

# NEW HAMPSHIRE TOBACCO DATA

## 2000-2007

New Hampshire Department of Health and Human Services  
Division of Public Health Services  
Bureau of Prevention Services  
Tobacco Prevention and Control Program



t • p • c • p

NH Tobacco Prevention & Control Program

Live **Tobacco** Free or Die

# New Hampshire Tobacco Data

2000-2007

---

**John H. Lynch, Governor**

**Nicholas Toumpas, Commissioner**  
Department of Health and Human Services

**Josè Thier Montero, Director**  
Division of Public Health Services

*Prepared By:*  
Aparna Nepal, M.A.  
New Hampshire Department of Health and Human Services  
Division of Public Health Services  
Bureau of Prevention Services  
Tobacco Prevention and Control Program  
September 2008

*For additional information on New Hampshire Tobacco Data, 2000-2007:*  
New Hampshire Department of Health and Human Services  
Division of Public Health Services  
Bureau of Prevention Services  
Tobacco Prevention and Control Program  
29 Hazen Drive, Concord, New Hampshire 03301-6504  
Phone: 603-271-6891 or 1-800-852-3345 ext. 6891  
TDD Access: 1-800-735-2964



---

THIS WORK IS SUPPORTED BY GRANT NUMBER U58/CCU122787 FROM CENTERS FOR DISEASE CONTROL AND PREVENTION.

**SUGGESTED CITATION:**

*NEW HAMPSHIRE TOBACCO DATA 2000-2007*; NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH SERVICES, BUREAU OF PREVENTION SERVICES; TOBACCO PREVENTION AND CONTROL PROGRAM.

## TABLE OF CONTENTS

---

CONTENTS		Page Number
Message from the Director.....		1
Executive Summary.....		2
Introduction.....		4
Frequently Asked Questions.....		6
Analytical Methods.....		8
<b>Data</b>		
<b>Healthy People Tobacco Use National Health Objective 2010.....</b>		9
<b>Adult Tobacco Use.....</b>		11
Cigarette Smoking.....		11
New Hampshire College Students.....		23
Adult Use of Other Tobacco Products.....		26
<b>Tobacco Use During Pregnancy.....</b>		27
<b>Youth Tobacco Use National Health Objective 2010.....</b>		34
Youth Cigarette Smoking.....		36
Youth Use of Other Tobacco Products.....		38
Youth Access to Tobacco and Compliance Checks.....		43
Tobacco Prevention in NH Schools.....		46
<b>Initiation.....</b>		49
<b>Cessation</b>		
Adult Cessation.....		53
Youth Cessation (High School).....		59
“1-800-QUIT NOW” National Quitline Data for New Hampshire.....		60
“1-800-Try-To-STOP” New Hampshire Smokers’ Helpline Data.....		62
Media – The Ex Campaign.....		63
<b>Secondhand Smoke Exposure</b>		
Smoke Free Policies.....		64
Smoke Free Homes.....		65
Adult Exposure to Secondhand Smoke.....		70
Youth Exposure to Secondhand Smoke.....		71
<b>Economic Facts about Tobacco in NH</b>		
Cigarettes Sale.....		72
Cigarette Tax.....		74
Other Tobacco Tax.....		77
Revenue.....		78
Tobacco Marketing and Media.....		85
<b>Health Consequences of Smoking and Tobacco Use.....</b>		87
Smoking-Attributable Mortality from Selected causes.....		88
<b>Tobacco Prevention and Control Community Coalitions.....</b>		94
<b>Data Sources</b>		
Surveys.....		95
Vital Statistics and Cancer Registry Data.....		98
Other Sources of Data.....		99
<b>Contributors/Reviewers.....</b>		102
<b>Appendices</b>		
A. State Law on Tobacco Sales to Minors.....		103
B. Indoor Smoking Act.....		105
C. Tobacco Prevention Community Coalitions.....		110
D. Acronyms.....		112
<b>References.....</b>		113

## MESSAGE FROM THE DIRECTOR

---

Tobacco use is the most preventable cause of disability and death among residents of New Hampshire and the Nation. According to the Institute of Medicine, 2007, *Ending the Tobacco Problem: A Blue Print for the Nation*, deaths associated with smoking and secondhand smoke account for more deaths than: AIDS, alcohol, cocaine and heroine use, homicides, suicides, motor vehicle crashes and fires combined.

Each year in New Hampshire, an estimated 1,764 people die from smoking related illness. An estimated 198,300 New Hampshire adults currently smoke, and many have serious illnesses such as heart disease, lung cancer, and chronic obstructive pulmonary disease, caused by this addiction. For every person who dies from smoking, 20 more people suffer from at least one serious, tobacco-related illness. Despite these risks, approximately 20 percent of U.S. adults smoke cigarettes.

This report on tobacco use in New Hampshire provides comprehensive information and describes the human and economic cost. Youth tobacco use and smoking prevalence has leveled off in NH's youth. In other words, it is no longer on the decline. Water pipe and cigar smoking, and chew tobacco use are on the rise, a trend that demonstrates a need for intervention and surveillance. Adult smoking rates have reached a plateau as well. We must further enhance our efforts, and implement a statewide comprehensive tobacco prevention and control program in order to further reduce the burden of this health crisis in our State.

The Department of Health and Human Services primary goal is to improve the health of the residents of New Hampshire. With assistance from the Centers for Disease Control and Prevention, the State of New Hampshire is working to reduce the toll of tobacco use by educating our residents and providing tools to help those willing to quit. The Department has set ambitious goals in our Healthy New Hampshire 2010 initiative to enhance the public health of our state. To meet these goals, information in reports such as this is invaluable.

I would like to thank the Tobacco Prevention and Control Program for their work in providing a comprehensive report on tobacco use and its health effects. The Department's public health staff has done an excellent job in developing this report and identifying both our success and areas where we must continue to work.

**Josè Thier Montero, Director**  
Division of Public Health Services  
Department of Health & Human Services  
State of New Hampshire

## EXECUTIVE SUMMARY

---

Tobacco use is the leading preventable cause of death in the United States.<sup>i</sup> According to a recent Surgeon General's Report, 70% of smokers want to quit every year, roughly half of them try, and most fail. An estimated 198,300 New Hampshire adults currently smoke cigarettes and of those who smoke everyday 59% tried to quit smoking in the past year and yet only 30% have reported being a former smoker. Smoking among adult men and women declined substantially following the first Surgeon General's Report on smoking in 1964. The trend data presented in this report from 2000 onwards shows that the percent of adults who smoke in New Hampshire has continued to decline but at a lower rate than in previous years. Smoking continues to be strongly associated with educational attainment, income, age and gender. Men are more likely to be cigarette smokers than women. Currently 20.1% of men and 18.6% of women report that they smoke cigarettes. Young adults are more likely to be cigarette smokers than older adults. The current survey data shows that 23.2% of New Hampshire young adults (18-24 years-old) smoked compared to 8.5% of persons aged 65 years or older. The prevalence of smoking decreased as educational level increased. Forty three percent of adults without a High School diploma were current smokers compared to 9.8% of college graduates. Adults with lower incomes were more likely to smoke than those with higher incomes. Current survey data shows that 38.4% of adults with a household income less than \$15,000 smoked compared to 13.7% of adults with a household income of \$50,000 or more. There are some regional variations across the state in regards to smoking prevalence. However because only two years of county level prevalence estimates were available at the time of this analysis, this data was not adequate to indicate significance for regional variation.

Cigarette smoking during pregnancy is a risk factor for poor birth outcomes. Smoking during pregnancy contributes to elevated risks of miscarriage, premature delivery, and having a low-birth weight and a pre-term baby. In 2005, 26.8% of NH women in the childbearing population, aged 18-44, smoked cigarettes. In that same year, the proportion of mothers aged 18-24, who smoked cigarettes during pregnancy remained higher than for mothers of other ages. Seventeen percent of New Hampshire women who gave birth in 2005 reported using tobacco while pregnant.

Priority health-risk behaviors, which contribute to the leading causes of morbidity and mortality among youth and adults, often are established during childhood and adolescence, extend into adulthood, are interrelated, and are preventable.<sup>ii</sup> Even occasional smoking among school-aged students is important to monitor because many occasional smokers transition into regular smokers in the years after they graduate from High School. Tobacco use among youth is measured and monitored through a school-based survey administered in High Schools and Middle Schools by the New Hampshire Department of Health and Human Services (DHHS). Preventing smoking among teenagers and providing tobacco treatment services is critical to address and prevent the likelihood of tobacco dependence among the state's younger population since smoking usually begins in adolescence. Based on the 2007 Youth Tobacco Survey (YTS), 39% of New Hampshire High School students and 11.2% of Middle School students reported trying cigarette smoking and 16.8% of High School students and 0.3% of Middle School students reported currently smoking. Male students were more likely to have smoked than female students. Currently 19.7% of male High School students smoke compared to 13.4% of female students. Surveys that collect tobacco data shows a decrease in cigarette smoking with increasing use of other tobacco products such as spit tobacco, pipes, *bidis* and cigars. Currently 7% of NH High School students reported using smokeless tobacco, 13.6% reported using cigars and 5.1% reported using pipe tobacco.

The NH Higher Education, Alcohol and Other Drug survey administered by the NH Higher Education Alcohol and Other Drug Committee (NHHEAOD) in collaboration with the University of New Hampshire (UNH), provides data related to tobacco use among college students. In 2005, 17.4% of college students reported smoking. Additionally, the Synar survey monitors retail access to tobacco by the underage population. Non-compliance with youth access laws (Appendix A) by tobacco retailers was 7.6% in 2000 and 10.2% in 2008 as measured by the NH Synar survey.

The Centers for Disease Control and Prevention (CDC) estimates that if the current smoking trends continue, 31,000 youth under age 18 in NH could die prematurely from tobacco-related disease.<sup>iii</sup> Sixteen disease categories have been identified to be associated with cigarette smoking. As the leading cause of preventable death and disease in the United States, smoking is associated with a significantly increased risk of heart disease, stroke, lung cancer, and chronic lung diseases. The average annual number of smoking-related deaths in New Hampshire in 2005 was 1,764, accounting for 17% of all deaths in the state during that year.

Some of the health economic data presented in this report are the state health expenditure and revenue data from the tobacco tax. Costs of medical expenditures and lost productivity in NH due to smoking are approximately \$969 million annually.<sup>iv</sup> Total tobacco industry expenditures for advertising and marketing of tobacco products in New Hampshire were approximately \$128 million in 2005. The average retail price of a pack of cigarettes in New Hampshire is currently \$4.19 compared to \$3.58 in 2003.

In 2006, 8.9% of adults reported that smoking was allowed in some enclosed public areas in their workplace and 5% reported having no official policy regarding smoking. Dramatic strides have been made over the past 20 years to reduce non-smokers' exposure to secondhand smoke (SHS); the recent amendment to the Indoor Smoking Act (ISA) was a giant step forward for New Hampshire in protecting the people and children of this State from secondhand smoke exposure. In September 2007 the ISA was passed, which prohibited smoking in enclosed areas in cocktail lounges and restaurants and public areas. (Appendix B) The ISA has protected about 43,800 NH restaurant and bar workers from exposure to SHS.

This document is the fourth compilation and review of current available data on tobacco use, health impacts, behaviors, knowledge and attitudes of New Hampshire residents. The Tobacco Prevention and Control Program (TPCP) plans to release the tobacco data book on a 2-3 year cycle and will also publish issue briefs in between these intervals. The data can be used in several ways to understand the extent of tobacco use in New Hampshire and in order to: 1) document the magnitude of the public health problem; 2) monitor trends over time; 3) detect changes in health care practices; 4) evaluate prevention strategies; and 5) facilitate strategic planning. Data is current as of December 2007.

When appropriate, the tobacco-related long-term objectives from *Healthy People 2010*, a set of national health targets for the decade, are included. The data in this report can be used in assessing progress towards meeting *Healthy People 2010* tobacco related objectives along with the goals of the TPCP.

## INTRODUCTION

---

Smoking is considered as a risk factor and a health behavior that has a significant effect on health outcomes. As a leading preventable cause of death and disease in New Hampshire, smoking is associated with significantly increased risk of lung cancer, heart disease, emphysema, and other respiratory diseases.<sup>v</sup> The Surgeon General's Report, *On the Health Consequences of Smoking*, states that smoking harms nearly every organ in the body and half of all long-term smokers die prematurely from smoking-related diseases. The 2006 report of the Surgeon General, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, states that secondhand smoke (SHS) is causing premature death and disease in children and adults who do not smoke. The major health risk from smoking is related to the chemicals found in cigarette smoke (inhaled, exhaled and sidestream). Tobacco smoke is a vastly complex mixture of more than 4,000 chemicals (including formaldehyde, cyanide, carbon monoxide, ammonia, and nicotine), many of which are known carcinogens. Research indicates that smokers die 13 to 14 years earlier than non-smokers.<sup>vi</sup>

Data from California, Florida, Massachusetts, Oregon and Texas has identified effective tobacco control interventions that are shown to decrease initiation of tobacco use and increasing quitting tobacco attempts. The recommended evidence based interventions to achieve substantial reductions in tobacco use include: increasing the unit price for tobacco, mass media campaigns in combination with other interventions, community mobilization and restriction of tobacco access to minors. Additional recommended interventions include: effective cessation therapies, multicomponent interventions (e.g., patient education, individual or group counseling, or nicotine replacement therapies) that include telephone quitlines, and health-care system changes (e.g. health care provider reminder systems). New Hampshire's Tobacco Prevention and Control Program (TPCP) goals are to: prevent initiation of tobacco use among young people, eliminate non-smokers' exposure to secondhand smoke, promote smoking cessation among adults and young people and identify and eliminate tobacco-related disparities. TPCP implements comprehensive tobacco control strategies recommended by the Centers for Disease Control and Prevention (CDC) Best Practices. These strategies include state and community interventions, health communication interventions, cessation interventions, surveillance and evaluation and administrative and management infrastructure.

To accomplish these goals, the TPCP program works in partnership with the Bureau of Prevention within the Department of Health and Human Services (DHHS) and with other state and national partners, which include: Breathe NH, NH Hospital Systems, NH Medicaid, NH Citizen's Health Initiative, NH insurance companies, NH Bureau of Liquor Commission (BLE), American Cancer Society, American Lung Association, Campaign for Tobacco-Free Kids, American Legacy Foundation, American Heart Association, other state Health Departments, CDC's Office on Smoking and Health (OSH) and Substance Abuse & Mental Health Services Administration (SAMSHA). Additionally, there are 13 community-based coalitions (Appendix C) that are currently being funded at the local level. TPCP funds and manages local coalition contracts for administering work plans that promote program goals. Collaborating with multiple local, state, and national organizations and agencies assists TPCP in reaching 2010 national objectives for decreasing the health burden and economic impact of tobacco-related diseases. A significant initiative for TPCP is sustaining the New Hampshire Try-To-STOP TOBACCO Resource Center. The four components of this important resource to NH residents include: The New Hampshire Smokers' Helpline, cost free and confidential telephonic tobacco treatment counseling (1-800-Try-To-STOP); [QUITWORKS-NH](#), an on-line primer available to all healthcare providers that implements best practices in tobacco treatment, utilizing the 5-A's model, and offers a direct referral by fax opportunity for any patient who is

interested in quitting tobacco; a print material resource library for mail-orders; and [www.trytostopnh.org](http://www.trytostopnh.org), a website dedicated to the Resource Center's information and for NH residents investigating quitting through an on-line resource or who are interested in receiving tobacco treatment counseling.

## FREQUENTLY ASKED QUESTIONS

---

*Why is data not presented by race or ethnicity?*

Based on the 2000 United States Census, New Hampshire's population is approximately 96.0% white, 1.3% Asian, 0.7% African American, 0.2% American Indian, and 0.6% persons reporting other cultural backgrounds. About 1.7% of the multi-cultural population is of Hispanic or Latino origin and no single racial or ethnic minority group exceeds 1.7% of the total population. The available tobacco-related data set for these groups is too small for analysis. Analyzing and presenting data on racial and ethnic minorities in the future depends on future census showing changes in NH's demographics as well as improvements in data collection techniques.

*Why is so much emphasis given to secondhand smoke exposure?*

Eliminating exposure to secondhand smoke, or environmental tobacco smoke, is one of the four main goals of both the New Hampshire and national tobacco control programs. The 2006 Surgeon General's Report, *Health Effects of Involuntary Exposure to Secondhand Smoke*, estimates that secondhand smoke causes 53,800 deaths nationally per year, heart disease (48,500), cancer (3,000) and sudden infant death syndrome (2,300) is attributable to exposure to secondhand smoke.<sup>vii</sup> Eliminating involuntary exposure to secondhand smoke will decrease preventable health risks to NH men, women and children.

*What is the Centers for Disease Control and Prevention (CDC)?*

The CDC is part of the United States Department of Health and Human Services. The CDC is considered the nation's disease, disability and death prevention agency. The National Tobacco Control Program (NTCP), which is part of CDC's Office on Smoking and Health (OSH), has developed recommendations for states on how to prevent and control tobacco use. CDC recommends a comprehensive tobacco control program consisting of five components: state and community interventions, health communication interventions, cessation interventions, surveillance and evaluation, and administration and management. New Hampshire, like many other states, has built its Tobacco Prevention and Control Program using CDC recommendations.

*I would like to see data for a specific town, but cannot find this information in the report. Why doesn't this report show town-level data?*

New Hampshire has a relatively small population of nearly 1.3 million people divided among 234 cities and towns. In a given year, the number of illnesses or deaths related to tobacco is too small to generate data on a town level. Where possible, data is presented by counties and Metropolitan Statistical Areas to provide information that is more detailed than state-level data.

*Some of the information in the report is identified as “age-adjusted.” What does this mean and why is it done?*

To compare populations where the distribution of age groups is different, an adjustment needs to be made. For example, the rate of cancer in New Hampshire may appear higher than that of the United States. However, this may be due to New Hampshire having a higher percentage of elderly adults, than the United States. Age-adjusted or standardized rates are calculated so that rates from populations with different age distributions are comparable. This makes it easier to know if there is a difference in rates that is not totally explained by differences in age distribution. To accomplish this, a ‘standard’ population is chosen. The standard population used in this report is the 2000 United States standard population. Standardized rates can be compared to each other as long as the same standard population is used for each calculation.

*Where can I obtain information about how to quit smoking?*

New Hampshire Tobacco Prevention and Control Program offers a toll free Smokers’ Helpline and Resource Center, **1-800-Try-To-STOP (1-800-879-8678)**. People can obtain information on how to quit by calling this number. For people ready to quit, the helpline provides evidence-based cessation counseling at no cost to the caller. For those not ready to quit, print materials are provided. Information can also be found at [www.trytostopnh.org](http://www.trytostopnh.org).

*What are the limitations of the data?*

There are a number of limitations of the data presented in this current version of New Hampshire data. The reason for limited data stems from a lack of financial and staffing resources to consistently collect and analyze data. For example, TPCP has not had the financial resources to conduct an Adult Tobacco Survey since 2002. Currently, adult tobacco data is regularly gathered through the Behavior Risk Factor Study Survey (BRFSS), however populations not included in the BRFSS statistics are young adults living at colleges or universities, incarcerated populations and those living in group homes or institutions due to mental illness or other life challenges requiring 24-hour care.

*When will the next Data Book be released?*

The next data book is anticipated for release in 2011, or three years from the release of this current version.

## ANALYTICAL METHODS

---

### CONFIDENCE INTERVAL (CI):

*Confidence Intervals* are used in lieu of statistical tests and p values. The overlap between CI is used to draw conclusions regarding the differences between population parameters. Overlapping confidence intervals indicates that the difference is not statistically significant at the selected significance level. If the confidence intervals do not overlap, the group's means are significantly different.

### POPULATION VS. SAMPLE:

*Population* is defined as the total set of individuals that we are interested in and a *sample* is a subset of the individuals selected in a prescribed manner of the study. Typically, population data is very hard or even impossible to gather. Therefore population parameters are based on a sample.

### MEAN:

The *sample mean* is computed as the sum of all the observed outcomes from the sample divided by the total number of events. We use  $\bar{x}$  as the symbol for the sample mean. In statistical terms:

$$\bar{x} = \frac{1}{n} \sum_{i=1}^n x$$

Where  $n$  is the sample size and the  $x$  corresponds to the observed value.

The population mean is the average of the entire population and is usually impossible to compute.

### MEDIAN:

If there is one outcome that is very far from the rest of the data, then the mean will be strongly affected by this outcome. Such an outcome is called an *outlier*. An alternative measure is the *median*. The *median* is the *middle score*. If we have an even number of events we take the average of the two middles. The mean value is reported rather than the median in most cases since the median ignores most of the information and is not algebraically defined. However, if the data is skewed, the median is used because it is not as sensitive to outliers.

### FREQUENCY DISTRIBUTIONS, BAR GRAPHS, CIRCLE GRAPHS:

The *frequency* of a particular event is the number of times that the event occurs.

The *bar graph* is called a Pareto Chart since the height represents the frequency. The width of the bars is always the same.

A *circle graph* often called a pie chart of this data by placing wedges in the circle of proportional size to the frequencies.

$$\text{Angle} = \frac{\text{Frequency}}{\text{TOTAL}} \times 360$$

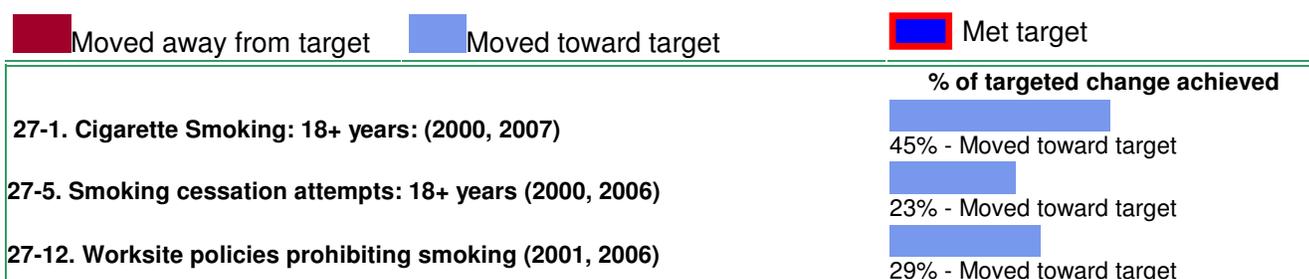
### PREVALENCE RATE:

The number of people in a population who have a disease at a given time: the numerator is the number of existing cases of disease at a specified time and the denominator is the total population.

## HEALTHY PEOPLE TOBACCO USE NATIONAL HEALTH OBJECTIVES 2010

TOBACCO USE	Objective number	NH Baseline Data		NH Current Data		US Healthy People 2010 Target
		Year	Estimate	Year	Estimate	
Healthy People 2010 Objective						
Reduction in tobacco use by adults aged 18 years and older.						
a. Cigarette Smoking	(27-1.)	2000	25.3%	2007	19.3%	12.0%
b. Spit Tobacco	(27-1.)	2002	1.4%	Data not available		0.4%
c. Cigars	(27-1.)	2002	5.6%	Data not available		1.2%
Increase in average age of first tobacco use						
b. Young adults aged 18 to 25 years	(27-4.)	2003	14.9 years	Data not available		16 years
Increase smoking cessation attempts by adult smokers.						
	(27-5.)	2000	53%	2006	58%	75%
Increase the proportion of persons covered by indoor worksite policies that prohibit smoking.						
	(27-12.)	2001	79.2%	2006	85.3%	100%

FIGURE 1. PERCENTAGE CHANGE TOWARD ACHIEVING ADULT TOBACCO USE NATIONAL HEALTH OBJECTIVES



**Data Highlights:** *Healthy People 2010* provides a set of evidence-based objectives for improving the health of all Americans to be achieved over 10 years. Its two overarching goals are to increase the quality and years of healthy life and to eliminate health disparities. Tobacco is one of the 28 focus areas. Progress toward reaching the objectives is an ongoing effort.

**Method:** Tracking data for objectives 27-3a and b, 27-4a and b, 27-6, 27-8a and b, 27-9, 27-13g and h, 27-14b, 27-15, 27-18a, b, and c, 27-19, and 27-20a, b, and c are unavailable. Objectives 27-1d and 27-8c were deleted at the midcourse review process after assessing the status of these objectives.

<http://www.healthypeople.gov/data/midcourse/default.htm#pubs> Years in parentheses in figure 1, represents the baseline data year and the most recent data year used to compute the percent of the Healthy People 2010 target achieved, by using the following formula:

$$\text{Percent of targeted change achieved} = \left( \frac{\text{Most recent value} - \text{baseline value}}{\text{Year 2010 target} - \text{baseline value}} \right) \times 100$$

**Data Source:** Behavioral Risk Factor Surveillance System, 2000-2007.



## ADULT TOBACCO USE

### Cigarette Smoking

FIGURE 2. ADULTS WHO ARE CURRENT SMOKERS – NH AND THE US, 2000 – 2007

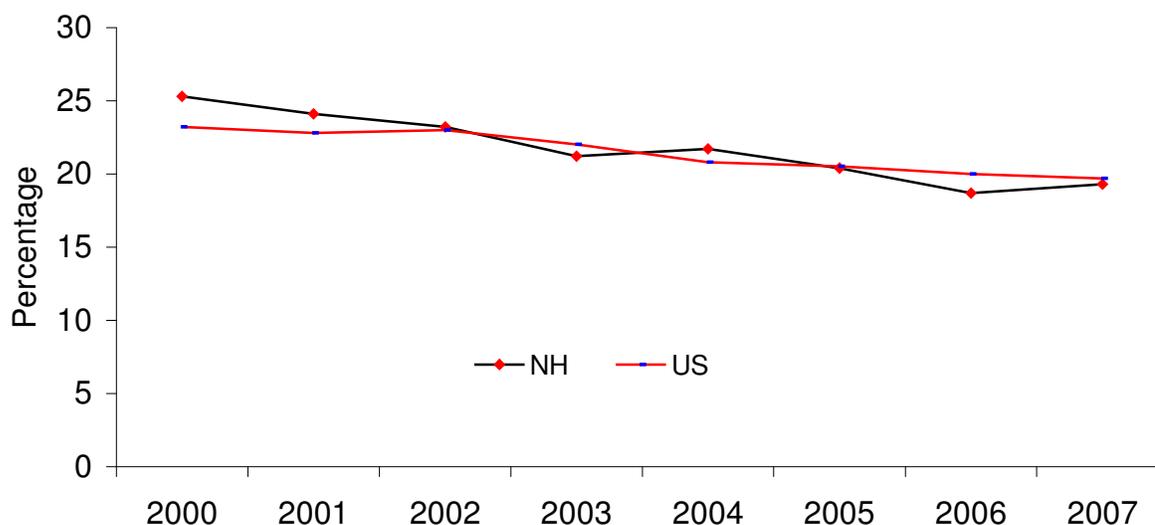


TABLE 1. PERCENTAGE OF ADULTS WHO ARE CURRENT SMOKERS – NH AND THE US, 2000-2007

	2000	2001	2002	2003	2004	2005	2006	2007
<b>NH</b>	25.3	24.1	23.2	21.2	21.7	20.4	18.7	19.3
(CI)	(23.0-27.6)	(22.6-25.6)	(21.8-24.6)	(19.8-22.6)	(20.3-23.1)	(19.1-21.7)	(17.4-20.0)	(17.9-20.7)
<b>US</b>	23.2	22.8	23.0	22.0	20.8	20.5	20.0	19.7

**Data Highlights:** In NH, current adult smoking rates have been declining since 2000, both at the state and the national level. The prevalence of smoking in New Hampshire and the median value for the United States are not significantly different. There has been a 6.6% decrease in smoking prevalence from 2000 to 2006. Even with this decrease, it is unlikely that New Hampshire will reach the Healthy People 2010 objective of reducing smoking prevalence in adults to 12%.

**Method:** All respondents were age 18 years or older. The numerator included all respondents who had smoked 100 cigarettes or more in their lifetime and reported smoking every day or on some days. The denominator included all survey respondents except those with “missing”, “don’t know” and “refused” answers. National data represents the median values, while New Hampshire data represents the mean values. The national data include all 50 states, the District of Columbia and territories. Hawaii did not conduct BRFSS in 2004 and is not included in U.S. rates for that year.

**Healthy People 2010 Objective:** (27-1a) Reduce cigarette smoking by adults aged 18 years or older to 12%.

**Data Source:** Behavioral Risk Factor Surveillance System, 2000-2007.

FIGURE 3. ADULTS WHO ARE CURRENT SMOKERS BY AGE – NH 2001 – 2007

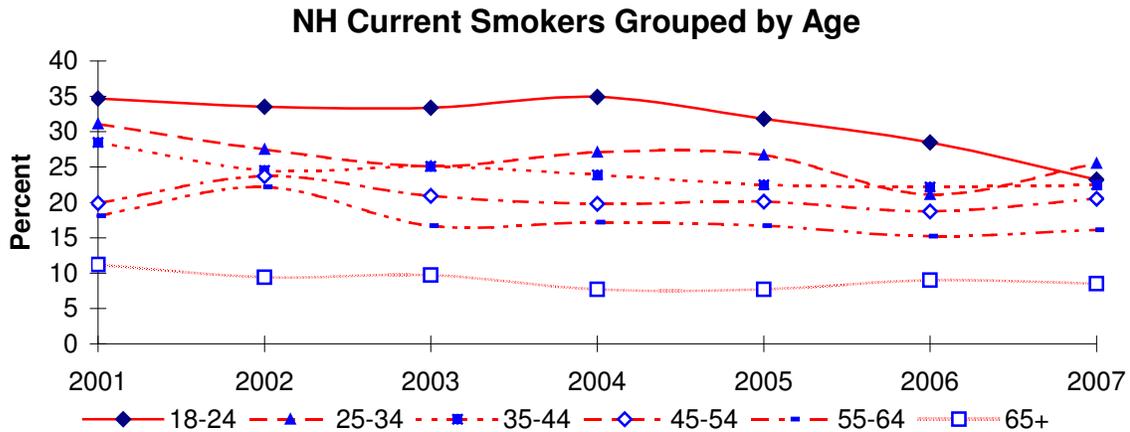


TABLE 2. ADULTS WHO ARE CURRENT SMOKERS BY AGE – NH AND THE US, 2001 – 2007

Age	Territories	2001	2002	2003	2004	2005	2006	2007
18-24	NH	34.7	33.5	33.4	34.9	31.8	28.5	23.2
	US	30.8	31.0	29.4	28.3	26.0	26.8	24.0
25-34	NH	31.1	27.5	25.1	27.1	26.7	21.1	25.5
	US	26.6	26.0	25.3	26.3	24.6	24.1	23.9
35-44	NH	28.5	24.5	25.1	23.9	22.5	22.2	22.5
	US	27.5	27.1	25.3	23.9	23.1	21.1	20.3
45-54	NH	19.9	23.7	20.9	19.8	20.1	18.7	20.5
	US	24.5	24.7	24.2	22.2	23.0	22.2	22.2
55-64	NH	18.1	22.2	16.7	17.2	16.7	15.2	16.1
	US	20.1	20.8	19.7	18.4	18.5	16.4	17.8
65+	NH	11.2	9.4	9.7	7.7	7.7	9.0	8.5
	US	10.0	10.1	9.5	9.2	8.8	8.6	9.0

**Data Highlights:** By age, smoking prevalence is highest among the youngest age group (18-24) and lowest among the oldest age group (65+) and it generally decreases further with age. Over the years the NH prevalence for the age group 18-24 is lower than the national average, also there is a sharper decline in prevalence among this age group compared to other age-group.

**Method:** All respondents were age 18 years or older. The numerator included all respondents who had smoked 100 cigarettes or more in their lifetime, and reported smoking every day or on some days. The denominator included all survey respondents except those with “missing”, “don’t know” and “refused” answers. National data represents the median values, while New Hampshire data are the mean value. The national data include all 50 states, the District of Columbia and territories.

**Data Source:** Behavioral Risk Factor Surveillance System, 2001-2007.

FIGURE 4. ADULTS WHO ARE CURRENT SMOKERS BY EDUCATION LEVEL – NH 2000 – 2007

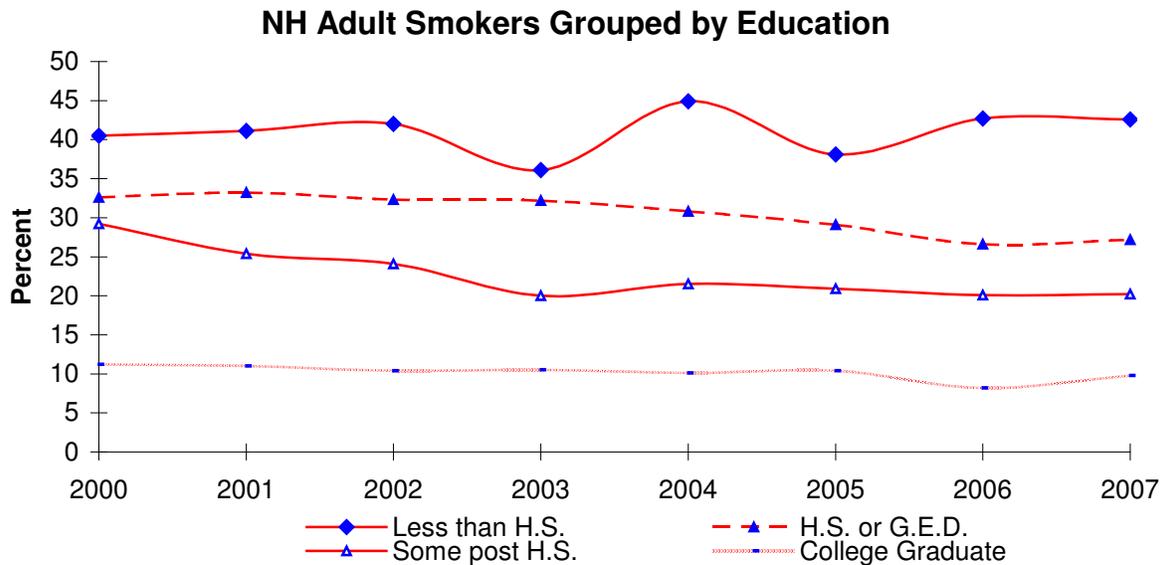


TABLE 3. ADULTS WHO ARE CURRENT SMOKERS BY EDUCATION LEVEL – NH AND THE US, 2000 – 2007

Education	Territories	2000	2001	2002	2003	2004	2005	2006	2007
Less than H.S.	NH	40.5	41.1	42	36.1	44.9	38.1	42.7	42.6
	US	31.4	32.0	34.4	33.3	32.9	31.1	32.2	32.9
H.S. or G.E.D.	NH	32.6	33.2	32.3	32.2	30.8	29.1	26.6	27.2
	US	27.8	28.6	28.7	28.2	27.1	26.9	26.3	26.0
Some post H.S.	NH	29.2	25.4	24.1	20.0	21.5	20.9	20.1	20.2
	US	23.5	24.5	24.0	23.2	23.1	22.1	20.9	21.2
College Graduate	NH	11.2	11.0	10.4	10.5	10.1	10.4	8.2	9.8
	US	12.3	12.5	12.7	11.9	11.1	10.9	10.3	9.6

**Data Highlights:** By education level, smoking prevalence was highest among adults who had less than a High School Education (42.6%) and those with only High School Education or earned a General Diploma (27.2%); prevalence generally decreased with increased education. NH prevalence is higher than the US prevalence for all age categories except for ‘College Graduates’.

**Method:** All respondents were age 18 years or older. The numerator included all respondents who had smoked 100 cigarettes or more in their lifetime, and reported smoking every day or on some days. The denominator included all survey respondents except those with “missing”, “don’t know” and “refused” answers. National data represents the median values, while New Hampshire data are the mean value. The national data include all 50 states, the District of Columbia and territories.

**Data Source:** Behavioral Risk Factor Surveillance System, 2000-2007.

FIGURE 5. ADULTS WHO ARE CURRENT SMOKERS BY INCOME LEVEL – NH, 2000 – 2007

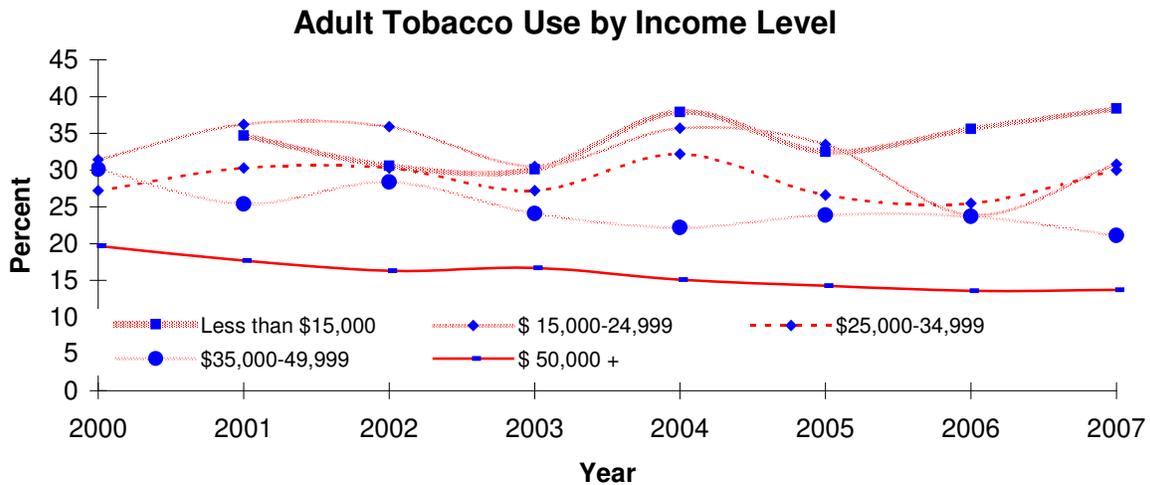


TABLE 4. ADULTS WHO ARE CURRENT SMOKERS BY INCOME LEVEL – NH AND THE US, 2000 – 2007

Income	Territories	2000	2001	2002	2003	2004	2005	2006	2007
Less than \$15,000	NH	N/A	34.7	30.6	30.1	37.9	32.5	35.6	38.4
	US	29.7	29.8	30.3	30.1	29.9	30.6	31.4	31.8
\$ 15,000-24,999	NH	31.4	36.2	35.9	30.5	35.7	33.5	23.9	30.8
	US	28.6	29.6	30.1	29.6	28.7	27.8	27.7	28.3
\$25,000-34,999	NH	27.2	30.3	30.3	27.2	32.2	26.6	25.5	30.0
	US	26.2	28.1	26.9	25.9	25.5	24.8	24.3	23.7
\$35,000-49,999	NH	30.1	25.4	28.4	24.1	22.2	23.9	23.7	21.1
	US	24.4	24.7	24.5	23.7	23.5	22.8	21.7	21.3
\$ 50,000 +	NH	19.7	17.7	16.3	16.7	15.1	14.3	13.6	13.7
	US	17.2	17.7	17.4	16.7	15.9	15.2	15.0	15.0

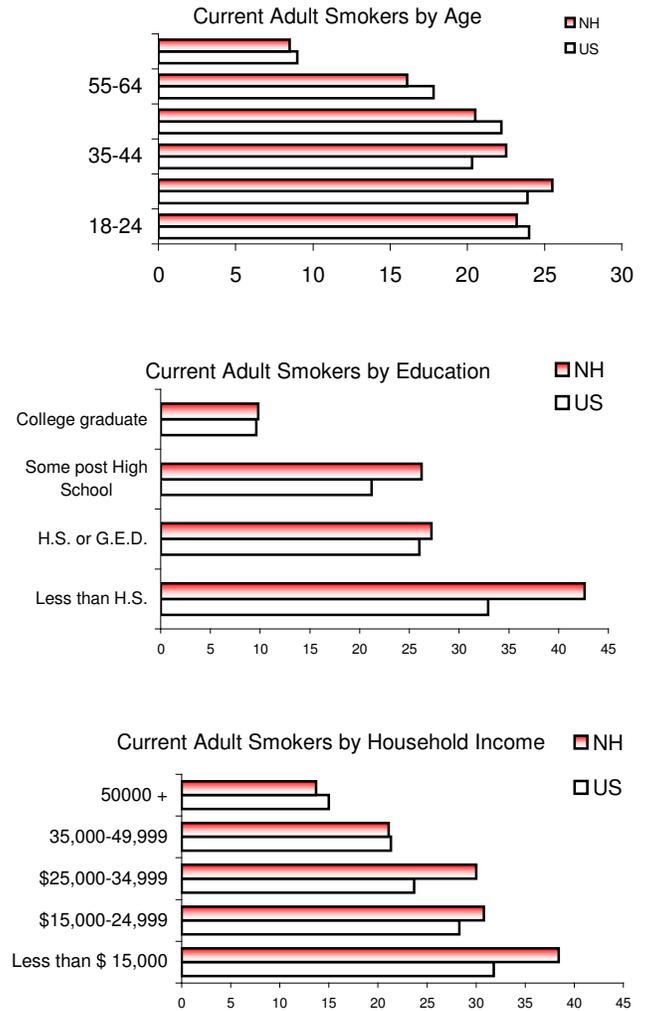
**Data Highlights:** The prevalence of current smoking is higher among adults with low-income levels (Less than \$15,000 and \$15,000 – \$24,999) than among those with higher incomes.

**Method:** All respondents were age 18 years or older. The numerator included all respondents who had smoked 100 cigarettes or more in their lifetime, and reported smoking every day or on some days. The denominator included all survey respondents except those with “missing”, “don’t know” and “refused” answers. National data represents the median values, while New Hampshire data represents the mean value. The national data include all 50 states, the District of Columbia and territories.

**Data Source:** Behavioral Risk Factor Surveillance System, 2000-2007.

FIGURE 6. SMOKING PREVALENCE AMONG ADULTS, BY DEMOGRAPHIC GROUP – NH & US, 2007

	NH%	US%
<b>All Current Smokers</b>	<b>19.3</b>	<b>19.7</b>
Male	20.1	21.2
Female	18.6	18.4
<b>Age</b>		
18-24	23.2	24.0
25-34	25.5	23.9
35-44	22.5	20.3
45-54	20.5	22.2
55-64	16.1	17.8
65 and older	8.5	9.0
<b>Education</b>		
Less than High School	42.6	32.9
H.S. or G.E.D.	27.2	26.0
Some post High School	26.2	21.2
College graduate	9.8	9.6
<b>Household Income</b>		
Less than \$15,000	38.4	31.8
\$15,000-24,999	30.8	28.3
\$25,000-34,999	30.0	23.7
\$35,000-49,999	21.1	21.3
\$50000 +	13.7	15.0



**Data Highlights:** Figure 6 above shows the following subgroups have a higher prevalence of smoking than the statewide estimate: males, 18-24 year-olds, adults with High School education, GED or less education and those with household income of less than \$34,999.

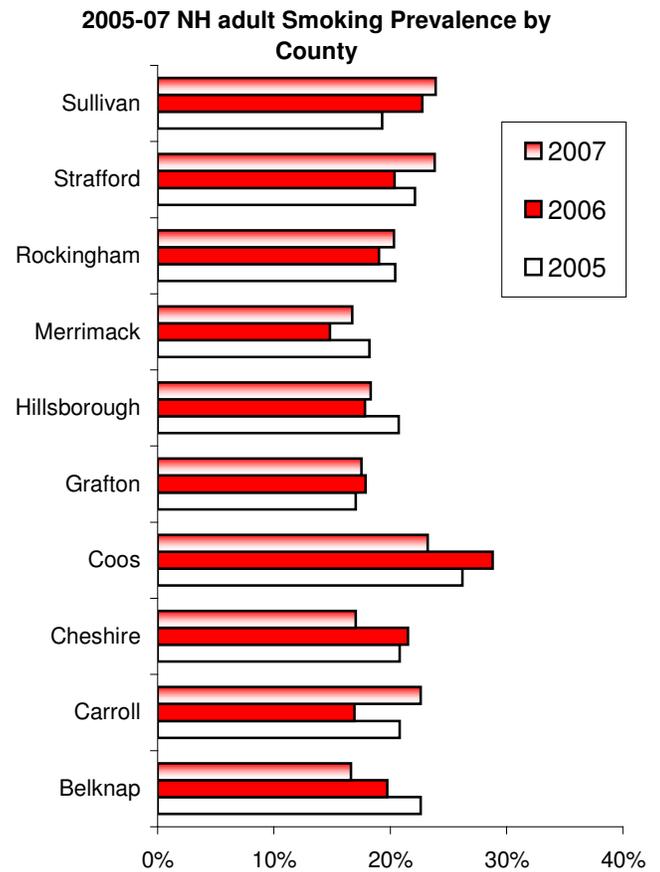
**Method:** The current smokers include persons who reported smoking at least 100 cigarettes during their lifetimes and who, at the time of interview, reported smoking every day or some days. The denominator included all survey respondents except those with “missing”, “don’t know” and “refused” answers. Income refers to total annual household income. National data represents the median values, while New Hampshire data represents the mean value. The national data include all 50 states, the District of Columbia and territories.

**Healthy People 2010 Objective:** (27-1a) Reduce cigarette smoking by adults aged 18 yrs or older to 12%.

**Data Source:** New Hampshire Behavioral Risk Factor Surveillance System, 2007.

FIGURE 7. SMOKING PREVALENCE AMONG ADULTS, BY COUNTIES – NEW HAMPSHIRE, 2005-2007

County	2005 (%)	2006 (%)	2007 (%)
Belknap (95% CI)	22.60 (17.20-28.0)	19.73 (15.11-25.34)	16.6 (12.0-21.2)
Carroll (95% CI)	20.80 (15.7-25.9)	16.91 (12.0-23.3)	22.6 (16.5-28.8)
Cheshire (95% CI)	20.80 (16.8-24.9)	21.51 (16.92-26.96)	17.0 (13.1-20.9)
Coos (95% CI)	26.20 (20.6-31.7)	28.80 (22.16-36.51)	23.2 (17.1-29.4)
Grafton (95% CI)	17.00 (12.8-21.1)	17.85 (13.53-23.17)	17.5 (13.4-21.7)
Hillsborough (95% CI)	20.70 (18.1-23.3)	17.81 (15.49-20.40)	18.3 (15.8-20.8)
Merrimack (95% CI)	18.20 (14.2-22.1)	14.79 (11.65-18.59)	16.7 (12.8-20.5)
Rockingham (95% CI)	20.40 (17.3-23.5)	19.02 (16.09-22.34)	20.3 (17.0-23.6)
Strafford (95% CI)	22.10 (18.2-26.0)	20.36 (16.58-24.74)	23.8 (19.0-28.6)
Sullivan (95% CI)	19.30 (14.2-24.4)	22.73 (17.56-28.89)	23.9 (17.3-30.4)



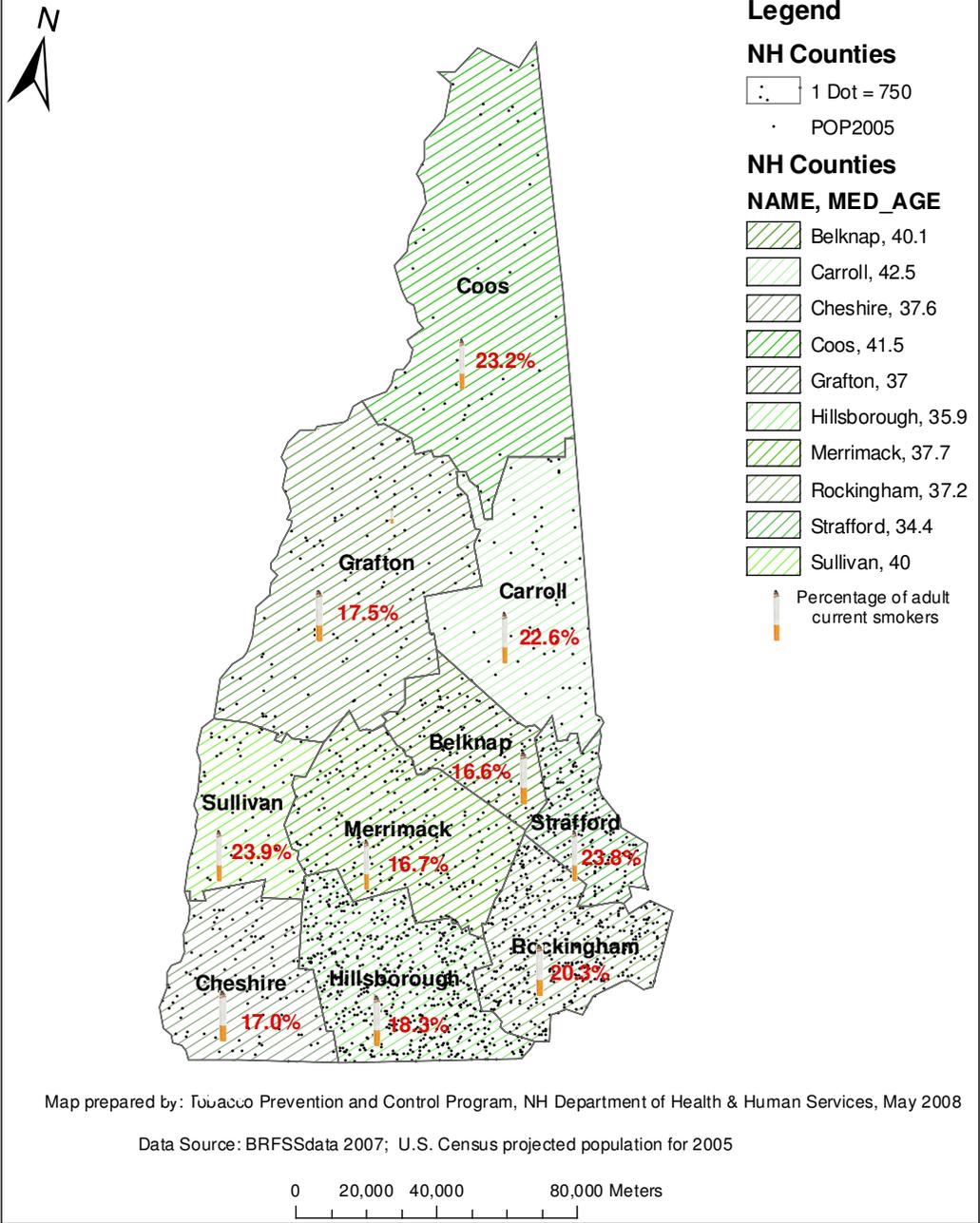
**Data Highlights:** There are no statistically significant differences either by county or by year within county for 2005 and 2006 and 2007. Greater percentage point increases in prevalence were observed in Carroll County. Belknap, Cheshire, Grafton, Hillsborough, and Merrimack Counties’ prevalence estimates were below the State’s average whereas the rest of the counties prevalence were above the State’s average, which is 19.3%. As new data becomes available for the counties in coming years, more accurate estimates regarding the trends will become available, as it is currently difficult to draw conclusions based on only three years of data. The map in the next page shows the population density and smoking prevalence of each county.

**Method:** The numerator included all respondents who were 18 years or older, had smoked 100 cigarettes or more in their lifetime, and reported smoking every day or on some days. The denominator included all survey respondents except those with “missing”, “don’t know” and “refused” answers. County level data is only available starting from year 2005. County level estimates from year 2002 were only available for the five largest counties in the state due to a limited sample size in the smaller population areas.

**Healthy People 2010 Objective:** (27-1a) Reduce cigarette smoking by adults aged 18 yrs or older to 12%.

**Data Source:** New Hampshire Behavioral Risk Factor Surveillance System, 2005-2007.

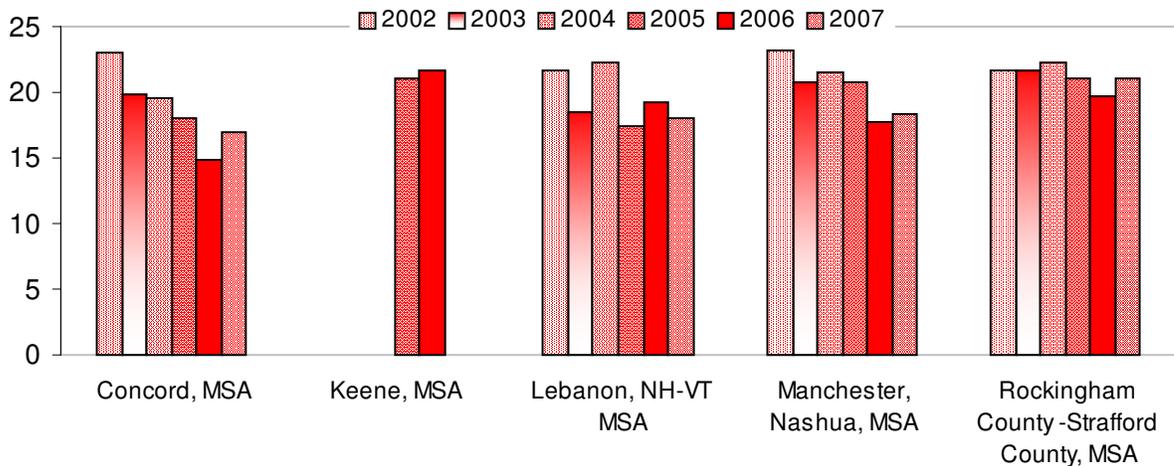
# Percentage of current smokers by counties, NH 2007



**TABLE 5. SMOKING PREVALENCE AMONG ADULTS BY METROPOLITAN/MICROPOLITAN STATISTICAL AREAS (MMSAs) – NEW HAMPSHIRE, 2002 - 2007**

	2002	2003	2004	2005	2006	2007
Concord, NH MSA % (95% CI)	23.0 (19.1 -26.9)	19.9 (16.2 -23.6)	19.5 (15.4 -23.7)	18.0 (14.1 -22.0)	14.8 (11.2 -18.3)	16.9 (12.9 -20.8)
Keene, NH MSA % (95% CI)	N/A	N/A	N/A	21.0 (16.8 -25.1)	21.6 (16.5 -26.6)	N/A
Lebanon, NH-VT MSA % (95% CI)	21.7 (18.6 -24.8)	18.5 (15.6 -21.4)	22.2 (19.5 -25.0)	17.5 (15.1 -19.8)	19.3 (16.1 -22.4)	18.0 (15.2 -20.7)
Manchester, Nashua, NH MSA % (95% CI)	22.5 (19.9 -25.1)	20.8 (18.3 -23.3)	21.5 (18.6 -24.5)	20.7 (18.2 -23.3)	17.8 (15.4 -20.1)	18.3 (15.7 -20.8)
Rockingham County-Strafford County, NH MSA % (95% CI)	21.7 (19.3 -24.1)	21.6 (19.0 -24.2)	22.2 (19.7 -24.8)	21.0 (18.5 -23.6)	19.7 (17.1 -22.2)	21.1 (18.3 -23.8)

**FIGURE 8. SMOKING PREVALENCE AMONG ADULTS, BY MMSAs – NH, 2002 AND 2007**



**Data Highlights:** Except for Concord Metropolitan Statistical Area (MSA) there has been no significant change over the years in smoking prevalence for other MSAs, though the smoking prevalence is gradually decreasing for most MSAs.

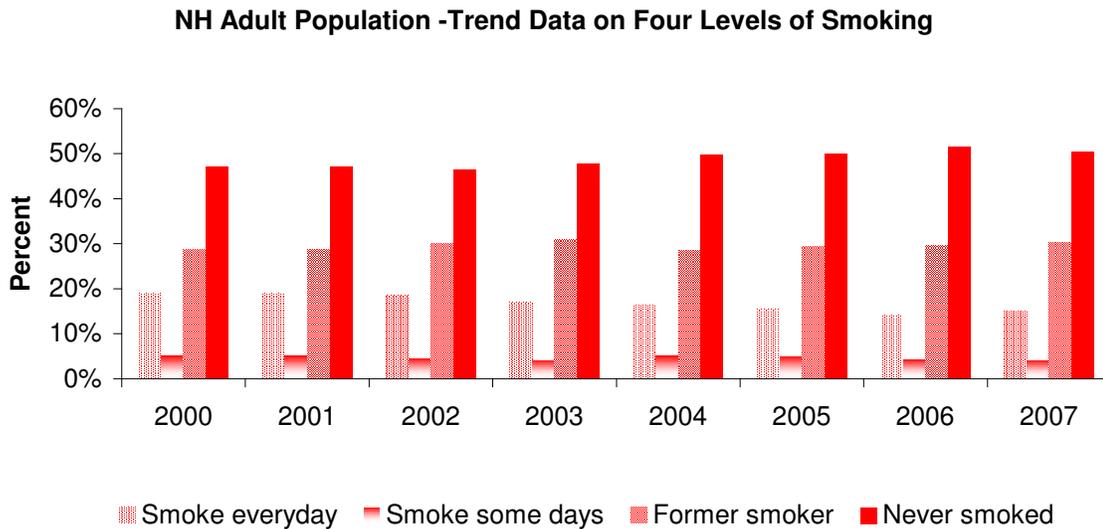
**Method:** The numerator included all respondents who were 18 years or older, had smoked 100 cigarettes or more in their lifetime, and reported smoking every day or on some days. The denominator included all survey respondents except those with “missing”, “don’t know” and “refused” answers. CDC has a project called the Selected Metropolitan/Micropolitan Area Risk Trend (SMART BRFSS) that provides data for small areas with adequate sample sizes. Therefore, starting in 2002, data for a few of NH’s larger counties are available. Metropolitan Statistical Area (MSA) is a group of counties that contain at least one urbanized area of 50,000 or more inhabitants. Micropolitan Statistical Area is a group of counties that contain at least one urban cluster of at least 10,000 but less than 50,000 inhabitants. Respondents were associated with a particular MMSA on the basis of their county code. There were 5 MMSAs that met the analysis criteria for the 2006 data year. The SMART project, uses BRFSS data to produce small-area-level estimates for MMSAs, as defined by the Bureau of the Census.

**Data Source:** SMART BRFSS, 2007.

**TABLE 6. TREND FOR FOUR LEVELS OF SMOKING IN THE ADULT NH POPULATION OVER THE YEAR**

	2000	2001	2002	2003	2004	2005	2006	2007
<b>Smoke everyday</b> (95% CI)	19.7% (17.6-21.8)	19.0% (17.6-20.4)	18.6% (17.3-19.9)	17.0% (15.7-18.3)	16.5% (15.2-17.8)	15.4% (14.2-16.6)	14.3% (13.1-15.5)	15.1% (13.9-16.3)
<b>Smoke some days</b> (95% CI)	5.6% (4.3-6.9)	5.1% (4.3-5.9)	4.6% (3.9-5.3)	4.2% (3.5-4.9)	5.1% (4.3-5.9)	5.0% (4.3-5.7)	4.4% (3.8-5.0)	4.2% (3.4-5.0)
<b>Former smoker</b> (95% CI)	29.7% (27.4-32.0)	28.8% (27.3-30.3)	30.2% (28.8-31.6)	31.0% (29.6-32.4)	28.5% (27.1-29.9)	29.5% (28.2-30.8)	29.7% (28.3-31.1)	30.3% (28.9-31.7)
<b>Never smoked</b> (95% CI)	45% (42.4-47.6)	47.1% (45.4-48.8)	46.6% (45.0-48.2)	47.8% (46.2-49.4)	49.8% (48.2-51.4)	50.1% (48.5-51.7)	51.6% (50.0-53.2)	50.4% (48.8-52.0)

**FIGURE 9. TREND FOR FOUR LEVELS OF SMOKING IN THE ADULT NH POPULATION OVER THE YEAR**



**Data Highlights:** Table 6 and Fig. 9 show that there has been a significant decline in everyday smoking among the adult population in New Hampshire. The smoking prevalence is higher for those who have reported “some days” smoking. There is a slight increase in the percentage of former smokers and of those who have never smoked.

**Method:** The four level smoker status included, everyday smoker, some days smoker, former smoker and non-smoker. Percentages are weighted to population characteristics. Less than 50 observations with a confidence interval greater than 10 have been suppressed. The denominator excludes respondents with “do not know/refused/missing” responses.

**Healthy People 2010 Objective:** (27-1a) Reduce cigarette smoking by adults aged 18 years or older to 12%.

**Data Source:** Behavioral Risk Factor Surveillance System, NH, 2000-2007.

**TABLE 7. FOUR LEVELS OF SMOKING STATUS FOR THE NH ADULT POPULATION FOR 2007**

<b>Gender</b>	<b>Smoke everyday (%)</b>	<b>Smoke some days (%)</b>	<b>Former smoker (%)</b>	<b>Never Smoked (%)</b>
<b>Total</b>	<b>15.1 (13.9-16.3)</b>	<b>4.2 (3.4-5.0)</b>	<b>30.3 (28.9-31.7)</b>	<b>50.4 (48.8-52.0)</b>
Male (95% CI)	16.3 (14.3-18.3)	3.8 (2.6-5.0)	31.4 (29.2-33.6)	48.5 (46.0-51.0)
Female (95% CI)	14.0 (12.6-15.4)	4.6 (3.6-5.6)	29.2 (27.4-31.0)	52.2 (50.2-54.2)
<b>Age:</b>				
18-24 (95% CI)	17.6 (11.1-24.1)	5.7 (1.6-9.8)	7.4 (3.9-10.9)	69.3 (61.7-76.9)
25-34 (95% CI)	20.6 (16.7-24.5)	4.9 (2.7-7.1)	18.5 (15.0-22.0)	55.9 (51.2-60.6)
35-44 (95% CI)	17.2 (14.5-19.9)	5.3 (3.7-6.9)	22.0 (19.1-24.9)	55.6 (52.1-59.1)
45-54 (95% CI)	16.0 (13.8-18.2)	4.5 (3.3-5.7)	31.9 (29.2-34.6)	47.6 (44.5-50.7)
55-64 (95% CI)	12.4 (10.2-14.6)	3.6 (2.4-4.8)	43.2 (40.1-46.3)	40.7 (37.6-43.8)
65+ (95% CI)	6.7 (5.3-8.1)	1.7 (0.9-2.5)	50.8 (48.1-53.5)	40.8 (38.1-43.5)
<b>Education:</b>				
Less than H.S. (95% CI)	35.0 (28.3-41.7)	7.6 (3.1-12.1)	28.2 (22.7-33.7)	29.2 (22.9-35.5)
H.S. or G.E.D. (95% CI)	22.8 (18.3-23.5)	4.4 (3.0-5.8)	31.8 (29.1-34.5)	41.0 (37.9-44.1)
Some post-H.S. (95% CI)	15.9 (13.4-18.4)	4.4 (3.0-5.8)	32.8 (29.9-35.7)	47.0 (43.7-50.3)
College graduate (95% CI)	6.2 (5.0-7.4)	3.5 (2.5-4.5)	28.0 (26.0-30.0)	62.3 (59.9-64.7)
<b>Income:</b>				
Less than \$15,000 (95% CI)	33.8 (27.5-40.1)	4.6 (1.5-7.7)	33.5 (28.0-39.0)	28.1 (22.6-33.6)
\$15,000- 24,999 (95% CI)	27.5 (22.8-32.2)	3.3 (1.9-4.7)	30.6 (26.5-34.7)	38.5 (33.6-43.4)
\$25,000- 34,999 (95% CI)	23.5 (18.6-28.4)	6.6 (3.3-9.9)	28.1 (23.4-32.8)	41.9 (36.2-47.6)
\$35,000-49,999 (95% CI)	15.8 (12.7-18.9)	5.3 (3.1-7.5)	33.8 (30.1-37.5)	45.1 (40.8-49.4)
\$50,000+ (95% CI)	9.6 (8.0-11.2)	4.0 (13.0-5.0)	30.8 (28.8-32.8)	55.5 (53.1-57.9)

**Data Highlights:** Four levels of smoking status have been presented in the above table for different demographic groups. About 19.3% of NH’s population smokes. Within that group of smokers, 15.1% smoke every day and 4.2% smoke some days. The BRFSS survey shows that 30.3% of New Hampshire population reported being a former smoker, whereas, 50.4% report having never smoked. More females than males report never smoking or being a former smoker. Variations are seen across the demographics.

**Methods:** The four level smoker status included are: everyday smokers, somedays smokers, former smokers and non-smokers. Percentages are weighted to population characteristics. A denominator of less than 50 (Less than 50 observations) or a confidence interval of greater than 10 have been suppressed. The denominator also excludes respondents with “do not know/refused/missing responses.”

**Data Source:** New Hampshire Behavioral Risk Factor Surveillance System, 2007.

TABLE 8. SMOKING FREQUENCY AND NUMBER OF CIGARETTES CONSUMED AMONG CURRENT ADULT SMOKERS – NH, 2002

	<b>% of current smokers</b>	<b>Average number of days smoking per month</b>	<b>Average number of cigarettes smoked per day</b>
<b>All current smokers</b>	100.0	25.0	16.4
Everyday smokers	82.3	30.0	19.1
Some day smokers	17.7	13.9	6.5

**Data Highlight:** Everyday smokers in New Hampshire consumed an average of a pack of cigarettes a day.

**Method:** All respondents were 18 years or older, had smoked 100 cigarettes or more in their lifetime and reported smoking every day or on some days.

**Data Source:** New Hampshire Adult Tobacco Survey, 2002.

TABLE 9. BRAND PREFERENCE BY CURRENT ADULT SMOKERS -NEW HAMPSHIRE, 2002

	%	95% CI
<b>Brand</b>		
Marlboro	49.8	44.9-54.8
Camel	7.4	4.7-10.2
Winston	5.3	2.8-7.8
Newport	4.5	2.5-6.5
Other	32.9	28.5-37.4
<b>Type</b>		
Plain	83.4	80.0-86.9
Menthol	16.6	13.1-20.0
<b>Price</b>		
Full priced	82.9	79.4-86.4
Discount	17.1	13.6-20.6
<b>Strength</b>		
Regular	43.5	38.6-48.5
Lights	41.6	36.8-46.5
Ultra lights	14.8	11.7-18.0

**Data Highlights:** Marlboro was the most popular cigarette brand among adult smokers in New Hampshire. The majority of adult smokers in New Hampshire used light or ultra-light cigarettes. However, scientific evidence shows that smoking light/ultra light cigarettes does not eliminate the risk of tobacco-related diseases. In fact, the risk of lung cancer is only slightly lower and these types of cigarettes have no effect on tobacco related heart disease or other tobacco related lung diseases. <sup>viii</sup>

**Method:** All respondents were 18 years or older, had smoked 100 cigarettes or more in their lifetime and reported smoking every day or on some days.

**Data Source:** New Hampshire Adult Tobacco Survey, 2002.

## ADULT TOBACCO USE

---

### New Hampshire College Students

TABLE 10. CURRENT USE OF TOBACCO PRODUCTS BY COLLEGE STUDENTS – NH, 2003, 2005

Tobacco Product	2003 % Who reported no use of product ( Total # of Respondents =3,743)	2005 % Who reported no use of (Total # of Respondents = 3, 260)	2007 % Who reported no use of product (Total # of Respondents = 3, 671)
Cigarettes (cigarettes, cigars, pipes)	68.2%	68.9%	75.0%
Smokeless tobacco (chew, snuff, dip)	94.2%	93.4%	94.1%

**Data Highlights:** NH residents 18-24 years of age are a key age group for tobacco control efforts, as the tobacco industry targets this age group to be replacement smokers of those who have quit. Currently, there are limited data collection tools targeted towards college students. It is seen that in surveys of adults in non-institutional settings, individuals aged 18-24 years have smoking rates significantly higher than the state average (28.5% compared to an average of 18.7% in the adult population). The high rates of tobacco use when these students were in High School seem to be mirrored among young adults living on college campuses. Consistent measurement of tobacco use by young adults on college campuses will shed light on the extent of the problem and provide a baseline for possible tobacco prevention programs within this population.

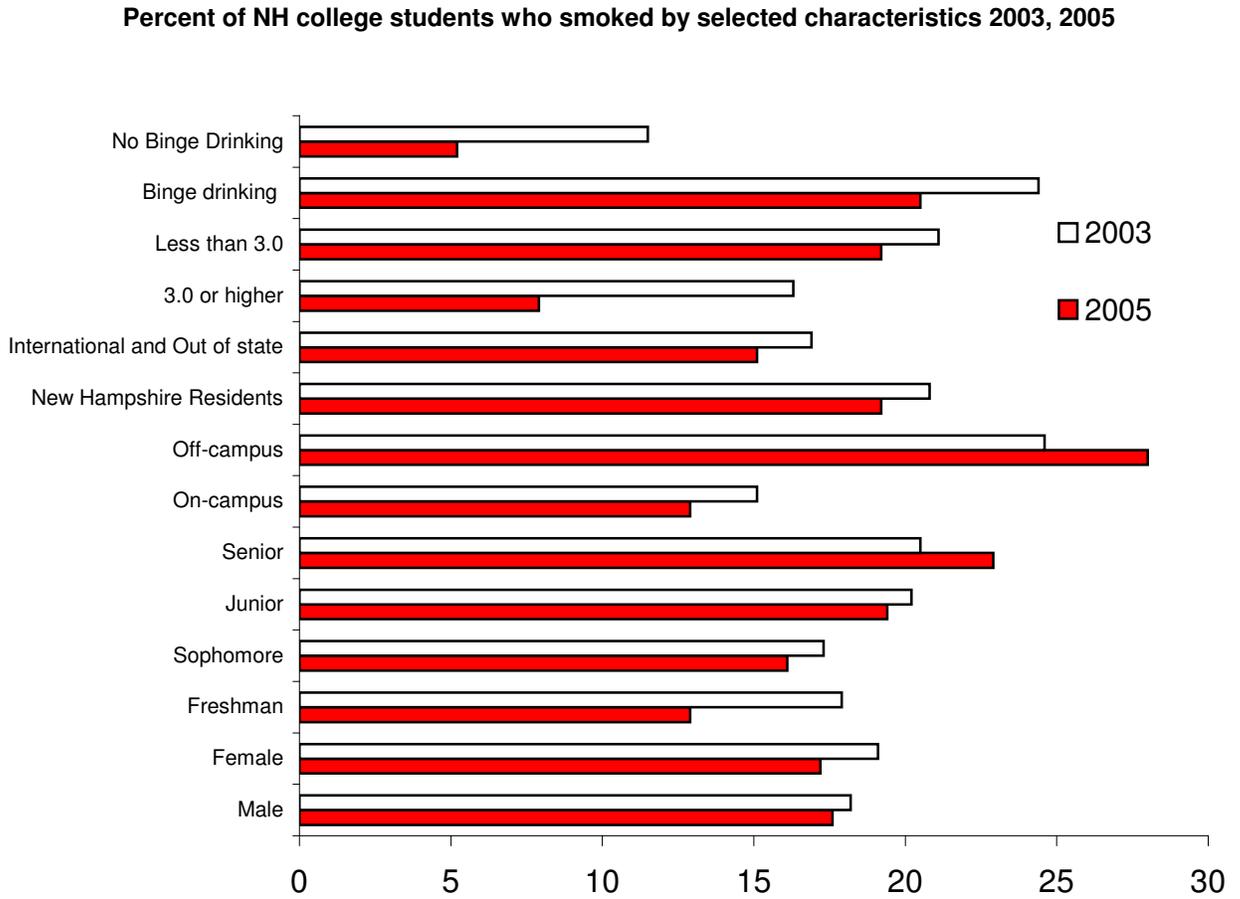
**Methods:** Smoking status was calculated on the basis of three items: (a) Have you tried cigarette smoking, even one or two puffs; (b) Have you smoked at least 100 cigarettes in your entire life; and (c) Do you now smoke cigarettes everyday, some days or not at all? Students who responded “no” to the first question or who did not smoke 100 or more cigarettes in their life were classified as non-smokers. Current smokers were those who smoked 100 cigarettes or more and who currently smoke everyday or some days. Current users of cigars, pipes or smokeless tobacco were defined as students having used these products during the past 30 days.

**Data Source:** New Hampshire Higher Education Alcohol, Tobacco, and Other Drug Survey, 2003, 2005 and 2007.

**TABLE 11. PREVALENCE OF CIGARETTE SMOKING AMONG COLLEGE STUDENTS BY SELECTED CHARACTERISTICS – NH, 2003, 2005**

<b>Characteristic</b>		<b>2003</b>	<b>2005</b>	<b>Change</b>
<b>All</b>	No. Respondents	3,743	3,260	
	<b>% who smoked</b>	<b>18.8</b>	<b>17.4</b>	↓
<b>Gender</b>				
Male	No. Respondents	1,540	911	
	<b>% who smoked</b>	<b>18.2</b>	<b>17.6</b>	↓
Female	No. Respondents	2,154	1205	
	<b>% who smoked</b>	<b>19.1</b>	<b>17.2</b>	↓
<b>Class</b>				
Freshman	No. Respondents	1,314	768	
	<b>% who smoked</b>	<b>17.9</b>	<b>12.9</b>	↓
Sophomore	No. Respondents	908	629	
	<b>% who smoked</b>	<b>17.3</b>	<b>16.1</b>	↓
Junior	No. Respondents	743	469	
	<b>% who smoked</b>	<b>20.2</b>	<b>19.4</b>	↓
Senior	No. Respondents	703	422	
	<b>% who smoked</b>	<b>20.5</b>	<b>22.9</b>	↑
<b>Housing</b>				
On-campus	No. Respondents	2276	1437	
	<b>% who smoked</b>	<b>15.1</b>	<b>12.9</b>	↓
Off-campus	No. Respondents	1413	497	
	<b>% who smoked</b>	<b>24.6</b>	<b>28.0</b>	↑
<b>State of Residence</b>				
New Hampshire	No. Respondents	1,882	1280	
	<b>% who smoked</b>	<b>20.8</b>	<b>19.2</b>	↓
Other	No. Respondents	1,861	1032	
	<b>% who smoked</b>	<b>16.9</b>	<b>15.1</b>	↓
<b>Grade Point average</b>				
3.0 or higher	No. Respondents	1,753	1380	
	<b>% who smoked</b>	<b>16.3</b>	<b>7.9</b>	↓
Less than 3.0	No. Respondents	1,990	927	
	<b>% who smoked</b>	<b>21.1</b>	<b>19.2</b>	↓
<b>Binge Drinking in Past 2 Weeks</b>				
Yes	No. Respondents	2,084	1331	
	<b>% who smoked</b>	<b>24.4</b>	<b>20.5</b>	↓
No	No. Respondents	1,567	998	
	<b>% who smoked</b>	<b>11.5</b>	<b>5.2</b>	↓

**FIGURE 10. PREVALENCE OF CIGARETTE SMOKING AMONG COLLEGE STUDENTS BY SELECTED CHARACTERISTICS – NH, 2003, 2005**



**Data Highlights:** Tobacco companies agreed to stop marketing tobacco products to minors as part of the 1998 Master Settlement Agreement. Marketing and promotion of tobacco products to young adults (i.e. persons 18-24 years of age) is widespread and is associated with increased smoking rates.<sup>ix</sup> Those who consumed 5 or more alcoholic beverages on occasions (binge drinking), those who scored less than 3.0 GPA, those who resided off-campus and seniors had a higher prevalence for smoking than those who did not binge drink, scored higher GPA and resided on campus and were in the non-senior class group. There is an increasing trend in smoking prevalence from freshman to senior years, from 12.2% in freshman to 22.9% in seniors.

**Method:** Current users of cigarettes were defined as students who reported having smoked 100 cigarettes in their lifetime and now smoke some days or every day. Current users of cigars, pipes or smokeless tobacco were defined as students having used these products during the past 30 days. Binge drinking was defined as consuming five or more alcoholic drinks in one sitting. The percentage has been calculated by using 2005 data less 2003 data divided by 2003 and multiplied by 100. As defined here, the college student population comprises of all full-time students, one to four years post-High School, enrolled in a two- or four-year college in March during the year of the survey.

**Data Source:** New Hampshire Higher Education Alcohol, Tobacco, and Other Drug Survey, 2005.

## ADULT TOBACCO USE

### Adult Use of Other Tobacco Products

FIGURE 11. CURRENT USE OF TOBACCO PRODUCTS AMONG ADULTS, BY GENDER – NH, 2002

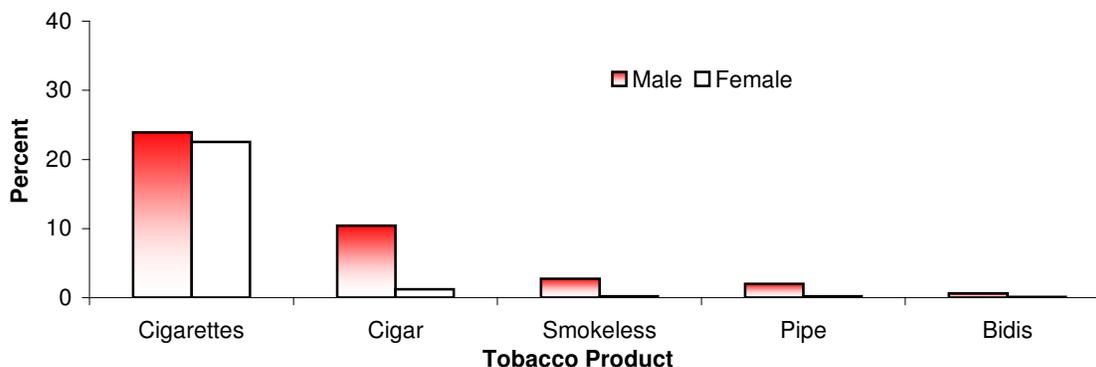


TABLE 12. CURRENT USE OF TOBACCO PRODUCTS AMONG ADULTS, BY GENDER – NH, 2002

	All		Male		Female	
	%	95% CI	%	95% CI	%	95% CI
Any tobacco product*	27.5	26.1-29.0	32.4	30.0-34.7	23.0	21.2-24.8
Cigarettes	23.2	21.8-24.6	23.9	21.8-26.0	22.5	20.7-24.3
Cigar	5.6	4.8-6.4	10.4	8.9-11.9	1.2	0.6-1.8
Smokeless tobacco	1.4	0.9-1.9	2.7	1.7-3.7	0.2	0.0-0.4
Pipe	1.1	0.8-1.5	2.0	1.4-2.7	0.2	0.0-0.5
Bidis	0.4	0.1-0.7	0.6	0-1.2	0.1	0-0.3

**Data Highlights:** Cigars are the second most commonly used tobacco product among NH adults. Cigars and smokeless tobacco also known as spit tobacco are not safe alternatives to cigarette smoking. The risk of both oral and esophageal cancer among cigar smokers is similar to that of cigarette smokers.<sup>x</sup> Cigar smokers also develop heart disease at the same rate as cigarette smokers.<sup>x</sup> Due to the additives used, smokeless tobacco actually has higher levels of nicotine than cigarettes and is therefore more addictive. Smokeless tobacco use is associated with cancer of the mouth, pharynx, esophagus, and pancreas.<sup>xi</sup>

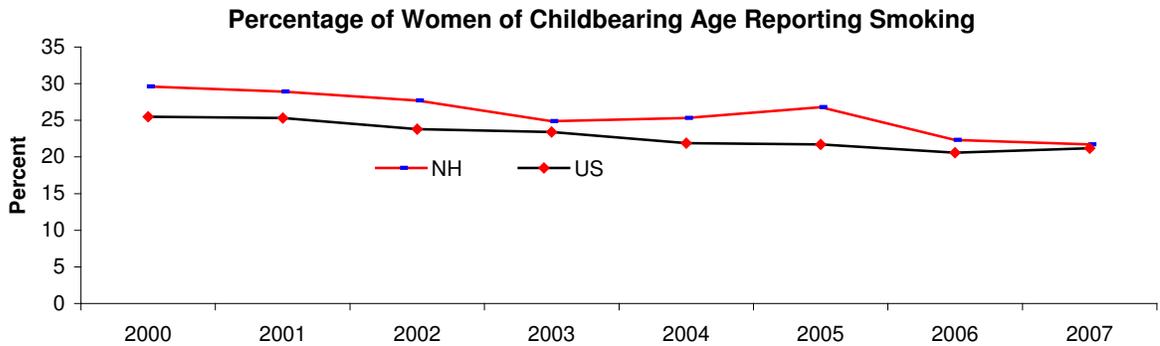
**Method:** Current use of cigarettes was defined as having smoked 100 cigarettes and now smoking some days or every day. Current users of cigars and spit tobacco were defined as adults who reported product use every day or some days. Any tobacco product included use of cigarettes, smokeless tobacco and cigars. Bidis (also known as beedis, beedies, or beads) are small, brown, hand-rolled cigarettes primarily made in India and other Southeast Asian countries. They consist of tobacco wrapped in a leaf and may be secured with a colorful string at one or both ends. Bidis can be flavored (e.g., chocolate, cherry, and mango) or unflavored.

**Healthy People 2010 Objectives:** (27-1a) Reduce cigarette smoking by adults aged 18 years or older to 12%. (27-1b) Reduce smokeless tobacco use by adults aged 18 years or older to 0.4%. (27-1c) Reduce cigar use by adults aged 18 years and older to 1.2%.

**Data Source:** New Hampshire Behavior Risk Factor Surveillance System, 2002.

## TOBACCO USE DURING PREGNANCY

FIGURE 12. PERCENTAGE OF WOMEN OF CHILDBEARING AGE (18-44) WHO REPORTED SMOKING



	2000	2001	2002	2003	2004	2005	2006	2007
<b>NH</b>	29.6	28.9	27.7	24.9	25.3	26.8	22.3	21.7
<b>US</b>	25.5	25.3	23.8	23.4	21.9	21.7	20.6	21.2

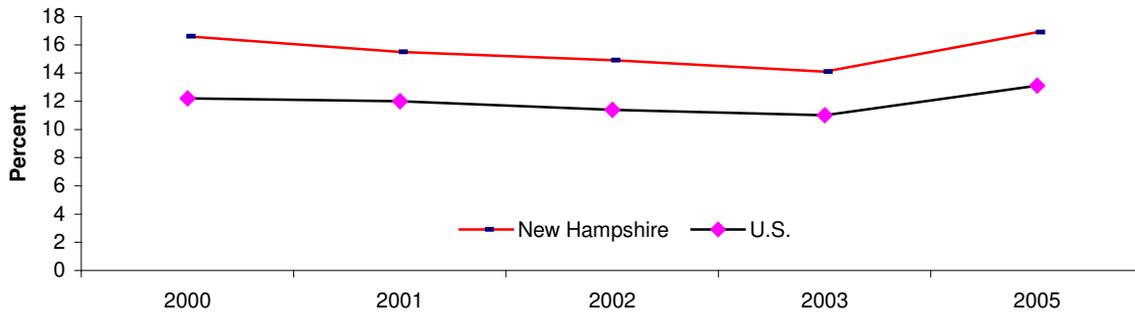
**Data Highlights:** In New Hampshire in 2007, 21.7% of women of childbearing age (18-44 years) reported smoking, compared to 21.2% of women nationally. There has been a 7.9 percentage point decrease from 2000 to 2007 for women of childbearing age who reported smoking. Smoking nearly doubles a women's risk of having a low birthweight baby. Studies show that smoking increases the risk of pre-term delivery. Low birthweight and premature babies face an increased risk of serious health problems during the newborn period, chronic lifelong disabilities (such as cerebral palsy, mental retardation and learning problems) and even death.<sup>xii</sup> Smoking is a preventable risk factor for low-birth weights (less than 5-1/2 pounds) and preterm births (before 37 weeks of gestation).

**Method:** Smoking is defined as having ever smoked 100 cigarettes in a lifetime and currently smoking everyday or some days. Percent reported is among women ages 18-44. Hawaii did not conduct BRFSS surveillance in 2004 and is not included in U.S. rates for that year.

**Healthy New Hampshire 2010 Objective:** Reduce the number of women who report smoking cigarettes during pregnancy to 10%.

**Source:** Behavioral Risk Factor Surveillance System, 2000-2007.

**FIGURE 13. PERCENTAGE OF BIRTHS IN WHICH WOMEN REPORTED USING TOBACCO DURING PREGNANCY – NH AND US, 2000-2005 (UNREVISED AND REVISED)**



**TABLE 13. PERCENTAGE OF BIRTHS IN WHICH WOMEN REPORTED USING TOBACCO DURING PREGNANCY – NH AND THE US, 2000-2005 (UNREVISED AND REVISED)**

Year	2000	2001	2002	2003	2004	2004	2005
<b>Birth Certificate</b>	<b>Unrevised (1989 Revision)</b>				<b>Revised (2003 Revision)</b>		
<b>NH</b>	16.6	15.5	14.9	14.1	N/A	N/A	16.9
<b>U.S.</b>	12.2	12.0	11.4	11.0	10.9	N/A	12.4

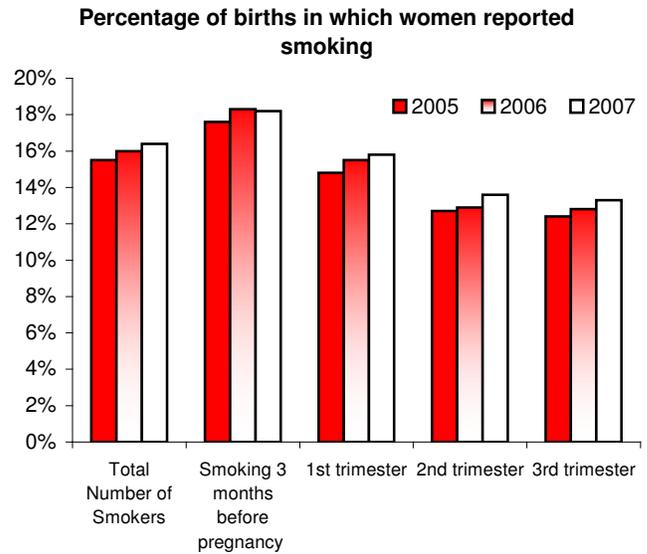
**Data Highlights:** New Hampshire administered the revised (2003) US Standard Certificate of Live Birth for in-state births in July of 2004. Therefore in the year 2004, the information on smoking was reported according to two different and non-comparable questions. There is an increase in the rate of maternal tobacco use in New Hampshire in 2005. There could be two possible reasons for this increase. Studies based on the unrevised smoking question have suggested some underreporting of smoking on birth certificates, because of the lack of a specific time reference; as in, when during the pregnancy the mother smoked. It is believed that the new question with a specific time reference on prenatal smoking in the revised certificate will provide higher quality, more valid information. Also the guidelines provided by Maternal and Child Health (MCH), suggest that the old and the new versions are uncomparable.

**Method:** The 1989 standard certificate asked for “tobacco use during pregnancy” with a simple “yes/no” question and the average number of cigarettes per day with no specificity on timing during pregnancy. In contrast, the 2003 revision collected information on smoking for each trimester of pregnancy as well as the 3-month period prior to pregnancy. Percentages are based on the number of live births where tobacco use was self-reported and indicated use any time during pregnancy for the unrevised certificate and in any of the three trimesters of pregnancy for the revised certificate. The US percentage for 2005 presented in this report excludes data from states that did not implement the 2003 Revision of the U.S. Standard Certificate and it also excludes data from Florida and California which account for 19% of US births. The 2005 data is limited to NH residents who had a live birth in NH only. Eleven to twelve percent of NH resident births occur out of state (OOS). The decision to give birth OOS is often related to a complicated pregnancy or location convenience. Complete records for NH residents who gave birth OOS are not yet available in the dataset from the division of vital records administration. OOS records are most likely to come in the old birth certificate version with only yes and no to tobacco.

**Data Sources:** US: National Center for Health Statistics (NCHS), NH: New Hampshire and National Vital Statistics Data; Health Statistics and Data Management Unit, NH DHHS.

**FIGURE 14. PERCENTAGE OF BIRTHS IN WHICH WOMEN REPORTED USING TOBACCO DURING PREGNANCY – NH 2005-2007 (REVISED BIRTH CERTIFICATE)**

NH Births	2005	2006	2007
N = Total # of birth record	<b>12,320</b>	<b>12,636</b>	<b>12,653</b>
Smokers	15.8%	16.0%	16.4%
Non-Smoker	84.2%	84.0%	83.6%
<b>Smoking by different intervals during pregnancy</b>			
3 months before pregnancy	17.6%	18.3%	18.8%
1 <sup>st</sup> trimester	14.8%	15.5%	15.8%
2 <sup>nd</sup> trimester	12.7%	12.9%	13.6%
3 <sup>rd</sup> trimester	12.4%	12.8%	13.3%



**Data Highlights:** In 2007, 16% of women who gave birth in NH reported smoking during pregnancy, which also includes the period of three months before pregnancy. If women indicated smoking any time during pregnancy and three months prior to pregnancy she was reported as a smoker. Average number of cigarettes for a smoker remained about 4 cigarettes per day in all three trimesters.

**Method:** Percentages are based on the number of live births where tobacco use was self-reported and indicated as being used in any of the following: 3 months before pregnancy, 1<sup>st</sup> three months of pregnancy, 2<sup>nd</sup> three months of pregnancy and last three months of pregnancy. The data is limited to NH residents who had a live birth in NH only. Out of state (OOS) births account for 11-12% of NH resident births. The decision to give birth OOS is often related to a complicated pregnancy or location convenience. Complete records for NH residents who gave birth OOS are not yet available in the dataset from the division of vital records administration. OSS records are most likely to come in the old birth certificate version with only yes and no to tobacco.

**Healthy New Hampshire 2010 Objective:** Reduce the number of women who report smoking cigarettes during pregnancy to 10%.

**Data Sources:** US: National Center for Health Statistics (NCHS), NH: New Hampshire and National Vital Statistics Data; Health Statistics and Data Management Unit, NH DHHS.

**FIGURE 15. PERCENTAGE OF BIRTHS IN WHICH WOMEN REPORTED TOBACCO USE DURING PREGNANCY BY AGE, EDUCATION, MARITAL STATUS AND INCOME OF MOTHER, NH AND US 2005**

Demographics	% Smokers	
	NH	US (revised states only) 25% of US births)
<b>Total</b>	<b>15.8</b>	<b>12.4</b>
<b>Birth Weight</b>		
Low	26.3	11.9
Normal	16.4	7.5
<b>Age of mother</b>		12.4
Under 15 years	20.0	5.2
15-19 years	40.8	16.6
20-24 years	32.3	18.6
25-29 years	16.0	11.5
30-34 years	7.8	7.1
35-39 years	7.5	7.1
40 years and over	9.8	8.0
<b>Maternal Education</b>		
Grammar School	30.3	5.4
Less than High School	47.5	20.2
High School diploma	28.7	19.3
Some college	18.7	11.6
College graduate	2.8	1.8
<b>Marital status</b>		
Married	8.1	1.85
Unmarried	38.8	5.5
<b>Income (payment for birth)</b>		
Medicaid/CHIP	39.5	N/A
Not Medicaid/ CHIP	8.9	N/A
Unknown	12.2	

**Data Highlight:** The following groups had significantly higher rates of maternal tobacco use: those who delivered a low birthweight (LBW) infant, were unmarried, had late or no prenatal care, had a High School education or less and had delivery or prenatal care paid by Medicaid. In 2005, 47.5% of women who attended but did not complete High School were smokers during pregnancy compared with 2.8% of college graduates. The concern about smoking during pregnancy has also been linked to adverse pregnancy outcomes, including LBW, which was

higher among infants born to mothers who reported smoking during pregnancy. Babies born to women who smoke are at substantially greater risk of LBW than babies born to non-smokers.

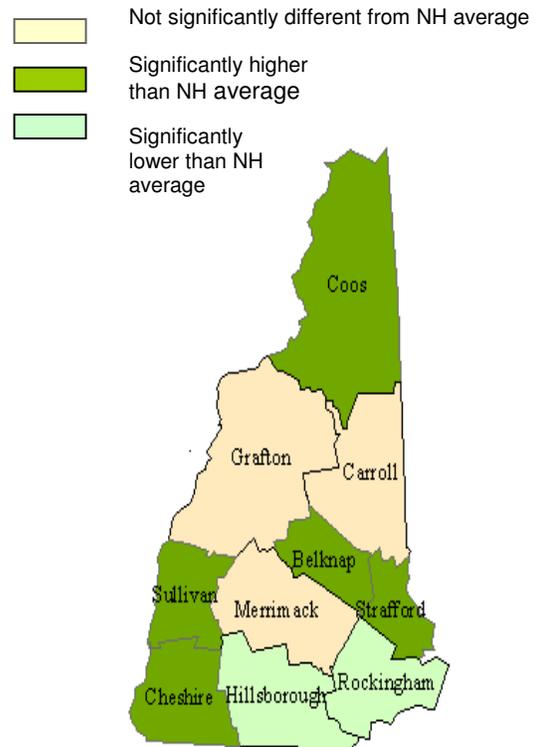
**Methods:** Tobacco use was self-reported and indicated use any time during pregnancy. Those who never smoked, or quit smoking more than 3 months before becoming pregnant are considered non-smokers. Percentages were based on the number of live births where selected characteristics were known. A birth was counted as a Medicaid birth if the Medicaid paid for either prenatal care or delivery. Low birthweight was defined as less than 2,500 grams (about 5.5 pounds). The US percentage includes data from 11 states, which implemented the revised version of the birth certificate. These states include Idaho, Kansas, Kentucky, Nebraska, New Hampshire, New York State (excluding New York City), Pennsylvania, South Carolina, Tennessee, Texas, and Washington. The 2005 data is limited to NH residents who had a live birth in NH only. Eleven to twelve percent of NH resident births occur out of state (OOS). The decision to give birth OOS is often related to a complicated pregnancy or location convenience. Complete records for NH residents who gave birth OOS are not yet available in the dataset from the division of vital records administration. OOS records are most likely to come in the old birth certificate version with only yes and no to tobacco. When comparing data between New Hampshire and the United States, it is important to note that information was obtained through different versions of birth certificates.

**Data Source:** New Hampshire Vital Statistics Data; Health Statistics and Data Management Unit, NH DHHS, CDC Wonder.

**TABLE 14. BIRTHS IN WHICH WOMEN REPORTED TOBACCO USE DURING PREGNANCY BY COUNTY, NH 2000, 2003, 2005**

County	Percent of women who used tobacco during pregnancy		
	2000	2003	2005
<b>Belknap</b>	24.6	21.1	22.1
<b>Carroll</b>	20.7	16.4	17.6
<b>Cheshire</b>	18.5	20.0	21.6
<b>Coos</b>	27.5	27.1	31.4
<b>Grafton</b>	19.5	17.8	17.8
<b>Hillsborough</b>	14.1	11.9	13.0
<b>Merrimack</b>	18.3	13.6	18.2
<b>Rockingham</b>	13.5	10.9	8.5
<b>Strafford</b>	18.9	15.3	19.9
<b>Sullivan</b>	23.9	24.7	22.0
<b>Total</b>	16.6	14.1	16.9

**FIGURE 16. BIRTHS IN WHICH WOMEN REPORTED TOBACCO USE DURING PREGNANCY, BY COUNTY – NEW HAMPSHIRE, 2005**



**Data Highlights:** Rates of tobacco use during pregnancy were significantly higher than the New Hampshire mean in Belknap, Cheshire, Coos, Grafton and Sullivan Counties; the rate was significantly lower than the statewide mean in Hillsborough and Rockingham Counties.

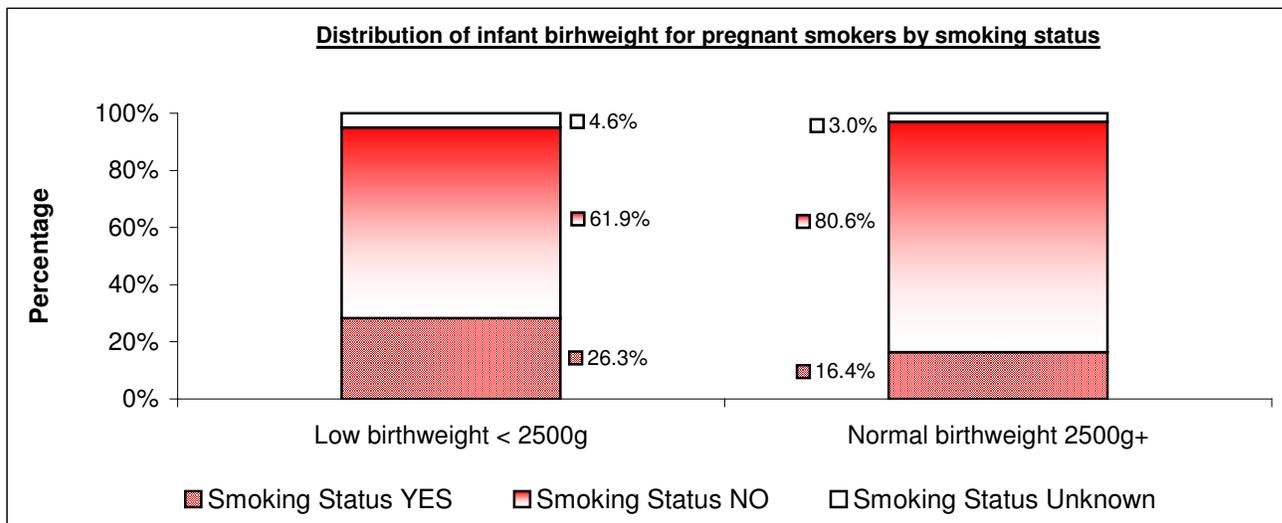
**Method:** Tobacco use was self-reported and indicated use any time during pregnancy. Percentages were based on the number of live births where tobacco use during pregnancy was known. Does not include those who reported unknown, missing or out of state births. The data is limited to NH residents who had a live birth in NH only. Out of state (OOS) births account for 11-12% of NH resident births. The decision to give birth OOS is often related to a complicated pregnancy or location convenience.

**Healthy People 2010 Objective: (16-17c)** Increase the number of pregnant women who report abstinence from cigarette smoking in the past month to 99%.

**Healthy New Hampshire 2010 Objective:** Reduce the number of women who report smoking cigarettes during pregnancy to 10%.

**Data Source:** New Hampshire Vital Statistics Data; Health Statistics and Data Management Unit, NH DHHS.

**FIGURE 17: PERCENTAGE OF LOW BIRTH WEIGHT BY SMOKING STATUS NH, 2005**



**Data Highlights:** In 2005, 1 in 10 (10.5%) of live births in New Hampshire were low birthweight (LBW) babies. Nationally (in the revised states) in 2005, 11.9% of babies born to smokers were LBW compared with 7.5% of babies born to non-smokers. Of all LBW category, 26.3% of women reported smoking during pregnancy, while only 16.4% of women reported smoking under the normal birthweight category. Smoking is considered a major risk factor for both low birth weight and pre term babies and the risk increases with the number of cigarettes smoked. The percentage of infants born at less than 2,500 grams or 5lb 8oz, has generally been on the rise over the last two decades. Differences in demographic characteristics such as maternal age and marital status, maternal education and income explain some of the overall differences in birth outcome among states.

**Methods:** Low birthweight is defined as less than 2500 grams or 5lb 8oz. It is also common to classify low birthweight births into moderately low birthweight (1500-2499 grams) and very low birthweight (less than 1500 grams or 3 1/3 pounds). Babies born too small are often born too soon. While the causes of low birthweight and preterm birth may be different in some cases, there is significant overlap within these populations of infants. Births where the mother reported use of tobacco at some point during the pregnancy divided by the number of births where tobacco use status was known. **Numerator:** Number of births to mothers who reported using tobacco during the pregnancy. **Denominator:** Number of births to mothers where tobacco use is complete on the birth certificate (not missing). The data is limited to NH residents who had a live birth in NH only. Out of state (OOS) births account for 11-12% of NH resident births. The decision to give birth OOS is often related to a complicated pregnancy or location convenience.

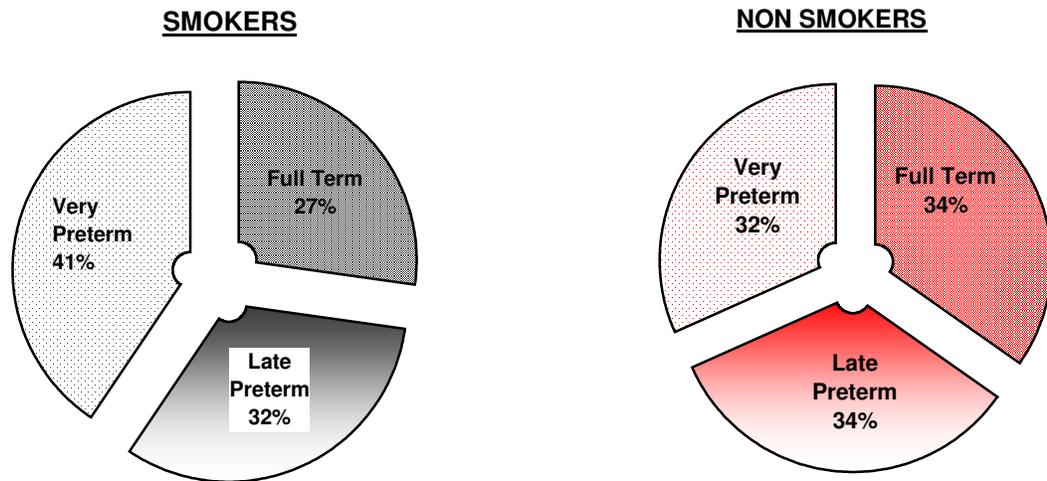
**Healthy People 2010 Objective:** Reduce low birthweight to no more than 5% of live births and reduce preterm births to no more than 7.6% of live births.

**Data Source:** NH Vital Records statistics and The National Center for Health Statistics, Final Natality Data.

TABLE 15. PERCENT SMOKING DURING PREGNANCY BY GESTATIONAL AGE, NH, 2005-2007 (AGGREGATE)

Smoking Status	Full Term	Late Preterm	Very Preterm	Total Counts
Smoker	16%	19%	24%	5870
Non-Smoker	84%	81%	76%	31024
Total Counts	33865 (100%)	2614 (100%)	415 (100%)	36894

FIGURE 18. DISTRIBUTION OF INFANT CLINICAL ESTIMATE OF GESTATIONAL AGE FOR WOMEN REPORTING “YES” AND “NO” TO TOBACCO USE DURING PREGNANCY



**Data Highlights:** The pre-term birth rate in NH increased by 28% from 1995 to 2005. Low weight and pre-term births often accompany each other. While the causes of low birthweight (LBW) and preterm birth may be different in some cases, there is significant overlap within these populations of infants. In 2005, 7.5% of all births were late preterm, whereas 1.6% of all births very preterm. Nationally (in 11 states with revised question) in 2005, 11.9% of babies born to smokers were LBW compared with 7.5% of babies born to non-smokers.<sup>xiii</sup> In New Hampshire between 2005 and 2007, of all very preterm births, 24% of mothers reported smoking cigarettes (100 mothers out of 415 reporting smoking) and for late preterm births, 19% of mothers reported smoking during pregnancy. This shows that smoking is a great risk factor for preterm births and the risk increases with the number of cigarettes smoked.

**Methods:** Preterm birth is defined as less than 37 completed weeks of gestation. It is also common to classify births into *full term* (37 weeks or more completed), *moderately preterm* (32-36 weeks completed) and *very preterm* (less than 32 weeks). **Numerator:** Number of births to mothers who reported using tobacco during the pregnancy. **Denominator:** Number of births to mothers where tobacco use is complete on the birth certificate (not missing). The data is limited to NH residents who had a live birth in NH only. Out of state (OOS) births account for 11-12% of NH resident births. The decision to give birth OOS is often related to a complicated pregnancy or location convenience.

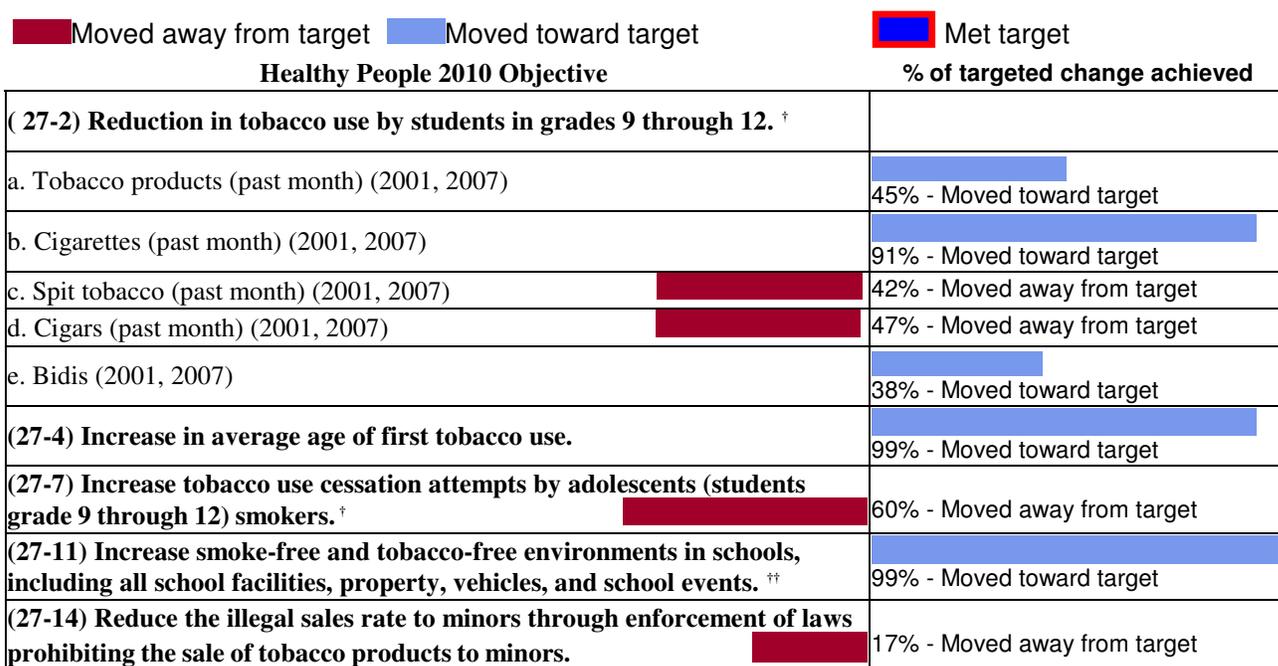
**Healthy People 2010 Objective:** Reduce low birthweight to no more than 5% of live births. Reduce preterm births to no more than 7.6% of live births.

**Data Source:** NH Vital Records statistics and The National Center for Health Statistics, Final Natality Data.

## YOUTH TOBACCO USE NATIONAL OBJECTIVES FOR 2010

TOBACCO USE		NH Baseline Data	NH Current Data	US Healthy People 2010
	Objective			
Healthy People 2010 Objective	Number	Year	Estimate	Year Estimate Target
Reduction in tobacco use by students in grades 9 through 12.				
a. Tobacco products (past month)	(27-2.)	2001	30.7%	2007 26.3% 21.0%
b. Cigarettes (past month)	(27-2.)	2001	25.3%	2007 16.8% 16.0%
c. Spit tobacco (past month)	(27-2.)	2001	4.5%	2007 7.0% 1.0%
d. Cigars (past month)	(27-2.)	2001	11.8%	2007 13.6% 8.0%
e. Bidis	(27-2.)	2001	6.5%	2007 4.8% 2.0%
Increase in average age of first tobacco use				
a. Adolescents aged 12 to 17 years ‡	(27-4.)	1995	12 years	2005 13 - 14 14 years
Increase tobacco use cessation attempts by adolescent (students grade 9 through 12) smokers. †	(27-7.)	2001	59.9%	2007 35.4% 64%
Increase smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles, and school events. ††	(27-11.)	2001	90.1%	2005 99.0% 100%
Reduce the illegal sales rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors. ††	(27-14.)	2000	7.6%	2007 11.9% 0%-5%

**FIGURE 19. PERCENTAGE CHANGE TOWARD ACHIEVING YOUTH TOBACCO-USE HEALTH OBJECTIVES**



**Data Highlights:** *Healthy People 2010* objectives include reduction of tobacco use by youth, preventing youth from starting to smoke and increasing tobacco use cessation for improving the health of all youth. The current data shows progress towards meeting the target goal of reducing cigarette smoking among youths, but reducing the use of other tobacco products, such as spit tobacco and cigars, is moving away from reaching its targeted goal. NH has laws prohibiting sale of tobacco to minors. Progress toward reaching this objective is an ongoing effort.

**Method:** Tracking data for objectives 27-3a and b, 27-4a and b, 27-6, 27-8a and b, 27-9, 27-13g and h, 27-14b, 27-15, 27-18a, b, and c, 27-19, and 27-20a, b, and c are unavailable. Objectives 27-1d and 27-8c were deleted at the midcourse. Years in parentheses represent the baseline data year and the most recent data year used to compute the percent of the Healthy People 2010 target achieved.

$$\text{Percent of targeted change achieved} = \left( \frac{\text{Most recent value} - \text{baseline value}}{\text{Year 2010 target} - \text{baseline value}} \right) \times 100$$

**Data Source:** † NH Youth Tobacco Survey (2001, 2007); ‡ NH Youth Risk Behavioral Survey (because data was not weighted in 1997, 1999 and 2001; 1995 estimate is reported); SYNAR; †† NH School Health Profile.

## YOUTH TOBACCO USE

### Youth Cigarette Smoking

FIGURE 20. CURRENT SMOKING PREVALENCE AMONG HIGH SCHOOL STUDENTS – NH, 1993-2007

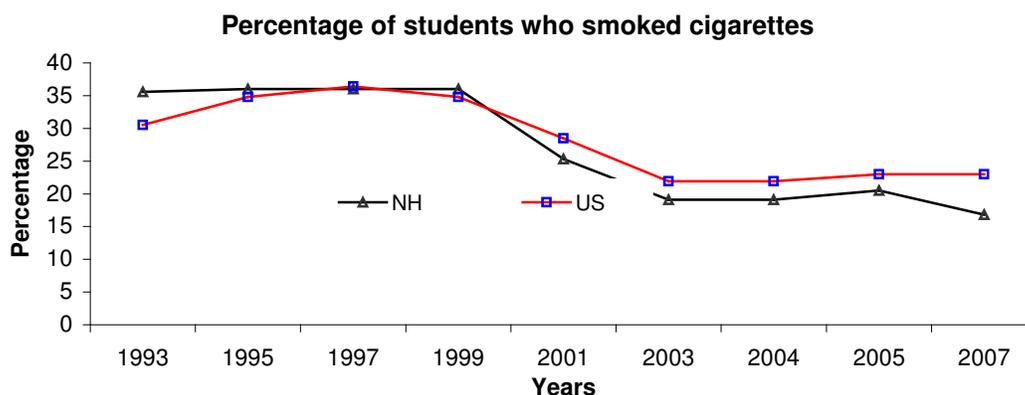


TABLE 16. CURRENT SMOKING PREVALENCE AMONG HIGH SCHOOL STUDENTS – NH, 1993-2007

Year	NH % who smoked	US % who smoked
1993	35.6	30.5
1995	36.0	34.8
1997	No Data	36.4
1999	No Data	34.8
2001	25.3	28.5
2003	19.1	21.9
2005	20.5	23.0
2007	19.0	20.0

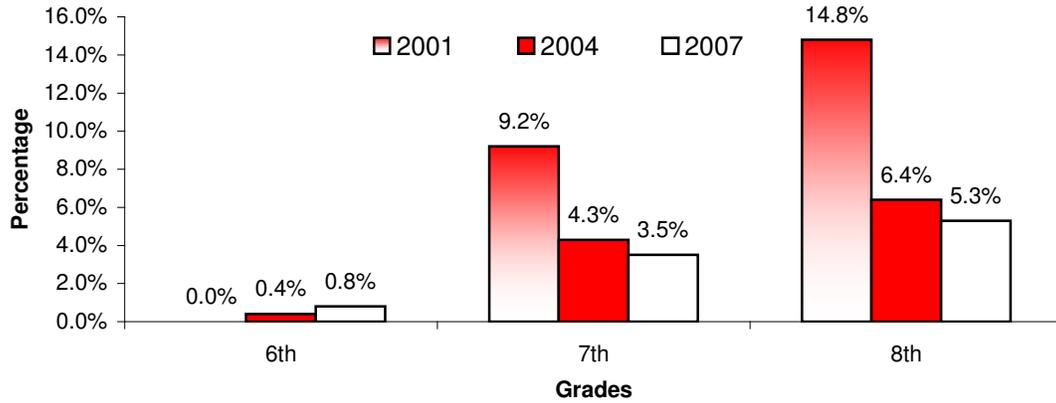
**Data Highlights:** Smoking prevalence among High School students in New Hampshire declined significantly between 1993 and 2007. This decline was attributed to tobacco awareness, education, media communications, enforcement and tobacco control policies. Similar trends have been reported nationally.

**Method:** Current smokers were defined as students who reported cigarette smoking on one or more of the 30 days preceding the survey. New Hampshire data for 1997 and 1999 were not reported due to low rates of response to the NH Youth Risk Behavior Survey and therefore it was not weighted for the state. For the purpose of the chart above, the year with ‘no data’ has been shown with the data from the previous year.

**Healthy People 2010 Objective:** (27-2b) Reduce current cigarette use in students in grades 9-12 to 16%.

**Data Sources:** New Hampshire Youth Risk Behavior Survey.

**FIGURE 21. CURRENT SMOKING PREVALENCE AMONG MIDDLE SCHOOL STUDENTS – NH, 2001-2007**



**TABLE 17. CURRENT SMOKING PREVALENCE AMONG MIDDLE SCHOOL STUDENTS – NH, 2003-2007**

Year	Grades		
	6th	7th	8th
2001	N/A	9.2%	14.8%
2004	0.4%	4.3%	6.4%
2007	0.8%	3.5%	5.3%

**Data Highlights:** Smoking prevalence among Middle School students in New Hampshire declined significantly between 1993 and 2007. This decline was attributed to tobacco awareness, education, media communications, enforcement and tobacco control policies. Similar trends have been reported nationally.

**Method:** Current smokers were defined as students who reported cigarette smoking on one or more of the 30 days preceding the survey. The 6<sup>th</sup> graders were not surveyed in 2001.

**Healthy People 2010 Objective:** (27-2b) Reduce current cigarette use in students in grades 9-12 to 16%.

**Data Sources:** New Hampshire Youth Tobacco Survey, 2001, 2004, and 2007.

## YOUTH TOBACCO USE

### Youth Use of Other Tobacco Products

FIGURE 22. PREVALENCE OF CURRENT USE OF TOBACCO, BY TYPE, AMONG NH HIGH SCHOOL STUDENTS, 2001, 2004, 2007

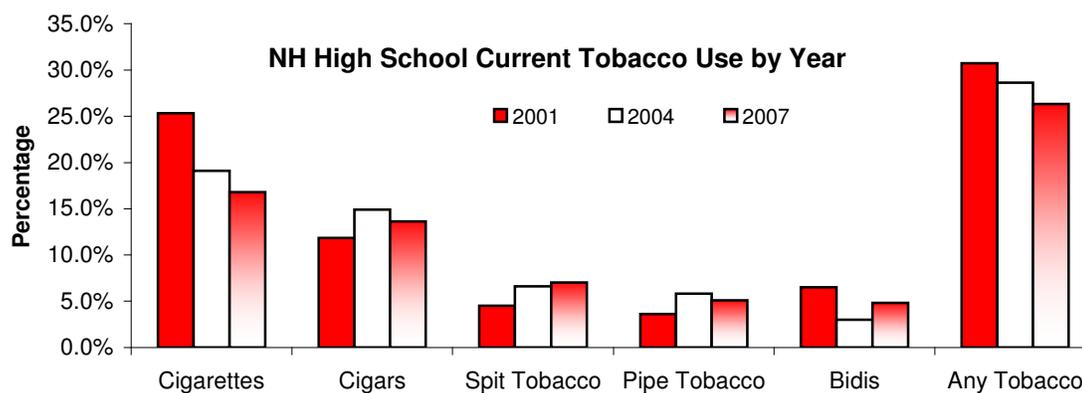


TABLE 18. PERCENTAGE OF HIGH SCHOOL STUDENTS REPORTING TOBACCO USE BY YEAR AND TYPE OF TOBACCO USE

Type	2001	2004	2007
Cigarettes	25.3%	19.1%	16.8%
Cigars	11.8%	14.9%	13.6%
Spit Tobacco	4.5%	6.6%	7.0%
Pipe Tobacco	3.6%	5.8%	5.1%
Bidis	6.5%	3.0%	4.8%
Any Tobacco	30.7%	28.6%	26.3%

**Data Highlights:** Smoking causes significant health problems among adolescents, including cough, phlegm production, increased number and severity of respiratory illnesses, decreased physical fitness, and reduced lung function.<sup>8</sup> Cigars are the most common alternative tobacco product used by High School students in New Hampshire. Use of novel tobacco products, such as bidis, is an emerging problem among youth<sup>xiv</sup>, though the survey shows that it is declining in NH. The survey also indicates an increasing trend for spit tobacco use among High School students.

**Method:** Percent of all respondents reporting having smoked cigarettes on one or more of the previous 30 days. Middle School refers to grades 6-8; High School refers to grades 9-12. Differences between Middle School data from New Hampshire and the United States should be interpreted with caution as the data are from different years. Current users were defined as students who reported product use on one or more of the 30 days preceding the survey. Bidis (also known as beedis, beedies, or beades) are small, brown, hand-rolled cigarettes primarily made in India and other Southeast Asian countries. They consist of tobacco wrapped in a leaf and may be secured with a colorful string at one or both ends. Bidis can be flavored (e.g., chocolate, cherry, and mango) or unflavored.

**Healthy People 2010 Objectives:** (27-2b) To reduce current cigarette smoking among 9-12<sup>th</sup> graders to 16%. (27-2c) To decrease current smokeless tobacco use in 9-12<sup>th</sup> graders to 1% (27-2d) and 8%.

**Data Sources:** New Hampshire Youth Tobacco Survey, 2001, 2004 and 2007.

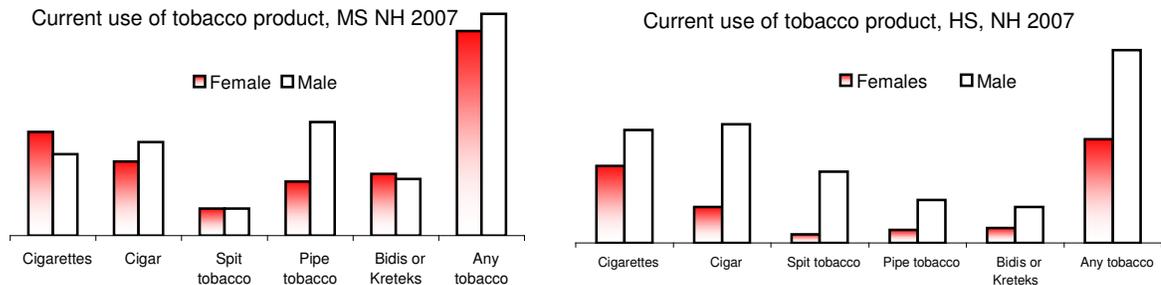
TABLE 19. CURRENT USE OF TOBACCO PRODUCTS AMONG HIGH SCHOOL STUDENTS, BY GENDER – NH, 2007

Tobacco Type	Females		Males	
	%	95% CI	%	95% CI
Cigarettes	13.4	10.5 - 16.3	19.7	16.5 - 22.9
Cigar	6.3	4.6 - 8.0	20.7	18.2 - 23.2
Spit tobacco	1.5	0.8 - 2.2	12.4	9.4 - 15.4
Pipe tobacco	2.3	1.3 - 3.3	7.5	5.5 - 9.5
Bidis or Kreteks	2.6	1.7 - 3.5	6.3	4.5 - 8.1
Any tobacco	18.1	15.1 - 21.1	33.6	30.2 - 37.0

TABLE 20. CURRENT USE OF TOBACCO PRODUCTS AMONG MIDDLE SCHOOL STUDENTS, BY GENDER – NH, 2007

Tobacco Type	Female		Male	
	%	95% CI	%	95% CI
Cigarettes	4.2	2.3 - 6.1	3.3	1.9 - 4.7
Cigar	3.0	2.0 - 4.0	3.8	1.8 - 5.8
Spit tobacco	1.1	0.4 - 1.8	1.1	0.5 - 1.7
Pipe tobacco	2.2	1.2 - 3.2	4.6	2.9 - 6.3
Bidis or Kreteks	2.5	1.5 - 3.5	2.3	1.2 - 3.3
Any tobacco	8.3	5.8 - 10.7	9.0	6.4 - 11.6

FIGURE 23. CURRENT USE OF TOBACCO PRODUCTS AMONG HS AND MS STUDENTS BY GENDER, NH 2007



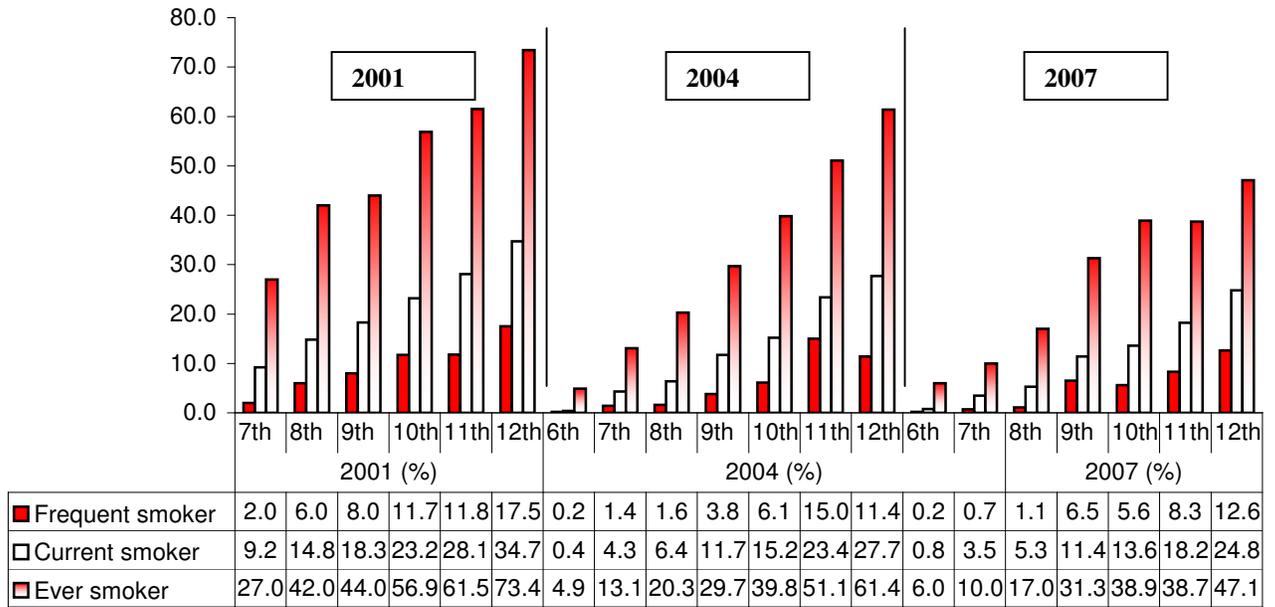
**Data Highlights:** Current use of tobacco products among male and female students in Middle School is similar. With the exception of the lower use of pipe tobacco among females, differences between male and female smokers are not statistically significant. Overall, males are significantly more likely to use some type of tobacco than females. With the exception of cigarettes and bidis in the Middle School, the prevalence of use by males is higher than that of females for all tobacco types. Current use of tobacco among males and females in High School is however significantly different. Male students are more likely to use tobacco products than female students. This difference is significant in all types of tobacco.

**Method:** Current users were defined as students who reported product use on one or more of the 30 days preceding the survey. Use of any tobacco product included use of smokeless tobacco, cigars, pipes, bidis, or cigarettes.

**Healthy People 2010 Objectives:** (27-2b) Reduce current cigarette smoking in students in grades 9-12 to 16%. (27-2c) Decrease the number of current users of smokeless tobacco in youth to 1%. (27-2d) Decrease the number of current cigar smokers among youth in grades 9-12 to 8%.

**Data Source:** New Hampshire Youth Tobacco Survey, 2007.

**FIGURE 24. HIGH SCHOOL STUDENTS WHO ARE FREQUENT SMOKERS, CURRENT SMOKERS, AND HAVE EVER TRIED CIGARETTE SMOKING, BY GRADE – NH, 2001, 2004, 2007**



**Data Highlights:** In New Hampshire, the greatest increases in youth cigarette smoking were between grades 8 and 9, which often represent the transition from Middle to High School. Prevalence continue to increase, but more gradually, between grades 9 and 12.

**Method:** Frequent smokers were defined as students who reported cigarette use on 20 or more of the 30 days preceding the survey. Current smokers were defined as students who reported cigarette smoking on one or more of the 30 days preceding the survey. Ever smokers of cigarettes were students who had ever smoked, even one or two puffs.

**Healthy People 2010 Objective:** (27-2b) Reduce current cigarette use in students in grades 9-12 to 16%.

**Data Sources:** New Hampshire Youth Tobacco Survey, 2007.

FIGURE 25, 26. CURRENT, FREQUENT AND EVER SMOKERS, NH HIGH SCHOOL STUDENTS

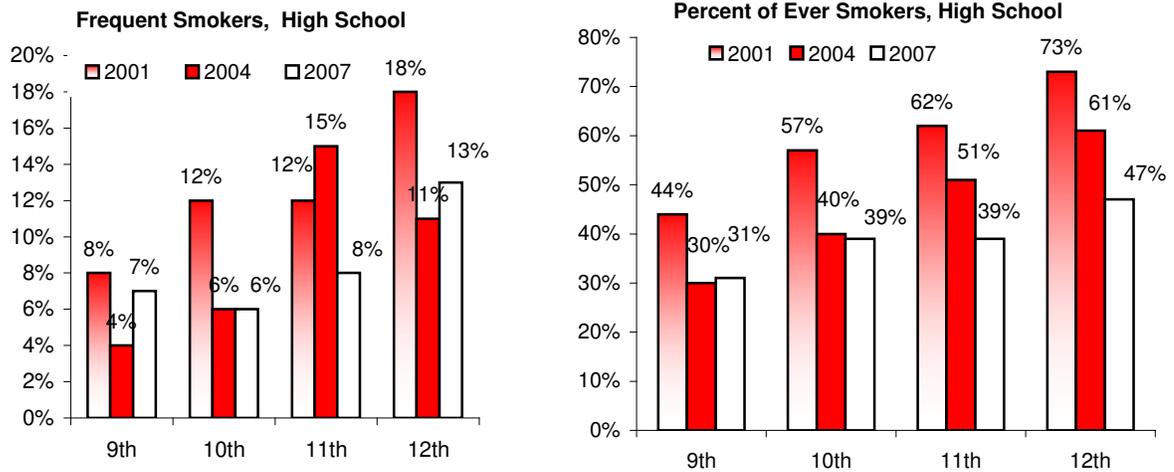
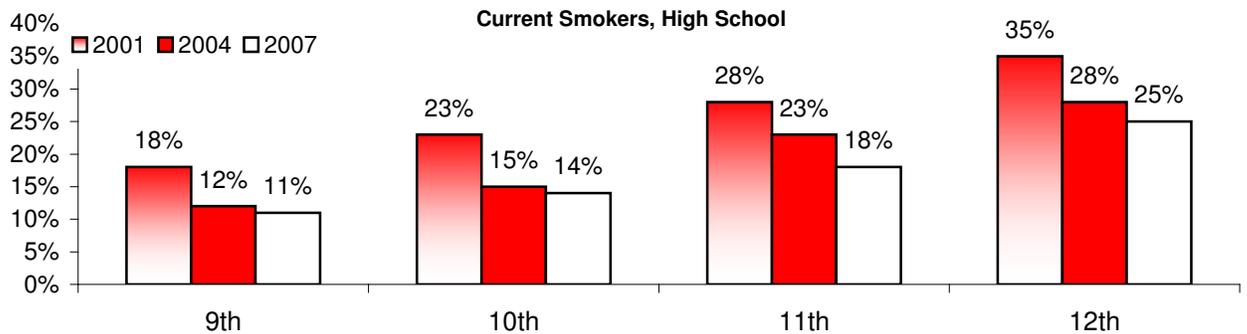


FIGURE 27. CURRENT SMOKERS, NH HIGH SCHOOL STUDENTS



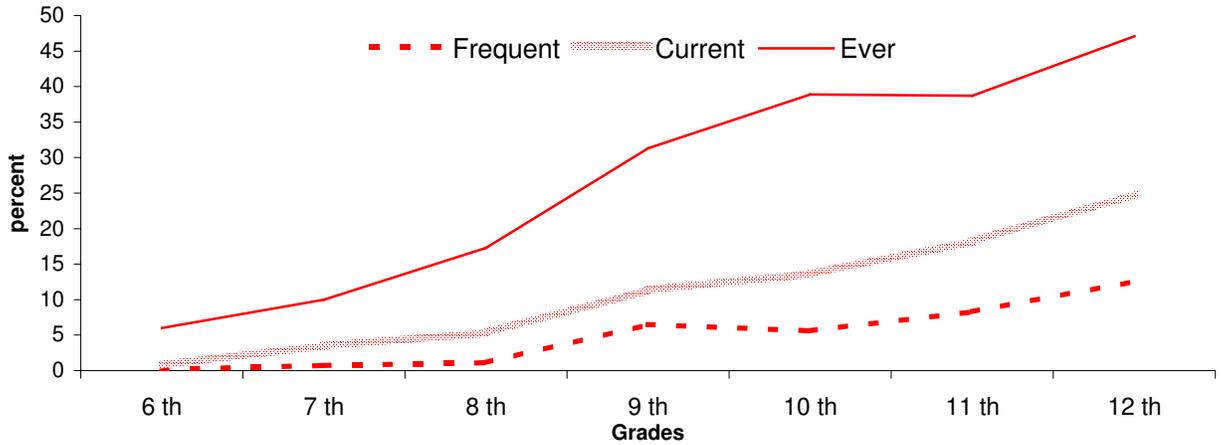
**Data Highlights:** In New Hampshire, the sharpest increases in youth cigarette smoking were between grades 8 and 9, which often represent the transition from Middle to High School. Rates continue to increase, but more gradually, between grades 9 and 12.

**Method:** Frequent smokers were defined as students who reported cigarette use on 20 or more of the 30 days preceding the survey. Current smokers were defined as students who reported cigarette smoking on one or more of the 30 days preceding the survey. Ever smokers of cigarettes were students who had ever smoked, even one or two puffs.

**Healthy People 2010 Objective:** (27-2b) Reduce current cigarette use in students in grades 9-12 to 16%.

**Data Sources:** New Hampshire Youth Tobacco Survey, 2007.

**FIGURE 28. HIGH SCHOOL AND MIDDLE SCHOOL STUDENTS WHO ARE FREQUENT SMOKERS, CURRENT SMOKERS, AND HAVE EVER TRIED CIGARETTE SMOKING, BY GRADE – NEW HAMPSHIRE, 2007**



**TABLE 21. HIGH SCHOOL AND MIDDLE SCHOOL STUDENTS WHO ARE FREQUENT SMOKERS, CURRENT SMOKERS, AND HAVE EVER TRIED CIGARETTE SMOKING, BY GRADE – NEW HAMPSHIRE, 2007**

	6 <sup>th</sup> Grade	7 <sup>th</sup> Grade	8 <sup>th</sup> Grade	9 <sup>th</sup> Grade	10 <sup>th</sup> Grade	11 <sup>th</sup> Grade	12 <sup>th</sup> Grade
<b>Frequent smoker (%)</b>	.2	.7	1.1	6.5	5.6	8.3	12.6
<b>Current smoker (%)</b>	0.8	3.5	5.3	11.4	13.6	18.2	24.8
<b>Ever smoker (%)</b>	6.0	10.0	17.3	31.3	38.9	38.7	47.1

**Data Highlights:** In New Hampshire, the sharpest increases in youth cigarette smoking were between grades 8 and 9, which often represent the transition from Middle to High School. Rates continue to increase, but more gradually, between grades 9 and 12.

**Method:** Frequent smokers were defined as students who reported cigarette use on 20 or more of the 30 days preceding the survey. Current smokers were defined as students who reported cigarette smoking on one or more of the 30 days preceding the survey. Ever smokers of cigarettes were students who had ever smoked, even one or two puffs.

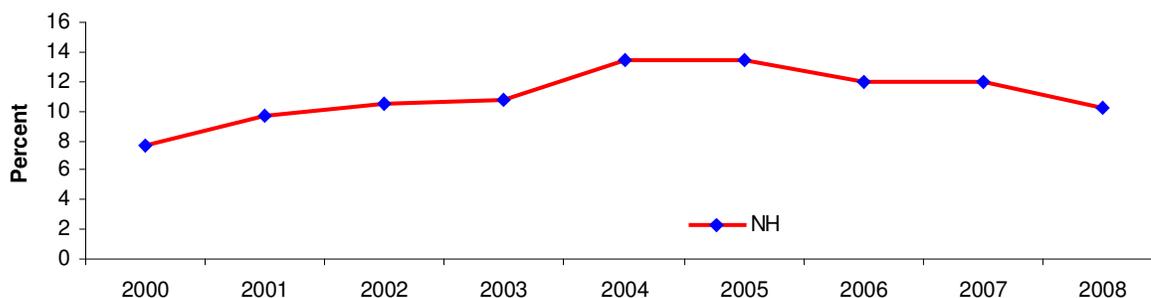
**Healthy People 2010 Objective:** (27-2b) Reduce current cigarette use in students in grades 9-12 to 16%.

**Data Sources:** New Hampshire Youth Tobacco Survey, 2007.

## YOUTH TOBACCO USE

### Youth Access to Tobacco and Compliance Checks

**FIGURE 29. THE PERCENTAGE OF INSPECTED RETAIL OUTLET SELLING TOBACCO PRODUCTS TO MINOR – NEW HAMPSHIRE, 1997-2008**



**TABLE 22. THE PERCENTAGE OF INSPECTED RETAIL OUTLET SELLING TOBACCO PRODUCTS TO MINOR – NEW HAMPSHIRE, 1997-2008**

Year	(%)	95% CI	Number of Outlets Inspected	Number of Outlets In Violation
2000	7.6	5.9-9.3	625	48
2001	9.7	7.7-11.7	567	55
2002	10.5	8.4-12.5	563	59
2003	10.7	8.6-12.8	666	63
2004	13.4	11.1-15.7	572	61
2005	13.4	11.1- 15.7	558	74
2006	12.0	8.5-15.5	324	39
2007	11.9	9.2-14.6	403	50
2008	10.2	8.0-12.4	493	51

**Data Highlights:** The Synar Amendment is a Federal Law that was enacted in July 1992. It requires states to enact and enforce laws restricting the sale and distribution of tobacco products to youth under the age of 18 and to monitor the rate of sales to minors. SAMSHA requires states to reduce the illegal sales rate to minors to less than 20%. New Hampshire has met this requirement since 1997 and has never been out of compliance with Synar regulations.

**Method:** The NH Alcohol & Drug Abuse Prevention Program conducts these inspections for the purpose of education and data collection. The Department of Revenue Administration provides a list of stores and vending machines from which the sample is selected. A stratified simple random sampling is used to select the sample. Underage buyers (UABs) must be 14-17 years old. Youth and adults are trained annually to conduct annual random, unannounced inspections of over the counter tobacco outlets and vending machine to ensure compliance with the law. Results are documented and analyzed to determine the rate of underage purchasing of cigarettes. Vendors are notified of the results at their establishment and educated as to the NH statute for underage buying.

**Healthy People 2010 Objectives:** (27-14) Reduce the illegal sales rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors to 5% or less by 2010.

**Data Source:** Tobacco Retailer Compliance check (Annual Synar Report), 1997-2008.

TABLE 23. NUMBER OF COMPLIANCE CHECKS AND SALES TO MINORS – NEW HAMPSHIRE, 2001-2003

FISCAL YEARS 2004 THROUGH 2008		
DATE OF COMPLIANCE CHECK	TOWN OF COMPLIANCE CHECK	NUMBER OF LICENSEES NOT IN COMPLIANCE
2/19/2004	HINSDALE	1
2/19/2004	WINCHESTER	1
6/26/2004	MANCHESTER	2
9/26/2004	CONWAY	1
10/26/2004	EXETER	4
11/12/2004	NASHUA	13
12/1/2004	FITZWILLIAM	1
12/1/2004	KEENE	2
12/1/2004	TROY	1
12/10/2004	KEENE	5
12/15/2004	KEENE	2
12/28/2004	HINSDALE	1
<b>TOTAL</b>		<b>50</b>
11/12/2006	KEENE	1
<b>TOTAL</b>		<b>1</b>
8/14/2007	PELHAM	1
<b>TOTAL</b>		<b>1</b>

**Data Highlights:** New Hampshire law prohibits the sale of tobacco to an individual under age 18 years (RSA 126-K: 4). The New Hampshire Liquor Commission’s (NHLC) Enforcement Bureau tasks investigators with enforcing the NH RSA 126K: 4, Youth Access Law (Appendix A.), by monitoring places where youth congregate to smoke such as parking lots, shopping malls, recreation parks, and sidewalks outside school ground.

**Method:** The New Hampshire Liquor Commission, Bureau of Liquor Enforcement (BLE), is tasked with enforcing RSA 126-K:4, The Youth Access Law, to prevent individuals under the age of 18 having possession of tobacco products. The BLE conducts spontaneous tobacco compliance checks year-round and investigates complaints about underage buying. Between October 2001 and June 2003 the TPCP created a Memorandum of Understanding (MOU) with the BLE to conduct comprehensive checks and report the data to TPCP. The purpose of these checks differ from Synar, as the youth are accompanied by a BLE Investigator and if a buy is completed, a summons is issued to the sales clerk on the spot.

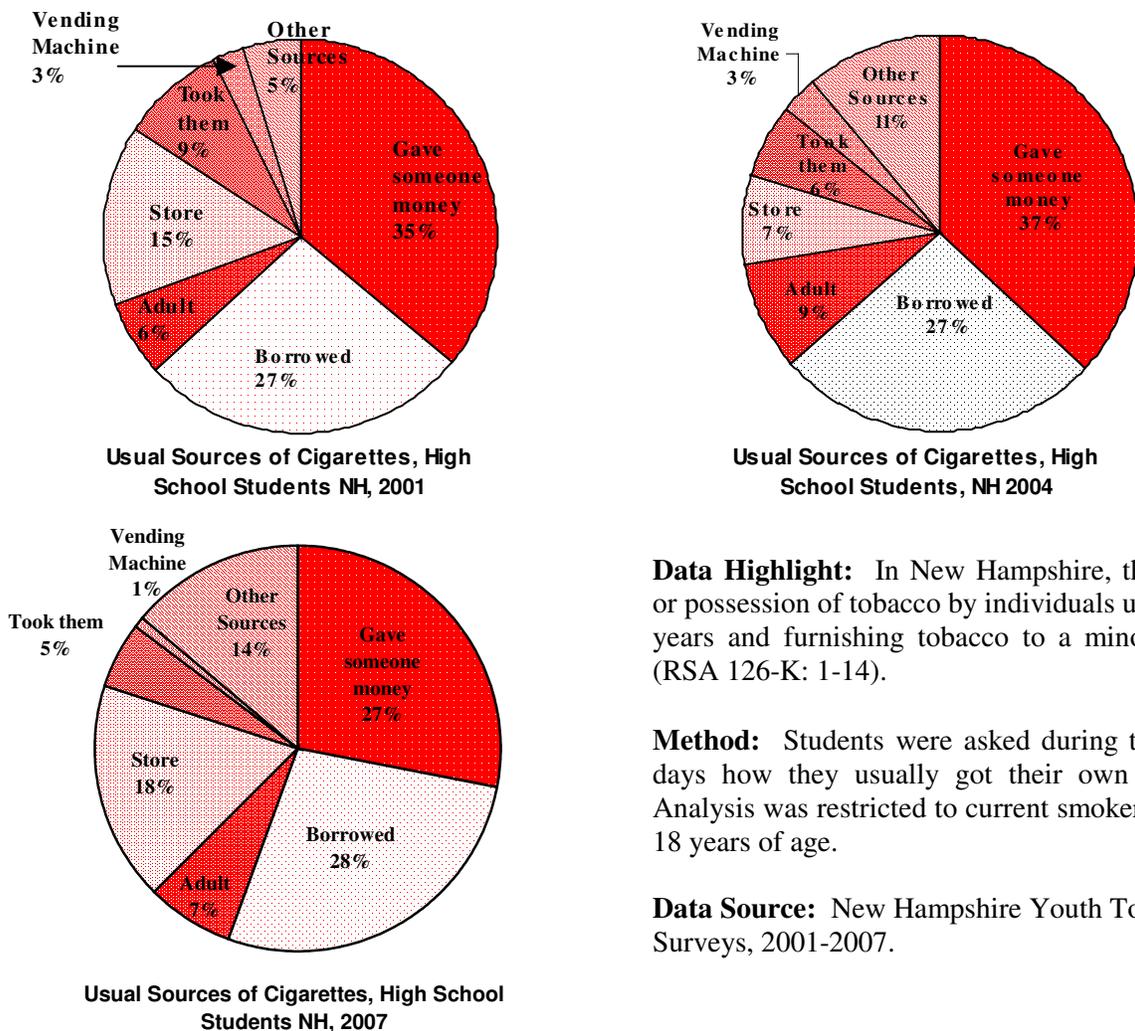
**Healthy People 2010 Objectives:** (27-14) Reduce the illegal sales rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors to 5% or less.

**Data Source:** New Hampshire Liquor Commission, Bureau of Liquor Enforcement.

TABLE 24. USUAL SOURCE OF CIGARETTES FOR HIGH SCHOOL STUDENTS WHO CURRENTLY SMOKE – NEW HAMPSHIRE, 2001, 2004, 2007

	2001	2004	2007
Gave someone else money to buy them for me	36.2%	36.6%	27.9%
Borrowed or bummed them from someone else	26.8%	26.5%	27.5%
Person >18 years of age gave them to me	6.4%	8.9%	7%
Bought them in a store such as convenience store, Supermarket, discount store, or gas station	14.8%	7.2%	17.6%
Took them from a store or family member	8.6%	6.0%	5.1%
Bought them from a vending machine	2.5%	3.1%	0.9%
Got them some other way	4.7%	11.1%	13.9%

FIGURE: 30, 31, 32. USUAL SOURCES OF CIGARETTES, HIGH SCHOOL STUDENTS, 2001, 2004, 2007



**Data Highlight:** In New Hampshire, the purchase or possession of tobacco by individuals under age 18 years and furnishing tobacco to a minor is illegal (RSA 126-K: 1-14).

**Method:** Students were asked during the past 30 days how they usually got their own cigarettes. Analysis was restricted to current smokers less than 18 years of age.

**Data Source:** New Hampshire Youth Tobacco Surveys, 2001-2007.

## YOUTH TOBACCO USE

### Tobacco Use Prevention In New Hampshire Schools

TABLE 25. POLICY PROHIBITING THE USE OF CIGARETTES BY NH SCHOOLS

NH schools that have a tobacco-free environment	52 %
NH schools that post signs marking a tobacco-free school zone	83 %
NH schools that provide referrals to tobacco cessation programs for faculty and staff	40 %
NH schools that prohibit all tobacco advertising	86 %
Among NH schools that require a health education course, % that taught 16 tobacco-use prevention topics	58 %
NH schools in which the lead health education teacher received staff development during the past 2 years on tobacco-use prevention	45 %

**Data Highlights:** By New Hampshire State Law, RSA 126-K:7<sup>xv</sup>, “No person shall use any tobacco product in any public educational facility or on the grounds of any public educational facility.” All public schools and most private schools in New Hampshire have adopted some type of policy prohibiting the use of cigarettes by students. According to the Centers for Disease Control and Prevention, a school policy on tobacco use must be consistent with state and local laws and should include the following elements: 1) an explanation of the rationale for preventing tobacco use; 2) prohibitions against tobacco use by students, all school staff, parents, and visitors on school property, in school vehicles, and at school-sponsored functions away from school property; 3) prohibitions against tobacco advertising in school buildings, at school functions, and in school publications; 4) a requirement that all students receive instruction on avoiding tobacco use; 5) provisions for students and all school staff to have access to programs to help them quit using tobacco; 6) procedures for communicating the policy to students, all school staff, parents or families, visitors, and the community; and 7) provisions for enforcing the policy.

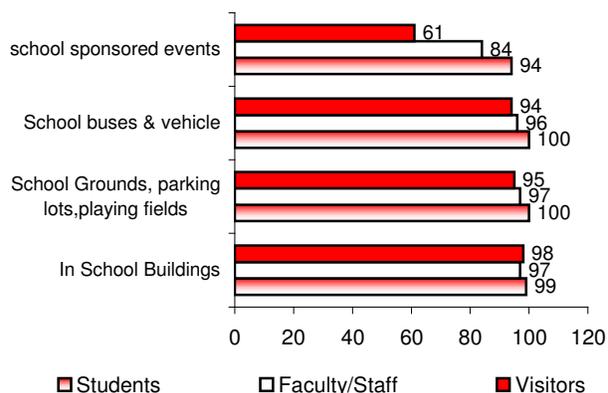
**Method:** Data was gathered from interviews with Principals in schools with grades 6 through 12. A tobacco-free environment prohibits all tobacco use by students, school staff members, and visitors in school buildings, on school property, in school buses or other vehicles used to transport students, and at off-campus school-sponsored events. Prohibits all tobacco advertising in school buildings; on school grounds including on the outside of the school building, on playing fields, or other areas of the campus; on school buses or other vehicles, in school publications, and through sponsorship of school events, and prohibits students from wearing tobacco brand-name apparel or carrying merchandise with tobacco company names, logos, or cartoon characters on it.

**Healthy People 2010 Objective:** (27-11) Increase smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles, and school events to 100%.

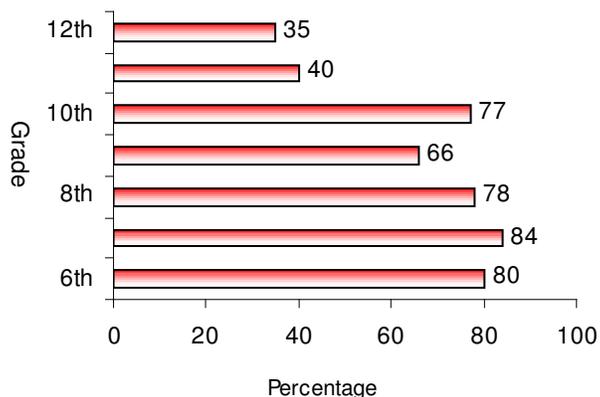
**Data Source:** New Hampshire Department of Education, 2006 School Health Profiles Report.

**FIGURE 33, 34, 35, 36 TOBACCO USE PREVENTION IN NEW HAMPSHIRE SCHOOLS**

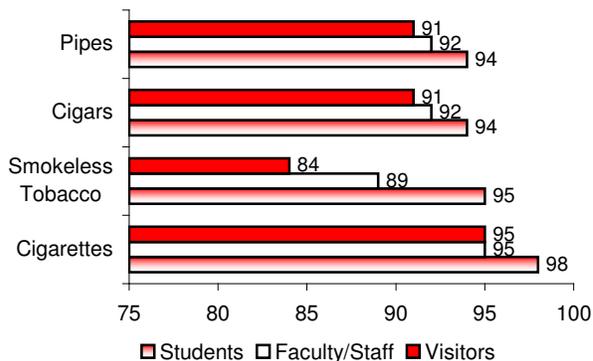
**Figure 33. Percentage of schools prohibiting tobacco-use for students, faculty, staff and visitors by location**



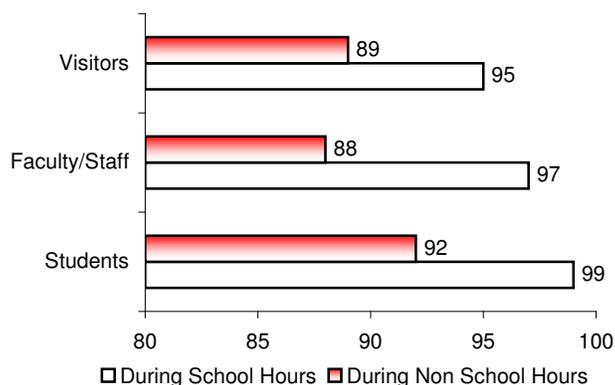
**Figure 34. Grades in which instruction on tobacco use prevention was provided-NH, 2006**



**Figure 35. Percentage of schools prohibiting tobacco use for students, faculty/staffs and visitors, NH 2006**



**Figure 36. Percentage of schools prohibiting tobacco use during hours of school, NH 2006**



**Data Highlights:** By New Hampshire State Law, RSA 126-K:7<sup>xvi</sup>, “No person shall use any tobacco product in any public educational facility or on the grounds of any public educational facility.” All public school and most private schools in New Hampshire have adopted some type of policy prohibiting the use of cigarettes by students.

**Method:** Data was gathered from interviews with Principals in schools with grades 6 through 12. A tobacco-free environment prohibits all tobacco use by students, school staff members, and visitors in school buildings, on school property, in school buses or other vehicles used to transport students, and at off-campus school-sponsored events.

**Healthy People 2010 Objective:** (27-11) Increase smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles, and school events to 100%.

**Data Source:** New Hampshire Department of Education, School Health Profiles Report, 2006

**TABLE 26. PERCENTAGE OF SCHOOLS IN WHICH TEACHERS TAUGHT EACH OF THE FOLLOWING TOBACCO-USE PREVENTION TOPICS IN A REQUIRED HEALTH EDUCATION COURSE.\***

	<b>N</b>	<b>Percent</b>
Short- and long-term health consequences of cigarette smoking (such as stained teeth, bad breath, heart disease, and cancer)	129	97
Benefits of not smoking cigarettes (including long- and short-term health benefits, social benefits, environmental benefits, and financial benefits)	129	96
Short- and long-term health consequences of cigar smoking	130	85
Short- and long-term health consequences of using smokeless tobacco	130	93
Benefits of not using smokeless tobacco Senior High School	131	93
Addictive effects of nicotine in tobacco products	131	95

\*Among those schools that require a health education course for students in any of grades 6 through 12.  
N=Unweighted total number of observations

**TABLE 27. PERCENTAGE OF SCHOOLS IN WHICH TEACHERS TAUGHT EACH OF THE FOLLOWING TOBACCO-USE PREVENTION TOPICS IN A REQUIRED HEALTH EDUCATION COURSE.\***

	<b>N</b>	<b>Percent</b>
How many young people use tobacco	130	90
Influence of families on tobacco use	130	92
Influence of the media on tobacco use	129	95
Social or cultural influences on tobacco use	129	86
How to find valid information or services related to tobacco-use prevention or cessation	129	79
Making a personal commitment not to use tobacco	130	70

\*Among those schools that require a health education course for students in any of grades 6 through 12.  
N=Unweighted total number of observations

**TABLE 28. PERCENTAGE OF SCHOOLS IN WHICH TEACHERS TAUGHT EACH OF THE FOLLOWING TOBACCO-USE PREVENTION TOPICS IN A REQUIRED HEALTH EDUCATION COURSE.\***

	<b>N</b>	<b>Percent</b>
How students can influence or support others to prevent tobacco use	130	83
How students can influence or support others in efforts to quit using tobacco	131	81
Resisting peer pressure to use tobacco	130	91
The health effects of environmental tobacco smoke (ETS) or second-hand smoke	130	94
All 16 tobacco-use prevention topics	123	58

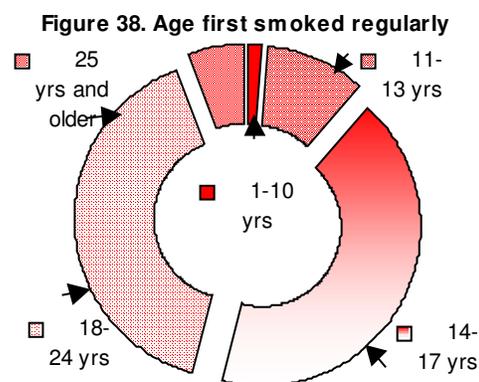
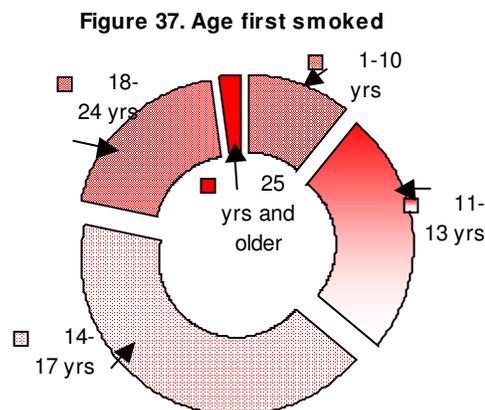
\*Among those schools that require a health education course for students in any of grades 6 through 12.  
N=Unweighted total number of observations

**Data Source.** New Hampshire Department of Education, School Health Profile Report, 2006. Weighted Lead Health Education Teacher Survey Results.

## INITIATION

TABLE 29. AGE ADULTS WHO SMOKED REPORTED FIRST SMOKING REGULARLY – NH, 2003

Age first smoked (years)	%	95% CI
<10	10.9	9.4-12.4
11-13	25.3	23.3-27.3
14-17	42.3	40.1-44.6
18-24	19.2	17.5-20.9
25 and older	2.3	1.7-2.9
Average age first smoked	14.9	14.7-15.1
Age first smoked regularly		
<10	1.5	1.0-2.1
11-13	10.1	8.6-11.6
14-17	42.7	40.3-45.0
18-24	40.0	37.7-42.2
25 and older	5.7	4.7-6.7
Average Age first smoked regularly	17.5	17.3-17.7



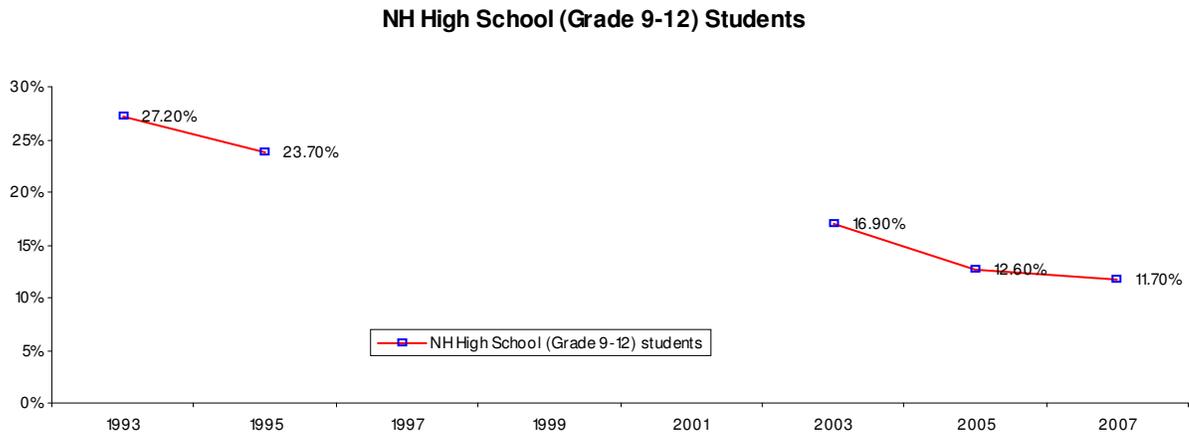
**Data Highlight:** Forty two percent of New Hampshire adults who are smokers (current and former) reported first smoking cigarettes when they were between the ages of 14-17 years. Adults also reported smoking regularly between ages 14-17 years and between 18-24 years, which are usually transition years at High School and when they start college. The average age of BRFSS respondents in 2003 was 49 years. So if, on average they started smoking when they were 15, it was (on average) 34 years ago. Seventy nine percent of adults who had smoked 100 or more cigarettes in their lifetime first smoked a cigarette before the age of 15. Fifty-four percent began smoking regularly before age 18. On average, adults reported smoking their first cigarette when they were 15 years old and started smoking regularly when they were 17 years old. This information is useful in designing and planning programs for targeted tobacco use prevention.

**Method:** Data were restricted to people who reported having smoked 100 cigarettes in their lifetime (current or former smokers). All respondents were 18 years or older.

**Healthy People 2010:** (27-4) Increase the average age of first tobacco use by a). Adolescents aged 12-17 years to 14 years and b). Young adults aged 18-24 years to 16 years of age.

**Data Source:** New Hampshire BRFSS, 2003, Health Statistics and Data Management.

**FIGURE 39. PERCENT OF YOUTH REPORTING SMOKING A WHOLE CIGARETTE FOR THE FIRST TIME BEFORE AGE 13**



Percentage of NH High School Youth reporting smoking a whole cigarette for the first time before age 13.	1993	1995	2003	2005	2007
	27.2%	23.7%	16.9%	12.6%	11.7%

**Data Highlights:** Initiation of smoking occurs most often in grade 6 through 9 (i.e., most often at ages 11-12 to 14-15). Analyses presented in the II volume of *Monitoring the Future Survey*<sup>1</sup> and elsewhere have shown that cigarette smoking evidences a clear “cohort effect.” That is, if a class (or birth) cohort establishes an unusually high rate of smoking at an early age relative to other cohorts, the rate is likely to remain high throughout the life cycle relative to that of other birth cohorts at equivalent ages. A more recent analysis, based on the 1995 follow-up survey, showed similar results. Nearly two-thirds (63%) of those who had been daily smokers in the 12th grade were still daily smokers seven to nine years later. In 1998 and 1999, while smoking was declining among secondary school students at all grades, smoking increased significantly for college students, no doubt reflecting the cohort effect from earlier, heavier-smoking classes of High School seniors moving into the older age groups.

**Method:** Data were restricted to people who reported having smoked 100 cigarettes in their lifetime (current or former smokers). All respondents were 18 years or older. The follow up samples in *Monitoring the Future*, which draws the college sample in senior year of High School, have considerable advantages for generating a broadly representative sample of college students who emerge from each graduating cohort (and it does so at very low cost). Further, its “before”, “during”, and “after” college measurement design permits examination of the many changes associated with the college experience.

**Healthy People 2010:** (27-4) Increase the average age of first tobacco use by a), Adolescents aged 12-17 years to 14 years and b), Young adults aged 18-25 years to 16 years of age.

**Data Source:** New Hampshire Youth Risk Behavioral Surveillance, 2007.

<sup>1</sup> Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2005). *Monitoring the Future national survey results on drug use, 1975-2004: Volume II, College students and adults ages 19-45* (NIH Publication No. 05-5728). Bethesda, MD: National Institute on Drug Abuse.

TABLE 30. PERCENT OF COLLEGE STUDENTS REPORTING TIME THEY FIRST TRIED SMOKING, 2005

		Frequency	Percent %
Valid	I have never smoked	1041	32.2
	Before I started college	1869	57.8
	After I started college	321	9.9
	Total	3231	100.0

FIGURE 40. PERCENT OF COLLEGE STUDENTS REPORTING TIME THEY FIRST TRIED SMOKING



**Data Highlights:** In 2005, 58% of NH college students reported first smoking before they started college and 10% reported smoking after starting college. The higher percentage of students reporting smoking cigarettes before college can be a cohort effect, meaning that this population already started smoking when they were in High School. In 2005 when this group was in high school, the high school smoking rate is higher than what it is today. With decreasing smoking rates in High School we should be able to see this proportion change over time. However, more college level surveys would be necessary to make this comparison.

**Methods:** Smoking status was calculated on the basis of three items: (a) Have you tried cigarette smoking, even one or two puffs; (b) Have you smoked at least 100 cigarettes in your entire life; and (c) Do you now smoke cigarettes everyday, some days or not at all? Students who responded “no” to the first question or who did not smoke 100 or more cigarettes in their life were classified as non-smokers. Current smokers were those who smoked 100 cigarettes or more and who currently smoked everyday or some days. Current users of cigars, pipes or smokeless tobacco were defined as students having used these products during the past 30 days.

**Data Source:** New Hampshire Higher Education Alcohol, Tobacco, and Other Drug Survey, 2005.

FIGURE 41. USUAL BRAND SMOKED BY HIGH SCHOOL STUDENTS – NEW HAMPSHIRE, 2001-2007

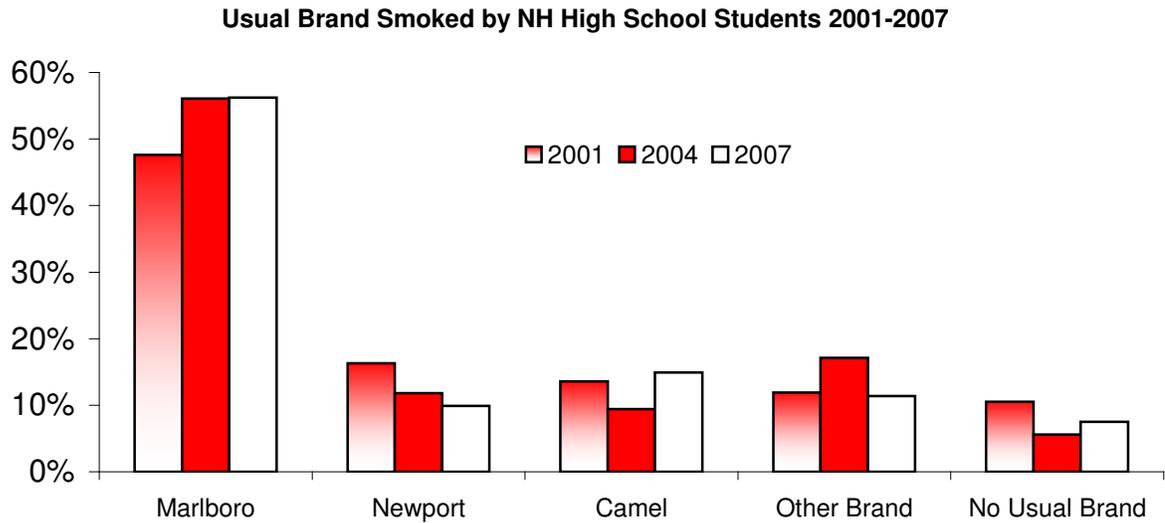


TABLE 31. USUAL BRAND SMOKED BY HIGH SCHOOL STUDENTS – NEW HAMPSHIRE, 2001-2007

	2001	2004	2007
<b>Marlboro</b>	47.6%	56.1%	56.2%
<b>Newport</b>	16.3%	11.8%	9.9%
<b>Camel</b>	13.6%	9.4%	14.9%
<b>Other Brand</b>	11.9%	17.1%	11.4%
<b>No Usual Brand</b>	10.5%	5.6%	7.5%

**Data Highlights:** In New Hampshire, Marlboro was the most popular brand of cigarettes for High School students who smoked. This is consistent with national data.<sup>xvii</sup> Based on data from New Hampshire Operation Storefront from 2001-2002, Marlboro was the most advertised brand of cigarettes in stores.

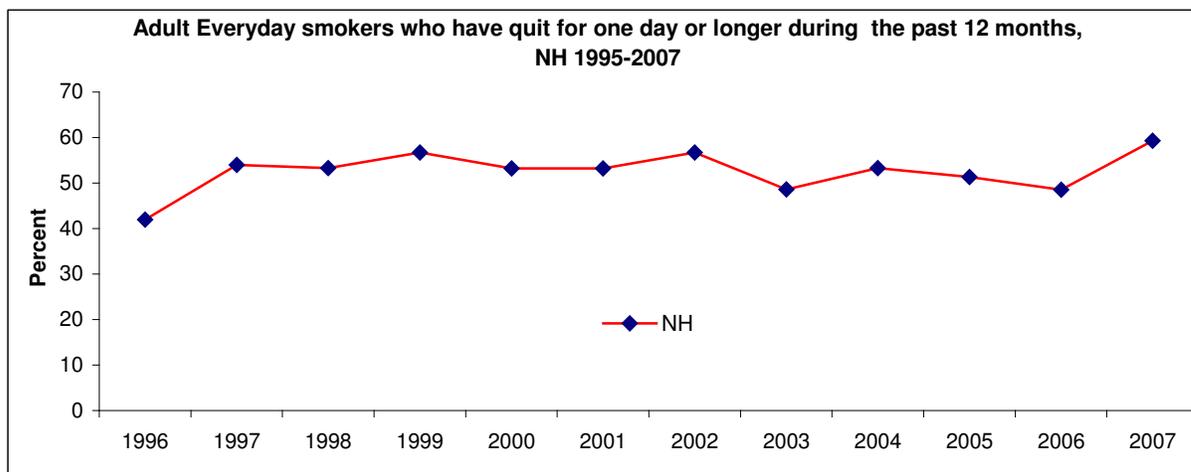
**Method:** YTS survey asks students in New Hampshire High School youth who currently smoked what brand of cigarettes they usually smoked.

**Data Source:** New Hampshire Youth Tobacco Survey, 2001, 2004, 2007.

## CESSATION

### Adult Cessation

**FIGURE 42. ADULT EVERYDAY SMOKERS WHO HAVE QUIT FOR ONE DAY OR LONGER DURING THE PAST TWELVE MONTHS – NH, 1995-2007**



**TABLE 32. PERCENT ADULT EVERYDAY SMOKERS WHO HAVE QUIT FOR ONE DAY OR LONGER DURING THE PAST TWELVE MONTHS – NEW HAMPSHIRE AND THE UNITED STATES, 1995-2007**

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>NH</b>	44.7	41.9	54.0	53.3	56.7	53.2	53.2	56.7	48.6	53.3	51.3	58.0	59.3
<b>US</b>	44.1	45.3	49.2	47.8	51.3	49.4	---	51.8	47.0	---	---	51.5	---

**Data Highlights:** The CDC reports “strategies to help people quit smoking can yield significant health and economic benefits. Effective cessation strategies include brief advice by medical providers, counseling, and pharmacotherapy and systems changes.”<sup>xviii</sup> Actions that increase quit rates include telephone tobacco treatment quitlines, covering treatment of tobacco use under both public and private insurance, and eliminating cost barriers to treatment for underserved populations, particularly the uninsured.<sup>xviii</sup>

**Method:** All respondents were 18 years or older. The denominator included all those that reported having smoked at least 100 cigarettes in their lifetime and now smoke every day. Those with “missing”, “don’t know”, “refused answers” or not reporting having smoked 100 cigarettes in their lifetime, were excluded from the denominator. National data represents the median values, while New Hampshire data represents the mean value. Percentages are weighted to population characteristics. Rows with less than 50 observations and cells that contain a confidence interval with a half-width of greater than 10, have been suppressed.

**Healthy People 2010 Objective:** (27.5) Increase cessation attempts by adult smokers to 75% per year.

**Data Source:** Behavioral Risk Factor Surveillance System, 1995-2007.

TABLE 33. ADULT EVERYDAY SMOKERS WHO HAVE QUIT FOR ONE DAY OR LONGER DURING THE PAST TWELVE MONTHS BY DEMOGRAPHIC CHARACTERISTICS – NH, 2007

Demographics		Adult Everyday Smoker	
		%	C.I. (95%)
<b>TOTAL</b>	<b>(Some Days)</b>	<b>81.9</b>	<b>76.1-87.7</b>
<b>TOTAL</b>	<b>(Everyday)</b>	<b>52.9</b>	<b>54.3-61.7</b>
	Male	48.6	42.6-54.7
	Female	51.4	45.3-57.4
<b>Age</b>			
	18-24	10.0	5.4-14.7
	25-34	26.3	20.3-32.3
	35-44	23.7	18.8-28.6
	45-54	22.9	18.4-27.4
	55-64	10.9	8.0-13.7
	65+	6.2	4.2-8.2
<b>Education</b>			
	Less than HS or GED	16.8	11.9-21.7
	H.S. or G.E.D.	39.9	34.0-45.8
	Some Post-H.S.	27.9	22.4-33.5
	College Graduate	15.4	11.3-19.5
<b>Income</b>			
	Less than \$15,000	11.5	7.6-15.4
	\$15,000- 24,999	18.7	13.9-23.5
	\$ 25,000-34,999	14.2	10.0-18.3
	\$35,000- 49,999	17.7	13.0-22.4
	\$50,000- 74,999	16.0	11.2-20.9
	\$75,000+	21.9	16.1-27.6

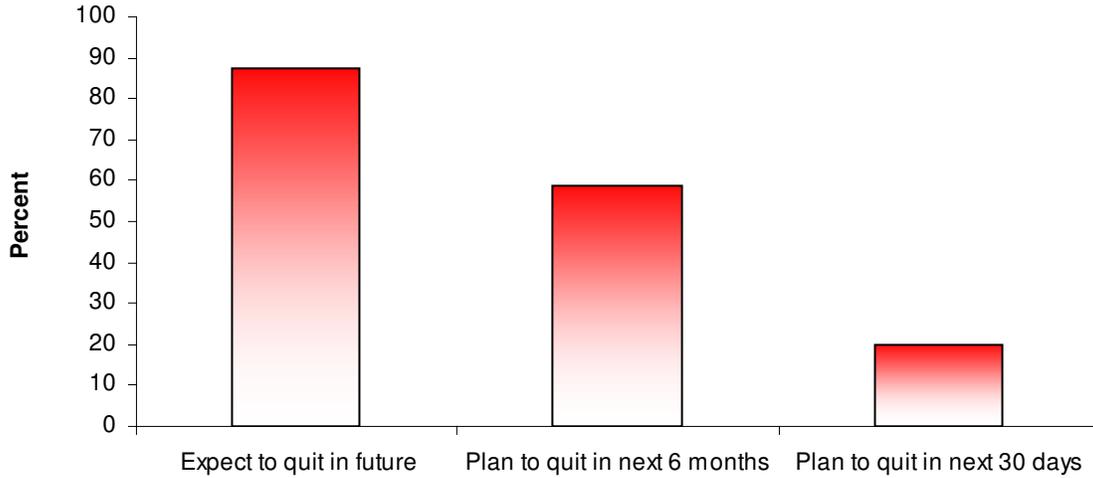
**Data Highlights:** Demographic groups with higher smoking prevalence have shown higher quit attempts. Quit attempts were calculated by asking if the current smokers have stopped smoking for one day or longer because you were trying to quit smoking, during the past 12 months. The quit attempts is higher for someday smokers, which is 81.9%.

**Method:** All respondents were 18 years or older. The denominator included individuals who had smoked 100 or more cigarettes in their lifetime and smoked everyday. Those with “missing”, “don’t know” and “refused” answers were excluded.

**Healthy People 2010 Objective:** (27.5) Increase cessation attempts by adult smokers to 75% per year.

**Data Source:** Behavioral Risk Factor Surveillance System, 2007.

**FIGURE 43. INTENTIONS OF CURRENT SMOKERS TO QUIT SMOKING – NH, 2002**



**TABLE 34. INTENTIONS OF CURRENT SMOKERS TO QUIT SMOKING – NEW HAMPSHIRE, 2002**

<b>Current smokers intentions to quit</b>	<b>%</b>	<b>95% CI</b>
<b>Expect to quit in future</b>	87.2	83.7-90.6
<b>Seriously considering quitting in next 6 months</b>	58.7	53.7-63.7
<b>Plan to quit in next 30 days</b>	19.8	16.0-23.7

**Data Highlights:** The vast majority of smokers expect to quit smoking one day. Over half of current smokers reported that they will seriously consider quitting in the next six months. Counseling and pharmacotherapy can help increase successful quit rates.

**Method:** Current smokers were asked if they expect to quit smoking. The denominator for all three proportions included adults who had smoked 100 or more cigarettes in their lifetimes and who smoked everyday or some days.

**Healthy People 2010 Objective:** (27-5) Increase cessation attempts by adult smokers to 75% per year.

**Data Source:** New Hampshire Adult Tobacco Survey (NHATS), 2002.

TABLE 35. ADULT CIGARETTE SMOKERS SEEN BY A HEALTH PROFESSIONAL DURING THE PAST 12 MONTHS, AND ADVISED TO QUIT – NH, 2001, 2003, 2005

Year	2001	2003	2005
%	79.0	79.6	71.3
95% CI	75.3-82.6	(76.1-83.1)	(67.8-74.9)

**Data Highlights:** Most smokers are seen annually by a health professional. Current guidelines from the U.S. Public Health Service recommend that clinicians assess tobacco use status for every patient, at every visit. For patients using tobacco, the Guidelines recommend the use of the “5A’s” for brief interventions with all tobacco users.<sup>xix</sup> Providers should Ask about smoking, Advise smokers to quit and Assess willingness to make a quit attempt, Assist in the quit attempt, and Arrange follow-up. This type of brief intervention can increase cessation rates.<sup>xix</sup> Between 2003 and 2004, the NH TPCP funded 47 trainings for medical practices to promote the *U.S. Public Health Service Clinical Practice Guidelines for Treating Tobacco Use and Dependence*. Medical practices and associations participating in these trainings included more than 570 medical professionals. Trainings focus on making changes in medical record systems, to increase brief interventions by the healthcare provider, provide assistance to smokers wanting to quit and increase awareness of the NH Smokers’ Helpline, 1-800-Try-To-STOP (1800-879-8678).

**Method:** Respondents were asked if they had been advised by their medical provider to quit smoking. The denominator excluded respondents that reported not smoking at least 100 cigarettes, respondents not smoking regularly within the past 12 months and respondents that have not received medical care within the past 12 months. This question has changed between 2003 and 2005 and could have impacted the prevalence estimate.

**Healthy People 2010 Objective:** (27.5) Increase cessation attempts by adult smokers to 75% per year.

**Data Source:** Behavioral Risk Factor Surveillance System, 2001, 2003, 2005.

TABLE 36. ADULT CIGARETTE SMOKERS SEEN BY A HEALTH PROFESSIONAL DURING THE PAST 12 MONTHS, ASKED ABOUT CIGARETTE USE, ADVISED TO QUIT AND ASSISTED IN QUIT ATTEMPT – NH, 2002

	%	95% CI
<b>Smokers seen in past 12 months by health professional</b>	85.4	81.7-89.2
<b>Among smokers seen, those asked about cigarette use</b>	89.7	86.5-92.9
<b>Among smokers asked about cigarette use, those advised to quit</b>	76.5	71.9-81.2
<b>Among smokers advised to quit, those assisted in quit attempt</b>	59.5	53.2-65.7

**Data Highlights:** Most smokers are seen annually by a health professional. Current guidelines recommend that providers use the “5A’s” for brief interventions with all smokers (Ask about tobacco use, Advise the user to quit, Assess willingness to make a quit attempt, Assist in the quit attempt, and Arrange follow-up). This type of brief intervention can increase cessation rates. In 2002, the New Hampshire Adult Tobacco Survey (NHATS) found that only 41% of smokers who had seen a health care provider had been Asked, Advised and Assisted with quitting.<sup>xx</sup>

**Method:** Smokers were defined as adults who had smoked 100 or more cigarettes in their lifetime and currently smoked some days or everyday. The Guidelines recommend assisting only those smokers ready to quit. Since the NHATS did not measure a smoker’s readiness to quit at the time of their provider visit, the proportion of those “advised to quit” presented may underestimate the true proportion of smokers advised to quit according to the Guideline. Assistance offered included prescription or recommendation of pharmacotherapy; suggested use of a smoking cessation class, program quit line or counseling, provided self-help materials, or suggested setting a specific date to stop smoking.

**Data Source:** New Hampshire Adult Tobacco Survey, 2002.

TABLE 37. CESSATION METHODS OFFERED TO CURRENT SMOKERS BY MEDICAL PROVIDERS – NH, 2002

	<b>Percent offered method</b>	<b>95% CI</b>
<b>Prescribed or recommended patch, nicotine gum, nasal spray, inhaler, or pills</b>	40.1	33.9-46.3
<b>Suggested setting specific date to stop smoking</b>	31.7	25.9-37.6
<b>Provided booklets, videos, or other materials</b>	25.4	19.9-30.9
<b>Suggested using smoking cessation class, program, quit line, or counseling</b>	20.1	15.1-25.3

**Data Highlights:** The U.S. Public Health Service Clinical Practice Guidelines recommends that providers practice the “5A’s” for brief cessation intervention. (Ask about tobacco use, Advise the user to quit, Assess willingness to make a quit attempt, Assist in the quit attempt, and Arrange follow-up). Fax referrals are available for healthcare providers through [QUITWORKS-NH \(www.quitworksnh.org\)](http://www.quitworksnh.org) allowing them to refer patients willing to make a quit attempt. Counselors proactively call patients and offer print materials, telephone counseling and/or local cessation program information. Counseling and pharmacotherapy have been shown to increase quit rates among smokers.

**Method:** The denominator was “current smokers who had seen a medical provider in the last 12 months and who were advised to quit by their provider.” Multiple responses were possible (a respondent could have said that their provider offered them one or more of the methods listed).

**Healthy New Hampshire 2010 Objective:** Increase availability of and access to treatment for adolescent alcohol use, adult alcohol and drug use, and adult tobacco use.

**Data Source:** New Hampshire Adult Tobacco Survey, 2002.

## CESSATION

### Youth Cessation (High School)

TABLE 38. PERCENT OF CURRENT SMOKERS WHO WOULD LIKE TO QUIT SMOKING CIGARETTES, NH 2001, 2004, 2007

	2001	2004	2007
<b>NH High School</b>	57.2%	48.3	41.1
<b>95% CI</b>	(50.4-64.0)	(41.7-54.9)	(34.8 - 47.4)

TABLE 39. YOUTH CURRENT SMOKERS ATTEMPTING TO QUIT AT LEAST ONCE IN THE PREVIOUS 12 MONTHS, NH 2001, 2004, 2007

	2001	2004	2007
<b>NH High School</b>	59.9%	48.2%	35.4%
<b>95% CI</b>	(54.3-65.5)	(41.7-54.7)	(29.9-40.9)

**Data Highlights:** Adolescents who use tobacco often become addicted and can experience withdrawal symptoms similar to those in adults. In 2001, 57% of High School youths who were current smokers said that they would like to quit and 60% tried to quit at least once in the past year. In 2004, 48% said they would like to quit and the same percentage reported trying to quit. However in 2007, 41% of High School students who were current smokers said that they would like to quit and only 35% actually tried quitting. There has been a decline in the percentage of youth smokers who would like to quit and decrease in the percentage attempting to quit.

**Method:** The denominator included all current smokers except those with “missing”, “don’t know” and “refused” answers.

**Healthy People 2010 Objective:** (27-7) Increase the percentage of current smokers in grades 9-12 who ever tried to quit smoking cigarettes to 84%.

**Data Source:** New Hampshire Youth Tobacco Survey, 2001, 2004 and 2007.

## CESSATION

### “1-800-QUIT NOW” National Quitline Data for New Hampshire

FIGURE 44. NUMBER OF NEW HAMPSHIRE CALLERS TO NATIONAL 1-800-QUIT NOW RESOURCE LINE

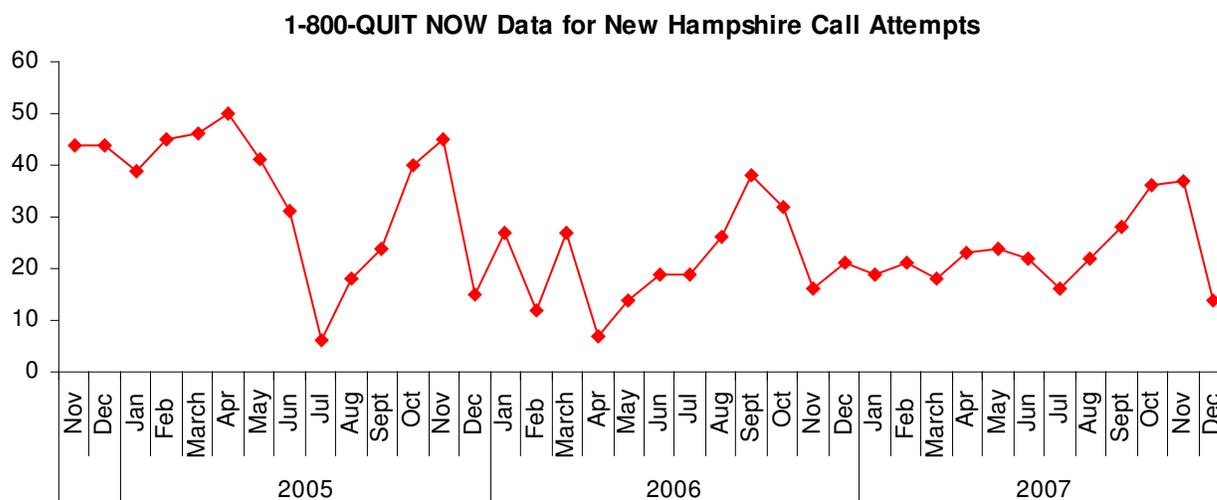


TABLE 40. NUMBER OF NEW HAMPSHIRE CALLERS TO NATIONAL 1-800-QUIT NOW RESOURCE LINE

Year	Jan	Feb	March	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2002							2	16	51	51	31	29
2003	128	73	62	52	40	44	31	26	26	11	25	23
2004	33	24	32	23	36	36	25	28	28	46	44	44
2005	39	45	46	50	41	31	6	18	24	40	45	15
2006	27	12	27	7	14	19	19	26	38	32	16	21
2007	19	21	18	23	24	22	16	22	28	36	37	14

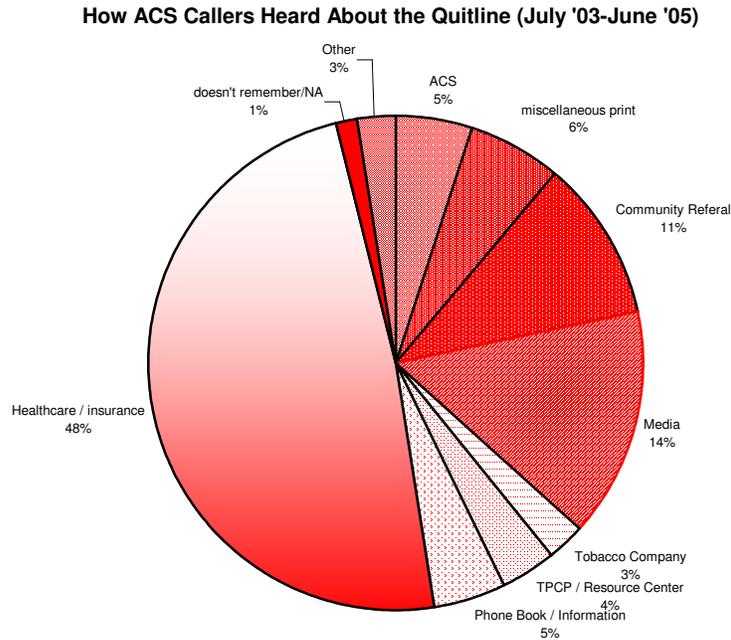
**Data Highlights:** 1-800-QUIT-NOW is a national portal for states under contract with a quitline vendor. Some states use 1-800-QUIT-NOW as a quitline vendor. New Hampshire’s 1-800 Try-To-STOP was hosted by the American Cancer Society until June 2005, when a new contract was negotiated with the John Snow Research and Training Institute, Inc (JSI). Any caller calling from NH to 1-800 QUIT NOW is automatically routed to 1-800-Try-To-STOP.

**Method:** Data were taken from Data for US states prepared by National Cancer Institute, the communication contractor for the US Department of Health. Call Attempts are the total number of calls routed through 1-800-QUIT NOW, regardless of whether those calls were answered or provided services at the destination. Even though some states use 1-800-QUIT NOW as their primary number, New Hampshire and other states contract with other quitline vendors.

**Goal:** Extend reach to 10% of the target population annually.

**Data Source:** National Cancer Institute, 1-800-QUIT NOW Data.

FIGURE 45. HOW THE ACS CALLERS HEARD ABOUT THE QUITLINE



**Data Highlight.** The most common information source for this period was from healthcare providers and insurance. Media and community referral was the second largest. NH Smokers Help Line was operated by the American Cancer Society (ACS) as a part of a tri-state collaboration until June 2005 and then it was transferred to John Snow Institute (JSI) in July 2005. Since NH lost its Master Settlement Agreement dollars the program has been facing a reduced budget to fund proactive services to increase the call volume. The program currently works with the tri-state collaboration (NH, MA, RI) to leverage resources, share media, media markets, and expertise. Even though the quitline budget has been scaled back, it has all the components to support a larger program if and when there is an additional funding. Today it covers only a small percentage of the State's current tobacco users.

**Method.** The data analyzed was the total call volume of 793 calls from July 2003 to July 2005 on self-reported response by ACS callers to quitline.

**Data Source.** ACS, NH Cumulative report, 2003-2005.

## CESSATION

### “1-800-Try-To-STOP” New Hampshire Smokers’ Helpline Data

FIGURE 46. TOTAL NUMBER OF CALLS COMING TO NH SMOKERS’ HELPLINE

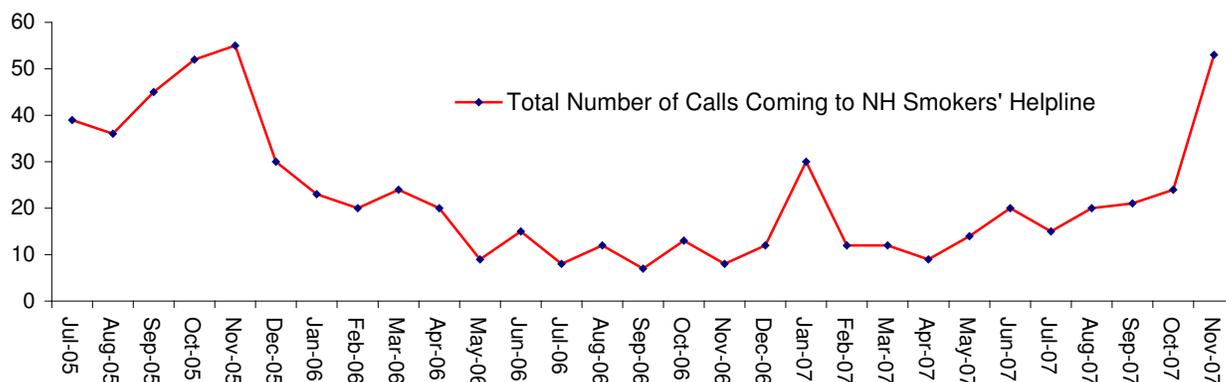


Table 41. Total Number of Calls Coming to NH Smokers’ Helpline

NH - Total Client Volume			
All Self Referred Calls and Fax Referrals			
YEAR	Self-Referral (SR)	Fax-Referred (FR)	TOTAL SR =FR
SYF 2006	340	371	711
SFY 2007	348	157	505
SFY 2008	227	301	528

**Data Highlights:** The 1-800-Try-To-STOP (1-800-879-8678) is the NH Smokers’ Helpline for residents to call for information and/or assistance in quitting tobacco use. All services are cost free and confidential. Self-referrals include the callers that are tobacco users, repeat callers, proxy callers and providers. After a brief interview, the caller will be offered print materials appropriate for their stage of readiness to quit (pre-contemplation, contemplation, preparation, action, maintenance) and/or cessation resources within their community. A Certified Tobacco Treatment Specialist is available for callers that want to set a quit date within 14 days. Fax referrals are submitted from healthcare providers using a fax referral found at [QUIWORKS-NH \(www.quitworksnh.org\)](http://www.quitworksnh.org). This form allows providers to refer patients willing to make a quit attempt. Counselors proactively call patients and offer print materials, telephone counseling and/or local cessation program information.

**Methods:** All abbreviated intakes and calls with missing or incomplete data for self-referred calls are included in the report. When fax referral is received, tobacco use status (user/quitter) is unknown. This information is gathered during the first proactive call by the counselor to the referred patient.<sup>1</sup> Total fax referrals made are reported as individual offices and as an aggregated number for a town, county and the state. Satisfaction surveys are conducted at 3 months and 6 months with callers and referred patients that have completed the initial abbreviated intake interview. Proxy callers are those callers who call the quitline to get information for someone else and professional callers are those who make calls to get information.

**Goal:** Extend reach to 10% of the target population annually.

**Data Source:** Tobacco Prevention and Control program, Community Health Initiative.

## CESSATION

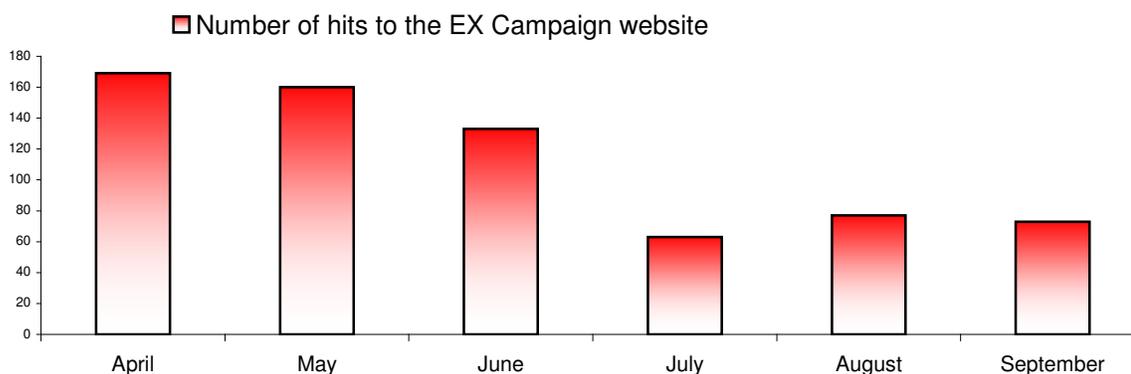
---

### Media-The EX Campaign

TABLE 42. APRIL –JUNE, 2008 HITS ON THE EX CAMPAIGN BY NH INTERNET USERS

Month	Number of Hits on EX Campaign Website
April	169
May	160
June	133
July	63
August	77
September	73
October	19

TABLE 43. APRIL –JUNE, 2008 HITS TO THE EX CAMPAIGN WEBSITE



**Data Highlights.** The American Legacy Foundation (Legacy) created the EX® Campaign and <http://www.becomeanex.org/>, which is about re-learning life without cigarettes, to supplement states quitline services. This is a web-based service. States that do not have media budgets to promote cessation services may purchase membership into legacy's National Alliance for Tobacco Cessation (NATC), which entitles states to tag onto extensive EX® media campaign. The EX® Campaign was launched in March 2008 nation wide after pilot testing media messages. "Individuals are interviewed for: reason for calling; demographics; and how they heard about the EX Campaign. Legacy provides each state with a monthly caller report.

**Method.** The numbers represent the number of NH individuals looking for assistance to quit smoking or stay quit using the <http://www.becomeanex.org/> site. Eighty six percent of these individuals heard about the service through national television media.

**Data Source.** The EX® Campaign, New Hampshire Data Tracking, 2008

## SECONDHAND SMOKE EXPOSURE

### Smoke Free Policies

FIGURE 47. WORKSITE POLICY - WORKERS EMPLOYED IN SMOKE-FREE WORKSITES – NEW HAMPSHIRE AND U.S., 1993-2006

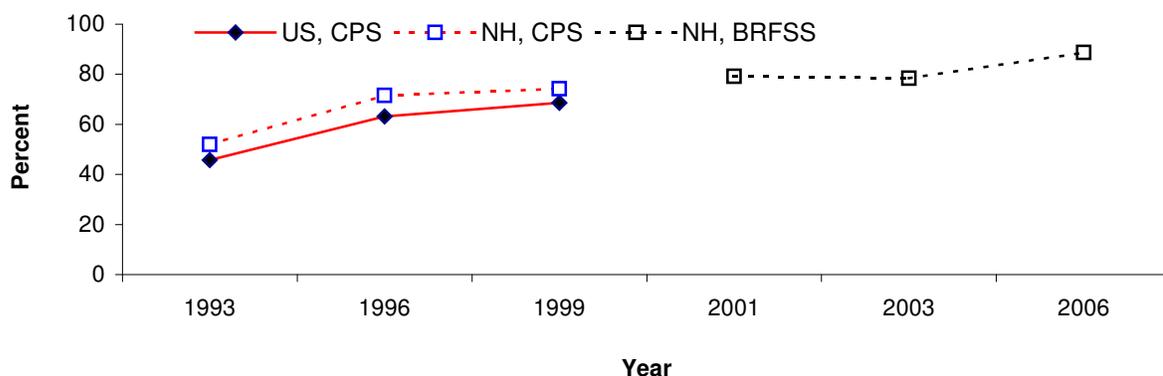


TABLE 44. INDIVIDUALS EMPLOYED IN WORKPLACES WITH SMOKE-FREE POLICIES - NEW HAMPSHIRE AND U.S, 1993-2006

	Aged 15 and older, CPS					Aged 18 and older, BRFSS		
	1992-1993	1995-1996	1998-1999	2001-2002	2003	2001	2003	2006
NH	52.1	71.6	74.2	76.2	83.3	79.2	78.6	81.9
U.S.	45.8	63.1	68.6	70.8	77.0	NA	NA	NA

**Data Highlight:** Nationally, 46% of people who worked indoors were working in a smoke-free environment in 1993 compared to 63% in 1996 and 69% in 1999. In New Hampshire, 78% of indoor workers were employed in a smoke-free worksite in 2003. The percentage of adults employed in workplaces with smoke-free policies increased greatly between 1993 and 2003 in both New Hampshire and the U.S.

**Method:** Results are based on self-reports of workers who were employed indoors. “Smoke-free” refers to workers who reported that their employer had an official workplace policy that restricted smoking and that policy did not allow smoking in any public or common areas of the workplace or in the work area. For the years 1993-1999, the population reported was aged 15 and older. Comparisons between the 1993-1999 period and the 2001-2003 period should be made with caution since both the age of the population and the data sources differ.

**Healthy People 2010 Objective:** (27.12) Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas from 79% to 100%.

**Data Source:** 1993-1999: Current Population Survey (CPS). 2001, 2003, 2006<sup>xxi</sup>, New Hampshire Behavioral Risk Factor Surveillance System (BRFSS).

## SECONDHAND SMOKE EXPOSURE

### Smoke Free Homes

TABLE 45. PERCENT OF ADULTS IN HOMES WITH RULES AGAINST SMOKING ANYWHERE INDOORS – NEW HAMPSHIRE, 1992-2006

	Aged 15 and older, CPS					Aged 18 and older, BRFSS		
	1992-1993	1995-1996	1998- 1999	2001-2002	2003	2001	2003	2006
NH	38.4	---	56.5	---	74.6	66.6	73.1	79.6
U.S.	43.2	---	60.2%	67.2	74.2	---	---	---

**Data Highlights:** The proportion of NH adults living in homes that had rules against smoking anywhere indoors increased significantly from 2001 to 2003 and from 2003 to 2006. Smoke-free homes protect children and non-smoking adults from chemicals and particulates that are released by burning cigarettes. Secondhand smoke is the smoke released by the smoker when exhaling, as well as from the burning end of the cigarette.

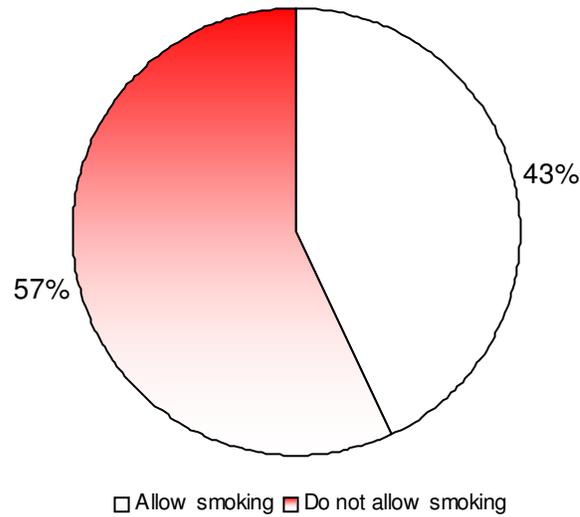
**Method:** Respondents were asked if rules in their homes allowed smoking anywhere inside, some places inside, nowhere inside or if there were no rules.

**Healthy People 2010 Objective:** (27-9) Reduce the proportion of children who are regularly exposed to tobacco smoke at home to 10%. (27-10) Reduce the proportion of non-smokers exposed to environmental tobacco smoke to 45%.

**Data Source:** New Hampshire Behavioral Risk Factor Surveillance System, 2001-2006, 1993-1999: Current Population Survey (CPS). 2001, 2003, 2006.<sup>xxii</sup>

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5620a3.htm>.

FIGURE 48. RESTAURANT SMOKING POLICIES – NEW HAMPSHIRE, 2001



**Data Highlights:** In 2001, of 402 restaurants surveyed, 43.5% (95% CI 38.7 - 48.3) allowed smoking. New Hampshire’s Indoor Smoking Act (RSA 155:64-77) was enacted to protect the health of the public by regulating smoking in enclosed workplaces and enclosed places accessible to the public, regardless of whether they are publicly or privately owned, and enclosed publicly owned buildings and offices. In 2003, four towns in New Hampshire (Colebrook, Columbia, Gorham, and Keene) had passed local ordinances, further regulating smoking in restaurants and bars. In August 2003, the New Hampshire Supreme Court issued a ruling that invalidated local ordinances prohibiting smoking in restaurants (2003-085, JTR Colebrook, Inc. d/b/a The Colebrook House v. Town of Colebrook). NH Statute 155: 64-77 was amended by the Legislature to prohibit smoking in restaurants, lounges and bars, effective July 16, 2007.

**Method:** Data were reported by restaurant owners/managers through a telephone survey.

**Healthy People 2010 Objective:** (27.12) Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas from 79% to 100%. (27-10) Reduce the proportion of non-smokers exposed to environmental tobacco smoke to 45%.

**Data Source:** New Hampshire Restaurant Survey, 2001.

FIGURE 49. TYPE OF RESTAURANT AND SMOKING POLICY – NEW HAMPSHIRE, 2001

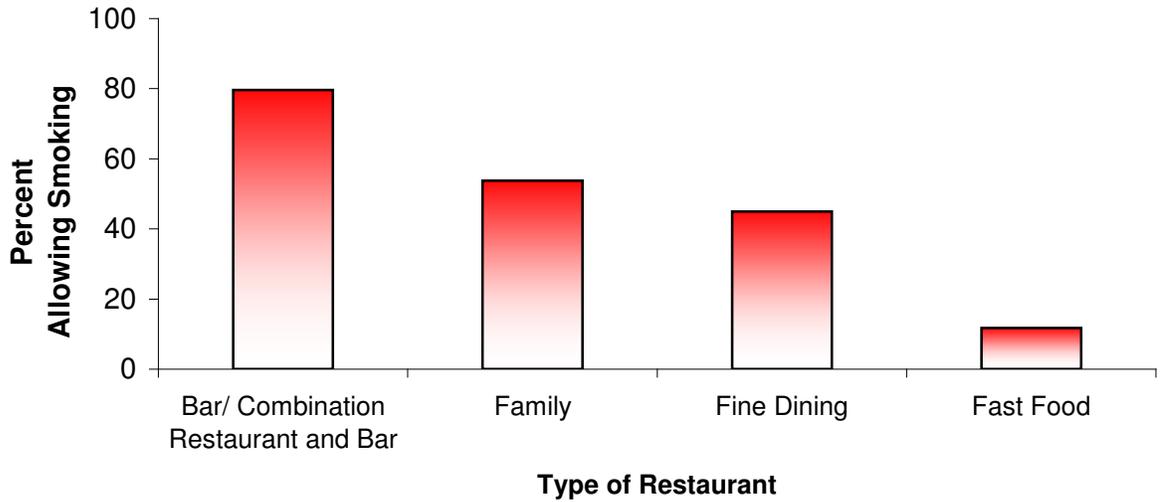


TABLE 46. TYPE OF RESTAURANT AND SMOKING POLICY – NEW HAMPSHIRE, 2001

Type of Restaurant	Number of Restaurants	Allow Smoking (%)	95% CI
Bar/Combination Restaurant and Bar	49	79.6	68.3-90.9
Family	177	53.7	46.4-61.0
Fine Dining	49	44.9	31.0-58.8
Fast Food	94	11.7	5.2-18.2

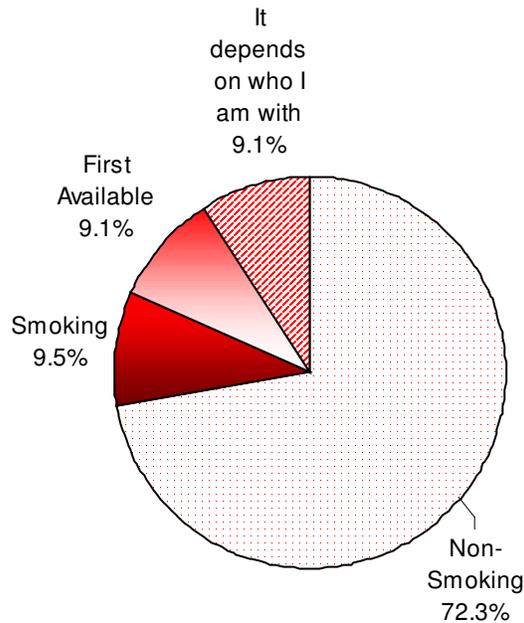
**Data Highlights:** In New Hampshire, bars and restaurants with bars had the highest rates of smoking, while fast food restaurants had the lowest rates. Other characteristics of restaurants positively associated with allowing smoking were: selling alcohol, selling tobacco, having the smoking policy determined by a manager as opposed to a corporate office, and having a large amount of seating.

**Method:** Data were reported by restaurant owners and managers through a telephone survey.

**Healthy People 2010 Objective:** (27.12) Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas from 79% to 100%. (27-10) Reduce the proportion of non-smokers exposed to environmental tobacco smoke to 45%.

**Data Source:** New Hampshire Restaurant Survey, 2001.

FIGURE 50. TYPE OF SEATING REQUESTED WHEN INDIVIDUALS DINE OUT – NEW HAMPSHIRE, 2000



**Data Highlight.** In 2000, a question on the Behavior Risk Factor Survey Study (BRFSS) asked about smoking choices in restaurants. Just under three-quarters of restaurant patrons in New Hampshire prefer non-smoking seating when dining out. The same survey also found that 50% of adults in New Hampshire think that smoking should not be allowed at all in restaurants. Secondhand smoke contains carcinogens, substances recognized as causing cancer. Studies have shown increased risks of lung cancer and other smoking-related illnesses in food service workers continually exposed to secondhand smoke.<sup>6</sup>

**Method:** The total number of respondents was 1810. All respondents were 18 years or older.

**Healthy People 2010 Objective:** (27.12) Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas from 79% to 100%. (27-10) Reduce the proportion of non-smokers exposed to environmental tobacco smoke to 45%.

**Data Source:** New Hampshire Behavioral Risk Factor Surveillance System, 2000.

TABLE 47. ADMINISTRATION OF THE NH INDOOR SMOKING ACT, 2006-2007

<b>Actions</b>	<b>(July 1, 2006-June 30, 2007)</b>	<b>(July 1, 2007-June 30, 2008)</b>
Public requests for information received	35	169
Complaints received	8	11
Complaints closed	8	1
Site visits by TPCP staff	2	5

**Data Highlights:** The NH indoor Smoking Act, RSA 155:64-77 (NH ISA) was enacted in 1991 for the purpose of “protecting the health of the public by regulating smoking in enclosed places accessible to the public.” The ISA and the accompanying Administrative Rules, instructs the Department of Health and Human Services to accept calls from the public and investigate complaints according to the Administrative Rules. In 2003 TPCP created the “Good Work! Creating a Smoke Free Workplace” toolkit to assist employers in developing smoke free workplace policies for the health of their employees and for cost effectiveness. The toolkit demonstrated how to implement a smoke free policy and how to assist employees that smoke to make quit attempts. Breathe NH has updated the toolkit with the 2007 ISA amendments for eliminating smoking in restaurants and cocktail lounges.

**Method:** Table data is gathered through TPCP activity logs for *Public Complaints and Requests for Information*. The ISA amendments became effective on September 17, 2007. Public complaints must be submitted in writing, using the *Secondhand Smoke Complaint Form* (accessible at <http://www.dhhs.state.nh.us/DHHS/ATOD/TPCP.htm>). Public inquiries may be over the phone, electronically, or by mail/fax. TPCP is responsible for the primary investigation and site visits. DHHS legal staff may assist in determining whether a workplace will be prosecuted for an unresolved violation of the ISA.

**Healthy People 2010 Objective:** (27.12) Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas from 79% to 100%. (27-10) Reduce the proportion of non-smokers exposed to environmental tobacco smoke to 45%.

**Data Source:** Tobacco Prevention and Control Program.

## SECONDHAND SMOKE EXPOSURE

### Adult Exposure to Secondhand Smoke

TABLE 48. EXPOSURE OF ADULTS TO SECONDHAND SMOKE IN THE PREVIOUS WEEK, BY SMOKING STATUS – NH, 2002

Exposure location	Current smoker % (95% CI)	Former Smoker % (95% CI)	Never Smoker % (95% CI)	Total % (95% CI)
In home	58.2 (53.3-63.1)	9.0 (6.9-11.1)	6.3 (4.8-7.9)	16.4 (14.9-18.0)
In car	68.0 (63.7-72.3)	14.3 (11.6-17.0)	11.1 (9.1-13.1)	22.2 (20.5-24.0)

**Data Highlight:** Eliminating exposure to secondhand smoke is one of the four goals of the State’s Tobacco Prevention and Control Program. Secondhand smoke exposure can cause lung cancer and heart disease among non-smokers as well as increased number and severity of asthma attacks among those with asthma.<sup>vii</sup>

**Method:** The denominator included all respondents except those with “missing”, “don’t know” and “refused” answers. The never smokers is the largest group and has the most weight. The total is the average based on the responses of all.

**Healthy People 2010 Objective:** Reduce the proportion of non-smokers exposed to environmental tobacco smoke to 45%.

**Data Source:** New Hampshire Adult Tobacco Survey, 2002.

## SECONDHAND SMOKE EXPOSURE

### Youth Exposure to Secondhand Smoke

TABLE 49. EXPOSURE TO SECONDHAND SMOKE AMONG HIGH SCHOOL STUDENTS – NH, 2004, 2007

	<u>2004</u>		<u>2007</u>	
	%	95% CI	%	CI
<b>Exposed to secondhand smoke in previous week in</b>				
Room	58.2	54.4 - 61.9	43.9	40.3-47.5
Car	43.4	39.2 - 47.6	25.0	22.0-28.0
Room or car	62.4	58.5 - 66.3	60.9	58.1-63.7
<b>Lived with someone who smokes</b>	38.6	34.8 - 42.4	--	--

**Data Highlight:** Children exposed to secondhand tobacco smoke have higher rates of middle ear infection and upper and lower respiratory infections.<sup>xxiii</sup> Approximately 62% and 61% of High School students reported exposure to secondhand smoke during the previous week in 2004 and in 2007 respectively. Close to 39% of students lived with someone who smokes in 2004.

**Method:** Data on exposure to secondhand smoke were self-reported by students who were surveyed in school during class time. All students were asked if they had been in a room or in a car with someone who was smoking cigarettes during the previous seven days. The above data is for those who are never smokers who were in the same room with someone who was smoking cigarettes on 1+ days during the past 7 days.

**Healthy People 2010 Objective:** (27-9) Reduce the proportion of children who are regularly exposed to tobacco smoke at home to 10%. (27-10) Reduce the proportion of non-smokers exposed to environmental tobacco smoke to 45%.

**Data Source:** New Hampshire Youth Tobacco Survey, 2004, 2007.

## ECONOMIC FACTS ABOUT NH TOBACCO USE

### Cigarettes Sales

FIGURE 51. PER CAPITA CIGARETTE SALES (PACKS) – NH AND US, 1991-2007

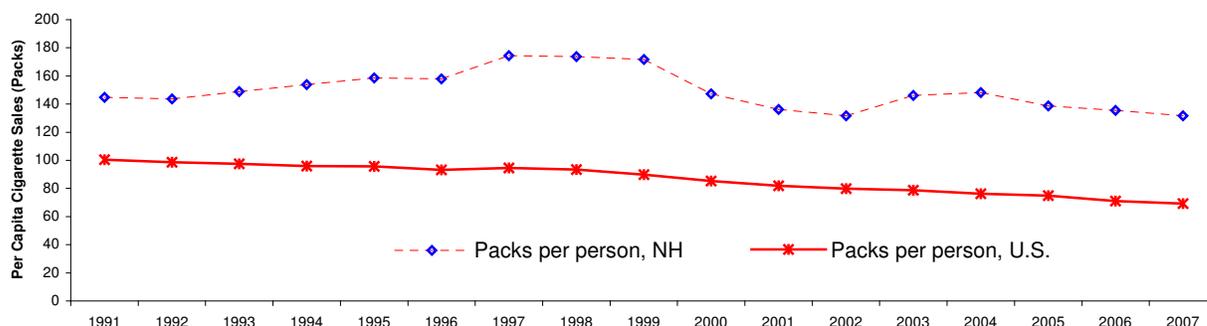


TABLE 50. PER CAPITA CIGARETTE SALES (PACKS) – NH AND US, 1991-2007

Year	Packs per person, NH	Packs per person, U.S.
1991	144.8	100.4
1992	143.7	98.7
1993	148.9	97.6
1994	153.8	96.0
1995	158.5	95.8
1996	158.0	93.3
1997	174.4	94.5
1998	173.8	93.4
1999	171.7	89.9
2000	147.3	85.2
2001	136.1	81.8
2002	131.6	79.8
2003	146.2	78.7
2004	148.1	76.2
2005	138.6	75.0
2006	135.6	71.0
2007	131.6	69.2

**Data Highlight:** Cigarette sales have continued to decline because of concerns about health, smoking restrictions and price increase. Between 1991 and 2007, per capita sales in New Hampshire decreased 21%. Per capita sales in the United States declined 35.2% between 1991 and 2007. One reason that may explain why we are seeing a higher per capita percent of cigarette packs per person in NH, is that a percentage of cigarette sales in the State is to residents of neighboring states where the cost of cigarettes is higher.

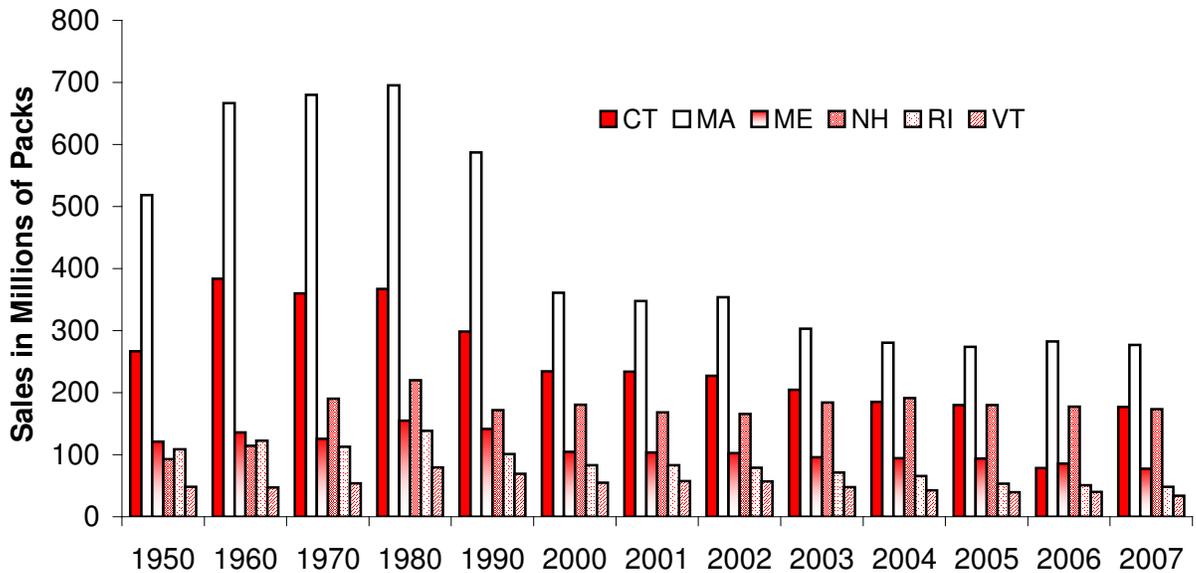
**Method:** All data are for the fiscal year ending June 30<sup>th</sup> of the respective fiscal year. For states, packs sold per capita are calculated by dividing the total number of cigarette packs sold by the population estimate for that state. National data are the weighted average of all states and the District of Columbia. (All taxing states weighted average). The population figures used for the states are census bureau estimates as of July 1st, of the respective fiscal year.

**Data Sources:** Tax Burden on Tobacco Historical Compilation, Volume 42, 2007.

**TABLE 51. NORTHEAST REGIONAL COMPARISON OF THE TREND IN CIGARETTE SALES (IN MILLIONS OF PACKS) 1950 – 2007**

Year	CT	MA	ME	NH	RI	VT
1950	266.9	518.6	121.2	92.6	108.8	48.0
1960	383.5	666.5	135.8	114.5	122.4	47.4
1970	360.1	679.8	125.7	190.5	112.9	53.8
1980	367.4	695.3	154.9	219.8	138.7	79.7
1990	298.7	587.1	141.5	171.7	101.1	69.2
2000	234.4	361.1	104.4	180.4	82.9	54.8
2001	234.0	347.8	103.6	168.2	83.3	57.4
2002	227.4	354.0	102.4	165.7	79.1	57.0
2003	204.4	303.2	96.0	184.2	71.2	47.7
2004	185.1	280.5	94.5	191.1	65.7	42.8
2005	179.8	273.9	94.0	180.1	53.4	39.7
2006	78.6	282.5	85.6	177.5	50.9	39.8
2007	176.9	277.1	77.4	173.1	48.3	34.0

**FIGURE 52. NORTHEAST REGIONAL COMPARISON OF THE TREND IN CIGARETTE SALES 1950 – 2007**



**Data Highlight:** Between 1990 and 2007, per capita sales in New Hampshire decreased 21%. Per capita sales in the United States declined 35.2% between 1990 and 2007. One reason that may explain why we are seeing a higher per capita percent of cigarette packs per person in NH, is that a percentage of cigarette sales in the State is to residents of neighboring states where the cost of cigarettes is higher.

**Method:** All data are for the fiscal year ending June 30<sup>th</sup> of the respective year. Data for the individual states are based on the total number of packages taxed. Sales indicated is in millions of packs.

**Data Sources:** Tax Burden on Tobacco Historical Compilation, Volume 42, 2007.

## ECONOMIC FACTS ABOUT TOBACCO IN NH

### Cigarette Tax

FIGURE 53. AVERAGE RETAIL PRICE OF A PACKAGE OF TWENTY CIGARETTES (INCLUDING GENERIC BRANDS) AND THE STATE AND FEDERAL EXCISE TAXES PER PACK – NH, 1963-2007

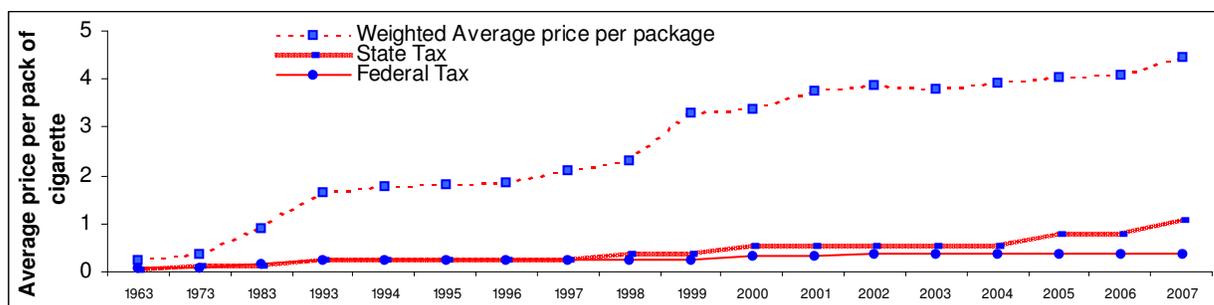


TABLE 52. AVERAGE RETAIL PRICE OF A PACKAGE OF TWENTY CIGARETTES (INCLUDING GENERIC BRANDS) AND THE STATE AND FEDERAL EXCISE TAXES PER PACK – NH, 1963-2007

Year	Weighted Average price per package	State Tax	Federal Tax	Taxes as a % of average retail price
1963	\$ 0.25	\$ 0.04	\$ 0.08	46.6
1973	0.38	0.11	0.08	50.1
1983	0.91	0.12	0.16	36.5
1993	1.67	0.25	0.24	29.4
1994	1.77	0.25	0.24	27.7
1995	1.81	0.25	0.24	27.1
1996	1.86	0.25	0.24	26.3
1997	2.09	0.25	0.24	29.2
1998	2.33	0.37	0.24	26.2
1999	3.29	0.37	0.24	23.1
2000	3.38	0.52	0.34	25.4
2001	3.74	0.52	0.34	23.0
2002	3.87	0.52	0.39	23.5
2003	3.79	0.52	0.39	24.0
2004	3.91	0.52	0.39	23.3
2005	4.07	0.80	0.39	29.2
2006	4.09	0.80	0.39	29.1
2007	4.48	1.080	0.39	32.8

**Data Highlight:** The percentage of the price of a pack of cigarettes contributed by taxes was highest in 1973 (50.1%) and lowest in 2001 (23%).

**Method:** The average retail price of a pack of cigarettes included all state and federal taxes and was current as of June 30<sup>th</sup> of the year indicated. Tax percentage of retail price was calculated by dividing the state and federal excise tax by the average retail price. After 1990, prices include generic brands. In NH, the 2007 tax on each pack containing 20 cigarettes was increased from \$.80 to \$1.08 per pack – a \$.28 increase. The tax for each pack containing 25 cigarettes was increased from \$1.00 to \$1.35 – a \$.35 increase. Generic brand not included in the average calculation. Price estimates do not generally reflect price changes that occur throughout the year.

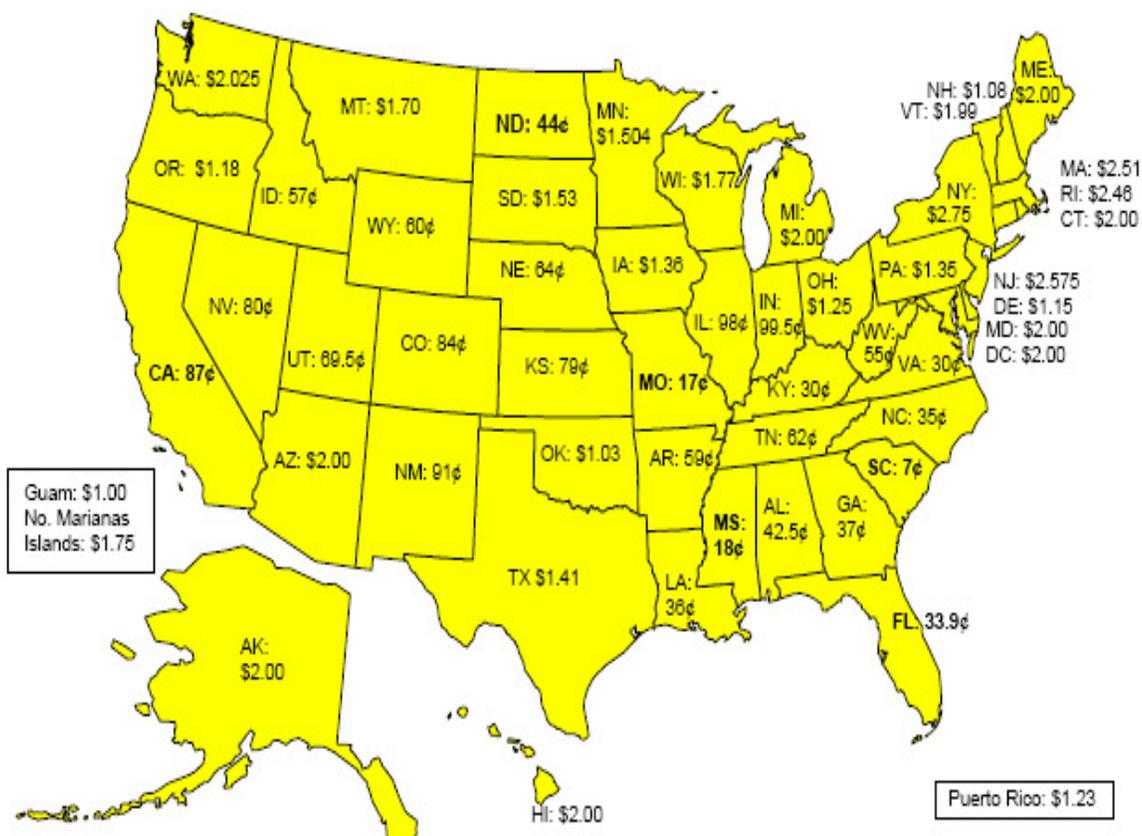
**Healthy People 2010 Objective:** (27-21a) Increase the state and federal tax on cigarettes to \$2.00.

**Data Source:** Tax Burden on Tobacco Historical Compilation, Volume 42, 2007.

Average State Cigarette Tax: \$1.184 per Pack

Average Cigarette Tax in Major Tobacco States: 33.5 cents per Pack

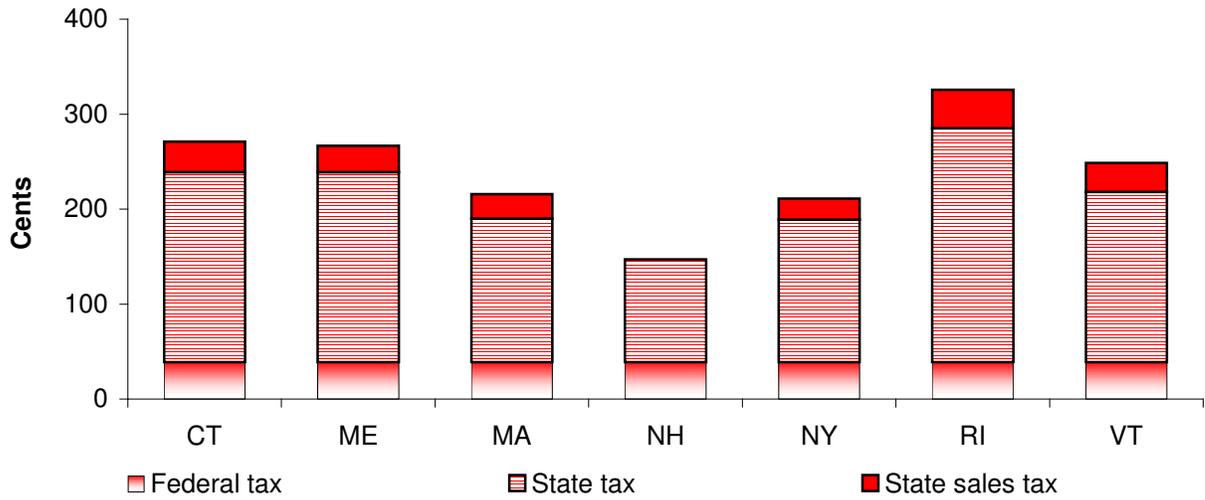
Average Cigarette Tax in Non-Tobacco States: \$1.297 per Pack



Map shows state cigarette tax rates in effect now and those that will go into effect by the end of 2008. The six states that have not increased their cigarette tax rate since 1999 or earlier are marked in bold. Currently, 26 states, DC, Puerto Rico, the Northern Marianas, and Guam have cigarette tax rates of \$1.00 per pack or higher. Thirteen states and DC have cigarette tax rates of \$2.00 per pack or higher. The state averages, listed above, do not include Puerto Rico (with a population larger than those in 20 different states) or any of the U.S. territories (such as Guam). Including Puerto Rico raises the state average slightly. The major tobacco states with extensive tobacco farming and, often, cigarette manufacturing, are NC, KY, VA, SC, TN, & GA. Federal cigarette tax is 39¢ per pack. Not shown are the special taxes or fees some states place on cigarettes made by Non-Participating Manufacturers (NPMs), the companies that have not joined the Master Settlement Agreement (MSA) between the states and the major cigarette companies. Some local governments also have their own cigarette taxes, such as Chicago (68¢), Cook County, IL (\$2.00), New York City (\$1.50), and Anchorage, AK (\$1.30). The U.S. Centers for Disease Control & Prevention estimates that smoking-caused health costs and productivity losses total \$10.28 per pack sold.

**Data Source:** Campaign for Tobacco-Free Kids, Accessed August 1, 2008.

**FIGURE 54. NORTHEAST REGIONAL COMPARISON OF THE AVERAGE STATE EXCISE, FEDERAL EXCISE, AND STATE SALES TAXES PER PACK OF TWENTY CIGARETTES (INCLUDING GENERIC BRANDS) – 2007**



**TABLE 53. NORTHEAST REGIONAL COMPARISON OF THE AVERAGE STATE EXCISE, FEDERAL EXCISE, AND STATE SALES TAXES PER PACK OF TWENTY CIGARETTES (INCLUDING GENERIC BRANDS) – 2007**

	CT	ME	MA	NH	NY	RI	VT
Average state sales tax per pack	\$0.32	\$0.28	\$0.26	0	\$0.22	\$0.41	\$0.31
State excise tax per pack	\$2.00	\$2.00	\$1.51	\$1.08	\$1.50	\$2.46	\$1.79
Federal excise tax	\$0.39	\$0.39	\$0.39	\$0.39	\$0.39	\$0.39	\$0.39
Weighted average price per pack	\$5.36	\$5.52	\$5.13	\$4.24	\$5.47	\$5.78	\$5.10

**Data Highlight:** Studies on cigarette demand have demonstrated that increases in cigarette prices lead to substantial reductions in cigarette smoking by deterring smoking initiation among youth, prompting smoking cessation among adults, and reducing the average cigarette consumption among continuing smokers.<sup>4</sup> The 1989 Surgeon General’s Report estimated that a 10% increase in cigarette prices would result in an overall decrease of 4.7% in the number of cigarettes consumed.<sup>7</sup> Regionally, in these seven northeastern states, the average retail price of a pack of cigarettes is highest in Rhode Island and lowest in New Hampshire. The state tobacco excise tax is highest in Rhode Island and lowest in New Hampshire.

**Method:** The average retail price includes generic brands. The state sales tax rates for each state are the following: CT 6%, ME 5%, MA 5%, NY 4% RI 7%, and VT 6%. Local sales taxes applied to tobacco are not included here. NH did not collect sales tax. Data is current as of November 1, 2007. Generic brand included in the calculation. Price estimates do not generally reflect price changes that occur throughout the year.

**Data Source:** Tax Burden on Tobacco, Historical Compilation, 2007.

## ECONOMIC FACTS ABOUT TOBACCO IN NH

### Other Tobacco Tax

State	Type of other tobacco taxed	Smokeless Tobacco product	All other tobacco product
Connecticut	*CSChSn	20% of manufacturer's price (chewing tobacco); 40¢ per ounce (snuff)	Cigars and Smoking tobacco: 20% of the wholesale sales price
Maine	CChSn	78% of wholesale price	20% of wholesale sales price
Massachusetts	ChSn	90% of wholesale price	30% of price paid by retail vendor
New Hampshire	ChSn	19% of wholesale price	Smoking tobacco only: 19% of wholesale sales price
New York	CChSn	37% of manufacturer's list price	37% of manufacturer's price
Rhode Island	CChSn	40% of wholesale price (chewing tobacco); \$1 per ounce (moist snuff)	40% of wholesale cost (capped at 50 cents per cigar)
Vermont	CChSn	41% of wholesale price (chewing tobacco); \$1.49 per oz (moist snuff)	41% of the wholesale price (pipe tobacco and large cigars; 99.5 mills per little cigar and 99.5 mills per 0.9 oz for roll-your-own)

\*C is Cigar; S is Smoking Tobacco, Ch is chewing tobacco, Sn is Snuff.

**Data Highlight.** A regional comparison between states shows that different states tax other tobacco products differently. Most of other states have higher taxes on other tobacco products compared to New Hampshire.

**Method.** The District of Columbia, Florida, New Hampshire, and Pennsylvania do not tax large cigars. The following states tax little cigars the same as cigarettes, CA, CT, IA, MT, CR, TN and VT.

**Data Source.** Tax Burden on Tobacco, Historical Compilation, 2007.

## ECONOMIC FACTS ABOUT TOBACCO IN NH

### Revenue

FIGURE 55. NEW HAMPSHIRE REVENUE FROM OTHER TOBACCO TAXES

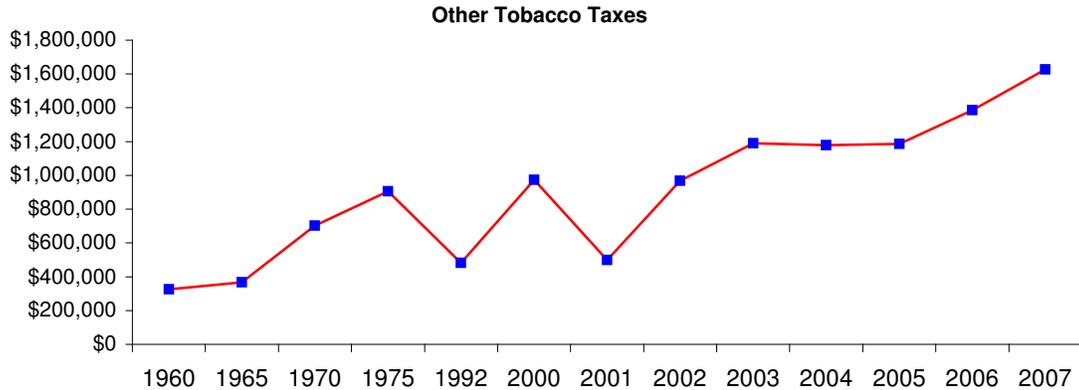


TABLE 54. NEW HAMPSHIRE REVENUE FROM OTHER TOBACCO TAXES

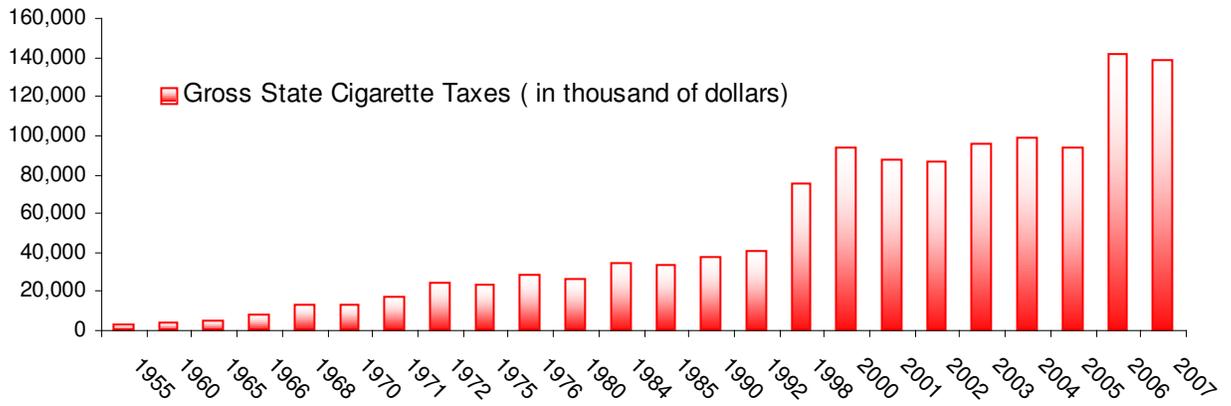
Year	Other tobacco Taxes	Type of Other Tobacco Taxed
1960	\$325,759	CShSn
1965	\$366,917	CShSn
1970	\$701,680	CShSn
1975	\$905,885	CShSn
	No other tobacco tax	
	No other tobacco tax	
	No other tobacco tax	
1992	\$482,476	ChSn
2000	\$973,595	ChSn
2001	\$ 499,000	ChSn
2002	\$967,942	ChSn
2003	\$1,190,000	ChSn
2004	\$1,179,000	ChSn
2005	\$1,186,489	ChSn
2006	\$1,385,070	ChSn
2007	\$1,627,373	ChSn

\*C is Cigar; S is Smoking Tobacco, Ch is chewing tobacco, Sn is Snuff.

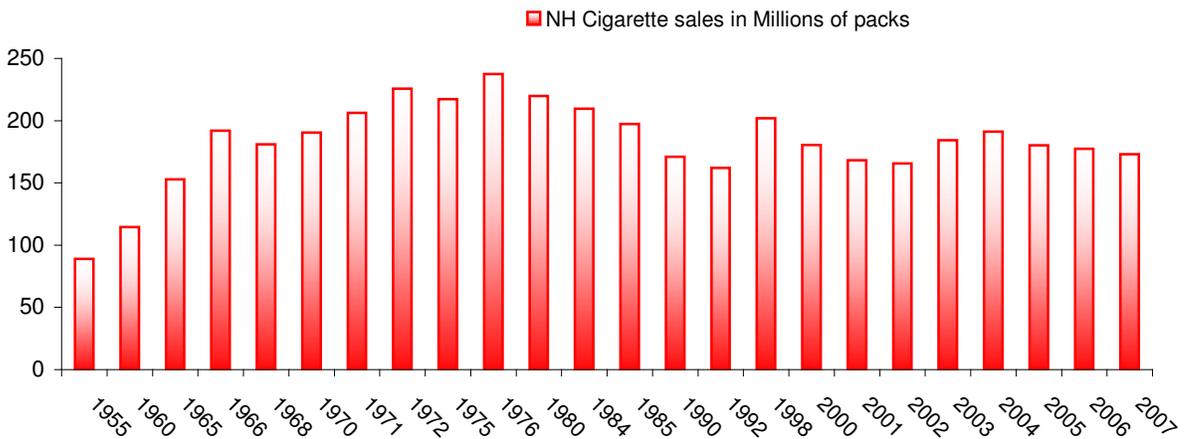
**Data Highlights.** NH did not tax other tobacco products from 1976-1991.

**Data Source.** Tax Burden on Tobacco, Historical Compilation, 2007.

**FIGURE 56. NEW HAMPSHIRE REVENUE IN THOUSANDS OF DOLLARS FROM CIGARETTE SALES**



**FIGURE 57. NEW HAMPSHIRE CIGARETTE SALES IN MILLIONS OF PACKS**



**Data Highlight.** Even with the increase in the average retail price of cigarettes, the data shows a slow change in the state tax paid from cigarette sales. Part of the reason for this is that the retailers have increased the price gradually by a fraction of the tax increase and the consumers don't realize the slow change in prices versus a sudden increase. The tax burden on tobacco does not completely account for retailer-based discounts, promotions, and coupons.

**Data Source.** Tax Burden on Tobacco, Historical Compilation, 2007.

TABLE 55. HISTORICAL CIGARETTE TAX DATA SINCE 1955, NEW HAMPSHIRE

Year	Date changed	Gross State Cigarette Taxes (in thousand of dollars)	State Tax paid Cigarette sales in Millions of packs	Average retail price (cents)
1955		2,732	89	21.5
1960		4,018	114.5	23.9
1965		5,346	152.9	24.7
1966	7/1/65	8,659	192	25.9
1968	7/1/67	12,806	181.1	29.9
1970		13,332	190.5	31.4
1971	7/1/70	17,821	206.3	34.1
1972		24,229	225.7	36.1
1975		23,913	217.4	40.8
1976	7/1/75	28,508	237.6	43.9
1980		26,373	219.8	55.3
1984	8/15/83	34,316	209.6	90.5
1985		33,552	197.4	89.2
1990	7/1/89, 2/20/90	37,639	171.1	135.9
1992		40,608	162	164.4
1998	7/1/97	74,917	201.9	197.0
2000	7/1/99	93,588	180.4	313.9
2001		87,461	168.2	321.5
2002		86,159	165.7	352.9
2003		95,760	184.2	357.7
2004		99,326	191.1	357.0
2005		93,440	180.1	351.6
2006	7/1/05	142,008	177.5	372.5
2007		138,574	173.1	376.4

**Data Highlight.** As with any other state tax based revenue, this source of revenue has increased with every tax increase in New Hampshire. The tax increase is projected to reduce smoking prevalence.

**Method.** The first cigarette tax was enacted in New Hampshire in 1939. In 1965 there was a 21% increase in cigarette tax and another 30% in 1967. There was no other tobacco tax increase between years 1976-1991. Prior to 1976, the tax rate was based on percentage of retail price. The tax was raised to \$.21 on 7/1/89. Then from \$.25 in 1950, cigarette tax was raised by \$.03 (15%) in 7/1/51; \$.35-\$.45 (21%) 7/1/65; \$.45-\$.70 (30%) 7/1/67; \$.70-\$.85 (34%) 7/1/70; \$.85-\$.1.05 (42%) 7/1/71; (42% of retail price to \$.12 7/1/75; \$.12-\$.17 8/15/83; \$.17-\$.21 7/1/89; \$.21-\$.25 2/20/90; \$.25-\$.37 7/1/97; \$.37-\$.52 7/1/99; \$.52-\$.80 7/1/05; \$.80 -\$.1.08 7/1/07 and the current cigarette tax rate is \$1.80. All figures are for fiscal year ending June 30. Prices shown, for 1991 onwards, include generic brands. Some benefits of increasing cigarette taxes has been that the states cigarette pack sales have declined from 2004 to 2005 to -1.4%, the revenue increase percentage was 51.9% from 2005 to 2006 and the new revenue in millions is +\$ 48.5. Even with the decrease in cigarette sales due to decline in smoking rate, New Hampshire received 51.9% increase in revenue through cigarette sales by significantly increasing its cigarette taxes in 2005.

**Data Source.** Tax Burden on Tobacco, Historical Compilation, 2007.

FIGURE 58. NORTHEAST REGIONAL COMPARISON OF THE REVENUE FROM CIGARETTE SALES – 2007

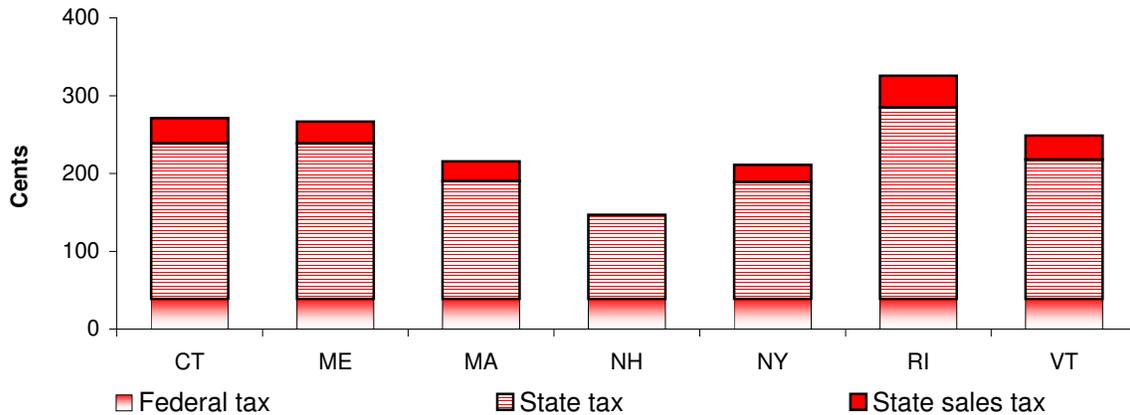


TABLE 56. NORTHEAST REGIONAL COMPARISON OF THE REVENUE FROM CIGARETTE SALES – 2007

	CT	ME	MA	NH	NY	RI	VT
<b>Cigarette taxes Gross amount (in millions)</b>	264	155	418	139	936	119	61
<b>Other Tobacco taxes gross amount (million)</b>	5	6	14	2	46	3	3
<b>Type of other tobacco taxed</b>	CSChSn	CSChSn	ChSn	ChSn	CSChSn	CSChSn	CSChSn
<b>Tobacco sales tax</b>	56,785	21,354	71,219	0	136,362	19,567	10,396
<b>Tax paid cigarette sales</b>	176.9	77.4	277.1	173.1	622.7	48.3	34

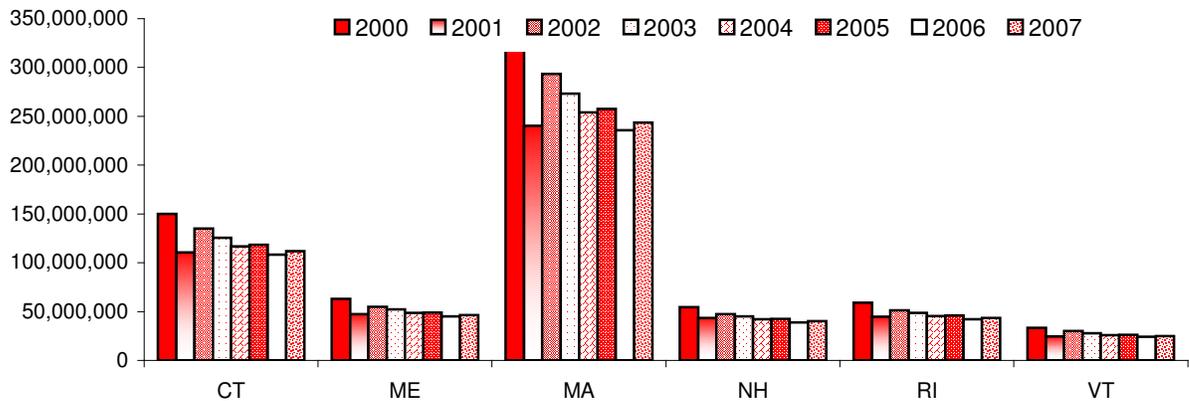
**Data Highlight.** New Hampshire levies no general sales or use tax on consumers. NH does not collect general sales tax on the sale of cigarette like some other states in the region.

**Method.** Tax paid cigarette sales is in millions of pack, Cigarette taxes Gross amount (is in thousand of dollars) (During Fiscal Years Ending June 30). Prices shown for 1991 onwards include generic brands.

TABLE 57. SETTLEMENT PAYMENTS RECEIVED BY STATE DURING FISCAL YEARS ENDING JUNE 30

State	2000	2001	2002	2003	2004	2005	2006	2007
CT	149,965	110,430	134,821	125,465	116,700	118,400	108,300	111,800
ME	62,961	47,268	54,648	51,993	48,400	49,000	44,900	46,300
MA	326,256	240,246	293,309	272,956	253,900	257,500	235,600	243,300
NH	54,502	43,304	47,302	45,004	41,900	42,500	38,800	40,100
RI	58,835	44,589	51,066	48,584	45,200	45,800	41,900	43,300
VT	33,214	24,458	29,860	27,788	25,800	26,200	24,000	24,800

FIGURE 59. SETTLEMENT PAYMENTS RECEIVED BY STATE DURING FISCAL YEARS ENDING JUNE 30

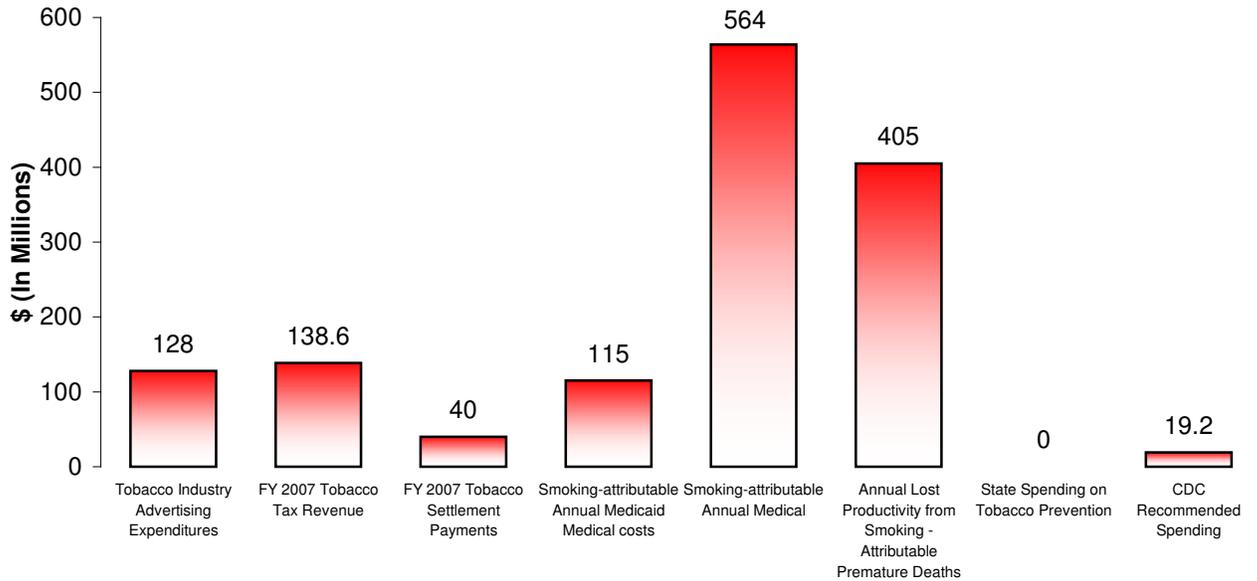


**Data Highlight.** Federal funding supported tobacco prevention in New Hampshire prior to 1998. The State’s funding of tobacco control began in 1998, the year that tobacco companies signed the tobacco master settlement agreement (MSA) with most states. The purpose of the settlement was to reimburse medical costs that states were paying for smokers with tobacco related illnesses. However in July 2003, the New Hampshire Tobacco Prevention and Control Program lost its MSA dollars. Some new funds will be available from 2008 to 2017, under the new “Strategic Contribution Fund” (SCF) for the MSA states and NH will be receiving an additional \$8 million as SCF fund from 2008.

**Methods.** These figures represent payments made by cigarette manufacturers to states in the New England region. The amount is in thousand of dollars.

**Data Source.** Tax Burden on Tobacco, Historical Compilation, 2007.

FIGURE 60. ANNUAL ECONOMIC IMPACTS ASSOCIATED WITH TOBACCO USE, 2007 – NH



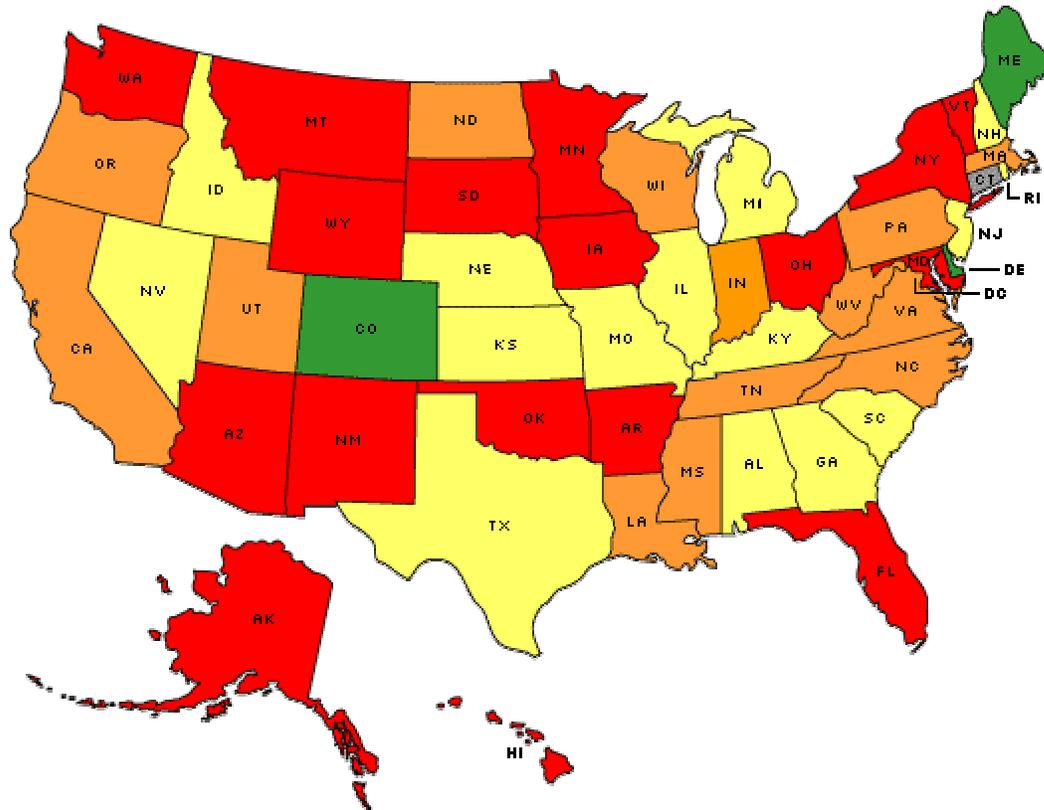
<b>CDC Recommended Annual Investment in NH</b>	\$19.2 million
Percent tobacco revenue to fund at CDC recommended level	11%
<b>Program Area</b>	<b>Per capita Recommendation</b>
State and Community Interventions	\$5.37
Health Communication Interventions	\$3.90
Cessation Interventions	\$3.41
Surveillance and Evaluation	\$1.27 or 10% of program costs
Administration and Management	\$0.63 or 5% of program costs

**Data Highlight:** Greater investments in State Tobacco Control Programs are independently and significantly associated with larger and more rapid declines in adult smoking prevalence, according to a study by researchers at the Centers for Disease Control and Prevention (CDC) and RTI International.<sup>xxiv</sup> According to CDC, the recommended level of investment for tobacco prevention and control in NH is 19.2 million per year or \$ 14.58 per capita, to have an effective, comprehensive tobacco prevention program. In 2007 the funding for the state’s Tobacco Prevention and Control Program was provided by a grant from CDC and the state did not allocate any spending for the program.

**Method:** Nationally, annual tobacco industry expenditures for cigarette advertising and marketing are \$13.4 billion. The New Hampshire portion of total industry expenditures is estimated to be \$128 million using the population estimates for New Hampshire and the United States (national expenditures multiplied by the proportion of the total population made up of New Hampshire residents). Medical costs related to smoking consist of ambulatory care, hospital, nursing home, drugs, and other costs. Smoking-attributable productivity losses were from 1997-2001. The recommended levels of investment (per capita and total) are presented in 2007 dollars using 2006 population estimates. These should be updated annually according to the U.S. Department of Labor Consumer Price Index and U.S. Census Bureau.

**Data Sources:** Office on Smoking and Health, CDC, Best Practices for Comprehensive Tobacco Control Programs.

## FUNDING FOR TOBACCO PREVENTION



- States that have funded tobacco prevention programs at a level that meets the CDC's minimum recommendation.
- States that have committed substantial funding for tobacco prevention programs (more than 50% of CDC minimum).
- States that have committed modest amounts for tobacco prevention programs (25% - 50% of CDC minimum).
- States that have committed minimal amounts for tobacco prevention programs (less than 25% of CDC minimum).
- States that have committed no tobacco settlement or tobacco tax money for tobacco prevention programs.

**Data Source:** Campaign for Tobacco-Free Kids.

**Special Note:** In SFY 2008, a budget reduction was necessary, resulting in a decrease in funding of the NH Cancer Plan Fund. Due to legislation, specific percentage allocations were removed from the plan's original formulary. **Result:** NH Comprehensive Cancer Collaboration Oversight Board provided \$200,000 in funding for tobacco specific initiatives.

## ECONOMIC FACTS ABOUT TOBACCO IN NH

---

### Tobacco Marketing and Media

TABLE 58. TOBACCO ADVERTISEMENT BY TYPE OF STORE – NEW HAMPSHIRE, 2002-2003

	Average number of Advertisements
<b>All</b>	10.5
Small Market	12.0
Gas Station	11.7
Chain Convenience	11.3
Other	10.3
Pharmacy	6.1
Chain Supermarket	5.9

**Data Highlight.** The number of tobacco advertisements varied by type of store in New Hampshire. Small markets, gas stations and chain convenience stores had the highest amounts of advertising, while pharmacies and chain supermarkets had the least. Tobacco advertisements seek to normalize smoking, which can alter young people’s perception of the true prevalence of tobacco use. Through their advertisements, tobacco companies glamorize smoking, using well-researched tactics that have been proven to be effective with youth. Decreasing the number of tobacco advertisements has the potential to reduce tobacco use by youth.<sup>xi</sup>

**Method:** New Hampshire Operation Store Front is a survey of store advertising done by youth, under adult supervision. Stores surveyed are a convenience sample. Survey forms were filled out by youth at the store. The “Other” category includes restaurants and tobacco stores.

**Data Source:** New Hampshire Operation Storefront, 2002-2003.

TABLE 59. STORES WITH TOBACCO ADVERTISEMENTS NEXT TO CANDY OR BELOW THREE FEET IN HEIGHT – NEW HAMPSHIRE, 2002-2003

<b>Type of Store</b>	<b>Number of stores</b>	<b>Tobacco ads next to candy (%)</b>	<b>Tobacco ads below three feet in height (%)</b>
<b>All</b>	472	40.5	46.6
Gas Station	113	53.5	41.6
Chain Convenience	91	43.0	37.2
Small Market	146	41.0	51.6
Pharmacy	50	36.4	43.5
Chain Supermarket	40	18.0	64.1
Other	25	16.0	45.8
Unknown	7	60.0	60.0

**Data highlights:** A total of 256 stores (54.2%) had advertisements placed either next to candy or below three feet in height (counter tops). Advertisements in these locations are particularly visible to children.

**Method:** New Hampshire Operation Store Front is a survey of store advertising done by youth, under adult supervision. Survey forms were filled out by youth at the store. The “Other” category includes restaurants and tobacco stores.

**Data Source:** New Hampshire Operation Storefront, 2002-2003.

## HEALTH CONSEQUENCES OF SMOKING AND TOBACCO USE

FIGURE 61. COMPARISON OF GENERAL HEALTH STATUS IN ADULTS, BY SMOKING STATUS – NH, 2007

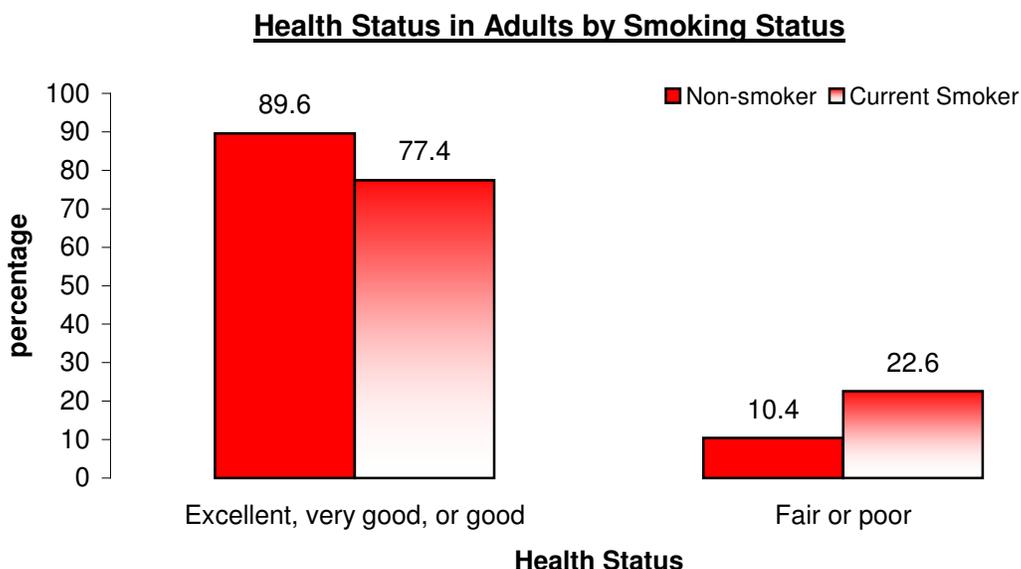


TABLE 60. COMPARISON OF GENERAL HEALTH STATUS IN ADULTS, BY SMOKING STATUS – NEW HAMPSHIRE, 2006

	Excellent, very good or good	Fair or Poor
	% (95% CI)	% (95% CI)
<b>Non-smoker</b>	89.6 (88.7 - 90.6)	10.4 (9.4 - 11.3)
<b>Current Smoker</b>	77.4 (74.1 - 80.7)	22.6 (19.3 - 25.9)

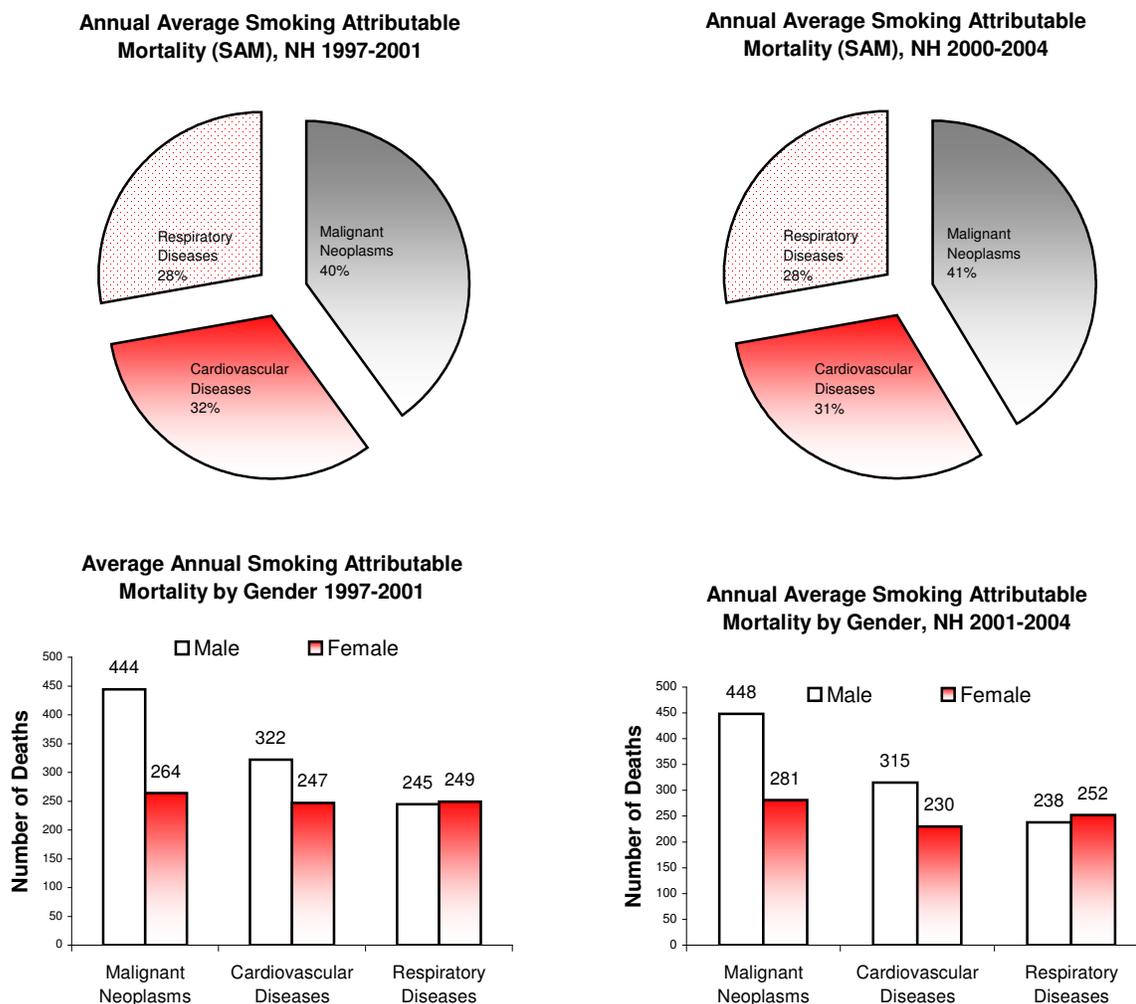
**Data Highlight:** A significantly higher percentage of non-smokers reported that their health was excellent or very good compared to current smokers. Current smokers were significantly more likely to report that their health was fair or poor compared to non-smokers.

**Method:** Respondents were asked to rate their general health as excellent, very good, good, fair, or poor. All respondents were 18 years or older. Current smoker was defined as having smoked 100 cigarettes or more in their lifetime, and reported smoking every day or some days. The denominator included all survey respondents except those with “missing”, “don’t know” and “refused” answers.

**Data Source:** New Hampshire Behavioral Risk Factor Surveillance System, 2007.

## SMOKING- ATTRIBUTABLE MORTALITY – NH, 2001, 2004

FIGURE 62. SMOKING- ATTRIBUTABLE MORTALITY FROM SELECTED CAUSES – NH, 2001, 2004



**Data Highlights:** Annual Average smoking-attributable deaths in New Hampshire is 1,764 compared to 1,778 in 2001. There is a decrease in smoking attributable deaths for Cardiovascular Diseases whereas Malignant Neoplasm has increased and there is no change for Respiratory diseases 2001 average to 2004 average. Smoking Attributable Mortality (SAM) is higher among men for all disease categories except for respiratory diseases. The SAM is also higher for people aged 65 years and older.

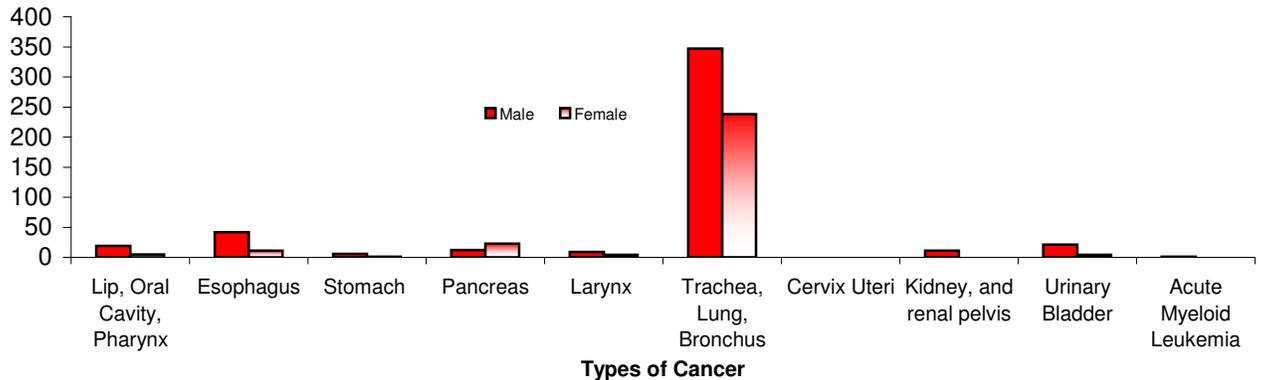
**Method:** Smoking-attributable mortality was based on NH mortality data from 1997-2004 and NH smoking prevalence rates for the same years from the NH Behavioral Risk Factor Surveillance System. Smoking -attributable mortality is calculated using these data elements in CDC’s SAMMEC software. The age group for SAMMEC calculation is 35 years and older since the risk is relatively lower for ages younger than 35 years.

**Data Sources:** Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): Adult SAMMEC and Maternal and Child Health (MCH) SAMMEC software, 2002c.

TABLE 61. AVERAGE ANNUAL SMOKING –ATTRIBUTABLE MORTALITY FOR CANCER DEATHS (NH, 2005)

Disease Category/ Causes of Death-ICD 10 codes	Relative Risks for Current Smokers		Relative Risk for Former Smokers		Annual Deaths (2005)		Smoking Attributable Mortality (2005)		Population Attributable risks (%)	
	Male	Female	Male	Female	Male	Female	Male	Female	M	F
<b>Malignant Neoplasm</b>										
Lip, Oral Cavity, Pharynx (C00-C14)	10.9	5.1	3.4	2.3	26	11	19	5	73%	45%
Esophagus (C15)	6.8	7.8	4.5	2.8	59	18	42	11	71%	61%
Stomach (C16)	2.0	1.4	1.5	1.3	24	13	6	1	25%	8%
Pancreas (C25)	2.3	2.3	1.2	1.6	68	89	12	23	18%	26%
Larynx (C32)	14.6	13.0	6.3	5.2	10	5	9	4	90%	80%
Trachea, Lung, Bronchus (C33-C34)	11.4	2.7	5	2.6	405	328	347	238	86%	73%
Cervix Uteri (C53)	0	1.6	0	1.1	0	17	0	0	0%	0%
Kidney, and Renal Pelvis (C64-65)	2.7	1.3	1.7	1.0	32	26	11	0	34%	0%
Urinary Bladder (C67)	3.3	2.2	2.1	1.9	49	16	21	4	43%	25%
Acute Myeloid Leukemia (C92.0)	1.7	1.1	1.3	1.4	14	16	1	0	7%	0%
<b>Total</b>					687	539	468	286	68%	53%

Figure 63. Smoking-Attributable Mortality, Malignant Neoplasms, 2005



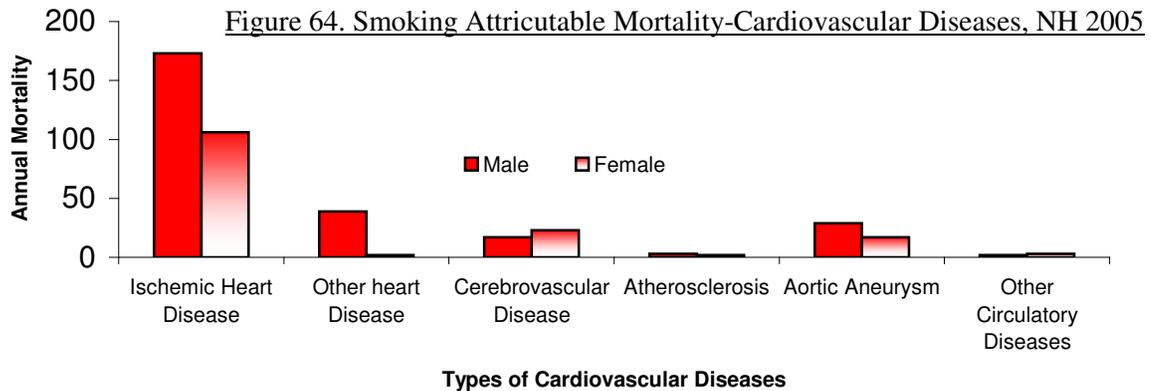
**Data Highlights.** Trachea, lung and bronchus are the leading cancers related to smoking. However this does not take into account lung diseases, which are substantial. The smoking attributable mortality is higher among men for all cancer types except for pancreatic cancer.

**Methods.** These estimates are calculated using CDC’s SAMMEC website and are based on results of the American Cancer Society’s Cancer Prevention Study (CPS II) by Thun and colleagues (1995), which used survey results from about 1,200,000 volunteers. Current smokers are defined as someone who has smoked at least 100 cigarettes over his or her lifetime and who does not smoke everyday or some day. The relative risk is the risk of death from cancer for smokers when compared to non-smokers. The annual deaths column is from the cancer registry and it is the number of deaths from each cancer type in NH in 2005. Smoking Attributable Mortality (SAM) is the number of deaths in 2005 from each cancer type in NH attributable to smoking. Population Attributable Risk (PAR) estimates the proportion of deaths attributable to a specific risk factor in a given population. It is calculated by dividing smoking attributable mortality by the number of annual death in that disease category and multiplying the result by 100. The data is limited to risks from cigarette smoking and does not include those attributable to smoke-less tobacco use, cigar smoking, or other forms of tobacco use.

**Data Sources:** Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): adult SAMMEC and Maternal and Child Health (MCH) SAMMEC software, 2002c.

TABLE 62. AVERAGE ANNUAL SMOKING ATTRIBUTABLE MORTALITY FOR CARDIOVASCULAR DEATHS (NH, 2005)

Disease Category/Causes of Death-ICD 10 codes	Relative Risks for Current Smokers		Relative Risks for Former Smoker		Annual Deaths (2005)		Smoking Attributable Mortality (2005)		Population Attributable risks (%)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<b>Cardiovascular Diseases</b>										
<b>Ischemic Heart Disease (I20-I25)</b>					932	838	173	106	19%	13%
<b>Person Aged 35-64</b>	2.80	3.08	1.64	1.32	234	42	84	14	36%	33%
<b>Person Aged 65+</b>	1.51	1.60	1.21	1.20	698	796	91	88	13%	11%
<b>Other heart Disease (I00-I09); (I26-I51)</b>	1.78	1.49	1.22	1.14	260	32	39	2	15%	6%
<b>Cerebrovascular Disease (I60-I69)</b>					168	329	17	23	10%	7%
<b>Person Aged 35-64</b>	3.27	4.00	1.04	1.30	27	22	9	9	32	40
<b>Person Aged 65+</b>	1.63	1.49	1.04	1.03	141	307	7	15	5	5
<b>Atherosclerosis (I70)</b>	2.44	1.83	1.33	1.00	19	32	3	2	16%	6%
<b>Aortic Aneurysm (I71)</b>	6.21	7.07	3.07	2.07	48	34	29	17	60%	50%
<b>Other Circulatory Diseases (I72-I78)</b>	2.07	2.17	1.01	1.12	30	30	2	3	7%	10%
<b>Total</b>					1457	1295	263	153	18%	12%



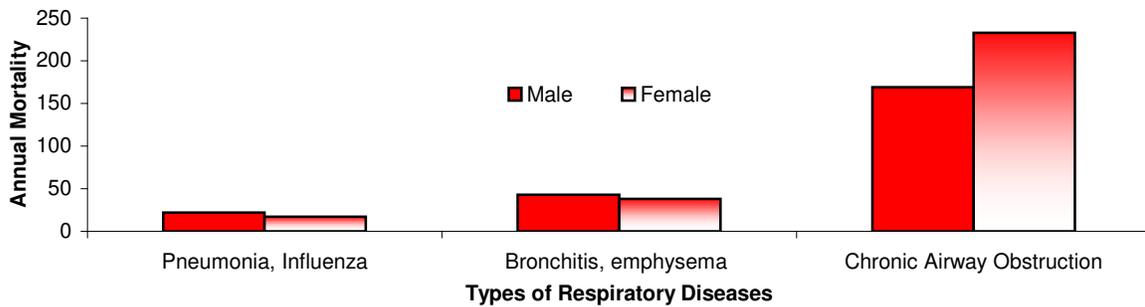
**Methods.** These estimates are calculated using CDC’s SAMMEC website and are based on results of the American Cancer Society’s Cancer Prevention Study (CPS II) by Thun and colleagues (1995), which used survey results from about 1,200,000 volunteers. Current smokers are defined as someone who has smoked at least 100 cigarettes over his or her lifetime and who does not now smoke everyday or some day. The relative risk is the risk of death from cardiovascular disease for smokers when compared to non-smokers. The annual deaths column is from the cancer registry and it is the number of deaths from each cardiovascular disease type in NH in 2005. Smoking Attributable Mortality (SAM) is the number of deaths in 2005 from each cardiovascular type in NH attributable to smoking. Population Attributable Risk (PAR) estimates the proportion of deaths attributable to a specific risk factor in a given population. . It is calculated by dividing smoking attributable mortality by the number of annual death in that disease category and multiplying the result by 100. The data is limited to risks from cigarette smoking and does not include those attributable to smoke-less tobacco use, cigar smoking, or other forms of tobacco use.

**Data Sources:** Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): adult SAMMEC and Maternal and Child Health (MCH) SAMMEC software, 2002c.

TABLE 63. AVERAGE ANNUAL SMOKING –ATTRIBUTABLE MORTALITY FOR RESPIRATORY DISEASES (NH, 2005)

Disease Category/Causes of Death-ICD 10 codes	Relative Risks for Current Smokers		Relative Risks for Former Smoker		Annual Deaths (2005)		Smoking Attributable Mortality (2005)		Population Attributable risks (%)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<b>Respiratory Diseases</b>										
<b>Pneumonia, Influenza (J10-J18)</b>	1.75	2.17	1.36	1.10	119	148	22	17	18%	11%
<b>Bronchitis, emphysema (J40-J42, J43)</b>	17.1	12.0	15.6	11.8	48	43	43	38	90%	88%
<b>Chronic Airway Obstruction (J44)</b>	10.6	13.1	6.8	6.9	215	303	169	233	79%	77%
<b>Total</b>					382	494	234	288	61%	58%

Figure 65. Smoking-Attributable Mortality, Respiratory Diseases



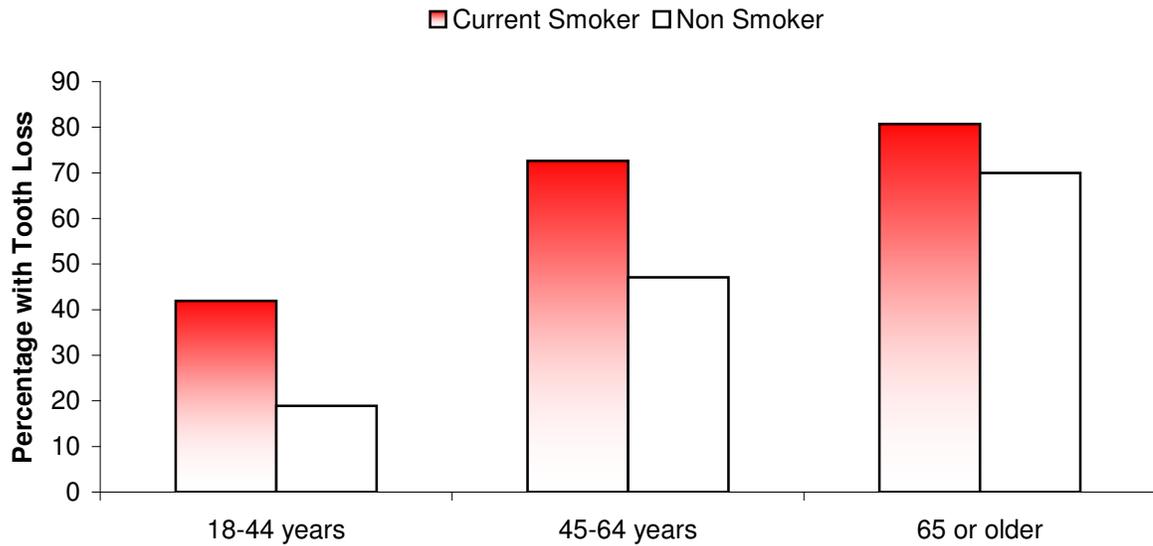
**Data Highlight.** “The evidence is sufficient to infer a causal relationship between active smoking and chronic obstructive pulmonary disease morbidity and mortality.”<sup>xxv2</sup>

**Methods.** These estimates are calculated using CDC’s SAMMEC website and are based on results of the American Cancer Society’s Cancer Prevention Study (CPS II) by Thun and colleagues (1995), which used survey results from about 1,200,000 volunteers. Current smokers are defined as someone who has smoked at least 100 cigarettes over his or her lifetime and who does now smoke everyday or some day. The relative risk is the risk of death from respiratory diseases for smokers when compared to non-smokers. The annual deaths column is from the NH vital records, death data and it is the number of deaths from each respiratory disease category in 2005. Smoking Attributable Mortality (SAM) is the number of deaths in 2005 from each respiratory diseases type in NH attributable to smoking. Population Attributable Risk (PAR) estimates the proportion of deaths attributable to a specific risk factor in a given population. It is calculated by dividing smoking attributable mortality by the number of annual death in that disease category and multiplying the result by 100. The data is limited to risks from cigarette smoking and does not include those attributable to smoke-less tobacco use, cigar smoking, or other forms of tobacco use. The mortality data excludes death from secondhand smoke or burn.

**Data Sources:** Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): adult SAMMEC and Maternal and Child Health (MCH) SAMMEC software, 2002c.

<sup>2</sup> The Health Consequences of Smoking, A Report of the Surgeon General.

**FIGURE 66. PROPORTION OF ADULTS WITH ONE OR MORE PERMANENT TEETH REMOVED DUE TO DECAY OR GUM DISEASE, BY AGE AND SMOKING STATUS, NEW HAMPSHIRE, 2006**



**TABLE 64. PROPORTION OF ADULTS WITH ONE OR MORE PERMANENT TEETH REMOVED DUE TO DECAY OR GUM DISEASE, BY SMOKING STATUS, NEW HAMPSHIRE, 2006**

Age	Smoking Status			
	Current smoker		Non-smoker	
	%	95% CI	%	95% CI
18-44 years	41.9	(36.2-47.6)	18.9	(16.5-21.3)
45-64 years	72.6	(67.8-77.3)	47.1	(44.6-49.6)
65 or older	88.2	(80.7-95.7)	72.9	(70.0-75.7)

**Data Highlight:** New Hampshire adults who had never smoked cigarettes were less likely to have experienced tooth loss due to decay or gum disease. Most teeth are lost because of periodontal (“gum”) disease or dental caries (“cavities”).<sup>xxvi</sup> The U.S. Surgeon General found that smoking and use of other tobacco products is a cause of periodontal disease and may be responsible for as much as half of adult periodontal disease. The Surgeon General has recommended that dental health professionals include tobacco prevention and cessation counseling as part of their periodontal disease prevention activities.<sup>x</sup>

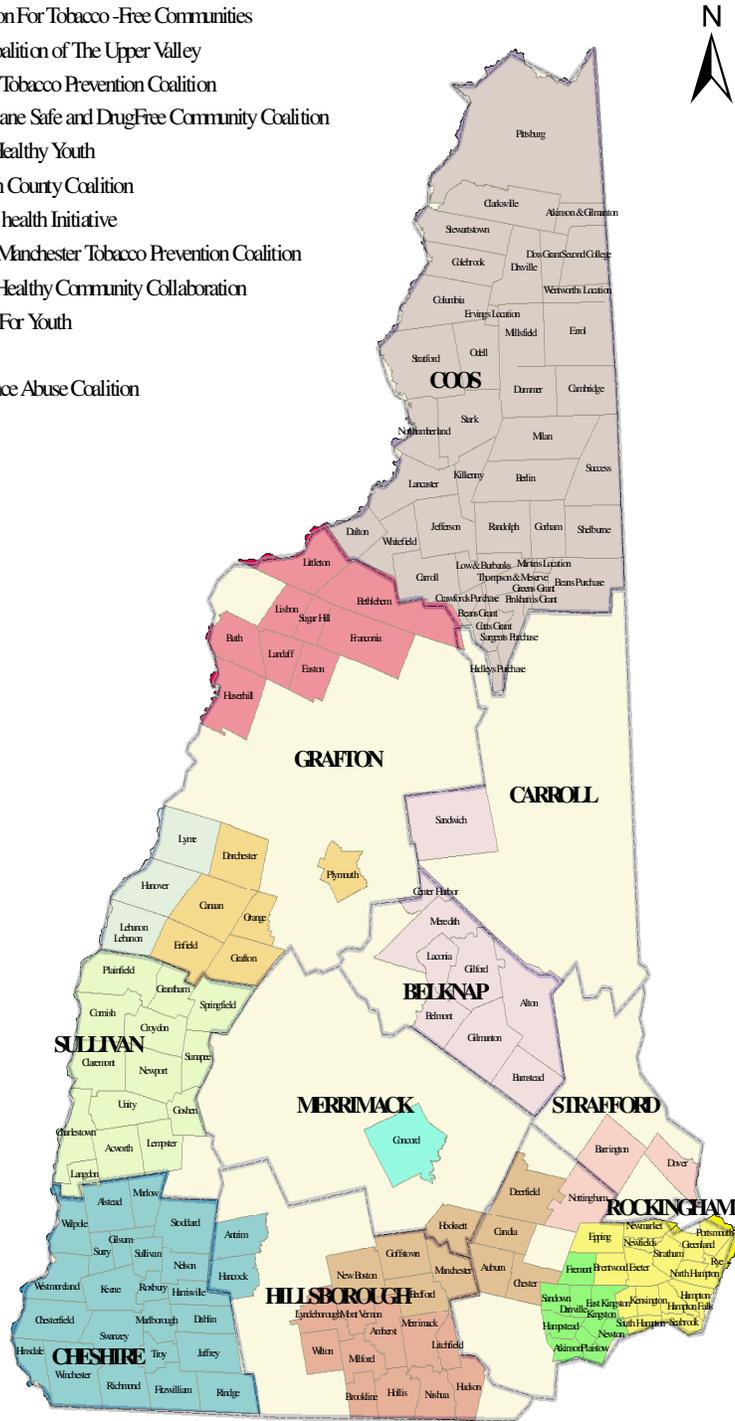
**Method:** Adults 18 years and older were asked how many of their permanent teeth had been removed because of tooth decay or gum disease. Results were presented by age and smoking status because of the relationship of tooth loss to both smoking and age.

**Data source:** NH Behavioral Risk Factor Surveillance System, 2006.

**FIGURE 67. COVERAGE AREA OF NH TOBACCO PREVENTION AND CONTROL COMMUNITY COALITIONS**

**Tobacco Prevention Community Coalitions**

- ◆ Coos County Coalition
- ◆ Cheshire Coalition For Tobacco -Free Communities
- ◆ Tobacco-Free Coalition of The Upper Valley
- ◆ Sullivan County Tobacco Prevention Coalition
- ◆ Sarbom/Timberlane Safe and DrugFree Community Coalition
- ◆ Partnership for Healthy Youth
- ◆ Northern Grafton County Coalition
- ◆ Mascoma Valley health Initiative
- ◆ Kickin' Butts In Manchester Tobacco Prevention Coalition
- ◆ Greater Nashua Healthy Community Collaboration
- ◆ Dover Coalition For Youth
- ◆ CoRe Coalition
- ◆ Concord Substance Abuse Coalition



Map prepared by: Tobacco Prevention and Control Program, NH Department of Health and Human Services, September, 2008

TABLE 65. TOBACCO PREVENTION AND CONTROL COALITIONS -- NEW HAMPSHIRE, 2007

<b>Coalition Name</b>
Cheshire Coalition for Tobacco-Free Communities
Concord Substance Abuse Coalition
Coos County Coalition
CoRe Coalition
Dover Coalition for Youth
Greater Nashua Healthy Community Collaborative
Kickin' Butts in Manchester Tobacco Prevention Coalition
Mascoma Valley Health Initiative
Northern Grafton County Coalition
Partnership for Healthy Youth
Sanborn/Timberlane Safe and Drug Free Community Coalition
Sullivan County Tobacco Prevention Coalition
Tobacco-Free Upper Valley Partnership

**Data Highlights:** Example of coalition activities; from SFY 2005 to 2007 focused on the prevention of secondhand smoke (SHS) exposure by encouraging smoke-free policies in homes and work-places and educating community members about the dangers associated with tobacco use.

<b>Number of presentations to community groups and leaders</b>	534
<b>Number of worksites evaluated for smoking policy</b>	838
<b>Number of smoke-free worksite policies adopted</b>	248
<b>Number of events attended with SHS information distributed</b>	462
<b>Number of "I will take it outside 'til I can quit" pledge cards distributed</b>	4684

**Method:** The NH Tobacco Prevention and Control Program currently funds 13 community coalitions that serve 146 towns in NH. Although coverage varies, every NH County has at least one town covered by a tobacco prevention coalition.

**Data source:** Tobacco Prevention and Control Program, 2005-2007.

## DATA SOURCES

---

### Surveys

#### *Adult Tobacco Survey (ATS)<sup>xxvii</sup>*

The Adult Tobacco Survey was a random-digit dialed telephone survey of the non-institutionalized adult population in New Hampshire. The survey instrument was based on one developed by the Centers for Disease Control and Prevention and consisted of 103 questions on knowledge, attitudes and behaviors related to tobacco. Three thousand respondents completed interviews from August through October 2002. The Council of American Survey Research Organization's response rate was 52.6%. When similar data for 2002 were available from both the Adult Tobacco Survey and the Behavioral Risk Factor Surveillance System, data from the Behavioral Risk Factor Surveillance System were used.

The report on the 2002 NH Adult Tobacco Survey can be found at: <http://www.dhhs.state.nh.us/DHHS/ATODPREVENTION/LIBRARY>.

#### *Behavioral Risk Factor Surveillance System (BRFSS)<sup>xxviii</sup>*

The Behavioral Risk Factor Surveillance System<sup>xxviii</sup> is a state-based, random-digit- dialed telephone health survey of civilian, non-institutionalized adults, aged 18 years and older. The survey is coordinated by the Centers for Disease Control and Prevention (CDC) and is conducted annually by all states. In New Hampshire, the Health Statistics and Data Management Section of the NH DHHS, Division of Public Health Services is responsible for the survey. The BRFSS includes questions on health behavior risk factors such as safety belt use, diet, weight control, tobacco and alcohol use, physical exercise, preventive health screenings, and use of preventive and other health care services. The data are weighted to more accurately reflect the population by accounting for age, gender, geographic location, and probability of selection. A core set of questions, which include smoking prevalence, is asked annually. Other tobacco-related topics are asked on a rotating basis. In New Hampshire, 6,043 interviews were completed in 2006 and 5,990 in 2007. The Council of American Survey Research Organization's (CASRO) response rate was 46.5% in 2006 and 37.7% in 2007. New Hampshire prevalence estimates are means, or an average calculated by pooling all NH responses for a given year. The national estimates provided are not calculated by pooling all BRFSS data as a sample of the nation as a whole, but are simply a calculation of the middle value of all the state prevalence estimates (the median). This method gives equal weight to smaller states and bigger states and minimizes the effects of extreme values. New Hampshire and national data can be accessed on line at: <http://www.cdc.gov/brfss/>. Additional information on the New Hampshire BRFSS is available on-line at: <http://www.dhhs.state.nh.us/DHHS/BHSDM/LIBRARY> or by calling (603) 271-5926.

#### *Tobacco Use Supplement to the Current Population Survey (TUS-CPS)<sup>xxi</sup>*

The Tobacco Use Supplement to the Current Population Survey is an NCI-sponsored survey of tobacco use that has been administered as a part of the US Census Bureau's Current Population Survey in 1992-1993, 1995-1996, 1998-1999, 2000, 2001-2002, and 2003. CDC has been a co-sponsor with NCI since 2001-02. Civilian, non-institutionalized population ages 15 years and older are included in the survey. National, state and some substate-specific estimates are available. State sample size varies by state. 75% of the respondents conducted by telephone and 25% by home visits. The survey provides state-specific estimates for secondhand smoke exposure at worksites. Information on the survey is available on-line at <http://riskfactor.cancer.gov/studies/tus-cps/future.html>

### ***New Hampshire Higher Education Alcohol, Tobacco, and Other Drug Survey***<sup>xxix</sup>

The New Hampshire Higher Education Alcohol, Tobacco and Other Drug Survey were done for the second time in 2003. The survey was conducted at nine colleges in the state (Colby-Sawyer, Daniel Webster, Franklin Pierce Universities, New Hampshire Technical Institute, Plymouth State Universities, Rivier, St. Anselm, Southern New Hampshire University and the University of New Hampshire). The questions were derived from three other surveys: the Core survey, the National College Health Assessment, and the Annual Student Health Behavior Assessment. A total of 3,717 students completed the survey with a range from approximately 116 to 677 students per school. Information on the survey is available at [http://www.unh.edu/student-life/assessment/alcohol\\_drug.htm](http://www.unh.edu/student-life/assessment/alcohol_drug.htm)

### ***New Hampshire Operation Storefront***

*Operation Storefront* was conducted in New Hampshire between November 2002 and February 2003. This was the second year the survey was done. Youth surveyed 472 stores, located in 68 towns in eight counties. Stores were selected by convenience in communities with local tobacco prevention coalitions; therefore, the results are not representative of all New Hampshire stores. Information was collected on the type, presence, and placement of tobacco advertising found in, on, and around stores. The location of tobacco products and the presence of tobacco-control signage were also recorded. The New Hampshire data collection form was adapted from one developed by the *Campaign For Tobacco-Free Kids* (<http://www.tobaccofreekids.com>).

### ***New Hampshire Restaurant Survey***

The New Hampshire Department of Health and Human Services, Tobacco Prevention and Control Program undertook a baseline survey in June 18-24, 2001 to assess tobacco policies in restaurants. The survey instrument was adapted from one developed by the Oregon Health Division for a 1998 survey. The telephone survey contained questions on type of restaurant, seating capacity, whether the restaurant was smoke-free, by whom the smoking policy was determined, number of years the restaurant has been smoke-free, complaints about smoking policy, and support for a local ordinance eliminating smoking in restaurants. A list of restaurants in New Hampshire was obtained from a marketing firm using Standard Industrial Classification Codes 5812 and 5813. Restaurants with no seating were ineligible to participate in the survey. Establishments were selected randomly until 402 had completed the 22-question survey. More information on the 2001 NH Restaurant Survey can be found at: <http://www.dhhs.state.nh.us/DHHS/ATODPREVENTION/LIBRARY> and in the January 2004 edition of the *Journal of Public Health Management and Practice*.<sup>xxx</sup>

### ***School Health Education Profiles***

The School Health Education Profiles are coordinated by the Centers for Disease Control and Prevention. They were first implemented in New Hampshire in 1996 and are conducted in alternate years. The self-administered survey includes two components, one for the lead health education teacher, and another for the school Principal of Middle and High Schools. The survey includes questions on tobacco education curricula, teacher training, availability of referrals for cessation, and school policy. The New Hampshire School Health Education Profiles are administered by the New Hampshire Department of Education. All public schools with grades 6-12 are eligible to participate. In 2002, 154 (73%) of 210 lead health education teachers completed the Profiles; 172 (82%) of 210 principals completed the Profiles. Available at: <http://www.ed.state.nh.us/education/doe/organization/instruction/HealthHIVAIDS/youthrisk.htm>

### ***Smoke Free New Hampshire Alliance, City of Keene Smoking Ordinance Survey 2003***

The Smoke Free New Hampshire Alliance contracted with The Survey Center at the University of New Hampshire to conduct a survey in Keene to assess the impact of the smoking ordinance that went into effect on February 2, 2002. A total of 439 adults were interviewed by telephone in January 2003.

### ***Synar Survey***

The Synar Amendment is a Federal Law enacted in July 1992. It requires states to enact and enforce laws restricting the sale and distribution of tobacco products to youth under the age of 18. States are required to conduct annual randomized scientific surveys to determine the degree to which tobacco retailers are complying with this law. The Bureau of Drug and Alcohol Services within the NH Department of Health and Human Services, conducted the New Hampshire survey. The survey employs a probability sample of tobacco outlets weighted to the number of establishments in each sampling area. Lists of retailers are provided from the tobacco-licensing database maintained by the Department of Revenue Administration. Purchase attempts are recorded in a database, which includes the following variables: county, type of business, whether age and/or identification was requested, results, and whether signs were posted for minimum age requirements. Information about the Synar Survey can be obtained from the Bureau of Drug and Alcohol Services within NH DHHS.

### ***Youth Risk Behavior Survey<sup>xxxi</sup>***

The Youth Risk Behavior Survey (YRBS) is a component of the Youth Risk Behavior Surveillance System, an epidemiologic surveillance system that was established by the Centers for Disease Control and Prevention to monitor the prevalence of youth behaviors that most influence health. The national school-based YRBS data are gathered through biennial school-based surveys that are self administered in classrooms to predominantly 9<sup>th</sup> through 12<sup>th</sup> grade students. National data are weighted to make the information representative of students in grades 9-12 in public and private schools in the 50 states and the District of Columbia. Survey procedures are designed to protect the students' privacy by allowing for anonymous and voluntary participation. The students complete the self-administered questionnaire in their classrooms during a regular class period, recording their responses directly on a computer scan-able booklet or answer sheet.

The New Hampshire Department of Education conducted the first statewide YRBS in 1990, and repeated the survey in 1991, 1993, 1995, 1997, 1999, 2001, and 2003. Procedures for administration of the statewide YRBS are similar to the national YRBS. From 1997 through 2001, New Hampshire was not able to meet the minimum overall participation rate of 60% therefore the data for those years were not weighted and were not representative of New Hampshire High School students. In 2003, forty-three public High Schools participated in the survey, so that 1,327 students completed the survey. The overall response rate was 62%. National data for 2003 were reported by the CDC in: Cigarette Use Among High School Students --- United States, 1991—2003, June 18, 2004 edition, available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5323a1.htm>. Data can also be accessed at: <http://www.cdc.gov/healthyyouth/yrbs>

### ***Youth Tobacco Survey***

The Youth Tobacco Survey is conducted nationally and in New Hampshire. The most recent data from the National Youth Tobacco Survey (NYTS) is from 2002. The American Legacy Foundation in collaboration with the CDC conducted the 2002 survey to measure tobacco use among Middle and High School students. The NYTS is representative of students in grades 6-12 in public and private schools in all 50 states and the

District of Columbia. A three-stage sample design was used to produce a nationally representative sample of students. Students completed a self-administered questionnaire in the classroom, recording their answers on an answer sheet. Results were obtained anonymously and the overall response rate was 75%. The CDC reported prevalence for use of tobacco products in the Morbidity and Mortality Weekly Report on November 14, 2003 (Volume 52, Number 45, Pages 1096-8).

During October and November of 2001 the New Hampshire Youth Tobacco Survey (NHYS) was conducted in public Middle and High Schools. Middle School was defined as grades six through eight and High School as grades nine through twelve. A two-stage cluster sample design was used to produce a representative sample of students. In the first stage, 50 Middle Schools and 50 High Schools were randomly selected. In the second stage, classes were randomly selected from within the participating schools. All students in the selected classes were eligible to participate. The 2001 NHYS used a pencil and paper questionnaire consisting of 81 multiple-choice-questions. Students completed a self-administered questionnaire in the classroom, recording their answers on an answer sheet. Results were obtained anonymously and the overall response rate was 73% for Middle Schools and 63% for High Schools.

Although both the NYTS and the NHYS were repeated in 2004, data was not available at the date of this publication.

## **Vital Statistics and Cancer Registry Data**

### ***New Hampshire Cancer Registry Data<sup>xxxii</sup>***

Statistical information on newly diagnosed primary cancers is reported to the New Hampshire State Cancer Registry. This database is comprised of information on reportable cancers from New Hampshire acute care hospitals and their tumor registries, medical records departments, oncology departments, physicians, and private pathology laboratories. The Registry has agreements for exchange of case information with the states of Connecticut, Florida, Maine, Massachusetts, New York, Rhode Island, and Vermont. The New Hampshire State Cancer Registry is operated by the Norris Cotton Cancer Center under a contract between the State and Dartmouth Medical School. The Health Statistics and Data Management Section in the Division of Public Health Services, New Hampshire Department of Health and Human Services analyzes the records of newly diagnosed cases of cancer (incidence data) collected by the New Hampshire State Cancer Registry. Information regarding NH Cancer Registry data may be found at: <http://www.dhhs.state.nh.us/DHHS/BHSDM/LIBRARY>

### ***Vital Statistics<sup>xxxiii</sup>***

New Hampshire law requires that reports of all birth, death, fetal death, marriage, and divorce be filed with the Division of Vital Records in the Office of the Secretary of State. Vital Records was located in the Department of Health and Human Services until September 2003 when it was moved to the Secretary of State's office. The Health Statistics and Data Management Section in the Bureau of Health Care Research, Office of Medicaid Business and Policy, Department of Health and Human Services maintains and analyzes these data. Depending on the event, filings are made by hospital personnel, physicians, funeral directors, city/town clerks, attorneys, and clerks of the courts. Reports of New Hampshire resident births and deaths in other states, and Canada, are provided to the State Registrar, for statistical purposes only, under an inter-state/Canadian agreement for the exchange of vital events information. New Hampshire Vital Statistics data may be accessed on line at: <http://www.dhhs.state.nh.us/DHHS/BHSDM/LIBRARY>.

## **Birth Methodology**

Percentages are based on birth certificate data. The specific characteristics reported in New Hampshire include: sex, age, county, birth weight (whether low or very low), and gestational age (whether low) of the infant. Additional reported information includes: whether or not the mother received appropriate prenatal care; the marital status of the mother; whether Medicaid provided payment for prenatal care, delivery, or both; whether the mother reported consuming tobacco or alcohol at any point during the pregnancy; and whether the mother had less than 12 years of education or did not complete High School or the equivalent.

National figures are also based on birth certificate data. During the 1990's the number of states that collected comparable data on smoking during pregnancy from the birth certificate changed. California was a non-reporting state throughout the entire period. New York City started reporting in 1994. Data for Indiana and New York State were available beginning in 1999. South Dakota began reporting in 2000. Information on births in New Hampshire is available on-line at: <http://www.dhhs.state.nh.us/DHHS/BHSDM/LIBRARY>.

## **Mortality Methodology**

The cause of death reported is the underlying cause of death. In a death record, the underlying cause of death is the specific disease, condition, or injury that initiated the chain of events leading to death. The underlying cause of death is not always the same as the immediate cause of death. For example, if a person was hospitalized for lung cancer, but developed pneumonia and died while in the hospital, the underlying cause of death would be lung cancer. Additional information on deaths in New Hampshire is available at: <http://www.dhhs.state.nh.us/DHHS/BHSDM/LIBRARY>.

## **Other Sources of Data**

### ***Compliance Data, Liquor Commission***

Between October 2001 and June 2003, with funding from the state's Tobacco Prevention and Control Program, Tobacco Use Prevention Fund, the NH Liquor Commission Bureau of Enforcement conducted systematic compliance checks on tobacco retailers throughout the state on an ongoing basis. Under the direction of Liquor Commission staff, compliance checks were performed with underage youth who attempted to purchase cigarettes. If the youth were able to purchase cigarettes, the clerk and retailer were cited for violation of the state's law prohibiting sale of tobacco products to minors.

### ***Federal Trade Commission Reports***<sup>xxxiv</sup>

The Federal Trade Commission (FTC) enforces a variety of federal antitrust and consumer protection laws. The Commission undertakes economic analyses in order to support its law enforcement efforts and to contribute to the policy deliberations of Congress, the Executive Branch, other agencies, and state and local governments. These analyses are periodically published as reports. FTC reports are used to estimate the amount of money spent by the tobacco industry annually on advertising and promotion in New Hampshire. Information is available on-line at <http://www.ftc.gov/reports/index.htm>.

### ***Healthy New Hampshire 2010***<sup>xxxv</sup>

Healthy New Hampshire 2010 is New Hampshire's health promotion and disease prevention agenda for the first decade of the 21<sup>st</sup> century. Similar to *Healthy People 2010*, it is a compilation of health objectives for

the next decade. A copy of Healthy New Hampshire 2010 can be obtained on-line at: <http://www.healthynh2010.org/>.

### ***Healthy People 2010<sup>xxxvi</sup>***

*Healthy People 2010* is a set of national health targets for the next decade. It builds on initiatives pursued over the past two decades including the 1979 Surgeon General's Report, *Healthy People*, and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. It is designed to achieve two overarching goals: 1) increase quality and years of healthy life; and 2) eliminate health disparities. A copy of *Healthy People 2010* can be obtained on-line at: <http://www.health.gov/healthypeople>.

### ***New Hampshire Department of Revenue Administration***

Data on cigarette sales in New Hampshire is determined by tobacco tax revenue collected by the New Hampshire Department of Revenue Administration. Packs of cigarettes sold are calculated by taking the cigarette tax total divided by the tax rate per pack. Packs sold per capita are calculated by dividing the total number of cigarette packs sold by the population estimate for New Hampshire. This data is published annually in *Tax Burden of Tobacco, Historical Compilation*.<sup>xxxvii</sup>

### ***New Hampshire Tobacco Prevention and Control Program***

Results of components of the New Hampshire Tobacco Prevention and Control Program are presented. These include: Community Coalitions; The Try-To-STOP TOBACCO Resource Center, including the NH Smokers' Helpline, [www.trytostopnh.org](http://www.trytostopnh.org), medical provider training on the U.S. Public Health Service Guidelines on Tobacco Use Prevention, activities by community coalitions to promote smokefree homes and businesses. Information about the NH Tobacco Prevention and Control Program can be found at: <http://www.dhhs.nh.gov/DHHS/ATOD/default.htm>

### ***Smoking-Attributable Morbidity, Mortality, and Economic Costs (SAMMEC)<sup>xxxviii</sup>***

SAMMEC is a web-based program (<http://apps.nccd.cdc.gov/sammec/intro.asp>) developed by the Centers for Disease Control and Prevention to calculate several measures of the impact of cigarette smoking on the entire United States and on each state. Using state-specific data on smoking prevalence, overall mortality rates, and population data, SAMMEC generates the number of deaths and death rates due to smoking, years of life lost due to premature death from cigarette smoking, and lost productivity (earnings) due to illness and premature death from smoking-related diseases.

*Birth File*—Information on cigarette smoking by the mother during pregnancy is based on Yes/No responses to the birth certificate item "Other risk factors for this pregnancy: Tobacco use during pregnancy." This information became available for the first time in 1989 with revision of the U.S. Standard Birth Certificate. In 1989, 43 States and the District of Columbia collected data on tobacco use. The following States did not require the reporting of tobacco use in the standard format on the birth certificate: California, Indiana, Louisiana, Nebraska, New York, Oklahoma, and South Dakota. In 1990 information on tobacco use became available from Louisiana and Nebraska, increasing the number of reporting States to 45 and the District of Columbia. In 1991–93, with the addition of Oklahoma to the reporting area, information on tobacco use was available for 46 States and the District of Columbia; in 1994–98, 46 States, the District of Columbia, and New York City reported tobacco use; in 1999 information on tobacco use became available from Indiana and New York, increasing the number of reporting States to 48 and the District of Columbia; starting in 2000, with the addition of South Dakota, the reporting area includes 49 States and the

District of Columbia. During 1989–2002 California did not require the reporting of tobacco use. The areas reporting tobacco use comprised 87 % of U.S. births in 1999–2002.

*Monitoring the Future Survey*—Information on current cigarette smoking is obtained for High School seniors (starting in 1975) and 8th and 10th graders (starting in 1991) based on the following question: “How frequently have you smoked cigarettes during the past 30 days?”

*National Health Interview Survey (NHIS)*—Information about cigarette smoking is obtained for adults 18 years of age and over. Starting in 1993 current smokers are identified based on the following two questions: “Have you smoked at least 100 cigarettes in your entire life?” and “Do you now smoke cigarettes every day, some days, or not at all?” Persons who smoked 100 cigarettes and who now smoke every day or some days are defined as current smokers. Before 1992 current smokers were identified based on positive responses to the following two questions: “Have you smoked 100 cigarettes in your entire life?” and “Do you smoke now?” (traditional definition). In 1992 the definition of current smoker in the NHIS was modified to specifically include persons who smoked on “some days” (revised definition). In 1992 cigarette smoking data were collected for a half-sample with half the respondents (one-quarter sample) using the traditional smoking questions and the other half of respondents (one-quarter sample) using the revised smoking question (“Do you smoke every day, some days, or not at all?”). An unpublished analysis of the 1992 traditional smoking measure revealed that the crude % of current smokers 18 years of age and over remained the same as 1991. The statistics for 1992 combine data collected using the traditional and the revised questions. In 1993–95 estimates of cigarette smoking prevalence were based on a half-sample. Smoking data were not collected in 1996. Starting in 1997 smoking data were collected in the sample adult questionnaire. For further information on survey methodology and sample sizes pertaining to the NHIS cigarette smoking data for data years 1965–92 and other sources of cigarette smoking data available from the National Center for Health Statistics, see: National Center for Health Statistics, *Bibliographies and Data Sources, Smoking Data Guide*, no. 1, DHHS pub. no. (PHS) 91-1308-1, Public Health Service. Washington, DC: U.S. Government Printing Office. 1991.

*National Survey on Drug Use & Health (NSDUH)*— Information on current cigarette smoking is obtained for all persons surveyed who are 12 years of age and over based on the following question: “During the past 30 days, have you smoked part or all of a cigarette?” *Youth Risk Behavior Survey*—Information on current cigarette smoking is obtained from High School students (starting in 1991) based on the following question: “During the past 30 days, on how many days did you smoke cigarettes?”

## CONTRIBUTORS/ REVIEWERS

---

Lida Anderson, M.D., MPH

David Laflamme, MPH, Ph.D

Teresa Brown, BS

Karyn Madore, M.Ed

Sai Cherela, M.D. MPH

Jeffrey Metzger, Ph.D

Christin D'Ovidio, MFA

Susan Morrison, M.Ed

Micheal Dumond, MS/MBA

Judith Nicholson, M.Ed

Donna Fleming, BS

Elizabeth Traore, MPH

Shasta Jorgensen, BA

Susan Knight, MPH

## Appendix A.

---

### STATE LAW TOBACCO SALES TO MINORS RSA 126-K 1-14

#### An Act Concerning Youth Access to Tobacco

##### Under this law:

- No person shall use **any** tobacco product in or on the grounds of any public educational facility.
- No person under 18 years of age shall use, buy or have tobacco in their possession.
- It is illegal to sell, give or furnish tobacco products to youth under age 18.
- Photo ID's must be checked for those purchasing tobacco products who appear under age 18.
- Other restrictions on samples and vending machines.

##### Fines for persons smoking in or on the grounds of any public educational facility:

- a maximum of **\$100** for each offense.

##### Fines for youth under age 18 using, buying or possessing tobacco:

- a maximum of **\$100** or must perform **20 hours** of community service.

##### Fines for retailers in violation of selling, giving or furnishing tobacco products to youth under age 18:

- a maximum of **\$250** for the first offense.
- a maximum of **\$500** for the second offense.
- For the third offense, the liquor commission shall issue a letter of warning detailing necessary corrective actions and a fine ranging from **\$500 to \$1,500**. In addition, the license to sell tobacco products shall be suspended for a period of **10 to 30 days**.
- For the fourth offense, the liquor commission shall issue either an administrative fine and a suspension for a period of **10 to 40 days**, or a suspension. The administrative fine shall range from **\$750 to \$3,000** while any suspension without a fine shall be **40 days**. For any violation beyond the fourth, the commission shall revoke any license.

**For more information call (800) 852-3345, ext. 6891 or (603) 271-6891**

**Appendix A. (continued)**

---

TITLE X  
PUBLIC HEALTH  
CHAPTER 126-K  
YOUTH ACCESS TO AND USE OF TOBACCO PRODUCTS  
Section 126-K:7

**126-K:7 Use of Tobacco Products on Public Educational Facility Grounds Prohibited. –**

I. No person shall use any tobacco product in any public educational facility or on the grounds of any public educational facility.

II. Any person who violates this section shall be guilty of a violation and, notwithstanding RSA 651:2, shall be punished by a fine not to exceed \$100 for each offense.

**Source.** 1997, 338:8, eff. Jan. 1, 1998.

**State Law: Tobacco Sales To Minors**

Last Revised: 09/21/2001

## Appendix B. Indoor Smoking Act

---

TITLE XII  
PUBLIC SAFETY AND WELFARE CHAPTER 155  
FACTORIES, TENEMENTS, SCHOOLHOUSES, AND PLACES OF PUBLIC  
ACCOMMODATION, RESORT OR ASSEMBLY  
Indoor Smoking Act

**155:65 Definitions.** – In this subdivision:

- I. "Cocktail lounge" means only that portion or specified area of a restaurant, hotel, motel, convention center or resort which is used primarily to serve liquor or other alcoholic beverages, irrespective of whether or not food is also served there.
- II. [Omitted.]
- III. "Commissioner" means the commissioner of the department of health and human services or designee.
- IV. "Department" means the department of health and human services.
- V. "Effectively segregated" means all the following conditions have been met:
  - (a) Procedures for accurately and fairly determining preference have been followed;
  - (b) The size and location of no-smoking and smoking-permitted areas are designed, designated, or juxtaposed so that smoke does not cause harm or unreasonably intrude into the area occupied by persons who are not smoking; and
  - (c) In buildings where existing ventilation systems are in place, areas designated as smoking areas are located, where reasonably possible, proximate to exhaust vents.
- VI. "Enclosed place" means a structurally enclosed location, or portion of such location, enclosed by a floor, ceiling, and 3 or 4 solid walls, partitions, or windows, exclusive of doors or passageways.
- VII. "Health care facility" means any enclosed place or portion of such place used for the purpose of providing medical or dental treatment, physical or mental health services, or any combination of such treatment or services. This definition shall include buildings or portions of buildings used exclusively for such purposes and buildings or portions of buildings leased, rented, or otherwise made available for such purposes.
- VIII. "Law enforcement authority" means the state, county, city, or town police having authority over a given area in the state.
- IX. "Person in charge" means:
  - (a) For enclosed places that are not publicly owned buildings or offices, the person who has responsibility for, directly or by appointment, policy making and overseeing adherence to laws, rules and regulations of an enclosed place of public access or a workplace. This definition shall not mean the owner of the property or place of public access or workplace unless he is routinely present and controls the day-to-day activities, or sets the policy, carried out within the enclosed place.
  - (b) For publicly owned buildings and offices, the person responsible for the operation of the building or office and the person responsible for the agency or organization occupying the building or office, or that person designated to act in the absence of the person in charge.
- X. "Public access" means any enclosed place of business, commerce, banking, financial service, or other service-related activity, whether publicly or privately owned and whether operated for profit or not, to which the general public has access or which the general public uses, including, but not limited to, buildings, offices, means of transportation, common carrier waiting rooms, arcades, restaurants, retail stores, grocery stores, libraries, theaters, concert halls, auditoriums, arenas, barber shops, hair salons, laundromats, shopping malls, museums, art galleries, sports and fitness facilities, planetariums, historical sites, and common areas of resorts, hotels and motels, including the lobbies, hallways, elevators, restaurants, restrooms and cafeterias.
- XI. "Public educational facility" means any enclosed place or portion of such place, which is supported by public funds and which is used for the instruction of students enrolled in grades kindergarten through 12.

This definition shall include areas within facilities supportive of instruction and subject to educational administration including, but not limited to, lounge areas, passageways, restrooms, laboratories, study areas, cafeterias, gymnasiums, libraries, maintenance rooms and storage areas.

XII. "Public conveyance" means any air, land, or water vehicle of public access, which has enclosed sections, used for the transportation of persons in the state of New Hampshire, whether or not for compensation, including, but not limited to, airplanes, trains, buses, boats, vans, or taxis. This definition shall not include privately owned vehicles when used for private purposes, but shall include all vehicles owned by the state and its political subdivisions.

XIII. "Publicly owned buildings and offices" means enclosed places or portions of such places owned, leased, or rented by state, county or municipal governments, or by agencies supported by appropriation of, or by contracts or grants from, funds derived from the collection of federal, state, county or municipal taxes. This definition includes, but is not limited to, legislative offices, legislative meeting rooms and other areas used by legislative bodies; courtrooms, jury rooms, and other court facilities; recreation facilities; police stations; fire stations; county, city and town offices; penal and detention institutions; armories; military training facilities; public housing; subsidized housing; common waiting areas, lobbies or common-use rooms; field offices of any government unit; and postsecondary educational institutions receiving funds appropriated by the state legislature. This definition also includes enclosed places periodically used by state, county or municipal governments or their agencies, including, but not limited to, polling places and rooms in which a public meeting, hearing or other proceeding open to the public is in progress. This definition shall also include, in accordance with federal laws and regulations, enclosed places and offices owned, leased, or rented by the federal government or agencies of the federal government.

XIV. "Restaurant" means any room or enclosed place used and kept open on a regular basis and in a bona fide manner for the serving of meals to guests for compensation. "Restaurant" shall include any such room or place in resorts, hotels, and motels.

XV. "Smoking" means having in one's possession a lighted cigarette, cigar, or pipe, or any device designed to produce the effect of smoking.

XVI. "Smoking-permitted area" means an effectively segregated area which is posted with "Smoking Permitted" signs in a building, facility, room, or group of rooms or other enclosed indoor area and in which smoking is allowed, as designated by the person in charge of the facility in accordance with applicable rules adopted by the commissioner pursuant to RSA 155:71.

XVII. "Workplace" means an enclosed place at which 4 or more individuals perform any type of a service for consideration of payment under any type or term of employment relationship with, but not limited to, a sole proprietorship, corporation, partnership, company, individual, governing body, government agency, private voluntary agency, and any public nonprofit agency. This definition also includes any enclosed place where 4 or more individuals perform services in a volunteer capacity for which individuals are ordinarily paid.

### **155:66 Smoking Prohibited. –**

I. Except as provided in RSA 155:67 and notwithstanding any law to the contrary, smoking is prohibited in:

(a) Public educational facilities at any time, and in child care agencies licensed under RSA 170-E during the hours of operation, except foster family homes and foster family group homes.

(b) Hospitals and other acute care facilities.

(c) Grocery stores by customers.

(d) Elevators, tramways, gondolas, and other such public conveyances.

(e) Public conveyances.

(f) Restaurants.

(g) Cocktail lounges.

(h) Enclosed places owned and operated by social, fraternal, or religious organizations when open to the general public. Purposes for which such places may be open to the general public may include, but not be limited to, public meetings, voting, suppers, bingo games, theatrical events, fairs, and bazaars.

II. Smoking may be permitted in enclosed places of public access and publicly-owned buildings and offices, including workplaces, other than those listed in paragraph I, in effectively segregated smoking-permitted areas designated by the person in charge. Smoking shall be totally prohibited in any such enclosed place, if smoking cannot be effectively segregated. The person in charge may declare any facility non-smoking in its entirety.

**155:67 Exemptions.** – The following shall be exempted from the requirements of this subdivision:

I. Public conveyances rented for private purposes.

II. Buildings owned and operated by social, fraternal, or religious organizations when used by the membership of the organization, their guests or families, or when they are rented or leased for private functions from which the public is excluded and arrangements are under the control of the sponsor of the function and not the organization.

III. Guest rooms of hotels, motels and resorts.

IV. Halls, ballrooms, dining rooms and conference rooms of hotels, motels, restaurants, resorts, and publicly accessible buildings or portions thereof, excluding those that are publicly owned, when rented or leased for private functions from which the public is excluded and arrangements are under the control of the sponsor of the function and not of the proprietor or person in charge of the facility.

V. Resident rooms in dormitories operated by postsecondary educational institutions, but such dormitories shall follow any appropriate procedures established under RSA 155:71, I.

VI. Resident rooms in public housing facilities, but such facilities shall follow any appropriate procedures established under RSA 155:71, I.

VII. Resident rooms in facilities such as nursing homes, sheltered care facilities, and residential treatment and rehabilitation facilities, and prisons and detention facilities, but such facilities shall follow any appropriate procedures established under RSA 155:71, I.

VIII. [Repealed.]

IX. [Repealed.]

X. Health care facilities, except for hospitals and other acute care facilities, provided that the health care facilities shall follow any appropriate procedures established under RSA 155:71, I.

XI. Patients with extraordinary medical conditions, psychiatric disorders, or patients in an alcohol and drug withdrawal program, provided that the patient's physician has written a prescription or an order allowing the patient to smoke.

**155:68 Written Policies.** – The person in charge of the enclosed places listed in RSA 155:66 shall develop, or oversee the development of, written policies in accordance with RSA 155:71, to achieve compliance with this subdivision. Such policies shall include, but not be limited to, the following:

I. If smoking is completely prohibited in any enclosed workplace, enclosed place of public ownership, or enclosed place accessible to the public, then the written policy shall state that smoking is prohibited in the entire facility.

II. If smoking-permitted areas are to be designated in any enclosed area identified in RSA 155:66, then the written policy shall state, in addition to the requirements of RSA 155:69, that smoking is permitted only in designated smoking-permitted areas and shall specify the area or areas where smoking is permitted in the building or facility.

III. Written policies regarding smoking restrictions shall be provided to, or posted, or otherwise made available to any person who works in or routinely uses any enclosed building or facility.

IV. Staff or employees subject to written policies regarding smoking restrictions in any enclosed building or facility shall receive orientation regarding the written policy to which they are required to adhere.

**155:69 Smoking-Permitted Areas; Procedures.** – If smoking-permitted areas are to be designated pursuant to the policy under RSA 155:68, II, the person in charge of the enclosed places listed in RSA 155:66 shall develop, or oversee the development of, written procedures in accordance with RSA 155:71, to achieve compliance with this subdivision. Such procedures may include, but not be limited to, the

following:

- I. Training procedures to assure that the provisions of this subdivision are understood.
- II. Reviewing and arbitrating complaints.
- III. Handling of persons who willfully continue to smoke in a "no smoking" area, after having been asked to stop smoking in that area.
- IV. The special consideration which may be given to protect individuals who have a medical condition which is medically recognized and medically proven to be directly and adversely affected by tobacco smoke, including, but not limited to, an allergic reaction, as documented by an occupational physician.
- V. Instructing security officers, ushers, receptionists, clerks, and other appropriate personnel to assist in ensuring compliance with this subdivision by asking those who smoke in designated "no smoking" areas to refrain from doing so, and to direct smokers to a smoking-permitted area, if appropriate.

**155:70 Signs.** – Signs shall be appropriately placed in all buildings and facilities regulated under this subdivision. Such signs shall state the smoking restrictions applicable to the building or facility, in accordance with RSA 155:68.

**155:71 Rulemaking.** – The commissioner shall adopt rules, pursuant to RSA 541-A, relative to:

- I. Criteria for smoking-permitted areas in a manner that effectively segregates areas, in accordance with RSA 155:65, V, where smoking may be permitted in the facilities under RSA 155:67, V, VI, VII, and X.
- II. Size and placement of appropriate signs to be used for notification of smoking restrictions.
- III. Procedures for resolving complaints and investigations of complaints under RSA 155:73 and 74.
- IV. Procedures for requesting a waiver and eligibility determination for a waiver requested under RSA 155:75, and stipulations of a waiver, including time stipulation.
- V. Procedures to ensure confidentiality under RSA 155:74.

**155:72 Retaliation Prohibited; Applicability.** –

- I. No person in charge shall retaliate in any manner against, or otherwise discriminate against, a person, employee, or subordinate who exercises any rights under this subdivision or rules adopted pursuant to this subdivision, or by any policy or procedure promulgated under this subdivision for enclosed places.
- II. Nothing in this subdivision shall be construed to authorize an employee to refuse to discharge his ordinary and customary duties in the workplace, including, but not limited to, entering a smoking-permitted area in the discharge of such duties.

**155:73 Noncompliance.** – If an employee or user of a building or facility determines or believes that the person in charge or others are not complying with this subdivision or rules adopted pursuant to this subdivision, a complaint shall be registered with the person in charge. If the complaint is not resolved within one calendar month, the complainant may proceed under the complaint procedures established by the commissioner under RSA 155:71.

**155:74 Complaints; Investigations; Confidentiality.** –

I. The commissioner or his designee shall investigate any complaint regarding noncompliance with the provisions of this subdivision or rules adopted under it. The investigation shall include a full opportunity for the person in charge to be informed of and to address the complaint. If during the investigation a probable violation of this subdivision is found, or if the person in charge requests, an adjudication proceeding shall be carried out in accordance with RSA 541-A:31-36 prior to the department seeking a penalty under RSA 155:76, III.

II. The name of any person registering a complaint regarding noncompliance shall not be divulged by the department of health and human services in any correspondence or meetings, nor shall it be made available over the telephone, unless specific written approval has been given to do so by the complainant. All complaints, except names, shall be a public record for purposes of RSA 91-A. The name of any complainant who requests anonymity, however, shall not be revealed under RSA 91-A.

**155:75 Waiver.** –

- I. The person in charge may seek a period of time to comply with this subdivision by submitting a written

request to the commissioner requesting a waiver, specifying the grounds for the waiver and the time period within which such enclosed place shall be subject to the provisions of this subdivision.

II. The person in charge shall have the burden to provide clear and convincing evidence to demonstrate that compelling reasons exist to necessitate a waiver; that the requested waiver will not jeopardize the health and well-being of those who habitually occupy the facility; or that the requirement in question causes undue hardship or interferes with other requirements imposed by policies of the facility in question.

III. The commissioner shall follow procedures adopted by rule in determining the eligibility for a waiver and the time period for which the waiver shall extend

**155:76 Enforcement; Penalties. –**

I. The person in charge or his designee may call law enforcement authorities if any person refuses to refrain from smoking in an area where smoking is prohibited.

II. Any person who smokes in an enclosed public place where smoking is prohibited shall be guilty of a violation and subject to a fine of not less than \$100.

III. Any person in charge who repeatedly fails to comply with any of the provisions of this subdivision and rules adopted pursuant to it and for which the department seeks a penalty under RSA 155:74 shall be guilty of a violation and, notwithstanding RSA 651:2, shall be subject to a fine of not less than \$100.

**155:77 Fire Protection, Safety and Sanitation. –** Nothing in this subdivision shall be construed to permit smoking where smoking is prohibited by any other provision of law or rule relative to fire protection, safety and sanitation.

## Appendix C. Tobacco Prevention and Control Community Coalitions

---

### **CHESHIRE COALITION FOR TOBACCO-FREE COMMUNITIES**

Kate McNally  
Cheshire Medical Center  
/Dartmouth - Hitchcock  
Keene  
580 Court Street  
Keene, NH 03431  
Phone: 354-5454, ext. 2306  
[kmcnally@cheshire-med.com](mailto:kmcnally@cheshire-med.com)

**Service area:** *Alstead, Walpole, Marlow, Surry, Gilsum, Stoddard, Sullivan, Westmoreland, Nelson, Antrim, Hancock, Harrisville, Keene, Chesterfield, Swanzey, Hinsdale, Winchester, Richmond, Fitzwilliam, Troy, Dublin, Roxbury, Marlborough, Jaffrey and Rindge.*

### **CONCORD SUBSTANCE ABUSE COALITION**

Shannon Swett  
Coalition Director  
Sarah Boucher  
Tobacco Coordinator  
46 South Main Street  
Concord, NH 03301  
Phone: 223-2023  
[shannon@concordprevention.org](mailto:shannon@concordprevention.org)  
[sarah@concordprevention.org](mailto:sarah@concordprevention.org)

**Service area:** *Concord*

### **COOS COUNTY COALITION**

Laura Remick  
Tobacco Prevention and Control Coordinator  
N. Country Health Consortium  
7 Main Street  
Whitefield, NH 03598

Phone: 837-2643 ext 222  
Berlin Office: 603 752-1035  
[vherres@nchcnh.org](mailto:vherres@nchcnh.org)

**Service area:** *Whitefield, Dalton, Carroll (Twin Mountain), Lancaster, Jefferson, Northumberland (Groveton), Stratford, Columbia, Colebrook, Clarksville, Errol, Stewartstown, Pittsburg, Dixville Notch, Dummer, Milan, Stark, Berlin, Randolph, Gorham, Millsfield, Odell, Cambridge, Success, Kilkenny, Thompson & Meserve, Hart's Location, Hadley Purchase, Crawford Purchase, Chandlers Purchase, Beans Grant, Cuffs Grant, Sargent Purchase, Low & Burbanks and Shelburne.*

### **CORE COALITION**

Jena Vincent  
Coalition Director  
103 Main Street  
Meredith, NH 03253  
Phone: 279-5305  
[jvincent@interlakes.org](mailto:jvincent@interlakes.org)

**Service area:** *Meredith, Center harbor, Sandwich, Alton, Barnstead, Laconia, Gilford, Gilmanton and Belmont.*

### **DOVER COALITION FOR YOUTH**

Dana Mitchell  
Prevention Coordinator  
Vicki Hebert  
Prevention Specialist

Police Department  
46 Locust Street  
Dover, NH 03820  
Phone: 516-3274  
[d.mitchell@ci.dover.nh.us](mailto:d.mitchell@ci.dover.nh.us)  
[vickiy2y@yahoo.com](mailto:vickiy2y@yahoo.com)

**Service area:** *Dover and specific projects in other surrounding areas Barrington and Nottingham.*

### **GREATER NASHUA HEALTHY COMMUNITY COLLABORATIVE**

Bernie Cameron  
Community Coordinator  
Foundation for Healthy Communities  
125 Airport Rd.  
Concord, NH 03301  
Phone: 225-0900 x235  
[bcameron@healthynh.com](mailto:bcameron@healthynh.com)

**Service area:** *Amherst, Brookline, Hollis, Hudson, Litchfield, Lyndeborough, Merrimack, Milford, Mont Vernon, Nashua and Wilton*

### **KICKIN' BUTTS IN MANCHESTER TOBACCO PREVENTION COALITION**

Kelley Hobbs  
Project Director  
Makin' It Happen Coalition  
27 Lowell Street, Suite 502  
Manchester, NH 03101  
Phone: 622-6116  
[Kelley@makinithappen.org](mailto:Kelley@makinithappen.org)

**Service area:** *Manchester, Auburn, Bedford, Candia,*

*Chester, Deerfield, Goffstown,  
Hooksett, and New Boston*

**MASCOMA VALLEY  
HEALTH INITIATIVE**

Lindsey Vacek  
Coalition Coordinator  
1192 Route 4  
PO Box 102  
Canaan, NH 03741  
Phone: 523-7100  
[Lindsey.Vacek@mvhi.org](mailto:Lindsey.Vacek@mvhi.org)

**Service area:** *Canaan,  
Dorchester, Enfield, Grafton,  
Orange, Plymouth and  
Lebanon*

**NORTHERN GRAFTON  
COUNTY COALITION**

Laura Remick  
N. Country Health  
Consortium  
7 Main Street  
Whitefield, NH 03598  
Phone: 837-2643 ext 222  
[Lremick@nchcnh.org](mailto:Lremick@nchcnh.org)

**Service area:** *Littleton,  
Bethlehem, Franconia,  
Easton, Sugar Hill, Lisbon,  
Bath, Landaff, Woodsville and  
Haverhill.*

**PARTNERSHIP FOR  
HEALTHY YOUTH**

Jackie Valley  
Executive Director  
Community Diversion  
Program  
440 Portsmouth Avenue  
Greenland, NH 03840  
Phone: 430-8570  
[jackieCDP@aol.com](mailto:jackieCDP@aol.com)

**Services area:** *Brentwood,  
East Kingston, Epping,  
Exeter, Greenland,  
Hampton, Hampton Falls,  
Kensington, New Castle,  
Newfields, Newmarket,  
North Hampton,  
Portsmouth, Rye, Seabrook,  
South Hampton and  
Stratham.*

**SANBORN/TIMBERLANE  
SAFE AND DRUG FREE  
COMMUNITY COALITION**

Andrea Bonner  
Executive Director, Sad Café  
Rich Cram  
Tobacco Free Program  
Manager  
Jennifer Selfridge, Coalition  
Coordinator  
Steppingstones Music  
Opportunities  
148 Plaistow Road  
PO Box 1051  
Plaistow, NH 03865  
Phone: 382-8893  
[andreabonner1@roadrunner.com](mailto:andreabonner1@roadrunner.com)  
[rcram@fmjs.org](mailto:rcram@fmjs.org)  
[Jennifer.selfridge@verizon.net](mailto:Jennifer.selfridge@verizon.net)

**Service area:** *Atkinson,  
Danville, Fremont,*

*Hampstead, Kingston,  
Newton, Plaistow and  
Sandown.*

**SULLIVAN COUNTY  
TOBACCO PREVENTION  
COALITION**

Dr. Jennifer Lipfert  
Coalition Coordinator  
Good Beginnings of Sullivan  
County  
169 Main St.  
Claremont, NH 03743  
Phone: 542-1848  
[gb.jenny@dianalovecenter.org](mailto:gb.jenny@dianalovecenter.org)

**Service area:** *Acworth,  
Claremont, Charlestown,  
Cornish, Croydon, Goshen,  
Grantham, Langdon,  
Lempster, Newport,  
Plainfield, Sunapee,  
Springfield and Unity.*

**TOBACCO-FREE  
COALITION OF THE UPPER  
VALLEY**

Lindsey Vacek  
Coalition Coordinator  
1192 Route 4  
PO Box 102  
Canaan, NH 03741  
Phone: 523-7100  
[Lindsey.Vacek@mvhi.org](mailto:Lindsey.Vacek@mvhi.org)

**Service area:** *Lebanon,  
Hanover, Lyme, Etna, West  
Lebanon, Plainfield, Meriden  
and Grantham.*

## Appendix D. Acronyms

---

BLE - Bureau of Liquor Enforcement  
BRFSS - Behavioral Risk Factor Surveillance System  
CASRO - Council of American Survey Research Organization  
CDC - Centers for Disease Control and Prevention  
CHIP - Children's Health Insurance Program  
CI - Confidence Interval  
CPS - Current Population Survey  
DHHS - Department of Health and Human Services  
FTC - Federal Trade Commission  
ISA - Indoor Smoking Act  
JSI - John Snow Research and Training Institute  
LBW - low birthweight  
MCH - Maternal and Child Health  
MMSA - Metropolitan/Micropolitan Statistical Area  
MOU - Memorandum of Understanding  
NCHS - National Center for Health Statistics  
NHATS - New Hampshire Adult Tobacco Survey  
NHHEAOD - New Hampshire Higher Education Alcohol and Other Drug  
NHIS - National Health Interview Survey  
NHYS - New Hampshire Youth Tobacco Survey  
NSDUH - National Survey on Drug Use & Health  
NTCP - National Tobacco Control Program  
NYTS - National Youth Tobacco Survey  
OOS - out of state  
OSH - Office on Smoking and Health  
PAR - Population Attributable Risk  
PHS - Public Health Service  
SAM - Smoking Attributable Mortality  
SAMMEC - Smoking Attributable Mortality, Morbidity, and Economic Costs  
SAMSHA - Substance Abuse & Mental Health Services Administration  
SCF - Strategic Contribution Fund  
SMART - Selected Metropolitan/Micropolitan Area Risk Trend  
SHS - secondhand smoke  
TPCP - Tobacco Prevention and Control Program  
UNH - University of New Hampshire  
YRBS - Youth Risk Behavior Survey

## REFERENCES

---

- <sup>i</sup> Centers for Disease Control and Prevention. [Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs—United States, 1995–1999](#). Morbidity and Mortality Weekly Report [serial online]. 2002;51(14) [cited 2006 Sep 23]. Available from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm>.
- <sup>ii</sup> CDC. Morbidity and Mortality Weekly Report. Surveillance Summaries. June 9, 2006/Vol.55/No.SS-5. Youth Risk Behavior Surveillance-United States, 2005
- <sup>iii</sup> CDC. Sustaining State Programs for Tobacco Control, Data highlights, 2006.
- <sup>iv</sup> SAMMEC, CDC/Office on Smoking and Health.
- <sup>v</sup> Health United States, 2004, <http://www.cdc.gov/nchs/data/hus/hus04.pdf> pg.7.
- <sup>vi</sup> Centers for Disease Control and Prevention. [The Health Consequences of Smoking: A Report of the Surgeon General](#). Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health; 2004 [cited 2006 Sep 23]. Available from: [http://www.cdc.gov/tobacco/data\\_statistics/sgr/sgr\\_2004/index.htm](http://www.cdc.gov/tobacco/data_statistics/sgr/sgr_2004/index.htm) .
- <sup>vii</sup> National Cancer Institute. *Health Effects of Exposure to Environmental Tobacco Smoke: The Report of the California Environmental Protection Agency. Smoking and Tobacco Control Monograph no. 10*. Bethesda, MD. U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, NIH Pub. No. 99-4645, 1999.
- <sup>viii</sup> National Cancer Institute. Risks Associated with Smoking Cigarettes with Low Machine Measured Yields of Tar and Nicotine. Smoking and Tobacco Control Monograph No. 13. Bethesda, MD: U.S. Department of Health and Human Services. National Institutes of Health, National Cancer Institute, NIH Pub. No. 025074, October 2001.
- <sup>ix</sup> Rigotti NA, Moran SE, Wechsler H. US College Students' Exposure to Tobacco Promotions: Prevalence and Association with Tobacco Use. *Am J Public Health*. 2004;94.
- <sup>x</sup> U.S. Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.
- <sup>xi</sup> U.S. Department of Health and Human Services. Reducing tobacco use: a report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.
- <sup>xii</sup> Martin J.A., et al. Births: Final Data for 2002, National Vital Statistics Reports.
- <sup>xiii</sup> Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Munson ML. Births: Final data for 2005. National vital statistics reports; vol 56 no 6. Hyattsville, MD: National Center for Health Statistics. 2007.
- <sup>xiv</sup> Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Tobacco Information and Prevention Source (TIPS). Available at: [http://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/tobacco\\_industry/bidis\\_kreteks.htm](http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/bidis_kreteks.htm) . Accessed January 20, 2005.
- <sup>xv</sup> New Hampshire RSA 126-K available at: <http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-X-126-K.htm> , accessed June 25, 2004.
- <sup>xvi</sup> New Hampshire RSA 126-K available at: <http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-X-126-K.htm> , accessed June 25, 2004.

- 
- <sup>xvii</sup> Centers for Disease Control and Prevention. Youth tobacco surveillance – United States, 2000. MMWR 2001;50(No. SS-4):1-84.
- <sup>xviii</sup> Centers for Disease Control and Prevention. Best practices for comprehensive tobacco control programs. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, August 1999.
- <sup>xix</sup> Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.
- <sup>xx</sup> Pelletier, P, Knight, S, Peterson E, Anderson L, et al. Provider Compliance with a Guideline for Treating Tobacco Use among Adults. American Journal of Preventive Medicine: 2004;Vol 27/2 (185).
- <sup>xxi</sup> Shopland DR, Gerlach KK, Burns DM, Hartman AM, Gibson JT. State-specific trends in smoke-free workplace policy coverage: the Current Population Survey Tobacco Use Supplement, 1993 to 1999. J Occup Environ Med. 2001;43:680-686.
- <sup>xxii</sup> Shopland DR, Gerlach KK, Burns DM, Hartman AM, Gibson JT. State-specific trends in smoke-free workplace policy coverage: the Current Population Survey Tobacco Use Supplement, 1993 to 1999. J Occup Environ Med. 2001;43:680-686.
- <sup>xxiii</sup> National Cancer Institute. Health effects of Exposure to Environmental Tobacco Smoke. The Report of the California Environmental Protection Agency. Smoking and Tobacco Control Monograph no. 10. Bethesda, MD. U.S. Department of health and Human Services, National Institute of health, National Cancer Institute, NIH Pub. No. 99-4645, 1999.
- <sup>xxiv</sup> Am J Public Health, 2008; 98: 304-309, The impact of Tobacco Control Programs on Adult Smoking.
- <sup>xxv</sup> U.S. Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.
- <sup>xxvi</sup> U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
- <sup>xxvii</sup> NH Department of Health and Human Services, Office of Community and Public Health, Division of Chronic Disease Prevention. New Hampshire Adult Tobacco Survey, 2002. Available at: <http://www.dhhs.nh.gov/DHHS/ATOD/LIBRARY/Data-Statistical+Report/default.htm>.
- <sup>xxviii</sup> Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1990-2003.
- <sup>xxix</sup> New Hampshire Higher Education Alcohol and Other Drug Committee. Data Report: 2003 New Hampshire Higher Education Alcohol, Tobacco and Other Drug Survey. Available at: [http://www.unh.edu/student-life/assessment/alcohol\\_drug.htm](http://www.unh.edu/student-life/assessment/alcohol_drug.htm).
- <sup>xxx</sup> Williams A, Peterson E, Knight S, Hiller M, Pelletier. A. Survey of restaurants regarding smoking policies. J Public Health Manag Pract. 2004 Jan-Feb;10(1):35-40.
- <sup>xxxi</sup> U.S. Department of Health Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health, Youth Risk Behavior Surveillance System. Available at: <http://www.cdc.gov/healthyyouth/yrbs/index.htm>.
- <sup>xxxii</sup> New Hampshire State Cancer Registry Data Provided by the New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Health Statistics and Data Management.
- <sup>xxxiii</sup> NH Department of Health and Human Services, Office of Community and Public Health, Bureau of Health Statistics and Data Management. New Hampshire Vital Statistics Data.
- <sup>xxxiv</sup> U.S. Federal Trade Commission. Federal Trade Commission Cigarette Report For 2002, Issued: 2004. Available at: <http://www.ftc.gov/reports/cigarette/041022cigaretterpt.pdf>

---

<sup>xxxv</sup> NH Department of Health and Human Services. Healthy New Hampshire 2010. Concord, NH. NH Department of Health and Human Services, 2001. Available at: <http://www.dhhs.nh.gov/DHHS/DPHS/healthy+new+hampshire+2010.htm>. Accessed December 2004.

<sup>xxxvi</sup> U.S. Department of Health and Human Services. Healthy people 2010 (conference ed. 2 vols), Washington, DC: U.S. Department of Health and Human Services, 2000.

<sup>xxxvii</sup> Orzechowski and Walker. The tax burden on tobacco: historical compilation, Volume 42, 2007. Orzechowski and Walker, 2007, Arlington, Virginia.

<sup>xxxviii</sup> Centers for Disease Control and Prevention. Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): Adult SAMMEC and Maternal and Child Health (MCH) SAMMEC software, 2002c. Available at: <http://apps.nccd.cdc.gov/sammec/index.asp>.

| Health, United states, 2004, <http://www.cdc.gov/nchs/data/hus/hus04.pdf>. *(Warning: This is a 500+ page PDF and may take several minutes to download)*  
National Center for Health Statistics. Health, United States, 2004. With Chartbook on Trends in the Health of Americans. Hyattsville, Maryland: 2004.  
Library of Congress Catalog Number 76-641496 For sale by Superintendent of Documents. U.S. Government Printing Office. Washington, DC 20402.

Formatted: Font: Italic