THE ONYX GROUP
Marketing Communications for a Healthier World

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Inclusion of Communities of Color in Discussions Regarding Future of Tobacco

Philadelphia, PA - Hearing from communities of color on the tobacco Settlement issue is vitally important. A detailed analysis of the implications of the Settlement Agreement developed by African American tobacco control and prevention activists has been circulating for approximately two weeks for review and input. Similar documents on the Settlement Agreement are being developed by leaders and activists in the Hispanic/Latino, Native American/Alaskan Native and Asian/Pacific Islander populations, addressing specific concerns of those group. The final Report issued by the Koop-Kessler Advisory Committee is also being reviewed by these communities.

A number of key issues have been raised in the African Analysis of the Settlement Agreement, which is accompanied by recommendations to Congress. These issues include:

- The importance of a process that avoids creation of future "black markets" in illegal tobacco sales, since such markets would most likely be linked to existing illegal drug sales which are already disrupting many inner city communities;
- Replacement funds, not only for sporting events and concerts, but also for Black cultural and educational programs that have received millions of dollars in support from tobacco companies.

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- Transitional funds for person whose livelihoods will be affected - small farm owners and employees in tobacco farming, manufacturing, sales and marketing, a disproportionate number of whom are persons of color.
- Language in any legislation assuring that the leadership of programs in tobacco control and prevention created as a result of the Settlement Agreement or any other process is fully representative of African Americans and other communities of color.
- Earmarking of funds proportionately to go back to poor and ethnic communities because they will be paying disporportunate costs through higher base prices on tobacco products and/or higher excise taxes on tobacco.
- Increased focus on cigars, which have become linked with marijuana use in many inner cities.
- Research on menthol, which is a component in the majority of cigarette brands preferred by African American smokers (especially youth) and may have connection to the higher rates of mortality and morbidity of African American smokers.

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EIGHT POINTS FOR CONGRESSIONAL ACTION ON TOBACCO

What Black people in the United States request of the Congress in its modification of the Settlement Agreement crafted by the attorneys generals, private attorneys and representatives of the major tobacco companies in the United States is as follows:

1. There should be specific language in any legislation passed by Congress indicating that diversity will be a major consideration in all aspects of tobacco prevention and control and that representation from the communities of color, from women, and from other special populations will be mandated.

2. Monies from the tobacco industry should be available to serve as replacement funding cultural and educational programs and projects, to provide paid advertising in Black-owned and Black-oriented mass media, and to provide transition funds for African American farmers and African American workers in tobacco manufacturing companies and in other companies that will be seriously impacted by the changes in how tobacco companies conduct their affairs.

3. Cigars should be regulated in ways similar to cigarettes and smokeless tobacco.

4. Research should be conducted to understand the role of menthol in cigarettes, since that is the formulation of choice for most African American smokers, and the best ways to provide cessation and prevention programs that are culturally appropriate to Black audiences of all ages: children, teenagers, adults, elders.

5. Funds should be set aside to provide health insurance for children and special efforts should be funded to educate parents to the dangers of secondhand smoke and to provide appropriate medical treatment for children suffering from illnesses for which exposure to environmental tobacco smoke is an identified risk factor.

6. Any language relating to class action law suits should be written so that restrictions apply to tobacco litigation only and not to serve as precedent for other areas that are unrelated to tobacco, given that class actions are a tool used by many urban and rural communities to effectuate justice in areas of health, environmental justice and discrimination.

7. Because of the international scope of the tobacco companies, monies should be allocated to fund tobacco prevention and control mass media campaigns in other countries, using information that we have gained to craft culturally appropriate messages for those populations.

8. The regressivity that will occur as a result of a pass-through Settlement Agreement cost to tobacco users and any additional government taxation on tobacco products should be offset by earmarking funds raised due to the higher cost of cigarettes and other tobacco products in ways that will allow people from poor communities and communities of color to receive proportionate benefits and service.

The Implications of the Report of the Koop-Kessler Advisory Committee on Tobacco Policy and Public Health On Black Smokers and the Black Community in the United States of America

Prepared by Charyn D. Sutton
The Onyx Group
August 1997

Introduction:

Persons involved in tobacco control and public health issues were convened in three meetings in June to discuss the implications of the Tobacco Settlement Agreement and to develop a "comprehensive and rational public health policy toward tobacco, containing clear goals and principles, in order to provide a benchmark against which future public and private activities can be measured." The meetings were chaired by Drs. C. Everett Koop, former Surgeon General, and Dr. David Kessler, former Director of the Food and Drug Administration. Both men are well known and widely respected for their work in tobacco control and prevention.

The advisory group was called together at the request of Congress and included individuals who took divergent positions on whether the Tobacco Settlement agreed to by the state Attorneys General, private attorneys and tobacco companies should be enacted. The final report was based on the recommendations of five task forces:

- Regulation of Nicotine and Tobacco Products
- Youth and Tobacco
- Current Users of Tobacco Products
- Environmental Tobacco Smoke
- Future of the Tobacco Industry and Tobacco Control Efforts

This document summarizes major recommendations of the report of this committee and adds commentary. Recommendations are only those that are included in the final document and do not include those items that appear only in the appendices. This is written as a companion document to the review and analysis of the Settlement Agreement.

Review and Assessment:

The report of the Koop/Kessler Advisory Committee:

Recommends that the FDA should continue to have the authority to regulate all areas of nicotine, as well as other constituents and ingredients, and that authority should be made completely explicit.

•In its Final Regulations, FDA did not to regulate tobacco itself as a drug (although it could have taken that option because of the drug elements contained in tobacco products) but rather chose to have cigarettes and smokeless tobacco regulated as "nicotine delivery devices." FDA already has authority to regulate nicotine as is evidenced by the FDA approval processes that have occurred for other nicotine-containing products such as nicotine gum, nicotine inhalants and nicotine patches but the Final Regulations and the ruling by Judge Osteen do not extend that regulatory power to tobacco "products" as drugs. Therefore, the provisions of the Food, Drug & Cosmetic Act that specify FDA's regulatory powers over drugs have not yet been extended to tobacco products. The advertising provisions specified in the Final Regulations were not upheld because while FDA has jurisdiction over advertising related to drugs, it does not have jurisdiction over advertising related to drug delivery devices. Thus, it is not a question of making continuing authority explicit but rather writing new law designating tobacco as a drug or having new Regulations in this area promulgated by FDA, followed by public comment and judiciary review. Either of those actions should be done because FDA authority over tobacco as drugs is essential to any national tobacco control policy.

Recommends that FDA should continue to have the authority to phase out nicotine and remove ingredients that contribute to the initiation of smoking and dependence on cigarettes and other tobacco products and that authority should be made completely explicit.

•On page 44422 of its Final Rule, FDA included the following statement: "The agency believes that, on balance, it is better for cigarettes and smokeless tobacco to remain available for use by adults." There was nothing in the Final Regulations that stated or suggested that the FDA was moving forward on any recommendation that nicotine in tobacco products be lowered or eliminated. Since FDA did not assert authority to regulate tobacco as a drug, it would have to use authority granted it under the 1938 legislation that governs regulation of drug delivery devices and there has been no review or assessment of any processes available to the agency under those guidelines. It would appear, then, that any authority for the FDA to phase out nicotine and other ingredients in tobacco products would have to be established by Congress or requested by FDA as part of a future rule-making process and cannot be assumed from existing laws or regulations.

Recommends that FDA should continue to have authority to regulate further nicotine, other constituents, and ingredients using the best science, information, and health policy.

•It appears political pressures rather than pure science caused FDA to concentrate on children and youth in its Final Rule rather than adults, and that strict adherence to science would have undoubtably led FDA to seek authority to regulate tobacco as a drug or combination drug/drug delivery device rather than simply as a drug delivery device. Furthermore, prior FDA directors have testified that tobacco should not be regulated as a drug and it is possible that under different leadership, FDA may shift its position in the future due to external political pressures.

•Furthermore, while science, information and health policy should certainly be the guiding forces behind any decision to adjust or eliminate nicotine from cigarettes, other factors should be considered such as the availability and affordability of resources to help persons who are addicted to nicotine, the establishment of mechanisms to prevent or limit the illegal sales of nicotine-containing products alongside other addictive drugs such as heroin and cocaine, and the impact that such a change in the formulation of cigarettes and other tobacco products will have on the economic viability of various communities. These other elements should be seen as part of a process to bring about the best health policy for the nation related to tobacco use, not as impediments to the development of a comprehensive national policy on tobacco.

•Establishment of guidelines and a timetable to address changes in the ingredients in tobacco products would probably be handled best by an appointed panel of experts, representing the diversity of this nation with respect to race, ethnicity, gender, socio-economic level and area of academic or professional specialization. This panel should be empaneled in a way that allows it to make judgements free of economic and political pressures.

•Implementation of the panel recommendations for the lowering or elimination of nicotine should be assigned to the governmental and private, non-profit entities that are most appropriate, which should include FDA but may also include private, non-profit organizations, the Center for Substance Abuse Treatment, the Office on Smoking & Health, and the various federal, state and local agencies involved in monitoring illegal sales of addictive drugs, including representation from the Attorneys Generals of the 50 states.

Recommends that the FDA should have the authority to test nicotine levels by brand, based on the best science and that authority should be made completely explicit.

•There is wide brand differentiation between cigarettes preferred by African Americans and those preferred by Whites and other racial and ethnic groups. Therefore, it is critical that any testing be done on a brand-by-brand basis.

Recommends that FDA should have authority and funding to conduct research on nicotine and other components of tobacco products.

•As a general rule, FDA reviews research findings and does not conduct its own scientific research. It would seem, therefore, that research should be conducted by the government agencies that already have been assigned the health research portfolio for this nation, such as the National Institutes of Health and the Centers for Disease Control and Prevention. However, it would be beneficial if all research into the addictive and toxic properties of tobacco products were housed in one governmental entity so that research could be better coordinated and used more effectively.

•Special research should be conducted to understand the role of menthol in cigarettes, since that is the formulation of choice for most African American smokers and little research has been done on this critical subject.

•Research on nicotine and other components of tobacco products should be look for possible differences based on gender, race, ethnicity and age, in order to determine the best ways of preventing addiction and promoting cessation. There should be ongoing research to determine the best ways to provide cessation and prevention programs that are culturally appropriate to Black audiences of all ages: children, teenagers, adults, elders.

Recommends the elimination of tobacco-branded promotional items and services; and promotion in public entertainment, such as product placements in movies and television.

•Promotion of items with the names and logos of tobacco products have been one of the major ways of reaching young people with a pro-tobacco message. These items are even popular among African American youth who have relatively low smoking rates. Young people and adults who wear these items serve as "walking unpaid billboards" that promote tobacco use.

•The reference to product placements should address unpaid as well as paid placements and should include arcade games and music videos, as well as movies and television shows.

Recommends that marketing, promotion, and advertising of all tobacco products directed at persons under age 18 should be banned.

• The refusal of the Koop-Kessler report to deal in any meaningful way with the marketing, promotion and advertising of tobacco products -- possibly because of First Amendment issues -- is troubling.

•There is no explicit mention of target marketing toward women or racial and ethnic groups and no recognition of any limits on advertising other than the vague statement that such advertising not be "directed at" persons under age 18.

•Unlike the Settlement Agreement, the Koop-Kessler report does not specifically call for the elimination of marketing containing cartoon or human images unless it can be shown that such marking, promotion and advertising is directed at underage individuals.

•There is no reference to monitoring or eliminating tobacco advertising on billboards -- an area that is vitally important to African American communities.

•There is no support provided for the FDA's proposal to restrict tobacco advertising in magazines or other publications and no statement that the FDA or other government agency should be allowed to regulate or eliminate tobacco advertising.

•There is no mention of reducing or eliminating the tax deductibility of tobacco advertising.

Recommends that the sale of tobacco products near schools, playgrounds, and other areas where children congregate should be banned.

•While this provision has been recommended with the best of intentions, the practical application of such a law or regulation would impact disproportionately on small grocery and convenience stores in urban communities, which would be placed at a competitive disadvantage to larger stores in more rural, isolated communities where schools tend to be located on campuses at some distance from commercial enterprises. This is important because low-income communities are already underserved by large supermarkets and further restricting access to goods and services would cause hardship.

Recommends that schools and other child-service institutions should adopt and enforce a "zero-tolerance" policy against tobacco use that applies to both minors and employees.

•There should be more attention to establishing smoking cessation programs for students, for teachers and other school staff that parallel the adoption and enforcement of zero-tolerance policies rather than simply a punitive approach of fines, suspension and dismissal. This should be done by establishing partnerships with other youth-serving and educational groups and linking tobacco prevention programs with other youth-oriented prevention programs addressing issues like violence, sexually-transmitted diseases, use of alcohol and other drugs.

Recommends that sponsorship of any athletic, social, or cultural events using the name of tobacco products present or future should be banned.

•Given the extent of sponsorship of Black music, art and dance by tobacco companies, any ban should include some identification of transitional funding so that the cultural life and heritage of African Americans in this country is not irreparably damaged.

•This prohibition does not address the historic involvement of tobacco companies in supporting educational and youth projects such as literacy programs, college scholarships, and school adoption efforts. Tobacco sponsorship should also be eliminated in these areas and transitional funds identified.

Recommends that schools should institute comprehensive tobacco prevention programs from pre-kindergarten through 12th grade, and such programs should be funded or supported by the tobacco industry.

•Given that tobacco companies already make curricula available to schools which allegedly promotes a "kids shouldn't use tobacco" message, this recommendation should clarify that while the programs should be funded by the tobacco industry, the programs themselves and the individuals who deliver the programs should not be under the direction of tobacco industries, but should be independent of those industries and fully accountable to government agencies responsible for tobacco prevention and to voluntary agencies that have worked in this area.

Recommends that excise taxes on tobacco products should be dramatically increased and should be indexed to inflation, both as a means of reducing consumption and as a means of raising revenues as one source of support for tobacco control activities. [combination of separate recommendations from two task forces.]

•Because of the regressive nature of tobacco excise taxes, funding from this revenue source should be returned to poor communities proportionately and should be used, whenever possible, for expenditures that are related to tobacco use reduction and transition from dependence on tobacco-generated revenues, including funds for African American farmers and African American workers in tobacco manufacturing companies.

•More studies should be done to validate that higher excise taxes on tobacco have a stronger impact on youth smoking rates than on adults, and that this is true across various racial and ethnic populations. In African American communities, higher priced items are often viewed as more prestigious and of greater quality, so significantly increasing the price of cigarettes may actually make the product more attractive to African American youth than it is currently.

• Funds from tax increases, along with funds from tobacco companies, should be available to serve as replacement funding for cultural and educational programs and projects, to provide paid advertising in Black-owned and Black-oriented mass media.

Recommends that a new private, non-profit corporation for tobacco prevention and control should be established with funding from tobacco industry, by excise taxes, and by fines from performance standard violations and that "educational" efforts should begin as soon as possible.

•There should be language that directs any new tobacco prevention and control corporation to have diversity in its staffing, governance and program delivery.

•Any private, non-profit corporation for tobacco prevention and control should be encouraged to form partnerships with government, foundations, voluntary health agencies and community-based groups.

•The scope of the corporation should not be restricted to "educational" efforts but should allow the use of advocacy advertising to reduce tobacco use.

Recommends that specific cessation programs and services should be developed for specific populations, including children, women, racial and ethnic minorities, and individuals with limited literacy.

•It is equally important that available cessation programs and services be age appropriate, culturally appropriate, offered within reasonable geographic proximity and promoted to various populations.

Recommends that tobacco use cessation programs and services should be available to adults, adolescents, and children who are addicted to tobacco products, regardless of their insurance status or ability to pay and the tobacco industry pay all costs for cessation programs and services, regardless of location of service delivery or initial source of payment. [combination of two separate recommendations.]

•While tobacco companies should certainly pay the lion's share of costs for cessation programs, since use of their products created the addiction problem, the governmental public health agencies, and voluntary organizations also should be involved in cessation activities in financial as well as programmatic ways. They should not maintain the pattern of inattention to cessation programs and services that has characterized the tobacco control movement in recent years, leading to a lack of cessation programs and services for specific target groups.

Recommends that policies designed to reduce the number of fires caused by tobacco products should be developed and implemented.

•The recognition that many deaths and injuries from fires are due to tobacco use is important. Fire-related deaths and injuries that result from careless smoking or misuse of smoking materials, such as matches or lighters, should always be classified as tobacco-related, along with more traditional tobacco-related categories such as lung cancer and emphysema.

Recommends that research projects should focus on the development of tobacco use cessation programs and services for pregnant women, children, and adolescents.

•Research on tobacco use and cessation programs for women should not focus solely on women of child-bearing years, but should include all women, taking into account racial, ethnic geographical and socio-economic differences.

•Research should focus on the development of tobacco use and cessation programs that address ethnic and racial issues, including the impact of menthol.

Recommends that all tobacco control and prevention activities be funded or supported by the tobacco industry at a level sufficient to ensure universal availability and effectiveness, and that the programs and services be developed and implemented in ways that are totally independent of the tobacco industry. [combination of two separate recommendations.]

•Because of the differences in tobacco use across geographic, racial, ethnic, gender, age and socio-economic levels, it is important to develop *targeted* programs and services rather than "universal" ones.

•All services should be developed and implemented by independent agencies, organizations and institutions that are completely free of direct or indirect control or manipulation by the tobacco industry and funding should also be provided through other means, such as through taxation, to assure some level of governmental oversight and involvement.

•Increased linkages must be established with communities of faith and with youth-serving programs to assure that programs and services have the broadest possible reach and effectiveness.

Recommends that research efforts related to the development of effective tobacco use cessation programs and services should be funded or supported by the tobacco industry.

•Research efforts in effective tobacco use cessation programs and services should be funded through a variety of sources -- foundations, government grants and tobacco industry underwriting.

•Because of continuing suspicious of the motives of the tobacco industry and their past history of duplicity, the tobacco industry should not be allowed to reap the benefits of positive publicity for their support of smoking cessation programs and services.

Recommends a comprehensive program to address environmental tobacco smoke through clean-indoor air legislation and regulations, public awareness campaigns, research into cardiovascular risks and economic incentives.

•There should be increased research on risks to children from exposure to environmental tobacco smoke.

• Funding should be provided for health insurance and related programs to provide appropriate medical treatment for children suffering from illnesses, such as asthma, for which exposure to environmental tobacco smoke is an identified risk factor.

•The recommendations should make explicit the need to include workplaces with high levels of exposure to second-hand smoke, such as restaurants and bars, in clean indoor-air legislation.

•Closer relationships should be developed with unions so that the ability to breathe clean air is viewed as a benefit for all employees rather than a work issue to be negotiated with management on behalf of smokers.

Recommends that regulation of tobacco products should contain unambiguous non-preemption provisions, expressly clarifying that higher standards of public health protection imposed by State and Local governments are preserved.

•While the elimination of all preemption related to tobacco regulation is theoretically beneficial, in reality African American communities are often poorly served when federal rules are unable to preempt state regulation that are discriminatory in intent or in practice and where a disproportionate burden falls on low-income persons, residents of urban communities and people of color.

•However, the right of local communities to enact tobacco regulations that offer a higher standard of public health protection than offered by the state and/or the federal government with respect to tobacco should never be abridged.

Recommends that all currently available avenues of litigation, both civil and criminal, must be fully preserved.

•The experience of the African American community in seeing major court victories of the 1950s and 1960s turned back in the 1980s and 1990s has made the community less willing to see litigation as the best way to effectuate major changes in the status quo. So while litigation may benefit individuals and their families, court victories may not necessarily benefit the larger community.

•If there are ways that the greater good of the community can be served through the channeling of funds to programs and services that benefit large numbers of people rather than having funds go to individuals and their families, those avenues should be fully explored.

•Language should also be included that encourages access to legal remedies and compensation to individuals regardless of race, ethnicity, geographic region, or income.

•Any language relating to class action law suits should be written so that restrictions apply to tobacco litigation only. The Settlement should not to serve as precedent for other areas that are unrelated to tobacco, given that class actions are a tool used by many urban and rural communities to effectuate justice in areas of health, environmental justice and discrimination.

Recommends that all internal tobacco company documents that bear upon the public health must be disclosed, including all information related to marketing, including opinion and behavioral research; and the targeting of children, women, and racial and ethnic minorities.

•This is an extremely important recommendation for African Americans and other communities of color, since access to this information will facilitate the development of programs, materials and outreach campaigns that will be more effective in preventing tobacco use and in helping current users of tobacco to quit.

Recommends that a Federal oversight board should be established to investigate all matters relating to public health and tobacco products and the tobacco industry.

•Given the political power that the tobacco industry has shown in the past, through its contributions to elected officials and use of lobbyists, it is important that the composition of any Federal oversight board be specified by public health advocates. At a minimum, such a board should not include any persons representing tobacco companies and their legal firms or any group that receives a significant amount of revenues from tobacco companies or their parent companies.

•It is important that any Federal oversight board include individuals from the private sector as well as government officials and that it reflect diversity with respect to gender, ethnicity, race, geography and other factors that may be viewed as desirable for review purposes.

Recommends a research policy that collects comprehensive data on tobacco use, behavior, attitudes (at national, regional, state, and local levels) and then disseminates information regarding innovative interventions, including demonstration projects for implementing effective interventions.

•There should be an awareness of the understandable suspicion of research projects in many low-income and African American communities given the history of how such studies have been conducted and used.

•There should be explicit recognition of the need to involve communities in the design and implementation of research and on the need to engage researchers who are knowledgeable of diverse communities and culturally competent.

•The leadership and composition of research projects should be diverse and inclusive of women and ethnic and racial minorities whenever possible.

Recommends that fines, punitive damages, and other forms of financial punishment imposed on the tobacco industry and its affiliates should not be recognized as an ordinary business expense and should not be tax-deductible or given other special tax treatment.

•The tobacco companies should not be permitted to benefit financially from their misdeeds, including their targeting of women, racial and ethnic groups and children through tax breaks.

Recommends that fines collected for failure to meet performance standards or violations of sales and promotion restrictions should be used for tobacco control activities.

•Under no circumstances should fines collected by tobacco companies be made part of the general fund and/or used for purposes entirely unrelated to tobacco prevention and control.

•In addition to using funds for direct tobacco control and prevention activities, funds should also be permitted to be used for related purposes such as health care benefits for children and the elderly and replacement funds for cultural, educational and employment-related activities that are impacted negatively due to the availability of fewer resources from tobacco companies.

Recommends that funding for nongovernmental tobacco control activities should be sufficient to allow the effective conduct of such efforts, with particular emphasis on community programs for racial and ethnic minorities.

•Governmental as well as nongovernmental tobacco control and prevention activities should emphasize programs for communities of color.

•Activities involving communities of color should include all range of programmatic activities including research, mass media campaigns and educational outreach in addition to the provision of programs through community-based organizations, agencies and institutions.

Recommends the creation of a blue-ribbon panel to look at economic issues related to tobacco including growing, manufacturing, and marketing policy, with a focus on developing strategies for reducing dependence of tobacco-growing states and communities.

•The importance of economic issues related to employment in tobacco manufacturing should be highlighted as a function of this panel and efforts should be identified to provide economic development assistance to tobacco-*manufacturing* communities as well as tobacco-growing communities, given the high percentage of people of color who work in tobacco-related companies.

•The panel should be representative of diverse groups including persons of color, tobacco workers and leaders from communities that will be seriously impacted by a downsizing of tobacco growing and manufacturing in the United States.

Recommends that an economic assistance and development fund should be established with funds provided by the tobacco industry to assist tobacco farmers, manufacturing workers and related non-farm workers.

•Appropriate federal departments should be involved in efforts to retool the workforce and develop alternatives to tobacco manufacturing and farming. Tobacco farmers, farm workers and non-farm workers should be eligible for economic development and employment/training programs that are ordinarily made available for workers in similar situations of economic crisis.

Recommends that the United States actively promote tobacco prevention and control throughout the world, including "the global adoption of United States domestic tobacco control policies through all appropriate international activities."

•The statement that the United States should attempt to get all nations to use the United States model does not recognize the excellent work that has been done in other nations, such as Canadian tax policies, the outspoken support of tobacco control by South African President Nelson Model, the replacement fund strategies of Australia, and other efforts of people around the world. This approach should not be part of any international strategy embraced by tobacco control and prevention

•The United States should participate as a full partner in the development and implementation of tobacco control activities by multilateral organizations, including the Pan-American Health Organization, the World Health Organization, UNICEF, and the Framework Tobacco Control Convention.

Recommends that the United States government cease its interference in tobacco control activities of other countries and modify the 1974 Trade Act so that excludes tobacco products

• The United States government should not actively promote any product for foreign use that it feels are inappropriate for domestic use, such as tobacco. However, since this will impact on the livelihoods of workers in this country, such actions must be supported with strategies that will assist displaced workers and farmers whose livelihoods will be affected in the United States.

Recommends that the United States support the development of a non-governmental International Tobacco Control Commission, governed by public health leaders.

•Since tobacco use, farming and manufacturing has implications for developing and developed societies that extend beyond health-related issues, it will be important to have a broader representation of specialties as part of any International Tobacco Control Commission.

•Because other societies are not structured in the same way as the United States, restricting participation on an International Tobacco Control Commission to persons who hold no official government status may not create an institution with sufficient power to impact tobacco policies in the nations of the world.

•Before creating a new institution, an identification of the capacities and agendas of existing international bodies should be completed. A new entity should be created only if no current organizations have the capacity and will to do this work.

• Any Commission that is created should come as a result of a broad consensus of nations of the world in the Americas, Asia, Australia and the islands of the Pacific, and Africa, and not as a concept that is supported primarily by the United States or by the United States and its Western allies.

Recommends that the United States support international research efforts to determine the most effective means of preventing the initiation of tobacco use and of smoking cessation.

•Research on international issues should be conducted by culturally competent researchers.

•Cessation programs should address all types of tobacco use, not only smoking, since chewing of tobacco is common in many of the cultures of the world.

•Support provided to international research efforts should include funding.

•Research should include effective ways of marketing the need for prevention and cessation to various populations as well as the most effective ways of providing prevention and cessation programs.

Recommends that the United States provide financial support for international governmental and non-governmental efforts to control tobacco use.

•Funds and other forms of support should also be available to government agencies in other countries or groups of countries, especially countries where there are established flows of migration to the United States, such as from Asian, Pacific Islander, South and Central America and the Caribbean.

•Funds should be available for prevention as well as tobacco use and should be focused on programs and services that reach children, youth and women -- since these are the groups that are generally targeted by tobacco companies in their advertising and promotional campaigns.

•Efforts should be made to facilitate linkages of persons of color in the United States who are involved in tobacco control as part of governmental and nongovernmental programs with their counterparts in other parts of the world.

Conclusion:

While the final report issued by the group covered many areas that are critical to a comprehensive tobacco prevention and control policy for the nation, there were significant gaps. Some of these gaps came as a direct result of the conveners' decision to limit participation in such a way that there were no representatives at all from the Latino community, the American Indian/Alaskan Native community or the Asian/Pacific Islander community.

In the committee's final report, the authors wrote: "The selection of organizations to be represented was an especially difficult task, inasmuch as so many highly qualified groups with great expertise are involved in tobacco control; nevertheless, in order to make the Committee of manageable size, we made hard choices to limit the number of members and urged them to consult with a wide range of other organizations and experts."

These "hard choices" were particularly burdensome with respect to communities of color. At the initial meeting, there was only one organization present that represented an African perspective -- The National Medical Association. Reverend Jesse W. Brown, Jr., an African American representing The Onyx Group, was added to the committee's roster for the second and final meetings. Reverend Brown did meet with various persons from other communities of color. However, as just one person, he was unable to represent all the various concerns of these ethnic and racial populations as well as their tobacco prevention and control leadership would have done had they had been permitted to participate as members of the committee. Furthermore, no one else on the committee made any *special* efforts to consult with these groups so that their concerns could be reflected in the discussion and debate. As a result, key issues such as the elimination or reduction of the target marketing of tobacco products to these groups did not emerge as final recommendations of the full committee.

The lack of diversity in the committee that formulated this document seriously limits its applicability to the nation as a whole as a "blueprint" for tobacco policy. Therefore, its findings should only be used in connection with other documents, like this one, that represent the concerns and issues of people of color and other marginalized groups.

The Potential Impact of the Proposed Settlement Agreement On Black Smokers and the Black Community in the United States of America

Prepared by Charyn D. Sutton
The Onyx Group
July 7, 1997

Introduction:

The Settlement Agreement, as agreed to by representatives of major tobacco companies and by attorneys general of 39 of the 50 states, the attorney general of Puerto Rican and other attorneys involved in current litigation against tobacco companies, contains a number of provisions that have the potential to directly impact Black people in the United States. This document provides a review and assessment of those provisions.

The majority of paragraphs in this document consist of a statement summarizing a provision of the Settlement Agreement, followed by discussion the potential impact of that provision. The document concludes with the identification of two key issues that are not addressed in the Settlement Agreement and a list of eight areas that should be addressed by the Administration and by Congress.

Review and Assessment:

The Settlement Agreement, as currently written:

- **Bans all billboard advertising of tobacco products, not just the tobacco advertising on billboards in places close to schools and other locations frequented by children.** *This is something that has long been important to Black communities. Billboard advertising tends to be far more extensive in Black communities -- especially the smaller versions (called eight-sheets) that are on the sides of buildings. Also, tobacco billboards are frequently on public transit which is used by large numbers of low-income people, and especially by Black children in major cities. In addition to attracting youth, these tobacco billboards serve as constant cues to adult smokers and make quitting more difficult. While the Baltimore victory in the Supreme Court makes it more likely that local communities will act to ban tobacco billboards, the process may be speeded up through the Settlement. An agreement by tobacco industry to end the use of billboards may be easier to get enacted into law than other approaches. The separate state consent decrees could bypass First Amendment issues. In most cities, the small billboard companies with specialized in eight-sheets (some of which were begun by Blacks) have been bought out by larger concerns, so this is not an area where Black-owned businesses will be affected. However, tobacco companies have underwritten the costs of billboards promoting Black groups, like the NAACP and the Urban League, and this resource will likely be lost.*

- **Eliminates all tobacco advertising using cartoon symbols (like Joe Camel and Willie Penguin) and all tobacco advertising using people (as with the Newport and Kool print advertisements).**
  When the cartoon-style Kool Penguin was introduced in the 1960s, it was enormously popular with Black teenagers and adults and was part of a marketing campaign that made Kools the #1 cigarette brand in the Black community for many years. Newport, which is currently the #1 cigarette brand in the Black community has used images of Black people in virtually all of their advertising. Brown & Williamson's efforts to resurrect the cartoon Penguin as a streetwise symbol failed in test-market. Yet, not to be outdone, the new Camel Menthol campaign is using its sax-playing, pool-playing "Smooth Joe" cartoon camel to try to reach Black smokers and potential smokers, including youth. Efforts to end this insidious campaign, which threatens to increase the relatively low smoking rates of Black youth, have been the basis of the ***Say No to Menthol Joe Community Crusade,*** *which has had some* successes. *A negative is that eliminating cartoon and human image advertising would probably reduce tobacco-related advertising revenues for Black-owned newspapers and magazines. There is less reason for tobacco companies to advertise in Black media unless the targeted advertising contains people or cartoon images that are identifiable as Black. A plus for Black media is that funds available for counter-advertising could be used to offset some of the revenue losses from any reduction in tobacco company advertising. This provision may also decrease the amount of in-store promotional items that are targeted to African Americans, thereby lowering the incentive payments that store-owners in Black communities receive for displaying these items. This could directly impact profitability of small stores in inner city communities.*

- **Bans all non-tobacco merchandise, including caps, jackets or bags bearing the name, logo or selling message of a tobacco brand, including gifts and proof-of-purchase promotional campaigns.**
  The Food & Drug Administration regulations on tobacco products contained this provision. However, implementation of the FDA rule, originally planned for August 28, 1997, has been delayed due to litigation brought by the tobacco industry. This is an important provision for Black people because tobacco-industry promotional items are quite popular in Black communities. NAAAPI (National Association of African Americans for Positive Imagery) has been leading the fighting against these items through activities like T-shirt Exchanges and coined the term "unpaid, walking billboards."

- **Bans sponsorships, including concerts and sporting events, in the name, logo or selling message of a tobacco brand.**
  Tobacco industry sponsorships have been quite important to many Black cultural programs, although not necessarily for Blacks in professional and amateur sports. This provision of the Settlement Agreement, if enacted, may have a disproportionate impact on Black musicians and dance companies since tobacco companies have traditionally been major sponsors of Black cultural events. Replacement funds should be made available in instances where other non-tobacco funding cannot be secured and Black audiences will have to be cultivated in order to provide revenues that these programs require to survive and prosper.

- **Bans direct and indirect payments for tobacco product placement in movies, television programs and video games and prohibits direct and indirect payments to "glamorize" tobacco use in media appealing to minors, including recorded and live performances of music.**
  These are media that attract Black youth. Removing the tobacco influences in these areas is an important step toward keeping children and youth tobacco-free. This is not an area that will impact Black business ownership in any major way, except possibly tobacco industry support for Black-owned advertising agencies and some Black-owned recording labels.

- **Bans most self-service tobacco product displays.**
  This provision may have disproportionate negative economic impact on small Mom & Pop stores in inner cities since tobacco often provides a significant profit margin and the availability of cigarettes often leads to purchases of other items. The removal of displays will have an additional impact on small retailers because the incentives they receive for these displays often provide additional revenues, which can be sizeable. However, the presence of self-service displays have been shown to contribute to shoplifting of tobacco products and many Black parents are concerned about any incentives that could increase unlawful activities among Black youth, particularly in view of the disproportionate penalties that the justice system imposes on people of color in this country.

- **Institutes tough, national licensing requirements for merchants selling tobacco products.**
  This provides communities with a mechanism to address merchants who are breaking the law. Such mechanisms can be particularly important in inner cities, where stores that illegally sell tobacco often illegally sell alcoholic beverages to underage youth. Tobacco licensing provides an additional mechanism for leverage.

- **Establishes a Scientific Advisory Panel to determine whether there is a threshold below which nicotine does not produce drug dependency.**
  This may be important since estimates are that as much as 10% of Black regular smokers are "chippers"– sporadic smokers who are not addicted to nicotine and who smoke relatively few cigarettes in week or month. Also, this may facilitate the determination if there is a difference between tobacco "use" and tobacco "abuse" as is the case with alcohol. The use/abuse definitions may also have an important benefit in allowing American Indians to use small amounts of traditionally grown tobacco in religious and cultural ceremonies without negative sanctions. These guidelines may also facilitate closer collaboration between alcohol and tobacco prevention and treatment programs in Black communities.

- **Mandates that no cigarette shall be sold in the United States which exceeds a 12 mg "tar" yield, using the testing methodology now being used by the Federal Trade Commission.**
  Current brands preferred by Black smokers tend to be high in both "tar" and nicotine. Both Newport (#1 among Black smokers, especially teenagers) and Kool (#2 among Black smokers) average 17 mg. "tar" per cigarette (Kings). Since the tar is considered one of the harmful ingredients in cigarettes, lowering the tar levels to a 12 mg. maximum could benefit African American smokers.

- **Extends coverage to "roll your own," "little cigars" and "fine cut," etc.**
  An important concern to many African Americans is that the Settlement Agreement does not yet cover cigars. This is an important issue since cigar displays are proliferating in inner city communities and cigar use is often linked to marijuana use among Black teenagers.

- **Allocates $100,000,000 annually to fund research and development of tobacco prevention and cessation methods.**
  There has been little research done on the effectiveness of various quit approaches for African American and other Black smokers. Research work should be focused in this area if funds are available, since Black smokers have higher morbidity from tobacco use than most other groups. The available of this funding would also offer an opportunity to study the impact of menthol in cigarettes, since mentholated cigarettes are smoked by the majority of Black smokers.

- **Allocates $75,000,000 annually (beginning in the second year) for 10 years to compensate events, teams or entries in such events, who lose tobacco industry. Sponsorship and/or funding and that cannot replace that funding from other sources, provided that the funding provided under the auspices of the Settlement Agreement is used to promote a tobacco-free theme.**
  It is critical that replacement dollars also should be available to fund cultural and educational programs in African American and other communities that depend heavily on funding from tobacco companies in addition to sports and music events that are "sponsored" by tobacco companies. Programs qualifying for such replacement monies would include visual and creative arts and educational and scholarship programs. This may require a different allocation formula.

- **Allocates $500,000,000 annually for multimedia campaigns to discourage and de-glamorize tobacco use with attention paid to the needs of particular populations.**
  This provision addresses the need for media campaigns directed at "certain populations" and allows for the purchase of paid media which can be used to purchase time and space in minority-owned media. The enactment of this provision could benefit African Americans in general and Black advertising agencies that are willing to break their ties with tobacco companies.

- **Funds large-scale smoking cessation programs with a focus on "special populations."**
  Poor and nonwhite groups have not been served adequately by existing smoking cessation programs and have been short-changed by the tobacco control's wholesale "paradigm shift" to policy issues. The importance that the Settlement Agreement places on cessation programs could offer major benefits to African Americans and others of African descent in this country. There is a clear need to develop programs for "special populations" like African Americans, because Black smokers differ in key ways from the general population and so need tailored materials, classes and approaches to increase quit rates. The explicit mention of "special populations" in the Settlement Agreement recognizes this reality and offers financial resources for this purpose.

- **Allocates $1 billion per year for the first four years and $1.5 billion thereafter to a Trust Fund to assist individuals who want to quit their use of tobacco. The Secretary of Health will set regulations governing eligibility and how programs offering cessation services will be governed.**
  Smoking cessation programs and materials have had a low priority in recent years, with the tobacco prevention movement shifting its focus to policy issues and away from individual treatment. This has had a negative impact on groups that still have high rates of smoking including Black adults, Native Americans, and women. In addition, there have been difficulties in providing government funding for African American cessation efforts that included references to religion, prayer and spirituality because of issues related to separation of church and state. The availability of these funds for culturally-appropriate cessation programs for Black adults and other groups with high smoking rates would be a positive step toward reducing the health-related risks of tobacco use in poor and minority communities.

- **Provides financial assistance and identifies effective programs, techniques and devices to help current tobacco users quit.**
  Providing financial resources to assist smokers would be beneficial to low-income individuals. This funding could also be utilized to fund a national hotline, modeled on the Cancer Information Service, that could provide brief counseling, self-help cessation materials and referrals to cessation programs. The American Lung Association's pioneering work with Black church groups and Black women smokers, the smoking cessation guide Pathways to Freedom that was developed under a grant from the National Cancer Institute could be used as the basis for further development, including uses of nicotine replacement products in ways that address cultural differences.

- **Permits individuals to sue for compensatory damages but designates that punitive damages would be part of the overall settlement and eliminates the option of class action suits.**
  Rather than having punitive damages go to individual smokers and their families, the punitive damages would go to society as a whole to be invested in programs to help smokers quit, replace funding for community events and activities formerly bankrolled by tobacco companies, provide research into cessation techniques and less hazardous tobacco products, and develop counter-marketing campaigns to prevent young people from beginning tobacco use and convince current smokers to quit. Given that it is unlikely that the percentage of Black participants in class action suits is proportionate to the percentage of Black people harmed by tobacco, there may be more opportunity for equity if punitive damage funds go to society as a whole rather than to individual smokers and their families. However, there is some concern that the elimination of class action suits as a mechanism to address major issues may set an unwelcome precedent, particularly in areas other than tobacco where such suits are a critical part of the strategy, such as corporate polluting, liquor store license fees to address issues of neighborhood viability and community empowerment. These actions are led, litigated and the classes are comprised of mostly Black people.

- **Allows the FDA to adopt "performance standards" that would not permit the total elimination of nicotine in less than 12 years and that also would mandate certain requirements: a) clear health benefit, b) technologically feasible, c) no creation of a "black market" for cigarettes and smokeless tobacco.**
  This is the provision that has caused the most concern among tobacco control advocates because it restricts the ability of the FDA to move immediately to ban nicotine-containing tobacco products. However, the potential of black market sales of cigarettes to disrupt community life is a real possibility for low-income, Black communities. The power of nicotine addiction and the potential of cigarettes as contraband has already been demonstrated in smoke-free correctional institutions (many of them populated disproportionately by Black people) where cigarettes are now selling for as much as $60 for a pack of 20 cigarettes -- an exorbitant amount given the low level of prison wages. Therefore, the requirement that the society take steps to assure that any decision to ban or severely restrict tobacco products does not create widespread opportunities for illegal tobacco sales in communities already hard-hit by illegal drug and alcohol sales. It is important that smokers, especially those in poor communities and communities of color, simply deprived of the option of purchasing cigarettes and other tobacco products legally, but that any action to ban or severely restrict the availability of cigarettes to adults occurs along with the implementation of culturally-appropriate cessation programs and nicotine replacement products that can significantly reduce the numbers of persons using tobacco regularly.

Additional Issues:

There are two additional issues that were addressed in the "Statement by Communities of Color in the United States on Private Negotiations Toward a Proposed 'Settlement' with the Tobacco Industry" that was issued earlier this year. Recognition of these issues is critical to any assessment of the impact of the Settlement Agreement and subsequent action by Congress on the items contained in the Settlement Agreement.

In the statement, Communities of Color representing African Americans/Blacks, Latinos/Hispanics, Native Americans/Alaskan Natives and Asian/Pacific Islanders said:

> **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. A disproportionate number of the individuals who receive Medicaid-funded health care are low-income and are from our racial, ethnic and tribal communities. We are concerned that a large monetary settlement 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 has the potential to victimize low-income smokers disproportionately, while allowing the investors in tobacco to realize enormous financial rewards by "immunizing" tobacco companies from many of the costs of further litigation. There must be a balance struck so that poor people and people of color, who are most likely to pay the higher costs of such a settlement through increased prices, also receive significant and measurable benefits from any agreement.**

Given the enormous financial outlays that such a settlement would require from tobacco companies, it is inevitable that these costs would be passed along to consumers with price increases that could approach $1 per pack of cigarettes. Since much of this increase would be paid by low-income individuals, who have the highest rates of tobacco use, it is critical that proportionate amounts of the funds that would be paid by the tobacco companies as a result of any Settlement Agreement go to fund programs that benefit poor people, many of whom are people of African descent in this country and other people of color. If this is done, the use of funds in this way will offset much of the regressivity that is contained in any initiative that has its greatest negative financial impact on those least able to pay.

The Communities of Color statement also highlighted international issues of tobacco sales and marketing by companies based in the United States. This issue is not addressed in the Settlement Agreement. The reference to international issues in the Communities of Color statement was as follows:

> **As people of color, we have links to our brothers and sisters worldwide. Some of our communities have large immigrant populations that are doubly impacted by the tobacco industry's targeted marketing practices here in the United States and in their home countries abroad. We do not view an increased international trafficking of tobacco addiction as a legitimate trade off in return for tougher sanctions on advertising and marketing to youth in the United States. All youth are important and all youth must be protected from tobacco marketing practices -- in the United States and throughout the world.**

This issue remains important and must be addressed in any discussion of the Settlement Agreement by the United States Congress. There are certainly ways that the United States can work with the World Health Organization and other groups in providing leadership in the reduction of the addictive use of tobacco products throughout the world.

Summary:

It is vital that African Americans and other persons in this country of African descent (including those from the islands of the Caribbean, from South and Central America, from Canada, from Europe and from Africa itself) review the Settlement Agreement from two perspectives: how it impacts on tobacco use in general and the specific impact that the various provisions of the Settlement Agreement will have on the Black community. This assessment and review document is designed to provide the latter analysis and should be considered together with other reviews of the Settlement Agreement that have specific racial or ethnic orientations.

As one of the population groups that has been harmed the most by mortality and morbidity due to use of tobacco products, the concerns of Black people must be heard on this issue. We are pleased that Dr. Lonnie Bristow, an African American who served as Past President of the American Medical Association, joined the Settlement talks to bring a public health perspective. However, African Americans from all walks of life should become actively involved in discussions regarding the Settlement Agreement and the future of tobacco in this country. Only in this way can we be assured that any legislation and regulations resulting from this Settlement Agreement will provide increased benefits to Black people in America and other Communities of Color.

Briefing for Congressional Staff on Minority Health Concerns for Passage of a Comprehensive National Tobacco Control Legislation

February 23, 1998
9:30 a.m. - 10:30 a.m.
2105 Rayburn House Office Building

AGENDA

1. Welcoming remarks
   Members of the Staff of the Hispanic, Asian and Pacific Islander, Black and Native American Caucuses

2. Moderator's remarks
   Dr. Jeannette Noltenius, Latino Council on Alcohol and Tobacco

3. Ms. Ruth Perot, Summit Health Coalition

4. Dr. Elena Rios, National Hispanic Medical Association

5. Ms. Charyn Sutton, The Onyx Group

6. Ms. Tessie Guillermo, Asian and Pacific Islander Health Forum

7. Mr. Rod Lew, Association of Asian Pacific Community Health Organizations

8. Dr. Jeannette Noltenius, Latino Council on Alcohol and Tobacco

9. Mr. Mike Mahsejcky, Indian Health Service

10. Mr. Neil Parekh, American Association of Physicians of Indian Origin

11. Dr. Mohammad Ahkter or Dr. Richard Levinson, American Public Health Association

12. Questions and Answers

Asian American and Pacific Islander
Blue Print for Tobacco Control
GUIDELINES AND RECOMMENDATIONS
2/22/98

Background

Developed in collaboration with health researchers, community-based organizations and public health advocates, this blue print for tobacco control highlights AAPI-specific tobacco-related service needs and outlines the requirements for: effective health research and data, promotion and disease prevention programs, restrictions on tobacco advertising and promotions, and international tobacco control for AAPIs.

Highlights of Asian American and Pacific Islander Demographics and Selected Tobacco Related Issues :

AAPIs are the fastest growing ethnic/racial group representing approximately 4% or 10 million of the total U.S. population. It is estimated that by 2050, the AAPI population will reach 10 percent of the total U.S. population.

A key characteristic of the AAPI population is its great diversity. The population, which includes a high proportion of immigrants and refugees, is extremely heterogeneous and bipolar in socioeconomic status and health indices.[1] Researchers, policy makers, case workers and health workers need to be mindful not only of cultural and linguistic differences reflecting more than 50 different subgroups, but also generational differences (e.g., the many generations of Chinese vs. the relatively newly-arrived Hmong).

Despite the rapid growth of AAPI populations nationwide, the paucity of data limits the understanding of tobacco-related health risks among AAPI populations. AAPIs are still viewed inaccurately as a homogeneous "model" minority with few health or social problems. Emerging data on AAPI subgroups show significant disparities in health status, as well as barriers to accessing health and social services that must be addressed as part of this blueprint. A few examples of these disparities and barriers include:

- Approximately 40% of the Asian and Pacific Islander population are limited English proficient. Among Chinese and Koreans, about 51% are limited English proficient and over 60% of Southeast Asians are limited English proficient.[2]
- Cancers of the lung and bronchus are the most common types of cancer deaths in the following AAPI ethnic groups: Chinese, Filipino, Hawaiian, and Japanese.[3]
- Chinese Americans have the highest rate of nasopharyngeal cancer compared to all other racial and ethnic groups.[4]
- Asian youth susceptibility to smoking has increased 30 to 50% and their smoking rates have increased dramatically by over 50% in California from 1993 to 1996.[5]
- A 1992 study conducted in Los Angeles by the University of Southern California found that AAPI neighborhoods had the greatest number of cigarette billboards, 17 times as many as in white neighborhoods.

- Tobacco use among recent AAPI immigrant men are much higher than in second and third generation AAPIs. Aggressive marketing by the tobacco industry in the Pacific Rim countries has resulted in AAPIs' addiction to tobacco by the time they arrive in the U.S.
- 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. In an Oakland Chinatown study, 40% of Chinese men did not know that smoking can cause heart disease.[6]
- At least three Asian immigrant groups have smoking rates far higher than the California or national average for men. Studies in California show that prevalence rates are: 65% for Vietnamese, 55% for Chinese-Vietnamese, and 71% for Cambodian men.[7]
- Cervical cancer incidence rates among Vietnamese women (43.0/100,000) are nearly five times higher than the rate among white women (8.7/100,000).[8]

This blueprint forms the basis for shaping tobacco control legislation that will ultimately improve the health status of AAPI communities by identifying the major risk factors to tobacco-related mortality and morbidity among AAPI communities, effectively implementing health intervention programs, and consistently campaigning against the influence of tobacco advertisements and promotion. It is hoped that administrators, legislators, and the AAPI community can collaborate as partners to meet the challenge of diversity, both in ethnic composition of AAPIs and their needs in tobacco control.

I. RESEARCH AND DATA

GOAL 1: Increase and improve the collection, analysis and dissemination of tobacco risk-related data on AAPI populations and sub-populations.

There is very little data to document the smoking prevalence of AAPIs. The data that exists often masks the problem because the data is aggregated for all AAPI groups. According to the few studies that are available on smoking prevalence rates among AAPI populations, studies reveal that tobacco use is significantly high among males especially in AAPI ethnic groups including 72% Laotian, 71% Cambodian, 42% Native Hawaiian, 53% Chuukese (FSM).

Moreover, very few studies exist on tobacco consumption and exposure among AAPIs. The National Heart, Lung and Blood Institute (NHLBI) funded the Ohio State University for a five-year study called "Lay-led Smoking Cessation Approach for Southeast Asian men." As a result of the scientifically-valid, ethnically-approved and linguistically-appropriate methods (use of Khmer, Lao, and Vietnamese languages), the study showed that 17% of participants in the intervention group had success in quitting versus 1% in the control group. This was the only NIH-funded study targeting smoking cessation for Southeast Asian men, and the only group specifically targeted in the Health People 2000 tobacco and cancer objectives. With Healthy People 2010 focusing on eliminating disparities, it is critical that the federal government support research to uncover the nature and extent of the disparities among AAPI sub-populations.

The lack of adequate data on minority populations is a continuing challenge. One suggestion is to oversample AAPIs in national surveys, which are the basis for setting health priorities and indicators which researchers widely use. Disaggregated and statistically-significant samples are essential in identifying and understanding the causes of health disparities among AAPIs, as well as in developing appropriate programs and interventions, and making decisions about resource allocations. While smoking rates and associated morbidity and mortality rates are declining among the white population, the rates of decline are less notable among AAPIs. The continued high prevalence of cigarette smoking in AAPIs, particularly among Southeast Asian populations, remains poorly understood.

The following objectives should be achieved in meeting the data needs of the AAPI population.

Objective 1.1: Increase funded tobacco research projects on AAPIs (e.g., baseline, tobacco use prevalence, surveillance outcomes).
Objective 1.2: Conduct long-term outcome research studies to assess the morbidity and mortality rates from tobacco-related products consumed or exposed to AAPIs (e.g., environmental tobacco smoke).
Objective 1.3: Evaluate the effectiveness of existing tobacco interventions to improve services (e.g., only two published tobacco intervention studies exist on AAPIs).
Objective 1.4: Develop a comprehensive biomedical and socio-cultural research agenda to increase community and academic research to assist in the development of effective intervention models and new survey instruments. Findings must be disseminated to the community.
Objective 1.5: Increase availability of training opportunities that encourage researchers and health professionals to address tobacco control issues of AAPI communities.

II. PROGRAMS: PREVENTION AND CESSATION

GOAL 2: Reduce the prevalence of tobacco use among AAPIs and reduce AAPI exposure to environmental tobacco smoke (ETS) focusing on high risk populations.

Prevention

Few intervention programs across the U.S. & Pacific Islands address the specific needs of all AAPI subgroups due to diversity and geographic distribution. Therefore, we recommend development of local programs that would be distributed across the U.S. and Pacific Islands with a geographic focus on the top 15 states and 6 jurisdictions addressing specific AAPI needs. Suggested regional tobacco education and control networks: Guam and Commonwealth of Northern Marianas; Federated States of Micronesia, Republics of Palau and the Marshall Islands; American Samoa; Hawai'i; California; Pacific Northwest; Southwest; Midwest; Northeast; and the South.

In addition, we recommend the development of a national center or institute for providing comprehensive technical assistance, training and resources for organizations and communities that will conduct individual programs in the AAPI population. The National AAPI Tobacco Control Center for the U.S. & Pacific Islands could serve as a coordinating body for national AAPI activities including leadership development, research and advocacy/policy efforts.

In order to effectively reduce tobacco use--a major preventable cause of death--in AAPI communities, legislation should prioritize public health prevention and cessation programs to decrease smoking and to facilitate the cessation of smoking particularly for high risk groups (e.g., Southeast Asians and Pacific Islanders). Socioeconomic levels, educational backgrounds, and the migration status of our AAPIs' nationalities are often overlooked in the design and implementation of interventions (i.e., foreign born versus U.S. born AAPI).

Objective 2.1: Assess the current infrastructure and capacity of tobacco control programs to plan for the integration of new prevention and cessation programs.
Objective 2.2: Develop and implement specific linguistic and culturally appropriate tobacco prevention programs for AAPIs and subgroups with a focus on the top 15 states and 6 regions.
Objective 2.3: Develop strategies to eliminate the disparities and increase AAPI participation in preventive health activities.
Objective 2.4: Increase the representation of AAPI employees on advisory boards, strategic planning committees, and task forces to ensure that multicultural programs are designed and implemented.
Objective 2.5: Improve the capability of AAPI community-based organizations and health care delivery systems to ensure the development of culturally and linguistically appropriate prevention programs through creation of a national center for tobacco control.

Cessation

Availability and access to effective cessation treatments for AAPIs remain limited. Not only do linguistically and culturally competent services need to be considered when developing intervention programs, but also the AAPI subgroup, gender and generation (i.e., years of immigration to U.S.). In addition, it is necessary and important to facilitate informal and formal support systems such as extended families, elders, and indigenous healers in the development of cessation programs. Barriers to making tobacco intervention an integral part of health care include:

1) lack of coverage for smoking cessation services;
2) lack of systems for integrating cessation into routine care;
3) lack of clinical practice guidelines that integrate a balance of cultural, linguistic needs for AAPI communities; and
4) lack of incentives for providers to deliver effective and systematic smoking cessation treatments and to include these interventions among the defined responsibilities of the provider.

Objective 2.6: Develop and implement cessation programs that address the linguistic, cultural and financial barriers that impede access to tobacco health services for many AAPIs.
Objective 2.7: Include AAPIs in ongoing health education intervention development to create effective methods to reach all AAPI populations, particularly underserved communities.

Environmental Tobacco Smoke (ETS)

Public health advocates understand that the health of one population is linked to the health of other sectors of society. Special attention needs to be given to workers of small businesses and establishments which have high rates of exposure to second hand smoke (e.g., restaurants, game houses, etc.). Outreach plans are needed to obtain compliance from owners of these establishments as well as health education campaigns that target the affected workers. Similarly, model behavior needs to be encouraged at home through education and outreach to eliminate ETS that heavily impacts spouses/partners and children in a household with a smoker. Additional studies are needed to document the severity of the ETS problem and effective strategies addressing ETS.

Objective 2.8: Develop and implement a comprehensive linguistic and culturally appropriate second-hand smoke campaign that emphasizes protection of families and individuals in homes, workplaces and federal facilities (e.g. prisons, immigration and naturalization service centers).

III. ADVERTISING AND PROMOTIONS

GOAL 3: Reduce and counter pro-tobacco influences in the AAPI community.

Advertising

We support full FDA authority to regulate tobacco advertising (e.g., billboards, print and electronic media, radio, and television.), marketing and promotions. Unless forceful steps are taken to eliminate the selective advertising and promotion of tobacco products to AAPI communities as well as other minority groups, AAPIs will continue to face high rates of consumption and exposure to tobacco products. Implementation of a comprehensive national tobacco control campaign together with international regulation will be key to the eradication of tobacco in our communities. Estimates reveal that in 1994-1995, the tobacco industry spent $4.83 billion on advertising, promotion, and marketing on tobacco products which translates to approximately $13 million spent per day. As stated above, one study in California has shown that AAPI neighborhoods have higher tobacco ad billboard density, 17 times more than compared to other neighborhoods (University of Southern California: 1992). Data collection of product preference needs to be conducted to better understand patterns of smoking in AAPI communities and to develop a counter advertising campaign.

Objective 3.1: Ban all forms of tobacco advertising (e.g., European Union health ministers agree to ban a majority of tobacco advertising by Year: 2006)

Promotions

It is well known that the tobacco industries promote their products aggressively through point-of-purchase advertising, sponsorship of sports and cultural events, and the provision of logo-bearing baseball caps, T-shirts, umbrellas, and other merchandises. Although there have been studies conducted for the mainstream population, there is the absence of any specific study in AAPI communities to show a strong correlation of cigarette promotion to smoking initiation, particularly among youth. A Dartmouth Medical School study found that tobacco companies' promotional items are highly visible in the public school setting, and their ownership is strongly associated with initiation and maintenance of smoking (12/15/97: "Pro-Smoking Gear Common in Some Schools" New York Times). The study also found that students were more likely to own cigarette promotional items (e.g., T-shirts, jackets, lighters, and caps) if their friends or relatives smoke.

In the AAPI community, the tobacco industry has been sponsoring youth and community events to project a positive image of smoking and legitimize its presence in communities already saturated with tobacco advertising. Research needs to be conducted in the AAPI community to reveal the association of promotions of tobacco merchandise to the initiation of smoking.

Examples of tobacco sponsorship and promotion that affect AAPIs include:

- Merchant displays
- Product placement (e.g. movies)
- Sponsorship of AAPI youth events, community events (e.g. Tet festival), sporting events (e.g. Salem Open), neighborhood events and community programs (e.g. Organization of Chinese American's directory of AAPI organizations).

- Promotional materials: T-shirts, ethnic specific items (e.g. Chinese red packets cigarettes, Vietnamese New Year's carton holders, etc.)
- Cigarette packaging that targets specific populations (e.g. Guam and Saipan's duty-free cigarettes, Long Life cigarettes)

Objective 3.2: Ban on all forms of tobacco industry sponsorship and promotion.

Counter Advertising Campaign

Given that the tobacco industry has selectively targeted minority communities through billboard advertising, promotions, and sponsorship, tobacco control legislation must include adequate funding for countering pro-tobacco influences through local, state, and national advertising campaigns for these minority groups. These campaigns need to contain cultural and linguistically appropriate messages for diverse AAPI targeted subgroups, including TV ads, radio spots, and print media. We strongly recommend that media campaigns utilize existing AAPI media outlets in order to solicit appropriate messages as well as the skills of AAPI media for targeted AAPI populations (e.g., Hmong Today, a radio station in Fresno, CA).

The California's Department of Health Services/Tobacco Control Section Media Campaign Unit and other AAPI community-based multi-media campaigns may be used as models for a national campaign. Moreover, all health warnings and health education advertisements should be reviewed for cultural and linguistic appropriateness to ensure that translations are accurate.

Objective 3.3: Develop and implement an AAPI anti-tobacco, multi-media campaign that is culturally sensitive and linguistically appropriate to outreach and educate AAPI communities (e.g., businesses, churches, health and social service organizations).
Objective 3.4: Determine the extent and impact of tobacco advertising and promotion in AAPI communities and evaluate the effectiveness of AAPI media campaigns.
Objective 3.5: Require health warning labels to be translated into culturally appropriate messages in different AAPI languages for all tobacco products, merchandise, and advertisements.

IV. FOCUS ON YOUTH

GOAL 4: Reduce access to and the prevalence of tobacco use among AAPI youth.

Although youth is an important component of any tobacco control strategy, we believe we cannot reduce smoking among youth without reducing smoking overall.

The tobacco industry has a compelling financial need to promote tobacco use among youth. In the U.S., teenagers are the primary source of new customers for the tobacco industry since very few people start smoking after the age of 19. Despite being illegal for anyone under 18 to purchase cigarettes, over 90% of U.S. smokers started before the age of 20.

Reducing tobacco use among AAPI youth require strong and comprehensive restrictions on tobacco advertising and promotion. AAPI youth smoking prevalence in California increased over 50% from 1995-1996.

To meet HHS's Healthy People 2000 goals of reducing tobacco use among young people by 50% and adult prevalence to 15%, specific intervention and cessation programs need to be developed for AAPI youth by subgroup, generation, age, and gender as well as geographic location (e.g. urban versus rural youth populations). Youth should be trained in areas of leadership, health advocacy, and positive role behavior. Effective intervention programs have to be developed for high risk populations such as immigrant youth who have acculturated tobacco consumption as a community norm in Asia or the Pacific Islands.

Objective 4.1: Ban tobacco marketing, advertising, and media targeting youth
Objective 4.2: Expand and evaluate existing cultural, linguistic, and age-appropriate tobacco prevention and cessation programs for youth.
Objective 4.3: Impose severe penalties on the tobacco industry for failing to reduce tobacco use among youth.
Objective 4.4: Outreach to retailers, especially AAPI retailers in reducing access to tobacco for youths.

V. INTERNATIONAL TOBACCO CONTROL ACTIVITY

GOAL 5: Ensure that tobacco control is global and consistent with tobacco control activities in the United States.

International and domestic double-standards in the business practices of U.S. tobacco corporations should not be permitted. International tobacco control programs should be supported to counter strong U.S. tobacco interests overseas. The U.S. tobacco companies should be held accountable for their activities abroad through such provisions as penalties proportionate to their market share in any given country.

Objective 5.1: Require tobacco companies to adhere to similar advertising and promotional restrictions abroad as in the U.S. (e.g. prohibition of advertisement on television, cultural sponsorships, and promotional items such as T-shirts, gadgets, cigarette lighters, caps, and jackets)
Objective 5.2: Require manufacturing of U.S. brand cigarettes exported and produced abroad adhere to same standards as those sold domestically (e.g., unrestricted nicotine content of U.S. brand cigarettes sold in Asian and the Pacific Islands)
Objective 5.3: Allocate a portion of funding to existing tobacco control programs in Asia and the Pacific Islands (e.g. China, Vietnam, WHO, etc.)
Objective 5.4: Support the development of an International Framework Convention for tobacco control under the auspices of the World Health Organization.
Objective 5.5: Require U.S. tobacco companies to compensate foreign government health agencies proportional to their market share.

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TOBACCO SETTLEMENT ISSUES FOR ASIANS AND PACIFIC ISLANDERS
2/22/98

- **Opposition to immunity**

Legal action is one of the reasons why we have come this far in tobacco control **where** the tobacco industry is now willing to make a deal. Ongoing litigation against tobacco companies has been crucial in forcing disclosure of damaging information about the tobacco industry's practices (e.g., product content of nicotine, advertising and promotion to youth and minorities), and forcing state settlements that enact public health measures without granting immunity. Tobacco control policy should be independent from the issue of immunity.

In addition, public health advocates in the AAPI community do not have the right or authority to barter away the rights of others to sue the tobacco industry. Therefore, we cannot support a national settlement with the tobacco industry which grants immunity from legal liability.

- **Increase tobacco price/tax**

Efforts should be made to make the U.S. a world leader in tobacco control. In 1995, U.S. tobacco taxes comprised an average of 30% of the retail price of cigarettes, while most other developed countries' were 50% to 86%. This is a key issue to reframe the tobacco settlement. If the Administration's analysis is correct, the proposed settlement will force tobacco companies to raise the price of cigarettes approximately $.50/pack. If the tobacco tax is increased through legislation to the level that the President wants ($1.50/pack) it would be comparable or even greater than other developed countries' tobacco taxes, and go much further in reducing smoking among youth. It is also important that public health is the top priority when considering distribution of funds raised from such a price/tax increase and be earmarked for prevention, cessation, and other tobacco control efforts. At the same time, it is critical to prevent smuggling of cigarettes.

- **Support full FDA authority**

The FDA must have full jurisdiction over tobacco advertising, tobacco products, and their ingredients. All of the FDA's tobacco provisions should be fully implemented, including bans on promotional items, billboard advertising, and sponsorship of cultural or sporting events. Warning posters should be posted in AAPI neighborhoods, translated and designed in a manner which is culturally and linguistically appropriate and work with AAPI retailers to implement policies.

- **Enact tough penalties for not reducing tobacco use among youth**

The framework of penalties that would be imposed on the tobacco industry should be formulated by different categories of direct and indirect advertising of tobacco products to minority children. Consistent enforcement needs to be developed across states in order to reduce selective marketing and advertising in states where enforcement of penalties are not maintained. Penalties should not be tax deductible nor should the penalties be limited at any threshold levels (i.e., no capping of penalties).

- **Disclose Tobacco industry documents**

The AAPI community supports full disclosure of tobacco industry documents, in particular scientific and health information regarding the manufacturing of their products.

- **Oppose preemption of stronger state and local government provisions**

Federal legislation should be the "floor" in tobacco control, and should not supersede stronger local laws.

- **Support protection of tobacco farmers and their communities**

We support efforts to ensure that tobacco is no longer profitable to grow and assist farmers in developing alternative crops.

SF. Examiner
2/19/98

ANH LE AND KIM PHUNG NGUYEN

The English-only tobacco warnings

TOBACCO ADS in publications reaching readers of the ethnic press in the Vietnamese and Chinese communities are translated into Vietnamese or Chinese — but the surgeon general's warnings are printed in English.

This double standard also exists on the awnings of restaurants and grocery stores, window ads, tobacco sweepstakes entry forms and other promotional items distributed in the Vietnamtowns and Chinatowns of California.

Examiner contributors: Anh Le works at Suc Khoe La Vang! *(Health Is Gold!), the Vietnamese Community Health Promotion Project at UCSF; Kim Phung Nguyen, M.D., is with the UCSF Department of Pediatrics.*

If the intent of the cigarette manufacturer is to convey the whole message in these ads, why not translate the entire thing?

Many people in ethnic communities in the United States had not been educated in their native lands about the health risks of tobacco, a message from the U.S. surgeon general to mainstream America for three decades.

A complaint was filed in 1996 with the U.S. Federal Trade Commission, asking the agency to require that tobacco advertisements and promotional materials that appear in Vietnamese, Chinese and other ethnic communities carry the surgeon general's warnings in the languages of those newcomers.

We hope positive action by the FTC on this issue will help save millions of Vietnamese, Chinese and others from premature deaths.

We came to the United States to seek freedom, liberty and opportunity for ourselves and our children. Let's make sure we keep this dream.

We say to the merchants of death, the tobacco drug pushers, "Don't peddle your lethal products in our community."

And now that the American people have awakened to the tactics and ploys of the tobacco industry, which is looking for other markets to recruit new smokers, we say to the companies:

Do not kill our brothers and sisters in Vietnam, China and other Asian nations by peddling your nicotine cancer sticks overseas.

Genetically altered tobacco being exported with high nicotine kick

Cigarette makers use more of special leaf for overseas

By Todd Lewan
ASSOCIATED PRESS

NEW YORK — American cigarettes packing genetically altered, high-nicotine tobacco are being exported to Asia, the Middle East and Western Europe, according to a deposition by an official of the third-largest U.S. cigarette maker.

Brown & Williamson Tobacco Corp. adds twice as much of the nicotine-rich leaf to cigarettes sold overseas as it does to brands marketed in the United States, said Roger Black, the company's director of leaf blending, in a deposition for New York state's class-action lawsuit against the major tobacco companies.

The Jan. 16 deposition was conducted in private and tobacco industry lawyers requested it remain confidential. However, a copy of a portion of the transcript was obtained by the Associated Press on Thursday.

Higher nicotine cigarettes

During his deposition, Black testified that:

▶The Viceroy King Size and Viceroy Lights cigarettes the company exports to Europe, the Middle East, Hong Kong and other parts of Asia are 6 percent high-nicotine tobacco.

▶Brown & Williamson uses the genetically altered leaf in at least nine brands sold in the United States. Black mentioned Prime, Summit, Raleigh King Size, Raleigh 100s, Pall Mall Plain King Size, Lucky Strike Plains, Raleigh XLP and Private Stock. The company last week said Richland also used the leaf. These brands are 2 to 4 percent high-nicotine leaf. The reason for the lower levels for American cigarettes was unexplained.

▶Hundreds of strains of high-nicotine leaf have been developed and at least five have been used in Brown & Williamson cigarettes sold in the United States.

▶Souza Cruz, a Brazilian company owned by BAT Industries, the same British conglomerate that controls Brown & Williamson, supplied Brazilian-grown high-nicotine tobacco used in the American cigarettes. Souza Cruz most recently shipped the tobacco to Brown & Williamson in 1995 and 1996.

▶A small quantity of genetically altered, nicotine-rich tobacco — code-named Y-1 — was grown in Kentucky in 1984 and 1985 and added to Brown & Williamson cigarettes sold in the United States.

Genetically altered tobacco

Black's deposition confirmed a report in December that Brown & Williamson had begun work on the genetically altered, nicotine-rich tobacco plant as early as 1981, and that the Brazilian company has been growing large quantities of the tobacco for the world market from seed originally supplied by Brown & Williamson.

Y-1 was the product of state-of-the-art breeding techniques, including processes known as protoplast fusion and hybrid sorting.

The FDA first learned in 1994 that Brown & Williamson had been using the nicotine-rich leaf in American cigarettes in 1993 and 1994. After the FDA informed Congress of this, the tobacco company admitted that up to 11 percent of the content of five of its brands was Y-1. It assured the FDA that it would stop using Y-1.

Black, in his deposition, said the company had also used Y-1 in 1992. He said executives ordered the 1994 halt because they feared bad publicity.

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STATEMENT OF PRINCIPLES

AND

ESSENTIAL POSITIONS

ON

NATIONAL TOBACCO CONTROL POLICY

JANUARY 24, 1998

"Networking to ensure meaningful health care reform"

SUMMIT HEALTH COALITION

1424 K Street, N.W., Suite 500
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STATEMENT OF PRINCIPLES AND ESSENTIAL POSITIONS ON NATIONAL TOBACCO CONTROL POLICY

As a public health advocate for African Americans and other vulnerable groups, Summit Health Coalition urges the President and the Congress to seize the moment and enact federal tobacco control legislation in 1998. This legislation must respond to the urgent and distressing reality that, despite the recent glare of publicity and intense public debate, tobacco use continues to climb and claim 420,000 lives every year in the United States.

Summit Principles

1. Tobacco use and addiction are prevalent among populations exposed to targeted marketing campaigns by the tobacco industry - African Americans and other people of color, children and women.

    - It is critically important to recognize, as a matter of public policy, that tobacco has had a disproportionate impact on these targeted groups - as evidenced by their disproportionate rates of tobacco use, addiction, morbidity and mortality. Resources required to counter the effects of these targeted campaigns should be allocated accordingly.

2. National tobacco control legislation must reflect awareness that tobacco sales and use will not decline without a concerted, frontal attack involving every major institution in American society. On the front lines will be "safety net" health providers, such as public health agencies, community health centers and clinics, public and teaching hospitals, minority health professions schools and community-based health professionals and workers.

- National tobacco control policy must strengthen and equip these institutions and individuals to do battle. These providers and the people they serve urgently need a renewed national commitment to their survival, backed by substantial resources, if current patterns of tobacco use and addiction are to be reversed.

3. Equally important partners in the campaign for tobacco-free communities are schools, faith institutions, community-based organizations and other groups that have the capacity to reach and teach people of all ages.

   - We must prevent tobacco use among children and youth. But it is equally important to help adults quit who are addicted to tobacco products, many of whom serve as role models for the young.

   - Well-funded "each one, reach one" community programs are a necessary complement to mass media marketing and educational efforts.

4. Differing patterns of tobacco use and effects among different racial/ethnic and socioeconomic groups signal a pressing need for research and the expanded training of researchers.

   - It is in the nation's best interests to assure the survival and expansion of minority health professions schools and to support these and other minority institutions and organizations as sponsors of culturally relevant and appropriate research and as major contributors to a diverse pool of researchers, educators and health professionals.

5. Racial and ethnic differences with regard to tobacco use and addiction also indicate that public policies that espouse a "one size fits all" approach to tobacco control will not be successful.

   - The recognition of the importance of diversity in all aspects of tobacco control-related public policy formulation, program design and service delivery is a prerequisite for effective national tobacco control policy.

6. Cigarettes, cigars and smokeless tobacco all contribute to excessive morbidity and mortality in the United States.

   - Comprehensive legislation should provide for the control and regulation of a range of tobacco products.

7. Although the nation has many pressing needs for which tobacco industry fees and penalties might be used, public health federal and state initiatives aimed at the prevention, regulation and cessation of tobacco sales and use must receive highest priority.

   - Fees and penalties paid by the tobacco industry, excise tax increases or other sources of revenue must be adequate to pay for regulation, monitoring and enforcement of tobacco control legislation and regulations - at federal and state levels.

   - Adequate funding must also be provided for public health initiatives related to tobacco use prevention, cessation, treatment, rehabilitation, research, education and anti-tobacco marketing - at federal and state levels.

Summit Essential Positions on National Tobacco Control Policy

1. Summit Health Coalition urges Congress and the President to ensure that tobacco control legislation will prohibit targeted marketing of tobacco products to children and youth, African Americans, women and other at-risk populations. At the same time, such legislation must require that targeted anti-tobacco marketing be aimed at these vulnerable groups with adequate funding.

2. Funds must be allocated for demographic, physiological and behavioral research to foster better understanding of such phenomena as differing tobacco consumption and use patterns, incidence, morbidity and mortality rates among African Americans and other vulnerable populations. This research should involve historically black colleges and universities (HBCUs) and other minority health professions schools, as well as other African American institutions involved in health care delivery and research, professional associations, non-profit organizations and individual African American researchers.

3. Funds derived from penalties on the tobacco industry, increased excise taxes and other sources must be allocated in relation to tobacco-related mortality and

morbidity rates among various population groups, as well as past targeted marketing practices by the tobacco industry. These funds should be used for culturally relevant and appropriate programs to support prevention, cessation, treatment and rehabilitation efforts aimed at reducing and eliminating tobacco addiction among African Americans and other vulnerable, at-risk groups.

4. In recognition of the impact that anti-tobacco legislation and regulations will have on certain communities and geographic areas, legislation should be enacted to protect these communities by means of economic development services and targeted resources. These services may include job retraining, small business loans, support for community redevelopment planning and program implementation, expansion or creation of empowerment zones.

5. The Food and Drug Administration (FDA) must have full jurisdiction over all tobacco products (i.e., cigarettes, cigars and smokeless tobacco) and nicotine delivery devices immediately upon enactment of legislation. Congress must affirm through legislation the FDA's authority to regulate the tobacco industry's marketing practices to prevent targeting of children, youth, women, African Americans and other people of color, and must provide the requisite funding for FDA's strengthening and expansion so as to fulfill these responsibilities.

6. We urge the passage of legislation that will require all health insurers, health benefit plans, managed care organizations and other entities providing health services to emphasize prevention and health promotion and provide information to enrollees, beneficiaries and patients to help them prevent and decrease smoking and improve their quality of life.

7. The federal government should support international tobacco control initiatives through legislation, regulation, Executive Orders, funding and other means, as well as through the dissemination of information on effective models and strategies for tobacco use prevention and control.

8. National tobacco control legislation must provide for a substantial and immediate increase in the price of tobacco products to support public health initiatives and to discourage tobacco consumption. An increase in the federal excise tax of at least $2.00 per cigarette pack is recommended.

Adopted by the Board of Directors of Summit Health Coalition*
January 24, 1998

* These positions do not reflect the policy statements of the Presbyterian Church (USA).

TOBACCO AND AFRICAN AMERICANS

Tobacco use is responsible for nearly one in five deaths in the United States, or 420,000 deaths annually. An estimated 47,000 African Americans die from smoking-related diseases every year. (American Lung Association)

African American men smoke at a rate (33.9%) that exceeds every other gender or racial/ethnic category except American Indian/Alaska Native men. (National Health Interview Survey, 1994)

Cancer is second only to heart disease as a leading cause of death among African Americans. Lung cancer accounts for the largest number of cancer deaths among both men (32%) and women (20%).

- The rate at which African American men die from lung cancer is approximately 50% higher than that for white men. (American Cancer Society)

- In the period 1957 to 1987, the rate of lung cancer among African American men increased by 259% and quadrupled for African American women. (American Cancer Society)

The mortality rate from oral cancer among African Americans is twice that of whites, and the 5-year survival rate for African Americans (31%) is 22 percentage points lower than for whites (53%). This 22-point difference is the largest difference between blacks and whites for all types of cancers. (National Dental Association)

Smoking Among African American Youth

Of the 420,000 people who die from tobacco-related causes each year, 378,000 of them started smoking as children. A 1997 University of Michigan study documents the highest smoking rate among high school seniors in 19 years. (Campaign for Tobacco-Free Kids)

According to the Centers for Disease Control and Prevention, smoking rates for African American male students in grades 9 to 12 almost doubled, 14.1% to 27.8%, from 1991 to 1995. (CDC, Youth Risk Behavior Surveillance)

Frequent smoking among African American high school girls increased as well, from 4.5% in 1991 to 8.5% in 1995. (Youth Risk Behavior Surveillance)

In 1995, 19.2% of African American high school students were current smokers, up from 15.4% only two years before (Youth Risk Behavior Surveillance, 1993 and 1995)

Another survey of African American high school students at 8th, 10th and 12th grade levels, showed increases in smoking between 1992 and 1996 of 80%, 85% and 60%, respectively. (University of Michigan, Monitoring the Future Survey Project, 1991-1996)

Smoking Patterns among African Americans

African Americans smoke fewer cigarettes per day and tend to begin smoking later in life than whites, yet their smoking-related disease mortality is higher. (American Lung Association)

Seventy-six percent (76%) of all African American smokers smoke menthol cigarettes as compared to 23% of white smokers. (American Lung Association/American Cancer Society)*

Of African American smokers surveyed in 1994, more than 71% indicated they want to quit smoking completely. (Centers for Disease Control and Prevention)

African American smokers are more likely than white smokers to have quit for at least one day during the previous year, but are much less likely than whites to remain abstinent for one year or more. (Campaign for Tobacco-Free Kids/National Medical Association)

*Menthol has been associated with higher cotinine levels and carbon monoxide concentrations, which are associated with increased health risks of smoking. (American College of Chest Physicians)

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NHMA

National Hispanic Medical Association

Statement by

The National Hispanic Medical Association

on the Introduction
of Tobacco Control Legislation

January 26, 1998

1700 17th Street, NW, Suite 405 • Washington, D.C. 20009 • (202) 265-4297 • FAX (202) 234-5468

THE NATIONAL HISPANIC MEDICAL ASSOCIATION POSITION ON TOBACCO CONTROL LEGISLATION

Background

The National Hispanic Medical Association was organized in 1994 to address the interests and concerns of Hispanic licensed physicians and dedicated to improving health care for Hispanics and other underserved communities. As a rapidly growing national resource based in the nation's capital, NHMA provides policymakers and health care providers with expert information and support in strengthening health service delivery to Hispanic communities across the nation. During its first years of operation, NHMA held strategic planning meetings with physicians in five regions of the country, identifying the most critical issues they face and taking steps to define a blueprint of future activities in the following areas: delivery system, medical education, research, policy, and communications.

The literature shows that Hispanic physicians on average, care for significantly more Hispanic patients than other physicians and care for more uninsured patients than physicians of other ethnic groups[1]. We have a tremendous stake in the development of a comprehensive tobacco control policy that establishes a solid framework to significantly reduce smoking among Hispanics. As Hispanic physicians, our role is to improve the health status of our patients by providing education and treatment as needed on smoking and its consequent diseases. Therefore, we will actively participate in developing effective legislation for tobacco control.

Justification

- Tobacco use is the single leading preventable cause of death and disease in the United States. It leads to illnesses such as: lung cancer, emphysema, stomach ulcers, ischemic heart disease, and strokes. Eighty-seven percent of all cancers are related to smoking.[2]
- Health care expenditures caused directly by smoking totaled $50 billion in 1993. Forty-three percent of these costs were paid by government funds, including Medicaid and Medicare. However, most of these costs are related to chronic disease management since Medicaid and Medicare programs rarely cover cessation treatment products (patches, gum, etc.).[3]
- The Hispanic community has the lowest rate of health insurance coverage. Approximately 33% of Hispanics, compared to 13% of Whites and 20% of Blacks, lack health insurance.[4]
- Fourteen and a half percent of Hispanic women and 22 % of Hispanic men, 18 years and older, are current smokers. However, Hispanic subgroups show a worse trend. Sixty-four percent of Cuban men and 52.3% of Puerto Rican men were most likely to

be heavy smokers compared to 33.8% of Mexican American males.[5]

- Age-adjusted lung cancer mortality rates (per 100,000) for Hispanics are at 35.6 overall and 56.8 for men and 20.1 for women. This is five times the rates of the 1950s, just one generation ago.[6]
- Hispanic youth have the highest smoking rate among high school students. Between 1991-1995, smoking among Hispanic high school students increased from 25.3% to 34.0%. Among Hispanic eighth graders, 18.3% had smoked within the past 30 days compared to 6.6% of Blacks and 17.8% of Whites. Moreover, it has been reported that almost 90% of adult smokers began as children.[7]
- Asthma, the leading serious chronic illness among all children, has been estimated to effect as many as 20.1% of Puerto Rican children 6 months to 11 years old. Smoking triggers asthma attacks and increases likelihood of respiratory infections in children. This is a greater percentage than children of any other ethnic group.[8]
- Cost for Hispanics is not readily available, because data that is collected does not specify race. Surveillance and research on Hispanic subgroups, women and adolescents is inadequate.
- Cessation materials are limited, effective models for Hispanics have not been developed, and most prevention and cessation programs are not reaching the Hispanic population.

Recommendations

The proposed tobacco litigation settlement represents an opportunity to achieve substantial and permanent reduction in tobacco use. However, there are provisions in the tobacco settlement that warrant reconsideration.

I. FDA Authority

The FDA must be granted full and unencumbered authority to regulate tobacco products using the same procedure, as would generally apply to drugs and devices under the Food, Drug, and Cosmetic Act. The FDA should have full jurisdiction over tobacco, including cigars, smokeless tobacco, nicotine delivery devices, and other constituents or ingredients of tobacco products. We caution that the FDA carefully consider whether or not their regulation policies will result in a significant demand for contraband; and if so, how they could mitigate these effects. However, this factor should not be an absolute precondition to any regulation.

II. Preemption

The federal government should explicitly ensure that state and local governments are not preempted from establishing or retaining requirements equal to or more stringent than any federal requirement relating to tobacco control. Local governments need to have the liberty to impose civil sanction on tobacco retailers beyond the federal minimum. Every community is different and the leaders of a community are better

informed and prepared to deal with problems facing their community than the federal government. All Federal advisory panels or committees related to tobacco control should have representation from Hispanics in proportion to the US population. An advisory committee should be established to provide guidance in needed tobacco prevention health care programs composed of Latinos and Latino serving health professionals.

III. International Provisions

There is significant concern about the absence of provisions preventing US tobacco companies from exporting tobacco products. With tough regulations in the US, tobacco companies will intensify marketing of tobacco products internationally. International tobacco control efforts should be funded. Tar and nicotine levels and non-tobacco ingredient regulation should apply worldwide to US-owned companies, including their subsidiaries. Warning labels should be placed on exported cigarettes in the language of the country where they are being exported to. Legislation should further specify that no government agencies promote and/or assist tobacco advertising, marketing and promotion internationally. Marketing to children and youth by US owned companies should be banned. Duty free shops should ensure that they are not selling to minors. Therefore, we propose that the US work with other countries to develop tobacco prevention programs and encourage the adoption of tobacco control policies. In addition, we propose that the US fund special programs to monitor US-Mexico border activities as well as the health status and tobacco use prevalence in border areas. This is of great importance since border areas and inner cities will face black market problems related to cigarette tax increase.

IV. Public Health Provisions

The national health agenda must address the need for adequate prevention and clinical treatment programs. In order to protect the health of Hispanic and other minority children, we believe that any tobacco legislation must place a primary emphasis on public health strategies. Programs and approaches must be designed to prevent and decrease tobacco use among youth, promote healthy smoke-free lifestyles for families, and encourage cessation. Effective public health programs should be culturally sensitive and language appropriate with a focus to abate initiation rates, consumption patterns, and change cultural norms among Hispanics. Therefore, it is imperative to provide needed resources for public education, professional health education, prevention, medical services, counseling and cessation programs and research and surveillance. Compared with other preventative interventions, smoking cessation is extremely cost effective. Hispanics, however, have been inadequately served by the majority of tobacco cessation programs due to language barriers and the lack of cultural sensitivity by health care professionals. Therefore, we have identified programs in San Francisco, CA directed by Eliseo J. Perez-Stable, M.D., in Nogales, AZ directed by Maria Elia Gomez-Murphey, and in Brownsville, TX directed by Amelie G. Ramirez, D.PH ., which have been

successful and can serve as national models for tobacco cessation programs[1]. These programs are culturally sensitive and language appropriate. According to a study by Dr. Eliseo Perez-Stable, culturally appropriate community intervention to promote non-smoking in Latino communities leads to significantly greater success rates as compared to traditional smoking cessation programs.[9] These programs should be accessible locally, at Veterans hospitals, free to uninsured working poor, and available to those receiving Medicaid or Medicare benefits.

We propose the following strategies for tobacco control targeting Hispanics:

- Large multi-media campaigns directed to youth and parents. They must be culturally sensitive and language appropriate. Existing media including Spanish language TV, radio, telecommunications, and printed media should be utilized. These resources could be used to educate people on the deleterious effects of tobacco, counter advertising, inform them on tobacco cessation programs in their communities, and, most importantly, to promote healthy family lifestyles.
- Some public education campaigns should concentrate on youth leadership development giving a major role in delivery of services to existing national and grassroots Community Based Organizations.
- Funding should be targeted to the National Hispanic Medical Association, the Hispanic-Serving Health Professional Schools and Hispanic-Serving Institutions for health professional and public education, material development, research, and conferences.
- Special attention should be given to workers that have high exposure to second hand smoke and to farm workers who have high exposure from direct, second-hand smoking, and environmental carcinogens (i.e. pesticides).
- Comprehensive culturally sensitive and language appropriate secondhand smoke campaigns should emphasize protection of families and individuals in workplaces and all federal facilities. Secondhand smoke campaigns should be comprehensive, multi-lingual, multi-media, include telecommunications, and be reinforced by local community leaders and existing CBOs.
- Provisions should protect Hispanics in their place of work, in prisons, in military installations, detention centers, schools and day care centers.
- Funding should be provided for tobacco dependent community programs and events that may lose sponsorship due to tobacco control legislation.
- There should be special funding for data collection and research. Data collection should be done for Latino subgroups by national origin at the national, state and local level. A research agenda should be developed for tobacco prevention and control among Latino subgroups, including the patterns of use of cigars, smokeless tobacco and menthol products.

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[1]Contact the National Hispanic Medical Association for more information.

V. Price Increases

The cost of tobacco products should be increased to at least $1.50 per pack to deter children from taking up their use, through an increase in federal excise taxes, modifications in the tax treatment of annual payments, and/or price hikes from the tobacco companies due to increased settlement costs. Most funds should be earmarked for prevention, cessation and tobacco control. Puerto Rico and US territories should be included in the allocation of these funds. Approximately 20% of the funds should be earmarked to develop culturally sensitive, language appropriate campaigns, programs and materials for the Hispanic community.

VI. Tough Penalties

The tobacco industry must be subject to significant penalties if tobacco use among Hispanic and minority children does not drop substantially. Penalties should be non-tax deductible, uncapped, escalating and brand-specific to youth tobacco use to give the industry the strongest possible incentive to stop targeting children and minorities. These penalties should be assessed based on the prevalence of teen smoking by state and by ethnic group in order to assure that the tobacco industry meets the goals of reducing smoking rates among Hispanic and minority youth.

Conclusion

The National Hispanic Medical Association, representing Hispanic physicians, is committed to being the Hispanic community's advocate to help pass strong, comprehensive, sustainable, and well-funded national tobacco control legislation. We offer our assistance to you and look forward to working with you.

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STATEMENT BY COMMUNITIES OF COLOR IN THE UNITED STATES ON PRIVATE NEGOTIATIONS TOWARD A PROPOSED "SETTLEMENT" WITH THE TOBACCO INDUSTRY

Many individuals and organizations within communities of color in the United States are concerned about the content and form of negotiations that are currently underway between the tobacco industry and attorneys general and lawyers for victims of tobacco. Our specific 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. 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 that any settlement that is negotiated without our voices as part of the discussion and debate 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. A disproportionate number of the individuals who receive Medicaid-funded health care are low-income and are from our racial, ethnic and tribal communities. We are concerned that a large monetary settlement 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 has the potential to victimize low-income smokers disproportionately, while allowing the investors in tobacco to realize enormous financial rewards by "immunizing" tobacco companies from many of the costs of further litigation. There must be a balance struck so that poor people and people of color, who are most likely to pay the higher costs of such a settlement through increased prices, also receive significant and measurable benefits from any agreement.

3. In some news stories, there have been references to a proposed "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, companies can continue to market their addictive tobacco products in other parts of the world -- especially in Latin America, Africa, Asia and the Islands of the Pacific. As people of color, we have links to our brothers and sisters worldwide. Some our communities have large immigrant populations that are doubly impacted by the tobacco industry's targeted marketing practices here in the United States and in their home countries abroad. We do not view an increased international trafficking of tobacco addiction as a legitimate trade off in return for tougher sanctions on advertising and marketing to youth in the United States. All youth are important and all youth must be protected from tobacco marketing practices -- in the United States and throughout the world.

These are our specific concerns, and are in addition to the basic core principals that have been articulated by other organizations such as the Attorneys General Working Group and the National Center for Tobacco-Free Kids. But beyond the concerns addressed in this statement looms the larger issue of principle. As communities of color, we believe strongly in the processes of consensus, inclusion, openness, and fairness. 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 discussions.

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. The issues must be brought into the light of public disclosure and debate so that all those 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 -- and especially in communities of color.

June 1997

February 17, 1998

CONSENSUS STATEMENT SUPPORTED BY MEMBERS OF THE HISPANIC HEALTH AND EDUCATION WORKING GROUP AND OTHER TOBACCO CONTROL ADVOCATES

CONSIDERATIONS FOR TOBACCO CONTROL LEGISLATION.

Summary

In order to protect the health of Hispanic and other minority children, we believe that any tobacco legislation must place a primary emphasis on public health strategies. Programs and approaches must be designed to prevent and curb tobacco use among youth, promote healthy smoke-free lifestyles for families and encourage cessation. Any revenue from tobacco tax increases, Attorneys General's (AG's) Settlements, industry penalties/contributions or Congressional appropriations should be used primarily for long-term, **sustained programs**. Effective public health programs should be **culturally sensitive and language appropriate** with the goal of changing initiation rates, consumption patterns and cultural norms among Hispanics, especially Hispanic youth. Funding should be allocated to each minority group based on the percentage of the population it represents nationally, and by the percentage of ethnic/minority youth in each state in 1998 and that amount should rise proportionally yearly. Latino youth will triple in size – increasing from 9% in 1995 (of the national youth population) to 19% in 2020.

Justification

- Between 1991 and 1995, smoking among Hispanic high school students increased from 25.3 to 34.0% (32.9% females) and 34.9 males (1)
- Among Hispanic eighth graders, 18.3 % had smoked within the past 30 days compared to 6.6% of Blacks and 17.8% of whites. They are more likely to use cigarettes than their peers (2)
- A 1990 survey showed that among Hispanic smokers living on the U.S. mainland, Cuban (64.1%) and Puerto Rican (52.3%) men were most likely to be heavy smokers (smoking more than a pack a day) compared to 33.8% % of Mexican American male smokers (3)
- One of 5 deaths in California is attributable to smoking (1993-1994) (4)
- Age-adjusted lung cancer mortality rates (per 100,000) for Hispanics are at 35.6 overall and at 56.8 for men and 20.1 for women. This is five times the rates of the 1950s, just one generation ago. (5)
- Asthma, the leading serious chronic illness among all children, has been estimated to effect as many as 20.1% of Puerto Rican children 6 months to 11 years old. Smoking triggers asthma attacks and increases likelihood of respiratory infections in children. This is a greater percentage than children of any other ethnic group. (6)
- Health care expenditures caused directly by smoking totaled $ 50 billion in 1993. (7)
- Forty-three percent of these costs were paid by government funds, including Medicaid and Medicare. (8) Cost for Hispanics is not readily available, because data that is collected does not specify race.Most Medicaid and Medicare programs do not cover cessation treatment products (patches, gum, etc.)

- In 1996, an estimated 6.0 million 14-19 year olds reported having smoked a cigar during the previous year. The rate for Hispanics was 26.2%: 20.5% for females and 32.3% for males.(9)
- Surveillance and research on Hispanic subgroups, women and adolescents is inadequate.
- Cessation materials are limited, effective models for Hispanics have not been developed, and most prevention and cessation programs are not reaching the Hispanic population.

Any tobacco legislation should take into account that the Hispanic community has the lowest rate of health insurance coverage (approximately 60%), therefore making it imperative to provide needed resources for public education, professional health education, prevention, medical services, counseling and cessation programs and research and surveillance.

This document is divided into three sections.

I. Guidelines for tobacco control legislation
II. Funding needed
III. Potential areas where there may not be consensus

I. Guidelines for Tobacco Control Legislation

1. **Public Health Initiatives:** Priority should be given to developing and sustaining public education and prevention programs that are culturally sensitive and language appropriate, inclusive of local communities and integrate multi-media components in order to effectively reduce initiation rates in youth and the demand for tobacco.

a) A public health campaign should have a comprehensive, culturally based medical health care prevention strategy that includes: health care delivery services, prevention, counseling, nicotine addiction and treatment programs. Training for community and professional staff should also be provided. Adequate reimbursements for clinics, physicians, Managed Care Organizations (MCOs) and mid-level providers in states should be provided . Alternative reimbursement and funding for these efforts could be enhanced by including tobacco prevention in traditional health care delivery services, through publicly funded programs through managed care services. Non-Hispanic health providers also need to receive education about how to best provide cessation services to Hispanics.

b) Some public education campaigns should concentrate on youth leadership development giving a major role in delivery of services to existing national and grassroots Community Based Organizations (CBO's). Campaigns should change behavior of future generations through work in schools and that include Hispanic high school dropouts (30 to 40%). Examples of such programs include ASPIRA's culturally sensitive Youth Leadership Development Model and the National Hispanic Leadership Initiative on Cancer, "Mirame".

c) Multi-media components include printed materials, public and private radio, television, telecommunications and local media campaigns aired through existing national and local entities. These campaigns should be directed to youth and parents integrating healthy family lifestyles. These campaigns should be sustainable, and should use existing media

including nationally-broadcast Spanish-language radio, TV and print. Health programs should include a hot line, toll free referral services to local CBOs and clinics, counseling, treatment and prevention programs, and include peer education, home visits, and church and community group involvement. Role models for these programs should be Hispanics. Healthy family lifestyles should be promoted through all health promotion materials. Partnerships between government agencies, academic institutions, the community and CBOs should be encouraged i.e. *En Accion*.

d) **Form an advisory committee** to provide guidance in needed tobacco prevention health care programs composed of Latinos and Latino serving health professionals. If a national advisory committee on these issues is developed, Latinos should be equitably represented.

2. Counter advertising campaigns should be national as well as state and locally driven. Nationwide programs should be culturally sensitive and language appropriate and include bilingual/bicultural culturally-based education messages. Campaigns should use multi-media, telecommunications and be tested locally to ensure their effectiveness. Campaigns should use Spanish language TV, radio, telecommunications and printed media. Programs and messages should air during prime time and in publications with strong Hispanics audiences.

3. Cessation programs should be accessible locally, free to the uninsured and the working poor, and available to those receiving Medicaid or Medicare benefits regardless of recidivism. States must be required to fund existing community-based organizations that serve various ethnic communities to conduct cessation programs and to develop cessation materials that are culturally sensitive and language appropriate. Total funding dedicated to CBOSs should be contingent upon and proportional to state demographic composition. These programs should be designed and funded to reach all the populations in the U.S. territories. Special model cessation programs should be held at all military installations in the US and abroad. Cessation programs should also become available at Veterans hospitals, health care delivery services, professional medical personnel and through reimbursements of Medicaid or Medicare payments.

4. All Federal advisory panels or committees related to tobacco control should have representation from Hispanics in proportion to the U.S. population. In addition:

a) **Funding should be targeted for Hispanics serving health professional schools,** Hispanic serving institutions for health professional and public education, materials development, research and conferences. Collaboration between academic institutions, the community and local CBOs should be encouraged.
b) **Data collection should be done for Latino subgroups by national** origin at the national, state and local level. This data should include gender, youth and adult prevalence and product preference and determine existing tobacco control infrastructure and efforts to market to each community.
c) **A research agenda should be developed for tobacco prevention and control among Latino subgroups,** including the patterns of use of cigars, smokeless tobacco and menthol products.

d) **Support should be provided to minority institutions and researchers** to conduct appropriate and needed research on factors such as ethnicity, national origin, sex, age, health care beliefs and cultural patterns.
e) **Special attention should be given to workers that have high exposure to second hand smoke** (restaurant, casinos, bingo parlors, etc.) and farmworkers and in respect to their exposure from direct and second hand smoking and environmental exposures in relation to secondary/underlying health conditions (i.e. relationship of pesticide and smoking in farmworkers).

5. Special programs should be funded to monitor border activities as well as the health status and tobacco use prevalence in border areas. Border areas and inner cities will face black market problems related to cigarette tax increases. Special provisions should be in place to monitor US border areas with Mexico. The impact of marketing, promoting and sales as well as initiation rates, youth access and consumption patterns should also be monitored.

6. Comprehensive culturally sensitive and language appropriate secondhand smoke campaigns should emphasize protection of families and individuals in workplaces and all federal facilities.

a) **Campaigns should be comprehensive**, multi-lingual, multi-media, include telecommunications, and be reinforced by local community leaders and existing CBOs.
b) **They should protect Hispanics in their place of work**. The ordinances such as the California's Section 6404.5 to the Labor Code and AB 13 Statutes should be promoted nationally. The ordinance states: "No employer shall knowingly or intentionally permit, and no person shall engage in, the smoking of tobacco products in an **enclosed space** at a place of employment. "Place of employment" does **NOT** include certain establishments such as employee break rooms, private smoker lounges, etc.
c) **To protect children from Environmental Tobacco Smoke (ETS) and role modeling behaviors**, smoking should not be permitted in schools and day care centers.
d) **Campaigns should include prisons, detention centers and youth facilities** (have a high percentage of minority population), where only special areas should be designated for smokers and the facility should be otherwise smokefree.
e) **Campaigns should be targeted to military installations,** in the US and abroad, where smoking could be allowed only special "breakroom" areas and not permitted in work areas. Cessation programs for veterans should be advertised and promoted at military PXs and/or commissaries where cigarettes are sold.

7. International tobacco control efforts should be funded. Appropriate federal agencies and existing international non-profit organizations such as the World Health Organization and the Pan American Health Organization should receive funds for the purposes of tobacco control in prevention and cessation activities.

a) **Tar and nicotine levels and non-tobacco ingredient regulations** should apply worldwide to US-owned companies, including their subsidiaries.

b) **Warning labels should be placed on exported cigarettes** in the language of the country where they are being exported to. Spanish should be used for most of Latin America and Spain (Portuguese for Brazil, English to English speaking Caribbean nations, etc).
c) Legislation should further specify that **no government agencies promote and/or assist tobacco advertising, marketing and promotion internationally.**
d) **Marketing to children and youth by US owned companies should be banned**.
e) **Duty free shops** should ensure that they are not selling to minors. Military PX stores abroad should also ensure that they are not selling cigarettes to minors and that they respect the tax code and public health laws of the host country. Military bases should abide by federal regulations regarding youth access, advertising and ETS.

8. Meaningful Community Driven Strategies for Tobacco Dependent Communities: The impact of the legislation on tobacco farmers, migrant workers and other affected communities should be studied with appropriate adjustments in training and transitional programs made in a timely manner. Displaced farmworkers should receive prompt and effective access to employment, education and job training services. Studies about the degradation of the environment by tobacco growers worldwide and the use of Hispanic children to select and harvest tobacco leaves for cigars should be initiated and funded both in the U.S. (i.e., New York, Connecticut, Florida) and internationally. Studies should look at alternative uses of tobacco.

9. Funds to replace tobacco sponsorship. Hispanic national and local organizations depending on tobacco companies for sponsorship of cultural events, concerts, programs and conferences should receive temporary funding to continue these activities while alternative sources of funding are obtained. Funds to replace tobacco sponsorship should include tobacco industry funding of the ongoing services and other all other programs offered by Community Based Organizations.

10. Full and Unencumbered FDA Authority: FDA must have full jurisdiction over tobacco products, including cigars, smokeless tobacco and nicotine delivery devices and other constituents or ingredients of tobacco products and should have the same standard of review and decisions on tobacco as they apply to the Food, Drug and Cosmetic Act. Legislation should include warning labels and provisions to eliminate youth access to tobacco. Warning posters of the dangers of smoking should be printed in Spanish to be distributed in predominantly Latino neighborhoods and in Puerto Rico.

11. Price Increases: The cost of tobacco products should be increased to at least $1.50 per pack to deter children from taking up their use, through an increase in federal excise taxes, modifications in the tax treatment of annual payments, and/or price hikes from the tobacco companies due to increased settlement costs. Most funds should be earmarked for prevention, cessation and tobacco control. The territories should be included in the allocation of these funds. Approximately 20% of the funds should be earmarked to develop culturally sensitive, language appropriate campaigns, programs and materials for the Hispanic community. At PX or military based commissaries, prices of cigarettes should be increased to reflect national standards of at least $ 1.50 increase in order to deter purchase by young recruits.

12. Tough Penalties: The tobacco industry must be subject to significant penalties if tobacco use among Hispanic and minority children does not drop substantially. Penalties should be non-tax

deductible, uncapped, escalating and brand-specific to youth tobacco use to give the industry the strongest possible incentive to stop targeting children and minorities. These penalties should be assessed based on the prevalence of teen smoking by state and by ethnic group in order to assure that the tobacco industry meets the goals of reducing smoking rates among Hispanic and minority youth.

13. No Marketing to Children and Youth: Tobacco marketing, advertising and targeting to all children must be prohibited and enforced.

14. Document Disclosure: Broad disclosure of industry documents should be achieved, including those containing scientific or other health information relating to the industry's attempts to market tobacco to children, women and minorities.

15. No Preemption: Any federal legislation should explicitly provide that state and local governments are not preempted from establishing or retaining requirements equal to or more stringent that any federal requirements (including taxation) relating to tobacco control, enforcement other than requirements regulating the content of tobacco products.

II. Funding Needed

Funds obtained from tax increases and other legislative measures should be **designated primarily to tobacco control activities**: cultural sensitive and language appropriate public education, prevention, multi-media campaigns, telecommunications and cessation in order to lower initiation and prevalence rates. All legislation, appropriations, settlements and penalties or contributions from tobacco companies should specifically earmark funds for prevention and cessation programs to Hispanic communities that are culturally sensitive and language appropriate. Furthermore, it is important to assure that the Hispanic community gets a **fair share** of these resources since youth smoking rates of Hispanics are higher than in other communities.

1. At least ____ billion annually should be dedicated to public health efforts.

a) Of these funds to be allocated for **national** programs, resources must pay for multi-media approaches, utilize existing national organizations and support ASSIST/ IMPACT type programs. At least 20% of the national program budget should specifically be designated to reach the Hispanic community.

b) Of funds that will be distributed through **state public health institutions**, these should be divided according to the percentage of each state population by ethnic groups. that is minority, For example, California's youth is 53% minority, of that percent, 40% is Hispanic, therefore, funds should be proportionately distributed to reach the Hispanic population. In other states like Alaska, funds should be distributed according to the percentage of the population that is Alaskan native and other.

c) Existing community based organizations should be strengthened in order to institutionalize tobacco control at the local level.

2. **FDA should be given the adequate funding** needed to carry out its responsibilities.

3. Funds should be made available for **research programs.** Hispanic serving institutions and Hispanic researchers, community health centers and programs should receive adequate funding to secure desegregated data on Hispanic communities.
4. Funds should be provided to assure effective **international tobacco** control.
5. Funds should be provided to **monitor border areas.**
6. Funds should be provided to compensate for **environmental tobacco control activities.**
7. Funds should be provided to **compensate communities dependent on the tobacco industry**, including national and local Hispanic organizations that have been receiving funds for cultural, civic and other programs.
8. The states must allocate from the amount of any Medicaid-related expenditure recovery the pro-rata share of which the federal government is equitably entitled. These funds should be used for tobacco education, prevention and cessation programs.

III. Potential Areas where there may not be consensus

1. Immunity

The public health community does not want to grant any liability protection for civil or criminal wrongdoing by the industry. However, there is disagreement on whether granting any protection would defeat achieving public health goals including reducing initiation and smoking rates in this country. Some groups believe that the tobacco companies must not be given any immunity, either civil or criminal liability protection for its wrong doings. It has never been part of the discussion to provide criminal liability protection to tobacco companies in the past. Others believe that any discussion on providing the tobacco industry protection for the industry's wrong doings should be deferred until public health concerns are adequately addressed.

COSSMHO and several tobacco control groups in California support The National Tobacco Control Coalition--Save Lives Coalition language. For COSSHMO this is a priority. The language specifically states that tobacco companies must not be given any immunity under any circumstances considering their criminal and unethical past practices. The language also states that "Immunity for the tobacco industry also will set a bad precedent that will be used by other industries to erode legal incentive that protect public health."

2. Environmental Tobacco Measures eliminating smoking in Restaurants

The concentration of smoke in restaurants is significantly greater than in other workplace, two to five times higher. In restaurants, many nonsmoking Latino workers may be affected by secondhand smoke. Measure should protect workers. But, these EST restrictions may be fought by restaurant associations and owners as well as other hospitality industry interests.

3. Funds to replace tobacco sponsorship: The AG's Settlement proposed to assign, beginning in the second year, $75 million annually for a period of ten years to compensate events, teams or such events who lose sponsorship by the tobacco industry, or who currently receive tobacco industry funding. If this provision becomes legislation, at least 12% of these funds should be assigned to replace funds currently given to Hispanic organizations, and in accordance with the

Settlement agreement. Hispanic organizations that reach the disadvantaged, populations at risk, and the most difficult to reach in both urban and rural areas should be given priority. Some groups feel that this provision may unduly support groups that have been receiving tobacco industry sponsorship and may not like this provision as part of a legislative proposal.

4. Allocating percentages of funds for minority communities and/or Latinos.
In order to reach HHS' goals and Goals 2000, of **reducing tobacco use among young people by 50% and adult prevalence to 15%;** some believe that 26% of the public health funds obtained through the legislative process should be specifically assigned to reach minorities until prevalence targets are reached by every minority ethnic group in each state, at least 12% of those funds should be allocated to Latino communities. **Some groups want to obtain from 12% to 20% since they believe that Hispanics have been unduly targeted by the industry and their numbers are usually undercounted.**

- Latino youth will triple in size –increasing from 9% (of the national youth population) to 19% in 2020. (US Dept of Commerce, Bureau of Census 1997)
- In 1992, 2 out of every 10 students in central city public schools were Hispanic. (US Dept. of Education NCES, 1995)
- Public school enrollment is expected to increase almost 44 million by 2000, and nearly all the increase will be in minority enrollments, especially Hispanic enrollment. (*Hispanic Americans: A Look Back, At Look Ahead*, Hodkinson & Outtz, Institute for Education Leadership, 1996.)

Furthermore, some groups would like to see that from the public education funds that are assigned for Latino communities, 50% of those funds should be earmarked for existing community based organizations CBOs that can reach low income Latinos and at-risk communities. The other 50% should be directed towards national and state programs. The actual percentages for allocation of resources to programs is still fluid and may be subject to various points of view.

In California the allocation of resources from the Cigarette and Tobacco Surtax Fund has been allocated among six accounts, though yearly appropriation determine funding levels within accounts: 20% health education, 35% hospital services;10% physician services;5% research; 5% public resources and 25% unallocated.

5. Creating a non-profit organization to distribute funds to minorities.
Some members of the Congressional Black Caucus may be proposing the creation of a new organization (NEWCO) to receive funds and then distribute them to minority groups. This idea may not be acceptable to all Hispanic/Latino groups because some people feel that it may exclude Latinos from the decision making process if such an outcome is to occur.

Conclusion

National and local Hispanic organizations, networks, and coalitions working to improve the health and education of the Hispanic community believe that comprehensive tobacco control legislation should focus on reaching public health goals. Funding should primarily be used to launch effective,

culturally sensitive and language appropriate campaigns designed to prevent and curb tobacco use among youth, promote healthy smoke-free lifestyles for families and encourage cessation.

The following organizations have signed on to this consensus document:

American Psychiatric Association
ASPIRA Association, Inc.
Center for Health Policy Development, Inc.
Hispanic Dental Association
Hispanic Radio Network
Institute for Puerto Rican Policy, Inc.
InterAmerican College of Physicians and Surgeons
Latino Council on Alcohol and Tobacco
League of United Latin American Citizens (LULAC)
Midwest Latino Health Research, Training and Policy Center for Medical Treatment and Effectiveness Program, University of Illinois
National Council of La Raza (NCLR)
National Hispanic Leadership Initiative on Cancer: *En Accion*
National Hispanic Medical Association
Resources for Cross Cultural Health Care
Society for the Advancement of Chicanos and Native Americans in Science
The Greenlining Institute

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9. Centers for Disease Control (CDC) MMWR, May 23, 1997, Vol. 46, Number 20:433-440.

If you have any questions, please contact Jeannette Noltenius, Latino Council on Alcohol and Tobacco at (202)371-1186 and/or any of the above organizations directly.

February 20, 1998

Dear Member of Congress:

The undersigned leaders of Hispanic community groups, working on a daily basis with all of our nation's youth, urge you to enact comprehensive tobacco legislation **only if it does not grant the tobacco industry special legal protections such as immunity from liability or limiting document disclosure.**

As recent document disclosures have shown, we do not know the whole story of tobacco marketing and must not limit the courts ability to demand such documents. Furthermore, no industry which has used deceptive marketing practices and harmed the health of American consumers has ever been granted immunity from liability. This is not a precedent that should be set by this Congress.

The focus of any tobacco industry legislation should be the protection of the well-being of the American public and future generations. To meet this goal, tobacco industry legislation must include the following core principles:

- **full and unencumbered FDA authority** to regulate nicotine, other constituents of tobacco products, and marketing and promotion of those products;
- **Hispanic youth smoking cessation and tobacco control goals** as well as goals that are specific to other communities targeted by tobacco promotion;
- **international marketing language** that requires all tobacco companies doing business in the U.S. to apply all marketing, advertising, promotion, and nicotine content regulations used in the U.S. to their other markets; and
- **tobacco control and cessation program funding that does not replace current tobacco industry funding** of civic and community organizations.

We look forward to your support of these core principles and will be reporting on them to the communities we represent.

Sincerely,

Jane L. Delgado, Ph.D.
President and CEO
National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)

Rene F. Rodriguez, M.D.
President
InterAmerican College of Physicians and Surgeons (ICPC)

Antonia Villarruel, Ph.D., F.A.A.N.
President
National Association of Hispanic Nurses (NAHN)

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Maria Gomez
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STATEMENT OF THE INDIAN HEALTH SERVICE ON THE TRIBAL PROVISIONS CONTAINED IN PROPOSED TOBACCO LEGISLATION

BEFORE

THE SENATE INDIAN AFFAIRS COMMITTEE

Good Morning: Mr. Chairman and Members of the Committee:

I am Dr. W. Craig Vanderwagen, Director, Division of Clinical and Preventive Services, Indian Health Service (IHS). The IHS is an agency of the Public Health Service (PHS) within the Department of Health and Human Services. The IHS is responsible for providing health services to members of Federally recognized American Indian and Alaska Native (AI/AN) tribes and also has limited authority and funding to provide services to urban populations of American Indians and Alaska Natives. The provision of these services is based on a special relationship between Indian Tribes and the U.S. Government and is defined by Constitutional provisions, executive orders, treaties, and a broad range of laws and judicial decisions.

IHS MISSION

The IHS goal is to raise the health status of AI/ANs to the highest possible level. The mission is to provide a comprehensive health services delivery system for AI/ANs with opportunity for maximum Tribal involvement in developing and managing programs to meet their health needs. I am pleased to be here today to further discuss the issue of tobacco related health concerns since there are significant impacts of tobacco abuse among the people we serve. We commend the Committee leadership's commitment to address the many issues related to tobacco usage among American Indians and Alaska Natives. As the primary agency responsible for the provision of health care to Indian people, we are particularly appreciative of your interest in making certain that Indian tribes are considered in any benefits that result from legislation related to the regulation of the tobacco industry.

PREVELANCE OF TOBACCO USE

Studies conducted by the IHS reveal that tobacco use is a common health risk factor. A study Studies by the staff of the IHS Cancer Prevention and Treatment Program revealed that 10% of all deaths in AI/ ANs are related to cigarette smoking or use of other tobacco products. This translates to well over $200 Million in health expenditures by IHS to provide care for tobacco related illness. But, the frequency of tobacco related disease has great geographic variability.

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 populations served by IHS were studied to assess regional differences in use and abuse of tobacco products.

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.

Variability of tobacco use by different regions was also documented in the IHS Oral health Monitoring System in 1991. In this survey, each AI/AN patient who was provided care in the IHS dental clinic (above age 5) was asked if he or she used any form of tobacco products routinely (other than for culturally/religiously determined events). The findings revealed a great deal of age and geographic variability. For example, 9% of 5-19 year Olds reported tobacco use, but 39% of 20-34 year Olds admitted routine use. Geographic variability was also extreme with Albuquerque, Phoenix, and Navajo reporting tobacco use in less than 30% of the adult population. By contrast,

Aberdeen, Alaska, Billings, and Bemidji reported in excess of 50% of adults routinely using tobacco.

The IHS has also analyzed the use of smokeless tobacco. These studies revealed that use of smokeless tobacco products has regional variability that mirrors the smoking trends. More distressing is the finding that young people from age 15-24 are using these products in significant numbers. There appears to be an especially high frequency of use among American Indians who participate in rodeos. This association with rodeo activities is currently being studied by an American Indian medical student who has received a grant to analyze the marketing of smokeless tobacco products to rodeo participants and American Indian participants in particular.

The significance of these findings is reflected in the diseases associated with tobacco abuse. 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 the still the leading cause of cancer mortality for the years 1989-1993. In Alaska, lung cancer is the leading cause of cancer related deaths among women in contrast with the rest of the IHS service population where reproductive cancers are the challenge in cancer prevention and treatment. Chronic obstructive pulmonary disease (COPD) also is a significant health problem in those regions where smoking is prevalent.

Current Activities to Treat and Prevent Tobacco Abuse

The IHS has undertaken a number of activities to treat patients with active addiction to tobacco products. This has included modifying materials from the American Cancer Society and the American Lung Association to make them more culturally relevant. These materials are being used by primary providers and also by Community Health Representatives to provide smoking cessation training and support. The success rate of cessation programs in Ai/AN communities does not appear to be different than rate in the general U.S. population.

Primary prevention efforts have been the major emphasis of the IHS and tribal organizations. The Northwest Portland Indian Health Board for example has developed a model Clean Indoor Air Policy which it is disseminating to tribal governments. The IHS has developed model policies for reducing youth access to tobacco products. Our agency is distributing this information for use by tribal governments in developing approaches to limiting youth access. Other materials have been developed by tribes and IHS to promote and support drug free rodeos, powwows, and other cultural events.

Lastly, State governments and state based organizations have increasingly included American Indian and Alaska Native tribes and organizations in their tobacco related activities. The Alaska Native Health Board working with others in the State of Alaska were able to promote a tax increase on tobacco products which has provided additional funds for educational efforts in the State. California and Arizona have also been states where program initiatives have been developed to specifically include American Indian concerns and populations.

In summary, tobacco use is a significant health issue in American Indian and Alaska Native communities. American Indians and Alaska Natives have the highest smoking rate of any racial sub-population. The IHS and its tribal and urban partners have committed themselves to treatment and prevention aimed at reducing the health impact. The principles articulated by Secretary Shalala in her recent testimony on the tobacco settlement are applicable to the needs of the population we serve. We will work under her direction and in consultation with our partners to continue to address these health needs.

Mr. Chairman, this conclude my prepared statement. I will be happy to answer any questions that you may have.

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For Immediate Release
February 23rd, 1998

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The American Association of Physicians of Indian Origin (AAPI) Supports Tobacco Control Legislation that Recognizes the Specific Concerns of Minority Populations

The American Association of Physicians of Indian Origin (AAPI) supports the call for a comprehensive approach to tobacco control legislation. Such an approach must be sustainable, effective, comprehensive and well-funded in order to take advantage of this unique and historic opportunity to protect children and save lives both in the US and abroad for years and years to come.

In order to be truly sustainable, truly effective and truly comprehensive, any such legislation must be culturally sensitive and language appropriate. Minority populations represent 25% of the nation's population. Comprehensive tobacco control legislation must address the needs of minorities and include specific language so that all populations benefit from these efforts.

Additionally, in order to protect communities with a high percentage of recent immigrants, comprehensive tobacco control legislation must include an international strategy as well. The US Trade Representative, Department of Commerce, US Embassies and other federal agencies should not interfere in efforts by foreign governments to curb tobacco use. Funding should also be provided for international education and prevention programs that are culturally sensitive and language appropriate.

Given that two-thirds of the Asian Pacific Islander American population are immigrants, international tobacco control must be a critical component of any comprehensive legislation. For example, in terms of the number of cigarettes smoked per day, per daily smoker, India has one of the highest if not the highest smoking rates in the world. Unfortunately, there is very little data to document smoking rates among APIA's here in the United States on the local, state or national levels. The data that does exist often masks the problem of tobacco use among specific groups because it aggregates all Asian Pacific Islander Americans into one category. **This problem specifically affects Indian Americans, as well as other Asian Pacific Islander Americans, Latinos, African Americans, and Native Americans.**

We are proud to be working with mainstream and minority public health groups in a united front in order to improve public health for everyone.

# # #

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MEMORANDUM

Date: February 10, 1998

To: Affiliate Presidents, Section Chairpersons, Caucuses, SPIGs

From: Richard Levinson, MD, MPH
Associate Executive Director, Programs and Policy

Subject: **Notification of APHA Affiliates on Tobacco Issues**

This letter serves to update you on the status of APHA's tobacco-related activities.

APHA is focused on working with Democratic and Republican Congressional staff to develop comprehensive tobacco control legislation that effectively addresses the nation's public health needs. Our approach to this issue is guided by the two resolutions on tobacco issues passed by the Governing Council during our 1997 Annual Meeting.

The goals of our tobacco control efforts are the following: (1) preventing the initiation of tobacco use by adolescents; (2) helping those who use tobacco products to stop; and (3) supporting the building of public health infrastructure at the state and local levels so as to better combat the uses of tobacco.

We are also devoting extensive efforts to develop a national tobacco control policy based on the following principles:

- Significant increases in the excise tax on tobacco products;
- Restrictions on advertising of tobacco products targeted at children and adolescents;
- Full FDA authority to regulate tobacco and tobacco products coupled with a guarantee of adequate funding the tobacco control programs of FDA, CDC, and NIH;
- Full disclosure of tobacco industry documents;
- No preemption of state or local laws or regulations;
- international tobacco control efforts;
- No special legal protections for the tobacco industry; and
- Provision of economic assistance to tobacco growers as the tobacco industry is downsized.

Should you have any questions about APHA's position on tobacco, or on our tobacco-related advocacy efforts, please contact Dr. Richard Levinson, Associate Executive Director for Programs and Policy at (202) 789-5651, or Mary Wallace, Director of Government Relations and Affiliate Affairs, at (202) 789-5648.

We look forward to working with you on this and other public health issues during the coming year.

The Washington Post

THURSDAY, SEPTEMBER 11, 1997

Mohammad Akhter

Expanding a Deadly Export Business

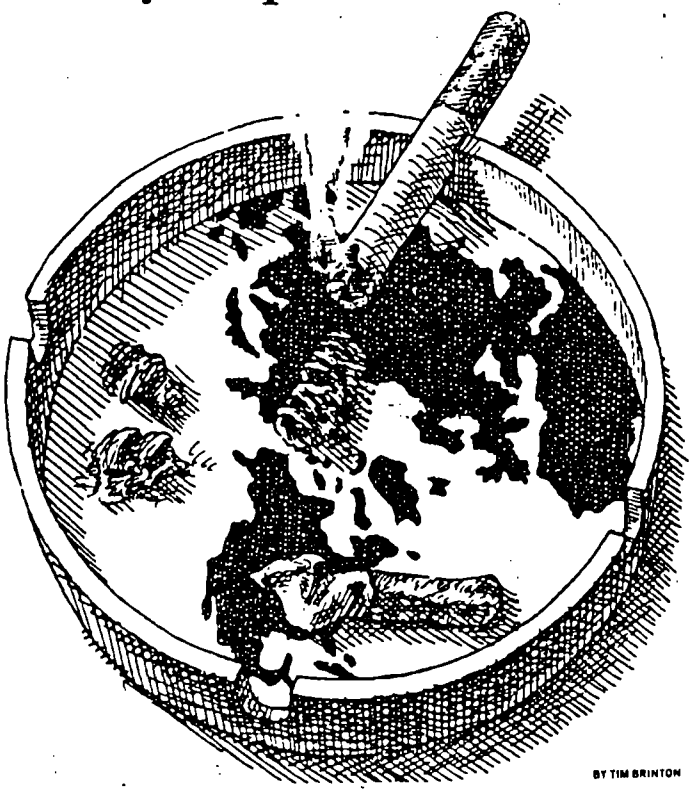
At the World Health Assembly last year in Geneva, something extraordinary happened. As the American delegate, I was prepared to hear the usual grumbling by the delegates from other countries about how the United States is not doing enough on this or that health initiative. But finally representatives from China, India, Russia and other countries had found a reason to sing America's praises: our get-tough stance on tobacco.

Unfortunately, I hear those compliments quickly turning into complaints, as President Clinton prepares to comment later this month on the proposed tobacco settlement, requiring tobacco companies to pay $368.5 billion over 25 years. So far neither side of Pennsylvania Avenue has been willing to confront the ugly reality that any agreement likely will be made at the expense of the rest of the world.

"If the settlement goes through, we have the potential to see children in the streets of Manila paying for Mississippi's Medicaid bills 10, 20 years later," said Greg Connolly, head of the Massachusetts public health department, at last month's World Tobacco Conference in Beijing.

U.S. tobacco companies have aggressively stepped up their overseas sales to make up for lost revenue at home. Last year, Philip Morris's international tobacco sales rose nearly 16 percent to more than $24 billion. Its major rival, R.J. Reynolds, increased its international sales by 12 percent to $3.6 billion. The tobacco giants now sell more cigarettes abroad than they do in the United States.

The health cost of these lethal exports is staggering. Every 10 seconds, someone in the world dies as a result of tobacco use. The World Health Organization estimates that cigarette smoking will kill 10 million people annually by 2025, accounting for almost 10 percent of the world's deaths. By that point, the annual smoking death toll will exceed that of AIDS, tuberculosis, automobile accidents, homicide and suicide combined.



BY TIM BRINTON

Developing countries will bear the brunt of any tobacco deal in the United States. While smoking rates have been relatively flat or slightly declining in much of the developed world, they are rising in developing countries. If this trend continues, adult smoking rates in developing countries will exceed those of developed countries shortly after the turn of the century.

China, which loses 700,000 people every year to smoking-related deaths, clearly illustrates the case. From 1985 to 1992, adult smoking rates in highly developed countries dropped by 13 percent. During this same time, smoking rates increased 20 percent in China. Unless this trend can be reversed, about 50 million Chinese youngsters who are alive today will die prematurely from smoking.

While somewhat smaller in magnitude, the smoking epidemic is as serious in other developing countries. Some 73 percent of men smoke in Vietnam. In Russia, 67 percent of men and 30 percent of women smoke. If smoking rates in Third World countries continue at the current pace, 70 percent of the world's smoking-related deaths in 2025 will be in developing countries.

The prime market for new customers in developing countries is women. Just as Virginia Slims ads once persuaded American women to take up the habit because they had "come a long way," U.S. tobacco marketers have been equally successful overseas in promoting smoking as a sign of women's independence. Even in Asian countries, where social traditions have kept smoking rates among women low, American marketing ingenuity is winning women over. Smoking rates for women have now surpassed 10 percent in many Asian countries where smoking among women was unheard of 20 years ago.

America alone cannot stop this worldwide epidemic. Health officials in other countries must act aggressively to enforce some of the same smoking restrictions that exist in the United States. Governments in some nations, including Spain and Italy, must divest themselves of the tobacco companies they control. Too often in countries where the government has a financial stake in tobacco, health ministers are muzzled. Japan's government owns two-thirds of Japan Tobacco, a former monopoly that still controls 80 percent of the market.

But the United States must do its part. We should join forces with other economic powers and the major tobacco-producing countries to discuss global tobacco-control measures. Tobacco companies should be required to meet the same manufacturing standards for sale both in the United States and abroad. Funds from any tobacco settlement should be used to educate people worldwide about the hazards of smoking, and to help developing countries create the kind of smoke-free environments that U.S. citizens now take for granted.

The writer, a physician, is executive director of the American Public Health Association. He serves on the president's Advisory Committee on Tobacco Policy and Public Health.