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GLOBAL ADULT TOBACCO SURVEY

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ROMANIA 2011

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Foreword

According to the World Health Organization (WHO), almost 6 million people die from tobacco use each year, either from direct use or from exposure to secondhand smoke. It is estimated that by 2020 this number will increase to 7.5 million and that tobacco will cause 10% of all deaths.

Smoking is closely associated with severe conditions such as cancer, pulmonary disease, and heart disease, and it causes about 70% of all lung cancers, about 40% of chronic respiratory disease, and 10% of cardiovascular disease. But tobacco is more than just a health scourge, as it impoverishes many of those who use it while putting enormous financial burdens on countries around the world. At the national level the costs of tobacco use encompass increased expenditures for health care, lost productivity due to illness and early death, and environmental damage. In the frightening framework of this epidemic, surveillance appears to be essential to control, as good monitoring may track the size and character of this phenomenon and indicate the best policies to be adopted.

Smoking behavior is strongly related to certain socioeconomic factors, affecting mostly the low-income countries and those nations in economic transition, like Romania. Lowering the prevalence of smoking is an important way to reduce the health and social costs of tobacco in both the medium and long term.

In Romania, smoking cigarettes represents one of the most socially accepted health-risk behaviors; the problem is of great concern because of the high prevalence of this habit among adults and young people. According to the Romania Reproductive Health Survey 1999, the estimated prevalence of smoking at that time was 54% among males and 39% females (from 1989 to 1999 the prevalence among females increased dramatically, from 11% to 39%).

The most recent statistics indicate that in Romania smoking kills over 33,000 persons annually, 70% of them between the ages of 35 and 69 years. One out of four deaths occurring before age 35 is caused by smoking-related disease. On average, smokers who die prematurely could have lived 21 years more by giving up this habit.

In 2005, Romania ratified the WHO Framework Convention on Tobacco Control (FCTC). Important legislative measures implemented since the ratification indicate that Romania is active in the fight against smoking. The measures include counseling for smoking cessation, the establishment of toll-free telephone lines (quit lines), providing access to recommended drugs at an affordable price, implementing a tax increase to discourage tobacco consumption, and introducing pictorial health warnings.

In 1999, WHO, the US Centers for Disease Control and Prevention (CDC), and the Canadian Public Health Association (CPHA) began the development of the GTSS, the Global Tobacco Surveillance System, which is aimed at enhancing the capacity of countries to design, implement, and evaluate tobacco control interventions and to monitor compliance with key articles of the WHO FCTC and components of the WHO MPOWER technical package.

In the WHO European Region, GATS was conducted in Turkey in 2008, Poland and Russian Federation in 2009, and Ukraine in 2010. Romania is therefore the fifth country in the region to participate in GATS.

The Romanian Ministry of Health includes tobacco control and the prevention of tobacco use among the very important public health priorities for the country. Having GATS conducted in Romania in 2011 has been an important element in the national tobacco control and prevention policies.

GATS offers very reliable data related to smoking behaviors among Romanian adults, giving us a good idea of the dimension and characteristics of tobacco consumption in this country. At the same time, it enables us to make comparative analyses on the same indicators with all other countries in which GATS was implemented.

GATS 2011 represents an important baseline for comparisons in future years. By repeating the GATS every 3-5 years, we will have an effective tool to measure over time the impact of the policies and programs developed for tobacco control and prevention. In the next few years, additional legislative and political measures will allow the extension of antismoking and smoking cessation programs. Their impact, as reflected in attitudinal and behavioral changes among Romanian adults, can be measured more effectively using the GATS; moreover, the impact of the measures taken in our country can also be compared with the impact that other public health measures might have in countries that use the same surveillance system.

In the end, all these efforts will represent actual years of life gained for Romanian citizens. We are looking forward with enthusiasm, and we are convinced that the declining trend in smoking will continue in the upcoming years. We thank all the people who made this possible through their continuous hard work. Let us all have a healthier and longer life in a smoke-free environment!

Dr. Ladislau Ritli
Minister of Health

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The Global Adult Tobacco Survey (GATS) in Romania represented a collective effort focused on obtaining high-quality results. The whole process was implemented by a team of dedicated people who shared a passion about their work – and this was an important driver to the success of the project and the very good results we obtained. All the people and all the institutions involved in this project deserve our gratitude and thanks.

We express our deepest gratitude to Bloomberg Philanthropies for its valuable support in conducting GATS in our country. We thank CDC Foundation for providing modern electronic equipment for data collection.

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Finally, we express our thanks and gratitude to the 4,601 respondents in GATS Romania and to all the local institutions that offered their support to the field interviewers' teams.

Dr. Amalia Fechete
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and Control in Public Health

Executive Summary

1. Methodology

The Global Adult Tobacco Survey (GATS), conducted in Romania in 2011, was a nationally representative household survey of tobacco use among men and women aged 15 years or older.

Using a standardized questionnaire, sample design, and data collection and management procedures, the survey was designed to produce internationally comparable data on tobacco use and tobacco control measures. A two-phase sampling for GATS Romania was conducted in which a subsample of primary sampling units (PSUs) was selected from the Master Sample EMZOT (Multifunctional Sample on Territorial Areas). The final selection probability of the sample units was equivalent to that of being selected under three-stage stratified cluster sampling in order to produce key indicators for the country as a whole as well as by residence (urban or rural) and by gender. Of the 5,629 sampled households, 4,601 completely filled in the household interview, and the computed household response rate was 89.9%. The household response rate was higher in rural areas than in urban areas (95.8% and 85.6%, respectively). Among individuals selected from the completely screened households, 4,517 completed the individual interview, and the computed person-level response rate was 98.4%. The total response rate was 88.5%.

GATS Romania provided information on tobacco use, cessation, exposure to secondhand smoke, economics, media, and knowledge, attitudes, and perceptions regarding tobacco use. The data were collected electronically using handheld computer devices (Hewlett-Packard iPAQ®).

GATS Romania was implemented under the supervision of the Ministry of Health through three agencies: National Institute of Public Health (NIPH), which was the agency nominated by the Ministry of Health to implement GATS in Romania, the National Statistical Training Center (NSTC), and Totem Communications (TC).

Technical assistance was provided by the US Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), including the WHO Country Office in Romania, and the Johns Hopkins Bloomberg School of Public Health. Financial support for the survey was provided by Bloomberg Philanthropies within the Bloomberg Initiative to Reduce Tobacco Use.

2. Key Results

Tobacco Use

The overall prevalence rate of current smoking was 26.7% (4.85 million). Prevalence was much higher among men than women (37.4% vs. 16.7%).

Almost one-fourth (24.3%) of persons aged 15 years or more were daily smokers (34.9% of males and 14.5% of females), and an additional 2.4% were occasional smokers (2.5% of males and 2.2% of females).

By age, the overall prevalence rate of current smoking of any tobacco products was highest among people aged 25-44 years (36.3%) and lowest among those aged 65 or older (7.6%). It was slightly higher for urban dwellers (28.4%) than rural residents (24.5%) but this difference was not statistically significant; overall prevalence did not differ by educational level. Among males, the lowest prevalence was among those with high education (36.4%), while among females, prevalence rates were highest among those with secondary and high education (19.6% and 20.0%, respectively) and lowest among those with only a primary education (14.7%).

The main type of smoked tobacco product used was manufactured cigarettes (overall: 26.5%; males: 37.1%; females: 16.7%), and the average number of cigarettes smoked per day among daily cigarette smokers was 16.6 overall, 17.7 for males, and 14.1 for females.

The overall prevalence for smoking other tobacco products was 1.0%, with urban dwellers more likely than rural residents (1.5% vs. 0.3%) to use these products.

Three of seven smokers (43.1%) initiated their daily smoking habit at age 17-19, with 21.7% beginning at age 15 or 16 and 18.1% at over 20. Of the 17.1% who started their daily smoking habit before age 15 the majority were from rural areas. In all, among daily smokers, 69.5% had their first smoke within the first 30 minutes after awakening, out of these 26.2% had their first smoke within first 5 minutes after awakening.

Cessation

Of current and former tobacco smokers (i.e., former smokers who had been abstinent less than 12 months) combined, 35.5% had made an attempt to quit in the previous 12 months. This proportion was 34.2% among males and 38.2% among females. More than two-fifths of smokers aged 15-24 years (41.0%) had tried to quit in the last 12 months, with this rate declining by increasing age. Proportions of trying to quit in the past 12 months were 33.6% for urban residents and 38.3% for those in rural areas; no differences were noted by educational level.

Among smokers who had visited a health care professional (HCP) during the previous 12 months, 82.1% had been asked by the HCP about their history of tobacco smoking and 81.9% had received advice to quit smoking. The rate of getting advice from the HCP was 80.8% among male smokers and 83.7% among female smokers. The proportion of those receiving advice to quit smoking ranged from 91.0% among smokers aged 65+ to 62.9% among smokers aged 15-24. Most of those who tried to quit (80.8%) tried to do so without assistance. Only 8.2% used nicotine replacement therapy; 1.4%, another prescribed medication; 1.7%, counseling and advice; 6.8% used natural plant products, acupuncture, or other methods for quitting.

The lowest percentage of trying to quit without assistance (62.6%) and the highest percentages for using nicotine replacement therapy (16.4%), another prescription medication (2.7%), and counseling/advice (2.8%) were found among those addicted to nicotine (judged by having their first smoke within 5 minutes after waking).

Overall, 39.2% of current smokers planned to quit or were thinking about quitting sometime in the future ("Will quit some day, but not in the next 12 months"), 15.6% within next 12 months, and only 7.9% within the next month. In contrast, essentially one-third of current smokers (33.6%) were not interested in quitting. Of this group, almost two-fifths (39.2%) did not think that smoking was bad for their health and 38.3% did not think they could quit. No differences were noted by gender, location (urban versus rural) or educational level in attitudes toward quitting smoking.

Exposure to Secondhand Smoke

More than a third (35.4%) of persons aged 15 or above (representing about 6.4 million people) had been exposed in the last 30 days to secondhand smoke (SHS) at home. Among nonsmokers, the prevalence of exposure to SHS at home was 24.4% (equivalent to about 3.2 million nonsmokers). People living in urban areas (40.9%) were significantly more likely to have such exposure than were rural residents (28.5%).

Among nonsmokers, exposure to SHS at home decreased with greater age, with the highest rate of exposure among those aged 15-24 years (38.6%) and the lowest rate among those aged 65 or above (14.7%).

Just about one-third (34.2% of workers, representing nearly 2 million people) had been exposed to SHS at work during the previous 30 days. Among nonsmoking workers only, this prevalence was 29.2% (equivalent to about 1.1 million nonsmoking workers). Among all workers, significant differences were not seen by gender (males, 36.8%;

females, 31.2%). Those with a college education or above (30.0%) were less likely to have such exposure at work than were those with less education (primary education, 39.9%; secondary education, 33.9%). For those employed in indoor workplaces, the pattern of exposure was similar for nonsmoking workers. Those with a college education or above (23.2%) were less likely to be exposed at work than were those with less education (primary education, 39.7%; secondary education, 29.8%).

Just over one-fifth of persons aged 15 or above (20.7%) had noticed smoking in government buildings, 1 in 10 (10.4%) in health care facilities, one-fourth (25.1%) in schools, and almost half (47.5%) in universities. Of smokers who had visited various public places in the last 30 days, the vast majority had been exposed to SHS in bars/nightclubs (94.4%) and in restaurants (86.6%). The pattern was similar for nonsmokers.

Economics

The five most frequently purchased brands were Kent (33.8%), Marlboro (9.7%), Winchester (8.2%), Viceroy (7.6%), and Winston (7.0%). The most common source was a store (84.3%), followed by kiosks (6.6%) and street vendors (3.5%). Very few smokers of manufactured cigarettes purchased them from another person (2.7%) or from other sources (2.7%). On average, a current smoker of manufactured cigarettes spent 273.1 RON per month (around 90 USD) on cigarettes.

Media

Most (83.6%) persons aged 15 years or above had noticed antismoking information broadcast through the media or displayed in a public place. Such information was seen on television by 76.7% of adults and on billboards (25.8%) and radio (25.3%) less frequently.

Almost all current smokers (95.2%) had noticed pictorial health warnings on cigarette packs and over one-fourth (27.5%) had thought about quitting smoking because of these warnings. More female (33.2%) than male (24.7%) smokers had thought about quitting because of these warning labels.

An estimated 40.5% of people aged 15 years or above had noticed some kind of tobacco advertising, sponsorship, or promotions. Men (45.2%), those in the 15-24 age group (58.8%) and those living in urban areas (50.4%) were more likely to have noticed any tobacco advertisement, sponsorship, or promotion than women (36.1%), those 25 and older (37.1%), and rural residents (28.0%), respectively. Overall, the percentage of adults who had noticed such media was highest for stores (26.7%), followed by the Internet (6.8%) and on public walls (4.9%).

Those living in urban areas were more exposed than rural residents to tobacco advertisements on the Internet (9.4% vs. 3.6%). Those aged 15-24 years were significantly more likely to notice tobacco advertisements on the Internet (16.9%) than were those aged 25 or older (5.0%). Among all adults, the percentage who had noticed sport sponsorships by tobacco companies was just 5.0%.

As for cigarette promotions, free gifts/discounts were the most common (8.1%), followed by “promotional girl” (7.0%), items with a brand name or logo (5.2%), free samples (4.4%), sale prices (4.0%), coupons (4.0%), and mail that promoted cigarettes (1.2%).

Knowledge, Attitudes, and Perceptions

Almost all adults (96.3%) believed that smoking causes serious diseases and illnesses. 98.3% believed that smoking causes lung cancer and 94.6% believed it causes other cancers, 89.2% believed that smoking causes stroke and 90.0%, heart attack. Smaller percentages of the population were aware that smoking causes bone loss (53.4%), premature birth (74.7%), and erectile dysfunction (66.5%). No significant differences in these beliefs were noted across age groups, by educational level, or by residence. Awareness of the health effects of smoking differed very little between current smokers and the population as a whole.

The great majority of adults (94.2%) believed that breathing SHS could cause serious illnesses in nonsmokers. Current smokers (90.7%) were less likely than nonsmokers (95.4%) to believe this.

Men did not differ from women in terms of awareness of health effects of SHS (93.5% vs. 94.8%).

Approximately one-fifth (21.0%) of adults believed that low tar-cigarettes are less harmful than regular cigarettes, with a significantly higher percentage of persons in the youngest age group, 15-24 (30.6%), believing this than persons in the other age groups. A higher percentage of males (24.9%) than females (17.4%) had this belief.

Almost one-fifth (18.9%) of adults believed that "slim" cigarettes are less harmful than regular cigarettes, current smokers (30.1%) being significantly more likely than nonsmokers (14.8%) to believe this. This pattern of current smokers versus nonsmokers was similar across age groups and by residence and educational level. By age, the highest percentage of current smokers believing that slim cigarettes are less harmful was noted for the youngest group 15-24 (41.3%) and the lowest (23.8%) for the oldest group (65 and over).

3. Implications for Public Health Policy

GATS Romania 2011 provides key indicators on tobacco use and the tobacco control situation in Romania. Using this valuable information, policy makers and experts in tobacco control can tailor the most effective interventions. These interventions can be efficiently implemented by using the WHO FCTC guidelines and the WHO MPOWER package:

- **Monitor tobacco use and prevention policies (Article 20 of the WHO FCTC)**. Strengthen the monitoring system to gather key tobacco-control–related indicators. Implement GATS, either by regularly repeating the survey or by including the GATS core questions in other ongoing surveys.
- **Protect people from tobacco smoke (Article 8 of the WHO FCTC)**. Despite positive changes in trends for tobacco smoking in Romania, the level of exposure to tobacco smoke, both active and passive, remains high. Exposure in the workplace is higher among those with lower levels of education, contributing to a level of social inequity. Romania should seek to enforce and complement the existing tobacco control legislation by banning smoking in all public places, including restaurants, bars, and clubs. Public support favors this step.
- **Offer help to quit tobacco use (Article 14 of the WHO FCTC)**. Strengthen existing cessation services at clinics by training health care professionals in counseling skills; expand cessation services and integrate these services into primary health care facilities. Tobacco companies should be required to prominently present cessation-oriented messages on all cigarette packages and at points of sale, and they should provide telephone numbers of "quit lines" that smokers can call for advice about quitting.
- **Warn about the dangers of tobacco (Article 11 of the WHO FCTC)**. Enhance communication campaigns carried out through antitobacco counteradvertising in the mass media, health education, and through schools, community groups, and health care providers to describe the health hazards of smoking. Campaigns should also target highly educated females, and they should inform the public that using tobacco can lead to bone loss, premature birth, and erectile dysfunction.
- **Enforce bans on tobacco advertising, promotion, and sponsorship (Article 13 of the WHO FCTC)**. GATS Romania found that well over one-third of adults had noticed some kind of advertising, sponsorship, or promotion of tobacco products, pointing to the necessity of adopting new regulations targeting the elimination of these ways of promoting tobacco use from the market.
- **Raise taxes on tobacco (Article 6 of the WHO FCTC)**.Taxation of tobacco products has been raised according to the European Union's (EU's) requirements. However, there remains a need to substantially increase cigarette prices to bring them up to the average price level in the EU.

1. Introduction

1.1 Global Burden of Tobacco

Tobacco use is well recognized as the most preventable cause of death worldwide, and yet 1 in 10 deaths among adults is attributable to the use of tobacco [1]. There are currently 1.1 billion smokers in the world, and if current trends are maintained, this number is expected to increase to 1.6 billion by the year 2030 [2].

The European Region of the World Health Organization (WHO), although it has only 15% of the world's population, bears nearly one-third of the worldwide burden of tobacco-related disease. The prevalence of smoking in this region, while it has fallen from 45% to 30% over the past 30 years and has recently stabilized, remains at a devastating level for the public's health and the health of future generations [3].

The WHO Tobacco Free Initiative (TFI) aims to reduce the global burden of disease and death caused by tobacco, and international efforts led by WHO have resulted in the rapid adoption of the WHO Framework Convention on Tobacco Control (WHO FCTC), which is the foundation stone in the global fight against the tobacco epidemic [4]. Parties to the WHO FCTC have committed themselves to protecting the health of their populations by joining this fight. The FCTC encourages countries to adhere to the FCTC's principles, and the TFI program supports countries in their efforts to implement tobacco control measures through MPOWER, an integral part of the WHO Action Plan for the Prevention and Control of Non-Communicable Diseases. In this context, monitoring the tobacco epidemic using an efficient surveillance system is an essential component of a comprehensive tobacco control program [5].

In August 2006, WHO and the US Centers for Disease Control and Prevention (CDC) convened a group of tobacco control experts to discuss the surveillance of adult tobacco use and to make recommendations for developing a standard survey protocol. During this consultation, the experts recognized the challenges of limited funding and methodological complexities when conducting systematic adult tobacco surveys and identified a lack of comparability between current national surveys on tobacco use.

The Bloomberg Initiative to Reduce Tobacco Use offered resources to fill the data gap for measuring adult tobacco use globally and to optimize the reach and results of the ongoing Global Tobacco Surveillance System (GTSS), a joint initiative of CDC and WHO [5]. GTSS originally comprised three school-based surveys for youth and selected adult populations: the Global Youth Tobacco Survey (GYTS), the Global School Personnel Survey (GSPS), and the Global Health Professions Students Survey (GHPSS).

A new survey, the Global Adult Tobacco Survey (GATS), was launched in February 2007 as part of the GTSS. The GATS enables countries to collect data on key tobacco control measures in the adult population, and the results assist countries in formulating, tracking, and implementing effective tobacco control interventions while offering them the possibility of comparing their results with those from other countries implementing GATS.

1.2 National Characteristics of Romania

Romania is located at the crossroads of Central and Southeastern Europe in the North of the Balkan Peninsula. The country borders the Black Sea and shares borders with Hungary and Serbia to the West, Ukraine and the Republic of Moldova to the Northeast, and Bulgaria to the South.

At 238,391 square kilometers (92,043 square miles), Romania is the ninth-largest country in the European Union (EU) and has the seventh-largest

population, with 21.4 million people. The capital, Bucharest, is the largest city in Romania and the sixth-largest city in the EU, with about two million inhabitants. Romania has nine historical regions, Banat, Bucovina, Crisana, Dobrogea, Maramures, Muntenia, Moldavia, Oltenia, and Transylvania, divided into 41 counties plus the capital of Bucharest, 262 towns, 2,686 communes, and 13,149 villages. At the local level the administrative authority is exercised by an official representing central government.

The total population of Romania at the beginning of 2010, according to the National Institute of Statistics, was 21.4 million, with 84.8% of the population aged 15 years or above [6]. In all, 51.3% of the total population was female and 48.7% male [6]. According to the National Institute of Statistics [6], the main causes of death in 2010 were cardiovascular diseases, followed by cancers and then road traffic accidents. Life expectancy at birth is 69.8 years for males and 77.4 years for females [7].

Key public health challenges in Romania include cardiovascular disease, cancer, road traffic accidents, and obesity. An unhealthy lifestyle, including smoking, consuming alcoholic drinks, bad nutrition, and a lack of exercise, have contributed over time to an increase in the risk for chronic diseases, which impose a huge burden on the health care system.

1.3 Burden of Tobacco Use in Romania

1.3.1 Cigarette Sales and Consumption

Romania, an Eastern European country, was Communist from 1947 to 1989; in 2007 it became a member state of the EU. After the change in political regime in 1989 there was an invasion of tobacco multinationals, which replaced the local tobacco industry, and in the absence of regulations to control the use of tobacco its consumption in Romania increased dramatically. In 2002, tobacco control policies in the country changed markedly to align national legislation with the requirements of the EU. Outside of price changes the toughest changes in policy took effect in January 2009, with the following measures becoming effective:

- Stricter provisions for smoking in closed public spaces. Smoking in public places is not totally banned, but the rules for smoking areas have become stricter and the penalties more significant.
- Pictorial health warnings on all tobacco products intended for smoking. These warnings on cigarettes packages became effective in July 2008, and in 2009 the measure was extended.
- The surface of the warnings was better defined, resulting in a slight increase in this surface.
- Uniform reporting of the ingredients used in the manufacture of tobacco products and uniform disclosure of those products, employing the format recommended by the European Commission. Romania is part of the EMTOC (Electronic Model Tobacco Control) project, which provides for electronic submission of tobacco constituents.
- Tougher penalties for breaking the law.
- Extended ban on the advertising of tobacco products. The most visible measure was the ban on outdoor advertising and on advertising in cinema, theatre, and concert halls.

In January 2010, the price of tobacco products increased sharply, for two reasons: (a) an increase in excise taxes, and (b) an increase in the exchange rate for the EURO-RON, Romania's currency. Following the road map established by the European Commission regarding the taxation of tobacco products, in 2010 the largest-ever (by percentage) increase in the excise tax was put into place.

In Romania the methodology used to measure the epidemiological and economical indices of tobacco use and its consequences have varied over time, thereby affecting the comparability of data. Beginning in 2004, however, the country implemented the EU reporting system and the WHO recommendations, and thus data became both comparable and accurate.

In 1989, 784 cigarettes were consumed per person; in 2002 this figure had almost doubled [8]. According to the first WHO Tobacco Atlas, however, in 2001

the number of cigarettes consumed per person was 1,676 [9], and thus the 2002 estimate would represent a substantial 1-year decline if the figures can be compared directly. In 2009 the estimate was 1,480 [10], slightly higher than the 2002 figure.

Total sales of cigarettes evolved in a similar fashion: the number of cigarettes released on the market grew from 18,190 million in 1990 [8] to a peak in 2006 of 41,025 million. In 2007, a decreasing trend began, with total sales of cigarettes declining progressively to 31,258 million in 2009 [11] and then to just 20,784 million in 2010 [11]. The decreases, however, reflect both lower consumption and increased smuggling.

In Romania the illegal trade of cigarettes is favored by geographical conditions (the country has land borders with non-EU countries in which the price of tobacco products is much lower) and by local economic and political conditions. Smuggling increased significantly in 2010 because of tax hikes reflecting a combination of increased VAT (value-added tax), the increased excise tax, and increased EURO–RON exchange rates. Although there are no officially published estimates for the proportion of cigarettes smuggled, studies carried out for the tobacco industry estimate that illegal sales accounted for more than 30% of the total market in the first months of 2010. However, because of the intensive actions of the custom and fiscal authorities, the illegal market decreased to 24% of cigarettes sold by the end of 2010 [12] and in August 2011 approached 14%, a level comparable to that of other countries [12]. The most heavily sold tobacco product on the Romanian market is manufactured cigarettes, while products like cigars, cigarillos, and similar items represent less than 1% of total tobacco products purchased [13]. In the last few years, however, these products have been viewed as a symbol of luxury, wealth, the privilege of "the trend setters." Use of the water pipe has some traditional roots in the country, having been brought to Romania by Turkish elite in the 18th and 19th centuries, and its use has increased in the last few years. Smoking a water pipe is perceived as "less harmful" or as an exotic leisure activity by many Romanians. Devices to "roll your own" cigarettes are not commonly sold in this country. Oral tobacco products do not have a tradition here because of the ban required by the European Tobacco Products Directive; their use has not grown in the last 20 years. Some tobacco growers would roll tobacco leaves in paper and smoke them, or chew the leaves, but as the land devoted to tobacco has almost disappeared, these practices have largely faded away.

1.3.2 Tobacco Smoking Among Adults

Until 2004, when a methodology based on WHO recommendations was implemented, the prevalence of tobacco use was only sporadically analyzed in nationwide studies of health status. During the Communist period and in the beginning of the 1990s, prevalence was estimated by the Ministry of Health (Centre for Medical Statistics and Medical Documentation) using random samples of the adult population. In 1989, an estimated 25.9% of Romanian adults overall were smokers, but only 11.3% of women smoked daily. In 1994, a study conducted by the Centre for Medical Statistics and Medical Documentation that used the same methodology found that 28% of the general adult population and 15.2% of women smoked daily; the percentage of smokers among men decreased slightly from 1990 to 2002, from 43.9% to 42.7% [14]. Surveys conducted by the ERC Statistic International [8] found an overall upward trend, with total prevalence rising from 28.5% in 1995 to 36.1% in 2000. The rate for females increased from 15.2% to 25%, while prevalence for males rose from 42.7% to 48%.

In 2000, the National Institute of Statistics noted in a survey [15] for monitoring the health status of the population that 20.8% of the population aged 15 years or over smoked. Only 10.1% of women were daily smokers, according to this report.

In 2004, Romania's Centre for Health Policies and Studies published the results of a survey [16] about the knowledge, attitudes, and behaviors of Romanian adults (14–60 years old) using the WHO recommendations: the prevalence of smokers (daily or occasional) was 35.3%, with a prevalence of 29.7% for daily smoking (19.5% for females).

A report of the Eurobarometer entitled *"Attitudes of Europeans towards Tobacco"* that was published in 2007 [17] noted a total prevalence of 31% for Romanian adults. A survey performed in the following year by the National Institute of Pneumology Marius Nasta, however, [18], found a total smoking prevalence of 36.1% for the population aged 15 or over, with a prevalence for females of 25%. The prevalence of daily smoking was 30.9%, surpassing the figure of 29.7% for 2004. In a study using the same methodology performed 1 year later, in 2009 [19], the overall prevalence of smoking was 32.4% and that of daily smoking, 27.9%. For the first time in a 20-year period the prevalence of female smokers decreased, to 21.9%.

According to WHO estimates [20], in 2009 the age- and gender-standardized prevalence of daily smoking among Romanian adults was 29%. However, the Eurobarometer "Opinion & Social, Tobacco" published in 2010 [21] noted an overall smoking prevalence of 30%, just one percentage point higher than the 29% for daily smoking in the WHO estimate.

The most recent study [13] showed a significant reduction in smoking prevalence, down to 26.0%. The highest prevalence of daily smoking was observed among men aged 25–34 years in both 2003 (48.3%) and 2009 (53.8%). Among women, the highest prevalence of daily smoking in 2003 was for those aged 25–34 years (23.3%); in 2009 it was highest among those aged 45–54 years (34.2%), the prevalence of daily smoking was the highest in the middle- and higher-education groups (29.2% and 29.9%, respectively) and in urban areas (30.1%).

1.3.3 Smoking Among Youth

The European Study Program for Alcohol and Drugs (ESPAD), conducted in 2004 by the Institute of Health Services Management and County Departments for Health Promotion and Health Education [22] found that an alarming 64% of 16-year-old students had ever smoked. The ESPAD 2007, however, found that this figure had gone down to 54% [23].

National rounds of the GYTS were conducted in 2004 and 2009; in Romania the GYTS obtained data on the prevalence of using cigarettes and other tobacco products as well as information on five determinants of tobacco use: access/availability and price, exposure to secondhand smoke (SHS), cessation, media and advertising, and the school curriculum for tobacco control. A comparison of the two surveys revealed that the prevalence of both ever smokers and current smokers decreased from 2004 to 2009 [24]. The prevalence of ever smokers dropped from 49.9% to 41.2%, albeit this was not a statistically significant decline. However, the stratified analysis by gender revealed a significant decrease among boys of ever smoking, from 60.2% in 2004 to 47.1% in 2009. The prevalence of current smokers also decreased, from 17.6% in 2004 to 13.5% in 2009 [24].

1.3.4 Health Consequences of Smoking in Romania

According to WHO [25], the principal noncommunicable diseases-diseases of the circulatory system, cancer, chronic respiratory diseases, and diabetes-accounted for 90% of all deaths in Romania in 2002 [26] and 91% in 2008 [26]. In all, 61% of deaths were caused by diseases of the circulatory system and 16% by cancer – two conditions for which tobacco smoking is a major risk factor. For Romanian males, tobacco accounts for more disease than any other cause of illness, while for females it is the fifth most important cause [27].

Ischemic heart disease was responsible for about a fifth of all deaths in 2002, a larger share than the corresponding average for the EU of 15% [26]. The largest excess mortality in Romania, judged by rates for the EU and particularly for the middle-aged population, is for cerebrovascular diseases: in the population aged 25–64 years, the mortality rate in 2002 for that category of diseases was six times that of the EU countries as a whole [26].

In 2008, the age-standardized death rate per 100,000 persons in Romania was 476.9 for males and 322.5 for females [26]. In 2003, respiratory diseases accounted for 6% of all deaths in Ro-

manian 2008, the age-standardized death rate per 100,000 persons for chronic respiratory diseases was 30.1 for males and 10.2 for females [26].

A study published in *Annals of Oncology* [27] evaluated the incidence and mortality rates of cancers in Europe in 2006. According to this study, the estimated age-standardized incidence rates (per 100,000) for all cancers were smaller in Romania than for the EU as a whole: 371.8 versus 463 for males and 279.1 versus 325.5 for females. For male lung cancer, however, the incidence rate was higher in Romania: 81 per 100,000 versus 71.8 per 100,000. The incidence rate for lung cancer was smaller and, in this case, lower for Romanians than in the EU: 15.4 versus 21.7 per 100,000. These lower rates no doubt reflect differences in rates of tobacco smoking between men and women.

From the second half of the 1980s through 2004, the mortality rate for cancer among Romanians under age 65 was higher than for the corresponding population in the EU [28]. In males only, the mortality rate for cancer of the lip, oral cavity, and pharynx and for cancer of the trachea, bronchus, and lung has been increasing rapidly. In 2006, the estimated age-standardized mortality rate of lung cancer per 100,000 persons was higher for male Romanians (66.9) than for men in the EU (62.4) [29]. The situation was the same for the male mortality rate (per 100,000) for all cancers: 244.8 versus 236.4. The corresponding mortality rate for Romanian women in 2006 was lower than for those in EU [29].

In terms of the cumulative lifetime (age 0–74 years) risk of lung cancer in men in Europe, Romania occupies 13th place of 39 countries. In 2008, the incidence rate (per 100,000) for male lung cancer remained almost the same (79.7) as it was in 2006 [29], but the mortality rate (per 100,000) had increased modestly to 68.8 [29]. Considering the population of the world as a whole and according to the WHO mortality database [30], the age-standardized mortality rate per 100,000 for lung cancer in men increased from 25.5 in 1963 to 49.2 in 2009, well below the rate in Romania. The corresponding rate for women increased from 5.6 in 1963 to 8.7 in 2009.

1.3.5 Economic Impact of Tobacco Use

Unfortunately, available data about the estimated economic and health costs of smoking in Romania are fragmentary or incomplete at this time. Currently, the report on the health costs of smoking in the EU commissioned by the Health and Consumer Protection Directorate General (DG SANCO) of the European Commission in 2009 [31] represents the most actual and reliable source of information.

In 2000, according to an estimate in the DG SANCO report, public spending on smoking-attributable diseases in Romania was 37 million euro, representing 5% of total health care spending in the country. As for the diseases caused by exposure to tobacco smoke (ETS), estimated public spending in 2002 was 1 million euro [31].

The well-known premature mortality due to smoking is a reality in Romania. Indeed, in 2000 the calculated monetary loss from premature mortality due to smoking was 22,891 million euro, representing 56.3% of gross domestic product (GDP), the largest percentage of any country in the EU. In truth, this situation is likely due in part to some methodological concerns, but it is also attributable to higher smoking-related mortality at younger ages in Romania. The causes here include a higher prevalence of smoking, higher per capita tobacco consumption among men, and less effective prevention.

Historically, Romania was one of the biggest tobacco-growing countries. Before 1989, when Communist rule ended, more than 35,000 hectares were cultivated with tobacco plants and Romanian cigarettes comprised the only official brands, but in 2009 tobacco was grown on only 1,127 hectares [32]. As the influence of tobacco growers decreased, the fear of the authorities that tobacco control measures could involve lost jobs and loss of revenues diminished as well.

1.4 Current Tobacco Control in Romania

1.4.1 FCTC Status in Romania

The WHO FCTC, the first international treaty negotiated under WHO's auspices, was adopted by the World Health Assembly on 21 May 2003 and took effect on 27 February 2005. Romania ratified the WHO FCTC in 2005.

The Stability Pact for South-Eastern Europe and the corresponding Health Network significantly contributed to bringing tobacco control onto the agenda of the new Romanian government installed in 2005 through the project "*Strengthening Tobacco Control in South-Eastern Europe*", whose goal was ratification of the FCTC. The project facilitated the communication of the elements of a comprehensive tobacco control policy to the health decision makers as well as an interaction between members of the government (from the ministries of finance, agriculture, foreign affairs, and internal affairs). In this way, an increased awareness of stakeholders about the need for a comprehensive tobacco control policy that was FCTC based was obtained.

Some of the treaty's provisions were implemented quickly, as they were consistent with both Romanian and EU health policy. The FCTC also provides the objectives and the measures of an action plan that aims to reduce the consumption of tobacco.

By ratifying the FCTC, Romania has begun the implementation of convergent and coherent tobacco control measures.

1.4.2 Implementation of MPOWER Strategy

The MPOWER standards are a package of six proven policies to reduce the use of tobacco products. At present, all six strategies are applied in Romania, but with different intensities:

1. **Monitoring of tobacco use and prevention policies.** National tobacco surveys on persons aged 15 years and above were conducted by the Ministry of Health in 2007, 2008, 2009, and 2011. Consumption of tobacco by youth has been monitored yearly among gymnasium and high school students (ages 1218 years) since 1997 in the National Program for Assessing Health Risk Behaviors on Youth (13–15 years old) and in GYTS 2004 and 2009.
2. **Protection of people from tobacco smoke by banning smoking in public places, including bars and restaurants**. The legislation for protection of nonsmokers has been improved. From the former total allowance of smoking, nowadays smoking is permitted in public places only in separated, ventilated rooms and is totally banned in medical care units and on public transportation. In restaurants and bars with a floor surface less than 100 square meters the owner can decide to allow smoking everywhere in the place.
3. **Offering help (by various available tools) for quitting tobacco use**. Treatment for tobacco addiction is freely available in the framework of a national program that has been funded by the Ministry of Health since 2007. A toll-free quit line is also available. A Romanian's smoking status must be registered in his/her medical files.
4. **Warning about the dangers of tobacco smoking**. In 2008, Romania became the second EU country to implementing pictorial health warnings on all tobacco products intended for smoking. These warnings have been modified according to the provisions of the EU Tobacco Directive and now cover 30% of the front side and 40% of the back side tobacco product packages.
5. **Enforcement of bans on tobacco advertising, promotion, and sponsorship**. In accordance with the EU Tobacco Advertising Directive, tobacco advertising has been banned on radio, TV, outdoor and indoor billboards, mass media, toys and nontobacco objects, and minors-intended events. Nowadays, in Romania we can see ads for tobacco only at the points of sale and in rooms dedicated to smoking.
6. **Raising taxes on tobacco**. Taxation of tobacco products has been modified according to the EU Tobacco Taxation requirements, constituting at present a specific and an ad valorem excise tax and a minimum level of this excise

tax. The price of a pack of 20 cigarettes of the most-sold brand increased from 6.5 RON in 2008 to 9.9 RON in 2010 [33]. In 2006, an earmarked tobacco tax for health was introduced, and 20 eurocents per every pack of cigarettes sold is now allocated to the Ministry of Health. A part of the funds collected from tobacco products finances the tobacco control program and the treatment of some smoking-related diseases.

In Romania, MPOWER policies support the government and various institutions in fighting the tobacco epidemic, serving as a tool to help stakeholders plan concrete actions.

Even though the regulation of tobacco ingredients is not mentioned in WHO MPOWER policy, it was included in the Romanian tobacco control law because of the provisions of the European Tobacco Product Directive and of the WHO FCTC. Thus, all tobacco manufacturers and importers have to notify the Ministry of Health about the ingredients used for manufacturing their products [34]. The notification uses the standard format recommended by the European Commission, is delivered electronically, and also includes confidential data about the ingredients. The general list of ingredients, but not the confidential data, is published on the website of the Ministry of Health. Because Romania was part of the EMTOC (Electronic Model Tobacco Control) project, the Ministry of Health has the intention of using a secured-Internet transmission of the data beginning in 2012.

1.4.3 Tobacco Control Legislation in Romania

Beginning in 1864 the tobacco trade in Romania was a state monopoly, and the Communists who took over in the 1940s expanded the role of the state. Thus, in its 45 years of Communism, Romania became a leader among European tobacco growers, and many cigarette factories appeared across the country that took care of all of Romania's internal requirements for cigarettes. Their price was established by the state, and no big tobacco companies were present in the market.

Despite the lack of tobacco control laws, some regulations were in place because of the Communist character of the political regime. Advertising and sponsorship for tobacco products were not very much a part of the daily life of the population, as in the Western countries; there were no TV or radio ads, no billboards, no events sponsored or grants offered by industry, and no promotional objects to be found. The international brands were allowed to be sold officially only in special shops with restricted access (for foreign persons only), and their price was considerably higher than that of indigenous cigarettes.

In the 1980s, professionals in disease prevention and health education for populations started to present smoking as an enemy for health and to sustain attempts at cessation, some "anti-smoking programs for preventing and fighting tobacco use" being developed in schools and colleges. Unfortunately, these pioneers of tobacco control advocacy did not enjoy a good reputation among their colleagues or the general population because their activity was seen as being imposed by the Communist authorities in order to eliminate one of the last pleasures and manifestations of the Western lifestyle. Moreover, their educational actions were linked with inspection activities, frequently very unpopular, a perception that contributed to their being seen as "fascists" and "enemies of the people." In this context, it is understandable that after the political change in 1989 there was a reluctance to pursue any tobacco control activities.

Even so, some regulatory measures were undertaken in Romania at an earlier point than in many other countries: for example, a "health tax" on tobacco products was introduced in the fiscal law in 1994, but it was never applied because of the lack of procedures to do so. In 2002, smoking in public places was banned, but this law was not applied immediately, again because of the lack of procedures. The only measure that was respected was the ban on TV advertising that started in 1999.

The real trigger for tobacco control measures was the obligation to align Romania's national legislation with European directives as part of the process of joining the EU. As the European Commission

had approved in 2001 the Tobacco Products Directive and Tobacco Advertising Directive, Romania had to implement the provisions of both directives. Thus, the first laws against smoking, after being published in 2002 and modified in 2004, established new rules for smoking in public places, for labeling, packaging, the content of tobacco products, and sales, to restrict advertising, sponsorship, and promotion, and to establish a road map for increasing taxation. Very quickly, mass media started to emphasize the negative impact of smoking, and the previous socially positive perception of smoking began to change. Smokers became interested in quitting, and as all of the medications for treating nicotine addiction were registered, more and more nongovernmental organizations (NGOs) developed educational activities for the prevention of smoking. Prices increased, and the visible influence of the industry was seen to be in decline. In this context, the year 2006 appeared to be crucial for the future development of tobacco control: a fixed tax for health on all tobacco products (0.20 euro/pack) was introduced and used to fund health programs and tobacco control activities. The Ministry of Health obtained approval of the toughest measures possible at that time: pictorial health warnings on all tobacco products (for smoking), restriction of smoking and of advertising in public places, disclosure of all ingredients used in tobacco products, free treatment for tobacco dependence, and educational programs in schools and colleges at the national scale.

Despite its historical roots and traditions, and the traditional social context in favor of smoking, Romania demonstrated that it is possible to introduce complex and efficient tobacco control legislation in a short period of time if there is the political will to adopt and implement legislative measures. From a high of almost 36% in 2003, the prevalence of daily smoking decreased by almost one-third in less than 8 years to reach 25% in 2011 [13].

1.4.4 Tobacco Control Programs

The **National Tobacco Control Program**, implemented in 2007 by the Ministry of Health, includes prevention activities (coordinated by the National Center for Health Promotion) and treatment and monitoring activities (coordinated by the National Institute of Pneumology Marius Nasta) related to tobacco use. One of the main goals is to reduce the prevalence of smoking by reducing the number of people who start smoking and by increasing the number of those who quit smoking.

Educational programs and **communication campaigns** are organized during the year, but special interventions are held on the 31st of May and the 17th of November (**International No Tobacco Day** and **National No Tobacco Day,** respectively).

A toll-free quit line was established in 2006 and is served by psychologists who talk with callers seeking help in stopping smoking. Medical treatment for quitting is free of charge, with prescriptions given by physicians trained in smoking cessation. Currently there are more than 60 MDs and psychologists in Romania offering complete support for smokers.

The prevalence of smoking is monitored periodically, using the same methodology every year. The State Sanitary Inspection and the National Authority for Consumers Protection are mandated by law to oversee the implementation of the relevant regulations.

Apart from the governmental program, a few public health campaigns are conducted by NGOs and professional associations. These entities incorporate a stop-smoking component in their programs addressing lung disease, cardiovascular disease, and cancer prevention. **AER PUR ROMANIA** (Pure Air Romania), a nonprofit NGO, has as a main goal the protection of nonsmokers, mainly by defending their right to breathe clean, fresh air. AER PUR continuously informs the public about the effects of active and passive smoking, undertakes campaigns to educate children and teenagers to convince them to continue to be nonsmokers, acts in line with the international strategies for preventing smoking and defending the rights of nonsmokers, fights against all types of cancer caused by smoking and polluted air, and promotes the adoption of proper legislation in this field. **PNEUMA FOUNDATION** provides training

programs for health care professionals in smoking cessation and supports activities for disseminating information about medical support for quitting smoking.

There are also media campaigns organized periodically in collaboration with international partners, such as the **HELP campaign** coordinated by the Public Health Program of the European Commission that was established in 2008. This integrated media campaign uses television, the Internet, and mobile phones to build capacity "for a life without tobacco" for youngsters and young adults.

Currently, funds available under the National Tobacco Control Program do not allow for comprehensive and integrated mass media campaigns, and community-based campaigns are difficult to organize because of very limited resources (human and financial) and a lack of coordination between responsible institutions.

1.5 Global Adult Tobacco Survey (GATS)

The Global Adult Tobacco Survey (GATS) is a nationally representative household survey of people aged 15 years or older that relies on a standard core questionnaire, sample design, data collection, and data management procedures that were reviewed and approved by international experts. In Phase I, GATS was successfully implemented in 14 countries (Bangladesh, Brazil, China, Egypt, India, Mexico, Philippines, Poland, Russian Federation, Thailand, Turkey, Ukraine, Uruguay, and Vietnam), which together represent 3.6 billion people – over half the world's population.

Romania joined the survey in Phase II, along with Argentina, Indonesia, Malaysia, Nigeria, Panama, South Africa, and Thailand (a repeating Phase I country).

The GATS methodology enables the assessment and comparison of indicators for tobacco use and control across all implementing countries. The GATS protocol, however, allows countries to adapt the core questions, to use optional questions, and to include country-specific questions that address their particular concerns.

The main purpose of the GATS Romania study was to evaluate the current status of tobacco use among the adult population. This evaluation will allow the establishment of priorities in socioeconomic and public health policies for reducing tobacco consumption.

The general objectives were to:

1. Produce baseline nationally representative data on adult tobacco use that would be comparable across countries.
2. Measure changes over time and compare these changes internationally.
3. Estimate exposure to environmental smoke and levels of cessation; evaluate public perceptions, knowledge and attitudes, and exposure to media; examine price and taxation issues; and investigate the impact of present legislative measures for tobacco control.
4. Evaluate the implementation of tobacco control legislation and highlight the aspects of laws that need to be enforced or complemented.
5. Prepare a scientific basis for the development of policies and programs designed to reduce the health consequences and financial burden of tobacco consumption in Romania.

2. Methodology

2.1 Study Population

The target population for GATS Romania included all civilian, noninstitutionalized adults, both men and women, who were aged 15 years or older (referred as "adults" in this report), lived in Romania, and considered the country to be their primary place of residence. Institutionalized people, such as those who lived in military barracks, prisons, hospitals, or nursing homes were excluded.

2.2 Sampling Design

The sample frame for GATS was a master sample, EMZOT (in Romanian, an acronym for Master Sample of Territorial Areas), that was comprised of combined enumeration units that were selected by the National Institute of Statistics, Romania, from 2002 data obtained in the Census of Population and Dwellings, with technical assistance provided by INSEE France. In the selection of the EMZOT, Romania was stratified by six Bucharest districts and 41 counties outside Bucharest. The 41 counties were further stratified by residence (urban or rural). Thus, there were 88 strata in total. Sampling units (called research centers), were formed specifically for the purpose of developing the master sample combining the existing census units. From the 88 strata, an independent sample was selected with an inclusion probability that was proportional to the size (PPS) of each stratum. A total of 780 research centers were selected, 427 in urban areas and 353 in rural areas.

The PPS sampling method was applied to subsample research centers, which served as primary sampling units (PSUs) for GATS. Subsequently, a simple random sampling with a fixed sample size, 27 from urban areas and 23 from rural areas, was applied to the sampled dwellings. All sampled dwellings had only one household. From the selected household, one eligible individual was randomly selected to be interviewed.
Romania became a member of the EU in 2007, and the proportion of Romanians moving to other EU countries to work has increased dramatically in the last several years. During the survey, we detected the problems caused by this outward migration and sampled 610 additional dwellings, which increased the planned sample size to 5,629.

2.3 Survey Questionnaire

The questionnaire of GATS Romania was adapted from the standard GATS core questionnaire [35], and Romania also included country-specific questions. The questionnaire was developed in English, translated into Romanian and Hungarian, and then back-translated into English to ensure the accuracy and quality of translation. The questionnaire was finalized in August 2011 based on the results of a pretest conducted in July (see Appendix A for details).

The questionnaire consisted of two parts: household and individual. The household questionnaire included the information needed to develop a household roster, such as the household eligible member's age, gender, and smoking status.

The individual questionnaire had eight sections:

A. **Background characteristics**: Gender, age, education, work status, possession of household items, and personal ownership status regarding the house.
B. **Tobacco smoking**: Patterns of use (consumed daily, consumed less than daily, did not consume at all), former/past tobacco consumption, age of initiation of daily smoking, consumption of different tobacco products, (manufactured and hand-rolled cigarettes,

pipes filled with tobacco, cigars, cigarillos and other products), nicotine dependence, and frequency of quit attempts.

C. **Smokeless tobacco**: Only four core questions were kept in this section of the Romanian GATS questionnaire; these questions permitted an assessment of possible current use or past use of these types of products. The remaining core questions were removed because the sale of smokeless tobacco products is banned by Romanian law.

D. **Cessation**: Advice to quit smoking by a healthare provider (HCP) and the method used to try to stop smoking. All questions on the cessation of smokeless tobacco use have been removed. A country- specific question on the reasons for not quitting smoking was added to obtain information that will allow the designing of more efficient programs for cessation.

E. **Secondhand smoke**: Questions about rules referring to smoking inside the home, exposure to secondhand smoke (SHS) at home, indoor smoking policy at the workplace, and exposure to SHS in the last 30 days in public places (government buildings/offices, health care facilities, public transportation, restaurants) were included. Additional optional questions referring to exposure to SHS in schools, universities, and bars and nightclubs as well as for assessing knowledge about the harmful effects of SHS were included. Other optional questions included asking for opinions on further extension of the banning of smoking in all restaurants, bars, clubs and discotheques, while driving a car, or while in the presence of children or pregnant women.

F. **Economics**: Questions referring to the most recent purchase of manufactured cigarettes, including quantity bought, cost of tobacco product(s), brand, and source of purchase.

G. **Media**: Questions on exposure to antitobacco information through newspapers/magazines, television, radio, billboards, and other sources; exposure to tobacco advertising in different places and through sporting events connected with tobacco; different types of cigarette promotion, impact of the health warning labels on cigarette packs. A specific-country question was added to assess the impact of pictorial warnings. The reference period for the questions in this section was the previous 30 days.

H. **Knowledge, attitudes, and perceptions**: Questions regarding knowledge about the health effects of smoking and about the health effects of different types of cigarettes (low-tar or light, and slim) as well as questions referring to attitudes toward increasing taxes on tobacco products.

2.4 Programming of the Questionnaires and Preparation of the Handheld Devices

GATS used General Survey System (GSS) software developed by RTI International (Research Triangle Park, NC, USA) for both the household and individual questionnaires. GSS software provides a variety of tools to facilitate the design, administration, collection, and management of survey data on handheld devices, specifically a Microsoft Windows-based platform (Microsoft Corporation, Redmond, Washington, USA) running Windows Mobile 5.0 or Mobile 6.0 (often called Pocket PC systems). The GSS software system is designed to support the collection of data in the field by interviewers using handheld devices. The systems have been developed and tested using the Hewlett-Packard (Palo Alto, California, USA) iPAQ Pocket PC (model: iPAQ hx2490c), which was used for data collection (refer to the manuals on GSS and Data Management and Implementation for more details) [36, 37].

Collecting the data electronically facilitated the complex skip patterns used in the GATS Romania questionnaire as well as the employment of some built-in validity checks during collection. Programming was mainly supported by RTI International and WHO. The programming of the questionnaire using GSS was carried out in collaboration with in-country IT (information technology) personnel involved in GATS Romania. The quality control mechanisms applied included version control/ verification, date and time verification, verifica-

tion of skip patterns, and validation checks. The entire process, including administration of the questionnaires, data collection using handheld devices, and data management and aggregation (preparing a raw data for analysis), was pretested. Handheld programming was finalized and the final questionnaire for data collection was uploaded to handheld devices by in-country IT personnel and WHO in September 2011. The electronic case file (used to identifying the sampled household addresses) was finalized in the same month and uploaded to each field investigator's handheld device during the full survey training held in Bucharest in September 2011. Details on management of the case file and quality control measures adopted in GATS can be found in GATS Quality Assurance: Guidelines and Documentation [38].

2.5 Data Collection

2.5.1. Implementing Agencies

GATS was implemented in Romania under the supervision of the Ministry of Health through three agencies: National Institute of Public Health, which was the agency nominated by the Ministry of Health to implement GATS in Romania, the National Statistical Training Centre, and TOTEM Communication, a Romanian research agency with over 7 years of experience in social and health care studies.

The National Statistic Training Centre was responsible for providing the GATS sample using EMZOT, the Romanian master sample. Totem Communication was responsible for conducting the fieldwork. The National Institute of Public Health was responsible for preparing the GATS Country Proposal, adapting the GATS questionnaire and other study documents, including GATS manuals, conducting the pretest and full survey trainings, aggregating the data collected, preparing the country analysis plan, producing the GATS Country Fact Sheet and the GATS Country Report in English and Romanian, and disseminating the study results in concert with the Ministry of Health and the WHO Country Office in Romania. TOTEM Communication was responsible for organizing and conducting along with the National Institute of Public Health the pretest and full survey trainings, preparing and conducting the fieldwork in the pretest and full survey, directly supervising the data collection process, and, in collaboration with the National Institute of Public Health, performing quality controls.

2.5.2 Pretest

The Romanian team pretested the questionnaire and data collection with close cooperation from CDC and WHO experts. The pretest aimed to test the Romanian GATS questionnaire in terms of its comprehensibility, skip patterns, sequencing of questions, completeness of response categories, interview time, data collection using the iPAQ, and the process of data transfer and aggregation.

The GATS Romania pretest took place between the 4th and 11th of July 2011. In the first four days the pretest training was conducted at the National Institute of Public Health, Bucharest, with the participation of CDC, WHO headquarters, the WHO European Office and Country Office, the National Institute of Public Health, and TOTEM Communication. Seven experienced interviewers and two supervisors attended the training. All the interviewers had a bachelor's of science (BS) degree and at least 2–3 years of experience in household surveys, and the two supervisors had a master's degree and more than 5 years of survey experience. Training was based on standard GATS procedures and included class presentations, mock interviews, and full-circle role play.

Pretest fieldwork was conducted on the 12th through 14th of July 2011. A total of 112 people, who were equally allocated into male and female, four age groups, urban and rural residence, and smoking status, were interviewed in Bucharest and a village 20 kilometers northwest of Bucharest. Data transmission was also tested. The minor problems encountered, mostly in wording, were addressed in the revised questionnaire.

2.5.3 Full Survey Training

Training before the full survey fieldwork took place was provided by implementing agencies. The National Institute of Public Health provided training on the background of GATS, the questionnaire, and the use of handheld devices. TOTEM Communication provided training on survey operation and interview techniques. All fieldworkers, including 25 interviewers and eight supervisors, attended the training. The training sessions also included mock interviews between participants. At the end of the training, all fieldworkers were provided with iPAQs loaded with the addresses of the assigned dwellings.

2.5.4 Fieldwork

The fieldwork was conducted in the eight socio-economic Romanian regions (Bucharest-Ilfov-Giurgiu, South, South-east, South-west, Central, Nord-west Region, Nord-east, and West Region) by eight regional teams. A total of 25 interviewers and eight supervisors participated in the fieldwork. There were eight field work teams in total, with three interviewers and one supervisor per team. In Bucharest-Ilfov-Giurgiu, the team had four interviewers. On each of the teams, all four members conducted interviews, but the supervisor had a smaller number because of his additional duties: organizing the team, providing transportation, and transmitting biweekly data files and daily progress reports. The supervisors also had to ensure the accuracy of the data collection by randomly visiting households where interviews had been conducted.

At the national level, the TOTEM Communication activity was coordinated by a project manager and two field coordinators. The field supervisors and interviewers were recruited from each Romanian region, all of them having solid experience in data collection. Three reserve field interviewers were prepared and trained together with the teams; one of them replaced a team member during the study.

All the documentation, instructions, and technical means were provided for each team during the training period before the fieldwork started. A fieldwork calendar was developed for each team; the weekly schedule included 5 days for the first visits in the households and 2 days for revisits. Four additional revisit days were allocated at the end of the fieldwork.

All the teams were in direct daily contact with the Totem field coordinators and the IT coordinator from the National Institute of Public Health for support and daily progress reports. In particular cases, local institutions (governmental administration, health institutions, or police) were asked for support, especially to identify particular addresses correctly. In these cases, a support letter signed by all the Romanian institutions involved in GATS was presented by the interviewers to the representatives of these public institutions.

Data was collected from the 12th of September, 2011, to the 3rd of November, 2011. In all, 4,517 individual interviews were conducted.

2.6 Data Processing and Aggregation

Romania used e-mail to transfer the data. Every day the field supervisors collected export files from each iPAQ using the GSS built-in utility Export Data. Twice a week, each field supervisor provided the most recent data (not aggregated) to the National Country Database (located at the Regional Center for Public Health Cluj). Data was aggregated at this level, and quality control was performed on the aggregated data. Each of the field interviewers' files was checked for any inconsistencies. The data was then reported to the partners at the CDC and to the fieldwork coordinators from TOTEM Communication. Household and individual response rates, as well as gender and age distribution, were calculated and reported on a weekly basis. At the end of data collection, a final check was made to ensure that all exported files had been counted and aggregated at the national level. The consolidated database was hosted at the National Data Center from the Regional Center for Public Health Cluj. The process of data aggregation was followed by the merging of all data files into one master file. The master file was cleaned and validated at the National Data Center.

2.7 Statistical Analysis

Complex survey data analysis was performed to obtain population estimates and their 95% confidence intervals (CIs) (asymmetric CIs). Sample weights were calculated using three components: base weight or design weight, which was calculated from all steps of random selection in the sample design, an adjustment for nonresponse, and a post-stratification calibration adjustment of the sample totals to project to the population aged 15 years and above in January 2011 by residence, gender, and age group. Details on the sample weighting process are provided in Appendix C. The final weights were used in all analyses to produce population estimates and their CIs. All the statistical analyses, including sample weighting and computations of estimates and their CIs, were performed using the complex sample module of a statistical package, SPSS 17.

3. Sample and Population Characteristics

Table 3.1 presents the number and percentages of households and persons interviewed and response rates by residence.

Of the 5,629 sampled households, 4,601 households completed the household interview, giving the household response rate of 89.9% The formula used to calculate the household and person-level response rates is shown in the footnotes of Table 3.1. The household response rate was higher in rural areas than in urban areas (95.8% and 85.6%, respectively). Overall, 3.9% of the selected households refused to respond to the survey, 7.7% were found unoccupied, in 4.1% nobody was found at home, and 1.3% of the addresses were not a dwelling.

Among individuals selected from the completely screened households, 4,517 were completely interviewed, and the person-level response rate was calculated to be 98.4%. As with households, the person-level response rate was a little higher in rural than in urban areas (99.1% and 97.8%, respectively). Overall, only 0.7% of the selected individuals refused to respond to the survey. In GATS Romania 2011, the total response rate was 88.5% (94.9% in rural areas and 83.6% in urban sites).

Table 3.2 presents the unweighted sample size and weighted population estimates by selected demographic characteristics of the adult population and survey respondents, including age, place of residence, and level of education.

The unweighted number of adults who completed the individual interview was 4,517, representing an estimated 18.17 million persons aged 15 and over in Romania. The sample comprised 2,070 men and 2,447 women, representing a population estimates of 8.76 million men and 9.41 million women.

For all eligible respondents aged 22 years and older, data were collected on level of education and grouped into three categories for analysis: primary, secondary, and high education. Primary education included no formal education, primary school completed, secondary school (gymnasium) completed, and vocational school. Secondary education included grades 9–10 or high school completed and post-high school completed. High education included college and above. An estimated 43.8% of Romanian adults had no more than a primary education, 40.2% had a secondary education, and 16.0% had high education.

Tables 3.3 and **3.4** show these data for men and women separately. The 65+ age group accounted for a significantly higher percentage of women (20.2%) than men (14.7%). There were no significant differences by gender for residence or educational level.

Table 3.1 Number of households and persons interviewed and response rates by residence and region (unweighted) – GATS Romania, 2011.

	Residence				Total	
	Urban		Rural			
	Number	Percent	Number	Percent	Number	Percent
Selected household						
Completed (HC)	2,501	77.3	2,100	87.8	4,601	81.7
Completed- No one eligible (HCNE)	6	0.2	0	0.0	6	0.1
Incomplete (HINC)	0	0.0	0	0.0	0	0.0
No screening respondent (HNS)	5	0.2	3	0.1	8	0.1
Nobody at home (NHH)	202	6.2	29	1.2	231	4.1
Refused (HR)	187	5.8	34	1.4	221	3.9
Unoccupied (HUO)	262	8.1	174	7.3	436	7.7
Address not a dwelling (HAND)	45	1.4	26	1.1	71	1.3
Other[1] (HO)	29	0.9	26	1.1	55	1.0
Total number of households Selected	3,237	100	2,392	100	5,629	100
Household response rate (HRR) (%)[2]	85.6%		95.8%		89.9%	
Selected person						
Completed (PC)	2,440	97.6	2,077	98.9	4,517	98.9
Incomplete (PINC)	3	0.1	0	0.0	3	0.1
Not eligible (PNE)	5	0.2	4	0.2	9	0.2
Not at home (PNAH)	25	1.0	7	0.3	32	
Refused (PR)	23	0.9	10	0.5	33	0.7
Incapacitated (PI)	1	0.0	0	0.0	1	0.0
Other[1] (PO)	4	0.2	2	0.1	6	0.1
Total number of sampled persons	2,501	100	2,093	100	4,601	100
Person-level response rate[3]	97.8%		99.1%		98.4%	
Total response rate[4]	83.6%		94.9%		88.5%	

[1] Other includes any other result code not listed.

[2] Calculate household response rate (HRR) by: $\frac{(HC+HCNE) * 100}{HC+HCNE+HINC+HNS+NHH+HR+HO}$

[3] Calculate person-level response rate (PRR) by: $\frac{PC * 100}{PC+PINC+PNAH+PR+PI+PO}$

[4] Calculate total response rate (TRR) by: (HRR x PRR) / 100

Table 3.2 Unweighted sample counts and weighted population estimates, by demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Weighted			Unweighted number of adults
	%	(95% CI[1])	Number of adults (in thousands)	
Overall	100.0		18,175.0	4,517
Age (years)				
15-24	15.8	(14.4-17.3)	2,875.3	387
25-44	37.6	(35.8-39.4)	6,834.9	1,310
45-64	29.0	(27.6-30.5)	5,278.7	1,499
65+	17.5	(16.4-18.7)	3,186.1	1,321
Gender				
Male	48.2	(46.4-50.0)	8,760.6	2,070
Female	51.8	(50.0-53.6)	9,414.4	2,447
Residence				
Urban	55.7	(53.7-57.7)	10,124.1	2,440
Rural	44.3	(42.3-46.3)	8,050.8	2,077
Education level [2]				
Primary or less	43.8	(41.6-46.0)	7,068.6	2,139
Secondary	40.2	(38.2-42.3)	6,494.7	1,527
High	16.0	(14.4-17.8)	2,587.9	580

[1] 95 % confidence interval.

[2] Education level is reported only among persons aged ≥22 years old. Primary or less education includes no formal education, primary school completed, secondary school (gymnasium) completed, vocational school. Secondary education includes grades 9–10 or high school completed and post-high school completed. High education includes college and above.

Table 3.3 Unweighted sample counts and weighted population estimates of men, by demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Weighted			Unweighted number of adults
	%	(95% CI [1])	Number of adults (in thousands)	
Male	100.0		8,760.6	2,070
Age (years)				
15-24	16.8	(14.7-19.1)	1,467.8	198
25-44	39.8	(37.1-42.5)	3,484.1	654
45-64	28.8	(26.8-30.9)	2,524.1	709
65+	14.7	(13.2-16.3)	1,284.5	509
Residence				
Urban	54.4	(51.3-57.6)	4,770.1	1,159
Rural	45.6	(42.4-48.7)	3,990.5	911
Education level [2]				
Primary or less	44.7	(41.6-47.9)	3,461.8	946
Secondary	40.0	(36.9-43.1)	3,092.3	705
High	15.3	(13.3-17.5)	1,185.2	280

[1] 95 % confidence interval
[2] Education level is reported only among persons aged ≥22 years. Primary or less education includes no formal education, primary school completed, secondary school (gymnasium) completed, and vocational school. Secondary education includes grades 9–10 or high school completed and post-high school completed. High education includes college and above.

Table 3.4 Unweighted sample counts and weighted population estimates of women, by demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Weighted			Unweighted number of adults
	%	(95% CI [1])	Number of adults (in thousands)	
Female	100.0		9,414.4	2,447
Age (years)				
15-24	15.0	(13.1-17.0)	1,407.5	189
25-44	35.6	(33.3-38.0)	3,350.8	656
45-64	29.3	(27.0-31.6)	2,754.5	790
65+	20.2	(18.7-21.8)	1,901.5	812
Residence				
Urban	56.9	(54.7-59.0)	5,354.1	1,281
Rural	43.1	(41.0-45.3)	4,060.3	1,166
Education level [2]				
Primary or less	42.9	(40.3-45.5)	3,606.8	1,193
Secondary	40.4	(37.8-43.1)	3,402.3	822
High	16.7	(14.7-18.9)	1,402.7	300

[1] 95 % confidence interval.
[2] Education level is reported only among adults aged ≥22 years. Primary education includes no formal education, primary school completed, secondary school (gymnasium) completed, and vocational school. Secondary education includes grades 9–10 or high school completed and post- high school completed. High education includes college and above.

4. Tobacco Use

KEY FINDINGS

- 37.4% of men, 16.7% of women, and 26.7% of persons aged 15 years or older (4.85 million persons) currently smoke tobacco.
- 24.3% (4.42 million) of Romanians aged 15 years or older are daily smokers (34.9% of men and 14.5% of women).
- Among females, but not males, the prevalence rates of current smoking are highest among people with secondary or a high level of education.
- 17.1% of Romanian adults aged 15 or over who smoke daily started their daily smoking habit at less than 15 years of age; the majority of these persons are from rural areas.
- Overall , 51.1% Romanian smokers aged 15 years or above smoke more than 20 cigarettes/day.
- More than two-thirds (69.5%) of daily smokers in Romania are addicted to nicotine (they have their first cigarette within 30 minutes of awaking).

This chapter describes smoking behaviors in the adult population of Romania, including 1) tobacco smoking status, and 2) demographic and behavioral patterns of smoking (e.g., number of cigarettes smoked daily, age at initiation of daily smoking, duration of daily smoking, and indicators of tobacco dependence).

4.1 Tobacco Smoking Status

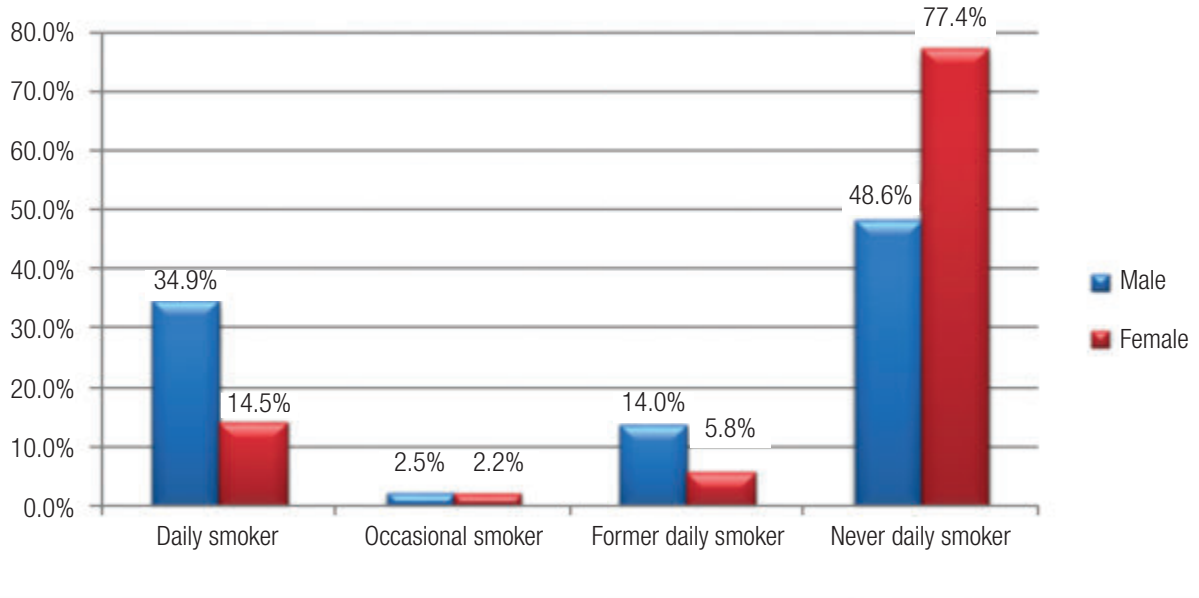
Tobacco smoking status was categorized as *"current tobacco smoker"* or *"nonsmoker"* Current tobacco smokers included "daily smokers" and "occasional smokers," and nonsmokers included "former daily smokers" and "never daily smokers."

Table 4.1 and **Figure 4.1** present the smoking status of persons aged 15 years or over ("adults") by detailed smoking status and gender. The overall prevalence rate of current smoking was 26.7%. This prevalence was much higher among men than women (37.4% vs. 16.7%).

In all, 24.3% of adults were daily smokers (34.9% of males and 14.5% of females), and 2.4% were occasional smokers (2.5% of males and 2.2% of females).

Nonsmokers accounted for 73.3% of adults. In all, 9.8% of adults were former daily smokers and 63.5% were never daily smokers. The survey found that 60.7% of adults had never smoked in their life-

Fig. 4.1 Smoking status by gender, GATS Romania 2011



times, 9.8% were former daily smokers, and 2.8% were former occasional smokers.

The estimated number of current adult smokers in Romania was 4.85 million (3.27 million males and 1.57 million females). The number of daily smokers was about 4.42 million (3.05 million male and 1.36 million female). There were an estimated 429,800 occasional smokers, of whom 219,900 were male and 209,900 female) (**Table 4.2**).

4.2 Use of Smokeless Tobacco

Article 8 of the Tobacco Products Directive 2001/37/CE for banning the use of smokeless tobacco was transposed into Romanian Law 349/2002, which completely forbids the sale of smokeless tobacco in Romania. Thus, smokeless tobacco products are not commonly used in this country. However, these products can be procured from contraband or illegal sales on the Internet. GATS data indicated that 99.3% of the population of interest never used smokeless tobacco and 99.7% were never daily users of this product.

4.3 Smoking Status by Demographic Characteristics

Table 4.3 reports current smoking of various smoked tobacco products, by gender and selected demographic characteristics.

The prevalence rate of current smoking (any type of smoked product) was significantly higher among males than females (37.4% vs. 16.7%).

Age

By age, the overall prevalence rate of current smoking was highest among persons aged 25-44 (36.3%) and 45-64 (28.0%) and lowest among those 65 or over (7.6%).

Gender

The pattern of current smoking by age was about the same for males as for the overall population, the prevalence rate of current smoking being highest among males aged 25-44 (48.2%) and 45-64 (38.8%) and lowest among those 65 or over (12.9%). Among females, the prevalence of current smoking was highest among those aged 25-44 (23.8%) and lowest among those aged 65+ (4.1%).

Residence

Overall, the prevalence rates of current smoking was slightly higher for urban (28.4%) than rural residents (24.5%) (difference not significant).

Among men, there was no difference by residence (37.8%, urban, vs. 36.9%, rural), but urban females (20.1%) had a significantly higher prevalence of current smoking than their rural counterparts (12.2%).

Educational level

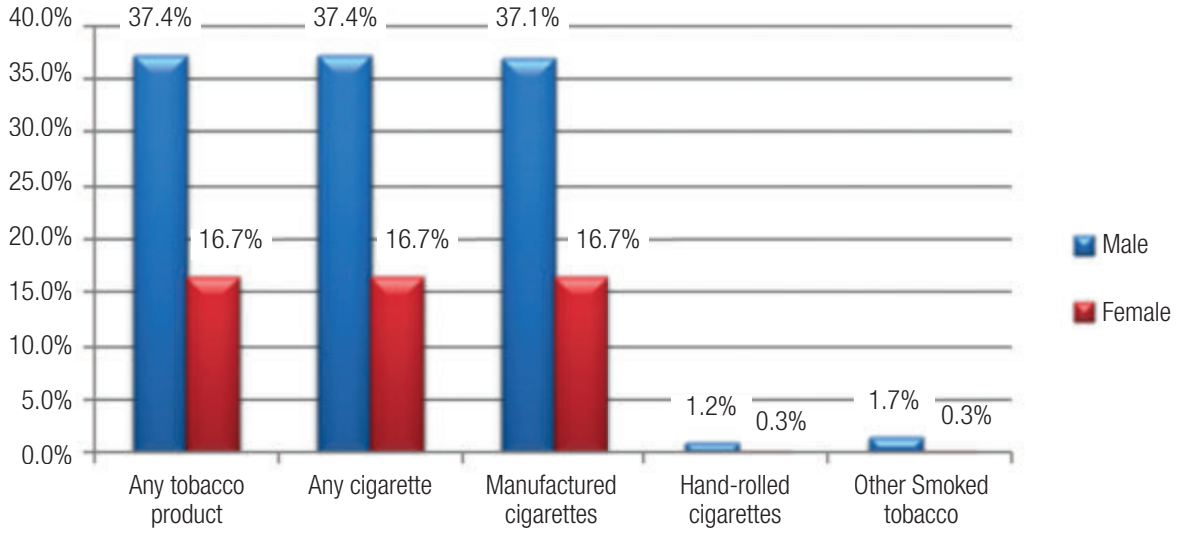
The overall prevalence rate of current smoking did not differ by educational level, and this pattern was similar among males. Among females, the prevalence rate of current smoking was highest among those with secondary and high education (19.6% and 20.0%, respectively) and lowest among those with primary education or less (14.7%).

4.4 Current Smoking Status by Type of Smoked Tobacco Products

Table 4.3 and **Figure 4.2** show data on smoking various types of tobacco products. In Romania these products include cigarettes and other smoked tobacco products, such as pipes, cigars, cigarillos and water pipes. Cigarettes fall into two categories: manufactured and hand-rolled. The overall proportion of adults who currently used any type of cigarette was virtually the same as the overall proportion using manufactured cigarettes. For any type of cigarette the overall proportion was 26.7% (37.4% among males, 16.7% among females). Prevalence was slightly higher in urban (28.4%) than in rural (24.5%) areas; by age, it was highest among those 25-44 (36.3%). Only 0.7% of adults used hand-rolled cigarettes (1.2% of males, 0.3% of females). The overall prevalence for smoking other kinds of tobacco products was just 1.0%.

Table 4.4 presents the estimated number of adults who smoked various smoked tobacco products by gender and selected demographic characteristics. The estimated number of adults who used any type of smoked tobacco product (the same

Fig. 4.2 Percentage of tobacco users by gender and type of tobacco product, GATS Romania 2011



estimate as for cigarette smoking) was 4.85 million. The number of manufactured-cigarette users was an estimated 4.82 million, with an estimated 135,600 uses of hand-rolled cigarettes. The number of persons who smoked tobacco products other than cigarettes was about 175,200.

4.5 Frequency of Tobacco Smoking

Table 4.5 reports the frequency of tobacco smoking among Romanian adults for three standard categories: daily smokers, occasional smokers, and nonsmokers. Overall, 24.3% of adults were daily smokers (34.9% of men and 14.5% of women), 2.4% were occasional smokers (2.5% of men and 2.2% of women), and 73.3% were nonsmokers (62.6% of men and 83.3% of women).

By age, the highest overall prevalence rate of daily smoking **(Figure 4.3)** was found in the 25-44 group (32.9%), followed by the 45-64 age group (25.7%), with the lowest prevalence among those 65+ (6.7%). The prevalence of occasional smoking followed the same pattern, with the highest percentage in the 25-44 age group (3.3%) and the lowest among those 65 or over (0.9%). Patterns were similar by gender (not shown in Figure 4.3).

Fig. 4.3 Smoking frequency by age, GATS Romania 2011

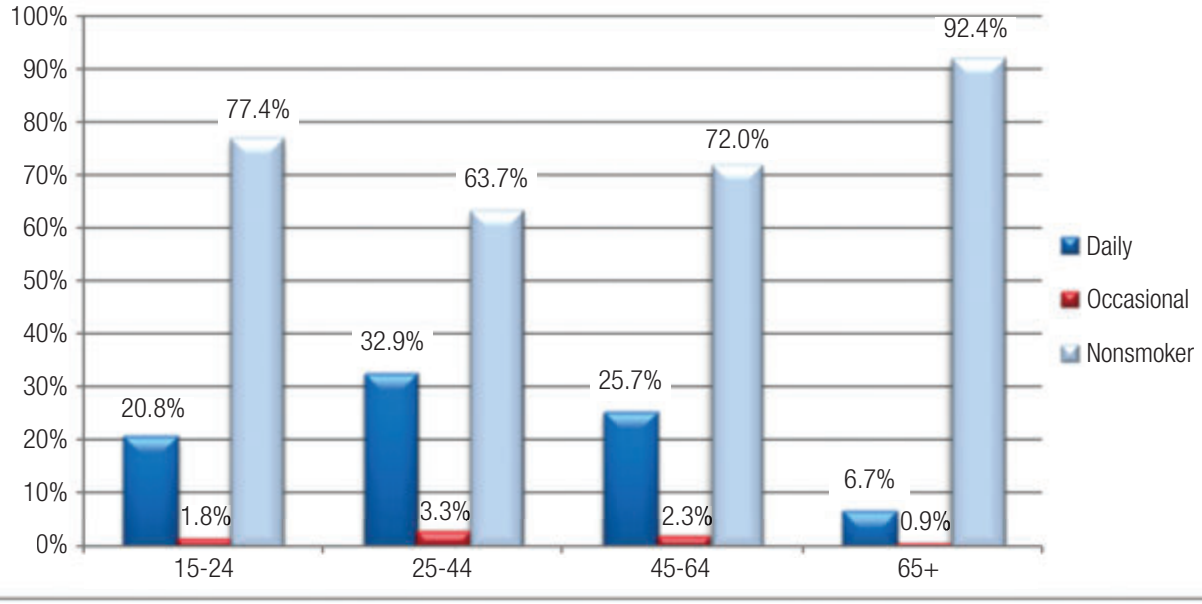
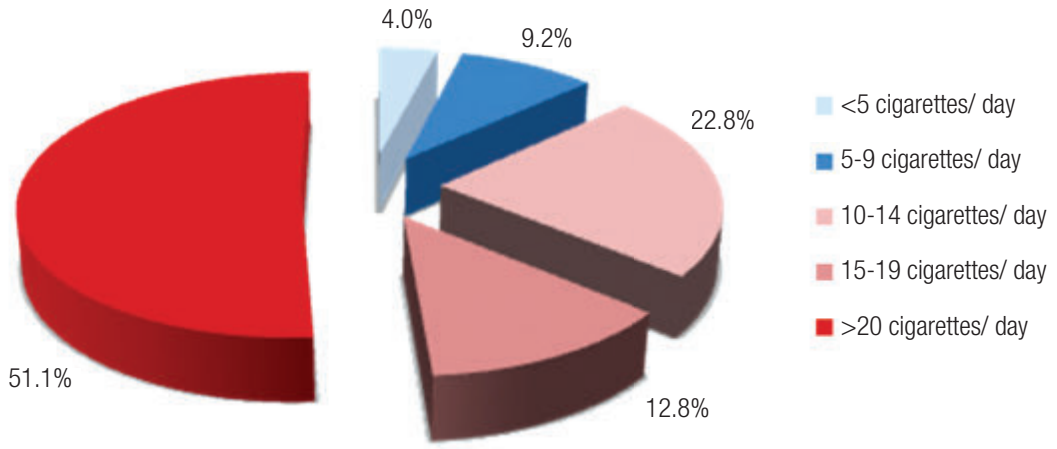


Fig. 4.4 Percentage distribution of cigarettes smoked per day among daily smokers, GATS Romania 2011



The prevalence of daily smoking **(Table 4.5)** was 25.6% in urban and 22.7% in rural area. There was essentially no difference by residence in the prevalence of daily smoking among men (34.9%, urban; 34.8%, rural), but among women the prevalence of daily smoking was significantly higher in urban than rural areas (17.3% versus 10.8%).

The overall prevalence rate of daily smoking did not differ significantly by educational level. Among females, the prevalence rates of daily smoking were higher among people with secondary and high education (17.2% and 16.5%, respectively) and lowest among those with a primary education or less (13.0%). Among males there was little difference by educational level.

4.6 Number of Cigarettes Smoked per Day

Figure 4.4 shows the percentage distribution of cigarettes smoked per day among daily smokers. Just over half of this group (51.1%) smoked 20 or more cigarettes per day.

Table 4.6 presents the average number and percentage distribution of cigarettes (either manufactured or hand-rolled) smoked per day by daily cigarette smokers by sociodemographic characteristics. Overall, the mean number of cigarettes smoked per day by daily smokers was 16.6 (17.7 for males and 14.1 for females). In all, 18.6% of males and 32.1% of females smoked 10-14 cigarettes/day, 12.7% of males and 13.2% of females smoked 15-19 cigarettes daily, and 58.2% of males and 35.3% of females smoked 20 or more cigarettes a day.

The percentage of daily cigarette smokers who smoked 20 or more cigarettes per day increased from 39.1% in the 15-24 age group to 55.2% among those aged 25-44 age group, equaled 54.0% in the 45-64 age group, and then decreased to 23.6% among those 65 or over.

The percentage distributions of daily cigarette smokers by cigarettes smoked per day were generally similar by residence. The highest proportions were among those who smoked ≥20 cigarettes per day (urban: 49.4%, rural: 53.7%) and the lowest proportions for those who smoked <5 cigarettes per day (urban: 4.3%, rural: 3.7%).

By education, the proportion of daily cigarette smokers who smoked 20 or more cigarettes per day was highest among people with a primary education or less (57.4%).

4.7 Age at Initiation of Smoking

Table 4.7 presents the percentage distribution of age at initiation of daily smoking among adults who were ever daily smokers and were currently aged 20–34 years. Overall, the highest proportion of initiation took place at age 17-19 (43.1%), followed by ages 15 to 16 (21.7%) and then 20 or

over (18.1%). The lowest proportion was found for less than age 15 (17.1%).

In all, 21.6% of males who were ever daily smokers initiated such a smoking pattern below the age of 15, and 22.3% did so at 15 or 16. By far the largest percentage (41.2%) was found for initiating at ages 17-19. Among females, the largest single proportion started at ages 17-19 (46.9%), followed by 20+ (24.9%). A significantly lower proportion of females (7.8%) than males (21.6%) started their daily smoking habit before age 15.

Rural residents (24.8%) were twice as likely as urban residents (12.7%) to begin their daily smoking before the age of 15.

4.8 Prevalence of Former Daily Smoking and the Quit Ratio

Table 4.8 presents data on the percentage of former daily smokers among all adults and the percentage of former daily smokers among ever daily smokers (the quit ratio for daily smoking).
Among all adults, 9.8% were former smokers; the quit ratio for daily smoking was 28.0%.
Many more males (14.0%) than females (5.8%) were former daily smokers. Among those who were daily smokers, no real difference was seen in the quit ratio by gender (28.2%, males; 27.5%, females). For both genders, the two measures increased by age through the first three categories. Among all adults, the percentage of former smokers was 2.1% for those aged 15-24 years, 8.2% for those 25-44, 14.0% for 45-64, and 13.2% for 65 or older.

A significant difference was found by residence in the percentage of adults who were former daily smokers (11.3%, urban; 7.9%, rural) but not for the quit ratio (29.9%, urban; 25.2%, rural).

Table 4.9 shows the percentage distribution of time since quitting among former daily smokers by selected demographic characteristics. Overall, the single largest proportion of time since quitting was found for ≥10 years (40.0%). By residence, a time since quitting of ≥10 years was more common in rural (44.6%) than urban (37.5%) areas.

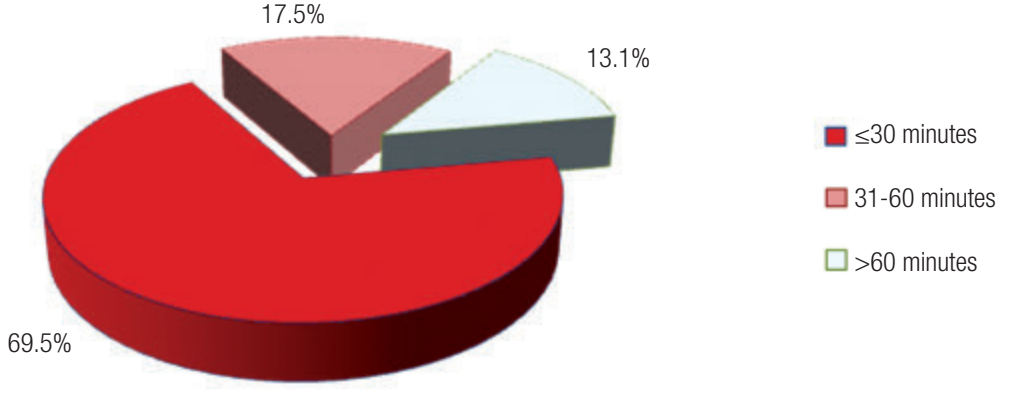
4.9 Time to First Smoke of the Day

An established measure for evaluating nicotine dependence is the time between awakening and smoking the first cigarette of the day [39].

Table 4.10 and **Figure 4.5** present such information; most of the daily smokers had their first smoke within the first 30 minutes after they woke up (69.5%).

By age (**Table 4.10**), persons aged 45-64 (31.8%) were the most likely to smoke within 5 minutes of waking, while those aged 65 or above (17.9%) were the least likely to do so. Essentially one-third (33.5%) of those with the least education smoked within 5 minutes, while 20.8% of those with a college education or more began this quickly.

Fig. 4.5 Percentage distribution of time to first smoke after awakening among current daily smokers, GATS Romania 2011



5. Cessation

KEY FINDINGS

- More than one-third of current smokers had made a quit attempt within the last 12 months.
- 81.9% of current smokers had been advised to quit by a health care professional.
- 80.8% of those with a recent quit attempt (last 12 months) had tried to quit without assistance.
- In trying to quit, only 8.2% used nicotine replacement therapy, 1.4% took prescribed medication, and 1.7% received counseling and advice.
- A third (33.6%) of current smokers were not interested in quitting, and 39.2% of current smokers interested in quitting did not think that smoking is bad for health.

5.1 Smoking Cessation and Health-Care-Seeking Behaviors

Smokers attempting to quit in the last 12 months were defined as including both current tobacco smokers who had tried to quit in the last 12 months and former tobacco smokers who had been abstinent for less than 12 months.

Table 5.1 reports the proportions of adult smokers who had made a quit attempt, visited a health care provider (HCP) in the past 12 months, were asked by the HCP about smoking, and received advice from a HCP to quit smoking.

Made quit attempt

Among current smokers and former smokers who had been abstinent for less than 12 months, 35.5% had made an attempt to quit in the previous year (34.2% of males and 38.2% of females). Among those aged 15-24, 41.0% had tried to quit; the lowest rate by age was among those aged 25-44 (33.9%). No differences were noticed in the pattern of quitting by educational level, and the difference by residence was only 4.7 percentage points.

Visited a health care provider

Visiting a health care provider (HCP) was defined as visited a doctor or other health care provider during the past 12 months for curative or preventive care or for counseling services. Essentially half (50.4%) of smokers attempting to quit had made such a visit. About three-fifths (60.8%) of females but less than half (45.3%) of males had made this type of visit.

By age group among smokers attempting to quit, those 65 or over were most likely to have visited an HCP (69.1%), while there was little variation among the other age groups. Rates were 56.2% among smokers in urban areas and 41.7% in rural areas. By educational level, smokers with a college education and above were most likely to have an HCP visit (58.3%), while those with the least education had the lowest rate (43.0%).

Asked by HCP about smoking tobacco

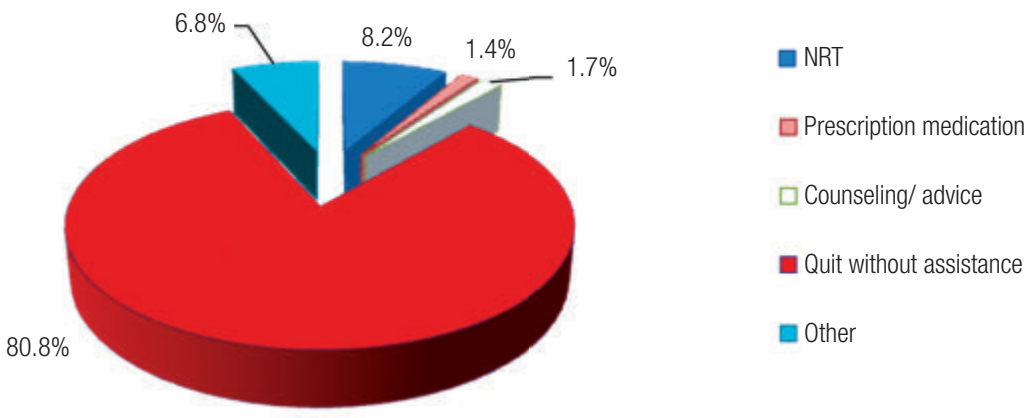
Among smokers trying to quit who had visited an HCP during the previous 12 months, 82.1% were asked by the HCP about their history of tobacco smoking (85.1% of males and 77.6% of females).

By age group, the highest proportion for being asked by the HCP about smoking was observed among those aged 45-64 (90.9%) and the lowest in the group aged 15-24 (66.3%). Proportions were very close by geography: 82.7%, urban; 81.0%, rural. By educational level, those with the least education had the highest percentage (89.7%), and the best-educated group had a significantly lower rate (75.2%) than the least educated.

Getting a health care provider's advice to quit smoking tobacco

Among the group of interest, 81.9% of those who had visited an HCP in the last 12 months received advice to quit (80.8% of males and 83.7% of females). By age, proportions receiving advice to quit ranged from 91.0% in the group aged 65+ down to 62.9% for the youngest group (a significant difference). No difference by residence was noted. By education, results ranged from 89.3% among smokers with the least education down to 78.1% among the best educated.

Fig. 5.1 Percentage of current smokers who made a quitt attempt in past 12 months by cessation methods used for their last attempt, GATS Romania 2011



5.2 Cessation Methods

Figure 5.1 presents the overall percentages for cessation methods. Most smokers (80.8%) who made a quit attempt tried do so without assistance. Only 8.2% used nicotine replacement therapy (NRT), 1.4% used another prescribed medication, and 1.7% used counseling and advice. The proportion of smokers who used natural plant products, acupuncture, and other methods for quitting was 6.8%.

Table 5.2 details cessation methods used in the past 12 months by the group comprised of current smokers who had made quit attempts in the last 12 months and recent quitters (abstinent less than 12 months) by demographic characteristics. The five methods shown are NRT (patches and chewing nicotine gum), other prescription medications (Zyban and Champix), counseling/ advice, trying to quit without assistance, and "other," which included natural plant products, acupuncture, and any other reported methods. Similar proportions of males (8.1%) and females (8.2%) used NRT for quitting; 8.1% of females used "other" methods but only 6.0% of males did so. By age, the proportion using NRT to quit was highest among those 25-44 (10.0%) and lowest in the 65+ group (5.0%).

Smokers in urban areas had slightly lower rates than their rural counterpart of using NRT (6.4% vs. 10.5%) and other prescription medications (0.8% vs. 2.1%), but relatively more smokers from urban areas received counseling/advice (2.2% vs. 1.0%).

Table 5.3 presents the percentages of using different methods for cessation among daily smokers who had tried to quit during the past 12 months, stratified by an indicator of tobacco dependency. The lowest percentage of trying to quit without assistance (62.6%) and the highest percentages of using NRT (16.4%), other prescription medications (2.7%), counseling/advice (2.8%), and other methods (8.7%) were found for the most addicted (first smoke within 5 minutes after waking).

5.3 Interest in Quitting Smoking

For GATS, interest in quitting smoking was defined as, among current tobacco smokers, planning to quit within the next month or thinking about quitting within the next 12 months or someday.

Table 5.4 presents five categories of "interest in quitting smoking."

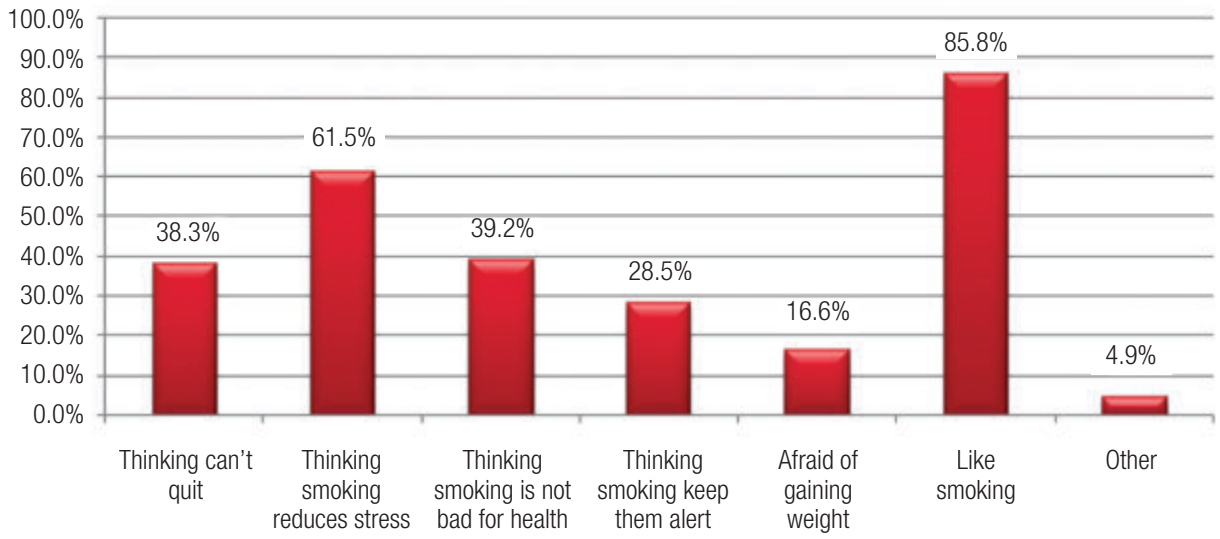
Overall, 39.2% of current smokers planned to quit someday but not in the next 12 months, 15.6% within the next 12 months, and only 7.9% within the next month. Essentially one-third of current smokers (33.6%) were not interested in quitting. No differences were noted by gender, residence, or educational level in attitudes towards quitting smoking.

Table 5.5 presents five categories of "interest in quitting smoking" stratified by an indicator of tobacco dependence. The highest percentage of smokers not interested in quitting (48.1%) and the lowest percentages planning to quit within the next month (4.3%) within the next 12 months (11.0%) were found among those most addicted (first smoke within 5 minutes after waking).

Figure 5.2 presents the main reasons (barriers) for not quitting among those not interested in doing so.

Table 5.6 details the most common reasons (barriers) for not being interested in quitting smoking, by demographic characteristics. Overall, the most common was liking to smoke (85.8%), followed by thinking that smoking reduces stress (61.5%), thinking that smoking is not bad for health (39.2%), and thinking they cannot quit (38.3%). Patterns were similar by gender.

Fig. 5.2 Percentage of current smokers who were not interested in quitting, by barriers to quit attempts, GATS Romania 2011



6. Secondhand Smoke

KEY FINDINGS

- 35.4% of persons aged 15 and above (about 6.4 million people) were exposed to secondhand smoke at home.
- 34.2% of all workers (nearly 2 million people) were exposed to SHS at work during the previous 30 days.
- 93.8% of nonsmokers had been exposed to SHS in bars and clubs and 86.6% had been exposed in restaurants.
- For less than one-third of adults, smoking was not allowed indoors at their workplace.

6.1 Exposure to Secondhand Smoke at Home

Table 6.1 shows the pattern of exposure to secondhand smoke (SHS) at home among Romanian adults in the past 30 days.

Just over one-third (35.4%) of Romanian adults (representing about 6.41 million people) had been exposed to SHS at home during the past 30 days. For nonsmokers only, the prevalence of at-home exposure to SHS was 24.4% (equivalent to about 3.25 million nonsmokers).

Overall, males (37.7%) had a slightly higher prevalence of exposure to SHS at home than did females (33.2%). By age, the highest rates of exposure were among those aged 15-24 (44.2%) and 25-44 (39.1%), and the lowest was among those aged 65 or above (18.6%).

People living in urban areas (40.9%) were significantly more likely to be exposed to SHS at home than were their rural counterparts (28.5%). By education, adults with the least education had the lowest rate of exposure (29.8%), while those with the most education had the highest rate (38.5%), albeit that rate was only marginally higher than the rate for those with a secondary education (37.6%).

Among ***nonsmokers***, exposure to SHS at home decreased with increasing age from 38.6% among those aged 15-24 to 14.7% among persons aged 65 years or above. Nonsmokers living in urban areas (28.4%) were more likely to be exposed than those living in rural areas (19.8%). By education, adults with the least education (19.5%) had the lowest prevalence rate of exposure, while those with college degrees or above (26.2%) had the highest rate, again, only marginally higher than the rate for those with a secondary education.

6.2 Exposure to Secondhand Smoke at Work

Exposure to SHS at work was considered for indoor workers only and measured for exposure to tobacco smoke at work in the past 30 days. Workers included those who worked outside the home and usually worked indoors or both indoors and outdoors.

Table 6.2 shows that, in Romania, 34.2% of all indoor workers (representing nearly 2 million people) had been exposed to SHS at work during the previous 30 days. Considering only nonsmoking workers, the prevalence of such exposure was 29.2% (equivalent to about 1.1 million nonsmoking workers).

Among all workers, a significant difference was not found by gender (36.8%, males; 31.2%, females), but those with a college education or above (30.0%) were less likely to be exposed than were those with less education.

The pattern of exposure was similar for non-smoking workers, as a significant difference was not found by gender (31.5%, males; 27.4%, females), but those with a college education or above (23.2%) were less likely to be exposed to SHS at work than were those with less education.

6.3 Exposure to Secondhand Smoke in Public Places

In GATS respondents were asked about visiting various public places in the past 30 days and whether they had noticed smoking occurring inside these places. Noticing smoking while visiting a public place was used as an indicator of exposure to SHS.

Figure 6.1 presents the overall percentages of people who had noticed tobacco smoking in public places. Among those who had visited various public places in the previous 30 days, 20.7% noticed smoking in government buildings, 10.4% in health care facilities, one-fourth (25.1%) in schools, and almost a half (47.5%) in universities. Vast majorities had been exposed to SHS in bars/nightclubs (94.4%) and restaurants (86.6%).

Table 6.3 presents the patterns of SHS exposure in public places, including government buildings, health care facilities, schools, universities, public transportation, restaurants, and bars and nightclubs in the general adult population and among nonsmoking adults by selected demographic characteristics. The rates of exposure in all sites but bars and nightclubs and health care facilities were higher for men than for women and, in general, were relatively lower for older people.

Public transportation had the lowest rate of exposure to SHS (8.9%), followed by health care facilities (10.4%). The prevalence rates of exposure at universities, schools, and government office buildings were 47.5%, 25.1%, and 20.7%, respectively. Among nonsmokers the highest proportion of exposure was found in bars and nightclubs (93.8%), followed by restaurants (83.8%).

Fig. 6.1 Percentage of persons who noticed tobacco smoking in public places, GATS Romania 2011

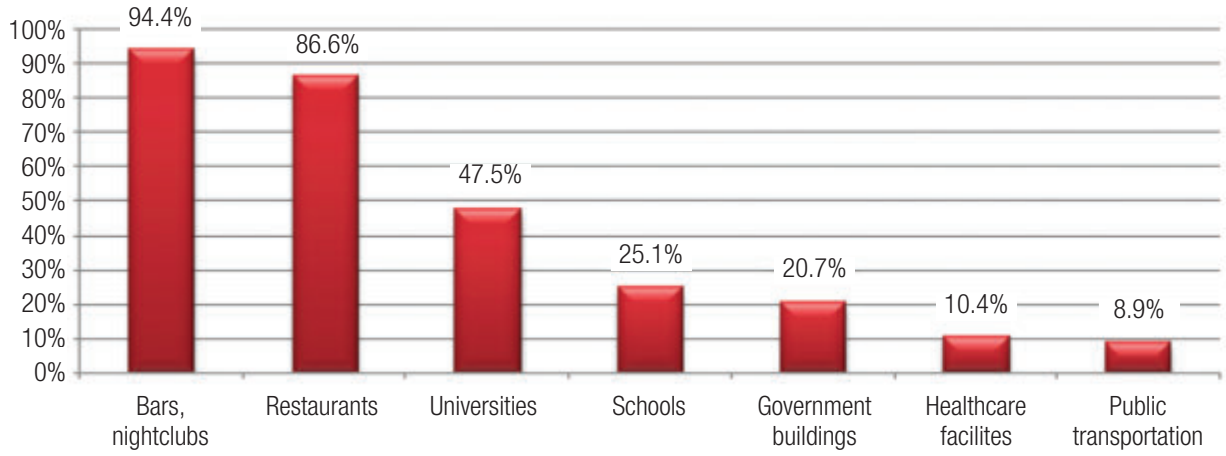


Table 6.4 presents smoking policies at home and work by smoking status. Overall, almost a half of Romanian adults either allowed smoking at home (23.0%) or allowed it with exceptions (24.4%). Current smokers (46.6%) were more likely than nonsmokers (14.4%) to allow smoking at their homes (46.6%), and nonsmokers were more likely than smokers to have a complete ban on smoking at their homes (56.7% versus 28.7%). Just over one-fourth (27.7%) of all adults worked at places where smoking was prohibited in all areas, while almost three-fifths (59.0%) worked in places where smoking was allowed in some indoor places.

Only 7.2% of adults worked in places where smoking was allowed everywhere. Current smokers were more likely to work in areas where smoking was permitted everywhere (12.1%) than were nonsmokers (4.5%).

7. Economics

KEY FINDINGS

- 84.3% of smokers buy their cigarettes from stores.
- On average, a current smoker of manufactured cigarettes spends 273.1 RON per month on cigarettes.
- The average amount of money spent for a pack of 20 manufactured cigarettes is 11.6 RON.
- About 4.5% of per capita gross domestic product (GDP) in Romania is spent on the purchase of manufactured cigarettes.

7.1 Last Brand of Manufactured Cigarettes Purchased

GATS Romania asked respondents to report on the brand name of the last cigarette product purchased. The five most frequently purchased brands were Kent (33.8%), Marlboro (9.7%), Winchester (8.2%), Viceroy (7.6%), and Winston (7.0%) (**Table 7.1**).

7.2 Source of Last Purchase of Cigarettes among Smokers of Manufactured Cigarettes

Figure 7.1 presents data on the source of the last purchase of manufactured cigarettes among current smokers of manufactured cigarettes. The most common source was the store (84.3%), followed by kiosks (6.6%) and street vendors (3.5%). Very few smokers of manufactured cigarettes purchased their cigarettes from another person (2.7%) or from other sources (2.7%).

Table 7.2 presents detailed information about the source of the last purchase of cigarettes among smokers of manufactured cigarettes, stratified by gender, age, and residence. There were no significant differences by demographic characteristics in the source.

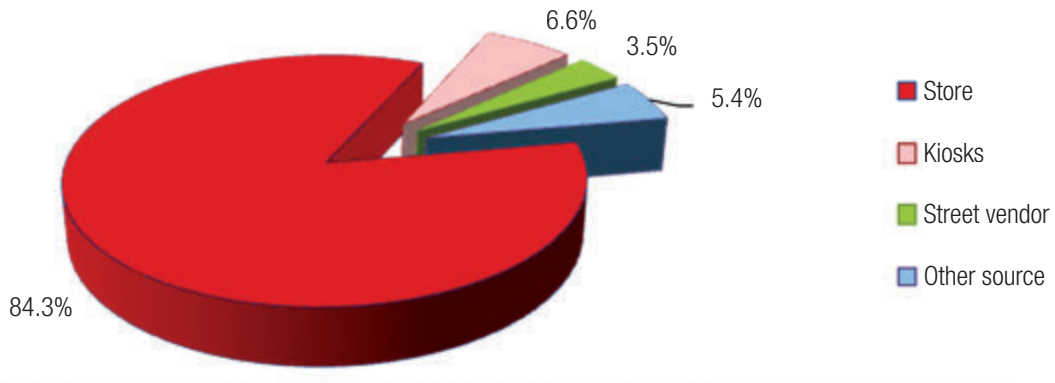
7.3 Expenditures for Cigarettes

Table 7.3 presents information on monthly expenditures for manufactured cigarettes among adult smokers of such cigarettes by selected demographic characteristics. On average, such a smoker spent 273.1 RON per month (around 90 US$). Male smokers spent 299.5 RON/month and females spent 216.9 RON/month.

By age, spending ranged from 218.0 RON/month among smokers aged 15-24 years to 298.0 RON/month among smokers aged 45-64.

By education, the highest monthly spending was found among smokers with the least education (318.1 RON); other averages were 249.5 RON (secondary) and 248.9 (high). No significant differences were noted by residence (rural, 278.8 RON/month; urban, 269.2 RON/month).

Fig. 7.1 Percentage distribution of the source of the last purchase of cigarettes among smokers of manufactured cigarettes, GATS Romania 2011



8. Media

KEY FINDINGS

- A strong majority (83.6%) of Romanian adults noticed antismoking information, with 76.7% of adults noticing such information on television.
- Over one-fourth (27.5%) of current smokers are thinking about quitting because of pictorial health warnings, with more female than male smokers thinking about quitting because of the warnings (33.2% vs 24.7%)
- 35.2% non-smokers noticed tobacco advertisement, promotion and sponsorship.

8.1 Awareness of Antismoking Information

This section covers the degree of awareness of antismoking information in the media or displayed in public places. These sources include newspapers or magazines, television, radio, and billboards.

Population awareness of antismoking information in various media sources

Table 8.1 shows that 83.6% of Romanian adults had noticed antismoking information that was broadcast through the media or displayed in public places at any location. The pattern was quite similar across age groups, gender, and residence. Among all adults who had noticed antismoking information in various places (**Figure 8.1**), television was the most common source (noticed by 76.7%), followed by newspapers and magazines (35.1%), billboards (25.8%), and radio (25.3%). A small proportion of adults noticed antismoking information somewhere else (6.7%).

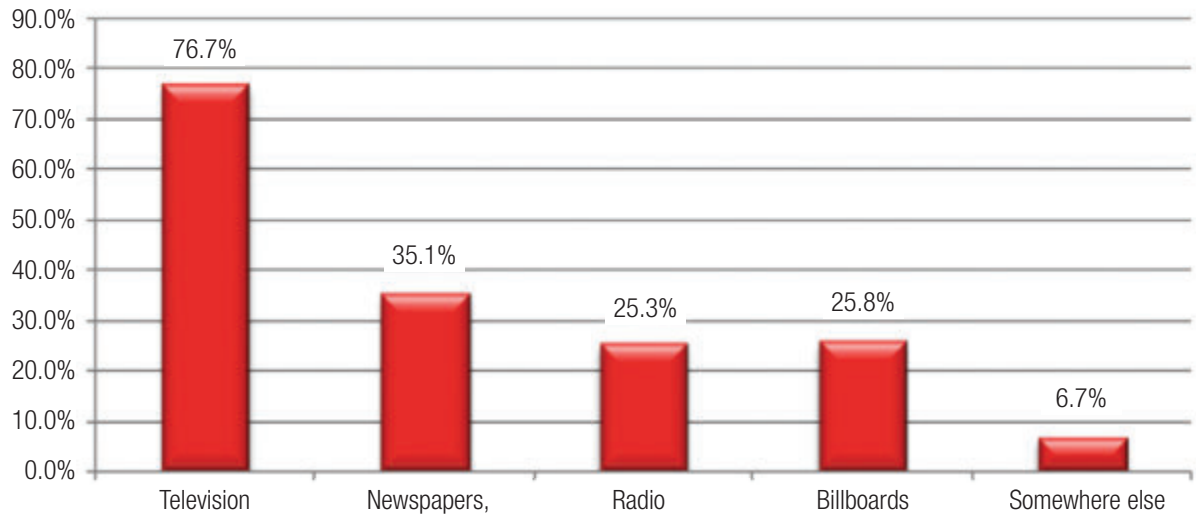
Current smokers' and nonsmokers' awareness of antismoking information in various media sources

Classified by smoking status (**Table 8.1**), the proportions of those noticing antismoking information from different media sources among current smokers as well as among nonsmokers were similar to those of the overall adult population.

8.2 Smokers Who Noticed Health Warning Labels on Cigarette Packets and Considering Quitting

Table 8.2 shows that 95.2% of current smokers had noticed health pictorial warnings on cigarette

Fig. 8.1 Places where antismoking information was noticed, GATS Romania 2011



packs and 27.5% of current smokers had thought during the last 30 days about quitting because of the labels (female, 33.2%; male, 24.7%). Fully one-third (33.4%) of those in the 65+ age group had thought about quitting because of the labels (percentages were lower for the other age groups).

Current smokers in urban areas were more likely than their rural counterparts to have noticed the health warnings (96.8% vs. 93.0%), but these two groups did not differ significantly in terms of thinking about quitting because of the labels. No differences were noted by educational level.

8.3 Adults Who Noticed Cigarette Marketing in Various Public Places

Table 8.3 presents the distribution of adults who had noticed tobacco advertising in stores where cigarettes are sold, on the Internet, on public walls, or somewhere else. In all, 40.5% had noticed any kind of tobacco advertising, sponsorship, or promotions. Men (45.2%), those aged 15-24 years (58.8%) and urban residents (50.4%) were more likely than women (36.1%), those 25 and older (37.1%), and rural residents (28.0%) to have noticed some type of marketing.

For advertisements, the percentage noticing was highest for stores (26.7%), followed by the Internet (6.8%) and public walls (4.9%). More men (31.0%) than women (22.7%), and more younger adults (15-24 years, 39.2%) than those 25 or older (24.4%) noticed advertisements in stores. Those living in urban areas were more exposed to cigarette advertisements on the Internet than were those from rural areas (9.4% vs. 3.6%). Those in the 15-24 age group were significantly more likely to notice tobacco advertisements on the Internet (16.9%) than were those aged 25 years or older (5.0%).

In all, 5.0% of adults had noticed sport sponsorships about tobacco. Men (6.7%) and urbanites (6.3%) noticed these sponsorships more than did women (3.4%) and rural residents (3.3%).

Among cigarette promotions, free gifts/discounts were the most commonly noticed (8.1%), followed by "promotional girl" (7.0%), items with a brand-name logo (5.2%), free samples (4.4%), sale prices (4.0%) and coupons (4.0%), and mail that promoted cigarettes (1.2%).

No differences by gender were noted for the different types of cigarette promotion, but significantly higher percentages for noticing all three types of marketing (ads, sports sponsorship, promotions) were found for the 15-24 age group versus those 25 or older (58.8% vs. 37.1%) as well as for urban versus rural residents (50.4% vs. 28.0%).

8.4 Nonsmokers Who Noticed Cigarette Marketing in Various Public Places

Table 8.4 shows the percentages of nonsmokers who had noticed cigarette advertisements, sport sponsorships, cigarette promotions, or event sponsorships by gender, age group, and residence.

In all, 35.2% of nonsmokers had noticed at least one of the kinds of marketing. Nonsmokers in the 15-24 age group (57.6%) and those living in urban areas (43.5%) had higher proportions of persons who noticed some kind of marketing than did their counterparts aged 25 or over (30.7%) or living in rural areas (25.3%).

The pattern of noticing cigarette marketing among nonsmokers was similar to that among adults as a whole. The place with the highest proportion of nonsmokers who noticed advertisements was in stores where cigarettes are sold (22.2%). Here, a higher proportion of those in the 15-24 age group (35.7%) had noticed the advertisements than those aged ≥25 years (19.4%). Urban residents were more likely than those living in rural areas to notice these store ads (27.2% vs. 16.1%).

In all, just 4.6% of nonsmokers noticed sports sponsorships about tobacco. The percentage of nonsmokers noticing cigarette promotions was generally higher among males, the younger group, and those living in urban areas.

9. Knowledge, Attitudes and Perceptions

KEY FINDINGS

- A solid majority of adults (82.6%) believe that smoking causes stroke, heart attack, lung cancer, and other cancers.
- The great majority (94.2%) of adults believe that exposure to secondhand smoke could cause serious illnesses in nonsmokers.
- About one-fifth (21.0%) of all adults believe that low-tar cigarettes are less harmful than regular ones, and 18.9% have the same belief about slim cigarettes.
- In all, 71.8% of Romanian adults are in favor of a complete ban on smoking in restaurants, and 56.8% in all bars, night and music clubs.

9.1 Beliefs That Tobacco Smoking Causes Serious Illnesses and Specific Diseases

Tables 9.1A and **Table 9.1B** present the percentages of Romanian adults who were aware of the health effects of tobacco smoking by socio-demographic groups.

Figure 9.1 shows that almost all adults (96.3%) believed that smoking causes serious diseases and illnesses. High percentages of adults were aware that smoking causes lung cancer (98.3%), stroke (89.2%), and heart attack (90.0%), cancers other than lung cancer (94.6%), periodontal disease (83.0%), bone loss (53.4%), premature birth (74.7%), and erectile dysfunction (66.5%). As shown in **Table 9.1A** and **Table 9.1B**, no significant differences in level of belief were noticed across age groups or by educational level or residence.

Beliefs among current smokers that tobacco smoking causes serious illnesses and specific diseases among current smokers

Tables 9.1A and **9.1B** show that the pattern of awareness among current smokers was quite similar to the pattern for the overall population.

Fig. 9.1 Percentage of persons ≥15 years old who were aware that smoking causes diseases, GATS Romania 2011

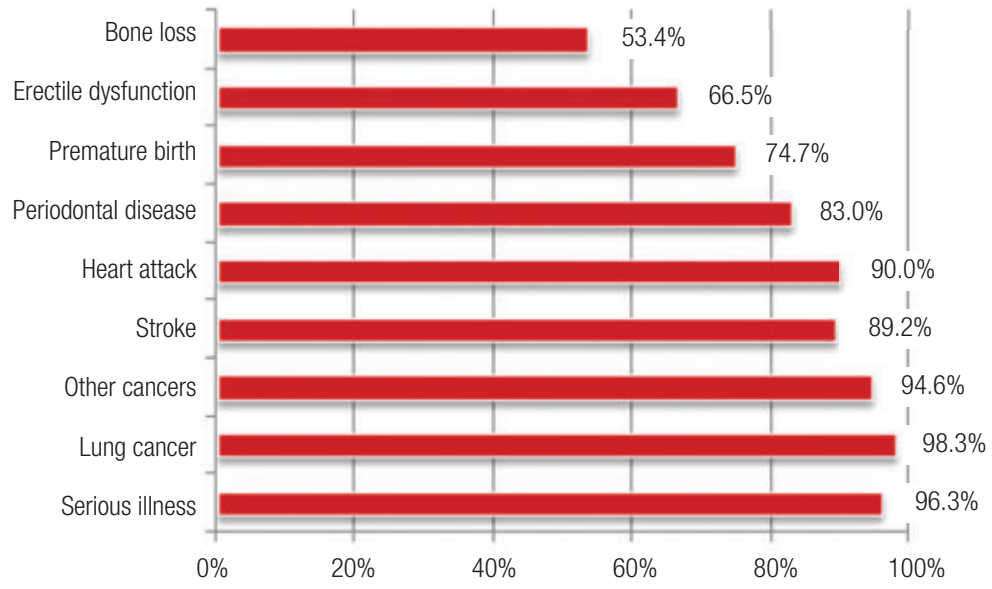
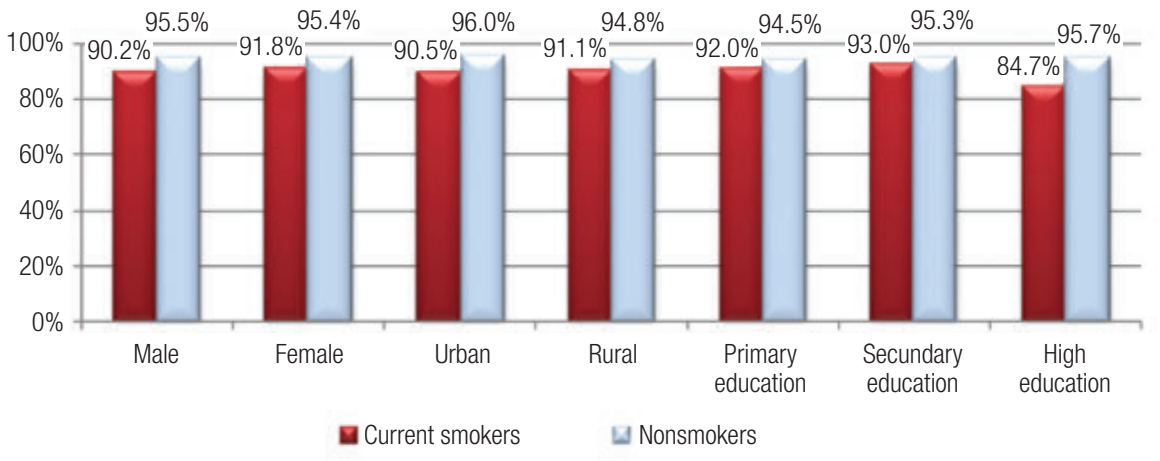


Fig. 9.2 Percentage of current smokers and nonsmokers who were aware that SHS causes serious illness, by selected demographic characteristics, GATS Romania 2011



Beliefs among nonsmokers that tobacco smoking causes serious illnesses and specific diseases

As shown in **Tables 9.1A** and **9.1B**, almost all nonsmokers (97.3%) believed that smoking causes serious diseases and illnesses. The pattern of awareness of the health effects of smoking among nonsmokers was quite similar to the pattern of the overall adult population. In all, 98.8% of nonsmokers believed that smoking causes lung cancer; 90.1%, stroke; 91.4%, heart attack; 95.2%, cancers other than lung cancer; 83.6%, periodontal disease; 55.6%, bone loss; 77.2%, premature birth; and 67.6%, erectile dysfunction. No significant differences in beliefs among nonsmokers were noticed by educational level, but those aged 65+ were less aware than younger persons about the health effects of tobacco smoking.

9.2 Beliefs That Secondhand Smoke Causes Serious Illness in Nonsmokers

As shown in **Table 9.2**, 94.2% of adults believed that breathing secondhand smoke (SHS) could cause serious illnesses among nonsmokers. Men did not differ from women in terms of awareness (93.5% vs. 94.8 %,), but nonsmokers were more aware of the health effects of SHS than were current smokers (95.4% vs. 90.7%).

Overall, no significant differences were noticed in awareness by age group, residence, or educational level. However, as shown in **Figure 9.2.** and **Table 9.2**, persentage of current smokers who were aware of the health effects of SHS was lower than that of nonsmokers across age groups, gender, residence, and educational levels.

9.3 Beliefs That Certain Types of Cigarettes Can Be Less Harmful Than Others

Table 9.3A shows the beliefs of Romanian adults about low-tar cigarettes by sociodemographic characteristics and smoking status.

Overall, 21% of adults (24.9% of males, 17.4% of females) believed that low-tar cigarettes are less harmful than regular cigarettes. A significantly higher proportion of adults in the youngest age (30.6%) believed that low-tar cigarettes are less harmful than regular ones in comparisons with the other three age groups (only 11.6% of adults aged 65+ believed this). No differences by residence were noted. Those with high education were more likely (23.2%) than those with a primary education or less (18.0%) to have such a belief.

Current smokers (35.0%) were significantly more likely than nonsmokers (15.9%) to believe that low-tar cigarettes are less harmful than regu-

lar cigarettes. Patterns were similar for current smokers versus nonsmokers across age groups, residence, and educational level. No differences among current smokers by gender were noticed. Somewhat less than half (43.3%) of current smokers in the youngest age group believed that low-tar cigarettes are less harmful, but less than one-third (32.5%) of current smokers aged ≥65 years believed that. Current smokers from rural areas (36.6%) and those with high education (37.9%) had higher rates of such a belief than those from urban areas (33.9%) or with secondary education (31.3%).

Table 9.3B shows the beliefs of Romanian adults about slim cigarettes by sociodemographic characteristics and smoking status.

Overall, just 18.9% of adults believed that slim cigarettes are less harmful than regular cigarettes. A significantly higher percentage of male (21.9%) than female (16.0%) adults had this belief. A significantly higher proportion of adults in the 15–24 age group (31.6%) believed that slim cigarettes were less harmful than did members of the other three age groups (lowest proportion: 9.2% among those 65+). No differences by residence were noted. Those with a primary education had the lowest proportion (15.5%) holding this belief, with the secondary (18.9%) and high education (18.2%) groups having somewhat higher percentages. Among current smokers, gender was not related to this belief.

Current smokers (30.1%) were significantly more likely than nonsmokers (14.8%) to believe that slim cigarettes are less harmful; this pattern was similar when comparing current smokers and nonsmokers across age groups, residence, and educational level.

By age, the highest percentage of current smokers having the belief about slim cigarettes was noted for the youngest group (41.3%) and the lowest (23.8%) among the oldest group. No differences were noted by residence or educational level.

9.4 Support for Tobacco Control

9.4.1 Support for Complete Ban on Smoking in Various Venues and Situations

Table 9.4 shows the opinion of Romanian adults on a complete ban of smoking in various venues and situations. Almost all were in favor of a complete ban in the presence of children (96.3%) or pregnant women (96.3%), with a somewhat lower figure for a ban while driving a car (81.5%). Nonsmokers were more likely than current smokers to be in favor of a complete ban in the presence of children (97.5% vs. 93.2%) and pregnant women (97.8% vs. 92.2%).

Almost three-fourths (72.0%) of adults were in favor of a complete ban on smoking in restaurants,

Fig. 9.3 Percentage of persons in favor of complete ban of smoking in various venues and situations by smoking status, GATS Romania 2011

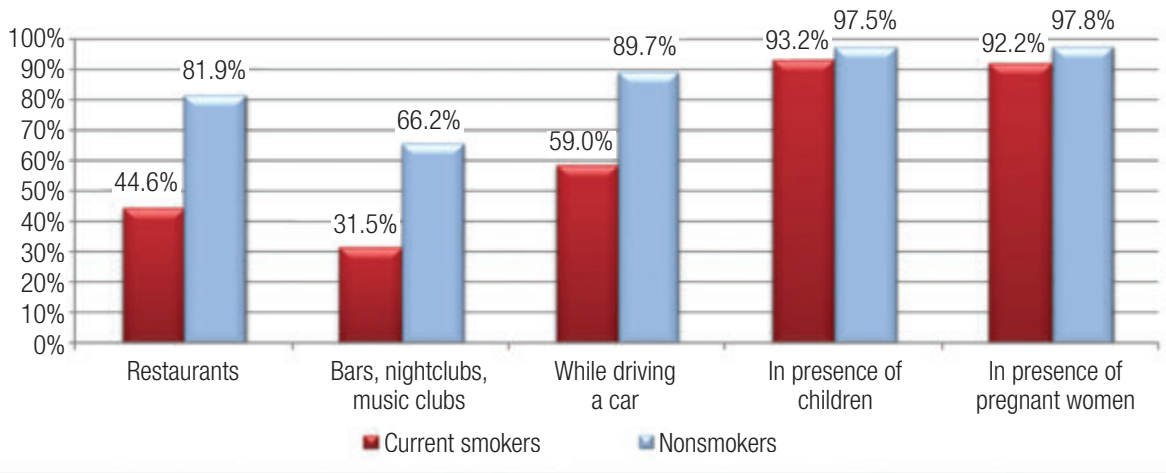
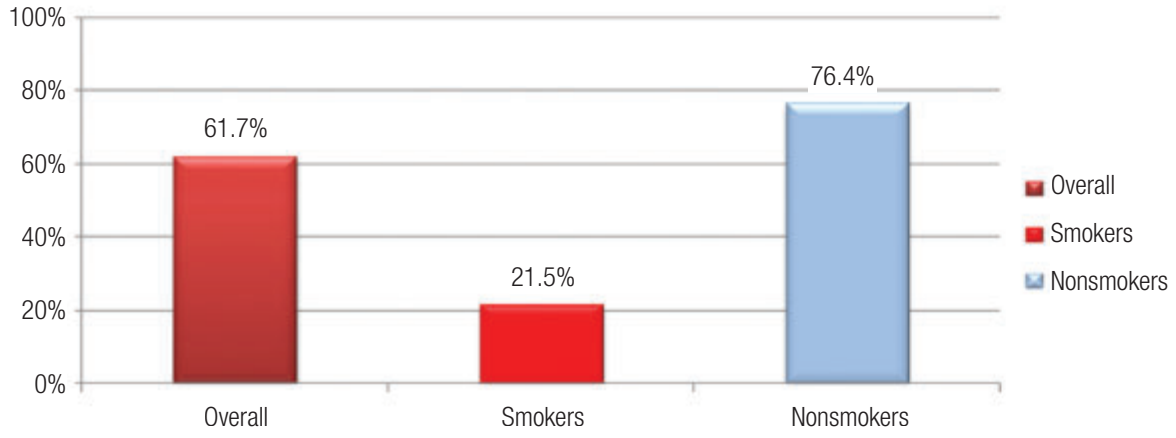


Fig. 9.4 Percentage of persons in favor of increasing taxes on tobacco products, GATS Romania 2011



and 57.0% of adults favored such a ban in all bars, nightclubs, and music clubs.

More than half of current smokers (54.0%) were against a complete ban on smoking in restaurants, and two-thirds (66.9%) of current smokers were against banning smoking in all bars and clubs. Conversely, nonsmokers were highly in favor of a ban on smoking in all restaurants (81.9%) and generally in favor for bars and clubs (66.2%).

Table 9.5 and **Figure 9.3** presents the proportion of adults who were in favor of a complete ban on smoking in various venues and situations by smoking status and socio-demographic characteristics.

More women than men were in favor of a complete ban in all restaurants (77.3% vs. 66.2%), bars and clubs (62.3% vs. 51.2%), and while driving a car (86.7% vs. 75.8%). Almost all adults, both men and women were in favor of a complete ban on smoking in the presence of children and pregnant women.

By age, adults 65+ had a larger proportion than those in each of the other age groups (15-24, 25-44, 45-64) of being in favor of a complete ban on smoking in all restaurants (85.5% vs. 67.8%, 67.6%, 71.6%), bars and clubs (75.6% vs. 48.3%, 50.1%, 59.3%), and while driving a car (91.7% vs. 76.9%, 77.0%, 83.7%).

Adults with a high educational level were less likely than other groups to favor a complete ban in all restaurants, bars and clubs, and while driving a car.

9.4.2. Support for Increasing Taxes on Tobacco Products

Figure 9.4 shows the percentage of persons ≥15 years old who supported increasing taxes on tobacco products by smoking status. **Table 9.6** details these data by selected demographic characteristics. Overall, 61.7% of adults, 21.5% of current smokers, and 76.4% of nonsmokers supported this measure. Males were less likely than females to support such a measure (55.8% vs. 67.2%).

By age, adults 65+ (75.4%) were significantly more likely to be in favor of increasing taxes on tobacco products than were those aged 15-24 years old (63.7%), 25-44 (57.3%), or 45-64 (58.0%). More rural residents (64.9%) than urbanites (59.1%) were in favor of increasing taxes.

10. Discussion and Implications for Public Health Policy

10.1 Smoking in Romania: GATS 2011 Versus Previous Romanian Surveys

The Global Adult Tobacco Survey (GATS), a component of the Global Tobacco Surveillance System (GTSS), allows for monitoring of smoking behaviors and attitudes in Romania according to the highest standards of tobacco surveillance and gives the opportunity to compare Romanian data to that of other countries. In brief, GATS sets out a standard for collecting data on tobacco use in Romania that will allow analyzing this information in a global context.

During the Communist period and at the beginning of the 1990s, the Ministry of Health (Centre for Medical Statistics and Medical Documentation) surveyed the prevalence of smoking in Romania by using random samples of the adult population. However, all of these surveys were based on small samples, used different sampling methods, and questionnaires, which make difficult to compare their results.

The prevalence of tobacco use and its characteristics was sporadically analyzed in nationwide studies of health status until 2004, when a methodology based on World Health Organization (WHO) recommendations was implemented. Yearly between 2007 and 2009 and in 2011, tobacco use in the adult population was assessed using the same methodology, which allowed for assessing trends in this phenomenon and the assurance of effectiveness in tobacco control measures.

The results of surveys on smoking behaviors in the adult Romanian population conducted from 1989 to 2011 suggest that changes in the prevalence of smoking resulted from phenomena in the recent historical past that affected both smoking habits and tobacco control policies. After the change in political regime in 1989, and in the context of the invasion of tobacco multinationals along with the lack of tobacco control regulations, consumption of tobacco increased dramatically, with the prevalence of current smokers rising from 25.9% in 1989 to 36.1% in 2000 [8].

In 2002, tobacco control policies in Romania underwent substantial changes determined by the necessity to align the national legislation to that of the European Community in view of the plan to join the European Union (EU). Regardless, in 2004 a survey [16] about the knowledge, attitudes, and behaviors of Romanian adults aged 14–60 years using the international recommendations found a prevalence of current smoking of 35.3% and a prevalence of female daily smokers of 19.5%. The prevalence of smoking among adults aged ≥15 years estimated from a survey conducted in 2008 was 36.1% [18]. The toughest non-price changes in recent history entered into force in January 2009, and in January 2010 the largest increase in the price of cigarettes occurred. A survey conducted in 2009 [19], using the same methodology as in 2004, showed that the prevalence of smoking had decreased to 32.4% and, for the first time in the last 20 years, that the prevalence of female smokers also decreased. A recent study [13] also showed a significant reduction in the prevalence of smoking.

The GATS results confirm the reduction in the prevalence of smoking prevalence among both males and females in the Romanian population. Incorporating a broad spectrum of socio-demographic indicators, GATS allows for detailed description of attitudes towards smoking in the adult population of Romania along with the perception of this habit in the society. Conducted according to the highest international methodological standards, its results constitute significant scientific evidence for the formulation of health policy, enhancing countries' capacity to design, implement, and evaluate tobacco control programs. A detailed analysis of GATS study results will allow policy makers and the whole community to act on both the local and central level to

implement tobacco control interventions addressed to various groups within the population.

10.2 MPOWER Standards and Implications for Public Health Policy in Romania

GATS assists countries in fulfilling their obligations under the WHO Framework Convention on Tobacco Control (FCTC) to generate comparable data within and across countries. The WHO FCTC, the first international treaty negotiated under the auspices of the WHO, was adopted by the World Health Assembly on 21 May 2003 and took effect on 27 February of 2005. Romania ratified the WHO FCTC in the same year.

To help countries fulfill the promise of WHO FCTC, WHO had developed MPOWER [40] as a technical assistance package of six evidence-based and effective tobacco control policies within the WHO FCTC, all of them proven to reduce tobacco use: 1) **M**onitor tobacco use and prevention policies; 2) **P**rotect people from tobacco smoke; 3) **O**ffer help to quit tobacco use; 4) **W**arn about the dangers of tobacco; 5) **E**nforce bans on tobacco advertising, promotion, and sponsorship; and 6) **R**aise taxes on tobacco. By effectively implementing the WHO FCTC and the MPOWER strategy, countries can do their part to limit the tobacco epidemic and meet their obligations as Parties to the treaty.

1. Monitoring of tobacco use and prevention policies.

Article 20 of WHO FCTC strongly recommends that countries develop surveillance programs: "The Parties shall establish, as appropriate, programs for national, regional and global surveillance of the magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke" [40]. The WHO MPOWER states that "Good monitoring provides information about the extent of the tobacco use epidemic in a country, as well as how to tailor policies to specific country needs."

Romania is one of the WHO European countries, where the monitoring of tobacco use and prevention policies fulfills high standards by producing recent, representative, and periodic data for both adults and youth. By conducting GATS in 2011 and repeating the survey and/or using GATS indicators periodically, Romania will have a strong tool for fighting tobacco.
Romania has participated in three surveys that are part of GTSS, including the Global Youth Tobacco Survey (GYTS) in 2004 and 2009, the Global School Personnel Survey (GSPS) in 2009, and the GATS in 2011.

The findings from GATS Romania 2011 have shown that the prevalence of tobacco use, especially smoking, has decreased but is still high. In 2011, an estimated 26.7% of the Romanian population aged 15 and over (37.3% of males, 16.5% of females) currently smoked tobacco. Thus, the estimated number of current adult smokers in Romania is about 4.85 million persons (3.27 million men and 1.57 million women). Furthermore, 69.5% of daily smokers could be considered addicted (had their first smoke within 30 minutes after waking up).

GATS 2011 reveals that among females, unlike males, the prevalence rates of current smoking are highest among people with a secondary or the highest education. This information needs to be strongly considered by policy makers, media campaigners, and cessation advisors/health care providers. Interestingly, at the same time, GATS reveals that health care providers are less likely to ask and advise patients with high educational levels about tobacco use.

GATS found that 17.1% of Romanian daily smokers aged 20 to 34 years started their daily smoking before age 15 years (before the legal age for buying tobacco), and rural residents were twice as likely to have done this as their urban counterparts. This reveals the need for enforcement of the legal age of sales to minors, particularly in rural areas.

2. Protection of people from tobacco smoke by banning smoking in public places, including bars and restaurants.

Article 8 of WHO FCTC urges the parties to implement control measures to avoid exposure to tobacco smoke and to enact and enforce laws provid-

ing protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places, and, as appropriate, other public places [3]. MPOWER also notes that "There is no safe level of exposure to secondhand smoke. Only a total ban on smoking in public places, including all indoor workplaces, protects people from the harms of secondhand smoke, helps smokers quit, and reduces youth smoking"[4].

Despite positive changes in trends for tobacco smoking in Romania the level of exposure to tobacco smoke, both active and passive, remains high. The GATS found that 35.4% of adults were exposed to tobacco smoke at home and a similar proportion (34.2%) were exposed in the workplace. Furthermore, those with less education were more likely to be exposed to secondhand smoke (SHS) in the workplace than those with a college education or above. This is indicative of a level of social inequity and consistent with global evidence that demonstrates that tobacco use and exposure to SHS consistently and disproportionately affect the most socially deprived groups in society.

Even though Romanian law bans smoking in health care facilities (total) and in all governmental buildings, schools, and universities allows smoking only in special designated rooms, GATS Romania 2011 found that a substantial percentage of Romanian adults saw people smoking in these venues (outside the special rooms dedicated to smoking), with the highest percentage being reported for universities with almost a half (47.5%).

As for restaurants, bars, and nightclubs (not covered in the current legislation), rates of exposure to SHS of 86.6% and 94.4% were found for restaurants and for bars/clubs respectively.

Effective enforcement of the smoking ban in public places and work sites will require the establishment of partnerships between governmental agencies, the public services responsible for compliance with the law, and a civil society that might support the law enforcement process.

GATS 2011 showed that public opinion strongly supports restrictive regulations. Almost three-fourths quarters of Romanian adults (72.0%), per the GATS, were in favor of a total ban on smoking in all restaurants, and more than a half (57.0%) favored such a ban in bars and clubs. Moreover, almost all Romanian adults (96.3%) were in favor of a complete ban on smoking in the presence of children and of pregnant women.

Taking into account these data, along with WHO FCTC requirements and while considering the successes achieved in smoke-free policy in the WHO European countries that enforced the complete ban on smoking in public places and work sites, Romanian legislators should seek to enforce and complete the existing tobacco control legislation and put in place a total ban on smoking in all public places, including restaurants, bars, and clubs. In addition to providing effective protection for nonsmokers against SHS, these regulations would be supportive for smokers in their attempt to quit smoking and, as a result, will contribute to the decreasing trends in the prevalence of smoking in Romania.

3. Offering assistance (by various available tools) for quitting tobacco use.

Article 14 of WHO FCTC recommends "Demand reduction measures concerning tobacco dependence and cessation" and that Parties implement best practices to promote cessation of tobacco use and implement the treatment of nicotine addiction [3]. MPOWER also emphasizes "Offering help to quit tobacco use" and recommends three types of treatment for tobacco dependence: advice on tobacco cessation incorporated into primary health care services, easily accessible and free quit lines, and access to low-cost pharmacological therapy [4].

In Romania, treatment for tobacco addiction has been freely available since 2007 in the framework of a national program funded by the Ministry of Health. A toll-free quit line is also available, and smoking status is mandated to be registered in the medical files.

GATS Romania 2011 found that more than a third (35.5%) of smokers had attempted to quit in the previous 12 months. Of the 50.4% of smokers who

visited a health care provider in the previous year, 82.1% were asked by the health care provider if they were smokers, and 81.9% were advised to quit. However, young adults (ages 15-24) were less likely to be asked and advised than others. Additionally, those with a high education level were less likely to be asked and advised about tobacco than those with a primary education or less. These findings have large policy implications, and health care providers need to be encouraged to ask and advise all patients, irrespective of their profile. This need is further underscored when one considers that prevalence rates for smoking among females were highest among those with a secondary or the highest category of education.

Only a very small proportion of quitters used nicotine replacement therapy (8.2%), another medical prescription (1.4%), or counseling or advice (1.7%), showing that although smoking cessation programs and services introduced have increased over the last few years and are seemingly accessible and affordable (medications are fully covered by national health system), the system of treatment for nicotine dependence requires further expansion. Support for smoking cessation is not available in all primary care facilities, hospitals, and offices of health professionals. The reasons for not using the available services and medications need to be further explored.

The GATS found that 33.6% of smokers were not interested in quitting in the future. Alarmingly, 39.2% of them did not think that smoking was bad for their health and almost the same percentage (38.3%) did not think they could quit. Clearly, the reach and effectiveness of media and educational campaigns need to be further evaluated.

4. Warning about the dangers of tobacco.

Article 11 of WHO FCTC, states that "Each Party will implement effective health warnings, including pictograms, on the packaging of all products of tobacco use within three years of adoption of the FCTC" [3]. MPOWER notes that "Health warnings on tobacco packaging reach all smokers and cost governments nothing… Pictures of diseases have a greater impact than words alone" [4].

In 2008, Romania became the second EU country to implementing the pictorial health warnings on all tobacco products intended for smoking. The health warnings have been modified according to the provisions of the EU Tobacco Directive, covering 30% on the front and 40% on the back of cigarettes packs.

Pictorial health warnings on cigarette packs have been effective in informing smokers about the dangers of tobacco smoking. Per GATS Romania, the warnings were noticed by the vast majority of smokers (95.2%). Further, more than one-quarter (27.5%) considered quitting because of the warnings. Moreover, it should be noted that two of the main arguments for pictorial warnings (beyond encouraging cessation) are to reduce the initiation of tobacco use among nonsmokers and to lower the number of cigarettes smoked among smokers. Also, very importantly, more female than male smokers thought about quitting because of the pictorial warning labels. This is crucial in the context of the recent doubling of female daily smokers (from 2000 to 2003) and is supportive of the current policy of requiring pictorial warnings. As more and more restrictions are being placed on conventional advertising, the tobacco pack itself has become a crucial part of the marketing strategy, and there are many packs that resemble lipstick cases and target females specifically. The results for GATS also emphasize the great need for support the revision of the European Commission Tobacco Products Directive and the possible advancement into larger pictorial warnings or plain/standardized packaging. Encouragingly, GATS found that 83.6% of Romanian adults noticed antitobacco information in the mass media.

Thankfully, the GATS shows that adults from Romania are largely aware of the risks associated with tobacco smoking. Almost all (96.3%) were aware that smoking causes serious illness. Even so, very small gaps were exposed in the level of awareness that smoking causes stroke (89.2%) and heart attacks (90%), and larger gaps were seen regarding knowledge about bone loss (53.4%), premature birth (74.7%), and erectile dysfunction (66.5%). These shortcomings may indicate the need to evaluate which pictorial warnings from the EU library

had been selected by Romanian authorities and whether more rotation is needed to increase the public's knowledge of such health effects as premature birth and erectile dysfunction.

Most Romanian adults (83.9%) noticed anti-smoking information, with the highest specific percentage for information appearing on television (76.7%). This is important to know for the evaluation of whether resources are being used effectively and whether any shifts are necessary (e.g., if heavy resources are used to place antismoking information on billboards but they are not noticed all that much [25.8% in this study], perhaps the resources should be redirected).

5. Enforcement of bans on tobacco advertising, promotion, and sponsorship.

Article 13 of WHO FCTC states that "Parties recognize that a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products" [3]. MPOWER specifies that "A total ban on direct and indirect advertising, promotion and sponsorship can substantially reduce tobacco consumption and protect people, particularly youths, from industry marketing tactics" [4].

In Romania, tobacco advertising has been banned in accordance with the EU Tobacco Advertising Directive, being banned on radio, TV, outdoor and indoor billboards, mass media, toys and non-tobacco objects, and minors-intended events. Ads for tobacco can be seen only at the points of sale and in rooms dedicated to smoking. Publicity on TV and radio is subject to requirements in the Broadcasting Act nr. 48/1992 as amended and supplemented, resulting in zero tolerance for tobacco advertising through those media.

The GATS found that 40.5% of Romanian adults had noticed some kind of advertising, sponsorship, or promotion of tobacco products. And, in spite of legislation, 5.0% had noticed the sponsorship of sports events by a cigarette marketer. Advertising was observed most often in stores where cigarettes are sold (26.7%), followed by the Internet (6.8%). The promotions that were noticed most often consisted of free gifts/discounts or other products, "promotional girls," and clothing or items with a brand or logo or other initiatives. These data reveal a relatively new phenomenon that shows the constant evolution of industry tactics in circumventing the current legislation. This points to the necessity of adopting new regulations targeting the elimination of these forms of tobacco promotion or advertising from the market.

6. Raising taxes on tobacco.

Article 6 of WHO FCTC states "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]. MPOWER concludes, "Tobacco taxes are generally well accepted by the public and raise government revenues… Taxes need to be increased regularly to correct for inflation and consumer purchasing power." [4]

Taxation of tobacco products in Romania has been modified according to the EU Tobacco Taxation requirements, a specific and an ad valorem excise tax, and the requirement that a minimum level of excise tax be present. In 2006, an earmarked tobacco tax for health was introduced, and 20 eurocents per every pack of cigarettes sold is allocated to the Ministry of Health. A part of the funds collected from tobacco products finances the tobacco control program and the treatment of some smoking-related diseases.
There is still a need, however, for a substantial increase in cigarette prices in order to bring these prices up to the average level in the EU. Analytical studies conducted by the World Bank have shown that price and tax policy measures represent two of the most effective instruments for reducing cigarette consumption, particularly when considering youth [1]. Based on assembled data, in the WHO Report on the Global Tobacco Epidemic, 2008 it was shown that a 10% increase in cigarette prices can result in a 4% decline in consumption and thereby result in a decline in the prevalence of smoking [13].

GATS 2011 showed that public opinion strongly supports (61.7%) increasing taxes on tobacco products. Increased revenue from tobacco taxes can provide the government with funds for other

tobacco control efforts.
Finally, it is vitally necessary to make policy makers aware of the economic costs of tobacco use for the state budget, including the burden on the health care system imposed by expenditures on the treatment of tobacco-related diseases.

10.3 Conclusions and Recommendations

Romania proved that it is possible to introduce complex and efficient tobacco control legislation in a short period of time because there is the political will to adopt and implement legislative measures.

This report provides evidence that despite positive changes in trends for tobacco smoking in Romania the level of exposure to tobacco smoke, both active and passive, remains high. The report also reveals that surveillance data can guide policymakers in implementing measures to reduce tobacco use.

While the current situation brings new challenges for health policy stakeholders, GATS study highlights the areas of tobacco control policy that requires new and effective interventions to increase effectiveness.

Key interventions, based on recommendations, are:

1. Monitor tobacco use indicators as well as the methods for tobacco control and use these indicators routinely in advocacy to strengthen public health policy.
2. Enact and enforce smoke-free environments in all indoor public places, including educational facilities, workplaces, restaurants and bars.
3. Establish partnerships between governmental agencies and public services responsible for compliance with the law to effectively implement smoke-free legislation.
4. Advocate for smoke-free home initiatives.
5. Mandate that primary health care providers offer tobacco cessation advice.
6. Expand and enhance existing smoking cessation programs and services, such as quitlines and smoking cessation clinics.
7. Adopt regulations for cigarette packaging that require rotating pictorial health warnings labels covering no less than half of cigarette packages.
8. Advocate for including information regarding quitline numbers on all tobacco products packages.
9. Enhance the media's role, including television and radio, in disseminating tobacco control information, as the media is highly influential.
10. Develop new communication channels for disseminating the messages related to the consequences of tobacco use such as Internet-based, social media methods.
11. Enact and enforce new legislation for a comprehensive ban on tobacco advertising, promotion, and sponsorship, including point-of-sale and online advertising.
12. Advocate for policies that stop the tobacco industry's deceptive marketing tactics and ban all false, misleading or deceptive tobacco marketing.
13. Advocate with policymakers to raise awareness about the economic costs of tobacco use.
14. Increase tax rates for tobacco products to EU levels, and ensure that they are adjusted periodically to account for inflation and economic growth.
15. Strengthen tax administration to reduce illicit trade of tobacco products.

Tables

Table 4.1 Percentage of persons aged ≥15 years by smoking status and gender – GATS Romania, 2011.

Smoking Status	Overall		Male		Female	
	%	(95% CI)	%	(95% CI)	%	(95% CI)
Current tobacco smoker	26.7	(25.0-28.4)	37.4	(34.8-40.0)	16.7	(15.2-18.4)
Daily smoker	24.3	(22.8-25.9)	34.9	(32.4-37.4)	14.5	(12.9-16.2)
Occasional smoker	2.4	(1.9-3.0)	2.5	(1.8-3.6)	2.2	(1.6-3.1)
Occasional smoker, formerly daily	0.9	(0.6-1.2)	0.8	(0.5-1.4)	0.9	(0.6-1.4)
Occasional smoker, never daily	1.5	(1.1-2.0)	1.7	(1.1-2.6)	1.3	(0.8-2.1)
Non-smoker	73.3	(71.6-75.0)	62.6	(60.0-65.2)	83.3	(81.6-84.8)
Former daily smoker	9.8	(9.0-10.7)	14.0	(12.7-15.6)	5.8	(5.0-6.8)
Never daily smoker	63.5	(61.8-65.3)	48.6	(46.0-51.2)	77.4	(75.7-79.1)
Former occasional smoker	2.8	(2.3-3.4)	3.2	(2.5-4.1)	2.4	(1.8-3.2)
Never smoker	60.7	(58.9-62.5)	45.4	(42.7-48.1)	75.0	(73.2-76.8)

Note: Current use includes both daily and occasional (less than daily) use. CI indicates confidence interval.

Table 4.2 Number of persons aged ≥15 years by smoking status and gender – GATS Romania, 2011.

Smoking Status	Overall	Male	Female
	Number in thousands		
Current tobacco smoker	4,847.4	3,273.0	1,574.4
Daily smoker	4,417.6	3,053.1	1,364.5
Occasional smoker	429.8	219.9	209.9
Occasional smoker, formerly daily	159.6	73.9	85.7
Occasional smoker, never daily	270.2	146.0	124.2
Non-smoker	13,327.6	5,487.6	7,840.0
Former daily smoker	1,779.8	1,230.7	549.1
Never daily smoker	11,547.8	4,256.9	7,290.9
Former occasional smoker	506.5	280.6	225.9
Never smoker	11,041.2	3,976.3	7,065.0

Note: Current use includes both daily and occasional (less than daily) use.

Table 4.3 Percentage of persons aged ≥15 years who were current users of various smoked tobacco products, by gender and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Any tobacco product		Any Cigarette [1] Manufactured		Type of cigarette				Other smoked tobacco [2]	
					Manufactured		Hand-rolled			
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	26.7	(25.0-28.4)	26.7	(25.0-28.4)	26.5	(24.9-28.2)	0.7	(0.5-1.1)	1.0	(0.6-1.5)
Age (years)										
15-24	22.6	(18.9-26.8)	22.6	(18.9-26.8)	22.4	(18.6-26.6)	1.1	(0.4-3.3)	2.2	(0.9-5.3)
25-44	36.3	(33.2-39.4)	36.3	(33.2-39.4)	36.1	(33.1-39.3)	0.8	(0.5-1.2)	1.3	(0.8-2.1)
45-64	28.0	(25.5-30.5)	28.0	(25.5-30.5)	27.7	(25.3-30.3)	0.9	(0.5-1.4)	0.3	(0.1-0.8)
65+	7.6	(6.1-9.5)	7.6	(6.1-9.5)	7.6	(6.1-9.5)	0.1	(0.0-0.5)	0.1	(0.0-0.8)
Residence										
Urban	28.4	(26.4-30.6)	28.4	(26.4-30.6)	28.3	(26.2-30.5)	0.8	(0.4-1.3)	1.5	(0.9-2.5)
Rural	24.5	(21.9-27.2)	24.5	(21.9-27.2)	24.3	(21.7-27.1)	0.7	(0.5-1.1)	0.3	(0.1-0.8)
Educational level [3]										
Primary or less	26.3	(23.8-28.9)	26.3	(23.8-28.9)	26.2	(23.8-28.8)	0.4	(0.2-0.9)	0.3	(0.1-1.0)
Secondary	29.9	(27.4-32.6)	29.9	(27.4-32.6)	29.6	(27.1-32.3)	0.8	(0.5-1.3)	0.9	(0.4-1.9)
High	27.5	(23.8-31.5)	27.5	(23.8-31.5)	27.5	(23.8-31.5)	0.8	(0.4-1.8)	2.4	(1.5-4.0)
Male	37.4	(34.8-40.0)	37.4	(34.8-40.0)	37.1	(34.5-39.7)	1.2	(0.8-1.9)	1.7	(1.0-2.7)
Age (years)										
15-24	30.5	(24.4-37.4)	30.5	(24.4-37.4)	30.1	(24.0-36.9)	2.2	(0.7-6.5)	3.1	(1.2-7.7)
25-44	48.2	(43.9-52.6)	48.2	(43.9-52.6)	48.0	(43.7-52.4)	1.0	(0.5-1.9)	2.3	(1.4-3.8)
45-64	38.8	(34.7-43.0)	38.8	(34.7-43.0)	38.4	(34.3-42.6)	1.6	(0.9-2.6)	0.7	(0.3-1.7)
65+	12.9	(10.1-16.3)	12.9	(10.1-16.3)	12.9	(10.1-16.3)	0.3	(0.1-1.3)	0.3	(0.0-2.0)
Residence										
Urban	37.8	(34.7-40.9)	37.8	(34.7-40.9)	37.4	(34.3-40.6)	1.4	(0.7-2.7)	2.6	(1.5-4.4)
Rural	36.9	(32.8-41.2)	36.9	(32.8-41.2)	36.7	(32.5-41.0)	1.0	(0.6-1.7)	0.5	(0.2-1.6)
Educational level [3]										
Primary or less	38.3	(34.1-42.7)	38.3	(34.1-42.7)	38.2	(34.0-42.6)	0.6	(0.3-1.5)	0.7	(0.2-1.9)
Secondary	41.3	(37.6-45.2)	41.3	(37.6-45.2)	40.8	(37.1-44.7)	1.4	(0.8-2.4)	1.8	(0.8-3.8)
High	36.4	(30.5-42.7)	36.4	(30.5-42.7)	36.4	(30.5-42.7)	1.2	(0.3-3.9)	3.6	(1.9-6.8)
Female	16.7	(15.2-18.4)	16.7	(15.2-18.4)	16.7	(15.1-18.4)	0.3	(0.2-0.4)	0.3	(0.1-0.7)
Age (years)										
15-24	14.3	(10.3-19.6)	14.3	(10.3-19.6)	14.3	(10.3-19.6)	0.0		1.3	(0.4-4.1)
25-44	23.8	(20.2-27.8)	23.8	(20.2-27.8)	23.8	(20.2-27.8)	0.6	(0.4-0.9)	0.3	(0.1-0.9)
45-64	18.1	(15.4-21.0)	18.1	(15.4-21.0)	17.9	(15.3-20.9)	0.3	(0.1-0.8)	0.0	
65+	4.1	(2.6-6.4)	4.1	(2.6-6.4)	4.1	(2.6-6.4)	0.0		0.0	
Residence										
Urban	20.1	(18.0-22.4)	20.1	(18.0-22.4)	20.1	(18.0-22.4)	0.2	(0.1-0.3)	0.5	(0.2-1.2)
Rural	12.2	(10.1-14.8)	12.2	(10.1-14.8)	12.2	(10.0-14.7)	0.4	(0.2-0.8)	0.0	
Educational Level [3]										
Primary or less	14.7	(12.1-17.8)	14.7	(12.1-17.8)	14.7	(12.1-17.8)	0.3	(0.1-0.8)	0.0	
Secondary	19.6	(16.5-23.1)	19.6	(16.5-23.1)	19.5	(16.4-22.9)	0.3	(0.1-0.5)	0.1	(0.0-0.4)
High	20.0	(15.8-25.0)	20.0	(15.8-25.0)	20.0	(15.8-25.0)	0.6	(0.5-0.7)	1.4	(0.6-3.6)

Note: Current use includes both daily and occasional (less than daily) use.
[1] Includes manufactured cigarettes and hand-rolled cigarettes.
[2] Includes pipe, cigars, cigarillos, water pipe.
[3] Education level is reported only for persons aged ≥22 years.

Table 4.4 Number of adults aged ≥15 years who were current smokers of various smoked tobacco products, by gender and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Any tobacco product	Any cigarette [1]	Type of cigarette		Other smoked tobacco [2]
			Manufactured	Hand-rolled	
	Number in thousands				
Overall	4,847.4	4,847.4	4,819.3	135.6	175.2
Age (years)					
15-24	649.8	649.8	643.2	31.9	63.0
25-44	2,478.1	2,478.1	2,470.0	53.4	91.5
45-64	1,476.2	1,476.2	1,462.9	46.5	17.0
65+	243.3	243.3	243.3	3.9	3.6
Residence					
Urban	2,878.8	2,878.8	2,862.8	77.8	153.5
Rural	1,968.6	1,968.6	1,956.5	57.8	21.7
Educational level[3]					
Primary or less	1,858.2	1,858.2	1,855.5	31.4	22.7
Secondary	1,943.5	1,943.5	1,924.9	51.8	57.3
High	711.6	711.6	711.6	21.8	62.7
Male	3,273.0	3,273.0	3,248.1	108.6	146.2
Age (years)					
15-24	448.3	448.3	441.7	31.9	45.1
25-44	1,680.3	1,680.3	1,672.2	33.4	80.4
45-64	978.9	978.9	968.8	39.4	17.0
65+	165.4	165.4	165.4	3.9	3.6
Residence					
Urban	1,801.5	1,801.5	1,785.5	67.7	124.5
Rural	1,471.5	1,471.5	1,462.7	40.9	21.7
Educational level [3]					
Primary or less	1,326.3	1,326.3	1,323.5	21.9	22.7
Secondary	1,278.0	1,278.0	1,262.5	42.3	55.4
High	431.1	431.1	431.1	13.8	42.6
Female	1,574.4	1,574.4	1,571.2	27.0	29.1
Age (years)					
15-24	201.5	201.5	201.5	0.0	17.9
25-44	797.8	797.8	797.8	19.9	11.1
45-64	497.3	497.3	494.1	7.1	0.0
65+	77.8	77.8	77.8	0.0	0.0
Residence					
Urban	1,077.3	1,077.3	1,077.3	10.1	29.1
Rural	497.1	497.1	493.9	16.9	0.0
Educational level[3]					
Primary or less	532.0	532.0	532.0	9.6	0.0
Secondary	665.6	665.6	662.3	9.5	1.9
High	280.5	280.5	280.5	8.0	20.0

Note: Current use includes both daily and occasional (less than daily) use.
[1] Includes manufactured cigarettes and hand-rolled cigarettes.
[2] Includes pipe, cigars, cigarillos, water pipe.
[3] Education level is reported only for persons aged ≥22 years.

Table 4.5 Percentage distribution of persons aged ≥15 years who were daily smokers, occasional smokers, or nonsmokers, by gender and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Smoking frequency						Total
	Daily		Occasional [1]		Nonsmoker		
	%	(95% CI)	%	(95% CI)	%	(95% CI)	
Overall	24.3	(22.8-25.9)	2.4	(1.9-3.0)	73.3	(71.6-75.0)	100
Age (years)							
15-24	20.8	(17.1-25.0)	1.8	(0.9-3.9)	77.4	(73.2-81.1)	100
25-44	32.9	(30.1-35.9)	3.3	(2.4-4.6)	63.7	(60.6-66.8)	100
45-64	25.7	(23.3-28.2)	2.3	(1.6-3.3)	72.0	(69.5-74.5)	100
65+	6.7	(5.2-8.6)	0.9	(0.6-1.6)	92.4	(90.5-93.9)	100
Residence							
Urban	25.6	(23.8-27.5)	2.8	(2.1-3.8)	71.6	(69.4-73.6)	100
Rural	22.7	(20.2-25.4)	1.8	(1.3-2.4)	75.5	(72.8-78.1)	100
Education level [2]							
Primary or less	24.6	(22.2-27.1)	1.7	(1.2-2.4)	73.7	(71.1-76.2)	100
Secondary	27.0	(24.5-29.6)	2.9	(2.1-4.1)	70.1	(67.4-72.6)	100
High	24.9	(21.6-28.4)	2.6	(1.5-4.6)	72.5	(68.5-76.2)	
Male	34.9	(32.4-37.4)	2.5	(1.8-3.6)	62.6	(60.0-65.2)	100
Age (years)							
15-24	28.5	(22.2-35.8)	2.0	(0.7-5.4)	69.5	(62.6-75.6)	100
25-44	44.8	(40.5-49.1)	3.5	(2.2-5.5)	51.8	(47.4-56.1)	100
45-64	36.8	(32.9-40.8)	2.0	(1.1-3.6)	61.2	(57.0-65.3)	100
65+	11.5	(8.7-14.9)	1.4	(0.7-3.0)	87.1	(83.7-89.9)	100
Residence							
Urban	34.9	(32.0-37.9)	2.9	(1.8-4.6)	62.2	(59.1-65.3)	100
Rural	34.8	(30.8-39.1)	2.1	(1.2-3.5)	63.1	(58.8-67.2)	100
Education level [2]							
Primary or less	36.6	(32.4-41.0)	1.7	(1.0-3.0)	61.7	(57.3-65.9)	100
Secondary	37.7	(34.1-41.5)	3.6	(2.1-6.0)	58.7	(54.8-62.4)	100
High	34.8	(29.2-40.7)	1.6	(0.7-3.5)	63.6	(57.3-69.5)	100
Female	14.5	(12.9-16.2)	2.2	(1.6-3.1)	83.3	(81.6-84.8)	100
Age (years)							
15-24	12.7	(8.6-18.2)	1.7	(0.5-5.4)	85.7	(80.4-89.7)	100
25-44	20.6	(17.4-24.3)	3.2	(1.9-5.2)	76.2	(72.2-79.8)	100
45-64	15.6	(12.8-18.8)	2.5	(1.5-4.1)	81.9	(79.0-84.6)	100
65+	3.5	(2.1-5.7)	0.6	(0.2-1.7)	95.9	(93.6-97.4)	100
Residence							
Urban	17.3	(15.2-19.7)	2.8	(1.8-4.3)	79.9	(77.6-82.0)	100
Rural	10.8	(8.6-13.4)	1.5	(0.9-2.6)	87.8	(85.2-89.9)	100
Educational level [2]							
Primary or less	13.0	(10.7-15.7)	1.7	(0.9-3.4)	85.3	(82.2-87.9)	100
Secondary	17.2	(14.1-20.8)	2.3	(1.5-3.6)	80.4	(76.9-83.5)	100
High	16.5	(13.1-20.6)	3.5	(1.7-7.0)	80.0	(75.0-84.2)	100

[1] Occasional refers to less than daily use.
[2] Education level is reported only among persons aged ≥ 22 years.

Table 4.6 Percentage distribution of cigarettes smoked per day among daily cigarette smokers aged ≥15 years, by gender and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Average number of cigarettes smoked per day[1]		Number of cigarettes smoked on average per day[1]										Total
			<5		5-9		10-14		15-19		≥20		
	Average	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	
Overall	16.6	(16.0-17.2)	4.0	(2.9-5.6)	9.2	(7.2-11.8)	22.8	(19.7-26.2)	12.8	(10.6-15.5)	51.1	(47.3-55.0)	100
Age (years)													
15-24	14.4	(12.8-16.0)	2.2	(0.6-6.9)	14.2	(7.5-25.2)	29.7	(20.1-41.4)	14.8	(9.0-23.5)	39.1	(27.2-52.5)	100
25-44	16.9	(16.0-17.7)	3.5	(1.8-6.4)	8.0	(5.4-11.7)	21.8	(18.1-26.1)	11.5	(8.4-15.6)	55.2	(50.3-60.1)	100
45-64	17.8	(16.7-18.9)	4.4	(2.7-7.2)	8.1	(5.5-12.0)	19.0	(14.7-24.2)	14.5	(10.8-19.2)	54.0	(47.9-59.9)	100
65+	12.8	(10.0-15.6)	13.2	(6.5-24.8)	14.8	(7.5-27.2)	37.4	(24.0-53.0)	11.1	(5.6-20.7)	23.6	(13.8-37.2)	100
Residence													
Urban	16.6	(15.8-17.4)	4.3	(2.8-6.5)	8.3	(6.1-11.2)	23.1	(19.2-27.5)	15.0	(11.9-18.7)	49.4	(44.8-54.0)	100
Rural	16.6	(15.5-17.6)	3.7	(2.2-6.2)	10.5	(6.9-15.6)	22.3	(17.6-27.9)	9.8	(7.0-13.6)	53.7	(46.8-60.4)	100
Education level [2]													
Primary or less	17.8	(16.7-18.9)	4.2	(2.6-6.9)	7.6	(5.1-11.3)	18.7	(14.1-24.3)	12.0	(8.5-16.5)	57.4	(50.8-63.9)	100
Secondary	15.8	(15.1-16.6)	3.4	(1.9-5.9)	9.2	(6.3-13.1)	26.3	(21.4-31.9)	12.0	(8.9-16.1)	49.1	(44.0-54.2)	100
High	16.7	(14.8-18.5)	6.3	(3.5-11.0)	7.9	(4.3-14.2)	21.1	(14.2-30.1)	18.2	(12.7-25.3)	46.6	(36.8-56.6)	100
Male	17.7	(16.9-18.5)	3.0	(1.9-4.8)	7.5	(5.2-10.7)	18.6	(15.2-22.6)	12.7	(9.9-16.0)	58.2	(53.5-62.8)	100
Age (years)													
15-24	15.6	(13.5-17.6)	0.0		14.1	(6.1-29.4)	25.3	(14.9-39.7)	11.7	(5.0-25.1)	48.8	(33.5-64.3)	100
25-44	17.7	(16.5-18.8)	2.9	(1.4-6.1)	7.1	(4.1-12.1)	17.8	(13.5-23.1)	11.5	(8.1-16.1)	60.6	(54.4-66.5)	100
45-64	19.3	(18.1-20.5)	2.7	(1.0-6.7)	4.3	(2.4-7.8)	15.0	(11.1-20.0)	14.9	(10.5-20.6)	63.1	(56.6-69.2)	100
65+	13.9	(10.1-17.7)	14.0	(6.3-28.1)	13.0	(5.7-26.6)	31.3	(18.7-47.3)	13.7	(6.6-26.2)	28.1	(15.7-45.0)	100
Residence													100
Urban	17.6	(16.7-18.5)	3.1	(1.6-5.8)	7.3	(4.9-10.8)	18.5	(14.0-24.1)	14.8	(11.0-19.7)	56.3	(50.8-61.6)	
Rural	17.8	(16.5-19.1)	2.9	(1.5-5.7)	7.8	(4.1-14.1)	18.7	(13.7-24.9)	10.1	(6.7-14.9)	60.5	(52.5-68.0)	100
Education level [2]													100
Primary or less	18.3	(17.1-19.6)	4.0	(2.1-7.3)	7.4	(4.2-12.5)	15.3	(10.4-22.0)	12.0	(8.3-17.0)	61.4	(53.6-68.6)	
Secondary	17.3	(16.5-18.2)	1.4	(0.5-3.8)	5.1	(2.7-9.7)	23.2	(17.8-29.7)	11.8	(7.6-17.8)	58.5	(52.5-64.3)	100
High	18.2	(15.9-20.4)	6.1	(2.7-13.1)	6.3	(3.1-12.4)	15.3	(7.8-28.0)	16.6	(10.2-25.7)	55.8	(43.6-67.2)	100
Female	14.1	(13.2-15.1)	6.4	(4.0-10.1)	13.0	(9.6-17.3)	32.1	(26.7-38.0)	13.2	(9.2-18.6)	35.3	(28.9-42.3)	100
Age (years)													
15-24	11.6	(9.8-13.4)	7.2	(2.1-21.8)	14.4	(7.4-26.2)	39.9	(23.7-58.8)	22.0	(10.0-41.8)	16.4	(6.2-36.6)	100
25-44	15.0	(13.5-16.6)	4.6	(1.9-10.9)	9.9	(5.7-16.8)	31.0	(23.5-39.5)	11.4	(6.0-20.6)	43.1	(33.2-53.5)	100
45-64	14.3	(12.3-16.3)	8.3	(4.6-14.5)	16.4	(9.9-25.9)	27.6	(18.1-39.8)	13.6	(7.7-22.8)	34.1	(23.4-46.8)	100
65+	*		*		*		*		*		*		100
Residence													
Urban	14.9	(13.6-16.2)	6.5	(3.8-11.1)	10.1	(6.7-14.9)	31.2	(24.6-38.7)	15.2	(10.0-22.4)	36.9	(28.6-46.2)	100
Rural	12.6	(11.5-13.7)	6.2	(2.5-14.6)	19.2	(12.1-29.1)	33.8	(25.3-43.5)	8.9	(4.1-18.1)	31.9	(23.4-41.9)	100
Education level [2]													
Primary or less	16.3	(14.4-18.3)	5.0	(1.9-12.8)	8.4	(4.5-15.0)	27.9	(18.4-40.0)	11.9	(5.1-25.2)	46.8	(35.3-58.6)	100
Secondary	12.9	(11.7-14.0)	7.4	(3.7-14.2)	17.1	(11.9-24.1)	32.4	(23.6-42.8)	12.5	(7.6-19.9)	30.5	(22.4-39.9)	100
High	14.0	(11.6-16.5)	6.6	(2.7-15.4)	10.8	(4.0-26.3)	31.3	(18.9-47.3)	21.0	(11.0-36.5)	30.2	(17.3-47.2)	100

[1] Among daily cigarette smokers. Cigarettes include manufactured and hand-rolled.
[2] Education level is reported only among persons aged ≥22 years.
*Unweighted sample size less than 25.

Table 4.7 Percentage distribution of age at initiation of daily smoking among ever daily smokers aged 20-34 years, by selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Age at daily smoking initiation (years)[1]								Total
	<15		15-16		17-19		20+		
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	
Overall	17.1	(12.6-22.8)	21.7	(16.5-28.0)	43.1	(36.0-50.4)	18.1	(13.4-24.0)	100
Gender									
Male	21.6	(15.2-29.8)	22.3	(16.2-30.0)	41.2	(32.4-50.6)	14.9	(9.8-21.9)	100
Female	7.8	(3.9-15.1)	20.3	(13.6-29.2)	46.9	(37.3-56.8)	24.9	(17.3-34.4)	100
Residence									
Urban	12.7	(9.0-17.7)	23.2	(16.7-31.2)	45.3	(36.6-54.3)	18.8	(12.8-26.8)	100
Rural	24.8	(15.4-37.6)	19.1	(11.6-29.6)	39.2	(27.4-52.4)	16.9	(10.6-26.0)	100

[1] Among persons 20-34 years of age who were ever daily smokers.

Table 4.8 Percentage of all persons and ever daily smokers aged ≥15 years who were former daily smokers, by selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Former daily smokers [1] (among all persons)		Former daily smokers [1] (among ever daily smokers)[2]	
	%	(95% CI)	%	(95% CI)
Overall	9.8	(9.0-10.7)	28.0	(25.8-30.3)
Gender				
Male	14.0	(12.7-15.6)	28.2	(25.6-31.1)
Female	5.8	(5.0-6.8)	27.5	(23.7-31.6)
Age (years)				
15-24	2.1	(1.1-3.9)	9.0	(4.6-16.6)
25-44	8.2	(6.9-9.8)	19.4	(16.3-22.9)
45-64	14.0	(12.1-16.2)	34.6	(30.5-39.0)
65+	13.2	(11.2-15.4)	64.0	(56.7-70.6)
Residence				
Urban	11.3	(10.2-12.4)	29.9	(27.2-32.7)
Rural	7.9	(6.8-9.2)	25.2	(21.6-29.1)
Educational Level[3]				
Primary or less	10.4	(9.2-11.8)	29.2	(25.5-33.1)
Secondary	11.0	(9.5-12.8)	28.3	(24.7-32.1)
High	10.8	(8.7-13.4)	29.3	(23.5-35.9)

[1] Current nonsmokers.
[2] Also known as the quit ratio for daily smoking.
[3] Education level is reported only among persons aged ≥22 years.

Table 4.9 Percentage distribution of time since quitting among former daily smokers aged ≥15 years-by selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Time since quitting smoking (years)[1]								Total
	<1		1 to <5		5 to <10		≥10		
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	
Overall	8.1	(5.4-11.9)	30.8	(26.1-36.1)	21.1	(17.2-25.5)	40.0	(35.9-44.3)	100
Gender									
Male	6.4	(3.7-10.9)	29.2	(24.1-35.0)	18.6	(13.9-24.5)	45.8	(39.5-52.2)	100
Female	11.8	(6.8-19.7)	34.4	(25.0-45.1)	26.6	(19.1-35.8)	27.2	(19.9-35.9)	100
Age (years)									
15-24	*		*		0.0		0.0		100
25-44	6.6	(3.1-13.5)	44.4	(34.4-54.9)	33.6	(24.9-43.6)	15.5	(9.3-24.5)	100
45-64	10.1	(5.9-16.8)	29.6	(22.2-38.3)	18.0	(12.7-24.8)	42.3	(35.5-49.4)	100
65+	2.5	(1.0-5.8)	10.0	(6.1-16.2)	12.7	(7.7-20.3)	74.8	(66.6-81.5)	100
Residence									
Urban	8.8	(5.3-14.2)	31.0	(25.4-37.2)	22.7	(18.0-28.3)	37.5	(32.7-42.5)	100
Rural	6.8	(3.5-12.7)	30.5	(22.2-40.3)	18.1	(12.2-26.0)	44.6	(36.9-52.7)	100
Education level [2]									
Primary or less	4.1	(1.9-9.0)	21.8	(15.7-29.4)	16.4	(11.1-23.7)	57.7	(50.5-64.5)	100
Secondary	10.1	(5.9-16.6)	36.5	(28.4-45.4)	25.3	(18.6-33.3)	28.1	(22.0-35.2)	100
High	11.4	(4.8-24.8)	34.8	(22.9-49.0)	24.6	(15.2-37.3)	29.2	(20.5-39.6)	100

[1] Among former daily smokers (current nonsmokers).
[2] Education level is reported only among persons aged ≥22 years.
*Unweighted sample size less than 25.

Table 4.10 Percentage distribution of time to first tobacco use after waking among daily smokers aged ≥15 years, by selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Time to first smoke								Total
	≤5 minutes		6-30 minutes		31-60 minutes		>60 minutes		
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	
Overall	26.2	(22.7-30.0)	43.3	(39.5-47.1)	17.5	(14.7-20.7)	13.1	(10.7-15.9)	100
Gender									
Male	27.5	(23.2-32.3)	44.5	(39.9-49.2)	15.5	(12.4-19.3)	12.4	(9.8-15.7)	100
Female	23.2	(17.8-29.7)	40.5	(33.7-47.6)	21.9	(16.0-29.2)	14.4	(10.2-19.9)	100
Age (years)									
15-24	23.9	(15.4-35.1)	32.7	(23.0-44.2)	18.7	(11.5-29.0)	24.7	(16.5-35.2)	100
25-44	24.3	(19.7-29.5)	47.7	(42.7-52.8)	18.1	(14.1-23.0)	9.9	(7.3-13.3)	100
45-64	31.8	(26.1-38.0)	42.8	(37.1-48.8)	15.0	(11.7-18.9)	10.4	(6.4-16.5)	100
65+	17.9	(9.7-30.5)	28.5	(19.0-40.5)	23.5	(14.1-36.3)	30.1	(20.0-42.7)	100
Residence									
Urban	23.4	(19.6-27.7)	44.8	(40.1-49.6)	18.9	(15.6-22.8)	12.9	(10.0-16.4)	100
Rural	30.2	(23.9-37.3)	41.1	(35.0-47.5)	15.4	(11.1-21.0)	13.3	(9.6-18.3)	100
Education level [2]									
Primary or less	33.5	(28.1-39.3)	43.0	(37.1-49.1)	14.2	(10.1-19.8)	9.3	(6.1-13.8)	100
Secondary	21.4	(16.8-26.9)	43.7	(38.0-49.6)	20.2	(16.3-24.8)	14.6	(11.0-19.2)	100
High	20.8	(13.7-30.3)	48.1	(39.4-57.0)	16.2	(11.2-22.8)	14.9	(9.2-23.2)	100

[1] Tobacco dependence indicator.
[2] Education level is reported only among persons aged 22 years.

Table 5.1 Percentages of smokers aged ≥15 years who in the past 12 months made a quit attempt, visited a health care provider, were asked by the provider if they were a smoker, and were advised to quit by the provider, by selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Smoking cessation and health-care–seeking behavior							
	Made quit attempt [1]		Visited a HCP [1,2]		Asked by HCP if a smoker [3]		Advised to quit by HCP [3]	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	35.5	(32.2-38.9)	50.4	(46.7-54.0)	82.1	(77.2-86.2)	81.9	(77.2-85.8)
Gender								
Male	34.2	(30.3-38.2)	45.3	(40.8-49.8)	85.1	(78.6-89.9)	80.8	(74.6-85.7)
Female	38.2	(32.3-44.5)	60.8	(54.5-66.7)	77.6	(71.2-83.0)	83.7	(76.5-89.1)
Age (years)								
15-24	41.0	(31.4-51.4)	46.2	(35.7-57.1)	66.3	(47.2-81.3)	62.9	(42.7-79.4)
25-44	33.9	(29.3-38.8)	48.0	(42.8-53.2)	79.4	(73.4-84.3)	79.5	(73.2-84.6)
45-64	35.4	(30.4-40.7)	53.0	(46.8-59.1)	90.9	(86.1-94.2)	88.3	(81.7-92.7)
65+	37.4	(26.8-49.3)	69.1	(56.7-79.2)	87.7	(74.6-94.5)	91.0	(80.1-96.2)
Residence								
Urban	33.6	(29.7-37.6)	56.2	(52.3-60.1)	82.7	(77.0-87.2)	80.4	(74.1-85.5)
Rural	38.3	(32.5-44.4)	41.7	(35.1-48.7)	81.0	(70.9-88.2)	84.8	(77.8-90.0)
Education level[4]								
Primary or less	34.6	(28.9-40.7)	43.0	(37.0-49.1)	89.7	(84.0-93.5)	89.3	(82.8-93.6)
Secondary	36.3	(31.8-41.1)	55.7	(50.9-60.4)	81.4	(74.2-86.9)	79.2	(70.3-86.0)
High	35.8	(26.8-46.0)	58.3	(49.1-67.0)	75.2	(65.9-82.6)	78.1	(64.7-87.4)

Note: Estimates in this table are based on current smokers and former smokers who had been abstinent for less than 12 months.
[1] Among current smokers and former smokers who had been abstinent for less than 12 months.
[2] HCP = health care provider.
[3] Among current smokers and former smokers who had been abstinent for less than 12 months and who visited a HCP during the past 12 months.
[4] Education level is reported only among persons aged ≥22 years.

Table 5.2 Percentage of smokers aged ≥15 years who made a quit attempt in the past 12 months by cessation method used for their last attempt, by selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Use of Cessation Method [1]									
	Nicotine replacement therapy [2]		Prescription medications [3]		Counseling/ advice [4]		Tried to quit without assistance		Other [5]	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	8.2	(5.7-11.5)	1.4	(0.5-3.7)	1.7	(0.8-3.5)	80.8	(76.5-84.5)	6.8	(4.5-10.2)
Gender										
Male	8.1	(5.0-13.1)	1.4	(0.4-5.1)	2.3	(1.0-5.2)	79.8	(73.5-85.0)	6.0	(3.2-11.2)
Female	8.2	(4.9-13.5)	1.2	(0.3-5.2)	0.6	(0.3-1.2)	82.6	(75.3-88.1)	8.1	(4.9-13.1)
Age (years)										
15-24	5.9	(1.0-27.7)	0.0		0.0		75.9	(60.6-86.6)	4.2	(0.6-24.7)
25-44	10.0	(6.5-15.3)	0.5	(0.1-3.6)	1.3	(0.4-4.4)	83.3	(76.3-88.6)	7.3	(3.9-13.2)
45-64	7.1	(3.6-13.3)	2.6	(0.6-10.4)	3.0	(1.1-7.8)	80.0	(72.2-86.0)	5.8	(2.9-11.3)
65+	5.0	(1.1-19.9)	5.5	(1.3-20.0)	2.3	(0.3-15.2)	78.8	(61.9-89.5)	15.3	(6.4-32.1)
Residence										
Urban	6.4	(3.8-10.6)	0.8	(0.2-3.4)	2.2	(0.9-5.0)	83.4	(78.3-87.4)	7.5	(4.6-12.0)
Rural	10.5	(6.4-16.8)	2.1	(0.6-7.8)	1.0	(0.2-4.5)	77.4	(69.5-83.8)	5.8	(2.6-12.2)
Education level [6]										
Primary or less	5.3	(2.4-11.2)	3.0	(0.9-9.3)	2.2	(0.7-6.8)	79.1	(69.0-86.5)	6.9	(3.2-14.0)
Secondary	9.4	(5.5-15.5)	0.7	(0.1-4.9)	2.1	(0.8-5.3)	83.6	(76.7-88.8)	7.3	(3.9-13.2)
High	9.2	(5.1-16.3)	0.0		0.0		84.6	(75.0-91.0)	8.3	(3.7-17.5)

[1] Among current smokers who made a quit attempt in the past 12 months and former smokers who had been abstinent for less than 12 months.
[2] Nicotine replacement therapy includes patches and chewing gums.
[3] Prescription medications include Zyban and Champix.
[4] Includes counseling by a specialist, including at a smoking cessation clinic, and a telephone quit line.
[5] Other includes natural plant products, acupuncture, and other listed methods.
[6] Education level is reported only for persons aged ≥22 years.

Table 5.3 Percentage of current daily smokers aged ≥15 years who made a quit attempt in the past 12 months, by cessation methods used for their last quit attempt and a tobacco dependence indicator[1] – GATS Romania, 2011.

Tobacco dependence indicator[1]	Methodes									
	Nicotine replacement therapy [2]		Prescription medications [3]		Counseling / advice [4]		Tried to quit without assistance		Other [5]	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	9.6	(6.7-13.5)	1.5	(0.5-4.4)	1.2	(0.4-3.1)	78.3	(73.1-82.7)	5.8	(3.5-9.5)
Time to first smoke after waking up										
≤5 minutes	16.4	(9.6-26.7)	2.7	(0.4-17.3)	2.8	(0.7-10.9)	62.6	(50.6-73.2)	8.7	(3.2-21.4)
6-30 minutes	6.5	(3.2-13.0)	1.7	(0.5-5.6)	1.0	(0.2-4.1)	84.5	(76.8-90.0)	3.5	(1.4-8.7)
31-60 minutes	14.4	(6.0-31.0)	0.0		0.5	(0.1-3.9)	79.3	(64.4-89.0)	5.8	(1.6-18.6)
>60 minutes	2.3	(0.5-10.4)	0.6	(0.1-4.1)	0.0		85.0	(71.4-92.8)	7.1	(2.9-16.1)

[1]Time to first smoke after waking up.
[2]Nicotine replacement therapy includes patches and chewing gums.
[3]Prescription medications include Zyban and Champix.
[4] Includes counseling by a specialist, including at a smoking cessation clinic, and a telephone quit line/advice/helpline.
[5] Other includes natural plant products, acupuncture, and other reported methods.

Table 5.4 Percentage distribution of current smokers aged ≥15 years by interest in quitting smoking and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	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
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	
Overall	7.9	(6.3-9.8)	15.6	(13.5-18.0)	39.2	(35.6-43.0)	33.6	(30.5-36.8)	3.6	(2.5-5.1)	100
Gender											
Male	7.2	(5.5-9.2)	15.7	(13.0-18.9)	39.6	(35.0-44.4)	34.5	(30.6-38.6)	3.0	(1.9-4.6)	100
Female	9.4	(6.6-13.1)	15.5	(11.8-20.1)	38.4	(32.1-45.2)	31.8	(26.0-38.2)	4.9	(2.9-8.0)	100
Age (years)											
15-24	11.3	(5.8-20.7)	15.5	(9.3-24.7)	36.9	(27.0-48.1)	31.9	(23.8-41.2)	4.5	(2.0-9.8)	100
25-44	5.6	(3.8-8.1)	17.5	(14.2-21.4)	39.5	(33.8-45.5)	34.1	(28.8-39.8)	3.3	(2.0-5.3)	100
45-64	10.0	(6.7-14.6)	13.5	(10.0-18.0)	40.7	(35.7-46.0)	32.3	(27.8-37.2)	3.5	(1.8-6.5)	100
65+	9.2	(5.1-16.2)	10.2	(5.8-17.3)	33.8	(22.9-46.8)	41.4	(28.3-55.8)	5.4	(2.1-13.2)	100
Residence											
Urban	8.7	(6.6-11.3)	18.8	(16.1-21.7)	36.0	(31.6-40.6)	32.2	(28.6-36.1)	4.3	(2.8-6.5)	100
Rural	6.8	(4.7-9.6)	11.1	(8.0-15.1)	44.0	(38.0-50.1)	35.6	(30.3-41.3)	2.6	(1.4-4.8)	100
Education level [2]											
Primary or less	5.0	(3.3-7.4)	17.3	(13.8-21.6)	36.7	(31.2-42.6)	37.4	(31.9-43.2)	3.6	(2.3-5.6)	100
Secondary	9.3	(6.9-12.5)	15.9	(12.3-20.4)	43.0	(37.8-48.4)	29.3	(25.0-33.9)	2.5	(1.3-4.5)	100
High	7.8	(4.0-14.7)	13.9	(9.2-20.4)	39.6	(31.5-48.4)	33.3	(25.1-42.6)	5.4	(2.5-11.4)	100

[1] Among current daily or less than daily smokers.
[2] Education level is reported only among persons aged ≥22 years.

Table 5.5 Percentage distribution of current daily smokers aged ≥15 years by interest in quitting smoking and tobacco dependence – GATS Romania, 2011.

Tobacco dependence indicator	Interest in Quitting Smoking [1]										
	Planning to quit within next month		Thinking about quitting within next 12 months		Will quit some-day, but not in the next 12 months		Not interested in quitting		Don't know		Total
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	
Overall	7.1	(5.7-8.7)	16.5	(14.2-19.1)	38.6	(34.9-42.5)	34.5	(31.3-37.9)	3.3	(2.3-4.8)	100
Time to first smoke after waking up											
≤5 minutes	4.3	(2.1-8.5)	11.0	(7.3-16.2)	33.9	(27.4-40.9)	48.1	(41.0-55.2)	2.8	(1.1-6.8)	100
6-30 minutes	8.5	(6.4-11.3)	19.5	(15.7-24.1)	41.6	(36.2-47.3)	26.0	(21.4-31.2)	4.3	(2.8-6.6)	100
31-60 minutes	6.9	(4.1-11.3)	16.5	(10.1-25.7)	39.4	(30.2-49.5)	34.3	(26.4-43.3)	2.8	(1.6-5.1)	100
>60 minutes	7.9	(4.0-14.8)	17.7	(11.2-26.8)	37.1	(28.3-46.8)	35.7	(27.0-45.6)	1.6	(0.5-4.8)	100

[1] Among current daily or less than daily smokers.

Table 5.6 Percentage of current smokers aged ≥15 years who were not interested in quitting smoking, by barriers to quitting and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Not Interested in Quitting Smoking [1]													
	Thinks can't quit		Thinks smoking reduce stress		Thinks smoking is not bad for health		Thinks smoking keeps them alert		Afraid of gaining weight		Likes smoking		Other [3]	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% Ci)	%	(95% CI)	%	(95% CI)
Overall	38.3	(32.6-44.3)	61.5	(54.8-67.9)	39.2	(32.6-46.2)	28.5	(22.5-35.3)	16.6	(11.8-23.0)	85.8	(80.4-89.9)	4.9	(3.2-7.3)
Gender														
Male	37.3	(30.1-45.2)	58.7	(50.5-66.4)	37.1	(29.9-44.9)	30.3	(23.6-37.8)	15.8	(10.3-23.6)	86.4	(80.0-91.0)	4.4	(2.5-7.5)
Female	40.4	(29.3-52.6)	68.0	(55.9-78.0)	44.1	(32.6-56.3)	24.4	(15.1-37.0)	18.4	(11.3-28.6)	84.5	(76.2-90.2)	5.9	(2.7-12.2)
Age (years)														
15-24	25.0	(11.1-47.1)	66.3	(42.1-84.2)	41.8	(24.4-61.6)	22.6	(10.3-42.6)	18.4	(5.9-44.7)	96.0	(83.5-99.1)	3.3	(1.0-9.9)
25-44	36.6	(27.6-46.7)	57.9	(48.6-66.6)	41.4	(32.6-50.8)	29.2	(20.6-39.6)	13.8	(8.9-20.8)	89.2	(82.4-93.6)	3.2	(1.6-6.5)
45-64	46.1	(36.4-56.0)	66.5	(55.3-76.0)	35.8	(27.0-45.7)	30.9	(24.2-38.6)	20.4	(11.8-33.0)	78.9	(67.6-87.1)	6.6	(3.6-12.0)
65+	42.5	(26.0-60.9)	59.2	(37.1-78.0)	31.7	(15.1-54.9)	22.8	(10.3-43.1)	17.9	(7.8-35.8)	69.6	(51.0-83.4)	13.2	(4.5-32.7)
Residence														
Urban	37.1	(30.5-44.2)	61.0	(52.6-68.7)	40.1	(31.4-49.5)	29.3	(21.2-39.0)	17.6	(11.0-26.8)	83.2	(75.4-88.9)	4.4	(2.7-7.1)
Rural	39.9	(30.3-50.3)	62.3	(51.0-72.4)	38.1	(28.4-48.8)	27.3	(19.2-37.3)	15.4	(9.2-24.6)	89.4	(81.2-94.3)	5.5	(2.8-10.5)
Education level [2]														
Primary or less	53.8	(44.8-62.7)	60.6	(49.1-71.0)	36.8	(27.0-47.9)	32.6	(23.0-43.8)	15.5	(8.8-26.0)	88.5	(79.6-93.8)	5.4	(2.5-11.2)
Secondary	30.2	(23.0-38.6)	58.6	(49.7-67.0)	40.3	(30.6-50.8)	23.4	(16.9-31.4)	14.8	(9.4-22.5)	81.4	(72.3-88.0)	5.5	(3.1-9.8)
High	24.8	(13.7-40.7)	68.5	(53.9-80.2)	46.4	(29.3-64.4)	30.0	(14.4-52.3)	22.8	(13.4-36.0)	83.4	(68.2-92.2)	2.3	(0.5-10.2)

[1] Among current daily or less than daily smokers.
[2] Education level is reported only among persons aged ≥22 years.
[3] Other includes all the others reported motives for not quitting.

Table 6.1 Percentage and number of persons aged ≥15 years who were exposed to tobacco smoke at home, by smoking status and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Exposed to tobacco smoke at home [1]		
	%	(95% CI)	Number (in thousands)
Overall	35.4	(33.7-37.1)	6,414.0
Gender			
Male	37.7	(35.0-40.5)	3,291.0
Female	33.2	(30.9-35.6)	3,123.0
Age (years)			
15-24	44.2	(39.1-49.5)	1,267.0
25-44	39.1	(36.4-41.9)	2,673.2
45-64	35.9	(32.8-39.0)	1,883.8
65+	18.6	(15.9-21.6)	590.0
Residence			
Urban	40.9	(38.7-43.0)	4,123.1
Rural	28.5	(25.9-31.3)	2,290.8
Education level [2]			
Primary or less	29.8	(27.5-32.3)	2,104.1
Secondary	37.6	(34.5-40.8)	2,432.4
High	38.5	(34.8-42.4)	997.1
Nonsmokers	24.4	(22.6-26.3)	3,251.8
Gender			
Male	22.7	(19.8-25.9)	1,241.8
Female	25.7	(23.5-28.0)	2,010.0
Age (years)			
15-24	38.6	(33.4-44.2)	858.3
25-44	25.2	(22.0-28.6)	1,096.9
45-64	22.8	(19.9-26.0)	864.0
65+	14.7	(12.2-17.7)	432.5
Residence			
Urban	28.4	(26.0-30.9)	2,050.9
Rural	19.8	(17.2-22.7)	1,200.8
Education level [2]			
Primary or less	19.5	(17.0-22.2)	1,011.7
Secondary	24.2	(20.8-27.9)	1,095.9
High	26.2	(22.5-30.3)	491.8

[1] In the past 30 days. Among those persons who smoked inside their home daily-weekly, or monthly.
[2] Education level is reported only among persons aged ≥22 years.

Table 6.2 Percentage and number of persons aged ≥15 years who worked indoors and were exposed to tobacco smoke at work, by smoking status and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Exposed to tobacco smoke at work [1]		
	%	(95% CI)	Number (in thousands)
Overall	34.2	(30.5-38.0)	1,997.7
Gender			
Male	36.8	(32.4-41.5)	1,135.2
Female	31.2	(26.8-36.0)	862.6
Age (years)			
15-24	35.6	(25.4-47.3)	183.0
25-44	34.2	(29.4-39.5)	1,269.8
45-64	33.5	(28.6-38.7)	536.3
65+	*		*
Residence			
Urban	34.9	(30.5-39.6)	1,468.8
Rural	32.2	(26.1-39.0)	529.0
Education level [2]			
Primary or less	39.9	(32.4-47.8)	451.3
Secondary	33.9	(30.1-38.0)	960.8
High	30.0	(23.5-37.4)	508.6
Nonsmokers	29.2	(25.2-33.7)	1,106.1
Gender			
Male	31.5	(26.4-37.1)	534.8
Female	27.4	(22.2-33.2)	571.3
Age (years)			
15-24	29.4	(18.8-42.8)	95.6
25-44	29.1	(23.7-35.2)	692.8
45-64	29.6	(24.1-35.8)	312.0
65+	*		*
Residence			
Urban	31.0	(25.9-36.5)	843.0
Rural	24.8	(18.6-32.3)	263.1
Education level [2]			
Primary or less	39.7	(30.2-49.9)	240.1
Secondary	29.8	(24.8-35.2)	555.7
High	23.2	(17.2-30.5)	275.2

[1] In the past 30 days. Among persons who worked outside of the home who usually worked indoors or both indoors and outdoors.
[2] Education level is reported only for persons aged ≥22 years.
*Unweighted sample size less than 25.

Table 6.3 Percentage of persons aged ≥15 years who were exposed to tobacco smoke in public places in the past 30 days, by smoking status and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Exposed to Tobacco Smoke [1] in…													
	Government buildings		Health care facilities		Schools		Universities		Public transportation		Restaurants		Bars, nightclubs	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	20.7	(17.5-24.2)	10.4	(8.6-12.6)	25.1	(21.8-28.7)	47.5	(40.6-54.5)	8.9	(7.5-10.6)	86.6	(84.3-88.6)	94.4	(91.6-96.3)
Gender														
Male	22.4	(17.8-27.7)	10.0	(7.5-13.2)	33.3	(27.0-40.2)	55.7	(46.6-64.5)	9.7	(7.7-12.2)	88.4	(85.7-90.6)	93.7	(89.8-96.1)
Female	19.0	(15.0-23.8)	10.7	(8.7-13.2)	19.9	(16.0-24.4)	39.8	(29.3-51.4)	8.3	(6.5-10.6)	84.3	(80.0-87.8)	96.1	(93.2-97.8)
Age (years)														
15-24	21.9	(13.1-34.3)	11.8	(6.8-19.9)	50.2	(43.0-57.4)	53.6	(42.9-64.0)	9.3	(5.8-14.6)	86.3	(79.8-91.0)	97.7	(94.2-99.1)
25-44	23.1	(18.0-29.3)	13.9	(10.5-18.2)	14.1	(10.4-18.9)	41.9	(29.9-54.8)	10.4	(8.4-12.7)	90.7	(87.7-93.1)	94.5	(90.1-97.0)
45-64	19.1	(14.0-25.6)	9.2	(6.7-12.5)	15.3	(9.9-23.1)	27.9	(14.7-46.6)	7.7	(5.9-10.0)	78.3	(72.0-83.5)	89.9	(83.0-94.2)
65+	12.1	(6.9-20.3)	5.9	(3.7-9.3)	14.2	(6.8-27.2)	*		7.0	(4.5-10.6)	77.0	(65.2-85.7)	76.4	(60.8-87.1)
Residence														
Urban	22.3	(18.3-27.0)	12.3	(9.7-15.4)	25.5	(21.1-30.5)	44.2	(37.1-51.6)	8.4	(6.8-10.3)	87.0	(84.2-89.3)	98.0	(96.9-98.7)
Rural	18.0	(13.3-23.7)	7.7	(5.6-10.5)	24.4	(19.7-29.9)	56.4	(40.6-71.0)	9.9	(7.4-13.0)	85.9	(81.5-89.4)	89.5	(83.4-93.5)
Education level [2]														
Primary or less	17.4	(12.8-23.2)	8.2	(6.0-11.1)	13.0	(7.6-21.4)	*		9.3	(7.0-12.1)	83.5	(76.9-88.5)	87.0	(78.9-92.3)
Secondary	19.7	(14.7-25.9)	11.2	(8.9-14.1)	13.4	(9.6-18.4)	46.2	(31.0-62.1)	8.2	(6.3-10.5)	90.1	(86.1-93.0)	95.2	(92.7-96.8)
High	24.5	(18.3-32.0)	11.7	(7.5-17.7)	19.7	(13.6-27.8)	54.1	(41.8-66.0)	9.7	(7.0-13.5)	84.3	(79.3-88.3)	99.0	(96.2-99.8)
Nonsmokers	17.0	(13.6-20.9)	9.2	(7.5-11.3)	27.2	(23.8-30.9)	48.3	(40.1-56.7)	8.3	(6.7-10.2)	83.8	(80.7-86.5)	93.8	(91.2-95.7)
Gender														
Male	19.9	(14.6-26.6)	8.7	(6.1-12.3)	36.2	(29.3-43.7)	55.9	(43.9-67.3)	8.0	(5.6-11.3)	85.7	(81.5-89.1)	93.6	(90.3-95.8)
Female	14.6	(11.2-18.9)	9.5	(7.5-12.0)	22.0	(17.9-26.8)	42.4	(30.8-55.0)	8.5	(6.4-11.1)	81.8	(76.4-86.3)	94.3	(90.0-96.8)
Age (years)														
15-24	17.9	(9.9-30.0)	10.1	(5.3-18.4)	52.8	(44.8-60.7)	53.6	(42.2-64.6)	8.2	(4.7-14.1)	83.9	(75.8-89.6)	97.5	(92.8-99.1)
25-44	19.2	(13.4-26.8)	12.8	(9.3-17.5)	13.8	(10.0-18.8)	41.2	(25.8-58.7)	9.6	(7.0-13.0)	87.8	(83.3-91.3)	94.3	(90.4-96.7)
45-64	15.6	(10.3-23.0)	8.4	(6.0-11.8)	17.0	(11.3-24.8)	33.7	(17.1-55.5)	7.3	(5.3-10.1)	75.7	(68.4-81.7)	86.7	(74.8-93.4)
65+	11.3	(6.4-19.3)	5.5	(3.4-8.8)	11.9	(5.6-23.4)	*		7.5	(4.8-11.4)	80.0	(66.9-88.8)	74.6	(57.2-86.5)
Residence														
Urban	16.9	(13.0-21.6)	10.4	(8.1-13.2)	27.9	(23.3-33.1)	46.7	(37.5-56.2)	7.5	(5.6-9.9)	83.7	(80.1-86.8)	97.7	(95.7-98.8)
Rural	17.1	(11.5-24.6)	7.6	(5.2-11.1)	26.4	(21.7-31.7)	52.0	(35.8-67.7)	9.6	(7.0-13.1)	84.0	(77.4-88.9)	88.9	(83.2-92.8)
Education level [2]														
Primary or less	12.4	(7.8-19.1)	6.2	(4.2-8.9)	12.0	(6.6-20.8)	*		9.2	(6.9-12.3)	78.4	(69.1-85.5)	83.3	(73.6-89.9)
Secondary	15.9	(10.4-23.5)	10.3	(7.7-13.5)	13.8	(9.5-19.8)	46.6	(29.9-64.1)	7.8	(5.6-10.7)	87.0	(80.6-91.5)	94.1	(90.5-96.4)
High	22.9	(16.3-31.2)	12.1	(8.0-17.9)	21.3	(14.6-29.9)	53.7	(37.5-69.2)	7.7	(4.9-12.0)	82.3	(76.2-87.1)	99.1	(93.6-99.9)

[1] In the past 30 days. Among those persons s who visited the place.
[2] Education level is reported only among persons aged ≥22 years.
*Unweighted sample size less than 25

Table 6.4 Percentage of persons aged ≥15 years by indoor smoking policies at home and work and smoking status – GATS Romania, 2011.

Smoking policy	Overall		Current smokers		Nonsmokers	
	%	(95% CI)	%	(95% CI)	%	(95% CI)
Smoking policy at home						
Never allowed	49.2	(47.3-51.2)	28.7	(25.4-32.2)	56.7	(54.4-58.9)
Allowed with exceptions	24.4	(22.8-26.1)	21.2	(18.5-24.0)	25.6	(23.6-27.6)
Allowed	23.0	(21.5-24.5)	46.6	(43.0-50.2)	14.4	(12.9-15.9)
No rules	3.4	(2.8-4.2)	3.6	(2.5-5.0)	3.4	(2.7-4.2)
Smoking policy at work						
Not allowed indoor place	27.7	(24.7-31.0)	29.6	(25.2-34.3)	26.7	(23.0-30.6)
Allowed in some indoor places	59.0	(55.5-62.4)	52.1	(46.6-57.5)	62.9	(59.0-66.6)
Allowed anywhere	7.2	(5.6-9.3)	12.1	(8.8-16.3)	4.5	(3.3-6.2)
No smoking policies	6.1	(4.5-8.2)	6.3	(4.3-9.1)	5.9	(3.9-8.9)

Table 7.1 Percentage of current smokers of manufactured cigarettes who were aged ≥15 years, by last brand purchased and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Last brand purchased									
	Kent		Winchester		Viceroy		Marlboro		Winston	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	33.8	(30.7-37.1)	8.2	(6.3-10.5)	7.6	(5.9-9.7)	9.7	(7.8-12.0)	7.0	(5.4-9.1)
Gender										
Male	32.6	(28.6-36.8)	7.8	(5.7-10.6)	8.7	(6.5-11.7)	11.6	(9.0-14.9)	5.8	(4.4-7.7)
Female	36.5	(30.4-43.0)	9.0	(6.0-13.4)	5.1	(3.1-8.4)	5.6	(3.5-8.9)	9.6	(6.3-14.4)
Age (years)										
15-24	55.3	(44.7-65.4)	2.1	(0.6-6.6)	5.1	(3.1-8.1)	4.8	(1.8-12.6)	5.0	(1.7-13.5)
25-44	34.0	(29.7-38.6)	7.2	(4.9-10.5)	6.7	(4.4-10.1)	13.3	(10.2-17.3)	7.5	(5.3-10.5)
45-64	28.2	(23.2-33.7)	11.2	(7.8-15.8)	9.6	(6.9-13.2)	6.0	(4.1-8.7)	6.4	(4.7-8.8)
65+	9.2	(4.7-17.0)	16.0	(8.4-28.3)	10.8	(5.8-19.4)	7.6	(3.7-15.1)	11.6	(6.4-20.4)
Residence										
Urban	39.4	(35.9-43.1)	5.8	(3.8-8.7)	4.9	(3.6-6.8)	8.6	(6.5-11.3)	7.5	(5.3-10.5)
Rural	25.6	(20.2-31.9)	11.6	(8.4-15.8)	11.4	(7.8-16.3)	11.3	(8.1-15.6)	6.4	(4.4-9.2)
Education level [1]										
Primary or less	28.6	(23.0-35.0)	10.9	(8.0-14.8)	12.2	(8.8-16.8)	9.1	(6.1-13.3)	6.8	(4.7-9.8)
Secondary	30.0	(25.8-34.6)	7.3	(4.8-10.9)	6.3	(4.2-9.3)	11.6	(8.4-15.7)	7.1	(4.8-10.4)
High	45.8	(37.4-54.4)	6.0	(2.7-12.8)	0.3	(0.0-2.3)	8.9	(5.0-15.1)	8.2	(4.2-15.2)

Note: Current-manufactured cigarette smokers include those with daily and occasional (less than daily) use.
[1] Education level is reported only among persons aged ≥22 years.

Table 7.2 Percentage distribution of the source of last purchase of cigarettes among smokers of manufactured cigarettes who were aged ≥15 years, by selected demographic characteristics – GATS Romania, 2011.

Source	Overall		Gender				Age (years)				Residence			
			Male		Female		15-24		≥ 25		Urban		Rural	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Store	84.3	(81.0-87.1)	84.1	(80.7-87.1)	84.6	(78.8-89.0)	88.0	(76.3-94.4)	83.7	(80.3-86.6)	82.7	(77.8-86.7)	86.6	(82.4-90.0)
Street vendor	3.5	(2.2-5.6)	3.7	(2.0-6.6)	3.2	(1.7-6.0)	3.8	(1.2-11.4)	3.5	(2.2-5.5)	3.0	(1.5-6.1)	4.3	(2.4-7.8)
Duty-free shop	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	
Outside the country	0.1	(0.0-0.5)	0.1	(0.0-0.7)	0.0		0.0		0.1	(0.0-0.5)	0.1	(0.0-0.8)	0.0	
Kiosks	6.6	(4.9-8.9)	6.1	(4.4-8.6)	7.6	(4.4-13.1)	3.9	(1.1-13.1)	7.1	(5.2-9.4)	9.3	(6.6-12.9)	2.8	(1.5-5.2)
Internet	0.0		0.0		0.0		0.0		0.0		0.0		0.0	
From another person	2.7	(1.7-4.2)	2.6	(1.5-4.5)	3.0	(1.3-6.5)	0.0		3.1	(2.0-4.9)	2.5	(1.3-4.7)	3.0	(1.7-5.3)
Other	2.7	(1.9-4.0)	3.3	(2.2-4.8)	1.6	(0.5-4.6)	4.3	(1.1-15.6)	2.5	(1.5-4.1)	2.4	(1.3-4.5)	3.2	(2.2-4.8)
Total	100		100		100		100		100		100		100	

Table 7.3 Average cigarette expenditure per month among smokers of manufactured cigarettes who were aged ≥15 years, by selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Cigarette expenditure per month (RON)		
	Average	(95% CI)	Median
Overall	273.1	(251.3-294.9)	262.3
Gender			
Male	299.5	(270.6-328.4)	304.2
Female	216.9	(195.4-238.3)	179.5
Age (years)			
15-24	218.0	(188.4-247.6)	182.5
25-44	275.3	(250.4-300.1)	304.2
45-64	298.0	(248.3-347.7)	273.8
65+	249.8	(116.5-383.1)	146.0
Residence			
Urban	269.2	(244.3-294.0)	262.3
Rural	278.8	(239.3-318.3)	273.8
Education Level [1]			
Primary or less	318.1	(270.9-365.2)	304.2
Secondary	249.5	(230.5-268.6)	250.9
High	248.9	(223.9-273.8)	262.3

[1] Education level is reported only for persons aged ≥ 22 years.

Table 8.1 Percentage of persons aged ≥15 years who noticed antismoking information during the last 30 days in various places, by smoking status and selected demographic characteristics - GATS Romania, 2011.

Place	Overall		Gender				Age (years)				Residence			
			Male		Female		15-24		≥ 25		Urban		Rural	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall														
In newspapers or in magazines	35.1	(33.4-36.7)	36.4	(34.0-38.9)	33.8	(31.7-35.9)	41.6	(36.6-46.8)	33.8	(32.1-35.6)	40.2	(38.0-42.5)	28.5	(26.1-31.1)
On television or the radio	78.6	(76.6-80.5)	78.4	(75.6-81.1)	78.8	(76.7-80.7)	79.9	(74.9-84.0)	78.4	(76.3-80.3)	78.2	(75.3-80.9)	79.1	(76.2-81.7)
On television	76.7	(74.5-78.7)	76.1	(73.1-78.8)	77.2	(75.1-79.3)	78.5	(73.5-82.7)	76.3	(74.2-78.4)	75.7	(72.6-78.5)	77.9	(75.0-80.6)
On the radio	25.3	(23.9-26.8)	26.8	(24.5-29.2)	24.0	(22.4-25.6)	22.3	(17.8-27.7)	25.9	(24.4-27.4)	26.6	(24.8-28.6)	23.7	(21.5-26.0)
On billboards	25.8	(24.1-27.6)	27.7	(25.2-30.4)	24.0	(22.0-26.1)	34.6	(30.6-38.8)	24.2	(22.3-26.1)	33.3	(30.9-35.9)	16.4	(14.3-18.7)
Somewhere else	6.7	(5.8-7.7)	7.1	(5.7-8.8)	6.3	(5.2-7.5)	11.7	(8.9-15.1)	5.7	(4.9-6.7)	7.4	(6.2-8.7)	5.8	(4.5-7.4)
Any Location	83.6	(81.9-85.1)	83.8	(81.7-85.8)	83.3	(81.4-85.1)	87.4	(83.3-90.6)	82.9	(81.1-84.5)	84.6	(82.3-86.8)	82.2	(79.8-84.5)
***Current smokers*[1]**														
In newspapers or in magazines	35.2	(32.2-38.4)	34.6	(30.8-38.7)	36.4	(31.4-41.8)	35.6	(25.7-46.9)	35.2	(31.8-38.7)	39.7	(35.7-43.9)	28.6	(24.2-33.6)
On television or the radio	77.0	(73.2-80.3)	76.0	(71.5-79.9)	79.0	(72.8-84.1)	73.8	(61.5-83.2)	77.5	(73.8-80.8)	75.6	(71.0-79.7)	79.0	(72.3-84.4)
On television	75.1	(71.2-78.6)	73.6	(69.0-77.7)	78.2	(72.1-83.3)	71.4	(59.3-81.1)	75.6	(71.9-79.0)	73.4	(68.7-77.6)	77.5	(70.7-83.1)
On the radio	22.3	(19.6-25.4)	25.0	(21.4-28.9)	16.9	(12.8-21.9)	17.5	(10.1-28.7)	23.1	(20.0-26.5)	24.2	(20.8-27.9)	19.7	(15.2-25.1)
On billboards	29.8	(26.7-33.1)	29.9	(26.4-33.7)	29.6	(24.0-35.9)	32.0	(24.0-41.4)	29.5	(26.0-33.2)	36.1	(31.8-40.5)	20.7	(16.8-25.2)
Somewhere else	9.2	(7.4-11.4)	7.5	(5.6-9.9)	12.7	(8.9-17.7)	12.4	(7.2-20.4)	8.7	(6.7-11.3)	9.9	(7.9-12.4)	8.1	(5.1-12.7)
Any Location	82.6	(79.1-85.5)	81.2	(77.0-84.7)	85.5	(79.6-89.8)	82.0	(71.6-89.1)	82.6	(79.1-85.7)	82.6	(78.3-86.2)	82.5	(76.6-87.3)
***Nonsmokers*[2]**														
In newspapers or in magazines	35.0	(33.2-36.9)	37.5	(34.4-40.7)	33.3	(31.0-35.6)	43.4	(37.9-49.1)	33.3	(31.4-35.3)	40.4	(38.0-42.9)	28.5	(25.6-31.6)
On television or the radio	79.2	(77.1-81.2)	79.9	(76.6-82.8)	78.7	(76.5-80.8)	81.6	(76.7-85.7)	78.7	(76.6-80.7)	79.2	(76.2-82.0)	79.2	(76.2-81.8)
On television	77.3	(75.2-79.2)	77.6	(74.3-80.6)	77.0	(74.8-79.1)	80.5	(75.5-84.7)	76.6	(74.4-78.7)	76.6	(73.6-79.4)	78.0	(75.1-80.8)
On the radio	26.4	(24.8-28.1)	27.9	(24.9-31.0)	25.4	(23.7-27.2)	23.8	(18.6-29.8)	26.9	(25.3-28.6)	27.6	(25.3-30.0)	25.0	(22.6-27.4)
On billboards	24.4	(22.5-26.3)	26.5	(23.4-29.7)	22.9	(20.7-25.3)	35.3	(30.5-40.4)	22.2	(20.2-24.3)	32.2	(29.4-35.2)	15.0	(12.9-17.3)
Somewhere else	5.7	(4.8-6.9)	6.9	(5.3-8.9)	5.0	(3.9-6.4)	11.5	(8.1-15.9)	4.6	(3.8-5.6)	6.4	(5.2-7.8)	5.0	(3.6-6.9)
Any Location	83.9	(82.2-85.6)	85.4	(83.1-87.5)	82.9	(80.7-84.9)	89.0	(84.7-92.1)	82.9	(81.1-84.7)	85.5	(82.8-87.7)	82.1	(79.6-84.4)

[1] Includes daily and occasional (less than daily) smokers.
[2] Includes former and never smokers.

Table 8.2 Percentages of current smokers aged ≥15 years who noticed health warnings on cigarette packages and who considered quitting because of the warning label on cigarette packages during the last 30 days, by selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Current smokers [1] who…			
	Noticed pictorial health warnings on cigarette package [2]		Thought about quitting because of pictorial warning label [2]	
	%	(95% CI)	%	(95% CI)
Overall	95.2	(93.6-96.5)	27.5	(24.2-31.0)
Gender				
Male	95.3	(93.0-96.9)	24.7	(21.0-28.9)
Female	95.1	(92.6-96.8)	33.2	(27.1-40.0)
Age (years)				
15-24	95.4	(87.7-98.3)	26.7	(17.7-38.1)
25-44	97.0	(94.9-98.3)	26.5	(21.9-31.7)
45-64	93.2	(90.1-95.5)	28.5	(24.2-33.2)
65+	88.9	(79.0-94.5)	33.4	(25.1-42.9)
Residence				
Urban	96.8	(95.0-97.9)	26.0	(22.4-29.9)
Rural	93.0	(89.6-95.3)	29.7	(23.9-36.2)
Education level [3]				
Primary or less	94.9	(92.4-96.6)	29.3	(23.2-36.2)
Secondary	95.1	(92.1-97.0)	28.1	(23.2-33.7)
High	96.8	(93.4-98.4)	22.6	(17.0-29.4)

[1] Includes daily and occasional (less than daily) smokers.
[2] In the past 30 days.
[3] Education level is reported only for persons aged ≥ 22 years.

Table 8.3 Percentage of persons aged ≥15 years who noticed cigarette marketing during the last 30 days in various places, by selected demographic characteristics – GATS Romania, 2011.

Place	Overall		Gender				Age (years)				Residence			
			Male		Female		15-24		≥ 25		Urban		Rural	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Noticed advertisements														
In stores where cigarettes are sold	26.7	(25.2-28.3)	31.0	(28.6-33.5)	22.7	(20.9-24.7)	39.2	(34.7-44.0)	24.4	(22.9-25.9)	32.9	(30.7-35.1)	19.0	(17.1-21.1)
On the Internet	6.8	(6.0-7.9)	7.8	(6.5-9.3)	6.0	(4.8-7.5)	16.9	(13.2-21.3)	5.0	(4.1-6.0)	9.4	(8.1-10.9)	3.6	(2.6-5.0)
On public walls	4.9	(4.1-5.7)	5.1	(4.1-6.3)	4.6	(3.7-5.7)	7.8	(5.6-10.7)	4.3	(3.5-5.3)	5.3	(4.4-6.4)	4.3	(3.2-5.9)
Somewhere else	1.7	(1.3-2.2)	1.9	(1.2-2.8)	1.5	(1.1-2.2)	3.2	(1.5-6.6)	1.4	(1.1-1.8)	2.4	(1.8-3.2)	0.8	(0.4-1.7)
Noticed sports sponsorship														
	5.0	(4.2-5.9)	6.7	(5.3-8.4)	3.4	(2.6-4.4)	4.8	(2.9-7.9)	5.0	(4.2-5.9)	6.3	(5.3-7.6)	3.3	(2.3-4.6)
Noticed cigarette promotions														
Free samples	4.4	(3.7-5.4)	4.4	(3.3-6.0)	4.4	(3.5-5.6)	8.6	(5.9-12.2)	3.7	(3.0-4.4)	6.6	(5.4-8.1)	1.7	(1.1-2.6)
Sale prices	4.0	(3.3-4.8)	4.5	(3.4-5.9)	3.5	(2.7-4.5)	6.8	(4.4-10.3)	3.5	(2.8-4.3)	5.4	(4.3-6.7)	2.2	(1.6-3.2)
Coupons	4.0	(3.4-4.7)	4.6	(3.7-5.8)	3.4	(2.5-4.6)	6.4	(4.4-9.2)	3.5	(2.8-4.4)	5.2	(4.3-6.4)	2.4	(1.7-3.3)
Free gifts/ discounts on other products	8.1	(6.9-9.3)	9.2	(7.5-11.1)	7.0	(5.9-8.4)	14.2	(11.0-18.2)	6.9	(5.8-8.2)	11.4	(9.7-13.3)	3.8	(2.7-5.5)
Clothing/item with brand name or logo	5.2	(4.3-6.2)	6.5	(5.2-8.0)	3.9	(2.9-5.2)	9.4	(6.8-12.7)	4.4	(3.5-5.5)	7.2	(5.8-8.9)	2.6	(2.0-3.4)
Mail promoting cigarettes	1.2	(0.7-1.9)	1.4	(0.7-2.9)	1.0	(0.5-2.0)	3.5	(1.8-6.4)	0.8	(0.5-1.2)	1.9	(1.2-3.1)	0.3	(0.1-0.7)
Promotional girl	7.0	(5.9-8.2)	7.6	(6.1-9.4)	6.4	(5.3-7.6)	12.2	(9.3-15.8)	6.0	(5.0-7.2)	10.6	(8.8-12.7)	2.4	(1.7-3.3)
Noticed any advertisement-sponsorship or promotion	40.5	(38.8-42.3)	45.2	(42.4-48.1)	36.1	(34.0-38.2)	58.8	(53.4-63.9)	37.1	(35.2-38.9)	50.4	(48.0-52.8)	28.0	(25.8-30.4)

Table 8.4 Percentage of nonsmokers aged ≥15 years who noticed cigarette marketing during the last 30 days in various places, by selected demographic characteristics – GATS Romania, 2011.

Place	Overall		Gender				Age (years)				Residence			
			Male		Female		15-24		≥ 25		Urban		Rural	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Noticed advertisements														
In stores where cigarettes are sold	22.2	(20.7-23.6)	26.1	(23.2-29.2)	19.4	(17.7-21.2)	35.7	(30.6-41.2)	19.4	(18.2-20.8)	27.2	(25.3-29.1)	16.1	(14.1-18.5)
On the Internet	6.6	(5.7-7.8)	8.6	(6.9-10.6)	5.3	(4.2-6.5)	17.2	(13.5-21.8)	4.5	(3.7-5.5)	9.0	(7.6-10.6)	3.9	(2.7-5.4)
On public walls	4.7	(3.9-5.6)	4.8	(3.6-6.4)	4.6	(3.7-5.6)	7.5	(5.5-10.3)	4.1	(3.3-5.1)	5.3	(4.2-6.6)	4.0	(3.0-5.2)
Somewhere else	1.7	(1.2-2.5)	1.9	(1.0-3.5)	1.6	(1.1-2.3)	3.3	(1.3-7.9)	1.4	(1.0-1.9)	2.5	(1.8-3.6)	0.8	(0.3-2.1)
Noticed sports sponsorship														
	4.6	(3.7-5.6)	6.6	(4.8-9.1)	3.1	(2.3-4.2)	5.2	(3.0-8.7)	4.4	(3.6-5.5)	5.6	(4.5-7.0)	3.3	(2.1-5.2)
Noticed cigarette promotions														
Free samples	3.7	(2.9-4.7)	4.0	(2.7-6.1)	3.5	(2.6-4.6)	7.8	(4.9-12.0)	2.9	(2.2-3.7)	5.4	(4.2-7.0)	1.6	(1.0-2.6)
Sale prices	2.6	(2.0-3.4)	3.2	(2.0-5.0)	2.2	(1.6-2.9)	5.7	(3.3-9.7)	2.0	(1.5-2.6)	3.6	(2.6-4.9)	1.4	(0.9-2.2)
Coupons	2.4	(1.8-3.1)	2.9	(1.9-4.4)	2.0	(1.4-2.7)	4.8	(2.9-7.9)	1.9	(1.4-2.5)	3.0	(2.2-4.1)	1.6	(1.0-2.5)
Free gifts/ discounts on other products	5.9	(5.0-7.1)	7.1	(5.4-9.2)	5.1	(4.1-6.4)	12.8	(9.4-17.2)	4.6	(3.7-5.6)	8.0	(6.7-9.6)	3.4	(2.2-5.2)
Clothing/ item with brand name or logo	4.3	(3.5-5.3)	5.8	(4.3-7.6)	3.3	(2.4-4.4)	9.0	(6.3-12.6)	3.4	(2.6-4.4)	5.9	(4.5-7.6)	2.4	(1.7-3.3)
Mail promoting cigarettes	1.1	(0.6-2.1)	1.3	(0.5-3.8)	0.9	(0.4-2.1)	3.1	(1.2-7.6)	0.7	(0.4-1.3)	1.8	(0.9-3.7)	0.3	(0.1-0.9)
Promotional girl	5.4	(4.3-6.7)	5.6	(4.0-7.7)	5.3	(4.3-6.5)	11.8	(8.4-16.2)	4.1	(3.3-5.1)	7.9	(6.2-10.1)	2.4	(1.6-3.5)
Noticed any advertise-ment-sponsorship-or promotion	35.2	(33.2-37.2)	39.7	(36.1-43.4)	32.0	(30.0-34.2)	57.6	(51.4-63.5)	30.7	(28.9-32.6)	43.5	(40.9-46.1)	25.3	(22.6-28.3)

Table 9.1A Percentage of persons aged ≥15 years who believed that smoking causes serious illness, stroke, heart attack, or lung cancer, by smoking status and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Believe that smoking causes…							
	Serious illness		Stroke		Heart attack		Lung cancer	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	96.3	(95.6-97.0)	89.2	(88.1-90.2)	90.0	(88.9-91.1)	98.3	(97.8-98.6)
Gender								
Male	95.4	(94.1-96.4)	88.4	(86.7-89.9)	88.6	(86.9-90.2)	98.4	(97.5-98.9)
Female	97.2	(96.4-97.8)	90.0	(88.4-91.3)	91.3	(89.8-92.6)	98.2	(97.4-98.7)
Age (years)								
15-24	96.5	(94.5-97.7)	82.8	(79.0-86.1)	85.0	(80.6-88.6)	98.4	(96.1-99.3)
25-44	95.9	(94.1-97.2)	88.9	(86.7-90.8)	89.4	(87.4-91.1)	98.3	(97.2-99.0)
45-64	96.8	(95.8-97.5)	92.4	(90.6-93.9)	93.2	(91.4-94.6)	98.5	(97.7-99.0)
65+	96.4	(95.2-97.3)	90.2	(88.1-92.0)	90.8	(88.8-92.4)	97.8	(96.7-98.5)
Residence								
Urban	97.0	(96.1-97.6)	89.9	(88.4-91.3)	89.8	(88.0-91.3)	98.0	(97.3-98.5)
Rural	95.6	(94.2-96.6)	88.3	(86.7-89.6)	90.4	(89.0-91.6)	98.6	(98.0-99.1)
Education level [1]								
Primary or less	96.5	(95.3-97.4)	89.7	(87.8-91.3)	90.0	(88.0-91.6)	98.6	(98.1-99.0)
Secondary	96.4	(95.0-97.5)	91.1	(89.2-92.8)	90.8	(88.8-92.5)	98.6	(97.7-99.1)
High	95.0	(92.5-96.7)	89.6	(86.4-92.1)	90.5	(87.1-93.0)	96.5	(93.8-98.1)
Current smokers [2]	93.6	(91.1-95.4)	86.8	(84.0-89.2)	86.3	(83.6-88.6)	96.8	(95.4-97.8)
Gender								
Male	92.5	(89.3-94.8)	86.7	(83.1-89.7)	86.9	(83.5-89.7)	97.2	(95.3-98.3)
Female	95.8	(92.3-97.7)	86.9	(82.6-90.3)	85.0	(79.6-89.2)	96.0	(92.5-97.9)
Age (years)								
15-24	93.3	(85.7-97.0)	84.9	(75.5-91.2)	85.0	(74.9-91.5)	99.1	(93.5-99.9)
25-44	93.0	(88.7-95.7)	86.6	(82.5-89.8)	84.5	(80.4-87.8)	96.8	(94.4-98.2)
45-64	95.1	(92.4-96.9)	88.7	(84.8-91.7)	91.1	(87.3-93.9)	96.9	(94.4-98.3)
65+	91.3	(83.1-95.7)	81.9	(70.5-89.6)	78.3	(67.5-86.3)	89.1	(78.5-94.8)
Residence								
Urban	94.1	(91.8-95.8)	86.6	(83.0-89.5)	85.4	(81.8-88.4)	95.9	(93.9-97.3)
Rural	92.8	(87.1-96.1)	87.1	(82.1-90.9)	87.5	(83.2-90.8)	98.0	(95.8-99.0)
Education level [1]								
Primary or less	95.4	(91.0-97.7)	87.1	(81.8-91.1)	85.6	(80.6-89.5)	97.9	(96.4-98.8)
Secondary	93.8	(90.2-96.1)	88.5	(84.6-91.4)	86.8	(82.8-90.0)	96.8	(94.0-98.4)
High	87.4	(80.3-92.2)	82.3	(74.7-88.0)	85.2	(78.0-90.3)	93.4	(86.3-97.0)
Nonsmokers [3]	97.3	(96.8-97.8)	90.1	(88.8-91.2)	91.4	(90.1-92.5)	98.8	(98.3-99.2)
Gender								
Male	97.2	(96.2-97.9)	89.4	(87.3-91.2)	89.7	(87.7-91.4)	99.1	(98.2-99.6)
Female	97.5	(96.6-98.1)	90.6	(88.9-92.0)	92.6	(91.2-93.8)	98.6	(97.9-99.1)
Age (years)								
15-24	97.4	(95.6-98.5)	82.2	(77.7-86.0)	85.1	(80.1-89.0)	98.2	(95.2-99.3)
25-44	97.6	(96.1-98.6)	90.2	(87.7-92.2)	92.2	(89.9-94.0)	99.1	(97.8-99.7)
45-64	97.4	(96.4-98.1)	93.9	(91.9-95.4)	94.0	(92.0-95.4)	99.1	(98.2-99.6)
65+	96.8	(95.7-97.7)	90.9	(88.8-92.6)	91.8	(89.9-93.4)	98.5	(97.6-99.1)
Residence								
Urban	98.1	(97.4-98.6)	91.3	(89.6-92.7)	91.5	(89.5-93.1)	98.8	(98.0-99.3)
Rural	96.5	(95.5-97.2)	88.6	(86.7-90.3)	91.3	(89.7-92.7)	98.8	(98.2-99.3)
Education level [1]								
Primary or less	96.9	(95.8-97.7)	90.6	(88.8-92.1)	91.5	(89.7-93.1)	98.9	(98.2-99.3)
Secondary	97.6	(96.3-98.4)	92.3	(90.0-94.1)	92.5	(90.2-94.4)	99.3	(98.6-99.7)
High	97.9	(95.5-99.0)	92.3	(88.4-95.0)	92.5	(89.1-94.8)	97.7	(94.2-99.1)

[1] Education level is reported only for persons aged ≥22 years.
[2] Includes daily and occasional (less than daily) smokers.
[3] Includes former and never smokers.

Table 9.1B Percentage of persons aged ≥15 years who believed that smoking causes different diseases, by smoking status and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Believes that smoking causes…									
	Other cancers [4]		Periodontal disease		Bone loss		Premature birth		Erectile dysfunction	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	94.6	(93.9-95.3)	83.0	(81.3-84.6)	53.4	(51.6-55.2)	74.7	(73.1-76.1)	66.5	(64.9-68.1)
Gender										
Male	94.8	(93.5-95.7)	81.8	(79.1-84.1)	49.7	(47.0-52.4)	70.5	(68.3-72.6)	67.7	(65.1-70.2)
Female	94.5	(93.5-95.5)	84.1	(81.9-86.1)	56.8	(54.3-59.3)	78.5	(76.6-80.3)	65.4	(63.3-67.4)
Age (years)										
15-24	95.1	(92.2-97.0)	86.2	(81.0-90.2)	48.6	(43.8-53.4)	74.4	(70.2-78.2)	63.4	(58.5-68.0)
25-44	94.5	(92.9-95.7)	82.5	(79.7-84.9)	50.5	(47.1-54.0)	75.5	(72.5-78.3)	69.3	(66.4-72.1)
45-64	95.6	(94.4-96.6)	83.2	(81.0-85.2)	56.5	(53.8-59.1)	75.1	(72.6-77.4)	65.6	(62.8-68.3)
65+	92.9	(91.4-94.2)	80.8	(77.9-83.4)	58.6	(55.5-61.6)	72.4	(69.3-75.3)	64.7	(61.4-67.8)
Residence										
Urban	94.3	(93.2-95.3)	82.0	(79.8-84.0)	52.3	(50.1-54.6)	73.7	(71.5-75.8)	67.3	(65.2-69.4)
Rural	95.0	(93.9-96.0)	84.2	(81.4-86.7)	54.7	(51.7-57.6)	75.8	(73.6-77.9)	65.5	(62.9-67.9)
Education level [1]										
Primary or less	94.7	(93.5-95.7)	83.1	(80.9-85.1)	54.9	(52.4-57.5)	74.4	(71.9-76.7)	64.5	(61.8-67.2)
Secondary	94.4	(92.9-95.5)	83.0	(80.4-85.4)	53.5	(50.7-56.2)	75.8	(73.0-78.3)	68.9	(66.6-71.1)
High	94.9	(92.2-96.7)	80.5	(76.3-84.1)	51.4	(45.9-56.8)	70.6	(65.7-75.0)	69.0	(63.6-73.9)
Current smokers [2]	93.1	(91.2-94.5)	81.3	(78.7-83.5)	47.3	(43.6-51.1)	67.7	(64.0-71.1)	63.6	(60.1-66.9)
Gender										
Male	92.4	(89.7-94.4)	80.6	(77.6-83.3)	45.6	(41.2-50.0)	65.0	(60.8-69.0)	62.6	(58.3-66.6)
Female	94.5	(90.7-96.8)	82.7	(77.4-86.9)	50.9	(45.1-56.7)	73.2	(66.7-78.8)	65.6	(60.4-70.5)
Age (years)										
15-24	96.4	(89.3-98.8)	85.1	(74.0-91.9)	46.2	(35.8-57.0)	69.3	(59.0-77.9)	63.8	(52.6-73.7)
25-44	91.8	(88.8-94.0)	79.7	(75.6-83.3)	45.3	(40.0-50.8)	67.0	(61.3-72.2)	63.4	(58.0-68.5)
45-64	94.5	(91.5-96.4)	82.5	(78.5-86.0)	51.6	(46.3-56.9)	67.7	(61.6-73.3)	64.5	(58.9-69.8)
65+	88.7	(79.3-94.1)	78.8	(68.2-86.6)	44.5	(33.0-56.6)	69.9	(57.5-80.0)	58.7	(46.4-69.9)
Residence										
Urban	93.0	(90.7-94.8)	79.7	(76.4-82.7)	47.9	(43.2-52.6)	66.5	(61.7-71.0)	64.8	(60.9-68.6)
Rural	93.1	(89.8-95.4)	83.5	(79.5-86.9)	46.5	(40.4-52.7)	69.4	(63.4-74.7)	61.7	(55.3-67.7)
Education level [1]										
Primary or less	95.3	(92.9-97.0)	84.3	(79.8-87.9)	46.6	(40.1-53.3)	66.0	(58.7-72.7)	59.9	(53.9-65.6)
Secondary	91.4	(87.8-94.0)	81.0	(76.9-84.5)	47.7	(42.6-52.8)	69.4	(64.7-73.6)	65.9	(61.4-70.2)
High	88.8	(81.2-93.5)	73.2	(65.5-79.7)	47.4	(37.8-57.3)	64.6	(54.8-73.4)	64.8	(54.3-74.1)
Nonsmokers [3]	95.2	(94.4-95.9)	83.6	(81.4-85.6)	55.6	(53.5-57.6)	77.2	(75.7-78.7)	67.6	(65.7-69.3)
Gender										
Male	96.2	(95.0-97.1)	82.5	(78.6-85.8)	52.1	(49.0-55.2)	73.8	(71.1-76.4)	70.8	(67.8-73.5)
Female	94.6	(93.3-95.6)	84.4	(82.1-86.5)	58.0	(55.2-60.7)	79.6	(77.6-81.4)	65.3	(62.9-67.7)
Age (years)										
15-24	94.8	(91.3-96.9)	86.6	(81.4-90.5)	49.3	(43.4-55.3)	75.9	(71.2-80.0)	63.3	(57.1-69.0)
25-44	96.0	(94.2-97.3)	84.0	(79.9-87.4)	53.5	(49.3-57.6)	80.3	(77.2-83.2)	72.7	(69.5-75.7)
45-64	96.1	(94.5-97.2)	83.5	(80.9-85.8)	58.4	(55.5-61.2)	77.9	(75.5-80.1)	66.0	(62.8-69.1)
65+	93.3	(91.8-94.5)	81.0	(78.0-83.6)	59.8	(56.5-62.9)	72.6	(69.5-75.5)	65.2	(62.0-68.2)
Residence										
Urban	94.9	(93.7-95.8)	82.9	(80.0-85.5)	54.1	(51.5-56.7)	76.6	(74.5-78.6)	68.3	(65.8-70.6)
Rural	95.7	(94.5-96.6)	84.5	(81.1-87.3)	57.3	(53.9-60.7)	77.9	(75.6-80.1)	66.7	(64.0-69.3)
Education level [1]										
Primary or less	94.5	(93.1-95.7)	82.7	(80.1-85.1)	57.9	(55.3-60.4)	77.3	(75.1-79.4)	66.2	(63.4-68.9)
Secondary	95.6	(94.2-96.8)	83.9	(80.7-86.7)	56.0	(52.4-59.5)	78.5	(75.3-81.4)	70.2	(67.3-72.9)
High	97.2	(94.8-98.6)	83.2	(77.8-87.6)	52.8	(47.6-58.0)	72.8	(67.5-77.5)	70.6	(64.5-76.0)

[1] Education level is reported only for persons aged ≥22 years.
[2] Includes daily and occasional (less than daily) smokers.
[3] Includes former and never smokers.
[4] Other cancers include bladder, stomach, and mouth cancer.

Table 9.2 Percentage of persons aged ≥15 years who believed that breathing other people's smoke causes serious illness in nonsmokers, by smoking status and selected demographic characteristics, GATS Romania, 2011.

Demographic characteristic	Believes that breathing other people's smoke causes serious illness in nonsmokers					
	Overall		Current smokers [1]		Nonsmokers [2]	
	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	94.2	(93.4-94.9)	90.7	(88.4-92.6)	95.4	(94.7-96.1)
Gender						
Male	93.5	(92.2-94.6)	90.2	(87.3-92.5)	95.5	(94.3-96.4)
Female	94.8	(93.7-95.7)	91.8	(87.9-94.6)	95.4	(94.4-96.2)
Age (years)						
15-24	95.0	(92.3-96.8)	86.6	(77.5-92.3)	97.4	(94.7-98.8)
25-44	94.6	(93.0-95.9)	92.0	(88.4-94.6)	96.1	(94.3-97.4)
45-64	94.1	(92.9-95.2)	90.8	(87.2-93.5)	95.4	(94.1-96.4)
65+	92.6	(91.1-93.9)	88.1	(78.7-93.7)	93.0	(91.5-94.2)
Residence						
Urban	94.4	(93.3-95.4)	90.5	(87.6-92.8)	96.0	(94.9-96.8)
Rural	93.9	(92.7-94.9)	91.1	(87.0-94.0)	94.8	(93.7-95.7)
Education level [3]						
Primary or less	93.8	(92.7-94.7)	92.0	(88.7-94.4)	94.5	(93.3-95.4)
Secondary	94.6	(93.2-95.7)	93.0	(89.8-95.3)	95.3	(93.7-96.5)
High	92.7	(89.8-94.8)	84.7	(78.1-89.5)	95.7	(92.7-97.5)

[1] Includes daily and occasional (less than daily) smokers
[2] Includes former and never smokers.
[3] Education level is reported only for persons aged ≥22 years.

Table 9.3A Percentage of persons aged ≥ 15 years who believed that low tar cigarettes can be less harmful than regular cigarettes, by smoking status, selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Believes that low tar cigarettes can be less harmful than others					
	Overall		Current smokers [1]		Nonsmokers [2]	
	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	21.0	(19.4-22.7)	35.0	(31.5-38.6)	15.9	(14.3-17.7)
Gender						
Male	24.9	(22.6-27.3)	35.0	(30.7-39.6)	18.9	(16.4-21.6)
Female	17.4	(15.3-19.7)	34.9	(29.1-41.1)	13.9	(11.9-16.2)
Age						
15-24	30.6	(25.6-36.1)	43.3	(32.7-54.6)	26.9	(22.0-32.4)
25-44	24.1	(21.2-27.3)	36.8	(31.5-42.5)	16.9	(13.9-20.4)
45-64	17.4	(15.5-19.6)	28.6	(23.9-33.8)	13.1	(10.9-15.8)
65+	11.6	(9.7-13.9)	32.5	(22.0-45.0)	9.9	(8.1-12.0)
Residence						
Urban	20.7	(18.6-23.0)	33.9	(29.6-38.4)	15.4	(13.3-17.9)
Rural	21.4	(19.1-23.9)	36.6	(30.9-42.7)	16.5	(14.1-19.3)
Education level [3]						
Primary or less	18.0	(16.0-20.3)	35.2	(29.4-41.5)	11.9	(10.1-13.9)
Secondary	20.7	(18.5-23.1)	31.3	(26.8-36.1)	16.2	(13.7-19.0)
High	23.2	(19.0-27.9)	37.9	(29.8-46.8)	17.6	(13.5-22.5)

[1] Includes daily and occasional (less than daily) smokers.
[2] Includes former and never smokers.
[3] Education level is reported only for persons aged ≥22 years.

Table 9.3B Percentage of persons aged ≥15 years who believed that slim cigarettes can be less harmful than regular cigarettes, by smoking status, selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Believe that slim cigarettes can be less harmful than others					
	Overall		Current smokers [1]		Nonsmokers [2]	
	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	18.9	(17.4-20.4)	30.1	(26.7-33.8)	14.8	(13.3-16.4)
Gender						
Male	21.9	(19.9-24.1)	30.5	(26.2-35.1)	16.8	(14.7-19.3)
Female	16.0	(14.1-18.0)	29.4	(24.0-35.4)	13.3	(11.3-15.6)
Age						
15-24	31.6	(26.7-37.0)	41.3	(31.3-52.1)	28.8	(23.3-35.0)
25-44	20.5	(18.0-23.3)	30.7	(25.7-36.2)	14.7	(12.0-18.0)
45-64	15.6	(13.7-17.7)	25.2	(21.1-29.9)	11.8	(9.7-14.3)
65+	9.2	(7.5-11.2)	23.8	(14.8-36.0)	8.0	(6.3-10.0)
Residence						
Urban	18.1	(16.1-20.2)	29.1	(24.9-33.7)	13.7	(11.6-16.0)
Rural	19.8	(17.8-22.0)	31.5	(25.9-37.7)	16.1	(14.0-18.3)
Education level [3]						
Primary or less	15.5	(13.4-17.8)	28.9	(23.3-35.2)	10.7	(9.0-12.7)
Secondary	18.9	(16.6-21.3)	28.5	(24.0-33.5)	14.7	(12.5-17.3)
High	18.2	(14.5-22.6)	30.5	(22.0-40.6)	13.5	(10.0-18.0)

[1] Includes daily and occasional (less than daily) smokers
[2] Includes former and never smokers.
[3] Education level is reported only forpersons aged ≥22 years.

Table 9.4 Percentage of persons aged ≥15 years who were in favor of or against a complete ban on smoking in various situations, by smoking status – GATS Romania, 2011.

Characteristic	Opinion of a complete ban on smoking:									
	In all restaurants		In all bars, nightclubs, and music clubs		While driving a car		In presence of children		In presence of pregnant women	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall										
Favor	72.0	(70.3, 73.5)	57.0	(55.0, 58.9)	81.5	(80.0, 82.9)	96.3	(95.4, 97.1)	96.3	(95.5, 97.0)
Against	26.1	(24.6, 27.7)	39.9	(38.0, 41.8)	16.8	(15.5, 18.3)	3.2	(2.5, 4.0)	2.9	(2.3, 3.7)
Don't know/ refuses	1.9	(1.5, 2.4)	3.1	(2.6, 3.9)	1.7	(1.3, 2.1)	0.5	(0.3, 0.8)	0.8	(0.5, 1.2)
Current smokers [1]										
Favor	44.6	(40.8, 48.5)	31.5	(27.7, 35.7)	59.0	(55.5, 62.4)	93.2	(90.8, 95.1)	92.2	(89.9, 94.0)
Against	54.0	(50.2, 57.8)	66.9	(62.9, 70.7)	38.6	(35.0, 42.4)	5.9	(4.1, 8.3)	6.3	(4.7, 8.5)
Don't know/ refuses	1.4	(0.8, 2.3)	1.6	(0.8, 3.1)	2.3	(1.4, 3.8)	0.9	(0.4, 1.8)	1.5	(0.8, 2.6)
Nonsmokers [2]										
Favor	81.9	(80.3, 83.5)	66.2	(64.2, 68.2)	89.7	(88.4, 90.8)	97.5	(96.7, 98.1)	97.8	(97.1, 98.3)
Against	16.0	(14.5, 17.6)	30.1	(28.1, 32.1)	8.9	(7.8, 10.1)	2.2	(1.7, 3.0)	1.7	(1.2, 2.3)
Don't know/ refuses	2.1	(1.6, 2.7)	3.7	(3.0, 4.7)	1.4	(1.1, 1.8)	0.3	(0.1, 0.7)	0.6	(0.3, 1.0)

[1] Includes daily and occasional (less than daily) smokers.
[2] Includes former and never smokers.

Table 9.5 Percentage of persons aged ≥15 years who were in favor of a complete ban on smoking in various situations, by smoking status and selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Favor a complete ban on smoking:									
	In all restaurants		In all bars, nightclubs, and music clubs		While driving a car		In presence of children		In presence of pregnant women	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Overall	72.0	(70.3-73.5)	57.0	(55.0-58.9)	81.5	(80.0-82.9)	96.3	(95.4-97.1)	96.3	(95.5-97.0)
Gender										
Male	66.2	(63.8-68.6)	51.2	(48.5-53.9)	75.8	(73.5-78.0)	95.5	(94.1-96.5)	95.3	(94.0-96.4)
Female	77.3	(75.4-79.1)	62.3	(59.9-64.8)	86.7	(85.1-88.2)	97.1	(96.0-97.9)	97.2	(96.2-98.0)
Age (years)										
15-24	67.8	(62.6-72.6)	48.3	(41.7-54.9)	76.9	(72.1-81.1)	93.5	(90.4-95.7)	95.2	(92.0-97.2)
25-44	67.6	(64.9-70.3)	50.1	(47.2-53.0)	77.0	(74.6-79.2)	96.6	(95.0-97.7)	96.1	(94.4-97.4)
45-64	71.6	(68.9-74.2)	59.3	(56.4-62.2)	83.7	(81.5-85.6)	96.9	(95.8-97.7)	96.6	(95.5-97.4)
65+	85.5	(82.9-87.7)	75.6	(72.5-78.5)	91.7	(89.5-93.5)	97.3	(95.9-98.3)	97.1	(96.0-98.0)
Residence										
Urban	68.9	(66.9-70.8)	52.8	(50.5-55.2)	80.4	(78.5-82.2)	96.6	(95.3-97.6)	96.5	(95.3-97.3)
Rural	75.8	(73.0-78.4)	62.1	(58.8-65.4)	82.8	(80.3-85.1)	96.0	(94.7-97.0)	96.1	(94.7-97.1)
Education level [1]										
Primary or less	76.7	(74.2-78.9)	65.0	(62.3-67.6)	84.0	(81.8-85.9)	96.5	(95.3-97.4)	96.6	(95.6-97.4)
Secondary	69.3	(66.5-72.0)	54.2	(51.2-57.3)	81.3	(78.8-83.5)	97.1	(95.9-98.0)	96.6	(95.2-97.7)
High	67.7	(63.6-71.6)	47.8	(43.2-52.3)	77.7	(74.4-80.6)	96.6	(93.2-98.3)	96.4	(93.2-98.2)
Current smokers [2]	44.6	(40.8-48.5)	31.5	(27.7-35.7)	59.0	(55.5-62.4)	93.2	(90.8-95.1)	92.2	(89.9-94.0)
Gender										
Male	43.4	(39.0-47.9)	29.3	(25.1-33.9)	55.0	(50.9-59.0)	92.7	(89.8-94.8)	92.5	(89.7-94.5)
Female	47.1	(40.8-53.4)	36.2	(30.3-42.4)	67.3	(61.3-72.8)	94.4	(90.3-96.8)	91.7	(87.1-94.7)
Age (years)										
15-24	47.2	(36.7-58.0)	31.4	(21.4-43.4)	51.6	(42.0-61.0)	86.0	(75.9-92.3)	90.0	(80.3-95.2)
25-44	41.9	(36.6-47.5)	28.6	(23.7-34.1)	57.1	(52.2-61.8)	93.7	(89.7-96.1)	91.5	(87.4-94.4)
45-64	46.2	(40.3-52.3)	35.2	(29.5-41.3)	63.1	(57.2-68.7)	95.3	(92.3-97.1)	94.2	(90.9-96.3)
65+	55.2	(42.6-67.2)	39.7	(28.2-52.4)	73.5	(60.5-83.4)	95.9	(87.8-98.7)	93.2	(85.4-97.0)
Residence										
Urban	43.3	(38.4-48.3)	28.8	(24.6-33.3)	58.1	(54.0-62.1)	93.9	(90.4-96.2)	92.9	(89.8-95.1)
Rural	46.5	(40.5-52.6)	35.6	(28.6-43.3)	60.3	(53.9-66.4)	92.3	(88.3-95.0)	91.2	(87.5-93.9)
Education level [1]										
Primary or less	48.5	(42.0-55.1)	35.9	(29.6-42.8)	61.1	(55.0-66.8)	93.2	(89.5-95.7)	92.4	(89.1-94.8)
Secondary	44.5	(39.4-49.8)	31.5	(25.9-37.7)	61.1	(55.4-66.6)	95.5	(92.9-97.2)	93.5	(90.1-95.8)
High	35.7	(27.3-45.1)	26.2	(19.7-33.8)	54.3	(46.3-62.0)	93.1	(81.7-97.6)	92.0	(81.3-96.8)
Nonsmokers [3]	81.9	(80.3-83.5)	66.2	(64.2-68.2)	89.7	(88.4-90.8)	97.5	(96.7-98.1)	97.8	(97.1-98.3)
Gender										
Male	79.9	(77.2-82.3)	64.3	(61.2-67.2)	88.2	(86.1-90.1)	97.2	(95.9-98.0)	97.0	(95.9-97.9)
Female	83.4	(81.5-85.1)	67.6	(65.0-70.0)	90.6	(89.2-91.9)	97.7	(96.6-98.4)	98.3	(97.5-98.8)
Age (years)										
15-24	73.9	(68.4-78.8)	53.2	(46.1-60.3)	84.3	(79.5-88.1)	95.7	(92.7-97.4)	96.7	(94.4-98.1)
25-44	82.3	(79.0-85.1)	62.3	(58.9-65.5)	88.2	(85.7-90.4)	98.3	(96.7-99.2)	98.7	(97.1-99.4)
45-64	81.5	(78.5-84.2)	68.7	(65.7-71.5)	91.6	(89.7-93.3)	97.5	(96.4-98.2)	97.5	(96.6-98.2)
65+	88.0	(85.8-89.8)	78.6	(75.5-81.4)	93.2	(91.2-94.8)	97.4	(96.0-98.4)	97.5	(96.2-98.3)
Residence										
Urban	79.1	(77.0-81.1)	62.4	(59.9-64.9)	89.3	(87.6-90.7)	97.7	(96.5-98.5)	97.9	(96.9-98.6)
Rural	85.3	(82.7-87.5)	70.7	(67.4-73.9)	90.1	(88.0-91.9)	97.2	(95.9-98.0)	97.6	(96.6-98.4)
Education level [1]										
Primary or less	86.7	(84.3-88.8)	75.4	(72.7-77.9)	92.1	(90.3-93.7)	97.7	(96.7-98.4)	98.1	(97.3-98.6)
Secondary	80.0	(77.2-82.5)	64.0	(60.5-67.4)	89.9	(87.8-91.6)	97.8	(96.6-98.6)	98.0	(96.7-98.8)
High	79.9	(76.0-83.2)	55.8	(49.9-61.6)	86.5	(82.5-89.7)	97.9	(94.5-99.2)	98.1	(95.1-99.3)

[1] Education level is reported only for persons aged ≥22 years.
[2] Includes daily and occasional (less than daily) smokers.
[3] Includes former and never smokers.

Table 9.6 Percentage of persons aged ≥15 years who supported increasing taxes on tobacco products, by smoking status, selected demographic characteristics – GATS Romania, 2011.

Demographic characteristic	Adults who supported increasing taxes on tobacco products					
	Overall		Current smokers [1]		Nonsmokers [2]	
	Percentage	(95% CI)	Percentage	(95% CI)	Percentage	(95% CI)
Overall	61.7	(59.7-63.7)	21.5	(18.3-25.0)	76.4	(74.6-78.1)
Gender						
Male	55.8	(52.6-58.9)	21.4	(17.3-26.1)	76.4	(73.6-79.1)
Female	67.2	(64.8-69.4)	21.7	(17.2-27.0)	76.3	(74.0-78.5)
Age						
15-24	63.7	(58.5-68.6)	26.0	(17.1-37.5)	74.8	(69.4-79.5)
25-44	57.3	(54.2-60.4)	24.4	(19.9-29.5)	76.2	(73.0-79.1)
45-64	58.0	(55.2-60.8)	14.3	(10.8-18.7)	74.9	(72.0-77.7)
65+	75.4	(72.2-78.3)	23.3	(14.2-35.8)	79.7	(76.4-82.6)
Residence						
Urban	59.1	(56.4-61.8)	21.3	(17.5-25.6)	74.3	(71.9-76.6)
Rural	64.9	(61.9-67.8)	21.8	(16.7-27.9)	78.9	(76.2-81.3)
Education level [3]						
Primary or less	62.5	(59.6-65.3)	19.5	(14.9-25.1)	77.8	(75.6-79.9)
Secondary	61.5	(58.5-64.4)	25.1	(20.8-29.9)	77.3	(74.3-80.0)
High	57.0	(52.1-61.7)	17.9	(11.8-26.1)	71.9	(65.2-77.8)

[1] Includes daily and occasional (less than daily) smokers
[2] Includes former and never smokers.
[3] Education level is reported only for persons aged ≥22 years.

Appendix A: Questionnaire

Global Adult Tobacco Survey (GATS) Romania Questionnaire

Contents

GATS Core Questionnaire Formatting Conventions

Text in RED FONT =

Programming logic and skip instructions.

Text in [BRACKETS] =

Specific question instructions for interviewers—not to be read to the respondents.

Text surrounded by *asterisks* =

Words that interviewers should emphasize when reading to respondents.

Household Questionnaire

INTRO. [THE HOUSEHOLD SCREENING RESPONDENT SHOULD 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. IF NEEDED, VERIFY THE AGE OF THE HOUSEHOLD SCREENING RESPONDENT TO MAKE SURE HE/SHE IS 18 YEARS OF AGE OR OLDER.
THE HOUSEHOLD SCREENING RESPONDENT CAN BE LESS THAN 18 YEARS OLD ONLY IF NO HOUSEHOLD MEMBERS ARE 18 YEARS OF AGE OR OLDER.]

Good morning (day, evening)

IF THE RESPONDENT ANSWERS … … IN ROMANIAN, THEN ASK:	… IN HUNGARIAN, THEN ASK:
A. Please tell me, is it easier for you to speak Romanian or maybe it is easier for you to speak Hungarian?	**A. Please tell me, is it easier for you to speak Romanian or maybe it is easier for you to speak Hungarian?**

ROMANIAN…1 → TAKE THE ROMANIAN QUESTIONNAIRE, MARK THE ANSWER AND CONDUCT THE INTERVIEW IN ROMANIAN
HUNGARIAN…2 → TAKE THE ROMANIAN QUESTIONNAIRE, MARK THE ANSWER AND CONDUCT THE INTERVIEW IN HUNGARIAN

INTRO1. Hello. My name is {first and last name} and I work on behalf of National Institute of Public Health. An important survey of adult tobacco use behavior is being conducted by the National Institute of Public Health throughout Romania and your household has been selected to participate. 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 and the data will be used by the Ministry of Health to develop activities for improvement of the public health. I have a few questions to find out who in your household is eligible to participate.

HH1. First, I'd like to ask you a few questions about your household. In total, how many persons live in this household?

[INCLUDE ANYONE WHO CONSIDERS THIS HOUSEHOLD HIS/HER USUAL PLACE OF RESIDENCE]

☐☐ PERSONS

HH2. How many of these household members are 15 years of age or older?

☐☐ PERSONS

[IF HH2 = 00 (NO HOUSEHOLD MEMBERS ≥ 15 IN HOUSEHOLD)]

[THERE ARE NO ELIGIBLE HOUSEHOLD MEMBERS.

THANK THE RESPONDENT FOR HIS/HER TIME.

THIS WILL BE RECORDED IN THE RECORD OF CALLS AS A CODE 201.]

HH4. I now would like to collect information only about the persons that live in this household who are 15 years of age or older. Let's start listing them from oldest to youngest.

HH4a. What is the {oldest/next oldest} person's first name? _____

HH4b. What is this person's age?

[IF RESPONDENT DOESN'T KNOW, PROBE FOR AN ESTIMATE]

[IF REPORTED AGE IS 15 THROUGH 17, BIRTH DATE IS ASKED]

HH4c. What is the month of this person's date of birth?

HH4cYEAR. What is the year of this person's date of birth?

[IF DON'T KNOW, ENTER 7777
IF REFUSED, ENTER 9999]

HH4d. Is this person male or female?

MALE ..... ☐ 1
FEMALE ..... ☐ 2

HH4e. Does this person currently smoke tobacco, including cigarettes, cigars, pipes?

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW ..... ☐ 7
REFUSED ..... ☐ 9

[REPEAT HH4a – HH4e FOR EACH PERSON REPORTED IN HH2]

HH5. [NAME OF THE SELECTED ELIGIBLE PERSON IS:

{FILL SELECTED HH MEMBER'S FIRST NAME}

ASK IF THE SELECTED RESPONDENT IS AVAILABLE AND IF SO, PROCEED TO THE INDIVIDUAL QUESTIONNAIRE.

IF THE SELECTED RESPONDENT IS NOT AVAILABLE, MAKE AN APPOINTMENT AND RECORD IT AS A COMMENT ON RECORD OF CALLS.]

Individual Questionnaire

CONSENT1. [SELECT THE APPROPRIATE AGE CATEGORY BELOW. IF NEEDED, CHECK THE AGE OF SELECTED RESPONDENT FROM THE "CASE INFO" SCREEN IN THE TOOLS MENU.]

15-17 ..... ☐ 1 → **GO TO CONSENT2**
18 OR OLDER..... ☐ 2 → **GO TO CONSENT5**
EMANCIPATED MINOR (15-17).... ☐ 3 → **GO TO CONSENT5**

CONSENT2. Before starting the interview, I need to obtain consent from a parent or guardian of [NAME OF RESPONDENT] and from [NAME OF RESPONDENT].

[IF BOTH SELECTED RESPONDENT AND PARENT/GUARDIAN ARE AVAILABLE, CONTINUE WITH INTERVIEW.

IF PARENT/GUARDIAN IS NOT AVAILABLE, BREAK-OFF INTERVIEW AND SCHEDULE AN APPOINTMENT TO RETURN.

IF MINOR RESPONDENT IS NOT AVAILABLE, CONTINUE WITH OBTAINING PARENTAL CONSENT.]

CONSENT3. [READ THE FOLLOWING TO THE PARENT/GUARDIAN AND SELECTED RESPONDENT (IF AVAILABLE):]

I am working on behalf of the National Institute of Public Health. At World Health Organization's request, this institution, along with the National Institute of Statistics and TOTEM Communication Agency is gathering information about tobacco use in Romania. This information will be used for public health purposes by the Ministry of Health.

Your household and [NAME OF RESPONDENT] have been randomly selected. [NAME OF RESPONDENT] responses are very important to us and the community, as these answers will represent many other persons.

The interview will last around 30 minutes. [NAME OF RESPONDENT] participation in this survey is entirely voluntary. The information that [NAME OF RESPONDENT] will provide will be kept strictly confidential and [NAME OF RESPONDENT] will not be identified by his/her responses. Personal information will not be shared with anyone else, not even other family members including you. [NAME OF RESPONDENT] can withdraw from the study at any time, and may refuse to answer any question. We will leave the necessary contact information with you. If you have any questions about this survey, you can contact the telephone numbers listed.

If you agree with [NAME OF RESPONDENT]'s participation in this survey, we will conduct a private interview with him/her.

[ASK PARENT/GUARDIAN:] Do you agree with [NAME OF RESPONDENT]'s participation?

YES..... ☐ 1 → **GO TO CONSENT4**
NO ..... ☐ 2 → **END INTERVIEW**

CONSENT4. [WAS THE SELECTED MINOR RESPONDENT PRESENT?]

PRESENT..... ☐ 1 → **GO TO CONSENT6**
NOT PRESENT ..... ☐ 2 → **GO TO CONSENT5**

CONSENT5. [READ TO THE SELECTED RESPONDENT:]

I am working on behalf of the National Institute of Public Health. This institution is collecting information about tobacco use in Romania. This information will be used for public health purposes by the Ministry of Health.

Your household and you have been selected at random. Your responses are very important to us and the community, as these answers will represent many other persons. The interview will last around 30 minutes. Your participation in this survey is entirely voluntary. The information that you will provide us will be kept strictly confidential, and you will not be identified by your responses. Personal information will not be shared with anyone else, not even other family members. You can withdraw from the study at any time, and may refuse to answer any question. We will leave the necessary contact information with you. If you have any questions about this survey, you can contact the telephone numbers listed.

{FILL IF CONSENT4=2: Your parent/guardian has given his/her permission for you to participate in this study**}**

If you agree to participate, we will conduct a private interview with you.

CONSENT6. [ASK SELECTED RESPONDENT:] Do you agree to participate?

YES..... ☐ 1 → **PROCEED WITH INTERVIEW**
NO ..... ☐ 2 → **END INTERVIEW**

INTLANG. [INTERVIEW LANGUAGE]

[ROMANIAN]..... ☐ 1
[HUNGARIAN]..... ☐ 2

Section A. Background Characteristics

A00. I am going to first ask you a few questions about your background.

A01. [RECORD GENDER FROM OBSERVATION. ASK IF NECESSARY.]

MALE..... ☐ 1
FEMALE..... ☐ 2

A02a. What is the month of your date of birth?

01..... ☐ 1
02..... ☐ 2
03..... ☐ 3
04..... ☐ 4
05..... ☐ 5
06..... ☐ 6
07..... ☐ 7
08..... ☐ 8
09..... ☐ 9
10..... ☐ 10
11..... ☐ 11
12..... ☐ 12
DON'T KNOW. ☐ 77
REFUSED..... ☐ 99

A02b. What is the year of your date of birth?

[IF DON'T KNOW, ENTER 7777
IF REFUSED, ENTER 9999]

[IF MONTH=77/99 OR YEAR=7777/9999, ASK A03. OTHERWISE SKIP TO A04.]

A03. How old are you?

[IF RESPONDENT IS UNSURE, PROBE FOR AN ESTIMATE AND RECORD AN ANSWER. IF REFUSED, BREAK-OFF AS WE CANNOT CONTINUE INTERVIEW WITHOUT AGE]

A03a. [WAS RESPONSE ESTIMATED?]

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7

A04. What is the last grade you have completed?

[SELECT ONLY ONE CATEGORY]

NO FORMAL EDUCATION..... ☐ 1
PRIMARY SCHOOL COMPLETED (4 GRADES)..... ☐ 2
SECONDARY SCHOOL COMPLETED (GRADES 5-8)..... ☐ 3
VOCATIONAL, APPRENTICE SCHOOL..... ☐ 4
GRADES 9-10 OF HIGH SCHOOL COMPLETED..... ☐ 5
HIGH SCHOOL COMPLETED..... ☐ 6
POST HIGH SCHOOL COMPLETED..... ☐ 7
COLLEGE COMPLETED (SHORT-TERM UNIVERSITY)..... ☐ 8
UNIVERSITY..... ☐ 9
POST GRADUATE DEGREE COMPLETED..... ☐ 10
DON'T KNOW..... ☐ 77
REFUSED..... ☐ 99

A05. Which of the following best describes your *main* work status over the past 12 months? Government employee, non-government employee, self-employed, student, homemaker, retired, unemployed-able to work, or unemployed-unable to work?

[INCLUDE SUBSISTENCE FARMING AS SELF-EMPLOYED]

GOVERNMENT EMPLOYEE ..... ☐ 1
NONGOVERNMENT EMPLOYEE .... ☐ 2
SELF-EMPLOYED ..... ☐ 3
STUDENT..... ☐ 4
HOMEMAKER ..... ☐ 5
RETIRED ..... ☐ 6
UNEMPLOYED, ABLE TO WORK.... ☐ 7
UNEMPLOYED, UNABLE TO WORK. ☐ 8
DON'T KNOW ..... ☐ 77
REFUSED..... ☐ 99

A06. The following questions are about different things that you may have in your household. Such questions are asked to all participants in this survey in all countries. You may skip any of these questions if you like. Please tell me whether this household or any person who lives in the household has the following items:

	YES ▼	NO ▼	DON'T KNOW ▼	REFUSED ▼
a. Functioning electricity?	☐ 1	☐ 2	☐ 7	☐ 9
b. Flush toilet?	☐ 1	☐ 2	☐ 7	☐ 9
c. Fixed telephone?	☐ 1	☐ 2	☐ 7	☐ 9
d. Cell telephone?	☐ 1	☐ 2	☐ 7	☐ 9
e. Television?	☐ 1	☐ 2	☐ 7	☐ 9
f. Radio?	☐ 1	☐ 2	☐ 7	☐ 9
g. Refrigerator?	☐ 1	☐ 2	☐ 7	☐ 9
h. Car?	☐ 1	☐ 2	☐ 7	☐ 9
i. Washing machine?	☐ 1	☐ 2	☐ 7	☐ 9
j. Computer	☐ 1	☐ 2	☐ 7	☐ 9
k. Internet access	☐ 1	☐ 2	☐ 7	☐ 9

AA07. Please tell me whether you or any person who lives in the household owns this house?

YES ..... ☐ 1
NO ..... ☐ 2
REFUSED ..... ☐ 9

AA08. How many rooms are there in your household (except for the kitchen and bathrooms)?

[IF DON'T KNOW, ENTER 77
IF REFUSED, ENTER 99]

☐☐ ROOMS

Section B. Tobacco Smoking

B01. Do you *currently* smoke tobacco on a daily basis, less than daily, or not at all?

DAILY ..... ☐ 1 → **SKIP TO B04**
LESS THAN DAILY ... ☐ 2
NOT AT ALL ..... ☐ 3 → **SKIP TO B03**
DON'T KNOW ..... ☐ 7 → **SKIP TO NEXT SECTION**
REFUSED..... ☐ 9 → **SKIP TO NEXT SECTION**

B02. Have you smoked tobacco daily in the past?

YES ..... ☐ 1 → **SKIP TO B08**
NO ..... ☐ 2 → **SKIP TO B10**
DON'T KNOW ..... ☐ 7 → **SKIP TO B10**
REFUSED..... ☐ 9 → **SKIP TO B10**

B03. In the *past*, have you smoked tobacco on a daily basis, less than daily, or not at all?

[IF RESPONDENT HAS DONE BOTH "DAILY" AND "LESS THAN DAILY" IN THE PAST, CHECK "DAILY"]

DAILY ..... ☐ 1 → **SKIP TO B11**
LESS THAN DAILY ... ☐ 2 → **SKIP TO B13**
NOT AT ALL ..... ☐ 3 → **SKIP TO NEXT SECTION**
DON'T KNOW ..... ☐ 7 → **SKIP TO NEXT SECTION**
REFUSED..... ☐ 9 → **SKIP TO NEXT SECTION**

[CURRENT DAILY SMOKERS]

B04. How old were you when you first started smoking tobacco *daily*?

[IF DON'T KNOW OR REFUSED, ENTER 99]

[IF B04 = 99, ASK B05. OTHERWISE SKIP TO B06.]

B05. How many years ago did you first start smoking tobacco *daily*?
[IF REFUSED, ENTER 99]

B06. 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.

[IF RESPONDENT REPORTS SMOKING THE PRODUCT BUT NOT EVERY DAY, ENTER 888
IF RESPONDENT REPORTS IN PACKS OR CARTONS, PROBE TO FIND OUT HOW MANY ARE IN EACH AND CALCULATE TOTAL NUMBER]

a.	Manufactured cigarettes?				*PER DAY*
a1.	**[IF B06a=888]** On average, how many manufactured cigarettes do you currently smoke each week?				*PER WEEK*
b.	Hand-rolled cigarettes?				*PER DAY*
b1.	**[IF B06b=888]** On average, how many hand-rolled cigarettes do you currently smoke each week?				*PER WEEK*
d.	Pipes full of tobacco?				*PER DAY*
d1.	**[IF B06d=888]** On average, how many pipes full of tobacco do you currently smoke each week?				*PER WEEK*
e.	Cigars or cigarillos?				*PER DAY*
e1.	**[IF B06e=888]** On average, how many cigars, cheroots, or cigarillos do you currently smoke each week?				*PER WEEK*
f.	Number of water pipe sessions per day?				*PER DAY*
f1.	**[IF B06f=888]** On average, how many water pipe sessions do you currently participate in each week?				*PER WEEK*
g.	Any others? (→ g1. Please specify the other type you currently smoke each day:_____)				*PER DAY*
g2.	**[IF B06g=888]** On average, how many [FILL IN PRODUCT] do you currently smoke each week?				*PER WEEK*

B07. How soon after you wake up do you usually have your first smoke? Would you say within 5 minutes, 6 to 30 minutes, 31 to 60 minutes, or more than 60 minutes?

WITHIN 5 MINUTES..... ☐ 1
6 TO 30 MINUTES..... ☐ 2
31 TO 60 MINUTES..... ☐ 3
MORE THAN 60 MINUTES.. ☐ 4
REFUSED..... ☐ 9

[SKIP TO NEXT SECTION]

[CURRENT LESS THAN DAILY SMOKERS]

B08. How old were you when you first started smoking tobacco *daily*?

[IF DON'T KNOW OR REFUSED, ENTER 99]

[IF B08 = 99, ASK B09. OTHERWISE SKIP TO B10.]

B09. How many years ago did you first start smoking tobacco *daily*?

[IF REFUSED, ENTER 99]

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

[IF RESPONDENT REPORTS DOING THE ACTIVITY *WITHIN THE PAST 30 DAYS*, BUT LESS THAN ONCE PER WEEK, ENTER 888

IF RESPONDENT REPORTS IN PACKS OR CARTONS, PROBE TO FIND OUT HOW MANY ARE IN EACH AND CALCULATE TOTAL NUMBER]

a. Manufactured cigarettes?.....				*PER WEEK*
b. Hand-rolled cigarettes?.....				*PER WEEK*
d. Pipes full of tobacco?.....				*PER WEEK*
e. Cigars or cigarillos?.....				*PER WEEK*
f. Number of water pipe sessions per week?				*PER WEEK*
g. Any others?				*PER WEEK*

g1. Please specify the other type you currently smoke during a usual week:

[SKIP TO NEXT SECTION]

[FORMER SMOKERS]

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

[IF DON'T KNOW OR REFUSED, ENTER 99]

[IF B11 = 99, ASK B12. OTHERWISE SKIP TO B13a.]

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

[IF REFUSED, ENTER 99]

B13a. How long has it been since you stopped smoking?

[ONLY INTERESTED IN WHEN RESPONDENT STOPPED SMOKING REGULARLY — DO NOT INCLUDE RARE INSTANCES OF SMOKING)

ENTER UNIT ON THIS SCREEN AND NUMBER ON NEXT SCREEN]

YEARS ..... ☐ 1
MONTHS..... ☐ 2
WEEKS..... ☐ 3
DAYS..... ☐ 4
LESS THAN 1 DAY ... ☐ 5 → **SKIP TO B14**
DON'T KNOW ..... ☐ 7 → **SKIP TO NEXT SECTION**
REFUSED..... ☐ 9 → **SKIP TO NEXT SECTION**

B13b. [ENTER NUMBER OF (YEARS/MONTHS/WEEKS/DAYS)]

[IF B13a/b < 1 YEAR (< 12 MONTHS), THEN CONTINUE WITH B14. OTHERWISE SKIP TO NEXT SECTION.]

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

YES ..... ☐ 1
NO ..... ☐ 2 → **SKIP TO B18**
REFUSED..... ☐ 9 → **SKIP TO B18**

B15. 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
REFUSED..... ☐ 9

B16. 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 → **SKIP TO B18**
REFUSED..... ☐ 9 → **SKIP 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?

YES ..... ☐ 1
NO ..... ☐ 2
REFUSED..... ☐ 9

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

	YES ▼	NO ▼	REFUSED ▼
a. Counseling, including at a smoking cessation clinic?	☐ 1	☐ 2	☐ 9
b. Nicotine replacement therapy, such as the patch or gum?	☐ 1	☐ 2	☐ 9
c. Other prescription medications, for example Zyban, Champix?	☐ 1	☐ 2	☐ 9
d. Natural plant products?	☐ 1	☐ 2	☐ 9
e. A quit line or a smoking telephone support line?	☐ 1	☐ 2	☐ 9
f. Acupuncture?	☐ 1	☐ 2	☐ 9
g. Quit without assistance?	☐ 1	☐ 2	☐ 9
h. Anything else?	☐ 1	☐ 2	☐ 9

→ h1. Please specify what you used to try to stop smoking:

_____

Section C. Smokeless Tobacco

C00. The next questions are about using smokeless tobacco, such as snuffing or chewing tobacco. Smokeless tobacco is tobacco that is not smoked, but is snuffed through the nose, held in the mouth, or chewed.

C01. Do you *currently* use smokeless tobacco on a daily basis, less than daily, or not at all?
[IF RESPONDENT DOES NOT KNOW WHAT SMOKELESS TOBACCO IS, EITHER PRESENT A SHOWCARD OR READ DEFINITION FROM QXQ SCREEN]

DAILY ..... ☐ 1 → **SKIP TO NEXT SECTION**
LESS THAN DAILY ... ☐ 2
NOT AT ALL ..... ☐ 3 → **SKIP TO C03**
DON'T KNOW ..... ☐ 7 → **SKIP TO NEXT SECTION**
REFUSED ..... ☐ 9 → **SKIP TO NEXT SECTION**

C02. Have you used smokeless tobacco daily in the past?

YES ..... ☐ 1 → **SKIP TO C19**
NO ..... ☐ 2 → **SKIP TO C19**
DON'T KNOW ..... ☐ 7 → **SKIP TO C19**
REFUSED ..... ☐ 9 → **SKIP TO C19**

C03. In the *past*, have you used smokeless tobacco on a daily basis, less than daily, or not at all?

[IF RESPONDENT HAS DONE BOTH "DAILY" AND "LESS THAN DAILY" IN THE PAST, CHECK "DAILY"]

DAILY ..... ☐ 1 → **SKIP TO NEXT SECTION**
LESS THAN DAILY ... ☐ 2 → **SKIP TO NEXT SECTION**
NOT AT ALL ..... ☐ 3 → **SKIP TO NEXT SECTION**
DON'T KNOW ..... ☐ 7 → **SKIP TO NEXT SECTION**
REFUSED ..... ☐ 9 → **SKIP TO NEXT SECTION**

C19. **[ADMINISTER IF B01=2 AND C01=2. ELSE GO TO NEXT SECTION.]**
You mentioned that you smoke tobacco, but not every day and that you also use smokeless tobacco, but not every day. Thinking about both smoking tobacco and using smokeless tobacco, would you say you use tobacco on a daily basis or less than daily?

DAILY ..... ☐ 1
LESS THAN DAILY ... ☐ 2
REFUSED ..... ☐ 9

Section D1. Cessation – Tobacco Smoking

IF B01 = 1 OR 2 (RESPONDENT CURRENTLY SMOKES TOBACCO), CONTINUE WITH THIS SECTION.
IF B01 = 3, 7, OR 9 (RESPONDENT DOES NOT CURRENTLY SMOKE TOBACCO), SKIP TO NEXT SECTION.

D01. During the past 12 months, have you tried to stop smoking?

YES 1
NO ..... 2 → **SKIP TO D04**
REFUSED..... 9 → **SKIP TO D04**

D02a. Thinking about the last time you tried to quit, how long did you stop smoking?

[ENTER UNIT ON THIS SCREEN AND NUMBER ON NEXT SCREEN]

MONTHS..... 1
WEEKS..... 2
DAYS..... 3
LESS THAN 1 DAY (24 HOURS) 4 → **SKIP TO D03**
DON'T KNOW ..... 7 → **SKIP TO D03**
REFUSED..... 9 → **SKIP TO D03**

D02b. [ENTER NUMBER OF (MONTHS/WEEKS/DAYS)]

D03. During the past 12 months, did you use any of the following to try to stop smoking tobacco?

	YES ▼	NO ▼	REFUSED ▼
a. Counseling, including at a smoking cessation clinic?	☐ 1	☐ 2	☐ 9
b. Nicotine replacement therapy, such as the patch or gum?	☐ 1	☐ 2	☐ 9
c. Other prescription medications, for example Zyban, Champix?	☐ 1	☐ 2	☐ 9
d. Natural plant products?	☐ 1	☐ 2	☐ 9
e. A quit line or a smoking telephone support line?	☐ 1	☐ 2	☐ 9
f. Acupuncture?	☐ 1	☐ 2	☐ 9
g. Quit without assistance?	☐ 1	☐ 2	☐ 9
h. Anything else?	☐ 1	☐ 2	☐ 9

→ h1. Please specify what you used to try to stop smoking:

_____

D04. Have you visited a doctor or other health care provider in the past 12 months?

YES ..... ☐ 1
NO ..... ☐ 2 → **SKIP TO D08**
REFUSED..... ☐ 9 → **SKIP TO D08**

D05. 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
REFUSED..... ☐ 9

D06. 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 → **SKIP TO D08**
REFUSED..... ☐ 9 → **SKIP TO D08**

D07. 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
REFUSED..... ☐ 9

D08. 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 someday but not within the next 12 months, or I am not interested in quitting?

QUIT WITHIN THE NEXT MONTH..... ☐ 1 **SKIP TO E01**
THINKING WITHIN THE NEXT 12 MONTHS .... ☐ 2 **SKIP TO E01**
QUIT SOMEDAY, BUT NOT NEXT 12 MONTHS . ☐ 3 **SKIP TO E01**
NOT INTERESTED IN QUITTING ..... ☐ 4
DON'T KNOW ..... ☐ 7 **SKIP TO E01**
REFUSED..... ☐ 9 **SKIP TO E01**

DD09. Which of the following are major reasons for why you are not interested in quitting smoking?

	YES ▼	NO ▼	REFUSED ▼
a. You are addicted to smoking and don't think you can quit?	☐ 1	☐ 2	☐ 9
b. You don't think smoking is bad for your health?	☐ 1	☐ 2	☐ 9
c. Smoking helps to reduce your stress?	☐ 1	☐ 2	☐ 9
d. Smoking keeps you alert?	☐ 1	☐ 2	☐ 9
e. You like to smoke?	☐ 1	☐ 2	☐ 9
f. You are afraid of gaining weight if you quit?	☐ 1	☐ 2	☐ 9
g. Are there any other major reasons for why you are not interested in quitting?	☐ 1	☐ 2	☐ 9

g1) Please specify_____

Section E. Secondhand Smoke

E01. 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 → **SKIP TO E04**
NO RULES ..... ☐ 4 → **SKIP TO E03**
DON'T KNOW ..... ☐ 7 → **SKIP TO E03**
REFUSED..... ☐ 9 → **SKIP TO E03**

E02. Inside your home, is smoking allowed in every room?

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

E03. How often does *anyone* smoke inside your home? Would you say daily, weekly, monthly, less than monthly, or never?

DAILY ..... ☐ 1
WEEKLY ..... ☐ 2
MONTHLY ..... ☐ 3
LESS THAN MONTHLY .. ☐ 4
NEVER ..... ☐ 5
DON'T KNOW ..... ☐ 7
REFUSED..... ☐ 9

E04. Do you currently work outside of your home?

YES ..... ☐ 1
NO/DON'T WORK..... ☐ 2 → **SKIP TO E09**
REFUSED..... ☐ 9 → **SKIP TO E09**

E05. At work, do you usually work indoors or outdoors?

INDOORS..... ☐ 1 → **SKIP TO E07**
OUTDOORS ..... ☐ 2
BOTH ..... ☐ 3 → **SKIP TO E07**
REFUSED..... ☐ 9

E06. Are there any indoor areas at your workplace?

YES ..... ☐ 1
NO ..... ☐ 2 → **SKIP TO E09**
DON'T KNOW .... ☐ 7 → **SKIP TO E09**
REFUSED..... ☐ 9 → **SKIP TO E09**

E07. Which of the following best describes the indoor smoking policy where you work: Smoking is allowed anywhere, smoking is allowed only in some indoor areas, smoking is not allowed in any indoor areas,
or there is no policy?

ALLOWED ANYWHERE..... ☐ 1
ALLOWED ONLY IN SOME INDOOR AREAS . ☐ 2
NOT ALLOWED IN ANY INDOOR AREAS.... ☐ 3
THERE IS NO POLICY..... ☐ 4
DON'T KNOW ..... ☐ 7
REFUSED..... ☐ 9

E08. During the past 30 days, did anyone smoke in indoor areas where you work?

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

E09. During the past 30 days, did you visit any government buildings or government offices?

YES ..... ☐ 1
NO ..... ☐ 2 → **SKIP TO E11**
DON'T KNOW .... ☐ 7 → **SKIP TO E11**
REFUSED..... ☐ 9 → **SKIP 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
REFUSED..... ☐ 9

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

YES ..... ☐ 1
NO ..... ☐ 2 → **SKIP TO E13**
DON'T KNOW .... ☐ 7 → **SKIP TO E13**
REFUSED..... ☐ 9 → **SKIP 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
REFUSED..... ☐ 9

E13. During the past 30 days, did you visit any restaurants?

YES ..... ☐ 1
NO ..... ☐ 2 → **SKIP TO E25**
DON'T KNOW .... ☐ 7 → **SKIP TO E25**
REFUSED..... ☐ 9 → **SKIP TO E25**

E14. Did anyone smoke inside of any restaurants that you visited in the past 30 days?

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

E25. During the past 30 days, did you visit any bars or nightclubs?

YES ..... ☐ 1
NO ..... ☐ 2 → **SKIP TO E15**
DON'T KNOW .... ☐ 7 → **SKIP TO E15**
REFUSED..... ☐ 9 → **SKIP TO E15**

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

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

E15. During the past 30 days, did you use any public transportation?

YES ..... ☐ 1
NO ..... ☐ 2 → **SKIP TO E21**
DON'T KNOW .... ☐ 7 → **SKIP TO E21**
REFUSED..... ☐ 9 → **SKIP 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
REFUSED..... ☐ 9

E21. During the past 30 days, did you visit any universities?

YES ..... ☐ 1
NO ..... ☐ 2 → **SKIP TO E19**
DON'T KNOW .... ☐ 7 → **SKIP TO E19**
REFUSED..... ☐ 9 → **SKIP TO E19**

E22. Did anyone smoke inside of any universities that you visited in the past 30 days?

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

E19. During the past 30 days, did you visit any other schools or educational facilities?

YES ..... ☐ 1
NO ..... ☐ 2 → **SKIP TO E17**
DON'T KNOW .... ☐ 7 → **SKIP TO E17**
REFUSED..... ☐ 9 → **SKIP TO E17**

E20. Did anyone smoke inside of any schools or educational facilities that you visited in the past 30 days?

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

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

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

EE23. In some European countries, there is a complete ban on smoking in restaurants. In Romania, according with the current legislation, smoking is still allowed in special designated areas in big restaurants or in all areas in some small restaurants, according to the owner's decision. Would you be in favor of implementing in Romania a complete ban on smoking in all restaurants?

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

EE24. Do you think that smoking should be completely banned in all bars, nightclubs, and music clubs?

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

EE25. Would you be in favor of a complete ban on smoking implemented…

	YES ▼	NO ▼	DON'T KNOW ▼	REFUSED ▼
a. While driving a car?	☐ 1	☐ 2	☐ 7	☐ 9
b. In presence of children?	☐ 1	☐ 2	☐ 7	☐ 9
c. In presence of pregnant women?	☐ 1	☐ 2	☐ 7	☐ 9

Section F. Economics. Manufactured Cigarettes

IF [B01 = 1 OR 2 (RESPONDENT CURRENTLY SMOKES DAILY OR LESS THAN DAILY)]
AND
[(B06a OR B10a) > 0 AND <= 888 (RESPONDENT SMOKES MANUFACTURED CIGARETTES)],
THEN CONTINUE WITH THIS SECTION.
OTHERWISE, SKIP TO NEXT SECTION

F01a. The next few questions are about the last time you purchased cigarettes for yourself to smoke.

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

[ENTER UNIT ON THIS SCREEN AND NUMBER ON NEXT SCREEN]

CIGARETTES ..... ☐ 1
PACKS ..... ☐ 2
CARTONS ..... ☐ 3
OTHER (SPECIFY) ..... ☐ 4 → F01c. [SPECIFY THE UNIT]:_____
NEVER BOUGHT CIGARETTES . ☐ 5 → **SKIP TO NEXT SECTION**
REFUSED ..... ☐ 9 → **SKIP TO F03**

F01b. [ENTER NUMBER OF (CIGARETTES/PACKS/CARTONS/OTHER)]

[IF F01a=CIGARETTES, GO TO F02]
[IF F01a=OTHER, GO TO F01dA]

F01d. Did each (pack/carton) contain (10/100) cigarettes, (20/200) cigarettes, or another amount?

10/100 ..... ☐ 1
20/200 ..... ☐ 2
OTHER AMOUNT ..... ☐ 7 →F01dA. How many cigarettes were in each (pack/carton/other)?
REFUSED ..... ☐ 9

F02. In total, how much money did you pay for this purchase?

[IF DON'T KNOW OR REFUSED, ENTER 9999]

RON [Valid range between 0.5 (price for the cheapest cigarette) and 1000 (5 cartons of the most expensive cigarettes)]

F03. What brand did you buy the last time you purchased cigarettes for yourself?

MARLBORO ..... ☐ 1
KENT ..... ☐ 2
LUCKY STRIKE ..... ☐ 3
VICEROY ..... ☐ 4
CAMEL ..... ☐ 5
VOGUE ..... ☐ 6
LM ..... ☐ 7
PARLIAMENT ..... ☐ 8
CHESTERFIELD ..... ☐ 9
ASSOS ..... ☐ 10
DUNHILL ..... ☐ 11
PALL MALL ..... ☐ 12
WINSTON ..... ☐ 13
VIRGINIA SLIM ..... ☐ 14
OTHER ..... ☐ 15 →F03A. [SPECIFY BRAND]:_____
REFUSED ..... ☐ 99

F04. The last time you purchased cigarettes for yourself, where did you buy them?

STORE ..... ☐ 1
STREET VENDOR ..... ☐ 2
DUTY-FREE SHOP ..... ☐ 3
OUTSIDE THE COUNTRY ... ☐ 4
KIOSKS ..... ☐ 5
INTERNET ..... ☐ 6
FROM ANOTHER PERSON. ☐ 7
OTHER ..... ☐ 8 →F04a. [SPECIFY LOCATION]:_____
DON'T REMEMBER ..... ☐ 77
REFUSED ..... ☐ 99

Section G. Media

Structure #1 – Asking about only one product (e.g., cigarettes)

G01intro. The next few questions ask about your exposure to the media and advertisements in the last 30 days.

G01. In the last 30 days, have you noticed *information* about the dangers of smoking cigarettes or that encourages quitting in any of the following places?

	YES ▼	NO ▼	NOT APPLICABLE ▼	REFUSED ▼
a. In newspapers or in magazines?	☐ 1	☐ 2	☐ 7	☐ 9
b. On television?	☐ 1	☐ 2	☐ 7	☐ 9
c. On the radio?	☐ 1	☐ 2	☐ 7	☐ 9
d. On billboards?	☐ 1	☐ 2	☐ 7	☐ 9
e. Somewhere else?	☐ 1	☐ 2		☐ 9

[DO NOT INCLUDE HEALTH WARNINGS ON CIGARETTE PACKAGES]
→ e1. Please specify where: _____

G02. In the last 30 days, did you notice any health warnings on cigarette packages?

YES ☐ 1
NO ☐ 2 → **SKIP TO G04**
DID NOT SEE ANY CIGARETTE PACKAGES ☐ 3 → **SKIP TO G04**
REFUSED ☐ 9 → **SKIP TO G04**

G03. **[ADMINISTER IF B01 = 1 OR 2. ELSE GO TO GG1]**

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
REFUSED ☐ 9

GG1. In the last 30 days, did you notice any *pictorial* health warnings (images, pictures) on cigarette packages?

YES ☐ 1
NO ☐ 2 → **SKIP TO G04**
REFUSED ☐ 9 → **SKIP TO G04**

GG2. **[ADMINISTER IF G03=1. ELSE GO TO G04]**

In the last 30 days, have *pictorial* health warnings (images, pictures) labels on cigarette packages led you to think about quitting?

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

G04. In the last 30 days, have you noticed any *advertisements or signs promoting* cigarettes in the following places?

	YES ▼	NO ▼	NOT APPLICABLE ▼	REFUSED ▼
a. In stores where cigarettes are sold?	☐ 1	☐ 2	☐ 7	☐ 9
h. On the Internet?	☐ 1	☐ 2	☐ 7	☐ 9
j. On public walls?	☐ 1	☐ 2	☐ 7	☐ 9
k. Anywhere else?	☐ 1			☐ 9

→k1. Please specify where: _____

G05. 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
REFUSED..... ☐ 9

G06. In the last 30 days, have you noticed any of the following types of cigarette promotions?

	YES ▼	NO ▼	DON'T KNOW ▼	REFUSED ▼
a. Free samples of cigarettes?	☐ 1	☐ 2	☐ 7	☐ 9
b. Cigarettes at sale prices?	☐ 1	☐ 2	☐ 7	☐ 9
c. Coupons for cigarettes?	☐ 1	☐ 2	☐ 7	☐ 9
d. Free gifts or special discount offers on other products when buying cigarettes?	☐ 1	☐ 2	☐ 7	☐ 9
e. Clothing or other items with a cigarette brand name or logo?	☐ 1	☐ 2	☐ 7	☐ 9
f. Cigarette promotions in the mail?	☐ 1	☐ 2	☐ 7	☐ 9
g. A promotional girl who trades a new pack of cigarettes for an open pack?	☐ 1	☐ 2	☐ 7	☐ 9

Section H. Knowledge, Attitudes & Perceptions

H01. Based on what you know or believe, does smoking tobacco cause serious illness?

YES ..... ☐ 1
NO ..... ☐ 2
DON'T KNOW .... ☐ 7
REFUSED..... ☐ 9

H02. Based on what you know or believe does smoking tobacco cause the following…

	YES ▼	NO ▼	DON'T KNOW ▼	REFUSED ▼
a. Stroke (blood clots in the brain that may cause paralysis)?	☐ 1	☐ 2	☐ 7	☐ 9
b. Myocardial infarction?	☐ 1	☐ 2	☐ 7	☐ 9
c. Lung cancer?	☐ 1	☐ 2	☐ 7	☐ 9
d. Bladder cancer?	☐ 1	☐ 2	☐ 7	☐ 9
e. Stomach cancer?	☐ 1	☐ 2	☐ 7	☐ 9
f. Mouth cancer	☐ 1	☐ 2	☐ 7	☐ 9
g. Periodontal disease (gum disease leading to tooth loss)?	☐ 1	☐ 2	☐ 7	☐ 9
h. Bone loss? (Fragile bones that break easily)…	☐ 1	☐ 2	☐ 7	☐ 9
i. Premature birth?	☐ 1	☐ 2	☐ 7	☐ 9
j. Erectile dysfunctions? (Impotence)…	☐ 1	☐ 2	☐ 7	☐ 9

HH04. Compared to regular cigarettes, do you think that low-tar tobacco cigarettes (light or extra light) are less harmful, no different, or more harmful?

LESS HARMFUL ..... ☐ 1
NO DIFFERENT ..... ☐ 2
MORE HARMFUL ... ☐ 3
DON'T KNOW ..... ☐ 7
REFUSED..... ☐ 9

HH05. Compared to regular cigarettes, do you think that slim cigarettes are less harmful, no different, or more harmful?

LESS HARMFUL ..... ☐ 1
NO DIFFERENT ..... ☐ 2
MORE HARMFUL ... ☐ 3
DON'T KNOW ..... ☐ 7
REFUSED..... ☐ 9

HH06. Are you in favor of raising taxes for tobacco products?

LESS HARMFUL ..... ☐ 1
NO DIFFERENT ..... ☐ 2
DON'T KNOW ..... ☐ 7
REFUSED..... ☐ 9

End Individual Questionnaire

I00. Those are all of the questions I have. Thank you very much for partcipating in this important survey.

I02. [RECORD ANY NOTES ABOUT INTERVIEW:]

_____

_____

_____

_____

_____

Appendix B: Sample Design

GATS Romania used a combination of two-phase and three-stage stratified cluster sampling in its sample design. We sampled enumeration units from a master sample prepared by the National Institute of Statistics. From the sampled enumeration units, dwellings were randomly selected.

The target population for GATS Romania was noninstitutionalized men and women aged 15 years or over primarily living in their usual residences in Romania. Institutionalized people, such as those who lived in military barracks, prisons, hospitals, or nursing homes, were excluded. The primary survey interests were the prevalence of current tobacco use, the percentage of exposure to secondhand smoke, and the percentage of current smokers who had tried to quit smoking, for both men and women.

The required sample size for developing estimates for men and women in GATS Romania was 2,000 for each and thus 4,000 in total. These numbers were based on the assumption of 3% precision, 95% confidence, 80% statistical power, and a design effect of 2 (see GATS Sample Design Manual 2010 [41]). According to information from national household surveys previously conducted by the National Institute of Statistics, we assumed that the percentage of ineligible dwellings would be 2%. In addition, we assumed that household nonresponse rate would be 5% in urban areas and 2% in rural areas and that the individual nonresponse rate would be 20% in urban areas and 10% in rural areas. The required 2,000 men and 2,000 women were equally allocated to urban and rural areas. The planned sample size was 2,686 dwellings in urban areas and 2,313 dwellings in rural areas, or 4,999 in all. We sampled 200 primary sampling units, with 27 dwellings in urban PSUs and 23 dwellings in rural PSUs, taking ineligible dwellings and nonresponse into account.

In the following section, we will first introduce the 2004 master sample, EMZOT. Second, we will introduce the selection probability of subsampling of the master sample to obtain PSUs for GATS. We will then describe the sampling of households and individuals. Finally, we will discuss the computation of sample weights.

The sample frame for GATS was a master sample, EMZOT (in Romanian, an acronym for Multifunctional Sample of Territorial Areas). The units of EMZOT were combined enumeration units used in the Romanian census and were selected by the National Institute of Statistics, Romania, from the 2002 census in 2004. EMZOT was selected on the basis of the data registered at the Census of the Population and Dwellings from 2002, with technical assistance provided by INSEE France. In the selection of EMZOT, Romania was stratified by six Bucharest districts and 41 counties outside Bucharest. The 41 counties were further stratified by residence (urban or rural). There were 88 strata in total. Sampling units were formed specifically for the purpose of developing the master sample (called research centers), combining existing census units. A research center had an average size of 1,900 dwellings. From the 88 strata, an independent sample was selected with an inclusion probability that was proportional to the size in each stratum: $p_{hj}^{EMZOT} = \alpha_h N_{hj}/N_{h.}$, where α_h was the number of PSUs to be selected in h^{th} stratum, N_{hj} was the number of permanent dwellings in j^{th} PSU, h^{th} stratum, and $N_{h.}$ is the total number of dwellings in stratum h (h=1,…,88). The number of PSUs to be selected, α_h, was proportionally allocated based on the number of dwellings in each stratum h. A total of 780 research centers were selected, of which 427 were in urban areas and 353 in rural areas. The master sample has been used in all Romania national household surveys. It was updated 1) using a 2006 micro-census to collect information on permanent dwellings, including new dwellings built after the 2002 census, and their household

members; and 2) using household surveys. EMZOT contains around 1.5 million permanent dwellings. The National Institute of Statistics prepared p_{hj}^{EMZOT}, the number of dwellings in a research center, N_{hj}, and the total number of dwellings in each of 88 strata, $N_{h.}$, from the updated EMZOT database.

Let p_{hjs}^{Sub} =subsampling selection probability of j_s^{th} PSU in h^{th} stratum, where j_s^{th} belongs to a subset of 1, ... J_h. The sample size of PSUs in each stratum was proportionally allocated based on the number of dwellings, i.e., the number of PSUs in h^{th} stratum, m_h, was $200x(N_{h.}/\Sigma_1^{88} N_{h.})$. The PPS sampling method was applied to subsample research centers, which served as PSUs for GATS. Subsequently, a simple random sampling with a fixed sample size, 27 from urban areas and 23 from rural areas, was applied to sample dwellings. In the sampled dwellings, all dwellings had only one household. From the selected household, one eligible individual was selected for interview.

Romania became a member of the European Union (EU) in 2007. The proportion of Romanians moving to other EU to work dramatically increased after entry into the EU until 2011. We detected the problems caused by this out-migration during the survey and sampled additional 610 dwellings, which increased the planned sample size to 5,629.

The sample weights for GATS contained three components, a base weight or design weight, which was calculated from all the steps of random selection in the sample design, an adjustment for nonresponse, and a post-stratification calibration adjustment of sample totals to the projection of the population aged 15 years old and above in January 2011 by residence, gender, and age group. The base weight was equal to the reciprocal of the probability of selection assigned to each sample person. The probability of selection was the product of the probabilities of selection of the PSU, the household within the selected PSU, and the eligible sample person within the selected household.The base weight was adjusted for nonresponse at both the household level and the person level. The adjustment for nonresponse at the person-level response rate was computed within strategically formed subgroups: age, gender, residence, and smoking status, using the weighting class approach. Population projections of persons aged 15 years over in January 2011 by age, gender, and residence, which were prepared by the National Institute of Statistics, were used for post-stratification calibration adjustment.The final weights assigned to each responding unit were computed as the product of the baseweights, the nonresponse adjustment, and post-stratification calibration adjustment.

Appendix C: Estimates of Sampling Errors

The following sampling error measures are presented for each of the selected indicators:

- **Standard error** (SE): Sampling errors are usually measured in terms of standard errors for a particular estimate or indicator (R). The standard error of an estimate is thus simply the square root of the variance of that estimate and is computed in the same units as the estimate.

- **Design effect** (DEFT) shows the efficiency of the sample design and is calculated for each estimate as the ratio between the standard error using the given sample design and the standard error that would result if a simple random sample had been used. A DEFT value of 1.0 indicates that the sample design is as efficient as a simple random sample, while a DEFT value above 1.0 indicates the increase in the standard error due to the use of a more complex sample design. In general, for a well-designed study, DEFT usually ranges from 1 to 3. It is common, however, for DEFT to be much larger, up to 7 or 8.

- **Relative error** (RE) is the ratio of the standard error to the value of the indicator.

- **Confidence limits (lower limit and upper limit)** are calculated to show the interval within which the true value for the population can be reasonably assumed to fall. For any given statistic calculated from the survey, the value of that statistic will fall within a range of plus or minus two times the standard error of the statistic in 95% of all possible samples of identical size and design.

Table C1 Sampling Errors –National Sample, GATS Romania, 2011.

Indicator	Value	Standard Error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
Current tobacco use	0.267	0.842	4,517	18,175.0	1.64	0.032	0.250	0.283
Current smoking	0.267	0.843	4,517	18,175.0	1.64	0.032	0.250	0.283
Current cigarette smoking	0.267	0.843	4,517	18,175.0	1.64	0.032	0.250	0.283
Current smokeless tobacco	0.003	0.080	4,498	18,101.4	0.99	0.276	0.001	0.004
Daily smoking	0.243	0.781	4,517	18,175.0	1.50	0.032	0.228	0.258
Daily cigarette smoking	0.243	0.781	4,517	18,175.0	1.50	0.032	0.228	0.258
Daily manufactured cigarette smoking	0.242	0.783	4,517	18,175.0	1.51	0.032	0.226	0.257
Daily smokeless tobacco use	0.003	0.077	4,498	18,101.4	1.00	0.287	0.001	0.004
Former daily smokers	0.098	0.418	4,517	18,175.0	0.90	0.043	0.090	0.106
Former daily smokers among ever daily smokers	0.280	1.146	1,493	6,357.0	0.97	0.041	0.258	0.302
First tobacco use within 5 mins	0.262	1.836	958	4,417.6	1.67	0.070	0.226	0.298
First tobacco use in 6-30 mins	0.433	1.919	958	4,417.6	1.44	0.044	0.395	0.470
Quit attempt in last 12 months	0.355	1.699	1,055	4,844.3	1.33	0.048	0.321	0.388
Health care provider asked about smoking	0.821	2.264	569	2,529.1	1.99	0.028	0.777	0.866
Health care provider advised to quit smoking	0.819	2.169	470	2,077.6	1.49	0.026	0.776	0.861
Used nicotine replacement for cessation attempt	0.082	1.435	420	1,897.1	1.15	0.176	0.054	0.110
Used prescription drugs for cessation attempt	0.014	0.696	420	1,897.1	1.52	0.512	0.000	0.027
Used counseling for cessation attempt	0.017	0.624	420	1,897.1	0.99	0.373	0.005	0.029
Cessation attempt on own	0.808	2.025	420	1,897.1	1.11	0.025	0.769	0.848
Used other method for cessation attempt	0.068	1.413	420	1,897.1	1.33	0.209	0.040	0.095
Planning to quit, thinking about quitting, or will quit smoking	0.628	1.669	1,053	4,838.9	1.26	0.027	0.595	0.661
Reason for not quitting - Addicted	0.383	2.976	342	1,618.9	1.28	0.078	0.324	0.441
Reason for not quitting - Not bad for health	0.392	3.451	342	1,618.4	1.70	0.088	0.325	0.460
Reason for not quitting - Reduces stress	0.615	3.313	343	1,621.6	1.59	0.054	0.551	0.680
Reason for not quitting - Keeps me alert	0.285	3.257	339	1,595.3	1.76	0.114	0.221	0.348
Reason for not quitting - Weight gain	0.166	2.815	341	1,598.8	1.94	0.169	0.111	0.222
Reason for not quitting - Like to smoke	0.858	2.393	341	1,613.0	1.60	0.028	0.811	0.905
Reason for not quitting - Other	0.049	1.002	342	1,617.3	0.74	0.206	0.029	0.068

Table C2 Sampling Errors –National Sample, GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
SHS exposure at home	0.354	0.860	4,501	18,130.3	1.45	0.024	0.337	0.371
SHS exposure at work	0.342	1.876	1,216	5,848.9	1.90	0.055	0.305	0.378
SHS exposure at govt buildings	0.207	1.692	844	3,613.7	1.47	0.082	0.174	0.240
SHS exposure at health care facility	0.104	0.989	1,755	6,672.9	1.84	0.095	0.085	0.124
SHS exposure at restaurants	0.866	1.081	1,124	5,538.4	1.13	0.012	0.845	0.888
SHS exposure on public transportation	0.089	0.770	2,071	9,069.7	1.51	0.086	0.074	0.104
SHS exposure at university	0.475	3.546	221	1,262.1	1.11	0.075	0.406	0.545
SHS exposure at school	0.251	1.750	814	4,187.6	1.33	0.070	0.216	0.285
Home policy - smoking allowed anywhere	0.230	0.738	4,515	18,172.1	1.39	0.032	0.215	0.244
Work policy - smoking allowed anywhere	0.072	0.916	1,349	6,467.3	1.69	0.127	0.054	0.090
Location of last purchase - store	0.035	0.831	1,037	4,772.6	2.10	0.235	0.019	0.052
Location of last purchase - street vendor	0.000	0.001	1,037	4,772.6	0.00	0.040	0.000	0.000
Location of last purchase - Kiosks	0.027	0.601	1,037	4,772.6	1.42	0.222	0.015	0.039
Antismoking information anywhere	0.836	0.822	4,516	18,173.0	2.22	0.010	0.820	0.852
Noticed health warning labels on cigarette packages	0.979	0.553	1,055	4,843.1	1.56	0.006	0.968	0.990
Thinking of quitting because of health warning labels on cigarette packages	0.306	1.829	1,055	4,843.1	1.66	0.060	0.270	0.341

Table C3 Sampling Errors –National Sample, GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
Noticed any cigarette advertising, sponsorship, or promotion	0.405	0.885	4,514	18,166.9	1.47	0.022	0.388	0.422
Believes that tobacco smoking causes serious illness	0.963	0.346	4,515	18,169.2	1.53	0.004	0.957	0.970
Believes that tobacco smoking Causes Strokes	0.892	0.517	4,515	18,168.7	1.25	0.006	0.882	0.902
Believes that tobacco smoking causes heart attacks	0.900	0.556	4,515	18,168.7	1.56	0.006	0.889	0.911
Believes that tobacco smoking causes lung cancer	0.983	0.208	4,515	18,168.7	1.15	0.002	0.979	0.987
Believes that tobacco smoking causes other cancer	0.946	0.365	4,514	18,167.6	1.18	0.004	0.939	0.954
Believes that tobacco smoking causes periodontal disease	0.830	0.833	4,513	18,157.7	2.22	0.010	0.813	0.846
Believes that tobacco smoking causes bone loss	0.534	0.915	4,514	18,167.6	1.52	0.017	0.516	0.552
Believes that tobacco smoking causes premature birth	0.747	0.759	4,514	18,167.6	1.38	0.010	0.732	0.761
Believes that tobacco smoking causes erectile dysfunction	0.665	0.818	4,511	18,161.0	1.36	0.012	0.649	0.681
Believes that secondhand smoke causes serious illness in nonsmokers	0.942	0.385	4,517	18,175.0	1.23	0.004	0.934	0.949
Believes that low tar cigarettes are less harmful than other	0.210	0.817	4,515	18,169.8	1.82	0.039	0.194	0.226
Believes that slim cigarettes are less harmful than other	0.189	0.750	4,515	18,169.8	1.66	0.040	0.174	0.203
Favors complete ban in restaurants	0.718	0.810	4,517	18,175.0	1.46	0.011	0.702	0.734
Favors complete ban in bars	0.568	0.989	4,517	18,175.0	1.80	0.017	0.549	0.587
Favors complete ban while driving	0.814	0.734	4,517	18,175.0	1.61	0.009	0.800	0.829
Favors complete ban around children	0.963	0.406	4,517	18,175.0	2.08	0.004	0.955	0.971
Favors complete ban around pregnant women	0.962	0.389	4,517	18,175.0	1.89	0.004	0.955	0.970
Favors increasing taxes	0.617	1.004	4,501	18,107.4	1.92	0.016	0.597	0.637
Average number of cigarettes smoked per day	16.604	0.325	958	4,417.6	1.52	0.020	15.966	17.241
Time since quitting smoking in years among former smokers	10.988	0.584	491	1,779.8	1.27	0.053	9.842	12.133
Total monthly expenditures on manufactured cigarettes	273.107	11.003	1,024	4,711.4	0.46	0.040	251.540	294.674
Age at daily smoking initiation	18.881	0.140	1,489	6,339.5	1.05	0.007	18.607	19.156

Table C4 Sampling Errors –National Sample (Male), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
Current tobacco use	0.374	1.297	2,070	8,760.6	1.49	0.035	0.348	0.399
Current smoking	0.374	1.297	2,070	8,760.6	1.49	0.035	0.348	0.399
Current cigarette smoking	0.374	1.297	2,070	8,760.6	1.49	0.035	0.348	0.399
Current smokeless tobacco	0.004	0.150	2,061	8,720.4	1.19	0.385	0.001	0.007
Daily smoking	0.349	1.258	2,070	8,760.6	1.44	0.036	0.324	0.373
Daily cigarette smoking	0.349	1.258	2,070	8,760.6	1.44	0.036	0.324	0.373
Daily manufactured cigarette smoking	0.346	1.262	2,070	8,760.6	1.46	0.037	0.321	0.370
Daily smokeless tobacco use	0.003	0.145	2,061	8,720.4	1.24	0.414	0.001	0.006
Former daily smokers	0.140	0.730	2,070	8,760.6	0.92	0.052	0.126	0.155
Former daily smokers among ever daily smokers	0.282	1.384	1,035	4,357.7	0.98	0.049	0.255	0.310
First tobacco use within 5 mins	0.275	2.299	657	3,053.1	1.74	0.083	0.230	0.320
First tobacco use in 6-30 mins	0.445	2.333	657	3,053.1	1.45	0.052	0.399	0.491
Quit attempt in last 12 months	0.342	2.003	707	3,276.1	1.26	0.059	0.302	0.381
Health care provider asked about smoking	0.851	2.841	346	1,527.3	2.20	0.033	0.795	0.907
Health care provider advised to quit smoking	0.808	2.801	297	1,299.9	1.50	0.035	0.753	0.863
Used nicotine replacement for cessation attempt	0.081	1.993	267	1,218.2	1.41	0.245	0.042	0.120
Used prescription drugs for cessation attempt	0.014	0.931	267	1,218.2	1.64	0.652	0.000	0.033
Used counseling for cessation attempt	0.023	0.969	267	1,218.2	1.12	0.426	0.004	0.042
Cessation attempt on own	0.798	2.877	267	1,218.2	1.37	0.036	0.742	0.855
Used other method for cessation attempt	0.060	1.932	267	1,218.2	1.75	0.320	0.022	0.098
Planning to quit, thinking about quitting, or will quit smoking	0.625	2.106	704	3,264.5	1.33	0.034	0.584	0.667
Reason for not quitting - Addicted	0.373	3.824	237	1,118.3	1.48	0.102	0.298	0.448
Reason for not quitting - not bad for health	0.371	3.798	238	1,121.3	1.47	0.102	0.296	0.445
Reason for not quitting - Reduces stress	0.587	4.042	238	1,121.0	1.60	0.069	0.508	0.666
Reason for not quitting - keeps me alert	0.303	3.601	235	1,096.3	1.44	0.119	0.232	0.373
Reason for not quitting - weight gain	0.158	3.346	237	1,102.5	1.98	0.211	0.093	0.224
Reason for not quitting - like to smoke	0.864	2.740	237	1,116.7	1.51	0.032	0.811	0.918
Reason for not quitting - other	0.044	1.201	238	1,121.0	0.81	0.273	0.020	0.068

Table C5 Sampling Errors –National Sample (Male), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
SHS exposure at home	0.377	1.370	2,058	8,727.1	1.64	0.036	0.350	0.404
SHS exposure at work	0.368	2.303	649	3,085.9	1.48	0.063	0.323	0.413
SHS exposure at govt buildings	0.224	2.486	423	1,795.3	1.50	0.111	0.175	0.272
SHS exposure at health care facility	0.100	1.424	672	2,603.5	1.52	0.143	0.072	0.128
SHS exposure at restaurants	0.884	1.249	664	3,192.3	1.01	0.014	0.859	0.908
SHS exposure on public transportation	0.097	1.127	934	4,154.9	1.36	0.116	0.075	0.119
SHS exposure at university	0.557	4.579	111	610.5	0.94	0.082	0.468	0.647
SHS exposure at school	0.333	3.331	303	1,630.3	1.51	0.100	0.267	0.398
Home policy - smoking allowed anywhere	0.246	1.141	2,069	8,759.4	1.45	0.046	0.224	0.268
Work policy - smoking allowed anywhere	0.096	1.321	766	3,622.8	1.54	0.138	0.070	0.122
Location of last purchase - store	0.841	1.627	696	3239.762	1.38	0.019	0.810	0.873
Location of last purchase - street vendor	0.037	1.099	696	3239.762	2.356	0.297	0.015	0.059
Location of last purchase - Kiosks	0.061	1.041	696	3239.762	1.306	0.169	0.041	0.082
Antismoking information anywhere	0.838	1.040	2,070	8,760.6	1.65	0.012	0.818	0.859
Noticed health warning labels on cigarette packages	0.980	0.724	707	3,273.0	1.92	0.007	0.966	0.994
Thinking of quitting because of health warning labels on cigarette packages	0.286	2.134	707	3,273.0	1.58	0.075	0.244	0.328

Table C6 Sampling Errors –National Sample (Male), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
Noticed any cigarette advertising, sponsorship, or promotion	0.452	1.441	2,070	8,760.6	1.73	0.032	0.424	0.481
Believe that tobacco smoking causes serious illness	0.954	0.573	2,070	8,760.6	1.55	0.006	0.943	0.965
Believe that tobacco smoking causes strokes	0.884	0.790	2,070	8,760.6	1.26	0.009	0.868	0.899
Believes that tobacco smoking causes heart attacks	0.886	0.820	2,070	8,760.6	1.38	0.009	0.870	0.903
Believes that tobacco smoking causes lung cancer	0.984	0.344	2,070	8,760.6	1.55	0.004	0.977	0.991
Believes that tobacco smoking causes other cancer	0.948	0.552	2,069	8,759.4	1.27	0.006	0.937	0.958
Believes that tobacco smoking causes periodontal disease	0.818	1.258	2,068	8,749.6	2.20	0.015	0.793	0.842
Believes that tobacco smoking causes bone loss	0.497	1.366	2,069	8,759.4	1.54	0.027	0.470	0.524
Believes that tobacco smoking causes premature birth	0.705	1.088	2,069	8,759.4	1.18	0.015	0.684	0.727
Believes that tobacco smoking causes erectile dysfunction	0.677	1.295	2,069	8,759.4	1.59	0.019	0.652	0.702
Believes that secondhand smoke causes serious illness in nonsmokers	0.935	0.603	2,070	8,760.6	1.24	0.006	0.923	0.947
Believes that low-tar cigarettes are less harmful than other	0.249	1.174	2,069	8,757.4	1.53	0.047	0.226	0.272
Believes that slim cigarettes are less harmful than other	0.219	1.048	2,069	8,757.4	1.33	0.048	0.199	0.240
Favors complete ban in restaurants	0.662	1.218	2,070	8,760.6	1.37	0.018	0.638	0.686
Favors complete ban in bars	0.512	1.349	2,070	8,760.6	1.51	0.026	0.485	0.538
Favors complete ban while driving	0.758	1.154	2,070	8,760.6	1.50	0.015	0.735	0.781
Favors complete ban around children	0.954	0.595	2,070	8,760.6	1.69	0.006	0.943	0.966
Favors complete ban around pregnant women	0.952	0.597	2,070	8,760.6	1.63	0.006	0.941	0.964
Favors increasing taxes	0.558	1.589	2,058	8,711.0	2.11	0.028	0.527	0.589
Average number of cigarettes smoked per day	17.704	0.380	657	3,053.1	1.45	0.021	16.959	18.449
Time since quitting smoking in years among former smokers	12.475	0.827	358	1,230.7	1.49	0.066	10.855	14.095
Total monthly expenditures on manufactured cigarettes	299.463	14.573	691	3,208.2	0.40	0.049	270.900	328.026
Age at initiation of daily smoking	18.118	0.156	1,033	4,348.4	1.14	0.009	17.812	18.425

Table C7 Sampling Errors –National Sample (Female), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
Current tobacco use	0.167	0.814	2447	9414.384	1.164	0.049	0.151	0.183
Current smoking	0.167	0.814	2447	9414.384	1.164	0.049	0.151	0.183
Current cigarette smoking	0.167	0.814	2447	9414.384	1.164	0.049	0.151	0.183
Current smokeless tobacco	0.002	0.064	2437	9380.995	0.509	0.327	0.001	0.003
Daily smoking	0.145	0.83	2447	9414.384	1.359	0.057	0.129	0.161
Daily cigarette smoking	0.145	0.83	2447	9414.384	1.359	0.057	0.129	0.161
Daily manufactured-cigarette smoking	0.145	0.824	2447	9414.384	1.342	0.057	0.128	0.161
Daily smokeless tobacco use	0.002	0.064	2437	9380.995	0.509	0.327	0.001	0.003
Former daily smokers	0.058	0.462	2447	9414.384	0.951	0.079	0.049	0.067
Former daily smokers among ever daily smokers	0.275	1.993	458	1999.268	0.911	0.073	0.236	0.314
First tobacco use within 5 mins	0.232	2.996	301	1364.472	1.51	0.129	0.174	0.291
First tobacco use in 6-30 mins	0.405	3.516	301	1364.472	1.54	0.087	0.336	0.474
Quit attempt in last 12 months	0.382	3.084	348	1568.252	1.398	0.081	0.322	0.443
Health care provider asked about smoking	0.776	2.96	223	1001.775	1.12	0.038	0.718	0.834
Health care provider advised to quit smoking	0.837	3.16	173	777.728	1.262	0.038	0.776	0.899
Used nicotine replacement for cessation attempt	0.082	2.11	153	678.966	0.899	0.257	0.041	0.123
Used prescription drugs for cessation attempt	0.012	0.914	153	678.966	1.038	0.737	0.000	0.03
Used counseling for cessation attempt	0.006	0.215	153	678.966	0.118	0.359	0.002	0.01
Cessation attempt on own	0.826	3.21	153	678.966	1.09	0.039	0.763	0.889
Used other method for cessation attempt	0.081	2.001	153	678.966	0.817	0.247	0.042	0.12
Planning to quit, thinking about quitting, or will quit smoking	0.633	3.188	349	1574.393	1.523	0.05	0.571	0.696
Reason for not quitting - addicted	0.404	6.009	105	500.601	1.56	0.149	0.286	0.522
Reason for not quitting - not bad for health	0.441	6.091	104	497.107	1.55	0.138	0.322	0.561
Reason for not quitting - reduces stress	0.68	5.639	105	500.601	1.519	0.083	0.569	0.79
Reason for not quitting - keeps me alert	0.244	5.555	104	498.921	1.722	0.227	0.136	0.353
Reason for not quitting - weight gain	0.184	4.348	104	496.3	1.296	0.236	0.099	0.27
Reason for not quitting - like to smoke	0.845	3.505	104	496.3	0.964	0.041	0.776	0.913
Reason for not quitting - other	0.059	2.246	104	496.3	0.94	0.383	0.015	0.103

Table C8 Sampling Errors –National Sample (Female), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
SHS exposure at home	0.332	1.164	2443	9403.2	1.492	0.035	0.309	0.355
SHS exposure at work	0.312	2.329	567	2762.988	1.43	0.075	0.267	0.358
SHS exposure at govt buildings	0.19	2.221	421	1818.331	1.344	0.117	0.147	0.234
SHS exposure at health care facility	0.107	1.149	1083	4069.384	1.493	0.107	0.085	0.13
SHS exposure at restaurants	0.843	1.947	460	2346.084	1.312	0.023	0.805	0.881
SHS exposure on public transportation	0.083	1.028	1137	4914.76	1.576	0.124	0.063	0.103
SHS exposure at university	0.398	5.66	110	651.579	1.457	0.142	0.287	0.509
SHS exposure at school	0.199	2.112	511	2557.281	1.43	0.106	0.157	0.24
Home policy - smoking allowed anywhere	0.214	1.006	2446	9412.715	1.47	0.047	0.195	0.234
Work policy - smoking allowed anywhere	0.042	0.935	583	2844.517	1.254	0.221	0.024	0.061
Location of last purchase - store	0.846	2.559	341	1532.885	1.71	0.03	0.796	0.896
Location of last purchase - street vendor	0.032	1.026	341	1532.885	1.151	0.319	0.012	0.052
Location of last purchase - kiosks	0.076	2.128	341	1532.885	2.18	0.278	0.035	0.118
Anti-smoking information anywhere	0.833	0.933	2446	9412.42	1.533	0.011	0.815	0.852
Noticed health warning labels on cigarette packages	0.976	0.877	348	1570.092	1.145	0.009	0.959	0.993
Thinking of quitting because of health warning labels on cigarette packages	0.347	3.341	348	1570.092	1.709	0.096	0.282	0.412
Noticed any cigarette advertising, sponsorship, or promotion	0.361	1.062	2444	9406.279	1.196	0.029	0.340	0.382

Table C9 Sampling Errors –National Sample (Female), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
Believe that tobacco Smoking causes serious Illness	0.972	0.361	2445	9408.627	1.167	0.004	0.965	0.979
Believe that tobacco smoking causes strokes	0.9	0.714	2445	9408.119	1.38	0.008	0.886	0.914
Believe that tobacco smoking causes heart attacks	0.913	0.698	2445	9408.119	1.506	0.008	0.900	0.927
Believes that tobacco smoking causes lung cancer	0.982	0.33	2445	9408.119	1.494	0.003	0.975	0.988
Believes that tobacco smoking causes other cancer	0.945	0.502	2445	9408.119	1.194	0.005	0.936	0.955
Believes that tobacco smoking causes periodontal disease	0.841	1.047	2445	9408.119	2.005	0.012	0.821	0.862
Believes that tobacco smoking causes bone loss	0.568	1.251	2445	9408.119	1.558	0.022	0.543	0.592
Believes that tobacco smoking causes premature birth	0.785	0.935	2445	9408.119	1.266	0.012	0.767	0.803
Believes that tobacco smoking causes erectile dysfunction	0.654	1.018	2442	9401.54	1.118	0.016	0.634	0.674
Believes that secondhand smoke causes serious illness in nonsmokers	0.948	0.493	2447	9414.384	1.209	0.005	0.938	0.958
Believes that low-tar cigarettes are less harmful than other	0.174	1.093	2446	9412.42	2.033	0.063	0.153	0.195
Believes that slim cigarettes are less harmful than other	0.16	0.982	2446	9412.42	1.757	0.061	0.141	0.179
Favors complete ban in restaurants	0.77	0.922	2447	9414.384	1.176	0.012	0.752	0.788
Favors complete ban in bars	0.62	1.23	2447	9414.384	1.572	0.02	0.596	0.644
Favors complete ban while driving	0.867	0.77	2447	9414.384	1.256	0.009	0.852	0.882
Favors complete ban around children	0.971	0.481	2447	9414.384	1.992	0.005	0.961	0.98
Favors complete ban around pregnant women	0.972	0.449	2447	9414.384	1.789	0.005	0.963	0.98
Favors increasing taxes	0.672	1.159	2443	9396.328	1.489	0.017	0.649	0.694
Average number of cigarettes smoked per day	14.141	0.499	301	1364.472	1.252	0.035	13.162	15.119
Time since quitting smoking in years among former smokers	7.654	0.689	133	549.105	1.184	0.09	6.303	9.004
Total monthly expenditures on manufactured cigarettes	216.855	10.806	333	1503.162	0.999	0.05	195.675	238.035
Age at daily smoking initiation	20.547	0.273	456	1991.125	0.959	0.013	20.011	21.083

Table C10 Sampling Errors –National Sample (Urban), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
Current tobacco use	0.284	1.065	2,440	10,124.1	1.36	0.037	0.263	0.305
Current smoking	0.284	1.065	2,440	10,124.1	1.36	0.037	0.263	0.305
Current cigarette smoking	0.284	1.065	2,440	10,124.1	1.36	0.037	0.263	0.305
Current smokeless tobacco	0.002	0.086	2,431	10,099.4	0.76	0.365	0.001	0.004
Daily smoking	0.256	0.953	2,440	10,124.1	1.16	0.037	0.237	0.275
Daily cigarette smoking	0.256	0.953	2,440	10,124.1	1.16	0.037	0.237	0.275
Daily manufactured-cigarette smoking	0.254	0.965	2,440	10,124.1	1.20	0.038	0.235	0.273
Daily smokeless tobacco use	0.002	0.079	2,431	10,099.4	0.75	0.391	0.000	0.004
Former daily smokers	0.113	0.553	2,440	10,124.1	0.75	0.049	0.102	0.124
Former daily smokers among ever daily smokers	0.299	1.398	896	3,823.0	0.84	0.047	0.271	0.326
First tobacco use within 5 mins	0.234	2.030	572	2,591.1	1.31	0.087	0.194	0.274
First tobacco use in 6-30 mins	0.448	2.411	572	2,591.1	1.34	0.054	0.401	0.495
Quit attempt in last 12 months	0.336	1.999	637	2,876.9	1.14	0.060	0.296	0.375
Health care provider asked about smoking	0.827	2.574	368	1,681.8	1.70	0.031	0.777	0.878
Health care provider advised to quit smoking	0.804	2.879	301	1,391.0	1.58	0.036	0.748	0.861
Used nicotine replacement for cessation attempt	0.064	1.651	235	1,086.2	1.06	0.258	0.032	0.096
Used prescription drugs for cessation attempt	0.008	0.583	235	1,086.2	1.02	0.741	-0.004	0.019
Used counseling for cessation attempt	0.022	0.923	235	1,086.2	0.94	0.426	0.004	0.040
Cessation attempt on own	0.834	2.295	235	1,086.2	0.89	0.028	0.789	0.879
Used other method for cessation attempt	0.075	1.805	235	1,086.2	1.10	0.240	0.040	0.111
Planning to quit, thinking about quitting, or will quit smoking	0.634	1.837	636	2,872.4	0.92	0.029	0.598	0.670
Reason for not quitting - addicted	0.371	3.483	203	918.6	1.05	0.094	0.302	0.439
Reason for not quitting - not bad for health	0.401	4.610	204	922.4	1.80	0.115	0.311	0.491
Reason for not quitting - reduces stress	0.610	4.099	204	921.3	1.43	0.067	0.529	0.690
Reason for not quitting - keeps me alert	0.293	4.526	203	919.4	2.00	0.155	0.204	0.381
Reason for not quitting - weight gain	0.176	3.958	204	921.3	2.20	0.225	0.098	0.253
Reason for not quitting - like to smoke	0.832	3.391	204	921.3	1.67	0.041	0.765	0.898
Reason for not quitting - other	0.044	1.077	204	921.3	0.56	0.246	0.023	0.065

Table C11 Sampling Errors –National Sample (Urban), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
SHS exposure at home	0.409	1.086	2,430	10,093.1	1.19	0.027	0.387	0.430
SHS exposure at work	0.349	2.290	888	4,206.9	2.05	0.066	0.304	0.394
SHS exposure at govt buildings	0.223	2.217	508	2,255.0	1.44	0.099	0.180	0.267
SHS exposure at health care facility	0.123	1.419	988	3,989.0	1.84	0.115	0.095	0.151
SHS exposure at restaurants	0.870	1.280	786	3,779.7	1.13	0.015	0.844	0.895
SHS exposure on public transportation	0.084	0.893	1,290	5,633.2	1.34	0.106	0.066	0.101
SHS exposure at university	0.442	3.695	174	922.8	0.96	0.084	0.370	0.515
SHS exposure at school	0.255	2.377	471	2,419.6	1.40	0.093	0.209	0.302
Home policy - smoking allowed anywhere	0.274	1.007	2,439	10,122.9	1.24	0.037	0.255	0.294
Work policy - smoking allowed anywhere	0.066	1.102	970	4,553.3	1.91	0.167	0.045	0.088
Location of last purchase - store	0.827	2.241	628	2830.559	2.199	0.027	0.783	0.871
Location of last purchase - street vendor	0.03	1.088	628	2830.559	2.549	0.362	0.009	0.051
Location of last purchase - kiosks	0.093	1.574	628	2830.559	1.845	0.17	0.062	0.124
Antismoking information anywhere	0.846	1.135	2,440	10,124.1	2.42	0.013	0.824	0.869
Noticed health warning labels on cigarette packages	0.991	0.360	637	2,878.8	0.91	0.004	0.984	0.998
Thinking of quitting because of health warning labels on cigarette packages	0.289	2.148	637	2,878.8	1.43	0.074	0.247	0.331
Noticed any cigarette advertising, sponsorship, or promotion	0.504	1.211	2,440	10,124.1	1.43	0.024	0.480	0.528

Table C12 Sampling Errors –National Sample (Urban), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
Believe that tobacco smoking causes serious illness	0.970	0.391	2,440	10,124.1	1.26	0.004	0.962	0.977
Believe that tobacco smoking causes strokes	0.899	0.717	2,440	10,124.1	1.39	0.008	0.885	0.914
Believe that tobacco smoking causes heart attacks	0.898	0.847	2,440	10,124.1	1.91	0.009	0.881	0.914
Believes that tobacco smoking causes lung cancer	0.980	0.303	2,440	10,124.1	1.15	0.003	0.974	0.986
Believes that tobacco smoking causes other cancer	0.943	0.507	2,440	10,124.1	1.17	0.005	0.933	0.953
Believes thattTobacco smoking causes periodontal disease	0.820	1.050	2,440	10,124.1	1.82	0.013	0.799	0.840
Believes that tobacco smoking causes bone loss	0.523	1.150	2,440	10,124.1	1.29	0.022	0.501	0.546
Believes that tobacco smoking causes premature birth	0.737	1.078	2,440	10,124.1	1.47	0.015	0.716	0.758
Believes that tobacco smoking causes erectile dysfunction	0.673	1.068	2,439	10,121.4	1.26	0.016	0.652	0.694
Believes that Secondhand Smoke Causes Serious Illness in nonsmokers	0.944	0.535	2,440	10,124.1	1.33	0.006	0.934	0.955
Believes that low-tar cigarettes are less harmful than other	0.207	1.110	2,439	10,120.9	1.83	0.054	0.185	0.229
Believes that slim cigarettes are less harmful than other	0.181	1.053	2,439	10,120.9	1.83	0.058	0.160	0.201
Favors complete ban in restaurants	0.687	0.993	2,440	10,124.1	1.12	0.014	0.668	0.707
Favors complete ban in bars	0.526	1.190	2,440	10,124.1	1.39	0.023	0.503	0.549
Favors complete ban while driving	0.804	0.911	2,440	10,124.1	1.28	0.011	0.786	0.822
Favors complete ban around children	0.965	0.575	2,440	10,124.1	2.41	0.006	0.954	0.977
Favors complete ban around pregnant women	0.964	0.521	2,440	10,124.1	1.89	0.005	0.953	0.974
Favors increasing taxes	0.591	1.363	2,430	10,077.2	1.87	0.023	0.565	0.618
Average number of igarettes smoked per day	16.637	0.407	572	2,591.1	1.40	0.024	15.840	17.434
Time in years since quitting smoking among former smokers	10.555	0.726	299	1,141.3	1.33	0.069	9.133	11.977
Total monthly expenditures on manufactured cigarettes	269.166	12.518	617	2,782.3	1.43	0.047	244.631	293.701
Age at initiation of daily smoking	19.230	0.162	894	3,813.7	0.87	0.008	18.912	19.547

Table C13 Sampling Errors –National Sample (Rural), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
Current tobacco use	0.267	0.842	4,517	18,175.0	1.64	0.032	0.250	0.283
Current smoking	0.267	0.843	4,517	18,175.0	1.64	0.032	0.250	0.283
Current cigarette smoking	0.267	0.843	4,517	18,175.0	1.64	0.032	0.250	0.283
Current smokeless tobacco	0.003	0.080	4,498	18,101.4	0.99	0.276	0.001	0.004
Daily smoking	0.243	0.781	4,517	18,175.0	1.50	0.032	0.228	0.258
Daily cigarette smoking	0.243	0.781	4,517	18,175.0	1.50	0.032	0.228	0.258
Daily manufactured-cigarette smoking	0.242	0.783	4,517	18,175.0	1.51	0.032	0.226	0.257
Daily smokeless tobacco use	0.003	0.077	4,498	18,101.4	1.00	0.287	0.001	0.004
Former daily smokers	0.098	0.418	4,517	18,175.0	0.90	0.043	0.090	0.106
Former daily smokers among ever daily smokers	0.280	1.146	1,493	6,357.0	0.97	0.041	0.258	0.302
First tobacco use within 5 mins	0.262	1.836	958	4,417.6	1.67	0.070	0.226	0.298
First tobacco use in 6-30 mins	0.433	1.919	958	4,417.6	1.44	0.044	0.395	0.470
Quit attempt in last 12 months	0.355	1.699	1,055	4,844.3	1.33	0.048	0.321	0.388
Health care provider asked about smoking	0.821	2.264	569	2,529.1	1.99	0.028	0.777	0.866
Health care provider advised to quit smoking	0.819	2.169	470	2,077.6	1.49	0.026	0.776	0.861
Used nicotine replacement for cessation attempt	0.082	1.435	420	1,897.1	1.15	0.176	0.054	0.110
Used prescription drugs for cessation attempt	0.014	0.696	420	1,897.1	1.52	0.512	0.000	0.027
Used counseling for cessation attempt	0.017	0.624	420	1,897.1	0.99	0.373	0.005	0.029
Cessation attempt on own	0.808	2.025	420	1,897.1	1.11	0.025	0.769	0.848
Used other method for cessation attempt	0.068	1.413	420	1,897.1	1.33	0.209	0.040	0.095
Planning to quit, thinking about quitting, or will quit smoking	0.628	1.669	1,053	4,838.9	1.26	0.027	0.595	0.661
Reason for not quitting - addicted	0.383	2.976	342	1,618.9	1.28	0.078	0.324	0.441
Reason for not quitting - not bad for health	0.392	3.451	342	1,618.4	1.70	0.088	0.325	0.460
Reason for not quitting - reduces stress	0.615	3.313	343	1,621.6	1.59	0.054	0.551	0.680
Reason for not quitting - keeps me alert	0.285	3.257	339	1,595.3	1.76	0.114	0.221	0.348
Reason for not quitting - weight gain	0.166	2.815	341	1,598.8	1.94	0.169	0.111	0.222
Reason for not quitting - like to smoke	0.858	2.393	341	1,613.0	1.60	0.028	0.811	0.905

Table C14 Sampling Errors –National Sample (Rural), GATS Romania, 2011.

Indicator	Value	Standard Error	Sample size	Population	Design Effect	Relative Error	Lower limit	Upper limit
Reason for not quitting – other	0.049	1.002	342	1,617.3	0.74	0.206	0.029	0.068
SHS exposure at home	0.354	0.860	4,501	18,130.3	1.45	0.024	0.337	0.371
SHS exposure at work	0.342	1.876	1,216	5,848.9	1.90	0.055	0.305	0.378
SHS exposure at govt buildings	0.207	1.692	844	3,613.7	1.47	0.082	0.174	0.240
SHS exposure at health care facility	0.104	0.989	1,755	6,672.9	1.84	0.095	0.085	0.124
SHS exposure at restaurants	0.866	1.081	1,124	5,538.4	1.13	0.012	0.845	0.888
SHS exposure on public transportation	0.089	0.770	2,071	9,069.7	1.51	0.086	0.074	0.104
SHS exposure at university	0.475	3.546	221	1,262.1	1.11	0.075	0.406	0.545
SHS exposure at school	0.251	1.750	814	4,187.6	1.33	0.070	0.216	0.285
Home policy - smoking allowed anywhere	0.230	0.738	4,515	18,172.1	1.39	0.032	0.215	0.244
Work policy - smoking allowed anywhere	0.072	0.916	1,349	6,467.3	1.69	0.127	0.054	0.090
Location of last purchase - store	0.843	1.552	1037	4772.647	1.885	0.018	0.813	0.873
Location of last purchase - street vendor	0.035	0.831	1037	4772.647	2.095	0.235	0.019	0.052
Location of last purchase - kiosks	0.066	1.012	1037	4772.647	1.714	0.153	0.046	0.086
Antismoking information anywhere	0.836	0.822	4,516	18,173.0	2.22	0.010	0.820	0.852
Noticed health warning labels on cigarette packages	0.979	0.553	1,055	4,843.1	1.56	0.006	0.968	0.990
Thinking of quitting because of health warning labels on cigarette packages	0.306	1.829	1,055	4,843.1	1.66	0.060	0.270	0.341
Noticed any cigarette advertising, sponsorship, or promotion	0.405	0.885	4,514	18,166.9	1.47	0.022	0.388	0.422

Table C15 Sampling Errors –National Sample (Rural), GATS Romania, 2011.

Indicator	Value	Standard error	Sample size	Population	Design effect	Relative error	Lower limit	Upper limit
Believe that tobacco smoking causes serious illness	0.963	0.346	4,515	18,169.2	1.53	0.004	0.957	0.970
Believe that tobacco smoking causes strokes	0.892	0.517	4,515	18,168.7	1.25	0.006	0.882	0.902
Believe that tobacco smoking causes heart attacks	0.900	0.556	4,515	18,168.7	1.56	0.006	0.889	0.911
Believes that tobacco smoking causes lung cancer	0.983	0.208	4,515	18,168.7	1.15	0.002	0.979	0.987
Believes that tobacco smoking causes other cancer	0.946	0.365	4,514	18,167.6	1.18	0.004	0.939	0.954
Believes that tobacco smoking causes periodontal disease	0.830	0.833	4,513	18,157.7	2.22	0.010	0.813	0.846
Believes that tobacco smoking causes bone loss	0.534	0.915	4,514	18,167.6	1.52	0.017	0.516	0.552
Believes that tobacco smoking causes premature birth	0.747	0.759	4,514	18,167.6	1.38	0.010	0.732	0.761
Believes that tobacco smoking causes erectile dysfunction	0.665	0.818	4,511	18,161.0	1.36	0.012	0.649	0.681
Believes that secondhand smoke causes serious illness in nonsmokers	0.942	0.385	4,517	18,175.0	1.23	0.004	0.934	0.949
Believes that low-tar cigarettes are less harmful than other	0.210	0.817	4,515	18,169.8	1.82	0.039	0.194	0.226
Believes that slim cigarettes are less harmful than other	0.189	0.750	4,515	18,169.8	1.66	0.040	0.174	0.203
Favors complete ban in restaurants	0.718	0.810	4,517	18,175.0	1.46	0.011	0.702	0.734
Favors complete ban in bars	0.568	0.989	4,517	18,175.0	1.80	0.017	0.549	0.587
Favors complete ban while driving	0.814	0.734	4,517	18,175.0	1.61	0.009	0.800	0.829
Favors complete ban around children	0.963	0.406	4,517	18,175.0	2.08	0.004	0.955	0.971
Favors complete ban around pregnant women	0.962	0.389	4,517	18,175.0	1.89	0.004	0.955	0.970
Favors increasing taxes	0.617	1.004	4,501	18,107.4	1.92	0.016	0.597	0.637
Average number of cigarettes smoked per day	16.557	0.535	386	1,826.5	1.70	0.032	15.508	17.605
Time (in years) since quitting smoking among former smokers	11.761	1.004	192	638.5	1.24	0.085	9.794	13.728
Total monthly expenditures on manufactured cigarettes	278.792	19.911	407	1,929.1	0.30	0.071	239.766	317.818
Age at initiation of daily smoking	18.355	0.248	595	2,525.8	1.29	0.014	17.869	18.842

Appendix D: Technical and Survey Staff

Name and Surname	Institution	Position
Amalia Fechete	**Ministry of Health**	Deputy Director Department of Public Health and Control in Public Health
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Ana Raluca Teodoru	**TOTEM Communication**	Fieldwork Project Manager
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Alina Negraru		Quality Manager
Andrei Adamecz		Field Coordinator

Andrei Ferche	**TOTEM Communication Bucharest, Giurgiu Ilfov, Fieldwork Team**	Field Coordinator
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Adriana Boboc		Field Interviewer
Cristi Rădulescu		Field Interviewer
Ana Gagheș		Field Interviewer
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Iulian Buda		Field Interviewer
Attila Fülöp		Field Interviewer
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Roxana Tomescu		Field Interviewer
Claudiu Vatău		Field Interviewer
Marian Vâlceanu		Field Interviewer
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Cristina Priveghiu		Field Interviewer
Maria Costache		Field Interviewer
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Irina Săndulescu		Field Interviewer
Georgeta Radu		Field Interviewer
Cristina Răducanu		Field Interviewer

Appendix E: Glossary of Terms

Questionnaire and Indicator Terminology	
Current tobacco smoker	Person who currently smokes any tobacco product, either daily or occasionally.
Daily smoker	Person who currently smokes any tobacco product every day.
Ever daily smoker	Person may or may not be a current smoker. Includes persons who are 'current daily smokers', 'current occasional smokers', formerly 'daily' or 'current' nonsmokers, formerly daily smokers'
Former daily smoker	Person is currently a nonsmoker but had previously smoked daily over a period of 1 month or more.
Occasional smoker	Person who currently smokes less than daily.
Nonsmoker	Person currently does not smoke at all.
Smoking status /smoking frequency	Classified into three categories: 1) ‚Current/daily smoker' means the person currently smokes at least one tobacco product every day, over a period of 1 month or more. 2) ‚Current/occasional smoker' means the person currently smokes less than daily (either formerly daily or never daily). 3) ‚Nonsmoker' means the person currently does not smoke at all. This includes ‚former daily smoker' (currently a nonsmoker but had previously smoked daily) and ‚Never daily smoker' (currently a nonsmoker and has never smoked daily, but instead a occasionally or never smoker).
Tobacco products	Two types: 1) Smoked tobacco includes: manufactured cigarettes, hand-rolled cigarettes, pipes full of tobacco, cigars/cigarillos, and any other reported smoked tobacco products. 2) Smokeless tobacco includes: snus (oral tobacco), snuffing tobacco (for nasal use), chewing tobacco (oral tobacco for chewing), and any other reported smokeless tobacco products.
Beliefs about the dangers of tobacco smoking	Believe that tobacco smoking causes serious illness and specific diseases.
Exposure to antitobacco information	Have noticed any information about the dangers of cigarettes or nonsmoking tobacco, or that encourages quitting of these tobacco products, in the last 30 days, in the areas of interest: newspapers/ magazines, television, radio, billboards, Internet, educational/health materials, and/or elsewhere.
Exposure to secondhand smoke at home	Indicates percentage of adults who saw someone smoking inside their home (daily, weekly, or monthly) in the past 30 days. This does not include areas outside such as patios, balcony, garden, etc. that are not fully enclosed.

Exposure to secondhand smoke in public places	Indicates percentage of adults who noticed someone smoking inside the public places of interest in the past 30 days: Government buildings: Covering indoor areas, which are non-smoking areas by the national smoke-free laws. Health care facilities: Covering indoor areas of both public and private health care facilities, which are nonsmoking areas by the national smoke free laws. Restaurants: not including place in front of any building and on the wayside. Bars/nightclubs, disco, music clubs: in indoor areas of these premises. Public transportation: All public transport.
Exposure to secondhand smoke in the workplace	Indicates percentage of adults who saw someone smoking at work inside in the past 30 days. This is among those adults who worked outside of the home or who usually worked indoors or both indoors and outdoors.
Exposure to cigarette advertisements, sponsorship, and promotion	Adults who had noticed any advertisements or signs promoting cigarettes in the last 30 days, in the areas of interest: stores where the products are sold, Internet, and/or elsewhere. Adults who had noticed any sport or sporting event associated with cigarette brands/companies. Adults who noticed any free samples of cigarettes or clothing/other items with a brand name or logo of cigarettes or sales prices or coupons or mails promoting cigarettes or cultural event sponsorship of cigarette companies/brands.
Health care provider (HCP)	Health care providers include various health professionals such as medical doctors, nurses, pharmacists, and other health professionals.
Interest in quitting smoking	Current tobacco smokers who are planning or thinking about quitting smoking within the next month, 12 months, or someday.
Pharmacotherapy	Nicotine replacement therapy (e.g., chewing gum, patches), prescription drugs (e.g., Zyban, Champix).
Public places	Public places - Include government buildings, health care facilities, schools, universities or other educational facilities, restaurants, bars/nightclubs, music clubs, public transportation.
Quit attempt	Current tobacco smokers who tried to quit during the past 12 months and former tobacco smokers who have been abstinent for < 12 months.
Quit ratio (among daily smokers)	Indicates how many ‘ever daily smokers’ were able to successfully quit (‘former daily smoker’/ ‘ever daily smoker’)
Secondhand smoke (SHS)	Inhalation of smoke from tobacco products used by others.

Abbreviations	
CDC	Centers for Disease Control and Prevention
CDCF	Centers for Disease Control and Prevention Foundation
CPHA	Canadian Public Health Association
DEFT	Design effect
EMTOC	Electronic Model Tobacco Control
EMZOT	Master Sample of Territorial Areas
ESPAD	EuropeanSchool Survey Project on Alcohol and Other Drugs
ETS	Environmental tobacco smoke
EU	European Union
FCTC	Framework Convention for Tobacco Control
FI	Field interviewer
FS	Filed supervisor
GATS	Global Adult Tobacco Survey
GDP	Gross domestic product
GHSPS	Global Health Profession Student Survey
GSPS	Global School Personnel Survey
GTSS	Global Tobacco Surveillance System
GYTS	Global Youth Tobacco Survey
HH	Household
JHUSPH	Johns Hopkins Bloomberg School of Public Health
MoH	Ministry of Health
NCS	National Commission for Statistics
NGOs	Nongovernmental Organizations
NIPH	National Institute of Public Health
NRT	Nicotine Replacement Therapy
NSTC	National Statistical Training Centre
PPS	Probability proportional to size
PSU	Primary sampling unit
RTI-I	Research Triangle Institute – International
TC	TOTEM Communication
TFI	Tobacco Free Initiative
UNCGSPH	University of North Carolina Gillings School of Public Health
WHO	World Health Organization
WHO-CO	World Health Organization – Country Office
WHO-ERO	World Health Organization – European Regional Office
WHO-HQ	World Health Organization – Headquaters

References

1. World Bank. *Curbing the Epidemic: Governments and the Economics of Tobaco Control*. Washington, DC: World Bank, 1999.

2. Mathers C.D., Loncar D., *Projections of global mortality and burden of disease from 2002 to 2030*. PLoS Med 2006;3(11):e442.

3. WHO Regional Office for Europe. *European Strategy for Tobacco Control*. Copenhagen: WHO Regional Office for Europe, 2002.

4. *WHO Framework Convention on Tobacco Control*, WHO 2003, updated reprint 2004, 2005, Geneva, Switzerland.

5. Warren C.W., Lea J., Lee V., et al. *Evolution of the Global Tobacco Surveillance System (GTSS) 1998-2008*. IUHPE – GlobalHealth Promotion Supplement, 2009, (2): 4-37 72.

6. Anuarul statistic 2010 (Yearly Statistical Publication 2010), National Institute of Statistics Romania.

7. Eurostat, *Life expectancy at birth by gender*, available at: http://eppeurostat.ec.europa.eu.

8. ERC Statistics International plc. *The World Cigarettes I and II: The 2001 Survey*. Suffolk, Great Britain, 2001.

9. Mackay J. & Eriksen M., *The Tobacco Atlas*, Second Edition 2002, WHO.

10. Shafey O., Eriksen M., Ross H., Mackay J., *The Tobacco Control Atlas*, Third Edition, American Cancer Society.

11. *DG Taxation and Customs*, accessed 10th November 2011. Available at: http://ec.europa.eu/taxation_customs/resources/documents/taxation/excise_duties/tobacco_products/rates/tobacco_releases_consumption.pdf.

12. Seenews (BG). *Smuggling to feed one-third of Romania's 2010 cigarette market.* Available at: http://seenews.com/news/latestnews/cigarettesmugglinginromaniaseenat30_ofoverallmarketin2010-163957/.

13. Ministry of Health and Institute of Pneumology Marius Nasta, *Evaluation of the impact of tobacco control measures on the smoching prevalence of Romanian adults*, Bucharest, 2011, www.ms.ro.

14. Center for Medical Statistics and Medical Documentation Center, Ministry of Health, *Health Status of Romanian Population 1990-2002*, Bucharest, April 2002.

15. National Institute of Statistics, *Health status of population in Romania*, April, 2002.

16. Centre for Health Policies and Studies, *Smoking and Public Health in Romania - Knowledge, Attitudes and Practices about Tobacco Products Consumption in Romanian Population*, Bucharest, 2004.

17. *Special Eurobarometer 272c. Wave 66.2 Attitudes of Europeans towards Tobacco, 2007*, European Commission – DG SANCO, available at: www/ec.europa.eu/public_opinion/archives/ebs/ebs_272c_en.pdf.

18. National Institute of Pneumology Marius Nasta, *Evaluation of knowledge, attitudes and practices of Romanian adults about active and passive smoking*, Bucharest, 2008, www.ms.ro.

19. Ciobanu M., Bursuc B., Păunescu B., *Evaluation of knowledge, attitudes and practices of Romanian adults about active and passive smoking*, National Institute of Pneumology Marius Nasta, Bucharest, 2009, www.ms.ro.

20. *WHO Report on the Global Tobacco Epidemic, 2011: Warning about the dangers of tobacco*, available at: www.whoint/tobacco/global_report/2011/en.

21. *The Special Eurobarometer 332 Wave 72.3- TNS Opinion&Social, Tobacco 2010*, available at: www/ec.europa.eu/health/tobacco/docs/ebs332_en.pdf.

22. *ESPAD Study* [online] 2004, [Accessed October 10, 2010], available at: http://www.esapad.org/romania.

23. Bjorn H. et al., *The 2007 ESPAD Report. Substance Use Among Students in 35 European Countries*, available at: www.espad.org/documents/Espad/ESPAD_reports/2007/.

24. Irimie S.*, Mireștean, I.M., Samoilă A.C., Beldean-Galea I., Decanovici A., *Tobacco Use among Students from Romania 2004 versus 2009,* GYTS Data, Applied Medical Informatics, Vol. 27, No. 4/2010, pp: 55-61.

25. *WHO EUROPE. Highlights on health in Romania. 2005*. Available at: http://www.euro.who.int/highlights

26. *Noncommunicable Diseases Country Profile 2011*, World Health Organization, available at: http/whqlibdoc. who.int/publication/2011.

27. Ferlay J., Autier P., Boniol M., Heanue M., Colombet M., Boyle P., *Estimates of the cancer incidence and mortality in Europe in 2006*. Ann Oncol 2007;18:581-92.

28. WHO EUROPE. *Highlights on health in Romania. 2005*. Available at: http://www.euro.who.int/highlights.

29. Ferlay, D.M., Parkin, E., Steliarova-Foucher, *Estimates of cancer incidence and mortality in Europe in 2008*. Eur J Cancer 2010;46(4):765–81.

30. *WHO mortality database*. Prepared by the CIN Section of IARC. Available at: http://www-dep.iarc.fr/).

31. *A study on liability and the health costs of smoking*. DG SANCO. 2009. A report submitted by GHK in association with University of Exeter, UK and the Public Health Advocacy Institute, USA, www.ghkint.com.

32. European Commission – *DG AGRI. Member States'communications* (Commission Regulation (EC) No 2095/2005), available at: http://ec.europa.eu/agriculture/markets/tobacco/production-statistics_en.pdf.

33. *WHO Report on the Global Tobacco Epidemic, 2011, Country profile Romania*, available at: http://www.who.int/tobacco/surveillance/policy/country_profile/rou.pdf.

34. *Legislation for Reporting of tobacco products ingredients*: available at: http://www.ms.ro/pag=138&id=3262.

35. Global Adult Tobacco Survey Collaborative Group. *Global Adult Tobacco Survey (GATS): Core Questionnaire with Optional Questions*, Version 2.0. Atlanta, GA: Centers for Disease Control and Prevention, 2010.

36. Global Adult Tobacco Survey Collaborative Group. *Global Adult Tobacco Survey (GATS): Programmer's Guide to General Survey System*, Version 2.0. Atlanta, GA: Centers for Disease Control and Prevention, 2010.

37. Global Adult Tobacco Survey Collaborative Group. *Global Adult Tobacco Survey (GATS): Data Management Implementation Plan*, Version 2.0. Atlanta, GA: Centers for Disease Control and Prevention, 2010.

38. Global Adult Tobacco Survey Collaborative Group. *Global Adult Tobacco Survey (GATS): Quality Assurance: Guidelines and Documentation*, Version 2.0. Atlanta, GA: Centers for Disease Control and Prevention, 2010.

39. Heatherton T.F., Kozlowski L.T., Frecker R.C., Fagerstrom K.O., *The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire*. British Journal of Addictions 1991;86:1119-27.

40. *Mpower A Policy Package to Reverse Tobacco Epidemic*, WHO 2008, available at: www.who.int/mpower/mpower¬english.pdf.

41. Global Adult Tobacco Survey Collaborative Group. *Global Adult Tobacco Survey (GATS): Sample Design Manual*, Version 2.0. Atlanta, GA: Centers for Disease Control and Prevention, 2010.

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