The Global Tobacco Surveillance System
"Purpose, Production, and Potential"

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INTRODUCTION

> **Public health surveillance is "the ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in the planning, implementation, and evaluation of public health practice" (1).**

In late 1998, the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) convened a meeting of tobacco control experts to discuss the need for a global tobacco surveillance system. At this meeting, two issues became clear. First, adult and youth behavior surveillance systems exist in many developed countries, and many of these systems include information on tobacco. However, few developing countries have such surveillance systems, and little information exists in developing countries about tobacco use by youths. Second, the existing surveillance systems are encumbered by a lack of common methodology, a lack of consistent questionnaire structure and wording, and different populations of interest. These differences make comparisons across countries impossible.

To bridge this information gap and to promote tobacco control at the global level, WHO and CDC developed the Global Tobacco Surveillance System (GTSS) to assist all 192 WHO Member States in collecting data on youth and adult tobacco use. The GTSS is a flexible system that includes common data items but also allows countries to include important unique information, at their discretion, uses a common survey methodology, uses similar field procedures for data collection, and uses similar data management and processing techniques (2). The GTSS includes collection of data for youths (Global Youth Tobacco Survey [GYTS]) and adults (Global School Personnel Survey [GSPS] and Global Health Professional Survey [GHPS]).

This article describes the development and characteristics of GYTS and discusses potential uses of the data. The GYTS provides systematic global surveillance of youth tobacco use. It can be used by countries to:

- enhance capacity to monitor tobacco use among youths

- guide development, implementation, and evaluation of a national tobacco prevention and control program
- allow comparison of tobacco-related data at the national, regional, and global levels

The GYTS uses a standardized methodology for constructing the sampling frame, selecting schools and classes, preparing questionnaires, carrying out field procedures, and processing the data. The GYTS includes data on the prevalence of cigarette and other tobacco use, perceptions and attitudes about tobacco, access and availability of tobacco products, exposure to secondhand smoke, school curricula, media and advertising, and cessation. By capturing factors important in assessing a country's tobacco epidemic and tobacco-related issues and through readministration of the survey every 3 to 4 years, GYTS data can stimulate the development and evaluation of comprehensive tobacco control programs and be a means of assessing progress in meeting program goals.

The GYTS has three components: country training, analysis, and program development. Research coordinators are nominated by the national government and can be from a Ministry, a health institute, a nongovernmental organization, or an academic institution. Training workshops for country research coordinators are held within each of the six WHO Regions (African Region [AFR], Americas Region [AMR], Eastern Mediterranean Region [EMR], European Region [EUR], Southeast Asia Region [SEAR], and Western Pacific Region [WPR]) to ensure that each GYTS is implemented in a standardized manner. After data collection, an analysis workshop is held to instruct research coordinators in the analysis and interpretation of their GYTS data; the workshop includes training in the use of EpiInfo software and the writing of research reports. Once the country reports have been finalized, a program development workshop is held with the goal of developing effective, evidence-based tobacco prevention and control programs (i.e., country tobacco control action plans).

METHODOLOGY

Since 1999, the GYTS has been conducted in 126 of the 192 WHO Member States. The GYTS data used here are weighted estimates for each of the six WHO Regions (3). The data in this

report were processed by CDC and approved by each country's research coordinator. The report includes 38 sites in 24 countries in AFR, 82 sites in 35 countries in AMR, 20 sites in 17 countries and the Gaza Strip/West Bank region in EMR, 25 sites in 22 countries in EUR, 34 sites in 6 countries in SEAR, and 25 sites in 14 countries in WPR (Table 1).

The GYTS uses a two-stage cluster sample design that produces representative samples of students in grades associated with ages 13–15 years. The sampling frame includes all schools containing any of the identified grades. At the first stage, the probability of a school being selected is proportional to the number of students enrolled in the specified grades. At the second stage, classes within the selected schools are randomly selected. All students in the selected classes attending school the day the survey is administered are eligible to participate.

A weighting factor was applied to each student record to adjust for non-response (by school, class, and student) and variation in the probability of selection at the school, class, and student levels. A final adjustment sums the weights by grade and sex to the population of school children in the selected grades each sample site. SUDAAN, a software package for statistical analysis of correlated data, was used to compute 95% confidence intervals (4). Differences between prevalence estimates were considered statistically significant if the 95% confidence intervals did not overlap.

School response rates ranged from 100% to 68.8% by site, student response rates ranged from 99.7% to 56.9%, and the overall response rates ranged from 97.1% to 55.2%. In total, more than 1.3 million students in more than 18,000 schools completed a GYTS. Details of the GYTS methodology and response rates were published previously (5, 6).

The GYTS findings are subject to at least three limitations. First, because the sample of youths surveyed was limited to those who attend school, it may not be representative of all youths aged 13–15 years. However, in most countries, the majority this age group attends regular, private, or technical schools (7). Second, these data apply only to youths in school the day the survey was administered and who actually participated in the survey. However, the median student response rate was 88.2%, and only 5 of the 393 sites had a school response rate less than 80%. Third, the

data are based on self-reports of students, who may under- or overreport their behavior or attitudes. Although the extent of this potential reporting bias cannot be determined, responses to questions about cigarette smoking and other tobacco use (as in the GYTS) have been analyzed and shown to have good test-retest reliability (8).

DATA FROM GYTS

Prevalence

Overall, 1 in 5 students had ever smoked cigarettes; the rate of having ever smoked was highest in AMR (49.4%) and lowest in SEAR (9.9%) (Table 2). Of the students who had ever smoked cigarettes, almost one-fourth started smoking before the age of 10 years; early initiation was highest in EUR and EMR (29.2% and 27.8%, respectively). Overall, 9.8% of students were current smokers (had smoked a cigarette on at least 1 day in the past 30 days); the rate of current smoking was highest in AMR (18.4%) and EUR (16.2%). One in 10 (11.8%) students currently used other tobacco products (e.g., pipes, water pipes, chewing tobacco, bidis, etc); the rate was highest in EMR (13.5%). Among students who had never smoked cigarettes, 17.0% indicated that they were likely to initiate smoking during the coming year; the rate of likely initiation was highest in AMR and EUR (26.1% and 17.9%, respectively).

Exposure to Secondhand Smoke

More than 40% of students had been exposed to tobacco smoke in their homes, and that figure was more than 75% in EUR (Table 2). Five in 10 students reported that they had been exposed to secondhand tobacco smoke in public places; exposure was highest in EUR (83.1%). Nearly 8 in 10 students thought that smoking should be banned from public places (more than three-fourths of students in all regions except AFR, where the percentage was 57.1%).

School Curriculum

In all regions except EMR (42.7%) and AMR (46.0), more than one-half of the students were taught in school about the dangers of smoking (Table 2). However, only 30% to 40% of students had discussed in class the reasons people their age smoke (48.8% in WPR).

Media and Advertising

Approximately 9 in 10 students in all regions reported having seen actors smoke on television, in videos, or in movies during the past month (Table 2). About one-half of the students had seen pro-cigarette ads on billboards (56.5%), in newspapers and magazines (48.8%), or at sporting events (40.4%) in the past month. Exposure on billboards was highest in AMR and WPR (81.4% and 81.1%, respectively). More than 6 in 10 students in AFR, AMR, EMR, and WPR were exposed to pro-cigarette ads in newspapers and magazines. Exposure at sporting events was highest in WPR (73.4%) and AMR (79.3%). Almost 1 in 5 students (17.3%) owned an object with a cigarette brand logo on it. This percentage was highest in AMR (19.2%) and was more than 10% in all regions.

Cessation

Overall, 69.2% of students who were current smokers stated that they desired to stop smoking, and 65.1% indicated that they had tried to stop smoking during the past year but had failed (Table 2). Eight in 10 current smokers in WPR (82.7%) and 7 in 10 in AFR (71.2%) and SEAR (71.1%) desired to stop smoking. Seven in 10 current smokers stated that they had received help in the past to stop smoking; more than 8 in 10 in WPR and SEAR stated that they had. Among current smokers, 9.0% indicated a strong dependency on cigarettes (i.e., they had or felt like having a cigarette first thing in the morning).

Access and Availability

Overall, 4 in 10 students who were current smokers could purchase cigarettes in stores (Table 2). The rate was highest in SEAR and EUR (61.6% and 55.1%, respectively) and lowest in AMR

(22.3%). Almost 7 in 10 students who bought cigarettes in a store were not asked to show proof of age; the rate was lowest in WPR (52.4%). One in 10 students had been offered free cigarettes; the rate was highest in EMR and AFR (13.4% and 12.8%, respectively) and lowest in WPR (7.4%)

POTENTIAL OPPORTUNITIES

Establishing GTSS

In March 1999, 11 countries (Barbados, China, Fiji, Jordan, Poland, Russian Federation, South Africa, Sri Lanka, Ukraine, Venezuela, and Zimbabwe) accepted the challenge of pilot testing the first GYTS. All 11 countries completed successful GYTSs during 1999. After this initial success, many countries asked WHO and CDC for assistance in participating in GYTS. As of early 2004, 126 of the 192 WHO Member States had completed the GYTS, 19 others are currently in the field, and 13 new countries will be trained during 2004–2005. Twenty-five countries have completed repeat GYTSs, and 17 others are in the field with their repeat. All six WHO regions and the countries within each of the regions have realized the importance of the GYTS and the need to establish the GYTS as the cornerstone of the GTSS.

In February 2000, during a GYTS workshop in Goa, India, the idea was raised of collecting data on school policy and curricula regarding tobacco control and use by personnel in schools selected for the GYTS. Research coordinators attending the workshop drafted a questionnaire for the Global School Personnel Survey (GSPS), and a methodology for data collection was determined. The GSPS was pilot tested in six states in India during 2000 (9) and has since been completed in more than 40 countries (including 25 states in India) and repeated in 20 countries.

During 2004, WHO and CDC held two meetings to discuss the feasibility of developing and implementing a survey of health professionals. Consensus was reached to pilot- test the Global Health Professional Survey (GHPS) in one country in each of the six WHO regions during 2004–2005. The GHPS will collect information on tobacco use from third-year students attending either dental, medical, nursing, or pharmacy school.

These three surveys—the GYTS, GSPS, and GHPS—form the core of the GTSS developed to date by WHO and CDC. Countries have embraced the GTSS as providing data crucial for monitoring and evaluating tobacco control programs. Countries and research partners are conducting a variety of data dissemination efforts through publications, presentations, and an active GTSS Web site hosted by CDC. Country GYTS reports and country fact sheets are now available on the GTSS Web site (10). More importantly, many countries have used GTSS data to inform politicians about the tobacco problem in their country, a result that has led to new policy decisions to prevent and control tobacco use (11).

Monitoring Country Action Plans

Country Action Plans are developed by governments to provide clear strategies for reducing and controlling tobacco use. A comprehensive tobacco control program generally includes public education campaigns to counteract tobacco advertising, community-based programs to reduce tobacco use, cessation-assistance programs, school-based programs, enforcement of existing tobacco restrictions, monitoring and evaluation of the control program, and related policy efforts to support the program, such as increased excise taxes, chronic disease programs targeting tobacco-related health problems, and environmental tobacco smoke restrictions. GTSS can provide countries with valuable feedback to evaluate and improve Country Action Plans and to develop plans where none exists.

Monitoring the WHO Framework Convention for Tobacco Control

The WHO Framework Convention for Tobacco Control (FCTC), adopted by the fifty-sixth World Health Assembly in May 2003, is the world's first public health treaty on tobacco control. The FCTC provides the driving force and blueprint for the global response to the pandemic of tobacco-induced death and disease. The convention embodies a coordinated, effective, and urgent action plan to curb tobacco consumption, laying out cost-effective tobacco control strategies on population-wide public policies, such as bans on direct and indirect tobacco advertising, tobacco taxes and price increases, smoke-free environments in all public places and

workplaces, and large, clear, graphic health messages on tobacco packaging. In addition, the convention encourages countries to address cross-border issues, such as illegal trade and duty-free sales (12). One important feature of the WHO FCTC is the call for countries to establish programs for national, regional, and global surveillance.

> ***Research, surveillance and exchange of information – The parties shall establish, as appropriate, programmes for national, regional and global surveillance of the magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke. Towards this end, the Parties should integrate tobacco surveillance programmes into national, regional and global health surveillance programmes so that data are comparable and can be analyzed at the regional and international levels, as appropriate.(12)***

The WHO FCTC and GTSS share the same goal: the development, implementation, and evaluation of effective tobacco control programs in all WHO Member States. What the WHO FCTC asks countries to monitor, the GYTS, GSPS, and GHPS can help to measure. As illustrated in Table 3, the three surveys are valuable instruments because they provide indicators for measuring achievement of seven WHO FCTC articles (surveillance and monitoring, prevalence, exposure to secondhand smoke, school-based tobacco control, cessation, media and advertising, and minor's access and availability). The WHO FCTC calls for countries to use consistent methods and procedures in their surveillance efforts. The three surveys were designed for exactly this purpose (i.e., the sampling procedures, core questionnaire items, training in field procedures, and analysis of data are consistent across all survey sites).

The WHO FCTC also requires countries to be able to monitor the treaty's application. The GTSS helps each country establish applied research in public health and contributes to establishing continuous tobacco control surveillance and monitoring. The FCTC also contributes to strengthening the leadership capacity of the Ministry of Health and other state health bodies responsible for tobacco control, not only in terms of public health advocacy, but also in negotiations with other sectors with respect to tobacco control. The GTSS also enhances the role

of the nongovernmental sector by supporting civil society participation in surveillance, monitoring, and policy and program development.

CONCLUSION

Tobacco use is the single greatest preventable cause of death worldwide. Every year, nearly 5 million persons die from tobacco-related illnesses, and this number is expected to more than double by 2030 (13). The WHO FCTC is the first international treaty directed toward the control of tobacco use. The GTSS is the most comprehensive tobacco surveillance system that has ever been developed and implemented. The synergy between the WHO FCTC and the GTSS offers countries a unique opportunity to develop, implement, and evaluate comprehensive tobacco control programs that both stand alone and stand up to global and regional comparisons.

Table 1: Global Youth Tobacco Survey sites included in the present report

AFR	AMR	EMR	EUR	SEAR	WPR
Benin – 2003	Antigua &	Bahrain - 2001	Albania - 2003	India – 2000	Cambodia - 2003
- Atlantique - Littoral	Barbuda - 2000	Djibouti - 2003	Belarus - 2003	- Arunchal Pradesh	China – 1999
- Borgou – Alibori	Argentina – 2003	Egypt - 2001	Bosnia &	- Assam	- Chongqing
Botswana - 2002	- Buenos Aires	Gaza Strip/West	Herzegovina – 2003	- Bihar	- Guangdong
Burkina Faso - 2001	- Federal District	Bank – 2001	- Federation BiH	- Goa	- Shandong
- Ouagadougou	Bahamas - 2000	- Gaza Strip	- Republika Srpska	- Maharashtra	- Tianjin
Cote d'Ivoire – 2003	Barbados - 2002	- West Bank	Bulgaria - 2002	- Manipur	China – 2001
- Abidjan	Belize - 2003	Islamic Republic	Croatia - 2002	- Meghalay	- Macau (SAR)
- Ville Sud	Bolivia – 2003	of Iran – 2003	Czech Republic - 2002	- Mizoram	Cook Islands - 2003
Ethiopia – 2003	- Cochabamba	Jordan - 2003	Estonia - 2002	- Nagaland	Federated States
- Addis Ababa	- El Alto	Kuwait – 2001	FYR Macedonia - 2002	- Sikkim	of Micronesia - 2000
Ghana - 2000	- La Paz	Lebanon - 2001	Georgia - 2002	- Tamil Nadu	Fiji - 1999
Kenya – 2001	- Santa Cruz	Libyan Arab	Hungary - 2002	- Tripura	Guam - 2002
Lesotho – 2002	Brazil – 2002	Jamahiriya - 2003	Kazakhstan - 2003	- West Bengal	Laos – 2003
Malawi – 2001	- Alagoas	Morocco - 2001	Kyrgyzstan - 2003	India – 2001	- Luang Prabang
- Blantyre	- Aracaju	Oman - 2003	Latvia - 2002	- Andra Pradesh	Province
- Lilongwe	- Boa Vista	Pakistan – 2003	Lithuania - 2001	- Delhi	- Savannakhet
Mali – 2001	- Curitiba	- Islamabad	Poland - 2003	India – 2002	- Vientiane
- Bamako	- Espirito Santo Vitoria	- Lahore	Republic of Moldova -	- Orissa	Municipality
Mauritania – 2001	- Fortaleza	Saudi Arabia – 2001	2003	- Uttar Pradesh	- Vientiane Province
Mauritius – 2003	- Goiania	- Riyadh	Russian	- Uttranchal	Malaysia – 2003
- Country Total	- Matto Grosso do Sul	Sudan - 2001	Federation – 1999	India – 2003	Mongolia - 2003
- Rodriquez	- Paraiba	Syrian Arab	- Moscow	- Gujarat	Northern

Mozambique – 2002	- Rio Grande do Norte	Republic - 2002	Russian Federation –	- Karnataka	Mariana
- Gaza Inhambe	- Rio Grande do Sul	Tunisia - 2001	2002	- Rajasthan	Islands - 2000
- Maputo City	- Tocantins	United Arab	- Sarov	India – 2004	Palau - 2000
Niger - 2001	British Virgin	Emirates - 2001	Serbia &	- Ahmedabad	Philippines – 2004
Nigeria – 2001	Islands - 2001	Yemen – 2002	Montenegro – 2003	- Chandigarh	Singapore - 2000
- Cross River State	Chile – 2003		- Montenegro	- Haryana	Viet Nam – 2003
Senegal – 2002	- Concepion		- Serbia	- Himichal Pradesh	- Haiphong
Seychelles - 2002	- Coquimbo		Slovakia - 2002	- Madhya Pradesh	- Hanang
South Africa – 2002	- Santiago		Slovenia - 2003	- Punjab	- Hanoi
Swaziland – 2001	- Valparaiso		Turkey - 2003	Indonesia – 2003	- Hochiminh
Tanzania – 2003	Colombia – 2001		Ukraine – 1999	- Bekasi	- Tuenquang
- Arusha	- Bogota		- Kiev	- Jakarta	
- Dar es Salaam	Costa Rica - 2002			Maldives – 2003	
- Kilimanjaro	Cuba – 2001			- Urban	
Togo – 2002	- Havana			Myanmar - 2001	
Uganda - 2002	Dominica - 2000			Nepal – 2003	
- Arua	Ecuador – 2001			- Biratnagar	
- Kampala	- Guayaquil			- Mahendranagar and	
- Mpigi	- Quito			Dhanga	
- Rest of Central	- Zamora			Sri Lanka - 2003	
Zambia – 2002	Grenada - 2004				
- Chongwe Luangwa	Guatemala – 2002				
- Lusaka	- Chimal Tenago				
- Kafue	- Guatemala City				
Zimbabwe – 2003	Guyana - 2004				
- Harare	Haiti – 2001				
- Manicaland	- Port-au-Prince				

- Matebeleland & Bulawayo	Honduras – 2003 - San Pedro Sula la Ceiba - Tegucigalpa Jamaica - 2001 Mexico – 2000 - Monterrey Mexico – 2003 - Chetumal - Cuernavaca - Guadalajara - Juarez - Mexico City - Nuevo Laredo - Oaxaca - Puebla - Tapachula - Tijuana Montserrat - 2000 Nicaragua - 2003 Panama - 2002 Paraguay – 2003 - Alto Parana - Amambay - Asuncion - Central Peru – 2003				

	St. Kitts & Nevis - 2002 St. Lucia - 2001 St. Vincent & The Grenadines - 2001 Suriname - 2000 Trinidad & Tobago - 2000 United States - 2000 Uruguay – 2001 - Colonia - Maldonado - Montevideo - Rivera Venezuela – 2000 - Barinas Venezuela – 2001 - Tachira - Yaracuy Venezuela – 2002 - Zulia Venezuela – 2003 - Cojedes - Crespo - Lara - Monagas - Nueva Esparta				

	Virgin Islands (Am) – 2004				

AFR, African Region; AMR, Americas Regio; EMR, Eastern Mediterranean Region; EUR, European Region; SEAR, Southeast Asia Region; WPR, Western Pacific Region.

Table 2. Global Youth Tobacco Survey (GYTS) Measures by WHO Framework Convention for Tobacco Control (FCTC) Article and WHO Region

WHO FCTC Articles/ GYTS Measures	WHO Regions						
	TOTAL	**AFR**	**AMR**	**EMR**	**EUR**	**SEAR**	**WPR**
Prevalence: Article 21							
- Percent ever smoked cigarettes	26.1	22.9	49.4	14.8	44.1	9.9	30.3
- Percent ever smokers who initiated smoking before age 10	23.1	24.9	20.4	27.8	29.2	19.0	18.3
- Percent current cigarette smokers	9.8	9.8	18.4	4.1	16.2	4.5	11.8
- Percent currently use other tobacco products	11.8	11.3	12.5	13.5	6.2	12.9	7.0
- Percent never smokers likely to initiate smoking next year	17.0	16.3	26.1	11.0	17.9	16.6	11.3
Exposure to Secondhand Smoke: Article 8							
- Percent exposed to smoke from others at home	42.7	30.3	43.1	39.1	75.5	37.5	43.2
- Percent exposed to smoke from others in public places	53.2	45.2	58.5	47.4	83.1	49.6	45.4
- Percent who think smoking should be banned from public places	78.0	57.1	76.9	86.6	83.3	75.8	82.1
School: Article 12							
- Percent taught dangers	52.5	57.4	46.0	42.7	57.5	52.8	69.8

of smoking							
- Percent who discussed reasons people their age smoke	35.7	38.0	30.8	32.4	37.2	34.8	48.8
- Percent taught about the effects of smoking	46.5	57.4	39.6	34.3	48.6	48.5	60.3
Media and Advertising: Article 13							
- Percent who saw actors smoking on TV, in videos, or in movies in past month	93.2	87.4	92.8	95.6	92.0	96.3	94.3
- Percent who saw ads for cigarettes on billboards in past month	56.5	66.8	81.4	62.3	56.0	43.2	81.1
- Percent who saw ads for cigarettes in newspapers or magazines in past month	48.8	66.1	74.7	60.8	54.7	30.3	69.4
- Percent who saw ads for cigarettes at sporting events in past month	40.4	66.4	79.3	60.6	64.4	14.6	73.4
- Percent who have an object with a cigarette brand logo on it	17.3	18.6	19.2	15.9	16.7	10.9	14.3
Cessation and Dependency: Article 14							
- Percent current smokers who desire to stop smoking	69.2	71.2	69.8	62.9	59.8	71.1	82.7
- Percent current smokers who tried to stop smoking during the past year	65.1	71.5	57.1	62.2	70.9	73.3	85.8
- Percent current smokers who received help to stop smoking	73.9	73.9	65.8	77.1	63.2	84.7	89.6

- Percent current smokers who have or feel like having a cigarette first thing in the morning	9.0	15.2	6.5	16.0	10.8	4.0	5.3
Minor's Access and Availability: Article 16							
- Percent current smokers who usually buy their cigarettes in a store	38.0	45.2	22.3	38.4	55.1	61.6	54.1
- Percent current smokers who buy their cigarettes in a store and who were not refused purchase because of their age	65.4	65.7	66.9	75.8	76.5	55.7	52.4
- Percent who have been offered "free" cigarettes by a tobacco company representative	9.8	12.8	10.9	13.4	8.4	8.4	7.4

AFR, African Region; AMR, Americas Region; EMR, Eastern Mediterranean Region; EUR, European Region; SEAR, Southeast Asia Region; WPR, Western Pacific Region.

Table 3. Global Youth Tobacco Survey (GYTS), Global School Personnel Survey (GSPS), and Global Health Professional Survey (GHPS) Measures That Can Be Used to Monitor the WHO Framework Convention for Tobacco Control (FCTC)

WHO FCTC Article	GYTS Measures	GSPS Measures	GHPS Measures
Article 20: Research, surveillance and exchange of information 2: The Parties shall establish, as appropriate, programmes for national, regional and global surveillance of the magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke. Towards this end, the Parties should integrate tobacco surveillance programmes into national, regional and global health surveillance programmes so that data are comparable and can be analysed at the regional and international levels, as appropriate.	GYTS was developed by WHO Headquarters, WHO Regional Officers, and CDC was initiated in 1999. To date, 112 countries have completed their initial GYTS, 35 are currently preparing to conduct the survey, and 18 are scheduled for initial training in 2003-2004. Also, 5 countries have repeated the GYTS once, 19 are preparing for their first repeat, and 8 will be re-trained for their first repeat in 2003.	GSPS was developed by WHO Headquarters, WHO Regional Officers, and CDC was initiated in 2000. To date, the GSPS has been conducted in 15 countries, the Gaza Strip/West Bank, and 25 states in India.	GHPS is being developed by WHO Headquarters, WHO Regional Officers, and CDC will be pilot tested in each of the six WHO Regions during 2004-2005.
<u>Prevalence</u> Article 21: Reporting and exchange of information 1: Each Party shall submit to the Conference of the Parties, through the Secretariat, periodic reports on its implementation of this Convention, which should include the following: (d) information on surveillance and research as specified in Article 20 (Research, surveillance and exchange of information)	- Ever smoked cigarettes - Initiated smoking before age 10 - Current cigarette smoking - Current other tobacco use - Never smokers, likely to initiate smoking in the next year	- Ever smoked cigarettes - Currently smoke daily or occasionally - Ever used other tobacco products - Currently use other tobacco products daily or occasionally	- Ever smoked cigarettes - Current cigarette smoking - Current other tobacco use
<u>Exposure to Secondhand Smoke</u> Article 8: Protection from exposure to tobacco smoke	- Exposed to smoke from others in their home - Exposed to smoke from others in public	- Smoke from others annoys them	- Exposed to smoke from others in their home - Exposed to smoke from others in public

2: Each Party shall adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.	places - Think smoking should be banned from public places		places - Think smoking should be banned from public places - Definitely think smoke from others is harmful to them
<u>School</u> Article 12: Education, communication, training and public awareness Each Party shall promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate. Towards this end, each Party shall adopt and implement effective legislative, executive, administrative or other measures to promote: (f) public awareness of and access to information regarding the adverse health, economics, and environmental consequences of tobacco production and consumption.	- During past year in school, students were taught about dangers of smoking - During past year in school, students discussed reasons people their age smoke - During past year in school, students were taught about the effects of smoking	- School has a policy specifically prohibiting tobacco use among students and/or teachers - School has a policy declaring it "tobacco free" - School enforces its tobacco policy - Anti-tobacco materials available - Received training	- Past year, were taught about dangers of smoking - Past year, discussed reasons people their age smoke - Past year, were taught about the effects of smoking - School has a policy specifically prohibiting tobacco use among students and/or teachers - School has a policy declaring it "tobacco free" - School enforces its tobacco policy
<u>Media and Advertising</u> Article 13: Tobacco advertising, promotion and sponsorship 1: Parties recognize that a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products	- During the past month, saw actors smoking on TV, in videos, or in movies - During the past month, saw ads for cigarettes on billboards - During the past month, saw ads for cigarettes in newspapers or magazines - During the past month, saw ads for cigarettes at sporting events, fairs, concerts, or		- During the past month, saw ads for cigarettes on billboards - During the past month, saw ads for cigarettes in newspapers or magazines - During the past month, saw ads for cigarettes at sporting events, fairs, concerts, or community events - Saw cigarette brand names at sporting events

	community events - Have an object with a cigarette brand logo on it		or on TV - Have an object with a cigarette brand logo on it
Cessation Article 14: Demand reduction measures concerning tobacco dependence and cessation 1: Each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence	- Current smokers who desire to stop smoking - Current smokers who tried to stop smoking during the past year - Current smokers who ever received help or advice from a program or professional to help them stop smoking - Current smokers who have or feel like having a cigarette first thing in the morning	- Current smokers who ever received help or advice from their school to stop using tobacco	- Current smokers who desire to stop smoking now - Current smokers who tried to stop smoking during the past year - Current smokers who ever received help or advice from a program or professional to help them stop smoking - Current smokers who have or feel like having a cigarette first thing in the morning
Minor's Access and Availability Article 16: Sales to and by minors 1. Each Party shall adopt and implement effective legislative, executive, administrative or other measures at the appropriate level to prohibit the sales of tobacco products to persons under the age set by domestic law, national law or eighteen. 2. Each Party shall prohibit or promote the prohibition of the distribution of free tobacco products to the public and especially minors	- Current smokers who usually get their cigarettes by buying them in a store, in a shop, or from a street vendor - Current smokers who were not refused purchase of cigarettes because of their age - Students who were offered "free" cigarettes by a cigarette company representative		- Has a (cigarette representative) ever offered you a free cigarette?

CDC, Centers for Disease Control and Prevention.

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