ACON SUBMISSION TO

The National Tobacco Strategy 2022-2030

March 2022

About ACON

ACON is Australia's largest health organisation specialising in community health, inclusion, and responses for people of diverse sexualities and genders. We are a fiercely proud community organisation, unique in our connection to our community and in our role as an authentic and respected voice.

Established in 1985, our early years were defined by community coming together to respond to the HIV/AIDS epidemic in NSW. As we have grown, ACON's work has expanded to create opportunities for people in our communities to live their healthiest lives. We have offices in Sydney and regional centres across NSW and provide services and programs locally, state-wide and nationally.

Members of Australia's sexuality and gender diverse communities experience health disparities when compared to health and wellbeing outcomes experienced by the total population. They may also face significant barriers to accessing traditional healthcare pathways. These health disparities are often the result of stigma and discrimination, and as a result, we are committed to protecting everyone from discrimination, equally.

We recognise that members of our communities share their sexual and gender identity with other identities and experiences and work to ensure that these are reflected in our work. These can include people who are Aboriginal and Torres Strait Islander; people from culturally, linguistically and ethnically diverse, and migrant and refugee backgrounds; people who use drugs; mature aged people; young adults; and people with disability.

ACON acknowledges that people with intersex variations experience health inequities and barriers to health services and should be considered in the development of the National Tobacco Strategy. People with intersex variations are sometimes included in evidence referenced in our submission. However, ACON does not represent the intersex community and recommend that consultation with Intersex Human Rights Australia to better understand the issues and needs of the intersex community.

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ACON acknowledges the Traditional Owners of the lands on which we work. We pay respect to Aboriginal Elders past, present and emerging.

Executive Summary

Tobacco smoking remains a leading cause of preventable disease and death in Australia. Significant progress has been made to prevent the uptake of smoking, reduce exposure to second-hand smoke, encourage smokers to quit and to denormalise smoking. These achievements have been the result of innovative and coordinated tobacco control policies across Australia. However, smoking prevalence rates are not equal across all parts of the Australian population. Smoking rates are significantly higher among LGBTQ communities and people living with HIV (PLHIV) and these populations face unique challenges to quitting.

The National Tobacco Strategy 2022-2030 is an important policy document to coordinate a comprehensive approach to tobacco control across the multiple levels, types and jurisdictions of the governments, organisations and service provides responsible for implementing these actions. The Strategy is well aligned with other policies and the goal, aims and targets, and objectives of the are appropriate. The 11 priority areas outlined in the Strategy are well supported by evidence, however there are opportunities to strengthen some actions, particularly in relation to equity approaches and working in partnerships with community-led organisations representing populations with high smoking rates. To support this an additional guiding principle of Equity should be added. The governance structure should also be clarified and include representation of priority populations, including LGBTQ people and PLHIV. Finally, the Strategy must strengthen its commitment to measuring and monitoring evidence of higher smoking rates among priority population groups. ACON supports the development of the National Tobacco Strategy 2022-2030 and looks forward to contributing to its implementation.

Introduction

ACON welcomes the opportunity to inform The National Tobacco Strategy 2022 – 2030. The National Tobacco Strategy is an important health policy that sets and coordinates an agenda across governments, non-government organisations and jurisdictions to reduce the devastating impact of tobacco smoking on Australians. Smoking prevalence is significantly higher among LGBTQ communities and people living with HIV (PLHIV) and these populations face unique challenges to quitting. We make this submission particularly as it relates to the LGBTQ communities and PLHIV we serve.

Broadly ACON supports the alignment of the National Tobacco Strategy with other health policies, most notably the World Health Organization's Framework Convention on Tobacco Control, the Australian National Preventive Health Strategy, and the Australian National Drug Strategy. This support is contingent on alignment not weaking the National Tobacco Strategy's to be world leading, particularly regarding inclusion and equity. The goal, aims and targets, and objectives of the National Tobacco Strategy are appropriate. Overall, ACON welcomes the 11 priority areas outlined in the consultation draft with some specific suggestions to strengthen actions detailed in our recommendations below.

While the four guiding principles are appropriate, an additional principle of Equity is essential, particularly due to the high smoking prevalence rates among priority population groups including LGBTQ communities and PLHIV and the disproportionate burden of smoking related disease and death experienced by those priority populations.

It is also important there is greater clarity on the governance for implementing and monitoring progress of the Strategy. Representation of priority populations must be included and clear in this governance structure.

Finally, while evidence of higher smoking rates among LGBTQ communities and PLHIV is improving it is extremely disappointing that another National Tobacco Strategy is developed without appropriate smoking prevalence data with sub-group analysis to measure progress and set specific targets. The National Tobacco Strategy 2022-2030 must make a commitment to addressing these evidence gaps.

Background

SMOKING PREVALENCE

International research suggests that LGBTQ communities and PLHIV have higher rates of smoking and are therefore at higher risk of cancer and other smoking-related diseases.

LGBTQ POPULATIONS

Of the general Australian population, 11 percent are daily smokers. Comparatively 16 percent of gay, lesbian, bisexual (GLB) people in Australia are daily smokers.[1] Only 57 percent had never smoked, compared with 63 percent among heterosexual people. Within our communities, a higher proportion of cisgender men were daily smokers (14.2 percent), compared with cisgender women (7.7 percent), non-

[1] AIHW, 2020. National Drug Strategy Household Survey 2019. [online] Canberra: Australian Institute of Health and Welfare. Available at: https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019.

binary participants (7.9 percent), trans men (9.3 percent) and trans women (9.5 percent). [2] The smoking rate is higher for young LBQ women aged 16 – 24 in Sydney (24 percent).[3] International research has found smoking rates much higher among transgender communities with one national US study finding 35.5 percent of trans people were daily smokers[4] and in another study from San Francisco 62.3 percent of trans women were daily smokers.[5]

Sexuality and gender data is not collected and reported consistently and appropriately across population health surveys, service records and health research. Lack of data limits the ability to accurately measure the extent and specifics of the situation and to monitor progress over time. The Australian Bureau of Statistics (ABS) has developed the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020 ("2020 Standard"). It standardises the collection and dissemination of data relating to sex, gender, variations of sex characteristics and sexual orientation.[6]

PLHIV

Rates of tobacco smoking among PLHIV are nearly double that of the Australian population. 28.1% of participants in the HIV Futures 9 study reported they were smokers and 18.4% reporting they were daily smokers (compared to 14.5% of Australians overall).[7] Differences in smoking rates between PLHIV and HIV-negative people do occur around the globe[8], including in high-income countries. [9]

High tobacco smoking rates among PLHIV contribute to a higher incidence of non-AIDS-related morbidity and mortality.[10] [11] In the United States, is has been estimated that life expectancy among HIV

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[2] Hill, A., Bourne, A., McNair, R., Carman, M., & Lyons, A. (2021). *Private Lives 3: The health and wellbeing of LGBTIQ people in Australia*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University. Retrieved from https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf

[3] Mooney-Somers, J., Deacon, R., Anderst, A., Rybak, L., Akbany, A., Philios, L., Keefe, S., Price, K. and Parkhill, N., 2020. Women in contact with the Sydney LGBTIQ communities: Report of the SWASH Lesbian, Bisexual and Queer Women's Health Survey 2016, 2018, 2020.. [online] Sydney: Sydney Health Ethics, University of Sydney. Available at: https://www.acon.org.au/wp-content/uploads/2020/10/SWASH-Report-2020_Final.pdf.

[4] Buchting, F., Emory, K., Scout, Kim, Y., Fagan, P., Vera, L. and Emery, S., 2017. Transgender Use of Cigarettes, Cigars, and E-Cigarettes in a National Study. American Journal of Preventive Medicine, 53(1), pp.e1-e7.

[5] Gamarel, K., Mereish, E., Manning, D., Iwamoto, M., Operario, D. and Nemoto, T., 2015. Minority Stress, Smoking Patterns, and Cessation Attempts: Findings From a Community-Sample of Transgender Women in the San Francisco Bay Area. *Nicotine & Tobacco Research*, 18(3), pp.306-313.

[6] Australian Bureau of Statistics. Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020. Canberra: Australian Bureau of Statistics; 2020. Available from: https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/latest-release

[7] Power, J., Amir, S., Brown, G., Rule, J., Johnson, J., Lyons, A., Bourne, A. and Carman, M., 2019. HIV Futures 9: Quality of Life Among People Living with HIV in Australia. [online] Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University. Available at: https://www.latrobe.edu.au/__data/assets/pdf_file/0007/1058614/HIV-Futures-9.pdf.

[8]Johnston, P. I., Wright, S. W., Orr, M., Pearce, F. A., Stevens, J. W., Hubbard, R. B., & Collini, P. J. (2021). Worldwide relative smoking prevalence among people living with and without HIV. *Aids*, 35(6), 957-970.

[9] Mdodo, R., Frazier, E. L., Dube, S. R., Mattson, C. L., Sutton, M. Y., Brooks, J. T., & Skarbinski, J. (2015). Cigarette smoking prevalence among adults with HIV compared with the general adult population in the United States: cross-sectional surveys. *Annals of internal medicine*, *162*(5), 335-344.

[10] Giles, M. L., Gartner, C., & Boyd, M. A. (2018). Smoking and HIV: what are the risks and what harm reduction strategies do we have at our disposal?. *AIDS Research and Therapy*, *15*(1), 1-5.

[11] Koroukian, S. M., Zhou, G., Navale, S. M., et al. Excess cancer prevalence in men with HIV: A nationwide analysis of Medicaid data. *Cancer*, 2022; DOI: 10.1002/cncr.34166

positive smokers is reduced by at least 16 years compared with HIV-positive non-smokers, and that 94% of lung cancer diagnoses among PLHIV could be prevented by eliminating cigarette smoking.[12]

SOCIETAL AND SYSTEMIC CONTEXT

LGBTQ communities experience disproportionately worse physical and psychological health outcomes compared to the general population in Australia[13] [14] [15] due to a number of systemic and societal factors. These disparities are, in many cases, a result of stigmatisation, discrimination and a lack of inclusive care for people of diverse sexualities and genders.[16] These factors impact our communities across the cancer continuum, resulting in greater cancer risk like higher smoking rates, as well as inequitable access to support services and care.

Higher rates of smoking are due to various factors including smoking as a coping mechanism for stress and anxiety (including minority stress), LGBTQ communities being targeted and marketed by tobacco industries, the fact that smoking is engrained in the culture and social lives of many LGBTQ people, as well as the extremely high proportional representation of smoking in LGBTQ media such as films and television.[17] [18] [19] [20]

While there is not specific evidence about PLHIV and LGBTQ people's utilisation of smoking cessation services, there is evidence about barriers to other services which may impact utilisation of smoking cessation services. Primary care plays an important role in the health care of LGBTQ people and in smoking cessation support in Australia. Despite LGBTQ people being more likely to visit a general practitioner than their heterosexual counterparts, LGBTQ people are often less satisfied with their

[12] National Cancer Institute. (2022). Tobacco and HIV. Retrieved from https://cancercontrol.cancer.gov/brp/tcrb/tobacco-hiv

[13] Australian Institute of Health and Welfare. (2022). Lesbian, gay, bisexual, transgender and intersex people. In *Australia's Health 2018*. Canberra: Australian Institute of Health and Welfare. Retrieved from https://www.aihw.gov.au/getmedia/61521da0-9892-44a5-85af-857b3eef25c1/aihw-aus-221-chapter-5-5.pdf.aspx

[14] Ussher, J., Perz, J., Kellett, A., Chambers, S., Latini, D., & Davis, I. et al. (2016). Health-Related Quality of Life, Psychological Distress, and Sexual Changes Following Prostate Cancer: A Comparison of Gay and Bisexual Men With Heterosexual Men. *The Journal Of Sexual Medicine*, 13(3), 425-434. doi: 10.1016/j.jsxm.2015.12.026

[15] Ussher, J. M., Allison, K., Perz, J., Power, R., & The Out with Cancer Study Team. (2022). LGBTQI Cancer Patients' Quality of Life and Distress: A Comparison by Gender, Sexuality, Age and Cancer Type *Frontiers in Oncology*, forthcoming.

[16] Ussher, J. M., Power, R., Perz, J., Hawkey, A. J., Allison, K., & The Out with Cancer Study Team. (2022). LGBTQI inclusive cancer care: A discourse analytic study of health care professional, patient and carer perspectives. Frontiers in Oncology, in press.

[17] Matthews, A., Cesario, J., Ruiz, R., Ross, N., & King, A. (2017). A Qualitative Study of the Barriers to and Facilitators of Smoking Cessation Among Lesbian, Gay, Bisexual, and Transgender Smokers Who Are Interested in Quitting. *LGBT Health*, 4(1), 24-33. doi: 10.1089/lgbt.2016.0059

[18] Truth Initiative. (2021). *Tobacco Use in LGBT Communities*. Retrieved 6 January 2022, from https://truthinitiative.org/sites/default/files/media/files/2021/06/Truth_LGBT%20FactSheet2021_FINAL_062221.pdf

[19] Spivey, J., Lee, J., & Smallwood, S. (2018). Tobacco Policies and Alcohol Sponsorship at Lesbian, Gay, Bisexual, and Transgender Pride Festivals: Time for Intervention. *American Journal Of Public Health*, 108(2), 187-188. doi: 10.2105/ajph.2017.304205

[20] Lee, J., Agnew-Brune, C., Clapp, J., & Blosnich, J. (2013). Out smoking on the big screen: tobacco use in LGBT movies, 2000–2011: Table 1. *Tobacco Control*, 23(e2), e156-e158. doi: 10.1136/tobaccocontrol-2013-051288

care.[21] [22] [23] Dissatisfaction may be due to assumptions of heterosexuality, inappropriate language, or assumptions that the primary health concern is sexual health.

The Out with Cancer study at Western Sydney University, funded by the Australian Research Council (ARC), has recently investigated discrimination in cancer care. Their research has found that a third of 430 LGBTQI+ study participants reported experiencing discrimination as part of their cancer care because of being LGBTQI, with transgender and people with intersex variations experiencing highest levels at 52.4% and 50.0% respectively.[24] International studies also report on issues of disclosure of sexual orientation and gender identity, perceived and experienced homophobia and transphobia, suboptimal healthcare professional behaviour, heteronormative language, systems, and care, as well as discomfort in predominantly heterosexual support groups and lack of LGBTQ support groups.[25]

There is a need for improved education and training on LGBTQ-inclusive practices for healthcare providers to increase knowledge and confidence. This in turn will reduce barriers to attending health services, enable healthcare professionals to provide person-centred care, give providers the courage to challenge discriminatory behaviour, and enable them to create safe and inclusive spaces. These factors are all important for improving outcomes and equity of care for gender and sexuality diverse people.[26]

Given that many gender and sexuality diverse people have had negative experiences in health settings, there is growing recognition that LGBTQ communities may be reluctant to engage with mainstream health promotion efforts or health care environments. From conversations with our communities, we know that a lack of targeted, inclusive, and representational messaging contributes to lower engagement among our communities. There is evidence that targeted interventions are more acceptable to these communities and may be more feasible in some contexts.[27] Interventions delivered by competent practitioners in safe settings include creating spaces for other LGBTQ people to connect, shifting peer norms around alcohol or tobacco use, experiencing inclusive healthcare, and connecting to LGBTQ-friendly health service providers. These experiences confirm and communicate to LGBTQ people that their health needs are important and that their gender and/or sexuality is recognised as relevant to and implicated within their health and wellbeing. Social marketing campaigns that are representative of LGBTQ people are also a powerful way to reach the community, shift attitudes and encourage health-seeking behaviours.

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[24] Ussher, J. M., Allison, K., Perz, J., Power, R., & The Out with Cancer Study Team. (2022). LGBTQI Cancer Patients' Quality of Life and Distress: A Comparison by Gender, Sexuality, Age and Cancer Type *Frontiers in Oncology*, forthcoming.

[25] Lisy, K., Peters, M., Schofield, P., & Jefford, M. (2018). Experiences and unmet needs of lesbian, gay, and bisexual people with cancer care: A systematic review and meta-synthesis. *Psycho-Oncology*, 27(6), 1480-1489. doi: 10.1002/pon.4674

[26] Wakefield, D. (2021). Cancer care disparities in the LGBT community. Current Opinion In Supportive & Palliative Care, 15(3), 174-179. doi: 10.1097/spc.0000000000000557

[27] Drysdale, K., Cama, E., Botfield, J., Bear, B., Cerio, R., & Newman, C. (2020). Targeting cancer prevention and screening interventions to LGBTQ communities: A scoping review. *Health & Social Care In The Community*, 29(5), 1233-1248. doi: 10.1111/hsc.13257

MOTIVATIONS AND BARRIERS TO QUITTING

In 2020, formative research was conducted to inform ACON's cancer screening and prevention campaigns. The data provides important insights on LGBTQ people's knowledge, beliefs, attitudes and behaviours around smoking and quitting. Key findings included:

- For many LGBTQ people, smoking (1) is perceived as delivering a sense of control in coping with stress and anxiety and (2) promotes a sense of social inclusion and connection.
- Current smokers said the most common smoking occasions were "when drinking alcohol", "when with friends who smoke", "when at a social event or party", as well as ritualistic occasions like "when taking a work or study break", and the "last thing before bed".
- 78 percent of respondents wanted to quit smoking in the future, with 51 percent wanting to quit "very much". However, only 56% were confident that they would succeed at quitting, with only 22 percent being "extremely confident" that they would succeed. These are comparable to the general NSW population of which 60% of smokers were considering quitting in the next 6 months and 45% seriously considering quitting in the next 6 months and the mean confidence to quit on a 0-10 scale was 7.0.[28]
- 64 percent of current smokers said they would not consider using the NSW Quitline phone support service, due to a reluctancy to talk to strangers on the phone, the belief that Quitline is only for those who need 'serious help' and a lack of understanding of how Quitline will help. In general NSW population, current and ex-smokers are more likely to use face to face support from a GP than phone support. Only 3% of current and ex-smokers are most likely to use phone support like Quitline as their cessation support.[29]
- Cutting down on the number of cigarettes (89 percent) and going 'cold turkey' (74 percent) were the techniques current smokers would be most likely to consider in a quit attempt, however ex-smokers reported that support from family and friends (5.3/7) and prescribed medication (5.3/7) were the most effective methods during their quit attempts. These findings differ from the general NSW smokers and ex-smokers who are more likely to seek face to face support from a GP and Nicotine Replacement Therapy "NRT".[30]

Additionally, most smokers (66%) have made at least one attempt to quit, with smokers over 40 years old more likely to have made an attempt. The median number of quit attempts among NSW smokers in 2019 was 3.0 attempts with 59% of current smokers making a quit attempt in the past year.[31] There is a range of factors associated with smoking and quitting among PLHIV in Australia, some of which may vary or overlap with those for LGBTQ people. One study identified lower income and education, and greater

[28] Cancer Institute NSW. NSW Smoking and Health Survey 2019 [Internet]. Sydney: Cancer Institute NSW; 2019. Available from: https://www.cancer.nsw.gov.au/getattachment/c18a65d9-9eac-4d22-89ef-c5a1240ffa45/nsw-smoking-and-health-survey-2019.pdf

[29] Cancer Institute NSW. NSW Smoking and Health Survey 2019 [Internet]. Sydney: Cancer Institute NSW; 2019. Available from: https://www.cancer.nsw.gov.au/getattachment/c18a65d9-9eac-4d22-89ef-c5a1240ffa45/nsw-smoking-and-health-survey-2019.pdf

[30] Cancer Institute NSW. NSW Smoking and Health Survey 2019 [Internet]. Sydney: Cancer Institute NSW; 2019. Available from: https://www.cancer.nsw.gov.au/getattachment/c18a65d9-9eac-4d22-89ef-c5a1240ffa45/nsw-smoking-and-health-survey-2019.pdf

[31] Cancer Institute NSW. NSW Smoking and Health Survey 2019 [Internet]. Sydney: Cancer Institute NSW; 2019. Available from: https://www.cancer.nsw.gov.au/getattachment/c18a65d9-9eac-4d22-89ef-c5a1240ffa45/nsw-smoking-and-health-survey-2019.pdf

alcohol and cannabis use, were associated with ever having smoked cigarettes regularly in PLHIV in Australia. [32] It suggests the need to address dual tobacco and cannabis use, as well as the potential for HIV diagnosis and antiretroviral therapy (ART) initiation to stimulate quit attempts. [33]

The concept of minority stress extends to and is amplified for PLHIV. PLHIV report high levels of depression and often experience poorer mental health than the general population: an intersection of the mental health burden of having a chronic illness; having a chronic illness that is still highly stigmatised; higher experiences of social isolation and stress and despite advancements in effective treatments, lower expectations concerning long-term mortality.

Research suggests that some PLHIV use smoking as a coping mechanism for dealing with their HIV diagnosis—a coping mechanism that is also perceived to help with other stresses such as economic stress or social isolation. As with other chronic illnesses, some PLHIV "believe that smoking helps relieve certain physical symptoms associated with HIV, such as bodily pain, respondents reported smoking as one way to help manage symptoms associated with peripheral neuropathy."[34]

There is evidence that indicates only limited success of the standard "abstinence-focused" cessation strategies among PLHIV[35]. Tobacco screening and cessation programs tailored for PLHIV and integrated into routine HIV care appear to be the most effective, such as the Infectious Diseases Society of America's primary care guidelines for PLHIV. It advises healthcare providers that "all patients who smoke should be strongly encouraged to stop smoking and offered smoking cessation assistance" and that "screening for smoking should be done at every healthcare encounter". [36] Frequent encouragement by HIV care providers regarding smoking cessation has been associated with increased likelihood of interest in cessation. [37] Some tailored smoking cessation programs have showed positive results. [38] Better understanding the characteristics of PLHIV who smoke and quit is key to tailor interventions. [39]

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[32] van Sighem, A. I., van de Wiel, M. A., Ghani, A. C., Jambroes, M., Reiss, P., Gyssens, I. C., ... & ATHENA Cohort Study Group. (2003). Mortality and progression to AIDS after starting highly active antiretroviral therapy. *Aids*, *17*(15), 2227-2236. Cited in Petoumenos, K., & Law, M. G. (2006). Risk factors and causes of death in the Australian HIV Observational Database. *Sexual health*, *3*(2), 103-112.

[33] Edwards, S. K., Dean, J., Power, J., Baker, P., & Gartner, C. (2020). Understanding the prevalence of smoking among people living with HIV (PLHIV) in Australia and factors associated with smoking and quitting. *AIDS and Behavior*, *24*(4), 1056-1063.

[34] Lifson, AR, Lando, HA (2012) Smoking and HIV: Prevalence, Health risks, and Cessation Strategies, *Curr HIV/AIDS Rep*, 9:226

[35] Bell SK, Mena G, Dean J, Boyd M, Gilks C, Gartner C. Vaporised nicotine and tobacco harm reduction for addressing smoking among people living with HIV: a cross-sectional survey of Australian HIV health practitioners' attitudes. *Drug Alcohol Depend*. 2017;177:67–70

[36] Thompson MA, Horberg MA, Agwu AL, et al. Primary care guidance for persons with human immunodeficiency virus: 2020 update by the HIV Medicine Association of the Infectious Diseases Society of America. *Clin Infect Dis* 2020; published online Nov 6. https://doi.org/10.1093/cid/ciaa1391.

[37] Pacek, L. R., Rass, O., & Johnson, M. W. (2017). Positive smoking cessation-related interactions with HIV care providers increase the likelihood of interest in cessation among HIV-positive cigarette smokers. *AIDS care*, *29*(10), 1309-1314.

[38] Kierstead, E. C., Harvey, E., Sanchez, D., Horn, K., Abroms, L. C., Spielberg, F., ... & Elf, J. L. (2021). A pilot randomized controlled trial of a tailored smoking cessation program for people living with HIV in the Washington, DC metropolitan area. *BMC research notes*, *14*(1), 1-7.

[39] Edwards, S. K., Dean, J., Power, J., Baker, P., & Gartner, C. (2020). Understanding the prevalence of smoking among people living with HIV (PLHIV) in Australia and factors associated with smoking and quitting. *AIDS and Behavior*, *24*(4), 1056-1063.

COMMUNITY-LED SOLUTIONS

ACON has over 35 years of experience targeting sexuality and gender diverse people with health messaging on a range of issues, including HIV prevention and support, sexual health, mental health, alcohol and drugs, domestic and family violence, ageing, and cancer. Because sexuality and gender diverse people may not read themselves into mainstream health promotion efforts and because we've experienced poor treatment in health services, there is decreased trust in the health sector. It is important that messaging, engagement, and where possible, access to services, is community based and builds on the experiences and knowledge of peers. Peer education and community based social marketing has been shown to be a very effective way of engaging LGBTQ communities – that is because our communities recognise that the messages are for them leading to increased reach through sharing among social networks and increased trust in the calls to action.

Since 2016, ACON has worked with Cancer Institute NSW to engage LGBTQ communities with cancer prevention and screening messaging. We've also delivered a community-led approach to improving workforce education, inclusion and programming for better service access and health outcomes for LGBTQ communities in NSW. This body of work has included a website with cancer information specifically for gender and sexuality diverse people, targeted social marketing campaigns for breast, bowel, and cervical cancer screening and smoking cessation, support for a community-led sexual health and cervical screening clinic for LGBTQ people known as Check OUT and an online learning module on LGBTQ inclusion for healthcare professionals working in cancer available to Cancer Institute NSW staff including Quitline NSW. Funding for this community partnership has also created opportunities for advocacy and education with other stakeholders in the cancer, LGBTQ health and health research sectors.

Peer-led and community-based programs aim to strengthen the capacity of communities to identify and respond to health issues[40] and have been a powerful health promotion and risk reduction tool for priority populations across a range of health issues.[41] Peer support as a health promotion tool is about sharing lived experiences to educate and support one another[42], whether it relates to age, ethnicity, sexuality, or gender.[43] Peer work embodies the notion of people and communities working together to address their own health behaviours, concerns and issues.[44]

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[40] McLeroy, K., Norton, B., Kegler, M., Burdine, J., & Sumaya, C. (2003). Community-Based Interventions. *American Journal Of Public Health*, 93(4), 529-533. doi: 10.2105/ajph.93.4.529

[41] Nickel, S., & von dem Knesebeck, O. (2019). Effectiveness of Community-Based Health Promotion Interventions in Urban Areas: A Systematic Review. *Journal Of Community Health*, 45(2), 419-434. doi: 10.1007/s10900-019-00733-7

[42] Svenson, G. (1998). European Guidelines for Youth AIDS Peer Education. Malmö, Sweden: Department of Community Medicine, Lund University. Retrieved from https://healtheducationresources.unesco.org/sites/default/files/resources/HIV%20AIDS%20102e.pdf

[43] Parkin, S., & McKeganey, N. (2000). The Rise and Rise of Peer Education Approaches. *Drugs: Education, Prevention And Policy*, 7(3), 293-310. doi: 10.1080/09687630050109961

[44] Molyneux, A., Delhomme, F., & Mackie, B. (2021). *It's Who We Are: Exploring the Role, Impact and Value of Peers*. Sydney: ACON. Retrieved from https://www.acon.org.au/wp-content/uploads/2021/10/Its-Who-We-Are-Exploring-the-Role-Impact-and-Value-of-Peers-1.pdf

LGBTQ communities in Australia have been remarkably successful in dealing with a range of health issues, most notably HIV, through the establishment of community-based and peer-led organisations and groups. The importance of these groups and initiatives for addressing the prevalence of HIV in LGBTQ communities have been recognised as evidenced by the emphasis of the importance of peers in guiding federal and state Government HIV Strategies.[45] [46]

Some examples include:

The Inner Circle was ACON's ground-breaking cervical cancer screening awareness campaign for all LGBTQ people with a cervix. Responding to our communities' questions about cervical screening, the relationship between HPV and cervical cancer, as well as the complicated medical rationale behind the change from the Pap Smear to the new Cervical Screening Test, The Inner Circle Phase 2 campaign produced a series of 10 new videos. Using diverse community talent, the video series LGBTIQ&A: Your Questions, Answered by The Inner Circle, were clear, concise, and accessible answers to FAQs. The videos garnered over 180,000 views across social media and drove over 3,000 visitors to The Inner Circle website. An overwhelming majority of people surveyed after the campaign thought the videos were informative, high quality and encouraged them to get tested.

Check OUT is a community led sexual health clinic run by ACON in partnership with Family Planning NSW. The clinic is staffed by expert sexual health nurses and trained LGBTIQ+ peer workers. Check OUT is open to anyone who identifies as LGBTIQ+, and sex workers are always welcome. In 2018-19, the clinic saw 285 clients for HIV and STI testing, and/or cervical screening. While the majority of our clients were queer-identified cis women, 25% were trans and gender diverse, 1.75 % had an intersex variation, 2.5% identified as Aboriginal and/or Torres Strait Islander, and 32% were born outside of Australia. Almost 20% identified as living with a disability. We hired and trained five new LGBTIQ+ peer workers, and over the 2018-19 period, 99% of clients were satisfied by our service and 99% would use the service again. The Check OUT clinic is temporarily closed due to COVID-19 but we look forward to reopening again soon.

Our United Front is an inclusive campaign to promote the importance of regular breast screening among LGBTQ people in NSW. The campaign was developed in partnership with BreastScreen NSW and supported by Cancer Institute NSW. Over the two year funding period, Our United Front produced 11 community engagement events across NSW including events that brought the BreastScreen NSW mobile screening van directly to LGBTQ communities. The campaign also collaborated with ACON's Aboriginal Project, Aboriginal Medical Services Redfern and BreastScreen NSW to promote regular breast screening among Aboriginal communities, which tend to have lower screening rates. The campaign launched with a video which had over 82,000 views and over 8,000 engagements across social media during the nine week digital campaign. The campaign concluded with an exhibition featuring the photography of ACON's Photographer in Residence Nicola Bailey who engaged with a diverse range of LGBTQ community groups and individuals across urban and regional NSW, exploring the importance of community in regard to

[45] Australian Government Department of Health. (2018). *Eighth National HIV Strategy 2018-2022*. Canberra: Australian Government Department of Health. Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/$File/HIV-Eight-Nat-Strategy-2018-22.pdf

[46] NSW Ministry of Health. (2020). *NSW HIV Strategy 2021 – 2025*. Sydney: NSW Ministry of Health. Retrieved from https://www.health.nsw.gov.au/endinghiv/Publications/nsw-hiv-strategy-2021-2025.pdf

LGBTQ health and wellbeing, particularly around breast cancer. The campaign was successful in reaching the target audience, reported a substantial level of recall, and received many positive comments about its inclusive and representative approach.

The Get Your Kit Together campaign promoted participation in the National Bowel Cancer Screening Program (NBCSP) for lesbian, gay, bisexual, transgender, and queer (LGBTQ) people aged 50-74 years old in NSW in June – August 2021. The campaign was implemented by ACON as part of a three-year funding agreement with the Cancer Institute NSW. A targeted media approach was used to promote the campaign through out-of-home media, print media and online channels. Overall the campaign was successful in communicating its key messages, had strong recall amongst the target audience and received positive feedback from community.

Can We is ACON's single brand platform for every cancer. Every cancer campaign, communication, conversation, and piece of information from previous and future campaigns sit 'under this umbrella'. The strategic purpose of the Can We brand is to raise awareness within community on the research findings that we're considered more at risk from cancer. We then build actions from this awareness, through empathetic engagement and the promotion of staying healthy. We achieve this through sharing real stories of success, actively promoting achievable ideas, and introducing community-centric health initiatives.

ACON's Pride Inclusion Programs comprise a suite of national support programs specifically designed to assist Australian employers, sporting organisations and service providers with all aspects of LGBTQ inclusion. These programs provide year-round support along with access to training, expert advice, resources, and tools that allow members to not only benchmark but accelerate their LGBTQ inclusion work. The three national programs collectively have a membership of over 430 organisations with staff situated in New South Wales, Western Australia, Victoria, and Queensland.

The Pride in Health + Wellbeing program specifically provides customised support to health and wellbeing organisations to assist them become more inclusive of LGBTQ people and improve the health and wellbeing of LGBTQ communities. The program currently has 47 members, including Camp Quality, NSW Agency for Clinical Innovation, Rural and Remote Medical Services (RARMS), Lifeline Australia and Australian Red Cross Lifeblood.

Conclusion

While Australian data on smoking and cessation among LGBTQ communities and PLHIV is limited, there is sufficient evidence that LGBTQ communities and PLHIV have higher smoking prevalence and experience barriers to quitting. The National Tobacco Strategy 2022-2030 should give more prominence to an equity approach to reducing the impact of tobacco smoking in Australia. That approach must include LGBTQ communities and PLHIV as priority populations. This approach should be underpinned by investments in community-led solutions and improvements to data collection and reporting to measure progress in reducing tobacco-related inequities.

The National Tobacco Strategy is underpinned by a guiding principle of working together in partnership. Community partnerships are instrumental in implementing appropriate and trusted campaigns, programs, and services.

Recommendations

ACON makes the following recommendations for the National Tobacco Strategy 2022 - 2030 to improve the health of all Australians and particularly for sexuality and gender diverse communities in Australia which we represent.

1) Strengthen Priority Areas and Actions
    a. Priority Area 2 – Mass Media Campaigns
        i. Action 2.1 – Ensure that population level campaigns are inclusive. Campaigns are often heteronormative and LGBTQ people are rarely represented in the campaigns.
        ii. Action 2.2 – Complementary/targeted campaigns should be community developed and community led to ensure trust and appropriateness. This amendment reinforces guiding principle of Working in Partnership.
        iii. Add community-led organisations in Responsibility throughout Priority Area 2 to distinguish between disease and health promotion NGOs and community organisations which represent populations with high smoking prevalence.
    b. Priority Area 3 – Reduce the Affordability of Tobacco Products
        i. ACON supports actions to continue and further reduce the affordability of tobacco products as long as the Australian Government invests sufficient tax revenues back into tobacco control and smoking cessation programs, particularly mass media, community-led initiatives, and access to evidence-based smoking cessation services and products.
    c. Priority Area 4 – Aboriginal and Torres Strait Islander
        i. Acknowledge the intersectionality of Aboriginal and Torres Strait Islander peoples and other priority population groups which can exacerbate the drivers for smoking prevalence and increase barriers to quitting and staying quit.
    d. Priority Area 5 – High Prevalence Groups
        i. ACON uses “LGBTQ” to describe the communities we serve as described above in “About ACON”. There is a growing segment of our communities who identify as queer. Thus, we recommend using the “LGBTQI” acronym, as opposed to “LGBTI”, for lesbian, gay, bisexual, transgender, queer and intersex communities throughout Priority Area 5 and the Strategy.
        ii. Include people living with HIV as an additional population group with high smoking prevalence. People living with HIV are diverse in their cultural, sexuality and gender identities and should be distinct from LGBTQI communities. Their lived experiences and intersectionality make reasons for smoking and barriers to quitting unique.
        iii. Add “community-led organisations” in Responsibility throughout Priority Area 5 to distinguish between disease/health promotion NGOs, social

service organisations, and community organisations which represent populations with high smoking prevalence.

iv. Strengthen this Priority Area by using language about working in partnership with community-led organisations. This reinforces the guiding principle of Working in Partnership and recognises a strength-based approach of community-led solutions.

v. Action 5.8 – Include making Quitline services culturally appropriate by implementing LGBTQI diversity and inclusion training and including community-led organisations in the Responsibilities.

vi. Action 5.9 – Ensure that data collection is in line with the ABS 2020 Standard on sex, gender, variations of sex characteristics and sexual orientation and report sub-group analysis on the next available National Drug Strategy Household Survey and continued monitoring and reporting in the future.

e. Priority Area 11 – Cessation Services

i. Add an action under this priority area in line with Action 5.8 to make Quitline services culturally appropriate by implementing LGBTQ diversity and inclusion training and including community-led organisations in Responsibility.

ii. Action 11.8 – Improve public awareness of services needs to demonstrate cultural appropriateness and safety for populations with high smoking prevalence such as LGBTQ people.

2) Guiding Principles

a. Add Equity as a Guiding Principle to support the evidence that whole of population measures like tax increases, mass media campaigns and smoke-free policies address inequities. This also strengthens the argument for targeted, community-led actions for groups with high smoking prevalence. The Equity principle should be separate to Working in Partnership.

b. The Working in Partnership principle should also recognise the need and opportunity to build on learnings from investments in Aboriginal and Torres Strait Islander community-led initiatives to address smoking and the extensive history LGBTQ organisations have in engaging our communities in health promotion programs and in health service provision. As well as recognising the role community organisations have in developing and delivering diversity and inclusion training and program. The National Tobacco Strategy should apply similar community-led approaches to develop solutions for other populations groups with high smoking prevalence.

3) Clarify the Governance structure(s) and specify how populations with high smoking prevalence will be represented within the governance structure.

4) Improve Monitoring and Evaluation by immediately implementing the ABS 2020 Standard for the collection of sex, gender, variations of sex characteristics and sexual orientation and analyse and report by sub-groups. There should also be a priority commitment to improving

smoking prevalence data with sub-group analysis to measure progress and set specific targets for identified populations with high smoking prevalence.