

Maryland Department of Health & Mental Hygiene
Cigarette Restitution Fund Program
Tobacco Use Prevention and Cessation Program

Report on Disparities in Tobacco use Behaviors by Adult Minority Populations in Maryland, 2006

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State of Maryland

Anthony G. Brown
Lieutenant Governor
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Director, Cigarette Restitution Fund Programs
Department of Health and Mental Hygiene

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STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street, Baltimore, Maryland 21201
Martin O'Malley, Governor. John M. Colmers, Secretary

Dear Fellow Marylander:

I am pleased to present this publication that is part of an on-going series of reports monitoring Maryland's progress in reducing the use of tobacco products. This document presents detailed information in the use of tobacco products among minority adult populations. The information provided is based on the latest available data source: the 2006 Maryland Adult Tobacco Survey (MATS). According to the 2000 Surgeon General's Report Reducing Tobacco Use, health disparities related to tobacco use is a major public health challenge. The CDC also considers that ethnic minorities suffer disproportionately from tobacco-related illness and death. Race/ethnicity thus is an important consideration in understanding smoking behaviors and in developing smoking prevention and treatment programs.

I want to share our successes. Since 2000, Maryland has made substantial progress in reducing smoking and tobacco use among racial and ethnic minority adult populations. Between 2000 and 2006, African-Americans in Maryland experienced a 24% decline in current cigarette smoking; Hispanic/Latino adults experienced a 46% decline in current cigarette smoking; and White adults experienced a 15% decline in current cigarette smoking. This progress must continue, particularly with respect to those with lower educational attainment and income status. An adult with less than a high school education is more than four times more likely to be a smoker than a college graduate (26.0% vs. 6.1%). An adult earning less than \$50,000 annually is almost twice as likely to smoke as is an adult earning more than that amount (20.0% vs. 10.4%).

While certainly applauding successes, it also must be recognized that more work must be done to preserve the positive changes achieved to-date, and to build on those for even greater successes in the future. We encourage using this document to identify and address determinants influencing a relatively higher tobacco use among certain adult minority populations and adults of low socio-economic status. In Maryland, we are committed to continue using a strategic approach allowing the revision and adjustment of our plans. We are confident that the data presented will significantly contribute to achieving our ultimate goals of reducing disparities in tobacco morbidity and mortality as well as eliminating disparities in tobacco behaviors.

There is no question that Maryland must strive for even greater future success. Smoking still causes disease and cancer in Maryland residents that result in an estimated \$2 billion in medical care annually (\$7.40 per pack sold). Government sponsored health care programs end up paying for at least 60% of these costs, adding \$590 to the tax bill of the average Maryland household each year. And finally, we cannot forget the almost 150,000 Maryland residents who currently live with one or more cancers or other diseases caused by their smoking, or the estimated 6,800 who die prematurely each year as a result of their smoking.

Quitting tobacco use can greatly improve the odds of avoiding a smoking-attributable disease or cancer, and the sooner one quits, the better the odds. Quitting is often not easy, but help is available with free

smoking cessation counseling through local health departments and the Statewide 1-800-QUITNOW telephone cessation counseling service. Many of these programs can also assist with nicotine replacement therapy (i.e., nicotine patches and gum). If you want to learn more about Maryland's efforts to reduce the use of tobacco, please call your local health department to get information about activities in your community, or the Center for Health Promotion, Education and Tobacco Prevention (410-767-1362) for information on Statewide initiatives.

Sincerely,

Carlessia A. Hussein, Dr. P.H.
Director
Cigarette Restitution Fund Program/Minority Health & Health Disparities
Office of Secretary
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EXECUTIVE SUMMARY

Since 2000, Maryland has made substantial progress in reducing smoking and tobacco use. Despite greater declines in cigarette smoking for African Americans and Hispanics than for Whites during 2000-2006, persistent disparities in tobacco-related disease and mortality remain (Maryland Department of Health and Mental Hygiene 2007). For example, lung and other cancer incidence and mortality rates vary by race, ethnicity, geography, gender, age, and socioeconomic status (The 2004 - 2008 Maryland Comprehensive Cancer Control Plan: Our Call to Action). While standardized components of our tobacco program work well in a variety of settings, it is important to find out if they deliver acceptable results for all Maryland residents.

Addressing the diversity of our community in our strategies and programs is important for consistent and comprehensive tobacco control in Maryland. We need to expand our understanding of disparities in tobacco use. No single factor determines patterns of tobacco use among racial/ethnic minority groups; these patterns are the result of complex interactions of multiple factors, such as socioeconomic status, cultural characteristics, acculturation, stress, biological elements, targeted advertising, price of tobacco products, and varying capacities of communities to mount effective tobacco control initiatives (Surgeon General Report 1998). This report is a result of rigorous surveillance and prevention research that is conducted to address cultural, psychosocial, and environmental factors influencing tobacco use. This information is crucial for improving our understanding of racial/ethnic smoking patterns and identifying strategic tobacco control opportunities.

Smoking is the leading preventable cause of disease and death in Maryland. In 2004, the Surgeon General concluded that smoking harms nearly every organ of the body and causes generally poorer health. Cigarette smoking alone is responsible for more than 6,800 premature deaths every year in Maryland, and the cause of disease and cancer for another 150,000 Marylanders (Maryland Department of Health and Mental Hygiene 2007). Medical treatment of disease and cancers caused by cigarette smoking costs the Maryland economy more than \$2 billion annually (Maryland Department of Health and Mental Hygiene 2007). An important way to reduce the human and economic costs of smoking and tobacco use on Marylanders and the economy is to reduce the use of tobacco through educational interventions, policies and research. Maryland's tobacco control program is comprised of activities reflecting our community's values, norms and behaviors.

The scientific literature provides information about the determinants that are influencing disparities in smoking use rates among different racial/ethnic groups. We encourage the use of this information to complement our report findings for identifying and recommending evidence-based tobacco use prevention and treatment programs for specific populations. For example, previous research has documented greater pro-tobacco advertising exposure for African-Americans than Whites (Primack et al. 2007), even though nicotine may be more addictive for African Americans (Okuyemi et al. 2007). Among African American light smokers, use of menthol cigarettes is associated with

lower smoking cessation rates (Okuyemi et al. 2007). Use of commercially available forms of nicotine replacement therapies (eg., gum, transdermal patch, nasal spray, inhaler and sublingual tablets/lozenges) increases smoking quit rates by 50-70% (Stead et al 2008). Telephone quitlines provide an important route of access to support for smokers, and call-back counseling enhances their usefulness (Stead et al. 2006).

This document presents detailed information on the use of tobacco products among minority adult populations. The current report includes data from the Maryland Adult Tobacco Survey (MATs) survey conducted in the fall of 2006. This report is intended to serve as a tool for identifying and addressing determinants influencing a relatively higher tobacco use among certain adult minority populations and adults of low socio-economic status. Findings from this report together with our logic models are important sources for developing effective decision-oriented evaluations. Planners, implementers, and evaluators working at both the local and the state levels can use this report to monitor progress in achieving short-term, intermediate, and long-term outcomes. This document consists of four chapters: 1) tobacco use behaviors; 2) attitudes; 3) knowledge; and 4) tobacco cessation. The following section highlights the findings on each of the four chapters.

1. Tobacco Use Behaviors

- Ever smoked cigarettes has been defined as having smoked at least 100 cigarettes over a lifetime. This is a commonly used measure of ever smoking in health interview surveys. In 2006, 37.9% of Maryland adults (general population) were ever smokers, with Whites having the highest rate (41.6%) and Asians having the lowest (15.6%).
- Regardless of race or ethnicity, men were more likely to be ever smokers than women. Approximately two out of every five men (42.2%) and one out of every three women (34.0%) from the general population were ever smokers. Adults with an annual income of less than \$50,000 were more likely to have ever smoked than Maryland adults with an annual income of at least \$50,000.
- In 2006, 17.6% of all Maryland adults were current tobacco users, with Asians having significantly lower use of tobacco (5.4%) than any other racial/ethnic group. Men and adults with lower education levels were more likely to report using tobacco in the previous 30 days regardless of race or ethnicity (general population). About one out of every four men used tobacco (23.4%). In general, the highest rates of current tobacco use in 2006 were among 18-29 year olds.
- The average number of cigarettes smoked per day by current smokers was 14.6 in 2006, and varied by race/ethnicity. American Indian current smokers smoked an average of almost a pack of cigarettes a day (19.9 cigarettes). Black current smokers smoked fewer cigarettes per day (10.5) than White current smokers (16.7).
- Current and former adult daily smokers (general population) smoked an average of 17.7 years. The number of years that current and former smokers smoked every day was greater for those with less education and with lower annual income among Whites, Blacks and the general population.

- Almost eight out of every ten (78%) respondents (general population) reported that smoking was not allowed in their home—ranging from 75.3% of Blacks, to 88.2% of Asians. In general, Maryland adults with less education were the least likely to have a rule prohibiting smoking inside the home.
- About one out of five (18.5%) Maryland adults reported being exposed to secondhand smoke in the car. In general, men and adults with less education and lower income were more likely to report recent exposure to secondhand smoke in a car.
- Around nine percent (9.4%) of Maryland adults reported ever using smokeless tobacco products such as chewing tobacco or snuff, however, few respondents of any group reported currently using smokeless tobacco products (1.1%). White adults (12%) were significantly more likely to report having ever used smokeless tobacco products compared to Blacks (4%), Hispanics (7.3%), or Asians (4.3%).
- Approximately one out of twenty Maryland adults (4.7%) reported having ever used bidi (flavored cigarettes from India) although less than one percent (0.2%) currently used bidi. Blacks (7%) and Hispanics (6.8%) were significantly more likely to have ever used bidi than Whites (3.2%).
- Approximately four percent (3.9%) of Maryland adults reported ever using kreteks (cigarettes made of tobacco and clove extract). However, less than one percent (0.4%) of all adults reported current use of kreteks. Whites (5.0%) were significantly more likely to report ever use of kreteks than Blacks (1.9%).
- Few Maryland adults use flavored cigarettes such as Camels Exotic or Casino Brands (e.g., Mandarin Mint, Lime Twister, Cinnzabar). In 2006, 6.6% of Maryland adults reported ever using flavored cigarettes; only 0.9% reported current use of flavored cigarettes. Whites (7.5%) were significantly more likely to report ever use of flavored cigarettes than Blacks (4.1%).
- Menthol is the most commonly used flavoring for cigarettes. Menthol-flavored cigarettes can mask the harsh taste of tobacco and provide a cooling effect for smokers. In 2006, 47.1% of current smokers in Maryland reported that they smoked menthol cigarettes rather than plain cigarettes. Blacks had the highest rates (82.4%) and Whites had the lowest (30.7%). Overall, Maryland current smokers with lower income (<\$50,000 per year) were more likely to use menthol cigarettes rather than plain cigarettes.
- In 2006, the percentage of Maryland households with minor children in which adults smoke cigarettes was 29.2%, ranging from 11.1% among Asians to 41.5% among American Indians. In general, Maryland adults with less education and lower income (<\$50,000 per year) were the most likely to have households with minor children residing where adults smoke.

2. Attitudes

- Current smokers rated their intention to quit on a ten-point scale. The average score, with little variation among ethnic groups, was 4.2 out of 10 which indicates a moderate intention to quit smoking.
- About one-third (34.5%) of former smokers cited *physical fitness* as a reason why they quit smoking. Hispanic former smokers (22.3%) were significantly less likely than White former smokers (36.6%) to state that physical fitness was a reason why they quit. For around one third (33.3%) of former smokers, concern about *health hazards* was cited as a reason that motivate them to quit. Health hazards are anticipated health problems. Hispanic former smokers (22.8%) were significantly less likely than White former smokers (35.5%) to cite concern about health hazards as a reason why they quit. One out of four (25.5%) former smokers reported that *smell* (of cigarette smoke) was a reason why they quit. Hispanic former smokers (13.2%) were less likely than Whites to cite smell as a reason why they quit. One out of four (24.7%) former smokers reported that a reason why they quit was to *be an example*—ranging from 51.8% for American Indians to 22.2% for Blacks. About one out of four (24.3%) former smokers stated that *health problems* were a reason why they quit.
- Four out of ten (40.7%) adult current smokers reported that *physical fitness* was a reason that may motivate them to quit smoking, with significantly lower rates for Hispanics (23%) than for Blacks (41.9%) and Whites (41.7%). In addition, 38.5% of current smokers stated that *health problems* were a reason why they may quit. It was also found that 37.7% of current smokers reported that “*to be an example*” was a reason why they may quit. The results also indicated that 37.2% felt that the *cost of tobacco* was a reason why they may quit. Finally, around one third of current smokers (32.4%) said that *encouragement by a friend* may motivate them to quit.
- Approximately eight out of every ten current smokers has seriously considered quitting cigarette smoking, with little variation by race/ethnicity.
- Approximately eight out of ten current smokers (79.1%) were confident in their ability to quit smoking. Hispanic and Black current smokers were more likely than White current smokers to report confidence in their ability to quit smoking (91.4%, 85.9%, and 75.5% respectively).
- Among 18-29 year old former and never smokers, 8.6% reported an intention to smoke in the next year, ranging from 4.2% for Blacks to 15% for Hispanics.
- One factor that influences individuals to quit smoking and stay abstinent is the perception that smoking, and more specifically nicotine, is addictive. Almost all respondents (98%) agreed that nicotine is addictive, with Whites (98.7%) more likely than Blacks (97.2%) and Hispanics (95.7%) to agree that smoking is addictive.
- The vast majority of Maryland adults (97.2%) are in favor of enforcing laws which prohibit the sale of tobacco products to minors, with little variation by race/ethnicity (95%-97.6%). In general, men were less likely than women to support enforcing laws which prohibit the sale of tobacco products to minors.

3. Knowledge

- White Maryland adults (16.5%) were the most likely, and Hispanics (49.9%) were the least knowledgeable, to know the health benefits for heavy smokers who quit smoking. Knowledge of the health benefits for heavy smokers who quit smoking was greater with increased education and increased income, regardless of race or ethnicity.
- Fifteen percent (15.3%) of Maryland adults (general population) believed that light cigarettes are safer than regular cigarettes, ranging from 14.8% for Hispanics and Blacks to 19.5% for Asians.
- The vast majority (96%) of Maryland adults were aware of the risks of smoking during pregnancy, ranging from 90.4% of American Indians to 96.8% of Whites. Knowledge of the health effects of smoking during pregnancy was greater with increased education, regardless of race or ethnicity. However, knowledge of the health effects of smoking during pregnancy was lower for Maryland adults with an annual income less than \$50,000 per year.
- The vast majority of Maryland adults (94.3%) were knowledgeable that smoking is physically addictive. Blacks (92.7%) and Hispanics (88.1%) were less likely than Whites (95.8%) to know that smoking is physically addictive. In general, Maryland adults with the least education were the least likely to know that smoking was physically addictive.
- Ninety-three percent (92.9%) of Maryland adults knew that secondhand smoking causes lung cancer.
- Ninety-seven percent (96.9%) of Maryland adults knew that secondhand smoking causes respiratory problems in children, with little variation by race/ethnicity ranging from 96.4% to 99.8%. However, Asians (99.8%) were significantly more knowledgeable than Whites (96.5%), American Indians (96.4%), Hispanics (97.5%) and Blacks (97.2%).
- Eighty-eight percent (88.1%) of respondents knew secondhand smoking causes heart disease. Hispanics and persons of Other race/ethnicity were more likely than Whites to know that secondhand smoking causes heart disease in adults.
- Six out of ten (58.8%) Maryland adults knew that secondhand smoking causes colon cancer. Hispanics, Asians, Blacks and American Indians were more likely than Whites to know that secondhand smoking causes colon cancer. Blacks and Hispanics with less education were more likely than their counterparts to know that secondhand smoking causes colon cancer.
- Sixty-five percent (64.7%) of Maryland adults knew that secondhand smoking causes Sudden Infant Death Syndrome (SIDS). Blacks (69.1%) and Hispanics (84.4%) were more likely than Whites (59.6%) to know that secondhand smoking causes SIDS. Adults with less education and with income less than \$50,000 were more knowledgeable that secondhand smoking causes SIDS.

- The vast majority of all employed adults (84.9%) reported that their workplaces do not allow smoking anywhere, ranging from 75.6% for Hispanics to 90.8% for persons of Other race/ethnicity. Hispanics were significantly less likely than Whites to report having a smoking ban in the workplace (75.6% vs. 86.9%).
- Although 79.1% of employed adults earning less than \$50,000 and 87.4% of employed adults earning at least \$50,000 work for employers who have banned smoking in the workplace, only 26.2% of employed adults were aware of any workplace stop smoking program or other types of help offered by their employer during the past 12 months. The percent of employed adults who were aware of any stop smoking programs or other types of help offered by their employer was higher with increased education and almost twice as high for those with an annual income of at least \$50,000.
- In 2006, 28.5% of Maryland were exposed to “1-800-QUIT-NOW” smoking cessation radio commercials in the past 30 days with American Indians (42.8%), Hispanics (35.2%) and Blacks (35.1%) reporting statistically significant higher exposure than Whites (24.7%). In general, Maryland adults with less education and lower incomes (<\$50,000 per year) were more likely to report having been exposed to 1-800-QUIT-NOW smoking cessation radio commercials in the past month.

4. Tobacco Cessation

- Among adults who were trying to quit smoking in the past year, 33.7% of Whites, 27.2% of Blacks, and 44.8% of Hispanics were successful in quitting smoking. The success of adults who were trying to quit smoking in the past year was lower for those with an annual income less than \$50,000.
- The average number of times that current adult smokers tried to quit smoking in their whole life was 5.6. The average number of quit attempts of former smokers who successfully quit smoking in the past year was 6.6.
- Among Maryland adults who have been to the doctor in the past year, slightly more than half (56.4%) were asked by a doctor, nurse, or other health professional whether they smoke or use tobacco products, ranging from 38.6% for Asians to 60% for American Indians.
- Seventy-eight percent (78%) of *current* adult smokers, who had been asked if they smoked by a doctor, nurse, or other health professional during the past 12 months, also reported having been advised to quit smoking. Of current smokers who received advice to quit smoking from a health professional in the past year, only 38.6% had received a recommendation for a product, program or prescription for a medication to help them quit using tobacco.
- Six out of ten (60.7%) current consumers of tobacco and smokeless tobacco products reported having been advised by their children to quit. Hispanics (33.6%) were less likely than Blacks (66.0%) and Whites (60.0%) to report that they had been advised by their children to quit using tobacco products. Male current tobacco users were also less likely to have been advised by their children to quit using tobacco products than female current tobacco users.

- Smokers who have their first cigarette within 5 minutes of waking up are considered to be highly addicted to nicotine. One out of four current smokers (25.2%) was highly addicted to nicotine. Hispanics were twice as likely to have their first cigarette one hour after waking in the morning compared to other racial/ethnic groups which suggests that Hispanic smokers were less dependent on cigarettes than other ethnic group smokers.
- Nearly 13 percent of smokers in the past year had stopped smoking with no significant difference between Whites (13.0%) and Blacks (12.4%). Men and women were similar in their rates of being successful in stopping smoking in the past year, regardless of race or ethnicity. Maryland adults with an annual income of less than \$50,000 were less likely to stop smoking than those with higher incomes.

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USING THIS REPORT

Data Analyses

Data analyses for the MATS were performed on the cleaned and weighted data set using the statistical software package SAS version 9.1. Crosstabs and frequencies were performed to produce the reported number and percent for each data point of interest.

Instructions for the Figures

The length of each bar corresponds to the percentage of persons having a characteristic as estimated from the 2006 Maryland Adult Tobacco Survey. The number at the end of each bar is the point estimate itself. The line segments superimposed on each bar show the 95% confidence limits for each point estimate. Non-overlapping confidence intervals for disjoint groups (e.g., White and Black) mean that point estimates for different groups are statistically significantly different from each other.

Target Population Size (N)

The population of interest is shown in each table, indicated by “N” and is estimated by the sum of the weights for the persons in the table cell. For example, in table 1.3, the number of estimated current smokers in the state of Maryland was 546,154 in 2006, which was 13.7% of the total population.

95% Confidence Level (Interval) Was Used for all Analysis

All estimates contained in this report were calculated at a 95% confidence level – meaning that if the survey was repeated many times, 95% of the confidence intervals constructed would contain the population value being estimated.

Determining Significance

In the tables, the point estimates are companied with 95% CI ($\pm$), i.e. with 1.96 times the standard error of the point estimate. One can determine whether the difference of two point estimates was significant by two methods. A) Construct the confidence intervals for the two point estimates by adding and subtracting the given 95% CI ($\pm$) to/from the point estimates in the tables, and check if the intervals are overlapping. B) Check the line segments superimposed on each bar in the figures. Non-overlapping line segments mean that point estimates for different groups are statistically significantly different from each other. Methods A) and B) are conservative procedures in the sense that the error rate is somewhat less than the nominal 5%.

Reliability Criteria

Any cell with sample size (unweighted n) less than 30 was deemed unreliable and thus not presented in the report. Also, an asterisk “*” was attached to the statistic where the relative standard error (RSE) was greater than 30%. The RSE of an estimate is obtained by dividing the standard error of the estimate (SE(r)) by the estimate itself (r). This quantity is expressed as a percent of the estimate and is calculated as follows: $RSE = 100 \times (SE(r)/r)$. Estimates with a RSE greater than 30% are considered unreliable by the National Center for Health Statistics (NCHS).

Asymmetric Confidence Intervals

Usually, the confidence interval (CI) of interest is symmetric around the estimate. The amount to be added and subtracted from a point estimate to form a confidence interval is shown in the tables on the line labeled 95% CI ($\pm$). However, in some cases in the report, confidence intervals for a percentage are asymmetric when either one of two conditions exists: 1) the lower bound of the usual confidence interval extends below 0% or 2) the upper bound reaches beyond 100%. In these cases the amounts to be subtracted and added to form the confidence interval are listed on two lines labeled 95% CI (-) and 95% CI (+). Also in these cases, a modified form of confidence interval was used that still has the 95% coverage rate property but has endpoints between 0 and 100%. The method was to calculate a confidence interval on the log-odds, defined as $\ln(\hat{p}/\hat{q})$ where $\hat{p}$ is the estimate of a proportion from the survey and $\hat{q} = 1 - \hat{p}$. The endpoints of this interval are then transformed to the percentage scale. The particular formulas used are:

$$\text{var}[\ln(\hat{p}/\hat{q})] \cong \text{var}(\hat{p})/(\hat{p}\hat{q})^2$$

$$\text{CI on log-odds: } \ln(\hat{p}/\hat{q}) \pm 1.96\sqrt{\text{var}(\hat{p})/(\hat{p}\hat{q})^2}$$

Inverse transform to the percentage scale:

$$\left\{ 100 * [1 + \exp(-\text{lower bound})]^{-1}, 100 * [1 + \exp(-\text{upper bound})]^{-1} \right\}.$$

Weighting Methods

Analysis weights were constructed to allow the data to be generalized to the adult population of the state of Maryland as a whole, as well as by jurisdiction. The initial sampling weight was constructed to reflect the selection probabilities of both the telephone number and the respondent within the household. This weight was then calibrated to 2005 population control totals, which were the most current available from the US Census Bureau at the time of weight creation. Because of the post-stratification, the weighted distribution of the data matches the adult population distribution in terms of basic demographic characteristics.

Taking Account of Stratification

The MATS sampling design created 24 strata for Maryland's 24 political jurisdictions. Based on differences in the size of the adult population across jurisdictions, the sampling design had different targets for the number of completed interviews by jurisdiction. Furthermore, the survey's sample design within each jurisdiction specified a list-assisted, random digit dial (RDD) sample of telephone-equipped Maryland households. Therefore, each political jurisdiction has a substratum of listed numbers and a substratum of unlisted numbers. The report took account of the stratification that has been implemented in the survey, giving a total of these 48 strata in the analysis.

Not Taking Account of Post-Stratification in Estimating Standard Errors

The post-stratification step adjusted the weights to population totals for cells defined according to age, race, and gender within each jurisdiction. Cells were collapsed in

jurisdictions where the number of survey respondents was too small to produce reliable estimates. The post-stratification adjustment is defined as dividing the population count for a particular cell by the sum of the selection weights in that cell (which is an estimate of the population count). In order to remain consistent with the previous report (Maryland Department of Health and Mental Hygiene, 2007), this report did not account for the post-stratification in standard error estimation. However, this may mean that the standard errors are somewhat too large for characteristics that are related to post-strata.

Weighted and Unweighted Estimates

Although not reported in this report, the differences between weighted and unweighted estimates were most striking for American Indians. Differences between weighted and unweighted numbers are due to the fact that the groups with varying weights provide different answers to certain questions. American Indians who have been assigned larger weights based on external data tended to give different answers from those with smaller weights.

Definitional Change – Race and Ethnicity

In a previous report using the 2006 Maryland Adult Tobacco Survey data (Maryland Department of Health and Mental Hygiene, 2007), the category “Native Hawaiian or Other Pacific Islander” was excluded from the analysis on race. We included this group of respondents in the “Total” category. When presenting data separately by race and ethnicity, we included “Native Hawaiian or Other Pacific Islander” in the “Other” racial category since there were only 37 people in this category (too few people to produce reliable statistics as a subpopulation). Also, it should be pointed out that individuals who did not choose White, Black, Hispanic, Asian or American Indian, but did choose “Other” were considered being of “Other” race.

Definitional Change – Employed Respondents

When estimating adults reporting exposure to secondhand smoke in the workplace, we included individuals who were “self-employed” as employed respondents, in contrast to the previous report (Maryland Department of Health and Mental Hygiene, 2007).

Individual Income Was Used in the Analysis

During the 2006 Maryland Adult Tobacco Survey, respondents were only asked for their individual income rather than household income.

Reference:

- Maryland Department of Health and Mental Hygiene. Monitoring Changing Tobacco-use Behaviors in Maryland, November, 2007. Available at <http://www.crf.state.md.us/html/stats.cfm>

SURVEY METHODOLOGY

The Maryland Adult Tobacco Survey (MATS) was developed by the DHMH with assistance from the CDC. It was administered according to CDC's Adult Tobacco Survey (ATS) protocol, using Computer-Assisted Telephone Interviewing (CATI) technology. A copy of the 2006 MATS questionnaire is reproduced in Appendix B. The MATS data collection began in September 2006 and concluded in January 2007. DHMH is required by statute to utilize the MATS to develop separate estimates of tobacco use by adults for each of Maryland's 23 counties and Baltimore City, as well as for the State as a whole. Thus, the MATS survey employed a stratified sampling design. This design specifies 24 geographic strata, which represent the 24 political jurisdictions.

MATS Design

A total of 290,700 telephone numbers were sampled from all non-institutionalized Maryland adults (ages 18 and older) residing in telephone equipped dwellings with 21,750 interviews as the target for completion. To prevent bias and ensure that the household sample was representative, the telephone numbers in the MATS were selected at random. To ensure the respondents selected were as representative as possible of the entire Maryland adult population, the CATI system randomly sampled all the eligible individuals in a household.

Survey Administration

Adult participation was wholly voluntary; respondents could decline participation at any time during the survey administration. DHMH's survey contractor administered the survey. Experienced, supervised personnel conducted the MATS interviews. To maximize response rates, calls were concentrated between 5 p.m. and 9 p.m. Monday through Friday and between 10 a.m. and 9 p.m. on Saturday and Sunday, EST. A portion of calls was conducted between 9 a.m. and 5 p.m. Monday through Friday, EST, in order to complete interviews with respondents who were only at home during the day.

To ensure data quality prior to entering the field, the MATS CATI survey was tested rigorously by several experienced program managers. Testing included: developing scenarios to test all possible paths through the questionnaire; checking frequencies of randomly generated data; and verifying frequencies of the data after the first day of interviewing. Quality control indicators were tracked by producing reports that read the survey data file, generating summary statistics on the following: interviewer efficiencies (completes per hour, both on an individual and project level); lower-bound and upper-bound response rates; demographics on completed interviews; all call dispositions; and sample status (number of attempts, percent complete, refusal rates).

As an additional layer of quality assurance, interviewer performance was monitored through supervisors and quality assurance (QA) assistants, as well as with formal and informal performance evaluations. At least 10% of all interviews were monitored by tapping into interviewers' telephone lines and using the CATI system's monitoring module to follow the course of the interview on a computer screen. Interviewers were

scored on several measures of interview performance designed to reinforce proper interviewer protocol and data quality.

Data were collected directly in electronic format to a secure server and upon completion of the fielding period were converted for delivery to DHMH. A total of 21,799 interviews were completed during the 126-day fielding period. The average interview length was 17.1 minutes. The interview length differed by smoking status. Current smokers had an average interview length of 24.5 minutes; former smokers had an average interview length of 18.2 minutes; and nonsmokers, 14.9 minutes. Results from the 2006 MATS can be compared to adult tobacco surveys of other states.



CHAPTER 1

Tobacco Use Behaviors

1 Tobacco Use Behaviors

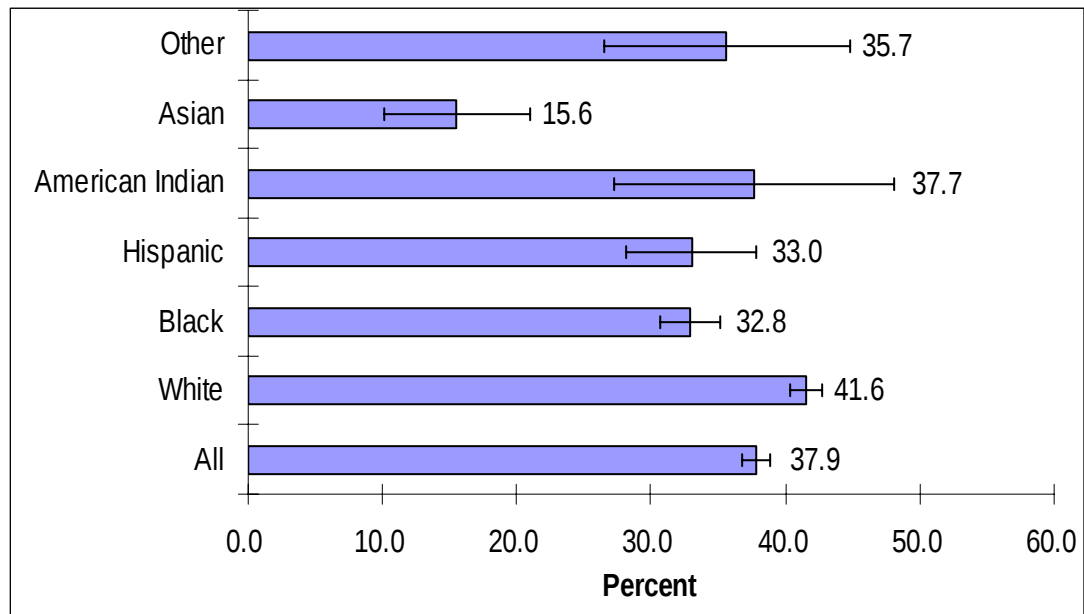
1.1. Ever Smoker Among Adults in Maryland by Race/Ethnicity

This study defined ever smoked cigarettes as having smoked at least 100 cigarettes over a lifetime. This is a commonly used measure of ever smoking in health interview surveys. Having smoked at least 100 cigarettes is equivalent to having smoked at least five packs of cigarettes. In 2006, 37.9% of Maryland adults (general population) reported having ever smoked at least 100 cigarettes in their lifetime, with Whites having the highest rate (41.6%) and Asians having the lowest (15.6%).

Table 1.1. Ever Smoker Among Adults in Maryland by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	37.9	41.6	32.8	33.0	37.7	15.6	35.7
95% CI(±)	1.0	1.2	2.2	4.9	10.5	5.4	9.1
N	1,505,971	1,021,197	339,767	88,831	15,162	17,544	23,471

Figure 1.1. Ever Smoker Among Adults in Maryland by Race/Ethnicity



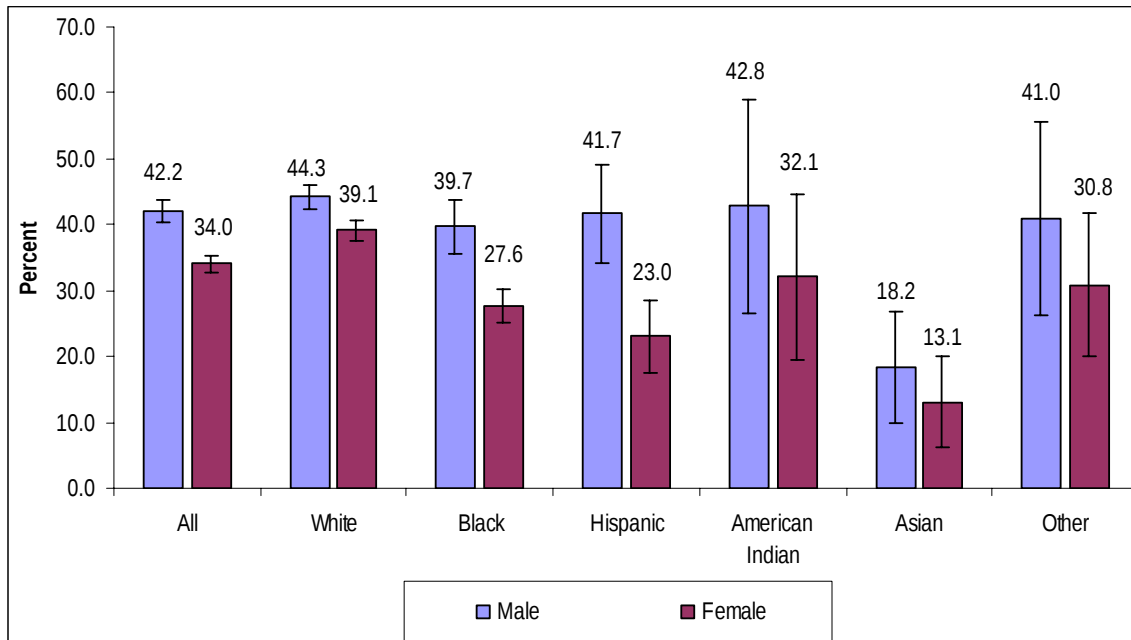
1.1.1. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Gender

Regardless of race or ethnicity, men were more likely to be ever smokers than women. Approximately two out of every five men (42.2%) and one out of every three women (34.0%) from the general population were ever smokers.

Table 1.1.1. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Gender

	All	White	Black	Hispanic	American Indian	Asian	Other
Male	42.2	44.3	39.7	41.7	42.8	18.2	41.0
95% CI(±)	1.7	1.9	4.0	7.5	16.3	8.5	14.8
N	789,837	521,105	177,084	59,979	8,968	9,869	12,831
Female	34.0	39.1	27.6	23.0	32.1	13.1	30.8
95% CI(±)	1.3	1.5	2.5	5.6	12.5	6.8	10.9
N	716,134	500,091	162,683	28,852	6,194	7,675	10,639

Figure 1.1.1. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Gender



1.1.2. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Age

In general, ever smoking rates were lower for younger adults regardless of race or ethnicity. Approximately half of Maryland adults at least 60 years of age (general population) had ever smoked.

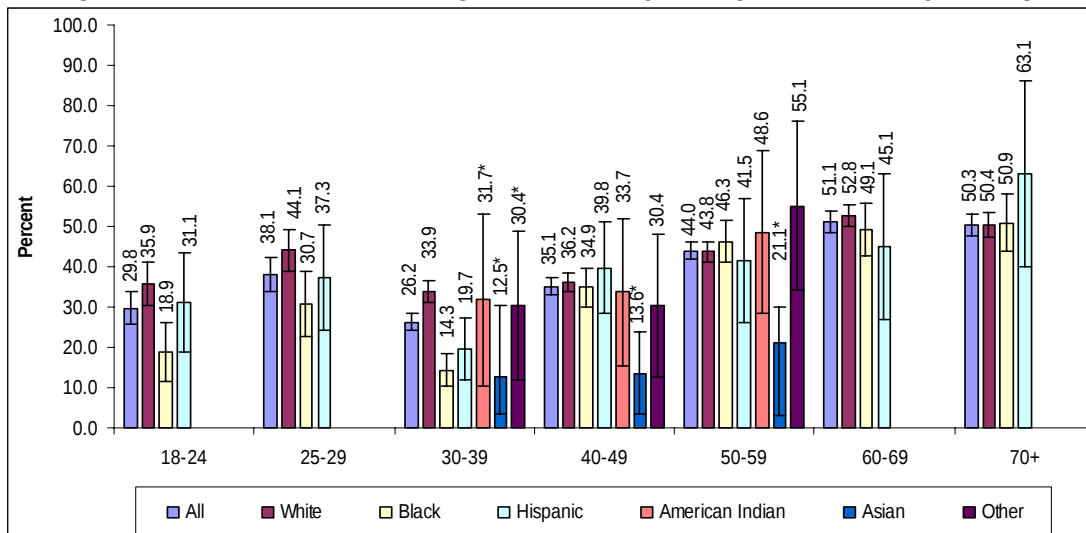
Table 1.1.2. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Age

	All	White	Black	Hispanic	American Indian	Asian	Other
18-24	29.8	35.9	18.9	31.1	–	–	–
95% CI(±)	4.1	5.4	7.2	12.2	–	–	–
N	133,044	87,610	24,203	15,871	–	–	–
25-29	38.1	44.1	30.7	37.3	–	–	–
95% CI(±)	4.2	5.3	8.1	13.2	–	–	–
N	119,674	70,038	29,678	15,182	–	–	–
30-39	26.2	33.9	14.3	19.7	31.7*	12.5*	30.4*
95% CI(±)	2.2	2.8	4.0	7.7	21.3	9.0	18.5
N	196,895	142,089	28,895	14,226	2,976	4,116	4,593
40-49	35.1	36.2	34.9	39.8	33.7	13.6*	30.4*
95% CI(±)	2.2	2.5	4.7	11.2	18.4	10.3	17.7
N	296,456	179,986	81,470	22,374	3,515	4,321	4,791
50-59	44.0	43.8	46.3	41.5	48.6	21.1*	55.1
95% CI(±)	2.2	2.5	5.1	15.4	20.3	17.9	20.9
N	315,053	208,680	85,889	10,581	3,430	3,109	3,365
60-69	51.1	52.8	49.1	45.1	–	–	–
95% CI(±)	2.6	2.7	6.6	18.1	–	–	–
N	225,340	163,775	48,416	6,419	–	–	–
70+	50.3	50.4	50.9	63.1	–	–	–
95% CI(±)	2.7	3.0	7.1	22.9	–	–	–
N	198,244	152,606	38,002	3,958	–	–	–

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.1.2. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Age



1.1.3. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Educational Attainment

In general, ever smoking rates were higher for those with lower education levels. For instance, 65.6% of white adults with less than a high school education were ever smokers compared to 33.0% of white college graduates. More than half of American Indian (54.6%) and White (52.4%) high school graduates had ever smoked.

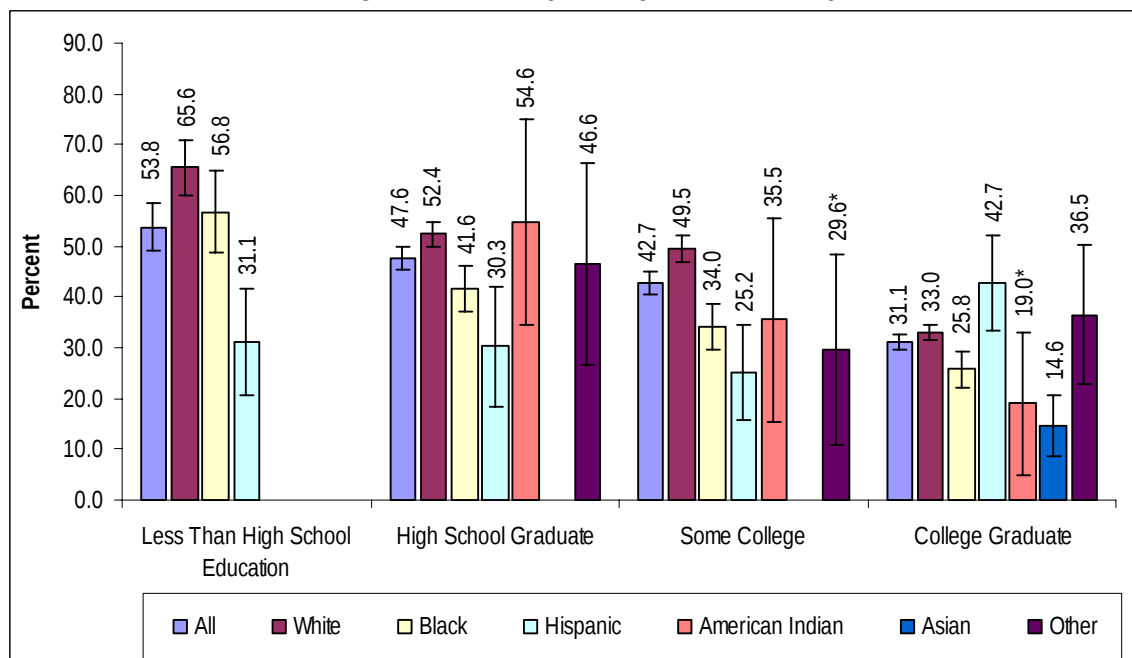
Table 1.1.3. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	53.8	65.6	56.8	31.1	–	–	–
95% CI(±)	4.5	5.4	8.0	10.6	–	–	–
N	127,420	61,531	45,082	17,673	–	–	–
High School Graduate	47.6	52.4	41.6	30.3	54.6	–	46.6
95% CI(±)	2.2	2.4	4.5	11.8	20.3	–	19.8
N	378,560	255,346	99,225	11,324	5,511	–	5,398
Some College	42.7	49.5	34.0	25.2	35.5	–	29.6*
95% CI(±)	2.3	2.6	4.5	9.4	20.2	–	18.9
N	328,911	228,734	79,797	11,585	3,269	–	3,003
College Graduate	31.1	33.0	25.8	42.7	19.0*	14.6	36.5
95% CI(±)	1.5	1.6	3.6	9.5	14.1	6.1	13.8
N	513,050	370,244	86,545	31,918	1,971	11,983	10,389

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.1.3. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Educational Attainment



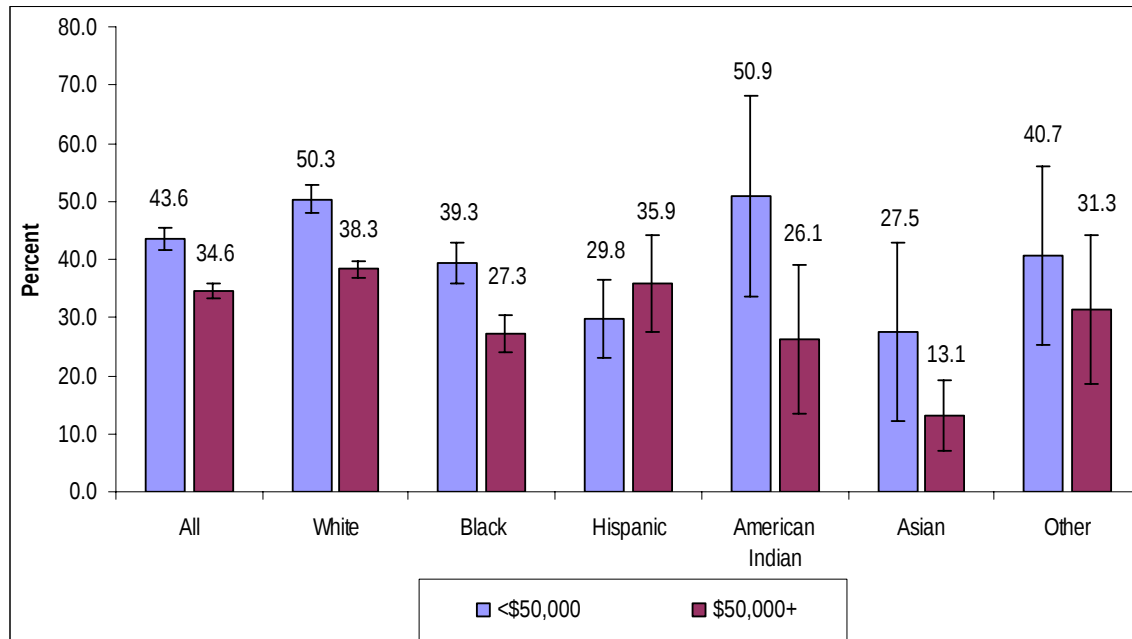
1.1.4. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Income

Consistent with the trends from the previous table, adults with an annual income of less than \$50,000 were more likely to have ever smoked than Maryland adults with an annual income of at least \$50,000.

Table 1.1.4. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	43.6	50.3	39.3	29.8	50.9	27.5	40.7
95% CI(±)	1.9	2.4	3.6	6.7	17.3	15.4	15.4
N	535,226	305,614	164,992	41,276	8,895	6,060	8,388
\$50,000+	34.6	38.3	27.3	35.9	26.1	13.1	31.3
95% CI(±)	1.3	1.5	3.2	8.4	12.8	6.0	12.7
N	756,765	563,624	134,738	31,622	4,879	10,085	11,817

Figure 1.1.4. Ever Smoker Among Adults in Maryland by Race/Ethnicity and Income



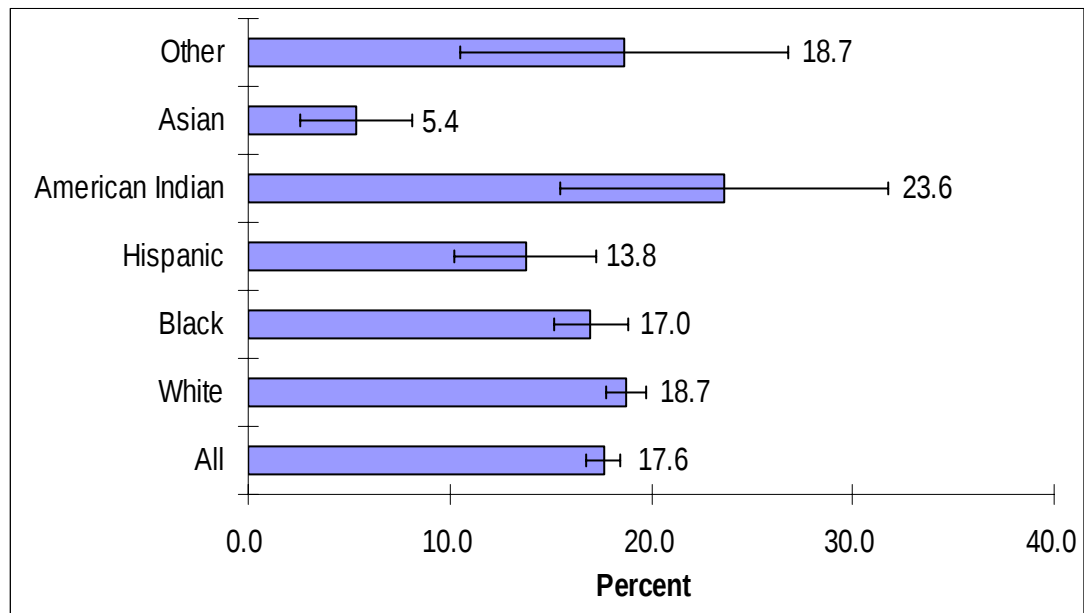
1.2. Prevalence of Current Tobacco Use¹ Among Adults in Maryland by Race/Ethnicity

In 2006, 17.6% of all Maryland adults were current tobacco users, with Asians having significantly lower use of tobacco (5.4%) compared to other racial/ethnic groups.

Table 1.2. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	17.6	18.7	17.0	13.8	23.6	5.4	18.7
95% CI(±)	0.8	1.0	1.9	3.5	8.1	2.8	8.2
N	697,175	457,270	175,297	36,999	9,485	6,001	12,123

Figure 1.2. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity



¹ Includes use of cigarettes, smokeless tobacco, cigars, pipes, bidis, kreteks in the past 30 days.

1.2.1. Prevalence of Current Tobacco Use² Among Adults in Maryland by Race/Ethnicity and Gender

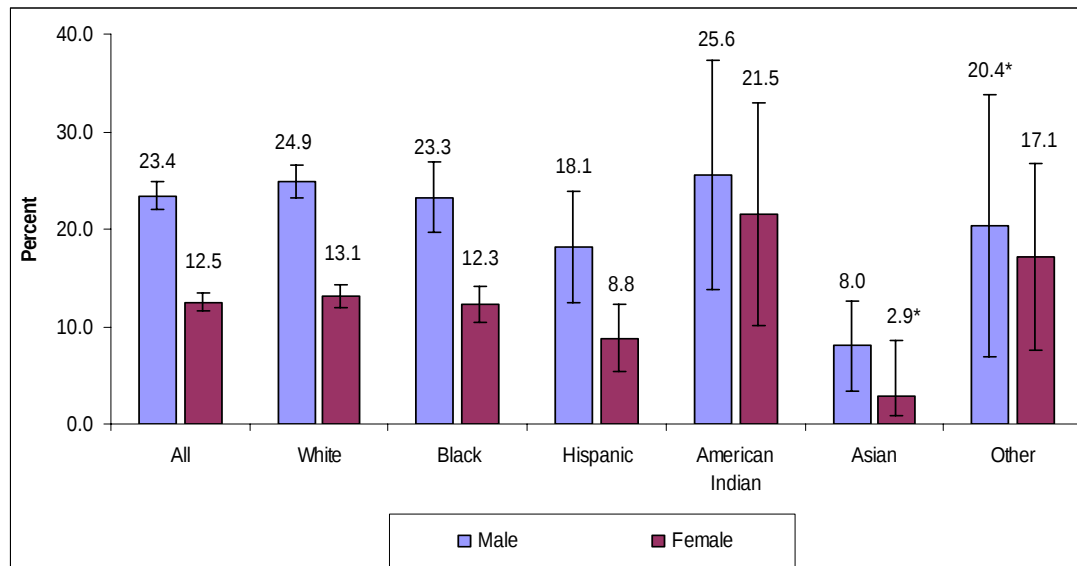
Consistent with the findings for ever tobacco use, men were more likely than women to report using tobacco in the previous 30 days regardless of race or ethnicity (general population). About one out of every four men used tobacco (23.4%).

Table 1.2.1. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity and Gender

	All	White	Black	Hispanic	American Indian	Asian	Other
Male	23.4	24.9	23.3	18.1	25.6	8.0	20.4*
95% CI(±)	1.5	1.7	3.6	5.7	11.8	4.6	13.4
N	436,424	291,453	103,019	25,945	5,358	4,327	6,321
Female	12.5	13.1	12.3	8.8	21.5	2.9*	17.1
95% CI(-)	0.9	1.2	1.8	3.5	11.4	2.0	9.5
95% CI(+)	0.9	1.2	1.8	3.5	11.4	5.7	9.5
N	260,751	165,816	72,277	11,054	4,127	1,674	5,802

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.2.1. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity and Gender



² Includes use of cigarettes, smokeless tobacco, cigars, pipes, bidis, kreteks in the past 30 days.

1.2.2. Prevalence of Current Tobacco Use³ Among Adults in Maryland by Race/Ethnicity and Age

In general, the highest rates of current tobacco use in 2006 were among 18-29 year olds. Due to small numbers, current tobacco use rates are not presented for 18-29 and 60+ year old American Indians, Asians or persons of Other race/ethnicity.

Table 1.2.2. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity and Age

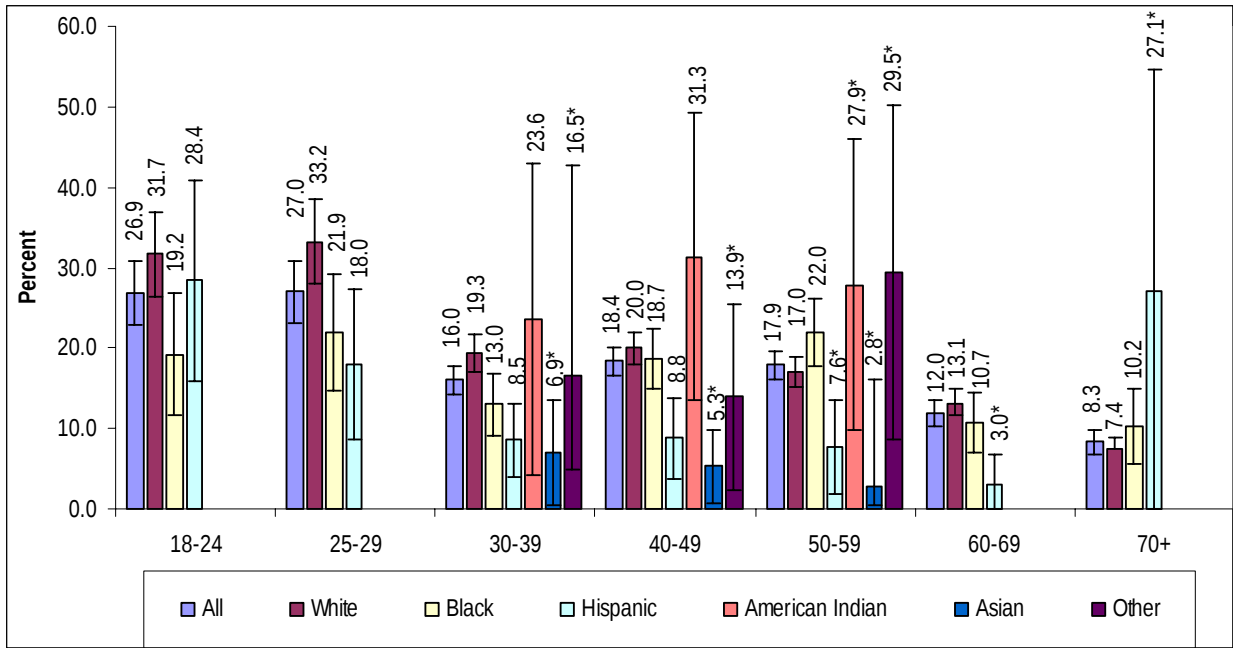
	All	White	Black	Hispanic	American Indian	Asian	Other
18-24	26.9	31.7	19.2	28.4	–	–	–
95% CI(±)	4.0	5.3	7.6	12.5	–	–	–
N	119,789	77,139	24,556	14,425	–	–	–
25-29	27.0	33.2	21.9	18.0	–	–	–
95% CI(±)	3.9	5.3	7.3	9.4	–	–	–
N	84,545	52,438	21,077	7,389	–	–	–
30-39	16.0	19.3	13.0	8.5	23.6	6.9*	16.5*
95% CI(-)	1.8	2.3	3.9	4.5	19.4	6.5	11.5
95% CI(+)	1.8	2.3	3.9	4.5	19.4	6.5	26.3
N	119,635	80,363	26,165	6,171	2,210	2,274	2,452
40-49	18.4	20.0	18.7	8.8	31.3	5.3*	13.9*
95% CI(±)	1.7	2.0	3.8	5.1	17.9	4.6	11.6
N	154,244	98,853	43,326	4,949	3,263	1,680	2,173
50-59	17.9	17.0	22.0	7.6*	27.9*	2.8*	29.5*
95% CI(-)	1.7	1.9	4.2	5.8	18.1	2.3	20.8
95% CI(+)	1.7	1.9	4.2	5.8	18.1	13.3	20.8
N	127,298	80,702	40,639	1,946	1,941	406	1,665
60-69	12.0	13.1	10.7	3.0*	–	–	–
95% CI(-)	1.6	1.9	3.7	3.0	–	–	–
95% CI(+)	1.6	1.9	3.7	3.7	–	–	–
N	52,510	40,304	10,514	419	–	–	–
70+	8.3	7.4	10.2	27.1*	–	–	–
95% CI(-)	1.5	1.5	4.7	27.1	–	–	–
95% CI(+)	1.5	1.5	4.7	27.6	–	–	–
N	32568	22343	7562	1700	–	–	–

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

³ Includes use of cigarettes, smokeless tobacco, cigars, pipes, bidis, kreteks in the past 30 days.

Figure 1.2.2. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity and Age



1.2.3. Prevalence of Current Tobacco Use⁴ Among Adults in Maryland by Race/Ethnicity and Educational Attainment

Rates of current tobacco use were lower with higher education levels. More than one out of three Whites and Blacks with less than a high school education were currently using tobacco (35.8% and 37.2% respectively).

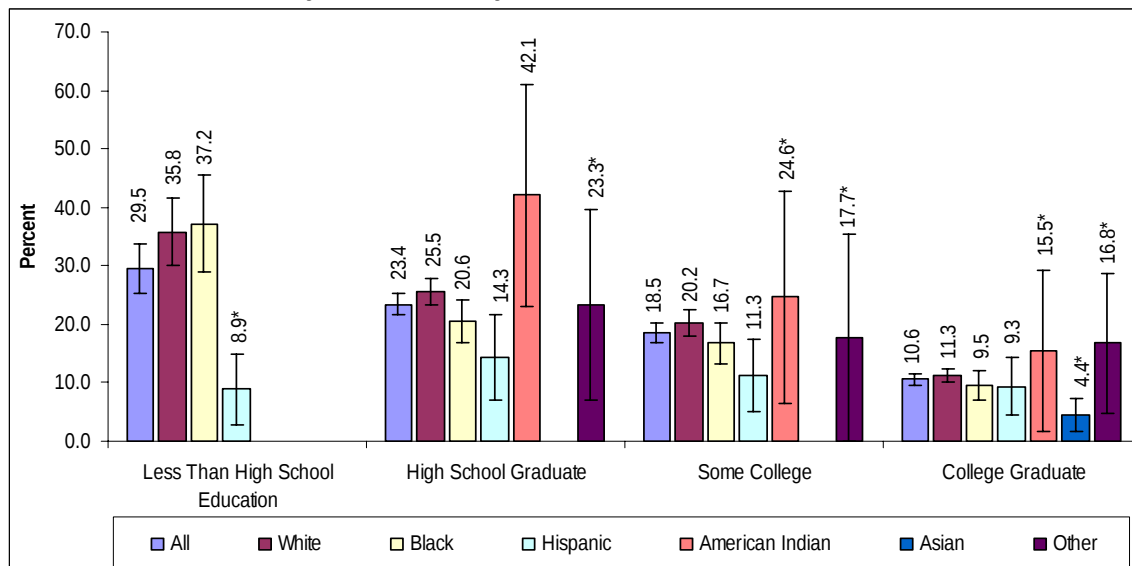
Table 1.2.3. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	29.5	35.8	37.2	8.9*	–	–	–
95% CI(±)	4.2	5.7	8.4	6.0	–	–	–
N	69,293	33,426	29,013	5,067	–	–	–
High School Graduate	23.4	25.5	20.6	14.3	42.1	–	23.3
95% CI(±)	1.9	2.2	3.7	7.4	18.9	–	16.3
N	185,125	123,796	48,784	5,352	4,203	–	2,700
Some College	18.5	20.2	16.7	11.3	24.6*	–	17.7*
95% CI(±)	1.8	2.2	3.5	6.2	18.2	–	17.7
N	141,663	92,238	39,108	5,214	2,272	–	1,773
College Graduate	10.6	11.3	9.5	9.3	15.5*	4.4*	16.8*
95% CI(±)	1.0	1.1	2.6	4.9	13.7	2.8	11.9
N	174,094	125,441	31,854	6,941	1,601	3,597	4,661

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.2.3. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity and Educational Attainment



⁴ Includes use of cigarettes, smokeless tobacco, cigars, pipes, bidis, kreteks in the past 30 days.

1.2.4. Prevalence of Current Tobacco Use⁵ Among Adults in Maryland by Race/Ethnicity and Income

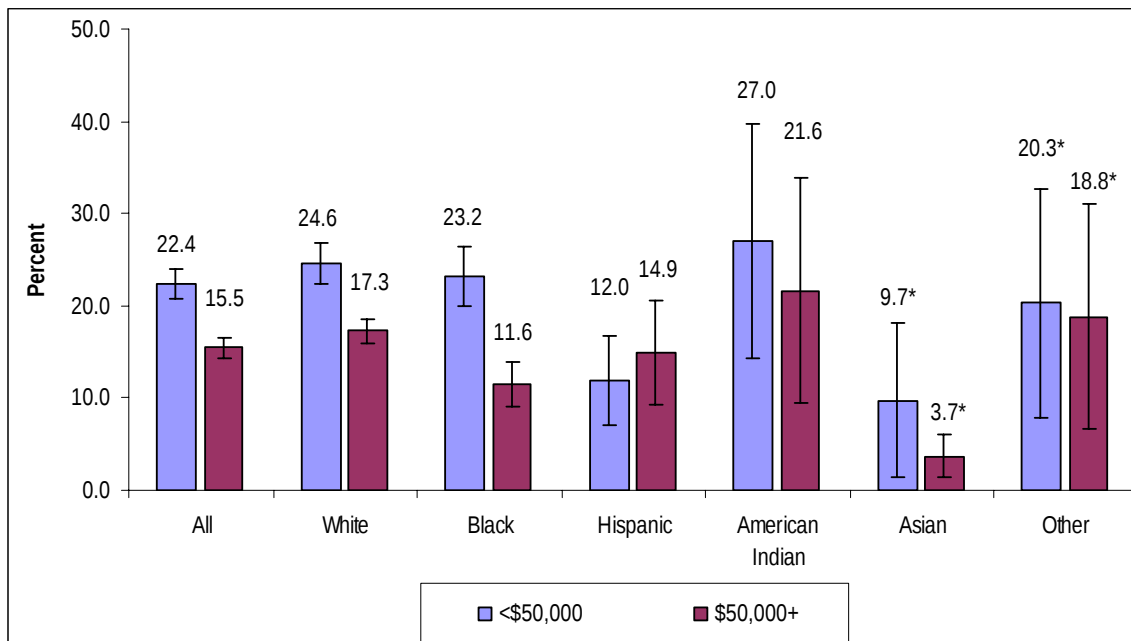
Consistent with the previous table, current tobacco use was more common among adults with less income (<\$50,000 per year) for Whites, Blacks, and the general population.

Table 1.2.4. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	22.4	24.6	23.2	12.0	27.0	9.7*	20.3*
95% CI(±)	1.7	2.2	3.2	4.9	12.7	8.4	12.4
N	273,407	148,934	96,995	16,534	4,696	2,103	4,145
\$50,000+	15.5	17.3	11.6	14.9	21.6	3.7*	18.8*
95% CI(±)	1.1	1.2	2.4	5.6	12.2	2.4	12.2
N	336,308	252,431	56,920	13,095	4,042	2,864	6,956

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.2.4. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity and Income



⁵ Includes use of cigarettes, smokeless tobacco, cigars, pipes, bidis, kreteks in the past 30 days.

1.2.5. Prevalence of Current Tobacco Use⁶ Among Adults in Maryland by Race/Ethnicity and Region

Rates of current tobacco use ranged from 12.7% in Suburban Washington to 22.3% in Upper Eastern Shore and 22.8% in Lower Eastern Shore.

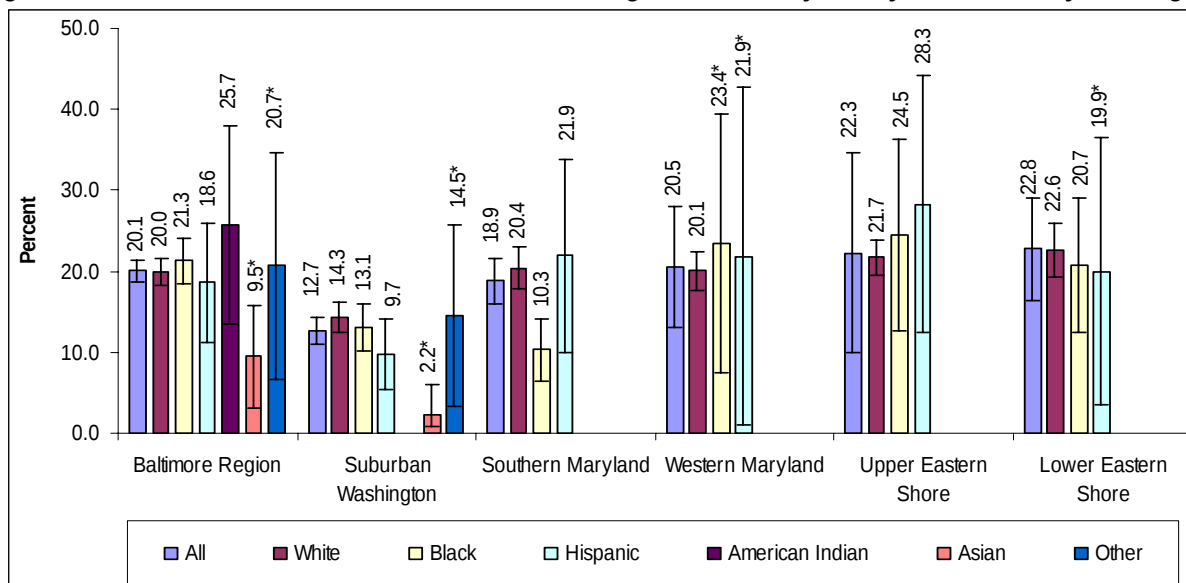
Table 1.2.5. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity and Region

	All	White	Black	Hispanic	American Indian	Asian	Other
Baltimore Region	20.1	20.0	21.3	18.6	25.7	9.5*	20.7*
95% CI(±)	1.4	1.7	2.8	7.4	12.3	6.3	14.0
N	371,397	244,153	98,310	14,070	5,538	3,666	5,661
Suburban Washington	12.7	14.3	13.1	9.7	–	2.2*	14.5*
95% CI(-)	1.4	1.8	2.8	4.3	–	1.4	11.2
95% CI(+)	1.4	1.8	2.8	4.3	–	3.9	11.2
N	177,289	90,496	64,589	15,570	–	1,463	4,451
Southern Maryland	18.9	20.4	10.3	21.9	–	–	–
95% CI(±)	2.2	2.6	3.9	12.0	–	–	–
N	42,804	34,401	3,784	2,908	–	–	–
Western Maryland	20.5	20.1	23.4*	21.9*	–	–	–
95% CI(±)	2.3	2.4	16.0	20.8	–	–	–
N	35,691	32,271	1,150	995	–	–	–
Upper Eastern Shore	22.3	21.7	24.5	28.3	–	–	–
95% CI(±)	2.2	2.2	11.8	15.9	–	–	–
N	37,727	31,687	2,679	2,147	–	–	–
Lower Eastern Shore	22.8	22.6	20.7	19.9*	–	–	–
95% CI(±)	3.0	3.3	8.2	16.5	–	–	–
N	32,266	24,262	4,785	1,310	–	–	–

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.2.5. Prevalence of Current Tobacco Use Among Adults in Maryland by Race/Ethnicity and Region



⁶ Includes use of cigarettes, smokeless tobacco, cigars, pipes, bidis, kreteks in the past 30 days.

1.3. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity

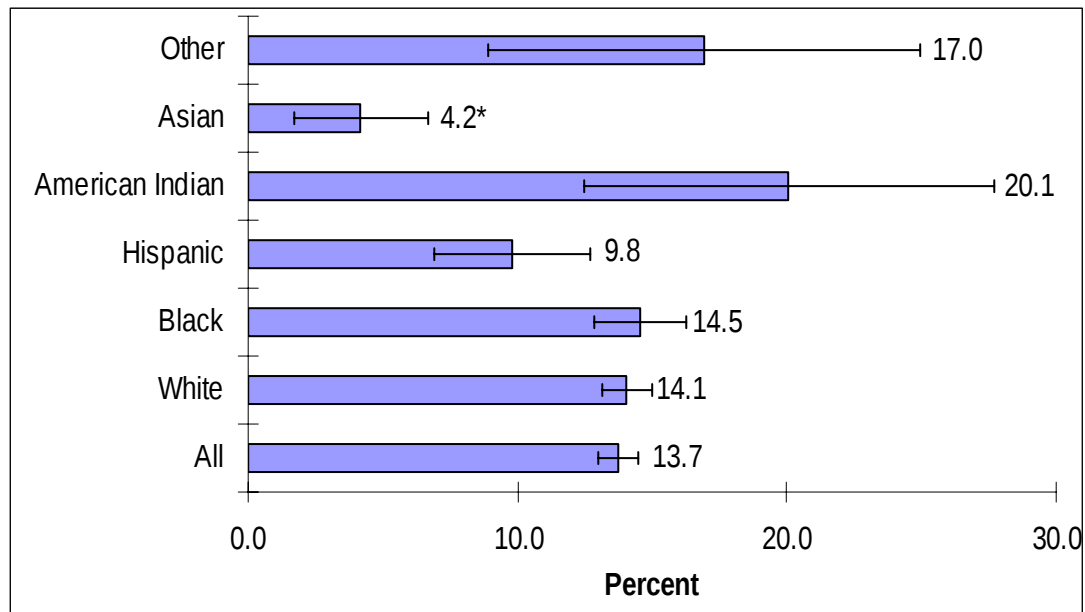
In 2006, 13.7% of all Maryland adults smoked cigarettes, ranging from 4.2% among Asians to 20.1% among American Indians.

Table 1.3. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	13.7	14.1	14.5	9.8	20.1	4.2*	17.0
95% CI(±)	0.8	0.9	1.7	2.9	7.6	2.5	8.0
N	546,154	345,280	150,544	26,392	8,077	4,726	11,134

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.3. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity



1.3.1. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Gender

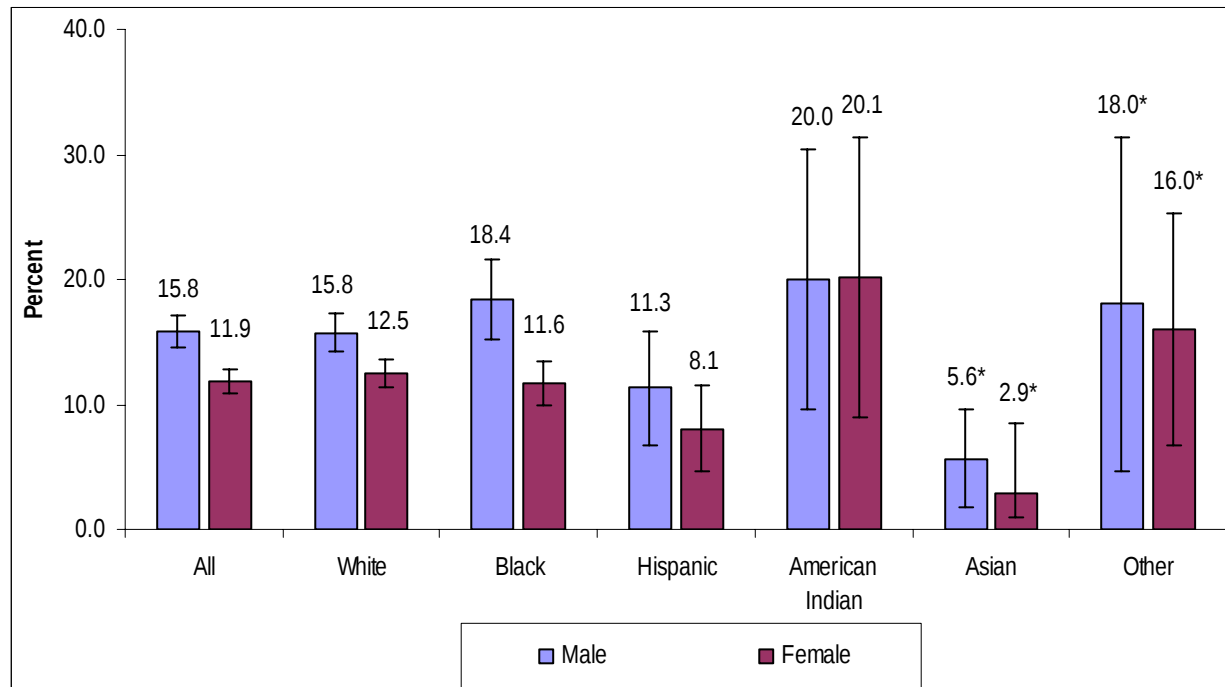
In general, men were more likely to smoke cigarettes than women (15.8% vs. 11.9%). Among American Indians, one out every five men and women smoked.

Table 1.3.1. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Gender

	All	White	Black	Hispanic	American Indian	Asian	Other
Male	15.8	15.8	18.4	11.3	20.0	5.6*	18.0*
95% CI(±)	1.3	1.5	3.2	4.6	10.4	3.9	13.4
N	296,754	185,478	82,128	16,277	4,197	3,052	5,623
Female	11.9	12.5	11.6	8.1	20.1	2.9*	16.0*
95% CI(-)	0.9	1.1	1.8	3.4	11.2	1.9	9.3
95% CI(+)	0.9	1.1	1.8	3.4	11.2	5.7	9.3
N	249,400	159,803	68,415	10,116	3,880	1,674	5,511

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.3.1. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Gender



1.3.2. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Age

Rates of current smoking were highest among 18-29 year olds. Due to small numbers, current smoking rates are not presented for 18-29 and 60+ year old American Indians, Asians or persons of Other race/ethnicity.

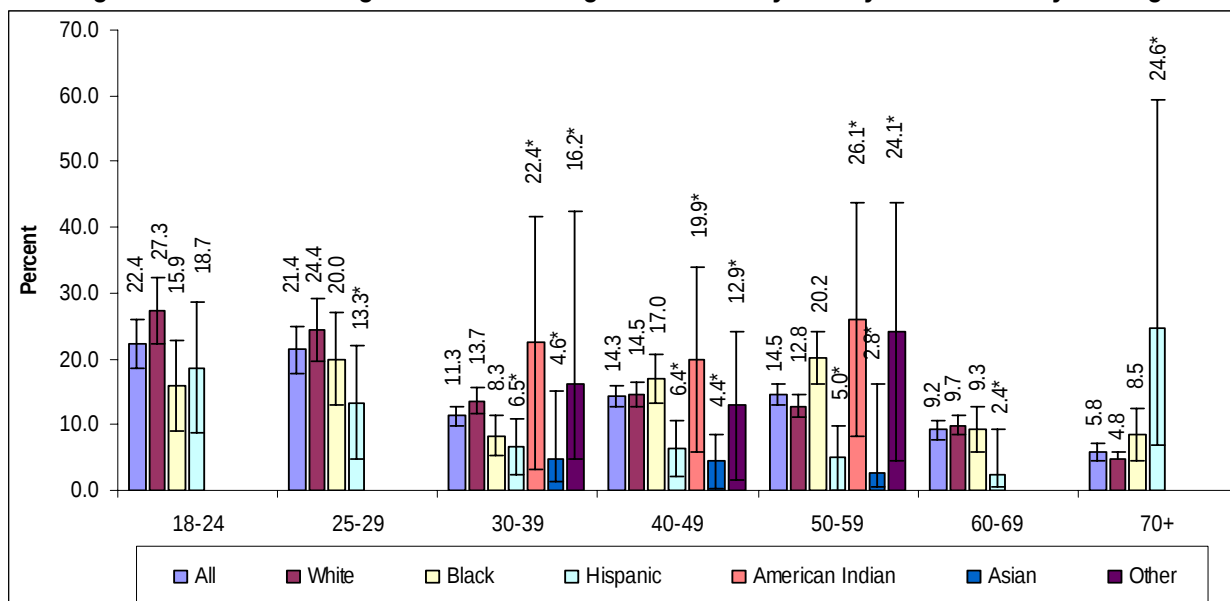
Table 1.3.2. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Age

	All	White	Black	Hispanic	American Indian	Asian	Other
18-24	22.4	27.3	15.9	18.7	–	–	–
95% CI(±)	3.7	5.1	6.9	10.0	–	–	–
N	99,970	66,682	20,386	9,524	–	–	–
25-29	21.4	24.4	20.0	13.3*	–	–	–
95% CI(±)	3.6	4.8	7.0	8.6	–	–	–
N	67,192	38,813	19,332	5,405	–	–	–
30-39	11.3	13.7	8.3	6.5*	22.4*	4.6*	16.2*
95% CI(-)	1.5	2.0	3.1	4.2	19.3	3.3	11.4
95% CI(+)	1.5	2.0	3.1	4.2	19.3	10.6	26.1
N	84,861	57,268	16,782	4,725	2,104	1,531	2,452
40-49	14.3	14.5	17.0	6.4*	19.9*	4.4*	12.9*
95% CI(±)	1.5	1.8	3.6	4.2	14.1	4.2	11.4
N	120,964	72,235	39,648	3,576	2,073	1,401	2,030
50-59	14.5	12.8	20.2	5.0*	26.1*	2.8*	24.1*
95% CI(-)	1.6	1.7	4.1	4.9	17.8	2.3	19.5
95% CI(+)	1.6	1.7	4.1	4.9	17.8	13.3	19.5
N	103,610	61,179	37,470	1,277	1,840	406	1,438
60-69	9.2	9.7	9.3	2.4*	–	–	–
95% CI(-)	1.5	1.7	3.5	1.8	–	–	–
95% CI(+)	1.5	1.7	3.5	7.0	–	–	–
N	40,488	30,074	9,141	339	–	–	–
70+	5.8	4.8	8.5	24.6*	–	–	–
95% CI(-)	1.3	1.2	4.1	17.9	–	–	–
95% CI(+)	1.3	1.2	4.1	34.9	–	–	–
N	23,020	14,428	6,335	1,546	–	–	–

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.3.2. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Age



1.3.3. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Educational Attainment

Current smoking rates were higher with lower education levels. About one out of three White and Black adults with less than high school education (32.1% and 33.7% respectively), and 37.6% of American Indians with a high school education, were current smokers.

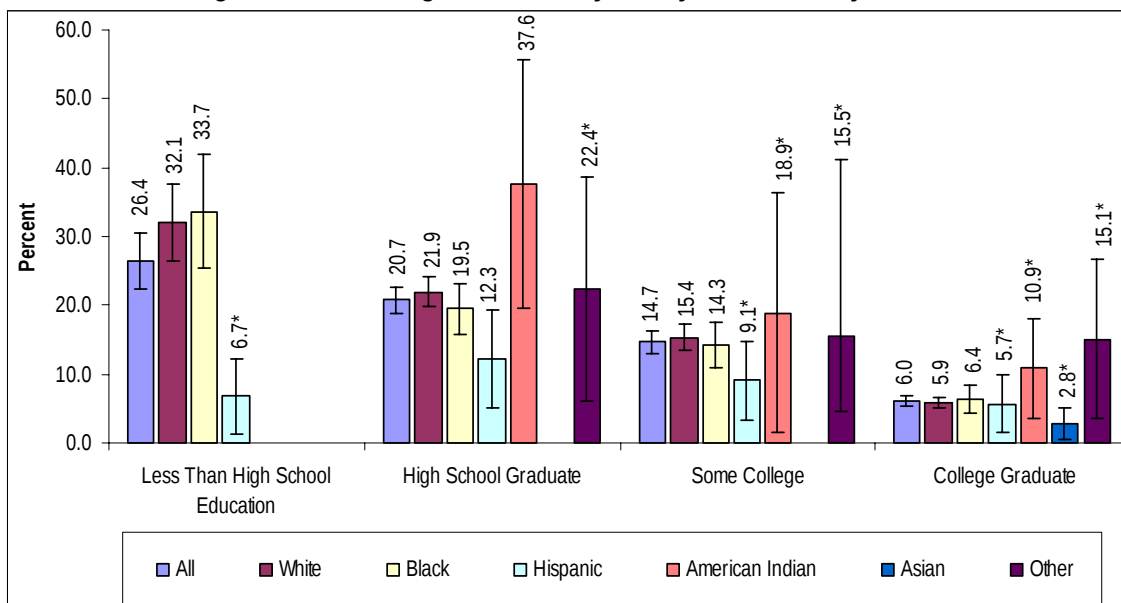
Table 1.3.3. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian		Other
Not High School Graduate	26.4	32.1	33.7	6.7*	–	–	–
95% CI(±)	4.1	5.6	8.2	5.5	–	–	–
N	62,445	30,101	26,722	3,836	–	–	–
High School Graduate	20.7	21.9	19.5	12.3	37.6	–	22.4*
95% CI(±)	1.8	2.2	3.6	7.1	18.1	–	16.3
N	164,644	106,845	46,537	4,586	3,793	–	2,594
Some College	14.7	15.4	14.3	9.1*	18.9*	–	15.5*
95% CI(-)	1.6	1.9	3.3	5.8	17.3	–	10.9
95% CI(+)	1.6	1.9	3.3	5.8	17.3	–	25.8
N	112,847	70,889	33,429	4,180	1,745	–	1,547
College Graduate	6.0	5.9	6.4	5.7*	10.9*	2.8*	15.1*
95% CI(-)	0.8	0.8	2.0	4.2	7.2	2.3	11.6
95% CI(+)	0.8	0.8	2.0	4.2	17.3	2.3	11.6
N	99,573	66,060	21,498	4,268	1,130	2,322	4,296

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.3.3. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Educational Attainment



1.3.4. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Income

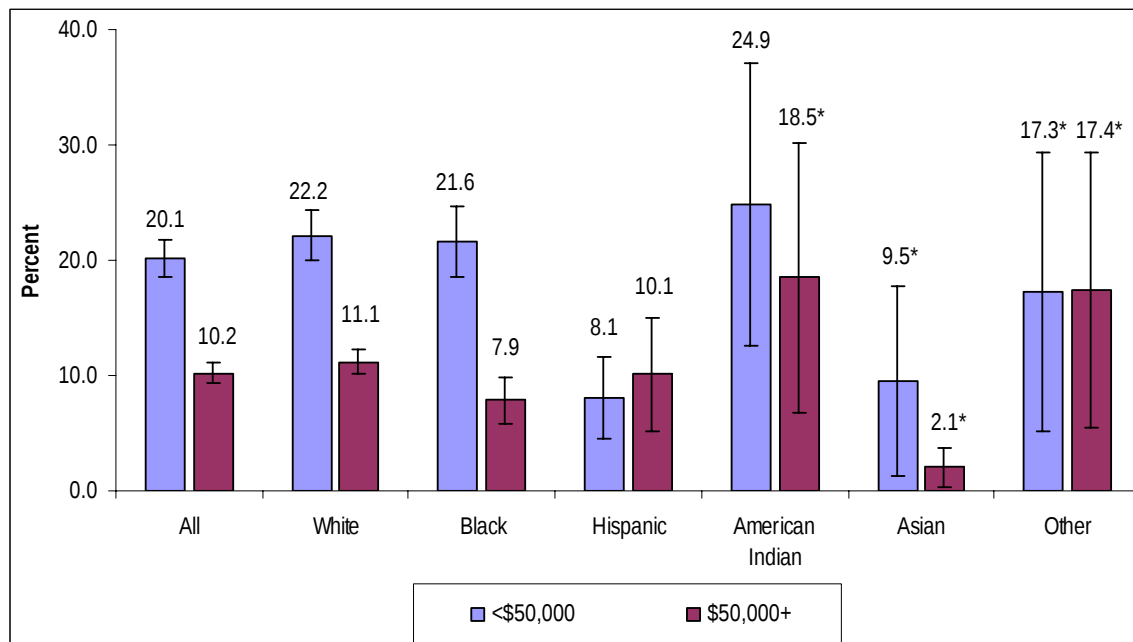
Maryland adults with an annual income of less than \$50,000 were twice as likely as those with an income of at least \$50,000 to smoke cigarettes (20.1% vs. 10.2%). This discrepancy was not found among Hispanics (8.1% and 10.1% respectively).

Table 1.3.4. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	20.1	22.2	21.6	8.1	24.9	9.5*	17.3*
95% CI(±)	1.6	2.2	3.0	3.5	12.2	8.2	12.1
N	246,672	134,716	90,733	11,204	4,348	2,103	3,568
\$50,000+	10.2	11.1	7.9	10.1	18.5*	2.1*	17.4*
95% CI(±)	0.9	1.0	2.0	4.9	11.8	1.7	12.0
N	223,216	163,958	38,777	8,894	3,454	1,589	6,545

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.3.4. Current Cigarette Use Among Adults in Maryland by Race/Ethnicity and Income



1.3.5. Current Cigarette Use Among Adults by Race/Ethnicity and Region

Consistent with patterns of current tobacco use, current smoking rates ranged from 9.2% in Suburban Washington to 17.6% in the Upper Eastern Shore and 18.2% in the Lower Eastern Shore.

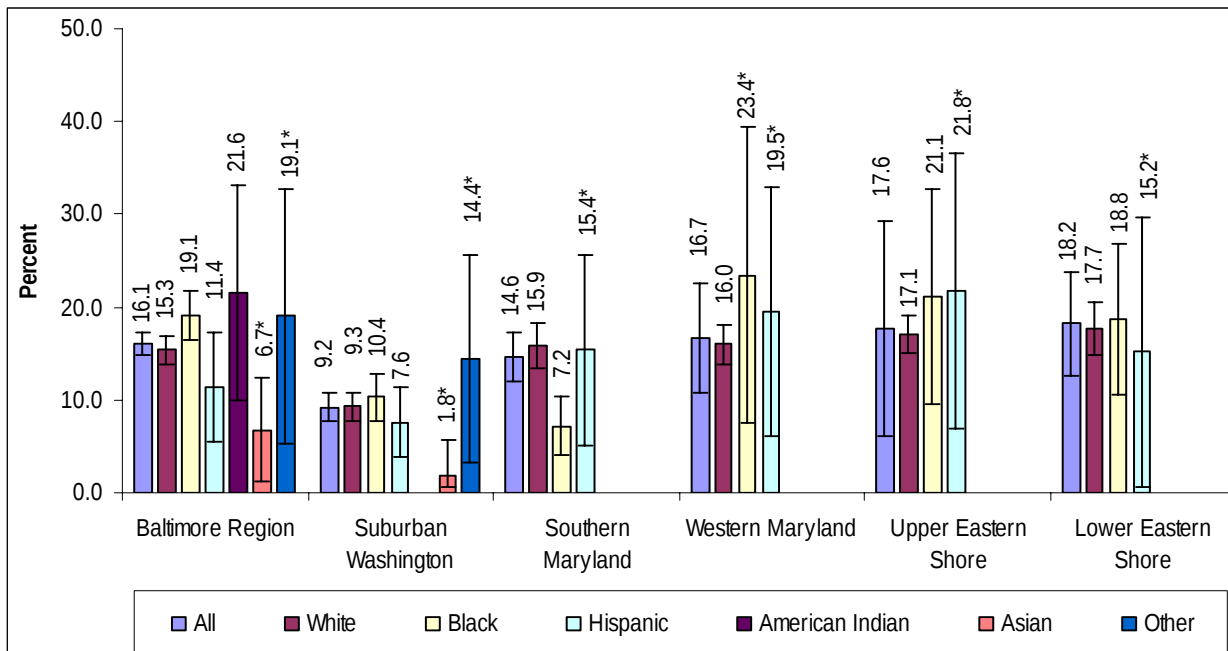
Table 1.3.5. Current Cigarette Use Among Adults by Race/Ethnicity and Region

	All	White	Black	Hispanic	American Indian	Asian	Other
Baltimore Region	16.1	15.3	19.1	11.4	21.6	6.7*	19.1*
95% CI(±)	1.3	1.5	2.7	5.8	11.6	5.6	13.7
N	299,014	188,832	88,911	8,629	4,666	2,644	5,332
Suburban Washington	9.2	9.3	10.4	7.6	–	1.8*	14.4*
95% CI(-)	1.2	1.5	2.5	3.7	–	1.3	11.1
95% CI(+)	1.2	1.5	2.5	3.7	–	4.0	11.1
N	128,983	59,411	51,159	12,216	–	1,210	4,451
Southern Maryland	14.6	15.9	7.2	15.4*	–	–	–
95% CI(±)	2.0	2.4	3.2	10.3	–	–	–
N	33,175	26,867	2,644	2,058	–	–	–
Western Maryland	16.7	16.0	23.4*	19.5*	–	–	–
95% CI(-)	2.2	2.2	16.0	13.5	–	–	–
95% CI(+)	2.2	2.2	16.0	28.4	–	–	–
N	29,010	25,803	1,150	888	–	–	–
Upper Eastern Shore	17.6	17.1	21.1	21.8*	–	–	–
95% CI(±)	2.1	2.1	11.6	14.8	–	–	–
N	29,998	25,160	2,310	1,604	–	–	–
Lower Eastern Shore	18.2	17.7	18.8	15.2*	–	–	–
95% CI(±)	2.7	2.8	8.1	14.5	–	–	–
N	25,974	19,207	4,369	997	–	–	–

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.3.5. Current Cigarette Use Among Adults by Race/Ethnicity and Region



1.3.6 Current Cigarette Use Among Young Adults (18-29) by Race/Ethnicity and Region

In 2006, Suburban Washington regions had the lowest smoking rate (14.5%) among 18-29 year old adults. The Baltimore region had the highest smoking rate (31.5%) for 18-29 year old Whites.

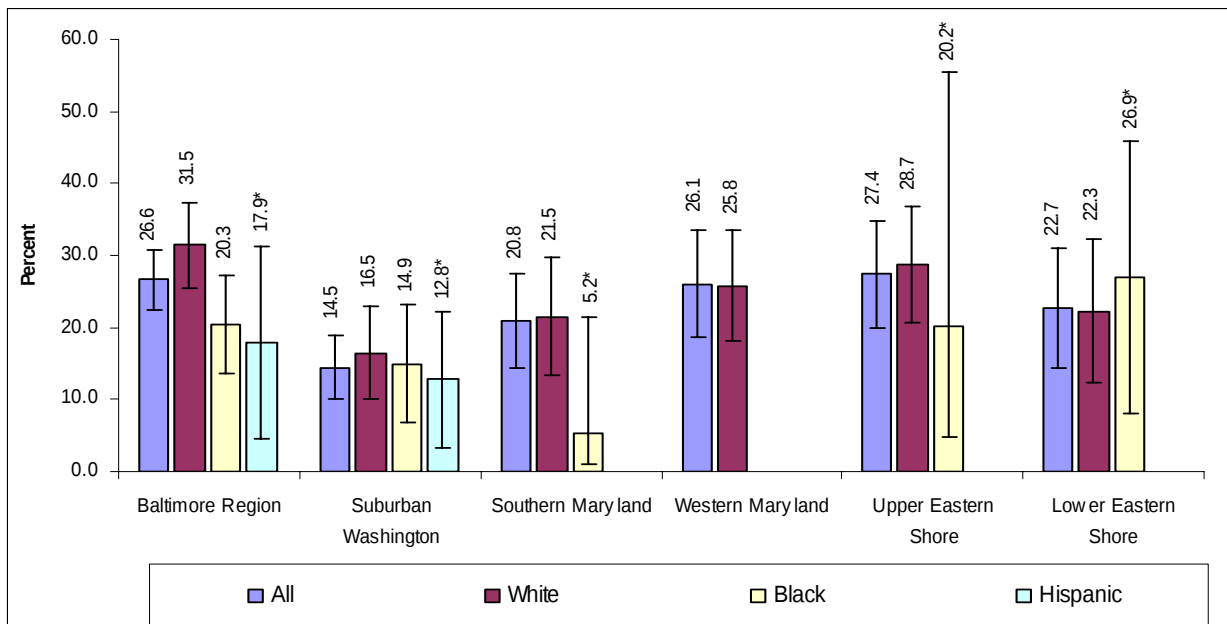
Table 1.3.6 Current Cigarette Use Among Young Adults (18-29) by Race/Ethnicity and Region

	All	White	Black	Hispanic
Baltimore Region	26.6	31.5	20.3	17.9*
95% CI(±)	4.2	5.9	6.8	13.3
N	96,231	64,225	22,393	4,934
Suburban Washington	14.5	16.5	14.9	12.8*
95% CI(±)	4.4	6.5	8.1	9.5
N	37,703	15,625	14,923	6,245
Southern Maryland	20.8	21.5	5.2*	—
95% CI(-)	6.6	8.2	4.1	—
95% CI(+)	6.6	8.2	16.1	—
N	9,747	6,890	332	—
Western Maryland	26.1	25.8	—	—
95% CI(±)	7.4	7.6	—	—
N	9,175	8,092	—	—
Upper Eastern Shore	27.4	28.7	20.2*	—
95% CI(-)	7.4	8.1	15.3	—
95% CI(+)	7.4	8.1	35.3	—
N	8,476	6,872	488	—
Lower Eastern Shore	22.7	22.3	26.9*	—
95% CI(±)	8.3	10.0	18.9	—
N	5,829	3,791	1,300	—

* The relative standard error (RSE) associated with the estimate is greater than 30%.

— Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.3.6 Current Cigarette Use Among Young Adults (18-29) by Race/Ethnicity and Region



1.4. Number of Cigarettes Adult Current Smokers Have Per Day by Race/Ethnicity

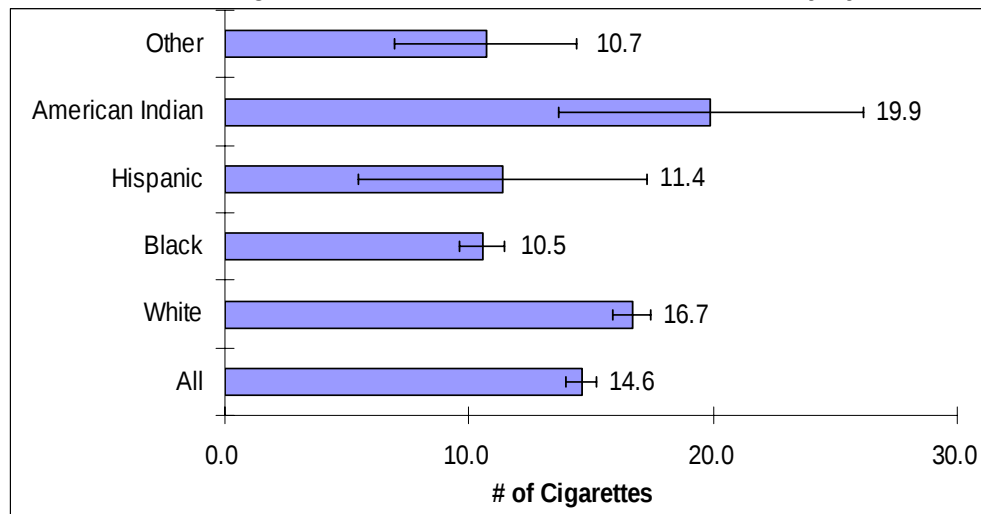
The average number of cigarettes smoked per day by current smokers was 14.6 in 2006, and varied by race/ethnicity. American Indian current smokers smoked an average of almost a pack of cigarettes a day (19.9 cigarettes). Black current smokers smoked fewer cigarettes per day (10.5) than White (16.7) and American Indian current smokers (19.9). Although not shown, current smokers with less education and lower incomes smoked more cigarettes. Within education and income categories, Blacks smoked fewer cigarettes than Whites.

One paradox is while current Black smokers smoke less, Blacks have higher rates of lung cancer. Possible explanations include environmental factors and smoking patterns. Blacks tend to work in occupations where they are exposed to higher amounts of workplace carcinogens and are more likely to live in neighborhoods closer to hazardous chemicals (Schwartz and Swanson 1997). In addition, 3 out of 4 Black adults use menthol cigarettes compared with 1 out of 4 Whites (Garten and Falkner 2004). Greater use of menthol cigarettes may contribute to higher rates of lung cancer among Blacks, as it is thought that menthol cigarettes anesthetize the throat and allow deeper inhalation.

Table 1.4. Number of Cigarettes Adult Current Smokers Have Per Day by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Other
# of Cigarettes	14.6	16.7	10.5	11.4	19.9	10.7
95% CI(±)	0.7	0.8	0.9	5.9	6.2	3.7
N	547,675	339,463	149,911	24,328	8,077	11,134

Figure 1.4. Number of Cigarettes Adult Current Smokers Have Per Day by Race/Ethnicity



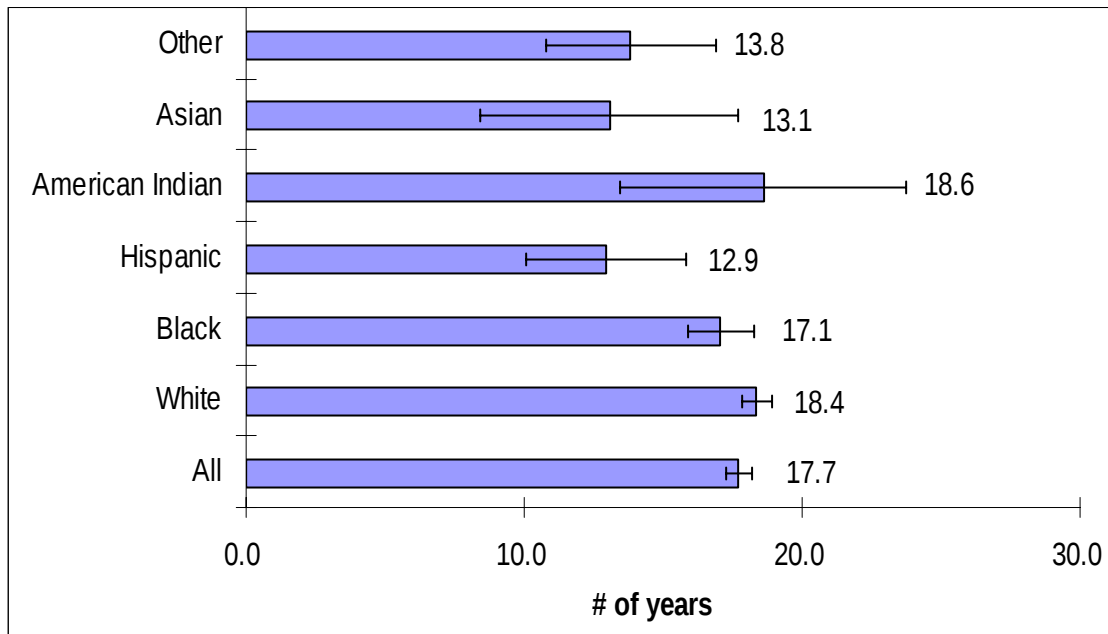
1.5. Number of Years That Current and Former Adult Smokers Smoked Everyday by Race/Ethnicity

Current and former adult daily smokers (general population) smoked an average of 17.7 years. Hispanic current and former daily smokers have smoked for fewer years than Whites (12.9 years vs. 18.4 years).

Table 1.5. Number of Years That Current and Former Adult Smokers Smoked Everyday by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
# of Years	17.7	18.4	17.1	12.9	18.6	13.1	13.8
95% CI(±)	0.5	0.5	1.2	2.9	5.2	4.6	3.0
N	1,229,042	849,236	260,557	56,873	13,578	11,088	14,927

Figure 1.5. Number of Years That Current and Former Adult Smokers Smoked Everyday by Race/Ethnicity



1.5.1. Number of Years That Current and Former Adult Smokers Smoked Everyday by Race/Ethnicity and Educational Attainment

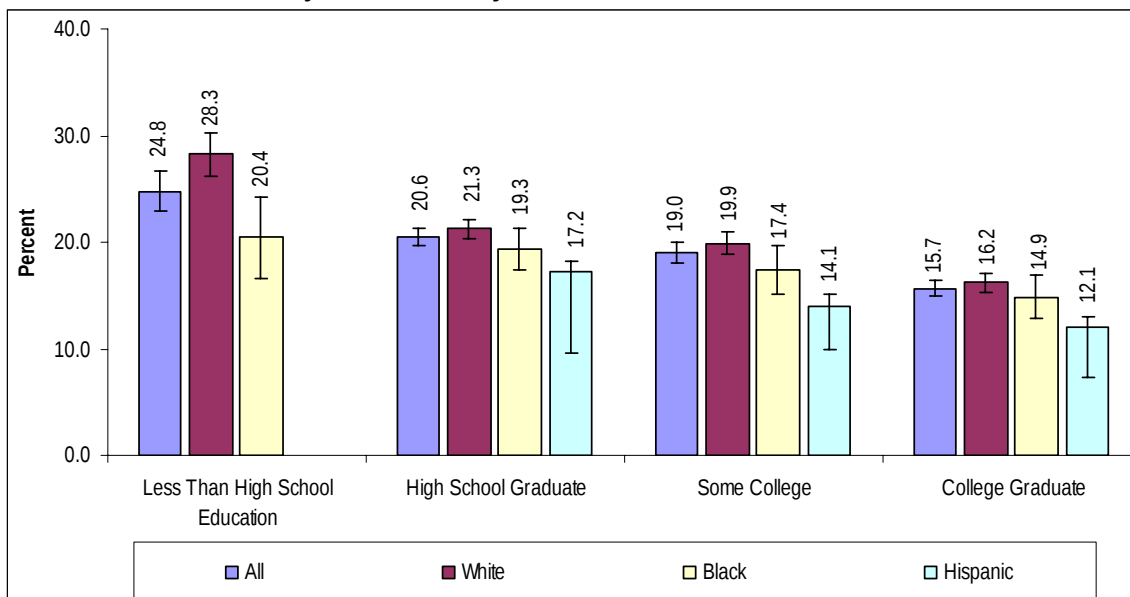
The number of years that current and former smokers smoked every day was greater for those with less education. For instance, Black smokers with less than a high school education smoked an average of 20.4 years compared to 14.9 years for Black smokers with a college education.

Table 1.5.1. Number of Years That Current and Former Adult Smokers Smoked Everyday by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic
Not High School Graduate	24.8	28.3	20.4	–
95% CI(±)	1.9	2.1	3.8	–
N	98,491	54,911	34,276	–
High School Graduate	20.6	21.3	19.3	17.2
95% CI(±)	0.8	0.9	2.0	7.6
N	325,867	229,822	77,173	8,341
Some College	19.0	19.9	17.4	14.1
95% CI(±)	0.9	1.0	2.2	4.1
N	271,836	193,509	63,279	8,011
College Graduate	15.7	16.2	14.9	12.1
95% CI(±)	0.8	0.9	2.1	4.7
N	400,555	289,412	69,008	26,137

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.5.1. Number of Years That Current and Former Adult Smokers Smoked Everyday by Race/Ethnicity and Educational Attainment



1.5.2. Number of Years That Current and Former Adult Smokers Smoked Everyday by Race/Ethnicity and Income

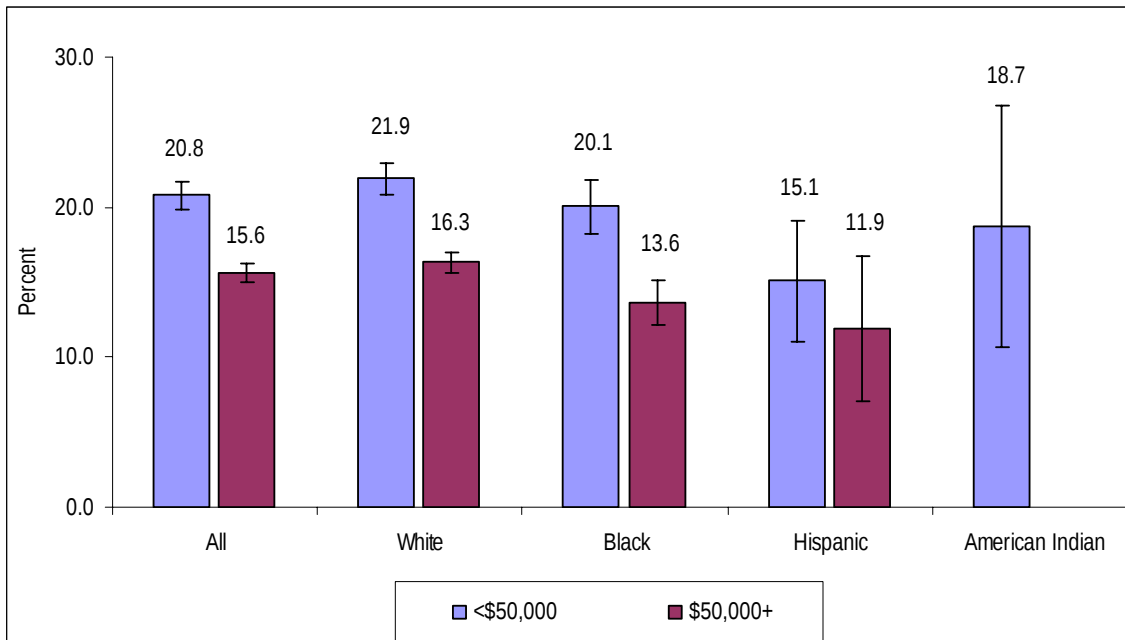
The number of years that current and former smokers smoked every day was greater with lower annual income for Whites, Blacks and the general population.

Table 1.5.2. Number of Years That Current and Former Adult Smokers Smoked Everyday by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian
<\$50,000	20.8	21.9	20.1	15.1	18.7
95% CI(±)	0.9	1.1	1.8	4.0	8.1
N	437,194	269,389	126,135	22,656	8,301
\$50,000+	15.6	16.3	13.6	11.9	–
95% CI(±)	0.6	0.7	1.5	4.9	–
N	601,793	453,331	106,411	24,898	–

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.5.2. Number of Years That Current and Former Adult Smokers Smoked Everyday by Race/Ethnicity and Income



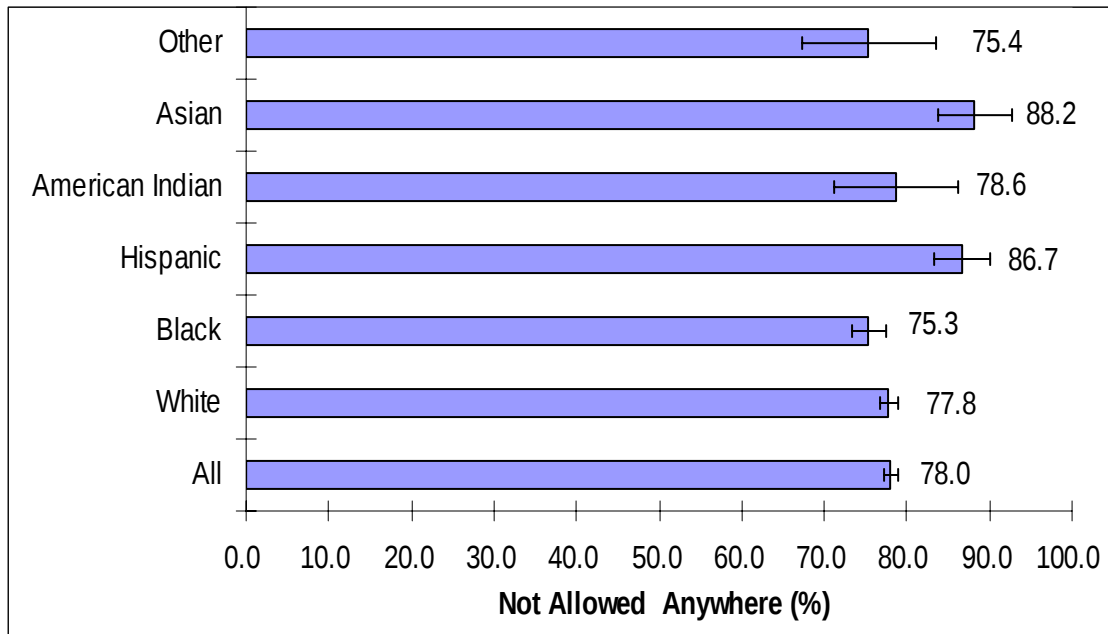
1.6. Smoking Not Allowed Inside Home by Race/Ethnicity

Almost eight out of every ten (78%) respondents (general population) reported that smoking was not allowed in their home—ranging from 75.3% of Blacks, to 88.2% of Asians.

Table 1.6. Smoking Not Allowed Inside Home by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Not Allowed Anywhere	78.0	77.8	75.3	86.7	78.6	88.2	75.4
95% CI(±)	0.9	1.0	2.1	3.5	7.5	4.5	8.0
N	3,113,042	1,911,845	785,021	234,545	30,987	101,005	49,640

Figure 1.6. Smoking Not Allowed Inside Home by Race/Ethnicity



1.6.1. Smoking Not Allowed Inside Home by Race/Ethnicity and Educational Attainment

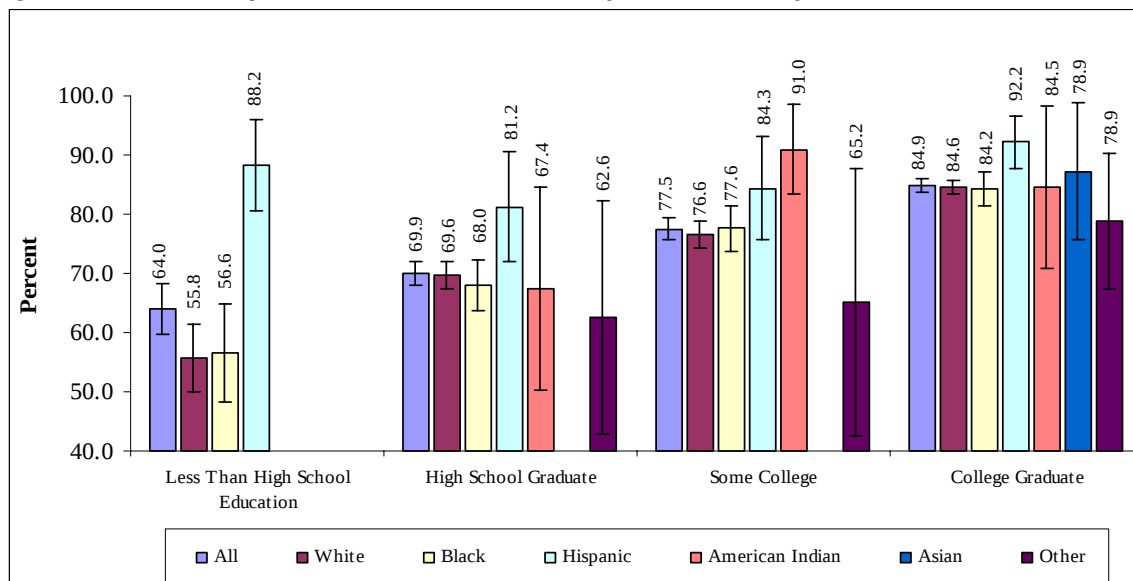
In general, Maryland adults with less education were the least likely to have a rule prohibiting smoking inside the home. Among adults with less than a high school education, Hispanics (88.2%) were the most likely to have a rule regarding smoking in the home.

1.6.1. Smoking Not Allowed Inside Home by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	64.0	55.8	56.6	88.2	–	–	–
95% CI(±)	4.4	5.7	8.3	7.7	–	–	–
N	151,235	52,392	45,042	50,511	–	–	–
High School Graduate	69.9	69.6	68.0	81.2	67.4	–	62.6
95% CI(±)	2.0	2.3	4.3	9.3	17.1	–	19.7
N	556,656	339,317	162,819	30,321	6,800	–	7,252
Some College	77.5	76.6	77.6	84.3	91.0	–	65.2
95% CI(±)	1.9	2.2	3.9	8.7	7.6	–	22.6
N	598,222	354,033	182,794	38,777	8,385	–	6,614
College Graduate	84.9	84.6	84.2	92.2	84.5	87.3	78.9
95% CI(±)	1.1	1.2	2.9	4.4	13.7	5.5	11.5
N	1,405,294	949,153	283,318	68,964	8,752	72,676	22,430

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.6.1. Smoking Not Allowed Inside Home by Race/Ethnicity and Educational Attainment



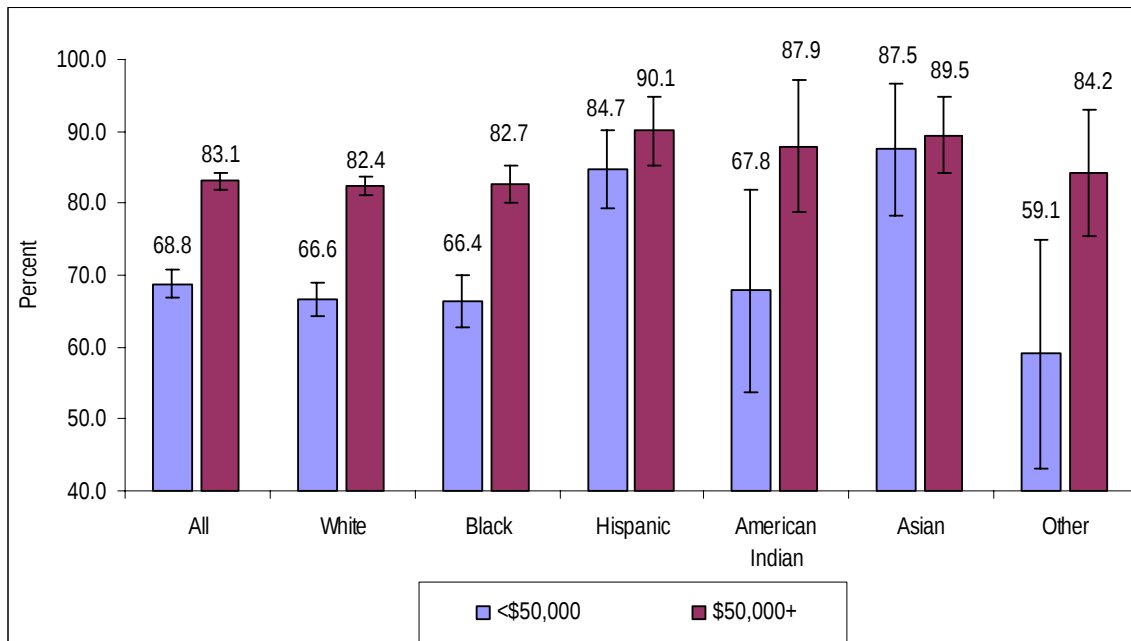
1.6.2. Smoking Not Allowed Inside Home by Race/Ethnicity and Income

Maryland adults with lower income (<\$50,000 per year) were less likely to have a rule prohibiting smoking in the home for whites, Blacks and the general population.

Table 1.6.2. Smoking Not Allowed Inside Home by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	68.8	66.6	66.4	84.7	67.8	87.5	59.1
95% CI(±)	1.9	2.4	3.5	5.4	14.0	9.2	15.8
N	846,487	405,085	280,790	117,475	11,846	19,121	12,169
\$50,000+	83.1	82.4	82.7	90.1	87.9	89.5	84.2
95% CI(±)	1.1	1.2	2.7	4.8	9.1	5.3	8.9
N	1,819,444	1,213,137	408,724	80,223	15,579	69,974	31,807

Figure 1.6.2. Smoking Not Allowed Inside Home by Race/Ethnicity and Income



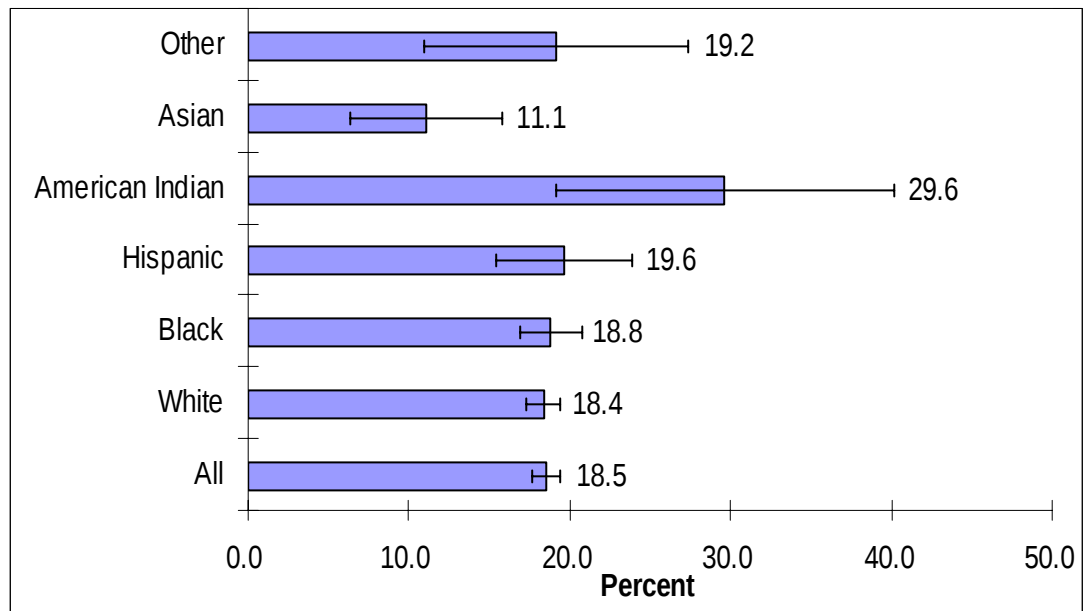
1.7. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity

About one out of five (18.5%) Maryland adults reported being exposed to secondhand smoke in the car, ranging from 11.1% among Asians to 29.6% among American Indians.

Table 1.7. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	18.5	18.4	18.8	19.6	29.6	11.1	19.2
95% CI(±)	0.9	1.0	1.9	4.2	10.5	4.7	8.2
N	738,530	452,342	196,135	52,904	11,960	12,683	12,505

Figure 1.7. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity



1.7.1. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity and Gender

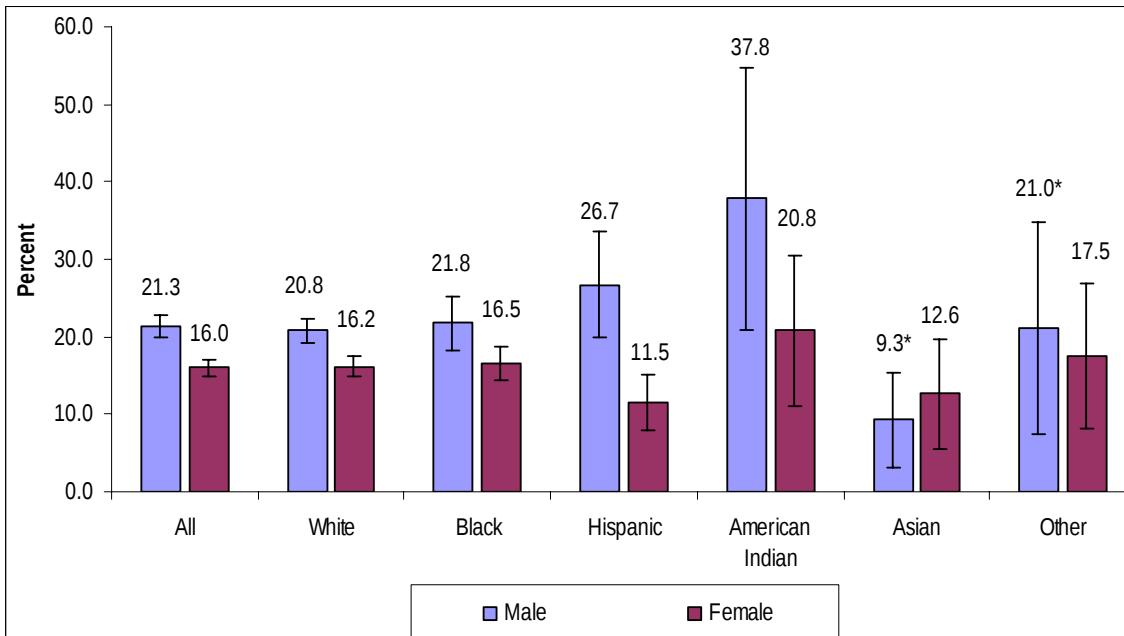
In general, men were more likely than women to report recent exposure to secondhand smoke in a car. Among American Indians, 37.8% of males and 20.8% of females reported recent exposure to secondhand smoke in a car.

Table 1.7.1. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity and Gender

	All	White	Black	Hispanic	American Indian	Asian	Other
Male	21.3	20.8	21.8	26.7	37.8	9.3*	21.0*
95% CI(±)	1.5	1.6	3.5	6.9	17.0	6.0	13.7
N	401,545	245,106	98,521	38,497	7,919	5,018	6,484
Female	16.0	16.2	16.5	11.5	20.8	12.6	17.5
95% CI(±)	1.0	1.3	2.1	3.6	9.7	7.1	9.3
N	336,985	207,236	97,614	14,408	4,041	7,664	6,021

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.7.1. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity and Gender



1.7.2. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity and Educational Attainment

In general, Maryland adults with less education were the most likely to be exposed to secondhand smoke in a car (consistent with the finding that those with lower incomes are more likely to smoke). More than half of American Indian high school graduates (53.2%) were exposed to secondhand smoke in a car.

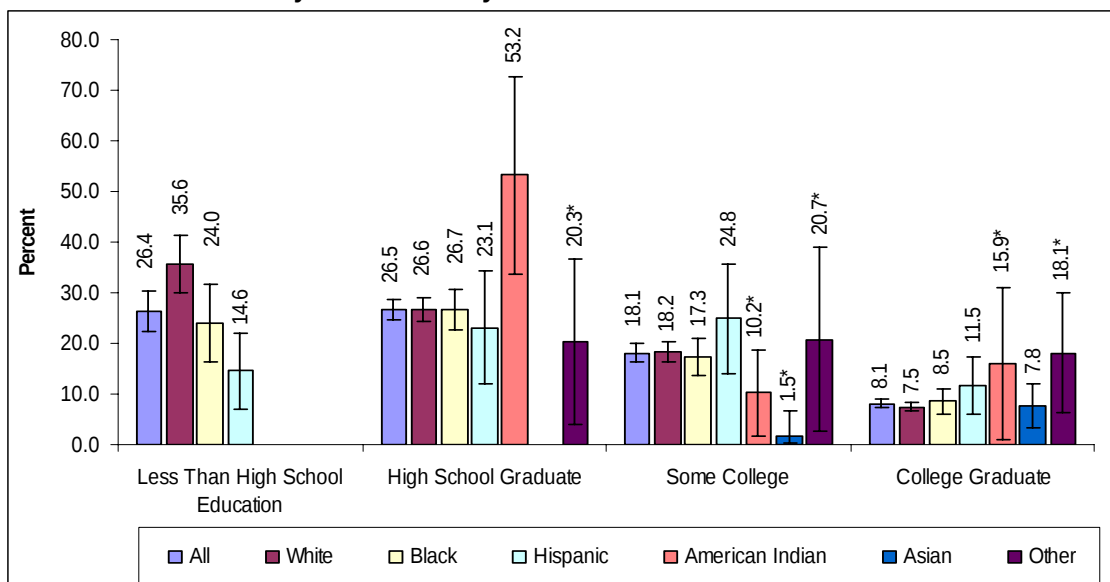
Table 1.7.2. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	26.4	35.6	24.0	14.6	–	–	–
95% CI(±)	4.0	5.6	7.6	7.5	–	–	–
N	62,639	33,659	19,091	8,296	–	–	–
High School Graduate	26.5	26.6	26.7	23.1	53.2	–	20.3*
95% CI(±)	2.0	2.3	4.1	11.1	19.5	–	16.3
N	211,615	130,009	63,846	8,639	5,363	–	2,352
Some College	18.1	18.2	17.3	24.8	10.2*	1.5*	20.7*
95% CI(-)	1.8	2.0	3.6	11.0	8.6	1.2	18.1
95% CI(+)	1.8	2.0	3.6	11.0	8.6	5.2	18.1
N	139,753	84,291	40,854	11,425	940	138	2,106
College Graduate	8.1	7.5	8.5	11.5	15.9*	7.8	18.1*
95% CI(±)	0.9	0.9	2.4	5.7	15.1	4.3	11.8
N	134,629	84,059	28,650	8,629	1,651	6,515	5,127

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.7.2. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity and Educational Attainment



1.7.3. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity and Income

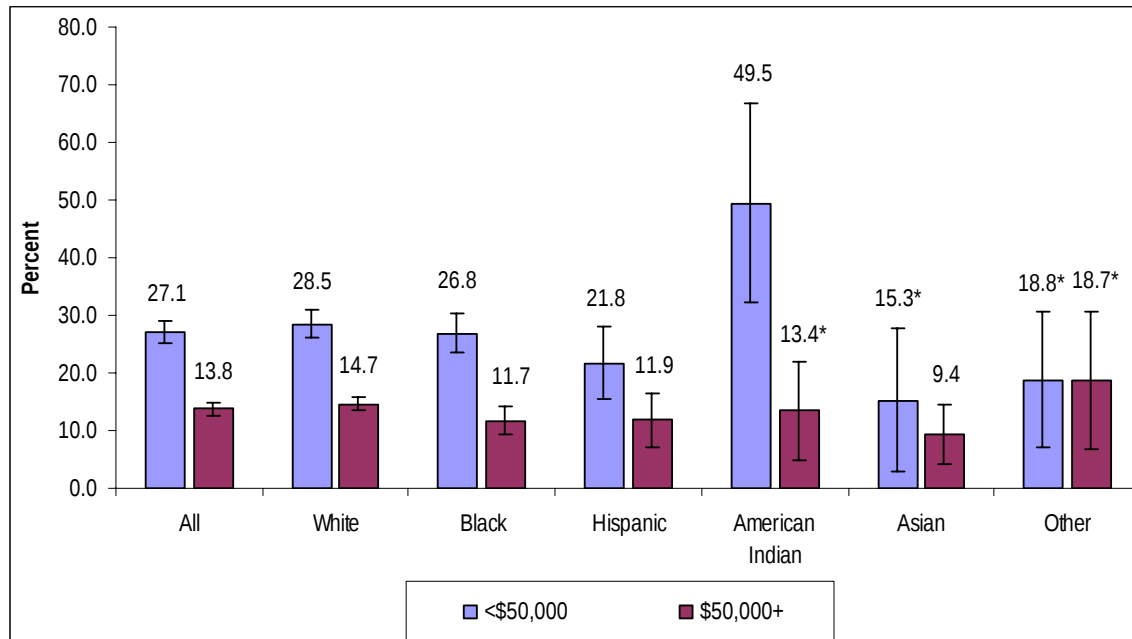
In general, Maryland adults with lower incomes were the most likely to be exposed to secondhand smoke in a car. Half of American Indians with an income of less than \$50,000 per year were exposed to secondhand smoke in a car.

Table 1.7.3. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	27.1	28.5	26.8	21.8	49.5	15.3*	18.8*
95% CI(±)	1.8	2.4	3.3	6.4	17.4	12.3	11.7
N	333,290	173,655	113,648	30,181	8,651	3,378	3,777
\$50,000+	13.8	14.7	11.7	11.9	13.4*	9.4	18.7*
95% CI(±)	1.0	1.2	2.4	4.7	8.7	5.2	11.9
N	301,607	216,372	57,735	10,621	2,508	7,311	7,060

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.7.3. Adults Reporting Recent Exposure to Secondhand Smoke in a Car by Race/Ethnicity and Income



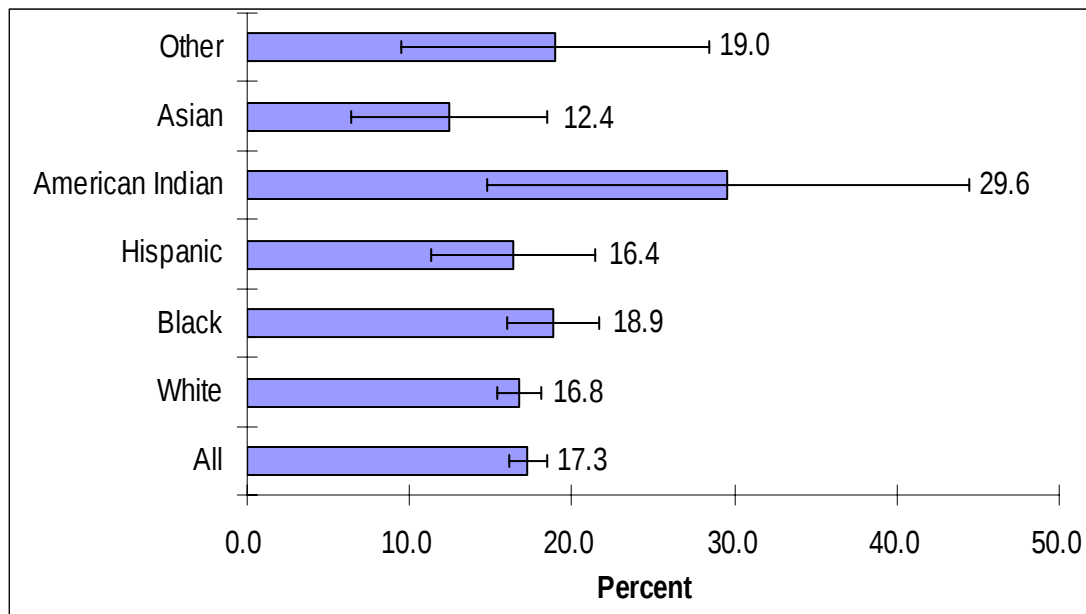
1.8. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity

Among all Maryland adults, 17.3% reported exposure to secondhand smoke in the workplace, ranging from 12.4% for Asians to 29.6% for American Indians. Hispanics (16.4%) and Whites (16.8%) had similar rates of exposure to secondhand smoke in the workplace.

Table 1.8. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	17.3	16.8	18.9	16.4	29.6	12.4	19.0
95% CI(±)	1.2	1.4	2.8	5.0	14.9	6.0	9.5
N	368,142	217,333	107,385	21,885	5,420	8,960	7,160

Figure 1.8. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity



1.8.1. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity and Gender

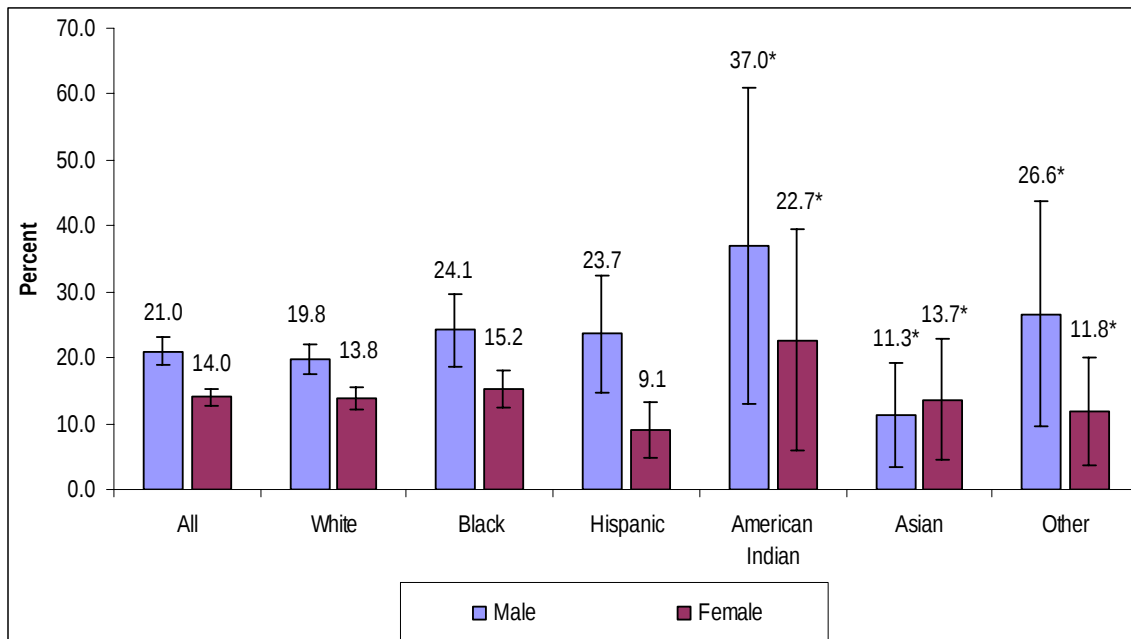
In general, men were more likely than women to be exposed to secondhand smoke in the workplace.

Table 1.8.1. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity and Gender

	All	White	Black	Hispanic	American Indian	Asian	Other
Male	21.0	19.8	24.1	23.7	37.0*	11.3*	26.6*
95% CI(±)	2.1	2.2	5.4	8.9	24.1	7.8	17.1
N	210,883	126,578	56,056	15,778	3,277	4,341	4,854
Female	14.0	13.8	15.2	9.1	22.7*	13.7*	11.8*
95% CI(±)	1.3	1.6	2.9	4.2	16.8	9.2	8.1
N	157,259	90,756	51,329	6,107	2,143	4,619	2,306

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.8.1. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity and Gender



1.8.2. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity and Educational Attainment

In general, Maryland adults with less education were more likely to report exposure to secondhand smoke in the workplace.

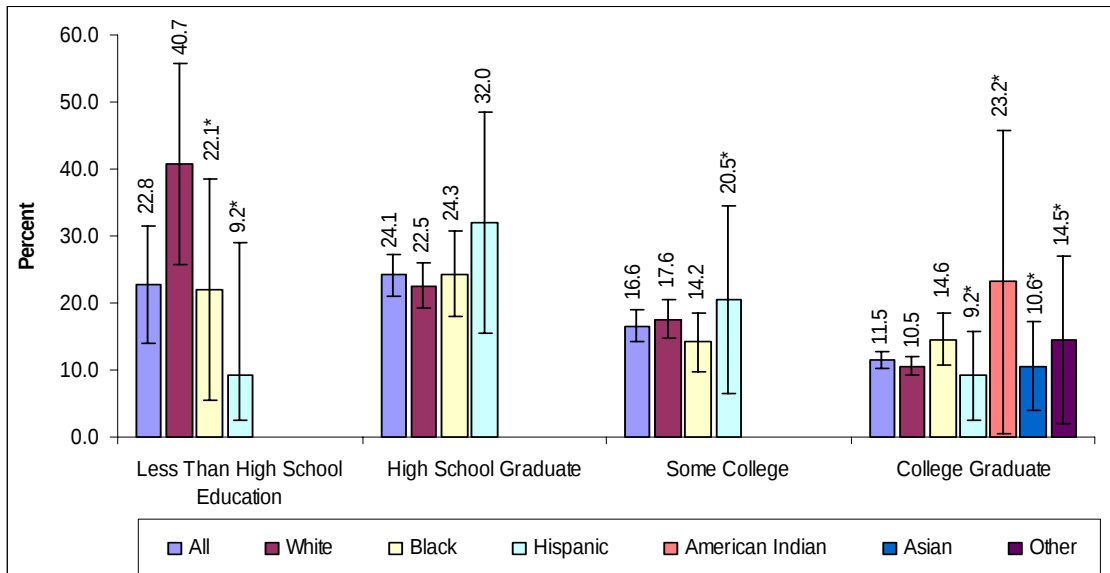
Table 1.8.2. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	22.8	40.7	22.1*	9.2*	–	–	–
95% CI(-)	8.7	15.0	16.5	6.7	–	–	–
95% CI(+)	8.7	15.0	16.5	19.8	–	–	–
N	11,350	6,297	3,261	1,729	–	–	–
High School Graduate	24.1	22.5	24.3	32.0	–	–	–
95% CI(±)	3.1	3.4	6.4	16.4	–	–	–
N	75,997	42,285	23,521	5,790	–	–	–
Some College	16.6	17.6	14.2	20.5*	–	–	–
95% CI(±)	2.4	2.9	4.4	14.0	–	–	–
N	66,174	39,432	19,285	4,760	–	–	–
College Graduate	11.5	10.5	14.6	9.2*	23.2*	10.6*	14.5*
95% CI(±)	1.4	1.4	3.8	6.6	22.7	6.7	12.5
N	125,677	75,163	35,052	5,012	1,554	5,865	3,031

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.8.2. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity and Educational Attainment



1.8.3. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity and Income

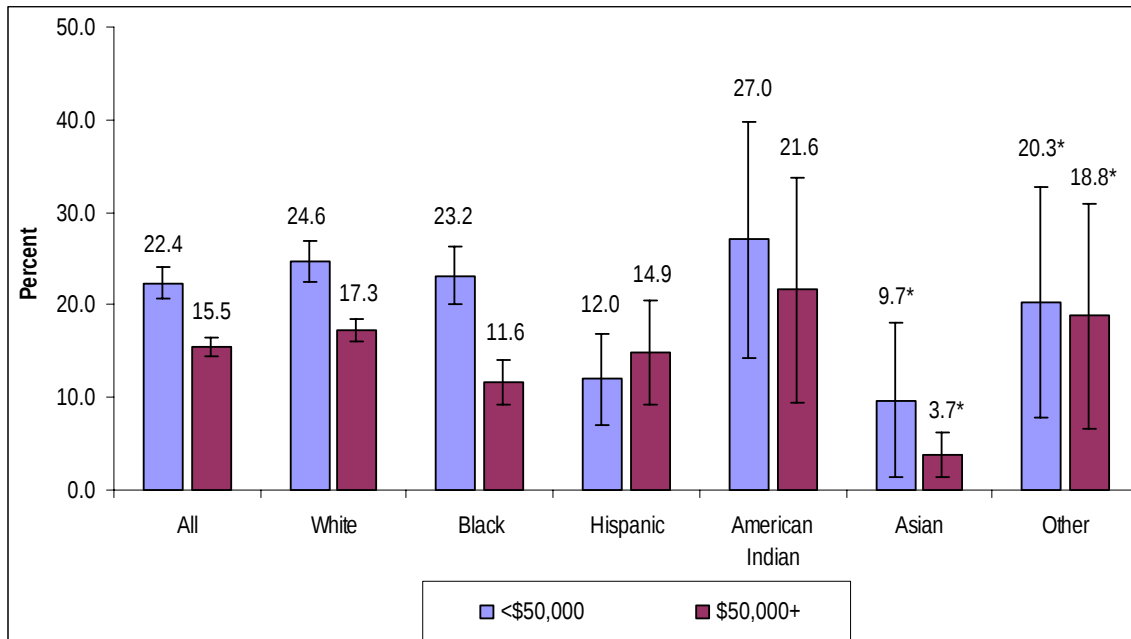
In general, adults with less income (<\$50,000 per year) were more likely to report exposure to secondhand smoke in the workplace than adults with more income.

Table 1.8.3. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	22.4	24.6	23.2	12.0	27.0	9.7*	20.3*
95% CI(±)	1.7	2.2	3.2	4.9	12.7	8.4	12.4
N	273,407	148,934	96,995	16,534	4,696	2,103	4,145
\$50,000+	15.5	17.3	11.6	14.9	21.6	3.7*	18.8*
95% CI(±)	1.1	1.2	2.4	5.6	12.2	2.4	12.2
N	336,308	252,431	56,920	13,095	4,042	2,864	6,956

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.8.3. Adults Reporting Exposure to Secondhand Smoke in the Workplace by Race/Ethnicity and Income



1.9. Use of Any Smokeless Tobacco Products Such As Chewing Tobacco or Snuff Among Maryland Adults by Race/Ethnicity

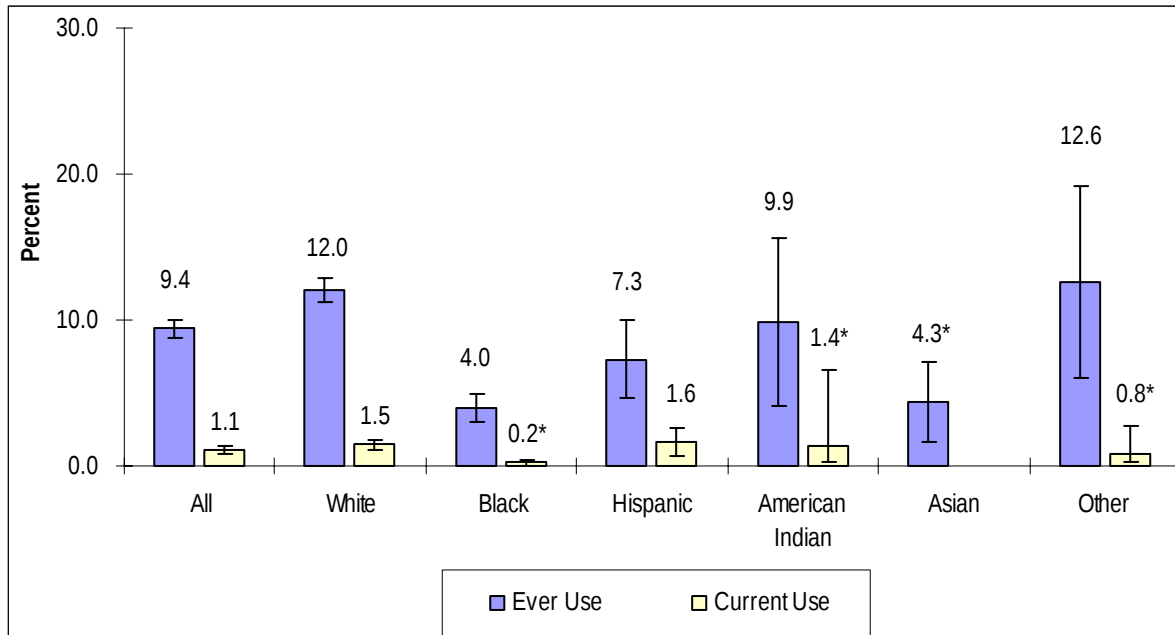
Around nine percent (9.4%) of Maryland adults reported ever using smokeless tobacco products such as chewing tobacco or snuff, however, few respondents of any group reported currently using smokeless tobacco products (1.1%). White adults (12%) were significantly more likely to report having ever used smokeless tobacco products compared to Blacks (4%), Hispanics (7.3%), or Asians (4.3%).

Table 1.9. Use of Any Smokeless Tobacco Products Such As Chewing Tobacco or Snuff Among Maryland Adults by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Ever Use	9.4	12.0	4.0	7.3	9.9	4.3*	12.6
95% CI(±)	0.6	0.8	1.0	2.6	5.8	2.7	6.6
N	375,327	296,382	41,970	19,723	3,989	4,960	8,302
Current Use	1.1	1.5	0.2*	1.6	1.4*	–	0.8*
95% CI(-)	0.2	0.3	0.2	0.9	1.1	–	0.6
95% CI(+)	0.2	0.3	0.2	0.9	5.3	–	2.0
N	43,760	36,205	2,151	4,326	549	–	502

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.9. Use of Any Smokeless Tobacco Products Such As Chewing Tobacco or Snuff Among Maryland Adults by Race/Ethnicity



1.10. Use of Cigars Among Maryland Adults by Race/Ethnicity

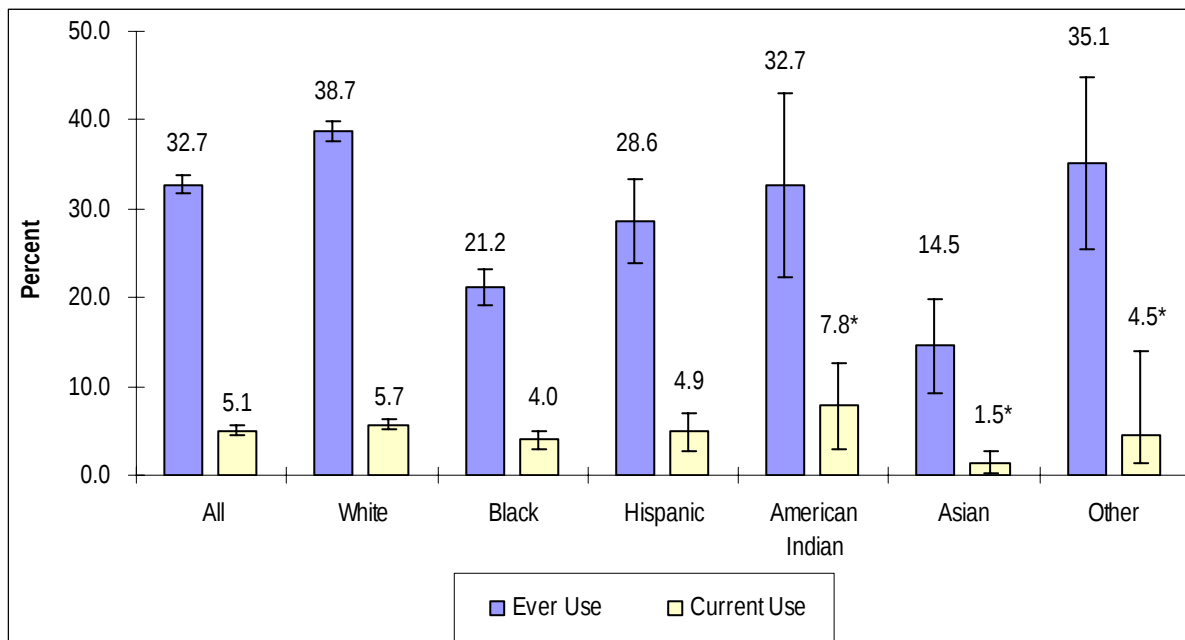
Around one out of three Maryland adults reported ever smoking cigars (32.7%) with Asians having substantially lower rates. Around five percent of all adults reported current use of cigars (5.1%).

Table 1.10. Use of Cigars Among Maryland Adults by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Ever Use	32.7	38.7	21.2	28.6	32.7	14.5	35.1
95% CI(±)	1.0	1.2	2.0	4.8	10.3	5.4	9.6
N	1,304,063	952,690	221,177	77,322	13,183	16,614	23,077
Current Use	5.1	5.7	4.0	4.9	7.8*	1.5*	4.5*
95% CI(-)	0.5	0.6	1.1	2.2	4.9	1.3	3.2
95% CI(+)	0.5	0.6	1.1	2.2	4.9	1.3	9.5
N	201,967	139,811	41,263	13,112	3,143	1,664	2,974

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.10. Use of Cigars Among Maryland Adults by Race/Ethnicity



1.10.1 Current Use of Cigars Among Maryland Adults by Race/Ethnicity and Gender

Men are more likely than women to smoke cigars, regardless of race and ethnicity (9.6% vs. 1.0%).

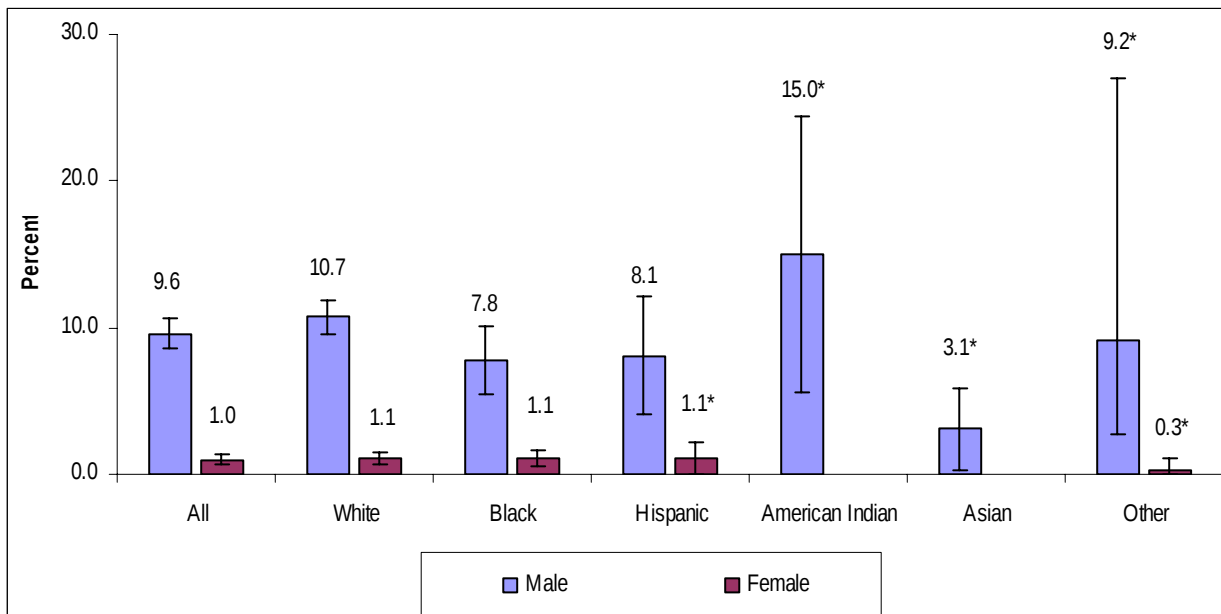
Table 1.10.1 Current Use of Cigars Among Maryland Adults by Race/Ethnicity and Gender

	All	White	Black	Hispanic	American Indian	Asian	Other
Male	9.6	10.7	7.8	8.1	15.0*	3.1*	9.2*
95% CI(-)	1.0	1.2	2.3	4.0	9.4	2.8	6.5
95% CI(+)	1.0	1.2	2.3	4.0	9.4	2.8	17.9
N	180,665	126,308	34,993	11,677	3,143	1,664	2,879
Female	1.0	1.1	1.1	1.1*	–	–	0.3*
95% CI(-)	0.3	0.4	0.6	1.1	–	–	0.2
95% CI(+)	0.3	0.4	0.6	1.1	–	–	0.9
N	21,302	13,503	6,269	1,435	–	–	95

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.10.1 Current Use of Cigars Among Maryland Adults by Race/Ethnicity and Gender



1.11. Use of Tobacco in a Pipe Among Maryland Adults by Race/Ethnicity

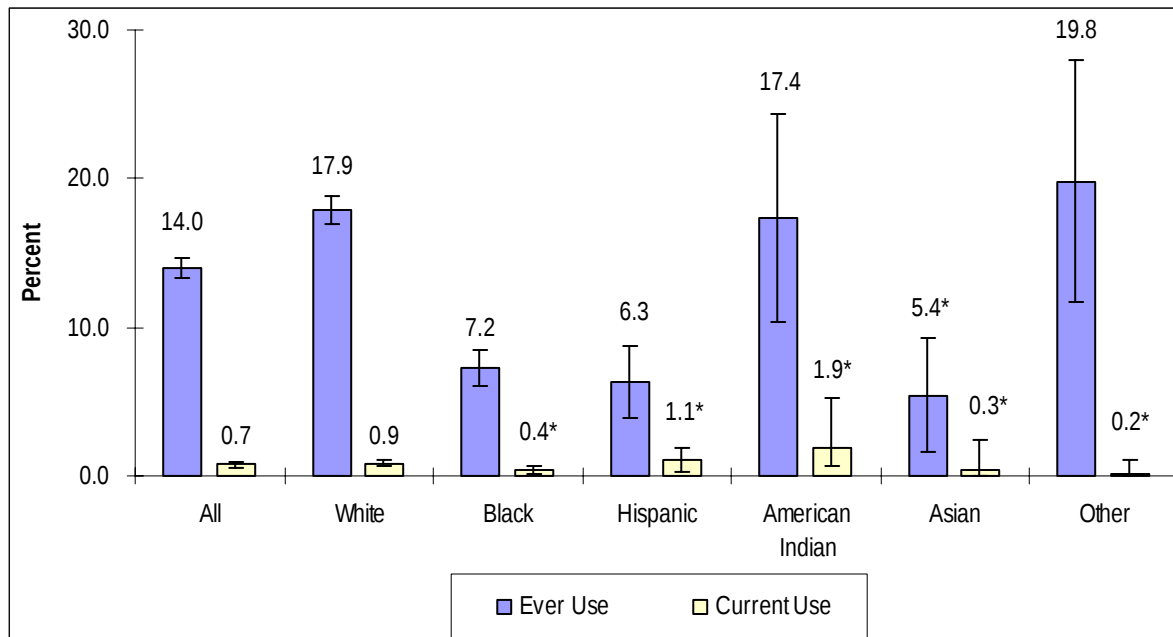
Fourteen percent (14.0%) of all Maryland adults ever used pipe tobacco, although less than one percent currently used pipe tobacco (0.7%). Whites (17.9%), American Indians (17.4%) and persons of Other race/ethnicity (19.8%) were the most likely to ever use pipe tobacco, with Blacks (7.2%), Asians (5.4%) and Hispanics (6.3%) being the least likely.

Table 1.11. Use of Tobacco in a Pipe Among Maryland Adults by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Ever Use	14.0	17.9	7.2	6.3	17.4	5.4	19.8
95% CI(±)	0.7	0.9	1.2	2.4	7.0	3.8	8.2
N	558,767	440,139	75,438	16,939	7,020	6,229	13,002
Current Use	0.7	0.9	0.4*	1.1*	1.9*	0.3*	0.2*
95% CI(-)	0.2	0.3	0.3	0.8	1.2	0.3	0.1
95% CI(+)	0.2	0.3	0.3	0.8	3.3	2.0	1.0
N	29,855	21,077	4,471	3,036	778	388	105

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.11. Use of Tobacco in a Pipe Among Maryland Adults by Race/Ethnicity



1.12. Use of Bidi (Flavored Cigarette From India) Among Maryland Adults by Race/Ethnicity

Approximately one out of twenty Maryland adults (4.7%) reported having ever used bidi (flavored cigarettes from India) although less than one percent (0.2%) currently used bidi. Blacks (7%) and Hispanics (6.8%) were significantly more likely to have ever used bidi than Whites (3.2%).

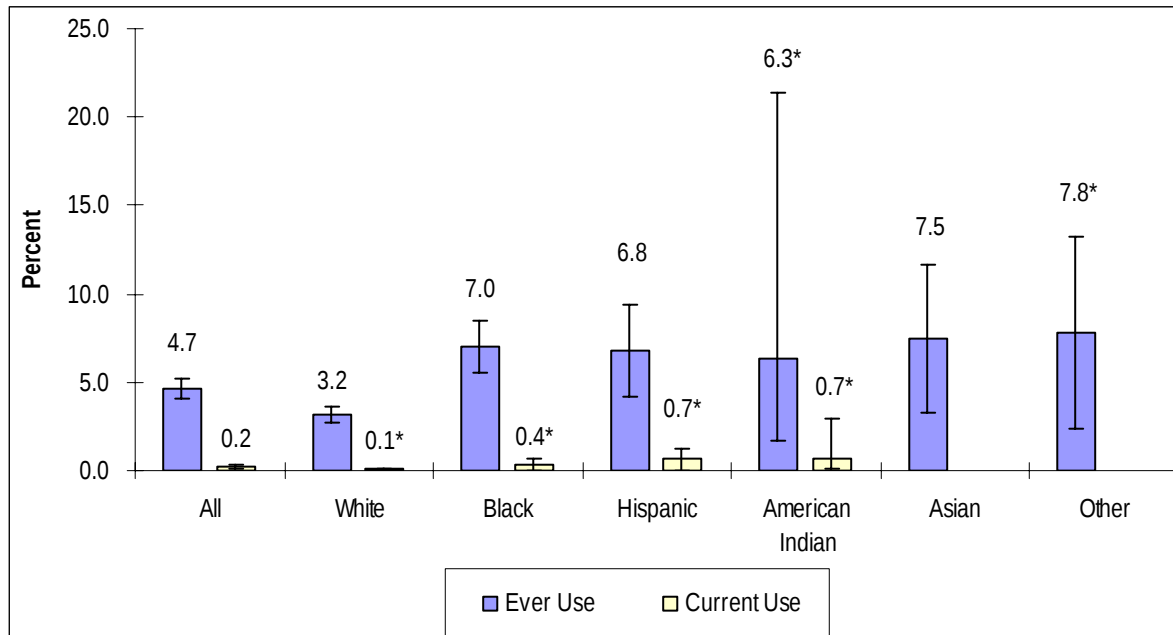
Table 1.12. Use of Bidi (Flavored Cigarette From India) Among Maryland Adults by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Ever Use	4.7	3.2	7.0	6.8	6.3*	7.5	7.8*
95% CI(-)	0.5	0.5	1.4	2.6	4.7	4.2	5.4
95% CI(+)	0.5	0.5	1.4	2.6	15.1	4.2	5.4
N	185,603	77,950	73,126	18,313	2,548	8,589	5,077
Current Use	0.2	0.1*	0.4*	0.7*	0.7*	–	–
95% CI(-)	0.1	0.1	0.3	0.6	0.5	–	–
95% CI(+)	0.1	0.1	0.3	0.6	2.2	–	–
N	7,560	1,766	3,726	1,798	270	–	–

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.12. Use of Bidi (Flavored Cigarette From India) Among Maryland Adults by Race/Ethnicity



1.13. Use of Kreteks (Cigarettes Made of Tobacco and Clove Extract) Among Maryland Adults by Race/Ethnicity

Approximately four percent (3.9%) of Maryland adults reported ever using kreteks (cigarettes made of tobacco and clove extract). However, less than one percent (0.4%) of all adults reported current use of kreteks. Whites (5.0%) were significantly more likely to report ever use of kreteks than Blacks (1.9%).

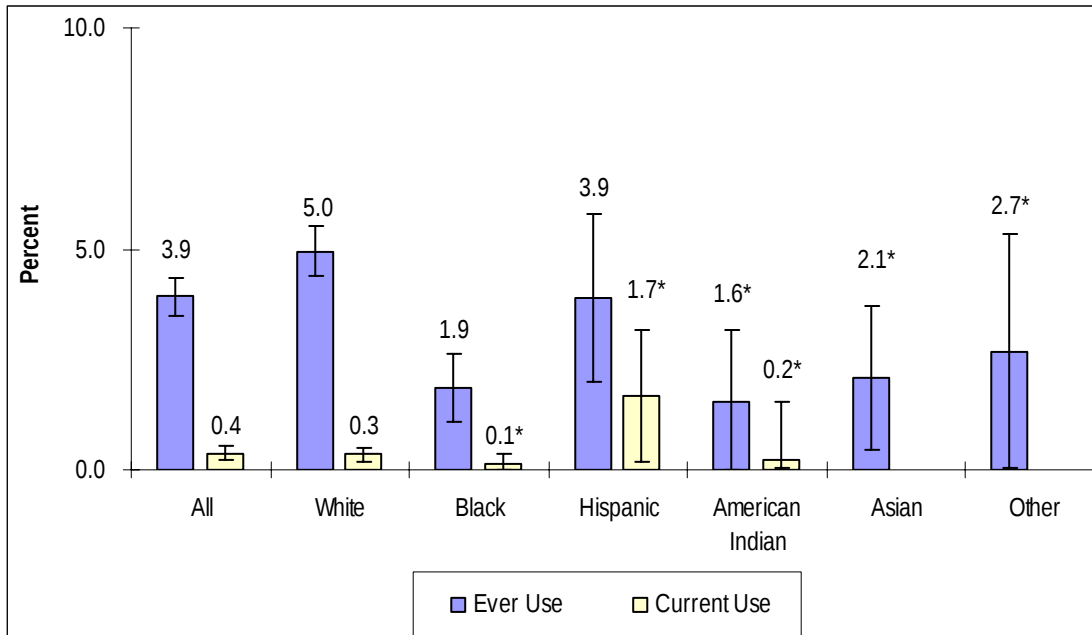
Table 1.13. Use of Kreteks (Cigarettes Made of Tobacco and Clove Extract) Among Maryland Adults by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Ever Use	3.9	5.0	1.9	3.9	1.6*	2.1*	2.7*
95% CI(±)	0.4	0.6	0.8	1.9	1.6	1.6	2.6
N	156,407	121,610	19,479	10,541	624	2,385	1,768
Current Use	0.4	0.3	0.1*	1.7*	0.2*	–	–
95% CI(-)	0.2	0.2	0.1	1.5	0.2	–	–
95% CI(+)	0.2	0.2	0.2	1.5	1.3	–	–
N	14,473	8,378	1,461	4,546	88	–	–

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.13. Use of Kreteks (Cigarettes Made of Tobacco and Clove Extract) Among Maryland Adults by Race/Ethnicity



1.14. Use of Flavored Cigarettes Among Maryland Adults by Race/Ethnicity

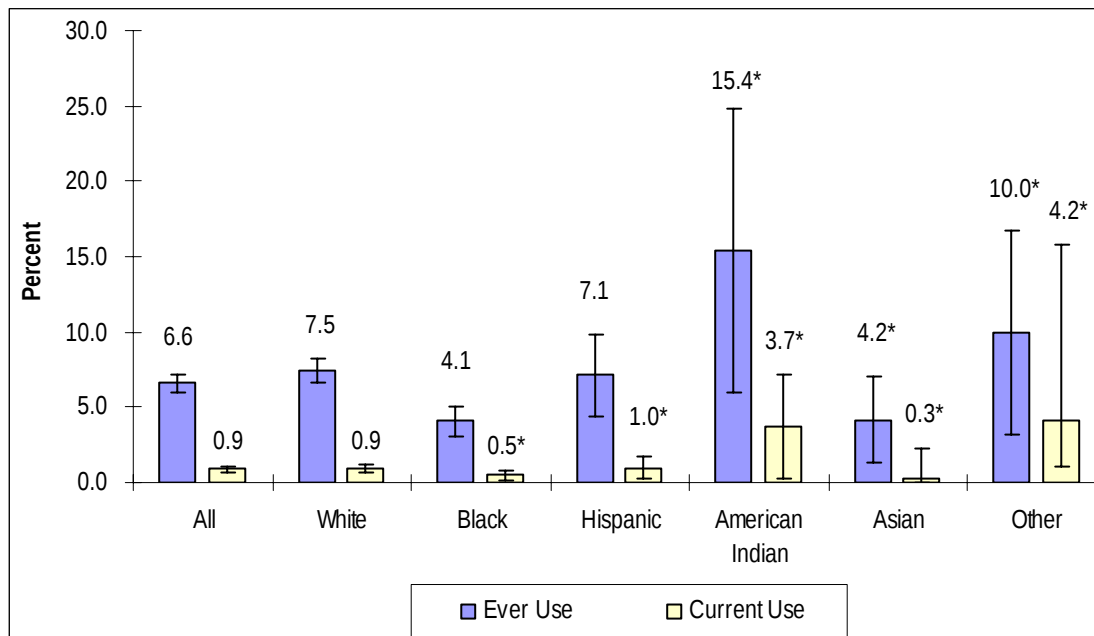
Few Maryland adults use flavored cigarettes such as Camels Exotic or Casino Brands (e.g., Mandarin Mint, Lime Twister, Cinnzabar). In 2006, 6.6% of Maryland adults reported ever using flavored cigarettes; only 0.9% reported current use of flavored cigarettes. Whites (7.5%) were significantly more likely to report ever use of flavored cigarettes than Blacks (4.1%).

Table 1.14. Use of Flavored Cigarettes Among Maryland Adults by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Ever Use	6.6	7.5	4.1	7.1	15.4*	4.2*	10.0*
95% CI(±)	0.6	0.8	1.0	2.7	9.5	2.8	6.8
N	261,647	182,932	42,122	19,149	6,166	4,760	6,518
Current Use	0.9	0.9	0.5*	1.0*	3.7*	0.3*	4.2*
95% CI(-)	0.2	0.3	0.3	0.7	3.5	0.3	3.2
95% CI(+)	0.2	0.3	0.3	0.7	3.5	2.0	11.6
N	34,928	22,505	5,189	2,657	1,488	371	2,719

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.14. Use of Flavored Cigarettes Among Maryland Adults by Race/Ethnicity



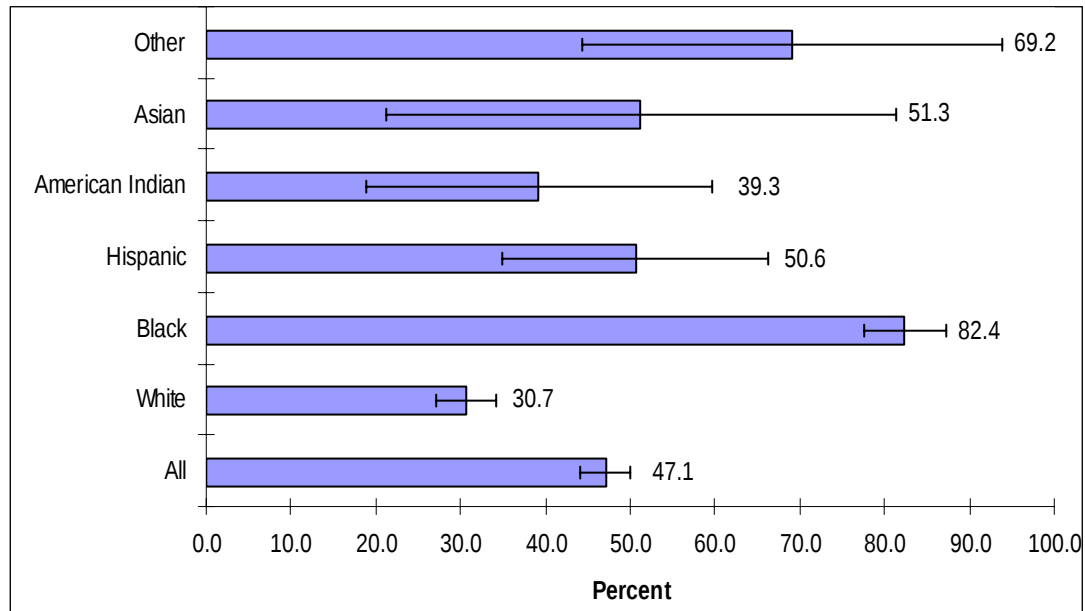
1.15. Current Smokers in Maryland Who Smoked Menthol Rather Than Plain Cigarettes Most Often by Race/Ethnicity

In 2006, 47.1% of current smokers in Maryland reported that they smoked menthol cigarettes rather than plain cigarettes. Blacks had the highest rates (82.4%) and Whites had the lowest (30.7%). This compares to a study of Garten and Falkner (2004) which found that 3 out of 4 Black adults use menthol cigarettes compared with 1 out of 4 Whites. Although not shown, there was little difference between current smoking men and women regarding whether they smoked menthol cigarettes rather than plain cigarettes.

Table 1.15. Current Smokers in Maryland Who Smoked Menthol Rather Than Plain Cigarettes Most Often by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	47.1	30.7	82.4	50.6	39.3	51.3	69.2
95% CI(±)	3.0	3.5	4.9	15.7	20.5	30.1	24.8
N	255,536	105,175	123,934	13,130	3,171	2,424	7,702

Figure 1.15. Current Smokers in Maryland Who Smoked Menthol Rather Than Plain Cigarettes Most Often by Race/Ethnicity



1.15.1. Current Smokers in Maryland Who Smoked Menthol Rather Than Plain Cigarettes Most Often by Race/Ethnicity and Income

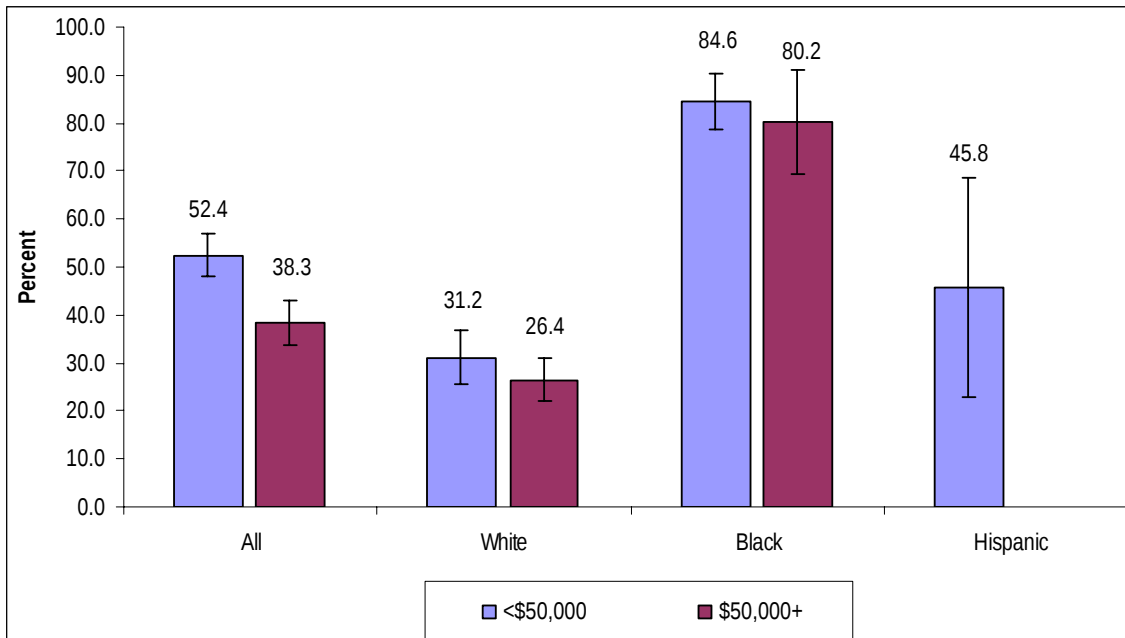
Overall, Maryland current smokers with lower income (<\$50,000 per year) were more likely to use menthol cigarettes rather than plain cigarettes compared to current smokers with higher incomes (52.4% vs. 38.3%). However, among Black current smokers, there was little variation by income—around eight out of ten Black smokers used menthol cigarettes rather than plain cigarettes.

Table 1.15.1. Current Smokers in Maryland Who Smoked Menthol Rather Than Plain Cigarettes Most Often by Race/Ethnicity and Income

	All	White	Black	Hispanic
<\$50,000	52.4	31.2	84.6	45.8
95% CI(±)	4.4	5.6	5.9	22.7
N	128,747	41,811	76,645	4,946
\$50,000+	38.3	26.4	80.2	–
95% CI(±)	4.6	4.5	10.7	–
N	84,912	42,843	31,104	–

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.15.1. Current Smokers in Maryland Who Smoked Menthol Rather Than Plain Cigarettes Most Often by Race/Ethnicity and Income



1.16. Percent of Maryland Households With Minor Children in Which Adults Smoke Cigarettes by Race/Ethnicity

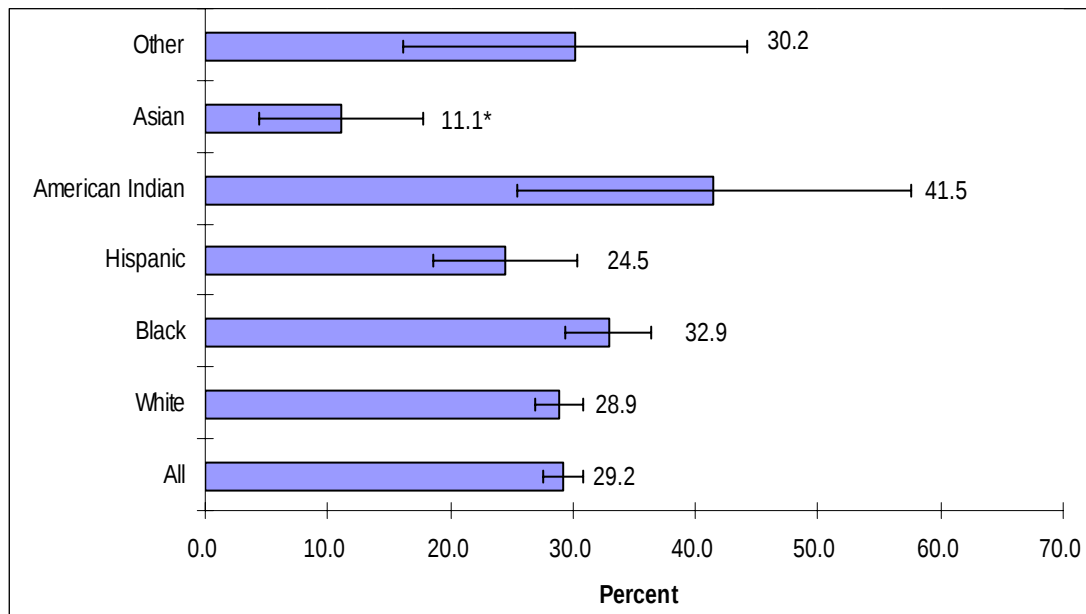
In 2006, the percentage of Maryland households with minor children in which adults smoke cigarettes was 29.2%, ranging from 11.1% among Asians to 41.5% among American Indians. Although not shown, there was little difference between men and women regarding whether they lived in households with minor children in which adults smoke cigarettes.

Table 1.16. Percent of Maryland Households With Minor Children in Which Adults Smoke Cigarettes by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	29.2	28.9	32.9	24.5	41.5	11.1*	30.2
95% CI(±)	1.6	1.9	3.5	5.8	16.0	6.7	14.0
N	488,645	264,219	161,818	39,548	9,033	6,083	7,944

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 1.16. Percent of Maryland Households With Minor Children in Which Adults Smoke Cigarettes by Race/Ethnicity



1.16.1. Percent of Maryland Households With Minor Children in Which Adults Smoke Cigarettes by Race/Ethnicity and Educational Attainment

In general, Maryland adults with less education were the most likely to have households with minor children residing where adults smoke. Among adults with less than a high school education, Black (57.6%) and White (77.9%) adults were more likely than Hispanics (17.7%) to have households with minor children residing where adults smoke.

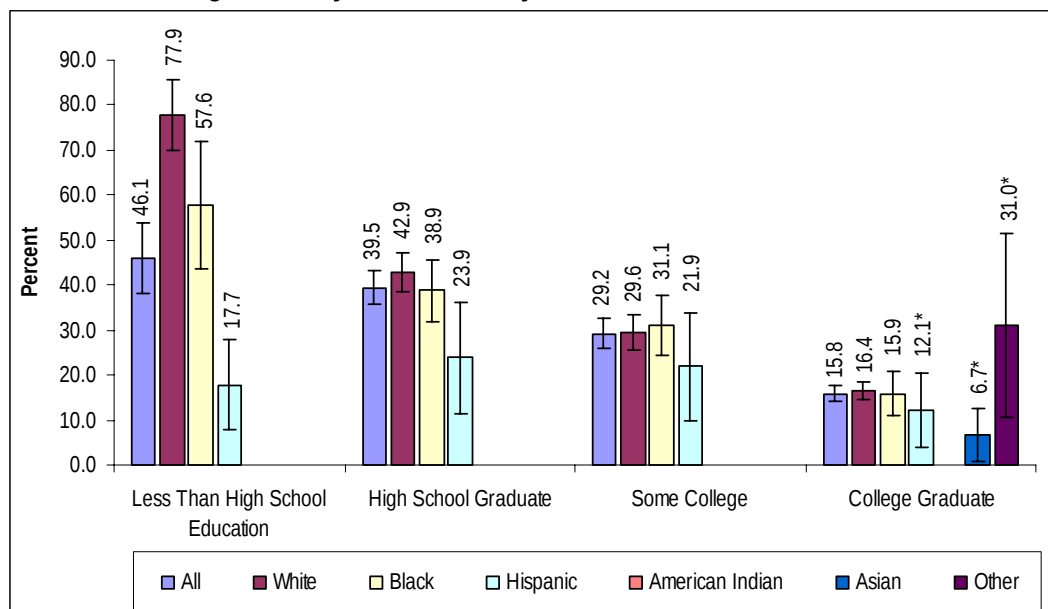
Table 1.16.1. Percent of Maryland Households With Minor Children in Which Adults Smoke Cigarettes by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	46.1	77.9	57.6	17.7	–	–	–
95% CI(±)	7.9	7.8	14.1	10.0	–	–	–
N	45,104	19,115	16,651	7,195	–	–	–
High School Graduate	39.5	42.9	38.9	23.9	–	–	–
95% CI(±)	3.7	4.4	6.9	12.4	–	–	–
N	122,212	68,738	42,241	6,605	–	–	–
Some College	29.2	29.6	31.1	21.9	–	–	–
95% CI(±)	3.4	3.9	6.8	12.1	–	–	–
N	91,500	49,099	34,678	5,243	–	–	–
College Graduate	15.8	16.4	15.9	12.1*	–	6.7*	31.0*
95% CI(±)	1.8	2.0	4.8	8.3	–	5.8	20.3
N	112,572	74,209	25,099	4,750	–	2,906	3,891

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.16.1. Percent of Maryland Households With Minor Children in Which Adults Smoke Cigarettes by Race/Ethnicity and Educational Attainment



1.16.2. Percent of Maryland Households With Minor Children in Which Adults Smoke Cigarettes by Race/Ethnicity and Income

In general, adults with lower incomes (<\$50,000 per year) were more likely to reside in households with minor children in which adults smoke cigarettes (40.3% vs. 23.9%).

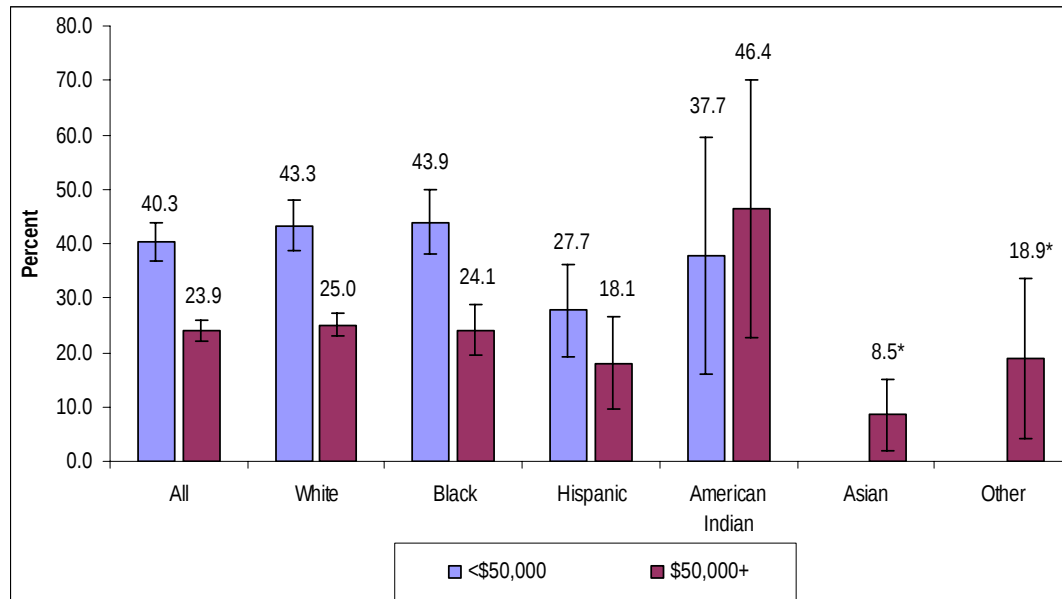
Table 1.16.2. Percent of Maryland Households With Minor Children in Which Adults Smoke Cigarettes by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	40.3	43.3	43.9	27.7	37.7	–	–
95% CI(±)	3.4	4.7	5.9	8.4	21.9	–	–
N	195,431	75,602	83,703	26,020	4,303	–	–
\$50,000+	23.9	25.0	24.1	18.1	46.4	8.5*	18.9*
95% CI(±)	1.9	2.1	4.7	8.5	23.8	6.6	14.6
N	240,450	159,778	61,396	8,313	4,438	3,327	3,198

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 1.16.2. Percent of Maryland Households With Minor Children in Which Adults Smoke Cigarettes by Race/Ethnicity and Income



1.17. Summary of Tobacco Use Behaviors

A consistent pattern of tobacco use behaviors was found among the different racial/ethnic groups in Maryland. Ever smoked cigarettes has been defined as having smoked at least 100 cigarettes over a lifetime. This is a commonly used measure of ever smoking in health interview surveys. In 2006, 37.9% of Maryland adults (general population) were ever smokers, with Whites having the highest rate (41.6%) and Asians having the lowest (15.6%).

Regardless of race or ethnicity, men were more likely to be ever smokers than women. Approximately two out of every five men (42.2%) and one out of every three women (34.0%) from the general population were ever smokers. Adults with an annual income of less than \$50,000 were more likely to have ever smoked than Maryland adults with an annual income of at least \$50,000.

In 2006, 17.6% of all Maryland adults were current tobacco users, with Asians having significantly lower use of tobacco (5.4%) than any other racial/ethnic group. Men and adults with lower education levels were more likely to report using tobacco in the previous 30 days regardless of race or ethnicity (general population). About one out of every four men used tobacco (23.4%). In general, the highest rates of current tobacco use in 2006 were among 18-29 year olds.

The average number of cigarettes smoked per day by current smokers was 14.6 in 2006, and varied by race/ethnicity. American Indian current smokers smoked an average of almost a pack of cigarettes a day (19.9 cigarettes). Black current smokers smoked fewer cigarettes per day (10.5) than White current smokers (16.7).

Current and former adult daily smokers (general population) smoked an average of 17.7 years. The number of years that current and former smokers smoked every day was greater for those with less education and with lower annual income.

Almost eight out of every ten (78%) respondents (general population) reported that smoking was not allowed in their home—ranging from 75.3% of Blacks, to 88.2% of Asians. In general, Maryland adults with less education were the least likely to have a rule prohibiting smoking inside the home.

About one out of five (18.5%) Maryland adults reported being exposed to secondhand smoke in the car. In general, men and adults with less education and lower income were more likely to report recent exposure to secondhand smoke in a car.

Around nine percent (9.4%) of Maryland adults reported ever using smokeless tobacco products such as chewing tobacco or snuff, however, few respondents of any group reported currently using smokeless tobacco products (1.1%). White adults (12%) were significantly more likely to report having ever used smokeless tobacco products compared to Blacks (4%), Hispanics (7.3%), or Asians (4.3%).

Approximately one out of twenty Maryland adults (4.7%) reported having ever used bidi, (flavored cigarettes from India), although less than one percent (0.2%) currently used bidi. Blacks (7%) and Hispanics (6.8%) were significantly more likely to have ever used bidi than Whites (3.2%).

Approximately four percent (3.9%) of Maryland adults reported ever using kreteks (cigarettes made of tobacco and clove extract). However, less than one percent (0.4%) of

all adults reported current use of kreteks. Whites (5.0%) were significantly more likely to report ever use of kreteks than Blacks (1.9%).

Few Maryland adults use flavored cigarettes such as Camels Exotic or Casino Brands (e.g., Mandarin Mint, Lime Twister, Cinnzabar). In 2006, 6.6% of Maryland adults reported ever using flavored cigarettes; only 0.9% reported current use of flavored cigarettes. Whites (7.5%) were significantly more likely to report ever use of flavored cigarettes than Blacks (4.1%).

In 2006, 47.1% of current smokers in Maryland reported that they smoked menthol cigarettes rather than plain cigarettes. Blacks had the highest rates (82.4%) and Whites had the lowest (30.7%). Overall, Maryland current smokers with lower income (<\$50,000 per year) were more likely to use menthol cigarettes rather than plain cigarettes.

The percentage of Maryland households with minor children in which adults smoke cigarettes was 29.2%, ranging from 11.1% among Asians to 41.5% among American Indians. In general, Maryland adults with less education and lower income (<\$50,000 per year) were the most likely to have households with minor children residing where adults smoke.



CHAPTER 2

Attitudes

2 Attitudes

To better understand tobacco use and the quitting process among population groups in Maryland, it is useful to examine the attitudes of current, former and never smokers; Maryland adults' attitudes toward policy issues; and addiction. What follows is a summary of the survey results addressing these topics.

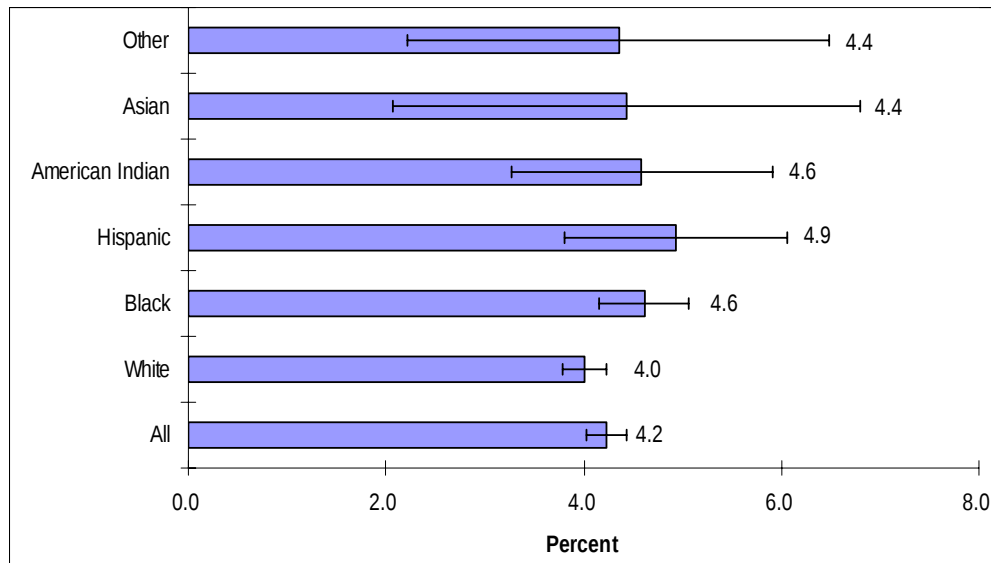
2.1. Self Ranking of Intention to Quit Among Current Smokers (Contemplation Ladder⁷)

Current smokers rated their intention to quit on a ten-point scale. The average score, with little variation by race/ethnicity was 4.2 out of 10 which indicates a moderate intention to quit smoking. Although not shown, there was little variation by income in intention to quit smoking among current smokers.

Table 2.1. Self Ranking of Intention to Quit Among Current Smokers (Contemplation Ladder)

	All	White	Black	Hispanic	American Indian	Asian	Other
Mean	4.2	4.0	4.6	4.9	4.6	4.4	4.4
95% CI(±)	0.2	0.2	0.4	1.1	1.3	2.4	2.1
N	543,783	338,688	147,178	25,396	7,938	4,179	10,567

Figure 2.1. Self Ranking of Intention to Quit Among Current Smokers (Contemplation Ladder)



⁷ The Contemplation Ladder is a measure of readiness to consider smoking cessation. The higher the score the more the smoker is ready to quit smoking.

2.2. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity

During the interview, respondents were asked if (...) was a reason why you tried to quit smoking: information about health hazards; health problems you experienced related to tobacco use; cost of tobacco; test of will power; to be an example to my children; smoking related illness of a friend or relative; physical fitness; advice of a doctor; encouragement of a friend or relative; restrictions on smoking in my workplace; restrictions on smoking in my home; restrictions on smoking in public places/bars/restaurants, etc; smell, taste, or looks; pregnancy; other.

Respondents answered yes or no to each question.

2.2.1. Physical Fitness

Around one-third (34.5%) of former smokers cited physical fitness as a reason why they quit smoking. Hispanic former smokers (22.3%) were significantly less likely than White former smokers (36.6%) to state that physical fitness was a reason why they quit.

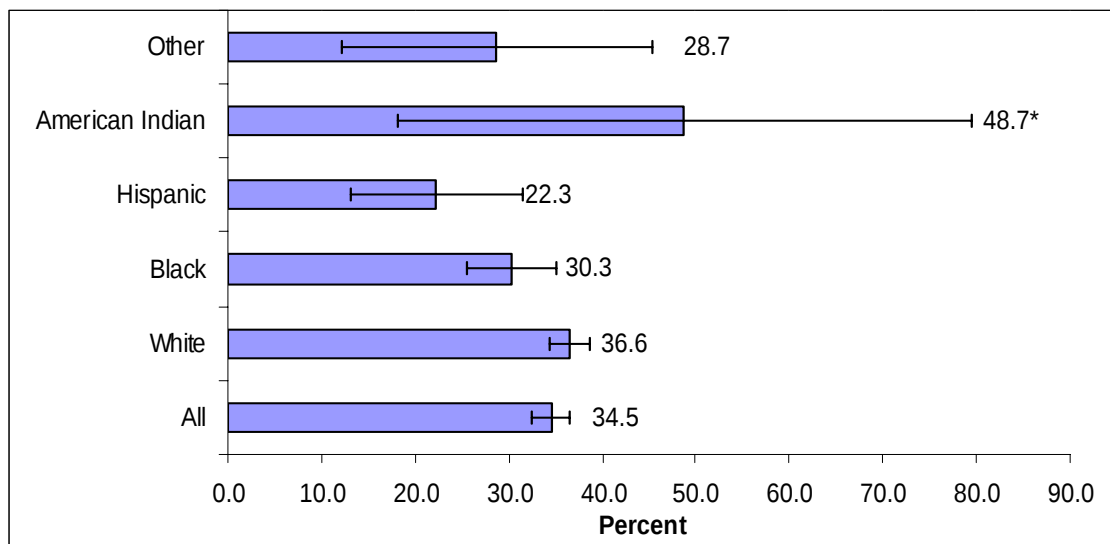
Table 2.2.1. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity – Physical Fitness

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	34.5	36.6	30.3	22.3	48.7*	–	28.7
95% CI(±)	2.0	2.1	4.9	9.2	30.7	–	16.6
N	322,819	241,581	56,192	13,428	3,324	–	3,126

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.2.1. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity – Physical Fitness



2.2.2. Health Hazards

For around one third (33.3%) of former smokers, concern about health hazards was cited as a reason that motivate them to quit. Health hazards are anticipated health problems. Hispanic former smokers (22.8%) were significantly less likely than White former smokers (35.5%) to cite concern about health hazards as a reason why they quit.

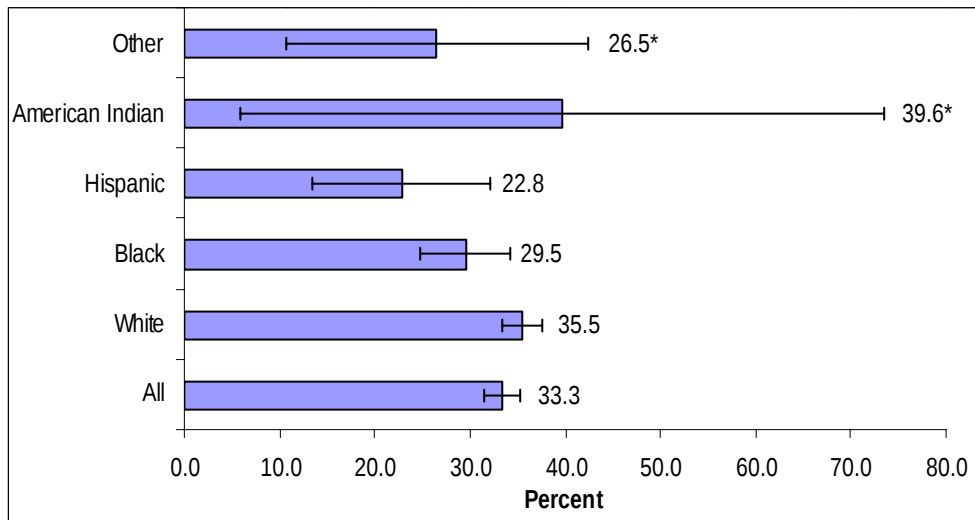
Table 2.2.2. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity – Health Hazards

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	33.3	35.5	29.5	22.8	39.6*	–	26.5*
95% CI(±)	1.9	2.1	4.7	9.3	33.8	–	15.9
N	311,966	234,419	54,715	13,731	2,704	–	2,887

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.2.2. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity – Health Hazards



2.2.3. Smell

One out of four (25.5%) former smokers reported that smell (of cigarette smoke) was a reason why they quit. Hispanic former smokers (13.2%) were less likely than Whites to cite smell as a reason why they quit.

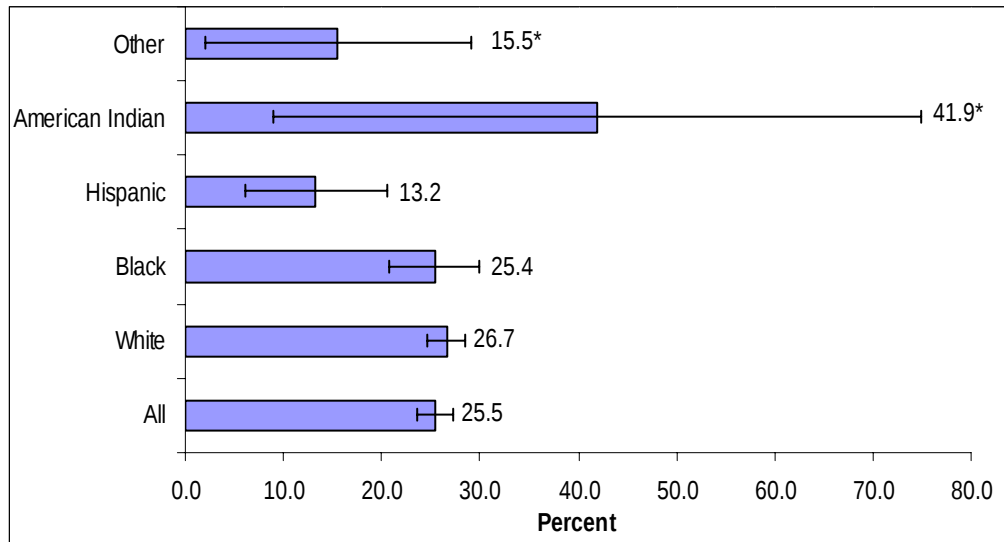
Table 2.2.3. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity – Smell

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	25.5	26.7	25.4	13.2	41.9*	–	15.5*
95% CI(±)	1.8	1.9	4.6	7.2	33.0	–	13.5
N	238,288	176,111	47,042	7,985	2,860	–	1,693

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.2.3. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity – Smell



2.2.4. To be an Example

One out of four (24.7%) former smokers reported that a reason why they quit smoking was to be an example—ranging from 51.8% for American Indians to 22.2% for Blacks.

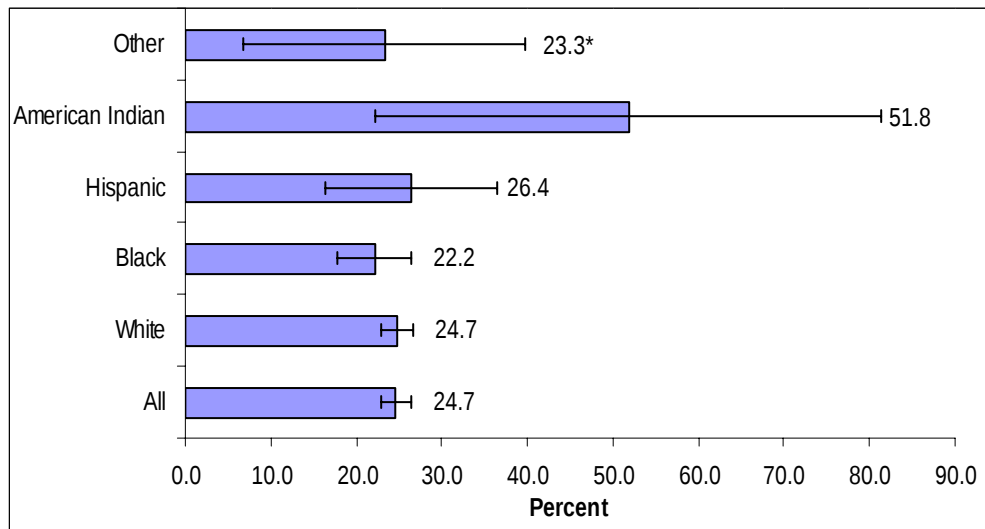
Table 2.2.4. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity – To be an Example

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	24.7	24.7	22.2	26.4	51.8	–	23.3*
95% CI(±)	1.8	1.9	4.3	10.0	29.6	–	16.5
N	230,664	163,347	41,084	15,934	3,534	–	2,538

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.2.4. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity – To be an Example



2.2.5. Health Problems

About one out of four (24.3%) former smokers stated that health problems were a reason why they quit.

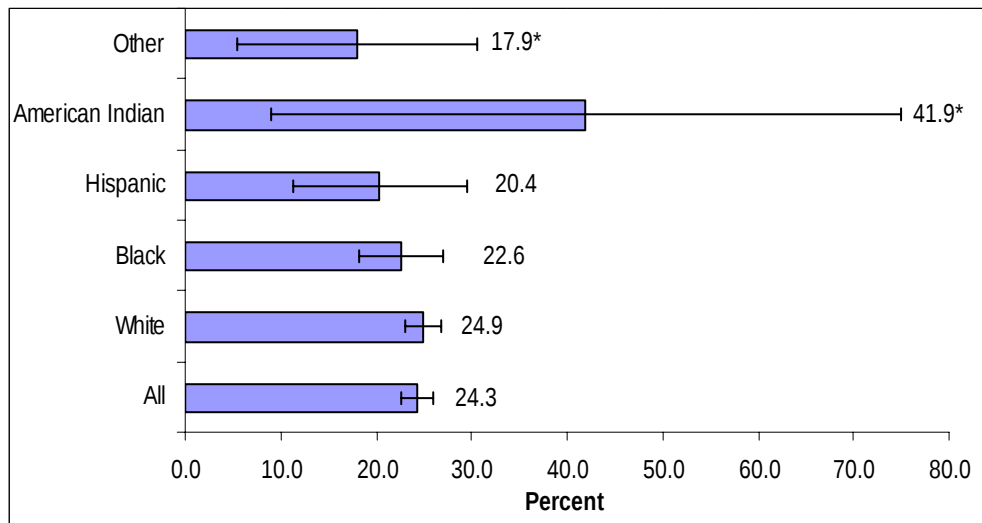
Table 2.2.5. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity – Health Problems

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	24.3	24.9	22.6	20.4	41.9*	–	17.9*
95% CI(±)	1.7	1.8	4.3	9.2	33.0	–	12.6
N	226,933	164,472	41,911	12,275	2,861	–	1,952

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.2.5. The Top 5 Reasons that Motivated FORMER Smokers to Quit by Race/Ethnicity – Health Problems



2.3. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity

During the interview, respondents were asked if (...) was a reason that might motivate you to want quit smoking some day: information about health hazards; health problems you experienced related to tobacco use; cost of tobacco; test of will power; to be an example to my children; smoking related illness of a friend or relative; physical fitness; advice of a doctor; encouragement of a friend or relative; restrictions on smoking in my workplace; restrictions on smoking in my home; restrictions on smoking in public places/bars/restaurants, etc; smell, taste, or looks; pregnancy; other.

Respondents answered yes or no to each question.

2.3.1. Physical Fitness

Four out of ten (40.7%) adult current smokers reported that physical fitness was a reason that may motivate them to quit smoking, with significantly lower rates for Hispanics (23%) than for Blacks (41.9%) and Whites (41.7%).

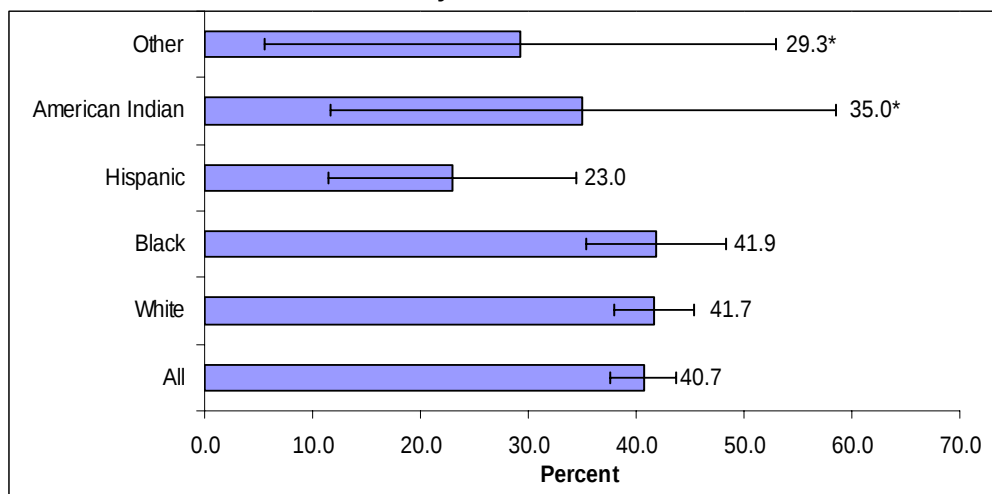
Table 2.3.1. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity – Physical Fitness

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	40.7	41.7	41.9	23.0	35.0*	–	29.3*
95% CI(±)	3.1	3.7	6.5	11.5	23.4	–	23.8
N	206,613	132,059	61,017	5,427	2,137	–	3,240

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.3.1. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity – Physical Fitness



2.3.2. Health Problems

The survey indicated that 38.5% of all current smokers stated that health problems were a reason that may motivate them to quit, ranging from 32.4% for Hispanics to 42.7% for American Indians.

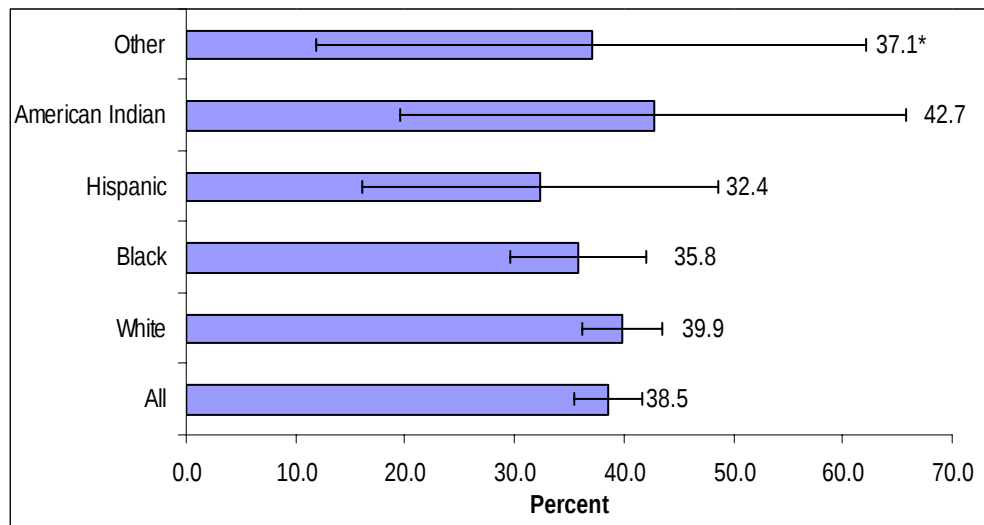
Table 2.3.2. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity – Health Problems

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	38.5	39.9	35.8	32.4	42.7	–	37.1*
95% CI(±)	3.1	3.7	6.3	16.2	23.2	–	25.1
N	195,377	126,167	52,115	7,650	2,608	–	4,101

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.3.2. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity – Health Problems



2.3.3. To be an Example

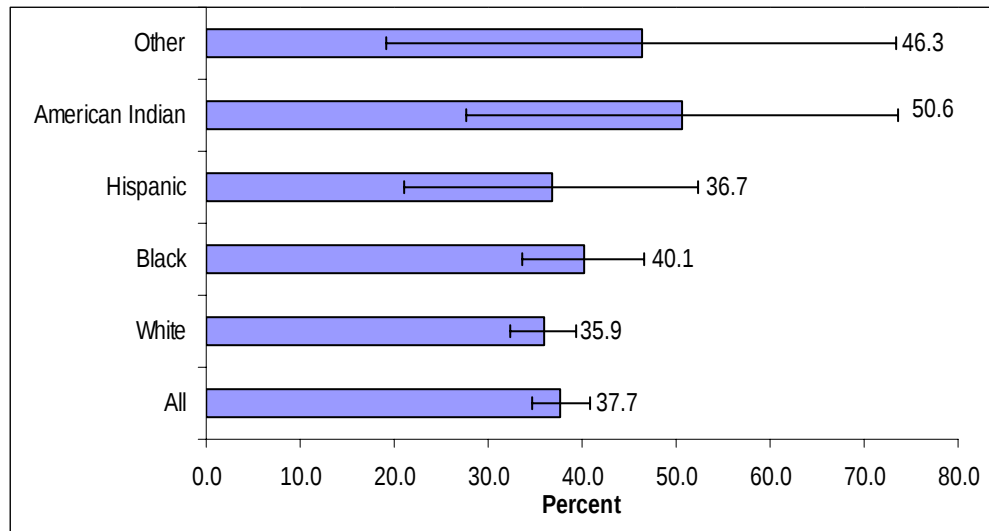
It was found that 37.7% of all current smokers reported that “to be an example” was a reason that may motivate them to quit, ranging from 35.9% for Whites to 50.6% for American Indians.

Table 2.3.3. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity – To be an Example

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	37.7	35.9	40.1	36.7	50.6	–	46.3
95% CI(±)	3.1	3.5	6.5	15.6	22.9	–	27.1
N	191,503	113,655	58,419	8,677	3,090	–	5,122

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.3.3. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity – To be an Example



2.3.4. Cost of Tobacco

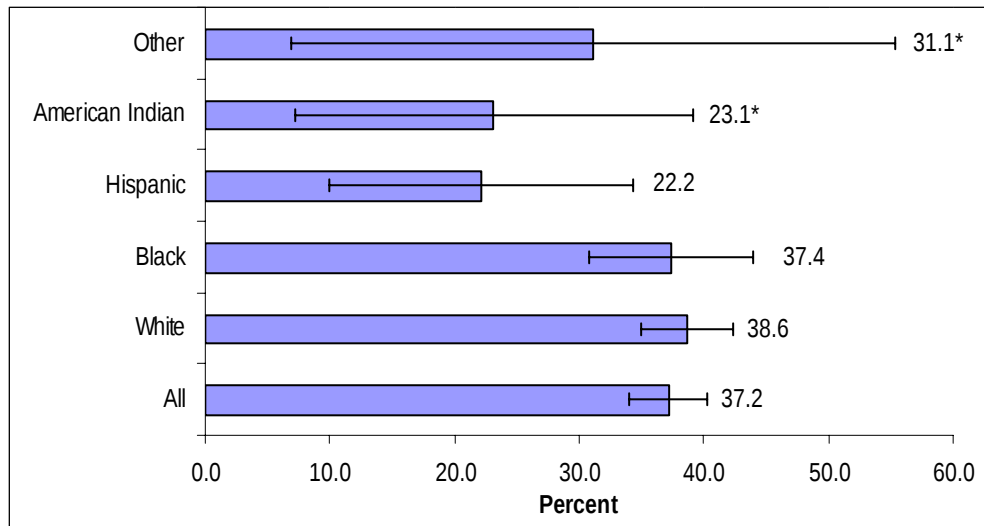
The results indicated that 37.2% of all current smokers felt that the cost of tobacco was a reason that may motivate them to quit, ranging from 22.2% for Hispanics to 38.6% for Whites.

Table 2.3.4. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity – Cost of Tobacco

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	37.2	38.6	37.4	22.2	23.1*	–	31.1*
95% CI(±)	3.1	3.6	6.6	12.2	15.9	–	24.2
N	188,622	122,318	54,522	5,234	1,413	–	3,439

* The relative standard error (RSE) associated with the estimate is greater than 30%.
 – Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.3.4. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity – Cost of Tobacco



2.3.5. Encouragement of a friend

Around one third of all current smokers (32.4%) said that encouragement by a friend may motivate them to quit.

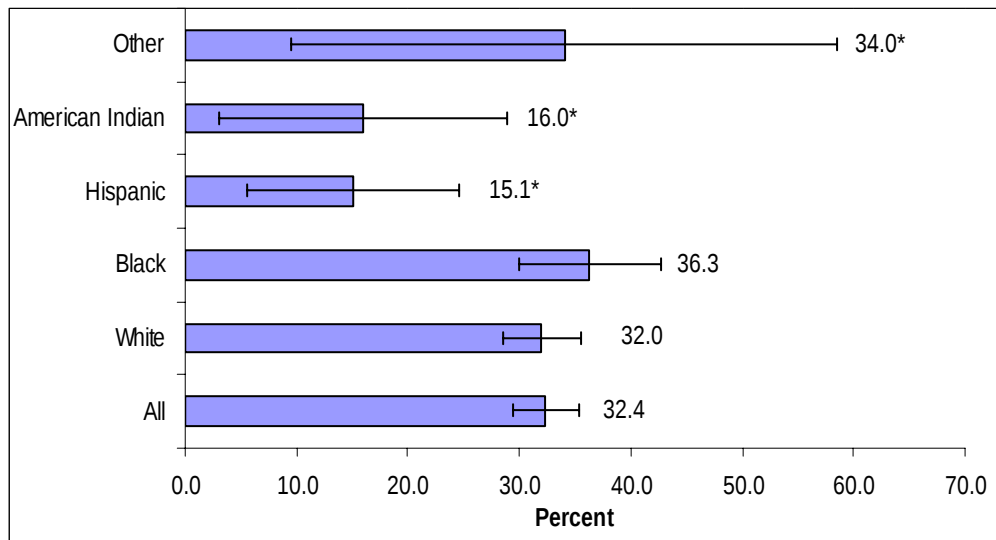
Table 2.3.5. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity – Encouragement of a Friend

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	32.4	32.0	36.3	15.1*	16.0*	–	34.0*
95% CI(±)	3.0	3.5	6.4	9.5	12.9	–	24.5
N	164,337	101,286	52,823	3,558	975	–	3,765

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.3.5. The Top 5 Reasons that May Motivate CURRENT Smokers to Quit by Race/Ethnicity – Encouragement of a Friend



2.4. Adult Current Smokers Who Have Ever Seriously Considered Quitting Cigarette Smoking by Race/Ethnicity

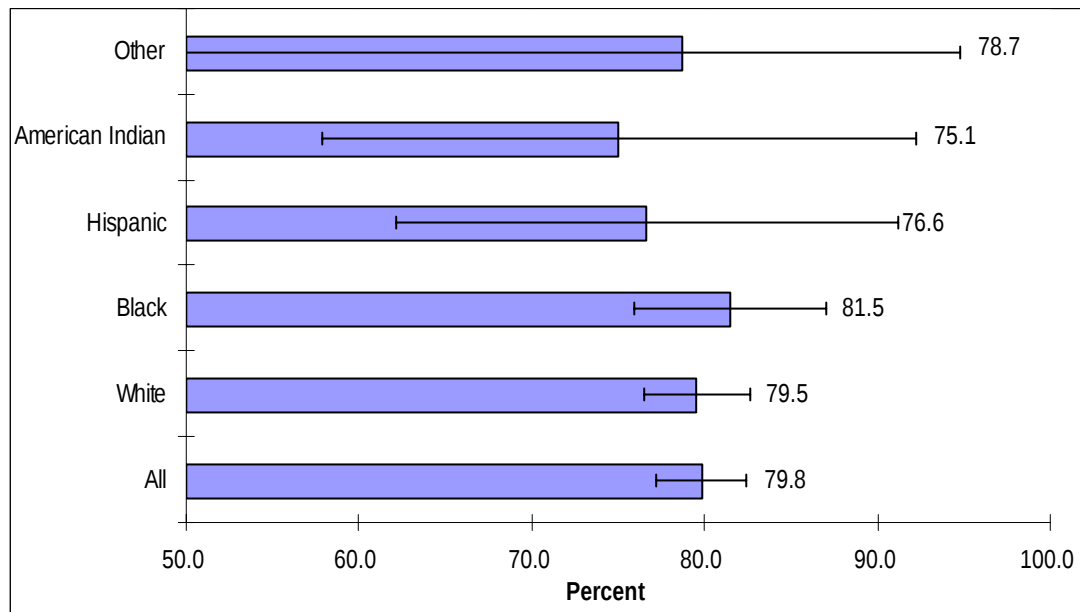
Eight out of every ten current smokers (79.8%) has seriously considered quitting cigarette smoking, with little variation by race/ethnicity, ranging from 75.1% for American Indian current smokers to 81.5% for Black current smokers.

Table 2.4. Adult Current Smokers Who Have Ever Seriously Considered Quitting Cigarette Smoking by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	79.8	79.5	81.5	76.6	75.1	–	78.7
95% CI(-)	2.7	3.1	5.6	14.5	17.2	–	36.1
95% CI(+)	2.7	3.1	5.6	14.5	17.2	–	16.2
N	434,322	273,926	121,863	20,225	6,005		8,761

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.4. Adult Current Smokers Who Have Ever Seriously Considered Quitting Cigarette Smoking by Race/Ethnicity



2.5. Current Adult Smokers' Attitudes (Likely Quit) on Their Ability to Give Up Smoking Altogether by Race/Ethnicity

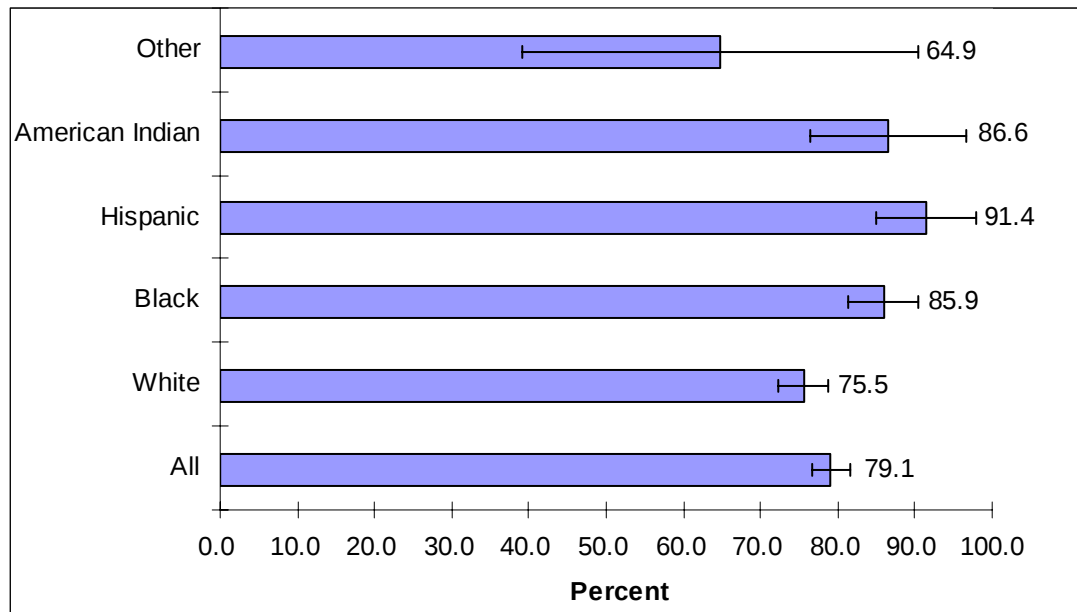
Around eight out of ten current smokers (79.1%) were confident in their ability to quit smoking. Hispanic and Black current smokers were significantly more likely than White current smokers to report confidence in their ability to quit smoking (91.4%, 85.9%, and 75.5% respectively).

Table 2.5. Current Adult Smokers' Attitudes (Likely Quit) on Their Ability to Give Up Smoking Altogether by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	79.1	75.5	85.9	91.4	86.6	–	64.9
95% CI(±)	2.5	3.2	4.6	6.5	10.2	–	25.6
N	416,783	252,606	124,526	22,399	6,356	–	6,960

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.5. Current Adult Smokers' Attitudes (Likely Quit) on Their Ability to Give Up Smoking Altogether by Race/Ethnicity



2.5.1. Current Adult Smokers' Attitudes (Likely Quit) on Their Ability to Give Up Smoking Altogether by Race/Ethnicity and Income

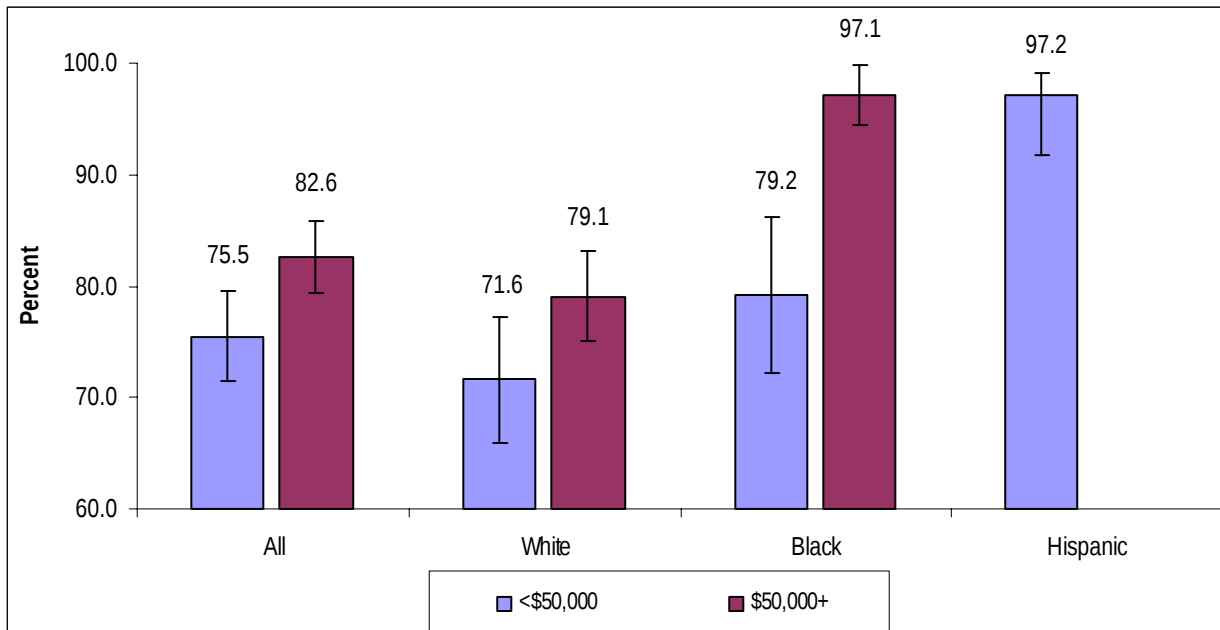
Among Black current smokers, 79.2% with an income less than \$50,000 per year were confident in their ability to quit smoking compared to 97.1% of Black current smokers with greater incomes.

Table 2.5.1. Current Adult Smokers' Attitudes (Likely Quit) on Their Ability to Give Up Smoking Altogether by Race/Ethnicity and Income

	All	White	Black	Hispanic
<\$50,000	75.5	71.6	79.2	97.2
95% CI(-)	4.1	5.6	7.0	5.4
95% CI(+)	4.1	5.6	7.0	1.9
N	180,014	93,631	68,934	10,801
\$50,000+	82.6	79.1	97.1	–
95% CI(±)	3.3	4.0	2.7	–
N	179,390	125,438	37,423	–

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.5.1. Current Adult Smokers' Attitudes (Likely Quit) on Their Ability to Give Up Smoking Altogether by Race/Ethnicity and Income



2.6. Intention to Smoke Cigarette in Next Year Among 18-29 Year Old Former Smokers and Never Smokers by Race/Ethnicity

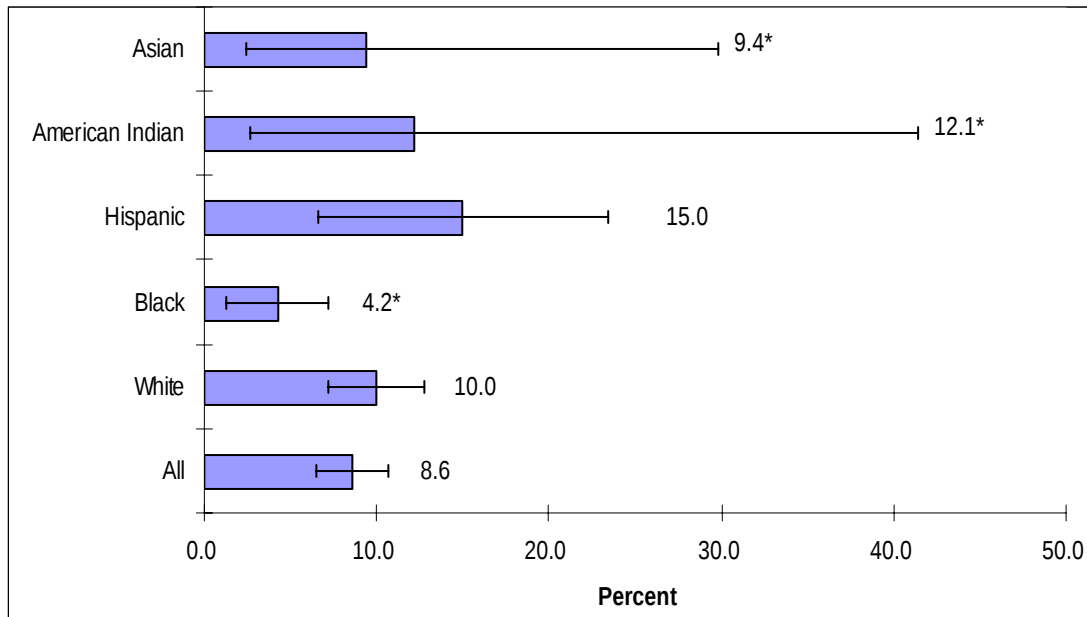
Among 18-29 year old former and never smokers, 8.6% reported an intention to smoke in the next year, ranging from 4.2% for Blacks to 15% for Hispanics. Although not shown, former and never smokers who had an annual income of less than \$50,000 were more likely than their higher income counterparts to express an intention to start smoking during the next year.

Table 2.6. Intention to Smoke Cigarette in Next Year Among 18-29 Year Old Former Smokers and Never Smokers by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian
Percent	8.6	10.0	4.2*	15.0	12.1*	9.4*
95% CI(-)	2.0	2.8	2.9	8.4	9.5	6.9
95% CI(+)	2.0	2.8	2.9	8.4	29.3	20.5
N	50,370	29,555	7,846	10,724	792	1,452

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 2.6. Intention to Smoke Cigarette in Next Year Among 18-29 Year Old Former Smokers and Never Smokers by Race/Ethnicity



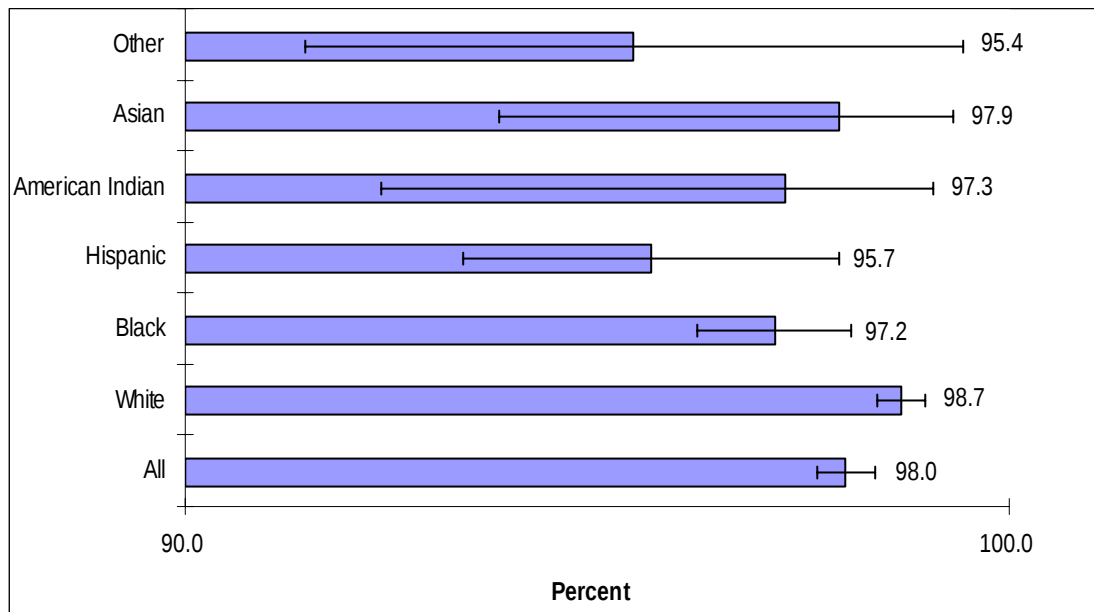
2.7. Adults' Perception of Nicotine Addiction by Race/Ethnicity

One factor that influences individuals to quit smoking and stay abstinent is the perception that smoking, and more specifically nicotine is addictive. Almost all respondents (98%) agreed that nicotine is addictive, with Whites (98.7%) more likely than Blacks (97.2%) and Hispanics (95.7%) to agree that smoking is addictive.

Table 2.7. Adults' Perception of Nicotine Addiction by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	98.0	98.7	97.2	95.7	97.3	97.9	95.4
95% CI(-)	0.4	0.3	0.9	2.3	4.9	4.1	4.0
95% CI(+)	0.4	0.3	0.9	2.3	1.8	1.4	4.0
N	3,775,520	2,371,925	974,153	227,676	38,226	104,684	58,856

Figure 2.7. Adults' Perception of Nicotine Addiction by Race/Ethnicity



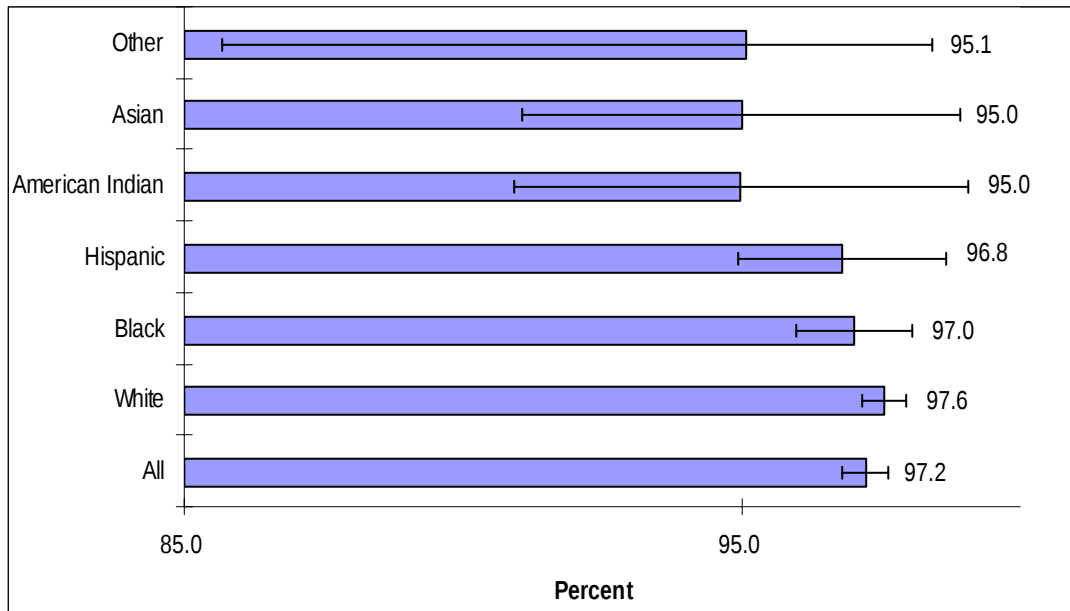
2.8. Adults' Attitudes on Enforcing the Laws Which Prohibit the Sale of Tobacco Products to Minors by Age/Ethnicity

The vast majority of Maryland adults (97.2%) are in favor of enforcing laws which prohibit the sale of tobacco products to minors, with little variation by race/ethnicity (95%-97.6%).

Table 2.8. Adults' Attitudes on Enforcing the Laws Which Prohibit the Sale of Tobacco Products to Minors by Age/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	97.2	97.6	97.0	96.8	95.0	95.0	95.1
95% CI(-)	0.4	0.4	1.0	1.9	4.1	3.9	9.4
95% CI(+)	0.4	0.4	1.0	1.9	4.1	3.9	3.3
N	3,856,260	2,386,891	1,003,308	258,095	38,160	108,058	61,749

Figure 2.8. Adults' Attitudes on Enforcing the Laws Which Prohibit the Sale of Tobacco Products to Minors by Age/Ethnicity



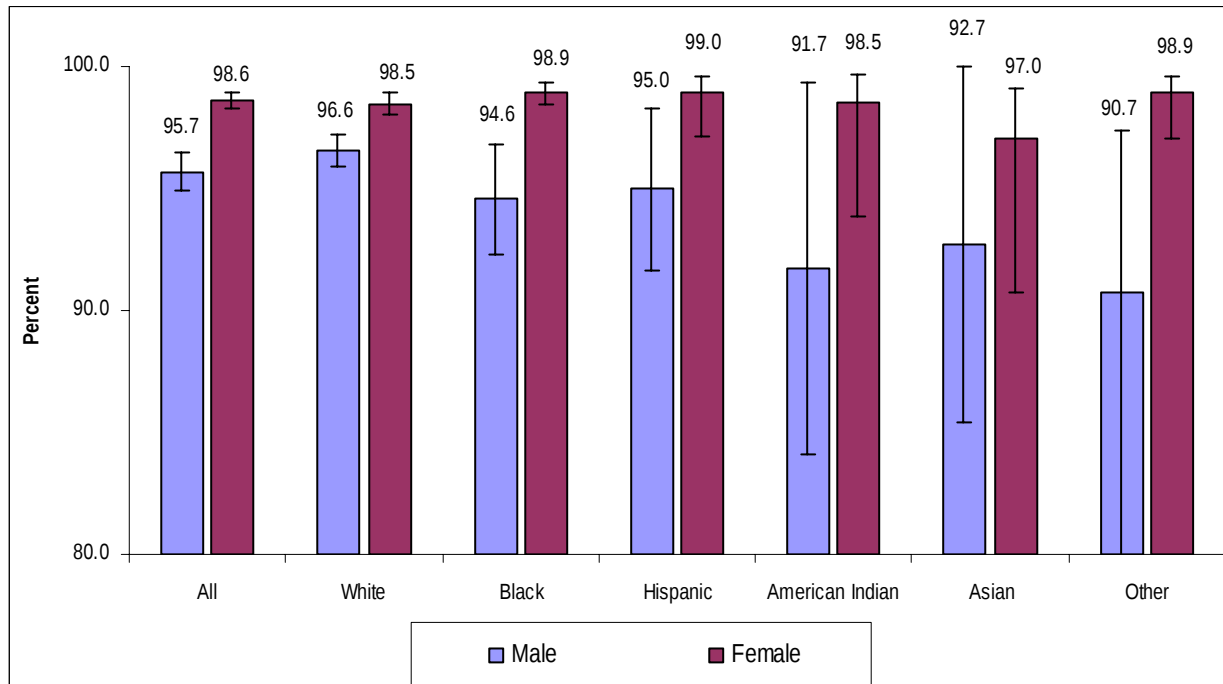
2.8.1. Adults' Attitudes on Enforcing the Laws Which Prohibit the Sale of Tobacco Products to Minors by Age/Ethnicity and Gender

In general, men were less likely than women to support enforcing laws which prohibit the sale of tobacco products to minors.

Table 2.8.1. Adults' Attitudes on Enforcing the Laws Which Prohibit the Sale of Tobacco Products to Minors by Age/Ethnicity and Gender

	All	White	Black	Hispanic	American Indian	Asian	Other
Male	95.7	96.6	94.6	95.0	91.7	92.7	90.7
95% CI(-)	0.8	0.7	2.3	3.3	7.6	7.3	18.6
95% CI(+)	0.8	0.7	2.3	3.3	7.6	7.3	6.6
N	1,789,929	1,134,113	423,875	135,699	19,022	49,488	27,731
Female	98.6	98.5	98.9	99.0	98.5	97.0	98.9
95% CI(-)	0.3	0.4	0.5	1.8	4.7	6.3	1.9
95% CI(+)	0.3	0.4	0.5	0.7	1.2	2.1	0.7
N	2,066,332	1,252,778	579,433	122,396	19,138	58,569	34,017

Figure 2.8.1. Adults' Attitudes on Enforcing the Laws Which Prohibit the Sale of Tobacco Products to Minors by Age/Ethnicity and Gender



2.8.2. Adults' Attitudes on Enforcing the Laws Which Prohibit the Sale of Tobacco Products to Minors by Age/Ethnicity and Educational Attainment

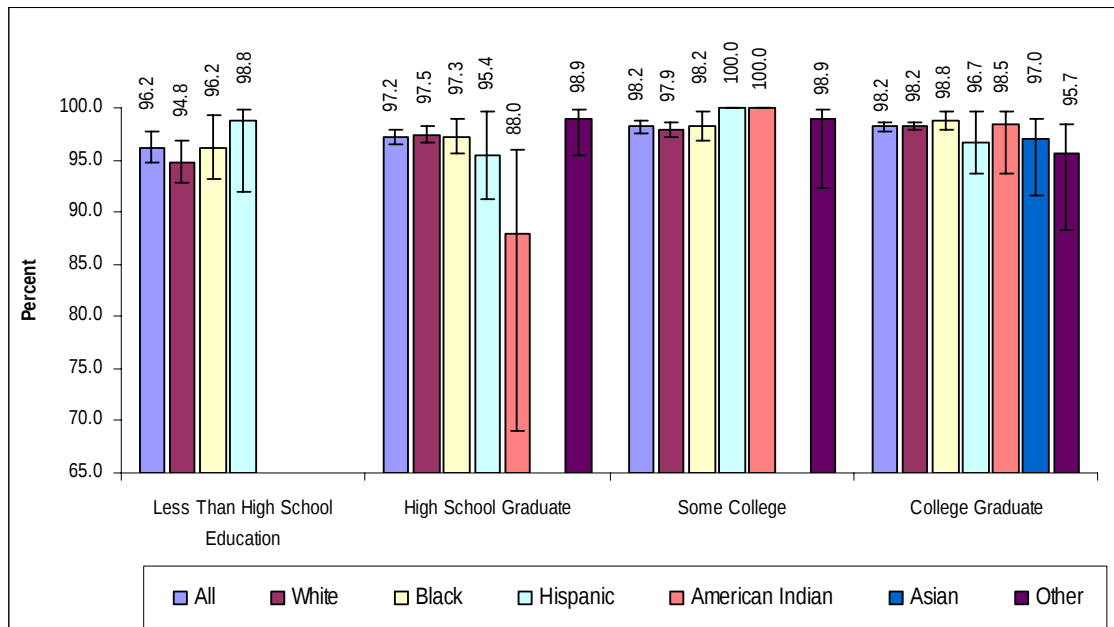
In general, there was strong support among all groups in support for enforcing laws which prohibit the sale of tobacco products to minors (96.2%-98.2%).

Table 2.8.2. Adults' Attitudes on Enforcing the Laws Which Prohibit the Sale of Tobacco Products to Minors by Age/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	96.2	94.8	96.2	98.8	–	–	–
95% CI(-)	1.5	2.0	3.0	6.8	–	–	–
95% CI(+)	1.5	2.0	3.0	1.0	–	–	–
N	223,311	87,386	74,993	54,699	–	–	–
High School Graduate	97.2	97.5	97.3	95.4	88.0	–	98.9
95% CI(-)	0.7	0.8	1.7	4.3	18.9	–	3.4
95% CI(+)	0.7	0.8	1.7	4.3	8.0	–	0.8
N	769,621	472,359	230,894	35,615	8,875	–	11,448
Some College	98.2	97.9	98.2	100.0	100.0	–	98.9
95% CI(-)	0.6	0.7	1.3	0.0	0.0	–	6.6
95% CI(+)	0.6	0.7	1.3	0.0	0.0	–	1.0
N	753,211	450,119	229,305	46,000	9,011	–	10,038
College Graduate	98.2	98.2	98.8	96.7	98.5	97.0	95.7
95% CI(-)	0.4	0.4	0.9	3.0	4.8	5.4	7.4
95% CI(+)	0.4	0.4	0.9	3.0	1.2	2.0	2.8
N	1,621,123	1,100,455	331,728	72,207	10,201	80,063	26,469

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 2.8.2. Adults' Attitudes on Enforcing the Laws Which Prohibit the Sale of Tobacco Products to Minors by Age/Ethnicity and Educational Attainment



2.9. Summary of Attitudes

Current smokers rated their intention to quit on a ten-point scale. The average score, with little variation among ethnic groups, was 4.2 out of 10 which indicates a moderate intention to quit smoking.

About one-third (34.5%) of former smokers cited physical fitness as a reason why they quit smoking. Hispanic former smokers (22.3%) were significantly less likely than White former smokers (36.6%) to state that physical fitness was a reason why they quit. For around one third (33.3%) of former smokers, concern about health hazards was cited as a reason that motivate them to quit. Health hazards are anticipated health problems. Hispanic former smokers (22.8%) were significantly less likely than White former smokers (35.5%) to cite concern about health hazards as a reason why they quit. One out of four (25.5%) former smokers reported that smell (of cigarette smoke) was a reason why they quit. Hispanic former smokers (13.2%) were less likely than Whites to cite smell as a reason why they quit. One out of four (24.7%) former smokers reported that a reason why they quit was to be an example—ranging from 51.8% for American Indians to 22.2% for Blacks. About one out of four (24.3%) former smokers stated that health problems were a reason why they quit.

Four out of ten (40.7%) adult current smokers reported that physical fitness was a reason that may motivate them to quit smoking, with significantly lower rates for Hispanics (23%) than for Blacks (41.9%) and Whites (41.7%). In addition, 38.5% of current smokers stated that health problems were a reason why they may quit. It was also found that 37.7% of current smokers reported that “to be an example” was a reason why they may quit. The results also indicated that 37.2% felt that the cost of tobacco was a reason why they may quit. Finally, around one third of current smokers (32.4%) said that encouragement by a friend may motivate them to quit.

Approximately eight out of every ten current smokers has seriously considered quitting cigarette smoking, with little variation by race/ethnicity.

Approximately eight out of ten current smokers (79.1%) were confident in their ability to quit smoking. Hispanic and Black current smokers were more likely than White current smokers to report confidence in their ability to quit smoking (91.4%, 85.9%, and 75.5% respectively).

Among 18-29 year old former and never smokers, 8.6% reported an intention to smoke in the next year, ranging from 4.2% for Blacks to 15% for Hispanics.

One factor that influences individuals to quit smoking and stay abstinent is the perception that smoking, and more specifically nicotine, is addictive. Almost all respondents (98%) agreed that nicotine is addictive, with Whites (98.7%) more likely than Blacks (97.2%) and Hispanics (95.7%) to agree that smoking is addictive.

The vast majority of Maryland adults (97.2%) are in favor of enforcing laws which prohibit the sale of tobacco products to minors, with little variation by race/ethnicity (95%-97.6%). In general, men were less likely than women to support enforcing laws which prohibit the sale of tobacco products to minors.



CHAPTER 3

Knowledge

3 Knowledge

This section examines the knowledge of adults in Maryland regarding health issues related to smoking and health effects of secondhand smoke, their exposure to information about smoking cessation, and their knowledge of workplace policies and programs. Below is a summary of the survey results addressing these topics.

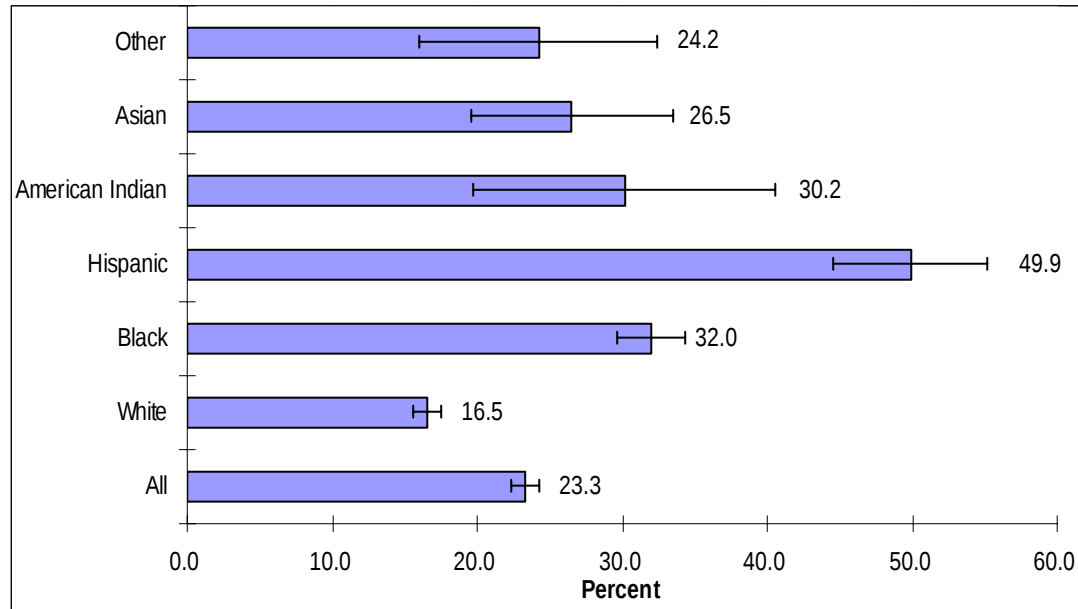
3.1. Adult's Lack of Knowledge of Health Benefits for Heavy Smokers (a Pack of Cigarettes a Day for More Than 20 Years) Who Quit Smoking by Race/Ethnicity

The results of the analysis indicate differences in the knowledge of the health benefits for heavy smokers who quit smoking among racial/ethnic groups. White Maryland adults (16.5%) were the most likely, and Hispanics (49.9%) were the least knowledgeable, to know the health benefits for heavy smokers who quit smoking.

Table 3.1. Adult's Lack of Knowledge of Health Benefits for Heavy Smokers (a Pack of Cigarettes a Day for More Than 20 Years) Who Quit Smoking by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	23.3	16.5	32.0	49.9	30.2	26.5	24.2
95% CI(±)	1.0	0.9	2.3	5.3	10.4	7.0	8.2
N	901,180	396,751	319,536	129,425	11,671	28,909	14,887

Figure 3.1. Adult's Lack of Knowledge of Health Benefits for Heavy Smokers (a Pack of Cigarettes a Day for More Than 20 Years) Who Quit Smoking by Race/Ethnicity



3.1.1. Adult's Lack of Knowledge of Health Benefits for Heavy Smokers (a Pack of Cigarettes a Day for More Than 20 Years) Who Quit Smoking by Race/Ethnicity and Educational Attainment

Knowledge of the health benefits for heavy smokers who quit smoking was higher with increased education. For example, 76.5% of Hispanics with less than a high school education were not knowledgeable of health benefits for heavy smokers who quit smoking compared to 32% of Hispanics with a college degree.

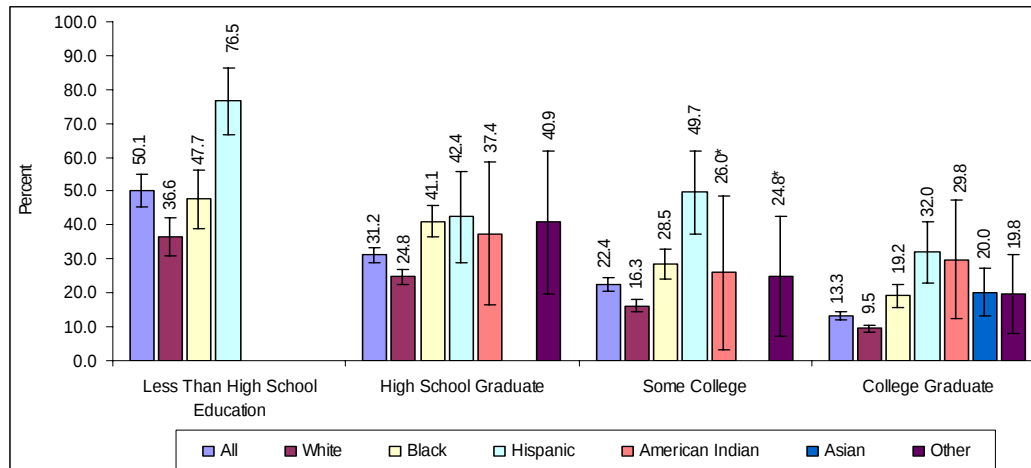
Table 3.1.1. Adult's Lack of Knowledge of Health Benefits for Heavy Smokers (a Pack of Cigarettes a Day for More Than 20 Years) Who Quit Smoking by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	50.1	36.6	47.7	76.5	–	–	–
95% CI(±)	4.7	5.6	8.6	9.8	–	–	–
N	110,368	31,648	35,144	41,170	–	–	–
High School Graduate	31.2	24.8	41.1	42.4	37.4	–	40.9
95% CI(±)	2.1	2.1	4.7	13.4	21.2	–	21.1
N	238,462	116,676	94,217	15,008	3,301	–	4,123
Some College	22.4	16.3	28.5	49.7	26.0*	–	24.8*
95% CI(±)	2.1	2.0	4.5	12.3	22.7	–	17.7
N	167,930	73,734	64,290	21,993	2,320	–	2,373
College Graduate	13.3	9.5	19.2	32.0	29.8	20.2	19.8
95% CI(±)	1.1	1.0	3.3	9.0	17.4	7.0	11.6
N	214,524	104,621	62,013	23,419	3,058	16,207	5,207

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.1.1. Adult's Lack of Knowledge of Health Benefits for Heavy Smokers (a Pack of Cigarettes a Day for More Than 20 Years) Who Quit Smoking by Race/Ethnicity and Educational Attainment



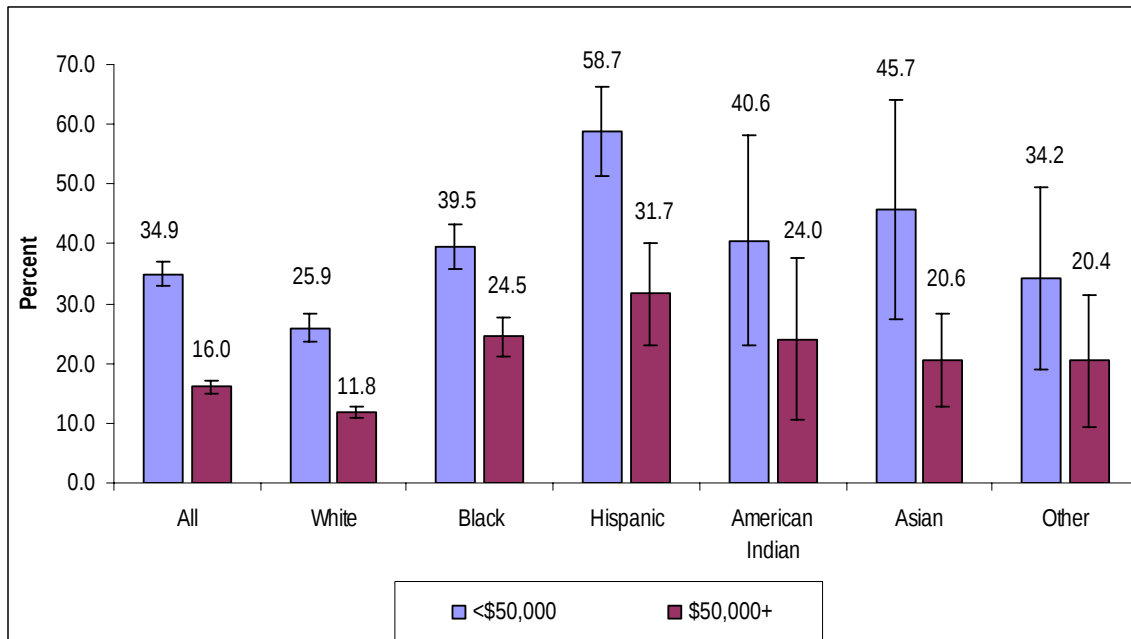
3.1.2. Adult's Lack of Knowledge of Health Benefits for Heavy Smokers (a Pack of Cigarettes a Day for More Than 20 Years) Who Quit Smoking by Race/Ethnicity and Income

Knowledge of the health benefits for heavy smokers who quit smoking was higher with increased income, regardless of race or ethnicity.

Table 3.1.2. Adult's Lack of Knowledge of Health Benefits for Heavy Smokers (a Pack of Cigarettes a Day for More Than 20 Years) Who Quit Smoking by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	34.9	25.9	39.5	58.7	40.6	45.7	34.2
95% CI(±)	2.0	2.2	3.7	7.5	17.6	18.3	15.3
N	413,087	153,278	159,284	77,907	6,903	9,047	6,669
\$50,000+	16.0	11.8	24.5	31.7	24.0	20.6	20.4
95% CI(±)	1.2	1.0	3.3	8.6	13.5	7.9	10.9
N	344,901	172,130	118,446	27,085	4,420	15,616	7,204

Figure 3.1.2. Adult's Lack of Knowledge of Health Benefits for Heavy Smokers (a Pack of Cigarettes a Day for More Than 20 Years) Who Quit Smoking by Race/Ethnicity and Income



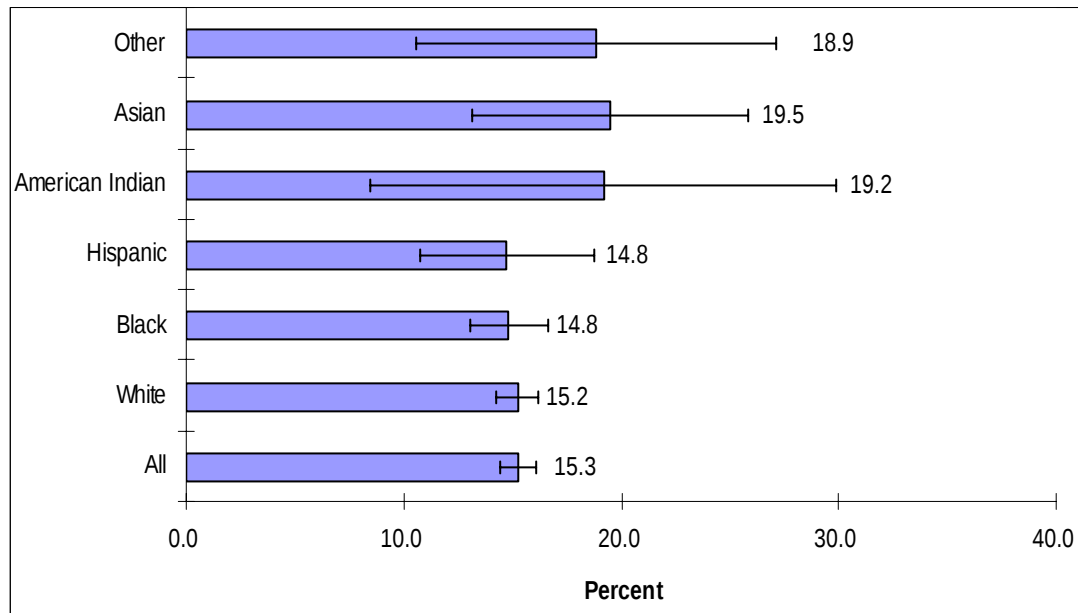
3.2. Adult's Knowledge of the Safety of Smoking Light Cigarettes Versus Regular Cigarettes by Race/Ethnicity

Fifteen percent (15.3%) of Maryland adults (general population) believed that light cigarettes are safer than regular cigarettes, ranging from 14.8% for Hispanics and Blacks to 19.5% for Asians.

Table 3.2. Adult's Knowledge of the Safety of Smoking Light Cigarettes Versus Regular Cigarettes by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	15.3	15.2	14.8	14.8	19.2	19.5	18.9
95% CI(±)	0.8	0.9	1.8	4.0	10.7	6.4	8.3
N	556,092	342,571	141,166	33,860	7,388	20,043	11,064

Figure 3.2. Adult's Knowledge of the Safety of Smoking Light Cigarettes Versus Regular Cigarettes by Race/Ethnicity



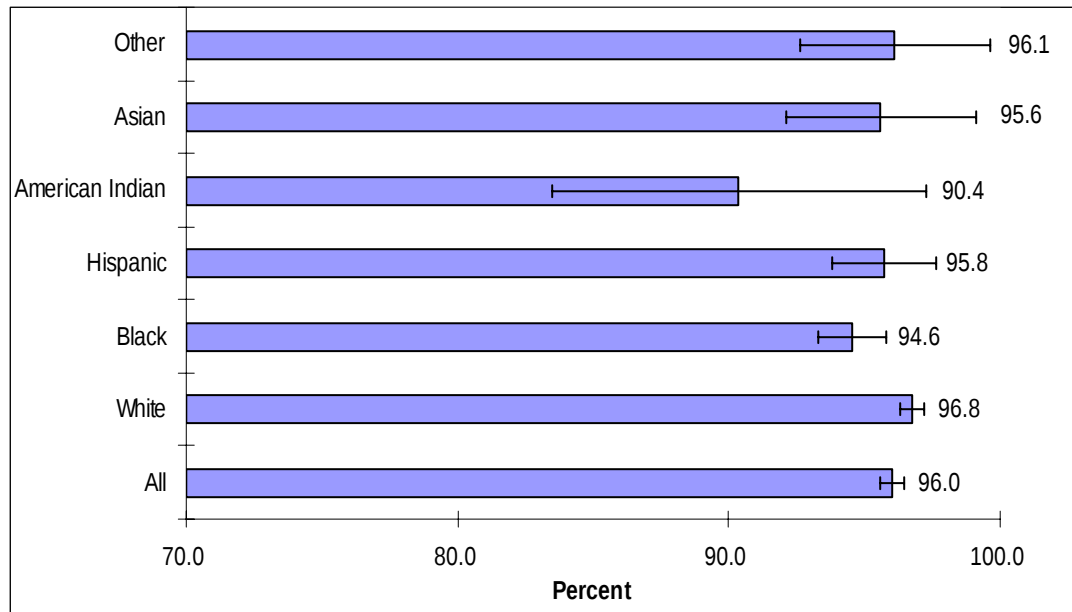
3.3. Adult's Knowledge of Smoking During Pregnancy by Race/Ethnicity

The vast majority (96.0%) of Maryland adults were aware of the risks of smoking during pregnancy, ranging from 90.4% of American Indians to 96.8% of Whites. Blacks were less likely to be aware of the risks than Whites (94.6% vs. 96.8%).

Table 3.3. Adult's Knowledge of Smoking During Pregnancy by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	96.0	96.8	94.6	95.8	90.4	95.6	96.1
95% CI(±)	0.5	0.4	1.2	1.9	6.9	3.5	3.5
N	3,774,743	2,335,678	973,931	256,562	36,266	109,632	62,674

Figure 3.3. Adult's Knowledge of Smoking During Pregnancy by Race/Ethnicity



3.3.1. Adult's Knowledge of Smoking During Pregnancy by Race/Ethnicity and Educational Attainment

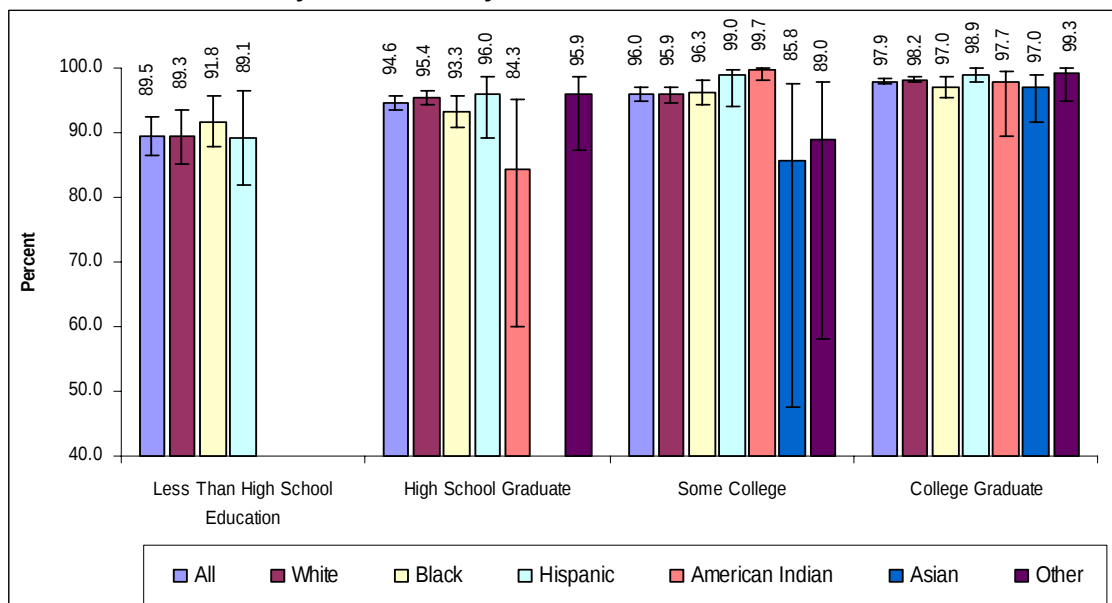
Knowledge of the health effects of smoking during pregnancy was higher with increased education, regardless of race or ethnicity. For example, 84.3% of American Indian high school graduates knew of the health effects of smoking during pregnancy, compared to 99.7% of American Indians with some college education.

Table 3.3.1. Adult's Knowledge of Smoking During Pregnancy by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	89.5	89.3	91.8	89.1	–	–	–
95% CI(±)	2.9	4.3	3.9	7.2	–	–	–
N	206,342	81,010	69,872	50,940	–	–	–
High School Graduate	94.6	95.4	93.3	96.0	84.3	–	95.9
95% CI(-)	1.1	1.1	2.4	6.8	24.2	–	8.6
95% CI(+)	1.1	1.1	2.4	2.6	10.7	–	2.9
N	739,853	454,326	220,773	35,722	8,432	–	11,030
Some College	96.0	95.9	96.3	99.0	99.7	85.8	89.0
95% CI(-)	1.0	1.2	2.0	5.0	1.6	38.2	30.9
95% CI(+)	1.0	1.2	2.0	0.8	0.2	11.8	8.9
N	729,847	433,399	225,014	45,538	9,139	7,790	8,967
College Graduate	97.9	98.2	97.0	98.9	97.7	97.0	99.3
95% CI(-)	0.5	0.4	1.6	1.1	8.2	5.4	4.4
95% CI(+)	0.5	0.4	1.6	1.1	1.8	2.0	0.6
N	1,600,084	1,085,740	323,278	72,489	10,120	80,707	27,750

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.3.1. Adult's Knowledge of Smoking During Pregnancy by Race/Ethnicity and Educational Attainment



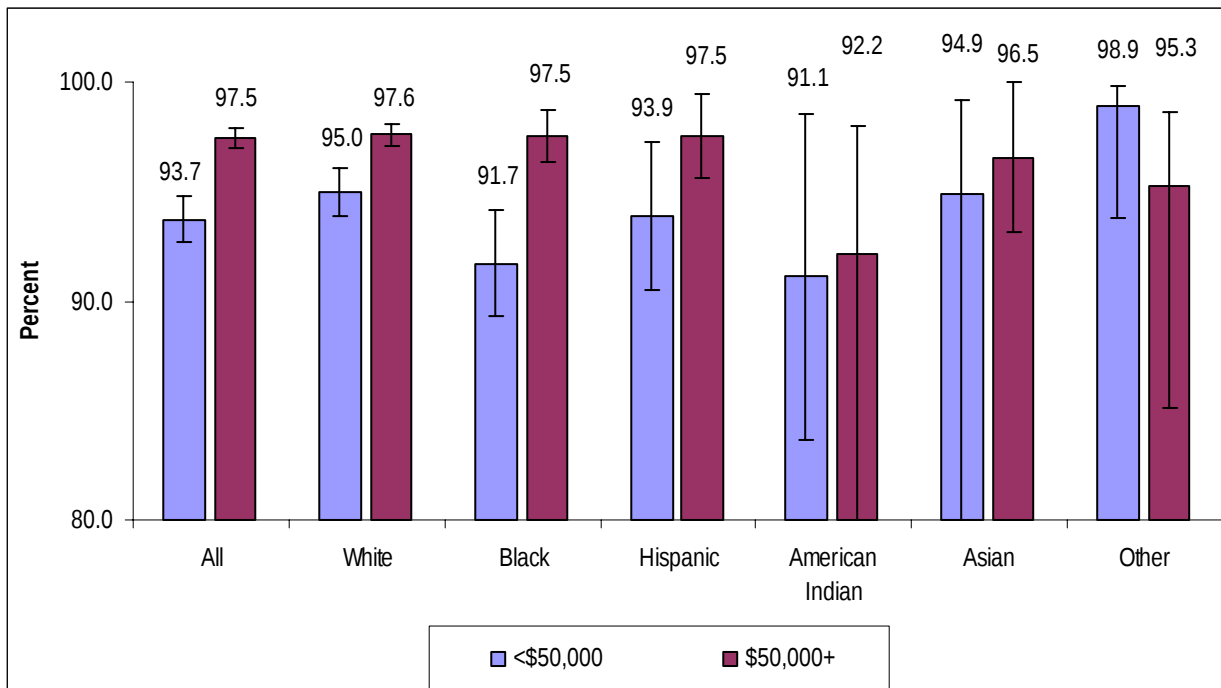
3.3.2. Adult's Knowledge of Smoking During Pregnancy by Race/Ethnicity and Income

Knowledge of the health effects of smoking during pregnancy was lower for Maryland adults with an annual income less than \$50,000 per year when compared to those with an income at least \$50,000 (93.7% vs. 97.5%).

Table 3.3.2. Adult's Knowledge of Smoking During Pregnancy by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	93.7	95.0	91.7	93.9	91.1	94.9	98.9
95% CI(-)	1.1	1.1	2.4	3.4	7.5	19.9	5.2
95% CI(+)	1.1	1.1	2.4	3.4	7.5	4.2	0.9
N	1,132,391	562,376	382,967	130,145	15,774	20,962	20,167
\$50,000+	97.5	97.6	97.5	97.5	92.2	96.5	95.3
95% CI(-)	0.5	0.5	1.2	1.9	18.0	3.4	10.1
95% CI(+)	0.5	0.5	1.2	1.9	5.8	3.4	3.3
N	2,118,289	1,424,169	481,066	84,373	17,232	75,461	35,988

Figure 3.3.2. Adult's Knowledge of Smoking During Pregnancy by Race/Ethnicity and Income



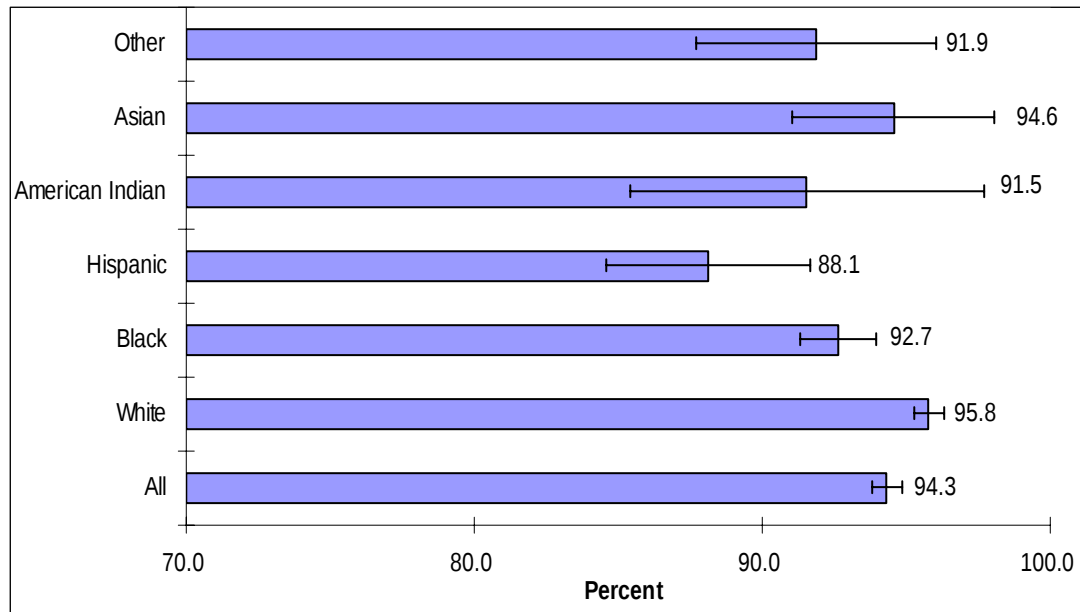
3.4. Adults' Knowledge of Smoking Physical Addiction by Race/Ethnicity

The vast majority of Maryland adults (94.3%) were knowledgeable that smoking is physically addictive. Blacks (92.7%) and Hispanics (88.1%) were less likely than Whites (95.8%) to know that smoking is physically addictive.

Table 3.4. Adults' Knowledge of Smoking Physical Addiction by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	94.3	95.8	92.7	88.1	91.5	94.6	91.9
95% CI(±)	0.5	0.5	1.3	3.6	6.2	3.5	4.2
N	3,712,822	2,330,730	947,538	231,053	36,416	107,619	59,466

Figure 3.4. Adults' Knowledge of Smoking Physical Addiction by Race/Ethnicity



3.4.1. Adults' Knowledge of Smoking Physical Addiction by Race/Ethnicity and Educational Attainment

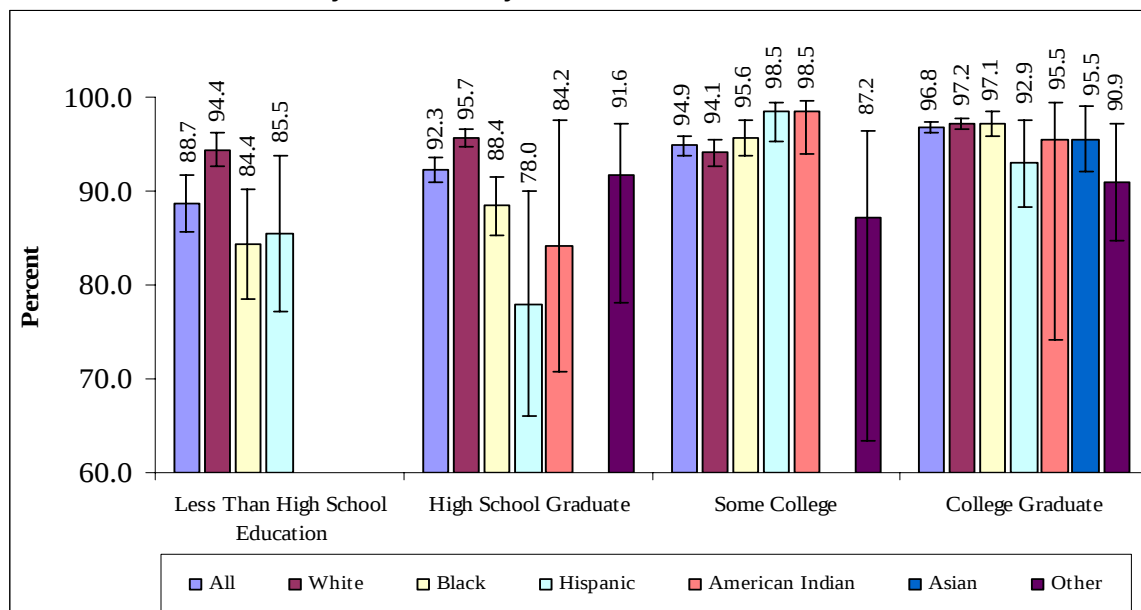
In general, Maryland adults with the least education were the least likely to know that smoking was physically addictive.

Table 3.4.1. Adults' Knowledge of Smoking Physical Addiction by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	88.7	94.4	84.4	85.5	–	–	–
95% CI(±)	3.0	1.8	5.9	8.3	–	–	–
N	203,938	87,660	64,765	45,852	–	–	–
High School Graduate	92.3	95.7	88.4	78.0	84.2	–	91.6
95% CI(-)	1.3	0.9	3.1	11.9	13.4	–	13.5
95% CI(+)	1.3	0.9	3.1	11.9	13.4	–	5.5
N	723,099	460,292	207,579	28,184	8,206	–	10,557
Some College	94.9	94.1	95.6	98.5	98.5	–	87.2
95% CI(-)	1.1	1.4	1.9	3.2	4.6	–	23.8
95% CI(+)	1.1	1.4	1.9	1.0	1.1	–	9.2
N	724,279	430,730	222,323	44,868	8,830	–	8,790
College Graduate	96.8	97.2	97.1	92.9	95.5	95.5	90.9
95% CI(-)	0.5	0.5	1.3	4.7	21.3	3.5	6.3
95% CI(+)	0.5	0.5	1.3	4.7	3.9	3.5	6.3
N	1,584,686	1,081,281	321,432	67,665	9,891	79,035	25,382

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.4.1. Adults' Knowledge of Smoking Physical Addiction by Race/Ethnicity and Educational Attainment



The next 5 questions consider Maryland adults' knowledge of the effects of secondhand smoking on health by race/ethnicity

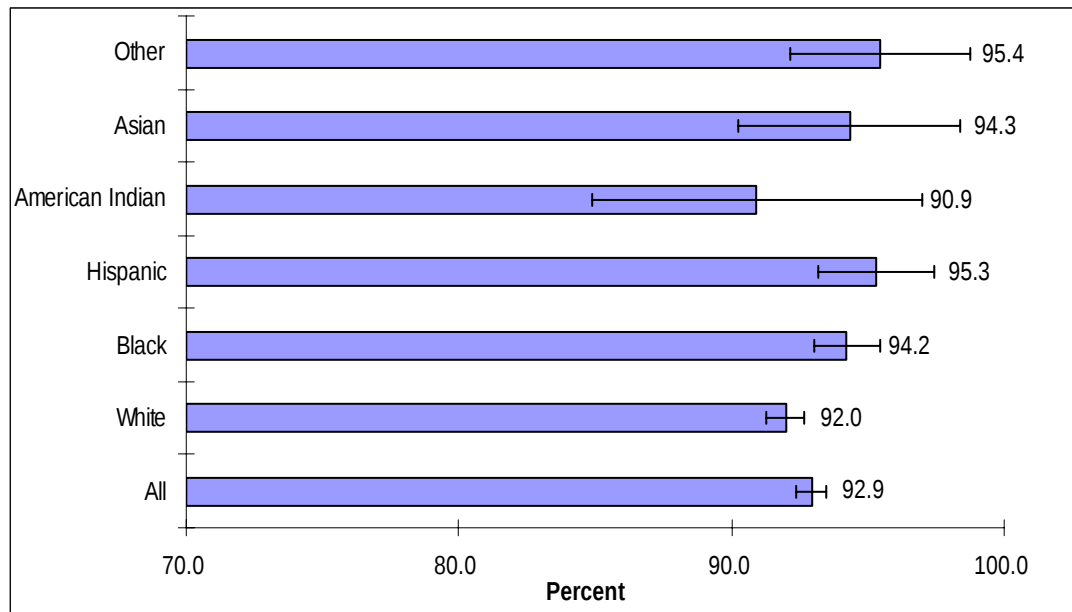
3.5. Adults' Knowledge of Secondhand Smoking Causing Lung Cancer in Adults by Race/Ethnicity

Ninety-three percent (92.9%) of Maryland adults knew that secondhand smoking causes lung cancer, ranging from 90.9% for American Indians to 95.4% for persons of Other race/ethnicity. Hispanics and Blacks were significantly more likely than Whites to know that secondhand smoking causes lung cancer (95.3%, 94.2% and 92.0% respectively).

Table 3.5. Adults' Knowledge of Secondhand Smoking Causing Lung Cancer in Adults by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	92.9	92.0	94.2	95.3	90.9	94.3	95.4
95% CI(±)	0.6	0.7	1.2	2.1	6.0	4.1	3.3
N	3,380,892	2,048,222	899,999	244,580	34,069	101,016	53,007

Figure 3.5. Adults' Knowledge of Secondhand Smoking Causing Lung Cancer in Adults by Race/Ethnicity



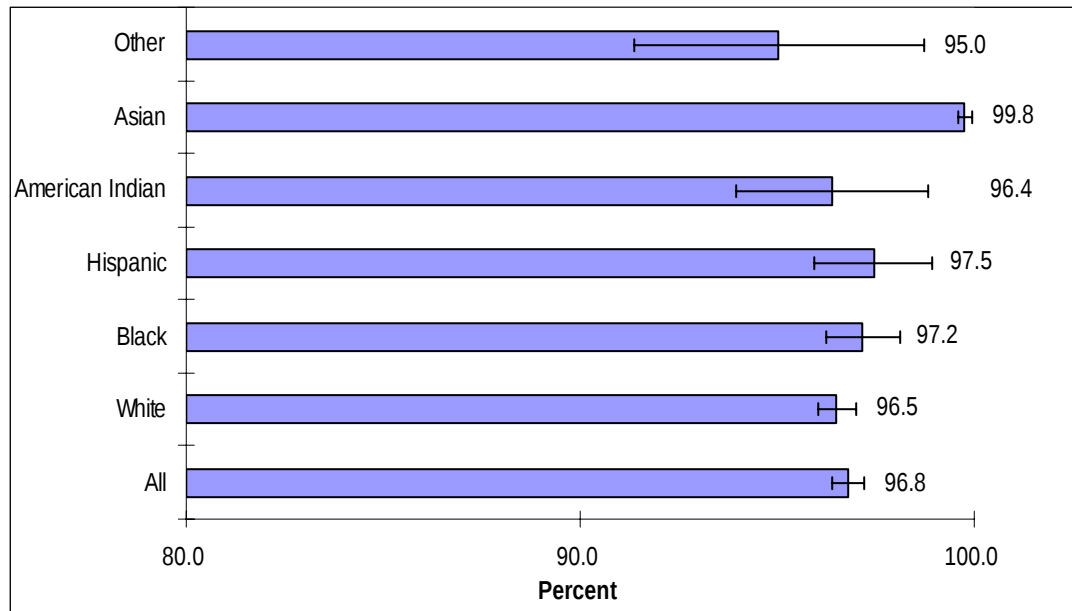
3.6. Adults' Knowledge of Secondhand Smoking Causing Respiratory Problems in Children by Race/Ethnicity

Ninety-seven percent (96.8%) of Maryland adults knew that secondhand smoking causes respiratory problems in children, with little variation by race/ethnicity (ranging from 96.4% to 99.8%). However, Asians (99.8%) were significantly more knowledgeable than Whites (96.5%), American Indians (96.4%), Hispanics (97.5%) and Blacks (97.2%). Although not shown, knowledge that secondhand smoking causes respiratory problems in children was slightly lower for adults with less education and lower income.

Table 3.6. Adults' Knowledge of Secondhand Smoking Causing Respiratory Problems in Children by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	96.8	96.5	97.2	97.5	96.4	99.8	95.0
95% CI(-)	0.4	0.5	1.0	1.5	7.1	0.8	3.7
95% CI(+)	0.4	0.5	1.0	1.5	2.5	0.2	3.7
N	3,291,860	2,008,748	869,925	231,714	32,890	94,642	53,941

Figure 3.6. Adults' Knowledge of Secondhand Smoking Causing Respiratory Problems in Children by Race/Ethnicity



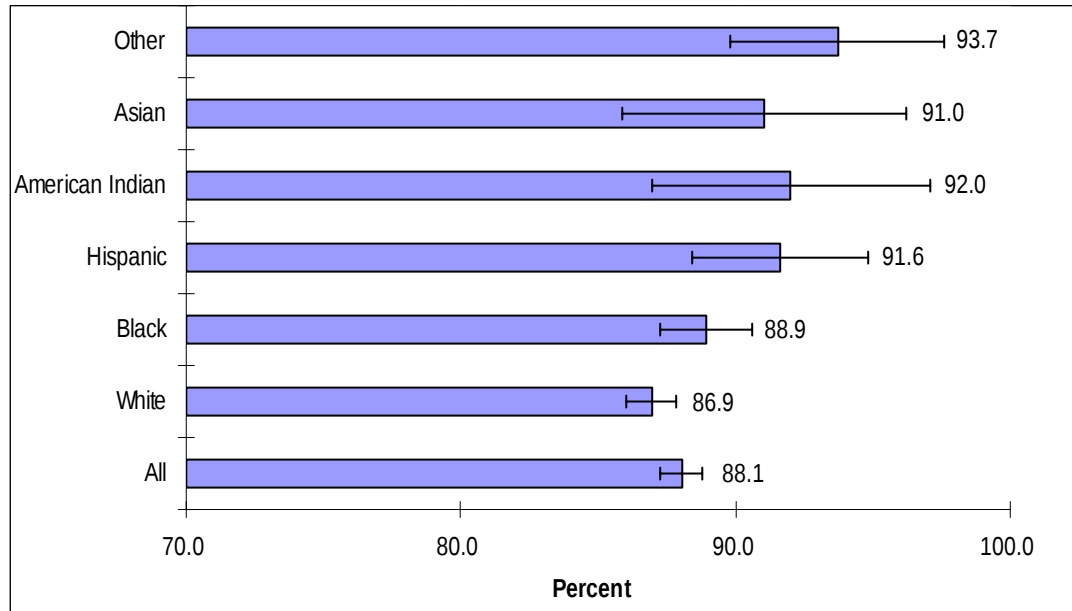
3.7. Adults' Knowledge of Secondhand Smoking Causing Heart Disease in Adults by Race/Ethnicity

Eighty-eight percent (88.1%) of respondents knew secondhand smoking causes heart disease. Hispanics (91.6%) and persons of Other race/ethnicity (93.7%) were significantly more likely than Whites (86.9%) to know that secondhand smoking causes heart disease in adults. Although not shown, knowledge that secondhand smoking causes heart disease was higher among Whites and Blacks with higher education and income.

Table 3.7. Adults' Knowledge of Secondhand Smoking Causing Heart Disease in Adults by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	88.1	86.9	88.9	91.6	92.0	91.0	93.7
95% CI(±)	0.8	0.9	1.7	3.2	5.1	5.2	3.9
N	2,890,749	1,756,542	761,844	205,638	31,234	86,996	48,496

Figure 3.7. Adults' Knowledge of Secondhand Smoking Causing Heart Disease in Adults by Race/Ethnicity



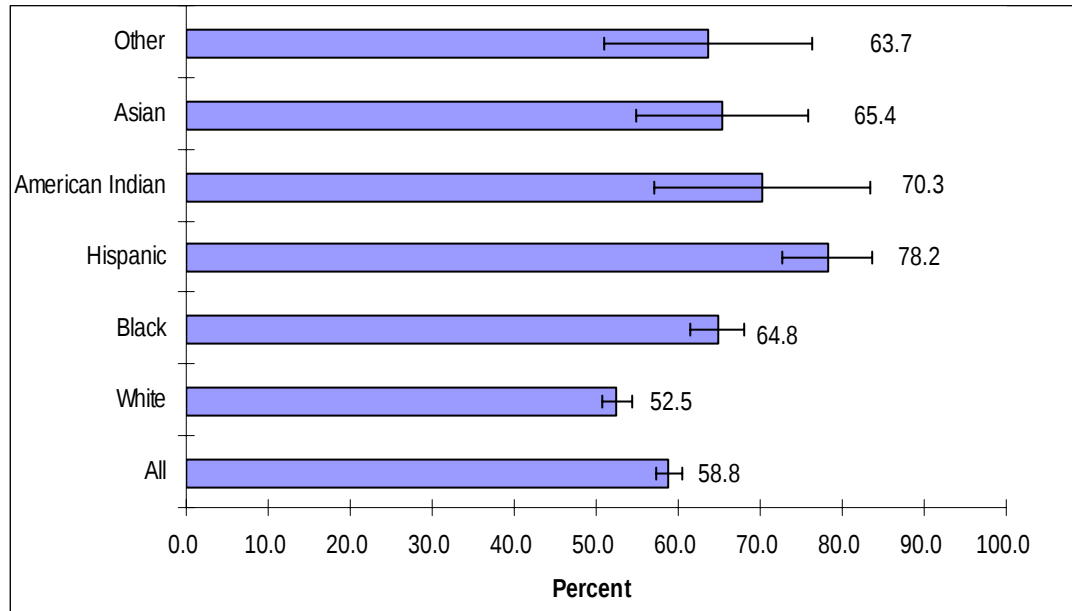
3.8. Adults' Knowledge of Secondhand Smoking Causing Colon Cancer in Adults by Race/Ethnicity

Around six out of ten (58.8%) Maryland adults knew that secondhand smoking causes colon cancer, ranging from 52.5% for Whites to 78.2% for Hispanics. Hispanics, Blacks, Asians and American Indians were significantly more likely than Whites to know that secondhand smoking causes colon cancer (78.2%, 64.8%, 70.3%, 65.4% and 52.5% respectively).

Table 3.8. Adults' Knowledge of Secondhand Smoking Causing Colon Cancer in Adults by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	58.8	52.5	64.8	78.2	70.3	65.4	63.7
95% CI(±)	1.5	1.8	3.2	5.4	13.2	10.5	12.7
N	1,136,184	580,492	365,933	117,084	15,657	37,385	19,633

Figure 3.8. Adults' Knowledge of Secondhand Smoking Causing Colon Cancer in Adults by Race/Ethnicity



3.8.1. Adults' Knowledge of Secondhand Smoking Causing Colon Cancer in Adults by Race/Ethnicity and Educational Attainment

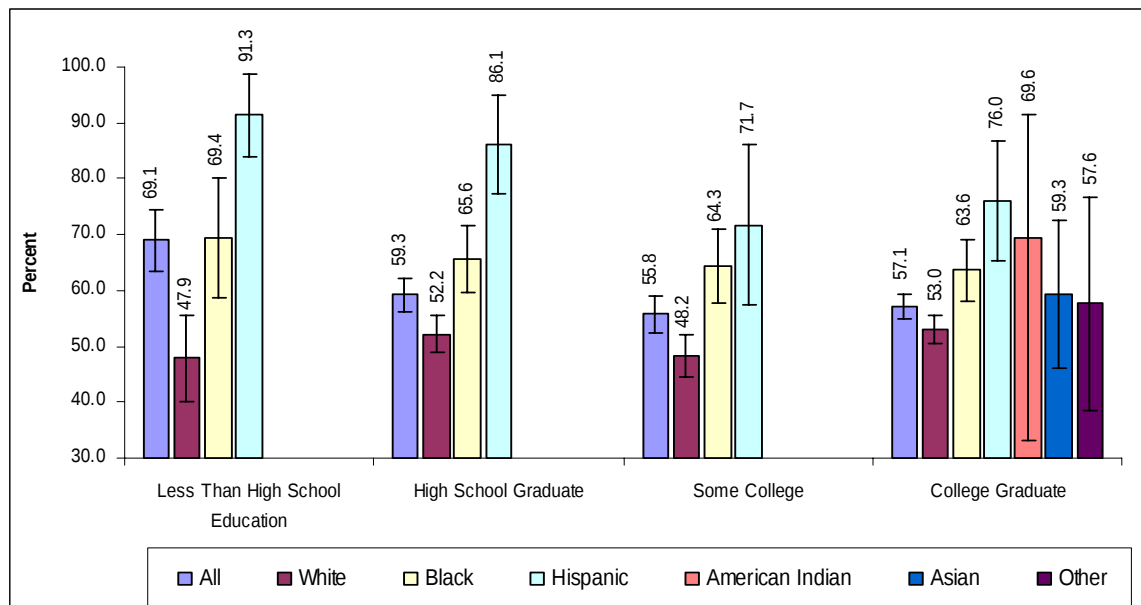
Blacks and Hispanics with less education were more likely than their counterparts to know that secondhand smoking causes colon cancer.

Table 3.8.1. Adults' Knowledge of Secondhand Smoking Causing Colon Cancer in Adults by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	69.1	47.9	69.4	91.3	–	–	–
95% CI(±)	5.5	7.8	10.6	7.3	–	–	–
N	92,579	21,094	30,950	37,805	–	–	–
High School Graduate	59.3	52.2	65.6	86.1	–	–	–
95% CI(±)	3.0	3.4	6.0	8.9	–	–	–
N	224,775	111,387	84,881	17,189	–	–	–
Some College	55.8	48.2	64.3	71.7	–	–	–
95% CI(±)	3.4	3.8	6.5	14.3	–	–	–
N	203,821	98,704	77,060	19,741	–	–	–
College Graduate	57.1	53.0	63.6	76.0	69.6	59.3	57.6
95% CI(-)	2.3	2.6	5.5	10.6	36.5	13.2	19.0
95% CI(+)	2.3	2.6	5.5	10.6	21.8	13.2	19.0
N	437,292	261,232	116,576	25,940	3,710	22,012	7,822

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.8.1. Adults' Knowledge of Secondhand Smoking Causing Colon Cancer in Adults by Race/Ethnicity and Educational Attainment



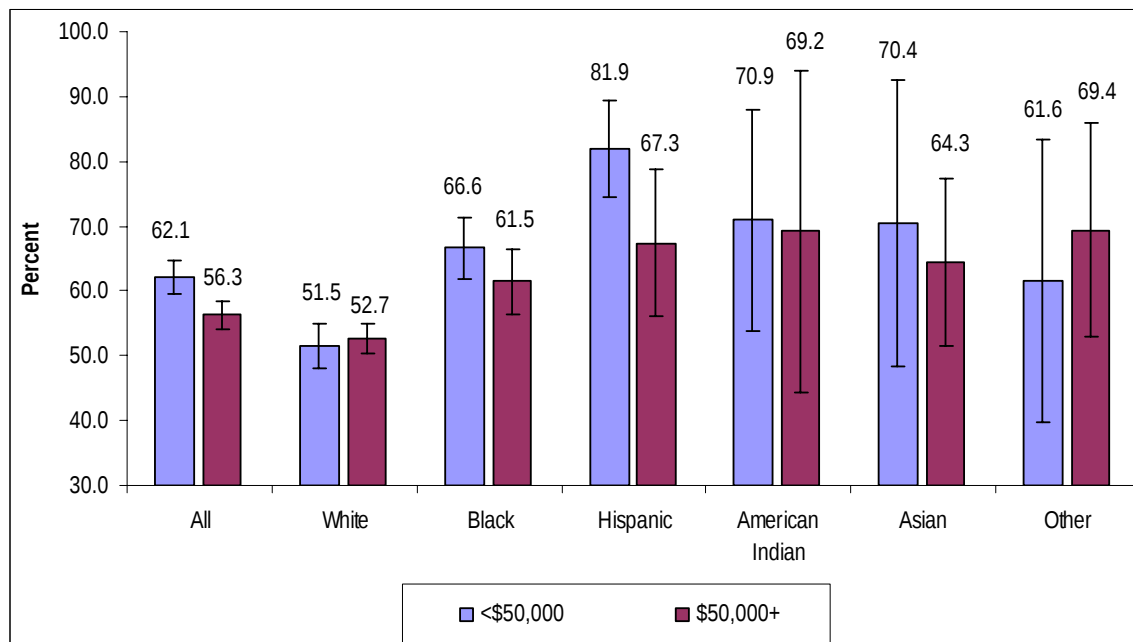
3.8.2. Adults' Knowledge of Secondhand Smoking Causing Colon Cancer in Adults by Race/Ethnicity and Income

Among people earning less than \$50,000, Hispanics (81.9%) were significantly more likely than Whites (51.5%) and Blacks (66.6%) to know that secondhand smoking causes colon cancer. Among people with salaries of at least \$50,000, Hispanics (67.3%) were significantly more likely than Whites (52.7%) to have that knowledge.

Table 3.8.2. Adults' Knowledge of Secondhand Smoking Causing Colon Cancer in Adults by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	62.1	51.5	66.6	81.9	70.9	70.4	61.6
95% CI(±)	2.7	3.5	4.7	7.3	17.0	22.0	21.7
N	401,809	145,024	163,666	70,971	8,533	7,758	5,857
\$50,000+	56.3	52.7	61.5	67.3	69.2	64.3	69.4
95% CI(±)	2.1	2.3	4.9	11.3	24.9	12.9	16.5
N	585,333	355,368	160,054	25,660	5,613	26,103	12,536

Figure 3.8.2. Adults' Knowledge of Secondhand Smoking Causing Colon Cancer in Adults by Race/Ethnicity and Income



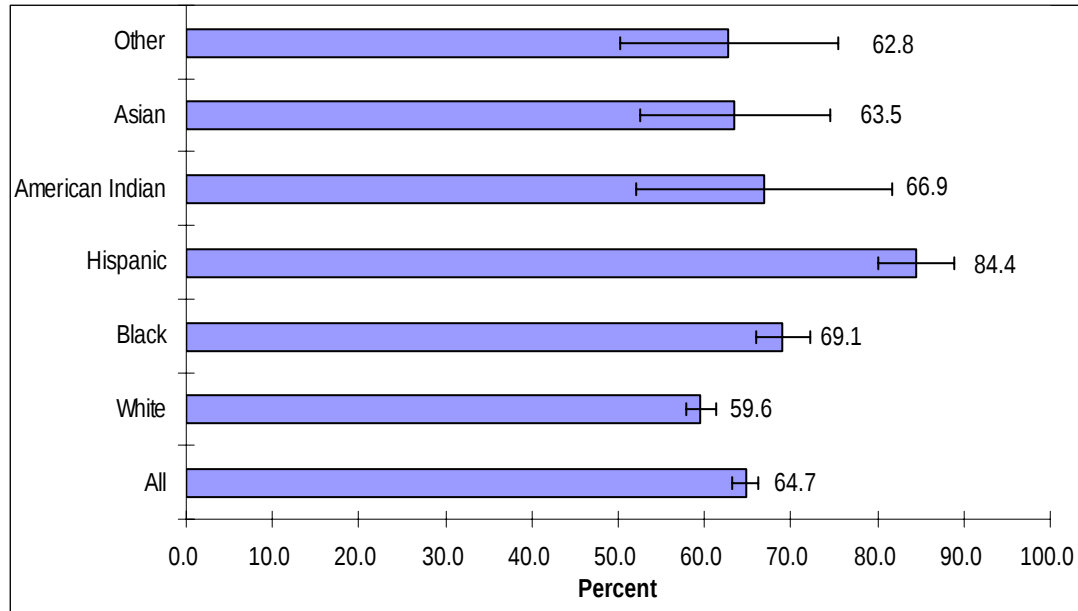
3.9. Adults' Knowledge of Secondhand Smoking Causing Sudden Infant Death Syndrome (SIDS) by Race/Ethnicity

Sixty-five percent (64.7%) of Maryland adults knew that secondhand smoking causes SIDS. Blacks (69.1%) and Hispanics (84.4%) were significantly more likely than Whites (59.6%) to know that secondhand smoking causes SIDS.

Table 3.9. Adults' Knowledge of Secondhand Smoking Causing Sudden Infant Death Syndrome (SIDS) by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	64.7	59.6	69.1	84.4	66.9	63.5	62.8
95% CI(±)	1.5	1.7	3.1	4.4	14.9	11.0	12.6
N	1,250,724	647,405	389,518	140,128	16,292	34,859	22,521

Figure 3.9. Adults' Knowledge of Secondhand Smoking Causing Sudden Infant Death Syndrome (SIDS) by Race/Ethnicity



3.9.1. Adults' Knowledge of Secondhand Smoking Causing Sudden Infant Death Syndrome (SIDS) by Race/Ethnicity and Educational Attainment

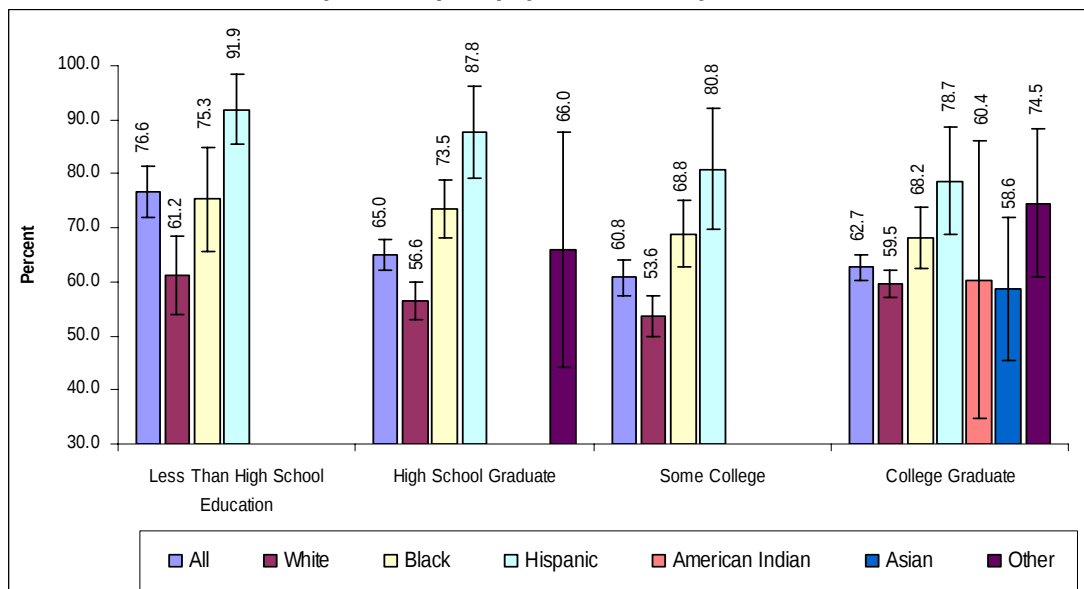
Adults with less education were more knowledgeable that secondhand smoking causes Sudden Infant Death Syndrome (SIDS).

Table 3.9.1. Adults' Knowledge of Secondhand Smoking Causing Sudden Infant Death Syndrome (SIDS) by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	76.6	61.2	75.3	91.9	–	–	–
95% CI(±)	4.7	7.3	9.5	6.4	–	–	–
N	111,103	27,905	36,703	42,997	–	–	–
High School Graduate	65.0	56.6	73.5	87.8	–	–	66.0
95% CI(±)	2.9	3.5	5.4	8.5	–	–	21.7
N	245,611	117,606	96,698	17,965	–	–	4,578
Some College	60.8	53.6	68.8	80.8	–	–	–
95% CI(±)	3.3	3.8	6.2	11.2	–	–	–
N	222,311	107,963	81,648	24,882	–	–	–
College Graduate	62.7	59.5	68.2	78.7	60.4	58.6	74.5
95% CI(±)	2.3	2.5	5.6	9.9	25.8	13.3	13.8
N	465,720	286,725	113,435	28,954	4,185	21,572	10,848

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.9.1. Adults' Knowledge of Secondhand Smoking Causing Sudden Infant Death Syndrome (SIDS) by Race/Ethnicity and Educational Attainment



3.9.2. Adults' Knowledge of Secondhand Smoking Causing Sudden Infant Death Syndrome (SIDS) by Race/Ethnicity and Income

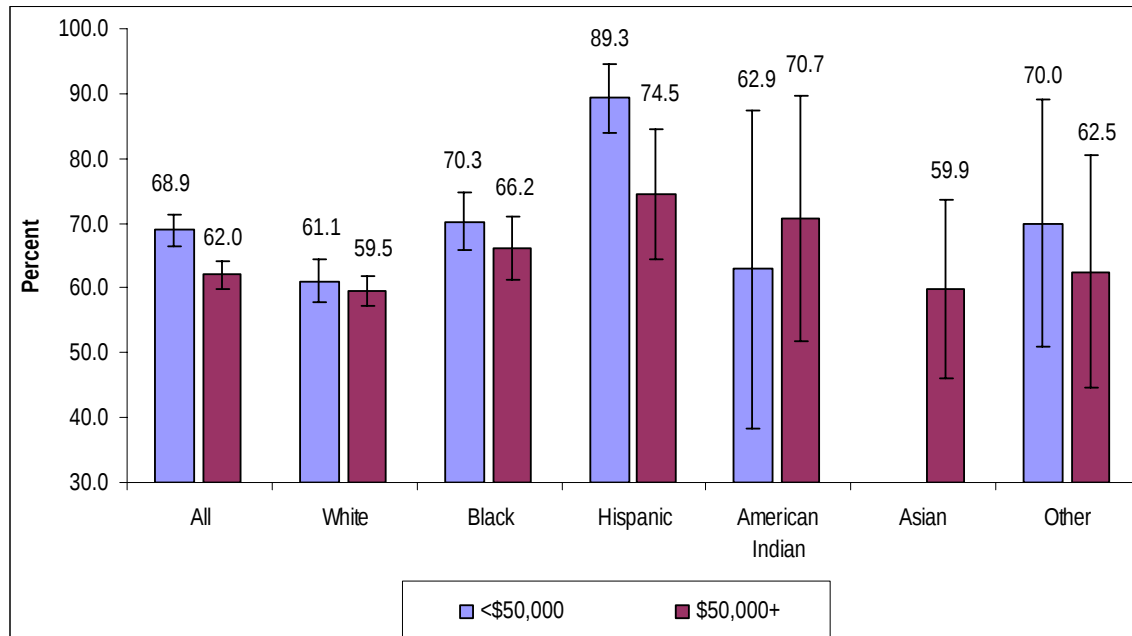
Adults with income of less than \$50,000 were more knowledgeable that secondhand smoking causes Sudden Infant Death Syndrome (SIDS) than those with an annual income of at least \$50,000.

Table 3.9.2. Adults' Knowledge of Secondhand Smoking Causing Sudden Infant Death Syndrome (SIDS) by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	68.9	61.1	70.3	89.3	62.9	–	70.0
95% CI(±)	2.5	3.3	4.5	5.3	24.6	–	19.2
N	460,389	173,816	179,188	84,360	6,905	–	7,826
\$50,000+	62.0	59.5	66.2	74.5	70.7	59.9	62.5
95% CI(±)	2.0	2.2	4.9	9.9	18.9	13.7	17.9
N	629,352	388,572	164,325	32,879	8,420	22,044	13,113

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.9.2. Adults' Knowledge of Secondhand Smoking Causing Sudden Infant Death Syndrome (SIDS) by Race/Ethnicity and Income



3.10. Sources That Tobacco and Smokeless Tobacco Users Have Employed to Find Quit-smoking Information by Race/Ethnicity

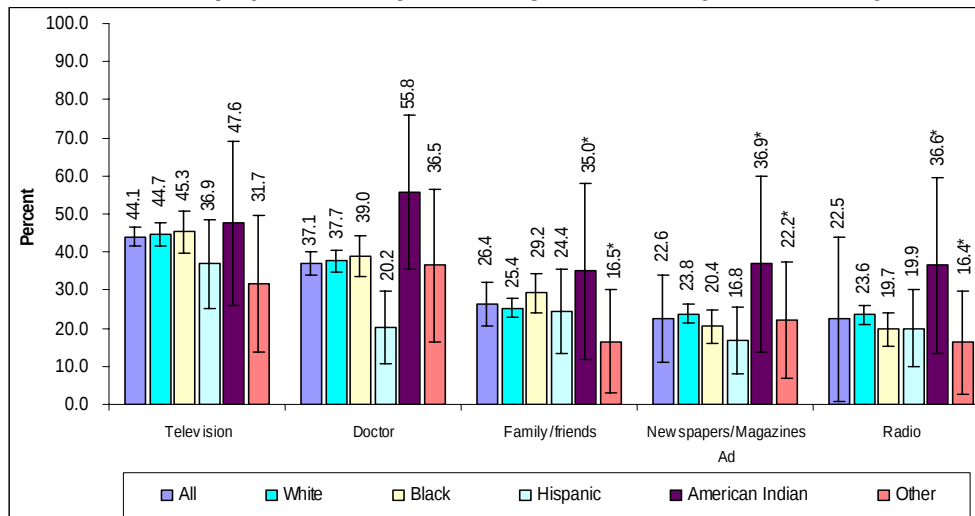
An examination of the different sources that people use to obtain quit-smoking information indicates a similarity among ethnic groups. Hispanics were much less likely to have received quit-smoking information from their doctor than any other racial/ethnic group.

Table 3.10. Sources That Tobacco and Smokeless Tobacco Users Have Employed to Find Quit-smoking Information by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Other
Television	44.1	44.7	45.3	36.9	47.6	31.7
95% CI(±)	2.5	2.9	5.6	11.5	21.5	18.0
N	343,042	222,877	88,717	17,994	5,574	4,675
Doctor	37.1	37.7	39.0	20.2	55.8	36.5
95% CI(±)	2.4	2.8	5.4	9.7	20.2	20.1
N	288,692	188,166	76,390	9,868	6,535	5,381
Family/friends	26.4	25.4	29.2	24.4	35.0*	16.5*
95% CI(±)	2.3	2.6	5.2	11.2	23.2	13.5
N	205,290	126,551	57,268	11,898	4,092	2,436
Newspapers/Magazines Ad	22.6	23.8	20.4	16.8	36.9*	22.2*
95% CI(±)	2.1	2.5	4.5	8.7	23.0	15.3
N	175,681	118,592	40,067	8,207	4,318	3,267
Radio	22.5	23.6	19.7	19.9	36.6*	16.4*
95% CI(±)	2.1	2.5	4.4	10.1	23.2	13.5
N	174,828	117,665	38,572	9,717	4,280	2,415

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 3.10. Sources That Tobacco and Smokeless Tobacco Users Have Employed to Find Quit-smoking Information by Race/Ethnicity



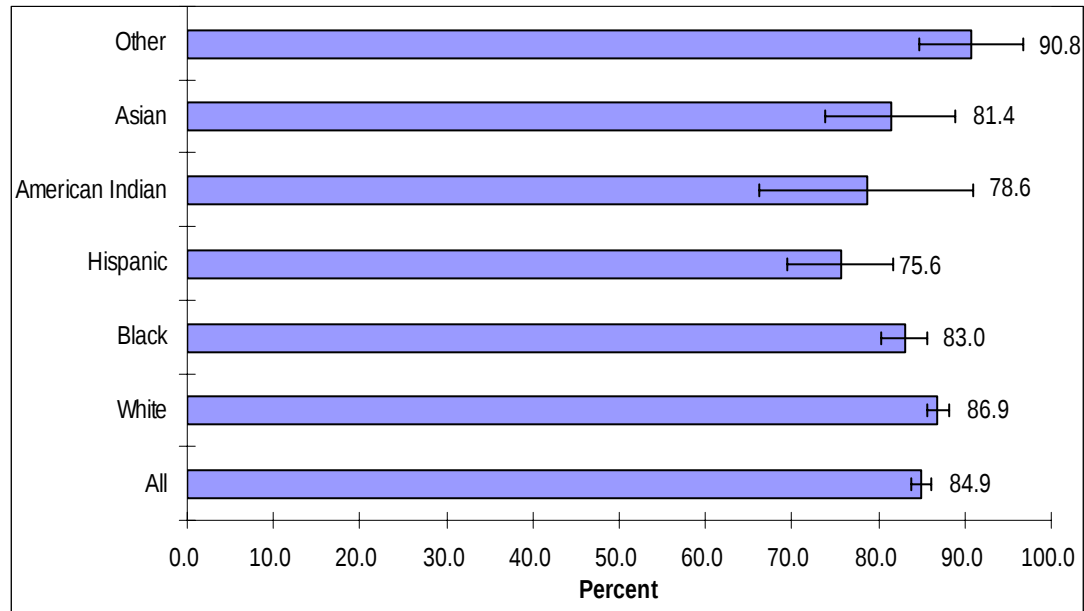
3.11 Employed Adults Reporting Rules About Smoking at Their Workplace by Race/Ethnicity

The vast majority of all employed adults (84.9%) reported that their workplaces do not allow smoking anywhere, ranging from 75.6% for Hispanics to 90.8% for persons of Other race/ethnicity. Hispanics were significantly less likely than Whites to report having a smoking ban in the workplace (75.6% vs. 86.9%).

Table 3.11 Employed Adults Reporting Rules About Smoking at Their Workplace by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Not Allowed Anywhere (%)	84.9	86.9	83.0	75.6	78.6	81.4	90.8
95% CI(±)	1.1	1.2	2.6	6.1	12.3	7.5	6.1
N	1,815,021	1,128,898	473,979	103,247	14,459	60,182	34,256

Figure 3.11 Employed Adults Reporting Rules About Smoking at Their Workplace by Race/Ethnicity



3.11.1. Employed Adults Reporting Rules About Smoking at Their Workplace by Race/Ethnicity and Educational Attainment

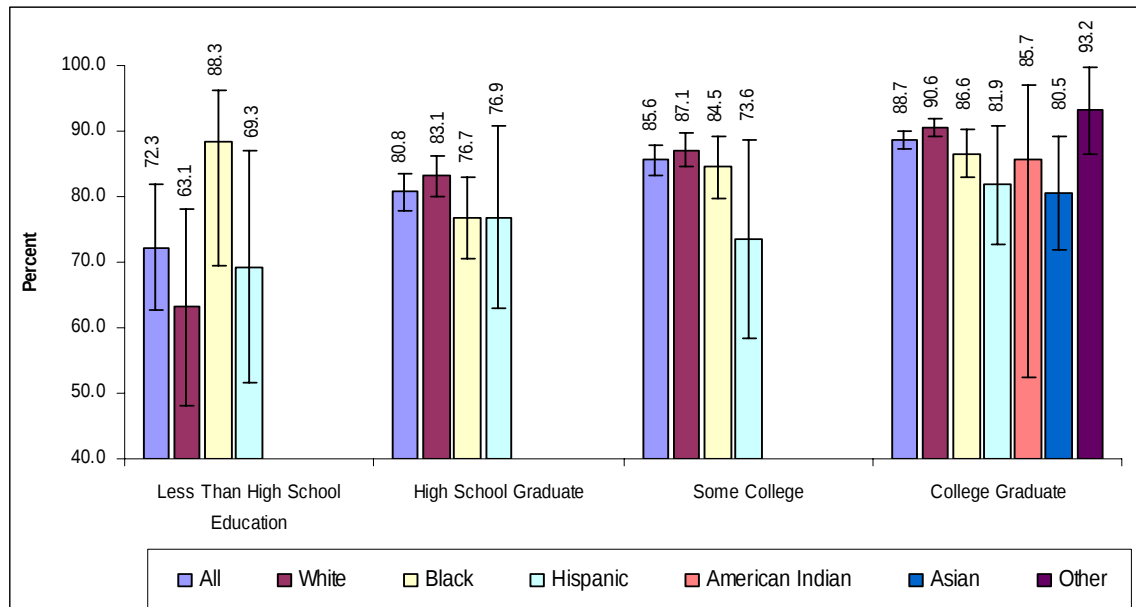
Among White employed adults, those with less than a high school education were the least likely to report rules about smoking in the workplace.

Table 3.11.1. Employed Adults Reporting Rules About Smoking at Their Workplace by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	72.3	63.1	88.3	69.3	–	–	–
95% CI(-)	9.6	15.0	18.7	17.8	–	–	–
95% CI(+)	9.6	15.0	7.9	17.8	–	–	–
N	36,614	9,859	13,037	13,491	–	–	–
High School Graduate	80.8	83.1	76.7	76.9	–	–	–
95% CI(±)	2.8	3.0	6.3	13.9	–	–	–
N	256,462	156,878	75,231	13,905	–	–	–
Some College	85.6	87.1	84.5	73.6	–	–	–
95% CI(±)	2.4	2.6	4.8	15.1	–	–	–
N	342,787	196,217	114,524	17,190	–	–	–
College Graduate	88.7	90.6	86.6	81.9	85.7	80.5	93.2
95% CI(-)	1.4	1.3	3.6	9.1	33.2	8.6	6.6
95% CI(+)	1.4	1.3	3.6	9.1	11.3	8.6	6.6
N	968,208	644,930	208,076	44,583	5,753	45,862	19,003

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.11.1. Employed Adults Reporting Rules About Smoking at Their Workplace by Race/Ethnicity and Educational Attainment



3.11.2. Employed Adults Reporting Rules About Smoking at Their Workplace by Race/Ethnicity and Income

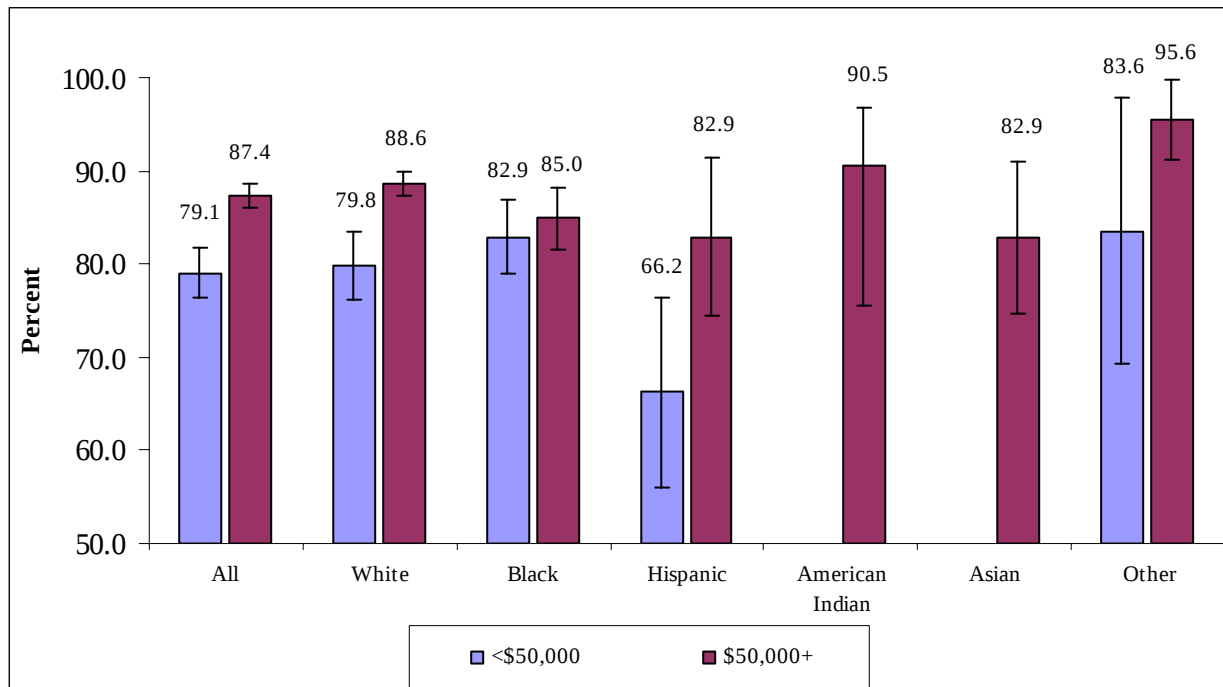
Among the general population and Whites, employed adults with lower income (<\$50,000) were less likely than employed adults who earn at least \$50,000 to report rules about smoking in the workplace.

Table 3.11.2. Employed Adults Reporting Rules About Smoking at Their Workplace by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	79.1	79.8	82.9	66.2	–	–	83.6
95% CI(±)	2.7	3.6	4.0	10.1	–	–	14.2
N	384,514	177,467	150,483	40,622	–	–	7,541
\$50,000+	87.4	88.6	85.0	82.9	90.5	82.9	95.6
95% CI(-)	1.3	1.3	3.3	8.4	14.9	8.1	4.3
95% CI(+)	1.3	1.3	3.3	8.4	6.2	8.1	4.3
N	1,248,454	825,649	291,919	47,803	9,618	49,244	24,220

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.11.2. Employed Adults Reporting Rules About Smoking at Their Workplace by Race/Ethnicity and Income



3.12. Employed Adults Aware of Any Stop Smoking Program or Other Types of Help Offered by Their Employer in the Last 12 Months by Race/Ethnicity

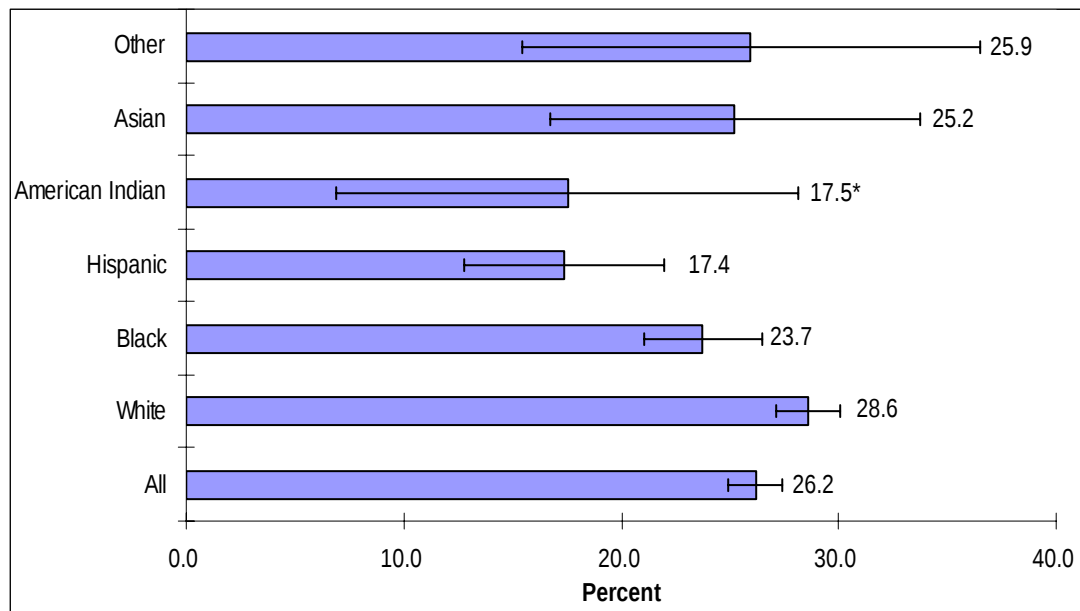
Although 79.1% of employed adults earning less than \$50,000 and 87.4% of employed adults earning at least \$50,000 work for employers who have banned smoking in the workplace (see table 3.11), only 26.2% of employed adults were aware of any workplace stop smoking program or other types of help offered by their employer during the past 12 months. Blacks (23.7%) and Hispanics (17.4%) were significantly less likely than Whites (28.6%) to be aware of any stop smoking program or other help offered by their employer. These differences may be due to higher rates of working for smaller employers who do not offer benefits, or part-time work for more than one employer.

Table 3.12. Employed Adults Aware of Any Stop Smoking Program or Other Types of Help Offered by Their Employer in the Last 12 Months by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	26.2	28.6	23.7	17.4	17.5*	25.2	25.9
95% CI(±)	1.2	1.5	2.7	4.6	10.6	8.5	10.5
N	621,736	407,412	150,213	31,660	4,707	17,028	10,715

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 3.12. Employed Adults Aware of Any Stop Smoking Program or Other Types of Help Offered by Their Employer in the Last 12 Months by Race/Ethnicity



3.12.1. Employed Adults Aware of Any Stop Smoking Program or Other Types of Help Offered by Their Employer in the Last 12 Months by Race/Ethnicity and Educational Attainment

The percentage of employed adults who were aware of any stop smoking program or other types of help offered by their employer was higher with increased education.

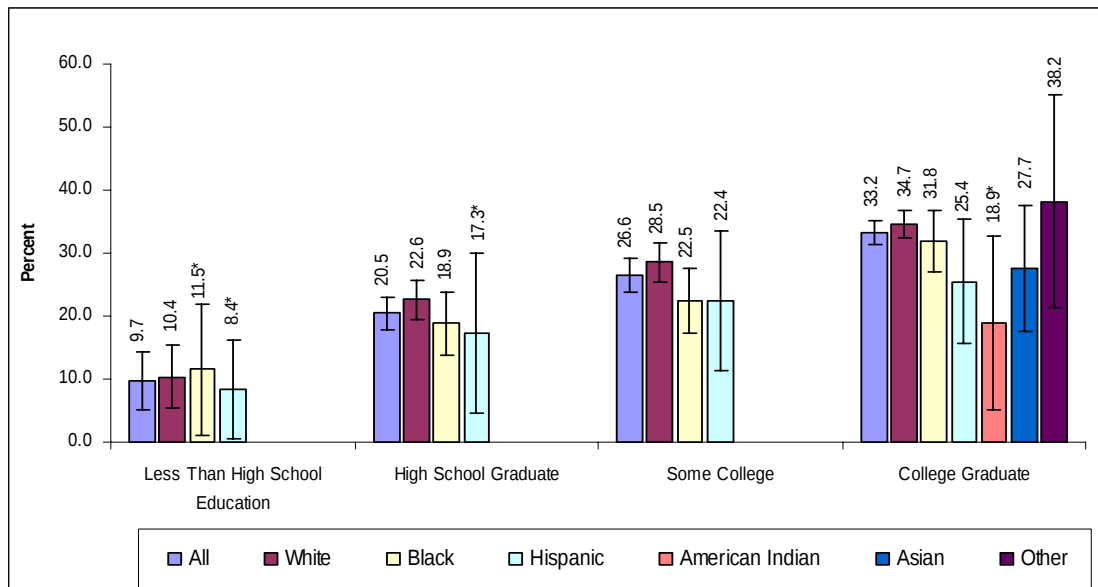
Table 3.12.1. Employed Adults Aware of Any Stop Smoking Program or Other Types of Help Offered by Their Employer in the Last 12 Months by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	9.7	10.4	11.5*	8.4*	–	–	–
95% CI(±)	4.6	4.9	10.4	7.9	–	–	–
N	10,150	3,289	3,134	3,726	–	–	–
High School Graduate	20.5	22.6	18.9	17.3*	–	–	–
95% CI(±)	2.5	3.1	5.0	12.8	–	–	–
N	88,510	58,492	25,257	3,907	–	–	–
Some College	26.6	28.5	22.5	22.4	–	–	–
95% CI(±)	2.7	3.1	5.1	11.1	–	–	–
N	124,189	75,255	34,069	7,392	–	–	–
College Graduate	33.2	34.7	31.8	25.4	18.9*	27.7	38.2
95% CI(±)	1.9	2.2	4.9	9.8	13.8	10.0	16.9
N	346,973	238,773	71,638	12,925	1,584	14,348	7,705

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.12.1. Employed Adults Aware of Any Stop Smoking Program or Other Types of Help Offered by Their Employer in the Last 12 Months by Race/Ethnicity and Educational Attainment



3.12.2. Employed Adults Aware of Any Stop Smoking Program or Other Types of Help Offered by Their Employer in the Last 12 Months by Race/Ethnicity and Income

The percentage of employed adults who were aware of any stop smoking program or other types of help offered by their employer was almost twice as high for those with an annual income of at least \$50,000 compared to those with an income less than \$50,000 (31.1% vs. 15.6%).

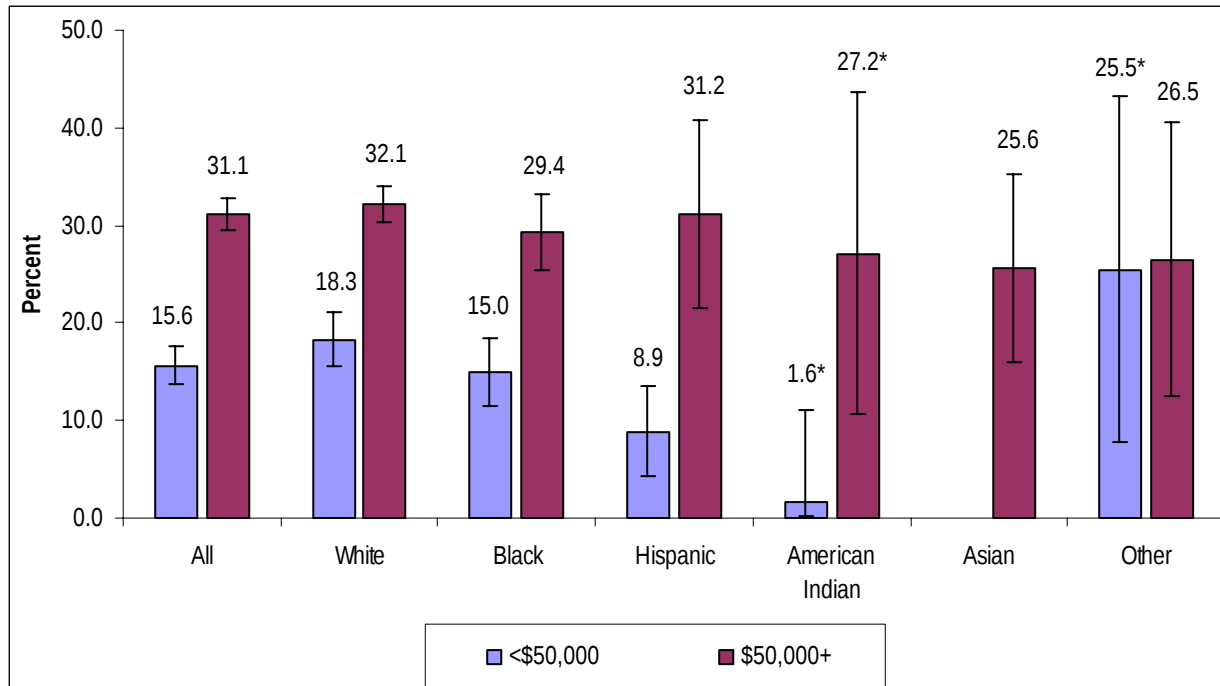
Table 3.12.2. Employed Adults Aware of Any Stop Smoking Program or Other Types of Help Offered by Their Employer in the Last 12 Months by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	15.6	18.3	15.0	8.9	1.6*	–	25.5*
95% CI(-)	2.0	2.8	3.5	4.6	1.4	–	17.7
95% CI(+)	2.0	2.8	3.5	4.6	9.4	–	17.7
N	99,268	52,579	32,872	8,757	157	–	2,793
\$50,000+	31.1	32.1	29.4	31.2	27.2*	25.6	26.5
95% CI(±)	1.6	1.8	3.9	9.7	16.4	9.7	14.0
N	467,403	317,362	106,560	18,802	4,101	13,461	7,117

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.12.2. Employed Adults Aware of Any Stop Smoking Program or Other Types of Help Offered by Their Employer in the Last 12 Months by Race/Ethnicity and Income



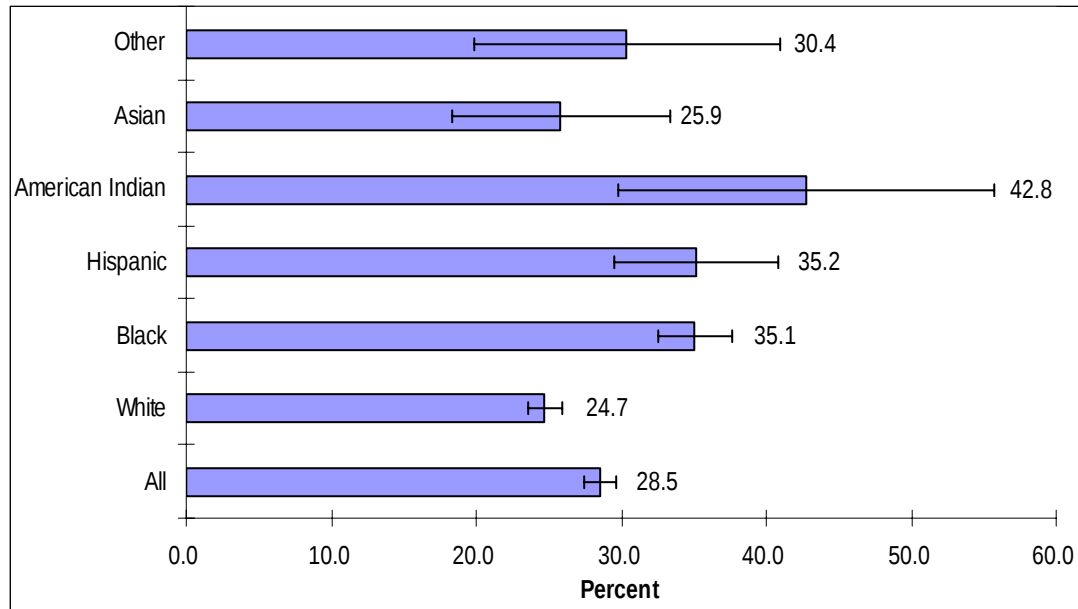
3.13. Exposure to “1-800-QUIT-NOW” Smoking Cessation Radio Commercials in the Past 30 Days Among Adults in Maryland by Race/Ethnicity

In 2006, 28.5% of Maryland were exposed to “1-800-QUIT-NOW” smoking cessation radio commercials in the past 30 days with American Indians (42.8%), Hispanics (35.2%) and Blacks (35.1%) reporting statistically significant higher exposure than Whites (24.7%).

Table 3.13. Exposure to “1-800-QUIT-NOW” Smoking Cessation Radio Commercials in the Past 30 Days Among Adults in Maryland by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	28.5	24.7	35.1	35.2	42.8	25.9	30.4
95% CI(±)	1.1	1.2	2.6	5.7	13.0	7.5	10.5
N	861,116	455,925	282,743	72,657	13,215	21,229	15,349

Figure 3.13. Exposure to “1-800-QUIT-NOW” Smoking Cessation Radio Commercials in the Past 30 Days Among Adults in Maryland by Race/Ethnicity



3.13.1. Exposure to “1-800-QUIT-NOW” Smoking Cessation Radio Commercials in the Past 30 Days Among Adults in Maryland by Race/Ethnicity and Educational Attainment

In general, Maryland adults with less education were more likely to report having been exposed to 1-800-QUIT-NOW smoking cessation radio commercials in the past month.

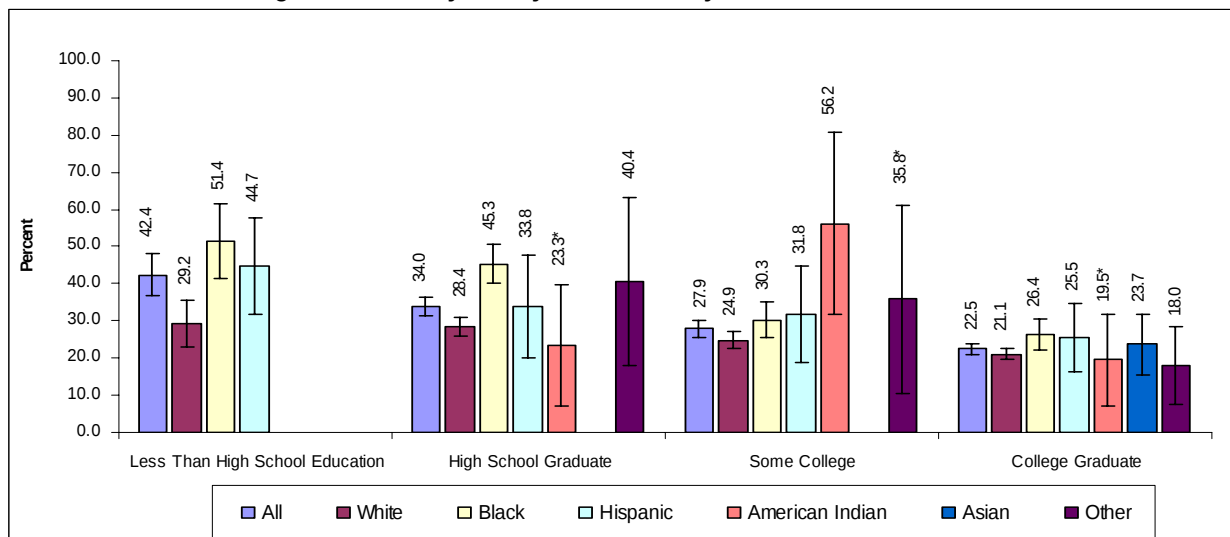
Table 3.13.1. Exposure to “1-800-QUIT-NOW” Smoking Cessation Radio Commercials in the Past 30 Days Among Adults in Maryland by Race/Ethnicity and Educational Attainment

	All	White	Black	Hispanic	American Indian	Asian	Other
Not High School Graduate	42.4	29.2	51.4	44.7	–	–	–
95% CI(±)	5.6	6.4	10.0	13.1	–	–	–
N	68,764	17,309	29,099	18,372	–	–	–
High School Graduate	34.0	28.4	45.3	33.8	23.3*	–	40.4
95% CI(±)	2.4	2.5	5.2	13.8	16.2	–	22.5
N	195,956	97,872	82,113	9,949	1,437	–	2,864
Some College	27.9	24.9	30.3	31.8	56.2	–	35.8*
95% CI(±)	2.4	2.5	5.0	13.0	24.5	–	25.3
N	161,568	84,831	54,789	11,906	3,704	–	3,098
College Graduate	22.5	21.1	26.4	25.5	19.5*	23.7	18.0
95% CI(±)	1.5	1.5	4.1	9.1	12.5	8.3	10.5
N	291,484	184,881	71,515	15,217	1,724	14,108	4,040

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 3.13.1. Exposure to “1-800-QUIT-NOW” Smoking Cessation Radio Commercials in the Past 30 Days Among Adults in Maryland by Race/Ethnicity and Educational Attainment



3.13.2. Exposure to “1-800-QUIT-NOW” Smoking Cessation Radio Commercials in the Past 30 Days Among Adults in Maryland by Race/Ethnicity and Income

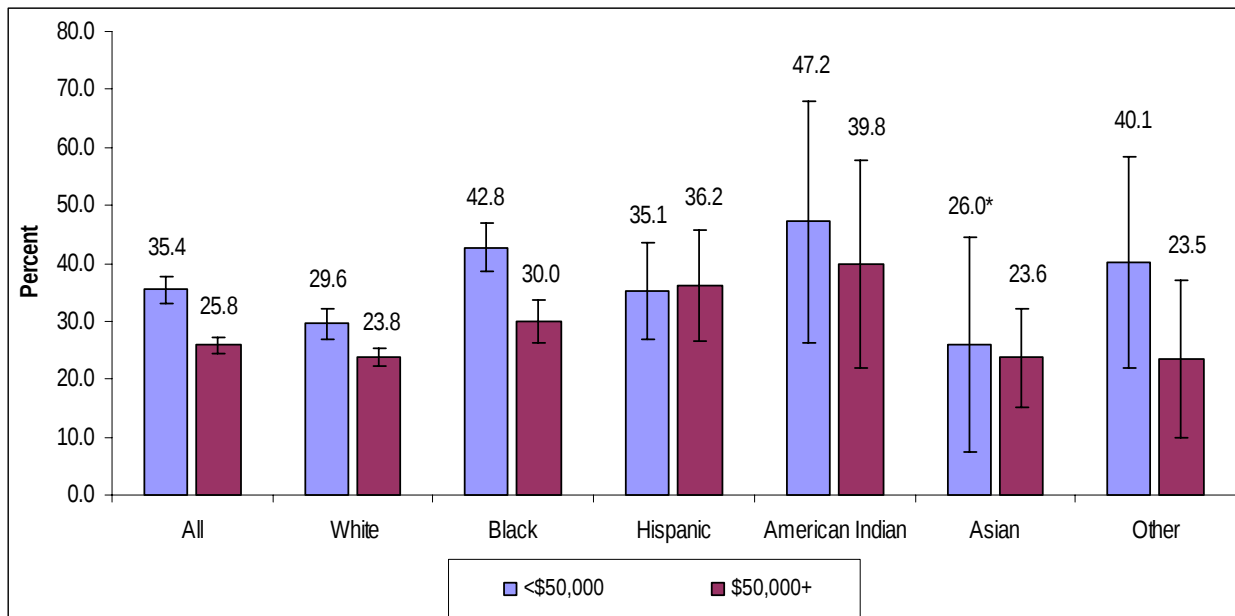
In general, Maryland adults with lower incomes (<\$50,000 per year) were more likely to have been exposed to 1-800-QUIT-NOW smoking cessation radio commercials in the past month than those with higher incomes. Among people earning less than \$50,000, Blacks (42.8%) were significantly more likely than Whites (29.6%) to have been exposed to these messages.

Table 3.13.2. Exposure to “1-800-QUIT-NOW” Smoking Cessation Radio Commercials in the Past 30 Days Among Adults in Maryland by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian	Asian	Other
<\$50,000	35.4	29.6	42.8	35.1	47.2	26.0*	40.1
95% CI(±)	2.3	2.7	4.2	8.3	20.9	18.6	18.3
N	424,430	125,579	138,193	36,457	6,197	3,444	6,455
\$50,000+	25.8	23.8	30.0	36.2	39.8	23.6	23.5
95% CI(±)	1.4	1.5	3.6	9.6	18.0	8.4	13.5
N	445,914	274,790	118,875	25,126	6,009	14,220	6,894

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 3.13.2. Exposure to “1-800-QUIT-NOW” Smoking Cessation Radio Commercials in the Past 30 Days Among Adults in Maryland by Race/Ethnicity and Income



3.14. Summary of Knowledge Questions.

White Maryland adults (16.5%) were the most likely, and Hispanics (49.9%) were the least knowledgeable, to know the health benefits for heavy smokers who quit smoking. Knowledge of the health benefits for heavy smokers who quit smoking was greater with increased education and increased income, regardless of race or ethnicity.

Fifteen percent (15.3%) of Maryland adults (general population) believed that light cigarettes are safer than regular cigarettes, ranging from 14.8% for Hispanics and Blacks to 19.5% for Asians.

The vast majority (96%) of Maryland adults were aware of the risks of smoking during pregnancy, ranging from 90.4% of American Indians to 96.8% of Whites. Knowledge of the health effects of smoking during pregnancy was greater with increased education, regardless of race or ethnicity. However, knowledge of the health effects of smoking during pregnancy was lower for Maryland adults with an annual income less than \$50,000 per year.

The vast majority of Maryland adults (94.3%) were knowledgeable that smoking is physically addictive. Blacks (92.7%) and Hispanics (88.1%) were less likely than Whites (95.8%) to know that smoking is physically addictive. In general, Maryland adults with the least education were the least likely to know that smoking was physically addictive.

Ninety-three percent (92.9%) of Maryland adults knew that secondhand smoking causes lung cancer.

Ninety-seven percent (96.9%) of Maryland adults knew that secondhand smoking causes respiratory problems in children, with little variation by race/ethnicity ranging from 96.4% to 99.8%. However, Asians (99.8%) were significantly more knowledgeable than Whites (96.5%), American Indians (96.4%), Hispanics (97.5%) and Blacks (97.2%).

Eighty-eight percent (88.1%) of respondents knew secondhand smoking causes heart disease. Hispanics and persons of Other race/ethnicity were more likely than Whites to know that secondhand smoking causes heart disease in adults.

Six out of ten (58.8%) Maryland adults knew that secondhand smoking causes colon cancer. Hispanics, Asians, Blacks and American Indians were more likely than Whites to know that secondhand smoking causes colon cancer. Blacks and Hispanics with less education were more likely than their counterparts to know that secondhand smoking causes colon cancer.

Sixty-five percent (64.7%) of Maryland adults knew that secondhand smoking causes Sudden Infant Death Syndrome (SIDS). Blacks (69.1%) and Hispanics (84.4%) were more likely than Whites (59.6%) to know that secondhand smoking causes SIDS. Adults with less education and with income less than \$50,000 were more knowledgeable that secondhand smoking causes SIDS.

The vast majority of all employed adults (84.9%) reported that their workplaces do not allow smoking anywhere, ranging from 75.6% for Hispanics to 90.8% for persons of Other race/ethnicity. Hispanics were significantly less likely than Whites to report having a smoking ban in the workplace (75.6% vs. 86.9%).

Although 79.1% of employed adults earning less than \$50,000 and 87.4% of employed adults earning at least \$50,000 work for employers who have banned smoking in the workplace, only 26.2% of employed adults were aware of any workplace stop smoking program or other types of help offered by their employer during the past 12 months. The percent of employed adults who were aware of any stop smoking programs or other types of help offered by their employer was higher with increased education and almost twice as high for those with an annual income of at least \$50,000.

In 2006, 28.5% of Maryland were exposed to “1-800-QUIT-NOW” smoking cessation radio commercials in the past 30 days with American Indians (42.8%), Hispanics (35.2%) and Blacks (35.1%) reporting statistically significant higher exposure than Whites (24.7%). In general, Maryland adults with less education and lower incomes (<\$50,000 per year) were more likely to report having been exposed to 1-800-QUIT-NOW smoking cessation radio commercials in the past month.



CHAPTER 4

Tobacco Cessation

4 Tobacco Cessation

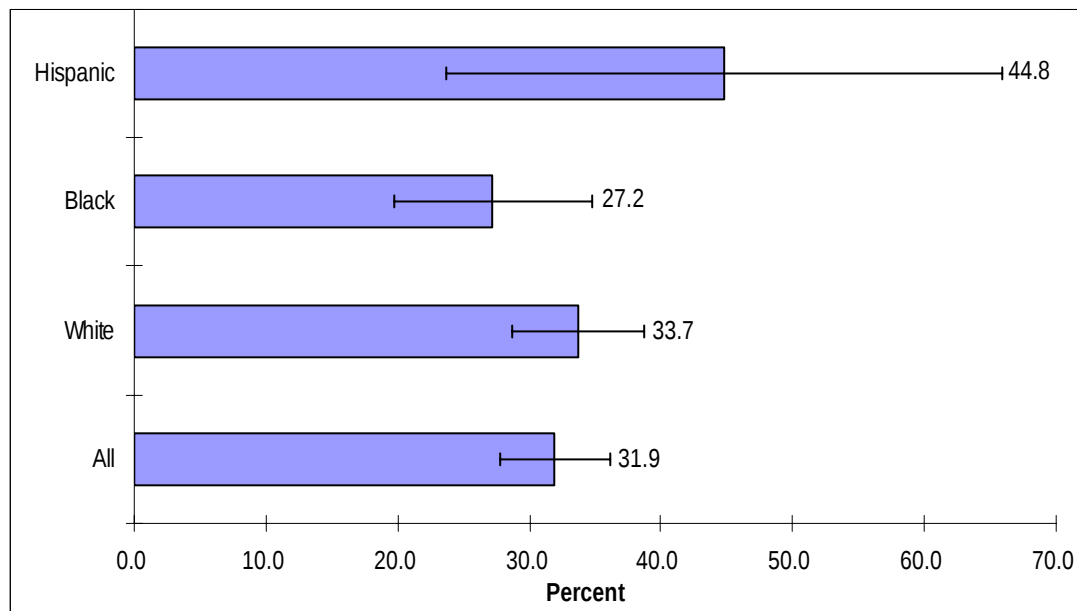
4.1. Among Adults who Tried to Stop Smoking in the Preceding Year, The Success Rate of Adults in Stopping Smoking by Race/Ethnicity

Among adults who were trying to quit smoking in the past year, 33.7% of Whites, 27.2% of Blacks, and 44.8% of Hispanics were successful in quitting smoking. These findings are similar to those from the 2006 Behavioral Risk Factor Surveillance System (BRFSS) which found an average 34.0% success rate for 18-35 year olds nationwide (CDC 2007). Although not shown there was little difference between men and women, who were trying to quit smoking in the past year, in whether they were successful in stopping smoking.

Table 4.1. Among Adults who Tried to Stop Smoking in the Preceding Year, The Success Rate of Adults in Stopping Smoking by Race/Ethnicity

	All	White	Black	Hispanic
Percent	31.9	33.7	27.2	44.8
95% CI(±)	4.1	5.0	7.5	21.1
N	87,763	54,262	23,732	6,888

Figure 4.1. Among Adults who Tried to Stop Smoking in the Preceding Year, The Success Rate of Adults in Stopping Smoking by Race/Ethnicity



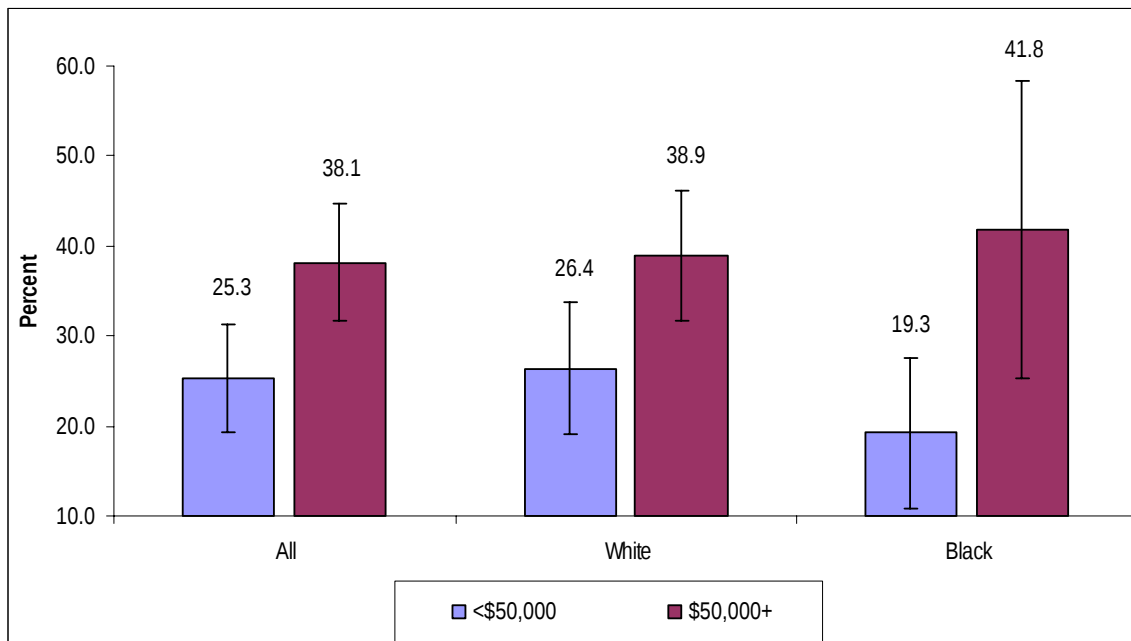
4.1.1. Among Adults who Tried to Stop Smoking in the Preceding Year, The Success Rate of Adults in Stopping Smoking by Race/Ethnicity and Income

The success of adults who were trying to quit smoking in the past year was lower for those with an annual income less than \$50,000 than those with an income of at least \$50,000.

Table 4.1.1. Among Adults who Tried to Stop Smoking in the Preceding Year, The Success Rate of Adults in Stopping Smoking by Race/Ethnicity and Income

	All	White	Black
<\$50,000	25.3	26.4	19.3
95% CI(±)	5.9	7.3	8.4
N	29,810	14,396	9,147
\$50,000+	38.1	38.9	41.8
95% CI(±)	6.5	7.2	16.5
N	46,308	33,731	11,263

Figure 4.1.1. Among Adults who Tried to Stop Smoking in the Preceding Year, The Success Rate of Adults in Stopping Smoking by Race/Ethnicity and Income



4.2. Number of Times That Current and Former Adult Smokers Tried to Quit Smoking in Their Whole Life by Race/Ethnicity

The average number of times that current adult smokers tried to quit smoking in their whole life was 5.6. The average number of quit attempts of former smokers who successfully quit smoking in the past year was 6.6.

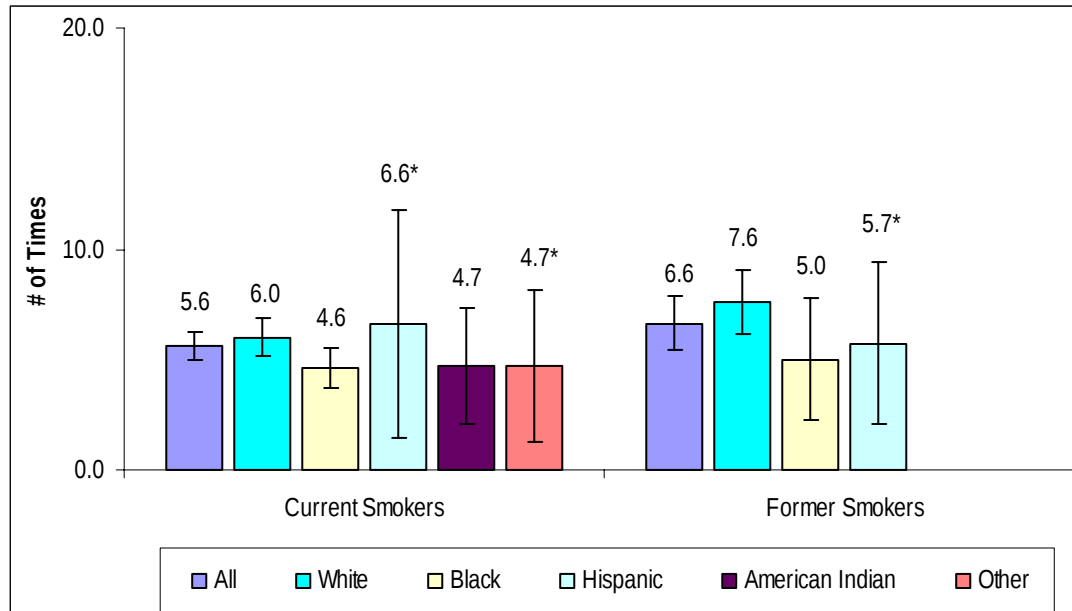
Table 4.2. Number of Times That Current and Former Adult Smokers Tried to Quit Smoking in Their Whole Life by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Current Smokers	5.6	6.0	4.6	6.6*	4.7	–	4.7*
95% CI(±)	0.7	0.9	0.9	5.2	2.6	–	3.5
N	533,290	336,658	139,761	23,200	7,895	–	11,134
Former Smokers	6.6	7.6	5.0	5.7*	–	–	–
95% CI(±)	1.2	1.5	2.7	3.7	–	–	–
N	196,675	124,669	45,034	18,143	–	–	–

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 4.2. Number of Times That Current and Former Adult Smokers Tried to Quit Smoking in Their Whole Life by Race/Ethnicity



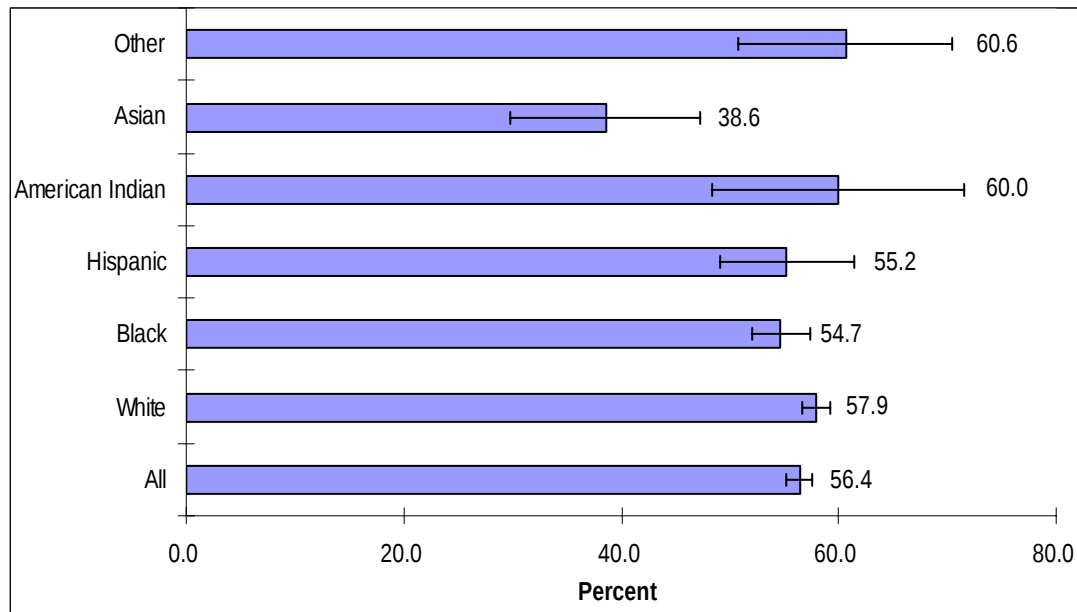
4.3. Adults in Maryland Who Have Been to the Doctor During the Past Year Reporting That Any Doctor, Nurse, or Other Health Professional Asked If They Smoke or Use Smokeless Tobacco During the Past 12 Months by Race/Ethnicity

Among Maryland adults who have been to the doctor in the past year, slightly more than half (56.4%) were asked by a doctor, nurse, or other health professional whether they smoke or use tobacco products, ranging from 38.6% of Asians to 60.6% for residents from Other racial/ethnic groups. Asians who had been to the doctor in the past year were the least likely to have been asked by a doctor, nurse or other health professional if they smoke or use smokeless tobacco. Although not shown, there was little difference between men and women regarding whether any doctor, nurse, or other health professional asked if they smoke or use smokeless tobacco during the past 12 months.

Table 4.3. Adults in Maryland Who Have Been to the Doctor During the Past Year Reporting That Any Doctor, Nurse, or Other Health Professional Asked If They Smoke or Use Smokeless Tobacco During the Past 12 Months by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	56.4	57.9	54.7	55.2	60.0	38.6	60.6
95% CI(±)	1.2	1.3	2.6	6.2	11.6	8.7	9.9
N	1,863,320	1,187,535	483,159	102,467	20,423	33,873	35,863

Figure 4.3. Adults in Maryland Who Have Been to the Doctor During the Past Year Reporting That Any Doctor, Nurse, or Other Health Professional Asked If They Smoke or Use Smokeless Tobacco During the Past 12 Months by Race/Ethnicity



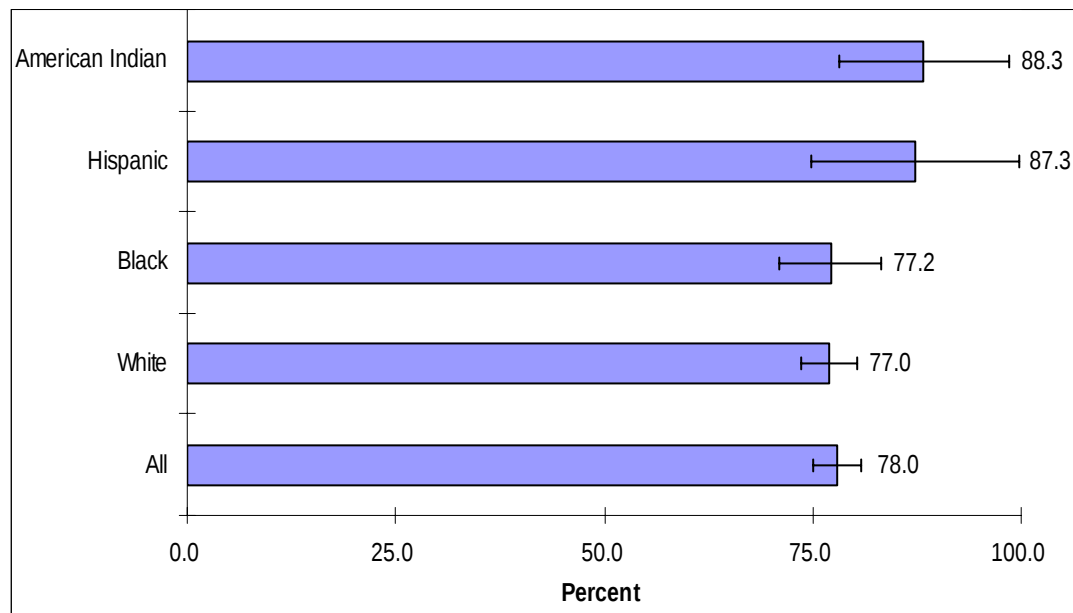
4.4. Current Adult Smokers in Maryland Reporting Have Been Advised During the Past 12 Months to Quit Smoking by a Doctor, Nurse, or Other Health Professional by Race/Ethnicity

Seventy-eight percent (78%) of current adult smokers, *who had been asked if they smoked* by a doctor, nurse, or other health professional during the past 12 months, also reported having been advised to quit smoking ranging from 88.3% among American Indian current smokers to 77.0% of White current smokers. Although not shown, there was little difference between current smoking men and women regarding whether they had been advised during the past year to quit smoking by a doctor, nurse, or other health professional.

Table 4.4. Current Adult Smokers in Maryland Reporting Have Been Advised During the Past 12 Months to Quit Smoking by a Doctor, Nurse, or Other Health Professional by Race/Ethnicity

	All	White	Black	Hispanic	American Indian
Percent	78.0	77.0	77.2	87.3	88.3
95% CI(±)	2.8	3.4	6.1	12.4	10.2
N	331,625	212,372	88,140	13,981	6,025

Figure 4.4. Current Adult Smokers in Maryland Reporting Have Been Advised During the Past 12 Months to Quit Smoking by a Doctor, Nurse, or Other Health Professional by Race/Ethnicity



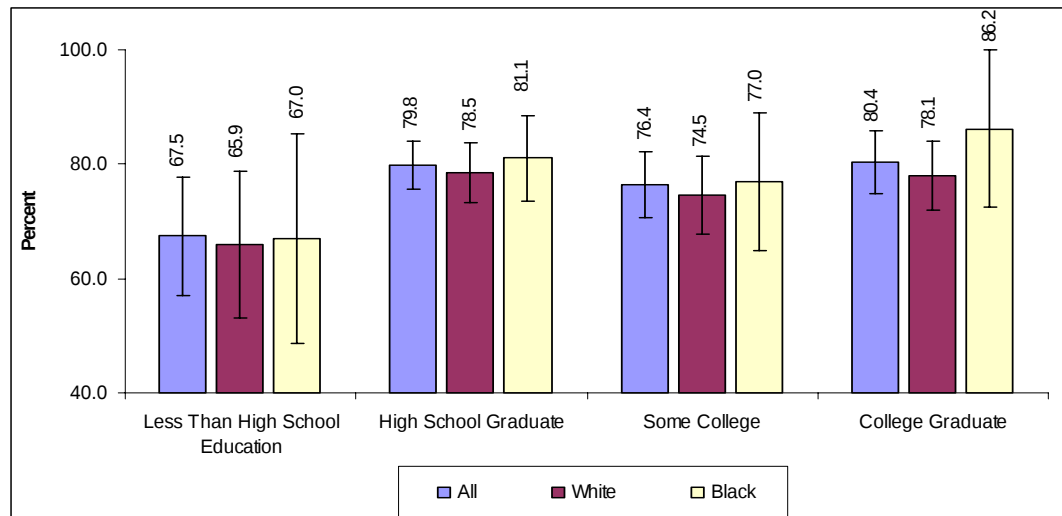
4.4.1. Current Adult Smokers in Maryland Reporting Have Been Advised During the Past 12 Months to Quit Smoking by a Doctor, Nurse, or Other Health Professional by Race/Ethnicity and Educational Attainment

Although not statistically significant, current smokers with less than a high school education, *who had been asked if they smoked* by a doctor, nurse, or other health professional during the past 12 months, were the least likely to have been advised during the past year to quit smoking by a doctor, nurse, or other health professional.

Table 4.4.1. Current Adult Smokers in Maryland Reporting Have Been Advised During the Past 12 Months to Quit Smoking by a Doctor, Nurse, or Other Health Professional by Race/Ethnicity and Educational Attainment

	All	White	Black
Not High School Graduate	67.5	65.9	67.0
95% CI(±)	10.4	12.8	18.3
N	31,813	16,912	12,914
High School Graduate	79.8	78.5	81.1
95% CI(±)	4.1	5.2	7.4
N	105,148	68,112	29,553
Some College	76.4	74.5	77.0
95% CI(±)	5.8	6.8	12.1
N	72,086	44,514	21,798
College Graduate	80.4	78.1	86.2
95% CI(±)	5.5	6.0	13.7
N	64,731	41,976	15,863

Figure 4.4.1. Current Adult Smokers in Maryland Reporting Have Been Advised During the Past 12 Months to Quit Smoking by a Doctor, Nurse, or Other Health Professional by Race/Ethnicity and Educational Attainment



4.5. Adults in Maryland Who Received Advice to Quit Using Tobacco or Smokeless Tobacco From a Health Professional Reporting That the Health Provider Also Recommended a Product, Program or Prescription for a Medication to Help Them Quit by Race/Ethnicity

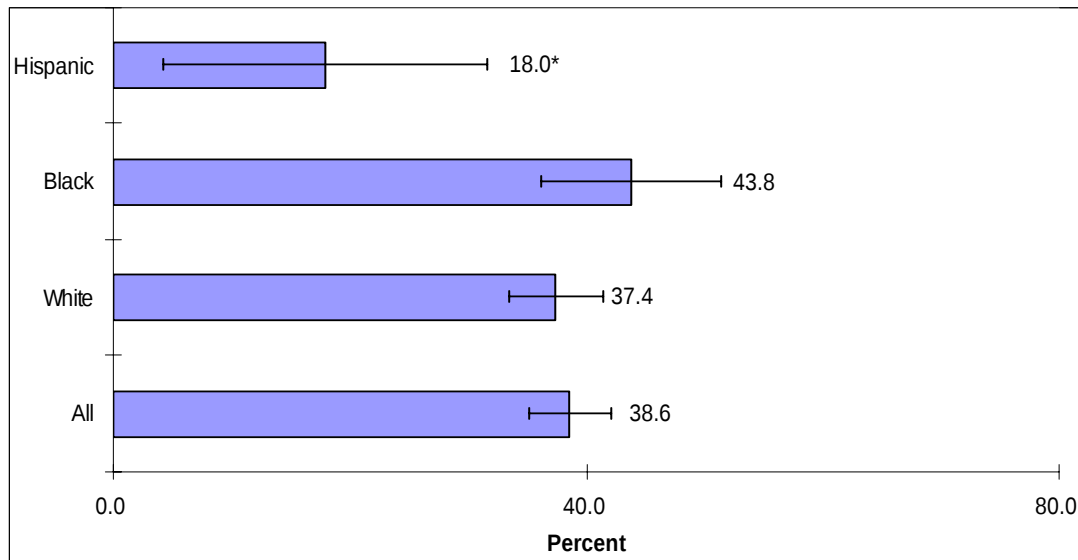
Of current smokers who received advice to quit smoking from a health professional in the past year, only 38.6% received a recommendation for a product, program or prescription for a medication to help them quit using tobacco. Although not shown, there was little difference between men and women regarding whether a health professional recommended a product, program or prescription for a medication to help them quit.

Table 4.5. Adults in Maryland Who Received Advice to Quit Using Tobacco or Smokeless Tobacco From a Health Professional Reporting That the Health Provider Also Recommended a Product, Program or Prescription for a Medication to Help Them Quit by Race/Ethnicity

	All	White	Black	Hispanic
Percent	38.6	37.4	43.8	18.0*
95% CI(±)	3.5	4.0	7.7	13.7
N	139,278	88,257	39,786	2,988

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 4.5. Adults in Maryland Who Received Advice to Quit Using Tobacco or Smokeless Tobacco From a Health Professional Reporting That the Health Provider Also Recommended a Product, Program or Prescription for a Medication to Help Them Quit by Race/Ethnicity



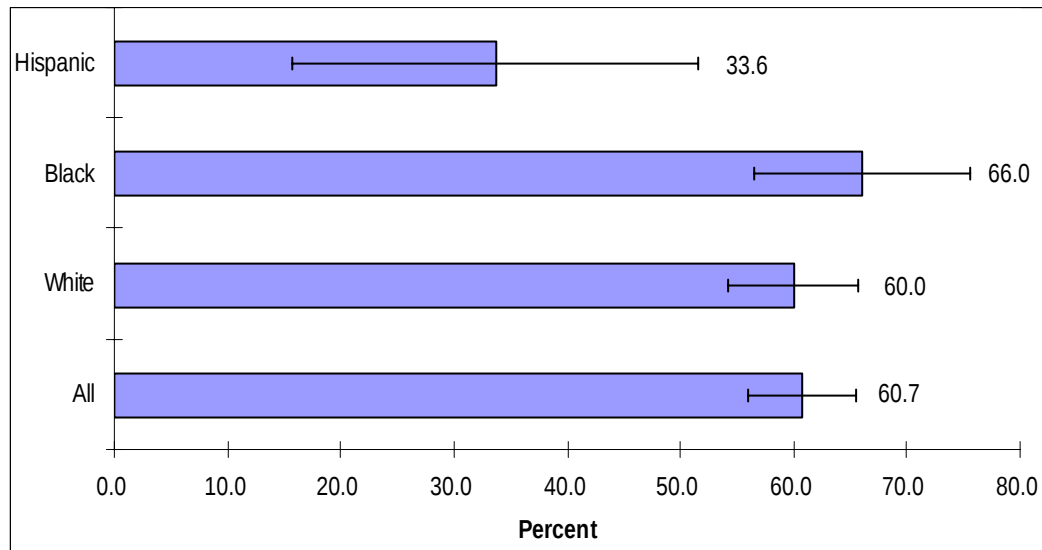
4.6. Current Adult Consumers of Tobacco and Smokeless Tobacco Products Reporting Having Been Advised by Their Children to Quit Using Tobacco Products by Race/Ethnicity

Six out of ten (60.7%) current consumers of tobacco and smokeless tobacco products reported having been advised by their children to quit. Hispanics (33.6%) were less likely to report than Blacks (66.0%) and Whites (60.0%) that they had been advised by their children to quit using tobacco products.

Table 4.6. Current Adult Consumers of Tobacco and Smokeless Tobacco Products Reporting Having Been Advised by Their Children to Quit Using Tobacco Products by Race/Ethnicity

	All	White	Black	Hispanic
Percent	60.7	60.0	66.0	33.6
95% CI(±)	4.8	5.7	9.5	18.0
N	130,724	78,876	43,488	3,869

Figure 4.6. Current Adult Consumers of Tobacco and Smokeless Tobacco Products Reporting Having Been Advised by Their Children to Quit Using Tobacco Products by Race/Ethnicity



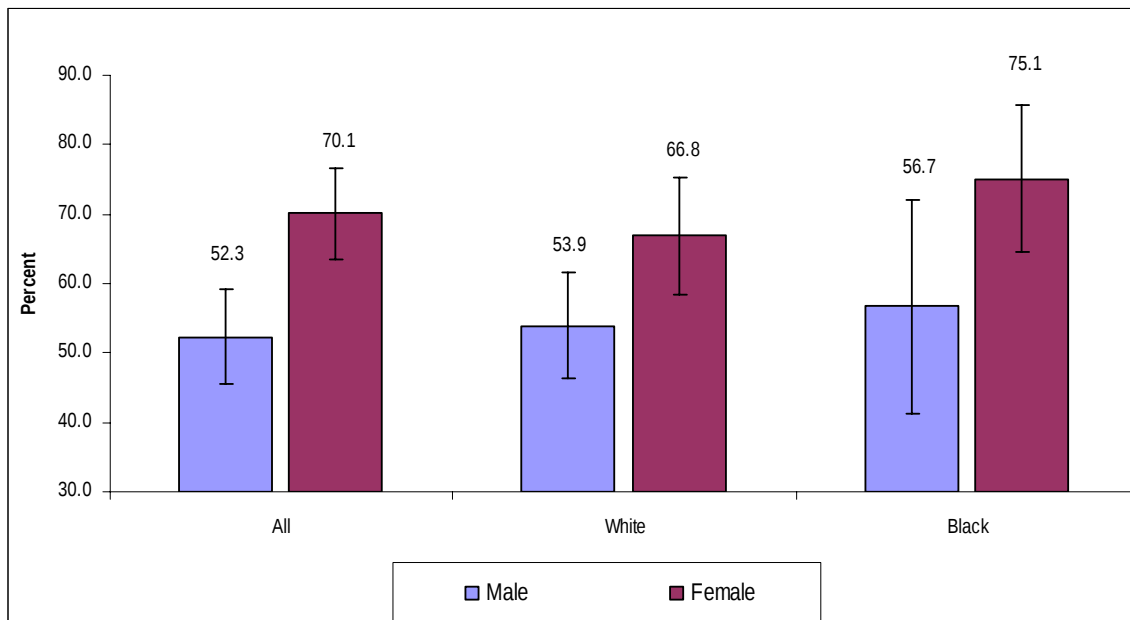
4.6.1. Current Adult Consumers of Tobacco and Smokeless Tobacco Products Reporting Having Been Advised by Their Children to Quit Using Tobacco Products by Race/Ethnicity and Gender

Male current tobacco users were less likely to have been advised by their children to quit using tobacco products than female current tobacco users.

Table 4.6.1. Current Adult Consumers of Tobacco and Smokeless Tobacco Products Reporting Having Been Advised by Their Children to Quit Using Tobacco Products by Race/Ethnicity and Gender

	All	White	Black
Male	52.3	53.9	56.7
95% CI(±)	6.8	7.6	15.4
N	59,172	37,193	18,462
Female	70.1	66.8	75.1
95% CI(±)	6.5	8.5	10.6
N	71,552	41,683	25,027

Figure 4.6.1. Current Adult Consumers of Tobacco and Smokeless Tobacco Products Reporting Having Been Advised by Their Children to Quit Using Tobacco Products by Race/Ethnicity and Gender



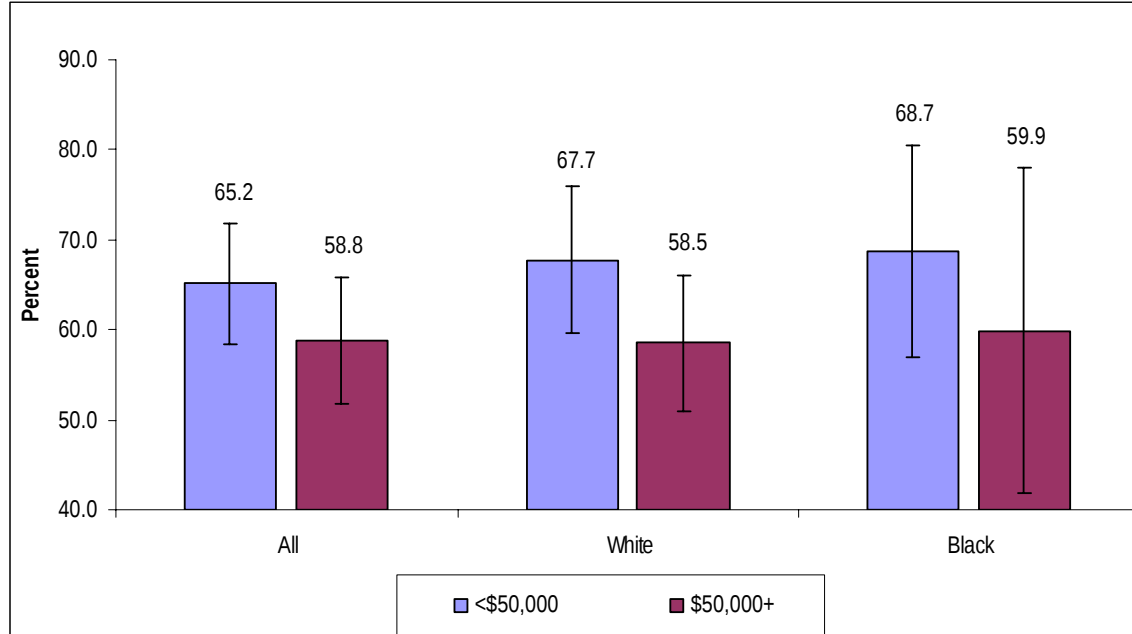
4.6.2. Current Adult Consumers of Tobacco and Smokeless Tobacco Products Reporting Having Been Advised by Their Children to Quit Using Tobacco Products by Race/Ethnicity and Income

Although not statistically significant, among current adult consumers of tobacco and smokeless tobacco products, those with annual incomes of less than \$50,000 were more likely to have been advised by their children to quit using tobacco products.

Table 4.6.2. Current Adult Consumers of Tobacco and Smokeless Tobacco Products Reporting Having Been Advised by Their Children to Quit Using Tobacco Products by Race/Ethnicity and Income

	All	White	Black
<\$50,000	65.2	67.7	68.7
95% CI(±)	6.7	8.2	11.8
N	62,558	31,718	26,017
\$50,000+	58.8	58.5	59.9
95% CI(±)	6.9	7.5	18.0
N	57,178	40,879	13,355

Figure 4.6.2. Current Adult Consumers of Tobacco and Smokeless Tobacco Products Reporting Having Been Advised by Their Children to Quit Using Tobacco Products by Race/Ethnicity and Income



4.7. How Soon After Wake Up Is the First Cigarette Smoked by Race/Ethnicity

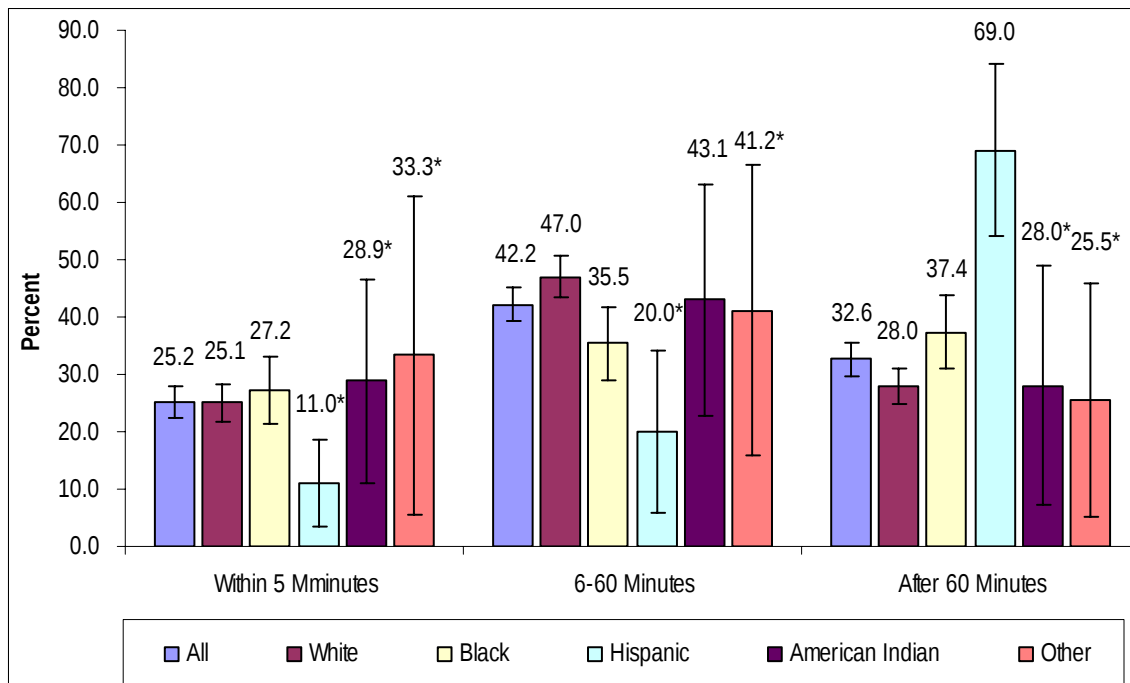
Smokers who have their first cigarette within 5 minutes of waking up are considered to be highly addicted to nicotine. One out of four current smokers (25.2%) was highly addicted to nicotine. Hispanics were twice as likely to have their first cigarette one hour after waking in the morning compared to other racial/ethnic groups which suggests that Hispanic smokers are less dependent on cigarettes than other ethnic group smokers.

Table 4.7. How Soon After Wake Up Is the First Cigarette Smoked by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Other
Within 5 Minutes	25.2	25.1	27.2	11.0*	28.9*	33.3*
95% CI(±)	2.8	3.3	5.9	7.7	17.8	27.8
N	134,242	84,294	40,181	2,795	2,241	3,705
6-60 Minutes	42.2	47.0	35.5	20.0*	43.1	41.2*
95% CI(±)	3.1	3.6	6.3	14.2	20.1	25.4
N	224,988	157,978	52,411	5,048	3,334	4,586
After 60 Minutes	32.6	28.0	37.4	69.0	28.0*	25.5*
95% CI(±)	2.9	3.2	6.3	15.0	20.9	20.5
N	173,782	94,009	55,233	17,461	2,168	2,843

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 4.7. How Soon After Wake Up Is the First Cigarette Smoked by Race/Ethnicity



4.8. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity

Nearly thirteen percent of smokers in the past year had stopped smoking with no significant difference between Whites (13.0%) and Blacks(12.4%).

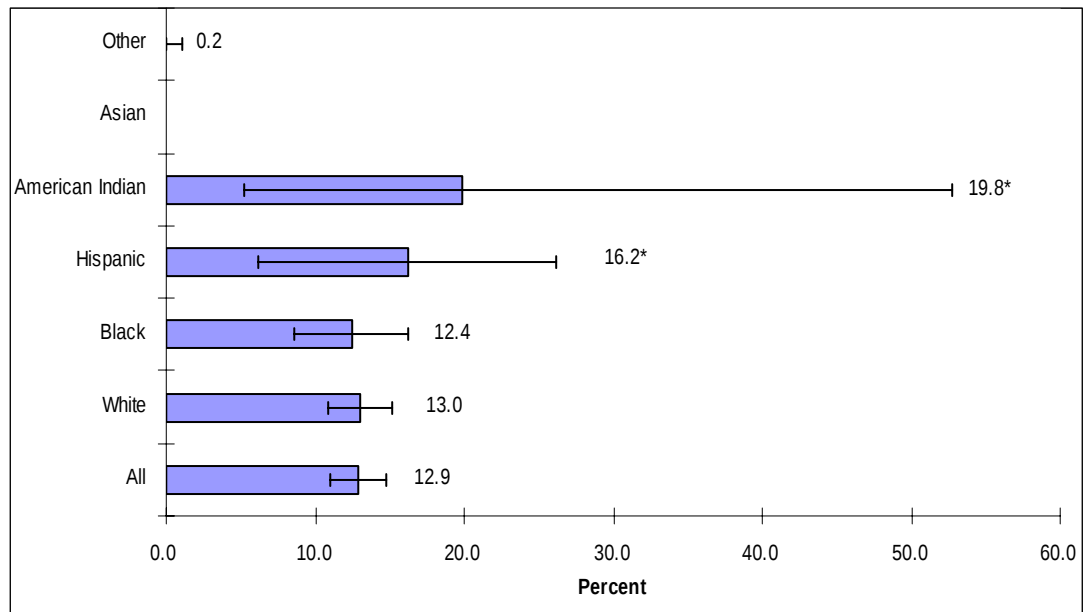
Table 4.8. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity

	All	White	Black	Hispanic	American Indian	Asian	Other
Percent	12.9	13.0	12.4	16.2*	19.8*	--	0.2*
95% CI(-)	1.9	2.2	3.8	10.0	14.6	--	0.1
95% CI(+)	1.9	2.2	3.8	10.0	33.0	--	1.0
N	87,763	54,262	23,732	6,888	2,480	--	18

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 4.8. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity



4.8.1. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Gender

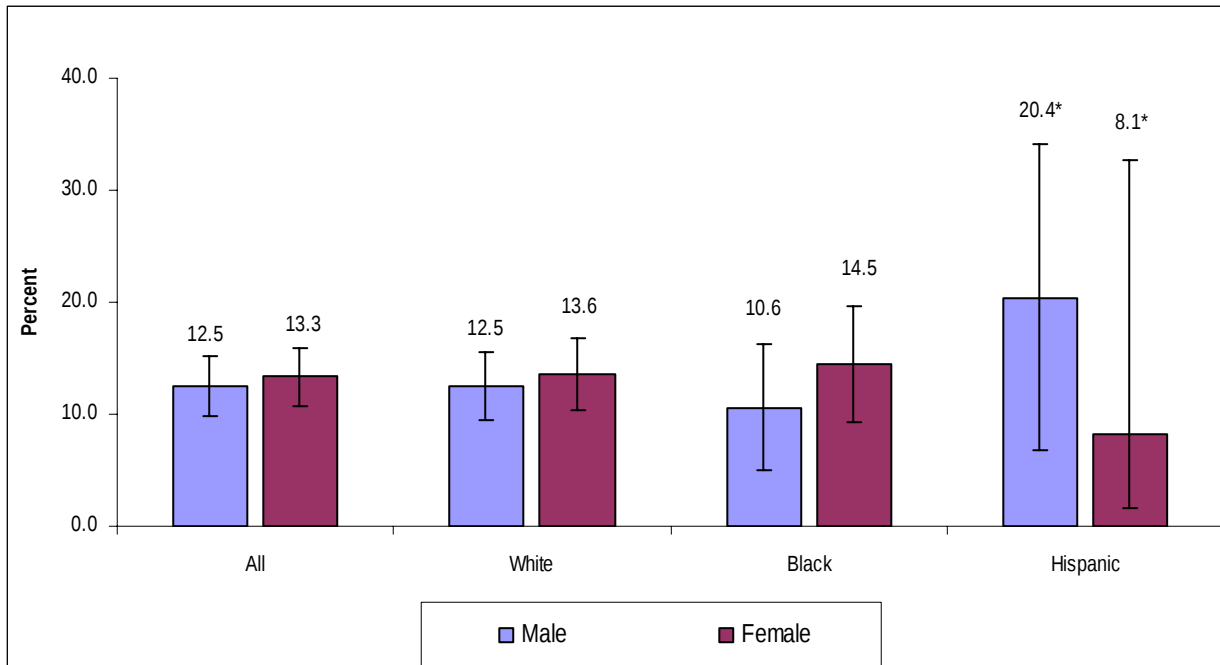
Men and women were similar in their rates of being successful in stopping smoking in the past year, regardless of race or ethnicity.

Table 4.8.1. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Gender

	All	White	Black	Hispanic
Male	12.5	12.5	10.6	20.4*
95% CI(±)	2.7	3.0	5.6	13.6
N	45,874	27,751	10,591	5,699
Female	13.3	13.6	14.5	8.1*
95% CI(-)	2.6	3.1	5.1	6.5
95% CI(+)	2.6	3.1	5.1	24.6
N	41,889	26,511	13,141	1,189

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 4.8.1. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Gender



4.8.2. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Educational Attainment

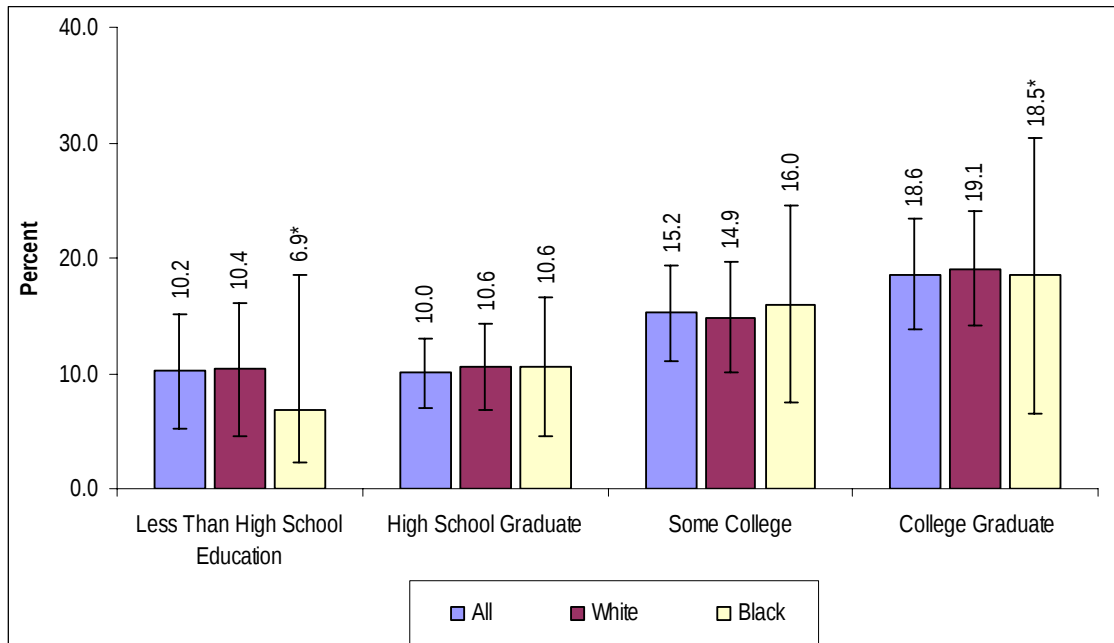
Although not statistically significant, Maryland adults with a college education were the most likely to stop smoking in the past year.

Table 4.8.2. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Educational Attainment

	All	White	Black
Not High School Graduate	10.2	10.4	6.9*
95% CI(-)	5.0	5.7	4.6
95% CI(+)	5.0	5.7	11.7
N	7,286	3,562	1,996
High School Graduate	10.0	10.6	10.6
95% CI(±)	3.0	3.8	6.0
N	19,592	13,183	6,171
Some College	15.2	14.9	16.0
95% CI(±)	4.2	4.8	8.6
N	20,872	12,503	6,870
College Graduate	18.6	19.1	18.5*
95% CI(±)	4.8	4.9	12.0
N	24,283	16,332	5,210

* The relative standard error (RSE) associated with the estimate is greater than 30%.

Figure 4.8.2. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Educational Attainment



4.8.3. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Income

Maryland general population and White adults with an annual income of less than \$50,000 were less likely to stop smoking than those with higher incomes.

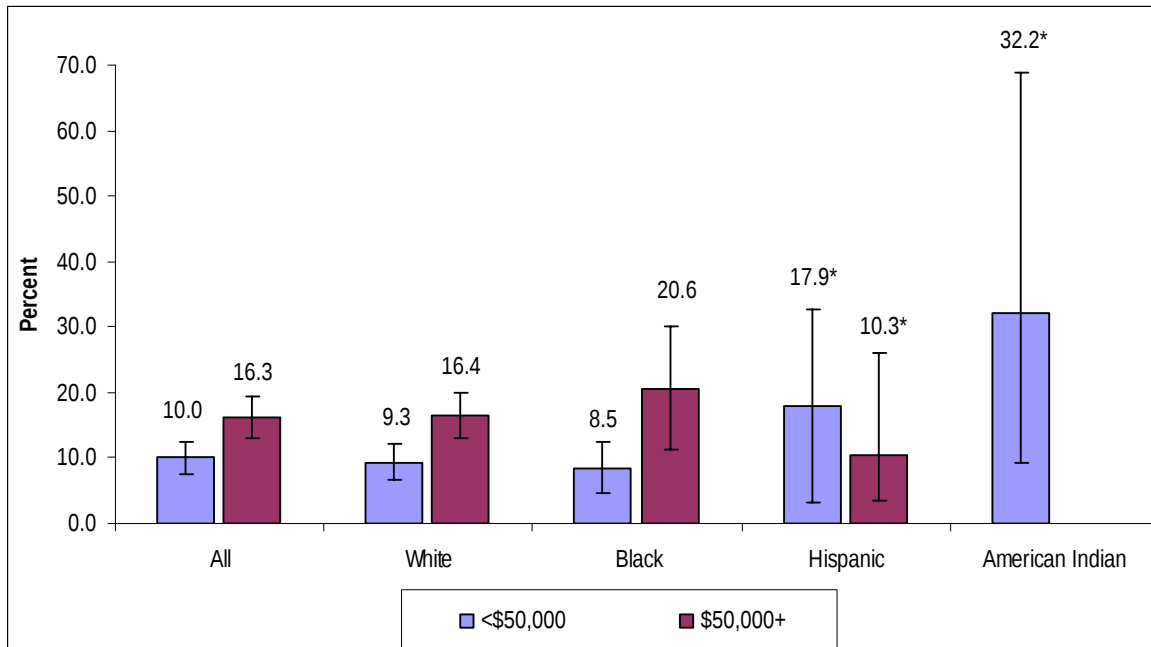
Table 4.8.3. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Income

	All	White	Black	Hispanic	American Indian
<\$50,000	10.0	9.3	8.5	17.9*	32.2*
95% CI(-)	2.5	2.8	4.0	14.8	22.9
95% CI(+)	2.5	2.8	4.0	14.8	36.5
N	29,810	14,396	9,147	3,680	2,480
\$50,000+	16.3	16.4	20.6	10.3*	–
95% CI(-)	3.2	3.5	9.4	6.7	–
95% CI(+)	3.2	3.5	9.4	15.8	–
N	46,308	33,731	11,263	1,021	–

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 4.8.3. Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Income



4.8.4 Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Region

Although not statistically significant, Southern Maryland had the highest percent of smokers in the past year who had stopped smoking (16.4%), while the Lower Eastern Shore had the lowest (9.7%).

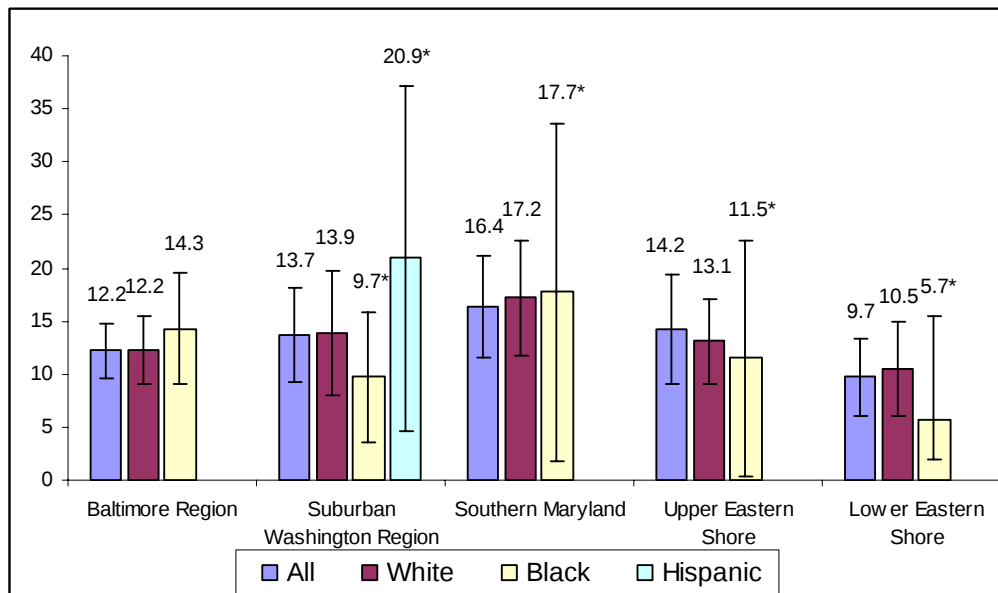
Table 4.8.4 Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Region

	All	White	Black	Hispanic
Baltimore Region	12.2	12.2	14.3	–
95% CI(±)	2.6	3.2	5.3	–
N	44,739	27,575	16,034	–
Suburban Washington Region	13.7	13.9	9.7*	20.9*
95% CI(±)	4.5	5.9	6.1	16.2
N	23,303	10,175	6,358	4,788
Southern Maryland	16.4	17.2	17.7*	–
95% CI(±)	4.8	5.4	15.9	–
N	7,007	5,989	624	–
Upper Eastern Shore	14.2	13.1	11.5*	–
95% CI(±)	5.2	4.0	11.1	–
N	5,364	4,003	373	–
Lower Eastern Shore	9.7	10.5	5.7*	–
95% CI(-)	3.7	4.5	3.8	–
95% CI(+)	3.7	4.5	9.8	–
N	2,931	2,347	273	–

* The relative standard error (RSE) associated with the estimate is greater than 30%.

– Estimate based on sample size (unweighted n) less than 30 was deemed unreliable and thus not presented.

Figure 4.8.4 Adults in Maryland Who Have Stopped Smoking in the Past Year by Race/Ethnicity and Region



4.9. Summary of Tobacco Cessation

Among adults who were trying to quit smoking in the past year, 33.7% of Whites, 27.2% of Blacks, and 44.8% of Hispanics were successful in quitting smoking. The success of adults who were trying to quit smoking in the past year was lower for those with an annual income less than \$50,000.

The average number of times that current adult smokers tried to quit smoking in their whole life was 5.6. The average number of quit attempts of former smokers who successfully quit smoking in the past year was 6.6.

Among Maryland adults who have been to the doctor in the past year, slightly more than half (56.4%) were asked by a doctor, nurse, or other health professional whether they smoke or use tobacco products, ranging from 38.6% for Asians to 60% for American Indians.

Seventy-eight percent (78%) of current adult smokers, who had been asked if they smoked by a doctor, nurse, or other health professional during the past 12 months, also reported having been advised to quit smoking. Of current smokers who received advice to quit smoking from a health professional in the past year, only 38.6% had received a recommendation for a product, program or prescription for a medication to help them quit using tobacco.

Six out of ten (60.7%) current consumers of tobacco and smokeless tobacco products reported having been advised by their children to quit. Hispanics (33.6%) were less likely to report than Blacks (66.0%) and Whites (60.0%) that they had been advised by their children to quit using tobacco products. Male current tobacco users were also less likely to have been advised by their children to quit using tobacco products than female current tobacco users.

Smokers who have their first cigarette within 5 minutes of waking up are considered to be highly addicted to nicotine. One out of four current smokers (25.2%) was highly addicted to nicotine. Hispanics were twice as likely to have their first cigarette one hour after waking in the morning compared to other racial/ethnic groups which suggests that Hispanic smokers were less dependent on cigarettes than other ethnic group smokers.

Nearly 13 percent of smokers in the past year had stopped smoking with no significant difference between Whites (13.0%) and Blacks (12.4%). Men and women were similar in their rates of being successful in stopping smoking in the past year, regardless of race or ethnicity. Maryland adults with an annual income of less than \$50,000 were less likely to stop smoking than those with higher incomes.

References:

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Appendix A

**Summary of Methodology
for the Maryland Adult
Tobacco Survey**

Summary of Methodology for the Maryland Adult Tobacco Survey

The purpose of the 2006 Maryland Adult Tobacco Survey (MATS) was to gather detailed data from adults regarding the prevalence of tobacco use, tobacco-related knowledge, exposure to secondhand smoke, and opinions regarding smoke-free environments, Statewide and within each of Maryland's 24 political jurisdictions (23 counties and Baltimore City). The MATS questionnaire built on a core Adult Tobacco survey (ATS) questionnaire developed collaboratively by CDC and the States collectively, to add questions of particular interest to Maryland. The MATS used Computer-Assisted Telephone Interviewing (CATI) technology, following CDC's methodology for the Adult Tobacco Survey (ATS). The MATS was administered among the residential population of adults aged 18-65. The 2006 MATS represented the second follow up on the baseline administration in 2000. A major purpose of the 2006 MATS was to describe changes in tobacco use—and in factors contributing to its use—from 2000 to the present.

Questionnaire Development

The MATS questionnaire built on a core questionnaire developed by CDC in collaboration with the states. DHMH modified the questionnaire to address issues specifically germane to Maryland to help assess awareness of various components of the Maryland tobacco control program. Local health departments made suggestions for revision of the MATS questionnaire. In addition, several contractors of the tobacco control program also offered suggestions, including the American Institutes for Research as the evaluator of the tobacco control program, Macro as the MATS contractor, and University of Maryland Baltimore County as a partner in analysis of MATS data. The MATS questionnaire covered the following topics:

- General health status
- Demographic characteristics of the respondent
- Tobacco use (all tobacco products: cigarettes, smokeless tobacco, cigars, tobacco in a pipe, bidis and kreteks)
- Age of initiation of cigarette smoking
- Exposure to secondhand smoke (community, work, home)
- Awareness of and access to cessation assistance/advice
- Smoking cessation
- Reasons for quitting/relapse
- Social context of smoking (family, friends)
- Tobacco use risk perception
- Media and advertising

The MATS questionnaire contained 186 items and was designed to be identical for all 24 of Maryland's political jurisdictions. The Computers for Marketing Corporation's (CfMC's) Computer-Assisted Telephone Interviewing (CATI) software package was used to program the MATS questionnaire for administration via CATI. The CfMC

questionnaire programming language provided call management and quota controls, inbound calling capabilities, data backup, and monitoring and incidence tracking.

Sample Design

The purpose of the MATS sampling design was to develop separate estimates for each of Maryland 24 political jurisdictions. Based on differences in the size of the adult population across jurisdictions, the sampling design had different targets for the number of completed interviews by jurisdiction. Each county was assigned a targeted number of completed interviews of 500, 750, 1000 or 1500 based on the size of the county's adult population. Counties with the largest adult populations, such as Montgomery and Prince George's, received the largest sample sizes while counties with the smallest adult populations, such as Garrett and Worcester, received the smallest sample sizes. These sample sizes are associated with error margins of +/-2.5% to +/-4.5% for a 95 percent confidence interval.

The eligible population consisted of adults (ages 18 and older) residing in telephone-equipped dwelling units. This excluded the institutionalized adult population. The MATS study provided for a proportional-to-adult population, stratified, statewide random sample of telephone-equipped Maryland households with a minimum of 21,750 interviews to be completed over the interviewing period. The sample for the MATS was generated using the contractor's in-house Genesys software. The survey's sample design specified a list-assisted, random digit dial (RDD) sample of telephone-equipped Maryland households that was stratified across 24 geographic strata representing Maryland's 24 political jurisdictions. The list-assisted RDD procedure assures that Maryland households with telephone numbers assigned since the publication of current directories, as well as those with deliberately unlisted numbers, are sampled in their correct proportions. List-assisted state RDD samples are generated by first preparing, and then maintaining, an up-to-date list of all current operating telephone exchanges (three-digit prefixes) in Maryland area codes. These telephone exchanges, when combined with all four digit numbers from 0000 to 9999, constitute the set of all possible working Maryland telephone numbers, both residential and non-residential.

This set of all possible telephone numbers is then arranged in ascending order by exchange and suffix, and divided into blocks of 100 numbers each. Cross-reference directories are utilized to determine which of these blocks contain at least one listed residential number (a.k.a. one-plus blocks). The one-plus blocks are then matched to a database of listed phone numbers to identify whether the phone number is listed or unlisted. A random sample of telephone numbers is generated from the one-plus blocks, sampling listed numbers relative to unlisted numbers at a 1.5:1 ratio. This procedure assures that all new and unlisted numbers are sampled in their correct proportions.

The generated sample was pre-screened for business numbers and configured in replicates of 50. The sample amount was based upon the efficiency of the sample frame in the 2002 MATS. A total of 290,700 telephone numbers were sampled for the 2006 MATS.

Data Collection Protocol

Data collection began September 26, 2006. The last day of calling was January 28, 2007. The sample design called for 21,750 completed interviews. In all, 21,799 interviews were collected.

Experienced, supervised personnel conducted the MATS interviews. To maximize response rates, calls were concentrated between 5 p.m. and 9 p.m. Monday through Friday and between 10 a.m. and 9 p.m. on Saturday and Sunday, EST. A portion of calls was conducted between 9 a.m. and 5 p.m. Monday through Friday, EST, in order to complete interviews with respondents who were only at home during the day.

The average interview length was 17.1 minutes. The interview length differed by smoking status. Current smokers had an average interview length of 24.5 minutes; the average interview length for former smokers was 18.2 minutes; for non-smokers, 14.9 minutes. One of the main advantages of using CfMC software was the incorporation of most data handling tasks within the interviewing process itself. The survey program automatically controlled skip and fill logic, as well as range-checking for numeric data. The programming logic directed the flow of the questionnaire and prevented an interviewer from entering data in the wrong place. On any given screen of the questionnaire, the program only accepted a predetermined range or type of response. These features of CfMC provided assurance of the validity of the data concurrent with data collection, thus reducing the amount of time required to check the validity of the data after they were collected. The CATI programming also adhered to ATS protocols, such as defined interviewing schedule, number of attempts required, callback procedures, refusal conversion processes, and documenting call history. In all areas, ATS protocols were met or exceeded.

Contacting Respondents

The following protocols were followed when contacting households and potential respondents:

Treatment of No Answers. If a call to a sampled telephone number was not answered, the number was repeatedly called at different times, during daytime and evening hours (9 a.m. to 9 p.m. Monday through Friday and 10 a.m. to 9 p.m. on Saturday and Sunday EST), on different days of the week, in a pattern designed to maximize the likelihood of contact with a minimum number of calls.

Rings Per Attempt. The telephone rang a minimum of five times on each attempt made on a record.

Busy Lines. Busy lines were called back at least twice at 10-minute intervals. If the line was still busy after the third attempt, the number was assigned a “busy” disposition and called during the next shift.

Respondent Selection. Once a household was contacted, an adult was selected for participation in the study. No interview was conducted if the adult was unavailable during the survey period, was unable or unwilling to participate, did not speak English or Spanish well enough to be interviewed, or the number was an occupant’s second residence and his or her stay was less than 30 days.

Language of Interviewing. Interviewing for the MATS was conducted in English and Spanish.

Converting Initial Refusals. Protocol for the MATS followed the refusal protocol developed for the Adult Tobacco Survey (ATS), which specifies two refusals by a selected respondent, or three refusals by a non-selected respondent, to terminate the record from calling. In special cases, the refusal protocol could be bypassed to expedite a number's removal. Once a household or individual initially refused participation, specially trained conversion interviewers contacted them to encourage participation in the survey. The refusal conversion rate for this study was 8.1 percent.

Interviewer Training

Prior to data collection, interviewers underwent extensive training specific to the MATS. The training, in conjunction with standard quality control measures, assured consistent, high quality interviewing during data collection. Training sessions for the MATS survey focused on these important aspects of the survey research process:

Introduction to the Survey. The training introduction discussed the study's purpose and scope, any terminology specific to the project, the significance of a high response rate, and the effect that a high number of refusals has on the study,. This part of the training also stressed the importance of confidentiality.

Introduction to Sampling. The second section of training focused on the type of sampling being used in the MATS, and described the interview targets. The importance of making multiple attempts and converting refusals was also stressed.

The Role of Contractor. In this training section, the role of each member of the Contractor's staff was explained to the interviewers. Specifically, the role of the project managers, the data collection management team, the interviewers, the quality assurance assistants, and the data processing team were discussed.

Approaches to Interviewing. During the MATS training, a brief refresher on interviewing techniques was conducted. This section focused on how to move a respondent through a survey and ask the questions appropriately. Also emphasized in this section was keeping question non-response to a minimum and avoiding respondent refusals. Probing techniques included clarification of respondent responses, open-end verification, and rereading of response categories. Protocols unique to the MATS were emphasized in this section—such as reading verbatim, respondent selection procedures, assuring respondent confidentiality, probing and clarifying, and dealing with refusals.

Knowing the Questionnaire. The next step in the training process involved an overview of the questionnaire and a brief review of the most important pieces of information related to administering the survey—such as the selection process, moving smoothly through the interview, use of dispositions, and leaving messages.

A Look at the Questionnaire. This final part of the training dealt specifically with administering the MATS. This included a word-for-word review of the questionnaire, done interactively with the CATI program. Each interviewer worked on a terminal and completed each screen of the CATI program. Many different scenarios—such as respondent reactions, skip patterns, and disposition protocols—gave interviewers a better understanding of the CATI program and the survey instrument.

Data Collection Quality Control. The MATS questionnaire was programmed using CfMC's software package, which is designed specifically for programming and managing CATI studies. CfMC software is a powerful questionnaire programming language that provides a wide array of quality control features. After programming, project managers rigorously tested the survey.

Testing included: developing scenarios to test all possible paths through the questionnaire; checking frequencies of randomly generated data; and verifying frequencies of the data after the first day of interviewing. Reports were produced on a regular basis to capture interviewer efficiencies (completes per hour, both on an individual and project level); lower bound and upper-bound response rates; demographics on completed interviews; all call dispositions; and sample status (number of attempts, percent complete, refusal rates). These reports were generated by the survey manager and immediately distributed to the project management team for review.

Interviewer Monitoring. As an additional layer of quality assurance, interviewer performance was monitored through supervisors and quality assurance (QA) assistants, as well as with formal and informal performance evaluations. The quality control team for this survey included the survey manager, the data collection manager, supervisors, and QA assistants. Monitoring was primarily conducted by special quality control staff, called QA assistants. QA assistants monitored at least 10 percent of the interviews by tapping into interviewers' telephone lines and using the CATI system's monitoring module to follow the course of the interview on a computer screen. Interviewers were scored on several measures of interview performance designed to reinforce proper interviewer protocol and data quality.

Issues with Survey Implementation

CATI Error and Data Loss. During the MATS fielding period, a data collection error was discovered that caused the loss of data for questions Q104c through Q109 in 4,482 completed interviews. The error that occurred was a result of a hard-coded date and time stamp running into – and overwriting – question Q104c through Q109, as well as the variable that captured the language of the interview. This error was the result of questionnaire programming changes that occurred after the completion of the pilot study.

Recouping Lost Data and Obtaining Feedback on Interview Quality. To recoup the lost data, a re-contact study was implemented for all respondents for whom these data were over-read. The re-contact study was aligned with measuring interviewer performance and quality assurance; therefore respondents were asked to report on the quality of the MATS interviewer and overall sound quality during the original MATS interview. Contractor personnel then re-asked questions 104c through 109. Due to question Q106 being of particular importance to the DHMH, this was the first question re-asked. The re-contact study also followed a one refusal protocol (one refusal and the record is removed from calling) and a maximum of ten attempts were made to reach a respondent. In total, 2,817 recontact interviews were completed (62.9 percent).

Editing

Minimal data editing and logic checks were required for the adult data after the conclusion of fielding. CfMC, the software used to program the CATI system, incorporates logic checks and data entry restrictions in the CATI program. These features allow data to be collected and checked simultaneously and reduce the amount of review required after data collection is complete. Logic checks and data entry restrictions that were included in the adult tobacco survey were based on guidance from DHMH. Using the final CATI dataset, a set of analytical variables was created based on previous cycles of the ATS study. The computed variables are the product of combining responses from a series of questionnaire variables into a computer variable that is useful for analysis. For example, the variable csmoker (adult who is a current smoker) is a combination of

question 22 (Have you smoked at least 100 cigarettes in your entire life?) and question 23 (Do you now smoke cigarettes everyday, some days, or not at all?).

Weighting Methods

Weighting Algorithm. Analysis weights were constructed to allow the data to be generalized to the adult population of the state of Maryland as a whole, as well as by jurisdiction. The initial sampling weight was constructed to reflect the selection probabilities of both the telephone number and the respondent within the household. This weight was then calibrated to population control totals based on data provided by the US Census, so that the weighted distribution of the data matches the adult population distribution in terms of basic demographic characteristics.

Sampling Weight. The sampling weight accounts for differential probabilities at both the household and respondent-within-household level. The first component of this weight reflects the probability of selecting a telephone number via the Random Digit Dial sample generation process: $\text{Household_weight} = (\text{frame_count} / \text{sample_count}) * (1/n_phones)$, where

- frame_count = number of possible telephone numbers that could be sampled,
- sample_count = number of telephone numbers sampled and released into the study, and n_phones = number of voice telephone lines ringing into the household.

This weight was computed for each jurisdiction and density stratum, reflecting the stratification of the telephone sample. The second component reflects the probability of selecting a respondent, given that a cooperative residential household has been reached at a telephone number. Given that we are following a random selection procedure, this weight is simply the number of adults in the household. $\text{Person_weight} = n_adults$, where N_adults = number of adults living in household at the time of contact. This weight was computed at the household level. The component weights were multiplied together to produce an overall sampling weight: $\text{Selection_weight} = \text{Household_weight} * \text{Person_weight}$

Post-stratification. The post-stratification adjusted the weights to population totals within jurisdiction, by cells defined according to age, race, and gender. Cells were collapsed in jurisdictions where the number of survey respondents were too small to produce reliable estimates. The poststratification adjustment was defined as the population estimate for a particular cell divided by the sum of the selection weights in that cell. Population counts used in the post-stratification were taken from the most current Census intercensal estimates available at the time. Currently these are the contained file CC-EST2005-alldata-md “County Population Estimates by Age, Sex, Race and Hispanic Origin April 1, 2000 to July 1, 2005” available from the US Census Bureau website. It is important to note that the 2005 estimates reflect the population as a whole, including those who live in group quarters. The 2000 Census is the most recent available source of data for adults living in households. In order to estimate the current household population distribution, the 2005 population estimates were adjusted by the percentage of adults living in households in 2000 for each post-stratification cell.

Response Rates

Response rates for the MATS survey were calculated using the AAPOR RR4, CASRO, Cooperation, and Lower-bound response rate formulas. The AAPOR RR4 response rate

for the MATS was 55.94 percent. The cooperation rate, which measures the ability to interview identified eligibles, was 67.62 percent. The CASRO response rate, calculated using the original 12 CDC dispositions was 20.94 percent and the CASRO rate using the new CDC dispositions was 33.69 percent. The lower bound measures sample frame efficiency because it shows the rate at which the total sample produced completed interviews; the lower bound was 7.5 percent.

Reference:

- Maryland Department of Health and Mental Hygiene. *Monitoring Changing Tobacco-use Behaviors in Maryland*, November, 2007. Available at: <http://www.crf.state.md.us/html/stats.cfm>



Appendix B

Maryland Adult Tobacco Survey

SCREENER

ALL RESPONDENTS

Hello, I'm _____ calling for the Maryland Department of Health and Mental Hygiene. We're gathering information on attitudes, use, and exposure to tobacco products. The information will be used to guide state and county health policies. Your phone number has been chosen randomly, and we'd like to ask some questions about day-to-day tobacco-related living habits that may affect health.

Is this telephone number?

NO Thank you very much, but I seem to have dialed the wrong number. It's possible that your number may be called at a later time. **END OF INTERVIEW**

YES=Continue

Is this a private residence?

NO Thank you very much, but we are only interviewing private residences. **END OF INTERVIEW**
YES=Continue

We need to randomly select one adult who lives in your household to be interviewed. In order to make this random selection, can you please tell me how many members of your household, including yourself, are 18 years of age or older?

_____ # of adults [Range 1-18; confirm if > 5]

If 1 adult in household then ask: Are you the adult?

If "yes" Then you are the person I need to speak with.
GO TO SECTION 1

If "no" May I speak with him or her?
GO TO "CORRECT RESPONDENT"

If more than 1 adult in household then ask: How many of these adults are men? [Confirm if >5]

- 0. None
- 1. One
- 2. Two
- 3. Three
- 4. Four
- 5. Five
- 6. Six
- 7. Seven
- 8. Eight
- 9. Nine

How many of these adults are women? [Confirm if >5]

- 0. None
- 1. One
- 2. Two
- 3. Three
- 4. Four
- 5. Five
- 6. Six
- 7. Seven
- 8. Eight
- 9. Nine

The person in your household that I need to speak with is _____.

If "you" Go to Section 1

Correct respondent

HELLO, I'm calling for the Maryland Department of Health and Mental Hygiene. We're gathering information on attitudes, use and exposure to tobacco products. The information will be used to guide state and county health policies. You have been chosen randomly to be interviewed, and we'd like to ask some questions about day-to-day tobacco related living habits that may affect health.

Section 1

ALL RESPONDENTS

Then you are the person I need to speak with. We do not ask for your name, address, or other personal information that identifies you. The phone number is erased once we finish all interviews. Taking part is up to you. You can skip any question you don't want to answer, and are free to end the interview at any time. The interview should take no more than 20 minutes, and may take much less. Your responses to the questions will be confidential. If you have any questions about this survey, I will provide a telephone number for you to call to get more information. [Robert Fiedler - 410-767-6878]

This call may be monitored for quality control purposes.

PRIMARY DEMOGRAPHICS

ALL RESPONDENTS

1. What county do you live in?

____ County FIPS Code
Note: Baltimore City is NOT Baltimore County, probe.
777. Don't Know/Not Sure
999. Refused

ALL RESPONDENTS

6. What is your age?

____ Age in years [Range 18-105]
777. Don't Know/Not Sure
999. Refused

REFERENCE VARIABLE:

AGELESS30="Yes" if Q6 does not equal "7" OR "8" AND Q6 is less than "30" AGELESS30

ASK ONLY IF NECESSARY

3. What is your gender?

1. Female
2. Male
777. Don't Know/Not Sure
999. Refused

REFERENCE VARIABLE:

FEMALE="Yes" if Q3 equals "1"

FEMALE

CO-MORBIDITY AND HEALTH STATUS

ALL RESPONDENTS

13. Would you say that in general your health is...?

Please Read:

- 1. Excellent
- 2. Very Good
- 3. Good
- 4. Fair
- 5. Poor
- 777. *Don't Know/Not Sure*
- 999. *Refused*

ALL RESPONDENTS

14. I am going to read a list of medical conditions that many people have. After each one, please tell me if you have EVER been told by a doctor or other health professional that you have that condition.

ALL RESPONDENTS

14A. Asthma, Bronchitis, or Emphysema?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

14A-1. If Q14A="Yes" follow up by asking: "Do you still suffer from asthma, bronchitis, or emphysema?"

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

14B. Diabetes?

- 1. Yes
- 2. No
- 3. Only during pregnancy
- 777. *Don't Know/Not Sure*
- 999. *Refused*

14C. Heart Disease?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

14D. Cancer?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

ALL RESPONDENTS

- 15. Are you limited in any way in your daily activities because of physical problems, disabilities, or handicaps?**

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

ALL RESPONDENTS

- 16. In the past 12 months have you gone to a doctor or other health professional for a check-up or medical treatment?**

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

DOCTORPASTYR="YES" if Q16 equals "Yes"

DOCTORPASTYR

ALL RESPONDENTS

17. In the past 12 months, have you seen a dentist?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

DENTISTPASTYR = "Yes" if Q17 equals "Yes"

DENTISTPASTYR

ALL RESPONDENTS

18. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMO's, or governmental plans such as Health Choice (Medicaid) or Medicare?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

18A. If Q18="Yes" follow up by asking: "What type of health care coverage do you use to pay for most of your medical care?"

- 1. Medicare
 - 2. HealthChoice (Medicaid)
 - 3. Champus, Champus-VA, TriCare, or Military
 - 4. Employer or union-based (your's or someone else's)
 - 5. Purchased directly by (you or someone else)
 - 6. Other (please specify)
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ALL RESPONDENTS

19. Was there a time in the past 12 months when you needed to see a doctor but did not because of the cost?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

AWARENESS OF CESSATION ASSISTANCE

ALL RESPONDENTS

20. During the past 7 days on average, how many hours a day did you:

20A. Watch television

_____ Number of hours to the nearest half hour [Range: 0-24; confirm if > 10]
555. *No access to television*
777. *Don't Know/Not Sure*
999. *Refused*

20B. Listen to the radio

_____ Number of hours to the nearest half hour [Range: 0-24; confirm if > 10]
555. *No access to radio*
777. *Don't Know/Not Sure*
999. *Refused*

20C. Browse or surf the Internet

_____ Number of hours to the nearest half hour [Range: 0-24; confirm if > 10]
555. *No access to internet*
777. *Don't Know/Not Sure*
999. *Refused*

ALL RESPONDENTS

21. Are you aware of assistance that is available to smokers to help them quit smoking, such as through local health departments or Maryland's telephone quit line (1-800-QUIT-NOW)?

1. Yes
2. No
777. *Don't Know/Not Sure*
999. *Refused*

21A. If Q21 = "Yes" follow up by asking: "I am going to read you a list of sources of information about quitting smoking. For each place, please tell me if that source was one of the ways that you became aware of the existence of the 1-800-QUIT-NOW quitline."

[Randomize Order Presented]

1. Local Health Department
2. 1-800-QUIT-NOW
3. Television
4. Radio
5. Newspaper or Magazine Ad
6. Poster or Sign inside Public Transportation
7. Poster or Sign outside Public Transportation
8. Your Doctor
9. Your Dentist
10. Your Employer/At Work
11. Community Organizations
12. Brochure or other printed materials
13. Promotional Item (magnets, mints, pencils, etc.)
14. Family or Friend
15. Other, please specify: _____
88. Never have seen information about 1-800-QUIT-NOW
777. *Don't Know/Not Sure*
999. *Refused*

CURRENT USE OF TOBACCO PRODUCTS

Cigarettes

ALL RESPONDENTS

22. Have you smoked at least 100 cigarettes in your entire life? [Note: 100 cigarettes is equal to 5 packs]

1. Yes
2. No
777. Don't Know/Not Sure
999. Refused

REFERENCE VARIABLE:

EverSmoker = "Yes" if Q22 equals "Yes"

EVERSMOKER

REFERENCE VARIABLE:

Never100Smoker = "Yes" if Q22 equals "No"

NEVER100SMOKER

AGELESS30 RESPONDENTS

- 22A. How old were you the first time you smoked a cigarette, even one or two puffs?

_____ Age in years [Acceptable Range = 2-104; confirm response if less than 6]
888. Never smoked cigarettes
777. Don't Know/Not Sure
999. Refused

EVERSMOKER RESPONDENTS

- 22B. How old were you when you first started smoking regularly?

_____ Age in years [Acceptable Range = 2-104; confirm response is greater than or equal to response in Q22A; Confirm age if response is less than 6; Confirm if Q22B – Q22A is greater than 3 years]
888. Never smoked cigarettes regularly
777. Don't Know/Not Sure
999. Refused

EVERSMOKER WHO ARE ALSO AGELESS30 RESPONDENTS

22C. If Q22B greater than 0 and less than 777, follow up by asking: "When you first began smoking regularly, what brand of cigarette did you smoke most often?"

1. Marlboro
2. Newport
3. Camel
4. Basic
5. Doral
6. Winston
7. GPC
8. Kool
9. Virginia Slims
10. Benson & Hedges
11. Salem
12. Merit
13. Pall Mall
14. Misty
15. Parliament
16. Capri
17. Other (specify)
777. *Don't Know/Not Sure*
999. *Refused*

ALL RESPONDENTS

23. Do you now smoke cigarettes everyday, some days, or not at all?

1. Every day
2. Some days
3. Not at all
777. *Don't Know/Not Sure*
999. *Refused*

REFERENCE VARIABLE:

EveryDaySmoker = "Yes" if Q23 equals "1"

EVERYDAYSMOKER

23A. If Q22="Some Days" follow up by asking: "During the past 30 days, on how many days did you smoke cigarettes?"

- _____ Number of days
777. *Don't Know/Not Sure*
 999. *Refused*

REFERENCE VARIABLE:

CurrentSmoker = "Yes" if Q23 equals (1 or 2) AND Q22 equals "Yes"

CURRENTSMOKER

REFERENCE VARIABLE:

FormerSmoker = "Yes" if Q23 = 3 AND Q22 = "Yes"

FORMERSMOKER

CURRENTSMOKER RESPONDENTS

24. On average, when you smoked during the past 30 days, about how many cigarettes did you smoke a day?

_____ Number of cigarettes smoked a day
777. *Don't Know/Not Sure (SKIP TO Q26)*
999. *Refused (SKIP TO Q26)*

CURRENTSMOKER RESPONDENTS

25. For approximately how many years have you been smoking [# cigarettes smoked daily from Q24] cigarettes a day?

_____ Number of years [Acceptable Range 1-105; Confirm if response is greater than 90]
777. *Don't Know/Not Sure*
999. *Refused*

CURRENTSMOKER RESPONDENTS

26. On the days that you smoke, how soon after you wake up do you have your first cigarette?

1. Within 5 minutes
2. 6-30 minutes
3. 31-60 minutes
4. After 60 minutes
777. *Don't Know/Not Sure*
999. *Refused*

CURRENTSMOKER AND FORMERSMOKER RESPONDENTS

28. Have you ever smoked cigarettes everyday for...

28A. At least 30 days?

1. Yes
2. No
777. *Don't Know/Not Sure*
999. *Refused*

28B. At least 6 months?

- 1. Yes
- 2. No
- 777. Don't Know/Not Sure
- 999. Refused

CURRENTSMOKER AND FORMERSMOKER RESPONDENTS IF Q28B=YES

29. What is the total number of years you smoked everyday?

- _____ Number of years [Acceptable Range 1-105; Confirm if response is greater than 80]
- 777. Don't Know/Not Sure
 - 999. Refused

CURRENTSMOKER AND FORMERSMOKER RESPONDENTS

30. Around this time last year, were you smoking cigarettes every day, some days, or not at all?

- 1. Every day
- 2. Some days
- 3. Not at all
- 777. Don't Know/Not Sure
- 999. Refused

CURRENTSMOKER RESPONDENTS

32. What brand of cigarette do you now smoke most often?

- _____ Brand from drop down list
- 777. Don't Know/Not Sure
 - 999. Refused

CURRENTSMOKER RESPONDENTS

34. What type of cigarettes are the [insert brand from Q32; If Q32= (777 or 999) insert "brand you smoke most often"]?

34B. Menthol or plain?

- 1. Menthol
- 2. Plain
- 777. Don't Know/Not Sure
- 999. Refused

34D. Regular, lights, ultra lights, special/mild, or flavored?

- 1. Regular
- 2. Lights
- 3. Ultra Lights
- 4. Special/Mild
- 5. Flavored
- 777. *Don't Know/Not Sure*
- 999. *Refused*

ALL RESPONDENTS

42C. Have you ever smoked flavored cigarettes such as Camels Exotic or Casino Brands (Mandarin Mint, Lime Twister, Cinnzabar)?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

42D. If 42c=1, ask: Do you now smoke flavored cigarettes every day, some days, or not at all?

- 1. Every day
- 2. Some days
- 3. Not at all
- 777. *Don't Know/Not Sure*
- 999. *Refused*

CURRENTSMOKER RESPONDENTS

35. In general, do you buy your cigarettes by the pack or by the carton?

- 1. I generally buy my cigarettes by the pack
- 2. I generally buy my cigarettes by the carton
- 3. I generally buy cigarettes by the pack and carton equally
- 4. I never buy cigarettes
- 777. *Don't Know/Not Sure*
- 999. *Refused*

If 35=4, skip to Q38

35A. If Q35="1 or 3" follow up by asking: "How much do you usually pay for a pack of cigarettes?"

_____. Amount usually paid for a pack [Acceptable Range \$1.50-\$9.99; confirm if response is less than \$2.00 or greater than \$5.00]

- 77777. *Don't Know/Not Sure*
 - 99999. *Refused*
-

35B. If Q35= 2 or 3 follow up by asking: "How much do you usually pay for a carton of cigarettes?"

_____. Amount usually paid for a carton [Acceptable Range \$10.00-\$90.00; Confirm if response is less than \$25.00 or greater than \$70.00]
77777. *Don't Know/Not Sure*
99999. *Refused*

Other Tobacco Products

ALL RESPONDENTS

38. Have you ever used or tried any smokeless tobacco products such as chewing tobacco or snuff?

1. Yes
2. No
777. *Don't Know/Not Sure*
999. *Refused*

REFERENCE VARIABLE:

EverChew = "Yes" if Q38 equals "Yes"

EVERCHEW

REFERENCE VARIABLE:

NeverChew = "Yes" if Q38 equals "No"

NEVERCHEW

EVERCHEW RESPONDENTS

38A. Do you currently use chewing tobacco or snuff everyday, some days, or not at all?

1. Every day
2. Some days
3. Not at all
777. *Don't Know/Not Sure*
999. *Refused*

ALL RESPONDENTS

39. Have you ever smoked a cigar?

1. Yes
2. No
777. *Don't Know/Not Sure*
999. *Refused*

REFERENCE VARIABLE:

EverCigar = "Yes" if Q39 equals "Yes"

EVERCIGAR

REFERENCE VARIABLE:

NeverCigar = "Yes" if Q39 equals "No"

NEVERCIGAR

EVERCIGAR RESPONDENTS

39A. Do you now smoke a cigar everyday, some days, or not at all?

- 1. Every day
- 2. Some days
- 3. Not at all
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

CurrentCigar = "Yes" if Q39A equals "1" or "2"

CURRENTCIGAR

ALL RESPONDENTS

40. Have you ever smoked tobacco in a pipe?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

EverPipe = "Yes" if Q40 equals "Yes"

EVERPIPE

EVERPIPE RESPONDENTS

40A. Do you now smoke [tobacco in] a pipe everyday, some days, or not at all?

- 1. Every day
- 2. Some days
- 3. Not at all
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

CurrentPipe = "Yes" of Q40A equals "1" OR "2"

CURRENTPIPE

ALL RESPONDENTS

41. A bidi is a flavored cigarette from India. Have you ever smoked a bidi?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

EverBidi = "Yes" of Q41 equals "Yes"

EVERBIDI

EVERBIDI RESPONDENTS

41A. Do you now smoke bidis everyday, some days, or not at all?

- 1. Every day
- 2. Some days
- 3. Not at all
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

CurrentBidi = "Yes" if Q41A equals "1" OR "2"

CURRENTBIDI

ALL RESPONDENTS

42. Kreteks are cigarettes made of tobacco and clove extract. Have you ever smoked a kretek?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

EverKretek = "Yes" if Q42 equals "Yes"

EVERKRETEK

EVERKRETEK RESPONDENTS

42A. Do you now smoke kreteks (clove cigarettes) every day, some days, or not at all?

- 1. Every day
- 2. Some days
- 3. Not at all
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

CurrentKretek = "Yes" if Q42A equals "1" OR "2"

CURRENTKRETEK

SECONDARY DEMOGRAPHICS

ALL RESPONDENTS

4. Which one or more of the following would you say is your race?

1. White
 2. Black or African American
 3. Asian
 4. Native Hawaiian or Other Pacific Islander
 5. American Indian, Alaskan Native
 6. Other [Specify: _____]
 777. *Don't Know/Not Sure*
 999. *Refused*
-

4A. When respondent identifies more than one race in Q4, follow up by asking: "Which one of these groups would you say best represents your race?"

1. White
 2. Black or African American
 3. Asian
 4. Native Hawaiian or Other Pacific Islander
 5. American Indian, Alaskan Native
 6. Other [Specify: _____]
 777. *Don't Know/Not Sure*
 999. *Refused*
-

ALL RESPONDENTS

5. Are you Hispanic or Latino?

1. Yes
 2. No
 777. *Don't Know/Not Sure*
 999. *Refused*
-

ALL RESPONDENTS

**7. [Marital Status] Are you?:
Please Read:**

1. Married
2. Divorced
3. Widowed
4. Separated
5. Never Married
6. Member of an unmarried couple
9. *Refused*

ALL RESPONDENTS

8. How many children age 17 or younger live in your household?

- _____ Number of children younger than 18 years old [Acceptable Range 0-15; confirm if response is greater than 5]
777. *Don't Know/Not Sure*
999. *Refused*

REFERENCE VARIABLE:

MINORHOUSE="Yes" if Q8 does not equal (7 OR 9) AND Q8 is greater than 0 **MINORHOUSE**

AGELESS\$30

9. Are you currently enrolled in a graduate or professional school, a 4 year college, a 2 year college, a technical or vocational school, or a GED Program?

1. Graduate or professional school
 2. 4 year college
 3. 2 year college
 4. Technical or vocational school
 5. GED Program
 6. Other
 7. Not enrolled
 777. *Don't Know/Not Sure*
 999. *Refused*
-

ALL RESPONDENTS

10. What is the highest grade or year of school you have completed?

1. Never attended school or only attended kindergarten
 2. Grades 1 through 8 (Elementary)
 3. Grades 9 through 11 (Some high school)
 4. Grade 12 or GED (High school graduate)
 5. College 1 year to 3 years (Some college or technical school)
 6. College 4 years or more (College graduate)
 777. *Don't Know/Not Sure*
 999. *Refused*
-

ALL RESPONDENTS

11. Is your annual income from all sources...?

1. Less than \$25,000 [If "No" ask response option 5]
2. Less than \$20,000 [If "No" code as \$20,000 - \$24,999]
3. Less than \$15,000 [If "No" code as \$15,000 - \$19,999]
4. Less than \$10,000 [If "No" code as \$10,000 - \$14,999]
[If "Yes" code as <\$10,000]
5. Less than \$35,000 [If "Yes" code as \$25,000 - \$34,999]
6. Less than \$50,000 [If "Yes" code as \$34,000 - \$49,999]
7. Less than \$75,000 [If "Yes" code as \$40,000 - \$74,999]
[If "No" code as \$75,000+]
777. *Don't Know/Not Sure*
999. *Refused*

SECOND-HAND SMOKE

In the Community

ALL RESPONDENTS

43. During the past 30 days have you gone to a restaurant?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ALL RESPONDENTS

44. How strongly would you support or oppose a proposal to make all restaurants in your community smoke-free?

Read List:

- 1. I would strongly oppose such a proposal
 - 2. I would oppose such a proposal
 - 3. I don't have an opinion either way
 - 4. I would support such a proposal
 - 5. I would strongly support such a proposal
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ALL RESPONDENTS

45. How strongly would you support or oppose a proposal to make all bars, taverns, and nightclubs in your community smoke-free?

Read List:

- 1. I would strongly oppose such a proposal
 - 2. I would oppose such a proposal
 - 3. I don't have an opinion either way
 - 4. I would support such a proposal
 - 5. I would strongly support such a proposal
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ALL RESPONDENTS

49. Do you think that that breathing smoke from other people's cigarettes, cigars, or pipes is:

Read List:

1. Not at all harmful to one's health
2. Not very harmful to one's health
3. Somewhat harmful to one's health
4. Very harmful to one's health
777. *Don't Know/Not Sure*
999. *Refused*

ALL RESPONDENTS

50. Do you agree or disagree with the following statement: Smoke from other people's cigarettes is harmful to children. Would you say you...?

Read List:

1. Strongly disagree
2. Somewhat disagree
3. Somewhat agree
4. Strongly agree
777. *Don't Know/Not Sure*
999. *Refused*

In the Home

ALL RESPONDENTS (WHERE SCREENER INDICATES MORE THAN 1 ADULT IN HOUSEHOLD)

51. Not including yourself, how many other adults who live in your household smoke cigarettes, cigars, or pipes?

_____ Number of resident adult smokers other than respondent [Acceptable Range: 0 to # adults in household minus 1]
777. *Don't Know/Not Sure*
999. *Refused*

ALL RESPONDENTS

52. Which statement best describes the rules about smoking inside your home?

Read List:

1. Smoking is not allowed anywhere inside your home
2. Smoking is allowed in some places or at some times
3. Smoking is allowed anywhere inside your home
4. There are no rules about smoking inside your home
777. *Don't Know/Not Sure*
999. *Refused*

If Q52=1, skip Q53

53. During the past 7 days, that is since [insert date], on how many days did anyone smoke cigarettes, cigars, or pipes anywhere inside your home?

___ RECORD NUMBER OF DAYS [Acceptable Range: 0 – 7]

777. *Don't Know/Not Sure*
999. *Refused*

ALL RESPONDENTS

54. In the past 7 days, that is since [insert date], have you been in a car with someone who was smoking?

1. Yes
2. No
777. *Don't Know/Not Sure*
999. *Refused*

In the Workplace

This next section of the survey asks about secondhand smoke in the workplace. In order to fully understand the nature of any such exposures, I would like to begin by asking a series of questions about your workplace.

ALL RESPONDENTS

55. Are you currently...? [Employment Status]

Read List:

1. Employed for wages
2. Self-employed
3. Out of work for more than one year
4. Out of work for less than one year
5. Homemaker
6. Student (but working also)
66. Student (not employed)
7. Retired
8. Unable to work
777. *Don't Know/Not Sure*
999. *Refused*

REFERENCE VARIABLE:

Employed = "Yes" if Q55 equals 1, 2, or 6

EMPLOYED

EMPLOYED RESPONDENTS

56. How many hours per week, on average, do you work at your job?

- 1. 35 or more hours per week
- 2. 20 to 34 hours per week
- 3. Less than 20 hours per week
- 777. *Don't Know/Not Sure*
- 999. *Refused*

EMPLOYED RESPONDENTS

58. Which one of the following best describes the area in which you work most of the time?

Read List:

- 1. Indoor office environment
- 2. Manufacturing or similar setting
- 3. Gas station/Convenience store
- 4. Liquor store
- 6. Retail establishment
- 7. Restaurant WITH a liquor license
- 8. Restaurant WITHOUT a liquor license
- 9. Bar, tavern, or nightclub serving liquor
- 10. School, university, or similar setting
- 11. In a home
- 12. Mainly work outdoors
- 13. Travel to different buildings and sites
- 14. In a motor vehicle
- 20. Other
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

WorkIndoors = "Yes" if Q58 equals 1-11

WORKINDOORS

WORKINDOORS RESPONDENTS

60. I'm going to read you a list of policies workplaces have about smoking. Please tell me which one is MOST like the INDOOR smoking policy at your workplace.

Read List:

- 1. Smoking is not allowed anywhere in the building
 - 2. Smoking is only allowed in designated smoking areas
 - 3. No official policy
 - 4. Some other policy [Please specify: _____]
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

WORKINDOORS RESPONDENTS

61. In a typical week, about how many hours would you say you are exposed to smoke from other people's cigarettes, cigars, or pipes at work?

_____ Hours [Range 0-95; Confirm if > 45]
08 Less than one hour
777. *Don't Know/Not Sure*
999. *Refused*

CIGARETTE & SMOKELESS CESSATION

ASK Q62 TO FORMERSMOKER RESPONDENTS

62. About how long has it been since you last smoked cigarettes?

1. Less than 1 month
2. Within the past 2 months (1 to 2 months ago)
3. Within the past 6 months (3 to 6 months ago)
4. Within the past year (7 to 12 months ago)
5. Within the past 5 years (1 to 5 years ago)
6. Within the past 10 years (>5 years but <= 10 years ago)
7. Over 10 years ago
8. Never smoked cigarettes regularly
777. *Don't Know/Not Sure*
999. *Refused*

REFERENCE VARIABLE:

FORMERCIG5="YES" if Q62 is less than 6

FORMERCIG5

REFERENCE VARIABLE:

FORMERCIG1="YES" if Q62 is less than or equal to 4

FORMERCIG1

ASK Q63 TO EVERCHEW WHO ARE NOT CURRENTCHEW RESPONDENTS

63. About how long has it been since you last used chewing tobacco or snuff?

1. Less than 1 month
2. Within the past 2 months (1 to 2 months ago)
3. Within the past 6 months (3 to 6 months ago)
4. Within the past year (7 to 12 months ago)
5. Within the past 5 years (1 to 5 years ago)
6. Within the past 10 years (>5 years but <= 10 years ago)
7. Over 10 years ago
8. Never used chewing tobacco or snuff regularly
777. *Don't Know/Not Sure*
999. *Refused*

REFERENCE VARIABLE:

FORMERCHEW5 = "YES" if Q63 is less than 6

FORMERCHEW5

REFERENCE VARIABLE:

FORMERCHEW1 = "YES" if Q63 is less than 4

FORMERCHEW1

ASK Q64 TO FORMERSMOKER OR NEVERSMOKER WHO ARE ALSO AGELESS30

64. Do you think you will smoke a cigarette anytime during the next year?

- 1. Definitely yes
 - 2. Probably yes
 - 3. Probably not
 - 4. Definitely not
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ASK Q67A TO CURRENTSMOKER RESPONDENTS

67A. Do you ever expect to quit smoking?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ASK Q68A TO CURRENTSMOKER RESPONDENTS

68A. If you decided to give up smoking altogether, how likely do you think you would be to succeed?

- 1. Very likely
 - 2. Somewhat likely
 - 3. Somewhat unlikely
 - 4. Very unlikely
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ASK Q69 TO CURRENTSMOKER OR FORMERCIG5 OR CURRENTCHEW OR FORMERCHEW5 RESPONDENTS

69. Have you ever used a nicotine skin patch, gum, inhaler, or nasal spray?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ASK Q70 TO EMPLOYED RESPONDENTS

70. During the past 12 months, has your employer offered any stop smoking program or any other help to employees who want to quit?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

STAGES OF CHANGE

ASK Q71A TO CURRENTSMOKER RESPONDENTS

71A. Have you ever seriously considered quitting cigarette smoking?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

CONSIDEREDQUIT="YES" if Q71 equals "YES"

CONSIDEREDQUITSMOKE

ASK Q71B TO CURRENTCHEW RESPONDENTS

71B. Have you ever seriously considered quitting smokeless tobacco?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

CONSIDEREDQUIT="YES" if Q71 equals "YES"

CONSIDEREDQUITCHEW

ASK Q72A TO CURRENTSMOKER OR FORMERCIG5 RESPONDENTS

72A. In your whole life, how many times did you stop smoking cigarettes for one day or longer because you were trying to quit?

- _____ Times [Range 0 -95; Confirm if times > 5]
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

EverTried="YES" if Q72 is greater than 0 and less than 777

EVERTRIEDSMOKE

ASK Q72B TO CURRENTCHEW OR FORMERCHEW5 RESPONDENTS

72B. In your whole life, how many times did you stop using smokeless tobacco for one day or longer because you were trying to quit?

____ Times (Acceptable Range 0 -95) [Confirm if response is greater than 5]
777. *Don't Know/Not Sure*
999. *Refused*

REFERENCE VARIABLE:

EverTried="YES" if Q72 is greater than 0 and less than 777 **EVERTRIEDCHEW**

ASK Q72C TO EVERTRIEDSMOKE RESPONDENTS

72C. Of all the times you...

[IF CURRENT... THEN SAY] ...have tried, what was
[IF FORMER... THEN SAY] ...did try to quit, what is

the longest period you stayed off cigarettes?

1 __ Days
2 __ Weeks
3 __ Months
4 __ Years
7 7 7 Don't know / Not sure
9 9 9 Refused

ASK Q72D TO EVERTRIEDCHEW RESPONDENTS

72D. Of all the times you...

[IF CURRENT... THEN SAY] ...have tried, what was
[IF FORMER... THEN SAY] ...did try to quit, what is

the longest period you stayed off smokeless tobacco?

1 __ Days
2 __ Weeks
3 __ Months
4 __ Years
7 7 7 Don't know / Not sure
9 9 9 Refused

ASK Q72E TO EVERTRIEDSMOKE RESPONDENTS

72E. During the past 12 months have you stopped smoking cigarettes for one day or longer because you were trying to quit?"

- 1. Yes
- 2. No
- 777. Don't Know/Not Sure
- 999. Refused

REFERENCE VARIABLE:

TriedPastYear = "YES" if Q69B equals "1"

TRIEDPASTYEARSMOKE

ASK Q72F TO EVERTRIEDCHEW RESPONDENTS

72F. During the past 12 months have you stopped using smokeless tobacco for one day or longer because you were trying to quit?"

- 1. Yes
- 2. No
- 777. Don't Know/Not Sure
- 999. Refused

REFERENCE VARIABLE:

TriedPastYear = "YES" if Q69B equals "1"

TRIEDPASTYEARCHEW

ASK Q72E-1 TO TRIEDPASTYEARSMOKE RESPONDENTS

72E-1. How many times during the past 12 months have you stopped smoking for 1 day or longer because you were trying to quit smoking?

- _____ Number of times [Acceptable Range 0-365; confirm if response is greater than 100]
 - 777. Don't Know/Not Sure
 - 999. Refused
-

ASK Q72E-2 TO TRIEDPASTYEARSMOKE RESPONDENTS

72E-2. During the past 12 months, what was the longest time you did not use cigarettes?

- 1 __ Days
- 2 __ Weeks
- 3 __ Months
- 777. Don't Know/Not Sure
- 999. Refused

ASK Q72F-2 TRIEDPASTYEARCHEW RESPONDENTS

72F-2. During the past 12 months, what was the longest time you did not use smokeless tobacco?

- 1 __ Days
 - 2 __ Weeks
 - 3 __ Months
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ASK Q72E-3 TO TRIEDPASTYEARSMOKE RESPONDENTS

72E-3. Have you increased or decreased your use of cigarettes since you decided you wanted to try to quit?

- 1. Increased
 - 2. Decreased
 - 3. No change
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ASK Q72F-3 TO TRIEDPASTYEARCHEW RESPONDENTS

72F-3. Have you increased or decreased your use of smokeless tobacco since you decided you wanted to try to quit?

- 1. Increased
 - 2. Decreased
 - 3. No change
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ASK Q73A TO CURRENTSMOKER RESPONDENTS

73A. Are you seriously planning to quit smoking cigarettes

- 1. Within the next 30 days
- 2. Within the next 3 months
- 3. Within the next 6 months
- 4. Within the next 12 months
- 5. Within the next 5 years
- 6. Sometime after 5 years
- 8. I am not planning on quitting
- 777. *Don't Know/Not Sure*
- 999. *Refused*

ASK Q73B TO CURRENTCHEW RESPONDENTS

73B. Are you seriously planning to quit using smokeless tobacco

1. Within the next 30 days
2. Within the next 3 months
3. Within the next 6 months
4. Within the next 12 months
5. Within the next 5 years
6. Sometime after 5 years
8. I am not planning on quitting
777. *Don't Know/Not Sure*
999. *Refused*

ASK Q74 TO CURRENTSMOKER OR CURRENTCHEW RESPONDENTS

74. Imagine that there are 10 steps in thinking about tobacco use. If you have NO thoughts of quitting, you would be at step 1. If you are taking some action right now, you are at step 10. What step would you say you are at in quitting?

- _____ Rung/Step
777. *Don't Know/Not Sure*
999. *Refused*

METHODS OF QUITTING

ASK Q75 TO FORMERCIG5 OR (CURRENTSMOKER + EVERTRIED) RESPONDENTS

75. [IF FORMERCIG5 RESPONDENT THEN SAY] When you quit smoking...

[IF CURRENTSMOKER+EVERTRIED RESPONDENT THEN SAY] The last time you tried to quit...

...did you use something such as nicotine patch, nicotine gum, other medication, counseling, or quitline to help you quit?

1. Yes
2. No
777. *Don't Know/Not Sure*
999. *Refused*

REFERENCE VARIABLE:

AssistedQuit = "YES" if Q71 equals "YES"

ASSISTQUITCIG

ASK Q76 TO ASSISTQUITCIG RESPONDENTS

76. If also **FORMERCIG5 RESPONDENT** ask:
"When you quit smoking..."

If also **CURRENTSMOKER+EVERTRIED RESPONDENT** ask:
"The last time you tried to quit smoking..."

...which of the following medications, products, and programs did you use, if any?

76A. Nicotine patch, gum, nasal spray or inhaler?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

76B. Zyban, Bupropion, Wellbutrin, or other non-nicotine prescription medicine?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

76C. A quit-smoking class or group?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

76D. A quit-smoking telephone hotline?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

76E. Hypnosis?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

76F. Acupuncture?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

76G. Self-help materials?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

76H. Something else, please specify?

- 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

ASK Q77 TO ASSISTQUITCIG RESPONDENTS

77. Was [Display/Read ONLY THE "Yes" items from preceding question] helpful to you?

77A. Nicotine patch, gum, nasal spray or inhaler?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

77B. Zyban, or other non-nicotine prescription medicine?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

77C. A quit-smoking class or group?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

77D. A quit-smoking telephone hotline?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

77E. Hypnosis?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

77F. Acupuncture?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

77G. Self-help materials?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

77H. Something else, please specify?

CESSATION ADVICE

ASK Q78 TO FORMERCIG5 OR FORMERCHEW5 OR CURRENTSMOKER OR CURRENTCHEW

78. I'm going to read you a list of places where you may have gotten quit-smoking information. Did you get information from? [Mark ALL that apply]

[NOTE: PROBE FOR ADDITIONAL RESPONSES AFTER FIRST RESPONSE]

DO NOT READ

1. Television
2. A Billboard
3. Radio
4. Newspaper or Magazine Ad
5. Poster/Sign on Public Transportation
6. Your Doctor
7. Your Dentist
8. Another health care professional
9. Local Health Department
10. At Work
11. Community Organization
12. A brochure or Other Printed Material
13. Family or Friend
14. Other: [specify: _____]
15. 1-800-QUIT-NOW (Maryland's telephone quitline)
88. I have not received any quit-smoking information
777. *Don't Know/Not Sure*
999. *Refused*

ASK Q79 TO DOCTORPASTYEAR RESPONDENTS

79. During the past 12 months, did any doctor, nurse, or other health professional ASK If you smoke or use smokeless tobacco?

1. Yes
2. No
777. *Don't Know/Not Sure*
999. *Refused*

ASK Q80A TO FORMERCIG5 OR CURRENTSMOKER RESPONDENTS

- 80A. Has a doctor, dentist, or other health professional EVER advised you to quit smoking?

1. Yes
2. No
777. *Don't Know/Not Sure*
999. *Refused*

ASK Q80B TO FORMERCHEW5 OR CURRENTCHEW RESPONDENTS

80B. Has a doctor, dentist, or other health professional EVER advised you to quit using smokeless tobacco?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

ASK Q80C TO FORMERCIG1 OR CURRSMOKER RESPONDENTS

80C. If Q80A "Yes" follow up by asking: "During the past 12 months, did any doctor, nurse, or other health professional ADVISE YOU not to smoke?"

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

DoctorQuitYear="YES" if Q76A equals "YES"

DRQUITYEARSMOKE

ASK Q80D TO DRQUITYEAR RESPONDENTS OR FORMERCHEW1 OR CURRENTCHEW RESPONDENTS

80D. If Q80B is "Yes" follow up by asking: "During the past 12 months, did any doctor, nurse, or other health professional ADVISE YOU to quit using smokeless tobacco?"

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

DoctorQuitYear="YES" if Q76A equals "YES"

DRQUITYEARCHEW

ASK Q80E TO DRQUITYEARSMOKE OR DRQUITYEARCHEW RESPONDENTS

80E. Did the doctor or health care provider that you saw recommend any product, program, or prescription for a medication to help you quit?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

ASK Q82A TO DENTISTPASTYR RESPONDENTS

82A. During the past 12 months, did your dentist ADVISE YOU not to... smoke?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

DDSQuitYear="YES" if Q82A equals "YES"

DDSQUITYEARSMOKE

ASK Q82B TO DENTISTPASTYR RESPONDENTS

82B. During the past 12 months, did your dentist ADVISE YOU not to use smokeless tobacco?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

REFERENCE VARIABLE:

DDSQuitYear="YES" if Q82B equals "YES"

DDSQUITYEARCHEW

ASK Q83 TO:

(DRQUITYRSMOKE AND FORMERCIG1 OR CURRENTSMOKER) RESPONDENTS

OR

**(DRQUITYRCHEW AND FORMERCHEW1 OR CURRENTCHEW)
AND (DDSQUITYRSMOKE AND FORMERCIG1 OR CURRENTSMOKER)
RESPONDENTS**

OR

**(DDSQUITYRCHEW AND FORMERCHEW1 OR CURRENTCHEW)
RESPONDENTS**

83. In the past 12 months, when a doctor, nurse, **dentist**, or other health professional advised you to [INSERT "quit smoking"/"quit using smokeless tobacco"], did they also do any of the following?

[IF **FORMERCIG1** OR **CURRENTSMOKER** RESPONDENT ASK:]

83A. Suggest that you set a specific date to stop smoking?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

[IF **FORMERCHEW1** OR **CURRENTCHEW** RESPONDENT ASK:]

83B. Suggest that you set a specific date to stop using smokeless tobacco?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

83C. Refer you to the Maryland telephone quitline at 1-800-QUIT-NOW?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

83D. Refer you to a tobacco use cessation program sponsored by or through your Local Health Department?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

83E. Refer you to an Internet web site that could provide you with information that would help you to quit on your own?

- 1. Yes
- 2. No
- 777. *Don't Know/Not Sure*
- 999. *Refused*

83F. Give you booklets, videos, or other materials to help you quit on your own?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

83G. Prescribe or recommend a nicotine patch, nicotine gum, nasal spray, an inhaler, or pills such as Zyban?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

83H. Provide one-on-one counseling from a doctor, dentist, nurse, assistant, or other person in the office?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

83I. Something else, please specify?

ASK Q84 TO EVERCIGAR WHO ARE NOT ALSO CURRCIGAR RESPONDENTS

84. About how long has it been since you last smoked cigars regularly a cigar?

1. Less than 1 month
2. Within the past 2 months (1 to 2 months ago)
3. Within the past 6 months (3 to 6 months ago)
4. Within the past year (7 to 12 months ago)
5. Within the past 5 years (1 to 5 years ago)
6. Within the past 10 years (>5 years but <= 10 years ago)
7. Over 10 years ago
8. Never smoked cigars regularly
777. *Don't Know/Not Sure*
999. *Refused*

ASK Q85 TO EVERPIPE WHO ARE NOT ALSO CURRPIPE RESPONDENTS

85. About how long has it been since you last smoked tobacco in a pipe?

1. Less than 1 month
2. Within the past 2 months (1 to 2 months ago)
3. Within the past 6 months (3 to 6 months ago)
4. Within the past year (7 to 12 months ago)
5. Within the past 5 years (1 to 5 years ago)
6. Within the past 10 years (>5 years but <= 10 years ago)
7. Over 10 years ago
8. Never smoked tobacco in a pipe regularly
777. *Don't Know/Not Sure*
999. *Refused*

ASK Q86 TO EVERBIDI WHO ARE NOT ALSO CURRBIDI RESPONDENTS

86. About how long has it been since you last smoked a bidi?

1. Less than 1 month
 2. Within the past 2 months (1 to 2 months ago)
 3. Within the past 6 months (3 to 6 months ago)
 4. Within the past year (7 to 12 months ago)
 5. Within the past 5 years (1 to 5 years ago)
 6. Within the past 10 years (>5 years but <= 10 years ago)
 7. Over 10 years ago
 8. Never smoked bidis regularly
 777. *Don't Know/Not Sure*
 999. *Refused*
-

ASK Q87 TO EVERKRETEK WHO ARE NOT ALSO CURRKRETEK RESPONDENTS

87. About how long has it been since you last smoked a kretek?

1. Less than 1 month
 2. Within the past 2 months (1 to 2 months ago)
 3. Within the past 6 months (3 to 6 months ago)
 4. Within the past year (7 to 12 months ago)
 5. Within the past 5 years (1 to 5 years ago)
 6. Within the past 10 years (>5 years but <= 10 years ago)
 7. Over 10 years ago
 8. Never smoked cigarettes regularly
777. *Don't Know/Not Sure*
999. *Refused*
-

REASONS FOR QUITTING AND RELAPSE

ASK Q88 TO FORMERSMOKER OR CURRENTSMOKER RESPONDENTS

88. I am going to read a list of reasons some people have for quitting for smoking. For each, tell me if it...

[IF FORMER... RESPONDENT ASK]...was a reason why you tried to quit smoking?

[IF CURRENT... RESPONDENT ASK]...is a reason that might motivate you to want quit smoking some day?

Read List: [randomize order]

1. Information about health hazards
 2. Health problems you experienced related to tobacco use
 3. Cost of tobacco
 4. Test of will power
 5. To be an example to my children
 6. Smoking related illness of a friend or relative
 7. Physical fitness
 8. Advice of a doctor
 9. Encouragement of a friend or relative
 10. Restrictions on smoking in my workplace
 11. Restrictions on smoking in my home
 12. Restrictions on smoking in public places/bars/restaurants, etc
 13. Smell, taste, or looks
 14. Pregnancy
 15. Other (Please specify: _____)
 777. *Don't Know/Not Sure*
 999. *Refused*
-

- 88A. If Q88 does not equal "777" or "999" then follow up by asking: "Of the reasons you told me, which reason is most important to you as a reason for quitting smoking?"

1. Information about health hazards
 2. Health problems you experienced related to tobacco use
 3. Cost of tobacco
 4. Test of will power
 5. To be an example to my children
 6. Smoking related illness of a friend or relative
 7. Physical fitness
 8. Advice of a doctor
 9. Encouragement of a friend or relative
 10. Restrictions on smoking in my workplace
 11. Restrictions on smoking in my home
 12. Smell, taste, or looks
 13. Pregnancy
 14. Other (Please specify: _____)
 777. *Don't Know/Not Sure*
 999. *Refused*
-

ASK Q88_2 TO CURRSMOKELESS OR FORMERSMOKELESS RESPONDENTS

88_2. I am going to read a list of reasons some people have for quitting for smokeless tobacco. For each, tell me if it...

[IF FORMER...RESPONDENT SAY]...was a reason why you tried to quit smoking?
[IF CURRENT...RESPONDENT SAY]...is a reason that might motivate you to want quit smokeless tobacco some day?

Read List: [randomize order]

1. Information about health hazards
 2. Health problems you experienced related to tobacco use
 3. Cost of tobacco
 4. Test of will power
 5. To be an example to my children
 6. Smoking related illness of a friend or relative
 7. Physical fitness
 8. Advice of a doctor
 9. Encouragement of a friend or relative
 10. Restrictions on smoking in my workplace
 11. Restrictions on smoking in my home
 12. Restrictions on smoking in public places/bars/restaurants, etc
 13. Smell, taste, or looks
 14. Pregnancy
 15. Other (Please specify: _____)
 777. *Don't Know/Not Sure*
 999. *Refused*
-

88A_2. If Q88 does not equal "777" or "999" then follow up by asking: "Of the reasons you told me, which reason is most important to you as a reason for quitting smoking?"

1. Information about health hazards
 2. Health problems you experienced related to tobacco use
 3. Cost of tobacco
 4. Test of will power
 5. To be an example to my children
 6. Smoking related illness of a friend or relative
 7. Physical fitness
 8. Advice of a doctor
 9. Encouragement of a friend or relative
 10. Restrictions on smoking in my workplace
 11. Restrictions on smoking in my home
 12. Smell, taste, or looks
 13. Pregnancy
 14. Other (Please specify: _____)
 777. *Don't Know/Not Sure*
 999. *Refused*
-

ASK Q89 TO (EVERTRIEDSMOKE WHO ARE ALSO CURRENTSMOKER) OR
(EVERTRIEDCHEW WHO ARE ALSO CURRENTCHEW) RESPONDENTS

89. I am going to read a list of reasons some people have for starting to use tobacco again after they had tried to quit. Which of these was most important to you as a reason for why you started using tobacco again?

Read List:

1. Fear of gaining weight
 2. Actual weight gain
 3. Headaches, irritability, difficulty concentrating, drowsiness
 4. Bored, blue, depressed
 5. Nervous, tense, angry, frustrated, stress
 6. Stressful life event
 7. Pressure from others to smoke
 8. No support from others
 9. Habit, situation where used to smoke regularly
 10. Addiction, craving
 11. Pleasure of smoking, enjoy it
 12. Others smoking around me
 13. Not ready to quit, didn't want to quit
 14. Didn't try hard enough
 15. Any mention of alcohol
 20. Other [Please specify: _____]
 777. *Don't Know/Not Sure*
 999. *Refused*
-

CONTEXTS OF TOBACCO USE

ALL RESPONDENTS

90. How many of your four closest friends use any tobacco products?

- _____ Number of my four closest friends who use tobacco products
888. I don't have at least four close friends
777. *Don't Know/Not Sure*
999. *Refused*
-

ALL RESPONDENTS

91. My next question is about your family (i.e. parents, spouses, brothers, sisters, or children). Does a family member close to you currently smoke or use other forms of tobacco?

1. Yes
2. No
3. There is no family member close to me
777. *Don't Know/Not Sure*
999. *Refused*
-

ALL RESPONDENTS

92. Would you say that nicotine is...?

1. Not at all addicting
2. Not very addicting
3. Somewhat addicting
4. Very addicting
777. *Don't Know/Not Sure*
999. *Refused*
-

ASK Q94 TO MINORHOUSE WHO ARE ALSO (CURRENTSMOKER OR CURRENTCHEW)
RESPONDENTS

94. Have your children talked with you about stopping...

94A. [IF CURRENTSMOKER ASK] ...smoking?

1. Yes
2. No
3. Children are too young
777. *Don't Know/Not Sure*
999. *Refused*

If Q94a=3 skip 94b

94B. [IF CURRENTCHEW ASK] ...your use of smokeless tobacco?

- 1. Yes
 - 2. No
 - 3. Children are too young
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

FAMILY INFLUENCES ON TOBACCO USE

ALL RESPONDENTS

96. Thinking about the rules you have in your household, which one of the following statements best describes the ground rules in your family regarding tobacco use?

Read List:

1. Tobacco use is not tolerated in our family
2. Tobacco use is OK for me only
3. Tobacco use is OK for me and for other adults, but not for children (minors)
4. The child can use tobacco in the house
5. The child can use tobacco outside the house only
6. We have no rules about tobacco
777. *Don't Know/Not Sure*
999. *Refused*

ASK Q97 IF MINORHOUSE RESPONDENTS

97. How old is the oldest child living with you who is not yet eighteen years old?

- _____ Years old [Range 0-17]
777. *Don't Know/Not Sure*
999. *Refused*
-

- 97A. If Q97 greater than "8" and less than "18" follow up by asking: Which of the following best describes the way you have talked to this child about the ground rules regarding tobacco use?

1. The child and I have talked about the rules
 2. The child knows how I feel about tobacco use, but I don't remember a specific conversation
 3. The child and I have not talked about the rules/it will not be discussed
 4. The child is too young, we will discuss it when he/she is older
 5. The child is too young, and it will not be discussed
 777. *Don't Know/Not Sure*
 999. *Refused*
-

IF Q97A=1 ASK:

- 97B. If Q97 greater than "8" and less than "18" follow up by asking: During the last 6 months, how many times have you talked to this child about what he/she can or cannot do when it comes to tobacco?

1. Never
 2. Once
 3. Twice
 4. Three or more times
 777. *Don't Know/Not Sure*
 999. *Refused*
-

ALL RESPONDENTS

98. If you were the parent of a teenager how would you feel about your teenager smoking cigarettes? On a scale from 1-10 where 1 means "don't care" and 10 means "strongly disapprove," which number would you choose?

____ Scale Number
777. *Don't Know/Not Sure*
999. *Refused*

ALL RESPONDENTS

99. How important is it that laws which prohibit the sale of tobacco products to minors be enforced?

1. Very important
2. Somewhat important
3. Not very important
4. Not at all important
777. *Don't Know/Not Sure*
999. *Refused*

RISK PERCEPTION

ALL RESPONDENTS

103. I'm going to read you a series of statements. After I finish each [each statement], please tell me whether you strongly agree, agree, disagree, or strongly disagree with the statement.

103A. If a person has smoked a pack of cigarettes a day for more than 20 years, there is LITTLE health benefit to quitting smoking.

- 1. Strongly agree
- 2. Somewhat agree
- 3. Somewhat disagree
- 4. Strongly disagree
- 777. *Don't Know/Not Sure*
- 999. *Refused*

103B. Smoking is physically addictive.

- 1. Strongly agree
- 2. Somewhat agree
- 3. Somewhat disagree
- 4. Strongly disagree
- 777. *Don't Know/Not Sure*
- 999. *Refused*

103C. Smoking light cigarettes is safer than smoking regular cigarettes.

- 1. Strongly agree
- 2. Somewhat agree
- 3. Somewhat disagree
- 4. Strongly disagree
- 777. *Don't Know/Not Sure*
- 999. *Refused*

103D. Smoking by pregnant women may harm the baby.

- 1. Strongly agree
- 2. Somewhat agree
- 3. Somewhat disagree
- 4. Strongly disagree
- 777. *Don't Know/Not Sure*
- 999. *Refused*

ALL RESPONDENTS

104. Would you say that breathing smoke from other people's cigarettes causes...:

Read Questions (randomize):

104A. Lung cancer in adults.

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

104B. Heart disease in adults.

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

104C. Colon cancer in adults.

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

104D. Respiratory problems in children.

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

104E. Sudden Infant Death Syndrome (SIDS).

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-

MEDIA AND TOBACCO

ALL RESPONDENTS

106. During the past 30 days, how often have you seen or heard commercials on TV, the Internet, or on the radio about the dangers of smoking?

1. Not in the past 30 days
 2. 1 to 3 times in the past 30 days
 3. 1 to 3 times per week
 4. Daily or almost daily
 5. More than once a day
 6. Did not watch/listen to TV, radio, or Internet in past 30 days
 777. *Don't Know/Not Sure*
 999. *Refused*
-

ALL RESPONDENTS

107. During the past 30 days, when you listened to the radio, how often did you hear "Smoking Stops Here" anti-smoking commercials?

1. Not in the past 30 days
 2. 1 to 3 times in the past 30 days
 3. 1 to 3 times per week
 4. Daily or almost daily
 5. More than once a day
 6. Did not listen to the radio in past 30 days
 777. *Don't Know/Not Sure*
 999. *Refused*
-

ALL RESPONDENTS

108. During the past 30 days, when you listened to the radio, how often did you hear "1-800-QUIT-NOW" smoking cessation commercials?

1. Not in the past 30 days
 2. 1 to 3 times in the past 30 days
 3. 1 to 3 times per week
 4. Daily or almost daily
 5. More than once a day
 6. Did not listen to the radio in past 30 days
 777. *Don't Know/Not Sure*
 999. *Refused*
-

Initiation of Tobacco Use

ASK Q109 TO AGELESS30 WHO ARE ALSO NEVER100SMOKER RESPONDENTS

109. Have you ever smoked a cigarette, even one or two puffs?

- 1. Yes
 - 2. No
 - 777. *Don't Know/Not Sure*
 - 999. *Refused*
-



Appendix C

Definition of Race, Education, Income and Region

Definition of Race, Education, Income and Region

Race

Race was defined using a combination of three questions: 1) Are you Hispanic or Latino? (Question 5), 2) Which one or more of the following would you say is your race? (Question 4), and 3) Which one of these groups would you say best represents your race? (Question 4A). A hierarchy was imposed on the response categories to assign respondents one racial/ethnic category for analytical purposes. During the survey, if a respondent indicated only one race/ethnicity response in the multiple response question, the respondent was not asked the “which best describes” race question. However, when a respondent indicated more than one racial/ethnic group in the multiple response question, they then were asked the “which best describes” question.

The process for this assignment is as follows:

```
/*Calculate single race variable for analysis purposes*/
if q4a=. then race = q4;
else race=q4a;
/* recode race to change order and add hispanic descent*/
if q5=1 then race2=3; /* Hispanic takes priority */
else do;
if race=1 then race2=1; /* White */
else if race=2 then race2=2; /* Black */
else if race=3 then race2=5; /* Asian */
else if race=4 then race2=6; /* Native Hawaiian or Other Pacific Islander as Other */
else if race=5 then race2=4; /* American Indian */
else if race=6 then race2=6; /* Other */
else race2=.;
end;
```

Education

To remain consistent with the previous report using the 2006 Maryland Adult Tobacco Survey (Maryland Department of Health and Mental Hygiene, 2007), education was defined using a combination of three questions: 1) What is the highest grade or year of school you have completed? (Question 10), and 2) What is your age? (Question 6). Respondents under 25 were excluded and the coding is as follows:

```
/*Exclude respondents under 25*/
if Q6>24 then do;
/* Recode Question 10 into 4 categories*/
if 1 <= Q10 <=3 then educa=1; /*Not High School Graduate*/
if Q10=4 then educa=2; /*High School Graduate*/
```

```
if Q10=5 then educa=3; /*Some College*/  
if Q10=6 then educa=4; /*College Graduate*/  
end;
```

Income

During the survey, respondents were only asked about their individual income. Income was defined using Question 11: Is your annual income from all sources...?

And the coding is as follows:

```
if 1<= Q11<=6 then income=1; /*<$50,000*/  
/*Respondents said no to "Less than $75,000" were recorded as "8"*/  
if 7<=Q11<=8 then income=2; /*$50,000+*/
```

Region

Six regions were identified with information in the county residence of the respondent.

- o Baltimore Region (Anne Arundel, Harford, Baltimore County, Howard, Carroll, Baltimore City)
- o Suburban Washington Region (Frederick, Montgomery, Prince George's)
- o Southern Maryland Region (Calvert, Charles, St. Mary's)
- o Western Maryland Region (Allegany, Garrett, Washington)
- o Upper Eastern Shore (Caroline, Cecil, Kent, Queen Anne's, Talbot)
- o Lower Eastern Shore (Dorchester, Somerset, Wicomico, Worcester)

Reference:

- Maryland Department of Health and Mental Hygiene. *Monitoring Changing Tobacco-use Behaviors in Maryland*, November, 2007. Available at: <http://www.crf.state.md.us/html/stats.cfm>

