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Tobacco-Settlement: Minorities-Surgeon General Report

Tob - sgt - minorities -
surgeon general report

April 26, 1998

SURGEON GENERAL'S REPORT ON TOBACCO

DATE:	April 27, 1998
LOCATION:	South Lawn (Tent)
BRIEFING TIME:	12:45 pm - 1:15 pm
EVENT TIME:	1:20 pm - 1:30 pm Meet and Greet
	1:30 pm - 2:00 pm Event
FROM:	Bruce Reed

I. PURPOSE

To release the Surgeon General's report on tobacco use among minority populations, which underscores the urgent need for comprehensive legislation to reduce youth smoking.

II. BACKGROUND

The report to be released tomorrow -- David Satcher's first as Surgeon General -- is the most comprehensive compilation of research to date on the use and health effects of tobacco on minority populations. The report will get minority health groups and Members of Congress invested in tobacco legislation, while also sending a broader message about the need to pass a comprehensive bill to reduce youth smoking. Senator Frist is on the program because he played a key role in getting the Satcher nomination through the Senate, and an indispensable part in ensuring that the provisions in the McCain bill on FDA jurisdiction would be acceptable to the Administration. A summary of the key findings of the Surgeon General's report follows.

The Surgeon General's Report Documents Disturbing Trends in Tobacco Use. African Americans, Hispanics, Asian Americans, and American Indians/Alaska Natives make up nearly one-fourth of the United States population. The report provides a comprehensive analysis on the effect of tobacco on these groups, including that:

- **Teen smoking rates are rising in many ethnic and minority groups, and adult smoking rates are strikingly high among certain populations.**

  -- Teen smoking rates rose dramatically among African-Americans and Hispanics from 1991-1997. Smoking rates among African-American high school students were up by a startling 80 percent, and smoking rates among Hispanic high school students increased by 34 percent.

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

-- The report also documents that American Indians have the highest adult smoking rates of any ethnic or minority group in the United States -- nearly 40 percent, compared to 25 percent of all adults.

- **Cigarette smoking is a major cause of death and disease among all minority and ethnic groups.** The report documents that:

  -- Lung cancer is the leading cancer death for all four minority groups. The increase in youth smoking threatens to reverse recent progress made against lung cancer among these groups.

  -- African-American men bear the greatest health burdens from lung cancer, with death rates about 50 percent higher than whites. Lung cancer incidence has increased substantially among Alaska Natives (93 percent increase for men and 241 percent increase for women) since the 1970s.

  -- Smoking increases infant mortality and low birth weight, with the risk of low birth weight babies almost twice as high for smokers than for non-smokers. Among smokers, the rate of sudden infant death syndrome is particularly high among Hispanics, African Americans, and Asians.

- **The tobacco industry has targeted advertising and promotion campaigns in ethnic and minority communities that pose serious challenges to reducing smoking among this population.** The report found that:

  -- Tobacco products are advertised intensively in racial and communities. For example, in one city, 62 percent of billboards in predominantly African American neighborhoods advertised cigarettes, compared with 36 percent of billboards citywide.

- **More research is needed to understand racial and ethnic smoking patterns and to reduce tobacco use among racial and ethnic minorities.**

  -- The Surgeon General's report highlights successful community-based tobacco prevention and cessation programs, as well as successful federal programs that are tailored to the needs of specific minority and ethnic communities.

  -- The report, however, demonstrates the need for further research to develop the prevention and cessation programs that will be most effective in minority communities.

III. PARTICIPANTS

Briefing Participants:
The Vice President
Secretary Shalala
Surgeon General David Satcher
Erskine Bowles
Bruce Reed
Larry Stein
Ron Klain
Cynthia Rice
Chris Jennings

Event Participants:
The Vice President
Secretary Shalala
Surgeon General David Satcher
Senator Bill Frist (R-TN)

Also on Stage:
32 students from Hine Junior High School, Hardy Elementary School, Bannekar High, and Wilson High School in D.C., who are involved in anti-tobacco activities at their schools, including the exposure of tobacco marketing targeted towards youth.

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- **YOU** will walk to the Tent on the South Lawn accompanied by the Vice President, Secretary Shalala, Surgeon General David Satcher, Senator Bill Frist, and 32 students.
- The Vice President will make remarks and introduce Secretary Shalala.
- Secretary Shalala will make remarks and introduce Senator Bill Frist.
- Senator Bill Frist will make remarks and introduce Surgeon General David Satcher.
- Surgeon General David Satcher will make remarks and introduce **YOU**.
- **YOU** will make remarks.
- **YOU** will work a ropeline and then depart.

VI. REMARKS

Remarks Provided by Speechwriting.

PRESIDENT SAYS NEW SURGEON GENERAL'S REPORT UNDERSCORES THE NEED FOR COMPREHENSIVE BIPARTISAN TOBACCO LEGISLATION
April 27, 1998

The President said today that a new Surgeon General's report on tobacco use among minority groups underscores the urgent need for comprehensive legislation to reduce youth smoking. The report shows that smoking has increased dramatically among minority youth, rising 80 percent among African American youth and 34 percent among Hispanic youth from 1991-1997. Tobacco use is also increasing among Asian American and American Indian/Alaska Native youth, according to the most recent data available. This report -- the first to be released by newly appointed Surgeon General David Satcher -- is the first comprehensive source of data on the use and health effects of tobacco among minority groups.

The Surgeon General's Report Documents Disturbing Trends in Tobacco Use. African Americans, Hispanics, Asian Americans, and American Indians/Alaska Natives make up nearly one-fourth of the United States population. The report provides a comprehensive analysis on the effect of tobacco on these groups, including that:

- **Teen smoking rates are rising in many ethnic and minority groups, and adult smoking rates are strikingly high among certain populations.**

  -- Teen smoking rates rose dramatically among African-Americans and Hispanics from 1991-1997. Smoking rates among African-American high school students were up by a startling 80 percent, and smoking rates among Hispanic high school students increased by 34 percent.

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

  -- The report also documents that American Indians have the highest adult smoking rates of any ethnic or minority group in the United States -- nearly 40 percent, compared to 25 percent of all adults.

- **Cigarette smoking is a major cause of death and disease among all minority and ethnic groups.** The report documents that:

  -- Lung cancer is the leading cancer death for all four minority groups. The increase in youth smoking threatens to reverse recent progress made against lung cancer among these groups.

  -- African-American men bear the greatest health burdens from lung cancer, with death rates about 50 percent higher than whites. Lung cancer incidence has increased substantially among Alaska Natives (93 percent increase for men and 241 percent increase for women) since the 1970s.

-- Smoking increases infant mortality and low birth weight, with the risk of low birth weight babies almost twice as high for smokers than for non-smokers. Among smokers, the rate of sudden infant death syndrome is particularly high among Hispanics, African Americans, and Asians.

- **The tobacco industry has targeted advertising and promotion campaigns in ethnic and minority communities that pose serious challenges to reducing smoking among this population.** The report found that:

  -- Tobacco products are advertised intensively in racial and communities. For example, in one city, 62 percent of billboards in predominantly African American neighborhoods advertised cigarettes, compared with 36 percent of billboards citywide.

- **More research is needed to understand racial and ethnic smoking patterns and to reduce tobacco use among racial and ethnic minorities.**

  -- The Surgeon General's report highlights successful community-based tobacco prevention and cessation programs, as well as successful federal programs that are tailored to the needs of specific minority and ethnic communities.

  -- The report, however, demonstrates the need for further research to develop the prevention and cessation programs that will be most effective in minority communities.

The President Renewed His Call for Comprehensive Bipartisan Tobacco Legislation. The President emphasized that this report again demonstrates the need to pass bipartisan comprehensive tobacco legislation to reduce youth smoking this year. Noting that Senator McCain's bill is a strong step in the right direction, the President renewed his call for Congress to send him legislation that:

- Raises the price of cigarettes by up to $1.50 a pack over the next ten years and imposes tough penalties on companies that continue to sell to kids;

- Confirms the FDA's authority to regulate tobacco products;

- Gets tobacco companies out of the business of marketing to children;

- Furthers public health research and goals; and

- Protects tobacco farmers and their communities.

Q&As
Surgeon General Report on Minority Tobacco Use
April 27, 1998

Q. What does the Surgeon General's Report say?

A. The Surgeon General's Report being released today is the first comprehensive report on the use and health effects of tobacco among minority groups. The report finds that from 1991 to 1997, smoking increased by 80 percent for African-American youths and by 34 percent for Hispanic youth. The report finds that cigarette smoking is a major cause of disease and death among minority populations, which will only get worse if these trends are not reversed. The report also documents that efforts to reduce and prevent smoking among minority and ethnic populations are undermined by the tobacco industry's heavily targeted advertising and promotion of tobacco products within these communities.

In short, the report demonstrates, once again, why Congress needs to pass comprehensive tobacco legislation to reduce youth smoking this year.

Additional Background

Youth Smoking: Smoking Among High School Students (9-12th graders)

	Percent Smoking, 1991	Percent Smoking, 1997	Percent Increase
African American	12.6%	22.7%	80%
Hispanic	25.3%	34.0%	34%
White	30.9%	39.7%	28%
All Students	27.5%	36.4%	32%

Youth Smoking: Smoking Among High School Seniors (12th graders)

	Percent Smoking, 1990	Percent Smoking, 1995	Percent Increase
Asian American/ Pacific Islander	17.5%	20.5%	17%
American Indians/ Alaska Natives	37.8%	47.7%	26%

Adult Smoking

	African American	Hispanic	Asian American/ Pacific Islander	American Indian/Alaska Native	White
Percent	26.5%	18.9%	15.3%	39.2%	25.9%

Q: What does the report say about the tobacco industry targeting of minority communities?

A: The Surgeon General's report shows the need for comprehensive tobacco legislation to reduce youth smoking that includes limits on advertising. The report found that the tobacco industry has targeted advertising and promotion campaigns intensively in minority and ethnic communities. For example, a 1990 study of San Francisco found that 62 percent of billboards in predominantly African American neighborhoods advertised cigarettes, compared with 36 percent of billboards citywide. A 1993 study of San Diego found the highest proportion of billboards featuring tobacco companies was in Asian American neighborhoods, followed by African-American then Hispanic neighborhoods.

The report chronicles how tobacco companies have promoted their products by sponsoring numerous ethnic activities and events, such as Chinese New Year festivities, Cinco de Mayo festivities, as well as activities related to Asian/Pacific Heritage month and African-American history month. A study of magazines found that there were 12 percent more cigarette advertisements in magazines targeted to African Americans *(Jet, Ebony* and *Essence*) then in magazines targeted to the general population (*Time, Newsweek, People,* and *Mademoiselle*).

Q. Does the President have a specific proposal to address the particular problem of tobacco use within minority communities?

A. Passing comprehensive tobacco legislation designed to reduce youth smoking will help all Americans -- regardless of their background or ethnicity. The Surgeon General's report illustrates that this is an extremely important issue in minority and ethnic communities. It also demonstrates that we need to better understand the use and effects of tobacco among minority and ethnic groups. For example, we want to look carefully at why smoking rates increased by 80 percent for African-American youth and by 34 percent among Hispanics from 1991 to 1997 so that we can develop the prevention and cessation programs that will work best in those communities. We will continue to work closely with minority health experts to determine how best to address these issues.

Q: Why are the smoking rates of African Americans lower than whites?

A: The Surgeon General report documents a number of studies that show that differences in social attitudes and lifestyle factors between white and African-American youth help account for their different smoking rates. However, further research is needed to better account for these different smoking rates as well as to understand the recent increases in smoking among African-American youth.

Additional Background

Studies cited in the Surgeon General's report show that over time African-American high school seniors have become increasingly more likely than white seniors to acknowledge

the health risks of tobacco, to claim that smoking is a "dirty habit", and to claim that they prefer to date non-smokers. African-Americans are also likely to start smoking later than whites.

One study in Tennessee showed that white high school age girls are four times more likely than their African-American counterparts and white boys twice as likely as African-American boys to believe that "smoking can help you control your weight and appetite." This same study revealed that 60 percent of white girls and nearly 20 percent of white boys cited weight control as a reason for smoking, whereas none of the African-American students cited weight as a reason for smoking. Another study showed that African-American teenage girls are less likely than white girls to think that smoking enhances their image.

A previous Surgeon General's report found that when parents express concerns about smoking it appears to reduce the likelihood that their children will smoke. Various studies across the country have documented that African-Americans are more likely to have received anti-smoking messages from their parents.

Q. Aren't the minority health organizations and the Congressional Minority Caucuses drafting legislation to address the problem of tobacco use among minorities, including by earmarking funds to this issue? What is your reaction to these proposals?

A. Comprehensive legislation that meets the principles that the President has outlined would address many aspects of this problem: the best way to reduce youth smoking among minority populations is to design effective, comprehensive legislation that will reduce youth smoking in all our communities. But the Surgeon General's report underscores the need to understand the use and effects of tobacco among minority communities, and to devise the prevention and cessation programs that will work best in those communities. We look forward to reviewing closely any proposals that address our shared concerns.

Q: Aren't the fees imposed by the Administration's plan and the McCain bill regressive and therefore hit minority communities hardest?

A: The tobacco industry has spent billions of dollars marketing to low-income and minorities, and made billions of dollars at their expense. Big Tobacco doesn't care about poor people -- it just wants to keep hooking future smokers. As a result, low-income people have suffered a disproportionate level of tobacco-related harm. The Administration is committed to making sure cessation programs are available to help all smokers quit -- and just as important, that we change the way the tobacco industry does business so it no longer preys on poor kids in the first place.

Q: Are you concerned about the information reported in last week's New York Times that young African Americans are smoking more to enhance the high from marijuana?

A: This Administration has long recognized that cigarettes, alcohol, and illegal drugs all pose a serious threat to our youth. Studies have shown that kids who make it to their 21st birthday without having smoked a cigarette, taken a drink or turned to drugs are almost certain to avoid chemical dependency throughout their lives. That is why our goal must be to keep teenagers from having that first drink, trying a cigarette, or experimenting with illegal drugs before they are old enough to know better and to realize the consequences of their decisions.

We are greatly concerned by data showing that smoking among African American youth has increased by 80 percent over the last six years. New information relating this trend to marijuana use is very disturbing, and provides still further reason to take strong action against illegal drugs. Of course, as The New York Times points out, the increase in tobacco use is even more heavily associated with advertising and other media messages that have a great impact on young people. That's why minority youth tend to smoke Kool and Newport, brands advertised with minority images, while white youth smoke Marlboro and Camel, whose ads feature white characters.

These facts underscore why we need comprehensive legislation to reduce youth smoking by raising the price of cigarettes, putting into place tough restrictions on advertising and access, imposing penalties on the industry if it continues to sell cigarettes to children, and ensuring that the FDA has authority to regulate tobacco products.

Q. What do you think of the House Republican proposal to link drugs and tobacco in a single bill?

A. Nobody disagrees about the need to be tough on drug use, but that is no excuse to be less than tough on youth smoking. We need to pass strong, comprehensive tobacco legislation this year that dramatically reduces youth smoking by raising the pack of cigarettes, imposing tough penalties on companies that continue to sell to kids, granting the FDA authority over tobacco products, and restricting advertising and marketing to children. The McCain bill, which passed the Senate Commerce Committee by a 19-1 vote three weeks ago, is a strong step in that direction. If Republicans want to add good anti-drug provisions to a comprehensive tobacco bill of this kind, we have no objections. But the bill must address the problem of youth smoking comprehensively; anti-drug provisions can't serve as an excuse for watered-down tobacco legislation.

Q: What exactly is the President's strategy on drugs?

A. This past February President Clinton released the 1998 National Drug Control Strategy, a comprehensive ten-year plan to reduce drug use and availability by 50% -- to a historic new low. The strategy is backed by a $17 billion anti-drug budget in FY 1999 -- the

largest ever presented to Congress, with a $1.1 billion increase over last year's budget.

While the strategy incorporates specific goals and objectives in the areas of drug treatment and prevention, domestic law enforcement, interdiction, and international programs, its number one goal is to educate and enable our youth to reject illegal drugs. That is why the largest budget increases (15% over last year's funding levels) are targeted for this purpose. In contrast, Speaker Gingrich and the House Republicans tried to cut the Safe and Drug-Free Schools program -- the program that funds anti-drug efforts in 97% of the nation's school districts -- by a full 50% just a few years ago.

Key initiatives in the drug strategy include:

Protecting Kids:

- $195 Million National Youth Anti-Drug Media Campaign to make sure that when kids turn on the television or surf the "net," they learn about the dangers of drugs.
- $50 Million for School Drug Prevention Coordinators to improve and expand the Safe and Drug-Free Schools program by hiring more than 1,000 new prevention professionals to work with thousands of schools in preventing drug use.

Strengthening Our Borders:

- $163 Million for Border Patrol to hire 1,000 new Border Patrol officers and for "force multiplying" technology.
- $54 Million for Advanced Technology for the Customs Service to deploy advanced technologies, such as X-ray systems and remote video surveillance.
- $75.4 Million to Support Interdiction Efforts in the Andean region and Caribbean, and to train Mexican counterdrug forces.

Strengthening Law Enforcement:

- $38 Million to Crack Down on Methamphetamine and Heroin by hiring 100 new DEA agents, expanding the Administration's anti-methamphetamine initiative, and targeting heroin traffickers.

Breaking the Cycle of Drugs and Crime:

- $85 Million to Promote Coerced Abstinence to help state and local governments implement drug testing, treatment, and graduated sanctions for drug offenders.

Closing the Treatment Gap:

- $200 Million Increase for Substance Abuse Block Grants to help states close the treatment gap.

Q. What is wrong with passing a "skinny" tobacco bill? Why do you need a comprehensive bill?

A. Every day, 3000 children and adolescents begin smoking, and 1,000 will die prematurely as a result. Experts agree that in order to dramatically reduce youth smoking we need to take a comprehensive approach that will attack the problem from a variety of angles.

- Price: All experts agree that the single most important step we can take to reduce youth smoking is to raise the price of a pack of cigarettes significantly. That is why the President has proposed raising the price of cigarettes by $1.10 over five years -- an increase that both the Treasury Department and the Congressional Budget Office agree should cut youth smoking by about a third.

- Advertising: Studies show that industry advertising significantly contributes to youth smoking rates. The Treasury Department has estimated that the advertising and marketing restrictions in the McCain bill should cut youth smoking by about 15 percent. This is a conservative estimate: a study recently published in the Journal of the American Medical Association found that a full 34% of teen smoking is attributable to promotional activities.

- FDA Jurisdiction: Reaffirming the FDA authority over tobacco products is necessary to help stop young people from smoking before they start. Currently, nearly 90 percent of people begin smoking before age 18, despite the laws that make it illegal to sell cigarettes to minors. FDA Authority will ensure that young people do not have access to these products.

- Penalties: Strong lookback penalties will act as an insurance policy to ensure that the tobacco industry takes meaningful steps to reduce youth smoking. If the bill's provisions on price, advertising, and FDA jurisdiction do not bring youth smoking down as much as expected, penalties will kick in to ensure that the industry has every incentive to take further action to reduce youth smoking.

All of these measures support and reinforce each other; all are necessary to ensure that legislation dramatically reduces youth smoking.

Q: Isn't the President's plan a big government, big tax proposal?

A: No. What the President's approach does is to attack the problem of youth smoking comprehensively, as all experts say we need to do, by combining strong provisions on price, penalties, advertising and access, and FDA jurisdiction. Although we have some differences with Senator McCain, he also recognizes the need to move forward on all these fronts to reduce youth smoking. That's not about big government. It's about sensible, bipartisan steps to dramatically reduce youth smoking.

Q. But won't the McCain bill create 17 new federal bureaucracies?

A. No -- this isn't about big government. That's just another Big Lie from Big Tobacco. What the bill does is to ensure that the federal government has the authority to regulate tobacco products in order to reduce youth smoking, as well as the ability to target tobacco revenues to strong public health and research efforts. The so-called "bureaucracies" that the industry is now complaining about are nothing more than what's necessary to protect the public health in this way -- to ensure that cigarettes are not sold to minors, to promote effective education, and to encourage smoking cessation. The proof that this is an industry con job is clear: almost all these provisions were in the June 1997 proposed settlement put forward by 41 state attorneys general, which the industry agreed to. The industry is criticizing these provisions now only because the political tide has turned against it, and certain other aspects of the legislation have gotten stronger.

Q: Hasn't the Administration proposed a big government scheme that would extend the reach of the federal government to every mom-and-pop grocery store?

A: No. The Administration has offered proposals designed to reduce smuggling that would require wholesalers, distributors, and retailers to identify themselves as such. That's no more than what any business has to do now to sell liquor -- and no more than what most states already require sellers of tobacco to do. The important thing is to work with Congress to devise a scheme that will facilitate the effort to prevent smuggling, while not burdening retailers. The Administration will work with Congress, and the retailers themselves, on this issue.

Q: Aren't you just trying to bankrupt the companies?

A: We don't want to put the tobacco companies out of business. We just want to put them out of the business of selling cigarettes to kids. A central feature of comprehensive tobacco legislation is to ensure that most of the payments made by the tobacco companies are passed on to price, in order to reduce youth smoking. As a result, there will be at most a modest impact on the profitability of the tobacco companies. This is also an industry with significant cash flow and net assets that will allow it to easily absorb this modest profit decline. The operating earnings of RJR, Philip Morris, and Loews last year were *$18 billion.* Even RJR, the most highly leveraged firm in this industry, had a $1.5 billion operating profit for its domestic tobacco business, and has over $4 billion in net assets from its Nabisco stock holdings. The only real risk of bankruptcy comes from losing a rash of lawsuits in court.

Tob- sct - ~~minorities~~ minorities - Surgeon General report

April 23, 1998

TO: Bruce Reed
Chris Jennings
Cynthia Rice
Toby Donenfeld

FROM: Victor Zonana

Victor Zonana

The following are a draft HHS press release, a fact sheet, and questions and answers on the Surgeon General's report. I have also attached draft remarks for Dr. Satcher. I assume that you will be writing a White House fact sheet for Monday's event. Please let me know if you have any questions or need additional information.

Thank you.

HHS NEWS

DRAFT

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Contact:

FOR RELEASE
at (time), April 27, 1998

HISTORIC SURGEON GENERAL'S REPORT HIGHLIGHTS DRAMATIC INCREASES IN TOBACCO USE AMONG RACIAL AND ETHNIC MINORITIES

Surgeon General David Satcher today released a landmark Surgeon General's report illustrating dramatic increases in smoking among racial and ethnic minority groups. This historic report is the first issued under new Surgeon General David Satcher, and the first Surgeon General's report to focus on tobacco use among racial and ethnic minorities. The report is the 24th Surgeon General's report to focus on tobacco use since the series began with Surgeon General Luther Terry's report in 1964.

According to the report, cigarette smoking is a major cause of death and disease in all four major racial and ethnic minority groups in this country: African-American, American Indian/Alaska Native, Asian American/Pacific Islander, and white. Of all four groups, American Indians and Alaska Natives have the highest rates of tobacco use, with little progress toward reducing use over the past decade and a half. African-American men bear one of the greatest health burdens of the four ethnic groups, with death rates from lung cancer that are 50 percent higher than that of white men.

The report also illustrates striking increases in tobacco use among adolescents from racial and ethnic minority groups. Though their rates remain lower than those of whites, cigarette smoking among African-American and Hispanic adolescents has increased in the 1990s after several years of substantial declines among adolescents of the major racial and ethnic groups. This increase is particularly striking among African-American youths, who had the greatest decline of the four groups during the 1970s and 1980s, but the steepest increase in use in the 1990s. Cigarette smoking among African-American teens has increased 80 percent over the last six years -- three times as fast as among white teens.

From 1990-1995, death rates from respiratory cancers declined substantially among African-American men, leveled off among African American women, and declined slightly among Hispanic men and women. However, the Surgeon General's report notes that the increasing rates of teenage smoking threaten to reverse the progress made against lung cancer among adults in these minority groups.

"This report sounds an urgent alarm," said Dr. Satcher. "We must use every tool at our disposal to reduce tobacco use among racial and ethnic minorities -- especially among adolescents -- and to reverse these frightening trends."

Dr. Satcher noted that the four groups studied by his new report make up about one-fourth of the U.S. population and are growing rapidly. By the year 2050, members of these racial/ethnic minority groups will comprise close to one-half of the United States population.

"This new report clearly shows tobacco's increasing grip on racial and ethnic minorities -- the fastest growing segments of the American population," said Secretary Shalala. "This new report underscores the need for Congress to pass comprehensive tobacco legislation this year."

In releasing the new report, Dr. Satcher also emphasized the implications of increased tobacco use on children's health.

"Not only does tobacco shorten the lives of kids who start smoking, but babies and children who are exposed to tobacco smoke have more ear infections, asthma, and a higher incidence of Sudden Infant Death Syndrome. Mothers who smoke during pregnancy are more likely to have a low birthweight baby and put their babies at increased risk of SIDS," emphasized Dr. Satcher.

The Surgeon General's report notes that prevalence of tobacco varies within racial and ethnic groups. For example, African-American men and Southeast Asian men have a high prevalence of smoking while Asian American women and Hispanic women have the lowest levels of smoking. The report also shows that, in general, smoking rates among Hispanics increase as they learn and adopt the values, beliefs, and norms of American culture.

According to the report, more research is needed to understand patterns of tobacco use and factors that affect tobacco use. Questions also remain about differences in tobacco-related disease and death rates among racial/ethnic minority groups.

A detailed summary of the Surgeon General's report, "Tobacco Use Among U.S. Racial/Ethnic Minority Groups," and other related information can be found on CDC's web site (www.cdc.gov/tobacco). Copies of the full report, Executive Summary, and report "At-a-Glance" can also be ordered by calling 1-800-CDC-1311 or writing Office on Smoking and Health, CDC, Mail Stop K-50, 4770 Buford Highway, Atlanta, Georgia 30341.

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DRAFT

At-a-Glance

Tobacco Use Among U.S. Racial/Ethnic Minority Groups

- African Americans
- American Indians and Alaska Natives
- Asian Americans and Pacific Islanders
- Hispanics

A Report of the Surgeon General

"Cigarette smoking is the leading preventable cause of disease and death in the United States. We have an enormous opportunity to reduce heart disease, cancer, stroke, and respiratory disease among members of racial and ethnic minority groups, who make up a rapidly growing segment of the U.S. population."

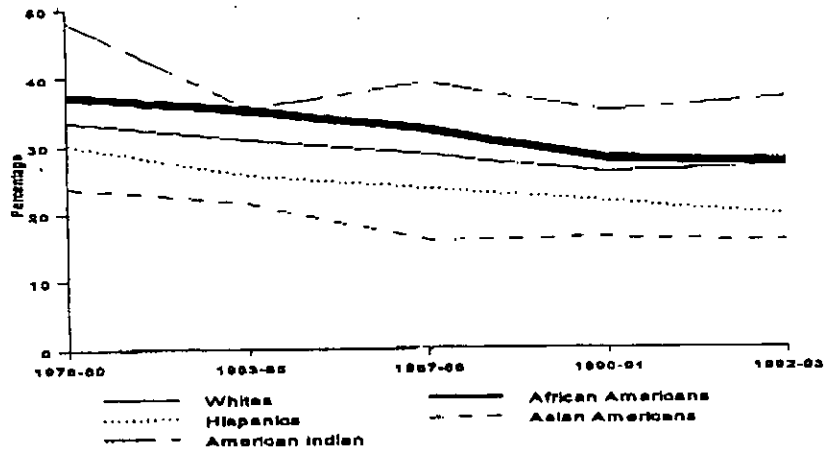
—David Satcher, M.D., Ph.D., Surgeon General

Major Conclusions of the Surgeon General's Report

- Cigarette smoking is a major cause of disease and death in each of the four population groups studied in this report. African Americans currently bear the greatest health burden. Differences in the magnitude of disease risk are directly related to differences in patterns of smoking.
- Tobacco use varies within and among racial/ethnic minority groups; among adults, American Indians and Alaska Natives have the highest prevalence of tobacco use, and African American and Southeast Asian men also have a high prevalence of smoking. Asian American and Hispanic women have the lowest prevalence.
- Among adolescents, cigarette smoking prevalence increased in the 1990s among African Americans and Hispanics after several years of substantial decline among adolescents of all four racial/ethnic minority groups. This increase is particularly striking among African American youths, who had the greatest decline of the four groups during the 1970s and 1980s.
- No single factor determines patterns of tobacco use among racial/ethnic minority groups; these patterns are the result of complex interactions of multiple factors, such as socioeconomic status, cultural characteristics, acculturation, stress, biological elements, targeted advertising, price of tobacco products, and varying capacities of communities to mount effective tobacco control initiatives.
- Rigorous surveillance and prevention research are needed on the changing cultural, psychosocial, and environmental factors that influence tobacco use to improve our understanding of racial/ethnic smoking patterns and identify strategic tobacco control opportunities. The capacity of tobacco control efforts to keep pace with patterns of tobacco use and cessation depends on timely recognition of emerging prevalence and cessation patterns and the resulting development of appropriate community-based programs to address the factors involved.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health

Percentage of U.S. adults who smoke



Source: National Health Interview Survey, National Center for Health Statistics, CDC, 1978-1993.

African Americans

- In the 1970s and 1980s, death rates from respiratory cancers (mainly lung cancer) increased among African American men and women. In 1990-1995, these rates declined substantially among African American men and leveled off in African American women.
- Middle-aged and older African Americans are far more likely than their counterparts in the other major racial/ethnic minority groups to die from coronary heart disease, stroke, or lung cancer.
- Smoking declined dramatically among African American youths during the 1970s and 1980s, but has increased substantially during the 1990s.
- Declines in smoking have been greater among African American men with at least a high school education than among those with less education.

American Indians and Alaska Natives

- Nearly 40 percent of American Indian and Alaska Native adults smoke cigarettes, compared with 25 percent of adults in the overall U.S. population. American Indians and Alaska Natives are more likely than any other racial/ethnic minority group to smoke tobacco or use smokeless tobacco.
- Since 1983, very little progress has been made in reducing tobacco use among American Indian and Alaska Native adults. The prevalence of smoking among American Indian and Alaska Native women of reproductive age has remained strikingly high since 1978.
- American Indians and Alaska Natives were the only one of the four major U.S. racial/ethnic minority groups to experience an increase in respiratory cancer death rates in 1990-1995.

Asian Americans and Pacific Islanders

- Estimates of the smoking prevalence among Southeast Asian American men range from 34 percent to 43 percent -- much higher than among other Asian American and Pacific Islander groups. Smoking rates are much higher among Asian American and Pacific Islander men than among women, regardless of country of origin.
- Asian American and Pacific Islander women have the lowest rates of death from coronary heart disease among men or women in the four major U.S. racial/ethnic minority groups.
- Factors associated with smoking among Asian Americans and Pacific Islanders include having recently moved to the United States, living in poverty, having limited English proficiency, and knowing little about the health effects of tobacco use.

Hispanics

- After increasing in the 1970s and 1980s, death rates from respiratory cancers decreased slightly among Hispanic men and women in 1990-1995.
- In general, smoking rates among Hispanics increase as they learn and adopt the values, beliefs, and norms of American culture.
- Declines in the prevalence of smoking have been greater among Hispanic men with at least a high school education than among those with less education.
- Factors that are associated with smoking among Hispanics include drinking alcohol, working and living with other smokers, having poor health, and being depressed.

Choosing health

- More than 10 million African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics smoke cigarettes. Without intervention, this number may swell in the coming decade.
- Both direct and passive exposure to cigarette smoking poses special hazards to pregnant women, babies, and young children. Babies and children who are exposed to tobacco smoke have more ear infections, asthma, and even die of SIDS more often. Mothers who smoke during pregnancy are more likely to have low-birthweight babies and put their babies at increased risk of SIDS.
- Smoking trends today will determine how heavy the health burden will be among communities tomorrow. Programs that reflect cultural diversity will be cornerstones in the battle against tobacco use.

Powerful influences undermine public health efforts

- Smoking is associated with depression, psychological stress, and environmental factors such as peers who smoke and tobacco marketing practices.
- Tobacco advertisements promote the perception of cigarette smoking as safe and far more widespread and socially acceptable than is actually the case.
- Tobacco companies garner community loyalty by hiring community members, providing communities with tobacco sales and advertising revenues, funding community organizations, and supporting educational, political, cultural, and sports activities.

Helping people enjoy smoke-free lives

- Group approaches for quitting smoking generally have not been successful with members of ethnic groups, possibly because the processes used have not been culturally relevant or because of a lack of transportation, money, and access to health care.
- To be effective in discouraging tobacco use among young people, strategies should include restricted access to tobacco products, school-based prevention programs, and mass media campaigns geared to young people's interests, attitudes, and cultural values.
- The most successful programs for quitting smoking do more than deliver culturally appropriate messages. They provide practical information about the health consequences of tobacco use, resources to help people quit, and specific techniques for quitting.

Cigarette smokers among U.S. racial/ethnic minority populations

These four groups now make up almost a fourth of the U.S. adult population of 194 million.

	1995 adult population	1994-1995 smoking prevalence	Number of adult smokers
African Americans	21.4 million	26.5%	5.7 million
American Indians and Alaska Natives	1.3 million	39.2%	0.5 million
Asian Americans and Pacific Islanders	6.2 million	15.3%	0.9 million
Hispanics	17.3 million	18.9%	3.3 million

Sources: National Center for Health Statistics and U.S. Bureau of the Census.

Percentage of U.S. adult smokers who would like to stop smoking

Characteristic	African Americans %	American Indians/ Alaska Natives %	Asian Americans/ Pacific Islanders %	Hispanics %	Whites %
Total	71.4	65.0	60.2	68.7	70.4
Men	68.6	57.3	58.3	63.8	67.8
Women	74.9	70.3	65.3	79.3	72.4

Source: National Health Interview Survey, National Center for Health Statistics, CDC, 1993.

Facts-at-a-glance

- In the 1970s and 1980s, smoking rates declined substantially among African American youths, regardless of gender, self-reported school performance, parental education, and personal income, but have increased markedly since 1992
- If current patterns continue, an estimated 1.6 million African Americans who are now under the age of 18 will become regular smokers. About 500,000 of those smokers will die of a smoking-related disease.
- Studies show that adverse infant health outcomes (e.g., the likelihood of pregnant women delivering low-birthweight babies, of SIDS, and of infant mortality) are especially high for African Americans and American Indians and Alaska Natives. Cigarette smoking also increases these risks, especially for SIDS, in Asian Americans and Pacific Islanders and in Hispanics.
- In all four racial/ethnic minority groups, the percentage of persons who have ever smoked and have quit increases with increasing age.
- In all racial/ethnic minority groups except African Americans, men are more likely than women to use smokeless tobacco.
- Asian Americans and Pacific Islanders are the least likely of the four U.S. racial/ethnic minority groups to smoke, but several local surveys report very high smoking rates among recent male immigrants from Southeast Asia.
- Most African American, Asian American and Pacific Islander, and Hispanic smokers smoke fewer than 15 cigarettes a day. Heavy smoking -- 25 or more cigarettes a day -- is most common among American Indians and Alaska Natives, but still lower than among whites who smoke.

Both complete and summary versions of *Tobacco Use Among U.S. Racial/Ethnic Minority Groups--African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General* are available. For more information about the report or to order a free executive summary, call (770) 488-5705 (press 2), access the Office on Smoking and Health's website at http://www.cdc.gov/tobacco, or write:

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DRAFT

Revision 4-23-98

SURGEON GENERAL of the United States

Dr. David Satcher, M.D., Ph.D.
Remarks for
Release of Surgeon General's Report

Tobacco Use Among U.S. Racial/Ethnic Minority Groups -- African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General

Press Conference
The White House
Washington, D.C.
April 27, 1998

Good morning. President and Mrs. Clinton, Vice President and Mrs. Gore, Secretary Shalala, distinguished guests, congressional leaders, minority caucus leaders, members of the press, ladies and gentlemen. Today, I am pleased to present my first report as Surgeon General -- and the first-ever report on smoking and health in racial and ethnic minority groups.

Today, I am especially proud to take my place beside some of my predecessors here with us: _____. They too have had the singular honor of presenting landmark reports on various aspects of smoking and the nation's health (acknowledge stack of 23 earlier reports on stage).

Since the first Surgeon General's report on smoking was released in 1964, we have made tremendous strides in reducing smoking among Americans, but tobacco still devastates the health and welfare of far too many of our fellow citizens. Regrettably in 1998, tobacco use is still the number one preventable cause of death in this country. Each year more than 400,000 Americans die from tobacco-related disease and each day 3,000 young people become regular smokers.

This new report leaves no doubt that cigarette smoking impairs and kills people of all racial and ethnic backgrounds. It is my hope that this new report will help the American public to better understand how tobacco is holding hostage the hopes for a better life for millions in our four major racial/ethnic minority groups -- African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics.

These four ethnic groups make up about one-fourth of this country's population and are growing rapidly. By the year 2050, members of these

ethnic groups will make up nearly one-half of the population. Now more than ever, we must have prevention research and public health programs that focus on preventing and reducing tobacco use in this growing segment of our society.

Today's report has five major conclusions.

The first conclusion is hardly surprising, but it cannot be overstated: Cigarette smoking is a major cause of disease and death in each of the groups studied in this report . African Americans bear one of the greatest health burdens, with death rates from lung cancer that are 50 percent higher than for white men. Each year, about 45,000 African Americans die from a smoking-related disease.

And, let me emphasize, when we speak of the burden of tobacco on the health of our minority groups, we are not just talking about lung cancer and heart disease in older adults. We're also talking about immediate harmful effects on babies and children. Those who are exposed to tobacco smoke have more ear infections, more asthma, even a greater risk of dying from SIDS.

The second major conclusion is that tobacco use varies widely within and among racial/ethnic minority groups (Refer to Graphic 1 - Adult Trends). More than 10 million adults in these groups smoke cigarettes. American Indians and Alaska Natives have the highest prevalence of tobacco use, a full 60 percent higher than the overall U.S. population, and little progress has been made to reduce these rates over the past decade and a half. Asian American and Hispanic women have the lowest prevalence of smoking.

Our third major conclusion: Among adolescents, cigarette smoking prevalence increased in the 1990s among all racial/ethnic groups. This new chart (refer to Graphic 2 - High School Senior Trends) includes data that became available after our report went to press. It shows this disheartening picture most

clearly. I say disheartening because these recent increases appeared after several years of substantial decline among teens in all the groups.

On a proportional basis, the increase is most striking among African American youths, who had the greatest decline of the four groups during the 1970s and 1980s. Still, African American teens smoke less than any other racial or ethnic group in the country. But if current patterns continue, an estimated 1.6 million African Americans who are now under the age of 18 will become regular smokers. About 500,000 of them will die of a smoking-related disease.

The report's fourth major conclusion is that no single factor determines patterns of tobacco use among racial/ethnic minority groups. These patterns are the result of complex interactions of multiple factors, such as socioeconomic status, cultural characteristics, acculturation, stress, biological elements, targeted advertising, and the price of tobacco products.

The report documents the close association between tobacco and significant events and rituals in the history of many ethnic communities. In addition to its marketing practices, the tobacco industry's long history of providing economic support to many ethnic groups poses a big challenge to prevention efforts.

Our final conclusion flows from the other four: We need more rigorous research on these patterns of tobacco use and all of these factors that influence them. Without aggressive prevention research programs, we will not be successful at finding ways to attack tobacco use in our minority communities.

We do know that smoking among members of the four ethnic groups is associated with depression, psychological stress, and environmental factors such as peers who smoke and tobacco marketing practices, as is also the case in the general population. Clearly, the role that these factors play in determining tobacco

use among ethnic groups deserves additional attention by researchers and those who develop prevention and cessation programs.

Ladies and gentlemen, those are the key findings from our report. So, we come full circle. So where do we go from here?

I'd like to end with some good news. And that is, while we await better tools and techniques from our research, we can take steps now to step the tide of tobacco use in our ethnic communities, especially among young people. We only have to look at California and Massachusetts, which have mounted intensive media and community programs funded by increases in the state tobacco tax. In those states, teen smoking rates have not increased as they have in the rest of the country.

The comprehensive strategies we need include strict enforcement of youth access laws, well-researched and culturally appropriate school and community programs, and counter-advertising campaigns geared to young people's interests, attitudes, and cultural values.

There already are success stories from efforts of dynamic national organizations, many of them represented here today, and of regional, state, and local groups and coalitions across the nation. Chapter five of today's report highlights many of these promising efforts:

— Like Life Skills Training, a school prevention program with proven effectiveness that has been adapted for African American and Hispanic students.

— Like Pathways to Freedom, a quit-smoking program for African Americans that has shown some remarkable success in helping smokers quit for good.

— Like Health is Gold!, a media-led program in San Francisco that targets Vietnamese men with messages through the media, doctors, and family members.

— Like the Southwest Cardiovascular Curriculum Project in New Mexico, which has led to measurable decreases in smoking among Navajo and Pueblo youth.

— Like Si Puedo, or "Yes I Can," a bilingual program in Queens, New York, that has been very effective in helping smokers quit who take part in all of the components offered: self-help materials, support groups, and media programs.

These are but a few examples. We now need to provide the resources to expand these efforts, spread those good ideas, and multiply their successes in minority and ethnic communities all across the nation.

I hope that this report informs, galvanizes, and inspires. I hope it sparks discussion, ideas, and creative solutions that will help our minority communities to lift the yoke of tobacco addiction off their backs and allow them a fair and equal chance to enjoy fuller lives.

With that, Mr. President, I present you with the twenty-fourth Surgeon General's report on smoking and health.

(The President comes forward and accepts the report from Dr. Satcher.)

DRAFT

TOBACCO USE AMONG U.S. RACIAL/ETHNIC MINORITY GROUPS
(Revised 4-23-98)

Q: What are the most significant findings of this report?

A: 1) Cigarette smoking is a major cause of disease and death in each of the four racial/ethnic minority groups studied in the report. African Americans currently bear the greatest health burden. Lung cancer incidence and death rates for African American men are about 50% higher than for white men.

2) Teen smoking rates rose in the 1990s among African Americans and Hispanics after several years of substantial decline among teens of all four racial/ethnic minority groups. This increase is particularly striking among African American youths, whose smoking rates were up 80 percent between 1991 and 1997.

3) We need to improve and intensify our research on prevention to distinguish differences in patterns of tobacco use and tobacco-related disease among racial/ethnic minority groups. Improved prevention research is essential to design effective strategies to prevent and reduce tobacco use in these groups.

4) The tobacco industry's targeted advertising and promotion campaigns, as well as economic contributions to community groups and leaders, pose a serious challenge to reducing tobacco use in racial/ethnic minority groups.

Other Cross-Cutting Health Messages

Progress in reducing tobacco use varies within and among racial/ethnic minority groups. Over the past decade, very little progress has been made in reducing tobacco use among American Indian and Alaska Native adults. For African Americans and Hispanics and for Asian males, increasing rates of adolescent smoking may soon reverse the progress being seen among adults.

Lung cancer incidence and death rates vary widely among U.S. racial/ethnic minority groups. However, lung cancer remains the leading cause of cancer deaths for African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics. Smoking accounts for 87 percent of the lung cancer cases in the United States.

In the 1970s and 1980s, death rates from respiratory cancers (mainly lung cancer) increased among African American, Hispanic, and American Indian and Alaska Native men and women. In 1990-1995, death rates from respiratory cancers declined substantially among African American men, leveled off in African American women, decreased slightly among Hispanic men and women, and increased for American Indian and Alaska Native men and women.

Group-Specific Health Messages

African American youths had the greatest decline in smoking prevalence during the 1970s and 1980s, but in the 1990s have experienced the greatest proportional increase among all four racial/ethnic minority groups.

American Indians and Alaska Natives have the highest prevalence of tobacco use of any major U.S. racial/ethnic minority group. The prevalence of smoking among American Indian and Alaska Native women of reproductive age has remained strikingly high since 1978.

Estimates of the smoking prevalence among Southeast Asian American men range from 34% to 43%--much higher than among other Asian American and Pacific Islander groups. Smoking rates are much higher among Asian American and Pacific Islander men than among women, regardless of country of origin.

The prevalence of smoking among adult Hispanic females traditionally has been lower than among Hispanic males. However, newly released data from the Youth Risk Behavior Survey for 1991-1997 indicate that smoking rates among Hispanic male and female youth both have been increasing and now are almost equal.

Q: **What prompted CDC to produce a report focusing on tobacco use among racial/ethnic minority groups? Didn't you just produce a report on smoking among ethnic youth?**

A: Several factors prompted the development of this report. First, the information in this report has never previously been compiled in one source. Consequently, policymakers, community leaders, researchers, and public health workers have had difficulty determining the extent of the problem and in identifying gaps in information regarding tobacco use among members of the various racial/ethnic minority groups. The information in the report will assist in prioritizing program interventions and initiatives to these communities.

The four main racial/ethnic minority groups currently constitute about one-fourth of the population of this country and, by 2050, will constitute nearly one-half of the U.S. population. Preventing health problems related to tobacco use among individuals in racial/ethnic minority groups will be integral to achieving U.S. public health objectives and supports objectives of the President's Initiative on Race.

The trend data from the Youth Risk Behavior Survey that were just published by CDC were part of a *Morbidity and Mortality Weekly Report (MMWR)* article that included data on cigarette smoking, smokeless tobacco use, and cigar smoking among U.S. high school

students. This Surgeon General's report provides a vast amount of information on a wide variety of topics relevant to tobacco use among racial/ethnic minority communities.

Q: What recommendations does the report make to help lower tobacco use among racial/ethnic minority groups?

A: The report calls for enhanced surveillance systems to document better trends and patterns of tobacco use among racial/ethnic minority groups. The report also calls for rigorous prevention research to help us develop effective tobacco-reduction strategies. While the report doesn't make policy recommendations, it does highlight characteristics of tobacco control efforts that address unique cultural needs. It also stresses the importance of restricting youth access to tobacco products, evaluates the appeal of tobacco products, and analyzes the effectiveness of media-based initiatives to control tobacco use. The report also outlines how the tobacco industry has targeted racial/ethnic minority communities.

Q: Does CDC have an anti-tobacco plan specifically targeted to racial/ethnic minority groups? What are its main elements?

A: CDC's tobacco control efforts have four main goals: (1) expand the amount and scope of scientific data relating to tobacco control; (2) implement prevention and control programs; (3) keep the public informed; and (4) develop partnerships and foster leadership on tobacco issues. CDC's tobacco control efforts among minority populations fit within these goals. CDC conducts research and data collection efforts on use of tobacco products and determinants of use among racial/ethnic minorities. CDC also supports prevention and control programs that address minority populations at the national, State, and local levels. CDC has developed educational and media campaigns that address racial/ethnic minority communities. Finally, CDC has developed partnerships with minority organizations and fostered leadership development on tobacco issues among minority organizations.

Q: How much did this report cost?

A: The overall cost of the report was approximately $600,000. The Surgeon General's Report on tobacco use in racial/ethnic minority populations is the first report detailing such information. This information will be used by public and private organizations to inform policy and program development officials.

Q: Previous SGRs have addressed health issues for the population at large. Will future SGRs address specific segments of the population instead? Has the overall purpose of the SGR changed?

A: Topics for these reports are discussed within HHS and based on perceived need. There has never been a report that focused totally on racial/ethnic minority groups. Of 24 previous reports, one was on smoking and women (1980) and another was on tobacco use among young people (1994). Some, but certainly not all, future reports may focus on specific segments of the population. The basic purpose of the report has not changed.

Q: This report does not address FDA regulations on smoking in racial/ethnic minority youths. Why not?

The FDA regulations are designed to address the broader population and do not target specific racial/ethnic minority populations. However, the FDA regulations can be effective in reaching racial/ethnic minority groups by addressing the broader population. For example, by decreasing advertising in general, a differential effect will occur in racial/ ethnic minority populations that have historically been targeted for advertising and promotional campaigns by tobacco companies. In this way, the FDA regulations can have a very positive effect on tobacco use among racial/ethnic minority populations.

Q: Does the government need to develop new programs or initiatives to address smoking in racial/ethnic minority communities?

A: Yes. It is vitally important that the government enhance existing programs and develop new programs to address tobacco use in racial/ethnic minority communities, which have been disproportionately affected by the health burdens of tobacco. Furthermore, these communities have been specifically targeted by tobacco companies through advertising and promotional campaigns. It is crucial that effective programs be specifically tailored to address the needs of these communities to reverse the recent disturbing trends noted in racial/ethnic minority youth tobacco use--as well as the high tobacco use rates among adults.

Q: Why is this report so late?

A: The Surgeon General's Report is a compilation of work from dozens of individual authors on specific aspects of tobacco use in U.S. racial/ethnic minority groups. Some authors were delayed because of other educational and professional commitments. Organizing the appropriate experts to provide the required data from each of the minority communities was complex and difficult. In addition, the report has been updated as trend

data on tobacco use have emerged. The report underwent its initial review processes at a time when the Surgeon General's post was vacant, which also contributed to the delay.

GENERAL QUESTIONS

Q: What were the major sources of information for the report?

A: The report relies primarily on published studies from the scientific literature and data from population-based, government-sponsored surveys.

Q: How accurate and complete are the data?

A: The survey data come primarily from the National Health Interview Survey, the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey, and the Monitoring the Future Surveys. However, numerous surveys that were conducted specifically to study tobacco use among members of various racial/ethnic minority groups are also discussed in the report. Many of these surveys were conducted in the respondents' native languages (e.g., Spanish, Vietnamese), as needed.

Q: How did researchers measure tobacco use?

A: Survey researchers measure tobacco use among adults by asking whether the person has ever used a specified amount of each product (e.g., smoked at least 100 cigarettes or used snuff at least 20 times) and then determining if that person currently uses a product (e.g., if they smoke every day or some days).

Q: Who wrote the report?

A: The report was written by more than 25 scientists who were selected because of their expertise and familiarity with topics covered in this report.

Q: What is the prevalence of smoking among racial/ethnic groups?

A: For U.S. adults in 1994 and 1995, 26.5% of African Americans, 39.2% of American Indians and Alaska Natives, 15.3% of Asian Americans and Pacific Islanders, 18.9% of Hispanics, and 25.9% of whites were current smokers.

For male high school seniors in 1990-1994, 11.6% of African Americans, 41.1% of American Indians and Alaska Natives, 20.6% of Asian Americans and Pacific Islanders, 28.5% of Hispanics, and 33.4% of whites were current smokers. For female high school seniors in 1990-1994, 8.6% of African Americans, 39.4% of American Indians and Alaska Natives, 13.8% of Asian Americans and Pacific Islanders, 19.2% of Hispanics, and 33.1% of whites were current smokers.

Q: Why is there a difference in prevalence of smoking between whites and African Americans?

A: The trends are different for the two groups. In the late 1970s, whites and African American high school seniors smoked at about the same rate (38% for whites and 37% for African Americans in 1977). Prevalence for whites declined to about 31% in the early 1980s and then leveled off. Prevalence for African Americans steadily dropped to about 9% in 1992, when it was 32% for whites. Prevalence for both groups subsequently increased so that by 1997, 14% of African Americans and 41% of whites smoked.

We have no clear answers and need more prevention research regarding culturally sensitive programs that work. Researchers have ruled out many factors that might have explained the difference. The lower smoking rate for African American adolescents is not explained by differential school dropout rates, differential misclassification bias, later age of initiation for African American smokers, differential use of alcohol and other drugs, or differences in background and lifestyle variables (e.g., socioeconomic status, personal income, school performance, importance of religion). It appears that the social acceptability of cigarette smoking has decreased in the African American adolescent community as compared to the white adolescent community. African American girls may not be as obsessed with being thin as white girls; hence, the possible weight controlling effects of cigarettes may not be as attractive to African American girls as to white girls. Also, it appears that the parents of African American adolescents are more likely than the parents of white adolescents to express disapproval with their children's smoking and to favor the use of tobacco-prevention policies. Finally, white girls are more likely to say that cigarette advertising "empowers" them.

Q: Didn't the report you just released on tobacco use among youth show a dramatic increase in smoking in the African American community? Why isn't that increase reflected in this SGR?

A: Recent data on tobacco use by young people did show an increase in smoking among African American youth. The Surgeon General's Report was already completed and under final review before 1998 data on youth smoking became available. Rather than delay the SGR to include these new data, we instead are including this information in

supplemental materials that are available with the report.

Q: The New York Times just ran a story indicating that some kids use tobacco to extend the effect of marijuana. Is there scientific evidence of that?

A: There are numerous anecdotal reports that some African American youths smoke tobacco products when they are also smoking marijuana to enhance or prolong the effects of marijuana. Both cigarettes and cigars are used for this purpose. The potential pharmacologic aspects of this phenomenon need to be explored. However, data presented in the Surgeon General's report for 1009-1994 indicate that fewer African American (3%) than white (12%) high school seniors reported that they used both cigarettes and marijuana during the previous month. This survey did not measure cigar use. Also, we have no laboratory evidence to date that such a "spiking" effect of tobacco and marijuana smoking actually occurs.

Q: Why were smoking prevalence data for Asian Americans and Native Americans excluded from the latest 1997 YRBS data?

A: The number of Asian American and Native American respondents was too low to provide a statistically valid estimate of smoking prevalence among these youth.

Q: It has recently been stated that the 1997 Youth Risk Behavior Survey (YRBS) data suggest that information on Hispanic youths may be biased by the relatively large proportion of Hispanics who leave school before graduating from high school. Is this true?

A: The recently published report on the 1997 YRBS did not present data by race/ethnicity and grade and cannot be used to substantiate such a claim. The Monitoring the Future data for 1997 indicate that the prevalence of smoking for Hispanic youths was 19.1% for 8th graders, 23.0% for 10th graders, and 25.9% for 12th graders. For African Americans, prevalence was 10.9% for 8th graders, 12.8% for 10th graders, and 14.3% for 12th graders. Among white students, prevalence was 22.8% for 8th graders, 34.4% for 10th graders, and 40.7% for 12th graders. The rate of increase from 8th to 12th grade was about the same for Hispanics and African Americans and lower than for whites. These findings, however, do not substantiate a dropout effect.

Additionally, unpublished data from three national household surveys (the 1993 Teenage Attitudes and Practices Survey, the 1992 YRBS National Health Interview Survey supplement, and the 1994/1995 National Household Survey on Drug Abuse) all indicate that smoking prevalence is higher in each of these three racial/ethnic minority groups for dropouts.

Q: How many people in the racial/ethnic minority populations die of smoking related illness a year?

A: It is difficult to precisely estimate smoking-attributable deaths for each of the racial/ethnic groups cited in the report. This is because there may be differing lifetime histories of smoking among the various groups.

However, the smoking histories among African Americans have been well documented and permit calculations of their smoking-attributable mortality. CDC has previously estimated that about 45,000 African Americans die each year from diseases caused by their smoking.

Q: Are some racial/ethnic minority groups more susceptible to smoking related illness than other groups?

A: There were no consistent reports of racial/ethnic minority differences in disease risk based on case-control and prospective studies. Efforts to predict racial/ethnic specific rates of disease incidence and mortality from racial- and ethnic- specific cigarette smoking prevalences are of limited value because other factors can also influence disease rates. Further research could clarify some of the relationships observed.

Q: Are children of racial/ethnic minority groups at greater risk of developing smoking-related asthma?

A: The Environmental Protection Agency has documented that exposure to secondhand smoke exacerbates and may even cause childhood asthma. Asthma rates are very high among African American youths who experience a disproportionately high rate of exposure to secondhand smoke.

Q: How much do the health consequences of smoking cost the racial/ethnic minority population every year?

A: Such calculations have not been made and such a study would be a substantial undertaking. However, health economists have stated that health care costs would be higher for smokers than nonsmokers regardless of racial/ethnic origin.

Q: What needs to be done to reduce tobacco use in racial/ethnic minority communities?

A: Tobacco use prevention activities should be designed to prevent the use of all tobacco products. Such activities should include increasing tobacco prices, reducing access (i.e., implementing and adequately enforcing minors' access restrictions), reducing the appeal of tobacco products (e.g., by restricting advertising and promotion), conducting mass media efforts geared to young people's interests and attitudes, and establishing culturally appropriate school-based prevention programs. Strengthening health-oriented social norms (e.g, by increasing provision of smoke-free indoor air and decreased use of tobacco by parents, teachers, and celebrities) and increasing support and involvement from parents and schools also will contribute to prevention.

Tobacco cessation has major and immediate health benefits for men and women of all ages. Factors that motivate quitting include increasing awareness of the deleterious health consequences of tobacco use, concern about the effects of one's use on others (both as a role model and because of concern about second hand smoke) , and the price of cigarettes. Interventions that present information in a culturally appropriate manner and that provide relevant skills training (e.g., stress-reduction techniques) help with quitting. Pharmacologic therapy can also assist quitting efforts.

Q: Do we have evidence that targeting teens with counter-advertising and community programs works?

A: Yes. In California and Massachusetts, where cigarette taxes have funded intensive and sustained community programs and counter-advertising campaigns, the rates of teen smoking have not increased as they have in the rest of the country.

Q: Have school health programs been effective in racial and ethnic minority groups?

A: To date, school-based tobacco education programs have been targeted to students at large, rather than tailored to the specific cultural characteristics of racial/ethnic minority students. One program with demonstrated effectiveness in preventing tobacco use, Life Skills Training, was initially developed for use with white youths, but the curriculum was later modified for use with Hispanics and African Americans. Pilot studies have found the curriculum is acceptable to these students, that it can be implemented with little difficulty in urban settings, and that it can produce significant reductions in knowledge, smoking behavior, and perceived norms among the targeted students.

Q: The tobacco industry has traditionally supported the racial/ethnic minority population and their educational, religious, and community organizations. What effect has this had on tobacco use among racial/ethnic minority groups?

A: Changing community values around tobacco use would in many instances help to decrease tobacco-use rates in racial/ethnic minority communities. This may help to explain why there has been more emphasis placed on working with community groups and grassroots organizations. The basic idea is to build broad-based coalitions to promote the rejection of tobacco use. Given the historical role played by the tobacco industry in the daily life of many racial/ethnic minority communities--supporting their organizations, programs, and leaders--it is understandable why strong anti-tobacco-use voices would be slow to emerge. This situation was compounded by a lack of racial/ethnic minority research regarding tobacco. Racial/ethnic minority community leaders were able to secure tremendous amounts of tobacco industry support but minimal support from other legitimate research institutions. Naturally, the emergence of strong non-tobacco use cultural norms was not encouraged. What is more, racial/ethnic minority communities have been overwhelmed with massive billboards and advertising campaigns glamorizing tobacco use. Nonetheless, there are indications of an emerging awareness in racial/ethnic minority communities of the true hazard of tobacco use along with a noticeable increase in community involvement in the tobacco-control movement.

Q: How important is tobacco to the economy of racial/ethnic minority communities?

A: Tobacco and the tobacco industry have historically had considerable economic impact on racial/ethnic minority communities, apart from the toll in health, productivity, and medical costs that result from tobacco use. Contributions made to racial/ethnic minority communities by the tobacco industry have been very important because: (1) they have been made over a period of many years; (2) they have been comprehensive, addressing the economic, cultural, social, and political infrastructure of the communities; and (3) they have been large in magnitude, particularly when compared to other sources of promotional funding available to racial/ethnic minority communities.

The African American community provides the longest historical record of dependence on tobacco and/or tobacco industry infrastructure. Africans were compelled as slaves to grow tobacco and ironically some used it as a cash crop to buy themselves out of slavery. This beginning defines the historical contradiction of the African American community and the tobacco industry. Today, over 22% of employees in the tobacco industry are African American.

The tobacco industry is quite diverse in its contributions, providing large sums to cultural, educational, and training programs. The most poignant example is a statement by a representative of the Alvin Ailey Dance Company who stated that for them the tobacco

industry was one of the "thousand points of light." African American media are dependent on the tobacco industry for dollars and a disproportionate amount of their profits from advertising is derived from tobacco in comparison to mainstream media. What is true of African Americans is also true for the Hispanic community. Many similar programs receive support, including legislative caucuses. American Indians rely heavily on income from smoke shops, and these have become integral components of the economic infrastructure of reservations. Asian American communities also receive support from the tobacco industry, but this has been not as well-documented in the literature as is the case for other communities of color.

Because of the tremendous amount of promotional money the tobacco industry pours into racial/ethnic minority organizations, moving communities of color to a position of independence and self-determination with regard to the tobacco industry is one of the most critical challenges facing the tobacco control movement.

Q: Don't cigarette tax increases place the burden largely on the economically handicapped shoulders of certain racial/ethnic minority groups?

A: Since smoking prevalence rates in this country have been significantly higher among lower income groups, the burden of illness and death caused by smoking has been borne disproportionally by lower income groups. Several studies have suggested that lower income smokers may be more sensitive to price increases, so they will benefit from the reduction in consumption levels the most. Although this does not completely remove the regressivity of the price increase, it makes the public health benefits achieved from the price increase more equitable. This also underscores the concerns of racial/ethnic minority community leaders who would like to see a greater portion of the revenue derived from excise taxes targeted to programs serving the economically disadvantaged.

Q: Some of the findings in the report seems to suggest that there may be a biological component in helping to determine why some racial/ethnic minority groups have varying levels and rates of smoking prevalence and cessation. Are you suggesting that biological aspects beyond a person's control, such as what race they are, would be to blame for why they take up the smoking habit and ultimately become lifelong smokers? Isn't that akin to blaming the victim?

A: Biological differences have not explained differences in smoking behaviors. The report describes the major biological determinant of tobacco use, i.e., nicotine addiction, and states that persons of all racial/ethnic backgrounds are vulnerable to becoming addicted to nicotine. Additionally, no consistent differences exist in the overall severity of addiction or symptoms of addiction across racial/ethnic minority groups. Although there appear to be differences between African Americans and whites in levels of serum cotinine (a

biomarker for tobacco exposure) for similar levels of daily cigarette consumption, variables such as group-specific patterns of smoking behavior (e.g., the number of cigarettes smoked daily, retention time of tobacco smoke in the lungs), rates of smoking metabolism, and brand mentholation need to be explored.

Q: Do tobacco-control strategies like counter-advertising and excise taxes work to decrease tobacco consumption in racial/ethnic minority communities?

A: Comprehensive community-based and state-wide programs have been shown to help racial/ethnic and minorities quit smoking as much as other groups. Data from Massachusetts and California show that when cigarette excise tax increases are combined with counter-advertising campaigns and other comprehensive tobacco control strategies, rates of smoking in racial/ethnic minority populations have declined about as rapidly as among whites.

Q: Have you developed other tobacco-control strategies that specifically address cultural differences?

A: We have developed other tobacco-control strategies that specifically address cultural differences. These include the following:

1. Cessation programs that are tailored to the needs of racial/ethnic minority communities. For example, the "Pathways to Freedom" program was designed for the African American community. CDC funded a project to identify ways to incorporate Pathways to Freedom into medical and public health practice. AHCPR has also conducted extensive activities to reach out to racial/ethnic minority communities regarding cessation. For example, the project has worked with the National Medical Association to develop a framework for implementing its smoking cessation guidelines in minority communities. The project also has made its consumer smoking cessation guide available in a number of languages including Spanish, Chinese, Vietnamese, Cambodian, Laotian, Korean, and Tagalog.

2. Training for state tobacco control program staff on tobacco control in diverse communities, with specific focus on African American, Asian Pacific Islander, American Indian, and Hispanic/Latino communities.

3. Collaborations between a variety of organizations such as:

   - Collaboration between the CDC and the Indian Health Service (IHS) to place a field staff person with IHS to work on tobacco issues with tribal entities

throughout the United States.

- Funding from CDC to the Historically Black Colleges and Universities (HBCU) health communications programs to conduct research into development of culturally sensitive communications strategies, courses, curricula, and products for African Americans and other racial/ethnic minority groups.

- Funding from CDC to the Minority Health Professions Foundation to develop and expand their participation in tobacco control activities.

- Support from CDC to the National Congress of Black Churches and the Black Clergy for Substance Abuse Prevention to respond to tobacco use among their congregations. Ministers within these groups use the "Pathways to Freedom" cessation program, developed for African American communities.

4. CDC funding for a National Organization Program (this is described more fully in the response to a separate question below)

5. The CDC and the National Cancer Institute have developed communication campaigns for other cultures and disseminate additional campaigns that have been developed by State and national partners.

6. CDC supports research regarding racial/ethnic minority differences in tobacco use among youth through Prevention Centers in Schools of Public Health. NCI also funds a variety of research projects related to tobacco control, including strategies for minority communities.

Q: **How have you modified the primary elements of your tobacco control programs to fit the unique cultural needs of different racial/ethnic minority groups?**

A: We have attempted to design programs from the beginning with the needs of different racial/ethnic minority groups taken into account. In some cases, programs were established with the unique purpose of reaching out to racial/ethnic minority communities (e.g., CDC's National Organizations Program). In other cases, broader efforts were tailored for specific communities (e.g., translations of the AHCPR smoking cessation guidelines and development of partnerships to implement the guidelines in minority communities). Other efforts included support for the development and evolution of tailored cessation protocols, the development of culturally specific channels (e.g., churches) for program dissemination, and the creation of culturally appropriate communication campaigns.

Q: Do you have a comprehensive national tobacco control program that addresses specific racial/ethnic minority groups?

A: CDC funds seven national organizations through the IMPACT National Organization Program to strengthen tobacco control in the following racial/ethnic minority populations: African American, Asian Pacific Islander, Hispanic/Latino, and Native American/American Indian.

Goals of the National Organization Program include:

1. To build programs within the racial/ethnic minority organization to organize, plan, and implement activities within their respective communities to address tobacco use.

2. To develop and implement a tobacco control agenda that reflects the specific needs of racial/ethnic minority communities.

3. To reduce the influence of the tobacco industry in racial ethnic minority communities.

4. To identify and strengthen leadership in racial/ethnic minority communities and ensure diversity within the tobacco prevention and control movement.

5. To establish outreach activities to mobilize significant leaders, agencies, and related organizations in racial/ethnic minority communities to broaden tobacco prevention and control initiatives.

6. To reduce adverse health effects of tobacco use in racial/ethnic minority communities.

Organizations funded under this program provide leadership on tobacco control within their communities, conduct training, and support tobacco control activities at the national, State, and local levels.

Q: Do you see any signs that tobacco control initiatives aimed at the racial/ethnic minority populations are working?

A: Tobacco control initiatives aimed at racial/ethnic minority populations have been successful in reaching their targeted communities. Depending on the nature of the initiative, success will be measured in different ways. Examples of successful initiatives are provided below:

CDC's Office on Smoking and Health supported the on-going development of Pathways to Freedom, which is considered the state-of-the-art tobacco control program designed for the African American community. This program has evolved and proved useful in community settings, including the African American church, and protocols have been developed for medical settings. Pathways to Freedom has also been integrated into successful national media campaigns disseminated in collaboration with the National Medical Association. Data from a study funded by the National Cancer Institute that is currently in press indicate that a trial using the Pathways to Freedom cessation program reflected a 39%, 12-month smoking cessation rate compared to 16% for independent efforts. Successful outcomes have also been demonstrated in cessation efforts targeting the Hispanic community with tailored materials, Guia para Dejar de Fumar. OSH supported additional efforts to develop "Guia" for medical settings. Tailored materials have also been developed for American Indians and Asian Americans; however, evaluation information is not available. OSH supports continued development of these materials that demonstrate effectiveness in their respective target populations.

Other successful programs and initiatives within minority communities include the following:

- The National Association of African Americans for Positive Imagery (NAAAPI) launched a national campaign "Say No to Menthol Joe" against a decision by RJ Reynolds Tobacco Corporation to market Camel cigarettes in a mentholated brand. The campaign led to the elimination of menthol Camel cigarettes for sale in 2,400 Walgreen stores nationwide.

- NAAAPI also collaborated with church-based activists in Boston and African American leaders in California in a successful nationwide mobilization campaign to have "X" cigarettes withdrawn from the market in Boston. Their efforts were instrumental in having the manufacturer sign an agreement not to produce this brand.

- Five of the national COSSMHO organizations have adopted policies to not accept tobacco industry sponsorship.

- The Little Havana Project in Miami incorporated tobacco control issues into an intergenerational program where Hispanic youth and elders were provided information on preventing tobacco use in their communities. This project disseminated the "Contract for Life' in which youth ask all smokers in their household to agree to make their home smoke-free.

- The Northwest Portland Area Indian Health Board (NPAIHB) conducted a tobacco training series with 8 tribes in Oregon. Tribal health staff conducted stop-smoking classes that included the history of tobacco and Indian-specific statistics.

- NPAIHB produced a "Tobacco Control Policy" manual that has been used by other States to develop and sustain smoke-free policies in public facilities. NPAIHB also has collaborated with the Oregon Tobacco Control Program in the development of a tribal-specific program.

- The Alaska Native Health Board established STUN (Stop Tobacco Use Now), a tribal community action group to develop tobacco control activities in villages. The Alaska Native Health board was a key partner in providing education on how increases in taxes decrease tobacco consumption. Alaska was successful in raising its excise tax by $0.71.

- The Asian Pacific Partners for Empowerment and Leadership (APPEAL) cosponsored the first National Asian and Pacific Islander Tobacco Control Leadership Summit. The summit included leadership training, coalition building, and strategies to address tobacco use in the Asian and Pacific Islander community.

- The Vietnamese Community Health Promotion Project in Santa Clara Country, California, conducted media-led smoking reduction campaigns targeting Vietnamese men in San Francisco and in Alameda and Santa Clara Counties, California. The programs included counteradvertising campaigns that used billboards, print, and television advertisements, published articles in Vietnamese-language newspapers; a videotape that aired on Vietnamese-language television stations; health education materials, a quit kit, posters; a continuing education course on smoking cessation counseling methods for Vietnamese physicians; and the distribution of printed "no smoking" signs and ordinances.

  The evaluation of the programs showed that the Santa Clara intervention did not influence cigarette smoking prevalence or recent quitting status. However, a program effect was observed in the San Francisco trial, such that the odds of being a smoker were significantly lower and the odds of quitting recently were significantly higher in San Francisco than in a comparison community. It would appear that the longer the duration of exposure to the antitobacco campaign in San Francisco (39 months) than in Santa Clara (24 months), the better the results. Further, San Francisco had the added school and family-based components, which also helped.

Q: What level of funding would be required at the Federal level to fund national tobacco control programs that would affect tobacco use behavior racial/ethnic minority populations?

A: The Secretary has proposed a significant increase in funding for racial/ethnic minority

community tobacco control programs in response to the disproportionate health effects of tobacco in these populations. It is important that the level of funding for tobacco control efforts in racial/ethnic minority communities be commensurate with the scope of the problem. The Secretary's proposal includes funding at $86.5 million per year for state and community prevention programs and $20 million per year for national organizations to address racial/ethnic minority tobacco use concerns. In addition, the Secretary's proposal includes $13 million for the Indian Health Service to expand tobacco use cessation efforts. Other categories of funding proposed by the Secretary, including media campaigns, surveillance, and research, do not have specific levels designated for minority communities; however, activities related to minority communities will be undertaken in all three of these areas.

Q: Why would CDC fund a separate national tobacco control program for racial/ethnic minority populations when it already funds 33 State programs?

A: Racial/ethnic minority groups are targeted by tobacco industry marketing and promotional strategies. They are also disproportionately affected by diseases caused by tobacco use. Progress in reducing prevalence rates has lagged behind that of the population at large. We think it is essential to direct resources to the groups most affected. Some States have very effective programs that specifically target tobacco use within racial/ethnic minority populations. However, not all States have been able to devote elements of their tobacco control programs to address specific cultural differences in tobacco use and its effects on racial/ethnic minority communities. It is in the national interest to reduce tobacco use across the board, and especially in racial/ethnic minority communities that are at higher risk. For that reason, CDC will fund a national tobacco control program for racial/ethnic minority populations in addition to its other State programs.

A very important element in CDC's tobacco control programs is involving communities in the program to ensure specific local issues are addressed and local resources are mobilized. As part of that effort, CDC funds liaison programs with national organizations because they have a direct relationship with their respective racial/ethnic minority communities and are in the best position to help develop culturally appropriate strategies and to identify community leaders who can help us achieve our goals. The more groups we can inform and educate, and the more groups we can encourage to become part of the solution, the more progress we can make in preventing tobacco use. It is important to facilitate the development capacity of infrastructure within the minority communities to ensure diversity within the tobacco control movement.

Q: What can the government do to ensure that its national surveys are more inclusive of non-English speaking populations to reflect subgroup populations more accurately?

A: The most practical way to obtain such data for Asian American and Pacific Islander subgroups would be to conduct surveys in geographical areas that have a high clustering of relevant subgroups. This technique would be preferred over one that simply oversamples national surveys, because the cultural, linguistic, and geographic diversity of Asian American and Pacific Islander subgroups is so immense. Obviously, such surveys could be translated into the relevant language.

For people who speak Sapnish, most national surveys are conducted in both English and Spanish, so oversampling national surveys is the best approach.

Q: What universities or medical institutions that serve largely racial/ethnic minority populations does the CDC provide funding for tobacco research? Why are there not more?

A: CDC funds a network of Prevention Centers based at leading universities. These projects, which are in their fourth year, have examined differences and similarities among minority teen populations' reasons for smoking, response to advertising, attitudes towards smoking, and proposed tobacco control legislation. Results are currently being used to formulate policy decisions, to plan programmatic efforts for tobacco control programs with minority populations, and to design counter-advertising media campaigns. Fourteen Prevention Centers situated throughout the United States communicate electronically and at conferences to design, conduct, and analyze collaborative studies on teen smoking.

Q: Why are there not more?

A: CDC funds a nationwide network of prevention centers engaged in research on tobacco use in teens. Currently, all 14 Prevention Centers are involved in the Tobacco Network research project that examines reasons for smoking, response to tobacco advertising, attitudes toward smoking, and proposed tobacco control legislation. These 14 Prevention Centers, based at universities, schools of public health, and medical schools all across the country, provide answers to critical questions on teen tobacco use. The Tobacco Network has provided a valuable model for collaborative tobacco research. Originally, the eligibility for participation in the Tobacco Network was restricted to CDC-funded Prevention Centers. However, in the very near future, we hope to have additional funding available for similar independent research networks to study topics such as tobacco use prevention and tobacco use cessation in racial/ethnic minority communities.

Q: What does the Surgeon General say to individual Americans about not smoking?

A: If you don't smoke or chew tobacco, don't start. If you do smoke or chew tobacco, quit. This is simple advice but not always easy. Regrettably in 1998, tobacco is still the leading preventable cause of death and disease in America.