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MORBIDITY AND MORTALITY WEEKLY REPORT

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Role of Media in Tobacco Control — World No-Tobacco Day, 1994

The mass media have played an important role in efforts to control and prevent tobacco use. To recognize the effectiveness of these efforts, the theme of the seventh World No-Tobacco Day, to be held May 31, 1994, is "The Media and Tobacco: Getting the Health Message Across." Activities will include press releases, videotape presentations, educational symposia, and radio announcements by World Health Organization experts on tobacco control.

The need for collaboration between public health workers and media representatives is particularly urgent in developing countries in which the prevalence of tobacco use is increasing. In these countries, the dissemination of information through the media also can assist in the development of educational and legislative measures to prevent and control tobacco use (1,2) and may help reduce the success of aggressive marketing campaigns by transnational tobacco companies. Examples of collaboration between the media and the tobacco-control groups in some countries include successful smoking-cessation and health-education campaigns (e.g., in Estonia, Finland, and New Guinea) and decisions by certain media to refuse cigarette advertising (e.g., in Australia, Canada, and the United States).

Additional information about World No-Tobacco Day 1994 is available from the Office of Information and Public Affairs, Pan American Health Organization (telephone [202] 861-3458) or from CDC's Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion (telephone [404] 488-5705).

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Current Trends

Cigarette Smoking Among Adults — United States, 1992, and Changes in the Definition of Current Cigarette Smoking

Use of tobacco in the United States is monitored continually by CDC to evaluate efforts to control and prevent the use of this substance. The prevalence of cigarette smoking among U.S. adults decreased from 1965 to 1990 (from 42.4% to 25.5%) and remained stable from 1990 to 1991 (from 25.5% to 25.6%) (1). To determine the prevalence of smoking among adults during 1992, the National Health Interview Survey—Cancer Control and Epidemiology Supplements (NHIS-CCES) collected self-reported information on cigarette smoking from a random sample of civilian, non-institutionalized adults aged ≥ 18 years. For 1992, the definition used to assess self-reported smoking prevalence was changed to more accurately assess some-day (i.e., intermittent) smoking because of a recognized higher prevalence of intermittent smoking (2). This report presents the prevalence estimates for 1992, compares findings with 1991, and assesses the impact of changes in the definition of current smoker on these estimates.

The overall response rate for the 1992 NHIS-CCES ($n=24,040$) was 86.5%. For 1992, two nationally representative random samples from the NHIS-CCES were used to assess the new definition of current smoking status that included intermittent smoking. The Cancer Control Supplement (CCS) ($n=12,035$) asked, "Have you smoked at least 100 cigarettes in your entire life?" and "Do you smoke cigarettes now?" Persons who said they did not smoke now were asked, "Do you now smoke cigarettes not at all or some days?" Current smokers were defined as those who had smoked 100 cigarettes and smoked now; persons who said they did not smoke now but subsequently stated they smoked on some days were also classified as current smokers. The Cancer Epidemiology Supplement (CES) ($n=12,005$) asked, "Have you smoked at least 100 cigarettes in your entire life?" and "Do you now smoke cigarettes every day, some days or not at all?" Current smokers were defined as those who had smoked 100 cigarettes and now smoked either every day or some days. Data were adjusted for nonresponse and weighted to provide national estimates. Confidence intervals (CIs) were calculated using standard errors generated by the Software for Survey Data Analysis (SUDAAN) (3).

Because the first two questions were the same for the 1991 NHIS—Health Promotion and Disease Prevention supplement and the 1992 CCS, these findings were compared directly. The overall prevalence of cigarette smoking among adults (25.6%) was the same in 1991 and 1992 (Table 1). The 1992 estimates that incorporated some-day smoking (CCS and CES) also were compared with 1991 and 1992 estimates based on the original definition. Estimates for both sets of definitions that incorporated an assessment of some-day smoking in 1992 were similar (CCS=26.7% and CES=26.3%) (Table 1). Because of the comparability of methods (i.e., assessing some-day smoking), results were combined to provide an overall prevalence estimate for 1992. Based on the inclusion of intermittent smoking, the prevalence of smoking increased by 0.9% (from 25.6% to 26.5%) (Table 1).

In 1992, an estimated 48 million (26.5% [95% CI= $\pm 0.5\%$]) adults in the United States were current smokers, reflecting prevalences of daily smoking of 22.1% (95%

TABLE 1. Percentage of adults aged ≥18 years who were current cigarette smokers*, by sex, age group, race/ethnicity, level of education, and socioeconomic status — United States, National Health Interview Survey, 1991 and 1992†

Characteristic	1991 Original (HPDP [§]) (n=43,154)		1992 Original (CCS [¶]) (n=11,875)		1992 Interim (CCS) (n=11,865)		1992 Revised (CES ^{**}) (n=11,881)		1992 Combination (CCS/CES) (n=23,746)	
	%	(95% CI ^{††})	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Sex										
Men	28.1	(±0.6%)	28.0	(±1.1%)	29.3	(±1.1%)	28.0	(±1.1%)	28.6	(±0.8%)
Women	23.5	(±0.5%)	23.5	(±0.9%)	24.3	(±1.0%)	24.8	(±0.9%)	24.6	(±0.7%)
Age group (yrs)										
18–24	22.9	(±1.2%)	24.4	(±2.2%)	25.8	(±2.3%)	27.1	(±2.3%)	26.4	(±1.6%)
25–44	30.4	(±0.6%)	29.7	(±1.1%)	30.9	(±1.1%)	30.6	(±1.1%)	30.8	(±0.8%)
45–64	26.8	(±0.8%)	27.3	(±1.4%)	28.2	(±1.4%)	26.4	(±1.4%)	27.3	(±1.0%)
≥65	13.3	(±0.7%)	13.3	(±1.3%)	13.7	(±1.3%)	14.2	(±1.3%)	14.0	(±0.9%)
Race/Ethnicity^{§§}										
White	26.0	(±0.4%)	26.2	(±0.8%)	27.1	(±0.8%)	27.3	(±0.8%)	27.2	(±0.6%)
Black	29.4	(±1.3%)	27.0	(±2.3%)	28.4	(±2.4%)	27.3	(±2.3%)	27.8	(±1.7%)
Hispanic	20.1	(±1.5%)	20.4	(±2.7%)	22.5	(±2.9%)	18.7	(±2.4%)	20.7	(±1.9%)
American Indian/ Alaskan Native ^{¶¶}	31.9	(±3.7%)	36.5	(±7.6%)	36.5	(±7.6%)	41.9	(±8.8%)	39.4	(±6.0%)
Asian/Pacific Islander	15.9	(±3.1%)	16.9	(±5.7%)	17.9	(±5.8%)	12.2	(±4.1%)	15.2	(±3.6%)
Education level (yrs)										
<12	32.0	(±0.9%)	32.2	(±1.6%)	33.4	(±1.6%)	30.3	(±1.6%)	31.8	(±1.1%)
12	29.9	(±0.6%)	29.8	(±1.2%)	30.6	(±1.2%)	31.4	(±1.3%)	31.0	(±0.9%)
13–15	23.4	(±0.9%)	23.8	(±1.6%)	24.8	(±1.6%)	23.3	(±1.5%)	24.1	(±1.1%)
≥16	13.6	(±0.7%)	13.4	(±1.3%)	14.5	(±1.3%)	16.5	(±1.4%)	15.5	(±1.0%)
Socioeconomic status^{***}										
At/Above poverty level	24.7	(±0.4%)	24.2	(±0.8%)	25.2	(±0.8%)	25.7	(±0.8%)	25.4	(±0.6%)
Below poverty level	33.1	(±1.5%)	37.0	(±2.1%)	38.4	(±2.1%)	31.4	(±2.0%)	34.9	(±1.5%)
Unknown	26.0	(±1.3%)	26.2	(±2.1%)	27.0	(±2.2%)	26.7	(±2.2%)	26.9	(±1.6%)
Total	25.6	(±0.4%)	25.6	(±0.7%)	26.7	(±0.8%)	26.3	(±0.7%)	26.5	(±0.5%)

* Persons who reported having smoked at least 100 cigarettes and who were currently smoking based on one of the following definitions: "Original" definition: Smoke now; "Interim" definition: Smoke now, or do not smoke now but on further questioning reported smoking some days; "Revised" definition: Smoke every day or some days now; "Combination" definition: Combined prevalence using the interim and revised prevalence estimates.

† Excludes 578 respondents in 1991 and 285 respondents in 1992 with unknown smoking status.

§ Health Promotion and Disease Prevention supplement.

¶ Cancer Control Supplement.

** Cancer Epidemiology Supplement.

†† Confidence interval.

§§ Excludes 317 respondents in 1991 and 252 respondents in 1992 in unknown, multiple, and other race categories.

¶¶ Estimates should be interpreted with caution because of the small number of respondents.

*** Poverty statistics are based on definitions originated by the Social Security Administration in 1964, subsequently modified by federal interagency committees in 1969 and 1980, and prescribed by the Office of Management and Budget as the standard to be used by federal agencies for statistical purposes.

Cigarette Smoking — Continued

CI=±0.5%) and some-day smoking of 4.4% (95% CI=±0.2%). Smoking prevalence was highest among persons aged 25–44 years (30.8% [95% CI=±0.8%]). Smoking prevalence was highest among American Indians/Alaskan Natives (39.4% [95% CI=±6.0%]) and lowest among Asians/Pacific Islanders (15.2% [95% CI=±3.6%]), declined with increasing levels of education, and was highest among persons who lived below the poverty level* (34.9% [95% CI=±1.5%]). Approximately 25 million men (28.6% [95% CI=±0.8%]) and 23 million women (24.6% [95% CI=±0.7%]) were current smokers (Table 2). For most demographic groups, smoking prevalence was higher among men than women.

Using the original definition of current smoking, smoking prevalence was the same in 1991 and 1992 overall, for both men and women, for all racial/ethnic groups, for all educational levels, and for persons with incomes above the poverty level (Table 1). Smoking prevalence was significantly higher in 1992 (37.0% [95% CI=±2.1%]) than in 1991 (33.1% [95% CI=±1.5%]) among persons living below the poverty level. However, among persons with incomes below the poverty level, there were substantial differences in smoking prevalence as measured by the two question formats that included some-day smokers. As a result, the combined prevalence estimate for 1992 was not significantly different from the 1991 estimate.

Reported by: Surveillance Program, National Cancer Institute. National Institutes of Health. Epidemiology Br, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion; Div of Health Interview Statistics, National Center for Health Statistics, CDC.

Editorial Note: The findings in this report indicate that the estimated prevalence of smoking in 1992 was the same as in 1991 overall and for most demographic groups. In addition, these findings indicate that including some-day smoking in the definition of current smoking will increase the prevalence estimate by approximately 1.0%. The definition used in the 1992 CES will become the standard for CDC efforts to measure smoking prevalence in the United States. The inclusion of intermittent smoking improves both the accuracy and precision of the definition of current smoking and facilitates efforts to monitor changes in current smoking status.

Based on use of the original definition of current smoker, which did not assess some-day smoking, the prevalence of smoking in 1992 was significantly higher than in 1991 among persons living below the poverty level. This finding was attributable to a substantial increase in the prevalence of smoking among women who live below the poverty level and to a smaller increase among men. The impact of changes in the question format that incorporated an assessment of some-day smoking substantially altered the prevalence estimates for persons living below the poverty level. Specifically, in the CCS survey—which used a two-part question to assess some-day smoking—smoking prevalence increased among persons living below the poverty level. In comparison, in the CES survey—which used a single question to assess some-day smoking—there was no change in smoking prevalence.

For the first time since 1983, smoking prevalence among persons aged 18–24 years did not decrease. Factors that may have contributed to the stabilization include the

*Poverty statistics are based on definitions originated by the Social Security Administration in 1964, subsequently modified by federal interagency committees in 1969 and 1980, and prescribed by the Office of Management and Budget as the standard to be used by federal agencies for statistical purposes.

TABLE 2. Percentage of men and women aged ≥ 18 years who were current cigarette smokers*, by race/ethnicity, level of education, age group, and socioeconomic status — United States, National Health Interview Survey, 1991 and 1992†

Characteristic	Men						Women					
	1991		1992		1992		1991		1992		1992	
	Original (HPDP [§]) (n=18,050)	(95% CI ^{††})	Original (CCS [¶]) (n=5,000)	(95% CI)	Combined (CCS/CES ^{***}) (n=10,061)	(95% CI)	Original (HPDP) (n=25,104)	(95% CI)	Original (CCS) (n=6,875)	(95% CI)	Combined (CCS/CES) (n=13,685)	(95% CI)
Race/Ethnicity^{§§}												
White	27.5	($\pm 0.7\%$)	27.9	($\pm 1.2\%$)	28.6	($\pm 0.9\%$)	24.6	($\pm 0.6\%$)	24.6	($\pm 1.0\%$)	25.9	($\pm 0.8\%$)
Black	35.5	($\pm 2.1\%$)	32.2	($\pm 3.6\%$)	32.3	($\pm 2.8\%$)	24.5	($\pm 1.5\%$)	22.9	($\pm 2.8\%$)	24.1	($\pm 2.0\%$)
Hispanic	25.2	($\pm 2.7\%$)	22.2	($\pm 3.9\%$)	23.6	($\pm 2.9\%$)	15.5	($\pm 1.7\%$)	18.6	($\pm 3.3\%$)	18.0	($\pm 2.3\%$)
American Indian/ Alaskan Native ^{¶¶}	27.5	($\pm 4.9\%$)	36.2	($\pm 13.3\%$)	39.0	($\pm 10.4\%$)	36.7	($\pm 5.8\%$)	36.7	($\pm 8.5\%$)	39.8	($\pm 6.8\%$)
Asian/Pacific Islander	24.1	($\pm 4.8\%$)	30.8	($\pm 10.4\%$)	26.3	($\pm 6.4\%$)	7.1	($\pm 2.9\%$)	3.2	($\pm 2.2\%$)	4.0	($\pm 2.0\%$)
Education level (yrs)												
<12	37.4	($\pm 1.4\%$)	37.8	($\pm 2.4\%$)	36.9	($\pm 1.8\%$)	27.4	($\pm 1.2\%$)	27.4	($\pm 1.9\%$)	27.5	($\pm 1.4\%$)
12	33.5	($\pm 1.0\%$)	33.8	($\pm 1.9\%$)	34.4	($\pm 1.3\%$)	27.1	($\pm 0.8\%$)	26.6	($\pm 1.6\%$)	28.2	($\pm 1.1\%$)
13–15	25.1	($\pm 1.3\%$)	24.8	($\pm 2.5\%$)	25.2	($\pm 1.7\%$)	22.0	($\pm 1.0\%$)	22.9	($\pm 2.0\%$)	23.1	($\pm 1.4\%$)
16	14.5	($\pm 1.0\%$)	13.8	($\pm 2.0\%$)	16.2	($\pm 1.4\%$)	12.5	($\pm 1.0\%$)	13.0	($\pm 1.8\%$)	14.6	($\pm 1.4\%$)
Age group (yrs)												
18–24	23.5	($\pm 1.7\%$)	26.0	($\pm 3.5\%$)	28.0	($\pm 2.5\%$)	22.4	($\pm 1.6\%$)	22.9	($\pm 2.6\%$)	24.9	($\pm 2.0\%$)
25–44	32.9	($\pm 0.9\%$)	31.3	($\pm 1.7\%$)	32.8	($\pm 1.2\%$)	28.0	($\pm 0.8\%$)	28.0	($\pm 1.4\%$)	28.8	($\pm 1.1\%$)
45–64	29.3	($\pm 1.1\%$)	30.1	($\pm 2.1\%$)	28.6	($\pm 1.5\%$)	24.6	($\pm 1.0\%$)	24.7	($\pm 1.9\%$)	26.1	($\pm 1.3\%$)
≥ 65	15.1	($\pm 1.2\%$)	15.8	($\pm 2.3\%$)	16.1	($\pm 1.6\%$)	12.0	($\pm 0.7\%$)	11.6	($\pm 1.6\%$)	12.4	($\pm 1.1\%$)
Socioeconomic status^{***}												
At/Above poverty level	26.8	($\pm 0.7\%$)	26.2	($\pm 1.2\%$)	27.1	($\pm 0.9\%$)	22.7	($\pm 0.6\%$)	22.3	($\pm 1.1\%$)	23.8	($\pm 0.8\%$)
Below poverty level	39.3	($\pm 2.3\%$)	42.5	($\pm 3.4\%$)	39.7	($\pm 2.6\%$)	29.3	($\pm 1.7\%$)	33.5	($\pm 2.4\%$)	31.7	($\pm 1.7\%$)
Unknown	31.0	($\pm 2.3\%$)	33.1	($\pm 3.6\%$)	33.8	($\pm 2.7\%$)	22.4	($\pm 1.5\%$)	21.3	($\pm 2.5\%$)	22.1	($\pm 1.8\%$)
Total	28.1	($\pm 0.6\%$)	28.0	($\pm 1.1\%$)	28.6	($\pm 0.8\%$)	23.5	($\pm 0.5\%$)	23.5	($\pm 0.9\%$)	24.6	($\pm 0.7\%$)

* Persons who reported having smoked at least 100 cigarettes and who were currently smoking based one of the following definitions: "Original" definition: Smoke now; "Interim" definition: Smoke now, or do not smoke now but on further questioning reported smoking some days; "Revised" definition: Smoke every day or some days now; "Combination" definition: Combined prevalence using the interim and revised prevalence estimates.

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Cigarette Smoking — Continued

steady growth in market share of discount cigarettes (4) and the \$4.6 billion in advertising and promotional expenditures by tobacco companies during 1991—a 16% increase in expenditures when compared with 1990 (5,6). Efforts to address smoking among young persons have included the 1994 Surgeon General's report (6) and a companion report for adolescents. In addition, CDC has published school guidelines for incorporating tobacco-use prevention and tobacco-cessation strategies (7).

The findings in this report are subject to at least two limitations. First, the prevalence estimate for 1992 was based on information collected from January through July 1992. In comparison, a different survey that collected data for the entire year indicated that smoking prevalence among adults declined in the second half of the year (Substance Abuse and Mental Health Services Administration, unpublished data, 1992), a finding consistent with a 3% per capita decrease in consumption of cigarettes in 1992 (8). Second, differences in prevalence among racial/ethnic groups may be influenced by differences in educational levels and socioeconomic status, as well as by social and cultural phenomena that require further explanation.

Acceleration of the decline in smoking prevalence will require intensified efforts to discourage the use of tobacco by helping smokers break the addiction to nicotine, persuading children to never initiate smoking, and enacting public policies that discourage smoking. Examples of such policies include increasing taxes on tobacco products, enforcing minors'-access laws, restricting smoking in public places, and restricting tobacco advertising and promotion. In January 1994, for the first time, all 50 states and the District of Columbia were receiving public funds for tobacco-control activities: 49 states and the District of Columbia were receiving federal funds, and California was receiving state funds.

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