A STRATEGIC APPROACH TO ELIMINATING SEXUAL ORIENTATION–RELATED HEALTH DISPARITIES

Max et al.,[1] investigating changes in self-reported tobacco use and household secondhand smoke (SHS) exposure in California, recently found good news: a reduction in SHS exposure over time, although lesbian, gay, and bisexual (LGB) nonsmokers remained at greater risk for SHS exposure than similar heterosexuals. As we reported in 2013,[2] SHS exposure is elevated among nonsmoking LGB individuals nationally. Using information from the National Health and Nutrition Examination Survey, which measured both self-report and serum cotinine levels, we observed greater risk of both household and workplace SHS exposure among nonsmoking LGB individuals compared with heterosexuals. However, this varied by gender and sexual orientation identity, underscoring both the diversity of health risks that affect sexual minorities and the need for well-targeted interventions.

While clearly national and state specific pictures may differ, research can benefit from building on previous studies. In this instance, our work offered some additional variables of interest for California's tobacco control efforts, including household composition, which may be a significant moderator in SHS exposure for nonsmoking sexual minority men, many of whom live alone.

We agree with the call by Max et al. for an intersectionality approach to LGB health research. We would like to advance this idea further using perspectives drawn from work by Thomas et al.[3] and Kilbourne et al.[4] They argued, using a four-generation health equity framework that racial/ethnic health disparities research must find a way to *eliminate* disparities. From their view, the first generation of work is to document that disparities exist; sexual orientation researchers have been doing this now for several years.[5] The second generation of studies seeks to identify factors that contribute to disparities. Here, an emerging body of sexual orientation research has begun to do just that—calls to intersectionality foci and documenting the impact of minority stress[6] are examples. The third generation, which as yet lies mostly over the horizon for sexual orientation research, is to propose and test interventions targeted at a specific disparity. And the fourth is to eliminate the risk of health disparities by removing their fundamental cause—in this case, likely social marginalization and stigmatization of LGB individuals.

While research on LGB populations is still in its infancy compared with research on racial/ethnic minorities, the ability to move the field forward and achieve health equity will only come, as it does generally in science, through building on findings generated by previous research. AJPH

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REFERENCES

1. Max WB, Stark B, Sung HY, Offen N. Sexual identity disparities in smoking and secondhand smoke exposure in California: 2003–2013. *Am J Public Health*. 2016;106(6):1136–1142.

2. Cochran SD, Bandiera FC, Mays VM. Sexual orientation-related differences in tobacco use and secondhand smoke exposure among US adults aged 20 to 59 years: 2003–2010 National Health and Nutrition Examination Surveys. *Am J Public Health*. 2013;103(10):1837–1844.

3. Thomas SB, Quinn SC, Butler J, Fryer CS, Garza MA. Toward a fourth generation of disparities research to achieve health equity. *Annu Rev Public Health*. 2011;32:399–416.

4. Kilbourne AM, Switzer G, Hyman K, Crowley-Matoka M, Fine MJ. Advancing health disparities research within the health care system: a conceptual framework. *Am J Public Health*. 2006; 96(12):2113–2121.

5. Stall R, Matthews DD, Friedman MR, et al. The continuing development of health disparities research on lesbian, gay, bisexual, and transgender individuals. *Am J Public Health*. 2016;106(5):787–789.

6. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull*. 2003;129(5):674–697.

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MAX ET AL. RESPOND

We thank Cochran et al. for their thoughtful comments regarding the needed research to eliminate health disparities, in this case, related to tobacco use and secondhand smoke (SHS) exposure in the lesbian, gay, and bisexual (LGB) community. As we reported in our study, both tobacco use and SHS exposure have fallen over time for sexual minority as well as heterosexual adults in California, although both prevalence rates remain higher for the former. A number of explanations have been suggested to explain the greater rates of tobacco use and SHS exposure in the LGB community, including