ADDRESSING TOBACCO RELATED HEALTH DISPARITIES

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University of Washington
Tobacco & Public Health (HSERV 558)
May 9, 2012
Agenda

- Why should we focus on tobacco-related health disparities?
- What contributes to tobacco-related health disparities?
- How do we address tobacco-related health disparities?
Why focus on tobacco-related health disparities?

- Prevalence is much higher in certain populations
US Adult Current Smokers, % 2000-2010

Racial/Ethnic data from NHIS, 1999-2009
LGB rates estimated from population-based ORs (Lee et al, 2009); Transgender rates from Grant et al. 2011 (LGBT data is not trend)
Adult Smoking by Subgroup, %
e.g. Asian-Americans

An, Cochran, Mays, & McCarthy, 2008
US Adult Current Smokers, %
2000-2010

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LGB rates estimated from population-based ORs (Lee et al, 2009); Transgender rates from Grant et al. 2011 (LGBT data is not trend)
Adult Smoking by Subgroup, %
e.g. Asian-Americans

An, Cochran, Mays, & McCarthy, 2008
2009 Affordable Care Act required new data collection standards

- 2011: Race, ethnicity, sex, primary language, and disability status
- “Any other demographic data as deemed appropriate by the Secretary regarding health disparities”


June 29, 2011 – Lead by Sec Sebelius, HHS released plan for SO and gender identity data collection
- Included in 2013 NHIS (data published ~2015)
Why focus on tobacco-related health disparities?

- Prevalence is much higher in certain populations
- Morbidity & mortality is much higher in certain populations
US Adult Current Smokers, %
2000-2010

Racial/Ethnic data from NHIS, 1999-2009
LGB rates estimated from population-based ORs (Lee et al, 2009); Transgender rates from Grant et al. 2011 (LGBT data is not trend)
Lung Cancer
per 100,000 (Males, 2001-2005)

American Cancer Society, 2009
What contributes to tobacco related health disparities?

“He who frames the question frames the debate.”

Why do people choose to smoke?

- Rational choice theories vs. social-ecological models
  (Balbach, Smith & Malone, 2006)
Rational choice theories

- Includes health belief model, theory of reasoned action, theory of planned behavior (Balbach, et al. 2010)
More emphasis on individual choice

People have a right to choose what they want to smoke. They, first of all, have a right to choose if they want to smoke. And they have a right to choose and are offered a whole variety of cigarettes for whatever they choose to use.

James Morgan, CEO of Philip Morris
More emphasis on individual choice

My own personal experience with people close to me that have been advised for different reasons somewhere in their life not to smoke and they stopped. They didn’t go for any cures. They didn’t sign up anywhere, they just chose not to smoke, just as they chose to smoke.

- Horrace Kornegay, President of the Tobacco Institute
But we believe that an adult has the right to see the full range of literature and information on a topic and then make the judgment call for themselves… we should not edit or not make that information available… We should just make the broad information available.

- Ellen Merlo, PM Senior VP of Corporate Affairs
Individual choice… or corporate responsibility?

People were hurt by making the choice to smoke.

- Ellen Merlo, PM Senior VP of Corporate Affairs, when asked about harm from the company’s products.
Individual choice... or addiction?

The allegation, or the implication that *people* are *hopelessly* hooked on cigarettes; therefore, *they* are not responsible for *their choices they make*. I don’t agree with it. *People* quit, and *they* quit widespread, 40 million of them.

- Donald Johnston, President and CEO of American Tobacco Co.

*It’s easy to quit smoking. I’ve done it hundreds of times.* - Mark Twain
Bronfenbrenner’s Social Ecological Model
What contributes to tobacco related health disparities?

- Known reasons for differences in smoking and quitting vary by population:
  - SES
  - Health care utilization
  - Access to cessation services and meds
  - Acculturation
  - Minority stress
  - Targeted marketing

- So, time to get specific...
Why do LGBT people smoke more?

- Most research reports on prevalence only (Lee et al., 2009)
- Yet, we know LGB people differ from heterosexual people on a number of dimensions that are also related to smoking:
  - Demographics
  - Mental health
  - Alcohol and substance use
  - Healthcare access
  - Exposure to tobacco marketing
Demographics

Compared to heterosexuals, LGB people are:

- More likely to be single
- More likely to live in an urban area
- More likely to have higher education
- Less likely to have higher income
- Less likely to have children

Gates & Ost, 2004; Rothblum, Balsam, & Mickey, 2004; Rothblum, Balsam, Todosijevic, & Solomon, 2006
Mental Health

- Literature demonstrates small but significantly higher rates of depression, anxiety and psychological distress among LGB populations compared to heterosexuals

Cochran, 2001; Balsam, Beuchlaine, Rothblum, & Mickey, 2005
Minority Stress

- Social stress theory: Conditions of the social environment may lead to physical and mental health problems

- For minority group members, stigma, prejudice, and discrimination contribute to stressful social environments:
  - External, objective stressful events
  - Expectations of these events
  - Internalization of negative societal attitudes

Hatzenbuehler, 2009; Meyer, 2003
LGBT Minority Stress

- Similar to other groups:
  - Range of stressful experiences
  - Internalized oppression
    - Such as self-blame, negative self-concept, feelings of inadequacy, hopelessness
  - Potential for multiple oppressions

- Different from other groups
  - Potentially concealable identity (not protective)
    - Can lead to hypervigilence, threat of discovery, social isolation
  - Different stressors according to “outness”
  - Childhood context
### Table 4: Family Rejection as Predictors of Negative Health Outcomes

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>Rejection Scale Score, OR (95% Confidence Interval)</th>
<th>Percentage of Participants Experiencing Outcome</th>
<th>Moderate Rejection, OR (95% Confidence Interval)</th>
<th>High Rejection, OR (95% Confidence Interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low Rejection Scores</td>
<td>Moderate Rejection Scores</td>
<td>High Rejection Scores</td>
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<tr>
<td>Mental health</td>
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<tr>
<td>Suicidal ideation</td>
<td>2.13 (1.53–2.95)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>11.8</td>
<td>21.6</td>
<td>43.2</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>3.09 (2.18–4.37)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>19.7</td>
<td>35.1</td>
<td>67.6</td>
</tr>
<tr>
<td>Depression (CES-D &gt;16)</td>
<td>2.21 (1.62–3.01)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>22.4</td>
<td>44.6</td>
<td>63.5</td>
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<tr>
<td>Substance use/abuse</td>
<td></td>
<td></td>
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<tr>
<td>Heavy drinking (past 6 mo)</td>
<td>0.84 (0.63–1.12)</td>
<td>40.8</td>
<td>47.3</td>
<td>36.5</td>
</tr>
<tr>
<td>Illicit substance use (past 6 mo)</td>
<td>1.83 (1.35–2.49)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>42.1</td>
<td>50.0</td>
<td>71.6</td>
</tr>
<tr>
<td>Substance-related problems (any, ever)</td>
<td>1.60 (1.19–2.14)&lt;sup&gt;e&lt;/sup&gt;</td>
<td>48.0</td>
<td>47.3</td>
<td>68.9</td>
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<tr>
<td>Sexual risk behavior</td>
<td></td>
<td></td>
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<tr>
<td>Unprotected sex with a casual partner (past 6 mo)</td>
<td>1.73 (1.25–2.40)&lt;sup&gt;e&lt;/sup&gt;</td>
<td>23.7</td>
<td>12.2</td>
<td>45.9</td>
</tr>
<tr>
<td>Unprotected sex with a casual partner (last intercourse)</td>
<td>1.72 (1.23–2.42)&lt;sup&gt;e&lt;/sup&gt;</td>
<td>13.2</td>
<td>13.9</td>
<td>35.1</td>
</tr>
<tr>
<td>STD diagnosis (any, ever)</td>
<td>1.32 (0.95–1.85)</td>
<td>24.0</td>
<td>27.1</td>
<td>32.8</td>
</tr>
</tbody>
</table>

All effects were adjusted for gender (female, male) and ethnicity (Latino, white).

<sup>a</sup> Continuous scale score, rescaled such that 1 unit = 1 SD; ORs can be interpreted as the change in odds of the outcome for a 1-SD change in rejection.

<sup>b</sup> Low rejection is the reference group.

<sup>c</sup> P < .001.

<sup>d</sup> P < .01.

<sup>e</sup> P < .05.

Percentage of HS students who reported select risk behaviors, by sexual orientation (N = 156,154) *(MMWR, 2011)*

<table>
<thead>
<tr>
<th>Risk behavior</th>
<th>Straight</th>
<th>G/L</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a physical fight at school</td>
<td>10.5</td>
<td>22.2</td>
<td>19.1</td>
</tr>
<tr>
<td>Threatened or injured with a weapon at school</td>
<td>6.1</td>
<td>18.5</td>
<td>15.5</td>
</tr>
<tr>
<td>Missed school because felt unsafe</td>
<td>4.8</td>
<td>21.1</td>
<td>12.7</td>
</tr>
<tr>
<td>Ever smoked</td>
<td>47.5</td>
<td>70.8</td>
<td>71.2</td>
</tr>
<tr>
<td>Ever smoked daily</td>
<td>7.6</td>
<td>23.4</td>
<td>24.8</td>
</tr>
<tr>
<td>Tried quitting smoking</td>
<td>54.4</td>
<td>52.3</td>
<td>55.5</td>
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<tr>
<td>Currently smoke</td>
<td>13.6</td>
<td>30.5</td>
<td>30.8</td>
</tr>
<tr>
<td>Currently use smokeless tobacco</td>
<td>4.6</td>
<td>14.7</td>
<td>9.5</td>
</tr>
<tr>
<td>Currently smoke cigars</td>
<td>11.0</td>
<td>25.6</td>
<td>20.4</td>
</tr>
<tr>
<td>Currently use any tobacco</td>
<td>18.9</td>
<td>35.4</td>
<td>39.6</td>
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Minority Stress

Percentage of HS students who reported select risk behaviors, by sexual orientation (N = 156,154) (MMWR, 2011)

- In a physical fight at school
- Threatened or injured with a weapon at school
- Missed school because felt unsafe
- Currently smoke

Legend:
- Straight
- G/L
- B

Graph showing the percentage of HS students reporting select risk behaviors, categorized by sexual orientation.
Alcohol Use

- LGB populations are more likely to drink alcohol, have an alcohol-related disorder, and report alcohol-related problems compared to heterosexuals.
- Difference is found more often among women than men.

Cochran, 2001; Hughes, 2005
LGB people report limited access to healthcare compared to heterosexuals:

- Lower income & greater tax disparities
- Perceived discrimination from healthcare providers
- Lack of partner/spousal insurance
Exposure to tobacco marketing

- Targeted ads in LGBT publications
- Sponsorship of LGBT events
- Funding for LGBT community groups
- Tobacco use in LGBT-themed movies and television
The People of the Philip Morris Companies

The Philip Morris Companies, which include Kraft Foods, Miller Brewing, and Philip Morris USA, are proud of our long-standing commitment to diversity. Diversity is at the heart of what Philip Morris stands for as a company and corporate citizen. We believe that a diverse work force strengthens Philip Morris. We are dedicated to creating and maintaining an environment where all employees can contribute creative ideas, seek challenges, assume leadership, and meet and exceed both business and personal objectives.

Philip Morris also has a 40-year history of contributing to non-profit organizations that make a difference in the communities where our employees live and work, including many with the gay and lesbian communities. Over the last 16 years, we have become one of the largest corporate contributors to the fight against HIV/AIDS in the United States.

Throughout our company, managers are held accountable for the diversity of their departments and business partners. In addition to offering domestic partner benefits, Philip Morris has maintained sexual orientation, anti-discrimination and anti-harassment policies for 16 years. Senior management recognizes and supports lesbian, gay, bisexual and transgender employee organizations. In addition, we have diversity awareness education and training programs for all employees, which, among many other areas, address sexual orientation.

For more information about Philip Morris, please visit our Web site, www.philipmorris.com

Working to make a difference.
The people of Philip Morris

THE PEOPLE OF THE PHILIP MORRIS COMPANIES
2011 PM grant recipients (WA State)

- Evergreen Freedom Foundation
- Seattle Crisis Clinic
- Lifelong AIDS Alliance
- WA Policy Center
- WA Research Council
- Children's Hospital Foundation
- Children's Hospital Guild Associated
- Washington Wine Industry Foundation
- College Success Foundation
- Washington State University
- Boys & Girls Club of King County
- Walla Walla Community College
- Washington State University Foundation
- University of Washington Foundation
- And hundreds of in-kind charitable donations (via Ste. Michelle Wine)
Exposure to tobacco marketing

- “When someone yells, ‘Dude, that’s so gay,’ we’ll be there.”
- Brown & Williamson was a premier sponsor of the 2002 GLAAD awards
- They set up a smoking lounge and gave out free samples of cigarettes
Exposure to tobacco marketing

- Ad appearing in The Advocate and Out magazines
- “the people of Santa Fe Natural Tobacco Company” owned by RJ Reynolds
Susceptible to marketing

Interviews with LGBT groups across the US:

- Little objection to tobacco advertising
- Saw targeted marketing as validating and countering historic invisibility
- Tobacco not perceived as an important LGBT health issue
- Tobacco use a matter of personal choice:
  - “Choice is the foundation of most of the civil rights we’re arguing for, choice and privacy.”

Smith, Thomson, Offen, Malone, 2008
Susceptibility: Also marketed

3) ISSUE DEVELOPMENT:

Obviously, the direct mail and print media placement is only as good as the content. Since it is apparent that we are not going to have the endorsement of most Gay and Lesbian leadership, it is important to use these campaign tools to bypass that and go directly to the Gay and Lesbian voter with a message that will resonate. There are several areas that would have special interest to this community. That would include lifestyle regulation, government intrusion into private lives, and removing choice as an option for one’s life decisions. These themes need to be developed carefully by focus groups and polling. We must be ready to immediately set the tone of the debate in early September. That means our message, materials and content must be decided by mid-August at the absolute latest or we will miss important deadlines.

Grant, I will keep you updated with information as I attain it. Best wishes for a successful meeting.

- 6/9/98 From a consultant’s memo to The Tobacco Institute (umbrella lobby group for US tobacco industries) http://tobaccodocuments.org
ADVOCATES CENSORSHIP

It comes as no surprise to anyone with their eyes open in LGBT communities that we have once again become one of the targets of the tobacco industry. By accepting tobacco industry ads, Lavender has become part of that industry's long, dark history of deception.

One of the tragedies of the campaign is that it is yet another effort by big tobacco to exploit our communities' passion for personal freedom and choice.

I know Lavender is a business, and that advertising revenue is key to the success of that business. But just as you would never accept an ad from a known homophobic organization, so should you refuse to accept advertising from the tobacco industry.

It is indisputable that the tobacco industry is targeting LGBT communities, as well as having a long history of campaign donations to politicians pushing for an antigay agenda.

Lavender should join the list of LGBT publications that have developed policies refusing to accept tobacco industry ads or dollars.

Doing that will not only make it harder for the industry to reach our communities, it will show that Lavender truly has the best interests of Minnesota's LGBT communities at heart.

LORETTA WORTHINGTON
EXECUTIVE DIRECTOR
RAINBOW HEALTH INITIATIVE

Letter's Note: Lavender believes in democracy, the essence of which is "freedom and choice." We uphold the First Amendment, which guarantees Americans freedom of speech and freedom of the press. Therefore, we reject censorship. To that end, we accept advertising from a wide spectrum: bars/alcohol companies and sobriety organizations; Democrats, Republicans, and Independents; churches and atheist groups. Lavender does not believe that tobacco use is homophobic. We will continue to give our readers the right to choose which advertisers they wish to support.

Letters are subject to editing for grammar, punctuation, space, and libel. They should be no more than 300 words. Letters must include name, address, and phone number. Unsigned letters will not be published. Priority will be given to letters that refer to material previously published in Lavender Magazine. Submit letters to Lavender Magazine, Letters to the Editor, 3715 Chicago Avenue South, Minneapolis, MN 55407; or e-mail <editor@lavendermagazine.com>. 
Data: Why do LGBs smoke more?

- Test a path model of risk and protective factors to help explain sexual orientation differences in smoking:

Sample

- WA State BRFSS data from 2003-2007
- N = 103,087
- 50.6% female
  - 774 (1.4%) lesbian; 705 (1.6%) bisexual; 61,923 (97.0%) heterosexual
- 49.4% male
  - 645 (1.9%) gay; 297 (0.9%) bisexual; 38,743 (97.2%) heterosexual
Gay rights by type
Control Variables

- Age
- Race/ethnicity
Potential Explanatory Variables

- Demographics
  - Employment status
  - Income
  - Education
  - Geographic location
  - Relationship status
  - Children in the home
Potential Explanatory Variables

- Psychosocial
  - Mental health
  - Emotional support
  - Life satisfaction
- Alcohol use
- Knowledge and attitudes about tobacco
- Marketing influences
Outcome variable

- Current smoking status
  - Do you now smoke cigarettes every day, some days, or not at all?
  - Only asked of individuals who smoke at least 100 cigarettes in lifetime (standard)
### Results, females

<table>
<thead>
<tr>
<th>Explanatory Variable</th>
<th>Sexual Orientation(^1)</th>
<th>Sexual Orientation -&gt; Explanatory Variable</th>
<th>Explanatory Variable -&gt; Smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Enhancing Pathways</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low income</td>
<td>Bisexual</td>
<td>1.90 (1.53, 2.36)</td>
<td>1.28 (1.22, 1.34)</td>
</tr>
<tr>
<td>Employed</td>
<td>Lesbian</td>
<td>1.59 (1.26, 1.96)</td>
<td>1.33 (1.22, 1.47)</td>
</tr>
<tr>
<td>Single</td>
<td>Lesbian</td>
<td>2.02 (1.66, 2.46)</td>
<td>1.38 (1.26, 1.51)</td>
</tr>
<tr>
<td></td>
<td>Bisexual</td>
<td>2.07 (1.68, 2.54)</td>
<td></td>
</tr>
<tr>
<td>No health plan</td>
<td>Bisexual</td>
<td>1.50 (1.15, 1.97)</td>
<td>1.48 (1.31, 1.68)</td>
</tr>
<tr>
<td>No recent doctor visits</td>
<td>Bisexual</td>
<td>1.50 (1.09, 2.07)</td>
<td>1.42 (1.25, 1.61)</td>
</tr>
<tr>
<td>Poor mental health days</td>
<td>Lesbian</td>
<td>1.74 (1.37, 2.21)</td>
<td>1.65 (1.54, 1.76)</td>
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<tr>
<td></td>
<td>Bisexual</td>
<td>3.29 (2.66, 4.06)</td>
<td></td>
</tr>
<tr>
<td>Life dissatisfaction</td>
<td>Lesbian</td>
<td>1.85 (1.49, 2.29)</td>
<td>1.37 (1.24, 1.51)</td>
</tr>
<tr>
<td></td>
<td>Bisexual</td>
<td>2.80 (2.16, 3.63)</td>
<td></td>
</tr>
<tr>
<td>Binge drinking</td>
<td>Bisexual</td>
<td>2.29 (1.75, 2.98)</td>
<td>2.58 (2.24, 2.96)</td>
</tr>
<tr>
<td>Heavy drinking</td>
<td>Lesbian</td>
<td>1.72 (1.20, 2.45)</td>
<td>1.83 (1.55, 2.17)</td>
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<tr>
<td></td>
<td>Bisexual</td>
<td>2.49 (1.71, 3.63)</td>
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<tr>
<td>Exposure to marketing</td>
<td>Lesbian</td>
<td>1.79 (1.32, 2.43)</td>
<td>3.49 (3.11, 3.92)</td>
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<tr>
<td></td>
<td>Bisexual</td>
<td>1.91 (1.42, 2.57)</td>
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<tr>
<td>Favorable attitude: Second hand smoke</td>
<td>Bisexual</td>
<td>1.68 (1.27, 2.23)</td>
<td>2.86 (2.67, 3.06)</td>
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<td><strong>Risk Reducing Pathways</strong></td>
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<td>High education</td>
<td>Lesbian</td>
<td>1.96 (1.61, 2.38)</td>
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<tr>
<td>No children in home</td>
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<td>3.50 (2.64, 4.65)</td>
<td>0.74 (0.69, 0.82)</td>
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<tr>
<td></td>
<td>Bisexual</td>
<td>2.75 (2.13, 3.56)</td>
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\(^*\)p < .05, \(^{**}\)p < .01, \(^{***}\)p < .001
## Results, males

<table>
<thead>
<tr>
<th>Explanatory Variable</th>
<th>Sexual Orientation</th>
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<td>OR</td>
<td>(95% CI)</td>
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<tr>
<td>Gay</td>
<td>3.56</td>
<td>(2.84, 4.56)</td>
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<td>(2.02, 3.89)</td>
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<td>(3.03, 5.00)</td>
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<td>No health plan</td>
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<td>Poor mental health days</td>
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<td>Gay</td>
<td>1.44</td>
<td>(1.03, 2.03)</td>
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<td>(1.43, 2.13)</td>
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<td>(4.95, 10.87)</td>
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<td>Bisexual</td>
<td>3.85</td>
<td>(2.44, 6.08)</td>
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</table>

*p < .05, **p < .01, ***p < .001
## Overall Findings

<table>
<thead>
<tr>
<th>Explanatory Variable</th>
<th>Females</th>
<th>Males</th>
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<tr>
<td></td>
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<td>No children in home</td>
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<td>***</td>
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<td>No recent doctor visits</td>
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<tr>
<td>Poor mental health days</td>
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<tr>
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<tr>
<td>Heavy drinking</td>
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<td>***</td>
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<tr>
<td>Exposure to marketing</td>
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<tr>
<td>Favorable attitude: Second hand smoke</td>
<td>ns</td>
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</tr>
<tr>
<td>Favorable attitude: Smoking doesn’t matter</td>
<td>ns</td>
<td>ns</td>
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</tbody>
</table>
Neutral variables

- Attitudes towards secondhand smoke
- Attitudes towards health effects of smoking

**Surprised?**

- “Neutral” means no difference between LGB groups and heterosexual group
- Translation: Should continue addressing these issues in overall public health strategies, but not strategies aimed to address health disparities
Why don’t they quit?

- Population-based data show: (Pitzacani et al; Balsam, Riggs, & Beadnell, In Review)
  - Desire, motivation, and attempts to quit do not differ by sexual orientation
  - Still, LGBs about 1/2 as likely to quit compared to heterosexuals (p < .001)
Why don’t they quit?

- **2007 survey in LGBT venues and online** *(Levinson et al, 2012)*
  - Explored quitting behaviors among LGBT smokers; compared LGBT smokers who were prepared to quit with those who were not
  - N = 1,633
  - 46.8% female, 50.2% male, 2% transgender, 1% other
  - 38.2% lesbian, 44.9% gay, 8.6% bisexual female, 5.3% bisexual male, 3% other

- **2003-2007 WA State BRFSS** *(Balsam et al, in review)*
  - Compared LGB and Hetero ever-smokers (at least 100 cigs in lifetime) and explored variables related to being LGB and quitting
  - N = 48,746
  - 56.4% female; 43.6% male
  - 1.6% lesbian; 1.8% gay; 1.6% bisexual female; 0.9% bisexual male; 96.8% hetero female; 97.3% hetero male
28.2% used NRT in last quit attempt
28% said intended to use NRT in next quit attempt

Lesbians and bisexual females less likely than gay men:
- Lesbians  (OR = 0.75, CI = 0.58-0.96)
- Bisexual females (OR = 0.57, CI = 0.36-0.90)
Why don’t they quit?—Levinson et al.

- 7.4% used a telephone quitline
- 13.3% LGBTs intended to use quitline in next quit attempt
- Features that would decrease likelihood of using QL:
  - Could not talk to same coach each time (43%)
  - QL did not offer LGBT-identified coaches (30.5%)
  - QL did not address SO or gender identity in coaching (21.3%)
Why don’t they quit?—Levinson et al.

- <1% used a Rx cessation med in last quit attempt
- <10% would use one in next quit attempt
- Of those with a regular doctor, 25.2% were somewhat or very uncomfortable asking their doctor for help with smoking cessation
  - Lesbians and bisexual females 1.44-2.12 times more likely to be uncomfortable compared to gay men
## Why don’t they quit?—Balsam et al

### Males

<table>
<thead>
<tr>
<th>Explanatory Variable</th>
<th>Sexual Orientation</th>
<th>Sexual Orientation → Explanatory Variable</th>
<th>Explanatory Variable → Having Quit Smoking</th>
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<tbody>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>p</td>
<td>OR (95% CI)</td>
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<tr>
<td>Urban</td>
<td>Gay</td>
<td>3.90 (2.76, 5.53)</td>
<td>0.95 (0.91, 0.99)</td>
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<td>Gay</td>
<td>3.36 (2.50, 4.51)</td>
<td>0.52 (0.46, 0.59)</td>
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<td>3.04 (1.99, 4.63)</td>
<td>0.52 (0.46, 0.59)</td>
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<td>Gay</td>
<td>1.61 (1.10, 2.38)</td>
<td>0.65 (0.58, 0.72)</td>
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<td>1.91 (1.08, 3.38)</td>
<td>0.65 (0.53, 0.80)</td>
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<td>Poor mental health days</td>
<td>Gay</td>
<td>1.67 (1.11, 2.51)</td>
<td>0.74 (0.66, 0.84)</td>
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<td></td>
<td>Bisexual</td>
<td>2.22 (1.31, 3.77)</td>
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<td>Heavy drinking</td>
<td>Bisexual</td>
<td>2.11 (1.14, 3.93)</td>
<td>0.65 (0.53, 0.80)</td>
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<td>0.74 (0.66, 0.84)</td>
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<td>High education</td>
<td>Gay</td>
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### Why don’t they quit?—Balsam et al

#### Females

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<td>1.56</td>
<td>1.19, 2.05</td>
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<td>1.54, 2.85</td>
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<td>1.17, 2.47</td>
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<td>2.45</td>
<td>1.96, 3.07</td>
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<td>Bisexual</td>
<td>1.52</td>
<td>1.15, 2.01</td>
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### Why don’t they quit?—Balsam et al.

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<td>No health plan</td>
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</table>
How do we address tobacco-related health disparities?

- Given what we now know about risk and protective factors for smoking in LGB populations, how do we address this problem?
Exo/Macro

- Empower LGBT organizations to reject industry funding
- Restrict marketing at LGBT events and in LGBT publications
- Establish policies that support same-sex relationships and families
- Support and facilitate organizations that promote healthy activities/environments
- Reduce income disparities
- Enhance healthcare access
### TABLE 2—Associations Between Religious Climate and Health Risk Behaviors Among Lesbian, Gay, and Bisexual Youths: Oregon Healthy Teens Study, 2006–2008

<table>
<thead>
<tr>
<th></th>
<th>Alcohol Abuse Symptoms</th>
<th>Sexual Partners</th>
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<tr>
<td></td>
<td>OR (95% CI)</td>
<td>P</td>
</tr>
<tr>
<td>Religious climate</td>
<td>0.58 (0.40, 0.85)</td>
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<tr>
<td>Community climate</td>
<td>1.35 (0.87, 2.10)</td>
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<tr>
<td>Population size</td>
<td>1.14 (0.74, 1.76)</td>
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<tr>
<td>Sex</td>
<td>0.64 (0.43, 0.95)</td>
<td>.027</td>
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<td>Race/ethnicity</td>
<td>1.21 (0.78, 1.86)</td>
<td>.399</td>
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<td>Depressive symptoms</td>
<td>1.18 (0.79, 1.75)</td>
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<tr>
<td>Physical abuse</td>
<td>1.71 (1.15, 2.56)</td>
<td>.009</td>
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<tr>
<td>Sexual abuse</td>
<td>1.35 (0.84, 2.17)</td>
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<tr>
<td>Peer substance use</td>
<td>1.88 (1.26, 2.82)</td>
<td>.002</td>
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<td>Injunctive norms</td>
<td>2.31 (1.07, 4.98)</td>
<td>.032</td>
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<tr>
<td>Perceived risk</td>
<td>1.30 (0.74, 2.29)</td>
<td>.365</td>
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</tbody>
</table>

*Note. CI = confidence interval; OR = odds ratio. Shown are the results of a final generalized estimating equations model predicting behavioral and sexual health outcomes.*

*Female = 0, male = 1.
*Non-White = 0, White = 1.
Exo/Macro Case Study:
Industry Marketing and Community Response

- Uptown Cigarettes
  - Multimillion-dollar test market
  - Philadelphia, PA
    - A neighborhood in North Philly
  - Set to launch Feb 5, 1990
    - Why February?
“Not in our community”

Industry had a history of targeting the Black community... Why object now?

Inoculation Theory

“Maybe, in retrospect, we would have been better off not saying we were marketing to blacks. But those were the smokers we were going after, so why shouldn't we be honest about it?”

- RJR Senior VP of PR to the New York Times, 1/20/1990
Fast forward 5 years...
America's Best Cigarette™
FIND OUT WHY

For a sample CARTON call:
1-800-872-6460 ext. 8700

SURGEON GENERAL'S WARNING: Cigarette Smoke Contains Carbon Monoxide.
The tipping point?

2009 NCI monograph:
- The total weight of evidence demonstrates a causal relationship between tobacco advertising and promotion and increased tobacco use.

Community leaders mobilizing “regular community folks” (Gardiner & Clark, 2010)

Common denominator, TBD
- Language matters:
  - Death & disease vs. health effects
  - Addiction vs. choice
  - Victimization vs. stigmatization
  - Skillpower vs. willpower
Enhancing tobacco-related knowledge and attitudes may not make a difference in the disparity in the disparity.

Interventions to support quit efforts — culturally tailored or one size fits all?
Persistence of general tobacco use rates and of elevated rates in certain populations indicate new treatments are needed (Borrelli, 2010)
2000 Recommendations:

- Whenever possible, tobacco treatments should be modified or tailored to be appropriate for the ethnic or racial populations with which they are used (SOE = C)

- Smoking cessation treatments have been shown to be effective across different racial and ethnic minorities. Therefore, members of racial and ethnic minorities should be provided treatments shown to be effective in this Guideline (SOE = A)
2008 Update:
- Interventions should be language and culturally appropriate and acceptable
- Clinicians should remain sensitive to the individual differences and spiritual and health beliefs that may affect treatment acceptance, use, and success in all populations
- The extent to which cultural tailoring enhances intervention effectiveness requires further research

Fiore, et al., 2008
Cultural tailoring is justified if...

- The target population differs from the general population:
  - Rates and patterns of smoking
  - Burden of tobacco-related health diseases
  - Predictors of smoking behavior
  - Risk factors for treatment failure
  - Protective factors that facilitate
    - Quitting
    - Treatment engagement
    - Treatment response
  - Percived social validity of the evidence-based therapy

Borrelli, 2010
What is cultural tailoring?

- **Surface structure**
  - Language, symbols, people, places, music, clothing
  - Receptivity, acceptance, fit

- **Deep structure**
  - Cultural, social, historical, environmental, psychological
  - Salience
Cultural tailoring
e.g. Hispanic/Latino

- **Surface:**
  - Context: Community-based, peer-led, social events
  - Language: Is meaningful as well as language appropriate

- **Deep:**
  - Bicultural/immigrant experiences
  - Collectivist approach (rather than individualist)
    - “Quitting smoking is important for your family’s health” vs. “quitting is important to your health”

Cupertino, 2010

DuPage County Health Dept, Wheaton, IL
Minority groups have higher rates of tobacco use, lower rates of successful quitting (but often comparable rates of desire, motivation, and attempts to quit)

Also higher rates of death and disease (even when prevalence rates are not higher)
- ½ of all adult smokers will die from smoking

Reasons vary by group, but all affected by:
- Systematic, subversive targeted marketing by the tobacco industry
- Minority stress
- Societal inequalities and discrimination
Summary—What can be done?

- **Macro needs:**
  - Engage the entire community
    - Surface/deep structure tailoring
  - Mobilize around a common denominator
  - Be patient and persistent (the arc of history is long…)

- **Micro needs:**
  - Understand unique needs related to tobacco use
  - Multiple risk factor interventions to address co-occurring risk factors
  - More research on effective culturally tailored interventions
References


Borrrell, B. Next steps for special populations research and innovative treatments. Journal of Consulting and Clinical Psychology, 78(1).


Rothblum, E. D., Balsam, K. F., & Mickey, R. M. (2004). Brothers and sisters of lesbians, gay men, and bisexuals as a demographic comparison group: An innovative research methodology to examine social change. Journal of Applied Behavioral Sciences, 283-301


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- Kimberly Balsam, PhD
- Blair Beadnell, PhD
- SRNT Tobacco Related Health Disparities Network and Advisory Committee (TRHD)
- WA State Department of Health Tobacco Prevention and Control Program (DOH TPCP)
Contact:

kriggs@uw.edu

riggs.kr@ghc.org
Local Resources

- WA DOH TPCP Networks:
  - Gay City Health Project: [http://gaycity.org/](http://gaycity.org/)
  - WA State DOH TPCP Tribal Coordinators: [http://www.doh.wa.gov/tobacco/other/tribalcoord.htm](http://www.doh.wa.gov/tobacco/other/tribalcoord.htm)