District of Columbia
Communities Putting Prevention to Work
Tobacco Use

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Vincent C. Gray, Mayor

DEPARTMENT OF HEALTH
Joxel Garcia, MD., MBA, Acting Director

CENTER FOR POLICY, PLANNING AND EVALUATION
Fern Johnson-Clarke, PhD, Senior Deputy Director
John Davies-Cole, PhD, MPH, State Epidemiologist

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM
Tracy Garner, Program Coordinator

PUBLIC INFORMATION OFFICER
Najma Roberts

AUTHORS
Tracy Garner, BRFSS Program Coordinator
Tilahun Kassaye, MPH Candidate
Tasha Lewis, Data Analyst

EDITORS
Fern Johnson-Clarke, PhD
John O. Davies-Cole, PhD, MPH
Najma Roberts

SPECIAL THANKS
Denise Grant, M.DIV, MA, Project Director
Tobacco Control Program

Bonita McGee
Tobacco Control Program

Joelle Robinson,
Tobacco Control Program

ICF Macro International, Contractor
District of Columbia
Behavioral Risk Factor Surveillance System
Communities Putting Prevention to Work survey

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Executive Summary

Based on current cigarette smoking patterns, an estimated 25 million Americans who are alive today will die prematurely from smoking-related illnesses, including 5 million people younger than 18 years of age.[1] The District of Columbia, Tobacco Control Program has made great strides in decreasing cigarette smoking among youth and adults despite the many challenges that are unique to the city. However, more work is required to meet the National Healthy People target to reduce cigarette smoking among adults to 12% and youth 12-17 years to 4.2%.

This report provides a snapshot of the District's current tobacco population and policies implemented in addition to regulations that aid in the decrease of tobacco use.

Some key Facts about Tobacco Use in Washington, DC:

- 400 youth (under 18 years) who become new daily smokers each year [2]
- 40,000 youth are exposed to secondhand smoke at home [2]
- 1.0 million packs of cigarettes are bought or smoked by youth each year [2]
- 15.6% of adults in Washington, DC smoke
- 720 adults die each year from their own smoking [2]
- 8,000 youth now under 18 years who live in Washington, DC will ultimately die prematurely from smoking [2]
- $243 million annual health care cost in Washington, DC directly caused by smoking [2]
- $78 million paid covered by the DC Medicaid program for smoking related illness [2]
- $592 per household residents' state and federal tax burden from DC residents for smoking-caused government expenditures [2]
- $232 million smoking-caused productivity losses in Washington, DC [2]
- $13.5 million estimated tobacco marketing expenditures in Washington, DC marketing each year[2]
- 23.6% of Ward 8 residents are current smokers (BRFSS/CPPW survey); highest among all wards
- 5.7% of Ward 3 residents are current smokers (BRFSS/CPPW survey); lowest among all wards
- 7% of residents are exposed to secondhand smoke at their workplace between 1-7 days
- 19% of residents are aware of the telephone quitline services
- 29.2% of residents called the telephone quitline when trying to quit smoking
- 13% of residents used some type of program to help them quit smoking
- 11.6% of residents have used a one-on-one counseling from a health professional to help them quit smoking
- 33.2% of residents used medication to help them quit smoking
- 40.6% of residents have a time frame in mind to quit smoking
- 46.1% of residents plan to quit smoking in the next six months (during time of survey)
- 55% residents who have no children were more likely to be smokers than residents who have children
- Residents who have diabetes were also more likely to be smokers
- Residents who suffered from a myocardial infarction were more likely to be smokers
- Residents who have coronary heart disease were more likely to be smokers

[1] Centers for Disease Control and Prevention. Smoking and Tobacco Use. Tobacco-Related Mortality. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/

[2] Campaign for Tobacco Free Kids - sThe Toll of Tobacco in Washington, DC http://www.tobaccofreekids.org/facts_issues/toll_us/dc. Accessed May 30, 2013

Survey Methodology

Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS is a telephone survey that uses random dialing and is conducted with adults within households containing telephones in the District of Columbia. This methodology for conducting BRFSS surveys is standardized by the CDC and is described in the BRFSS User's Guide and related policy memos. (See CDC website at http://www.cdc.gov/brfss/). ICF Macro, an independent survey research company, collected survey data for the 2010 District of Columbia BRFSS following this methodology summarized below.

The Centers for Disease Control and Prevention (CDC) provided funding to 50 local communities under the Communities Putting Prevention to Work (CPPW) project. The CPPW was designed for local communities to tackle obesity and tobacco use through surveillance and strategic planning efforts. Through these efforts communities can aid in effectively reducing obesity and tobacco use through environmental change at the local level, and making a significant impact on preventing serious health problems, such as heart disease, stroke, type 2 diabetes, and cancer.

Survey Sample

The BRFSS protocol calls for a probability sample of all households with telephones within each participating state or territory. With this method, each household with a telephone in the survey area has a known chance of selection for the study. The 2010 District of Columbia BRFSS accomplished this with a disproportionate stratified random digit dial (RDD) sample based on a list-assisted frame. Marketing Systems Group (MSG), using their proprietary Genesys sampling software, generated the sample for the District of Columbia BRFSS, as they do for all states participating in the BRFSS. The Genesys sample was drawn quarterly from all working banks of District of Columbia telephone numbers, and provided to Macro each month. The sample included both listed and unlisted numbers. The sample was pre-screened for non-working and business numbers.

Behavioral Risk Factor Surveillance System, Communities Putting Prevention to Work Survey Questionnaire

The "*core*" questionnaire consists of a standard set of questions, designed by the CDC, that are included in the survey for every state. Core modules administered for the 2010 District of Columbia Behavioral Risk Factor Surveillance System, Communities Putting Prevention to Work (CPPW) were:

- General Health Status
- Health Care Access
- Exercise
- Cardiovascular Disease Prevalence
- Tobacco Use
- Fruits and Vegetables
- Demographics
- Sugar Sweet Beverages and Menu Labeling
- Disability
- Physical Activity
- Secondhand Smoke
- Smoking Cessation
- Emotional Support and Life Satisfaction
- Mental Illness and Stigma

Interviewing Protocol

A total of 1500 completed interviews were obtained during a three (3) month calling period beginning October 1, 2010 and ending December 31, 2010. Interviewers adhered to the following procedures when contacting households for interviews:

Random Respondent Selection: For each household contacted, one adult was selected for an interview using a household roster and automated random selection process. If that adult was unavailable during the survey period, unable or unwilling to participate, or did not speak English well enough to be interviewed, no survey was conducted.

Contact Attempts: Up to 15 attempts, over a minimum five-day period (typically 15 days), were made to reach each sampled telephone number. Once contact was made at a residence, as many calls as necessary were made to reach the randomly selected adult (within the permitted time schedule). Attempts were made on different days of the week and at different times of day, in a pattern chosen to maximize the likelihood of contact with the minimum number of calls.

No attempts were made to conduct an interview in a household where the randomly selected adult could not be interviewed in English. When a Spanish-speaking individual was contacted, a bilingual interviewer attempted to determine if the selected person was capable of completing the survey in English.

Converting Initial Refusals: Specially trained interviewers re-contacted households that initially refused, at least three days later, to persuade respondents to participate in the survey.

Quality Control Measures: Supervisors monitored 10% of interviews using a remote monitoring feature of the CATI software. During these sessions, the supervisor simultaneously monitored both the interviewer-respondent interaction on the telephone and the data entered by the interviewer into the CATI system; scoring the interviewer on a variety of performance measures. Neither interviewers nor respondents were aware when calls were monitored.

Data Analyses

Data for the 2010 DC CPPW/BRFSS survey were delivered to the CDC each month; the data were then aggregated and weighted after interviewing was completed. Data were weighted to adjust for differences in the probabilities of selection of each respondent. This weight accounted for the probability of selection of a telephone number, the number of adults in a household, and the number of telephones in a household. In this report, all data are weighted unless otherwise noted.

Limitations of the Data

As with any sample survey, depending on the confidence limit selected, the results of the District of Columbia BRFSS can vary from those that would have been obtained with a census of all adults living in telephone-equipped households. The results of this sample survey could differ from the "true" figures because some households cannot be reached and others refused to participate. These non-responding households may differ from respondents (those who actually participate in the survey) in terms of attributes relevant to the study.

The sample-design used in the District of Columbia BRFSS results in a 95% confidence interval. In other words, 95 times out of 100, the BRFSS results will vary no more than a given number of percentage points from the figure that would have been obtained if data had been collected for all adults in District of Columbia households with telephones.

Small Numbers

Small numbers of respondents are also an issue when analyzing data. A difference in the responses of only a few individuals can result in a large difference in percentage of the total for that group. Small numbers of respondents in a group generally occur in one of two ways. First, very few respondents in the total sample have a particular characteristic under analysis. Second, the survey logic limits the number of respondents receiving a particular question, thereby reducing the number of respondents in each analytical unit from that item. Where counts are less than 50 respondents per subgroup, caution should be used in drawing conclusions from the data.

The survey population excludes adults:

- In penal, mental, or other institutions
- Living in group quarters such as dormitories, barracks, convents, or boarding houses
- Contacted at a second home during a stay of less than 30 days
- Who do not speak English well enough to be interviewed
- Living in households without telephones

Youth Risk Behavioral Surveillance System (YRBSS)

YRBSS is a data tool designed to determine the prevalence of health-risk behaviors among high school students; to assess the increase or decrease of behaviors over time, in addition to examining the co-occurrence of health-risk behaviors. Rather than focusing on the determinants of behaviors, the YRBSS focuses on health behaviors (e.g., alcohol and other drug use and sexual behaviors) that are associated with educational and social outcomes, including absenteeism, poor school achievement, and dropping out of school.

Operational Procedures

The DC YRBSS is primarily collected during the fall or spring of each odd-number years. Separate samples and operational procedures are used in the national survey and state and local surveys. The national sample is not an aggregation of the state and local surveys, and state or local estimates cannot be obtained from the national survey. All regular public schools containing 9th, 10th, 11th, and 12th grade were included in the sample. One school was ineligible. Systematic equal probability sampling with a random start was used to select classes from each school that participated in the survey.

Survey Questionnaire Topics:

- Safety
- Bullying
- Tobacco Use
- Marijuana
- Sexual Behaviors
- Food and Drinks
- HIV Education
- Violence Related Behaviors
- Suicide
- Alcohol Use
- Other Illicit Drugs
- Body Weight
- Physical Activity
- Asthma

Sampling and Weighting

Response Rates

The response rates for schools were 100% (19 of the 19) sampled eligible schools sampled participated in the survey. Of the 1,879 students who were sampled, 74% participated (1432) and 1,396 questionnaires were usable after data editing.

The overall response rate was 74% (computed as number of participating schools/number or eligible sampled schools * number of usable questionnaires/number of eligible students sampled in participating schools, rounded to the nearest integer (100% *74% = 74%).

Weighting

W1= the inverse of the probability of selecting the classroom within the school
f1= a student -level nonresponse adjustment factor calculated by class
f2= a post stratification adjustment factor calculated by gender and by race/ethnicity

$$W=W1 * f1 * f2$$

Data Limitations

The YRBSS has multiple limitations:

- Self-report
- Underreporting and over-reporting of behaviors cannot be determined
- Not collected by ward and zip code
- Data only applies to youth who attend school
- Survey addresses behaviors that contribute to the leading causes of morbidity and mortality among youth and adults
- Data is not available among all 50 states

Introduction

Cigarette smoking over the last several years has seen a decline. Despite great efforts, 1 in 5 deaths occur each year in the United States from cigarette smoking. Further, cigarette smoking is estimated to cause 443,000 deaths annually (including deaths from secondhand smoke), 49,400 deaths per year from secondhand smoke exposure, 269,655 deaths annually among men and 173,940 deaths annually among women. [1]

The Communities Putting Prevention to Work (CPPW) was designed for local communities to tackle obesity and tobacco use through surveillance, strategic planning and evidence based modeling in an effort to limit access and exposure to tobacco products among at risk populations. [2]

Communities that are informed with accurate information regarding the harmful effects of tobacco are in a better position to create an environment that is responsive and participatory, and ensures that residents have access to resources that prevent early onset of tobacco use as well as provide tobacco education and smoking cessation resources for current users. Engaging communities in what goes on in their living environment can change many of the cultural norms and attitudes towards smoking.

Over the past several years, legislation has been passed that only to protects the health of current smokers but also individuals exposed to the harmful effects of secondhand smoke. On average, adults who smoke cigarettes will die 14 years earlier than nonsmokers.[2] Exposure to secondhand smoke—sometimes called environmental tobacco smoke—causes nearly 50,000 deaths each year among adults in the United States. Secondhand smoke causes 3,400 annual deaths from lung cancer and causes 46,000 annual deaths from heart disease.[3]

Approximately 3,800 youth under the age of 18 try their first cigarette every day. Since cigarette smoking normally begins for many under the age of 18, many of those users tend to continue to smoke during their adult years.

Over the past several years, policies have been implemented to change how the tobacco industry can market cigarettes. The era of promoting cigarettes on television with the assistance of celebrities has changed. Under the new rules, the FDA [4] will:

- Ban tobacco companies from sponsoring sporting and entertainment events.
- Outlaw free cigarette samples and giveaways of non-tobacco items with the purchase of tobacco.
- Prohibit the sale of cigarettes in packs of fewer than 20, eliminating so-called "kiddie packs" that public health experts say make cigarettes more affordable.
- Restrict tobacco products in vending machines and self-service displays to adult-only facilities, and require stores to place them behind the counter.
- Forbid tobacco sales to children younger than 18 and require photo identification for over-the-counter sales.
- Provide for federal enforcement against violators, ranging from warning letters to criminal penalties.

Despite these efforts, the tobacco industry remains creative with various marketing ploys and has spent $13.5 million in the District of Columbia to attract new users.[5] As older users quit or die of a premature from smoking related illnesses; the tobacco industry has introduced creative but indirect way to attract new smokers who will generate sales revenue. More than 2,500 youth and young adults who have been occasional smokers will become regular smokers on any given day and an estimated one-third of these replacement smokers will die early from smoking.[6]

Global Trend of Tobacco

"Tobacco kills up to half of those who use it. Yet tobacco use is common throughout the world due to low prices, aggressive and widespread marketing, lack of awareness about its dangers, and inconsistent public policies against its use."[7]

According to the World Health Organization:[8]

- Tobacco kills nearly 6 million people each year, of which more than 5 million are users and ex-users and more than 600,000 are nonsmokers exposed to second-hand smoke.
- The annual death toll could rise to more than eight million by 2030 if aggressive action is not taken.
- Nearly 80% of the world's one billion smokers live in low and middle-income countries.
- Consumption of tobacco products is increasing globally despite decreasing in some high-income and upper middle-income countries.

Tobacco Use in the United States

According to the 2012 U.S. Surgeon General report, more than 1,200 people die daily due to smoking. For each of those deaths, at least two youth or young adults become regular smokers each day. Almost 90% of those replacement smokers smoke their first cigarette by age 18.[9]

During the period 2005 – 2010, 1 in 5 (45.3 million) adults in the U.S. were cigarette smokers. The smoking prevalence declined from 20.9% in 2005 to 19.3% in 2010, representing a decline by 3 million. If the decline in smoking continues at the same rate, adult smoking rates will reach approximately 17% by 2020, substantially higher than the Healthy People 2020 target goal of ≤12%.[10]

Among the active adult smokers in 2010, non-Hispanic American Indian/Alaska Natives had the highest prevalence (31.4%), followed by non-Hispanic multiple race (25.9%) and non-Hispanic whites (21.0%). The smoking rate among non-Hispanic black was 20.6% and 12.5% among Hispanic.[10]

During the same year, the number of adult male smokers were higher (21.5%) than female smokers (17.3%). The smoking rate was also different by education and economic status.

Smoking prevalence generally decreased with increasing education and was higher among adults living below the poverty level (28.9%) than among those at or above the poverty level (18.3%).[10]

Results from the 2011 national Youth Risk Behavior Surveillance System (YRBSS) indicated that many high school students were engaged in behaviors associated with the leading causes of death among the age group ≥25 years. Eighteen percent (18.1%) of high school students smoked cigarettes and 7.7% had used smokeless tobacco.[11]

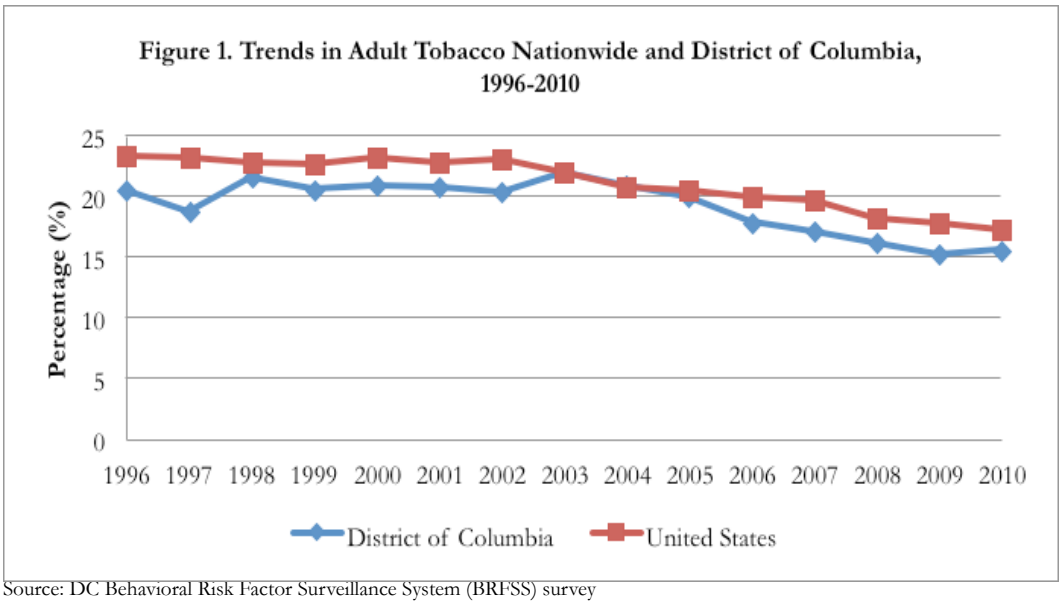
The harmful effects of smoking go beyond the smoker. Exposure to secondhand smoking accounts for an estimated 88 million nonsmoking Americans, including 54% of children aged 3 - 11 years.[12]

Tobacco Use in the District of Columbia

- In 2007, 17% of adults and 11% of high school students in the District of Columbia reported being active smokers.[13]

- The 2011 YRBSS indicated that among high school students, 43% tried cigarette smoking.[14]

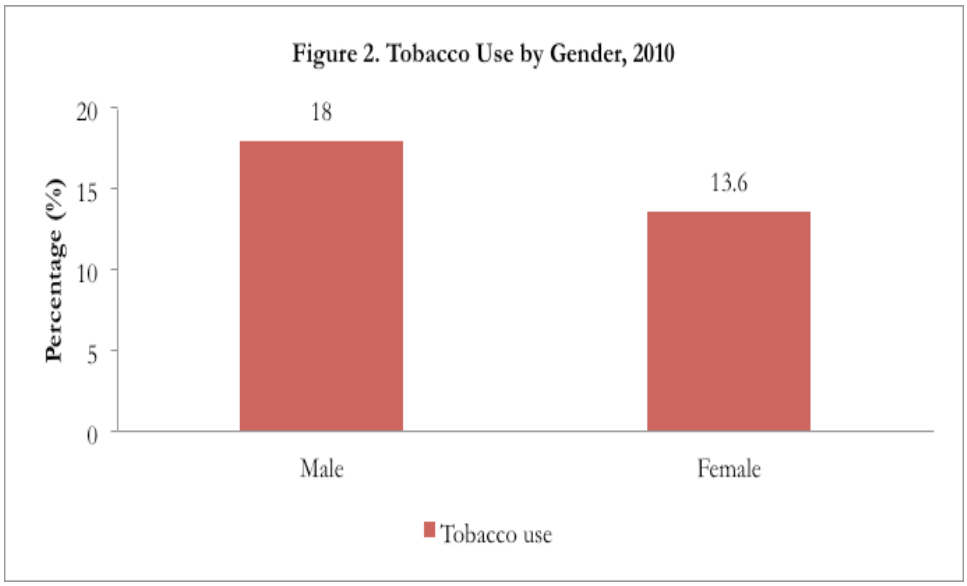
- Tobacco use among adults has declined by an average of 6.4% between 2003 (22%) and 2010 (15.6) and is slightly lower than the nationwide rate as shown in Figures 1.[15] Yet, tobacco-use rates are disproportionately high among certain populations such as African American adults (22.1%) in DC whose the rates are higher than the national average. The rates among lesbian, gay, bisexual, and transgender adults in the city are even higher at approximately 34%.[16]



Source: DC Behavioral Risk Factor Surveillance System (BRFSS) survey

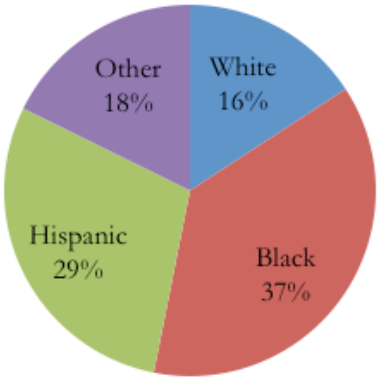
Demographic Tobacco Use

According to the 2010 BRFSS survey, adult tobacco use in the District was higher among males (18%) than females (13.6%) (Figure 2). The variation in tobacco use was also disproportionately higher among minorities, accounting for 37% among African Americans and 27% among Hispanics compared to (16%) Caucasians (Figure 3). Tobacco use among adults aged 45-54 years old was at least 6.6% higher than the other age groups (Figure 4). Tobacco use increased with decreasing income level. Tobacco use among people with an income of < $15,000 was 3.5 times (i.e., 38.5%) higher than the rate among those earning > $50,000 (11%) as shown in (Figure 5). Similar variations occurred for tobacco use by education level. Adults with less than a high school education used tobacco 3.5 times higher (31.7%) than those with college degrees (8.9%) (Figure 6).

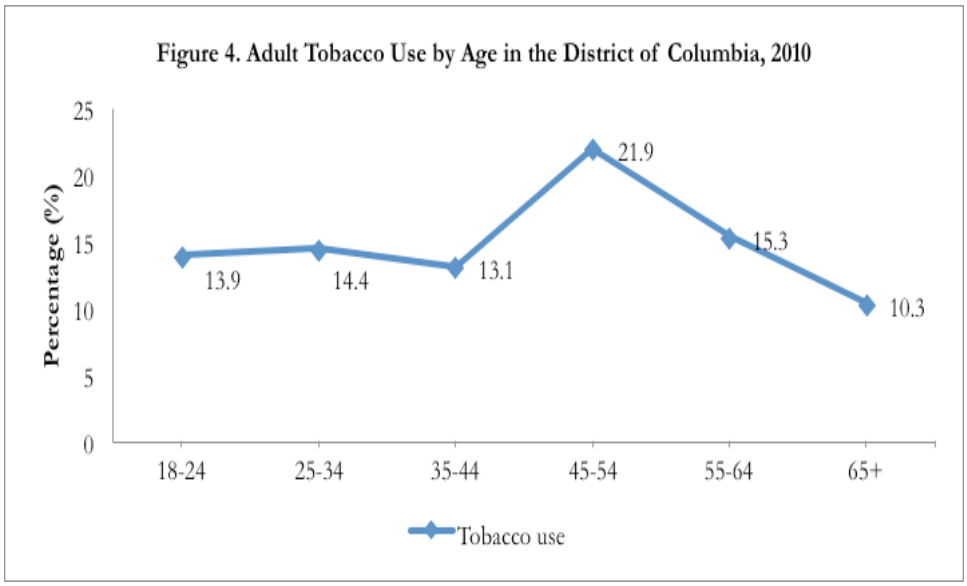


Source: DC Behavioral Risk Factor Surveillance System (BRFSS) survey, 2010

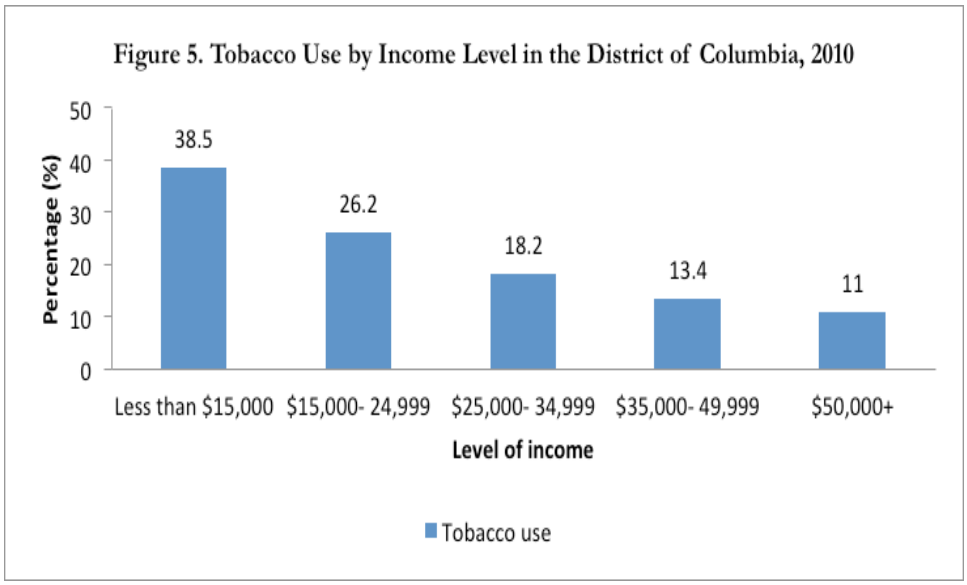
Figure 3. Tobacco Use by Race/Ethnicity, 2010



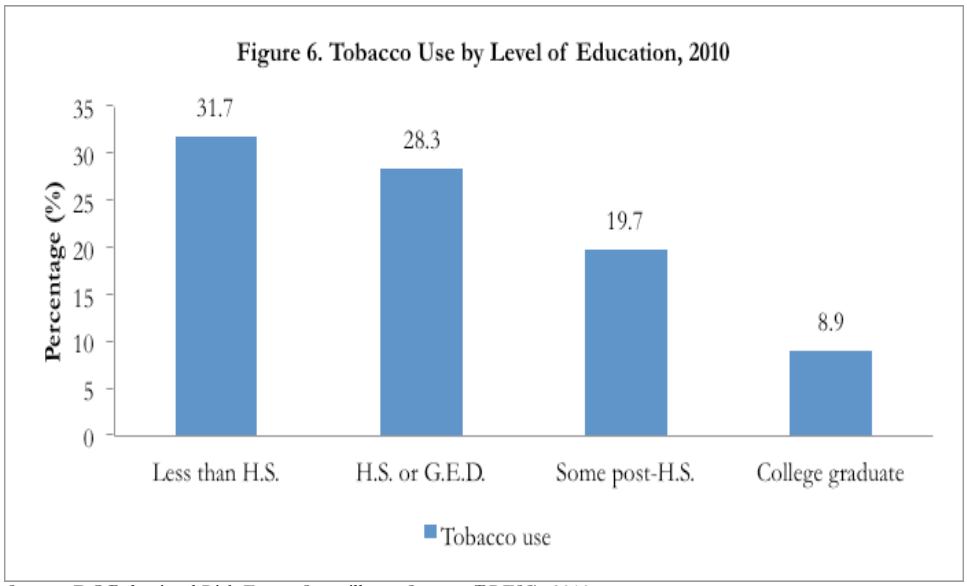
Source: DC Behavioral Risk Factor Surveillance System (BRFSS), 2010



Source: DC Behavioral Risk Factor Surveillance System (BRFSS), 2010



Source: DC Behavioral Risk Factor Surveillance System (BRFSS), 2010



Source: DC Behavioral Risk Factor Surveillance System (BRFSS), 2010

Health Burden

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, an estimated 438,000 people in the U.S. die prematurely from smoking or exposure to secondhand smoke, and another 8.6 million have a serious illness caused by smoking.[12]

Because of exposure to secondhand smoke, an estimated 3,000 nonsmoking Americans die from lung cancer, more than 46,000 die from heart disease, and about 150,000 - 300,000 children younger than 18 months have lower respiratory tract infections annually.[12]

Smoking harms nearly every organ of the body and diminishes a person's overall health. Smoking is the leading cause of cancer illness as well as deaths from cancer. It causes cancers of the lung, esophagus, larynx, mouth, throat, kidney, bladder, pancreas, stomach, and cervix, as well as acute myeloid leukemia.[15] Smoking also causes heart disease, stroke, aortic aneurysm, chronic obstructive pulmonary disease (COPD) i.e., chronic bronchitis and emphysema, asthma, hip fractures, and cataracts.[16] During 2000 – 2004, smoking was the primary causal factor for at least 30% of all cancer deaths, for nearly 80% of deaths from COPD, and for early cardiovascular diseases and deaths in the U.S.[17]

Smoking during pregnancy negatively affects the health of the mother and the baby. A pregnant smoker is at higher risk of having her baby born too early and with an abnormally low birth weight. A woman who smokes during or after pregnancy increases her infant's risk of death from Sudden Infant Death Syndrome (SIDS).[17, 18]

According to a CDC estimate, the age-adjusted average annual smoking-attributable mortality rate for the District of Columbia during 1997 – 2001 was 257.3 persons per 100,000.[19]

Economic Burden

During 2000 - 2004, cigarette smoking was estimated to be responsible for $193 billion in annual health-related economic losses in the United States (nearly $96 billion in direct medical costs and an additional $97 billion in lost productivity). It also causes 5.1 million years of potential life lost annually.[18]

The average annual smoking-attributable productivity losses for the period 1997 – 2001 and smoking-attributable expenditures in 2008 for the District of Columbia were estimated to be $219,192,000 and $190,000,000, respectively.[19]

The 2012 U.S. Surgeon General report indicates that tobacco companies spend more than a million dollars an hour in this country alone to market their products.[9]

Tobacco Use and the Healthy People 2020 Objectives

Due to the serious health consequences of tobacco use, tobacco use was one of the most significant topic areas addressed in the Healthy People 2010. It continues to be an area of importance in the Healthy People 2020.[20]

In the Healthy People 2020, tobacco use objectives are organized into three key areas:

1. *Tobacco use prevalence:* Implementing policies to reduce tobacco use and initiation among youth and adults.

2. *Health system changes:* Adopting policies and strategies to increase access, affordability, and use of smoking cessation services and treatments.

3. *Social and environmental changes:* Establishing policies to reduce exposure to secondhand smoke, increase the cost of tobacco, restrict tobacco advertising, and reduce illegal sales to minors.

The following are the targets for tobacco covered in the Healthy People 2020 objectives:
Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Baseline: 20.6 percent of adults aged 18 years and older were current cigarette smokers in 2008

Target: 12 percent

Communities Putting Prevention to Work

Prevalence of Adult Tobacco Use

As indicated in Table 1, 19.8% of the adults in the District of Columbia were more likely to use tobacco during the year 2010. Current and everyday smokers accounted for 13.3% followed by 6.5% occasional (some days) smokers.

Table 1. Adult Tobacco Use in the District of Columbia, 2010		
Tobacco Use	Estimate	Unweighted Count
No	80.2%	1313
Yes	19.8%	178
Total		1491
Every day	13.3%	106
Some days	6.5%	72
Former smoker	22.7%	461
Never smoked	57.5%	852
Total		1491

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Youth and Tobacco

The tobacco industry uses clever marketing and strategic efforts to create a variety of tobacco flavors are some of the factors that influence youth interest in and introduction to early smoking.

Each day in the United States, approximately 3,800 young people under 18 years of age smoke their first cigarette, and an estimated 1,000 youth in that age group become daily cigarette smokers.[16] Smoking at an early age leads to long-term adult smoking.[21]

Overall, 12% of DC Public high school students stated that they smoked cigarettes on more than one occasion within the past 30 days.

- Males were more likely to indicate that they tried cigarette smoking, even one or two puffs, at 44% (Figure 7).
- Twelfth grade males were slightly more likely than females and all grade levels to indicate they tried cigarette smoking, even one or two puffs, at 50% (Figure 8).
- Males were more likely to indicate they smoked a whole cigarette for the first time before age 13 years (Figure 9).
- Male students were more likely than females among all grade levels to smoke a whole cigarette for the first time before age 13 years old (Figure 10).
- Males were more likely than females to smoke cigarettes on one or more of the past 30 days, at 15% (Figure 11).

- Eleventh grade males were more likely than females and all other grade levels to smoke cigarettes on one or more of the past 30 days, at 20% (Figure 12).

- Males were more likely than females to smoke cigarettes on school property on one or more of the past 30 days, at 5% (Figure 13).

- Twelfth grade males were more likely than all other grade levels to smoke cigarettes on school property on one or more occasion of the past 30 days, at 7% (Figure 14).

- Male students were more likely to indicate they smoked cigarettes on 20 or more occasions within the past 30 days, at 6% (Figure 15).

- Males in all grade levels were more likely than females to smoke cigarettes on 20 or more of the past 30 days (Figure 16).

- Male students were more likely than females to smoke cigarettes daily, that is, at least one cigarette every day for 30 days, at 10% (Figure 17).

- Males in all grade levels were more likely than females to smoke cigarettes daily, that is at least one cigarette every day for 30 days (Figure 18).

- Males were more likely than females to indicate they used chewing tobacco, snuff, or dip on one or more of the past 30 days, at 6% (Figure 19).

- Ninth and 10th grade males were more likely than females at all grade levels to use chewing tobacco, snuff, or dip on one or more of the past 30 days, at 6% (Figure 20).

- Males were more likely than females to chew tobacco, snuff, or dip on school property one or more of the past 30 days, 3% (Figure 21).

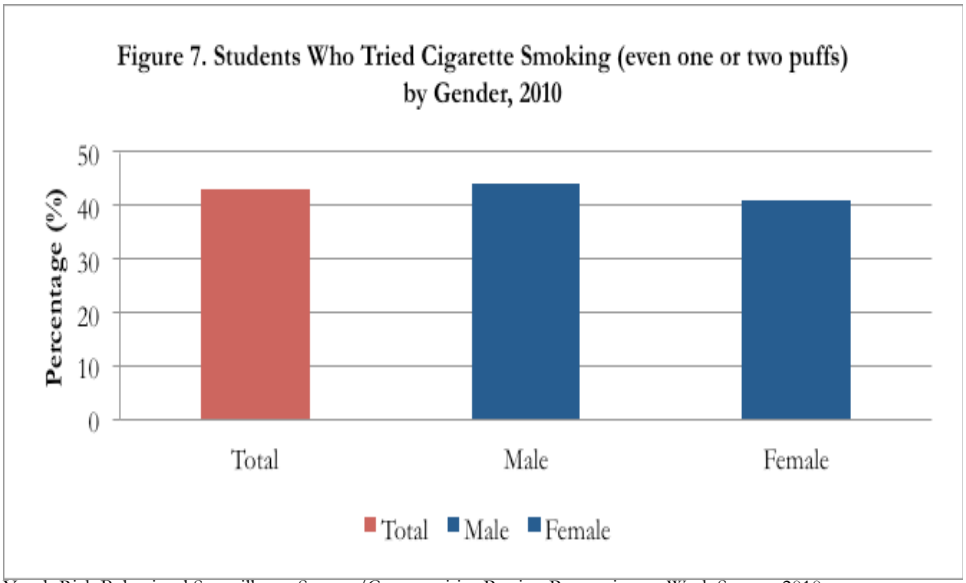
- Overall, males were more likely than females to chew tobacco, snuff, or dip on school property one or more of the past 30 days (Figure 22).

- Males were more likely than females to smoke cigars, cigarillos, or little cigars on one or more of the past 30 days, 17% (Figure 23).

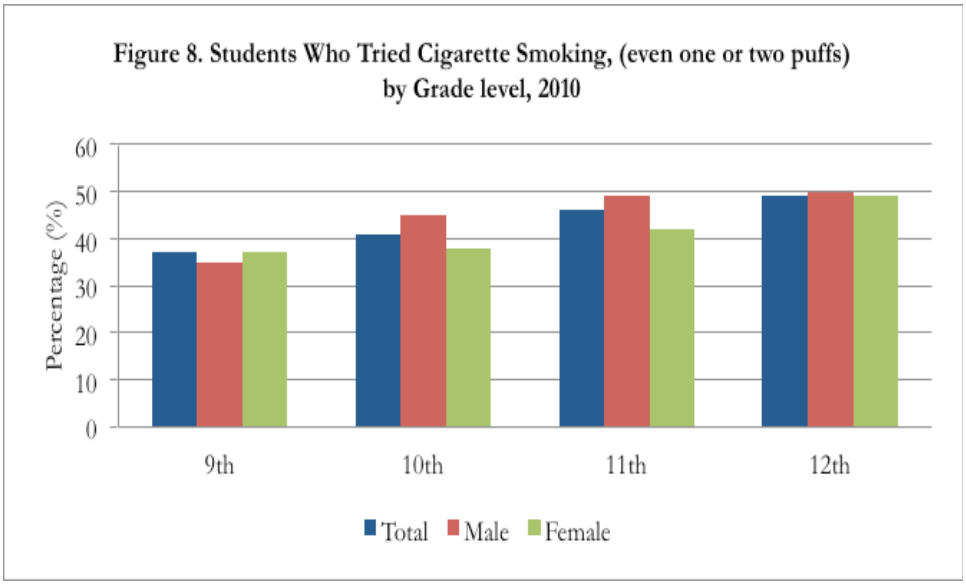
- Males in all grade levels were more likely than females to smoke cigars, cigarillos, or little cigars on one or more of the past 30 days, at 18% (Figure 24).

- Males were more likely than females to smoke cigarettes or cigars or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days, at 20% (Figure 25).

- Males in all grade levels were more likely than females to smoke cigars, cigarettes, cigarillos or use chewing tobacco, snuff, or dip on one or more of the past 30 days (Figure 26).



Youth Risk Behavioral Surveillance System/Communities Putting Prevention to Work Survey, 2010



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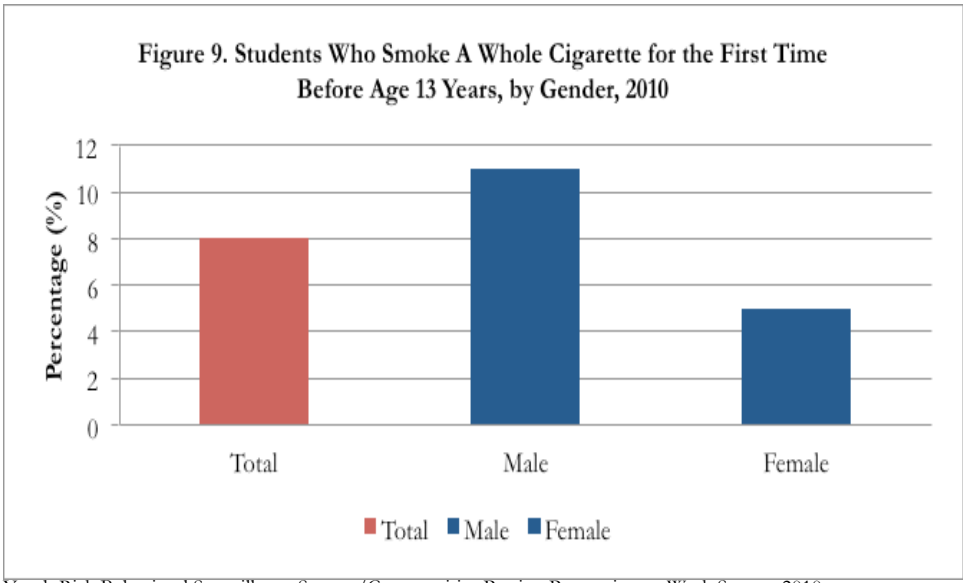

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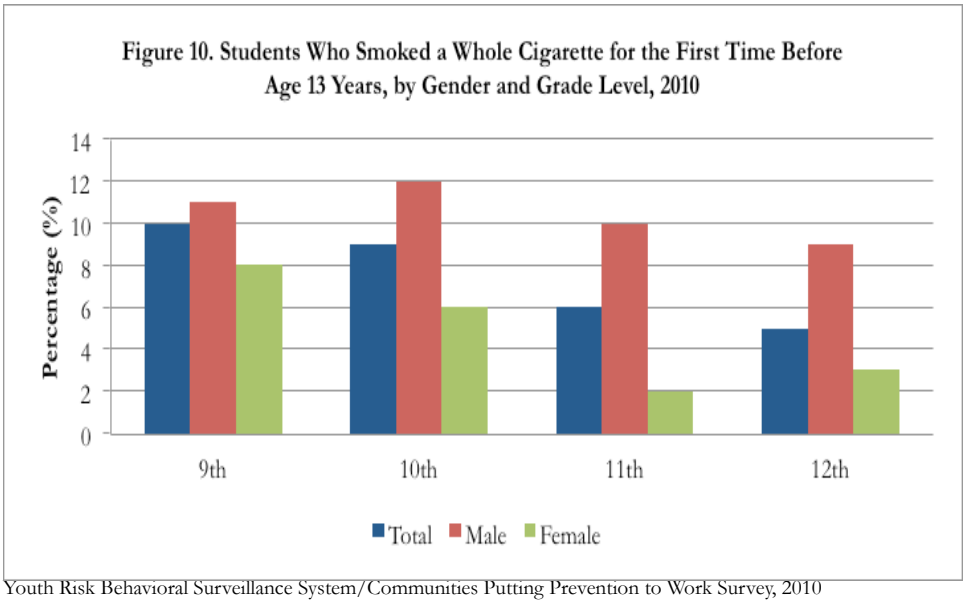

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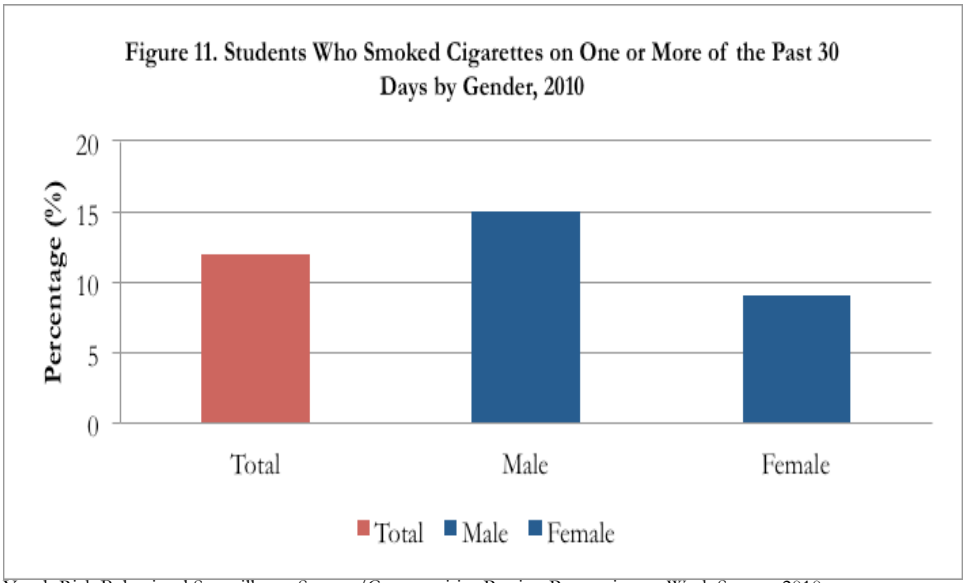

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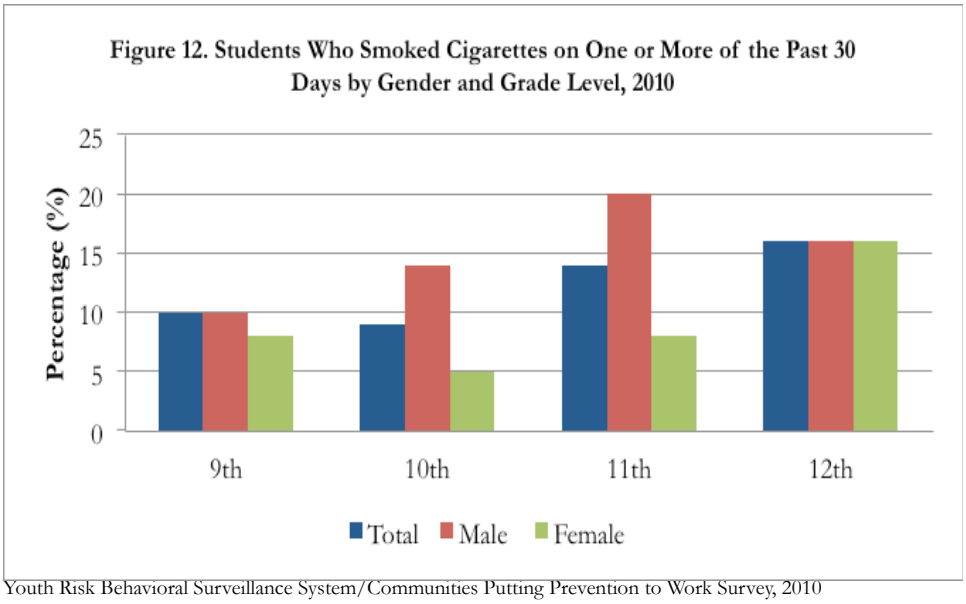

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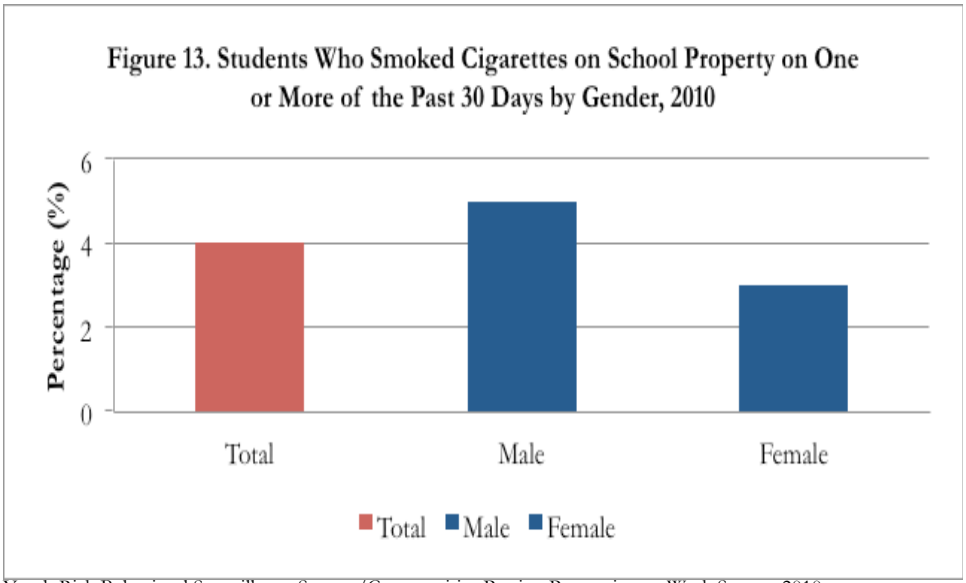

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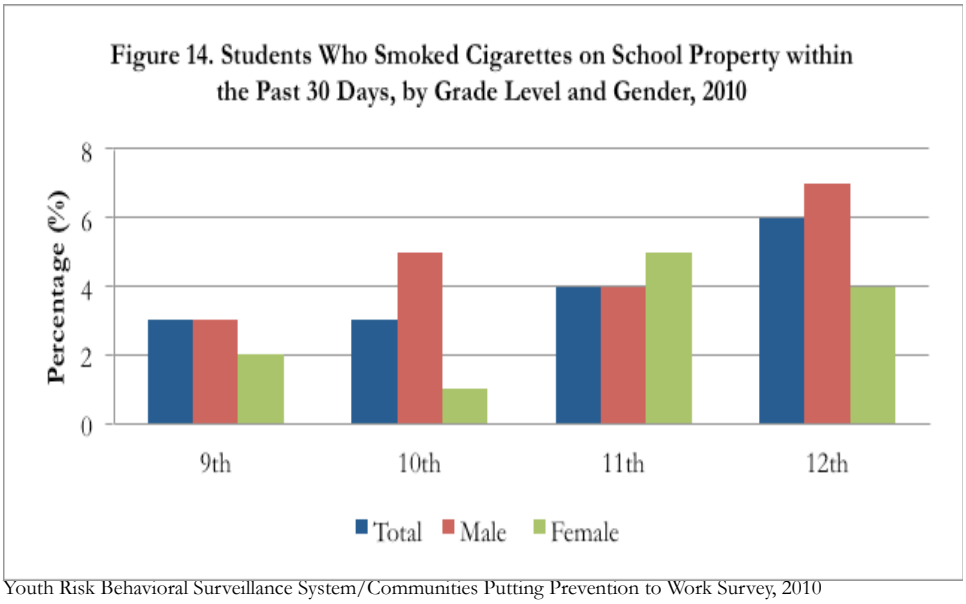

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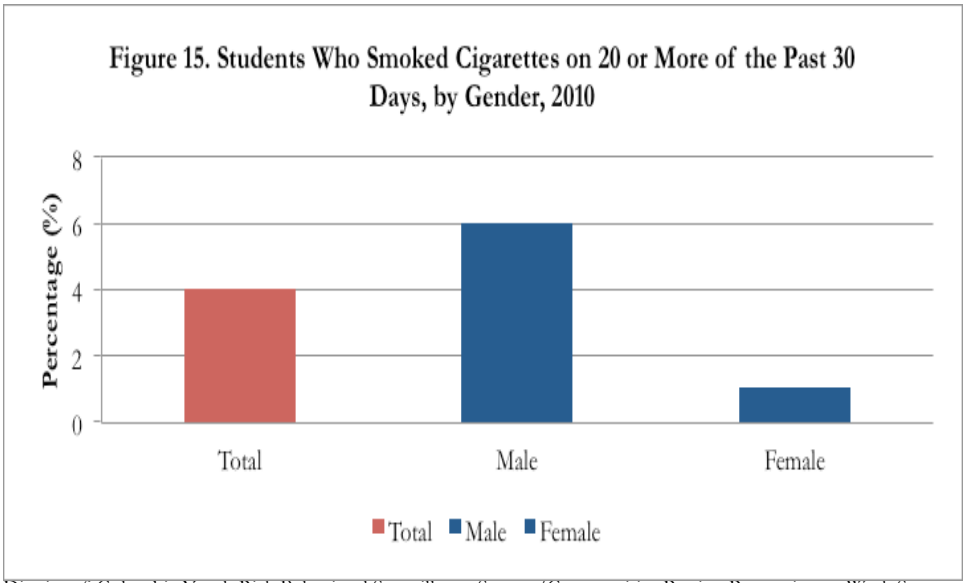
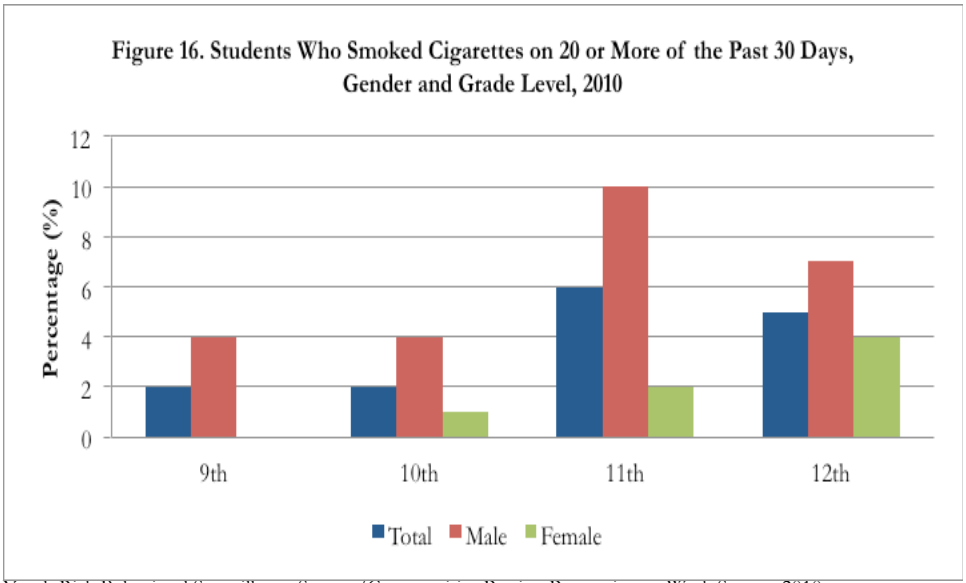


District of Columbia Youth Risk Behavioral Surveillance System/Communities Putting Prevention to Work Survey, 2010



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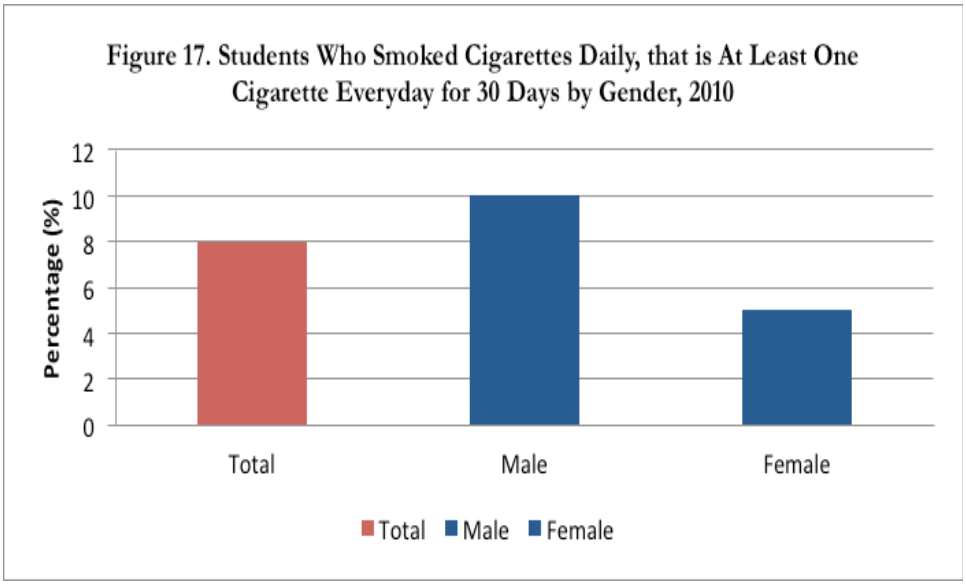

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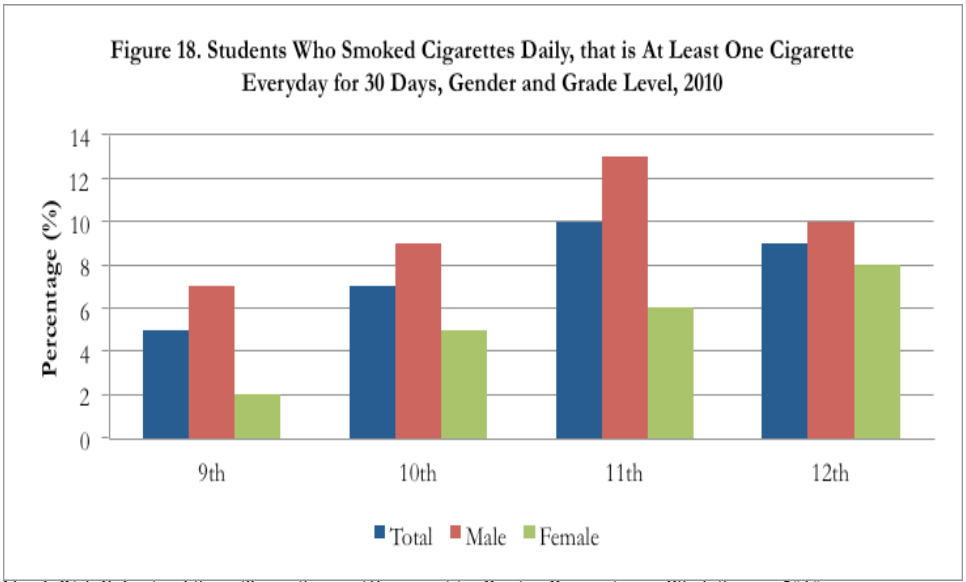

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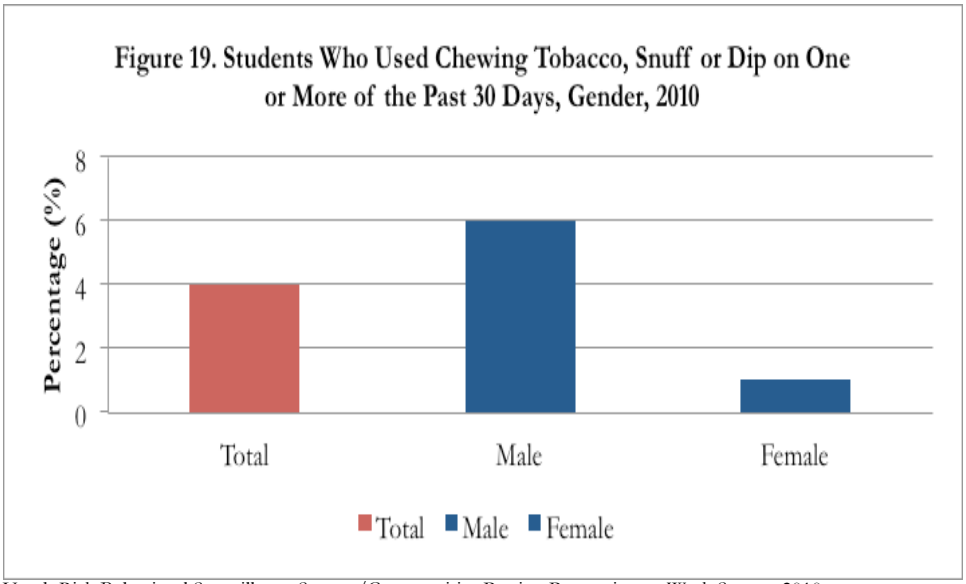

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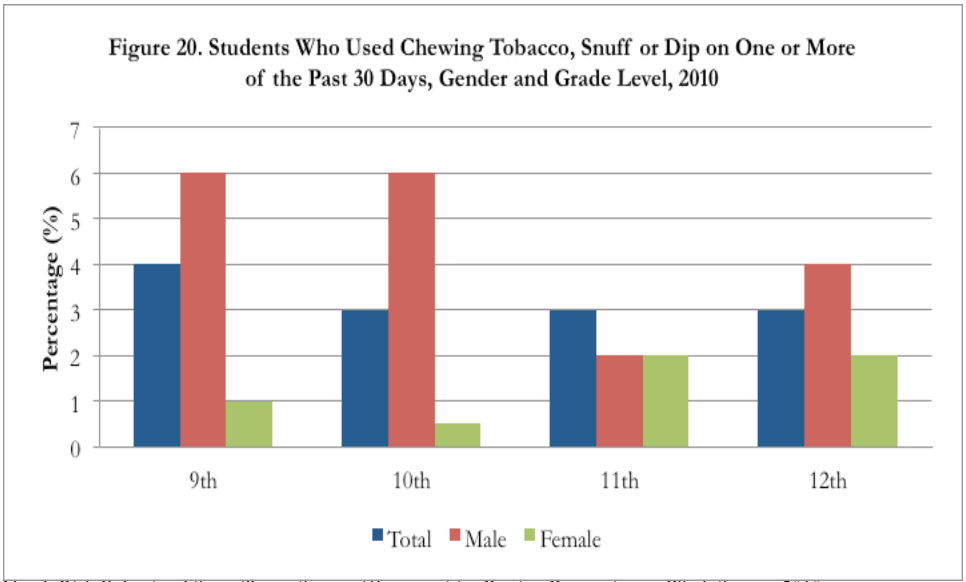

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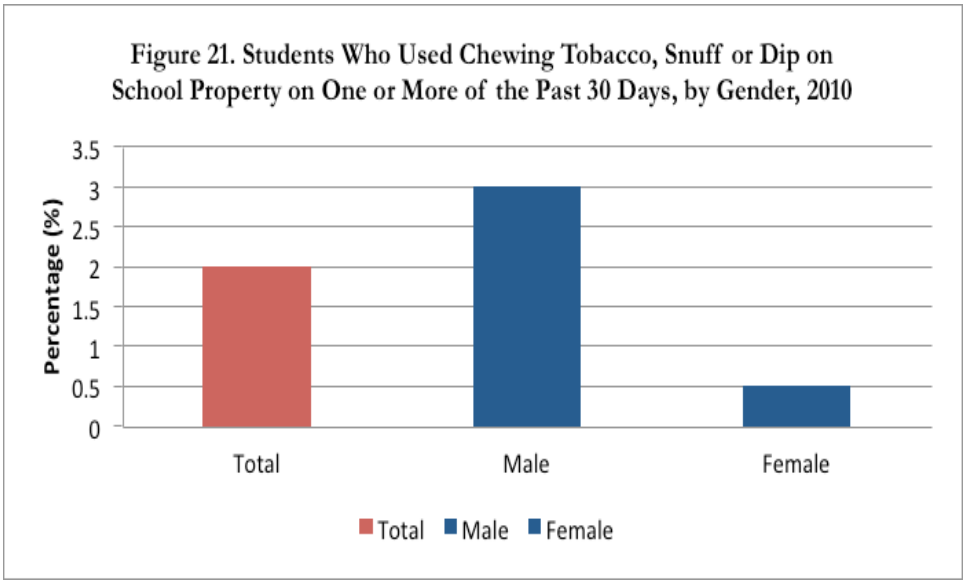

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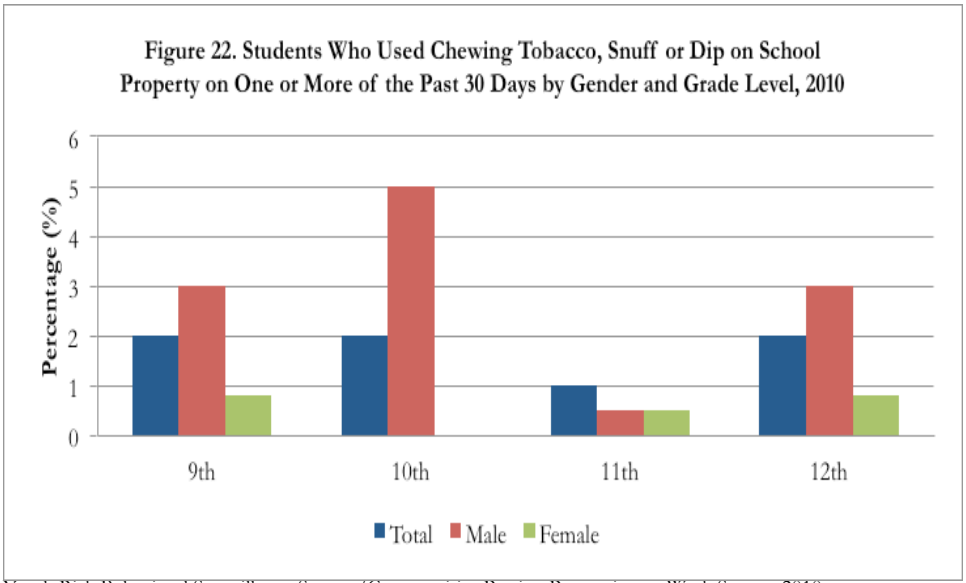

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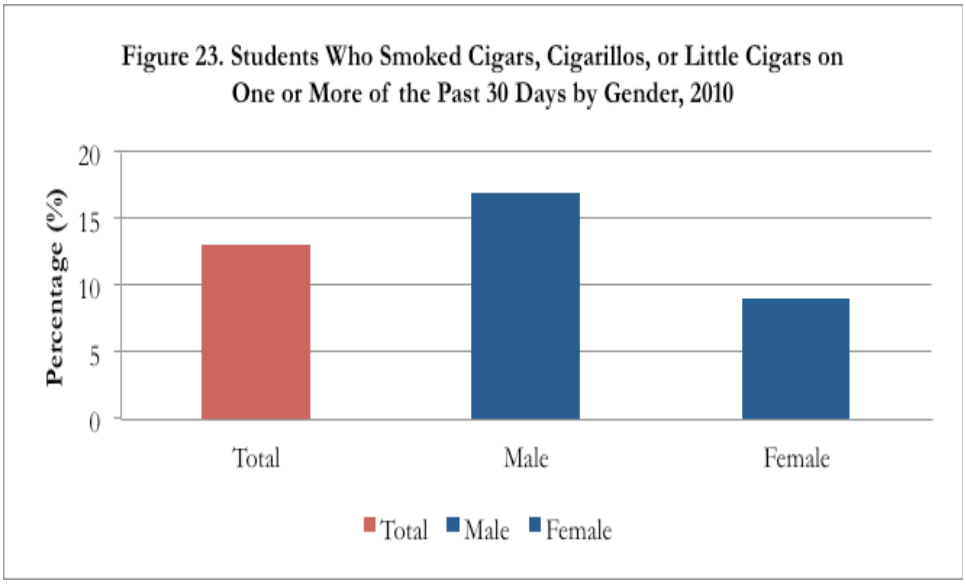

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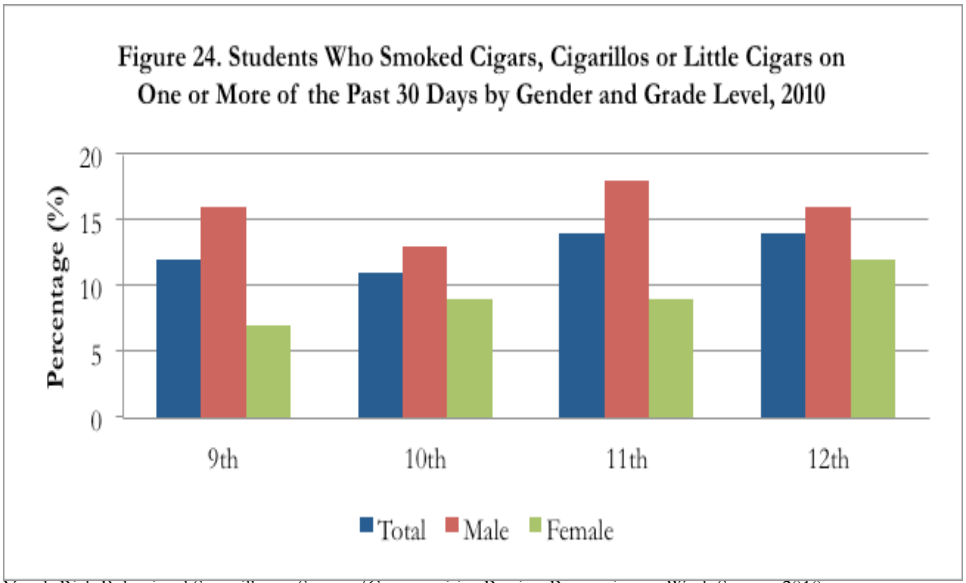

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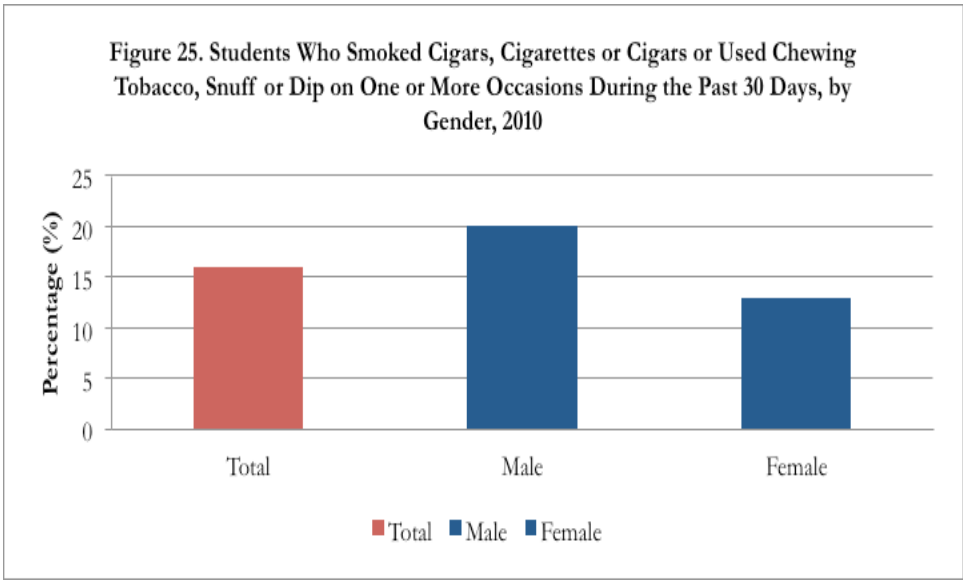

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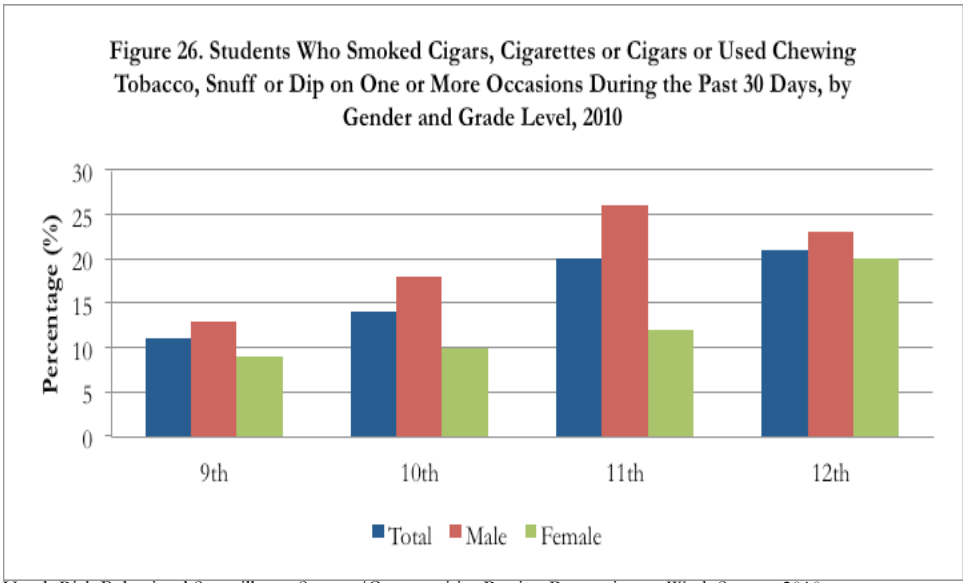

Youth Risk Behavioral Surveillance System/Communities Putting Prevention to Work Survey, 2010

Demographic Disparity in Tobacco Use

According to the BRFSS/CPPW survey, adult males were more likely to use tobacco (59%) than females (41%). The rate of tobacco use was higher among adults aged 45 – 54 years old (36.3%) followed by 18 – 34 years old (34.3%). Adults 65 years or older were less likely to use tobacco (4.6%) (Table 2).

The disparity in tobacco use by race/ethnicity is staggering; 75% of African Americans use tobacco, followed by Caucasians (16%), Hispanic (5.1%), and Other race/ethnic group (3%). This indicates that the rate of tobacco use among African Americans was 4.7 times higher than Caucasians and 14.7 times higher than Hispanic respondents.

The rate of tobacco use was different by the level of education, income, marital status, and ward (Table 2). Adults with some college/technical school education were more likely to use tobacco (37.7%), followed by high school graduates (33.9%), college graduates (15.8%), and adults with less than a high school education (12.6%). The rate of tobacco use was higher among adults with the lowest household income (<$15,000, 30.6%), followed by adults with a household income of $15,000 - $24,999 (18.3%).

Adults who resided in Ward 8 had higher rate of tobacco use (23.6%) followed by Ward 5 (16.9%), Wards 6 (15.2%) and 7 (15.2%), (Table 2).

Table 2: Disparity in tobacco use by demographics and ward				
Sex		Current Smokers		
		No	Yes	Total
Male	Estimate	43.2%	59.0%	46.3%
	Unweighted Count	471	73	544
Female	Estimate	56.8%	41.0%	53.7%
	Unweighted Count	842	105	947
Total	Unweighted Count	1313	178	1491
Race/Ethnicity				
Caucasian/White	Estimate	38.7%	16.8%	34.3%
	Unweighted Count	662	47	709
African American/Black	Estimate	47.0%	75.0%	52.6%
	Unweighted Count	493	110	603
Other	Estimate	5.7%	3.0%	5.1%
	Unweighted Count	70	11	81
Hispanic	Estimate	8.6%	*	7.9%
	Unweighted Count	58	*	65
Age				
18-34	Estimate	38.3%	34.3%	37.5%
	Unweighted Count	153	26	179
35-44	Estimate	21.0%	8.4%	18.5%
	Unweighted Count	182	17	199
45-54	Estimate	11.6%	36.3%	16.6%
	Unweighted Count	196	47	243
55-64	Estimate	11.7%	16.4%	12.6%
	Unweighted Count	282	60	342
65 or older	Estimate	17.4%	4.6%	14.8%
	Unweighted Count	462	27	489
Education				
Did not graduate high school	Estimate	15.1%	12.6%	14.6%
	Unweighted Count	78	15	93
High school graduate	Estimate	17.7%	33.9%	20.9%
	Unweighted Count	170	52	222
Some college or technical school	Estimate	17.0%	37.7%	21.1%
	Unweighted Count	190	50	240
College graduate (also technical school)	Estimate	50.2%	15.8%	43.4%
	Unweighted Count	865	60	925

Table 2 continue: Disparity in tobacco use by demographics and ward				
Income				
Less than $15,000	Estimate	11.3%	30.6%	14.7%
	Unweighted Count	84	36	120
$15,000-$24,999	Estimate	15.3%	18.3%	15.8%
	Unweighted Count	105	32	137
$25,000-$34,999	Estimate	6.3%	5.0%	6.0%
	Unweighted Count	71	12	83
$35,000-$49,999	Estimate	10.3%	12.8%	10.8%
	Unweighted Count	110	16	126
$50,000-$74,999	Estimate	12.9%	16.3%	13.5%
	Unweighted Count	157	22	179
75,000 or older	Estimate	43.9%	17.0%	39.1%
Ward				
Ward 1	Estimate	9.8%	10.7%	10.0%
	Unweighted Count	109	15	124
Ward 2	Estimate	7.9%	6.4%	7.6%
	Unweighted Count	107	11	118
Ward 3	Estimate	12.7%	5.7%	11.3%
	Unweighted Count	267	15	282
Ward 4	Estimate	15.0%	6.4%	13.3%
	Unweighted Count	161	20	181
Ward 5	Estimate	14.7%	16.9%	15.2%
	Unweighted Count	130	27	157
Ward 6	Estimate	15.0%	15.2%	15.0%
	Unweighted Count	156	15	171
Ward 7	Estimate	11.7%	15.2%	12.4%
	Unweighted Count	100	20	120
Ward 8	Estimate	13.1%	23.6%	15.2%
	Unweighted Count	86	21	107

N = Unweighted Count
% = Weighted Percentage
* = Cell Sizes less than 50 or cell width greater than 10 are suppressed
Race Category Other = Asian, Native Hawaiian, Pacific Islander, American Indian or Alaska Native
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Secondhand Smoking

Seven percent of respondents breathe tobacco smoke at their work place at least once during the past week (Table 3). Fifteen percent of the respondents said someone had smoked inside their home and 11.6% of them rode in a vehicle where someone was smoking tobacco (Table 4). Regarding smoke exposure at public places, 12.4% of adults stated they did breathe tobacco smoke in an outdoor public place during the past week (Table 5).

When asked if tobacco smoking is allowed inside their homes (except decks, porches, or garages), 8.1% of them responded it was always allowed and 15.3% allowed only some times in some places (Table 6). Either the respondents or family members (6.8%) who live with them were always allowed to smoke inside vehicles, whether rented or owned (Table 7). Not counting motorcycles, 78.7% of respondents stated that smoking should never be allowed in vehicles they own or lease (Table 8). Residents were asked whether indoor smoking in public place should be allowed or not. Eighty percent of District residents stated smoking should never be allowed at the work place followed by sometimes be allowed (17.5%) and always (2%), (Table 9).

Table 3: Exposure to secondhand smoking
How many days did you breathe smoke at your workplace from someone other than you who was smoking tobacco?
District of Columbia, 2010

Days	Estimate	Unweighted
1-7 days	7.0%	50
None	93.0%	746

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 4: Exposure to secondhand smoking
"How many days did you ride in a vehicle where someone other than you was smoking tobacco?"
District of Columbia, 2010

Days	Estimate	Unweighted
1-7 days	11.6%	90
None	88.4%	1364

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 5: Exposure to secondhand smoking
"How many days did you breathe the smoke from someone else who was smoking in an indoor public place?"
District of Columbia, 2010

Days	Estimate	Unweighted
1-7 days	12.4%	111
None	87.6%	1317

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 6: Exposure to secondhand smoking "Not counting decks, porches or garages, inside your home is smoking allowed?" District of Columbia, 2010		
Days	Estimate	Unweighted
Always allowed	8.1%	112
Allowed only at some times in some places	15.3%	133
Never allowed	76.2%	1179
Family does not have a smoking policy	0.3%	12

Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey
N = Unweighted Count
% = Weighted Percentage

Table 7: Exposure to secondhand smoking "How many days did someone other than you smoke tobacco inside your home while you were at home? District of Columbia, 2010		
Days	Estimate	Unweighted
1-7 days	15.0%	97
None	85.0%	1356

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 8: Exposure to secondhand smoking "Not counting motorcycles, in the vehicles that you or family members who live with you own or lease, is smoking allowed?" District of Columbia, 2010		
Days	Estimate	Unweighted
Always allowed in vehicles	6.8%	67
Allowed only at some times in some places	10.9%	113
Never allowed	78.7%	1180
Family does not have a smoking policy	*	*
Respondents family does not own or lease a vehicle	2.7%	60

N = Unweighted Count
* = Data Suppressed
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 9: Exposure to secondhand smoking "At work place, do you think smoking indoors should be allowed?" District of Columbia, 2010		
Days	Estimate	Unweighted
Always allowed	2.0%	26
Allowed only at some times in some places	17.5%	201
Never allowed	80.5%	1169

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Smoking Cessation

Overall, 19.5% of respondents were aware of the presence of telephone quitline (Table 10). Regarding future plans to quit smoking, 40.6% of current smokers had a time frame in mind to quit (Table 11).

Table 10: Smoking Cessation
"Are you aware of any telephone quitline services?"
District of Columbia, 2010

Days	Estimate	Unweighted
Yes	19.5%	230
No	80.5%	1178

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 11: Smoking Cessation
"Do you have a time frame in mind for quitting?"
District of Columbia, 2010

Days	Estimate	Unweighted
Yes	40.6%	69
No	59.4%	97

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Diabetes, Cardiovascular Disease and Current smokers

Among current smokers, 13.7% were diabetic (Table 12). The rate of myocardial infarction (6%), coronary heart disease (6.6%) among current smokers was higher than the non-smokers. The rates among non-smokers were 2.7%, 2.2%, and 3.4%, respectively, (Tables 13, 14 and 15).

Table 12: Tobacco Use Among Diabetic Respondents
District of Columbia, 2010

Adults who are current smokers		Diabetes				
		Yes	Yes, but pregnant	No	No, per-diabetes or borderline diabetes	Total
No	Estimate	10.1%	1.1%	88.2%	0.6%	1309
	Unweighted Count	151	13	1133	12	
Yes	Estimate	13.7%	N/A	86.3%	0.0%	177
	Unweighted Count	22	*	154	*	

N = Unweighted Count
% = Weighted Percentage
* = Cell Sizes less than 50 or cell width greater than 10 are suppressed
N/A= Not available
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 13. Tobacco Use by Myocardial Infarction
District of Columbia, 2010

Adults who are current smokers		Myocardial infarction		
		Yes	No	Total
No	Estimate	2.7%	97.3%	1308
	Unweighted Count	51	1257	
Yes	Estimate	6.0%	94.0%	176
	Unweighted Count	12	164	

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 14: Tobacco Use by Angina or Coronary Heart Disease
District of Columbia, 2010

Current Smokers		Angina or Coronary Heart Disease		
		Yes	No	Total
No	Estimate	2.2%	97.8%	1301
	Unweighted Count	60	1241	
Yes	Estimate	6.6%	93.4%	175
	Unweighted Count	12	163	

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 15: Tobacco Use by Stroke District of Columbia, 2010				
Current Smokers		STROKE		
		Yes	No	Total
No	Estimate	3.4%	96.6%	1308
	Unweighted Count	48	1260	
Yes	Estimate	*	96.4%	177
	Unweighted Count	*	170	

N = Unweighted Count
* = Data Suppressed
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Social, Emotional and Mental Health

Current smokers were less likely (35.4%) to receive social and emotional support compared to the 47% among non-smokers (Table 16). Mental illness and stigma were assessed by asking the respondents if they experienced nervousness, hopelessness, restlessness, depression, and worthlessness in the past 30 days. Current tobacco users were more likely to experience nervousness (31.7%), and restlessness/fidgety (31.9%) compared to 23.4%, and 21.8% among non-smokers, respectively, (Tables 17, 18 and 19). In terms of feeling depressed, 83% of the non-smokers stated that they did not experience any depression during the past 30 days compared to 59.8% of the current smokers, (Table 20).

Table 16: Current smokers by social and emotional status
District of Columbia, 2010

Current Smokers		How often do you get the social and emotional support you need?					
		Always	Usually	Sometimes	Rarely	Never	Total
No	Estimate	47.1%	22.1%	15.1%	5.5%	10.1%	1222
	Unweighted Count	556	336	172	32	126	
Yes	Estimate	35.4%	11.6%	16.7%	7.7%	28.6%	162
	Unweighted Count	58	27	34	13	30	

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 17: Current smokers by emotional status
District of Columbia, 2010

Current Smoker		About how often during the past 30 days did you feel nervous would you say all of the time?					
		Always	Usually	Sometimes	Rarely	Never	Total
No	Estimate	2.8%	2.0%	23.4%	30.8%	40.9%	1238
	Unweighted Count	16	26	256	401	539	
Yes	Estimate	*	*	31.7%	21.4%	37.9%	163
	Unweighted Count	*	*	45	36	66	

N = Unweighted Count
*= Data Suppressed
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 18: Current smokers by mental health District of Columbia, 2010							
Current Smokers		During the past 30 days about how often did you feel hopeless?					
		All	Most	Some	A Little	None	Total
No	Estimate	*	2.8%	8.1%	10.7%	78.0%	1242
	Unweighted Count	*	13	94	114	1014	
Yes	Estimate	*	*	6.9%	22.4%	61.2%	167
	Unweighted Count	*	*	19	27	112	

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 19: Current smokers by mental health District of Columbia, 2010							
Current Smokers		During the past 30 days about how often did you feel restless or fidgety?					
		All	Most	Some	A Little	None	Total
No	Estimate	1.2%	2.8%	21.8%	22.6%	51.6%	1236
	Unweighted Count	12	20	239	315	650	
Yes	Estimate	*	*	31.9%	25.5%	32.7%	166
	Unweighted Count	*	*	45	42	63	

N = Unweighted Count
*= Data Suppressed
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 20: Current smokers by mental health District of Columbia, 2010							
Current Smokers		During the past 30 days how often did you feel so depressed that nothing could cheer you up?					
		All	Most	Some	A Little	None	Total
No	Estimate	*	1.2%	7.2%	6.3%	83.0%	1240
	Unweighted Count	*	16	46	95	1078	
Yes	Estimate	*	*	20.8%	15.0%	59.8%	165
	Unweighted Count	*	*	17	29	109	

N = Unweighted Count
*= Data Suppressed
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 21: Current smokers by mental health District of Columbia, 2010							
Adults who are current smokers		During the past 30 days about how often did you feel worthless?					
		All	Most	Some	A Little	None	Total
No	Estimate	*	2.5%	2.8%	10.9%	83.3%	1236
	Unweighted Count	*	11	46	87	1086	
Yes	Estimate	-	*	3.9%	10.8%	76.2%	164
	Unweighted Count	-	*	11	13	135	

N = Unweighted Count
* = Data Suppressed
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Table 22: Current smokers by mental health District of Columbia, 2010							
Current smokers		During the past 30 days about how often did you feel that everything was an effort?					
		All	Most	Some	A Little	None	Total
No	Estimate	2.7%	9.8%	15.2%	24.1%	48.2%	
	Unweighted Count	28	51	178	256	716	1229
Yes	Estimate	*	7.6%	30.3%	14.2%	45.6%	164
	Unweighted Count	*	14	41	33	68	

N = Unweighted Count
*= Data Suppressed
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Tobacco Use and Physical Activity

Tobacco smokers were less likely (69.4%) to participate in any physical activity during the past 30 days compared to the non-smokers (81.8%) (Table 23).

Table 23: Tobacco Use and Physical Activity
District of Columbia, 2010

Current Smokers		During the past month, did you participate in any physical activity?		
		Yes	No	Total
No	Estimate	81.8%	18.2%	1299
	Unweighted Count	1063	236	
Yes	Estimate	69.4%	30.6%	177
	Unweighted Count	133	44	
Total	Estimate	79.4%	20.6%	1476
	Unweighted Count	1196	280	

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Tobacco use and Disability

Physical, mental, or emotional problems limiting physical activity were more prevalent among the current adult smokers (27.8%) compared to the non-smokers (15.5%) (Table 24).

Table 24. Tobacco Use and Disability
District of Columbia

Current smokers		Are you limited in any activities because of physical, mental, or emotional problems?		
		Yes	No	Total
No	Estimate	15.5%	84.5%	1304
	Unweighted Count	235	1069	
Yes	Estimate	27.8%	72.2%	
	Unweighted Count	50	126	176
Total	Estimate	17.9%	82.1%	
	Unweighted Count	285	1195	1480

N = Unweighted Count
% = Weighted Percentage
Source: 2010 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), Communities Putting Prevention to Work (CPPW) survey

Tobacco – Population and Outlets

There are a total of 1,002 tobacco outlets in the District of Columbia. Wards 5, 7, and 8 have the highest rates of current smokers. Ward 2 has the largest number of tobacco outlets but the lowest rate of current smokers as well as largest population and ranked 6th among wards with the highest median household income (Table 25). Ward 3 has the least amount of tobacco outlets and ranked 3rd among current smokers, with the 2nd highest population and a median income of $71,875, highest among all wards (Table 25).

Table 25: Tobacco Rate in Relation to Population, Income and Number of Tobacco Outlets in the District of Columbia

Ward	Tobacco Rate	Population	Median Income	Number of Tobacco Outlets
Ward 1	10%	76,197	$36,902	160
Ward 2	7.6%	79,915	$44,742	212
Ward 3	11.3%	77,152	$71,875	58
Ward 4	13.3%	75,775	$46,408	107
Ward 5	15.2%	74,308	$43,433	148
Ward 6	15.0%	76,598	$41,554	137
Ward 7	12.4%	71,068	$30,533	79
Ward 8	15.2%	70,712	$25,017	101

Source: DC Tobacco Control Program, Addiction, Prevention and Recovery Administration (APRA)

Overview of Promotion and Advertising Restrictions

On March 19, 2010, FDA published in the Federal Register its final regulations entitled Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco to Protect Children and Adolescents; and these regulations became effective on June 22, 2010. These final regulations at 21 C.F.R. Part 1140 are designed to: 1) restrict access to cigarettes and smokeless tobacco by persons under the age of 18 years; and 2) reduce the appeal of such products to persons under the age of 18, through restrictions on marketing, labeling, and advertising.[22]

Specifically, the Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco to Protect Children and Adolescents impose the following restrictions: Prohibition of Sale and Distribution to Persons Younger than 18 Years of Age (Youth Access)[22]

Retailers of tobacco products MUST:[18]

- Not sell cigarettes or smokeless tobacco to persons younger than 18 years of age. 21 C.F.R. 1140.14(a).

- Verify the age of purchasers of cigarettes or smokeless tobacco who are under the age of 27 years by means of photographic identification that contains the bearer's date of birth. 21 C.F.R. 1140.14(b).

- Sell cigarettes or smokeless tobacco in direct, face-to-face transactions, with certain exceptions. 21 C.F.R. 1140.14(c), 1140.16(c).

- Not have tobacco vending machines or self-service displays in their facilities unless they can ensure that persons younger than 18 years of age are never present or not permitted to enter at any time. 21 C.F.R. 1140.16(c).

- Not break or otherwise open any cigarette or smokeless tobacco package to sell or distribute individual cigarettes or a number of unpackaged cigarettes that is smaller than the quantity in a minimum cigarette package size of 20 cigarettes, or any quantity of cigarette tobacco or smokeless tobacco that is smaller than the smallest package distributed by the manufacturer for individual consumer use. 21 C.F.R. 1140.14(d), 21 C.F.R. 1140.16(b).

- Not distribute or cause to be distributed free samples of tobacco products, except for samples of smokeless tobacco products in a qualified adult-only facility, as defined by the regulations at 21 C.F.R. 1140.16(d)(2)(iii). 21 C.F.R. 1140.16(d). This provision also applies to manufacturers and distributors.

- Not sell or distribute, or cause to be sold or distributed, cigarettes or smokeless tobacco with labels, labeling, or advertising not in compliance with subpart D of 21 C.F.R. Part 1140 (specifically, 21 C.F.R. 1140.30, 1140.32, and 1140.34) and other applicable requirements. 21 C.F.R. 1140.16(e). This provision also applies to manufacturers and distributors.

Labeling and Advertising

Manufacturers, Distributors, and Retailers of tobacco products MUST:

- Not market, distribute, license, or sell any item (other than cigarettes or smokeless tobacco or roll-your-own paper) or service that bears the brand name (alone or in conjunction with any other word), logo, symbol, motto, selling message, recognizable color or pattern of colors, or any other indicia of product identification identical to or similar to, or identifiable with, those used for any

brand of cigarettes or smokeless tobacco. 21 C.F.R. 1140.34(a). This provision only applies to manufacturers and certain distributors.

- Not offer any gift or item (other than cigarettes or smokeless tobacco) to any person purchasing cigarettes or smokeless tobacco in consideration of the purchase of the cigarettes or smokeless tobacco product or to any person in consideration of furnishing evidence, such as credits, proofs-of-purchase, or coupons, of such a purchase. 21 C.F.R. 1140.34(b).

- Not sponsor any athletic, musical, artistic, or other social or cultural event, or any entry or team in any event, in the brand name, logo, symbol, motto, selling message, recognizable color or pattern of colors, or any other indicia of product identification, identical or similar to, or identifiable with, those used for any brand of cigarettes or smokeless tobacco. 21 C.F.R. 1140.34(c).

- Notify FDA 30 days prior to the dissemination of advertising or labeling for cigarettes or smokeless tobacco in a medium not listed in 21 C.F.R. 1140.30(a)(1). 21 C.F.R. 1140.30(a)(2). The notice must describe the medium and discuss the extent to which the advertising or labeling may be seen by persons younger than 18 years of age.

There are two additional provisions of the regulations, 21 C.F.R. 1140.16(a) and 1140.32(a), that restrict labeling and advertising of tobacco products. However, as discussed below, FDA intends to exercise enforcement discretion to not enforce these two provisions at this time.

21 C.F.R. 1140.16(a) [restriction on the use of trade name or brand name of a non-tobacco product as the trade name or brand name for a cigarette or smokeless tobacco product]. FDA is aware of concerns regarding this provision and is considering what changes, if any, would be appropriate to address those concerns. While FDA has this issue under consideration, it intends to exercise its enforcement discretion concerning 21 C.F.R. 1140.16(a) not to commence enforcement actions under this provision for the duration of its consideration where:

(1) The trade or brand name of the cigarette or smokeless tobacco product was registered, or the product was marketed, in the United States on or before June 22, 2009; or

(2) The first marketing or registration in the United States of the tobacco product occurs before the first marketing or registration in the United States of the non-tobacco product bearing the same name; provided, however, that the tobacco and non-tobacco product are not owned, manufactured, or distributed by the same, related, or affiliated entities (including as a licensee).

The Tobacco Control Act amends the Federal Food, Drug, and Cosmetic Act (FD&C Act), 21 U.S.C. 301 et seq., and contains additional provisions relating to the promotion and advertising of tobacco products. Relevant sections of the Tobacco Control Act and the FD&C Act, as amended by the Tobacco Control Act, include, among others:

- Section 201(rr)(4) of the Tobacco Control Act (21 U.S.C. 321(rr)(4)) – a tobacco product shall not be marketed in combination with any other article or FDA-regulated product.

- Section 201 of the Tobacco Control Act, amending section 4 of the Federal Cigarette Labeling and Advertising Act (15 U.S.C. 1333) -- requires that cigarette packages and advertisements bear new, larger, and more prominent health warnings. FDA must issue regulations requiring that graphic images accompany the new health warning statements on cigarette packs and advertisements. Companies must submit rotation plans for the new health warning statements to the FDA for review

and approval. These requirements are effective 15 months after issuance of the regulations requiring graphic images.

- Section 204 of the Tobacco Control Act, amending section 3 of the Comprehensive Smokeless Tobacco Health Education Act of 1986 (15 U.S.C. 4402) -- requires that smokeless tobacco packages and advertisements bear new, larger, and more prominent health warnings. Companies must submit rotation plans for the new health warning statements to the FDA for review and approval. These provisions took effect on June 22, 2010.

- Section 903(a)(1) of FD&C Act (21 U.S.C. 387c(a)(1)) – a tobacco product shall be deemed misbranded if its labeling is false or misleading in any particular. In addition, FDA may issue regulations implementing other misbranding provisions of FD&C Act, including the requirement that a tobacco product bear its (if it has one) established name prominently, and the requirement that its labeling bear adequate directions for use, or adequate warnings against use by children, that are necessary for the protection of users.

- Section 905 of FD&C Act (21 U.S.C. 387e) – requires every person who registers under FD&C Act to provide to FDA a list of all tobacco products that are being manufactured, prepared, compounded, or processed by that person for commercial distribution, and include copies of the labeling and a representative sampling of advertisements for such tobacco products.

- Section 907(a)(1)(A) of FD&C Act (21 U.S.C. 387g(a)(1)(A)) – this special rule for cigarettes bans all cigarettes containing an artificial or natural flavor (other than tobacco or menthol) or an herb or spice that is a characterizing flavor, including strawberry, grape, orange, clove, cinnamon, pineapple, vanilla, coconut, licorice, cocoa, chocolate, cherry, or coffee.

- Section 910(b)(1)(F) of FD&C Act (21 U.S.C. 387j(b)(1)(F)) -- requires any application for review of a new tobacco product to include specimens of the labeling proposed to be used for such tobacco product.

- Section 911(b)(2)(A)(ii) of FD&C Act (21 U.S.C. 387k(b)(2)(A)(ii)) – As of July 22, 2010, manufacturers, including importers of finished tobacco products, may not introduce into the domestic commerce of the U.S. any tobacco product for which the label, labeling, or advertising contains the descriptors "light," "mild," or "low," or any similar descriptor, irrespective of the date of manufacture, without an FDA order in effect under section 911(g) of FD&C Act (21 U.S.C. 387k(g)) (permitting the marketing of a modified risk tobacco product).

- Sections 911(a) & (b) of FD&C Act (21 U.S.C. 387k(a) & (b)) – prohibit any person from introducing or delivering for introduction into interstate commerce any modified risk tobacco product without an FDA order in effect under section 911(g) of FD&C Act (21 U.S.C. 387k(g)). Whether a product is a modified risk tobacco product is based on representations made in the label, labeling, or advertising of such product and/or other actions directed to consumers taken by the manufacturer with respect to such product.
- Section 911(d) of FD&C Act (21 U.S.C. 387k(d)) – any application for a modified risk tobacco product must include any proposed advertising and labeling for the product.

- Section 911(h)(5) of FD&C Act (21 U.S.C. 387k(h)(5)) – an order permitting a modified risk tobacco product to be commercially marketed may require that the product comply with requirements relating to advertising and promotion of the tobacco product.

In accordance with FDA regulations, it is also unlawful to advertise cigarettes or smokeless tobacco on any medium of electronic communications subject to the jurisdiction of the Federal Communications Commission.

The guidance is available on FDA's website at http://www.fda.gov/TobaccoProducts/default.htm.

Strategies and Policies on Tobacco Use in the District

The Tobacco Control Program within the District of Columbia Department of Health (DOH) strives to create awareness among District residents on the health consequences of smoking thereby promoting smoking prevention and cessation-coordinated activities.[23] The results reported here related to residents support for policy initiatives are based on a two (2) wave population based survey conducted in 2012 to assess changes in knowledge, awareness, and attitudes of the community regarding tobacco control restrictions and to assess the effectiveness of the DC DOH CPPW anti-tobacco media/education campaign. Using random digital-dial sampling methods a total of 842 adult residents in Wards 4, 5, 6, 7, and 8 participated in the survey.

Policies implemented and proposed along with the respective strategies to prevent and control tobacco use in the District are summarized below:

MAPPS Lead and Policy, System, & Environmental Initiatives	Outcome/Status
Media Campaign -60% of District residents will be exposed to a multi-dimensional media campaign with specific emphasis on African-Americans, Hispanics, Youth, Young Adults, LGBTQ, and populations living in Wards 5-8. (Media)	From February to April of 2012 DC implemented a local anti-tobacco multi-media/education campaign which ran concurrently with a national CDC anti-smoking media/education campaign. A population based survey of residents in Wards 4-8 revealed that between 44% and 50% reported seeing some aspect of the campaign. Data from the media contractors indicates that the overall campaign had 16,622,800 total impressions. Additionally, calls to the DC Quitline increased in the time period during and after the media campaign was executed; with 30-46% of callers reporting hearing of the Quitline through a media source in during this period.
School Buffer Zones- Adoption of a city-wide retail licensing policy that restricts tobacco retailers from operating within 1,000 feet of schools. (Access)	A considerable level of community support has been garnered for this policy through CPPW activities. Between 74% and 77% of District residents living in Wards 4-8 felt that stores within 1,000 feet of schools should not be able to sell tobacco products. Additionally CPPW community grantees were able to collect approximately 7,000 resident signatures of support for this policy. Currently the District's Tobacco Control Program is drafting legislative language to address this policy.
Quitline - Increase DC Quitline use by 10% over baseline (i.e., 3.5%) ensuring communities of highest need are targeted and are provided with NRT directly (e.g., AA men, Wards 5-8, publicly and underinsured). (Social Support)	During the CPPW project period of March 2011 to March 2012, the DC Quitline provided services to 4,153 tobacco users; equating to 5.3% of the tobacco using population. This is a 50% increase from the baseline reach of 3.5% of the tobacco using population.
Banning Price Discounts – Adoption of a city-wide policy banning price discounts through limits on coupon redemption at retail locations. (Price)	The DC Tobacco Control Program is currently drafting legislative language that includes this policy initiative.

Power Walls/ Advertising Restrictions - Passage of legislation restricting/banning power walls at tobacco retail locations. (Point of Purchase)	A Community Wellness Survey was conducted with CPPW funding to assess the tobacco advertising environment in the District. Continued analysis of this data is currently in progress to identify any significant differences in amounts of tobacco advertising geography or based on store types. This data will be used to support further policy or environmental initiatives related to tobacco advertising in the District.
Smoke-Free Public Housing- DC Housing Authority will pass a District-wide smoke-free housing policy. (Access)	There was a 20% increase in the number residents who are in favor of smoke-free housing policies. In March 2012, 54% of resident in Wards 4-8 supported policies that restricted smoking in multi-unit housing, such as apartment buildings. However, in a follow up survey conducted in July—after the media campaign concluded --65% of residents were in support of such policies. Several CPPW funded community grantees worked with individual public housing properties to engage residents and property managers around the voluntary adoption of smoke-free housing policies. Currently, DOH and community grantees continue to work with the DC Housing Authority and individual properties to adopt smoke-free housing policies.
License Fee Increase – Adoption of a retail licensing policy that increases tobacco retail license fees city wide. (Access)	In 2011, a revision to the District of Columbia Governments Fiscal Year 2012 budget was proposed to include an increase in tobacco retailer license fees. However, this amendment was not incorporated into city's the final 2012 budget. Currently, this policy initiative is included in the draft legislative language being developed by the DC Tobacco Control Program.
Tobacco Free Universities- Targeted colleges and universities will implement tobacco-free campus policies. (Access)	At the close of the CPPW project period, the funded community grantees were successful in implementing a Tobacco Free Campus policy at 1 out of 5 targeted universities (University of the District of Columbia).

Source: DC Tobacco Control Program, Addiction, Prevention and Recovery Administration (APRA)

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Government of the District of Columbia
Department of Health
Center for Policy, Planning and Evaluation
Behavioral Risk Factor Surveillance System (BRFSS)
899 North Capitol Street NE 5th Floor
Washington, DC 20002
Web Address: www.doh.dc.gov

Government of the District of Columbia
Vincent C. Gray, Mayor

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