Appendix 14.1
Tobacco Control Efforts in the Department of Defense

Tobacco Control Efforts in the Department of Defense

During the past 50 years, the U.S. Department of Defense's (DoD's) stance on tobacco has shifted markedly. A widespread perception, even today, is that the U.S. military promotes tobacco use, either subtlety or directly. However, although tobacco use was encouraged in the middle of the twentieth century (e.g., minipacks of cigarettes in K-rations until 1975) (Smith et al. 2007) and tolerated well into the 1980s, the antitobacco use tide turned in the late 1990s as evidence of the immediate health and readiness consequences of smoking started to emerge. Cigarettes were banned from all military rations in 1975 (Smith and Malone 2009a). All federal buildings became smokefree in 1997 (Executive Order 13058). Between 1985 and 2001, both DoD and Congress attempted to increase commissary cigarette prices, but these efforts were largely thwarted by the tobacco industry (Smith et al. 2007). Finally in 2001, DoD Directive 1330.9 established that tobacco prices on U.S. military bases should be "no lower than 5 percent below the most competitive commercial price in the local community" (Smith et al. 2007). Sadly, even with this policy, a recent investigation of pricing differences between 145 matched Walmart stores and military exchanges found that the average savings at an exchange was 25.4% (Jahnke et al. 2011).

Awareness of the impact of tobacco on mission readiness continues to drive expanded tobacco control policies. A recent Action Memo by Assistant Secretary of the Navy (Manpower and Reserve Affairs) Juan M. Garcia addressing tobacco use in the U.S. Department of the Navy recommended: (1) supplies of nicotine replacement therapy on ships, base clinics and pharmacies, and battalion aid stations to ensure availability to sailors and Marines; (2) adjusting the price of tobacco products sold in Navy and Marine Corps exchanges to match prices in the commercial sector and, thereby, end the 5% discount permitted by DoD policy; and (3) initiating the development and dissemination of information and education campaigns for smoking cessation, even during Navy and Marine Corps recruit training. The Secretary of the Navy issued a memo executing these policies on March 2, 2012 (Mabus 2012).

Despite the continued struggles with pricing, many DoD installations have expanded tobacco control policies extending the number of tobacco-free installations (Joseph et al. 2005). For example, the U.S. Air Force has prohibited tobacco use, virtually everywhere, on an Air Force installation with the exception of designated tobacco areas. Tobacco use outside of designated tobacco areas, including while walking anytime outside of designated tobacco areas, is prohibited (U.S. Air Force 2012b).

One important event that has influenced the DoD even further against tobacco use was the Institute of Medicine (IOM) report on smoking in the military and veteran populations (IOM 2009). Citing extensive research, the IOM concluded, among other things, that tobacco negatively affects "military readiness." Readiness is, in essence, the ability to do one's job in peace and war conditions. Readiness is the single most important metric in the DoD. As such, tobacco use has been included as a behavior that negatively affects readiness, along with obesity and at-risk drinking behaviors (IOM 2009). The report recommended that tobacco use should be prohibited anywhere on military installations. Following the publication of this report, restrictions on the use of tobacco products in Air Force facilities has been expanded, and e-cigarettes have also been classified as tobacco products on Air Force hospital grounds (inside and outside) (U.S. Air Force 2012b).

Table 14.1.1 lists the DoD-wide tobacco policies and documents that reflect just how "tobacco unfriendly" contemporary military bases are, although it is not clear what agency or agencies have regulatory control over these policies. As such, it is unclear how rigorously these policies are enforced. It should be noted that these are DoD policies and are in place across all of the U.S. Armed Services (Air Force, Army, Coast Guard, Marines, and Navy).

The military is both an understudied and vulnerable population. Less than 1% of tobacco-related publications include information on the military population (IOM 2009). Despite the very high prevalence of tobacco use (IOM 2009), tobacco control efforts in the U.S. military have received little attention. In addition to a high prevalence of tobacco, the prevalence of adult onset tobacco use is markedly high in the first year following entry into military service (Klesges et al. 1999, 2006). Understanding tobacco use patterns and methods for reducing the tobacco problem in the military should be the focus of careful study in the future.

Table 14.1.1 Department of Defense (DoD) policies and regulatory mandates

(1)	No tobacco product in any workplace buildings, any internal "spaces," DoD vehicles, aircraft, or naval vessels. This includes e-cigarettes and all new and emergent tobacco products.
(2)	Tobacco products sold in commissaries must be within 5% of the price sold in local retail establishments.
(3)	Suitable, uniform signs reading "Designated Smoking Area" must be furnished and installed by the occupant agency. As mentioned above, these are called "smoke pits" and are typically located long walks from the duty area and are in undesirable places (e.g., often next to trash dumpsters).
(4)	Military retail outlets will not enter into any merchandise display or promotion agreements.
(5)	Self-service promotion displays will not be used outside the tobacco department.
(6)	There shall not be "military only" coupons or other promotions unique to the military.
(7)	Military retail outlets will not increase total tobacco shelf-space.
(8)	Military treatment facilities and hospitals are completely tobacco free. This includes parking lots and any indoor or outdoor space on the hospital grounds.
(9)	No tobacco vending machines are allowed anywhere on any military base.
(10)	Advertisements of tobacco products are prohibited in all official print and electronic publications.
(11)	Distribution of tobacco samples on the installation is prohibited. No "samples" of products are allowed and no discount coupons are allowed. This includes smokeless tobacco and all new and emergent tobacco (e.g., e-cigarettes). This policy is more aggressive than the *Family Smoking Prevention and Tobacco Control Act* of 2009, which allows the distribution of certain free tobacco products.

Source: U.S. Department of Defense 2003, 2005a,b; U.S. Air Force 2004, 2009, 2012a,b; U.S. Navy 2008; 41 *Code of Federal Regulations,* Part 102-74, 2011.

Tobacco Prevalence in the U.S. Military

The military has had a reputation as an environment where tobacco use is accepted and even encouraged (Bray et al. 2010). In fact, in 1980 more than 50% of military personnel reported using cigarettes in the past 30 days (Bray et al. 2009). The rate of smoking steadily declined to 30% by 1998, but increased to 34% in 2002 and has remained static since then. Smokeless tobacco use actually increased in 2002 from 12–15% and has remained stable at this very high level (Bray et al. 2009). Although progress has been made, tobacco use in the military remains a serious problem.

Across the military services, the Marines have the highest prevalence of tobacco use at 37% and the Air Force has the lowest at 23% (Bray et al. 2009). The prevalence of past 30-day cigarette use is associated with age, with younger military personnel (18–25 years of age) having the highest prevalence of tobacco use (38%) and older military personnel (46–64 years of age) having the lowest prevalence of tobacco use (11%). Although younger military personnel report a higher prevalence of past 30-day cigarette use compared with a civilian comparison group (38% vs. 34%), older military personnel report significantly lower past 30-day cigarette use than a civilian comparison group (11% vs. 18%). Rank in the military is characterized by pay grades from the lowest enlisted rank (E1) to the highest (E9) and the same for officers from officer rank O1 to O10. For all services, the rate of current smoking (30-day point prevalence) was highest among the lowest pay grades (E1–E3 = 40%) with the lowest prevalence in the highest officer rank (O4–O10 = 5%). Higher rates of smoking for junior and midlevel enlisted personnel compared to other pay grades is consistent across services (Bray et al. 2009).

Those military personnel who use tobacco products (cigarettes, smokeless tobacco, cigars, and pipes) were more likely to believe that their supervisors were tobacco users (Bray et al. 2009). Of military personnel who smoke, almost one-third (30%) report that they started smoking_after joining the military. In addition, 14% of males between 18–55 years of age reported that they started using smokeless tobacco after joining the military (Bray et al. 2009).

The deployed environment (i.e., serving outside the continental United States) has been identified as a potential critical contributing factor to tobacco use (Talcott et al. 2013). In June 2001 (preceding the September 11, 2001, attacks), the United States had approximately 26,000 military personnel stationed in the U.S. Central Command region, which encompasses Afghanistan, Iraq, and neighboring areas (Belasco 2009). Since that time, more than 800,000 military personnel have deployed to this region multiple times (Tan 2009). A recent study (Talcott et al. 2013) conducted a longitudinal investigation of 278 U.S. Air Force Security Forces who were assigned to a 365-day deployment to Iraq to train Iraqi police transition teams, a high-risk "outside the wire" (e.g., outside the safe confines of the military base) mission. Airmen reported on their cigarette and smokeless tobacco use prior to, during, and post-deployment (6–9 months). These airmen had a high prevalence of tobacco use before deployment (>50%). During the transition from pre-deployment to active deployment to a combat zone, 1 in 6 airmen (16.9%) either initiated use of tobacco or engaged in increased use of tobacco. Only a small percentage (4.9%) either stopped or decreased the amount of tobacco used. Finally, Talcott and colleagues (2013) reported that although there were increases in tobacco use during deployment, there were also decreases in tobacco use from deployment to post-deployment, lending support to the belief that tobacco is used as a coping strategy in the deployed environment to manage stress and boredom (Poston et al. 2008). In summary, consistent with previous investigations (Forgas et al. 1996; Boos and Croft et al. 2004; DiNicola et al. 2006; Smith et al. 2008; Hermes et al. 2012), military personnel increase or initiate tobacco use during deployment. However, there appears to be a concomitant decrease in tobacco use upon return home (post-deployment) (Talcott et al. 2013). Clearly, further research is needed to identify the contribution of deployments to the overall prevalence of tobacco use in military personnel.

Tobacco Company Influences on Tobacco Use in U.S. Military

Tobacco use is still prevalent in the military, despite the official DoD policy of strongly discouraging tobacco use, including prolonged and efficacious total tobacco bans during training (Klesges et al. 1999, 2006). However, the tobacco industry continues to reach this vulnerable military population, such as through the placement of a coupon inside the cigarette carton when external coupons/promotions were prohibited (Stirlen 1994). Additionally, the industry has sent smokeless tobacco to Marines in Iraq while maintaining that it was not a violation of the policy against distribution of free tobacco product samples because they "responded to direct requests from troops" (Elliott 2003). Further, in response to tobacco advertising regulations, the tobacco industry has turned to promotional opportunities in adult-only venues such as bars and pubs (Katz and Lavack 2002), particularly those near military bases as stated in one marketing report, "...it seems the venues located in close proximity to the bases attract a large crowd of demographically desirable consumers" (National Field Marketing Report 1992).

In recent years, the tobacco industry has increasingly focused on targeted marketing in commercial magazines that are attractive to the military (e.g., *Air Force Times)* (Haddock et al. 2009). Note that the ownership of these magazines is independent from the military and cannot be controlled by the DoD. The full extent of tobacco industry marketing strategies for existing or new and emerging tobacco products that target military populations is still unknown, however.

A few examples will give a true sense of the military-targeted tobacco marketing: (1) Industry members believe "there is no other market in the country that has the sales potential of the military" and "the plums are here to be plucked" (Smith and Malone 2009b); (2) Phillip Morris' advertising firm, Leo Burnett, reported that the world military market was a "force to be reckoned with" since its size could be compared to the second largest U.S. city, it had a large concentration of young adult males, and was an "economic giant." In addition to the young demographics of military personnel, the military community is a lucrative market because of the socioeconomic and cultural profiles of military recruits. The report added, "One half million military personnel filter back into the civilian market every year, product preferences and all… And that's just one reason why the military market… is an important market…" (Joseph et al. 2005); and (3) As American troops were deployed to Saudi Arabia in August 1990, Philip Morris sent 10,000 cartons of Marlboro cigarettes via the 82nd Airborne Division from Pope Air Force Base in North Carolina. An internal document added, "We will be everywhere the soldier is…" (Smith and Malone 2009a).

Every service branch (Air Force, Army, Coast Guard, Marines, and Navy) has a form of basic military training (BMT) ranging from 8½ to 14 weeks during which all trainees are tobacco- and alcohol-free (IOM 2009). However, although these military personnel are tobacco-free and the no-smoking policy during BMT is efficacious in promoting cessation in those who smoked before BMT (Klesges et al. 1999, 2006), after the end of BMT the pattern of tobacco use changes quickly. This change takes place even though

recently collected data indicate that nearly 80% of former tobacco users in military training intend to stay tobacco-free (n = 8904) (Klesges et al. unpublished data collected in 2012 and 2013). Not only is there considerable relapse in former smokers but also a marked initiation use of tobacco products as well: 82% of former smokers, smokeless tobacco users, and dual tobacco users resume tobacco use within 1 year and another 17% of previous nontobacco users adopt regular use of cigarettes, smokeless tobacco, or cigars during the same period of time (Klesges et al. 1999, 2006). Although there is a slight upward increment in civilian tobacco initiation rates in this age group, the rapid uptake seen in former nontobacco users in the military is far greater (Freedman et al. 2012).

A common tactic for tobacco companies, as indicated above, is to give military personnel either free cigarettes or smokeless tobacco products (Elliott 2003; Proctor 2011). However, the *Family Smoking Prevention and Control Act* (2009) now prohibits the free distribution of cigarettes and restricts the distribution of free smokeless tobacco (U.S. Food and Drug Administration [USFDA] 2013). Tobacco companies may have avoided the ban on free cigarettes by distributing discount coupons. Brock and Moilanen (2012) reported that of 660 tobacco direct-mail pieces, 87% (n= 574) had discount coupons in the mailers. The average coupon was $3.99 with coupons as high as $25.00. Currently, there are no restrictions on such coupons, and the tobacco companies can, in essence, give away their products through couponing.

Summary

Given that officers in the U.S. military have very low rates of tobacco use in general (5%) (Bray et al. 2009), a tobacco-free military leadership is certainly viable and possible. Because officers are seen as role models for enlisted personnel, the resultant trickle down effect on rates of tobacco use by enlisted personnel is likely not to be trivial. Simultaneously, all military installations could strive to become completely tobacco-free.

Despite the development of strong tobacco control policies, including tobacco-free installations, these efforts are diluted when tobacco products are deeply discounted and readily available. Because Congress has oversight for commissaries, it is very difficult for the services to regulate pricing (Smith et al. 2007). Prices for tobacco products on military installations should be as high as the civilian sectors, thus eliminating discounted tobacco.

Although the military is both an underserved and vulnerable population, very little research on tobacco control in the military has been conducted. For example, although some tobacco cessation programs in the military have been successful, tobacco initiation in the military is common, and no intervention study has been successful at preventing this initiation (Klesges et al. 1999, 2006).

Tobacco use in deployed (i.e., not in the continental United States) military personnel has increased (Poston et al. 2008), although it is unclear through longitudinal research whether this increase is permanent (Talcott et al. 2013). Increased use of distance-based interventions (e.g., tobacco quit lines, Web-based interventions) could benefit those in deployed settings, many of whom are at risk for combat- and stress-related tobacco initiation.

Given that all service arms of the DoD have BMT and all require trainees to be tobacco-free, methods for maintaining this abstinence (8 ½–14 weeks, depending on the service branch) should be developed.

Although the military is largely made up of young males, which is the demographic most likely to use tobacco, there are also active tobacco company influences that aggressively campaign and target the military. While the smoking prevalence rates of military personnel entering the military are already high (Klesges et al. 1999, 2006), some tobacco initiation occurs after individuals join military service. More intensive antitobacco efforts are needed, not only in DoD but also in agencies whose missions include health promotion and disease prevention (e.g., National Institutes of Health, FDA, Centers for Disease Control and Prevention) for the young men and women who serve and sacrifice for our nation.

References

41 *Code of Federal Regulations*, Part 102-74, 2011.

Belasco A. *Troop Levels in the Afghan and Iraq Wars, FY2001–FY2012: Cost and Other Potential Issues*. Washington: Library of Congress, Congressional Research Service, 2009. CRS Report R0682.

Boos CJ, Croft AM. Smoking rates in the staff of a military field hospital before and after a wartime deployment. *Journal of the Royal Society of Medicine* 2004; 97(1):20–2.

Bray RM, Spira JL, Olmstead KR, Hout JJ: Behavioral and occupational fitness. *Military Medicine* 2010;175 (Suppl 1):39–56.

Bray RM, Pemberton MR, Hourani LL, Witt M, Olmsted KLR, Brown JM, Weimer B, Lane ME, Marsden ME, Scheffler S, et al. *2008 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel: A Component of the Defense Lifestyle Assessment Program (DLAP)*. Research Triangle Park (NC): RTI International, 2009; <http://www.tricare.mil/tma/2008HealthBehaviors.pdf>; accessed: January 10, 2014.

Brock B, Moilanen M. Tracking and exposing tobacco industry marketing: How the tobacco industry uses direct mail marketing. Presentation at the National Conference on Tobacco on Health; August 15, 2012; Kansas City (MO).

DiNicola AF, Stanton EL, Destfino DR. Cigarette smoking among enlisted military personnel during deployment. *Military Medicine* 2006;171(6):v–vi.

Elliott S. The media business: advertising—addenda; Congress examines tobacco donations. *The New York Times* June 19, 2003; <http://www.nytimes.com/2003/06/19/business/the-media-business-advertising-addenda-congress-examines-tobacco-donations.html>; accessed: January 10, 2014.

Executive Order 13058, 3 *C.F.R.* 216 (1997), *reprinted in* 5 U.S.C. § 7301.

Family Smoking Prevention and Tobacco Control Act, Public Law 111-31, 123 *U.S. Statutes at Large* 1776 (2009).

Forgas LB, Meyer DM, Cohen ME. Tobacco use habits of naval personnel during Desert Storm. *Military Medicine* 1996;161(3):165–8.

Freedman KS, Nelson NM, Feldman LL. Smoking initiation among young adults in the United States and Canada, 1998-2010: a systematic review. *Preventing Chronic Disease* 2012;9:E05.

Haddock CK, Taylor JE, Hoffman KM, Poston WS, Peterson A, Lando HA et al. Factors which influence tobacco use among junior enlisted personnel in the United States Army and Air Force: a formative research study. *American Journal of Health Promotion* 2009;23(4):241–6.

Hermes ED, Wells TS, Smith B, Boyko EJ, Gackstetter GG, Miller SC, et al. Smokeless tobacco use related to military deployment, cigarettes and mental health symptoms in a large, prospective cohort study among US service members. *Addiction* 2012;107(5):983–94.

Institute of Medicine. *Combating Tobacco in Military and Veteran Populations*. Washington: National Academies Press, 2009.

Jahnke SA, Haddock CK, Poston WS, Hyder ML, Lando H. A national survey of cigarette prices at military retail outlets. *JAMA: the Journal of the American Medical Association* 2011;306(22):2456–7.

Joseph AM, Muggli M, Pearson KC, Lando H. The cigarette manufacturers' efforts to promote tobacco to the U.S. military. *Military Medicine* 2005;170(10):874–80.

Katz SK, Lavack AM. Tobacco related bar promotions: insights from tobacco industry documents. *Tobacco Control* 2002;11(Suppl 1):I92–I101.

Klesges RC, DeBon M, Vander Weg MW, Haddock CK, Lando HA, Relyea GE, Peterson AL, Talcott GW. Efficacy of a tailored tobacco control program on long-term use in a population of U.S. military troops. *Journal of Consulting and Clinical Psychology* 2006;74(2):295–306.

Klesges RC, Haddock CK, Lando H, Talcott GW. Efficacy of forced smoking cessation and an adjunctive behavioral treatment on long-term smoking rates. *Journal of Consulting and Clinical Psychology* 1999;67(6):952–8.

Mabus R. Tobacco Cessation in the Department of the Navy, March 2, 2012; <http://www.med.navy.mil/sites/nmcphc/Documents/health-promotion-wellness/tobacco-free-living/sec-navy-memo-tobacco-cessation.pdf>; accessed: January 10, 2014.

National Field Marketing Corp. *Virginia Test Market Final Report, Kool Bar Promotion.* 1992. Brown & Williamson Collection. Bates No. 300119932/9971. <http://legacy.library.ucsf.edu/tid/wtc40f00>.

Poston WS, Taylor JE, Hoffman KM, Peterson AL, Lando HA, Shelton S, Haddock CK. Smoking and Deployment: Perspectives of Junior-Enlisted U.S. Air Force and U.S. Army Personnel and Their Supervisors. *Military Medicine*. 2008; 173(5): 441-447.

Proctor RN. *Golden Holocaust: Origins of the Cigarette Catastrophe and the Case for Abolition*. Berkeley (CA): University of California Press, 2011.

Smith B, Ryan MAK, Wingard DL, Patterson TL, Slymen DJ, Macera CA, et al. Cigarette smoking and military deployment: a prospective evaluation. *American Journal of Preventive Medicine* 2008;35(6):539–46.

Smith EA, Blackman VS, Malone RE. Death at a discount: how the tobacco industry thwarted tobacco control policies in U.S. military commissaries. *Tobacco Control* 2007;16(1):38–46.

Smith EA, Malone RE. "Everywhere the solider will be": Wartime tobacco promotion in the US military. *American Journal of Public Health* 2009a;99(9):1595–1602.

Smith EA, Malone RE. Tobacco promotion to military personnel: "The plums are here to be plucked." *Military Medicine* 2009b;174(8):797–806.

Stirlen R. Re: military volume [note]. 1994. Philip Morris Collection. Bates No. 2045453537B/3538. <http://legacy.library.ucsf.edu/tid/cey92e00>.

Talcott GW, Cigrang J, Sherrill-Mittleman D, Snyder DK, Baker M, Tatum J, Cassidy D, Sonnek S, Balderrama-Durbin C, Klesges RC, et al. Tobacco use during military deployment. *Nicotine & Tobacco Research* 2013;15(8):1348–54.

Tan M. A million soldiers deployed since 9/11. *Army Times Prime,* 12. 2009; <http://www.armytimes.com/news/2009/12/army_deployments_121809w/>; accessed: January 10, 2014.

U.S. Air Force. Health Promotion. Air Force Instruction 40-101, 2009; <http://static.e-publishing.af.mil/production/1/af_sg/publication/afi40-101/afi40-101.pdf>; accessed: January 10, 2014.

U.S. Air Force. Air Education and Training Command. Administration of Military Standards and Discipline Training. AETCI 36-2216, 2004; <http://www.ndri.org/ctrs/ibhr/docs/AETC%20Instruction%2036-2216%20Administration%20of%20Military%20Standard.pdf>; accessed May 2, 2013.

U.S. Air Force. Air Education and Training Command. AETCI36-2203, 2012a; <http://www.au.af.mil/au/awc/awcgate/edref/aetci36-2203.pdf>; accessed May 2, 2013.

U.S. Air Force. Tobacco Use in the Air Force. Air Force Instruction 40-102, March 26, 2012b; <http://static.e-publishing.af.mil/production/1/af_sg/publication/afi40-102/afi40-102.pdf>; accessed: January 10, 2014.

U.S. Department of Defense. Health Promotion and Disease/Injury Prevention. DoD Directive 1010.10, 2003; <http://www.dtic.mil/whs/directives/corres/pdf/101010p.pdf>; accessed May 2, 2013.

U.S. Department of Defense. Armed Services Exchange Policy. DoD Directive 1330.09, 2005a; <http://www.dtic.mil/whs/directives/corres/pdf/133009p.pdf>; accessed May 2, 2013.

U.S. Department of Defense. Armed Services Exchange Policy. DoD Directive 1330.21, 2005b; <http://www.dtic.mil/whs/directives/corres/pdf/133021p.pdf>; accessed May 2, 2013.

U.S. Navy. Navy and Marine Corps Tobacco Policy. SECNAVINST 5100.13E, 2008; <http://www.mccsmiramar.com/pdfs/5100_13E.pdf>; accessed May 2, 2013.

U.S. Food and Drug Administration. Compliance with Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco To Protect Children and Adolescents, 2013; <http://www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/ucm252758.htm>; accessed: January 10, 2014.