



Testimony

of

**Kevin Schroth, Senior Legal Counsel for Tobacco Control
New York City Department of Health and Mental Hygiene**

before the

New York City Council Committee on Health

on

Smokeless Tobacco and Hookah

February 25, 2016

Committee Room – 250 Broadway

New York City

1

Good morning, Chairman Johnson and members of the Committee. I am Kevin Schroth, Senior Legal Counsel for Tobacco Control at the Department of Health and Mental Hygiene. I am joined by Tom Merrill, General Counsel and Dan Kass, Deputy Commissioner for Environmental Health. Thank you for the opportunity to testify today on a suite of tobacco and hookah-related legislation.

New York City has long been on the forefront nationally and, indeed internationally, in protecting people from tobacco-related illness and death. Since 2002, we have worked to dramatically reduce tobacco use by banning tobacco from bars, restaurants, and, later, parks and beaches; limiting the places where people can purchase and use tobacco products, including e-cigarettes; restricting cigarette sales to people 21 or over; creating disincentives to purchase these products by making them expensive through taxation, minimum pricing and discount restrictions; helping smokers quit by giving away hundreds of thousands of nicotine patches; educating people about the dangers of smoking through world-renowned media campaigns; and evaluating the effectiveness of these interventions. The Council has been a tremendous partner in this work, and the results have been very gratifying. Since 2002, New York City's adult smoking rate has dropped 35 percent, to a record low of 13.9 percent¹ in 2014, and the youth smoking rate has dropped 53 percent between 2001 and 2013, to 8.2 percent². These reductions will have prevented 136,000 deaths in New York City by 2060. But we can't rest on our accomplishments. About 900,000 adults and 21,000 youth still smoke, and an estimated 12,000 New Yorkers die from tobacco-related illnesses annually.³ These illnesses and deaths are preventable, and it is a priority of the Administration and the Department to protect New Yorkers from the dangers associated with tobacco use.

I commend the Council for making it a priority as well, which is evident by the five bills under discussion today. I want to acknowledge today's bill sponsors – Chairman Johnson, Councilmember Rodriguez, and Councilmember Gentile, who has been a longtime champion of reducing hookah use in this City – and thank them for taking on these issues. We're committed to working with the Council on these issues and other approaches to reduce tobacco use in New York City.

I will comment first on Intro 1068, which would prohibit the use of smokeless tobacco products at ticketed sports arenas and recreational areas. Using smokeless tobacco is associated with serious negative health outcomes, such as cancers,^{4,5} diseases of the mouth,⁶ increased risk for early delivery and stillbirth when used during pregnancy,⁷ and increased risk of cardiovascular disease.^{8,9}

Every year, roughly 415,000 kids nationwide, ages 12-17, try smokeless tobacco for the first time.¹⁰ It is very troubling that in just six years, from 2007 to 2013, youth smokeless use in New York City doubled from 2.2 percent to 4.4 percent.¹¹ Using smokeless tobacco is associated with, and reinforces, use of other tobacco products like cigarettes^{12,13} and youth who use smokeless tobacco may be more likely to pick up smoking.^{14,15} Smokeless tobacco products are heavily advertised and promoted, and are addictive because they too contain nicotine.^{16,17} Unfortunately, our young people repeatedly see professional athletes, especially baseball players, using smokeless tobacco, making this practice appear socially acceptable. Sports fans may think smokeless tobacco is harmless or can even enhance athletic performance.¹⁸ While professional athletes may seem superhuman to young fans, when it comes to tobacco, they're just like the rest of us. Long-time smokeless tobacco user and baseball Hall of Famer Tony Gwynn recently died

of cancer in his salivary glands and former All-Star baseball player Curt Schilling has battled oral cancer.

The Department supports Intro 1068 as a common sense measure that would reduce exposure, especially for young people, to users of smokeless tobacco. Similar prohibitions have successfully passed in San Francisco, Boston, and Los Angeles. The Department is hopeful that the City's athletes and teams will embrace this proposal as a way to protect the health of our impressionable youth.

Next, I'll turn to the four bills addressing hookah smoking. Despite declines in cigarette smoking, smoking using a hookah—or a water pipe—is increasing in popularity among youth in our City. The product smoked in a hookah is often called “shisha,” and it comes in tobacco and non-tobacco varieties. Both tobacco and non-tobacco shisha burned during hookah smoking emit harmful particulate matter and potentially harmful toxicants. The use of charcoal to ignite shisha adds to the emissions. Many hookah smokers underestimate the health risks associated with the practice.^{19,20,21} Smokers of non-tobacco shisha are exposed to many of the same harmful substances as those who smoke tobacco-containing shisha, such as polycyclic aromatic hydrocarbons (PAH), carbon monoxide (CO), fine particulate matter (PM), tar, and volatile aldehydes.^{22,23,24} Exposure to these substances has been associated with cancer,²⁵ cardiovascular disease, heart attacks, decreased lung function, increased respiratory symptoms, and, among those with cardiovascular and lung disease, premature death.^{26,27} These toxic emissions not only affect hookah smokers, but also expose others to risks associated with secondhand hookah smoke.^{28,29,30}

The number of establishments offering hookah smoking has increased dramatically in recent years, particularly near college campuses. By one estimate, the number of hookah bars in

the City more than doubled between April 2012 and August 2015.³¹ Hookah catering businesses, which bring hookahs to bars, nightclubs, or restaurants on particular nights, are also increasing.

As these establishments have proliferated, the rates of hookah smoking have sharply increased. Use among middle school and high school students in New York City increased from 8.9 percent in 2008 to 13 percent in 2014.³² Hookah use among Hispanics in middle and high school more than doubled, and use among black youth more than tripled from 2008 to 2014.³³ For adult New Yorkers, hookah smoking is more than three times more likely among those aged 18 to 20 than those 21 years and older.³⁴ The increase in younger New Yorkers' hookah smoking is particularly troubling because it may contribute to cigarette smoking and long-term tobacco addiction.³⁵

Currently, the Smoke Free Air Act (SFAA) prohibits smoking tobacco-containing shisha in bars, restaurants, and other places, but does not address non-tobacco shisha. Intro 139-A would prohibit all non-tobacco hookah smoking in places covered by the SFAA unless they register with the Department to operate as a "non-tobacco bar" or "non-tobacco smoking establishment." The bill would reduce hookah use as well as exposure to harmful secondhand hookah smoke for workers and other patrons.

The prohibition would also help the Department enforce the SFAA with respect to tobacco-containing shisha. Because only tobacco-containing shisha is currently prohibited, when the Department observes shisha smoking at a restaurant or bar, inspectors must take shisha samples and send them to a lab for analysis to determine whether the shisha contains tobacco or not. This process is time-consuming and expensive. A recent investigation by the Department of 13 hookah bars revealed that all 13 were illegally serving tobacco-containing shisha.³⁶ Based on our experience enforcing the SFAA, the Department has suggestions for further strengthening

this bill, including incorporating the warning signs required in Intro 1075 and increasing the legal sales age from 18 to 21 in Intro 1076. These steps would help to educate the public on the dangers of hookah smoking and to reduce youth exposure and use. We also suggest that, rather than requiring the “non-tobacco smoking bars” to register with the Department, the bill instead create a new category of permit that would enable the City to collect on penalties, and could be revoked if the establishment does not live up to its terms. It would enable a food service establishment to continue operating, even if it could not continue to offer hookah. We look forward to working with Council on this issue.

Finally, the Department supports the intent of Intro 617 to restrict the availability of tobacco and non-tobacco shisha. We would welcome a discussion with the Council on making *all* tobacco products—not just shisha—more difficult to buy in New York City.

Thank you for the opportunity to testify. We are happy to answer questions.

- ¹ New York City Department of Health and Mental Hygiene. Community Health Survey, 2010-2014. Internal analysis of data.
- ² New York City Department of Health and Mental Hygiene. Youth Risk Behavior Survey, 2007-2013. Survey of NYC public high school students. Internal analysis of data.
- ³ Estimate derived from a *SimSmoke* NYC-specific simulation model. For more information regarding SimSmoke, please see: Levy DT, Bauer JE, Lee HR. Simulation modeling and tobacco control: creating more robust public health policies. *Am J Public Health* 2006;96:494–8.
- ⁴ World Health Organization. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans. Volume 89: Smokeless Tobacco and Some Tobacco-Specific N-Nitrosamines*. [PDF 3.18 MB] Lyon (France): World Health Organization, International Agency for Research on Cancer, 2007 [accessed 2014 Oct 31]
- ⁵ U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2014 Oct 31].
- ⁶ World Health Organization. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans. Volume 89: Smokeless Tobacco and Some Tobacco-Specific N-Nitrosamines*. [PDF-3.18 MB] Lyon (France): World Health Organization, International Agency for Research on Cancer, 2007 [accessed 2014 Oct 31]
- ⁷ U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2014 Oct 31].
- ⁸ World Health Organization. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans. Volume 89: Smokeless Tobacco and Some Tobacco-Specific N-Nitrosamines*. [PDF-3.18 MB] Lyon (France): World Health Organization, International Agency for Research on Cancer, 2007 [accessed 2014 Oct 31]
- ⁹ Piano MR, Benowitz NL, Fitzgerald GA, Corbridge S, Heath J, Hahn E, et al. Impact of Smokeless Tobacco Products on Cardiovascular Disease: Implications for Policy, Prevention, and Treatment: A Policy Statement from the American Heart Association. *Circulation* 2010;122(15):1520–44 [cited 2014 Oct 31].
- ¹⁰ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. The NSDUH Report: Trends in Smokeless Tobacco Use and Initiation: 2002 to 2012, July 24, 2014.
- ¹¹ New York City Department of Health and Mental Hygiene. Youth Risk Behavior Survey, 2007-2013. Survey of NYC public high school students. Internal analysis of data.
- ¹² Hatsukami DK, Lemmonds C, Tomar SL. Smokeless tobacco use: harm reduction or induction approach? *Prev Med*. 2004;38(3):309–17.
- ¹³ Tomar S. Is use of smokeless tobacco a risk factor for cigarette smoking? The U.S. experience. *Nicotine Tob Res*. 2003;5(4):561–9.
- ¹⁴ Lund I, Scheffels J. Smoking and Snus Use Onset: Exploring the Influence of Snus Debut Age on the Risk for Smoking Uptake With Cross-Sectional Survey Data. *Nicotine and Tobacco Research* 2014;16(6):815–9 [cited 2014 Oct 31].
- ¹⁵ Tomar S. Is use of smokeless tobacco a risk factor for cigarette smoking? The U.S. experience. *Nicotine Tob Res*. 2003;5(4):561–9.
- ¹⁶ World Health Organization. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans. Volume 89: Smokeless Tobacco and Some Tobacco-Specific N-Nitrosamines*. [PDF-3.18 MB] Lyon (France): World Health Organization, International Agency for Research on Cancer, 2007 [accessed 2014 Oct 31]
- ¹⁷ U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2014 Oct 31].
- ¹⁸ Walsh MM, Ellison J, Hilton JF, Chesney M, Ernster VL. Spit (smokeless) tobacco use by high school baseball athletes in California. *Tob Control* 2000;9(Suppl 2):II32–9.
- ¹⁹ Unpublished data, Hunter Focus Groups 2013
- ²⁰ Sutfin EL McCoy TP, Reboussin BA, Wagoner KG, Spangler J, Wolfson M. Prevalence and correlates of waterpipe tobacco smoking by college students in North Carolina. *Drug Alcohol Depend* 2011.
- ²¹ Heinz AJ, Giedgowd GE, Crane NA, et al. A comprehensive examination of hookah smoking in college students: use patterns and contexts, social norms and attitudes, harm perception, psychological correlates and co-occurring substance use. *Addict Behav* 2013;38:2751–60.
- ²² Apsley A, Galea KS, Sánchez-Jiménez A, Semple S, Wareing H, Tongeren Mv. Assessment of polycyclic aromatic hydrocarbons, carbon monoxide, nicotine, metal contents and particle size distribution of mainstream Shisha smoke. *Journal of Environmental Health Research* 2008;11:93.
- ²³ Shihadeh A, Salman R, Jaroudi E, et al. Does switching to a tobacco-free waterpipe product reduce toxicant intake? A crossover study comparing CO, NO, PAH, volatile aldehydes, "tar" and nicotine yields. *Food and Chemical Toxicology* 2012;50:1494–8.
- ²⁴ Hammal F, Chappell A, Wild TC, et al. 'Herbal' but potentially hazardous: an analysis of the constituents and smoke emissions of tobacco-free waterpipe products and the air quality in the cafes where they are served. *Tob Control* 2013. E pub ahead of print.
- ²⁵ International Agency for Research on Cancer. *Agents classified by the IARC monographs volumes 1-107*. Accessed 5 2013
- ²⁶ Environmental Protection Agency. *Particulate Matter - Health*. Last updated 3/18/2013, accessed 5 2013.
- ²⁷ Environmental Protection Agency. *Integrated Science Assessment for Particulate Matter (Final Report)* 2010.
- ²⁸ NYC Department of Health & Mental Hygiene. Indoor air monitoring results - unpublished data 2007.
- ²⁹ Orgeon Health Authority. 2010 Indoor Clean Air Act Compliance Study. P.12, 13
- ³⁰ Cobb et al. Indoor air quality in Virginia waterpipe cafés. *Tob Control* 2011
- ³¹ Based on Yelp! searches conducted by DOHMH staff on April 9, 2012 and August 8, 2015.
- ³² New York State Youth Tobacco Survey 2008-2014.
- ³³ New York State Youth Tobacco Survey 2008-2014.
- ³⁴ New York City Department of Health and Mental Hygiene. NYC Community Health Survey, 2014. Internal analysis of data.
- ³⁵ Heinz, A., Giedgowd, G., Crane, N., Veilleux, J., Conrad, M., Braun, A., . . . Kassel, J. (n.d.). A comprehensive examination of hookah smoking in college students: Use patterns and contexts, social norms and attitudes, harm perception, psychological correlates and co-occurring substance use. *Addictive Behaviors*, 2751–2760.
- ³⁶ Zhou, S., Weitzman, M., Air quality in New York City hookah bars, *Tobacco Control*-2014-051763, Sept. 16, 2014, last accessed on August 26, 2015 at <http://tobaccocontrol.bmj.com/content/early/2014/09/09/tobaccocontrol-2014-051763.full.pdf+html>.

NYC SMOKE-FREE



Public Health Solutions

Testimony of **Patrick Kwan**

Director

NYC Smoke-Free at Public Health Solutions

before the

New York City Council Health Committee

Regarding

Int. 1068

In relation to prohibiting the use of smokeless tobacco at ticketed sports arenas and recreation areas.

February 25th, 2016

14th Floor Committee Room
250 Broadway
New York, NY 10007

Good morning and thank you Council Member Johnson and members of the Health Committee for the invitation and opportunity to speak today.

My name is Patrick Kwan, and I am the Director of NYC Smoke-Free - a program of Public Health Solutions, one of the country's largest public health institutes and one of New York's leading nonprofit organizations. NYC Smoke-Free (formerly the NYC Coalition for a Smoke-Free City) works to protect the health of New Yorkers through tobacco control policy, advocacy, and education. We partner with community members, legislators, and health advocates to support local efforts to end the devastating tobacco epidemic throughout New York City. We believe every New Yorker has the right to breathe clean, smoke-free air where they live, work and play.

Int.1068 would help protect generations of New Yorkers and youth from deadly and addictive smokeless tobacco products as well as make it clear that recreational sports should not promote the recreational use of harmful tobacco products.

According to the Centers for Disease Control¹, while high school athletes who play on sports teams smoke tobacco products at lower rates than non-athletes (15.8% to 19.6% vs 21.3%), they use smokeless tobacco products – like chew, dip, and snuff – at nearly double the rates of non-athletes (11.1% vs 5.9%). The data suggests that while high school athletes do a better job than other youth in avoiding tobacco products like cigarettes, they might be more prone to use smokeless tobacco products because they believe chewing tobacco or snuff are harmless – or even helpful to their athletic performance. In addition to these misconceptions, high school athletes might simply be just emulating their coaches, older athletes, or their favorite sports stars at Yankee Stadium, Citi Field, or other arenas.

Professional athletes who chew tobacco know they are role models for kids and they know smokeless tobacco products are harmful, deadly, and addictive. The issue is not just that smokeless tobacco products are terrible for professional athletes and everyone else who uses them, but also that allowing the continued use of smokeless tobacco at sports arenas sets a terrible example for kids by normalizing chewing tobacco and leading to generations of deadly tobacco addiction. It can also threaten the successes that New York City has had in saving lives through tobacco control efforts.

¹ Morbidity and Mortality Weekly Report, 2015. Centers for Disease Control and Prevention

We must not forget that tobacco remains the number one cause of preventable, premature death in New York City and across the country. 12,000 New Yorkers die each year from smoking-related illnesses.

While significant disparities persist in some of NYC's most vulnerable populations and communities – such as those with limited income and education who use and are exposed to tobacco at a much higher rate than other New Yorkers – the City of New York has been a leader in putting in place best practices in comprehensive tobacco control that have saved thousands of lives, increased life expectancy, prevented smoking addiction, and improved health for all New Yorkers.

Thanks to this comprehensive approach that includes bold policies, limiting youth access to tobacco products through sales restrictions and cigarette price increases, hard-hitting media campaigns, and cessation services, the percentage of adults smoking in New York City is now at lows of 13.9%,⁴ and the percentage of public high school students has fallen to 8.2%.⁵

New York now has the opportunity to join other major cities like Boston, San Francisco, and Los Angeles in making sure our national pastime is tobacco-free because baseball and tobacco simply don't belong together.

Thank you.

⁴ Community Health Survey, 2014. New York City Department of Health and Mental Hygiene.

⁵ Youth Risk Behavior Survey, 2013. New York City Department of Health and Mental Hygiene.



Founders Affiliate
122 East 42nd Street, 18th Floor | New York, NY 10168
www.heart.org

Testimony

In Support of
Int 1068-2016, a local law to amend the administrative code of the city of New York, in relation to prohibiting the use of smokeless tobacco at ticketed sports arenas and recreation areas

Submitted by:
American Heart Association / American Stroke Association
Robin Vitale, Senior Director, Government Relations

February 25, 2016

Members of the Committee on Health:

On behalf of the American Heart Association / American Stroke Association (AHA), thank you for this opportunity to share our thoughts related to the city's latest efforts in the fight against the tobacco industry. The AHA is our nation's largest, voluntary-led, science-based organization focused on the prevention and treatment of cardiovascular diseases and stroke. Approximately 80% of diagnoses involving these chronic diseases could be prevented if Americans improved their lifestyles and adopted healthier behaviors¹.

In the last 50 years, 20 million Americans have died prematurely due to tobacco-caused illnesses. No tobacco product is considered safe to use. Smokeless tobacco has been associated with an increased risk for fatal heart attacks and strokes.² Alarming, smokeless tobacco use is on the rise, with more than 10% of young adult males (aged 18–25 years) reporting use in the last 30 days. And this percentage is consistent when looking at high school-aged males, with about 9.9% reporting use of smokeless tobacco.³

There are many factors that are collaborating to drive the increased use of smokeless tobacco. However, looking at the disparity that exists between male and female use (with just 1.2% of high-school aged girls reporting use in the past month), it is clear that there is a significant

¹ <http://www.cdc.gov/vitalsigns/HeartDisease-Stroke/index.html>

² Piano MR, et al Impact of smokeless tobacco products on cardiovascular disease: implications for policy, prevention, and treatment. *Circulation*. 2010; 122(15):1520-44.

³ U.S. Department of Health and Human Services. [The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General](http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm)(http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm). Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

*"Building healthier lives,
free of cardiovascular
diseases and stroke."*

life is why™ es por la vida™ 全為生命™

Please remember the American Heart Association is your will.

motivating factor that is compelling young men to experiment with highly addictive, and highly dangerous, smokeless tobacco, potentially leading to a lifetime of tobacco addiction. Adding to this assessment, we must consider data from the CDC that shows a higher rate of smokeless tobacco use among high school athletes than compared to non-athletes. For these reasons, the American Heart Association strongly supports the passage of Int 1068 as a mechanism to remove all tobacco use from New York City's stadiums.⁴

Smokeless tobacco use has been prohibited in minor league baseball since 1993. It's time that major league baseball follow its lead. For far too long, our baseball celebrities have been able to use smokeless tobacco during games, sending a strong message to young athletes that its use is acceptable and could give them an athletic advantage. Nothing could be further from the truth.

San Francisco, Los Angeles, and even Boston have now passed similar laws, banning the use of smokeless tobacco in sports arenas. We look forward to the day when New York City is added to their ranks.

Regarding the remaining proposals addressing the use of herbal shisha or hookah smoking, the American Heart Association appreciates the intention behind these proposals. Hookah use is proliferating, particularly among college-aged youth.⁵ And hookah smoking is not a safer alternative to traditional tobacco use.⁶

Additionally, last year's investigation achieved by the New York City Department of Health and Mental Hygiene points to an important concern. When 13 samples sold for indoor use from city hookah bars are analyzed and found to have tobacco in all 13 sources, it is clear that these retail locations need stronger regulation.

New York City would be well-served to implement thoughtful policies that restrict the use of hookah indoors and also forbid the sale of shisha and hookah-related paraphernalia to individuals under the age of 21. While we support closing the loophole in the city's Tobacco 21 law, the American Heart Association has concerns regarding any exemptions for hookah bars in our city's Smoke Free Air Act.

We share the enthusiasm for strong, effective public health policy in the city's campaign to curb tobacco addiction. As you consider additional strategies, the American Heart Association encourages your continued focus on efforts to increase the price of tobacco as it relates to tax parity on all products, increasing the city's excise tax on cigarettes, reducing the number of retail locations in the city and improving vital funding for the city's Bureau of Tobacco Control as a proven resource in addressing disparities in New York City's diverse population.

Thank you for your attention regarding these exciting proposals. We look forward to working with you on these and future tobacco control proposals.

⁴ Centers for Disease Control and Prevention. 2015 Youth Risk Behavior Survey. Available at: www.cdc.gov/yrbs(<http://www.cdc.gov/healthyouth/data/yrbs/index.htm>). Accessed on February 23, 2016.

⁵ U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health, 2012 [accessed February 24, 2016].

⁶ American Lung Association. An Emerging Deadly Trend: Waterpipe Tobacco Use. [PDF-222 KB] Washington: American Lung Association, 2007 [accessed February 24, 2016].

Michael Weitzman City Council Hookah Testimony 2.25

My name is Michael Weitzman and it is a great honor for me to testify before you today. I am a pediatrician by training who is a professor of Pediatrics, Environmental Medicine and Global Public Health at New York University. I have more than 40 years of experience caring for and training others to care for children, adolescents and young adults; conducting research; and consulting to a large number of city, county, state and federal agencies, including the Centers for Disease Control (CDC) and Prevention and the Environmental Protection Agency on the effects of environmental contaminants such as lead and tobacco smoke on health.

For the past 5 years my work has largely focused on water pipes, also known as hookahs, narghile, and hubble bubble. The tobacco and non-tobacco based combustible material smoked in water pipes is known as shisha, which is unregulated; the health dangers it poses is in no way limited to tobacco smoke as studies show comparable levels of toxic pollutants in both tobacco and non-tobacco based shisha.

A. The Water Pipe Epidemic. The epidemic in the use of water pipes and the rapid and extensive increase in commercial establishments where their use is allowed and encouraged have led the CDC and the World Health Organization to state that water pipes are threatening to eradicate the successes of the past half-century's anti-tobacco efforts. Tobacco use and exposure to secondhand smoke are the leading preventable causes of ill health and mortality in the US and worldwide. There is no safe level of exposure for children, adolescents or adults, and hookah use now is more common among our adolescents and young adults than is cigarette smoking and may in fact lead to the uptake of cigarette smoking by those who use or are exposed to water pipes.

Tobacco- and non-tobacco based shisha are used in water pipes. Water pipes bubble smoke through water before inhalation of the combustion products of shisha and the charcoal used to heat it. Despite evidence that water pipe use may be as addictive and harmful as cigarette use, users still perceive it as a safer and less addictive alternative. Remarkably, studies, including one that we just published demonstrate that

university students and medical students in multiple countries, including the United States are unaware of these dangers.

While cigarette use in the US has decreased by 33% in the past decade, the use of water pipes and other smoking agents, has increased by a disconcerting 123%. Most alarmingly, we and others have documented that water pipe use is especially popular among adolescents and young adults, with 23% of US high school seniors reporting annual use in 2014, an increase from 17% in 2010. Studies of college students reveal remarkably high rates of use, with comparable rate of individuals reporting lifetime hookah and cigarette use of about 40%. Hookah bars are proliferating rapidly in the US and we have recently documented that NYC has about 125 such establishments. Given that most smoking begins in adolescence, it is essential that age limits be set for individuals to even enter such establishments.

B. Active Hookah Smoking. Existing data on smoking water pipes are remarkably consistent in finding significant adverse health outcomes for smokers. *The World Health Organization estimates that a single water pipe session can equate to smoking 5 packs of cigarettes and yield greater levels of nicotine, tar, and carbon monoxide than cigarettes.* It also results in a 56-fold greater inhaled smoke volume compared to cigarette smoking. Hookah use has been linked to decreased lung function and exercise capacity, increased rates of lung cancer, heart arrhythmias and increased heart rates and blood pressure, as well as systemic inflammation, indicating that virtually every organ is affected by exposure to water pipe smoke. *On every measure so far investigated, hookah smoking is as bad or worse than smoking cigarettes.*

C. Air quality in Hookah Bars. We and others have demonstrated markedly poor indoor air quality in hookah bars, with significant elevations in particulate matter, carbon monoxide, nicotine, and multiple trace elements. Our own study in hookah bars in the East Village found carbon monoxide levels that were dangerously high and indoor particulate matter levels significantly higher than the EPA's air quality standard. Smoke from water-pipes has been found to contain volatile aldehydes that can cause respiratory disorders, emphysema, and lung cancer. Each of these pollutants has the potential to cause profound harm to those exposed, even those who are not actively smoking. In our study, also, airborne nicotine was found in every

hookah bar studied, indicating the use of tobacco-based shisha, despite NYC codes which ban tobacco use in hookah bars.

D. Effects of Water Pipe Smoke on Hookah Bar Workers. Another study that we conducted in the East Village study was the first study to look at occupational exposure to hookah smoke. It demonstrated that over the course of a 10-12 hour work shift there were elevations in heart rate and in exhaled carbon monoxide levels, indicating that workers had significant compromises in their delivery of oxygen to their organs and tissues. Elevated levels of inflammatory markers in their blood were also found, indicating systemic, or body-wide distress.

It is of vital importance to note that secondhand smoke exposure is an enormous public health problem even in the absence of tobacco. Worldwide, exposure to household smoke from indoor use of stoves to cook or heat homes without proper ventilation causes more than double the number of deaths annually as those attributable to HIV/AIDS or malaria. The levels of air pollutants, including multiple cancer and heart disease causing agents in NYC hookah bars are comparable to those found in homes in the developing world where inefficiently ventilated cook stoves are used.

Clean air acts in public places. The documentation of negative health consequences of exposure to cigarette secondhand smoke provided the major impetus to create and implement restrictions on smoking in workplaces, as well as in public settings such as restaurants, public transportation, and recreational settings. Rigorous comprehensive local, state, and national policies have resulted in marked decreases in the involuntary exposure of individuals to secondhand smoke.

Hookah bars represent a new and largely unregulated setting for individuals to be extensively exposed to secondhand smoke. The CDC, FDA, and the American Lung Association each has expressed grave concerns about hookah use. A growing number of local communities and states have adopted wide-ranging clean indoor air laws, particularly regarding cigarette smoking, as a result of negative health effects of cigarette SHS in workers. However, hookahs are not subject to the same regulations as cigarettes. Hookah bars can often claim exemption from clean air indoor ordinances, even though higher levels of air pollutants have been found in hookah bars than in cigarette-smoking bars, both active and passive hookah smoke exposure damage the

health of non-smoking patrons and workers, and a growing literature indicates that hookah smoking leads to cigarette smoking. All of this, I believe, leads to a clarion call for regulation of these establishments, and I applaud Councilman Gentile and the City Council for their efforts to stem this epidemic that has the potential to kill and impair the health of countless New Yorkers and others across the world. Thus, I am fully supportive of Code 139A and wholeheartedly hope that our City Council passes this bill.

NYC SMOKE-FREE



Public Health Solutions

Testimony of **Deidre Sully**

Deputy Director

NYC Smoke-Free at Public Health Solutions

before the

New York City Council Health Committee

regarding

Int. 139-A

A Local Law to amend the administrative code of the City of New York, in relation to non-tobacco smoking products

February 25th, 2016

14th Floor Committee Room
250 Broadway
New York, NY 10007

Good morning and thank you Council Member Johnson and members of the Health Committee for the invitation and opportunity to speak today.

My name is Deidre Sully, and I am the Deputy Director of NYC Smoke-Free - a program of Public Health Solutions, one of the country's largest public health institutes and one of New York's leading nonprofit organizations. NYC Smoke-Free (formerly the NYC Coalition for a Smoke-Free City) works to protect the health of New Yorkers through tobacco control policy, advocacy, and education. We partner with community members, legislators, and health advocates to support local efforts to end the devastating tobacco epidemic throughout New York City. We believe every New Yorker has the right to breathe clean, smoke-free air where they live, work and play.

Int.139-A would create an oversight and regulatory framework for hookah establishments to promote and ensure compliance of the Smoke-Free Air Act, which keeps tobacco products away from kids and protects New Yorkers – especially the workers who are employed at hookah establishments – from harmful secondhand smoke exposure.

A recent investigation¹ conducted by New York University students found that over a dozen of the City's most popular hookah-serving establishments were in violation of the Smoke-Free Air Act and laws that restrict youth under 21 years of age from tobacco products. All of the hookah establishments surveyed claimed to only use non-tobacco shisha; however, laboratory tests of the samples collected at all of locations showed that the shisha contained tobacco. This means that the establishments were illegally serving tobacco to youth under 21 years of age and exposing everyone in the establishment to second-hand tobacco smoke.

For more than a decade, NYC has achieved great successes in tobacco control, including a decline in teen use of cigarettes. The Smoke-Free Air Act was expanded to include bars and restaurants, hospital entryways, public parks, beaches, and pedestrian plazas and to prohibit the use of e-cigarettes wherever “conventional” smoking is banned. Unfortunately, now the use of non-tobacco smoking products, such as hookah, is a growing trend spreading among bars, restaurants and lounges across NYC – and is compromising all of the progress we have made. Currently, teens and young adults under the age of 21 can legally enter non-tobacco smoking establishments – such as hookah lounges and restaurants – that provide hookah products and

¹ New York City Department of Health and Mental Hygiene. (2015) Undercover Health Department Investigation Found 13 Hookah Bars in Violation of The Smoke-Free Air Act [Press Release] Retrieved from <http://www1.nyc.gov/site/doh/about/press/pr2015/pr001-15.page>

services. Being exposed to use of hookah, re-normalizes smoking in general and may discourage those who are trying to quit using cigarettes.

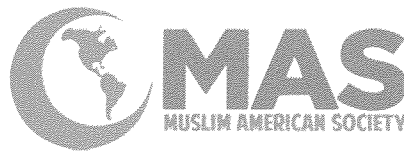
According to the Centers for Disease Control, some studies show that preparations for both tobacco and non-tobacco based shisha contain carcinogens that may lead to smoking related cancers as well as both heart and lung disease.² There is a common misconception that smoking hookah tobacco is safer and less addictive than cigarette smoking. In reality, hookah use can be as dangerous as smoking cigarettes. A number of studies suggest that hookah smoking may be just as addictive and perhaps even more harmful because of the way people smoke while using a waterpipe (i.e., hookah). Hookah smoke – whether tobacco-based or non-tobacco – contains many of the same harmful toxins as cigarette smoke and has been associated with lung cancer and respiratory illnesses.

While significant disparities exist in some of NYC's most vulnerable populations and communities – such as those with limited income and education who use and are exposed to tobacco at a much higher rate than other New Yorkers – the City of New York has been a leader in putting in place best practices in comprehensive tobacco control that have saved thousands of lives, increased life expectancy, prevented smoking addiction, and improved health for all New Yorkers. Thanks to this comprehensive approach that includes bold policies, limiting youth access to tobacco products through sales restrictions and cigarette price increases, hard-hitting media campaigns, and cessation services, the percentage of adults smoking in New York City is now 13.9%,³ and the percentage of public high school students has fallen to 8.2%.⁴ Evidence-based, best practices work, and we should continue to use them by regulating hookah in order to protect New Yorkers from adverse health effects of tobacco resulting from the increased use of a product which may seem new or trendy especially to youth and is misconstrued to harmless.

² Center for Disease Control and Prevention. Smoking & Tobacco Use. (Last Updated 2015, September 14)

³ Community Health Survey, 2014. New York City Department of Health and Mental Hygiene.

⁴ Youth Risk Behavior Survey, 2013. New York City Department of Health and Mental Hygiene.



Muslim American Society

New York Chapter

1933 Bath Avenue, Brooklyn, NY 11214 - Tel: (718)232-5905 / Fax: (718)232-5103

E-mail: info@masnewyork.org

www.masnewyork.org

Dear sir or madam at the New York City Council health committee,

I represent Muslim American Society, which opposes the use of hookah in establishments within New York City. **We find that hookah is a severe health risk both to those who directly inhale the shisha smoke and to those who inhale it secondhand.** It has been found that the use of hookah results in the intake of more toxic chemicals and harmful substances, including tar and carbon monoxide, than smoking cigarettes. In fact, the same cancer-causing chemicals found in cigarettes are found in abundance in hookah. **There is no reason why hookah should not be included in NYC's Smoke Free Air Act ("SFAA").**

We formally grant our support to Int. 139 by Council Member Vincent Gentile and others in the Council, which would add hookah to the SFAA.

In addition, we are aware that, as an investigation by DOHMH brought to light, many hookah bars illegally mix tobacco with the shisha that is smoked on the premises. Enforcement against this is currently difficult due to the extensive effort needed to prove that the compounds being smoked include tobacco. The bill would also curtail the expansion of this illegal activity. Since hookah bars would have to be licensed, they would need to comply much more with government inspections and be less likely to add tobacco.

Furthermore, we don't see any act of discrimination against the Arab or Middle Eastern Culture, it is only a matter of severe health issues caused by hookah smoke inhalation to both Middle Eastern and other backgrounds.

It is for the overall health concerns caused by hookah, including that of added tobacco, that we emphatically urge you to support Int. 139. Hookah is dangerous to people of all backgrounds and needs to be regulated like all other forms of smoking!

Hisham Morgan

Director of Administration

Muslim American Society of New York

TESTIMONY OF ARIEL FERREIRA, BUSINESS CONSULTANT & SMALL BUSINESS ADVOCATE

NEW YORK CITY COUNCIL

COMMITTEE ON HEALTH

HEARING

February 25, 2016

My name is Ariel Ferreira, a small business consultant and advocate based out of Northern Manhattan. I submit this testimony on behalf of 40 business owners whom either own a restaurant, bar, and/ or nightclub in Northern Manhattan.

We would like to thank the committee members for holding this hearing and allowing us to voice our concerns in regards to the following three bills on the agenda today.

- **Int. 0139-2014** - This bill would add non-tobacco shisha to the City's Smoke-Free Air Act. It would allow existing non-tobacco bars, commonly known as hookah bars, that derive the majority of their income from non-tobacco shisha and paraphernalia to continue operating as long as they register and meet certain standards.
- **Int. 1075-2016** - The proposed legislation would require that any restaurant which permits the use of non-tobacco shisha to restrict its use to a section of the restaurant that is no greater than 5 percent of the restaurant's seating capacity. The bill would also require such locations to post signs warning customers of the adverse health effects of using non-tobacco shisha products in devices lit with charcoal.
- **Int. 0617-2015** - This bill would prohibit the sale of shisha in New York City, except for shisha sold at hookah bars, tobacco bars, and tobacco stores.

The passing of these bills will negatively affect the restaurants, bars, and night clubs that currently provide hookah to their patrons.

Jobs & Business Retention

The ability to provide hookah goes hand in hand with jobs creation and business survival within many restaurants, bars, and nightclubs throughout the City of New York. Please take note of the following to facts.

- The establishments who provide hookah employ an average 4-5 people designated to serve hookahs.
 - As I mentioned before, I am here representing 40 businesses which if this legislation ~~were to take place~~ would be put in effect, it would create the loss of jobs for approximately ²⁰⁰ people.
- Hookah sales represent 20 to 30 percent of business revenues. This could be translated to approximately \$10,000 to \$20,000 in monthly sales. This additional

revenue has helped many restaurants, bars, and nightclubs stay in business when combating rising and uncontrollable commercial rents.

- o Just to mention one example, a business I represent today, when faced with renewing their lease last year, had a \$10,000 increase in their monthly rent. Revenues from their hookah sales helped prevent them from laying people off and/or shutting down.

Misperceptions & Realities

Many of the studies identifying health risk factors are based on the use of tobacco shisha and traditional charcoal or the use of non-tobacco/non-nicotine shisha and traditional charcoal. The one real problem, aside using tobacco based products, identified in these publicized studies is the use of traditional charcoal which is the creator of the carbon monoxide.

Now, we do understand the health risks and concerns related to hookah. However, these studies published newspapers and presented in the media, are not complete true to all of the available products on the market within in the hookah industry.

Currently, on the market there are products such as natural coals made of compressed coconut shells or recently introduced e-bowl and e-charcoals which are electronic devices that can be mounted on any hookah ~~generate~~ to generate heat and vapor.

According to an article published in InsideScience.org, The University of Cincinnati conducted a study on the use of traditional charcoal versus the use of e-charcoal and various shisha. Amberlie Clutterbuck, the leading scientist of the study, based on her results suggest hookah smoking may be safer than traditional hookah tobacco when smoked with e-charcoal depending on the shisha because in her experiment produced smoke with a high concentration of toxins, was because of the charcoal¹.

This~~s~~ shows that there are existing solutions to eliminate concerns of health risks related to the use of hookah in restaurants.

Other Issues

Int. 1075-2016, which restricts use of non-tobacco shisha to a section of the restaurant that is no greater than 5 percent, would create various problems for businesses because it would contradict with **Int. 0139-2014** and **Int. 0617-2015**. This would create opportunities for inspectors to fine restaurants, bars, and night clubs based on **Int. 0139-2014** and **Int. 0617-2015**.

¹ <https://www.insidescience.org/content/steam-stones-safer-hookah-only-if-you-smoke-them-right/2886>

Second, the restaurants, bars, and night clubs also consider 5 percent of the seating capacity to be too small of a space. For example, if you have 20 seats within in your restaurant, only one seat could be designated for hookah use or if you have 100 seats only 5 seats.

Conclusion

We are asking the committee to table the aforementioned bills for further investigation and research on alternate hookah products that are safer and to also investigate the negative affect that these bills would have on the restaurants, bars, and night clubs.

We understand it is an industry that needs to be regulated and we are open to discuss solutions that would satisfied all parties involved and affected by the use of hookah. Let's work together.

**Testimony of the American Lung Association in New York
New York City Council
Health Committee Hearing on Intros 139-A, 617, 1068, 1075, 1076**

February 25, 2016

New York City Council
City Hall
New York, NY 10007

Chairman Johnson and Members of the Health Committee:

My name is Michael Seilback and I am the Vice President, Public Policy & Communications at the American Lung Association of the Northeast. The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and public policy.

The American Lung Association strongly supports Intro 1068, which would make ticketed sports arenas and recreation areas 100% tobacco-free. In 2011, we cheered when New York City took the step to remove combustible tobacco (and e-cigarettes in 2014) from public parks, and this is the next step to show our impressionable youth that no tobacco product is safe. Smokeless tobacco, like other tobacco products, causes significant health risks, and according to the National Cancer Institute, at least 28 cancer-causing chemicals have been identified in smokeless tobacco.¹

Regardless of intent, Major League Baseball players, including many Mets and Yankees, serve as heroes to many of our youth. As a young boy, while playing little league, I tried to emulate swinging the bat like Darryl Strawberry, while my kids today try to emulate David Wright: the last thing we would want is for our youth to emulate harmful or deadly traits that some baseball players illustrate like using smokeless tobacco that can lead to lifelong addiction. Having my own kids has made it even more important to me that we knock tobacco out of the park and protect our children from these deadly products.

¹ National Cancer Institute, "Smokeless Tobacco and Cancer," Accessed September 9, 2014.
<http://www.cancer.gov/cancertopics/factsheet/Tobacco/smokeless#r1>.

Currently, about 535,000 kids aged 12-17 use smokeless tobacco for the first time every year.² While cigarette smoking has decreased among boys by 25 percent in the past decade, smokeless tobacco has not seen a similar decline.

By making our baseball stadiums completely tobacco-free, we are sending a strong message to our youth that all tobacco is dangerous. For these reasons, we urge you to quickly pass Intro 1068.

With regard to the suite of hookah bills being considered, the American Lung Association has produced a policy brief³ about hookah smoking that guides the recommendations we will make today. First and foremost, the American Lung Association opposes smoking in bars, restaurants and workplaces. As our brief states, "Exemptions for hookah bars should be closed in existing laws when possible and not included in new smokefree workplace laws." Most of the hookah bills being considered today would actually be creating a new loophole in our existing smokefree law; we do not think this is sound policy for New York City, which has been a global leader on tobacco control.

Hookah (or waterpipe) smoking is gaining popularity nationwide, especially among urban youth, college students, and young professionals. Despite the growing popularity and increased adoption of state and local smokefree workplace laws, hookah bars remain largely unregulated. In addition, many hookah smokers consider the practice less harmful than smoking cigarettes. This is troubling from a public health perspective since evidence shows that hookah smoking carries many of the same health risks and has been linked to many of the same diseases caused by cigarette smoking. As the American Lung Association and its public health partners continue to move forward to protect workers and patrons from the harmful effects of secondhand smoke, it is vital that we address the health risks hookah use poses to youth and young adults, and close the loopholes in smokefree workplace laws that often exempt hookah bars.

Many users think hookah smoking is less addictive and exposes them to less nicotine than cigarette smoking. As research on the health effects of hookah smoking increases, studies suggest hookah smokers may inhale larger amounts of smoke than cigarette smokers during a single smoking session. Hookah smoking sessions are generally longer (1/2 hour or more) which results in considerably greater nicotine exposure.

² Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2013, <http://www.samhsa.gov/data/NSDUH/2013SummNatFindDetTables/DetTabs/NSDUH-DetTabsSect4peTabs1to16-2013.htm#tab4.10a>.

³ <http://www.lung.org/assets/documents/tobacco/hookah-policy-brief-updated.pdf>

The tobacco or non-tobacco shisha used in hookah is often enhanced with flavors that act as soothing agents and mask the harshness of the smoke. The increasing popularity of hookah smoking is in part driven by the social context in which use occurs, the attractive flavors and the perception that it is safer than cigarette smoking. This makes hookah smoking more appealing to young people and college kids, who are the target market for hookah lounges.

One way that we could limit use and exposure to hookah by teenagers and young adults is to close a loophole in New York City's existing Tobacco 21 law. By restricting the sale of non-tobacco shisha and its related paraphernalia to individuals 21 and over, we can expect to see a reduction of youth usage of these products, for the same reasons we saw when New York City passed tobacco 21 legislation in 2013. For those reasons, we support the passage of Intro 1076.

We also urge the Council to consider other tobacco policies which would prevent kids from starting to smoke and help smokers quit their deadly addiction. Specifically, New York City should: tax other tobacco products at the same level as the city's tax on cigarettes; reduce the amount of retailers that sell tobacco products including retailers near our schools and in places that deliver healthcare like pharmacies; and ensure that the City's Department of Health and Mental Hygiene sees its Tobacco Control Program funding restored so that it could continue doing its important work and so they could reach the disparate populations which haven't seen tobacco use rates drop as much as the greater population has.

Thank you for your time and consideration.



GASP

P.O. Box 116
Summit, NJ 07902
Phone: 908-273-9368
Cell: 908-377-3900
info@njgasp.org
www.njgasp.org

February 25, 2016

Karen Blumenfeld, Esq. Executive Director

Committee on Health
New York City Council
250 Broadway, 14th Floor
New York, NY 10007

Re: Bills to regulate hookah, prohibit smokeless tobacco use at ticketed sports arenas/rec areas events

Dear Chairman Johnson and Committee Members:

Thank you, Chairman Johnson and Committee Members for this opportunity to speak. I am Karen Blumenfeld, Esq., Executive Director of Global Advisors on Smokefree Policy, a nonprofit with a mission to promote tobacco-free living. We focus on emerging trends and issues in tobacco control like hookah and e-cigarettes, and serve as a resource provider on these topics to policymakers and the public.

Over the years, on behalf of GASP I have provided key resources to The New York City Council and testified at NYC Council hearings on banning the use of electronic smoking devices in public places and workplaces, raising the age of sale to 21 to be sold tobacco and electronic smoking devices, and making all city parks and recreational areas smokefree, all of which became law.

Today's focus is on hookah smoking and making ticketed events tobacco-free. Regulations that help to curb *all* tobacco use, including hookah smoking, can lower smoking initiation rates and encourage people to quit smoking and tobacco use which is the #1 cause of preventable death and disease.

I would like to commend Chairman Johnson and his fellow sponsors of bill 1068-2016 which will set an excellent example for young people to follow, and perhaps help the ball players and public to quit smokeless tobacco too. I also applaud the Mets and Yankees for supporting this initiative, and look forward to perhaps a celebration on World No Tobacco Day, which is May 31 (Mets have a home game against the Chicago White Sox, Yankees at an away game against Toronto)!

Moving on to the hookah bills, I'd like to start with bill 139-2014 sponsored by Councilman Gentile and his colleagues. This bill is important for many reasons, one of which is that it will institute a **tracking system** for non-tobacco hookah bars and establishments, so that the city health department can provide merchant education and ensure compliance with city laws, rather than rely on public search engines.

Bill 139-2014 will also **ban the opening of new non-tobacco hookah bars** and smoking establishments, set a minimum 50% revenue threshold and impose other requirements. This is key because 139-2014 will **limit the accessibility** of the product to youth and young adults who are **smoking hookah at alarming rates:**

- A survey of 100,000 U.S. college students found that 30.5% smoked hookah (in the past 30 days), of which half did not smoke cigarettes (University of Pittsburgh 2012 study).
- For the first time in history, hookah tobacco use was higher than cigarette use amongst high school students, according to the U.S. Centers for Disease Control and Prevention in 2015.
- 1 in 5 high school seniors smoked hookah in the past year, with one-third reporting that they smoked hookah often enough to be a regular smoker. (University of Pittsburgh's 2015 study).

Regulating existing non-tobacco hookah bars like tobacco bars needs to be addressed, since studies show that smoking non-tobacco shisha can **produce levels of toxic substances** similar to that in

tobacco shisha: carbon monoxide (CO contributes to heart disease), and other chemicals that cause lung disease (volatile aldehydes) and cancer (polycyclic aromatic hydrocarbons).

Regulating existing non-tobacco hookah bars provides an opportunity to educate the public on the **misperceptions** and false sense of security when smoking hookah. **Contrary to popular belief:**

- The water in the hookah doesn't remove the toxins,
- The flavorings actually reduce the sensation of harshness when smoking, and
- The carbon monoxide and benzene levels generated during a session are very high, even with no tobacco being smoked. Benzene, a known risk factor for leukemia, is produced from the burnt charcoal and is also in tobacco smoke.

Hookah smokers are most likely unaware of the fact that partaking in hookah can greatly increase their risk of contracting communicable diseases. Hookah smoking is usually a communal experience, wherein multiple people share a single waterpipe. Even if disposable mouthpieces and hoses are attached to the hookah apparatus, there is currently no requirement to **sanitize or sterilize** them between sessions. Hookah sharing has the World Health Organization concerned, since it estimates that 20% of tuberculosis cases in the Middle East are most likely caused by shared hookah.

Not sanitizing the apparatus between sessions is analogous to being served clean utensils but a dirty dish at a restaurant, which is clearly a public health concern and unacceptable. Fortunately, Bill 139-2014 includes section 17-513.6 which enables the city's health department to promulgate rules and regulations to develop a system to verify sales. If this **enabling language** is broader, the health department can promulgate rules to help implement the registration requirements such as:

- A requirement for hookah apparatus sanitization between sessions (we have sample sanitization language from Ontario Canada to share, if that is helpful),
- The need to be at least 21 years old to enter the premises and be sold product, and
- Ensure that smoke inside the establishment does not migrate into neighboring business or into upstairs multi-unit housing.

Regarding the other hookah bills up for discussion today:

Bill 617-2015 is important since it will limit accessibility of the **retail sale** of hookah product to hookah bars, retail tobacco stores and tobacco bars.

Bill 1076-2016 would **raise the age to 21** to be sold non-tobacco shisha, pipes and rolling paper which makes it consistent with tobacco and e-cigarette products.

Bill 1075-2016 would allow non-tobacco shisha hookah smoking in 5% of restaurants, exposing nonsmokers to unexpected hookah smoking, which knows no boundaries. More stringent measures outlined in proposed bill 139-2014 seem more prudent. 1075-2016 also requires **signage** be posted that hookah smoking is hazardous to one's health, but so long as it is still holds the businesses accountable, meaning that the signage does not waive a customer or employee's right to future legal action against that business, or the products sold for use inside the location.

In closing, I would like to thank you for your time, and give a special thank you to the bill sponsors for their passion and commitment to help New Yorkers live tobacco-free.

Sincerely,

Karen Blumenfeld, Esq.

Executive Director
908-377-3900 cell
kblumenfeld@njgasp.org

About Global Advisors on Smokefree Policy (GASP)

GASP is a globally recognized nonprofit that for more than forty years has dedicated its mission to educating the public about the benefits of smokefree and tobacco-free living. Our expertise is on emerging trends and issues in tobacco control and policy initiatives.

We provide expert educational guidance and technical assistance to governmental entities, companies and the public at large. Not only in New Jersey, but in New York City, New York State, Pennsylvania, Delaware, Connecticut and across the United States as well as globally.

Our areas of expertise include compliance with federal, state, county and local laws on tobacco use and sales, including raising the age of sale to 21 for tobacco products and electronic smoking devices, and regulation of points of sale including self-service and retail licensing of all tobacco products and electronic smoking devices.

For decades, GASP has provided educational resources that have resulted in state, county and local laws, and policies made by governmental and private corporations. The initiatives include mandating 100% smokefree and tobacco-free environments for multi-unit public and private housing, outdoor recreational areas, college campuses and downtown public spaces, and point of sale regulations that require tobacco 21 be the minimum age of sale for tobacco products and electronic smoking devices, and local licensing of electronic smoking device retailers.

In addition, GASP tracks all state, county and local tobacco control ordinances in New Jersey, and maintains and continually updated ordinance database. **Learn more about GASP at www.njgasp.org.**

Visit our Facebook page <https://www.facebook.com/pages/Global-Advisors-on-Smokefree-Policy/266843356853575> to explore our community and statewide highlights and activities.

DISCLAIMER: The information in this letter and the attachments are created by the Tobacco Control Policy and Legal Resource Center of New Jersey GASP, which provides expert information, guidance, and technical assistance about policy, legislation, and litigation, especially regarding smokefree air. **The information presented is not intended as, nor to be construed, or used, as legal advice, and should not be used to replace the advice of your legal counsel.**

NYC Council Health Committee Public Hearing On 2/25/16

Hello, my name is Phil Konigsberg and I'm with the Queens Tobacco Control Coalition, a public health fellowship funded by the CDC and I'm here this morning to speak in support of Intros 139A, 617, 1068 and 1076. I have reservations about Intro 1075 as it reminds me of the former Clean Indoor Air Act, which permitted smoking in bar areas of restaurants until the NYC SFAA finally eliminated that provision.

With respect to Intro 139A, it is crucial that it be amended that the use of non-tobacco shisha apply to users age 21 and above which coincides ^{with} the existing Tobacco 21 bill passed by the Council in 2013 for the same reasons that the T21 bill is now the law.

^{Now for 1068}
It's time for the City Council to stand up for health in the ballpark, something that the Major League Baseball Players Association refuses to do.

Smokeless tobacco is banned from all professional minor leagues yet because of the unyielding MLB Players Association collective bargaining agreement continues to be an acceptable part of our national pastime.

One would think the 2014 senseless death of Hall of Famer Tony Gwinn at the age of 54 due to cancer attributed to chewing tobacco and former pitcher Curt Schilling admitting his addiction to smokeless tobacco after being diagnosed with oral cancer he attributes to chewing tobacco would finally purge smokeless tobacco from baseball. Apparently not. So the legislators in the cities of Los Angeles, San Francisco and Boston did.

It's time to knock tobacco out of baseball for good in NYC.

Needless to say, the tobacco industry does not want Intro 1075 to be enacted and once again ^{with} show their ironclad fist in a velvet glove in some way either at this hearing or through their lobbying efforts.

Incidentally, one of the current major league ballplayers who use smokeless tobacco is the Los Angeles Dodgers' Chase Utley, whose illegal slide broke the leg of NY Mets shortstop Ruben Tajada in last year's National League playoffs. Chase Utley will most likely serve a two game suspension at the start of the 2016 baseball season, however passing Intro 1075 will inflict a more significant penalty on him by prohibiting him from dipping while playing at CitiField or at Yankee Stadium when the Dodgers play in New York this year.

Since I mentioned CitiField, I would like to ask this committee to find out why the Mets continue to maintain three designated smoking areas at CitiField as indicated on their website (see below) when the ballpark is situated on New York City parkland. Since the NYC Smokefree Air Act prohibits smoking in all NYC parks, with the exception of parking lots and on sidewalks on the perimeter of a park, I maintain the Mets are in violation of the SFAA and this practice should be stopped before opening day. By the way, Yankee Stadium is a 100% smokefree venue, as it should be.

SMOKING

Smoking within Citi Field is prohibited, except for the three designated smoking areas located at:

- Plaza Level - Left Field Gate
- Field Level - Center field staircase landing across from the back of the CitiVision video board
- Promenade Level - The top of the ramp across from section 527

Any ticketholder smoking in any location other than the three specified above is subject to ejection.

Phil Konigsberg
Smokefree Community Advocate
Queens Tobacco Control Coalition



Community Board Ten

8119 5th Avenue • Brooklyn, NY 11209
(718) 745-6827 • Fax (718) 836-2447
Communitybd10@nyc.rr.com
www.bkcb10.org

DORIS N. CRUZ
Vice Chairperson
RONALD GROSS
Secretary
GREGORY AHL
Treasurer

BRIAN KIERAN
Chair
JOSEPHINE BECKMANN
District Manager

COMMUNITY BOARD TEN TESTIMONY SUPPORT OF INT. 139-A TO ADD HOOKAH TO SMOKE FREE AIR ACT

Josephine Beckmann, District Manager
(718) 745-6827

My name is Josephine Beckmann and I am here to speak in support of Intro 139-A that adds tobacco free hookah to the Smoke Free Air Act. I want to take this opportunity to thank Council Member Vincent Gentile and the bill's sponsors. I am confident that this legislation will expand health gains achieved by protections that are included in the Smoke Free Air Act.

By way of background, members of Community Board Ten first began working on concerns raised by parents, merchants and residents following what became a sudden increase in hookah lounges opening within Community District Ten in 2010.

Community complaints covered three areas of concern including health impacts from second hand smoke, adolescent usage, improper ventilation and inadequate labeling of shisha. CB10's Health Committee held several meetings and their recommendations were supported by the full Board.

Hookah smoking continues to be a popular fad in Bay Ridge – especially at several nightspots that appeal to adolescents. With the great strides that have been made in curtailing adolescent cigarette use – we at CB 10 are deeply concerned about young people beginning their lifetime of smoking at these now unregulated hookah lounges. While we support the registration components of this bill that allows for tobacco testing – and the addition of tobacco free hookah to the Smoke Free Air Act, we ask that you consider including consistent age restrictions so the same laws prohibiting underage purchases of cigarettes, and e-cigarettes, will apply to young people seeking to smoke hookah in lounges or other establishments.

ERIC ADAMS, BOROUGH PRESIDENT



TESTIMONY OF:

**Kevin O'Flaherty
Campaign for Tobacco-Free Kids**

IN SUPPORT OF:

**Int. 1068
An Ordinance to Prohibit the Use of Smokeless Tobacco at
Ticketed Sporting Events**

**Committee on Health
New York City Council**

**New York, NY
February 25, 2016**

Good afternoon. My name is Kevin O’Flaherty. I am here today on behalf of the Campaign for Tobacco-Free Kids. Our organization is the nation’s largest non-profit, non-governmental advocacy organization solely devoted to leading the fight to reduce tobacco use and its deadly toll in the United States and around the world.

Thank you, Chairman Johnson and other members of the committee for the opportunity to testify on several bills today. I will focus my comments on Intro. 1068 and have brief remarks on Intros 1075, 1076, 139-A, and 617.

Int. 1068 – An Ordinance to Prohibit Smokeless Tobacco at Ticketed Sporting Events

I am here today to stand in strong support of Intro 1068, a bill that would prohibit the use of smokeless tobacco at ticketed sporting events across the city. This proposal will reduce the number of children who use and become addicted to smokeless tobacco in New York City and throughout the country. As a result, it will save lives.

For too long we have witnessed the impact on our nation’s youth from the use of smokeless tobacco by Major League Baseball players. Major leaguers who use smokeless tobacco not only endanger their own health but the millions of kids who idolize them and idolize their every move.

As the evidence shows, ballplayers aren’t indulging a harmless habit when they use smokeless tobacco. They’re damaging their health with an addictive product that causes cancer and other serious diseases. And by serving as role models to youth throughout New York City and the country, they’re endangering the well-being of millions of kids who look up to them, and who copy everything big leaguers do.

Because young fans idolize and imitate them, baseball players are powerful marketers to our kids. A recent study out of the University of California San Francisco (UCSF) School of Dentistry makes clear what seems obvious to many of us – kids see athletes as role models, and when baseball stars use smokeless tobacco the kids who look up to them are much more likely to as well. According to the research, high school athletes were at 60 percent greater odds of using smokeless tobacco than were non-athletes. (I would like to enter the full UCSF report – *Smokeless Tobacco in Sport and Use Among Adolescents* – into the record.)

Baseball should not be helping market tobacco to kids. We are proud to join Council Member Johnson and other leading health advocates in support of legislation that will prohibit – once and for all – the use of tobacco products – including smokeless tobacco – in ticketed sporting events in New York City. This will apply to players, coaches, managers, fans, and any other personnel at all baseball facilities – including Yankee Stadium and Citi Field.

I believe we can create a generation of kids who won't even remember it ever existed.

The time to act is now. Recent headlines have driven home the seriousness of the problem. Last June, Hall of Famer Tony Gwynn died at age 54 after a long battle with salivary gland cancer, which he attributed to his longtime use of chewing tobacco.

Two months later, Boston's own Curt Schilling, who is only 48, announced his treatment for oral cancer that he said was "without a doubt, unquestionably" caused by 30 years of chewing tobacco. Curt appeared recently with the mayor and me and other advocates in announcing support for this legislation.

We also know what will happen if we don't act. Over the last 15 years, we have made dramatic progress reducing cigarette smoking among our kids – especially

here in New York. Nationally, we have cut cigarette use among high school boys by more than half. But during the same period there has been no progress in reducing the use of smokeless tobacco among teenage boys, especially teenage boys who participate in organized sports. According to the Centers for Disease Control and Prevention (CDC), in 2013, almost 15 percent of high school senior boys reported current use of smokeless tobacco products, virtually the same percentage as in 2000. And each year, about 535,000 kids age 12 to 17 use smokeless tobacco for the first time.

Sadly, baseball is one reason. If we are going to change that course and save those kids, today is the first step down that path. I can promise you that if New York passes this measure, you are going to see healthier young kids who no longer associate tobacco use of any kind with their heroes.

We know that smokeless tobacco companies spent over \$435 million on marketing in 2012 – that’s the most recent year available – three times the amount they spent in 1998. But that doesn’t even take into account the literally hundreds of millions of dollars of free advertising they get when baseball players on TV and in the ballpark use these products.

Smokeless tobacco use in baseball reinforces the industry’s message that “real men” dip or chew. Every time a kid sees a big league player using smokeless tobacco, baseball is promoting it for free.

This “Knock Tobacco Out of the Park” campaign is gaining momentum. San Francisco became the first city to adopt such a measure in April of last year. Boston and Los Angeles have also passed laws and all three will be in effect for the 2016 season which starts in little more than a month. Now when New York— with its rich baseball history and long history as a leader of the tobacco control movement – takes a step like this, we are confident that other cities will take notice and follow suit. More importantly, we are on the verge of reaching a tipping point where the league and the players association will agree to do

something that would have seemed impossible a few short years ago... to eliminate the use of tobacco in all games throughout the league. New York City, with two storied franchises and tens of millions of fans across the country, is poised to make that happen.

I believe we can make that history, that we can make tobacco history, before the start of the next year's baseball season.

We all care about the health of our players. But make no mistake – Intro. 1068 is about the health and future of every one of our children.

Passage of Intro 1068 is a crucial step toward achieving our goal of the first tobacco-free generation.

Intros 1075, 1076, 139-A and 617

The growth of hookah usage and the growth in the number of hookah establishments in New York City is a disturbing trend that we agree needs to be addressed. However, we are concerned that any solution that continues to allow the use of hookah inside workplaces could undermine the Smoke-Free Air Act and further establish hookah use in the city.

Hookah Use Among Youth Is on the Rise

There is good reason to be concerned about Hookah use. At a time when smoking is declining to record lows, hookah use is on the rise in our country. According to the 2014 Youth Tobacco Survey (YTS), 9.4 percent of high schoolers, or 1.3 million youth nationwide, have used hookah in the past month.¹ Hookah is the second most popular tobacco product among youth, behind e-cigarettes. Additionally, while use of most other tobacco products is on the decline, hookah use among

¹U.S. Centers for Disease Control and Prevention (CDC), "Tobacco Use Among Middle and High School Students — United States, 2011-2014," *Morbidity and Mortality Weekly Report (MMWR)* 64(14):381-385, April 2015, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6414a3.htm?s_cid=mm6414a3_e

high school students has more than doubled since 2011, when the prevalence of current use was just 4.1 percent.

Hookah Is Not Harmless

According to the CDC, using a hookah to smoke tobacco poses serious health risks to smokers and others exposed to the smoke from the hookah.² Secondhand smoke from hookah comes from both the tobacco and the charcoal typically used to heat it and can be a health risk for nonsmokers.³ And just like with cigarette smoke, separate sections don't work to protect from the health effects. The World Health Organization's Study Group on Tobacco Product Regulation recommends that, "hookahs should be prohibited in places consistent with bans on cigarette and other forms of tobacco smoking."⁴

The Problem Deserves a Comprehensive Approach

Over the past few years, New York City has taken bold action to reduce and prevent tobacco use, helping to lower youth and adult smoking rates to historic lows. We acknowledge and appreciate the Council's desire to address hookah use, especially in public places and workplaces. It is clear that hookah use needs to be addressed, but we believe that a more comprehensive approach is necessary. We do not want to firmly establish these businesses in New York City law or codify an exemption where smoking is permitted under the Smoke-Free Air Act.

If the Council seeks the most effective way to further protect citizens and improve health in New York, then we urge you to work with the public health groups on proposals that will finally close the loophole in the law that and protect workers and patrons from secondhand hookah smoke.

² Centers for Disease Control and Prevention. "Hookahs." Available at http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/hookahs/

³ Centers for Disease Control and Prevention. "Hookahs." Available at http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/hookahs/

⁴ Centers for Disease Control and Prevention. "Dangers of Hookah Smoking." Available at <http://www.cdc.gov/features/hookahsmoking/>

As a result, we offer our strong support for Intro 1076, which would raise the minimum sale age (MLSA) of non-tobacco shisha and related paraphernalia to 21. It makes sense to treat these products in the same way we treat tobacco products to make sure that our kids, who are most likely to become addicted to these types of products, are less able to try them.

However, we cannot take any position on Intros 1075, 139-A, or 617. Each of these bills would open up the New York City Clean Indoor Air Act to create a new exemption for these types of establishments, when the current standard for smokefree laws would be to prohibit these types of establishments in their entirety. You were right in 2002 when this body voted to say that bar workers are as important as restaurant workers or office workers, and that all of them should have equal protection from second hand smoke. The same reasoning applies today, and employees who work in restaurants and bars should not be exposed to the types of health risks that are inherent in hookah exposure.

While we truly appreciate the efforts of Council Members Gentile and Rodriguez, and acknowledge that there may be some positive impact of these intros if adopted, they are not consistent with our national policies on smokefree laws and we believe they put both workers and consumers at risk in ways that we have worked hard to eliminate with comprehensive clean indoor air laws.

We urge you to pass Intros. 1068 and 1076 to protect kids from smokeless tobacco and hookah.

Thank you again and I would be glad to answer any questions.



TobaccoFreeBaseball.org

It's Time To Take Tobacco Out of Baseball

Smokeless tobacco use by Major League Baseball (MLB) players endangers the health of impressionable youth who follow their lead, as well as the players themselves. It sets a terrible example for the millions of young people who watch baseball and see players and managers using tobacco. It is time to take tobacco out of baseball once and for all – both to set the right example for America's kids and for the health of baseball players.

PROBLEM

Recent headlines have driven home the seriousness of the problem. Last June, Hall of Famer Tony Gwynn died at age 54 after a long battle with salivary gland cancer, which he attributed to his longtime use of chewing tobacco. Two months later, pitching great Curt Schilling, only 47, announced his treatment for oral cancer that he said was “without a doubt, unquestionably” caused by 30 years of chewing tobacco. How much more tragic news should we have to endure? Face facts:

- **Smokeless tobacco is harmful to health**

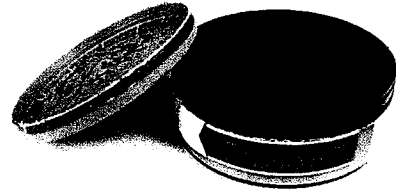
Public health authorities, including the U.S. Surgeon General and the National Cancer Institute, have found that smokeless tobacco use is hazardous to health and can lead to nicotine addiction. Smokeless tobacco contains at least 28 cancer-causing chemicals and causes oral, pancreatic and esophageal cancer – as well as other health problems.

- **Too many kids are using smokeless tobacco**

Even as cigarette use continues a steady decline among youth, smokeless tobacco use has remained troublingly steady. According to the Centers for Disease Control and Prevention (CDC), in 2013, 14.7 percent of high school boys (and 8.8 percent of all high school students) reported current use of smokeless tobacco products. Each year, about 535,000 kids age 12-17 use smokeless tobacco for the first time.

- **Tobacco use in baseball reinforces tobacco marketing**

Smokeless tobacco companies spent \$435 million on marketing in 2012 (the most recent year available), three times the amount spent in 1998. Smokeless tobacco use in baseball reinforces the industry's message that teen boys can't be real men unless they chew.



- **Professional baseball players are role models for youth**

A CDC expert stated, "Athletes serve as role models for youth, and smokeless tobacco manufacturers have used advertising, images, and testimonials featuring athletes and sports to make smokeless tobacco products appear attractive to youth."

SOLUTION

It's time for city and state leaders to step up to the plate and protect our kids by passing laws to make the game of baseball completely tobacco-free.

*It's time for city and state
leaders to step up to the plate
and protect our kids by passing
laws to make baseball stadiums
completely tobacco-free.*

For years, leading health organizations have called for an end to smokeless tobacco in baseball. We mounted a major campaign in 2010-2011 that made some strides – including securing a prohibition on players carrying tobacco tins in their uniforms and using smokeless tobacco during TV interviews. But these restrictions did not eliminate smokeless tobacco use at ballparks – the step that can best prevent young people from ever starting down the road to addiction, disease and premature death. It's time — finally — to take tobacco out of baseball completely. The obvious solution is for MLB and the players association to agree to rid baseball of tobacco for good. However, the league cannot unilaterally prohibit smokeless tobacco and no agreement has been reached to date.

Since baseball has been unable to address this threat to kids across the country, it's now up to cities and states with major league teams to step up and protect our kids. They can take a critical step by prohibiting use of all tobacco products, including smokeless tobacco, at baseball venues. San Francisco passed such a law earlier this year. Now, Los Angeles and Boston are pursuing that route as well.

RATIONALE

Such legislation will send a simple and powerful message to kids: baseball and tobacco don't mix. Our national pastime should be about promoting a healthy and active lifestyle, not a deadly and addictive product.

This action will not affect what players can do in their personal lives, although they should be encouraged to quit using tobacco for their own health. Baseball stadiums, however, are workplaces and public places. It's entirely appropriate to restrict the use of a harmful substance in such a setting. While players are on the job — on the field or in front of a camera — they have a responsibility to set the right example for kids.



TobaccoFreeBaseball.org

Don't just take our word for it

Baseball experts, editorial boards, sportswriters and others all agree that it's time to take tobacco out of baseball.

The Fresno Bee, June 18, 2014

"[Y]ou can bet that many kids wanted to emulate their heroes. ... So this should be another teachable moment — for teenage boys in particular — on the dangers of smokeless tobacco. ... [P]layers ought to think about the example they're setting as well as their own health as they try to break the addiction."

Keith Olbermann, noted baseball commentator, June 22, 2014

"Banning the habit would be a good idea, not just as a way of remembering Tony Gwynn but protecting players' health and as an example for the fans of the game."

The Boston Globe, Aug. 23, 2014

"It's time for the Major League Baseball players' union to honor [Tony] Gwynn, [Curt] Schilling, and other victims of chewing tobacco by banning it from baseball."

Jim Caple, ESPN columnist and senior writer, June 17, 2014

"[Tony] Gwynn was a wonderful man. The best way to honor him is to eliminate the very thing that killed him. Let's get rid of chewing tobacco so that no other player suffers and dies as Tony did."

The Chicago Sun-Times, July 19, 2014

"The tobacco tin may be carefully stowed away, but when Major League Baseball players head out to the field there's no mistaking a cheek bulging with chaw. In honor of Tony Gwynn, it's time to end the charade. MLB players can honor Gwynn ... by agreeing to ban all smokeless tobacco products on the field."

Joe Garagiola, Sr., ex-MLB player, TV host and longtime advocate against chewing tobacco in baseball, June 17, 2014

"Let's do something ... Tony Gwynn's death is sad enough. I hope it triggers [a ban]." In a separate interview, he said, "I just wish that [the players association] would take a more serious look at it and don't wait for good people to die, good guys like Tony Gwynn. That's a big loss for baseball."

Deron Snyder, sportswriter, The Washington Times, June 18, 2014

"Now that he's dead from oral cancer at 54, I wish baseball had banned the practice [of dipping tobacco] during his 20-year Hall of Fame career. ... Here's hoping the players' union supports a ban in the next labor agreement, to assist the loved ones of current and future ballplayers."

Connor O'Gara, sportswriter, The Kearney Hub in Nebraska, June 17, 2014

"Major League Baseball has slept far too long on the growing epidemic of chewing tobacco in its game. The argument that 'it's just part of the culture,' is the problem and the excuse. Gwynn's death needs to show the players union that a ban on chewing tobacco has to happen and it has to happen now."



February 25, 2016

New York City Council
250 Broadway
New York, NY 10007

Dear Honorable Council Members,

The use of smokeless tobacco remains a serious blot on the game of baseball. Smokeless tobacco use by Major League Baseball (MLB) players endangers the health of impressionable youth who follow their lead, as well as the players themselves. We are excited that New York City has the opportunity to join San Francisco, Boston and Los Angeles as national leaders to make baseball completely tobacco-free.

Ridding baseball of the use of all smokeless tobacco products – such as dip, chew and snuff – will make clear that the health of our youth is a top priority. And it will send a simple and powerful message to kids: baseball and tobacco don't mix. America's pastime should be about promoting a healthy and active lifestyle, not a product that addicts, sickens and kills.

Even as smoking among boys has fallen by 25 percent in the last decade, smokeless tobacco use has remained troublingly steady. According to the Centers for Disease Control and Prevention (CDC), in 2013, 14.7 percent of high school boys (and 8.8 percent of all high school students) reported current use of smokeless tobacco products. Each year, about half a million kids age 12-17 use smokeless tobacco for the first time.

Major league players are idolized by millions of our young people who watch baseball and see players, coaches and managers using tobacco. Baseball must stop creating images that associate tobacco use with masculinity and athleticism – when in fact its use causes increased death and disease.

Two shocking events in 2014 should have been enough to convince MLB and its players to remove the indelible stain smokeless tobacco has left on the game. In June, Hall of Famer Tony Gwynn died at age 54 after a long battle with salivary gland cancer, which he attributed to his longtime use of chewing tobacco. Two months later, Red Sox pitching great Curt Schilling, only 47, announced his treatment for oral cancer that he said was “without a doubt, unquestionably” caused by 30 years of chewing tobacco.



Tobacco use is the number one preventable cause of death in the United States. Public health authorities, including the U.S. Surgeon General and National Cancer Institute, have found that smokeless tobacco use is hazardous to health and can lead to nicotine addiction. Smokeless tobacco contains at least 28 cancer-causing chemicals and causes oral, pancreatic and esophageal cancer – as well as other health problems.

We are up against some powerful opposition. Smokeless tobacco companies spent \$450 million on marketing in 2011 (the most recent year available), more than three times the amount spent in 1998. Smokeless tobacco use in baseball reinforces the industry's message that teen boys can't be real men unless they chew. We need to do our part to counter this deceptive messaging.

No one is talking about dictating what players can do on their own time in their personal lives, although we would urge players to quit using tobacco for their own health. Baseball stadiums, however, are workplaces and public places. While players are on the job – on the field or anywhere in their stadium – they have a responsibility to set the right example for kids.

For the sake of the children and families who love baseball and look up to their heroes, and for the sake of the health of the players themselves, we look forward to a day when our national pastime is tobacco-free.

We are proud to join the fight to prevent young people from ever starting down the road to addiction, disease and premature death. We strongly encourage the players and the league to do what's right for players, children and the game of baseball and Knock Tobacco Out of the Park. Our kids can't wait any longer.

Sincerely,

Academy of Family Physicians – New York State Chapter

American Academy of Pediatrics

American Medical Association

American Cancer Society

American Cancer Society – Cancer Action Network

American Heart Association/American Stroke Association



American Lung Association

Campaign for Tobacco-Free Kids

Chinese-American Planning Council - Brooklyn

Coalition for Asian American Children and Families

JCC of Staten Island

Montefiore Medical Center

National Association for the Advancement of Colored People
– New York State Conference

National Association for the Advancement of Colored People
– Williamsburg Branch

NYC Treats Tobacco - NYU Langone Medical Center

Oral Health America

Smokeless Tobacco in Sport and Use Among Adolescents



April 10, 2015

Benjamin W. Chaffee, DDS MPH PhD, Elizabeth T. Couch, RDH MS, Margaret M. Walsh, RDH MS MA EdD
University of California San Francisco, School of Dentistry, Division of Oral Epidemiology and Dental Public Health
San Francisco, CA 94143-1361

Main Findings

- *Smokeless tobacco use substantially increases the risk of oral and pancreatic cancer, gum disease, nicotine addiction, and initiation of cigarette smoking among adolescents.*
- *Nearly 15% of U.S. high school males currently use smokeless tobacco, and use prevalence is higher among high school students who participate in organized sports than among non-athlete peers.*
- *There is little evidence that smokeless tobacco improves athletic performance, yet use among participants in certain sports and athletic events, such as ice hockey, baseball, wrestling, and rodeo, far exceed levels observed in the general population.*
- *Modeling of smokeless tobacco use by family, friends, respected coaches, and elite athletes is strongly associated with smokeless tobacco initiation among adolescent males.*
- *Competitive organized baseball, including professional leagues, exhibits exceptionally high levels of smokeless tobacco use among its players.*
- *On-camera use at the major league level is broadcast to millions of viewers: an implicit product endorsement to children and adolescents.*
- *An environmental context that embraces smokeless tobacco as normative within athletic culture stimulates greater smokeless tobacco initiation and continued use on the part of young male athletes.*

Smokeless tobacco, which includes both oral moist snuff and chewing tobacco, imbues substantial health risks, not limited to increased chances of oral and pancreatic cancer, gum disease, nicotine addiction, and, among adolescents, increased likelihood of smoking initiation. There is little evidence that use of smokeless tobacco enhances athletic performance; yet, sporting events and athletic participation are consistently identified as key contexts associated with smokeless tobacco use. The tobacco industry has long marketed smokeless tobacco products at sporting events and targeted elite athletes for product endorsements in order to integrate smokeless tobacco into the sporting culture. Young males, whether striving to gain the acceptance of admired peers or to emulate respected athletes and coaches, often engage in smokeless tobacco experimentation and continued use during sports participation or attendance at sporting events. In the United States, male high school athletes are significantly more likely to use smokeless tobacco than their

* For more information, contact Benjamin W. Chaffee, DDS, PhD, University of California San Francisco, School of Dentistry - Division of Oral Epidemiology and Dental Public Health, 3333 California St. Suite 495, San Francisco, CA 94143-1361. benjamin.chaffee@ucsf.edu. This report is available in the UC eScholarship Repository at: www.escholarship.org/uc/item/6rc6v9t2

non-athlete counterparts. The same holds true for female high school athletes, although smokeless tobacco use is much less common among females overall. In contrast, cigarette smoking is less prevalent among high school athletes than non-athletes. Baseball, in particular, is one of several sports, including rodeo, wrestling, ice hockey, and football, that are associated with high levels of smokeless tobacco use among its participants, extending across the high school, college, and professional ranks. Smokeless tobacco use is prohibited on the field of play in college baseball and in the minor leagues. Major League Baseball bars its players from carrying smokeless tobacco products in their uniforms but does not ban use during play, which results in the broadcast of implicit product endorsements to millions of viewers worldwide.

Smokeless Tobacco and Health Risks

The term smokeless tobacco includes oral tobacco products that are placed in the mouth and absorbed through the oral tissues, as well as powder tobacco mixtures that are inhaled and absorbed in the nose [1]. The predominant forms of smokeless tobacco used by U.S. adolescents and adults are oral moist snuff (known as dip) and chewing tobacco [2]. Oral snuff is a finely ground tobacco leaf, packaged either loose or in a tea-bag-like sachet. Snuff users place a small amount of oral snuff between the cheek and the gum. Chewing tobacco is a more coarsely shredded tobacco leaf. Tobacco chewers place a “chaw” of loose-leaf tobacco or a “plug” of compressed tobacco in the cheek. Oral snuff and chewing tobacco users generally spit out the tobacco juices and generated saliva, but sometimes such users swallow them. Many smokeless tobacco products contain much larger amounts of cancer-causing chemicals (nitrosamines) than those commonly found in cigarettes [3]. Manufacturers control the amount of free nicotine available for uptake into the body by controlling the acidity (pH) of their products, as nicotine is absorbed more readily under less acidic (more alkaline) conditions [4]. This product feature serves as part of a broader strategy to tailor products to specific groups of users [5]. For example, the low-pH (more acidic) Skoal Bandits product was introduced in the 1980s, allowing new users to initiate with a low-nicotine product and avoid the unpleasant side effects of nicotine toxicity (e.g., nausea, vomiting) [6-8]. Users commonly graduate to higher nicotine, more alkaline products that are highly addictive and difficult to quit [9].

The high prevalence of smokeless tobacco use among young males puts them at risk for serious adverse health effects. Smokeless tobacco use increases the likelihood of smoking onset in adolescent males [10-13] and is associated with an increased risk of oral [14], esophageal [14], and pancreatic cancer [15-18], nicotine dependence [19], and possibly cardiovascular disease [20,21]. Other negative health effects of smokeless tobacco use include gingival and periodontal disease (gum disease), dental caries (cavities), tooth staining, tooth wear (erosion), mouth sores, and salivary gland abnormalities [22-27]. In a national study of U.S. middle and high school students, oral lesions (mouth sores) were present in 27% of those adolescents who reported use of oral snuff or chewing tobacco at least once in the prior 30 days [28].

Dual use of smokeless tobacco along with other forms of tobacco, such as cigarettes, is associated with a heightened risk of adverse health effects, greater nicotine dependence, and reduced smoking cessation [29-31]. Adolescents dependent on nicotine are less likely

to successfully quit and are more likely to smoke as adults, thereby increasing associated mortality and costs [32-34]. Estimates of the percentage of high school males who used smokeless tobacco in the past 30 days and also smoked cigarettes are as high as 60% [31,35].

Smokeless Tobacco Use: Youth Prevalence and Trends

Although smoking among U.S. high school students has gradually declined over the past decade, use of oral moist snuff and chewing tobacco has not. Including males and females, youth smokeless tobacco use in the U.S. declined from 1995 to 1999, but has since remained relatively unchanged, increasing slightly from 7.8% (1999) to 8.8% (2013) [36]. In 2013, smokeless tobacco use continues to be sharply higher among high school males (14.7%) than females (2.9%) [37], and use prevalence rises steadily with grade in school: current use among males increases from 11.2% in the 9th grade to 16.6% in the 12th grade [37].

Smokeless Tobacco Use by Athletes

Among all U.S. adult men, in 2012-2013, 4.8% reported regular use of smokeless tobacco “every day” or “some days” [2]. However, smokeless tobacco use is dramatically higher among young athletes participating in certain sports. In a 2009 National Collegiate Athletic Association (NCAA) survey of substance use by college student-athletes, for example, prevalence of using smokeless tobacco at least once in the past year among men’s sports participants was 54.2% for ice hockey, 52.3% for baseball, 47.6% for wrestling, 41.0% for lacrosse, and 27.9% for football [38]. Smokeless tobacco was the second-most commonly used substance among college baseball athletes, after alcohol, with more than twice as many players having used smokeless tobacco (52.3%) than had used cigarettes (19.2%) or marijuana (21.5%) [38].

In the early 1990s, the NCAA and Minor League Baseball both instituted measures to ban the use of smokeless tobacco during competition [39]. Following these regulations, from 1998 to 2003, there was a gradual decline in use prevalence among minor league players [40]. However, the NCAA and minor league bans have been criticized for lax enforcement, and smokeless tobacco use on playing fields remains widespread [41,42].

In contrast to the decline in smokeless tobacco use observed among minor league players, use of smokeless tobacco in Major League Baseball (MLB), which does not prohibit use by players and coaches during competition, remained unchanged at 36% during the same time period [40]. Recent evidence suggests that the high prevalence of smokeless tobacco use persists among major league players today. This year, a new study reported that 37% of 159 surveyed MLB players and coaches were smokeless tobacco users [43], nearly identical to the prevalence estimates recorded a decade prior [40].

While chewing tobacco has been present in MLB for many decades, oral snuff became increasingly commonplace in the major leagues during the 1970s and 1980s [8,40]. At the time, the health risks of cigarette smoking were achieving broad public attention, and smokeless tobacco companies launched aggressive marketing campaigns to target

professional baseball athletes, including sample distribution in major league clubhouses [8,40]. As a result, professional baseball athletes have a lengthy history of unpaid, nationally broadcast smokeless tobacco endorsements via on-camera product use during widely broadcast games, such as the World Series [44,45].

Sports announcers have drawn attention to players' smokeless tobacco use, once, for example, relaying a story that a pitcher was told to improve his delivery to home plate by positioning his body "to show the catcher his Skoal" in his back pocket [45]. Major League Baseball barred its players from carrying tobacco products in their uniforms beginning with the 2012 season [46], but the league stopped short of an outright ban. Public health advocates have expressed outrage at what has been described as deliberate infiltration into professional baseball on the part of the smokeless tobacco industry and the co-opting of smokeless tobacco into the values and traditions of the sport for the promotion of a dangerous product [8].

Smokeless Tobacco and Athletic Performance

Nicotine raises resting heart rate and blood pressure but does not cause an increase in maximal oxygen uptake or cardiac output and may decrease muscular strength [47]. A clinical study of oral and other health effects of smokeless tobacco use among 1109 professional baseball players and coaches was completed during Major League Spring Training in 1988 [25,26,48]. Oral leukoplakia, a form of pre-cancerous mouth lesion, was detected in nearly half (46%) of current weekly smokeless tobacco users [25]. Moreover, in areas of the mouth adjacent to where players held the smokeless tobacco, there was significantly greater loss of the supporting tissues of the teeth (gums and bone) than in similar sites in non-users [26]. However, there was no discernible difference in the in-season, on-field performance between players who did or did not report smokeless tobacco use [49].

The World Anti-Doping Agency is currently monitoring nicotine as a doping product [50]. Even without evidence of enhanced performance, nicotine can still be named a forbidden substance for its health risks and for failure to respect the spirit of the sport [47].

Smokeless Tobacco and Role Modeling

Modeling of smokeless tobacco use by family, friends, and others is strongly associated with initiation and use intensity among high school males [51-53]. Acceptance into male-oriented social networks and emulation of respected male figures has been repeatedly described as central to the process of smokeless tobacco initiation for young males [54,55]. Adult men who use smokeless tobacco commonly report use while attending or participating in sporting events [54,56], and sporting events can be settings for initial smokeless tobacco experimentation [54]. In a study of male ice hockey players in Sweden, socialization related to sports participation was a major factor in the decision to use oral snuff [57]. Smokeless tobacco use by admired elite players and coaches normalized smokeless tobacco within the sporting environment, which then fostered initiation among younger players [57].

Tobacco companies have exploited peer influence and role modeling to sell smokeless

tobacco products. Tobacco advertising may particularly influence youth, who look to messages delivered through marketing and other media for examples and cues related to socially endorsed behavior and appearance [58,59]. In a 1989 review of advertising and promotion of smokeless tobacco products, Ernster cited instances of famous athletes endorsing the products and encouraging consumers to use them [60]. Smokeless tobacco logos appeared as promotional devices on baseball caps and other athletic paraphernalia [60].

Smokeless tobacco products continue to be heavily promoted in male-centric and sports-oriented magazines with substantial youth readership [61]. In 2014, ads for the Skoal brand of smokeless tobacco products returned to mainstream magazines after a 5-year hiatus, with ads featuring young men engaged in outdoor activities and peer camaraderie, rejoining the persistent magazine campaigns from the Grizzly brand that stress masculinity [62,63].

Smokeless Tobacco and High School Athletes

Professional and college athletes provide a powerful model for boys and young men to use smokeless tobacco by legitimizing chewing and dipping as an integral part of being a successful athlete, and the high levels of smokeless tobacco use observed in the college and professional ranks are mirrored among adolescent athletes. Adolescents who participate in high school sports are at greater risk of using smokeless tobacco. Pooling the results of six studies [64-69], Diehl and colleagues [70] reported that high school athletes were at 60% greater odds of using smokeless tobacco than were non-athletes. This association was found in all of these six studies; yet, the opposite association held for cigarette smoking: in each study, high school athletes were less likely than non-athletes to smoke cigarettes, despite the increased risk for using smokeless tobacco [64-69]. Overall, high school females were much less likely than their male counterparts to use smokeless tobacco, but female athletes used smokeless tobacco at higher levels than female non-athletes [67,71]. Smokeless tobacco use was strongly associated with particular sports and athletic activities. Davis and colleagues [65] reported levels of use from 22% to 28% among high school males who participated in a set of “medium intensity” sports that included baseball, football, wrestling, track, and rodeo. In a survey of high school male baseball athletes in California, 46% had ever tried smokeless tobacco, and 15% were defined as current users [52].

Higher levels of smokeless tobacco use were significantly associated with perceived use by baseball coaches, by teammates, and by other baseball athletes of similar age [52]. Taken together, an environmental context that embraces smokeless tobacco use as normative behavior within sporting culture stimulates greater smokeless tobacco initiation and continued use on the part of young male athletes.

References

1. National Cancer Institute & Centers for Disease Control and Prevention. Smokeless tobacco fact sheets. Proceedings of the International Conference on Smokeless Tobacco; 2002 Sep 22-25; Stockholm, Sweden.
2. Agaku IT, King BA, Husten CG, Bunnell R, Ambrose BK, Hu SS, Holder-Hayes E, Day HR; Centers for Disease Control and Prevention (CDC). Tobacco product use among adults--United States, 2012-2013. *MMWR Morb Mortal Wkly Rep.* 2014;63(25):542-7.
3. Hoffmann D, Djordjevic MV. Chemical composition and carcinogenicity of smokeless tobacco. *Adv Dent Res.* 1997;11(3):322-9.
4. Tomar SL, Henningfield JE. Review of the evidence that pH is a determinant of nicotine dosage from oral use of smokeless tobacco. *Tob Control.* 1997;6(3):219-25.
5. Alpert HR, Koh H, Connolly GN. Free nicotine content and strategic marketing of moist snuff tobacco products in the united states: 2000-2006. *Tob Control.* 2008;17(5):332-8.
6. Dougherty PN. Moving smokers to snuff. *New York Times.* January 13, 1984:4.
7. Connolly GN, Orleans CT, Kogan M. Use of smokeless tobacco in major-league baseball. *N Engl J Med.* 1988;318(19):1281-5.
8. Connolly GN, Orleans CT, Blum A. Snuffing tobacco out of sport. *Am J Public Health.* 1992;82(3):351-3.
9. Tomar SL, Giovino GA, Eriksen MP. Smokeless tobacco brand preference and brand switching among US adolescents and young adults. *Tob Control.* 1995;4(1):67-72.
10. Haddock CK, Weg MV, DeBon M, Klesges RC, Talcott GW, Lando H, Peterson A. Evidence that smokeless tobacco use is a gateway for smoking initiation in young adult males. *Prev Med.* 2001;32(3):262-7.
11. Forrester KK, Biglan A, Severson HH, Smolkowski K. Predictors of smoking onset over two years. *Nicotine Tob Res.* 2007;9(12):1259-67.
12. Severson HH, Forrester KK, Biglan A. Use of smokeless tobacco is a risk factor for cigarette smoking. *Nicotine Tob Res.* 2007;9(12):1331-7.
13. Walsh MM, Langer TJ, Kavanagh N, Mansell C, MacDougal W, Kavanagh C, Gansky SA. Smokeless tobacco cessation cluster randomized trial with rural high school males: intervention interaction with baseline smoking. *Nicotine Tob Res.* 2010;12(6):543-50.
14. International Agency for Research on Cancer. Smokeless Tobacco and Some Tobacco-Specific N-Nitrosamines. Lyon, France: World Health Organization International Agency for Research on Cancer. 2007.
15. Zheng W, McLaughlin JK, Gridley G, Bjelke E, Schuman LM, Silverman DT, Wacholder S, Co-Chien HT, Blot WJ, Fraumeni, JF, Jr. A cohort study of smoking, alcohol consumption, and dietary factors for pancreatic cancer (United States). *Cancer Causes and Control.* 1993;4(5):477-82.
16. Alguacil J, Silverman DT. Smokeless and other noncigarette tobacco use and pancreatic cancer: a case-control study based on direct interviews. *Cancer Epidemiol Biomarkers Prev.* 2004;13(1):55-8.
17. Boffetta P, Aagnes B, Weiderpass E, Andersen A. Smokeless tobacco use and risk of cancer of the pancreas and other organs. *Int J Cancer.* 2005;114(6):992-5.
18. Luo J, Ye W, Zendeheh K, Adami J, Adami HO, Boffetta P, Nyren O. Oral use of Swedish moist snuff (snus) and risk for cancer of the mouth, lung, and pancreas in male construction workers: a restrospective cohort study. *Lancet.* 2007;369(9578):2015-20.
19. Ebbert JO, Carr AB, Dale LC. Smokeless tobacco: an emerging addiction. *Med Clin North Am.* 2004;88(6):1593-605.
20. Hatsukami D, Slade J, Benowitz N, Giovino G, Gritz ER, Leischow S, Warner KE. Reducing tobacco harm: research challenges and issues. *Nicotine Tob Res.* 2002;4(Suppl 2):S89-101.
21. Hatsukami D, Lemmonds C, Tomar S. Smokeless tobacco use: harm reduction or induction approach? *Prev Med.* 2004;38(3):309-17.
22. Greer RO Jr, Poulson TC. Oral tissue alterations associated with the use of smokeless tobacco by teenagers. *Oral Surg.* 1983;56(3):275-84.
23. Poulson TC. A comparison of the use of smokeless tobacco in rural and urban teenagers. *CA Cancer J Clin.* 1984;34(5):248-61.
24. Offenbacher S, Weathers DR. Effects of smokeless tobacco on the periodontal mucosal and caries status of adolescent males. *J Oral Pathol.* 1985;14(2):169-81.
25. Ernster V, Grady D, Greene JC, Walsh M, Robertson P, Daniels TE, Benowitz N, Siegel D, Gerbert B, Hauck WW. Smokeless tobacco: prevalence and health effects among professional baseball players. *JAMA.* 1990;

SMOKELESS TOBACCO IN SPORT AND USE AMONG ADOLESCENTS

- 264(2):218-24.
26. Robertson PB, Walsh M, Greene J, Ernster V, Grady D, Hauck W. Periodontal effects associated with the use of smokeless tobacco. *J Periodontol.* 1990;61(7):438-43.
 27. Little SJ, Stevens VJ, LaChance PA, Severson HH, Bartley MH, Lichtenstein E, Leben JR. Smokeless tobacco habits and oral mucosal lesions in dental patients. *J Public Health Dent.* 1992;52(5):269-76.
 28. Tomar SL, Winn DM, Swango PA, Giovino GA, Kleinman DV. Oral mucosal smokeless tobacco lesions among adolescents in the United States. *J Dent Res.* 1997;76(6):1277-86.
 29. Mumford E, Levy D, Gitchell J, Blackman K. Smokeless tobacco use 1992-2002: Trends and measurement in the current population survey –tobacco use supplements. *Tob Control.* 2006;15(3):166-71.
 30. Bombard J, Rock V, Pederson L, Asman K. Monitoring polytobacco use among adolescents: do cigarette smokers use other forms of tobacco? *Nicotine Tob Res.* 2008;10(11):1581-9.
 31. Tomar SL, Alpert HR, Connolly GN. Patterns of dual use of cigarettes and smokeless tobacco among US males: Findings from national surveys. *Tob Control.* 2010;19(2):104-9.
 32. Horn K, Hernandez A, Dino G, Massey C, Kalsekar I. Adolescent nicotine dependence and smoking cessation outcomes. *Addict Behav.* 2003;28(4):769-76.
 33. Storr C. Characteristics associated with rapid transition to tobacco dependence in youth. *Nicotine Tob Res.* 2008;10(6):1099-104.
 34. DiFranza JR, Sweet M, Savageau J, Ursprung W. The assessment of tobacco dependence in young users of smokeless tobacco. *Tob Control.* 2011; 21(5): 471-76.
 35. Soldz S, Huyser D, Dorsey E. Characteristics of users of cigars, bidis, and kreteks and the relationship to cigarette use. *Prev Med.* 2003;37(3):250-8.
 36. Kann L, Kinchen S, Shanklin SL, Flint KH, Kawkins J, Harris WA, Lowry R, Olsen EO, McManus T, Chyen D, Whittle L, Taylor E, Demissie Z, Brener N, Thornton J, Moore J, Zaza S; Centers for Disease Control and Prevention (CDC). Youth risk behavior surveillance--United States, 2013. *MMWR Surveill Summ.* 2014;63 Suppl 4:1-168.
 37. Centers for Disease Control and Prevention (CDC). 1991-2013 High School Youth Risk Behavior Survey Data. Available at <http://nccd.cdc.gov/youthonline/>. Accessed: March 30, 2015.
 38. National Collegiate Athletic Association. National Study of Substance Use Trends Among NCAA College Student-Athletes. 2012. Available at: <http://www.ncaapublications.com/productdownloads/SAHS09.pdf>. Accessed: March 29, 2015.
 39. National Collegiate Athletic Association. Legislative Services Database - LSDBi. <https://web1.ncaa.org/LSDBi/exec/bylawSearch>. Accessed: March 29, 2015.
 40. Severson HH, Klein K, Lichtenstein E, Kaufman N, Orleans CT. Smokeless tobacco use among professional baseball players: Survey results, 1998 to 2003. *Tob Control.* 2005;14(1):31-6.
 41. Livingstone S. Will Major League Baseball toss tobacco? *USA Today.* September 27, 2011.
 42. Abraham P. Players find tobacco habit hard to shake. *Boston Globe.* March 7, 2014.
 43. Conrad AK, Hutton SB, Munnely M, Bay RC. Screening for smokeless tobacco use and presence of oral lesions in major league baseball athletes. *J Calif Dent Assoc.* 2015;43(1):14-20.
 44. Jones RB. Use of smokeless tobacco in the 1986 world series. *N Engl J Med.* 1987;316(15):952.
 45. Jones RB. Use of smokeless tobacco in the world series, 1986 through 1993. *Am J Public Health.* 1995;85(1):117-8.
 46. Carlson D. MLB season opens with curbs on smokeless tobacco use. *Ethics & Religious Liberty Commission.* Available at <https://erlc.com/article/mlb-season-opens-with-curbs-on-smokeless-tobacco-use>. Accessed: April 2, 2015.
 47. Chagué F, Guenancia C, Gudjoncik A, Moreau D, Cottin Y, Zeller M. Smokeless tobacco, sport and the heart. *Arch Cardiovasc Dis.* 2015;108(1):75-83.
 48. Siegel D, Benowitz N, Ernster VL, Grady DG, Hauck WW. Smokeless tobacco, cardiovascular risk factors, and nicotine and cotinine levels in professional baseball players. *Am J Public Health.* 1992;82(3):417-21.
 49. Robertson PB, DeRouen TA, Ernster V, et al. Smokeless tobacco use: How it affects the performance of major league baseball players. *J Am Dent Assoc.* 1995;126(8):1115-21; discussion 1121-4.
 50. World Anti-Doping Agency. Monitoring Program. 2014. Available at: <https://www.wada-ama.org/en/resources/science-medicine/monitoring-program>. Accessed: March 27, 2015.
 51. Riley WT, Barenie JT, Mabe PA, Myers DR. The role of race and ethnic status on the psychosocial correlates of smokeless tobacco use in adolescent males. *J Adolesc Health.* 1991;12(1):15-21.
 52. Walsh MM, Ellison J, Hilton JF, Chesney M, Ernster VL. Spit (smokeless) tobacco use by high school baseball athletes in California. *Tob Control.* 2000;9 Suppl 2:II32-9.

SMOKELESS TOBACCO IN SPORT AND USE AMONG ADOLESCENTS

53. Gansky SA, Ellison JA, Kavanagh C, Isong U, Walsh MM. Patterns and correlates of spit tobacco use among high school males in rural California. *J Public Health Dent.* 2009;69(2):116-24.
54. Helme DW, Cohen EL, Parrish AJ. Health, masculinity and smokeless tobacco use among college-aged men. *Health Commun.* 2012;27(5):467-77.
55. Nemeth JM, Liu ST, Klein EG, Ferketich AK, Kwan MP, Wewers ME. Factors influencing smokeless tobacco use in rural Ohio Appalachia. *J Community Health.* 2012;37(6):1208-17.
56. Cohen-Smith D, Severson HH. A comparison of male and female smokeless tobacco use. *Nicotine Tob Res.* 1999;1(3):211-8.
57. Rolandsson M, Hallberg LR, Hugoson A. Influence of the ice-hockey environment on taking up snuff: An interview study among young males. *Acta Odontol Scand.* 2006;64(1):47-54.
58. Krugman DM, Quinn WH, Sung Y, Morrison M. Understanding the role of cigarette promotion and youth smoking in a changing marketing environment. *J Health Commun.* 2005;10(3):261-78.
59. Solomon MR, Polegato R, Zaichkowsky JL. *Consumer behavior: buying, having, and being.* Vol. 6. Upper Saddle River, NJ: Pearson Prentice Hall, 2009.
60. Ernster VL. Advertising and promotion of smokeless tobacco products. *NCI Monogr.* 1989;8:87-94.
61. Morrison MA, Krugman DM, Park P. Under the radar: Smokeless tobacco advertising in magazines with substantial youth readership. *Am J Public Health.* 2008;98(3):543-8.
62. Trinkets & Trash. Surveillance Update. April 2014. Available at: <http://www.trinketsandtrash.org/documents/TrinketsSurveillanceUpdate-April2014.pdf>. Accessed: March 30, 2015.
63. Campaign for Tobacco-Free Kids. Tobacco Unfiltered (blog). May 28, 2014. Available at: http://www.tobaccofreekids.org/tobacco_unfiltered/post/2014_05_28_smokeless. Accessed: March 30, 2015.
64. Rainey CJ, McKeown RE, Sargent RG, Valois RF. Patterns of tobacco and alcohol use among sedentary, exercising, nonathletic, and athletic youth. *J Sch Health.* 1996;66(1):27-32.
65. Davis TC, Arnold C, Nandy I, Bocchini JA, Gottlieb A, George RB, Berkel H. Tobacco use among male high school athletes. *J Adolesc Health.* 1997;21(2):97-101.
66. Baumert PW J, Henderson JM, Thompson NJ. Health risk behaviors of adolescent participants in organized sports. *J Adolesc Health.* 1998;22(6):460-5.
67. Pate RR, Trost SG, Levin S, Dowda M. Sports participation and health-related behaviors among US youth. *Arch Pediatr Adolesc Med.* 2000;154(9):904-11.
68. Sabo D, Miller KE, Melnick MJ, Farrell MP, Barnes GM. Athletic participation and the health risks of adolescent males: a national study. *Int J Mens Health.* 2002;1:173-93.
69. Castrucci BC, Gerlach KK, Kaufman NJ, Orleans CT. Tobacco use and cessation behavior among adolescents participating in organized sports. *Am J Health Behav.* 2004;28(1):63-71.
70. Diehl K, Thiel A, Zipfel S, Mayer J, Litaker DG, Schneider S. How healthy is the behavior of young athletes? A systematic literature review and meta-analyses. *J Sports Sci Med.* 2012;11(2):201-20.
71. Melnick MJ, Miller KE, Sabo DF, Farrell MP, Barnes GM. Tobacco use among high school athletes and nonathletes: Results of the 1997 youth risk behavior survey. *Adolescence.* 2001;36(144):727-47.

Combustible and Smokeless Tobacco Use Among High School Athletes — United States, 2001–2013

Israel T. Agaku, DMD¹; Tushar Singh, MD, PhD^{1,2}; Sherry Everett Jones, PhD, JD³; Brian A. King, PhD¹; Ahmed Jamal, MBBS¹; Linda Neff, PhD¹; Ralph S. Caraballo, PhD¹

Athletes are not a typical at-risk group for smoking combustible tobacco products, because they are generally health conscious and desire to remain fit and optimize athletic performance (1). In contrast, smokeless tobacco use historically has been associated with certain sports, such as baseball (2). Athletes might be more likely to use certain tobacco products, such as smokeless tobacco, if they perceive them to be harmless (3); however, smokeless tobacco use is not safe and is associated with increased risk for pancreatic, esophageal, and oral cancers (4). Tobacco use among youth athletes is of particular concern, because most adult tobacco users first try tobacco before age 18 years (5). To examine prevalence and trends in current (≥ 1 day during the past 30 days) use of combustible tobacco (cigarettes, cigars) and smokeless tobacco (chewing tobacco, snuff, or dip [moist snuff]) products among athlete and nonathlete high school students, CDC analyzed data from the 2001–2013 National Youth Risk Behavior Surveys. Current use of any tobacco (combustible or smokeless tobacco) significantly declined from 33.9% in 2001 to 22.4% in 2013; however, current smokeless tobacco use significantly increased from 10.0% to 11.1% among athletes, and did not change (5.9%) among nonathletes. Furthermore, in 2013, compared with nonathletes, athletes had significantly higher odds of being current smokeless tobacco users (adjusted odds ratio [AOR] = 1.77, $p < 0.05$), but significantly lower odds of being current combustible tobacco users (AOR = 0.80, $p < 0.05$). These findings suggest that opportunities exist for development of stronger tobacco control and prevention measures targeting youth athletes regarding the health risks associated with all forms of tobacco use.

The national Youth Risk Behavior Survey is a biennial, school-based survey of U.S. high school students.* For each survey, a three-stage cluster sample design was used to produce a nationally representative sample of students in grades 9–12 who attend public and private schools. Students completed the self-administered questionnaire during one class period and recorded their responses directly on a computer scannable

*The national Youth Risk Behavior Survey (YRBS), conducted by CDC, is part of a larger school-based surveillance system, the Youth Risk Behavior Surveillance System (YRBSS). In addition to the national YRBS, the YRBSS includes other state, territorial, tribal government, and local surveys, conducted by departments of health and education, which provide data representative of mostly public high school students in each jurisdiction. Available at <http://www.cdc.gov/yrbss>.

booklet or answer sheet. During 2001–2013, sample sizes ranged from 13,583 to 16,410; overall response rates ranged from 63% to 71%.

Current use of combustible tobacco products, smokeless tobacco products, and any tobacco product was self-reported.† Athletic status was assessed with the question, “During the past 12 months, on how many sports teams did you play? (Count any teams run by your school or community groups.)” Response options were “0 teams,” “1 team,” “2 teams,” or “3 or more teams.” Students who selected a response other than “0 teams” were categorized as athletes; all other responses were categorized as nonathletes.

Data were weighted to yield nationally representative estimates. Prevalence estimates were computed overall and by grade (9th, 10th, 11th, or 12th), sex (male or female), race/ethnicity (non-Hispanic white, non-Hispanic black, or Hispanic),§ and athletic status (athlete or nonathlete). Estimates were also computed on the basis of the number of sports teams on which students participated (0, 1, 2, ≥ 3). Estimates with relative standard errors $> 30\%$ are not reported. Logistic regression models were fit, controlling for grade, sex, and race/ethnicity, to assess linear trends in tobacco use during 2001–2013, as well as measure the association between athletic status and tobacco use during each survey year.

Among U.S. high school students during 2001–2013, significant declines occurred in current use of any tobacco (33.9% to 22.4%) and combustible tobacco products (31.5% to 19.5%) ($p < 0.05$ for linear trend); no significant change was observed in current smokeless tobacco use (Table). During the same period, significant declines in current use of any tobacco product occurred among all subgroups (sex, grade, race/ethnicity, and athletic status), with the exception of 11th grade athletes. Significant declines in

†To ascertain past 30-day use of cigarettes, cigars, and smokeless tobacco, respondents were asked the following questions: 1) “During the past 30 days, on how many days did you smoke cigarettes?”; 2) “During the past 30 days, on how many days did you smoke cigars, cigarillos, or little cigars?”; and 3) “During the past 30 days, on how many days did you use chewing tobacco, snuff, or dip, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen?” Categorical response options to all three questions were “0 days,” “1 or 2 days,” “3 to 5 days,” “6 to 9 days,” “10 to 19 days,” “20 to 29 days,” or “all 30 days.” Students who provided a response other than “0 days” were categorized as current users of each respective product.

§Data are presented only for non-Hispanic white, non-Hispanic black, and Hispanic students because sample sizes for other race/ethnic groups were too small to provide statistically reliable estimates.

TABLE. Proportion of high school students who reported current any tobacco use, combustible tobacco use, or smokeless tobacco use, overall and by athletic status — Youth Risk Behavior Surveys, United States, 2001–2013

Population	Characteristics	Any tobacco use*				Combustible tobacco use†				Smokeless tobacco use‡			
		2001		2013		2001		2013		2001		2013	
		%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	Total	33.9	(31.9–36.0)	22.4	(20.0–25.0)[¶]	31.5	(29.7–33.4)	19.5	(17.5–21.7)[¶]	8.2	(6.8–9.9)	8.8	(7.3–10.6)
	Sex												
	Female	29.5	(27.4–31.7)	17.8	(15.3–20.7) [¶]	28.9	(26.7–31.1)	17.2	(14.8–19.8) [¶]	1.9	(1.5–2.4)	2.9	(2.0–4.2)
	Male	38.5	(36.0–41.1)	27.0	(24.4–29.8) [¶]	34.4	(32.3–36.4)	22.0	(19.9–24.1) [¶]	14.8	(12.2–18.0)	14.7	(12.3–17.5)
	Grade												
	9th	28.1	(24.9–31.5)	15.5	(13.1–18.1) [¶]	25.7	(22.8–28.9)	12.6	(10.6–14.9) [¶]	6.6	(5.0–8.7)	7.3	(5.7–9.4)
	10th	32.6	(29.5–35.9)	19.9	(17.3–22.8) [¶]	30.1	(27.3–33.0)	16.7	(14.5–19.3) [¶]	8.7	(7.1–10.6)	8.1	(6.5–10.2)
	11th	36.1	(32.4–40.1)	27.2	(22.3–32.7) [¶]	33.7	(30.0–37.6)	24.5	(20.3–29.2) [¶]	9.0	(7.1–11.4)	10.5	(7.5–14.3)
	12th	41.0	(37.1–45.1)	28.2	(25.3–31.4) [¶]	39.0	(35.2–42.9)	25.6	(22.9–28.5) [¶]	8.7	(6.9–10.9)	9.4	(7.9–11.2) [¶]
	Race/Ethnicity**												
	White, non-Hispanic	37.7	(35.5–40.0)	26.9	(23.9–30.2) [¶]	34.9	(33.0–36.8)	22.9	(20.3–25.7) [¶]	10.3	(8.5–12.5)	11.9	(10.0–14.1)
	Black, non-Hispanic	19.4	(16.6–22.6)	14.3	(11.8–17.2) [¶]	18.6	(15.6–22.0)	13.5	(11.1–16.4) [¶]	1.8	(1.2–2.7)	2.7	(1.9–3.8)
	Hispanic	29.4	(25.5–33.5)	18.0	(15.1–21.2) [¶]	28.8	(25.0–32.9)	16.2	(13.3–19.5) [¶]	4.1	(3.4–4.9)	5.6	(4.5–6.8)
Athletes^{††}	Total	32.8	(30.5–35.2)	22.0	(19.4–24.7)[¶]	29.7	(27.6–31.8)	18.0	(15.9–20.3)[¶]	10.0	(8.3–12.1)	11.1	(9.1–13.5)[¶]
	Sex												
	Female	26.7	(23.9–29.7)	14.6	(12.3–17.3) [¶]	25.9	(23.0–28.9)	13.5	(11.3–16.0) [¶]	2.2	(1.6–3.0)	3.4	(2.3–5.2) [¶]
	Male	38.1	(35.3–41.0)	28.1	(24.9–31.5) [¶]	32.9	(30.8–35.2)	21.7	(19.2–24.4) [¶]	16.8	(13.8–20.3)	17.4	(14.3–21.0) [¶]
	Grade												
	9th	26.8	(23.1–30.7)	15.5	(13.2–18.1) [¶]	23.9	(20.6–27.5)	11.4	(9.5–13.7) [¶]	7.2	(5.3–9.7)	8.9	(7.1–11.0)
	10th	31.3	(27.6–35.2)	19.5	(16.8–22.4) [¶]	27.9	(24.7–31.4)	15.1	(13.0–17.5) [¶]	10.9	(8.8–13.5)	10.2	(8.1–12.8)
	11th	36.2	(32.0–40.6)	27.5	(21.7–34.3)	33.0	(29.2–37.0)	23.3	(18.5–29.0) [¶]	11.8	(9.1–15.3)	13.6	(9.5–19.1) [¶]
	12th	41.4	(36.5–46.5)	27.9	(24.2–31.8) [¶]	38.2	(33.2–43.4)	24.6	(21.4–28.2) [¶]	11.1	(8.3–14.7)	12.2	(9.7–15.2) [¶]
	Race/Ethnicity**												
	White, non-Hispanic	35.7	(33.0–38.6)	25.5	(22.1–29.2) [¶]	31.8	(29.6–34.2)	20.0	(17.2–23.1) [¶]	12.0	(9.8–14.7)	14.3	(11.6–17.6)
	Black, non-Hispanic	19.0	(15.7–22.8)	14.8	(12.2–17.8) [¶]	18.3	(14.8–22.3)	13.7	(11.2–16.6) [¶]	2.8	(1.7–4.5)	3.7	(2.6–5.3)
	Hispanic	29.1	(25.1–33.4)	18.4	(15.0–22.3) [¶]	28.2	(24.2–32.7)	15.5	(12.5–19.1) [¶]	6.3	(4.9–8.1)	8.0	(6.4–9.9) [¶]
Nonathletes^{§§}	Total	35.1	(32.8–37.4)	22.7	(20.2–25.4)[¶]	33.7	(31.5–36.0)	21.3	(19.0–23.8)[¶]	5.9	(4.6–7.4)	5.9	(4.7–7.3)
	Sex												
	Female	32.3	(29.8–34.9)	20.6	(17.7–23.8) [¶]	31.8	(29.2–34.5)	20.4	(17.5–23.5) [¶]	1.5	(1.1–2.2)	2.3	(1.6–3.3)
	Male	39.0	(35.9–42.1)	25.4	(22.7–28.4) [¶]	36.4	(33.7–39.3)	22.6	(20.1–25.3) [¶]	11.8	(9.1–15.1)	10.6	(8.6–13.0)
	Grade												
	9th	29.6	(26.5–33.0)	15.6	(12.3–19.4) [¶]	28.2	(25.1–31.5)	14.4	(11.4–18.2) [¶]	5.5	(3.9–7.7)	5.1	(3.3–7.7)
	10th	34.2	(30.8–37.7)	19.6	(16.4–23.2) [¶]	32.6	(29.6–35.8)	18.5	(15.3–22.1) [¶]	6.1	(4.3–8.6)	4.8	(3.1–7.2)
	11th	36.0	(31.4–40.8)	26.7	(22.1–31.9) [¶]	34.3	(29.6–39.3)	25.4	(21.2–30.2) [¶]	5.5	(3.8–8.0)	7.0	(5.0–9.8)
	12th	40.8	(36.6–45.2)	28.6	(25.2–32.2) [¶]	39.9	(35.9–44.1)	26.5	(23.4–29.9) [¶]	6.3	(4.7–8.3)	6.6	(4.9–8.8)
	Race/Ethnicity**												
	White, non-Hispanic	40.2	(37.7–42.8)	28.4	(25.3–31.6) [¶]	38.8	(36.5–41.2)	26.3	(23.5–29.3) [¶]	7.9	(6.2–10.0)	8.5	(7.1–10.1)
	Black, non-Hispanic	19.7	(16.6–23.2)	13.6	(10.6–17.3) [¶]	18.7	(15.5–22.4)	13.2	(10.2–17.0) [¶]	^{¶¶}	^{¶¶}	1.3	(0.8–2.3)
	Hispanic	29.7	(25.6–34.2)	17.6	(14.3–21.5) [¶]	29.6	(25.6–33.9)	16.9	(13.5–20.9) [¶]	1.9	(1.2–2.9)	3.1	(2.1–4.5) [¶]

Abbreviation: CI = confidence interval.

* Current any tobacco use was defined as having smoked cigarettes or cigars, cigarillos, or little cigars, or having used smokeless tobacco (chewing tobacco, snuff, or dip) on ≥1 day during the 30 days before the survey.

† Current combustible tobacco use was defined as having smoked cigarettes or cigars, cigarillos, or little cigars on ≥1 day during the 30 days before the survey.

‡ Current smokeless tobacco use was defined as having used chewing tobacco, snuff, or dip on ≥1 day during the 30 days before the survey.

¶ Significant linear trend during 2001–2013 ($p < 0.05$). Although the table only presents data from the surveys in 2001 and 2013, data from the surveys in 2001, 2003, 2005, 2007, 2009, 2011, and 2013 were used in the trend analysis.

** Data are presented only for non-Hispanic white, non-Hispanic black and Hispanic students as sample sizes for other race/ethnic groups were too small to provide statistically reliable estimates.

†† Athletes were defined as students who played on at least one sports team, run by their school or community groups, during the 12 months before the survey.

§§ Nonathletes were students who did not play on a sports team during the 12 months before the survey.

¶¶ Estimate not presented because relative standard error >30%.

current use of combustible tobacco occurred among all subgroups (sex, grade, race/ethnicity, and athletic status). Significant increases in current smokeless tobacco use were observed among 12th grade students and athletes overall. Among athletes, significant increases

in current smokeless tobacco use were observed among both sexes, 11th- and 12th-grade students, and Hispanic students; among nonathletes, a significant increase was observed among Hispanic students only ($p < 0.05$ for linear trends).

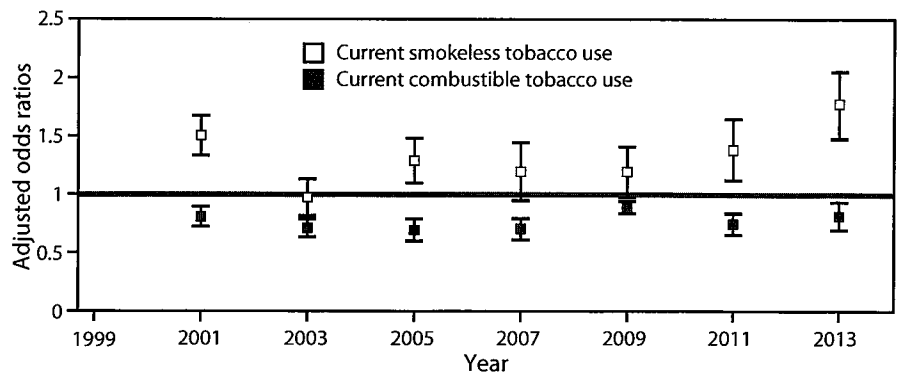
During 2013, the adjusted odds of current use of any tobacco, combustible tobacco, and smokeless tobacco were significantly higher among male students than female students, overall, and among athletes ($p < 0.05$). Among nonathletes, the odds of current use of any tobacco and smokeless tobacco were significantly higher among male students, whereas no sex difference was observed for combustible tobacco use. Students in 9th and 10th grades had significantly lower odds of current use of any tobacco and combustible tobacco than 12th grade students, overall as well as among athletes and nonathletes; however, with the exception of 9th grade athletes, no significant grade differences existed for current use of smokeless tobacco. Students in 11th grade did not differ significantly in current use of any tobacco, combustible tobacco, or smokeless tobacco compared with 12th grade students, overall or among athletes or nonathletes. Overall and among both athletes and nonathletes, non-Hispanic black and Hispanic students had significantly lower odds of current use of any tobacco, combustible tobacco, and smokeless tobacco compared with non-Hispanic white students, with one exception: Hispanic athletes did not differ significantly from non-Hispanic white athletes in current use of combustible tobacco.

Athletes had significantly lower adjusted odds of current combustible tobacco use than nonathletes during 2001–2013; conversely, athletes had significantly higher adjusted odds of current smokeless tobacco use than nonathletes in 2001, 2005, 2011, and 2013 ($p < 0.05$) (Figure 1). An inverse association between level of sports team participation and the prevalence of combustible tobacco use was identified; during 2013, prevalence of combustible tobacco use was 21.3%, 19.6%, 17.1%, and 15.8% among students participating in zero, one, two, or three or more sports teams, respectively ($p < 0.05$) (Figure 2). In contrast, a positive association between the level of sports team participation and the prevalence of smokeless tobacco use was identified; during 2013, prevalence of smokeless tobacco use was 5.9%, 10.2%, 11.5%, and 12.5% among students participating in zero, one, two, or three or more sports teams, respectively ($p < 0.05$).

Discussion

During 2001–2013, current use of smokeless tobacco increased significantly among high school athletes, but not among high school nonathletes; athletes reported higher use of smokeless tobacco, but lower use of combustible tobacco products than nonathletes. The lower use of combustible

FIGURE 1. Adjusted odds ratios,* with 95% confidence intervals, for current use of combustible[†] and smokeless[‡] tobacco products among high school athletes[¶] compared with nonathletes — Youth Risk Behavior Surveys, United States, 2001–2013



* Adjusted for grade, sex, and race/ethnicity in a binary logistic regression model. Adjusted odds ratios are for athletes, using nonathletes as the reference category.

[†] Current combustible tobacco use was defined as having smoked cigarettes or cigars, cigarillos, or little cigars on ≥ 1 day during the 30 days before the survey.

[‡] Current smokeless tobacco use was defined as having used chewing tobacco, snuff, or dip on ≥ 1 day during the 30 days before the survey.

[¶] Athletes were defined as students who played on at least one sports team, run by their school or community groups, during the 12 months before the survey. Nonathletes were students who did not play on a sports team during the 12 months before the survey.

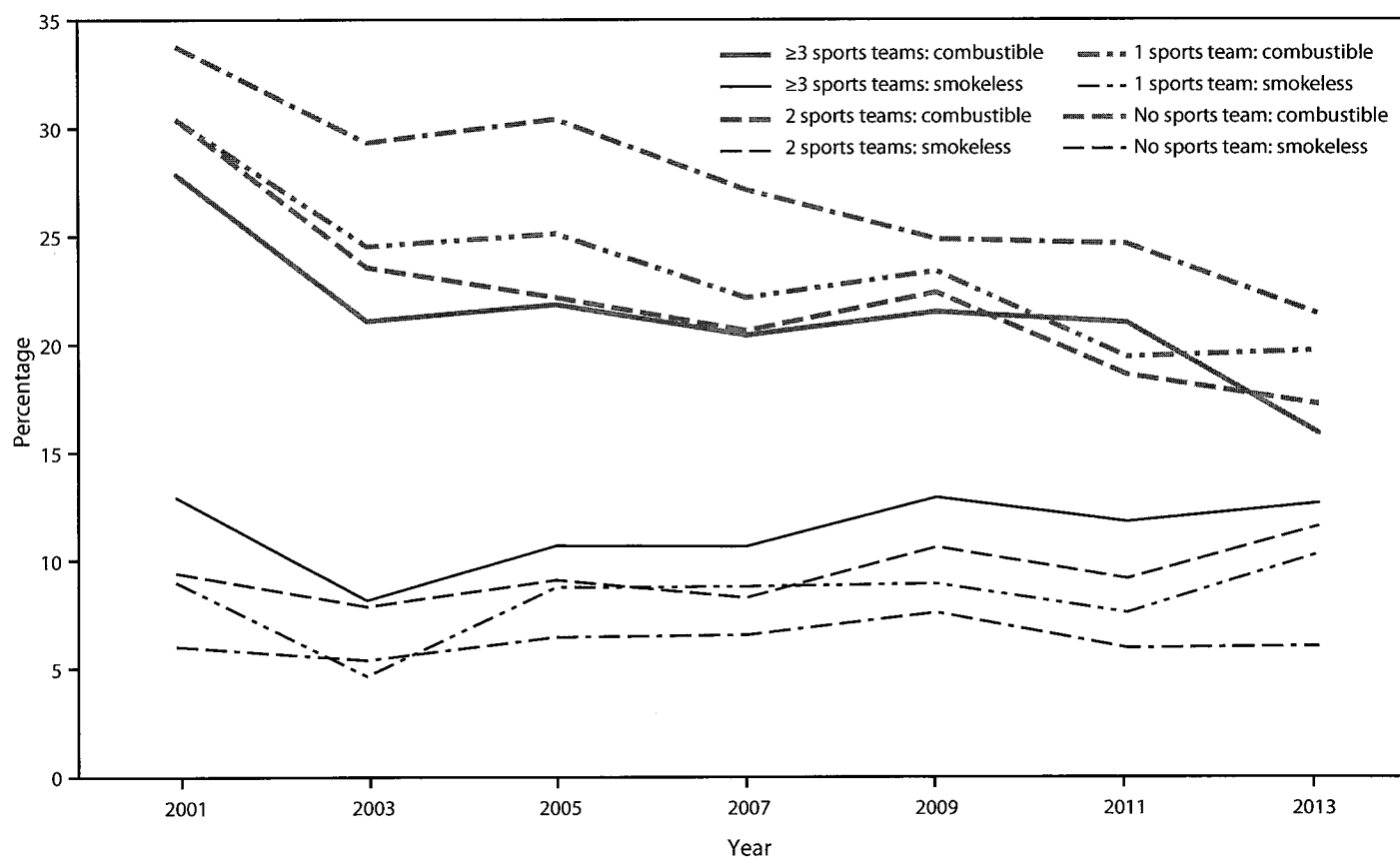
tobacco products among athletes might reflect an awareness of the adverse consequences of smoking on athletic performance, including reduced lung and cardiovascular function, reduced overall fitness, and poor wound healing (6). However, the higher smokeless tobacco use among athletes compared with nonathletes suggests athletes might perceive these products as being harmless, socially acceptable, or even a way to enhance athletic performance (3,7). Using smokeless tobacco products can adversely affect athletic performance and cause disease and premature death because they can contain nicotine, toxins, and carcinogens (4,6). For example, several professional U.S. athletes with a history of smokeless tobacco use have had a diagnosis of, or died from, oral cancer (8). Given that use of tobacco by youth in any form is unsafe, efforts are warranted to educate youth about the dangers of use of all forms of tobacco products, irrespective of whether they are combustible, noncombustible, or electronic (6).[¶]

The tobacco industry has marketed smokeless tobacco products as an alternative to cigarettes in situations where smoking is prohibited (9), which might further promote smokeless tobacco use among athletes. Although smokeless tobacco use is prohibited in minor league baseball, its use is restricted but not prohibited in major league baseball.^{**} Smokeless tobacco use among professional athletes is an important issue because they often are considered role models by youth (5). On May 8, 2015, San Francisco,

[¶] Additional information available at <http://cancercontrol.cancer.gov/brp/tcrb/global-perspective/index.html>.

^{**} Additional information available at http://mlb.mlb.com/mlb/downloads/2011_CBA.pdf.

FIGURE 2. Percentage of high school students who reported current use of combustible tobacco* and smokeless tobacco,† by extent of sport team participation§ — Youth Risk Behavior Surveys, United States, 2001–2013



* Current combustible tobacco use was defined as having smoked cigarettes or cigars, cigarillos, or little cigars on ≥ 1 day during the 30 days before the survey.

† Current smokeless tobacco use was defined as have used chewing tobacco, snuff, or dip on ≥ 1 day during the 30 days before the survey.

§ Extent of sport participation was defined with the question "During the past 12 months, on how many sports teams did you play? (Count any teams run by your school or community groups.)" Response options were "0 teams," "1 team," "2 teams," or "3 or more teams."

California, became the first U.S. city to pass a law prohibiting the use of smokeless tobacco at all baseball venues and athletic fields, effective January 1, 2016.^{††} The city of Boston, Massachusetts has also proposed an ordinance prohibiting smokeless tobacco use at all professional and amateur sports venues in Boston.^{§§} Implementing and enforcing tobacco-free policies that prohibit all tobacco use on school campuses and at all public recreational facilities, including stadiums, parks, and school gymnasiums, by players, coaches, referees, and fans might help reduce tobacco use among student athletes (5). In addition to tobacco-free policies, continued implementation of other population level, evidence-based interventions outlined in the CDC *Best Practices for Comprehensive Tobacco Control Programs*^{¶¶} is also critical to

reducing all forms of tobacco use among youth; these interventions include increasing tobacco product prices, warning about the dangers of tobacco use, and increasing access to tobacco use cessation resources.

The differences in tobacco use among population subgroups (overall and among athletes), including the higher prevalence of both combustible tobacco and smokeless tobacco use among male students, non-Hispanic white students, and students in 11th and 12th grade, might be related to dissimilarities among these groups in socialization with tobacco-using peers, exposure and receptivity to pro-tobacco advertising, and targeted marketing of tobacco products by the tobacco industry (5).

The findings in this report are subject to at least six limitations. First, sports team participation and tobacco use were self-reported and might be subject to misreporting of tobacco use, which could lead to under- or overestimating tobacco use, as well as misclassification of athlete status (e.g., respondents who engaged fitness activities, but did not play on a school or community team would

†† Additional information available at https://www.tobaccofreekids.org/press_releases/post/2015_05_08_baseball.

§§ Additional information available at http://tobaccofreebaseball.org/content/press-release-08_05_15/.

¶¶ Additional information available at http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/comprehensive.pdf.

Summary

What is already known on this topic?

Athletes might be more likely to use certain tobacco products, such as smokeless tobacco, if they perceive them to be harmless; however, smokeless tobacco use is not safe, and is associated with increased risk for oral, esophageal, and pancreatic cancers.

What is added by this report?

Data from national Youth Risk Behavior Surveys indicate that current (≥ 1 day during the past 30 days) use of any tobacco product by U.S. high school students declined from 33.9% in 2001 to 22.4% in 2013; however, current smokeless tobacco use increased from 10.0% to 11.1% among high school athletes. Compared with nonathletes, athletes had higher odds of being current smokeless tobacco users, but lower odds of being current combustible tobacco users.

What are the implications for public health?

Tobacco education programs tailored to high school athletes, coupled with other population-level, evidence-based interventions, have the potential to increase awareness of the harmfulness of all tobacco products and reduce all forms of tobacco use, including smokeless tobacco, among youth.

have been classified as nonathletes). Second, the prevalence of tobacco use among athletes and nonathletes might be underestimated since emerging smokeless tobacco products (e.g., snus [a smokeless tobacco product developed in Sweden], electronic cigarettes, hookah, and dissolvable tobacco) were not assessed. Third, differential time frames in assessing current tobacco use (past 30 days) and sports team participation (past 12 months) might miss seasonal patterns of tobacco use (e.g., tobacco use patterns during a sports season might differ from off-season use among athletes). Fourth, tobacco use by type of sport could not be assessed, because these data were not collected. Fifth, although the data were weighted to adjust for school and student nonresponse and the distribution of students by grade, sex, and race/ethnicity in each jurisdiction, nonresponse bias is possible and might have affected the results. Finally, these data apply only to youth who attend school and are not representative of all youth, including those who are homeschooled or who have dropped out of school nationwide. However, in 2013, 96.1% of U.S. youth aged 14–17 years were enrolled in traditional schools (10); thus, the extent of any bias from this exclusion is likely minimal.

Sports activities present opportunities to reach young persons with public health interventions.*** Tobacco education programs tailored to high school athletes, coupled with other population-level evidence-based interventions, have the potential to increase awareness of the dangers of tobacco use and to reduce the use of all forms of tobacco, including smokeless tobacco, among youth.

*** Additional information available at <http://www.cdc.gov/tobacco/youth/sports>.

¹Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC; ²Epidemic Intelligence Service, CDC; ³Division of Adolescent and School Health, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC.

Corresponding author: Israel Agaku, Iagaku@cdc.gov, 770-488-5138.

References

1. Terry-McElrath YM, O'Malley PM, Johnston LD. Exercise and substance use among American youth, 1991–2009. *Am J Prev Med* 2011;40:530–40.
2. Severson HH, Klein K, Lichtensein E, Kaufman N, Orleans CT. Smokeless tobacco use among professional baseball players: survey results, 1998 to 2003. *Tob Control* 2005;14:31–6.
3. Walsh MM, Ellison J, Hilton JF, Chesney M, Ernster VL. Spit (smokeless) tobacco use by high school baseball athletes in California. *Tob Control* 2000;9(Suppl 2):II32–9.
4. International Agency for Research on Cancer. IARC monographs on the evaluation of carcinogenic risks to humans: personal habits and indoor combustions. Vol. 100E. Lyon, France: International Agency for Research on Cancer, World Health Organization; 2012. Available at <http://monographs.iarc.fr/ENG/Monographs/vol100E/index.php>.
5. US Department of Health and Human Services. Preventing tobacco use among youth and young adults: a report of the surgeon general. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2012.
6. US Department of Health and Human Services. The health consequences of smoking: 50 years of progress: a report of the surgeon general. Atlanta, GA: US Department of Health and Human Services, CDC; 2014. Available at <http://www.surgeongeneral.gov/library/reports/50-years-of-progress>.
7. Myers KA. Cigarette smoking: an underused tool in high-performance endurance training. *CMAJ* 2010;182:E867–9.
8. The Oral Cancer Foundation. Sports figures. Newport Beach, CA: The Oral Cancer Foundation; 2014. Available at <http://www.oralcancerfoundation.org/people/sports-figures.php>.
9. Carpenter CM, Connolly GN, Ayo-Yusuf OA, Wayne GF. Developing smokeless tobacco products for smokers: an examination of tobacco industry documents. *Tob Control* 2009;18:54–9.
10. US Census Bureau. School enrollment: current population survey 2013 [detailed tables]. Washington, DC: US Census Bureau. Available at <https://www.census.gov/hhes/school/data/cps/2013/tables.html>.

16th FL

THE COUNCIL THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____
 in favor in opposition

Date: _____

(PLEASE PRINT)

Name: Hisha Morg

Address: 1933 Bath Ave, BK NY 11214

I represent: Muslim American Society

Address: 1933 Bath Ave, BK NY 11214

THE COUNCIL THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 11 Res. No. _____
 in favor in opposition

Date: _____

(PLEASE PRINT)

Name: Michael Davoli

Address: _____

I represent: American Cancer Action Network

Address: _____

THE COUNCIL THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1066 Res. No. _____
 in favor in opposition

Date: _____

(PLEASE PRINT)

Name: KEVIN O'FLAHERTY

Address: 1400 I STREET NW, #1200 WASH DC 20005

I represent: CAMPAIGN FOR TOBACCO-FREE KIDS

Address: _____

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. 1068 Res. No. _____

in favor in opposition

Date: _____

(PLEASE PRINT)

Name: ROBERT ARENA

Address: 2155 EAST 72ND STREET BROOKLYN, NY

I represent: SELF 11234

Address: _____

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. 1068 Res. No. _____

in favor in opposition

Date: 2/25/16

(PLEASE PRINT)

Name: Robin Vitale

Address: _____

I represent: American Heart Association

Address: 122 E. 42nd St 18th Floor, NY NY

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. 139-A Res. No. _____

in favor in opposition

Date: _____

(PLEASE PRINT)

Name: Deidre Sully

Address: _____

I represent: NYC Smoke-Free at Public Health Solutions

Address: 40 Worth Street 5th Fl NY, NY 10013

Please complete this card and return to the Sergeant-at-Arms

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. A11 Res. No. _____

in favor in opposition

Date: 2/25/16

(PLEASE PRINT)
Name: MICHAEL SEILBICK

Address: 134 Council Dr Council NY 11222

I represent: AMERICAN LUNG ASS'N

Address: 21 W 38th St NY NY

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. 139A Res. No. _____

in favor in opposition

Date: 2/25/16

(PLEASE PRINT)
Name: Michael Weitzman MD

Address: NY 50th Park Ave

I represent: Michael Weitzman

Address: same as above

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. 1068-2016 Res. No. _____

in favor in opposition

Date: _____

(PLEASE PRINT)
Name: Karen Blumenfeld

Address: Summit NJ

I represent: Global Advisors on Smokefree Policy

Address: Summit NJ

◆ Please complete this card and return to the Sergeant-at-Arms ◆

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. 1068 Res. No. _____

in favor in opposition

Date: 2/25/16

(PLEASE PRINT)

Name: Robert Arena
Address: 2155 East 72nd Street Brooklyn, NY 11234
I represent: Brooklyn Baseball Association
Address: 2155 East 72nd Street Brooklyn, NY 11234

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. 1068 Res. No. _____

in favor in opposition

Date: 2-25-2016

(PLEASE PRINT)

Name: Patrick Kwon
Address: 40 Worth St NY NY 10013
I represent: NYC Smoke Free
Address: _____

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

in favor in opposition

Date: 2.25

(PLEASE PRINT)

Name: Dan Kossill
Address: _____
I represent: NYC Dept of Health
Address: _____

Please complete this card and return to the Sergeant-at-Arms

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

in favor in opposition

Date: 2.25

Name: KEVIN SCHROTH (PLEASE PRINT)

Address: _____

I represent: NTC Dept of Health

Address: _____

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

in favor in opposition

Date: 2.25

Name: ROMAN ROMAN (PLEASE PRINT)

Address: _____

I represent: NTC Dept of Health

Address: _____

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

in favor in opposition

Date: 2.25

Name: MOHAMMED BASHIR (PLEASE PRINT) 8

Address: 4111 20 AVG ASTORIA NY 1103

I represent: RENTAL UNIT / KASLOVA LUGER

Address: 244 E 51 ST NY 10022

Please complete this card and return to the Sergeant-at-Arms

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. ⁰¹³⁹⁻²⁰¹⁴ Res. No.

in favor in opposition

Date: 2-25-16

(PLEASE PRINT)

Name: Ariel Ferreira

Address: 560 w 181st Street 2nd Floor NY, NY 10033

I represent: 40 Restaurant, Bar, and Night Club Owners

Address:

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. Res. No.

in favor in opposition

Date: 2/25/16

(PLEASE PRINT)

Name: Ramsey Joudet

Address: 466 Bay Ridge Ave

I represent: AAANY

Address: 711 5th Ave Bklyn, NY

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. Res. No.

in favor in opposition

Date: 2/25/16

(PLEASE PRINT)

Name: HABIB JONDEH

Address: 6914 54th Ave Bklyn. NY 11209

I represent: AAANY. PHARMACY on 4th St

Address: 6914 54th Ave Bklyn NY 11209

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

in favor in opposition

Date: 2/25/2016

(PLEASE PRINT)

Name: Dr Ahmad Jaber

Address: 711 5th Ave Brooklyn 11209

I represent: AAANY

Address: 711 5th Ave Brooklyn 11209

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 139-A 617, 1068 Res. No. 1073, 11076

in favor in opposition

Date: 2-25-16

(PLEASE PRINT)

Name: WALTER DROBENKO, ESQ

Address: 25-84 STEINWAY STREET
ASTORIA, NY 11103

I represent: AMERICAN HOOKAH ASSOCIATION

Address: 25-84 STEINWAY ST. ASTORIA, NY 11103

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

in favor in opposition

Date: _____

(PLEASE PRINT)

Name: Phil Konigsberg

Address: Bay Terrace

I represent: Queens Tobacco Control Coalition

Address: _____

Please complete this card and return to the Sergeant-at-Arms

16th FL

THE COUNCIL THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____
 in favor in opposition

Date: _____

(PLEASE PRINT)

Name: Mahmoud Mokhtar

Address: 7122 Ridgsc Blvd #2 Brooklyn

I represent: Horus Cafe

Address: 293 E 10th Street, NY, NY, 10009

16th FL

THE COUNCIL THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____
 in favor in opposition

Date: 2/25/16

(PLEASE PRINT)

Name: P. Adem Carra VI

Address: see below

I represent: Nafis Salaam Muslims against Smoking

Address: 44-10 25 Ave Astoria NY 11103

16th FL

THE COUNCIL THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. B9A Res. No. _____
 in favor in opposition

Date: _____

(PLEASE PRINT)

Name: Josephine Beckmann

Address: CB 10 8119 5 Ave

I represent: Community Board Ten

Address: 8119 5 Ave