limited to a single effort, but should be tailored to the needs of individual smokers according to standards established by the Secretary using the best available scientific guidelines.

E. Public Health Trust Fund Presidential Commission- A Presidential commission will be appointed to include representatives of the public health community, Attorneys General, Castano attorneys and others to determine the specific tobacco-related medical research for which the \$25 billion Public Trust Fund will be used.

Women and all members of minority communities must be specifically represented on the commission.

TITLE VIII: CIVIL LIABILITY

A. General - Current Attorney General actions (or similar actions brought by or on behalf of any governmental entity), *parens patriae* and class actions are legislatively settled. No future prosecution of such actions. All "addiction" and dependence claims are settled and all other personal injury claims are reserved. As to signatory states, pending Congressional enactment, no stay applications will be made in pending actions, based upon the fact of this resolution, without mutual consent of the parties.

B. Provisions as to Civil Liability for Past Conduct: The following provisions apply to suits for relief arising from past conduct—i.e., suits by persons claiming injury or damage caused by conduct taking place prior to the effective date of the Act.

1. All punitive damages claims resolved as part of overall settlement. No punitive damages in individual tort actions.

2. Individual trials only: i.e., no class actions, joinder, aggregations, consolidations, extrapolations or other devices to resolve cases other than on the basis of individual trials, without defendant's consent.

This provision is especially harsh to the majority of minority communities where individuals do not have the funds to file suit against a tobacco company due to legal fees. Only allowing class action suits on condition of the defendant's consent is not good policy.

..... 9. Annual aggregate cap for judgments/settlements: 33% of annual industry base payment (including any reductions for volume decline). If aggregate judgments/settlements for a year exceed annual aggregate cap, excess does not have to be paid that year and rolls over.

C. Provisions as to Civil Liability for Future Conduct

Paragraphs 2, 3, 5, 6, 7, 8, 9, 10, and 11 in Section B apply.

As in the Provisions as to Civil Liability for Past Conduct, these provisions are significantly flawed due to the restrictions of class action suits. The rich are the only people who could possibly benefit from this sort of policy. All avenues of litigation must be kept open.

TITLE X: BOARD APPROVAL

The terms of this resolution are subject to approval by the Boards of Directors of the participating tobacco companies.

This analysis was written by Jeannette Noltinius and John Walker of the Latino Council on Alcohol and Tobacco.

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◆ LCAT NEWS ◆

Volume 11, Issue 3

Summer 1997

Don't repeal the beer tax!

LCAT joins CSPI and NCADD in protest of bill to lower beer taxes. On May 15, LCAT, along with the Center for Science in the Public Interest (CSPI) and the National Council on Alcoholism and Drug Dependence (NCADD), participated in a protest against HR 158, legislation that would reduce federal excise taxes on beer.

In 1991, the tax on a 31-gallon barrel of beer was \$18, which amounts to roughly 5 cents per 12-ounce serving, or 32 cents per six-pack. Had the tax, which was originally imposed in the 1950's, kept up with inflation, today the tax on the same barrel of beer would be approximately \$49, or 84 cents per six-pack.

In 1996, beer taxes contributed more than \$3.3 billion to the U.S. Treasury, only a small fraction of the enormous economic societal costs generated by excessive beer consumption. Adjusting the tax rate for inflation and requiring automatic inflation adjustments in the future would provide billions more dollars to the treasury and help reduce the cost of alcohol problems, particularly among young people.

At the May 15 protest all members of Congress received empty beer bottles

The American people strongly support excise tax increases

⇒ 87% FAVORED A 50 CENT TAX INCREASE ON A SIX-PACK OF BEER (WSJ / NBC-TV NEWS POLL,



3/12/93)
⇒ 77% SUPPORTED THE SAME BEER TAX INCREASE IN A 4/93 WASHINGTON POST/ABC NEWS POLL.
⇒ ONE MONTH LATER (5/93), A GALLUP POLL FOUND AN ALCOHOL TAX INCREASE TO BE THE MOST POPULAR OPTION AMONG A RANGE OF TAX INCREASES, AT 75% APPROVAL.

bearing labels proclaiming "A child's life is worth more than cheaper beer." The results of a study showing that an increase of the tax would save 600 young lives each year was released at the protest. The tax increase would also decrease school dropouts, crime, unwanted pregnancies, accidental deaths, and numerous other injuries and social and economic costs to society. Other studies have previously shown that lowering the beer tax would increase the frequency of drinking among youth.

While teenagers distributed the beer bottles in the background, representatives from CSPI and NCADD spoke to members of the press. Latino and African American teenagers that supported LCAT's work were interviewed by *Bill Moyer's Journal* on their personal experiences with alcohol and underage drinking. The teens interviewed felt that higher prices would reduce consumption and violence in their neighborhoods and schools.

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Alcohol Tax Equalization

Rep. Eleanor Holmes Norton reintroduces "Alcohol Tax Equalization Act of 1997". Concerned that the July 4th celebration would once again result in accidents, violence and other dire consequences for those young and old who insist on celebrating by consuming too much alcohol, Rep. Holmes Norton on June 24th reintroduced a bill that would raise beer and wine taxes to the same level as the tax on hard liquor. She said: "Beer is what America, and especially young America, drinks. In 1995, 60.3% of all alcohol sold was beer and 11.4% was wine. Only 28.4 % was hard liquor. America is getting drunk on beer and wine. It is time for the taxes on beer and wine to reflect their alcohol content. A can of beer, a 5 ounce of wine, a wine cooler and a shot of vodka are the same thing." Alcohol equivalence is a reality. A drink, is a drink, is a drink! Taxes have not reflected this. Beer and wine taxes are almost half of those imposed on liquor. This bill will increase taxes on beer and wine and will discourage teens from drinking. If you want a copy of this bill call (202) 225-3002.

FCC Deadlocked on Hard Liquor Ads on TV

On July 9th, the Federal Communications Commission (FCC) voted 2-2 on whether to investigate liquor advertising on TV and radio. Despite Reed Hundt's efforts to have an investigation take place, Commissioners Quello and Chong did not budge from their previously stated position. Quello argued that the FCC should wait until the FTC comes out with a "report" on

their investigation on deceptive TV advertising, even though a "report" may not be forthcoming for some time. He also argued that the key members of Congress in charge of the pertinent committees stated that they don't consider this an FCC matter. For Quello, the less you do, the better. Yet, the less the FCC does, the more it risks harming our country's children. According to a survey conducted by the alcohol industry, 73% of the public believes alcohol advertisements are a major contributor to underage drinking. Over 50 percent of teen mothers conceive under the influence of alcohol, and 60 percent of young violent crime victims are found to have alcohol in their system. When will we finally wake up and demand regulation? Latino and minority groups are encouraged to monitor both Spanish and English local radio stations and TV cable channels to determine the content, time, frequency and actual lyrics of the ads. LCAT intends to submit a petition to the FCC for a Notice of Inquiry on advertising in Spanish and/or directed at Spanish-speaking audiences. *Please tape the radio and TV messages. We need this data to request special counter-advertising messages down the road. Seagram's, Allied Dome (Kahlua) and International Distillers (Heublein) have been advertising on TV. Keep an eye on BET, Univision and Telemundo. Those of you who listen to Spanish radio, please listen for these ads. Let's keep up the pressure, by providing data on occurrence. If you want more information call CSPI at (202) 332-9110 or NCADD at (202) 737-8122.*

Hard liquor ads may be trickling onto cable and ethnic networks, as well as radio stations. Please tape them and send them to LCAT.

TOBACCO SETTLEMENT DISCUSSIONS GET SENT UP TO THE WHITE HOUSE!

***The Settlement
does address im-
portant issues that
will improve pub-
lic health. It
doesn't address
other vital issues
for minority com-
munities. We
need to be at the
table making rec-
ommendations not
just saying No.
As we oppose we
can propose.***

July 11, 1997. After the hoopla and celebration by the Attorneys General the day of the "Global Tobacco Settlement" announcement and after the closing meeting of the Koop/Kessler Committee deliberations, the talks move to the White House. From news accounts and reliable sources inside the White House, all the players will be asked to say their piece about the Settlement and the "Blueprint for Tobacco Control" (Koop/Kessler). LCAT has requested a meeting not just to present LCAT's point of view, but to give the opportunity to minority representatives from the Tobacco Control Networks of California, American Indian, Asian and African American groups nationwide to have a chance to express themselves directly at the White House. Our moment will come the week of July 21st. If it doesn't, we will complain.

LCAT's position is:

1) From the beginning of this process, minority communities were not represented in the Settlement negotiations and underrepresented on the Koop/Kessler Committee. Therefore, minorities have been excluded from the process, just as they have been excluded from most national tobacco control and policy activities in the past. In such states as California, state-assigned funds have made a difference since prevention programs have been designed and implemented by and for

minorities.

2) Minorities have been specifically targeted by the tobacco companies since before the early 1960's and have received a double dose of advertising (i.e. in Spanish and English). The minority leadership has been effectively silenced by sponsorships of conferences, civil rights, political and social organizations, as well as the arts and sports, where groups have received "philanthropic" support. The minority political leadership has received Tobacco PAC funds, as have most politicians, and, therefore, has not confronted the tobacco companies.

3) Congress and local legislatures still are essentially pro-tobacco, even though some states have raised taxes on tobacco and banned vending machines and billboards advertising tobacco. This Congress' \$0.20 tax increase in the child health bill is still in trouble, even though the initial proposal was for a \$1 increase, then fell to \$0.43 and finally settled at \$0.20. And is still in trouble.

4) Appropriations for the FDA's tobacco rule, proposed at \$34 million, have already been cut to \$15 million at the Subcommittee level and it is still uncertain whether that whole amount will come out of the budget reconciliation process. The Administration's Tobacco Rule was good, but if Congress doesn't appropriate funds for its implementation, it

The Tobacco Settlement continued.....

will simply stay on the books and not spring into meaningful campaigns to request ID. The other provisions to limit advertising that would really curb tobacco use among children is still pending in the 4th District Court. FDA financing requirements and Congressional reaction to them gives public health advocates a "read" on what can happen if we rely solely on funding from Congress for greater public health campaigns. For years, Surgeon Generals have talked about the public health consequences of smoking, yet the budgets requested or allotted for tobacco control have not mirrored these concerns. Minorities have not been active, and we should admit this.

5) LCAT has no expertise to comment on the effectiveness or impact of litigation on the industry or the public health community as a whole, only that ETS rules may be strengthened. Minorities have traditionally not been a party to litigation either individually or through class action. As we understand it, some Attorneys General have been successful in obtaining compensation for state expenditures on tobacco-related illnesses and the settlement does pay for 40 AG suits. There are more AG cases in the pipeline that may hurt the tobacco companies, such as the Minnesota case. The Liggett Settlement and others have brought to light documents that show the insidious lies and deceptions of the industry. And the Minnesota AG attests to have many more documents that, when they see the light of day, could improve chances for litigation. The litigation process, if continued successfully, could in time break the financial stability of the industry and that has been

one of the reasons why they went for the settlement. But this could be a long and treacherous road, with some results for individuals and class action cases. But what does all of this really mean in terms of public health gains?

6) The Settlement does effectively address issues of youth access, advertising and marketing, and if modified fairly, with specific funds assigned to cover specific minority concerns, could in the future curb smoking addiction in America.

BUT it doesn't fully address other important issues such as :

- The FDA's ability to regulate nicotine and tobacco products, including company oversight and its impact on black market. It should incorporate cigars in the definition of tobacco products.
- The inability to file class action suits against tobacco in the past and the future—the poor and minorities will likely not be able to file individual suits.
- Inadequate penalties for failing to reduce children's use, and remedies not specifically targeted at ethnic minority groups.
- High tobacco prices will be a burden to the poor, women and minority adults who are hooked, affecting their ability to buy basic items. The poor will pay for settlement costs.
- A black market will be created that will likely take hold in minority inner city communities.
- It doesn't deal with the need for international tobacco control activities, thereby putting the world's children at risk. Minority immigrant populations are particularly affected. The percentage of the world's cigarette consumption in 1995 indicates that 91% is consumed outside the US and only 9% inside the US market.



World Cigarette Consumption:

32% People's Rep. of China
 12% Europe
 9% United States
 6% Japan
 13% Other Asian countries
 28% Other countries
The Washington Post, 7/7/97

(For a complete analysis of LCAT's concerns with the tobacco settlement, please contact us at 202-371-1186).

The Settlement is a politically "realistic" option and may provide a viable solution for tobacco control at this political time; but has serious consequences and omissions. In order for LCAT to support it a legislative package based on the settlement, it must deal effectively with the issues mentioned above and consider inserting the following recommendations:

Domestically:

- FDA should have full authority to regulate nicotine and all ingredients in tobacco products.
- Cigars and all tobacco products should be regulated.
- Tobacco company penalties for not curbing youth cigarette use should be raised considerably per percentage point and determined by ethnic/racial and gender-specific statistics. If the percentage of young white smokers decreases, so should the percentages of all ethnic minorities and genders. These penalties should not be tax deductible.
- Cessation programs need to be promoted and targeted at specific ethnic/racial groups, for adults and adolescents. Funds should be available to purchase nicotine patches, gum and other products and/or make these products affordable to low income smokers. Funds should be allotted according to the ethnic and gender composition of each state, to minority entities to design and implement continuous, culturally sensitive and language appropriate cessation education and counseling programs.
- Public education and prevention campaigns should be in the appropriate language and have culturally sensitive and gender sensitive messages. Multimedia campaigns should be funded through minority-owned advertising agencies, newspapers, magazines, radio and television stations that focus on each of the ethnic minority populations. These funds should be appropriated according to potential viewership and/or readership at the community level. American Indian publications should be funded in order to incorporate appropriate messages.
- The Scientific Advisory Panel should fund research to determine how minority communities will be affected by all provisions of the agreement, including: youth access, marketing, advertising,

sponsorship, cessation, public education, addiction rates and consequences of various brands and types of tobacco products (Cubans and cigars, African-Americans and mentholated cigarettes, American Indians and smokeless tobacco, etc.) and recommendations and funds should be correspondingly allocated.

- A specific percentage of the \$ 75 million assigned to compensate for loss of sponsorship by the tobacco industry to minority cultural, political, social, economic, arts, sports, education and health national and community groups should be provided for minority lead and related groups. Minorities should determine process of allocation of resources.
- The Koop/Kessler recommendations on compensation to small tobacco farmers should be incorporated into the Settlement.
- The exception of "adult only" facilities in the Settlement should be revisited, taking into consideration that places such as casinos, nightclubs, liquor stores, bars, etc., are disproportionately located in minority communities. Adult only facilities could include bingo salons, lottery outlets, etc., but before making this determination feedback should be obtained from minority leaders.

Internationally:

- HHS should assign a yearly portion of the \$50 million it will receive to international control activities. This should be done through the World Health Organization. A portion should specifically be earmarked for PAHO's interagency Tobacco Control Task Force. Funds should be used to standardize tobacco control worldwide, restricting advertising, promotion and sponsorship.
- US tar and nicotine levels and non-tobacco ingredient regulations should apply worldwide to US owned companies, including its subsidiaries.
- All US exported cigarettes should have warnings in language of port of entry.
- Add other Koop/Kessler provisions, such as restrictions on government promoting tobacco abroad.

Beer Sting in Washington, DC

The "We ID" campaign doesn't work. 62.5% of the time kids can purchase beer without being asked for ID!

LCAT participated in CSPI's sting on Washington DC beer retailers. On May 19, the Center for Science in the Public Interest (CSPI) released the results of a sting operation performed with LCAT's support to show the ineffectiveness of the beer industry's national "We ID" campaign. The "We ID" campaign distributed stickers to retailers who sell beer to promote age checks. To prove that young people without proof of age have little trouble buying beer, CSPI had adults who look under 21 attempt to purchase beer at retailers in the area. Unfortunately, the sting proved successful—62.5% of the time the purchaser was able to buy beer without using any proof of age. "Kids don't need fake IDs in DC," said George Hacker, Director of CSPI's Alcohol Policies Project, "many retailers just don't check." Representatives from the Latin American Youth Center and 'Cause Children Count Coalition also shared their views at the press conference, whose audience included representatives from FOX News, News 7, ABC, and reporters from the *Washington Post* and *Washington Times*. Copies of the press release and study conducted are available at CSPI (202) 332-9110, ext. 341.

SMOKING CESSATION

LCAT, 'Cause Children Count Coalition and LAYC co-sponsor their first training for Latino Smoking Cessation Facilitators. A group of 18 enthusiastic and dedicated young people (most under 21) met in May and June for five sessions to become smoking cessation facilitators. Representatives of the Latin American Youth Center (LAYC), the PTA of Bell Multi-Cultural School, Americorps and neighborhood students took the course that was held at LAYC's offices. Roberto Noriega of the Tobacco Control Department of DC's Health Department held the bilingual workshop. He distributed a training manual in Spanish and provided materials in both languages. In order to teach by observation, sessions included five people who wanted to quit smoking, and the facilitators who wanted to become cessation facilitators observed the process. Three of the smokers quit through this workshop. If you want to learn more about follow up activities in the Latino community, please contact Dr. Carmen Duran at LAYC (202) 265-9225. Cessation programs for youth start in the fall.

FDA makes ID poster available in Spanish.

The Food and Drug Administration (FDA) is printing 10,000 posters in Spanish to allow national and community groups to distribute them to retailers across the country. The attached poster is a small, black and white version of the color poster. If you would like to receive copies of the color poster please contact the following number: **1-888-FDA4KIDS**. Retailer brochures in English are available in the tobacco section of the FDA's web site, www.fda.gov. Please feel free to copy and post the attached mini-poster. HHS will hold a National Hispanic Health Symposium, "Building a Healthy Nation", Sept. 11-13, 1997, in Los Angeles. Call (202) 797-4313 for more information.

¿Cuál de Las Dos Tiene 16 Años?



Lena



Anita

Photograph by Rhoda Bear

La venta de cigarrillos o tabaco para mascar, a cualquier persona menor de 18 años de edad es ilegal.*

Para eliminar las dudas, los comerciantes deben verificar la edad de los compradores menores de 27 años.

Si usted tiene menos de 27 años favor de mostrar su tarjeta de identidad con su fotografía. Solamente toma un momento. Si usted tiene menos de 18 años, ningún comerciante puede venderle productos de tabaco.

Lena tiene 16 años. Anita tiene 25 años.

*La edad mínima es más alta en algunos estados.



ADMINISTRACION
DE DROGAS Y ALIMENTOS

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*Committed to combat-
ing alcohol & to-
bacco related harm
and their underlying
causes in the Latino
Community.*

In This Issue...

Don't Repeal Beer Tax, FCC on Hard Liquor Ads, Tobacco Settlement.....

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◆ LCAT NEWS ◆

Volume II, Issue 2 Special Tobacco Issue

Spring 1997

The Latino Council on Alcohol and Tobacco (LCAT) is dedicating this issue to tobacco control. We will be sending our members an update of recent activities and alcohol policy developments in our Summer issue.

DID YOU

KNOW THAT?

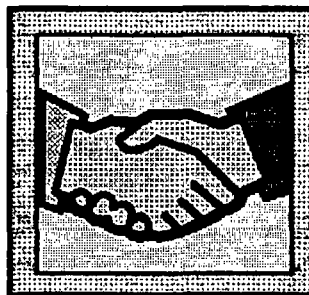
- ◆ 19.5 % of Latino adults (24.3% of men and 15.2% of women), are currently smokers.
- ◆ A 1990 survey showed that, among Latinos living in the US, Cuban (64.1%), and Puerto Rican (52.3%) men were most likely to be heavy smokers, (1+ pack(s) per day), compared to 33.8% of Mexican American male smokers.

Campaign for Tobacco-Free Kids. 1997

Tobacco Settlement? Maybe. Will it blow up in smoke and/or protect public health interests? Who is or should be at the table?

Spring 1997 will be remembered by many tobacco control advocates as a series of rounds in a boxing match against the tobacco giants. Sometimes tobacco winning, sometimes losing, but mostly as a tough fight whose outcome may be ultimately decided by a technical knock-out, or called off in favor of a negotiated settlement. Who are the fighters? Attorneys general, plaintiffs' lawyers, tobacco CEOs, smokers that are dying prematurely and some longtime tobacco control advocates are in the ring.

But, if there is a settlement, who represents the public health community at the negotiating table? Will it be better to fight to the 10th round or settle? If tobacco advocates are at the table, can they be free to walk out? The giants have duped us in the past, will they get what they want at the expense of public health? What is best for the health of the nation? What is best for the public health con-



cerns of the whole world: fight or settle? Who should be at the negotiation's table representing public health interest at large? At this moment, it appears that Matt Myers of the Campaign for

Will a "Deal" protect the health and interest of all Americans?

Tobacco-Free Kids

will be doing the punching, some others joining in as it evolves. But can one or two advocates really represent all sectors of the tobacco control movement? Who is representing the point of view of communities of color? Why should these negotiations be done in a secretive and selective manner? Why should we be left out?

Round one: Dr. David Kessler, as Commissioner of the Food and Drug Adminis-

tration (FDA), was able to push an FDA Tobacco Rule that gave the FDA the authority over nicotine since FDA proved it was a drug, and cigarettes were devices that delivered this addictive drug to the public. The FDA demonstrated that tobacco companies tampered with tobacco in order to increase the levels of nicotine delivered through cigarettes. The FDA also proved that many of the "additives" were specifically selected because they increased the nicotine "punch" for smokers. Lastly, the FDA made a strong case for regulating the sale, distribution, advertising and promotion of cigarettes since these were luring children into becoming addicts before the age of 18. President Clinton supported Dr. Kessler and the final rule was approved. On February 28th, 1997, in most states, sales clerks started asking for photo ID's for those under 27 years of age before selling them cigarettes; no cigarette sales to anyone under 18 or higher in some states.

Round two: The Liggett Settlement brought to light docu-

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Tobacco Settlement? Maybe. Will it protect the gains achieved..

ments that proved that tobacco companies knew that nicotine was addictive and that they were deliberately targeting youth and minorities. Liggett broke the code of silence forcing tobacco executives around the country to admit that they purposefully produce, promote, advertise, and sell an addictive drug that damages vital organs and ultimately is responsible for a smoker's death.

Round three: The tobacco companies sued the federal government claiming the FDA has no jurisdiction over nicotine or over the advertising of these products. North Carolina Judge Osteen's decision was a surprising victory for tobacco control since it sustained the FDA's jurisdiction over nicotine, as a "drug" or as a "device," but a setback since it ruled that the FDA cannot rule over advertising to children. The decision will be appealed by the tobacco companies and the government alike. If the decision is upheld, Judge Osteen's ruling would give great power to the FDA and this gain cannot be watered down or blown away in any "settlement" negotiation.

Round four: Before round three was decided, pressure mounted against the two largest cigarette makers Philip Morris Cos. and RJR Nabisco Holdings Corp. representing themselves as well as major US tobacco companies, Loews Corp's Lorillard and B.A.T.

Industries PLC's Brown & Williamson's unit, who made an unexpected move by seeking a deal. They are besieged by current mounting liability lawsuits and a black cloud over their future profits; they want to pay now, and ensure their future profitability. In addition, the non-smoker's rights movement has successfully promoted ordinances prohibiting smoking in public and some commercial spaces. After recent insider document disclosures made it evident that tobacco companies knew of the dangers of their addictive products and deliberately marketed them to teenagers. (Tobacco executive's 1994 Congressional testimony is a joke.) Tobacco wants to pay now and be free from future liability. But as the "settlement" talks get underway, the tobacco companies seem to be backing away from requiring "immunity" for their "\$300 billion fund" to settle all smoking-related claims brought by individuals and states in exchange for complete legal protection. Finally we are heading a resounding "NO" to blanket immunity! But will this hold through the round of negotiations starting in May in Dallas? Some think that there is only a 50-50 chance the negotiations will proceed. Others believe that since the tobacco companies are on the run (even if they "win" some individual cases) settlement is a give away.

Round five: Technical Knockout or Settlement. Negotiations are going on

and maybe they will result in a settlement whether the public health community agrees with it or not. And/or whether communities of color as a whole or representatives of individual constituencies are at the table or not. Some newspaper articles, editorials and OpEds question whether the Campaign for Tobacco-Free Kids has the "authority" to negotiate for the public health community and/or whether the attorneys general interested in recuperating funds immediately are the best suited to negotiate the future. What is necessary is to carry out an open discussion as to what is best for the nation's children, the world's children and public health in general.

LCAT believes that a settlement at this point of the game is premature. Negotiations are going on, whether we like it or not. Latinos and other minorities should make their positions known to the attorneys general, the Campaign for Tobacco-Free Kids (see article), the major groups, and the general public. We don't want to be sold out; we insist that minority concerns be heard and taken into account. Communities of Color will not stop fighting until our communities are not targeted by tobacco and the world's children are protected and free from all worldwide marketing strategies and sales.

Communities of Color take a position on the Settlement ...continues page3

Members of NAAAPI, African American, Asian, American Indian and Latino organizations as members of Communities of Color in the US are concerned about the content and form of negotiations currently underway between the tobacco industry and attorneys general and lawyers for victims of tobacco. Our major concerns are in three areas:

1. As African-Americans, Asian Americans/Pacific Islanders, Latinos/

Hispanics, Native Americans and Alaskan Natives, we understand that tobacco use and abuse has impacted each of our communities differently and that the tobacco industry has deliberately targeted our communities in various ways. Since people of color are not included "at the table" in these negotiations and discussions, we are concerned that the issues currently being brokered do not fully address our concerns as racial groups, ethnicities and tribal nations. Our fear is

a settlement that is negotiated without our voices as part of the discussion will continue to leave our communities vulnerable to the ravages of tobacco.

2. With respect to the issues being negotiated by the Attorneys General, the major reason for the litigation is that public monies are being spent on health services to persons with illnesses caused by tobacco.

Campaign for Tobacco-Free Kids at the table.

On April 24th, 1997, the National Center for Tobacco-Free Kids sent a Dear Colleague letter. What follows is a partial presentation of what it says. "As you know, discussions are taking place among representatives of the tobacco industry, state attorneys general, plaintiffs' lawyers and others. We have been involved, not as an official repre-

sentative of any other organization, but to represent a set of public health principles. Because of your commitment to protecting children from tobacco addiction, and all that is at stake, we want to explain the principles that have been central to the discussions thus far, and will remain so. These principles were developed in conjunction with several leading public health organizations including American Cancer Society, American Heart Association, American Medical Association, American Lung Association, American Academy of Pediatrics, and the American Academy of Family Physicians. We believe strongly that there must be no compromise with the tobacco industry that fails to meet these fundamental goals:

"We believe strongly that there must be no compromise ...that fails to meet these fundamental goals:"

far, and will remain so. These principles were developed in conjunction with several leading public health organizations including American Cancer Society, American Heart Association, American Medical Association, American Lung Association, American Academy of Pediatrics, and the American Academy of Family Physicians. We believe strongly that there must be no compromise with the tobacco industry that fails to meet these fundamental goals:

1. Regulatory Authority: The FDA must have the authority to regulate the manufacture, sale, labeling, distribution, and marketing of tobacco products.

2. Minimum Standard: The current FDA requirements governing youth access and tobacco marketing are essential minimum components of any public policy initiative. The agency's ability to augment these requirements should not be curtailed.

3. Public Education: A well funded, effective sustained public education campaign that is protected from political pressure is critical to reducing tobacco use.

4. Preemption: Congress should not preempt state or local laws that are stronger than federal laws, nor should the FDA be preempted from revising the form, content, and placement of the warnings on cigarette packs.

5. Public Disclosure: The tobacco industry must disclose its research and studies about the effects of its products, including nicotine on the human body and the marketing of tobacco to children.

6. Rights of Victims: The rights of victims of the To-

bacco industry to seek compensation for the injuries they have suffered should not be abridged and the tobacco industry should not be immunized from accountability for its wrongdoing. We are aware that any discussion with the tobacco industry involves risks. Our participation represents our view that while we are rightly skeptical, we are prepared to explore any alternative that truly will accomplish our public health goals." ... "We believe that our presence ..strengthens the position of those who share the common desire to protect public health.." signed: Matt Myers and William Novelli.

Since the date of this letter, the Campaign has modified these principles and has obtained further feedback from many of the tobacco control and advocacy groups nationally and from across the nation. These modified basic principles were printed in an advertisement in The Washington Post.

If you have any questions and or comments, contact the Campaign for Tobacco-Free Kids at (202)296-5469 or (202)296-5427 fax, or 1-800-824-KIDS.

Communities of Color take a position on the Settlement..page 4

A disproportionate number of these individuals are low-income and from our racial, ethnic and tribal communities. We are concerned that a monetary settlement—even one in the range of \$ 300 billion over 25 years— will only shift the burden of payment from the general public to individual smokers as tobacco companies raise prices on their addictive products to

pay the settlement costs. This represents regressivity as its worse and has the potential to victimize low-income smokers, while allowing the investors in tobacco to realize enormous financial rewards by "immunizing" tobacco companies from the costs of further litigation.

3. In some news stories, there have been references to a pro-

posed "global" settlement. The only thing that is "global" is that these negotiations give the tobacco industry a way to effectively rid itself of liabilities in the United States, while at the same time, tobacco companies can continue to market their addictive products in other parts of the world—especially in Latin America, Africa, Asia and the

6th Biennial Symposium on Minorities, the Medically Underserved and Cancer

More than 900 cancer minority professionals, researchers, survivors and students met in Washington DC from April 22 to April 27 to share their professional knowledge and human concerns about cancer and its toll on minority communities. The Intercultural Cancer Council, in association with Baylor College of Medicine and scores of foundations, organizations and non-profit organizations organized a very successful meeting. The planned goals stated by the organizers were:

1) Exchange the latest scientific and treatment information and to share strategies for reducing the disproportionate incidence of cancer morbidity and mortality among minorities and the medically underserved in the US;

2) Enhance the competency of health care providers, laypersons and survivors in the areas of primary and secondary cancer prevention, early detection and treatment; and

3) Promote culturally competent cancer care and services and ethnically balanced research, especially clinical trials. Presymposium workshops included the following topics: Survivorship: from the moment of diagnosis; Achieving culturally-competent health care delivery; and Achieving Ethnically Balanced Clinical Trials.

One of the main speakers at the opening ceremony was Dr. Richard D. Klausner, who spoke about The Role of the National Cancer Institute; the keynote address was delivered by The Honorable Louis Stokes, Congressman from Ohio.

The current status of cancer research was discussed as well as: liver, leukemia, lymphoma, prostate, colorectal, lung, gynecological and breast cancer research.

At the public policy luncheon the Honorable Kevin L. Thurm, Deputy Secretary of DHHS gave the overall perspective. FDA Associate Commissioner Sharon Natanblut, presented the FDA Tobacco Rule, its origins and current battle for implementation. Dr. Joseph Simone discussed the National Cancer Policy Board and Dr. Valeria Setlow presented the perspective from the Institute of Medicine NIH Review.

Selected abstracts for oral presentation were on basic, clinical and behavioral research and community-based program research and evaluation. These sessions allowed participants the opportunity to interact with the speakers on special topics of interest.

Dr. John Alderete presented the Hispanic perspective at the Con-

gressional Briefing receiving a standing ovation, for his moving speech about the real conditions of Latinos in America. Attendance by House/Senate members was scarce. Minority researchers and activists have to make a case about the needs and realities of minority communities affected by cancer, or else Congress won't respond to our needs.

LCAT with support from www.smokescreen.org made communicating directly with Congress an easy and effective system. Letters in support of the FDA were sent via fax through the WWW site.

LCAT's interns, Aldo Tinoco, 2nd year Medical Student at Georgetown University and Gina Engler, pre-med student at Howard University, circulated petitions in support of the Hatch-Kennedy bill that would raise tobacco taxes to pay for medically uninsured children. Advocacy is a vital part of community action.

If you want to get involved in tobacco control through the Web, sign on to site:

www.smokescreen.org, which is the easiest way to express your tobacco concerns.

Cancer affects minorities disproportionately. Minority health professionals are working to make a difference at the local, state and national levels.

Communities of Color take a position on the Settlement..page 5

Islands of the Pacific. As people of color we have links to our brothers and sisters worldwide. We do not view an increased international trafficking of tobacco addiction as a legitimate trade off in return for tougher actions on advertising and marketing to youth in the United States. All youth are important and all youth must be protected from tobacco marketing practices, here and abroad.

These are our specific concerns, but beyond the specifics loom the large issue of principle. As communities of color, we believe strongly in the processes of consensus, inclusion, openness, and fairness. These back room negotiations toward a possible "settlement" have an air of secrecy and deception—which is in keeping with the history of the tobacco industry in this country. We oppose the clandestine nature of these discus-

sions. We are not asking that a few representatives of our communities be allowed to enter these closed meetings. Instead, we are joining our voices together with others to ask that all secret negotiations designed to cut a "deal" with the tobacco industry end immediately. These issues must be brought into the light of public disclosure and debate so that all those

LCAT's core principles on Tobacco Control

The Campaign for Tobacco-Free Kids and members of the larger tobacco control advocacy groups, drafted some core principles, that LCAT has modified. The modifications are in bold capital letters. LCAT also used ASTHO's clause on international concerns.

Core Principles for Considerations of the Resolution of Current Outstanding Tobacco Issues

Any resolution of the current outstanding tobacco issues —whether in the Courts, in Congress, or elsewhere —should be guided by a number of clearly enunciated principles. They include:

- **Regulatory Authority:** The FDA must have the authority to regulate the manufacture, sale, labeling, distribution and marketing of tobacco products.
- **Minimum Standard:** The current FDA requirements governing youth access and tobacco marketing are essential minimum components of any public policy initiative. The agency's ability to augment these requirements should not be curtailed.
- **The rights of victims of the tobacco industry to seek compensation for the injuries they have suffered should not be abridged and the tobacco industry should not be immunized from accountability for its wrongdoing. ADEQUATE MECHANISMS MUST BE IN PLACE TO SUPPORT VICTIMS WHO BECAUSE OF ECONOMIC CONSTRAINTS CANNOT PURSUE COMPENSATION.**
- **Public education and tobacco control:** a well funded, **INCLUSIVE**, effective sustained public education and tobacco control **AND CESSATION** campaign that is protected from political pressure is critical to reducing tobacco use.
- **Preemption:** Congress should not preempt state or local laws that are stronger than federal laws, nor should the FDA be preempted from revising the form, **PACKAGING**, content, and placement of the warnings on cigarette packs.
- **Public Disclosure:** The tobacco industry must disclose its research and studies about the effects of its products, including nicotine, **AND OTHER INGREDIENTS**, on the human body and the marketing of tobacco to children, **WOMEN AND MINORITIES**.
- **INTERNATIONAL SALES AND PROMOTION: CHILDREN IN EVERY NATION MUST BE PROTECTED FROM THE PROMOTION AND UNREGULATED SALE OF TOBACCO PRODUCTS. INTERNATIONAL STANDARDS FOR RESPONSIBLE PUBLIC HEALTH AND BUSINESS PRACTICES MUST BE ESTABLISHED TO PREVENT CHILDHOOD NICOTINE ADDICTION. (This is ASTHO's clause.)**

In addition to these principles, it is vital to recognize that there are other issues which are key components of any overall comprehensive tobacco control plan, including items such as increased tobacco taxes and protection of non-smokers from environmental tobacco smoke.

Please circulate these "Principles" and provide LCAT with feedback so that your concerns are also addressed. (202)371-1186

Communities of Color take a position on the Settlement

who are touched by tobacco can have their concerns acknowledged and addressed. We urge the public to speak out on this important issue and let all those who are part of these secret meetings —especially the individuals who are elected public officials— know how the public feels. As people of color, we will continue to raise our voices and to express our concerns. No one else can speak for us on the critical matter of the abusive sales and marketing of tobacco

in all communities — especially in communities of color.

This statement was circulated among leaders and advocates of communities of color nationwide for their input and consideration. If you would like to make a contribution to this statement and/or have any comments or desire more information about what you can do about this matter, please call (215) 477-4113 or fax your comments to (215) 477-5535.

LCAT urges action on the part of our community leaders to make the concerns stated above known to public officials and the public in general.

Communities of Color must protect their own children and the children of the world from the ravages of tobacco addiction and the greed of the tobacco companies. ###

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*Committed to combat-
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In This Issue...

Tobacco Settlement, Communities of Color take a stand, Campaign for Tobacco....

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Network Mission Statement

"TO EMPOWER, BUILD

LEADERSHIP AND ADVOCATE FOR

THE HEALTH OF THE LATINO

COMMUNITY STATEWIDE WITH

INDIVIDUALS AND AGENCIES

COMMITTED TO A TOBACCO -

FREE CALIFORNIA "

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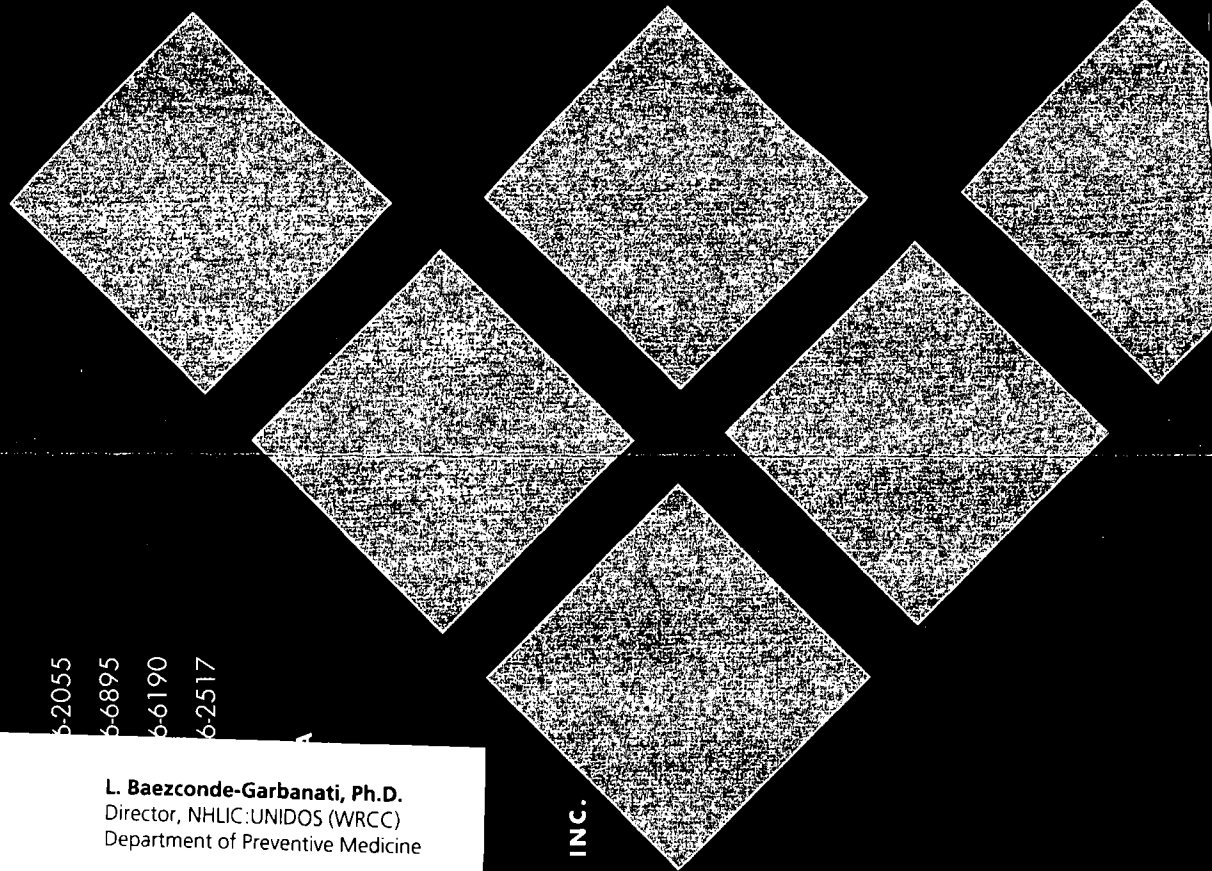
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6-6190
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RADIO BILINGUE, INC.

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Fax (209) 264-9309



**HISPANIC/LATINO
NETWORK FOR TOBACCO
EDUCATION**



The Partnership

- The **University of San Francisco**, as the fiscal agency will coordinate the Network activities, such as community outreach, planning, technical assistance, training, and conferences.
- The **Latino Coalition for a Healthy California** brings the advocacy, policy support, and community mobilization expertise to this partnership.
- **Radio Bilingue, Inc.** of Fresno, will collaborate in media outreach and will serve as the distribution channel for anti-tobacco messages, mainly to rural Latino communities through its affiliate radio stations statewide.

Goals and Objectives

- To increase capacity and build leadership within agencies and individuals serving the Latino community so that they can advocate in behalf of their communities and youth in particular, for tobacco control locally and statewide.
- To involve Latino leaders and other community members that have not previously participated in tobacco control activities.
- To support the Latino community in its involvement in tobacco control related issues locally and statewide, especially on youth access to tobacco products and environmental tobacco smoke.
- To enhance the ability of Network agencies to counter the strategies used by the tobacco industry targeting Latino youth and the Latino community in general.
- To inform and educate businesses and chambers of commerce about local and state tobacco control activities, in the planning and implementation of new policies.

Activities

- To engage Latino groups and organizations not currently receiving state funds in a mini-grant process to stimulate broad based participation in innovative tobacco control activities throughout California.
- To coordinate with regional community linkages, Local Lead Agencies, Department of Health Services grantees, and other agencies to develop coalitions in the Latino community to assist with tobacco control efforts.
- To provide regional trainings to help members develop skills and strategies to reduce tobacco use in the Latino community.
- To hold a Network-specific statewide conference and to co-sponsor a statewide joint ethnic network conference with the purpose of strengthening collaboration between ethnic communities as we reduce tobacco use and abuse.

Training and Technical Assistance

Two regional trainings (northern and central California), and one statewide training during the Network conference (southern California) will be offered to the members. Topics will be decided by the membership through a statewide survey. Dates will be given with sufficient notice.

Mini-Grants

Funds will be available to engage those Latino groups/organizations not receiving state funds (Proposition 99 monies). State funded programs may apply but must demonstrate that use of the funds will be for activities not included in their current work plan. Mini-grants must be used for activities which support the California Department of Health Services Tobacco Control Section priority programs: Reduction of Environmental Tobacco Smoke; Youth Access; and Counteracting Pro-Tobacco Influences in the Latino community.

Membership

Is open to organizations and individuals who are committed to creating a healthy and tobacco free community among Latinos in California. There is no charge for membership.

Membership Benefits

- Networking with colleagues interested in the health and well-being of Latinos in California.
- Statewide trainings and conferences on tobacco control activities in the Latino community.
- Nuestros Recursos, the network's newsletter
- Culturally relevant health education and tobacco control materials and resources.
- Legislative updates, and more!

Membership Responsibilities

- Participation in annual statewide conferences and trainings.
- Participation in Network's committees and coalitions.
- Serve as contacts for other agencies/individuals to share experiences and expertise.
- Support the goals, objectives, and activities of the Hispanic/Latino Network for Tobacco Education.

Made possible by funds received from the Tobacco Tax Health Protection Act of 1988-Proposition 99, under Grant number 94-21113



The Associated Press

WORD GOES OUT: Dr. Lourdes Baezconde-Garbanati, a USC health educator and public-health specialist, on Thursday announces the launch of the state's anti-tobacco campaign aimed at ethnic communities.

State's new anti-tobacco ads target ethnic communities

HEALTH: The \$4 million campaign paid for by Proposition 99 funds was developed by minority firms.

By **DENNIS ANDERSON**
The Associated Press

LOS ANGELES — A state-sponsored anti-smoking ad campaign aimed at California's large communities of Hispanics, blacks and Asians will take to air waves and billboards next week, health officials said Thursday.

To advance California's leadership against tobacco interests, the \$4 million campaign of television, print and radio advertising will feature messages that emphasize the cultural values of each of the targeted communities.

The state hired minority advertising firms to design each of the campaigns.

For example, in the campaign that kicks off Monday, one TV ad

depicts a group of Asian men traveling in a van on an excursion marked by jovial male-bonding camaraderie. When one man reaches for a cigarette instead of a salty snack, he gets kicked out of the van next to a highway sign that points to Death Valley.

That ad will be broadcast in Mandarin, Cantonese, Vietnamese and Korean.

Another ad, aimed at Hispanics, shows a father and his young children grieving at the grave site of the mother, who died from secondhand smoke.

A billboard ad with a skeleton draped in a handsome jacket takes a poke at the Marlboro man's machismo image, posing the question in Spanish, "Are you dying for a leather jacket?" in reference to tobacco companies that heavily market brand-labeled clothing.

Several of the ads, including those aimed at the black community, emphasize the danger to children from secondhand smoke. In one radio ad, a little

boy recounts that his father always cautioned him to buckle his seat belt. Meanwhile, his father always smoked in the car.

"Focus groups conducted during the past two years found that a key message that can affect behavior change — particularly in ethnic communities — is the danger of secondhand smoke to children and families," said Dr. James Stratton, director of prevention services for the state Department of Health Services.

The ethnic ad campaign augments the \$20 million in general anti-smoking advertising funded by Proposition 99 tobacco tax funds.

Voters approved the initiative in 1988 to underwrite efforts to combat tobacco-related health problems. It raised the state tobacco tax 25 cents per pack of cigarettes.

Stratton said California leads the nation in the anti-smoking effort, with the percentage of smokers dropping from 27 percent to 18 percent since Prop. 99 was passed.

LOURDES BAEZCONDE-GARBANATI, Ph.D., MPH, SCRIPT ETHNIC AD LAUNCH PRESS CONFERENCE

JULY 17, 1997

The health consequences of smoking have been well established since 1964 with the first U.S. surgeon generals report linking smoking and lung cancer. With nearly 4,000 different compounds in cigarette smoke, of which 43 are known carcinogens, it is little wonder that over 430,000 people across the country die each year from smoking-related diseases. In California, that figure translates to over 42,000 deaths each year, a rate equal to wiping out the entire population of a city such as Chico or San Clemente. An additional 5,000 Californians die each year from the health effects of second hand smoke.

Despite the successful accomplishments of Californias tobacco control programs, prevalence rates for all adults and youth this past year began to rise. The increase among ethnic youth, ages 15 to 17, is particularly disturbing. In this age group, the number of addicted smokers doubled among African Americans, and increased by 33 percent among Hispanics; among Asian adolescents there was an increase of over 50% in the prevalence of those who had smoked in the last 30 days.

The risk of death and disease from smoking-attributable causes among adults and children in ethnic communities, in some instances, is even higher than in the general population. For instance, in the general population nationwide, lung cancer accounts for 13% of all cancers, but among African Americans its 25%. Additionally, lung cancer deaths among African American males are nearly 50% higher than for white males. Forty-two percent of deaths among Californias American Indian women and 37% among American Indian men are attributable to smoking, versus 12 and 18 percent in the general population.

Asthma is another chronic disease that affects some of our ethnic communities to a much higher degree than the general population nationwide. While the prevalence of asthma has increased worldwide in the past decade, Kevin Gibson of the University of Pittsburgh School of Medicine states that "the prevalence has escalated at a more rapid rate in black and Hispanic communities." For example, among Puerto Rican children, it is estimated that asthma affects as many as 20% and is the leading serious chronic illness for children. According to a report issued just this week, the American Lung Association refers to the "crisis of lung health among African Americans," citing that nearly twice as many black children suffer from asthma as white children and that the death rate from asthma is four to seven times higher for blacks, ages 5-34, than for whites. In 1994, African Americans represented 22% of all asthma-related deaths.

Chronic obstructive pulmonary disease, which includes emphysema and chronic bronchitis, is another disease category for which ethnic health statistics are most troubling, are coronary heart disease and tuberculosis (TB). Chronic obstructive pulmonary disease affects more than 16 million Americans. In 1990, chronic obstructive pulmonary disease was the fourth leading cause of death for chronic disease among Asian men and the 7th among Asian women. African Americans have higher rates of coronary heart disease than any other population group in the United States and the overall risk of contracting TB is 13 times greater for Asians and Pacific Islanders than for whites. Prevalence rates for tuberculosis among Hispanics are also very high.

These statistics just begin to show the picture of the health risks related to tobacco. A new California Tobacco Survey shows that while there has been an increase in the number of children and adolescents protected from secondhand smoke in the home, between 1990 and 1996 African American children experienced no statistically significant increase in protection. This lack of protection is critical, not only for

ethnic communities, but for the general population as well; a study reported in the July issue of the Archives of Pediatrics and Adolescent Medicine, says that parents who smoke contribute to the deaths of at least 6,200 children in the US every year. Researchers at the University of Wisconsin say that "more young children are killed by parental smoking than by all unintentional injuries combined."

Additionally, even though California implemented smokefree work place regulations over two years ago, 18 percent of Hispanics in California still are unprotected from secondhand smoke in the work place.

Californias ethnic communities are vulnerable targets for tobacco advertising and promotion. Many of the newly arrived residents of these communities come with strongly-held, culturally-based smoking traditions and so are extremely susceptible to this advertising.

The campaign that is being unveiled today is intended to educate and hopefully, turn around the tragic statistics of death and disease that affect our communities. These ads are unique and critically important for the overall efforts in tobacco education for California. As Dr. Stratton mentioned, these ads have been researched, created and produced by ethnic agencies for each community, and they are tailored to specific tobacco-related challenges in those communities.

I am pleased to be a part of tobacco education efforts in this state, which have actively involved in culturally specific ways the ethnic communities of California. It is only by the inclusion of our ethnic population groups in overall tobacco education efforts that we can truly begin to make a difference in the reduction of tobacco prevalence for California.

Thank You!

Celebrating Californias Coalitions: We Make It Happen Conference Update

Steering Committee members have been working hard to develop a conference agenda that will provide meaningful exchanges of information at the Celebrating Californias Coalitions Conference, which will be held on September 14-16 at the Oakland Marriott City Center and Oakland Convention Center. Six workshops tracks will explore what it takes to build strong coalitions and will focus on issues coalitions are facing, such as tobacco advertising issues, promoting smoke-free bars, working with law enforcement agencies, chew dip and other tobacco use, etc. Here is the tentative list of workshops that will be offered during three 1 hour sessions:

TRACK 1: Environmental Tobacco Smoke
Californias Helplines: State of the Art Cessation
Beyond AB-13: Where There is SmokePut Out the Fire
Moving ETS Out of Our Personal Space: ETS Free or Bust
Tribal Issues Regarding ETS
Smoke-Free Bars

HISPANIC/LATINO TOBACCO EDUCATION NETWORK

Welcome to the Hispanic/Latino Tobacco Education Network at the University of Southern California. Along with our partners, the Multicultural Area Health Education Center (MAHEC), Durazo Communications, Radio Bilingue and the California Hispanic Commission on Alcohol and Drug Abuse, we are committed to empowering our communities, to build leadership and advocate for the health of the Hispanic/Latino community statewide, with individuals and agencies committed to a tobacco-free California. During this grant cycle our objectives focus on countering pro-tobacco influences, reducing youth access to tobacco products and increasing the number of tobacco-free establishments, addressing issues of environmental tobacco smoke (ETS).

To counter pro tobacco influences we will:

- 1.- work with the Hispanic/Latino business community and employers with a large number of Hispanics/Latinos, with Chambers of Commerce, and other such entities to promote and adopt policies that prohibit the acceptance of tobacco industry funds, tobacco products and tobacco sponsorship in several communities throughout the state of California.
- 2.- reduce tobacco industry print advertising that specifically targets Hispanic communities
- 3.- implement a community audit pilot project to assess the tobacco industry's influence in targeted Hispanic/Latino communities

To promote environments that are tobacco-free we will:

- 1.- work with Hispanic owned establishments, or those which employ a large percentage of Hispanics/Latinos to help them become 100% smoke free prior to the full implementation of AB 13.

To help reduce youth access we will:

- 1.- work as part of a Joint Ethnic Networks' (African American, American Indian, Asian/Pacific Islanders, Hispanic/Latino) effort in the development of a Multiethnic Youth Summit, and participate in a series of other activities focusing on youth from a multiethnic perspective.
- 2.- Develop Hispanic/Latino youth councils that will collaborate with local and statewide efforts regarding youth access, such as the Multiethnic Summit, Operation Storefront, World No Tobacco Day, among other.

In addition, we will focus our efforts in cessation activities. These include:

- 1.- Statewide promotion of the Spanish Speaking Helpline number 1-800-No Fume to Hispanics/Latinos

2- The development of cessation services for medically underserved Hispanics/Latinos throughout the State of California.

Many of these activities will be accomplished through active participation of Network members throughout the state, our Advisory Committee and a cadre of Local Network Area Representatives, as well as through the funding of mini-grants.

We invite you to join as a member of our Hispanic/Latino Tobacco Education Network. As a member you will regularly receive our Network Newsletter - Nuestros Recursos, receive updates regarding Mini-grants activities and be invited to participate in that effort, and to participate in the multiple activities, trainings, conferences, programs and educational campaigns envisioned for Hispanics/Latinos throughout California. Membership is free of charge.

To join, simply complete the form below and mail or fax to:

Lourdes Baezconde-Garbanati, Ph.D, MPH, Director, Hispanic/Latino Tobacco Education Network, Institute for Prevention Research, University of Southern California, 1540 Alcazar St. No. 207, Los Angeles, California, 90033. Telephone Number of the Network: 213-342-2500, fax number 213-342-2601 (attention: Julia Gutierrez Marron).

MEMBERSHIP APPLICATION FORM

(Mark all that apply)

YES! I would like to join the Hispanic/Latino Tobacco Education Network _____

I would like to receive information about the Network _____

I would like to receive information about mini-grants _____

I would like to receive your newsletter _____

Please add me to your mailing list _____

I would like to become a Local Network Area Representative _____

I would like information about your Advisory Committee _____

I would like more information about your programs _____

Other: _____

Tell us a little bit about your self:

Name: _____ Title: _____

Agency: _____

Project Name: _____

Address: _____

State _____, Zip Code _____

Telephone: _____ Fax: _____ e-Mail _____

Are you a state funded project? _____ Do you perform tobacco education work? _____

Are you a new agency to tobacco education? _____ Any thing else you would like us to know about you? _____

Made possible with funds received through the Tobacco Tax initiative of 1988, Proposition 99, under contract #96-26185 awarded to the University of Southern California by the Department of Health Services Tobacco Control Section.

Did You Know?

Tobacco has a sacred purpose with many American Indian tribes.

Tobacco was never meant to be abused. Sacred use of tobacco does not include the use of commercial tobacco products.

Smoking one or two cigarettes a day is "abuse" and harmful to your health.

American Indians in California smoke and chew commercial tobacco twice as much as other Californians.

All American Indian deaths in California, 39% are related to abusing commercial tobacco.

Traditional use of tobacco and the plant itself, varies from tribe to tribe. It is used for prayer, to show respect, healing and spiritual protection.

How To Get Involved

You have an opportunity to make a difference! Become a member of the Network. Simply call or write to:

**American Indian
Tobacco Education Network
AITEN**
Calif. Rural Indian Health Board
1451 River Park Drive, Suite 220
Sacramento, California, 95815
Phone: 1-916-929-9761
Fax:: 1-916-929-7246

*We can protect our people by
learning and teaching others about
our ways of life.*
We are a proud and strong nation.

The AITEN is made possible by funds received from the
Tobacco Tax Health Protection Act of 1988 - Proposition 99
under contract #94-20985-01.

American Indian Tobacco Education Network AITEN



Working To Keep Tobacco Sacred



Our Mission

American Indian Tobacco Education Network's (AITEN) mission is to promote, support, and protect the health, traditions, and cultural values of American Indians as they relate to sacred tobacco use and commercial tobacco abuse.

Who We Are

AITEN consists of dedicated people and agencies in California who seek to enhance the general health, as it relates to tobacco, of American Indians. This includes working to increase the commitment and capacity of American Indian communities and agencies in these efforts..



What We Do

AITEN supports and participates in the following activities:

Tobacco free cultural events, youth activities, and media campaigns;

Technical assistance, training, and support to agencies serving American Indians;

Presentations by American Indian speakers on sacred tobacco use and cultural traditions;

Production and distribution of the AITEN newsletter;

Culturally specific information and assistance to agencies as requested.

Mini-Grant Program

Approximately \$60,000 will be awarded through the AITEN Mini-Grant Program. It seeks to provide support to local and statewide tobacco education efforts with American Indian communities in these areas:
Environmental Tobacco Smoke
Youth Access to Tobacco
Counteracting Pro-Tobacco Influences
And Sacred Use of Tobacco Issues

Tobacco Policies For American Indian Communities

A manual is available for communities and agencies who serve American Indians and wish to develop tobacco policies. This is provided free of charge.

Commercial Tobacco Abuse In American Indian Communities

A. Commercial Tobacco Abuse Effects

Indian Health Service statistics show **two out of five deaths among American Indians are related to smoking**. According to a report from the University of California Medical Center, 42 percent of deaths among California American Indian women and 37 percent of deaths among men were attributable to smoking. These numbers are very different from women (12%) and men (18%) in other California populations.

Cancer

Cancer is the third leading cause of death among American Indians.

- Lung cancer was the first disease identified as caused by smoking.
- Lung cancer is now the leading cause of cancer death in women.
- Tobacco is one of the risk factors considered to elevate the risk of cervical cancer. **Indian women have cervical cancer rates 3.5 times higher than the national average.**
- Smoking and other tobacco use cause or contribute to a variety of cancers, including those of the voice box, mouth, esophagus, bladder, kidney, pancreas, and cervix.

Heart Disease

- Smoking triples the risk of death from heart disease. Smoking combined with either high blood pressure or elevated cholesterol, quadruples the risk of death. **Twenty-five percent of adult American Indians in Northern California have high blood pressure.**



Diabetes

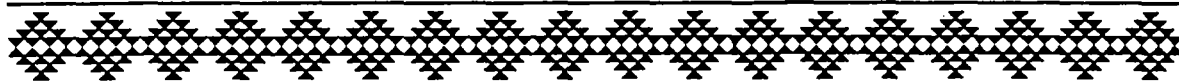
- According to the American Diabetes Association, smoking damages and constricts the blood vessels. This can worsen foot ulcers and lead to blood vessel disease, leg and foot infections. Of people with diabetes who need amputations, 95 percent are smokers.¹
- Smokers with diabetes are more likely to get nerve damage and kidney disease.¹
- People with diabetes are three times more likely to die of cardiovascular disease.¹
- Smoking raises your blood glucose levels, making it harder to control your diabetes.¹

Pregnancy

- One in five women in the United States smokes during pregnancy. In some areas, more than 50 percent of American Indian women smoke while pregnant. This is a known risk factor for premature birth and low birth weight babies. Birthweight is an indicator of how well the baby has been developing inside the mother. Low birthweight is not healthy for the baby.
- Toxins from cigarette smoke that reach the mother's bloodstream go to the developing baby and cause damage.
- Smoking and secondhand smoke increase the risk of birth defects, because the cancer causing chemicals damage the genetic material (DNA).
- One in 10 stillborn babies is due to the mother's smoking while pregnant.
- Nicotine can enter breast milk and can also reduce breast milk production.
- Smoking by parents has been linked to higher rates of sudden infant death for their children.

Secondhand Smoke

- The Federal Environmental Protection Agency has identified secondhand smoke as a Class A carcinogen (a cancer causing agent). This category includes only the most potent cancer-causing agents, such as benzene, vinyl chloride, asbestos and arsenic.



- Secondhand smoke is extremely devastating to young children, contributing to some 150,000 to 300,000 respiratory infections in babies (mainly bronchitis and pneumonia).
- Childhood exposure to secondhand smoke has been reported to double a child's risk of developing lung cancer as an adult.
- Nonsmoking women married to smokers were found to have a 40 percent higher risk of lung cancer than women married to nonsmokers.

Youth

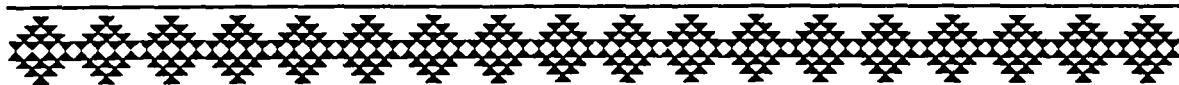
- American Indian youth begin smoking at earlier ages than whites.
- Use of smokeless tobacco is on the rise among Indian youth, particularly teenage girls.
- American Indian youth identify peer pressure as the number one reason for tobacco use.

Information abstracted from:

American Diabetes Association, 1995.

Stanton A. Glantz, Ph.D. "Tobacco Biology and Politics." HEALTH EDCO, 1992

Windsor, Richard A., Ph.D., MPH, & Orleans, Tracy C. "Guidelines and Methodological Standards for Smoking Cessation Intervention Research Among Pregnant Women Improving the Science and Art." *Health Education Quarterly*. Vol. 13(2): 131-161 (Summer 1986)



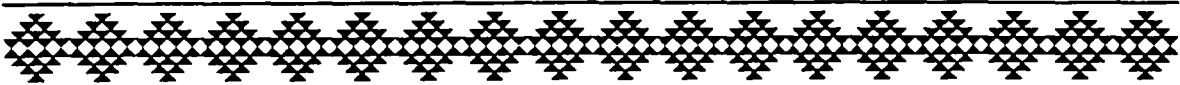


CONSEQUENCES OF COMMERCIAL TOBACCO ABUSE

- American Indian adults in California smoke cigarettes at a rate of 40%. This is more than double the rate of U. S. smokers (25.7%) and twice the rate of California adult smokers (20%), reported during 1991.
- Fourteen percent (14%) of American Indian males and two percent (2%) of American Indian females use smokeless tobacco, compared to 5.2% males and 1.5% females in the general population.
- A report from the University of California at San Francisco indicated that 42% of deaths among California American Indian women and 37% of deaths among California American Indian men were attributed to smoking. These numbers are very different from women (12%) and men (18%) in other California populations.
- Evidence indicates that alcohol and tobacco use among American Indians begins at a very early age. Northern California Indians reported that they began to smoke cigarettes at age 15 with some beginning at age 10.
- Among adult American Indians, the number of cigarettes smoked was related to alcohol problems.
- From 1986-1988, tobacco related diseases killed 9,566 American Indians (44% of 22,943 AI deaths).
- An average of two out of every five American Indians die from tobacco abuse.
- The death rate among American Indians due to tobacco abuse is double the death rate of other Americans in the United States.

Data provided by:

*The American Indian Cancer Control Project, 1991 Study, Berkeley, CA.
IHS Trends in Indian Health, 1991.
Bureau of Indian Affairs, 1994.*



Sacred Tobacco Use in American Indian Communities

Traditional Uses Of Tobacco

Tobacco has been used by American Indian people for thousands of years. Many tribes have stories on the origin of tobacco and how it was given to them as a gift from the spirit world. These stories help one to understand the relationship between American Indian people and the creation. Tobacco has had, and continues to have, many positive uses in its purest form.

Tobacco is a medicine and medicine affects well-being. When used in a prescribed way, it can promote good health and assist with spiritual guidance and growth. Since tobacco use varies from tribe to tribe, there is no one way to portray its ceremonial use of tobacco. Some tribes use other medicines and/or plants in ways similar to tobacco, although there are some forms of wild tobacco grown in California. While this document is not meant to exhaust all possible uses of tobacco, it is intended to give those unfamiliar with traditional American Indian tobacco practices a better understanding of the important place tobacco has among many tribes.

There are various types of tobacco. It is unknown what the differences are between processed tobacco sold in stores and tobacco that is grown and harvested by traditional Indian people. It is known that commercial tobacco products contain many added chemicals that are harmful to the health of American Indian people. Some tribes have or had (i.e., the practice was lost in some cases) people who were trained to plant, harvest, and prepare tobacco for use by traditional or spiritual people. These people knew the proper way and attitude in which to care for the tobacco. This type of tobacco has many names including natural tobacco, wild tobacco, or mountain smoke.

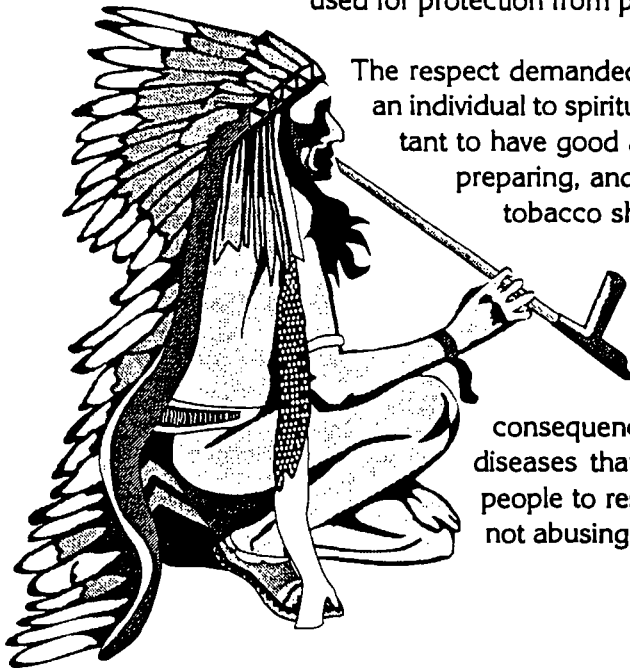


When non-American Indians refer to the "use of tobacco" they are actually referring to the use of commercial tobacco. Commercial tobacco is an abuse of the native traditional plants and is harmful to a person's health. It is not surprising to American Indian people that daily, non-prescribed use of a medicine such as tobacco is harmful. This is the equivalent of using any medicine in a non-prescribed way.

When used at the right time, the right place, and in the right way, native tobacco use promotes good health. However, if used in a random, unspecified or improper way, it can cause illness or lead to death. The rules that apply to the traditional use of native tobacco must be followed or the user will experience harmful spiritual and/or physical consequences. Traditional uses of native tobacco are also part of a culture and belief which is not for sale.

There are no health risks when native tobacco is used in a sacred and respectful manner. Among medicine people who are involved with various ceremonies, the practice of using tobacco cannot be classified as recreational or addictive.

Traditional uses of native tobacco do not always involve smoking. It is often used as sign of respect and as an offering when praying to the Creator. Tobacco is sometimes placed in a fire while praying, and the smoke that rises can carry prayers to the Creator. When someone wishes to show respect to an elder, tobacco may be given. Traditional healers sometimes use tobacco to help cure illnesses. When a person is traveling to a foreign area and wishes to pay respect to the ancestors of that land, he or she may offer tobacco to the earth. Tobacco can also be used for protection from physical, mental, or spiritual harm.



The respect demanded through the traditional use of tobacco helps an individual to spiritually grow. Our traditions teach that it is important to have good attitudes and thoughts while planting, picking, preparing, and using tobacco. When treated in this fashion, tobacco shows respect towards the Creator and leads to good health and harmony.

In stark contrast to promoting respect, the attitude of those who raise and cultivate tobacco for profit is often one of greed. The harmful consequences of this lack of caring are cancer and other diseases that result from tobacco abuse. AITEN asks all people to respect the traditional uses of native tobacco by not abusing it or using commercial tobacco products.





ASIAN & PACIFIC ISLANDER
TOBACCO EDUCATION NETWORK

a statewide partnership for the wellness of the Asian and Pacific Islander communities

Statement of the Asian and Pacific Islander Tobacco Education Network:

Tobacco Settlement Will Further Set-up the Asian Pacific Islander Community for Tobacco Industry Targeting and Exploitation

The California-based Asian and Pacific Islander Tobacco Education Network (APITEN) is opposed to the tobacco industry settlement on the grounds that it would allow the tobacco industry to continue targeting and exploiting the Asian and Pacific Islander communities both domestically and in Asia and the Pacific Islands. Although the preamble to the proposed resolution specifically states the settlement's intention to prevent youth usage of tobacco, address the adverse health effects of tobacco use, and change the corporate culture of the tobacco industry, the settlement would actually be inadequate for and detrimental to the Asian and Pacific Islander communities. The settlement does not address the tobacco industry in the context of global health and economic impacts; these impacts are particularly critical to the Asian and Pacific Islander American community given the high percentage of immigrants in the community (approximately 65% of Asian Pacific Islanders in the U.S. are immigrants). APITEN's primary concerns are in the areas of industry sponsorship of major Asian Pacific Islander events and organizations in the U.S.; lack of information provided in Asian languages; and unrestricted advertising and sales of tobacco products in Asia and the Pacific Islands. APITEN is also concerned about the lack of Asian or Pacific Islander representation on the Advisory Committee reviewing the settlement.

- ***Sponsorship of Asian and Pacific Islander Events and Organizations:***

The proposed settlement ignores the tobacco industry's sponsorship of Asian and Pacific Islander cultural events. Tobacco company logos, brand names and products are prominently displayed at these events, thereby marketing tobacco products to hundreds of thousands of Asian and Pacific Islander Americans nationwide. In addition, though the settlement claims to seek the prevention of underage use of tobacco, it would not prevent the tobacco industry from reaching thousands of Asian and Pacific Islander American youth who attend such events as the Vietnamese Tet festivals or Chinese and Korean Lunar New Year celebrations. The members of APITEN are highly concerned about this, given the recent 50% rise in Asian and Pacific Islander American youth smoking rates in California (1996 California Tobacco Survey).

The sponsorship of Asian and Pacific Islander organizations allows tobacco companies to project a positive image and their supposed commitment to supporting the community, while their true intention is to sell tobacco products. These monies would undermine the ability of community organizations to mount credible health promotion campaigns which educate communities about the risks of using tobacco products. Tobacco companies may also place program restrictions on Asian and Pacific Islander organizations receiving the money, preventing the organizations from implementing comprehensive community health programs which include tobacco use prevention.

**consortium
agencies:**

ASIAN & PACIFIC ISLANDER AMERICAN
HEALTH FORUM (*lead agency*)
116 New Montgomery, Ste. 531
San Francisco, CA 94105
(415) 512-3403 fax: (415) 541-0748

ASIAN PACIFIC HEALTH CARE VENTURE
300 West Cesar E. Chavez Ave.
Los Angeles, CA 90012
(213) 346-0370 x19 fax: (213) 346-0373

UNION OF PAN ASIAN COMMUNITIES
1031-25th St.
San Diego, CA 92102
(619) 235-4277 fax: (619) 235-9002

- ***Lack of Access to Services and Information for Asian and Pacific Islander Americans:***

The settlement fails to address the need to provide accessible and culturally and linguistically competent services and information to Asians and Pacific Islanders. While the settlement would provide funding to states to pay for the costs of treating smoking-related illnesses, many uninsured and underinsured Asian and Pacific Islanders would not have access to potential services. In addition, although the settlement would provide financial assistance to smokers for a 10-week smoking cessation program, there are no provisions for ensuring the cultural and linguistic competence of the program.

The settlement also would require tobacco products to carry black warning labels covering the top fourth of each cigarette pack and 25% of the principal display panel of smokeless tobacco products. However, these warnings would be printed in English only, which would be ineffective for monolingual Asians and Pacific Islanders. While Asians and Pacific Islanders would be unable to benefit from the proposed information and services, smokers in those communities would still shoulder the burden of paying higher prices for cigarettes, thereby subsidizing the \$368.5 billion settlement.

- ***Advertising and Sales of U.S. Tobacco Products in Asia and the Pacific Islands:*** Although the settlement would restrict advertising of tobacco products in the U.S., no restrictions would be placed on advertising abroad; historically, restrictions on advertising in the U.S. have led to aggressive advertising campaigns in Asian countries. Given the large number of immigrants in the Asian and Pacific Islander populations residing in the U.S., and the cultural norms and practices they bring with them to the U.S., Asian and Pacific Islander Americans cannot ignore the connection between cigarette addiction exported abroad and tobacco-related diseases in this country. Tobacco advertising in Asian and the Pacific Islander countries has resulted in high smoking prevalence rates in these countries, with four of the five top brands of cigarettes smoked being U.S. brands. The settlement, however, does not provide monetary compensation nor treatment for Asians or Pacific Islanders who develop tobacco-related diseases from smoking U.S.-brand cigarettes.

The settlement also fails to address the political strings that the tobacco industry has pulled in order to open Asian markets to and prevent any governmental regulations of sales of tobacco products. Furthermore, although the tobacco industry has conceded to the provisions of the U.S. settlement, the industry has continued to fight the Hong Kong government over similar legislation recently passed in that country.

Although the U.S. Food and Drug Administration (FDA) may have the authority to regulate the nicotine content of cigarettes sold domestically, U.S. tobacco companies would continue to have the power to determine the nicotine content of cigarettes sold in Asia and the Pacific Islands, leaving Asians and Pacific Islanders vulnerable to highly addictive cigarettes. By allowing tobacco corporations to inundate Asia and the Pacific Islands with their products, the settlement will perpetuate the cycle of addiction in the Asian and Pacific Islander community.

APITEN is staunchly opposed to this settlement which excludes the needs and concerns of Asians and Pacific Islanders and would increase tobacco-caused addiction, disease and death in the Asian and Pacific Islander communities. We will not support any settlement that allows the tobacco industry to continue exploiting and compromising the health of our communities.

Asian & Pacific Islander Tobacco Education Network

ADVISORY COMMITTEE

Name	Address	Organization	Phone/Fax
Mary Anne Foo	12377 Lewis St., Ste. 205 Garden Grove, CA 92840	Orange County Asian Pacific Health Alliance	714/663-9313 714/663-9324 - fax
Percival Leha'uli	14112 S. Kingsley Drive Gardena, CA 90247	SSG/Tongan Community Service Center	310/327-7501 310/516-9226 - fax
Gordon Mar	123 Waverly, 3rd Floor San Francisco, CA 94108	Chinese Progressive ~~Assoc.~~ Association	415/391-6986 415/391-6987 - fax
Dev Parlikar	981 Vale Terrace Vista, CA 92084	Vista Community Health	619/631-5000 x 135 619/726-2730 - fax
Thi Pham	4905 Central Ave., Ste. 300 Richmond, CA 94804	Bay Area Region Tobacco Education Resource	510/559-5595 510/559-5597 - fax
Lola Sablan-Santos	511 Pier Ave., Ste. 8 Santa Monica, CA 90405	Guam Communications Network	310/396-0166 310/396-0682 - fax
Caroline Uhm	32 Titian Alisa Viejo, CA 92656		714/588-7668 714/586-1132 - fax

CONSORTIUM MEMBERS

Name	Address	Organization	Phone/Fax
Maryann Reyes	1031-25th Street San Diego, CA 92102	Union of Pan Asian Communities	619/235-4277 619/235-9002 - fax
Michael Salazar	1530 Hillhurst Ave., Ste. 200 Los Angeles, CA 90027	Asian Pacific Health Care Venture	213/644-3880 x 31 213/644-3892 - fax



ASIAN & PACIFIC ISLANDER
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Facts on Asians and Pacific Islanders and Tobacco

- According to the 1990 Census, the Asian and Pacific Islander (API) population in California is 2,845,659. In 1992, the combined Asian and Pacific Islanders represents approximately 10% of the state's population.
- A 1992 study by the University of Southern California found Asian neighborhoods had 17 times the number of cigarette billboards than white neighborhoods.
- Although several California and national studies indicate that API (as one group) has a lower smoking rate than the general population overall, these statistics can be somewhat misleading. These studies do not break down the smoking rates by API subgroup or by birth place, thereby masking high-risk smoking segments of the API community. Other studies, such as the 1992 Tobacco Use in California survey conducted by the California Department of Health Services were conducted only in English and Spanish, thereby resulting in an underestimation of API smoking rates.
- While little formal data is available in the Pacific, the consensus among the U.S.-associated Pacific Island jurisdictions is that tobacco use is growing in Pacific Island countries and is a direct cause of premature morbidity and mortality among Pacific Islander populations. (U.S. Pacific Tobacco Prevention & Control Workshop, April 25, 1994.) In *Toward a Tobacco-Free Hawai'i: Hawai'i's Trends in Tobacco Use 1986-1993* cigarette smoking is considered the nation's "number one" public health problem. In *Smoking in the Kingdom of Tonga: report from a national survey* the report concludes that "Tonga will experience high levels of tobacco-related disease in the future . . . unless smoking rates are reduced." Pacific Islanders in the United States are not only influenced by the tobacco industry's heavy marketing in the islands but also by tobacco industry targeting of Pacific Islander neighborhoods in the U.S. It is also important to know that 75% of all Pacific Islanders in the U.S. live in California and Hawai'i.
- Tobacco use among recent API immigrant males is much higher than in second and third generation Asian Americans. For immigrants, smoking cigarettes is woven into the social fabric of the culture. Aggressive marketing by the tobacco industry in the Pacific Rim countries has resulted in API's addiction to tobacco by the time they arrive the U.S.
- Three Asian American immigrant groups have smoking rates far higher than the California or national average for males. Recent studies in California show that prevalence rates are: 65% for Vietnamese, 55% for Chinese-Vietnamese and 71% for Cambodian males. (Rumbaut, R.G. "Portraits, Patterns and Predictor of the Refugee Adaptation Process: Result and Reflection from the IHARP Panel" In: Haines, D.W. (ed): *Refugees as Immigrants*; Totonia, NJ: Routtan and Littlefield, 1989.)
- Among the Chinese population, the most recent immigrant and non-English-speaking are more likely to be smokers than those who speak English and are American-born. Many Asian immigrants are not aware of the hazards associated with smoking. In an Oakland Chinatown study, 40% of Chinese males did not know that smoking can cause heart disease. (Chen, A.M. and Lew, R., Asian Health Services, Oakland, and 1991 *CDC Cigarette Smoking among Chinese, Vietnamese and Hispanics, California, 1989-1991*. MMWR 1992; 41:362-367).

consortium
agencies:

ASIAN & PACIFIC ISLANDER AMERICAN
HEALTH FORUM (lead agency)
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(415) 512-3403 fax: (415) 541-0748

ASIAN PACIFIC HEALTH CARE VENTURE
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UNION OF PAN ASIAN COMMUNITIES
1031-25th St.
San Diego, CA 92102
(619) 235-4277 fax: (619) 235-9002

- While the smoking rate between 1971 and 1985 has fallen in countries like the US., Great Britain, Australia and New Zealand, the consumption in many developing countries has been increasing, mainly due to the U.S. tobacco industry's aggressive marketing. During that same time frame, tobacco use increased in Asia by 22%. (Masironi, R. and K. Rothwell. *"Trends in and Effect of Smoking in the World."* **World Health Statistics Quarterly**, 41 (3-4:) 228-41).
- U.S. tobacco companies are making up for dwindling domestic sales by expanding sales abroad. Asian health officials complain that the influx of fancy foreign brands hurts their efforts to control the habit, particularly among the young. (*"Where There's Smoke"* **Time Magazine**, November 29, 1992.)



ASIAN & PACIFIC ISLANDER
TOBACCO EDUCATION NETWORK

a statewide partnership for the wellness of the Asian and Pacific Islander communities

Policy Statement

Our Asian and Pacific Islander communities reflect many nationalities, ethnicities, socioeconomic levels, and degrees of acculturation. People in many of our communities, especially newly arrived immigrants, smoke at higher rates than the general California population. The consequences of smoking tobacco on people's health are very clear: Lower quality of life, disease, disability, and premature death. Smoking not only hurts the smoker but his/her family and children also fall victim to the harmful effects of second hand cigarette smoke.

The Asian and Pacific Islander Tobacco Education Network (APITEN) is a partnership throughout California working to promote wellness in the Asian and Pacific Islander communities. We are here to ask legislators to join us in our fight against the tobacco industry in the hopes of healthy, tobacco-free Asian and Pacific Islander communities in California.

- We call for a continued, vigorous anti-tobacco public health education campaign in Asian Pacific Islander communities.
- We call on our legislators to recognize and address the health rights of Asian Pacific Islanders and the critical health needs of our diverse communities. To properly address the needs of our culturally and linguistically distinct communities, we call for adequate funding from the legislature.
- We call on our state legislators to be leaders in this anti-tobacco public health campaign by restoring and preserving the integrity of the voter-enacted initiative Proposition 99, thereby demonstrating their commitment to this battle to combat these addictive and deadly tobacco products.
- We call on our legislators to join with our Asian Pacific Islander communities, along with other ethnic networks in California, in deploring the tobacco industry tactics that addict new smokers.
- We call on our elected officials to enact strong legislation to restrict tobacco advertising in our neighborhoods. We call for legislation that prohibits advertising of deadly tobacco products near school grounds, and on government owned property.
- We call on our legislatures to enact laws that limit access of tobacco products to our youth, and enforcement of laws prohibiting cigarette sales to minors.
- We call on our elected officials to refuse campaign contributions from the tobacco corporations. The tobacco industry makes its profits from peddling their products of addiction and death in our neighborhoods. We urge our legislators to take the moral leadership of refusing tobacco "death profits," and to join us in driving the tobacco industry out of our neighborhoods.
- We call on our own community based organizations and event planning committees to refuse sponsorship, promotional items, and monies from the tobacco industry. We will not legitimize their thinly-veiled guise of "friend of the community," nor allow them to buy our silence.

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HEALTH FORUM (*lead agency*)
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- We strongly endorse an increase on the California and federal excise tax on cigarettes.
- We stand united with the Asian Pacific Association for the Control of Tobacco (APACT) which most recently met in Thailand. We join APACT in vigorously deploring the tobacco industry's dumping of their deadly products in Asian markets.
- We call on President Clinton to continue to take bold steps to fight against the tobacco industry, not only in its targeting of youth and people of color in the U.S. but to help end the morally outrageous "dumping" practice of the tobacco industry in Asia.

THE TOBACCO INDUSTRY: TARGETING OUR COMMUNITIES

DID YOU KNOW?

- Smoking is the number one cause of preventable death in the U.S., resulting in almost one-half million deaths each year from smoking and second-hand smoke.
- American tobacco companies are turning toward Asia, waging an aggressive advertising campaign to hook smokers. Immigrants and refugees arriving from Asia are the double targets of the tobacco industry, receiving exposure to advertising in both Asia and the U.S.
- A 1992 study by the University of Southern California found that Asian neighborhoods had 17 times the number of cigarette billboards than white neighborhoods.
- Stressors such as racism, linguistic isolation, poverty, and immigration and refugee experiences all contribute to high smoking levels among Asians and Pacific Islanders.

As the tobacco industry loses smokers among the mainstream population, it increasingly targets people of color, women and youth.

- Traditional Asian and Pacific Islander values regarding tobacco and alcohol use also make it difficult to address smoking as a health problem in the community.



ASIAN & PACIFIC ISLANDER
AMERICAN HEALTH FORUM
116 New Montgomery, Suite 531
San Francisco, CA 94105

Asian &
Pacific
Islander
Tobacco
Education
Network

The Asian & Pacific Islander Tobacco
Education Network (APITEN)

is a partnership throughout

California working to promote

wellness in the Asian and

Pacific Islander communities.

A Statewide Partnership for Wellness

The Asian & Pacific Islander Tobacco Education Network (the Network) was formed in 1990 with the mission to organize individuals and organizations to advocate for tobacco-free Asian and Pacific Islander communities. The Network strives to counteract the factors that contribute to high smoking levels in our communities, such as:

- Tobacco advertising
- Easy accessibility of tobacco to youth
- Lack of public knowledge about the health needs of Asians and Pacific Islanders
- Lack of public knowledge about Asian and Pacific Islander cultures

Help Us Build A Healthier Community

Membership in the Network is free and open to organizations and individuals who are working in the Asian and/or Pacific Islander communities. Our membership includes health educators, tobacco and substance abuse service providers, church leaders, media and policy advocates and other concerned individuals.

We encourage new member involvement in the following areas:

- Planning media events
- Making presentations
- Distributing mini-grants statewide
- Coordinating informational visits to policy makers
- Organizing trainings and conferences

For More Information:

Call or write to one of the following organizations:

LEAD AGENCY:

**ASIAN & PACIFIC ISLANDER
AMERICAN HEALTH FORUM**
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CONSORTIUM PARTNERS:

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Fax: 619.235.9002



The Asian & Pacific Islander Tobacco Education Network is funded by Proposition 99, the Tobacco Tax and Health Promotion Act of 1988, grant #94-20986.

AATEN Adheres to KWANZAA principles year 'round.

1. UMOJA

Unity: to work together peacefully, with our family, our community, our nation, our race.

2. KUJICHAGULIA

Self determination: to create a mindset to accomplish the goals we have set for ourselves.

3. UJIMA

Collective work and responsibility: Create partnership to make our community a safe and productive place.

4. UJAMMA

Cooperative economics: to build and maintain our own. To fund and promote events and programs for African Americans.

5. NIA

Purpose: to have a plan for the future and to be willing to help others succeed as well.

6. KUUMBA

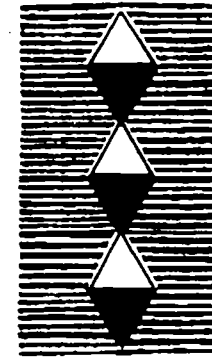
Creativity: to always do as much as we can in any way we can, in order to make our community a better and more beautiful place.

7. IMANI

Faith: to believe with all our heart in our people, our parents, our teachers, our leaders, and the righteousness and victory of our struggle.

KWANZAA MEANS
"First Fruits"

Health Education Council
1721 2nd Street, Suite 102
Sacramento, CA 95814



African
American
Tobacco
Education
Network



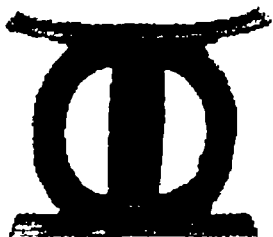
This project is made possible by funds received from the Tobacco Tax Health Protection Act of 1988-Proposition 99, under grant #44-219984 with the California Department of Health Services Tobacco Control Section 933

Health Education Council
1721 2nd Street, Suite 102
Sacramento, Ca 95814

The AATEN Mission

The Mission of the African American Tobacco Education Network is to engage communities throughout California in campaigns to reduce the use of tobacco products by African Americans. The Network has made the following resolutions to achieve their mission:

- To increase awareness of the disproportionately adverse health consequences of tobacco use among African Americans.
- To increase the effectiveness of tobacco control programs targeting African American communities.
- To increase participation by African American community-based organizations in the campaign to reduce tobacco use.
- To enhance African American leadership and reduce tobacco use in African American communities.
- To integrate the priorities of the Department of Health Services, Tobacco Control Section, with the mandate of the people we serve.



About the Network

The African American Tobacco Education Network (AATEN) is funded by the California Department of Health Services, Tobacco Control Section to "develop a collaboration" of tobacco education programs statewide who are serving the African American Community. The AATEN is administered by the Health Education Council. The Network is advised by a board of dedicated African American representatives who advocate for the health and well being of all Californians.

SERVICES AND ACTIVITIES

The AATEN engages in the following activities to assist tobacco education statewide:

- *Provides mini-grants to fund appropriate programs or priorities.*
- *Hosts statewide conferences.*
- *Co-hosts multi-ethnic conferences and trainings.*
- *Provides technical assistance through workshops and seminars.*
- *Publishes and distributes newsletters and bulletins.*
- *Reviews all Afrocentric tobacco education materials developed for the African American community.*
- *Provides sponsorship for group activities or events that address tobacco issues.*
- *Provides input to the State of California Department of Health Services, Tobacco Control Section on media and policy activities.*

The AATEN Membership

The African American Tobacco Education Network is a voluntary association. Membership is open to all interested residents of California who subscribe to the purpose of the organization and who support its goals and objectives.

Members represent agencies, organizations and individuals with special expertise in the health and social needs of African Americans, and those with expertise and knowledge of how to empower community members to advocate for themselves on tobacco related issues. Current AATEN membership includes representatives from churches, youth organizations, community based organizations, the media, advocacy groups, business, health organizations, other drug programs and legislators.

AATEN STANDING COMMITTEES

California residents interested in participating in the AATEN are encouraged to join any of the standing committees:

- Nomination and Membership Committee — identifies, recruits and recommends members for open committee positions, and network officers.
- Planning/Evaluating Committee—oversees the annual work plan and evaluates the effectiveness of Network campaigns.
- Policy Committee works on the development of Network Position Papers and advises the Advisory Board on policy issues relating to the African American community.
- Communication and Materials Review Committee reviews and makes recommendations on media and educational materials.
- Mini Grant committee reviews and recommends funding for tobacco education activities.

APIAHF

* Ed Lee

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Asian & Pacific
Islander American
Health Forum

National Advocates for Asian & Pacific Islander Health

Dong Suh, M.P.P.

Policy Analyst

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African
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Tobacco
Education
Network

Brenda Bell Caffee

Network Coordinator

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June 24, 1997

Drs. C. Everett Koop, M.D., Dr. David Kessler, and Advisory Committee on Tobacco Policy and Public Health
c/o The C. Everett Koop Institute,
Bethesda, MD

Distinguished Drs. Koop, Kessler and
Advisory Committee members:

As you embark in a thoughtful revision of the proposed tobacco industry settlement, the Joint Ethnic Tobacco Education Networks representing California's diverse ethnic communities, African Americans, Asian/Pacific Islanders, American Indians and Hispanic/Latinos, want to express our serious concerns regarding this settlement.

Our main concern is that the current settlement as it stands fails to address the issues faced by the disproportionate amount of ethnic minorities affected by the use of tobacco products throughout the country, and thus will not achieve the gains in public health it is claiming.

For example, a current analyses of the settlement proposal by the Latino Council on Alcohol and Tobacco points out wording regarding exemption of restrictions for tobacco advertising in "adult-only facilities" that will directly affect minority communities. We would like to stress that such "adult only facilities" which include liquor stores, bars, card rooms, taverns, and casinos, among other, are disproportionately more frequently located in minority communities. This is an area of great concern to us at the Joint Ethnic Tobacco Education Networks, and we request that provisions be included that will specifically address advertising in communities of color.

Although the tobacco industry advertises and promotes its products in culturally and language specific ways to communities of color, there is no mention throughout the settlement of the need to disseminate information regarding tobacco and new warnings in languages which reach our ethnic population groups (i.e., Spanish, Chinese, Korean and other frequently spoken Asian languages). We request that these provisions be included and moneys allocated to address the diverse language needs of these population groups in any final wording of this proposed legislation.

As currently stipulated it appears that settlement provisions will pay states for the cost of tobacco related illnesses. However, large proportions of our population groups are heavily uninsured or underinsured, and therefore states which carry a heavy burden of the uninsured and underinsured, who are also affected by tobacco related deaths and diseases, will not be guaranteed benefiting in the same way as other states from medic-aid reimbursements. What provisions, if any, have been included that will reimburse states and/or specific counties such as Los Angeles County for the tobacco related deaths and illnesses of the uninsured or underinsured?

In addition, we are extremely concerned about the little attention paid to provisions which will allow for aggressive advertising of the tobacco industry in developing countries. Many of these nations in Asia, Africa, Central, South America, the Caribbean, and Eastern Europe, have traditionally and continue to be allies to the United States. Would we knowingly allow "lethal weapons" to be exported into our allied nations? In the same way are we prepared to allow the tobacco industry to aggressively move even further into these nations advertising an "addictive American product" without preparing these countries for the forthcoming onslaught? This raises an additional concern to us, because many ethnic populations living now in the U.S. began smoking in their countries of origin, where overall smoking prevalence is lower for some groups. However, once in the U.S. prevalence rates among these population groups increase dramatically as they become more assimilated in the United States. Are we then helping to set the baseline in these countries of origin at a much higher prevalence rate? This will certainly hurt our standing around the world, and question our leadership and social responsibility towards these nations. As communities of color, the Joint Ethnic Tobacco Education Networks request provisions be established that require the tobacco industry advertising to follow consistent regulations, both domestically and internationally; providing compensation for individual smokers who would indirectly pay for such a settlement; and that monies be allocated for programs that will allow for collaboration between nations and the U.S. of educational efforts regarding the deleterious effects of tobacco products on the public's health.

Furthermore, we are terribly concerned that the FDA's ability to regulate nicotine may be weakened and recent gains in the judicial system compromised. If the FDA is not allowed to retain its currently gained authority to fully regulate nicotine unless they can ensure it will not create a black market, does this suggest FDA-related provisions will not be fully enforced? We are opposed to any language that restricts the FDA's impressive gains in this arena.

Another mayor concern of the ethnic communities is that penalties paid by the industry will be easily recovered by passing the cost along to their addicted consumers. Smoking prevalence in California is lower than for the rest of the nation. However, in the ethnic communities smoking prevalence among American Indians in California has been estimated as high as 42%, 19% among African Americans and 17% among Asian and Latinos, and among ethnic youth it is increasing. It is quite obvious then that a disproportionate burden of cost for the settlement will also fall on ethnic communities around the country. It will be our economically deprived ethnic communities that will in a large part help defray the cost of the tobacco industry's sale of an addictive product. The costs will be passed on to the consumers if the tobacco industry does not meet proposed standards. And although this may curtail smoking by some, it is those most addicted in our communities of color by tobacco products who will carry an added burden of payment for their addiction which was originally brought about by specific marketing of tobacco products in communities of color.

Any settlement proposal endorsed by your commission needs to address and resolve the concerns of the ethnic communities of this country. These communities are extremely diverse. We ask you consider including at your table the voices of individuals from each of these diverse ethnic communities, who understand the

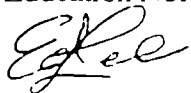
In closing, we the members of the Joint Ethnic Networks of the State of California, representing African Americans, Asian Americans, American Indians, Hispanic/Latinos and Pacific Islanders, are opposed to any legal or legislative settlement which protects the tobacco industry from regulations, restrictions, or responsibility from any past, present or future abuses and or deliberate targeting of our ethnic people, our children, our families and our communities. Further, we refuse acceptance of private back room deals made with the tobacco industry because the health and well being of our youth, our families, and our communities are not negotiable. There are dangers to the health and well being of communities of color that may be overlooked if we are not appropriately represented in this process. We will no longer be exploited by treaties, compromises or settlements, that are not in the best interest of our people.

We are encouraged by the quality of the members of your commission and know you will pay close attention to and act upon the issues we have outlined above. You may contact any one of the ethnic conveners at the telephones listed on the cover page. We thank you beforehand for your prompt and serious attention to this matter.

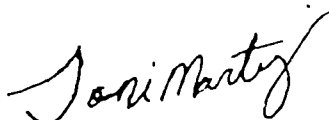
Most Sincerely,



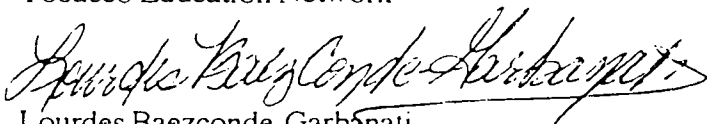
Brenda Bell-Caffee
African American Tobacco
Education Network



Ed Lee
Asian/Pacific Islander
Tobacco Education Network



Toni Martinez
American Indian
Tobacco Education Network



Lourdes Baezconde-Garbanati
Hispanic/Latino Tobacco
Education Network

Multi-Ethnic Youth Council Vision

- Mobilize Youth
- Educate Youth to Educate Other Youth
- Boycott the Industry
- Mobilize youth to pledge to be tobacco abuse free
- Free Promotional Items Given Away- T-shirts, etc
- Kick Butt Day
- Get Rid of Tobacco
- Tobacco Free Rave, Dance, Etc - At The Cow Palace
- Basketball Tournament/Games with Youth and Have
- Basketball Stars Come To Speak To Youth
- Worldwide Retreat
- Worldwide Billboards - "Just Say NO"
- Anti Tobacco Abuse Messages
- Free Promotional Items
- Music Video
- Youth Rally in Washington D.C.
- No Tobacco Abuse Day
- Worldwide Tour
- Newsletter
- Use Media

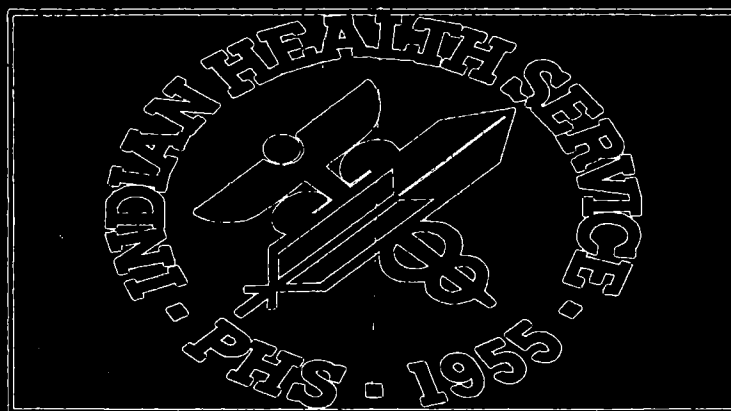


■ Involve other youth

■ Tobacco Free Gear with own logo

■ Booths with education

■ A teenline



Tobacco Settlement Meeting with Communities of Color
August 7th, 1997
White House Staffers, Washington D.C.

Briefing Paper with Indian Health Service (IHS) Information
Presented By: Don Reece, Tobacco Control Coordinator
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Executive Summary

The Indian Health Service (IHS) is an agency of the Public Health Service (PHS) within the Department of Health and Human Services. The IHS is responsible for providing Federal health services to American Indians and Alaska Natives. The provision of these services to members of Federally recognized Tribes is based on a special relationship between Indian Tribes and the U.S. Government first set forth in the 1830's by the U.S. Supreme Court.

The IHS goal is to raise the health status of American Indians and Alaska Natives to the highest possible level. The mission is to provide a comprehensive health services delivery system for American Indians and Alaska Natives with opportunity for maximum Tribal involvement in developing and managing programs to meet their health needs. It is also the responsibility of the IHS to work with the people involved in the health delivery programs so that they can be cognizant of entitlements of Indian people, as American citizens, to all Federal, State, and local health programs, in addition to IHS and Tribal services. The IHS also acts as the principal Federal health advocate for American Indian and Alaska Native people in the building of health coalitions, networks, and partnerships with Tribal nations and other government agencies as well as with non-Federal organizations.

Lung cancer was the leading cause of cancer mortality for all IHS Areas combined (1984-1988). The trend has continued and in the next publication of "Cancer Mortality Among Native Americans in the United States," lung cancer is still the leading cause of cancer mortality for the years 1989-1993. (Publication expected, Spring 1997.)

Using the Behavioral Risk Factor Surveillance System Surveys (BRFSS), Sugarman, et al compared tobacco use among American Indians (AI) in the 36 states participating during the years 1985 through 1988 (Alaska did not participate in the BRFSS during this time period); these states were divided into four geographic regions: the Southwest, the Plains, the West Coast and Other States. The prevalence of current cigarette smoking varied by geographic region more than twofold for AI Men and more than fourfold for AI women. For example, in Southwest States, 18.1% of Indian males and 14.7% of Indian females reported current smoking compared to the Plains States where 48.4% of Indian males and 57.3% of Indian females reported current smoking. Cigarette smoking is one factor in which regional differences among Indians were markedly different from those among whites, as the prevalence of current smoking reported by white respondents varied relatively little by geographic region.

The United States Federal government has entered into Treaty relationships with American Indians and Alaska Natives establishing a special government to government relationship. Among other agreements provided for in the various treaties was the provision of health services. Currently these obligations are met primarily through the IHS which funds health programs provided by tribes, urban organizations, and services provided directly through Federal programs. The funding for these programs is inadequate to meet the health needs of the population served. The tobacco settlement offers an opportunity to provide the best possible health services in meeting the treaty obligations entered into in the treaty relationships.

Appendix III - Application to Indian Tribes

A. Application of Act

1. The provisions of the FDCA, the regulations of the FDA, and the Act relating to the manufacture, distribution and sale of tobacco products shall apply on Indian lands as defined in 18 U.S.C § 1151 and on any other trust land subject to the jurisdiction of a Indian Tribe. To the extent that an Indian tribe engages in the manufacture, distribution or sale of tobacco products, the provisions of this act shall apply to such a tribe.

2. Any federal tax or fee imposed on the manufacture, distribution or sale of tobacco products shall be paid by any Indian tribe engaged in such activities on such Indian lands to the same extent such tax or fee applies to other persons under the law.

B. Tribal Programs and Authority

1. For the purposes the provisions of the this Act, FDA is authorized to treat any federally-recognized Indian tribe as a state, and is authorized to provide any such tribe grant and contract assistance to carry out the licensing and enforcement functions provided by this section.

2. Such treatment shall be authorized only if :

(a) the Indian tribe has a governing body carrying out substantial governmental powers and duties;

(b) the functions to be exercised by the Indian tribe under this section pertain to activities on trust lands within the jurisdiction of the tribe ; and

(c) the Indian tribe is reasonably expected to be capable of carrying out the functions required under this Act.

[Source /precedent: Clean Air Act, 42 U.S.C. § 7601(d)]

3. FDA regulations which establish a retail licensing program shall apply on Indian trust lands, and each tribe's program shall be no less strict than the program of the State in which the tribe is located.

4. If FDA determines that an Indian tribe does not qualify for treatment as a state, FDA will directly administer the retailer licensing program, or may delegate such authority to the state.

C. Tobacco Compensation And Public Health Grants

1. A portion of the settlement funds to which a state is otherwise entitled shall be paid to HHS for distribution to the Indian tribes which have been certified by FDA for treatment as states. The funds to be paid for such purposes on behalf of Indian tribes shall be determined by the proportion of registered tribal members resident on the reservation to the total population of the state in which the tribe is located. The funds to be distributed to the Indian tribes shall be used for the same purposes as those funds are to be used by the states and be subject to the same compliance with the requirements of the Act and any applicable regulations.

2. The Department of Health and Human Services will annually pay to the governing body of each Indian tribe its share of the funds for use under an FDA-approved plan after annual certification by FDA, requirements of the Act and any applicable regulations.

3. If HHS does not distribute all, or a portion, of an Indian tribe's share of the funds in any given year because the tribe has not qualified under the terms of this section or has not yet met the compliance requirements for retail sales to minors, those funds will be distributed to other qualified tribes in the same state for the same purposes and on the same proportional basis, less the non-qualified tribe's population, as other settlement funds are to be distributed to the tribes.

D. Obligations of Tobacco Manufacturers

1. Tobacco manufacturers shall not engage in any activity on Indian lands subject to this Act which activity the manufacturers may not otherwise do within a state.

2. Tobacco manufacturers also agree not to sell tobacco products for manufacture, distribution or sale to an Indian tribe, or to a manufacturer, distributor, or retail seller subject to the jurisdiction of an Indian tribe, except under the same terms and conditions as the tobacco manufacturers impose under other manufacturers, distributors and retail sellers under the Act, or any applicable regulations.

**Issues Related to the Recent Tobacco Settlement Agreement
involving American Indians and Alaska Natives. (IHS)**

(1) Both the Indian Health Service (IHS) and the tribes have over the years expended large sums of money treating tobacco related diseases. The agreement does not appear to offer either IHS or the tribes any method or avenue to recover these expenses. Class action suits are banned, third party payor claims are barred except on a subrogation basis, and it is unclear if the Federal Medical Care Recovery Act (FMCRA) is still available. This latter is probably not viable unless tied to a class action suit since it is handled on a case by case basis. Presumably the Departments of Defense and Veterans Affairs would have similar concerns.

(2) It is our understanding that a group of tribes have initiated a class action suit against the tobacco industry or were attempting to be included in either: one of the existing class action suits or the negotiations that lead to the agreement under review. The basis of this understanding was from contact by an attorney (Mark Hutton) to which we responded with the attached letter.

(3) There are many tribal jurisdiction questions raised by the proposed agreement which should be addressed by the Department of the Interior.

(4) Although "Appendix III - Application to Indian Tribes" (page 46) attempts to address the impact and implementation of the agreement and the proposed resulting Federal and state legislation there are still many questions remaining. In many places the term, "State and local governments" is used. The term "local government" does not include "tribes" unless specifically provided in statute or regulation. Appendix III would propose to make tobacco related provisions of the implementing act, the Food Drug and Cosmetic Act, and FDA regulations apply to Indian tribes and Indian lands (including trust lands subject to tribal jurisdiction).

Further, the Appendix to authorize the FDA "to treat any federally-recognized Indian tribe as a state" under provisions of the proposed act. Since it appears that not everything in the agreement would be included in the proposed act, there is some question as to when the tribes would or could share in the benefits or be governed by the restrictions and penalties. For example, Title VII (A) (1) (page 36) authorizes the Secretary to make grants from tobacco industry payments to state health departments for a number of purposes including programs to reduce use of tobacco. Does this authority include the tribes as "states" if they have been so designated by the FDA or does Appendix III C. 2 (page 47) limit tribes to compensation settlement funds, or are these the same funds? If the same, how can tribes obtain settlement funds if they have not been designated as a state by FDA? It is possible that tribes may wish to share in the settlement funds without having to assume the role of a state.

(5) Would the FDA treating a tribe as a state under Appendix III have the effect of applying the many state responsibilities spelled out in “Appendix VI: State Enforcement Incentives” (page 58).

(6) Would violations of numerous restrictions, including sale to minors, environmental tobacco smoke, etc. on tribal lands be dealt with in tribal courts?

(7) Under “B. State Authority” of “Title V: Scope and Effect” (page 32) is the statement that “The legislation retains similar flexibility for Indian tribes . . . and other federal agencies.” In context it is not clear how this statement applies to IHS. With regards to Indian tribes, it only adds to the confusion since it is not clear to what degree and under what conditions a tribe will be considered a state and what options/benefits/incentives and obligations/restrictions/penalties will apply under the various situations.

(8) The agreement states (page 4) that it ensures, “that a portion of the costs of treatment for diseases and adverse health effects linked to the use of tobacco products is borne by the manufacturers of these products. . . .” From the IHS perspective, and presumably from the tribal perspective, this goal is not achieved unless and until some of the funds are used as recompense for past expenditures associated with treating tobacco related diseases, at the expense of other needed but unprovided health care.

(9) Will tribes be able to access tobacco cessation (page 5) funds; will funds be available to individuals or to tribal entities/IHS/urban organizations? Will FDA cessation program **accreditation** be required of tribal tobacco cessation programs for receipt of funds? What if tribes choose to accredit their own tobacco cessation programs?

(10) An exemption for and/or consideration regarding production and use of tobacco for **traditional ceremonial practices** should be developed..

(11) How would any preemption clauses apply to Tribes?

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Dear Mr. Hutton:

I am responding to your recent telephone request on whether the Indian Health Service (IHS) and the tribes have had substantial costs related to providing treatment for tobacco related diseases. Latest statistics suggest that tobacco use is the second ranking preventable cause of Indian deaths annually contributing to about 11% of such deaths. I believe it is fair to say that over the years both the IHS and the tribes have expended substantial sums treating tobacco related illnesses.

To make things worse, because we are not an entitlement program and both the IHS and the tribes must constantly adjust their medical priorities to reflect the funds available through appropriations and authority to bill third parties, e.g., Medicare, Medicaid, private insurers, tobacco related expenditures are made at the expense of other needed services. The IHS would, arguably, have the right to recover the cost of its treatment of tobacco related diseases from third party tort feasons under authority of the Federal Medical Care Recovery Act (FMCRA). Though tribes might not be covered by the FMCRA, the same costs exist and the same theories that justify the FMCRA would apply to tribal recovery of such expenditures.

Many tribes have taken over the operation of IHS programs using the authority of the Indian Self-Determination Act, Public Law (P.L.) 93-638. Both the IHS and the tribes operating IHS programs are faced with the fact that, on average, the available funds cover only 60% of the need. Therefore, any expenditure to treat smoking related disease is, in effect, an excess expense and acts as a diminution of available funds resulting in other needed services not being provided. The cost to and impact on many tribal providers is exacerbated where the tribe supplements the IHS funds with their own funds.

In summary, both the tribes and the IHS have had excess expenses over the years caused by the need to treat diseases caused by tobacco use and the cost is measured in human suffering, funds expended, and other needed services not provided to the Indian people.

[Trujillo]

Smoking Cessation for the Indian Health Service

With the exception of southwestern tribes, American Indians and Alaska Natives (AI/AN) smoke more than other Americans, with smoking prevalence ranging from 25% to 40% or more. Smokeless tobacco use is also highly prevalent, especially among youth. A comprehensive tobacco cessation program for all AI/AN would have to include consideration of certain issues that are important to this population:

1. Tobacco is a sacred plant for many tribes, and smoking ceremonies are among the highest forms of religious behavior. For many American Indian groups, complete cessation of tobacco use is not an acceptable alternative. Smoking cessation programs for this population must be designed to accentuate the distinction between the habitual abuse of tobacco and its appropriate religious use.
2. AI/AN people often live in remote areas, with limited access to media and communications systems. Phone hotlines and electronic media campaigns are of limited value in these communities.
3. AI/ANs have higher poverty and lower literacy rates than most other groups, which can also serve to limit access by traditional health education approaches.
4. Approximately 30% of IHS facilities are now run by Tribes through Self-Governance agreements. These facilities are quite autonomous; IHS could receive the funds and pass appropriate shares on to them.

To reach every AI/AN smoker, a trained tobacco control specialist would have to be located in each hospital or clinic of IHS. They would receive encouragement, materials, and technical support from IHS Headquarters, but would have considerable latitude to tailor their programs to the unique needs of the local population. Because poverty is a major issue, the cost of nicotine replacement therapy would have to be fully subsidized. In service units where tobacco prevalence is low, the counsellor could be cross-trained as a diabetes counsellor and serve a valuable function in that role as well.

IHS delivers care through 144 Service Units; putting a tobacco cessation counsellor in each (at \$50k for salary, benefits, and overhead) would cost \$7.2 million per year. There are 1.4 million AI/ANs who regularly receive care from the IHS. Of these 910,000 (65%) are over the age of 15. Smoking prevalence averages 25%, so there are about 227,500 smokers in our patient population. If 10% of the smoking population uses the cessation services each year, at \$200 apiece for NRT and materials, that would cost \$4.6 million per year. Total = \$11.8 million per year.

PROPOSAL FOR INVESTMENT IN MEETING TREATY OBLIGATIONS FOR AMERICAN INDIANS AND ALASKA NATIVES: THE BEST HEALTH CARE POSSIBLE.

Issue: The United States Federal government has entered into Treaty relationships with American Indians and Alaska Natives establishing a special government to government relationship. Among other agreements provided for in the various treaties was the provision of health services. Currently these obligations are met primarily through the Indian Health Service (IHS) which funds health programs provided by tribes, urban organizations, and services provided directly through Federal programs. The funding for these programs is inadequate to meet the health needs of the population served. The tobacco settlement offers an opportunity to provide the best possible health services in meeting the treaty obligations entered into in the treaty relationships.

Background: The mission of the IHS, through partnership with tribes, is to elevate the health status of Indian people to the highest possible level. The Indian Health Service provides funding for a variety of health programs to accomplish this mission. These include medical and behavioral health programs in hospitals and clinics, prevention and outreach programs in clinics and communities, and community based programs for public health such as solid and liquid waste facilities and services. This mission is codified in the Indian Health Care Improvement Act. The partnership between the Agency and tribal governments is a critical component of the government to government relationship and is codified in the Indian Self Determination Act.

The IHS has never received funding to fully achieve its mission. Per capita funding of IHS programs is less than 50% of the per capita funding expended for health services in the general U.S. population. Further detailed comparison of service capacity compared to industry standards reveals that IHS receives less than 60% of the funding needed to assure the highest quality, most efficient health services program available. Based on these technical analyses, the IHS budget should be funded annually at the level of \$3-4 Billion. Tribal leadership has offered an even larger figure based on the inclusion of investment in a variety of educational and economic development activities in assuring health that would place the IHS annual budget at the level of \$10 Billion.

Baseline: IHS budget FY1997 is \$2.12 Billion

Justification/Proposal: *The IHS would propose that the base budget be raised incrementally (approximately \$250M/year) to a minimum of \$3.5 Billion over five years.* Reassessment of the adequacy of the investment would be conducted at the five year point to determine the effectiveness and efficiency of the investment at that point. Revisions to the target would be made in light of such factors as health status indicators, contemporary health economics, and the future of the settlement process. The attached documents propose investments for year one at the level of \$290M.

Tribal Contract Support Costs

Issue: Tribal governments are increasingly exercising their right under the Indian Self Determination Act to assume managerial control of IHS funded programs. Currently, 43% of IHS funded programs are operated directly by tribal governments. Funding for the administrative support costs need by the tribes to assure successful program management is inadequate.

Background: The IHS is authorized to enter into legal agreements with tribes transferring operational control and funding for delivery of health services to the tribes. The tribal governments must assume responsibility for the management overhead for these programs as well as the service delivery components. The capacity to perform these administrative functions in support of the program is often missing in tribal governments. In addition, law and court rulings have established that the tribes have a right to reasonable, negotiated contract support funds. These funds are critical to the success of the program.

The IHS has not been adequately funded for these costs and has rationed the allocation of these costs through policy. Currently tribes are awarded funds for these costs through a queuing mechanism that essentially pays on a "first come, first served" basis. This means that the majority of tribes wait many years before receiving these funds. Currently there are tribes in the queue awaiting payments of \$36 Million.

Baseline: The IHS budget for this activity in FY1997 is \$7.5 Million.

Justification/Proposal: The IHS proposes that \$29.5Million be invested in this activity. These funds will fully fund those tribes that have undertaken the responsibilities of operating their own health care programs.

URBAN INDIAN HEALTH PROGRAMS - \$6,000,000

Baseline Costs: \$24,768,000 in FY 1997

Justification: The urban Indian population remains the most underserved among IHS beneficiaries with an estimated funded level at 22 percent of need. The IHS proposes increasing the amount identified for Urban Indian Programs by \$6,000,000. In addition to prevention and treatment of alcoholism provided in the passback, the increase will be used to provide a base increase to all Urban programs to generally offset unmet needs. An amount will be set aside in grants to explore regional administrative structures for urban programs to produce cost savings in program administration to be used for health care. An amount will be used to stabilize base funding of select programs where access to primary health care is a major problem. This will enable these programs to achieve provider status under State managed care initiatives.

INJURY PREVENTION - \$5,000,000

Background: Remarkable progress has been made over the last five years in demonstrating improvements in health status and reductions in Federal expenditures for medical treatment of traumatic injury due to successful community-based injury prevention programs. A grant based program to tribes as described in the passback is consistent with the Agency initiative on injury prevention.

Baseline Costs: \$ 5 million in FY 1997

Justification: Injuries are the leading cause of death for Indians ages 1-44 years, and injuries pose one of the most significant public health problems facing American Indian and Alaska Native (AI/AN) people today. The annual toll is devastating:

- over 1,300 Native Americans die prematurely from trauma as the direct result of injuries;
- over 10,000 Native Americans are hospitalized for injury trauma;
- over 50,000 days are spent in Indian Health Service (IHS) and contract care hospitals;
- over 330,000 outpatient visits are recorded for the treatment of injuries; and
- over \$150 million is spent on transportation/treatment of Native American injury victims.

The IHS believes that the current investments in injury prevention at the community level need to be expanded to more tribes to fully realize the true benefits. Annually less than 20% of the tribes which apply for injury prevention intervention resources actually receive them due to the lack of funding availability. The IHS proposes increasing the amount identified for injury prevention by \$5,000,000 to support community-based injury prevention and control programs. IHS believes the most effective approach for community health programs is developing the capacity of tribes to address their health problems. This level would allow for support more than 100 additional community-based projects.

CONTRACT HEALTH SERVICES - \$40,000,000

Background: The Indian Health Service (IHS) provides a comprehensive range of primary prevention and treatment services through its many hospitals and clinic facilities. Given the focus on primary care services, the IHS has not built or staffed its facilities to include many specialized or secondary and tertiary care outpatient and inpatient services. Accordingly, it purchases these services through its Contract Health Care program from private and public providers of such services when the need arises and funds are available. Such factors as transportation, isolation, weather, and other accessibility factors condition the use of such services as well.

The IHS has not had sufficient funding to meet the needs of all of its patients in providing these specialized services. The IHS functions like a managed care organization in controlling access to these specialized services and the costs associated with providing specialized care. The IHS has limited access to this level of care to those cases determined to be consistent with its priorities.

This has meant in most locations that only those cases deemed urgent or emergent are referred for IHS payment. These determinations are made by local Contract Health Care committees charged with reviewing the appropriateness of the referral and the availability of alternate resources for payment.

Although the Agency has sought to negotiate competitive price contracts with its vendor providers, the inflation rate in rural environments has been difficult to control. The IHS facilities are often isolated and have few alternative choices should a provider refuse to negotiate more competitive pricing. In FY1996 however, the inflation rate came into single digits and approached the CPI rates for the first time in the decade of the 90's.

As a consequence of these realities, the IHS has had to defer a large number of cases that would otherwise be benefited by care. This is particularly true for communities where an IHS hospital is unavailable and all inpatient care must be provided through contract mechanisms. Of special concern are those cases where morbidity and mortality would have been prevented if the intervention had been accessible earlier in the course of the disease.

The cost of catastrophic cases has also climbed inexorably over the last decade and the Agency has significantly more requests than it is able to fund. Under this program, communities may apply for relief when they have medical catastrophes in which the costs exceed \$20,000 per case. The Agency provides additional funding over the \$20,000 floor to assist small communities in avoiding bankrupting the contract health care funds in their budget. In FY1996, the Agency received requests for catastrophic assistance in excess of \$20Million. The identified resources for this need are only \$12Million.

Baseline Costs: \$368,325,000 in FY 1997

Justification: As noted above, the three areas of concern in the Contract Health Care service program are: deferred services, catastrophic care, and unmet needs.

The deferred services are documented through annual analysis of those cases that were deemed medically of concern, but did not reach the threshold of urgent or emergent. Based on the last full year of analyzed data (FY1996), 86,125 individual episodes of deferred services were recorded. It is anticipated that this workload would generate costs in excess of \$18 million.

The catastrophic care component of the program has a need of at least \$8 million as described above. This is probably a low estimated since the communities stopped submitting requests relatively early in the year since they were aware that the fund would be depleted rapidly. Therefore an additional \$2 million (or a total of \$10 million) would be appropriate based on projections of expenditure rates from FY1996.

Lastly, the Agency routinely estimates the need for public health and preventive services that are needed but unavailable because of the limitations of the funds driven priority system. Such

services include routine mammography screening, cervical cancer screening, well child care, and other services that would only be available through the contract health care system in some communities. Costs are estimated to be in excess of \$12 million.

COST ESTIMATES:

Total cost is estimated to be \$40 million for this service component of the program.

WOMEN'S HEALTH - \$3,400,000

Background: Indian women comprise 51 percent of the 1.4 million AI/AN population. In the past 3 years, the IHS has given renewed emphasis to women's health issues including access to preventive services, increased surveillance and screening for diseases, increased community education, self-image development strategies, and increased leadership roles occupied by women within the IHS. Indian women have been viewed as a stable force with the strength, ability, and determination to promote healthy lifestyles in communities and families. However, despite progress in women's health issues, statistics continue to indicate a need to improve health services to Indian women.

- injury and poisoning deaths at approximately three times the rate for non-Indian women
- alcoholism deaths at ten times the rate for non-Indian women
- cervical cancer deaths at approximately twice the rate for non-Indian women
- diabetes deaths at approximately triple the rate for non-Indian women

Baseline Costs: \$800,000 in FY 1997 (an additional \$500,000 is requested in FY 1998)

Justification: Partnership grants to community women would increase ability to address and resolve issues. The tribes/tribal organizations that receive grants will be able to provide training/education in health promotion, domestic violence, chemical abuse, and child abuse; implement programs to increase cultural pride, self-identity, and spirituality; develop/implement mentoring programs, such as mother/daughter, youth/elder, etc.; provide training to increase ability to network, collaborate, and educate policy makers, consumers, and others on women's issues; and develop/implement support groups, e.g., cancer survival. The remaining funds will be used to increase the comprehensive and culturally appropriate preventive, diagnostic, and treatment services provided to women. This will be done by increasing the number of female providers and community-based providers (i.e., CHRs, PHNs, and health educators) and by increasing the number of women's health clinics. Additionally, the funds will be used for one FTE for national coordination of this initiative.

ELDER HEALTH - \$3,300,000

Background: Approximately 150,000 elder AI/AN, a substantial growth over the last decade, require more services and a shift over the last 50 years in prevalence from acute and infectious

diseases to chronic and degenerative ones.

Baseline Costs: \$800,000 in FY 1997 (an additional \$500,000 is requested in FY 1998)

Justification: Improve access of health care/continuity of care for elders.

- Evaluate ambulatory services for elders
- Establish community-based elder services
- Develop elder specific clinics
- Maintain continuity of care with same provider

Develop training in geriatrics/gerontology for all providers.

- Develop culturally competent geriatric health care.
- Prevent and reduce disability and improve quality of life.
- Provide cost-savings and high quality health care.

Provide technical assistance/expertise to IHS/Tribal/Urban (I/T/U) entities to develop home/community-based programs.

- Prepare Indian Health Service/Tribal/Urban entities for partnership roles.
- Integrate a continuum of care: prevention, acute care, transitional care, and self-help assistance.
- Provide short-term care services: geriatric assessment and consultation, home health/help services, care giver support, and self-help technology in chronic care.

Develop a program site located in a resource center.

- Provide advocacy, consultation and networking with I/T/U entities.
- Update geriatric/interdisciplinary education
- Provide one physician geriatrician, one R.N. trained in gerontology, and one program analyst.
- Coordinate elder health care efforts nationally.

MENTAL HEALTH SERVICES - \$50,000,000

Background: Mental illness intervention, treatment and prevention services for American Indian and Alaska Native children and adolescents are seriously underfunded. Needed services include the identification and treatment of children and youth who are victims of child abuse, for youth at risk for violent behaviors and suicide, and for programs to prevent child abuse and suicide. Currently, only four tribes have been provided with resources for child abuse victim treatment services, with three others receiving funds for child abuse prevention initiatives. Only three tribes have adolescent suicide prevention programs. These programs have demonstrated that child abuse can be effectively treated and prevented, and that adolescent suicide attempts can be dramatically reduced through community-based specific program activity. Additional programs are needed for family therapies, services for the chronically mentally ill, and those that are dually diagnosed with chemical dependency and mental illness.

Baseline Costs: \$38,341,000 in FY 1997 (\$4,150,000 for child abuse).

Justification: It is estimated that at least 50 additional tribes are currently prepared to implement child abuse/suicide treatment and prevention programs. The minimum costs per tribal program grant is estimated at \$200,000 - 400,000. Community based prevention programs for gang violence, spousal abuse, and homicide will also consume an additional \$15 million. Services for dysfunctional families including treatment and prevention would require an additional \$10 million. Lastly, services for the chronically mentally ill, including schizophrenia, would also benefit from an additional \$5 million.

INHALANT ABUSE - \$1,600,000

Background: Inhalant abuse prevention and intervention is a needed service to address the growing inhalant abuse problem in American Indian/Alaska Native communities. It is estimated that approximately 10% of the American Indian and Alaska Native youth receiving treatment services acknowledge a positive history of inhalant use which is being addressed by staff in the ten youth regional treatment centers (RTC'S) and the community rehabilitation/aftercare programs.

Baseline Costs: Currently, there is not an amount targeted specifically for inhalant abuse. The estimated annual cost of treatment and aftercare/continuing care is approximately \$1.6 million.

Justification: The additional funding would augment the RTC and aftercare treatment programs in providing appropriate treatment to the inhalant abuse client(s). This would enhance current screening, assessment, and intervention technology. A portion of the funding would be set aside for training on inhalant abuse for the RTC staff and community rehabilitation/aftercare staff toward enhancing their treatment capabilities.

ORAL HEALTH - \$15,000,000

Background: In FY 1996, clinical dental services were provided to almost 300,000 AI/ANs. Approximately half these individuals were children and adolescents. Over 2 million services were provided to Indian patients during this period. In addition, community-based health promotion/disease prevention services were provided to an additional 400,000 people. These activities include community education, school-based fluoride tablet and mouth rinse programs, promotion of community water fluoridation, technical support of head start programs, and other activities aimed at providing access to large groups within the community.

Baseline Costs: While it is difficult to precisely attribute current costs to specific age groupings it is estimated that approximately half of IHS expenditures on dental care are for children and adolescents. In FY 1996 this is approximately \$31,400,000.

Justification: Although oral health problems rarely represent life threatening conditions for AI/ANs, recent evidence has shown that dental conditions can profoundly impact the quality of their lives. Findings from the IHS Dental Program participation in the World Health Organization International Collaborative Study of Oral Health Outcomes (ICSII) documented alarming suffering that greatly exceeded that found in other countries and other study sites in the U.S. hat of the U.S. in general (1:3,000 in IHS vs. 1:1,600 U.S.). The intensity of resources need to address this condition clearly takes away from IHS capacity to address the oral health needs of other members of the community.

This proposal is designed to: 1) increase access to clinical services for young children; and 2) increase capacity for clinic-based primary and secondary interventions to reduce the incidence and prevalence of early childhood caries. Primary interventions include the use of fluoride and sealants, and secondary preventive measures include treating lesions using the Atraumatic Restorative Treatment (ART). This procedure is basically a "scoop and fill" technique in the removal of carious lesions with hand instrumentation and filling with a glass ionomer (fluoride-release). These restorative techniques serve as an interim filling, and in many cases, delays the need for definitive care until the child is older and then may not require restraint, sedation, or general anesthesia. This technique can be taught to dental auxiliaries in the Indian Health Service who have already been trained to place restorative materials in simple fillings. The utilization of these specially-trained auxiliaries would greatly expand the capacity to provide basic preventive and restorative treatment. These procedures will be targeted to Native American children ages one to five years old who are at the greatest risk for tooth decay. Use of dental sealants would also be incorporated into the preventive regimen of these children. In addition to risk assessment, early intervention and referral, education of parents/caregivers and preventive recalls would be incorporated in the treatment and preventive protocol. These interventions are patterned after the Access to Baby and Children's Dentistry program from the Department of Pediatric Dentistry at the University of Washington.

COST ESTIMATE: It is estimated that the cost of this project would be \$15,000,000. Resources will be used to increase access to clinical services for young children by contracting with Pediatric Dentists to address the high backlog of services which exist in many Indian communities as well as to provide training for a cadre of pediatric dental auxiliaries. These auxiliaries will be trained at the 13 sites where pediatric dentists are stationed and within that geographic Area or region. Some urban communities may choose to contract with a private-practice pediatric dentist to provide training to these pediatric auxiliaries. Training on the treatment as well as management of these young children will be included. Creating child and family-friendly dental clinics is a critical part of the training. Training providers to work with caregivers on education and other prevention techniques for parents and caregivers will also be included. These sites will be used as test sites in the treatment component of the disease. Training would be provided to all IHS clinic staff and communities through a series of train-the-trainers approach to include education for the community and treatment and prevention component. This training would be focused on the early intervention and education in a

community setting. Training will be coordinated by the IHS Pediatric National Consultant and the Director, Dental Disease Prevention Program as well as the Dental Assistant Trainers.

Evaluation of this project would include a demonstrated increase in access to care for children ages 0 -5 years and well as a reduction in the incidence and prevalence of BBTD/ECC.

DIABETES PREVENTION - \$40,000,000

Background:

Type II diabetes occurs at dramatically higher rates among AI/ANs than in the general U.S. population. Sequelae of this disease phenomenon lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general U.S. population. As noted in the 1996 IHS publication, *Trends*, diabetes mortality is 2.7 times higher in the AI/AN population than in the U.S. population. Although IHS has had an active clinical diabetes program for twenty years, the incidence of various complications has continued to increase. While progress has been made in reducing the rate of increase of blindness and amputations, these complications continue to occur at unacceptably high levels, and ESRD is escalating at a rapid rate. Increased primary prevention and expanded secondary prevention efforts are needed in addition to the existing clinic-based programs. Based on preliminary information from international and domestic literature reports, there are promising community-based primary and well documented secondary prevention efforts that have been inadequately utilized and evaluated in the U.S. and among AI/AN populations.

NEW GRANT PROGRAM

We are proposing to initiate enhanced services within Indian communities that focus on the prevention of diabetes and its complications. Up to now, expanded clinical services for AI/AN diabetics have been delivered primarily to limited populations where specialized services have been authorized and funded by Congress as Diabetes Centers of Excellence. In most IHS service locations, however, the clinical care which has been provided to diabetics has been characterized by the use of older methods and approaches. These services also have been free-standing and not necessarily linked to primary prevention efforts. Consequently, for the IHS service population the vast majority of hospitalizations and ambulatory medical visits related to diabetes are to address advanced complications of the disease which are preventable. While newer methods for primary and secondary prevention efforts are available and have been used in limited settings, these have not been incorporated into routine clinical services widely available to AI/ANs.

The proposed grant program will allow for the first time within IHS populations, wide-scale and more intensive application of primary and secondary prevention methods and newly available pharmaceuticals. It will involve wider applications of methods for intensive glucose control, including the use of newly developed oral hypoglycemics. Research in Type I diabetes has shown that tighter overall glucose control reduces the frequency of blindness, amputations and

kidney damage in diabetics. Research in the use of newer oral hypoglycemics shows that glucose is more effectively controlled by these agents. This combination of tighter control methods and newer agents will relieve many diabetics of the multi-system organ failure that accompanies this disease, if the application of these interventions is as effective among AI/AN Type II diabetics as it has been in other populations. The proposal also will allow for the evaluation of the routine use of newer antihypertensive medications to prevent renal failure. Information from limited use trials suggest that in diabetics with evidence of early renal damage, this approach will reduce further renal damage significantly. This grant program will allow for the first wide-scale application and evaluation of multi-year, multi-community, nutrition and dietary modification programs among children (including Headstart programs and elementary schools) at risk for diabetes. These programs hold the promise of reducing the rate of this disease through preventing obese children who go on to diabetes in early adult life.

Obesity prevention interventions and MNT to address the significant problems of overweight and chronic disease with workforce (i.e., nutritionist to population ratio) is approximately 80 percent **below** what is recommended for populations at high nutritional risk. Currently 20 percent of the Indian people have access to nutrition services. While effective methods to prevent obesity have not yet been well established in the general population and developing these programs are challenging, community and individual-directed interventions are needed to prevent obesity and diabetes, conditions that have not always characterized this population.

Baseline Costs: An estimated \$12 million of present IHS resources supports nutrition professionals. The Diabetes program has a budget of \$7 million.

Justification:

This program would provide two kinds of grants for tribes and Indian organizations. First, multi-year awards in the amounts of \$350,000 - \$500,000 per year would be awarded competitively to approximately 20 programs in small communities with demonstrated needs and sound program and evaluation proposals. The grants would allow these communities to provide and evaluate a variety of intervention services such as public health nutrition, public health nursing, exercise physiology, school-based health education, and standardized approaches to providing primary and specialized medical services aimed at the prevention of diabetes and its complications. Because the age at diagnosis has been decreasing and most AI/AN now develop diabetes in younger adult years instead of late adulthood, specific age groups would be targeted for primary prevention, including pre-school and school-age children and adolescents. Secondary prevention would target those with abnormal glucose handling. Tertiary prevention would target those with diabetes and evidence of end organ involvement (such as proteinuria). These grants would allow for expansion of innovative prevention efforts in smaller, more isolated communities. The successful proposals would need to link both primary and secondary prevention in a coherent manner that would achieve measurable goals in both the short-term and long-term. This model would also allow for evaluation of the effect of these interventions in a variety of different tribal communities. These grants would significantly increase the number of communities employing

these newer prevention strategies, and there would be a significant increase in knowledge gained about the efficacy of these promising interventions.

In addition, we propose a single \$17 million per year, multi-year award for a large-scale, coordinated primary, secondary and tertiary prevention effort among the Navajo to meet the diabetes prevention needs of a large single tribe population with a significant concentration of both diabetics and those at risk for diabetes. This would engage sizable areas of Arizona, New Mexico, and include Utah and Colorado in an effort to control the epidemic in the Navajo population of these states. It would involve significant media messages, school-based prevention, exercise activities, as well as intensive medical intervention for glucose control and treatment aimed at preventing end organ disease (e.g. retinal screening, podiatric services, and hypertension control). This larger grant program would significantly expand our knowledge about wide-scale applications of these intensive prevention strategies and methods in a single tribal population. The understanding of genetic variation in response to these interventions may be enhanced by evaluating outcomes in this large and homogenous American Indian population. Results from this major demonstration program will be replicable nationwide for other AI/AN populations.

The grant program also would establish a research and evaluation center (with annual funding of \$2 million) to coordinate the evaluation of the grants and disseminate and publish the findings of the evaluation studies.

While these proposed activities will be based on sound scientific findings and will include strong evaluation components, they do not include a substantial focus on basic research. Most tribal leaders now assert that American Indians have been “researched to death.” This sentiment has been voiced in local meetings at Pima, for instance, where NIDDK has been conducting good basic research for many years. In addition, when a meeting of tribal leaders was convened recently to establish a research agenda in diabetes, they were more supportive of expanded use of promising or proven methods rather than basic research. While the Navajo Nation did recently pass a resolution in support of the “study of genetics,” even this does not appear to wholeheartedly endorse an emphasis on basic research on diabetes in Indian country.

A School-Based Nutrition Monitoring protocol (for grades 4 and 8) developed by the Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention, will be implemented in elementary schools located on or near Indian reservations. Other parts of the program include development of community-directed/community-based obesity prevention interventions and implementation of a focused obesity prevention effort for young and adolescent children aged 0 to 13. An estimated \$13 million is needed to support the project. Of this amount, \$11 million would expand nutrition services and \$2 million would be directed toward implementing a school-based nutrition survey.

Cost Estimate: Total cost is estimated to be \$40 million.

SANITATION FACILITIES CONSTRUCTION - \$60,000,000

Background:

This activity provides essential sanitation facilities to Indian homes and communities, an integral component of the IHS disease prevention activity, and has carried out those activities since 1960.

Analysis of unmet needs for water and sewage handling, as well as solid waste management, are in excess of \$600 million. This includes services to homes currently unserved, as well as replacement of aging or flawed facilities.

Baseline Costs: \$87,000,000 in FY 1997

Justification:

A \$60,000,000 supplement to the sanitation facilities construction activity would reduce the backlog of sanitation facilities projects by approximately 10 percent. Projects would be funded based on an established priority system where water, sewer, and solid waste facilities needs are identified. Over the 10-year life of the proposed tobacco settlement, this investment would reduce all unmet needs for financially feasible sanitation facilities.

MAINTENANCE AND IMPROVEMENT - \$20,000,000

Background:

The objectives of the maintenance and improvement activity are providing routine maintenance for facilities, achieving compliance with all buildings and grounds accreditation standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and other applicable accreditation bodies; and providing improved facilities for inpatient and outpatient care. Most recent surveys of facilities reveal a Backlog of Essential Maintenance and Repair (BEMAR) of approximately \$200 million.

Baseline Costs: \$39 million in FY 1997

Justification:

A \$20,000,000 supplement to the maintenance and improvement activity would contribute to reducing the backlog of maintenance and repair projects by approximately 10 percent. These projects are funded based on space needs and level of deficiencies.

HEALTH CARE FACILITIES CONSTRUCTION - \$15,000,000

Background:

The health care facilities construction activity constructs health care facilities and staff quarters. To determine the locations where new and replacement facilities are most critically needed, the IHS has implemented a comprehensive priority system methodology. Once projects are approved they are placed on a planned construction budget. The total unfunded amount of the plan is \$829,000,000. The average age of IHS facilities now exceeds 30 years.

Congress has authorized in the Indian Health Care Improvement Act, Public Law 94-437 the following authorities which assist tribes in providing health care facilities:

Non-IHS Funds Renovation (Section 305) - program in which a tribe renovates an existing IHS facility, with IHS approval, and IHS provides the additional staff and equipment needed.

Small Ambulatory Health Center Grants (Section 306) - provides grants to tribes that present an acceptable proposals to construct, expand, or modernize tribally-operated non-IHS facilities.

Joint Venture Demonstration (Section 818) - program for tribes that develop an acceptable plan to construct a facility and lease it to the IHS for 20 years at no cost. IHS equips, staffs, and operates the facility.

In addition, P.L. 85-151 authorizes expenditure of funds for construction of community hospitals that will provide services to American Indians and Alaska Natives.

Baseline Costs: Variable funding on a year-by-year basis.

Justification:

A \$15,000,000 supplement to the new facilities construction activity would be applied to the special authorities described in the Indian Health Care Improvement Act (see above).