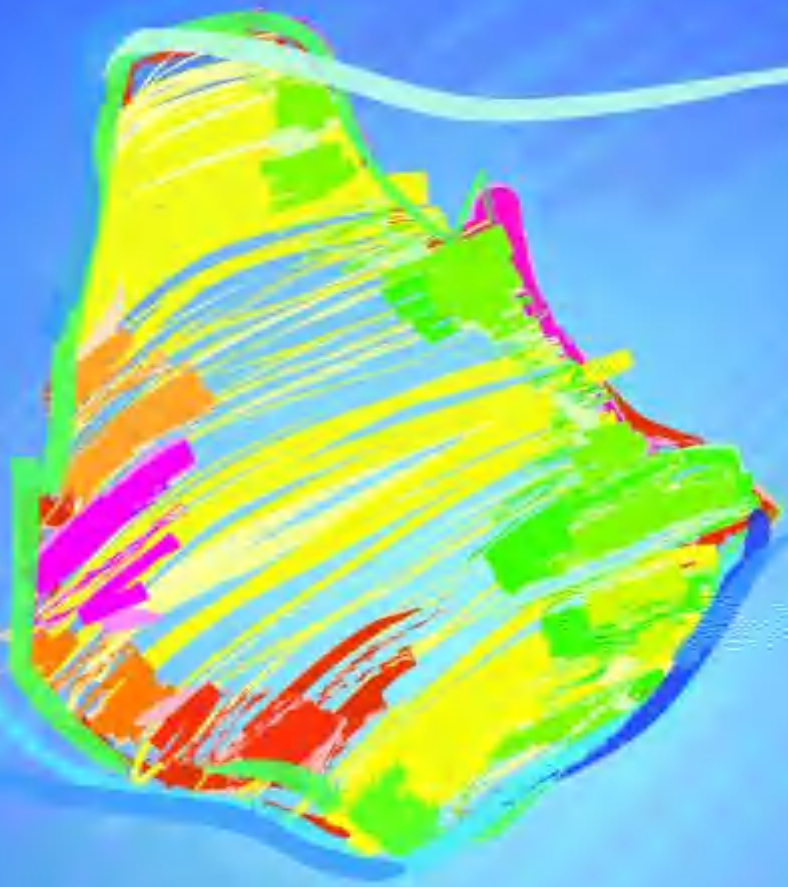
GATS Uruguay '09



Global Adult Tobacco Survey

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GATS
Uruguay 2009

GLOBAL TOBACCO SURVEILLANCE SYSTEM
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Pan American Health Organization
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MESSAGE FROM THE MINISTRY OF PUBLIC HEALTH

Uruguay ratified the Framework Convention on Tobacco Control (FCTC) of the World Health Organization in September 2004 and was among the first countries to do so. Since then, it has implemented the measures contained therein, and therefore, on the basis of Article 20 of the FCTC, a national survey of the magnitude, patterns and determinants of tobacco consumption and tobacco smoke exposure has been carried out through the Global Adult Tobacco Survey (GATS), which is part of the World Health Organization´s (WHO) global surveillance system.

GATS was originally designed for and carried out in those countries with the highest absolute number of smokers in the world. At the same time, a proposal was submitted by a group of international experts, to select a country that had already implemented a comprehensive program of tobacco control measures. Based on the progress that Uruguay has clearly achieved in this area, it was invited to participate in this survey, in order to measure and understand the impact of its policies.

Tobacco consumption has created a health catastrophe in terms of the burden of disease and disability, and because it causes more than five million deaths per year worldwide. The fact that tobacco consumption kills one person every six seconds highlights the magnitude of the problem, and therefore the importance of preventive measures that must be undertaken to address the epidemic caused by this addictive disease.

The tobacco industry has become the vector of the epidemic, by promoting social acceptance of tobacco consumption, and consistently opposing to all measures that would seek to control it. It has participated in advertising campaigns across the world to promote smoking initiation and maintain the tobacco dependence. As a result, the industry reaps huge profits at the expense of human health, household economies, and health systems.

In planning tobacco control strategies, the socioeconomic context must be taken into account. At the lowest socioeconomic levels, a significant portion of household income is spent on tobacco products, diverting resources that could otherwise be used to meet basic household needs and helping perpetuate the vicious cycle of tobacco consumption and poverty. Tobacco consumption also has an economic impact on health systems, which must cover the cost of tobacco-dependent diseases.

It becomes clear that while States must address the costs of health care and provide social protection to smokers or others harmed by exposure to tobacco smoke, the tobacco industry continues to benefit from the significant profits this business produces.

Uruguay's government realized the magnitude of the problem and therefore decided to take the necessary measures, as clearly defined in the WHO Framework Convention on Tobacco Control.

In March 2008, Uruguay approved the Law Nº 18,256 on tobacco control, which included six strategic areas:

- 100% tobacco-smoke free environments (Article 3, Law Nº 18,256)

- The process of enforcement of that rule (Articles 4 and 5, Law Nº 18,256)

- Health warnings with pictures and captions on both major sides of product´s packaging (Article 9, Law Nº 18,256)

- A comprehensive ban on advertising (Article 7, Law Nº 18,256)

- Inclusion of diagnosis and treatment of tobacco addiction at the first level of health care in public and private health services, including smoking cessation clinics (Article 10, Law Nº 18,256)

- A ban on packaging and labels that promote tobacco products in a false, misleading or deceptive way. It also prohibits the use of terms, descriptors, trademarks or trade names or figurative signs that have the effect, directly or indirectly of creating the false impression that one tobacco product is less harmful than another. (Article 8, Law Nº 18,256)

In addition and complementary to the above strategy, the Uruguayan government has a policy of progressively raising the price of tobacco products through increased taxes.

Uruguay is currently introducing a new dimension in the fight against smoking with respect to communication and education. Through the National Public Education Administration we are promoting the inclusion of thematic units

into the curricula of primary, secondary and technical professional education about the negative individual and social impact of the consumption of legal and illegal addictive substances.

On the other hand, we are designing media messages to promote healthy lifestyles and address the negative social and individual impact of consumption of those substances.

Continuing in this direction we have decided to introduce bill in the National Parliament that would deepen the fight against tobacco smoking. A second law would include communicational and educational aspects not present in the current strategy. A parliamentary-hearing has already demonstrated support from all political parties to deepen the fight against tobacco use.

For all these reasons, we needed to carry out this survey in Uruguay, both to assess the results of the government's public health policy and to provide input for planning the development of new tobacco control activities in line with the new health care model based on prevention and health promotion.

I am pleased to present this work, both to the Uruguayan people and to the international community, and at the same time to express my appreciation to the World Health Organization and the Pan American Health Organization, which along with the Centers for Disease Control and Prevention (CDC), the CDC Foundation, and the Bloomberg Initiative, joined together to help us implement the Global Adult Tobacco Survey (GATS). I would also like to express my appreciation to the commitment and hard work of the National Institute of Statistics of Uruguay, the GATS Coordinating Committee of Uruguay, and the Latin American Center for Human Economy.

Ec. Daniel Olesker
Minister of Public Health
Uruguay

MESSAGE FROM THE PAN AMERICAN HEALTH ORGANIZATION

Tobacco use is the leading preventable cause of premature death and disease throughout the world. At present, almost 6 million people die every year due to diseases related to tobacco consumption and to second-hand smoke exposure. Unless urgent measures are adopted, the number of smokers will continue to increase, especially in developing countries. It is estimated by 2030 that more than 80% of the mortality associated with tobacco will be in low and medium income countries, causing an increased burden of mortality, disease, and disability for families and national health systems generating great health, economic, and social costs.

Uruguay is recognized as one of the leaders of tobacco control in the world. They were the first country of the Region of the Americas to become 100% smoke-free nationally in 2006 and since 2010 to have among the world's largest health warnings on cigarette packages. Uruguay's successful experience in the implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) shows that any country, regardless of its resources and despite the strategies of the tobacco industry to undermine its efforts, can carry forward effective policies that protect their populations from tobacco use and the exposure to tobacco smoke.

An essential component in the implementation of tobacco control policies is surveillance. It provides evidence of the effectiveness of existing policies and assistance to allocate resources where are more necessary. Thus, the United States Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), with the support of the CDC Foundation and financing from the Bloomberg Initiative to Reduce Tobacco Use, developed the Global Adult Tobacco Survey (GATS). This is a nationally representative and standardized survey that has been implemented in 14 countries in the world (Bangladesh, Brazil, China, Egypt, Philippines, India, Mexico, Poland, Russia, Thailand, Turkey, Ukraine, Uruguay and Viet Nam) that represents two-thirds of the world's population of smokers. Uruguay was selected to participate in this initiative in recognition of its tremendous efforts in the implementation of key measures of the WHO FCTC.

This report presents GATS results for Uruguay. In addition to serving as a baseline for future analyses, the survey reports the progress already achieved and identifies areas where it is necessary to increase efforts (such as protection of the low-income population and complete ban on the advertisement, promotion and sponsorship of tobacco products , especially in points of sale).

The implementation of GATS in Uruguay is the result of a global effort to monitor the tobacco epidemic and is a powerful instrument for strengthening the national tobacco control program. The Pan American Health Organization congratulates and recognizes this effort made by national and international partners and appreciates the financial support received from the Bloomberg Foundation.

Mirta Roses Periago
Director

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EXECUTIVE SUMMARY

The consumption of tobacco is the leading cause of illness and death, accounting for more than five million deaths per year worldwide. In Uruguay, more than 5,000 people die each year from this cause, mainly due to cardiovascular diseases and cancer. The World Health Organization´s Framework Convention on Tobacco Control (FCTC) was implemented with the aim of controlling and preventing the consequences of tobacco consumption on health, economy and environment, and it includes measures that have proven effective in controlling this epidemic.

According to recent surveys carried out in Uruguay about one third of the population was current smokers:

a. 36% (CI 33.8 - 38.2) were current smokers[1] and 32.7% (CI 30.5 - 34.9) were daily users of tobacco (population 25 to 64 years of age) according to the 1st. National Survey of Risk Factors -("STEPS", MSP 2006)

b. 31.8% (CI 30.7-32.9) of the population aged 12 to 65 were current smokers, according to data from the 4th National Survey on Drug Use - National Drug Board (JND 2006).

Uruguay ratified the WHO-FCTC in September 2004, and began implementing the measures contained therein. In 2005 the National Program for Tobacco Control was established under the Ministry of Public Health to act as the focal point for tobacco control policies at the national level.

On March 1st, 2006 all enclosed spaces of public use were mandated to be 100% tobacco smoke-free, making Uruguay the first country in the Americas to be a tobacco smoke-free country.

In the following three years, Uruguay has complied with most of its obligations as a party to the WHO Framework Convention. This policy package can be found in Law Nº 18,256, comprehensive legislation for tobacco control, approved by the Uruguayan Parliament in March 2008.

In addition to 100% smoke-free environments, Uruguay has also raised the price of tobacco products by applying a tax policy in line with the health objectives, put health warnings on tobacco packaging that occupy 80% of both major faces and include pictures, established a comprehensive ban on advertising, promotion and sponsorship of tobacco products, and incorporated the diagnosis and treatment of tobacco addiction into primary health care services, based on the National Guidelines for Addressing Tobacco Addiction.
Thus, Uruguay has become a world leader in tobacco control.

Article 20.2 of the FCTC states the need to systematically monitor the consumption of tobacco, to ensure comparability across countries. To fulfill this mandate Uruguay participates in the Global Adult Tobacco Survey (GATS), which is part of the Global Tobacco Surveillance System (GTSS), developed by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), with the support of the Bloomberg Initiative and the CDC Foundation.

GATS is a nationally representative survey that applies to all persons 15 years or older. Through a standardized questionnaire that allows comparability among countries, GATS allows the evaluation of not only the prevalence of tobacco, but also the main measures of the FCTC through key indicators.

Given the progress made by Uruguay, the implementation of this survey is of particular importance, in order to assess processes already carried out and to define future courses of action.

Methodology

The GATS sample design proposed for Uruguay used a multistage stratified random sample, as defined below.

A. Random: random procedures were applied at all stages of selection. This allowed a probability sample representing the entire country.

B. Stratified: the sample represented both urban and rural areas. Each sub-population was divided into geographic/socioeconomic strata. Socioeconomic stratification was used in Montevideo, consisting of four strata: Low, Medium Low, Medium High and High. In the rest of the country the cities and towns were classified according to their size. Rural areas were considered as a single stratum in the whole country.

[1]Current smokers include daily and occasional smokers.

C. Multistage: the final sample units (men or women who would respond to the survey questionnaire) were selected by three or more steps, each corresponding to units of selection that were progressively smaller than the previous step unit and completely enclosed within it. The Primary Sampling Units (PSUs) were formed by Census Segments. A Census Segment was a group of approximately 10 Census Zones, that corresponded to the Secondary Sampling Units (SSUs). The Tertiary Sampling Units, were the occupied private dwellings (households) addressed in the selected Census Zones. Finally, in the last step of sampling, only one person in the target age group was selected from each household.

A total of 76 interviewers were hired to do the field work, making up 15 teams. For the monitoring and organization of field interviewers there were 12 field supervisors, a general supervisor, and a team of quality control personnel at the headquarters of the National Institute of Statistics.

Target population: Persons age 15 and older, living in private households throughout the urban and rural national territory.

Sample size: 6,558 cases without replacement (missed cases were not replaced due to the non-updated sampling frame, or other causes).

Type of interview: Personal, face-to-face, applying a standard questionnaire with an average duration of 15 minutes.

Actual Number of interviews: 5,581 completed interviews.

Survey time: 47 days with a start date of October 19, 2009 and an end date of December 4, 2009.

Results

Tobacco use

In Uruguay, 25% (CI 23.3-26.6) of persons 15 years or older currently smoke, either daily or occasionally, 30.7% (CI 28.2-33.4) of men and 19.8% (CI 18.1-21.6) of women. 20.4% (CI 19.1-21.8) of persons 15 years old and older are daily smokers. Almost all the smokers, 99.1% (CI 97.3-99.7) of current smokers consume cigarettes, either manufactured or hand-rolled. When analyzing the type of cigarette smoked, it is observed that 85.3% (CI 81.9 to 88.1) of current smokers smoke manufactured cigarettes, and 32.6% (CI 28,6-36.8) smoke hand-rolled cigarettes. The sum exceeds 100% because some smokers use both types of product.

The average number of cigarettes smoked by daily smokers is 15 per day (15.4, CI 14.6 – 16.3); this was higher in men (17.6, CI 16.4 - 18.8) than in women (12.5, CI 11.5 - 13.5). On average, young smokers (20 to 34 years) began their tobacco consumption at age 16 (16.5, CI 16.2 - 16.8). Only 11.2% (CI 8.3 - 15.1) in this age group started smoking at over 20 years of age. The group aged 20 to 34 years was selected to determine age of onset, because it allowed investigation of current behavior patterns. The older population reflects older onset patterns which do not necessarily coincide with those of today.

Smoking cessation

The Uruguayan population showed great interest in abandoning the use of tobacco: 76.6% (CI 72.3-80.3) said they were planning to or thinking about quitting. Almost half or 48.6% (CI 45.0-52.3) of those who smoked in the year prior to the survey had made an attempt to quit in the past 12 months; 8.0% (CI 6.3-10.7) were able to quit smoking in the last year, and remain non-smokers, while 16.4% (CI 15.2-17.7) of the population said they were ex-smokers.

The “quit rate" refers to the percentage of persons who had ever smoked on a daily basis and who are now former smokers. This rate is an important indicator of the success of policies to promote the cessation of tobacco consumption in smokers. GATS Uruguay showed a “quit rate" of 42.0% (39.4 - 44.7), which was quite impressive, since the aim is to reach 100%. The GATS definition of an ex-smoker is simply "a person who has stopped smoking", without establishing a minimum length of time since cessation. At the same time, having had one puff of a cigarette does not invalidate a person's designation as an ex-smoker for the GATS. However, in Uruguay it is considered important to establish the percentage of former smokers who have not even had a puff in the last year, since in many cases those who have a puff resume smoking in the following months. When comparing the percentage of ex-smokers, according to the GATS definition, with the percentage using the stricter definition of one year of total abstinence (89.5%, CI 86.6 - 91.9) it was evident that most Uruguayan ex-smokers are

consolidated ex-smokers, who had spent more than one year without even one puff.

Of daily smokers who had managed to quit, 32.7% (CI 29.1 - 36.6) had done so in the past four years, with females (40.9%, CI 34.9 - 47.2) predominating over males (27.0%, CI 22.7 - 31.8). As for the age range, the highest percentage of cessation in this time period was observed among those between 25 and 44 years old (46.1%, CI 39.0 - 53.4).

Of all current smokers who had visited a health service in the past 12 months, 76.6% (CI 72.3 - 80.3) said they were asked about their smoking status, and 54.5% (CI 49.4 - 59.4) said they were advised to quit. However, only 15.1% (CI 11.7 - 19.3) received guidance on how to do so. On average, 48.7% (CI 44.7 - 52.8%) of people age 15 years or older knew of places where they could get help to quit smoking, and this knowledge was more prevalent in males (53.9%, CI 48.2 - 59.6), individuals living in urban areas (50.0%, CI 45.7 - 54.3) and those with higher educational level (tertiary 75.3%, CI 60.8 - 85.7).

Secondhand smoke exposure

A total of 16.5% (CI 14.1-19.3) of the population 15 years or older that worked mainly indoors reported having been exposed to tobacco smoke in their workplaces -in the previous 30 days-. Men (21.4%, CI 17.7 - 25.5) and persons with primary education (20.2%, CI 15.7 - 25.7) were more exposed than women (11.8%, CI 9.2 - 14.9) and those with tertiary education (10.6% CI 6.8 - 16.1), which could be related to type of occupation. The level of exposure was very low in public offices (6.9%, CI 5.7 - 8.4), health facilities (3.8%, CI 2.8 - 5.0), restaurants (4.4%, CI 3.2 - 6.1) and means of transportation (5.4 %, CI 4.5 - 6.4), but higher levels were reported at the university and colleges (27.5%, CI 21.7 - 34.1) and in bars, pubs and discos (23.4%, CI 20.2 - 27.0), places where a younger population predominates.

On average, 29.2% (CI 27.4-31.1) of respondents said they were exposed to tobacco smoke inside their homes, at least weekly, and this rate was highest in the age range of 15 to 24 (40.8%, CI 36.4 - 45.3). More than half of households nationwide (55.5%, CI 53.4 - 57.5) had no smokers living there.

Economics

Consumers of manufactured cigarettes spent an average of $U 991 (2009 current Uruguayan pesos) per month on tobacco[2], which has a different weight depending on the level of household income -the greatest effect on the poorest sectors of society-. On the other hand, the lower tax imposed on pouches of loose tobacco, promotes the consumption of hand-rolled cigarettes, by facilitating access by youth to a product that sickens and kills.

Uruguayan smokers said they bought their cigarettes mainly in grocery stores (49.7%, CI 44.6 - 54.8) followed by kiosks (25.7%, CI 21.7 - 30.3), and large supermarkets (12.7%, CI 10.2 - 15.6).

Media

A total of 20.9% (CI 19.1-22.8) of the surveyed population 15 years or older reported seeing cigarette advertising in the venues where they were sold; this percentage was much higher in the 15 to 24 year age group, suggesting that younger people were more likely to be affected by such advertising.

Health warnings on cigarette boxes are an effective measure: 96.1% (CI 94.5 - 97.3) of current smokers surveyed said they had noticed them and 44.6% (CI 41.0-48.2) of current smokers reported they were thinking about quitting because of these warnings.

Knowledge, attitudes and perceptions

The vast majority of the surveyed population, 97.6% (CI 97.0-98.1), believed that smoking causes serious diseases in smokers, such as stroke or heart disease, or lung cancer, and 93.8% (CI 92.9-94.5) believed that exposure to secondhand tobacco smoke causes serious diseases in nonsmokers. However, almost 25% (CI 22.8-26.7) of adults were ignorant to the fact that light, ultralight or menthol cigarettes are as harmful as regular cigarettes.

Future recommendations based on GATS data

Tobacco control measures are one of the most important public health policies due to the consequences they have

[2] In February 2010, after the presentation of the GATS data, the President approved a decree raising the specific tax to loosen to 70% thus equating it to what is payed for manufactured cigarettes.

on disease prevention and promotion of the public´s health.

Monitoring the impact of tobacco control policies implemented in Uruguay is important, both nationally and internationally, because this country has implemented almost all the measures of the WHO Framework Convention on Tobacco Control.

GATS results showed that these measures have been effective in controlling the smoking epidemic and at the same time, allowed Uruguay to define future strategies in line with its public health objectives, to defend the right of individuals to health and life, as granted in the Constitution.

The following activities for future work in the tobacco control area have been identified for Uruguay:

1 - Although in Uruguay smoking is not allowed in enclosed public spaces and workplaces, there is still some exposure in homes. Further reducing exposure to secondhand smoke will require implementation of information and public awareness campaigns about the different types of exposure, sometimes unnoticed, especially when there are children and pregnant women in the home, so that citizens will voluntarily take control of this epidemic in the private confines.

2 - Although compliance with tobacco smoke-free regulations is high, it has not yet reached optimal levels and therefore information campaigns should continue, along with strengthening systems to control and monitor compliance.

3 - The work should focus on populations of lower socioeconomic status, where tobacco use is the most prevalent, in order to break the vicious cycle of poverty and tobacco use referenced in the international literature.

4 - Tobacco consumption cessation programs should be strengthened and coordinated nationwide, since nearly 8 in 10 current smokers said they are thinking about quitting.

5 - Uruguay must fully comply with Article 13 of the FCTC by completely banning tobacco advertising, promotion and sponsorship, since it is currently allowed inside point of sale under regulating conditions. More than a third of those between the ages of 15 and 24 reported having seen tobacco advertising in shops where it is sold.

1. INTRODUCTION

The consumption of tobacco is the leading preventable cause of premature death and disease, responsible for more than five million deaths per year worldwide. Unless current trends change, it is estimated that by 2030, deaths will exceed 8 million annually and over 80% will occur in the developing world [(1)].

With the aim of reducing the global burden of disease and death and to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to secondhand smoke, the World Health Organization (WHO) promoted the Framework Convention on Tobacco Control (FCTC) [(2)], encouraging countries to adhere to its principles and implement the measures contained therein.

In August 2006, WHO and the Centers for Disease Control and Prevention (CDC) of the United States agreed to an expert consultation to discuss monitoring tobacco consumption among adults and make recommendations for the development of a standard surveillance protocol. The expert consultation also recognized the challenge of limited resources and the methodological complexity for the design and comparability among countries in adult tobacco consumption surveys.

The Bloomberg Initiative to Reduce Tobacco Consumption contributed resources toward the creation of a Global Tobacco Surveillance System, (GTSS), which originally consisted of three surveys, the Global Youth Tobacco Survey, (GYTS), the Global School Personnel Survey (GSPS) and the Global Health Professions Students Survey, (GHPSS).

The Global Adult Tobacco Survey (GATS) is a household survey that was included as a new component of the GTSS in 2007. GATS allow countries to collect key data to establish control measures of tobacco in the entire adult population. Its results will support countries in the formulation and implementation of effective interventions for the control of tobacco consumption.

Several countries throughout the world are implementing GATS supported by WHO, CDC, CDC Foundation, Johns Hopkins Bloomberg School of Public Health (JHSPH) and Research Triangle Institute (RTI).

GATS was initially designed to be implemented in those countries with the highest absolute number of smokers in the world: Bangladesh, Brazil, China, Egypt, India, Mexico, Philippines, Poland, Russian Federation, Thailand, Turkey, Ukraine and Vietnam.

Due to its demographic characteristics Uruguay was not included in the group of countries selected initially, but given that it has shown a strong commitment to tobacco control and has made significant progress since ratification of the FCTC in September 2004, it was invited to participate. It was determined that the Ministry of Public Health (MSP, in Spanish Ministerio de Salud Pública) would be the coordinating agency and the National Institute of Statistics (INE, in Spanish Instituto Nacional de Estadísticas), would implement the survey.

To track the various stages of implementation of the study a GATS National Coordinating Committee was nominated, composed of representatives of different institutions currently working in tobacco control: Ministry of Public Health (Health Surveillance Department and the National Program for Tobacco Control), National Institute of Statistics (INE), Pan American Health Organization (PAHO), Faculty of Medicine of the University of the Republic of Uruguay, University Hospital, and the Honorary Commission to Fight Against Cancer (CHLCC, in Spanish Comisión Honoraria de Lucha Contra el Cáncer).

1.1 Tobacco control policies in Uruguay

Consumption of tobacco was a socially accepted behavior until recently, when awareness increased, especially among non-smokers, about people's right not to be exposed to second hand tobacco smoke, reflecting a change in the social concept of the problem.

Since the 1950's, true pioneers such as Dr. José Saralegui and Prof. Dr. Helmut Kasdorf, some nongovernmental organizations (NGOs) such as the Tobacco Control Commission of Uruguay (CATU, in Spanish Comisión Antitabáquica del Uruguay) and the Uruguayan League of Volunteers for Education Prevention and Control of Cancer (LUVEC, in Spanish Liga Uruguaya de Voluntarios para Educación, Prevención y Control del Cáncer) and later some institutions such as the Faculty of Medicine, the CHLCC and the Honorary Committee for Cardiovascular Health (CHSCV in Spanish Comisión Honoraria para la Salud Cardio Vascular), have been

working on various aspects of tobacco control; however it was only in 2000 that Uruguay began a coordinated movement and steady advance in tobacco control policies.

At that time, the National Alliance for Tobacco Control was created, promoted by the Directorate General of Health (DIGESA) of the MSP and comprising the following governmental and academic agencies and NGOs:

A. Ministry of Public Health
B. National Drugs Board (JND)
C. City Council of Montevideo (IM)
D. National Resources Fund (FNR)
E. Faculty of Medicine, University of the Republic
F. Honorary Commission to Fight Against Cancer
G. Honorary Commission for Cardiovascular Health
H. Medical Union of Uruguay (SMU)
I. Countryside Medical Federation (FEMI)
J. Uruguayan Passive Smokers (FPU)
K. Tobacco Control Commission of Uruguay
L. Family Medicine Society of Uruguay
M. Association of Chronic Lung Disease Patients
N. Pan American Health Organization (PAHO)

This partnership between government agencies and civil society, acting at different levels of government and politics managed to achieve consensus and change the position of the executive branch and legislators regarding tobacco control, such that in 2005 the National Alliance for Tobacco Control received recognition by PAHO/WHO on World Non Tobacco Day.

In more recent years other organizations have been created, and joined the already existing ones, to address different aspects of tobacco control, such as the Research Center for the Tobacco Epidemic (CIET) and the Uruguayan Society of Tobaccology (SUT).

1.1.1 Framework Convention on Tobacco Control

The process of cohesion and empowerment of the tobacco control movement in Uruguay began by providing knowledge and then advocating for the signing and ratification of the FCTC. This gave the tobacco issue a public health perspective for the first time in the media, and provided visibility to the organized movement for tobacco control in Uruguay. The signing of the FCTC was made possible in June 2003 and was ratified in September of 2004, Uruguay being among the forty initial ratifying countries and the first in South America.

1.1.2 National legislation

Until the last decade of the twentieth century tobacco control legislation in Uruguay was weak, obsolete and had minimal compliance, as it was in most countries. Furthermore, contents were not aligned with the new tobacco control concepts and policies established by the FCTC.

In 2004 the MSP appointed an Inter Agency Advisory Committee and then in 2005 created the National Program for Tobacco Control which provided a national focal point, and made a tobacco control a priority program. The executive branch, with the active participation of the National Program for Tobacco Control and MSP Advisory Committee, was now able to develop a new body of laws based on the recommendations of the WHO-FCTC, which have transformed Uruguay into a world pioneer in tobacco control, and garnered international recognition. Significant momentum for this process was generated by President Dr. Tabaré Vázquez, a medical oncologist who was highly sensitive to the issues.
WHO established a strategy called MPOWER to implement the FCTC, composed of six steps to address the tobacco epidemic, including:

M onitor tobacco use and prevention policies,
P rotect people from tobacco smoke,
O ffer help to quit tobacco use,
W arn about the dangers of tobacco,
E nforce bans on tobacco advertising, promotion and sponsorship,
R aise taxes on tobacco.

The current situation of tobacco control in Uruguay based on the FCTC and the MPOWER package is presented below.

1.2 Implementation of WHO-FCTC provisions relating to the MPOWER package

M - Monitor tobacco use and prevention policies

Article 20 ° of the FCTC: Research, surveillance and exchange of information. Paragraph 2: The Parties shall establish, as appropriate, national, regional and global surveillance programs of the magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke. Toward this end, the Parties should integrate tobacco surveillance in national, regional and global health surveillance programmes so that data can be analyzed at the regional and international levels, as appropriate."

Tobacco consumption in adults.

Analyzing and describing the evolution of the prevalence of tobacco use in Uruguay has faced many operational difficulties due to the fact that until the 1990's data were incomplete and based on non comparable surveys, with samples typically unrepresentative of the total population, using dissimilar age groups and applying different definitions of who was a smoker. Most previous estimates of tobacco smoking prevalence were around 45% [3]. In the National Survey on Psychoactive Substance Use carried out by the National Drug Board in 1994 among the urban population from 12 to 65 years, the prevalence found was 40.3% [4].

Before the implementation of tobacco control measures, prevalence rates of tobacco consumption had remained fairly stable over several years. Since 1994, the National Drug Board (JND) has conducted surveys in the urban population aged 12 to 65 years using a standardized methodology. Prevalence remained steady at around 32% from 1998 to 2006 [5] [6] [7], a rate similar to that of the first National Survey of Risk Factors (STEPS) [8] carried out in the 25 to 64 age group, by the MSP in 2006 at the national level.

One of the aims of GATS was to show whether there was a change in tobacco consumption among the Uruguayan adult population, after full implementation of tobacco control measures.

Tobacco consumption among youth

Regarding the prevalence of tobacco consumption among young Uruguayans, the National Drug Board has carried out two different surveys. As background to these investigations a 1994 survey carried out in the country´s capital city, by the CHLCC [9] among third-year students from secondary schools, which showed that 23% of students between ages 13 and 15 smoked. Behavior differed between sexes, 29% of girls and 16% of boys smoked, indicating a feminization of tobacco consumption.

a- Global Youth Tobacco Survey (GYTS) in 2001 and 2006 among high school students aged 13 to 15. Results of the two surveys were not comparable, because in 2001 it was not implemented nationally.

The Global Youth Tobacco Survey (GYTS) conducted in Uruguay in 2001 in four areas of the country [10], showed that 24.1% of students had smoked one or more cigarettes in the past 30 days, with a higher rate among females (26.5%) than males.

In 2006, the GYTS was repeated, this time on a nationally representative sample [11]. The prevalence of smokers (1 or more cigarettes in the last month) was 22.8%, maintaining the higher rates among females (24.6%).

b- National Survey on Drug Use in High School, implemented in 2003, 2006, 2007 and 2010, among the population aged 12 to 17. The results allowed follow up to determine the evolution of consumption in this age group, since the same survey was repeated regularly.

In 2003 the first National Survey on Drug Use in High School Students [12] was carried out, to determine the prevalence of consumption of alcohol, tobacco and other drugs. It found a prevalence of tobacco consumption in the last 30 days (regular consumption) of 30.2% overall, 25% in males and 34% in women, showing a clear feminization of consumption.

The second survey (2006) [13] revealed a smoking prevalence in the last 30 days of 24.8%. The decrease verified

when compared to 2003 survey, was related to less young men initiating tobacco consumption as well as more young men quitting. Consumption was still significantly prevalent in women, and was especially noticeable at age 15, when a prevalence of 35% was found in women versus 22% in men.

The third survey (2007) [14] showed a prevalence of consumption in the last 30 days of 22%.

The fourth survey (2010) [15] showed the prevalence of current smokers was 18.4% which was still higher in women (21.1%) than in men (15.5%). The decline was greater in men than in women compared 2006 rates. These results show a steady decline in prevalence, with a further decline in the most recent years, probably as a result of tobacco control measures implemented. This survey also confirmed the role of legal drugs (alcohol and tobacco) as a risk factor for the consumption of illegal ones, since for the first time a decrease in the consumption of marijuana was also observed, a fact that the authorities of the National Drug Board thought might be linked, at least in part, to the decline in tobacco consumption, although additional studies are needed to confirm this hypothesis.

Tobacco consumption among health professionals

A key population to monitor for tobacco consumption is health professionals because they act as role models in society and are responsible for the health care of the smoking population and advocacy of control measures. It has been observed that changes among this population often precede those in the general population. However, tobacco consumption among health professionals presents a scientific and ethical contradiction.

Tobacco consumption prevalence rates among health professionals remain high. In 1992 Kasdorf measured the prevalence of smoking in a private health institution, and found that 30% of health professionals smoked, and among those smokers 30% did so in front of their patients[3].

The prevalence of tobacco use among Uruguayan doctors stood at 27% [16] in 2001, a figure very close to that of the general population. In 2007, the Medical Union of Uruguay [17] conducted a telephone survey in a representative sample of active physicians in the country, where 17% identified themselves as being smokers. Although the data were not comparable, there might be an encouraging trend towards reduction of tobacco consumption in the medical profession. Other studies will be required to verify whether this is so. These figures could be reflecting behavioral changes due to the diffusion of information and knowledge at the level of general public and at the academic level.

Mortality attributable to the use of tobacco

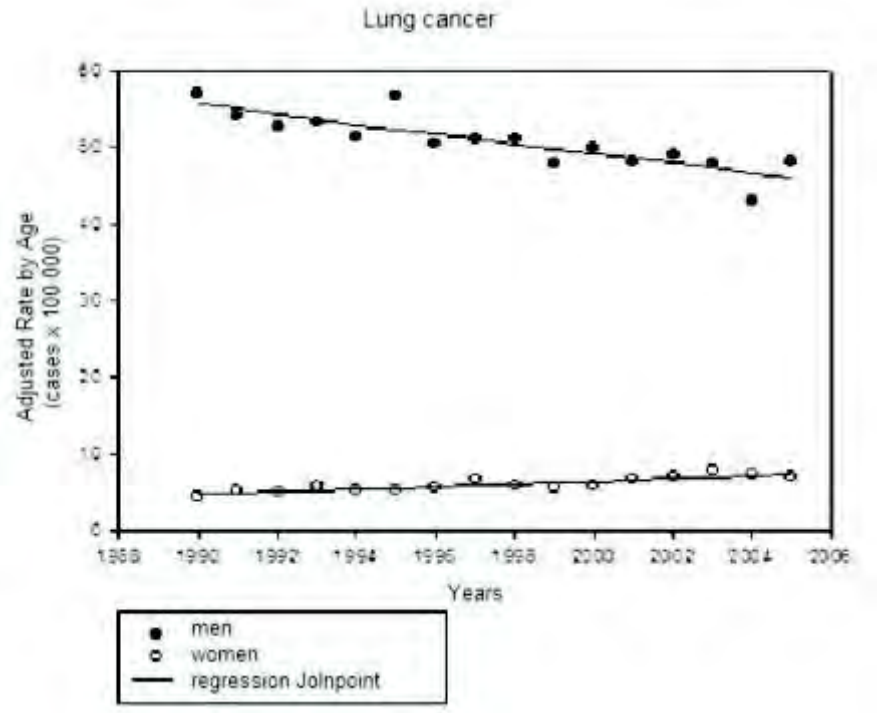
Uruguay has undergone a demographic and epidemiological transition and now displays an epidemiological disease profile similar to that of developed countries. Non communicable diseases are currently responsible for more than 60% of annual deaths.

Diseases related to tobacco consumption have been estimated using an attributable fraction set by WHO [18]. In 2002, based on MSP data, estimate of annual deaths due to cardiovascular and respiratory diseases and cancer attributable to the use of tobacco in Uruguay was 14.5% of all deaths, which accounted for 4,589 deaths in that year. This calculation did not consider deaths from complications of pregnancy, perinatal mortality and deaths related to secondhand tobacco smoke exposure.
This figure is especially worrying when compared to overall mortality rates among the Uruguayan population, because it exceeds the combined total number of deaths from traffic accidents, homicides, suicides, AIDS, tuberculosis and alcoholism, according to MSP figures, as is the case in other countries.

With respect to lung cancer in women, the National Cancer Registry and the Epidemiological Surveillance Area of CHLCC, found that while in 1990 approximately 130 women died from lung cancer each year, and about 160 new cases were registered annually, in 2006 about 200 women died from this disease and about 240 new cases were registered. The percentage increase in incidence and mortality was estimated at 55% during the period from 1990-2006. This trend seemed to have been sustained and even worsened according to the preliminary results of 2008, when 263 women died from lung cancer. The age-adjusted rate of lung cancer mortality in women has grown at over 3% per year. (See Figure A).

[3] "Smoking prevalence among health professionals in a private healthcare institution" survey. Kasdorf, H, 1992. Not published.

Figure A. Mortality annual rate trend of lung cancer adjusted by age, for men and women. Period 1988 to 2006.



Source: Epidemiological Surveillance, CHLCC

Based on the percentage of mortality from exposure to secondhand tobacco smoke in developed countries, it is estimated that there are approximately 600 deaths a year from this cause in Uruguay. Future evaluations of the impact of tobacco control measures will be based on these estimates.

Studies of tobacco smoke air pollution

On March 1st, 2006, Uruguay became a smoke-free country. Before and after this date, several studies were developed to monitor secondhand smoke exposure as well as air pollution.

In 2003, the "Tobacco Smoke Exposure Surveillance Study in Uruguay" [19] was conducted as part of a multi-centric study designed by PAHO and Johns Hopkins University (USA). By measuring the amount of nicotine in the air, it demonstrated the magnitude of secondhand smoke exposure and revealed the presence of high levels of nicotine in all environments studied, including hospitals, public offices, airports, bars, restaurants and pubs.

In 2007 the study was repeated, and a year and a half after the law stating that enclosed public places should be 100% tobacco smoke-free was enacted, a significant decrease in the levels of nicotine was found. Comparing 2007 levels with the first study, the average reduction in nicotine levels was 91%, with the greatest reduction at educational facilities (97%). The study highlighted the significant reduction in secondhand smoke exposure observed after nationwide implementation of comprehensive legislation for tobacco smoke-free environments. [20]

In 2005, CIET conducted an investigation in Montevideo, of "air pollution from tobacco smoke in enclosed public spaces ", which measured the number of respirable suspended particulates (RSP) in bars and restaurants [21]. In 2007, the same study was repeated and found a significant average decrease in RSP in public settings, from 210 to 25 g/m [22]. However, measurements of RSP in private homes remained in a high level.

In 2006, together with the Johns Hopkins University, a study of "tobacco smoke exposure at the household" was conducted [23], which involved measuring nicotine in the air and in the hair of children and women living in households with smokers and nonsmokers. This study showed that 82% of parents who smoked did so close to their children. In households with smokers, nicotine values were 17 times higher than in non-smoker households, increasing with the number of smokers in the household.

Economic Studies

Given that health costs generally represent between 7% and 11% of the Gross Domestic Product (GDP) of Southern Cone countries, in 2003 it was estimated that smoking-related health expenditures represented about 1% of GDP in any given year. In Uruguay, this represents USD 150 million annually in direct costs [24], to which it may

be added the indirect costs resulting from increased employee absenteeism and social security expenses for disability.

P - Protect people from secondhand tobacco smoke

FCTC Article 8: Protection from exposure to tobacco smoke: 1Parties recognize that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability. 2. Each Party shall adopt and implement in areas of existing national jurisdiction as determined by national law, and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public environments and, as appropriate, other public places "

Implementation of tobacco smoke-free environments

In 1981, Uruguay had already begun to work in protecting the public against exposure to tobacco smoke as there was a rule banning smoking by passengers on buses of the inter-departmental transportation system.

In 1994, the CHLCC (Population Education Department), began addressing the issue of tobacco smoke-polluted environments, with the aim of raising public awareness.

In 1994, the Faculty of Medicine declared its main building a "Smoke-Free Area". Although there were difficulties in implementation, it demonstrated a change in attitudes of academic bodies towards the problem.

In 1996, an executive decree prohibited the use of tobacco in public offices and all buildings of common public use, especially where foods were sold or consumed, except in predetermined areas, properly marked as "Smoking Area", which location should guarantee the rights of nonsmokers. However, since the decree failed to provide sanctions, compliance was low.

In 2000, PAHO launched the Tobacco Smoke-Free America Initiative, to protect non-smokers from secondhand tobacco smoke. Under this initiative, in 2001 Uruguay subscribed to the Tobacco Smoke-Free Environments Project, with participation from the City Council of Montevideo and the University Hospital. Although implementation and enforcement of this measure was very difficult, declaration of these important buildings as “tobacco smoke-free" marked a conceptual change towards the problem. Additionally, the subject was actively discussed by the public and in the press.

Since 2004, various regulations have expanded the 100% tobacco smoke-free environments to include health institutions and government agencies. Continuing this process, in September 2005 a regulation was approved, to take effect 6 months later, making the entire country 100% tobacco smoke-free. This action was preceded and facilitated by an intensive information and awareness campaign among all sectors of the population.

Bars, restaurants, and shops in general were critical partners in this process. The first contacts were difficult, as the tobacco industry had disseminated misinformation regarding the economic losses they would suffer if such measures were passed. The National Tobacco Control Program of the MSP made numerous contacts with merchants and bar and restaurant owners, providing accurate scientific information and support. Organizations such as the Association of Shopkeepers in Old Town (a district frequented at night by the young people of Montevideo), merchant associations in other regions of the country, board directors of major department stores and shopping centers, and the Association of Bar, Grocery and Retail Owners of Uruguay (CAMBADU) which brings together thousands of small shopkeepers, ended up providing great support for implementation of the measure.

During this period various media campaigns were instrumental in informing and sensitizing the public and strengthening compliance, at the same time.

a) - "Don´t make me smoke ... your air is also mine." (Year 2005)
This campaign consisted of posters, information leaflets and stickers addressing the harms of secondhand tobacco smoke, and radio advertising based on old, well-known advertisements. One radio piece won an award in 2005 from the Golden Bell Contest of the Advertisers Chamber of Uruguay.

b) - "A million thanks." (Year 2006, before the smoke-free legislation)
The focus of this campaign was to communicate a positive message that brought together two central features: involvement and interaction with the public. It aimed to involve the whole society in recognizing the effort that smokers would have to make to keep the environment smoke-free.

The idea was to create a participatory movement in which a million "thanks" were actually collected and passed on to those who commited to stop smoking in enclosed public spaces starting from March 1st 2006.

This was a way to involve the whole population in concrete actions to accompany these measures. "Thanks" could be given by signing paper forms, through a website, or through a toll-free 0800SMOKE phone line.

The campaign was launched by the President of the Republic, in a national video conference which convened personalities from all fields, including politics, art, journalism, and sports. The campaign ended on World Health Day, when a bus traveled through Montevideo displaying the results: 1,112,643 "thanks" collected.

c) - "Uruguay tobacco smoke free" (Year 2006, after smoke free legislation was enacted)
This campaign was designed to support the tobacco smoke-free environments policy and highlight the positive aspects. It began several weeks prior to the effective date of the decree, continuing the above described campaign.

A logo identifying tobacco smoke-free environments was created, in order to standardize the process throughout the country. Posters and stickers using this logo were printed and distributed for free as a way of supporting implementation of the decree.

In March 2006, Uruguay became the first country in the Americas to become completely tobacco smoke free in all public places and workplaces, including bars, restaurants, nightclubs and casinos, with sanctions defined in case of default.

From 2008 to the present, the Population Education Department of the CHLCC has promoted campaign for "tobacco smoke-free homes for the health of our children". It includes the release of a publication, workshops, TV spots, posters and stickers, with the aim of increasing protection from exposure to secondhand smoke in environments that are not covered by legislation, such as private homes.

Assessing the impact of regulations.

Opinion survey of the population

A survey of the urban population over 18 years of age in November 2006 [25], showed that 80% of respondents were in favor of 100% tobacco smoke-free environments, even among smokers (2 of 3). Six months after the regulation was enacted, 99% of the population throughout the country was aware of the rules, with 88% perception of enactment of the decree. Seventy percent of Uruguayans said they had not changed their choice of social venues such as bars, restaurants and/or clubs, while 10% said they were going out more than before. The majority of the population responded that they felt better being in public places and a quarter of smokers said they had reduced the frequency of tobacco consumption. The population´s response to this decree met all expectations.

Economic impact

An economic study on the impact of the "100% smoke-free environments" decree on bars, restaurants, grills, pubs, cafes and pizza stores, was carried out in 2006 by Ramos for PAHO [26]. It concluded that the law "had not affected sales of the business analyzed in the study."

The 2009 study "Analysis of the economic impacts of the legislation on tobacco smoke in bars, restaurants and casinos in Montevideo", carried out by Arbulo et al[27], after two and a half years after implementation of the legislation, concluded that it had had no effect on either short- or long-term income in restaurants, grills, bars, cafes, tea rooms and casinos.

Health impact

In March 2010, the CIET presented a study evaluating the "impact of the ban on enclosed public spaces smoking on myocardial infarction in Uruguay [28]. It compared the incidence of hospital admission for myocardial infarction during the two year period before and the two year period after the effective date of the decree prohibiting smoking in enclosed public spaces. In the period after the decree was enacted a net decrease of 22% of myocardial infarction was observed. This study demonstrated the rapidity of the positive impact of the measure on acute cardiovascular disease.

Environmental impact

Studies that measured respirable suspended particles as well as the amount of nicotine in the air, comparing the periods before and after enactment of tobacco smoke-free legislation [20, 22], showed a reduction in air pollution greater than 90%.

O - Offer help to stop using tobacco

Article 14 of the FCTC. "Each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence."

Promoting smoking cessation and proper treatment of tobacco addiction are closely linked to the training of health professionals in these areas.

In 1988 the first official Clinic to Address Smoking was opened at the University Hospital, with activities around health care, teaching, and research and community education. The University Hospital trained undergraduates and conducted workshops for health professionals.

In 1999 the CHLCC Technical-Professional training section began organizing courses on "The theoretical bases for the prevention, diagnosis and treatment of smoking" aimed at all health workers. From that time until 2005, centers in various parts of the country slowly joined the program. The legislation to ban smoking in enclosed public spaces generated a significant and rapid increase in demand for smoking cessation aid.

In response, since 2004, the National Resource Fund has placed strong emphasis on the creation of new treatment programs through training health professionals and free provision of medication (chewing nicotine and bupropion) to all units upon request. In a short time, Uruguay went from having very few treatment centers, to achieving national coverage.

In 2009, the Faculty of Medicine of the University of the Republic inserted content about tobacco use into its new curriculum, starting from the first years of training and including the importance of health professionals as role models, so as to ensure that future generations of doctors would have appropriate training and commitment to the issue.

Article 14 of the FCTC set forth the need for clinical guidelines for the treatment of tobacco dependence. In 2009, Uruguay established national guidelines for addressing tobacco use [29] and a manual for primary health care, based on broad consensus at the national level. A plan for dissemination of the guide and manual, which included training workshops to optimize its management, was subsequently defined. Assessments of the degree of implementation of these strategies will be conducted in future.

In Uruguay, current legislation mandates inclusion of diagnosis and treatment of tobacco dependence in the first level of health care services in the whole country, as well as the obligation to implement the recommendations contained in the national guidelines. It is mandatory to register smoking status in the patient´s history, as well as the intervention made. The MSP has established training goals around various risk factors, including smoking, and is promoting them by offering financial compensation to health institutions.

During the years 2008 and 2009, Uruguay had a quit-line that belonged to a pharmaceutical company. A project to implement an official quit-line is currently being developed through the National Program for Tobacco Control.

W - Warn about the dangers of tobacco

Article 11 of the FCTC: Each Party shall, within a period of three years after entry into force of this Convention for that Party, adopt and implement, in accordance with its national law, effective measures to ensure that: (a) tobacco product packaging and labelling do not promote a tobacco product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions, including any term, descriptor, trademark, figurative or any other sign that directly or indirectly creates the false impression that a particular tobacco product is less harmful than other tobacco products. These may include terms such as "low tar", "light", "ultra-light", or "mild"; and (b) each unit packet and package of tobacco products and any outside packaging and labeling of such products also carry health warnings describing the harmful effects of tobacco use, and may include other appropriate messages. These warnings and messages: (i) shall be approved by the competent national authority, (ii) shall be rotating,(iii) shall be large, clear, visible and legible,(iv) should be 50% or more of the principal display areas but shall be no less than 30% of the principal display areas,(v) may be in the form of or include pictures or pictograms.

Between 1982 and 2005 the legislation on health warnings on tobacco packaging was very weak and had little impact. The required text was simply: *"Smoking is injurious to health. MSP "*. The phrase was amended in 2003 to read: *"Smoking can cause lung cancer, and heart and lung diseases. Smoking during pregnancy harms your child. MSP"*. Although better than the previous one, the text remained insufficient from the public health point of view.

In 2005, after the ratification of the FCTC, the size of the warning was increased to cover 50% of both main faces of the packaging, included pictograms and misleading terms were prohibited. For the first round of pictograms, images from the " Do not make me smoke" campaign posters were used, rather than being especially designed for the cigarette pack. Subsequently, images were based on a qualitative assessment of public opinion (focus groups), with the MSP selecting those that demonstrated the greatest effectiveness on the target population.

In June 2009 Uruguay became the first country where health warnings occupied 80% of both main package display areas, and one of the entire side faces bears the legend: "This product contains nicotine, tar and carbon monoxide" without specifying quantities. Also, it only exists a single presentation by trade mark in the market, which prevents tobacco companies from creating the impression that one product is less harmful than other by using different colors or symbols.

E - Enforce bans on advertising, promotion and sponsorship of tobacco products

Article 13 of the FCTC. "Tobacco advertising, promotion and sponsorship. 1. Parties recognize that a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products. 2. Each Party shall, in accordance with its constitution or constitutional principles, undertake a comprehensive ban of all tobacco advertising ,promotion and sponsorship. This shall include, subject to the legal environment and technical means available to that Party, a comprehensive ban on cross-border advertising, promotion and sponsorship originating from its territory. In this respect, within the period of five years after entry into force of this Convention for that Party, each Party shall undertake appropriate legislative, executive, administrative and/or other measures and report accordingly in conformity with Article 21".

In the GYTS 2001 survey [10] high school students reported having seen more cigarette advertising than health information in the media.

Until 2005, the government banned all promotion of tobacco products directly or indirectly in any teaching and medical care center and prohibited the implementation of promotions using awards. However, regulations regarding advertising, promotion and sponsorship of tobacco products were incomplete and compliance was low.

Once Uruguay ratified the FCTC, tobacco advertising was banned on open, cable, or encoded television during hours established as “hours of protection for minors”, as well as sponsoring in sports arenas and in all activities related to the practice of sports.

In 2008, once the comprehensive law on tobacco control was adopted, it established a prohibition of all kinds of advertising, promotion and sponsorship, except advertising inside points of sale under certain regulatory conditions that is tobacco advertising had to be accompanied by a health message established by the MSP of equal size, in a contiguous location and with equal visibility.

R - Raise taxes on tobacco

Article 6 of the FCTC: "1. The Parties recognize that price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular young persons. 2. Without prejudice to the sovereign right of the Parties to determine and establish their taxation policies, each Party should take account of its national health objectives concerning tobacco control and adopt or maintain, as appropriate, measures which may include: (a) implementing tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption; and (b) prohibiting or restricting, as appropriate, sales to and/or importations by international travelers of tax- and duty-free tobacco products”.

In Uruguay there has historically been a substantial difference between the specific domestic tax (IMESI) applied to manufactured cigarettes and that applied to hand-rolled tobacco, which was very low for the latter. Tobacco products were also exempt from payment of value added taxes (VAT) which tax most consumable products, even those of primary need.

Since July 1st of 2007, as a result of tax reform in Uruguay, tobacco products have been subject to VAT at a rate of 22%. Meanwhile, the IMESI rate for hand-rolled tobacco had increased differentially, applying higher percentages to hand-rolled tobacco so as to equalize the tax paid by manufactured cigarettes. Thus, IMESI for hand-rolled tobacco went from 27% in 2005 to 50% in 2009 and, after GATS field work, IMESI was increased to reach 70%. At the present time, an equal rate applies both to manufactured cigarettes and hand-rolled tobacco.

Since ratification of the FCTC, the Uruguayan government has maintained a policy of gradual price increases, by applying a tax policy focused on the public´s health, with the certainty that this measure benefits particularly the most vulnerable population, young people and people with lower incomes. Thus, the price of a pack of 20 cigarettes of the best-selling brand has doubled in the past 3 years.

Current tobacco control legislation in Uruguay

The various measures taken firmly by the MSP to gain control of the tobacco epidemic, as well as discussion of tobacco control laws in the Parliament, have been opposed by the tobacco industry. It has also sought to hinder implementation of the legislation, using intense advocacy with parliamentarians and advertising and media companies. The MSP, backed by strong political will to control the tobacco epidemic, as well as support from the

majority of parliamentarians, looked at the scientific evidence without taking into account biased arguments from the tobacco industry. The Law Nº18.256 [30] adopted in 2008, a comprehensive tobacco control act, was the result of all these efforts. The law validated and extended norms already established in the various previous decrees.

Key provisions of Law Nº 18.256 include the following:

- All workplaces and public enclosed places are to be 100% smoke free. Tobacco consumption is also prohibited in open areas that belong to a healthcare or educational building.

- Health warning labels are mandatory on all packaging of tobacco products, including images. They are to be rotated every year and currently cover 80% of the front and back sides of each package.

- The law establishes a comprehensive ban of advertising, promotion and sponsorship of tobacco products. Advertising is only allowed inside the point of sale, under defined regulatory conditions.

- Diagnosis and treatment of tobacco dependence is incorporated at the primary healthcare level, including free cessation medication. Healthcare workers must follow the National Clinical Guidelines recommendations when treating their patients.

2. OBJECTIVES OF THE SURVEY

The objectives of GATS were to:

· Systematically monitor the consumption of tobacco (smoked and smokeless) in the Uruguayan population aged 15 and older, as well as certain key indicators, using a nationally representative sample.

· Track the implementation of the tobacco control policies recommended in the FCTC and outlined in the MPOWER package.

3. METHODOLOGY

The main objective of GATS was to provide estimates of tobacco use, second-hand smoke exposure, exposure to pro- and anti-tobacco information, frequency of smoking cessation attempts and prices paid for tobacco products. This survey design requirements were developed to produce accurate estimates for each country at the national level, as well as for two sub-groups of analysis defined by urban/rural residence and sex[31].

3.1 Study population

The target population consisted of men and women aged 15 and over living in private households who consider Uruguay as their country of residence. Uruguayan geographic features, as well as its social-political stability, allowed access to the entire national territory, except in cases of floods or fire, which generally occur in restricted areas.

Tourists, all institutionalized persons (hospitals, group residences, prisons, monasteries, rural migrant workers, student residences), military personnel residing on military bases, and people who did not consider Uruguay as their country of residence were excluded from the target population.

In a specific private household, all persons aged 15 or older and who considered that housing as their primary residence were eligible:

i. Persons who were absent when the household was visited by the GATS interviewer, but habitually lived there, were included.

ii. Persons present or living in that household at the time of the survey, but did not normally live there or did not consider it as their main residence, were excluded.

The reference time for listing residents that met all of the above conditions was "last night" or the night prior to the visit of the GATS interviewer.

An informed consent form was used for everyone in the sample, before beginning the interview, giving them the right to refuse to participate without having to explain their decision.

3.2 Sample design

3.2.1 Sampling frame

The sampling frame for the selection of the primary selection units (PSU) and secondary selection units (SSU) was obtained from the Phase 1 National Population Census (CF1), developed between July and September 2004. The CF1 constituted a general list of dwellings, households and persons habitually residing in Uruguay. The sampling frame provided the detailed geographical census units needed for the GATS, called Census Zones.

The sampling frame for tertiary units in the sample selection (TSU) was also obtained from the CF1 and consisted of a list of all units (households or not) found by the CF1 field staff. This sampling frame is not accessible to the public, and normally used only by INE statisticians and computer analysts for the design, selection and management of the Continuous Households Survey (CHS).

The sample had the disadvantage of not having been updated. The fundamental problem was that household status was unknown at the time of GATS, so there was the possibility of finding many unoccupied homes. For this reason, it was not possible to compute some quality indicators established by the QA Handbook of GATS.

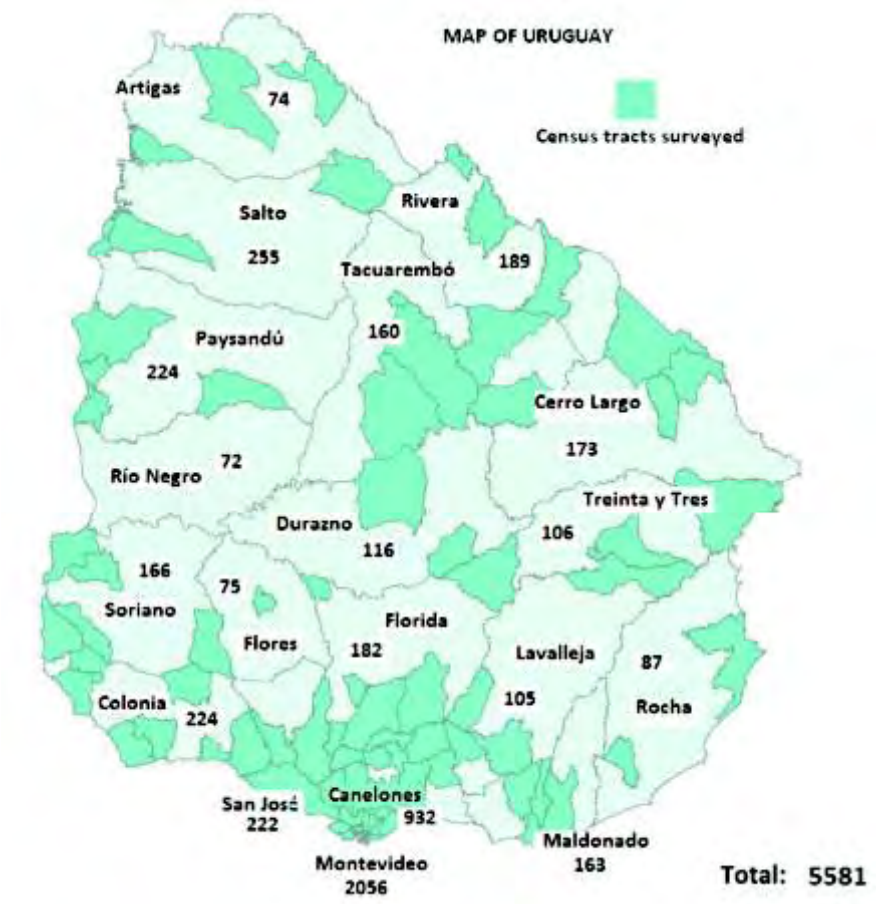
3.2.2 Sampling design

The proposed GATS sample design for Uruguay was stratified multistage random sampling. Stratification was performed considering the rural areas and the size of the urban units (see Annex B). In total there were ten strata, 9 urban and 1 rural.
GATS Uruguay had four stages. In the first stage, within each urban stratum Census Segments were selected with probability proportional to size (pps). A Census Segment is a group of Census Zones. Size was measured by the number of occupied private dwellings. One hundred Segments (100) were selected in urban areas, and 50 (see Annex B) in rural areas. An additional Segment per stratum was selected to account for attrition during the survey.

As mentioned above regarding the limitations of the sampling frame, it was expected that many cases of unoccupied dwellings would be found. Therefore, there were 109 Segments in the urban area and 51 in the rural.
At the second stage, within each Segment Census Zones were selected with probability proportional to size. Size was measured in terms of the number of occupied private dwellings within Zones. Census Zones are equivalent to blocks in urban areas, and equivalent to land areas with easy-to-identify boundaries in rural areas (routes, paths, rivers, any stream, permanent references or other features). Four Zones were selected from each Segment.
In the third stage, within each selected Zone, 10 occupied private dwellings were selected using simple random sampling.

In the last stage, one person in the target age group was selected from each of the 10 selected households. PDA software was used to randomly select a male or female respondent, age 15 or older. The target number of completed interviews for GATS was 6000. The final number of interviews was 5.581.
A geographical sample distribution is presented in the following map:

Figure B – Selected census zones and number of cases by department.



3.2.3 Weighting of the GATS survey data

Calculation of the sample weights was performed separately for each of the stages described above, and the final weighting was obtained from the product of the previous weights. Following the approach suggested in the GATS sampling weights manual details of the formulas used are explained in Annex B.

3.2.4 Statistical analyses

Complex survey estimates were performed with R software [32] using the survey package [33] for database weighting and following the standard procedures established in the GATS sample design and sample weights manual for GATS data. The details of the sample weighting process are described in Annex B.

3.2.5 Socio-economic index

The questionnaire implemented in GATS did not include questions based on variables needed to construct a socio-economic level index (SELI), such as personal and/or household income.

Therefore, two methodological options for sorting the study population by socio-economic level were proposed, based on information that was available from GATS:

1. Information from the continuous household survey (CHS 2009) would be used to group households according to income quintiles and estimate a regression model of discrete response, thus defining three income groups (quintiles 2, 3 and 4 would be merged). To do this, 17 variables included in the GATS questionnaire would be used (see Table A). The proposed model was a binomial or multinomial logistic regression. After being tested, the model would be applied in GATS. The option 1 model provided appropriate explanatory power, with a 68% success rate; i.e., once the model was adjusted, almost 70% of all households could be reclassified into three income groups. However, a limitation was that the 32% of unexplained error would be transferred by applying the model to households surveyed in GATS.

2. A factorial multiple correspondence analyses would be applied to the 17 variables relating to household comfort, thus reducing the number of indexes. From these, a cluster analysis technique would be used to create a typology that would allow classification of households into 3 or 4 groups.

Multiple correspondence factor analysis (MCA) is a multivariate descriptive technique that achieves a simplification of the problem through an algebraic process, by considering a much reduced of variables, which are called factors and that are linear combinations of the investigated variables. Each variable is given a weight or importance through the coefficients estimated by the MCA method. The final factors can be graphically represented by using dispersion diagrams, which are called factorial plans.

Those factors are used to classify households into a small number of groups, through the clusters technique (CA), which groups households, according to a preset distance that identifies households located within the same vicinity. For GATS, the Ward´s hierarchical method was applied, using the Euclidean distance, considering that groups are formed over factors that are not correlated.

Finally two factors are considered and graphically represented in the factorial plans, to show how the different variables are associated. Each of the 17 variables is coded with a label with the variable name and a suffix (1 if it is in that category and 0 if not).

In this new factorial plan, one can clearly see how households are grouped according to how they are associated with different comfort variables, defined as those elements available in the household that produce welfare and comfort.

Option 2 was selected for GATS Uruguay.

Table A - List of different comfort goods referred to in the questionnaire

1	Flush toilet	10	[illegible]
2	Fixed telephone	11	Cable TV subscription
3	Television	12	DVD player
4	Radio	13	Dishwasher
5	Refrigerator	14	Microwave oven
6	Car	15	Air conditioning equipment
7	Automatic washing machine	16	"Plan Ceibal" computer
8	Clothes dryer	17	Internet connection
9	Telephone (cell phone)		

Table B - Distribution of groups in the population according to comfort index

Groups	%
Low	20,5
Medium low	12,8
Medium high	34,2
High	32,5
Total	**100**

Figure C - Main factorial plan of multiple correspondence analysis used in the construction of the social-economic level index (SELI).

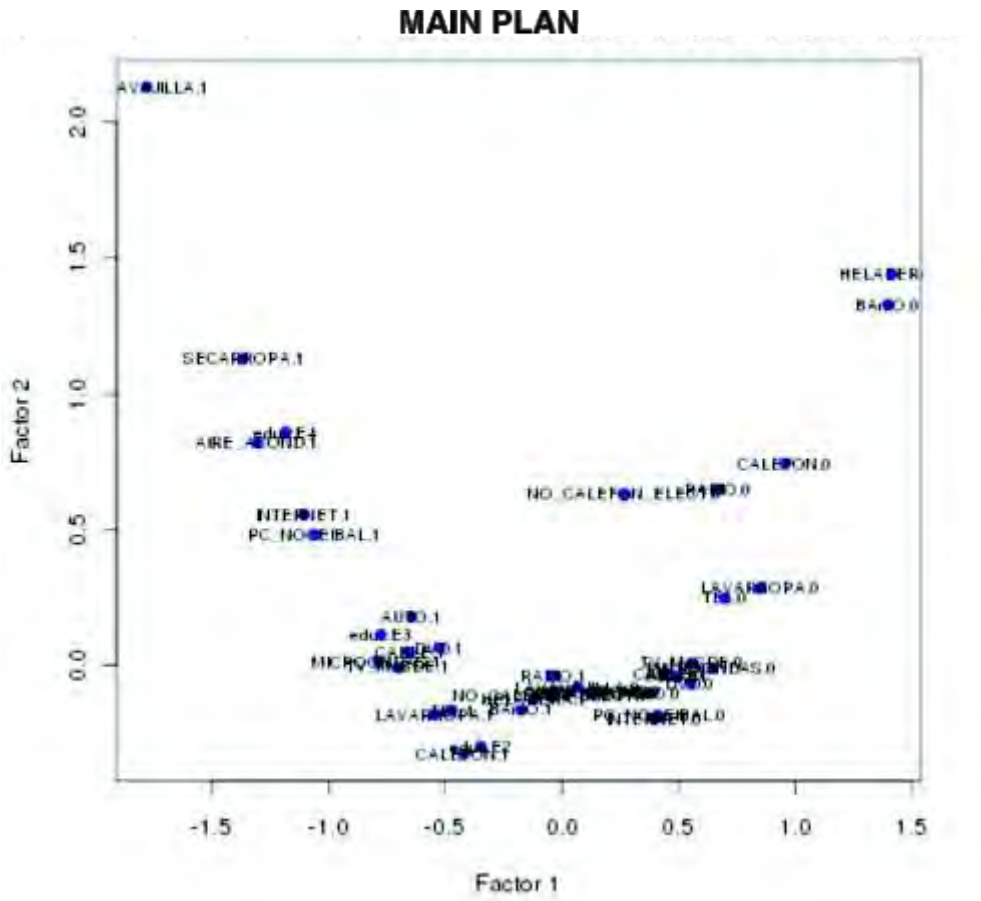
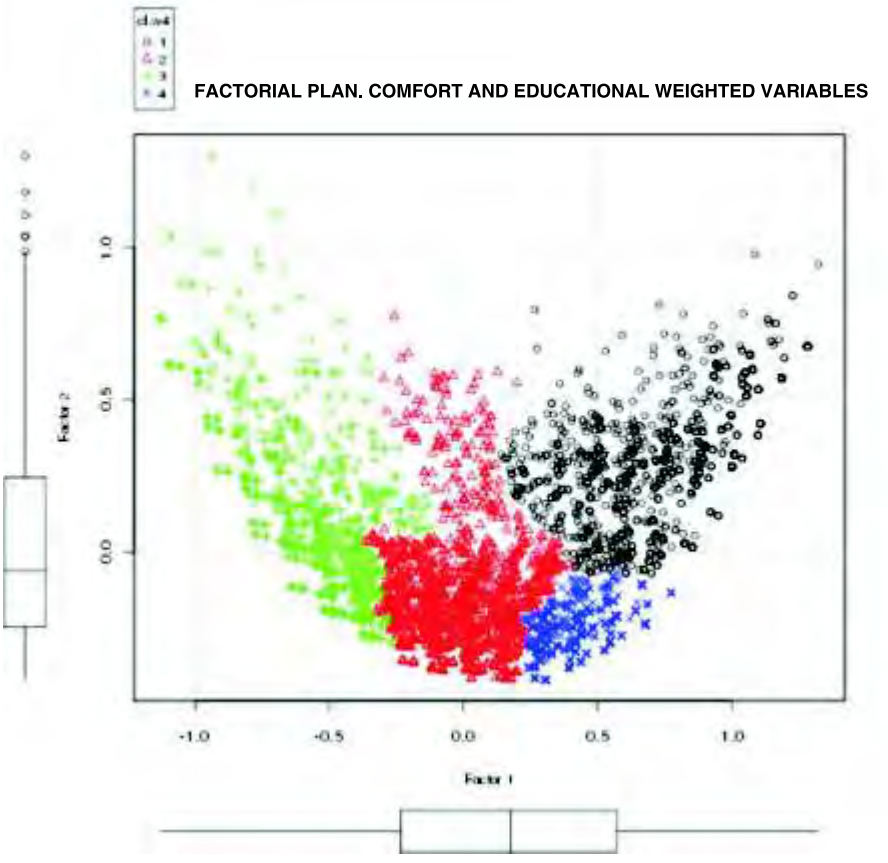


Figure D – Factorial plan. Comfort and education weighted variables.



3.3 Pilot phase or pre-test

The collection of data for the pilot phase of the survey was succesfully conducted in the field process over a total of five working days for 107 cases.

Two mandatory training workshops had been previously conducted for people applying to be on the survey field team. The first training was carried out exclusively by an INE technical team, while the second was conducted by INE/MSP with advice from National GATS Committee and RTI International.

Survey data were collected by three teams, with a total of 16 interviewers and 3 supervisors; field work extended from Monday May 11 until Friday, May 15, 2009.

3.3.1 Objectives of the pilot phase

- Test the questionnaire, particularly in terms of drafting and understanding, inconsistencies in jumps, sequencing of questions, completeness of response categories, work load, interview time and any other issues.

- Test the programmed questionnaire for data collection with electronic hand-held devices (PDA).

- Identify and assess any problems in the process of gathering and handling of data.

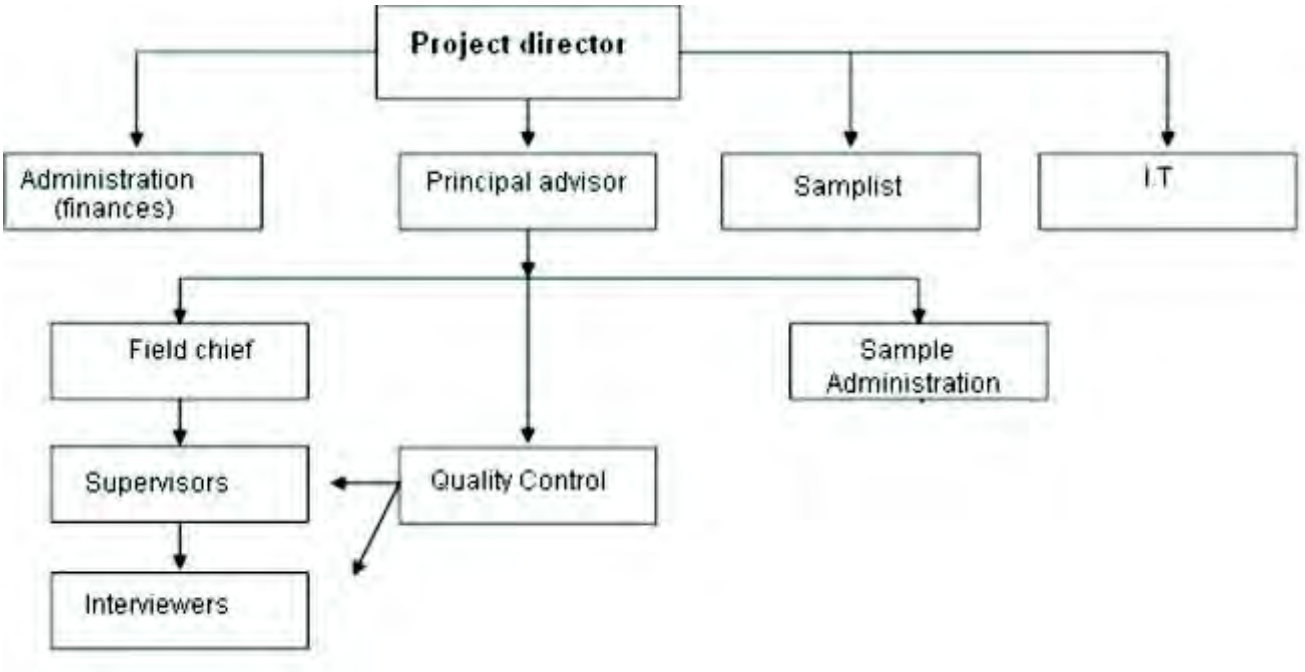
The sample design was based on deliberate selection of respondents. The sampling frame was obtained from the monthly national survey known as the Continuous Households Survey (CHS), which was developed by the National Institute of Statistics and conducted hroughout the year.

Thus, respondents in the GATS pretest had completed the CHS questionnaire for the INE, during the years 2009 and 2008, prior to the sample selection for GATS.
The final pretest was carried out in the department of Montevideo, using a sample of about 400 cases to collect data on the prevalence of smoking as a function of three variables: age, sex and geographic area (urban or rural).

The target sample size for the pilot phase was initially 72 interviews, aimed at persons aged 15 or older, with smokers and nonsmokers in equal proportions. Each category had at least four respondents in urban areas and two in rural areas.

3.4 Final phase

Organizational structure of the project at INE:



3.4.1 Data collection procedures

3.4.1.1 Logistics support

Each field team had a vehicle with a driver, and when conditions required, vehicles with four-wheel traction, providing permanent support for data collection in rural areas and small urban locations. This was especially important considering that climate was a constant obstacle hindering access to various locations.

Advice was also available through a modality similar to Call Center, where two operators offered continuous real-time information regarding map reading and geographic location of areas and housing, as well as the main public transportation options available, including appropriate information on costs and schedules.

3.4.1.2 Acquisition of data and field work organization

Electronic hand-held (PDA) latest-generation devices were used to capture data throughout the national territory. These devices contained software that facilitated the implementation of the questionnaire, provided basic rules to assure consistency, and allowed thorough and real-time follow-up of the interviewers´ work.

Data were transmitted on-line through e-mail sent weekly to the central offices of the INE.
To optimize efficiency, the survey area was organized into 8 regions covered by 12 teams, each consisting of a supervisor and five or six interviewers.

3.4.1.3 Transmission of data

Data were transmitted through IPAQ SD removable memory cards. The interviewers followed a preset pattern of sending data. The field staff was provided with an SD card reader with a USB port, to facilitate and expand interviewers´ access to a PC with an Internet connection. The e-mail box was also used as a forum for various queries from field staff.

3.4.2 Quality control of field work

Quality control of field work was achieved by two mechanisms:

A) Supervision of field work. The modality of supervision involved both:

1) on-site monitoring, where the interviewer was accompanied during the collection of data, specially at the beginning of the field work; and

2) "a posteriori" supervision, where the supervisor made follow-up visits to some of the families surveyed, checking the consistency of key questions.

In both instances supervisors had standardized guidelines to ensure uniform control procedures (see annexes).

These control mechanisms allowed the supervisor to make an objective assessment of each interviewer, and also allowed the Field Chief make a general assessment of each team and assure an adequate balance between productivity and quality.

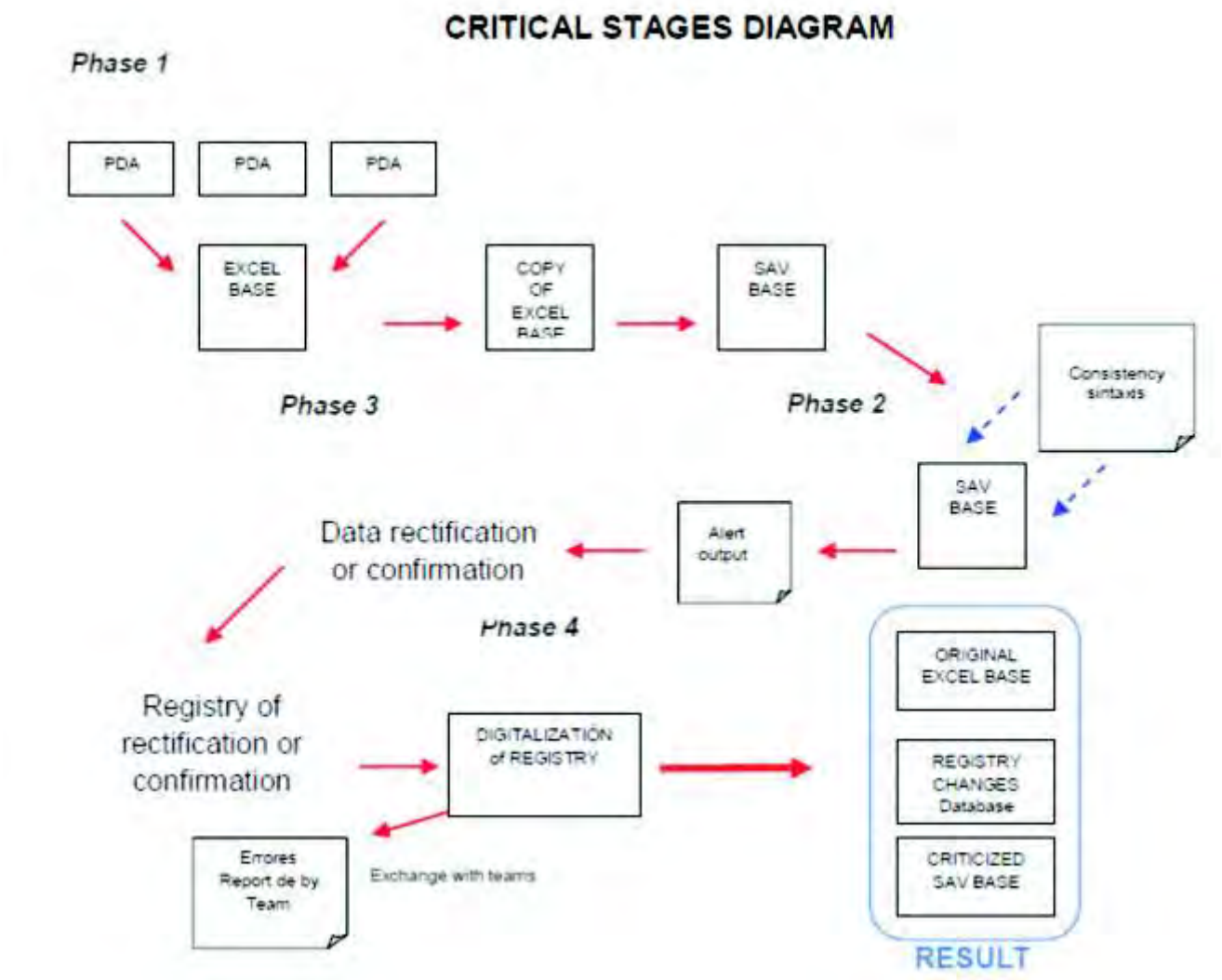
B) Control of the consistency of the data in the Office of the INE

This mechanism involved a comprehensive review of 100% of the interviews, identifying inconsistencies or incoherence in the questionnaire, using the SPSS statistical package data analysis. A work team kept up fluid communications with field staff (interviewers and supervisors) and households whenever confirmation or consultation on any data query was needed.

A total of 110 consistency rules were drafted. For proper administrative management, during the process it was necessary to identify the Error number, the variables involved and the identification number of the form.

Once households were surveyed by the interviewer and the information passed on to appropriate administrative office, the criticism process began, which involved four phases as illustrated in Figure E below.

Figure E - Critical stages diagram .



3.4.3 Process evaluation by field staff

In order to improve and evaluate action processes, it was considered important to obtain insights and views from the participating supervisors and interviewers. Therefore, a questionnaire was designed and filled out anonymously at the end of the field work, with the intention of capturing both positive and negative aspects identified by staff.

Table C - Result of the evaluation of fieldwork by the interviewers.

C1

The thematic of the survey and its goals have been to you:

	%
Very interesting	37,6
Interesting	60,0
Indifferent	2,4
Little interesting	0,0
Not interesting	0,0

C2

The thematic of the survey and its goals have been to households:	
	%
Very interesting	15,3
Interesting	70,6
Indifferent	9,4
Little interesting	4,7
Not interesting	0,0

C3

This project introduced some specific features such as the use of electronic equipment for the collection of information (PDA), sending data via internet and virtual communication with the Office. In your work, these innovations were for you:	
	%
Very comfortable	77,6
Comfortable	17,6
Acceptable	3,5
Uncomfortable	1,2
Very uncomfortable	0

C4

Do you feel that some data were not collected with fidelity or got them influenced by any of the following reasons?	
	%
Presence of other people that inhibited the respondent	
Yes	21,2
No	78,8
Being he/she of different sex and/or age than yours	
Yes	0
No	100
Reach home in a "bad" time	
Yes	12,9
No	87,1
Your appearence, dress, name colour of skin	
Yes	0
No	100

C5

Finally, in general terms, how would you evaluate this work experience?	
	%
Very good	71,8
Good	27,1
Acceptable	1,2
Bad	0
Very bad	0

4. RESULTS

4.1 Tobacco use

Table 1 shows the prevalence of smoking among people aged 15 or older in Uruguay. The prevalence of smoking in men was almost 50% higher than in women. In 2009, 30.7% of men were smokers, either daily or occasional, compared with 19.8% of women. This represented approximately 615.000 people age 15 years or older who were current smokers.

Table 1 - Distribution of person's ⩾15 years by sex according to tobacco smoking status.

Tobacco smoking status	Men (CI 95 %)	Women (CI 95 %)	Total (CI 95 %)
Current smoker	30.7 (28.2 - 33.4)	19.8 (18.1- 21.6)	25.0 (23.3 - 26.6)
Non smoker	69.3 (66.6 - 71.8)	80.2 (78.4 - 81.9)	75.0 (73.4 - 76.7)
Total	**100**	**100**	**100**

Most current smokers (> 80%) were daily smokers. Daily smoking prevalence was 24.8% in men and 16.4% in women, while the proportion of occasional smokers was 5.9% in men and 3.4% in women. (Figures 1A and B).

Figure 1A - Prevalence of tobacco smoking in men.

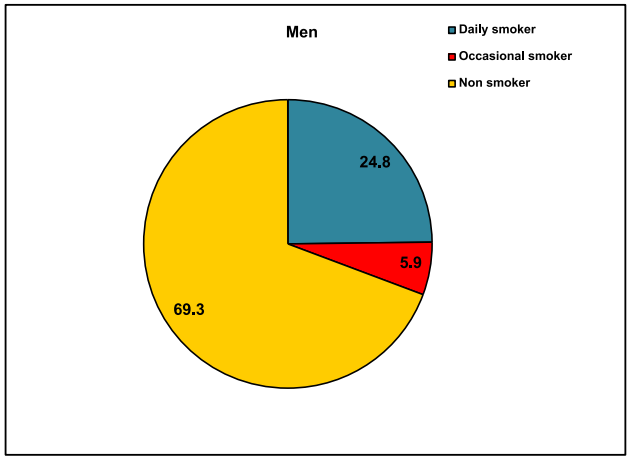


Figure 1B - Prevalence of tobacco smoking in women.

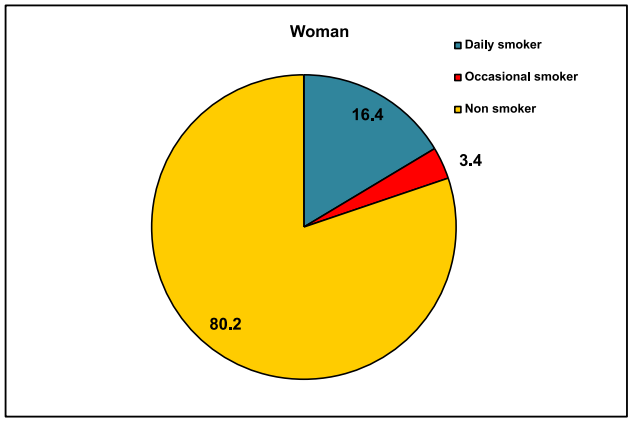


Table 2 shows the prevalence of daily and occasional smokers by age group and sex. Among men, the highest prevalence of daily smokers (31.1%) was observed in the 45-64 age group, while in women, the highest prevalence of daily smokers was observed in the 25-44 age group (21.7%). When analyzing global data by sex, there was a statistically significant difference in prevalence of tobacco smoking between men and women (Table 4.5 Annex).

Table 2a - Frequency of tobacco smoking by sex according to age.

AGE (years)	Daily smoker	
	Men % (CI 95%)	Women % (CI 95 %)
15 - 24	20.3 (15.7 - 25.8)	15.9 (11.8 - 21.2)
25 - 44	28.1 (24.3 - 32.2)	21.7 (18.4 - 25.4)
45 - 64	31.1 (26.5 - 36.1)	19.2 (15.8 - 23.3)
65 y más	10.6 (7.5 - 14.8)	4.5 (3.2 - 6.3)
Total	**24.8 (22.5 - 27.3)**	**16.4 (14.8 - 18.1)**

Table 2b - Frequency of tobacco smoking by sex according to age.

AGE (years)	Occasional smoker	
	Men % (CI 95 %)	Women % (CI 95 %)
15 - 24	8.6 (5.2 - 13.8)	4.3 (2.5 - 7.3)
25 - 44	6.9 (5.0 - 9.6)	4.3 (2.9 - 6.2)
45 - 64	3.8 (2.3 - 6.3)	3.6 (2.3 - 5.6)
65 and over	2.6 (1.3 - 4.9)	0.7 (0.2 - 2.0)
Total	**5.9 (4.7 - 7.3)**	**3.4 (2.6 - 4.2)**

Table 2c - Frequency of tobacco smoking by sex according to age.

AGE (years)	Non smoker	
	Men % (CI 95 %)	Women % (CI 95 %)
15 - 24	71.1 (65.0 - 76.6)	79.8 (74.2 - 84.4)
25 - 44	65.0 (60.5 - 69.3)	74.0 (70.5 - 77.3)
45 - 64	65.1 (60.3 - 69.6)	77.2 (72.9 - 80.9)
65 and over	86.8 (82.5 - 90.2)	94.8 (92.9 - 96.2)
Total	**69.3 (66.6 - 71.8)**	**80.2 (78.4 - 81.9)**

Table 3 presents the proportion of nonsmokers: 16.4% of persons aged 15 and over (20.5% men and 12.7% women) were former daily smokers, which in absolute numbers would mean there were around 404,000 people in Uruguay who were previously daily smokers and had succeeded in quitting. Approximately 41.5% of men and 59.8% of women had never smoked, either daily or occasionally.

Table 3 - Percentage of non-smokers by sex depending on type of tobacco smoking status.

TOBACCO SMOKING TYPE	Men % (CI 95%)	Women % (CI 95%)	Total % (CI 95%)
Former daily smoker	20.5 (18.6 – 22.5)	12.7 (11.1 – 14.5)	16.4 (15.2 – 17.7)
Former occasional smoker	7.3 (6.1 – 8.8)	7.7 (6.5 – 9.3)	7.5 (6.6 – 8.6)
Never smoker	41.5 (38.9 – 44.1)	59.8 (57.5 – 62.0)	51.1 (49.2 – 53.0)

Table 4 describes the prevalence of current tobacco smoking by type of product, place of residence and sex. The vast majority of those smokers surveyed said they smoked cigarettes, either manufactured or hand-rolled. The prevalence of consumption of manufactured cigarettes in the general population was 24.3% in men and 18.6% in women.

Table 4 - Prevalence of smoking by type of product according to sex and place of residence.

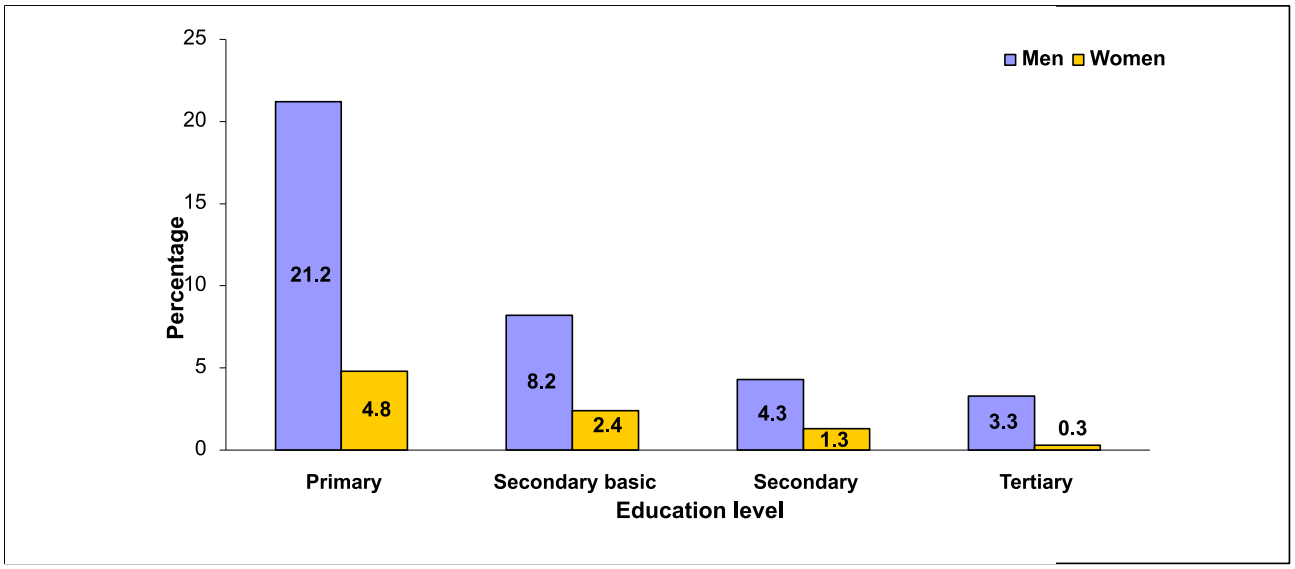
Region	Manufactured		
	Total % (CI 95%)	Men (CI 95%)	Women (CI 95%)
Urban	21.8 (20.2-23.5)	25.0 (22.6-27.6)	18.9 (17.1-20.9)
Rural	15.1 (12.3-18.5)	16.4 (13.3-20.0)	13.6 (10.2-17.8)
Total	**21.3 (19.8-22.9)**	**24.3 (22.0-26.7)**	**18.6 (16.9-20.4)**

Region	Hand-rolled		
	Total (CI 95%)	Men (CI 95%)	Women (CI 95%)
Urban	7.7 (6.5-9.1)	12.9 (10.8-15.2)	3.1 (2.4-4.1)
Rural	13.6 (11.5-16.0)	19.9 (16.8-23.3)	5.8 (3.7-9.0)
Total	**8.1 (7.0-9.4)**	**13.5 (11.6-15.6)**	**3.3 (2.6-4.2)**

Among smokers, 79.1% of men and 94.0% of women consumed manufactured cigarettes (Table 4.3a Annex). Men who smoked were about three times more likely than women (43.9% vs. 16.7%) to smoke hand-rolled cigarettes. In total, less than 4% of smokers consumed naco, pipes, cigars and other tobacco products. Hand-rolled cigarette smoking was more prevalent in the rural areas compared to urban areas (57.9% to 30.7%). This pattern was observed both in men and women. In turn, the consumption of manufactured cigarettes was more prevalent in urban areas (86.8% to 64.5%). There was a high prevalence of hand-rolled cigarettes smoking among men from rural areas.

Hand-rolled smoking prevalence was inversely proportional to the level of education (social-economic level marker). Among men 25 and older with primary education, hand-rolled smoking prevalence was 21.2%, while among those with a tertiary education level it was 1.4% (Table 4.3 Annex).

Figure 2 - Smoking of hand-rolled cigarettes according to sex and education *.



*** Includes surveyed population 25 years and older.**

Overall daily smokers consumed an average of 15.4 cigarettes/day. Men significantly smoked more daily cigarettes than women (17.6 vs. 12.5). Minor differences were observed among other social-demographic groups, as age, educational level or residence. (Table 4.6a Annex).

Table 5 shows the average age of starting to smoke among daily smokers 20 to 34 years of age: 90.5% of men and 86.8% of women said they began smoking on a daily basis before age 20. In general, the average start-up age was 16.5 years, which was similar for men and women and by place of residence (Table 4.7a Annex).

Table 5 - Distribution of smoking start up age by sex and place of residence *.

	Less than 20 years (CI 95%)	20 years and more (CI 95%)
Men	90.5 (84.8-94.2)	9.5 (5.8-15.2)
Women	86.8 (81.6-90.7)	13.2 (9.3-18.4)
Urban	88.7 (84.6-91.8)	11.3 (8.2-15.4)
Rural	89.6 (84.5-93.1)	10.4 (6.9-15.5)
Total	**88.8 (84.9-91.7)**	**11.2 (8.3-15.1)**

*** Among 20 to 34 years of age who were always daily smokers**

The time that elapsed between awakening and smoking the first cigarette of the day was the criteria used to evaluate smokers´ nicotine dependence. Overall, 12.8% of daily smokers had their first cigarette within the first 5 minutes and 22.6% smoked their first cigarette between 6 to 30 minutes after awakening (Table 4.11 Annex). Figure 3 shows the distribution of the time before the first cigarette consumption in men and women who were daily smokers. A greater proportion of men tended to smoke their first cigarette within the first 60 minutes of waking up than women (59.0% to 48.4%).

Figure 3A – Distribution of daily smokers by time between awakening and smoking the first cigarette of the day in men.

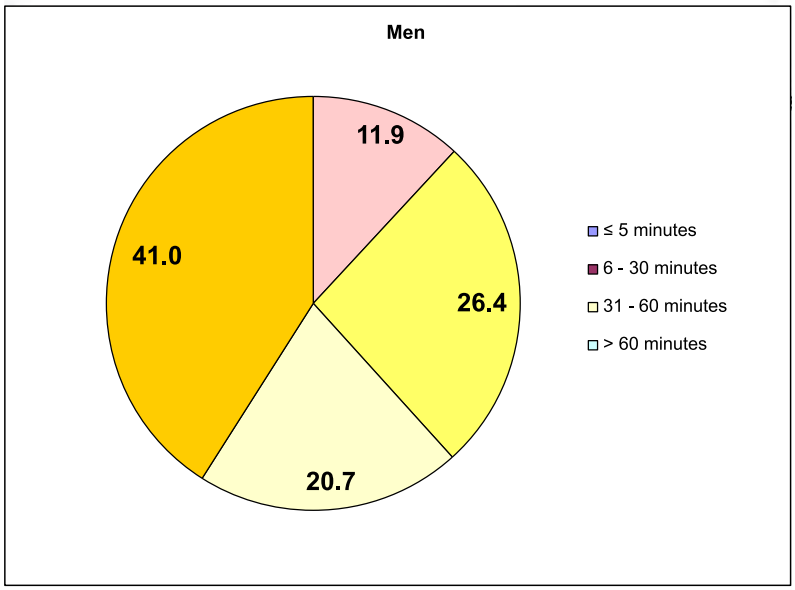
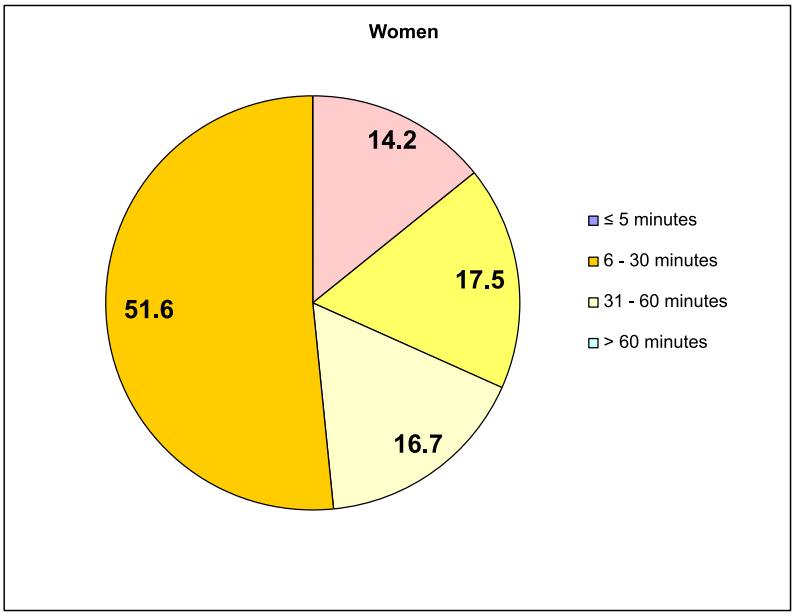


Figure 3B – Distribution of daily smokers by time between awakening and smoking the first cigarette of the day in women.



The prevalence of smoking among various socio-economic levels of the population, which was measured using the socio-economic level index (SELI) based on information about different comfort assets in the home, showed a higher rate in the lowest sectors (35.0%) in relation to the highest socioeconomic sectors (19.6%), in both urban and rural areas (Figures 4 and 5).

Figure 4 - Tobacco smoking according to SELI.

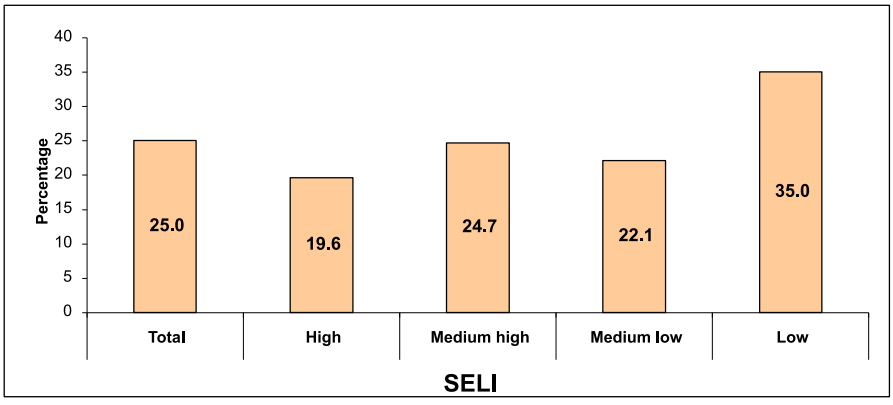


Figure 5A - Tobacco smoking according to SELI by place of residence, urban or rural.

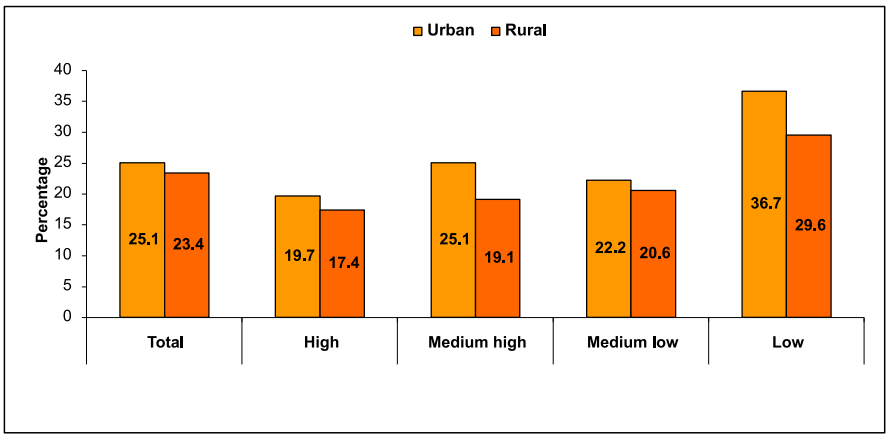
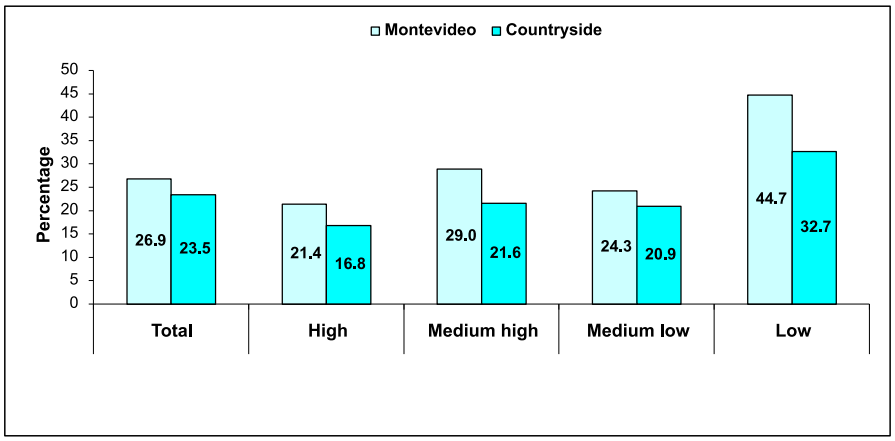


Figure 5B - Tobacco smoking according to SELI by place of residence, Montevideo or countryside.



4.2 Cessation

Table 6 shows the proportion of people who said they were once daily smokers but had quit smoking, known as the "quit ratio" (former daily smokers / former daily smokers and current daily smokers x 100). The overall quit ratio was 42.0% and was similar between men and women. There was also no difference observed in the quit ratio according to place of residence or educational level. As may be expected, the proportion of former daily smokers increased with age (Table 4.8 Annex).

Table 6 - Quit ratio* according to sex.

SEX	QUIT RATIO (CI 95%)
Men	42.8 (39.1 – 46.5)*
Women	41.0 (36.7 – 45.4)*
Total	**42.0 (39.4 – 44.7)***

*** Quit ratio = former daily smokers / (Former daily smokers + current daily smokers)**

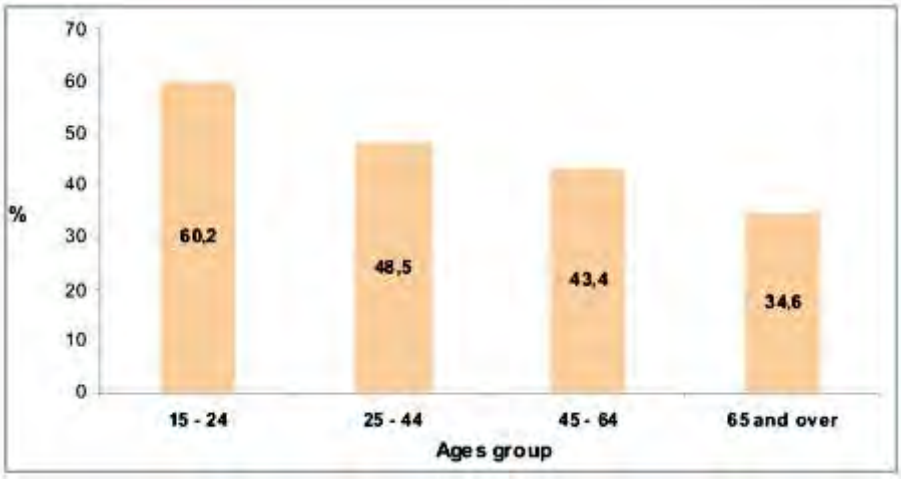
Table 7 shows time of smoking cessation by age, and reveals that 46.1% of ex-smokers from 25 to 44 years, 29.8 % of those aged 45 to 64 and 8% of those 65 and over, said they had quit smoking in the past four years. (More details in Table 4.9b Annex)

Table 7 - Distribution of former daily smokers by time of quitting smoking according to age.

	TIME OF QUITTING TOBACCO SMOKING	
AGE	1 to 4 years (CI 95%)	5 years or more (CI 95%)
25 - 44	46.1 (39.0-53.4)	53.9 (46.6-61.0)
45 - 64	29.8 (24.2-36.1)	70.2 (63.9-75.8)
65 and over	8.0 (5.2-12.0)	92.0 (88.9-94.8)
TOTAL	**32.7 (29.1-36.6)**	**67.3 (63.4-70.9)**

A total of 48.6% of smokers aged 15 or older said they had made an attempt to quit in the past year. There were no major differences in the rate of cessation attempt by sex and place of residence (Table 5.1 Annex). Among smokers aged 15 to 24, 60.2% had made an attempt to quit in the past year, compared to 34.6% of smokers of aged 65 and over (Figure 6).

Figure 6 – Percentage of smokers who made a quit attempt by age groups.



Among smokers who had visited a healthcare institution in the last year, 23.4% said they were not asked if they smoked, 45.5% said they were not advised to quit, and only 15.1% received support about stopping from healthcare staff. The proportions were similar for both sexes (Table 8) and by place of residence, suggesting that there was no disparity in health team interventions regarding tobacco use. However, smokers from rural areas (41.9%) visited healthcare institution to a lesser extent than smokers from urban areas (56,9%), which may imply limited access to medical advice and counseling in the healthcare system. (Table 5.1 Annex)

Table 8 - Percentage of smokers* by attempt to quit and medical advice according to sex.

	CONDUCT			
	Tried to stop smoking (CI 95%)	Asked if he/she was smoker** (CI 95%)	Was advised to quit** (CI 95%)	Received counseling from a health care provider (CI 95%)
SEX				
Men	48.4 (43.8 – 53.0)	75.1 (68.2 – 80.9)	56.7 (49.8 – 63.3)	15.2 (10.5-21.4)
Women	48.9 (43.5 – 54.4)	77.9 (71.8 – 83.0)	52.3 (46.0 – 58.5)	15.1 (11.2-20.1)
Total	**48.6 (45.0 – 52.3)**	**76.6 (72.3 – 80.3)**	**54.5 (49.4 – 59.4)**	**15.1 (11.7-19.3)**

*** Includes current smokers and former smokers who have less than 1 year of abstinence**
**** Refers to health personnel in the last 12 months**

Figure 7 shows the distribution of interest in quitting tobacco use among current smokers aged 15 and over. Overall, three out of four smokers expressed interest in quitting. Almost 11% of smokers said they were thinking about quitting in the next month and 22.6% was considering doing so in the next 12 months. The highest proportion of smokers, 42.1%, said they intended to quit someday, but not in the next 12 months. There was no significant difference in interest in quitting by sex or place of residence. Interest in quitting was higher among young adult smokers: 84.7% of the 15-24 age group were thinking of quitting, compared to 50.1% of smokers aged 65 and over (Figure 8). For more details see Table 5.3 of the Annex.

Coupled with interest in quitting, almost half of current smokers said they knew where to find help to quit. (Table 5.4 Annex).

Figure 7 - Smokers according to interest in quit smoking.

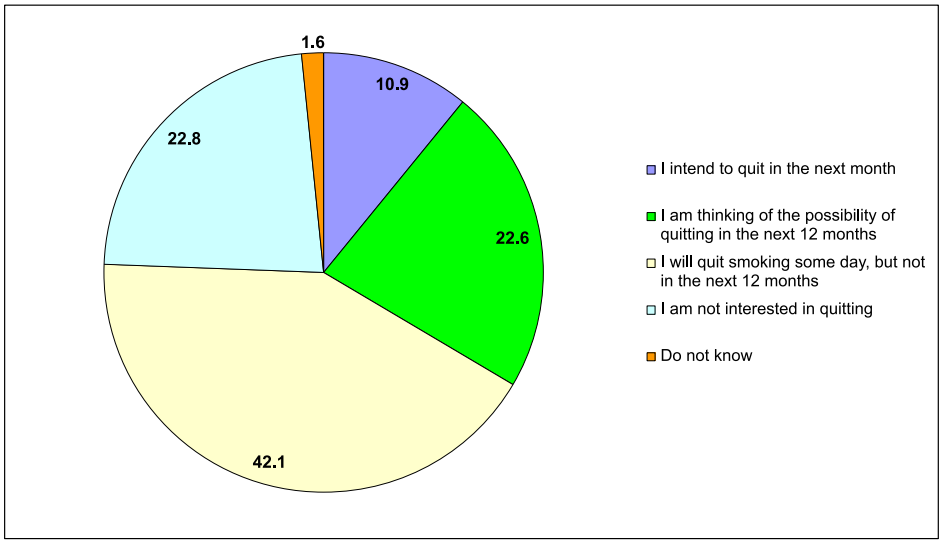
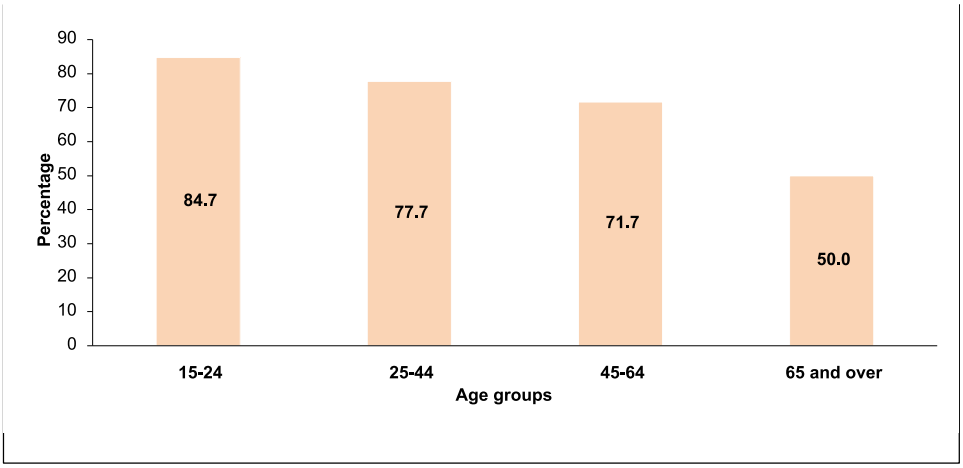


Figure 8 - Percentage of smokers with interest in quitting smoking, according to age groups.



4.3 Exposure to tobacco smoke

In the 30 days prior to the survey, 16.5% of those working in indoor environments said they were exposed to smoke in the workplace (table 9). The proportion of men exposed at work (21.4%) was higher than that of women (11.8%).

Table 9 - Percentage of adults exposed to tobacco smoke in the workplace* by smoking status and sex.

Sex	Total population (CI 95%)	Non smokers (CI 95%)
Men	21.4 (17.7 – 25.5)	19.9 (15.7 – 24.9)
Women	11.8 (9.2 – 14.9)	11.9 (8.9 – 15.7)
Total	**16.5 (14.1 – 19.3)**	**15.6 (12.7 – 19.0)**

*** In the last 30 days, who work outside the household in indoor environments. Does not include those who work in open places.**

Table 10 describes the proportion of people who reported being exposed to tobacco smoke while visiting a public place in the previous 30 days. A small percentage of those who visited public buildings (6.9%), healthcare institutions (3.8%) and restaurants (4.4%) reported being exposed to tobacco smoke during their stay. However, reported exposure at the university, and in bars, pubs and discos was significantly higher. For example, 27.5% of those who were at the university in the previous 30 days said they were exposed to tobacco smoke. Similarly, more than 20% of those who had been in bars, pubs and discos, in the last 30 days were exposed to smoke in those environments (Table 6.4 Annex).

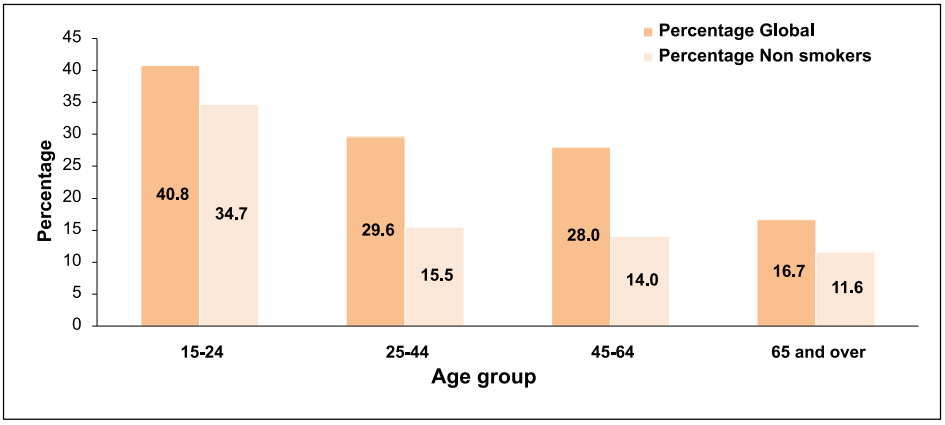
At the university, as well as bars, pubs and discos, exposure to tobacco smoke was higher among young adults. More than 30% of the 15 to 24 age group was exposed, compared with the 20.4% of the 25-44 age group and 12.8% of those aged 45 to 64. There was no significant difference between sexes.

Table 10 - Percentage of people 15 years and older than in the past 30 days were exposed to tobacco smoke in public places according to socio-demographic characteristics.

	EXPOSURE TO TOBACCO SMOKE IN...				
	Public buildings (CI 95%)	Health care centers (CI 95%)	Restaurants (CI 95%)	Universities or Colleges (CI 95%)	Bars, Pubs and Discotheques (CI 95%)
TOTAL	6.9 (5.7-8.4)	3.8 (2.8-5.2)	4.4 (3.2-6.1)	27.5 (21.7-34.1)	23.4 (20.1-27.0)
Sex					
Men	8.6 (6.3-10.6)	4.2 (2.6-6.7)	5.7 (3.9-7.3)	29 (18.7-34.8)	25.2 (20.5-30.6)
Women	5.8 (4.2-8.0)	3.5 (2.6-4.8)	4.8 (2.6-6.7)	29.1 (19.8-40.6)	21.8 (18.4-26.1)
Age groups					
15-24	11.5 (9.5-19.1)	5.7 (2.9-10.8)	6.4 (3.6-11.0)	34.2 (23.9-46.2)	32.5 (26.5-39.1)
25-44	6.7(4.8-9.2)	3.0 (2.0-4.6)	5.1(3.2-7.9)	25.1 (18.0-33.9)	20.4 (16.1-25.5)
45-64	4.2 (3.0-6.9)	4.1 (2.8-6.6)	1.3 (0.6-3.0)	15.8 (7.7- 29.5)	12.8 (9.0- 18.0)
65+	6.2 (2.6-6.8)	3.0 (1.6-5.3)	5.2(2.0-12.7)	8.4 (1.1- 43.2)	13.8 (6.9- 25.5)
Region					
Urban	7.0 (5.6-8.6)	3.9 (2.9-5.2)	4.3 (3.0-6.1)	27.6 (21.6- 34.4)	23.1 (19.8- 26.9)
Rural	6.3 (4.5-8.6)	2.6 (1.6-4.1)	7.6 (4.7-12.6)	24.3 (13.2- 40.6)	28.5 (22.4- 35.4)
Education level					
Primary	4.0 (2.7-5.8)	3.6 (2.6-5.1)	4.0 (2.4-6.9)	7.6 (1.1- 37.4)	26.2 (19.0- 35.0)
Secondary Basic	5.2 (3.7-8.7)	3.1 (1.7-5.4)	3.7 (1.8-7.6)	17.7 (6.6- 44.0)	19.6 (9.9- 34.0)
Secondary	6.0 (3.8-9.4)	2.3 (1.1-4.9)	4.0 (2.0-7.6)	25.7 (16.8- 37.2)	14.2 (9.1- 20.5)
Tertiary	9.7 (6.8-12.0)	5.9 (3.2-10.6)	2.5 (1.0-5.9)	22.8 (14.1- 34.8)	33.3 (8.4- 20.6)

Young people were more exposed to smoke at home (Figure 9). In the group aged 15 to 24, 40.8% reported having smokers in the home on a weekly basis, while in the 65 and over age group only 16.7% reported smoking in the home. In total, nearly 30% of people 15 years or more declared that there was someone smoking in their home at least once a week (Table 6.2a Annex).

Figure 9 - Percentage of adults exposed to tobacco smoke in the household, according to age groups.

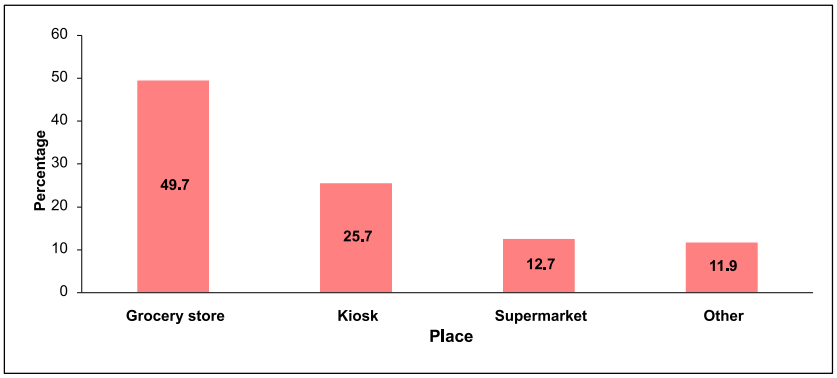


Less than half (44.5%) of persons aged 15 or older in Uruguay live in a household with at least one smoker (Table 6.5 Annex). A greater proportion of persons aged 65 and older lived in households without smokers (78.2%) than those aged 15-24 (45.1%).

4.4 Economics

Around half of those who smoked manufactured cigarettes said they made their last purchase of cigarettes in a grocery store (49.7%), followed by 25.7% in duty free shops, kiosks, or lounges. A total of 12.7% bought cigarettes at the supermarket[4], while more than 10% purchased them from a street vendor, or in service stations, canteens, bars or restaurants or other places (Figure 10).

Figure 10 - Place where the last purchase of cigarettes was made.



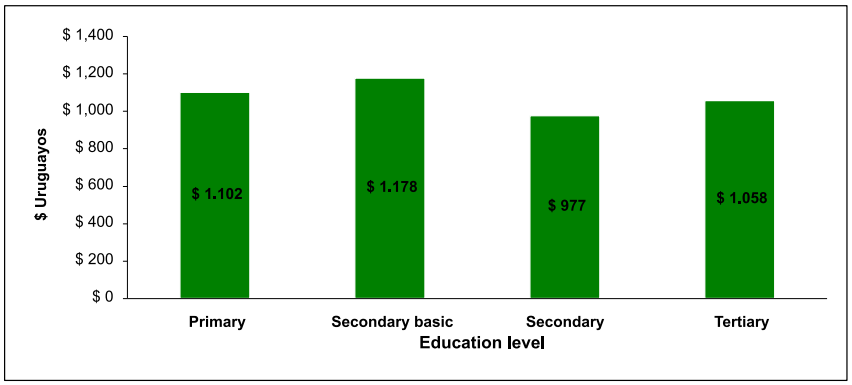
Buying patterns did not present significant variations between sexes, or by age or place of residence. Rural residents were somewhat more likely to have made their last purchase of cigarettes in a grocery store (57.8%) than urban residents (49.3%) (Table 7.2 Annex)
During GATS Uruguay, the average price of a pack of 20 cigarettes was 60.4 Uruguayan pesos. The average price of 20 hand-rolled cigarettes was 10.1 Uruguayan pesos[5].

Manufactured cigarette smokers reported spending on average 991 pesos per month on cigarettes, while hand-rolled cigarette consumers said they spent on average 187 pesos per month. (Table 7.3 Annex). Among smokers of manufactured cigarettes, the average monthly expenditure was similar for both high and low education levels (Figure 11).

[4] In Uruguay supermarkets are different from grocery stores. The supermarkets are Large stores with higher sales and product variability.

[5] It is estimated that 50 cigarettes are made from a pack of 45 gr of chopped tobacco.

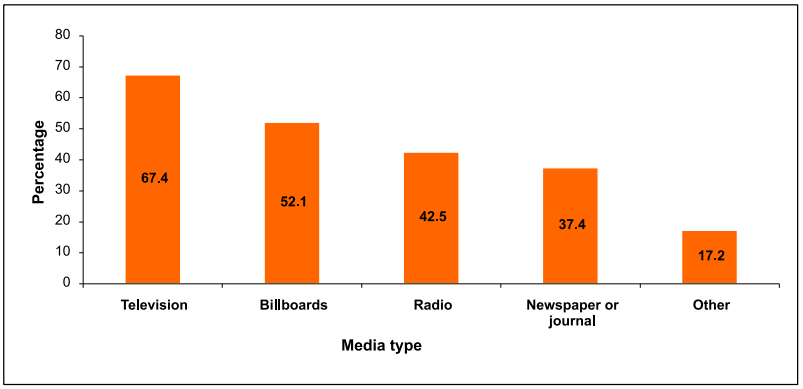
Figure 11 - Average spending in manufactured cigarettes by month, according to educational level.



4.5 Media

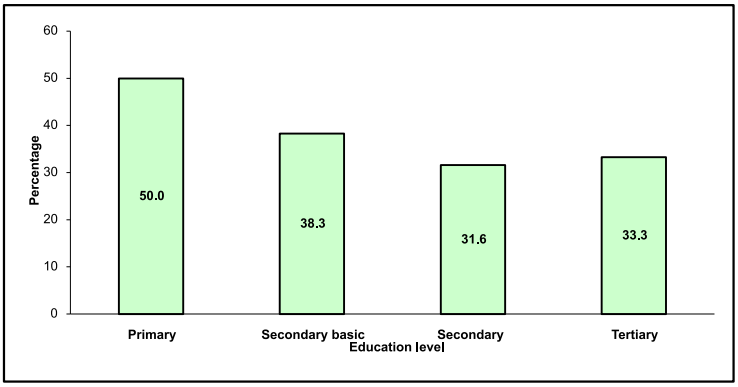
Approximately 85% of people said they had noticed anti-tobacco information somewhere. No differences were observed between smokers and nonsmokers, or by sex, age, place of residence or educational level. Figure 12 describes the places where people noticed anti- tobacco information. Around 72% received anti- tobacco information through television or radio (Table 8.1 Annex).

Figure 12 – Percentage of people who have seen anti-tobacco information according to media type in the last 30 days



Among current smokers 96.1% said they had seen health warnings on cigarette packs during the last 30 days. Almost 45 % said they thought about quitting due to the health warning and this proportion was over 50% in the 15-24 age group. Among those with lower levels of education, 50% thought about quitting due to health warnings (Table 8.2 Annex).

Figure 13 – Percentage of smokers who thought about quitting due to health warning by educational level.



About 20% of people surveyed said they had observed cigarettes advertising in shops. The 15-24 age groups had noticed advertising more significantly than those over age 25.

Table 11 - Percentage of persons of 15 or more years that noticed advertising of tobacco products, according to demographic characteristics.

	Saw advertising in shops (CI 95%)	Saw any advertising, promotion or sponsorship (CI 95%)
Total	20.9 (19.1-22.8)	44.3 (42.0- 46.5)
Sex		
Men	23.3 (20.8-25.9)	49.0 (46.0- 52.0)
Women	18.8 (16.7-21.1)	40.0 (37.2- 42.8)
Age groups		
15-24	36.3 (31.8-41.0)	61.2 (56.2- 66.0)
25 or more	17.0 (15.4-18.7)	40.0 (37.8-42.2)
Region		
Urban	21.3 (19.4-23.4)	44.7 (42.3- 47.2)
Rural	15.3 (12.9-18.1)	38.4 (34.7- 42.3)

Among the general population, 44.3% had noticed some kind of tobacco advertising and promotions. Persons aged 15 to 24 were 50% (1.5 times) more likely to have noticed any advertising or promotions that those over age 25. This pattern was observed both in smokers and nonsmokers (Table 8.3 Annex).

4.6 Knowledge, attitudes and perceptions

The vast majority (over 90%) of people 15 years or older said they believed that smoking caused serious diseases, especially heart attacks and lung cancer. However a much smaller proportion knew that smoking could lead to cerebro-vascular stroke (76.5%). Young people aged 15-24 were significantly less likely than older adults to believe that smoking caused stroke (63.7%). (Table 9.1 Annex)

Approximately 90% of the population believed that breathing in others' tobacco smoke could cause serious health problems for non-smokers. Differences by age, sex, level of education or place of residence were not significant. (Table 9.2 Annex).

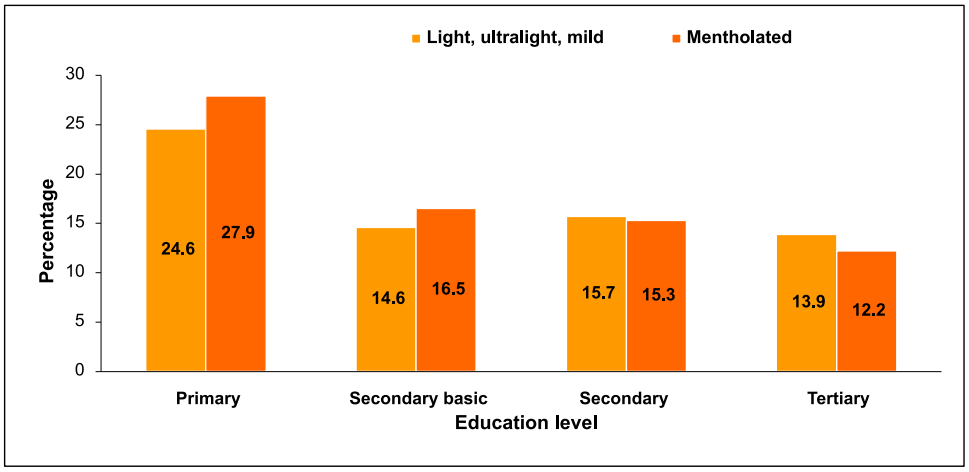
Among those who knew smoking caused serious illnesses, 19.2% did not know that light, ultra light, and mild cigarettes were as harmful as regular cigarettes. In the same group, 20.3% were unaware that menthol cigarettes are as harmful as regular cigarettes. Persons 65 years and older were significantly less aware that light, ultra light, soft or menthol cigarettes are as harmful as regular cigarettes compared to other age groups (table 12). Figure 14 shows that, in general, people with only primary education were significantly less likely to have this information about light, ultra light or mild cigarettes (Table 9.3 Annex).

Table 12 - Percentage of people who are unaware that light, ultralight and mild cigarette are as harmful as regular cigarettes according to tobacco use and age.

	TOBACCO SMOKING		
	Total	Current smokers*	Non smokers
Age groups	**(CI 95%)**	**(CI 95%)**	**(CI 95%)**
15 – 24	17.2 (13.9 – 21.0)	11.5 (6.8 – 18.6)	19.1 (15.1 – 23.7)
25 – 44	13.5 (11.4 – 16.0)	13.9 (10.6 – 18.1)	13.4 (11.2 – 15.9)
45 – 64	20.3 (17.4 – 23.4)	20.0 (15.3 – 25.6)	20.4 (17.2 – 24.0)
65 and over	31.9 (28.5 – 35.4)	34.0 (23.6 – 46.3)	31.7 (28.2 – 35.4)
Total	**19.2(17.4 – 21.1)**	**16.3 (13.6 – 19.3)**	**20.1 (18.2 – 22.2)**

*** Includes daily and occasional smokers.**

Figure 14 - percentage of people who are unaware that menthol, light, ultralight and mild cigarettes are as harmful as regular cigarettes according to educational level.



Most respondents believed that cigarettes were addictive with no significant differences by sex, age, place of residence or smoker status. There was a slight difference by educational level although in general the level of knowledge was approximately 92%. (Table 9.4 Annex).

5. DISCUSSION

5.1 Tobacco use

Smoking prevalence in Uruguay has declined significantly in recent years. Surveys conducted by the National Drug Board showed that the prevalence of current smoking remained virtually constant in 1998, 2001 and 2006, at 32.5% 32.3% and 31.8% respectively. Likewise, the Risk Factors National Survey conducted by the Ministry of Public Health in 2006, showed a prevalence of current smoking of 36.0%[6]. These data indicated no significant variation in the prevalence of smoking for nearly a decade in Uruguay.

However in 2009, the Global Adult Tobacco Survey (GATS) found that 25.0% of the adult populations (age 15 or older) were smokers, which suggested of a substantial decrease in relation to previous findings.

In order to compare the prevalence of tobacco smoking in Uruguay between 2006 and 2009, estimates of the prevalence of daily smoking among 25-64 years old were generated using data from the 2006 STEPS and the 2009 GATS, which asked comparable questions about tobacco smoking. In 2006, 32.7% of 25-64 year old adults in Uruguay said they were daily tobacco smokers. By 2009, tobacco smoking prevalence had declined to 25.0%. This represents an absolute decline of 7.7 percentage points and a relative decline of 23.6% from 2006 to 2009.

Such significant changes in the prevalence of tobacco use in such a short time period can be attributed to government policies and tobacco control measures undertaken in recent years.

The decline in the prevalence was found both in men and women, going from 37.2% in STEPS (2006) to 29.5% in GATS (2009) in the case of men, and from 28.6% in STEPS to 20.9% in GATS in the case of women. This implied a reduction of approximately 21% in men and a decline of 27% among women, although the decline was different when analyzed by age group.

While tobacco consumption was greater among men than women in all age groups, the gap between the sexes was lower in adolescents. This was in line with what was observed in the 2006 Global Youth Tobacco Survey (GYTS 2006, JND) which showed that 24.6% of women and 19.7% of men smoked in the population aged 13 to 15 at the national level. Among the youngest, female consumption already surpassed males, probably due to the tobacco industry's strategy in recent decades to focus its marketing on women, particularly young women, deliberately linking smoking in a misleading and false way to greater independence and gender equality, as demonstrated by various international studies.[34, 35] While men had already reached a considerable level of consumption (35% in developed and 50% in developing countries), an important margin of growth still exists among women (22% prevalence in developed countries and 9% in developing ones)[36]. That is why the tobacco industry has targeted its marketing activities to women.

An analysis of the data by age yielded the following results:

Prevalence of daily smokers by age groups for STEPS/GATS

	STEPS	GATS	
Age groups	2006	2009	Difference 2006-2009
25 – 34	33.8	28.4	5.4
35 - 44	35.2	20.8	14.4
45 – 54	33.3	29.3	4.0
55 – 64	27.2	20.3	6.9
TOTAL	32.7	25.0	7.7

[6] Both surveys are nationally representative.

The above verified that the decline was different for different age groups and was very significant for the 35 to 44 age group, marking a decline of almost 15 points in absolute terms compared to the year 2006 and implying a percentage variation of 41%. Among the 55-64 year age group, prevalence declined almost 7 points in relation to 2006 (a 27% variation between the two measurements). It was particularly noticeable that in the 25-34 age group the decline in prevalence was more significant among women, while for all other age groups, the decline was greater among men.

Smoking behavior differed by socio-economic level of the persons[7]. Respondents in the lowest socio-economic level reported the highest prevalence of tobacco consumption, 35% as compared to 19.6% in the highest level, indicating that a priority should be focusing on those in the lowest socio-economic stratum.

According to the 2008 National Households Survey (INE 2008), households with fewer resources generally had more members, including more children under age 14, and lived in houses with fewer rooms per person. They also had less access to comprehensive health services and thus greater difficulty in adequately meeting their health needs. When considering these factors, it is clear the scale of the problem in terms of the high prevalence among the poorest.

The economic cost of smoking both for individuals and for households remains a significant issue, especially for people of few resources. In these cases cigarette or tobacco purchases may represent a significant proportion of their total income and/or the family budget. Further study is needed to understand the determinants of consumption, the effectiveness of tobacco control messages and the mechanisms established for smoking cessation and their accessibility within this specific population group. According to the SELI, the highest smoking prevalence was found in the poorest populations both in Montevideo (44.7%) and in the countryside (32.7%), and this is where specific programs of action should be developed, aimed at reducing tobacco use (Figure 5B of Results).

Almost 100% of tobacco consumed in Uruguay was smoked; GATS did not find any smokeless tobacco use. The vast majority of smokers smoked manufactured cigarettes while only 8.1% of people smoked hand-rolled cigarettes, which reflected large differences in educational attainment, sex and place of residence of smokers. Using the STEPS survey data (2006) for comparison, GATS found a slight increase in hand-rolled cigarettes smoking (6,0 % vs. 8.1%).

According to GATS, hand-rolled cigarettes smoking decreased significantly as education and socio-economic levels of people increased. While 21.8% of those with only primary education smoked hand-rolled tobacco, among tertiary educated smokers the percentage did not exceed 1.4%. One factor might be that the price of hand-rolled tobacco is considerably less than that of manufactured cigarettes.

When hand-rolled cigarettes smoking was analyzed by geographic residence, it was notable that consumption in rural areas (13.6%) was almost double than that reported in the urban environment (7.7%). Consumption of hand-rolled tobacco was also predominant among men, which may be linked with traditional cultural aspects of rural men in Uruguay. Advertising and marketing that associated manufactured cigarettes with elegance and sensuality, would certainly affect lower consumption of hand-rolled cigarettes among women (3.3%) in relation to men (13.5%).

This analysis points to the need for a pricing policy with public health objectives in order to reduce access to a product that is extremely harmful to one's health. Even the difference in price between manufactured and hand-rolled cigarettes hamper the impact of prevention policies, since lower income persons can simply switch to hand-rolled tobacco, which is equally harmful but significantly cheaper.

The degree of dependence on tobacco used by GATS was based on how many minutes elapsed between awakening and the first cigarette smoked. More than 30% of respondents indicated a moderate or severe dependence, both men and women, and even among the youngest. The GYTS survey (JND 2006) showed that more than half of young people aged 13 to 15 had tried to quit smoking without success and over one-third showed significant signs of dependence. Succesful cessation will probably require some sort of specialized help and thus it will be important to strengthen the network of currently available care and implement specific programs for adolescents.

The average daily consumption of cigarettes shown in GATS (15.4 per day), remained unchanged with respect to average consumption shown by both the JND (14.3 per day) and STEPS (14.8 per day) surveys.

[7] See chapter on Methodology and Annexes on development of SELI.
[8] Figure obtained by considering the prevalence recorded in GATS 2009 and population projections for the year 2009 (INE).

Despite the progress made to control the epidemic, 50% of the approximately 615.000[8] current smokers in Uruguay will die from tobacco related causes, half of them prematurely between 35 and 70 years old [37]. Tobacco control measures must continue to be strengthened so as to reduce the consequences of tobacco use as far as possible.

Smokeless tobacco consumption is virtually nonexistent in Uruguay. The interviewers received adequate information on the characteristics of this product during training prior to fieldwork, so as to explain to the population what it was, if necessary, and to ensure that the question was correctly understood. Progress in tobacco control measures could eventually lead the industry to attempt to market alternatives to smoked tobacco, such as smokeless tobacco. Its prevention must be incorporated into future health strategies.

5.2 Cessation

While nearly half of smokers (48.6%) said they had attempted to quit in the past 12 months, the proportion was very high among young adults (60%) indicating that various informational and educational campaigns have reached the younger population. An investigation conducted in May 2009 [38] for the MSP showed that "quitting" was an important topic of conversation among young smokers and the vast majority were attempting to or wanted to stop smoking. In the same sense, they manifested an almost unanimous support for smoke-free environments, and said legislation had allowed them to become aware of the rights of nonsmokers to the point that they would not smoke in enclosed spaces, even if it were no longer legally prohibited.

In addition to the cessation attempts, future intent should be noted. More than 75% of smokers said they were planning to or thinking about quitting, of these 11% wished to quit immediately. Again, the 15–24 age group had the highest proportion, over 80%, reinforcing the need to strengthen the system of cessation programs, and confirming the effectiveness of tobacco control measures in promoting smoking cessation.

For GATS, an ex-smoker was simply "a person who had quit smoking", without establishing a minimum lengthen of time since cessation. Having an isolated puff did not invalidate the GATS definition of ex-smoker. However, in Uruguay it is considered important to establish the percentage of ex-smokers who have not had even a puff in the last year. Because in many cases those who take a few puffs often resume smoking in the following months. Using the strictest definition of 1 year of complete abstinence the observed rate was 89.5% (CI 86.6 - 91.9) (Table 4.9a Annex) which was similar to the rate obtained using the GATS definition. Therefore, it may be concluded that most Uruguayan ex-smokers were consolidated ex-smokers, having spent more than 1 year without even having a puff.

Currently, diagnosis and treatment of tobacco dependence is mandated at the primary care level of health centers. In agreement with the National Resources Fund, most services provide free medication (nicotine replacement therapy and bupropion), when prescribed. In spite of this, only 77% of smokers who had visited a health service in the last year said they were questioned about whether they smoked or not, and only 55% were advised to quit while barely 15% received guidance on how to do it. In July 2009 Uruguay completed its National Guidelines for Addressing Tobacco, aimed at all health staff, which established the need to ask about smoking status and register it on the patient's chart, as well as to give brief advice about cessation and treating or referring patients, as appropriate (ABC cessation). These recommendations established current norms that must be followed by legal mandate. During the second half of 2009, which coincident with GATS field work, Uruguay was just in the dissemination phase of the national guidelines, so that the rate of ABC implementation in smoking patients can be expected to grow substantially in the coming years.

The small proportion of smokers who had received guidance on how to quit (15%) points out the need for training of professionals in cessation. Health workers often believe they do not have the necessary tools to help their patients through this process. The Honorary Commission for the Fight against Cancer has ongoing training courses. At the same time, the National Guidelines for Addressing Tobacco provides essential support and recommendations based on international scientific evidence, while taking into account the national context, as it developed the methodology based on participation and broad consensus among professionals working on smoking treatment throughout the country.

GATS showed that there was a good amount of information on where to get help to quit smoking, in both urban and rural settings. However, accessibility is different according to residence. Smokers who reside in rural areas have limited access to such services.

The system of public and private treatment centers for tobacco dependence has increased since 2004, such that there are now specialized services in all departments (provinces) in Uruguay. Synergies with other tobacco control measures have resulted in a 42% quit ratio, i.e., out of every 100 people who have ever smoked on a daily basis, 42

have successfully stopped smoking. When cessation rates are analyzed by age, the largest percentage of those who had stopped smoking in the past four years were between 25 and 44 years old (46.1% compared with 29.8% in the 45-to-64 age group), which could be a consequence of specific policies promoting the cessation of tobacco use among young people.

The lowest relative difference (percentage change) of prevalence between males and females by age group was recorded in the group aged 25 to 44 years (26%). This could be linked to a higher rate of cessation among women in that age range. Among daily smokers who quit smoking, 32.7% (29.1 - 36.6) did so in the past four years. When cessation rates for the past four years were analyzed by sex, 40.9% (34.9 - 47.2) of former daily smokers were women and 27.0% (22.7 - 31.8) were men. This suggests that messages promoting cessation of tobacco use have been more effective in women, given the emphasis on women in tobacco control policies and considering that the age at initiation of daily smoking was similar between men and women: 22.5% of males and 21.0% of women said they began smoking before age 15 (Table 4.7 Annex).

5.3 Secondhand tobacco exposure

Since the establishment of smoke-free environments, exposure of individuals to secondhand smoke in public places has greatly declined. However, there remain important differences by specific venues. While exposure in public offices, health services, restaurants and public transportation was reported to be very low, strikingly higher percentages were observed at the University and in bars, pubs and discos. In the first group of venues, it was understandable that, although there was a certain level of infringement, the degree of compliance with the rules was very high. However, in places where the population present was mostly young people, the level of exposure was greater, which could be related to a greater breach of rules on their part, and therefore priority should be placed on reaching this population. More research is needed on the possibility of contamination of indoor environments through doors and windows contiguous to smoking areas in open spaces.

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A recent study showed a decline of 22% in hospitalizations for acute myocardial infarction among the general population, comparing a two-year period after enactment of the 100% smoke-free regulation with a similar period previous to the smoke-free regulation. The largest decline occurred in the population less than 45 years old and on particular days of the week (Friday and Saturday)[28]. Though further studies are required to assess the significance of this last finding, it may be related to improvement of air quality in bars and clubs that young people frequent on weekends. While GATS showed higher rates of secondhand smoke in bars, pubs and discos, overall rates have improved significantly. As stated in the introduction, air pollution in enclosed public spaces has been reduced by more than 90% since the implementation of the 100% tobacco smoke-free environments law [22].

At the university, smoking in open spaces constitutes a violation of the existing regulation, because smoking is banned in both enclosed and open educational spaces, as it is in health centers. The role of educational centers in training and transmission not only of information but also of values, highlights the need for implementing specific efforts to reverse this reality.

Exposure to secondhand smoke in the workplace was higher among men, which could be related to type of occupation. Before smoke-free environments regulations, the percentage of exposure was 36.2% (STEPS), falling to 17.1% in the months immediately following enactment thereof [8]. In the following three years, this level of exposure (16.5%) was maintained, indicating more than 80% compliance in spite of the fact that there were insufficient human resources in the inspective area. At the same time, it suggests the need to strengthen control mechanisms in order to reduce levels of occupational exposure.

Information provided to the general population regarding smoke-free environments extended to the level of households, stressing the need for them to transform themselves voluntarily into smoke-free spaces.

The proportion of respondents reporting exposure to secondhand smoke at home in the last seven days was 29.2%. Men and young people aged 15 to 24 were the most exposed (40.8%). This might be explained by the fact that this young age group was more inclined to break rules and that their exposure occurred in the context of activities with peers, either studying or socializing. Further research is required to assess trends pertaining to secondhand smoke exposure in the home.

5.4 Economics

Almost half of the smokers said they bought cigarettes in small grocery stores (49.7%) followed by kiosks, lounges

or newspapers stands (25.7%) and lasty large supermarkets (12.7%). Grocery stores are more accessible given their proximity to households, while kiosks and large supermarkets may require travelling a greater distance. The extent to which the prohibition to display cigarettes in supermarket cashier stands has influenced these figures is unknown. Current regulations ban the display of tobacco products in cashier stands in stores greater than 100 m^2 in order to discourage impulsive purchases.

Tobacco smoking is higher at lower socioeconomic level and greater impact on the economic situation of low-income families. Low socioeconomic level is generally also associated with a lower educational level and greater difficulty in accessing health care. The poorest families must allocate an important portion of their limited resources if they purchase tobacco, which could otherwise be used for food, housing, or health care. Monthly average spending on cigarettes represents more than one fifth of the national minimum wage, which was $ 4.441 Uruguayan pesos during the GATS period.

While new legislation substantially increased taxes for both manufactured cigarettes and chopped tobacco for hand-rolled cigarettes, the impact on the final sale price to the consumer was much higher for manufactured cigarettes. The tax increase process started from a very uneven baseline in 2005, when purchasers of manufactured cigarettes paid 68.5% in specific domestic tax (IMESI) while those buying chopped tobacco only paid 27%. Through a progressive increase by February 2010, and after GATS, the IMESI was 70% for both manufactured cigarettes and chopped tobacco. In spite of this, the final cost of hand-rolled cigarettes is still much less than that of manufactured, which may explain the higher consumption of the former in the poorest population sectors.

5.5 Media

More than 80% of those surveyed reported having seen some sort of anti-tobacco advertising or message, including both men and women and in all age ranges, urban and rural. This implied that informational and educational campaigns had been successful and tobacco control messages reached the majority of people in all segments of society. Government information campaigns consisted basically of radio, spots and printed materials such as brochures, posters or billboards on public roads. For television, a spot was produced in 2006, as part of "Uruguay tobacco smoke free" campaign, in support of the enactment of the ban on smoking in all enclosed public space. However, the diffusion of this TV spot was very low due to high broadcasting costs. It was aired for free only by the official channel and those channels that believed it was an important public service. Other means of transmitting the messages via television included news, shows that were especially interested in the issue of tobacco control, when a new regulation was approved, or a tobacco control activity constituted a new item, or when significant sanctions for non-compliance with tobacco control policies were applied. Transmission of the message through segments in journalistic programs was also very effective in radio, hence the importance of developing strategies to periodically put the issue of tobacco control on the public agenda. As a result it has been verified that 72.4% of the population has received anti-smoking information through radio or television, constituting the most important media. Radio has been found to be a better medium to communicate with the older audience, since 31.2% of youth aged 15 to 24 while 45.3% of those older than 25 years heard the message by radio.

The second most effective way to transmit anti-tobacco information was posters in public places (52.1%) and this medium was more effective in reaching the population aged 15-24 (56.6%) than those 25 or older (51.0%).

In the third place was the written press: newspapers and magazines.

Health warnings on cigarette packs are another effective way of reaching the population. More than 96% of GATS respondents said they had seen them, and 44.6% thought about quitting as a result, both men and women. These findings demonstrate the effectiveness of health warnings with compelling images for helping smokers to decide to quit, as has been proven in other countries. When designing the current health warnings, qualitative research was conducted to select images that most impacted in young people, since they had been defined as a target population for tobacco control policies that year. GATS found that while 42% of those aged 25 to 44 and those aged 45 to 64, thought about quitting due to those images, in the group aged 15-24 the percentage was 54.3%, which demonstrated the importance of designing health warnings directed to specific target audiences.

Health warnings were also shown to have greater impact on people with lower educational levels: 50.0% of those who only completed primary education and 33.3% of those who had tertiary education, which indicated that the message was easily understandable and helped people at lower social-cultural levels to acquire new information. However, the warnings effectively delivered the health message to all people, regardless of educational attainment, sex, or place of residence.

Advertising of tobacco products, in Uruguay is allowed only inside points of sale. While the advertisements are exposed for all to see, perceptions varied among different age groups. Overall, 20.9% of people said they saw the advertising, but young people most often reported seeing tobacco advertising in the previous 30 days (36.3% in the 15-24 age group) compared to 17.0% among those over 25. This implied that the tobacco industry targeted its advertising and messages to the younger more susceptible population.

When noticing advertising not only at points of sale but any type of advertising, promotion or sponsorship was considered, the differences remained 61.2% in the 15 to 24 age group noticed tobacco advertising, compared to 40.0% in those over age 25. This aspect may include indirect promotion of tobacco through clothing or other items with logos or brands of cigarettes. According to GATS, 9.8% of people aged 15 to 24 had seen this kind of advertising, while only 4.3% had in 25 or older group. Delivery of free tobacco products is prohibited by law; and the percentage of those who reported this type of promotion was very low (1.6%). Still there was a noticeable difference between younger and older groups in terms of having received free tobacco products from the tobacco industry: 3.6% of the population aged 15-24 had received tobacco products free of charge as opposed to only 1.1% of those over 25.

Both direct and indirect advertising have the most impact on youth. These strategies must be counteracted by a total ban on advertising, promotion and sponsorship of tobacco, at the same time developing mechanisms to reach this population with educational messages about the harm caused by tobacco consumption.

5.6 Knowledge, attitudes and perceptions

According GATS, 97.6 % of those surveyed recognized that smoking causes serious damage, associating it with first lung cancer and secondly with cardiovascular events. No difference was observed between urban and rural populations.

Considering beliefs of smokers and nonsmokers, 98.3% of the latter believed that tobacco causes serious damage and 97.6 % of former did so. Although non-smokers saw the damaging impact more clearly, almost the entire population clearly understood the damage tobacco does through lung cancer and myocardial infarction. However, tobacco's relation to stroke was not known in equal measure (76.5%). This finding suggests that future educational campaigns should consider targeting specific diseases.

Regarding second-hand smoke, 93.8% recognized the damage that it causes. It is interesting to note that 91.9% of smokers had this perception while for non-smokers the proportion was 94.40%. No observable differences were observed between urban and rural populations. These figures demonstrated a high level of knowledge among the population, due to educational campaigns implemented even prior to enactment of the smoke-free environments law.

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Almost a quarter of the population (24.7%) were not aware that light, ultralight or menthol cigarettes were as harmful as regular ones, especially persons older than 65 (37.8%). Young people seemed to have the most information about it (only 21.3% unaware). Lack of knowledge was higher among those with lower educational levels and in rural areas compared to the urban area. This finding underscores the need to continue to educate the whole population about this issue; even though that information was provided when the regulation prohibiting misleading information on packaged cigarettes was enacted.

There was a very high level of knowledge about the addictive nature of tobacco products (92.0%), among all age ranges. It was observed less in rural (88.0%) than in urban (92.3%) areas, and among those with lower education levels (primary 88.1%, tertiary 95.6%), but it still can be said that the Uruguayan population generally knew that tobacco was an addictive product.

6. CONCLUSIONS AND FUTURE RECOMMENDATIONS

From the epidemiological standpoint, Uruguay presents a profile similar to that of developed countries. Average life expectancy at birth is 75 years (men: 72 years, women: 79 years) and the population is ageing, in that 13.6% of the population is 65 or older. Completing this epidemiological transition, the leading causes of death in Uruguay are now linked to non-communicable diseases. The top two causes of death are cardiovascular diseases and cancer, which together are responsible for almost 60% of annual deaths. Both diseases are closely linked to smoking, which underscores the importance of ensuring effective control of this epidemic.

Before GATS, the most recent official data available at the national level showed a high prevalence of current smokers, at 32%. Implementation of comprehensive tobacco control measures has led to a significant reduction in tobacco consumption, which has had a notable impact for Uruguay, both in health and economic terms. The pillar of this process has been the enactment of "100% smoke-free environments", which not only protects people from the serious damage caused by passive smoking, but changes the culture so that smoking is no longer considered normal and socially acceptable behavior. This approach creates citizen ownership of the problem, thus increasing acceptability and adherence to legislation.

The tobacco control measures used in Uruguay constitute a strategy that is accessible to any country, regardless of whether it is high, medium, or low income. Most measures, such as increasing prices and taxes on cigarettes or enacting smoke-free environment legislation, cost virtually nothing and only require effective dissemination of information and sensitization of the population, as well as strategic alliances with civil society for implementation and enforcement.

However, it is important to note that in Uruguay the reduction in tobacco consumption was not accompanied by a decrease in tax revenue, but rather an increase, even while the percentage of current smokers declined by 23% over three years. Not only did the annual collection of specific internal tax (IMESI) on tobacco and cigarettes increased by 20% from 2005 to 2009, but from 2007 on, the value-added tax on tobacco products (VAT) also added tax revenue because tobacco products began to pay VAT from which they were previously exonerated.

Even as tax revenues increased, substantial savings from the health and economic point of view occurred. According to a study entitled "The impact of the smoking ban in enclosed public spaces on hospital admissions for acute myocardial infarction in Uruguay" , (March 2010), the 22% reduction in these hospital admissions represents a significant and immediate economic savings to the nation's health system.

Regarding the impact of the 100% smoke-free environments legislation, Uruguay went from having one of the highest levels of inside air pollution in the world to being in second place in terms of air quality, after New Zealand, within the space of only two years [28].

This analysis has proven that a comprehensive tobacco control policy was appropriate for Uruguay from the point of view of its health, economic and environmental impact. Based on the results obtained in GATS, the following lines of action have been defined for the next 5 years:

- Assess the determinants of smoking in the lower socioeconomic levels of the population, both in Montevideo and the countryside, in order to reduce consumption in that specific population, through education and promotion of cessation activities and facilitating access to specialized health services.
- Learn about the determinants of smoking in the female population, especially young women, for the elaboration of a gender approach to reducing smoking.
- Strengthen the structure of smoking cessation programs at the national level.
- Strengthen inspection mechanisms, with the emphasis on university buildings and discos and entertainment facilities where young people congregate, in order to reduce exposure to secondhand tobacco smoke.
- Move towards a total ban on advertising, promotion and sponsorship of tobacco products, pursuant to Article 13 of the FCTC and protect especially the youngest in the population from starting to smoke.
- Alert the public about the dangers of using other forms of tobacco such as smokeless tobacco. The tobacco industry might introduce it in Uruguay as an alternative to cigarettes, as a response to tobacco control measures, especially smoke-free environments.
- Alert the public about the damage caused by cigarettes reported by the tobacco industry as having "lower tar and nicotine content" as well as by menthol tobacco products.

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ANNEXES

ANNEX A
Uruguay Questionnaire

GLOBAL ADULT TOBACCO SURVEY

GATS URUGUAY

Household Questionnaire
Individual Questionnaire

GLOBAL ADULT TOBACCO SURVEY 2009

1. GEOGRAPHICAL IDENTIFICATION

YEAR:

DEPARTAMENT:

SECTION:

SEGMENT:

ZONE:

HOUSEHOLD:

WEEK:

2. HOUSEHOLD'S ADDRESS

EXTERIOR NUMBER INTERIOR NUMBER

(STREET, AVENUE, ALLEY, HIGHWAY, ROAD, BOULEVARD, KM.)

(COLONY, DIVISION, NEIGHBORHOOD, RESIDENTIAL UNIT)

|____|____|____|____|____|

POSTAL CODE

3. FOLIO OF THE HOUSEHOLD

PROGRESSIVE NUMBER

OF THE HOUSEHOLD.....|____|____|____|

4. CONTROL OF THE QUESTIONNAIRE

HOUSEHOLD .....|____| OF |____|

OF THE HOUSE

QUESTIONNAIRE .....|____| OF |____|

OF THE HOUSEHOLD

5. RESULTS OF THE VISIT

VISIT NUMBER / 1ST 2ND 3RD / DEFINITIVE RESULT

INTERVIEWER'S CODE NAME

DATE (dd mm yy)

RESULT (*)

TIME IN WHICH THE INTERVIEW STARTED

TIME IN WHICH THE INTERVIEW ENDED

(*) CODE FOR THE VISIT RESULT

Note: The standard codes used for the programming of the handhelds will be used. See the manual for the description of the codes

6. RESULTS OF THE VISIT TO THE SELECTED RESPONDENTS

STUDY SUBJECTS / RESIDENT CODE / 1ST 2ND 3RD 4TH

ADULT |___|___|___|___|___|___|___|___|___|___|___|___| |___|___| |___|___| |___|___| |___|___|

TEENAGER |___|___|___|___|___|___|___|___|___|___|___|___| |___|___| |___|___| |___|___| |___|___|

HOUSEHOLD QUESTIONNAIRE

TIME IN WHICH THE INTERVIEW STARTED
[USE THE 24 HOURS SYSTEM]

___ ___. ___ ___
HOUR MIN

INTERVIEWER: THE HOUSEHOLD SCREENING RESPONDENT MUST BE 18 YEARS OF AGE OR OLDER AND YOU MUST BE CONFIDENT THAT THIS PERSON CAN PROVIDE ACCURATE INFORMATION ABOUT ALL MEMBERS OF THE HOUSEHOLD.

INTRODUCTION: An important survey of adult tobacco use behavior is being conducted by the ***Instituto Nacional de Estadística*** (INE) throughout **Uruguay** and your household has been selected to participate. Your house was selected. All houses selected were chosen from a scientific sample and it is very important to the success of this project that each participates in the survey. All information gathered will be kept strictly confidential.
I have a few questions to find out who in your household is eligible to participate.

HH1. First, I'd like to ask you some questions about you. In total, how many persons live in this household?
INTERVIEWER: INCLUDE ANYONE WHO (UNTIL THE PREVIOUS NIGHT) LIVE HABITUALLY UNDER THE SAME ROOF AND SHARE ONE COMMON FUND FOR FOOD
_____PERSONS

HH2. How many of these persons are 15 years old or older?
_____PERSONS

HH3. How many (male/female) of these persons are 15 years old or older?
_____PERSONS

IF HH3 = 00 (NO ELIGIBLE MALES/FEMALES IN THE HOUSEHOLD), END INTERVIEW AND GO TO THE COVER PAGE TO RECORD THE EVENT. ENTER RESULT CODE.

HH4. I now would like to collect information about the (male(s)/female(s)) that live in this household who are 15 years of age or older. Let's start from oldest to youngest male(s)/female(s).

POSE THE FOLLOWING QUESTIONS AND NOTE THE ANSWERS IN THE FOLLOWING TABLE:

a. What is the person's first name?
b. What is this person's age? IF RESPONDENT DOESN'T KNOW, ASK FOR AN ESTIMATE
c. IF THE REPORTED AGE OF A HOUSEHOLD MEMBER IS 15 TO 17, YOU WILL ASK FOR DATE OF BIRTH IN ORDER TO VERIFY THE AGE. What is the month and year of this person's date of birth?

VERIFY THAT THE DATE OF BIRTH IS PREVIOUS TO [WRITE MONTH/DATE] THUS YOU WILL KNOW WITH CERTAINTY THAT THE PERSON HAS, AS A MINIMUM, 15 YEARS OF AGE. IF IT DOES NOT SATISFY THIS REQUIREMENT (AGE), ERASES THE LINE.

IF THE HOUSEHOLD RESPONDENT DOES NOT KNOW DATE OF BIRTH, CONTINUE TO QUESTION d.

D. RECORD GENDER OF RESPONDENT
e. Does this person currently smoke tobacco, including cigarettes, cigars or pipes?

A. FIRST NAME / B. AGE / ONLY IF AGE = 15 TO 17. C. DATE OF BIRTH / D. GENDER

M F / E. ¿CURRENTLY SMOKE? YES NO DON'T KNOW

NOTE: THE SELECTION OF THE RESPONDENT PERSON WILL BE DONE AT RANDOM AND AUTOMATICALLY THROUGH THE PROGRAM INSTALLED IN THE HANDHELD.

- o IF IN THE HOUSEHOLD RESIDES ONLY ONE PERSON (MAN/WOMEN) WHO MEETS THE REQUIREMENTS, WRITE"1" IN HH5;
- o IF IN THE HOUSEHOLD DOES NOT RESIDE ANY PERSON WHO MEETS THE REQUIREMENTS, WRITE "0" IN HH5 AND CONCLUDE THE INTERVIEW;

HH5. NUMBER OF THE PERSON (MAN OR WOMAN) WHO MEETS THE REQUIREMENTS THAT WAS SELECTED FOR THE INTERVIEW (REFER TO THE LIST OF PEOPLE IN THE HOUSEHOLD):

HH6. WRITE THE IDENTIFICATION NUMBER OF OF THE QUESTIONNAIRE:
IDENTIFICATION NUMBER OF THE HOUSEHOLD _ _ _ _ _ _ _ _ _ _ _ _ _

INTERVIEWER: IF YOU DO NOT TALK TO THE SELECTED RESPONDENT OR IF HE/SHE IS NOT AVAILABLE TO RESPOND THE QUESTIONNAIRE IMMEDIATELY, WRITE DOWN THE NAME OF THE RESPONDENT AND SCHEDULE ANOTHER VISIT (DATE AND HOUR).

NAME:
DATE OF THE NEXT VISIT: _____ HOUR: _____
DATE OF THE NEXT VISIT: _____ HOUR: _____
DATE OF THE NEXT VISIT: _____ HOUR: _____
DATE OF THE NEXT VISIT: _____ HOUR: _____

TIME IN WHICH THE INTERVIEW WAS CONCLUDED
[USE THE 24 HOURS SYSTEM]

_ _. _ _
HOUR MIN.

GLOBAL ADULT TOBACCO SURVEY 2009

SECTION A. PERSONAL DATA

INTRODUCTION: I am going to first ask you a few questions about your background.

A1. INTERVIEWER: RECORD GENDER FROM OBSERVATION. ASK IF NECESSARY.

MALE..... 1

FEMALE 2

A2. What is the month and year of your date of birth?

MONTH: IF "DON'T KNOW", ENTER "77"

YEAR: IF "DON'T KNOW", ENTER"7777"

INTERVIEWER: IF MONTH = 77 OR YEAR =7777 IN A2, GO TO A3. OTHERWISE GO TO A4.

A3. Then, how old are you?

INTERVIEWER: IF RESPONDENT IS UNSURE, PROBE FOR AN ESTIMATE AND RECORD AN ANSWER

_____ YEARS OLD

A3a. THIS RESPONSE, IS AN ESTIMATE?

YES 1

NO 2

DON'T KNOW . 7

A4. What is the highest level of education you have completed?

INTERVIEWER: SELECT ONLY ONE CATEGORY

NO FORMAL SCHOOLING	1
STANDARD PRIMARY SCHOOL	2
SPECIAL PRIMARY SCHOOL	3
BASIC CYCLE OF HIGH SCHOOL OR UTU (1ST to 3rd)	4
SECONDARY BACCALAUREATE (4th to 6th)	5
UTU TECHNICAL BACCALAUREATE (4th to 6th)	6
TECHNICAL EDUCATION	7
PRIMARY, SECONDARY TEACHING DEGREE	8
UNIVERSITY OR SIMILAR	9
TERTIARY NOT UNIVERSITY	10
POSTGRADUATE	11
DON'T KNOW	77

A5. Which of the following best describes your work status over the past 12 months? Private employee, Public employee, Member of production cooperative, Employer, Self-employed without investment or facility, Self-employed with investment or facility, Unpaid member of household, Social employment program, Retired, Pensionist, Land owner, Student, Homemaker, Unemployed-able to work and seeking for a job, Unemployed-able to work and not seeking for a job, or Unemployed-unable to work?

INTERVIEWER: CARRY OUT THE NECESSARY QUESTIONS UNTIL YOU ARE SURE THE RESPONDENT UNDERSTOOD THE QUESTION

PRIVATE EMPLOYEE 1
PUBLIC EMPLOYEE 2
MEMBER OF PRODUCTION COOPERATIVE 3
EMPLOYER 4
SELF-EMPLOYED WITHOUT INVESTMENT OR FACILITY 5
SELF-EMPLOYED WITH INVESTMENT OR FACILITY 6
UNPAID MEMBER OF HOUSEHOLD 7
SOCIAL EMPLOYMENT PROGRAM 8
RETIRED 9
PENSIONIST 10
LAND OWNER 11
STUDENT 12
HOMEMAKER 13
UNEMPLOYED, ABLE TO WORK AND SEEKING FOR A JOB 14
UNEMPLOYED, ABLE TO WORK AND NOT SEEKING FOR A JOB 15
UNEMPLOYED, UNABLE TO WORK 16
DON'T KNOW 77

A6. Please tell me whether this household or any person who lives in the household has the following items:

READ EACH ITEM	YES	NO	DON'T KNOW
a. Electricity?	1	2	7
b. Flush toilet?	1	2	7
c. Fixed telephone?	1	2	7
d. Cell telephone?	1	2	7
e. Television?	1	2	7
e1. (IF "YES" IN A6e:) The television is color or black and white?	B/W	COLOR	
e2. (IF "COLOR" IN A6e1:) How many color TV?	ONE	MORE THAN ONE	
f. Radio?	1	2	7
g. Refrigerator?	1	2	7
h. Car?	1	2	7
i. Moped/scooter/motorcycle?	1	2	7
j. Washing machine?	1	2	7
k. Clothes dryer?	1	2	7
l. Tank-style water heater?	1	2	7
m. Instantaneous water heater?	1	2	7
n. Cable TV subscription?	1	2	7
o. VCR?	1	2	7
p. DVD player?	1	2	7
q. Dishwasher?	1	2	7
r. Microwave oven?	1	2	7
s. Air conditioner?	1	2	7
t. Personal computer (include laptop)?	1	2	7
t1. (IF "YES" IN A6t:) is any of the "Ceibal plan?"	1	2	7
t2. (IF "YES" IN A6t1:) How many? _____			
u. Internet connection?	1	2	7

SECTION B. TOBACCO SMOKING

INTRODUCTION: I would now like to ask you some questions about smoking tobacco products, including cigarettes, hand-rolled cigarettes, naco, cigars, pipes.

B1. Do you currently smoke any tobacco product on a daily basis, less than daily, or not at all?

DAILY ..... 1 → GO TO B4
LESS THAN DAILY 2
NOT AT ALL ..... 3 → GO TO B3
DON'T KNOW ..... 7 → GO TO SECTION C

B2. Have you smoked any tobacco product daily in the past?

YES ..... 1 → GO TO B8
NO ..... 2 → GO TO B10
DON'T KNOW ..... 7 → GO TO B10

B3. In the past, have you smoked tobacco on a daily basis, less than daily, or not at all?

INTERVIEWER: IF RESPONDENT HAS DONE BOTH "DAILY" AND "LESS THAN DAILY" IN THE PAST, CHECK "DAILY"

DAILY ..... 1 → GO TO B11
LESS THAN DAILY ..... 2 → GO TO B13
NOT AT ALL ..... 3 → GO TO SECTION C
DON'T KNOW ..... 7 → GO TO SECTION C

[RESPONDENTS THAT CURRENTLY SMOKE DAILY]

B4. How old were you when you first started smoking tobacco daily?

_____ YEARS OLD [IF DON'T KNOW ENTER "99"]

INTERVIEWER: IF B4 = "99", GO TO B5. OTHERWISE GO TO B6

B5. How many years ago did you first start smoking tobacco daily?

_____ YEARS [IF DON'T KNOW ENTER "99"]

B6. On average, how many of the following products do you currently smoke each day? Also, let me know if you smoke the product, but not every day.

INTERVIEWER: IF RESPONDENT REPORTS SMOKING THE PRODUCT BUT NOT EVERY DAY, ENTER "888"

INTERVIEWER: IF RESPONDENT REPORTS IN PACKS OR CARTONS, TRY TO FIND OUT HOW MANY ARE IN EACH AND CALCULATE TOTAL NUMBER

READ EACH ITEM:

a. Manufactured cigarettes?				Daily
				Weekly
b. Hand-rolled cigarettes?				Daily
				Weekly
c. Chopped naco?				Daily
				Weekly
d. Pipes full of tobacco?				Daily
				Weekly
e. Cigars?				Daily
				Weekly
f. Number of water pipe sessions with tobacco?				Daily
				Weekly
g. Any others? Specify _____				Daily
				Weekly

B7. In a typical day in which you smoke, how soon after you wake up do you usually have your first smoke? Would you say less than 5 minutes, 6 to 30 minutes, 31 to 60 minutes, or more than 60 minutes?

LESS THAN 5 MINUTES 1

6 TO 30 MINUTES 2

31 TO 60 MINUTES 3

MORE THAN 60 MINUTES..... 4

INTERVIEWER: GO TO SECTION C

PERSON THAT CURRENTLY SMOKE SOME DAYS BUT IN THE PAST HAVE SMOKED EVERY DAY

B8. How old were you when you first started smoking tobacco daily?

_____ YEARS OLD [IF DON'T KNOW ENTER "99"]

INTERVIEWER: IF B8 = 99, GO TO B9. OTHERWISE GO TO B10

B9. How many years ago did you first start smoking tobacco daily?

_____ YEARS [IF DON'T KNOW ENTER "99"]

B10. How many of the following do you currently smoke during a usual week?

INTERVIEWER: IF RESPONDENT REPORTS DOING THE ACTIVITY BUT LESS THAN ONCE PER WEEK, ENTER '888'

INTERVIEWER: IF RESPONDENT REPORTS IN PACKS OR CARTONS, TRY TO FIND OUT HOW MANY ARE IN EACH AND CALCULATE TOTAL NUMBER

READ EACH ITEM:

a. Manufactured cigarettes?				Weekly
b. Hand-rolled cigarettes?				Weekly
c. Chopped naco?				Weekly
d. Pipes full of tobacco?				Weekly
e. Cigars?				Weekly
f. Number of water pipe sessions with tobacco?				Weekly
g. Any others? Specify _____				Weekly

INTERVIEWER: GO TO SECTION C

PERSON THAT CURRENTLY SMOKE SOME DAYS BUT IN THE PAST HAVE SMOKED EVERY DAY

B8. How old were you when you first started smoking tobacco daily?

_____ YEARS OLD [IF DON'T KNOW ENTER "99"]

INTERVIEWER: IF B8 = 99, GO TO B9. OTHERWISE GO TO B10

B9. How many years ago did you first start smoking tobacco daily?

_____ YEARS [IF DON'T KNOW ENTER "99"]

B10. How many of the following do you currently smoke during a usual week?

INTERVIEWER: IF RESPONDENT REPORTS DOING THE ACTIVITY BUT LESS THAN ONCE PER WEEK, ENTER '888'

INTERVIEWER: IF RESPONDENT REPORTS IN PACKS OR CARTONS, TRY TO FIND OUT HOW MANY ARE IN EACH AND CALCULATE TOTAL NUMBER

READ EACH ITEM:

a. Manufactured cigarettes?				Weekly
b. Hand-rolled cigarettes?				Weekly
c. Chopped naco?				Weekly
d. Pipes full of tobacco?				Weekly
e. Cigars?				Weekly
f. Number of water pipe sessions with tobacco?				Weekly
g. Any others? Specify _____				Weekly

INTERVIEWER: GO TO SECTION C

PERSONS THAT ARE FORMER SMOKERS

B11. How old were you when you first started smoking tobacco daily?

_____ YEARS OLD [IF DON'T KNOW ENTER "99"]

INTERVIEWER: IF B11 = 99, GO TO B12. OTHERWISE GO TO B13

B12. How many years ago did you first start smoking tobacco daily?

_____ YEARS [IF DON'T KNOW ENTER "99"]

B13. How long has it been since you stopped smoking?

INTERVIEWER: ONLY INTERESTED IN WHEN RESPONDENT STOPPED SMOKING REGULARLY. DO NOT INCLUDE RARE INSTANCES OF SMOKING

ENTER ONLY ONE UNIT AND WRITE THE NUMBER

YEARS ..... 1 _____ _____ _____

MONTHS ..... 2 _____ _____ _____

WEEKS..... 3 _____ _____ _____

DAYS..... 4 _____ _____ _____

LESS THAN 1 DAY (24 HOURS) 5

DON'T KNOW 7

BU13a. Since you stopped smoking, have you ever had as little of a puff of a tobacco product?

YES 1

NO ..... 2 → GO TO INTERVIEWER INSTRUCTION BEFORE B14

BU13b. How long ago did you smoke your last puff?

ENTER ONLY ONE UNIT AND WRITE THE NUMBER

YEARS ..... 1 _____ _____ _____

MONTHS ..... 2 _____ _____ _____

WEEKS..... 3 _____ _____ _____

DAYS..... 4 _____ _____ _____

LESS THAN 1 DAY (24 HOURS) 5

DON'T KNOW 7

INTERVIEWER: IF B13 <1 YEAR (<12 MONTHS), GO TO B14. OTHERWISE, GO TO SECTION C

B14. Have you visited a doctor or another health care provider in the past 12 months?

YES 1

NO ..... 2 → GO TO B18

B15. How many times did you visit a doctor or another health care provider in the past 12 months? Would you say 1 or 2 times, 3 to 5 times, or 6 or more times?

1 OR 2 1
3 TO 5..... 2
6 OR MORE 3

B16. During any visit to a doctor or health care provider in the past 12 months, wee you asked if you smoke tobacco products?

YES 1
NO ..... 2 → GO TO B18

B17. During any visit to a doctor or health care provider in the past 12 months, were you advised to quit smoking tobacco products?

YES 1
NO ..... 2 → GO TO B18

BU17 – During any visit to a doctor or health care provider in the past 12 months, did you receive counseling on how to stop smoking tobacco products?

YES 1
NO 2

B18. During the past 12 months, did you use any of the following options to try to stop smoking ?

READ EACH ITEM:	YES	NO
a. Counseling in a specialized cessation service?..…	1	2
b. Nicotine replacement therapy, such as the patch or gum?.....	1	2
c. Other prescription medications, for example: Wellbutrin, Buprion, Bupril, Odranal, Nixin, or Champix?	1	2
d. Alternative treatments: acupuncture, laser, homeopathy, hypnosis?	1	2
e. A quit line or a smoking telephone support line?.....	1	2
f. Tried to stop smoking without aid?..... ..	1	2
g. Anything else? Please specify _____.....	1	2

BU19. When you stopped smoking, did you suddenly stop or did you gradually decrease the number of cigarettes?

SUDDENLY STOPPED 1

GRADUALLY DECREASED..... 2

SECTION C. SMOKELESS TOBACCO

INTRODUCTION: The next questions are about using smokeless tobacco, such as: chewing tobacco.

C1. Do you currently use smokeless tobacco on a daily basis, less than daily, or not at all?

DAILY ..... 1 → GO TO C6

LESS THAN DAILY 2

NOT AT ALL ..... 3 → GO TO C3

DON'T KNOW ..... 7 → GO TO D1

USE SMOKELESS TOBACCO SOME DAYS

C2. Have you used smokeless tobacco daily in the past?

YES ..... 1 → GO TO C10

NO ..... 2 → GO TO C10

DON'T KNOW ..... 7 → GO TO C10

CURRENTLY DO NOT USE SMOKELESS TOBACCO

C3. In the past, have you used smokeless tobacco on a daily basis, less than daily, or not at all?

DAILY ..... 1 → GO TO D1

LESS THAN DAILY ..... 2 → GO TO D1

NOT AT ALL ..... 3 → GO TO D1

DON'T KNOW ..... 7 → GO TO D1

C6. On average, how many times a day do you use smokeless tobacco?

INTERVIEWER: IF RESPONDENT REPORTS DOING THE ACTIVITY BUT LESS THAN ONCE A DAY, ENTER '888'

READ EACH ITEM:

a. Chewing tobacco?				Daily
b. Other? Specify _____				Daily

INTERVIEWER: GO TO SECTION D1

C10. On average, how many times a week do you use smokeless tobacco?

INTERVIEWER: IF RESPONDENT REPORTS DOING THE ACTIVITY, BUT LESS THAN ONCE A WEEK, ENTER '888'

READ EACH ITEM:

a. Chewing tobacco?				Weekly
b. Other? Specify _____				Weekly

SECTION D1. CESSATION – TOBACCO SMOKING

INTERVIEWER:

VERIFY THE ANSWER TO B1 AND WRITE IT HERE:

B1 = _____

IF B1 = 1 OR 2 (RESPONDENT CURRENTLY SMOKES TOBACCO PRODUCTS), CONTINUE WITH THIS SECTION 1

IF B1 = 3 OR 7 (RESPONDENT CURRENTLY DOES NOT SMOKE TOBACCO PRODUCTS), GO TO THE NEXT SECTION E..... 2

INTRODUCTION: The next questions ask about any attempts to stop smoking that you might have made during the past 12 months. Please think only about tobacco products.

D1. During the past 12 months, have you tried to stop smoking?

YES 1

NO ..... 2 → GO TO D4

D2. Thinking about the last time you tried to quit, how long did you stop smoking?

INTERVIEWER: ENTER ONLY ONE UNIT AND WRITE THE NUMBER

IF LESS THAN ONE DAY (24 HOURS), MARK THE CORRESPONDING BOX BELOW.

MONTHS .....1 _____ _____ _____

WEEKS.....2 _____ _____ _____

DAYS.....3 _____ _____ _____

LESS THAN 1 DAY (24 HOURS) 4

DON'T KNOW 7

D3. During the past 12 months, have you used any of the following options to quit smoking?

READ EACH ITEM:	YES	NO
a. Counseling in a specialized cessation service?.....	1	2
b. Nicotine replacement therapy, such as the patch or gum?.....	1	2
c. Other prescription medications, for example: Wellbutrin, Buprion, Bupril, Odranal, Nixin, or Champix?	1	2
d. Alternative treatments: acupuncture, laser, homeopathy, hypnosis?..	1	2
e. A quit line or a smoking telephone support line?.....	1	2
f. Tried to stop smoking without aid?.....	1	2
g. Anything else? Please specify _____.....	1	2

D4. Have you visited a doctor or other health care provider in the past 12 months?

YES 1

NO ..... 2 → GO TO D8

D5. How many times did you visit a doctor or health care provider in the past 12 months? Would you say 1 or 2 times, 3 to 5 times, or 6 or more times?

1 OR 2 1

3 TO 5..... 2

6 OR MORE 3

D6. During any visit to a doctor or health care provider in the past 12 months, were you asked if you smoke tobacco?

YES 1

NO ..... 2 → GO TO D8

D7. During any visit to a doctor or health care provider in the past 12 months, were you advised to quit smoking tobacco?

YES 1

NO ..... 2 → GO TO D8

DU7. During any visit to a doctor or health care provider in the past 12 months, did you receive counseling on how to quit smoking tobacco?

YES 1

NO 2

D8. Which of the following best describes your thinking about quitting smoking? I am planning to quit within the next month, I am thinking about quitting within the next 12 months, I will quit some day but not within the next 12 months, or I am not interested in quitting?

I AM PLANNING TO QUIT WITHIN THE NEXT MONTH 1

I AM THINKING ABOUT QUITTING WITHIN THE NEXT 12 MONTHS 2

I WILL QUIT SOME DAY BUT NOT WITHIN THE NEXT 12 MONTHS..... 3

I AM NOT INTERESTED IN QUITTING 4

DON'T KNOW 7

DU8. Do you know places to get aid to stop smoking?

YES..... 1

NO..... 2

SECTION E. SECONDHAND SMOKE

INTRODUCTION: I would now like to ask you a few questions about smoking in various places.

E1. Which of the following best describes the rules about smoking inside of your home: Smoking is allowed inside of your home, smoking is generally not allowed inside of your home but there are exceptions, smoking is never allowed inside of your home, or there are no rules about smoking in your home?

ALLOWED 1
NOT ALLOWED, BUT EXCEPTIONS..... 2
NEVER ALLOWED ..... 3 → GO TO EU3
NO RULES ..... 4 → GO TO E3
DON'T KNOW ..... 7 → GO TO E3

E2. Inside your home, is smoking allowed in every room?

YES 1
NO 2
DON'T KNOW 7

E3. How often does anyone (any person) smoke inside your home? Would you say daily, at least weekly, at least monthly, at least once a year, or never?

DAILY 1
AT LEAST ONCE A WEEK..... 2
AT LEAST ONCE A MONTH 3
AT LEAST ONCE A YEAR..... 4
NEVER 5
DON'T KNOW 7

EU3. How many smokers live in your household?

0.....0
1.....1
2.....2
3 OR MORE 3
DON'T KNOW 7

E4. Do you currently work outside of your home?

YES 1
NO/DON'T WORK..... 2 → GO TO E9

E5. Do you usually work indoors or outdoors?

INDOORS..... 1 → GO TO E8

OUTDOORS..... 2

BOTH..... 3 → GO TO E8

E6. Are there any indoor areas at your workplace?

YES 1

NO ..... 2 → GO TO E9

DON'T KNOW ..... 7 → GO TO E9

E8. During the past 30 days, did anyone smoke in indoor areas where you work?

YES 1

NO ..... 2 → GO TO E9

DON'T KNOW ..... 7 → GO TO E9

E8a. How often a person smoked in indoor areas where you work? Would you say every day, every week, every month, less than once a month?

DAILY 1

WEEKLY..... 2

MONTHLY 3

LESS THAN MONTHLY..... 4

E9. During the past 30 days, did you visit any government buildings or government offices?

YES 1

NO ..... 2 → GO TO E11

DON'T KNOW . 7 → GO TO E11

E10. Did anyone smoke inside of any government buildings or government offices that you visited in the past 30 days?

YES 1

NO 2

DON'T KNOW . 7

E11. During the past 30 days, did you visit any health care facilities?

YES 1

NO ..... 2 → GO TO E13

DON'T KNOW . 7 → GO TO E13

E12. Did anyone smoke inside of any health care facilities that you visited in the past 30 days?

YES 1
NO 2
DON'T KNOW . 7

E13. During the past 30 days, did you visit any restaurants?
YES 1
NO ..... 2 → GO TO E15
DON'T KNOW . 7 → GO TO E15

E14. Did anyone smoke inside of any restaurants that you visited in the past 30 days?
YES 1
NO 2
DON'T KNOW . 7

E15. During the past 30 days, did you use any public transportation?
YES 1
NO ..... 2 → GO TO E21
DON'T KNOW . 7 → GO TO E21

E16. Did anyone smoke inside of any public transportation that you used in the past 30 days?
YES 1
NO 2
DON'T KNOW . 7

E21. During the past 30 days, did you visit any University or Faculty?
YES 1
NO ..... 2 → GO TO E25
DON'T KNOW . 7 → GO TO E25

E22. Did anyone smoke inside of any University or Faculty that you visited in the past 30 days?
YES 1
NO 2
DON'T KNOW . 7

E25. During the last 30 days, did you visit any bars, pubs or discotheques?
YES 1
NO ..... 2 → GO TO E17
DON'T KNOW . 7 → GO TO E17

E26. Did anyone smoke inside of any of the bars, pubs or discotheques that you visited in the past 30 days?

YES 1

NO 2

DON'T KNOW . 7

E17. Based on what you know or believe, does breathing other people's smoke cause serious illness in non-smokers?

YES 1

NO 2

DON'T KNOW . 7

EU17. Are you aware that in Uruguay since March 2008 exists a law that requires all indoor public and private places to be completely free of tobacco smoke?

YES 1

NO 2

DON'T KNOW . 7

SECTION F. ECONOMICS – MANUFACTURED CIGARETTES

INTERVIEWER:

CHECK THE ANSWERS ON B1, B6a AND B10a. AND WRITE THEM DOWN BELOW:

B1 = ___

B6a = ___

B10a =___

IF B1 = 1 OR 2 (RESPONDENT CURRENTLY SMOKE EVERY DAY OR SOME DAYS)

AND

[B6a OR B10a]> 0 OR = 888 (RESPONDENT CURRENTLY SMOKES MANUFACTURED CIGARETTES)

CONTINUE WITH THIS SECTION

OTHERWISE GO TO FU6comp

INTRODUCTION: The next few questions are about the last time you purchased cigarettes for yourself.

F1. The last time you bought cigarettes for yourself, how many cigarettes did you buy?

ENTER NUMBER AND CHECK MEASUREMENT UNIT

CIGARETTES 1

PACKS .... 2 How many cigarettes were in each pack?_____

CARTONS..... 3 How many cigarettes were in each carton? _____

OTHER (SPECIFY). _____..... 4 How many cigarettes were in each one? _____

NEVER BOUGHT CIGARETTES..... 5 → GO TO FU6comp

F2. In total, how much money did you pay for this purchase?

IF “DON’T KNOW” WRITE "999”

$ Uruguayan Pesos _____

F3. What brand did you buy the last time you purchased cigarettes for yourself?

NEVADA..... 1

CORONADO..... 2

FIESTA..... 3

MARLBORO..... 4

PALL MALL..... 5

LUCKY STRIKE..... 6

OTHER, WHICH BRAND? _____ 7

FU3a. Is this your usual brand?

YES 1

NO ..... 2 → GO TO FU3d

FU3b. During a typical month, do you usually buy other complementary brand?

YES 1

NO ..... 2 → GO TO F4

FU3c. Which one do you buy as a complementary brand?

NEVADA..... 1

CORONADO..... 2

FIESTA..... 3

MARLBORO..... 4

PALL MALL..... 5

LUCKY STRIKE..... 6

OTHER, WHICH BRAND? _____ 7

--- INTERVIEWER: GO TO F4

FU3d. Which is your usual brand?

NEVADA..... 1

CORONADO..... 2

FIESTA..... 3

MARLBORO..... 4

PALL MALL..... 5

LUCKY STRIKE..... 6

OTHER, WHICH BRAND? _____ 7

F4. The last time you purchased cigarettes for yourself, where did you buy them?

GROCERY STORE 1

SUPERMARKET..... 2

STREET VENDOR..... 3

GAS STATION..... 4

DUTY-FREE SHOP..... 5

KIOSKS, PARLORS OR NEWSSTANDS..... 6

OUTSIDE THE COUNTRY 7

INTERNET 8

TAVERNS, BARS OR RESTAURANTS..... 9

OTHER SPECIFY: _____ 10

DON'T REMEMBER..... 77

FU6comp. IF B6b OR B10b > 0 OR 888 (RESPONDENT CURRENTLY SMOKES HAND ROLLED CIGARETTES), GO TO FU6. OTHERWISE GO TO SECTION G

FU6. The last time you purchased tobacco for hand rolled cigarettes for yourself, how many packages did you buy?

IF RESPONDENT NEVER BOUGHT TOBACCO FOR HAND-ROLLED CIGARETTES, WRITE 66.

IF DON'T KNOW WRITE "77"

NUMBER OF PACKS:_____

IF FU6= 66 OR 77, GO TO SECTION G

FU7. In total, how much money did you pay for this purchase?

IF "DON'T KNOW" " WRITE "999"

$ Uruguayan Pesos _____

FU8. How many days did each packet last you?

IF "DON'T KNOW" WRITE "77"

NUMBER OF DAYS: _____

FU9. What brand did you buy the last time you purchased tobacco for hand-rolled cigarettes?

CERRITO 1

SARANDÍ..... 2

PERUANO..... 3

OTHER SPECIFY: _____ 4

SECTION G. MEDIA

INTRODUCTION: The next few questions ask about your exposure to the media and advertisements in the last 30 days.

G1. In the last 30 days, have you noticed any information about the dangers of smoking cigarettes or that encourages quitting in any of the following places?

READ EACH ITEM	YES	NO	NOT APPLICABLE
a. In newspapers or in magazines?	1	2	7
b. On television?	1	2	7
c. On the radio?	1	2	7
d. On billboards?	1	2	7
e. Somewhere else?	1	2	7
Please specify where._____			

G2. In the last 30 days, did you notice any health warnings on cigarette packages?

YES 1

NO ..... 2 → GO TO G4

DIDN'T SEE ANY CIGARETTE PACKAGE..... 3 → GO TO G4

G3. APPLY IF B1 = 1 OR 2, ELSE GO TO G4

In the last 30 days, have warning labels on cigarette packages led you to think about quitting?

YES 1

NO 2

DON'T KNOW . 7

G4. In the last 30 days, have you noticed any advertisements or signs promoting cigarettes in the following places?

READ EACH ITEM	YES	NO	NOT APPLICABLE
a. In stores where cigarettes are sold?	1	2	7
b. On television?	1	2	7
c. On the radio?	1	2	7
d. On billboards?	1	2	7
e. On posters?	1	2	7
f. In newspapers or magazines?.....	1	2	7
g. In cinemas?	1	2	7
h. On the internet?	1	2	7
i. On public transportation vehicles or stations?	1	2	7
j. On public walls?	1	2	7
k. Anywhere else?	1	2	7

Please specify where._____

G5. In the last 30 days, have you noticed any sport or sporting event that is associated with cigarette brands or cigarette companies?

YES 1
NO 2
DON'T KNOW . 7

G6. In the last 30 days, have you noticed any of the following kinds of cigarette promotions?

READ EACH ITEM	YES	NO	DON'T KNOW
a. Free samples of cigarettes?	1	2	7
b. Cigarettes at sale prices?	1	2	7
d. Free gifts or special discount offers on other products when buying cigarettes?	1	2	7
e. Clothing or other items with a cigarette brand name or logo?	1	2	7
c. Cigarette promotions in the e-mail?	1	2	7
d. Cigarette promotions per message on the cell phone?	1	2	7

l. GU7. In the last 12 months, how often did you see actors smoking on TV, movies or theater? Very often, sometimes, never.

Very often 1

Sometimes 2

Never 3

DO NOT KNOW 7

SECTION H. KNOWLEDGE, ATTITUDES, & PERCEPTIONS

H1. The next question is asking about smoking tobacco.

Based on what you know or believe, does smoking tobacco cause serious illness?

YES 1

NO ..... 2 → GO TO H2_3

DON'T KNOW . 7

H2. Based on what you know or believe, does smoking tobacco cause the following?

READ EACH ITEM	YES	NO	DON'T KNOW
a. Stroke (blood clots in the brain that may cause paralysis)?	1	2	7
b. Heart attack?	1	2	7
c. Lung cancer?	1	2	7

HU1. Do you think that light, ultrallight, or mild cigarettes are less harmful to health than regular cigarettes?

YES 1

NO 2

DON'T KNOW 7

HU2. Do you think that mentholated cigarettes are less harmful to health than regular cigarettes?

YES 1

NO 2

DON'T KNOW 7

H2_3. Do you believe that cigarettes are addictive?

YES 1

NO 2

DON'T KNOW 7

H3. Based on what you know or believe, does chewing tobacco cause serious illness?

YES 1

NO 2

DON'T KNOW 7

END INDIVIDUAL QUESTIONNAIRE

Those are all of the questions I have. Thank you very much for partcipating in this important survey.

RECORD ANY NOTES ABOUT INTERVIEW: _____

INTERVIEWER: DO NOT FORGET TO LEAVE THE INFORMATION CARD ON THE GATS SURVEY TO THE INTERVIEWED PERSON

ANNEX B
Sampling Design

ANNEX B - Sampling Design

Weighting of the Base GATS Survey

The calculation of the sample weights is performed separately for each of the stages, resulting in the final weighting, which is the product of the previous weights. The sampling was conducted in four stages. In the first one Census Segments were selected with probability proportional to size (pps). At the second stage, within each Segment Census Zones were selected with probability proportional to size. Size was measured in terms of the number of occupied private dwellings within Zones. In the third stage, within each selected Zone, 10 occupied private dwellings were selected using simple random sampling. In the last stage, one person in the target age group was selected from each of the 10 selected households.

We used the approach suggested in the GATS sampling weights manual; the formulas used are explained in detail below.

Formulas used

Let, p_I, p_{II}, p_{III} and p_{IV} the inclusion probabilities for each of the four stages respectively. Given the design proposed before, the calculations for each of the probabilities are made as follows:

$$p_I = n_I \frac{t_i}{\sum_{U_I} t_i}$$

Where n_I is the number of segments to be selected in stratum h, t_i is the number of occupied private dwellings in the segment i and $\sum_{U_I} t_i$ is the total number of occupied private dwellings in the stratum. The weight w_I is obtained as $1/p_I$.

$$p_{II} = n_{II} \frac{t_{ij}}{t_i}$$

Where n_{II} is the number of zones to be selected in the selected segment, (4 in our case), t_{ij} is the number of occupied private dwellings in the zone j of segment i and $t_i = \sum_j t_{ij}$ is the total of occupied private dwellings in the selected segment. The weight w_{II} is obtained as $1/p_{II}$.

$$p_{III} = n_{III}/t_{ij}$$

Where n_{III} is the number of homes available for selection in the zone (10, in our case). The weight w_{III} is obtained as $1/p_{III}$.

$$p_{IV} = 1/hog_i$$

Where hog_i is the number of people aged over 15 years in the selected household. The weight w_{IV} is obtained as $1/p_{IV}$.

The final weight for the individual k is then calculated as the product of the four weights corresponding to the four sampling stages: w_I, the weight for the Census segments; w_{II}, the weight for the Census zone; w_{III}, the weight for the private occupied dwelings; and w_{IV}, the weight for the person in the target age group selected in the dwelling.

$$w_k = w_I \times w_{II} \times w_{III} \times w_{IV}$$

Adjustment for non-response

The adjustment for non response has two components: non response of household (e.g., refusal or absence of residents), and non response of people (where household data is obtained, but the person chosen to interview will not or can not participate in the survey).

Non-response households

The non-response adjustment is done at SSU (zones) level, except for zones with no dwellings, in which case the adjustment is made at the PSU (segment) level. This last case happened in only six zones in the sample.

The adjustment follows the approach proposed in the GATS Sample Weights Manual: namely, calculation of the ratio between number of dwellings interviewed in the zone or segment and the eligible dwellings in the zone or segment. In this context, unoccupied dwellings are classified as non-eligible.

No person-level response

A total of 128 people did not participate in the survey. In this case, still following the procedures recommended by GATS Supervisor Manual, the individuals persisted in rejecting the survey.

Three subgroups were used for non response adjustment as recommended by the GATS Sample Weights Manual: gender, age, and smoking status. The table below shows the adjustement terms for each group.

Response rates at the person level

		Male	Female
Non smokers (by age, in years)	15 to 24	0,996337	1
	24 to 35	0,98586572	0,99709302
	36 to 45	0,98502994	1
	46 to 55	0,97378277	0,99688474
	More than 55	0,99708029	0,99903661
Smokers (by age, in years)	15 to 24	0,95535714	0,93333333
	24 to 35	0,97790055	0,96296296
	36 to 45	0,98717949	0,94827586
	46 to 55	0,94736842	0,92682927

More than 55	0,94196429	0,83216783

Note: the biggest adjustment is for women 55 years or older who are smokers.

The adjustment for non-response is calculated as the inverse of the response rates for each group shown in the table above.

Calibration Procedure

Tipically, post-stratification is used as the calibration procedure in population-based surveys that use a probability sampling methodology. Post-stratification is required to provide auxiliary information in such surveys. As mentioned previously, the sampling frame used in our survey is based on the Phase I Census, which does not provide the auxiliary information necessary for the adjustment of non-response. Therefore, in order to adjust by gender, age and educational level, we could only work with the marginal distributions of each of these variables, which we obtained through an alternative data source that is more frequently updated, based on the Encuesta Continua de Hogares (ECH). The last adjustment is made by a generalized raking algorithm, where the weights adjusted for non-response are calibrated so that the totals represent the totals estimated population of an auxiliary variable.

In this case, we used three variables for calibration:

- Gender
  - Men
  - Women
- Age (in years)
  - 15 to 24
  - 25 to 34
  - 35 to 44
  - 45 to 54
  - 55 or older

- Educational Level
  - Primary
  - High School First Cycle (first three years in High School)
  - Secondary Second Cycle and UTU (last three years in High School or technical careers)
  - University – Post Graduate

Raking is a procedure where population cell counts are estimated by adjusting the original weights iteratively using the auxiliary information of marginal totals. In this case, we used the variables mentioned above: gender, age and educational level.

For raking, it is necessary to know the marginal population of these variables. To modify the original weights without error as they consider these totals iterative adjustement is made, which is the procedure called raking.

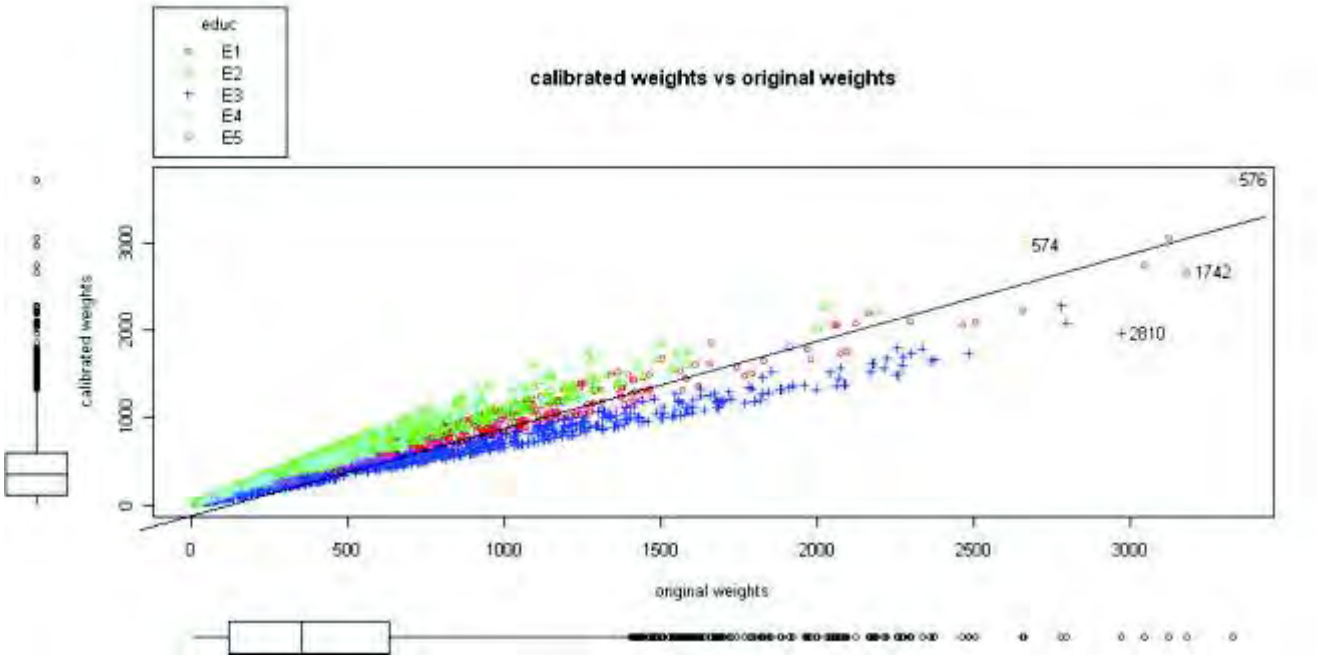
We used the package "survey" of R software[1] to carry out these procedures.

Measures of Quality: Sampling, Sampling Error and Weights

Patterns of Post – Stratification weights

The scatter plot below shows the distribution of the original and calibrated weights. These results show the existence of patterns based on educational levels.

[1] T. Lumley (2009) "survey: analysis of complex survey samples". R package version 3.19.



Each line corresponds to one educational level category. These data show that the calibration is useful, especially with regards to educational level. In this graph, all the points on the diagonal represent weights that didn't change with calibration adjustment. On the other side, the larger the distance from the diagonal, the larger the adjustment. The diagonal shows when the adjusted weights and the original weights are equal. For those categories that are overrepresented, the adjustment is less than one; for this reason, the points appeared under the diagonal in the graph. The opposite is true for those that were underrepresented.

Multiplicative effect of Variable Sample Weights on the Precision of Survey Estimates

The sample values of the multiplicative effective (Meff) were 1.805 for the overall sample, 1.887 for males and 1.731 for females. The tables below show the Meffs for the different stratas and age groups.

Strata	**Meff**
Low MVD[2]	1,330
Medium-low MVD	1,368
Medium-high MVD	1,312
High MVD	1,506
Metropolitan ring[3]	1,25
Rest of the country[4]	
15.000 +	1,369
5.000 to 15.000	1,278
1.000 to 5.000	1,305
< 1.000	1,417
Rural	1,387

Age group (in years)	**Meff**
15 to 24	1,629
25 to 34	1,723
35 to 44	1,744
45 to 54	1,799
55 or older	1,769

Overall Design Effect on the Precision of Survey Estimates

For estimates of tobacco use prevalence, the design effect (Deff) result for the overall sample is 1.70. By gender, the Deff for males is 4.01, and for females, 2.72. The formula used by the R software to calculate de Deff is as follows:

$$Deff = \frac{\hat{V}_{GATS}(\hat{p})}{\hat{V}_{SI}(\hat{p})}$$

Where $\hat{V}_{GATS}(\hat{p})$ is the estimation of the variance for the GATS-implemented design mentioned above, and $\hat{V}_{SI}(\hat{p})$ is the estimate of the variance for a Simple Random Design without reposition[5]. In this case

2 MVD means Montevideo

3 The metropolitan ring is the sorrounding area of Montevideo

4 The country as a whole except Montevideo and the sorrounding areas

$$\hat{V}_{SI}(\hat{p}) = N^2\left(1-\frac{n}{N}\right)\frac{\hat{p}(1-\hat{p})}{n}$$

To calculate the estimation of the variance for a domain of study, for example the variance of the proportion of males who smoke or females who smoke, the R Software does not use the formula of Simple random sampling in the denominator of the previous formula of Deff. Instead, it uses the formula for the estimation of the variance for a domain:

$$\hat{V}_{SI}(\hat{p}_d) = N^2\left(1-\frac{n}{N}\right)\frac{\hat{p}_d(1-\hat{p}_d)}{n}$$

For this reason the Deffs obtained will be high for domains.
The estimation for Intra Class Coefficient (ICC) was performed indirectly using the Deff and Meff formulation[6]. The following results were obtained for overall sample and by gender;

ICC prevalence

Overall	-0.001784212
Males	0.03420915
Females	0.01743269

Margin of Error for Key Survey Estimates

The estimated margin of error for a 95% of confidence can be computed as 1.96 times the standard error of an estimate. The table below lists margins of error for some key variables:

Variable	Prevalence	Margin of Error
Current Tobacco Smoker	24.96	1.6308
Smoking Quit Attempt in the Past 12 Months	48.60	3.62405
Quit smoking on their own	94.12	2.614
Exposure to Secondhand Smoke at Work	16.51	2.5716
Adults Exposed to Secondhand Smoke at Home	33.96	2.0175

[5] In a Simple Random Design without reposition the individuals are selected with equal probabilities from the population without replacement

[6] $\text{ICC} = \rho = \dfrac{\dfrac{Deff(\hat{\theta})}{Meff_w} - 1}{\bar{m} - 1}$

Measures of quality: Coverage, Non response, and other Non sampling Errors

Household Frame Coverage Rate

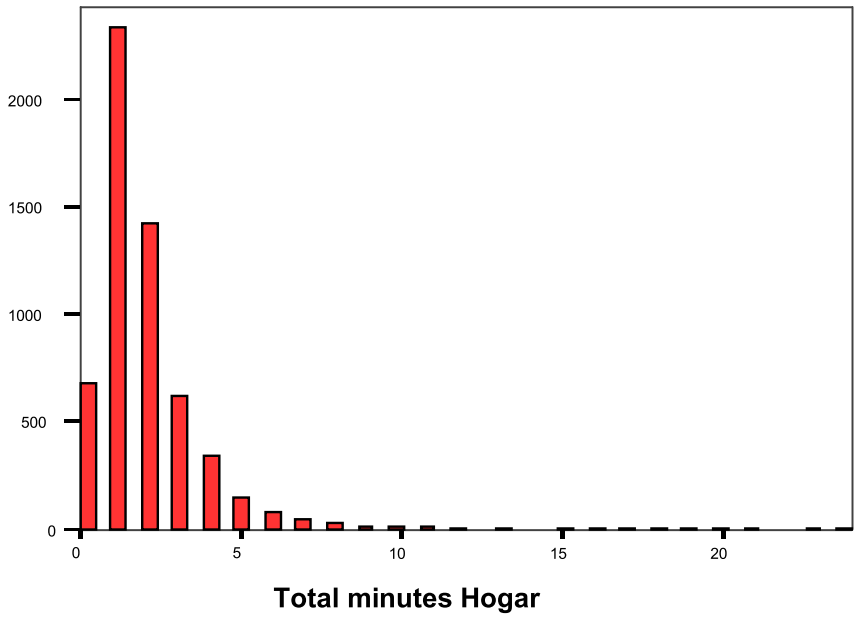
As mentioned previously, the frame used Phase 1 National Population Census (CF1) is not updated, and the rate of undercoverage is unknown. If the survey had allowed for listing the zone before sampling households, it would have been possible to calculate the factor coverage rate, and we could have obtained a measure of the frame coverage; however this was not the case.

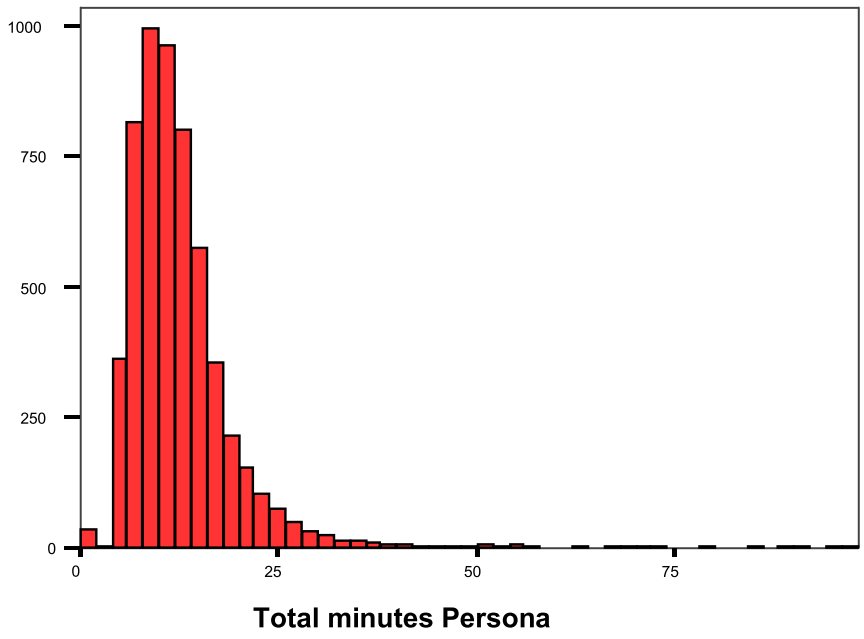
Patterns of Respondents Cutoff Rates

Only 23 respondents gave an incomplete interview, making the overall respondent cutoff rate 0.4%. This rate is very low; hence, it was not necessary to analyze the partial respondents rates among demographic subgroups.

The low number of partial respondents can be explained by the mean length of the person interview, 13 minutes. The brief duration of the in terview allows very little time for the respondent to end it prematurely.

The mean for the household interview (roster) was 1.92 minutes. In the following graphs, we can see the histogram for both the households and person interviews:





Patterns of Household–Level Response Rate Among Adjustment Cells

The household level American Association for Public Opinion Research (AAPOR) response rate was 97%, the comparable person level response rate was 98.5% and the combined response rate was 95.5%. These high response rates are attributable to the fact that participation in INE surveys is legally mandated in Uruguay.

Patterns of Person–Level Refusal Rates Among Adjustment Cells

The total number of person-level refusals was 32 cases, a refusal rate of 0.6%.

ANNEX C
Tables GATS Uruguay, 2009

ANNEX C - Tables GATS Uruguay, 2009

Table 3.2: Distribution of adults ≥ 15 years old by selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Weighted		Un-weighted Number of Adults
	Percentage (95% CI[1])	Number of Adults (in thousands)	
Overall	100 (0.0, 100)	2,465,3	5,581
Gender			
Male	47.4 (45.7, 49.1)	1,169,3	2,634
Female	52.6 (50.9, 54.3)	1,296,0	2,947
Age (years)			
15-24	20.2 (18.1, 22.4)	497,0	748
25-44	35.4 (33.4, 37.4)	871,7	1,918
45-64	27.2 (25.8, 28.8)	671,8	1,653
65+	17.2 (15.8, 18.8)	424,8	1,262
Residence			
Urban	92.7 (92.3, 93.0)	2,284,8	3,668
Rural	7.3 (7.0, 7.7)	180,5	1,913
Education level[2]			
Primary	49.5 (46.2, 52.7)	974,1	2,839
Secondary basic	16.8 (15.2, 18.6)	331,0	883
Secondary	24.5 (22.1, 27.0)	481,2	685
Tertiary	9.2 (7.9, 10.7)	181,9	426

Note: The following observations were missing: *[1]* for education

[1] 95 % confidence interval

[2] Education level is reported only among respondents 25+ years old

Table 4.1: Percentage of adults ≥15 years old, by detailed smoking status and gender – GATS Uruguay, 2009.

Smoking Status	Overall	Male	Female
	Percentage (95% CI)		
Current tobacco smoker	25.0 (23.3, 26.6)	30.7 (28.2, 33.4)	19.8 (18.1, 21.6)
Daily smoker	20.4 (19.1, 21.8)	24.8 (22.5, 27.3)	16.4 (14.8, 18.1)
Occasional smoker	4.5 (3.8, 5.3)	5.9 (4.7, 7.3)	3.4 (2.6, 4.2)
Occasional smoker, formerly daily	2.2 (1.8, 2.8)	2.5 (1.9, 3.5)	1.9 (1.3, 2.7)
Occasional smoker, never daily	2.3 (1.8, 3.0)	3.3 (2 .3, 4.7)	1.4 (1.0, 2.0)
Non-smoker	75.0 (73.4, 76.7)	69.3 (66.6, 71.8)	80.2 (78.4, 81.9)
Former daily smoker	16.4 (15.2, 17.7)	20.5 (18.6, 22.5)	12.7 (11.1, 14.5)
Never daily smoker	58.6 (56.9, 60.4)	48.8 (46.2, 51.4)	67.5 (65.4, 69.5)
Former occasional smoker	7.5 (6.6, 8.6)	7.3 (6.1, 8.8)	7.7 (6.5, 9.3)
Never smoker	51.1 (49.2, 53.0)	41.5 (38.9, 44.1)	59.8 (57.5, 62.0)

Note: Current use includes both daily and occasional (less than daily) use.
*Estimate based on less than 25 un weighted cases.

Table 4.2: Number of adults ≥15 years old, by detailed smoking status and gender – GATS Uruguay, 2009.

Smoking Status	Overall	Male	Female
	Number in thousands		
Current tobacco smoker	615.2	359.0	256.3
Daily smoker	503.4	290.6	212.8
Occasional smoker	111.9	68.4	43.4
Occasional smoker, formerly daily	54.5	29.8	24.7
Occasional smoker, never daily	57.4	38.6	18.7
Non-smoker	1,850.2	810.3	1,039.8
Former daily smoker	404.4	239.5	164.9
Never daily smoker	1,445.7	570.8	874.9
Former occasional smoker	186.1	85.8	100.3
Never smoker	1,259.6	485.1	774.6

Note: Current use includes both daily and occasional (less than daily) use.
*Estimate based on less than 25 un weighted cases.

Table 4.3: Percentage of adults ≥15 years old who are current smokers of various smoked tobacco products, by gender and selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Any smoked tobacco product	Any cigarette[1]	Type of Cigarette		Other smoked tobacco[2]
			Manufactured	Hand-rolled	
	Percentage (95% CI)				
Overall	25.0 (23.3, 26.6)	24.7 (23.1, 26.4)	21.3 (19.8, 22.9)	8.1 (7.0, 9.4)	0.9 (0.5, 1.5)
Age (years)					
15-24	24.7 (21.0, 28.9)	24.7 (21.0, 28.9)	23.1 (19.5, 27.2)	9.2 (6.9, 12.2)	1.0 (0.4, 2.4)
25-44	30.4 (27.7, 33.3)	30.2 (27.5, 33.0)	25.9 (23.3, 28.6)	10.0 (8.0, 12.3)	0.9 (0.5, 1.6)
45-64	28.6 (25.5, 32.0)	28.3 (25.2, 31.5)	23.8 (21.0, 26.8)	7.9 (6.2, 9.9)	1.0 (0.5, 2.2)
65+	8.1 (6.4, 10.3)	7.9 (6.1, 10.1)	5.8 (4.3, 7.7)	3.5 (2.3, 5.2)	0.4 (0.1, 1.0)
Residence					
Urban	25.1 (23.4, 26.9)	24.8 (23.2, 26.6)	21.8 (20.2, 23.5)	7.7 (6.5, 9.1)	0.8 (0.4, 1.5)
Rural	23.4 (20.1, 27.1)	23.2 (19.8, 26.9)	15.1 (12.3, 18.5)	13.6 (11.5, 16.0)	1.2 (0.7, 1.9)
Education level[3]					
Primary	25.5 (23.4, 27.8)	25.1 (23.1, 27.3)	18.6 (16.8, 20.5)	12.6 (10.8, 14.8)	1.0 (0.5, 2.0)
Secondary basic	28.2 (24.3, 32.4)	28.0 (24.1, 32.2)	26.4 (22.4, 30.7)	5.3 (3.6, 7.9)	0.3 (0.1, 1.1)
Secondary	23.3 (19.7, 27.2)	23.1 (19.6, 27.0)	21.7 (18.3, 25.6)	2.6 (1.5, 4.4)	0.8 (0.4, 1.9)
Tertiary	21.3 (16.8, 26.7)	20.8 (16.3, 26.1)	20.5 (16.0, 25.8)	0.7 (0.3, 1.9)	0.8 (0.3, 2.2)

Note: Current use includes both daily and occasional (less than daily) use.
[1]Includes manufactured and hand-rolled cigarettes.
[2]Includes chopped naco, pipes, cigars, water pipe, and any other reported smoked tobacco products.
[3] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.3 (cont.): Percentage of adults ≥15 years old who are current smokers of various smoked tobacco products, by gender and selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Any smoked tobacco product	Type of Cigarette			Other smoked tobacco[2]
		Any cigarette[1]	Manufactured	Hand-rolled	
			Percentage (95% CI)		
Male	30.7 (28.2, 33.4)	30.2 (27.7, 32.8)	24.3 (22.0, 26.7)	13.5 (11.6, 15.6)	1.6 (0.9, 2.9)
Age (years)					
15-24	28.9 (23.4, 35.0)	28.9 (23.4, 35.0)	26.7 (21.4, 32.7)	13.6 (9.9, 18.4)	1.8 (0.7, 4.5)
25-44	35.0 (30.7, 39.5)	34.5 (30.3, 39.0)	28.1 (24.0, 32.5)	14.6 (11.4, 18.6)	1.6 (0.9, 2.9)
45-64	34.9 (30.4, 39.7)	34.1 (29.7, 38.7)	25.7 (22.0, 29.7)	14.4 (11.3, 18.2)	1.7 (0.7, 4.1)
65+	13.2 (9.8, 17.5)	12.5 (9.2, 16.9)	6.9 (4.4, 10.6)	8.0 (5.4, 11.8)	1.0 (0.4, 2.7)
Residence					
Urban	30.9 (28.1, 33.8)	30.4 (27.7, 33.2)	25.0 (22.6, 27.6)	12.9 (10.8, 15.2)	1.6 (0.8, 3.0)
Rural	28.9 (25.0, 33.1)	28.4 (24.5, 32.7)	16.4 (13.3, 20.0)	19.9 (16.8, 23.3)	1.9 (1.1, 3.2)
Education level[3]					
Primary	34.3 (30.5, 38.4)	33.6 (29.9, 37.5)	22.1 (18.9, 25.7)	21.2 (18.2, 24.6)	1.8 (0.8, 3.8)
Secondary basic	29.6 (24.2, 35.6)	29.2 (23.8, 35.3)	26.7 (21.4, 32.8)	8.2 (5.4, 12.3)	0.7 (0.2, 2.2)
Secondary	26.3 (20.2, 33.4)	25.9 (19.9, 33.1)	23.3 (17.6, 30.0)	4.3 (2.2, 8.3)	1.5 (0.6, 3.6)
Tertiary	29.2 (20.7, 39.5)	27.9 (19.6, 38.1)	27.3 (19.0, 37.7)	1.4 (0.4, 4.8)	2.0 (0.7, 5.8)
Female	19.8 (18.1, 21.6)	19.8 (18.1, 21.6)	18.6 (16.9, 20.4)	3.3 (2.6, 4.2)	0.2 (0.1, 0.5)
Age (years)					
15-24	20.2 (15.6, 25.8)	20.2 (15.6, 25.8)	19.2 (14.7, 24.7)	4.4 (2.5, 7.5)	0.1 (0.0, 0.6)
25-44	26.0 (2 2.7, 29.5)	26.0 (22.7, 29.5)	23.8 (20.5, 27.3)	5.4 (3.9, 7.6)	0.2 (0.0, 0.7)
45-64	22.8 (19.1, 27.1)	22.8 (19.1, 27.1)	22.0 (18.4, 26.2)	1.7 (1.0, 3.0)	0.4 (0.1, 1.7)
65+	5.2 (3.8, 7.1)	5.2 (3.8, 7.1)	5.1 (3.7, 7.0)	0.9 (0.4, 2.2)	0.0 (0.0, 0.0)
Residence					
Urban	20.0 (18.2, 21.9)	20.0 (18.2, 21.9)	18.9 (17.1, 20.9)	3.1 (2.4, 4.1)	0.2 (0.1, 0.5)
Rural	16.7 (12.7, 21.7)	16.7 (12.7, 21.7)	13.6 (10.2, 17.8)	5.8 (3.7, 9.0)	0.2 (0.0, 1.7)
Education Level[3]					
Primary	17.4 (15.4, 19.7)	17.4 (15.4, 19.7)	15.4 (13.5, 17.5)	4.8 (3.5, 6.7)	0.3 (0.1, 0.9)
Secondary Basic	26.7 (21.7, 32.4)	26.7 (21.7, 32.4)	26.0 (20.9, 31.9)	2.4 (1.2, 4.8)	0.0 (0.0, 0.0)
Secondary	20.9 (16.7, 25.9)	20.9 (16.7, 25.9)	20.5 (16.3, 25.5)	1.3 (0.6, 2.8)	0.3 (0.0, 2.2)
Tertiary	16.5 (12.1, 22.1)	16.5 (12.1, 22.1)	16.3 (11.9, 21.8)	0.3 (0.1, 1.3)	0.0 (0.0, 0.0)

[1]Includes manufactured and hand-rolled cigarettes.
[2]Includes chopped naco, pipes, cigars, water pipe, and any other reported smoked tobacco products.
[3] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.3a: Percentage of adults ≥15 years old who are current smokers of various smoked tobacco products, by gender and selected demographic characteristics – GATS Uruguay, 2009. Among current smokers of tobacco

Demographic Characteristics	Any smoked tobacco product	Any cigarette[1]	Type of Cigarette		Other smoked tobacco[2]
			Manufactured	Hand-rolled	
			Percentage (95% CI)		
Overall	100 (100, 100)	99.1 (97.3, 99.7)	85.3 (81.9, 88.1)	32.6 (28.6, 36.8)	3.4 (2.0, 5.8)
Age (years)					
15-24	100 (100, 100)	100 (100, 100)	93.4 (88.4, 96.3)	37.1 (29.5, 45.5)	4.0 (1.7, 9.4)
25-44	100 (100, 100)	99.2 (97.4, 99.7)	85.0 (79.8, 89.1)	32.8 (26.9, 39.2)	2.9 (1.7, 5.0)
45-64	100 (100, 100)	98.7 (93.6, 99.7)	83.0 (77.5, 87.4)	27.5 (22.1, 33.5)	3.5 (1.6, 7.6)
65+	100 (100, 100)	97.1 (90.7, 99.1)	71.2 (59.6, 80.5)	43.3 (31.9, 55.4)	4.5 (1 .7, 11.7)
Residence					
Urban	100 (100, 100)	99.1 (97.1, 99.7)	86.8 (83.2, 89.8)	30.7 (26.4, 35.3)	3.3 (1.8, 6.0)
Rural	100 (100, 100)	99.0 (97.1, 99.6)	64.5 (58.0, 70.5)	57.9 (52.0, 63.6)	4.9 (2.9, 8.2)
Education level[3]					
Primary	100 (100, 100)	98.6 (94.4, 99.6)	72.8 (66.8, 78.1)	49.6 (44.1, 55.2)	3.8 (1.9, 7.6)
Secondary basic	100 (100, 100)	99.4 (96.6, 99.9)	93.6 (89.3, 96.2)	19.0 (13.1, 26.7)	1.2 (0.4, 3.9)
Secondary	100 (100, 100)	99.4 (95.6, 99.9)	93.4 (86.3, 97.0)	11.1 (6.6, 18.2)	3.6 (1.6, 7.9)
Tertiary	100 (100, 100)	97.6 (91.7, 99.3)	96.1 (90.6, 98.4)	3.3 (1.2, 9.0)	3.6 (1.2, 9.9)

Note: Current use includes both daily and occasional (less than daily) use.
[1]Includes manufactured and hand-rolled cigarettes.
[2]Includes chopped naco, pipes, cigars, water pipe, and any other reported smoked tobacco products.
[3] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.3a (cont.): Percentage of adults ≥15 years old who are current smokers of various smoked tobacco products, by gender and selected demographic characteristics – GATS Uruguay, 2009. Among current smokers of tobacco.

Demographic Characteristics	Any smoked tobacco product	Any cigarette[1]	Type of Cigarette		Other smoked tobacco[2]
			Manufactured	Hand-rolled	
			Percentage (95% CI)		
Male	100 (100, 100)	98.4 (95.5, 99.4)	79.1 (74.2, 83.2)	43.9 (38.6, 49.2)	5.2 (2.9, 9.1)
Age (years)					
15-24	100 (100, 100)	100 (100, 100)	92.4 (84.3, 96.5)	47.0 (36.0, 58.3)	6.3 (2.5, 14.9)
25-44	100 (100, 100)	98.5 (95.5, 99.5)	80.1 (72.8, 85.9)	41.8 (33.8, 50.2)	4.6 (2.6, 8.1)
45-64	100 (100, 100)	97.7 (89.5, 99.5)	73.6 (65.7, 80.3)	41.4 (33.1, 50.3)	4.8 (1.9, 11.3)
65+	100 (100, 100)	95.1 (84.7, 98.6)	52.5 (36.3, 68.2)	60.8 (44.9, 74.6)	7.6 (2.8, 19.5)
Residence					
Urban	100 (100, 100)	98.4 (95.1, 99.5)	81.0 (75.6, 85.5)	41.7 (36.1, 47.5)	5.1 (2.6, 9.5)
Rural	100 (100, 100)	98.5 (95.9, 99.5)	56.7 (49.7, 63.4)	68.9 (61.7, 75.3)	6.6 (3.8, 11.0)
Education level[3]					
Primary	100 (100, 100)	97.8 (91.5, 99.4)	64.3 (56.5, 71.4)	61.8 (54.9, 68.2)	5.1 (2.4, 10.6)
Secondary basic	100 (100, 100)	98.8 (93.6, 99.8)	90.2 (82.9, 94.6)	27.7 (19 .6, 37.7)	2.3 (0.7, 7.4)
Secondary	100 (100, 100)	98.7 (91.0, 99.8)	88.5 (74.8, 95.2)	16.3 (8.6, 28.8)	5.7 (2.5, 12.7)
Tertiary	100 (100, 100)	95.4 (84.2, 98.8)	93.6 (82.9, 97.8)	4.9 (1.3, 16.1)	6.9 (2.3, 19.0)
Female	100 (100, 100)	100 (100, 100)	94.0 (90.7, 96.2)	16.7 (13.2, 21.1)	0.9 (0.3, 2.5)
Age (years)					
15-24	100 (100, 100)	100 (100, 100)	95.0 (88.1, 98.0)	21.6 (12.8, 34.1)	0.4 (0.1, 2.9)
25-44	100 (100, 100)	100 (100, 100)	91.4 (84.9, 95.3)	20.9 (1 5.0, 28.4)	0.7 (0.2, 2.8)
45-64	100 (100, 100)	100 (100, 100)	96.5 (92.3, 98.4)	7.5 (4.4, 12.7)	1.8 (0.4, 7.4)
65+	100 (100, 100)	100 (100, 100)	98.4 (93.3, 99.6)	17.9 (8.0, 35.3)	0.0 (0.0, 0.0)
Residence					
Urban	100 (100, 100)	100 (100, 100)	94.7 (91.2, 96.9)	15.8 (12.1, 20.3)	0.9 (0.3, 2.6)
Rural	100 (100, 100)	100 (100, 100)	81.1 (69.6, 89.0)	34.6 (24.9, 45.8)	1.5 (0.2, 9.8)
Education level[3]					
Primary	100 (100, 100)	100 (100, 100)	88.2 (80.3, 93.2)	27.8 (20 .6, 36.4)	1.5 (0.5, 4.8)
Secondary basic	100 (100, 100)	100 (100, 100)	97.4 (92.6, 99.1)	9.1 (4.5, 17.5)	0.0 (0.0, 0.0)
Secondary	100 (100, 100)	100 (100, 100)	98.1 (93.4, 99.5)	6.2 (2.8, 13.0)	1.5 (0.2, 10.0)
Tertiary	100 (100, 100)	100 (1 00, 100)	98.7 (91.7, 99.8)	1.7 (0.4, 7.5)	0.0 (0.0, 0.0)

[1]Includes manufactured and hand-rolled cigarettes.
[2]Includes chopped naco, pipes, cigars, water pipe, and any other reported smoked tobacco products.
[3] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.4: Number of adults ≥15 years old who are current smokers of various smoked tobacco products, by gender and selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Any smoked tobacco product	Any cigarette[1]	Type of Cigarette		Other smoked tobacco[2]
			Manufactured	Hand-rolled	
			Number in thousands		
Overall	615.2	609.5	524.8	200.3	21.0
Age (years)					
15-24	123.0	123.0	114.8	45.7	4.9
25-44	265.3	263.1	225.5	86.9	7.7
45-64	192.5	189.9	159.8	52.8	6.8
65+	34.5	33.5	24.6	14.9	1.6
Residence					
Urban	573.0	567.6	497.5	175.9	18.9
Rural	42.3	41.8	27.3	24.5	2.1
Education level[3]					
Primary	248.4	244.8	180.9	123.2	9.5
Secondary basic	93.2	92.6	87.2	17.7	1.2
Secondary	111.9	111.2	104.5	12.5	4.0
Tertiary	38.8	37.9	37.3	1.3	1.4

Note: Current use includes both daily and occasional (less than daily) use.
[1]Includes manufactured and hand-rolled cigarettes.
[2]Includes chopped naco, pipes, cigars, water pipe, and any other reported smoked tobacco products.
[3] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.4 (cont.): Number of adults ≥15 years old who are current smokers of various smoked tobacco products, by gender and selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Any smoked tobacco product	Any cigarette[1]	Type of Cigarette		Other smoked tobacco[2]
			Manufactured	Hand-rolled	
			Number in thousands		
Male	359.0	353.2	283.9	157.4	18.6
Age (years)					
15-24	75.0	75.0	69.3	35.3	4.7
25-44	150.3	148.1	120.5	62.8	6.9
45-64	113.2	110.6	83.3	46.9	5.4
65+	20.5	19.5	10.7	12.4	1.6
Residence					
Urban	330.2	324.9	267.6	137.6	16.7
Rural	28.8	28.3	16.3	19.8	1.9
Education level[3]					
Primary	159.5	155.9	102.5	98.5	8.2
Secondary basic	49.5	48.9	44.7	13.7	1.2
Secondary	54.8	54.1	48.5	8.9	3.1
Tertiary	20.2	19.3	18.9	1.0	1.4
Female	256.3	256.3	240.9	42.9	2.4
Age (years)					
15-24	47.9	47.9	45.5	10.4	0.2
25-44	115.0	115.0	105.1	24.1	0.8
45-64	79.3	79.3	76.5	6.0	1.4
65+	14.1	14.1	13.9	2.5	0.0
Residence					
Urban	242.7	242.7	230.0	38.2	2.2
Rural	13.5	13.5	11.0	4.7	0.2
Education level[3]					
Primary	88.9	88.9	78.4	24.7	1.3
Secondary basic	43.7	43.7	42.6	4.0	0.0
Secondary	57.1	57.1	56.1	3.5	0.9
Tertiary	18.6	18.6	18.3	0.3	0.0

[1]Includes manufactured and hand-rolled cigarettes.

[2]Includes chopped naco, pipes, cigars, water pipe, and any other reported smoked tobacco products.

[3] Education level is reported only among respondents 25+ years old.

*Estimate based on less than 25 un weighted cases.

Table 4.5: Percentage distribution of adults ≥15 years old, by smoking frequency, gender and selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Smoking Frequency			Total
	Daily	Occasional[1]	Non-smoker	
	Percentage (95% CI)			
Overall	20.4 (19.1, 21.8)	4.5 (3.8, 5.3)	75.0 (73.4, 76.7)	100
Age (years)				
15-24	18.2 (15.3, 21.5)	6.5 (4.3, 9.8)	75.3 (71.1, 79.0)	100
25-44	24.8 (22.3, 27.5)	5.6 (4.4, 7.2)	69.6 (66.7, 72.3)	100
45-64	25.0 (22.0, 28.1)	3.7 (2.6, 5.1)	71.4 (68.0, 74.5)	100
65+	6.8 (5.2, 8.8)	1.4 (0.7, 2.7)	91.9 (89.7, 93.6)	100
Residence				
Urban	20.5 (19.1, 21.9)	4.6 (3.9, 5.5)	74.9 (73.1, 76.6)	100
Rural	19.7 (16.7, 23.1)	3.7 (2.9, 4.7)	76.6 (72.9, 79.9)	100
Education level[2]				
Primary	21.9 (19.8, 24.1)	3.6 (2.7, 4.8)	74.5 (72.2, 76.6)	100
Secondary basic	24.8 (21.3, 28.7)	3.3 (2.3, 4.9)	71.8 (67.6, 75.7)	100
Secondary	18.7 (15.5, 22.4)	4.6 (3.1, 6.6)	76.7 (72.8, 80.3)	100
Tertiary	15.3 (11.5, 20.0)	6.0 (3.6, 10.0)	78.7 (73.3, 83.2)	100

[1]Occasional refers to less than daily use.
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.5 (cont.): Percentage distribution of adults ≥15 years old, by smoking frequency, gender and selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Smoking Frequency			Total
	Daily	Occasional[1]	Non-smoker	
	Percentage (95% CI)			
Male	24.8 (22.5, 27.3)	5.9 (4.7, 7.3)	69.3 (66.6, 71.8)	100
Age (years)				
15-24	20.3 (15.7, 25.8)	8.6 (5.2, 13.8)	71.1 (65.0, 76.6)	100
25-44	28.1 (24.3, 32.2)	6.9 (5.0, 9.6)	65.0 (60.5, 69.3)	100
45-64	31.1 (26.5, 36.1)	3.8 (2.3, 6.3)	65.1 (60.3, 69.6)	100
65+	10.6 (7.5, 14.8)	2.6 (1.3, 4.9)	86.8 (82.5, 90.2)	100
Residence				
Urban	24.9 (22.4, 27.6)	6.0 (4.7, 7.5)	69.1 (66.2, 71.9)	100
Rural	24.1 (20.6, 28.1)	4.7 (3.7, 6.1)	71.1 (66.9, 75.0)	100
Education level[2]				
Primary	29.7 (25.8, 33.8)	4.7 (3.2, 6.8)	65.7 (61.6, 69.5)	100
Secondary basic	26.2 (21.2, 31.8)	3.4 (2.0, 5.8)	70.4 (64.4, 75.8)	100
Secondary	20.9 (15.4, 27.8)	5.4 (3.2, 9.0)	73.7 (66.6, 79.8)	100
Tertiary	18.5 (12.2, 26.9)	10.7 (5.4, 20.3)	70.8 (60.5, 79.3)	100
Female	16.4 (14.8, 18.1)	3.4 (2.6, 4.2)	80.2 (78.4, 81.9)	100
Age (years)				
15-24	15.9 (11.8, 21.2)	4.3 (2.5, 7.3)	79.8 (74.2, 84.4)	100
25-44	21.7 (18.4, 25.4)	4.3 (2.9, 6.2)	74.0 (70.5, 77.3)	100
45-64	19.2 (15.8, 23.3)	3.6 (2.3, 5.6)	77.2 (72.9, 80.9)	100
65+	4.5 (3.2, 6.3)	0.7 (0.2, 2.0)	94.8 (92.9, 96.2)	100
Residence				
Urban	16.6 (14.9, 18.4)	3.4 (2.7, 4.4)	80.0 (78.1, 81.8)	100
Rural	14.4 (10.8, 18.9)	2.4 (1.4, 3.9)	83.3 (78.3, 87.3)	100
Education level[2]				
Primary	14.8 (12.8, 17.0)	2.7 (1.7, 4.2)	82.6 (80.3, 84.6)	100
Secondary basic	23.5 (18.9, 28.8)	3.2 (1.9, 5.5)	73.3 (67.6, 78.3)	100
Secondary	17.0 (12.8, 22.2)	4.0 (2.3, 6.7)	79.1 (74.1, 83.3)	100
Tertiary	13.3 (9.5, 18.5)	3.1 (1.3, 7.3)	83.5 (77.9, 87.9)	100

[1]Occasional refers to less than daily use.
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.6: Percentage distribution of daily cigarette smokers ≥15 years old, by cigarettes smoked per day, gender and selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Number of cigarettes smoked on average per day[1]					Total
	<5	5-9	10-14	15-24	≥25	
	Percentage (95% CI)					
Overall	9.1 (6.9, 12.0)	17.6 (14.6, 21.0)	26.7 (23.3, 30.4)	32.1 (28.5, 36.0)	14.4 (12.0, 17.2)	100
Age (years)						
15-24	10.5 (5.9, 18.1)	23.7 (16.2, 33.4)	34.0 (25.3, 43.9)	20.6 (13.7, 29.8)	11.2 (6.2, 19.3)	100
25-44	7.7 (5.3, 11.2)	16.2 (12.6, 20.6)	25.6 (20.5, 31.5)	35.5 (29.8, 41.5)	15.0 (11.0, 20.2)	100
45-64	9.5 (5.9, 14.9)	14.8 (10.2, 21.0)	24.4 (19.5, 30.1)	35.6 (29.9, 41.7)	15.8 (12.1, 20.2)	100
65+	13.7 (6.5, 26.6)	24.7 (15.8, 36.5)	26.0 (16.3, 38.9)	23.3 (15.3, 33.8)	12.3 (6.0, 23.3)	100
Residence						
Urban	9.0 (6.6, 12.1)	17.5 (14.4, 21.2)	27.2 (23.6, 31.2)	32.3 (28.4, 36.5)	14.0 (11.5, 17.0)	100
Rural	11.6 (8.2, 16.2)	18.3 (13.9, 23.8)	20.9 (15.6, 27.3)	29.4 (24.5, 34.8)	19.9 (15.3, 25.3)	100
Education level[2]						
Primary	8.3 (5.6, 12.0)	13.8 (10.4, 18.0)	25.0 (19.8, 31.1)	33.7 (28.0, 40.0)	19.2 (15.1, 24.1)	100
Secondary basic	8.6 (5.2, 13.8)	20.6 (14.1, 29.2)	17.2 (11.7, 24.5)	39.4 (31.2, 48.2)	14.2 (9.2, 21.3)	100
Secondary	11.3 (6.2, 19.6)	16.2 (9.9, 25.2)	32.1 (23.4, 42.2)	33.2 (24.7, 42.9)	7.3 (4.0, 12.9)	100
Tertiary	6.0 (2.2, 15.0)	21.9 (14.2, 32.3)	27.2 (16.9, 40.7)	32.8 (21.3, 46.8)	12.1 (5.4, 25.0)	100

[1] Among daily cigarette smokers. Include manufactured and hand-rolled cigarettes.
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.6 (cont.): Percentage distribution of daily cigarette smokers ≥15 years old, by cigarettes smoked per day, gender and selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Number of cigarettes smoked on average per day[1]					Total
	<5	5-9	10-14	15-24	≥25	
			Percentage (95% CI)			
Male	6.0 (3.8, 9.6)	13.7 (10.3, 18.0)	24.7 (20.2, 29.8)	36.9 (31.8, 42.2)	18.6 (15.2, 22.6)	100
Age (years)						
15-24	8.3 (3.3, 19.5)	20.9 (11.5, 35.0)	34.7 (24.6, 46.5)	22.7 (12.8, 37.0)	13.4 (6.9, 24.4)	100
25-44	3.5 (1.7, 7.1)	10.8 (7.4, 15.6)	23.8 (16.7, 32.7)	42.2 (34.0, 50.7)	19.7 (13.9, 27.2)	100
45-64	6.3 (3.0, 12.8)	13.2 (7.5, 22.3)	19.7 (13.9, 27.3)	40.3 (32.5, 48.6)	20.4 (15.1, 27.0)	100
65+	16.5 (6.0, 38.1)	15.1 (7.5, 28.2)	29.8 (16.4, 47.8)	21.9 (12.6, 35.3)	16.6 (7.5, 33.0)	100
Residence						
Urban	5.7 (3.3, 9.7)	13.6 (10.0, 18.4)	25.5 (20.6, 31.1)	37.1 (31.7, 43.0)	18.0 (14.4, 22.3)	100
Rural	9.6 (6.1, 14.9)	14.6 (10.6, 19.8)	16.2 (12.1, 21.4)	33.6 (27.3, 40.7)	25.8 (19.4, 33.5)	100
Education level[2]						
Primary	5.7 (3.0, 10.5)	9.7 (6.4, 14.5)	23.5 (17.1, 31.4)	37.2 (29.8, 45.3)	23.8 (18.6, 30.0)	100
Secondary basic	6.6 (2.7, 15.6)	16.9 (9.8, 27.5)	15.7 (8.7, 26.7)	40.1 (30.2, 50.9)	20.7 (13.3, 30.6)	100
Secondary	4.8 (1.5, 14.2)	14.6 (6.5, 29.5)	26.8 (15.5, 42.2)	47.3 (33.5, 61.4)	6.5 (2.7, 15.1)	100
Tertiary	2.7 (0.5, 12.9)	12.6 (3.7, 35.2)	20.5 (8.5, 41.6)	43.9 (24.1, 65.9)	20.4 (7.7, 44.1)	100
Female	13.3 (9.6, 18.0)	22.7 (18.5, 27.5)	29.4 (24.8, 34.6)	25.8 (21.2, 31.0)	8.8 (5.9, 12.8)	100
Age (years)						
15-24	13.5 (6.1, 27.3)	27.6 (17.2, 41.2)	33.0 (19.8, 49.5)	17.7 (9.7, 30.0)	8.2 (2.7, 22.5)	100
25-44	13.0 (8.5, 19.3)	22.9 (16.7, 30.5)	27.8 (21.6, 35.1)	27.2 (20.9, 34.5)	9.2 (4.9, 16.5)	100
45-64	14.2 (7.8, 24.4)	17.0 (11.6, 24.2)	31.3 (23.1, 40.8)	28.6 (20.0, 39.0)	8.9 (4.9, 15.6)	100
65+	9.9 (3.2, 27.1)	37.2 (21.7, 55.9)	21.1 (9.7, 40.1)	25.1 (12.9, 43.3)	6.6 (1.3, 27.5)	100
Residence						
Urban	13.2 (9.4, 18.2)	22.5 (18.2, 27.6)	29.4 (24.5, 34.8)	26.1 (21.3, 31.6)	8.8 (5.9, 13.1)	100
Rural	15.5 (9.1, 25.3)	25.8 (15.1, 40.3)	30.2 (19.2, 44.2)	20.8 (14.4, 29.0)	7.7 (4.2, 13.8)	100
Education level[2]						
Primary	12.8 (8.4, 19.2)	20.9 (14.6, 29.0)	27.7 (20.3, 36.5)	27.5 (20.2, 36.2)	11.1 (6.0, 19.5)	100
Secondary basic	10.8 (6.1, 18.4)	24.8 (15.2, 37.9)	18.9 (11.5, 29.4)	38.6 (27.5, 50.9)	7.0 (2.8, 16.3)	100
Secondary	17.4 (9.1, 30.8)	17.6 (8.9, 31.9)	37.0 (24.7, 51.4)	19.9 (11.6, 32.1)	8.0 (3.4, 17.7)	100
Tertiary	8.7 (2.6, 25.5)	29.7 (19.2, 42.9)	32.9 (20.2, 48.7)	23.5 (11.9, 41.1)	5.2 (1.5, 17.1)	100

[1] Among daily cigarette smokers. Include manufactured and hand-rolled cigarettes.

[2] Education level is reported only among respondents 25+ years old.

*Estimate based on less than 25 un weighted cases.

Table 4.6a: Mean and median of daily cigarette consumption among daily cigarette smokers >15 years old, by selected demographic characteristic - GATS Uruguay 2009.

Demographic Characteristics	Overall		Male		Female	
	Mean	Median	Mean	Median	Mean	Median
Overall	15.4 (14.6, 16.3)	12.9	17.6 (16.4, 18.8)	15.0	12.5 (11.5, 13.5)	10.0
Age (years)						
15-24	13.3 (11.3, 15.4)	10.0	14.6 (11.8, 17.4)	10.0	11.7 (9.0, 14.4)	10.0
25-44	15.8 (14.6, 17.0)	15.0	18.3 (16.7, 19.9)	20.0	12.8 (11.3, 14.2)	10.0
45-64	16.4 (14.8, 18.0)	15.0	18.9 (16.5, 21.3)	20.0	12.7 (11.1, 14.4)	10.0
65+	13.2 (10.7, 15.6)	10.0	13.9 (10.4, 17.3)	10.0	12.2 (9.0, 15.5)	10.0
Residence						
Urban	15.3 (14.4, 16.3)	12.0	17.5 (16.2, 18.8)	15.0	12.6 (11.5, 13.6)	10.0
Rural	16.3 (15.0, 17.5)	14.0	18.5 (16.7, 20.4)	15.7	11.7 (10.2, 13.3)	10.0
Education level[2]						
Primary	17.2 (15.9, 18.4)	15.0	19.4 (17.6, 21.2)	20.0	13.2 (11.6, 14.8)	10.0
Secondary basic	15.9 (13.9, 17.9)	15.0	18.0 (15.4, 20.6)	20.0	13.6 (10.9, 16.2)	10.0
Secondary	13.2 (11.6, 14.8)	10.0	15.0 (12.7, 17.3)	15.0	11.6 (9.4, 13.7)	10.0
Tertiary	14.5 (12.3, 16.8)	10.0	17.9 (14.3, 21.6)	19.0	11.7 (9.3, 14.1)	10.0

Note: Education level is reported only for respondents 25+ years old.

Table 4.7: Percentage distribution of ever daily smokers 20-34 years old by age at daily smoking initiation, gender and residence - GATS Uruguay 2009.

Demographic Characteristics	Age at Daily Smoking Initiation (years)[1]				Total
	<15	15-16	17-19	20+	
	Percentage (95% CI)				
Overall	21.8 (17.8, 26.3)	31.8 (26.5, 37.5)	35.2 (30.0, 40.8)	11.2 (8.3, 15.1)	100
Gender					
Male	22.5 (16.8, 29.3)	33.2 (25.8, 41.6)	34.9 (27.8, 42.6)	9.5 (5.8, 15.2)	100
Female	21.0 (15.4, 27.9)	30.2 (23.4, 37.9)	35.6 (28.5, 43.4)	13.2 (9.3, 18.4)	100
Residence					
Urban	21.2 (17.1, 26.0)	32.2 (26.7, 38.4)	35.3 (29.8, 41.2)	11.3 (8.2, 15.4)	100
Rural	30.1 (22.0, 39.5)	25.4 (19.1, 32.8)	34.2 (26.7, 42.5)	10.4 (6.9, 15.5)	100

[1] Among respondents 20-34 years of age who are ever daily smokers
*Estimate based on less than 25 un weighted cases.

Table 4.7a: Percentage distribution of ever daily smokers 20-34 years old by age at daily smoking initiation, gender and residence - GATS Uruguay 2009.

Demographic Characteristics	Age at Daily Smoking Initiation (years)[1]				
	<20	20+	Total	Mean (STE)	Median
	Percentage (95% CI)				
Overall	88.8 (84.9, 91.7)	11.2 (8.3, 15.1)	100	16.5 (16.2, 16.8)	16.0
Gender					
Male	90.5 (84.8, 94.2)	9.5 (5.8, 15.2)	100	16.3 (15.9, 16.7)	16.0
Female	86.8 (81.6, 90.7)	13.2 (9.3, 18.4)	100	16.7 (16.2, 17.2)	16.0
Residence					
Urban	88.7 (84.6, 91.8)	11.3 (8.2, 15.4)	100	16.5 (16.2, 16.8)	16.0
Rural	89.6 (84.5, 93.1)	10.4 (6.9, 15.5)	100	16.0 (15.5, 16.6)	16.0

[1] Among daily smokers 20-34 years old.

Table 4.7b: Percentage distribution of ever daily smokers 25-34 years old by age at daily smoking initiation, gender and residence - GATS Uruguay 2009.

Demographic Characteristics	Age at Daily Smoking Initiation (years)[1]				
	<20	20+	Total	Mean (STE)	Median
	Percentage (95% CI)				
Overall	86.5 (81.7, 90.2)	13.5 (9.8, 18.3)	100	16.7 (16.3, 17.1)	16.0
Gender					
Male	89.1 (81.9, 93.6)	10.9 (6.4, 18.1)	100	16.3 (15.8, 16.8)	16.0
Female	83.4 (77.0, 88.2)	16.6 (11.8, 23.0)	100	17.1 (16.5, 17.7)	17.0
Residence					
Urban	86.4 (81.3, 90.3)	13.6 (9.7, 18.7)	100	16.7 (16.3, 17.1)	16.0
Rural	87.0 (80.2, 91.7)	13.0 (8.3, 19.8)	100	16.3 (15.6, 16.9)	16.0

Table 4.8: Percentage of all adults and ever daily smokers >15 years old who are former daily smokers, by selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Former Daily Smokers[1] (Among All Adults)	Former Daily Smokers[1] (Among Ever Daily Smokers)[2]
	Percentage (95% CI)	
Overall	16.4 (15.2, 17.7)	42.0 (39.4, 44.7)
Gender		
Male	20.5 (18.6, 22.5)	42.8 (39.1, 46.5)
Female	12.7 (11.1, 14.5)	41.0 (36.7, 45.4)
Age (years)		
15-24	4.8 (2.9, 7.9)	18.9 (11.9, 28.6)
25-44	12.9 (11.0, 15.1)	31.8 (27.5, 36.6)
45-64	24.3 (21.4, 27.3)	47.3 (42.3, 52.4)
65+	24.7 (21.7, 28.0)	76.3 (70.5, 81.2)
Residence		
Urban	16.5 (15.2, 17.8)	42.0 (39.2, 44.9)
Rural	15.8 (14.1, 17.7)	42.0 (36.9, 47.3)
Education level[3]		
Primary	19.8 (18.0, 21.8)	45.8 (42.2, 49.4)
Secondary basic	16.9 (14.1, 20.1)	38.8 (32.8, 45.1)
Secondary	20.6 (17.2, 24.4)	49.0 (42.3, 55.7)
Tertiary	17.8 (13.8, 22.6)	48.3 (38.9, 57.9)

[1] Current non-smokers.
[2] Also known as the quit ratio for daily smoking.
[3] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.9: Percentage distribution of former daily smokers >15 years old, by time since quitting smoking and selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Time since quitting smoking (years)[1]				Total
	<1	1 to <5	5 to <10	≥10	
	Percentage (95% CI)				
Overall	8.2 (6.3, 10.7)	24.5 (21.0, 28.2)	17.1 (14.1, 20.6)	50.2 (46.3, 54.1)	100
Gender					
Male	6.3 (4.3, 9.3)	20.6 (16.4, 25.6)	16.2 (12.7, 20.5)	56.8 (51.4, 61.9)	100
Female	11.0 (7.7, 15.5)	29.9 (24.3, 36.2)	18.3 (13.5, 24.4)	40.8 (35.1, 46.7)	100
Age (years)					
15-24	32.9 (17.8, 52.6)	64.5 (44.7, 80.3)	2.7 (0.3, 17.7)	0.0 (0.0, 0.0)	100
25-44	10.7 (6.9, 16.3)	35.4 (28.4, 43.0)	26.4 (19.4, 35.0)	27.4 (20.6, 35.5)	100
45-64	7.1 (4.4, 11.4)	22.7 (17.2, 29.3)	19.2 (14.5, 25.0)	51.0 (44.4, 57.6)	100
65+	1.7 (0.6, 4.7)	6.3 (4.0, 9.6)	7.2 (4.5, 11.3)	84.9 (79.1, 89.2)	100
Residence					
Urban	8.1 (6.1, 10.7)	24.9 (21.3, 29.0)	17.5 (14.3, 21.2)	49.5 (45.3, 53.7)	100
Rural	10.5 (7.3, 15.0)	18.0 (14.1, 22.8)	12.0 (8.2, 17.2)	59.4 (52.2, 66.3)	100
Education level[2]					
Primary	6.8 (4.6, 10.1)	17.5 (14.0, 21.7)	15.7 (11.7, 20.8)	59.9 (54.2, 65.3)	100
Secondary basic	4.8 (2.4, 9.5)	22.3 (15.6, 30.9)	18.3 (11.7, 27.4)	54.6 (44.1, 64.7)	100
Secondary	8.8 (4.8, 15.5)	32.0 (22.9, 42.7)	19.3 (12.8, 28.2)	39.9 (31.7, 48.8)	100
Tertiary	2.8 (0.8, 9.2)	17.4 (9.1, 30.8)	27.0 (17.3, 39.6)	52.7 (40.7, 64.5)	100

[1] Among former daily smokers (current non-smokers).
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.9a: Percentage distribution of former daily smokers >15 years old, by time since last puff and selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Time since last puff (months)[1]			Total
	<6 months	6 to <12 months	≥12 months	
	Percentage (95% CI)			
Overall	7.0 (5.0, 9.7)	3.5 (2.2, 5.5)	89.5 (86.5, 91.9)	100
Gender				
Male	7.6 (5.1, 11.0)	1.9 (0.9, 4.0)	90.5 (86.8, 93.3)	100
Female	6.2 (3.9, 9.7)	5.8 (3.2, 10.1)	88.0 (83.5, 91.4)	100
Age (years)				
15-24	15.7 (5.2, 38.6)	22.3 (10.1, 42.4)	62.0 (41.2, 79.2)	100
25-44	14.4 (9.3, 21.8)	2.4 (0.8, 6.8)	83.2 (75.6, 88.8)	100
45-64	4.9 (2.9, 8.0)	3.3 (1.7, 6.4)	91.9 (87.9, 94.6)	100
65+	1.0 (0.3, 3.9)	0.9 (0.2, 3.5)	98.1 (95.0, 99.3)	100
Residence				
Urban	6.7 (4.6, 9.6)	3.5 (2.2, 5.8)	89.8 (86.6, 92.3)	100
Rural	11.6 (7.9, 16.5)	2.5 (1.3, 4.8)	85.9 (81.1, 89.7)	100
Education level[2]				
Primary	6.0 (3.9, 8.9)	1.8 (0.8, 3.8)	92.3 (88.8, 94.7)	100
Secondary basic	6.2 (3.1, 11.8)	3.1 (1.2, 7.3)	90.8 (84.9, 94.5)	100
Secondary	8.9 (4.1, 18.0)	3.3 (1.2, 9.2)	87.8 (78.6, 93.4)	100
Tertiary	3.3 (0.9, 12.1)	1.7 (0.3, 10.3)	95.0 (85.9, 98.3)	100

[1] Among former daily smokers (current non-smokers).
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.9b: Percentage distribution of former daily smokers >15 years old, by time since quitting smoking and selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Time since quitting smoking (years)[1]		Total
	<5	≥5	
	Percentage (95% CI)		
Overall	32.7 (29.1, 36.6)	67.3 (63.4, 70.9)	100
Gender			
Male	27.0 (22.7, 31.8)	73.0 (68.2, 77.3)	100
Female	40.9 (34.9, 47.2)	59.1 (52.8, 65.1)	100
Age (years)			
15-24	97.3 (82.3, 99.7)	2.7 (0.3, 17.7)	100
25-44	46.1 (39.0, 53.4)	53.9 (46.6, 61.0)	100
45-64	29.8 (24.2, 36.1)	70.2 (63.9, 75.8)	100
65+	8.0 (5.2, 12.0)	92.0 (88.0, 94.8)	100
Residence			
Urban	33.0 (2 9.1, 37.1)	67.0 (62.9, 70.9)	100
Rural	28.6 (23.3, 34.5)	71.4 (65.5, 76.7)	100
Education level[2]			
Primary	24.3 (20.4, 28.7)	75.7 (71.3, 79.6)	100
Secondary basic	27.1 (19.4, 36.5)	72.9 (63.5, 80.6)	100
Secondary	40.7 (31.6, 50.6)	59.3 (49.4, 68.4)	100
Tertiary	20.2 (11.4, 33.4)	79.8 (66.6, 88.6)	100

[1] Among former daily smokers (current non-smokers).
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 4.11: Percentage distribution of daily smokers >15 years old, by time first tobacco use upon waking and selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Time to first smoke				Total
	≤5 minutes	6-30 minutes	31-60 minutes	>60 minutes	
	Percentage (95% CI)				
Overall	12.8 (10.4, 15.7)	22.6 (19.4, 26.1)	19.0 (16.4, 22.0)	45.5 (41.8, 49.2)	100
Gender					
Male	11.9 (8.9, 15.7)	26.4 (22.4, 30.8)	20.7 (16.9, 25.1)	41.0 (36.1, 46.2)	100
Female	14.2 (10.6, 18.7)	17.5 (13.4, 22.5)	16.7 (13.0, 21.3)	51.6 (46.0, 57.2)	100
Age (years)					
15-24	10.0 (5.2, 18.5)	21.2 (14.1, 30.5)	14.5 (8.7, 23.2)	54.3 (44.4, 63.9)	100
25-44	14.4 (10.7, 19.1)	24.3 (20.0, 29.3)	18.5 (14.3, 23.4)	42.8 (36.9, 48.9)	100
45-64	12.4 (8.8, 17.3)	21.2 (16.1, 27.5)	21.3 (16.7, 26.9)	45.0 (38.5, 51.7)	100
65+	12.6 (6.1, 24.2)	22.2 (14.2, 33.0)	24.3 (15.0, 36.9)	40.8 (29.0, 53.8)	100
Residence					
Urban	12.9 (10.3, 16.0)	22.4 (19.0, 26.2)	19.0 (16.1, 22.2)	45.7 (41.8, 49.7)	100
Rural	12.2 (8.5, 17.2)	25.7 (20.6, 31.5)	19.7 (15.4, 25.0)	42.4 (36.9, 48.1)	100
Education level[1]					
Primary	13.4 (10.0, 17.8)	24.3 (19.5, 29.9)	20.0 (16.5, 24.2)	42.2 (37.0, 47.7)	100
Secondary basic	15.9 (10.6, 23.1)	22.9 (16.6, 30.8)	18.9 (12.9, 26.7)	42.3 (34.4, 50.6)	100
Secondary	14.2 (8.4, 23.0)	20.8 (13.5, 30.7)	18.3 (11.2, 28.4)	46.7 (36.0, 57.7)	100
Tertiary	4.2 (1.4, 11.7)	19.1 (10.2, 32.7)	29.2 (18.5, 42.7)	47.5 (35.3, 60.1)	100

[1] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 5.1: Percentage of smokers >15 years old who made a quit attempt and received health care porvider assistance in the past 12 months, by selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Smoking cessation and health care-seeking behavior				
	Made quit attempt[1]	Visited a HCP[1,2]	Asked by HCP if a smoker[2,3]	Advised to quit by HCP[2,3]	Received counseling by HCP[2,3]
	Percentage (95% CI)				
Overall	48.6 (45.0, 52.3)	55.8 (51.8, 59.8)	76.6 (72.3, 80.3)	54.5 (49.4, 59.4)	15.1 (11.7, 19.3)
Gender					
Male	48.4 (43.8, 53.0)	47.6 (42.3, 52.9)	75.1 (68.2, 80.9)	56.7 (49.8, 63.3)	15.2 (10.5, 21.4)
Female	48.9 (43.5, 54.4)	67.0 (62.5, 71.3)	77.9 (71.8, 83.0)	52.3 (46.0, 58.5)	15.1 (11.2, 20.1)
Age (years)					
15-24	60.2 (51.7, 68.1)	57.4 (48.8, 65.6)	75.9 (64.1, 84.7)	55.6 (43.7, 66.9)	14.4 (8.1, 24.3)
25-44	48.5 (43.3, 53.7)	53.1 (47.7, 58.4)	73.7 (67.2, 79.3)	48.3 (41.7, 54.9)	12.2 (8.0, 18.1)
45-64	43.4 (38.0, 49.0)	56.8 (50.5, 62.9)	83.7 (76.0, 89.3)	63.5 (55.2, 71.0)	20.3 (14.1, 28.4)
65+	34.6 (25.6, 44.9)	65.9 (57.1, 73.7)	62.3 (47.7, 75.1)	46.0 (31.7, 60.9)	11.1 (5.1, 22.5)
Residence					
Urban	48.4 (44.5, 52.3)	56.9 (52.6, 61.1)	76.6 (72.1, 80.6)	54.5 (49.2, 59.7)	15.3 (1 1.7, 19.7)
Rural	51.9 (46.1, 57.7)	41.9 (37.0, 47.1)	75.8 (65.8, 83.6)	53.3 (43.7, 62.6)	12.1 (8.5, 17.0)
Education level[4]					
Primary	47.8 (42.1, 53.5)	49.0 (42.9, 55.2)	75.6 (68.7, 81.5)	57.8 (50.8, 64.5)	15.7 (11.3, 21.4)
Secondary basic	45.3 (38.4, 52.4)	60.1 (51.9, 67.8)	68.6 (60.0, 76.1)	46.6 (38.1, 55.4)	10.0 (6.0, 16.2)
Secondary	42.9 (33.6, 52.7)	62.5 (53.8, 70.4)	84.4 (72.7, 91.7)	55.4 (43.7, 66.6)	20.0 (11.5, 32.5)
Tertiary	39.9 (27.8, 53.4)	64.4 (51.0, 75.9)	77.4 (62.0, 87.8)	48.7 (33.4, 64.2)	11.6 (5.7, 22.1)

[1] Among current smokers and former smokers who have been abstinent for less than 12 months.
[2] HCP = Includes doctor or health care provider.
[3] Among current smokers and former smokers who have been abstinent for less than 12 months, and who visited a HCP during the past 12 months.
[4] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 5.2: Percentage of smokers ≥15 years old who attempted to quit smoking in the past 12 months, by cessation methods used and selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Use of Cessation Method[1]				
	Pharmacotherapy[2]	Counseling/Advice[3]	Quit Line[4]	Tried to Quit on Own[5]	Other[6]
			Percentage (95% CI)		
Overall	18.2 (14.5, 22.7)	10.9 (7.9, 14.9)	2.8 (1.3, 5.8)	94.1 (90.9, 96.3)	5.4 (3.5, 8.3)
Gender					
Male	15.6 (11.4, 21.1)	8.7 (5.5, 13.4)	3.6 (1.4, 9.2)	94.7 (89.6, 97.3)	5.5 (2.9, 10.1)
Female	21.7 (16.2, 28.4)	13.9 (8.9, 21.2)	1.6 (0.6, 4.3)	93.4 (88.3, 96.4)	5.2 (2.9, 9.3)
Age (years)					
15-24	17.5 (10.8, 27.1)	2.9 (0.8, 9.9)	1.4 (0.3, 7.9)	96.6 (90.6, 98.8)	6.1 (2.6, 13.6)
25-44	15.9 (11.2, 22.1)	9.4 (5.7, 15.1)	2.7 (1.1, 6.3)	97.5 (94.1, 99.0)	3.6 (1.6, 7.7)
45-64	24.0 (16.4, 33.6)	19.7 (11.9, 30.6)	4.5 (1.4, 13.7)	87.1 (77.2, 93.1)	7.3 (3.3, 15.6)
65+	8.4 (3.3, 19.7)	19.7 (9.1, 37.6)	0.0 (0.0, 0.0)	90.2 (70.1, 97.3)	7.4 (1.8, 25.6)
Residence					
Urban	18.6 (14.6, 23.4)	11.5 (8.3, 15.8)	2.9 (1.4, 6.2)	93.8 (90.2, 96.1)	5.5 (3.5, 8.7)
Rural	13.3 (8.0, 21.4)	4.1 (2.2, 7.8)	0.6 (0.1, 4.3)	98.6 (95.9, 99.5)	3.8 (2.1, 6.7)
Education level[5]					
Primary	15.6 (11.1, 21.6)	9.8 (6.0, 15.7)	0.9 (0.2, 3.4)	95.3 (90.2, 97.9)	3.4 (1.5, 7.5)
Secondary basic	13.3 (7.7, 22.0)	10.6 (5.6, 19.2)	8.0 (3.2, 18.9)	97.3 (92.7, 99.0)	4.8 (1.8, 12.1)
Secondary	27.8 (16.3, 43.1)	26.3 (14.8, 42.4)	4.8 (0.8, 22.8)	86.6 (70.0, 94.7)	6.5 (1.7, 22.1)
Tertiary	23.6 (9.2, 48.3)	10.9 (4.7, 23.4)	3.7 (0.5, 22.4)	88.3 (70.7, 95.9)	15.0 (5.7, 33.9)

[1] Among current smokers who made a quit attempt in the past 12 months and former smokers who have been abstinent for less than 12 months.
[2] Pharmacotherapy includes nicotine replacement therapy and prescription medications.
[3] Counseling in a specialized cessation service.
[4] Quit line or smoking telephone support line.
[5] Tried to stop smoking without aid.
[6] Other includes alternative treatments (e.g., acupuncture, homeopathy, hypnosis) and any other reported methods.
[7] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 5.3: Percentage distribution of current smokers ≥15 years old by interest in quitting smoking and selected demographic characteristics – GATS Uruguay, 2009.

Demographic Characteristics	Interest in Quitting Smoking[1]					
	Planning to Quit Within Next Month	Thinking About Quitting Within Next 12 Months	Will Quit Someday, But Not in the Next 12 Months	Not Interested in Quitting	Don't Know	Total
	Percentage (95% CI)					
Overall	10.9 (8.9, 13.4)	22.6 (19.8, 25.6)	42.1 (38.9, 45.5)	22.8 (20.2, 25.5)	1.6 (0.8, 3.1)	100
Gender						
Male	12.1 (9.1, 15.8)	22.3 (18.4, 26.7)	42.3 (37.8, 46.9)	22.1 (18.4, 26.2)	1.3 (0.5, 3.0)	100
Female	9.3 (6.9, 12.5)	23.0 (19.3, 27.3)	41.9 (37.0, 47.0)	23.7 (19.3, 28.8)	2.0 (0.8, 5.0)	100
Age (years)						
15-24	13.0 (7.6, 21.3)	21.8 (15.4, 30.1)	49.9 (40.9, 59.0)	15.1 (10.3, 21.6)	0.2 (0.0, 1.1)	100
25-44	11.5 (8.8, 14.9)	21.8 (17.9, 26.2)	44.4 (39.5, 49.5)	19.7 (15.9, 24.2)	2.6 (1.1, 6.3)	100
45-64	9.8 (7.0, 13.4)	25.1 (20.0, 31.0)	36.9 (31.4, 42.9)	27.1 (22.3, 32.5)	1.2 (0.4, 3.1)	100
65+	6.2 (3.0, 12.5)	17.8 (10.2, 29.1)	26.1 (17.3, 37.3)	49.3 (38.0, 60.6)	0.7 (0.1, 5.1)	100
Residence						
Urban	10.8 (8.6, 13.4)	22.8 (19.8, 26.1)	42.2 (38.7, 45.8)	22.6 (19.9, 25.6)	1.6 (0.8, 3.3)	100
Rural	13.4 (9.2, 19.1)	19.9 (15.9, 24.7)	41.2 (35.2, 47.4)	24.9 (20.9, 29.5)	0.6 (0.1, 2.9)	100
Education level[2]						
Primary	10.1 (7.5, 13.7)	21.4 (17.2, 26.3)	44.1 (38.7, 49.6)	23.1 (19.2, 27.5)	1.2 (0.4, 3.6)	100
Secondary basic	11.7 (7.8, 17.3)	17.2 (12.1, 24.0)	39.7 (32.4, 47.5)	29.3 (22.5, 37.0)	2.1 (0.8, 5.7)	100
Secondary	8.6 (4.9, 14.9)	29.2 (21.8, 38.0)	33.4 (26.2, 41.6)	25.3 (19.0, 32.9)	3.4 (1.1, 9.5)	100
Tertiary	14.3 (7.6, 25.4)	26.1 (18.3, 35.7)	36.0 (27.0, 46.2)	21.8 (13.5, 33.3)	1.8 (0.2, 11.6)	100

[1]Among current daily or less than daily smokers.
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 5.4: Percentage distribution of current smokers >15 years old who are aware of places to get aid to stop smoking, by selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Current smokers[1] who know of places to get aid to stop smoking
	Percentage (95% CI)
Overall	48.7 (44.7, 52.8)
Gender	
Male	45.0 (40.0, 50.2)
Female	53.9 (48.4, 59.4)
Age (years)	
15-24	45.5 (36.5, 54.9)
25-44	48.6 (42.7, 54.5)
45-64	53.9 (48.2, 59.6)
65+	32.3 (24.3, 41.5)
Residence	
Urban	50.0 (45.7, 54.3)
Rural	31.4 (25.9, 37.5)
Education level[2]	
Primary	36.5 (31.4, 41.9)
Secondary basic	49.7 (41.2, 58.3)
Secondary	69.5 (61.2, 76.6)
Tertiary	75.3 (60.8, 85.7)

[1] Includes daily and occasional (less than daily) smokers.
[2] Education level is reported only among respondents 25+ years old.

Table 6.1: Percentage and number of adults >15 years old who work indoors and are exposed to tobacco smoke at work, by smoking status and selected demographic characteristics GATS Uruguay 2009.

Demographic Characteristics	Adults Exposed to Tobacco Smoke at Work[1]			
	Overall		Non-smokers	
	Percentage (95% CI)	*Number in thousands*	*Percentage (95% CI)*	*Number in thousands*
Overall	16.5 (14.1, 19.3)	168.8	15.6 (12.7, 19.0)	116.6
Gender				
Male	21.4 (17.7, 25.5)	108.0	19.9 (15.7, 24.9)	69.3
Female	11.8 (9.2, 14.9)	60.8	11.9 (8.9, 15.7)	47.3
Age (years)				
15-24	18.3 (12.7, 25.6)	28.7	17.5 (11.2, 26.3)	19.5
25-44	16.7 (13.6, 20.4)	82.7	15.2 (11.7, 19.5)	55.2
45-64	16.4 (12.8, 20.8)	55.2	16.4 (12.2, 21.8)	40.0
65+	6.0 (2.4, 14.3)	2.2	6.5 (2.3, 17.0)	1.9
Residence				
Urban	16.3 (13.8, 19.2)	161.0	15.5 (12.5, 19.0)	111.4
Rural	21.1 (16.0, 27.3)	7.8	18.4 (13.2, 24.9)	5.1
Education level[2]				
Primary	20.2 (15.7, 25.7)	53.6	19.0 (14.2, 24.9)	36.0
Secondary basic	19.5 (14.5, 25.8)	33.0	20.9 (15.0, 28.4)	24.7
Secondary	13.2 (9.4, 18.2)	39.3	12.2 (7.8, 18.5)	27.0
Tertiary	10.6 (6.8, 16.1)	14.2	8.9 (5.0, 15.4)	9.5

[1] In the past 30 days. Among those respondents who work outside of the home who usually work indoors or both indoors and outdoors.
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 6.2: Percentage of number of adults >15 years old who are exposed to tobacco smoke at home, by smoking status and selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Adults Exposed to Tobacco Smoke at Home[1]			
	Overall		Non-smokers	
	Percentage (95% CI)	*Number in thousands*	*Percentage (95% CI)*	*Number in thousands*
Overall	34.0 (32.0, 36.0)	837.1	23.9 (21.8, 26.1)	441.4
Gender				
Male	36.8 (34.0, 39.6)	429.9	25.0 (21.9, 28.3)	202.2
Female	31.4 (29.1, 33.9)	407.2	23.0 (20.6, 25.6)	239.2
Age (years)				
15-24	46.1 (41.4, 50.8)	228.9	41.4 (36.0, 47.1)	155.0
25-44	35.0 (32.2, 37.9)	305.2	22.3 (19.2, 25.8)	135.4
45-64	32.4 (29.1, 35.9)	217.6	19.2 (16.1, 22.6)	91.8
65+	20.1 (17.2, 23.5)	85.4	15.2 (12.6, 18.2)	59.2
Residence				
Urban	34.0 (31.8, 36.2)	776.4	23.8 (21.6, 26.2)	407.9
Rural	33.6 (30.4, 37.0)	60.7	24.2 (21.3, 27.4)	33.5
Education level[2]				
Primary	32.6 (29.8, 35.6)	317.7	21.6 (18.9, 24.5)	156.5
Secondary basic	31.1 (27.2, 35.3)	103.0	18.1 (14.8, 22.0)	43.1
Secondary	27.8 (23.8, 32.1)	133.7	16.2 (12.2, 21.1)	59.7
Tertiary	29.7 (24.5, 35.6)	53.9	19.0 (14.1, 25.1)	27.1

[1] Adults reporting that smoking inside their home occurs daily, weekly, or monthly.
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 6.2a: Percentage and number of adults >15 years old who are exposed to tobacco smoke at home, by smoking status and selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Adults Exposed to Tobacco Smoke at Home[1]			
	Overall		Non-smokers	
	Percentage (95% CI)	*Number in thousands*	*Percentage (95% CI)*	*Number in thousands*
Overall	29.2 (27.4, 31.1)	719.8	18.2 (16.4, 20.1)	335.9
Gender				
Male	32.0 (29.5, 34.5)	373.7	18.9 (16.4, 21.8)	153.5
Female	26.7 (24.5, 29.1)	346.1	17.6 (15.3, 20.1)	182.4
Age (years)				
15-24	40.8 (36.4, 45.3)	202.6	34.7 (29.7, 40.2)	130.0
25-44	29.6 (26.9, 32.5)	258.3	15.5 (12.9, 18.4)	93.7
45-64	28.0 (24.9, 31.3)	188.2	14.0 (11.4, 17.2)	67.1
65+	16.7 (13.9, 19.8)	70.8	11.6 (9.2, 14.4)	45.1
Residence				
Urban	29.3 (27.3, 31.3)	669.3	18.2 (16.3, 20.3)	311.8
Rural	28.0 (24.6, 31.7)	50.5	17.4 (14.7, 20.5)	24.1
Education level[2]				
Primary	28.5 (25.9, 31.3)	277.6	16.5 (14.2, 19.1)	119.7
Secondary basic	27.0 (23.0, 31.3)	89.2	13.6 (10.5, 17.4)	32.3
Secondary	22.5 (18.9, 26.5)	108.2	10.2 (7.1, 14.4)	37.7
Tertiary	23.3 (18.5, 28.9)	42.2	11.4 (7.1, 17.9)	16.3

[1] Adults reporting that smoking inside their home occurs daily, weekly.
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 6.3: Percentage of adults > 15 years old who were exposed to tobacco smoke in various public places in the past 30 days, by smoking status and selected demographic characteristics GATS Uruguay 2009.

Demographic Characteristics	Adults Exposed to Tobacco Smoke[1] in…					
	Government Buildings	Health Care Facilities	Restaurants	Public Transportation	University or Faculty	Bars, Pubs, Discotheques
	Percentage (95% CI)					
Overall	3.6 (3.0, 4.4)	1.9 (1.5, 2.6)	1.5 (1.1, 2.1)	3.3 (2.8, 3.9)	3.0 (2.3, 3.9)	6.5 (5.5, 7.6)
Gender						
Male	4.4 (3.5, 5.6)	1.7 (1.1, 2.8)	1.7 (1.1, 2.6)	3.2 (2.5, 4.2)	3.1 (2.1, 4.5)	8.8 (6.9, 11.0)
Female	2.9 (2.1, 4.0)	2.1 (1.5, 2.9)	1.3 (0.9, 2.1)	3.4 (2.6, 4.4)	2.9 (1.9, 4.4)	4.4 (3.5, 5.5)
Age (years)						
15-24	6.6 (4.5, 9.5)	2.4 (1.2, 4.7)	2.7 (1.5, 4.7)	4.9 (3.3, 7.2)	7.8 (5.1, 11.6)	17.5 (13.6, 22.2)
25-44	3.9 (2.8, 5.4)	1.6 (1.0, 2.4)	2.0 (1.3, 3.1)	3.7 (2.8, 4.9)	3.3 (2.3, 4.8)	6.0 (4.6, 7.8)
45-64	2.4 (1.7, 3.4)	2.2 (1.4, 3.3)	0.4 (0.2, 1.0)	2.5 (1.7, 3.6)	0.7 (0.3, 1.5)	2.3 (1.6, 3.3)
65+	1.7 (1.0, 2.7)	1.8 (1.0, 3.3)	0.9 (0.4, 2.4)	1.7 (0.9, 3.1)	0.1 (0.0, 1.0)	1.1 (0.5, 2.3)
Residence						
Urban	3.7 (3.0, 4.6)	2.0 (1.5, 2.7)	1.5 (1.1, 2.1)	3.3 (2.7, 3.9)	3.1 (2.4, 4.1)	6.5 (5.4, 7.7)
Rural	3.1 (2.2, 4.2)	1.1 (0.7, 1.8)	1.5 (0.9, 2.7)	3.6 (2.5, 5.1)	1.0 (0.5, 2.2)	6.4 (5.0, 8.1)
Education level[2]						
Primary	1.7 (1.1, 2.5)	1.7 (1.2, 2.4)	0.7 (0.3, 1.4)	1.9 (1.3, 2.8)	0.1 (0.0, 0.8)	3.2 (2.2, 4.6)
Secondary basic	3.2 (2.0, 4.9)	1.7 (1.0, 2.9)	1.3 (0.6, 2.6)	2.6 (1.7, 4.0)	0.7 (0.2, 2.5)	3.5 (2.3, 5.2)
Secondary	4.1 (2.6, 6.4)	1.4 (0.7, 3.0)	2.2 (1.1, 4.2)	4.0 (2.8, 5.7)	4.2 (2.7, 6.4)	4.5 (3.0, 6.6)
Tertiary	5.8 (3.6, 9.2)	3.8 (2.0, 6.9)	1.7 (0.7, 4.1)	5.8 (3.6, 9.3)	5.8 (3.5, 9.6)	4.7 (2.9, 7.3)
Non-smokers	4.0 (3.1, 5.0)	2.0 (1.4, 2.8)	1.5 (1.1, 2.2)	3.3 (2 .7, 4.1)	2.6 (1.9, 3.6)	5.5 (4.5, 6.7)
Gender						
Male	4.9 (3.7, 6.4)	1.5 (0.8, 2.7)	1.9 (1.1, 3.2)	3.4 (2.5, 4.6)	2.8 (1.8, 4.2)	7.8 (5.9, 10.2)
Female	3.3 (2.3, 4.6)	2.4 (1.7, 3.3)	1.3 (0.8, 2.1)	3.3 (2.4, 4.5)	2.5 (1.5, 4.2)	3.8 (2.8, 5.0)
Age (years)						
15-24	7.4 (4.7, 11.3)	2.0 (0.7, 5.0)	3.2 (1.8, 5.9)	5.1 (3.3, 7.9)	6.6 (4.2, 10.5)	16.4 (12.4, 21.2)
25-44	4.3 (2.9, 6.2)	1.7 (1.0, 2.8)	1.6 (0.9, 3.0)	3.9 (2.7, 5.5)	3.5 (2.2, 5.3)	4.7 (3.2, 6.7)
45-64	2.7 (1.8, 4.1)	2.4 (1.4, 4.0)	0.6 (0.3, 1.3)	2.6 (1.6, 4.0)	0.4 (0.1, 1.4)	2.0 (1.3, 3.3)
65+	1.8 (1.1, 2.9)	2.0 (1.1, 3.6)	1.0 (0.4, 2.6)	1.7 (1.0, 3.1)	0.2 (0.0, 1.1)	0.8 (0.3, 2.0)
Residence						
Urban	4.0 (3.1, 5.2)	2.1 (1.5, 2.9)	1.5 (1.0, 2.3)	3.3 (2.6, 4.2)	2.8 (2.0, 3.9)	5.5 (4.4, 6.8)
Rural	3.3 (2.3, 4.7)	1.0 (0.6, 1.8)	1.8 (1.0, 3.1)	3.4 (2.3, 5.2)	0.8 (0.3, 1.7)	6.3 (4.8, 8.3)
Education level[2]						
Primary	1.6 (1.0, 2.5)	1.9 (1.3, 2.8)	0.4 (0.2, 1.1)	1.7 (1.1, 2.8)	0.1 (0.0, 1.0)	2.3 (1.5, 3.4)
Secondary basic	3.2 (2.0, 5.2)	2.1 (1.2, 3.9)	1.2 (0.5, 2.9)	2.6 (1.5, 4.4)	0.1 (0.0, 0.6)	2.8 (1.5, 5.0)
Secondary	4.6 (2.8, 7.4)	1.3 (0.5, 3.3)	2.4 (1.2, 4.7)	4.1 (2.6, 6.2)	4.1 (2.3, 7.0)	3.4 (2.0, 5.8)
Tertiary	6.8 (4.2, 11.0)	3.8 (2.0, 7.4)	1.3 (0.5, 3.2)	6.1 (3.5, 10.7)	4.9 (2.7, 8.7)	3.7 (2.0, 6.9)

[1] Among all adults in the past 30 days.
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 6.4: Percentage of adults >15 years old who visited various public places in the past 30 days and were exposed to tobacco smoke, by smoking status and selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Exposure to Tobacco Smoke[1] in…					
	Government Buildings	Health Care Facilities	Restaurants	Public Transportation	University or Faculty	Bars, Pubs, Discotheques
	Percentage (95% CI)					
Overall	6.9 (5.7, 8.4)	3.8 (2.8, 5.0)	4.4 (3.2, 6.1)	5.4 (4.5, 6.4)	27.5 (21.7, 34.1)	23.4 (20.2, 27.0)
Gender						
Male	8.0 (6.3, 10.0)	4.2 (2.6, 6.7)	4.7 (2.9, 7.3)	5.7 (4.4, 7.4)	26.0 (18.7, 34.8)	25.2 (20.5, 30.6)
Female	5.8 (4.2, 8.0)	3.5 (2.6, 4.8)	4.2 (2.6, 6.7)	5.2 (4.0, 6.8)	29.1 (19.8, 40.6)	20.8 (16.4, 26.1)
Age (years)						
15-24	13.5 (9.4, 19.1)	5.7 (2.9, 10.8)	6.4 (3.6, 11.0)	7.1 (4.8, 10.5)	34.2 (23.9, 46.2)	32.5 (26.5, 39.1)
25-44	6.7 (4.8, 9.2)	3.0 (2.0, 4.6)	5.1 (3.2, 7.9)	5.9 (4.5, 7.7)	25.1 (18.0, 33.9)	20.4 (16.1, 25.5)
45-64	4.2 (3.0, 5.9)	4.3 (2.8, 6.6)	1.3 (0.6, 3.0)	4.4 (3.1, 6.4)	15.8 (7.7, 29.5)	12.8 (9.0, 18.0)
65+	4.2 (2.6, 6.8)	3.0 (1.6, 5.3)	5.2 (2.0, 12.7)	3.3 (1.8, 5.9)	8.4 (1.1, 43.2)*	13.8 (6.9, 25.5)
Residence						
Urban	7.0 (5.6, 8.6)	3.9 (2.9, 5.2)	4.3 (3.0, 6.1)	5.3 (4.4, 6.4)	27.6 (21.6, 34.4)	23.1 (19.8, 26.9)
Rural	6.3 (4.5, 8.6)	2.6 (1.6, 4.1)	7.8 (4.7, 12.6)	7.0 (5.1, 9.6)	24.3 (13.2, 40.6)	28.5 (22.4, 35.4)
Education level[2]						
Primary	4.0 (2.7, 5.9)	3.6 (2.6, 5.1)	4.9 (2.3, 9.9)	3.6 (2.5, 5.3)	7.6 (1.1, 37.4)	26.2 (19.0, 35.0)
Secondary basic	5.7 (3.7, 8.7)	3.1 (1.7, 5.4)	3.7 (1.8, 7.6)	4.3 (2.7, 6.6)	17.7 (5.6, 44.0)	14.6 (9.9, 21.0)
Secondary	6.0 (3.8, 9.4)	2.3 (1.1, 4.9)	4.0 (2.0, 7.6)	5.9 (4.0 , 8.4)	25.7 (16.8, 37.2)	14.3 (9.7, 20.5)
Tertiary	7.7 (4.8, 12.0)	5.9 (3.2, 10.6)	2.5 (1.0, 5.9)	8.6 (5.5, 13.3)	22.8 (14.1, 34.8)	13.3 (8.4, 20.6)
Non-smokers	7.7 (6.1, 9.8)	3.7 (2.6, 5.1)	4.5 (3.1, 6.6)	5.6 (4.5, 6.9)	24.8 (18.6, 32.3)	22.4 (18.6, 26.7)
Gender						
Male	8.7 (6.6, 11.5)	3.4 (1.9, 6.0)	5.1 (3.0, 8.6)	6.2 (4.5, 8.3)	23.1 (15.9, 32.2)	24.5 (19.2, 30.6)
Female	6.8 (4.8, 9.6)	3.8 (2.7, 5.4)	4.0 (2.4, 6.8)	5.2 (3.8, 7.1)	26.6 (16.6, 39.7)	19.8 (14.5, 26.4)
Age (years)						
15-24	15.3 (10.0, 22.8)	4.4 (1.7, 11.2)	7.6 (4.1, 13.5)	7.5 (4.8, 11.5)	29.6 (19.7, 42.0)	32.6 (26.0, 40.0)
25-44	7.3 (5.0, 10.5)	3.1 (1.9, 5.0)	3.9 (2.1, 7.0)	6.2 (4.4, 8.7)	24.7 (16.5, 35.3)	17.5 (12.7, 23.7)
45-64	4.9 (3.3, 7.4)	4.4 (2.6, 7.3)	1.9 (0.8, 4.2)	4.6 (2.9, 7.1)	9.5 (2.9, 27.4)	12.9 (8.0, 20.1)
65+	4.6 (2.8, 7.5)	3.2 (1.7, 5.7)	5.6 (2.2, 13.8)	3.3 (1.9, 5.7)	9.1 (1.2, 45.6)*	9.9 (3.8, 23.5)
Residence						
Urban	7.8 (6 .1, 10.0)	3.8 (2.7, 5.3)	4.3 (2.9, 6.5)	5.5 (4.4, 6.9)	25.0 (18.6, 32.7)	21.9 (17.9, 26.5)
Rural	6.4 (4.5, 9.0)	2.3 (1.4, 3.9)	8.9 (5.3, 14.8)	6.8 (4.6, 9.8)	20.2 (9.5, 37.7)	29.7 (22.7, 37.9)
Education level[2]						
Primary	3.9 (2.5, 6.0)	3.7 (2.5, 5.4)	3.2 (1.3, 7.7)	3.5 (2.1, 5.6)	10.7 (1.7, 46.1)*	23.8 (16.4, 33.1)
Secondary basic	5.9 (3.6, 9.5)	3.8 (2.0, 6.9)	3.7 (1.5, 8.8)	4.2 (2.4, 7.2)	2.5 (0.3, 15.8)*	13.0 (7.1, 22.6)
Secondary	7.1 (4.4, 11.5)	2.1 (0.9, 5.1)	4.3 (2.1, 8.5)	6.0 (3.8, 9.2)	26.3 (15.5, 40.9)	12.0 (7.2, 19.3)
Tertiary	9.3 (5.8, 14.7)	6.1 (3.2, 11.2)	1.9 (0.8, 4.9)	9.2 (5.3, 15.5)	20.2 (11.8, 32.6)	12.5 (6.5, 22.7)

[1] Among those that visited the place in the past 30 days.

[2] Education level is reported only among respondents 25+ years old.

*Estimate based on less than 25 un weighted cases.

Table 6.5: Percentage of number of smokers who live in the household, by selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Number of smokers who live in the household				Total
	0	1	2	3 or more	
	Percentage (95% CI)				
Overall	55.5 (53.4, 57.5)	26.8 (25.2, 28.5)	12.7 (11.3, 14.2)	5.1 (4.1, 6.3)	100
Gender					
Male	52.4 (49.7, 55.2)	28.8 (26.6, 31.2)	13.3 (11.4, 15.5)	5.4 (4.0, 7.3)	100
Female	58.2 (55.6, 60.8)	25.0 (22.8, 27.4)	12.1 (10.4, 14.0)	4.7 (3.6, 6.1)	100
Age (years)					
15-24	45.1 (40.6, 49.8)	27.4 (23.2, 32.1)	18.5 (15.3, 22.2)	8.9 (6.3, 12.6)	100
25-44	52.6 (49.3, 55.8)	27.9 (25.4, 30.5)	14.1 (12.2, 16.4)	5.4 (3.9, 7.4)	100
45-64	52.4 (49.2, 55.6)	32.2 (28.6, 36.1)	11.4 (8.9, 14.4)	4.0 (2.7, 5.8)	100
65+	78.2 (74.6, 81.5)	15.3 (12.9, 18.1)	4.9 (3.3, 7.0)	1.6 (0.7, 3.7)	100
Residence					
Urban	55.2 (53.0, 57.4)	26.8 (25.1, 28.6)	12.7 (11.3, 14.3)	5.2 (4.2, 6.5)	100
Rural	58.6 (54.2, 63.0)	26.5 (24.0, 29.1)	11.9 (9.5, 15.0)	2.9 (1.8, 4.8)	100
Education level[1]					
Primary	56.6 (53.6, 59.7)	26.5 (24.2, 29.1)	12.0 (10.3, 14.0)	4.8 (3.3, 7.0)	100
Secondary basic	57.1 (52.9, 61.2)	28.4 (24.9, 32.3)	11.0 (8.3, 14.3)	3.5 (2.1, 5.8)	100
Secondary	59.7 (55.6, 63.7)	25.3 (22.0, 29.0)	10.6 (7.9, 14.2)	4.3 (2.7, 6.9)	100
Tertiary	63.0 (58.3, 67.5)	27.6 (22.9, 32.8)	8.6 (5.6, 12.9)	0.8 (0.2, 3.2)	100

[1] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 7.2: Percentage distribution of manufactured cigarette smokers ≥15 years old, by the source of last purchase of cigarettes and selected demographic characteristics – GATS Uruguay, 2009.

		Gender		Age (years)		Residence	
Source	**Overall**	**Male**	**Female**	**15-24**	**≥ 25**	**Urban**	**Rural**
				Percentage (95% CI)			
Grocery store	49.7 (44.6, 54.8)	47.9 (41.5, 54.3)	51.9 (45.4, 58.3)	57.4 (46.7, 67.4)	47.6 (42.2, 53.0)	49.3 (43.9, 54.7)	57.8 (49.3, 65.8)
Supermarket	12.7 (10.2, 15.6)	9.2 (6.4, 13.1)	16.7 (13.3, 20.8)	13.4 (7.8, 21.8)	12.5 (9.9, 15.6)	12.8 (10.2, 15.8)	10.7 (6.3, 17.6)
Street vendor	2.5 (1.5, 4.2)	1.6 (0.7, 3.7)	3.5 (1.9, 6.3)	1.5 (0.4, 6.2)	2.7 (1.6, 4.6)	2.4 (1.4, 4.2)	3.4 (1.6, 6.8)
Gas station	4.5 (3.0, 6.7)	6.9 (4.5, 10.4)	1.6 (0.8, 3.3)	5.1 (2.2, 11.3)	4.4 (2.8, 6.7)	4.5 (3.0, 6.9)	4.0 (2.1, 7.7)
Duty-free shop	0.4 (0.1, 2.5)	0.0 (0.0, 0.2)	0.8 (0.1, 5.6)	0.0 (0.0, 0.0)	0.5 (0.1, 3.2)	0.4 (0.1, 2.7)	0.3 (0.0, 1.9)
Kiosks, parlors or newsstands	25.7 (21.7, 30.3)	29.7 (24.2, 35.9)	21.0 (16.3, 26.7)	19.4 (13.1, 27.8)	27.5 (23.0, 32.6)	26.1 (21.9, 30.9)	18.7 (14.1, 24.3)
Outside the country	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)
Internet	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)
Taverns, bars or restaurants	2.3 (1.4, 4.0)	2.1 (1.1, 4.0)	2.6 (1.2, 5.8)	1.5 (0.4, 5.6)	2.6 (1.4, 4.6)	2.2 (1.3, 4.0)	3.9 (2.0, 7.5)
Other	2.2 (1.3, 3.7)	2.5 (1.3 , 4.8)	1.9 (0.9, 4.0)	1.7 (0.5, 6.0)	2.3 (1.3, 4.1)	2.3 (1.3, 3.8)	1.2 (0.3, 4.6)
Total	100	100	100	100	100	100	100

*Estimate based on less than 25 un weighted cases.

Table 7.3: Average manufactured cigarette expenditure and hand-rolled cigarette expenditure per month among cigarette smokers >15 years old, by selected demographic characteristics GATS Uruguay 2009.

Demographic Characteristics	Manufactured cigarette expenditure per month (In *pesos*)	Hand-rolled cigarette expenditure per month (In *pesos*)	Total cigarette expenditure per month (in (In *pesos*)
		Average (95% CI)	
Overall	991.1 (848.4, 1,133.8)	186.6 (166.0, 207.1)	908.2 (782.8, 1,033.6)
Gender			
Male	1,112.8 (864.6, 1,361.0)	187.9 (166.7, 209.1)	970.7 (765.4, 1,175.9)
Female	847.8 (739.4, 956.2)	181.3 (129.1, 233.4)	822.1 (719.6, 924.5)
Age (years)			
15-24	655.4 (549.8, 761.1)	156.1 (125.9, 186.3)	661.6 (558.1, 765.1)
25-44	996.9 (874.4, 1,119.4)	185.7 (152.0, 219.5)	911.4 (802.0, 1,020.9)
45-64	1,245.6 (804.5, 1,686.8)	221.5 (174.8, 268.2)	1,103.3 (730.9, 1,475.8)
65+	797.7 (580.4, 1,015.0)	147.1 (102.2, 192.1)	637.4 (468.8, 806.0)
Residence			
Urban	987.3 (837.6, 1,136.9)	187.1 (163.9, 210.4)	917.3 (783.4, 1,051.3)
Rural	1,060.8 (769.8, 1,351.8)	182.5 (160.8, 204.2)	784.6 (584.8, 984.4)
Education level[1]			
Primary	1,102.8 (718.4, 1,487.1)	199.5 (171.5, 227.6)	906.5 (619.0, 1,193.9)
Secondary basic	1,178.7 (903.4, 1,454.1)	238.7 (186.6, 290.8)	1,152.1 (889.5, 1,414.8)
Secondary	977.4 (823.0, 1,131.8)	92.3 (52.6, 132.1)*	926.7 (774.4, 1,078.9)
Tertiary	1,058.8 (769.2, 1,348.4)	61.6 (32.3, 91.0)*	1,051.2 (763.9, 1,338.6)

[1] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 8.1: Percentage of adults ≥15 years old who noticed anti-cigarette smoking information during the last 30 days in various places, by smoking status and selected demographic characteristics – GATS Uruguay, 2009

Places	Overall	Gender		Age (years)		Residence	
		Male	Female	15-24	≥ 25	Urban	Rural
				Percentage (95% CI)			
Overall							
In newspapers or in magazines	37.4 (35.3, 39.5)	37.7 (34.9, 40.7)	37.1 (34.3, 40.0)	32.7 (28.8, 37.0)	38.6 (36.4, 40.8)	37.7 (35.5, 40.0)	32.9 (30.0, 35.8)
On television or the radio	72.4 (70.7, 74.0)	72.8 (70.5, 75.0)	71.9 (69.5, 74.3)	65.8 (61.4, 70.0)	74.0 (72.3, 75.7)	72.0 (70.2, 73.7)	77.5 (74.7, 80.1)
On television	67.4 (65.5, 69.3)	66.8 (64.1, 69.4)	67.9 (65.3, 70.4)	61.1 (56.4, 65.6)	69.0 (67.0, 70.9)	67.3 (65.2, 69.3)	68.9 (66.0, 71.7)
On the radio	42.5 (40.3, 44.7)	45.3 (42.3, 48.5)	39.8 (37.3, 42.4)	31.2 (26.5, 36.4)	45.3 (43.0, 47.6)	41.5 (39.1, 43.8)	54.9 (50.8, 59.0)
On billboards	52.1 (49.9, 54.3)	53.9 (50.7, 57.1)	50.5 (47.7, 53.2)	56.6 (51.5, 61.6)	51.0 (48.7, 53.2)	52.6 (50.2, 54.9)	46.0 (42.3, 49.7)
Somewhere else	17.2 (15.4, 19.3)	15.8 (13.5, 18.5)	18.5 (16.2, 21.0)	18.5 (15.3, 22.2)	16.9 (15.0, 19.1)	17.2 (15.2, 19.4)	18.2 (15.4, 21.3)
Any location	84.8 (83.4, 86.1)	85.6 (83.7, 87.3)	84.0 (82.1, 85.7)	83.7 (79.3, 87.3)	85.0 (83.7, 86.2)	84.6 (83.1, 86.0)	86.6 (84.7, 88.3)
Current smokers[1]							
In newspapers or in magazines	34.2 (31.1, 37.4)	32.9 (28.7, 37.5)	36.0 (31.0, 41.2)	31.7 (25.0, 39.2)	34.8 (31.3, 38.6)	34.5 (31.2, 37.9)	30.7 (25.7, 36.2)
On television or the radio	73.5 (70.1, 76.7)	75.0 (70.1, 79.3)	71.5 (66.7, 75.9)	70.6 (61.7, 78.1)	74.3 (70.5, 77.7)	73.4 (69.8, 76.7)	75.6 (69.9, 80.5)
On television	68.5 (64.8, 71.9)	67.9 (62.8, 72.6)	69.3 (64.3, 73.8)	66.4 (57.8, 74.1)	69.0 (64.9, 72.8)	68.6 (64.7, 72.3)	66.3 (60.5, 71.6)
On the radio	43.2 (39.0, 47.5)	47.4 (41.3, 53.7)	37.3 (32.4, 42.5)	35.4 (26.5, 45.6)	45.1 (40.8, 49.6)	42.7 (38.2, 47.2)	50.5 (43.8, 57.2)
On billboards	52.6 (49.1, 56.1)	53.6 (48.5, 58.6)	51.3 (46.3, 56.2)	63.5 (53.9, 72.2)	49.9 (46.4, 53.4)	53.4 (49.6, 57.1)	42.5 (37.3, 47.8)
Somewhere else	15.6 (13.0, 18.6)	14.3 (11.0, 18.4)	17.4 (13.9, 21.5)	14.9 (9.8, 22.0)	15.8 (13.0, 19.0)	15.5 (12.7, 18.8)	16.5 (12.5, 21.5)
Any location	84.0 (81.1, 86.5)	84.6 (80.7, 87.9)	83.1 (78.9, 86.5)	86.8 (79.3, 91.9)	83.3 (80.2, 85.9)	83.9 (80.9, 86.6)	84.8 (79.6, 88.9)
Non-smokers[2]							
In newspapers or in magazines	38.5 (36.1, 40.8)	39.9 (36.5, 43.4)	37.3 (34.4, 40.4)	33.1 (28.7, 37.8)	39.8 (37.2, 42.4)	38.9 (36.3, 41.4)	33.5 (30.5, 36.7)
On television or the radio	72.0 (70.0, 73.9)	71.9 (69.1, 74.5)	72.0 (69.2, 74.7)	64.3 (59.1, 69.1)	73.9 (71.7, 76.0)	71.5 (69.3, 73.5)	78.1 (75.0, 80.9)
On television	67.0 (64.8, 69.2)	66.3 (63.2, 69.3)	67.6 (64.6, 70.4)	59.4 (53.7, 64.7)	69.0 (66.6, 71.3)	66.8 (64.5, 69.1)	69.7 (66.5, 72.7)
On the radio	42.2 (39.9, 44.6)	44.4 (41.3, 47.6)	40.5 (37.6, 43.4)	29.8 (24.7, 35.5)	45.3 (42.8, 47.9)	41.1 (38.6, 43.6)	56.3 (52.2, 60.3)
On billboards	51.9 (49.5, 54.3)	54.1 (50.6, 57.5)	50.3 (47.3, 53.3)	54.4 (48.2, 60.4)	51.3 (48.7, 53.9)	52.3 (49.7, 54.9)	47.1 (42.9, 51.2)
Somewhere else	17.8 (15.7, 20.1)	16.5 (13.8, 19.6)	18.8 (16.4, 21.5)	19.7 (15.9, 24.1)	17.3 (15.2, 19.7)	17.7 (15.5, 20.2)	18.7 (15.9, 22.0)
Any location	85.0 (83.4, 86.5)	86.0 (83.9, 87.9)	84.3 (82.0, 86.3)	82.7 (77.7, 86.7)	85.6 (84.0, 87.1)	84.8 (83.1, 86.5)	87.2 (85.3, 88.9)

[1] Includes daily and occasional(less than daily) smokers.
[2] Includes former and never smokers.
*Estimate based on less than 25 un weighted cases.

Table 8.2: Percentage of adults > 15 years old who noticed health warnings on cigarette packages and considered quitting because of the warning labels during the las 30 days, by selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Current smokers[1] who…	
	Noticed health warnings on cigarette package[2]	Thought about quitting because of warning label[2]
	Percentage (95% CI)	
Overall	96.1 (94.5, 97.3)	44.6 (41.0, 48.2)
Gender		
Male	95.8 (93.5, 97.2)	42.2 (36.9, 47.8)
Female	96.6 (93.8, 98.2)	47.8 (42.7, 53.0)
Age (years)		
15-24	98.0 (93.5, 99.4)	54.3 (45.1, 63.1)
25-44	99.1 (98.1, 99.6)	42.4 (37.5, 47.6)
45-64	93.2 (88.8, 95.9)	42.6 (35.9, 49.5)
65+	83.1 (68.7, 91.7)	36.2 (25.6, 48.4)
Residence		
Urban	96.3 (94.5, 97.5)	44.2 (40.4, 48.1)
Rural	94.1 (90.4, 96.4)	50.2 (43.6, 56.8)
Education level[3]		
Primary	93.8 (90.8, 95.8)	50.0 (45.1, 54.8)
Secondary basic	98.6 (95.2, 99.6)	38.3 (30.2, 47.1)
Secondary	96.5 (89.2, 99.0)	31.6 (23.4, 41.0)
Tertiary	98.3 (93.7, 99.6)	33.3 (23.0, 45.4)

[1] Includes daily and occasional(less than daily) smokers.
[2] During the last 30 days.
[3] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 8.3: Percentage of adults ≥15 years old who noticed cigarette marketing during the last 30 days in various places, by selected demographic characteristics – GATS Uruguay, 2009.

		Gender		Age (years)		Residence	
Places	**Overall**	**Male**	**Female**	**15-24**	**≥ 25**	**Urban**	**Rural**
				Percentage (95% CI)			
Noticed advertisements							
In stores	20.9 (19.1, 22.8)	23.3 (20.8, 25.9)	18.8 (16.7, 21.1)	36.3 (31.8, 41.0)	17.0 (15.4, 18.7)	21.3 (19.4, 23.4)	15.3 (12.9, 18.1)
On television	13.1 (11.5, 14.8)	14.0 (12.1, 16.3)	12.3 (10.4, 14.4)	15.6 (12.4, 19.3)	12.5 (11 .0, 14.2)	13.1 (11.5, 15.0)	12.6 (10.4, 15.0)
On the radio	6.2 (5.0, 7.7)	6.9 (5.5, 8.5)	5.6 (4.2, 7.4)	4.1 (2.4, 6.9)	6.7 (5.5, 8.2)	6.0 (4.7, 7.6)	9.0 (7.1, 11.3)
On billboards	13.1 (11.5, 14.9)	14.9 (12.9, 17.0)	11.5 (9.6, 13.7)	19.5 (15.5, 24.2)	11.5 (10.0, 13.1)	13.3 (11.6, 15.2)	10.6 (8.7, 12.8)
On posters	10.5 (9.3, 11.9)	11.7 (10.0, 13.8)	9.4 (8.0, 11.1)	14.7 (11.7, 18.2)	9.5 (8.3, 10.8)	10.7 (9.4, 12.2)	8.1 (6.4, 10.3)
In newspapers or magazines	6.9 (6.0, 7.9)	6.5 (5.4, 7.8)	7.2 (6.0, 8.6)	6.7 (4.6, 9.7)	6.9 (6.0, 7.9)	7.0 (6.0, 8.0)	5.7 (4.4, 7.5)
In cinemas	1.0 (0.7, 1.6)	1.0 (0.6, 1.9)	1.0 (0.6, 1.8)	1.1 (0.4, 2.8)	1.0 (0.6, 1.6)	1.1 (0.7, 1.6)	0.8 (0.4, 1.5)
On the Internet	4.6 (3.8, 5.5)	5.3 (4.0, 6.9)	4.0 (3.1, 5.3)	10.8 (8.2, 14.1)	3.1 (2.4, 3.9)	4.8 (3.9, 5.7)	2.9 (2.0, 4.2)
On public transportation	7.6 (6.3, 9.2)	9.4 (7.6, 11.4)	6.1 (4.7, 7.8)	11.2 (8.2, 15.0)	6.7 (5.6, 8.1)	7.7 (6.3, 9.4)	6.8 (5.3, 8.7)
On public walls	6.7 (5.6, 8.0)	6.8 (5.4, 8.5)	6.6 (5.1, 8.4)	11.3 (8.5, 14.9)	5.5 (4.6, 6.5)	6.7 (5.5, 8.1)	5.9 (4.4, 7.8)
Somewhere else	2.1 (1.6, 2.8)	2.6 (1.9, 3.7)	1.6 (1.1, 2.4)	3.5 (2.2, 5.5)	1.8 (1.2, 2.5)	2.2 (1.6, 2.9)	1.5 (0.8, 2.8)
Noticed sports sponsorship	5.2 (4.3, 6.3)	7.3 (5.9, 9.0)	3.3 (2.5, 4.3)	7.6 (5.2, 11.0)	4.6 (3.7, 5.6)	5.3 (4.3, 6.5)	3.2 (2.3, 4.4)
Noticed cigarette promotions							
Free samples	1.6 (1.2, 2.3)	1.6 (1.0, 2.7)	1.6 (1.1, 2.6)	3.6 (2.1, 6.2)	1.1 (0.8, 1.6)	1.7 (1.2, 2.4)	1.2 (0.8, 1.9)
Sale prices	7.8 (6.6, 9.2)	9.9 (8.2, 11.9)	5.9 (4.7, 7.4)	7.4 (5.3, 10.1)	7.9 (6.6, 9.5)	8.0 (6.7, 9.5)	5.6 (4.0, 7.6)
Free gifts/discounts on other products	0.9 (0.6, 1.3)	0.6 (0.3, 1.2)	1.1 (0.7, 2.0)	1.0 (0.3, 3.0)	0.8 (0.5, 1.4)	0.9 (0.6, 1.4)	0.6 (0.3, 1.2)
Clothing/item with brand name or logo	5.4 (4.6, 6.4)	7.0 (5.7, 8.5)	4.0 (3.2, 5.1)	9.8 (7.4, 12.9)	4.3 (3.6, 5.2)	5.6 (4.7, 6.6)	3.8 (2.8, 5.2)
E-mail promoting cigarettes	1.0 (0.7, 1.5)	1.0 (0.5, 1.7)	1.0 (0.6, 1.8)	3.7 (2.3, 5.9)	0.3 (0.2, 0.6)	1.0 (0.7, 1.5)	0.8 (0.4, 1.4)
Cell phone text messages	0.4 (0.3, 0.7)	0.3 (0.1, 0.8)	0.5 (0.3, 1.0)	1.2 (0.5, 2.7)	0.2 (0.1, 0.4)	0.4 (0.2, 0.7)	0.5 (0.3, 1.1)
Noticed any advertisement, sponsorship, or promotion	44.3 (42.0, 46.5)	49.0 (46.0, 52.0)	40.0 (37.2, 42.8)	61.2 (56.2, 66.0)	40.0 (37.8, 42.2)	44.7 (42.3, 47.2)	38.4 (34.7, 42.3)

*Estimate based on less than 25 un weighted cases.

Table 8.3a: Percentage of adult's ≥15 years old who noticed cigarette marketing during the last 30 days in various places, by selected demographic characteristics – GATS Uruguay, 2009.

Places	Overall	Gender		Age (years)				Residence	
		Male	Female	15-24	25-44	45-64	65+	Urban	Rural
	Percentage (95% CI)								
Noticed advertisement									
In stores	20.9 (19.1, 22.8)	23.3 (20.8, 25.9)	18.8 (16.7, 21.1)	36.3 (31.8, 41.0)	22.0 (19.3, 25.0)	14.7 (12.3, 17.4)	10.4 (8.8, 12.2)	21.3 (19.4, 23.4)	15.3 (12.9, 18.1)
On television	13.1 (11.5, 14.8)	14.0 (12.1, 16.3)	12.3 (10.4, 14.4)	15.6 (12.4, 19.3)	14.0 (11.8, 16.5)	10.8 (8.6, 13.5)	12.1 (9.6, 15.0)	13.1 (11.5, 15.0)	12.6 (10.4, 15.0)
On the radio	6.2 (5.0, 7.7)	6.9 (5.5, 8.5)	5.6 (4.2, 7.4)	4.1 (2.4, 6.9)	6.2 (4.9, 7.8)	7.0 (5.2, 9.4)	7.4 (5.5, 9.8)	6.0 (4.7, 7.6)	9.0 (7.1, 11.3)
On billboards	13.1 (11.5, 14.9)	14.9 (12.9, 17.0)	11.5 (9.6, 13.7)	19.5 (15.5, 24.2)	13.5 (11.3, 16.1)	12.2 (10.0, 14.7)	6.2 (4.6, 8.3)	13.3 (11.6, 15.2)	10.6 (8.7, 12.8)
On posters	10.5 (9.3, 11.9)	11.7 (10.0, 13.8)	9.4 (8.0, 11.1)	14.7 (11.7, 18.2)	10.6 (8.9, 12.6)	10.7 (8.7, 13.0)	5.3 (3.9, 7.2)	10.7 (9.4, 12.2)	8.1 (6.4, 10.3)
In newspapers or magazines	6.9 (6.0, 7.9)	6.5 (5.4, 7.8)	7.2 (6.0, 8.6)	6.7 (4.6, 9.7)	6.7 (5.4, 8.3)	8.8 (6.9, 11.2)	4.4 (3.3, 5.8)	7.0 (6.0, 8.0)	5.7 (4.4, 7.5)
In cinemas	1.0 (0.7, 1.6)	1.0 (0.6, 1.9)	1.0 (0.6, 1.8)	1.1 (0.4, 2.8)	1.4 (0.8, 2.5)	1.1 (0.5, 2.3)	0.1 (0.0, 0.6)	1.1 (0.7, 1.6)	0.8 (0.4, 1.5)
On the Internet	4.6 (3.8, 5.5)	5.3 (4.0, 6.9)	4.0 (3.1, 5.3)	10.8 (8.2, 14.1)	5.0 (3.7, 6.7)	2.3 (1.4, 3.7)	0.3 (0.1, 1.1)	4.8 (3.9, 5.7)	2.9 (2.0, 4.2)
On public transportation	7.6 (6.3, 9.2)	9.4 (7.6, 11.4)	6.1 (4.7, 7.8)	11.2 (8.2, 15.0)	8.3 (6.6, 10.4)	7.0 (5.2, 9.5)	3.1 (2.2, 4.3)	7.7 (6.3, 9.4)	6.8 (5.3, 8.7)
On public walls	6.7 (5.6, 8.0)	6.8 (5.4, 8.5)	6.6 (5.1, 8.4)	11.3 (8.5, 14.9)	7.3 (5.8, 9.1)	4.5 (3.3, 6.1)	3.4 (2.4, 4.8)	6.7 (5.5, 8.1)	5.9 (4.4, 7.8)
Somewhere else	2.1 (1.6, 2.8)	2.6 (1.9, 3.7)	1.6 (1.1, 2.4)	3.5 (2.2, 5.5)	2.4 (1.6, 3.7)	1.4 (0.8, 2.5)	0.9 (0.5, 1.7)	2.2 (1.6, 2.9)	1.5 (0.8, 2.8)
Noticed sports sponsorship	5.2 (4.3, 6.3)	7.3 (5.9, 9.0)	3.3 (2.5, 4.3)	7.6 (5.2, 11.0)	4.4 (3.4, 5.6)	5.9 (4.2, 8.1)	2.9 (1.8, 4.6)	5.3 (4.3, 6.5)	3.2 (2.3, 4.4)
Noticed cigarette promotions									
Free samples	1.6 (1.2, 2.3)	1.6 (1.0, 2.7)	1.6 (1.1, 2.6)	3.6 (2.1, 6.2)	1.3 (0.8, 2.0)	1.3 (0.8, 2.3)	0.6 (0.2, 1.4)	1.7 (1.2, 2.4)	1.2 (0.8, 1.9)
Sale prices	7.8 (6.6, 9.2)	9.9 (8.2, 11.9)	5.9 (4.7, 7.4)	7.4 (5.3, 10.1)	9.4 (7.4, 11.8)	8.8 (6.9, 11.2)	3.5 (2.4, 5.1)	8.0 (6.7, 9.5)	5.6 (4.0, 7.6)
Free gifts/discounts on other products	0.9 (0.6, 1.3)	0.6 (0.3, 1.2)	1.1 (0.7, 2.0)	1.0 (0.3, 3.0)	0.8 (0.4, 1.6)	1.2 (0.5, 2.6)	0.5 (0.1, 1.8)	0.9 (0.6, 1.4)	0.6 (0.3, 1.2)
Clothing/item with brand name or logo	5.4 (4.6, 6.4)	7.0 (5.7, 8.5)	4.0 (3.2, 5.1)	9.8 (7.4, 12.9)	5.7 (4.4, 7.2)	3.7 (2.7, 5.1)	2.4 (1.6, 3.6)	5.6 (4.7, 6.6)	3.8 (2.8, 5.2)
E-mail promoting cigarettes	1.0 (0.7, 1.5)	1.0 (0.5, 1.7)	1.0 (0.6, 1.8)	3.7 (2.3, 5.9)	0.6 (0.3, 1.2)	0.2 (0.1, 0.7)	0.0 (0.0, 0.0)	1.0 (0.7, 1.5)	0.8 (0.4, 1.4)
Cell phone text messages	0.4 (0.3, 0.7)	0.3 (0.1, 0.8)	0.5 (0.3, 1.0)	1.2 (0.5, 2.7)	0.2 (0.1, 0.5)	0.3 (0.1, 0.7)	0.2 (0.0, 1.0)	0.4 (0.2, 0.7)	0.5 (0.3, 1.1)
Noticed any advertisement, sponsorship, or promotion	44.3 (42.0, 46.5)	49.0 (46.0, 52.0)	40.0 (37.2, 42.8)	61.2 (56.2, 66.0)	45.8 (42.7, 49.0)	38.9 (35.4, 42.5)	29.6 (26.5, 33.0	44.7 (42.3, 47.2)	38.4 (34.7, 42.3)

*Estimate based on less than 25 un weighted cases.

Table 8.3b: Percentage of adults ≥15 years old who noticed cigarette marketing during the last 30 days in various places, by age – GATS Uruguay, 2009.

		Gender		Age (years)				Residence	
Places	**Overall**	**Male**	**Female**	**15-24**	**25-44**	**45-64**	**65+**	**Urban**	**Rural**
				Percentage (95% CI)					
Noticed advertisement									
In stores	26.8 (24.8, 28.9)	29.9 (27.1, 32.8)	24.0 (21.6, 26.5)	40.9 (36.3, 45.6)	28.8 (25.7, 32.1)	22.2 (19.2, 25.6)	13.4 (11.6, 15.4)	27.3 (25.2, 29.6)	19.6 (16.6, 23.0)

*Estimate based on less than 25 un weighted cases. In store consists of three items.

Table 8.4: Percentage of current smokers ≥15 years old who noticed cigarette marketing during the last 30 days in various places, by selected demographic characteristics – GATS Uruguay, 2009.

Places	Overall	Gender		Age (years)		Residence	
		Male	Female	15-24	≥ 25	Urban	Rural
				Percentage (95% CI)			
Noticed advertisements							
In stores	21.2 (18.2, 24.5)	23.9 (19.9, 28.4)	17.4 (13.6, 21.9)	31.1 (24.0, 39.2)	18.7 (15.8, 22.0)	21.3 (18.1, 24.8)	19.9 (15.8, 24.8)
On television	11.8 (9.5, 14.7)	12.8 (9.8, 16.5)	10.4 (7.5, 14.4)	18.2 (13.1, 24.7)	10.2 (8.0, 13.0)	11.6 (9.1, 14.7)	14.4 (10.3, 19.6)
On the radio	5.7 (4.3, 7.6)	7.2 (5.1, 10.0)	3.7 (2.3, 6.0)	4.2 (2.0, 8.8)	6.1 (4.5, 8.3)	5.3 (3.9, 7.3)	11.3 (7.8, 16.0)
On billboards	12.8 (10.4, 15.6)	14.6 (11.5, 18.2)	10.3 (7.3, 14.4)	18.6 (12.6, 26.4)	11.4 (9.0, 14.2)	12.7 (10.2, 15.7)	13.6 (9.7, 18.9)
On posters	11.2 (9.1, 13.7)	12.6 (9.5, 16.5)	9.3 (6.5, 13.1)	14.4 (9.5, 21.1)	10.4 (8.1, 13.2)	11.3 (9.1, 14.0)	9.5 (6.1, 14.5)
In newspapers or magazines	5.9 (4.4, 8.0)	6.4 (4.4, 9.1)	5.4 (3.1, 9.0)	7.8 (3.9, 15.0)	5.5 (4.0, 7.5)	5.9 (4.3, 8.1)	6.2 (3.7, 10.4)
In cinemas	0.7 (0.3, 1.5)	0.6 (0.2, 1.8)	0.9 (0.3, 2.5)	0.7 (0.1, 3.6)	0.7 (0.3, 1.6)	0.7 (0.3, 1.5)	0.6 (0.1, 2.3)
On the Internet	5.0 (3.6, 6.8)	5.3 (3.4, 8.3)	4.5 (2.6, 7.6)	13.3 (8.2, 21.0)	2.9 (1.8, 4.6)	5.1 (3.7, 7.1)	2.9 (1.4, 5.8)
On public transportation	9.0 (6.6, 12.2)	10.8 (7.6, 15.1)	6.5 (4.4, 9.5)	11.3 (6.9, 18.1)	8.4 (6.1, 11.5)	9.2 (6.7, 12.6)	6.0 (3.6, 9.7)
On public walls	7.3 (5.4, 9.8)	8.0 (5.5, 11.6)	6.3 (4.2, 9.3)	11.0 (6.3, 18.4)	6.4 (4.7, 8.5)	7.4 (5.4, 10.1)	5.9 (3.2, 10.5)
Somewhere else	2.2 (1.3, 3.8)	3.0 (1.5, 5.7)	1.2 (0.4, 3.0)	5.1 (2.3, 10.9)	1.5 (0.7, 3.0)	2.3 (1.3, 4.0)	1.1 (0.4, 3.0)
Noticed sports sponsorship	5.6 (4.0, 7.6)	7.5 (5.4, 10.4)	2.8 (1.5, 5.3)	6.4 (3.2, 12.6)	5.4 (3.8, 7.5)	5.6 (4.0, 7.8)	4.5 (2.8, 7.3)
Noticed cigarette promotions							
Free samples	2.7 (1.6, 4.6)	2.8 (1.3, 5.6)	2.7 (1.1, 6.3)	5.6 (2.4, 12.6)	2.0 (1.2, 3.3)	2.7 (1.5, 4.8)	2.9 (1.6, 5.3)
Sale prices	12.7 (10.3, 15.6)	13.7 (10.4, 17.8)	11.3 (8.5, 15.0)	14.0 (8.8, 21.4)	12.4 (9.8, 15.5)	13.1 (10.5, 16.2)	7.9 (5.1, 11.8)
Free gifts/discounts on other products	0.8 (0.3, 1.8)	0.4 (0.1, 1.5)	1.2 (0.4, 3.8)	0.0 (0.0, 0.4)	1.0 (0.4, 2.2)	0.8 (0.3, 1.9)	0.6 (0.1, 3.0)
Clothing/item with brand name or logo	6.7 (5.0, 8.9)	8.1 (5.9, 11.0)	4.6 (2.7, 7.9)	10.0 (5.8, 16.7)	5.8 (4.1, 8.1)	6.8 (5.0, 9.2)	5.2 (2.7, 9.8)
E-mail promoting cigarettes	1.4 (0.7, 2.8)	1.5 (0.5, 3.9)	1.3 (0.5, 3.7)	5.8 (2.6, 12.2)	0.3 (0.1, 1.7)	1.4 (0.6, 3.0)	1.7 (0.6, 4.8)
Cell phone text messages	0.1 (0.0, 0.5)	0.2 (0.0, 0.9)	0.1 (0.0, 0.6)	0.1 (0.0, 0.5)	0.2 (0.0, 0.6)	0.1 (0.0, 0.6)	0.4 (0.1, 1.7)
Noticed any advertisement, sponsorship, or promotion	45.9 (42.5, 49.4)	49.0 (44.2, 53.7)	41.7 (36.7, 46.9)	59.9 (50.5, 68.6)	42.5 (39.1, 45.9)	46.0 (42.3, 49.7)	45.3 (38.8, 52.0)

Note: Current smokers includes daily and occasional (less than daily) smokers.
*Estimate based on less than 25 un weighted cases.

Table 8.4a: Percentage of current smokers ≥15 years old who noticed cigarette marketing during the last 30 days in various places, by selected demographic characteristics – GATS Uruguay, 2009.

			Gender				Age (years)				Residence	
Places	**Overall**		**Male**		**Female**		**15-24**	**25-44**	**45-64**	**65+**	**Urban**	**Rural**
							Percentage (95% CI)					
Noticed advertisements												
In stores	21.2	(18.2, 24.5)	23.9	(19.9, 28.4)	17.4	(13.6, 21.9)	31.1 (24.0, 39.2)	22.4 (18.1, 27.4)	14.7 (10.6, 19.9)	12.4 (6.2, 23.3)	21.3 (18.1, 24.8)	19.9 (15.8, 24.8)
On television	11.8	(9.5, 14.7)	12.8	(9.8, 16.5)	10.4	(7.5, 14.4)	18.2 (13.1, 24.7)	11.5 (8.4, 15.7)	8.6 (5.9, 12.4)	9.4 (4.3, 19.1)	11.6 (9.1, 14.7)	14.4 (10.3, 19.6)
On the radio	5.7	(4.3, 7.6)	7.2	(5.1, 10.0)	3.7	(2.3, 6.0)	4.2 (2.0, 8.8)	5.7 (3.9, 8.4)	6.6 (3.9, 10.9)	6.5 (2.5, 15.6)	5.3 (3.9, 7.3)	11.3 (7.8, 16.0)
On billboards	12.8	(10.4, 15.6)	14.6	(11.5, 18.2)	10.3	(7.3, 14.4)	18.6 (12.6, 26.4)	11.0 (7.9, 15.1)	12.5 (9.1, 16.9)	8.1 (3.4, 17.9)	12.7 (10.2, 15.7)	13.6 (9.7, 18.9)
On posters	11.2	(9.1, 13.7)	12.6	(9.5, 16.5)	9.3	(6.5, 13.1)	14.4 (9.5, 21.1)	11.3 (8.0, 15.6)	9.9 (7.1, 13.6)	6.7 (2.4, 16.9)	11.3 (9.1, 14.0)	9.5 (6.1, 14.5)
In newspapers or magazines	5.9	(4.4, 8.0)	6.4	(4.4, 9.1)	5.4	(3.1, 9.0)	7.8 (3.9, 15.0)	4.0 (2.6, 6.3)	7.9 (4.7, 12.9)	3.1 (0.8, 10.9)	5.9 (4.3, 8.1)	6.2 (3.7, 10.4)
In cinemas	0.7	(0.3, 1.5)	0.6	(0.2, 1.8)	0.9	(0.3, 2.5)	0.7 (0.1, 3.6)	0.9 (0.4, 2.4)	0.5 (0.1, 3.3)	0.0 (0.0, 0.0)	0.7 (0.3, 1.5)	0.6 (0.1, 2.3)
On the Internet	5.0	(3.6, 6.8)	5.3	(3.4, 8.3)	4.5	(2.6, 7.6)	13.3 (8.2, 21.0)	3.5 (2.0, 6.3)	2.5 (1.0, 6.3)	0.0 (0.0, 0.0)	5.1 (3.7, 7.1)	2.9 (1.4, 5.8)
On public transportation	9.0	(6.6, 12.2)	10.8	(7.6, 15.1)	6.5	(4.4, 9.5)	11.3 (6.9, 18.1)	8.3 (5.5, 12.3)	8.0 (5.1, 12.3)	11.4 (5.4, 22.4)	9.2 (6.7, 12.6)	6.0 (3.6, 9.7)
On public walls	7.3	(5.4, 9.8)	8.0	(5.5, 11.6)	6.3	(4.2, 9.3)	11.0 (6.3, 18.4)	8.9 (6.3, 12.4)	3.2 (1.8, 5.8)	4.5 (1.7, 11.7)	7.4 (5.4, 10.1)	5.9 (3.2, 10.5)
Somewhere else	2.2	(1.3, 3.8)	3.0	(1.5, 5.7)	1.2	(0.4, 3.0)	5.1 (2.3, 10.9)	2.1 (0.9, 5.0)	0.7 (0.2, 2.8)	1.4 (0.2, 9.4)	2.3 (1.3, 4.0)	1.1 (0.4, 3.0)
Noticed sports sponsorship	5.6	(4.0, 7.6)	7.5	(5.4, 10.4)	2.8	(1.5, 5.3)	6.4 (3.2, 12.6)	4.4 (2.8, 7.0)	7.3 (4.7, 11.4)	1.5 (0.3, 8.0)	5.6 (4.0, 7.8)	4.5 (2.8, 7.3)
Noticed cigarette promotions												
Free samples	2.7	(1.6, 4.6)	2.8	(1.3, 5.6)	2.7	(1.1, 6.3)	5.6 (2.4, 12.6)	2.3 (1.2, 4.2)	2.0 (0.8, 4.9)	0.0 (0.0, 0.0)	2.7 (1.5, 4.8)	2.9 (1.6, 5.3)
Sale prices	12.7	(10.3, 15.6)	13.7	(10.4, 17.8)	11.3	(8.5, 15.0)	14.0 (8.8, 21.4)	13.8 (10.1, 18.6)	12.0 (8.6, 16.5)	3.8 (1.4, 10.2)	13.1 (10.5, 16.2)	7.9 (5.1, 11.8)
Free gifts/discounts on other products	0.8	(0.3, 1.8)	0.4	(0.1, 1.5)	1.2	(0.4, 3.8)	0.0 (0.0, 0.4)	1.2 (0.4, 3.4)	0.8 (0.2, 3.5)	0.0 (0.0, 0.0)	0.8 (0.3, 1.9)	0.6 (0.1, 3.0)
Clothing/item with brand name or logo	6.7	(5.0, 8.9)	8.1	(5.9, 11.0)	4.6	(2.7, 7.9)	10.0 (5.8, 16.7)	7.1 (4.6, 10.7)	4.5 (2.7, 7.3)	3.4 (0.8, 12.9)	6.8 (5.0, 9.2)	5.2 (2.7, 9.8)
E-mail promoting cigarettes	1.4	(0.7, 2.8)	1.5	(0.5, 3.9)	1.3	(0.5, 3.7)	5.8 (2.6, 12.2)	0.5 (0.1, 3.5)	0.1 (0.0, 0.6)	0.0 (0.0, 0.0)	1.4 (0.6, 3.0)	1.7 (0.6, 4.8)
Cell phone text messages	0.1	(0.0, 0.5)	0.2	(0.0, 0.9)	0.1	(0.0, 0.6)	0.1 (0.0, 0.5)	0.1 (0.0, 0.6)	0.3 (0.1, 1.6)	0.0 (0.0, 0.0)	0.1 (0.0, 0.6)	0.4 (0.1, 1.7)
Noticed any advertisement, sponsorship, or promotion	45.9	(42.5, 49.4)	49.0	(44.2, 53.7)	41.7	(36.7, 46.9)	59.9 (50.5, 68.6)	47.4 (42.4, 52.5)	37.8 (32.4, 43.5)	30.4 (21.0, 41.9)	46.0 (42.3, 49.7)	45.3 (38.8, 52.0)

Note: Current smokers includes daily and occasional (less than daily) smokers.
*Estimate based on less than 25 un weighted cases.

Table 8.5: Percentage of current non-smokers ≥15 years old who noticed cigarette marketing during the last 30 days in various places, by selected demographic characteristics – GATS Uruguay, 2009.

Places	Overall	Gender		Age (years)		Residence	
		Male	Female	15-24	≥ 25	Urban	Rural
				Percentage (95% CI)			
Noticed advertisements							
In stores	20.8 (18.9, 22.8)	23.0 (20.2, 26.0)	19.1 (16.8, 21.7)	38.0 (32.9, 43.4)	16.4 (14.8, 18.3)	21.4 (19.3, 23.5)	13.9 (11.5, 16.7)
On television	13.5 (11.8, 15.5)	14.6 (12.3, 17.2)	12.7 (10.6, 15.2)	14.7 (11.2, 19.2)	13.2 (11.5, 15.2)	13.7 (11.8, 15.8)	12.0 (9.9, 14.5)
On the radio	6.3 (4.9, 8.1)	6.7 (5.1, 8.9)	6.0 (4.4, 8.2)	4.0 (2.3, 7.1)	6.9 (5.5, 8.7)	6.2 (4.7, 8.1)	8.3 (6.4, 10.6)
On billboards	13.2 (11.4, 15.2)	15.0 (12.6, 17.7)	11.8 (9.7, 14.3)	19.8 (14.9, 25.7)	11.5 (9.9, 13.3)	13.5 (11.6, 15.6)	9.6 (7.8, 11.8)
On posters	10.3 (9.0, 11.8)	11.4 (9.4, 13.7)	9.5 (7.8, 11.4)	14.8 (11.3, 19.1)	9.2 (7.9, 10.6)	10.5 (9.1, 12.2)	7.7 (6.0, 9.9)
In newspapers or magazines	7.2 (6.2, 8.4)	6.6 (5.3, 8.2)	7.6 (6.3, 9.2)	6.4 (4.2, 9.6)	7.4 (6.3, 8.6)	7.3 (6.2, 8.6)	5.6 (4.2, 7.3)
In cinemas	1.2 (0.7, 1.8)	1.3 (0.7, 2.3)	1.1 (0.6, 2.0)	1.2 (0.4, 3.3)	1.1 (0.7, 1.9)	1.2 (0.7, 1.9)	0.8 (0.4, 1.7)
On the Internet	4.5 (3.6, 5.6)	5.2 (3.8, 7.1)	3.9 (2.9, 5.4)	9.9 (7.1, 13.8)	3.1 (2.4, 4.1)	4.6 (3.7, 5.8)	2.9 (1.9, 4.3)
On public transportation	7.2 (6.0, 8.6)	8.7 (7.0, 10.8)	6.0 (4.5, 7.9)	11.1 (7.9, 15.4)	6.2 (5.1, 7.5)	7.2 (5.9, 8.8)	7.1 (5.4, 9.3)
On public walls	6.5 (5.3, 7.8)	6.2 (4.8, 8.1)	6.6 (5.1, 8.6)	11.4 (8.1, 15.8)	5.2 (4.3, 6.3)	6.5 (5.3, 8.0)	5.9 (4.4, 7.9)
Somewhere else	2.1 (1.5, 2.8)	2.5 (1.5, 3.9)	1.8 (1.2, 2.7)	3.0 (1.6, 5.5)	1.8 (1.3, 2.6)	2.1 (1.5, 2.9)	1.6 (0.9, 3.1)
Noticed sports sponsorship	5.0 (4.0, 6.4)	7.2 (5.5, 9.3)	3.4 (2.4, 4.7)	8.0 (5.1, 12.3)	4.3 (3.4, 5.5)	5.2 (4.1, 6.7)	2.8 (2.0, 4.0)
Noticed cigarette promotions							
Free samples	1.3 (0.9, 1.9)	1.1 (0.6 , 2.2)	1.4 (0.8, 2.3)	3.0 (1.5, 5.7)	0.8 (0.5, 1.4)	1.3 (0.9, 2.0)	0.7 (0.3, 1.4)
Sale prices	6.2 (5.0, 7.5)	8.2 (6.5, 10.4)	4.6 (3.5, 6.0)	5.2 (3.4, 8.0)	6.4 (5.2, 8.0)	6.3 (5.1, 7.8)	4.9 (3.4, 6.8)
Free gifts/discounts on other products	0.9 (0.5, 1.5)	0.6 (0.2, 1.5)	1.1 (0.6, 2.2)	1.3 (0.4, 3.9)	0.8 (0.4, 1.5)	0.9 (0.5, 1.6)	0.6 (0.3, 1.2)
Clothing/item with brand name or logo	5.0 (4.2, 6.0)	6.5 (4.9, 8.4)	3.9 (3.0, 5.1)	9.7 (7.3, 12.9)	3.8 (3.0, 4.8)	5.1 (4.2, 6.2)	3.4 (2.4, 4.8)
E-mail promoting cigarettes	0.9 (0.5, 1.4)	0.7 (0.4, 1.5)	1.0 (0.5, 1.9)	3.0 (1.6, 5.9)	0.3 (0.2, 0.6)	0.9 (0.5, 1.5)	0.5 (0.2, 1.0)
Cell phone text messages	0.5 (0.3, 0.9)	0.4 (0.1, 1.1)	0.6 (0.3, 1.2)	1.6 (0.7, 3.5)	0.3 (0.1, 0.5)	0.5 (0.3, 1.0)	0.6 (0.2, 1.3)
Noticed any advertisement, sponsorship, or promotion	43.7 (41.2, 46.2)	49.0 (45.8, 52.3)	39.5 (36.4, 42.7)	61.7 (56.7, 66.5)	39.1 (36.6, 41.7)	44.3 (41.6, 47.0)	36.3 (32.6, 40.1)

Note: Current non-smokers includes former and never smokers.
*Estimate based on less than 25 un weighted cases.

Table 8.5a: Percentage of current non-smokers ≥15 years old who noticed cigarette marketing during the last 30 days in various places, by selected demographic characteristics – GATS Uruguay, 2009.

			Gender				Age (years)								Residence			
Places	**Overall**		**Male**		**Female**		**15-24**		**25-44**		**45-64**		**65+**		**Urban**		**Rural**	
	Percentage (95% CI)																	
Noticed advertisements																		
In stores	20.8	(18.9, 22.8)	23.0	(20.2, 26.0)	19.1	(16.8, 21.7)	38.0	(32.9, 43.4)	21.8	(18.9, 25.2)	14.7	(12.0, 17.9)	10.2	(8.6, 12.1)	21.4	(19.3, 23.5)	13.9	(11.5, 16.7)
On television	13.5	(11.8, 15.5)	14.6	(12.3, 17.2)	12.7	(10.6, 15.2)	14.7	(11.2, 19.2)	15.1	(12.5, 18.0)	11.6	(8.7, 15.3)	12.3	(9.7, 15.4)	13.7	(11.8, 15.8)	12.0	(9.9, 14.5)
On the radio	6.3	(4.9, 8.1)	6.7	(5.1, 8.9)	6.0	(4.4, 8.2)	4.0	(2.3, 7.1)	6.4	(4.7, 8.7)	7.2	(4.9, 10.4)	7.4	(5.5, 10.0)	6.2	(4.7, 8.1)	8.3	(6.4, 10.6)
On billboards	13.2	(11.4, 15.2)	15.0	(12.6, 17.7)	11.8	(9.7, 14.3)	19.8	(14.9, 25.7)	14.6	(12.1, 17.5)	12.0	(9.4, 15.3)	6.0	(4.5, 8.1)	13.5	(11.6, 15.6)	9.6	(7.8, 11.8)
On posters	10.3	(9.0, 11.8)	11.4	(9.4, 13.7)	9.5	(7.8, 11.4)	14.8	(11.3, 19.1)	10.3	(8.5, 12.4)	11.0	(8.6, 14.0)	5.2	(3.8, 7.1)	10.5	(9.1, 12.2)	7.7	(6.0, 9.9)
In newspapers or magazines	7.2	(6.2, 8.4)	6.6	(5.3, 8.2)	7.6	(6.3, 9.2)	6.4	(4.2, 9.6)	7.8	(6.1, 10.0)	9.2	(7.1, 11.7)	4.5	(3.4, 6.0)	7.3	(6.2, 8.6)	5.6	(4.2, 7.3)
In cinemas	1.2	(0.7, 1.8)	1.3	(0.7, 2.3)	1.1	(0.6, 2.0)	1.2	(0.4, 3.3)	1.6	(0.8, 3.1)	1.4	(0.6, 3.0)	0.1	(0.0, 0.6)	1.2	(0.7, 1.9)	0.8	(0.4, 1.7)
On the Internet	4.5	(3.6, 5.6)	5.2	(3.8, 7.1)	3.9	(2.9, 5.4)	9.9	(7.1, 13.8)	5.7	(4.1, 7.8)	2.2	(1.3, 3.6)	0.4	(0.1, 1.3)	4.6	(3.7, 5.8)	2.9	(1.9, 4.3)
On public transportation	7.2	(6.0, 8.6)	8.7	(7.0, 10.8)	6.0	(4.5, 7.9)	11.1	(7.9, 15.4)	8.3	(6.6, 10.4)	6.6	(4.5, 9.7)	2.4	(1.6, 3.4)	7.2	(5.9, 8.8)	7.1	(5.4, 9.3)
On public walls	6.5	(5.3, 7.8)	6.2	(4.8, 8.1)	6.6	(5.1, 8.6)	11.4	(8.1, 15.8)	6.6	(5.0, 8.6)	5.0	(3.5, 7.1)	3.3	(2.4, 4.7)	6.5	(5.3, 8.0)	5.9	(4.4, 7.9)
Somewhere else	2.1	(1.5, 2.8)	2.5	(1.5, 3.9)	1.8	(1.2, 2.7)	3.0	(1.6, 5.5)	2.6	(1.5, 4.3)	1.7	(0.9, 3.3)	0.9	(0.4, 1.7)	2.1	(1.5, 2.9)	1.6	(0.9, 3.1)
Noticed sports sponsorship	5.0	(4.0, 6.4)	7.2	(5.5, 9.3)	3.4	(2.4, 4.7)	8.0	(5.1, 12.3)	4.3	(3.1, 6.0)	5.3	(3.4, 8.1)	3.0	(1.9, 4.9)	5.2	(4.1, 6.7)	2.8	(2.0, 4.0)
Noticed cigarette promotions																		
Free samples	1.3	(0.9, 1.9)	1.1	(0.6, 2.2)	1.4	(0.8, 2.3)	3.0	(1.5, 5.7)	0.8	(0.4, 1.6)	1.1	(0.5, 2.1)	0.6	(0.2, 1.5)	1.3	(0.9, 2.0)	0.7	(0.3, 1.4)
Sale prices	6.2	(5.0, 7.5)	8.2	(6.5, 10.4)	4.6	(3.5, 6.0)	5.2	(3.4, 8.0)	7.4	(5.6, 9.8)	7.5	(5.5, 10.3)	3.5	(2.4, 5.2)	6.3	(5.1, 7.8)	4.9	(3.4, 6.8)
Free gifts/discounts on other products	0.9	(0.5, 1.5)	0.6	(0.2, 1.5)	1.1	(0.6, 2.2)	1.3	(0.4, 3.9)	0.6	(0.2, 1.6)	1.3	(0.5, 3.3)	0.5	(0.1, 2.0)	0.9	(0.5, 1.6)	0.6	(0.3, 1.2)
Clothing/item with brand name or logo	5.0	(4.2, 6.0)	6.5	(4.9, 8.4)	3.9	(3.0, 5.1)	9.7	(7.3, 12.9)	5.1	(3.7, 6.8)	3.4	(2.2, 5.2)	2.4	(1.6, 3.5)	5.1	(4.2, 6.2)	3.4	(2.4, 4.8)
E-mail promoting cigarettes	0.9	(0.5, 1.4)	0.7	(0.4, 1.5)	1.0	(0.5, 1.9)	3.0	(1.6, 5.9)	0.6	(0.3, 1.2)	0.3	(0.1, 1.0)	0.0	(0.0, 0.0)	0.9	(0.5, 1.5)	0.5	(0.2, 1.0)
Cell phone text messages	0.5	(0.3, 0.9)	0.4	(0.1, 1.1)	0.6	(0.3, 1.2)	1.6	(0.7, 3.5)	0.3	(0.1, 0.7)	0.2	(0.1, 0.8)	0.2	(0.0, 1.1)	0.5	(0.3, 1.0)	0.6	(0.2, 1.3)
Noticed any advertisement, sponsorship, or promotion	43.7	(41.2, 46.2)	49.0	(45.8, 52.3)	39.5	(36.4, 42.7)	61.7	(56.7, 66.5)	45.1	(41.6, 48.7)	39.3	(35.1, 43.7)	29.6	(26.3, 33.0)	44.3	(41.6, 47.0)	36.3	(32.6, 40.1)

Note: Current non-smokers includes former and never smokers.
*Estimate based on less than 25 un weighted cases.

Table 8.6: Percentage distribution of adults >15 years old who noticed actors smoking on TV, movies or theater in the past 12 months, by selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Adults who saw actors smoking on TV, in movies, or theater[1]			Total
	Very Often	Sometimes	Never	
	Percentage (95% CI)			
Overall	14.9 (13.6, 16.4)	53.4 (51.5, 55.4)	31.6 (29.7, 33.6)	100
Gender				
Male	17.0 (14.8, 19.4)	54.7 (51.9, 57.5)	28.3 (25.9, 30.9)	100
Female	13.1 (11.3, 15.1)	52.3 (49.9, 54.7)	34.6 (32.1, 37.2)	100
Age (years)				
15-24	22.2 (18.4, 26.6)	60.4 (56.1, 64.5)	17.4 (14.2, 21.3)	100
25-44	14.9 (12.9, 17.1)	57.2 (54.3, 60.0)	28.0 (25.5, 30.5)	100
45-64	13.2 (11.1, 15.5)	50.7 (47.3, 54.0)	36.2 (32.9, 39.5)	100
65+	9.3 (7.5, 11.5)	41.9 (38.2, 45.6)	48.8 (45.0, 52.6)	100
Residence				
Urban	15.3 (13.9, 16.9)	53.9 (51.9, 56.0)	30.7 (28.7, 32.8)	100
Rural	10.3 (8.2, 12.9)	47.2 (44.0, 50.4)	42.5 (38.4, 46.6)	100
Education level[2]				
Primary	11.9 (10.1, 13.9)	43.8 (40.9, 46.8)	44.3 (41.3, 47.3)	100
Secondary basic	14.3 (11.3, 17.8)	53.9 (49.5, 58.3)	31.8 (27.7, 36.3)	100
Secondary	14.4 (11.6, 17.7)	61.3 (57.3, 65.1)	24.3 (20.9, 28.1)	100
Tertiary	14.2 (11.1, 17.9)	64.5 (58.6, 69.9)	21.4 (16.3, 27.4)	100

[1] In the past 12 months.
[2] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 9.1: Percentage of adults > 15 years old who believe that smoking causes serious illness, stroke, heart attack, or lung cancer, by smoking status and selected demographic characteristics GATS Uruguay 2009.

Demographic Characteristics	Adults who believe that smoking causes…			
	Serious illness	Stroke	Heart attack	Lung cancer
	Percentage (95% CI)			
Overall	97.6 (97.0, 98.1)	76.5 (74.5, 78.4)	92.0 (90.8, 93.1)	96.8 (96.2, 97.3)
Gender				
Male	97.4 (96.2, 98.2)	75.9 (72.9, 78.6)	92.3 (90.6, 93.8)	96.9 (95.8, 97.7)
Female	97.8 (97.0, 98.4)	77.0 (74.9, 79.1)	91.7 (90.3, 93.0)	96.7 (95.9, 97.4)
Age (years)				
15-24	99.0 (97.5, 99.6)	63.7 (58.0, 68.9)	94.5 (91.6, 96.4)	98.4 (96.9, 99.2)
25-44	98.7 (97.7, 99.3)	77.9 (75.3, 80.4)	93.9 (92.3, 95.2)	98.4 (97.3, 99.1)
45-64	96.1 (94.5, 97.2)	83.1 (80.3, 85.6)	90.8 (88.4, 92.7)	95.6 (94.2, 96.7)
65+	96.1 (94.5, 97.2)	78.1 (75.0, 80.9)	87.3 (85.0, 89.2)	93.5 (91.7, 95.0)
Residence				
Urban	97.6 (97.0, 98.2)	76.4 (74.3, 78.4)	92.1 (90.8, 93.2)	96.9 (96.2, 97.5)
Rural	96.9 (95.7, 97.8)	77.2 (74.1, 80.0)	90.8 (89.0, 92.3)	95.7 (94.3, 96.7)
Education level[1]				
Primary	96.5 (95.3, 97.4)	78.7 (76.3, 81.0)	89.7 (87.7, 91.4)	94.9 (93.6, 95.9)
Secondary basic	97.3 (95.8, 98.2)	77.2 (73.6, 80.4)	93.2 (90.4, 95.1)	98.0 (96.7, 98.8)
Secondary	98.1 (96.6, 99.0)	83.1 (79.0, 86.5)	93.4 (91.1, 95.2)	97.7 (96.4, 98.6)
Tertiary	99.0 (97.4, 99.6)	80.8 (75.3, 85.2)	92.1 (87.6, 95.1)	98.1 (95.8, 99.1)

[1] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 9.2: Percentage of adults > 15 years old who believe that breathing other people´s smoke causes serious illness in non-smokers, by smoking status and selected demographic characteristics. - GATS Uruguay 2009.

Demographic Characteristics	Believe that breathing other people's smoke causes serious illness in non-smokers		
	Overall	Current smokers[1]	Non-smokers[2]
	Percentage (95% CI)		
Overall	93.8 (92.9, 94.5)	91.9 (90.0, 93.5)	94.4 (93.3, 95.2)
Gender			
Male	93.2 (91.7, 94.4)	91.7 (88.8, 93.8)	93.9 (92.1, 95.2)
Female	94.3 (93.1, 95.3)	92.3 (89.2, 94.5)	94.8 (93.5, 95.8)
Age (years)			
15-24	94.3 (91.6, 96.2)	97.5 (92.9, 99.2)	93.2 (89.7, 95.6)
25-44	96.5 (95.2, 97.4)	95.9 (93.4, 97.5)	96.7 (95.0, 97.9)
45-64	91.2 (89.2, 92.8)	85.2 (80.3, 89.1)	93.6 (91.3, 95.3)
65+	91.6 (89.7, 93.2)	78.9 (67.5, 87.1)	92.7 (90.8, 94.3)
Residence			
Urban	93.7 (92.8, 94.6)	91.9 (89.8, 93.6)	94.3 (93.2, 95.3)
Rural	94.2 (92.8, 95.3)	92.3 (89.6, 94.4)	94.7 (93.0, 96.0)
Education level[3]			
Primary	93.3 (91.9, 94.4)	90.4 (87.1, 93.0)	94.3 (92.9, 95.4)
Secondary basic	94.9 (93.0, 96.3)	92.3 (88.0, 95.2)	95.9 (93.5, 97.4)
Secondary	93.0 (90.0, 95.2)	88.3 (81.7, 92.7)	94.5 (9 0.9, 96.7)
Tertiary	94.8 (92.1, 96.6)	93.4 (86.3, 96.9)	95.1 (92.1, 97.0)

[1] Includes daily and occasional (less than daily) smokers
[2] Includes former and never smokers.
[3] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

Table 9.3: Awareness of harm of cigarette types among those adults >15 years old who believe that smoking causes serious illness, by selected demographic characteristics - GATS Uruguay 2009.

	Adults[1] who are unaware that…					
Demographic Characteristics	**Light, ultralight, or mild cigarettes are as harmful as regular cigarettes**			**Mentholated cigarettes are as harmful as regular cigarettes**		
	Overall	**Current smokers[2]**	**Non-smokers[3]**	**Overall**	**Current smokers[2]**	**Non-smokers[3]**
	Percentage (95% CI)					
Overall	19.2 (17.4, 21.1)	16.3 (13.6, 19.3)	20.1 (18.2, 22.2)	20.3 (18.6, 22.0)	18.6 (15.7, 22.0)	20.8 (19.0, 22.8)
Gender						
Male	19.3 (16.9, 22.0)	17.6 (14.1, 21.7)	20.1 (17.2, 23.2)	19.9 (17.4, 22.7)	18.8 (14.8, 23.6)	20.4 (17.6, 23.5)
Female	19.1 (17.1, 21.2)	14.4 (11.1, 18.5)	20.2 (18.0, 22.5)	20.6 (18.7, 22.7)	18.4 (14.8, 22.6)	21.1 (18.8, 23.6)
Age (years)						
15-24	17.2 (13.9, 21.0)	11.5 (6.8, 18.6)	19.1 (15.1, 23.7)	15.9 (12.6, 19.9)	11.5 (6.1, 20.7)	17.4 (13.8, 21.7)
25-44	13.5 (1 1.4, 16.0)	13.9 (10.6, 18.1)	13.4 (11.2, 15.9)	16.8 (14.7, 19.2)	18.8 (14.5, 23.9)	16.0 (13.7, 18.6)
45-64	20.3 (17.4, 23.4)	20.0 (15.3, 25.6)	20.4 (17.2, 24.0)	20.4 (17.8, 23.3)	21.2 (16.3, 27.1)	20.1 (17.0, 23.5)
65+	31.9 (28.5, 35.4)	34.0 (23.6, 46.3)	31.7 (28.2, 35.4)	32.7 (29.3, 36.4)	31.2 (21.7, 42.5)	32.8 (29.2, 36.7)
Residence						
Urban	18.7 (16.9, 20.8)	15.9 (13.1, 19.2)	19.7 (17.6, 21.9)	19.7 (18.0, 21.6)	18.2 (15.1, 21.8)	20.2 (18.3, 22.3)
Rural	25.0 (21.9, 28.3)	21.0 (17.1, 25.5)	26.1 (22.7, 29.9)	27.7 (24.2, 31.3)	24.7 (19.7, 30.4)	28.5 (24.7, 32.7)
Education level[4]						
Primary	24.6 (21.8, 27.6)	19.4 (15.3, 24.2)	26.3 (23.3, 29.6)	27.9 (25.3, 30.7)	23.9 (19.2, 29.5)	29.2 (26.4, 32.2)
Secondary basic	14.6 (12.1, 17.5)	9.7 (6.0, 15.5)	16.5 (13.3, 20.1)	16.5 (13.7, 19.8)	13.5 (9.6, 18.8)	17.7 (14.1, 22.0)
Secondary	15.7 (12.4, 19.8)	23.1 (15.7, 32.6)	13.6 (10.5, 17.5)	15.3 (12.3, 18.8)	23.2 (15.7, 32.8)	13.0 (9.9, 16.9)
Tertiary	13.9 (10.5, 18.1)	9.5 (4.3, 19.8)	15.0 (11.4, 19.4)	12.2 (9.0, 16.4)	8.5 (3.7, 18.7)	13.2 (9.6, 17.8)

[1] Among those who believe that smoking causes serious illness.
[2] Includes daily and occasional (less than daily) smokers.
[3] Includes former and never smokers.
[4] Education level is reported only among respondents 25+ years old.

Table 9.3a: Awareness fo harm of cigarette types among those adults >15 years old who believe that smoking causes serious illness, by selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Adults[1] who are unaware that... Light, ultralight, mild or menthol cigarettes are as harmful as regular cigarettes		
	Overall	Current smokers[2]	Non-smokers[3]
	Percentage (95% CI)		
Overall	24.7 (22.8, 26.7)	23.5 (20.1, 27.2)	25.1 (23.0, 27.2)
Gender			
Male	25.0 (22.2, 28.0)	25.0 (20.5, 30.1)	25.0 (21.8, 28.4)
Female	24.4 (22.2, 26.8)	21.4 (17.2, 26.2)	25.2 (22.7, 27.8)
Age (years)			
15-24	21.3 (17.4, 25.7)	16.9 (10.3, 26.6)	22.7 (18.4, 27.8)
25-44	20.5 (18.0, 23.2)	23.1 (18.4, 28.6)	19.4 (16.7, 22.3)
45-64	24.6 (21.5, 28.0)	25.6 (20.4, 31.6)	24.2 (20.7, 28.1)
65+	37.8 (34.2, 41.7)	41.5 (30.8, 53.0)	37.5 (33.7, 41.5)
Residence			
Urban	24.1 (22.1, 26.3)	23.1 (19.5, 27.1)	24.5 (22.3, 26.8)
Rural	31.9 (28.2, 35.8)	29.3 (24.2, 34.8)	32.6 (28.5, 37.0)
Education level[4]			
Primary	32.1 (29.2, 35.1)	28.3 (22.9, 34.4)	33.3 (30.3, 36.5)
Secondary basic	19.9 (16.9, 23.3)	18.1 (12.8, 24.9)	20.6 (16.7, 25.1)
Secondary	20.1 (16.4, 24.4)	29.9 (21.3, 40.1)	17.3 (13.6, 21.8)
Tertiary	16.0 (12.4, 20.4)	10.0 (4.7, 20.2)	17.6 (13.8, 22.0)

[1] Among those who believe that smoking causes serious illness.
[2] Includes daily and occasional (less than daily) smokers.
[3] Includes former and never smokers.
[4] Education level is reported only among respondents 25+ years old.

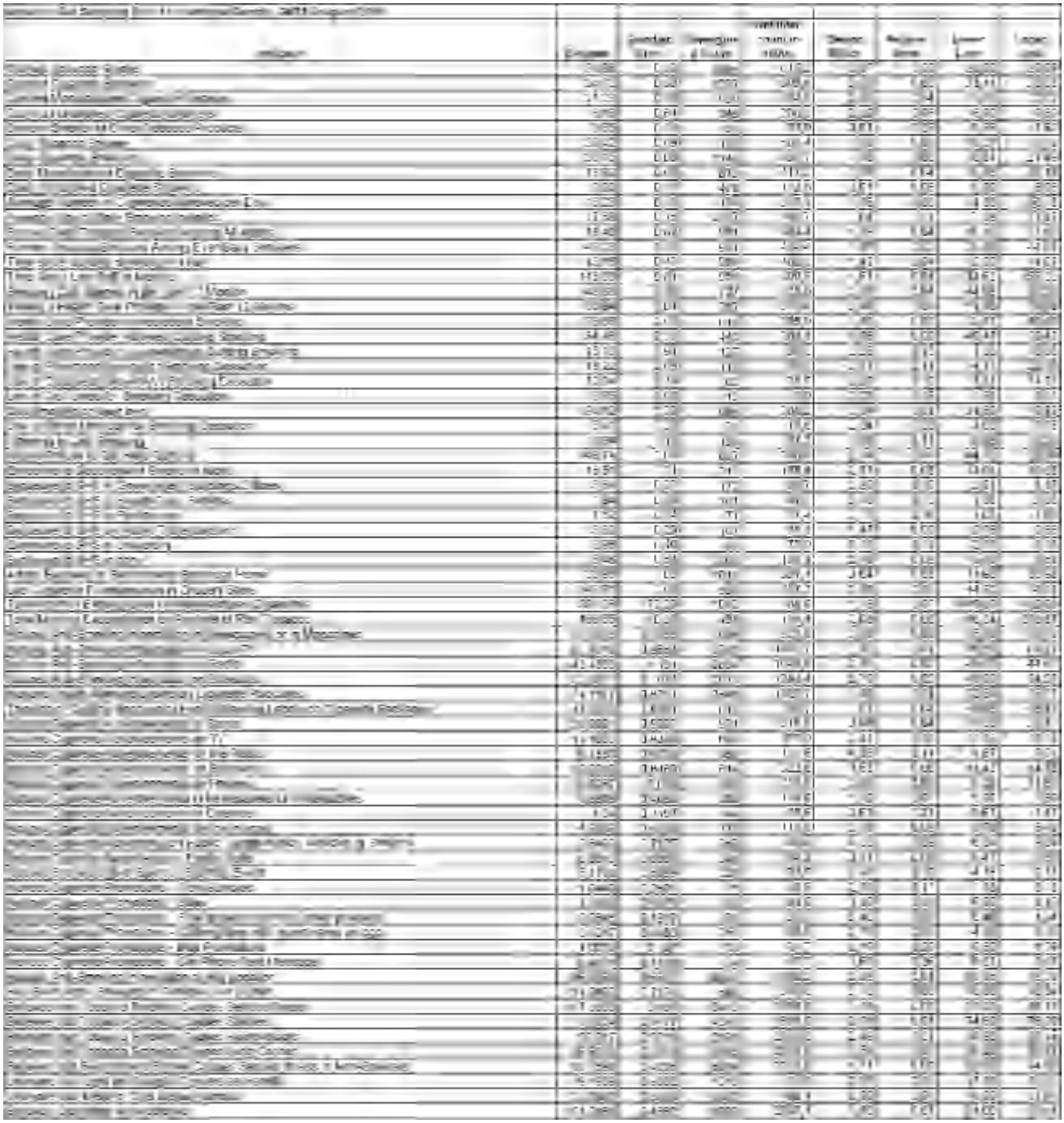
Table 9.4: Percentage of adults > 15 years old who believe cigarettes are addictive, by selected demographic characteristics - GATS Uruguay 2009.

Demographic Characteristics	Believe that cigarettes are addictive		
	Overall	Current smokers[1]	Non-smokers[2]
	Percentage (95% CI)		
Overall	92.0 (90.9, 92.9)	91.1 (89.1, 92.8)	92.2 (91.0, 93.3)
Gender			
Male	90.6 (88.9, 92.0)	89.5 (86.2, 92.1)	91.1 (89.1, 92.7)
Female	93.2 (91.8, 94.4)	93.4 (91.0, 95.2)	93.1 (91.4, 94.5)
Age (years)			
15-24	94.9 (92.8, 96.4)	96.2 (92.6, 98.1)	94.4 (91.7, 96.3)
25-44	93.0 (91.1, 94.5)	91.8 (88.3, 94.3)	93.6 (91.2, 95.4)
45-64	91.0 (89.0, 92.7)	89.1 (85.4, 92.0)	91.8 (89.4, 93.7)
65+	87.8 (85.2, 90.0)	79.7 (69.7, 87.0)	88.5 (85.8, 90.8)
Residence			
Urban	92.3 (91.2, 93.2)	91.8 (89.6, 93.6)	92.4 (91.1, 93.5)
Rural	88.0 (86.0, 89.7)	82.1 (77.7, 85.8)	89.8 (87.6, 91.6)
Education level[3]			
Primary	88.1 (86.3, 89.8)	87.6 (83.2, 90.9)	88.3 (86.2, 90.2)
Secondary basic	92.0 (89.4, 94.0)	89.1 (83.7, 92.8)	93.2 (90.0, 95.4)
Secondary	95.3 (93.1, 96.8)	94.7 (90.1, 97.3)	95.4 (92.7, 97.2)
Tertiary	95.6 (92.5, 97.5)	92.6 (82.9, 97.0)	96.4 (93.0, 98.2)

[1] Includes daily and occasional (less than daily) smokers
[2] Includes former and never smokers.
[3] Education level is reported only among respondents 25+ years old.
*Estimate based on less than 25 un weighted cases.

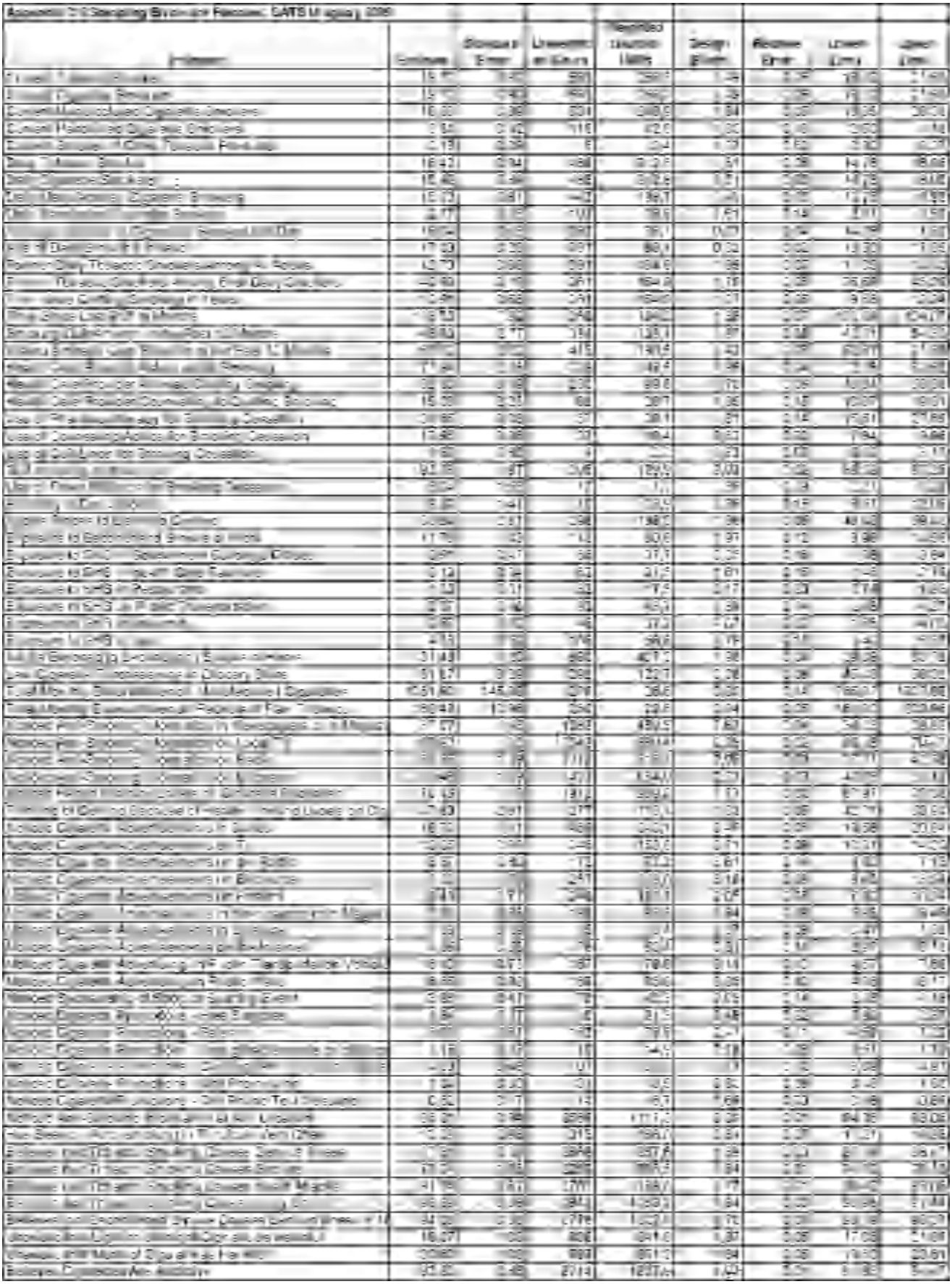
ANNEX D
Sampling Errors

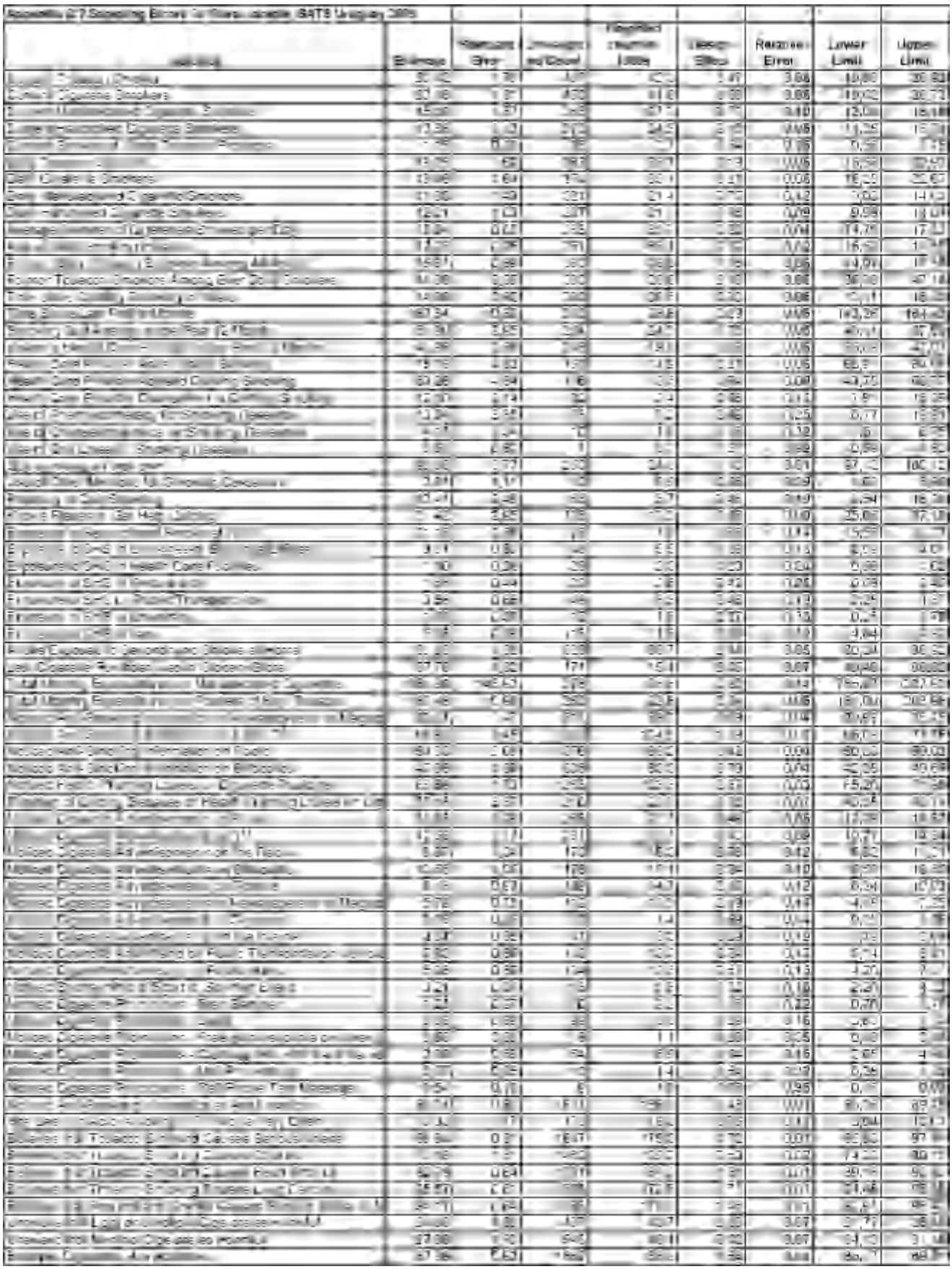
Appendix D.1 List of Indicators for Sampling Errors, GATS Uruguay 2009		
Indicator	Estimate	Base Population
Current Tobacco Smokers	Proportion	Adults ≥ 15 years old
Current Cigarette Smokers	Proportion	Adults ≥ 15 years old
Current Manufactured Cigarette Smokers	Proportion	Adults ≥ 15 years old
Current Handrolled Cigarette Smokers	Proportion	Adults ≥ 15 years old
Current Smokers of Other Tobacco Products	Proportion	Adults ≥ 15 years old
Daily Tobacco Smokers	Proportion	Adults ≥ 15 years old
Daily Cigarette Smokers	Proportion	Adults ≥ 15 years old
Daily Manufactured Cigarette Smokers	Proportion	Adults ≥ 15 years old
Daily Handrolled Cigarette Smokers	Proportion	Adults ≥ 15 years old
Average Number of Cigarettes Smoked per Day	Mean	Current smokers ≥ 15 years old
Age at Daily Smoking Initiation	Mean	Ever daily smokers ≥ 15 years old
Former Daily Tobacco Smokers Among All Adults	Proportion	[illegible]
Former Tobacco Smokers Among Ever Daily Smokers	Proportion	Adults ≥ 15 years old
Time since Quitting Smoking (in Years)	Mean	Former daily smokers ≥ 15 years old
Time Since Last Puff in Months	Mean	Former daily smokers ≥ 15 years old
[illegible] in the Past 12 Months	Proportion	Current Tobacco Users ≥ 15 years old
Visited a Health Care Provider in the Past 12 Months	Proportion	Adults ≥ 15 years old
Health Care Provider Asked about Smoking	Proportion	Current Tobacco Users ≥ 15 years old
Health Care Provider Advised Quitting Smoking	Proportion	Current Tobacco Users ≥ 15 years old
Health Care Provider Counseling on Quitting Smoking	Proportion	Current Tobacco Users ≥ 15 years old
Use of Pharmacotherapy for Smoking Cessation	Proportion	Current smokers ≥ 15 years old who made Quit Attempt in the Past 12 Months
Use of Counseling/Advice for Smoking Cessation	Proportion	Current smokers ≥ 15 years old who made Quit Attempt in the Past 12 Months
Use a Quit Line for Smoking Cessation	Proportion	Current smokers ≥ 15 years old who made Quit Attempt in the Past 12 Months
[illegible]	Proportion	Current smokers ≥ 15 years old who made Quit Attempt in the Past 12 Months
Use of Other Method for Smoking Cessation	Proportion	Current smokers ≥ 15 years old who made Quit Attempt in the Past 12 Months
Planning to Quit Smoking	Proportion	Current Smokers ≥ 15 years old
[illegible] Help Line	Proportion	Current smokers ≥ 15 years old
Exposure to Secondhand Smoke at Home	Proportion	Adults ≥ 15 years old
Exposure to SHS in Government Buildings/Offices	Proportion	Adults ≥ 15 years old
Exposure to SHS in Health Care Facilities	Proportion	Adults ≥ 15 years old
Exposure to SHS in Restaurants	Proportion	Adults ≥ 15 years old
Exposure to SHS in Public Transportation	Proportion	Adults ≥ 15 years old
Exposure to SHS in University	Proportion	Adults ≥ 15 years old
Exposure to SHS in Bars	Proportion	Adults ≥ 15 years old
Adults Exposed to Secondhand Smoke at [illegible]	Proportion	Adults ≥ 15 years old
Last Cigarette Purchase was in Grocery Store	Proportion	Current manufactured cigarette smokers ≥ 15 years old
Total Monthly Expenditures on Manufactured Cigarettes	Proportion	Current manufactured cigarette smokers ≥ 15 years old
Total Monthly Expenditures on Packets of [illegible]	Proportion	Current handrolled cigarette smokers ≥ 15 years old
Noticed Anti-Smoking Information at Newspapers or Magazines	Proportion	Adults ≥ 15 years old
Noticed Anti-Smoking Information on Television	Proportion	Adults ≥ 15 years old
Noticed Anti-Smoking Information on Radio	Proportion	Adults ≥ 15 years old
Noticed Anti-Smoking Information on Billboards	Proportion	Adults ≥ 15 years old
Noticed Health Warning Labels on Cigarette Packages	Proportion	Adults ≥ 15 years old
Thinking of Quitting Because of Health Warning Labels on Cigarette Packages	Proportion	Adults ≥ 15 years old
Noticed Cigarette Advertisements in Stores	Proportion	Adults ≥ 15 years old
Noticed Cigarette Advertisements on TV	Proportion	Adults ≥ 15 years old
Noticed Cigarette Advertisements on the Radio	Proportion	Adults ≥ 15 years old
Noticed Cigarette Advertisements on Billboards	Proportion	Adults ≥ 15 years old
Noticed Cigarette Advertisements on Posters	Proportion	Adults ≥ 15 years old
Noticed Cigarette Advertisements in Newspapers or Magazines	Proportion	Adults ≥ 15 years old
Noticed Cigarette Advertisements in Cinemas	Proportion	Adults ≥ 15 years old
Noticed Cigarette Advertisements on the Internet	Proportion	Adults ≥ 15 years old
Noticed Cigarette Advertising on public transportation vehicles or stations	Proportion	Adults ≥ 15 years old
Noticed Cigarette Advertising on Public walls	Proportion	Adults ≥ 15 years old
Noticed Sponsorship of Sport or Sporting Event	Proportion	Adults ≥ 15 years old
Noticed Cigarette Promotion – Free Samples	Proportion	Adults ≥ 15 years old
Noticed Cigarette Promotion – Sales	Proportion	Adults ≥ 15 years old
Noticed Cigarette Promotion – Free gifts/discounts on other products	Proportion	Adults ≥ 15 years old
Noticed Cigarette Promotion – Clothing/item with brand name or logo	Proportion	Adults ≥ 15 years old
Noticed Cigarette Promotion – Mail Promotions	Proportion	Adults ≥ 15 years old
Noticed Cigarette Promotion – Cell Phone Text Message	Proportion	Adults ≥ 15 years old
Noticed Cigarette Promotion on the Internet	Proportion	Adults ≥ 15 years old
Has seen [illegible] smoking in TV Movies Very Often	Proportion	Adults ≥ 15 years old
Believes that Tobacco Smoking Causes Serious Illness	Proportion	Adults ≥ 15 years old
Believes that Tobacco Smoking Causes Stroke	Proportion	Adults ≥ 15 years old
Believes that Tobacco Smoking Causes Heart Attack	Proportion	Adults ≥ 15 years old
Believes that Tobacco Smoking Causes Lung Cancer	Proportion	Adults ≥ 15 years old
Believes that Secondhand Smoke Causes Serious Illness in Non-Smokers	Proportion	Adults ≥ 15 years old
Unaware that Light or Ultralight Cigs are less harmful	Proportion	Adults ≥ 15 years old
Unaware that Menthol Cigs are [illegible]	Proportion	Adults ≥ 15 years old
Believes Cigarettes Are Addictive	Proportion	Adults ≥ 15 years old



Appendix B.7 Sampling Errors for Males, GATS Uruguay 2009

Indicator	Estimate	Standard Error	Unweighted Count	Weighted Count in 1000s	Design Effect	Relative Error	Lower Limit	Upper Limit
Current Tobacco Smoker	30.72	[illegible]	911	368.8	2.18	[illegible]	[illegible]	[illegible]
Current Cigarette Smoker	30.21	[illegible]	796	[illegible]	2.06	[illegible]	[illegible]	[illegible]
Current Manufactured Cigarette Smoker	[illegible]	[illegible]	550	[illegible]	1.69	[illegible]	[illegible]	[illegible]
Current Hand-rolled Cigarette Smoker	11.46	[illegible]	430	157.4	[illegible]	[illegible]	[illegible]	[illegible]
Current Smoker of Other Tobacco Products	[illegible]	0.48	31	19.6	2.90	[illegible]	[illegible]	[illegible]
Daily Tobacco Smoker	[illegible]	[illegible]	677	280.6	2.09	[illegible]	[illegible]	[illegible]
Daily Cigarette Smoker	[illegible]	[illegible]	658	271.8	2.18	[illegible]	[illegible]	[illegible]
Daily Manufactured Cigarette Smoker	18.88	[illegible]	436	215.4	[illegible]	[illegible]	[illegible]	[illegible]
Daily Hand-rolled Cigarette Smoker	11.08	[illegible]	375	128.8	2.30	[illegible]	[illegible]	[illegible]
Average Number of Cigarettes Smoked per Day	17.16	[illegible]	677	268.8	[illegible]	[illegible]	[illegible]	[illegible]
Age at Daily Smoking Initiation	[illegible]	[illegible]	341	259.5	[illegible]	[illegible]	[illegible]	[illegible]
Percent Daily Tobacco Smokers Among Smokers	30.48	[illegible]	600	239.9	1.65	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	600	239.8	[illegible]	[illegible]	[illegible]	[illegible]
Time since Quitting Smoking in Years	14.70	[illegible]	596	237.4	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	596	228.4	[illegible]	[illegible]	[illegible]	[illegible]
Smoking Quit Attempt in the Past 12 Months	49.18	2.04	403	185.8	1.31	[illegible]	[illegible]	[illegible]
Visited a Health Care Provider in the Past 12 Months	17.56	[illegible]	[illegible]	162.9	[illegible]	[illegible]	[illegible]	[illegible]
Health Care Provider Asked About Smoking	[illegible]	[illegible]	356	137.4	[illegible]	[illegible]	[illegible]	[illegible]
Health Care Provider Advised Quitting Smoking	58.71	[illegible]	213	108.7	1.76	[illegible]	[illegible]	[illegible]
[illegible]	15.18	2.74	56	27.6	2.14	[illegible]	[illegible]	[illegible]
[illegible]	16.65	[illegible]	57	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.84	[illegible]	[illegible]	[illegible]
[illegible]	3.03	[illegible]	8	8.6	2.32	[illegible]	[illegible]	[illegible]
[illegible]	94.68	[illegible]	386	[illegible]	2.71	[illegible]	[illegible]	[illegible]
Use of Other Methods for Smoking Cessation	[illegible]	[illegible]	10	[illegible]	2.32	[illegible]	[illegible]	[illegible]
[illegible]	12.76	[illegible]	64	42.4	2.16	[illegible]	[illegible]	[illegible]
[illegible]	45.04	2.09	305	181.8	2.30	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	304	169.8	2.31	[illegible]	[illegible]	[illegible]
Exposure to SHS in Government Buildings/Offices	[illegible]	2.50	106	52.0	1.67	[illegible]	[illegible]	[illegible]
Exposure to SHS in Health Care Facilities	[illegible]	[illegible]	[illegible]	20.4	2.67	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	99	9.8	[illegible]	[illegible]	[illegible]	[illegible]
Exposure to SHS on Public Transportation	3.27	[illegible]	[illegible]	37.0	[illegible]	[illegible]	[illegible]	4.00
[illegible]	1.78	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	3.78	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	47.86	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	144.6	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	447.4	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Noticed Anti-Smoking Information on Radio	49.34	1.67	[illegible]	500.2	2.62	[illegible]	[illegible]	[illegible]
[illegible]	50.81	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Noticed Health Warning Labels on Cigarette Packages	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Noticed Cigarette Advertisements in Stores	[illegible]	[illegible]	312	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Noticed Cigarette Advertisements on TV	14.04	[illegible]	245	[illegible]	3.40	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Noticed Cigarette Advertisements in Newspapers or in Magazines	3.53	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Noticed Cigarette Advertisements on the Internet	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	196	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Noticed Cigarette Advertising on Public Walls	3.06	[illegible]	160	[illegible]	2.39	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	131	[illegible]	[illegible]	[illegible]	[illegible]	5.80
Noticed Cigarette Promotions: Free Samples	[illegible]	[illegible]	[illegible]	[illegible]	2.62	[illegible]	[illegible]	[illegible]
Noticed Cigarette Promotions: Sale Prices	3.40	[illegible]	107	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	11	6.6	[illegible]	[illegible]	[illegible]	[illegible]
Noticed Cigarette Promotions: Clothing/Item with Brand Name	[illegible]	[illegible]	44	21.5	2.01	[illegible]	[illegible]	[illegible]
Noticed Cigarette Promotions: Mail Promotions	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Noticed Cigarette Promotions: Cell Phone Text Message	[illegible]	[illegible]	10	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	371	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Believes that Tobacco Smoking Causes Serious Illness	[illegible]	[illegible]	2560	[illegible]	2.46	[illegible]	[illegible]	[illegible]
Believes that Tobacco Smoking Causes Stroke	[illegible]	[illegible]	[illegible]	[illegible]	2.04	[illegible]	[illegible]	[illegible]
Believes that Tobacco Smoking Causes Heart Attack	[illegible]	[illegible]	[illegible]	[illegible]	2.37	[illegible]	[illegible]	[illegible]
Believes that Tobacco Smoking Causes Lung Cancer	96.81	[illegible]	[illegible]	[illegible]	2.04	[illegible]	[illegible]	[illegible]
Believes that Secondhand Smoke Causes Serious Illness in Non-Smokers	[illegible]	[illegible]	2160	1069.6	2.35	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	2.71	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	2.52	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.37	[illegible]	[illegible]	[illegible]





ANNEX E
Health Warnings, 2009

ANNEX E – Health warnings 2009

ANNEX F
Glossary

Anti-tobacco Information	Messages issued through various media in order to inform the population about the damage caused by the consumption of tobacco and tobacco smoke exposure as well as about the benefits of quitting.
Basic cycle of High School or UTU	The first level of middle education. It is mandatory. It promotes the practical domain of different disciplines
Carton of cigarettes	Packaging containing 10 box of cigarettes. A carton is equivalent to 200 cigarettes.
Chopped tobacco	Loose tobacco used to make hand-rolled cigarettes
Counseling for smoking cessation	Includes both aid received in a specialized cessation service, and aid received in the normal visit of any health service. Orientation in a specialized cessation service implies behavioral and/or pharmacological support. Orientation in a health service means any guide or provision of strategies provided by a health worker, to help smokers stop consumption.
Current smoker	Person who currently smoke some tobacco product regularly, either daily or occasional.
Daily smoker	Person who smoke at least one product of tobacco daily or almost daily, for a period of one month or more. Short periods of time in which the person do not smoke due to special circumstances, such as illness, does not invalidate the daily smoker concept.
Employer	Person who exploits its own economic enterprise and is responsible for one or more workers on salary or wages.
Enclosed space	Are defined according to tobacco control legislation currently in force, as "those physical units bounded on its perimeter and its height by walls and ceiling" It is indifferent the material with which these enclosures are constructed, if they are temporary or permanent, and if they possess separate doors, windows and ventilation. In the case of external spaces in a building, if they have a ceiling, shall be considered closed space if the lateral enclosure exceeds 50% of the roofing perimeter.
Ex-smoker	Person that previously consumed some tobacco product regularly, either daily or occasionally, and currently does not smoke, regardless of the time which has elapsed since he/she quit smoking. For the purposes of the GATS survey - Uruguay, it was also investigated the percentage of ex-smokers with a year of sustained abstinence (without having even one puff).
Hand-rolled cigarettes	Cigarettes are made manually, winding a leave of paper or rolling papers with loose tobacco in its interior.
Health care facility	Any facility belonging to the public or private system, in which some type of health service is provided, which includes, among others: medical care, dental, psychological, nursing, etc

Health worker	Workers of different disciplines that can be part of a health team. Includes doctors, dentists, nurses, psychologists and nutritionists, among others.
Naco	Tobacco leaf twisted into a rope which is then spread with molasses. The rope or roll thus formed is chopped with a knife and rolled into a cigarette with paper or a leaf of corn.
Never smoker	Person that never smoked; he/she can have tested smoking but has smoked less than 100 cigarettes in his/her life
No formal schooling	People who do not attend or attended a formal education Institute and do not read or write.
Non-smoker	Person that doesn't currently smoke. Includes never-smoked and ex-smokers.
Occasional smoker	Person who smoke at least one product of tobacco on a regular basis, but not daily.
Place where to get aid to stop smoking	Anywhere, whether public or private, which provides guidance and strategies to help smokers to quit.
Postgraduate	Specific studies of high specialization. Requirement is to have university degree. Quaternary education.
Public building or office	Government building or dependence.
Public transport	Any means of land, sea or air transportation, of public use.
Quit line to stop smoking	Telephone service provided by specially trained staff that provides strategies for smokers to quit smoking. There are 2 methods: reactive, in which the smoker call for guidance, and proactive, in which a preset number of calls are scheduled and that a trained operator will perform to the smoker weekly.
Secondary Baccalaureate	Middle education with a greater degree of guidance and specialization than Basic Cycle of High School. It has 3 modalities: 1 - general education aimed at continuity with tertiary education, 2 - technological and 3 - the technical-professional. Is requirement to have approved the basic cycle of High School and the completion of this Secondary Baccalaureate enables tertiary studies.
Secondhand tobacco smoke	It is tobacco smoke found in the environmental. Is a mixture of the smoke that exhales a smoker and the smoke from a lit tobacco product between puff and puff.
Self-employed with investment or facility	Person that without having a boss, exploits his/her own economic business without hiring any paid worker and may be assisted by one or more unpaid family workers. Has some installation or necessary investment (offices, profession, machinery, etc.) for the development of his/her activity.
Self-employed without investment or facility	Person that without having a boss, exploits their own economic business without hiring any paid worker and may be assisted by one or more unpaid family workers. In this case, do not have investment or facilities considered relevant to

	the development of his/her activity
Smokeless tobacco	Tobacco product which does not emit smoke. Includes tobacco to be chewed sucked, insufflated or "snuffed" through the nose or any other product of tobacco than is not smoked.
Social employment program	Transitional jobs created within the framework of State social programs aimed at low resources population.
Special primary school	Aimed at people with different capacities like intellectual difficulties. These are specialized education centers to provide basic education to this population.
Specialized smoking cessation service	Any service which provides behavioral and/or pharmacological support to quit smoking, that may be located in a health care facility or not, as in workplaces, schools, or others.
Standard primary education	Includes six years of compulsory education oriented to provide education in oral and written expression and reasoning
Starting age	Age in full years that a person begins to use some tobacco products on a regular basis. The initial period in which the person consumes tobacco in experimental form is not considered.
Technical education	Include schools in specialties of the armed forces (mechanics, radio-operators, etc), Don Bosco Institutes, Institute of education in construction and all basic professional training courses. Not necessarily requires complete primary education and does not enable to attend high school or University.
Tertiary education, not University	Deepens and expands training in any branch of knowledge, and includes scientific, technical and technological education. Requirement is to have completed Secondary Baccalaureate. Includes Center of industrial design, Military School, Naval Academy, School of Aeronautics, Technicians of public and private universities, etc. Careers are usually 3 years or less.
Unemployed, able to work and seeking for a job	Person of working age, not working, and carrying out specific activities to find a job.
Unemployed, unable to work and not seeking for a job	Person of working age, not working, not looking for a job and that do not have permanent health problems or physical disabilities.
Unemployed, unable to work	Person of working age, doesn't work, not seeking for a job and have permanent health problems or disabilities that prevent him/her from performing those tasks.
Unpaid member of the household	Person who works in the company or business of a member of his/her household and does not perceive a wage monetary or in-kind by his/her work.
UTU (Work University of Uruguay) Technical Baccalaureate	Middle education with a greater degree of guidance and specialization. It aims to introduce students to the world of work. Is requirement to have approved the basic cycle of High School or UTU and approval enables tertiary studies.
Water pipe	Device where tobacco sits, which also has a water receptacle and a long tube by which is inhaled the tobacco smoke. It can be used individually or in group. Sometimes combines tobacco consumption with alcohol in the same apparatus.

ANNEX G
Fact Sheet Uruguay, 2009

GATS Objectives

The Global Adult Tobacco Survey (GATS) is the global standard for systematically monitoring adult tobacco use (smoking and smokeless) and tracking key tobacco control indicators.

GATS is a nationally representative survey, using a consistent and standard protocol across countries including Uruguay. GATS enhances countries' capacity to design, implement and evaluate tobacco control programs. It will also assist countries to fulfill their obligations under the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) to generate comparable data within and across countries. The WHO has developed MPOWER, a technical assistance package of six evidence-based policies that include:

mpower

Monitor tobacco use and prevention policies
Protect people from tobacco smoke
Offer help to quit tobacco use
Warn about the dangers of tobacco
Enforce bans on tobacco advertising, promotion, and sponsorship
Raise taxes on tobacco

GATS Methodology

GATS uses a global standardized methodology. It includes information on respondents background characteristics, tobacco use (smoking and smokeless), cessation, second-hand smoke, economics, media, and knowledge, attitudes and perceptions towards tobacco use. In Uruguay, GATS was conducted in 2009 as a household survey of persons 15 years of age and older by the National Statistics Institute (INE). A multi-stage, geographically clustered sample design was used to produce nationally representative data. One individual was randomly chosen from each selected household to participate in the survey. Survey information was collected using handheld devices. The household response rate was 97.0%, the person response rate was 98.5% and the overall response rate was 95.6%. There were a total of 5581 completed interviews.

GATS Highlights

Tobacco Use

- In Uruguay, 25.0% of people age 15 years and older, 30.7% of men and 19.8% of women, currently smoke tobacco.

Cessation

- Nearly 9 in 10 current smokers plan to, or are thinking about quitting.

Second-hand Smoke

- 16.5% of adults are exposed to tobacco smoke at the workplace.
- 29.2% of adults are exposed to tobacco smoke at home at least weekly.

Media

- 44.6% of current smokers thought about quitting because of a warning label.
- Nearly 3 in 10 adults have noticed cigarette marketing in stores where cigarettes are sold.

Knowledge, Attitudes and Perceptions

- 97.6% of adults believe smoking causes serious illness.
- 1 in 4 adults are unaware that light, ultralight or menthol brand cigarettes are as harmful as regular cigarettes.

Global Adult Tobacco Survey (GATS)

Fact Sheet
Uruguay 2009

Tobacco Use

TOBACCO SMOKERS

Economics

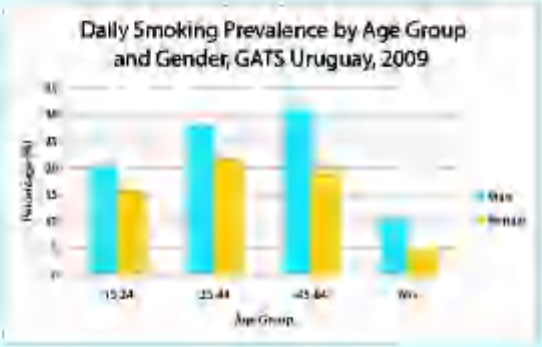
Media

TOBACCO INDUSTRY ADVERTISING

COUNTER ADVERTISING

Knowledge, Attitudes and Perceptions

Daily Smoking Prevalence by Age Group and Gender, GATS Uruguay, 2009



Cessation

Second-hand Smoke

GATS
Uruguay '09

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