TBM

PRACTICE AND PUBLIC HEALTH POLICIES

SBM recommends policy support to reduce smoking disparities for sexual and gender minorities

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The Society of Behavioral Medicine supports the inclusion of gender and sexual minorities in all local, state, and national tobacco prevention and control activities. These activities include surveillance of tobacco use and cessation activities, targeted outreach and awareness campaigns, increasing access to culturally appropriate tobacco use dependence treatments, and restricting disproportionate marketing to lesbian, gay, bisexual, and transgender communities by the tobacco industry, especially for mentholated tobacco products.

Keywords

Health policy, Gender and sexual minorities, Tobacco prevention and control, Lesbian, Gay, Bisexual, Transgender (LGBT) persons

Implications

Practice: As the level of comfort and competency in addressing lesbian, gay, bisexual, and transgender (LGBT) health issues remains low among healthcare providers, more training on the health promotion needs of gender and sexual minorities related to tobacco use and beyond is needed.

Policy: Policymakers should include gender and sexual minorities in all local, state, and national tobacco prevention and control activities, including surveillance of tobacco use and cessation activities, targeted outreach and awareness campaigns, increasing access to culturally appropriate tobacco use dependence treatments, and restricting disproportionate marketing to LGBT communities by the tobacco industry.

Research: Consistent and valid measures of both sexual orientation and gender identity on all local, state, and national health surveys is needed, as well as increased funding for tobacco research in gender and sexual minority populations.

Background

Smoking remains the leading preventable cause of death and disease in the USA, and each year more than 480,000 people die prematurely from smoking or secondhand smoke exposure [1]. Sexual and gender minorities (e.g., LGBT persons) are at elevated risk for tobacco-related health disparities due to disproportionately high rates of tobacco use [2, 3]. Reasons cited for this elevated risk include discrimination, stigma, targeted marketing by the tobacco industry, and normalization of tobacco in community spaces and organizations [4, 5]. For example:

- A recent national study found that 24% of lesbian, gay, or bisexual adults smoked compared to 17% of heterosexual adults [6].
- A 2013 study found transgender adults to have an even larger disparity, with 36% reporting smoking compared to 21% of heterosexual adults [7].
- LGBT youth smoke at disproportionately higher rates than their heterosexual peers [8].
- There is a higher prevalence of mentholated tobacco use among LGBT smokers [9], which increases nicotine addiction levels and increases difficulty in smoking cessation [10].
- Sexual and gender minorities are more likely to be exposed to involuntary smoking than their heterosexual counterparts [11].
- Several major cigarette companies have launched strategic advertisement campaigns aimed at LGBT communities [12, 13].
- LGBT smokers are exposed to few tobacco cessation messages in LGBT-focused media [14, 15].

Despite these disparities, gender and sexual minorities are not systematically included in tobacco prevention and control efforts [16]. Little is known as to whether evidence-based tobacco control interventions improve or exacerbate disparities for sexual and gender minority populations [16]. What we do know:

- Evidence-based smoking cessation coaching services (e.g., quit lines) may be under-used by LGBT smokers [17].
- Rigorously conducted smoking cessation intervention studies have not been published with LGBT smokers [16].

- While the Center for Disease Control's (CDC) Tips from Former Smokers campaign highlights stories from the LGBT community [18], only one evaluation of an LGBT-targeted media campaign has been published to date [19].
- The U.S. Food and Drug Administration's (FDA) Real Cost Campaign [20], which invested $36 million in changing LGBT young adults' social norms around tobacco use, represents an important movement toward investing in targeted media campaigns.

In the Fall of 2016, the National Institutes of Health (NIH) designated the LGBT community as a health disparity population [21], underscoring the importance of advocating for the inclusion of sexual and gender minority persons in tobacco prevention and control efforts now.

ASSESSMENT OF CURRENT POLICIES

1. Surveillance for monitoring tobacco use and policy interventions is limited by gaps in knowledge and systems.

- Monitoring tobacco use at the local, state, and national levels does not systematically include gender and sexual minorities [22].
- Comprehensive and valid sexual orientation and gender identity questions are often omitted from demographics section of surveys [22].
- There is a lack of systematic clinical data and outcome data on smoking-related death and disease among LGBT populations [23].
- Tracking of organizational policies on tobacco use, industry funding, and cessation services at community festivals (e.g., Pride Parades/Festivals), healthcare organizations (e.g., LGBT-serving health centers), and advocacy groups (e.g., LGBT-rights organizations) [24].
- Assessment of if evidence-based tobacco control interventions effectiveness is moderated by sexual orientation, as they are by socioeconomic status [25].

2. Outreach to at-risk group using media, healthcare providers, and research and dissemination efforts is limited.

- National educational and outreach campaigns inconsistently include gender and sexual minorities [16].
- Limited funding to support the development of effective smoking cessation interventions for LGBT smokers [26].
- Lack of mandated education on the needs of gender and sexual minority smokers among smoking cessation treatment providers [27].

3. Healthcare provider training is limited.

- Reported rates of discrimination in healthcare settings remains high among LGBT persons [28].
- Level of comfort and competency in addressing LGBT health issues remains low among providers [29].
- While state quitline trainings regarding LGBT smokers are available not all states have undergone systematic training to increase cultural competency [30].

4. Disproportionate tobacco industry marketing to LGBT communities.

- The tobacco industry consistently funds LGBT pride and other community events [31].
- Same-sex couples are more likely to reside in areas with higher tobacco retailer density [32].
- LGBT people are disproportionately impacted by tobacco industry marketing [12].

5. Lack of national action on regulation and taxation of tobacco products.

- Lack of FDA regulation of menthol flavored tobacco products, which are used by higher percentages of LGBT smokers [9].
- No national clean indoor air acts aimed at reducing exposure to involuntary smoking which LGBT individuals experience at higher rates [11].
- State tobacco taxes are a deterrent to smoking initiation among youth [33]; however, tobacco taxes are inconsistent from state to state.

POLICY RECOMMENDATIONS

Recommendations for departments of public health and healthcare organizations on surveillance:

1. Include gender and sexual minorities in all local, state, and national surveys of smoking behaviors.
2. Use consistent and valid measures of both sexual orientation and gender identity on all local, state, and national tobacco-specific as well as other health surveys.
3. Advocate for the inclusion of gender and sexual orientation in electronic health records and include information about gender identity and sexual orientation in state cancer registries.

Recommendations for health organizations, campaigns, and research-funding bodies:

1. Develop targeted smoking cessation media campaigns for gender and sexual minorities including smokers who also belong to ethnic and racial minority groups.
2. Include gender- and sexual minority-specific messages in all media campaigns aimed at increasing education and outreach regarding tobacco prevention and smoking cessation treatment services.
3. Allocate funding to increase research on tobacco prevention and cessation among LGBT individuals.
4. Increase training of healthcare providers on the health and health promotion needs of gender and sexual minorities, especially as it relates to tobacco use.

Recommendations for federal policymakers:

1. Develop national clean air acts aimed at reducing exposure to secondhand smoke among LGBT nonsmokers.
2. Advocate for a minimal level cost for all tobacco products that would deter youth from initiating smoking

and motivate current smokers to make a quit attempt [34].

3. Given evidence of wage discrimination against LGBT communities [35], increase the per-unit cost of tobacco products to reduce LGBT disparities [25].
4. Monitor and address disproportionate tobacco industry marketing in LGBT communities and publications.

PARTNERSHIPS

The organizations that have endorsed this policy brief are:

- African American Tobacco Prevention Network
- American Academy of Nursing
- Gay and Lesbian Medical Association (GLMA)
- Howard Brown Health Center, Chicago, IL
- Institute for Sexual and Gender Minority Health and Wellbeing at Northwestern University
- LGBT HealthLink, a Program of CenterLink
- National LGBT Cancer Network
- Pride Action Tank of the AIDS Foundation of Chicago

RESOURCES

- American Lung Association's *Disparities in Lung Health Series: Smoking Out a Deadly Threat*; Tobacco Use in the LGBT Community Report. This report examines tobacco use in the LGBT community and highlights the need for additional research. http://www.lung.org/assets/documents/research/lgbt-report.pdf.
- Center for Disease Control and Prevention's *Tips From Former Smokers™* campaign. This campaign features "Real Stories: Lesbian, Gay, Bisexual, and Transgender (LGBT) People Featured in Tips™." https://www.cdc.gov/tobacco/campaign/tips/groups/lgbt.html.
- *MPOWERED*: *Best and Promising Practices for LGBT Tobacco Prevention and Control*. http://www.lgbthealthlink.org/Assets/U/documents/mpowered.pdf.

Compliance with Ethical Standards

Conflict of Interest: The authors have no conflicts of interest.

Author Disclosures: The findings reported have not been previously published and the manuscript is not being simultaneously submitted elsewhere. A shortened version of this brief has been included in a press release from SBM in 2017. The authors have full control of all primary data and that they agree to allow the journal to review their data if requested. This policy brief was written as a part of the SBM Health Policy Committee. The manuscript does not contain any information that would violate human rights nor does the manuscript have any impact on the welfare of animals. No IRB approval was required nor was informed consent required as the manuscript does not contact any information collected from human subject research. This manuscript does not violate the ethical standards of the declaration of Helsinki as it does not involve any human subjects research.

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