# BURNING ISSUES

TRDRP Newsletter

Volume 4, Number 1, July 2001

## 23.4 Million Awarded to 67 Grantees

In the 10th funding cycle, TRDRP awarded a total of $23.4 million for 67 grants to individual investigators at 29 California institutions. The number of applications was up again this year, 273 versus 259 last year. Unfortunately, the funds available were much less, $23.4 million versus $33.3. The result was a sharp reduction in the overall funding pay line to 24.5% (from 37%). To achieve this level of support, TRDRP imposed a 17% administrative cut on all Research Project awards as well as full CARA and SARA proposals in order to have a funding pay line of at least 20% for that award type. Despite this drastic cut, many excellent proposals still fell below the pay line. Continuing fiscal constraints will likely affect the number and degree to which grants will be supported next year, as TRDRP's appropriation for 2001-2002 is expected to decrease to $19.4 million, a 17% reduction compared to last year (*see Future TRDRP Budgets*). Funding levels by award mechanism and area are listed on page 2.

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## Future TRDRP Budgets

*by Susanne Hildebrand-Zanki*

TRDRP's budget continues to decline. This is paradoxically good news because it is a direct consequence of the continued decline in cigarette consumption in the state. However, the real problem is that a significant reduction in TRDRP's budget is a result of the state's decision to utilize TRDRP's revenue source, the Prop 99 Research Account, to support the California Cancer Registry. Since the beginning of Prop 99, the Cancer Registry has received about $1.7 million each year from the research account. However, for the second year in a row now, this support has been increased to nearly $5 million.

In fiscal years 2000-01 and 2001-02, the appropriation to the registry from the Research Account has been over 40% of the registry's total budget. In previous years, this percentage had been between 10% and 20%. If the current allocation pattern persists along with the decline in tobacco use, within two years the registry will receive in excess of 25% of the Research Account funds (this calculation is based

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## Tobacco Industry Philanthropy in the Black Community

*by Phillip Gardiner*

The "softer and gentler" tobacco industry of the last few years may have caught some people off guard, however tobacco control activists in the African-American community have been sorely aware of the decades long support this industry has provided to national and local Black community organizations. Coupled with direct appeals to smoke mainly menthol brands and use other high tar and high nicotine cigarettes, tobacco industry philanthropy has definitely been a dual-edged sword in the African-American community. The upshot of this attention has been that, while African-Americans have reaped a modicum of increased services and financial support from tobacco money, at the same time they are dying disproportionately from tobacco-related diseases. Moreover, many national cultural groups, community-based organizations, and educational initiatives are now heavily dependent on tobacco industry funding. Below is a synopsis of tobacco funding in the African American community. The quandary this funding presents is discussed, including the question of "replacement" dollars. Future research needs are also identified.

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| Award Mechanism | Percent Funded |
|---|---|
| Research Project | 21.7 |
| IDEA | 15.6 |
| Community-Academic | 25.0 |
| School-Academic | 20.0 |
| New Investigator | 41.7 |
| Postdoctoral Fellowship | 34.5 |
| Dissertation | 38.5 |

| Area | # Awards | (%) | $ (%) |
|---|---|---|---|
| Health Effects | 36 | ( 54) | 13,100,794 ( 56) |
| Nicotine Dependence | 12 | ( 18) | 3,312,040 ( 14) |
| Interventions/Policy | 19 | ( 28) | 6,955,923 ( 30) |
| **Total** | **67** | **(100)** | **23,368,757 (100)** |

## Grantees

*Continued from page 1*

Acomplete list of all grant recipients and the abstracts describing their research projects will be published in the 2001 Compendium of Awards, which will be available in September (both in hard copy and online). All currently funded investigators and 10th cycle applicants will receive a copy; others interested may obtain copies upon request from TRDRP or via our website in pdf format.

### The realities of fiscal constraints

Over the last couple of years, TRDRP had increased the soft cap on direct costs. The rationale for this change was feedback from our peer reviewers and California investigators suggesting that TRDRP awards may be perceived as less supportive relative to NIH grants (i.e., fewer years support at a lower yearly budget). Most applicants requested direct costs at or near the soft cap limit; unfortunately, the increased cost per funded grant coupled with the reduced funding available resulted in a pay line below 20% for the Research Awards. As a result, TRDRP’s Scientific Advisory Committee recommended that all full research awards be cut by 17% in order to raise the funding pay line for this award mechanism above 20%. In addition, starting with the next funding cycle TRDRP will impose a hard cap on direct costs of $170,000 per year for research involving human subjects and $140,000 per year for all other Research Projects as well as full CARA and SARA proposals. This reduction in direct costs should alleviate the necessity to make post-award administrative cuts.

## Future

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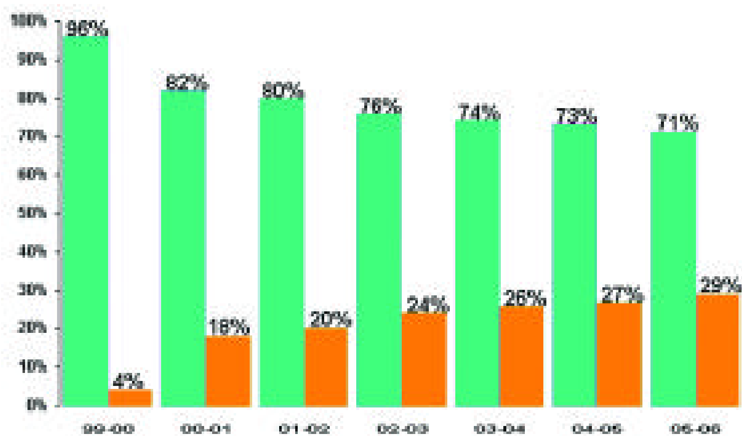
on a projected 5% annual decline in revenues). At the last meeting of the Tobacco Education and Research Oversight Committee meeting, members agreed that the Cancer Registry is clearly a valuable resource in California that needs to be fully funded. However, they expressed their concern that it is not appropriate that the Prop 99 Research Account, and by extension TRDRP, so disproportionately contribute to its support, and moved to voice this opinion in a letter to the Governor.

TRDRP's ability to accomplish its mission is clearly hampered by the reduction of available funds to the program. After the restorations of full funding following the diversions of the mid-90's, the program worked hard to attract top researchers in California to apply again to TRDRP. The program has been successful in reestablishing itself as a reliable and stable funding source. TRDRP is the 3rd largest funder of tobacco-related research in the nation, after NIH and the Robert Wood Johnson Foundation, and its investigators have made critical contributions to tobacco control, especially in the areas of treatment, policy, and environmental tobacco smoke. However, diversions of funds to other programs in addition to the projected decline in revenues adversely impact the ability of the program to make awards and to retain the efforts of tobacco researchers. Ultimately, without sufficient funding, the program will not be able to meet the needs of the tobacco control community and medical practitioners to combat the adverse consequences of tobacco use.




| | 99-00 | 00-01 | 01-02 | 02-03 | 03-04 | 04-05 | 05-06 |
|---|---|---|---|---|---|---|---|
| To TRDRP | $36,726 | $22,627 | $19,434 | $15,215 | $14,208 | $13,251 | $12,342 |
| To DMS Cancer Registry | $1,719 | $5,050 | $4,930 | $4,930 | $4,930 | $4,930 | $4,930 |

# Community

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## Tobacco Money in the Hood

Charitable contributions are a cornerstone of the tobacco industry's strategy to maintain goodwill and the veil of respectability in the African-American community. Tobacco industry philanthropy has also served to blunt attacks on its products, and maintain a large cohort of African-American smokers. Philip Morris, though not historically first, is now far and away the largest donor among tobacco companies for all groups and causes, including contributions to the African-American community. Starting in 1956, the Philip Morris "family of companies" has been making grants to local, national and international non-profit organizations. As their website proudly points out, during the 1990s, Philip Morris contributed over $1 billion in cash and food [1]. All of these grants didn't go to the African-American community, but when you consider the contributions of R.J. Reynolds, Brown and Williamson, British & American Tobacco (BAT), and Lorillard, then the amount of charitable donations, grants and advertising revenues going into the African- American community is substantial. A conservative estimate could place the extent of tobacco industry revenues and charitable contributions at over $25 million a year.

Drawing on earlier work of Robinson, et al.,[2, 3] and Blum, et al, [4] the 1998 Report of the Surgeon General targets seven broad categories of the tobacco industry's financial intervention in the African-American community: employment opportunities; advertising revenues; funding community agencies; support for education; support for political, civic and community campaigns; support for cultural activities; and support of sports events.[5] Indeed, the tobacco industry sponsors most of the major political civil rights organizations operating in the African-American community, including the NAACP, the National Urban League, and PUSH.[5] Moreover, the tobacco industry's monetary contributions to political parties are not limited to national campaigns, but are also targeted to state and local races of Black elected officials.[6]

*Essence Awards 2000 co-sponsor Kraft Foods, Phillip Morris "**family of companies**"*

The placement of advertising in Black publications, especially those with a limited circulation, has meant millions of dollars in revenues for the owners of these media outlets. While clearly this support has been lucrative, it has led to many publications becoming dependent on tobacco industry advertising. In fact, in 1992, the president of an African-American advertising agency predicted that "if they kill off cigarette and alcohol advertising, black papers may as well stop printing."[7] Moreover, publications such as Jet, Ebony and Essence receive proportionately higher revenues from tobacco advertising compared to mainstream publications.[8]

Starting with Richard Joshua Reynolds' support of Winston Salem University in North Carolina in 1891, the tobacco industry has a 100-year track record of providing financial support for historically and predominantly African- American colleges and universities.[5] Today, Philip Morris, R.J. Reynolds, and Brown and Williamson all support the United Negro College Fund (UNCF), the proud recipient of millions of dollars each year. The tobacco industry supports many other scholarship programs in the black community, but next to the UNCF, Philip Morris' Thurgood Marshall Scholarship fund is one of the largest. This fund is a merit scholarship program founded in 1987 that provides four-year scholarships to students who attend historically black public colleges and universities. To date, the fund has awarded scholarships totaling more than $6 million.[9] Over 200 people have already graduated, and 160 are currently receiving awards at 38 historically black public colleges and universities that participate in the fund's programs.[9]

Tobacco industry sponsorship of specifically African-American cultural activities and events reads like a virtual who's who of the US Black cultural community. Michael Siegel, writing in the "Tobacco Industry Sponsorship in the United States 1995-1999," lists 14 separate national charitable contributions, including the Alvin Ailey American Dance Theater, the National Black Arts Festival, and the Dance Theatre of

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Harlem.[10] Additionally, the tobacco industry is a contributor to numerous local black history month events throughout the United States. However, one of the most conspicuous examples of tobacco company promotion in the African-American community has been the promotion of musical events. These events have included the Brown and Williamson's Kool Jazz Festival, Parliament's World Beat Concert Series, Benson & Hedges's blues and jazz concerts and Philip Morris's Superband Series. [5]

The tobacco industry certainly is not the only group of corporations making charitable contributions and pouring millions of advertising dollars into the African-American community. The alcohol industry is another African-American "friendly" donor and advertiser. This industry has also been singled out for their predatory practices of lining boulevards in the black community with billboards calling on people to drink cheap whiskeys, malt liquor and fortified wines.[11] However, only the tobacco industry sells a product that, when used as intended, will kill you.

## The Cost of Tobacco Industry Support

Clearly, the African-American community, both historically and today, is in need of money. The cumulative effect of years of oppression, discrimination and outright disenfranchisement has had a devastating effect not only on individual tobacco users, but also on the community as a whole. Therefore, one might ask: is accepting money from the tobacco industry helping to alleviate the historic problem of African-American disenfranchisement or are these charitable contributions perpetuating the existing state of affairs?

Tobacco industry money has helped to maintain African-American publications, as indicated above. Then again, some authors have noted that this support has also translated into reduced coverage of tobacco-related diseases in these publications.[2,12] A study of cancer coverage and tobacco advertising over a six-year period in three African-American popular magazines (Ebony, Essence and Jet) found that these magazines published only 6 articles on lung cancer, and cigarette smoking was rarely mentioned as the main cause of the disease.[13] While tobacco money has kept many of these publications afloat, this source of funding has also blunted dissemination of the message that smoking and the use of tobacco products is deadly.

Similarly, the tobacco industry has been responsible for increasing educational opportunity in the African-American community. This support has allowed, for example Philip Morris to produce "feel-good" commercials touting the virtues of their company, which made it possible for some youths to graduate from college. Increasing the number of college-trained African-American professionals is nothing to sneeze at. With affirmative action in higher education under attack coupled with the general downturn in the economy, educational scholarships provided by the tobacco industry are even more significant than they were in the past.

It is no wonder that African-American smoking rates remain high and the resulting deaths even higher when everyone from UNCF, the Alvin Ailey's American Dance Theater to the Kool Jazz Festival bring respectable, if not positive images of tobacco into the African-American community. The facts are sobering: 45,000 African-Americans die each year from using tobacco products. This carnage is visited most heavily on African-American males, whose disproportionately high cancer and heart disease rates have continued for the last quarter of a century. African-American males, as compared to other race and ethnic groups, have the highest death rates from cancers of the lip, oral cavity and pharynx cancer; esophagus, stomach, pancreas, larynx, trachea, bronchus and lung.[5] Also, African-American males have the highest death rates from cardiovascular and

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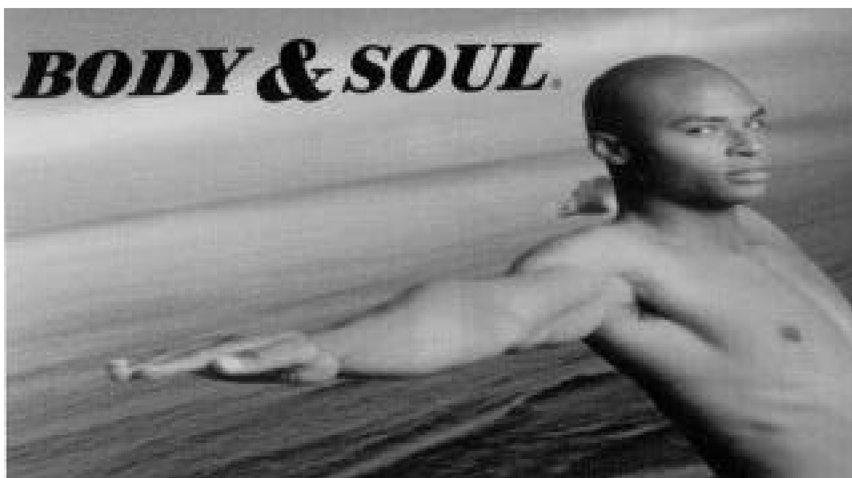


*South Africa: this recent promotion, Body & Soul a postcard for BAT's Benson & Hedges (B&H) brand, given away at fashionable cafes, bars, cinemas, restaurants, and tobacco point of sales, sometimes handed unsolicited to customers.* - Tobacco Control, winter 1999, vol. 8, n. 364

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cerebrovascular disease and they are running a close second to white men for bronchitis, emphysema and COPD.[(5)]

Considering the health facts just quoted, one might ask, how exactly has the tobacco industry's philanthropy benefited that African-American community? Have scholarships for African-Americans served to rein in the disproportionately high mortality among this population? Not only have individuals become addicted to tobacco; now national and community based organizations are also dependent on tobacco (funding).

## Replacement Dollars: The Road Forward?

African-American tobacco control advocates are developing a strategy that states if organizations in the black community are going to refuse tobacco industry money, and some of the beneficial services they provide, then monies must be found from other institutions, foundations or governmental agencies. The argument goes like this:

The tobacco industry took up supporting education and cultural events in the African-American community back in the 50's when most corporations would not touch black-only issues. Since the industry was based in the South and the majority of Black people lived and worked in the South, it was to the advantage of the tobacco industry to develop a strategic relationship with the African-American community. Moreover, the tobacco industry was one of the first major corporate employers to hire and promote African-Americans, not just in the processing of tobacco, but also as executives. In this regard, the National Urban League presents the Herbert H. Wright Awards to African-American executives of major corporations who have excelled in working on behalf of humanitarian causes. The award is named in the memory of one of the first African-American executives at Philip Morris.[(5)]

Long time African-American tobacco control author and activist, Charyn Sutton of the Onyx Group states: "Should the Alvin Ailey American Dance Theater refuse tobacco industry funding and in doing so stop its performances?" "Isn't more gained from them promoting African-American culture to millions around the world, than folding their tent because of tobacco industry funding, no matter how despicable it may be?" "If African-American tobacco control advocates are really interested in getting the tobacco industry out of the Black community, then we must find other sources to replace tobacco industry funding."[(14)] Similarly, the argument can be made that college scholarships provided by the tobacco industry do much more good than they do harm; the public relations benefits gained by the tobacco industry from scholarships are relatively small compared to the tangible increases in education garnered by certain African-Americans.

The idea that tobacco control advocates will be able to identify, leverage and deliver literally tens of millions of dollars a year to replace tobacco industry investment and philanthropic support in the African-American community may be a bit unrealistic. The tobacco industry gifts, donations and educational programs are on such a grand scale that a wholesale assault may not be possible. Still, many activists are identifying local community-based organizations that they have worked with in the hope of developing plans to wean them of tobacco money.

Detractors of the tobacco industry continuing to give money to the African-American community suggest that the industry has ulterior motives with their support of the black community. Not only do charitable contributions blunt strong anti-smoking messages, this type of gift giving gives the industry the halo of corporate responsibility. Moreover, it should be pointed out that, at the same time the industry made a major push toward philanthropic donations to the African-American community in the mid 50's, they also began aggressively marketing mentholated cigarettes to Blacks. It is hypothesized that disproportionate mentholated cigarette use on the part of African-Americans may be in part responsible for elevated lung cancer deaths, especially among males.[(15)]

## Further Research Needed

Certainly, there are pros and cons on the issue of accepting tobacco industry money for activities in the African-American community. Still, it remains to be seen what has actually been the extent of the tobacco industry's largesse. This is an important research question that must be answered before further studies and analyses can be done on the impact of these funds. There is no one place that provides the answer. The tobacco industry gives only a partial view of its philanthropic activities on its web sites. Michael Siegel at Boston University School of Public Health recent report, "Tobacco Industry Sponsorship in the United States, 1995-1999," has a section on charitable contributions to the African-American community, but isn't comprehensive.[(10)] Additionally, electoral support for African-American lawmakers and revenues from advertising in Black publications will have to be garnered from still other sources.

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# Women, Smoking and Disease

## Part I: Epidemic is the only word that fits

*by: Margaret Shield*

***"Less irritating, easier on the throat"***
*Cigarette advertising marketed directly to women, circa 1950's*

Women can find cold comfort that there is at least one aspect of the U.S. lifestyle that has no glass ceiling: cigarette smoking is an equal opportunity killer. Smoking-induced diseases such as cancer, cardiovascular disease, emphysema and stroke attack women just as severely as they do men; other health impacts are specific to female reproductive functions or exacerbated by sex-related biological differences. This reality is described in an important report released by the office of the Surgeon General in March that is a thorough analysis of the health impacts of smoking on U.S. women and girls of all ages.[1]

The 2001 report is a more comprehensive follow-up to the first Surgeon General's report on women and smoking released in 1980. The 1980 report profiled a developing health crisis produced by the increased number of women who smoked during previous decades. The 2001 report documents a full-blown epidemic in which approximately 165,000 U.S. women died of smoking-related illnesses in 1999 and in which the death rate of women from lung cancer is now 600% higher than it was in 1950. The report supports a clear conclusion "Smoking is the leading known cause of preventable death and disease in women." Bringing together current understanding of demographic patterns, medical studies and intervention practices, this report is a valuable resource for researchers and presents a challenge for tobacco control and health care for years to come. It should serve as a call to stop this epidemic of smoking-related disease by increasing our efforts and making women more aware of the hazards in store when they light up.

### You've come a long way, baby

In early U.S. history, a very small percentage of women smoked pipes or used snuff. Cigarette smoking, however, was socially taboo, a vulgar, dirty behavior beneath the high morals and grooming of a proper lady. But as society changed to allow women more freedoms and greater access to previously male-only professions, so too did social mores change. In the 1920's, significant numbers of U.S. women adopted cigarette smoking as a rebellious and glamorous activity that signified their independence. The number of women smokers also increased during World War I and World War II.[1]

Recognizing the possibilities for profit, the tobacco industry aggressively targeted women with advertising strategies, packaging and brands designed just for women.[1,2,3] These campaigns played on women's desires to be glamorous, sophisticated and liberated. Agents of tobacco companies even tried to stage political events, such as the well-hyped and well-documented "Torches of Freedom" campaign orchestrated by the American Tobacco Company in 1929 that recruited women to hold a public smoking protest in New York City.[3,4] Magazines targeted towards women have also been a favorite stomping ground for cigarette ads, always showing happy, healthy, attractive women enjoying a smoke.[1]

The motives of the tobacco companies in these marketing efforts were

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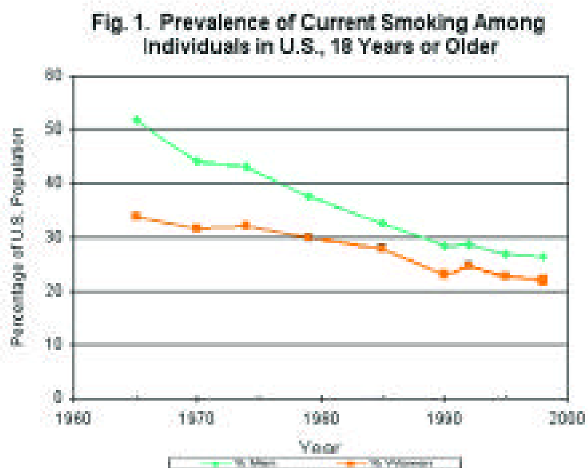


Fig. 1- Prevalence of current smoking is the percentage of all persons in every demographic category who reported smoking >100 cigarettes in their lifetime and who smoked at the time of the survey. Data presented is excerpted from Table 2.3 of the U.S. Surgeon General's Report (1).

## Women

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of course transparent to many women. There was some backlash from women's organizations that found the slogans demeaning and co-opting to their feminist message; however, many of these groups also have accepted substantial tobacco industry contributions.[1] Clearly the impact of such pervasive advertising was as intended by Big Tobacco: the number of women who smoked increased, and so did the daily cigarette consumption of the average woman smoker.[1] Smoking prevalence peaked in 1965 at about 34% of the female population of the U.S. Although many brands were marketed to women, the first brand specifically designed for the female audience was Virginia Slims, introduced to the market in 1968.[1,2] This brand name was seemingly everywhere in the long-running "You've come a long way, baby" television and print ads, that portrayed the triumph of women over male chauvinism as synonymous with gaining the right to smoke. The tall, slim shape of the packaging and the cigarette itself wordlessly conveyed to women that this product could help them achieve a tall, slim, glamorous look.[1,2] Philip Morris also kept this brand name prominently displayed in the high profile sponsorship of the Virginia Slims Women's Tennis events, long after tobacco's TV commercial privileges were revoked. This marketing strategy was only recently curtailed, in the 1999 season, as a result of the Master Settlement Agreement stipulation that restricts each tobacco company to one brand name sponsorship per year (Philip Morris continues to sponsor auto racing).[5] The association of top women athletes with Philip Morris's products through this tennis tournament created an entirely false image - that smoking and health can go hand-in-hand.

The anti-smoking crusades of the late '60s and early '70's, as well as a greater understanding of the serious health impacts of smoking, had a dramatic impact on smoking customs in the U.S. Yet the prevalence of smoking among men has fallen faster than that of women (see Fig. 1). The result has been a narrowing of the smoking gender gap to its current status of within 5 percentage points. In 1998, 22% of all women in the U.S. - or more than 1 in 5 - smoked cigarettes. In California, thanks to strong tobacco control measures, this rate is lower at 14% in 1997.[6]

Specific groups of women exhibit smoking prevalences that are significantly higher or lower than this overall average of 22%.[1] In survey data from 1997-1998, the percentage of current smokers ranged from a low of 11% among Asian or Pacific Islander women, to a high of 34% among American Indian or Alaskan Native women (see Fig. 2). 14% of Hispanic women reported smoking, which is lower than the percentage of White (24%) or Black (22%) women who smoke, a trend that has been consistent for many decades. Historically, white women in America began smoking in larger numbers earlier, demonstrating a dramatic increase in smoking in the 1910-1914 birth cohort, than Black women, who had the largest increase in smoking in the 1920-1924 birth cohort.[1] Education level is one of the most important correlates of smoking behavior in women, more predictive than either occupation type or income level. Women who have completed 9-11 years of education have the highest smoking prevalence (33% in 1998) and the percentage who smoke gradually declines in women who have completed more education, with a low of 11% in 1998 among women with at least a college education. By age group, smoking prevalence is fairly similar among women aged 18 through 64 (ranging from 22% to 26% in 1998); since 1965, however, women of reproductive age (18-44 years) have always had slightly higher smoking prevalence than women aged 44 and

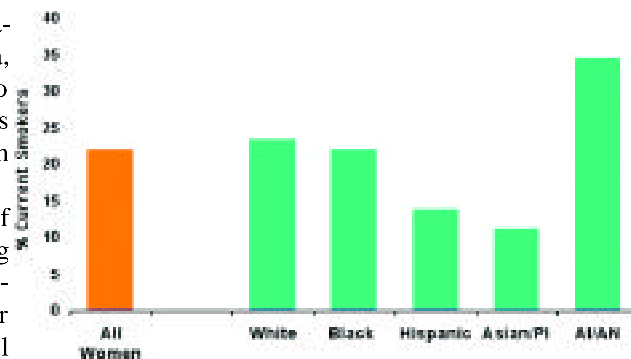


Fig.2 - Data Source: National Health Interview Survey, 1997-1998; data summarized in Table 2.4 of the U.S. Surgeon General's Report (1).

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# “Don’t Buy the Ventilation Lie”

## *Secondhand smoke, tobacco industry strategies and indoor air quality.*

*by Jeffrey Cheek*

*The author gratefully acknowledges that the main title of this article, and many of the references and facts supporting it, were obtained from the “Ventilation” section of the Americans for Nonsmokers’Rights web site, <www.no-smoke.org/ventlie.html> and the web site of GASP of Colorado <www.gaspforair.org>. Readers who are particularly interested in the tactics employed by the tobacco industry to combat ordinances against exposure to secondhand smoke are encouraged to peruse the extensive documentation provided on these web sites.*

The numerous diseases either caused or aggravated by exposure to secondhand smoke have been comprehensively documented.(1) Furthermore, a recent report highlights that workers exposed to high levels of secondhand smoke, such as in bars and restaurants, can see their risk of lung cancer triple.(2) Despite such overwhelming evidence that secondhand or environmental tobacco smoke (ETS) is a hazardous air toxin, regulations of indoor air quality reflect a sobering reality: public policy often restricts sound public health approaches in order to accommodate fiscal or political concerns. For example, the Oregon legislature has passed a bill that, while not affecting existing ordinances, would nonetheless prohibit future local ordinances from banning smoking in restaurants and bars.(3) For tobacco control professionals and health effects researchers, a principal question regarding the debate over how to best resolve secondhand smoking exposures in indoor environments may well be “why is there *any* debate?”

As other states and municipalities are considering implementing comprehensive bans on indoor smoking, the tobacco industry has intensified its counteroffensive public relations strike. Intending to divert focus from the health hazards associated with exposure to secondhand smoke the tobacco industry advocates ventilation technology that can purportedly “accommodate” smoking indoors. Far from conceding that secondhand smoke poses any health risks to nonsmokers, the industry’s goal, as stated on its websites, is to promote ventilation technology as one possible option among many for hospitality businesses (e.g., bars, restaurants and casinos). In essence, the tobacco industry seeks to appeal to public opinion by raising ventilation issues in political arenas, but engineering experts and public health officials agree that anything short of a complete ban on smoking will fail to prevent the risks associated with exposure to secondhand smoke in indoor environments.

### Indoor secondhand smoke and technical limitations

As it contains toxins that, individually, are considered hazardous to human health, the National Environmental Health Information Service has listed secondhand smoke as a “known human carcinogen” in and of itself,(4) essentially meaning that there is no acceptable exposure level. Indeed, based on the air toxics present in secondhand smoke, secondhand smoke emitted into outdoor air from a smokestack industry would qualify for regulation as a hazardous air pollutant mixture, similar to coke-oven emissions.(5) Within indoor environments, secondhand smoke provides additional challenges for hazardous exposure controls. Most occupational guidelines regarding “point source” hazardous emissions are based on known production rates within a defined and well-contained area (e.g., indoor use of organic solvents). In contrast, large fluctuations in the number of people smoking (up to a factor of three) (4) and any noncompliance with smoking restrictions mean that absolute containment of indoor secondhand smoke is unrealistic. Also, secondhand smoke rapidly diffuses throughout a room and

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# Ventilation

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persists long after its initial production. At one air change per hour (a standard turnover rate of indoor ventilation set to limit carbon dioxide levels), more than three hours are needed for approximately 95% of the smoke to dissipate once smoking has ended.[6]

Indoor ventilation standards are set by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc. (ASHRAE) and implemented by local building codes throughout the U.S. ASHRAE's most recent standard (62-1999) clarifies that, in the absence of a dedicated ventilation system that completely exhausts all indoor air from a contained room to the outside, the use of standard "dilution ventilation" cannot eliminate the risks of secondhand smoke exposure. In other words, while filters and other ventilation controls may reduce, for example, the particle or odor content, "out of sight and out of mind" does not equate with protection from all the toxins present in secondhand smoke. Addressing the limitations of currently available ventilation technology, ASHRAE further clarifies that Standard 62-1999 is and shall be in the future based upon "an assumption of no smoking" for most indoor places, including restaurants.[7]

## The tobacco industry's response to smokefree air policies

Previous ASHRAE standards deliberately avoided addressing the issue of secondhand smoke in indoor environments. Notably, ASHRAE's previous ventilation standard (62-1989), which is still promoted by the tobacco industry, specifically avoided any statements on the health effects of secondhand smoke. It is noteworthy, however, that the tobacco industry has previously played an active role in ASHRAE's ventilation standards development process. Several members of ASHRAE's board of directors are known to have tobacco industry ties.[8] However, the weight of health effects data supporting restrictions on exposure to secondhand smoke was sufficient to overcome this influence in the establishment of ASHRAE Standard 62-1999, which favors the elimination of indoor smoking. In spite of litigation efforts by Philip Morris, RJ Reynolds, and other tobacco interests to dismantle Standard 62-1999, the American National Standards Institute rejected the tobacco industry's appeal and reaffirmed ASHRAE's standard last year.[9]

> ***In other words, while filters and other ventilation controls may reduce, for example, the particle or odor content, "out of sight and out of mind" does not equate with protection from all the toxins present in secondhand smoke.***

On Philip Morris' web site, "improved" ventilation systems are touted as "reasonable alternatives to accommodating smokers and nonsmokers in public places." However, the health effects evidence and engineering standards clearly point out that the "ventilation" solution is only the latest public relations gimmick from the tobacco industry; it is consistent with their past efforts designed to bury secondhand smoke as only one of many indoor air quality issues. The challenge for tobacco control is to keep the focus specifically on secondhand smoke and thus avoid any "dilution" effect with regard to restricting exposure. Jim Repace, a former EPA official, has succinctly summarized this challenge in a report prepared for the California EPA, in which he states "It is clear that dilution ventilation, air cleaning, or displacement ventilation technology, even under moderate smoking conditions, cannot control ETS risk to de minimis levels for workers or patrons in hospitality venues without massively impractical increases in ventilation…Smoking bans remain the only viable control measure to ensure that workers and patrons of the hospitality industry are protected from exposure to the toxic wastes from tobacco consumption."[10]

## Conclusions

Given the persistence of secondhand smoke in indoor environments and its classification as a known human carcinogen, ventilation rates would have to be increased more than a thousand-fold - that is, to the equivalent of tornado-force winds, to eliminate all health concerns.[6] Modifications to current ventilation systems that would sufficiently eliminate the risk of exposure to secondhand smoke are thus cost-prohibitive at best and completely impractical or ineffective at worst. The industry's steadfast refusal to acknowledge secondhand smoke's health effects, coupled with its focus on categorizing secondhand smoke as a mere "annoyance," serve only to obfuscate its true objectives (i.e., maintain revenue) and its underlying concerns. Specifically, behavioral studies have shown that cessation efforts are bolstered by smoking bans (i.e., restricting indoor exposure to secondhand smoke greatly facilitates smokers' efforts to quit the habit). It is thus not surprising that the tobacco industry continues to promote its alternative "accommodations". In brief, ventilation cannot serve to elimi-

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# Religion - Health - Tobacco The Research Connection

*by Teresa Johnson & Francisco Buchting*

** In this article, the term religion represents both concepts of religion and spirituality*

The guiding principles for tobacco use vary among different religions/spiritual practices and belief systems from a fundamental prescribed role for tobacco use in religious ceremonies to an explicit prohibition of its use. The discussion and utilization of a role for religion in tobacco control has increased in recent years at the state, national, and global level. The World Health Organization (WHO) has identified religious organizations as potential partners in the global tobacco control movement (see box). In California, religion is playing a significant role in tobacco control efforts in American Indian and Alaskan Native (AIAN) communities and in some African-American communities. For example, the tobacco control approach by the NATIVE (Native Americans Taking Initiative on Values and Education) Tobacco Project is to utilize cultural and traditional values associated with ceremonial tobacco use as means to differentiate and to stop the use of commercial tobacco.

The scientific inquiry and the body of literature looking at the association between religion and health (physical and mental) are numerous, with a significant increase in numbers in recent years.[1] Along with a recent increase of work, this area of study has seen a systematic development in its methodology and understanding of its multidimensional constructs, improvement in the quality of research and scholarship, and increased interest and involvement of diverse fields of research.[2,3] This article will highlight the religion and health research related to tobacco in order to indicate potential research opportunities for tobacco.

## Epidemiology of tobacco-related disease and religion

Research looking at the connection between religion, health, and tobacco use dates back to the 1950s with published studies linking smoking to negative health consequences. Specifically, two studies reported lower rates of lung cancer among members of the Seventh-day Adventists as a possible consequence of religious prohibition on tobacco use.[4, 5] Both studies were included in the 1964 Surgeon General's Report: Reducing the Health Consequences of Smoking. Subsequent epidemiological studies in the United States looking at incidences of lung cancer, as well as other tobacco-related diseases, among Seventh-day Adventists and among Mormons have replicated the findings of lower incidence rates for these groups.[6, 7, 8, 9, 10] Similarly, these findings have been replicated in studies that also look at inter-denominational group differences in incidences of tobacco-related diseases in other countries.[11, 12, 13, 14, 15, 16]

Fewer studies have looked at differences in rate of tobacco-related diseases within a specific denominational group. A repeated finding among theses intra-denominational group studies has been a lower incidence of tobacco related diseases

The **WHO's Tobacco Free Initiative Program** directly addresses the problem of widespread tobacco consumption. Religion and tobacco control is viewed as a new frontier of great partnership opportunities according to the WHO. On May 3, 1999, the WHO held a conference on tobacco and religion in Geneva, Switzerland. This conference brought together tobacco control and religious leaders to discuss and explore the spiritual dimensions and ethical dynamics of tobacco use and tobacco-addiction. Following is a summation of religious precepts applying to tobacco use as presented by religious leaders at the meeting. (Note: only religions represented at the conference are included in this summary.)

### Bahá'í

*Bahá'í views are that the emotional, intellectual, and spiritual well being are required for an individual and the community to be healthy. The teachings emphasize the importance on the investigation of reality. Even though, Bahá'í teachings do not prohibit smoking; it is seen as unclean and unhealthy, smoking is strongly discouraged. The basis for this position is the overwhelming evidence of the negative health effects of smoking.*

### Buddhism

*Buddhism teaches the path of freedom which implies a way of life without dependence on anything and a life of mental clarity. It is the Buddhist's responsibility not to purposefully harm the body or the mind, thus taking great care of the mind and body is of extreme importance. Thus, tobacco consumption and dependence should be avoided because it impedes the mind and mental clarity and the ability to attain the true meaning of life.*

### Hinduism

*In Hinduism, tobacco is viewed as an unnecessary dependence in preserving life. The goal to spiritual living is freedom from suffering, freedom from nature's bondage and the attaining of happiness. Hindus believe that the heart is the holy seat of God. The heart is the essential focal point in many forms of mediation. An individual's heart, body and mind can be positively or negatively effected by what they consume. Since it has been proven that smoking affects the heart, Hindus see smoking as an aggressive attack on the holy seat of god and thus its use should be limited.*

### Islam

*Muslim law, which is based on the Koran and prophetic traditions, proposes a classification of prescription. One prescription, "the protection of the individual", stipulates that any product or form of consumption that might jeopardize the life or health of the individual are forbidden and contrary to the teachings of Islam. Tobacco is regarded as a product that is harmful to health and whose consumption is in complete contradiction with the tenets of Islam.*

### Judaism

*Judaism teaches that all human beings are created in God's image, thus every human life is precious, and the Torah asks for the individual to choose life. According to Maimonides, a Jewish theologian, this imperative from the Torah compels one to choose that which does not endanger health or weaken the body envelope that carries the soul. Tobacco is considered as one of those things that jeopardizes the body, and thus life.*

### Protestantism

*A broad spectrum of attitudes are represented in over 300 distinct groups. These attitudes on tobacco/smoking range from laissez-faire to stern warning to outright prohibition. For example, while the majority of Protestant churches caution against any form of dependence being contrary to Christian freedom, the Evangelical churches, the Quakers, the Seventh Day Adventists and Mormons have always prohibited the use of tobacco.*

### Roman Catholicism

*The Pontifical Council recognizes the harmful effects of tobacco use and is reflected in the reaffirmation of the idea of mens sana, in corpore sano (sound mind, sound body). Recently, the Roman Catholic Church has declared an official position on smoking and its harmful effects. In addition, Pope John Paul II called for Catholics to abstain from tobacco products for one day and donate the savings.*

In many societies religion plays a critical role in social policies. WHO's Tobacco Free Initiative realizes that religious groups have the potential to contribute to the decrease in consumption of tobacco products and the prevention of tobacco related diseases on an individual, community, country and global level. To that end, several religions have begun efforts to address the issues of tobacco use/smoking. For example, Bahá'í are participating in the Primary Health Care (PHC) campaign geared at disease prevention with an educational component about the harmful effects of smoking. Additionally, the Central Conference of American Rabbis (CCAR) have passed a resolution against targeting of the advertisement of tobacco products to youth and the consumption of these products. The WHO's Tobacco Free Initiative and religious organization will continue the dialogue and develop collaborations to address the issue of tobacco.

***The full report can be found at http://tobacco.who.int/en/religion/index.html.***

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# Religion

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among members of the group with higher adherence to religious doctrines/teachings that prohibit tobacco, as compared to members of the group with lower adherence.[17, 18, 19]

## Behavioral epidemiology of smoking and religion

Most studies report an inverse association between polysubstance use (simultaneous use of multiple drugs) and the construct of religion for both adolescents and adults. It was found that for adolescents, higher religious participation/service attendance[20] and higher religiosity[21, 22] were associated with lower polysubstance use, including tobacco smoking. Similar findings were reported for adults, i.e., lower polysubstance use associated with higher religious attendance[23] and with higher religiosity.[24, 25] In addition, differences in rates of polysubstance use were found depending on religious affiliation.[26]

Studies that report specifically on the association between smoking and the construct of religion provide similar results. Higher religious activity/attendance to religious services was found to be inversely associated with smoking.[27,28] Similarly, other studies report higher religiosity to be one of the factors in characterizing non-smokers and ex-smokers,[29] a deterrent for smoking among women[30] and as a protective factor against smoking[31] In addition, higher religiosity and church attendance was found to positively correlate with health promoting behavior, including not smoking, among African-Americans.[32, 33] In twin studies, the construct of religion was found to be an important familial-environmental factor that interacts with the heritable risk for smoking initiation and persistence (addiction).[34,35]

Nevertheless, the construct of religion is not always significantly associated with lower levels of smoking or not smoking. In some studies, it did not emerge as a correlate for polysubstance use, including use of cigarettes[36] or as a predictor of smoking status.[37] In a different study, the construct of religion was found to be protective for alcohol use but insignificant for smoking status among African-American twins.[38]

## Further Research

The research literature has a significant number of religion and health articles that look at tobacco use, but most often as part of a larger focus, e.g., polysubstance use, health behavior, violence, and mortality. In most cases, tobacco use is limited to smoking. Fewer articles specifically address religion and tobacco use. Studies that look specifically at the multidimensionality pertinent to the construct of religion and at tobacco use have begun to provide significant information into this very complex connection. Most research shows that religion/spirituality confers health benefits by deterring tobacco use. Despite the religious diversity in California, the recent activities by the tobacco control community and by the WHO in addressing religion and tobacco use, little research is being conducted in California on this topic. Are researchers missing an important opportunity and a potentially explanatory or confounding variable?

A number of research questions addressing religion, health and tobacco use need to be addressed. The identification of protective factors in preventing the initiation of smoking or in helping tobacco users quit as it relates to different religious practices and beliefs needs further investigation. More specifically, what does religion provide to its followers or how does religion motivate certain behaviors among its followers that may lead to healthier lifestyles (living tobacco free living or quitting tobacco use)? Given the role that the religious construct may play in attenuating tobacco initiation and use among certain groups, is this construct confounding research results in genetic and behavioral studies? There is also research interest and potential for partnerships between the tobacco control community and researchers in studies of the efficacy of faith-specific smoking cessation interventions, as well as public health tobacco control campaigns. All these potential avenues call for a more direct and focused investigation regarding religion, health, and tobacco that departs from most of past religion-health research where tobacco has not been a major focus. In addition, such studies may provide the opportunity to obtain important information from and create partnerships with communities where religious organizations play an important role.

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## Women

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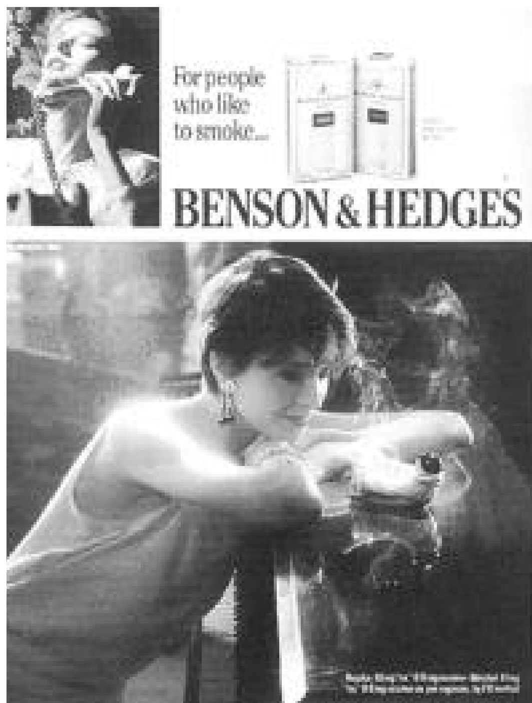
older.[1]

Most alarming are the statistics related to cigarette smoking among high school age girls because most




*Advertising:The women who smoke are glamorous, sophisticated, sensual and liberated; circa 1980's.*

smokers start before age 18. After declines between 1970 and 1990, the number of teenage girls who smoke climbed back up during the 1990's. According to the University of Michigan's longitudinal study of current smoking among high school seniors, smoking prevalence among girls has evolved from 39% in 1976, to a low of 26% in 1992, then increased to approximately 33% in 1998.[7] In 1998, 63% of high school senior girls reported having ever smoked one or more cigarettes. Smoking prevalence among high school age Black girls has fallen faster and been lower than that of White girls for several decades.[1] Initial studies, such as the Youth Tobacco Surveillance study of 1998-1999,[8] have investigated smoking prevalence, preferences and attitudes among girls of different racial and ethnic groups, but further analysis is needed to fully understand this problem. Although recent surveys about girls' attitudes toward smoking often uncover a majority agreeing to negative perceptions, such as "smoking is a dirty habit," too many girls and young women are still lighting up and getting hooked.

Use of other tobacco products - such as cigars, pipes and smokeless tobacco – by women has traditionally been very low in the U.S. (< 1%); however, several studies have shown that more women began smoking cigars in the 1990's as part of a fad of cigar popularity.[1] Studies of cigar use in younger girls show a higher prevalence of occasional use; however, girls were less likely than boys to be current cigar smokers.

### Where there's tobacco smoke, there's disease

Predictably, the increase in smoking rates among U.S. women has been followed by an increase in disease incidence and mortality.[1] Estimates stated in the Surgeon General's Report are that an average of about 160,000 to 170,000 U.S. women have died from smoking-related causes each year from 1995-2000.[9] The overall smoking related mortality in the past twenty years is a staggering 3 million U.S. women (unpublished CDC data cited in 1). The Surgeon General's report presents a detailed summary of the long list of diseases resulting from tobacco use and exposure to environmental tobacco smoke, as well as current understanding of the epidemiology and etiology of these diseases in women and how some diseases disproportionately affect different women in the population.

Women smokers are at greater risk of developing a number of serious diseases than nonsmoking women,[1] but much emphasis is placed on the incidence of lung cancer in women because the increase is so large and the prognosis for this disease so grim. Incidence and mortality of lung cancer increased dramatically for U.S. women in the 1970's, about a decade later than the spike seen for U.S. men. In 1987, lung cancer became the leading cancer killer of U.S. women, accounting for fully 25% of all cancer deaths in women. The Surgeon General attributes nearly 90% of all lung cancer deaths, as well as 90% of deaths due to chronic obstructive pulmonary disease, to smoking.[1]

Women may be surprised to know that 67,000 more women died of lung cancer than of breast cancer in 1998.[10] If judged by the number of newspaper articles, television shows, magazine covers, charitable foundations and patient support groups, an observer could easily conclude that breast cancer is the biggest cancer killer of U.S. women. Mortality rates from breast cancer have remained fairly constant at roughly 25-27 per 100,000 women for the past 50 years; lung cancer deaths however have soared from 5 per 100,000 in 1948 to almost 35 per 100,000 currently (data source: Fig. 1.3 of (1). Thus, women who smoke should be aware that they face a different threat, and fortunately it is a preventable threat.

While there is absolutely no justification to reduce our efforts in combating breast cancer, there is clearly a need to increase women's awareness of the risks of lung cancer, as well as to destigmatize this disease and provide support to patients. Perhaps most importantly, the inequity of funding for lung cancer

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## Women

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research must be addressed. Lung cancer kills more people each year than breast, prostate and colorectal cancer combined. When U.S. funding for research into causes and therapies for these cancers is assessed on a per death basis, lung cancer research receives just 10% of the funds dedicated to breast cancer research.[13]

Regarding breast cancer and smoking, the Surgeon General's report concludes "The totality of the evidence does not support an association between smoking and risk for breast cancer. Several studies suggest that exposure to environmental tobacco smoke is associated with an increased risk of breast cancer, but this association remains uncertain." However a recent study from UC Davis suggests that women smokers with breast cancer are more likely to develop pulmonary metastasis, leading to a higher mortality rate for this group of patients.[11] Another recent study from researchers at the Mayo Clinic reports that smoking is a risk factor for breast cancer in families with a history of breast cancer.[12] Thus correlation between smoking and increased risk of breast cancer may become apparent if research studies are focused on women smokers with a particular genetic makeup, rather than surveying a more diverse population in which these effects may be obscured.

Tobacco control campaigns have used the increased risk of male impotence as a tactic to encourage men to stop smoking. Arelated campaign might be directed toward women who want to become mothers by explaining the increased risk of delayed conception, infertility, ectopic pregnancy and spontaneous abortion produced by smoking.[1] The dangers of smoking during pregnancy, such as low-birth weight, pre-term delivery and stillbirth, are more commonly known. However, it is still a major health concern that women addicted to nicotine are unable to quit smoking during their pregnancies. Women using oral contraceptives to prevent pregnancy should also take note that an increased risk of heart disease and heart attack is associated with their use by women who smoke.[1] Analysis of the epidemiology of diseases related to smoking with oral contraceptive use has been complicated by changes in how doctors prescribe the pill to smoking patients and by changes in the hormonal content of the pills themselves.

### Conclusion

In sum, the Surgeon General's report leaves no doubt that reducing smoking and improving treatments for smoking related diseases should be at the top of the agenda for clinicians, researchers, public health professionals and tobacco control advocates involved in women's health. TRDRP is in its 10th year of funding California researchers examining critical behavioral, social, epidemiological and biomedical issues in smoking and disease. Many TRDRP-funded researchers participated in the creation of the Surgeon General's report.[14] California's efforts in tobacco control were also recognized in the Surgeon General's report in a citation in the preface that suggests hope for the future: "Thanks to an aggressive, sustained anti-smoking program, California has seen a decline in women's lung cancer rates while they are still rising in the rest of the country." California researchers and tobacco control activists should take such praise as further encouragement to share their knowledge and best practices with colleagues around the country, as well as around the world.

*This article will be continued in the next TRDRP newsletter, with Part II: Putting out the epidemic's fire.*

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# Religion

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# Community

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Once the actual amount and distribution of tobacco industry contributions can be tabulated, then other questions can be approached. For example, what is the correlation between the tobacco industry's charitable contributions and smoking incidence in the African-American community; is there any relation at all? It would be important to compare communities who have a regular tobacco industry sponsored cultural event (Kool Jazz Festival, for example) with those communities that don't; do attitudes in these different Black communities differ toward tobacco? Another interesting research question would be to find out the state of the knowledge, attitude, and behaviors of African-Americans who have received tobacco monies to attend college? What is their smoking status; do they speak out against tobacco use; and are they aware of the devastation that tobacco use has had on the African-American community? Other interviews could be conducted with major recipients of tobacco industry donations (e.g., Alvin Ailey American Dance Theater) to see how they deal with the mixed messages their acceptance of funding may have generated. These are just some of the important questions that could be asked.

Charitable donations for the tobacco industry will be hard for the African-American community to refuse. These funds support some of the major educational and cultural events in this community. On the other hand, the disproportionate death and disease meted out by the tobacco industry to the African-American community possibly should give pause to all those receiving funds. Research to clarify exactly what the extent and impact of tobacco industry funds have had and are having on the African-American community can go a long way toward clarifying this thorny issue.

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## Ventilation

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nate the hazardous toxins in secondhand smoke to any acceptable level, thus bans on indoor smoking offer the only adequate solution. Again, Jim Repace has best summarized the issue: "Smoking bans represent the most cost-effective, easiest-to-enforce, and lowest risk alternative for ETS control. They appear profitable for business, and are also the only control measure known which is capable of yielding *zero risk*."[5]

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## Women

Continued from page 13


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# More TRDRP Highlights

## Cornelius Hopper Diversity Award Supplements

This year marked the second year of funding for the **Cornelius Hopper Diversity Supplement Awards (CHDAS)**. The aim of the CHDAS is to encourage TRDRP-funded principal investigators to mentor individuals who want to pursue careers in research on tobacco use and tobacco-related disease. Qualifications for the CHDAS include individuals from groups that are underrepresented among researchers who investigate tobacco use or tobacco-related disease, and/or facilitating training of key personnel who will work directly with underrepresented groups that are disproportionately impacted by tobacco use. We are pleased to announce that seven of our currently funded investigators will receive supplements to their TRDRPgrants for support of new personnel on their projects (see box for list of P.I.s and supplement beneficiaries).

| CHDAS Trainee | Principal Investigator | Institution |
|---|---|---|
| Tina Griffith | Richard Olmstead | University of California, Los Angeles |
| LaTasha Mason | Bruce Allen | Charles R. Drew University of Medicine & Science |
| Thang-Giao Nguyen | Tanima Gudi | University of California, San Diego |
| Theresa Operana | John Cashman | Human BioMolecular Research Institute |
| Michael Romney | Connie Pechmann | University of California, Irvine |
| Darya Soto | George Caughey | University of California, San Francisco |
| Frederick Zamora | James Tucker | Lawrence Livermore National Laboratory |

### CARA/SARA Workshops

In early October, TRDRP will again hold workshops for potential applicants for Community-Academic Research Awards (CARAs) and School-Academic Research Awards (SARAs). The aims of the workshops are to expose participants to the tenets of participatory research, learn from successful CARA and SARA applicants, identify potential research collaborators, and review the nuts and bolts of the application process. (see registration form next page). Information about these workshops will be posted on the TRDRPwebsite after September 1, 2001. For further information, please contact:

**Francisco Buchting**
**510-987-9883**
**francisco.buchting@ucop.edu**
or
**Phillip Gardiner**
**510-987-9853**
**phillip.gardiner@ucop.edu**

### TRDRP 6th Annual Investigator Meeting (AIM 2001)
#### Focus: Racial and Ethnic Disparities in Tobacco-Related Research

Mark your calendar for this year's annual meeting, which will be held at the Westin Los Angeles Airport Hotel on Thursday and Friday, **December 6 & 7, 2001**. The focus of the plenary session on Friday morning will be on racial and ethnic disparities in tobacco-related research. Speakers will discuss how biology and behavior interact with the social construct of race and ethnicity, the impact on biological and behavioral research, and the federal research agenda for addressing diverse populations. Following the successful format of the last few years, TRDRP will again host workshops on Thursday, organized on several themes relevant to tobacco-related research. The workshops will be followed by a reception on Thursday evening. As usual, Friday afternoon will be devoted to poster sessions, where TRDRP-funded investigators will present the latest findings from their research projects. TRDRP will issue a Call for Abstracts to investigators in August.

### 1st Conference on Menthol Cigarettes: Setting the Research Agenda

TRDRP is co-sponsoring a groundbreaking conference on mentholated cigarettes and tobacco use. This conference will be held in Atlanta, Georgia, on **October 11-12, 2001**. Other sponsors of the conference include the American Legacy Foundation, the Centers for Disease Control and Prevention, the National Cancer Institute, the Robert Wood Johnson Foundation, Battelle, and Onyx Group. For years, community advocates and some researchers have speculated that disproportionately high deaths of African-American males from lung cancer may be in part due to elevated menthol use among this population. Participants of this conference will examine the current state of knowledge of the epidemiology, sociology, economics, biochemistry, and physiology of menthol use and make recommendations for future research directions.

## SARA/CARA Workshop Registration Form

**October 1, 3 & 4, 2001**

***RSVP no later than September 14th; lunch will be provided.***

Name: ____________________________________________

Position/Title: ____________________________________________

Institution/Organization: ____________________________________________

Department: ____________________________________________

Address: ____________________________________________

City: ____________________ State: __________ Zip: ______________

Telephone: [ ] ______________ Fax: [ ] ______________ email: ______________

Please indicate type of Institution/Organization: School, Community or Research/Academic

____________________________________________

*Please indicate location you plan to attend:*

| | | |
|---|---|---|
| **[ ] Oakland, CA**<br>**October 1st**<br>**9 a.m. - 1 p.m.** | **[ ] San Diego, CA**<br>**October 3rd**<br>**9 a.m. - 1 p.m.** | **[ ] Los Angeles, CA**<br>**October 4th**<br>**10 a.m. - 1 p.m.** |

***Registration form can be faxed to the TRDRP office at: 510-835-4740 or mailed.***

## OAKLAND

**October 1st**

**9 a.m. - 1 p.m.**

Alameda Tobacco Control Section
Alameda County Health Care Services
1000 Broadway, 5th Floor
Oakland, CA 94607

## SAN DIEGO

**October 3rd**

**9 a.m. - 1 p.m.**

San Diego State University Foundation
Conference Room
5250 Campanile Drive
San Diego, CA 92182

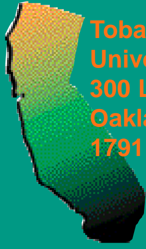
## LOS ANGELES

**October 4th**

**9 a.m. - 1 p.m.**

University of Southern California
Specific Location TBA
Los Angeles, CA 90007

*registrants will be notified by email*



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# July 2001 Newsletter

**The Tobacco-Related Disease Research Program (TRDRP) supports innovative and creative research that will reduce the human and economic cost of tobacco-related diseases in California and elsewhere.**

## HOLD THESE DATES

### CARA/SARA Workshops

**Oakland - October 1st**
**San Diego - October 3rd**
**Los Angeles - October 4th**

### November 27-29, 2001

**2001 National Conference on Tobacco Control**
**New Orleans, LA**

### December 6-7, 2001

**TRDRP – AIM 2001**
**Los Angeles, CA**