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Eliminating Tobacco-Related Disease and Death: Addressing Disparities

Your Guide to the Surgeon General's Report

Note From U.S. Surgeon General Dr. Vivek Murthy

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U.S. Surgeon General

As the Nation's Doctor, I believe all Americans deserve to live a healthy life, free from commercial tobacco-related disease, disability, and premature death. Commercial tobacco use and exposure to secondhand tobacco smoke are the leading preventable cause of disease and death in the United States (U.S.). The good news is we have made remarkable progress reducing tobacco use in the U.S. over the last 60 years. But that progress has not been the same across all population groups. Across the country, income, race and ethnicity, sexual orientation and gender identity, level of education, geography, and mental health play a significant role in determining who uses tobacco and who suffers from its harmful health consequences.

It doesn't have to be this way. That's why I am releasing a new Surgeon General's Report, *Eliminating Tobacco-Related Disease and Death: Addressing Disparities*. The new report includes updated scientific evidence about commercial tobacco-related health disparities. The report also offers a bold vision and a call to action for all sectors of society for a tobacco-free future, for everyone, once and for all.

We must address the multitude of social and environmental factors and tobacco product industry factors that drive tobacco-related disparities. We must also implement strategies proven to reduce tobacco use and exposure to secondhand tobacco smoke. These evidence-based strategies include tobacco product price increases, smokefree air policies, hard-hitting media campaigns, and equitable access to smoking cessation resources.

The time is now to accelerate a whole-of-society effort to reach the tobacco endgame—a world in which zero lives are harmed by or lost to tobacco. By driving down the appeal, availability, and addictiveness of tobacco products, we can make this a reality. Working together, we can advance tobacco-related health equity.

To read the full report and its related materials, go to **surgeongeneral.gov**.

The Surgeon General is the Nation's Doctor. As the Nation's Doctor, the Surgeon General provides Americans with the best scientific information to help people improve their health and well-being. The Surgeon General releases comprehensive scientific reports on specific health issues, such as the new report on tobacco-related health disparities. The new report, the 35th on tobacco, is the latest in the U.S. Department of Health and Human Services' (HHS) longstanding tradition of tobacco prevention and control efforts.

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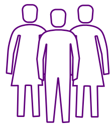
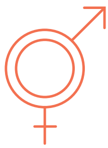
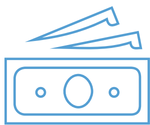
Tobacco-Related Disparities Are a Persistent but Solvable Problem

Smoking is the leading cause of preventable disease, disability, and death in the United States (U.S.). The good news is the U.S. has made progress in reducing tobacco use in the overall population. Cigarette smoking has declined by more than 70% since 1965. But progress in the form of improvements in tobacco-related policies, regulations, programs, research, clinical care, and other areas has not resulted in the same outcomes across all U.S. population groups. As a result, some groups continue to experience tobacco-related health disparities.

Disparities in commercial tobacco use exist by:


race and ethnicity


sexual orientation and gender identity


income and education level

occupation

geography

mental health condition

The report recognizes that tobacco-related health disparities are a social injustice, in addition to an economic and health burden. These disparities are rooted in the complex history of commercial tobacco—how it has been grown and sold in the U.S. The commercialization of tobacco has led to generational social, political, and economic disadvantages for some population groups, including Black and Indigenous people. These groups have also faced decades of social injustices, including racism, discrimination, and targeting by the commercial tobacco industry. This history is important to understanding why inequities exist, without blaming communities for their present-day experiences of disparities.

Commercial Tobacco

Commercial tobacco is manufactured and sold for recreational use. It includes cigarettes, e-cigarettes (vapes), smokeless tobacco, pipe tobacco, cigars, hookahs, and other products.

Commercial tobacco products are the most common form of tobacco used in the U.S. The use of commercial tobacco products is the nation's leading cause of preventable disease and death.

The term *tobacco* used in the Surgeon General's Report and this Consumer Guide refers to commercial tobacco products. It does not refer to tobacco used by some American Indian communities for ceremonial or sacred purposes.

The report outlines additional factors that drive tobacco-related health disparities. These include:

- Social, structural, and commercial determinants of health,[1] such as poverty and inequitable economic and social conditions;
- The design and aggressive marketing of flavored tobacco products (including menthol cigarettes and flavored cigars) by the tobacco industry;
- Strategies by the tobacco industry to keep tobacco product prices low, including coupons and discounts;
- Geographic gaps or differences in protections provided by tobacco prevention and control strategies, such as smokefree air policies;
- Preemptive laws[2] that block communities from taking action to protect their community members' health, such as restrictions on the sale of flavored tobacco products; and
- Financial and other obstacles to get treatments proven to help people quit smoking.

[1] Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age.

[2] Preemption occurs when a higher level of government blocks or overrides the action of a lower level of government. For example, some states preempt, or block, local communities from passing local laws that are more stringent than or differ from a state's tobacco control policies related to retail licensing, smokefree policies, and youth access to tobacco products.

The report examines tobacco prevention and control strategies that have the potential to reduce tobacco-related health disparities. Strategies include:

- Increasing tobacco product prices;
- Implementing smokefree air policies;
- Reducing nicotine levels in tobacco products;
- Eliminating flavored tobacco products;
- Regulating the location of tobacco retailers;
- Raising awareness of the harms and health risks of tobacco use through media campaigns; and
- Increasing access to evidence-based quitting resources, such as quitlines.

These strategies have not been implemented equitably (for everyone, everywhere, and to the extent needed). This has left some groups less protected by policies or with less access to resources to help them quit using tobacco products.

The report concludes by laying out a tobacco "endgame" to finally put an end to tobacco-related disease and death—for everyone. The "endgame" focuses on strategies to eliminate the use of tobacco products and to remove obstacles to tobacco-related health equity. Tobacco-related health equity means having fair and just opportunities and conditions for all people to live a healthy life, free from commercial tobacco-related disease and death.

The pursuit of tobacco-related health equity requires a whole-of-society approach. This approach involves government, healthcare, public health, and research organizations; funding entities; schools and academic institutions; businesses; and members of the public. Everyone can and should play a role in advancing tobacco-related health equity.

Tobacco-Related Disparities Today

Disparities in tobacco product use and secondhand smoke exposure persist by race and ethnicity, income and education, sexual orientation and gender identity, occupation, geography, and behavioral health status.

Disparities in Tobacco Use

The report highlights several key findings about disparities in tobacco use:

Cigarette smoking is highest among American Indian and Alaska Native adults and youth.

In the U.S., smoking is also higher among:

- People with lower incomes compared to people with higher incomes.
- People with lower levels of education compared to people with higher levels of education.
- People who identify as gay, lesbian, or bisexual compared to people who identify as heterosexual.
- People living with a mental health condition or substance use disorder compared to people living without a mental health condition or substance use disorder.
- People who work in manual labor and service jobs compared to people with other jobs. Manual labor and service jobs can include lodging and food service, construction, and mining jobs.
- People living in the South and Midwest compared to people living in other regions.
- People living in rural areas compared to people living in urban areas.

Menthol cigarette use is higher among:

- Black and Native Hawaiian and other Pacific Islander people compared to White or Hispanic people who smoke.
- People who identify as lesbian, gay, or bisexual compared to people who identify as heterosexual.
- Women compared to men.
- People with lower incomes compared to people with higher incomes.
- Younger adults compared to older adults.

Disparities in Quitting Tobacco Use

Disparities in quitting behaviors, such as attempts to quit smoking, exist among certain population groups. For example:

- Black adults who smoke are more likely than White adults to try to quit. But Black adults are less likely to successfully quit than White adults.
- Lesbian, gay, or bisexual adults who smoke are more likely than heterosexual adults to try to quit and have similar quitting success as heterosexual adults.

Differences in quitting success may be due to, in part, whether a person gets advice to quit from a healthcare provider or uses proven quitting treatments. The number of people who receive advice to quit from a healthcare provider has increased over time, but gaps remain. Cost and lack of insurance coverage for quitting treatments also impact access to and use of treatments.

For example:

- Hispanic adults are less likely to receive advice from a healthcare provider or to use proven quitting treatments than White adults.
- Adults who identify as lesbian, gay, or bisexual are less likely to use proven quitting treatments than heterosexual adults.
- Adults without health insurance are less likely to receive advice from a healthcare provider or to use proven quitting treatments than adults with private insurance.

Differences in quitting success may also be driven, in part, by differences in access to healthcare services and resources and differences in tobacco use patterns. Additionally, menthol cigarettes can make quitting more difficult.

Disparities in Exposure to Secondhand Smoke

Previous Surgeon General's Reports have concluded that there is no safe level of secondhand tobacco smoke. Yet millions of Americans are exposed to secondhand smoke in their homes, vehicles, workplaces, and other public places. Smokefree policies reduce exposure to secondhand smoke. Despite progress in the adoption of smokefree policies, these policies have not been implemented everywhere. This has left some population groups less protected than others from the harms of tobacco smoke.

Secondhand smoke exposure is higher among:

- **Youth** compared to adults.
- **Black people** compared to other racial or ethnic groups.
- **Families with lower incomes** compared to families with higher incomes.
- **Adults with lower levels of education** compared to adults with higher levels of education.

Disparities in secondhand exposure by age, race, income, and education have increased since 2000.

Disparities in Smoking-Related Diseases and Death

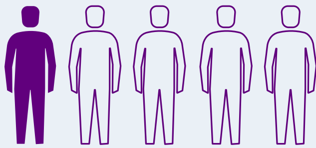
As documented in the report, cigarette smoking remains a major cause of disease and death—including cancer, heart disease, and chronic obstructive pulmonary disease (COPD)—for all racial and ethnic groups.

Each year in the U.S., more than

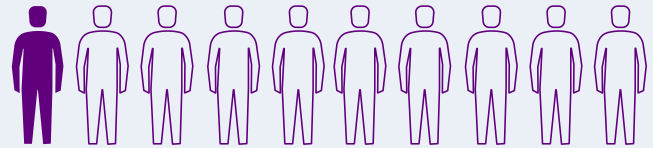
470,000

adults are estimated to die from cigarette smoking.

Smoking accounts for about one in five deaths among Black people and among White people.



Smoking accounts for 1 in 10 deaths among Hispanic or Latino people.



Lung cancer incidence and death rates are highest among Black men. Among women, lung cancer incidence rates are highest among American Indian and Alaska Native women, while death rates are highest among White women. Cigarette smoking is the primary cause of lung cancer.

The prevalence of heart disease is highest among Black men and among White men. Among women, the prevalence is highest among Black women. Cigarette smoking is a major cause of heart disease.

Chronic obstructive pulmonary disease (COPD) is highest among American Indian and Alaska Native adults. Cigarette smoking is a primary cause of COPD and the primary risk factor for the worsening of COPD.

In the U.S., more than

19,000

people die from exposure to secondhand smoke each year.

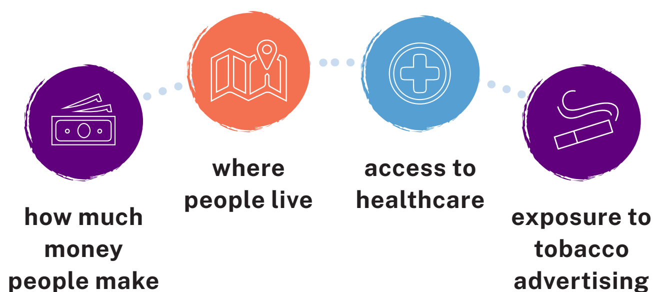
The actual number of deaths may be even higher. This is because deaths due to stroke caused by secondhand smoke exposure have not been estimated. The good news is, since 2006, deaths from secondhand smoke exposure in the U.S. have decreased by more than half. But these decreases have been slower among Black, Hispanic or Latino, and other racial and ethnic groups compared to White people.

Factors That Influence Tobacco-Related Disparities

Multiple factors influence tobacco-related health disparities, including social and environmental factors. The tobacco industry also plays a role in driving tobacco-related disparities. The industry targets their advertising and marketing to specific population groups. Together, these factors influence tobacco use and related disparities.

Multiple Factors Influence Tobacco Use

Whether someone uses tobacco products is not just an individual choice. Tobacco use is heavily influenced by social determinants of health. Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age. Examples of social determinants of health include:



The report concludes that poverty, racism, and discrimination are important and longstanding social determinants of health. For decades, these determinants have created disadvantages for certain population groups. This has helped drive tobacco-related health disparities.

The tobacco industry also plays a key role influencing individual tobacco use. Most people start using tobacco products when they are young. Flavored tobacco products mask the harshness of tobacco and are especially appealing to young people. Such products promote the start of and regular use of tobacco among young people. Further, menthol tobacco products are more addictive and can be harder to quit. The tobacco industry markets menthol and other flavored tobacco products to young people and other population groups.

Social Influences

The report highlights several key findings about the social influences of tobacco use:

- Family members and friends influence youth tobacco use. Youth are more likely to smoke if their friends smoke. This is especially true for White, Black, and Hispanic or Latino American youth. Studies have shown an association between youth tobacco use and connectedness to parents and exposure to parental smoking.
- Acculturation is the process by which people, such as immigrants, adapt to the cultural beliefs, social norms, and practices of a new community. Research suggests that adults tend to adopt the smoking behavior of their new community. For example, as Asian American and Hispanic or Latino immigrants acculturate to life in the U.S., women are more likely to smoke while men are less likely to smoke.
- Experiences with discrimination can lead to stress and anxiety. People under stress may turn to smoking or tobacco use because they think it helps them cope. There is a strong link between discrimination and tobacco product use among Black and LGBTQI+ people.

Flavors in Tobacco Products

Flavors used in tobacco products and the targeted marketing of these products help drive tobacco-related disparities. All commercial tobacco products contain natural or synthetic (artificial or man-made) flavors and other additives. Common flavors include sweeteners and cooling agents, such as menthol. The tobacco industry adds flavors to its products to help increase their appeal.

Research has found that individual preferences for certain flavors and tobacco products are not random. Rather, flavor preferences are influenced by chemosensory (taste and smell) and physiological (cooling and burning sensations) factors. Research also suggests that genes may play a limited role in influencing preferences for certain flavors, such as menthol.

The tobacco industry has used information about flavor preferences to target their marketing to certain population groups. This contributes to tobacco-related disparities.

Environmental Influences

Homes, schools, work environments, and healthcare settings can influence tobacco use, and are known as environmental influences. The report highlights several key findings about these influences:

The home is a main source of exposure to secondhand smoke.

Smokefree air policies that prohibit smoking indoors can protect people from secondhand smoke. But these policies are not implemented equitably. Research shows that a lack of smokefree protections for many people living in multi-unit housing contribute to disparities in exposure to secondhand smoke.

Youth spend a significant amount of time in schools.

Research shows that students who participate in extracurricular activities or feel a sense of belonging at school are less likely to start smoking. However, compared to White students, Black and Hispanic or Latino students report less connectedness to their school. This may increase the likelihood that these students will start using tobacco products.

Stress and exposure to hazards in the workplace.

Stress and exposure to hazards in the workplace are linked to smoking and difficulty in quitting smoking. Smokefree policies in the workplace can reduce the use of tobacco products and encourage quitting. But not everyone is protected by these policies at work.

Disparities in access to and use of proven quitting treatments.

Disparities in access to and use of proven quitting treatments, such as Food and Drug Administration (FDA) approved medication and counseling, exist by race and ethnicity, income, and health insurance status.

Over time, more people overall have received advice to quit smoking from a healthcare provider. But disparities in receiving advice to quit persist among people in certain racial, ethnic, and lower socioeconomic status groups.

Tobacco Industry Influences on Disparities

The tobacco industry is a driving force behind tobacco use and tobacco-related health disparities. For decades, the industry has targeted their products and marketing to specific population groups. Tobacco companies also work to oppose evidence-based tobacco prevention and control efforts.

The report highlights the marketing and advertising strategies tobacco companies use to target some population groups and influence tobacco use:

- Tobacco advertising is more common in neighborhoods with higher percentages of Black residents and residents with lower incomes. This includes advertising for menthol cigarettes, cigars, and cigarillos.
- Tobacco products are cheaper in neighborhoods with higher percentages of residents from diverse racial and ethnic groups, youth, and people with lower incomes.
- Price promotions, such as coupons, are more often used by members of the LGBTQI+ community and people with lower socioeconomic status. People may be more likely to start using tobacco and less likely to quit if they receive a coupon.

The tobacco industry uses multiple tactics to market its products. Federal regulations prohibit tobacco companies from advertising cigarettes and smokeless tobacco products (but not other tobacco products) on television and radio. Despite these regulations, the tobacco industry has found ways to market its products to consumers. This includes marketing inside and around stores and online.

The tobacco industry continues to use tactics that undermine tobacco prevention and control efforts. Tactics include:

- Engaging in legal actions to contest laws and policies that seek to regulate tobacco products at local, state, and federal levels;
- Offering price discounts and coupons to maintain sales in response to tobacco tax increases; and
- Sponsoring organizations and events in certain communities to enhance their image, normalize the use of tobacco, and develop brand loyalty.

The Impact of Tobacco Advertising on Tobacco-Related Health Disparities

In 2022, the tobacco industry spent

$8 Billion to market cigarettes and **$572.7 Million** to market smokeless tobacco products

Exposure to tobacco advertising increases the chance that someone will try smoking for the first time or progress to the regular use of tobacco products.

The tobacco industry has a long history of targeting its advertising and promotions to certain population groups.

The targeted advertising of tobacco products, including menthol cigarettes and other flavored products, contributes to persistent disparities in their use. This is one example of a social injustice.

Strategies to Address Tobacco-Related Disparities

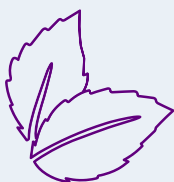
Previous Surgeon General's Reports have found that core tobacco prevention and control strategies can reduce tobacco use, reduce secondhand smoke exposure, and increase cessation in the population overall. However, these strategies have not been implemented equitably (for everyone, everywhere, and to the extent needed). The report highlights strategies that can, or have the potential to, reduce tobacco-related health disparities. Further, the report underscores that more research is needed to understand the full impact of these strategies on disparities. What is clear is that a comprehensive approach is needed to maximize public health impact. The approach must combine broad, population-level strategies with interventions focused on priority population groups.

Government Policies

Tobacco control policies across all levels of government—federal, tribal, territorial, state, and local—can, or have the potential to, reduce tobacco-related health disparities. These policies include:

Comprehensive smokefree policies for all indoor areas of public places, workplaces, and multi-unit housing

Reduce the amount of nicotine allowed in cigarettes and other tobacco products so that they are less addictive or not addictive



Restrictions on the sale of flavored tobacco products, including menthol cigarettes and flavored cigars

Regulation of the location and number of stores that sell tobacco

Tobacco product price increases

State and local governments are often at the forefront of advancing evidence-based tobacco control strategies. However, the tobacco industry uses preemption strategies to block or override state or local tobacco control policies. Preemption limits the ability of local governments and communities to protect the health and safety of their members. This can create significant obstacles to implementing efforts to address tobacco-related health disparities.

Federal, State, and Local Actions to Address Tobacco-Related Health Disparities

At the federal level, steps are underway that are expected to address tobacco-related health disparities. The FDA has the authority to establish product standards that limit what kinds of products can be manufactured. For example:

- In April 2022, the FDA proposed two product standards: one to prohibit menthol as a characterizing flavor in cigarettes and another to prohibit all characterizing flavors in cigars. Research shows that these proposed rules would prevent the use of tobacco products, increase quitting, reduce disparities in tobacco use, and save lives.
- In June 2022, FDA announced its plan to establish a maximum nicotine level to reduce the addictiveness in cigarettes and other combusted tobacco products through a product standard. Reducing nicotine levels would prevent an estimated 33 million people from starting to smoke. It is estimated it would reduce adult smoking to a low of 1.4% and save more than *8 million* lives.

Although tobacco control efforts have stalled in many places, some states and localities have moved forward with efforts to address tobacco-related health disparities. For example:

In October 2021, the Navajo Nation Council passed the Niłch' éí Bee Ííńá (Air is Life) Act of 2021. The Air is Life Act bans commercial tobacco use in all public areas in the Navajo Nation, including casinos. The act is the first comprehensive ban on the use of commercial tobacco products on American Indian tribal lands.

As of 2024, two states (California and Massachusetts) and more than 200 communities prohibit the sale of flavored tobacco products, including menthol cigarettes. This helps protect about one-sixth of the population.

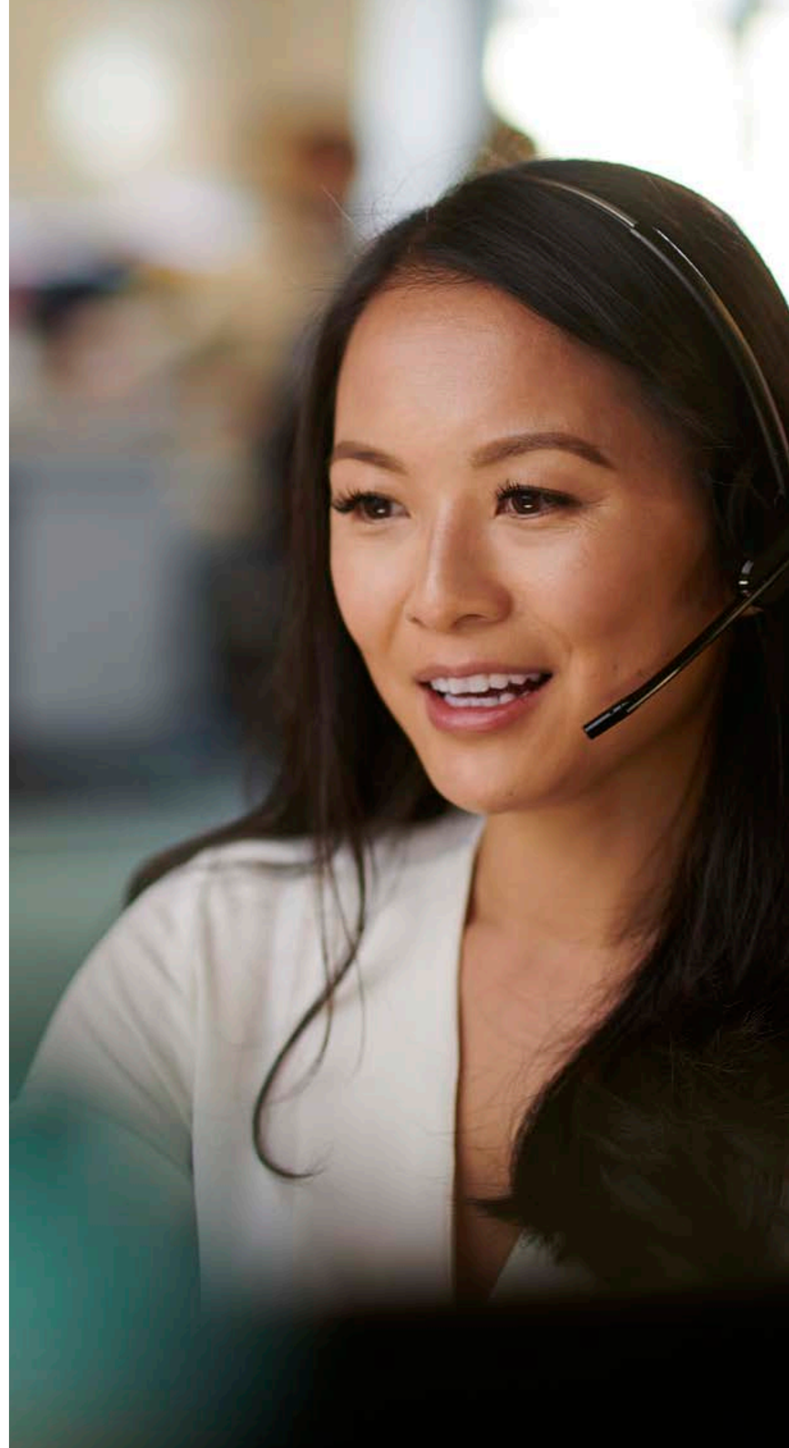
Between 2008 and 2022, the number of states with comprehensive coverage of tobacco cessation treatments for people enrolled in Medicaid increased from 6 to 19.

Community-Level Efforts and Programs

Community-level programs such as tobacco quitlines and mass media campaigns can reduce tobacco use in the population overall. Research shows these strategies also have the potential to reduce disparities.

Quitlines can increase access to quitting treatments among population groups affected by tobacco-related disparities. This is particularly true when quitline promotions and services are designed and delivered with attention to the specific needs of these groups. Researchers are exploring strategies to expand the reach and use of quitlines by diverse population groups. Strategies include using digital technologies and increasing healthcare provider referrals to quitlines.

Mass media campaigns can prevent the start of tobacco use, increase calls to quitlines, increase quitting smoking, and reduce tobacco use. The evidence presented in the report found that mass media campaigns can increase quit attempts among many population groups impacted by tobacco-related disparities. This is especially true when campaigns are designed and delivered with attention to the specific needs of these groups. It is not yet clear if campaigns designed for a specific group are more or less effective at decreasing tobacco-related disparities than those designed for the general population.



Quitlines are a free, convenient, and confidential resource that help people quit using tobacco products. They are available in all 50 U.S. states, the District of Columbia, and U.S. territories by calling **1-800-QUIT-NOW.** Quitlines are also available in several different languages:

- 1-855-DÉJELO-YA (Español)
- 1-800-556-5564 (한국어)
- 1-800-838-8917 (中文)
- 1-800-778-8440 (Tiếng Việt)

Organizational-Level Programs and Interventions

Opportunities exist to address tobacco-related health disparities in the environments where people learn, seek healthcare, and work. Most people start using tobacco products when they are young. School-based tobacco prevention programs provide opportunities for reaching youth and young adults at a time when they are trying or experimenting with tobacco products. Tobacco-free campus policies that prohibit the use of tobacco products on school and college campuses are one promising strategy. Tobacco-free college campus policies are just one tool to address tobacco use among young adults. Other policies are also important for reaching young adults, including those who do not attend college.

Most adults who smoke see a healthcare provider at least once a year. Healthcare settings offer another important way to reach people with treatment to help them quit using tobacco products. Treatment can be delivered in a variety of healthcare settings and by a variety of providers. However, some population groups impacted by tobacco-related disparities may not have the same access to healthcare as other groups. Increasing access and removing obstacles to receiving and using treatments are key to addressing tobacco-related disparities.

Finally, the report highlights opportunities to address disparities in the workplace. Strategies include:

- Increasing access to quitting services;
- Expanding smokefree and tobacco-free policies to cover all workplaces; and
- Removing obstacles to treatment services that help people quit tobacco use.

Interpersonal Interventions

Social factors influence individual tobacco use. These factors include exposure to tobacco use in the home, tobacco use by family and friends, and cultural norms and beliefs. Interventions to address these social influences have the potential to reduce tobacco-related health disparities. For example, interventions that increase adoption of smokefree home and car rules can reach groups that experience tobacco-related disparities.

Individual Interventions

Individual-level interventions to help people stop using tobacco products are an important part of comprehensive efforts to reduce tobacco use. Treatments like medications and counseling help adults quit smoking. However, there is a need to consider the unique needs of specific populations. Cultural tailoring of quitting interventions is promising for increasing quit readiness and attempts among Black or African American adults, though it may not increase successful quitting in this group. Tailored interventions also show promise for increasing successful quitting among Asian American adults. Pairing incentives with treatment may increase successful quitting among adults with lower socioeconomic status.

Address Social Determinants of Health

To address disparities, it is crucial to ensure people have opportunities to be tobacco-free across the lifespan. This involves:

- Eliminating social and structural obstacles to living a tobacco-free life and being free from exposure to secondhand smoke;
- Increasing availability of, access to, and promotion of quitting services; and
- Addressing social determinants of health including transportation, food security, housing security, and financial obstacles.

Advancing Tobacco-Related Health Equity

It's time we put an end to tobacco-related health disparities and advance tobacco-related health equity. This means advancing opportunities and conditions for all people to live a healthy, tobacco-free life.

We've made great progress reducing tobacco use in the U.S. However, disparities in the use of commercial tobacco products, exposure to secondhand smoke, and some tobacco-related health outcomes persist among certain groups. These disparities are driven by multiple factors. Examples include discrimination, racism, poverty, and targeted marketing by the tobacco industry.

The report lays out a vision and call to action to advance tobacco-related health equity. This goes beyond achieving equality (or the same rates of tobacco use and exposure to secondhand smoke for all). It embraces equity so that everyone has fair and just opportunities to live a life free from commercial tobacco-related disease and death. And it envisions freedom from social and structural obstacles that drive tobacco-related health disparities.

Meaningful Progress Requires:

- Acknowledging events, actions, and conditions in our nation's history that have influenced tobacco-related health disparities;
- Removing social and structural obstacles to health equity, including poverty, racism, discrimination; and inequitable access to healthcare and education;
- Ensuring that the burden of efforts to address social injustices does not fall on the population groups that have been subjected to them; and
- Undertaking a "both/and" approach to addressing tobacco-related disparities that combines tobacco-specific interventions with efforts to address social and structural drivers of these disparities.

Tobacco-Specific Interventions Include Efforts to:

- Make tobacco products less appealing, addictive, affordable, and available. This includes efforts to make tobacco products less addictive or not addictive and prohibit the sale of flavored tobacco products;
- Reduce the tobacco industry's influence on society; and
- Reduce tobacco use at the population level using proven strategies. These strategies include tobacco price increases, smokefree policies, hard-hitting media campaigns, and increased access to quitting support. Portions of tobacco tax revenues can be dedicated to social and structural interventions, such as early childhood education, affordable and smokefree housing, and healthcare.

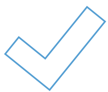
Now is the time to create opportunities and conditions for all people to live a life free from commercial tobacco-related disease, disability, and death.

What You Can Do to Eliminate Tobacco-Related Disparities

Everyone has a role to play to eliminate tobacco-related disparities. This approach involves government, funding, healthcare, public health, and research organizations; schools and academic institutions; businesses; and members of the public.

Actions that *everyone* can take include:

Working together to be accountable and ensuring resources, stated commitments, and actions align with advancing health equity.



Measuring progress, rewarding successes, acknowledging and learning from mistakes, and deploying resources when shortcomings need to be addressed.

Encouraging friends, family members, and coworkers—including youth—to quit the use of tobacco products and supporting them in getting help to quit through resources such as **1-800-QUIT-NOW** and **smokefree.gov**.

Working together, we can end tobacco-related disease and death —for everyone.

To read the full report and access related materials, visit:

SurgeonGeneral.gov
CDC.gov/EndTobaccoDisparities

To learn more about tobacco control and prevention, and quitting tobacco use, visit:

CDC.gov/tobacco
CDC.gov/quit
CDC.gov/tobacco-health-equity
smokefree.gov