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# Global Adult Tobacco Survey (GATS) China 2010 Country Report

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## Executive Summary

Li Qiang , Jason Hsia , Yang Yan , Xiao Lin , Wang Congxiao , Feng Guoze , Yang Gonghuan

It is essential to establish an effective monitoring, supervising and evaluation system to monitor tobacco use and obtain nationally representative periodic data on the key indicators of tobacco use among adolescents and adults. This is a responsibility clearly given by the WHO Framework Convention on Tobacco Control (FCTC) to all parties. The WHO FCTC and its guidelines provide the foundation for countries to implement and manage tobacco control. To help make this a reality, WHO introduced a package of measures, entitled MPOWER, that were intended to assist in the country-level implementation of effective measures to reduce the demand for tobacco, as contained in the WHO FCTC.

The Global Adult Tobacco Survey (GATS) is a household survey coordinated by various international and national partners. The Bloomberg Initiative to Reduce Tobacco Use and the Bill and Melinda Gates Foundation provided resources and the U.S. Centers for Disease Control and Prevention and WHO provided technical support. So far, 14 countries have implemented the survey, which has provided them with strong evidence for developing, monitoring, and implementing effective tobacco controls.

The 2010 Global Adult Tobacco Survey in China (GATS China) was a nationally representative household survey of non-institutionalized men and women aged 15 and older. The questionnaire elicited information on background and characteristics, tobacco use (smoking and smokeless), cessation, secondhand smoke, economics, media, and knowledge, attitudes, and perceptions. Stratified multi-stage cluster sampling was used. One eligible person was randomly selected from each selected household. The iPAQ handheld computer was used to collect data. The household and the individual response rates were 97.5% and 98.5%, respectively, and the total response rate was 96.0%. A total of 13,354 people completed the individual questionnaire.

The main results were as follows:

**Tobacco use:** The current smoking rate among people aged 15 and above was 28.1%, representing 301 million current smokers. The current smoking rate among men was 52.9%, and that among women was 2.4%; the current smoking rate for the male population aged 15-69 was 54.0%. The prevalence among male adults was higher in rural areas than in urban areas (56.1% vs. 49.2%). Most of the current smokers were daily smokers (85.6%) and

smoked manufactured cigarettes (94.8%). Current smokers smoked 14.2 manufactured cigarettes a day on average. More than half of young ever daily smokers (20-34 years) became daily smokers before the age of 20.

There was a slight decline in the current smoking rate compared to the results of the 1996 National Prevalence Survey of Smoking Pattern, but it still remained at a high level. The decrease in current smoking between 2002 and 2010 was less than that between 1996 and 2002. Current smoking rates for males aged 40-59 and females aged 15-19 had increased.

**Nicotine dependence and smoking cessation:** Among ever smokers, 16.9% had quit smoking and 11.7% had quit for 2 years or longer, while 36.4% of current smokers and those who had been abstinent for less than a year had tried to quit smoking in the previous 12 months. However, 91.8% of those who had tried to quit during the past 12 months had never received quitting assistance. Among those who had recently visited health care providers, 33.9% received advice on quitting smoking. The proportion of relapsed smokers among ever smokers was high at 33.1%, which was similar to the survey results in 2002.

**Secondhand smoke exposure:** Secondhand smoke exposure remained a serious issue. Among nonsmokers, 72.4% said they had been exposed to secondhand smoke and 38.0% said they were exposed to secondhand smoke on a daily basis.

It was extremely common for respondents to notice smoking (an indicator of exposure to tobacco smoke) in indoor public places and at workplaces. The proportion of adults noticing smoking in restaurants was 88.5%, 58.4% noticed it in government buildings, and around 35% in medical and health care institutions, in schools, and on public transportation. Among adults aged 15 and older, 67.3% said tobacco smoking occurred at home.

Among respondents who worked indoors, 37.7% reported that there was no rule against smoking at work and 31.0% reported that there was a complete ban on smoking; 89.2% of those who worked indoors and reported a no-smoking ban at workplaces had noticed smoking at work in the previous 30 days. Although the prevalence of exposure to secondhand smoke was lower in workplaces with a complete ban on smoking, the proportion of adults who had noticed smoking in those places was still as high as 25.5%. Overall, 63.3% reported smoking occurred at indoor workplaces. Therefore, protection from exposure to secondhand smoke in indoor public places and workplaces was not sufficient and second-hand smoke exposure remained a very serious health problem.

**Economics:** Cigarette prices in China followed a skewed distribution. Although some respondents reported buying expensive cigarettes, 50% of people spent RMB 5 Yuan or less on one pack of cigarettes. The median amount spent on 100 packs of manufactured

cigarettes was only 2.0% of the 2009 per capita Gross Domestic Product (GDP). Compared to other countries conducting the GATS, cigarette prices in China were very low.

**Warning and awareness of tobacco's harms:** In the previous 30 days, 40.2% of adults indicated they had not seen any message warning about the dangers of tobacco use or encouraging smokers to quit, either via the media or in public places. Despite that fact that 86.7% of current smokers said they had seen a warning label on a cigarette pack ("Smoking is harmful for your health") in the previous 30 days, 63.6% of them did not consider quitting. Currently, the health warnings on Chinese cigarette packages do not play a sufficient warning and educational role. While most people agreed that smoking and secondhand smoking were harmful to health, they did not know what the specific consequences were, such as stroke, heart attack and lung cancer, and that secondhand smoke caused adult heart disease, lung cancer and lung diseases in children. More than three fourths of adults did not fully understand the harms of smoking and secondhand smoke, and there was even less understanding in rural areas. Among adults aged 15 and older, 35.8% did not correctly understand and 50.2% said they did not know (86.0% total) that the belief that low-tar cigarettes are less harmful than regular cigarettes has been proven to be erroneous. Health care professionals (54.7%), teachers, and those with more education had high levels of misconceptions. Further studies are needed to explain this unusual phenomenon.

**Tobacco advertisement, promotion and sponsorship:** Nearly one fifth of adults had noticed tobacco advertisements or promotional activities in the past 30 days. Among adults who had noticed tobacco advertisements or promotions during the past 30 days, 49.8% reported having noticed advertisements on TV.

**Conclusions:** About 301 million people smoke in China. Current smoking rate among men is among the highest in the world. Exposure to secondhand smoke is also very high. There has not been a significant improvement in smoking or cessation rates since 2002. The current smoking rate among men has remained at a high level. Although the number of people quitting smoking had increased compared with the 2002 survey, the relapse rate was similar to 2002. Secondhand smoke exposure remained a very serious issue in indoor workplaces, indoor public places and homes. There was a lack of clear understanding of the harms of smoking and secondhand smoke. Although most adults agreed that smoking was harmful to health, they were not aware of the specific health consequences. A high proportion of health care professionals, teachers and other highly-educated people believe that low tar cigarettes are less harmful. Tobacco control measures are poorly enforced.

**Suggestions:** It is vital to introduce mid- and long-term plans for national tobacco control forthwith. This should include the implementation of WHO FCTC at the national, regional and local level. Introducing laws addressing the prevention and control of tobacco

harms at the national level would provide the legal basis for tobacco control and implementation of WHO FCTC, and increases in the retail price of tobacco would prevent many youth from starting to smoke.