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## **Tobacco Use in the Lesbian, Gay, Bisexual, Transsexual, Transgendered, Two-Spirited, Intersex, and Queer (LGBTTTIQ) Communities**

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### **1. Tobacco as an LGBTTTIQ Health Disparity**

Tobacco use has declined in Canada's general population over the past few decades. According to the latest results from the Canadian Tobacco, Alcohol and Drugs Survey (CTADS) for data collected in 2013, 14.6% of the population aged 15 years and older were current smokers, down from 25% in 1999.<sup>1</sup> In Alberta, 16% of the population aged 15 and up uses tobacco, with 16.0% of men and 13.3% of women reporting current smoking.<sup>2</sup> Despite the reduction in overall smoking rates, a significant amount of deaths are still attributable to smoking.<sup>3</sup>

There is evidence that lesbian, gay and bisexual people are more likely to smoke than the general population.<sup>4,5</sup> The 2009–2010 National Adult Tobacco Survey in the United States found that 38.5% of lesbian, gay, bisexual and transgender (LGBT) adults use tobacco, compared to 25.3% of heterosexual adults.<sup>6</sup>

However, far more research on the subject exists in the United States than in Canada. The smoking prevalence of lesbian, gay, bisexual, transsexual,

transgender, two-spirit, intersex and queer (LGBTTTIQ) communities in Canada is not documented by the Canadian Tobacco Use Monitoring Survey (CTUMS) or CTADS.

Research that has been documented includes a 2005 British Columbia survey, which showed that 36% of LGBTTTIQ adults smoke compared to 16% of the general population and a study from 2006 showed that 54.5% of young Men who have Sex with Men (MSM) smoke compared to 25.9% of the male B.C. population.<sup>7</sup>

An Ontario study called the Rainbow Tobacco Intervention Project (RTIP) examined patterns of tobacco use within Toronto's LGBTTTIQ communities in 2006.<sup>8</sup> The median age of the sample was 34, with an age range of 13–91 years, and the majority of the participants identified as lesbian (30.3%) or gay (41.9%).

Overall, 36% of LGBTTTIQ participants reported current smoking. Of those, 25% were past smokers and 39% had never smoked. This compares with Toronto Public Health reports of smoking prevalence in Toronto adults, with 17% reporting current smoking, 22% reporting past smoking and 61% reporting never smoking.<sup>11</sup> The smoking prevalence rates ranged from 24% to 45% across the different sexual orientation and gender identity groups, with lesbians reporting a rate of 33%, trans women reporting a rate of 34%, queer women reporting a rate of 39% and bisexual women reporting the highest rate of 45% (see Figure 1).

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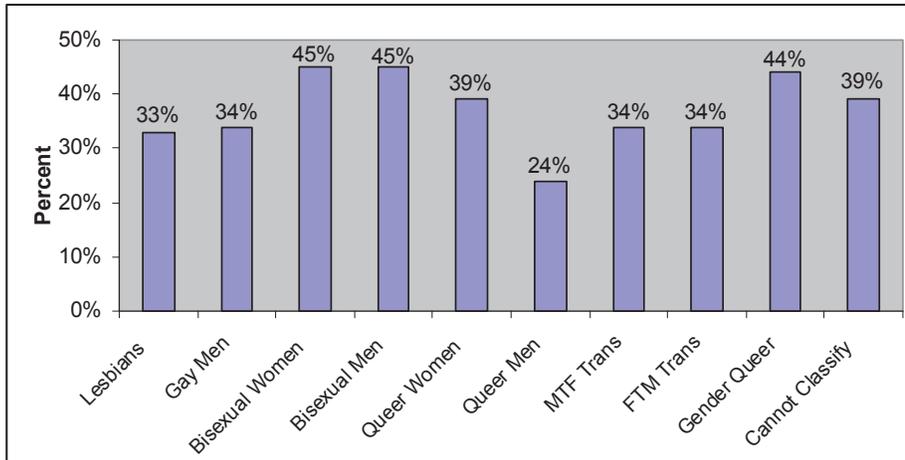


Figure 1: Smoking Prevalence by LGBTTTIQ Identity Group

Despite limited Canadian data, the two- to three-fold higher rates of smoking in the LGBTTTIQ community is consistent with the much higher rates of tobacco use found in U.S. studies. There are many identifiable factors that may contribute to higher smoking rates in LGBTTTIQ communities, including facing more stress due to homophobia, biphobia and transphobia, as well as heterosexism. Smoking tends to be more prevalent among groups that experience high stress levels.

Places where smoking is prevalent, such as bars, have historically been an important social focus for LGBTTTIQ communities, possibly because of a history of discrimination or exclusion in other social settings. Behaviour associated with smoking, such as drug and alcohol use, has also been shown to be higher in LGBTTTIQ communities. Evidence suggests that the tobacco industry has targeted the LGBTTTIQ market through direct advertising, sponsorship and promotional events.<sup>9</sup>

Research also shows that lesbian, gay and bisexual youth are more likely to be depressed or lonely, more likely to attempt suicide and more likely to be physically and verbally victimized than heterosexual youth. These are all factors that may contribute to increased substance use. Smoking prevalence may also be higher in LGBTTTIQ communities because of the unique role smoking may play during identity formation in queer adolescents (e.g., assumption of masculinity for

males, assertion of power and independence for females), the stresses of coming out, the potential lack of support from parents, family members, and peers, feelings of isolation and loneliness, and anti-gay harassment.<sup>10</sup>

## 2. Barriers to Health Care and Cessation Support

An examination of any health issue that affects LGBTTTIQ people must include a discussion of the broader health care context that affects LGBTTTIQ health.

Unfortunately, the barriers to accessing health care faced by LGBTTTIQ people can be great, and these barriers have a direct impact on access to health care and health-seeking behaviours for the LGBTTTIQ communities, which means that sexual orientation and gender identity serve as social determinants of health, even though they are not explicitly listed as such in the World Health Organization's definition of health.

The barriers to care can include:

- Fear of real or perceived discrimination—LGBTTTIQ people are more likely to delay or decline seeking health-care altogether to avoid having a negative experience.
- Homophobia, biphobia and transphobia—Health-care providers may be biased against LGBTTTIQ people and treat them unfairly. It is important that people in the health-care system be treated with dignity and respect, regardless of their gender identity.

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- Heterosexual and gender identity assumptions—LGBTTTIQ patients can experience heterosexism in that health-care providers may assume that they are heterosexual. Patients are rarely asked about sexual orientation during assessment or on medical history forms. This assumption of heterosexuality perpetuates LGBTTTIQ invisibility and marginalizes LGBTTTIQ health needs. Health-care providers can be less likely to take the sexual and reproductive health of LGBTTTIQ women seriously if they do not have male partners. This prejudice can create barriers to basic things like pap smears or other sexual health check-ups.
- Lack of awareness of LGBTTTIQ health issues—Most educational health-care programs do not include discussion of LGBTTTIQ health issues and thus most health providers are not sensitive to or knowledgeable about the particular health risks and needs.

Due to these and other barriers, LGBTTTIQ people do not have the same access to health care that many Canadians take for granted. This reduces their interaction with the health-care system and thus there is less intervention from health-care providers with regards to negative health behaviours, such as tobacco use.

### 3. Tobacco Use in LGBTTTIQ Female Youth

In the 2006 Toronto Rainbow Tobacco Survey (TRTS), there were no gender differences in

smoking prevalence rates within the different sexual orientation and gender identity groups, except that the rates were higher for queer women (39%) compared to queer men (24%). However, recent studies in the U.S. have indicated that with younger LGBTTTIQ smokers, females smoke more than males.<sup>12</sup>

The TRTS found a similar gender difference for participants under the age of 25 (see Figure 2). In this age group, lesbians (53%) smoked more compared to gay men (43%), bisexual women (50%) smoked more compared to bisexual men (42%), queer women (55%) smoked more compared to queer men (30%) and FTM transpeople smoked (63%) more compared to MTF transpeople (40%). While young FTM transpeople are not women, at that age they would have had a significant amount of life experience living in female bodies, which may explain the direction of the gender difference for this group.

The gender difference seen in the overall LGBTTTIQ sample between queer women and queer men seems to be a product of the small sample size for queer men and this under-25 age/gender effect. The demographics show that 78% of the smokers in the queer men sample are under the age of 39, compared to 95% of the smokers in the queer women sample.

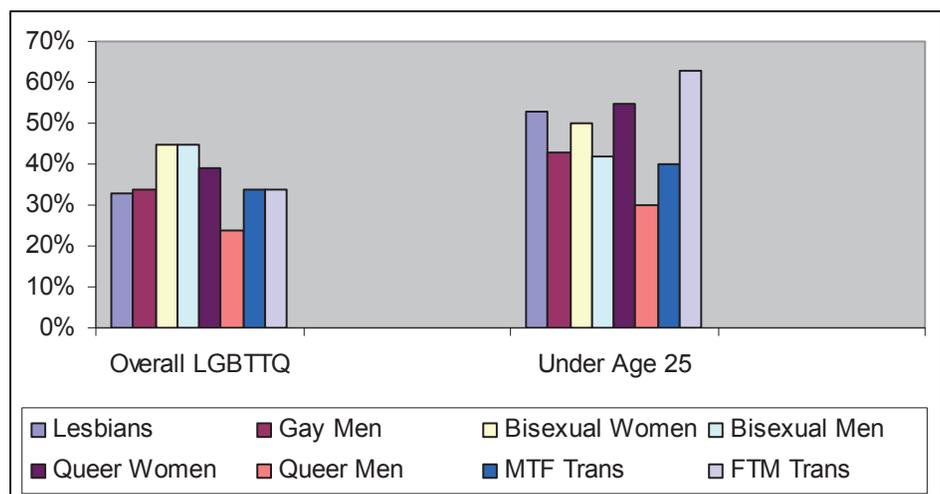


Figure 2: Comparison of Smoking Prevalence by Gender by Age Group

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## *Recommendations*

1. Tobacco control efforts need to be targeted at the LGBTTTIQ population, including social marketing campaigns to raise awareness and educate LGBTTTIQ people about this significant health issue in their communities.
2. Treatment resources need to be expanded beyond the current programs to address the most at-risk communities, including youth, bisexual people and gender-queer people.
3. The providers of tobacco-cessation programs and services need to be educated about LGBTTTIQ smoking issues and their particular cessation concerns.
4. CTADS and other Canadian smoking surveys need to include sexual orientation and gender identity demographic items on their questionnaires to produce more information on LGBTTTIQ smoking prevalence across Canada.
5. Further research needs to be conducted on the determinants of tobacco use among LGBTTTIQ communities, as a better understanding is required to design effective smoking interventions.

For more information and support, visit **albertaquits.ca** or call toll-free **1-866-710-QUIT (7848)**.

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