MPOWERED: Best and Promising Practices for LGBT Tobacco Prevention and Control

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It is with great pride that the Network for LGBT Health Equity presents the MPOWERED: Best and Promising Practices for LGBT Tobacco Prevention and Control document that follows.

Every disparity population struggles with the lack of precedent for their work, the lack of scientific testing of tailored strategies, and the lack of acknowledgement for the undeniable wisdom built by years of work in a field. The resources needed to build a portfolio of evidence-based tobacco interventions are rarely available for disparity populations, creating a catch-22 whereby existing strategies that could perhaps become evidence-based tobacco interventions are not tested.

There needs to be a middle ground between having a portfolio of evidence-based tobacco interventions and little information on best practices at all, one where existing strategies are subjected to rigorous review and the best collected for dissemination. The Network for LGBT Health Equity has reviewed the science to date and engaged in a yearlong process to build just such a document—the document you see here.

I am very proud of the hundreds of hours of volunteer effort put into this document by community reviewers and network leaders. Our Best Practices Committee has done an outstanding job not just tackling this problem but literally building a new precedent to assemble such a collection of best and promising practices. I know of nowhere else where you will find such a science-based, community and expert reviewed assemblage of effective strategies in one place.

We have tried to keep this document as simple and straightforward as possible. But do not let its length belie the effort behind each line, each strategy. An untold number of people running local LGBT tobacco control programs have struggled to build this wisdom base. As each person reads and uses this document, these pioneers can be assured that their efforts will live on.

Sincerely,

Scout, Ph.D.

Acknowledgements

The Network for LGBT Health Equity extends its deepest gratitude to the Best Practices Committee members for leadership in advancing the area of LGBT tobacco prevention and control by volunteering hundreds of hours and their expertise to compile this collection of best and promising practices. This report will improve the health of lesbian, gay, bisexual, and transgender communities by reducing tobacco-related health disparities. We are also grateful to ETR Associates for leading the preparation of this report.

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Part 1
INTRODUCTION

In the decades that data have been amassed on Lesbian, Gay, Bisexual, and Transgender (LGBT) tobacco disparities, the findings from research studies remain remarkably consistent. No matter how large or small the study—if it is regional or national, full probability or otherwise—most all report that LGBT people smoke at rates from 35% to almost 200% higher than the general population.[1] Stigma creates community-level vulnerabilities that are a marketing opportunity for the tobacco industry, one they have not ignored.

The lack of routine data collection still profoundly affects this arena.[2] As a result, there is too little information about the outcomes of this smoking disparity—about the inevitable cancer, heart disease, lung disease and other burdens the naturally follow higher smoking rates. This lack of information drives the lack of tailored intervention for the LGBT communities in these health areas.

The lack of routine data collection hinders progress primarily by not providing the right type of data upon which policy and funding decisions are made. While there may be sufficient data to prove a profound disparity nationwide, states setting priorities want statewide data, which is rarely available for LGBT people. Federal applicants for funding are sometimes allowed to include an LGBT focus if they prove the need via data from recognized datasets, which rarely collect LGBT information.

The omission of LGBT data in the beginning of the decision-making process about where tobacco control resources are deployed too often results in omissions further downstream: lack of LGBT focus in statewide tobacco control efforts; lack of tailored LGBT tobacco control projects; lack of research on the utilization of quitlines by this disparity population, and so on.

Ultimately, the national landscape for LGBT tobacco control has become a sporadic scattering of inclusion, projects, and prioritization. This uneven distribution makes it that much more important to share the best practices built in this arena.

The Network for LGBT Health Equity is dedicated to culling the effective strategies learned from programs and making them accessible to the many other people who want to build similar projects in their regions. The Network is one of six CDC- funded tobacco disparity networks, each dedicated to convening people, identifying best practices and fostering the growth of the field. Our work is very much informed by the other disparity networks we work alongside. We benefit not only from information about how LGBT people of color and low socioeconomic status are impacted by tobacco, but also from seeing what similar barriers are encountered by other disparity networks.

There is actually a wealth of information on how to integrate LGBT people and the other overlapping disparity populations into the larger fabric of tobacco control. It is perhaps the lack of formal precedent that has led to the growth of this knowledge base. Many local project directors have had to experiment with their strategies, just as we have at the Network. At the national level we often try two, three, or even five different strategies before we find one that succeeds. This trial and error is the heart of scientific experimentation, and it yields a wealth of information.

Each year a dozen states contact the Network for LGBT Health Equity asking for assistance in expanding their LGBT integration in tobacco control work. The demand for best practices knowledge is clearly there.

Until now, too much of this information has been scattered across different people. Are you conducting your first needs assessment? Do you know that looking at the finding reports is much more illustrative than looking up sample instruments? Do you know to talk to Oregon, Missouri, Minnesota, and Georgia people for different perspectives on successful strategies? Do you know what pitfalls to avoid? While the Network has often tried to provide this community overview as part of technical assistance, it was not documented anywhere accessible.

We want this best and promising practices report to fix that gap.

In the pages that follow, you will find a unique assemblage of detail on the specific practices that have been used repeatedly at the local levels to create effective projects and policies. Under the guidance of our Best Practices Committee, a national call for information was released, a scientific committee reviewed the scientific literature and created a framework, then successive calls for additional data were released until we felt comfortable that the juried result was a balanced and detailed collection of the range of practices used by people across the country to reduce the burden of the LGBT tobacco disparity.

We have built this document on the World Health Organization's preeminent best practices model outlining key steps for every tobacco control program, MPOWER: Monitor, Protect, Offer, Warn, Enforce, Raise.[3] But upon close scrutiny, this model was not enough for our disparity-based lens. Two additional letters were decided upon to address the key challenges LGBT people and so many overlapping disparity populations face: E for Evaluate (and disseminate) and D for Diversify.

Because this document is the most comprehensive list of those practices built over decades of experimentation by hundreds of research and tobacco control projects across the country, we hope it will be read by policy makers, grant makers, and grant applicants. Simply put, if you want to eliminate LGBT tobacco disparities, here is your roadmap.

Part 2
METHODOLOGY

Lesbian, gay, bisexual, and transgender people are at higher risk of tobacco use.[1,4] There is virtually no research on the interventions specific to tobacco dependence treatment or prevention among LGBT populations,[1,5,6] and the research literature is inconclusive on the etiology of this disparity.[7] Yet there is a compelling need for intervention, and community organizations and health departments across the U.S. have LGBT interventions underway in bars, telephone cessation services, smoking cessation groups, evaluation systems, and community coalitions.[8-12]

What these interventions are has not been enumerated; nor have researchers or funders identified the most promising of them. It has become clear that the diffusion of best practices is challenging, in part, due to differences between the interests of academic researchers and the practical realities of community and state public health professionals.[13] These differences have led to calls for capturing and testing innovations developed by community organizations, local health departments, and others outside of academia.[14] Evaluators have developed a technique of evaluability assessment to vet innovations for further research on efficacy and effectiveness.[15] However, evaluability is only one part of a larger screening process. To help translate practice into research for the most promising innovations and programs, the Robert Wood Johnson Foundation and Centers for Disease Control and Prevention developed a Systematic Screening and Assessment (SSA) method to identify, vet, and assess innovative programs in obesity prevention[16] with the express goal of translating practice into research.[17]

Since SSA provides an excellent method for identifying existing interventions developed outside of the academic research community and currently being implemented in communities across the U.S., the Network for LGBT Health Equity modified the SSA process to develop a list of promising and best practices for tobacco prevention and treatment in LGBT communities. To do this, the Network convened a Best Practices Committee pulling together a team of experts from community and academic institutions with diverse interests and knowledge across multiple LGBT identities. This group of eight developed the process, collected nominations, reviewed submissions, and synthesized findings with the existing research on best practices in tobacco prevention and control.

The group chose to use a modified version of the World Health Organization's MPOWER framework[3] to structure the collection of programs and the reporting of best and promising practices, MPOWER is an acronym which stands for the following strategies:

- Monitor the epidemic
- Protect from secondhand smoke
- Offer support to quit
- Warn of the dangers of tobacco use
- Enforce protections
- Raise tobacco taxes

The Network added two additional strategies—Evaluate programs and disseminate findings and Diversify the tobacco control movement—to create MPOWERED: Best and Promising Practices for LGBT Tobacco Prevention and Control.

To solicit innovations, the Network created weekly prompts, one for each MPOWERED letter, that were distributed to the Network's discussion list and via blog and twitter postings over an eight-week period. Prompts were sent at the beginning of the work week, and a reminder was sent prior to closing at the end of the week. Respondents were randomly selected for gifts (e.g., Network pens and a gift card). The MPOWERED team met for an in-person, two-day meeting to review and synthesize submissions. Each letter was reviewed by a subcommittee and then by the full group. A final draft was posted on the Network's discussion list and blog for final input from the Network's membership. Following the last solicitation for comments, the group of eight finalized the report.

Future efforts should include further evaluability assessment on these promising practices and should invest in rigorous evaluation, the final two steps of SSA. Both researchers and practitioners should be aware that the processes of developing, implementing, and evaluating interventions may be as or more important than following evidence-based programs when translating interventions across populations.[18]

Part 3
BEST AND PROMISING PRACTICES

MPOWERED: Monitor the Epidemic

Monitoring is critical for LGBT tobacco control. If we are not counted, we don't exist!

Effective tobacco control starts with high quality data. Effective monitoring of the tobacco pandemic must include diverse and marginalized populations such as LGBT communities. However, even though LGBT communities are disproportionately affected by the tobacco epidemic, they are consistently left out of critical surveillance at the national, state, and local levels.[19,20] Until sexual orientation and gender identity are systematically measured in health surveys, LGBT deaths from tobacco-related causes will remain in the closet.

Fortunately, federal precedent on collecting data is finally evolving to include LGBT measures. In 2011, Secretary of Health and Human Services Kathleen Sebelius announced that the premier federal benchmark health survey, National Health Interview Survey, would include LGBT measures. That inclusion is underway now. Even before that, the National Adult Tobacco Survey had already set precedent by including an LGBT-combined measure. A growing number of individual states, such as New Mexico, Massachusetts, and Minnesota, also include LGB, or preferably LGBT, measures. This trend is expected to continue in coming years.

Research has demonstrated that when included as a standard demographic question, the sexual orientation question is no more sensitive than other variables (and is actually less sensitive than questions about income).21 Response rates from a recent study of the New Mexico quitline conducted by Free & Clear indicate that only 2.5% of 3,549 callers refused to answer the sexual orientation question. Further, "callers who refused to answer one sensitive question were much more likely to refuse to answer any other questions considered personal and sensitive. This finding suggests that the refusal may be less related to the topic per se (race, sexual orientation, etc) and more associated with general unwillingness to report on any personal issue."

In the Massachusetts Behavioral Risk Factor Social Survey, an average of 3.6% of people (spanning five years) refused to answer the sexual orientation identity question, compared with 5.3% who refused to answer the income question. In a survey of the North American Quitline Consortium members, refusals to this question (asked at intake) ran from 1.9% to 2.9%. Again these compared very favorably with refusals for other demographic questions.

In three different methodological studies, researchers have shown that a sexual orientation question can be asked early in a demographic section as part of a phone or household survey with no notable adverse effect. Strikingly, the National Epidemiological Survey on Alcohol and Related Conditions has had zero breakoffs on the sexual orientation question in over 30,000 interviews (with only 1.7% refusal rate). Likewise, the Nurses Health Study II had zero breakoffs in 91,000 paper surveys administered with a sexual orientation identity question in 1995 (with only 0.9% refusal rate).

In short, concerns about breakoffs or agitating the respondents with this question are largely unfounded. In the words of one researcher, "Most people are happy to state that they are straight."

Monitoring is a critical component for LGBT tobacco control at the local, state, national level—Myths about the difficulties of collecting LGBT data on surveys continue to hinder the inclusion of LGBT questions on health monitoring surveys.[21–23] Until measurement of sexual orientation and gender identity becomes a routine part of the core demographic sections of health surveys, tobacco disparities will persist.

Best and Promising Practices:

- LGBT questions should be routinely included in the demographic sections of health monitoring and evaluation surveys.
  - Examples include: Behavioral Risk Factor Social Survey, Youth Risk Behavior Survey, Adult Tobacco Survey, and all relevant federal surveys.
- Routine state and national surveillance should be augmented by community-level data on tobacco use among subpopulations.
  - Examples include: attitudes about tobacco use; attitudes about targeting; awareness of community smoking disparity; awareness of cessation services; use of quitlines; attitudes about wellness policies; awareness of wellness policies; frequency of social smoking; and concomitant stress-related health markers such as addictions or mental health variables.

Monitoring must be scientifically valid—There are a number of considerations for developing surveillance systems to capture tobacco use in LGBT communities, including measurement, sampling, and ensuring the validity of data. A mix of full probability and non-probability methodology is needed to effectively monitor the health status of the population.

Best and Promising Practices:

- State and national surveys (e.g., full probability surveys) should:
  - Use standardized sexual orientation and gender identity measures that are cognitively and field tested.[24]
  - Be sure to consistently collect both sexual orientation and gender identity.
- Non probability survey methods:
  - A first step in creating valid surveillance of smaller groups within the LGBT communities may first call for community needs assessment and/or ethnographic study.
  - Need to ensure that the sampling plan to be implemented will yield a representative sample of the community. For example, recruiting exclusively from bars does not yield a representative sample of the LGBT community.
    - The Tobacco Research Network on Disparities (TReND) with funding from the National Cancer Institute and American Legacy Foundation pulled together sampling challenges for LGBT of color using a tobacco lens. The resulting report compiles the best thinking of community-based researchers and calls for a broader approach to mixed methods sampling when looking at hidden populations.[25]

- Additional monitoring strategies:
  - Look for other opportunities for surveillance, such as research studies, quitline intakes, and any other place where tobacco control knowledge is being amassed.

More research is needed to fully understand LGBT tobacco use disparities and potential points of intervention—Understanding the complicated profile of LGBT tobacco disparities requires measuring factors beyond prevalence.[7]

Best and Promising Practices:

- Additional studies should be considered to address gaps in the areas of tobacco-related LGBT issues. The following list is not comprehensive but provides a few examples:
  - Uptake.
  - Outcomes.
  - Attitudes, norms, and beliefs.
  - Quitline utilization.
  - Impact for LGBT of color, bisexuals, and Transgender people.

Publicize findings—In the absence of routine inclusion in state and federal surveillance, local studies take on particular importance. Current justification of LGBT tobacco projects often relies on local study data from other jurisdictions. It is particularly important to collect data and routinely publish findings.

Best and Promising Practices:

- Report LGBT breakout data in all routine surveillance and disparity monitoring reports.
- Report community-based study data broadly.

MPOWERED: PROTECT LGBT People from Tobacco Smoke

All people deserve equal protection from the dangers of secondhand smoke

Secondhand smoke (SHS) is a known carcinogen, and there is no safe level of exposure.[26] Comprehensive clean air policies are effective in protecting LGBT communities from the dangers of SHS and changing community norms around tobacco use, and LGBT communities are overwhelmingly supportive of clean air policies. However, the tobacco industry has aggressively worked to undermine policies to protect communities from secondhand smoke. Tobacco-free policies where people work, play, and live are key to protecting LGBT communities.[27]

As North Carolina's General Assembly prepared to vote on House Bill 2, a bill to require clean indoor air in virtually all restaurants and bars, tobacco control advocates in that state became worried that the tobacco industry would seek to influence LGBT rights groups to oppose the measure. Advocates from the University of North Carolina and the NC Alliance for Health met with EqualityNC, a statewide advocacy and educational group for LGBT rights, to provide information about the burden of tobacco-related disease among LGBT people. These connections and information sharing led EqualityNC's board to officially endorse legislation promoting clean indoor air in a tobacco growing and manufacturing state. Thanks in part to this work, North Carolinians started enjoying clean indoor air in bars and restaurants on January 2, 2010.

Best and Promising Practices:

***Protect LGBT people where they* WORK**

- ***Engage the LGBT community in comprehensive clean indoor air policy adoption***—Engaging LGBT community to support comprehensive clean indoor air policies has been quite effective. The history of tobacco industry co-opting LGBT leadership to institute exemptions makes it especially important to gain support from the LGBT communities for smoke-free policies.
- ***Protect employees from tobacco exposure in the workplace***—Smoke-free policies do not hurt businesses and protect the health of patrons and staff from tobacco-related illnesses.

***Protect LGBT people where they* PLAY**

- ***Make LGBT community events smoke-free***—Smoke-free policies at community events are effective at protecting LGBT communities from the dangers of secondhand smoke and changing community norms around tobacco use. Some gains have been made in certain venues, but further work is needed:
  - Pride events.
  - LGBT community events/festivals .
  - Gay rodeos.
  - LGBT sports events.
  - LGBT community centers.
- ***Make restaurants and bars smoke-free***—Smoke-free policies not only protect the staff but the patrons as well. Smoke-free establishments are welcomed by LGBT people and have had no negative impact on business revenue. Some gains have been made in certain venues, but further work is needed to expand the types of smoke-free spaces and increase compliance with existing policies:
  - LGBT bars.
  - LGBT restaurants and outdoor dining.
  - LGBT special events.

***Protect LGBT people where they* LIVE**

- ***Make LGBT living environments smoke-free***—Smoke-free homes protect residents and increase quit attempts. It is important that LGBT homes are included in smoke-free and multi-unit housing campaigns. There are significant opportunities for coalitions working on smoke-free homes and multi-unit housing to partner with LGBT communities.

MPOWERED: Offer Support to Quit

LGBT smokers want to quit, and they welcome help that is culturally appropriate

The majority of LGBT smokers are interested in quitting. Effective smoking cessation treatments are available, including stop smoking medications, counseling approaches, and self-help methods.[5] However, LGBT smokers experience multiple barriers to accessing effective and culturally appropriate treatments. Multi-dimensional approaches to treatment are needed to increase LGBT smoking cessation rates.

Blue Cross Blue Shield of Minnesota engaged the Network for LGBT Health Equity to assist with part of their multi-faceted campaign to make quitlines more accessible to Minnesotans. While ad materials, a quitline LGBT educational booklet, and best surveillance questions were developed, the main component of the campaign was to train quit coaches from several different quitline vendors in LGBT cultural competency. The Network developed a training curriculum and administered it times to staff from quitline vendors across the country. Evaluations of the training were uniformly very high and even quit coaches who had felt comfortable admitted they learned about issues they hadn't considered previously. The high volume of trainings helped hone and refine the training issues employed. Ultimately the final curriculum was embedded into the GLMA online LGBT tobacco continuing education training, so it's still accessible today.

To ensure equal access, all smoking cessation awareness campaigns and treatment services should include programs targeted and/or tailored to LGBT—Public health approaches are relatively cost-effective strategies for raising awareness, increasing knowledge, and improving access to smoking cessation services. Tobacco prevention and smoking cessation messages that are targeted to specific communities may be effective in reducing smoking-related health disparities. Targeted messaging for disparity populations should also include LGBT communities.

Best and Promising Practices:

- Highlight in public health advocacy campaigns LGBT disparities in smoking prevalence rates.
- Outreach and awareness campaigns for LGBT smokers should include information about the availability and effectiveness of stop smoking treatments.
- Include LGBT-specific elements in all media campaigns targeted for disparity populations.
- Use traditional and social media approaches.
- Use messaging that has been tested with LGBT people.
- Message framing focusing on successes and overcoming may be more successful than focusing on the size of the disparity.

Increase quitline utilization and efficacy for LGBT communities—Few smokers get the help they need to quit smoking. Telephone coaching services are now available in all 50 states and U.S. territories. State-supported quitlines serve as a cost effective treatment strategy that overcomes traditional barriers to treatment including ability to pay, geographical location, and transportation. Cultural competency training and targeted outreach can increase utilization of state quitlines among LGBT smokers.

Best and Promising Practices:

- Require cultural competency trainings for all state quitline staff.
- Include sexual orientation and gender identity as part of standard demographic questions to tailor information and resource dissemination.
- Increase the saliency of coaching by providing LGBT-specific information.
- Ensure quit coaches are trained to answer questions about the health implications of smoking for people living with HIV and AIDS and transgender people using hormones.
- Offer supplemental LGBT-specific written materials that can be mailed to callers.
- Provide callers with additional referrals to any locally available LGBT-specific cessation resources.
- Target outreach efforts specifically to LGBT communities (e.g., targeted billboards, advertisements in LGBT media outlets) in order to increase utilization.
- Conduct more research on LGBT utilization of quitlines and evaluate smoking cessation outcomes based on sexual orientation.

Provide culturally competent quit advice and smoking cessation services—Research among racial and ethnic minority communities demonstrates the benefits of culturally targeted smoking cessation interventions. Culturally competent and targeted smoking cessation services reduce barriers to treatment and improve cessation outcomes.

Best and Promising Practices:

- Use current best practices to guide smoking cessation services for LGBT smokers.
- Offer smoking cessation treatment programs at locations that are safe and affirming to LGBT individuals.
- Ensure that treatment providers (individual therapists, group facilitators, peer counselors) are culturally competent and knowledgeable about community–level barriers to smoking cessation (e.g., minority stress, higher rates of depression and substance use, bars as a social venue).
- When possible, provide LGBT specific treatment groups to increase comfort, trust, and mutual support.
- Evaluate and consider offering culturally targeted smoking cessation curriculums such as "The Last Drag,"[12] "Bitch to quit," and "Out to quit."
- Consider online cessation methods to increase access to LGBT persons living in non-urban areas (e.g., iQuit).

Clinical Practice Guidelines[5] that address health care systems and providers should be consistently implemented—Providers and health care systems serving patients should adhere to clinical practice guidelines because doing so improves quit rates. Integrating tobacco intervention into the delivery of health care represents an opportunity to increase rates of accessing tobacco dependence treatments, quit attempts, and successful smoking cessation.

Best and Promising Practices for Health Care Providers:

- Implement the 3As: ASK about and document smoking status, ADVISE smokers to quit, and ASSIST patients with accessing cessation services.
- Provide LGBT smokers with information about local cessation services (including LGBT specific services if available).

Best and Promising Practices for Healthcare Systems:

- Implement a systematic method for identifying tobacco users in the medical records (e.g., make smoking assessment a "vital sign" at intake).
- Ensure that assessment and delivery of smoking cessation treatment is included in staff performance evaluations.
- Provide training and resources on cessation for all of their health care providers.

Funding for treatment should address LGBT tobacco users—Despite elevated smoking prevalence rates, LGBT populations are not consistently included as a disparity population in efforts to reduce tobacco-use disparities. All general and disparity population cessation services should include LGBT-specific programs to ensure equal access.

Best and Promising Practices:

- Funding should be provided to offer and evaluate culturally tailored programs such as "The Last Drag,"[12] "Bitch to quit," and "Out to Quit."

MPOWERED: Warn About the Impact of Tobacco Use on the LGBT Community

LGBT communities are not invisible to the tobacco industry; they should not be invisible in tobacco control media campaigns

LGBT people are more likely to smoke than non-LGBT people. In fact, they have one of the highest smoking rates among disproportionally affected populations. However, even though media campaigns that are part of comprehensive tobacco control are effective and there is clear evidence of extensive tobacco industry media and marketing campaigns that target LGBT communities, there has not been a comprehensive media campaign that counters the toll of the tobacco epidemic in LGBT communities. As a result, it is critical to develop and implement well-tested and LGBT-specific media campaigns to counter the tobacco epidemic.

The tobacco industry's aggressive targeting of the LGBT and questioning communities and the harassment, disenfranchisement and marginalization this group faces contribute to its growing tobacco use. The Cigarettes Are My Greatest Enemy is anti-tobacco counter-marketing campaign developed with the Billy DeFrank LGBT Center (San Jose, CA) and The LGBT Center Orange County and funding from American Legacy Foundation. Advertisements were developed based on focus groups of LGBT smokers and then designed to be used in multiple formats—print ads, posters, palm cards, postcards, billboards, transit ads. The campaign ran primarily during 2003 in LGBT press outlets in San Francisco and Los Angeles and appeared in venue-based displays (i.e., restrooms, lobbies) in retail and community agency settings in Orange and Santa Clara counties. The powerful ads featured real people from the LGBT community who had dealt with and overcome personal battles such as drug and alcohol use, depression, HIV, or rape—all issues of high prominence or concern in the LGBT community—but who also had issues with tobacco use. For example, one ad captured Terry's story: "I didn't survive crystal meth so I could die from lung cancer. I had to stop smoking." Each ad included the headline: Cigarettes Are My Greatest Enemy" and the fact: Tobacco causes more deaths than AIDS, drugs, breast cancer and gay bashing combined.

Response to the advertisements was positive and they generated interest by media outlets as well as public health programs across the United States and overseas. A post-campaign evaluation found that 74 percent of respondents indicated that they gained an awareness of the high rates of smoking in the LGBT community as a result of the ads. Further, 64 percent of respondents indicated that they thought about or decided to quit smoking as a result of these advertisements.[28]

Create media campaigns that effectively reach and impact LGBT communities—A well-designed public education campaign that is integrated with community programs, strong enforcement efforts and help for smokers who want to quit has been documented to successfully counter tobacco industry marketing. Effective warning labels, anti-tobacco advertising, and the proactive use of earned media are three key ways to communicate health risks of tobacco. LGBT media may be particularly cost effective yielding a solid return on investment. LGBT media placements can shape dialogue within the community and encourage action by community leaders.

Best and Promising Practices:

- Include an authentic representation of the diversity of LGBT people during campaign development and advertising message testing and utilize community groups for recruitment/outreach in testing.
- Recognize that differences exist within the LGBT community, so messages and approaches should be developed and tailored as appropriate based on geography, culture, background, etc.
- Make tobacco use salient by linking the issue with existing community priorities (e.g., combine messages about tobacco and HIV, violence, civil rights, obesity, etc.)
- Engage the LGBT community—via community promotion and leadership engagement to increase awareness about LGBT smoking disparities.
- Seek dedicated funding for campaigns that include and target LGBT communities (i.e., imagery, ad buys).
- Consider how existing ads can be easily modified and tailored for LGBT communities (look at tobacco industry examples).
- Share campaigns with partners widely (i.e., submit advertisements to clearinghouses, post information online) in order to allow for broader use.
- Negotiate rights upfront that allow for use by other organizations over time and permit easy adaptation by partners.

Use LGBT media outlets and social media channels for earned, paid, and online media campaigns—LGBT media outlets provide a concentrated, qualified LGBT audience and are highly trusted by LGBT people. "Earned media" and social media can be an inexpensive way to effectively reach LGBT communities. Surveys show that the LGBT communities are more active on social networks than heterosexuals. Aside from being more active on Facebook and Twitter, they are also more likely to read blogs, and as a result, most likely to be receptive to social media marketing. Social media strategies can be particularly effective for rural, youth populations.

Best and Promising Practices:

- Seek dedicated and sustained funding for advertising placement in LGBT media outlets.
- Proactively support LGBT events such as film festivals with advertising and sponsorships to counter tobacco industry support and reach LGBT people.
- Utilize best practice earned media approaches (e.g., localize messages; identify media-worthy issues to capture attention) and tactics (e.g., press releases and PSAs) and media advocacy (e.g., letters to the editor/publisher) targeted to LGBT-focused media outlets.
- Supplement traditional paid and earned media campaigns with social media tactics and low-cost social media advertising placement.
- Develop social media campaigns to take advantage of viral marketing.
- Build relationships with LGBT bloggers.
- Consider creating and maintaining own blogs.

Partner with mainstream organizations to leverage LGBT inclusion in tobacco prevention and control campaigns—Working with partners to incorporate LGBT messages and media venues can leverage others' investments in media campaigns and extend reach to LGBT communities.

Best and Promising Practices:

- Advocate for LGBT representation in mainstream media campaigns and inclusion in efficacy testing of media campaigns and warning labels.
- Work with other organizations (e.g., American Cancer Society, American Lung Association) to seek inclusion of LGBT messages/issues into mainstream campaigns.
- Maximize instances when other organizations include LGBT messages/issues in their campaigns via LGBT-earned media, social media, and wide dissemination.
- Seek funding from mainstream organizations to support the development of campaigns to LGBT people.

MPOWERED: Enforce Bans on Tobacco Industry Promotions and Sponsorships

LGBT communities are not for sale.

Tobacco companies have targeted LGBT populations for decades both through product advertising and philanthropic support.[29] Through these efforts, tobacco companies have sought to attract LGBT smokers, curry support, and blunt criticism from LGBT community leaders. Tobacco industry advertisements are filled with subtle and not-so-subtle LGBT imagery and messaging. In addition, tobacco companies offer an unknown amount of financial support to LGBT festivals, bars, media, and local organizations. Sometimes this money comes with conditions such as prohibiting gay bars from allowing clean air and tobacco prevention efforts onsite. As early supporters of LGBT causes, the tobacco companies garnered positive community responses since many other organizations avoided LGBT organizations. This tobacco industry funding sometimes compromised tobacco prevention activities by LGBT community organizations.

For decades tobacco companies have targeted LGBT populations leading to tobacco product addiction among friends, family and colleagues and compromising the communities' work against this devastating public health threat.

One example of this targeting has been documented by tobacco control professionals who discovered internal tobacco industry documents that revealed a tobacco company marketing campaign that was designed to increase smoking and brand loyalty among homeless people and lesbian, gay, and bisexual adults in San Francisco's Castro district. The marketing document was titled Sub Culture Urban Marketing or Project SCUM.

Project SCUM, according to TobaccoDocuments.org, was an R.J. Reynolds plan circa 1995–1997 to increase promotion of its flagship brand Camel cigarettes to low socioeconomic consumer subcultures in the San Francisco Bay area. Specifically those targeted were gay people in the Castro district, young people ("rebellious, Generation X" –ers), immigrants and foreigners (people of "International influence") and the homeless ("street people"). By marketing Camel cigarettes in less-traditional retail outlets like "head shops", the company hoped to leverage what it believed was a higher incidence of smoking and drug use among these urban subcultures.

R.J. Reynolds was not alone in seeking to attract LGBT people to smoke. A 1994 internal Philip Morris report on reaching the gay market with its Marlboro brand identified its advertising icon the Marlboro Man as "the ultimate stud," "orally fixated (positive)," and "maybe a great one-nighter."

Counter tobacco industry influence in the LGBT community—tobacco industry documents reveal a long history of manipulative marketing tactics.[29–31] The industry has spent billions to strategically market its products to targeted populations, including LGBT people. Other strategies include funding LGBT organizations[32] and making campaign contributions to LGBT politicians. These "corporate social responsibility" tactics serve to cultivate positive perceptions of the industry and undermine tobacco prevention efforts. Public health and community groups have had success exposing tobacco industry tactics.

Best and Promising Practices in Monitoring: [33]

- Monitor the tobacco industry's non-media tactics (corporate social responsibility, recruitment, etc.).
- Monitor the tobacco industry's media buys and promotions,[34] including point of sale, that target LGBT communities.
- Monitor the tobacco industry's campaign contributions to political candidates
- Encourage use of tobacco industry documents to expose tobacco industry efforts aimed at the LGBT community.

Best and Promising Practices in Education:

- Challenge the tobacco industry's co-opting of LGBT community imagery[35] and messaging in their targeted advertising.
- Educate the LGBT community on the history of tobacco industry attempts to market to and infiltrate LGBT communities, including supporting LGBT-elected officials.[36,37]
- Build awareness about tobacco industry marketing and ad buys focused on the LGBT community.
- Expose tobacco industry sponsorship of LGBT organizations, programs and events and juxtapose this with the deadly impact of using their products. Speak out against any depictions of smoking in gay-oriented media. Publicly challenge the tobacco industry when its tactics are found to be counter to public health, societal ethics, etc.

Eliminate tobacco industry marketing in venues that serve the LGBT community—Bars and nightclubs have traditionally been a safe social space for the LGBT communities.[8] The tobacco industry utilizes these spaces to market tobacco products through venue-based promotions (giveaways, events, name recruitment) and provision of functional items (coasters, napkins, signage) that include tobacco brands and pro-tobacco imagery.[30] The tobacco industry contracting with establishments may present barriers to implementing tobacco control work in those venues.

Best and Promising Practices:

- Adopt policies that reject tobacco industry advertising, event sponsorships, and other promotions.[38]
- Hold LGBT media outlets and partner organizations accountable to ensure they refuse offers of tobacco industry advertising buys or other support.
- Engage local organizations and coalitions to ban point of sale tobacco product advertising and promotions, and when possible, partner with mainstream organizations working on restrictions/bans and enforcement.
- Include LGBT leaders/communities in policy advocacy and policy change efforts.

MPOWERED: Raise Taxes on Tobacco Products

Tobacco taxes improve health and should fund programs for LGBT people

Tobacco taxation is one of the most effective strategies for lowering tobacco use consumption and prevalence, especially for youth.[27] Similar to the positive influence on the general population, increasing tobacco taxation may have a positive influence on lowering initiation rates among LGBT youth and increasing cessation rates among regular adult LGBT smokers.

The Yes on Prop. 29 campaign in 2012, which sought to raise the tax on tobacco in California by $1.00, put out a call to organizations to support the tobacco control tax initiative. This was encouraged by the African American Control Leadership Council, which urged the campaign to include more diverse populations. In response to the call, a proposal from the Coalition of Lavender-Americans on Smoking and Health (CLASH) was selected to assist the campaign with LGBT voter outreach.

Engage LGBT communities in mainstream policy change campaigns—LGBT people are disproportionately affected by tobacco use and thus stand to greatly benefit from comprehensive tobacco control policies, especially those that fund LGBT-specific tobacco control programs. LGBT organizations are well equipped with advocacy skills and experience to mobilize the community in favor of tobacco tax increases.

Best and Promising Practices:

- Engage local LGBT organizations and communities in tobacco control to increase awareness of and support for tobacco tax campaigns.
- Include LGBT organizations and leadership in tobacco control coalitions.
- Fund community-based organizations to engage and activate LGBT communities on tobacco tax and media counter-advertising campaigns.
- Leverage existing relationships with LGBT-friendly policy makers to promote tobacco control aims.
- Work with LGBT organizations and LGBT politicians to divest of or refuse to accept tobacco industry donations.
- Avoid inclusion of anti-LGBT organizations in coalitions.
- Provide resources that will sustain the capacity of LGBT groups involved in tobacco control efforts.

Use Tobacco taxes to fund local tobacco control programs and initiatives, especially those serving disparity populations inclusive of LGBT communities—Historically, tobacco taxes have rarely been invested in comprehensive tobacco control efforts. Unfortunately when funds are made available for tobacco control, less than recommended funds are dedicated to priority populations inclusive of LGBT communities. Funding to support prevention and cessation in LGBT communities is needed.

Best and Promising Practices:

- Engage community leadership to increase support for funding for tobacco control efforts.
- Include community-based funding for priority populations to build support for tax increases on tobacco products.
- Allocate tobacco tax revenue towards community-based tobacco control programs and initiatives among priority populations.

Counter potential tobacco industry manipulation of the LGBT community in tobacco tax campaigns—The tobacco industry has a long history of influencing the LGBT community through targeted campaigns and funding opportunities and has previously manipulated the community in specific tobacco tax campaigns. Countering the tobacco industry's influence around tax increases presents an opportunity to expose the industry's exploitation of the LGBT community while working towards reducing smoking within the population.

MPOWERED: Evaluate Programs and Disseminate Findings

The evaluators gaze: picking up and improving programs

Innovative programs to address the tobacco epidemic in LGBT communities exist; however, few of these programs have been evaluated. Thus, is it unclear which of these programs work best and where resources should be targeted. Evaluation can build the evidence base for developing better ways of preventing and treating tobacco addiction.

North Carolina's comprehensive statewide tobacco prevention and cessation initiative was administered by the North Carolina Health and Wellness Trust Fund, which received a portion of that state's Master Settlement Agreement funds. The NC Tobacco-Free Colleges Initiative and the Teen Tobacco Prevention and Cessation Initiative ("Tobacco. Reality. Unfiltered.") funded programs across the state to work on youth empowerment and college campus policy change. The Commission funded an independent evaluation team at the University of North Carolina at Chapel Hill to develop program logic models, collect monthly program data, and provide quarterly and annual reports. To ensure program reach to priority populations, both programs collected routine, monthly data on the number of meetings, media messages, and organizations supporting policy change that directly involved priority populations including LGBT. By including LGBT reach as a core program indicator, each grantee had to consider on a monthly basis their work with LGBT populations.

Programs and funders should give clear guidelines for evaluation outcomes and provide adequate funding to ensure that rigorous evaluation practices are followed—evidence-based programs are needed to guide the best uses of limited resources in LGBT tobacco control. Investment in well-designed and well-implemented evaluation can strengthen efforts to address the tobacco epidemic.

Best and Promising Practices:

- Treatment groups should follow standard best practices documented in Howard Brown's "How to run tailored LGBT culturally competent cessation treatment groups."[39]
- Funders should ensure that at least 10% of budgets are devoted to program monitoring and evaluation.[40]
- Evaluators should be incorporated into program planning and design.
- Organizations and state agencies should ensure that evaluation approaches are relevant to programs, improve quality, and are actionable.[10] Principles of utilization-focused or empowerment evaluation may be a particularly good fit.
- Funding streams are more effective when evaluation is incorporated into the funding stream.

State tobacco control evaluators should include measures of LGBT reach, access and impact in comprehensive program and media campaign evaluations—LGBT indicators should be part of the core reporting requirements.

Best and Promising Practices:

- Specific care should be taken with the measurement of quit attempts and their duration.[39] Standardized questions should be used whenever possible.
    - Standard optional quitline intake questions.[41]
    - Surveillance questions.[24]

There is a compelling need for better sharing of evaluation results and lessons learned by LGBT community organizations, evaluators, and funders to disseminate findings—In an environment of limited resources and local community efforts, there is considerable value in sharing lessons learned and innovations between programs. Innovations developed in one state need to be available for other states.

Best and Promising Practices:

- Results from evaluations should be submitted to the Network for LGBT Health Equity's resources page for sharing.
    - Funders should require that project reports and lesson learned be submitted to such a clearinghouse.
- Funders should examine their reporting requirements and develop reports in a format that lends itself to wider dissemination.
- Partnerships between academic organizations and community organizations can result in academic publication of findings.
- Whenever possible, evaluation results should be shared back to communities for further discussion and development of next steps and to build advocacy campaigns.

MPOWERED: Diversify the Tobacco Control Movement to be Inclusive of Race, Ethnicity, Youth, Sexual Orientation and Gender Identity.

We are stronger together

The mainstream tobacco control movement is committed to reducing smoking disparities but has often neglected to engage the LGBT community in tobacco control efforts. Additionally, LGBT organizations have not consistently been inclusive of the diversity of subpopulations harmed by tobacco. Tobacco control efforts are stronger with the involvement of coalitions across populations and can more effectively address tobacco disparities. Marginalized groups that are especially affected and targeted by tobacco are valuable stakeholders in tobacco control initiatives.

Engage the Transgender community

The New Mexico Community Planning and Action Group (CPAG) engaged the transgender community in tobacco control by creating The Transgender Taskforce. Established as a partnership between the New Mexico Department of Health and the local transgender community, the taskforce seeks to address HIV, substance abuse (including alcohol and tobacco), and other health disparities in the local transgender community. The CPAG and the Transgender Taskforce have since collaborated with the community-based LGBT health organization Fierce Pride in tobacco control initiatives

Engage LGBT youth and youth of color:

YouthPride Services, with support from the National Youth Advocacy Coalition and the American Legacy Foundation, conducted youth-led focus groups centered around tobacco use among LGBT youth of color. Black, MSM and LGBT youth of color were given decision-making power in the formation of the focus group, the group's activities and participation in events relevant to tobacco control. These focus groups were engaged in discussions around tobacco use in the community, and participants interviewed peers on tobacco-related behavior and perceptions of smoking.

Tobacco policy must be created with LGBT community input at all levels—LGBT organizations bring considerable community-organizing and advocacy expertise and experience to tobacco control campaigns. Tobacco control programs and policies benefit from LGBT engagement at the local, state, and federal levels and also at all stages of program planning, implementation and evaluation.

Best and Promising Practices:

- Enlist the expertise of LGBT organizations on community advisory bodies, especially those determining funding.

- Ensure representation of the diversity within the LGBT community.
- Ensure constructive engagement by identifying LGBT representatives who are recognized community leaders with access to other LGBT and allied leadership and organizations.
- Avoid bringing politicized, anti-LGBT organizations into policy change coalitions.

LGBT-community based activities are strengthened through collaboration with nontraditional partners and allied organizations—Partnerships with non-LGBT organizations represent a missed opportunity in strengthening LGBT tobacco control efforts. Tobacco control aims can be achieved by building collaborations and developing relationships with potential allies.

Best and Promising Practices:

- Require cross-training between priority population organizations.
- Build linkages and collaboration with relevant organizations including racial and ethnic minority groups and professional and health-related networks.
- Encourage LGBT community-based organizations to support the initiatives of allied organizations.

Engage LGBT youth to build current and future capacity for tobacco control—LGBT youth smoke at higher rates likely due to tobacco industry targeting as well as a coping mechanism against isolation and systemic homophobia. Fostering LGBT youth leadership around tobacco control is a sustainable and effective strategy to change cultural norms, involve an at-risk population, and develop capacity for the future.

Best and Promising Practices:

- Foster tobacco control programs within existing LGBT-relevant youth organizations.
- Involve LGBT youth in tobacco control-related activities and policy campaigns.
- Promote inclusion of LGBT youth in tobacco control youth leadership programs.
- Use successful youth-led leadership programs as a model for tobacco control.
- Utilize messaging shown to resonate with youth.
- Consult and include youth in the development of traditional and social media campaigns around tobacco issues.
- Develop youth leadership by accommodating the practical needs of youth through provision of training, ongoing mentorship, resources, transportation, and appropriate reimbursement.

Engage LGBT communities of color in tobacco control initiatives—Tobacco industry targeting of communities of color and LGBT people increases risks for those at the intersection of these communities.[42] Tobacco control efforts at all levels are more effective when programs demonstrate cultural competence and utilize the networks and leadership within LGBT communities of color.

Best and Promising Practices:

- Highlight and acknowledge issues of multiple identities, including issues of competing priorities across organizations.
- Provide culturally competent and targeted outreach, interventions, and materials.
- Establish relationships with LGBT communities of color-specific organizations.

Engage Transgender communities in tobacco control initiatives[43]—The transgender community has been especially marginalized relative to other affected populations.[2] Tailoring programs to meet the specific needs of the transgender community will improve the reach and success of tobacco control efforts for this population.

Best and Promising Practices:

- Ensure cultural competency training is mandated for all staff and volunteers.
- Ensure cultural competency around pronoun and preferred name usage as well as access to services and facilities such as gender neutral restrooms.
- Address different capacity needs in order to effectively target the transgender community in tobacco control.
- Understand that being "out"/perceived as Trans and/or "passing" as one's preferred gender affects and elevates smoking rates in this population.
- Build awareness among providers about the relationship between smoking and transgender-specific healthcare needs, e.g., the risk associated with smoking and hormone replacement therapy.
- Include smoking cessation as a standard part of clinical models of care for transgendered individuals.

Engage Bisexual communities in tobacco control initiatives—Evidence suggests higher rates of smoking among bisexual individuals compared to lesbian and gay populations. Further research and intervention are needed in order to better understand and serve this community.

Best and Promising Practices:

- Ensure that studies of LGBT tobacco use and other tobacco-related research involve bisexual populations in addition to other disparate groups.
- Include bisexual community leaders, representatives and organizations in LGBT community-based tobacco programs.

Part 4
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