

Creating an Effective Tobacco Plan for Minnesota's Gay, Lesbian, Bisexual & Transgender Communities



a final report



Antonio Cardona
Project Manager

Paula Hastings
Community Outreach Coordinator

Beth Zemsky, MAEd, LICSW,
Consultant

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This report was prepared by:

Rainbow Health Initiative
Minneapolis, Minnesota

Antonio Cardona
Project Manager

Paula Hastings
Community Outreach Coordinator

Beth Zemsky, MAEd, LICSW
Consultant

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EXECUTIVE SUMMARY

Creating an Effective Tobacco Plan for Minnesota's Gay, Lesbian, Bisexual and Transgender Communities, is the product of a project executed by Rainbow Health Initiative. This project was funded by a grant from the Minnesota Partnership for Action Against Tobacco (MPAAT). The purpose of this grant is to prepare a community based report which addresses the prevalence of tobacco use, awareness of use and exposure hazards, issues surrounding cessation, and attitudes toward smoke-free initiatives in Gay, Lesbian, Bisexual and Transgender (GLBT) communities.

It is recognized that GLBT communities may smoke at higher rates than the general population for various reasons (Stall et. al, 1997; Gruskin et. al, 2001; , 2001; Eisenberg and Wechsler, 2003). These suspicions have been based on the assumption that the adult GLBT population faces higher levels of stress due to homophobia, heterosexism and discrimination. In addition, it has been shown that the tobacco industry specifically targets marketing efforts toward GLBT communities (Goebel, 1994).

In order to gather information, five methods of data collection were employed. Staff executed assessments at educational venues, 13 focus groups, 2 annual surveys based on convenience samples at GLBT Pride celebrations, in depth community leader interviews and a review of the current body of literature available on the issues surrounding tobacco in GLBT communities. Recognizing that many diverse and often autonomous sub-groups make up the larger GLBT community, recruitment and outreach efforts were required to be as broad and strategic as possible.

Project findings reflect much of the data that already exists. One unique contribution of this project is the qualitative data collected on tobacco use in transgender communities. In much of the research currently available, little to no research exists around these specific issues. Based on qualitative information collected at two focus groups, the health effects of tobacco use may be severe for individuals who are transitioning and utilizing hormone therapy. Anecdotally, risks of smoking while on hormones may include increased risk of heart attack and stroke. It is recommended that more research be done in the area of transgender health and tobacco use.

Other recommendations include implementing smoke-free policies for staff and clients at agencies offering GLBT-specific chemical dependency treatment. Respondents speculated that smoking rates in such agencies are very high and reinforced by staff who smoke.

Focus group participants also reviewed cessation materials directed at GLBT populations. It was noted that such materials need to address GLBT-specific reasons for smoking and feature a demographically broad range of images when such materials include images of people.

INTRODUCTION TO PROJECT

Goal: Prepare a community based report which addresses the prevalence of tobacco use, awareness of use and exposure hazards, issues surrounding cessation, and attitudes toward smoke-free initiatives in Gay, Lesbian, Bisexual and Transgender communities.

In 2003, Rainbow Health Initiative received a grant from the Minnesota Partnership for Action Against Tobacco (MPAAT) to develop a community-based plan to address issues surrounding tobacco use and exposure to secondhand smoke in Minnesota GLBT communities. The grant project includes formalizing and expanding networks and relationships within Minnesota GLBT communities, collaborative dialogues with non-profit organizations, businesses and health care providers serving GLBT communities, in addition to gathering opinions and reflections from community members concerning social norms surrounding tobacco use.

The project also examined literature and smoking cessation resources to assess their appropriateness for GLBT individuals. Several educational venues and focus groups were planned over the course of the project to gather information about the awareness of smoking hazards, reactions to existing smoking cessation resources, and the potential effectiveness of, and points of resistance to tobacco policies in GLBT communities. In addition to the educational venues and focus groups, surveys were conducted at the 2004 and 2005 GLBT Pride festivals, including Twin Cities Pride and MN Soul Essence, the local African-American pride.

The end result of this project will be a plan generated from entities and individuals from within GLBT communities to reduce the harms caused by tobacco, and to improve the overall health of Minnesota GLBT communities. This plan will include findings

from all information gathered as well as recommendations on how to more effectively address tobacco issues within GLBT communities.

Objectives of the project are listed below. All work for the project was directly related to at least one of the four objectives.

Objective A: Formalize and expand the community networks and liaisons to address tobacco as a health issue in GLBT communities through involvement of GLBT identified community organizations and commercial entities serving GLBT populations.

Objective B: Create a resource library of information and literature concerning tobacco use and exposure to secondhand smoke in GLBT communities.

Objective C: Assess community awareness of the hazards of tobacco use and exposure to secondhand smoke; attitudes toward cessation materials and barriers to cessation; and effective policies to reduce tobacco use and exposure to secondhand smoke in community organizations.

Objective D: Draft a final report regarding best practices to reduce tobacco use and secondhand smoke exposure in GLBT communities and seek community feedback.

In order to approach the project in the most efficient and comprehensive way possible, some guiding assumptions needed to be developed. There are four assumptions that this project is based on:

First Assumption: The development of a community based report, specific to GLBT communities, will be more successful in reducing the harm caused by tobacco use than by using existing strategies designed for the general population.

Second Assumption: The GLBT community is more accurately described as GLBT communities. There is not one separate or cohesive group that can be labeled, “the GLBT community.” Rather, it is a collection of inter-related and often autonomous sub-groups which may have differing tobacco use rates, different levels of knowledge regarding hazards, and different attitudes towards cessation and policies. For example, a 50 year-old African-American lesbian may have different attitudes toward smoke-free initiatives than a 20 year-old white gay male because of differences related to age, race, gender or orientation. For this reason, methods of collecting information were required to be as broad and strategic as possible. It was necessary to be conscious of age, race, gender, ability, and socio-economic status when dissecting issues surrounding tobacco.

Third Assumption: Partnering with community

organizations and businesses serving GLBT communities is the most effective way to reach GLBT individuals. Leaders in these two areas serve as “gatekeepers” to the community, can be used as experts, and have access to the communities they serve. Partnering with these agencies and individuals provided legitimacy to the project and greatly assisted in outreach to the communities.

Fourth Assumption: The development of a community-based report with recommendations will involve interactions with various segments of GLBT communities and community organizations to gather information and present findings. This process, by developing a “community” around the issue of tobacco, will raise awareness, develop synergy, and encourage partnerships, which will ultimately reduce tobacco use and exposure within GLBT communities.

PROJECT PLAN

The project employed five methods of information gathering. It was important to reach a wide range of individuals to ensure inclusion of the multiple GLBT communities. To gather information, the project executed assessments at two educational venues, 13 focus groups, community surveys, interviews with community leaders, and a literature review of available research addressing GLBT-specific tobacco issues. Below is an explanation of each method.

Educational Venues

Project Staff used the first educational venue as a way to raise community awareness of the issue and a way to recruit potential partners to assist in recruitment efforts. For this venue, staff invited GLBT non-profit organization leaders, GLBT business leaders and health care providers who have knowledge of GLBT communities. People in attendance were shown a presentation titled *LGBT Populations and Tobacco*. Perry Stevens, a consultant for the Tobacco Technical Assistance Consortium at Emory University in Atlanta, Georgia, created this presentation. The presentation focuses on four points; The Background and Scope of LGBT Tobacco Use; How the Tobacco Industry Targets LGBT; Combating Tobacco Myths Among LGBT; and Communication Strategies for Reaching LGBT.

The second educational venue had a different focus. Because of initial themes seen in the focus groups, it was decided to look at chemical dependency treatment. Many participants spoke of the special issues surrounding tobacco use while participating in chemical dependency treatment. It was widely speculated by those who had gone through such treatment, that a great majority of people in treatment smoked. Participants viewed smoking as a necessary vice to help them overcome other addictions.

For this reason, staff looked to Alternatives, a GLBT-specific chemical dependency treatment center. This venue shared the same Perry Stevens presentation. A brief assessment was also developed and

administered, as well as a facilitated discussion on tobacco issues. The purpose of the venue was to raise community awareness and collect information on GLBT-specific tobacco issues in a chemical dependency treatment facility setting. Attendees of these venues were current clients seeking treatment.

Focus Groups

Staff executed 13 focus groups between March 7, 2005 and May 17, 2005. Keeping in mind that there are many sub-groups within the GLBT community, it was essential to be as broad as possible in outreach efforts. Connecting with all Gay, Lesbian, Bisexual and Transgender communities, including communities of color, involved a long recruitment and community partnering process. For this reason, staff structured the groups as follows: two groups for Gay men, two groups for Lesbian women, two groups for Bisexual people, two groups for Transgender people, two groups for People of Color, one for Deaf people, one open group in Rochester, MN and one open group in Duluth, MN. The first five communities had two focus groups offered. There are two reasons for this structure. First, it gave people an option of a date to attend. Second, it allowed staff to identify common themes running through each sub-group. This also recognizes that each sub-group has even more sub-groups within it. For example, the first Gay men's group had a mix of people who did not know each other, whereas the second group consisted mostly of men who knew each other and frequented the same bar.

Information gathered during the focus groups fit into

five objectives identified by staff. The five objectives were:

1. Assess GLBT community awareness of GLBT tobacco prevalence and practices
2. Assess knowledge of secondhand smoke and risks of smoking
3. Assess barriers and facilitators to cessation
4. Obtain reactions to GLBT-specific and non GLBT specific cessation materials and programming
5. Assess knowledge and attitudes towards policy initiative

“Postcard outreach” was a very effective tool for this project. 5,000 full-color flyers were printed and distributed widely throughout the city, including locations heavily frequented by GLBT people. This included organization offices, bars, clubs, restaurants, coffee shops, second hand clothing stores, and youth drop-in centers. \$40 gift cards were offered as an incentive for participation in a focus group. The postcards used this fact as its primary focus. In large green letters, the question, “Do you want to make \$40?” ran above a series of multi-colored silhouetted faces.

Surveys

For this project, Rainbow Health Initiative designed and administered two community surveys. The first one was done in the summer of 2004 at GLBT pride events, and the other one was done in the summer of 2005 at GLBT pride events. For each survey, two events were used; the Twin Cities Pride Festival in Loring Park, and Pride events coordinated by Soul Essence, the local African-American Pride organization.

The purpose of the one page survey was to collect basic demographic data, assess GLBT individuals personal top three health concerns, assess attitudes toward smoke-free policy initiatives, assess attitudes toward tobacco use, establish smoking status and assess issues surrounding cessation. Surveys for both

years were virtually the same. A few adjustments were made to the 2005 survey. Some complications in data entry occurred in the 2004 survey and certain questions had flaws in them. Another difference in the survey recognizes that some communities had recently adopted smoke-free initiatives. The 2005 survey addresses this fact more appropriately.

Interviews with GLBT Community Leaders

Keeping a pulse on GLBT community leaders was also essential for this project. It is important to raise community awareness of tobacco as a major GLBT health concern. To do this, and to also create a “community” around this issue, staff met with selected leaders to gather further information, and introduce them to the community that already exists around tobacco through Tobacco-Free Lavender Communities of Minnesota (TLC). The people interviewed represented GLBT businesses, non-profit organizations and health care providers.

The meetings were short in order to respect the time of the professionals. Each meeting was approximately 30 minutes. 5 questions were asked to gather information similar to that gathered at the focus groups. In addition to the questions, a three-page survey was given to health care providers and social service agencies, primarily those dealing with HIV/AIDS and chemical dependency treatment. The survey focused on availability of cessation resources and agency attitudes toward tobacco issues.

Literature Review

Before any major work on the project began, it was essential for staff to have a clear understanding of the current body of literature and research available around tobacco issues in GLBT communities. This provided a basis for staff to act as “community experts” around these issues. In order to gather available information, staff searched online and electronic resources. Searches utilized PubMed, Google, and Yahoo search engines. The following

words were searched in various combinations: Gay, Lesbian, Bisexual, Transgender, Queer, GLBT, LGBT, Tobacco, Secondhand Smoke, Smoking, Quitting, Cessation, Rates, Prevalance, Tobacco Industry. Personal contact was also made with various tobacco control experts across the nation to request referrals to any information they considered essential. In addition to gathering literature and research, various cessation materials were also

collected and reviewed. Cessation materials collected included GLBT specific materials as well as materials developed for a general audience.

The literature review is intended to provide a snapshot of the current body of knowledge around GLBT tobacco issues. While staff obtained a large number of publications, it is recognized that some information may have been missed.

KEY FINDINGS

In this section, key findings from the project are shared. Information collected will assist in the development of a strategic plan to best address tobacco issues within GLBT communities. Please see the Conclusions section for recommendations developed from the following information.

A REVIEW OF THE LITERATURE

It has long been suspected that Gay, Lesbian, Bisexual and Transgender (GLBT) adult populations have higher rates of smoking than the general population. These suspicions have been based on the assumption that the adult GLBT population faces higher levels of stress due to homophobia, heterosexism and discrimination. While there appears to be sufficient information regarding the tobacco industry's efforts to target the GLBT population, there has been a dearth of representative studies that explore the smoking behaviors of adult GLBT populations, the causes of those behaviors and the impact of those behaviors on this population. Even less explored has been the issue of best practices for cessation within the community or the effectiveness of current GLBT specific cessation programs. Despite this overall limitation there do exist several key representative random and nonrandom studies, case studies and anecdotal information that have explored these issues.

GLBT Adult Smoking

Recent research has indicated that Lesbians, Gay men and Bisexual women and men smoke at higher rates than their respective counterparts in the general population. (Stall et. al, 1997; Gruskin et. al, 2001; Eisenberg and Wechsler, 2003) Additionally, a review of the current literature found that while published information regarding the prevalence of smoking in the LGBT community is limited, it does appear that smoking rates in Lesbians, Gays and Bisexuals, both adolescents and adults, are higher than those in the general population. (Ryan et. al, 2001) Other studies have focused on tobacco smoking and HIV. A review of the literature done in 1993 by Arday et. al in

Tobacco Control suggests that while gay men do appear to have higher smoking rates than their counterparts in the general population, and despite the certainty that smoking is positively associated with other diseases and adverse affects upon the immune and other organ systems, an association between smoking and HIV-associated morbidity cannot be firmly concluded.

Tobacco Industry Targeting

Another focus of the limited research literature on GLBT smoking is the role of the tobacco industry in targeting the community. Critical media reviews, newspaper articles, case studies and tobacco industry documents themselves all indicate that in fact the tobacco industry has been targeting the GLBT community through direct and indirect advertising in the gay press, event and organization sponsorship, corporate philanthropy and through outreach efforts and community promotions. (The Wall Street Journal, 1992; Goebel, 1994; Tobacco Technical Assistance Consortium, Emery University, Unpublished Presentation, 2001; Smith & Malone, 2003; Offen et. al, 2003; American Legacy Foundation-Project S.C.U.M. industry documents, 1995) Only one case study in 2003 done by Offen et. al, in *Tobacco Control* evaluated the impact of an effort to resist tobacco industry targeting of the LGBT community. This case study found that efforts to boycott Philip Morris's Marlboro cigarettes and Miller beer backfired as Philip Morris settled the boycott by pledging large amounts of money to fight AIDS and exploiting differences within the LGBT community itself. The researchers found that LGBT organizations in need of funding and desiring

recognition from mainstream businesses welcomed the additional resources without considering the health impacts of tobacco on the community.

LGBT Cessation Research

Little to no research evidence currently exists evaluating the impact of formal tobacco cessation

strategies directed at the LGBT community. While internal program evaluations of individual cessation efforts specific to LGBT populations suggest that cessation efforts tailored to the LGBT community are successful in helping these smokers quit, at this time there are no formal research studies supporting this theory.

FOCUS GROUPS

13 Focus groups were held during the Spring of 2005. In total, 101 people participated. For a demographic breakdown, please see Appendix E. Beth Zemsky, MAEd, LICSW a consultant at One Ummah Consulting, was contracted to assist in the development of the questions and facilitate the groups. The information contained in this section was compiled by Beth Zemsky for Rainbow Health Initiative. Focus group participants' statements are included in quotations.

Objective 1: Assess GLBT community awareness of GLBT tobacco prevalence and practices

Questions:

How many people do think smoke in the GLBT community? How do you think this might compare to smoking prevalence in the general community?

If the number of people who smoke is different in the GLBT community, why might this be the case?

Response themes:

Most of the respondents believed that smoking rates in the GLBT community were higher than in the general public.

Many respondents noted that there were different smoking rates for different segments of the GLBT community. Smoking prevalence was perceived to be correlated with age, race, class, and gender. Specifically, GLBT youth, GLBT elders, FTM transgender people, African American GLBT people, and gay men were thought to have higher rates of smoking than other segments of the GLBT community.

- “40 – 50% smoke. Age, race, and gender play

different roles in these rates. Lots of queer kids start out young – then become addicted, It is an element of our own self destruction. I think upper class white gay men smoke less.”

- “A larger percentage of African-Americans smoke compared to non-African Americans...I will no longer subscribe to Essence magazine because of the high percent of tobacco ads.”
- “Youth feel invisible. When I started smoking, I was invisible. I didn't care.”
- “Younger GLBT people smoke more related to peer pressure. Smoking provides a way to affiliate and bond with others and try to fit in. Young people smoke out of a desire not to be alone and stand out when everyone else is smoking.”

In addition, what “scene” a person was part of and their typical location for socializing was also perceived to be correlated with smoking prevalence.

- “There is a definite divide between groups that smoke or don't... the bar crowd who smoke versus the activists who don't.”
- “65% of GLBT people smoke. That is higher than the general population. There is a connection between smoking, drinking, and bar culture. We socialize there because of inner-homophobia and oppression.”

Respondents identified the following reasons for their determination that smoking rates were higher in the GLBT community:

1. Stress
2. Social and Peer Pressure
3. Targeted marketing and the mystique of being “cool”
4. Association between smoking, alcohol and other addictions

1. Stress:

Respondents identified stress as a significant factor contributing to the beginning and continuation of smoking. In addition, stress was identified as a major component leading to relapse during attempts to quit. Some of the stressors mentioned were not GLBT specific such as stress related to money and the stress related to a history of child abuse.

However, many respondents identified GLBT specific stressors such as the stress associated with coming out, living in a homophobic society, and coping with internalized homophobia and self-hatred. Respondents in Greater Minnesota noted stress related to coming out and internalized homophobia were bigger factors in smaller towns.

- “As gays we tend to self-abuse more than straights.”
- “For some, there is internalized homophobia and self-destruction. They think, “I’m queer, I’m screwed anyway.”

2. Smoking as a social tool

Respondents identified social and peer pressure as a significant factor contributing to the beginning and continuation of smoking. Specifically, respondents noted that smoking was a social tool that provided a way to affiliate and bond with others, to be “part of the gang” and fit in, particularly when one was already feeling like an outcast as a GLBT person. The GLBT community was perceived to be an isolated and struggling community. Respondents noted that smoking provided camaraderie with peers and an identity group status to affiliate with that was less deviant than being GLBT.

- “Smoking provides a way to affiliate and bond with others. GLBT people have a less mainstream way of building community. Smoking provides a way to build community... or at least 15 minutes of community interaction while smoking.”

3. Targeted marketing and the mystique of being “cool”

Many respondents identified that there was a certain “tobacco chic” that glamorized smoking and made it seem cool. Respondents also observed that the specific tobacco advertising targeted at GLBT communities has an impact on reinforcing the association between being sexual, a sense of liberation, being a trendsetter, and smoking. For GLBT youth, who are often already feeling like misfits, the association of smoking with “being cool” was perceived to be particularly significant.

- “Young people smoke to appear to be “a bad ass” and get back at parents and friends. They start because it “is cool and they don’t want to be an outcast”
- “Rates are higher for our community because of specific targeting such as media campaigns, handing out cigarettes, materials, and other incentives like tee shirts and hats at the bar. Targeting focuses on ‘less desirable’ communities like ours.”

4. Association between smoking and alcohol and other addictions

Respondents strongly associated smoking with drinking and bar culture. If respondents saw themselves as part of the “bar scene” they were more likely to report higher rates of smoking in the GLBT community and to report knowing more smokers personally. A number of respondents noted the social importance of the gay bar as a location where GLBT could go to “be themselves.” Higher smoking rates were also associated with the higher prevalence in the GLBT community of other addictions (e.g. alcoholism and other chemical dependencies.)

- “We tend to socialize in bar settings. Smoking goes with drinking. I am a non-smoker, but I smoke at the bar.”
- “Even clients with HIV who wanted to stop, and those who had quit previous to CD treatment,

smoked during treatment. Smoking was perceived to be associated with the desire not to feel isolated or ostracized in treatment group, It was a temporary escape from pressure from stress of treatment and dealing with HIV”

- “Smoking gives the illusion that it is okay to be addicted to something. It carries over to other things.”

Objective 2: Assessing knowledge of secondhand smoke and risks of smoking

Questions:

What do you think happens, if anything, to smokers physically

What do you think happens, if anything, to smokers socially

What do you think happens, if anything, to smokers economically?

Response themes:

Information about the potential physical, social, and economic consequences of smoking and secondhand smoke is available and known by the participants.

Physical Impact

Responses regarding the physical impact of smoking can be sorted into the following categories:

1. **Negative impact on health**
2. **Positive physical impact**
3. **No impact on health (denial)**
4. **Transgender specific health concerns**

Negative impact on health

Respondents were aware of a wide range of potential negative physical and health risks associated with smoking. A large majority of responses to this question fell into this category. These included: high blood pressure, bad circulation in hands and feet, lung cancer and other forms of cancer, cardio-pulmonary disease, congestion and inflammation of the lungs, stroke, lower endurance levels, skin tone changes and premature aging, emphysema, asthma,

decreased ability to taste, decrease in overall immune function, decreased fertility, blood clots, memory loss, sleep difficulties, addiction, and death. In addition, a number of respondents noted that many GLBT people do not have access to adequate healthcare and, as a marginalized community, tend not to seek out healthcare, potentially compounding the negative impact of smoking on the health of GLBT persons.

- “Gay men at risk of HIV/AIDS have weaker immune systems due to smoking.”
- “Access to care for lesbians is a problem because of high insurance premiums or when you can’t get benefits from your partner. This affects smoking because you can’t get help quitting.”

In addition, respondents noted a number of negative physical consequences from smoking that impact self image and social interaction. These included: discoloration of teeth, hands, and skin, smell, bad breath, and lower overall energy level.

- “I can’t run and I don’t have energy to go to the gym. This impacts how I feel about myself.”
- “It (smoking) is bad for the skin and causes wrinkles.... A definite downer when looking in the mirror.”

Positive physical impact

A number of respondents reported physical reactions to smoking that they perceived to be beneficial. These included decreasing appetite, providing a sense of calmness and relaxation and providing an energizing “buzz.”

- “When I stopped smoking, I gained weight. I know people who had to start smoking just to lose weight.”
- “I stopped for 6 months and gained 50 pounds so I started again.”

No impact on health

A few respondents challenged the notion that smoking directly lead to negative health consequences by evoking the story of someone who

had smoked for a long time who is currently healthy. For example:

- “My grandma smokes everyday. You can’t gauge healthiness by smoking status.”
- “My mom, 82, smoked all her life. Cigarettes and coffee every day, but she still gets around.”

Transgender specific health concerns

Most members of the transgender specific focus groups were aware of smoking related health concerns specific for members of the transgender community. For those transgender people taking estrogen these included: decreased effectiveness of hormone therapy, increased risk of heart attack, blood clots, and osteoporosis. Respondents also noted that smoking has a negative impact on skin tone and quickens aging. Some respondents believed that for those taking testosterone, smoking could lead to stunted growth or interfere with muscular development. One participant noted that a positive physical impact of smoking for FTM people was that it deepened the voice and made one look more male and tougher.

- “MTF trans people may smoke less because of the impact of hormones. If on estrogen hormones, the medications won’t be as effective and you have an increased risk of blood clots and heart attack.”
- “Estrogen therapy increases the risk of heart attack, stroke, blood clots, osteoporosis, and cancer. Cancer risk is not known, but there is a lot of concern and speculation about this in the trans community.”
- “My doctors (Program in Human Sexuality, University of MN mentioned specifically) tell clients to quit smoking before beginning medical treatments associated with transition. They give a 10-minute lecture about the relationship between estrogen and smoking risks. This information is also in the “warning” literature provided with the hormone therapy.
- “You also have to worry about osteoporosis when taking hormones and smoking.”
- “Smoking gives you wrinkles, increased acne, skin

problems and ages your skin. Why would I spend all this energy trying to be a beautiful woman and have smoking ruin my look.”

- “I’ve heard it stunts growth and the development of muscular structure. This isn’t good for small trans men.”
- “Smoking lowers your voice and makes you look more male, more tougher.”
- “When I tried nicotine replacement methods (e.g. the patch, gum), they interacted with the estrogen and produced “hot flashes.”
- “I know of T men who have lied about smoking to their doctors in order to be eligible for surgery.”
- “My smoking increased after starting hormones as a result of dealing with all the stress of the multiple changes in my life.”

Social Consequences

Respondents identified the following social impacts from smoking:

1. **Social division in the GLBT community between smokers and non-smokers**
2. **Smokers feel ostracized from others in the GLBT community**
3. **Impact on dating and intimate relationships**
4. **The smell of smoking becomes a social deterrent**
5. **Smoking provides a means to make social connections**
6. **Smoking enhances images of masculinity**

Social division in the GLBT community between smokers and non-smokers

The social division in the GLBT community between smokers and non-smokers was the most frequent comment from participants in all the focus groups in response to this question. Within the GLBT community, the participants perceive that this social division segregates GLBT smokers from non-smokers.

- “Because Rochester does not have a gay bar, Gay and Lesbian Community Services (GLCS) is the only organized place to go. GLCS events have been smoke free for two years. Many people are

concerned that the organization is not serving the whole community since smokers might not attend the only GLBT space. We are trying to balance needs of smokers and non-smokers but it is hard.”

Smokers feel ostracized from others in the GLBT community

Smokers report increasingly feeling ostracized from others in the GLBT community and on occasion being treated disrespectfully.

- “Smoking is a crime. It is legal, but smokers are a target. I’ve been stigmatized all my life for being gay. Now I am stigmatized for being a smoker.”

Impact on dating and intimate relationships

A number of respondents noted that they would not choose a smoker as a partner. In addition, respondents discussed challenges in their intimate relationships specifically related to smoking.

- “It effects dating. I am less likely to date a smoker. If you are a past smoker, it might make you smoke again.”
- “Smokers compromise relationships because of how they take smoke breaks... When smokers step out to smoke after sex, it breaks the connection. Or I chose to allow them to smoke in bed to maintain connection and compromise my own health.”
- “We had arguments because of smoking. Relationship activities and our schedule needed to be arranged around my ex-partner’s need to smoke. Our relationship disintegrated over smoking. There was no issue bigger in our relationship than smoking.”
- “We lose people in our lives because of smoking.”

Smoking as social tool that facilitates connections

For those who smoke, they perceive smoking as an important tool that helps them break the ice, form relationships, and build community.

- “If you want to know what is going on, ask a

smoker. They know the gossip.”

- “Friendship groups and networks are formed through smoke breaks. Smoking provides an icebreaker. There is a ‘culture of smoking’ that permits people who don’t know each to engage with each other on a smoke break while they would never think of talking to each other in another situation such as while waiting at a bus stop.”

Smoking enhances images of masculinity

Respondents noted that smoking in the GLBT community was associated with women and transgender men who desire a masculine gender presentation.

- “Smoking is a more masculine thing and women going for a more masculine look it helps them look more masculine.”
- “Smoking is a sign of virility.”

Economic Impact:

Respondents identified the following social impacts from smoking: the cost of purchasing cigarettes; the cost of smoking cessation products; increased cost of health and car insurance and healthcare expenses; cleaning costs associated with getting the smell of smoke out of clothes, furniture, and other household items; and material costs such as car depreciation and other items damaged by smoke or ashes. In addition respondents mentioned costs related to smoking that would be born by the entire community such as the cost of fires began by cigarette ash and the environmental damage from improperly discarded cigarette butts

- “It’s a financial burden. For me sometimes it is a choice between lunch and a pack of cigarettes. Sometimes I’ll smoke instead of eat.”
- “We aren’t concerned about cost. We buy cigarettes for \$5 at the bar when we could easily go across the street to Super America and buy them for \$3.”
- “My smoking put a lot of money into Jesse Helm’s pocket. So it hurt me financially and politically.”

- “We (respondent and partner) quit smoking 20 weeks ago and have saved about \$1,000. www.quitsmoke.com has a money counter to helped people know how much money they have saved how many minutes they have added to their lives as they quit.”

Respondents also identified both positive and negative consequences for smokers in the workplace. Potential negative impacts identified included lost income due to increased illness and lost productivity associated with frequent smoke breaks during the workday. Other respondents noted that smoking potentially increases productivity due to the calming influence of smoke breaks and the workplace networking that takes place while smoking.

- “I’ve missed work due to smoking related illness.”
- “At work smoking is a guaranteed 3 – 5 minute break. This is especially important if you have an hourly job. At work the nurses who smoke get breaks and those that don’t do not.”
- “Smokers are more productive at work because smoking is calming. They come back from breaks relaxed and refreshed.”

A. What do you think happens, if anything, physically, socially, and economically to people because of secondhand smoke?

Response themes:

Information about the potential physical, social, and economic consequences of secondhand smoke is available and known by the participants.

Responses regarding the impact of secondhand smoke can be sorted into the following categories:

1. **Negative impact on health, including negative health impact for children and pets**
2. **No impact on health (denial)**
3. **Secondhand smoke is a social deterrent**
4. **Costs associated with exposure to secondhand smoke**

Negative impact on health

Respondents were aware of a wide range of potential negative physical and health risks associated with secondhand smoke. A large majority of responses to this question fell into this category. A number of respondents noted that exposure to second hand smoke led to the same health risks as for smokers. These included: high blood pressure, lung cancer and other forms of cancer, cardio-pulmonary disease, congestion and inflammation of the lungs, stroke, lower endurance levels, premature aging, emphysema, asthma, decreased ability to taste, decrease in overall immune function, and death. They differentiated these effects for smokers, who they perceived to have a choice about their behavior, from adults, child, and pets who were exposed to secondhand smoke in ways that were beyond their control.

- “Non-smokers do not have a choice. If you don’t drink, you don’t order a beer. If you are vegetarian, you don’t eat meat. But if you don’t smoke, you don’t have a choice!”
- “Secondhand smoke is different than smoking because it affects children more. They have no choice if their parent smokes. They have more illness at a younger age.”
- “Pets don’t have the ability to remove themselves.”

No impact on health

A few respondents challenged the notion that secondhand smoke lead to negative health consequences.

- “Cars leave smoke that harms people too. I don’t think there are consequences of secondhand smoke.”

Secondhand smoke is a social deterrent

Respondents noted that the possible presence of secondhand smoke deters people from going to locations or attending community events where they may be exposed to secondhand smoke. For

individuals already experiencing some degree of isolation due to the impact of homophobia and heterosexism, the social deterrent associated with secondhand smoke serves to further isolate them.

- “I was a social smoker. I could tolerate it when I was younger, but now I don’t go to smoking places because it makes me sick the next day.”
- “Smokers don’t pay attention while you are talking because they are busy smoking. Some deaf smokers will be signing and the cigarette will fly through the air. It could start a fire!”
- “When I was young, my parents smoked. Kids at school would tell me they could smell it on me.”

Costs associated with exposure to secondhand smoke

Several respondents noted that the direct economic costs associated with tobacco use are also borne by those exposed to secondhand smoke:

- “Secondhand smoke is a bother to non-smokers. You have to deal with all the dry cleaning costs from the smell and all the stuff that goes along with getting rid of the smell.”
- “My partner buys things that will make his mouth cleaner for me. He buys a lot of gum. We had to buy an expensive air purifier.”

Objective 3: Assess barriers and facilitators to cessation

Questions:

If you have smoked, or if you have a loved one or friend in the community who has smoked ... Have you/they tried to quit? If so, what barriers, if any, did you/they encounter? Think broadly about economic, social, cultural, environment, psychological, emotional factors that may have influenced the attempt.

Given the responses you’ve just given, what, if any, of these do you think might be specific factors facing members of the GLBT community in their cessation efforts?

If you have smoked, or if you have a loved one or friend in the community who has smoked... What kind of services or products have you/they accessed to try to help quit smoking? Think broadly about support groups, hypnosis, acupuncture, nicotine replacement aids (inhaler, patch, gum), medication, yoga or meditation, etc.... How effective have these methods been?

A. Participants mentioned the following barriers to quitting smoking:

- 1. Addictive habit**
- 2. Stress, Anxiety, depression, hopelessness**
- 3. The routine of smoking associated with other daily activities, or ritualistic smoking**
- 4. Social ties to smokers and the accessibility of cigarettes and locations to smoke**
- 5. Lack of success with cessation methods**

1. Addictive habit

Respondents reported having difficulty finding anything that would take the craving away.

- “The 30 second head rush associated with smoking “keeps me coming back”
- “It is hard for me to give up the “idea of smoking.”
- “Smoking is my best friend! I have a cigarette before I get out of bed. To quit I would need to majorly change my life. I like to smoke.”

The respondents also associated smoking with other addictions.

- “I have multiple addictions. The doctor suggested that it would be hard to quit smoking and stay off other substances”
- “Former smokers will return to smoking in chemical dependency treatment.”
- “I could make it, but I’m scared about going back to drugs and alcohol.”
- “For me smoking is associated with drinking and caffeine.”

2. Stress, Anxiety, depression, hopelessness

Respondents reported that these emotions contributed both to initially beginning smoking and relapsing after attempts to quit smoking.

- “Smoking is associated with hopelessness. Before (gender) transition I felt ‘hopeless.’”
- “I live in a homeless shelter. It is harder to deal with the stress without it. Stressors make you want to smoke.”

3. The routine of smoking associated with other daily activities, or ritualistic smoking.

- “It is something to do with your hands. I used to be a journalist and the habit was to type a paragraph, then take a drag and drink some coffee.”
- “I have certain routines. I have a cigarette when I get up. I have one on the toilet. If I don’t have cigarettes I get crabby.”
- “It is a habit to smoke at a bar, not necessarily a craving.”

4. Social ties to smokers and the accessibility of cigarettes and locations to smoke

- “The accessibility to cigarettes I have if I am in a social location (such as a bar) or around friends or family members who smoke makes it tough.”
- “We had friends who quit together. It worked, but once one started, the other did too.”

5. Lack of success with cessation methods.

The majority of respondents relayed accounts of their own or a loved one’s failed attempt to quit smoking. There was general agreement in the groups that quitting was very difficult, not all cessation aids worked for everyone, and the search for the right cessation method and/or cessation aide could often be long, frustrating, and discouraging. There was also general consensus that no cessation method would be successful if a smoker was not mentally prepared to quit smoking.

- “Some people don’t think cessation aids work so having many options are better. You don’t know what to think. You don’t know what the success rates are. Smokers don’t have good information so they try to do it alone and it doesn’t work.”
- “The patch and Nicotrol, it leaves a mark on your arm. It gives you bad dreams. You have to be ready to quit.... It is a process to get internally happy in order to be ready to quit. It is getting emotionally ready.”
- “I used the nicorette patch and the gum and then started smoking a week later because it was so easy to quit!”
- “I tried the inhaler cigarette, but it tastes bad, but you get used to it. I can’t do hypnosis because I am deaf. You have to close your eyes and listen, but as soon as I do that I don’t know what is going on.”
- “I tried the gum, but it tasted like pepper so I just started smoking again. I tried the patch, but it was too strong. There are no dosages for under a pack. I only smoked 6 cigarettes a day so I overdosed on the nicotine dose of the patch.”

C. Successful cessation methods

Respondents reported numerous methods that they thought were helpful in their own or a loved one's attempt to stop smoking. Participants discussed the importance of trying different things and the importance of switching to new methods or aids if the previously attempted method was no longer working. Some participants believed that the type of cessation materials available didn't matter. What was most important to a cessation effort was individual responsibility and motivation. Most participants noted that successful attempts to quit smoking included the use of some kind of aid to help manage the physical addiction and a psychological component that they either developed on their own or with professional assistance. Again, the participants emphasized that no one method would work for everyone. They stressed the importance of mental preparation and having multiple cessation methods available.

Suggested cessation methods included:

- “Willingness and desire is essential to any method. Success depends upon how strong one's mental frame is.”
- “Learning to manage anxiety and stress.”
- “Supportive professionals or supportive friends who check in and support without judging is crucial.”
- “Affirmations – tell yourself you are a non-smoker. Believe and manifest it.”
- “When experiencing craving substitute something else like a walk or having something else to give oral gratification.”
- “Cessation support groups with additional access to personal professional support with whom I could check in regularly.”
- “Motivation – health reasons and then, now that I have made the transition (transgender FTM) I really want to live!”
- “Therapy that helped examines the reasons for smoking.”
- “Avoided target areas and activities e.g. no cigarettes in the car.”

- “I gave myself a time limit. I couldn't smoke until 10 pm. Easier to decrease smoking knowing that smoking was possible later. I quit after 5 days.”
- “I quit smoking because I got angry at tobacco companies when I realized that tobacco companies were targeting the GLBT community.”
- “Nicotine Anonymous – 12 step support group, particularly for smokers who are multiply addicted and already successfully using a 12 step model.”
- “To help people quit you could provide an option for buying single cigarettes instead of a pack. This could help provide an option to decrease the accessibility of cigarettes for people trying to quit.”

Objective 4: Obtain reactions to GLBT-specific and non GLBT-specific cessation materials and programming

Each respondent was shown six samples of cessation materials. These samples included posters specifically designed for the GLBT community and brochures. Some of the brochures were designed specifically for the GLBT community while others were made for a general audience. In addition, all focus group members reviewed a 13 minute smoking cessation video, *The Last Drag*, that was produced specifically for the GLBT community. All respondents recorded their comments to these materials on a material on a pen and paper survey that utilized a 1 – 5 Likert scale plus room for comment about each sample of material reviewed. After written material review was complete, each focus group discussed their reactions to the materials by focusing on the following question:

Questions:

What are your reactions to the GLBT specific materials? How are these, if at all, potentially more useful than material gearing towards the general population?

Many participants liked the material presented with a specific GLBT focus. However, participants noted that since many of the factors that lead GLBT people to smoke were associated with issues related to sexual identity, GLBT materials specifically needed to address these issues rather than just present the same content as the material designed for a general audience with GLBT symbols (such as rainbow colors.) For example, as one participant noted, the material needs not just to have GLBT images, but also to have specific GLBT material, including more transgender specific content such as facts about the impact of smoking on transitioning bodies.

Several participants shared ideas about what they thought should be included in successful GLBT cessation materials. These ideas included:

- “I liked the comprehensive cessation materials that included specific information about cessation methods, including costs. This material should be presented with a specific GLBT focus... including material that addressed the specific reasons GLBT people smoke.”
- “Smoking cessation materials should be widely available like at bars they should pass out nicotine gum. Like in the early days of AIDS prevention efforts when condoms were first handed out in bars. At first there was a lot of resistance. Over time, it became part of the culture.”
- “The problem with cessation efforts is that smoking addiction is not treated with the same seriousness as other addictions. Specifically, the GLBT press runs stories and ads about other addictions in the GLBT community, but not smoking. How come GLBT treatment facilities are not doing anything about smoking addiction?”
- “GLBT specific messages need to be in GLBT specific locations (e.g. magazines, etc.) plus in places that reach a broader public to reach GLBT people who mostly live in these environments.”
- “The GLBT materials were more emotional so are more impactful, although some may respond to emotions and others to facts.

In addition to providing general reactions to the differences between the GLBT specific materials and those designed for the general public, respondents also provided comment regarding their reactions to the GLBT cessation material samples.

Reaction to Sample #1: The Protest Poster

Many respondents had a positive reaction to the “protest poster.” Participants thought the language of “rights” resonated well for the GLBT community. Participants also thought that the poster successfully provided an image that separated smoking as a behavior from someone’s identity. Many participants commented that they liked that the image built on ideas of community unity and empowerment. They found it inspiring. They also responded well to the inclusion of the facts about the percentage of smokers in the GLBT community.

A few participants had quite negative reactions to this poster. They thought the activist stereotype was perceived to be too narrow to speak to the majority of the GLBT community, although the poster might be effective with a specific activist audience.

Reaction to Sample #2:

Multiple “playful” images with captions

A number of participants thought poster series #2 reinforced stereotypes of GLBT people, was overdone, scary looking, and “super ridiculous.”

One participant liked that the images in poster series #2 showed people in relationship to each other and showed connections in the community.

Reaction to Sample #3: Multiple

“My Greatest Enemy” images with captions

The majority of participants resonated very positively to poster series #3. They found the images realistic to their lives (the people looked like their social circle) and the messages powerful. They commented that the posters showed real people having real experiences and dealt more with facts and specific issues relevant to GLBT people. Participants thought

that the poster carried the most “normalcy” and the images personalized the issues, drew on inner strength and were motivating and inspiring about overcoming other difficulties. As one participant noted, “Everyone has survived something.” The respondents thought the images personalized the issues, drew on inner strength and were motivating and inspiring.

A few participants did not like poster series #3. One participant suggested that this campaign could be read as “victimy” and associated with increased victimization of GLBT people. Other participant thought poster #3 was too “fear based.”

Reaction to *The Last Drag* video

The majority of the respondents did not care for the video. They perceived the video to be too entertaining, too “jokey” and annoying. Many commented that it didn’t stick to the topic. Some thought that it had poor production quality and was too long, although it had some good information that needed to be presented in a tighter and shorter format. A few participants also noted that the images in the video needed to more inclusive of images of the young GLBT people who are targeted for smoking, and who may smoke for “fashion.” They perceived that to be effective, the video needed to have images that various parts of the community can relate to so there was a sense of reality that hits closer to home.

Some participants liked the video. They thought messages worked and the humor caught their attention and kept their interest. They particularly appreciated the image of the GLBT community as a caring community who supported smokers to stop.

Despite their overall reaction to the video, the majority of respondents found the last segment of the video in which diverse representatives of the GLBT community talked directly into the camera about their own attempts to quit smoking and their reasons

for wanting to create a smoke-free GLBT community to be most positively impactful.

Members of the GLBT deaf community found the video useful. They noted that members of the deaf community are very visual. In their opinion, if the pictorial representation is strong and the message is strong, words are less important. These respondents also noted that some deaf people have more English skills than others. They suggested that it would be more effective to use an ASL interpreter or deaf actors to put the message in native ASL language (which is a conceptual language rather than a direct translation of literal English) to reach this community.

Objective 5: Assess knowledge and attitudes towards policy initiatives

Questions:

What impact do you think the smoking ban that begins (began) April 1st will have on the people who go to GLBT bars, clubs, and cafes?

How do you think the smoking will specifically impact smokers?

Given that these focus groups took place during the time that the new smoking ban went into effect in Minneapolis, it is not surprising that respondents were aware of the new restrictions regarding tobacco use in bars and restaurants in Minneapolis and in some bars in St. Paul. However, despite widespread media coverage, some respondents had considerable misinformation about what exactly the ban covered and how it would be implemented. In addition, respondents were divided about what they thought about the ban and how they thought it might impact the community.

Participants who responded positively to the ban often cited the ban’s potential impact on the health of people who worked in GLBT bars, and the ban’s

impact on helping members of the GLBT community quit smoking. Approximately half the participants said they would go out more once the bars and cafes were smoke free and they thought the ban would encourage a wider variety of people to go out to clubs and GLBT establishments. Some respondents also thought the ban would cause GLBT smokers to form different social groups that included non-smokers, thus decreasing the social divide they observed in the community.

- “I am glad. I can see and breathe in the bars. I can now go out with friends who have asthma... although it might take awhile to get residue smoke out of the bars.”
- “The need to go outside to smoke will increase motivation to quit, particularly during the winter.”

Participants who responded negatively to the ban believed that the ban would decrease the frequency with which people went out to GLBT clubs or attended GLBT community events where smoking was prohibited. They cited concern about the impact the loss of business could have for GLBT clubs. In addition, they cited concern about the safety of patrons of GLBT bars who would now need to go outside to smoke potentially becoming easy targets for homophobic related hate crimes. A number of respondents expressed concern that a decrease in smoking in the bars would be associated with an increase in drinking and an overall increase in violence inside and outside the bars. Finally, many respondents expressed concern that as GLBT

smokers decreased their attendance of GLBT clubs, they would become more and more isolated.

- “I am concerned about on overall increase in violence will lead to more violence and crime... People will go to the bar, drink more (because they can't smoke), get angry and cause trouble for people in the community and the police.”
- “I worry about underage patrons in clubs or GLBT community events. Because they can't drink, smoking gave them something to do. Now they can't do anything in the clubs so their attendance will decrease.”
- “I hate the ban. I want to be able to smoke while drinking so the ban will push me to drink more at home.”

Finally, a few respondents questioned the logic of the new smoking ban noting that it targets smokers, not cigarettes. In addition, others challenged the effectiveness of the ban as a strategy given the patchwork of tobacco related regulations in the area.

- “Why are they just banning were people smoke? If society didn't want people to smoke, why not just ban cigarettes?”
- “The ban would just move the smokers around given that ban is uneven throughout the state. “
- There is no ban in Wisconsin. The only GLBT bar in the Duluth/Twin Ports area is in Wisconsin so there is still smoking there. Non-smokers tend to go early and leave early and then the smokers come. If they had a ban in Wisconsin, it would increase attendance of non-smokers.”

SURVEY

In 2004, 879 surveys were completed at the Twin Cities Pride Festival in Loring Park and at Pride celebrations organized by Soul Essence, the local African-American Pride organization. In 2005, 680 surveys were completed at the same events. The following are selected data from both surveys. Survey data was analyzed by Gail Babes, MPH.

2004 Survey Results

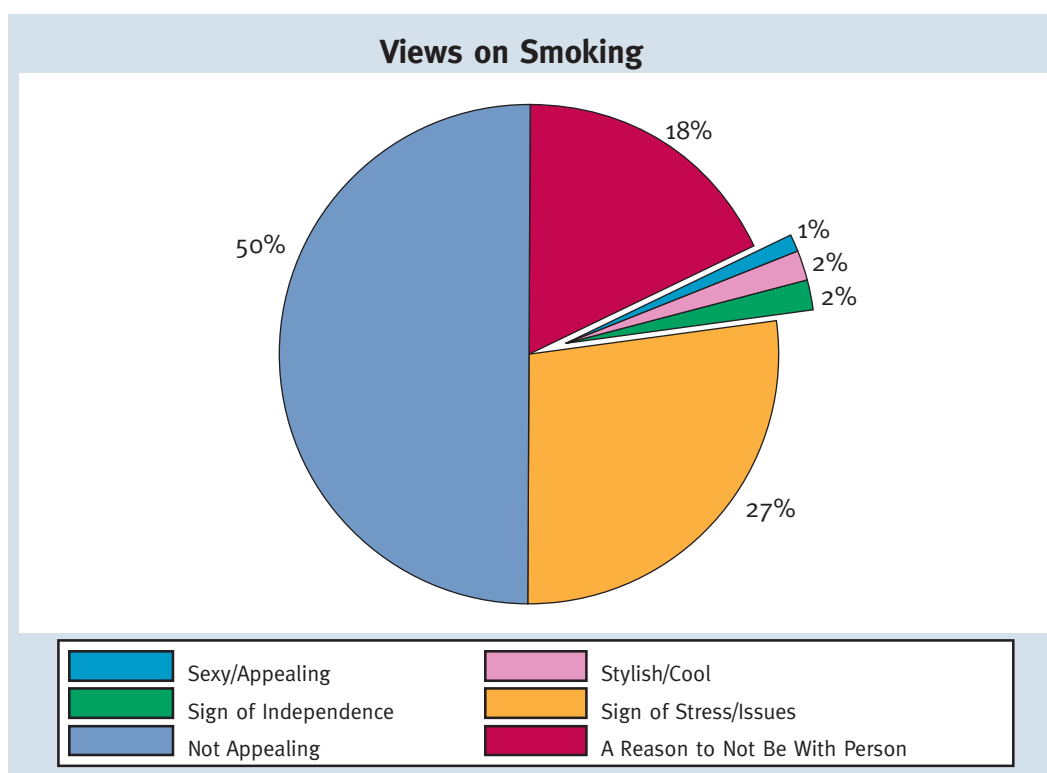
Descriptive Statistics of Sample 2004

Socio-demographic Information of Survey Respondents (n=879)		
	Overall %	% of Sub-group with Health Insurance
Demographics		
Age	Mean: 34.9 (SD12.3)	
Sexual Orientation & Sex		
Gay Female	32.1	78
Gay Male	31.3	76
Bisexual Female	7.8	76
Bisexual Male	3.9	76
Heterosexual Female	13.2	83
Heterosexual Male	9.0	74
Transgender	2.0	91
Other	1.0	50
Race/Ethnicity		
Asian	2.0	60
American Indian/Native Alaskan	1.0	56
Black Non-Hispanic	9.0	73
White Non-Hispanic	78.0	77
Native Hawaiian/Pacific Islander	0.5	65
Multi-Racial	6.0	73

Views on Smoking 2004

Q: What best describes your view of smoking and use of tobacco?

Total Sample	Percent
Sexy / Appealing	1
Stylish / Cool	2
Sign of Independence	2
Sign of Stress and/or Emotional Issues	27
Not Appealing	50
A Reason Not to Be With a Person	18



Smoking View Findings

- A cross tabulation analysis found that the majority of people who found smoking sexy, stylish and a sign of independence were current smokers.
- 62% of current smokers felt that smoking was a sign of stress
- 35% of current smokers, 63% of past smokers, and 74% of non-smokers found smoking to not be appealing

Smoking Status 2004

Survey Respondents

The majority of the sample (53.4%) were current smokers or past smokers.

Total Sample	Percent	Cumulative
Current Smoker	28	
Past Smoker	25	53
Never Smoked	46	

Concerns about Secondhand Smoke 2004

Q: How concerned are you about the health impact of secondhand smoke?

Total Sample	Percent	Cumulative
Very Concerned	43	
Somewhat Concerned	38	81
Not Very Concerned	14	
Not at all Concerned	5	

- The majority of people sampled (81%) were concerned about secondhand smoke.

Support for Smoke-Free Policies in Worksites & Public Places 2004

Q: Would you support or oppose a law in your city or county that requires workplaces and public places, including restaurants & bars, to be smoke free?

Total Sample	Percent	Cumulative
Strongly Support	52	
Somewhat Support	15	67
Support if Allowed in Bars	11	
Somewhat Oppose	7	
Strongly Oppose	14	

- The majority of people sampled (67%) were in support of completely smoke-free policies.

Smoke-Free Impact on Restaurant & Dining 2004

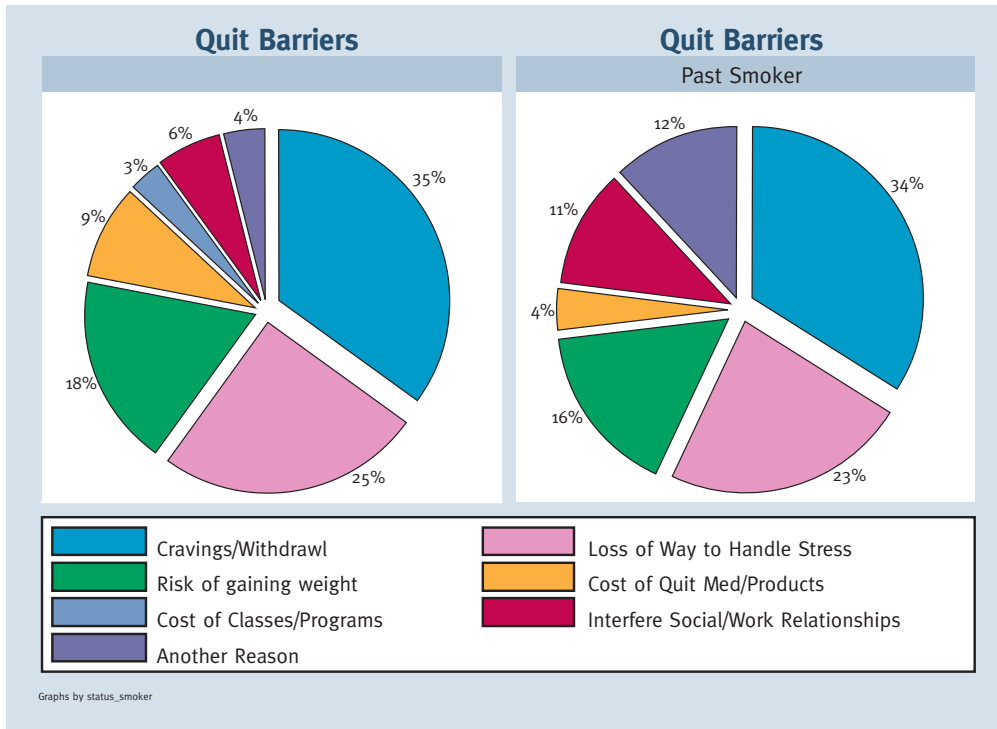
Q: If your county or city passed a law requiring restaurants to be smoke-free, would you eat out more or less often?

Total Sample	Percent	Cumulative
More Often	37	
About the Same	48	84
Less Often	15	

- The sampled audience found smoke-free dining facilities to be an incentive; 84% either felt that they would eat out more, or remain the same; only 15% would eat out less.
- A cross tabulation analysis found that the majority of current smokers (51%) to be in supportive of smoke-free dining experiences.

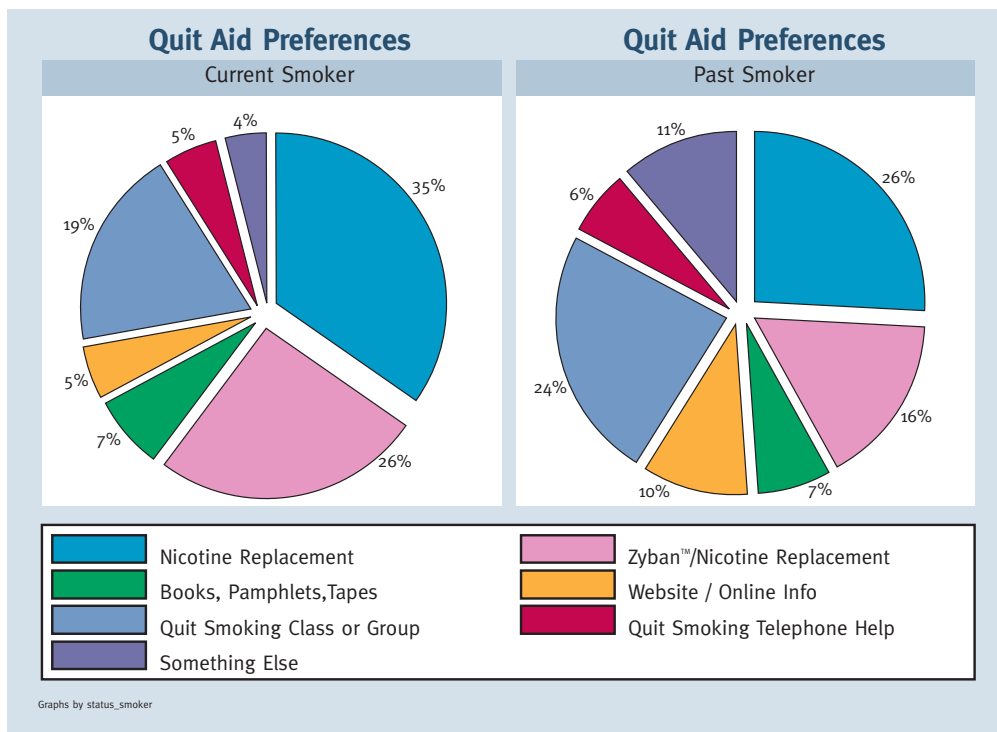
Tobacco Use Barriers 2004

Q: What do/did you feel are/were barriers to quitting smoking?



Tobacco Quit Aids 2004

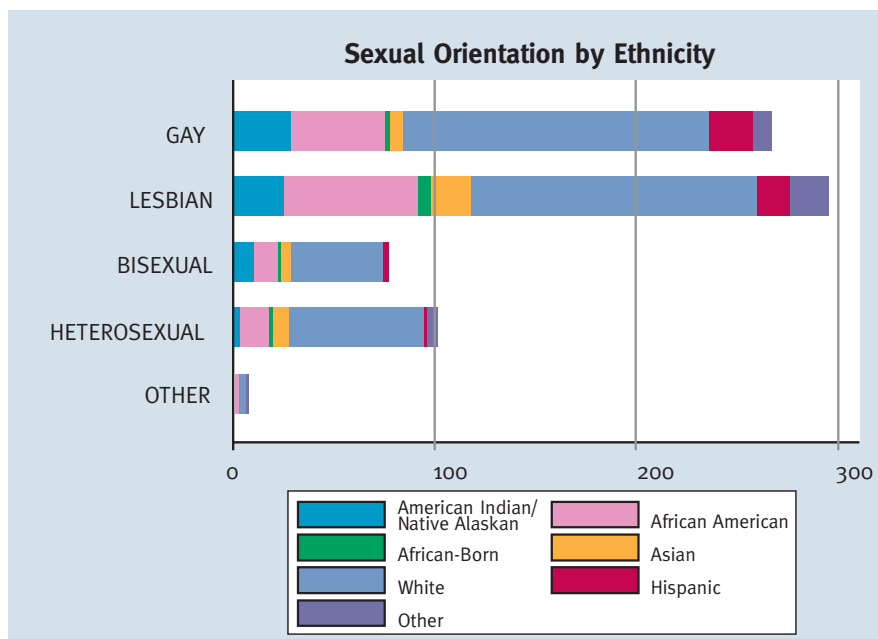
Q: If you are/were a smoker and cost was not an issue, what types of aid would/did you prefer?



2005 Survey Results

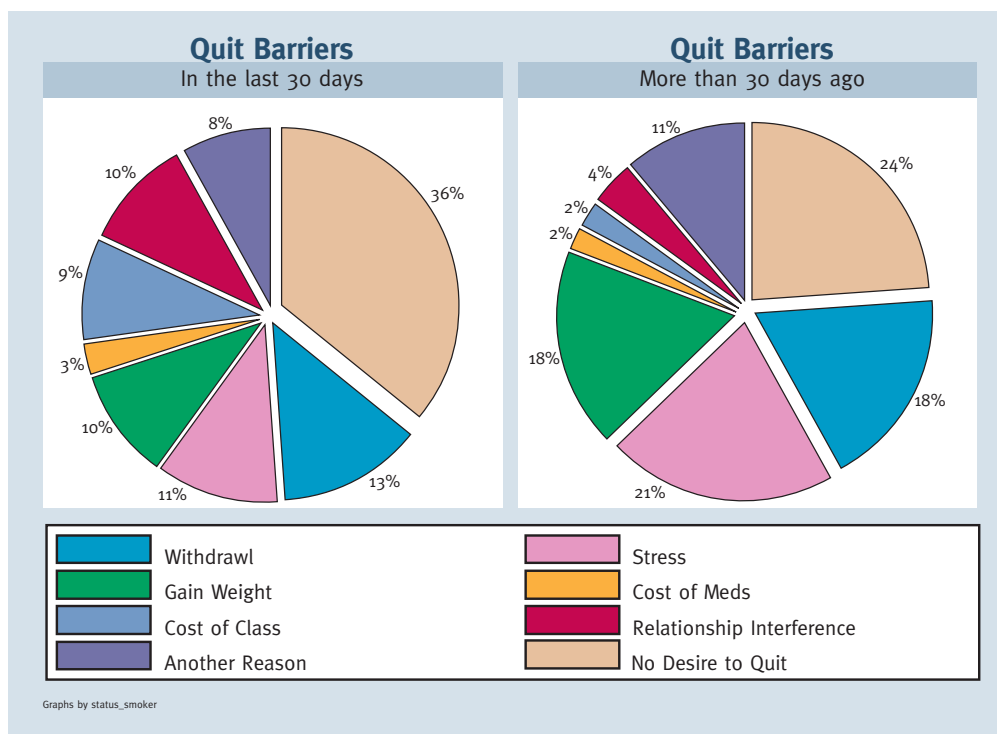
Descriptive Statistics of Sample 2005

Socio-demographic Information of Survey Respondents (n=680)		
	Overall %	% of Sub-group with Health Insurance
Demographics		
Age	Mean: 31.7 (SD11.4)	
Sex		
Male	39.7	60.4
Female	53.8	65.0
Male-to-Female Transgender	4.7	46.9
Female-to-Male Transgender	1.8	91.7
Sexual Orientation		
Gay	35.8	63.6
Lesbian	38.9	65.8
Bisexual	10.7	51.4
Heterosexual	13.4	63.7
Other	1.2	50.0
Race/Ethnicity		
African American	18.3	66.7
African-Born	0.5	66.7
American Indian/Native Alaskan	7.4	28.0
Asian	5.5	32.4
Hispanic	3.6	41.7
White	56.2	69.8
Native Hawaiian/Pacific Islander	0.0	-----
Multi-Racial	6.8	60.9



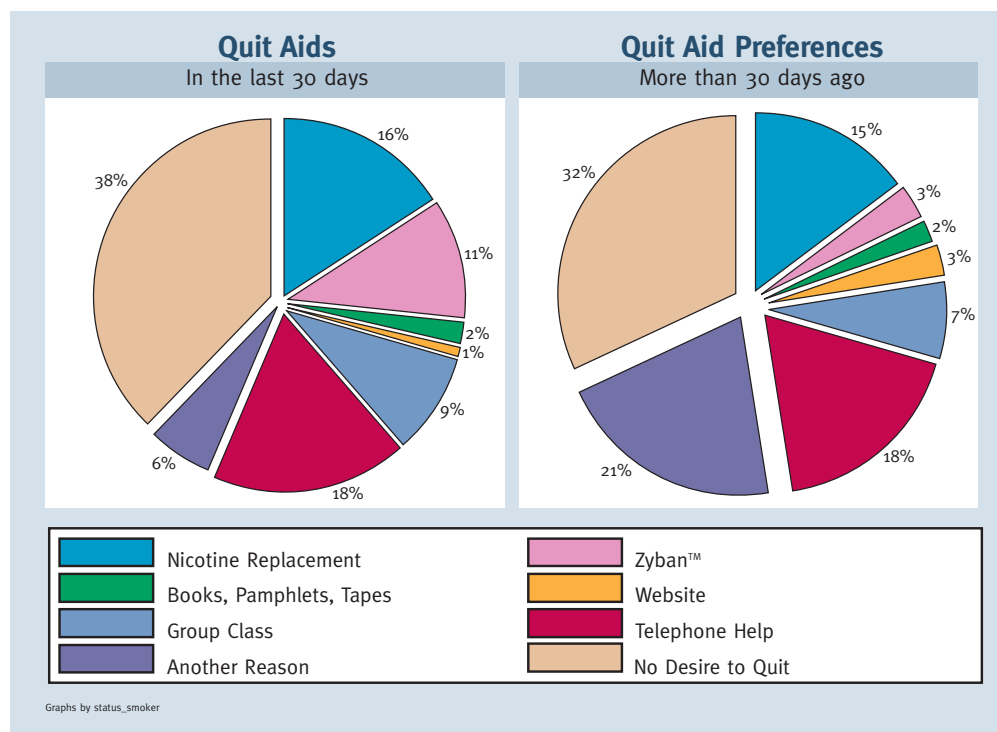
Tobacco Use Cessation Barriers 2005

Q: What do/did you feel are/were barriers to quitting smoking?



Tobacco Quit Aids 2005

Q: If you are/were a smoker and cost was not an issue, what types of aid would/did you prefer?



Views on Smoking 2005

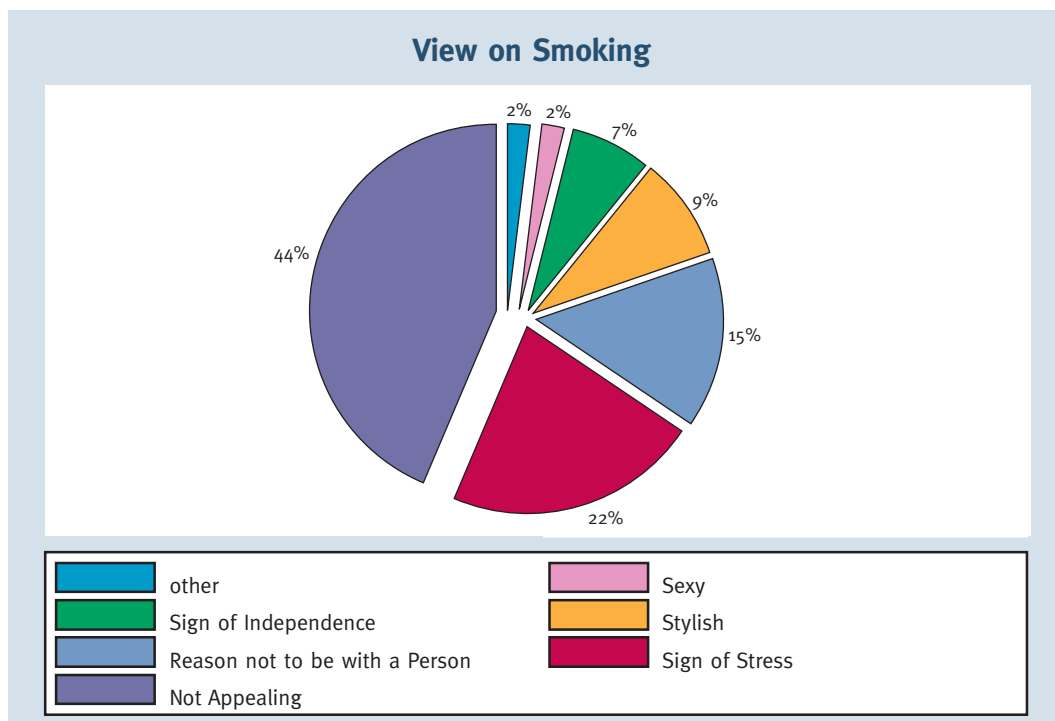
Q: What best describes your view of smoking and use of tobacco?

Total Sample	Percent
Sexy / Appealing	2
Stylish / Cool	9
Sign of Independence	7
Sign of Stress and/or Emotional Issues	22
Not Appealing	44
A Reason Not to Be With a Person	15

(p value .05)

Smoking View Findings

- The majority of respondents, 59% felt that smoking was not appealing and a reason not to be with a person.
- 51% of respondents who felt smoking was not appealing were under 30 years old.
- The majority of people who felt smoking sexy, stylish and a sign of independence were current smokers.
- 62% of current smokers felt that smoking was a sign of stress



Smoking Status 2005

Q: When is the last time you smoked a cigarette?

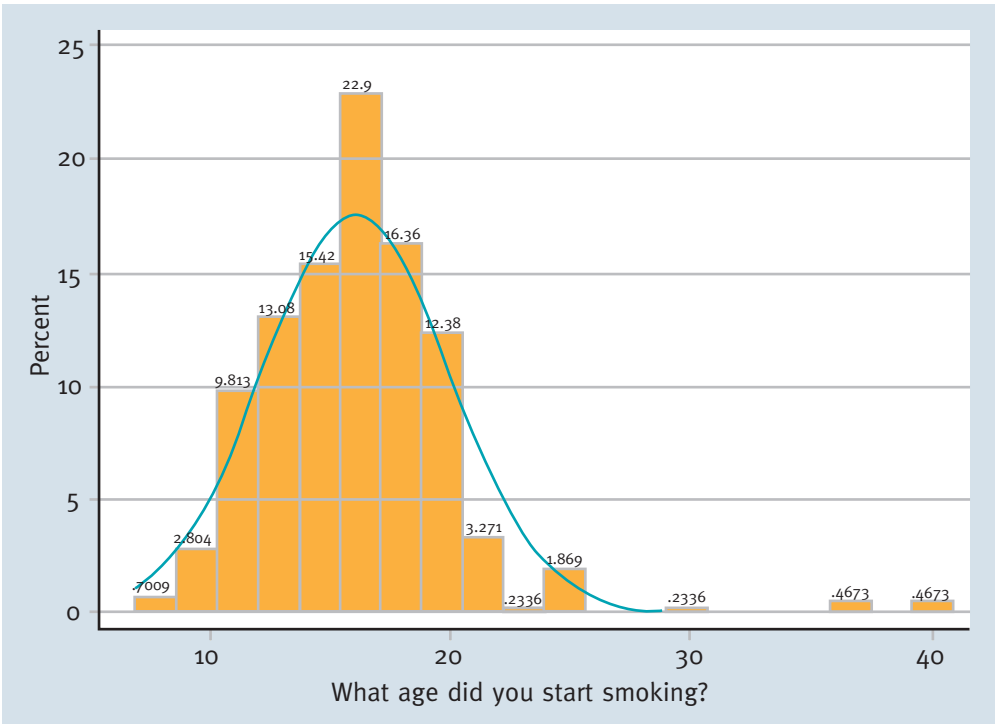
Total Sample	Percent
Never smoked	39
In the last 30 days	41
More than 30 days ago	20

- The majority of people sampled (61%) were current or past smokers.
 - Statistical significance was found based on respondent’s age. Persons 20-29 were more than 2 times more likely to be current smokers than any other age category.
 - Current smokers were twice as likely to be low income and below the poverty level than past smokers.
- The sample’s populations showed a higher rate of tobacco by sex than the national average.

Age of Tobacco Initiation (N=428) 2005

Q: What age did you start smoking?

Respondents reflected that tobacco is indeed an adolescent problem. The mean and median age of tobacco initiation was about 16 years old with a standard deviation of 3.8 years. There was no statistical difference in tobacco initiation by sex or orientation. People of native heritage appear to start smoking tobacco at a substantially younger age 14 years old with a standard deviation of 2.7 years.



Concerns about Secondhand Smoke 2005

Q: How concerned are you about the health impact of secondhand smoke?

Total Sample	Percent
Very Concerned	41
Somewhat Concerned	38
Not Very Concerned	16
Not at all Concerned	5

- The majority of people sampled (79%) were concerned about secondhand smoke. Of the people who were not concerned about secondhand smoke, the majority were current smokers.

Support for Smoke-Free Policies in Worksites & Public Places 2005

Q: Do you support or oppose a law in your city or county that requires workplaces and public places, including restaurants & bars, to be smoke free?

Total Sample	Percent
Strongly Support	49
Somewhat Support	14
Support if Allowed in Bars	12
Somewhat Oppose	7
Strongly Oppose	14
Don't Know	4

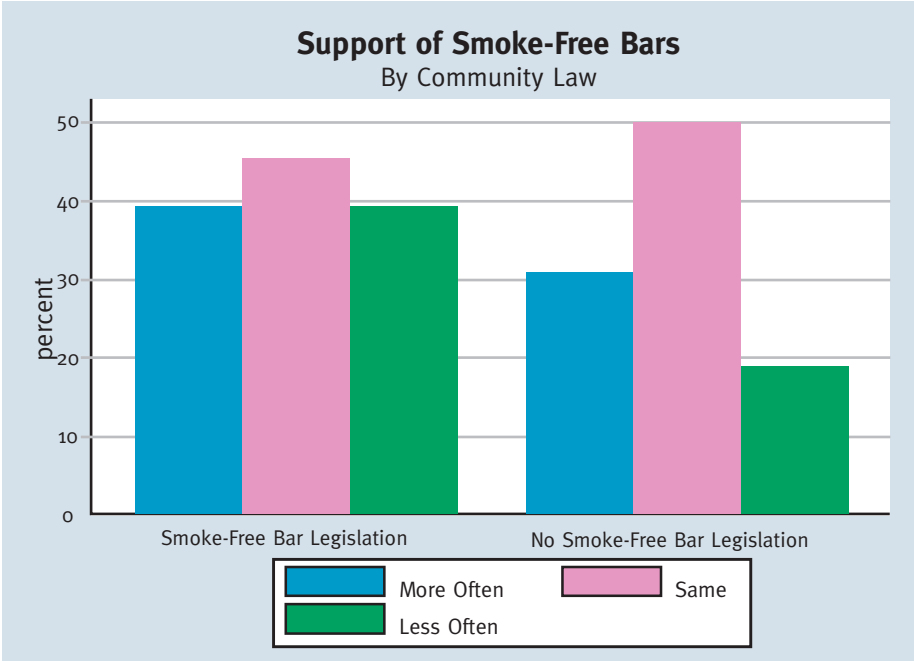
- The majority of people sampled (63%) are still in support of completely smoke-free policies.
- Cross tabulation displayed significant differences in support across income. Self-reported high-income persons were 2.5 times more likely to strongly support legislation (84.8%) than low-income persons. Conversely, persons who self-reported living below poverty and with low-income were 2.5 times (19%) more likely than high-income persons to strongly oppose the laws.
- Statistical significance was found based on respondent's county. The majority of Olmsted county residents were in opposition to such legislation (62%) and were 2.8 times as likely (37.5%) to strongly oppose legislation compared to Hennepin, Ramsey, and all surrounding counties combined. (p value .05)

Support for Smoke-Free Policies in Bars 2005

Q: If your city/county passed a law requiring bars to be smoke-free, would you go out more or less often?

Total Sample	Percent	Cumulative %
More Often	36.1	
About the Same	47.1	83.2
Less Often	16.8	

- The majority of people sampled (83.2%) indicated they would go out to bars at equal and higher rates with the smoke-free policies.
- No significant difference of opinion was found based on respondent’s city/county bar laws. Simply, respondents from communities with, and without such policies felt they would support smoke-free bars.



Tobacco Use Quantity 2005

Q: When you smoke/d, how many cigarettes do/did you smoke a day?

Total Sample	In the last thirty days	More than 30 days ago
1-2 cigarettes	24.9%	27.0%
Less than half a pack	30.1%	40.0%
Half a pack	39.8%	24.4%
One pack	5.2%	8.7%

INTERVIEWS WITH GLBT COMMUNITY LEADERS

Keeping a pulse on GLBT community leaders was essential for this project. It is important to raise community awareness of tobacco as a major GLBT health concern. To do this, and to also create a “community” around this issue, staff met with selected leaders to gather further information, and introduce them to the community that already exists around tobacco through Tobacco-Free Lavender Communities of Minnesota (TLC). The people interviewed represented GLBT businesses, non-profit organizations and health care providers. Many were managers or directors. Information gathered during these interviews was similar to information gathered at the focus groups.

A majority of those interviewed stated that they felt smoking rates within GLBT communities were higher than the general population. One common reason for this assessment was the belief that bar culture has a heavy influence in Minnesota’s GLBT communities. “It is telling that here, we have so many queer bars, but no queer community center. The addiction within the community gets reinforced,” said one staff person interviewed. In this regard, smoking was viewed as a socializing tool. Another staff person said, “The peer pressure of smoking isn’t about smoking, it’s about socializing and fitting in. People don’t really care if you smoke. It’s more complex than that. It’s really a social icebreaker.”

GLBT bar and café managers were interviewed for this project. Conversion for most of these establishments centered around the recent Hennepin County smoking ban. Establishments in St Paul were less concerned about the ban since they are not covered under it. Opinions on the ban were varied. One manager views smoke-free ordinances as a positive for restaurants. “In a restaurant setting, smell is such a big part of the food experience. It is hard to smell the food with smoke in the air. Also, people come dressed up and don’t want their clothes to smell,” he said.

A majority of those interviewed stated that they felt the ban was a positive and effective move, in regard to improving the health of GLBT people. The same respondents were less supportive of the ban in regard to the effect on their business. One bar manager estimated that his business has seen a 30% loss since the ban took effect. Another restaurant manager stated that his business hadn’t seen any noticeable decline, but that he was waiting to see what would happen during the winter months, when it isn’t as convenient for smokers to go outside. Multiple managers mentioned a non-income related effect of the ban. This has to do with smokers having to stand outside to smoke and potentially being subjected to hate crimes. “Now the community are targets, having to stand outside on Hennepin. They’re in a position for discrimination. It is dangerous to stand out front. Those who don’t want to be seen don’t have an option if they want to smoke,” said one manager.

Two agencies that provide chemical dependency treatment to GLBT people were also interviewed. Representatives from both agencies stated that a great majority of clients smoked while utilizing their services. It was pointed out that many clients did not want to quit smoking in addition to overcoming other addictions. “There is a struggle with people not wanting to give up everything at the same time. I’m for giving it all up at once, but there’s a lot of resistance. It’s the last vice they have,” said one representative.

Both people interviewed stated that they felt high smoking rates among clients was reinforced by high smoking rates among staff. “90% of our staff are smokers, so telling clients to quit is hypocritical. We had a psychiatrist who tried to implement a non-smoking facility, but was met with a lot of staff resistance,” one said. “We need to look at staff. It’s amazing how many nurses and physicians smoke. You need to look at it from a client’s perspective. How can we teach good health care when we’re not doing it ourselves,” said another.

EDUCATIONAL VENUES

Because of initial themes seen in the focus groups, it was decided to look at chemical dependency treatment. Many participants spoke of the special issues surrounding tobacco use while participating in chemical dependency treatment. It was widely speculated by those who had gone through such treatment, that a great majority of people in recovery smoked. Participants viewed smoking as a necessary vice to help them overcome other addictions.

For this reason, staff looked to Alternatives, a GLBT-specific chemical dependency treatment center. This venue shared a presentation by Perry Stevens, entitled *LGBT Populations and Tobacco*, a presentation on tobacco industry marketing. A brief assessment was also developed and administered, as well as a facilitated discussion on tobacco issues. The purpose of the venue was to raise community awareness and collect information on GLBT-specific tobacco issues in a chemical dependency treatment facility setting. Attendees of these venues were current clients seeking treatment.

Questions asked at this venue were similar to questions asked at the focus groups. Attendees gave similar answers in regard to reasons why GLBT people may smoke at higher rates than the general population. These included peer pressure, a stress reliever, part of a deviant image, part of a gay identity, and as a way to gain acceptance.

Based on conversations with focus group and educational venue attendees, there appears to be a high rate of smoking associated with chemical dependency treatment. Both clients and staff consistently estimated smoking rates around 90 percent. Smoking is perceived to be a way to cope with overcoming addiction to other substances. Some believed it was necessary to hold onto one vice if you gave up others.

Many people stated that smoking is a part of the “culture” of recovery. “If you didn’t smoke when you got here, you smoke now,” one client said. Clients stated that one contributing element to higher smoking rates may be that many health care professionals and staff also smoke. There is a perceived hypocrisy in positive health promotion while staff openly smoke around clients.

Clients suggested that discussions of tobacco cessation need to be included from the beginning of treatment. Rather than have smoking be a part of the culture, cessation needs to be a part of the culture of recovery. Some clients said that tobacco should be treated the same way as other addictions while in recovery. It was also noted that staff should be encouraged to quit smoking in order to better serve and support clients.

CONCLUSION

Over the course of two years, staff for this project have made connections with many diverse Gay, Lesbian, Bisexual and Transgender communities. These communities have greatly contributed to the information contained within this report. The purpose of this report is to gather information to establish parameters that can be used to develop a strategic plan to reduce the harm tobacco causes GLBT communities in Minnesota. This report is just one step in this process. There are still many issues surrounding tobacco use that need to be explored and researched. The following are recommendations based on the information gathered during this project. Statements in quotations are recommendations directly received from focus group, interview and educational venue participants. It is important for this project that community members are heard in their own voices.

1) More research needs to be done in the area of transgender health in relation to tobacco use. Little to no research currently exists addressing tobacco issues for transgender individuals. Based on qualitative information collected at two focus groups, the health effects of tobacco use may be severe for individuals who are transitioning and utilizing hormone therapy. Anecdotally, risks of smoking while on hormones may include increased risk of heart attack and stroke.

2) Address GLBT-specific reasons for smoking in cessation materials targeted at GLBT people. One material reviewed during focus groups simply had a rainbow on the cover and one phrase addressing high smoking rates in GLBT populations. Participants felt that materials would be more effective if they more comprehensively addressed GLBT-specific concerns.

3) Be cautious not to reinforce stereotypes through images or messages included in cessation materials or campaigns to reduce smoking. One advertising campaign reviewed during focus groups was interpreted by a majority of participants as outrageous and stereotypical.

4) Include a demographically diverse range of models in cessation materials that feature images of people. Some participants in the People of Color focus groups did not identify with materials featuring

predominately Caucasian images. One campaign that received praise from the majority of all focus group participants featured images of people of various ages, races, and orientations.

Participant Recommendations

5) “To help people quit you could provide an option for buying single cigarettes instead of a pack. This could help provide an option to decrease the accessibility of cigarettes for people trying to quit.”

6) “Smoking cessation materials should be widely available. At bars, they should pass out nicotine gum. Like in the early days of AIDS prevention efforts when condoms were first handed out in bars. At first there was a lot of resistance. Over time, it became part of the culture.”

7) “GLBT specific messages need to be in GLBT specific locations (e.g. Magazines, etc.) plus in place that reach a broader public to reach GLBT people who mostly live in these (rural) environments.”

8) “The GLBT community needs to be especially conscious of being respectful to smokers given that GLBT people already feel like second class smokers.”

9) “The GLBT community is underinsured so we have less access to health resources including those needed to quit smoking.”

10) “Campaigns showing manipulation are needed. (The) Target Market (campaign) was effective because it exposed the lies of the tobacco industry. People don’t like being manipulated.”

11) “The media influence about smoking is powerful, like movies, TV, billboards. Use posters and different images in GLBT press, in deaf publications, and mainstream places.”

12) “Youth need the opportunity to speak out against it (smoking). Target Market was a good example. Guilt doesn’t work with young people.”

For Agencies offering Chemical Dependency Treatment

13) Implement smoke-free policies that prohibit staff from smoking on premises or around clients.

14) “The problem with cessation efforts is that smoking addiction is not treated with the same seriousness as other addictions. Specifically, the GLBT press runs stories and ads about other addictions in the GLBT community, but not smoking. How come GLBT treatment facilities are not doing anything about smoking addiction?”

15) “One thing that would help us (service providers) is to have a card that can fit into a Rolodex with a list of five cessation program phone numbers. Something that is easy to locate without having to shuffle through papers or packets. Have multiple options to accommodate different insurance plans. Something simple.”

16) “Education for both clients and staff would be helpful.”

17) “One thing that would help us (address tobacco issues) is to have resources available, like a kiosk of information.”

18) “We need staff training and to address their attitudes and behaviors around smoking.”

19) “We could offer space to a Nicotine Anonymous Group.”

20) “We could connect with insurance companies and get reimbursed for (cessation) classes.”

RAINBOW HEALTH INITIATIVE

The Rainbow Health Initiative (RHI) is a 501(c)3 non-profit organization founded in the year 2000 by a group of community activists, physicians and health advocates. Our mission is to improve the health of gay, lesbian, bisexual and transgender people in Minnesota through education, clinic practice, research and advocacy.

This group identified significant health disparities affecting gay, lesbian, bisexual, and transgender (GLBT) communities living in Minnesota. Despite being named the healthiest state in the union for 14 of the past 15 years, Minnesota GLBT persons have significant health disparities in smoking, HIV, cancer, anxiety, depression and health care access.

From the 2001 Rainbow Health Initiative needs assessment survey, 22% of GLBT Minnesotans did not have health insurance; that is compared to 6.9% of the total population in Hennepin County. (Shape 2002 Data) Nearly 1 in 4 women and 1 in 5 men report discrimination in a health care setting due to their sexual orientation or gender identity. It may be for this reason that 4 in 10 GLBT Minnesotans had not disclosed their sexual orientation or gender identity to their health care provider. Almost half of the people in GLBT communities would prefer a GLBT health care provider, but only 1 in 4 men and 1 in 8 women actually had one.

Initially founded with the intention of opening a queer health clinic, the Rainbow Health Initiative

has shifted its focus to improving health by using advocacy and education strategies. Research has been an important component of the mission as well. RHI has conducted key informant interviews of leaders within GLBT communities, and surveys in 2001, 2004 and 2005 during the annual Pride festivals.

As part of the Rainbow Health Initiative's goal to bring together organizations within GLBT communities to improve health, RHI was a founding member of the Tobacco-free Lavender Communities of Minnesota (TLC). TLC is a diverse constituency of leaders and advocates within Minnesota GLBT communities whose goal is to examine social norms surrounding tobacco use in our community and to begin to reduce the harm that tobacco causes our community.

In 2003, Rainbow Health Initiative received a grant from the Minnesota Partnership for Action Against Tobacco (MPAAT) to develop a community-based plan to address issues surrounding tobacco use and exposure to secondhand smoke in Minnesota GLBT communities. The grant project includes formalizing and expanding networks and relationships within Minnesota GLBT communities, collaborative dialogues with non-profit organizations, businesses and health care providers serving GLBT communities, in addition to gathering opinions and reflections from community members concerning social norms surrounding tobacco use.

PROJECT STAFF

Antonio Cardona - Project Manager

Antonio Cardona is currently the GLBT Tobacco Plan Project Manager for Rainbow Health Initiative. He recently graduated from the University of Minnesota with a B.A. in Global Studies. Antonio has been active in GLBT community organizing for the last six years, primarily as Co-Chair of the Queer Student Cultural Center, in addition to working to build coalitions between many local GLBT and non-GLBT organizations. He has written and led workshops on GLBT non-profit organizations at multiple universities focusing on locating funding sources, increasing community participation and effective Board leadership.

Paula Hastings

Community Outreach Coordinator

Paula Hastings is currently the Community Outreach Coordinator for Rainbow Health Initiative. She was born in Minneapolis MN and has been an active member of the GLBT community. She has had a significant role in community organizing within communities of color for *Soul Essence*, the Twin Cities African American GLBT organization.

Paula served on the Board of Director's for the *Center for Cross Cultural Health* and on several committees advocating for inclusive education. Her professional background and education is in early childhood development as a Parent Educator. She has worked for 15 years, with families experiencing a pregnancy and / or having young children in the home, to increase literacy and school readiness.

Beth Zemsky, MAEd, LICSW

Consultant, One Ummah Consulting

Beth has delivered training, lectures, workshops and developed curricula at the University, community, professional and business levels locally, regionally, and nationally for more than twenty years. She has extensive experience working as an educator and community organizer about issues concerning multiculturalism, GLBT communities, HIV/AIDS, and violence against women. Beth also has ten years of direct practice experience as a psychotherapist working primarily with GLBT communities. In addition, Beth has been adjunct faculty at the University of Minnesota, Augsburg College, and University of Missouri, Saint Louis, and she was selected as an Education Policy Leadership Fellow for the Institute for Educational Leadership, Washington DC, where she and national education leaders studied education policy issues.

Gail Babes, MPH - Survey Analyst

Gail Babes is an epidemiologist dedicated to unearthing socio-behavioral and structural determinants of public health disparities. Currently employed as a statistical analyst for a Medicaid HMO, Gail has provided consultation to university research projects, policy agencies, and non-profit health centers. A long-time advocate of GLBT health issues and research, Gail has worked professionally to help research understand the complexity of gender, sex, and sexuality in public health.

Gail holds a MPH in Community Health Epidemiology from the University of Minnesota, and her undergraduate degree is in Cultural Anthropology and Archaeology. She is a member of the American Public Health Association (APHA) and has the American Anthropological Association (AAA).

Kim Milbrath, MPH

Rainbow Health Initiative Board Member

Kim Milbrath joined the Rainbow Health Initiative Board in 2003. She recently left her position as the Secondhand Smoke Advocacy Coordinator with the Minnesota Smoke-Free Coalition where she worked with communities interested in passing clean indoor air policies to attend graduate school at the

University of Minnesota's Master's in Public Health Program. Her areas of interest include global health policy, women's health and the overall economic, social and cultural factors that impact health status. Kim also worked in the Minnesota battered women's movement, with the Girl Scout Council of Greater Minnesota and the Center for Urban and Regional Affairs at the University of Minnesota.

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Generated by Gary Remafedi, MD, MPH of Tobacco-free Lavender Communities (TLC). Available through the support of the Minnesota Partnership for Action Against Tobacco (MPAAT) and the University of Minnesota.

APPENDIX A

Current Known GLBT Tobacco Cessation Options List compiled by Gail Babes, MPH.

Please be aware that RHI does not control or guarantee the accuracy, relevance, timeliness, or completeness of this outside information. Providing this information is not intended to reflect their importance, nor is it intended to endorse any views expressed or products or services offered by the author of the reference or the organization operating the site on which the reference is maintained.

ONLINE

Iquit

University of California, San Francisco
<http://www.iquit.medschool.ucsf.edu>
415-597-9279

As of 2005 the online cessation option was not accepting more participants, but USCF is accepting contact info if another cessation treatment begins.

ARIZONA

Lesbian Health Project (formerly Lesbian Cancer Project)

P.O. Box 45260
Phoenix, AZ 85064
(602) 263-5622
LCParizona@aol.com
www.lcparizona.org

Lesbian Health Project provides a free course sensitive to LGBTQ persons. Course is 9-weeks long (45mins/session), 1/2 price nicotine patches offered by county. A possible hotline and office space are in the future. Website is not up to date.

CALIFORNIA

The Last Drag

1800 Market Street, San Francisco, CA 94102
415-339-7867
800-NO-BUTTS
info@lastdrag.org
www.lastdrag.org

The Last Drag is a free cessation class in San Francisco for lesbian, gay, bisexual, transgender, intersex and HIV+ smokers. Group classes run for 7 weeks (2hours/session), and are lead by an ALA certified clinic leader. Classes run four times a year. The Last Drag also has pamphlets and videos for purchase.

Pacific Pride Foundation

Kick Butt Tobacco Cessation Program

South County Office
126 East Haley Street Suite A-11
Santa Barbara, CA 93101
805-963-3636 ext.121 (phone) Jessica Humphrey
805-963-9086 (fax)
www.pacificpridefoundation.org

A tobacco cessation program for the LGBT community, Kick Butt offers three cessation options: group classes, individual programs, and a workshop for smokers who are not ready to quit yet. Group classes run for _ - weeks (hours/session). The individual program allows participants the ability to meet with the tobacco prevention to design a tailored cessation plan.

The last option is a *Not Ready to Quit Workshop* to help smokers look at increasing motivation for quitting and eliminating roadblocks to making the big decision to stop smoking. Partners of smokers are welcome. Advance registration is required.

Free nicotine replacement therapy is available for LGBT participants of the cessation classes.

DISTRICT OF COLUMBIA / WASHINGTON, DC

The Mautner Project

1707 L Street, NW Suite 230 Washington, DC 20036
202-332-5536
jhall@mautnerproject.org
www.mautnerproject.org

Open to the LGBT community, Mautner offers an 8-week (1 hour/wk) tobacco cessation group in Washington D.C. Free or \$50 donation. Curriculum based on individual needs.

HAWAII

The Center

PO BOX 22718 Honolulu HI 96823
808-951-7000 (phone)
info@thecenterhawaii.org
<http://www.thecenterhawaii.org/tobacco.htm>

Smoking cessation drop-in services available weekly on Mondays from 1-2pm. The center provides tobacco cessation pamphlets and information. It is possible to develop a personalized plan with a staff member to quit smoking. The cessation program does not appear to be specifically tailored to the LGBT community.

ILLINOIS

Lesbian Community Cancer Project/Howard Brown
Bitchtoquit (B2Q)
4753 North Broadway, Suite 602, Chicago, IL 60640
773-561-4662 (phone)
773-561-1830 (fax)
info@lccp.org
http://bitchtoquit.com

Smoking cessation groups for lesbian, queer, bi women. A 7-week (1.5 hour/session) clinic allows women to share experiences in a support group setting while covering the reasons for smoking, social cues and smoking alternatives. The clinics and workshops are free and open to all women. Telephone support is available.

PENNSYLVANIA

Mazzoni Center
215-563-0663, ext.274 (phone)
1201 Chestnut Street, 2nd Floor, Philadelphia, PA
www.mazzonicenter.org

Three support programs. A free smoking cessation group meets for 7 weeks (1.5 hours /session). Provides free nicotine replacement. A monthly drop-in support group for persons at various stages of change is available as well as individual cessation counseling.

MICHIGAN

Kick Butts Affirmations Community Center
195 West Nine Mile Road Ferndale, MI 48220
248-398-7105 (ask for Debra)
info@goaffirmations.org
www.goaffirmations.org

The GLBT community center offers monthly (1 hour/session) tobacco cessation workshops and everyday online blog support. \$2 donation. Provides substance free youth events.

NEW JERSEY

The Pride Center of NJ Inc.
1048 Livingston Ave, North New Brunswick, NJ 08902
732-235-8229 (phone ask for Donna)
info@pridecenter.org
www.pridecenter.org

Not an ongoing group, but can provide if requested LGBT-sensitive tobacco cessation material and a LGBT therapist if a group is wanted desired.

NEW YORK

The Lesbian, Gay, Bisexual & Transgender Community Center in NYC
208 West 13th Street

New York, NY 10011
(212) 620-7310 ext. 259 (please call Christopher)
gaycenter@gaycenter.org
www.gaycenter.org

The Center remains the only LGBT-specific cessation resource group in the New York metropolitan area. Advance registration is required. There are two free workshops:

Not Quite Ready to Quit, the first workshop in the series, helps smokers look at increasing motivation for quitting and eliminate roadblocks to making the big decision to stop smoking.

Commit to Quit is a 6-week group for smokers who have decided to quit smoking and have attended *Not Quite Ready to Quit*.

The Bronx Lesbian and Gay Health Resource Consortium
940 Garrison Avenue
Bronx, NY 10474
718-292-4368
718-842-9832 (fax)
866-4-GAY-CARE (health link line)
may@blghrc.org
http://www.blghrc.org

Two smoking support groups: (1) Gurlz Kick Ash, and (2) Boyz Kick Ash. Free 8-week (2hour/session) support group tailored to the LGBT community. Drop-in available. Provides nicotine patches. Now available to travel to various locations to perform group.

WASHINGTON

Gay City Health Project
1505 Broadway, Seattle, WA
206-860-6969 (phone)
info@gaycity.org
www.gaycity.org

Gay City Health Project offers free quit-kits for gay, lesbian, bisexual and transgender smokers, featuring *Out To Quit*: your friendly guide to quitting smoking, and four other helpful booklets. Website provides summary of GLBT *Out to Quit* Guide.

Verbena
LGBT Community Center #1333
1115 East Pike Street
Seattle, WA 98122
(206) 323-6540 or 877-323-6540 (phone)
info@verbenahealth.org
http://www.verbenahealth.org

Uses *Out to Quit* format to provide a tobacco cessation program for lesbian, queer, trans, and bisexual women of all ages. Course is 10-weeks (2hrs/session). Free nicotine replacement therapy available. Free.

APPENDIX B

Smoking Prevention and Cessation Resources for Minnesota and U.S.

Please be aware that TLC and RHI do not control or guarantee the accuracy, relevance, timeliness, or completeness of this outside information. Providing this information is not intended to reflect their importance, nor is it intended to endorse any views expressed or products or services offered by the author of the reference or the organization operating the site on which the reference is maintained.

NAME	SPONSOR	DESCRIPTION	COST	CONTACT
Minnesota Outpatient Programs				
Freedom from Smoking Classes	American Lung Association	8 group sessions	\$90. Insurance may cover a portion.	651-227-8014
Nicotine Anonymous	Nicotine Anonymous World Service	12-step program	Free	TC: 952-404-1488 US: 415-750-0328
Smoke Free	Learning Strategies Corporation	CDs will be avail Jan. 16, 2006	To be determined	952-476-9200 www.paraliminal.com
A Call to Change	Health Partners	Telephone counseling	\$25/Health Partners members; \$105/non-members	952-883-7800
Blueprint for Health Stop-Smoking Program	Blue Cross/Blue Shield	Telephone counseling	Available for Blue Cross members	1-800-835-0704
Free and Clear	Medica	Various cessation options	Available for Medica members	1-800-292-2336
Health Promotion Department	Ucare Minnesota	Telephone counseling	Available for Ucare members	612-676-3351 or 1-800-203-7225
Call Link	Medica	Various cessation options	Available for Medica members	1-800-626-7944
QUITPLAN Help line	MN Partnership for Action Against Tobacco	Professional counseling	Free	1-888-354 PLAN (7526)
Minnesota Residential Programs				
Mayo Nicotine Dependence Center	Mayo Clinic, Rochester MN	Stress management, relapse prevention, discharge planning	\$5,000. Insurance may cover	507-266-1930
Tobacco Dependence Clinic	Hennepin County Medical Center	Counseling and medication	\$100/session; insurance may cover	612-873-2300
Your Next Step	Hazelden Residential	7-day holistic in patient program	\$2,525	651-257-7810 or 1-800-257-7810
U.S. Programs				
Cancer Information Service	National Cancer Institute	Information in English and Spanish.	Free	1-800-4-CANCER (226237)
Clean Break		5 2-hour sessions plus 3 mos. telephone counseling	\$420. Health Partners & Medica get 20% discount	1-800-318-5903
Health Initiatives Department	American Cancer Society	Written info & referrals to groups, programs	Free	1-800-227-2345
Internet Programs				
Smokeless	American Institute for Preventive Medicine	Training for stress management, behavior mod, Self-help materials	\$200 for training, but call for more information	248-539-1800, ext.222
Smoking Cessation & Prevention Information for Teens	American Academy of Family Physicians	Educational materials & cessation resources	Free	http://familydoctor.org/274.xml 1-800-274-2237, x3135
Freedom From Smoking Online	American Lung Association	Information, message board, exercises in 7 modules (for adults)	Free	www.lungusa.org
QuitNet	Boston University & American Legacy Foundation	Counseling, support, and cessation planning	Free	www.quitnet.org
QUITPLAN	MN Partnership for Action against Tobacco	Advice, support, self-assessment tools	Free	www.quitplan.com
Smokefree.gov	Various US health organizations	Information, resources, cessation guides, instant messaging	Free	www.smokefree.gov

Generated by Gary Remafedi, MD, MPH of Tobacco-free Lavender Communities (TLC). Available through the support of the Minnesota Partnership for Action Against Tobacco (MPAAT) and the University of Minnesota.

APPENDIX C

RAINBOW HEALTH INITIATIVE'S 2004 TWIN CITIES PRIDE SURVEY

Demographic data *(for statistical use only)*

Gender M F TG Age _____ Sexual Orientation Gay/Lesbian Bisexual Heterosexual
Zip code _____ Have health insurance? Y N Race/Ethnicity *(please check all that apply)* ___Native American ___Caucasian
___ African American ___ Hispanic/Latino ___ Asian ___Native Hawaiian/Pacific Islander ___ Other _____

What are your top 3 health concerns? *(Please list in order of concern to you, personally.)*

1. _____
2. _____
3. _____

What best describes your view of smoking and use of tobacco?

- | | |
|---|--|
| <input type="checkbox"/> Sexy /Appealing | <input type="checkbox"/> A sign of stress and/or emotional or psychological issues |
| <input type="checkbox"/> Stylish / Cool | <input type="checkbox"/> Not appealing |
| <input type="checkbox"/> A sign of independence or maturity | <input type="checkbox"/> A reason to not be with or get to know someone better |

How concerned are you about the health impact of secondhand smoke?

- Very concerned Somewhat concerned Not very concerned Not at all concerned

Would you support or oppose a law in your city or county that requires workplaces and public places, including restaurants and bars, to be smoke-free? *(Please indicate your level of support or opposition.)*

- | | |
|---|--|
| <input type="checkbox"/> Strongly support | <input type="checkbox"/> Somewhat oppose |
| <input type="checkbox"/> Somewhat support | <input type="checkbox"/> Strongly oppose |
| <input type="checkbox"/> Support only if smoking is still allowed in bars | <input type="checkbox"/> Don't know |

If your county or city passed a law requiring restaurants to be smoke-free, would you eat out more or less often?

- More often About the same Less often Don't know
 My community already has a smoke-free law, and I now eat out . . . *(please check answer above that applies)*

About how many of your friends smoke or use tobacco? *(Please check the answer that seems closest.)*

- Almost none 1 in 4 (25%) Half of them (50%) 3 in 4 (75%) Just about all

Would you classify yourself as a:

- Current smoker (have smoked at least 100 cigarettes in lifetime & now smoke every day or some days).
 Past smoker (smoked at least 100 cigarettes in lifetime but now do not smoke).
 Never smoked (have not smoked 100 cigarettes in lifetime and now do not smoke).

If you are a current or past smoker, please answer just 3 more questions:

How many cigarettes a day do/did you smoke?

- Less than 15 15-24 25+

What do/did you feel are/were barriers to your quitting smoking? *(Please check all that apply/applied.)*

- | | |
|--|--|
| <input type="checkbox"/> Cravings/feelings of withdrawal | <input type="checkbox"/> Cost of classes/other programs |
| <input type="checkbox"/> Loss of way to handle stress | <input type="checkbox"/> Interference with social/work relationships |
| <input type="checkbox"/> Risk of gaining weight | <input type="checkbox"/> Another reason _____ |
| <input type="checkbox"/> Cost of medications/products to help quit | <input type="checkbox"/> No desire to quit |

If you are/were a smoker and cost were not an issue, what types of aid would/did you prefer?

- | | |
|--|--|
| <input type="checkbox"/> Nicotine replacement | <input type="checkbox"/> Quit smoking class or group |
| <input type="checkbox"/> Zyban or another non-nicotine prescription medicine | <input type="checkbox"/> Quit smoking telephone helpline |
| <input type="checkbox"/> Books, pamphlets, tapes | <input type="checkbox"/> Something else _____ |
| <input type="checkbox"/> Website/online information and counseling | <input type="checkbox"/> No aid |

Data Collection

2004 Twin Cities Pride Survey

The Rainbow Health Initiative (RHI), under the sponsorship of Minnesota Partnership for Action Against Tobacco (MPAAT) was responsible for the collection of all survey data. A convenience sample of persons attending the 2004 Pride Events were asked to volunteer as respondents for a self-report survey on tobacco. RHI volunteers were told to sample anyone who walked by, irrespective of assumed tobacco use, gender, or sexuality.

Location Information: Twin Cities Pride events are held in Minneapolis, Minnesota.

Data Intent

Rainbow Health Initiative currently dedicates resources to executing and planning activities that address three primary project objectives: developing a community-sensitive strategic plan for changing social norms around tobacco and exposure to secondhand smoke in the GLBT community, highlighting and catalyzing actions that deal constructively with access to healthcare for GLBT individuals, and education and prevention efforts surrounding health issues of concern to or disproportionately affecting the GLBT community (www.rainbowhealth.org).

Administration of the survey was intended to assess tobacco use, opinions, and targeted needs.

Ethical Consideration

The Rainbow Health Initiative Board of Directors approved data use and analysis. The analysis was performed by a consultant. All supplied data for the analysis was anonymous to the consultant. While analysis was thought to qualify as exempt under 45 CFR 46.101(b)(4), statistical analysis has challenged this original status. Namely, since zip code and gender identity were sampled, persons identifying as transgender who also live in rural communities have the possibility of being identified through this data. Therefore, I strongly urge the owners of this data to be selective about data use in the future. Due to these findings, I chose to not report gender identity by zip code in this analysis.

Data Description

Sample Size

There were a total of 879 surveys administered.

Coding Discrepancies

Data coding proved to be problematic. Data cleaning predominantly occurred in STATA, with a few changes occurring in Excel format. Within variables and across observations, data was coded in a multitude of ways: from number, to string (word), to unknown combinations. Data was also coded out of sync from the intended coding scale. For example, a question organized on a 3-point Likert scale was coded as 1,3,4 instead of 1,2,3. Additionally, individual variables were merged into one Excel cell. Data entry had to be manually fixed by analyst in cases where a cell (variable) read “1 thru 7” or “1-7” or “1 to 7” instead of entry into 7 distinct cells. This proved to be even more problematic when Excel translated certain entries into dates.

Missingness

Missing variables were consistently coded as “999”.

Data Steps

Data Transfer

Data was originally coded by RHI in Microsoft Excel. For the purpose of this analysis, data was converted into a comma-delimited (.CSV) file and imported into STATA 8.

Data Manipulation

Attempts to circumvent variable confounding

When the survey was administered, a serious design flaw was not recognized. When respondents were asked their sexual orientation, the option for “gay” or “lesbian” was listed as “gay/lesbian”. As the term “gay” has been used synonymously in the recent past for “lesbian” and “gays” alike, a large number of respondents circled the entire phrase. In an attempt to clear up the discrepancy, a new variable was created that combined the respondents “gender” with their “sexual orientation”. While this appeared to clear up the majority of the confusion, the new variable has its own problems. Gender identity and sexual orientation are two completely different questions, and the new variable will invariably miss cases of gender variability. The transgender category was merged into one category regardless of sexual orientation due to small sample size. It is important to note that the transgender respondent’s sexual orientation was found in all categories.

Weights

Frequency weights were used when analyzing variables against ethnicity/race.

Decisions on Coding Discrepancies

All variables were cleaned for coding discrepancies. New variables were made for questions on sexual orientation/gender, race/ethnicity, status as a smoker, tobacco quit barriers and tobacco quit aids.

Census ZCTAs as Income Proxy

The only income-related variable asked was the participant’s zip code. Census 200 data using the national ZIP Code Tabulation Areas were imported into the dataset along with corresponding individual per capita income variables.

Zip codes are not sampled by the Census, but due to the enormous marketing interest in zip code demographics, the Census has put together ZIP Code Tabulation Areas (ZCTAs). ZCTAs are distinct from other Census measures. They are distinct from statistical areas such as census tracts because they are not stable over time and are computer delineated using addresses rather than formally delineated before the census. (www.census.gov). Unlike tracts and block groups, ZCTAs span varying density and geographic areas, and are typically not homogenous in their sociodemographic characteristics. Zip codes and thus ZCTAs, can merge markedly different types of neighborhoods. It is possible that the poorest neighborhood and the richest could share the same zip code. Therefore the reliability and validity of this income proxy is called into question.

APPENDIX D

RAINBOW HEALTH INITIATIVE'S 2005 TWIN CITIES PRIDE SURVEY

Demographic data (for statistical use only)

Sex M F M2F Transgender F2M Transgender 5 Other _____ (please specify)

Age _____

Sexual Orientation 1 Gay 2 Lesbian 3 Bisexual 4 Heterosexual 5 Other _____ (please specify)

Do you have health insurance? 1 Yes 2 No

Race/Ethnicity (please check all that apply)

1 American Indian/Alaskan Native 2 African American 3 African-born 4 Asian 5 Caucasian
 6 Hispanic/Latino 7 Native Hawaiian/Pac Islander 8 Other _____ (please specify)

What best describes your household income level?

1 Below Poverty Level 2 Low Income 3 Middle Income 4 High Income

What are your top three (3) personal health concerns overall? (please specify)

1. _____ 2. _____ 3. _____

Which Minnesota County do you live in?

1 Beltrami 2 Hennepin 3 Olmsted 4 Ramsey 5 Other _____ (please specify)
 6 I do not live in Minnesota

Do you support or oppose a law in your city or county that requires workplaces and public places, including restaurants and bars, to be smoke-free? (Please indicate your level of support or opposition.)

1 Strongly support 2 Somewhat support 3 Support only if smoking is still allowed in bars
 4 Somewhat oppose 5 Strongly oppose 6 Don't know

If your city/county passed a law requiring bars to be smoke-free, would you go out more or less often?

1 My community has a smoke-free bar law
(if applies please mark this & answer the following response) 1 More Often 2 About the same 3 Less often

What best describes your view of smoking and use of tobacco?

1 Sexy /Appealing 2 Stylish / Cool 3 A sign of independence or maturity
 4 A sign of stress and/or emotional or psychological issues 5 Not appealing 6 A reason to not be with or get to know someone better

How concerned are you about the health impact of secondhand smoke?

1 Very concerned 2 Somewhat concerned 3 Not very concerned 4 Not at all concerned

When is the last time you smoked a cigarette?

1 Current smoker (have smoked at least 100 cigarettes in lifetime & now smokes every day or some days).
 2 Past smoker (smoked at least 100 cigarettes in lifetime, but now does not smoke).
 3 Never smoked (have not smoked 100 cigarettes in lifetime, and now does not smoke).

If you are a current or past smoker, please answer just 5 more questions:

What age did you start smoking? _____

Do you smoke every day? 1 Yes 2 No

When you smoke/d, how many cigarettes do/did you smoke (1 pack = 20 cigarettes) a day?

1 1-2 cigs 2 Less than half a pack 3 Half a pack 3 One pack 4 More than one pack

What do/did you feel are/were barriers to your quitting smoking? (Please check all that apply/applied.)

1 Cravings/feelings of withdrawal 2 Loss of way to handle stress 3 Risk of gaining weight 4 Cost of medications/products to help quit
 5 Cost of classes/other programs 6 Interference with social/work relationships 7 Another reason _____ (please specify) 8 No desire to quit

If you are/were a smoker and cost were not an issue, what types of aid would/did you prefer?

1 Nicotine replacement 2 Zyban or another non-nicotine prescription medicine 3 Books, pamphlets, tapes 4 Website/online information and counseling
 5 Quit smoking class or group 6 Quit smoking telephone helpline 7 Something else _____ (please specify) 8 No aid

Data Collection 2005 T Twin Cities Pride Survey

The Rainbow Health Initiative (RHI), under the sponsorship of Minnesota Partnership for Action Against Tobacco (MPAAT) was responsible for the collection of all survey data. A convenience sample of persons attending the 2005 Pride Events were asked to volunteer as respondents for a self-report survey on tobacco and other personal health concerns. RHI volunteers were told to sample anyone who walked by, irrespective of assumed tobacco use, gender, or sexuality.

Location Information: Twin Cities Pride and Soul Essence events are held in Minneapolis, Minnesota.

Data Intent

Rainbow Health Initiative currently dedicates resources to executing and planning activities that address three primary project objectives: developing a community-sensitive strategic plan for changing social norms around tobacco and exposure to secondhand smoke in the GLBT community, highlighting and catalyzing actions that deal constructively with access to healthcare for GLBT individuals, and education and prevention efforts surrounding health issues of concern to or disproportionately affecting the GLBT community (www.rainbowhealth.org).

Administration of the survey was intended to assess tobacco use, opinions, and targeted needs.

Ethical Consideration

The Rainbow Health Initiative Board of Directors approved data use and analysis. The analysis was performed by a consultant. All supplied data for the analysis was anonymous to the consultant.

Data Description Sample Size

There were a total of 680 surveys administered.

Coding

Coding methods were developed a priori to the survey administration. Such discussions allowed for cleaner data to interpret and less data entry error. As data entry questions usually arise after the survey's administration, it is suggested that a log of questions and their subsequent decisions be maintained for the analyst as well as the organization. For example, a question asks respondents to pick the best choice, yet instead people choose to pick many and write-in their own answers. For data quality and integrity, a log should be maintained.

Missingness

Missing variables were consistently coded as "999".

Significance

Statistical significance is set at the $\alpha = 0.05$ level.

Data Transfer

Data was originally coded by RHI in Microsoft Excel. For the purpose of this analysis, data was converted into STATA 8 by the program StatTransfer.

APPENDIX E

Focus Group Participant Demographics

13 groups: 2 Gay, 2 Lesbian, 2 Bisexual, 2 People of Color, 2 Transgender, 1 Deaf,
1 in Rochester, MN and 1 in Duluth, MN
Conducted between March 7, 2005 – May 17, 2005

51	female
36	male
5	FTM
8	MTF
1	gender queer
23	African –American
1	African-British
3	Asian-American
67	Caucasian
2	Latino
2	Multi-racial
2	Native-American
1	Other
31	nonsmokers
26	past smokers
44	smokers
36	gay
32	lesbian
25	bi-sexual
1	poly-sexual
7	heterosexual
Age 18 – 25	= 18
Age 26 – 35	= 24
Age 36 – 45	= 33
Age 46 – 55	= 19
Age 56 – 65	= 6
Age 65 +	= 1

Total # of participants: 10



41 North 12th Street, Minneapolis, MN 55403
612/252-1222
www.rainbowhealth.org