

## Special Topic: Tobacco Control

### The Director's Perspective: The Challenge and Promise of Tobacco Control

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It has been just over 40 years since the first Surgeon General's report on smoking and health alerted the American public to the link between tobacco use and cancer. Since that release, our knowledge about the negative health consequences of tobacco use has greatly increased. It is now well documented that tobacco use causes cancer, heart disease, chronic lung disease, and many other diseases. Amazingly, despite its clear connection to premature death and one of the most feared diseases of our time (cancer), tobacco use remains the leading preventable cause of death in the United States.

What we didn't know in 1964 was how overwhelming the burden of tobacco would prove to be: 8.6 million Americans suffer from heart disease, emphysema, and other debilitating diseases caused by tobacco use. In addition, we were yet to discover that the risks of tobacco use extend beyond the actual users. Exposure to secondhand smoke increases nonsmokers' risk for lung cancer and heart disease. Babies in utero can suffer serious, life-compromising effects from nicotine exposure.

Secondhand smoke is also associated with serious respiratory problems, including asthma, pneumonia, and bronchitis among children.

Each year about 440,000 adults die of a smoking-attributable illness in the United States. But this figure is only the tip of the iceberg. For every person who dies, 20 people suffer at least one serious illness caused by tobacco use.

CDC is committed to tobacco prevention and control as one of its highest priorities in protecting the health of the nation. We focus significant effort on preventing young people from ever starting to use tobacco, and we support smokers' efforts to overcome their addiction. Eliminating exposure to secondhand smoke and closing disparity gaps among populations hardest hit by tobacco use round out CDC's tobacco control agenda.

#### We know what works

The best way to accomplish these goals is through comprehensive tobacco control programs. By comprehensive programs, we mean state and local programs that use evi-

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## The Director's Perspective

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dence-based tobacco control strategies that tackle tobacco use on a variety of fronts. Key strategies include health care interventions; telephone quitlines; counter-marketing campaigns; school health education; establishment and enforcement of laws and policies to limit minors' access, increase tobacco pricing, and decrease exposure to secondhand smoke; insurance coverage for tobacco cessation; surveillance of tobacco use rates; and evaluation of programs and policies designed to prevent tobacco use.

To reach the greatest number of people with these proven strategies, CDC works with many partners such as state and local public health agencies, professional associations and voluntary groups, training and continuing education groups, and organizations that fund and support state tobacco control programs. We encourage our state tobacco control programs to develop similar partnerships.

Another powerful partner for CDC and the states are the physicians, dentists, and health care staff who provide clinical care. Too many health care providers miss the opportunity to help their patients stop tobacco use. To address this problem, state tobacco control programs are reaching out to physicians, dentists, and their staffs, and providing them with tools and strategies that help people quit.

## One day tobacco-related death and disease will be history

Despite all the knowledge we have amassed about the link between tobacco use and poor health, tobacco is not an easy foe. In the face of overwhelming evidence of harm, about 3,900 young people try their first cigarette each day. While this statistic defies logic, it is a reality we must understand better and combat effectively. On the other side of the coin, our efforts to assist tobacco users who wish to quit will, due to the addictive properties of nicotine, remain a formidable challenge for some time to come.

Clearly, we have made considerable progress against tobacco use during the past several decades, and tobacco control programs serve as a model for public health interventions. If reducing tobacco use were not such an urgent and important mission, we might be satisfied with the progress made to date. Instead we must commit to re-doubling our efforts once again to achieve the public health victory within our grasp. ☀

Commentary

## Eliminating Tobacco-Related Death and Disease

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The percentage of adults in the United States who smoke continues to decline, and former smokers now outnumber current smokers. After a dramatic increase in youth smoking in the early 1990s, rates have declined to their lowest level ever. Exposure to secondhand smoke in public places decreased as state and local governments restricted smoking in public places and workplaces. Through the National Network of Tobacco Cessation Quitlines, the basic infrastructure for quitline services is now available throughout the United States and in several territories, increasing smokers' access to telephone-based tobacco-cessation counseling.

Despite these successes, our work is far from over. More than 45 million Americans smoke, and recent data show that rates of decline among young people may have stalled. Funding for smoking-prevention media campaigns significantly declined from 2002 to 2004, just as state funding for tobacco prevention and control programs overall decreased by 28%. At the same time, tobacco industry expenditures on advertising and promotion rose substantially (from \$5.7 billion in 1997 to \$15.2 billion in 2003).

Comprehensive statewide tobacco control programs have been shown to reduce tobacco-related deaths and disease. California's decade-long program reduced deaths from heart

disease by 33,000 over 8 years.

In addition, from 1988 to 2001, the incidence of lung cancer in California declined significantly more than in other parts of the country.

The more states spend on comprehensive tobacco control programs, the greater the reductions in smoking. And the longer states invest in such programs, the greater and faster the impact. For example, cigarette sales dropped more than twice as much in states that invest heavily in comprehensive tobacco control programs as in the United States as a whole, and the smoking prevalence of young people declined faster as spending for tobacco control programs increased.

Unfortunately, recent fiscal crises have eroded states' investment in tobacco control. Total spending is now less than 3% of the more than \$19 billion that states received in 2004 from tobacco excise tax and tobacco settlement payments. A mere 8% of funds from these sources would allow all state tobacco control programs to meet CDC's minimum recommended spending level. Spending only 1% of what is spent each year on health care costs and lost productivity from tobacco use could fund comprehensive programs in every state.

Although long-term success depends on preventing the initiation of tobacco use, helping current tobacco users to quit is the only way to decrease tobacco-related illness, death, and economic costs in the near



term. Resources to prevent tobacco use are eroding, which is slowing decreases in rates of tobacco use by middle and high school students. Therefore, we need improvements in evidence-based programs that reduce adolescent smoking and prevent tobacco-related disease and death.

Progress in policy implementation and changes in social norms must be maintained. We need to continue our surveillance, epidemiologic, and behavioral research to increase our understanding of ways to sustain policy, environmental, and normative change in support of tobacco control. We also need 1) to expand research to address emerging threats like the new tobacco products and their marketing by a sophisticated industry, 2) to maintain close collaboration with our valued partners, and 3) to make new partnerships with the business community and purchasers of health care. Together we can reduce tobacco use and improve the length and quality of life for all Americans. 🌞

## The Burden of Smoking Remains High

The recent death of Peter Jennings from lung cancer brings home the tragic consequences of nicotine addiction. Because smoking rates in the United States have been declining, there may be a tendency to underestimate the magnitude of the health problems tobacco use still causes. Although significant progress has been made in many areas of tobacco control, millions of Americans are still affected by tobacco addiction and related diseases. In 2003, an estimated 45.4 million U.S. adults were smokers.<sup>1</sup>

Each year approximately 440,000 adults die of a smoking-attributable illness in this country. But this is only one part of the story, because for every person who dies, there are 20 people who suffer at least one serious illness from smoking.

In the United States, cigarette smoking also has important financial costs: \$75 billion in direct medical costs and \$92 billion in lost productivity each year, or more than \$3300 per person in the United States.<sup>1</sup> About 14% of all Medicaid expenditures are related to smoking. Further, the Society of Actuaries recently reported an estimated \$10 billion per year cost associated with exposure to secondhand smoke.<sup>2</sup>

### Tobacco's Effects on Infants and Young Children

Some of the most tragic health effects of smoking are those that involve children. When pregnant women smoke or are regularly exposed to secondhand smoke, the consequences for their unborn children

### The Harmful Effects of Smoking

- During the past 40 years, cigarette smoking has caused an estimated 12 million deaths in the United States. This includes 4.1 million deaths from cancer, 5.5 million deaths from heart disease and stroke, and 94,000 deaths of infants whose mothers smoked during pregnancy.
- Today, more than 8.6 million people in this country have a serious illness caused by smoking.
- Each year, approximately 440,000 U.S. residents die of diseases caused by tobacco use.
- On average, smokers die about 14 years earlier than nonsmokers.
- Secondhand smoke causes lung disease and lung cancer in people who do not smoke.
- Smoking causes 20% of low-birth-weight deliveries, 8% of preterm deliveries, and 5% of perinatal deaths in this country.

can be severe. The results may be spontaneous abortions, preterm deliveries, perinatal deaths (after 20 weeks gestation or within the first 28 days of life), problems requiring neonatal intensive care, and sudden infant death syndrome (SIDS).

Mothers who smoke during pregnancy are three times more likely than nonsmokers to have a baby die of SIDS. Exposure to secondhand smoke from smoking by household members increases a baby's risk for SIDS.

Each year, an estimated 150,000–300,000 children younger than 18 months of age have respiratory tract infections because of exposure to secondhand smoke.<sup>3</sup> Secondhand smoke can also cause infants and children to develop

respiratory illnesses that are expensive to treat. Often, public funds are needed to cover these costs.

Smoking-attributable neonatal health care costs for the Medicaid system total almost \$228 million, or about \$738 per smoker whose delivery is paid for by state Medicaid programs.<sup>4</sup>

In 1998, the proportion of pregnant women covered by Medicaid who smoked during the last 3 months of pregnancy ranged from 15.8% to 38.5% in 15 states. On average, smoking among pregnant women on Medicaid was 2.5 times that of pregnant women without Medicaid coverage.<sup>5</sup>

Smoking during pregnancy also is costly in terms of hospital expenses,<sup>6</sup> according to Kathleen Adams, PhD, Associate Professor in the Rollins School of Public Health at Emory University and a CDC visiting scientist. For example, one recent study found that maternal smoking increased an infant's relative risk of being admitted to a neonatal intensive care unit (NICU) by almost 20%, and these infants typically stayed longer than infants whose mothers did not smoke.<sup>7</sup>

In addition, hospital costs for these infants were higher: \$2,496 per night in NICU and \$1,796 in a regular nursery versus \$748 for non-NICU infants. Among mothers who smoke, smoking adds more than \$700 in highly preventable neonatal costs, the researchers concluded.

## Tobacco's Effects on Teenagers and Young Adults

Rates of smoking among high school students have dropped after a rapid increase in the mid-1990s. In 2003, smoking rates among high school students were 22%. However, the 2004 National Youth Tobacco Survey found that middle and high school smoking rates essentially remained unchanged from 2002 to 2004, indicating that the rapid decline in smoking by young people may be stalling.

Several factors may contribute to the leveling off of cigarette use by young people. First, funds for state tobacco use prevention programs and national counter-marketing campaigns have been drastically reduced. Meanwhile, tobacco industry expenditures on advertising and promotion increased from nearly \$6 billion in 1997 to \$15 billion in 2003.<sup>8,9</sup>

In addition, smoking remains glamorized in films, which are known to influence whether young people start smoking.<sup>10</sup> Young people also



report seeing a significant increase in the number of tobacco advertisements on the Internet. And underage buyers are still able to purchase cigarettes relatively easily. Among current high school smokers, 63.9% were not asked to show proof of age when they purchased or attempted to purchase cigarettes from a store, and 62.1% were not refused purchase of cigarettes because of their age.<sup>11</sup>

Lastly, the tobacco industry has kept prices low through special offers and promotions, offsetting the benefits of tax increases in reducing rates of tobacco use by young people. Since 80% of adult smokers began smoking before age 18, preventing young people from starting to smoke is essential to curb future tobacco use.

“The critical issue is around kids and youth,” said CDC medical officer and health communication specialist David Nelson, MD, MPH. “Cutbacks in programs are affecting young people. The lack of substantial decreases in the use of almost all tobacco products among middle and high school students underscores the need to fully implement evidence-based strategies.”

### Smoking Prevalence Declines Among Adults

CDC epidemiologists recently noted important evidence of the decline in the number of U.S. smokers. During 1983–2004, the percentage of adults who smoke declined from 32% to 20.9%. The decline was greatest during the 1980s, leveled off during the early 1990s, and fell again between 1997 and 2004.<sup>11</sup> Reasons for the dramatic decline in smoking rates

include increases in the price of cigarettes, increases in the percentage of smoke-free indoor places, and a decline in the social acceptability of smoking. The pattern was consistent across all age groups—with only one exception. Among adults aged 18–24 years, smoking prevalence increased in the 1990s but declined in 2003. Reasons for the increase in smoking among young adults include 1) an increase in tobacco industry advertising and promotions targeted to this age group and 2) higher adolescent rates of the early 1990s being reflected in young adult rates in the late 1990s.

An estimated 45.9 million adults were former smokers in 2003. That number is 50.3% of those who had ever smoked. For the second consecutive year, more adults have quit than are still smokers. In 2003, more smokers were exposed to physician counseling to help them quit and to public health efforts such as population-based smoking cessation programs (e.g., telephone quitlines).<sup>12</sup>

In the past, smoking rates were higher for African Americans than for whites. For example, during the 1980s, African American smoking rates were three to five percentage points higher than those for whites. In the 21st century, that trend was reversed. Starting in 2000 and continuing through 2003, the percentage of African Americans who smoked was about one percentage point less than the percentage of whites who smoked.<sup>13</sup>



### Some Populations Harder Hit than Others

Disparities exist in tobacco use initiation, quit rates, illness and death from tobacco-related causes, and exposure to secondhand smoke. For example, racial and ethnic groups have varying rates of smoking prevalence. In 2003, smoking prevalence was highest among American Indians/Alaska Natives (39.7%) and lowest among Asians (11.7%) and Hispanics (16.4%), although high smoking rates have been reported for some groups of Asians.<sup>1</sup>

To reduce the health effects of smoking, focusing on specific high-risk populations is essential. New initiatives target American Indians and Alaska Natives (AI/AN), the groups with the highest smoking rates. These initiatives include support for Tribal Support Centers (TSC), which will conduct implementation and evaluation of culturally relevant and community-competent tobacco control and prevention strategies. Another initiative is the Evidence-Based Approaches, Measures, and Tools for Promoting Tobacco Cessation Efforts Among

American Indians and Alaskan Natives, which will evaluate cessation materials, guides, and tools that were tailored for AI/AN populations.

### Secondhand Smoke Affects Nonsmokers, Service Workers

The health consequences of smoking extend beyond smokers. Each year, an estimated 3,000 deaths due to lung cancer and 35,000 deaths due to coronary heart disease among adult nonsmokers are attributed to secondhand smoke.

Some populations are affected more than others [see *Eliminating Tobacco-Related Health Disparities*, p.16.] Despite a significant decline in the percentage of nonsmokers exposed to secondhand smoke in the United States in the last 10 years, the percentage of decrease was smaller for African Americans than for whites or Hispanics, and it was smaller for children than for adults.

In addition, waiters, waitresses, and bartenders are significantly less likely than other occupations to work in locations with smoking restrictions. One study estimated that food service workers have a 50% greater risk of developing lung cancer than the general population, resulting in part from occupational exposure to secondhand smoke.<sup>14</sup>

### CDC's Tobacco Control Program

CDC's Office on Smoking and Health (OSH) supports comprehensive approaches to tobacco control and prevention programs through the National Tobacco Control Program (NTCP). OSH created the NTCP to encourage coordinated, national

efforts to reduce tobacco-related diseases and deaths. The NTCP provides technical support and funding to all 50 states, the District of Columbia, seven U.S. territories, several Tribal Support Centers, and eight national networks.

With fiscal year 2004 funding of about \$104 million, OSH supports a comprehensive evidence-based approach to reducing tobacco use, in collaboration with a diverse network of government agencies, professional and voluntary organizations, and academic institutions. A comprehensive approach involves programs to achieve these goals:

- Preventing young people from starting to smoke.
- Eliminating exposure to second-hand smoke.
- Promoting quitting among young people and adults.
- Identifying and eliminating disparities in tobacco use among different population groups.

A *Journal of Health Economics* study found that between 1990 and 2000, cigarette sales dropped more than twice as much in states with comprehensive tobacco control programs than in the United States overall.<sup>15</sup> Essential elements of this approach include state- and community-based interventions, counter-marketing, policy development, surveillance, and evaluation. These activities are population-based, but they also target groups at highest risk for tobacco-related health problems.

In addition to its long-term goals described earlier, CDC focuses on four strategic priorities for accelerating progress toward a tobacco-free future; these priorities are shorter term and designed to take advantage of timely opportunities:

- Sustaining state tobacco control programs.
- Expanding research on tobacco products.
- Engaging businesses in promoting comprehensive tobacco control.
- Expanding global tobacco control activities.

### Reaching the Goal

Although the successes in preventing and controlling tobacco use are encouraging, we are not close to achieving the *Healthy People 2010* goal of only 12% of U.S. adults to be smokers. To reach that goal, the decline in tobacco use must accelerate.<sup>1</sup> A key component of a comprehensive approach, as well as one of OSH's four strategic goals, is promoting tobacco use cessation among adults and young people. Through the NTCP and its partnerships, OSH developed and supported national, state, and local infrastructure to help more Americans quit. All smokers who want to quit need access to support from their health care providers, employers, and state-based quitlines (part of the National Network of Tobacco Use Cessation Quitlines). Interventions tailored to the groups with the highest smoking rates will also make a difference.

“We’ve known that tobacco is the leading preventable cause of death for a long time,” said OSH Acting Director Corinne Husten, MD, MPH. “The good news is that we know more than enough to be able to act now to reduce the death rate.” ☀

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## Sustaining State Programs

The recent history of U.S. tobacco control is divided into two parts: before and after November 23, 1998. On this date, the Attorneys General and other representatives of 46 states, six U.S. territories, and the District of Columbia signed an agreement with the five largest U.S. tobacco manufacturers, ending a 4-year legal battle between the states and the tobacco industry. Four states (Florida, Minnesota, Mississippi, and Texas) had previously settled with tobacco manufacturers for \$40 billion.

This Master Settlement Agreement (MSA) ordered the tobacco companies to reimburse the states for tobacco-related Medicaid expenditures and also prohibited tobacco advertising that targets people younger than 18 years of age. In addition, the tobacco companies were ordered to contribute \$300 million a year for 5 years ending in 2003 to support the American Legacy Foundation, which would create a public education program to reduce underage use of tobacco products.

### Fiscal Crises

Recent fiscal crises dramatically eroded states' investment in tobacco control. During fiscal years 2002–2005, the money states spent on tobacco control fell 28%; total spending is now less than 3% of the more than \$19 billion that states received in 2004 from tobacco excise tax and tobacco settlement payments. A mere 8% of funds from these sources would allow all state tobacco control programs to be funded at CDC's min-

imum recommended level. Research shows that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking. The longer states invest in such programs, the greater and faster the impact. If states could spend the minimum amount recommended by CDC on tobacco prevention and control, smoking rates for young people could be between 3% and 13% lower than they are.

Tobacco control advocacy groups warned that tobacco settlement funds could evaporate, but no one imagined how completely they would disappear.

According to the Federal Trade Commission (FTC), the major cigarette manufacturers spent \$15.15 billion on advertising and promotion in 2003, an increase of \$2.68 billion (21.5%) from 2002 and the most ever reported to the Commission. "As a result," reports the Campaign for Tobacco-Free Kids, a Washington, D.C.-based advocacy organization, "the states are being massively outspent, with state tobacco prevention efforts amounting to only a small fraction of tobacco industry marketing."

### Sustaining State Programs

The goal of comprehensive tobacco control programs is to reduce disease, disability, and death related to tobacco use. The health and economic burden of tobacco use can be dramatically reduced by implementing proven strategies. Achieving this goal will require collaboration among state decision makers, public

## The Sustaining States Objectives are to

- Provide strategic consultation to states and territories for the purpose of sustaining their programs.
- Develop and maintain partnerships that provide leadership for sustaining state and territorial funding.
- Provide and expand scientific knowledge about specific best-practice components.
- Develop and provide training for states and territories to support and promote program sustainability.

*“If states could spend the minimum amount recommended by CDC on tobacco prevention and control, smoking rates for young people could be between 3% and 13% lower than they are.”*

health officials, business leaders, and community members. Data from California and Massachusetts show that investment in comprehensive tobacco control programs can produce substantial reductions in tobacco use. Organizations such as the American Cancer Society, American Heart Association, American Legacy Foundation, American Lung Association, Americans for Nonsmokers Rights, Campaign for Tobacco-Free Kids, National Cancer Institute, and The Robert Wood Johnson Foundation are important contributors to the work of community and state coalitions.

CDC works strategically and collaboratively with such partners to coordinate how best to provide technical assistance to tobacco control efforts in states and territories. These partner relationships lead to better coordination and stronger support for states and territories. Many national partners have also faced financial issues that have limited their outreach efforts. The challenges faced together made these partnerships stronger and the collab-

oration allows the use of resources to be maximized.

These partners have assisted CDC with the sustaining states trainings, which help tobacco control professionals and advocates develop plans and strategies for sustaining their programs. As of October 2004, 23 state teams had participated in the planning and goal-setting process.

## State Success Stories

After the CDC and national partner training, the states developed and implemented unique plans that contributed to a number of successes.

In Colorado, which had one of the lowest cigarette excise taxes in the nation, advocates were able to raise the cost of cigarettes, a strategy that is expected to lower smoking rates.

In other states, similar strategies have proven effective. In Nebraska, state legislators restored \$2.5 million for tobacco prevention and control programs. In Virginia, legislators raised the tobacco excise tax and maintained the current funding level for tobacco control programs. New York was able to increase funding for tobacco control and prevention. (See details of these states' stories starting on page 13.)

Spending more on tobacco prevention and control would allow further improvements in public health. Increasing the amount of MSA funding that states are spending now (which ranges from 0% to 2.7%) to 8% would fund all states at the minimum level recommended by CDC. Tobacco control is a key component of public health

that needs to be sustained if the nation is to reduce the toll of death and disease from tobacco use.

## Colorado

In 2003 and 2004, the Colorado state legislature drastically reduced Master Settlement Agreement (MSA) funding for the State Tobacco Education and Prevention Partnership (STEPP) of the Colorado Department of Public Health. The result was that, in 2004, Colorado's spending on tobacco prevention and control fell from \$15 million to \$4.3 million. CDC's *Best Practices for Comprehensive Tobacco Control Programs* calls for spending at least \$24.5 million a year.

At the time, Colorado had one of the lowest cigarette excise taxes in the nation. Looking to replace the lost MSA funding, a coalition called Citizens for a Healthier Colorado worked to pass Amendment 35: Tobacco Tax Increase for Health-Related Purposes. The plan was to earmark the money for tobacco control programs; health care for low-income state residents; and cancer, heart disease, and lung disease programs, about \$25 million each.

Voters responded by approving a 66-cents-per-pack increase in the state cigarette excise tax and a 40% excise tax on non-cigarette tobacco products. The money will be used to expand the Medicaid Children's Health Insurance Program and the state's community health centers. In addition, 16% will go to tobacco control programs, and 16% will fund chronic disease programs. The funds cannot be reallocated—as the MSA

money was—without a popular vote. An added value of the coalition's work is that it provides a model for other states.

## Nebraska

In 2000, the Nebraska state legislature approved \$7 million a year for 3 years to fund Tobacco Free Nebraska (TFN), a comprehensive tobacco control program that targets prevention of smoking among young people, cessation, elimination of exposure to secondhand smoke, and elimination of disparities related to tobacco use and its effects among different population groups.

In 2003, citing budget concerns, the legislature cut TFN's budget from \$7 million to \$405,000 a year. According to CDC's *Best Practices for Comprehensive Tobacco Control Programs*,\* the minimum recommendation for Nebraska is \$15.3 million a year for a comprehensive tobacco control program.

Although tobacco control advocates wanted \$13.3 million a year, they decided the state's budget would not allow that level, and asked for \$5 million instead. Community members, tobacco control program staff, young people, and state and local coalitions invited state legislators to hear personal stories from TFN participants, held an educational breakfast that focused on cancer-related issues, and contacted legislators through face-to-face meetings, letters, e-mails, and telephone calls.

As a result of these efforts, in 2004, state legislators used MSA money to increase Tobacco Free Nebraska's

funding to \$2.5 million, and they earmarked this funding specifically for the TFN program so it would not be threatened in the future.

\*CDC. *Best Practices for Comprehensive Tobacco Control Programs—August 1999*. Atlanta, GA: CDC; 1999.

## Virginia

According to CDC's *Best Practices for Comprehensive Tobacco Control Programs*, the minimum recommendation for Virginia is \$38.9 million a year for a comprehensive tobacco control program. Currently, the state spends only about one-third that amount—\$13 million.

Before 2004, Virginia's cigarette excise tax was only 2.5 cents a pack, the nation's lowest. A coalition called Virginians for a Healthy Future was founded in 2002 to improve the health, education, and welfare of children, families, and communities by reducing the use of tobacco products in Virginia. The immediate goal was to raise the excise tax to the national average, which was 75 cents. The coalition also wanted tobacco products other than cigarettes to be taxed.

Virginians for a Healthy Future included representatives from the Virginia Education Association and the AARP. It also was part of the Southern Neighbors Collaborative, a partnership of public health organizations in seven southern states that seeks to raise cigarette taxes in tobacco-growing states.

In addition, the coalition was supported by the American Cancer

Society, American Heart Association, and American Lung Association, which paid for radio and television advertisements. A Web site urged visitors to become involved in the campaign.

Adopting the slogan "From 2.5 Cents to Common Sense," coalition members pointed out that Virginia's cigarette excise tax had not been raised for 37 years. They argued that increasing the tax would benefit state public health programs and ease the state's budget crisis. Their claims were bolstered by a poll that showed that most Virginians favored the increase.

As a result of the coalition's work, the state's cigarette excise tax was increased by 20 cents in September 2004; an additional 10-cent increase followed in July 2005. In addition, a new 10% tax was added to tobacco products other than cigarettes. The money raised was used to create the Health Care Trust Fund, which will be used solely to provide health care services, including prevention services, to Virginia residents.

## New York

In 2004, New York spent \$39.5 million a year on its comprehensive tobacco control program. That amount is less than half the recommended minimum. An independent evaluation of the program in 2004 led to a legislative hearing in February 2005. At the hearing, national experts, state health officials, independent evaluators, and funded community partners told policy makers that the burden of tobacco-related illness in New York was extraordinarily high and had

an impact in every community. Unmet needs could be addressed with more financial resources.

State and community leaders developed a funding-sustainability program for communitywide programs. In the end, tobacco control advocates won a \$4 million increase in funding, bringing the total to \$43.4 million a year.

### States Honored in Celebration of Successes

In May 2005, as part of the 2005 National Conference on Tobacco or Health, CDC's Office on Smoking and Health (OSH) in collaboration with the Campaign for Tobacco Free Kids, celebrated the success of tobacco control program managers and advocates in all 50 states. The celebration recognized policy successes such as increases in tobacco prices, protection of MSA funding for tobacco control programs, increases in MSA funding for tobacco control programs, reductions in prevalence rates for young people and adults, and expansion of cessation efforts.

"We're totally thrilled by the success we've seen," said CDC program consultant Monica Eischen. "We wanted people to know that we appreciated them, and we wanted to recognize their hard work and dedication to the issue."

"Ensuring the continued operation of evidence-based state programs is critical because we know that comprehensive tobacco control programs work," Ms. Eischen added. "We have the science to prove it." 

### Materials Developed for States

The following materials can be found at <http://www.cdc.gov/tobacco/sustainingstates/index.htm>

- Data Highlights 2004
- A Summary of State Tobacco Control Program Evaluation Literature
- Research Synopsis of State Tobacco Control Programs — Working Template
- Sustaining State Funding For Tobacco Control — The Facts
- Sustaining State Funding For Tobacco Control — OSH Strategic Priority
- Sustaining State Funding For Tobacco Control — Snapshot from Nebraska
- Sustaining State Funding For Tobacco Control — Snapshot from Virginia
- New — Sustaining State Funding For Tobacco Control — A Story from Colorado

## Eliminating Tobacco-Related Health Disparities

The burden of tobacco use is not evenly distributed within the U.S. population. Some groups are more adversely affected than others in several key areas, including risk of starting to use tobacco, quit rates, incidence of tobacco-related diseases, morbidity and mortality from these diseases, and exposure to second-hand tobacco smoke. In addition, there are important differences in the capacity of various organizations to address tobacco control and in people's access to prevention and cessation resources.

In 2003, smoking prevalence was highest among American Indians/Alaska Natives (39.7%) and lowest among Asians (11.7%) and Hispanics (16.4%). Among income groups, smoking prevalence was higher for adults living below the poverty level (30.5%) than for those at or above the poverty level (21.7%). By education level, adults who had earned a General Educational Development (GED) diploma (44.4%) had the highest prevalence of smoking; those with advanced degrees had the lowest prevalence (7.5%).<sup>1</sup>

Because these disparities exist both in tobacco use and in its effect, it is vitally important to develop and implement approaches to address and eliminate these disparities.

CDC's Office on Smoking and Health (OSH) funds national networks to develop capacity for addressing tobacco use prevention and control among priority populations, such as African Americans, American Indians/Alaska Natives, Asian Americans/Pacific Islanders,

Hispanics/Latinos, lesbian/gay/bisexual/transgender individuals, persons with low socioeconomic status, women, and young adults. The national network organizations were established among each specific population to plan, initiate, coordinate, and evaluate tobacco-use prevention and control activities within respective communities. They work to identify and develop culturally competent strategies to reach and affect their population.

OSH maintains a commitment to working closely with states, territories, and other partners to reduce and eliminate tobacco-related disparities and to develop strategic plans to address those disparities. In addition, OSH developed tools, resources, and materials to assist states in identifying disparities and implementing population-specific interventions. For example, states may use Locate and Learn, a detailed checklist to help states compile qualitative and quantitative data into meaningful state profiles, to drive their disparity-reduction initiatives.

Tailoring surveillance mechanisms toward specific populations is essential. Currently there are targeted efforts to develop surveillance tools that are "community-competent" and able to assess the diversity within specific populations. One such effort is to modify the Adult Tobacco Survey (ATS) instrument so that it is culturally appropriate for Hispanic/Latino populations. A corresponding training manual will also be developed. The ATS has already been adapted for both the American

Indian and Alaska Native (AI/AN) populations, and these instruments are currently in the field. To respect the sovereignty of these populations, agreements were reached to ensure that all collected data will be owned by the tribes and tribal communities being surveyed.

Among the AI/AN populations, OSH works with the Tribal Support Centers Program to implement and evaluate culturally relevant and community-competent tobacco control and prevention strategies for use with broader AI/AN populations. In addition, the AI/AN Cessation Workgroup Project reviewed cessation materials, guides, and tools that were tailored for AI populations and recommended some of these materials for evaluation.

Progress is being made. From 1990 to 2001, the smoking prevalence rate for African Americans older than age 18 declined twice as much as the prevalence for whites. The steady decline in smoking rates for African Americans was caused by a number of factors, according to Robert G. Robinson, DrPH, Associate Director for Health Equity of OSH.

One factor leading to the decreased smoking rates among African Americans was the increase in excise taxes adopted by many states. Research shows that low-income groups are more likely to quit in response to price increases.

Smoking among African Americans declined dramatically

starting in the late 1970s. This decline is beginning to affect overall prevalence as the 1970s quitters age. In addition, improvements in capacity and infrastructure allowed interventions that resonated with black smokers to develop. OSH funded capacity-building and infrastructure development starting in 1993, which continues to the present. Community-based advocacy flourished through comprehensive public health efforts that included funding, technical support, and community-competent programs.

“We are confident that efforts organized by national networks in collaboration with community and state-based partners contributed to countering tobacco advertising, creating policy change, encouraging cessation initiatives, and setting new community norms,” said Dr. Robinson. Supported by the national campaign that facilitated a comprehensive approach to address the goal of eliminating population disparities, the local campaigns became a vital asset in this effort.

This story has application for other underserved communities, according to Dr. Robinson. Many of these underserved communities are not homogenous, which reinforces the need for surveillance mechanisms that will collect and allow for the disaggregation of data. Disadvantaged people may lack health insurance, which makes it more difficult for public health programs to reach them. “To be effective,” Dr. Robinson pointed out, “smoking cessation and treatment

*“From 1990 to 2001, the smoking prevalence rate for African Americans older than age 18 declined twice as much as the prevalence for whites.”*

programs must be accessible, affordable, and relevant to underserved populations. Thus, it is critical to rely on and account for diversity as a tool to ensure competency in our communication campaigns and our services.” Even uninsured smokers must have access to effective cessation treatment programs and prescription drugs that aid in cessation. ☀

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## Evidence-Based Interventions Offer Proven Strategies

Effective tobacco control programs need interventions that work. Such interventions are the topic of the *Guide to Community Preventive Services: Tobacco Use Prevention and Control (Community Guide)*, which offers evidence-based recommendations to prevent people from starting to smoke, increase the number of people who quit, and reduce exposure to secondhand smoke.<sup>1</sup> The following interventions are recommended on the basis of strong evidence: banning or restricting smoking; increasing the price of tobacco products; organizing mass media campaigns combined with other interventions; restricting minors' access to tobacco products; developing reminder systems and education for health care providers; reducing client out-of-pocket costs for cessation therapies; and setting up patient telephone quitlines combined with other interventions.

The *Community Guide* is the product of the independent, nonfederal Task Force on Community Preventive Services, whose work is supported by the U.S. Department of Health and Human Services and CDC, and several public or private partners. "The *Community Guide* outlines proven strategies that we have made the basis of our National Tobacco Control Program," said CDC Office on Smoking and Health (OSH) Acting Director Corinne Husten, MD, MPH. "These strategies are what we ask states to implement and report on. Having a strong evidence base for the programs makes it easy to recommend strategies that will work for states."

### Surgeon General's Reports and CDC Publications

CDC works with the Office of the Surgeon General to produce reports on the health effects of tobacco use. Since 1964, the Office of the Surgeon General has released 28 reports on smoking and health in the United States (available at <http://www.cdc.gov/tobacco/sgr>). The latest, published in 2004, is *The Health Consequences of Smoking: A Report of the Surgeon General*.<sup>2</sup>

The Surgeon General's reports support state and community programs to reduce tobacco use, communicate research findings related to tobacco use, and inform the public of anti-smoking messages. "As scientific knowledge of the health hazards of smoking and the benefits of quitting have grown, the reports have been an important way to keep people aware of the dangers of smoking and breathing environmental tobacco smoke," said Dr. Husten. "They increase the availability of programs to prevent young people from starting to smoke and to help smokers quit. They promote the adoption of policies that discourage use of tobacco. Equally important, they document the benefits of comprehensive approaches to tobacco use."

The Office of the Surgeon General and CDC are working on a new report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, which updates a 1986 report by the same name. This report evaluates and synthesizes evidence on the health consequences of passive smoking.

“Cessation interventions are more cost-effective than mammograms, Pap smears, and screenings for colorectal cancer or treatment of hypertension.”

## The National Network of Tobacco Cessation Quitlines

Free telephone quitlines are a convenient way for smokers to get the support they need. Trained counselors are available to answer questions and schedule support sessions according to the individual’s needs. The personalized service essentially allows the smoker to develop a customized plan for quitting.

The National Network of Tobacco Cessation Quitlines, a program to ensure access to tobacco-use cessation services for all Americans, creates and enhances state tobacco quitline services while linking all state quitlines through the national portal number 1-800-QUIT-NOW. The network is a collaborative effort of CDC, the Cancer Information Service of the National Cancer Institute, the North American Quitline Consortium, and state tobacco control programs.<sup>3</sup>

OSH provides technical assistance and funding to states to establish or expand their quitline services. States with quitlines receive funding to enhance their services, and states without quitlines receive grants to build them. Because of this network, the basic infrastructure for quitline services is now available throughout the United States and in several U.S. territories. For more information, see *Telephone Quitlines: A Resource for Development, Implementation, and Evaluation*, available at <http://www.cdc.gov/tobacco/quit/Quitlines/>.

## Helping Smokers Quit

Seventy percent of smokers, or 32 million people, want to quit. During 2003, more than 40% of adult smokers in the United States stopped smoking for at least one day because they were trying to quit. Unfortunately, less than 5% of these quitters abstain for 3 months or longer.<sup>4</sup>

A significant science base now demonstrates the effectiveness of treatment (medication or counseling) for nicotine dependence. Tobacco-use cessation is the most cost-effective method of disease prevention for adults. Cessation interventions are more cost-effective than mammograms, Pap smears, and screenings for colorectal cancer or treatment of hypertension.<sup>5</sup>

The Public Health Service clinical practice guideline *Treating Tobacco Use and Dependence* recommends a multicomponent strategy to help smokers quit, including counseling and pharmacologic treatments such as nicotine replacement therapy.<sup>6</sup> This guideline is a blueprint for health care providers, health care systems, and insurance providers for treating nicotine addiction. The 5 A’s approach [see box, page 21] is one of many resources for helping smokers quit.<sup>7</sup>

Research shows that reducing or eliminating patient out-of-pocket costs for treatment increases the use of cessation therapies and the number of people who stop using tobacco. The Public Health Service Clinical Practice Guidelines and the Community Preventive Services Task Force recommend that health insurers cover tobacco cessation services.

Because many tobacco users try to quit at least 6 times before they succeed, insurance benefits must be structured accordingly. Current recommendations are to cover two courses of counseling and medications annually. Medicare recently implemented coverage for cessation counseling, removing substantial barriers to cessation services.

CDC recommends that doctors make smoking-cessation counseling a part of their prenatal visits with pregnant smokers. Pregnant mothers are far more likely to quit smoking when their doctors use an effective intervention like the 5 A's.

Counseling pregnant smokers takes a trained health care provider just 5–15 minutes. It increases the proportion of women who quit by 30% and substantially reduces health care costs associated with smoking. A case-control study of the 5 A's program found that most of the costs averted were dollars that would have been spent on treating infants made ill by tobacco use.<sup>8</sup>

### Targeting People Where They Live, Work, Learn, or Play

CDC's Coordinated School Health Programs help young people develop the skills they need to avoid tobacco use. Most people begin using tobacco in early adolescence, typically by age 16; almost all first use occurs before high school graduation. School policies and programs are part of the comprehensive tobacco control programs CDC supports.

*CDC's Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* call for tobacco-free policies, evidence-based curricula, teacher training, parental involvement, and cessation services; implementing evidence-based curricula; and linking school-based efforts with local community coalitions and statewide media and educational campaigns. Oregon developed a funding model

### The 5 A's: Helping Pregnant Women Stop Smoking

- Ask:** Ask the patient if she smokes.
- Advise:** Clearly advise the patient to quit, describing how smoking affects her and her fetus.
- Assess:** Find out how willing the patient is to make a quit attempt in the next 30 days.
- Assist:** Suggest and encourage her to use problem-solving methods and skills for cessation.
- Arrange:** Continue to assess the patient's smoking status, and encourage her to quit if she has not.

Source: Smoke-Free Families, <http://www.smokefreefamilies.org>. For more information, visit the National Partnership to Help Pregnant Smokers Quit at <http://helppregnant smokersquit.org>.

for school programs based on CDC's *Best Practices* guidelines and found that smoking prevalence declines were significantly greater at schools that implemented the guidelines at high or medium levels than at schools that did not follow the guidelines. At an annual funding level of approximately \$1.60 per student, Oregon was able to provide grants to approximately 30% of its school

districts. Assuming 100% coverage of school districts using a funding model similar to the Oregon model, \$4–\$6 per student in grades K–12 should be budgeted for tobacco-use prevention.

## Business Models to Support Quitters

U.S. businesses can give millions of adults the help they need to quit smoking and stay tobacco-free, and they could be a powerful force in reducing tobacco use. But only 24% of employers offer any insurance coverage for tobacco-use treatment.<sup>9</sup>

“Most employers don’t understand how much smoking costs them,” said CDC health educator Abby Rosenthal, MPH. In 1999, each adult smoker cost employers \$1,760 in lost productivity and \$1,623 in excess medical expenses.<sup>10</sup> In contrast, the cost of a comprehensive tobacco cessation benefit is just 10–40 cents per member per month.<sup>11,12</sup> Employees who stop smoking are more productive, are absent from work less, and have lower health care and life insurance costs.<sup>13,14</sup>

There is strong evidence that smoking cessation programs covered by employers’ health insurance can reduce health care costs.<sup>15</sup> Pitney Bowes is one company that has benefited from a successful employee cessation program. Pitney Bowes addresses health promotion and tobacco cessation on multiple fronts, including programs offering cash incentives, smoke-free workplaces, and access to on-site medical clinics and prescription drug coverage for nicotine replacement therapy and

bupropion. The on-site medical clinic in their Connecticut facility reported a 50% quit rate for those that participated.<sup>16</sup> ☀

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## Tobacco Update

### Smokeless Tobacco Use During Pregnancy—Alaska

Cigarettes and cigars are not the only tobacco products that worry public health scientists. Since the 1970s, smokeless tobacco use among young people aged 17–19 years has increased 15-fold.

Research shows that smokeless tobacco users face many of the same health risks that smokers do: heart disease and circulatory problems such as aneurysms, hypertension, blood clots, and strokes. In addition, smokeless tobacco increases the risk of oral cancer and gum disease. During pregnancy, smokeless tobacco use may cause increased fetal death, premature labor, low-birth-weight infants, and sudden infant death syndrome (SIDS).

An area of concern is the prenatal use of smokeless tobacco among Alaska Native women. Although trend data showed a decrease during the last 6 years, Alaska's Pregnancy Risk Assessment Monitoring System (PRAMS) data show a high rate of prenatal smokeless tobacco use among Alaska Native women (21.8%).

CDC is exploring ways to study the implications of the data. CDC medical officer Lucy England, MD, MSPH, plans to conduct research on Alaska Natives who use "iq'mik," a unique type of smokeless tobacco. Loose-leaf tobacco is mixed with ash from punk, a fungus that has a high pH level. The ash is mixed with a handful of tobacco leaves and pre-chewed to form pellets that are

used later. Adding ash to the tobacco increases the amount of freebase nicotine available for absorption.

In Yukon-Kuskokwim (a rural region populated mostly by Alaska Natives), nearly 60% of women used smokeless tobacco during their pregnancy, according to data from the Alaska Department of Health and Social Services. Anecdotal evidence suggests that some people regard smokeless tobacco as a safer alternative to smoking and consider iq'mik more natural than other tobacco products. It is likely that some preschool children use smokeless tobacco as well.<sup>1</sup>

Because of the high rates of use, the Yukon-Kuskokwim Health Corporation added smokeless tobacco users to the treatment schedules of its nicotine dependence program in 2001 and is studying nicotine exposure among Alaska Native women and their infants. Focus groups were conducted with pregnant women. Findings will be used to design better interventions.

Kathy Perham-Hester, MS, MPH, Alaska's PRAMS coordinator, said that there is a need to tease out the prevalence of iq'mik use from the prevalence of commercial smokeless tobacco use, especially on a population-based level for this high-risk population of pregnant women. Also, because of the potential for high nicotine delivery to the developing fetus, knowing whether respondents mixed iq'mik in their mouths during pregnancy is important. Starting with 2004 births, the Alaska PRAMS questionnaire now asks specifically about

iq'mik use. Questions distinguish it from commercial product chew and also ask about mixing it in the mouth.

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## New and Nontraditional Tobacco Products

Many new tobacco products and nicotine delivery devices are entering the market today accompanied by expressed or implied claims of reduced health risk. However, these so-called “potentially reduced-exposure products (PREPs)” have not been evaluated comprehensively enough for researchers to conclude whether they convey reduced risk. Regardless, some supporters of such products argue that millions of smokers will die or suffer from tobacco-related illnesses if they continue to smoke and that these smokers should switch from cigarettes to alternative products that may pose less of a health risk for some tobacco-related illnesses. Others posit that an implied reduced exposure message may prevent smokers from quitting, promote relapse, and encourage initiation of tobacco use, thus potentially increasing harm to the population as a whole.

Experience with low-tar/low-nicotine (“light”) cigarettes suggests that the public health community must be cautious about promoting any tobacco product. “Light” cigarettes

were introduced in the late 1960s and widely endorsed as potentially safer substitutes for the typical cigarette on the market at that time. It took more than 20 years for researchers to conclude that smokers who switched to “light” cigarettes did not reduce their disease risk and that the existence of such products may have resulted in smokers who were concerned about health risks switching rather than quitting.

CDC continues to provide critical leadership on this emerging issue by working to assess toxicity measures that will allow for better evaluation of the tobacco industry’s claims of safer alternatives. CDC is also conducting research to understand the messages consumers receive about PREPs, because this will provide insights necessary to develop effective counter-messages.

In 2003, U.S. Surgeon General Richard Carmona testified before Congress, “I cannot recommend as a quitting aid the use of any tobacco product that causes disease and death when there is a whole menu of other safe and proven ways to help patients stop smoking. The best quitting strategy for smokers is not to trade one cancer-causing product for another, but to use FDA-approved methods like nicotine replacement products.” CDC researchers agree. Corinne Husten, MD, MPH, Acting Director of CDC’s Office on Smoking and Health, said, “Until we have the science base to draw firm conclusions regarding the potential health effects on the individual as well as the population

as a whole, we must continue to convey a clear and consistent message: There is no safe form of tobacco use.”

## Global Tobacco Surveillance

Tobacco use is the single greatest preventable cause of death worldwide. Every year, nearly 5 million people die from tobacco-related illnesses, and this number is expected to more than double by 2030, when 70% of tobacco-related deaths will occur in developing countries. To effectively reduce tobacco-related death and disease, effective and expansive surveillance systems are essential.

In May 2003, the member countries of the World Health Organization adopted an international tobacco control treaty, the Framework Convention on Tobacco Control (FCTC). The treaty was signed by an international alliance of organizations committed to reducing the health and economic consequences of tobacco use. The Global Tobacco Surveillance System (GTSS) (developed by CDC, the World Health Organization [WHO], and the Canadian Public Health Association [CPHA] in 1999) is expected to play a key role in fulfilling the FCTC’s obligations to track its own effectiveness and application.

The GTSS, the most comprehensive tobacco surveillance system ever developed and implemented, promotes tobacco control globally by assisting countries worldwide in collecting data on tobacco use by young people and adults. The purpose of the GTSS is to enhance the capacity of countries to design, implement, and evaluate their comprehensive National Tobacco Action Plans and

to monitor implementation of the FCTC.

The GTSS consists of three surveys: the Global Youth Tobacco Survey (GYTS), the Global School Personnel Survey (GSPS), and the Global Health Professionals Survey (GHPS). The GYTS focuses on young people aged 13–15 years and collects information from students in schools. The GSPS focuses on teachers and administrators from the same schools that participate in the GYTS. The GHPS focuses on third-year students pursuing advanced degrees in medicine, dentistry, nursing, or pharmacology.

As of July 2005, 139 countries had completed the GYTS with repeat surveys in 32 countries. In 2005, the GSPS was completed in more than 40 countries, and the GHPS was completed in 10 countries. 

## For More Information

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## Conferences

**2006 National Oral Health Conference**

“Education, Prevention and Access: A Bridge to Optimal Oral Health” is the theme of the next National Oral Health Conference, to be held May 1–3, 2006, at the State House Convention Center, Peabody Little Rock Hotel, in Little Rock, Arkansas. Preconference sessions will be held on April 29 and 30. The 2006 sessions will share information on effective state and community programs as well as the latest scientific information on oral health promotion and disease prevention. Featured topics include effective strategies to increase collaboration; overcome barriers to providing effective programs; and increase oral health workforce diversity, capacity, and flexibility. The meeting is cosponsored by the Association of State and Territorial Dental Directors; the American Association of Public Health Dentistry; CDC; and the Health Resources and Services Administration, Maternal and Child Health Bureau. More information about the conference is available at the following Web sites: <http://www.astdd.org> or <http://www.aaphd.org>.

**Diabetes Annual Conference**

CDC’s Division of Diabetes Translation will convene its annual diabetes conference May 16–19, 2006, at the Adams Mark Hotel, 1550 Court Place, Denver, Colorado. This conference is a first-time collaboration between the Division of Diabetes Translation and the Division of Nutrition and Physical Activity to discuss issues concerning both diabetes and obesity. The conference will bring together approximately 800 participants from a wide range of local, state, federal, and territorial governmental agencies and private diabetes and obesity partners. For more information, visit <http://www.cdc.gov/diabetes/conferences/index.htm>.

**24<sup>th</sup> National DHPE/CDC Conference on Health Promotion and Education**

The Directors of Health Promotion and Education (DHPE) and CDC are hosting the 24<sup>th</sup> National Conference on Health Promotion and Education: “Advancing the National Health Promotion and Education Agenda Through Effectiveness and Practice.” The conference will take place May 23–26, 2006, in Arlington, Virginia, at the Hyatt Regency Crystal City. Sessions will address topics such as innovative approaches to health education and health promotion practice, collaborating with nontraditional partners, and the economics of health education and health promotion. For more information, visit <http://www.dhpe.org/nationalconference>.

**Conferences - *continued***

**2006 International Cancer & Tobacco Control Conferences: July 8–15, 2006**

For the first time, two of the world’s preeminent conferences, the International Union Against Cancer (UICC) World Cancer Congress and the World Conference on Tobacco OR Health, will converge in Washington, D.C., in 2006. This event will unite the cancer and tobacco control communities in a global campaign against tobacco-related cancer, which threatens to kill half a billion people living today. In a bonus event, the CDC Cancer Partners Summit will bring together new and existing partners to explore top strategies for collaboration in cancer prevention and control, and future opportunities to create and strengthen these partnerships.

The event will begin with the 2006 International Union Against Cancer World Cancer Congress, “Bridging the Gap: Transforming Knowledge into Action,” to be held July 8–12 in Washington, D.C. For more information, visit <http://worldcancercongress.org/index.php>.

Immediately following the close of the UICC World Cancer Congress, the CDC Cancer Partners Summit, “Empowering Partners for Effective Integration: Charting a New Generation of Cancer Control Partnerships,” will convene July 12–13, 2006, in Washington, D.C. For more information, visit <http://www.2006conferences.org/summit.php>.

The 13<sup>th</sup> World Conference on Tobacco OR Health: “Building Capacity for a Tobacco-Free World,” will be held July 12–15, 2006, in Washington, D.C. For more information, visit <http://worldcancercongress.org/index.php>.

**CDC’s 2006 National Health Promotion Conference**

The first joint conference of CDC’s Coordinating Center for Health Promotion (CoCHP) and its constituent groups will be held September 12–14, 2006, at the Atlanta Hilton. The conference theme is “Innovations in Health Promotion: New Avenues for Collaboration.” For updates and more information, visit <http://www.cdc.gov/cochp>.

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## Communications

**Key Outcome Indicators for Comprehensive Tobacco Control Programs**

*Key Outcome Indicators for Comprehensive Tobacco Control Programs* identifies evidence-based outcome indicators for evaluation of comprehensive state tobacco control programs. This resource can aid state health departments in identifying and selecting short-term, intermediate, and long-term indicators to monitor and evaluate programs, identify and fill existing data gaps in national and state data systems, and encourage evaluation research to strengthen links between tobacco program outcomes. Available at <http://www.cdc.gov/tobacco/Indicators/KeyIndicators.htm>.

**Telephone Quitlines: A Resource for Development, Implementation, and Evaluation**

*Telephone Quitlines: A Resource for Development, Implementation, and Evaluation* was developed to help state health departments, health care organizations, and employers to contract for and monitor telephone-based tobacco cessation services. It is also intended to help states, health care organizations, and quitline operators enhance existing quitline services, and to inform those who are interested in learning more about population-based approaches to tobacco cessation. Available at <http://www.cdc.gov/tobacco/quitlines.htm>.

**Effective Tobacco Counter-Marketing Campaigns**

*Designing and Implementing an Effective Tobacco Counter-Marketing Campaign* is a comprehensive resource for state health departments and other organizations that are developing, implementing, and evaluating their tobacco counter-marketing campaigns. This manual contains a wealth of information on a wide range of counter-marketing topics including target audience insights, reaching specific populations, advertising, public relations, media advocacy, and media literacy. Available at <http://www.cdc.gov/tobacco/MCRC/countermarketing/index.htm>.

**State Tobacco Control Program Evaluation Literature**

*Evidence of Effectiveness: A Summary of State Tobacco Control Program Evaluation Literature* summarizes the major evaluation studies of comprehensive state tobacco control programs. It describes recent, relevant evidence; studies on states other than those cited most often; and unpublished state or independent evaluation reports. It also organizes the major evaluation findings by the outcomes in the *Key Outcome Indicators for Comprehensive Tobacco Control Programs* report. Available at [http://www.cdc.gov/tobacco/sustainingstates/Lit\\_Review.pdf](http://www.cdc.gov/tobacco/sustainingstates/Lit_Review.pdf).

### **Mexico's Report on Tobacco Control**

On May 31, 2005, Mexico's Ministry of Health released its first full report on tobacco control in Mexico, *Primer Informe Sobre el Combate al Tabaquismo: México ante el Convenio Marco para el Control del Tabaquismo*. This 446-page report details Mexico's advances in tobacco control and concludes that tobacco control measures implemented there have helped reduce cigarette smoking by 15% from 2000 to 2005. The report also provides information on how a tax imposed on each pack of cigarettes (1 Mexican peso per pack) has generated funds for several government agencies. This report represents a tobacco control effort in Mexico in collaboration with the Secretary of Health and with the financial help of CDC and the Institute for Global Tobacco Control, The Johns Hopkins University.

### **Report Finds Improvements in Oral Health of Americans**

A new report, *Surveillance for Dental Caries, Dental Sealants, Tooth Retention, Edentulism, and Enamel Fluorosis —United States, 1988–1994 and 1999–2002*, provides the most current estimates from the National Health and Nutrition Examination Survey (NHANES) of dental conditions such as cavities, tooth loss, and enamel fluorosis. Among the major findings are improvements since 1994 in the percentage of children, adolescents, and adults who have never had tooth decay in their permanent teeth; increased use of dental sealants; and increased tooth retention among older adults. Yet decay remains a widespread problem of childhood; 65% of adolescents aged 16–19 years have had tooth decay or fillings in their permanent teeth. The report is available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5403a1.htm>.

### **Better Diabetes Care**

The National Diabetes Education Program developed the "Better Diabetes Care" Web site as a practical tool for health care professionals to enhance diabetes prevention and treatment practices. This Web site provides models, links, and resources to help public health professionals. For more information, visit <http://www.betterdiabetescare.nih.gov> or <http://www.cdc.gov/diabetes/ndep/index.htm>.

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## Communications - *continued*

### Cessation Resource Center

The Cessation Resource Center (CRC) is a Web portal that links registered state and organizational tobacco cessation programs with available cessation resources. CRC's database houses resources that were developed and tested by state tobacco control programs and CDC's Office on Smoking and Health partner organizations. By providing access to cessation resources, CRC enables states, organizations, and government agencies not only to save time and costs associated with production, but also to reduce duplication of effort. CRC is available at <http://www.cdc.gov/tobacco/crc>.

### National Youth Tobacco Survey

The National Youth Tobacco Survey (NYTS) 2004 Public Use Data Set is the product of a population-based survey of middle and high school students (grades 6–12) regarding their use of cigarettes, cigars, smokeless tobacco, pipes, bidis, and kreteks; their knowledge of and attitudes toward tobacco; their exposure to environmental tobacco smoke; and their exposure to influences that promote or discourage tobacco use, such as portrayals of tobacco in advertising and mass media, enforcement of age restrictions in the sale of tobacco to minors, provision of school-based and community-based interventions, and access to supports in attempting to stop using tobacco. These data are available at <http://www.cdc.gov/tobacco/NYTS/nyts2004.htm>.

### Media Campaign Resource Center

The Media Campaign Resource Center (MCRC) is a Web-based clearinghouse that licenses and maintains an inventory of tobacco control advertisements developed by U.S. states, organizations, and federal agencies. By providing access to advertising materials, MCRC allows states, organizations, and government agencies to save time and avoid the high cost of producing new advertisements. MCRC is available at <http://www.cdc.gov/tobacco/mcrc/index.htm>.

### BRFSS State Prevalence Tables and Maps

CDC is pleased to announce the release of the 2003 Behavioral Risk Factor Surveillance System (BRFSS) state prevalence tables. Information on health-related risk factors is available for all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. The tables can be found at <http://www.cdc.gov/brfss>.

BRFSS maps for 2002 data are also available on the BRFSS Web site. This interactive mapping application graphically displays the prevalence of behavioral risk factors at the state and metropolitan/micropolitan statistical area levels. The maps can be accessed at <http://apps.nccd.cdc.gov/gisbrfss>.

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