Tobacco Resource File
Internet Search

Search Results

by excite

tobacco and health | Search Again | Help

Select words to add to your search..: cdc, substances, albertans, anr, morbidity, among, dingwall, benzo, illnesses, departments

Reviewed Web sites on Netcenter

Web sites about Tobacco Abuse
Web sites about Issues

Top 10 of 1747580 matches About Your Results | Narrow Your Search

Display: Full Descriptions | No Descriptions | Web Site Only | Change Display

✓ **76% Quit Tobacco! Tobacco Education for Tobacco Chew rs!**
http://www.quittobacco.com/
Helping dentists & hygienists help their patients quit chewing tobacco
More Like This

✓ **75% INWAT home pag**
http://www.inwat.org/
Find Out More! The International Network of Women Against Tobacco (INWAT) was founded 1990 by women tobacco control leaders to address the complex issues of tobacco use among women and young girls.
More Like This

75% Canadian Council on for Tobacco Control (CCTC), formerly Canadian C ur
http://www.cctc.ca/index.html
The Canadian Council for Tobacco Control (CCTC), (formerly the Canadian Council on Smoki

and Health), is a national non-profit organization specializing in tobacco and health issues.
More Like This

74% The Tobacco Trials HomePa; e
http://www.tobacco-litigation.com/index.html-ssi
Important information about the tobacco lawsuits and why states are taking "Big Tobacco" to
Tell us what you think about smoking, the use of tobacco, who should pay the health costs associated with tobacco, and other critical issues involved in these trials.
More Like This

74% The QuitNet - A Free Resource To Quit Smok ig
http://www.quitnet.org/
The QuitNet helps smokers kick their nicotine addiction, providing tools, information and supp people quitting smoking.
More Like This

73% Selected PSA documents and Publicati is
http://www.who.org/psa/press.htm
PSA Press Releases and Fact Sheets PRESS RELEASES FACTS SHEETS World No Tobac Day: Growing Up Without Tobacco (WHO/42), 1998 WHA says Non-Communicable Diseases Global Priority (WHO/39), 1998
More Like This

73% Tobacco Control Archiv s
http://galen.library.ucsf.edu/tobacco/
Brown & Williamson Collection -- select this link to search and view the documents in the Bro Williamson Collection. Mangini v. Reynolds Tobacco Company Collection -- select this link to the plantiff's legal analysis of the case and supporting industry documents
More Like This

72% Canadian Centre on Substance Abuse, CCSA, addictions, drugs, al ohol
http://www.ccsa.ca/
Canadian Centre on Substance Abusea non-profit organization working to minimize the harm associated with the use of alcohol, tobacco and other drugs Search the CCSA Web Site:
More Like This

72% Lose Weight, Reduce Cholesterol and Lower Blood Pressure: Scientifi al...
http://www.healthauthority.com/
The Health Authority: A perspective on health news and information
More Like This

72% Tobacco Related Issu :
http://www.miph.org/miph_tobacco.html
Copyright 1995, Posted 09/96 Copyright 1995, Posted 09/96 Copyright 1995, Posted 09/96 Copyright 1995, Posted 09/96 Copyright 1995, Posted 09/96

More Like This

Next Results

tobacco and health | Search Again | Help

Select words to add to your search..

cdc	substances	albertans	anr	morbidity	
among	dingwall	benzo	illnesses	departments	

Give us yourfeedback

Political Issues

by excite

Find a job Look up a frien

Directory
Web Directory
↓ News
↓ Current Events
↓ Political Issues
Abortion
Animal Rights
Campaign Finance Reform
Censorship
Children's Rights
Civil Rights
Death Penalty
Disabilities
Environmental Science
Euthanasia
Gay & Lesbian
Gun Control
Health Care
Homeless
Human Rights
Immigration
Pro Life
Tobacco
Volunteering
Women's Issues

Recommended Web Sites

☆ **Institute for Public Accuracy**
Assesses the research and policy proposals coming out of the most prestigious think tanks.

☆ **Policy.com**
Bipartisan guide to issues, organizations, and individuals shaping public policy.
review

More Sites

- **American Political Science Association - Policy Sec** - A newsletter and policy papers for this organization dedicated to applying political science to policy issues.
- **The Brookings Institutic** - Well-respected Washington, D.C. policy think-tank on economics, politics, education, and the media.
- **Center for Media and Public Affa** - A nonpartisan research and educational organization targeting the news media.
- new! **Defend Your Data - What They Do Know Can Hurt Y** - The ACLU campaigns to defend the right to privacy.
- **The Freedom Forur** - Organization dedicated to protecting the First Amendment.
- **The Heritage Foundatic** - News and commentary from this conservative think tank.
- **National Political Index - Political Think Ta** - A list of over 45 of the most prestigious think tanks.
- **Public Agenda Onlir** - News on public opinion and policy issues.
- **Russian Roulett** - PBS's Frontline tackles the scary thought of the unraveling Russian nuclear weapons facilities.
- new! **Second Harves** - Fighting world hunger online.
- **Y? - The National Forum on Peoples' Differen** - Honest questions and answers from real people. Ask the race/gender realted questions you were always afraid to ask.

contact arAccount Executive!

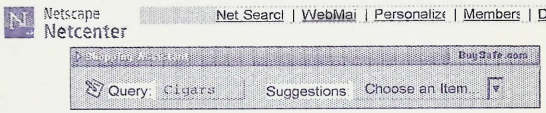
Search the Web

Search

Classified | Web Director | What's Coc | What's Nev |
People Finde | Yellow Page: | Member Directory

Helr | Site Mai | Company Informatic | How to Get Netscape Produc | Advertise With L | Add Site

Autos | Busines | Computing & Intern | Educatio | Entertainmer | Gamer | Healt | Kids & Fami | Lifestyle | Loca | Netscape | News | Personal Financ | Real Estat | Shoppin | Small Busines | Sports | Travel



You are here Home > Net Searcl > Search Results

Search Results

by excite

TOBACCO | Search Again | Help

Select words to add to your search.. smokeless | cessation | nicotine | chewing | cigarettes | rjr | infact | tobaccos | glantz | flue

Reviewed Web sites on Netcenter

Web sites about Tobacco Abuse
Web sites about Issues

Top 10 of 98355 matches About Your Results Narrow Your Search

Display: Full Descriptions No Descriptions Web Site Only Change Display

63% Tobacco Junction V [
http://www.tobacco-junction.qpg.com/
The Tobacco Junction VII is your full service tobacco shop.
More Like This

Amazon.com
Books about: TOBACCO

63% Tobacco For Le$
http://www.tobacco-for-less.com/
Tobacco For Le$$ specializes in providing a wide variety of tobacco products at discount pric
More Like This

62% The Tobacco Associated Brands Home Pa e
http://www.tobacco.co.uk/
Tobacco, cigarettes, smoking - read all about it.
More Like This

62% **Quit Tobacco! Tobacco Education for Tobacco Chew rs!**
http://www.quittobacco.com/
Helping dentists & hygienists help their patients quit chewing tobacco
More Like This

62% **QuitChew.com--Quit chewing tobacco forc er**
http://www.quitchew.com/
QuitChew-The most affordable and effective program for quiting chewing tobacco. Be tobacco Dr. recommended weaning program. Highest quit rate. Little or no emotional upset. Quit smok tobacco. Quit spit tobacco.
More Like This

62% **Tobacco News. Get up to date with tobacco-related is ues**
http://www.tobaccowars.com/
Tobacco litigation news, Liggett, and other tobacco-related issues. Cash in on the tobacco wa Free smokers claim registration. This site will be updated regularly to bring you the latest abo war on tobacco.
More Like This

62% **INWAT home pag**
http://www.inwat.org/
Find Out More! The International Network of Women Against Tobacco (INWAT) was founded 1990 by women tobacco control leaders to address the complex issues of tobacco use among women and young girls.
More Like This

62% **Coalition for a Tobacco Free Pennsylvania Home I ige**
http://www.tobaccofreepa.org/
The website of the Coalition for a Tobacco Free Pennsylvania contains the policies we advoc tobacco-related news and information, and searchable databases of smoking cessation progr and smoke-free restaurants in Pennsylvania.
More Like This

61% **Committee on Commerce Tobacco Docume :s**
http://www.house.gov/commerce/TobaccoDocs/documents.html
39,000 Documents Released April 22, 1998 A Sample of the Documents in the Committee He Room Subpoenaed Documents by Company 400 Supplemental Documents Released June 8,

More Like This

61% **Canadian Council on for Tobacco Control (CCTC), formerly Canadian C ur**
http://www.cctc.ca/index.html
The Canadian Council for Tobacco Control (CCTC), (formerly the Canadian Council on Smoki and Health), is a national non-profit organization specializing in tobacco and health issues.

More Like This

Next Results

TOBACCO Search Again Help

Select words to add to your search.. smokeless cessation nicotine chewing cigarettes rjr infact tobaccos glantz flue

Give us yourfeedback.

24.3.99

Ma'am,

We need info from the Region - Tobacco, Bangladesh, Thailand & Sri Lanka - Pl. check on Internet Chapter 5 Dr Prof / Dr. Deep. rep. which may be compiled for Dr [illegible] by 17/4/99

These are the addresses of a few websites on Tobacco & Health & Medical Ethics that I downloaded from the Internet. Instead of browsing through all the websites, if you could tick whatever is relevant / of interest to us, it would be faster. Thanx / Aparna.

6-2

Chronic Sublethal Exposure

The premise here is simple: it may not be tobacco that's killing all those smokers. Has anyone else noticed that the Surgeon General's warnings never mention tobacco - only smoking? In this section I suggest that almost all smoking-related death is preventable without depriving people who like to smoke of the pleasure of doing so simply by eliminating chemical contaminants and poisonous synthetic materials and requiring manufacturers to use 100% natural tobacco leaf.

Table of Contents

This document was last revised on 12/16/98

Return To Site Index

- Is It The Tobacco, Or The Pesticides?
  - An Unnecessary Three Generations
    - Chlorinated Hydrocarbons And Cigarette Carcinogenicity
    - Cigarette Research Methods
      - Organophosphorous and Carbamate Cigarette Pesticides
    - A Curious Blindness
    - Pesticides, Cigarettes, and Tumors - Early Evidence
  - The Cigarette Industry Line On Pesticides
  - Cigarettes And Tobacco - Key Differences
  - A Long And Winding Trail Of Research
  - Research On Pesticides And Human Health
  - The Smoking Guns of 1996
  - Chlorinated hydrocarbon Pesticides In Cigarettes
    - Aldrin
    - Dieldrin
    - Endrin
    - DDT
    - Toxaphene
    - Heptachlor
    - Chlordane
  - Organophosphorus Pesticides In Cigarettes
    - Paraoxon
    - Disulfoton
    - Dimethoate
    - Demeton
    - Malathion
    - BHC
    - Lindane
    - Parathion
    - Diazinon
    - Leptophos

Is It The Tobacco?

Return To Table Of Contents

A proposition for reasonable people to consider - what if it hasn't been the tobacco in cigarettes that's been killing cigarette smokers?
This isn't a trick question, or a joke.
What if the combinations of pesticide residue contaminants on the tobacco and reconstituted tobacco portions of cigarettes and other so-called tobacco products are enough in themselves to explain a large proportion of cigarette-related disease and death?
Then what if residues from chemicals which are known carcinogens like benzene, hexane, and phosgene, used in the processing of industrial waste into synthetic smoking materials for cigarette manufacturing, and for manufacturing into smokeless and pipe "tobaccos", are enough to explain a large portion of the remaining cigarette-related death and disease?
I've been tracking the activities of the cigarette industry for almost twenty years and while my research resources have been limited, I've pieced together enough of a picture to convince me that it may very well not be the tobacco at all that's killing many, or even most smokers.
This document, and the associated documents on this site, are dedicated to raising the question of whether smoking-related disease and death can be largely prevented without having to try to change the desire to inhale volatilized plant materials for chemical satisfaction, an activity which appears to be hardwired into the pleasure centers of the brains of a significant portion of the human race, and just as firmly hardwired into the aversion centers of the brains of everyone else.
If it isn't the tobacco that's killing people, then almost all of the millions of deaths to come over the next 20-50 years from cigarettes and other so-called tobacco products are preventable by requiring that all tobacco products be manufactured from natural and uncontaminated tobacco.

It's important to know from the beginning, and to keep in mind as you review what I've assembled here as evidence, that American cigarettes stopped being 100% real leaf tobacco decades ago, and instead are manufactured using a combination of materials, including:
Real US-grown tobacco leaf - this kind of component is very uncommon in US cigarettes.
Foreign-grown tobacco leaf - this component makes up most of any actual leaf tobacco used in US cigarettes, but leaf itself is uncommon.
Reconstituted smoking materials made from ground-up foreign tobacco stems, stalks, and waste and a wide range of additives, glues, fungicides, etc. Use of this ***tobacco sheet*** became very common in US cigarettes beginning in the late 1970's and accelerated in the late 1980's. Because of the industry's secret status and lack of research into the question, nobody knows which US brands, many using images and words implying that there's tobacco in the pack, are composed mostly or exclusively of this kind of reconstituted tobacco. We do know that Winston was the first to do so as early as the 1950s.
Synthetic smoking materials are made from materials like recycled paper mill waste, food processing waste, and recycled municipal cellulosic waste. This material is extremely common in US cigarettes, especially the Low T&N brands. Again due to secrecy and lack of regulatory oversight, nobody knows which brands are partly or exclusively made from these synthetic smoking materials.
The giveaway to both synthetic and reconstituted tobacco is that the leafy material in the cigarette tube has no natural leaf ribs which, if they are present, can be easily detected with any magnifying glass.
With the limited exception of US-grown tobacco, all of the other three materials used to manufacture cigarettes are normally and commonly contaminated with residues of pesticides which in themselves are well-established causal agents for breast, lung, and other cancers, for nervous system degeneration, for fetal malformation and irreversible genetic damage. In the 1985 Food Security Act the US government put a limited set of regulations in place to deal with pesticide residues on tobacco, requiring that imported Flue-Cured and Burley leaf tobacco be certified to have been grown using only pesticides registered under the US Federal Insecticide, Fungicide and Rodenticide Act. As we'll see this is actually tricky wording, allowing enormous amounts of tobacco waste and scrap to slip through unregulated, and begging the question of what smoking even regulated pesticides does to human health.
The unbelievable fact is that very few of the common pesticide contaminants of tobacco appear to have ever been tested for their health effects when consumed by smoking. This isn't to say that the pesticides

haven't been studied for their human health effects - they certainly have. The EPA, the FDA, the USDA, and others have all done extensive work with the tobacco pesticides. There has been a significant amount of published research on the human health effects of chronic sub-lethal exposure, and of exposure by inhalation, to many of the common tobacco product pesticide contaminants. There have also been oral/dermal toxicity studies which have shown many of the common tobacco contaminants are far more toxic when ingested orally than when absorbed through the skin, which implies similar toxicity when they are smoked. However, I've searched in vain for literature references to studies on what happens to these pesticides when they are volatilized by dry distillation and inhaled in combination.
By the time you finish browsing the evidence assembled here, this odd oversight probably won't seem all that strange any more.

In another section of this document I've included a broad range of references, but during 1996 alone, US medical/scientific teams have reported findings that ought to bring the issue of pesticide contamination of cigarettes into sharp focus:
At least four of the pesticides commonly contaminating US cigarettes, when ingested together even in trace amounts, become extremely potent chemical agents capable of causing cancers, birth deformities, and genetic damage even at trace levels. A study by Dr. John MacLachlan of Tulane University, reported in ***Science, June, 1996,*** which had nothing to do with tobacco or cigarettes in particular, demonstrates that the extremely small dosages of pesticide residues on US cigarettes, which the industry has been debunking as negligible for decades, turn out to radically enhance each other's toxic, fetus-damaging, and cancer-causing properties when consumed together. PLEASE NOTE: AS OF LATE AUGUST 1997 DR. MACLACHLAN'S STUDY IS COMING UNDER CRITICISM BECAUSE OTHERS HAVE NOT BEEN ABLE TO REPLICATE HIS RESULTS. **http://www.sciencemag.org:80/science** The combinant effects of trace pesticides in this study were on the order of 1:1600, so those tiny traces of Endosulfan, Dieldrin, Disulfoton etc which in themselves may or may not be harmless, are beyond doubt serious health risks when consumed together - as they are when smoking pesticide-contaminated cigarettes or inhaling contaminated second-hand smoke.
The risks of inhaling the raw pesticides are great enough, but those risks are compounded by the presence of xenobiotic combustion by-products. For example, DDT has been a common contaminant of US cigarettes since the 1950s, and when DDT is burned it creates among other compounds a chemical named benzo-a-pyrene. This benzo-a-pyrene has been known for at least 35 years to cause lung cancer as fast as anything known to the industrial world, and it has shown up in assays of cigarette smokestreams since at least the early 1950s. For many years scientists have been trying to link benzo-a-pyrene to the lung cancer they know it causes. In 1996 a team led by Mikhail Denissenko reports in ***Science, October 1996*** that they have traced this chemical step-by-step from the cigarette smokestream to a human chromosome site called P53 where the mutations leading to human lung cancer are stimulated by BAP's presence.
On the internet see this report at
http://www.sciencemag.org:80/science/scripts/display/full/274/5286/430.html
For many years researchers have also been working to demonstrate the link between cigarette smoking and human breast cancer, and although laboratory research showed several possible strong connections they weren't able to prove it. Researchers at National Cancer Institute reported in ***JAMA*** on ***Nov. 12, 1996*** that in women with a weak gene, called NAT2, that defends against toxins and carcinogens, the risk of breast cancer from smoking a pack of cigarettes a day increases 400% over women with a normal NAT2. This research shows that a sizeable proportion of women, about 50% of all white women and nearly 40% of all Black, Hispanic and Asian women inherit this weak NAT2 gene, increasing their risk of breast cancer from exposure to toxic and carcinogenic chemicals - such as the raw and combusted pesticide compounds found in cigarette smoke.
For another angle on this increasingly likely link between environmental pesticides and human cancer, with strong implications for women smokers, see:

Davis D.L., Bradlow H.L., Wolff M., Woodruff T., Hoel D.G., Anton-Culver H. 1993, ***Medical hypothesis: Xenoestrogens as preventable causes of breast cancer***. Environmental Health Perspectives v101 n372 p. 7

MacMahon, B. , ***Pesticide Residues And Breast Cancer?*** Journal of the National Cancer Institute: JNCI
April, 1994 v 86 n 8, p.572

Hunter, D. J., Kelsey, K. T., ***Pesticide Residues and Breast Cancer: The Harvest of a Silent Spring,*** Journal of the National Cancer Institute: JNCI
April 1993 v85 n8, p.598

Soto, Ana M., Chung, Kerrie L., Sonnenschein, Carlos, ***The Pesticides Endosulfan, Toxophene, and Dieldrin Have Estrogenic Effects on Human Estrogen-Sensitive Cells*** Environmental Health Perspectives: EHP
April 1994 v102 n4 p. 380

Chlorinated Hydrocarbons And Cigarette Carcinogenicity

"***Organochlorine pesticides are carcinogenic as a class.***"

Origins of Human Cancer

H.H. Hiatt, et al., Eds. Cold Spring Harbor, 1977

As reported in this 1977 study, by the late 1970s many scientists, including those working for the cigarette industry, knew that cigarettes and other so-called tobacco products were contaminated with cancer-causing pesticides in concentrations sufficient to explain cancer in cigarette smokers. As an example, the following table from the study displays what was already known about many of the common tobacco pesticides and the concentrations in which they were known to be carcinogenic under conditions of chronic exposure.

Common Name	Manufacturer	Carcinogenicity	Carcinogenic Concentration
Dieldrin	Shell	+	2.5 PPM
Endosulfan	FMC	-(a)	?
Endrin	Shell/Velsicol	+	3.2 PPM
BHC	Diamond/Hooker	+	0.50 PPM
DDT	multiple	+	10.0 PPM
Lindane	Diamond/Hooker	+	236.0 PPM
TDE	Allied/Rohm & Haas	+	?
Aldrin	Shell	+	3.0 PPM (c)
Chlordane	Velsicol	+	25.0 PPM
Heptachlor	Velsicol	+	10.0 PPM
Toxaphene	multiple	+	?

(a) Endosulfan is listed as non-carcinogenic on the basis of a single study in one species only (mice). Innes et al, (1969). (site editor's note: This classification has since been reversed and endosulfan is now recognized as a human carcinogen.)

(b) "Based on the best available data," National Cancer Institute (1979).

(c) "Causes tumor development in mice at the lowest doses tested. Indeed, it has been impossible to establish a safe level for this compound." Hart et al (1976).

The authors of this study point out that

"It must be appreciated that the carcinogenicity data on the OCP's, as for the great majority of other pesticides, are based on ingestion rather than inhalation as the route of exposure, which is likely to be of relevance to humans. Also the carcinogenicity of "inert ingredients" in pesticide formulations, particularly benzene, asbestos and petroleum oils, must be recognized."

It remains to compare the levels at which these compounds are considered carcinogenic, and the concentrations reported on commercial cigarettes by competent, scientific literature. Note that some of the studies are as much as 25 years old, and do not represent the true situation in 1996, which may very well be much worse for a number of reasons discussed following the data. These studies were all available to the tobacco industry by the time of the 1977 ***Origins of Human Cancer*** study cited above; indeed, many of these studies were industry-funded.

Pesticide	Concentration Found	Tobacco Product	Reference
Dieldrin	0.04 PPM	cigarettes	Dorough & Bryant 76
Endosulfan	0.28 PPM	cigarettes	Dorough & Bryant 76
Endosulfan	23.00 PPM	cured leaf	Reif 77
Endrin	0.06 PPM	cigars	Dorough-Bryant 78
Endrin	0.72 PPM	cigarettes	Sheets 1976
BHC	1.11 ug/pack	cigarettes	Kamata 1977
BHC	0.51 PPM	cigarettes	Ceschini 1980*
DDT	278.00 ug	cigars	Kamata 1977
DDT	7.20 PPM	cigarettes	Richter 1977
DDT	6.90 PPM	cigarettes	Dorough & Bryant 77
Lindane	0.33 PPM	cigarettes	Richter 1978

Aldrin	0.01 PPM	cigarettes	Ceschini 1980*
Toxaphene	2.33 PPM	cigarettes	Domanski 1977
Toxaphene	0.38 PPM	cigarettes	Dorough-Bryant 77
Toxaphene	4.30 PPM	cured leaf	U.S.D.A. 1977

*16 U.S. brands

Cigarette Research Methods

It's important to keep in mind a couple of points whenever you're examining cigarette research data.

Off-the-shelf cigarettes are rarely tested for pesticide residues in this country, and when they are, testing methods and procedures are often quite inadequate.

It is extremely difficult to test for pesticides which may only be present in very small concentrations -- which are nevertheless potent enough to cause serious damage through repeated, low level exposure through smoking.

Pesticide residue testing, when performed, tests only for the presence of the pesticide itself, and not for its combustion by-products. Thus when a potent carcinogen such as Dieldrin is reported in cigarettes at concentration of .51 PPM, we have no way of knowing how much Dieldrin is present in byproduct form.

Cancer-causing properties are only one of the sources of damage from these compounds. They are also involved in neurological, genetic, cardiac and pulmonary and other injury to humans, in ways which have never been documented by testing for health impact through combustion/inhalation.

There is very sparse data available on the human health impact of pesticides in tobacco because almost all such testing is done on mice and rats. These animals are extremely susceptible to pure tobacco smoke itself, it is extremely difficult to separate the effects of tobacco from the effects of minute traces of pesticide.

Many of the chlorinated hydrocarbon compounds are very difficult to detect, particularly with electron capture detection, the most common measuring technology. Thus, the residue levels detected in cigarettes are probably much lower than actually exist.

Most recent available data has been used in illustrating concentrations of pesticides in commercial cigarettes and tobacco products. In the 1950s and 1960s concentrations were much higher. For instance, published research by scientists at North Carolina State University reported DDT and TDE concentrations in cigarettes in the late 1950s and early 1960s as high as 600-800 PPM. Of course DDT has been banned for nearly 20 years in the US, but it is still being used on tobacco crops in third world countries, along with other banned chlorinated hydrocarbons like endrin. Since smoking-related diseases such as lung cancer can take decades to develop and emerge, we are just now seeing the results of this kind of cigarette pesticide contamination in the period 1950-1975.

Each pesticide that contaminates cigarettes has multiple fates, each of which is relevant in a different way to the smoker. When the cigarette is smoked, air is sucked through the coal at the tip of the cigarette, and this glowing coal creates an intense dry heat that instantly vaporizes the leaf, or smoking materials in the zone just behind the coal. These vaporized, partly burned and partly boiled-off sugars, proteins, nicotine, flavorings, additives, and pesticide residues combine in the airstream created by the smoker's suction to create smoke.

Some pesticides survive the boiling-off process better than others. Some are simply incinerated, leaving no trace of the original compound and creating nothing harmful as a result of combustion. Others burn completely, but create daughter compounds that range from unknown to hazardous in their health effects. Others burn incompletely, so that the smoker receives a volatilized dose of the original pesticide plus the by-products of combustion of the pesticide, range from unknown to hazardous in their health effects.

The key point here is that out of the combustion and volatilization of the multiple pesticide residues which can be shown to be common contaminants of the US cigarette supply create a wide range of hazards many of which need no further proof of their severity as an immediate preventable threat to public health. If the pesticide contamination were removed from the US supply, and if the industrial process contaminants like benzene and hexane were also removed, then there would be a material reduction in the level of public health threat posed by cigarettes and other so-called tobacco products, and the rest of the hidden aspects of this problem could be brought to light and worked on by scientists, legislators, and citizens.

A Curious Blindness

Where has the Surgeon General been? In some ways, this chief protector of the public health has been trying to tell us about the problem all along -- it's just that the tobacco industry is so powerfully sheltered that the Surgeon General hasn't really had the information available. Also, let's not underestimate the reach and power of the tobacco industry. It certainly seems from the available literature that the Surgeon General has been pretty much duped along with everyone else in the official health establishment on the subject of pesticides in commercial tobacco. Take for example the following paragraph from the 1981 Surgeon General's report on "The Changing Cigarette."

Influence of Raw Product Modification on the Pharmacology of Cigarette Smoke.

"The composition of smoke is determined by the physical and chemical properties of leaf tobacco. Modification of the raw product therefore changes the pharmacology of cigarette smoke. The diversity of available tobacco germplasm along with known genetic techniques permits reduction of hazards in cigarettes through plant breeding and selection. Cultural and curing practices are constantly changing in response to market demands and the needs of farmers. Pesticides currently registered for use on tobacco have been tested as contributors to the carcinogenic activity of cigarette smoke condensates. When used as directed, these materials caused no significant change in biological activity. However, the pesticides used in tobacco farming change from time to time in response to the occurrence of new plant pests; for example, the recent spread of blue mold in tobacco-growing regions has led to the use of a new pesticide. It is not known whether the use of such materials may result in changes in the hazards of cigarette smoke."

This paragraph gives the reader the unfortunate impression that pesticide residues have been looked into and found not harmful on cigarettes when properly applied in the field. However, the two studies cited, by G.B. Gori and T.C. Tso are extremely limited in scope, and examine only what happens to certain legal pesticides when they are applied at carefully monitored rates onto experimental tobacco plants which are made into laboratory cigarettes and tested by limited methods for a restricted range of effects. These tests do not show the Surgeon General, or the public, anything about the realities of enormous amounts of illegal pesticides on cigarettes, or about even the residues of legal pesticides illegally applied in Third World countries at excessive rates.

The Surgeon General, elsewhere in this same report, admits to a large degree of powerlessness with respect to monitoring anything that the tobacco companies put in their products. The issue is additives, which get a great deal of attention throughout the report, but the observations apply equally well to pesticides.

"We must continue to monitor the changing cigarette to ensure that when new cigarette products appear they do not bring with them new hazards to health. Throughout this report the need to know about substances added to cigarettes is stated repeatedly. At present, there is no mechanism by which government or the scientific community can require disclosure of these additives, which must obviously be a first step in assessing their health effects. This needs to be corrected by voluntary action or, if necessary, by legislation."

Secretary of Health Education and Welfare Patricia Harris, in a letter to Tip O'Neill, House Speaker, on 1/12/79

Another closely related concern about lower "tar" and nicotine cigarettes is the use of flavorings and other chemical additives. In order to enhance consumer acceptability, flavoring substances are added to cigarettes; it may be that the lower the "tar" yield, the more flavoring additives are used. It is impossible to make an assessment of the risks of these additives, as cigarette manufacturers are not required to reveal what additives they use. No agency of the federal government currently exercises oversight or regulatory authority in the manufacture of cigarette products. Further, no agency is empowered to require public or confidential disclosure of the additives actually in use by the cigarette manufacturers.

Since the Surgeon General hasn't been able to "officially" identify and test for carcinogenicity in the flavor and processing additives, much less the agricultural chemicals and pesticides in cigarettes, it is little wonder that so much of the research coming from government health sources has a confused and frustrated tone.

"It cannot be determined whether the unidentified mutagens in cigarette smoke are an important cause of lung cancer in humans; however, added exposure to any tumor initiators probably carries an incremental risk of cancer." (p. 38, Changing Cigarette, US Surgeon General, 1981.)

"Several carcinogens from cigarette smoke should be studied for synergistic, additive or antagonistic effects on carcinogenesis because tobacco constituents are inhaled or swallowed as a mixture, not individually." (p. 101, Changing Cigarette, US Surgeon General, 1981.)

"Of particular concern is the potential teratogenic (fetus damaging) effect of additives and their combustion products." (p. 12, Changing Cigarette, US Surgeon General, 1981.)

"In recent years, a number of flavoring additives or cellulose-based tobacco substitutes may have been included in manufactured cigarettes. The nature and amounts of such additives as actually used are not known, nor is it known what influence these additives may have on the chemical composition or subsequent biological activity of cigarette smoke." (p. 17, Changing Cigarette, US Surgeon General, 1981.)

"More data is needed on cigarette flavor additives and their combustion products. Flavoring agents and additives should be studied by the tobacco companies for carcinogenicity and toxicity before their commercial use is permitted, and the results of such studies should be made available." (p. 26, Changing Cigarette, US Surgeon General, 1981.)

Return To Table Of Contents

Pesticides, Cigarettes, and Tumors: Early Evidence

Return To Table Of Contents

Almost all of the significant U.S. work on carcinogens in tobacco smoke has involved a handful of researchers. By consensus, Dr. Deitrich Hoffman is the most prominent American expert on the cancer-causing role of compounds found in cigarette smoke. Dr.Hoffman's *American Health Foundation* is the source of almost all of the U.S. Surgeon General's data on carcinogenic compounds in the smoke of U.S. cigarettes, and this distinguished scientist, along with a skilled team of researchers, has uncovered much of what little is known about pesticides in cigarettes, and cancer.

That's why it is particularly important, as we begin to look at the evidence accumulated on the role of pesticides in cigarette-related cancer, that we pay attention to this simple statement from the American Health Foundation in a personal letter to the author, 5/13/82. "There appear to be few - if any - studies on chronic sublethal exposure of mammals to the tobacco pesticides ... "

In a 1972 study, *Chemical Decomposition & Tumorigenicity of Tobacco Smoke*, funded by both the National Cancer Institute and the American Cancer Society, Dr. Hoffman along with others found both pesticides and their pyrolytic products carcinogenic. In their conclusion the researchers stated

"One specific characteristic of tobacco smoke is its tumor-promoting activity. Until now, only limited information has been available as tothe chemical nature of the tumor promoters. Although volatile phenols and long chain fatty acids are known tumor promoters when applied in high concentrations, the majority of the promoters in the "Tar" remain unknown and need to be identified."

Earlier in the report, in one of the rare literature references to the carcinogenic potential of pesticides in cigarettes, Dr. Hoffman notes:

"We found that trans-4, 4-dicholorstilbene, a major pyrolysis product of DDT and the alkylating carbazoles are active as tumor accelerators." "Tumor accelerators are defined as agents which by themselves are inactive as carcinogens, tumor initiators, or tumor promoters which, however, accelerate the activity of carcinogens and/or tumor initiators."

This 1979 study marked a major statement of position for Dr. Hoffman on the matter of "tar" coming from cigarettes.

"The carcinogenicity of the particular matter of tobacco smoke is primarily explained by three types of tumorigenic agents: tumor initiators, tumor accelerators, and tumor promoters. The majority of the tumor initiators are polynuclear aromatic hydrocarbons, and, as recently found, a number of alkylated polynuclear aromatic hydrocarbons. A significant inhibition of the pyrosynthesis of these carcinogenic polycyclics leads to a significant reduction of the tumorigenicity of tobacco smoke condensate as does the experimental quantitative reduction of these hydrocarbons in the "tar."

From this point on, Dr. Hoffman's research has focused increasingly on the issue of carcinogenic agents in the innocently-named "tar", as well as in the gasses of cigarette smoke. In the process, he has increasingly become interested in the role of pesticides as sources of carcinogenic agents in cigarettes, although this has almost been incidental to the main focus of these studies. For instance, in a 1978 paper on Hydrazines, Dr. Hoffman reports one of the first indications that Maleic Hydrazide, a suckering agent

used in enormous quantities in the U.S. and almost universally worldwide, was probably contributing potent carcinogens to cigarette smoke.

"The apparent reluctance of researchers to study hydrazines as environmental carcinogens may reflect the difficulty of locating and analyzing them. One obvious place to look is agricultural crops treated with Maleic Hydrazide. We therefore investigated tobacco (which is treated extensively with MH-30)."

"Our studies with MH-30 also demonstrated the presence in tobacco of N-nitrosodiethanolamine ... and ethyl carbamate. These two additional carcinogens may contribute to tobacco carcinogenesis."

"It is apparent from the number and variety of hydrazines shown to be animal carcinogens that all hydrazines should be suspect pending animal studies. It appears that most hydrazines are tumorogenic in the lungs and blood vessels of laboratory animals."

Dr. Hoffman's research led to themid-1980s de-registration of Nitrosodiethanolamine as a carrier solution for the application of Maleic Hydrazide. In the process of his investigations into this chemical, called NDELA for short, he discovered that it is not only smokers who are put at hazard through pesticides and herbicides or tobacco.

"Snuff, which is increasingly used as a smoke substitute by young people and which is a carcinogen in the oral cavity of its long-term users, was shown to contain between 3.2 and 6.8 PPM of NDELA. Thus, this N-nitrosamine adds to the carcinogenic potential of the tobacco-specific N-nitrosamines in snuff (which range from 5.5 to 106 PPM, according to an article in preparation by Dr. Hoffman in May '82)."

Dr. Hoffman's work on pesticides, while the most prominent in the country, only touches on the health issues involved in pesticide residues on cigarettes, a fact which the skilled researcher himself admits.

"It is apparent that relatively little is known of the fate of pesticides or herbicides that are applied to agricultural products, while they are in contact with the latter, and when they are ingested (or inhaled) by man. Certainly more effort is needed in this area of study that is important to public health." (D. Hoffman, J. Anal. Tox. 11/78).

While there have been only the few studies by Dr. Hoffman and others into the direct role of pesticides as sources of chemical carcinogens in cigarette smoke, there is a great deal of evidence that since the pesticides are indisputably present, often in some quantities, then they must be a major source of the cancerous results of cigarette smoking.

Shortly after Dr. Hoffman's research began to close the research gap, other researchers traced certain types of cancer directly to cigarettes, but weren't able to describe the process in minute detail in humans.(This has happened for the first time in 1996 with the work in California tracing benzo-a-pyrene in cigarette smoke to the exact spot on a human chromosome where lung cancer arises.) Thus the tobacco companies have been able to buy three decades of profits merely by pointing out insistently, continually, and deceitfully that no direct connection has been made between cancer and smoking.

In the December 1982 New England Journal of Medicine, Dr. Emmanuel Farber stated that "about one third of the cancer in North American and Europe is related to the use of cigarettes and other tobacco products." Dr. Farber went on to say that:

"the conceptual advances concerning ... initiation and promotion are well-known. However, their mechanistic bases are-only now unfolding ... The basic validity of these concepts for cancer development in human beings has been established in a few instances, and as such is reassuring both for the physician and the scientist. For instance

... a limited exposure for only a few months to a known chemical hazard, such as vinyl chloride, may lead years later to the appearance of angiosarcoma of the liver."

Vinyl chloride is a major pyrolytic byproduct present in cigarette smoke, and is one of the organ-specific carcinogens described in the research of Dr. Dietrich Hoffman.

The tobacco industry's shoulder-shrugging explanation of the presence of these known carcinogens in cigarette smoke has always been that the tobacco plant is one of nature's wonders, that it produces thousands of different compounds when its leaves are burned, that it takes up immense amounts of soil minerals, metals and heavy elements, and that, generally, there's just no accounting for how that damned plant eats up all that stuff that the scientists are forever finding in the smoke of the leaves. Gee whiz, fellers, can't you just take our word fur it -- all that stuff in tobacco jes' there natchurlly.

Many pesticides inhaled in cigarettes are able to cross the human placental barrier. Some of these are potent known carcinogens such as Endrin and Parathion. So what happens when they enter the body of the unborn child? Dr. Farber tells us:

"The presence of many proliferating cells is probably one basis for the susceptibility of the fetus and neonate [newborn baby] to many chemical carcinogens and would account for the peak in cancer incidence in the first decade of life. (Author's note: either that, or the first decade of life that we're seeing now is a preview of things to come for all ages.) The human fetus, unlike the rodent fetus, acquires the capability of activation of some carcinogens early in development and thus may be at greater risk than some laboratory animals for cancer development with chemicals."

This paper is full of chilling possibilities, once you understand the role of cigarettes-pesticides in the widespread health problems of people all over the world. For example, Dr. Farber engages in a discussion of how the human body, specifically the liver, adapts to the stream of carcinogenic chemicals which enter the body by several pathways:

" The liver is by far the most active and most versatile organ in the metabolism of procarcinogens and of xenobiotic agents generally. It and other organs have an ability to detoxify potential carcinogens as well as activate them, and the ultimate fate of a chemical depends largely on the balance between activation and inactivation -- a balance that is easily modulated in major ways by drugs and other chemicals, age, nutrition and hormones, as well as genetics.

For example, the carcinogenicity of several aromatic amines for the liver can be completely prevented by simultaneous exposure to phenobarbital or 3-methylcholanthrene -- agents that induce many liver enzymes. This phenomenon of resistance of the induced liver to some carcinogens may be of great practical importance to human beings. Virtually all people in the Western world have levels of several xenobiotic agents, such as chlorophenothane, dieldrin, aldrin, polychlorinated biphenyls, and dioxins, in their adipose and other tissues. These agents as a group are effective enzyme inducers in the liver. In addition, many drugs induce microsomal or other enzymes in the liver or other tissues. Are these inducers making tissues more or less susceptible to the acute toxic or carcinogenic effects of other environmental agents?"

Aromatic amines are produced with abandon by burning pesticides, and there is no dispute as to their carcinogenicity. Yet, Dr. Farber points out, their cancerous potential can be completely neutralized by phenobarbital. The phenobarbital causes the liver to produce enzymes which attack and render the aromatic amines powerless to cause cancer - sometimes.

Can this in any way explain the association between cigarette smoking and the drinking of alcohol, an intense barbiturate drug? And might one not conclude, given that-we all have pesticides in our fat, muscle, brain, organ and nerve tissue, that our liver must be kept in a constant state of arousal, just to deal with this constant or increasing pesticide contamination of our bodies? Are alcohol and pills a screaming necessity to millions of us because of pesticides in the most intimate tissues of our being?

Dr. Farber makes many other interesting points in his article. He points out that

"The absolute activities of the various enzymes and especially their relative balance may have key roles in determining which organ will be a target for a particular carcinogen. An interesting example of modulation at this level is the liver-kidney axis with dimethylnitrosamine. This potent carcinogen normally induces liver cancer when taken through the gastrointestinal tract. However, if the animal is placed on a low-protein diet, the hepatic activation and metabolism fall off. This pattern allows more of the carcinogen to be available for action on the kidney and changes the dominant cancer pattern from the liver to the kidney."

Dimethylnitrosamine is present in cigarette smoke as a combinant pesticide combustion byproduct. So what Dr. Farber's research shows that if you prefer cancer of the liver, keep smoking but don't go on a diet. If you want kidney cancer instead, go on a diet and you might even up your smoking a little, like most folks do. To be fair, that is not Dr. Farber's conclusion. Instead, he concluded

" Clearly, the pathologic consequences of exposure to any potentially toxic xenobiotic are related not only to the pathways available for its metabolism but also to the physiologic state at the time of exposure. Thus, the presence of a known mutagen or carcinogen in the environment is by no means synonymous with a mutagenic or carcinogenic response by the exposed person."

Let's switch focus from the larger issues to the very smallest, at least in proportion -- the role of DNA breaks in initiating cancer. This is the process by which almost all long-established pesticides which have been shown to be cancer-causing have been thought to operate. Dr. Farber writes,

"In view of the essentially irreversible nature of initiation with chemicals and the apparent focal nature of the initiation process, major emphasis at the molecular level is given to DNA as the target for initiation. However, the evidence is largely circumstantial."

Dr. Farber then goes into some detail on the most hopeful route toward a cure for chemically-caused cancers, DNA repair. In particular there is hope that cellular enzymes do much more than just serve human cells like little programmed slaves; that they can spring to life and perform intricate repairs of cell DNA when properly stimulated to do so.

Then comes the hook, as far as cigarette smokers are concerned.

" Although a majority of chemical carcinogens fall well within the current paradigm in which initiating effects are related to some form of DNA damage, there are known carcinogens that appear to be exceptions. A growing list of hypolipidemic agents and several pesticides, herbicides and other xenobiotics have not been shown to generate mutagenicity or other DNA damaging effects. Is this merely a reflection of deficiencies in our technology, or are there new pathways to cancer that do not involve DNA damage of exogenous origin as essential early steps in the process?"

New pathways for cancer? Caused by a new generation of pesticides and herbicides which operate in new ways? Many of these new chemicals being used on tobacco in the Third World, long before they are even registered for use in the United States? So, before scientists have even begun to successfully cancers caused by the old-style pesticides and herbicides, and before the commercial tobacco industry is brought under even the smallest degree of rational, humanistic control, we are now seeing "new pathways to cancer" opening up as a result of untested, unexamined, unregulated pesticides and herbicides used on Third World tobacco and other crops.

There is an enormous irony to chemically induced cancer, and that is, as Dr. Farber points out at the conclusion of his paper, that:

"Some of the most effective chemotherapeutic agents for cancer are carcinogenic. For treatment of cancer in patients above 50 or 60 years old, the importance of the risk of carcinogenicity is clearly minimal, given the long latent period for cancer development. However, in children and young adults, the development of second cancers years after the effective treatment of the primary tumor is now becoming a recognizable problem."

So when environmental chemicals, particularly those in cigarettes, give a person cancer, just about all that the physicians can do at present is to treat that cancer with chemicals which in themselves are likely to cause another type of cancer, and about all that the doctors can hope that the person is old enough that he or she will die before the second cancer comes on.

The Cigarette Industry Line On Pesticides

Early in the inquiries which led me into this complex subject it became clear that there was a cigarette industry line in place to deal with inquisitive folks. "There is no problem. Once, in the 1950's, there might have been, but now there is no need for concern."

I talked with scientists who ought to have known better who insisted that a teeny bit of pesticides in your smoke wasn't going to hurt you. I talked with bureaucrats who clearly knew that tobacco was drenched with dangerous chemicals but, because of tobacco's unregulated status and potent political clout to assure that it stayed that way - no comment, pure stonewall. " I guess they're pretty much self-regulating on that one" a senior USDA official once told me, when I pushed him publicly to explain what if anything the department was doing to determine the health risks to smokers of known insecticide residues in US tobacco crops. I spoke with a statewide doctors group who ridiculed the idea that it might be the pesticides and not the tobacco by saying "What's a little more poison in the poison?" And I talked with a few people who agreed that, if what I said was true, there was a terrible thing happening. But anyone connected with the industry had, unremarkably, the same line - "There is no problem. Please stop being a pest. Case closed."
Actually the cigarette industry line is a little more complex than that - better reasoned, more compelling. Enough so to have stopped those few inquiries aimed in their direction dead in their tracks for decades.

It's important to realize that the cigarette industry, the US government, the captive university research community, much of the scientific and medical establishment, and much of the press have been thoroughly immersed in a complex line of reasoning which has caused and enabled them to ignore, deliberately or not, the clear implications of what selling, or allowing the sale, or facilitating the sale of heavily contaminated products to unsuspecting public for decades has done- which is to move almost universal public opinion to the point where the attitude when a smoker dies is - "Too bad, but what did they expect?"
It should come as no surprise to anyone who knows the cigarette industry that they have a very well reasoned line in place for just about every issue that may arise concerning pesticide residues in tobacco products. I've seen one variation or another of this line used in those few occasions when the issue has been raised in a public forum, and include it here along with some commentary in the hope that it will be useful to others making fresh inquiries based on the information presented at this site.
Summary of the line

"Pesticide residues on cigarettes? Well, of course there are bound to be a few traces of agrichemicals left on the tobacco. But we've never heard of any research that says these pesticides are harmful in such tiny amounts."
" In fact, we've run tests of our own for years, and we've found that levels of important pesticides have been consistently going down for years on all US tobacco. We've also run our own tests and found that almost none of the pesticides get through the smoking process. Also, the US government itself has established residue levels in foods and just about everything else, and US grown tobacco is carefully inspected by USDA."

"You know, if our farmers weren't able to use some of these pesticides, under careful government control, then insects would do millions of dollars in damage to valuable crops, and many small farmers could be wiped out. "

"And of course, these chemicals are also used on just about every other agricultural commodity, without any cause for alarm as long as residues are kept to a minimum. Just about everything you eat has some kind of agricultural chemical in it, so why get excited about a few traces of chemicals in your cigarette - especially if you smoke a filtered, low nicotine brand?"

The Industry Argument - Point By Point

There are bound to be a few traces of agrichemicals left on the leaves

With some of these pesticides, chronic exposure by inhalation to a trace is all it takes. Others are present in far more than trace amounts when you take their known human health impact into account - for example, traces of dieldrin are cumulative and stored in fatty tissue in a supertoxic form. So over time, and at the rate of 50,000 exposures a year for pack-a-day smokers, traces of dieldrin become pools of supertoxic dieldrin waiting to be released by any kind of weight loss - like the weight loss associated with AIDS or with cancer, for example. What a great time to have your body fat releasing a mix of supertoxic, supercarcinogenic, super immunity busting chemicals which have been stored away by your body in the best way it knew how.

We've never heard of any research that says these tiny traces are bad for you.

That's because so little published research has been done in this field. However, there are very strong indications that in unpublished research by the chemical companies and the cigarette industry scientists, done primarily as they went through the EPA registration process, the question of the health hazards presented by these residues were investigated. In the published literature there have been very few scientists working on establishing causal connections between any of the common pesticide contaminants of cigarettes, and the studies which have been done have focused ironically on one of the more innocuous tobacco chemicals - maleic hydrazide. Well, innocuous may not be the right word since, when burned, maleic hydrazide does produce copious amounts of a known high-impact carcinogen benzo-a-pyrene, but in comparison to the combustion by-products of some of the other common tobacco pesticide contaminants, MH is not high on the *immediate threat* list.

Guthrie, F.E. and Sheets, T.J. ***Pesticide Residues On Tobacco: A Continuing Problem***, (in) Tobacco, 170 (13): pp17-21, March 1970. One in a very long string of publications by these scientists who, working for the tobacco industry, have tracked pesticides for decades. They note that the magnitude of insecticide residues on tobacco leaf compared to other plants exposed to equal amounts of chemicals is caused by physiological properties of the tobacco leaf itself; specifically, it's high surface-to-volume ratio. They also note what they call the "time-honored practice of preventative insecticide treatments rather than adherence to economic thresholds" and that complain that tobacco company technologists won't recognize the problem as a major one.

If the danger to the smoker isn't sufficient to grab the attention of health authorities, you'd think that an understanding of the relationship between the pesticide residues on cigarettes and children's brain cancer would do the trick, wouldn't you. A high Centers for Disease Control official at a 1993 Waste Management conference http://atsdr1.atsdr.cdc.gov:8080/cx1d.html explained the results of exposure to Lindane and certain other common household pesticides - which also happen to be common contaminants of cigarettes, with the following observations:

Fortunately, childhood cancer is extremely rare and is often curable according to the definition of 5 year survival. Studies of the link between childhood cancer and potential environmental exposures have been done under a variety of circumstances, some involving paternal occupational exposure, some maternal occupational or other exposure, and some direct neonatal household exposures (Ahlbom 1990, DL Davis et al. 1990b, O'Leary et al. 1991).

Preliminary studies by the Missouri State Health Department showed that children exposed to certain home and garden pesticides had a rate of brain cancer that was up to 6 times higher than that of children without those exposures (JR Davis et al. 1993). This is an exceptionally strong association, which is seldom seen in environmental epidemiology.

Another Missouri State Health Department survey (JR Davis et al. 1992) found that a wide variety of pesticides were being used in households, and people were often unaware that they were using pesticides. For example, many consumers did not know that pet shampoo and flea collars contain active, toxic, pesticide ingredients, despite warning labels that advise that children should not be in contact with them. Surprisingly, 80% of pregnant women polled in this study also reported using some sort of pesticide while pregnant.

In a case control study comparing reported exposures in children who had brain cancer and other cancers and using friends without disease as controls, these same authors reported several troubling results associated with residential uses of pesticides and home and garden insecticides. They divided children's lives into 3 time periods: the time of pregnancy, birth to 6 months of age, and 7 months to diagnosis.

They found some suggestion of an increased risk of brain cancer when exposures took place from birth to 6 months and from 7 months to diagnosis. If the family used a termite pesticide, the risk of brain cancer was 2.9 times greater, or almost 3 times greater compared with other cancer controls. For the specific termite pesticide, chlordane, the risk of brain cancer was 1.5 times greater, but this included a confidence interval of from 0.5 to 4.9.

This study also showed that several specific residential uses increased the risk of childhood brain cancer. Fog bombs for flea or roach control conveyed a 2 fold higher risk of childhood brain cancer, when used during pregnancy. Surprisingly, when brain cancer cases were compared with other cancer controls, children whose families had used flea bombs had a 6 fold higher rate. Flea collars for dogs and cats are another widely used household pesticide. The data suggest that, for exposure to the flea collar and the treated pet combined, from birth to 6 months and from 7 months to diagnosis, the relative risk for childhood brain cancer may also be quite high.

Ought to make a Mom think twice before lighting up.

We've been running our own tests for years and have found that almost none of these chemicals get through the smoking process.

In 1980 the Swiss State Tobacco Monopoly conducted tests on the efficacy of filters in trapping pesticide residues and found that an average of 17% of the pesticides on the tobacco got through even the best filters in mainstream smoke. Then, of course, you always have to watch the use of language by this industry. While it is true that many of the pesticide residues are unstable under heat, and therefore do not "come through" after being burned, what isn't being said is that their decomposition by-products, such as benzo-a-pyrene, can often be more dangerous than the precursor pesticide itself. A favorite assertion in the industry literature is that the 800°C burning coal of the cigarette will take care of most of the little bit of pesticide that may be in the tobacco. However, there are very well-documented EPA incineration tests on many of the common tobacco pesticide contaminants, and the EPA believes that it takes a high-pressure, oxygen-fed incinerator operating at 1500°C for 10-15 seconds to 100% incinerate many of these pesticides. Besides, the burning coal argument is just plain silly coming from industry scientists, who know that the smoke which is inhaled and blown into the environment doesn't come from the burning coal of the cigarette anyway, but from the much cooler region just behind the burning coal where the smoking materials - not necessarily tobacco - are being dry-distilled along with the complex toxic soup of contaminants and additives to produce the final product - mainstream smoke.

Ceschini, P; Chauchaix, R. (Research Div., Tabacofina SA, Geneva, Switzerland (1980) ***Transfer of organochlorine pesticide residues into cigarette smoke as a function of tobacco blends and filter types.*** Beitrang Tabakforsch 10(2):134-138 (English) (11 references)***Determinations were made of the transfer of pesticides into the smoke from 4 different tobacco blends. The pesticides studies were BHC, lindane, aldrin, DDT isomers, DDE isomers, TDE isomers, dieldrin, endrin, endosulfan, and endosulfan sulfate. The average total pesticide transfer rate was 17% and appeared to be independent of tobacco type - American blend, Maryland, Virginia, or Oriental.***
The US government has established residue levels in food and just about every other agricultural commodity

In fact the US government has established residue levels in everything but tobacco products. While USDA does regulate what US tobacco growers can put on their crop, it has absolutely no say about what residues are present on foreign-grown tobacco, including tobacco manufacturing scrap and waste, other than to assure that there are no residues of pesticides specifically banned for use on tobacco in the US. It also has no say on what pesticide residues are present in any of the materials it uses to create reconstituted smoking materials and synthetic smoking materials. Synthetic smoking materials which are commonly made from paper mill waste have very real potential for having dioxin contamination, which is common in forest products industry waste. There is no regulation imposed on what the cigarette industry uses to make its synthetic smoking materials, and thus no inspection of what is going into the lungs of smokers and their families.
US grown tobacco is carefully inspected by the USDA

Absolutely true, and very misleading. Of course the US crop is inspected and the growers don't use anything but approved chemicals. What little DDT there is in US-grown tobacco is soil residual, and in many places in the US it has disappeared along with Endrin and some of the other early heavy hitters. However, US-grown tobacco is the least common ingredient of American

cigarettes, for one thing because it's too expensive compared with foreign-grown. In addition, the USDA doesn't look at the final product - cigarettes - but only at the American tobacco coming out of the fields and into the US system. Finally, the USDA is not inspecting to enforce health regulations but to assure that growers don't violate environmental laws.

If farmers didn't use pesticides, millions of dollars would be lost each year, and many farmers would be wiped out

This kind of talk preserves the image of the small independent tobacco farmer making a living on a few acres, rugged and all-American in their character and dedication. Unfortunately the image and the reality of the small tobacco grower are quite different. and in many ways they are more serf than farmer, more slave than freeman.

The reason that US tobacco farmers use so many chemicals on their crop is that the industry grading system forces them to try to kill everything - using only approved chemicals of course - because at auction time even the slightest blemish or discoloration, much less a bunch of insect holes, will cost them dearly in the amount of money they get. Of course this is largely a sham because the way the final product is manufactured and homogenized the presence or absence of insect damage is hardly an economic factor, but the grading system forces small farmers to use every chemical weapon possible in order to be able to get a high enough price for their crop to make a living.

These chemicals are used on just about every agricultural commodity

Naturally you don't smoke a tomato (do you?), and you don't eat cigarettes. Also, foreign tomatoes are inspected by the US and those contaminated with dangerous pesticides are banned. But foreign-grown tobacco leaf, stems, stalk and waste are inspected only for the presence of pesticides banned for use on tobacco in the US, not for the wide range of pesticides not covered by this narrow classification. The only really close attention the US government pays to foreign tobacco imports is to count them and make sure taxes are paid.

When you eat a tomato or strawberry contaminated with Toxaphene or Dieldrin, at least! all you're exposed to is the parent chemical. Your gut has also evolved over millions of years to handle a wide range of dangerous compounds that mother nature can deliver up in tasty disguises, but it's only over the past 50 years that our lungs have had to deal with much more than wood smoke and coal dust, and even that has only been around the human body for 1000 or so years. But when you smoke a cigarette contaminated with pesticide compounds, or breathe the smoke from one, you get not only the parent compounds that made it through but also all the daughter compounds, which are frequently more dangerous in smaller quantities than the originals. And the part of your body exposed to these potent chemicals isn't your gut, but your lungs.

It might be useful in this regard to look over the list of the EPA's Top Twenty Hazardous Substances list for 1996 to see how many of these substances are present in cigarettes (shown in Bold). This list is compiled annually to alert government agencies and environmental health authorities to the 20 most dangerous substances currently causing significant health risks to humans.

Lead
Arsenic - frequently used in fungicides and snailbait in tropical tobacco production
Mercury, metallic- frequently used in fungicides and snailbait in tropical tobacco production
Vinyl Chloride - a combustion byproduct of several known cigarette pesticide residues including DDT and Endrin
Benzene - a common solvent leaving residues, used to place flavorants into inert carrier materials like alpha-cellulose
Polychlorinated Biphenyls
Cadmium - common in snailbait in tropical cigar tobacco production
Benzo(a)pyrene - a combustion byproduct produced when common cigarette pesticide contaminants are combusted, especially the chlorinated hydrocarbons.
Chloroform - produced as a combustion byproduct of pesticide contaminants of cigarette materials
Benzo(b)fluoranthene
DDT, p'p' - a known contaminant of tobacco worldwide
Aroclor 1260
Trichloroethylene
Aroclor 1254
Chromium (+6)
Chlordane - a known contaminant of US cigarettes throughout the period 1955-1975, and possibly later
Dibenz[a,h]anthracene - - a combustion byproduct of several of the cigarette/tobacco pesticides
Hexachlorobutadiene

There may be a few others from this list that are present in cigarette smoke as the result of preventable contamination and deliberate production decisions, but the fact that ten out of the top twenty are preventable hazards in cigarettes ought to get somebody's attention, don't you think? Don't worry, especially if you smoke a filtered, low tar brand.

Your friendly tobacco company would like it very much if you didn't worry at all; however, if you are a smoker and worry enough to smoke a low-tar, low-nicotine, filtered cigarette you may think you have an edge on safety. Unfortunately, when it comes to pesticides, that's not the case. Low T&N cigarettes don't have less harmful components in their smokestream, it's just that the harmful components which would ordinarily come across as tar have been gasified by burning them at the higher temperatures produced by either special chemicals, or by the design of the tube, or both.

Please contribute comments, information, research or suggestions, which will enhance the effectiveness of this site to bdrake@ouramp.net

Cigarettes And Tobacco - Not The Same Thing

There is a critical and poorly understood distinction between the health hazards of smoking tobacco, and smoking cigarettes manufactured partially or totally out of synthetic materials. The medical & health community has been conned along with the public into participating in debates around largely phoney issues concerning the hazards of smoking *tobacco* when this so-called tobacco industry knows that many consumers are smoking little or no real, natural uncontaminated tobacco in their cigarette brand, but instead are smoking man-made and synthetic smoking materials containing a wide range of known carcinogens, fetus-damaging compounds, neurological toxins, and genetic mutagens that are extremely dangerous independent of any hazards that may be caused by the tobacco, if any, in that same cigarette.

One of the principal man-made ingredients of today's cigarettes is reconstituted tobacco, which the industry uses to justify its references to tobacco on the packaging of its product. It is manufactured in large part from waste, or junk tobacco, following roughly the same path from one cigarette company to another:

The stems and stalks of tobacco grown and processed in foreign countries is brought in duty-free to the US. These plant parts were waste in their own country of origin, since the leaf components were separated to be made into cheap cigarettes for third world markets. These stems and stalks cost the companies nothing to produce, and so even after the cost of transporting them they are zero-cost materials to use as the basis for the ground up, pressed and glued compound the industry calls "sheet tobacco". When many cigarette, pipe tobacco, and snuff brands use words or pictures to imply that there is tobacco in their product, what they technically mean is that there is a lot of this pressboard scrap material they themselves refer to as sheet.

The Manufacturing of Sheet

To manufacture reconstituted tobacco sheet, tobacco scrap and waste materials are first ground to a fine powder. Then using various acids and solvents, residual nicotine and natural tobacco materials are chemically stripped from the cellulose tobacco material.

At this point in the process, non-tobacco filler is added. This filler material is manufactured from a variety of cellulosic waste materials like recycled municipal paper waste, forest products industry waste, and food processing waste. This is one of the reasons for the apparently strange alliances one sees between tobacco companies and companies in industries like paper manufacturing and food processing - the cigarette industry uses their wastesireams as a source of alpha-cellulose.

Artificial flavoring chemicals & a wide variety of task-specific chemical additives are then incorporated into the slurry, using a range of solvents as carrier solutions. Solvents commonly used in sheet manufacturing include benzene, cyclohexane, and toluene - which are all known carcinogens, and which all occur in medically significant concentrations as residues in cigarettes and in assays of cigarette smokestreams.

This problem is discussed very early by the industry, as in U.S.Patent # 3,920,026 dated November 18, 1975 and assigned to Liggett & Myers Inc., of Durham, N.C. In this patent the inventors discuss the use of carcinogenic solvents to inject flavor into inert synthetic smoking materials, and the inability to remove these carcinogenic residues.

"Undesirable taste characteristics of reconstituted tobacco products are often encountered, which are related to the green taste of poor tobaccos, or the papery taste of stem materials. Incorporation of flavorants or flavorant release agents into tobacco has typically been accomplished by dissolving the flavorant or agent into a suitable solvent. The solution of flavorant material is thereupon sprayed on the tobacco or injected into the tobacco matrix - in the case of reconstituted sheet.

The solvent employed depends upon the particular flavorant material employed. Solvents have included water and various organic materials such as alcohol, acetone, or cyclohexane. Distribution of additives on the tobacco fibers may often be uneven, and more importantly, full penetration of the added substances into the cellular structure may not be achieved. Removal of residual solvent is often a problem."(emphasis added)

At the beginning of the sheet manufacturing process, Nicotine is removed from whatever natural materials are used, and that same Nicotine is later re-incorporated in precise dosages using nicotine-impregnated polysaccharide fibers and a variety of other ingenious bio-engineering techniques.

A wide range of other materials and chemicals are used in production of this reconstituted sheet tobacco, including glue, burn rate control agents, flavorants, humectants, filler materials, etc.

This chemical slurry mixture is then rolled out into a thin sheet. Using a variety of chemical and physical processes, this sheet material is then expanded, or "puffed up". The resulting sheet looks like particle board, and it is ready to be fed into giant mills which shave it into the little golden curls you see if you take many modern cigarette brands apart. It looks like tobacco, and by stretching the truth the manufacturer can claim that it offers real tobacco taste, pure tobacco pleasure, and imply in every other way that the cigarette contains tobacco.

That little bit of shading of the truth - calling reconstituted stems and stalks, and even synthetic materials with nicotine added "tobacco" - may turn out to be a central clue to why so many cigarette smokers are sick and dead from what they had every reason to believe was their tobacco smoking habit.

A very significant portion of the stems and stalks used to produce American sheet are of **third world** origin, where very large volumes of unregulated pesticides, often concocted in mixtures on-site by illiterate workers, are routinely used on tobacco crops. Many of these agrichemicals are specifically designed to translocate from leaves into the stems, stalks, and roots where they are concentrated. After the relatively pesticide-free tobacco leaves have been removed for sale to quality markets, the remaining stems and stalks, where the systemic pesticides have translocated, are sent to the US where they become sheet in the lungs of smokers.

Foreign-grown tobacco stems & stalks are routinely shown in European assays to be heavily contaminated with soil-applied chemicals and suckering agents, as well as solvent residues. Stems, stalks, and scrap routinely receive heavy fumigation in storage because by their nature they are heavily infested. For example both leaf and scrap tobacco in storage around the world is regularly fumigated with methyl bromide, a highly dangerous wide spectrum insecticide, which is known to leave high concentrations of residue in high protein plant materials like tobacco.

Synthetic Tobacco Smoking Materials Patents

Synthetic smoking materials have been an industry fascination for many years. These are smoking materials of something other than tobacco, whether synthetic or natural plant materials. The prime motivation behind development of synthetic smoking materials is economic, but there is also a strong element of unregulated science, technocracy gone mad. Here's a small selection of cigarette industry patents in the area of synthetic smoking materials which suggest why nobody should call these multinational corporations the "tobacco" industry. If you want to do a complete review of all of the patents the industry has in this and related areas, on the internet go to http://patents.cnidr.org/pto/classes/us/131/131.html

---

Patent # 4,243,056 January 6, 1981

Assignee: Philip Morris

Discusses a method of impregnating smoking materials with flavorant agents. A very significant discussion of the difficulties of removing residual solvents used in such impregnation. Such solvents include acetone, cyclohexane, and benzene- all identified as carcinogens long before the date of issuance of this patent. Establishes that industry continued using such solvents after their danger was well known.

Patent # 4,379,464 April 12, 1983

Assignee: Philip Morris

Discusses the use of tobacco scrap parts, especially stems and leaf midribs, for production of smoking materials. Specifically describes the motivation for such development as economic.

U.S. Patent #3,529,602 Sept. 22, 1970 *Tobacco Substitute Sheet Material*

Assignee: Philip Morris Incorporated, NY.

One of the earliest references to the manufacture of tobacco sheet. It's worth a long quote just to see what the cigarette companies were up to way back when - and of course they've come a long way since, baby.

"The nature of smoking products is such that the manufacture of a tobacco substitute is an extremely difficult operation. The subtleties of smoking and of producing a product which will be satisfactory to the smoker, both from a taste and flavor aspect and from the aspect of the other qualities of tobacco that are desired by smokers, make synthesis of such a product difficult. Thus while many attempts have been made to prepare tobacco substitutes, including many attempts which were made during wartime when tobacco was difficult to obtain, none have resulted in the development of a satisfactory tobacco substitute."

"The biological requirements for the growth of a tobacco plant are very different from the chemical and physical requirements for the generation of a smoke which is desirable from the smoker's viewpoint. Thus, there are often constituents in tobacco which result in a less

desirable smoke from a smoker's viewpoint and which tend to adversely affect the character of smoke from tobacco products."
"A nicotine-donating ingredient is not essential, but is a preferred ingredient. The nicotine may be added in any of the known ways of incorporating nicotine in tobacco. For example, it may be added per se to the tobacco or it may be added in the form of a material which releases nicotine upon burning of the tobacco substitute. The latter method is illustrated in US Pat. 3,109,436, wherein the addition of a nicotine-ion exchange resin to tobacco is described. The nicotine may also be incorporated into other portions of the tobacco product, such as the wrapper or filter to accomplish the same result."

Patent # 4,079,742 March 21, 1978
Assignee: Philip Morris
This patent deals with a new process for manufacture of synthetic smoking materials. Pages 1-5 contain an excellent summary of the existing patent literature devoted to development of synthetic smoking materials, showing a long-term trend in this direction in the industry. The patent discusses the wide range of cellulosic materials, primarily industrial and agricultural waste materials, used in development of synthetic smoking materials.

Patent # 3,943,943 March 16, 1976
Assignee: Liggett & Myers
Discusses a method of adding flavor and aroma to reconstituted and synthetic smoking materials. Good evidence of the industry motivation to use such materials.

Patent # 3,920,026 November 18, 1975
Assignee: Liggett & Myers
Discusses methods of masking the undesirable taste and aroma characteristics of poor quality tobacco, and tobacco waste, allowing these materials to be used in manufacturing cigarette products. Shows industry trend toward use of trash materials.

Return To Table Of Contents
US Patent No. 4,022,223 May 10, 1977
Assignee: unknown
A patent for a new kind of cigarette filter material. ***"Certain heavy metal salt-amine complexes deposited on suitable bases are highly effective in absorbing or removing hydrogen cyanide from the smoke of tobacco or a tobacco substitute."*** (emphasis added)

Patent # 4,319,585 March 16, 1982
Assignee: unknown
Discusses development of synthetic flavoring agents. Makes several very important statements. "It is well known, as far as the ultimate consumer is concerned, that flavor & aroma are perhaps the largest factors in his selection of a smokable Tobacco product." "The term "tobacco", as used throughout this specification, is intended to mean any composition intended for use by smoking or otherwise, whether composed of tobacco plant parts or substitute materials, or both." In addition, this patent refers to toxicity studies done on several of the synthetic flavoring components under discussion- indicating that such studies are carried out by industry.

US Patent # 3,964,496 June 22, 1976
Assignee: R.J. Reynolds Tobacco Company
Includes commentary like
"Puffed rice is employed as a tobacco substitute by itself or with other non-tobacco materials to form smoking products such as cigarettes, cigars, and pipe smoking products. When so used, it is presently preferred that the puffed rice simulate tobacco and accordingly appropriate procedures can be employed to provide the puffed rice in the desired size and shape. The burning rate, flavor, and other properties of non-tobacco smoking products can be altered by incorporating with the puffed rice suitable additives such as flavorants, tobacco extracts, nicotine, humectants, ash improving additives, etc."
A little challenge: look at the contents of any cigarette under magnification, and see how much of it looks like actual, natural leaf material, and how much looks like granular little strips of brown flavored glued pressed powder. Can you tell?
Return To Table Of Contents
Please contribute comments, information, research or suggestions, which will enhance the effectiveness of this site to bdrake@onramp.net

Research On Pesticides And Human Health

In environmental health studies one often finds initial remarks similar to this one in the report on the Toxic Waste Conference of 1993, held by the US government "For several diseases, including cancer, tobacco use is the most important known preventable cause." This statement is almost always followed by a disclaimer which points out that despite best efforts people seem to continue smoking, so this leading form of death is usually set aside and the scientists go on to discuss all the environmental hazards that they believe can be addressed - things like exposure to chemical contaminants, toxic fumes, and hazardous materials.

What a terrible irony is would be if it is precisely these things in cigarettes, and not the tobacco, which is the preventable source of much of the disease and death from smoking, which these scientists believe is an intractable problem.

Here is a selected list of recent publications detailing the relationship between agricultural pesticides and human health. You'll find many more citations organized by topic in the bibliography section of this site. While many mention smoking as a leading cause of preventable disease and death, and others mention smoking as a source of exposure to hazardous chemicals, none make the connection between man-made, deliberately applied, knowingly contaminated non-tobacco and reconstituted smoking materials and the public health crisis created by smoking cigarettes.

Ahlbom A. (1990). ***Some notes on brain tumor epidemiology***. In: Davis DL, Hoel D, eds. ***Trends in cancer mortality in industrial countries***. Annals of the New York Academy of Sciences, 609:179-90. New York: New York Academy of Sciences.

Colburn T, Clement C, eds. (1992). ***Chemically induced alterations in sexual and functional development: The wildlife/human connection***. Advances in Modern Environmental Toxicology, Vol. 21, Princeton, N.J.: Princeton Scientific Publishing.

Davis DL, Friedler G, Mattison D, Morris R. (1992a). ***Male-mediated teratogenesis and other reproductive effects: Biologic and epidemiologic findings and a plea for clinical research***. Reprod Toxicol 6:289-92.

Davis DL, Hoel D, Fox J, Lopez A. (1990a). International trends in cancer mortality in France, West Germany, Italy, Japan, England, and Wales, and the United States. In: Davis DL, Hoel D, eds. ***Trends in cancer mortality in industrial countries***. Annals of the New York Academy of Sciences 609:5-48. New York: New York Academy of Sciences.

Davis DL, Hoel D, Percy C, Ahlbom A, Schwartz J. (1990b). ***Is brain cancer mortality increasing in industrial countries?*** In: Davis DL, Hoel D, eds. Trends in cancer mortality in industrial countries. Annals of the New York Academy of Sciences 609: 191 -204. New York: New York Academy of Sciences.

Davis DL, Blair A, Hoel DG. (1992b). ***Agricultural exposures and cancer trends in developed countries.*** Environ Health Perspect 100:39 44.

Davis DL, Bradlow HL, Wolff M, Woodruff T, Hoel DG, Anton-Culver H. 1993. ***Medical hypothesis: Xenoestrogens as preventable causes of breast cancer***. Environ Health Perspect 101 :372-7.

Davis JR, Brownson RC, Garcia R. (1992). ***Family pesticide use in the home, garden, orchard, and yard.*** Arch Environ Contam Toxicol 22:260-6.
Davis JR, Brownson RC, Garcia R, Bentz BJ, Turner A. (1993). ***Family pesticide use and childhood brain cancer.*** Arch Environ Contam Toxicol 24:87-92.
Glickman LT, Schofer FS, McKee LJ, Reif JS, Goldschmidt MH. (1989). ***Epidemiologic study of insecticide exposures, obesity, and risk of bladder cancer in household dogs.*** J Toxicol Environ Health 28(4):407-14.
Hoel DG, Davis DL, Miller AB, Sondik EJ, Swerdlow AJ. (1992). ***Trends in cancer mortality in 15 industrialized countries, 1969-1986.*** J Natl Cancer Inst 84:313-20.
Krieger NK, WolffMS, Hiatt RA, Rivera M, Vogelman J, Orentreich N. (1994). ***Breast cancer and serum organochlorines: A prospective study among white, black, and Asian women.*** J Natl Cancer Inst 86:589-99.
Lopez A (1990). ***Competing causes of death: A review of recent trends in mortality in industrialized countries with special reference to cancer.*** Ann NY Acad Sci 609:58-76.
Montgomery LE, Carter-Pokras O. (1993). ***Health status by social class and/or minority status: Implications for environmental equity research.*** Toxicology & Industrial Health 9(5):729-75.
Moses M, et al. (1993). ***Environmental equity and pesticide exposure.*** Toxicology & Industrial Health 9(5):913-60.
National Research Council (NRC). (1991). ***Environmental epidemiology Volume 1: Public health and hazardous wastes.*** Washington, D.C.: National Academy Press.
O'Leary LM, Hicks AM, Peters JM, London S. (1991) ***Parental occupational exposures and risk of childhood cancer: a review.*** Am J Ind Med 20:17-35.
Olsen JH, Brown P, Schulgen G, Jensen OM. (1991). ***Parental employment at time of conception and risk of cancer in offspring.*** Eur J Cancer 27:958-65.
Rios R, Poje GV, Detels R. (1993). ***Susceptibility to environmental pollutants among minorities.*** Toxicology & Industrial Health 9(5):797-820.
Sexton, K., Olden, K., Johnson, B. (1993). ***Environmental justice: The central role of research in establishing a credible scientific foundation for informed decision making.*** Toxicology & Industrial Health 9(5):685-728.
Silbergeld, E.K. (1994). ***Evaluating the success of environmental health programs in protecting the public's health.*** In: Andrews JS Jr. Frumkin H, Johnson BL, Mehlman MA, Ximaras C, Bucsela J, eds. ***Hazardous waste and public health: International congress on the health effects of hazardous waste***; 1993 May 3-6; Atlanta. Atlanta: Agency for Toxic Substances and Disease Registry, Public Health Service, U.S. Department of Health and Human Services. pp 43-8.
Strohmer, H., Boldizsar, A., Plockinger, B., Feldner-Busztin, M., Feichtinger, W., (1993). ***Agricultural work and male infertility.*** Am J Ind Med 24(5):587-92.
Wolff, MS., Paolo, G., Toniolo, P., Lee, Eric W., Rivera, M., Dubin, N., (1993). ***Blood levels of organochlorine residues and risk of breast cancer.*** J Natl Cancer Inst 85(8), April 21.
Lazarus, Philip, Idris, Ali M., Hoffmann, Dietrich, ***p53 Mutations in Head and Neck Squamous Cell Carcinomas from Sudanese Snuff (Toombak) Users*** Cancer Detection And Prevention, 1996 v20 n4
The year 1997 is off to a very promising start with research like that of Dr. Joe DePierre of Lund, Sweden

Studies on xenobiotic metabolism and its relationship to the effects of xenobiotics on living organisms

http://www.biokemi.su.se/Gallery/depierre_j.html

"It has become increasingly clear that hormonal regulation of xenotiobic-metabolizing enzymes is a general phenomenon, in addition to the genetic up-regulation of these same enzymes upon exposure to xenobiotics through the process referred to as induction. Our interest is focused primarily on the hormonal regulation of different isozymes of cytochrome P-450 and of glutathione transferase by steroid and peptide hormones. There are large differences in the levels of certain of these hormones in male and female animals and at different stages of development (e.g., during ontogenesis, after birth, in connection with puberty, pregnancy and menopause). Again, this project encompasses three major goals: a) to elucidate the molecular mechanism underlying the hormonal regulation of xenobiotic-metabolizing enzymes; b) to understand why such regulation occurs; and c) to determine the consequences of such hormonal regulation for the organism's response to exposure to xenobiotics. "

Return To Table Of Contents

The Smoking Guns of 1996

Two scientific studies were published in 1996 which, when all the dots are finally connected, will reveal a clear picture of the cause of much if not most of the smoking-related disease and death. Both studies were published in the journal Science. The first, published in June by Dr. Robert McLachlan and his colleagues at Tulane University, published research demonstrating that if you combine extremely low doses of four pesticides, each in itself well below the threshold for hazard to humans, you get far more than what they expected, which was along the lines of 1+1=2. What they found was that when any of the pesticides were combined - endosulfan, dieldrin, disulfoton, and toxaphene - the resulting increase in hazard to humans was more like 1+1=1600. The ingestion of even very tiny amounts of these pesticides in combination appears to create a health hazard many magnitudes beyond what would occur if you ingested them one at a time.

The red flag here is that all four of these pesticides have been extremely common contaminants of U.S. cigarettes since the 1960's. This means that pack-a-day smokers, and their families, have been exposed to radically enhanced chemical hazard 50,000 times a year with no opportunity to know about the hazard and make decisions based on this knowledge.

The second 1996 Smoking Gun study was published in Science in October by Mikhail Denissenko and Gerd Pfeifer of the Beckman Research Center, City of Hope, Duarte, California and Annie Pao and Moon-shong Tang of the M.D. Anderson Cancer Center Science Park in Smithville, Texas. They follow the trail of benzo-a-pyrene from ingestion as part of the cigarette smokestream, to conversion into a compound called BPDE, to BPDE's attachment at the exact spot on the P53 gene where mutations arise that prevent

the gene from performing its tumor-suppressing tasks in lung and other smoking related cancers.

The researchers write " Our study provides a direct link between a defined cigarette smoke carcinogen and human cancer mutations."

What the researchers didn't deal with was the origin of the benzo-a-pyrene, and whether any of it was from pesticide residues, or from reconstituted or synthetic smoking materials, rather than from tobacco? It's important not to become focused just on this current benzo-a-pyrene finding. This extremely lethal chemical has been identified as a likely cause of lung cancers in cigarette smokers since at least the early 1960's when smokestream studies identified its presence. What this research has finally done is to prove, step by step, how benzo-a-pyrene causes cancer in smokers by tracing its path directly to the spot on P53 where the lung cancer begins. Any doubt that remains that the benzo-a-pyrene component of cigarette smoke causes lung cancer is unreasonable - but there are at least two other pieces of this part of the total cigarette health hazard puzzle which are still uncertain:

What other smokestream components, already fully identified as carcinogenic and mutagenic, are combustion by-products of pesticide contaminants, of deliberate additives, and of reconstituted tobacco and synthetic smoking materials?

How does the smokestream profile of a sample of commercial cigarettes compare with the smokestream profile of natural, uncontaminated tobacco - specifically which identified carcinogenic and mutagenic chemicals are present in commercial cigarette smoke that are not present, or are present in different amounts or proportions, in natural tobacco smoke.

Once we know the answers to these questions, we will have the answer - is it the tobacco, or is it something else, something largely preventable?

However, serious public health concerns ought to be raised in light of the known health hazards of chronic exposure to minute environmental amounts of the tobacco pesticides, the 40-50 year research record tracking the persistent and increasing presence of carcinogenic, mutagenic, fetus-damaging chemicals in cigarettes specifically designed to attack life in some of its most resistent forms and known to cause severe damage in humans .

This record also raises questions of responsibility - who knew or, by virtue of their command authority, ought to have known about (1) the deliberate incorporation of designed and patented chemicals for their predictable behavioral and economic benefits and effects, and (2) about the deliberate use of agrichemicals known to leave contamination at levels known to be dangerous when consumed by humans under chronic sublethal conditions, which constitutes normal tobacco product usage.

The following descriptions attempt to summarize what is known about the effects on humans of the pesticides which have shown up persistently in the research data tracking concentrations of pesticide residues in commercial US cigarettes, as well as reports tracking pesticide residues in Europe and Japan.

Research On Pesticides And Human Health

Return To Table Of Contents

In environmental health studies studies one often finds initial remarks similar to this one in the report on the Toxic Waste Conference of 1993, held by the US government "For several diseases, including cancer, tobacco use is the most important known preventable

cause." This statement is almost always followed by a disclaimer which points out that despite best efforts people seem to continue smoking, so this leading form of death is usually set aside and the scientists go on to discuss all the environmental hazards that they believe can be addressed - things like exposure to chemical contaminants, toxic fumes, and hazardous materials.

What a terrible irony is would be if it is precisely these things in cigarettes, and not the tobacco, which is the preventable source of much of the disease and death from smoking, which these scientists believe is an intractable problem.

Here is a selected list of recent publications detailing the relationship between agricultural pesticides and human health. You'll find many more citations organized by topic in the **bibliography section of this site.** While many mention smoking as a leading cause of preventable disease and death, and others mention smoking as a source of exposure to hazardous chemicals, none make the connection between man-made, deliberately applied, knowingly contaminated non-tobacco and reconstituted smoking materials and the public health crisis created by smoking cigarettes.

Ahlbom A. (1990). ***Some notes on brain tumor epidemiology***. In: Davis DL, Hoel D, eds. ***Trends in cancer mortality in industrial countries***. Annals of the New York Academy of Sciences, 609:179-90. New York: New York Academy of Sciences.

Colburn T, Clement C, eds. (1992). ***Chemically induced alterations in sexual and functional development: The wildlife/human connection***. Advances in Modern Environmental Toxicology, Vol. 21, Princeton, N.J.: Princeton Scientific Publishing.

Davis DL, Friedler G, Mattison D, Morris R. (1992a). ***Male-mediated teratogenesis and other reproductive effects: Biologic and epidemiologic findings and a plea for clinical research***. Reprod Toxicol 6:289-92.

Davis DL, Hoel D, Fox J, Lopez A. (1990a). International trends in cancer mortality in France, West Germany, Italy, Japan, England, and Wales, and the United States. In: Davis DL, Hoel D, eds. ***Trends in cancer mortality in industrial countries***. Annals of the New York Academy of Sciences 609:5-48. New York: New York Academy of Sciences.

Davis DL, Hoel D, Percy C, Ahlbom A, Schwartz J. (1990b). ***Is brain cancer mortality increasing in industrial countries?*** In: Davis DL, Hoel D, eds. Trends in cancer mortality in industrial countries. Annals of the New York Academy of Sciences 609: 191 -204. New York: New York Academy of Sciences.

Davis DL, Blair A, Hoel DG. (1992b). ***Agricultural exposures and cancer trends in developed countries***. Environ Health Perspect 100:39 44.

Davis DL, Bradlow HL, Wolff M, Woodruff T, Hoel DG, Anton-Culver H. 1993. ***Medical hypothesis: Xenoestrogens as preventable causes of breast cancer***. Environ Health Perspect 101 :372-7.

Davis JR, Brownson RC, Garcia R. (1992). ***Family pesticide use in the home, garden, orchard, and yard***. Arch Environ Contam Toxicol 22:260–6.

Davis JR, Brownson RC, Garcia R, Bentz BJ, Turner A. (1993). ***Family pesticide use and childhood brain cancer***. Arch Environ Contam Toxicol 24:87-92.

Glickman LT, Schofer FS, McKee LJ, Reif JS, Goldschmidt MH. (1989). ***Epidemiologic study of insecticide exposures, obesity, and risk of bladder cancer in household dogs***. J Toxicol Environ Health 28(4):407-14.

Hoel DG, Davis DL, Miller AB, Sondik EJ, Swerdlow AJ. (1992). ***Trends in cancer mortality in 15 industrialized countries, 1969-1986***. J Natl Cancer Inst 84:313-20.

Krieger NK, WolffMS, Hiatt RA, Rivera M, Vogelman J, Orentreich N. (1994). ***Breast cancer and serum organochlorines: A prospective study among white, black, and Asian women.*** J Natl Cancer Inst 86:589-99.

Lopez A (1990). ***Competing causes of death: A review of recent trends in mortality in industrialized countries with special reference to cancer.*** Ann NY Acad Sci 609:58-76.

Montgomery LE, Carter-Pokras O. (1993). ***Health status by social class and/or minority status: Implications for environmental equity research.*** Toxicology & Industrial Health 9(5):729-75.

Moses M, et al. (1993). ***Environmental equity and pesticide exposure.*** Toxicology & Industrial Health 9(5):913-60.

National Research Council (NRC). (1991). ***Environmental epidemiology Volume 1: Public health and hazardous wastes.*** Washington, D.C.: National Academy Press.

O'Leary LM, Hicks AM, Peters JM, London S. (1991) ***Parental occupational exposures and risk of childhood cancer: a review.*** Am J Ind Med 20:17-35.

Olsen JH, Brown P, Schulgen G, Jensen OM. (1991). ***Parental employment at time of conception and risk of cancer in offspring.*** Eur J Cancer 27:958-65.

Rios R, Poje GV, Detels R. (1993). ***Susceptibility to environmental pollutants among minorities.*** Toxicology & Industrial Health 9(5):797-820.

Sexton, K., Olden, K., Johnson, B. (1993). ***Environmental justice: The central role of research in establishing a credible scientific foundation for informed decision making.*** Toxicology & Industrial Health 9(5):685-728.

Silbergeld, E.K. (1994). ***Evaluating the success of environmental health programs in protecting the public's health.*** Tn: Andrews JS Jr. Frumkin H, Johnson BL, Mehlman MA, Xintaras C, Bucsela J, eds. ***Hazardous waste and public health: International congress on the health effects of hazardous waste;*** 1993 May 3-6; Atlanta. Atlanta: Agency for Toxic Substances and Disease Registry, Public Health Service, U.S. Department of Health and Human Services. pp 43-8.

Strohmer, H., Boldizsar, A., Plockinger, B., Feldner-Busztin, M., Feichtinger, W., (1993). ***Agricultural work and male infertility.*** Am J Ind Med 24(5):587-92.

Wolff, MS., Paolo, G., Toniolo, P., Lee, Eric W., Rivera, M., Dubin, N., (1993). ***Blood levels of organochlorine residues and risk of breast cancer.*** J Natl Cancer Inst 85(8), April 21.

Lazarus, Philip, Idris, Ali M., Hoffmann, Dietrich, ***p53 Mutations in Head and Neck Squamous Cell Carcinomas from Sudanese Snuff (Toombak) Users*** Cancer Detection And Prevention, 1996 v20 n4

The year 1997 is off to a very promising start with research like that of Dr. Joe DePierre of Lund, Sweden

Studies on xenobiotic metabolism and its relationship to the effects of xenobiotics on living organisms

http://www.biokemi.su.se/Gallery/depierre_j.html

"It has become increasingly clear that hormonal regulation of xenotiobic-metabolizing enzymes is a general phenomenon, in addition to the genetic up-regulation of these same enzymes upon exposure to xenobiotics through the process referred to as induction. Our interest is focused primarily on the hormonal regulation of different isozymes of cytochrome P-450 and of glutathione transferase by steroid and peptide hormones. There are large differences in the levels of certain of these hormones in male and female

animals and at different stages of development (e.g., during ontogenesis, after birth, in connection with puberty, pregnancy and menopause). Again, this project encompasses three major goals: a) to elucidate the molecular mechanism underlying the hormonal regulation of xenobiotic-metabolizing enzymes; b) to understand why such regulation occurs; and c) to determine the consequences of such hormonal regulation for the organism's response to exposure to xenobiotics. "

Return To Table Of Contents

The Smoking Guns of 1996

Two scientific studies were published in 1996 which, when all the dots are finally connected, will reveal a clear picture of the cause of much if not most of the smoking-related disease and death. Both studies were published in the journal Science. The first, published in June by Dr. Robert McLachlan and his colleagues at Tulane University, published research demonstrating that if you combine extremely low doses of four pesticides, each in itself well below the threshold for hazard to humans, you get far more than what they expected, which was along the lines of 1+1=2. What they found was that when any of the pesticides were combined - endosulfan, dieldrin, disulfoton, and toxaphene - the resulting increase in hazard to humans was more like 1+1=1600. The ingestion of even very tiny amounts of these pesticides in combination appears to create a health hazard many magnitudes beyond what would occur if you ingested them one at a time.

The red flag here is that all four of these pesticides have been extremely common contaminants of U.S. cigarettes since the 1960's. This means that pack-a-day smokers, and their families, have been exposed to radically enhanced chemical hazard 50,000 times a year with no opportunity to know about the hazard and make decisions based on this knowledge.

The second 1996 Smoking Gun study was published in Science in October by Mikhail Denissenko and Gerd Pfeifer of the Beckman Research Center, City of Hope, Duarte, California and Annie Pao and Moon-shong Tang of the M.D. Anderson Cancer Center Science Park in Smithville, Texas. They follow the trail of benzo-a-pyrene from ingestion as part of the cigarette smokestream, to conversion into a compound called BPDE, to BPDE's attachment at the exact spot on the P53 gene where mutations arise that prevent the gene from performing its tumor-suppressing tasks in lung and other smoking related cancers.

The researchers write " Our study provides a direct link between a defined cigarette smoke carcinogen and human cancer mutations."

What the researchers didn't deal with was the origin of the benzo-a-pyrene, and whether any of it was from pesticide residues, or from reconstituted or synthetic smoking materials, rather than from tobacco? It's important not to become focused just on this current benzo-a-pyrene finding. This extremely lethal chemical has been identified as a likely cause of lung cancers in cigarette smokers since at least the early 1960's when smokestream studies identified its presence. What this research has finally done is to

prove, step by step, how benzo-a-pyrene causes cancer in smokers by tracing its path directly to the spot on P53 where the lung cancer begins. Any doubt that remains that the benzo-a-pyrene component of cigarette smoke causes lung cancer is unreasonable - but there are at least two other pieces of this part of the total cigarette health hazard puzzle which are still uncertain:

What other smokestream components, already fully identified as carcinogenic and mutagenic, are combustion by-products of pesticide contaminants, of deliberate additives, and of reconstituted tobacco and synthetic smoking materials?

How does the smokestream profile of a sample of commercial cigarettes compare with the smokestream profile of natural, uncontaminated tobacco - specifically which identified carcinogenic and mutagenic chemicals are present in commercial cigarette smoke that are not present, or are present in different amounts or proportions, in natural tobacco smoke.

Once we know the answers to these questions, we will have the answer - is it the tobacco, or is it something else, something largely preventable?

However, serious public health concerns ought to be raised in light of the known health hazards of chronic exposure to minute environmental amounts of the tobacco pesticides, the 40-50 year research record tracking the persistent and increasing presence of carcinogenic, mutagenic, fetus-damaging chemicals in cigarettes specifically designed to attack life in some of its most resistent forms and known to cause severe damage in humans .

This record also raises questions of responsibility - who knew or, by virtue of their command authority, ought to have known about (1) the deliberate incorporation of designed and patented chemicals for their predictable behavioral and economic benefits and effects, and (2) about the deliberate use of agrichemicals known to leave contamination at levels known to be dangerous when consumed by humans under chronic sublethal conditions, which constitutes normal tobacco product usage.

The following descriptions attempt to summarize what is known about the effects on humans of the pesticides which have shown up persistently in the research data tracking concentrations of pesticide residues in commercial US cigarettes, as well as reports tracking pesticide residues in Europe and Japan.

6.11

Upcoming Major Tobacco Trials

Last Updated 3/18/99
Note that this is far from a complete listing. If you have trial information to share, please let us know.

IN TRIAL - *Engle, et al. v. R.J. Reynolds Tobacco, et al.*
(Dade County, Florida, Eleventh Judicial Circuit)
First class action on behalf of smokers to go to trial. This case is brought on behalf of Florida residents injured as a result of smoking cigarettes and plaintiffs are seeking as much as $200 billion. Judge Robert Kaye presided over the flight attendants secondhand smoke class action settled last Fall. (See opt out notice web site). The defense Began to present its case in March and this phase of the trial may be wrapped up in the first weeks of Spring.

VERDICT FOR DEFENDANTS 3/18/99 - - *Iron Workers Local Union No. 17 Insurance Fund v. Philip Morris Inc., et al.*, No. 1:97-cv-1422, (N.D. Ohio (Akron)).
Class of about 100 Ohio unions seeking recovery of fund assets (as well as treble and punitive damages) related to treating members suffering from tobacco-caused disease brought under theories of racketeering, antitrust and conspiracy. The class was certified on October 20, 1998. After three days of deliberations, an eleven member jury unanimously voted to find the industry not liable.

One possible explanation for the pro-industry verdict, which came as a surprise to most observers, is the compressed time frame for the trial. Under an accelerated schedule ordered by the trial judge, in four weeks, the allegations of a first of its kind class action trial dealing with fraud and civil racketeering charges had to be proven. Likely, the one week provided to the plaintiffs to present the critical fraud and conspiracy aspects of the case to the jury was insufficient. Normally, long trials caused by industry litigation tactics benefit the industry. Here, an exceptionally and exceedingly short trial may have benefited the industry.

While some have characterized this loss as an end to union fund recovery litigation against Big Tobacco, a similar trial is scheduled for September in Seattle (*Northwest Laborers*

For Tobacco File -
JN
3/31/99

Employers Health & Security Trust Fund et al. v. Philip Morris, Inc. et al.).

Plaintiff counsel includes Robert Connerton of Connerton & Ray who has about two dozen similar proposed class actions pending around the nation. Other firms representing the plaintiff include: Schwarzwald & Rock in Cleveland; the Landskroner Law Firm of Cleveland; Milberg, Weiss, Bershad, Hynes & Lerach in New York and San Diego; Stritmatter, Kessler, Whelan & Withey in Seattle; Kargianis, Watkins, Marler in Seattle; Roger M. Adelman of Washington, D.C.; G. Robert Blakey of Notre Dame Law School; and Einer R. Elhauge of Harvard Law School.

2/22/99 IN TRIAL - *Joann Williams-Branch v. Philip Morris, Inc.,* No. 9705-03957, (Circuit Court for the County of Multnomah (Portland)).
A wrongful death individual lung cancer case against Philip Morris. Plaintiff counsel includes: Ray Thomas and James Coon of Swanson, Thomas, & Coons; Bill Gaylord, Gaylord & Eyerman; Charles Tauman; and Professor Richard Daynard.

IN TRIAL - *Olanda Carter v. R.J. Reynolds Tobacco Co.*, No. 88570-8-T.D.; *Edith Karney v. Philip Morris Inc.*, No. 89196-8-T.D.; *Denise McDaniel v. Brown & Williamson Tobacco Corp.*, 90832-8 T.D.; *Ruby Settle v. B.A.T. Industries*, No. 89226-8-T.D.(Memphis, Tennessee, 13th Judicial District)
First consolidated tobacco trial will be conducted in 2 phases: Phase One will deal with industry liability on theories of negligence, strict liability, conspiracy and breach of warranty while Phase Two will address causation and damages for each of the five plaintiffs. The same jury will preside over both phases.

Reportedly, the trial is moving rather slowly and the judge has not allowed more than about a dozen pieces of documentary evidence for each plaintiff. This is in sharp contrast to recent trials in which the jury was allowed to see hundreds of tobacco industry "secret" documents. The excluded documents undermined the assertions made by the defendants in trial. By preventing the jury from seeing potential evidence of industry deceit, the plaintiffs are operating at a distinct disadvantage. The Plaintiffs' attorneys are lead by Curtis D. Johnson, Jr., of

Memphis,TN and Norwood S. Wilner, of Jacksonville, FL.

VERDICT FOR PLAINTIFF 2/9/99 - *Henley v Philip Morris Inc., et al,* Sup Ct of CA, SF Case No. 995172.
2/9/99 - In first verdict against Philip Morris, a California Jury gives $50 million in punitive and $1.5 million in compensatory damages to smoker with lung cancer!
The jury found Philip Morris liable for Product defect, failure to warn (before July 1969), Negligence, Fraud, False Promise, Express Warranty, and Conspiracy.
This is an individual personal injury action on behalf of a 52 year old woman dying of lung cancer. Marlboro (mfg. by Philip Morris) was her primary brand although all major cigarette companies are defendants under fraud and conspiracy allegations. Plaintiff's attorney is Madelyn Chaber, Wartnick, Chaber, Harowitz, Smith & Tigerman, San Francisco, CA.. William Ohlemeyer, Shook, Hardy & Bacon, Kansas City, MO, is lead defense counsel. See First Amended Complaint

VERDICT FOR DEFENDANTS 2/12/99 - *Lacy v. Lorillard Tobacco Company et al.,* No. 94-01894 (Sup. Ct., Norfolk County, Mass.)
A Kent Micronite filter case in which a smoker of Kent cigarettes during the mid 1950s was stricken with mesothelioma, a rare and fatal form of lung cancer caused exclusively by exposure to "blue" asbestos. This is a wrongful death action in which punitive damages may be awarded under Massachusetts law. This deadly material was used as a loosely packed filtering agent for several years by Lorillard. Plaintiff counsel includes Charles Patrick of Ness, Motley, Loadholdt, Richardson & Poole (Charleston, SC)as well as noted Micronite filter expert, Daniel Childs of Johnson & Childs (Philadelphia, PA). The Massachusetts firm of Hollingsworth & Vose, which assembled the filters for Lorillard, is a co-defendant but has reportedly been indemnified by Lorillard.
The Estate of Mildred Lacy is represented by Charles Patrick of Ness Motley Richardson Loadholdt & Poole (Charleston, SC) and by Daniel Childs of Johnson & Childs (Philadelphia, PA).

Back

World Health Organization
Tobacco or Health Programme

Tobacco or Health: A Global Status Report

Country Profiles by Region, 1997

Regional Profiles

Africa
The Americas
Eastern Mediterranean
Europe
Southeast Asia
Western Pacific

Global Alphabetical Country Listing

International Issues

World Health Organization: Tobacco or Health
http://www.who.org/programmes/psa/toh.htm

This information is provided on the Internet as a service by the Office on Smoking and Health of the CDC's National Center for Chronic Disease Prevention and Health Promotion, in its role as a World Health Organization (WHO) Collaborating Center for Tobacco or Health. Data and information for the country profiles were assembled by the WHO from a number of existing reports and publications and shared with WHO Regional Offices and member countries for validation.

Tobacco Free Initiative

Home Search

According to WHO estimates, there are currently 3.5 million deaths a year from tobacco, a figure expected to rise to about 10 million by 2030. By that date, based on current smoking trends, tobacco is predicted to be the leading cause of disease burden in the world, causing about one in eight deaths. 70% of those deaths will occur in developing countries. The sheer scale of tobacco's impact on global disease burden, and particularly what is likely to happen without appropriate intervention in developing countries, is often not fully appreciated. The extremely negative impact of tobacco on health now and in the future is the primary reason for giving explicit and strong support to tobacco control on a world-wide basis.

In response to these concerns the Director-General, Dr Gro Harlem Brundtland, established a Cabinet project, the Tobacco Free Initiative (TFI), in July 1998 to coordinate an improved global strategic response to tobacco as an important public health issue. The long-term mission of global tobacco control, which will take several decades to achieve, is to reduce smoking prevalence and tobacco consumption in all countries and among all groups, and thereby reduce the burden of disease caused by tobacco. In support of this mission, the goals of the Tobacco Free Initiative are to:

- Galvanize global support for evidence-based tobacco control policies and actions
- Build new, and strengthen existing partnerships for action
- Heighten awareness of the need to address tobacco at all levels of society
- Accelerate national, regional and global strategy implementation
- Commission policy research to support rapid, sustained and innovative actions
- Mobilize resources to support required actions

In achieving these goals, the Tobacco Free Initiative will build strong internal and external partnerships "with a purpose" with each WHO Cluster and Regional and Country Offices, and with a range of organizations and institutions around the world. The purpose of these partnerships will reflect the unique and complementary roles of WHO's partners and of WHO at all levels of the organization. Success will be measured in terms of actions achieved at local, country and global levels that lead to better tobacco control.

The Tobacco Free Initiative will take a global leadership role in promoting effective policies and interventions that make a real difference to tobacco prevalence and associated health outcomes. Despite the seriousness of the problem, there is evidence to show that countries which undertake concerted and comprehensive actions to address tobacco control can bring about significant reductions in tobacco related harm. These success stories indicate the importance of considering the best mix of specific interventions required to achieve

Information About TFI

- Why Focus on Tobacco?
- Mission and Goals of TFI
- Managing the TFI Initiative
- Upcoming Events
- Contacts

- World No-Tobacco Day 1999

WHO Tobacco Info

- Executive Board, 103rd Session TFI: Towards Stronger Global Action
- Director-General's Comments Relating to Tobacco
- Director-General's Speeches Relating to Tobacco
- WHO Press Releases & Fact Sheets Relating to Tobacco
- WHO Publications, Technical Reports, Journal Articles, Resolutions, etc. on Tobacco
- Full Text of Selected WHO Documents on Tobacco
- World No-Tobacco Day 1998
- World No-Tobacco Day 1997
- World No-Tobacco Day 1996

Tobacco on the Web

- Links to tobacco-related sites

TOBACCO FREE INITIATIVE

considering the best mix of specific interventions required to achieve the same goal: increased cessation and lowered initiation. The specific mix of interventions in a broad policy framework will vary according to each country's political, social, cultural and economic reality.

Critical to the success of these global tobacco control actions, will be the ability to mobilize human, institutional and financial resources to support enhanced activity. Current allocations at regional and global levels are severely inadequate, especially when faced with a $400 billion industry which promotes these harmful tobacco products. Increased allocations will enable improved international research, policy development and action to address the massive public health impact of tobacco.

▲
Back to top

Why Focus on Tobacco?

Public health impact

The extremely negative impact of tobacco on health now and in the future is the primary reason for giving explicit and strong support to tobacco control on a worldwide basis. Figure 1 indicates the current percentage of deaths attributable to tobacco by region and likely projections by the year 2020. The increased impact of tobacco looms as one of the greatest public health threats in the 21st century.

Figure 1: Percent of all deaths attributable to tobacco

WHO estimates that there are currently 3.5 million deaths a year from tobacco, a figure expected to rise to about 10 million by 2030. By that date 70% of those deaths will occur in developing countries. Mortality data does not reflect the enormous additional toll caused by tobacco that is felt in terms of morbidity, disability and suffering among children and adults.

Over a billion smokers

There are currently over a billion smokers in the world. The largest single number is in Asia. From Figure 2 it is clear that the proportion of women that smoke is comparatively higher in Europe and North America than in other parts of the world. However, recent estimates suggest growing numbers of smokers in developing countries, particularly amongst women (WHO 1997).

Figure 2: Number of smokers by region 1997 (in millions)

Recent trends indicate that the smoking prevalence rate in adolescent boys and girls is rising in many countries where previously tobacco control had been considered successful (Figure 3a & 3b). Thus, while new markets are being opened by industry actions, old markets have not been closed - tobacco is a global threat.

Figure 3a: Youth smoking (F) Figure3b:Youth smoking (M)

Tobacco use is bad economics

The economic impact of tobacco has been analysed in many countries in recent years. Studies in countries as diverse as Thailand, South Africa, Switzerland, China and Brazil are now available to complement some of the previous studies done in the United Kingdom, USA and Canada. Together, these studies show that the alleged economic benefits of tobacco are illusory. There are, however, large direct, indirect and

Info About TFI

Why Focus on Tobacco?
Mission and Goals of TFI
Managing the TFI Initiative
Upcoming Events
Contacts

World No-Tobacco Day 1999

WHO Tobacco Info

Executive Board, 103rd Session TFI: Towards Stronger Global Action

Director-General's Comments Relating to Tobacco

Director-General's Speeches Relating to Tobacco

WHO Press Releases & Fact Sheets Relating to Tobacco

WHO Publications, Technical Reports, Journal Articles, Resolutions, etc. on Tobacco

Full Text of Selected WHO Documents on Tobacco

World No-Tobacco Day 1998
World No-Tobacco Day 1997
World No-Tobacco Day 1996

Tobacco on the

intangible costs associated with tobacco that hamper economic development rather than promote it.

Tobacco harms the environment

In many of the tobacco growing countries evidence indicates negative environmental impacts of tobacco agriculture, particularly when associated with deforestation required to increase farmland and cure tobacco plants.

Effective policies and interventions make a difference

Effective policies and interventions make a real difference to tobacco prevalence and consumption, and associated health outcomes. Most of the documented successes have occurred in developed countries where effective approaches have been implemented for several years. In more recent years, several developing countries have introduced similar measures (Table 1). Early indications are that they too will be effective.

Table 1: Recent policies in selected countries

The Finnish experience is particularly important since it stresses the need to consider success in periods of decades rather than years. Figure 4 indicates the combined impact of legislation, increased tax and comprehensive community-based strategies on tobacco consumption in adults in Finland. Further, it should be noted that when Finland began addressing tobacco in the 1960s, it was then not the wealthy country it is today. This has implications for other countries wishing to consider the Finnish model as one way to move ahead.

Figure 4: Consumption of tobacco per adult in Finland

One major study has analysed the individual and combined effects of a range of policies and interventions on future prevalence (Townsend 1998). The results are summarised in Table 2. Price increases (through excise taxes on tobacco products) constitute by far the most important policy tool available. The other interventions have demonstrated effectiveness when properly enacted and enforced. The UK study highlights the need for policy makers to use the best mix of policies that will be supported within a particular country at a particular time.

Table 2: Policies to reduce smoking prevalence to 20% by the year 2000 in the UK

Figure 5 demonstrates the long-term impact (1965 to 1985) of increasingly graduated health education campaigns combined with smoke free policies in the USA. It shows that, whereas there were about 50 million smokers in 1985, there would have been 90 million if public health measures had not been introduced in the 20-year period. This excess translates into many hundreds of thousands of lives saved.

Figure 5: US Public Health success

These success stories indicate the importance of considering the best

Web

Links to tobacco-related sites.

mix of specific interventions required to achieve the same goal: increased cessation and lowered initiation. The elements of the WHO comprehensive policy supported by Member States are summarised in Table 3. The specific mix of interventions in a broad policy framework will vary according to each country's political, social, cultural and economic reality. Public support, mediated through the media and the legislative process, are crucial determinants of success.

Table 3: Elements of a comprehensive national policy

Resources are inadequate relative the size of the problem

Human, institutional and financial resources for all aspects of tobacco control at country, regional and global levels are severely inadequate. Faced with a US$400 billion industry, global spending on tobacco control has not addressed most countries' need for even a modicum of human and institutional capacity. Tobacco control is often tagged onto other functions. Financial support for international research, policy development and action to address the impact of tobacco has been restricted to a few modest initiatives.

The combination of current and future threats combined with the availability of successful tools for action led to the development of the tobacco free initiative by Dr Gro Harlem Brundtland as one of her first two cabinet projects.

Upcoming Events Through 1999

The next ten to twelve months will be decisive for the Tobacco Free Initiative. A number of important meetings at which tobacco control policy decisions will emerge are listed below.

- FCTC technical meeting, Canada, 2-4 December 1998
- WHO Interregional focal point meeting, Egypt, 14-16 December 1998
- International Consultation on Environmental Tobacco Smoke and Child Health, Geneva, 11-14 January 1999
- WHO/Executive Board, 25 January-3 February 1999
- EURO, AMRO, AFRO meeting, Gran Canaria, 23-27 February 1999
- World Bank report on economics of tobacco for release, DC, March 1999
- International legislators in support of tobacco control, DC, March 1999
- WHO/World Health Assembly, Geneva, 17-26 May 1999
- International NGO meeting, Geneva, May 1999
- World No Tobacco Day, 31 May 1999 (Cessation)
- International Conference on Youth and Tobacco, Singapore, September 1999

Info About TFI

WHO Tobacco Info

Tobacco on the Web

Managing the Tobacco-Free Initiative

The success of TFI, considering its many partners within and outside WHO, requires an effective management structure and demonstrable WHO leadership. Diagram A provides the major elements of the structure of the Tobacco Free Initiative. TFI is housed within the Noncommunicable Disease Cluster with whom it shares a common Management Support Unit. In addition, it reports directly to the Office of the Director-General especially on issues related to policy and strategy. The Director-General has appointed Judith Mackay to Chair TFI's Policy Advisory Committee and Richard Peto to Chair TFI's Scientific Advisory Committee.

Diagram A: Tobacco-Free Initiative: major elements

Building **national capacity for tobacco control** at country level is a function that has long been performed by WHO under the previously designated Tobacco or Health Program. This function will be strengthened to give emphasis to:

- Assessment of country and global needs to expedite tobacco control
- Multi-country support to strengthen capacity building through collaborating center networks, thereby creating a more sustainable mechanism for building capacity for tobacco control
- Performance enhancement in certain weak areas: media advocacy, legislation and economics

The **information management** "virtual unit" works closely with CDC, IDRC (TRIC) Canada, the World Bank, academic institutions and an international network of NGOs on the Internet to:

- support the development of a solid evidence base for TFI
- ensure that a global surveillance system becomes operational and is used at country level as a policy tool

Info About TFI

Why Focus on Tobacco?
Mission and Goals of TFI
Managing the TFI Initiative
Upcoming Events
Contacts

World No-Tobacco Day 1999

WHO Tobacco Info

Executive Board, 103rd Session TFI: Towards Stronger Global Action

Director-General's Comments Relating to Tobacco

Director-General's Speeches Relating to Tobacco

WHO Press Releases & Fact Sheets Relating to Tobacco

WHO Publications, Technical Reports, Journal Articles, Resolutions, etc. on Tobacco

Full Text of Selected WHO Documents on Tobacco

World No-Tobacco Day 1998
World No-Tobacco Day 1997
World No-Tobacco Day 1996

Tobacco on the Web

Links to tobacco-related sites.

- **United Nations Foundations**:

The largest single amount awarded for international tobacco control activities from the United Nations Foundation. This WHO-led proposal has the support of UNICEF, World Bank, CDC, Campaign for Tobacco-Free Kids, IDRC and many other NGOs. It will test new partnerships in the field and explicitly reach out and involve youth in developing countries.

- **United Nations Radio:**

TFI's first media workshop involved tobacco control policy-makers, United Nations Radio and key journalists mainly from developing countries. It resulted in the development of a proposal aimed at enhancing journalists' knowledge about tobacco control, strengthening their ability to work more closely together and developing new media-based tobacco control products.

- **Framework Convention on Tobacco Control**:

The WHO Cabinet has given its support for a fast-track approach for the Framework Convention on Tobacco Control. Technical meetings are planned over the next six to twelve months during which time national framework convention commisions/advisory councils will be established in a number of developing countries.

- **1999 World No-Tobacco Day –Cessation**

The focus of the 1999 World No-Tobacco Day will be on cessation. A consortium comprising IFPMA, World Self-Medication Industry, World Medical Association, International Council of Nurses, International Network Against Tobacco and UICC will support TFI to implement a global campaign to give greater public emphasis to cessation. If many of the adults who now smoke were to quit over the next 20 years, they could prevent about one-third of the expected tobacco deaths in 2020!

Tobacco Free Initiative Contacts

Geneva:

Douglas Bettcher, Framework Convention on Tobacco Control
Fax: 41 22 7914828
Email: bettcherd@who.ch

Neil Collishaw, National/Multicountry Capacity,
World No Tobacco Day 1999
Fax: 41 22 791 4828
Email: collishawn@who.ch

Leanne Riley, UN Foundation Youth and Tobacco Project
Fax: 41 22 791 4828
Email: rileyl@who.ch

Chitra Subramaniam, External Liaison
Fax: 41 22 791 4828
Email: subramaniamc@who.ch

Derek Yach, Project Manager
Fax: 41 22 791 4828
Email: yachd@who.ch

Regional Advisers for Tobacco Control:

WHO Regional Office for Africa
Mr. L. Sanwogou
Regional Adviser on Health Education
World Health Organization
Regional Office for Africa
Medical School, C Ward
Parirenyatwa Hospital
Mazoe Street
P.O. Box BE 773
Belvedere
Harare Zimbabwe
Tel: +263 4 70 69 51 / 70 74 93
Fax: +263 4 70 56 19 / 70 20 44
Email: sanwogoul@whoafr.org

WHO Regional Office for the Americas
Dr. Enrique Madrigal
Regional Adviser on Drug Abuse
525, 23rd Street, N.W.
Washington, D.C. 20037
USA

Info About TFI

WHO Tobacco Info

Tobacco on the Web

Tel: +1202 974 3331
Fax: +1202 974 3631
Email: madrigen@paho.org

WHO Regional Office for the Eastern Mediterranean
Dr. M. Al Khateeb
Regional Adviser on Health Education
World Health Organization
Regional Office for the Eastern Mediterranean
P.O Box 1517
Alexandria 21511
Egypt
Tel: +203 48 202 23
Fax: +203 48 38 916
Email: alkhateebm@who.sci.eg

WHO Regional Office for Europe
Dr. P. Anderson
Action Plan for a Tobacco-free Europe
World Health Oganization
Regional Office for Europe
8, Scherfigsvej
2100 Copenhagen Ø
Denmark
Tel: 45 39 17 12 48
Fax: 45 39 17 18 54
Email: pan@who.dk

(Asst: Galina Kaern, Phone: 45 39 17 14 35; Email: gka@who.dk

WHO Regional Office for South-East Asia
Ms. Martha Osei
Regional Adviser on Health and Behaviour
World Health Organization
Regional Office for South-East Asia
World Health Health
Indraprastha Estate
Mahatma Gandhi Road
New Delhi 110002
India
Tel: +91 11 331 7804
Fax:+91 11 331 8607
Email: martha@who.ernet.in

WHO Regional Office for the Western Pacific
Mr. Stephen Tamplin
Regional Focal Point for Tobacco or Health
World Health Organization
Regional Office for the Western Pacific
P.O. Box 2932
1099 Manila
Philippines
Tel: +632 528 8001
Fax: +632 52 11 036/53 60279

Email: tamplins@who.org.ph

Key contacts in partnership organizations:

Samira Asma, CDC: global surveillance; methods support
Fax: 1 770 488 5848
Email: sea5@cdc.gov

Enis Baris, IDRC, Canada: global research
Fax: 1 613 567 7748
Email: EBaris@idrc.ca

Bruce Dick, UNICEF: youth and tobacco
Fax: 1 212 824 6465
Email: bdick@unicef.org

Delon Human, World Medical Association: health professionals
Fax: 33 4 50 40 59 37

Ruben Israel, UICC: Globalink
Fax: 41 22 809 1810
Email: Israel@uicc.ch

Prabhat Jha, World Bank: excise tax, economic benefits of control
Fax: 1 202 614 0068
Email: pjha@worldbank.org

Sushma Palmer, ACT USA: media and communications
Fax: 1 202 965 5996
Email: Spalmer.ceche.dc@worldnet.att.net

Rosa Rivera, United Nations Radio:media and communications
Fax: 1 212 963 3410
Email: riveraz@un.org

Karen Slama, INGCAT Paris: NGO collaboration
Fax: 33 1 43 29 90 87
Email: kslama@worldnet.fr

Elaine Wolfsen, Global Alliance for Women: women and tobacco
Fax: 1 212 286 9561

Selected Collaborating Centres:

Vera Luiza Costa e Silva, Brazil
Fax: 5521 2217006
Email: costaesilva@ax.apc.org

Michael Eriksen, USA
Fax: 770 488 5767

Email: mpeo@cdc.gov

Bernadette Roussille, CFES, Comité Français

Update:Mon May 3 11:11:18 1999

d'Education pour la Santé
Fax: (33) 01 41 33 33 90
Email: cfes@imaginet.fr

Richard Peto, UK
Fax: 44 1865 58817

Bengt Wrammer
WHO Collaborating Centre for an
Action Plan for a Tobacco-free Europe
Department of Public Health Sciences
Norrbacka Building
Karolinska Institute
SE-171 76 Stockholm
Sweden
Fax: 46 500 41 60 60 or 46 8 3346 93
Office: 46 8 5177 00 00
Email: mail@skaraborg-institute.se

Weng Xinzhi, China.
Fax: 86 10 - 6500 5359

Naohito Yamaguchi, Japan.
Fax: 81 3 3546 0630,
Email: nyamaguc@gan2.ncc.go.jp

Witold Zatonski, Poland.
Fax: 48 22 643 9234/222429
Email: canepid@ikp.atm.com.pl

BMJ 1998;316:723
(7 March)

News

India

Ganapati Mudur,
New Delhi

The Indian health ministry has spent more than five years trying to get government agreement over legislation to ban tobacco advertisements and prohibit smoking in public. Antitobacco activists say that progress has been slow because of the perceived economic importance of tobacco in India and because of lobbying by the tobacco industry.

The government estimates that about 200 million men and 48 million women in India above the age of 15 use tobacco, and the industry says that tobacco consumption is growing by 2% each year. Manufactured cigarettes account for less than a fifth of the tobacco consumed in India. Traditional, hand rolled cigarettes called bidis, which contain unprocessed tobacco and high levels of tar and nicotine, make up 60% of smoked tobacco. Processed and roasted tobacco is also chewed or inhaled as snuff.

Two of India's 25 states--Delhi and Goa--have laws to curb smoking in public that cover educational institutions, hospitals, hotels, and local transport. But antitobacco campaigners say that the government lacks the machinery to enforce the legislation and to penalise offenders. Sanjoy Sengputa, programme officer at the Voluntary Health Association of India, said: "India needs far more aggressive campaigns to highlight the hazards of tobacco. Smokers in public often do not encounter objections because passive smoking is not yet a major issue here."

A survey covering 10 cities by the independent National Organisation for Tobacco Eradication last year found that 14% of children between the ages of 13 and 17 smoked cigarettes. "The top priority should be to ban advertisements and tobacco sponsorships," said Dr Sharad Vaidya, chairman of the organisation. "Our survey has revealed that a significant proportion of teenagers who had decided initially not to take up smoking changed their minds and turned into smokers after they witnessed sports events sponsored by the tobacco industry," he said.

India is the world's third largest producer of tobacco, after the United States and China. The industry has said that curbs on tobacco would harm the national economy. Tobacco farms and industry provide jobs for six million people, and India earned more than $200m (£125m) last year from tobacco exports. The Indian Council of Medical Research has, however, told the government that the health costs of tobacco far outweigh any economic benefits to the country.

Problems in discontinuing tobacco cultivation

1. Revenue losses Rs.14,000-16,000 million (US $812-1123 million) in excise and foreign exchange earnings.
2. Unemployment for hundreds of thousands of trained rural men and women, posing a social problem for the Government.
3. Unemployment for workers working in cigarette factories, established with huge investment.
4. Aggravation of pesticide residue problems, since alternative commercial and food crops requuire heavy use of pesticides.
5. Decreased security for farmers, since no other crop is as drought-tolerant.
6. Unemployment for hundreds of thousands of tribal people who collect tendu leaves from the forest for the bidi industry.
7. Lack of motivation from the Government and social agencies to persuade traditional tobacco farmers to cultivate profitable substitute crops.
8. Altered socio-economic conditions of the tobacco farmers if the present hectarage of 400,000 occupied by tobacco is utilised for the production of non-tobacco crops.

Plans for Altered Tobacco Production

1. Evolve economically viable, tobacco based cropping systems.
2. Examine the potential of tobacco as an oil seed crop.
3. Examine alternative uses of tobacco. Development of viable, integrated technology for the manufacture of edible proteins from green leaves of tobacco and for extraction of solanesol, nicotine sulfate, malic and citric acids from tobacco and its wastes.
4. Identification and development of varieties to suit changing quality specifications in respect of tar and nicotine contents, with emphasis on export quality tobacco.

Source: Challenges in tobacco control in India - by L.D. Samhvi, ICMR.

Economic aspects

Tobacco contributes to both the negative and positive aspects of the country's economy, but the losses of the country's economy far outweigh the gains.

- The losses occur in the form of costs incurred in providing health care for people with tobacco-related diseases due to loss of productivity caused by decreased efficiency, disability and premature death.
- The use of wood in tobacco curing, resulting in environmental degradation and soil erosion, also has serious economic implications.
- Cost of treatment of three major tobacco-related diseases, namely cancers, heart diseases and bronchitis, is that it costs the Government about Rs.24190 million (US $1422.8 million) annually, which is Rs.6850 million (US $ 402.9 million) more than the revenue and foreign exchange provided by tobacco to the Government.

***Source**: Tobacco Control in India - by Luthra et al, Indian Council of Medical Research, New Delhi.*

Tobacco Economics in India (1992)

Tobacco production is a major industry in India. The current gross product value of manufactured tobacco is estimated to be of the order of Rs.36,000 million (US $2117 million). Twelve companies with 20 factories manufacture cigarettes in India. In 1987, of the 75,420 million cigarettes, 51% of them were filter tipped, were produced in India. The cigarette industry is capital intensive in the organised sector, providing direct employment for hundreds of thousands of people,

The bidi industry, which is essentially a cottage industry, provides gainful employment for more than three million people, mostly in rural areas. Annual production of bidi is estimated to be over 550,000 million pieces.

The excise revenue earned from tobacco is second only to that from mineral oils, amounting to Rs.15515 million (US $916 million) in 1986-87. Tobacco products are an important source of foreign exchange earning in India. During 1986-87, Rs.1711 million (US $ 101 million) were earned through the export of unmanufactured tobacco and manufactured tobacco products like bidis, cigarettes, chewing tobacco, snuff zarda and scented tobacco. India also imports a limited amount of tobacco and its products. In 1984-85, tobacco products worth Rs.3.8 million (US $22300) were imported.

***Source**: Tobacco Control in India by K. Luthra, et.al., Indian Council of Medical Research, Delhi.*

1. Area of cultivation - 440.1 (x 10^3 ha)
2. Production - 497.1 (x10^3 tonnes)
3. People engaged in the cultivation - 12,00,000 people

***Source**: Challenges in Tobacco Control in India by Sanghul.*

UPDATED INFORMATION: 1997 : - 98 INDIA – EARNINGS FROM TOBACCO EXPORTS AND EARNINGS FROM TAX REVENUES:

EXPORTS – Rs. 8000 million or Rs 800 crores [SOURCE: MEDLINE SEARCH - ARTICLES BY GANAPATI MUDUR BMJ 1998; 316: 723 (7th March)

TAX REVENUE – Rs 68,000 million or Rs 6800 crores [Source - Prabhat Jha, World Bank (unpublished data, 1997) as cited in the Nicotine Cartel, World watch, July/August 1997 pg # 19-27

TOTAL EARNINGS FROM TOBACCO – Rs 7600 crores

Health problems of Tobacco Processing workers

Source: 95 Medico Friend Circle Bulletin, November 1983 (Indian Scene) by Dhruv Mankad.

- The process of converting raw tobacco into processed zarda or beedi zarda consists of a number of part-manual, part-mechanical operations of winnowing.

Winnowing and blending causes a lot of fine tobacco dust to fly up into the air of the closed rooms that pass off as factories. For a newcomer, it is impossible to stand there even for a half a minute without retching or getting about of coughing and sneezing. New recruits often feel giddy and vomit while working. The whole process also entails direct contact of the skin with tobacco. During the blending which is done with the legs, the heat generated by constant sprinkling of the tobacco zarda with water is a problem added to the risk of constant skin contact.

The workers would be suffering from the following:

1. Respiratory diseases: Chronic bronchitis, emphysemea, bronchial asthma etc., due to constant inhalation of tobacco dust.
   - Malignancies of the respiratory tract.
   - Laryngitis, Laryngeal tuburcle, etc.
   - Increased proneness to tuberculosis.

2. Skin diseases like contact dermatitis and allergic disorders.

Many problems not considered earlier have been encountered.

(a) The incidence of dyspeptic systems, hyperacidity and even peptic ulcer may be quite high.

(b) The commonest complaint that the workers have is low backache and pain between the shoulder blades. This problem seems almost universal amongst the tobacco workers. To this, one can add the problem of painful stiff joints.

Chronic dacryocystitis seems to be more common than encountered elsewhere. It may be because of chronic inflammation as a result of tobacco induced irritation, blocking of the nasolachrymal duct, or as a result of physical blockage of the duct by tobacco dust.

(c) Chronic dacrocystitis seems to be more common than encountered elsewhere. Ir may be because of chronic inflammation as a result of tobacco induced irritation, blocking the nasolachrymal duct, or as a result of physical blockage of the tobacco dust.

Tobacco and Sustainable Development

- The leaf of tenbumi plant which grows in wild is used in making bidis. Collection of these leaves from forest provides seasonal employment to hundreds of thousands of tribal people in central India, but is causing great strain on environment.
- Replacement of tobacco tanning to other cash crops is a difficult proposition since net returns per hectare are three times higher for tobacco as compared to other crops.
- Export decline already and so it is wise to give incentive to tobacco industry to other export oriented consumer products
- Revenue generated from tax increases on tobacco be potentially profitable enterprises so as to compensate for the eventual decline and ultimate depletion of this source at revenue.
- Rise in tobacco related diseases will increase the economic burden on scarce resources of Health Ministry.
- CGHS and ESIC cover up cost will raise.
- Higher sickness rate and premature death in smokers is not only a loss to productivity but to the productive workforce as well.
- Considerable part of the income in poor smokers household is consumed to buy bidis or cigarettes etc. and consequently less money spending on food adds to pre-existing malnutrition problem.
- Smoking habits are responsible for large number of fires in industry and agriculture.

Agriculture and Labour Force

Cultivation is most labour intensive. From raising the nursery to marketing, it is one continuous chain of operations needing labourers all through.

- It is estimated that labour required per acre for all the operations from ploughing to marketing is 304 man and woman days.
- Apart from farmers, the buyers (companies) need large army of women labourers for grading and reducing.
- Most of the workers are migrant labourers and their problems are:
- Contract wages are low - Rs.5/- for 12 hours in1978;
- Housing is poor;
- Mothers do not get time to breast-feed their babies;
- There is absolutely no provisions for medical care, nobody cares for the sick persons, no wages, Govt. hospitals far away not able to reach in sickness.
- Non-working children who accompany the parents do not get any schooling facility, no evening class for working children, 90% of gang labourers are illiterate.
- Continued cultivation of tobacco over the last 50 years with minimal crop rotation has exhausted the soil and crop pests have become endemic. The problem of soil exhaustion have been compounded by the indiscriminate felling of trees as a fuel for curing purposes. As a result, problems of salinity in the soil have increased. The ecological degradation has tended to push up the costs. It is estimated each kilogram of tobacco required 100-130 kg of wood for processing. This results in deforestation. Further use of chemical insecticides, weedicides etc, pollute soil and water. In

addition, the nutritional elements available in the soil are consumed for production of a harmful product.

~~Work related diseases of tobacco processing~~

Economic arguments

The widely held perception that tobacco control will lead to loss of revenues is really a perception!

- Social and health costs of tobacco far outweigh the direct economic benefits that may be possible because of tobacco cultivation.
- It is reasonable to assume that consumers who stop smoking will reallocate their tobacco expenditure to other goods and services in the economy. Therefore, falling employment in the tobacco industry will be offset by increases in employment in other industry. However, in the short-term, for countries which rely heavily on tobacco exports entail employment losses.
- The need for a multilateral fund to assist those countries which will bear the highest adjustment cost needs to be established.
- It is worth noting that the current 1.1 billion smokers in the world are predicted to raise to 1.64 billion by 2025, so no tobacco farmers or workers will be out of work in the foreseeable future.
- Argument of workers and income is like arguing that World War II should have continued to prevent job losses in munition factories making bombs.
- Nowhere do they cost the value of human life.

Source:

1. 'Selling and buying Deception in the Tobacco Industry' by Prof. Judith Mackay - Director, Asian Consultancy on Tobacco Control, Hong Kong.
2. The Framework Convention on Tobacco Control - Draft - Document of FCTC.

Health problems of Tobacco Processing workers

Source: 95 Medico Friend Circle Bulletin, November 1983 (Indian Scene) by Dhruv Mankad.

- The process of converting raw tobacco into processed zarda or beedi zarda consists of a number of part-manual, part-mechanical operations of winnowing.

Winnowing and blending causes a lot of fine tobacco dust to fly up into the air of the closed rooms that pass off as factories. For a newcomer, it is impossible to stand there even for a half a minute without retching or getting about of coughing and sneezing. New recruits often feel giddy and vomit while working. The whole process also entails direct contact of the skin with tobacco. During the blending which is done with the legs, the heat generated by constant sprinkling of the tobacco zarda with water is a problem added to the risk of constant skin contact.

The workers would be suffering from the following:

1. Respiratory diseases: Chronic bronchitis, emphysemea, bronchial asthma etc., due to constant inhalation of tobacco dust.
   - Malignancies of the respiratory tract.
   - Laryngitis, Laryngeal tuburcle, etc.
   - Increased proneness to tuberculosis.

2. Skin diseases like contact dermatitis and allergic disorders.

   Many problems not considered earlier have been encountered.

   (a) The incidence of dyspeptic systems, hyperacidity and even peptic ulcer may be quite high.

   (b) The commonest complaint that the workers have is low backache and pain between the shoulder blades. This problem seems almost universal amongst the tobacco workers. To this, one can add the problem of painful stiff joints.

   Chronic dacryocystitis seems to be more common than encountered elsewhere. It may be because of chronic inflammation as a result of tobacco induced irritation, blocking of the nasolachrymal duct, or as a result of physical blockage of the duct by tobacco dust.

Tobacco situation
Shocking facts – Alarming statistics

India

- India has over 20 companies involved in cigarette production and sales, offering more than 100 brands in the Indian market.
- It is estimated that over 142 million men and 37 million women above 15 years of age are regular tobacco users.
- It is estimated that 4 million children below 15 years are regular tobacco users.
- Tobacco is reported to cause about 635,000 deaths annually.
- As many as 25% of all persons above the age of 40 in urban India who smoke are estimated to suffer from chronic bronchitis.
- The number of avoidable cases of chronic heart disease and chronic obstructive lung disease has been estimated at 12 million per year.
- The incidence of oral cancer caused by tobacco chewing in India is one of the world's highest – about one-third of all cancer cases, with 90% of patients being tobacco chewers.

Source: World No-Tobacco Day WHO Publication, 31 May 1998.

The Tobacco Situation:
The Regional Perspective

India (population 935 million)

India produces about 576,200 metric tons of tobacco, making it the third largest producer in the world. It is estimated that 0.4 million people are engaged in the tobacco production in the country. A total of about 100 billion cigarettes and 850 million bidis are manufactured in India. Tobacco is used in a wide variety of smokeless forms. The last decades have seen a phenomenal growth in the chewing tobacco industry.

It is estimated that 65% of men use tobacco. In some parts of India, women are heavy consumers of chewing tobacco and bidis (from 15-65%). Annually, about 635,000 deaths are attributed to tobacco. India has one of the world's highest incidence of oral cancer, about 33.3% of all cancers, caused by tobacco. About half of all cancers among men and a fourth of those among women are tobacco-related. The number of avoidable tobacco-related cancers of the upper alimentary and respiratory tract, coronary heart disease and chronic obstructive lung disease has been estimated as 0.2 million per year. Many still-births, low-birth infants, and prenatal mortality have been reported among female tobacco chewers in India.

There is no national programme on tobacco control but health warnings are mandatory on packs and there is a ban on tobacco promotion and advertising over state controlled media. Significant initiatives have included a smoking ban in public places in the National Capital Territory of Delhi, and on domestic and some

international flights. Community and youth educational programmes by non-governmental organizations have been successful in many states.

Source : World No-Tobacco Day WHO Publication, 31 May 1998.

Tobacco Control Measures

WHO calls for redoubled efforts

A ten-point programme for successful tobacco control

1. Protection for children from becoming addicted to tobacco.
2. Use of fiscal policies to discourage the use of tobacco, such as tobacco taxes.
3. Use of a portion of money raised from tobacco taxes to finance other tobacco control and health promotion measures.
4. Health promotion, health education and smoking cessation programmes.
5. Protection from involuntary exposure to environmental tobacco smoke (ETS).
6. Elimination of socio-economic, behavioural and other incentives which maintain and promote the use of tobacco.
7. Elimination of direct and indirect tobacco advertising, promotion and sponsorship.
8. Controls on tobacco products; prominent health warnings on tobacco products / advertisements; limits on and mandatory reporting of toxic constituents.
9. Promotion of economic alternatives to tobacco growing / manufacturing.
10. Effective management, monitoring and evaluation of tobacco programmes.

***Source**: World No-Tobacco Day WHO Publication, 31 May 1998.*

617

Pakistan

Socio-demographic characteristics			
Population	**1990**	**1995**	**2025**
Total	121,933,000	140,497,000	284,827,000
Adult (15+)	68,130,000	78,275,000	195,582,000
% Urban	32.0	34.7	56.7
% Rural	68.0	65.3	43.3

Health Status

Life expectancy at birth, 1990-95 : 60.6 (males), 62.6 (females)
Infant mortality rate in 1990-95 : 91 per 1,000 live births

Socio-Economic Situation

GNP per capita (US$), 1991 : 400, *Real GDP per capita (PPP$), 1991* : 1,970
Average distribution of labour force by sector, 1990 - 92 : Agriculture 47%; Industry 20%; Services 33%
Adult literacy rate (%), 1992 : Total 36; Male 49; Female 22

Tobacco production, trade and industry

Agriculture In 1992, 54,626 hectares were harvested for tobacco (0.2% of arable land), slightly more than in 1985. Small quantities of tobacco are also grown for personal own use and for sale in local markets.

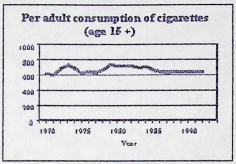
Production and trade Several types of tobacco are grown, including dark tobaccos for bidis, hookah smoking, snuff, and chewing, with around 50% of the tobacco grown used for cigarette production. Although there has been some variation, it appears that production of unmanufactured tobacco is increasing in Pakistan; 108,000 tonnes were produced in 1992 (1.3% of the world total), up from 68,000 tonnes in 1990. An annual average of 31,000 million cigarettes were produced in the period 1990-92. This increased to 36,644 million in 1994. Export of cigarettes has been less than 5% of production during the early 1990s, with 500 million cigarettes exported in 1994. Export earning of cigarettes and tobacco leaves amounted to US$ 4.9 million in 1993 (less than 0.1% of total exports). Legal cigarette imports are negligible. During the early 1990s, when foreign imports were illegal, a wide selection of foreign brands were reportedly sold openly.

Industry There were 33 cigarette companies in 1993 (3 of which were major companies, affiliated with tobacco multinationals), operating 35 manufacturing plants. There are many small organizations producing tobacco products on a very small scale. In 1990, tobacco revenue constituted 0.7% of GNP.

Tobacco consumption

During the past 20 years, adult per capita consumption of manufactured cigarettes has fluctuated between 650 and 700 cigarettes per annum; recorded tobacco consumption per adult has been about 1200g. However, two-thirds of the population live in rural areas where tobacco consumption is mainly in non-cigarette forms. Therefore, it is likely that more tobacco is used for smoking in bidis and the hookah as well as for chewing and snuffing than is smoked as cigarettes.

Consumption of Manufactured Cigarettes	
	Annual average per adult (15+)
1970-72	630
1980-82	720
1990-92	640



Tar/Nicotine/Filters In 1992, tar content was between 16.3- 66 mg, while nicotine was between 1.2-14.2 mg for cigarettes and bidis sold in Pakistan In 1994, 99% of the manufactured cigarettes were filter-tipped.

Prevalence

Studies in Karachi found that tobacco is smoked as cigarettes, in bidis and in the hookah, chewed in a variety of forms and snuffed. Many people practice mixed habits. According to a 1980 survey among 1600 adults age 20 and over in Karachi, 27.4% of males smoked, as did 4.4% of females, compared to 1972 prevalence of 30.3%(M) and 2.2% (F). In 1980, an additional 33% of men and 44% of women chewed pan, or pan and tobacco, or smoked and chewed. Among women, pan and tobacco chewing were the main habits.

Tobacco control measures

Control on tobacco products The warning "Smoking is injurious to health - Ministry of Health" must be printed in English and Urdu on all tobacco packaging. The same warning must appear on all advertisements in the press and on television. There are no stipulations on tar and nicotine yields of cigarettes. Television advertising of tobacco products is prohibited before 10 p.m. and must not exaggerate the pleasures of smoking. Taxation has passed through several stages since 1980, originally it was 54% of the retail price, then tax banding was introduced in 1987 with luxury cigarettes carrying a tax of 73%. In 1988, all cigarettes were taxed at 73%. Additionally, a sales tax of 12.5% is levied on all goods, including cigarettes. Other forms of smoking are not taxed.

Protection for non-smokers Smoking is banned in medical colleges and teaching hospitals.

Health Education The government has instituted a long-running anti tobacco campaign via television and film advertisements. In recent years it has stepped up its campaigns to increase the public awareness to the lung cancer risks associated with smoking. There are two anti-smoking groups: the Hamdard Foundation and the Cancer Association, however due to budgets constraints, their activities are limited.

Previous Country | Eastern Mediterranean | Next Country

The Electronic Telegraph carries daily news and opinion from the UK and around the world.

Pakistan in breach of tobacco law

By Nelson Clare in Brisbane

4 January 1997

PAKISTAN batsmen ignored an Australian government order to remove tobacco sponsor's logos when they faced the West Indies in a day-night match here yesterday. The players took to the crease wielding bats with the slogans, even though they are breaching tobacco-advertising laws.

Pakistan team manager Yawar Saeed said the batsmen were awaiting orders from their board before removing the logos from their bats. ``I'm not the policy-maker so I'll have to wait until I get the new instructions,'' he said.

The Australian government have given Pakistan until Tuesday to remove the Wills Kings cigarette company slogan from their bats.

The Australian Cricket Board face a #32,000 fine unless Pakistan remove the advertising but Saeed said he did not know whether the Pakistan board would comply with the order. ``If we knew that we were violating advertising laws, we would not do it. We don't violate rules of our own country or any other country,'' he said.

Source: The Electronic Telegraph
Editorial comments can be sent to The Electronic Telegraph at et@telegraph.co.uk
Contributed by CricInfo Management
Date-stamped : 25 Feb1998 - 14:41

TOBACCO

Rates of 06 June, 1997

Company	Open	Close	Change	High	Low	Volume
Lakson Tobacco	40.00	40.00	-	40.00	40.00	-
Pak Tobacco	28.25	28.25	-	-	-	-
Premier Tob.	40.00	40.00	-	-	-	-
Sarhad Cig.*	97.40	97.40	-	-	-	-
Souvenir Tob.	9.75	9.75	-	-	-	-

NOTE: All rates in Rupees. Unless indicated otherwise, each share is valued at Rs.10.
Shares valued at Rs.5, ** Shares valued at Rs.50, *** Shares valued at Rs.100

KSE Front Page
Auto & Allied
Bonds
Cables & Electric
Cement
Go to Selected Page !

Dawn Front Page| Sitemap| KSE Front Page

Menu for June 07, 1997

6.18

Annual Revenues from Tobacco Taxes, Selected Countries, by percent of total

Country	Percent of total tax revenue	U.S. Dollars (millions)
Sri Lanka	10.6	214
China	9.0	8,600
Japan	8.3	24,000
India	5.9	1,700
Indonesia	5.5	1,500
Ghana	3.8	30
Pakistan	3.8	340
Venezuela	3.7	320
Chile	3.6	350
Australia	2.0	2,500
Turkey	1.9	1,000
United States	1.5	12,700
Lithuania	0.5	5
South Africa	0.1	450

Source: *Prabhat Jha, World Bank,* (Unpublished data, 1997);
as cited in "The Nicotine Cartel, *World Watch*, July/August, 1997, pg. 19-27.

[Statistics - Tobacco Economics]

6 19

home
current issue
to subscribe
to advertise
archive
contact us
links
中文版

subscribe now.....

The only magazine written and edited for the tobacco industry of Asia today

1999 SUBSCRIPTION SUB RATES*

	Price(US$)	
	1Yr.	2Yr.
ASIA		
Australia	$38	$67
Bangladesh	$30	$52
Brunei	$30	$52
Cambodia	$30	$52
China	$30	$52
Fiji	$30	$52
Hong Kong	$30	$52
India	$30	$52
Indonesia	$30	$52
Japan	$30	$52
Korea	$30	$52
Loas	$30	$52
Macao	$30	$52
Malaysia	$30	$52
Myanmar	$30	$52
Nepal	$30	$52
New Zealand	$38	$67
Pakistan	$30	$52
Papua N.G.	$30	$52
Philippines	$30	$52
Singapore	$30	$52
Sri Lanka	$30	$52
Taiwan	$30	$52
Thailand	$30	$52
Vietnam	$30	$52
OTHER AREAS		
America	$45	$80
Africa	$38	$67

Africa	$38	$67
Europe	$38	$67

(*If frequency increases above four times a year,subscribers will get their full y of TOBACCO ASIA at the above rates.)

MAIL,FAX OR E-MAIL TO:

lockwood Trade Journal Co.,SNC Tower 11E,33 Sukhumvit Soi4 (Nana Tai),Kong Toey,
Bangkok 10110 THAILAND.

Tel:(+66)(2)656-9394/5;

Fax:(+66)(2)656-9396

e-mail:smokeasia@aol.com

Editorial and circulation offices: TOBACCO ASIA

Lockwood Trade Journal Co., Inc.
SNC Tower Unit Unit 11E
33 Sukhumvit Soi 4, Klong Toey
Bangkok, THAILAND 10110
Tel: (+66)(2) 656-9394/5
Fax: (+66)(2) 656-9396
e-mail: info@tobaccoasia.com

New York office:
Lockwood Trade Journal Co., Inc.
130 West 42nd Street, Suite 1050
New York, New York 10036, United States
Tel: (+1)(212) 391-2060
Fax: (+1)(212) 827-0945
e-mail: info@tobaccoasia.com

Designed and Created by
FLYDATA

01/17/99 - San Francisco set to Fine Bar Patrons for Smoking

01/14/99 - Long-term Smoking Linked to Pancreatic Cancer

01/10/99 - China Issues Punishment for Embezzlement

01/07/99 - Children's Behavior Affected by Mother's Smoking

01/03/99 - Great Britain Releases Plan to Reduce Smoking

12/31/98 - Minnesota Coalition Campaigns for Tobacco Money

12/27/98 - Tobacco Billboards set to Come Down

12/24/98 - Florida's Anti-Smoking Campaign Raises Awareness

[top of page]

Tobacco Addiction | Weight Loss | Cholesterol Management | Hypertension | Exercise | PICS, Inc Home | LifeSign | DietMate | The Health Authority | International Distributors | Comments | Customer Service

---

Headlines...

03/22/99: Butts, nicotine products can sicken children, pets

A recent article published in the Cincinnati Enquirer indicates that cigarette butts are not only unsightly but also toxic to toddlers and pets. The most normal reaction is vomiting, says Dr. Karen Krummen, manager of the Cincinnati Drug & Poison Information Center. "If a large enough amount is ingested, initially you'd see stimulation, which includes being irritable and jerking of limbs. It's possible the heart rate and blood pressure could go up. Seizures are unlikely with cigarettes, but if somebody had enough, it would be possible." According to Dr. Krummen, there is a 90% chance that if a child has three butts or more, it may cause symptoms which are at times severe enough to take the child to a hospital! "Be aware that nicotine is in the cigarette and cigarette butt, which people don't think about. Those things need to be kept out of reach of children." Not to mention cats and dogs, whose symptoms can mimic those of small children.

[top of page]

03/19/99 : Women Smoking Menthol Cigarettes Have Greater Nicotine Exposure

Results from a recent study conducted by Ahijevych, a researcher with Ohio State's Comprehensive Cancer Center, indicate that women who smoke menthol cigarettes may be more likely to inhale deeper with each drag on their cigarette and potentially take in more nicotine than do smokers of non-menthol cigarettes. The study also showed that users of menthol cigarettes tend to smoke their first cigarette of the day sooner than do users of non-menthol cigarettes. The sooner a person smokes his or her first cigarette of the day, the more nicotine dependent the person is thought to be. "These results should caution smokers who believe that menthol cigarettes are in some way healthier or less irritating than non-menthol brands. There is no safe cigarette," said Karen Ahijevych, associate professor of nursing at Ohio State University.

[top of page]

03/14/99 - Make Violence Linked to Smoking while Pregnant

A study just published said that males born to women who smoke during pregnancy run a risk of violent and criminal behavior that lasts well into adulthood. The researchers at Emory University in Atlanta stated that the finding was consistent with studies conducted earlier that linked prenatal smoking by women to lawbreaking as well as impulsive behavior and attention deficit behavior. Although these results are similar the researchers said that their study, which was based on the arrest histories up to age 34 of 4,169 males born between 1959 and 1961 in Denmark, is the first to show that the impact lasted beyond adolescents into adulthood. "Our results support the hypothesis that the maternal smoking during pregnancy is related to increased rates of crime in adult offspring," the study said. The reasoning behind the results might be damage done by smoking to the central nervous system of the fetus, researchers said.

[top of page]

03/11/99 - "Truth" Campaign in Jeopardy

Florida's groundbreaking pilot program to stop teen smoking is in trouble of getting canceled, and not because of tobacco lobbyists. Although the tobacco industry contributed $425,000 into the Florida political campaigns last fall they say they are not the ones who want to kill the "Truth" campaign. "We are watching from the sidelines," said John French, lobbyist for Phillip Morris. "Heck we're way out beyond the stadium on the other side of the railroad tracks, we're so far away from this." The main reason the campaign is in jeopardy is because the Republican leaders are divided on whether or not the campaign is working. Supporters, who insist it is working, are hoping the Senate will allocate the $61.5 million recommended by Gov. Bush. The money for the campaign comes from the state's $13.2 billion settlement with the tobacco industry reached in 1997.

[top of page]

03/07/99 - FTC Wants Disclaimer on 'No Bull' Ads

The Federal Trade Commission, detecting confusion from consumers, is making RJ Reynolds Tobacco Co. put a disclaimer on their 'No Bull' advertisements. It seems that many people were thinking that because they advertise no additives in their cigarettes that the cigarettes were safer for them. RJR spokeswoman said that the disclaimer would read "No additives in our tobacco does not mean a safer cigarette." The commission conducted its own research and concluded that people were indeed confused by the advertisements, said Jodie Bernstein, director of the agency's Bureau on Consumer Protection. Carole Crosslin, spokeswoman for RJR, commented on the decision saying "We disagree with the FTC's premise, and our own research demonstrated that smokers do not interpret the phrases to mean that Winston is safe or safer than other cigarettes." The order from the FTC will go into effect in May after a comment period, said Bernstein.

[top of page]

03/03/99 - International policy conference on Children and Tobacco Announced

The first-ever International Policy Conference on Children and Tobacco was announced to be held from March 17 to 19 at the Organization of American States in Washington, DC. This monumental conference, which is being sponsored by U.S. Sens. Dick Durbin, Ron Wyden, and Susan Collins, will bring together legislators, parliamentarians, and other political leaders representing more than 30 countries and 75 percent of the world's population. The main issue of the conference is going to be to identify key policies that nations throughout the world can pursue to reduce tobacco use by children. The sponsors of the event include American Cancer Society, The American Public Health Association, the Campaign for Tobacco-Free Kids and the Robert Wood Johnson Foundation. As far as international participants World Health Organization, UNICEF and the Organization of American States will all be in attendance.

[top of page]

02/28/99 -Passive Smoke Linked to Breast Cancer Risk

US researchers are reporting that exposure to passive smoke may trigger cell changes that lead to breast cancer. According to the study, which was published in the American Journal of Epidemiology, the risk of the cell changes is highest in those exposed to second hand smoke during childhood, before the breast tissue matures. "Our results show that passive exposure to cigarette smoke increases risk, and many earlier studies didn't take that into account, which dilutes their results," said lead author Dr. Timothy Lash. "If you compare a group of women smokers to a group of nonsmokers and don't exclude women exposed to passive smoke, then the differential in risk between the two groups is diminished," he said. The main theory behind Dr. lash's approach is that breast tissue is vulnerable to genetic damage when the cells are dividing, which occurs at puberty and again during pregnancy.

[top of page]

02/24/99 - Phillip Morris to close Louisville Plant

Phillip Morris announced that it would be closing its Louisville plant by the end of 2000, elimination 1,400 jobs. "It's all about capacity," said Phillip Morris spokesman Rusty Cheuvront. "It's going to allow the company to properly align production with demand." The Louisville plant has been in operation since 1944, and is the state's last major cigarette manufacturing facility. Workers at the plant earned and average of $21.50 per hour, and the loss of the 1,400 jobs will cost the local economy close to $63 million in annual payroll. "To be frank this announcement mean a loss of jobs that will really hurt," said Louisville mayor Dave Armstrong. Gov. Paul Patton said that Phillip Morris had told him two years ago that closing the plant was an option, but the announcement came as a surprise to him. Joe Phelps, secretary-treasurer of the tobacco workers union, said the closing will come in phases with workers being laid off in July 1999, April 2000 and July 2000 and the final round in December 2000.

[top of page]

02/21/99 - Big Tobacco Secretly Pushed for Tort Reform

In 1995 Big Tobacco waged a secret effort through front groups to change civil tort laws to make Minnesota's upcoming suit against the industry harder to prosecute. The effort, according to once secret documents, included tobacco executives privately enlisting a diverse group of people and

associations to start an aggressive agenda of changing the state's tort laws. Part of the cigarette manufacturer's plan was to fund their effort through groups with no obvious ties to the industry. These efforts, mostly unsuccessful, were part of a multi-million dollar national campaign by the industry in which the tobacco industry would remain in the background while pushing reform through other organizations. "One of the things that is notable is that the tobacco industry is not the out-front industry on tort reform, but they've been a major funder and strategist of the campaign in Congress and maybe even more so in the state campaigns," said Robert Weissman, co-director of Essential Action, a corporate accountability group funded by Ralph Nader.

[top of page]

02/17/99 - Cigarette Toxic Substances Revealed

The Minnesota Department of Health reported that a survey of more than 700 brands of cigarettes, cigars, pipe tobacco and snuff shows that they may contain one or all of the toxic substances arsenic, ammonia, cadmium, lead, or formaldehyde. This report introduces the first time that the tobacco industry has admitted publicly that their products contain such substances commonly identified as poisons or cancer causing agents. The report comes in response to a deadline this week for a new Minnesota law that requires tobacco firms to report annually, in order to continue selling their products in the state, to the health commissioner whether their products contain "detectable levels" of ammonia or ammonia compounds, arsenic, cadmium, formaldehyde, and lead. "I think we have to step back now and look at what the information is telling us," said Janet Olstad, assistant director of the Family Health Division. "I think it helps confirm for the public's mind that the substances are contained in tobacco products."

[top of page]

02/14/99 - Research Looks at Low Tar Labeling

New research indicates that the tobacco industry mislead people about the tar and nicotine that can be inhaled from "light" cigarettes. The study found that some cigarettes without filters, sold as "full flavor," have less than half the nicotine content of brands sold as "ultra light" that were fitted with filters. In addition, the researchers found that smokers inhibit filters that are the main device for reducing tar and nicotine inhalation by unconsciously blocking the vent holes. The study included 92 brands of cigarettes sold in Britain, the United States and Canada and was conducted by researchers from University College London, St. George's Hospital Medical School, London, and Penn State University, Pennsylvania. The study indicated that the tobacco company's claims that their cigarettes were low tar came from tests that were conducted with smoking machines, which did not replicate how people smoke.

[top of page]

02/11/99 - Carcinogens Stay in Body After Smoker Quits

Researcher at Minnesota Cancer Center have found that cancer causing substances found only in tobacco remain in the body at significant levels for up to six weeks after people stop smoking. Even though the discovery shows that carcinogens remain after quitting it also shows that they will eventually disappear, which is good news for ex-smokers. "We have very limited data on how the human body takes up and disposes of carcinogens," said Stephen Hecht, the study's lead

investigator. "It will give us a better understanding of what is happening and give us new ideas on how to get rid of it or prevent its action." In the study researchers collected urine samples from 27 participants before they stopped smoking and at one, three, six, 14, and 18 weeks afterward. The urine was tested for two substances NNAL, and NNAL-Gluc, which the body makes from a carcinogen found in tobacco. Six weeks after quitting, the two substances had dropped to 7.6% of the original levels. Levels continued to drop with additional tests; 5% after 10 weeks; 3% after 14 weeks; and 2% after 18 weeks.

[top of page]

02/07/99 - Warrant Withdrawn by the Queen

After 122 years the Queen of England has announced that she will withdraw her royal warrant from the manufacturer of Benson and Hedges cigarettes. Anti-smoking activists have welcomed this gesture from the queen after many years of complaining the she was endorsing a product that took the life of her father, grandfather and great grandfather. Some say that the Prince of Wales, who is known to be a huge opponent of smoking, had a lot of influence on his mother to withdraw her warrant. By removing her warrant Gallaher, maker of Benson and Hedges and Silk Cut brands in Britain, will have to eliminate the Queen's coat of arms from their packages by the end of the year. "Most of the royal family do not smoke and changing attitudes to smoking have affected the demand," said Ana Krysztofiak, secretary to the royal household's tradesmen's warrants committee.

[top of page]

02/03/99 - Phillip Morris and 4-H Team Up

Officials from the National 4-H council have announced that Phillip Morris has committed $4.3 million over two years to support a program 4-H is developing to discourage underage smoking. Spokeswoman Mary Carnovale said the 4-H deal is part of the $100 million Phillip Morris announced it would spend on advertising, education, and community based programs to discourage kids from smoking. Richard Sauer, president of the National 4-H council said 4-H officials decided to develop a smoking prevention program after youngsters identified smoking as a key concern. Sauer also said that Phillip Morris was contacted about supporting the effort as the suggestion of a council member who works for Kraft Foods. "We have complete independence. They are not going to tell us how to do it or what to do," said Sauer. As of right now Phillip Morris is the only corporate backer if the 4-H program. Some anti-smoking activists were a little skeptical of the arrangement. "We are concerned that by partnering with reputable organizations like the 4-H, Phillip Morris will gain a degree of legitimacy that will enable it to continue its way; addicting millions of kids to tobacco as it has done for decades," said William Novelli of Tobacco Free Kids.

[top of page]

01/30/99 - Traces of Tobacco Found in Fetal Fluids

A British study has found that a nicotine metabolite, cotinine, accumulates in the fluid surrounding a fetus as early as 7 weeks' gestation in both women who smoke and those who are exposed to smoke at work or in their homes. The study itself involved 85 women who had

requested abortions between 7 and 17 weeks' gestation. Forty of these women were nonsmokers with little or no exposure to smoke; nineteen did not smoke but were exposed to smoke at home or work; and 26 of the women smoked between 5 and 25 cigarettes per day. Researchers reported that levels of cotinine in the fetal serum and amniotic fluid of non-smokers exposed to passive smoke reached 30% to 44% of the corresponding levels in active smokers. Among the 40 that had little to no exposure to smoke only 5 were found have levels of cotinine in their urine or blood above the detection limit. "Our results further support anti-smoking advice, suggesting that women should not only stop cigarette consumption before conception, but also avoid environmental tobacco smoke exposure during pregnancy," wrote the researchers in the Journal of Obstetrics and Gynecology.

[top of page]

01/27/99 - Gene Found to Influence who will Smoke

New research has found that a certain gene can determine the difference as to whether or not someone will start smoking and then become addicted. In two articles appearing in American Psychological Association's journal of Health Psychology, researchers wrote that people carrying a particular version of the dopamine transporter gene are less likely to begin smoking before age 16 and are more likely to be able to quit smoking if they start. In the study of 289 smokers and 233 non-smokers, psychologist Caryn Lerman, Ph.D, of the Georgetown University Medical Center, found that individuals with an SLC6A3-9 genotype were less likely to be smokers than individuals without that gene. "We found that individuals who have the SLC6A3-9 gene were one and a half times more likely to have quit smoking than individuals lacking the gene," said Dr. Dean Hamer, of the National Cancer Institute.

[top of page]

01/24/99- Farmers are Set to Receive Aid from Tobacco Companies

The Governors from five tobacco growing states announced this week that they finally struck a deal with the largest U.S. cigarette makers to help farmers struggling with lost income due to the recent national tobacco settlement. This agreement, although still tentative, would establish a $5.15 billion trust fund to be divided among tobacco states over 12 years. At first RL Reynolds held out on the deal saying that they preferred their plan of buying more domestic leaf as the best way to help the farmers. The other companies however said that they would not agree to any deal unless all four major companies were on board. The financially strapped Reynolds finally agreed to the plan when the initial payments were lowered and the time frame was lengthened. "This took some very hard talking ... We hope it will come very close to compensating," said North Carolina Governor Jim Hunt. The other states involved in the deal include South Carolina, Virginia, Georgia, and Kentucky.

[top of page]

Headlines...

01/21/99 - Canada Drafts Anti-Tobacco Plan

var count = 0; var text = " Register your claim against the tobacco companies... Register your claim against the tobacco companies..."; scroll(); function scroll () { window.status = text.substring (count, text.length) + text.substring (0, count) if (count < text.length) count ++; else count = 0; setTimeout ("scroll()", 333); }

Abstract - Tobacco litigation news, including Liggett and other tobacco-related issues. Cash in on the tobacco wars. Free smokers claim registration.

General Tobacco News

Last updated March 23, 1999

Provides information about the latest lawsuits and class action suits that are popping up all over the country.

03/22/99: Butts, nicotine products can sicken children, pets

03/19/99 : Women Smoking Menthol Cigarettes Have Greater Nicotine Exposure

03/14/99 - Make Violence Linked to Smoking While Pregnant

03/11/99 - "Truth" Campaign in Jeopardy

03/07/99 - FTC Wants Disclaimer on 'No Bull' Ads

03/03/99 - International policy conference on Children and Tobacco Announced

6.21

Stanton Glantz

The interview

Professor of medicine at the University of California, San Francisco and anti-tobacco researcher.

Q: TELL ME FIRST OF ALL WHAT THE IMPORTANCE OF BROWN & WILLIAMSON'S DOCUMENTS ARE?

Glantz: The Brown & Williamson documents give the public the first really clear and comprehensive view inside the tobacco industry during the period in which the evidence that nicotine was addictive became available, that smoking caused cancer, heart disease, and other diseases, and shows us that at least this tobacco company and its multinational parent, British American Tobacco, fully understood that nicotine was addictive, fully understood that smoking caused cancer and other diseases, and was actively working to try and reduce those dangers. At the same time that they had a massive and high quality scientific enterprise underway in secret, their public posture was that the case wasn't proven, that there was nothing wrong with smoking, that it was controversial and the documents show how they developed a bevy of legal strategies and public relations strategies to keep this information away from the public, away from the courts, away from the government, to keep people smoking.

And other documents have come to light since then. For instance, Congressman Henry Waxman got hold of a bunch of documents from Philip Morris which he put into the public record. I've read those documents, and they're not nearly as complete and comprehensive as what we have from Brown &Williamson, but the important thing is that they are completely consistent with the kinds of things we see in the Brown

&Williamson documents. And so the industry, for 40 or 50 years has succeeded in building an incredible wall between itself and the public, and running a completely separate reality inside and outside, and I think many millions of people have died as a result. And that, I think, is going to be much harder for them to continue getting away with when the public has a chance to look at these things and understand them. It's going to generate a tremendous amount of public pressure. It think it's going to make it much easier for the courts to deal with them, for the federal government to deal with them. And the kinds of subterfuges and ridiculous statements that they've gotten away with for years, are just going to be much harder to do.

Q: JOURNALISTICALLY HOW WOULD YOU RATE THIS STORY?

Glantz: I was really looking at it more as a scientist than a campaigner really. I've obviously been involved in tobacco control for years because when you know what I know about the science, you have no choice in the matter. I mean there's an ethical imperative on you. But really when these documents arrived on my doorstep, the things that sucked me into them was not their potential political or legal import, it was the documents as history, the documents as science. It as just an unbelievable find. As a professor, it would be like an archaeologist finding a new tomb in Egypt or something. And in fact, historically, I hadn't really been that interested in the issues these documents deal with. My work had been on passive smoking, and tobacco policy work, not on nicotine pharmacology and cancer. And I'd actually read about the documents in the New York *Times* a week or so before I got them. Phil Hilts had run a story. But, and you know, and I thought it was very interesting, but I...was very interesting, and I went about my business. But when the documents first arrived and I realized what they were, my initial reaction was, well, these are very interesting, and I'll make them available and somebody can deal with them. But spending 20 minutes looking at them, you just get sucked into the story that they tell. I mean it's an amazing, amazing story of what was going on inside these cigarette companies during this crucial period. I mean I dropped what I was doing, or piled this on top of the other things I was doing, because it was such a compelling story. That's not exactly answering your question.

Now to answer your question, I think that the thing this shows to journalists is how they've been duped all these years, you know. And it outlines the tremendously

effective public relations campaign that the industry has used, and how cleverly they've manipulated the press in terms of keeping the public confused about the actual dangers of tobacco use. They've had a tremendously sophisticated public relations campaign underway, which has not only used public relations firms and all those standard things, but made use of high level executives, the...lobby high level executives of media outlets, which is involved in the sub rosa funding of scientists, who were so called independent experts, that the media could then be referred to. It involved hiring people or underwriting the costs of writing articles critical of the Surgeon General and other anti-tobacco forces. And that continues to this day.

Q: IN A SENSE YOU FACED THE SAME PREDICAMENT AS ACTUALLY SOME OF THE NETWORKS FACE, WHICH WAS WHETHER TO PUBLISH THIS MATERIAL. AND WHAT WENT THROUGH YOUR MIND?

Glantz: Yes. There was never any question about publishing it with me. I mean that's what you do at university. And it was very clear to me very shortly after I started looking at these documents that we were going to write something about them. I didn't have a clue that we were going to write as much as we ended up writing. I thought we'd write a paper and send it to a scientific journal, which is what you're supposed to do when you are a professor. And as I got...assembled the research team and got into it...it was very clear that this was turning into a very major project, so then we thought we were going to write a couple of papers, and then we ended up writing a book and 5 papers, which were published in *JAMA* which took a tremendous amount of guts on their part. And my hope had been that, as it is in anything we do, whether it's this or the research I do in my laboratory on how hearts work, was that the quality of the work we could produce would overcome the fear of the tobacco industry, and I think when you are dealing with the academic community, there is a very strong commitment in that community to the truth, and that commitment, I think, carried the day in helping to get these papers published, because of the commitment to have information out there. I mean, that's one of the core values of the university. And I...when these documents arrived...it was very clear to me that sooner or later the shit was going to hit the fan. The tobacco companies, the kind of seige warfare that they run against everybody, it was just a matter of time before they started doing that against the university and against me. And I went down and informed the attorney at U.C.

that these had arrived, and that I intended to use them as research materials. And I'd been told, I'm not to talk about exactly what was said, but the university was obviously very supportive, and have not wavered, and it's been from the highest level down. And the chancellor of this campus, people in the General Counsel's office, have just been very strong and very supportive.

And I have to say there were periods when Brown & Williamson came in and started threatening the library, and it was obvious, threatening to sue the university, and I figured this is where the rubber hits the road. And I remember being called down to a meeting with people from the General Counsel's office, Chris Patti and others, and I remember riding down the elevator thinking, this is the time to walk the plank, this is my little adventure, it's going to hit a wall. That's not at all what I was told. What I was told was, this is what the University of California is for. The university is here to bring the truth to people, to write about things, to do scholarly research, and we'll defend you. And they did, and they did spectacularly well. And I think the lesson for that is that these guys, the tobacco companies, can be beaten, they can be stood up to if you are willing to do it. And the university did a superb job, and I think the contrast between the behaviour of the University of California as a public institution, standing up to the tobacco companies, at a time when our Governor's campaign for President was being run by Philip Morris, Craig Fuller, the Vice-President of Philip Morris was running his governatorial campaign, and he's been destroying the voter mandate for tobacco education programs, when our legislature has been dominated by tobacco interests, when the big networks were caving in to them, when a lot of other publications--newspapers, magazines--would rather not do tobacco stories, to not be bothered, really makes me proud to be affiliated with this institution. Because not only did they do the right thing, but they did it for the right reasons. They did it for the right reasons, they did it because of a commitment to the public interest and to the truth.

I didn't mean to be ranting and raving along. I mean I feel quite strongly.

Q: SO LET'S COMPARE WHAT HAPPENED TO WHAT HAPPENED WITH ABC AND CBS.

Glantz: Well, I think the situations at ABC and CBS were a bit different. I think at ABC, I mean, they were similar and they were different. I mean from my point of view they were both driven by basic greed and

cowardice. The situation at ABC was they did what I thought was a superb piece of journalism. They took a fairly complicated issue and explained it in very clear and concise terms to the public. The tobacco industry did then what they do best. They seized on one little word, spiking, which when you talk about reconstituted tobacco, I don't even know what the word spiking means. When you're talking about a manufactured product, it is like saying, this mouse is spiked with plastic. I mean a cigarette is a manufactured product, you know. There is no such thing as a natural cigarette that you go buy from the tobacco company. It's a very carefully engineered product where every aspect of that cigarette is controlled to very high standards, quality control standards. And so when Philip Morris was complaining about the word 'spiking' I mean it's crazy. My initial reaction to the suit against ABC was that it was purely a public relations device. For one thing, under Kentucky law, pardon me, or under Virginia Law they couldn't sue them for 10 billion dollars. There were very severe limitations on the actual exposure that the company had. So it was all just hot air. And ABC's initial response was a very very aggressive and well mounted defence. I was actually contacted by their lawyers to see if I would be willing to serve as an expert, and I just didn't have time. I was buried in the Brown & Williamson documents, and also working with O.S.I.A. at the time, and also I didn't want to sign a non-disclosure agreement. I felt that that was something I just won't do. And, but, it was clear to me from talking to the people I talked to and what they were allowed to tell me, that the lawyers and the technical experts they had brought in were mounting this superb defence. The other thing that was very true from the material that Congressman Waxman had put into the public record was that all the same kinds of things that were going on in the Brown & Williamson, appeared to be going on inside Philip Morris. If anything Philip Morris had more sophisticated work going on than Brown & Williamson did. And my feeling was that Philip Morris would never actually let the case go to trial, because I think that for the kind of materials that one can reasonably expect to see introduced into the public record at the trial, that would have been a legal disaster for Philip Morris, it would have had huge implications in the products liability actions that are pending, and it would have provided a gold mine of material for the Food and Drug Administration. As the case proceeded, Philip Morris was actually dropping a lot of its own complaints, and when ABC management capitulated, basically to grease a merger, was the way it looks to me, I think they did a huge public disservice, and they did a huge disservice to

the journalists working for them, who I think, had put together an absolute first rate piece of journalism, and a very important piece of journalism.

Q: WHAT ABOUT CBS? WHAT'S YOUR VIEW ON THAT?

Glantz: The situation at CBS is a bit different, and in some ways, even worse, because there they weren't even sued. Basically it looks to me like there was a big merger or buy-out going on. Key CBS management were standing to make big bonuses if that buy-out went through by a certain date. And they just didn't want to be bothered. And that's part of what the tobacco companies do. If you deal with them, you know they are going to hassle you. And you know they're going to do all kinds of things just to make your life miserable, and they didn't want to be bothered. And so they didn't even wait to be sued. They...here we had the media making up theories under which they can be sued for suppressing or not suppressing information. It was just outrageous. But I think it's very much to the credit of the producers and the other people at *60 Minutes* that that piece did get on the air, and the subsequent stories that ran recently with Jeff Wigand, the two part piece, which I thought were very well done, and that, I think showed, that within CBS the journalists were able to ultimately force the corporate interests to let the story run. And that, I think, a lot of people inside the news division at CBS deserve a lot of credit for pulling that off.

One other thing about this, I think in the end though, the bullying tactics of the tobacco industry against the media are beginning to backfire, because after ABC caved in, and after CBS pulled the original story, I started getting calls from major reporters saying, what can you tell us. My editors want to do a tobacco story to show that we're not like ABC. We're not like CBS. I mean here, you're doing the story. And I think in the short run it was very chilling. In the intermediate term, it has actually increased the level of interest in tobacco. What the long run implications are, you know, time will tell.

Next

According to WHO estimates, there are currently 3.5 million deaths a year from tobacco, a figure expected to rise to about 10 million by 2030. By that date, based on current smoking trends, tobacco is predicted to be the leading cause of disease burden in the world, causing about one in eight deaths. 70% of those deaths will occur in developing countries. The sheer scale of tobacco's impact on global disease burden, and particularly what is likely to happen without appropriate intervention in developing countries, is often not fully appreciated. The eximemely negative impact of tobacco on health now and in the future is the primary reason for giving explicit and strong support to tobacco control on a world-wide basis.

In response to these concerns the Director-General, Dr Gro Harlem Brundtland, established a Cabinet project, the Tobacco Free Initiative (TFI), in July 1998 to coordinate an improved global strategic response to tobacco as an important public health issue. The long-term mission of global tobacco control, which will take several decades to achieve, is to reduce smoking prevalence and tobacco consumption in all countries and among all groups, and thereby reduce the burden of disease caused by tobacco. In support of this mission, the goals of the Tobacco Free Initiative are to:

- Galvanize global support for evidence-based tobacco control policies and actions
- Build new, and strengthen existing partnerships for action
- Heighten awareness of the need to address tobacco at all levels of society
- Accelerate national, regional and global strategy implementation
- Commission policy research to support rapid, sustained and innovative actions
- Mobilize resources to support required actions

In achieving these goals, the Tobacco Free Initiative will build strong internal and external partnerships "with a purpose" with each WHO Cluster and Regional and Country Offices, and with a range of organizations and institutions

Information About TFI

- Why Focus on Tobacco?
- Mission and Goals of TFI
- Managing the TFI Initiative
- Upcoming Events
- Contacts

World No Tobacco Day 1999

WHO Material on Tobacco

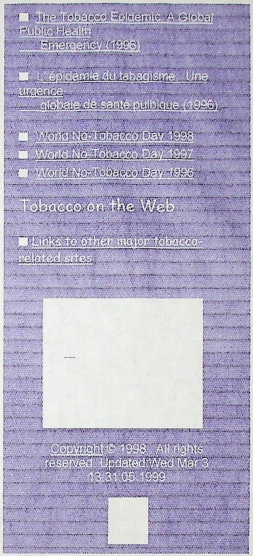
- Executive Board 103rd Session: TFI: Towards Stronger Global Action
- Director-General's Comments Relating to Tobacco
- Director-General's Speech Relating to Tobacco
- WHO Press Releases & Fact Sheets Relating to Tobacco
- WHO Publications, Technical Reports, Journal Articles, Resolutions, etc on Tobacco
- Full Text of Selected WHO Documents on Tobacco
- Guidelines for Controlling and Monitoring the Tobacco Epidemic
- Tobacco Alert: A Quarterly Bulletin
- Tobacco or Health: A Global Status Report (1997)

Dr. UK

around the world. The purpose of these partnerships will reflect the unique and complementary roles of WHO's partners and of WHO at all levels of the organization. Success will be measured in terms of actions achieved at local, country and global levels that lead to better tobacco control.

The Tobacco Free Initiative will take a global leadership role in promoting effective policies and interventions that make a real difference to tobacco prevalence and associated health outcomes. Despite the seriousness of the problem, there is evidence to show that countries which undertake concerted and comprehensive actions to address tobacco control can bring about significant reductions in tobacco related harm. These success stories indicate the importance of considering the best mix of specific interventions required to achieve the same goal: increased cessation and lowered initiation. The specific mix of interventions in a broad policy framework will vary according to each country's political, social, cultural and economic reality.

Critical to the success of these global tobacco control actions, will be the ability to mobilize human, institutional and financial resources to support enhanced activity. Current allocations at regional and global levels are severely inadequate, especially when faced with a $400 billion industry which promotes these harmful tobacco products. Increased allocations will enable improved international research, policy development and action to address the massive public health impact of tobacco.



6.22

STRATEGIES FOR A SUCCESSFUL WORLD NO-TOBACCO DAY 31 MAY 1998

For World No-Tobacco Day 1998, WHO has chosen the slogan "Growing up without tobacco". Although the issue of young people and tobacco was previously addressed by WHO in 1990, the subject bears repeating. On the occasion of World No-Tobacco Day, WHO calls upon governments, communities, organizations and schools, families and individuals to focus attention on the seriousness of the tobacco epidemic, to take strong actions to prevent nicotine addiction in young people and to protect them from the dangers of environmental tobacco smoke. World No-Tobacco Day is also a day marked by an appeal to those who use tobacco to quit for at least 24 hours, as a first step toward breaking their tobacco addiction.

The material in this special issue of Tobacco Alert is intended to assist in the commemoration of World No-Tobacco Day 1998. Although specific strategies will need to be adapted to the cultural and socio-economic conditions of individual countries and communities, it is hoped that the ideas conveyed in this issue will stimulate further progress towards a tobacco-free world.

Opportunities for Action: World No-Tobacco Day and beyond

We live in a world where tobacco kills three and a half million every year, and the death toll is increasing steadily. One day of activities will not reverse this epidemic --- concerted year-round efforts are necessary. Even so, World No-Tobacco Day provides an opportunity to spotlight efforts that are already underway or to launch new tobacco control initiatives. For example, in countries that are striving to enact tobacco control legislation, health advocates could use the occasion of this year's World No-Tobacco Day to promote the message that the legislation will help protect young people from tobacco. For some countries, this could be an opportunity to announce measures to ensure improved enforcement of existing legislation.

The hazards of tobacco use are vastly underestimated by the public and even by many of those responsible for promoting and protecting public health. In many countries, this may well be the greatest obstacle to effective tobacco control. World No-Tobacco Day is an ideal opportunity to raise awareness of the great harm caused by tobacco. Awareness raising activities can take many forms, including special World No-Tobacco Day seminars, speeches, debates, television segments, and quit smoking contests. Wherever possible, activities should be framed in a newsworthy manner.

This year's slogan lends itself well to active participation by young people. This could range from artwork contests to advocacy work, in which young people "take on the tobacco industry" and demand such measures as tobacco advertising bans. For example, children could engage in letter writing campaigns to public officials as well as tobacco industry executives, with copies of the letters sent to major newspapers. Young people could also take inventories of all of the tobacco advertisements near their schools, or stage a protest at a tobacco company sponsored sports or cultural event. To increase the visibility of these types of actions, and in turn to raise the collective awareness, media representatives should always be invited to these events.

Dr. VK

With proper planning and imagination, World No-Tobacco Day can be a very useful catalyst for tobacco control action. However, the real challenge will be to continue to maintain momentum for improved tobacco control thoughout the year. Some countries may find it useful to coordinate future actions with the year's specific theme, thereby launching a year-long campaign which focuses on tobacco and young people. For others, a different strategy may be more appropriate. The fact remains that much needs to be done to reverse the tobacco epidemic, yet with concerted and sustained efforts on the parts of many concerned organizations and indviduals, we can sooner come to a time where every day is World No-Tobacco Day.

In 1998, World No-Tobacco Day falls on a Sunday, a day of rest in many countries. Many countries may therefore wish to plan media and other activities associated with World No-Tobacco Day on a particular day in the previous week 25-30 May 1998. Alternatively, a full week of events could be undertaken, finishing with World No-Tobacco Day on Sunday, 31 May 1998.

Next | Previous

6-2-3

THE TOBACCO EPIDEMIC: A CRISIS OF STARTLING DIMENSIONS

Tobacco kills nearly 10,000 people every day

The facts speak for themselves. Tobacco use worldwide has reached the proportion of a global epidemic with little sign of abatement. Each year, tobacco causes about three and a half million deaths throughout the world. This translates to nearly ten thousand deaths per day. Based on current trends, this will increase to ten million annual deaths during the 2020s or 2030s, with seven million of these deaths occurring in developing countries. Based on current patterns of consumption, it is predicted that over 500 million people currently alive will be killed by tobacco.

In developed countries, where smoking became widespread during the 1940s and 1950s, the catastrophic effect of past smoking trends can now be seen. About 20% of all deaths occurring at present in developed countries are due to tobacco. By 2020, it is predicted that tobacco use will cause over 12% of all deaths globally. By 2020, it is predicted that tobacco will cause more deaths worldwide than HIV, tuberculosis, maternal mortality, motor vehicle accidents, suicide and homicide combined.

HOW TOBACCO AFFECTS YOUNG PEOPLE

Tobacco affects young people in an extraordinary number of ways. Due to environmental tobacco smoke (ETS) and maternal smoking, children's health may even be compromised from before the time they are born. In many countries, children may grow up in a haze of tobacco smoke, wreaking further havoc with their health. Household money that is spent on tobacco reduces the amount available for food, education and medical care. Children may also suffer the emotional pain and financial insecurity that comes from the loss of a parent or caretaker who dies an untimely death due to tobacco.

On another level are the pervasive pressures for young people to use tobacco. People everywhere seem to be smoking. Attractive advertisements and exciting tobacco promotions are difficult to resist. Especially when the price is affordable, and it's no problem for minors to buy tobacco.

Even if the health risks are understood, the message that tobacco kills is not very relevant to young smokers, who believe themselves to be immortal. By the time they are ready to quit smoking, addiction has taken hold. These factors all contribute to the grim statistics. Based on current trends, about 250 million children alive in the world today will eventually be killed by tobacco.

WHO believes that every child has the right to grow up without tobacco. This means without the rampant pressures to use tobacco, which in many countries emanates from all corners. There is a need to change the environment to one where non-smoking is considered normal social behviour

Dr. VK

and where the choice not to smoke is the easier choice.

Tobacco is fast becoming a greater cause of death and disability than any single disease

Research shows that the risks from smoking are substantially higher than previously thought. With prolonged smoking, smokers have a death rate about three times higher than non-smokers at all ages starting from young adulthood. On average, smokers who begin smoking in adolescence and continue to smoke regularly have a 50% chance of dying from tobacco. And half of these will die in middle age, before age seventy, losing around 22 years of normal life expectancy. Therefore, a lifelong smoker is as likely to die as a direct result of tobacco use as from all other potential causes of death combined.

Tobacco is a known or probable cause of about 25 diseases, and the sheer scale of its impact on global disease burden is still not fully appreciated. For example, it is well know that tobacco is the most important cause of lung cancer. Less known is the fact that tobacco kills more people through many other diseases, including cancers in other parts of the body, heart disease, stroke, emphysema and other chronic diseases. Studies in the United Kingdom have shown that smokers in their 30s and 40s are five times more likely to have a heart attack than non-smokers.

TOBACCO USE IS A KNOWN OR PROBABLE CAUSE OF DEATH FROM:

Cancers of the:

- Lip, oral cavity and pharynx
- Oesophagus
- Pancreas
- Larynx
- Lung, trachea and bronchus
- Urinary bladder
- Kidney and other urinary organs

Cardiovascular diseases:

- Rheumatic heart disease
- Hypertension

Respiratory diseases:

- Tuberculosis
- Pneumonia and influenza
- Bronchitis and emphysema
- Asthma
- Chronic airway obstruction

Paediatric diseases:

- Low birth weight
- Respiratory distress syndrome
- Newborn respiratory conditions
- Sudden infant death syndrome

- Ischaemic heart disease
- Pulmonary heart disease
- Other heart diseases
- Cerebrovascular diseases
- Atherosclerosis
- Aortic aneurysm
- Other arterial diseases

Lung cancer and other diseases caused by passive smoking

Fires caused by smoking materials

According to WHO estimates, there are around 1.1 billion smokers in the world--about one-third of the global population aged 15 years and over. Of these, 800 million are in developing countries. Data suggest that, globally, approximately 47% of men and 12% of women smoke. In developing countries, 48% of men and 7% of women smoke, while in developed countries, 42% of men smoke as do 24% of women. By the mid 2020s, the transfer of the tobacco epidemic from rich to poor countries will be well advanced, with only about 15% of the world's smokers living in rich countries. Health care facilities in poorer countries will be hopelessly inadequate to cope with this epidemic.

In certain regions, the health consequences of tobacco use are particularly devastating. In the Former Socialist Economies, around 17% of all deaths in 1995 were due to tobacco use. This figure is expected to increase so that in 2020, more than 22% of all deaths in this region will be due to tobacco. In 1995, it was estimated that 41% of all deaths among men aged 35-69 years in this region were caused by tobacco.

There has occured a shifting of the tobacco epidemic. The apparent success in tobacco control in some countries has been negated by growth in tobacco use in less developed countries. So, globally there has been no net progress in reducing tobacco consumption. In absolute figures, the biggest and sharpest increases in disease burden are expected in India and China, where the use of tobacco has grown most steeply. In China alone, where there are about 300 million smokers, new data show there are already about three-quarters of a million deaths a year caused by tobacco. Based on current trends, of all the children and young people under the age of 20 years alive today in China, at least 50 million of these will eventually die prematurely because of tobacco use.

Although life expectancy for both sexes is predicted to rise, in many countries, the gap between them is growing significantly due to the large number of men who smoke and die of tobacco-related diseases. However, the number of women and girls who smoke is also rising, and so too will the number of tobacco-related deaths among women.

HEALTH BENEFITS OF QUITTING SMOKING

- One year after quitting, the risk of coronary heart disease (CHD) decreases by 50%, and within 15 years, the relative risk of dying from CHD for an ex-smoker approaches that of a long-time non-smoker.
- The relative risk of developing lung cancer, chronic obstructive lung diseases, and stroke also decreases, but more slowly.
- Ten to fourteen years after smoking cessation, the risk of mortality from cancer decreases to nearly that of those who have never smoked.
- Quitting smoking benefits health, no matter at what age one quits.

ENVIRONMENTAL TOBACCO SMOKE SERIOUSLY DAMAGES HEALTH OF NON-SMOKERS

Environmental tobacco smoke (ETS) contains basically all of the same carcinogens and toxic agents that are inhaled directly by smokers. Evidence is quickly mounting as to the serious health consequences of ETS, both for adults and for children. These findings make a strong case for swift and tough policies to limit smoking in public places.

Exposure to ETS is a cause of disease, including lung cancer and possibly coronary heart disease in healthy non-smokers. Prolonged exposure to environmental tobacco smoke increases the risks of lung cancer and heart disease in healthy adults, possibly by as much as 20-30%.

ETS can also result in aggravated asthmatic conditions, impaired blood circulation, bronchitis and pneumonia. It also is a frequent cause of eye and nasal irritation.

Health consequences of ETS particular to young people:

Children exposed to ETS

- get more coughs and colds and are more likely to suffer acute upper and lower respiratory tract infections. One study showed that children exposed to ETS during the first 18 months of life have a 60% increase in the risk of developing lower respiratory illnesses such as croup, bronchitis, bronchiolitis and pneumonia.
- have an increased chance of developing asthma. If they already have asthma, second-hand smoke can bring on asthma attacks and make them worse.
- are at risk of impaired lung function, and may have breathing problems in the future.
- have an increased frequency of middle-ear infections, which can lead to reduced hearing.

- Babies born to women who smoke during pregnancy, as well as those infants exposed to ETS have a significantly greater risk of dying of sudden infant death syndrome (SIDS).

Smokeless tobacco use - A growing addiction

Smokeless tobacco is used in many forms around the world. In the United States and parts of Europe, it is marketed as chewing tobacco and as oral snuff . In south and south east Asia, it is most commonly consumed in a 'betel quid' or 'pan' consisting of tobacco flakes, mixed with powdered or chopped areca nut, slaked lime and catechu, wrapped in a betel leaf. This practice is a part of culture and tradition. Smokeless tobacco use has also been reported in parts of Africa and the former Soviet Union. In India, the more recent trend of chewing prepacked powdered areca nut with tobacco, lime and catechu (termed 'pan masala') has started to replace the habit of betel quid chewing. In Sudan, "toombak" is used orally, while "nass" is widely used in Central Asian republics.

Although the term "smokeless tobacco" is commonly used for tobacco products used orally, this is a term promoted by the tobacco industry that suggests that the product is harmless. To avoid that innocuous connotation, the term "spit tobacco" is increasingly used in countries such as the United States.

In the United States, recent surveys have shown alarming increases in use of spit tobacco among children and younger adults . This increase is primarily due to the growing popularity of oral snuff use among teenage and young adolescent males. It is estimated that in one million adolescent boys in the USA use spit tobacco. Spit tobacco is also used by many athletes, particularly baseball players, who are often role models for these boys. Other populations with notable patterns of spit tobacco consumption are south and southeast Asian immigrant communities in the United States and the United Kingdom. These groups continue to use spit tobacco products manufactured and imported from the Indian subcontinent.

Use of smokeless tobacco, including snuff and chewing tobacco varieties, has been established to cause oral cancer (one of the ten leading cancers worldwide), irreversible gingival recession, other oral pathologies, nicotine addiction and cardiovascular diseases. Smokeless tobacco and betel quid chewing, particularly with tobacco, is the most common cause of oral cancer in high incidence regions, and ranks globally as the greatest single risk factor for oral cancer. There have been cases of six year old children in India with submucous fibrosis, a precancerous condition . In south and southeast Asia, more than 100,000 new cases of oral cancer are diagnosed annually. Some 1,700 and 30,000 cases of oral cancer are diagnosed in the UK and the USA respectively, each year. It is believed that as many as 75% of oral cancers diagnosed in the United States are attributed to regular use of smokeless tobacco products and alcohol combined.

Next Previous

6-234

World No-Tobacco Day, 31 May 1999

Some facts on global tobacco use

Scientific evidence has shown that smoking, the major preventable c
world-wide, has a profound impact on public health. WHO estimates
of the global adult population, or 1.1 billion people, of whom 200 mill
smokers. Data suggest that globally nearly 47% of men and 12% of
developing countries, 48% of men and 7% of women smoke while in
countries, 42% of men smoke as do 24% of women. Typically, there
differences in prevalence rates. For example, in Vietnam, the numbe
above the age of 15 is strikingly high, at 50%, while just 3% of femal
1980s, about 20% of all deaths of men in Shanghai were due to smc
rates were much lower. This number will only increase as we start tc
of increased cigarette consumption, especially in the younger gener

Each year, tobacco causes 3.5 million deaths, or about 10 000 deatl
million of these deaths currently occur in developing countries. The
epidemic is predicted to prematurely claim the lives of some 250 mill
adolescents, a third of whom are in developing countries. China, for
that of the 300 million males now aged 0-29, about 200 million will b
these 200 million smokers, around 100 million will eventually be kille
diseases and half of these deaths will occur in middle-age and befor
has shown that smoking cessation greatly reduces the risk of tobacc
that most of these 100 million deaths are potentially preventable by i
interventions. By 2020, it is predicted that tobacco will become the le
and disability, killing more than 10 million people annually, 2 million
alone, thus causing more deaths world-wide than HIV, tuberculosis,
motor vehicle accidents, suicide, and homicide combined.

Back to Table of Contents

[Previous] [Next]

The Advisory Kit 1999 in PDF format
World No-Tobacco Day 1998, 1997, 1996
The Tobacco Free Initiative Home Page

Dr. UK

WHO TO CONTACT

For further information, please contact:

WHO Headquarters
Mr Neil E. Collishaw
Programme on Substance Abuse
World Health Organization
1211 Geneva 27
Switzerland

Tel: +41 22 791 3423
Fax: +41 22 791 4851

WHO Regional Office for Africa
Mr L. Sanwogou
Regional Adviser on Health Education
World Health Organization
Regional Office for Africa
P.O. Box No. 6
Brazzaville
Congo

Tel: +226 30 23 12/30 23 13/30 23 01
Fax: +226 30 21 47

WHO Regional Office for the Americas
Dr Enrique Madrigal
Regional Adviser on Drug Abuse
525, 23rd Street, N.W.
Washington, D.C. 20037
USA

Tel: +1 202 861 3200
Fax: +1 202 223 5971

WHO Regional Office for the Eastern Mediterranean
Dr M. Al Khateeb
Regional Adviser on Health Education
World Health Organization
Regional Office for the Eastern Mediterranean
P.O. Box 1517
Alexandria 21511
Egypt

Tel: +203 48 202 23
Fax: +203 48 38 916

WHO Regional Office for Europe
Dr P. Anderson
Regional Adviser for the Action Plan for a Tobacco-free Europe
World Health Organization
Regional Office for Europe
8, Scherfigsvej
2100 Copenhagen
Denmark

Tel: +45 39 17 12 48
Fax: +45 39 17 18 54

WHO Regional Office for South-East Asia
Ms Martha Osei
Regional Adviser on Health and Behaviour
World Health Organization
Regional Office for South-East Asia
World Health House
Indraprastha Estate
Mahatma Gandhi Road
New Delhi 110002
India

Tel: +91 11 331 7804
Fax: +91 11 331 8607

WHO Regional Office for the Western Pacific
Dr Rosemarie Erben
Regional Adviser in Health Promotion
World Health Organization
Regional Office for the Western Pacific
P.O. Box 2932
1099 Manila
Philippines

Tel: +632 522 9800
Fax: +632 521 1036

NEW DIRECTIONS IN INTERNATIONAL INFORMATION EXCHANGE

The effective use of timely and accurate information and data is an important component of tobacco control efforts. Tobacco control workers with access to the Internet now have opportunity to receive and exchange information in a greatly facilitated manner through use of the GLOBALINK computer network. Managed by the International Union Against Cancer (UICC), GLOBALINK uses Internet and the World Wide Web to provide tobacco-related news bulletins, electronic conferences, databases and directories. GLOBALINK members around the world range from individuals to international organizations: health educators, news editors, cancer societies, project officers, and government workers. All parties who are interested in tobacco control and whose membership application is approved by a membership review committee (and who have access to the Internet), are offered free membership to GLOBALINK.

For a GLOBALINK membership application, click on http://www.uicc.ch/glob/gtap.html

For further information, contact GLOBALINK at:

International Union Against Cancer
Rue du Conseil-Général 3
1205 Genève
Suisse

Tel: +41 22 809 1850
Fax:+41 22 809 1810
E-mail globalink@uicc.ch

World Wide Web: http://www.uicc.ch/globdemo/mainmenu.html

Next Previous

Women and Tobacco: Of Smoke and Mirrors

Back to Fact Sheets Home

Source: Heart and Stroke Foundation of Ontario
Produced in cooperation with the Canadian Council on Smoking and Health, January 1991

Heart and Stroke Foundation of Ontario
477 Mount Pleasant Road, 4th Floor
Toronto, Ontario M4S 2L9
Tel: (416) 489-7100
Fax: (416) 481-3439

True Liberation: saying no to tobacco

The ads say you're liberated enough to smoke, but they don't tell you that really taking control comes from being smoke-free. They don't say that you can lead a healthier life without tobacco. And they don't portray the powerless feeling that comes with addiction.

Make no mistake, advertisers have known how to market to women. In the short history (about 60 years) of women's smoking, cigarette advertisers have successfully manipulated women's hopes and desires to lure them into tobacco addiction. Recall these popular slogans.

- ***You've Come a Long Way Baby***- Virginia Slims
- ***Reach for a Lucky Instead of a Sweet***- Lucky Strikes
- ***After a Man's Heart***- Chesterfields

Independence, a slim body, romance: what more could a woman want? Well, let's start with good health and a longer life, instead of tobacco-related disease, disability and death.

Why Women Smoke

Despite what the ads say, the reasons most women smoke are not glamorous at all. In reality, women smoke:

- because of the loneliness, stress and poverty that often result from being a single parent.
- as a way to keep the lid on feelings of anger or frustration about women's unequal status in society and within the family.
- to try to measure up (down, in fact) to society's unrealistic weight expectations
- because smoking provides frequent and 'acceptable' breaks from the stringent demands of child caring and housekeeping
- because of a desire to project what is portrayed as a sophisticated or desirable image
- because of the social influences of family, friends and co-workers who smoke
- because women, like men, have believed the tobacco industry's lies
- because smoking is addictive.

for Tobacco file.
JN
30/3/99

The Women Who Smoke

- Overall, about **30% of Canadian women** use tobacco (occasional and regular smokers).
- **Unemployed women** have high smoking rates: 40%, as compared to 28% of employed women.
- **Less educated women** are more likely to smoke: about 36% of women with high school but no post-secondary school education smoke, compared to only about 19% of women who have attained a university degree.
- **Teenage girls** are a real cause for concern: about 24% of all teenage girls in Canada use tobacco, slightly higher than the rate for teenage boys.
- By their early 20s, **almost 38% of young women** are smoking, slightly more than men of the same age, and more than any other age group of women.

Some women are at extremely high risk:

- Native women have extraordinarily high smoking rates. In the Northwest Territories, 65% of the Dene women and almost 80% of the Inuit women smoke, as compared to 39% of non-native women in the Northwest Territories.
- Francophone women smoke more than anglophone women (and men).
- Young women with less than high school education; multi-disadvantaged women; and women in blue-collar jobs are all more likely to smoke and less likely to have access to prevention information and support.
- Women who smoke and are exposed to industrial substances that interact with tobacco; older women smokers with health problems; women who smoke and use oral contraceptives; and women who smoke heavily are at high risk of developing and dying form tobacco-related diseases.

An equal opportunity to reduce the risks

Here are some of the major positive effects of a tobacco-free lifestyle:

- Women report feeling a strong sense of well-being after taking control by quitting smoking; it often leads to resolving other difficult aspects of their lives.
- Cardiovascular benefits of being smoke-free begin within 8 hours of the last cigarette smoked: the carbon monoxide level drops and the oxygen level in the blood returns to normal.
- Within 72 hours of not smoking, the bronchial tubes expand and lung volume increases, enhancing exercise capacity.
- Several days after quitting, nerve endings begin to recover, revitalizing the senses of smell and taste.
- The increased risk of heart disease caused by cigarette smoking is reduced by half after 1 year and to that of a never smoker in 10 to 15 years after quitting smoking.
- Quitting smoking also, over time, reduces cancer risks.

In the early 1900s, the first women smokers liked to see themselves as fashionable, liberated, and more than a little risqué. Today we know how

deceptive this image really is: we know about the epidemic of disease caused by tobacco use.

You Probably Smoked Your First Cigarette With Your Best Girlfriends: Why Not Smoke The Last One With Them Too! Women have always been good at supporting each other. Women can use these nurturing skills to help their female friends and relatives stop smoking because...**IT'S A HARD ADDICTION TO BREAK.** It's easy to become hooked on nicotine, even after three or four cigarettes. Nicotine can be as powerfully addictive as heroin or cocaine. It often takes more than one attempt to quit.

Tobacco doesn't discriminate

Tobacco gives women an equal chance to develop emphysema, chronic bronchitis, peripheral vascular disease, heart disease, stroke, cancers of the mouth, larynx, bladder and cervix. Women can also experience special problems associated with reproduction:

- Women smokers can experience decreased fertility and, if pregnant, a higher risk of miscarriage.
- Women smokers who use contraceptive pills are 10 to 20 times more likely to suffer from heart disease and are at greatly increased risk for stroke than non-smokers.
- Cigarette smoking has recently been associated with cancer of the cervix, a disease likely to strike younger women.
- Smoking causes reduced estrogen levels in women, thereby contributing to menstrual disorders, early menopause and osteoporosis.
- If a pregnant woman smokes, the carbon monoxide and nicotine in her bloodstream crosses the placenta and enters the bloodstream of the fetus. This can slow down the development of the fetus, result in lower birth weights and increase the risk of stillbirths and perinatal deaths.

Tobacco use is the leading cause of premature death in Canada and in the world. Every 35 minutes a Canadian woman dies prematurely from tobacco-related cancers, coronary heart disease, and chronic obstructive lung diseases; in 1988, approximately 15,000 women in Canada died as a result of tobacco-related illness and disease. Lung cancer is now overtaking breast cancer as the leading cancer-killer of women and smoking is related to 90% of all lung cancer cases.

Second-hand smoke is harmful to all those exposed to it. The risk of lung and cervical cancer increases for both smokers and non-smokers who breathe in second-hand smoke. Nicotine and other chemicals unique to tobacco smoke have been found in samples of breastmilk from non-smoking mothers exposed to second-hand smoke.

Help women choose to be tobacco-free

We can all help women choose to be tobacco-free.

- First and foremost, we can give women non-judgmental support
- in their efforts to quit smoking.
- We can take a women-centered approach in our prevention and cessation programs. In women-centered programs, women's health is seen as important in itself, not because how it contributes to

appearance or child-bearing capabilities. Women deserve to have healthy bodies they feel good about. In a society that promotes less than normal weights, many women have the added, though often unfounded, fear of weight gain when they give up smoking.

- Some innovative programs are specific to women with low education and low incomes who are at high risk of starting or continuing to smoke. These programs are helping women develop the self-esteem and determination necessary to stop smoking.
- Effective smoking prevention and cessation programs have to be accessible to all women including disabled women and women who need child care.
- School curricula need to address the very serious problem of low self-esteem
- in many young girls. Young girls report using tobacco as a way to control weight, as a stress release or 'calming' mechanism and as a means to portray a certain image.
- Let's help young girls make the decision to not start to smoke. Prevention can have a major effect on the number of women smokers, since most female smokers become addicted to tobacco as teenagers.

Back to top

THE NEXT WAVE OF THE TOBACCO EPIDEMIC: WOMEN

Tobacco use is one of the greatest burdens to the health and well-being of women and girls around the world. At present, tobacco is killing more than half a million women per year. However, by the year 2020, it is estimated that the yearly death toll will double. In several countries, lung cancer has already surpassed breast cancer as the leading cause of cancer deaths among women. In India, where betel quid chewing is widespread among women, oral cancer is more common among women than breast cancer. In addition, studies have shown that women are at special risk from tobacco use. Women who smoke experience all the negative health consequences that male smokers do, as well as others that are gender specific. For example, women who smoke are at increased risk of cervical cancer, premature menopause and impaired fertility. When women smoke during pregnancy, there are also serious risks to the unborn baby. Women who smoke in the home also expose their children to the dangers of second-hand smoke. However, in many countries, there is still a perception that smoking is a mainly a male problem.

Particularly in developed countries, tobacco use is steadily decreasing among men. However, tobacco companies have quickly shifted their attention to potential new users, and in less developed countries, transnational tobacco companies are employing sophisticated marketing tactics to target new potential users, mainly youth and women. These are the same marketing techniques that have been used to promote smoking among women in developed countries. Their efforts have been rewarded, and in many developed countries, there already is a trend toward more smoking among teenage girls than boys. From these examples, it is likely that the smoking patterns among women and girls in the developing countries will follow the same trends.

There is a need to frame women's tobacco use and exposure as a major health and social problem, and build consensus around this issue. Women's organizations, as well as other sectors of society could be activated to address the problem. Also recommended is the formation of women's networks on all levels: local, national and international, including establishing a national coordinating body focusing on women and smoking. These types of networks could help in the development and implementation of successful smoking prevention and cessation programmes directed to women and young girls. The International Network of Women Against Tobacco (INWAT), comprised of some of the world's leading tobacco control advocates, promotes information exchange and strategising on issues of women and smoking. With coordinated efforts at all levels, INWAT aims to reduce tobacco use among women and girls in the developed countries and to prevent tobacco use from becoming established in developing countries, thereby averting the next wave of the tobacco epidemic.

For further information on INWAT contact:

Margaretha Haglund
National Institute of Public Health
Box 27 848
115 93 Stockholm
Sweden

Tel:+46 878 3 3535
Fax:+46 878 3 3505

Next Previous

6-2-8

Members

Founding members:

International Union Against Cancer
International Union Against Tuberculosis and Lung Disease
World Heart Federation

Full members:

Danish National Association Against Lung Disease

Associate members:

ADHUNIK, Bangladesh
ADRA Cambodia
Africa Tobacco Media Programme
Agir pour le Gabon
Alcohol and Drug Information Centre, Ukraine
A.S.B.L. Hainaut-Santé, Belgium
Association Africaine d'Education pour le Développement
Association Malienne de Lutte Contre le Tabagisme
Association Togolaise de Lutte Contre l'Alcoolisme et le Tabagisme
Atmata Kendram, Kerala State, India
Australian Cancer Society
British Medical Association
Bulletin CLAACTA
CATU, Uruguay
CDTMR, Vaucluse, France
Cyprus Non Smokers' League
Czech Committee of EMASH
Espérance, Mali
Heart Foundation of Jamaica
Hungarian Red Cross
Independent Sobriety Association, Russia
India Consumer Protection Program - Consumers International
International Union for Health Promotion and Education
Israel Cancer Association
Ligue Vie & Santé (France)
MADNR/Aer Pur, Romania
National Council for the Prevention of Alcoholism and Drug Dependency, Sierre Leone
Non-smokers Association, Calcutta, India
National Center for Tobacco-Free Kids, USA
National Non-smokers Forum, Bangladesh
Nigerian Heartcare Foundation
ONCADA, Curaçao, Netherlands Antilles
Pakistan Society for Cancer Prevention
Program on Tobacco Prevention and Control, Cuba
Skaraborgs Institute, Sweden
Société Syrienne Contre le Tabac
Stivoro (Dutch Foundation on Smoking and Health), Netherlands
Swarna Hansa Foundation, Sri Lanka
Victorian Smoking and Health Program, Australia
Voluntary Health Association of India (New Dehli)
Zambia Anti-Smoking Society

Back to the top

6.29

Tuesday, June 30, 1998 Published at 07:36 GMT 08:36 UK

World: South Asia
Sri Lanka: Tailor sues Ceylon Tobacco

A Sri Lankan tailor has become the first smoker on the island to try to sue a tobacco company for damages.

The man, Kurukulasuriyage Cecil Perera, is claiming about forty-thousand dollars from the Ceylon Tobacco Company, which, he says is responsible for his addiction and illnesses, including lung cancer.

The BBC Colombo correspondent says the case will be watched closely in Sri Lanka where a large proportion of the male population smokes.

The Ceylon Tobacco Company is owned largely by the international consortium, British-American Tobacco.

It is the biggest private sector tax-payer in Sri Lanka.

From the newsroom of the BBC World Service

Search
Advanced options | Search tips

Back to top | BBC News Home | BBC Homepage

Africa | Americas | Asia-Pacific | Europe | Middle East | South Asia

In this section

Nepalis turn out to vote
Arrests in missionary murder case
From Sci/Tech
'Earliest writing' found
Afghanistan embraces cricket
Everest pioneer's body found
Anti-Taleban forces advance
Nepal: Politics and pessimism

Bangladesh Tobacco Company Ltd

Company Index | Previous | Next

Bangladesh
P.O. Box 6069, Gulshan
Dhaka 1212

Primary Exchange: Dhaka
Manufacturer: Cigarettes

BUSINESS SEGMENT BREAKDOWN

(U.S. $ millions)

FY end 12/31		1996		1995		1994		3-Yr Avg	
Revenues	Tobacco	81.6	100%	66.9	100%	58.3	100%	68.9	100%
	Total	81.6		66.9		58.3		68.9	
Op. Income	Tobacco	11.4	100%	9.0	100%	10.2	100%	10.2	100%
	Total	11.4		9.0		10.2		10.2	

Financial figures converted from Bangladeshi Taka using the exchange rate of $0.0235 U.S. on Dec. 31, 1996.

NATURE OF PRESENCE IN THE INDUSTRY

Tobacco-Related Subsidiaries and Affiliates

The company's annual report lists no subsidiaries.

Tobacco Operations

Bangladesh Tobacco Co. Ltd. manufactures, markets and distributes cigarettes in Bangladesh. The company also cultivates, processes, markets and exports leaf tobacco. The company's major international brands are State Express 555 and John Player Gold Leaf, while its leading local brands are Star and Scissors, both of which experienced outstanding sales growth (130% and 145%, respectively) in 1996. Overall, the company's sales grew by more than 20% in 1996, and profit after taxation increased by 9% over 1995.

Top of Page

6.30

Virtual Bangladesh : Brief Facts

Official Name
The People's Republic Of Bangladesh

Location
Latitude between 20 degree 34' and 26 degree 39' north. Longitude between 88 degree 00' and 92 degree 41' east.

Area
1,43,988 sq. km.

Boundary
Bounded by India from the north, east and west and by the Bay of Bengal and Burma from the south.

Climate
Main seasons : Winter (Nov - Feb), Summer (Mar - Jun), Monsoon (Jul - Oct). Temp : Max 34 degree Celsius, Min 8 degree Celsius.

Rainfall
Lowest 47" and highest 136"

Capital
Dhaka (Present area 414 sq. km. Master plan 777 sq.km.)

Population
Total estimated population 110 million. Density of population per sq.km. is about 1185

State Language
Bangla. English is also widely spoken and understood

National Days
National Martyrs Day - February 21 independence Day - March 26 Victory Day - December 16

Principal Rivers
Padma, Meghna, Jamuna, Brahmaputra, Madhumati, Surma and Kushiara

Principal Crops
Jute, rice, tobacco, tea, sugarcane, vegetables, potato, pulses, etc.

Important Fruits
Mango, banana, pineapple, jack-fruit, water-melon, green coconut, guava, licis, etc.

Major Industries
Jute, sugar, paper, textiles, fertilizers, cigeratte, cement, steel, natural gas, oil-refinery, newsprint, power generation, rayon, matches, fishing and food processing, leather, soap, carpet, timber, ship-building, telephone, etc.

Sea Ports
Chittagong and Mongla

Airports
Zia international airport, Dhaka, Chittagong, domestic airports at Chittagong, Jessore, Sylhet, Cox's Bazar, Rajshahi and Saidpur

Electricity
220 Volts A.C. in all cities and towns

Tourist Seasons
October to March

Main Tourist Attractions
Colorful tribal life, longest sea beach, centuries' old archeological sites, home of the Royal Bengal Tiger, largest tea gardens, interesting riverine life, etc.

Wearing Apparel
Tropical in summer, and light-woolen in winter

Currency
The unit of currency is the Taka. Notes are in denominations of 1,2,5,10,20,50,100 and 500 Taka. Coins are 1,5,10,25,50 and 100 Paisa (100 Paisa = 1 Taka)

BANGLADESH

Socio-demographic characteristics

Population	1990	1995	2025
Total	108,118,000	120,433,000	196,128,000
Adult 15 +	62,878,000	72,874,000	148,951,000
% Urban	15.7	18.3	40.0
% Rural	84.3	81.7	60.0

Health Status

Life expectancy (1990-95): at birth 55.6 (males), 55.6 (females); **at age 15** 51.0 (males), 50.6 (females)

Infant mortality rate in 1990-95 : 108 per 1,000 live births

Socio-Economic Situation

GNP per capita ($ US), 1991 : 220

Real GDP per capita (PPP$*), 1991 : 1,160

* PPPS = Purchasing Power Parity

Average distribution of labour force by sector, 1990 - 92 :

Agriculture : 59%
Industry : 13%
Services : 28%

Adult literacy rate (%) :

Total : 37
Male : 49
Female : 23

Tobacco production, trade and industry

Agriculture In 1993, 47,192 hectares were harvested for tobacco down from 51,855 in 1985. 0.5 % of all arable land is used for tobacco growing.

Production and Trade Since 1990, about 75,000 tonnes of unmanufactured tobacco were produced annually, about 0.7% of the world total. In 1992, Bangladesh produced about 75,000 million manufactured cigarettes and bidis (about 1.3% of world total), up from about 41,000 in 1985. In 1993, earnings from tobacco export amounted to $US 10 million. Import costs of tobacco rose from $US 1.7 million in 1985 to $US 20 million in 1993. The increase was mainly due to an increase of over 500% in tobacco leaf import costs.

Industry In 1993 about 131,000 people were employed full-time in tobacco leaf processing and tobacco manufacturing, wholesaling and retailing occupations. About 204,500 people are engaged full-time in farming tobacco.

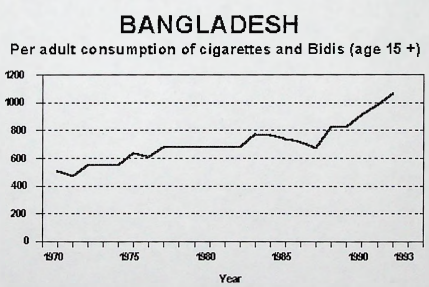
Tobacco consumption

According to surveys in 1979 and 1981, over 80% of all smokers smoked bidis,* frequently in addition to other forms of tobacco consumption. Bidi consumption was especially popular among people living in rural and poorer areas. Cigarettes and bidis account for about 70% (by weight) of the tobacco produced, with 20% used for chewing tobacco, and the remainder for cigars, oral snuff, and pipe tobacco. It appears that consumption of bidis continues to increase, while (due largely to an increase in taxes) cigarette sales are declining. The import of manufactured tobacco products is banned, although it is reported that smuggling is substantial.

Consumption of Manufactured Cigarettes and Bidis*

Annual average per adult (15+)	Cigarettes	Bidis	Total
1970-72	390	120	510
1980-82	310	370	680
1990-92	210	780	990

*Bidi: A small hand-rolled cigarette of unprocessed tobacco, rolled in a tendu leaf.



Tar/Nicotine/Filters Cigarettes have a tar range of 19-27 mg, with the tar content of bidis being in excess of 23 mg. In 1990, an estimated 7% of all cigarettes produced were filter-tipped.

Relative cost of cigarettes Average labour time required to purchase a pack of 20 cigarettes is approximately half a day. Bidis, however, are much less expensive, costing only a fraction of the price of cigarettes.

Prevalence

It is estimated that about 60% of men and 15% of women in Bangladesh are smokers. Combined smoking prevalence is about 37%.

Tobacco use among population sub-groups Since 1980, smoking prevalence among males has decreased from 67% to 60%, but smoking rates for females have increased rapidly, from 1% up to 15% (among female workers in 1980, the smoking rate was already 20%). Smoking prevalence is especially high among lower income groups; for example, 80% of the country's rickshaw pullers smoke. In a 1979 survey of medical students, 28% were found to be smokers, with 94% of them smoking only cigarettes.

The smoking rate among physicians increased from around 39% in 1979, to approximately 45% in 1990.

Mortality from Tobacco Use

The Bangladesh Cancer Society estimates that a significant proportion of all cancers in Bangladesh is related to tobacco use, and that cancers of the oral cavity, pharynx and larynx account for 30% of all cancers. Smoking is also considered to be an important risk factor for male ischaemic heart disease patients in their 40s and 50s in Bangladesh.

Tobacco Control Measures

Control on Tobacco Products Health warnings are required on cigarette packages and in advertisements. However, effectiveness is limited because the warning is small and general in nature, the literacy rate is low, and the warning applies only to domestic and legally imported cigarettes, which account for only a minority of the tobacco consumed in the country.

In 1989 tobacco advertising was banned in most media. Although this ban was respected for some time, now advertisements are widespread. Currently, there are no bans on sales to children.

Annually, US $18.5 million is raised from taxes (on legal cigarettes only), accounting for 8% of total government tax revenue. Cigarette tax increases are scheduled, however.

Protection for non-smokers Administrative measures to create smoke-free areas have been implemented in hospitals, public transport, elevators, theatres, cinemas and government premises. Some other workplaces have taken voluntary measures to ensure smoke-free areas.

Health education World No-Tobacco Day is celebrated annually in Bangladesh. Various governmental and non-governmental organizations are actively working to create public awareness through mass media, posters, leaflets, billboards, and seminars. The Consumer Association of Bangladesh is especially active in organizing anti-smoking campaigns over radio and television. High school teachers have to address the hazards of tobacco. The Ministry of Education has provided articles about the hazards of tobacco use for publication in school textbooks. However, in rural Bangladesh, many children do not attend school, and thus do not receive this information.

Afghanistan

Socio-demographic characteristics			
Population	**1990**	**1995**	**2025**
Total	15,045,000	20,141,000	45,262,000
Adult (15+)	8,468,000	11,935,000	29,730,000
% Urban	18.3	20.0	40.0
% Rural	81.7	80.0	60.0

Health Status

Life expectancy at birth, 1990-95 : 43.0 (males), 44.0 (females)
Infant mortality rate in 1990-95 : 163 per 1,000 live births

Socio-Economic Situation

Average distribution of labour force by sector, 1990 - 92 : Agriculture 61%; Industry 14%; Services 25%
Adult literacy rate (%), 1992 : Total 32; Male 48; Female 15

Tobacco production, trade and industry

Agriculture Although it is likely that tobacco is grown on a small scale for traditional use (such as bidis, hookah, and chewing), there are no data available to document tobacco being grown or its products being manufactured in Afghanistan.

Production and Trade Approximately 1,400 million cigarettes were imported into Afghanistan in 1992 (0.2% of world total), with little change since 1980. However, it is likely that this is greatly underestimated, since other reports indicate that in 1988, imports from Pakistan alone amounted to 2,336 million cigarettes. In 1993, it was reported that tobacco imports totalled US$ 11.5 million, up from US$ 8.6 million in 1990.

Considerable uncontrolled cross-border traffic has been reported in this region, particularly between Afghanistan, Iran and Pakistan. Contraband cigarettes, coming from Eastern Europe and the Gulf States, are available in the markets of Pakistan and it is likely that they also appear in Afghanistan.

Tobacco consumption

Although reliable prevalence data are not available, it is known that traditional methods of using tobacco are practised extensively. The annual adult per capita consumption of manufactured cigarettes has remained around 150 since the 1970s. However, due to the reported uncontrolled cross-border traffic, actual consumption may be higher.

Consumption of Manufactured Cigarettes	
	Annual average per adult (15+)
1970-72	**150**
1980-82	**160**
1990-92	**140**

Tar/Nicotine/Filters In 1990, the tar content ranged from about 16.3 mg. to 66 mg., while the nicotine yields ranged from 1.2 mg. to 14.2 mg. During the early 1990s, the majority (95%) of cigarettes in Afghanistan were filter-tipped.

Tobacco Control Measures

The advertising of cigarettes has been prohibited in Afghanistan since 1971.

Eastern Mediterranean | Next Country

Bhutan

Socio-demographic characteristics			
Population	**1990**	**1995**	**2025**
Total	1,544,000	1,638,000	3,136,000
Adult (15+)	916,000	966,000	2,056,000
% Urban	5.3	6.4	19.0
% Rural	94.7	93.6	81.0

Health Status

Life expectancy at birth, 1990-95 : 49.1 (males), 52.4 (females);
Infant mortality rate in 1990-95 : 124 per 1,000 live births

Socio-Economic Situation

GNP per capita (US$), 1991 : 190, Real GDP per capita (PPP$), 1991 : 620
Average distribution of labour force by sector, 1990 - 92 : Agriculture 92%; Industry 3%; Services 5%
Adult literacy rate (%), 1992 : Total 41; Male 55; Female 26

Tobacco production, trade and industry

Agriculture In 1985, 80 hectares were harvested for tobacco, mainly on a non-commercial basis, accounting for less than 0.1% of all arable land in Bhutan.

Industry There is no tobacco manufacturing industry in Bhutan.

Tobacco consumption

Tobacco is smoked in the form of bidis, or rolled in maize leaves; it is also chewed and used as snuff.
ie. cigarette smoking + HNC effect- law

Mortality from Tobacco Use

Chronic lung disease is reported to be an important cause of morbidity and mortality in Bhutan. However, cases of lung cancer are rare. Almost all the ischaemic heart disease patients attending hospitals are found to be smokers.

Tobacco Control Measures

There is no known national committee on smoking or health, however in the mid 1990s, discussions began about government legislation on the sale and consumption of tobacco products. There is also increasing governmnent efforts to inform people about the health hazards of tobacco use.

Health education In Bhutan, smoking is generally not approved of due to religious reasons, and is frowned upon by the elders and religious leaders. Physicians also counsel their patients not to smoke, but there is still a lack of adequate information to the population on the hazards of smoking "No Smoking Day" is held every year in Bhutan to coincide with WHO's World No Tobacco Day.

Previous Country | **Southeast Asia** | **Next Country**

IN SEARCH OF NEW CUSTOMERS: ADVERTISING PLAYS AN IMPORTANT ROLE

The tobacco industry needs to recruit new smokers every year to replace those who die from tobacco-related diseases. The industry's very survival depends on new teenage customers. Few people start smoking as adults. Thus, children are the industry's most significant target. The tobacco industry's own documents (see box) demonstrate this proposition. It is therefore little wonder that tobacco companies spend billions of dollars in their efforts to entice children into smoking.

In 1984, a tobacco company market researcher wrote in a previously secret internal report:

"Younger adult smokers have been the critical factor in the growth and decline of every major brand and company over the last 50 years. They will continue to be just as important to brands/companies in the future for two simple reasons: The renewal of the market stems almost entirely from 18-year-old smokers. No more than 5 percent of smokers start after age 24... [And] the brand loyalty of 18-year-old smokers far outweighs any tendency to switch with age... Brands/companies which fail to attract their fair share of younger adult smokers face an uphill battle. They must achieve net switching gains every year to merely hold share... Younger adult smokers are the only source of replacement smokers... If younger adults turn away from smoking, the industry must decline, just as a population which does not give birth will eventually dwindle."

Young Adult Smokers: Strategies and Opportunites, R.J. Reynolds Tobacco Company, 29 February 1984.

Children around the world are surrounded by advertisements portraying tobacco use as fun, sophisticated, modern and Western. In many countries, cigarette advertisements dominate the radio stations most popular with teenagers. Tobacco advertising exploits the vulnerabilities of youth by offering tobacco as the means to a positive self-image and as the key to acceptance by their peers. Advertising also sends the message that smoking is an "adult" behaviour, and offers cigarettes as a badge of independence and maturity.

Tobacco advertising conveys the message that smoking is the key to social success and upward mobility, a powerful draw for young people. This is despite the fact that in many developed countries, smoking rates are significantly higher among the poor and less educated. Some

Sent by Dr. Unnikrishnan on 7/4/99 by floppy
Aparna

tobacco companies have used cartoon images in their advertising, with very successful results. The "Joe Camel" campaign catapulted Joe's brand of cigarettes from one smoked by less than 1% of U. S. smokers under age 18 to a one-third share of the youth market within three years. That same cartoon camel was found to have a high level of recognition among three-year-olds, who were as familiar with him as with Mickey Mouse.

In the United States, the tobacco industry began aggressively targeting women, with the introduction of a "women's cigarette" in 1968. Within six years, the number of teenaged girls smoking had more than doubled. The same patterns are being repeated in a host of other countries.

Tobacco companies say that tobacco advertising is only used to promote brand switching among smokers. However, studies suggest that the more cigarette companies advertise, the more people, especially young people start or continue to smoke. Studies show that adolescents smoke the most heavily advertised brand, in a proportion far greater than among adults. Cigarette advertising also reinforces environmental stimuli to smoke.

Tobacco advertising and promotion aims at expanding the market for their products, specifically through the targeting of those populations among which there is greatest potential for growth, including youth.

Cigarette advertisements undermine and deflect smokers' concerns about safety, and serve to reassure smokers or potential smokers that cigarettes are not harmful. Many people do not take the risks of smoking seriously partly because advertising portrays smoking as innocent and benign.

Tobacco companies claim that they should have the freedom to advertise their products.

However, most smokers begin smoking when they are too young to understand the risks, and by the time they are old enough to make an informed choice, their addiction undermines their freedom of choice. When unfair and untruthful commercial speech is not restricted, other important freedoms are placed in jeopardy, including children's freedom from deception, misrepresentation, and psychological manipulation by advertising.

Product placement is another means of increasing the social acceptability of smoking.

Tobacco companies pay large sums of money to film companies so that their cigarettes will be used in feature films. For example, a prominent American actor was paid US $ 500,000 to ensure the placement of one company's cigarettes in his films. Product placement payment can also influence script writing decisions. Lois Lane in Superman movies was a smoker, but the comic book Lois Lane never smoked!

Sponsorship

As more countries around the world move to ban tobacco advertising, tobacco companies are quick to divert their attention to the sponsoring of sports and cultural events. This gives them an ideal opportunity to reach large audiences of young people. In addition to cleverly circumventing tobacco advertising bans, companies attempt to use these events to improve their image.

In many developing countries, rock concerts, with their enormous following of young fans, have been a magnet for tobacco industry sponsorship. In countries where cigarette advertising is

banned or restricted, sponsoring live or televised concerts enables the companies to get around local regulations. In Taiwan, one multinational tobacco company sponsored a concert with a popular teen idol in which the only accepted admission "ticket" was five empty packets of the company's cigarettes.

Through the promotion of sports events, tobacco companies gain widespread exposure for their brands and are able to link tobacco with health and athletic prowess. Young people seeing cigarette logos linked with health, excitement, speed and triumph are likely to lose sight of the reality of death, disease and addiction. A 1994 advertisment by Formula One race promotors directed to the tobacco industry claimed that the "...Formula One car is the most powerful advertising space in the world."

Free Cigarette Giveaways

With an addictive product, it doesn't take much to hook a new customer. For the tobacco companies, the expense of giving away free samples is overshadowed by the potential for long-term gains, especially from new young customers. Although some countries have already banned free cigarette samples, this practice still continues in many countries. At rock concerts and discos around the world, attractive young women hand out popular brands of international cigarettes. In some cases, those who accept a lit cigarette on the spot are rewarded with a free gift. A multitude of other examples where young people have been targeted for free cigarette samples have been reported around the world, particularly in less developed countries.

When children become walking cigarette advertisements: Cigarette-Branded Merchandise

Another popular means of keeping cigarette brands in the public eye and circumventing restrictions on advertising using cigarette logos on other products such as caps and T-shirts. Many of these products are popular with children around the world, and they soon become walking cigarette advertisements.

Counteradvertising can be a useful addition to a tobacco control campaign

In countries around the world, young people are exposed to highly effective tobacco advertising on a daily basis. Tobacco companies spend billions of dollars each year to promote tobacco products, an amount which dwarfs the resources available to most tobacco control programmes. Thus, one important requirement for an effective prevention programme is to seriously limit the ability of the tobacco industry to hook a new generation of smokers through advertising.

At the same time, a number of countries have produced anti-tobacco advertisements for distribution via mass media. Many of these ads are targeted at young people, with the aim of de-glamorizing tobacco. There are often possibilities for free distribution of these ads in the form of public service announcements. However, they are only useful if they are seen, and not broadcast only during times when most viewers are asleep. In some situations, carefully selected paid counter-advertising campaigns may be worth the cost. In the USA, Doctors Ought to Care (DOC) pioneered the concept of using paid counteradvertising to ridicule brand name tobacco advertising and promotion.

Health interests can never hope to match the spending by tobacco interests on paid

media advertising, and probably should not try. However, paid media advertising, when used with precision, can be an effective tool in a comprehensive effort to discourage tobacco consumption. One way of funding this would be to use a portion of increased cigarette taxes for this purpose. Examples of this strategy may be seen in several states in the USA as well as in other countries, such as Australia, France, and New Zealand.

Next Previous

World No-Tobacco Day, 31 May 1999

Message from Dr. Gro Harlem Brundtland,
Director-General of the World Health Organization for World No-Tobacco Da

Giving up smoking is not easy. We know that nicotine is powerfully addictive, and
who have tried to give up, smoking, only to find themselves drawn back to it a few
challenge for us all, and we have to rise to it because we know that getting more s
to reducing the projected tobacco-related death toll over the next two decades. A
developing country revealed that two-thirds of smokers mistakenly believe that sm
harm; few are interested in quitting, and fewer still have successfully quit. At prese
successfully give up do so without formal help. But we need to greatly increase ra
Today we know that successful and cost-effective treatments exist. Nicotine repla
as nicotine gum, patches, nasal spray and inhalers as well as non-nicotine medici
can double people's chances of succeeding. These need to be more widely availa
needs to be reduced to bring them within the reach of smokers everywhere. The g
are real health gains to be made from stopping at any age. Those who give up in t
expectancy similar to people who never smoked. I therefore invite all smokers to t
better health and "leave the pack behind."

[Previous] [Next]

Back to Table of Contents

The Advisory Kit 1999 in PDF format
World No-Tobacco Day 1998, 1997, 1996
The Tobacco Free Initiative Home Page

6.35

Tobacco Control Archives

How You Can Help

- Tobacco Control Archives Collections
  - **Brown & Williamson Collection** -- select this link to search and view the documents in the Brown & Williamson Collection.
  - **Joe Camel Campaign: Mangini v. R. J. Reynolds Tobacco Company Collection** -- select this link to view the plantiff's legal analysis of the case and supporting industry documents
  - **California Documents from the State of Minnesota Depository** -- select this link to search and view the documents. NEW
- Archival Project Documentation Plan
- Additional Tobacco Resources available via GALEN II
  - Tobacco/Nicotine/Smoking
  - Tobacco/Nicotine/Smoking - Archives
  - Tobacco/Nicotine/Smoking - Legislation & Jurisprudence
  - Tobacco/Nicotine/Smoking - Mass Media
  - Tobacco/Nicotine/Smoking - Publications

The Cigarette Papers Online, the electronic version of *The Cigarette Papers*, is now available through GALEN II. *The Cigarette Papers*, by Stanton A. Glantz, John Slade, Lisa A. Bero, Peter Hanauer, and Deborah E. Barnes, is based on the Brown & Williamson documents. Foreword by C. Everett Koop, former Surgeon General of the United States. The print version was published by the University of California Press.

Purpose

California has been and remains one of the world centers of tobacco control activity and thus is a natural laboratory for studying the development and impacts of tobacco control policies. Many researchers have sought to study these policies, but they have been hampered by the lack of a central, organized source of information. The Tobacco Control Archives (TCA), a project sponsored by UCSF Library & Center for Knowledge Management, Department of Archives & Special Collections, will be a central, organized source of information. Its purpose is to collect, preserve, and provide access to papers, unpublished documents and electronic resources relevant to tobacco control issues primarily in California.

Collection Overview

The TCA project places special emphasis on Proposition 99, the California anti-tobacco health education initiative approved in 1989. Proposition 99 was the successful outcome of the efforts of health and community groups to help reduce smoking by legislative means. The archival effort will document the emergence of the non-smokers' rights movement, the Proposition 99 campaign effort, implementation of the legislation by California country

offices, and judicial challenges to the proposition.

The TCA will also collect materials relating to other nonsmoking legislative initiatives and local ordinances, including California propositions and the campaigns of "Proposition 99 Clones" in other states. In addition, the TCA will collect the following categories of materials: papers and records of individuals and organizations active in the nonsmoking movement, political campaigns or involved in scholarly research of health effects of tobacco use; tobacco control investigating issues in general; and the tobacco industry in specific.

Send your comments or inquires about the Tobacco Control Archives to tobacco-info@library.ucsf.edu.

Last updated: Tuesday, 30-Mar-1999 15:48:29 PST

A bill under consideration in the West Virginia House of Representatives would raise the penalty for retailers who sell tobacco to minors. First-time offenders will face a maximum fine of $300 and risk suspension of their right to sell tobacco, under the new bill.

Source: "West Virginia," USA TODAY, March 5, 1997, p. A9.
(sdb 3/5/97)
Courtesy of: The Advocacy Institute

Date: 3/5/1997

Distributed by:

JOIN TOGETHER:
441 Stuart Street, Sixth Floor
Boston, MA 02116
Email: info@jointogether.org
Gopher: gopher.jointogether.org 7003
URL: http://www.jointogether.org
Tel. 617/437-1500
Fax. 617/437-9394

6.36

Advocacy Institute (Tobacco)

Topic(s): Tobacco/Nicotine/Smoking ,Tobacco/Nicotine/Smoking-Mass Media

Title:
Advocacy Institute (Tobacco)
Creator:
The Advocacy Institute (DOE)
Location (URL):
gopher://gopher.igc.apc.org:7003/11/news/tob
Provider:
Institute for Global Communications/Join Together
Description:
Accessing international newspapers and periodicals, the Advocacy Institute has provided a newsclipping service for articles concerning all aspects of tobacco use, production, anti-smoking campaigns, legislation, and medical research. This gopher site includes a look at the recent month's tobacco news, and a database to search for specific tobacco news articles. This Advocacy Institute site is part of the public gopher of the Institute for Global Communications which runs four computer networks known as PeaceNet(TM), EcoNet(TM), ConflictNet and LaborNet. IGC is the U.S. member of the Association for Progressive Communications, a 16-country association of computer networks working for peace, human rights, environmental protection, social justice, and sustainability.
Access Type:
Gopher
MeSH:
Tobacco; Nicotine; Smoking
Publication Date:
ISBN/ISSN:
Frequency:
Monthly
Submitted By:
rlc
Date Submitted:
06/30/97

Last updated: Wednesday, 08-Apr-1998 16:44:57 PDT

FRONTLINE: Smoke in the Eye

Topic(s): Tobacco/Nicotine/Smoking-Mass Media

Title:
FRONTLINE: Smoke in the Eye
Creator:
Written by Dan Zegart for Dog and Pony Studios
Location (URL):
http://www2.pbs.org/wgbh/pages/frontline/smoke/
Provider:
WGBH Educational Foundation, FRONTLINE
Description:
Since 1983, FRONTLINE has served as the Public Broadcasting System's flagship public-affairs series producing television broadcast documentaries that feature tough,controversial issues or stories others avoided because they seemed too gray and complex for the black and white spectrum of conventional broadcast journalism. FRONTLINE has developed a website or internet "webumentary" to compliment their television productions. On April 2, 1996, FRONTLINE broadcast "Smoke in the Eye," a documentary which traced the efforts of commercial television news journalists to air stories concerning the tobacco industry and the ensuing litigation efforts which attempted to and in some cases succeeded in blocking the broadcast of those news stories. This website includes a reprise of the major points in the television broadcast by featuring text versions of interviews in the documentary. The webumentary entitled "The Cigarette Papers: a Docu-Drama in Three Acts" compliments "Smoke in the Eye," by guiding us through a selection of documents from the Brown and Williamson Collections maintained by the UCSF Library and CKM, Tobacco Control Archives. This selection of documents highlights the research efforts by the tobacco industry to understand the hazardous effects of tobacco and addictive properties of nicotine, as well as the strategies employed to conceal this information from the public.
Access Type:
Web (http)
MeSH:
Tobacco; Nicotine; Television
Publication Date:
April 2, 1996
ISBN/ISSN:
Frequency :
None/Not Applicable
Submitted By:
rlc

Date Submitted:
06/30/97

Last updated: Wednesday, 08-Apr-1998 16:30:42 PDT

Search Internet Resources: Titles only Search

FRONTLINE Smoke in the Eye

home
the paper trail
interviews
readings
tobacco on the web
feedback

James Goodale

The interview

GENERAL COUNSEL FOR THE NEW YORK *TIMES* DURING THE PENTAGON PAPERS CASE.

Q: LET'S TALK ABOUT THE PENTAGON PAPERS FIRST.

WHAT WAS YOUR INSTINCT WHEN SUDDENLY YOU'RE FACED WITH THIS DILEMMA THAT THE NEWSPAPER ASKS YOU ABOUT?

Goodale: With respect to the Pentagon Papers, you have to look at the law. That is to say the law that you can read in the case books. Then you have to ask about the law that you don't read about in the case books, the First Amendment. Because the First Amendment isn't attached to the Pentagon Papers espionage statute. You have to look at the statutes and then ask yourself constitutionally can you nonetheless print, at least in this country.

Q: WHAT CAUSED TO SORT OF GIVE SUCH WEIGHT TO THE BIBLE OF HUMAN RIGHTS OVER THE OTHER LAW?

Goodale: I was lucky because I had been at the New York *Times* for a period of 8 years before the Pentagon Papers came along and being in

First Amendment in real life and then I began to teach myself the constitutional law as applied to the newsroom. So I was lucky. I thought about the First Amendment.

Q: YOU WENT TO OUTSIDE COUNSEL FOR ADVICE.

Goodale: We went, yes.

Q: WHAT HAPPENED?

Goodale: Well they put out this statute upon which I just told you and the statute didn't say anything about the First Amendment and they said there's an Espionage Act, it applies to you, you can't publish. You're going to go to jail.

Q: AND DIDN'T THAT SCARE YOU?

Goodale: I don't get easily scared. I'm a former hockey player by the way.

Q: SO YOU WOULD GO BACK TO YOUR CLIENT AND SAY, THIS IS WHAT THEY SAY BUT---WHAT DID YOU SAY THEN?

Goodale: Well I said look, here's the statute. It says in black and white what you can't do. You can't be a spy. First of all I don't think that applies to you. We're not spies. We're providing information to the public and that process is protected by the First Amendment. So you have to read the Constitution with the statute and then make a judgment whether the statute is constitutional or not or whether it applies. And I said look, I just don't think this statute applies, first of all and if it does, I don't think it's constitutional. It can't be.

Q: AND GIVE ME THE SUMMARY.....

Goodale: Well what happened was that my advice was listened to. The advice of this eminent old law firm, which unfortunately no longer is with us, was not followed. And by the way that eminent firm had as it's principle

partner the former Attorney General of the United States. He told me I was wrong. I told him--I was only 37 and he was 62--I told him he was wrong. He said, I resign. I'm not going to defend this case, I'm not going to have this firm defend, you didn't follow my advice. And for a period of time about midnight of this event, I was the only lawyer to defend that New York *Times*. But I got some others and the next day, we went to court and in 8, 9 days later I was proven right.

Q: AND YOU PUBLISHED THE PENTAGON PAPERS.

Goodale: We published 2 or 3 times and then we got stopped. And that 9-day period about which I've just told you was a period where we didn't publish.

Q: THE MORAL IS THAT IF A LAWYER HAS HIS EYE ON THE FIRST AMENDMENT YOU CAN DO A LOT IN TERMS OF INFORMING THE PEOPLE.

Goodale: Absolutely. Absolutely.

Q: WHAT HAPPENED AT CBS?

Goodale: Well I think that CBS is very much like the Pentagon Papers case. They looked at a law, it's called `inducing breach of contract.' You and I have a contract and Mike Wallace comes along he tries to make you the employee tell him something about our relationship and the lawyers at CBS were worried that that three partied event would cause something that's known as inducing breach of contract. And they thought that applying that law, which does exist but it doesn't apply to the press in my view, could be applied to the press. And I think that's where they made the mistake.

Q: IT DOESN'T APPLY TO THE PRESS. HOW DO YOU COME TO THAT VIEW.

Goodale: Well you ask yourself does the First Amendment protect the publication of the

information that's the subject of our contract. And you then ask yourself well suppose that information that's subject to our contract is in the public interest. If it's in the public interest then the Constitution of the United States says effectively that type of information ought to be published. Now if the information is not in the public interest, suppose it's a trade secret about how I make Coca Cola and you're an employee, well that's a different matter. But if it's information that informs the public, the First Amendment protects the publication of that type of information.

Q: WHAT LEADS A DISTINGUISHED CBS LAWYER, A DISTINGUISHED OUTSIDE CONSULTING LAWYER TO COME TO THE DIAMETRICALLY OPPOSITE CONCLUSION?

Goodale: Well I think that we have tremendous corporate conglomeration going on in the United States of media companies. They're all combining with each other and that activity requires the concentration of really skilled corporate people, it takes all their time. They really don't have the time to focus on the First Amendment aspects of what they're doing. And so there's a tilt in corporate media American now on the business aspects and the aspects of the First Amendment are I'm afraid are not getting the same type of attention. So I think that's what happened.

Q: HOW DANGEROUS IS THIS?

Goodale: Well I think it's extreme extremely dangerous because we're in an information revolution, we need these large corporations and if they do not take into consideration their principle mission in my view, which is to inform the public, we're going to end up with the public not being informed.

Q: HOW MUCH, IN YOUR LEGAL EXPERIENCE, HAVE YOU HEARD ABOUT THIS NOTION OF TORTIOUS INTERFERENCE?

Goodale: Well the only time I ever heard it before was from the famed editor Harry Evans who was the editor of the Sunday *Times* before it was bought by Murdoch and an absolute kingpin in the media business. And he told me that in England, this was long ago, that they had this law and he was prevented from publishing information about thalidomide which you remember caused terrible damage to women and children, because the English courts recognized that this relationship between a corporation distillers and its employees was so sacrosanct that he couldn't publish information that he wanted to publish about thalidomide. And I said to him, this was many years ago, gosh aren't we lucky. In the United States that will never happen, but it almost did.

Q: ...IT SORT OF DID.

Goodale: Well it did, but you know CBS finally did publish the information.

Q: BUT THE PRECEDENT STANDS.....THEY BLINKED WHEN CONFRONTED WITH THIS ARCANE NOTION.... WHAT DOES THAT DO TO THE REST OF THE MEDIA...WITH THAT AS A PRECEDENT?

Goodale: Well I think the blink is a very serious thing because it sends a signal to lawyers who are defending those companies, those entities who don't want information about those entities published. And that signal is that, if you find yourself in a situation where you can claim against the media inducing breach of contract, the media is going to take the claim seriously. So I think that's a bad signal to send to those entities.

Q: WHAT'S TO BE DONE ABOUT THAT NOW?

Goodale: Well I'm here talking. That's not going to be enough. I think probably what's going to have to happen is that someone is going to bring a test case based on this theory

and the test case will have to go to the Supreme Court and the Supreme Court will have to tell us, as I'm sure they will, we have a First Amendment in this country and that kind of claim just doesn't work.

Q: WHEN CBS BLINKED, WAS THAT A KIND OF REFLEXIVE REACTION ON THEIR PART OR WAS THERE A REAL EXTERNAL DANGER FACING THEM?

Goodale: I think it was the former. I think that the lawyers looked at this particular situation where they had a contract, they knew they [had] a contract between the employer and employee and they were worried in sort of a conventional terms that when a corporation gets in the middle of that relationship, a corporation might have some legal liability. I think what they forgot about in making that analysis is that CBS isn't any old corporation. It's in the business of broadcasting news in some part and because they forgot the distinction they fell into this traditional legal analysis.

Q: HOW PARANOID WOULD A REPORTER BE IN FEELING THAT THIS IS A NEW FRONT OPENING UP....THERE WAS DEFAMATION, THERE WAS LIABLE, THERE WAS ESPIONAGE, NOW WE HAVE A NEW FRONT OPENING THAT'S GOING TO BE FAR MORE INSIDIOUS FROM OUR POINT OF VIEW.

Goodale: I think because CBS took so much time to worry about this new legal threat that it's created a sense of paranoia in the reporting groups. But in reality I don't think the threat is real and that the reporters ought to forget their paranoia. But let's face it, it's a huge corporation that was in the news business that was held up for a long period of time so.

Q: AND BEFORE THEM ABC, ANOTHER HUGE CORPORATION, WAS FOUGHT TO A STANDSTILL ON A STORY.

Goodale: Well I think some of the fight's gone out of the old press dog here or tiger. I like to think that the press should fight like tigers for their freedoms but in this world of mega corporations, huge business deals, I think the dollar is controlling a lot of what's going on in these huge corporations and some of the fight's gone.

Q: FROM A LAWYER'S INTERPRETATION, WHAT EFFECT WOULD IT HAVE ON THE OVERALL CLAIM OF TORTIOUS INTERFERENCE OR INDUCING BREACH OF CONTRACT, THE FACT THAT CBS MADE A DEAL WITH MR. WIGAND? IN EFFECT A CONTRACT WITH HIM WHICH WAS THAT THEY WOULD NOT BROADCAST UNTIL HE WAS SATISFIED THAT HIS INTERESTS WERE PROTECTED. WOULD THAT HAVE ADDED TO OR WOULD IT HAVE HAD ANY EFFECT ON THE REALITY OF A CLAIM OF TORTIOUS INTERFERENCE?

Goodale: Well I don't think it'd have any effect on the claim of tortious interference but let's face it if there was such an agreement and CBS went ahead and published, the source would be very unhappy and perhaps could sue CBS. So that could have been a problem for CBS. I am fairly well satisfied that there was no such agreement that lasted for a long period of time. But had that been in place, it could have been a problem for CBS.

Q: IN TERMS OF THEIR RELATIONSHIP WITH WIGAND.

Goodale: With the source, yeah.

Q: WITH THE SOURCE. BUT THE HYPOTHESIS IS THAT SOMEHOW THE EXISTENCE OF THIS CONTRACTUAL ARRANGEMENT BETWEEN CBS AND THE SOURCE GAVE SUBSTANCE TO THE CLAIM OR

THE ANTICIPATED CLAIM BY THE TOBACCO COMPANY THAT THIS ACTUAL INTERFERENCE HAD HAPPENED.

Goodale: I don't think that legally works. I think what happened is the Wall Street *Journal* did a big story on what happened and it seemed to have had a lot of documents leaked to it by CBS to justify what CBS did. And I think what is effectively being said here, well here's another justification for CBS in not moving ahead with the story. But I think it operates on a different plane than the technical legal thing that you and I have been talking about.

Association Of State and
Territorial Health Officials
1275 K Street NW
Suite 800
Washington, DC 20005-4006
phone: (202)-371-9090
fax: (202)-371-9797

Policy Statement

ASTHO

Tobacco Control Page
Hot News
Project Information
State Highlights
Tobacco Settlement
Tobacco Free Press
Policy Statements
Documents
Resources & Announcements
Links to State Programs
Links to National Organizations
E-mail

ASTHO
The Association of State and Territorial Health Officials

NACCHO
NATIONAL ASSOCIATION OF COUNTY & CITY HEALTH OFFICIALS

Executive Summary

Through this joint policy statement, the combined memberships of ASTHO and NACCHO clearly states their intention to eliminate - to the extent possible - the devastation wreaked on the Americans by a product that when used as intended leads to disease, disability and death. This policy statement that there can be no hesitation or delay in implementing measures necessary to protect the public from substances that kill nearly half a million Americans each year. Within this framework, ASTHO and NACCHO jointly support the following actions:

- **Prohibit access to tobacco by Minors;**
- **Support actions that limit advertising and promotion of tobacco products;**
- **Support efforts at the Federal level to increase the regulation of tobacco products;**
- **Support actions that remove barriers to smoking cessation;**
- **Restrict exposure to environmental tobacco smoke (ETS);**
- **Use the media to advocate for regulatory action and to promote knowledge of tobacco issues;**
- **Increase excise taxes to make the price of tobacco products more prohibitive;**
- **Support, as appropriate, state and local governments involved in legal action related to tobacco control;**
- **Assess the health and economic impact of tobacco use; and**

➢**Advocate for the preservation of local government autonomy in tobacco control ordinances and regulation.**

These policy goals are interdependent, none standing alone as a solution to this country's single most preventable cause of death. However they are also inflexible and will be revised and redirected as circumstances require.

ASTHO's and NACCHO's goal is to assist state and local agencies as they institutionalize tobacco control programs, including effective prevention activities, media advocacy, and policies to address the goals outlined in *Healthy People 2000* activities that foster a society and environment supportive of non-use of tobacco as a social norm. State and local health agencies do not act alone in this effort, but must take the lead as the primary agents for protecting and improving the health of the nation. NACCHO, which represents over 2,800 local health officials, and ASTHO, representing the chief health officials in each state and territory, are committed to promoting healthy behaviors and preventing disease and premature death resulting from the use of tobacco products.

To obtain a hard copy of this policy statement, contact the ASTHO Tobacco Control Project at (202)371-9090.

Policy Statement on Tobacco Use Prevention and Control

The Problem:

When used as intended, tobacco products are known to cause disease, disability, and the death of over 420,000 Americans each year at a cost of over $50 billion, according to the Centers for Disease Control and Prevention. The public health community must take action to minimize the consequences of tobacco use by greatly reducing, if not eliminating, its use. State and local health agencies must work with state legislatures and policy making bodies, the federal government, community members, voluntary and civic organizations, health care institutions, educators, the business community and the media to overcome this public health crisis of a magnitude unequaled by any other disease.

Data:

State and local health agencies must collect, analyze, and utilize data and information to respond effectively to rapidly changing tobacco issues. By using vital statistics records, Behavioral Risk Factor Surveillance System [BRFSS], Smoking Attributable Morbidity and Mortality Economic Costs [SAMMEC], Current Population Survey [CPS], Youth Risk Behavior Survey [YRBS], etc.), state health agencies, in partnership with local health departments, have the unique expertise and resources available to assemble and disseminate this information in an organized and understandable manner that will serve to protect the health of the public.

Institutionalization

Tobacco use prevention and control programs must be institutionalized within

state and local health agencies to ensure that activities supported by this policy statement are completed. Institutionalization occurs as programs become integral parts of state and local health agencies, with adequate organizational and financial support to ensure significant program outcomes. Furthermore, efforts need to be made through public-private partnerships to ensure the durability of tobacco use prevention and control initiatives within the states and communities.

Counter Measures:

States and local public health officials should recognize that the promotion practices of the tobacco industry are often targeted at women, youth, and communities of color. These practices need to be countered by programs tailored to the development of advocacy leadership in these communities, and the promotion of diversity within state and local coalitions and program personnel.

Strategic Actions:

For these goals to be achieved, specific actions must be strategically designed to address each aspect of the tobacco issue. In addition, state and local health agencies must be flexible and adaptable in responding to changing situations and new research. For example, questions regarding exposure to environmental tobacco smoke (ETS) have increased with the growing body of scientific knowledge about tobacco and ETS. Policy proposals to protect children from nicotine addiction are another example of an emerging issue requiring rapid response by public health and its allies. In both cases, a high level of media focus on these issues has elevated the public's awareness of the hazards of tobacco. It remains essential that action at the state and local level be sufficiently strengthened to address the challenge from a tobacco industry that employs the best lobbying, advertising, marketing, and legal expertise that unlimited financial resources can buy.

NACCHO and ASTHO Encourage and Support State and Local Health Officials to Take the Following Actions:

1) Prohibit access to tobacco by Minors.

- Support strict enforcement of statutes banning sale or distribution of tobacco products to minors. Health agencies should collaborate implement and report on enforcement of youth access laws, educate tobacco vendors about laws regarding the sale of tobacco products to minors, and inform vendors of the dangerous characteristics of the tobacco products they are selling to underage youth.

- Ban cigarette vending machines or, at a minimum, restrict youth access and enact significant penalties for sales to underage youth.

- Encourage the enactment of state legislation or ordinances that require licenses to sell tobacco products, exact fines and revocation of licensure for non-compliance, and allow licensing fees to fund enforcement efforts.

2) Support actions that limit advertising and promotion of tobacco products. (ASTHO and NACCHO endorse the Food and Drug Administration regulation of tobacco product promotions appealing to children)

- Initiate or support extensive restrictions of tobacco advertising, on billboards, public transportation vehicles, sports stadiums or arenas, etc.
- Encourage and assist organizations supported by the tobacco industry to secure alternative sponsorship of community activities, especially those activities where the use of tobacco products is clearly contradictory, such as athletics.

3) Support efforts at the Federal level to increase the regulation of tobacco products.

- Advocate for regulation of the nicotine levels in cigarettes and stronger warning labels.
- Support FDA regulation pertaining to the sale and marketing of tobacco products as drug delivery devices.
- Endorse Occupational Safety and Health Administration (OSHA) proposal to eliminate ETS in worksites.
- Advocate for greater regulation by the Federal Trade Commission.

4) Support actions that remove barriers to smoking cessation.

- Encourage formal smoking cessation counseling, including the use of cessation products in combination with personal advice and assistance from health educators or care providers.
- Advocate for third party reimbursement for cessation programs.
- Train health care providers to council and refer patients to appropriate cessation programs.
- Collaborate with cessation program providers to assure that clients of public health clinics have ready access to services.
- Promote and support the development of adolescent-specific tobacco reduction or cessation programs that provide underage users adequate opportunities to "quit."

5) Restrict exposure to environmental tobacco smoke (ETS).

- Promote legislation or regulations that effectively provides for clean indoor air that is free from ETS.

- Provide data and expert testimony to promote the passage of state or local legislation, regulations or policies aimed at enhancing smoking restrictions in places where non-smokers would be exposed to ETS.

- First emphasize regulation of public areas where people are required to assemble, then direct efforts at privately owned facilities. Areas where children gather should be of special concern since children are especially vulnerable to ETS and have little control over their environment.

- Provide technical assistance to agencies and businesses in the development and implementation of smokefree policies.

- Declare meetings sponsored by public health agencies to be "tobacco-free" and announce them as such in programs and promotional brochures.

- Provide educational campaigns designed to help citizens reduce their exposure to ETS, especially in places not be covered by laws and ordinances.

6) Use the media to advocate for regulatory action and promote knowledge of tobacco issues.

- Develop comprehensive media plans related to legislative or public policy matters.

- Promote counter-advertising to rebut tobacco industry advertising directed to youth, minorities or women. Women of child bearing age are of special concern.

- Provide clear information about available resources, such as smoking cessation programs or educational materials regarding tobacco that are easily accessible by the public. For instance, a toll-free hotline could be established.

7) Increase excise taxes to make tobacco prices more prohibitive.

- Advocate higher federal, state and local excise taxes on all tobacco products. Higher prices have been demonstrated to be especially effective in limiting the initial use of tobacco by youths and in reducing consumption by smokers.

- Utilize revenue generated by increased taxes to institutionalize tobacco control activities, such as health promotion, smoking cessation, enforcement of tobacco control laws, and to counteract tobacco industry efforts to promote the use of its products.

8) Support, as appropriate, state and local governments involved in legal action related to tobacco control.

- Provide state or local health data, medical and economic cost information (SAMMEC), and tobacco related mortality statistics.
- Submit amicus curiae briefs on behalf of state or local government cases.
- Provide consultation to state attorneys general and local prosecutors.

9) Assess and report the health and economic impact of tobacco use.

- Advocate for required notation on death certificates of smoking or other tobacco use as a contributor to mortality.
- Conduct in each state the Behavioral Risk Factor Surveillance Survey, Smoking Attributable Morbidity and Mortality Economic Costs, Current Population Survey, and Youth Risk Behavioral Survey to monitor tobacco use on an annual basis in each state.
- Assure that surveillance of minors' access to tobacco is maintained and compliance with state laws regarding youth access is monitored.
- Estimate Medicaid costs related to tobacco-induced illness.

10) Advocate the preservation of local government autonomy in tobacco control ordinances and regulation.

- Support the inclusion of specific anti-preemption language in all tobacco control legislation
- Counter legislative tactics that seek to rescind existing local tobacco control ordinances by adding language to minor or unrelated bills that includes "super-preemption" of all tobacco control legislation.
- Be aware that the tobacco industry supports preemptive state laws because local control is especially effective. To the extent possible, do not make compromises just to get legislation passed, if resulting language will weaken a bill and preempt the right of local government to pass stronger, more comprehensive regulations.
- Be prepared to counter legislative strategies of the tobacco industry by withdrawing support from bills that have been weakened by the addition of preemptive language.
- Support initiatives to replace preemptive language in existing state legislation with specific non-preemptive language.

Furthermore...

The legislative and regulatory strategies recommended above must be precise

and specific in addressing certain issues, however the goals and policies advocated here are not fixed or permanent. Rather, they must remain flexible and adaptable so that each State and locality is able to respond to increasing scientific knowledge or changing contingencies. None of the laws, policies, or actions stand alone; all are part of nationwide strategies intended to protect the public from what is by far the single most preventable cause of death and disease in the United States. State or local health agencies do not act alone in this effort, although each may function as leaders, conveners, and key contributors to broad-based coalitions acting in concert to address tobacco use prevention and control issues.

Association Of State and Territorial Health Officials
1275 K Street NW
Suite 800
Washington, DC 20005-4006
phone: (202)-371-9090
fax: (202)-371-9797

(Note: Many of these articles were originally produced for the ASTHO Report or Tobacco Free Press)

Tobacco Control Page
Hot News
Project Information
State Highlights
Tobacco Settlement
Tobacco Free Press
Policy Statement
Documents
Resources & Announcements
Links to State Programs
Links to National Organizations
E-mail

Past "Hot News" Articles

- Dr James Howell Discusses Florida's Mega Tobacco Prevention And Control Program (March April 1998 *ASTHO Report*)
- Texas Survey Says Youth Consider Driver's Licenses More Important Than Tobacco (March April 1998 *ASTHO Report*)
- Recent Conference Shows Managed Care Expanding Tobacco Control Efforts (March April 1998 *ASTHO Report*)

DR. JAMES HOWELL DISCUSSES FLORIDA'S MEGA TOBACCO PREVENTION AND CONTROL PROGRAM (March April 1998 *ASTHO Report*)

Interview with James T. Howell, MD, State Health Officer, Florida Department of Health (March April 1998 *ASTHO Report*)

Question: Florida settled with the tobacco industry for $11.3 billion dollars. How much of this money will be set aside for tobacco prevention and control activities?

Howell: The set-aside that we have right now is $200 million to be used within the next two years for tobacco prevention and control -- the two-year mark beginning September of 1997. That is $100 million per year to be used specifically to implement a tobacco prevention and control pilot program. Of the $11.3 billion, the state legislature will determine on an annual basis during appropriations, how much of the money will be used to continue tobacco prevention and control programs.

Question: Do I understand you correctly that the $200 million must be used by September 1999?

Howell: Yes; however, the tobacco settlement in Texas has sparked the state to look again at the definition of the "Most Favored Nations" clause. In Texas, it is being interpreted as stating that their settlement funds for tobacco prevention

couldn't be used in *any less* than two years. Florida could turn around and decide to use that same language in our own "Most Favored Nations" clause.

Question: It was reported that Florida Judge Harold Cohen released $57 million of these funds to begin moving forward with tobacco prevention campaigns. When will you have full use of the pilot program funds?

Howell: The $57 million was released; however, the state legislature only have given us budget authority to spend $10.3 million to begin implementing activities for the next 45 days. The total release for the remainder of the fiscal year we hope will be at least $23 million. However, we are going through a process every 45 days to increase these funds. Right now, the appropriations process is in full motion for next year's funding. Hopefully we will be successful in releasing significantly more money.

Question: What are the stipulations from the negotiated settlement on how the money needs to be used?

Howell: In the settlement language, the tobacco prevention pilot program provides for five funded categories that all programs need to be developed around: 1) Media & Communications, 2) Enforcement, 3) Education & Training, 4) Community-Youth Partnerships, and 5) Research & Evaluation.

To start the counter-advertising efforts, Governor Chiles in October brought in about 45 kids from around the state to serve in a focus group to look at all the video announcements that CDC has collected from throughout the country, and narrowed them down to 8 favorites. Florida will also be using the input from kids to develop their own campaign. We recently made a contract with an advertising company to begin developing those ads.

Another large focus of our department has been to develop community partnerships and coalitions in each of Florida's 67 counties that we are calling "Tobacco Free Partnerships." We sent out a proposal to conduct a number of activities on the local level, and now have in every county a maturing partnership.

Research and Evaluation has also been given priority. State universities will be funded to conduct evaluations of the pilot program during its operation and post operation. We are building an initial evaluation component to all of the funded budget categories that I mentioned.

Question: Obviously, having a sudden flow of such a tremendous amount of money for tobacco prevention and control efforts would cause anybody to scramble to decide how it could be used the most effectively. Describe your efforts to develop programs that would most effectively utilize the money to decrease tobacco use.

Howell: Initially in September, we brought in a number of professionals from other states such as California, Arizona, Massachusetts, and from the CDC Office on Smoking and Heath to look at what they recommended and what has worked in their states. In November, we brought together 120 tobacco prevention and control advocates from the state and local levels to go through a strategic planning progress, look at the language of the Settlement, formulate ideas, tell us what kinds of things are working in their area, and tell us what they would like to see on a statewide level in the pilot program.

Fortunately, the Governor's Office has been very collaborative with us in seeking out information from organizations such as the American Cancer Society and American Lung Association. The Governor's office has sent representatives traveling around the country to learn about different programs. The Governor also formed an interagency team and sent them to the CDC for a full day of meetings to learn about best practice programs and look at what the CDC experts know are

effective in the states. You would be interested to know that Florida has received over 100 written proposals from in and out of the state on what needs to be done - and we have used that input to our advantage.

We will be bringing in again in the near future a number of states to look at our budged programs and gather feedback and input. We are continuing statewide "tobacco team" meetings, and an interdepartmental team of experts including legal, budget, and many others will be putting together pieces of the program.

Question: What are you doing to gather input concerning the needs of special populations in the state?

Howell: Florida brought together about 60 people from Florida's minority community to brainstorm on what programs are effective for special populations, and to recruit them to participate in local partnerships and review media that will be sent to them. Funding was also requested to develop a statewide network of minority tobacco prevention leaders.

Question: What are some very unique qualities about your program?

Howell: There are three things that are very unique about our program. The first has been the involvement of youth. The Governor has felt that substantial number of youth is essential to having impact. Second, every county (67 counties) no matter what size, will have a tobacco coordinator to build partnerships with local organizations and youth, with financial accountability lying with the county health director. We have requested over $9 million going out to these coalitions for support. Third, our Governor is completely involved in this issue and the decision making process. He is committed to reducing tobacco use in Florida.

Question: What advice would you have to other State Health Officers who may be faced with difficult decision on how to best use millions of dollars from tobacco settlement funds?

We have found that utilizing the expertise of our statewide coalition and building bridges with the Governor and other state powers have been essential. We recommend working with the medical association to garner their support. We would also encourage ASTHO to sponsor a large retreat with state health officers from all other states and their immediate staff to share ideas and discuss how to most effectively use large budgets.

Return to top of page

TEXAS SURVEY SAYS YOUTH CONSIDER DRIVER'S LICENSES MORE IMPORTANT THAN TOBACCO (March April 1998 *ASTHO Report*)

The Texas Department of Health (TDH) conducted a statewide survey which demonstrated that the threat of losing their driver's license would be a strong deterrent to prevent youth from smoking. Some 64 percent of the youth who responded said the threat would be sufficient to keep them from smoking, while another 23 percent said such a sanction would make them at least cut back.

The survey was part of a public education campaign conducted by TDH in response to a bill recently passed by the Texas Legislature that will impose a range of penalties for Texans under 18 who use tobacco. Penalties include a $250 fine, mandatory attendance at tobacco education classes, required community service, and suspension of the driver's license for repeat offenders. The bill also banned vending machines except in "adult only establishments".

NuStats International conducted the survey in Texas for the purpose of identifying

the attitudes of Texas children ages 10 through 17 and their parents about tobacco and the new state law. Two hundred and thirty-three sets of parents and 466 children were surveyed from Texas's broad diversity of people.

TDH Commissioner Dr. William Archer says, "We surveyed young Texans and their parents to find out what would have the best chance of making kids think twice before using tobacco. Overwhelmingly, teens said that losing their driver's license is the sanction most likely to deter them from using tobacco."

Survey findings include:

Youth said the threat of losing driver's licenses (64 percent) and the $250 fine (48 percent) would be the top two deterrents for youth smoking.

Tobacco education class (45 percent) and community service (44 percent) would be slightly less effective deterrents.

More than half (58 percent) of Texas youth say family members smoke and about a third (34 percent) have close friends who smoke.

86 percent of parents and 87 percent of youth approve of Texas' new tobacco prevention law.

Commissioner Archer said, "Texas is getting tough on tobacco because we care about our children's future and because tobacco is seizing a death grip on our kids at increasingly early ages." He said statistics from the Texas Commission on Alcohol and Drug Abuse show that tobacco use by Texas youth increased 25 percent from 1992 to 1996. An estimated 410,000 Texas secondary school students, including 50,000 seventh-graders, were using tobacco in 1996. "It's alarming to know that 17 percent of all seventh-graders are using tobacco products," Archer said.

For more information, contact Dr. Philip Huang, Chief, Bureau of Chronic Disease Prevention and Control, at 512-458-7200 or phuang@chronic.tdh.state.tx.us.

Return to top of page

RECENT CONFERENCE SHOWS MANAGED CARE EXPANDING TOBACCO CONTROL EFFORTS (March April 1998 *ASTHO Report*)

Although the price tag on the human suffering caused by tobacco is not possible to tabulate, measurable costs of tobacco use are increasingly catching the attention of leaders within managed care organizations (MCO).

A recent conference, attended by several hundred health professionals, "Addressing Tobacco in Managed Care: Partnering for Success," stands as evidence of the increasing visibility of tobacco use within managed care settings. The conference, held in early February, emphasized the responsibilities that managed care organizations have to reduce tobacco-caused health disparities. The meeting showcased successes of those organizations that have already instituted programs and partnerships with diverse organizations.

The Keynote speaker, Phil Nudelman, PhD, chairman and president of Kaiser/Group Health, spoke about the particulars of a program to reduce tobacco use that have proven successful. He reported that in the state of Washington, where the program has matured, there have been significant measurable success rates. Dr. Nudelman repeatedly said, "Removing financial barriers is the key to any successful smoking cessation program." He also said that to be successful, other efforts must include: 1) Counseling creating programs and guidelines for physicians to speak to their patients about smoking; 2) Education through supporting

community health education with state and local health departments, through advertisements in local magazines and newspapers, and through warnings on publications with cigarette ads in clinic waiting rooms; 3) Muscle lobbying for clean-air and vending machine restrictions and other policy change advocacy; 4) Participation getting involved with local organizations; and 5) Commitment distributing seed grants for coalitions and other smoking prevention groups.

The HMO Group, American Association of Health Plans (AAHP), and the Prudential Center for Health Care Research, who co-sponsored the conference, also spotlighted their efforts to reduce tobacco. Said Daniel Wolfson, President and CEO of The HMO Group, "There is no more valuable public health goal we can tackle than improving HMOs' and managed care's resources and skills to implement successful tobacco control programs, and to measure their performance."

The AAHP recently began a new initiative, Addressing Tobacco in Managed Care (ATMC), that will distribute to heath plans, consumers, and the academic and medical communities, information about health plan practices that have worked more effectively, as well as providing extensive information on tobacco prevention and cessation efforts. Says Ronald Davis, co-director of ATMC, "As leaders in managed care organizations, we have a special interest in helping people stop tobacco use and in helping them avoid initiating tobacco use."

One well-received feature of the two-day meeting was a panel of HMO staff who had conducted a variety of tobacco prevention activities. Moderated by Dr. Michael Eriksen, director of the Office on Smoking and Health at CDC, the presentations described a variety of strategies utilized by managed care organizations to promote social and policy change concerning tobacco use.

The Health Plan of Nevada and Sierra Community Healthcare Foundation has been conducting the "Smoking Stinks" campaign for the past year. It incorporates radio PSAs, teacher education and activity guide, and a week of activities surrounding the Great American Smoke Out.

Kaiser Foundation Health Plan of Colorado and Group Health Northwest received funding to utilize the CDC Tobacco Counter-Advertising Campaign materials. Focus groups were used to select ads for broadcast, and partnerships were developed with other community organizations to ensure wide exposure to the messages. Ads were tagged to identify the local sponsorship.

HealthPartners in Minnesota has produced its own anti-smoking video targeted to youth entitled "Garbage Face." They have also developed "quit" calendars to assist with cessation. HealthPartners also takes an active role in advocacy efforts to change public policy.

Dr. David Kessler, former FDA Commissioner, was the keynote speaker for the closing luncheon. When introduced, he received a standing ovation from the audience. Dr. Kessler, with the skill of a practiced storyteller, related the history of FDA's decision to assert jurisdiction over nicotine and tobacco. He credited many on his staff for their creative and intensive work that resulted in the historic 1996 regulation. In spite of law suits and potential legislation, Dr. Kessler is confident that much of the regulation will stand and that the health of the American public will be improved because of this creative and historic decision by his agency.

Return to top of page

Association Of State and
Territorial Health Officials
1275 K Street NW
Suite 800
Washington, DC 20005-4006
phone: (202)-371-9090
fax: (202)-371-9797

ASTHO's Tobacco Prevention & Control Project:

Strengthening National, State and Local Tobacco Prevention Activities to Reduce the Nation's #1 Preventable Cause of Death

ASTHO

- ASTHO Home
- HIV/AIDS
- Infectious Disease
- Environmental Health
- Tobacco Control
- Immunizations
- Adolescent and School Health
- Primary Care & MCH Projects

State Highlights

Project Information

Policy Statement

Tobacco Settlement

Resources & Announcements

Tobacco Free Press

Documents

Arizona Dept. of Health

Links to National Organizations

Links to State Programs

E-mail

6-45

16 Fitzhardinge Street, London W1H 9PL Tel: 0171 224 0743 Fax: 0171 224 0471

Press release

ASH
Action on Smoking and Health

15 October 1997

Four changes to the legal system that would bring justice for victims of tobacco

Smokers and their health carers have suffered from an extraordinary toll of illness and premature death, but their ability to seek damages is hampered by the English legal system. The deep pockets of tobacco companies and massive costs of litigation mean that only the most overwhelmingly strong lung cancer cases have been brought s far. At a conference organised jointly by ASH and the British Medical Association featuring two top American lawyers, delegates heard that new cases could include:

- 'Addiction as injury' and a failure to warn of the addictive properties of nicotine (like the US Castano cases and its successors)
- Heart disease - recently a successful case in Brazil
- Passive smoking - recently Airline staff settled in Florida (The Broin case)
- Health Authorities and private medical insurers suing for recovery of expenditure on smoking-related disease.
- Criminal proceedings against tobacco company executives
- Developing world claims heard in the UK

ASH believes that British citizens have suffered no less than Americans, but that it is much harder for them to see justice. ASH is calling for four changes to the legal system that would open the way for new fronts in the battle t hold tobacco companies legally accountable for their wrong doing. These are each features of the US system:

1. **Expansion of the no-win, no-fee system to all cases where money is at stake**
2. **Punitive damages to be awarded to punish wrong-doing by tobacco companies**
3. **Plaintiffs not to be liable for defendants costs if they lose**
4. **Trials to be heard before juries instead of judges**

Clive Bates, Director of ASH, said "Tobacco companies have done enormous damage to the health of British pe and if they have been negligent or deceitful they should be sued and pay heavily. English law tends to deny justic victims of the the tobacco industry - though it may be a long haul to change it, even the longest jouney starts with single step."

Contact	Clive Bates, Director	0171 224 0743 or 0181 800 1336 (hm)
	Amanda Sandford, Communications Director	0171 224 0743 or 0181 257 3501 (hm)

16 Fitzhardinge Street, London W1H 9PL Tel: 0171 224 0743 Fax: 0171 224 0471

Press release

August 19, 1997

ASH
Action on Smoking and Health

World Conference on Tobacco or Health. Beijing, August 24-28, 1997

Landmark conference will lead the international fightback against the tobacco epidemic

Smokers and their health carers have suffered from an extraordinary toll of illness and premature death, but their ability to seek damages is hampered by the English legal system. The deep pockets of tobacco companies and massive costs of litigation mean that only the most overwhelmingly strong lung cancer cases have been brought s far. At a conference organised jointly by ASH and the British Medical Association featuring two top American lawyers, delegates heard that new cases could include:

- 'Addiction as injury' and a failure to warn of the addictive properties of nicotine (like the US Castano cases and its successors)
- Heart disease - recently a successful case in Brazil
- Passive smoking - recently Airline staff settled in Florida (The Broin case)
- Health Authorities and private medical insurers suing for recovery of expenditure on smoking-related disease.
- Criminal proceedings against tobacco company executives
- Developing world claims heard in the UK

There is a new mood in the anti-tobacco world and the gathering in China will herald a major intensification of tl fight against the health problems of tobacco world-wide. As the tobacco industry is increasingly squeezed in the industrialised world, the companies are aggressively chasing markets in the developing world and Eastern Europ

"Following the US deal, the mood has changed - everyone is saying that if tobacco is guilty in the States, then it' guilty everywhere. Every country is looking at where it stands on tobacco and health. At this conference we hop find the common will to confront tobacco companies where they are really staking their future - in developing countries and Eastern Europe" said Clive Bates, Director of ASH in London.

"It is good to be attending the conference now that Britain has taken a hard line position on tobacco control. Wh the home of BAT, Imperial Tobacco, and Gallaher gets tough on tobacco, it sends a very positive signal to Brita friends in the Commonwealth and wider international community" said Bates.

ASH calls for international convention on tobacco and health

The restrictions in the US settlement do not extend to the activities of the same US tobacco companies operating abroad. At the conference ASH representatives will argue for an international convention on tobacco and health under the auspices of the World Health Organization building on existing initiatives. [1] The convention would include as a minimum:

- Broad objectives related to tobacco consumption;
- Tobacco control protocol detailing measures to be implemented by the parties;
- Reporting requirements and information exchange;
- Financial mechanism to fund institution strengthening, crop substitution, implementation and monitoring i

developing countries and Eastern Europe.

The tobacco control protocol would include as a minimum:

- Minimum restrictions on advertising, promotion and sponsorship by tobacco companies;
- Minimum health warnings and other information on the pack;
- Maximum tar and nicotine content of cigarettes;
- Co-operation against smuggling.

ASH Director Clive Bates, said: "It's now time for action not words. Joint action worldwide is essential if we are to reduce the horrendous toll of tobacco-induced death and disease which is now as common in many developing countries as in the West."

continues .../2

Notes to editors:

[1] The call for an international convention follows a resolution passed by the 49th World Health Assembly of the WHO which urged member states to implement comprehensive tobacco control strategies. The resolution, which was passed on 25 May 1996, requested the Director-General of the WHO:

(1) to initiate the development of a framework convention

(2) to include as part of this framework convention a strategy to encourage Member States to move progressively towards the adoption of comprehensive tobacco control policies and also to deal with aspects of tobacco control that transcend national boundaries.

Document WHA49.17

Forty-ninth World Health Assembly, 25/5/96

ENDS

At the conference press office - tel. 00 8610 6424 8985; fax 00 8610 6426 0978

Our hotel: Xiyuan Hotel - 008610 68313388

Contact	**Clive Bates, Director**	**0171 224 0743 or 0181 800 1336 (hm)**
	Amanda Sandford, Communications Director	**0171 224 0743 or 0181 257 3501 (hm)**

6.47

ASH Briefing on the tobacco industry

TOBACCO INDUSTRY STATEMENTS ON SMOKING AND HEALTH:

PUBLIC STATEMENTS VERSUS PRIVATE ADMISSIONS

Public standpoint

In 1954, the tobacco companies in the US issued a joint public statement entitled

"A Frank Statement to Cigarette Smokers". Published in 448 newspapers across the US, the statement said:

"Recent reports on experiments with mice have given wide publicity to a theory that cigarette smoking is in some way linked with lung cancer in human beings. Although conducted by doctors of professional standing, these experiments are not regarded as conclusive..."

"We accept an interest in people's health as a basic responsibility, paramount to every other consideration in our business."

From the mid 1950s onwards, the tobacco industry has sought to play down the scientific evidence on the health consequences of smoking and adopted a policy of spreading doubt and confusion. A massive PR campaign was mounted to attack not only the scientific data but also science itself. Thus industry statements suggested that connections between smoking and disease were not real but "merely statistical". One of many examples comes from BAT in 1981:

"Despite a never-ending stream of research on the possible health hazards of smoking, there is no proof of a cause and effect relationship between cigarette smoking and various alleged smoking diseases."

Dr. L Blackman, Director of R&D, BAT 1981

If pressed, tobacco executives would retreat behind the facade of not being able to comment on health issues:

"All the tobacco industry can do is adopt its neutral stance."

C. Burell, Rothmans, 1989

Some, however, felt that the public should at least be aware of the "alleged" dangers:

"The tobacco manufacturers do not believe that the alleged dangers to health have been scientifically proven, b agree that smokers should continue to be made aware of such allegations."

P J Hoult, President RJR Macdonald, Canada, 1987

Meanwhile, internal industry documents painted a rather different picture:

Internal documents:

"There are biologically active materials present in cigarette tobacco. These are:

a) cancer causing b) cancer promoting c) poisonous d) stimulating, pleasurable and flavorful."

Extract from 1961 memo by Arthur D Little Inc. (research partner with Liggett & Myers)

"..evidence is building up that heavy smoking contributes to lung cancer."

Report by C V Mace, Philip Morris scientist, 1958.

"Smoking is a habit of addiction."

" The central fact in this subject is that in sufficient doses, tobacco condensate acts as a carcinogen when paint on the backs of mice or when injected subcutaneously into rats..."

Sir Charles Ellis, senior scientist, BAT, 1962.

"Moreover nicotine is addictive. We are, then, in the business of selling nicotine, an addictive drug effective in release of stress mechanisms."

Addison Yeaman, vice president and general counsel,

Brown & Williamson, 1963

"..we should adopt the attitude that the causal link between smoking and lung cancer is proven because then at least we could not be any worse off."

Dr. Sidney Green, chief of research at BAT, 1962

Date: 12 March 1998

Embargo: 11 Mar 1998

BMA RESPONSE TO DAMNING NEW EVIDENCE OF THE EFFECTS OF PASSIVE SMOKING ON CHILDREN'S HEALTH

Responding to a series of papers in the Journal Thorax, which shows that passive smoking is linked to respiratory illness, sudden infant death syndrome, asthma and middle ear disease in children, the BMA today renewed its attack on the tobacco industry for attempting to deny and downplay the health damage caused by environmental tobacco smoke.

Dr Bill O'Neill, Science Adviser to the BMA says:

"Today's evidence clearly explains why the tobacco industry has been engaged in a desperate disinformation campaign. They do not want to be linked to death and illness in children. But they cannot escape that link. They spend millions recruiting new young smokers who will be the parents of tomorrow's sick children."

Dr O'Neill also called for urgent action to improve support for parents who want to quit.

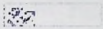
"We have a major problem. We have been losing the struggle to persuade young people not to start smoking. More than a third of 15 year old girls smoke and by the time they start a family they are thoroughly hooked. 32 per cent of pregnant women are smokers and this rises to 49 per cent in women from poorer households.

"The stresses and strains of being a parent can make it very difficult for parents to cope with the idea of giving up smoking. But it is important that the public understands just how damaging the effects of tobacco smoke are on their children's health. And as that awareness grows, parents will want to stop. They need and deserve help and support to succeed."

ends

Issued by: BMA Public Affairs Division
BMA House
Tavistock Square
London WC1H 9JP

tel: 0171 387 4499



Home
Back

Press release archive | Campaigns | Home

TOBACCO FREE INITIATIVE BANNER

World No-Tobacco Day, 31 May 1999

WHO TO CONTACT

For further information, please contact:

WHO Headquarters
Dr Derek Yach
Project Manager
Tobacco Free Initiative
World Health Organization
1211 Geneva 27
Switzerland

Tel: +41 22 791 2736
Fax: +41 22 791 4769
E-mail: yachd@who.ch

WHO Regional Office for Africa
Mr L. Sanwogou
Regional Adviser on Health Education
World Health Organization
Regional Office for Africa
Medical School, C Ward
Parirenyatwa Hospital
Mazoe Street
P.O. Box BE 773
Belvedere
Harare
Zimbabwe

Tel: +263 4 70 69 51/70 74 93
Fax: +263 4 70 56 19/70 20 44
E-mail:sanwogoul@server.whoafr.org

WHO Regional Office for the Americas
Dr Enrique Madrigal
Regional Adviser on Drug Abuse
525, 23rd Street, N.W.
Washington, D.C. 20037
USA

Tel: +1 202 974 3331
Fax: +1 202 974 3631

Back to Table of Contents

Dr. UK

E-mail: madriqen@paho.org

WHO Regional Office for the Eastern Mediterranean
Dr M. Al Khateeb
Regional Adviser on Health Education
World Health Organization
Regional Office for the Eastern Mediterranean
P.O. Box 1517
Alexandria 21511
Egypt

Tel: +203 48 202 23
Fax: +203 48 38 916
E-mail: alkhateebm@who.sci.eg

WHO Regional Office for Europe
Dr P. Anderson
Regional Adviser for the Action Plan for a Tobacco-Free Europe
World Health Organization
Regional Office for Europe
8, Scherfigsvej
2100 Copenhagen Ø
Denmark

Tel: +45 39 17 12 48
Fax: +45 39 17 18 54
E-mail: pan@who.dk

WHO Regional Office for South-East Asia
Ms Martha Osei
Regional Adviser on Health and Behaviour
World Health Organization
Regional Office for South-East Asia
World Health House
Indraprastha Estate
Mahatma Gandhi Road
New Delhi 110002
India

Tel: +91 11 331 7804
Fax: +91 11 331 8607
E-mail: martha@who.ernet.in

WHO Regional Office for the Western Pacific
Mr Stephen Tamplin
Regional Focal Point for Tobacco or Health
World Health Organization
Regional Office for the Western Pacific
P.O. Box 2932

World No-Tobacco Day, 31 May 1999

DP.UK

The Advisory Kit 1999 in PDF format
World No-Tobacco Day 1998, 1997, 1996
The Tobacco Free Initiative Home Page

Minnesota v. Tobacco

Despite efforts to remove the transcripts from the Internet, *The Putnam Pit* is posting what has been suggested are the verbatim proceedings of the lawsuit

STATE OF MINNESOTA AND BLUE CROSS AND BLUE SHIELD OF MINNESOTA,
PLAINTIFFS,
V.
PHILIP MORRIS, INC., ET. AL.,
DEFENDANTS

We want to know if these are accurate transcripts. Please help us.
As a watchdog press, we are posting these files to determine their authenticity and accuracy, and to monitor the performance of the state lawyers and judiciary. We need to be certain that all information is correct. Can you help us? Please advise us of any incorrect information contained here.
email *The Putnam Pit.*

The Putnam Pit has received electronically the following files, ostensibly the transcripts from the trial:

- February 19, 1998
- February 20, 1998
- February 23, 1998
- February 24, 1998
- February 25, 1998
- February 26, 1998
- February 27, 1998
- March 2, 1998
- March 3, 1998
- March 4, 1998
- March 5, 1998
- March 6, 1998
- March 9, 1998
- March 10, 1998
- March 11, 1998
- March 12, 1998
- March 13, 1998
- March 17, 1998
- March 18, 1998
- March 19, 1998
- March 20, 1998
- March 23, 1998
- March 24, 1998
- March 25, 1998
- March 26, 1998
- March 27, 1998
- March 30, 1998
- March 31, 1998
- April 1, 1998
- April 2, 1998
- April 3, 1998
- April 6, 1998
- April 7, 1998
- April 8, 1998
- April 9, 1998
- April 10, 1998

Trial Transcripts from the State of Minnesota v. Philip Morris, Inc., et. al.

Topic(s): Tobacco/Nicotine/Smoking-Legislation and Jurisprudence

Title:
Trial Transcripts from the State of Minnesota v. Philip Morris, Inc., et. al.
Creator:
The Putnam Pit
Location (URL):
http://www.putnampit.com/tobacco.html
Provider:
The Putnam Pit
Description:
Court transcripts from the State of Minnesota and Blue Cross and Blue Shield of Minnesota, plaintiffs, v. Philp Morris, Inc., et. al., defendants. Transcripts span the dates February 19, 1998 - to the present. The files are made available by The Putnam Pit, an alternative newspaper and website serving Putnam County, Tennessee.
Access Type:
Web (http)
MeSH:
Tobacco - legislation and jurisprudence; Nicotine - legislation and jurisprudence
Publication Date:
February 1998
ISBN/ISSN:
ISSN 1091 9171
Frequency :
Daily
Submitted By:
RLC
Date Submitted:
03/18/98

Last updated: Wednesday, 08-Apr-1998 16:27:40 PDT

The Cigarette Papers

A Webumentary™ on the secrets of the tobacco industry

The Trail of the Secret Brown & Williamson Documents

The saga of those tan-hot-ta-handle internal papers. Who got them and what they did with them.

Readings

A full-text selection of background material and analyses on the ABC and CBS run-ins with tobacco companies.

The Interviews

Interviews with journalists, First Amendment lawyers, media analysts, and others, talking newsroom policies, practices, and ethics.

Tobacco on the Web

Taking a look at the range of worthwhile information offered via the Internet.

Feedback Tapes & Transcripts Return to Frontline

text version of this page

An article in the NEW YORK TIMES noted that persons with an overabundance of iron in their blood should stop smoking to help alleviate their condition. Because cancer cells cannot multiply without iron and oxygen in the blood stream, and tobacco leaves are rich in iron, smokers acquire high levels of iron in their lung tissues and increase their risk of lung cancer. One study indicates that a high iron level is second only to smoking as a cause of heart attacks.

Source: Jane E. Brody, "Personal Health," NEW YORK TIMES, March 5, 1997, p. C8. (sdb 3/5/97)
Courtesy of: The Advocacy Institute

Date: 3/5/1997

Distributed by:

JOIN TOGETHER:
441 Stuart Street, Sixth Floor
Boston, MA 02116
Email: info@jointogether.org
Gopher: gopher.jointogether.org 7003
URL: http://www.jointogether.org
Tel. 617/437-1500
Fax. 617/437-9394

FRONTLINE Smoke in the Eye

Interviews

home
the paper trail
interviews
readings
tobacco on the web
feedback

Ben Bagdikian

Media critic and former Dean of the Graduate School of Journalism, University of California, Berkeley.

Walter Cronkite

Former CBS News anchor and correspondent

Stanton Glantz

Professor of Medicine at the University of California, San Francisco

James Goodale

General Counsel for the New York *Times* during the Pentagon Papers case.

Lawrence Grossman

Former President of NBC News and PBS

Philip Hilts

Reporter/correspondent for The New York *Times*

Victor Kovner

First Amendment lawyer

Christopher Patti

Lawyer for UCSF

1-10 matches for "tobacco & health - Indian situation" from the entire Web

WHO Responds To Worsening World **Tobacco Situation**
The 500 Sites Yahoo is Afraid to List. WHO Responds To Worsening World **Tobacco Situation**. September 16, 1998. HARARE, Zimbabwe (PANA) - World **Health**...
From Size 4K - 25-Dec-98
http://www.africanews.org/PANA/science/19980916

Tobacco Situation & Significance
Tobacco Situation & Significance by Joe Coffey. October 27, 1997. **Tobacco**'s contribution to the nation's Gross National Product (GNP) in 1996 was nearly..
From Size 8K - 02-Feb-98

Monthly Information
Monthly Information. Agricultural Market Service, "Stocks Report" Economic Research Service, "**Tobacco Situation**", "Agricultural Outlook" Crop Reporting...
From Size 1K - 28-Nov-98

News & Other Events
nbsp; News. Agricultural and Family & Consumer Sciences Newspacket (for the week of: November 13, 1998) Newspacket Archives (Oct.'97 - current) Green...
From Size 4K - 13-Nov-98

Lifestyle and Nutrition: Smoking Facts For Maori: Compiled by Dr Paparangi Re
Smoking Facts For Maori Compiled by Dr Paparangi Reid. CURRENT **SITUATION**. **Tobacco** smoking is the single greatest preventable cause of early death amongst..
From Size 4K - 18-Mar-97

News & Other Events
nbsp; News. Agricultural and Family & Consumer Sciences Newspacket (for the week of: September 4, 1998) Newspacket Archives (Oct.'97 - current) Green...
From Size 4K - 04-Sep-98

UT Extension, Newsletter Home Page
Agricultural and Family and Consumer Sciences Packet. Current Week's Packet: August 21, 1998. Archives. Green Tennessee 1998Newspacket (formerly known as..
From Size 1K - 24-Aug-98

ASH - What's new
ASH 'Whats New' aims to give an insight into what is happening in **tobacco** policy, legislation and litigation. Here articles describe the **situation** as
From Size 8K - 01-Oct-98

ASH - What's new
ASH 'Whats New' aims to give an insight into what is happening in **tobacco** policy, legislation and litigation. Here articles describe the **situation** as

Redefining Liberation

FACT SHEET FOR THE WOMEN'S HEALTH PROJECT

Tobacco Advertising and Women

In 1994, the tobacco industry spent $4.83 billion on advertising and promotion. CDC study, 1994

"Within six years of the tobacco companies introduction of feminine cigarettes and accompanying advertisement, the number of girls smoking increased 110%."

Smoking initiation by Adolescent Girls, 1944 through 1988, An Association with Targeted Advertising, John P. Pierce, Journal of the American Medical Association, Feb. 23, 1994, p610

Tobacco billboards are disproportionally placed in ethnic neighborhoods.

"As in tobacco advertising, smoking in the movies is associated with youthful vigor, good health, good looks, and personal/professional acceptance."

Anna Russo Hazan, PhD, MPH, Helen Levenns Lipton, PhD, and Stanton A. Glantz, PhD. "Popular Films Do Not Reflect Current Tobacco Use." American Journal of Public Health. June 1994, Vol. 84, No. 6.

Magazines that accept tobacco ads are 38 percent less likely to run articles on tobacco related health risks.

California Department of Health Services, Tobacco Control Section

"As long as women are led to think that smoking makes them beautiful, successful, slender and all the other images toured by the tobacco industry, then lung cancer will be a woman's issue." *Ellen Gritz, PhD, director of the Division of Cancer Control at the Jonsson Comprehensive Cancer Center*

NOW Foundation Home Page / Donate to the NOW Foundation / Go to NOW Inc. page

India

Socio-demographic characteristics			
Population	**1990**	**1995**	**2025**
Total	850,638,000	935,744,000	1,392,086,000
Adult (15+)	542,391,000	606,250,000	1,071,802,000
% Urban	25.5	26.8	45.2
% Rural	74.5	73.2	54.8

Health Status

Life expectancy at birth, 1990-95 : 60.4 (males), 60.4 (females)
Infant mortality rate in 1990-95 : 82 per 1,000 live births

Socio-Economic Situation

GNP per capita (US$), 1991 : 330, *Real GDP per capita (PPP$), 1991* : 1,150
Average distribution of labour force by sector, 1990 - 92 : Agriculture 62%; Industry 11%; Services 27%
Adult literacy rate (%), 1992 : Total 50; Male 64; Female 35

Tobacco production, trade and industry

Agriculture In 1993, 417,700 hectares were harvested for tobacco, down from 436,600 hectares in 1985. About 0.2% of all arable land is used for tobacco growing.

Production and Trade In 1992, 578,800 tonnes (7.0% of world total unmanufactured tobacco) was produced in India, making it the world's third largest tobacco-growing country. In 1992, India produced about 767,436 million manufactured cigarettes and bidis, accounting for 13.5% of the world total. About 2,100 million cigarettes were exported. Only 30 million manufactured cigarettes were imported. In 1990, India's earnings from tobacco exports totalled US$ 127.7 million, compared with US$ 122.2 million in 1985. Import costs of cigarettes rose tenfold in the

Dr. UK

same period to US$ 3.0 million.

Industry In 1993, 3.4 million people were estimated to be engaged full-time in tobacco manufacturing. This accounts for 11.7% of all manufacturing work. Almost 0.9 million people (full-time equivalent) work in growing and curing tobacco.

Tobacco consumption

Annual consumption of manufactured cigarettes declined between 1984 and 1992 from around 90 billion to about 85 billion. In 1992, 6.1% of world total unmanufactured tobacco and 1.5 % of world total manufactured cigarettes were consumed in India. Only about 20% of the total tobacco consumed in India (by weight) is in the form of cigarettes. Bidis account for about 40% of tobacco consumption (about 675,000 million bidis), with the rest divided among chewing tobacco, pan masala, snuff, hookah, hookli, chutta dhumti, and other tobacco mixtures featuring ingredients such as areca nut. Chuttas and dhumtis are also smoked in reverse fashion, with the lighted end inside the mouth. Consumption patterns of tobacco show major differences across regions.

Consumption of Manufactured Cigarettes			
	Annual average per adult (15+)		
	Cigarettes	Bidis	Total
1970-72	170	840	1,010
1980-82	180	1,130	1,310
1990-92	150	1,220	1,370

Tar/Nicotine/Filters In 1990, tar levels of cigarettes ranged from 18.0 - 28.0 mg, and nicotine levels from 0.9 -

1.8 mg. Tar levels of bidis are much higher at 45-50 mg. In 1990, 51% of the cigarettes sold were filter-tipped, however, there is little difference in nicotine yields of filter and non-filter cigarettes manufactured in India.

Prevalence

Adequate national data on tobacco prevalence of tobacco is not currently available. However, based on estimated per capita consumption figures, it appears that bidi smoking has risen substantially during the last three decades. Cigarette smoking increased up to the 1970s, remained stationary or declined somewhat during the 1980s. Other forms of tobacco use have declined considerably over the years.

Tobacco use among population sub-groups It is estimated that 65% of all men use some form of tobacco, (about 35% smoking, 22% smokeless tobacco, 8% both). Prevalence rates for women differed widely, from 15% in Bhavnagar to 67% in Andhra Pradesh. However, overall prevalence of bidi and cigarette smoking among women is about 3%. The use of smokeless tobacco is similar among women and men. About one-third of women use at least one form of tobacco. Differences in tobacco use also vary among other groups; Sikhs do not use tobacco at all, and Parsis use very little, while tobacco use is permissible among Hindus, Moslems and Christians. Smoking rates tend to be higher in rural areas than urban areas. Smoking is a status symbol among urban educated youths, but most appear to be unaware of the hazards of smoking.

Mortality from Tobacco Use

Tobacco is responsible for a significant amount of morbidity and mortality among middle-aged adults. India has one of the highest rates of oral cancer in the world, and the rates are still increasing. Tobacco-related cancers account for about half of all cancers among men and one-fourth among women. Oral cancer accounts for one-third of the total cancer cases, with 90% of the patients being tobacco chewers. Clinical observations in some areas have revealed that over 60% of heart disease patients under 40 years of age are tobacco users; over half of the patients aged 41-60 are also smokers.

Tobacco Control Measures

Control on Tobacco Products Tobacco advertising has been banned in state-controlled electronic media, but continues without restriction in newspapers, magazines, on posters, billboards, and in the video cassettes of Indian films. A proposal for a total ban on advertising and sponsorship of all tobacco products is under consideration by the Indian Government.

Health warnings are required on cigarette packets since the "Cigarette Act" of 1975. The government has appointed a full-time coordinator of tobacco control activities. However, also in 1975 the government dropped restrictions on package size and contents for cigarettes, cigars and 22 other products, and initiated a Tobacco Development Board for promoting tobacco by offering direct subsidies and a price support system to farmers.

Taxes are levied on tobacco products, at varying rates and with varying degrees of effectiveness. Between 1987 and 1992, excise duty on many Indian cigarettes increased between 64% - 112%. Cigarette taxes represent about 75% of the retail price. Taxes are much lower on packaged chewing tobacco and are rarely collected on bidis and unpackaged tobacco products. Regulatory control and the application of retail taxes on these products is extremely difficult as there is a large sector which operates outside of official control. For example, the bidi industry is highly decentralized and many manufacturers are unlicensed. Much of bidi manufacturing is one in cottage industry. Often whole families, including women and children, are engaged in bidi production.

High taxes on manufactured cigarettes and low taxes on bidis and other tobacco products are encouraging

substitution of bidis and other products for manufactured cigarettes.

Protection for non-smokers In 1990, through an executive order, the government implemented a prohibition on smoking in all health care establishments, government offices, educational institutions, air-conditioned railway cars, chaircars, buses, and domestic passenger flights.

Health education There is no organization currently working at the national level for tobacco control. Several non-governmental organisations and committed individuals at the local levels are also involved, but to date, no perceptible attitudinal changes among tobacco consumers have been found.

Previous Country | Southeast Asia | Next Country

1 of 17

TI: Nutrition and chronic diseases--Indian experience.
AU: Gopinath-N
AD: Sitaram Bhatia Institute of Science and Research, New Delhi, India.
SO: Southeast-Asian-J-Trop-Med-Public-Health. 1997; 28 Suppl 2: 113-7
This source is Available in S.J.M.C Library
Call Number: From: 1980+
LA: ENGLISH
AB: Socio-economic changes are taking place all over the world, especially in developing countries, and these influence all aspects of life an all age periods. Resultant disparities have brought about alarming and increasing manifestations of malnutrition and non-communicable disease. Illiteracy, poor health facilities have damaging effects on children. Raising the literacy of girls and adolescents will reduce the leading cause of malnutrition in children, since these future, better educated mothers will be responsible for the children's welfare: child care status with mother care. Protein calorie sufficiency is only present in approximately 60% of the rural population of India: the remainder has differing degrees of malnutrition. When they move into better socio-economic status people are at increased risk from coronary heart disease and diabetes mellitus, for which several theoretical explanations have been proposed. There is a difference in the patterns of these diseases in urban and rural populations, the exact basis for which is not yet clear. For example, in the 25-64 years age group, coronary heart disease prevalence in Delhi is 97/1,000 while in a rural area it is 27/1,000, while the respective figures for hypertension are 127/1,000 and 29/1,000. The patterns in both groups have changed within 3-5 years. The geriatric age group has its own, changing features, due to increasing longevity of life, and to break up of social customs and family structure.

2 of 17

TI: Cardio vascular morbidity in proteinuric south Indian NIDDM patients.
AU: Viswanatham-V; Snehalatha-C; Mathai-T; Jayaraman-M; Ramachandran-A
AD: Diabetes Research Centre, Chenmai, India.
diabetes.research@gems.vsnl.net.in
SO: Diabetes-Res-Clin-Pract. 1998 Jan; 39(1): 63-7
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Proteinuria is a well known risk factor for cardiovascular morbidity. There has been no report on cardiovascular morbidity in Indian NIDDM patients with proteinuria. Hence this study has been undertaken to estimate the prevalence of cardiovascular diseases (CVD) in South Indian NIDDM with proteinuria. We studied two groups of NIDDM patients with diabetes for > or = 5 years: group PR with persistent proteinuria of > 500 mg/day (n = 297) and group NPR with normoalbuminuria (albuminuria < or = 30 micrograms/mg creatinine)(n = 296), who reported for review during the study period. They were matched for age, duration of diabetes and BMI. The prevalence of cardiovascular diseases, namely myocardial infarction, the presence of ischaemic heart disease and the history of coronary bypass surgery were compared in the two groups. The prevalence of hypertension was higher among the PR than the NPR patients (56.5 vs 24.7%, chi 2 = 61.3, P < 0.01). CVD were detected in 39.2% (n = 116) of the PR and 13.2% (n = 39) of the NPR groups. (chi 2 = 54.85, P < 0.001). The risk was thus three-fold higher in the PR group. Univariate analysis showed that in the proteinuric group, the prevalence of complications was higher in association

with hypertension (45.8% vs 30.2%, chi 2 = 6.82, P = 0.009). Multiple logistic regression analysis showed that the factors associated with CVD were proteinuria (odds ratio 5.03), age (OR 1.08) and BMI (OR 1.07) while sex, age at onset of diabetes, duration of diabetes, hypertension, smoking, HbA1, serum creatinine, cholesterol and triglycerides did not show independent contribution. The study, highlights the high risk conferred by macroproteinuria in Indian NIDDM patients. This risk is found to be independent of the presence of associated hypertension.

3 of 17

TI: Prevalence of respiratory symptoms and increased specific IgE levels in West-African workers exposed to isocyanates.
AU: Deschamps-F; Sow-ML; Prevost-A; Henry-L; Lavaud-F; Bernard-J; Kochman-S
AD: Department of Occupational Diseases, CHU Maison Blanche, Reims, France.
SO: J-Toxicol-Environ-Health. 1998 Jul 10; 54(5): 335-42
This source is Available only few issues in S.J.M.C. Library
LA: ENGLISH
AB: Respiratory symptoms and immunological effects from chronic exposure to isocyanates (toluene diisocyanate) were studied in a cross survey of workers from West African factories producing paints and polyurethane foam. A questionnaire, a pulmonary function test, immunoglobulin E (IgE) levels, radioallergosorbent test (RAST) and an atmospheric sample to quantify isocyanate exposures were carried out in the workplace for each worker. Ninety-six workers, of whom 44 had occupational isocyanate-induced asthma, were included in the study. Twenty-four viral-infected subjects were excluded from the immunological study. Specific antibodies to isocyanates were detected in two of the symptomatic individuals. This low proportion appeared to be a common feature of this disease. The prevalence of isocyanate-induced asthma in a West African working population appears to be significant in the context of chronic human exposure, as current data are based on excessive acute exposure due to an accident as seen in India.

4 of 17

TI: Predictors of smoking in a cross section of novice mine workers.
AU: Kleinschmidt-I
AD: Epidemiology Research Unit, Johannesburg, South Africa.
immok@csa.pwv.gov.za
SO: Cent-Afr-J-Med. 1997 Nov; 43(11): 321-4
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: OBJECTIVE: To determine demographic predictors of smoking status amongst novice mine workers. SETTING: Prospective mine workers undergoing fitness examination at the Medical Bureau for Occupational Diseases. DESIGN: Cross sectional study. MAIN OUTCOME MEASURES: Current smoking status. RESULTS: Smoking status is significantly linked to age, race group, nationality and previous employment status. Education is also a predictor of smoking status, but the association is weak. Smoking prevalence in subgroups of novice mine workers varies from less than 10% to nearly 75%. CONCLUSION: Assumptions of very high smoking rates amongst all mine workers are too simplistic. Smoking cannot be regarded globally as a major confounder of occupational exposure and occupational lung disease for all groups of mine workers.

5 of 17

TI: Lifestyle factors and stomach cancer [letter]
AU: Krishnamurthy-S
SO: Int-J-Epidemiol. 1998 Feb; 27(1): 153
This source is Available only few issues in S.J.M.C. Library
LA: ENGLISH

6 of 17

TI: Cardiovascular risk factors in non-insulin-dependent diabetics compared to

non-diabetic controls: a population-based survey among Asians in Singapore.
AU: Hughes-K; Choo-M; Kuperan-P; Ong-CN; Aw-TC
AD: Department of Community, Occupational and Family Medicine, National University of Singapore, National University Hospital, Singapore. cofkh@nus.sg
SO: Atherosclerosis. 1998 Jan; 136(1): 25-31
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Cardiovascular risk factors were compared between 126 people with non-insulin-dependent diabetes mellitus (NIDDM) and 530 non-diabetics (controls), in a random sample of people (Chinese, Malays, and Asian Indians) aged 40-69 years from the general population of Singapore. Data were adjusted for age and ethnicity. For both genders, people with NIDDM had higher mean body mass indices, waist-hip ratios and abdominal diameters. They also had a higher prevalence of hypertension, higher mean levels of fasting serum triglyceride, slightly lower mean levels of serum high-density-lipoprotein cholesterol, and higher mean levels of plasma plasminogen activator inhibitor-1 and tissue plasminogen activator (antigen). These factors are components of syndrome X (metabolic syndrome) and increase the risk of atherosclerosis and thrombosis. In contrast, there were no important differences for cigarette smoking, serum total and low-density-lipoprotein cholesterol, serum apolipoproteins A1 and B, plasma factor VIIc and plasma prothrombin fragment 1 + 2. Females with NIDDM, but not males, had a higher mean serum fibrinogen level than non-diabetics, which could explain why NIDDM has a greater cardiovascular effect in females than males. Serum lipoprotein(a) concentrations were lower in people with NIDDM. Mean levels of serum ferritin, a pro-oxidant, were higher in people with NIDDM than controls, but there were no important differences for plasma vitamins A, C and E, and serum selenium, which are anti-oxidants.

7 of 17

TI: Tobacco use in rural Indian children.
AU: Krishnamurthy-S; Ramaswamy-R; Trivedi-U; Zachariah-V
AD: Department of Community Oncology, S.S.B. Cancer Hospital and Research Center, Kasturba Medical College and Hospital, Manipal.
SO: Indian-Pediatr. 1997 Oct; 34(10): 923-7
This source is Available in S.J.M.C Library
Call Number: From: 1969+
LA: ENGLISH

8 of 17

TI: Clinical profile of lean NIDDM in south India.
AU: Mohan-V; Vijayaprabha-R; Rema-M; Premalatha-G; Poongothai-S; Deepa-R; Bhatia-E; Mackay-IR; Zimmet-P
AD: Madras Diabetes Research Foundation, India.
SO: Diabetes-Res-Clin-Pract. 1997 Nov; 38(2): 101-8
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: The majority (> 80%) of patients with non insulin dependent diabetes mellitus (NIDDM) present in Europe and America are obese. In developing countries like India, most NIDDM (> 60%) are non-obese and many are actually lean with a body mass index (BMI) of < 18.5 and are referred to as 'lean NIDDM'. This paper compares the clinical profile of a cohort of 347 lean NIDDM, with a group of 6274 NIDDM of ideal body weight (IBW) and 3252 obese NIDDM attending a diabetes centre at Madras in South India. The lean NIDDM who constituted 3.5% of all NIDDM patients seen at our centre, had more severe diabetes and an increased prevalence of retinopathy (both background and proliferative), nephropathy and neuropathy. Although a larger percentage of the lean NIDDM patients were treated with insulin, 47% of the males and 53% of the females were still on oral hypoglycaemic agents even after a mean duration of diabetes of 9.2 +/- 8.1 years. Studies of GAD antibodies, islet cell antibodies (ICA) and fasting and stimulated C-peptide estimations done in a small subgroup of the lean NIDDM showed that they were distinct from IDDM patients. More

studies are needed on metabolic, hormonal and immunological profile of lean NIDDM seen in developing countries like India.

9 of 17

TI: A baseline study of tobacco use among the staff of Aligarh Muslim University, Aligarh, India.
AU: Yunus-M; Khan-Z
AD: Dept. of Community Medicine, J N Medical College, Aligarh Muslim University, India.
SO: J-R-Soc-Health. 1997 Dec; 117(6): 359-65
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: A cross-sectional study of 2,439 university employees and research scholars was carried out using the questionnaire method. The objective was to assess the prevalence and type of tobacco usage and to collect background data for planning health education programmes. The overall prevalence of tobacco usage was 31.5% among males and 30.3% among females. There were no female smokers, the preferred habit of tobacco usage among women being chewing. The prevalence of smoking among non-teaching staff members was significantly higher. Among females, the prevalence of tobacco chewers was higher in non-teaching staff members. Tobacco usage (both smoking and usage of other forms) rose with age. However, even at 20-30 years of age 25.4% of males were addicted to smoking. A majority of 60.6% had smoked for more than 10 years. Among the staff members (both teaching and non-teaching) the reason for smoking was either to relax or because of addiction, whereas the research scholars smoked to improve their image or for enjoyment/pleasure. The reasons given by users of other forms of tobacco were boredom, to pass the time or for no reason at all. Among non-users, the majority were aware of the harmful effects of smoking. Family pressure and traditions were also important reasons for not smoking. The study provides a clear picture of tobacco usage within the University.

10 of 17

TI: Magnesium status and risk of coronary artery disease in rural and urban populations with variable magnesium consumption.
AU: Singh-RB; Niaz-MA; Moshiri-M; Zheng-G; Zhu-S
AD: Centre of Nutrition and Heart Research Laboratory Medical Hospital and Research Centre, Moradabad, India.
SO: Magnes-Res. 1997 Sep; 10(3): 205-13
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: This survey was conducted to determine the association between amount of magnesium intake and prevalence of coronary artery disease (CAD) and coronary risk factors in north India. There were 3575 subjects aged 25-64 years including 1769 rural (894 men, 875 women) and 1806 urban (904 men, 902 women) subjects. The survey methods were questionnaires for 7-day food intake record, physical examination and electrocardiography using World Health Organization criteria. The overall prevalence of CAD was three-fold greater in urban compared to rural subjects (9.0 vs 3.3 per cent, $p < 0.001$). The prevalence of CAD was significantly higher among subjects consuming lower dietary magnesium. Lower magnesium status was inversely associated with risk of CAD in both rural and urban subjects in both sexes. Among subjects with low magnesium status, there was a higher prevalence of hypertension, hypercholesterolemia and diabetes mellitus showing a significant increasing trend with decrease in magnesium status. Multivariate logistic regression analysis after pooling of data from rural and urban subjects and after adjustment of age showed that magnesium intake had an inverse association with prevalence of CAD. Serum magnesium (odds ratio: men 1.14, women 1.05), dietary magnesium (men 1.21, women 1.12), serum cholesterol (men 1.15, women 1.15), blood pressure (1.26 men, women 1.21), diabetes mellitus (men 1.20, women 1.18) in both sexes and smoking in men (1.05) were significant risk factors of CAD. Lower consumption of dietary magnesium and low serum Mg level in north India have a higher

prevalence of CAD and of the coronary risk factors hypertension, hypercholesterclemia and diabetes mellitus. It is possible that increased intake of magnesium to about 500 mg/day may be of benefit in the prevention of CAD.

11 of 17

TI: The epidemiology of gestational trophoblastic disease.
AU: Di-Cintio-E; Parazzini-F; Rosa-C; Chatenoud-L; Benzi-G
AD: Istituto di Ricerche Farmacologiche Mario Negri, Milano, Italy.
SO: Gen-Diagn-Pathol. 1997 Nov; 143(2-3): 103-8
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Considerable progress has been made in the knowledge of the epidemiology of gestational trophoblastic disease (GTD) in the last few years. There are two main and widely known points related to this disease: its geographical distribution and the different frequency in the various classes of age. GTD is more frequent in South-East Asia, India and Africa, and is rare in European and North American populations. For example, in the United States, the frequency of GTD was 108 per 100,000 pregnancies in the 1970's. In Europe, particularly in Italy, frequencies are lower. In northern Italy, the frequency of hydatidiform mole, in the period 1979-1982, was equal to 62 per 100,000 pregnancies, but in Indonesia and in China, the reported rates were 793 and 667 per 100,000 pregnancies respectively. GTD disease is more frequent in the extreme classes of age (under 20 and over 40 years) and the risk may be more than 100 times greater over 50 years. Besides these risk factors, the possible role of both genetic (familiarity, blood groups) and environmental factors (diet, cigarette smoking, etc.) has been investigated on the onset of GTD. This paper reviews the epidemiologic knowledge on GTD.

12 of 17

TI: Tobacco sponsorship of Formula One motor racing [letter]
AU: Vaidya-SG; Vaidya-JS
SO: Lancet. 1998 Feb 7; 351(9100): 452
This source is Available in S.J.M.C Library
Call Number: From: 1930+
LA: ENGLISH

13 of 17

TI: Prevalence, detection, and management of cardiovascular risk factors in different ethnic groups in south London.
AU: Cappuccio-FP; Cook-DG; Atkinson-RW; Strazzullo-P
AD: Department of Medicine, St George's Hospital Medical School, London, UK. f.cappuccio@sghms.ac.uk
SO: Heart. 1997 Dec; 78(6): 555-63
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: OBJECTIVE: To assess the prevalence of cardiovascular risk factors and their level of detection and management in three ethnic groups. DESIGN: Population based survey during 1994 to 1996. SETTING: Former Wandsworth Health Authority in South London. SUBJECTS: 1578 men and women, aged 40 to 59 years; 524 white, 549 of African descent, and 505 of South Asian origin. MAIN OUTCOME MEASURES: Age adjusted prevalence of hypertension, diabetes, obesity, raised serum cholesterol, and smoking. RESULTS: Ethnic minorities of both sexes had raised prevalence rates of hypertension and diabetes compared to white people. Age and sex standardised prevalence ratios for hypertension were 2.6 (95% confidence interval 2.1 to 3.2) in people of African descent and 1.8 (1.4 to 2.3) in those of South Asian origin. For diabetes, the ratios were 2.7 (1.8 to 4.0) in people of African descent and 3.8 (2.6 to 5.6) in those of South Asian origin. Hypertension and diabetes were equally common among Caribbeans and West Africans and among South Asian Hindus and Muslims. Prevalence of severe obesity was high overall, but particularly among women of African descent (40% (35% to

45%)). In contrast, raised serum cholesterol and smoking rates were higher among white people. Of hypertensives, 49% (216 of 442) had adequate blood pressure control. Overall, 18% (80 of 442) of hypertensives and 33% (62 of 188) of diabetics were undetected before our survey. Hypertensive subjects of African descent appeared more likely to have been detected ($p = 0.034$) but less likely to be adequately managed ($p = 0.085$). CONCLUSIONS: Hypertension and diabetes are raised two- to threefold in South Asians, Caribbeans, and West Africans in Britain. Detection, management, and control of hypertension has improved, but there are still differences between ethnic groups. Obesity is above the Health of the Nation targets in all ethnic groups, particularly in women of African descent. Preventive and treatment strategies for different ethnic groups in Britain need to consider both cultural differences and underlying susceptibility to different vascular diseases.

14 of 17

TI: Prevalence of coronary artery disease and coronary risk factors in rural and urban populations of north India.
AU: Singh-RB; Sharma-JP; Rastogi-V; Raghuvanshi-RS; Moshiri-M; Verma-SP; Janus-ED
AD: Centre of Nutrition, Heart Research Laboratory, Medical Hospital and Research Centre, Moradabad, India.
SO: Eur-Heart-J. 1997 Nov; 18(11): 1728-35
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: OBJECTIVE: This study was conducted to determine and compare the prevalence of coronary artery disease and coronary risk factors in both a rural and an urban population of Moradabad in north India. DESIGN AND SETTING: A cross-sectional survey of two randomly selected villages from the Moradabad district and 20 randomly selected streets in the city of Moradabad. SUBJECTS AND METHODS: The 3575 subjects were between 25 and 64 years old; 1769 (894 men and 875 women) lived in the countryside and 1806 (904 men and 902 women) lived in the city. The survey methods were questionnaires, physical examination and electrocardiography. RESULTS: The overall prevalence of coronary artery disease, based on a clinical diagnosis and an electrocardiogram, was 9.0% in the urban and 3.3% in the rural population. The prevalences were significantly ($P < 0.001$) higher in the men compared with the women in both urban (11.0 vs 6.9%) and rural (3.9 vs 2.6%) populations, respectively. The prevalence of symptomatic coronary artery disease (known coronary disease and Rose questionnaire-positive angina) was 2.3% in the men ($n = 19$) and 1.5% in the women ($n = 13$) in the rural subjects, and 8.5% in the men ($n = 77$) and 3.4% in the women ($n = 31$) in the urban population. When diagnosed on the basis of electrocardiographic changes alone, the prevalences were 1.5% ($n = 26$) in the rural population and 3.0% ($n = 55$) in the urban. Coronary risk factors were two- or three-fold more common among urban subjects compared to the rural population in both sexes. Central obesity was four times more common in the urban population compared to the rural in both sexes. Sedentary lifestyle and alcohol intake were significantly ($P < 0.01$) higher in the urban population compared to the rural subjects. There was a significant association between coronary disease and age, hypercholesterolaemia, hypertension and central obesity in both sexes. Smoking was a significant risk factor of coronary disease in men. CONCLUSIONS: Coronary artery disease and coronary risk factors were two or three times higher among the urban compared with the rural subjects, which may be due to greater sedentary behaviour and alcohol intake among urbans. It is possible that some Indian populations can benefit by reducing serum cholesterol, blood pressure and central obesity and increasing physical activity.

15 of 17

TI: Relation of fetal growth to adult lung function in south India.
AU: Stein-CE; Kumaran-K; Fall-CH; Shaheen-SO; Osmond-C; Barker-DJ
AD: MRC Environmental Epidemiology Unit, Southampton General Hospital, UK.

SO: Thorax. 1997 Oct; 52(10): 895-9
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: BACKGROUND: Follow up studies in Britain have shown that low rates of fetal growth are followed by reduced lung function in adult life, independent of smoking and social class. It is suggested that fetal adaptations to undernutrition in utero result in permanent changes in lung structure, which in turn lead to chronic airflow obstruction. India has high rates of intrauterine growth retardation, but no study has examined the association between fetal growth and adult lung function in Indian people. We have related size at birth to lung function in an urban Indian population aged 38-59 years. METHODS: Two hundred and eighty six men and women born in one hospital in Mysore City, South India, during 1934-1953 were traced by a house-to-house survey of the city. Their mean forced expiratory volume in one second (FEV1) and forced vital capacity (FVC) were measured using a turbine spirometer. These measurements were linked to their size at birth, recorded at the time. RESULTS: In both men and women mean FEV1 fell with decreasing birthweight. Adjusted for age and height, it fell by 0.09 litres with each pound (454 g) decrease in birthweight in men (95% confidence interval (CI) 0.01 to 0.16) and by 0.06 (95% CI -0.01 to 0.13) in women. Likewise, mean FVC fell by 0.11 litres (95% CI 0.02 to 0.19) with each pound decrease in birthweight in men, and by 0.08 litres (95% CI 0.002 to 0.16) in women. FEV1 and FVC were lower in men who smoked, but the associations with size at birth were independent of smoking. Small head circumference at birth was associated with a low FEV1/FVC ratio in men which may reflect restriction in airway growth in early gestation. CONCLUSION: This is further evidence that adult lung function is "programmed" in fetal life. Smoking may be particularly detrimental to the lung function of populations already disadvantaged by poor rates of fetal growth.

TI: Vasectomy and prostate cancer: a case-control study in India.
AU: Platz-EA; Yeole-BB; Cho-E; Jussawalla-DJ; Giovannucci-E; Ascherio-A
AD: Department of Epidemiology, Harvard School of Public Health, Boston, MA, USA.
SO: Int-J-Epidemiol. 1997 Oct; 26(5): 933-8
This source is Available only few issues in S.J.M.C. Library
LA: ENGLISH
AB: BACKGROUND: The role of vasectomy in the development of prostate cancer remains controversial. In particular, there has been concern about detection bias and confounding in the previously published epidemiological studies examining this hypothesis. With the goal of minimizing detection bias, we have evaluated the relation between vasectomy and prostate cancer in a population without routine prostate cancer screening. METHODS: A case-control study consisting of 175 prostate cancer cases and 978 controls with cancer diagnoses other than prostate cancer was conducted at hospitals covered by the Bombay Cancer Registry in Bombay, India. History of vasectomy, demographic, and lifestyle factors were obtained by structured interview. Multiple logistic regression was used to estimate odds ratios (OR) and 95% confidence intervals (CI). RESULTS: Standardizing by age, 8.7% of cases and 8.3% of controls had had a vasectomy. The OR for prostate cancer comparing men who had had a vasectomy to those who did not was 1.48 (95% CI: 0.80-2.72) controlling for age at diagnosis, smoking status, alcohol drinking, and other demographic and lifestyle factors. Risk of prostate cancer associated with vasectomy appeared to be higher among men who underwent vasectomy at least two decades prior to cancer diagnosis or who were at least 40 years old at vasectomy. CONCLUSIONS: Although not statistically significant, the results of this hospital-based case-control study are consistent with the hypothesis of a positive association between vasectomy and prostate cancer. Because routine prostate cancer screening is not common in this population, detection bias was unlikely to account for this association.

TI: Strokes in the elderly: prevalence, risk factors & the strategies for prevention.

AU: Dalal-PM

AD: Department of Neuroscience, Medical Research Centre Lilavati Hospital, Mumbai.

SO: Indian-J-Med-Res. 1997 Oct; 106: 325-32

LA: ENGLISH

AB: Current demographic trends suggest that the Indian population will survive through the peak years of occurrence of stroke (age 55-65 yr) and stroke-survivors in the elderly with varying degree of residual disability, will be a major medical problem. The available data from community surveys from different regions of India for 'hemiplegia' presumed to be of vascular origin indicate a crude prevalence rate in the range of 200 per 100,000 persons. Thus, the anticipated costs of rehabilitation of stroke-victims will pose enormous socio-economic burden on our meagre health-care resources, similar to what is now faced by industrialised nations in the West. Therefore, prevention of strokes at any age should be our main strategy in national health planning. Among all risk factors for strokes, hypertension is one of the most important and treatable factor. Community screening surveys, by well defined WHO protocol, have shown that nearly 15 per cent of the urban population is 'hypertensive' (160/95 mm Hg or more). Though high blood pressure has the highest attributable risk for stroke, there are many reasons such as patient's compliance in taking medicines and poor follow up in clinical practice that may lead to failure in reducing stroke mortality. In subjects who have transient ischaemic attacks (TIAs), regular use of antiplatelet agents like aspirin in prevention of stroke is well established. It is also mandatory to prohibit tobacco use and adjust dietary habits to control body weight, and associated conditions like diabetes mellitus etc., should be treated. It is advisable to initiate community screening surveys on well defined populations for early detection of hypertension and TIAs. Primary health care centres should be the base-stations for these surveys because data gathered from urban hospitals will not truly reflect the crude prevalence rates for the community to design practical prevention programmes.

1 of 5

TI: Serum cholesterol and coronary artery disease in populations with low cholesterol levels: the Indian paradox.
AU: Singh-RB; Rastogi-V; Niaz-MA; Ghosh-S; Sy-RG; Janus-ED
AD: Heart Research Laboratory and Centre of Nutrition, Medical Hospital and Research Centre, Moradabad, India.
SO: Int-J-Cardiol. 1998 Jun 1; 65(1): 81-90
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: OBJECTIVE: To examine the relation between serum cholesterol and coronary artery disease prevalence below the range of cholesterol values generally observed in developed countries. DESIGN AND SETTING: Cross-sectional survey of two randomly selected villages from Moradabad district and 20 randomly selected streets in the city of Moradabad. SUBJECTS AND METHODS: 3575 Indians, aged 25-64 years including 1769 rural (894 men, 875 women) and 1806 urban (904 men, 902 women) subjects. The survey methods were questionnaires, physical examination and electrocardiography. RESULTS: The overall prevalences of coronary artery disease were 9.0% in urban and 3.3% in rural subjects and the prevalences were significantly (P<0.001) higher in men compared to women in both urban (11.0 vs. 6.9%) and rural subjects (3.9 vs. 2.6%). The average serum cholesterol concentrations were 4.91 mmol/l in urban and 4.22 mmol/l in rural subjects without any sex differences. The prevalences of coronary artery disease were significantly higher among subjects with low and high serum cholesterol concentration compared to subjects with very low cholesterol and showed a positive relation with serum cholesterol within the range of serum cholesterol level studied in both rural and urban in both sexes. Among subjects with low serum cholesterol, there was a higher prevalence of coronary risk factors, hypertension, diabetes, obesity and sedentary lifestyle. Serum cholesterol level showed a significant positive relation with low density lipoprotein cholesterol and triglycerides in all the four subgroups. Logistic regression analysis after pooling of data from both rural and urban, with adjustment of age showed that low serum cholesterol level (odds ratio: men 0.96, women 0.91) had a positive strong relation with coronary artery disease and there was no evidence of any threshold. Diabetes mellitus (men 0.73, women 0.74) and sedentary lifestyle (men 0.86, women 0.74) were significant risk factors of coronary disease in both sexes. Hypertension (men 0.82, women 0.64) and smoking (men 0.81, women 0.52) were weakly associated with coronary disease in men but not in women. CONCLUSION: Serum cholesterol level was directly related to prevalence of coronary artery disease even in those with low cholesterol concentration (<5.18 mmol/l). It is possible that some Indian populations may benefit by increased physical activity and decline in serum cholesterol below the range of desired serum cholesterol in developed countries.

2 of 5

TI: Social class and coronary artery disease in a urban population of North India in the Indian Lifestyle and Heart Study.
AU: Singh-RB; Niaz-MA; Thakur-AS; Janus-ED; Moshiri-M
AD: Centre of Nutrition, Medical Hospital and Research Centre, Moradabad-10, India.
SO: Int-J-Cardiol. 1998 Apr 1; 64(2): 195-203
this source is not Available in S.J.M.C.Library
LA: ENGLISH

AB: OBJECTIVE: To determine the association of social class with prevalence of coronary risk factors and coronary artery disease (CAD). DESIGN AND SETTING: Total community cross sectional survey of 20 randomly selected streets in the city of Moradabad. SUBJECTS AND METHODS: 1806 urban (904 men and 902 women) randomly selected subjects aged 25-64 years. The survey methods were physician and dietitian administered questionnaire, physical examination and electrocardiography. All subjects were divided into social classes 1-5 based on attributes of education, occupation, per capita income, housing condition and consumer durables and other family assets. RESULTS: Social classes 1, 2 and 3 were mainly high and middle socioeconomic groups and 3 and 4 low income groups. The prevalence of CAD and coronary risk factors hypercholesterolemia, hypertension, diabetes mellitus and sedentary lifestyle were significantly higher among social classes 1, 2 and 3 in both sexes compared to lower social classes. Mean serum cholesterol, triglycerides, low density lipoprotein cholesterol and blood pressure were significantly associated with higher and middle social classes. Smoking was significantly associated with lower social classes. Multivariate logistic regression analysis after adjustment of age revealed that social class was positively associated with CAD (odds ratio: men 0.84, women 0.86), hypercholesterolemia (men 0.87, women 0.85), hypertension (men 0.91, women 0.89), diabetes mellitus (men 0.71, women 0.68) and sedentary lifestyle (men 0.68, women 0.66). Smoking was significantly associated with CAD in men. CONCLUSION: Social class 1, 2 and 3 in an urban population of India have a higher prevalence of CAD and coronary risk factors hypercholesterolemia, hypertension, diabetes mellitus and sedentary lifestyle in both sexes.

3 of 5

TI: Oral submucous fibrosis in India: a new epidemic?
AU: Gupta-PC; Sinor-PN; Bhonsle-RB; Pawar-VS; Mehta-HC
AD: Tata Institute of Fundamental Research, Maharashtra, India.
SO: Natl-Med-J-India. 1998 May-Jun; 11(3): 113-6
This source is Available in S.J.M.C Library
Call Number: From: 1988+
LA: ENGLISH
AB: BACKGROUND: Oral submucous fibrosis (OSF) is a precancerous condition caused by use of the areca nut. The reported prevalence of OSF in Bhavnagar district during 1967 was 0.16%. We investigated whether the impression of an increase in the incidence of the disease was real. METHODS: A house-to-house survey was conducted in Bhavnagar district, Gujarat state. The use of areca nut-containing products and tobacco was assessed through an interviewer administered questionnaire. The oral examination was done by dentists. The diagnostic criteria for OSF was the presence of palpable fibrous bands. RESULTS: A total of 11,262 men and 10,590 women aged 15 years and older were interviewed for their tobacco habits. Among 5018 men who reported the use of tobacco or areca nut, 164 were diagnosed as suffering from OSF. All but four cases were diagnosed among 1786 current areca nut users (age-adjusted relative risk: 60.6). Areca nut was used mostly in mawa, a mixture of tobacco, lime and areca nut, and 10.9% of mawa users had OSF (age-adjusted relative risk: 75.6). The disease as well as areca nut use was concentrated (about 85%) in the lower (< 35 years) age group. CONCLUSIONS: An increase in the prevalence of OSF, especially in the lower age groups, directly attributable to the use of areca nut products was observed. This could lead to an increase in the incidence of oral cancer in the future.

4 of 5

TI: Low birth weight and associated maternal factors in an urban area.
AU: Deshmukh-JS; Motghare-DD; Zodpey-SP; Wadhva-SK
AD: Department of Preventive and Social Medicine, Government Medical College, Nagpur.
SO: Indian-Pediatr. 1998 Jan; 35(1): 33-6
This source is Available in S.J.M.C Library

Call Number: From: 1969+
LA: ENGLISH
AB: OBJECTIVE: To study the prevalence of low birth weight (LBW) and its association with maternal factors. DESIGN: Cohort study. SETTING: Urban community. SUBJECTS: Cohort of 210 pregnant women. RESULTS: The LBW prevalence was 30.3%. On multivariate analyses the maternal factors significantly associated with LBW were anemia (OR-4.81), low socioeconomic status (OR-3.96), short birth interval (OR-3.84), tobacco exposure (OR-3.14), height (OR-2.78), maternal age (OR-2.68), body mass index (OR-2.02), and primiparity (OR 1.58). CONCLUSIONS: Anemia, low socioeconomic status, short stature, short birth interval. Tobacco exposure, low maternal age, low body mass index, and primiparity are significantly risk factors for LBW.

5 of 5
TI: Prevalence of respiratory symptoms, bronchial hyperreactivity, and asthma in a megacity. Results of the European community respiratory health survey in Mumbai (Bombay).
AU: Chowgule-RV; Shetye-VM; Parmar-JR; Bhosale-AM; Khandagale-MR; Phalnitkar-SV; Gupta-PC
AD: Department of Chest Medicine, Bombay Hospital Institute of Medical Sciences and Tata Institute of Fundamental Research, Mumbai, India.
SO: Am-J-Respir-Crit-Care-Med. 1998 Aug; 158(2): 547-54
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: To estimate adult asthma prevalence in the world's most rapidly growing mega-city, we applied epidemiologic surveillance tools, as a cooperating center of the European Community Respiratory Health Survey, to a randomly selected sample of Mumbai (Bombay) residents in 1992 through 1995. From a metropolitan population of over 10 million, we took a one-in-ten random sample from electoral rolls in a socially diverse residential district, and examined asthma symptoms in adults age 20 to 44 yr. In Phase I, we interviewed 2,313 adults about symptoms, asthma diagnosis, and medications in the previous 12 mo. In Phase II, family and smoking history, socioeconomic data, housing characteristics, serum IgE, allergy skin tests, spirometry, and methacholine challenge tests were obtained in a subset of 20% of those who had completed Phase I. House dust mite was the most common positive skin test (18% prevalence) and the only one of the nine applied that was significantly associated with asthma symptoms and physician-diagnosed asthma. Asthma prevalence was 3.5% by physician diagnosis, and 17% using a very broad definition including those with asymptomatic bronchial hyperreactivity. Asthma prevalence was strongly associated with positive house dust mite skin test, family history of asthma, and total IgE.

1 of 7

TI: Alcohol as an additional risk factor in laryngopharyngeal cancer in Mumbai--a case-control study.
AU: Rao-DN; Desai-PB; Ganesh-B
AD: Division of Epidemiology and Biostatistics, Parel, Mumbai, India.
SO: Cancer-Detect-Prev. 1999; 23(1): 37-44
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: A retrospective case-control study of 1698 male pharyngeal and laryngeal cancers seen at the Tata Memorial Hospital, Mumbai from 1980 to 1984 was undertaken to assess the association between the cancers and chewing, smoking, and alcohol habits. Male controls were chosen from persons who attended the hospital during the same period and who were diagnosed as free from cancer, benign tumor, and infectious disease. Statistical analysis was based on unconditional logistic regression method. Bidi smoking and alcohol drinking emerged as significant factors for pharyngeal and laryngeal cancers. Illiterates had 50 to 60% excess risk for pharyngeal cancer only. Nonvegetarian diet did not emerge as significant factor in our study.

2 of 7

TI: Dietary factors in oral leukoplakia and submucous fibrosis in a population-based case control study in Gujarat, India.
AU: Gupta-PC; Hebert-JR; Bhonsle-RB; Sinor-PN; Mehta-H; Mehta-FS
AD: Epidemiology Research Unit, Tata Institute of Fundamental Research, Bombay, India.
SO: Oral-Dis. 1998 Sep; 4(3): 200-6
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: OBJECTIVES: To investigate the relationship of specific nutrients and food items with oral precancerous lesions among tobacco users. DESIGN: A population-based case-control study. SETTING: Villages in Palitana taluk of Bhavnagar district, Gujarat, India. SUBJECTS AND METHODS: An interviewer-administered food frequency questionnaire, developed and validated for this population, was used to estimate nutrient intake in blinded, house-to-house interviews. Among 5018 male tobacco users, 318 were diagnosed as cases. An equal number of controls matched on age (+/- 5 years), sex, village, and use of tobacco were selected. MAIN OUTCOME MEASURES: Odds ratios (OR) from multiple logistic regression analysis controlling for relevant variables (type of tobacco use and economic status). RESULTS: A protective effect of fibre was observed for both oral submucous fibrosis (OSF) and leukoplakia, with 10% reduction in risk per g day-1 ($P < 0.05$). Ascorbic acid appeared to be protective against leukoplakia with the halving of risk in the two highest quartiles of intake (versus the lowest quartile: OR = 0.46 and 0.44, respectively; $P < 0.10$). A protective effect of tomato consumption was observed in leukoplakia and a suggestion of a protective effect of wheat in OSF. CONCLUSION: In addition to tobacco use, intake of specific nutrients may have a role in the development of oral precancerous lesions.

3 of 7

TI: Drug abuse in Nepal: a rapid assessment study.
AU: Chatterjee-A; Uprety-L; Chapagain-N; Kafle-K
AD: University of California at Los Angeles, Fogarty International Training Program, School of Public Health, Department of Epidemiology, USA.

~~PH-6~~
PH-6.

SO: Bull-Narc. 1998; 48(1-2): 11-33
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: A rapid assessment of drug abuse in Nepal was conducted at different sites, including eight municipalities in the five development regions of the country. To interview various groups of key informants, such methods as semi-structured interviews, in-depth interviews and focus group discussions were used. A snowball sampling strategy for respondents who were drug abusers and a judgemental sampling strategy for the non-drug-using key informants were applied. About one fifth of the sample was recruited from the treatment centres and the rest from the community. Drug abusers in prison were interviewed, and secondary data from treatment centres and prisons analysed. The study revealed that the sample of drug abusers had a mean age of 23.8 years and was overwhelmingly male. Most respondents lived with their families and were either unemployed or students. About 30 per cent of the sample was married. A large majority of the sample had a family member or a close relative outside the immediate family who smoked or drank alcohol and a friend who smoked, drank or used illicit drugs. Apart from tobacco and alcohol, the major drugs of abuse were cannabis, codeine-containing cough syrup, nitrazepam tablets, buprenor-phine injections and heroin (usually smoked, rarely injected). The commonest sources of drugs were other drug-using friends, cross-border supplies from India or medicine shops. The commonest source of drug money was the family. There has been a clear trend towards the injection of buprenorphine by abusers who smoke heroin or drink codeine cough syrup. The reasons cited for switching to injections were the unavailability and rising cost of non-injectable drugs and the easy availability and relative cheapness of injectables. About a half of the injecting drug users (IDUs) commonly reported sharing injecting equipment inadequately cleaned with water. Over a half of IDUs reported visiting needle-exchange programmes at two of the study sites where such programmes were available. Infection by the human immunodeficiency virus (HIV) appears to be low among IDUs, although systematic surveillance is absent. Two thirds of the sample had experienced sexual intercourse. The last sex partners reported by respondents were commercial sex workers, wives or girl friends. Condom use was low with primary partners and relatively high with sex workers. Treatment facilities, mostly located in the central urban areas of the country, are meagre. An overwhelming majority of drug abusers felt the need to stop abusing drugs. Cost-effective drug treatment and HIV prevention programmes for IDUs are urgently needed in all areas of the country.

4 of 7

TI: Head and neck cancer: a global perspective on epidemiology and prognosis.
AU: Sankaranarayanan-R; Nasuyer-E; Swaminathan-R; Ferlay-J; Whelan-S
AD: Unit of Descriptive Epidemiology International Agency for Research on Cancer 150, Lyon, France.
SO: Anticancer-Res. 1998 Nov-Dec; 18(6B): 4779-86
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Head and neck cancers (ICD-9 categories 140-149 and 161) are common in several regions of the world where tobacco use and alcohol consumption is high. The age standardized incidence rate of head and neck cancer (around 1990) in males exceeds 30/100, 000 in regions of France, Hong Kong, the Indian sub-continent, Central and Eastern Europe, Spain, Italy, Brazil, and among US blacks. High rates (> 10/100,000) in females are found in the Indian sub-continent, Hong Kong and Philippines. The highest incidence rate reported in males is 63.58 (France, Bas-Rhin) and in females 15.97 (India, Madras). The variation in incidence of cancers by subsite of head and neck is mostly related to the relative distribution of major risk factors such as tobacco or betel quid chewing, cigarette or bidi smoking, and alcohol consumption. Some degree of misclassification by subsites is a clear possibility in view of the close proximity of the anatomical subsites. While mouth and tongue cancers are more common in the Indian sub-continent, nasopharyngeal cancer is more common in

Hong Kong; pharyngeal and/or laryngeal cancers are more common in other populations. While the overall incidence rates show a declining trend in both sexes in India, Hong Kong, Brazil and US whites, an increasing trend is observed in most other populations, particularly in Central and Eastern Europe, Scandinavia, Canada, Japan and Australia. The overall trends are a reflection of underlying trends in cancers of major subsites which seem to be related to the changing prevalence of risk factors. The five year relative survival varies from 20-90% depending upon the subsite of origin and the clinical extent of disease. While primary prevention is the potential strategy for long term disease control, early detection and treatment may have limited potential to improve mortality in the short term.

5 of 7

TI: Acute respiratory disease survey in Tripura in case of children below five years of age.
AU: Deb-SK
AD: Department of Paediatrics, IGM Hospital, Agartala.
SO: J-Indian-Med-Assoc. 1998 Apr; 96(4): 111-6
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: This epidemiological study has been carried out in urban and rural areas of West Tripura district, to determine the incidence, causes, risk factors, morbidity and mortality associated with acute respiratory infection (ARI) and impact of simple case management in children under 5 years of age. The annual attack rate (episode) per child was more in urban area than in rural area. Monthly incidence of ARI was 23% in urban area, 17.65% in rural area. The overall incidence of ARI was 20%. The incidence of pneumonia was 16 per 1000 children in urban area and 5 per 1000 in rural area. The incidence of pneumonia was found to be the highest in infant group; 3% of ARI cases in rural area and 7% in urban area developed pneumonia. Malnourishment in urban area was 34% and in rural area 65%. Malnourished children have higher likelihood for developing respiratory infection. The relative risk (RR) of developing pneumonia was 2.3 in malnourished children. Most children (59%) had been immunised with measles and diphtheria, pertussis and tetanus (DPT) vaccine earlier. The immunisation had a protective role in pneumonia. The RR was 2.7 in non-immunised group. Air pollution of the urban area had stronger relation for bronchial asthma than pneumonia. Breastfeeding had protective role in pneumonia and severe disease. Bottlefeeding had greater risk of developing pneumonia. Lower socio-economic status had the greater risk of ARI episodes. ARI was decreased as the per capita income increased. An increase in magnitude of ARI was observed with the decrease of literacy rate. Administration of co-trimoxazole for pneumonia case by trained health worker using simple case management strategies can reduce deaths from pneumonia significantly. Health education can change health care seeking behaviours and attitude of parents and other family members to take care of the ARI child in the home itself for preventing pneumonia death.

6 of 7

TI: Risk assessment of tobacco, alcohol and diet in cancers of base tongue and oral tongue--a case control study.
AU: Rao-DN; Desai-PB
AD: Division of Epidemiology and Biostastistics, Tata Memorial Hospital, Parel, Mumbai, India.
SO: Indian-J-Cancer. 1998 Jun; 35(2): 65-72
This source is Available in S.J.M.C Library
Call Number: From: 1963+
LA: ENGLISH
AB: This is a retrospective case-control study of male tongue cancer patients seen at Tata memorial Hospital, Bombay, during the years 1980-84. The purpose of the study was to identify the association of tobacco, alcohol, diet and literacy status with respect to cancers of two sub sites of tongue namely anterior portion of the tongue (AT) (ICD 1411-1414) and base of the tongue (BT)

PH-6.

Tob Control 1998;7:397-408 (Winter)

Special communication

Tobacco control advocates must demand high-quality media campaigns: the California experience

Edith D Balbach, Stanton A Glantz

Institute for Health Policy Studies, University of California at San Francisco, San Francisco, California, USA

Correspondence to: Dr ED Balbach, Community Health Program, Tufts University, 112 Packard Avenue, Medford, Massachusetts 02155, USA; ebalba01@emerald.tufts.edu

Abstract

OBJECTIVE—To document efforts on the part of public officials in California to soften the **media** campaign's attack on the tobacco industry and to analyse strategies to counter those efforts on the part of tobacco control advocates.
METHODS—Data were gathered from interviews with programme participants, direct observation, written materials, and **media** stories. In addition, internal documents were released by the state's Department of Health Services in response to requests made under the California Public Records Act by Americans for Nonsmokers' Rights. Finally, a draft of the paper was circulated to 11 key players for their comments.
RESULTS—In 1988 California voters enacted Proposition 99, an initiative that raised the tobacco tax by $0.25 and allocated 20% of the revenues to anti-tobacco education. A **media** campaign, which was part of the education programme, directly attacked the tobacco industry, exposing the **media** campaign to politically based efforts to shut it down or soften it. Through use of outsider strategies such as advertising, press conferences, and public meetings, programme advocates were able to counter the efforts to soften the campaign.
CONCLUSION—Anti-tobacco **media** campaigns that expose industry manipulation are a key component of an effective tobacco control programme. The effectiveness of these campaigns, however, makes them a target for elimination by the tobacco industry. The experience from California demonstrates the need for continuing, aggressive intervention by non-governmental organisations in order to maintain the quality of anti-tobacco **media** campaigns.
(*Tobacco Control* 1998;7:397-408)

Keywords: **media** campaigns; anti-tobacco **advocacy**; California

Introduction

In 1988 California voters enacted Proposition 99, an initiative that raised the tobacco tax by $0.25 and allocated 20% of the revenues to anti-tobacco education.[1] In its first years, this dedicated tax generated over $100 million per year for anti-tobacco education, making it the largest tobacco control programme in the world.[2] For the supporters of the Proposition 99 education programmes, however, the passing of the initiative was just the first step in securing a strong anti-tobacco education programme; the legislature still had to appropriate the money to the programme and the administration had to implement it. In the first authorising legislation—Assembly Bill 75 (AB75)—the tobacco industry tried to prevent any of the education money from being spent on an anti-tobacco **media** campaign, but it failed, due to the obvious and heavy-handed tactics it used to influence the legislature and the nearness of the election.[2,3]

The California Department of Health Services (DHS), one of the agencies charged with programme implementation under AB75, envisioned delivering an aggressive anti-tobacco programme that combined statewide **media** with local community-based activities.[4,5] Under Governor George Deukmejian (Republican), DHS moved quickly to implement the **media** campaign. The Request for Proposals was released on 1 December 1989, 59 days after Deukmejian signed the appropriations bill, with responses from advertising agencies due on 10 January 1990. The advertising agency keye/donna/perlstein was selected to run the **media** campaign on 26 January,[6] and the first advertisements were released 73 days later, on 10 April 1990,[7] accompanied by a full-page newspaper advertisement on 11 April 1990 (figure 1 and box).

The Proposition 99 **media** campaign took a substantially different approach than previous anti-tobacco education campaigns had. As recounted by Paul Keye, one of the principals in the advertising firm:

> "The cigarette companies were never in any of the advertising agency's original thoughts or conversations with the Department of Health Services. You can't find the topic in our first work. . . . What happened was that—as we dug into each topic—there, right in the middle of everything were the Smokefolk, making their quaint, nonsensical arguments and—by sheer weight of wealth and power and privilege—getting away with it. . . . Frankly, the tobacco industry pissed us off. They insulted our intelligence."[8]

So, instead of traditional public health messages that "tobacco is bad for you", Keye started the campaign on the tack of directly attacking the tobacco industry, a strategy that DHS soon adopted and advocated.[3,8] The aggressive tone of the **media** campaign is credited with contributing to a tripling of the rate of decline of tobacco consumption in California.[9-11]

First, the smoke. Now, the mirrors.

In less than a generation, the bad news about cigarettes has become no news. Most Americans —even the very young—know the unavoidable connection between smoking and cancer, smoking and heart disease, smoking and emphysema and strokes.

Today a surprising number of us can tell you that cigarettes are our #1 preventable cause of death and disability.

So, we seem to know about the smoke. But what about the really dangerous stuff—all those carefully polished, fatal illusions the tobacco industry has crafted to mess with our minds so they can mess with our lives?

"Smoking is important. It makes you beautiful and fun and sexy. (Okay, it's dangerous. But lots of exciting things are dangerous.) Smoking makes you powerful. It says you're sensitive and grown up."

That's one hell of a message. How can you fight it?

Today, the California Department of Health Services begins a fifteen month advertising campaign that goes right at the tobacco companies' predatory marketing—the selective exploitation of minorities, the seduction of the young, the selling of suicide.

Well, won't the tobacco industry fight this campaign?

Sure. The smokescreen has already begun. *"This effort pits smokers against non-smokers."*

Wrong. This program would have never happened without the active support of California's smokers. Despite their habit, or maybe because of it, they wanted people to know the truth about addiction and discomfort and disease and death. (Ask smokers if they want their children to smoke. Or their grandchildren. Ask them if they'd start smoking if they could have the decision back.)

"This is a threat to our First Amendment right to advertise a legal product."

On the contrary, we intend to make you more aware of the tobacco industry's advertising. And, if we pinch the right nerve, we expect them to make you more aware of ours.

This is going to be a **media** campaign about a **media** campaign—as much about hype as hygiene. It's going to talk about a shared community opportunity and a shared community menace.

There's never been anything quite like it. But this is California. We don't need to do it the way it was done before.

CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Figure 1 A copy of the full-page advertisement that ran in newspapers to mark the advent of the **media** campaign, along with a reproduction of the text from the ad.

The first television advertisement, "Industry Spokesman" (figure 2), portrayed tobacco industry executives discussing the need to hook kids on tobacco, while laughing that, "We're not in this for our health". These advertisements generated major controversy, with the tobacco industry complaining publicly that it was inappropriate for government to attack a legal business.[12]

View larger version (110K):
[in this window]
[in a new window]

Figure 2 The first advertisement in the California campaign, "Industry Spokesman," depicted a group of tobacco industry executives sitting around a boardroom joking about recruiting new smokers. Despite being the advertisement with the highest recall in the California programme, the Wilson administration refused to air it.

The internal response of the tobacco industry was immediate. By 18 April 1990, Samuel D Chilcote Jr, president of The Tobacco Institute, the Washington-based lobbying organisation for the tobacco industry, sent out a memo to members of his executive committee, providing a "further update on our efforts to deal with the anti-smoking advertising campaign in California". The Tobacco Institute outlined a four-part strategy for dealing with the **media** campaign. The first part was to encourage the California legislature to intervene, the second part was to cooperate with other groups to encourage them to oppose the campaign, the third was to convince Ken Kizer, the DHS director, to "pull or modify" the advertisements, and fourth was to encourage the governor to intercede against the campaign. Because the Institute believed that Kizer would not modify the advertisements without pressure from the administration and because Deukmejian, as a lame-duck governor, was unlikely to pressure Kizer, it concluded: "It is clear that our efforts should center on the first two strategies".[13]

Since its inception, the **media** campaign has remained the source of controversy, with California tobacco control advocates working to maintain an aggressive tone and the tobacco industry and its allies seeking to soften the tone and limit the scope of the campaign. These issues marked the debate over the **media** campaign in 1996-1997. As this paper will document, while health groups succeeded in stopping the explicit legislative restrictions against attacking the tobacco industry that the pro-tobacco forces tried to include in the Budget Act, decisions and processes by the administration of Governor Pete Wilson, who had succeeded Deukmejian, tried to achieve the same goals. Eventually, by mounting outside pressure on the administration, public

View larger version (64K):
[in this window]
[in a new window]

health groups were able to push the **media** campaign back towards its original posture. The experience from California demonstrates the need for continuing, aggressive intervention by non-governmental organisations to maintain the quality of anti-tobacco **media** campaigns.

Methods

The information used to prepare this report was gathered from interviews with the participants, direct observation, written correspondence, and **media** stories. Where **media** stories have been based on California Public Records Act requests, we have also obtained the documentation on which the storied were based to verify the accuracy of the reported information.

In addition, internal documents about the 1996-1997 **media** campaign were released by the Department of Health Services in response to requests made under the California Public Records Act by Americans for Nonsmokers' Rights. These materials document the internal response to the events occurring outside of the Department. Finally, a draft of the paper was circulated to 11 observers of the 1996-1997 conflict for their comments.

Early controversies over the media campaign

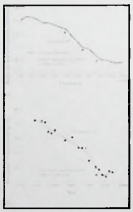
The flexibility the **media** campaign enjoyed under Deukmejian dissipated with the inauguration of Pete Wilson (R) as governor in January, 1991. Deukmejian had taken a "hands off" policy with regard to the development and production of the advertisements, leaving the control of the campaign in the hands of the professionals in the Department of Health Services.[14] [15] According to Kizer, once Wilson became governor, there were comments from Wilson's office that they wanted the subsequent advertisements toned down and wanted to review them.[15] Wilson eventually attempted to shut the **media** campaign down completely and, failing that, imposed increasingly tight political control over it.

Wilson's first overtly hostile action toward the **media** campaign was to attempt to end it entirely. In his budget proposal of 10 January 1992, Governor Wilson suspended the **media** campaign by diverting all of its funding for the current and subsequent fiscal years, claiming that it was of "secondary" importance.[16] Dr Molly Joel Coye, who had replaced Kizer as the director of the Department of Health Services, and Betsy Hite, departmental spokeswoman, claimed that the local programmes funded by Proposition 99 were a more effective use of resources and that the smoking decrease that followed the beginning of the **media** campaign was actually part of a trend that began in 1987, rather than the result of the anti-smoking advertising campaign.[17] [18] [19] The move was supported by the tobacco industry,[20] which had planned as early as 1990 to work with a variety of minority groups, the hospital groups, the California Medical Association, and business groups to divert money from the **media** account into other health programmes.[13]

The claims that the **media** campaign was unimportant or ineffective were contradicted a few days later, on 14 January 1992, when John Pierce, a professor from the University of California at San Diego and director of the California Tobacco Survey (which is done under contract to DHS), speaking at the American Heart Association Science Writers Conference, released preliminary data from the survey. The data demonstrated a 17% drop in the percentage of adults who smoked since Proposition 99 passed, and Pierce attributed this drop to the combined effects of the tax, educational efforts, and the **media** campaign.[21] [22]

Rather than claiming credit for this success, the administration attacked Pierce's result, asserting that the conclusions were overstated.[17] [23] [24] Hite pressured staff members in the DHS Tobacco Control Section (TCS) to provide data to show that the tobacco control programmes were ineffective. Hite specifically told Jacquolyn Duerr, then head of the **media** campaign, to back up Hite's assertion that the rapid decline in smoking had nothing to do with Proposition 99. Duerr and Michael Johnson, the head of the DHS's evaluation efforts, and Pierce's contract monitor, refused to comply. (Hite's activities did not come to light until December 1996.)[25] [26]

Wilson and Coye, however, refused to issue the contract of 1 January 1992 to the advertising agency to continue the **media** campaign, which shut the campaign down im**media**tely.[27] [28] Although the local programme efforts kept the tobacco control programme moving forward,[8] during the time the **media** campaign was suspended, the decline in tobacco consumption did slow[11] (figure 3) . The American Lung Association sued successfully to restore the **media** campaign,[29] [30] and the administration was required to sign the contract with the advertising agency for the period 20 May 1992 to 30 June 1993.[31]



View larger version (17K):
[in this window]
[in a new window]

Figure 3 Long-term patterns of cigarette consumption in California show that when the **media** (and other aspects of the tobacco control programme) were suspended or weakened, the progress in reducing cigarette use was arrested.

In the fiscal years, 1994-95 and 1995-96, the legislature continued to allocate money—nearly $12 million annually—to the **media** campaign. The allocation of money, however, did not ensure that a quality programme would result or even that the money would necessarily be spent. There was little new anti-tobacco advertising produced during that period, and none at all between September 1995 and 20 March 1997. In 1995-1996, the Wilson administration only spent $6.5 million of the $12.2 million the legislature appropriated for the **media** campaign. This weakening of the **media** campaign, in content and intensity, was associated with a lessening of the effect of the overall anti-tobacco programme on tobacco consumption and an increase in adult smoking prevalence[11] (figure 3).

There was also growing political control and controversy over the content of the campaign. Three anti-industry advertisements—two for television and one billboard—were pulled from use. One

advertisement, "Nicotine Soundbites" (figure 4), was constructed from news coverage of the hearing of 14 April 1994 conducted in the United States Congress by Representative Henry Waxman, in which tobacco industry executives were shown claiming that nicotine is not addictive. The advertisement ended with the tag line: "Do they think we're stupid?" The advertisement was shown briefly in autumn 1994. RJ Reynolds threatened to sue, claiming defamation,[32] but Kimberly Belshe, the new DHS director, publicly defended "Soundbites", and it remained on the air.[33] After this public display of support, however, DHS quietly shelved "Nicotine Soundbites" in early 1995,[34] and it has not been shown since in California, despite repeated requests to do so by public health advocates, including the Tobacco Education and Research Oversight Committee (TEROC),[10] which has statutory oversight over the programme. Another advertisement, "Insurance", pointed out that insurance companies owned by the tobacco industry charged non-smokers less for life insurance. The advertisement was reportedly finished but was not being used. Public health advocates held a press conference on 12 December 1995, to urge that the advertisement be broadcast,[35-37] but the Wilson administration refused.[38]

View larger version (133K):
[in this window]
[in a new window]

Figure 4 The "Nicotine Soundbites" advertisement was based on the Congressional hearings at which tobacco executives denied that nicotine was addictive. The Wilson administration pulled the advertisement after the tobacco industry complained, and kept it off the air, despite repeated demands by public health advocates that it be put back on the air.

A billboard was also pulled from use. In September 1994 (although this information did not become public until two years later), Sandra Smoley, secretary of health and welfare, the cabinet secretary over DHS and a Wilson appointee, personally ordered that 190 billboards saying: "Are you choking on tobacco industry lies?" be papered over at a cost of $10 000, even though the billboards had been approved by Belshe. When challenged on this, and related actions by the American Cancer Society, the American Heart Association, and Americans for Nonsmokers' Rights, Smoley defended her position, saying:

> "The billboard `Are you choking on tobacco company [*sic*] lies?' was pulled because it was found to be offensive for government to use taxpayer funds to call a private industry a liar. . . . I also supported DHS's decision to stop airing the ad called `Nicotine Soundbites.' DHS made the judgment call that continuing to air the ad would raise unacceptable legal risks . . . Your organisations have given unwarranted emphasis to the decision not to air an ad known as `Insurance'. . . . While the ad had much potential, and *could have been aired* with further work, DHS dropped the ad im**media**tely after your press conference [emphasis in the original]."[39]

Smoley, a registered nurse, did not approve of accusing the tobacco industry of lying.

Legislative attempts to weaken the media campaign

Following litigation and political action by programme advocates,[2] [40] in June 1996, the legislature provided full funding for the Proposition 99 education and research programmes for the first time since Proposition 99 passed, including $25 million for **media**. Although he acquiesced in the decision to provide full funding, Assembly Speaker Curtis Pringle (R-Garden Grove) attempted to include language in the budget to prohibit the **media** account from being used to attack the tobacco industry. His proposed bill language specified that advertisements "be based solely on the health implications of tobacco use and on the health implications of refraining from tobacco use."[41] Such messages, stressing health effects of smoking, are not particularly effective at preventing young people from smoking or motivating adults to stop.[11] [42] Pringle's justification was that taxpayer dollars should not be used to attack a legal industry,[41] a position similar to that taken by Smoley.

The governor's office reportedly did not support the proposed budgetary language restricting the **media** account,[41] although the governor reportedly thought Pringle's points were valid. According to the *Contra Costa Times*, Governor Wilson said that: "There is not a necessity to defame people in order to send a very strong message that smoking is not a good thing."[43]

Pringle was widely criticised for his stance. The editorial in the *Sacramento Bee* on 28 June 1996 was representative. It said:

> "Tobacco industry executives plainly don't enjoy turning on the television and seeing ads telling Californians that the industry profits at the expense of their health. They don't like it when researchers unmask their marketing and political strategies. It's not hard to understand why they want the legislature to undermine those elements of Proposition 99. What's harder to explain, and impossible to justify, is the speaker's willingness to do their work."[44]

Pringle's language putting limits on the **media** account was eventually dropped because of opposition from key Democrats who were involved in the final budget negotiations.

Using contracting procedures to cut the media campaign

The successful defeat of legislative language to restrict the **media** account, however, did not mean that public health professionals would be allowed to run the **media** campaign without political interference. As the year unfolded, it became clear that the Wilson administration was restricting the **media** account quietly and behind the scenes without legislation. Before the budget even passed, those inside the administration were already implementing restrictions similar to those Pringle had proposed.

At the time the 1996-1997 budget was signed, the contract to administer the **media** account was held by the advertising agency Asher/Gould, which had been awarded the contract in May 1994. When the new budget passed in 1996, the Department of Health Services extended Asher/Gould's contract for producing **media** through 31 December 1996 and issued a new Request for Proposals (RFP)

for the **media** campaign for the period from 1 January 1997 through 31 December 1999. The new RFP was not necessary because the existing contract with Asher/Gould had an option by which the state could have extended it through June 1998 without going through the lengthy process of rebidding the contract.

The short extension that was given to Asher/Gould was done with the anticipation that new **media** could be developed by September 1996, and that the placement of advertisements could continue, both hard-hitting ones from the California arc**hive**s and ones from other states.[45] This effort to bridge the gap, however, was largely cosmetic, because no new **media** was produced under the contract extension and the effort to re-run advertisements from the arc**hive**s was effectively stopped. Even after Asher/Gould was issued a new contract on 1 December 1996, at the conclusion of the public bidding process, new **media** was not released until 20 March 1997,[40] which meant that from September 1995 until March 1997 no new **media** was released. By the time the new **media** was released, prevalence rates in adults had begun to rise, and those under the age of 18 were showing increased susceptibility to smoking.[10] During the period when no new **media** was being produced, DHS continued to run a few of the most recently produced advertisements, despite warnings from departmental staff that the advertisements were so over-exposed that they had likely lost their effectiveness.[46] The contracting process was also used as an excuse to, in effect, cut the size of the **media** campaign in half; in 1995-1996, only $6.5 million of the $12.2 appropriated by the legislature for **media** was spent, because of the delays in approving the extension.[40]

Implementing Pringle's policies administratively

Asher/Gould had been prepared to issue new advertisements under the contract extension. As early as June 1996, Asher/Gould had delivered story boards (pen and ink versions of the proposed advertisements) to TCS for new **media** production under the contract extension. Following a presentation of the story boards set for 1 and 2 July 1996, production was scheduled to begin on 15 July with a proposed air date of 2 September.[47]

Based on the past successes of the campaign, several of these proposed advertisements featured attacks on the tobacco industry. One of these advertisements was "Cattle", which showed cowboys rounding up children as a metaphor for the tobacco industry hooking kids on cigarettes. "Cattle" began with the words: "This is how the Tobacco Industry wants you to see them . . .", and was originally to feature a kid being lassoed by one of the cowboys and dragged to where another cowboy was waiting with a brand reading, "Tobacco Industry". The brand was to be photographed moving towards the camera, which represented the child's point of view. The final line was: "The Tobacco Industry. If you knew what they thought of you, you'd think twice." Another advertisement: "Thank you", a television advertisement that eventually became a radio spot, was a sarcastic "thank you" letter from the tobacco industry to kids in appreciation for their loyalty despite overwhelming evidence that tobacco kills. It began with the line: "The Tobacco Industry would like to thank . . ." and ended with the line: "Sincerely, the Tobacco Industry". Three billboards were also presented, two of which are shown in figure 5.

View larger version (148K):
[in this window]
[in a new window]

Figure 5 Two billboards produced in March 1997. These billboards were submitted to the Department of Health Services by the advertising agency in June 1996. During the intervening nine months, there was a tug-of-war between administration officials, who watered down the advertisements, and public health advocates, who wanted the advertisements strengthened. The nine-month review process resulted in no changes in these billboards.

In July 1996, Mike Genest, assistant deputy director for prevention services at DHS, who was widely viewed as representing the governor's interests in the department, was concerned that everything that Asher/Gould had presented for young people was controversial and would need to be approved several layers up the chain of command. He questioned the efficacy of the approach of attacking the tobacco industry, prompting Bruce Silverman, president of Asher/Gould, to write to Dileep Bal, Chief of the Cancer Control Branch (which includes TCS), that: "The only effective method I know of to achieve that [reduction in tobacco use] via advertising is with the "Manipulation" strategy that we just tested".[48] In addition to general concerns about attacking the industry, Genest wanted the words: "Tobacco Industry" changed to "Big Tobacco".[49] Nothing was approved to go into production. It would take nearly nine months for these advertisements to appear, with minor changes from the original proposals. During this time, the ads would be watered down, then re-strengthened.

In addition to slowing the approval process, the Wilson administration made other changes designed to tone down and slow down the **media** campaign. Prior policy had been that once an anti-tobacco advertisement was approved, it was up to TCS and the **media** contractor's professional judgement when to run a given advertisement. In August 1996, when Asher/Gould suggested running "Industry Spokesman" again because it had not been aired for several years, Genest announced a new policy that every advertisement, even those previously approved, be cleared for each use.[50] Bal described this new policy as "a fundamental change that I for one was unaware of until now."[51] Between the delay over the new **media** and the need for re-approval of the old, there was clearly no intention of getting the **media** campaign up and running in a hurry.

There were other steps taken inside the administration to impose tighter political controls on the **media** campaign. On 16 September 1996, the DHS Office of Public Affairs (OPA) released a memo requiring that all advertising concepts be reviewed by OPA before being focus group tested or shared with "stakeholders/interested parties".[52] In other words, an official charged with protecting the administration's political and public relations positions would review proposed advertisements for political acceptability before any formal evaluation of the advertisements for quality or effectiveness as public health messages could take place.

Finally, DHS was asked not only to justify **media** spots attacking the tobacco industry, but was also required to justify the whole "countering pro-tobacco influences in the community" strategy.[53] This strategy, along with "reducing exposure to environmental tobacco smoke" and "reducing youth access to tobacco", is one of the three main themes in all of DHS's programming, including **media**, local

programmes, and the competitive grants. Robin Shimizu, chief of technical services, TCS, who oversees the **media** campaign, warned that:

> "These priorities were developed and renewed with the assistance of the tobacco control communities throughout California and do not simply belong to DHS/TCS. To back away from, or to have to justify the use of any one of them, or to eliminate one of the priorities would be viewed harshly by everyone involved in tobacco control in the state as well as other states, unless there were a very strong rationale for doing so."[53]

Bal, writing to Don Lyman, chief, Division of Chronic Injury and Disease Control, gave a similar assessment:

> "Countering pro-tobacco influences in the community' is the very signature piece of our efforts to date, as any of the cognoscenti within or without the state will attest to. To have that questioned in an issue memo you or I have not seen is beyond anything. Any fundamental shift of these proportions without community input will produce quite a mushroom-cloud, besides being ill-conceived. *Caveat emptor.*"[54]

Bal further offered to host "a full-scale consensus conference of the national cognoscenti" to discuss the issue, suggesting that those who were requesting the justification did not really want this level of public discussion of the issue. He also suggested that the "countering" strategy was being held to a higher burden of proof that it worked than other interventions pursued by DHS.[55]

Shutting the public health community out of the process

Bal's offer to open up discussion of the basic campaign strategy to include the public health community flew in the face of the general approach taken by DHS in the fall of 1996. During the first years of the California anti-tobacco **media** campaign, DHS and the advertising agency had actively involved members of the public health community in the development of the advertising campaign.[5] Recognising that efforts to slow down and weaken the **media** campaign would spark controversy within the public health community, the administration shut the public health community out of the review process. In the initial stages of the campaign, DHS had involved a broad cross-section of the public health community in the process of developing new **media** through a large, somewhat informal **media** advisory committee. This committee stopped being convened, and the administration even quit involving TEROC in the review of the story boards.

At its meeting on 10 December 1996, TEROC discussed the delays in the **media** campaign and the new closed review process. James Stratton, the state health officer and DHS deputy director for prevention services, announced that decision making about the **media** campaign had been removed from TCS and that he had the final say over the content of the advertisements. TEROC made a formal request to be allowed back into the process, in particular to have the opportunity to see and comment on the story boards when new advertisements were being developed.[56] Stratton refused.[57]

The veil of secrecy extended to the advertising firm as well. The new Asher/Gould contract issued on 1 December 1996 contained a new clause barring it from discussing the **media** campaign with anyone outside the official process.[58]

Administration secretly toned down the ads

The administration had, in fact, weakened the June advertisements, just as public health advocates had feared. All the story boards submitted by Asher/Gould in June 1996 had been modified by removing the words "the tobacco industry" and "addiction". For example, "Cattle" now began: "This is how the guys who make cigarettes . . ." and the final line was: "If you knew what they thought of you, you'd think twice." The words "tobacco industry" did not appear. The advertisement, "Thank you" had also been changed from: "The Tobacco Industry would like to thank . . ." to: "Those of us who make cigarettes would like to thank you . . .". The final line: "Sincerely, the Tobacco Industry" was still included in the presentation attended on 5 December by TCS staff, Lynda Frost, the deputy director of the office of public affairs, Genest, and Stratton, but it was later deleted.[59]

A new anti-industry advertisement, "Rain", featured cigarettes raining down on a playground and discussed the tobacco industry's need to hook kids, but it never mentioned the tobacco industry by name. The opening line was: "We have to sell cigarettes to your kids" and the final line was: "How low will they go to make a profit?"

Another proposed new advertisement, "Voicebox", did attack the industry as it was proposed. It featured a woman smoking through a tracheotomy, stating that the tobacco industry had lied to her about the addictive nature of its products. In December, the industry attack was deleted, and the advertisement instead promoted the state's toll-free (freephone) quit line. In the revised December version neither addiction nor the tobacco industry is mentioned by name. The advertisement instead featured a smoker who could not quit despite having a tracheotomy, urging others to give quitting a try. An anti-industry advertisement had been converted into a cessation spot that said that quitting was impossible—a strange message from a public health department.

In early 1997, Asher/Gould expressed concerns that all the advertisements as approved lacked clarity, but they were particularly concerned with the way "Rain" had been changed by DHS, because it could be misunderstood to include tobacco retailers and business in general, as opposed to just the tobacco industry. TCS's relationship with the retailers was fragile and their cooperation was needed to implement the state programme designed to reduce tobacco sales to the young.[60]

The effort to tone down the attacks on the tobacco industry flew in the face of the research done for TCS by Asher/Gould. In Asher/Gould's Summary Report[61] of its focus group research on different advertising messages, Christine Steele, an Asher/Gould senior vice president, reported that five advertising strategies were tested on young people, aged 12 to 18, in focus groups in Sacramento and Los Angeles.[42] The messages tested were: (a) manipulation of kids by the tobacco industry, (b) the dangers of secondhand smoke, (c) the short term health effects of smoking, (d) the risk of romantic rejection, and (e) the elimination of risks to the environment caused by smoking, including cleaner beaches, fewer trees destroyed to produce cigarettes, and fewer animals harmed by eating butts. Of the five, manipulation by the industry tested very strongly with young people. According to Steele: "The body language of kids clearly revealed that this strategy [the anti-industry strategy] provided kids with an emotional wake up call. They sat up straight, they grimaced, they shook their heads, they became riled up and vocal—they at least became concerned about this formerly `low interest' topic."[42]

Public health advocacy groups begin to protest

On 4 February 1997, the presidents of the American Cancer Society (ACS), American Heart Association (AHA), and Americans for Nonsmokers' Rights (ANR) wrote to Smoley to express their frustration with the "administration's ostensible defense of an industry responsible for the deaths of more than 42 000 Californians each year—the tobacco industry". The three organisations protested the long delay in the production of new **media** and urged Smoley to release a campaign that featured the original campaign themes: "the tobacco industry lies", "nicotine is addictive", and "secondhand smoke kills". Meanwhile, John Miller, chief of staff to Senator Diane Watson (D-Los Angeles), chair of the state Senate Health Committee, was threatening to hold hearings on the conduct of the **media** campaign.

Cook called an emergency meeting of TEROC for Monday, 10 February 1997, to follow up on Stratton's refusal to share information about the **media** campaign with TEROC and to decide what action TEROC should take in response.

The TEROC purge

On the Friday before the emergency TEROC meeting, Stratton announced a major shakeup of TEROC. Three physicians on TEROC who had been strong advocates for the anti-tobacco education campaign, were replaced with individuals closely allied with the Wilson administration. Lester Breslow, former dean of the UCLA School of Public Health and former director of DHS, who had been on TEROC since its formation in 1990, and Reed Tuckson, president of Drew University of Medicine and Science in Los Angeles, were told that they had been replaced in an action allegedly taken three months earlier by Assembly Speaker Pringle (R), the day before the Democrats took over the Assembly. Neither Pringle nor DHS had given any indication of these changes before 7 February, even though TEROC had met in December, after the date that Pringle supposedly made the appointments. Jennie Cook, TEROC chair, had been unaware of them. Spokesmen for Pringle and the Governor said that either DHS was not informed or the appointment letters had been lost.[62] In the physicians' places, Pringle appointed Hal Massey, a retired Rockwell executive who had been active in ACS, and Doug Cavanaugh, the president of Ruby's Restaurants, who was, according to Pringle, "familiar with the tobacco debate, balancing regulations with people's right to smoke".[62] DHS also announced that Governor Wilson had replaced Dr Paul Torrens of the UCLA School of Public Health with Dr George Rutherford, who had been the state health officer in the Wilson administration and responsible for the Proposition 99 programme until he left to join the faculty at the University of California. Wilson also appointed Stratton to TEROC, making him a member of his own oversight committee.

On Monday morning, before the TEROC meeting scheduled for that afternoon, ACS, AHA, ANR, and the American Lung Association (ALA) called a press conference to protest the changes in the TEROC

membership and to express their concerns about the administration of the programme. Alan Henderson, president-elect of ACS, Carolyn Martin, a volunteer with ALA and former chair of TEROC, John Schaffer, of AHA, and Stanton Glantz, of the University of California at San Francisco, spoke at the press conference. They pointed out that it was inappropriate for Stratton to sit on TEROC, because he had asserted direct responsibility for the day-to-day management of the DHS tobacco programme, particularly the **media** campaign, setting up a potential conflict of interest. Indeed, Stratton, at the meeting on 10 December, had claimed responsibility for putting in place the secrecy policies that had led to the TEROC emergency meeting in the first place.

Between the controversy caused by the lack of a **media** campaign and the controversy over the purge of the three widely respected committee members, the **media** gave substantial coverage to the meeting, particularly to the absence of the **media** campaign and the lack of information about it.[62-68] Well over a hundred people came to the TEROC meeting on the afternoon of 10 February. TEROC normally meets in a conference room and has 10-15 non-members in attendance; this meeting was held in an auditorium. Audience members included the heads of a number of county programmes for tobacco use prevention, who emphasised the key role the **media** campaign played in their efforts. Without the "air cover" created by the **media**, the impact of their local programmes was more limited. Steve Hansen, a member of the board of the California Medical Association, suggested Stratton was guilty of "public health malpractice".[57]

TEROC agreed that Cook should write to Belshe, informing her of the committee's unanimous vote (including Stratton, the person who was refusing to make the story boards available to the committee) to request a meeting to review the story boards for the current **media** and to request other, similar meetings to include the committee in the **media** development process. TEROC also voted that it favoured "the most aggressive **media** ads possible" and "sustaining of continuous **media** coverage, using, if necessary, the strongest existing ads currently available."[69]

The advertisements are strengthened

In February 1997, DHS responded to the pressure about the advertisements by again revising them, although this fact was not made public at the time. For example, Frost approved putting "The tobacco industry" back into the "Cattle" advertisement, changing: "If you knew what they thought of you, you'd think twice" to: "The Tobacco Industry. If you knew what they . . .". In "Rain", the voice over at the end was changed to: "The tobacco industry. How low will they go to make a profit?" In addition, "Thank you", which had become a radio spot, had the words "Tobacco Industry" added back in, both in the opening sentence and in the last line.

By the time Asher/Gould prepared the final story boards on 3 March 1997, two versions of "Voicebox" were planned. In addition to the cessation advertisement, a version was re-created that emphasised addiction and the behaviour of the tobacco industry. In it, the actor says: "They say nicotine is not addictive. How can they say that?" while the tag line at the end reads: "The tobacco industry denies that nicotine is addictive."

On 7 March, ACS, ALA, and ANR received a response to their letter of 4 February to Smoley, which had criticised the administration's management of the **media** campaign. Smoley responded by saying that: "It was found to be offensive for government to use taxpayer funds to call a private industry a liar".

although she did state that it was appropriate to counter industry tactics. In response, AHA, ACS, and ANR took out a full-page advertisement in the *New York Times*, accusing the Wilson administration of refusing to release hard-hitting television spots and removing the "Lies" billboard to protect the tobacco industry. Smoley, with Governor Wilson's explicit approval, was implementing Pringle's programme of refusing to attack the tobacco industry, even though the legislature had refused to pass it.[70]

Despite movement in private on the **media** campaign by TCS, the public health community was still shut out of the review process. On 19 March, Belshe responded to the TEROC letter, indicating that TEROC would not be involved in the process of developing the **media**.[71] The administration argued that TEROC was a "security risk" and that sharing the advertisements with TEROC would increase the likelihood that the tobacco industry would gain access to them. Cook expressed her disappointment in a letter on 2 April, commenting that: "The TEROC is not an outside party; it is to be part of the process; and it is being deprived of the tools necessary to function".[69] One of the other TEROC members stated that it appeared that the department considered 12 year olds in a focus group less of a security risk than the members of TEROC.[69]

TEROC was finally shown the new advertisements at its meeting on 25 March, after they were released to the public, and Cook indicated that their reactions were mixed.[69] Only the version of "Voicebox" that emphasised addiction and the industry was shown. The advertisements as released, nine months after Asher/Gould originally proposed them, were similar to those originally proposed by the advertising agency.

At the TEROC meeting on 25 March, John Pierce, director of the California Tobacco Survey, presented the latest California smoking prevalence data, which showed that smoking rates for young people and adults appeared to be going up. Overall, youth smoking, which had been as low as 8.7% in 1992, rose to 11.9% in 1995 and remained flat in 1996 at 11.6%. The annual Behavioral Risk Factors Survey conducted in-house at DHS showed that adult smoking prevalence had increased from 16.7% to 18.6% from 1995 to 1996,[72] reversing a downward trend that had existed for nearly a decade.[10 73] The increase in smoking rates received wide **media** coverage.[73-75] Public health groups blamed the increase on the fact that the administration had not fully funded Proposition 99's anti-tobacco education programmes and on its reluctance to attack the tobacco industry. Sean Walsh, the Governor's press secretary, commented that he was frustrated with Wilson being blamed for everything "including [the comet] Hale-Bopp".[73] He referred to criticisms by the public health groups as "Chicken Little-like comments made by zealots in the anti-smoking community".[75] The actions by the public health groups, however, far from reflecting "Chicken Little" zealotry, did call attention to and partially block the administration's attempt to run a poor quality tobacco control programme.

The key role played by tobacco activists was confirmed in October 1998, by asher & partners (the new name of the Asher/Gould agency), when they responded to questions from the Senate Judiciary Committee regarding censorship of the **media** campaign. The Judiciary Committee subpoenaed asher & partners to allow them to speak frankly despite the "gag clause" that the Wilson administration had added to their contract. They said: "We were told in 1997 that we should not use the words *The Tobacco Industry* in our advertisements. . . . After intense pressure from tobacco control activists, the administration finally allowed us to use the phrase *the tobacco industry* and asked us to quickly redo all of our creative materials to reflect the reneging of this restriction [emphasis in the original]."[76]

Since 27 March 1997, the policies of secrecy and the cumbersome approval process surrounding the **media** campaign have remained in place. On 15 April 1997, ACS, AHA, and ANR wrote to Governor Wilson, asking him to intervene personally to get the programme back on track. They specifically requested that he allow "Nicotine Soundbites" and "Insurance" to the air and that he actively support the implementation of Assembly Bill 13 (AB13), California's law mandating smoke-free workplaces. The

governor's deputy chief of staff wrote back on 16 May 1997, saying that Belshe and Smoley "forthrightly" represented the governor's position.[70] Public health professionals within TCS still do not control the content of the advertisements.

Smoley took several actions to prevent the **media** campaign from interfering with the tobacco industry's efforts to overturn smoking restrictions in California. In 1994, Smoley prohibited use of the advertising campaign to publicise AB13,[77] because Philip Morris was mounting an initiative campaign, Proposition 188,[78] to overturn California's workplace smoking restrictions. Even after Proposition 188 was defeated, however, there was still no advertising to educate the public that virtually all workers had a right to a smoke-free workplace. In 1997, Smoley delayed advertisements to implement California's smoke-free bar law (which went into effect on 1 January 1998) for several months. Those advertisements, first proposed in May 1997, were not approved until October, because Smoley did not want advertisements on the air promoting the smoke-free bar law while the tobacco industry was attempting to get the law overturned in the legislature. In late November 1997, DHS began running two advertisements promoting smoke-free bars—one on the radio and one on television.

Discussion

Anti-tobacco **media** campaigns are key components of effective tobacco control programmes.[4] With adequate funding, it is possible for tobacco control professionals to pursue a sophisticated marketing strategy that includes market segmentation and research on the effectiveness of anti-smoking messages.[11] [79] These advertisements can then be professionally produced and aired in prime television and radio times, providing "air cover" for other tobacco control efforts, such as community-based programmes or policy interventions.

The recent influx of tobacco control monies into the public sector has, in fact, allowed this kind of marketing effort to occur, and the marketing research that has been conducted by professional firms has indicated that the **media** messages that are likely to be effective for prevention are not those that emphasise the health consequences of tobacco use but instead appeal to other emotions, such as resentment at being manipulated by the tobacco industry.[42] This need to appeal not to facts or reason but instead to emotions and feelings has long been recognised by the tobacco industry as a key to its success at selling tobacco products.[80]

The efforts of the tobacco industry to curtail or end various **media** campaigns indicates that it understands that **media** campaigns, correctly designed and run, can help to lower prevalence and consumption, and thus, it uses its political influence to weaken **media** campaigns (if it cannot simply prevent them from being funded). In California, it worked through the legislature and the administration to limit the scope and aggressiveness of the **media** campaign. In Arizona, another state with a large anti-tobacco advertising campaign funded by a dedicated tobacco tax, the Arizona Department of Health Services has mounted a large campaign that does not mention or attack the tobacco industry and avoids the word "addiction".[81] When the tobacco industry settled the Florida and Texas lawsuits designed to recover the state's smoking-induced Medicaid costs, the settlement included funding for an anti-tobacco education programme, but explicitly prohibited advertisements that attack specific tobacco companies or brands.[11]

Effective advertisements must personify and expose industry manipulation, but the experience of

California and other states demonstrates that these advertisements are precisely the ones that the industry will work the hardest to stop. Given the importance of **media** to tobacco education programmes, tobacco control advocates must be aware of the industry's efforts to place controls on anti-tobacco **media** campaigns, and be willing to take strong actions to see that executive branch officials charged with implementing the campaign do not succumb to this pressure.

The California experience also illustrates the key role that programme advocates in non-governmental organisations can play in protecting **media** campaigns. The public health professionals who work in government agencies will be subject to the limits set by their politically appointed superiors. Thus, advocates outside of government must carefully monitor the quality and scope of government funded **media** campaigns and be ready to pressure these agencies to run effective advertisements. Public health interventions that are opposed by the tobacco industry will survive only through the continuing advocacy efforts of the public health community.

In California, with no experience in running an advertising campaign, the Department of Health Services in 1989-90 launched its **media** campaign—including writing the Request for Proposals, awarding the advertising contract, developing, approving, producing, and placing the first round of ads—in 189 days, or a little over six months after the governor signed the budget. By 1996-97, with seven years of experience and a seasoned advertising firm, it took the department eight months from the signing of the budget to produce an advertisement. The process slowed rather than becoming more routine because of a variety of political manoeuvres, including adding layers of approvals for the advertisements, rescinding approvals of advertisements that had successful negotiated the approval process, adding in requirements for approvals by political appointees instead leaving the decision in the hands of public health and advertising professionals, and re-bidding contracts that could have been extended. The new DHS procedures have reduced the effectiveness of the anti-tobacco **media** campaign, once the centerpiece of Proposition 99, and this reduced effectiveness, combined with overall programme budget cuts,[2] is reflected in a failure to make progress in reducing tobacco use (figure 3).[11]

It is clear, however, that the public health groups have been effective in forcing the Wilson administration to run a more aggressive campaign than it wanted. Their repeated requests to be involved in the review process were denied, although by the end of the year the pressure they brought on the programme from the outside, combined with the threat of a legislative hearing, appeared to have had a positive effect on the quality of the **media** campaign. Through use of paid and free **media** to call attention to the administration's behaviour, public health advocates succeeded in forcing the administration to strengthen the advertisements to reflect good public health practice.

The use of these kinds of outsider strategies are essential in protecting public health programmes from powerful insiders, like the tobacco industry. Outsider strategies are typically used by non-governmental organisations who have popular support and fewer resources, such as campaign contributions, for lobbying elected officials. Among the key outsider strategies that have been used successfully by advocates in California have been using the public forum provided by TEROC, creating print advertisements to call attention to programme problems, taking advantage of free **media**, and monitoring internal departmental activities through use of the public records act.

TEROC was established legislatively to provide oversight for the tobacco education and research programmes funded by Proposition 99. By having programme advocates among its members and, importantly, having one as its chair, TEROC has been able to question publicly the conduct of the programme. As its meetings are open to the public, it also creates a venue for members of the press to follow programme controversies. For public health advocates, the existence of oversight bodies for public programmes can create an opportunity for putting public accountability into public health programmes. When such bodies are created by legislation or by administrative action, their

responsibilities, powers, and membership are potentially important for the conduct of the programme and should be treated as such by programme lobbyists. It is important who is eligible for membership, who makes appointments to the body, and what responsibilities the body is given.

The **media**—both paid advertising and free **media**—are important vehicles for putting pressure on public agencies. By running their own advertisements, programme advocates can create a forum in which they are able to frame issues publicly in a way that reflects their viewpoint. This is a particularly powerful strategy if other forums, such as legislatures or oversight bodies, have not been responsive. Such advertisements reach decision makers, the public, and reporters, and call attention to the fact that there are problems with the programme. This may also be an important avenue to obtaining free **media** in the form of news coverage. According to Steve Scott, managing editor of the *California Journal*, " A lot of times what we look at as journalists to sort of guide us in determining what's a real issue and what's not a real issue is the attitude of the constituent groups. . . . [T]he assumption was that if nobody's making any noise about this then it's just not that big a deal."[82] By taking an action as public as running an advertisement, public health groups can alert the **media** to an interesting story and thus provide heightened monitoring of programme implementation.

In recent years, the tobacco industry has been using public records acts to try to impede agency functioning and to discredit agency programmes.[83] Public records acts, however, can also be used by programme advocates to monitor how programme monies are being spent and the ways in which political appointees may be impeding the work of public health professionals. If information on programme implementation is not freely shared with programme advocates, then it may be necessary for them to force such information into the public domain.

The challenge for the public health community is maintaining this level of outsider pressure over long periods of time, because the industry will continue its pressure on the inside to protect its interests. As more states embark on anti-tobacco advertising campaigns, either due to state and local initiatives or due to settlements of industry lawsuits, public health advocates need to understand the importance of helping to establish the rules by which this money will be spent and monitoring the process of spending it. Public health groups can help campaigns if they are allowed to be involved; if they are not, however, they can still protect the quality of the programme through outsider, **advocacy** strategies designed to hold public agencies accountable for mounting high-quality campaigns.

Acknowledgments

This work was supported by the National Cancer Institute (Grant CA-61021).

References

1. Traynor MP, Glantz SA. California's tobacco tax initiative: the development and passage of Proposition 99. *J Health Policy Politics Law* 1996;**21**:543-585[Medline].
2. Glantz SA, Balbach ED. *California tobacco wars*. Berkeley, California: University of California Press. (In press.)
3. Scott S. Smoking out tobacco's influence. *California Journal*, 1997 Apr:14-18.
4. State of California Department of Health Services, Tobacco Control Section. *National Cancer Institute planning model.* California Department of Health Services, December 1989.
5. Bal DG, Kizer KW, Felten PG, *et al*. Reducing tobacco consumption in California: development of a statewide anti-tobacco use campaign. *JAMA* 1990;**264**:1570-1574[Medline].
6. Lee P. Keye/Donna to do anti-smoking ads for state. *Los Angeles Times*, 1990 Jan 27:D2.
7. Scorching attack on cigarette firms. *Los Angeles Times* 1990 Apr 10:1A.
8. Keye P. What don't we know, and when haven't we known it? Speech given at Johns Hopkins University, 13 October 1993.
9. Glantz SA. Changes in cigarette consumption, prices, and tobacco industry revenues associated with California's Proposition 99. *Tobacco Control* 1993;**2**:311-314.
10. Tobacco Education and Research Oversight Committee. Toward a tobacco-free California: renewing the commitment 1997-2000. Sacramento, California: State of California Department of Health Services, 31 July 1997.
11. Goldman L, Glantz S. Evaluation of antismoking advertising campaigns. *JAMA* 1998;**279**:772-777[Medline].
12. Johnson B. Anti-smoke torch flickers. *Advertising Age*, 1990 Apr 16:1.
13. Malmgren KL. Memorandum to Samuel D Chilcote, Jr. The Tobacco Institute, 18 April 1990.
14. Lucas G. Deukmejian cool to blitz on smoking. *San Francisco Chronicle*, 1990 Apr 11:1.
15. Warren J, Morain D. Bid to dilute anti-smoking effort revealed. *Los Angeles Times*, 1998 Jan 2.
16. State of California Office of the Governor. *Governor's budget 1992-1993.* Sacramento, California: Office of the Governor, January, 1992.
17. Lucas G. Demos assail Wilson plan to cut funds for anti-smoking drive. *San Francisco Chronicle*, 1992 Jan 23:A15.
18. Gray T. Wilson's plan to shift funds disguises tax hike, critics say. *Sacramento (California) Bee*, 1992 Jan 26:A3.
19. Russell S. Anti-smoking program big hit—but governor seeks to cut it. *San Francisco Chronicle*, 1992 Jan 15:14.
20. Grubb K. California governor wants to extinguish anti-tobacco ads. Associated Press, 23 January 1992.
21. Pierce JP. Evaluating Proposition 99 in California. American Heart Association, Nineteenth Science Writers Forum, 12-15 January 1992.
22. Winslow R. California push to cut smoking seen as success. *Wall Street Journal*, 1992 Jan 15:B1.
23. State set to scrap anti-smoking TV ads. *Los Angeles Times* 1992 Jan 16:B8.

24. State study lauds anti-smoking drive. *San Francisco Examiner* 1992 Jan 25:A5.
25. Duerr J. Memo to Dileep Bal. Sacramento, California: State of California Department of Health Services, 29 January 1992.
26. Williams L. Officials: Wilson undercut TV ads on smoking. *San Francisco Examiner*, 1996 Dec 22:A1.
27. American Cancer Society. Memo to unit executive directors from Ron Hagen. California: American Cancer Society, 23 January 1992.
28. Americans for Nonsmokers' Rights. *Prop 99 $$ slashed: **media** campaign killed already!* Americans for Nonsmokers' Rights, 22 January 1992.
29. Skolnick A. Court orders California governor to restore antismoking **media** campaign funding. *JAMA* 1992;**267**:2721-2723[Medline].
30. Skolnick A. American Heart Association seeks to delay state health department director's confirmation. *JAMA* 1992;**267**:2723-2726[Medline].
31. Hite B. State of California Department of Health Services signs contract for tobacco education **media** campaign. Sacramento, California: State of California Department of Health Services, 11 June 1992.
32. Johnston JW. Letter to Belshe. R J Reynolds Tobacco Company, 13 October 1994.
33. Belshe SK. Letter to Martin G Glick. Sacramento, California: State of California Department of Health Services, 12 October 1994.
34. Stevens C. Email to Dileep Bal. Sacramento, California: State of California Department of Health Services, 1 February 1995.
35. Sweeney JP. State accused of shelving anti-smoking ad. *San Diego Union-Tribune*, 1995 Dec 13:A3.
36. Tachibana J. Groups accuse Wilson of blocking anti-tobacco ad. *Sacramento (California) Bee*, 1995 Dec 14:B4.
37. Russell S. Furor over anti-smoking TV ad. *San Francisco Chronicle*, 1995 Dec 23:A23.
38. Belshe SK. Letters to Mary Adams, Alan Henderson, and Tony Najara [sic]. Sacramento, California: State of California Department of Health Services, 8 February 1996.
39. Smoley SR. Letter to Bailey, Pertschuk, and Fung. Health and Welfare Agency, State of California, 7 March 1997.
40. Balbach ED, Monardi FM, Fox BJ, *et al.* Holding government accountable: tobacco policy making in California, 1995-1997. Institute for Health Policy Studies, University of California, San Francisco, June 1997.
41. Morain D. Pringle targets anti-tobacco research, ads. *Los Angeles Times*, 1996 Jun 27:A3.
42. Steele C. Letter to Colleen Stevens. Asher/Gould Advertising, 4 December 1996.
43. State nixed anti-tobacco TV ads in `95. *Contra Costa Times* 1996 Aug 12.
44. The speaker's smoke machine. *Sacramento (California) Bee* 1996 Jun 28:B6.
45. Belshe SK. Memorandum to Sandra R Smoley. Sacramento, California: State of California Department of Health Services, June 1996?
46. Lyman DO. Memo to James W Stratton. Sacramento, California: State of California Department of Health Services, 25 September 1996.
47. Contract extension creative development timeline. [Sacramento, California: State of California Department of Health Services], June 13 1996.
48. Silverman BG. Letter to Dileep G. Bal. Asher/Gould Advertising, 2 July 1996.
49. Shimizu R. Email to Colleen Stevens. Sacramento, California: State of California Department of Health Services, 5 July 1996.
50. Genest M. Email to Dileep Bal. Sacramento, California: State of California Department of Health Services, 23 August 1996.
51. Bal D. Email to Mike Genest. Sacramento, California: State of California Department of Health Services, 21 August 1996.
52. Munso J. Memo to all deputy directors. State of California, 16 September 1996.

53. Shimizu R. Email to Dileep Bal. Sacramento, California: State of California Department of Health Services, 10 October 1996.
54. Bal D. Email to Don Lyman. Sacramento, California: State of California Department of Health Services, 10 October 1996.
55. Bal D. Email to Don Lyman. Sacramento, California: State of California Department of Health Services, 11 October 1996.
56. Cook JR. Letter to Stratton. Tobacco Education and Research Oversight Committee, 31 December 1996.
57. Tobacco Education and Research Oversight Committee. *Minutes*. Sacramento, California: State of California Department of Health Services, Tobacco Control Section, 10 February 1997.
58. State of California, State of California Department of Health Services. *Standard agreement with Asher/Gould Advertising*. State of California, 1 December 1996.
59. Stevens C. Memo to Nikki. State of California Tobacco Control Section, March? 1997.
60. Shimizu R. Email to J Howard and D Bal. Sacramento, California: State of California Department of Health Services, 27 January 1997.
61. Friedman M. Teen anti-smoking strategy focus groups. Summary report. Prepared for State of California Department of Health Services, Tobacco Control Section & Asher/Gould Advertising, November 1996.
62. Morain D. Controversy flares over state's anti-tobacco efforts. *Los Angeles Times*, 1997;A3.
63. Health groups rap Wilson. *Oakland (California) Tribune* 1997 Feb 11.
64. Health groups say governor too soft on tobacco. *San Jose Mercury News* 1997 Feb 11.
65. Anti-smoking groups demand state get tougher. *Modesto (California) Bee* 1997 Feb 11.
66. Bernstein D. Health groups: anti-smoking ads stifled? *Sacramento (California) Bee*, 1997 Feb 11.
67. Geissinger S. Governor chided for policies on tobacco. *Contra Costa Times*, 1997 Feb 11.
68. Gunnison RB. Wilson Administration hit for hiding anti-smoking ads. *San Francisco Chronicle*, 1997 Feb 11:A18.
69. Cook JR. Letters to S Kimberly Belshe. Tobacco Education and Research Oversight Committee, 2 April 1997, 11 Feb 1997.
70. Haddad BA. Letter to Lisa Bailey, Gordon L Fund, and Mark Pertschuk. Governor's Office, 16 May 1997.
71. Belshe SK. Letter to Jennie Cook. Tobacco Education and Research Oversight Committee, 19 March 1997.
72. Tobacco Education and Research Oversight Committee. Meeting notes (observation by Edith Balbach). Sacramento, California: State of California Department of Health Services, 25 March 1997.
73. Matthews J. Smoking by adults increases. *Sacramento (California) Bee*, 1997.
74. Gunnison RB. More Californians are lighting up. *San Francisco Chronicle*, 1997 Mar 26:A1.
75. Morain D. Adult smoking rises sharply in California. *Los Angeles Times*, 1997 Mar 26:A1.
76. asher & partners. *Response to questions for October 16th hearing*. Los Angeles: asher & partners, 1998.
77. MacDonald HR, Glantz SA. The political realities of statewide smoking legislation. *Tobacco Control* 1997;**6**:41-54[Abstract].
78. MacDonald H, Aquinaga S, Glantz SA. The defeat of Philip Morris' "California Uniform Tobacco Control Act". *Am J Public Health* 1997;**87**:1989-1996[Medline].
79. Kotler P. Social marketing of health behavior. In: Frederiksen L, Solomon LJ, Brehony KA, eds. *Marketing health behavior : principles, techniques, and applications*. New York: Plenum, 1984.
80. Pollay RW. Propaganda, puffing and the public interest. *Public Relations Review* 1990;**16**:39-54.
81. Aguinaga S, Glantz S. Tobacco control in Arizona, 1973-1997. Institute for Health Policy Studies, University of California at San Francisco, October 1997.
82. Scott S. Interview with Edith Balbach, 18 September 1996.

83. Aguinaga S, Glantz SA. The use of public records acts to interfere with tobacco control. *Tobacco Control* 1995;**1995**:222-230.

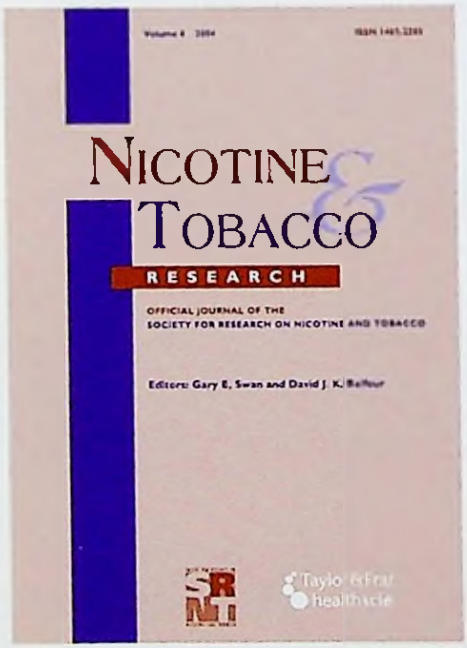
This article has been cited by other articles:

- Rohrbach, L. A., Howard-Pitney, B., Unger, J. B., Dent, C. W., Howard, K. A., Cruz, T. B., Ribisl, K. M., Norman, G. J., Fishbein, H., Johnson, C. A. (2002). Independent Evaluation of the California Tobacco Control Program: Relationships Between Program Exposure and Outcomes, 1996-1998. *Am J Public Health* 92: 975-984 [Abstract] [Full Text]
- Malone, R. E. (2002). Tobacco Industry Surveillance of Public Health Groups: The Case of STAT and INFACT. *Am J Public Health* 92: 955-960 [Abstract] [Full Text]
- Dixon, H. G, Hill, D. J, Borland, R., Paxton, S. J (2001). Public reaction to the portrayal of the tobacco industry in the film The Insider. *Tob Control* 10: 285-291 [Abstract] [Full Text]
- GLANTZ, S. A (2000). Tobacco Related Disease Research Program. *Tob Control* 9: ii2-3 [Full Text]
- Pechmann, C., Reibling, E. T. (2000). Anti-smoking advertising campaigns targeting youth: case studies from USA and Canada. *Tob Control* 9: ii18-31 [Abstract] [Full Text]
- Fichtenberg, C. M., Glantz, S. A. (2000). Association of the California Tobacco Control Program with Declines in Cigarette Consumption and Mortality from Heart Disease. *N Engl J Med* 343: 1772-1777 [Abstract] [Full Text]
- Sly, D. F, Heald, G. R, Ray, S. (2001). The Florida "truth" anti-tobacco **media** evaluation: design, first year results, and implications for planning future state **media** evaluations. *Tob Control* 10: 9-15 [Abstract] [Full Text]
- Goldman, L. K, Glantz, S. A (1999). The passage and initial implementation of Oregon's Measure 44. *Tob Control* 8: 311-322 [Abstract] [Full Text]

- Abstract of this Article
- **Reprint (PDF) Version of this Article**
- Email this link to a friend
- **eLetters: Submit a response to this article**
- Similar articles found in:
  Tobacco Control Online
  PubMed
- PubMed Citation
- This Article has been cited by:
- Search Medline for articles by:
  Balbach, E. D || Glantz, S. A
- Alert me when:
  new articles cite this article
- Download to Citation Manager

HOME HELP FEEDBACK SUBSCRIPTIONS ARCHIVE SEARCH SEARCH RESULT

NICOTINE & TOBACCO RESEARCH



Aims and Scope

Nicotine & Tobacco Research, the official journal of the **Society for Research on Nicotine and Tobacco (SRNT),** is one of the few peer-reviewed journals dedicated exclusively to nicotine and tobacco research. For further information about the Society visit **www.srnt.org**

Nicotine & Tobacco Research aims to provide a forum for empirical findings on the many aspects of nicotine and tobacco including research from the biobehavioral, neurophysiological, epidemiological, prevention, and treatment arenas. Along with manuscripts from each of the areas mentioned above, we seek to encourage submissions that are integrative in nature and that may cross traditional disciplinary boundaries.

Nicotine & Tobacco Research is a peer-reviewed journal. Its goal is to serve international and interdisciplinary scientific communication devoted exclusively to nicotine and tobacco research. A specific objective of the Journal is to stimulate submissions that are multidisciplinary in nature. Submissions are sought that not only are technically competent but are original and contain information or ideas of fresh interest to our international readership.

Abstracting Information

Nicotine & Tobacco Research is noted in *Addiction Abstracts, Centre National De La Recherche Scientifique (INIST), Clinical Medicine, Combined Health Information Database (CHID), Current Contents: Social & Behavioural Science, EMBASE, e-psyche, Index Medicus/MEDLINE, ISI Alerting Services, PsycINFO/PsycLIT/ClinPsyc/PsycAbstracts, Science Citation Index Expanded, Social Science Citation Index* and *Social SciSearch.*

Taylor & Francis
healthsciences

Recent and Forthcoming Articles:

Methods of payment

1 ☐ **Payment enclosed.** Cheques or bank drafts should be made payable to **Taylor & Francis Ltd** and be drawn on a UK or US bank. Customers in Australia and New Zealand please note that all AU$ cheques should be sent to our Australian office.

2 **Please charge**

☐ Visa ☐ Mastercard
☐ Eurocard ☐ American Express

Card Number

Expiry Date

Signature

Date

3 **Payment has been made by bank transfer to one of the following accounts (please indicate):**

☐ **UK**
National Westminster Bank Plc
3 London Street, Basingstoke, Hants RG21 7NS, UK
£ Account No. 01 484400. US$ Account No. 01 328735
Sort Code: 60-02-49 Swift Code: NWBKGB2L
Account Name: Taylor & Francis

☐ **USA**
Fleet National Bank, 3rd Floor
1185 Avenue of the Americas, New York, NY 10036 USA
Account No: 9417201589
ABA No: 021200339. Swift Code: FNBBUS33
Account Name: Taylor & Francis

4 **VALUE ADDED TAX (VAT)**
If you are a European organisation please enter your VAT registration number below to ensure that you are excluded from being charged VAT

VAT Reg No.

Country

☐ We are not registered for VAT

Please return this order form to one of the offices listed overleaf.

[illegible]

Order form

1 ☐ Please enter my subscription to:
Nicotine & Tobacco Research
Volume 6, 2004, 6 issues per year
Print ISSN 1462-2203, Online ISSN 1469-994x

Institutional Rate (includes free online access)

☐ US$552 ☐ £333

Members of the **Society for Research on Nicotine and Tobacco (SRNT)** receive the Journal as part of their annual membership. Please contact the Society for further information: www.srnt.org

Subscription rates include postage/air speeded delivery. The Sterling prices quoted apply in the UK and Republic of Ireland only.

2 To request an online sample copy of ***Nicotine & Tobacco Research,*** please visit the Taylor & Francis website at www.tandf.co.uk/journals

PLEASE SEND MY JOURNALS TO:

NAME (BLOCK CAPITALS)	
INSTITUTION/COMPANY*	
DEPARTMENT*	
STREET	
TOWN	
STATE/COUNTY	
COUNTRY	
POST/ZIP CODE	
TELEPHONE	
EMAIL	

**** Please complete this information only if you are taking out an institutional subscription.***

Please note: personal rate subscribers must give a personal address.

3 To receive information on related publications from the Taylor & Francis Group, please tick here*:

☐ by email ☐ by post

** Your personal details will not be passed on to any third party.*

Methods of payment overleaf

Taylor&Francis
healthsciences

TAYLOR & FRANCIS ONLINE SERVICES

Scholarly Articles Research Alerting
SARA is a free email contents alerting service designed to deliver tables of contents for over 850 journals of your choice in advance of the printed edition. Registering for the service is simple and you can now request to receive alerts by main category, subcategory, title or keyword. For more information visit **www.tandf.co.uk/sara**

Online Access
Institutional subscribers to the print version of the 2004 volume can enjoy online access free of charge. For further information connect to **www.tandf.co.uk/online**

Online Sample Copies
A fully searchable sample copy of this journal is available by visiting www.tandf.co.uk/journals

Arena
Visit **www.addictionarena.com** for the latest research and information in your subject area including author resources, books, online journals, conferences and learned societies.

Libsite
Visit the new Taylor & Francis web resource for Librarians and information professionals.
www.tandf.co.uk/libsite

CrossRef
An international active reference linking service. Visit **www.crossref.org** for more information.

NOTES FOR CONTRIBUTORS

Contributions to the journal are welcomed. Please contact the Editor directly.

By post: Gary E. Swan, Center for Health Sciences, SRI International, 333 Ravenswood Ave., Menlo Park, CA 94025. USA

Or by email: NTRmaster@ntrjournal.org

Full instructions for authors are available at. www.tandf.co.uk/journals/authors/cntr-typesofsub.asp

ORDERING INFORMATION

Nicotine & Tobacco Research
Volume 6, 2004, 6 issues per year, Print ISSN 1462-2203, Online ISSN 1469-994X

Institutional Rate. US$552/£333 (includes free online access)

Members of the **Society for Research on Nicotine and Tobacco (SRNT)** receive the Journal as part of their annual membership. Please contact the Society for further information: www.srnt.org

Subscription rates include postage/air speeded delivery. The Sterling prices quoted apply in the UK and Republic of Ireland only.

Please complete in full the details on the attached Order Form and return to:

Taylor & Francis Ltd, Customer Services Department, Rankine Road, Basingstoke, Hants, RG24 8PR, UK
Tel. +44 (0)1256 813002, Fax: +44 (0)1256 330245

OR TO

Taylor & Francis Ltd, Customer Services Department, 325 Chestnut Street, 8th Floor, Philadelphia, PA 19106, USA
Tel +1 215 625 8900, Fax +1 215 625 8914

BY EMAIL: journals.orders@tandf.co.uk

WEBSITE: www.tandf.co.uk/journals

ORDER ONLINE AT: www.tandf.co.uk/journals/titles/14622203.html

WEBSITE: www.tandf.co.uk/journals

OR HAND THE ORDER FORM TO YOUR LIBRARIAN WITH A RECOMMENDATION TO SUBSCRIBE

PH-6.

A case-control study of tobacco smoking and tuberculosis in India

R. Prasad, Suryakant, R. Garg, S. Singhal, R. Dawar, G. G. Agarwal[1]

Department of Pulmonary Medicine, Chhatrapati Sahuji Maharaj Medical University (Erstwhile K. G. Medical University), [1]Department of Statistics, Lucknow University, Lucknow, India

Abstract:

OBJECTIVES: To evaluate the role of smoking as a risk factor for the development of pulmonary tuberculosis.

MATERIALS AND METHODS: A total of 131 sputum smear-positive patients of pulmonary tuberculosis and 333 controls matched for age and sex were interviewed according to a predesigned questionnaire.

RESULTS: The adjusted odd ratio of the association between tobacco smoking and pulmonary tuberculosis was 3.8 (95% confidence interval, 2.0 to 7.0; P value <.0001). A positive relationship between pack years, body mass index and socioeconomic class was also observed.

CONCLUSION: There is a positive association between tobacco smoking and pulmonary tuberculosis.

Key words:

Diagnosis, India, smoking, tobacco, tuberculosis

Nearly 17% of smokers of the world live in India.[1,2] Recent household surveys from India have shown that more than one third of men and a few percent of women who smoke tobacco are in the middle age group.[3-6] It has been consistently shown from various disease surveys in India that the prevalence of pulmonary tuberculosis among males aged ≥15 years is 2-4 times higher than in females of the same age,[7] so it might be possible that there is an association between tobacco smoking and the higher rate of tuberculosis in adolescent males.

Therefore, a case-control study was carried out to determine the association between pulmonary tuberculosis and smoking.

Materials and Methods

This study was carried out in the Department of Pulmonary Medicine of the Chhatrapati Sahuji Maharaj Medical University. We included subjects from Uttar Pradesh only, whereas the rest were excluded. Thus a population of 166,197,921 subjects (total population of U.P.) was surveyed and was the source for cases and controls for the present study. Patients were recruited from September 2004 to August 2005.

Sputum smear-positive pulmonary tuberculosis patients were taken as cases. For each case, 3 controls were taken from among the healthy bystanders of that patient. They were matched for age (±5 years), sex and place. To exclude any respiratory disease, all controls were subjected to clinical evaluation, chest radiograph and sputum examination. All subjects with comorbid conditions such as diabetes mellitus, human immunodeficiency virus infection and malignancy, and those on any immunosuppressive drugs were also excluded from the study.

Informed consent was taken from all subjects. Approval for this study was also obtained from the review board of our institution. A predesigned questionnaire enquiring about smoking history, household smoke exposure, environmental smoke exposure, tobacco chewing, alcoholism, housing characteristics and score on the modified Kuppuswamy socioeconomic status scale was used as instrument for data collection. This modified Kuppuswamy socioeconomic status classification contemplates five social classes: Upper (I), upper middle (II), lower middle (III), upper lower (IV) and lower (V). Details of smoking were noted carefully with regard to type, current smoking status, age of starting smoking, duration of smoking and quantity of smoking. Trained MD students (trained in the subject of 'tuberculosis and chest disease') interviewed the subjects in the hospital. 'Smoker' was defined as a person who had smoked more than 100 cigarettes/bidis during his/her lifetime. 'Nonsmoker' was defined as a person with exposure less than that stated above.

Statistical analysis

Data was entered into Microsoft Excel and subsequently converted to an SAS file for performing univariate and multivariable analysis. Univariate analysis was carried out by computing unadjusted matched odds ratios (ORs) and their 95% CIs to compare cases and controls for each categorical variable of interest, where as *t* test statistics was used to make the corresponding comparison for the continuous variables. Multivariable analysis was conducted through conditional logistic regression to identify risk factors independently associated

Address for correspondence:
R. Prasad,
Department of Pulmonary Medicine, Chhatrapati Sahuji Maharaj Medical University (Erstwhile K. G. Medical University), Lucknow - 226 003, India.
E-mail: rpmdsa2@rediffmail.com

Submission: 28-01-09
Accepted: 20-04-09
DOI:

with pulmonary tuberculosis and to calculate their adjusted matched odds ratios.

Results

A total of 111 patients and 333 controls were enrolled in the study. Smoking history was present in 33.3% of the patients as compared to 13.8% of controls. The mean pack/year was 4.77 among patients and 0.88 among controls. After controlling for the effect of other variables in the model, the odds of developing pulmonary tuberculosis among smokers was 3.8 times more than that among nonsmokers [OR = 3.8 (95% CI, 2.0 to 7.0), $P < .0001$].

The risk was higher for the persons who were smoking ≥5 pack years [adjusted OR = 4.6 (95% CI, 2.1 to 10.1)] than persons who were smoking ≤5 pack years [adjusted OR = 2.9 (95% CI, 1.2 to 6.9)]. Persons smoking more number of bidis or cigarettes per day and for lesser duration and vice versa can have the same pack/year [Table 1]. Analysis was also done to answer the question, which is more hazardous, a large number of bidis or cigarettes per day or a long duration of smoking [Table 1]? The odds of developing pulmonary tuberculosis among persons who smoked ≤10 bidis or cigarettes per day [adjusted OR = 4.0 (95% CI, 1.7 to 9.1)] was slightly more in comparison to persons who smoked ≥10 bidis or cigarettes per day [adjusted OR = 3.6 (95% CI, 2.1 to 13.1)]. However, the odds of developing pulmonary tuberculosis among persons who smoked for a duration of ≥10 years [adjusted OR = 5.7 (95% CI, 2.1 to 13.1)] was more in comparison to persons who smoked for a duration of ≤10 years [adjusted OR = 2.5 (95% CI, 1.1 to 5.7)]. These analyses reveal that long duration of smoking is more hazardous than a large number of bidis or cigarettes per day.

Analyses were also done to assess the association between pulmonary tuberculosis and various factors like socioeconomic status, body mass index (BMI), type of housing, alcohol intake and environmental exposure [Tables 2 and 3]. The odds of developing pulmonary tuberculosis among social class V [adjusted OR = 5.3 (95% CI, 1.8 to 16.0)] was more than that among social class IV [adjusted OR = 2.3 (95% CI, 0.8 to 6.7)] with reference to social class type III. Alcohol intake was also found to have an association with the occurrence of pulmonary tuberculosis [adjusted OR = 1.7 (95% CI, 0.9 to 3.3)]. Having BMI < the median value of 19.4 was strongly associated with pulmonary tuberculosis [adjusted OR = 4.1 (95% CI, 2.5 to 6.8)]. Persons living in kuchcha or semi-pucca houses [adjusted OR = 3.2 (95% CI, 1.4 to 7.5)] had almost similar odds of developing pulmonary tuberculosis when compared with persons living in pucca houses [adjusted OR = 2.3 (95% CI, 1.0 to 5.1). Other factors like chewing tobacco, alcohol, mosquito coil and biomass fuel were not found to be associated with pulmonary tuberculosis in the univariate analysis [Table 3].

Table 1: Association of pulmonary tuberculosis with smoking

Variables	Cases 111 (100%)	Controls 333 (100%)	Matched OR (95% CI)	Adjusted* OR (95% CI)	*P* value
Pack/year					
≤5	15 (13.5)	27 (8.1)	2.4 (1.1, 5.0)	2.9 (1.2, 6.9)	0.02
>5	22 (19.8)	19 (5.7)	4.6 (2.3, 9.2)	4.6 (2.1, 10.1)	0.0001
No. of bidis or cigarettes per day*					
≤10	19 (17.1)	24 (7.2)	3.4 (1.7, 7.0)	4.0 (1.7, 9.1)	0.001
≥10	18 (16.2)	22 (6.6)	3.4 (1.7, 6.8)	3.6 (1.7, 7.9)	0.001
Duration of smoking (years)*					
≤10	15 (13.5)	30 (9.0)	2.0 (1.0, 4.2)	2.5 (1.1, 5.7)	0.03
>10	22 (19.8)	16 (4.8)	5.6 (2.7, 11.8)	5.7 (2.4, 13.1)	<0.0001

*Reference category is "nonsmoker"; *Adjusted for BMI, social class and house type

Table 2: Multivariable logistic regression model for the factors associated with pulmonary tuberculosis

Variables	Matched OR (95% CI)	Adjusted OR (95% CI)	*P* value
Smoking	3.4 (2.0, 5.8)	3.8 (2.0, 7.0)	< 0.0001
Social class*			
Type V	5.3 (1.8, 16.0)	3.6 (1.0, 12.8)	0.04
Type IV	2.3 (0.8, 6.7)	1.9 (0.6, 6.4)	0.3
House type**			
Kuchcha	3.2 (1.4, 7.5)	2.8 (1.1, 7.2)	0.03
Semi-*pucca*	2.3 (1.0, 5.1)	2.3 (0.9, 5.6)	0.07
Body mass index***	4.1 (2.5, 6.8)	4.2 (2.4, 7.3)	< 0.0001

*Reference category is "type III socioeconomic status"; **Reference category is "pakka house"; ***Reference category is "BMI > 19.4 (median value)

Table 3: Univariate analysis of various other factors for their possible association with pulmonary tuberculosis

Variables	Cases 111 (100.0%)	Controls 333 (100.0%)	Matched OR (95% CI)
Chewing tobacco	24 (21.6)	76 (22.8)	0.9 (0.6, 1.6)
Alcohol	19 (17.1)	37 (11.1)	1.7 (0.9, 3.3)
Mosquito coil	25 (22.5)	70 (21.0)	1.1 (0.7, 1.9)
Biomass fuel	29 (26.1)	92 (27.6)	0.9 (0.6, 1.5)

Discussion

In our case-control study of 111 sputum smear-positive pulmonary tuberculosis (TB) patients and 333 controls, the odds of developing pulmonary tuberculosis among smokers was 3.4 times more than that among nonsmokers, a figure that increased to 3.8 after controlling for the effect of other confounders like socioeconomic status, body mass index and house type [OR = 3.8 (95% CI, 2.0 to 7.0)]. Most of our subjects belonged to low socioeconomic class, in which bidi smoking is the prevalent mode of smoking. The relatively low combustibility and nonporous nature of the tendu leaves (used in manufacturing of bidis) require more frequent and deeper puffs by the smoker to keep bidis lit, which is therefore more harmful to active smokers as compared to passive smokers.

The above result is in agreement with the previous Indian studies, which also report the higher odds ratio of developing tuberculosis among smokers as compared to nonsmokers.[6-9] Recent meta-analysis[10] also showed that OR for TB disease ranged from 2.33 (95% CI, 1.97 to 2.75) to 2.66 (95% CI, 2.15 to 3.28). The reason for the increased risk of developing

pulmonary tuberculosis among smokers is not clear, but the increased risk among smokers may be explained by the effects of smoking on pulmonary host defenses. Chronic exposure to tobacco, as well as to a number of environmental pollutants, impairs the normal clearance of secretions on the tracheobronchial mucosal surface and may thus allow the causative organism, Mycobacterium tuberculosis, to escape the first level of host defenses, which prevent bacilli from reaching the alveoli.[10] Smoke also impairs the function of pulmonary alveolar macrophages (AMs), which are not only the cellular target of *M. tuberculosis* infection but also constitute an important early defense mechanism against the bacteria. AMs isolated from the lungs of smokers have reduced phagocytic ability and a lower level of secreted proinflammatory cytokines than do those from the lungs of nonsmokers.[10] Recent work has suggested a novel mechanism for the effect. Nicotine is hypothesized to act directly on nicotine acetylcholine receptors on macrophages to decrease production of intracellular tumor necrosis factor and thus impair killing of M. tuberculosis.[10] These effects of smoking on pulmonary host defense support a causal link between smoke exposure and either an increased risk of acquiring TB or progression of TB to a clinical disease. In our study, duration of smoking was found to be more significantly associated with development of pulmonary tuberculosis in comparison to quantity of bidis or cigarettes. According to other studies, stronger association was found to be present between numbers of bidis or cigarettes per day and development of pulmonary tuberculosis.[6,7] This difference may be due to the difference in sample size. In our study, socioeconomic status, alcohol and BMI were also found to have significant association with the development of tuberculosis, whereas the type of house in which one lived and non-inhalation mode of tobacco exposure were not found to be significantly associated. This is in conformity with other studies.[11,12] Recent meta-analysis found substantial evidence that passive smoking and indoor air pollution increased the risk of TB disease.[16] It can be concluded that smoking is associated with high prevalence of tuberculosis in India. Therefore, in India, where both smoking and tuberculosis are common conditions, preventing initiation of smoking and promoting quitting of smoking are important TB-preventive measures.

Limitation

Most of the patients attending our hospital are of low and middle socioeconomic class. Therefore, our sample may not be the true representative of the population.

References

1. John R. Tobacco consumption patterns and its health implications in India. Health Policy 2005;71:213-22.
2. Yach D. Tobacco consumption in India-Commentary. J Public Health Policy 2003;24:246-50.
3. Special fertility and mortality survey, 1998. A report on 1.1 million homes. New Delhi, India: Registrar-General of India, 2005.
4. Rani M, Bonu S, Jha P, Nguyen SN, Jamjoum L. Tobacco use in India: Prevalence and predictors of smoking and chewing in a national cross sectional house-hold survey. Tob Control 2003;12:e4.
5. Anon. Tuberculosis prevention trial, Madras: Trial of BCG vaccines in South India for tuberculosis prevention. Indian J Med Res 1980;72:1-74.
6. Gajalakshmi V, Peto R, Kanaka S, Jha P. Smoking and mortality from tuberculosis and other diseases in India: Retrospective study of 43,000 adult male deaths and 35,000 controls. Lancet 2003;362:507-15.
7. Kolappan C, Gopi PG. Tobacco smoking and pulmonary tuberculosis. Thorax 2002;57:964-6.
8. Shenoy ST, Sheela ST, Leena KB, Peto R. Sociodemographic characteristics of tobacco use and health profile among 107,654 individuals and the association of tobacco use and tuberculosis in Kerala, India. In: Tobacco Research in India. Proceedings of expert meeting on efforts to reduce harm, 2002 Apr 10-11, New Delhi, India. Mumbai: Tata Institute of Fundamental Research; 2003.
9. Gupta D, Aggarwal AN, Kumar S, Jindal SK. Smoking increases risk of pulmonary tuberculosis. Journal of Environmental Medicine 2001;3:5-9.
10. Bates MN, Khalakdina A, Pai M, Chang L, Lessa F, Smith KR. Risk of tuberculosis from exposure to tobacco smoke. Arch Intern Med 2007;167:335-42.
11. Houtmeyers E, Gosselink R, Gayan-Ramirez G, Decramer M. Regulation of mucociliary clearance in health and disease. Eur Respir J 1999;13:1177-88.
12. Sopori M. Effects of cigarette smoke on the immune system. Nat Rev Immunol 2002;2:372-7.
13. Wang H, Yu M, Ochani M, Amella CA, Tanovic M, Susarla S, *et al.* Nicotinic acetylcholine receptor alpha 7 subunit is an essential regulator of inflammation. Nature 2003;421:384-8.
14. Altet MN, Alcaide J, Plans P, Taberner JL, Salto E, Folguera LI, *et al.* Passive smoking and risk of pulmonary tuberculosis in children immediately following infection. A case-control study. Tubercle Lung Dis 1996;77:537-44.
15. Brown KE, Campbell AH. Tobacco, alcohol and tuberculosis. Brit J Dis Chest 1961;55:150-8.
16. Lin HH, Ezzati M, Murray M. Tobacco smoke, indoor air pollution and tuberculosis: A systematic review and meta-analysis. Plos Med 2007;e:e20.

Source of Support: Nil, Conflict of Interest: None declared.