

A SOCIAL ECOLOGICAL APPROACH TO REDUCING TOBACCO EXPOSURE ACROSS GENERATIONS

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- FRESH Delivers: An Innovative Approach to Reducing Tobacco Use Among Rural/Black African American Smokers (FRESH Delivers). Project through the Center for Research, Health, and Social Justice. NIMHD (P50MD017319-02; subproject 7977).
- Measurement, Evaluation, and Methods Team. Core through the Center for Research, Health, and Social Justice. NIMHD (P50MD017319-02; subproject 7973).
- Food as Medicine: Addressing Social Determinants of Health (food insecurity) to improve Clinical Outcomes. WESTAT/NHLBI (IOT2HL156812-03).
- Arkansas Department of Health, Tobacco Prevention and Cessation Program.

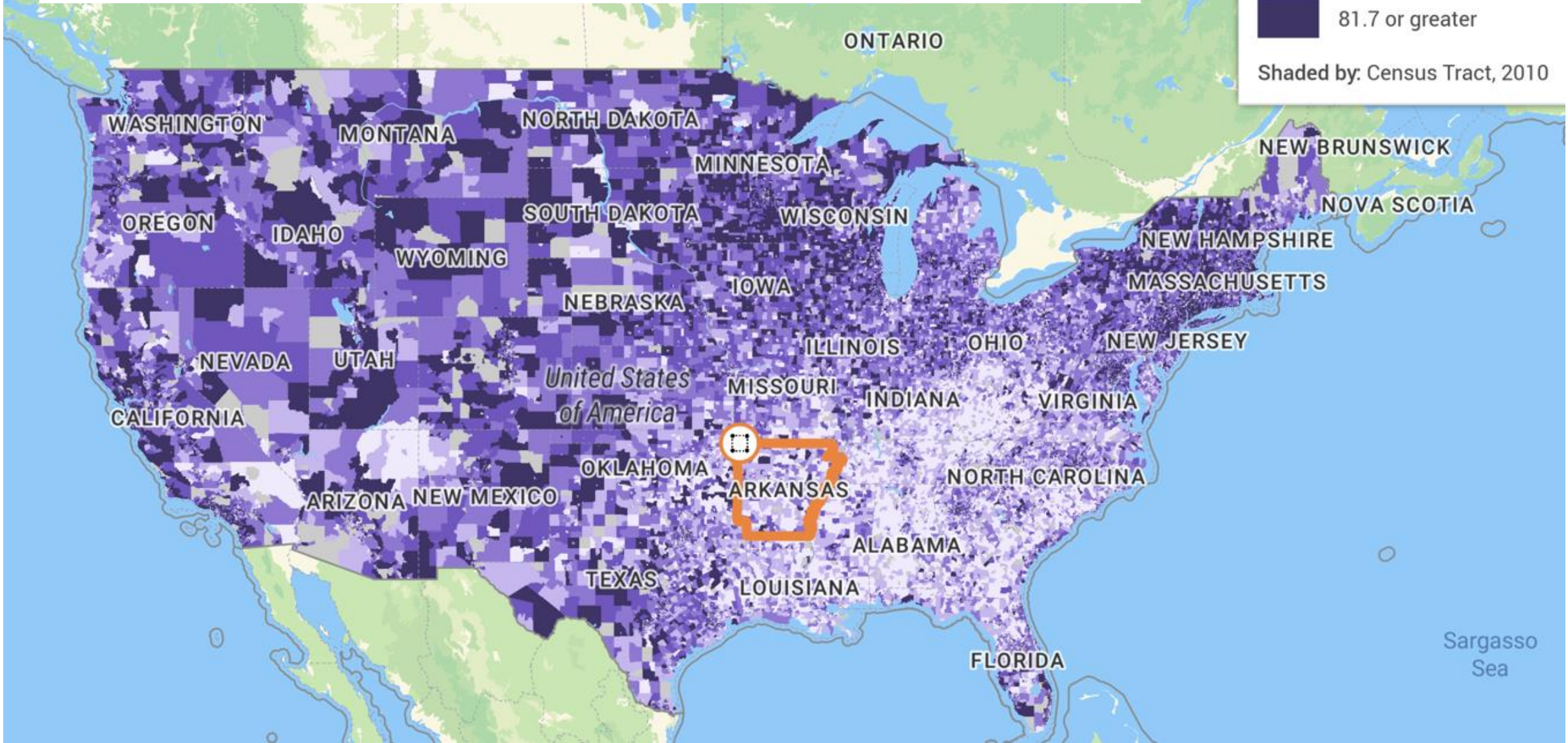
LEARNING OBJECTIVES

1. Describe differences in children's exposure to environmental tobacco smoke and tobacco use.
2. Understand the intergenerational transmission of tobacco use across generations.
3. Describe resources to reduce child exposure to nicotine and tobacco.

LIFE EXPECTANCY AT BIRTH, AS OF 2010-2015

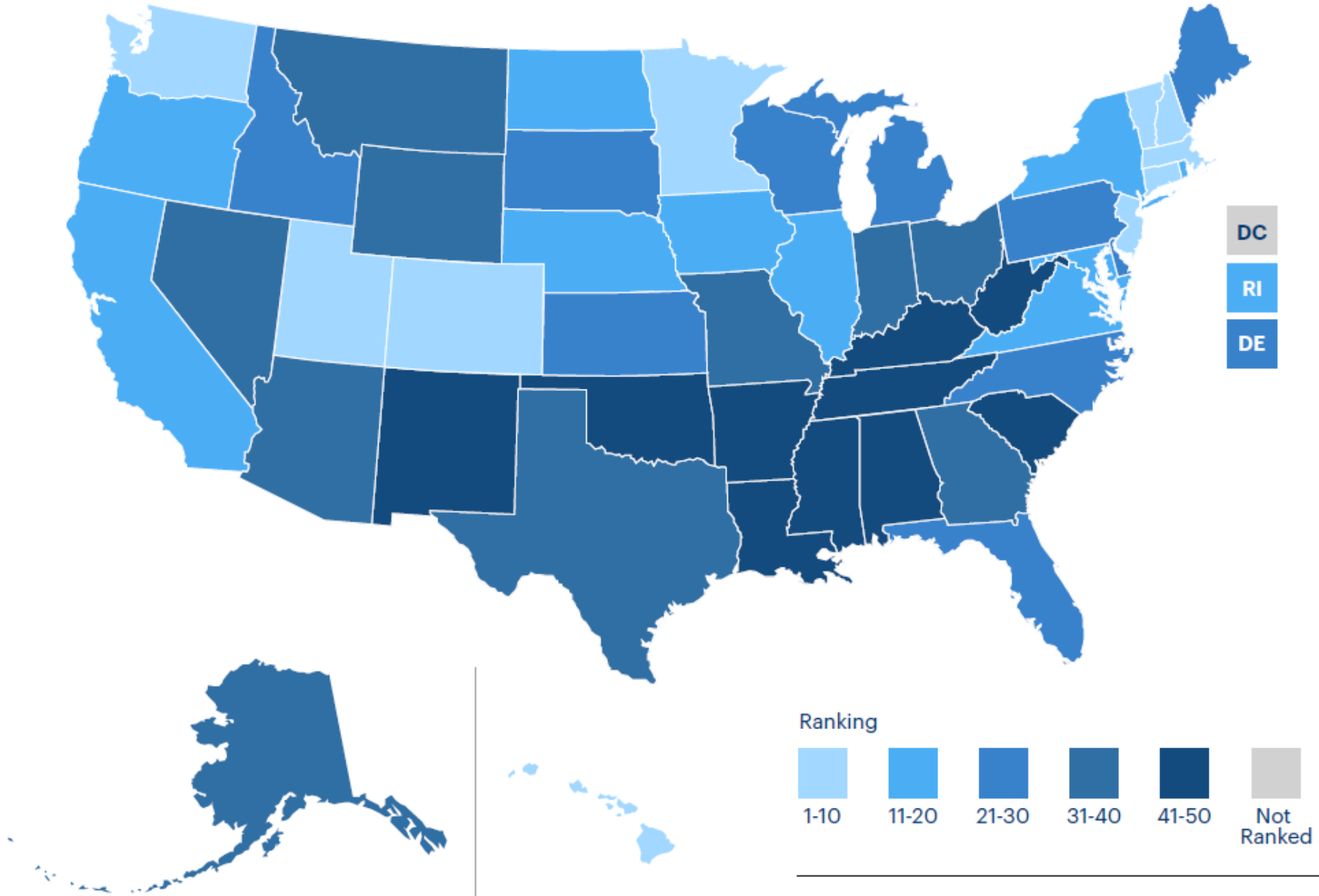


Shaded by: Census Tract, 2010



Comprehensive State Rankings

2023 Health of Women and Children Report



Source: America's Health Rankings composite measure, 2023.

2023 Health of Women and Children Report State Rankings

Healthiest and least healthy states for women and children ranked across the following categories: social and economic factors, physical environment, clinical care, behaviors and health outcomes.

Source: *America's Health Rankings* composite measure, 2023.

● Healthiest States

1. Minnesota
2. Massachusetts
3. Vermont
4. New Hampshire
5. Hawaii

● Least Healthy States

50. Mississippi
49. Arkansas
48. Louisiana
47. Oklahoma
46. West Virginia

No.1



No.2



No.3



No.4



No.5



No.50



No.49



No.48



No.47

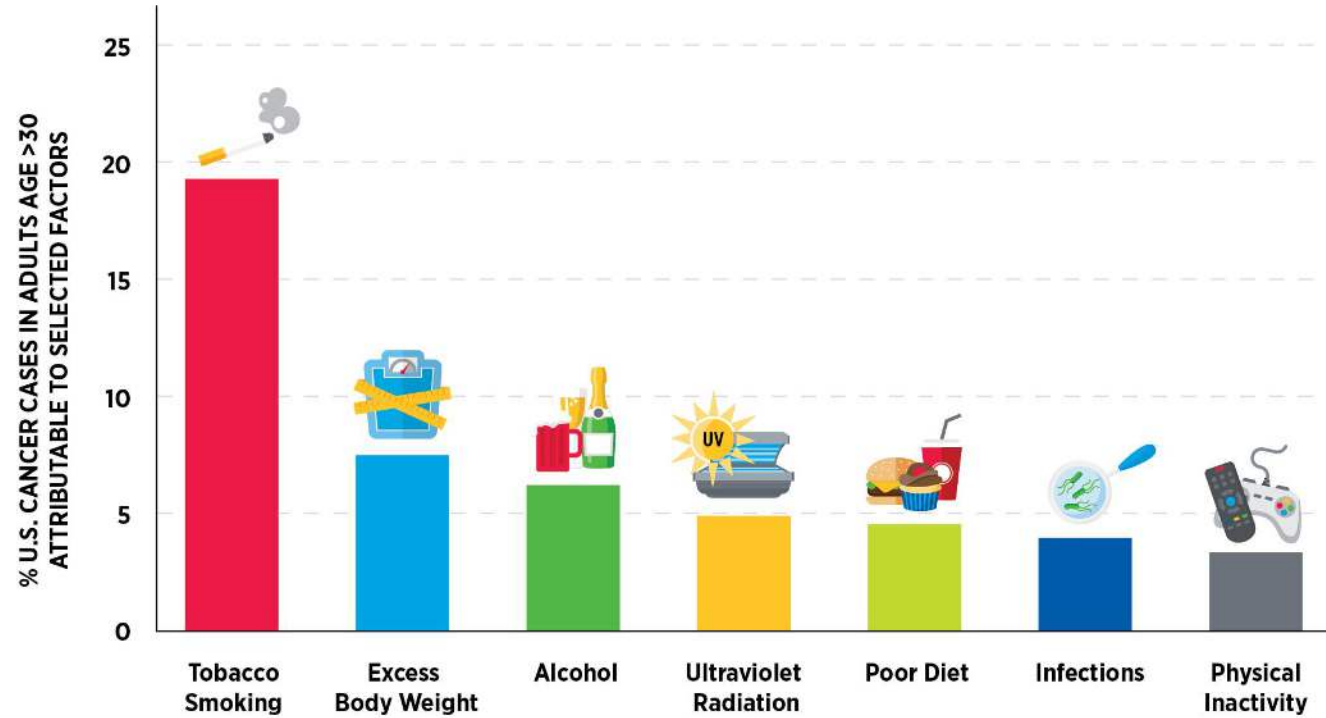


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FIGURE 7

Increasing Cancer Risk



Research has identified numerous factors that increase an individual's risk for developing cancer. The higher prevalence of many of these risk factors among racial and ethnic minorities and other medically underserved populations can be attributed to adverse differences in

social determinants of health. Developing and implementing comprehensive and integrated cancer control efforts, including public education and policy initiatives, could help reduce the burden of cancers related to disparate exposure to preventable cancer risk factors.



SECONDHAND SMOKE

41,000

Secondhand smoke causes the premature death of 41,000 adults and more than 400 infants each year.

Secondhand smoke contains more than 7,000 chemical compounds.



Secondhand smoke is known to cause cancer in humans and animals.



Dogs and cats are twice as likely to develop nasal cancer if their owner smokes, as compared to animals in households without cigarette smoking.

Some known carcinogens found in secondhand smoke:

- arsenic (used in pesticides)
- lead (formerly found in paint)
- polonium-210 (a radioactive element)
- formaldehyde (used to embalm the dead)
- benzene (a gasoline additive)

42%

of Americans are not protected by smoke-free laws. Only 28 states and territories have enacted comprehensive smoke-free laws.

98.3%

of youth who live with a smoker have been exposed to secondhand smoke.

Clean indoor air laws reduce nonsmokers' secondhand smoke exposure by 28%.

Lower-income communities are less likely to be protected by smoke-free laws.

Blue-collar workers are more likely to be exposed to secondhand smoke at work.

Smoking can cause cancer almost anywhere in your body.

mouth and throat (oral cavity and pharynx)



You can quit.
For free help: 1-800-QUIT-NOW.



CDC.gov/quit



TOBACCO-RELATED HEALTH DISPARITIES



NIMHD HEALTH AND HEALTH DISPARITIES RESEARCH FRAMEWORK (ALVIDREZ, 2019)

Health Disparity Populations: Race/Ethnicity, Low SES, Rural, Sexual/Gender Minority Other Fundamental Characteristics: Sex/Gender, Disability, Geographic Region				
Domains of Influence	Levels of Influence			
	Individual	Interpersonal	Community	Societal
Biological	Biological Vulnerability and Mechanisms	Caregiver–Child Interaction Family Microbiome	Community Illness Exposure Herd Immunity	Sanitation Immunization Pathogen exposure
Behavioral	Health Behaviors Coping Strategies	Family Functioning School/Work Functioning	Community Functioning	Policies and Laws
Physical/Built Environment	Personal Environment	Household Environment School/Work Environment	Community Environment Community Resources	Societal Structure
Sociocultural Environment	Sociodemographics Limited English Cultural Identity Response to Discrimination	Social Networks Family/Peer Norms Interpersonal Discrimination	Community Norms Local Structural Discrimination	Societal Norms Societal Structural Discrimination
Health Care System	Insurance Coverage Health Literacy Treatment Preferences	Patient–Clinician Relationship Medical Decision-Making	Availability of Health Services Safety Net Services	Quality of Care Health Care Policies
Health Outcomes	Individual Health	Family/Organizational Health	Community Health	Population Health

There are multilevel influences on tobacco-related disparities.

For example:

■ **Contextual factors:**

- segregation, poverty, living conditions, school conditions, healthcare access, exposure to ETS

■ **Interpersonal factors:**

- Family health behaviors
- family functioning
- experiences of discrimination

■ **Individual factors:**

- mental and behavioral health

Note. SES= socioeconomic status. Available at: <https://www.nimhd.nih.gov/about/overview/research-framework.html>. Accessed February 19, 2018.

SOCIAL ECOLOGICAL APPROACH TO ADDRESSING HEALTH DISPARITIES (NCI, 2017)

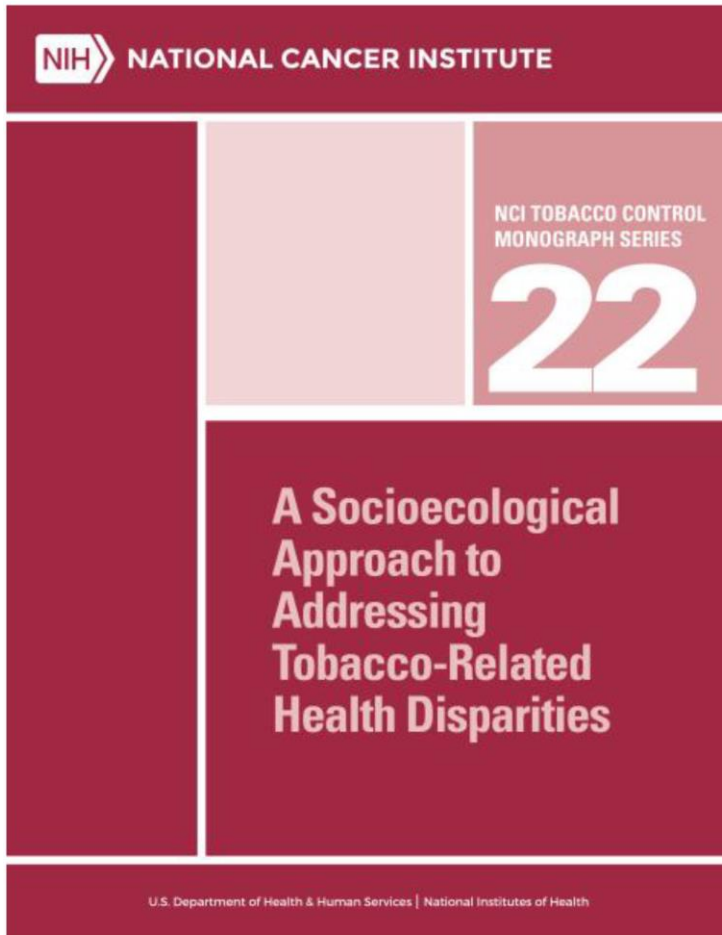
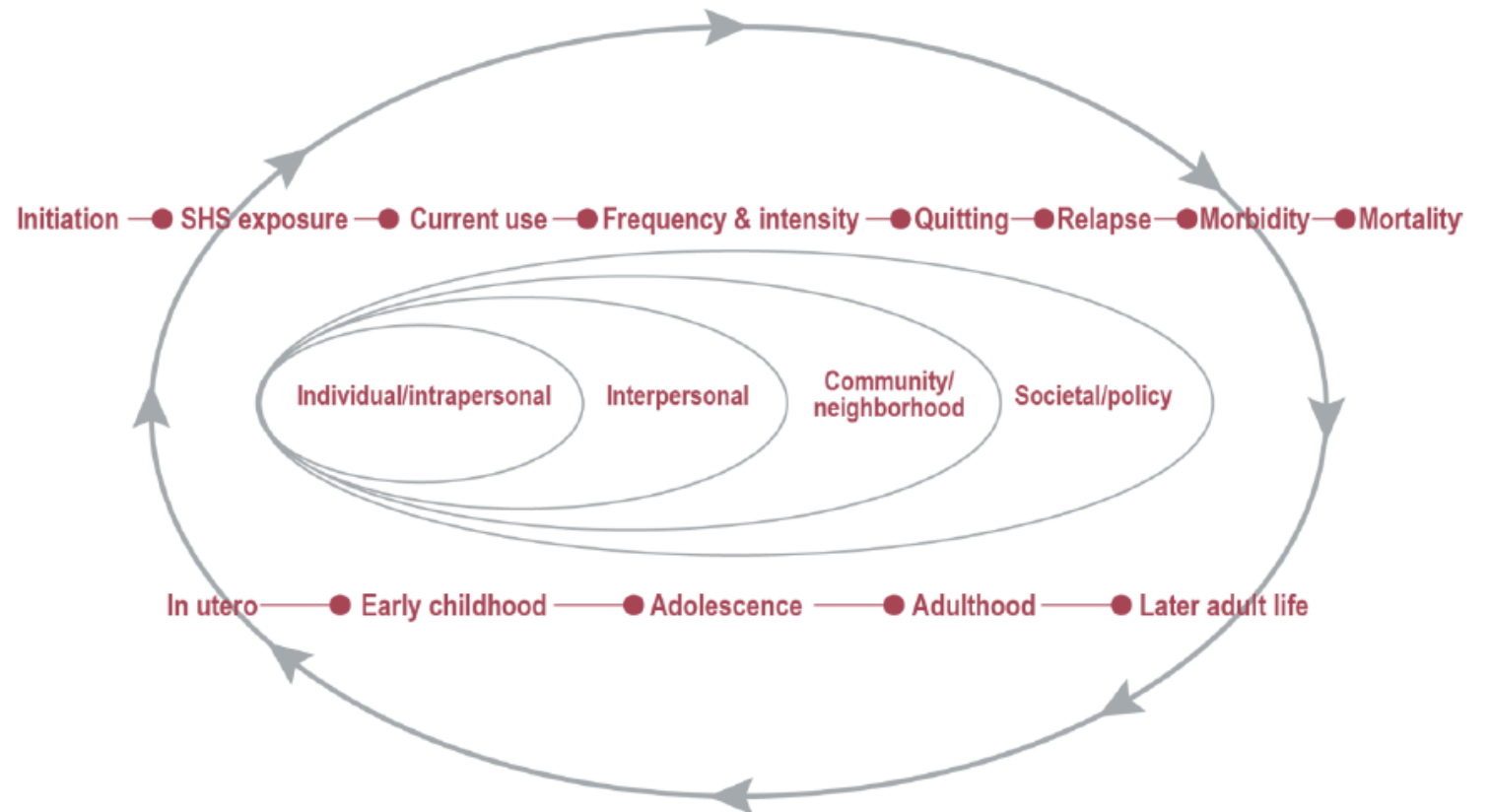


Figure 1.1 The Socioecological Model: Factors Influencing TRHD Across the Tobacco Use Continuum and Life Course



Notes: In addition to the experience of TRHD over time, there may be critical periods during development and throughout the life course when tobacco use or secondhand smoke exposure is significantly more detrimental than at other times. SHS = secondhand smoke.

TOBACCO-RELATED HEALTH DISPARITIES

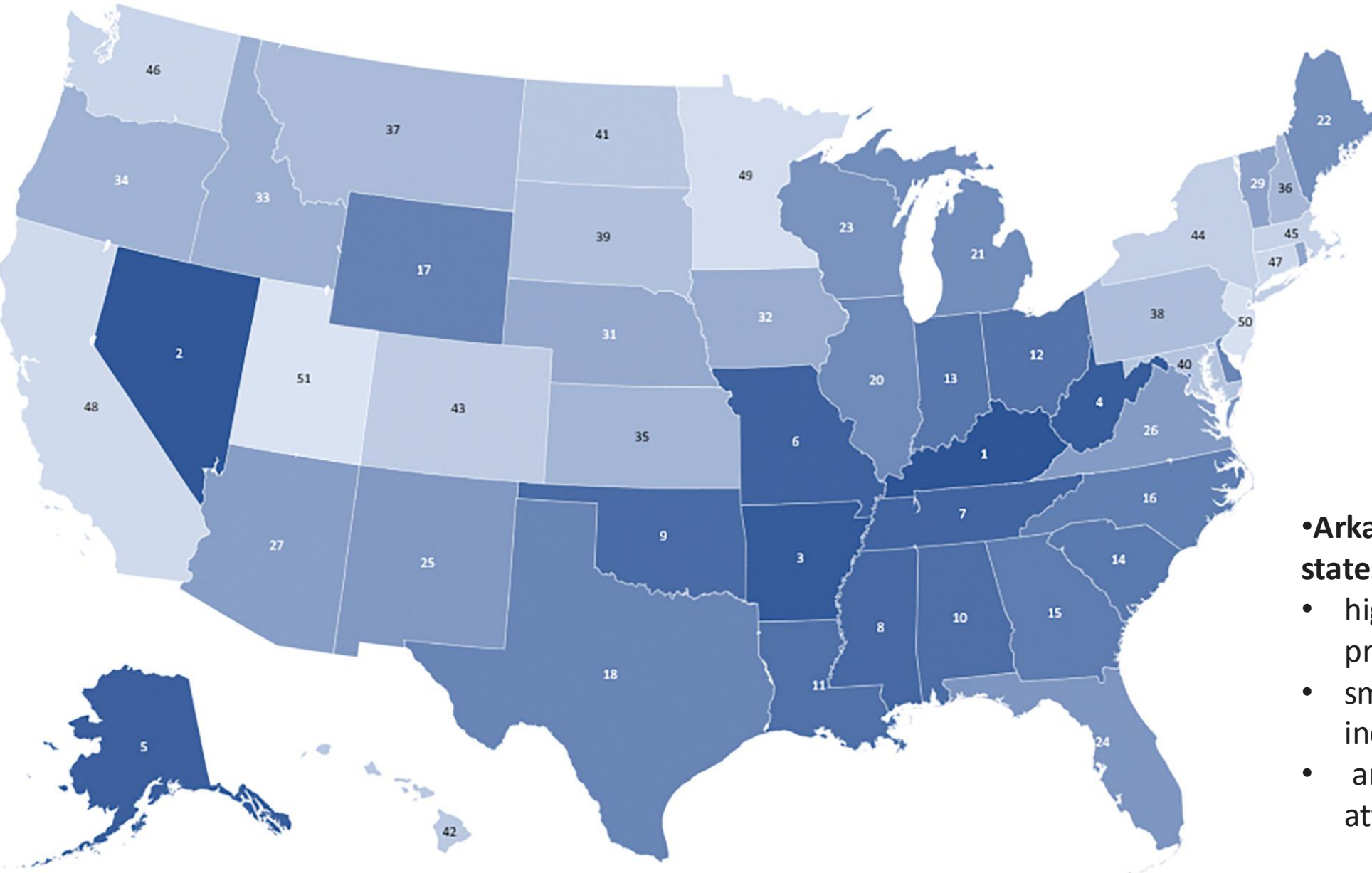
- **Some groups of people suffer disproportionately from tobacco-caused diseases, including:** ¹⁻⁶
 - Certain racially minoritized populations
 - Black/ African American peoples
 - American Indian/ Alaska Native peoples
 - Hispanic and Latino people (with differences based on country of birth and ethnicity and other factors)
 - People living in rural areas and certain regions
 - People with lower socioeconomic statuses
 - People with certain behavioral or mental health conditions
 - LGBTQ+ people



LET'S CONSIDER TOBACCO-RELATED HEALTH
DISPARITIES AND PLACE....



Map of state-level ranking according to proportion of smoking-associated cancer deaths attributable to cigarette smoking in 2014



- **Arkansas was 1 of the 5 rural states that ranked in top 10 for**
 - highest cigarette smoking prevalence
 - smoking-associated cancer incidence and mortality
 - and proportion of smoking-attributable cancer deaths.

TOBACCO NATION



In Tobacco Nation,

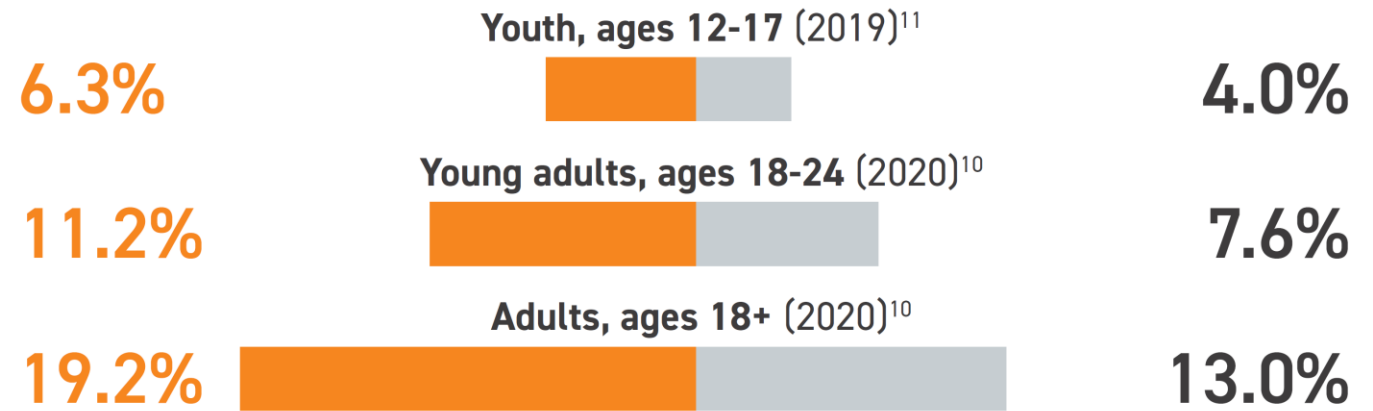
- Adult and youth smoking rates are higher than people living in other states.
- People smoke more cigarettes per year.
- Adult smoking rates have been consistently higher than the rest of the country since 2011.

Smoking prevalence

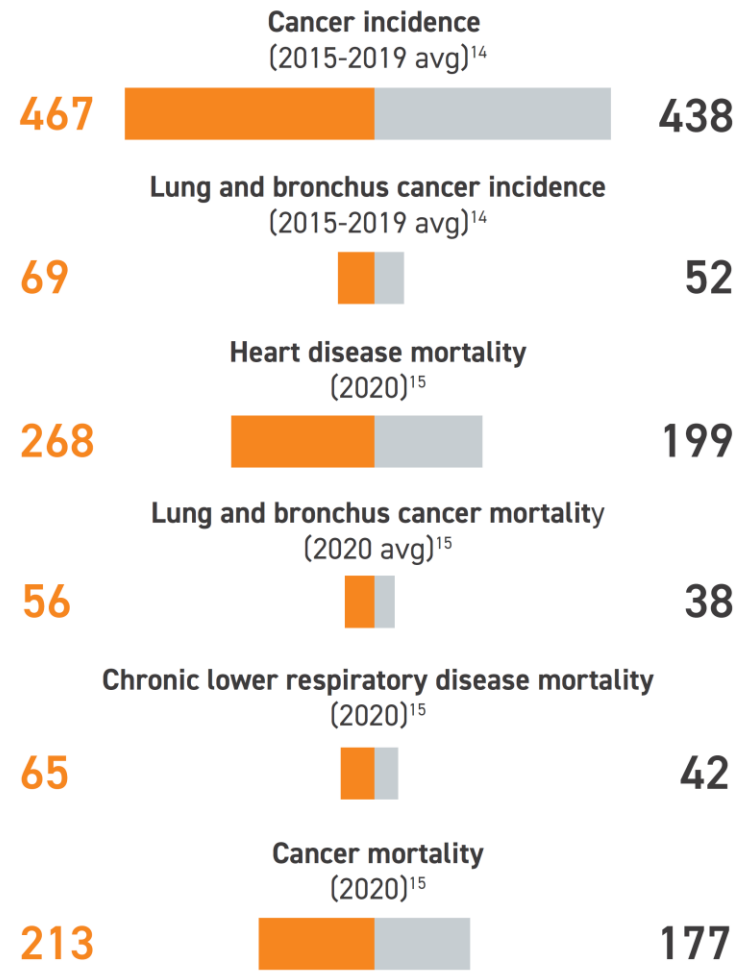
Tobacco Nation

VS.

U.S. population
(excluding Tobacco Nation)



Tobacco Nation **vs.** **Rest of the U.S.**

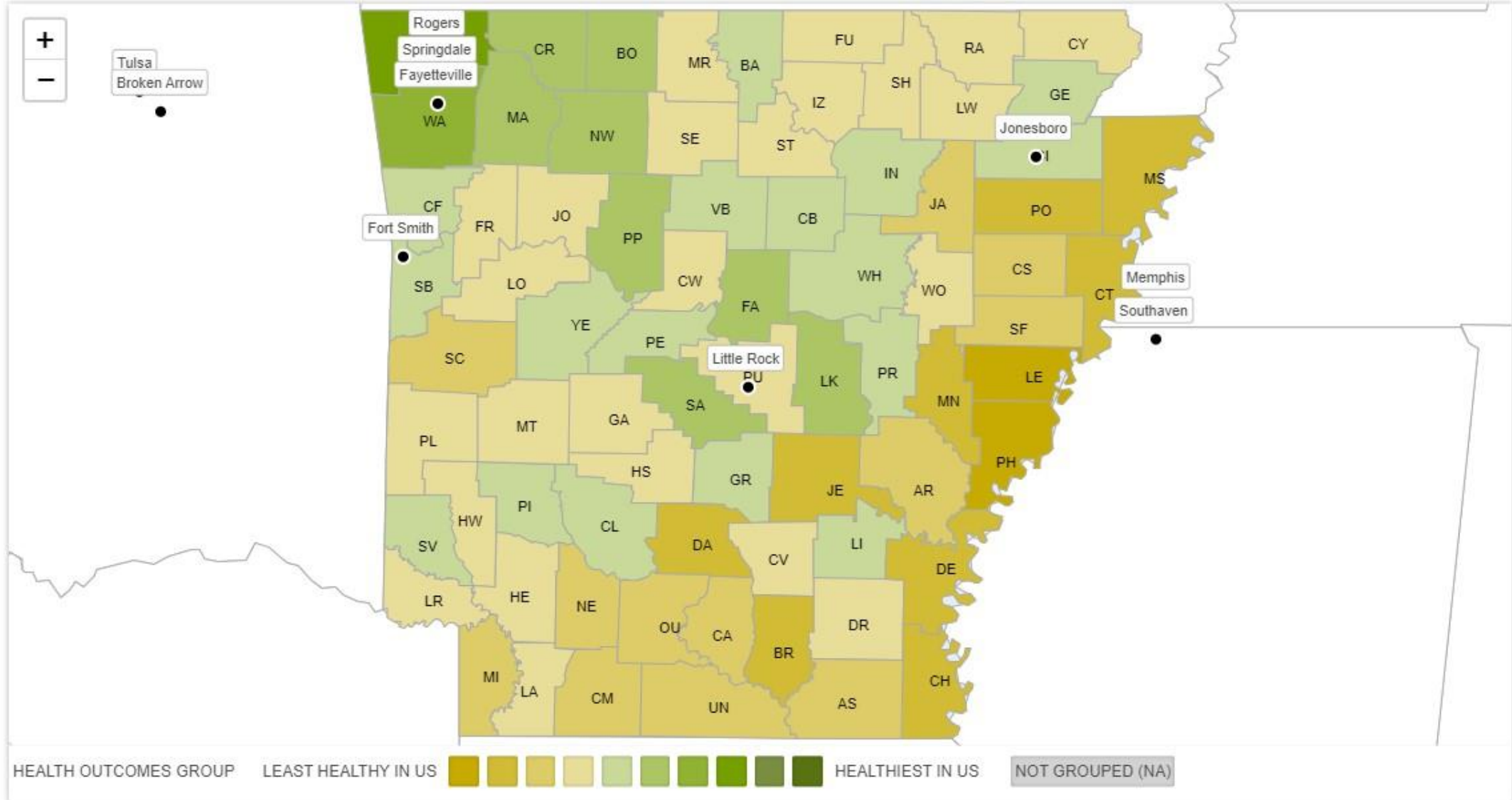


*Mean age-adjusted health rates
(rate per 100,000 persons)*



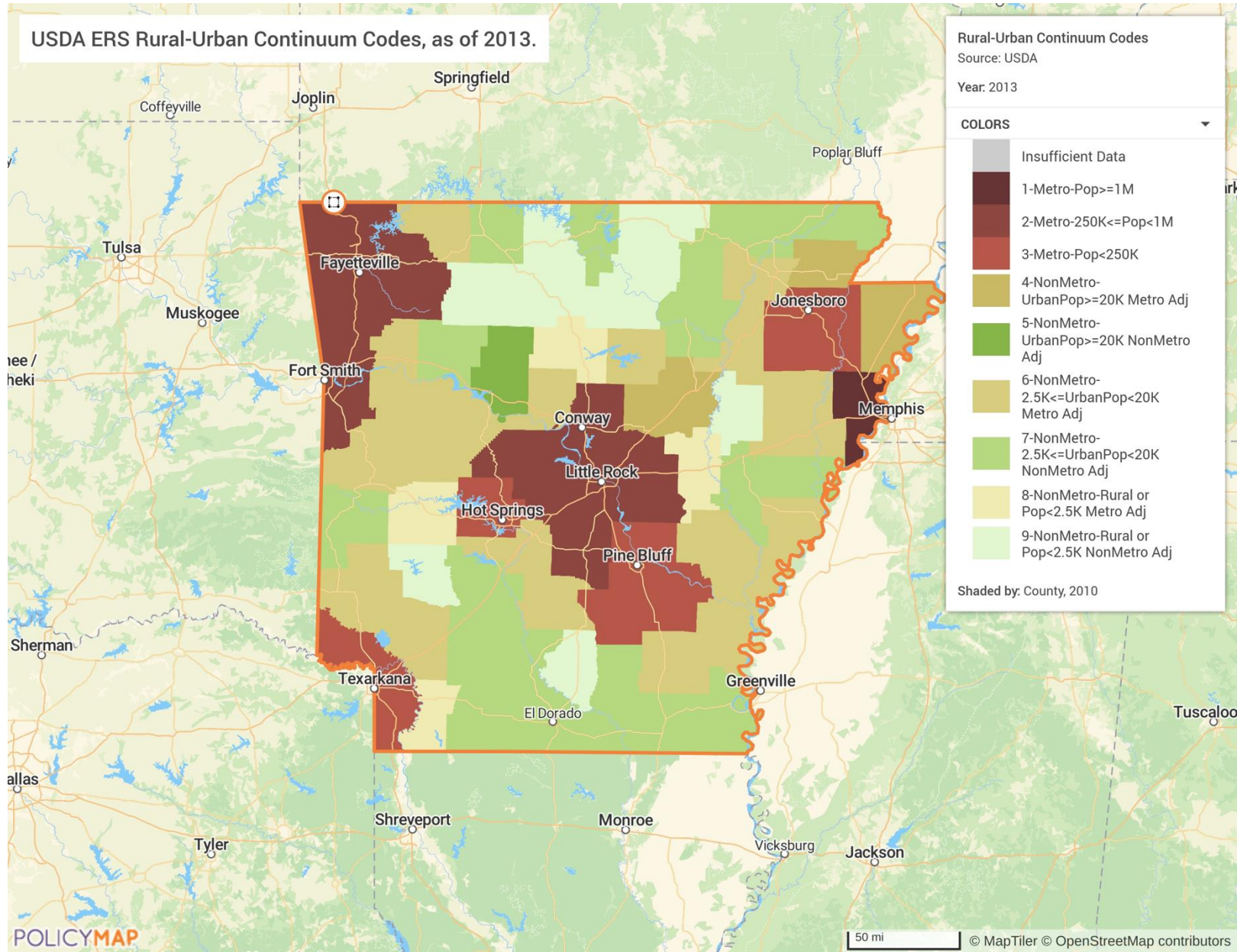
LET'S LOOK AT PLACE PLUS MORE...





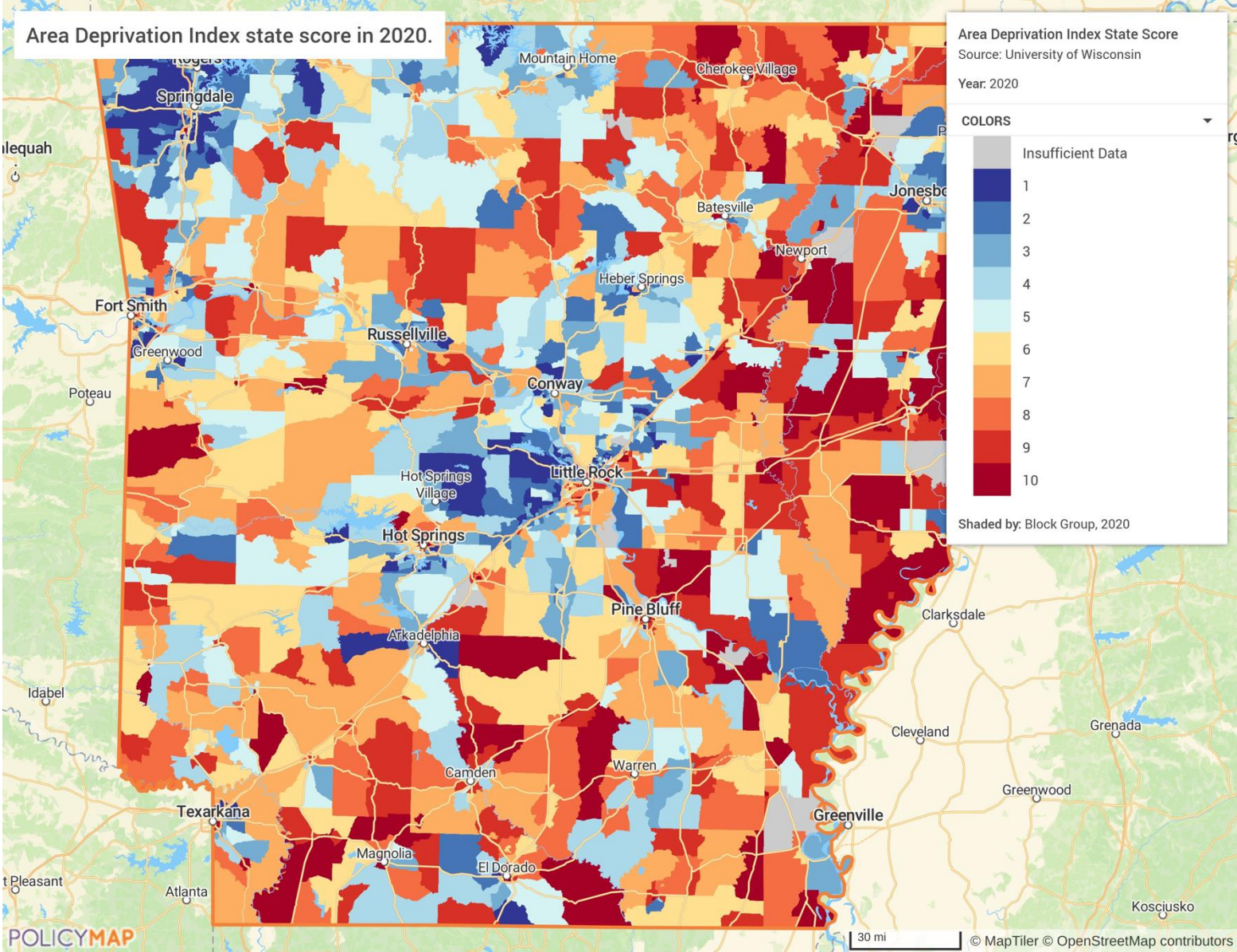
Cities Congressional District Lines ([Learn More](#))

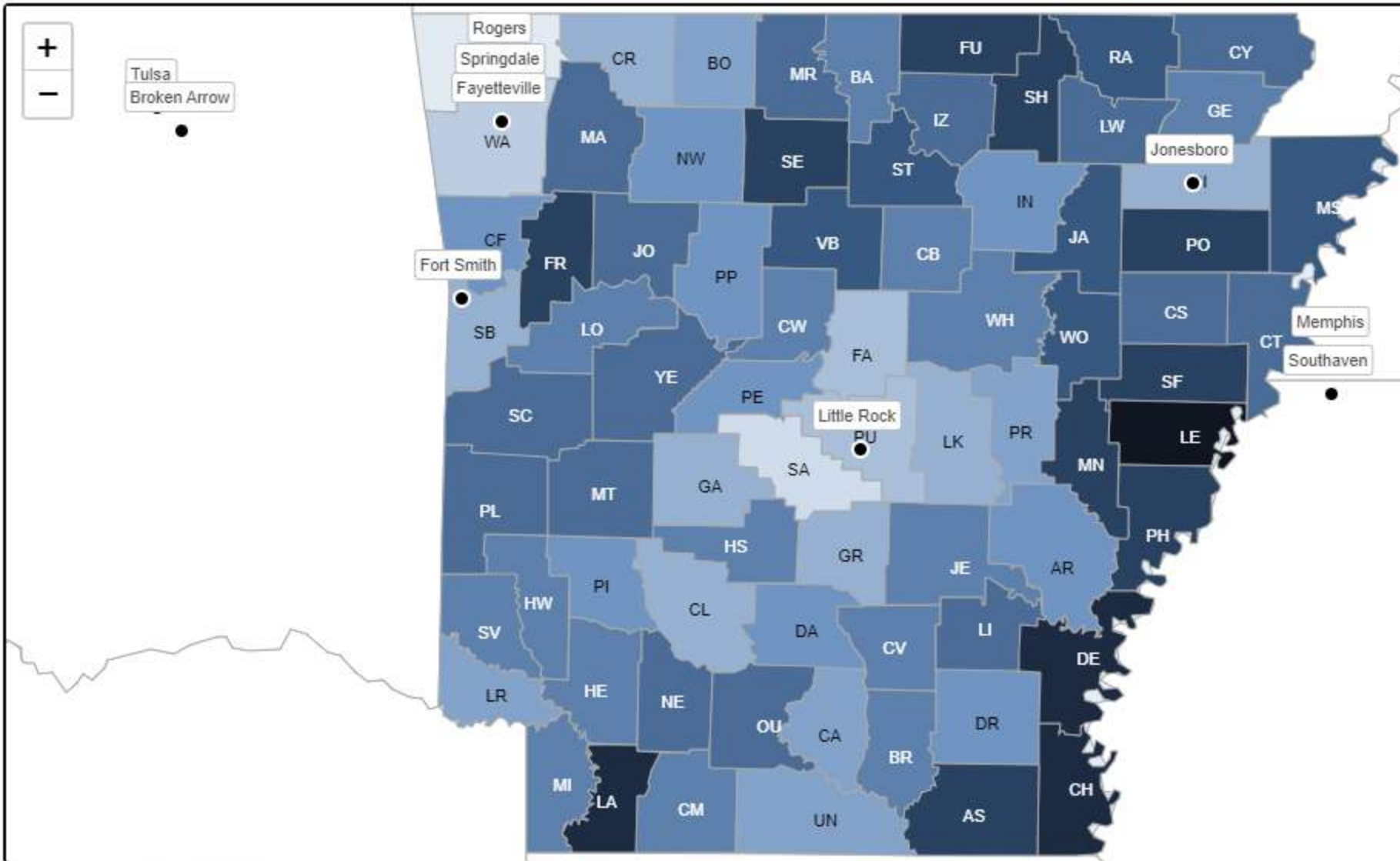
USDA ERS Rural-Urban Continuum Codes, as of 2013.



In Arkansas, 41% of our population lives in rural areas.

Area Deprivation Index state score in 2020.





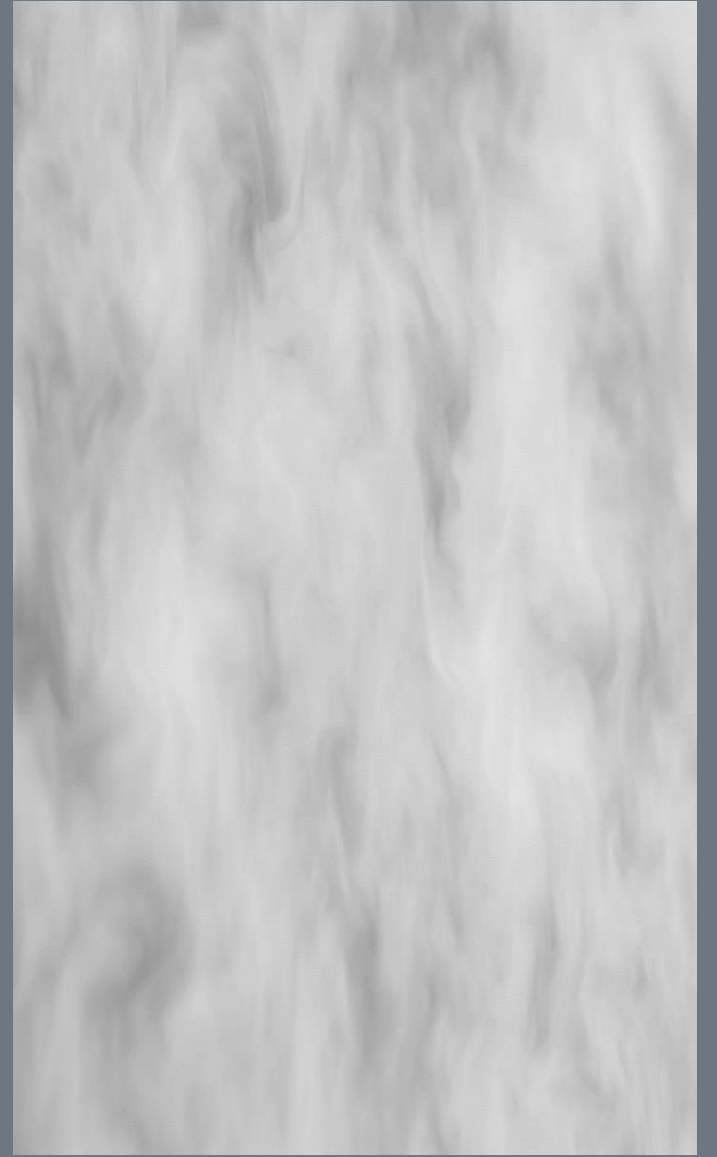
Adult Cigarette Smoking

In Arkansas, 22% of adults are current cigarette smokers.

This ranged from 16% to 28% of adults across counties in the state.

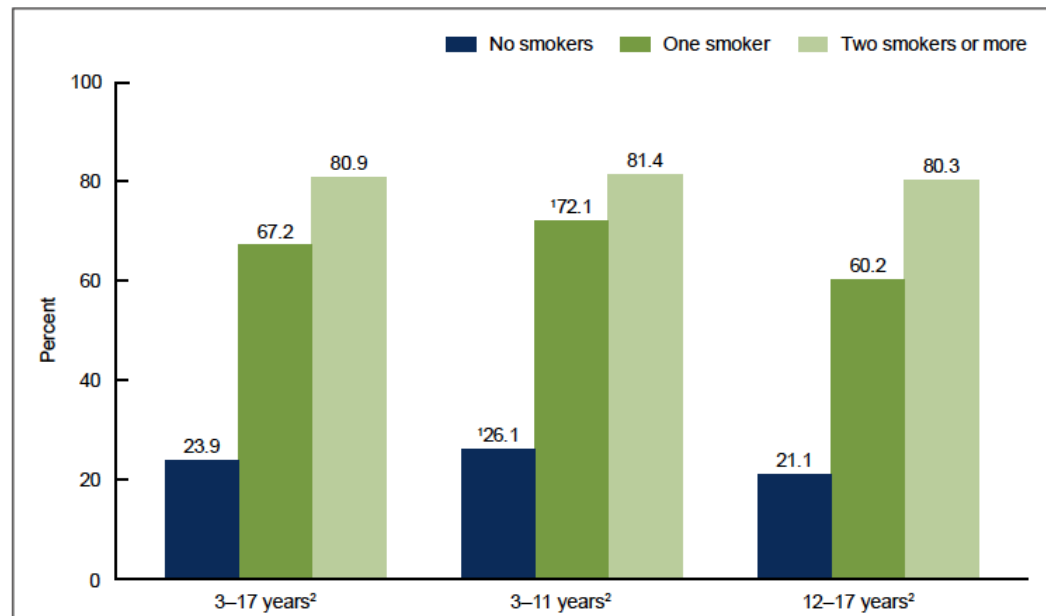
BEST WORST MISSING

YOUTH
ENVIRONMENTAL
TOBACCO
SMOKE/VAPOR
EXPOSURE (ETSE)



YOUTH ETSe

Figure 4. Percentage of youth with secondhand smoke exposure, by age and number of tobacco smokers living in their home: United States, 2013–2016



- **Parental smoking is the most common source of child ETSe.^{1,2}**
- **Parental smoking poses compounded risk for youth due to...**
 - **the health effects of ETSe**
 - **the increased chance of smoking uptake.^{3,4}**

¹ Brody, 2019; ² Ding et al., 2010; ³ USDHHS, 2006; ⁴ Vuolo & Staff, 2013

YOUTH ETSe

- **ETSe has declined over time, but rates remain high:^{1,2,3}**
 - **38% among children aged 3-11**
 - **32% among children aged 12-19**
- **Among children 3-11 years old:³**
 - **Heavy ETSe significantly declined over time among White and Hispanic children but not Black children**
 - **The disparity in ETSe among children has widened for Black children.**

¹ Brody et al., 2021; ² Brody, 2019; ³ Twum et al., 2023

YOUTH ETS_e

- **Populations more likely to be exposed to ETS: ¹**
 - **Children aged 3-11**
 - **Non-Hispanic, Black individuals**
 - **People with lower incomes**
 - **People with less education**
 - **People who live in rental and multi-unit housing**
 - **People who live with someone who smokes in the home**
 - **People who work in traditionally “blue collar” occupations**

¹ CDC. Trends and Disparities in Secondhand Smoke.

Figure 3. Percentage of youth with secondhand smoke exposure, by age and family income level: United States, 2013–2016

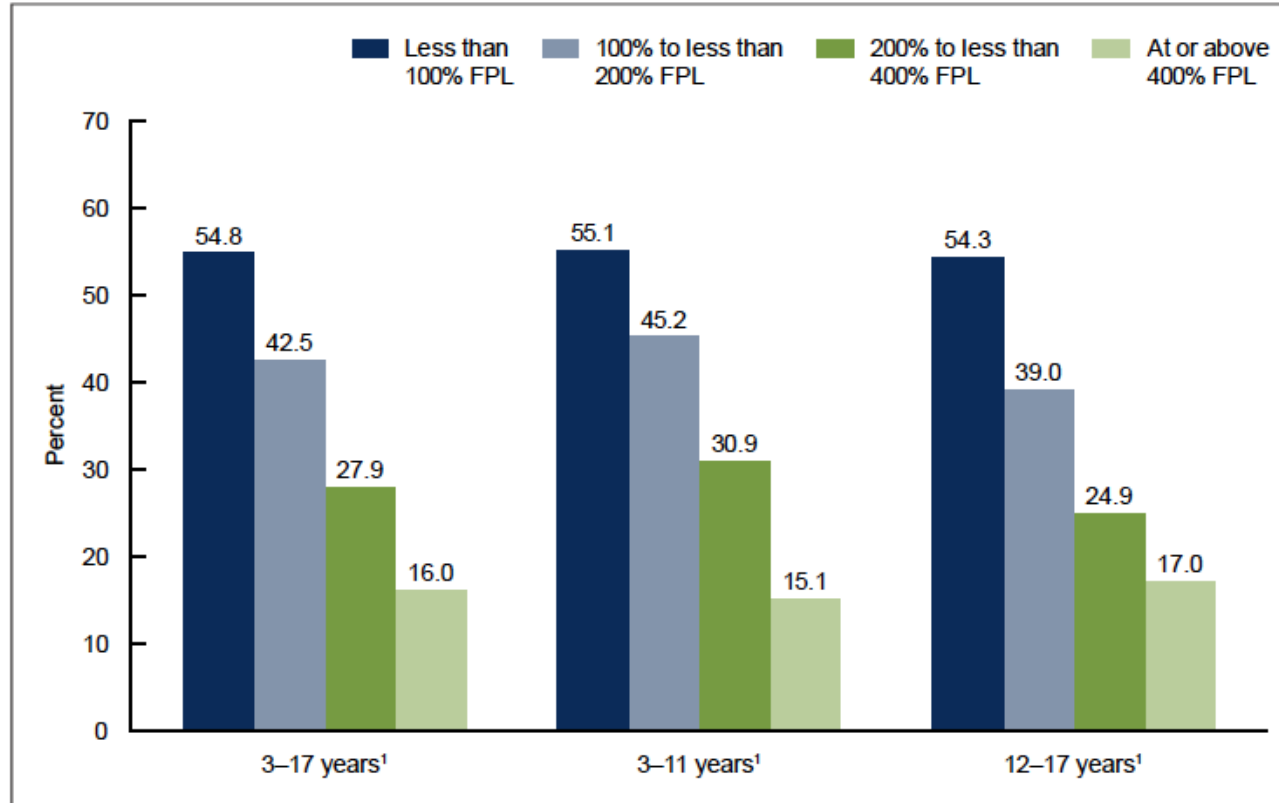
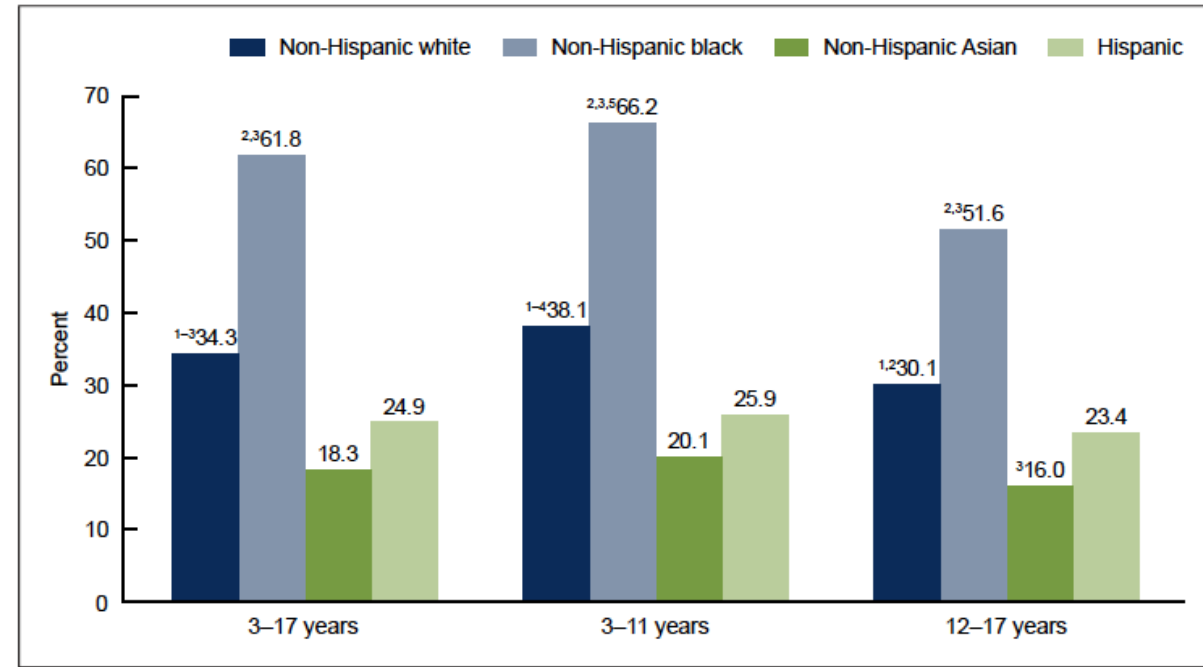
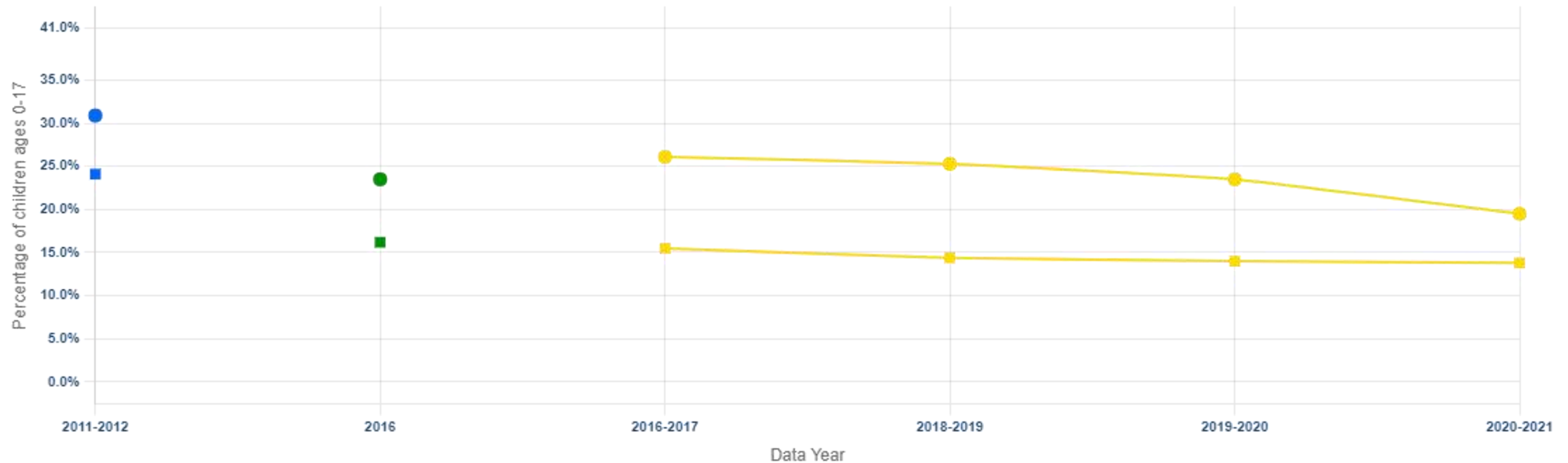


Figure 2. Percentage of youth with secondhand smoke exposure, by age and race and Hispanic origin: United States, 2013–2016



PERCENTAGE OF CHILDREN AGES 0-17 WHO LIVE IN HOUSEHOLDS WHERE SOMEONE USES CIGARETTES, CIGARS OR PIPE TOBACCO (2-YEAR ESTIMATE)



- Arkansas
- United States

Arkansas Value:

19.5%

Arkansas Rank:

43

Percentage of children ages 0-17 who live in households where someone uses cigarettes, cigars or pipe tobacco (2-year estimate)

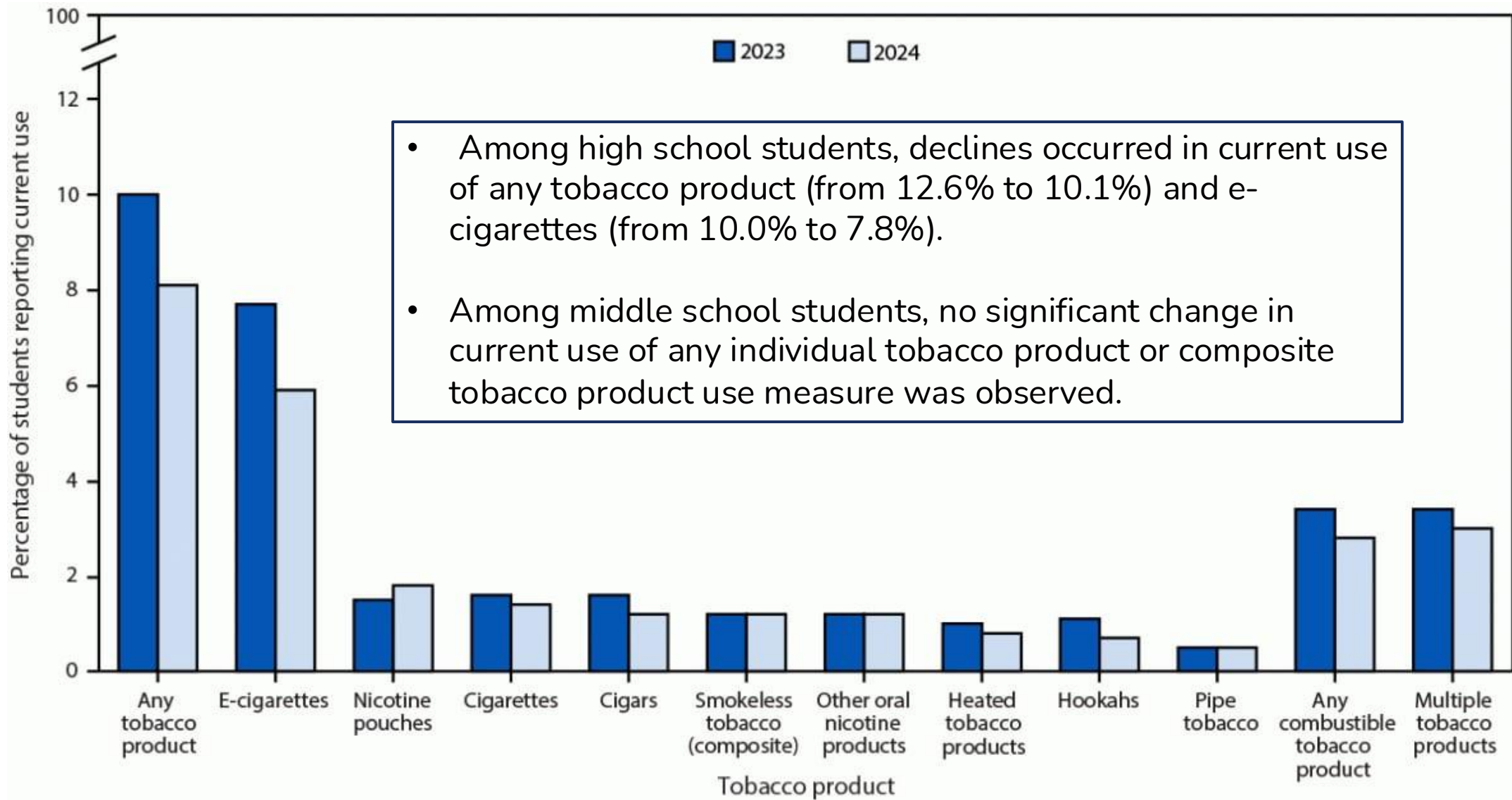
WHY ARE THERE DISPARITIES?

- Differences in adoption smokefree policies
- Tobacco industry predatory marketing and advertising in specific communities and spread of misinformation about ETSe.
- Social, structural, and political determinants of health

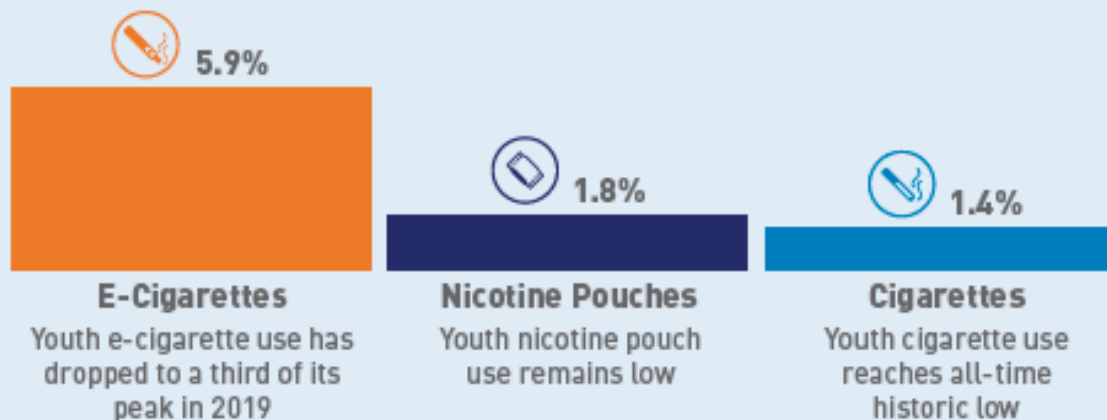


YOUTH TOBACCO AND NICOTINE USE

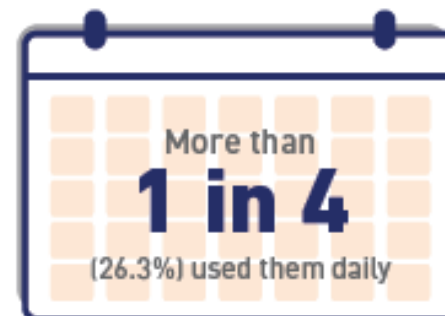
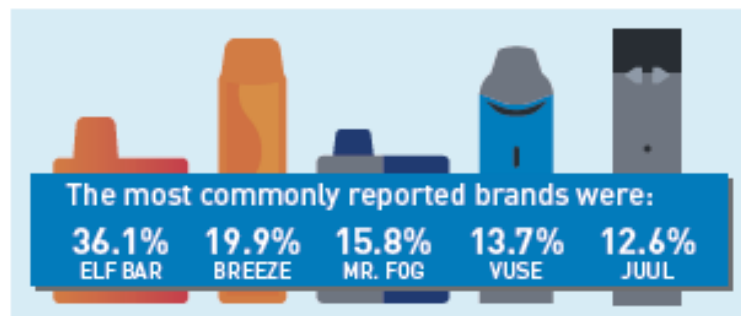




Most commonly used products among middle and high school students:



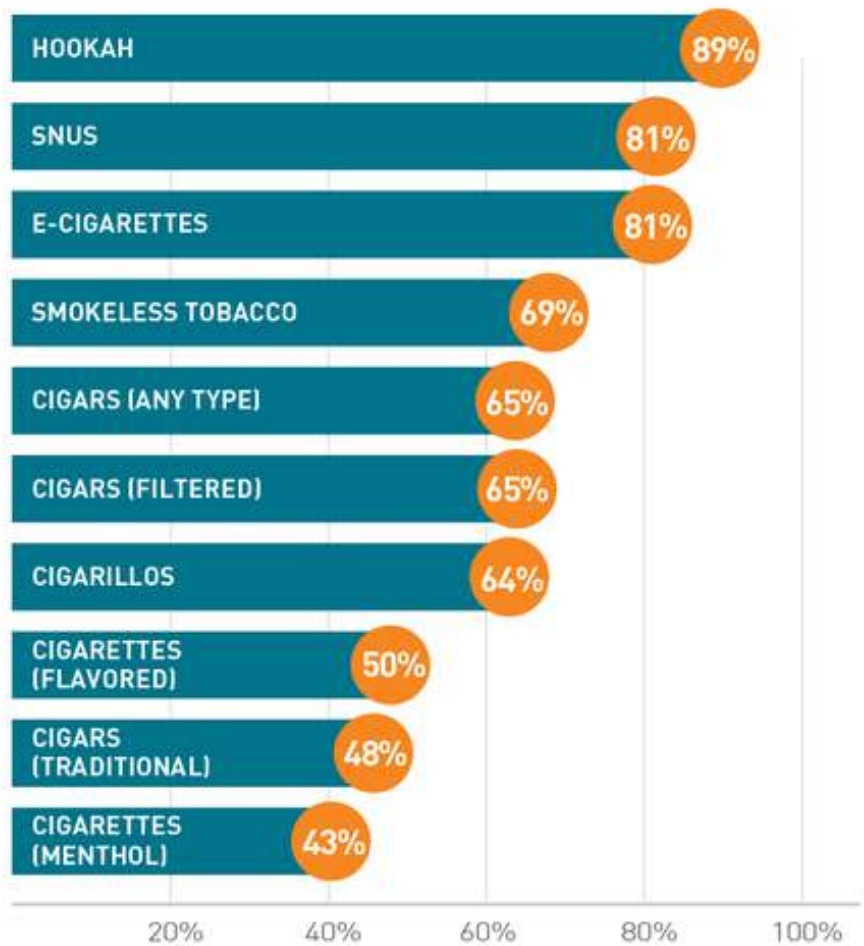
Among those who reported current e-cigarette use:



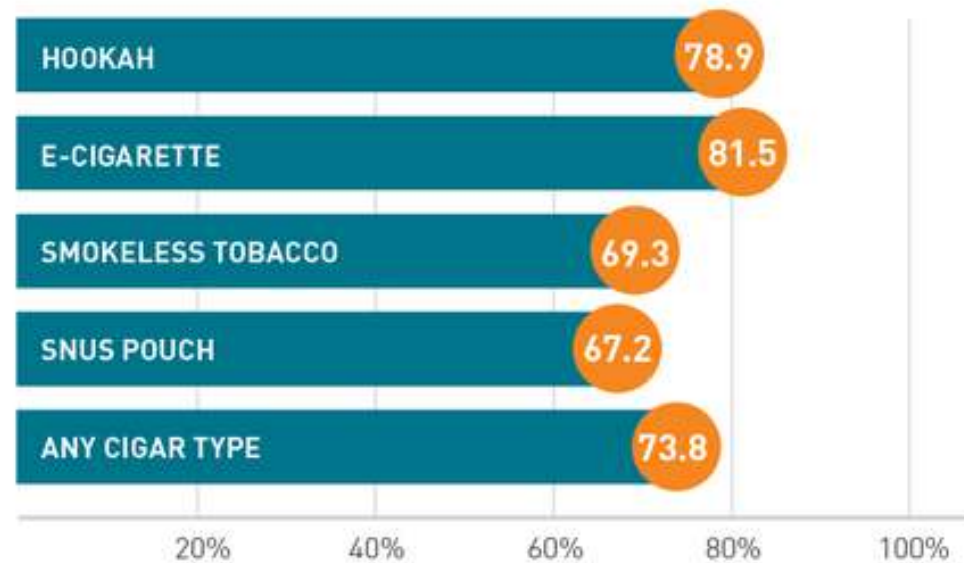
Majority (87.6%) used **flavored e-cigarettes**
with fruit flavors being the most popular, followed by candy and mint



First Product Was Flavored Among Youth Ever Tobacco Users (Ages 12-17), by Tobacco Product⁹



Flavored Tobacco Product Use Among Youth Non-Cigarette, Past 30 Day Tobacco Users (ages 12-17)⁸



Tobacco Product	Overall	Girls	Boys
Any tobacco product†	5.4%	5.5%	5.3%
Electronic cigarettes	3.5%	3.9%	3.1%
Nicotine Pouches	1.0%	0.9%	1.1%
Cigarettes	1.1%	1.2%	0.9%
Cigars	0.8%	0.8%	0.7%
Smokeless tobacco	0.8%	0.7%	1.0%
Other oral nicotine products§	0.9%	0.9%	0.8%
Heated tobacco products	0.7%	0.7%	0.8%
Hookah	0.6%	0.7%	0.4%
Pipe tobacco	0.5%	0.4%	0.5%

CURRENT TOBACCO PRODUCT USE AMONG MIDDLE SCHOOL STUDENTS IN 2024

Tobacco Product	Overall	Girls	Boys
Any tobacco product†	10.1%	9.3%	10.9%
Electronic cigarettes	7.8%	7.7%	7.8%
Nicotine Pouches	2.4%	0.8	3.9%
Cigarettes	1.7%	1.1%	2.2%
Cigars	1.5%	1.0%	2.1%
Smokeless tobacco	1.5%	0.6%	2.3%
Other oral nicotine products§	1.4%	0.9%	2.0%
Heated tobacco products	0.9%	0.7%	1.0%
Hookah	0.8%	0.7%	0.9%
Pipe tobacco	0.5%	0.4%	0.6%

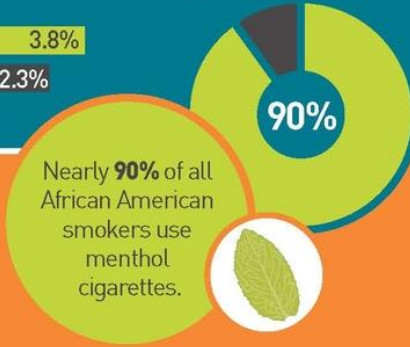
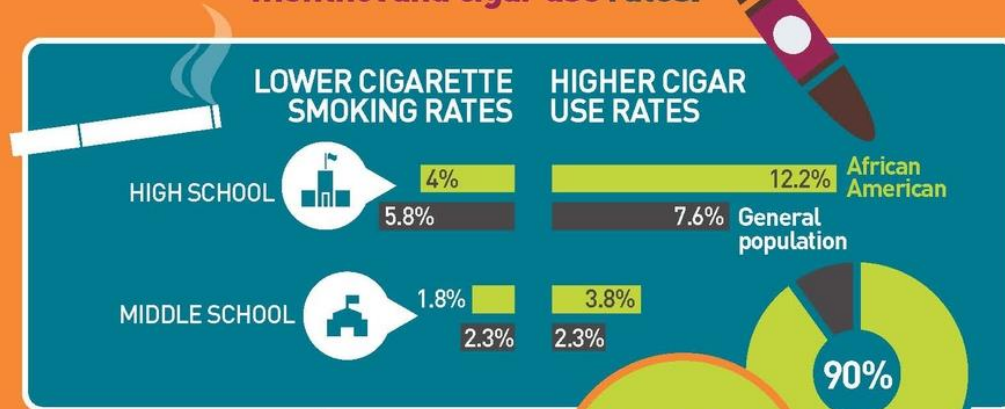
CURRENT TOBACCO PRODUCT USE AMONG HIGH SCHOOL STUDENTS IN 2024

Percentage of middle and high school students who reported current tobacco product use,* overall and by school level, product, sex, and race and ethnicity — National Youth Tobacco Survey, United States, 2024

Tobacco product	Race and ethnicity						Total
	A/IAN	Asian	Black or African American	White	Hispanic or Latino	Multiracial	
Overall							
Any tobacco product	16.3 (12.8–20.5)	3.3 (2.3–4.6)	10.0 (8.4–11.9)	7.8 (6.6–9.3)	8.4 (7.5–9.3)	9.0 (7.4–11.0)	8.1 (7.4–8.9)
E-cigarettes	11.5 (8.4–15.5)	2.3 (1.5–3.7)	7.0 (5.7–8.6)	5.9 (4.8–7.1)	6.1 (5.5–6.9)	6.6 (5.2–8.3)	5.9 (5.3–6.6)
Nicotine pouches	4.4 (2.8–7.0)	—**	1.0 (0.6–1.4)	2.2 (1.8–2.8)	1.7 (1.4–2.1)	1.4 (0.8–2.4)	1.8 (1.5–2.1)
Cigarettes	3.5 (2.1–5.6)	—	0.9 (0.6–1.4)	1.4 (1.2–1.8)	1.6 (1.3–2.0)	2.1 (1.3–3.5)	1.4 (1.2–1.6)
Cigars	—	—	2.2 (1.5–3.1)	0.9 (0.7–1.2)	1.4 (1.1–1.8)	—	1.2 (1.0–1.5)
Smokeless tobacco	3.6 (2.0–6.4)	—	0.8 (0.5–1.3)	1.3 (1.1–1.7)	1.3 (1.0–1.6)	1.3 (0.7–2.2)	1.2 (1.0–1.4)
Any combustible tobacco product	6.3 (4.1–9.5)	—	4.1 (3.2–5.2)	2.4 (2.0–2.9)	2.9 (2.5–3.5)	3.9 (2.8–5.4)	2.8 (2.5–3.2)
Multiple tobacco products	6.9 (4.5–10.4)	1.1 (0.6–2.0)	3.3 (2.5–4.4)	3.0 (2.5–3.7)	3.1 (2.7–3.5)	3.8 (2.7–5.2)	3.0 (2.7–3.4)

AFRICAN AMERICANS

African American youth tend to **smoke cigarettes less** than the general population, but they have much **higher menthol and cigar use rates.**



Nearly **90%** of all African American smokers use menthol cigarettes.

African Americans have been **targeted with menthol cigarette advertising** in predominantly black neighborhoods and in publications that are popular with black audiences.

More than 39,000 **African Americans die** from tobacco-related cancers each year.

x39,000

TOBACCO USE IN ARKANSAS

- Dr. Oliveto said the recent data on nicotine and tobacco use in Arkansas has been presented...

Arkansas Prevention Needs Assessment 2023 Report

TABLE 2-3

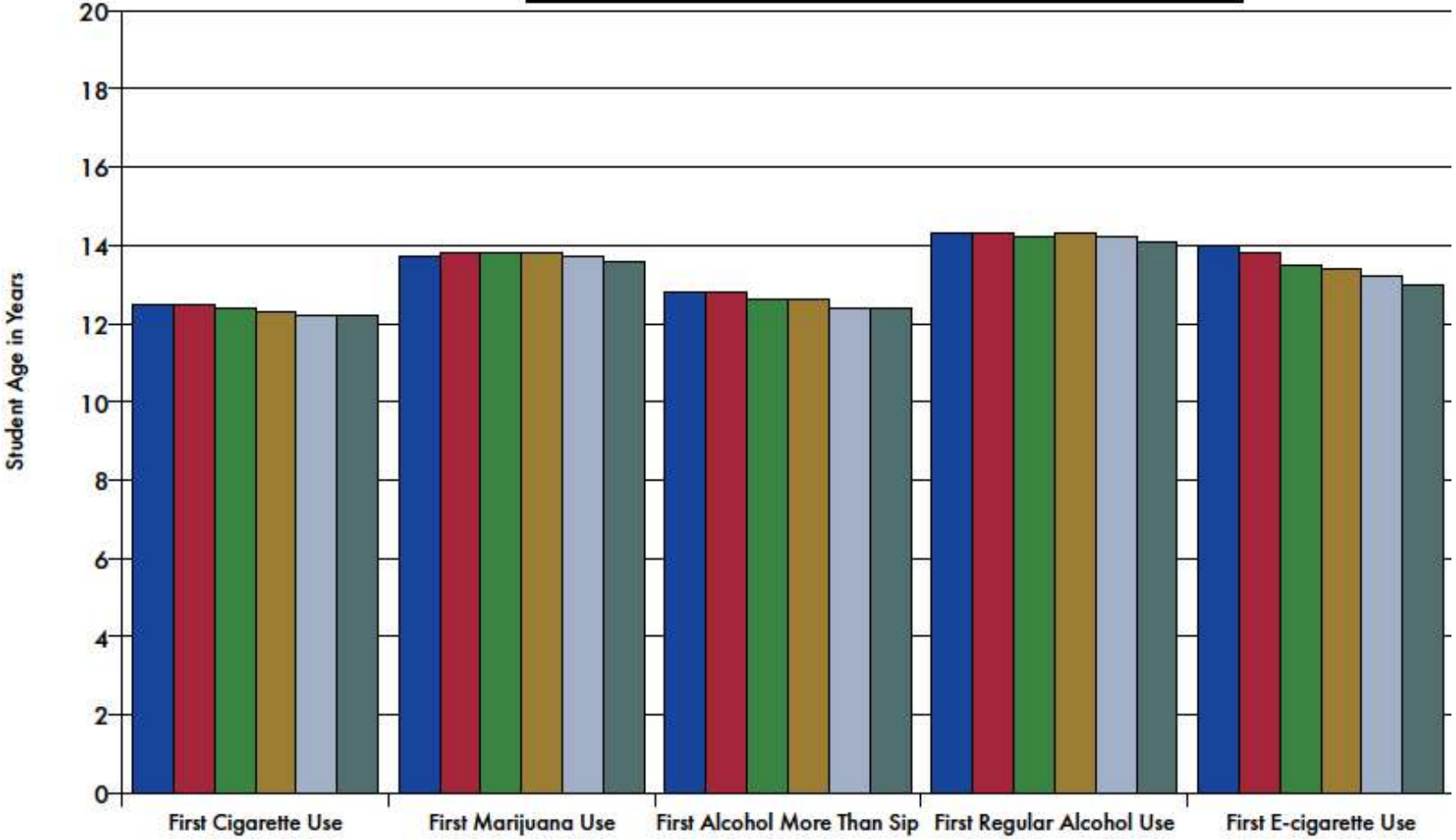
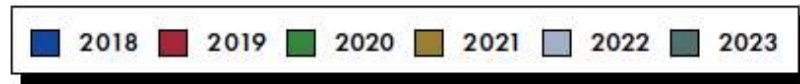
Difference in Lifetime Prevalence Rates on Directly Comparable Measures between Arkansas Students and MTF 2023 Findings

Grade Level	Alcohol	Cigarettes	Smokeless Tobacco	Vape Flavoring	Vape Nicotine	Vape Marijuana	Marijuana	LSD/Hallucinogens	Cocaine	Inhalants	Methamphetamines	Opiates/Heroin	MDMA[Ecstasy]	Steroids
8th	-0.6%	1.4%	0.1%	-4.8%	-5.4%	-2.8%	-4.8%	-0.5%	-0.7%	-4.9%	-0.1%	-0.6%	-0.5%	-0.3%
10th	-8.8%	1.7%	1.5%	-7.3%	-7.6%	-5.0%	-8.6%	-0.6%	-0.4%	-3.7%	-0.2%	-0.3%	-0.8%	-0.3%
12th	-19.5%	-0.3%	1.1%	-10.7%	-11.2%	-7.6%	-15.0%	0.0%	-0.7%	-4.4%	-0.1%	0.0%	-0.7%	0.0%

Values above 0 (pink background) indicate Arkansas use above MTF value. Values below 0 (green background) indicate Arkansas use below MTF findings. NOTE: "Any vaping" is not reported by grade level in the 2023 MTF data; thus, it is excluded from this comparison.

FIGURE 2-1

Average Age of First Substance Use (of Students Who Indicated That They Had Used)



ARKANSAS
PREVENTION
NEEDS
ASSESSMENT 2023
REPORT

TABLE 2-4

Percentage of Arkansas Respondents Who Used ATODs During Their Lifetime by Grade

Drug Used	Arkansas Grade 6						Arkansas Grade 8						MTF Grade 8	Arkansas Grade 10						MTF Grade 10	Arkansas Grade 12						MTF Grade 12	Total											
	2018	2019	2020	2021	2022	2023	2018	2019	2020	2021	2022	2023	2023	2018	2019	2020	2021	2022	2023	2023	2018	2019	2020	2021	2022	2023	2023	2018	2019	2020	2021	2022	2023	2023	2018	2019	2020	2021	2022
Alcohol	8.4	9.0	8.3	12.1	12.7	12.2	21.7	21.3	17.9	20.3	19.9	19.5	20.1	36.4	35.5	28.9	30.3	29.8	27.0	35.8	48.1	45.8	35.9	38.3	37.1	33.3	52.8	25.9	25.6	20.4	23.3	23.0	21.2						
Cigarettes	5.4	5.6	4.4	4.6	4.5	3.8	13.8	12.4	10.1	9.1	7.9	7.2	5.8	19.9	17.4	14.7	13.4	11.8	11.1	9.4	28.2	24.4	17.2	18.0	15.7	14.7	15.0	15.3	13.8	10.5	10.3	9.1	8.3						
Smokeless Tobacco	3.5	4.0	3.1	3.4	3.4	2.9	8.1	7.5	6.4	5.6	4.8	4.6	4.5	12.4	10.6	10.2	8.5	7.0	7.0	5.5	16.3	14.8	11.0	11.5	10.0	8.9	7.8	9.2	8.6	7.0	6.6	5.8	5.3						
Marijuana	1.4	1.7	1.4	1.7	1.6	1.5	8.8	8.9	7.0	7.1	7.3	6.7	11.5	19.9	19.6	15.1	15.9	16.4	13.9	22.5	29.5	29.7	22.9	24.7	23.5	21.5	36.5	12.9	13.2	9.7	10.5	10.5	9.2						
Inhalants	3.6	3.9	2.7	3.3	3.4	3.6	6.5	6.5	4.3	4.3	3.9	4.1	9.0	4.4	4.6	3.2	3.3	3.1	2.8	6.5	3.3	3.1	2.0	2.4	2.6	1.9	6.3	4.5	4.7	3.2	3.4	3.4	3.3						
Hallucinogens	0.3	0.2	0.1	0.2	0.1	0.2	0.7	0.8	0.6	0.6	0.6	0.6	1.1	2.0	1.9	1.6	1.6	1.6	1.5	2.1	3.8	4.1	3.1	3.5	3.2	3.1	3.1	1.4	1.5	1.1	1.2	1.1	1.1						
Cocaine	0.3	0.4	0.2	0.3	0.3	0.3	0.6	0.6	0.4	0.3	0.5	0.3	1.0	1.2	0.9	0.4	0.6	0.5	0.6	1.0	2.1	2.1	1.0	0.9	1.0	0.6	1.3	0.9	0.9	0.4	0.5	0.5	0.4						
Methamphetamines	0.2	0.3	0.1	0.2	0.2	0.1	0.4	0.4	0.3	0.3	0.2	0.2	0.3	0.7	0.5	0.4	0.3	0.4	0.3	0.5	0.9	0.9	0.4	0.4	0.6	0.5	0.6	0.5	0.5	0.3	0.3	0.3	0.2						
Ecstasy	0.1	0.1	0.1	0.2	0.1	0.2	0.4	0.6	0.3	0.4	0.3	0.4	0.9	1.1	1.1	0.8	1.0	0.7	0.6	1.4	2.0	2.4	1.4	1.5	1.3	0.9	1.6	0.8	0.9	0.5	0.7	0.5	0.5						
Steroids	--	--	0.4	0.6	0.5	0.6	--	--	0.4	0.6	0.8	0.9	1.2	--	--	0.4	0.5	0.6	0.9	1.2	--	--	0.3	0.4	0.7	0.9	0.9	--	--	0.4	0.5	0.7	0.8						
Opiates/Heroin	0.2	0.2	0.1	0.3	0.2	0.1	0.3	0.3	0.1	0.2	0.3	0.2	0.8	0.9	0.7	0.3	0.4	0.4	0.2	0.5	1.1	1.1	0.5	0.6	0.5	0.2	0.2	0.6	0.5	0.2	0.4	0.3	0.2						
Prescription Drugs	2.8	3.1	2.7	3.6	3.3	3.3	5.8	5.3	4.0	4.7	4.7	4.6	--	8.1	6.7	5.0	4.7	4.6	4.6	--	9.8	8.6	5.3	5.3	5.0	4.5	8.5	6.2	5.6	4.1	4.5	4.3	4.2						
OTC Drugs	1.0	1.1	1.4	1.1	1.0	1.2	2.2	2.2	1.8	1.5	1.6	1.6	--	3.0	2.5	2.1	1.9	1.7	1.5	--	3.2	2.8	1.8	1.6	1.6	1.8	--	2.2	2.1	1.7	1.5	1.5	1.5						
Alcopops	3.1	3.1	2.6	3.2	3.0	2.8	11.2	10.3	7.5	8.4	7.7	7.5	12.4	20.8	20.1	14.0	15.1	14.3	12.8	26.4	29.8	28.8	18.8	21.8	19.9	17.9	44.3	14.4	14.0	9.3	10.8	9.9	9.0						
CBD Products	--	--	--	4.4	3.6	2.8	--	--	--	5.3	5.0	4.4	--	--	--	--	8.8	9.0	7.6	--	--	--	--	12.1	12.3	11.3	--	--	--	--	7.0	6.8	5.7						
Any Drug	8.7	9.7	8.9	13.9	12.9	10.0	17.1	17.0	14.4	16.8	17.2	15.0	--	24.8	24.2	19.8	22.5	23.1	20.3	--	32.3	32.5	26.0	29.4	28.3	26.0	--	19.2	19.4	15.8	19.4	19.2	16.5						
Vape Flavoring	--	--	4.1	4.7	4.6	4.4	--	--	10.6	9.9	9.4	8.0	12.8	--	--	14.8	13.7	11.9	10.1	17.4	--	--	15.0	13.8	12.7	11.0	21.7	--	--	10.3	9.9	9.2	7.9						
Vape Nicotine	--	--	3.6	4.4	4.3	4.7	--	--	12.7	13.1	12.4	11.1	16.5	--	--	22.1	22.4	20.3	17.5	25.1	--	--	26.0	27.0	25.2	22.3	33.5	--	--	14.3	15.1	14.1	12.5						
Vape Marijuana	--	--	0.9	1.2	1.3	1.3	--	--	4.9	5.4	5.9	5.6	8.4	--	--	10.7	12.2	13.5	11.8	16.8	--	--	15.3	18.7	18.9	17.9	25.5	--	--	6.7	8.0	8.6	7.7						
Any Vaping	--	--	5.7	6.7	6.8	7.0	--	--	15.8	16.1	15.2	14.0	--	--	--	25.1	25.5	23.5	20.5	--	--	--	29.4	30.5	29.1	25.9	--	--	--	17.1	18.0	17.1	15.3						
Injection of Illegal Drugs	--	--	--	0.8	0.8	0.8	--	--	--	1.0	1.0	1.1	--	--	--	--	1.2	1.2	0.9	--	--	--	--	1.5	1.4	1.5	--	--	--	--	1.1	1.1	1.0						

a. -- indicates data are not available because the question was not asked that year or the MTF data are not comparable to the Arkansas data.

b. Any Drug category should not be compared across the years because the types of drugs assessed changed over the years in order to add emerging drugs being used (or drop those that had become unpopular). See full explanation in Section 2.3.2.

ARKANSAS PREVENTION NEEDS ASSESSMENT 2023 REPORT

Table 11.110: During this school year, were you taught in any of your classes about the dangers of tobacco use?

	Grade 6 State %	Grade 8 State %	Grade 10 State %	Grade 12 State %	Combined State %
Never	30.9	29.8	39.0	46.2	34.9
Rarely	19.6	22.2	23.2	21.0	21.5
Sometimes	25.8	26.6	23.5	20.1	24.6
Often	15.2	15.0	10.3	9.2	13.0
Almost always	8.5	6.4	3.9	3.5	6.0
N of Valid	13,016	13,726	10,471	6,769	43,982
N of Miss	1,136	830	1,004	743	3,713

ARKANSAS PREVENTION NEEDS ASSESSMENT 2023 REPORT

Table 11.109: Which statement best describes rules about smoking inside your home or your family cars?

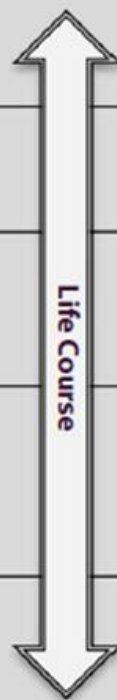
	Grade 6 State %	Grade 8 State %	Grade 10 State %	Grade 12 State %	Combined State %
Smoking is not allowed anywhere inside the home or cars	60.8	59.2	64.3	67.4	62.2
Smoking is allowed in some places and at some times or in some cars	8.9	9.2	8.1	7.9	8.7
Smoking is allowed anywhere inside the home or cars	2.4	2.5	2.2	2.6	2.4
There are no rules about smoking inside the home or cars	3.4	4.6	5.0	5.4	4.5
I don't know	24.5	24.5	20.4	16.7	22.3
N of Valid	13,102	13,770	10,561	6,862	44,295
N of Miss	1,050	786	914	650	3,400



HOW DO WE REDUCE TOBACCO AND NICOTINE
EXPOSURE ACROSS GENERATIONS?



Health Disparity Populations: Race/Ethnicity, Low SES, Rural, Sexual/Gender Minority Other Fundamental Characteristics: Sex/Gender, Disability, Geographic Region				
Domains of Influence	Levels of Influence			
	Individual	Interpersonal	Community	Societal
Biological	Biological Vulnerability and Mechanisms	Caregiver–Child Interaction Family Microbiome	Community Illness Exposure Herd Immunity	Sanitation Immunization Pathogen exposure
Behavioral	Health Behaviors Coping Strategies	Family Functioning School/Work Functioning	Community Functioning	Policies and Laws
Physical/Built Environment	Personal Environment	Household Environment School/Work Environment	Community Environment Community Resources	Societal Structure
Sociocultural Environment	Sociodemographics Limited English Cultural Identity Response to Discrimination	Social Networks Family/Peer Norms Interpersonal Discrimination	Community Norms Local Structural Discrimination	Societal Norms Societal Structural Discrimination
Health Care System	Insurance Coverage Health Literacy Treatment Preferences	Patient–Clinician Relationship Medical Decision-Making	Availability of Health Services Safety Net Services	Quality of Care Health Care Policies
Health Outcomes	Individual Health	Family/ Organizational Health	Community Health	Population Health



Note. SES = socioeconomic status. Available at: <https://www.nimhd.nih.gov/about/overview/research-framework.html>. Accessed February 19, 2018.

FIGURE 1—The National Institute on Minority Health and Health Disparities Research Framework: 2017



THE FAMILY SYSTEM: INTERGENERATIONAL PATTERNS OF SUBSTANCE USE



PARENTAL SMOKING

- **Parental smoking has been associated with the following among children:**
 - greater adolescent intentions to smoke
 - early onset smoking
 - rapid escalation of smoking
 - long-term persistence of smoking
 - reduced quit attempts
 - reduced probability of cessation.¹⁻⁵
- **Risk factor for adolescent smoking through mechanisms such as...**
 - modeling
 - increased access to tobacco^{3,4,6}
 - genetic predisposition for nicotine dependence.⁷
 - Shared contextual factors (e.g., exposure to poverty, racial stress, racism)

INTERGENERATIONAL TOBACCO USE PATTERNS AMONG RURAL FAMILIES

- **Intergenerational patterns of tobacco use** are key drivers of lower life expectancy and higher cancer and cardiovascular disease morbidity and mortality in rural vs. urban populations.*
- Compared to non-rural youth, rural youth experience more **family-level tobacco use risk factors**: They are more likely to live with caregivers who use tobacco, have ETSes, and be offered tobacco by caregivers.
- They are less likely to receive anti-tobacco socialization from caregivers.
- Rural children with caregivers who use tobacco are in critical need of **selective family-focused interventions** to prevent child tobacco use.
 - This is further supported by research demonstrating that a universal tobacco prevention program (not tailored to youth with parents who smoke) was not effective for rural children whose parents smoked but showed promise for those whose parents did not smoke.
- Yet, while 70% of rural caregivers who use tobacco are willing to participate in family health promotion interventions,¹³ rural families' 1) have inadequate access to the tobacco programming and 2) are rarely represented in family-level prevention research.

* Please email Dr. Clawson for the references for this section of the presentation...there are too many for these slides.

SMOKE-FREE KIDS

- There is only one evidence-based intervention focused on preventing child smoking *among families with caregivers who smoke*, **Smoke-free Kids**, but the effectiveness among rural families is unknown.
- It is a mailed caregiver-child program that addresses barriers faced by caregivers who use tobacco that deter their efforts to prevent offspring tobacco use, including low self-efficacy for preventing child tobacco use and feelings of guilt and hypocrisy.
- It is a low-intensity program (5 printed modules, booster module, telephone support: 1 proactive call from the team and then unlimited caregiver-initiated calls, incentives) focused on increasing caregiver self-efficacy and anti-tobacco socialization (caregiver-child communication about tobacco; home smoking bans; monitoring and rules about child tobacco use; child refusal and media literacy skills).

SMOKE-FREE KIDS

- Despite its effectiveness, Smoke-free Kids has not been widely adopted. This may be because
 - it addresses only cigarette smoking, rather than all tobacco use
 - it uses a printed format that costs more to update and is more difficult to disseminate, relative to digital formats
 - its dissemination relies on caregivers being identified as tobacco users and then provided with intervention materials (caregivers are the intervention deliverers)
 - it may need to be adapted for use in a rural state
 - no studies have addressed optimizing its implementation.
- The Family Tobacco Project pilot study addresses this by using a systematic intervention adaptation process (Intervention Mapping ADAPT) to assess the fit of Smoke-free Kids to rural families and identify needed adaptations to maximize family engagement and intervention effectiveness.



FAMILY TOBACCO PROJECT

FAMILY TOBACCO PROJECT

Mixed methods evaluation of the feasibility and acceptability of an evidence-based tobacco prevention intervention for rural children with caregivers who use tobacco. Pilot project through the Center for Research, Health, and Social Justice. NIMHD (P50MD017319-02).

PROJECT AIMS



- **Central objective:** Identify the feasibility, acceptability, and appropriateness of Smoke-free Kids to rural families and identify needed modifications to maximize rural families' engagement and intervention response.
- **Aim 1 :** Complete a needs assessment and assess the fit of Smoke-free Kids for use with rural families by evaluating the following among rural caregivers who use tobacco and their children (aged 8-10 years old; 22-47 dyads):
 - the feasibility and acceptability of recruitment methods
 - the feasibility, acceptability, and appropriateness of Smoke-free Kids and
 - caregiver perceptions about intervention effects on motivation to quit.
- **Aim 2 :** Synthesize quantitative and qualitative data to identify key adaptations to Smokefree Kids delivery and content to address all tobacco use and be culturally-responsive to rural families.

METHODS/STUDY DESIGN



- **Study Population:** Caregivers who use tobacco, and their 8-10-year-old children, who live in the Arkansas Delta region (Phillips, Chicot, Lee, and Desha counties).
- **Study Design:** The explanatory sequential study design will build upon and integrate quantitative and qualitative data to guide intervention adaptation.
- **Participant Incentives:** Caregivers and children will receive a gift card if they participate in this study.

WHAT ARE WE ASKING FAMILIES TO DO IN THIS STUDY?



- **Step 1: Caregivers complete an online screener to see if they are eligible to participate.**
- **Step 2: Caregiver and child survey completion**
 - Caregivers and children will complete an online survey assessing tobacco exposure, antitobacco socialization, and multilevel factors that influence tobacco use.
 - The survey can also be administered over the phone or during an in-person study visit.
- **Step 3: Caregivers and children get to review the Smoke-free Kids Program!**
 - Dyads will be mailed the Smoke-free Kids program and asked to review it prior to qualitative data collection.
- **Step 4: Caregivers and children will complete in interview or focus group and then complete a brief survey.**
 - Separate focus groups or semi-structured interviews will be conducted with caregivers and children.
 - Questions are related to perceptions about child tobacco use, antitobacco socialization, feedback about the Smoke-free Kids program, and perceptions about successful recruitment methods.
 - The interviews/ focus groups can be done in-person or via Zoom.

FAMILY TOBACCO PROJECT



- **The Family Tobacco Project pilot study will generate pilot data to support the resubmission of a larger-scale research project, “*An Adapted Evidence-Based Tobacco Prevention Intervention for Arkansas Children with Caregivers who Use Tobacco,*”** which is 1 of 4 interrelated projects of the of the Healthy Arkansas Kids (HARK) NHLBI P01 application.
 - The long-term goal of my P01 project is to disrupt intergenerational tobacco use patterns by maximizing the impact, adoption, and implementation of an updated version of Smoke-free Kids that addresses all tobacco use, is available in print and online, and is culturally responsive to rural families.

WE ARE RECRUITING NOW!



- We are recruiting now and are eager to create partnerships with people interested in helping to refer families to our study and/or helping with distributing study flyers.
- We believe in partnerships that benefit both partners and are eager to learn how a partnership might benefit you!
- If you are interested in partnering on this study, please email Dr. Clawson or go to the brief survey connected to this QR code to let us know you are interested in partnering!
- Together we can disrupt intergenerational patterns of tobacco use in Arkansas!



PLEASE EMAIL ME TO GET MORE INFORMATION OR GET FLYERS!

DO YOU USE TOBACCO OR VAPES?

DO YOU HAVE AN 8-10 YEAR OLD CHILD ?



What do you have to do?

You and your child will complete a survey, then review a free copy of a tobacco prevention program, and then participate in a group discussion or interview.

Will I receive compensation?


Families can receive up to \$100 for full participation, which takes about 3 hours.

Why are we doing this?

Your participation will help us learn how to improve a program focused on preventing tobacco use and vaping in children.

If you live in Desha, Phillips, Lee, or Chicot county, find out more by:

 familytobaccoproject@uams.edu

 501-830-1280

Scanning here:



Principal Investigator: Ashley Clawson, Ph.D



WE NEED YOUR HELP!



What are we doing?

We want to learn how to prevent tobacco use and vaping in children.

Why are we doing this?

We want to improve a program focused on preventing tobacco use in children whose caregivers use tobacco.

What do you have to do?

You and your child will complete a survey, review a free copy of a tobacco prevention program, and participate in a group discussion or interview. Participation takes about 3 hours.

Will I receive compensation?

Families can receive up to \$100 for their time, if they complete all study parts.

Who are we looking for?

- Parents (or legal guardians) and their 8-10 year old child
- Parents must currently use tobacco (cigarettes, cigars, snus, smokeless, vapes, etc.)
- Families must live in Desha, Phillips, Lee, or Chicot county

How do I find out more?

Scan this QR code to see if you are eligible:



Want to learn more?

 familytobaccoproject@uams.edu

 501-830-1280

Principal Investigator: Ashley Clawson, Ph.D





WILL IMPLEMENTING HOME BASED INTERVENTIONS WORK FOR ARKANSAS FAMILIES?

PRELIMINARY DATA SURROUNDING HOME SMOKEFREE POLICIES



COUNTY-LEVEL RATES OF HOME/ CAR SMOKING RULES ARE ASSOCIATED WITH COUNTY-LEVEL RATES OF YOUTH SMOKING IN ARKANSAS

Aim:

- This study identifies the associations between county-level youth smoking rates and county-level adult smoking rates (risk factor) and home/car smoking rules (protective factor).

Methods:

- Data on youth lifetime smoking history (dependent variable), home/car smoking rules (independent variable), and student demographics were from the 2021 Arkansas Prevention Needs Assessment (APNA), a school-based survey based on the validated Risk and Protective Framework.
- Valid data were obtained from 55,449 6th, 8th, 10th, and 12th graders across 61 of our 75 counties.
- Data were aggregated to produce county-level estimates; counties with < 50 APNA respondents were excluded.
- County-level adult smoking rates were drawn from 2021 CDC PLACES data (independent variable).
- Regression models identified the associations between county-level rates of student-reported lifetime history of smoking cigarettes and county-level adult smoking rates and county-level rates of student-reported home/car smoking rules; models adjusted for county population and county-level estimates of student mean age, percent female, and percent White.
- Overall models included data from 60 counties; models stratified by rurality included 12 urban counties and 45 rural counties.

RESULTS

Overall Models:

- County-level adult smoking was not significantly related to the county-level percent of students who had smoked.
- Counties with a higher percentage of students reporting that smoking was not allowed in their homes/cars and that they did not know their home/car smoking rules had lower smoking rates (-0.61, $p < .001$ and -0.72, $p < .001$, respectively).

Urban Counties:

- Adult smoking was not significantly related to youth smoking.
- Counties with a higher percentage of students reporting that smoking was allowed anywhere (0.44, $p = .01$) and reporting no smoking rules (0.30, $p = .001$) had higher smoking rates.

Rural Counties:

- Adult smoking was not significantly related to youth smoking.
- Counties with a higher percentage of students reporting that smoking was not allowed anywhere and that they did not know their home/car smoking rules had lower smoking rates (-.49, $p < .001$ and -.66, $p < .001$, respectively).

DISCUSSION

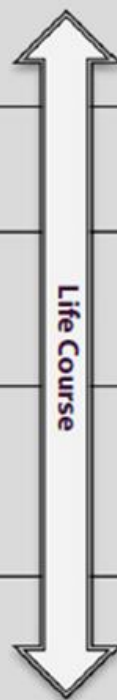
- Home/ car smoking rules are associated with youth smoking rates in rural and urban counties in a state with geographic tobacco disparities.
- Interventions, programs, and policies that support families to create smokefree homes may reduce tobacco exposure.



HOW DO WE REDUCE TOBACCO AND NICOTINE
EXPOSURE ACROSS GENERATIONS...CONTINUED?



Health Disparity Populations: Race/Ethnicity, Low SES, Rural, Sexual/Gender Minority Other Fundamental Characteristics: Sex/Gender, Disability, Geographic Region				
Domains of Influence	Levels of Influence			
	Individual	Interpersonal	Community	Societal
Biological	Biological Vulnerability and Mechanisms	Caregiver–Child Interaction Family Microbiome	Community Illness Exposure Herd Immunity	Sanitation Immunization Pathogen exposure
Behavioral	Health Behaviors Coping Strategies	Family Functioning School/Work Functioning	Community Functioning	Policies and Laws
Physical/Built Environment	Personal Environment	Household Environment School/Work Environment	Community Environment Community Resources	Societal Structure
Sociocultural Environment	Sociodemographics Limited English Cultural Identity Response to Discrimination	Social Networks Family/Peer Norms Interpersonal Discrimination	Community Norms Local Structural Discrimination	Societal Norms Societal Structural Discrimination
Health Care System	Insurance Coverage Health Literacy Treatment Preferences	Patient–Clinician Relationship Medical Decision-Making	Availability of Health Services Safety Net Services	Quality of Care Health Care Policies
Health Outcomes	Individual Health	Family/ Organizational Health	Community Health	Population Health



Note. SES = socioeconomic status. Available at: <https://www.nimhd.nih.gov/about/overview/research-framework.html>. Accessed February 19, 2018.

FIGURE 1—The National Institute on Minority Health and Health Disparities Research Framework: 2017



POLICY



POLICY

Tobacco Prevention and Cessation Funding	Smokefree Air	Tobacco Taxes	Access to Cessation Services	Flavored Tobacco Products
F	C	F	C	F

The American Lung Association calls for the following actions to be taken by Arkansas' elected officials to reduce tobacco use and exposure to secondhand smoke:

1. Ensure continued access to tobacco use treatment services for all those who want to quit smoking, including comprehensive coverage for such services under Medicaid;
2. Allocate state funding of \$14.6 million for the Arkansas Tobacco Prevention and Cessation Program and ensure that funding is spent according to CDC's Best Practices for Comprehensive Tobacco Control Programs; and
3. Repeal state preemption of local tobacco control authority.

Arkansas Information

Learn more about your state specific legislation regarding efforts toward effective Tobacco Control.

[HIGHLIGHTS](#)

[LAWS & POLICIES](#)

[HISTORICAL DATA](#)



Under current federal law, flavored smokeless tobacco, cigars, hookah and most e-cigarette products are allowed on the market.

ACTION NEEDED: FLAVORED TOBACCO USE AMONG YOUTH AND YOUNG ADULTS

Restricting the marketing of flavors, including menthol, that appeal to youth and young adults would have significant public health benefit. Given their well-documented appeal to youth, all flavors, including menthol and concept flavors, should be eliminated from all tobacco products, with the limited exception described below.

- The FDA must issue product standards eliminating flavors from all tobacco products. A narrow exception may apply to proven harm-minimized products. The burden should always be on manufacturers to show that their products would not appeal to youth before going to market. Given what we now know about how dramatically flavors influence youth tobacco use, the burden should be high. We support a permanent ban on flavored tobacco unless a manufacturer can demonstrate three things to the FDA:
 1. that a particular flavor helps current tobacco users to switch completely to a substantially less hazardous product,
 2. it will not lead non-tobacco users, such as youth, to start, and
 3. it does not increase the risk of harm from using the product.
- Until a federal ban takes effect, state and local entities should enact policies prohibiting all flavors, including menthol, mint and wintergreen flavors, from all tobacco products.
- The marketing of all flavored tobacco products should be restricted so that it does not target youth.

Civil rights, medical groups sue FDA over ‘almost unconscionable’ delay in ban on menthol tobacco products



By [Jen Christensen](#), CNN

🕒 6 minute read · Updated 9:34 PM EDT, Tue April 2, 2024



“This is profits over people, and we are just really asking on behalf of the national associations that people are put first,” Dr. Yolanda Lawson, president of the National Medical Association, the nation’s oldest group representing Black physicians, said at a news conference Tuesday.



The other plaintiffs are the African American Tobacco Control Leadership Council and Action on Smoking and Health.



SCHOOL-BASED INTERVENTIONS



STANFORD MEDICINE TOBACCO PREVENTION TOOLKIT

For High Schools (Click here to view lessons)



Lesson 1 >



Lesson 2 >



Lesson 3 >



Lesson 4 >



Lesson 5 >



Lesson 6 >

All of our lessons are mapped to the **California** and **National Common Core State Standards, Health Education Content Standards**, and the **National Health Education Standards**. Please see the links within each Lesson to see the Standards associated with each lesson.



Youth Vaping Prevention & Resources to Quit

To educate America's students about the health dangers of e-cigarette use and reverse the pervasive youth vaping public health crisis, Truth Initiative and Kaiser Permanente in collaboration with the American Heart Association, have launched a national youth vaping prevention curriculum called *Vaping: Know the truth*. This free digital learning experience is part of Truth Initiative's nationally recognized **truth** campaign and made available to schools by leading social impact education innovator, EVERFI.

In addition to encouraging students to live vape-free lives, this self-led interactive-curriculum offers resources to help young people who are currently using e-cigarettes to quit through **truth**'s first-of-its-kind text message youth quit vaping program called **This is Quitting** already helping over 700,000 youth and young adults on their journeys to quit.

RECOMMENDED
GRADE LEVELS:

8-12

TOTAL TIME

30-40

MINUTES

COST:

\$0

VAPING: KNOW THE TRUTH is a new course created by Truth Initiative and Kaiser Permanente, in collaboration with the American Heart Association, on vaping prevention and resources to quit made available at no cost to students and teachers.

CATCH MY BREATH



Proven Effective

CATCH My Breath is an evidence-based youth vaping prevention program for grades 5-12 that has been proven to substantially reduce students' likelihood of vaping. The vape education program's effectiveness was published in a peer-reviewed journal and the program is listed in [SAMHSA's Evidence-Based Resource Guide Series](#).

[Learn More](#) ▶

Robust Program & Resources

Developed by The University of Texas Health Science Center at Houston (UTHealth) School of Public Health, the vape education program includes grade-level specific and health education standards-aligned classroom curriculum alongside a variety of engaging supplemental materials including STEM/Humanities/PE extensions, self-paced modules, and virtual field trips.



CATCH MY BREATH VAPING PREVENTION CURRICULUM

(FREE TO U.S. SCHOOLS)

– Includes –

Pre-Recorded Training ⓘ

Free Program Supplements

ACCESS →

Access includes **English** & **Spanish** versions of the core curriculum for grades 5-12.

OPTIONAL CATCH MY BREATH ADD-ONS

(SINGLE SIGN ON AVAILABLE
FOR DISTRICTS)

Video Lessons (\$49 / school)
[Purchase](#) ▶

Live Implementation
Training ⓘ (\$99 / seat)
[Purchase](#) ▶

Live Train-the-Trainer
Training ⓘ (\$425 / seat)
[Purchase](#) ▶

Private Training
[Inquire by email to](#)
catchmybreath@catch.org ▶

<https://catch.org/program/vaping-prevention/>

PREVENTION WORK THROUGH ARKANSAS DEPARTMENT OF HEALTH

Project Prevent is the statewide youth tobacco prevention coalition in Arkansas. Its members consist of local Chapters across the state that choose to live their lives free from tobacco and nicotine, and encourage others to do the same.

Coral's Reef is a vaping prevention campaign that includes videos and activities. It was specifically created to be appealing and understandable to younger (1st grade) and older children.



<https://projectpreventar.org/>





CLINICAL INTERVENTIONS



HELP CAREGIVERS AND KIDS TO QUIT USING TOBACCO

- Meta-analytic shows that cessations interventions focused on parents who smoke are efficacious.¹
- Provider advice to adolescent and adult patients to quit improves quit rates.²
 - Ask, Advise, Act (or Refer)
 - Ask all patients if they use tobacco
 - Advise tobacco users to quit through personalized messages
 - Refer tobacco users to cessation services
- Clinical practice resources
 - Smoking Cessation: A Report of the Surgeon General 2020
 - Clinical practice guidelines and other clinical resources
 - <https://www.cdc.gov/tobacco/patient-care/clinical-tools/index.html>

¹ Scheffers-Van Schayck et al., 2021; ² Treating Tobacco Use and Dependence Clinical Practice Guidelines, 2008.

HELP CAREGIVERS TO QUIT USING TOBACCO

- **Clinical Effort Against Secondhand Smoke Exposure (CEASE)**
 - Research from Dr. Winicoff's team shows that parents want help with quitting smoking from their children's doctor but often do not get it.
 - The CEASE training and implementation materials have been designed to help clinicians and staff in child healthcare settings to implement family-centered tobacco control strategies.
- **The three simple steps of CEASE:**
 - **1. Ask**

Does your child live with anyone who uses tobacco?
 - **2. Assist**

Your child's doctor or nurse can help you quit tobacco and help you have a tobacco-free home and car.
 - **3. Refer**

Call 1-800-QUIT-NOW or sign up with [Smokefree TXT](#).
- <https://www.massgeneral.org/children/cease-tobacco/resources>

CEASE

Training

The CEASE training and implementation materials have been designed to help clinicians and staff in child healthcare settings to implement family-centered tobacco control strategies.

- [CEASE Training Video](#)
- [CEASE Training Manual](#): The training manual contains information and instructions on how to use the three easy steps of CEASE: Ask, Assist, Refer.
- [CEASE Implementation Guide](#): The Implementation Guides focuses on four key areas that will help child healthcare practices implement the CEASE intervention and guides practices through creating a team to address family tobacco use and exposure.
- [CEASE Action Sheet \(front\)](#): The CEASE Action Sheet (CAS) is the core of the CEASE intervention. It helps identify and document families with tobacco use and exposure issues and learn and document what cessation assistance was provided. The CAS also contains information about billing codes for tobacco assistance delivery and tear-off pre-printed prescriptions for nicotine replacement therapy.

Email us to customize materials >

ARKANSAS DEPARTMENT OF HEALTH PROGRAMS

■ Be Well Arkansas

- See right
- Educational materials for healthcare provider offices, schools, community organizations, etc.

How does Be Well help Arkansans?

- Counseling and resources for quitting tobacco and nicotine products
- Wellness counseling to help manage diabetes
- Wellness counseling to help manage high blood pressure

What does Be Well provide?

- Telephone counseling for interested callers
- In-person counseling at select locations for Arkansans
- Referrals to resources in your area
- Nicotine Replacement Therapy (NRT) for adult Arkansans
- Online resources available to help all Arkansans, including online chat, texting programs, and mobile apps
- For more information on the local services Be Well can link patients to, [click here](#).

How to refer patients:

- Use the Be Well fax form which can be downloaded using the button below
- Call 833-283-WELL to connect patients to the Be Well Call Center. If counselors are not available, leave the patient's contact information and they will receive a callback within one business day. The number 1-800-QUIT-NOW still works and will route callers to the Be Well Call Center.

Ready to
QUIT TOBACCO?

Be Well Arkansas can help.

WHAT HAPPENS AFTER YOU QUIT USING TOBACCO?

WITHIN 20 MINUTES heart rate and blood pressure drop.

WITHIN 12 HOURS the carbon monoxide in your blood drops and your oxygen level increases.

WITHIN 1 to 9 MONTHS you will cough less and breathe easier.

AFTER 1 YEAR your risk of heart disease is cut in half.

AFTER 5 YEARS the risk of stroke is the same as someone who does not smoke.

AFTER 10 YEARS risk of death from lung cancer is cut in half and risk of cancer in the kidney, pancreas, and other areas decrease.

833-283-WELL • BEWELLARKANSAS.ORG

ARKANSAS DEPARTMENT OF HEALTH PROGRAMS

- Be Well Baby
 - There are no age, income or insurance requirements for any participants. This program is free to all users.
 - Participants that enroll can earn up to \$250 in diaper vouchers that can be redeemed at Walmart stores and Walmart.com.
 - <https://www.bewellarkansas.org/be-well-baby/>

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smokefree.gov
[smokefreevet](https://smokefreevet.com)
[smokefreewomen](https://smokefreewomen.com)
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[QUIT SMOKING](#)
[CHALLENGES WHEN QUITTING](#)
[QUIT VAPING](#)
[HELP OTHERS QUIT](#)

[I Want to Quit](#)
[My Quit Day](#)
[I Recently Quit](#)
[Staying Quit](#)

Tools & Tips
 Learn about different tools to help you quit and how to use them.

- Build Your Quit Plan
- Smokefree Texting Programs
- Using Nicotine Replacement Therapy
- Smokefree Social Media
- Smokefree Apps

[HTTPS://SMOKEFREE.GOV/](https://smokefree.gov/)

[healthychildren.org](https://www.healthychildren.org)
 Powered by pediatricians. Trusted by parents.
From the American Academy of Pediatrics

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Health Issues

HEALTH ISSUES


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Conditions

- Abdominal
- ADHD
- Allergies & Asthma
- Autism
- Cancer
- Chest & Lungs
- Chronic Conditions
- Cleft & Craniofacial
- COVID-19
- Developmental Disabilities
- Ear, Nose & Throat
- Emotional Problems

How to Quit: When the Smoker is You

It can be very hard to quit using tobacco products. Knowing that it will help improve the health of your children may help give you more motivation to quit and stay free from tobacco. There are many options out there to assist you in your quit efforts.



Note: Though the information below talks mostly about smoking, the information can be helpful for users of other tobacco products as well.

[WWW.HEALTHYCHILDREN.ORG](https://www.healthychildren.org)

RESOURCES FOR CAREGIVERS ABOUT TOBACCO CESSATION

HELP CAREGIVERS TO REDUCE CHILD EXPOSURE AND RISK FOR TOBACCO USE INITIATION

- Teach caregivers about the importance of anti-tobacco socialization, which includes:
 - Creating smoke and vapor environments
 - Restricting the child's access to tobacco and nicotine products
 - Creating clear expectations about tobacco and nicotine use among youth
 - Engaging in communication with your child about tobacco
 - Monitoring child tobacco use
 - Teaching children about refusal skills
 - Teaching media literacy skills



FAMILY
TOBACCO
PROJECT



QUESTIONS?

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