Congressman

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Minority Journalist

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FROM:

___ *Congressman Bennie G. Thompson*

___ *Tammy Boyd* ___ *Todd Gee* ___ *Edward Jackson*

___ *Minnie Langham* ___ *Marsha McCraven* ___ *La Tario Powell*

___ *Walter Vinson* ___ _____

Pages, Including This Cover Page Total: 28

COMMENTS:

Minority caucuses' tobacco bill to be introduced tomorrow.

CONFIDENTIALITY NOTICE:

Congress of the United States

Washington, DC 20515

June 23, 1998

BECOME AN ORIGINAL CO-SPONSOR OF MINORITY CAUCUSES' TOBACCO LEGISLATION

Dear Colleague:

Members of the Congressional Black Caucus, the Congressional Hispanic Caucus, the Congressional Asian Pacific Caucus, and the Congressional Native American Caucus will be introducing legislation this week which outlines the provisions any national tobacco legislation must include in order to properly address the disproportionate effects of tobacco use on the minority community.

Numerous studies, including the Surgeon General's report entitled "Tobacco Use Among U.S. Racial/Ethnic Minority Groups" released in May, have found that Native Americans and African Americans have the highest smoking rates of any ethnic group, Hispanic youth have smoking rates which have almost overtaken white youth, and many Asian American/Pacific Islander subpopulations display frighteningly high rates of tobacco use. According to a report released last month by the Centers for Disease Control, these trends continue to worsen as past-month smoking increased among African American high school students by 80 percent and among Hispanic high school students by 34 percent from 1991 through 1997. Minority populations have also consistently display the highest rates of tobacco-related diseases, particularly lung cancer.

Tobacco's devastation of the minority community has been a direct result of the tobacco industry's targeting of minority populations. One 1978 Lorrilard Research Study, for example, stated that "the success of Newport has been fantastic during the past few years. Our profile taken locally shows this brand being purchased by black people (all ages), young adults (usually college age), but the base of our business is the high school student."

While the legislation the Members of the minority caucuses will introduce is a stand-alone bill, its provisions are designed to be included in more comprehensive national tobacco legislation such as the Hansen/Meehan "Bipartisan NO Tobacco for Kids Act of 1998." The bill will include provisions to provide the Office of Minority Health with the authority to design a comprehensive minority anti-tobacco plan in order to ensure any tobacco-related federal programs funded by national tobacco legislation will reduce tobacco use among both minority youth and adults. The bill will ensure the Office of Minority Health has a role in approving state block grant applications if national tobacco legislation includes substantial block grants to the states for cessation, prevention, and education programs. State Block Grant funds can also be used for establishing or improving state offices of minority health at the state's discretion. Finally, the bill will require any national tobacco legislation to include $1 billion over ten years for conducting biomedical, children's health, and tobacco-related research at minority education institutions across the nation.

Despite the Senate's defeat of the legislation introduced by Senator John McCain, Congress must continue its work towards enacting comprehensive national tobacco legislation which President Clinton will be willing to sign. The bill to be introduced by Members of the minority caucuses this week offers substantial policy initiatives that any genuinely comprehensive national tobacco legislation must

include. Without these provisions, it will be impossible to guarantee reductions in youth smoking among all sectors of the American population. Moreover, the substantial increase in tobacco prices mandated in many bills introduced in Congress to date could serve as a regressive tax on low-income minorities if national tobacco legislation does not include efforts to reduce tobacco use among both youth and adult smokers.

We encourage you to send a signal to Congress that the needs of the minority community must be properly addressed in any national tobacco legislation by supporting this legislation. If you would like to become an original co-sponsor of this bill, please have your staff contact Todd Gee in Representative Bennie Thompson's office at 5-5876 or "tgee@mail.house.gov".

Sincerely,

Representative Patsy Mink
Chairwoman of the Congressional Asian Pacific Caucus

Representative Bennie G. Thompson
Chairman of the Congressional Black Caucus Tobacco Working Group

Representative Robert Underwood
Chairman of the Congressional Hispanic Caucus Health Task Force

Representative Dale Kildee
Co-Chair of the Congressional Native American Caucus

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HLC

DISCUSSION DRAFT

JUNE 23, 1998

12:45 p.m.

105TH CONGRESS
2D SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. UNDERWOOD (for himself and Mr. THOMPSON) introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Public Health Service Act to establish authorities of the departmental Office of Minority Health with respect to tobacco products, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "*[.....]".

SEC. 2. FINDINGS.

The Congress finds as follows with respect to cigarettes and other tobacco products:

(1) Smoking rates among African American and Hispanics teenagers rose dramatically from 1991 to 1997. During those years, smoking rates among African American high school students increased by a startling 80 percent, and smoking rates among Hispanic high school students increased by 34 percent.

(2) Smoking increases the rate of infant mortality and low birthweight births, with the risk of low birthweight infants almost twice as high for smokers than for nonsmokers. Among smokers, the rate of sudden infant death syndrome is particularly high for Hispanics, African Americans, and Asians.

(3) The most recent data shows disturbing trends among Asian American and American Indian/Alaska Native youth. From 1990 to 1995, smoking increased by 17 percent among Asian American 12th graders and by 26 percent among their American Indian and Alaska Native counterparts.

(4) Smoking is a major cause of death and disease among all racial and ethnic minority groups.

(5) Lung cancer is the leading cancer death for all such groups. The increase in youth smoking threatens to reverse progress made against lung cancer among these groups.

(6) The tobacco industry has targeted minority communities in carrying out advertising and promotion campaigns, posing serious challenges to reducing smoking in such communities.

(7) Antitobacco efforts should be undertaken at levels sufficient to ensure that rates of smoking are reduced among minority groups, both adults and youths. Without such efforts, significant increases in the retail price of tobacco products, which some proposals for national tobacco legislation have included, would constitute a regressive tax on racial and ethnic minority groups.

(8) Reductions among minority groups in the rate of smoking and in tobacco-related diseases should be facilitated by requiring that—

(A) the Office of Minority Health for the Department of Health and Human Services (established within the Public Health Service) to prepare, in collaboration with other officials in the Public Health Service, a comprehensive plan that concerns the use of tobacco products by

minority groups and is administered by agencies of the Service; and

(B) if programs are established under which the Secretary of Health and Human Services makes block grants to the States for carrying out public health activities regarding tobacco products, a portion of such grants be made available for directing such activities toward minority groups.

(9) In order to redress the past targeting of minority youth by the tobacco industry, financial support of educational institutions that serve significant numbers of minority youth should be increased.

(10) If national tobacco legislation restricts the ability of the tobacco industry to sponsor athletic, musical, artistic, or other social or cultural events or activities, the resulting reduction in funds could lead to the discontinuation of small, community-based events and activities, and could force small, community-based newspapers and other periodicals into bankruptcy. Any temporary transition assistance provided by national tobacco legislation to events, activities, and periodicals that have received sponsorship in the past from the tobacco industry must give special consideration to small, community-based

events, activities, and periodicals until new sponsors can be found.]

TITLE I—AUTHORITIES OF DEPARTMENTAL OFFICE OF MINORITY HEALTH WITH RESPECT TO TOBACCO PRODUCTS

SEC. 101. AUTHORITIES OF DEPARTMENTAL OFFICE OF MINORITY HEALTH.

(a) IN GENERAL.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.)) is amended by inserting after section 1707 the following new section:

"MINORITY HEALTH AND USE OF TOBACCO PRODUCTS

"SEC. 1707A. (a) IN GENERAL.—

"(1) INTERAGENCY COORDINATION OF MINORITY TOBACCO ACTIVITIES.—With respect to minority tobacco activities of the Public Health Service, the Secretary shall plan, coordinate, and evaluate all such activities that are conducted or supported by the agencies of the Service that are designated in subsection (b)(2), including activities relating to disease prevention, health promotion, service delivery, and research.

"(2) ALLOCATION FROM AMOUNTS UNDER NATIONAL TOBACCO LEGISLATION.—Of the amounts made available for a fiscal year to a designated

agency of the Service for carrying out public health activities regarding tobacco products (including amounts made available to the agency pursuant to national tobacco legislation), there shall be made available, for carrying out minority tobacco activities under paragraph (1) through the agency in accordance with the plan under subsection (c), not less than the percentage constituted by the ratio of—

"(A) the number of individuals in the United States who smoke or otherwise use tobacco products and are members of racial or ethnic minority groups, as determined by the Director of the Centers for Disease Control and Prevention; to

"(B) the total number of individuals in the United States who smoke or otherwise use such products, as so determined.

"(b) ADMINISTRATION THROUGH OFFICE OF MINORITY HEALTH.—

"(1) IN GENERAL.—The Secretary shall carry out this section, including with respect to functions under paragraph (3) and the plan under subsection (c), acting through the Deputy Assistant Secretary for Minority Health and in consultation with the advisory committee under subsection (e).

"(2) COLLABORATION WITH DESIGNATED AGENCIES OF PUBLIC HEALTH SERVICE.—The Secretary shall carry out this section, including with respect to functions under paragraph (3) and the plan under subsection (c), in collaboration with the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, the Director of the National Institutes of Health, and the Administrator of the Substance Abuse and Mental Health Services Administration (which agencies are collectively referred to in this section as the 'designated agencies').

"(3) COORDINATION.—In carrying out this section, the Secretary shall act as the primary Federal official with responsibility for overseeing all minority tobacco activities conducted or supported by the agencies referred to in paragraph (2), and—

"(A) shall serve to represent matters regarding minority tobacco activities at all relevant Executive branch task forces and committees; and

"(B) shall maintain communications with all relevant agencies of the Service and with various other departments of the Federal Gov-

ernment in order to ensure the timely transmission between such agencies of information concerning such activities, including advances in research, and to ensure the dissemination of information to affected communities and health care providers.

"(c) COMPREHENSIVE PLAN FOR MINORITY TOBACCO ACTIVITIES OF DESIGNATED AGENCIES.—

"(1) IN GENERAL.—Subject to the provisions of this subsection and other applicable law, the Secretary, in planning minority tobacco activities under subsection (a)(1), shall—

"(A) establish a comprehensive plan for the conduct and support of minority tobacco activities by the designated agencies of the Service (which plan shall be first established under this paragraph not later than ____ months after the effective date of this paragraph);

"(B) ensure that all amounts appropriated for the minority tobacco activities of such agencies are expended in accordance with the Plan;

"(C) review the Plan not less than annually, and revise the Plan as appropriate; and

"(D) ensure that the Plan serves as a broad, binding statement of policies regarding

the minority tobacco activities of such agencies, but does not remove the responsibility of the heads of the agencies for the approval of specific programs or projects, or for other details of the daily administration of such activities, in accordance with the Plan.

"(2) CERTAIN COMPONENTS OF PLAN.—The Plan shall provide for the conduct or support by the designated agencies of the Service of each category of minority tobacco activities (as applicable to the agency involved), as follows:

"(A) Assisting individuals in ceasing the use of tobacco products.

"(B) Providing education regarding the health risks associated with the use of tobacco products.

"(C) Making awards of grants or contracts for the provision of health services for conditions related to the use of tobacco products.

"(D) Providing for biomedical and behavioral research relating to such conditions.

"(3) USE OF CRITERIA IN REPORT OF SURGEON GENERAL.—The Secretary shall in developing the Plan, and the designated agencies of the Service shall in carrying out the Plan, follow the criteria

that are relevant to the activity involved and are presented in the report published in 1998 and entitled "Tobacco Use Among U.S. Racial and Ethnic Minority Groups---A Report of the Surgeon General" (relating to the Surgeon General of the Public Health Service), including criteria under the following topics in such report:

"(A) Patterns of tobacco use.

"(B) Health consequences of tobacco use.

"(C) Factors that influence tobacco use.

"(D) Tobacco control and education efforts.

"(4) CULTURAL CONTEXT OF ACTIVITIES.—The Secretary shall ensure that minority tobacco activities under the Plan are provided in contexts that are culturally and linguistically appropriate for the populations of individuals for whom the activities are intended.

"(5) COLLECTION OF DATA ON RATES AND HEALTH EFFECTS.—With respect to the rates of use of tobacco products among racial and ethnic minority groups, and the health effects in such groups of the use of such products, the Secretary shall ensure that the Plan requires that data on such rates and such effects be collected and evaluated through one

or more of the designated agencies of the Service, including data categorized in accordance with the following:

"(A) Race and ethnicity, including subgroups.

"(B) Gender.

"(C) Age, including a category for individuals under the age of 18.

"(d) AGENCY ACTIVITIES; GRANTS AND CONTRACTS.—

"(1) IN GENERAL.—Activities under subsection (a)(1) may be carried out—

"(A) directly by the Secretary and the designated agencies of the Service; and

"(B) through awards of grants, cooperative agreements, and contracts to public and nonprofit private entities.

"(2) SPECIAL CONSIDERATION REGARDING GRANTS AND CONTRACTS.—In making awards under paragraph (1)(B), the Secretary shall ensure that special consideration is given to the following entities:

"(A) Community-based organizations that principally serve individuals from disadvantaged backgrounds, including members of racial and

ethnic minority groups, and that have a history of carrying out minority tobacco activities (such as Hispanic-serving institutions, tribal colleges and universities, historically Black colleges and universities, and Native Hawaiian organizations) or that have the capacity to begin carrying out such activities.

"(B) Statewide and regional organizations that principally serve such individuals, and that have a history of carrying out minority tobacco activities or have the capacity to begin carrying out such activities.

"(C) Educational institutions that principally serve such individuals.

"(D) Federally qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act).

"(E) Indian tribes and tribal organizations.

"(e) ADVISORY COMMITTEE REGARDING MINORITY TOBACCO ACTIVITIES.—The Secretary shall ensure that there is in operation an advisory committee to advise the Secretary on carrying out this section, and that such committee is appointed from among individuals who are not officers or employees of the Federal Government and who

are experienced with respect to minority health concerns. The Secretary shall carry out the preceding sentence by appointing an advisory committee whose only responsibility is so advising the Secretary, except that such responsibility shall be assigned to an advisory committee whose function is generally advising the Office of Minority Health, if such an advisory committee is required by law.

"(f) EVALUATIONS.—Evaluations under subsection (a)(1) shall include evaluations of the extent to which minority tobacco activities under such subsection have been successful in facilitating a reduction in the consumption of tobacco products by racial and ethnic minority groups.

"(g) ANNUAL REPORTS.—Not later than February 1, 2000, and annually thereafter, the Secretary shall submit to the Congress a report that provides with respect to the preceding fiscal year the following:

"(1) A description of the programs carried out under subsection (a)(1).

"(2) The results of evaluations under such subsection (including evaluations required pursuant to subsection (f)).

"(3) The recipients of awards under paragraph (1)(B) of subsection (d), including a specification of the total amount awarded for each of the categories

of entities specified in subparagraphs (A) through (E) of paragraph (2) of such subsection.

"(h) REQUIREMENTS REGARDING BLOCK GRANTS FOR TOBACCO ACTIVITIES.—

"(1) ALLOCATIONS FOR MINORITY TOBACCO ACTIVITIES; INVOLVEMENT OF STATE OFFICE OF MINORITY HEALTH.—If from amounts received by the Federal Government pursuant to national tobacco legislation one or more programs are established under which the Secretary makes block grants to the States, and if the purposes of the program involved include one or more tobacco activities, then the Secretary may not make a grant under the program unless the State involved submits to the Secretary (in the application for the grant) agreements as follows:

"(A) Of the amounts provided in the grant, the State will make available, for directing such tobacco activities at members of racial and ethnic minority groups (subject to paragraph (2)), not less than the percentage constituted by the ratio of—

"(i) the number of individuals in the State who smoke or otherwise use tobacco products and are members of racial or ethnic minority groups, as determined by the

Director of the Centers for Disease Control and Prevention; to

"(ii) the total number of individuals in the States who smoke or otherwise use such products, as so determined.

"(B) If the State has established an office of minority health, the expenditure of the amounts made available pursuant to subparagraph (A) will be administered by such office, or by another office or agency of the State in collaboration with the office of minority health.

"(2) USE OF GRANTS TO ESTABLISH AND OPERATE STATE OFFICES OF MINORITY HEALTH.—

"(A) IN GENERAL.—With respect to a program of block grants to which paragraph (1) applies, a State may, from the portion of the grant made available pursuant to subparagraph (A) of such paragraph, expend amounts to establish or operate (or both, as applicable) an office of minority health, subject to subparagraph (B).

"(B) MAINTENANCE OF EFFORT REGARDING EXISTING OFFICES.—If as of the effective date of this section a State has established an office of minority health, the authority in sub-

paragraph (A) to expend amounts for the operation of such office is subject to the condition that the State submit to the Secretary (in the application referred to in paragraph (1)) an agreement that the State will maintain expenditures of non-Federal amounts for such office at a level that is not less than the level of such expenditures maintained by the State for the office for the fiscal year preceding the fiscal year for which the State is applying to receive a grant under the program involved.

"(3) APPLICABILITY OF CERTAIN PROVISIONS.—With respect to the administration of this subsection, subsections (a) through (g) do not apply to this subsection. The Secretary of Health and Human Services may carry out this subsection acting through such offices or agencies of the Public Health Service as the Secretary determines to be appropriate.

"(i) DEFINITIONS.—

"(1) MINORITY TOBACCO ACTIVITIES.—For purposes of this section:

"(A) The term 'minority tobacco activities' means tobacco activities that are directed to-

ward members of racial and ethnic minority groups.

"(B) The term 'tobacco activities' means each of the following activities:

"(i) Assisting individuals in ceasing the use of tobacco products.

"(ii) Providing education regarding the health risks associated with the use of tobacco products.

"(iii) Providing health services for conditions related to the use of tobacco products.

"(iv) Providing for biomedical and behavioral research relating to such conditions.

"(2) OTHER TERMS.—For purposes of this section:

"(A) The term 'designated agencies', with respect to the agencies of the Public Health Service, has the meaning indicated for such term in subsection (b)(2).

"(B) The terms 'Indian tribe' and 'tribal organization' have the same meaning given such terms in section 4(b) and section 4(c) of the In-

dian Self-Determination and Education Assistance Act.

"(C)(i) The term 'racial and ethnic minority group' means each of American Indians (including Alaska Natives, Eskimos, and Aleuts); Asian Americans and Pacific Islanders; Blacks; Hispanics; and Native Hawaiians.

"(ii) The term 'Hispanics' means individuals whose origin is Mexican, Puerto Rican, Cuban, Central or South American, or any other Spanish-speaking country.

"(D) The term 'State' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, and American Samoa.".

TITLE II—ADDITIONAL AUTHORITIES

SEC. 201. FUNDS FROM NATIONAL TOBACCO LEGISLATION; ALLOCATION FOR GRANTS TO MINORITY MEDICAL SCHOOLS.

Part B of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.) is amended by adding at the end the following section:

"SEC. 741. GRANTS TO MINORITY MEDICAL SCHOOLS FOR ENDOWMENTS; PUBLIC HEALTH PROGRAMS REGARDING TOBACCO PRODUCTS.

"(a) IN GENERAL.—From amounts reserved under subsection (c), the Secretary shall make grants to schools specified in subsection (b) for the purpose of establishing at the schools endowments each of whose income is used exclusively to carry out—

"(1) public health programs; and

"(2) programs of biomedical research on diseases for which the consumption of tobacco products is a principal causal factor.

"(b) RELEVANT SCHOOLS.—The schools referred to in subsection (a) are the following medical schools (schools of medicine or osteopathic medicine):

"(1) The four medical schools in the United States whose enrollment for academic year 1998 of Black individuals constituted a higher percentage of such individuals than other medical schools in the United States.

"(2) The four medical schools in the United States (or consortia of such schools) whose enrollment for academic year 1998 of Hispanic individuals constituted a higher percentage of such individuals than other medical schools in the United States.

"(3) The three medical schools in the United States (or consortia of such schools) whose enrollment for academic year 1998 of Asian American individuals and Pacific Islander individuals constituted a higher percentage of such individuals than other medical schools in the United States.

"(4) The two medical schools in the United States (or consortia of such schools) whose enrollment for academic year 1998 of Native American individuals constituted a higher percentage of such individuals than other medical schools in the United States.

"(c) FUNDING.—From amounts received by the Federal Government pursuant to national tobacco legislation, the Secretary shall, for each of the first 10 fiscal years following the date of the enactment of such legislation, reserve amounts for making a grant under subsection (a) to each of the schools specified in subsection (b). Each such grant shall be made in the amount of $5,000,000.".

SEC. 202. FUNDS FROM NATIONAL TOBACCO LEGISLATION; ALLOCATION FOR CHILD HEALTH AND OTHER BIOMEDICAL RESEARCH AND RELATED PROGRAMS.

(a) IN GENERAL.—From amounts reserved under subsection (e), the Secretary of Health and Human Serv-

ices (in this section referred to as the "Secretary") shall make grants to public and nonprofit private entities for research, training, and demonstrations regarding child health and human development and other biomedical research (including with respect to tobacco products), and for related programs.

(b) USE OF CRITERIA IN REPORT OF SURGEON GENERAL.—Programs under subsection (a) shall follow the criteria that are relevant to the activity involved and are presented in the report published in 1998 and entitled "Tobacco Use Among U.S. Racial and Ethnic Minority Groups---A Report of the Surgeon General" (relating to the Surgeon General of the Public Health Service).

(c) FACILITATION OF RESEARCH PROGRAMS.—The Secretary shall under subsection (a) give priority to programs of education and training to prepare individuals to conduct the research described in such subsection and to programs for ensuring that health professions schools have the capacity to provide such education and training. The Secretary shall carry out the preceding sentence primarily through programs under title VII of the Public Health Service Act for individuals from disadvantaged backgrounds, including individuals who are members of racial and ethnic minority groups, and for schools that serve significant numbers of such individuals, including programs

regarding undergraduate education, graduate education, scholarships, fellowships, loan repayments, faculty-related activities, curriculum development, and improving research facilities.

(d) DEFINITION.—For purposes of this section, the term "health professions schools" means all schools and programs described in section 799 of the Public Health Service Act.

(e) FUNDING.—From amounts received by the Federal Government pursuant to national tobacco legislation, the Secretary shall, for each of the first 10 fiscal years following the date of the enactment of such legislation, reserve $50,000,000 for carrying out this section. Of the amounts so reserved for a fiscal year, the Secretary shall reserve 55 percent for programs referred to in subsection (c) with respect to undergraduates, and 35 percent for programs referred to in such subsection with respect to health professions schools and graduate students at such schools.

SEC. 203. PREVENTION ACTIVITIES OF COMMUNITY, MIGRANT, AND HOMELESS HEALTH CENTERS.

(a) PROGRAM.—From amounts reserved under subsection (b), the Secretary of Health and Human Services shall in accordance with such subsection make available amounts to community, migrant, and homeless health cen-

ters receiving grants under section 330 of the Public Health Service Act. The purpose of such amounts is to assist such health centers in providing health services for diseases related to tobacco and in preventing tobacco-related diseases.

(b) FUNDING.—

(1) IN GENERAL.—From amounts received by the Federal Government pursuant to national tobacco legislation, the Secretary shall, for each of the first 10 fiscal years following the date of the enactment of such legislation, reserve $300,000,000 for carrying out subsection (a), except as provided in paragraph (2).

(2) LIMITATION.—No amount may be reserved under paragraph (1) for any fiscal year for which the amount appropriated for such year for community, migrant, and homeless health centers under section 330 of the Public Health Service Act is less than the amount appropriated for such health centers for the previous fiscal year.

SEC. 204. TRANSITION ASSISTANCE REGARDING EFFECTS OF RESTRICTIONS ON ADVERTISING AND PROMOTION OF TOBACCO PRODUCTS.

(a) APPLICABILITY.—This section applies if—

(1) national tobacco legislation significantly restricts the authority or capacity of tobacco manufacturers or distributors to advertise or promote tobacco products; and

(2) the Secretary of Health and Human Services (in this section referred to as the "Secretary") carries out a program of awarding grants or contracts to public or private entities for the purpose of offsetting the adverse financial effects that such entities may experience as a result of the loss of revenues associated with the advertising or promotion of tobacco products.

(b) GRANTS TO CERTAIN ENTITIES.—

(1) IN GENERAL.—With respect to entities that are eligible for grants referred to in subsection (a)(2), the Secretary shall include among such entities public or private entities that, before the date of the enactment of this Act, had—

(A) a history of holding or carrying out one or more athletic, musical, artistic, or other social or cultural events or activities that were sponsored in whole or in part by a tobacco manufacturer or distributor;

(B) a history of participating, with financial support provided by a tobacco manufac-

turer or distributor, in an athletic, musical, artistic, or other social or cultural event or activity; or

(C) a history of publishing one or more periodicals for which the publication of advertisements or promotions for tobacco products has been a significant source of revenue.

(2) SPECIAL CONSIDERATION FOR CERTAIN ENTITIES.—In making awards under paragraph (1), the Secretary shall give special consideration to small, community-based events, activities, and periodicals, including—

(A) events and activities held or significantly sponsored by, and periodicals published by, businesses in which the predominant ownership interests are held by individuals who are from disadvantaged background, including members of racial or ethnic minority groups;

(B) events and activities held in communities in which a substantial number of such individuals reside; and

(C) periodicals whose circulation is primarily among such individuals.

(3) USE OF ASSISTANCE FOR EVENT, ACTIVITY, OR PERIODICAL INVOLVED; CONDITION REGARDING

APIAHF

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Asian & Pacific Islander American
Health Forum

National Advocates for Asian & Pacific Islander Health

May 1, 1998

Bruce Reed
Domestic Policy Council,
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mr. Reed :

The White House and Congress have an historic opportunity to protect the health of this nation by enacting comprehensive tobacco control legislation that would change the aggressive practices of the tobacco industry both domestically and internationally. Last year's "global statement" fell far short of achieving comprehensive tobacco control policy. However, it did mobilize the Asian American and Pacific Islander (AAPI) communities to unite in addressing the requirements to provide effective tobacco control programs locally, statewide, and nationally for AAPI communities. This "Asian American and Pacific Islander Blue Print for Tobacco Control Guidelines and Recommendations" provides an overview of what is currently necessary for comprehensive tobacco control policy for AAPIs. The authors of this Blue Print include the Asian & Pacific Islander American Health Forum (APIAHF), the Association of Asian Pacific Community Health Organizations (AAPCHO), and the Vietnamese Community Health Promotions Project.

Research studies have shown that the tobacco industry has selectively targeted communities of color domestically and abroad. We urge you to take a leadership role and seriously consider addressing our recommendations as your commitment to promote global public health by crafting genuine and concrete measures for comprehensive tobacco control legislation.

To provide a comprehensive picture of tobacco control legislation needs that would be responsive to AAPIs and those of other communities of color, we have enclosed for your review the following documents:

- Asian American and Pacific Islander Blue Print for Tobacco Control Guidelines and Recommendations with 75 signatories
- Multicultural Organizations Mobilize to Demand Congressional Action on Comprehensive Tobacco Control Legislation

We, the undersigned, are in agreement with the attached "Asian American and Pacific Islander Blue Print for Tobacco Control Guidelines and Recommendations." Our recommendations for comprehensive tobacco control policy targeted towards Asian American and Pacific Islanders include the following:

APIAHF
Asian & Pacific Islander American Health Forum

- Research and data collection by ethnic subgroup;
- Culturally and linguistically accessible prevention and cessation programs;
- Establishment of environmental tobacco smoke protection campaigns;
- Culturally and linguistically accessible media-based counter tobacco advertising campaigns;
- Reduction of tobacco access and use by youth;
- International tobacco control policy and standards.

In addition, the following summarizes the AAPI position on other key public health provisions of proposed tobacco legislation.

- Opposition to granting immunity from past, present, or future misdeeds (i.e., exclusion of any limitation on the industry's liability such as annual caps on damages, immunity from punitive damages, and a ban on class-action lawsuits);
- Full authority for FDA regulation of all tobacco products;
- Immediate excise tax in the range of $1.50 - $2.00 per cigarette pack to deter smoking by children and adolescents;
- Ban advertising and promotion of tobacco products that entice children, youth, and adults domestically and internationally;
- Design substantial penalties for underage use based on assessments of youth reduction rates;
- Protect state and local governments from federal preemption clauses; and
- Compensate tobacco farmers adequately for loss of sales and assist them in development of alternative crops or other job training opportunities.

As national advocates for public health, we urge you to enact tobacco control legislation that addresses the above recommendations.

Sincerely,

Tessie Guillermo
Executive Director
Asian & Pacific Islander American Health Forum

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Asian American and Pacific Islander Tobacco Control Blue Print for the New Millennium Executive Summary

Introduction

In collaboration with a wide community of health scientists, Asian American and Pacific Islander (AAPI) community-based organizations, and tobacco advocates for AAPI's, this blue print was developed to highlight the specific health and social service needs of AAPIs. Specifically, this document outlines the essential requirements for effective health research and data, promotion and disease prevention programs, restrictions on tobacco advertising and promotions, and international tobacco control for AAPIs.

According to the U.S. Census Bureau, AAPIs are the fastest growing ethnic/racial group in the United States, comprising approximately 4 percent of the total U.S. population. Currently, there are over 10 million AAPIs in the U.S. and in its associated Pacific Island jurisdictions.

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. According to the Census, approximately 40% of AAPIs are limited English proficient. As a reflection of this diversity, the limited English proficiency ranges from 3% among Hawaiians to 76% among Hmong.

Although AAPI populations are growing rapidly, adequate data on health status are not available and no data system has been developed to monitor systematically the health status of AAPI populations. Despite their heterogeneity in this country, AAPIs are still often viewed inaccurately as a homogeneous "model" minority with few health or social issues. Based on the limited API health data available, disparities in health status are revealed.

- Most common types of cancer deaths are lung and bronchus cancers in the following AAPI ethnic groups: Chinese, Filipino, Hawaiian, and Japanese according to National Cancer Institute.
- Prevalence of tobacco use is significantly high in AAPI ethnic groups especially among males (e.g., 72% Laotian, 71% Cambodian, 42% Native Hawaiian, 53% Chuukese (FSM)).

As a priority, AAPI communities need to access culturally competent services which provide care from a multicultural viewpoint addressing the patient's perspectives and integrating the patient's beliefs, practices, and attitudes into preventive interventions for effective smoking cessation and abstinence.

This blue print forms the basis for shaping tobacco control legislation that will ultimately improve the health status of AAPI communities through identification of the major risk factors to tobacco-related mortality and morbidity among AAPI communities, effective health intervention programs, and constant protection against the adverse influences of tobacco advertisements and promotion.

I. Research and Data

There is very little data to document the smoking prevalence locally, statewide, and nationally on AAPIs. The data that exist often masks the problem of tobacco because the data is aggregated for all AAPI groups and data collection is conducted in English. It is critical to increase and improve the collection, analysis and dissemination of health data about AAPI populations and sub-populations.

Therefore we recommend support to increase and improve the collection, analysis, and dissemination of tobacco risk related data about AAPI populations and subpopulations to:

- determine baseline data and monitoring on tobacco use prevalence by ethnicity at various regions using appropriate AAPI languages.
- determine impact of tobacco use on smokers and their families.
- evaluate and improve existing tobacco prevention and cessation programs for AAPIs.

II. Programs: Prevention and Cessation

Despite the high rate of tobacco use prevalence in certain AAPI communities and effective targeting by the tobacco industry, intervention programs across the U.S. & Pacific Islands addressing the specific needs of all AAPI subgroups are lacking. However, there are models of effective intervention programs implemented by local community-based organizations. Given the relevance of community based interventions, we recommend to expand the model programs to other regions where no programs exist. With an overall goal of reducing the burden of disease and death due to tobacco use and exposure among AAPIs particularly among high risk groups, we recommend the following:

- Develop local programs across the U.S. and Pacific Islands with a focus on the top 15 states and six Pacific Islander jurisdictions with highest number of AAPIs.
- Develop a national center for providing comprehensive technical assistance, training and resources for organizations and communities that will conduct individual tobacco control programs in the AAPI population.
- Expand and develop linguistically and culturally competent prevention, cessation and environmental tobacco control programs.
- Increase the accessibility to youth and adult cessation programs for all.
- Develop outreach/education plans to obtain compliance of owners of small business regarding youth access to tobacco and environmental tobacco smoke.

III. Advertising and Promotions

The tobacco industry has been promoting tobacco among minority populations including the AAPI population through ethnic media, sponsorship of community organizations and activities, and advertisements in AAPI neighborhoods. It is critical to reduce and counter pro-tobacco influences in the AAPI community.

- Ban all forms of tobacco advertising (e.g., European Union health ministers agree to ban a majority of tobacco advertising by Year: 2006).
- Ban on all forms of tobacco industry sponsorship and promotion.
- Expand an AAPI anti-tobacco, multi-media campaign that is culturally sensitive and linguistically appropriate.
- Require health warning labels to be translated into culturally appropriate messages in different AAPI languages for all tobacco products, merchandise, and advertisements.
- Outreach and educate AAPI organizations & merchants about tobacco sponsorship and funding that attempts to alter attitudes towards the tobacco industry.

IV. Youth

Given that most smokers initiate their addiction during adolescence, it is critical to reduce prevalence of tobacco use among the AAPI youth population. Despite being illegal for anyone under 18 to purchase cigarettes, over 90% of U.S. smokers started before the age of 20. In order to reduce tobacco use among AAPI youth, comprehensive restrictions on tobacco advertising and promotion need to be enacted. Similarly, significant funding needs to be allocated to develop and implement specific intervention and cessation programs targeted for youth. Therefore, we recommend:

- Ban all tobacco marketing, advertising, and media targeting youth.
- Expand existing cultural, linguistic, and age-appropriate tobacco prevention and cessation programs for high risk and underserved youth.
- Develop programs for AAPI youth population that lack tobacco control programs.
- Impose severe penalties on the tobacco industry for failing to reduce tobacco use among youth.

V. International Tobacco Control Activity

Given that two-thirds of AAPI population are immigrants, international tobacco control is critical to tobacco control in the U.S. Double-targeting of AAPIs in the Pacific Rim has resulted in high U. S. brand utilization (four out of the top brands being smoked are from the U.S.) in the Asian-Pacific Region. Any tobacco control legislation should require U.S. tobacco industry policies/operations to adhere to the same restrictions domestically as those in Asia and the Pacific Islands.

- Require standards for tobacco products, advertising and promotion practices, and manufacturing to meet U.S. restrictions.
- Develop tobacco education materials where Asians emigrate from their country to the U.S. including health risks to tobacco consumption and exposure and tobacco restriction to youth access.
- Support the development of an International Framework Convention for tobacco control under the auspices of the World Health Organization.

Asian American and Pacific Islander Blue Print for Tobacco Control Signatories 1998

National

American Association of Physicians of Indian Origin, Washington, DC
Asian Pacific Environmental Network, Oakland, CA
Asian & Pacific Islander American Health Forum, SF, CA
Association of Asian Pacific Community Health Organizations, Oakland, CA
Chinese American Citizens Alliance, SF, CA
Federation of Chinese American & Chinese Canadian Medical Societies, SF, CA
Filipino Civil Rights Advocates, Washington, DC
Intercultural Cancer Council, Houston, TX
National Asian Pacific American Families Against Substance Abuse, LA, CA

State

American Cancer Societies, Hawai'i-Pacific Division, Honolulu, HI
Coalition For A Tobacco Free Hawai'i, Honolulu, HI
Economic and Employment Development Center, LA, CA
Hawai'i Medical Association, Honolulu, HI
Hawai'i Public Health Association, Honolulu, HI
Micronesia Human Resource Development Center, Micronesia
Office of Senator Lou Leon Guerrero, Agana, Guam
University of Guam, Mangilao, Guam
Vietnamese Minnesotans Association, St. Paul, MN
Washington Asian Pacific Islanders Families Against Substance Abuse, Seattle WA

Local

Alameda County Tobacco Control Program, Oakland, CA
Asian Advocacy Project of Catholic Charities, San Rafael, CA
Asian Americans For Community Involvement, SF, CA
Asian American Women's Advancement Coalition, Visalia, CA
Asian Americans For Community Involvement, San Jose, CA
Asian Community Mental Health Services, Oakland, CA
Asian Health Services, Oakland, CA
Asian Immigrant Women Advocates, Oakland, CA
Asian Law Alliance, San Jose, CA
Asian Pacific AIDS Intervention Team, LA, CA
Asian Pacific Health Care Venture, LA, CA
Asian Pacific Islander Coalition on HIV/AIDS, NY, NY
Asian Pacific Islander Wellness Center, SF, CA
Asian Pacific Islanders for Reproductive Health, Oakland, CA
Asian Youth Center, San Gabriel, CA
Bay Area Region Tobacco Education Resource, Richmond, CA
Cambodian Family Inc., Santa Ana, CA
Charterhouse Center Refugee Services, Stockton, CA
Chinatown Health Clinic, NY, NY
Chinatown Public Health Center, SF, CA
Chinatown Service Center, LA, CA
Chinese American Planning Council, NY, NY

Chinese Community Health Care, SF, CA
Chinese Progressive Association, SF, CA
Clinical Educational Organizational Services, Newton, MA
Family Health Project, Inc., NY, NY
Filipino American Service Group Inc., LA, CA
Filipino Task Force on AIDS, SF, CA
Gay Asian Pacific Alliance, SF, CA
Guam Communications Network, Santa Monica, CA
Hmong American Women Association, Fresno, CA
Hmong Youth Foundation, Inc., Fresno, CA
Indochinese Community Center, Washington, DC
Indochinese Youth Center, Gardena, CA
International Community Health Services, Seattle, WA
Khmer Health Advocates, Inc., Hartford, CT
Korean Health Education, Information & Referral Center, LA, CA
NICOS Chinese Health Coalition, SF, CA
Orange County Asian & Pacific Islander Community Alliance, Garden Grove, CA
People's CORE, LA, CA
Pilipino Bayanihan Resource Center, Daly City, CA
Rehabilitation Hospital of the Pacific, Honolulu, HI
Samoan Community Development Center, SF, CA
Search to Involve Pilipino Americans, LA, CA
Self-Help for the Elderly, SF, CA
Southeast Asian Council, Visalia, CA
Southern Coast Region, San Diego, CA
Special Services Groups / Tongan Community Service Center, Gardena, CA
Stone Soup Fresno, Fresno, CA
Sunset Park Family Health Center at Lutheran Medical Center, NY, NY
Union of Pan Asian Communities, San Diego, CA
Vietnamese American Health Care Association, Madison, WI
Vietnamese Community Health Promotion Project, SF, CA
Vietnamese Community Of Orange County, Santa Ana, CA
Vietnamese Evangelical Church Burnsville, Plymouth, MN
Vietnamese Tobacco Free Community Task Force, SF, CA

Asian American and Pacific Islander Blue Print for Tobacco Control
GUIDELINES AND RECOMMENDATIONS
April 16, 1998

Background

Developed in collaboration with health researchers, community-based organizations and public health advocates, this Blue Print for Tobacco Control highlights Asian American & Pacific Islander (AAPI) specific tobacco-related service needs and outlines the requirements for: effective health research and data, health promotion and disease prevention programs, restrictions on tobacco advertising and promotions, and international tobacco control.

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. Indicators of socioeconomic and health status show a bimodal distribution, where some are healthy and well educated while significant others are not.[1] In addition, 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 differences in immigration history to the U.S. For example, third-generation Chinese born in the U.S. may have little in common with recently arrived Hmong.

Despite the rapid growth and diversity 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 blue print. 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, Hawaiian, Japanese men and women, and Filipino men.[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.[6]
- 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 could cause heart disease.[7]
- Surveys conducted in California among the Vietnamese have shown male smoking rates ranging from 35% to 56%. In fact, API immigrant groups have smoking rates far higher than the California or national average for men.[8] Other studies have shown high rates among Korean males (33%), Laotian males (70%), Kampuchean males (71%), and Chinese-Vietnamese males (55%).[9]
- 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).[10]

The purpose of this blue print is to serve as a basis for comprehensive tobacco control policy 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 policymakers 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 36% Korean[11], 71% Cambodian[12], 34% Vietnamese[13], and 70% Laotian.[14]

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."[15] 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 Healthy 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 such as the National Health Interview Survey (NHIS), Behavioral Risk Factor Survey (BRFS), and the National Health and Nutrition Examination Surveys (NHANES), which are the basis for setting health priorities and research. Disaggregated data 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 funding for tobacco research on AAPIs to develop baseline and conduct tobacco use prevalence; fund the NHIS, BRFS, or NHANES to allow regular, measurement of smoking behaviors. Ensure that measurements are conducted using culturally and linguistically appropriate instruments and methods.

Objective 1.2: Conduct long-term outcome research studies among AAPIs to assess the morbidity and mortality rates resulting from tobacco consumption or exposure to environmental tobacco smoke.

Objective 1.3: Evaluate the effectiveness of existing tobacco interventions to improve

prevention services. There are 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 tobacco control intervention models and new linguistically appropriate survey instruments. Findings must be disseminated to the community.

Objective 1.5: Increase availability of training opportunities for underrepresented AAPIs to enter into health research and health policy fields to improve the policy and programs that address tobacco control.

II. PROGRAMS: PREVENTION AND CESSATION

GOAL 2: Reduce the prevalence of tobacco use and exposure to environmental tobacco smoke (ETS) among AAPIs focusing on high risk populations such as Southeast Asian communities.

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 key 15 states with significant AAPI populations and the 6 Pacific Island jurisdictions to address specific AAPI needs. We propose the development of 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 and training and adequate resources for organizations to conduct individual programs in AAPI communities. This new entity, 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 policy efforts.

In order to effectively reduce tobacco use in AAPI communities, tobacco control policy should prioritize public health prevention and cessation programs to decrease smoking and to facilitate the cessation of smoking particularly for high risk groups such as Southeast Asians and Pacific Islanders. Prevention programs should take into account the socioeconomic levels, gender, educational backgrounds, culture and language, and nativity of our AAPIs' nationalities, which are often overlooked in the design and implementation of interventions.

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 linguistically and culturally appropriate tobacco prevention programs for AAPIs and subgroups with a focus on the key 15 states with significant of AAPI populations and the 6 Pacific Island jurisdictions.
Objective 2.3: Increase the representation of AAPIs on advisory boards, strategic planning committees, and task forces to ensure that multi-cultural programs are designed and implemented.
Objective 2.4: Improve the capability of health care delivery systems to ensure the development of culturally and linguistically appropriate prevention programs through creation of a National AAPI Tobacco Control Center for the U.S. & Pacific Islands.

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 support systems such as extended families, elders, and indigenous healers in the development of cessation programs. Barriers to making tobacco cessation an integral part of health care include:

- lack of health insurance coverage for smoking cessation services;
- lack of systems for integrating cessation into routine care;
- lack of clinical practice guidelines that integrate cultural and linguistic needs for AAPI communities; and
- 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/social (e.g., gender roles, family structure) 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 others. 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 with work place smoking restrictions from owners of these establishments as well as health education campaigns to raise awareness of the hazards of ETS. 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 linguistically and culturally appropriate second-hand smoke campaign that emphasizes protection of families and individuals from ETS in homes, workplaces and federal facilities.

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., outdoor, print and electronic media), marketing and promotions. Last year, the European Union health ministers agreed to ban a majority of tobacco advertising by Year: 2006. Similarly, the United States must take forceful steps to eliminate the selective advertising and promotion of tobacco products to AAPI communities as well as other communities. Unless strict regulations are designed and enforced, 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 previously stated, one study in California has shown that AAPI neighborhoods have tobacco billboard density 17 times higher in comparison to other neighborhoods. In advertisements targeting AAPI ethnic subgroups such as Chinese and Vietnamese, the tobacco industry follows a double-standard in advertising. Although the advertisement is translated into Chinese or Vietnamese, the surgeon general's warning label is in English.[16] 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.

Promotions

It is well known that the tobacco industry promotes its 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 merchandise. Although there are no studies in AAPI communities to show a strong correlation of cigarette promotion with smoking initiation, particularly among youth, one 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.[17] 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. Research needs to be conducted in the AAPI community to reveal the association of promotions of tobacco merchandise to the initiation of smoking.

In the AAPI community, the tobacco industry has been sponsoring civil rights and health promotion organizations and community events to project a positive image of smoking and legitimize its presence in communities already saturated with tobacco advertising.

Examples of tobacco promotion and sponsorship that affect AAPIs include:
Promotion:

- Merchant displays

- Product placement (e.g. movies)
- 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)

Sponsorship:

- Sponsorship of AAPI youth events, community events in California (e.g. Vietnamese Tet festival), sporting events, neighborhood events and community programs (e.g. Organization of Chinese American's directory of AAPI organizations).

Objective 3.2: Ban on all forms of tobacco industry sponsorship and promotion.
Objective 3.3: Provide economic development assistance and training for AAPI organizations that have previously relied on tobacco company sponsorship in order to offer them opportunities for alternative funding.

Counter Advertising Campaign

Given that the tobacco industry has selectively targeted minority communities through billboard advertising, promotions, and sponsorships, tobacco control policy must include adequate funding for countering pro-tobacco influences through local, state, and national advertising campaigns for minority groups. These campaigns need to contain culturally and linguistically appropriate messages for diverse AAPI subgroups, including TV ads, radio spots, and print media ads. We strongly recommend that media campaigns utilize existing AAPI community based organizations to develop and produce media campaign messages and products. These products should be placed in existing AAPI media outlets such as Hmong Today, a radio station in Fresno, California.

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 3.4: Develop and implement an AAPI anti-tobacco, multi-media campaign that is culturally sensitive and linguistically appropriate to educate AAPI communities about the hazards of smoking and the benefits of quitting.
Objective 3.5: Determine the extent and impact of tobacco advertising and promotion in AAPI communities and evaluate the effectiveness of AAPI media campaigns.
Objective 3.6: Require the surgeon general's health warning labels to be translated into in different AAPI languages.

IV. FOCUS ON YOUTH

GOAL 4: Reduce access to tobacco and the prevalence of tobacco use among AAPI youth. We believe that focus on youth is an important component of any tobacco control strategy, however, 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. Although it is illegal for anyone under 18 to purchase cigarettes, over 90% of U.S. smokers started before the age of 20. AAPI youth smoking prevalence in California increased over 50% from 1995-1996. [18]

Reducing tobacco use among AAPI youth requires strong and comprehensive restrictions on tobacco advertising and promotion as well as restriction in access to tobacco.

To meet Health and Human Service'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. 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 started smoking in Asia or the Pacific Islands, where smoking is a community norm.

Objective 4.1: Expand and evaluate existing cultural, linguistic, and age-appropriate tobacco prevention and cessation programs for youth.
Objective 4.2: Impose severe penalties on the tobacco industry for failing to reduce tobacco use among youth.
Objective 4.3: Conduct outreach to retailers, especially AAPI retailers, to reduce 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 all U.S. regulations to apply equally to cigarettes made in the United States for domestic consumption, those produced abroad by U.S. subsidiaries and those produced for export.
Objective 5.6: Require U.S. tobacco companies to agree to a code of conduct embodying the regulatory provisions contained in any U.S. settlement in areas such as but not limited to marketing to children, advertising and marketing, labeling and performance requirements for reduction of new children smokers.
Objective 5.7: Ensure that there be no immunity or limits on liability granted to the tobacco companies' export, activities, or investments abroad and that non-American victims be entitled to the same level of compensation in U.S. courts as American victims.
Objective 5.8: Require U.S. tobacco companies to offer to compensate foreign government health agencies, proportional to their market share and reflecting the formula used to determine their payment to the states for Medicaid reimbursement.
Objective 5.9: Require explicit stipulation by the tobacco companies that they will not seek assistance from the U.S. Trade Representative, the U.S. Department of Commerce, U.S. Embassies or other U.S. Government agencies to resist or repeal other countries' tobacco control regulations and laws.
Objective 5.10: Require strong controls on the tobacco companies to ensure that they do not continue the practice of smuggling their goods into target countries.
Objective 5.11: Require U.S. tobacco companies to compensate foreign government health agencies for the cost of treating tobacco related diseases proportional to their market share.

TOBACCO SETTLEMENT ISSUES FOR ASIANS AND PACIFIC ISLANDERS
5/1/98

- **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 submit to federal regulation and make payments. In addition, 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. Funds raised from such a price/tax increase should be earmarked for prevention, cessation, and other tobacco control efforts as a top priority. 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 neither 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.

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Asian American and Pacific Islander Blue Print for Tobacco Control Signatories 1998

National
American Association of Physicians of Indian Origin, Washington, DC
Asian Pacific Environmental Network, Oakland, CA
Asian & Pacific Islander American Health Forum, SF, CA
Association of Asian Pacific Community Health Organizations, Oakland, CA
Chinese American Citizens Alliance, SF, CA
Federation of Chinese American & Chinese Canadian Medical Societies, SF, CA
Filipino Civil Rights Advocates, Washington, DC
Intercultural Cancer Council, Houston, TX
National Asian Pacific American Families Against Substance Abuse, LA, CA

State
American Cancer Societies, Hawai'i-Pacific Division, Honolulu, HI
Coalition For A Tobacco Free Hawai'i, Honolulu, HI
Economic and Employment Development Center, LA, CA
Hawai'i Medical Association, Honolulu, HI
Hawai'i Public Health Association, Honolulu, HI
Micronesia Human Resource Development Center, Micronesia
Office of Senator Lou Leon Guerrero, Agana, Guam
University of Guam, Mangilao, Guam
Vietnamese Minnesotans Association, St. Paul, MN
Washington Asian Pacific Islanders Families Against Substance Abuse, Seattle WA

Local
Alameda County Tobacco Control Program, Oakland, CA
Asian Advocacy Project of Catholic Charities, San Rafael, CA
Asian Americans For Community Involvement, SF, CA
Asian American Women's Advancement Coalition, Visalia, CA
Asian Americans For Community Involvement, San Jose, CA
Asian Community Mental Health Services, Oakland, CA
Asian Health Services, Oakland, CA
Asian Immigrant Women Advocates, Oakland, CA
Asian Law Alliance, San Jose, CA
Asian Pacific AIDS Intervention Team, LA, CA
Asian Pacific Health Care Venture, LA, CA
Asian Pacific Islander Coalition on HIV/AIDS, NY, NY
Asian Pacific Islander Wellness Center, SF, CA
Asian Pacific Islanders for Reproductive Health, Oakland, CA
Asian Youth Center, San Gabriel, CA
Bay Area Region Tobacco Education Resource, Richmond, CA
Cambodian Family Inc., Santa Ana, CA
Charterhouse Center Refugee Services, Stockton, CA
Chinatown Health Clinic, NY, NY
Chinatown Public Health Center, SF, CA
Chinatown Service Center, LA, CA
Chinese American Planning Council, NY, NY

Chinese Community Health Care, SF, CA
Chinese Progressive Association, SF, CA
Clinical Educational Organizational Services, Newton, MA
Family Health Project, Inc., NY, NY
Filipino American Service Group Inc., LA, CA
Filipino Task Force on AIDS, SF, CA
Gay Asian Pacific Alliance, SF, CA
Guam Communications Network, Santa Monica, CA
Hmong American Women Association, Fresno, CA
Hmong Youth Foundation, Inc., Fresno, CA
Indochinese Community Center, Washington, DC
Indochinese Youth Center, Gardena, CA
International Community Health Services, Seattle, WA
Khmer Health Advocates, Inc., Hartford, CT
Korean Health Education, Information & Referral Center, LA, CA
NICOS Chinese Health Coalition, SF, CA
Orange County Asian & Pacific Islander Community Alliance, Garden Grove, CA
People's CORE, LA, CA
Pilipino Bayanihan Resource Center, Daly City, CA
Rehabilitation Hospital of the Pacific, Honolulu, HI
Samoan Community Development Center, SF, CA
Search to Involve Pilipino Americans, LA, CA
Self-Help for the Elderly, SF, CA
Southeast Asian Council, Visalia, CA
Southern Coast Region, San Diego, CA
Special Services Groups / Tongan Community Service Center, Gardena, CA
Stone Soup Fresno, Fresno, CA
Sunset Park Family Health Center at Lutheran Medical Center, NY, NY
Union of Pan Asian Communities, San Diego, CA
Vietnamese American health Care Association, Madison, WI
Vietnamese Community Health Promotion Project, SF, CA
Vietnamese Community Of Orange County, Santa Ana, CA
Vietnamese Evangelical Church Burnsville, Plymouth, MN
Vietnamese Tobacco Free Community Task Force, SF, CA

For Immediate Release **Contact: 703-841-9128**

Statement of Dong Suh
Policy Analyst
Asian & Pacific Islander American Health Forum
April 28, 1998

Multicultural Organizations Mobilize to Demand Congressional Action on Comprehensive Tobacco Control Legislation

Good morning. My name is Dong Suh. I am a policy analyst at the Asian & Pacific Islander American Health Forum. We are a national policy organization dedicated to improving the health status of Asian and Pacific Islanders. One of our programs at the Health Forum is the Asian and Pacific Islander Tobacco Education Network, a network of community-based organizations in California that conduct tobacco control programs.

As one of the minority communities that has high rate of smokers and is a target of tobacco industry, we urge the Congress to pass a comprehensive tobacco control legislation with a specific focus on minority communities. The tobacco control legislation should include culturally and linguistically appropriate prevention, cessation and education programs utilizing community-based organizations, increase in research and data collection, protection from environmental tobacco smoke and international tobacco control. The Surgeon Generals' report, "Tobacco Use Among U.S. Racial/Ethnic Minority Groups," that was released yesterday underscores the need for such a comprehensive effort.

Lest we talk in abstracts, I would like to provide a picture of tobacco in the Asian and Pacific Islander and other minority communities. If you walk down many Asian and Pacific Islander and other minority neighborhoods, you will see ubiquitous billboards and signs of tobacco advertising near schools, playgrounds and recreation centers. In fact, a University of Southern California study has found that the number of cigarette billboards in Asian and Pacific Islander neighborhoods is 17 times higher than the number of billboards in white neighborhoods.

Moreover, the Surgeon General's report cited a study that showed that the "highest proportion of billboards featuring tobacco products was in Asian American neighborhoods, followed by African American, Hispanic, and white neighborhoods." The report also cited higher concentration of in-store tobacco promotion displays in minority neighborhoods. In addition, the report stated that tobacco industry has been advertising in ethnic magazines and newspapers and hawk their deadly products using racial and ethnic symbols, names and events.

(more)

If you continue to walk down the neighborhoods, you will see mostly adolescent and adult males, but also increasing number of girls and women, smoking. In the Asian and Pacific Islander community, some of the studies found smoking rates ranging from 33% to 70% for men. The residents of many of these neighborhoods are immigrants from countries where up to 70% of the men smoke. They are from the countries where the tobacco companies, with the help of the United States government, have been actively promoting their deadly products.

It is important to note that the high smoking rate among male teens and adults not only effect their health but the health of women and children due to second hand smoke. The Asian and Pacific Islander and other minority children face double jeopardy: a barrage of tobacco advertising that tempt them and the second hand smoke from their brothers and fathers. As the Surgeon General's report stated, "lung cancer is the leading cancer death for all four minority groups" and that smoking increases infant mortality, low birthweight and sudden infant death syndrome.

The key to tobacco control is to de-normalize tobacco through outreach to these communities and counteract tobacco industry's efforts to target them. Tobacco industry has develop sophisticated culturally and linguistically appropriate marketing where everything but the Surgeon General's warning label is written in the languages of the targeted communities.

The most effective method of de-normalizing tobacco is to empower the community-based organizations to work with their communities. The community-based organizations are the ones who know their communities, know what works and what doesn't, can assist in research and data collection and can provide culturally and linguistically appropriate education and prevention activities. In California, there are four ethnic tobacco education networks: African American, Asian and Pacific Islander, Latino/Hispanic and Native American. Their work with the community-based organizations in their respective communities and with each other has been instrumental in California's tobacco prevention, cessation and counter advertising efforts.

As you have heard from other speakers, the minority population has been disproportionately targeted and disproportionately affected by the tobacco industry. Moreover, disproportionate amount of revenue from tobacco surcharge will be raised from minority communities. Therefore, a fair share of the resources should be focused on minority populations.

In February, the President has announced a race and health initiative to eliminate race and ethnic disparity by the year 2010 in infant mortality, heart disease, cancer, diabetes, HIV/AIDS and immunization. We challenge the Congress and the President to enact a comprehensive tobacco control legislation to eliminate the race and ethnic disparity in tobacco prevalence, morbidity and mortality by the year 2010.

MINORITY PUBLIC HEALTH CONSENSUS POSITION ON TOBACCO CONTROL LEGISLATION

People of color -- African Americans, Asian Americans/Pacific Islanders, Latinos/Hispanics, American Indians, and other communities of color -- represent about 25 percent of the U.S. population. These groups have been targeted disproportionately by the tobacco industry, and as a result bear a disproportionate burden in terms of tobacco-related illness and mortality. Comprehensive federal tobacco control legislation must address the needs of minority communities in the following areas and the majority of any funding derived from such legislation must be devoted to these public health efforts.

Prevention Federal legislation must support culturally competent and linguistically appropriate public health and education tobacco prevention initiatives, including culturally competent and linguistically appropriate anti-tobacco advertising in a broad variety of national, local, and minority-owned media. Culturally competent public-education and advertising campaigns should also target age, gender, and immigrant subgroups in communities of color in order to maximize their effectiveness.

Cessation Federal tobacco legislation must also assure that free or easily affordable cessation programs in communities of color are widely available, culturally competent, linguistically appropriate, and convenient to reach for persons of color who want to overcome their dependence on tobacco.

Research Public health agencies must be required to collect and analyze data concerning all aspects of tobacco use and related health effects in communities of color, including data disaggregated by age and gender within specific groups. Research by or on behalf of community based or culturally specific entities must also be encouraged and supported.

Protection Legislative provisions concerning second-hand smoke must protect children and families of color in public places, as well as employees in business and industries, especially those highly dependent on workers of color.

Policy Development Communities of color must be represented on policymaking bodies concerning tobacco at all levels of government. The Food and Drug Administration should have full authority for federal regulation of tobacco products. Federal provisions must not preempt or displace more stringent state or local regulations. No federal agency should promote tobacco products in other countries.

Economic Impacts Any distribution of tobacco legislation funds among states and American Indian tribes (for Indian Health Services eligible Indians as defined in the Indian Health Care Improvement Act) must also provide for the equitable treatment of District of Columbia, Puerto Rico, Pacific Island jurisdictions, and other overseas polities.

Signatories to the Minority Public Health Consensus Position on Tobacco Control Legislation:

American Association of Physicians of Indian Origin
American Indian Alaskan Native Hawai'ian Caucus
Asian & Pacific Islander American Health Forum
Asian & Pacific Islanders for Health Promotion
Asian Pacific Partners for Empowerment & Leadership
Association of American Indian Physicians
Bay Area Region Tobacco Education Resource
California Black Health Network
California Primary Healthcare Association
California Rural Indian Health Board
Council on Black Minnesotans
Health Education Council
Intercultural Cancer Council
Latino Council on Alcohol and Tobacco
National Asian Pacific American Families Against Substance Abuse
National Asian Women's Health Organization
National Council of La Raza
National Hispanic Medical Association
National Medical Association
Onyx Group
Smokeless Hawai'i
Summit Health Coalition
Tongan Community Service Center
Vietnamese American Health Care Association

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Tobacco minorities - Gw

HLC

"DISCUSSION DRAFT"

APRIL 17, 1998

10:15 a.m.

105TH CONGRESS
2D SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. UNDERWOOD introduced the following bill; which was referred to the Committee on _____

A BILL

To provide for the use of funds from the national tobacco settlement to carry out public health programs for individuals who are members of racial or ethnic minority groups.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "[Minority Populations and Tobacco Products Public Health Act of 1998]".

SEC. 2. FUNDS FROM NATIONAL TOBACCO SETTLEMENT; ALLOCATION FOR PUBLIC HEALTH PROGRAMS REGARDING RACIAL AND ETHNIC MINORITY GROUPS.

Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by inserting after section 1707 the following section:

"MINORITY HEALTH AND TOBACCO PRODUCTS

"SEC. 1707A. (a) IN GENERAL.—

"(1) ALLOCATION FROM NATIONAL TOBACCO SETTLEMENT.—Of the amount that is received by the Federal Government for a fiscal year pursuant to the national tobacco settlement and reserved for programs regarding the public health, there shall be made available 25 percent for carrying out public health programs (including programs of research) that concern the consumption of tobacco products and are directed toward individuals who are members of racial or ethnic minority groups.

"(2) ADMINISTRATION OF PROGRAMS.—Programs under paragraph (1) shall be carried out by the Secretary, acting through the Deputy Assistant Secretary for Minority Health, and—

"(A) in collaboration with the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, the Director of the National Institutes of Health, and the Administrator of the Substance Abuse and Mental Health Services Administration;

"(B) in collaboration with the directors of the offices of minority health within such agencies (including the Office of Research on Minority Health within the National Institutes of Health); and

"(C) in consultation with the advisory committee established under paragraph (4).

"(3) AGENCY ACTIVITIES; GRANTS AND CONTRACTS.—Activities under paragraph (1) may be carried out—

"(A) directly by the Deputy Assistant Secretary and the heads of the agencies and offices referred to in paragraph (2); and

"(B) through awards of grants, cooperative agreements, and contracts to public and nonprofit private entities.

"(4) ADVISORY COMMITTEE.—The Secretary shall appoint an advisory committee to advise the

Deputy Assistant Secretary on carrying out programs under paragraph (1). Such committee shall be appointed from among individuals from the public health community who represent racial and ethnic minority groups and who are not officers or employees of the Federal Government.

"(b) ACTIVITIES REGARDING DISPARITIES IN HEALTH STATUS.—Activities under subsection (a)(1) shall include activities directed toward the goal of eliminating, with respect to the consumption of tobacco products, disparities between the health status of individuals who are members of racial or ethnic minority groups and the health status of individuals who are not members of such groups.

"(c) COLLECTION OF DATA.—Activities under subsection (a)(1) shall include the collection and analysis of data on the health effects in racial and ethnic minority groups of the consumption of tobacco products, including data categorized in accordance with the following:

"(1) Race and ethnicity including subgroups.

"(2) Gender.

"(3) Youth by age.

"(4) Mortality, mobility, and disability, including cancer and other tobacco-related diseases.

"(5) Cancer.

"(6) Other diseases related to the consumption of tobacco products.

"(7) Consumption of cigars.

"(d) EVALUATIONS.—Beginning with fiscal year 2000, the Secretary shall provide for the conduct of evaluations of programs carried out under subsection (a)(1), including the extent to which such programs have been successful in facilitating a reduction in the consumption of tobacco products by racial and ethnic minority groups.

"(e) ANNUAL REPORTS.—Not later than February 1, 2000, and annually thereafter, the Secretary shall submit to the Congress a report that provides with respect to the preceding fiscal year the following:

"(1) A description of the programs carried out under subsection (a)(1).

"(2) The results of evaluations under subsection (d).

"(3) The recipients of awards under subsection (a)(3), including a specification of the total amount awarded for each of the following categories of entities:

"(A) Community-based organizations that principally serve racial and ethnic minority groups.

"(B) Statewide and regional organizations that principally serve such groups.

"(C) Educational institutions that principally serve such groups.

"(D) Indian tribes and tribal organizations.

"(E) States and units of local government.

"(f) DEFINITIONS.—For purposes of this section:

"(1) The term 'Deputy Assistant Secretary' means the Deputy Assistant Secretary for Minority Health.

"(2) The terms 'Indian tribe' and 'tribal organization' have the same meaning given such terms in section 4(b) and section 4(c) of the Indian Self-Determination and Education Assistance Act.

"(3)(A) The term 'racial and ethnic minority group' means each of ~~American Indians~~ Native Americans (including Alaska Natives, Eskimos, and Aleuts), Asian American and Pacific Islanders, Blacks, and Hispanics.

"(B) The term 'Hispanic' means individuals whose origin is Mexican, Puerto Rican, Cuban, Central or South American, or any other Spanish-speaking country.

"(4) The term 'State' means each of the several States, the District of Columbia, the Commonwealth

of Puerto Rico, Guam, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, and American Samoa.".

[DISCUSSION DRAFT]

APRIL 16, 1998

PROPOSED SECTION

DEFENSE AUTHORIZATION ACT FOR FY99

SEC. ___. REPORT ON PLAN FOR USE OF UTILITY SYSTEM CONVEYANCE AUTHORITY.

Not later than ____, the Secretary of each military department shall submit to Congress a report containing the criteria that the Secretary will use to select utility systems, and related real property, under the jurisdiction of the Secretary for conveyance to a municipal, private, regional, district, or cooperative utility company or other entity under the authority of section 2688 of title 10, United States Code. The report shall include a list of each utility system, and the location of the utility system, that, as of the date of the submission of the report, the Secretary considers is likely to be conveyed under such section.

HLC

DISCUSSION DRAFT

APRIL 22, 1998

11:45 a.m.

105TH CONGRESS
2D SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. THOMPSON introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Public Health Service Act to establish authorities of the departmental Office of Minority Health with respect to tobacco products, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "*[.....]".

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) The tobacco industry has disproportionately targeted racial and ethnic minority groups, especially youths in such groups, in its campaigns to increase the use of tobacco products.

(2) Such minority groups suffer from higher rates of smoking than other population groups.

(3) Minority groups have disproportionately higher rates of smoking-related diseases.

(4) Anti-tobacco efforts should be undertaken at levels sufficient to ensure that rates of smoking are reduced among minority groups, both adults and youths. Without such efforts, significant increases in the retail price of tobacco products, which some proposals for national tobacco legislation have included, would constitute a regressive tax on minority groups.

(5) Reductions among minority groups in the rate of smoking and in tobacco-related diseases should be facilitated by requiring the Office of Minority Health for the Department of Health and Human Services (established within the Office of the Assistant Secretary for Health) to prepare, in collaboration with other officials in the Public Health

Service, a comprehensive plan regarding the use of tobacco products by minority groups.

(6) In order to redress the past targeting of minority youth by the tobacco industry, financial support of education institutions that serve significant numbers of minority youth should be increased.

TITLE I—AUTHORITIES OF DEPARTMENTAL OFFICE OF MINORITY HEALTH WITH RESPECT TO TOBACCO PRODUCTS

SEC. 101. AUTHORITIES OF DEPARTMENTAL OFFICE OF MINORITY HEALTH.

(a) IN GENERAL.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.)) is amended by inserting after section 1707 the following new section:

"MINORITY HEALTH AND USE OF TOBACCO PRODUCTS

"SEC. 1707A. (a) IN GENERAL.—

"(1) INTERAGENCY COORDINATION.—With respect to activities of the Public Health Service that are directed toward minority health concerns regarding tobacco products, the Secretary shall plan, coordinate, and evaluate all activities conducted or supported by the agencies of the Service (other than the regulation of tobacco products through the Food and Drug Administration), including activities relat-

ing to disease prevention, health promotion, service delivery, and research that are carried out pursuant to national tobacco legislation. In carrying out the preceding sentence, the Secretary shall evaluate the activities of each of such agencies and shall provide for the periodic reevaluation of such activities.

"(2) ADMINISTRATION THROUGH OFFICE OF MINORITY HEALTH.—The Secretary shall carry out this section (including with respect to functions under paragraph (4) and the plan under subsection (b)(1)) acting through the Deputy Assistant Secretary for Minority Health and in consultation with the advisory committee under subsection (c).

"(3) COLLABORATION THROUGH INTERAGENCY PANEL.—The Secretary shall carry out this section in collaboration with the heads of the agencies of the Service that have significant responsibilities regarding minority tobacco activities and in collaboration with the directors of the offices of minority health within the agencies. In collaborating with the Secretary under the preceding sentence, the heads of such agencies shall consult with the advisory committees for the agencies, and the directors of such offices shall consult with the advisory committees for the offices.

"(4) COORDINATION.—In carrying out paragraph (1), the Secretary shall act as the primary Federal official with responsibility for overseeing all minority tobacco activities conducted or supported by the Service, and—

"(A) shall serve to represent matters regarding minority tobacco activities at all relevant Executive branch task forces and committees; and

"(B) shall maintain communications with all relevant agencies of the Service and with various other departments of the Federal Government in order to ensure the timely transmission between such agencies of information concerning such activities, including advances in research, and to ensure the dissemination of information to affected communities and health care providers.

"(b) COMPREHENSIVE PLAN FOR EXPENDITURE OF APPROPRIATIONS.—

"(1) IN GENERAL.—Subject to the provisions of this subsection and other applicable law, the Secretary, in carrying out duties under this section, shall—

"(A) establish a comprehensive plan for the conduct and support of all minority tobacco activities of the agencies of the Service (which plan shall be first established under this paragraph not later than 6 months after the effective date of this paragraph);

"(B) ensure that the Plan establishes priorities among the minority tobacco activities that such agencies are authorized to carry out;

"(C) ensure that the Plan establishes objectives regarding such activities, describes the means for achieving the objectives, and designates the date by which the objectives are expected to be achieved;

"(D) ensure that all amounts appropriated for such activities are expended in accordance with the Plan;

"(E) review the Plan not less than annually, and revise the Plan as appropriate; and

"(F) ensure that the Plan serves as a broad, binding statement of policies regarding minority tobacco activities of the agencies, but does not remove the responsibility of the heads of the agencies for the approval of specific programs or projects, or for other details of the

daily administration of such activities, in accordance with the Plan.

"(2) CERTAIN COMPONENTS OF PLAN.—With respect to minority tobacco activities of the agencies of the Service, the Secretary shall ensure that the Plan provides for the following:

"(A) Activities for the promotion of health and for the prevention and control of diseases, disorders, and injuries.

"(B) The delivery of services.

"(C) Basic research, applied research, behavioral research, and social sciences research.

"(D) Activities that are conducted directly by the agencies.

"(E) Activities that are supported by the agencies through grants or contracts.

"(F) Proposals developed pursuant to solicitations by the agencies and proposals developed independently of such solicitations.

"(3) COUNTERADVERTISING.—The Secretary shall ensure that the Plan provides for an education campaign regarding the health risks associated with smoking or otherwise consuming tobacco products.

"(4) GRANTS REGARDING COMMUNITY-BASED PROGRAMS.—The Secretary shall ensure that minor-

ity tobacco activities under the Plan include the award, by the Secretary, of grants to community-based organizations for—

"(A) carrying out innovative activities to discourage the consumption of tobacco products and to provide assistance in ceasing the use of such products; and

"(B) assisting such organizations in developing or increasing the capacity to carry out such activities.

"(5) ALLOCATIONS FOR PLAN.—The Secretary shall ensure that the Plan provides that, of the amounts made available to an agency of the Service for a fiscal year for carrying out public health activities regarding tobacco products (including amounts made available to the agency pursuant to national tobacco legislation), the percentage made available for minority tobacco activities of the agency is not less than the percentage constituted by the ratio of—

"(A) the number of individuals in the United State who smoke or otherwise consume tobacco products and are members of racial or ethnic minority groups; to

"(B) the total number of individuals in the United States who smoke or otherwise consume such products.

"(6) PRIORITIES REGARDING GRANTS AND CONTRACTS.—The Secretary shall ensure that the Plan provides that, in awarding grants and contracts for minority tobacco activities under the Plan, the agencies of the Service are to give priority to entities in accordance with the following:

"(A) First, to community-based organizations and educational institutions that have a history of carrying out minority tobacco activities, or that have the capacity to begin carrying out such activities.

"(B) Second, to national, statewide, and regional organizations, and to networks or coalitions consisting of affiliations of such organizations, that have a history of carrying out minority tobacco activities, or that have the capacity to begin carrying out such activities.

"(C) Third, to public health departments of units of local government.

"(D) Fourth, to States, the territories of the United States, and Indian tribes and tribal organizations.

"(7) BUDGET ESTIMATES; SUBMISSION TO SECRETARY .—

"(A) IN GENERAL.—With respect to a fiscal year, the Secretary shall prepare and submit to the Secretary the budget estimates required in subparagraphs (B) through (D) for carrying out the Plan for the fiscal year. The Secretary shall consider each of such estimates in making recommendations to the President regarding a budget for the Plan for such year.

"(B) FULL-FUNDING BUDGET.—For purposes of subparagraph (A), the budget estimate required in this subparagraph for a fiscal year is an estimate of the amounts necessary for the agencies of the Service to carry out all minority tobacco activities determined by the Secretary to be appropriate, without regard to the probability that such amounts will be appropriated.

"(C) ALTERNATIVE BUDGET.—For purposes of subparagraph (A), the budget estimate required in this subparagraph for a fiscal year is an estimate developed on the assumption that the amounts appropriated will be sufficient only for—

"(i) continuing the conduct directly by the agencies of the Service of existing minority tobacco activities (if approved by the agency for continuation);

"(ii) continuing the support by the agencies through grants or contracts of minority tobacco activities for which the agencies have made a commitment of continued support; and

"(iii) carrying out such activities in addition to activities specified in clauses (i) and (ii) as the Secretary determines to be necessary to address the most substantial needs.

"(D) OTHER BUDGETS.—For purposes of subparagraph (A), the budget estimates required in this subparagraph for a fiscal year are such estimates in addition to the estimates required in subparagraphs (B) and (C) as the Secretary determines to be appropriate.

"(c) ADVISORY COMMITTEE REGARDING MINORITY TOBACCO ACTIVITIES.—The Secretary shall ensure that there is in operation an advisory committee to advise the Secretary on carrying out this section, and that such committee is appointed from among individuals who are not

officers or employees of the Federal Government and who are experienced with respect to minority health concerns. The Secretary shall carry out the preceding sentence by appointing an advisory committee whose only responsibility is so advising the Secretary, except that such responsibility shall be assigned to an advisory committee whose function is generally advising the Office of Minority Health, if such an advisory committee is required by law.

"(d) REPORT.—Not later than February 1, 2000, and annually thereafter, the Secretary shall submit to the Congress a report that describes the various categories of minority tobacco activities carried out under this section during the preceding fiscal year and that specifies the amount of Federal funds obligated for each of such categories.

"(e) DEFINITIONS.—For purposes of this section:

"(1)(A) The term 'minority tobacco activities' means activities that are directed toward minority health concerns regarding tobacco products.

"(B) The term 'minority health concerns' means the health concerns of individuals from disadvantaged backgrounds, including racial and ethnic minorities.

"(2) The term 'Plan' means the plan under subsection (b)(1).

"(3)(A) The term 'racial and ethnic minority group' means each of American Indians (including Alaska Natives, Eskimos, and Aleuts); Asian Americans and Pacific Islanders; Blacks; and Hispanics.

"(B) The term 'Hispanic' means individuals whose origin is Mexican, Puerto Rican, Cuban, Central or South American, or any other Spanish-speaking country.

"(g) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—For the purpose of carrying out this section other than subsection (b)(4), there are authorized to be appropriated ____ for each of the fiscal years 1999 through ____.

"(2) CERTAIN COMMUNITY-BASED PROGRAMS.—For the purpose of carrying out subsection (b)(4), there are authorized to be appropriated ____ for each of the fiscal years 1999 through ____.".

TITLE II—EDUCATION INITIATIVES

SEC. 201. GRANTS TO MINORITY MEDICAL SCHOOLS.

Part B of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.) is amended by adding at the end the following section:

"SEC. 741. GRANTS TO MINORITY MEDICAL SCHOOLS FOR ENDOWMENTS; PUBLIC HEALTH PROGRAMS REGARDING TOBACCO PRODUCTS.

"(a) IN GENERAL.—The Secretary shall make grants to schools specified in subsection (b) for the purpose of establishing at the schools endowments each of whose income is used exclusively to carry out—

"(1) public health programs; and

"(2) programs of biomedical research on diseases for which the consumption of tobacco products is a principal causal factor.

"(b) RELEVANT SCHOOLS.—The schools referred to in subsection (a) are the following medical schools (schools of medicine or osteopathic medicine):

"(1) The four medical schools in the United States whose enrollment for academic year 1998 of Black individuals constituted a higher percentage of such individuals than other medical schools in the United States.

"(2) The four medical schools in the United States (or consortia of such schools) whose enrollment for academic year 1998 of Hispanic individuals constituted a higher percentage of such individuals than other medical schools in the United States.

"(3) The two medical schools in the United States (or consortia of such schools) whose enroll-

ment for academic year 1998 of Native American individuals constituted a higher percentage of such individuals than other medical schools in the United States.

"(c) FUNDING.—From amounts received by the Federal Government pursuant to national tobacco legislation and reserved for public health programs regarding the consumption of tobacco products, the Secretary shall, for each of the first 10 fiscal years following the date of the enactment of such legislation, reserve amounts for making a grant under subsection (a) to each of the schools specified in subsection (b). Each such grant shall be made in the amount of $10,000,000.".

SEC. 202. ADDITIONAL FUNDING FOR BUILDINGS AND STRUCTURES AT HISTORICALLY BLACK COLLEGES AND UNIVERSITIES.

Subsection (d) of section 507 of the Omnibus Parks and Public Land Management Act of 1996 (16 U.S.C. 470a note; 110 Stat. 4156) is amended to read as follows:

"(d) FUNDING.—For fiscal years beginning after fiscal year 1998 $377,500,000 shall be made available pursuant to section 108 of the National Historic Preservation Act to carry out the purposes of this section. In addition to other funds covered into the Historic Preservation Fund under section 108 of the National Historic Preserva-

tion Act or under any other authority of law, there is authorized to be appropriated to such Fund $377,500,000 for fiscal years beginning after fiscal year 1998.".

ICE MILLER DONADIO & RYAN

Bruce Minority - ew

TRANSMITTAL COVER SHEET

DATE: April 29, 1998 **14 PAGES INCLUDIN THIS PAGE**

HARD COPY TO FOLLOW: ___Yes _X_No **VIA:** ___Mail ___Couri

TO:	Tom Freedman	TO:	Sarah Bianchi
COMPANY:	Domestic Policy Council/White House	COMPANY:	The White House
FAX #:	202/456-7431 ✓	FAX #:	202/456-5557
PHONE #:	202/456-5587	PHONE #:	202/456-5585
TO:	Bruce Reed	TO:	
COMPANY:	The White House	COMPANY:	
FAX #:	202/456-2878	FAX #:	
PHONE #:	202/456-6515	PHONE #:	
TO:		TO:	
COMPANY:		COMPANY:	
FAX #:		FAX #:	
PHONE #:		PHONE #:	
TO:		TO:	
COMPANY:		COMPANY:	
FAX #:		FAX #:	
PHONE #:		PHONE #:	

FROM: Lacy Johnson **TELEPHONE NUMBER:** 236-2209

SUBJECT: Latest CBC Draft

COMMENTS:

CLIENT/MATTER NO.: 15259.0001 **JOB CODE** *(Fax Center Use Only):* 194 33

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[DISCUSSION DRAFT]

cc John Freedman
Sarah Bianchi
Bruce Reed

SECTION 1. SHORT TITLE.

This Act may be cited as the "*[.....]".

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) The tobacco industry has disproportionately and successfully targeted racial and ethnic minority groups, especially youths in such groups, in its campaigns to increase the use of tobacco products.

(2) Such minority groups suffer from higher rates of smoking than other population groups.

(3) Minority groups have disproportionately higher rates of smoking-related diseases.

(4) Anti-tobacco efforts should be undertaken at levels sufficient to ensure that rates of smoking are reduced among minority groups, both adults and youths. Without such efforts, significant increases in the retail price of tobacco products, which some proposals for national tobacco legislation have included, would constitute a regressive tax on minority groups.

(5) Reductions among minority groups in the rate of smoking and in tobacco-related diseases should be facilitated by requiring the Office of Minority Health for the Department of Health and Human Services (established within the Office of the Assistant Secretary for Health) to prepare, in collaboration with other officials in the Public Health

Service, a comprehensive plan regarding the use of tobacco products by minority groups.

(6) In order to redress the past targeting of minority youth by the tobacco industry, financial support of educational institutions that serve significant numbers of minority youth should be increased.

TITLE I—AUTHORITIES OF DEPARTMENTAL OFFICE OF MINORITY HEALTH WITH RESPECT TO TOBACCO PRODUCTS

SEC. 101. AUTHORITIES OF DEPARTMENTAL OFFICE OF MINORITY HEALTH.

(a) IN GENERAL.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.)) is amended by inserting after section 1707 the following new section:

"MINORITY HEALTH AND USE OF TOBACCO PRODUCTS

"SEC. 1707A. (a) IN GENERAL.—

"(1) INTERAGENCY COORDINATION OF MINORITY TOBACCO ACTIVITIES.—With respect to activities of the Public Health Service that are directed toward minority health concerns regarding tobacco products, the Secretary shall plan, coordinate, and evaluate all activities conducted or supported by the agencies of the Service (other than the regulation of tobacco products through the Food and Drug Ad-

ministration), including activities relating to disease prevention, health promotion, service delivery, and research.

"(2) ALLOCATION.—Of the amounts made available to an agency of the Service for a fiscal year for carrying out public health activities regarding tobacco products (including amounts made available to the agency pursuant to national tobacco legislation), there shall be made available, for carrying out minority tobacco activities under this section through the agency, not less than the percentage constituted by the ratio of—

"(A) the number of individuals in the United State who smoke or otherwise consume tobacco products and are members of racial or ethnic minority groups; to

"(B) the total number of individuals in the United States who smoke or otherwise consume such products.

"(b) ADMINISTRATION THROUGH OFFICE OF MINORITY HEALTH.—

"(1) IN GENERAL.—The Secretary shall carry out subsection (a)(1) (including with respect to functions under paragraph (3) and the plan under paragraph (4)) acting through the Deputy Assistant Sec-

retary for Minority Health and in consultation with the advisory committee under subsection (f).

"(2) COLLABORATION THROUGH INTERAGENCY PANEL.—The Secretary shall carry out this section in collaboration with the heads of the agencies of the Service that have significant responsibilities regarding minority tobacco activities and in collaboration with the directors of the offices of minority health within the agencies.

"(3) COORDINATION.—In carrying out subsection (a)(1), the Secretary shall act as the primary Federal official with responsibility for overseeing all minority tobacco activities conducted or supported by the Service, and—

"(A) shall serve to represent matters regarding minority tobacco activities at all relevant Executive branch task forces and committees; and

"(B) shall maintain communications with all relevant agencies of the Service and with various other departments of the Federal Government in order to ensure the timely transmission between such agencies of information concerning such activities, including advances in research, and to ensure the dissemination of in-

formation to affected communities and health care providers.

"(4) [COMPREHENSIVE PLAN.—In planning minority tobacco activities under subsection (a)(1), the Secretary, subject to applicable law, shall establish a comprehensive plan for the conduct and support of all minority tobacco activities of the agencies of the Service, and shall ensure that all amounts appropriated for such activities are expended in accordance with the Plan.]

"(c) AGENCY ACTIVITIES; GRANTS AND CONTRACTS.—

"(1) IN GENERAL.—Activities under subsection (a)(1) may be carried out—

"(A) directly by the Secretary and the agencies of the Service; and

"(B) through awards of grants, cooperative agreements, and contracts to public and nonprofit private entities.

"(2) SPECIAL CONSIDERATION REGARDING GRANTS AND CONTRACTS.—In making awards described in paragraph (1)(B), the Secretary shall ensure that special consideration is given to the following entities:

"(A) Community-based organizations and educational institutions that have a history of carrying out minority tobacco activities, or that have the capacity to begin carrying out such activities.

"(B) National, statewide, and regional organizations, and networks or coalitions consisting of affiliations of such organizations, that have a history of carrying out minority tobacco activities, or that have the capacity to begin carrying out such activities.

"(C) Public health departments of units of local government.

"(D) States, the territories of the United States, and Indian tribes and tribal organizations.

"(d) CERTAIN ACTIVITIES.—

"(1) ACTIVITIES REGARDING DISPARITIES IN HEALTH STATUS.—Activities under subsection (a)(1) shall include activities directed toward the goal of eliminating, with respect to the consumption of tobacco products, disparities between the health status of individuals who are members of racial or ethnic minority groups and the health status of individuals who are not members of such groups.

"(2) COLLECTION OF DATA.—[With respect to the health effects in racial and ethnic minority groups of the consumption of tobacco products, the Secretary shall ensure that data on such effects is collected and evaluated through one or more of the agencies of the Service], including data categorized in accordance with the following:

"(A) Race and ethnicity including subgroups.

"(B) Gender.

"(C) Youth by age.

"(D) Mortality, mobility, and disability, including cancer and other tobacco-related diseases.

"(E) Cancer.

"(F) Other diseases related to the consumption of tobacco products.

"(G) Consumption of cigars.

"(e) ADVISORY COMMITTEE REGARDING MINORITY TOBACCO ACTIVITIES.—The Secretary shall ensure that there is in operation an advisory committee to advise the Secretary on carrying out this section, and that such committee is appointed from among individuals who are not officers or employees of the Federal Government and who are experienced with respect to minority health concerns.

The Secretary shall carry out the preceding sentence by appointing an advisory committee whose only responsibility is so advising the Secretary, except that such responsibility shall be assigned to an advisory committee whose function is generally advising the Office of Minority Health, if such an advisory committee is required by law.

"(f) ANNUAL REPORTS.—Not later than February 1, 2000, and annually thereafter, the Secretary shall submit to the Congress a report that provides with respect to the preceding fiscal year the following:

"(1) A description of the programs carried out under subsection (a)(1).

"(2) The results of evaluations under subsection (a)(1).

"(3) The recipients of awards under subsection (c)(1)(B), including a specification of the total amount awarded for each of the following categories of entities:

"(A) Community-based organizations that principally serve racial and ethnic minority groups.

"(B) Statewide and regional organizations that principally serve such groups.

"(C) Educational institutions that principally serve such groups.

"(D) Indian tribes and tribal organizations.

"(E) States and units of local government.

"(h) DEFINITIONS.—For purposes of this section:

"(1)(A) The term 'minority tobacco activities' means activities that are directed toward minority health concerns regarding tobacco products.

"(B) The term 'minority health concerns' means the health concerns of racial and ethnic minorities.

"(2)(A) The term 'racial and ethnic minority group' means each of American Indians (including Alaska Natives, Eskimos, and Aleuts); Asian Americans and Pacific Islanders; Blacks; Hispanics; and Native Hawaiians.

"(B) The term 'Hispanic' means individuals whose origin is Mexican, Puerto Rican, Cuban, Central or South American, or any other Spanish-speaking country.".

TITLE II—EDUCATION INITIATIVES

SEC. 201. GRANTS TO MINORITY MEDICAL SCHOOLS.

Part B of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.) is amended by adding at the end the following section:

"SEC. 741. GRANTS TO MINORITY MEDICAL SCHOOLS FOR ENDOWMENTS; PUBLIC HEALTH PROGRAMS REGARDING TOBACCO PRODUCTS.

"(a) IN GENERAL.—From amounts reserved under subsection (c), the Secretary shall make grants to schools specified in subsection (b) for the purpose of establishing at the schools endowments each of whose income is used exclusively to carry out—

"(1) public health programs; and

"(2) programs of biomedical research on diseases for which the consumption of tobacco products is a principal causal factor.

"(b) RELEVANT SCHOOLS.—The schools referred to in subsection (a) are the following medical schools (schools of medicine or osteopathic medicine):

"(1) The four medical schools in the United States whose enrollment for academic year 1998 of Black individuals constituted a higher percentage of such individuals than other medical schools in the United States.

"(2) The four medical schools in the United States (or consortia of such schools) whose enrollment for academic year 1998 of Hispanic individuals constituted a higher percentage of such individuals than other medical schools in the United States.

"(3) The two medical schools in the United States (or consortia of such schools) whose enrollment for academic year 1998 of Native American individuals constituted a higher percentage of such individuals than other medical schools in the United States.

"(c) FUNDING.—From amounts received by the Federal Government pursuant to national tobacco legislation and reserved for public health programs regarding the consumption of tobacco products, the Secretary shall, for each of the first 10 fiscal years following the date of the enactment of such legislation, reserve amounts for making a grant under subsection (a) to each of the schools specified in subsection (b). Each such grant shall be made in the amount of $10,000,000.".

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to other funds covered into the Historic Preservation Fund under section 108 of the National Historic Preservation Act or under any other authority of law, there is authorized to be appropriated to such Fund $377,500,000 for fiscal years beginning after fiscal year 1998.".

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& RYAN

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DATE: April 29, 1998 **14 PAGES INCLUDIN THIS PAGE**

HARD COPY TO FOLLOW: ___Yes _X_No **VIA:** ___Mail ___Couri

TO:	Tom Freedman	TO:	Sarah Bianchi
COMPANY:	Domestic Policy Council/White House	COMPANY:	The White House
FAX #:	202/456-7431 ✓	FAX #:	202/456-5557
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FROM: Lacy Johnson **TELEPHONE NUMBER:** 236-2209

SUBJECT: Latest CBC Draft

COMMENTS:

CLIENT/MATTER NO.: 15259.0001 **JOB CODE** *(Fax Center Use Only):* 194 33

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cf Jon Kaufman
Sarah Bianchi
Bruce Reed

SECTION 1. SHORT TITLE.

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SEC. 2. FINDINGS.

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(1) The tobacco industry has disproportionately and successfully targeted racial and ethnic minority groups, especially youths in such groups, in its campaigns to increase the use of tobacco products.

(2) Such minority groups suffer from higher rates of smoking than other population groups.

(3) Minority groups have disproportionately higher rates of smoking-related diseases.

(4) Anti-tobacco efforts should be undertaken at levels sufficient to ensure that rates of smoking are reduced among minority groups, both adults and youths. Without such efforts, significant increases in the retail price of tobacco products, which some proposals for national tobacco legislation have included, would constitute a regressive tax on minority groups.

(5) Reductions among minority groups in the rate of smoking and in tobacco-related diseases should be facilitated by requiring the Office of Minority Health for the Department of Health and Human Services (established within the Office of the Assistant Secretary for Health) to prepare, in collaboration with other officials in the Public Health

Service, a comprehensive plan regarding the use of tobacco products by minority groups.

(6) In order to redress the past targeting of minority youth by the tobacco industry, financial support of educational institutions that serve significant numbers of minority youth should be increased.

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"(2) ALLOCATION.—Of the amounts made available to an agency of the Service for a fiscal year for carrying out public health activities regarding tobacco products (including amounts made available to the agency pursuant to national tobacco legislation), there shall be made available, for carrying out minority tobacco activities under this section through the agency, not less than the percentage constituted by the ratio of—

"(A) the number of individuals in the United State who smoke or otherwise consume tobacco products and are members of racial or ethnic minority groups; to

"(B) the total number of individuals in the United States who smoke or otherwise consume such products.

"(b) ADMINISTRATION THROUGH OFFICE OF MINORITY HEALTH.—

"(1) IN GENERAL.—The Secretary shall carry out subsection (a)(1) (including with respect to functions under paragraph (3) and the plan under paragraph (4)) acting through the Deputy Assistant Sec-

retary for Minority Health and in consultation with the advisory committee under subsection (f).

"(2) COLLABORATION THROUGH INTERAGENCY PANEL.—The Secretary shall carry out this section in collaboration with the heads of the agencies of the Service that have significant responsibilities regarding minority tobacco activities and in collaboration with the directors of the offices of minority health within the agencies.

"(3) COORDINATION.—In carrying out subsection (a)(1), the Secretary shall act as the primary Federal official with responsibility for overseeing all minority tobacco activities conducted or supported by the Service, and—

"(A) shall serve to represent matters regarding minority tobacco activities at all relevant Executive branch task forces and committees; and

"(B) shall maintain communications with all relevant agencies of the Service and with various other departments of the Federal Government in order to ensure the timely transmission between such agencies of information concerning such activities, including advances in research, and to ensure the dissemination of in-

formation to affected communities and health care providers.

"(4) [COMPREHENSIVE PLAN.—In planning minority tobacco activities under subsection (a)(1), the Secretary, subject to applicable law, shall establish a comprehensive plan for the conduct and support of all minority tobacco activities of the agencies of the Service, and shall ensure that all amounts appropriated for such activities are expended in accordance with the Plan.]

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"(1) IN GENERAL.—Activities under subsection (a)(1) may be carried out—

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"(2) SPECIAL CONSIDERATION REGARDING GRANTS AND CONTRACTS.—In making awards described in paragraph (1)(B), the Secretary shall ensure that special consideration is given to the following entities:

"(A) Community-based organizations and educational institutions that have a history of carrying out minority tobacco activities, or that have the capacity to begin carrying out such activities.

"(B) National, statewide, and regional organizations, and networks or coalitions consisting of affiliations of such organizations, that have a history of carrying out minority tobacco activities, or that have the capacity to begin carrying out such activities.

"(C) Public health departments of units of local government.

"(D) States, the territories of the United States, and Indian tribes and tribal organizations.

"(d) CERTAIN ACTIVITIES.—

"(1) ACTIVITIES REGARDING DISPARITIES IN HEALTH STATUS.—Activities under subsection (a)(1) shall include activities directed toward the goal of eliminating, with respect to the consumption of tobacco products, disparities between the health status of individuals who are members of racial or ethnic minority groups and the health status of individuals who are not members of such groups.

"(2) COLLECTION OF DATA.—[With respect to the health effects in racial and ethnic minority groups of the consumption of tobacco products, the Secretary shall ensure that data on such effects is collected and evaluated through one or more of the agencies of the Service], including data categorized in accordance with the following:

"(A) Race and ethnicity including subgroups.

"(B) Gender.

"(C) Youth by age.

"(D) Mortality, mobility, and disability, including cancer and other tobacco-related diseases.

"(E) Cancer.

"(F) Other diseases related to the consumption of tobacco products.

"(G) Consumption of cigars.

"(e) ADVISORY COMMITTEE REGARDING MINORITY TOBACCO ACTIVITIES.—The Secretary shall ensure that there is in operation an advisory committee to advise the Secretary on carrying out this section, and that such committee is appointed from among individuals who are not officers or employees of the Federal Government and who are experienced with respect to minority health concerns.

The Secretary shall carry out the preceding sentence by appointing an advisory committee whose only responsibility is so advising the Secretary, except that such responsibility shall be assigned to an advisory committee whose function is generally advising the Office of Minority Health, if such an advisory committee is required by law.

"(f) ANNUAL REPORTS.—Not later than February 1, 2000, and annually thereafter, the Secretary shall submit to the Congress a report that provides with respect to the preceding fiscal year the following:

"(1) A description of the programs carried out under subsection (a)(1).

"(2) The results of evaluations under subsection (a)(1).

"(3) The recipients of awards under subsection (c)(1)(B), including a specification of the total amount awarded for each of the following categories of entities:

"(A) Community-based organizations that principally serve racial and ethnic minority groups.

"(B) Statewide and regional organizations that principally serve such groups.

"(C) Educational institutions that principally serve such groups.