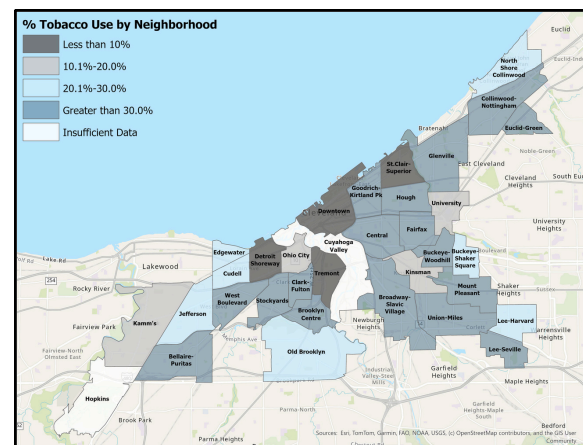


# The State of Tobacco Cleveland, Ohio (2025)

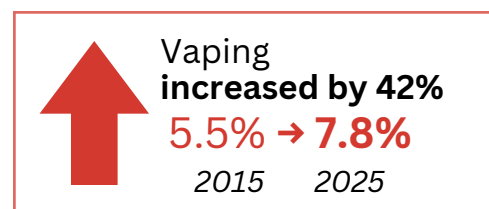
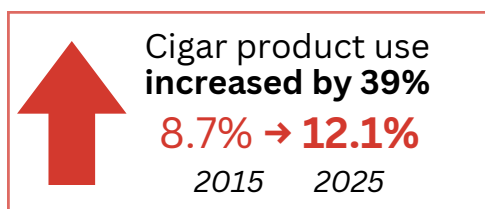
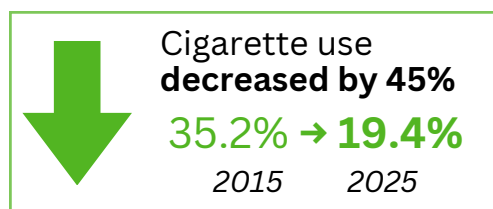
## Tobacco Use is Declining

Despite noteworthy strides over the past 20 years, tobacco use remains the leading cause of preventable illness and death. The City of Cleveland, Ohio has historically had some of the **highest rates of tobacco use in the country**. In 2015, 35% of adults used combustible tobacco products (e.g., cigarettes, cigars) which has since **declined to 25%**. This decline represents remarkable progress towards improving the health and well-being among adult residents.



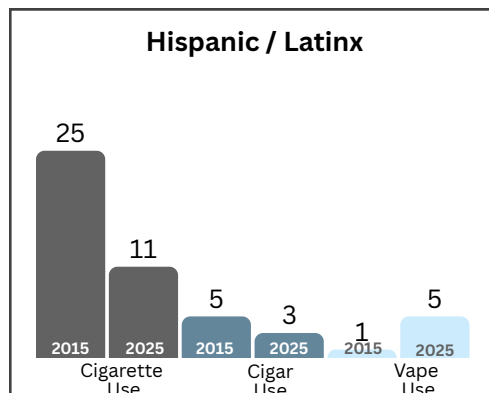
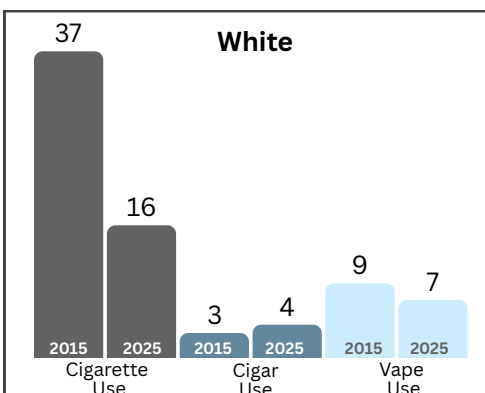
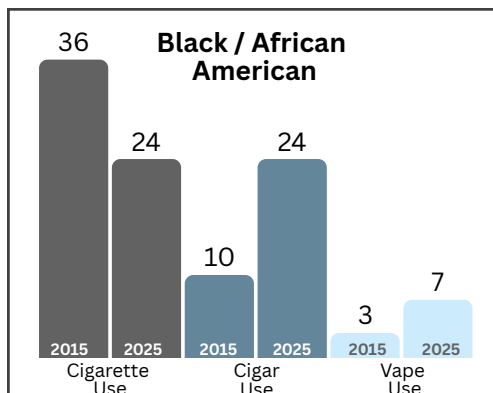
## Cigarettes are Driving Downward Trends

The decline in tobacco use is largely due to fewer people using cigarettes, which remain the most commonly used tobacco product in Cleveland. It should be noted, however, that **use of non-cigarette tobacco products, have increased since 2015**. In addition, Cleveland residents are still nearly twice as likely to use cigarettes compared to the rest of the U.S.



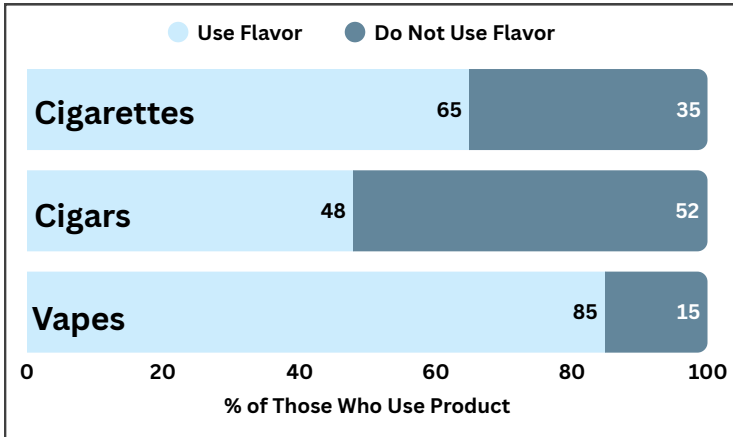
## Cigar Products are a Public Health Concern

Cigars are a broad category of tobacco products that include little cigars and cigarillos, (e.g., Black & Milds) and other cigar products. Cigars are frequently sold in lower-cost units and are available in a wide variety of flavors. Additionally, cigars are often modified to be used with cannabis as a blunt. In Cleveland, **increases in cigar product use disproportionately impact Black or African American residents where the rate of use has more than doubled since 2015 and is used at the same rate as cigarettes (24%)**.



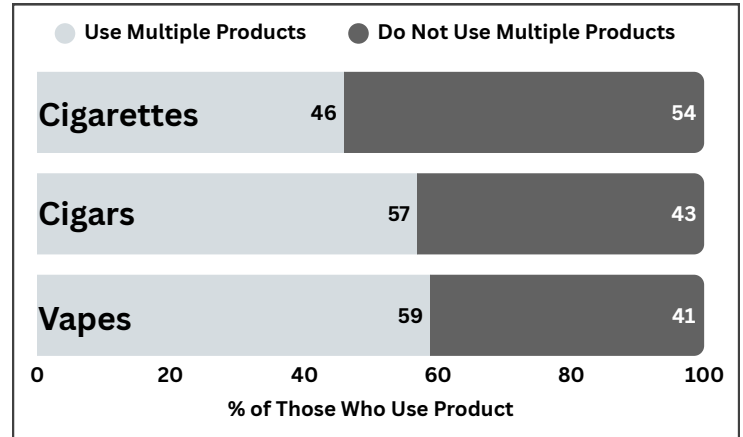
## Use of Flavored Tobacco

Flavored tobacco is a highly appealing attribute particularly among young people. Evidence suggests that use of flavor may increase nicotine dependence making it much more difficult to successfully quit smoking. **In Cleveland, 60% of adults who use tobacco currently use menthol cigarettes or another flavored product** though differences exist across each product.



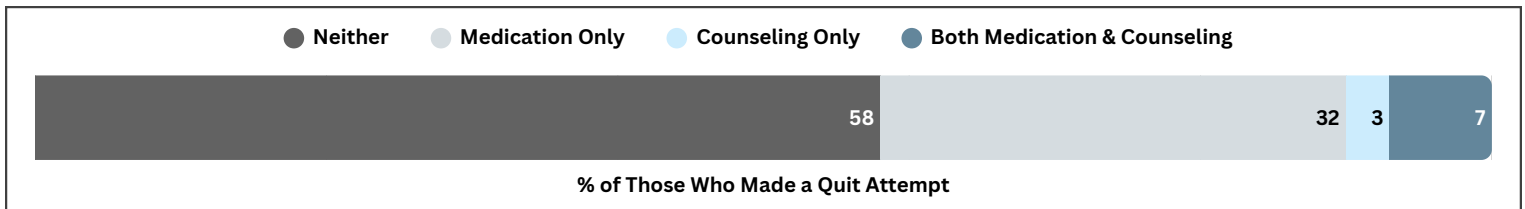
## Use of Multiple Tobacco Products

Use of multiple tobacco products increases risks of nicotine exposure and dependence. In Cleveland, **9.3% of adults use two or more tobacco products** which means that 1 out of every 3 individuals who use tobacco use multiple tobacco products. **Use of multiple tobacco products is 4x greater among those who use flavors** compared to those who do not use a flavored product.



## Smoking Cessation

**In Cleveland, 52% of adults who use tobacco tried to quit at least once in the past year.** To support individuals in quitting, prescription (e.g., varenicline) and non-prescription medications (e.g., nicotine patches) are available to help make nicotine less pleasurable and/or reduce unpleasant side effects from withdrawal. Those who use medication in combination with counseling have the highest chances of successfully quitting. While information is not available regarding those who successfully quit, **58% of those who currently smoke did not use medication or counseling** during their last quit attempt. This highlights an opportunity to improve access to and utilization of medication and counseling.



**Data and Funding Sources:** Data used in this research were drawn from the 2025 Cleveland Health Survey by the Prevention Research Center for Healthy Neighborhoods in collaboration with the Cleveland Department of Public Health. A hybrid sample of 1,497 adult residents completed the survey online or over the phone between November 2024 and January 2025. Data are weighted to represent the Cleveland adult population. More information about this data can be found on our website at [www.prchn.org/clehealthsurvey/](http://www.prchn.org/clehealthsurvey/). The Cleveland Health Survey was funded with support from the Mt. Sinai Foundation, UnitedHealthcare Community Plan, the Case Western Reserve University (CWRU) Clinical and Translational Science Collaborative (through support from National Institutes of Health), the CWRU the Mary Ann Swetland Center for Environmental Health and the CWRU School of Medicine. This brief report represents the views of the authors and does not necessarily represent the official position of the funding organizations or of CWRU.

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