2018

CIGARETTES: The most used tobacco product

among adults in Iowa

OVERVIEW

While fewer adult Iowans are smoking, cigarette smoking continues to be a leading cause of death and disability in Iowa.

Smoking has declined from 23.2% in 2000 to 16.6% in 2018[1]

In 2018, an estimated 390,800 Iowa adults smoked cigarettes.[1]

Cigarette smoking is the leading cause of death and disability in Iowa, accounting for more than 5,100 deaths every year, or 1 of every 6 deaths.[2]

For every person who dies from smoking, at least 30 more are suffering from serious smoking-caused disease and disability.[3, 4]

GENDER[1]

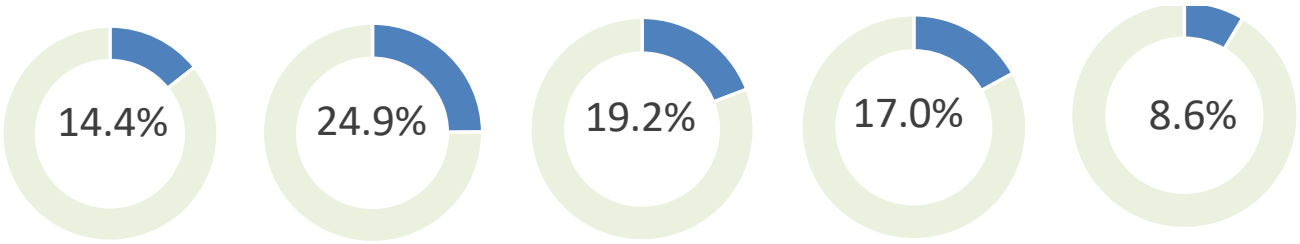
Men are more likely to smoke than women.

17.9%
Almost 18 of every 100 adult men smoke.

15.3%
More than 15 of every 100 adult women smoke.

AGE[1]

Smoking rates rise substantially between ages 18-24 years and 25-34 years.



More than 14 of every 100 adults aged 18-24 years smoke.

Almost 25 of every 100 adults aged 25-34 years smoke.

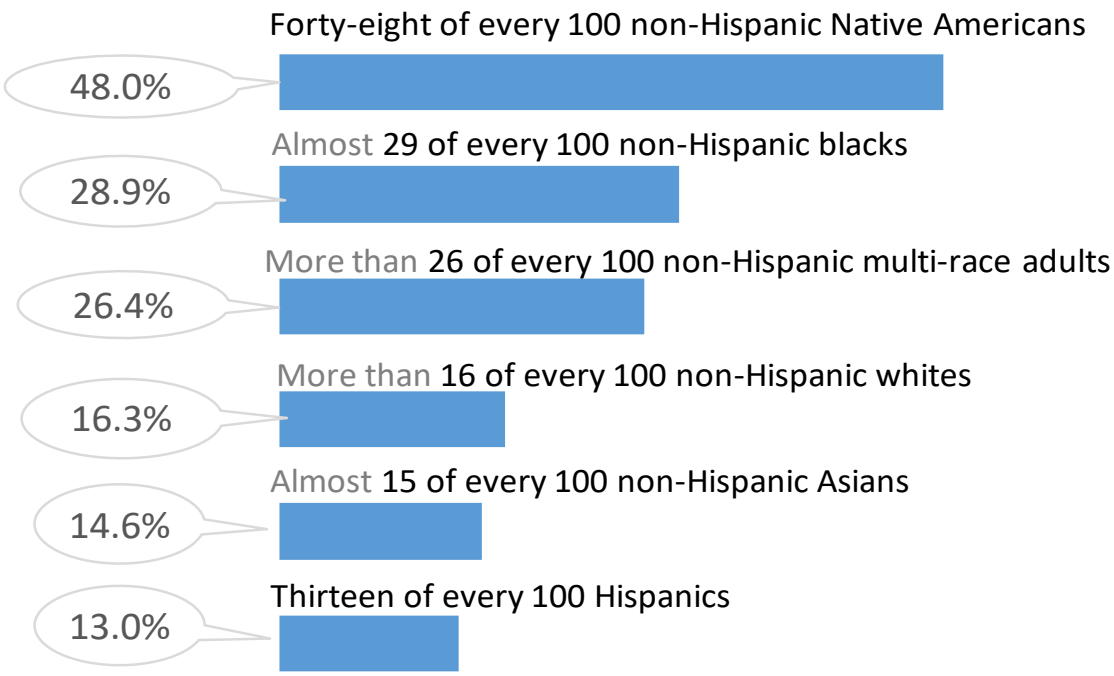
More than 19 of every 100 adults aged 35-54 years smoke.

Seventeen of every 100 adults aged 55-64 years smoke.

Almost 9 of every 100 adults aged 65 years and older smoke.

RACE/ETHNICITY[1]

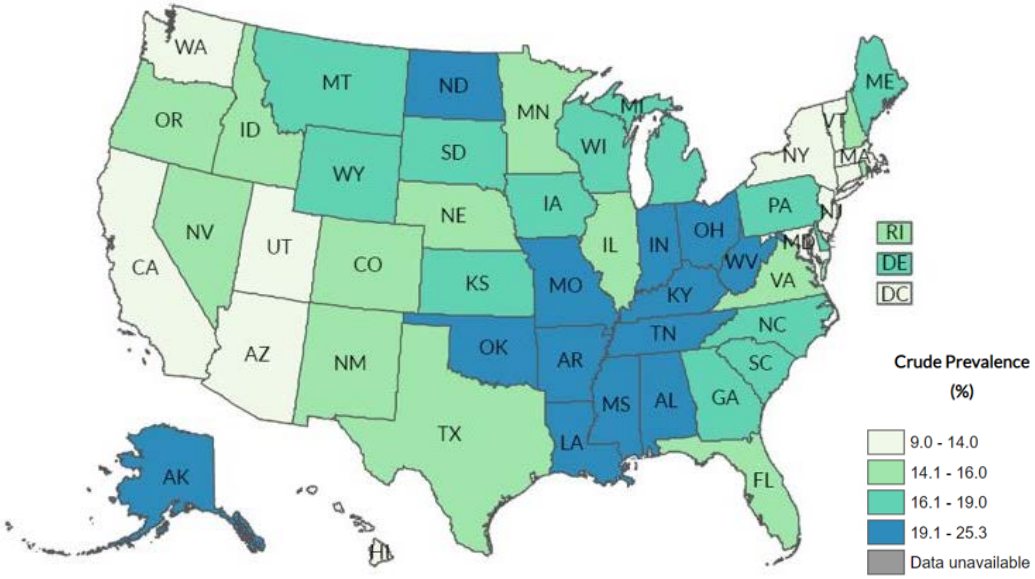
Non-Hispanic Native American, multi-race and black adult Iowans are most likely to smoke cigarettes.



THE NATION[5]

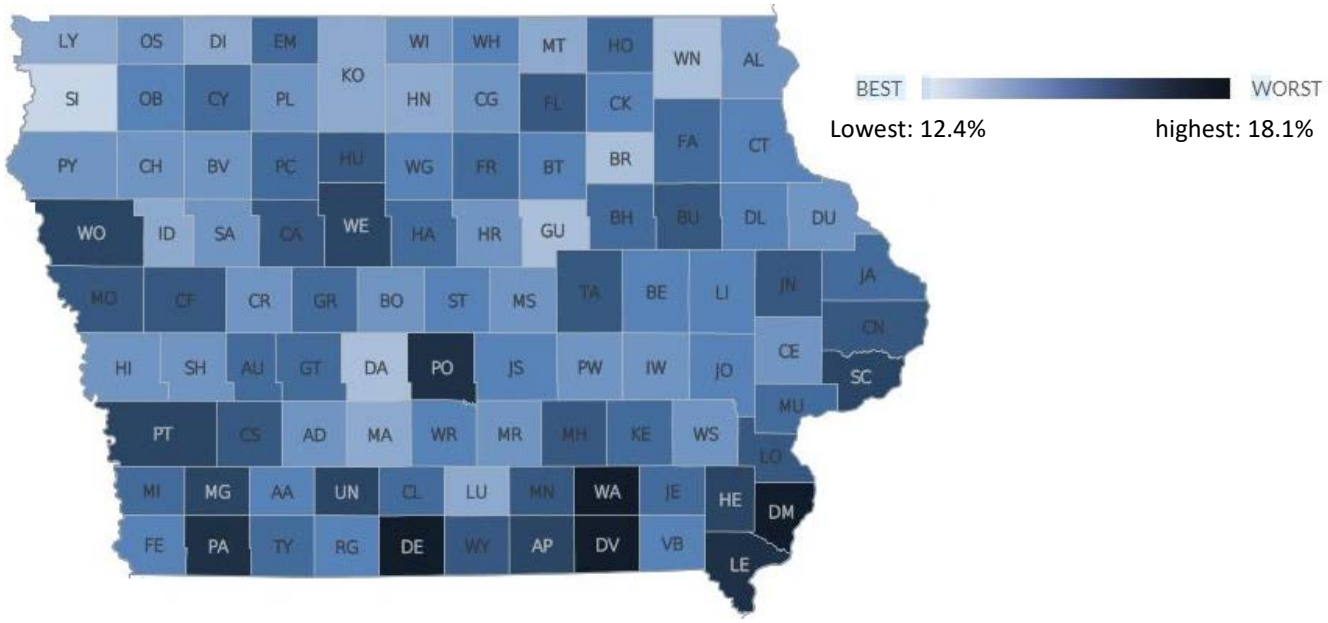
Among the 50 states and the District of Columbia, Utah has the lowest (9.0%) and West Virginia the highest (25.3%) smoking rate.

The national median rate is 16.1%. Iowa's smoking rate is 16.6%, the 23th highest in the nation.



IOWA COUNTIES[6]

Iowa's 10 counties with the highest populations accounted for almost half of all adult cigarette users: Polk, Linn, Scott, Johnson, Black Hawk, Woodbury, Pottawattamie, Story, Dubuque and Dallas. Counties with the highest estimated rates were Wapello (18.1%), Decatur (18.0%), Des Moines (18.0%), Davis (17.9%), Polk (17.4%), Lee (17.4%) and Page (17.1%). The median county smoking rate was 15.0% (half of counties had rates above, half below 15.0%).



EDUCATION[1]

Iowans with less education are more likely to smoke than those with more education.

Almost 30 of every 100 (28.8%) adults with less than a high school education smoke.

More than 20 of every 100 (21.8%) adults with a high school education smoke.

Sixteen of every 100 (16.0 %) adults with some college smoke.

Just over 7 of every 100 (7.3%) adults with a college degree smoke.

INCOME[1]

Iowans with higher incomes are less likely to smoke than those with lower incomes.

28.3%

About 28 **of every 100** adults with incomes below $20,000 smoke.

10.0%

Ten of every 100 adults with incomes above $75,000 smoke.

VETERANS[1]

Veterans are more likely to smoke than nonveterans.

25.6%

Almost 26 of every 100 veterans younger than 65 years smoke.

18.7%

About 19 of every 100 non-veterans younger than 65 years smoke.

DISABILITY[1]

Iowans with a disability are more likely to smoke than those without one.

More than **24% o**f adults who report having a disability smoke.

Almost **14%** of adults who report not having a disability smoke.

SEXUAL ORIENTATION[1]

Lesbian, gay, bisexual or transgender (LGBT) Iowans are more likely to smoke than heterosexual Iowans.

23.8%

Almost 24 of every 100 adults who are LGBT smoke.

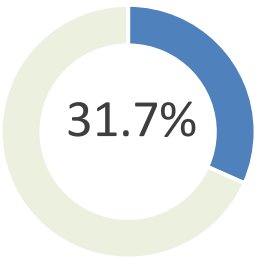
16.0%

Sixteen of every 100 adults who are not LGBT smoke.

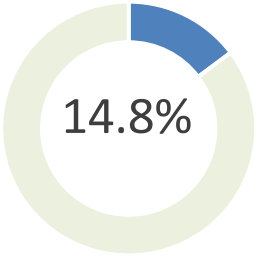
MENTAL HEALTH, ALCOHOL USE[1]

Iowa adults with poor mental health are more likely to smoke than are those in good mental health. Iowa adults who use alcohol heavily are more likely to smoke than are adults who do not use alcohol heavily.

Mental health

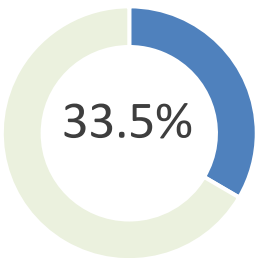


About 32 of every 100 adults **with poor mental health** smoke.

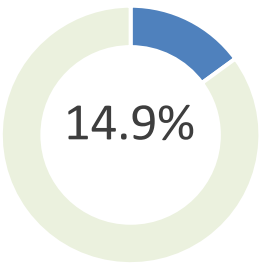


About 15 of every 100 adults **with good mental** health smoke.

Alcohol use



Almost 34 of every 100 adults who **use alcohol heavily** smoke.



About 15 of every 100 adults who **do not use alcohol heavily** smoke.

OTHER IOWA ADULT POPULATIONS WITH HIGH SMOKING RATES[1]

Smoking rates are also elevated in: women of childbearing age (18-44 years, 18.0%) compared to older women (13.7%); adults with adverse childhood experiences (ACEs—abuse, neglect, other trauma) (20.0%) compared to adults with no ACEs (10.3%) and the uninsured (32.0%) compared to the insured (20.0%) age 64 years and younger.

SOCIAL DETERMINANTS OF TOBACCO USE[7]

Low levels of education, income and employment (low socio-economic status (SES)) are recognized as the predominant drivers for disparities in tobacco use in the general population.

Low SES interacts with many other factors, including ethnicity/race, cultural characteristics, acculturation, social marginalization, stress, adverse childhood experiences, disempowerment, substance abuse, mental illness, tobacco industry influence, and tobacco control policies and interventions to determine the differences in cigarette use seen in this infographic.

STRATEGIES ESSENTIAL TO REDUCING SMOKING RATES[2]

In addition to addressing the social determinants of health, evidence-based strategies essential to reducing smoking rates include: strong smoke-free air laws; making quit help easy to access; raising the price of tobacco products; running mass media campaigns about the benefits of not smoking/harm caused by smoking; youth focused interventions that discourage young people from ever starting to smoke or use other tobacco products; and the monitoring and evaluation of interventions to improve their quality and effectiveness.

REFERENCES

1. Iowa Department of Public Health, Division of Tobacco Use Prevention and Control, unpublished data from the 2016, 2017 and 2018 Iowa Behavioral Risk Factor Surveillance System (BRFSS) surveys.

   Iowa adult smoking rates for race/ethnicity are average annual rates for 2016-18; for veterans, LGBT adults and women of childbearing age status are 2017-18 annual average rates. County rates are for 2016. All other rates are for calendar year 2018.

2. Centers for Disease Control and Prevention, *Best Practices for Comprehensive Tobacco Control Programs*, 2014.
3. Centers for Disease Control and Prevention, *Smoking and Tobacco Use, Diseases and Death*, http://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm, accessed January 2020.
4. U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General* (http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm) Atlanta: 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, 2014
5. Centers for Disease Control and Prevention, *BRFSS Prevalence and Trends Data (2018 BRFSS)*. https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocationType=StatesAndMMSA&islClass=CLASS17&islTopic=TOPIC15&islYear=2018&rdRnd=55882 , accessed January 2020.
6. Robert Wood Johnson Foundation and University of Wisconsin, Population Health Institute, *2019 County Health Rankings and Roadmaps*, http://www.countyhealthrankings.org/rankings/data, accessed January 2020. (2016 BRFSS data).
7. Garrett, Bridgette et al., *Addressing the Social Determinants of Health to Reduce Tobacco-Related Disparities*, Nicotine and Tobacco Research. 2015 Aug; 17(8): 892–897.