Introductory case presentation:

Imagine you are a nurse, medical student, resident or a physician working in the Emergency Department of a middle sized city. Your next patient is LH. You walk into the room and begin to obtain the following information.

LH is a 21 year old male to female (MTF) transsexual individual presenting to the Emergency Department with a complaint of increasing diffuse abdominal pain for 2 to 3 days. She reported that the pain did not radiate to other parts of her abdomen. She denied any vomiting, blood in the stool, dark tarry stools, or any changes in her bowel habits. She denied any fevers or weight loss, changes in diet or blunt force trauma to the abdomen.

Past Medical History: None

Past Surgical History: None

Medications: Premarin (a form of conjugated estrogen) as prescribed by her endocrinologist for hormonal transitioning

Allergies: No Known Drug Allergies

Social History: LH denied using tobacco. She reported social alcohol use. She denied illicit drugs or intravenous drug use. She reported working as a female impersonator at a local night club.

Family History: Negative for gastrointestinal disease

Physical Exam:

General appearance: LH was in no apparent distress. She was androgynous appearing.
Vital Signs: Afebrile, vital signs stable.
Abdominal exam: Except for slight diffuse abdominal tenderness to light palpation, the exam was normal. LH declined genital and rectal exams.
The patient’s exam was otherwise unremarkable.

At this time what additional information would you like to obtain from LH?
You obtain the additional information:

Sexual History:
LH is currently single, partners with males. She reports using barrier methods (condoms) inconsistently. She has not had sexual reassignment surgery. She denied any penile or rectal symptoms.

Medication History:
Although LH had been prescribed Premarin to take BID (twice daily), but she had been taking 5-10 pills daily for the last two weeks. The patient reported desiring the effect of the hormonal treatment to occur more rapidly and believed that greater doses of the medication would achieve that goal.

Additional Social History:
Moreover, LH just attended a “pump party” where some female to male transsexuals go to obtain non-medical physical augmentation services to enhance physical attributes. LH paid $500 for a local “beautician” (non-licensed, non-medically trained personnel) to provide injections of industrial grade quality silicone into her breasts for augmentation purposes.

**Case Summary and Questions to Consider:**

The common causes of abdominal pain including appendicitis, colitis, gallbladder disease, infectious hepatitis and pancreatitis were ruled out based on physical exam and history findings for LH. Her abdominal pain was attributed to the supratherapeutic overdose of the Premarin. Premarin is metabolized by the liver and excessive amounts can cause some degree of drug-induced hepatitis. She was discharged from the emergency department with instructions to decrease her intake of Premarin to the dose prescribed. A follow-up note was sent to her endocrinologist informing him of her evaluation.

How does one decide what pronoun is appropriate to use in addressing LH?

How does one ask about sexual behaviors, gender identity, and sexual orientation in a culturally competent manner?

With the information you have obtained from LH, what additional measures, if any, should be or could be taken to address her presenting problem of abdominal pain?

What is this patient’s anticipatory guidance or aftercare education? How would you counsel her to prevent this from occurring again?

What other health conditions is she at risk?

What health resources are available to her to reduce risks of illness and promote health?

LH was not a fictitious character, but an actual patient I provided care for in my second year of medical residency. The health concerns and problems illustrated in her case are not uncommon for members of the Lesbian, Gay, Bisexual and Transgender (LGBT) community. Hopefully, after reading this online textbook chapter you become more comfortable and familiar terms used in the LGBT community, health issues and health disparities of LGBT patients, and resources available for providing health care for LGBT patients.
I. **Historical Homophobia and LGBT Health 101**

In order to appreciate nuances in LGBT health, it is important to review some basic terminology and the historical effect of homophobia on health care for LGBT populations.

Not until December 1973, did the American Psychiatric Association’s Board of Trustees delete homosexuality from its official nomenclature of mental disorders, the Diagnostic and Statistical Manual (DSM). Prior to that time, homosexuality was considered a mental illness that required conversion therapy or other treatments. Up until 1980, the DSMIII included “ego dystonic homosexuality” as a category for people ‘whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation.” By 1987: DSMIIIR deleted “ego dystonic homosexuality,” recognizing that many if not most individuals who experience self-discovery of their sexual orientation may go through a period of dissonance and denial (1). These changes have occurred in only the last 30 years and there are those who still believe that homosexuality is a pathology that can or must be treated. This continues to have a chilling effect on the mental health of LGBT individuals.

Historically, formal training in sexuality and LGBT health has been minimal in both undergraduate and graduate medical education. In 1992, Wallick et al found that an average of 3 hours and 26 minutes were provided for exposure to LGBT health in 4 years curriculum (2). In a follow-up study by Tesar in 1998, this had decreased to 2 hours and 30 minutes (3). Additionally, attitudes toward LGBT patients mirrors prejudices held by general public. In a 1991 national survey of 1121 physicians 35% reported feeling “nervous around homosexuals” and one-third of respondents stated that “homosexuality was a threat to many of society’s basic institutions” (4). In another 1991 survey of 473 internists, family physicians, general practitioners and obstetrician-gynecologists, 36% of the respondents reported that “homosexual behavior between two men was just plain wrong” (5).

However, Sanchez et al in 2006 reported that medical students with increased clinical exposure to LGBT patients tended to perform more comprehensive histories, hold more positive attitudes toward LGBT patients and possess greater knowledge of LGBT health care concerns than students with little or no clinical exposure (6). This finding is likely not limited to medical students, but trainees in health fields at various levels of training.

II. **Terminology and Definitions**

In order to provide culturally competent services and engage LGBT individuals in population based research, one needs to master a fundamental understanding of terminology used within the LGBT community and outside the LGBT community to describe its members.

**Sexual Orientation:** refers to an individual’s pattern of physical and emotional arousal toward other persons

**Gender Identity:** One’s knowledge of oneself being male or female

**Gender Role:** One’s outward expression of maleness or femaleness (7).

**Transgender:** an inclusive term that describes individuals whose gender identities, expressions or behaviors are not traditionally associated with their natal sex. This categorical term includes individuals who may have disorders of sexual differentiation (previously called intersex conditions including hermaphroditism), transvestites, drag king, drag queens, and transsexuals (8).

**Homophobia:** The unreasoning fear of or antipathy toward homosexuals and homosexuality.
Transphobia: The unreasoning fear of or antipathy toward transgender individuals and transgenderism

Heterosexism: A prejudiced attitude or discriminatory practices against homosexuals by heterosexuals, a view that heterosexual relationships and associations are normative.

Many terms and labels can be ascribed to or assumed by members of the LGBT community. Some of these include more conventional terms such as “Gay” or “Lesbian” to refer to men and women whose primary attraction and relationships are with the same gender. The term “Bisexual” refers to those individuals whose pattern of attraction includes both genders. Yet other terms may be used to describe either sexual behaviors or gender based behaviors. Terms such as “Butch” and “Femme” are used within lesbian communities to describe individuals who align along a spectrum of masculinity and femininity in terms of their behaviors and appearance. Terms such as “Boy/Soft Boy” and “Stud” are used similarly.

Other terms may be used more commonly by subgroups within the LGBT community, such as members or ethnic/racial minority groups. Terms such as “Same Gender Loving” or the “Down Low”/ “DL” are terms that may allow members of racial/ethnic minority groups to acknowledge their sexual orientation or behavior, while mitigating challenges of homophobia within their respective communities.

Other terms such as “Queer” may be adopted by younger members of the LGBT community as an all-encompassing term describing non-gender conforming identities or behaviors. On the contrary, many older Gay and Lesbian individuals may recoil from this label as a result of personal experiences of the negative connotation of this term with discrimination.

Finally, MSM (Men who have sex with Men) and WSW (Women who have sex with Women) are terms used in both scientific and non-scientific literature to describe only the sexual behaviors of groups of individuals.

Important caveats to keep in mind when using any and all of these terms include recognizing that (1) different subgroups and individuals within the LGBT community ascribe to different labels, and (2) not all individuals identify with a specific label and its social connotations.

This is especially important when working with LGBT populations as discordant sexual orientation and behavior has been reported. In a cross sectional, randomized telephone survey of 4193 men from New York City from March – August 2003, Pathela et al (9) asked the respondents about concurrent measures of sexual behaviors including the number and sex of sex partners and condom use during last sexual encounter and the frequency of recent HIV testing.

She found that although 12.4% of respondents reported sex with other men, 72.8% of men who had sex with men identified as “straight” (8.9% of sample). 3.3% respondents identified as “Gay” and 0.2% identified as” Bisexual.” The MSMs with discordant behavior/identity were more likely to be foreign born, members of racial/ethnic minorities, have lower education/income, or be married (10).

Pathela’s findings have important public health implications for researchers, public health workers and policy makers. MSMs who do not identify with LGBT community may not have access to prevention, treatment, support and health improvement systems in place in LGBT communities (11). Health promotion plans targeted at the LGBT community may fail to promote health messages and reduce risk behaviors for heterosexual-identified MSMs.
III. Demographic data and Epidemiology a.k.a “Who is LGBT?”

Few studies have been performed in large populations to enumerate the true number of LGBT individuals in the United States. Often, these studies have used one of three constructs—attraction, behavior or identity—to measure sexual orientation. As a result, different studies have reported different prevalence values for non-heterosexual orientation. Studies have estimated the prevalence of homosexuality from as low as 1.4% of the population to 7.7%, but there have been few population based studies overall.

The popular statistic that 10% of the US population is gay or lesbian originates from the work of Kinsey in his *Sexual Behavior in the Human Male* (1948) and *Sexual Behavior in the Human Female* (1953) (12, 13). In his report, 37% of males and 13% of females had at least some overt homosexual experience to orgasm, and 10% of males were more or less exclusively homosexual. An additional 8% of males were exclusively homosexual for at least three years between the ages of 16 and 55. Females ranged between 2 - 6% for more or less exclusively homosexual experience/response. Kinsey reported that 4% of males and 1-3% of females had been exclusively homosexual after the onset of adolescence up to the time of the interview.

Researchers do recognize that many studies have underestimated sub-segments of the LGBT population. Underestimation may occur due to fear social consequences of “Coming Out,” a term used to describe self-disclosure of one’s sexual orientation or gender identity to friends, family and coworkers. This is especially true for those individuals with layered identities from racial/ethnic minority groups, youth populations, bisexual individuals, transgender individuals and elder populations.

The US Census, at best, can serve as a proxy for LGBT relationships by offering respondents the choice to select “Unmarried household partner” to describe their living situation on the census survey. This selection can be either a same or opposite sex partner and does not describe the context of the relationship. In 2004, there were 707,196 same sex couples identified in the American Community Survey (14). Sexual identity, behavior and attraction were measured in the 2002 National Survey of Family Growth and revealed that 4.1% of the US population aged 18 to 44 years (> 4.5 million individuals) identified as homosexual or bisexual (15).

A review of the prevalence of same sex couples by county in the United States reveals that same-sex couples reside in nearly every county in the United States (16). The following map shows the highest density areas with same sex couples residence colored in darkest green. With a distribution of same sex couples residence in virtually all of the United States, health care providers likely will encounter LGBT patients in their practices and will be asked to provide health care services to this patient population.
IV. Why does LGBT Health Matter?

Many arguments can be made to defend the importance of addressing LGBT Health. Proponents of diversity have argued that individual characteristics, both visible and invisible, are inherently important and measures should be taken to respect the differences of others. Yet others make moral arguments stating that all forms of discrimination are wrong and unjust. Even others hold to public health arguments and remind us that important illnesses affect LGBT populations and need to be addressed to improve community health. But these arguments and positions may fall short when opposition adhere to value-laden beliefs that LGBT individuals and communities do not deserve equal treatment or are receiving preferential treatment.

However, the current economic reality for most health professionals is that they do not have the ability to select their patients. Unless providers work in boutique practices, many will receive compensation from managed care plans, Medicare and Medicaid. Many of these insurance plans have a form of clinician reimbursement or incentive that is tied to patient satisfaction. Poor care delivered to LGBT patients may ultimately affect the provider’s bottom line and pocketbook.

Moreover, culturally competent and culturally effective medical care delivery to diverse populations is considered a core competency for health care providers and is addressed by codes of Conduct and Ethics of various professional organizations, including the American Medical Association (AMA) (17). Potential consequences of unprofessional behavior can include probation or loss of state licensure.
Addressing uses of providing culturally competent care is already a medical school accreditation standard of the Liaison Committee on Medical Education (LCME) as well as resident physician education by the Accreditation Council on Graduate Medical Education (ACGME). At the hospital system level, The Joint Commission has partnered with the Gay, Lesbian, Medical Association and other agencies to develop a set of hospital standards for patient-centered, culturally competent care that is inclusive of sexual orientation and gender identity. (18)

V. LGBTQ Youth

“...The prevalence of homosexuality among adolescents is unknown because gender roles and sexual identity may take years to evolve and be acknowledged. . .Although only 1% of 12th-grade males and less than 1% of 12th-grade females viewed themselves as mostly or completely homosexual, 10% were unsure of their sexual orientation” (19). More recently, review of local Cleveland Youth Risk Behavior Survey data suggests that youth continue to identify as Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) in about the same proportion as in previous studies, but more are choosing a identity earlier in their adolescence (20).

Despite the uncertainty of sexual orientation during adolescence, youth value and appreciate sexual health messages from their health care providers. In a study of adolescents aged 12-15 from the Washington, DC area, Boekeloo et al (21) found that 89% valued physician opinions about sex and 99% of youth found it easier to talk to a physician about sex during visit. Greater youth comfort was noted if the provider was addressing issues of general sexual health, if the adolescents had high self-esteem, or if the physician was adolescent’s regular provider.

The HEADS FIRST mnemonic developed by Goldenring and Cohen (22) is a useful tool for clinicians who care for adolescents as it addresses important psychological, social, spiritual, and parental issues in adolescence:

**Home.** Space, privacy, frequent geographical moves, neighborhood.

**Education/School.** Frequent school changes, repetition of a grade, grades in each subject, teachers' reports, vocational goals, after-school educational clubs (language, speech, math, etc.), learning disabilities.

**Abuse.** Physical, sexual, emotional, verbal abuse; parental discipline.

**Drugs.** Tobacco, alcohol, marijuana, inhalants, “club drugs,” “rave” parties, others. Drug of choice, age of initiation, frequency, mode of intake, rituals, alone or with peers, quit methods, and number of attempts.

**Safety.** Seat belts, helmets, sports safety measures, hazardous activities, driving while intoxicated.

**Sexuality/Sexual Identity.** Reproductive health (use of contraceptives, presence of STDs, feelings, pregnancy)

**Family and Friends.** Family: family constellation, genogram, single/married/separated/divorced/blended family, family occupations and shifts; history of addiction in first-and second-degree relatives, parental attitude toward alcohol and drugs, parental rules; chronically ill physical or mentally challenged parent. Friends: peer cliques and configuration (“preppies,” “jocks,” “nerds,” “computer geeks,” cheerleaders), gang or cult affiliation.
Image. Height and weight perceptions, body musculature and physique, appearance (including dress, jewelry, tattoos, body piercing as fashion trends or other statement).

Recreation. Sleep, exercise, organized or unstructured sports, recreational activities (television, video games, computer games, Internet and chat rooms, church or community youth group activities [e.g., Boy/Girl Scouts; Big Brother/Sister groups, campus groups]). How many hours per day, days per week involved?

Spirituality and Connectedness. Adherence, rituals, occult practices, community service or involvement.

Threats and Violence. Self-harm or harm to others, running away, cruelty to animals, guns, fights, arrests, stealing, fire setting, fights in school.

Potential psychosocial problems of homosexual adolescents as described by Remafedi (23) include:

- Social isolation
- Running away
- Prostitution
- Substancce abuse
- Compromised mental health
- Damaged self-esteem
- Depression
- Anxiety
- Suicide

Recently, Ryan et al identified family rejection as a predictor of negative health outcomes in sexual minority youth populations. Through retrospective surveys and interviews, she questioned 224 self-identified LGB youth, ages 21-25 about the nature and frequency of parental/caregiver reactions to their LGB experience during adolescence. The youth in the study were 48% Caucasian and 52% Latino and 51% male and 49% female. She measured nine negative health indicators (in domains of mental health, substance abuse, sexual risk) and stratified the rejection frequency into terciles to define a “Rejection Score” (24).

Ryan found that higher rates of family rejection associated with poorer health outcomes. Specifically, LGB adolescents who reported higher levels of rejection were:

- 8.4 times more likely to have attempted suicide
- 5.9 times more likely to report high levels of depression
- 3.4 times more likely to use illegal drugs
- 3.4 times more likely to have engaged in unprotected intercourse

VI. Bisexuality

Bisexual individuals often experience rejection by both heterosexual and homosexual communities. They can experience both the effects of heterosexism and “homosexism,” in which bisexual individuals experience discrimination not only from heterosexual but also gay and lesbian individuals. Bisexuals have been depicted in the lay press and in gay and lesbian communities as being on the “Down Low,” “Gay for the Day” or “Gay for Pay,” or as confused. They have been perceived as “playing on both
teams,” or experiencing a phase before ultimate declaring their homosexuality. Most negatively, they have been labeled as “spreaders of HIV and STDs.”

Little literature historically has been dedicated to health concerns specifically of bisexual individuals and most researchers have lumped data on bisexual health in with LGBT populations in general. Bisexuals remain an undercounted subgroup with invisibility due to “heterosexual” and “homosexual privilege.” That is to say, bisexual individuals may not be identifiable by visual recognition nor by reporting the current status of a relationship or the gender of their partner.

The existing literature on bisexual health has focused more on males than on females, and has addressed the following topics:

- HIV treatment and prevention
- Drug abuse
- Mental health issues
- Tobacco abuse
- Eating Disorders
- Discrimination

VII. Transgender

Gender Identity Disorder (GID) is the medical diagnosis that is given to transgender individuals who meet specific criteria in the Diagnostic and Statistical Manual, Revision IV (DSM-IV). These include a strong and persistent cross-gender identification which is not merely a desire for any perceived cultural advantages of being the other sex. This cross-gender identification may be manifested by symptoms such as (1) the desire to be the other sex, (2) frequent passing as the other sex, (3) the desire to live or be treated as the other sex, or (4) the conviction that s/he has the typical feelings and reactions of the other sex. The diagnosis can also be further categorized as Adult/Adolescent for those with a presentation over age 16, or Pediatric for children who exhibit cross-gender behavior and identity prior to age 16 (25).

Natal males who transition to become female may identify as Male to Female (MTF, M2F) transgender individuals, or as Transwomen. Natal females who transition to become male may identify as Female to Male (FTM, F2M) Transgender individuals, or as Transmen. Some individuals may choose to simply identify as Transgender (26).

The transitioning experience for transgender individuals is a continuum which has been described to have three phases. This medical model for transitioning includes (1) Real life Experience, (2) Hormonal Transitioning, and (3) Surgical Reassignment. From a medical perspective, the initiation of Real Life Experience in desired role, essentially living as the opposite gender all the time (referred as passing “24/7”) is an important first milestone in transitioning. Medical and mental health professionals consider a minimum standard of living Real Life Experience for three months before consideration of further medical therapy. During this period of time, a transgender person will live as the desired gender while being supported with psychotherapy. Transgender individuals may elect for non-pharmacologic care such as vocal training.

The initiation of hormonal therapy heralds the next phase in transitioning for many transgender individuals. Many Transgender individuals may seek hormonal therapy from endocrinologists or primary care physicians. They may experience varying degrees of success with obtaining hormonal therapy, as few providers have received formal training nor are they familiar with the medical management and side effects associated with prescribing hormonal therapy. A discussion of the details of hormonal therapy and medical monitoring is beyond the scope of this chapter, but suffice to say a clinician who prescribes
hormonal treatments for medical transitioning requires additional training to ensure the safe medical
transitioning of his or her patients. The use of hormonal therapies is not without medical risk and can
have life-threatening side effects including the development of blood clots (venothromboembolism) and
other metabolic consequences. Some transgender individuals seek services like electrolysis in
conjunction with their medical treatments. Frequently, transgender individuals may be taking hormonal
therapy on their own without the advice of a trained physician and receive their medications from internet
pharmacies. Such practices may be dangerous as the safety of preparations obtained from internet
pharmacies is uncertain and inadvertent self-induced overdosing of hormonal medications can occur.

The final stage of transitioning in a medical model is obtaining surgery to change the genitalia and other
sex characteristics. Common procedures requested include what is referred to as “Top” surgery in the
transgender community, i.e. breast reduction (“BR”), mastectomies or breast augmentation (“BA”).
Some transgender individuals also pursue “Bottom” surgeries in which the genitalia may be changed to
that of the desired gender. These procedures may or may not involve the transposition of the urethra and
are often complicated procedures. Other procedures such as facial recontouring, the use of cosmetic
implants may be employed as well to help the Transgender patient obtain the appearance of the desired
gender. Once again, few surgeons (urologists, urogynecologists, plastic surgeons) have received formal
training in performing such procedures. Sex reassignment surgical procedures are not covered by most
insurance programs and are expensive undertakings for transgender individuals. Some seek surgical care
outside of the United States in localities such as Thailand where the cost of the surgical care is less
expensive.

A transgender person’s decision to pursue hormonal therapy or surgery is an individual decision and does
not represent a common final endpoint to his or her journey. The gender identity of the individual may be
manifested by the choice to pursue hormonal care or surgery, but the choice not to do so does not negate
one’s Transgender identity.

The World Professional Association for Transgender Health (WPATH), which was formerly known as
the Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA), is a professional
organization devoted to the understanding and treatment of gender identity disorders (27). This
organization suggests obtaining a letter of support, referred to in the Transgender community commonly
as “The Letter,” from a mental health professional prior to hormone therapy and/or sex change surgery.
One letter is required for instituting hormone therapy, or for breast surgery and two letters are generally
required for genital surgery.

Many other issues are important in the care of transgender individuals, but the focus of this chapter it to
provide an overview of Transgender health and the associated medical issues. Legal issues, such as name
changes on birth records and other identification documents; social issues such as violence against
transgender people, and financial and mental health concerns—all are important factors in the lives and
well-being of transgender individuals.

VIII. LGBT Elders

An estimated 1.75 to 3.5 million LGBT elders resided in the US in 2003 (28), and every year 500,000
lesbians and gay men turn age 50 (29). With an ever growing and aging LGBT population, access to
culturally competent health care services for LGBT elders becomes increasingly important. Yet there is
little available research on LGBT elder health and health needs. Much health research on homosexuality
has focused on younger cohorts. And as noted by Quam & Whitford, “society had largely portrayed older
lesbians as a social embarrassment, as outcasts without emotions, while older gay men had been described
as lonely, oversexed, and depressed” (30).
“the older lesbian...is purported to be a cruel witch. Cold, unemotional, and heartless and she despises men. Devoted solely to masculine interested and career pursuits, she has no friends and is repeatedly frustrated by the rejections of younger women... (31).

...the older gay man is said to become increasingly isolated and effeminate as he ages. Lacking family and friends, he is portrayed as desperately lonely. He must setting for no sex life at all, or he must prey upon young boys to satisfy his lust” (32).

Negative portrayals of LGBT elders serve to compound health issues and concerns already mediated by social determinants of health. LGBT Elder health issues and access to care may be affected by factors such as “Coming Out,” insurance coverage, one’s financial situation, one’s living arrangements and family relationships, and the degree to which one is supported by his/her social network and community. Worries about discrimination in elder care facilities and nursing homes are an important concern for LGBT elders. End of Life issues in particular are a potentially complicated issue for LGBT elders.

A 2005 study by Johnson et al investigating perceptions of discrimination at long term care facilities found that female respondents were more suspicious of discrimination from administrators and staff then males, and respondents with lower incomes and from smaller communities were more optimistic about utility of resident education. An overwhelming majority of respondents believed a gay/gay-friendly retirement facility would be a positive development (98%) and a majority of respondents believed discrimination existed in typical retirement center (73%) (33).

Self-disclosure of one’s sexual orientation (i.e. “Coming Out”) is an important means for LGBT elders to have social connectedness and interact with LGBT organizations and services. However, a sizeable number of LGBT elders are not “mostly or completely out.” In the 2006 MetLife study, 44% of the responders reported being “completely out” and 31.7% “mostly out” with respect to self-disclosure of sexual orientation. However, nearly a quarter of the respondents answered that they were “somewhat out, a little out or not at all” (34).

Many factors may influence a person’s choice to self-disclose his/her sexual orientation. Many older LGBT people fear discrimination, homophobia and elder abuse in disclosing identity to service providers (35). Many lived their youth and young adult lives in very hostile environments, prior to the modern day gay liberation movement in the late 1960’s that was highlighted by the Stonewall Riots (36).

Potential for discrimination exists not only at retirement facilities, but also conceivably can occur with home based services. Inviting strangers, albeit trained health professionals, into one’s home places the potentially dependent elder in a situation where s/he must decide if benefit of the service provided outweighs the potential for discrimination. Common home based services such as physical therapy, occupational therapy, speech therapy, home based mental health services, Visiting Nurse Association visits, Home Health Aides, hospice visits, and even services such as Meals on Wheels can represent potential threats for LGBT elders in their safest place, their own homes.

One myth that Lesbians and Gay men have more discretionary income and are affected less by poverty has been recently investigated in the Williams Institute Report: Poverty in the LGB Community. The researchers found that after adjusting for a range of family characteristics that help explain poverty, gay and lesbian couple families are significantly more likely to be poor than are heterosexual married couple families. Notably, lesbian couples and their families were found to be much more likely to be poor than heterosexual couples and their families. The researchers noted that within the LGB population, several
groups are much more likely to be poor than others including African American people in same-sex couples and same-sex couples who live in rural areas (37).

While a small percentage of all families receive government cash supports intended for poor and low-income families, gay and lesbian individuals and couples are more likely to receive these supports than heterosexuals (38).

Social Security pays survivor benefits to widows and widowers but not to the surviving same-sex life partner of someone who dies. According to the report by the National Gay Lesbian Task Force, this may cost LGBT elders $124 million/year in unaccessed benefits (39). Married spouses are eligible for Social Security spousal benefits, which can allow them to earn half their spouse's Social Security benefit if it is larger than their own Social Security benefit. Unmarried partners in lifelong relationships are not eligible for spousal benefits. Medicaid regulations protect the assets and homes of married spouses when the other spouse enters a nursing home or long-term care facility. Currently, no such protections are offered to same-sex partners (40).

Additionally, tax laws and other regulations of 401(k)s and pensions discriminate against same-sex partners, costing the surviving partner in a same-sex relationship tens of thousands of dollars a year, and possibly more than $1 million during the course of a lifetime (41).

LGBT elders’ family relations constitute another important factor that may contribute to health outcomes. With regard to biological families, LGBT elders may be less linked to their families of origin. Some may have children and grandchildren from previous heterosexual relationships with varying degrees of closeness within those relationships. The literature has reported the importance of large social networks and the concept of “fictive kin,” that is, friends who become family as important persons in the lives of LGBT elders. Unfortunately, these relationships with non-biological family may be unrecognized by health care providers and systems. Conflict can arise when providers turn to biological family over fictive kin for decision-making issues (42).

The 2000-2001 Canadian Gay and Lesbian Elder Study reported on the experiences of gay and lesbian seniors from all over Canada about a broad range of health and social services. This study utilized a snowball sampling method and qualitative exploratory design based on focus group interviews. The central theme reported by the participants was the profound marginalization experienced by older gays and lesbians in all aspects of social and political life. Five subthemes identified including the historical experiences of discrimination, homophobia in present-day context, the profound invisibility of gay and lesbian seniors, Long term care services, and Gay and lesbian support networks (43).

Invisibility continues to be an important factor mitigating LGBT elder health. Many LGBT elders recall past and current experiences of discrimination and maintain secrecy about their sexual orientation. Others do not come out for fear of discrimination or being treated badly in a long term care network. As a result, LGBT elders experience absolute invisibility in senior care networks which serves as barriers to social and political voices. LGBT elders historically have been excluded from all discussion, planning, programming process in main stream senior networks and LGBT organizations (44).

Invisibility in Long Term Care settings continues to isolate LGBT elders. Invisibility may be a result of staff behaviors, as assessments of seniors frequently overlook important aspects of social life including sexuality. Outward expressions of affection may represent major barriers to health and well-being of older lesbians and gays (45).

“One woman told me that she would just like to know that if she ever has to go into a facility, that she can hold hands with her partner in the tv room” (46).
On the other hand, some LGBT elders may utilize their invisibility as a survival tool.

“I heard a story once that one lesbian couple. . . one of the partners changed her last name so that they would be taken for sisters. To be put in the same room” (47).

LGBT community itself can serve as a barrier to care for its very own elders. Historically, much energy and resources have been focused on youth, but much less effort for elder services. Fiscal appropriations, combined with a youth-focused image of LGBT communities continue to create challenges to access and engage senior members. Older gays and lesbians are confronted with negative attitudes about their age and can experience discrimination related to ageism, and a community’s emphasis on youthfulness and beauty (48).

Finally, end of life issues present a unique challenge for LGBT elders. A majority of respondents in the MetLife survey stated that they wished to die in their homes either with (47%) or without hospice care (16%) and the majority of them (72%) had discussed end-of-life issues with someone. Yet, significant numbers of LGBT boomers have not yet completed paperwork for advanced directives. Among the MetLife respondents, 26% of those aged 40-49 and 16% aged 50-61 had not addressed advanced directives (49).

**IX. Health Disparities**

The previous discussion of LGBT demographics and subpopulations illustrated some ways that sexual orientation and gender identity and expression may impact health. This next section addresses the known health disparities facing LGBT populations.

Healthy People 2010 is a selected set of objectives that represent the overall progress toward improving the health of the Nation (50). These objectives include:

1. Physical Activity/Fitness
2. Overweight and Obesity
3. Tobacco Use
4. Substance Abuse
5. Responsible Sexual Behavior
6. Mental Health
7. Injury and Violence
8. Environmental Quality
9. Immunization
10. Access to Health Care

These ten leading health indicators were then further divided into 28 focus areas. In Healthy People 2010, there were six focus areas that had been identified as areas for health disparities for LGBT patients. These included: Tobacco Abuse, Substance Abuse and Alcohol Abuse, Mental Health, Obesity and Nutrition, Cancer, and HIV. Of note, four of the six identified focus areas are also Leading Health Indicators of Healthy People 2010.
A. Cancer Disparities

Various cancer health disparities in LGBT populations have been described in the literature for the last 30 years. In the late 1980’s, Daling et al. (51) and Beckman et al. (52) and several other researchers found exposure to human papilloma virus (HPV) was precursor to the development of anal carcinoma in MSM. Thee researchers reported that there were associations between receptive anal intercourse, the rectal administration of recreational drugs, having a higher number of lifetime partners, and a greater prevalence of tobacco smoking to anal carcinoma.

In 1996, Kolbin et al. (53) found increased incidence of both non-Hodgkin’s lymphoma (NHL) as well as Hodgkin’s lymphoma in gay men. Using a cohort study that reviewed medical records from New York City and San Francisco cancer registries and National Health index from 1978-1990, his group found That there was no difference in incidence of cancers at other sites of the body, but NHL and Hodgkin’s lymphoma appeared overrepresented in gay males. In later studies, the increased incidence of NHL and Hodgkin’s was found to be related to HIV infection.

Breast cancer disparities have also been discovered to disproportionately affect bisexual and lesbian women. In the mid-1990’s, Haynes (54) and Denenberg et al. (55) found that Lesbians are at increased risk to develop breast cancer compared to heterosexual women. Factors that mitigated this disparity included higher rates of nulliparity (never having had a pregnancy) and rare/no use of oral contraceptive medications—both factors which allow for greater exposure to estrogen over a woman’s lifetime. Increased obesity and alcoholism in lesbian populations were also identified risk factors for breast cancer.

Finally, the role of access to care and cancer screening has been problematic for bisexual and lesbian women. As early as 1981, Robertson et al. noted less frequent gynecologic care in lesbian women with resultant failures to diagnose sexually transmitted infections (including HPV infection) as well as failure to screen for gynecologic malignancies (56).

B. HIV Disparities

Health Disparities in HIV have been well documented. The most recent 2005 statistics from the Centers for Disease Control continue to reflect these trends. In 2005, 33 states with long-term, confidential name-based HIV reporting documented 19,620 incident cases of HIV infection in MSMs. The overwhelming majority of new cases of HIV infection in MSM were not related to intravenous drug abuse. Approximately, 6.7% of the incident cases were related to IV drug use in MSMs. These incident cases of HIV accounted for 71% male adults and adolescents with HIV that year and 53% of all people diagnosed with HIV that year. The 2005 CDC report demonstrated an 11% increase in incident cases of HIV in MSM compared to 2001 (57). Researchers and epidemiologists were unsure if the increase in incident HIV diagnoses in MSMs was related to increased number of infections or effect of more widespread testing. In a 2005 HIV prevalence study performed in five large metropolitan areas (New York City, Los Angeles, San Francisco, Baltimore, Miami), researchers found that 46% of the African American MSM in their study were HIV positive and that 67% of the same men unaware of their serostatus until the time of diagnosis in the study (58).

The prevalence of HIV in Lesbian and WSW populations is largely unknown. Contrary to belief that Lesbians and WSWs have low to no risk of contracting sexually transmitted infections (STDs) or HIV, the reality is that the risk is not negligible. Although less than a quarter of the women in the National Lesbian Health Care Survey reported they were worried about contracting STDs, Bauer et al. (59) found a 13% prevalence of STDs in cohort of women with only female partners. Bauer surveyed women recruited from 1997 Twin Cities Gay/Lesbian/Bisexual/Transgender Pride festival and asked the
participants if they had ever been diagnosed with HIV, hepatitis B, gonorrhea, syphilis, chlamydia, genital warts, genital herpes, and trichomoniasis or pelvic inflammatory disease (PID). Less than 10% of women who reported a positive STD history reported regular testing for STDs.

Like other research surrounding disease prevalence in Transgender populations, few studies have been performed to obtain accurate estimates of HIV infection among Transgender men and women. The available literature does suggest that there is a high prevalence rate among MTF transgender people. Several studies, including those by Nemoto et al (60), Xaiver et al (61), and McCowan et al (62) have noted HIV prevalence rates between 22% to 47% among urban subpopulations of MTF Transgender patients. It remains unclear the degree of “survival sex”—that is sex in exchange for food, money, drugs—plays in HIV transmission for MTF transgender individuals. HIV prevalence rates are largely unknown for FTM individuals.

C. Mental Health

Mood disorders and mental health concerns are over-represented in LGBT populations. Research by Cochran and Mays (63) has found that gay men report higher rates of depression and anxiety disorders than heterosexual counterparts.

In the Geneva Gay Men’s Health Study, 2002—a comprehensive health survey among 571 gay men in Geneva, Switzerland—43.7% of participants fulfilled criteria for one of five DSM-IV disorders. Nearly one fifth of the respondents had experienced major depression in last 12 months (19.2%), and over one fifth of the respondents had a specific and/or social phobia in last 12 months (21.9%). 16.7% of respondents reported an alcohol or drug dependence disorder in last 12 months and more than a quarter of men surveyed reported a comorbid mental health condition. 35.7% of the men surveyed had consulted a mental health provider in the last 12 months for mental health care (64).

The mental health of lesbian women as reported in the National Lesbian Health Survey (1984-1985) found that mental health concerns were prevalent. In this survey of 1925 Lesbians from all 50 states, over half of the women surveyed reported thoughts of suicide at some time and nearly one fifth had attempted suicide (18%). Issues related to relationship violence and sexual abuse were also common with 37% of women reporting being abused as a child or adult, 32% reporting being raped or sexually attacked, and 19% having been involved in an incestuous relationship. In this cohort of women, nearly a third used tobacco daily, 30% drank alcohol more than once a week and 6% drank alcohol daily (65).

D. Obesity and Nutrition

In addition to mental health concerns, health disparities have been reported for Lesbians and Gay men with regard to nutrition and weight. Roberts et al (66), Seiver (67) and several non-randomized studies have found that Lesbians are more likely to be overweight. Seiver’s study revealed that Lesbians seemed less preoccupied with weight and body image compared to heterosexual women (68). On the other hand, Valanais et al (69) compared data from the Women’s Health Initiative and found that Lesbians consume fewer fruits and vegetables than heterosexual women. Other differences in eat behaviors may exist, but have not yet been discovered or reported.

With regard to Gay and bisexual men and nutrition, very little is known and variable findings have been reported in the literature. Some studies reported correlations between eating disorders and sexual orientation among men (Beren et al, 70), while others did not (Turnbull et al, 71; Pope et al, 72).
One phenomenon that has been described was termed “Gay male gym culture” by Bernard (73). This term suggests a set of behaviors including aggressive exercise and dieting, sometimes with dietary supplements to appear healthy and muscular. Bernard reported this as a response to appear healthy during the time of HIV/AIDS epidemic. Some individuals included anabolic steroid use in order to enhance their physical appearance and appear healthy. Inherent risks of long term anabolic steroid use include hypertension, severe acne, mood changes as well as the inherent risks for skin infection (cellulitis), and blood borne pathogen transmission (HIV, hepatitis) associated with using intramuscular injection delivery of the steroids.

In 2004, Kaminski et al studied body image, eating behaviors and attitudes toward exercise among gay and heterosexual men (74). Kaminski developed a specific tool to evaluate eating behaviors in men as previous studies used instruments designed to assess eating disorder symptoms in women. Using this tool called the Male Eating Behavior and Body Image Evaluation (MEBBIE) tool, Kaminski found that Gay men dieted more, were more dissatisfied with their degree of muscularity, were more dissatisfied with their bodies in general and were more fearful of becoming fat compared to heterosexual men. No difference was noted in terms of the degree of exercise performed or feeling guilty about missing workout between heterosexual and Gay men (75).

E. Substance Abuse

McKirnan and Peterson (76) provided one of the first estimates of drug and alcohol use in the Lesbian and Gay community. Although their study suffered from selection bias, as participants were recruited from gay bars and similar establishments, it provided a glimpse into the complex interplay of sexual orientation and substance and alcohol use. McKirnan and Peterson surveyed 748 Lesbians and 2652 Gay men and compared their self-report of drug and alcohol use to that of the general population. They found that there were higher numbers of Lesbians and Gay men who reported using alcohol, marijuana and cocaine, but Lesbians and Gay men did not have rates of heavy alcohol use any higher than general population. However, Gay men and Lesbians reported problems with alcohol twice as often as matched heterosexual counterparts. Additional research by Skinner (77) found that alcohol consumption rates do not seem to decrease with age as quickly as they do among heterosexuals. This finding is particularly concerning given the health effects of prolonged exposure to the toxic effects of alcohol over one’s lifetime including alcoholic hepatitis and cirrhosis.

The use of club drugs remains popular among younger gay men and lesbians and some other groups, but the exact prevalence is unknown. The use of club drugs and mood enhancing substances such as MDMA (Ecstasy, E), methamphetamine (Crystal Meth, Ice, Tina), ketamine (Special K), Gamma Hydroxy Butyrate (GHB) and amyl nitrite (Poppers) combined with alcohol and other illicit substances poses a threat to healthy behavior choices for the user.

Remafedi investigated the effect of drug use patterns on sexual risk behavior in a cohort of 13 to 21 year old MSMs during a three year period from 1994-1997. (78) He found associations between unprotected anal intercourse and use of multiple substances including alcohol, marijuana, cocaine, amphetamines, barbiturates, heroin, LSD, volatile nitrites, tranquilizers, and methaqualone. Cocaine was found to be an independent predictor of the failure to use condoms in the study sample (79).

Prescription medications also have been used in combination with substances of abuse or alcohol and have been implicated in high risk sexual behaviors. In a 2006 study by Benotsch, the researcher found that phosphodiesterase (PDE) inhibitors—a class of medications which can be used to treat erectile dysfunction—are commonly used by MSM travelers (80). Benotsch studied a group of 304 MSM vacationers to Key West or Rehoboth Beach and noted that the study participants had 1.33 unprotected
anal intercourse encounters over an average of 3.6 days of vacation stay. The MSM reported that they were unaware of the HIV status of over half of their sexual partners. In the study population, 11% of the MSM reported use of PDE inhibitors, with sildenafil (brand name Viagra) being the most commonly reported medication. Benotsch found a higher incidence of unprotected anal sex with PDE inhibitor use. However, he found no difference in rates of alcohol, cocaine methamphetamine or other substance use between PDE users and non-users (81). In 2007, Halkatis independently reported that sildenafil (Viagra) often used with club drugs in MSM populations (82).

Very recently, reports that combinations of prescription medications and drugs of abuse have made the popular press. One combination, *MTV*, is not an acronym for “Music Television,” but instead a combination of Methamphetamine, Tenofovir (brand name Viread), and Viagra (sildenafil). For the user, methamphetamine can cause a euphoric high that may intensify sexual experience, but can lead to temporary erectile dysfunction, colloquially referred to as *crystal dick*. The use of Viagra obviates this side effect of methamphetamine. The effects of methamphetamine may last for hours or even days.

Tenofovir is a medication in a class called nucleotide analogue reverse transcriptase inhibitors (nRTIs), which block reverse transcriptase, an enzyme crucial to viral production in HIV-infected people that is used in treatment regimens. This combination is being used by some MSM for “PnP,” a.k.a. “Party and Play”, in which methamphetamine is used in combination with other drugs to heighten sexual experience and pleasure. Users believe that this combination offers some form of pre-exposure prophylaxis against HIV infection, but there have been no studies that have shown evidence of efficacy nor established a recommended standard for pre-exposure prophylaxis. MSMs who engage in PnP often have encounters with partners whose HIV status is unknown (83).

With regard to Transgender populations and substance abuse, very little research is available to document the extent of problem. The few studies in the literature have utilized research design methods with convenience samples from urban areas which limit the ability to generalize the research findings to the larger transgender population. Despite study limitations, the San Francisco Department of Health (1999) community participatory research study found that for MTF transsexuals drug use patterns within a six month period, the most commonly included abuses were of marijuana (64% of respondents), followed by heroin/speed (30%) and crack cocaine (21%). Among FTM transgender individuals in the same study, the most commonly reported substance of abuse was marijuana (43% of respondents) (84).

F. Tobacco Abuse

Tobacco abuse is another health behavior that has been reported as a health disparity for LGBT communities. In a 2004, study, researchers found that cigarette smoking in Lesbians is 70% higher than heterosexual women (25.3% vs. 14.9%). The prevalence of cigarette smoking in Gay men was nearly 50% greater, with 33.2% of Gay men in the sample who reported tobacco abuse vs. 21.3% of heterosexual male controls. The demographic risk factors noted in this study were: (1) age between 35-44 years, (2) Non-Hispanic White racial/ethnic background, (3) having a low-education attainment (< high school), and (4) having a low household income (<$30,000) (85).

X. Examples of Successful Public Health Models for LGBT Health Care

In their article, Sexual and Gender Minority Health: What We Know and What Needs to Be Done, Mayer et al make recommendations about how clinicians and public health professionals can impact research, clinical outcomes and service delivery to LGBT populations (86). The authors note that clinicians’ efforts should work in tandem with public health departments. Although, some health departments have dedicated staff addressing LGBT public health issues, resources at the state and federal level are still
sorely needed. Furthermore, data collection and analysis of LGBT health markers is lacking (87). Colorado, Massachusetts, North Dakota and Vermont currently collect information about sexual orientation using the Behavioral Risk Factor Surveillance System. The first transgender question appeared in Massachusetts Behavioral Risk Survey in 2007 (88).

The following programs and initiatives are examples of clinical, public health, research and legislative action to improve the health of LGBT populations. Each one exemplifies community engagement with public health and clinical medicine providers, as well as providing opportunities for research and education.

A. The Fenway Institute

In 2007, the Fenway Institute at Fenway Community Health became the first community-based organization to be awarded a Population Research Development Grant by the federal government and in doing so, it became the first federally-funded research center to focus specifically on sexual minority population research. The grant supports the creation of technical resources and compiling of data in order to produce cutting-edge research on LGBT communities and training the next generation of LGBT researchers, clinicians, educators and scholars. Behavioral research on the transmission of HIV; characteristics and quality of life of LGBT families and households; and demographic aspects of LGBT health, morbidity, disability and mortality—all have been identified as priority research areas for this grant.

The $1 million grant— which will be distributed over five years— will be supplemented by additional funding and administrative support from Fenway Community Health.

The National Institute of Child Health and Human Development within the National Institutes of Health conducted scientific peer review and selected the Fenway Institute as the recipient of this award. The Fenway Institute will work in partnership with Boston University’s School of Public Health and the Inter-university Consortium for Political and Social Research (ICPSR), a leader in social science research data archiving and accessibility.

According to the Fenway Institute website, key features of their program will include:

- Developing and supporting a multidisciplinary faculty of nationally recognized research scientists to advance the study of gender and sexual minority populations;
- Building an academic “pipeline” of graduate studies in LGBT health in conjunction with Boston University and supporting nationally-selected students to participate;
- Working with academic, professional and nonprofit partner organizations to advance the field of LGBT health;
- Creating a comprehensive public access research data library that will be accessible over the Internet by researchers across the country and around the world;
- Disseminating findings through the Internet, peer-reviewed journal articles, a monograph addressing methodological best practices for LGBT health studies, and documents for Healthy People 2020 (89).

The Fenway website provides information on health studies currently being conducted on three groups of individuals: women, HIV-positive individuals, and HIV-negative individuals. Educational modules on LGBT health are also available for self-directed learning via the Fenway website. Introductory topics
includes “Ending Invisibility: Improving Care for LGBT Populations;” “Knowing your Patients: Taking a History and Providing Risk Reduction;” and “Health Promotion and Disease prevention” (90).

B. Howard Brown Older Adult Services – Aging as We Are

In January of 2009, the Howard Brown Health Center created the Chicago Elder Services Community Initiative at Howard Brown LGBT Health Center (91). Also known as “Aging as We Are,” this program was funded by the Baxter International Foundation ($120,000), as well as federal grant monies ($383,000). This program will provide medical care, behavioral health counseling, case management, drop-in services, Peer-to-Peer support, transportation support/assistance to services, and in-home care to LGBT elders in the Chicago area. This project is a multi-organizational collaboration between Howard Brown, Rush University Medical Center, CJE-Senior Life, Heartland Alliance, and Midwest Palliative & Hospice CareCenter. Central to providing culturally effective services to LGBT elders is the program’s training for local healthcare and social service providers to improve competencies working with LGBT seniors (92).

C. PRIDE Clinic

The PRIDE Clinic at MetroHealth Medical Center in Cleveland, Ohio, was created in April 2007 to provide primary care for LGBTQ individuals, their friends and families regardless of ability to pay. One of twelve programs in the United States and one of only three programs in the Midwest, this once weekly evening clinic has seen over 150 patients in over 400 visits in its first year. The PRIDE Clinic is the only medical home for LGBTQ patients which is part of county hospital system.

The clinic was developed with the support of local Cleveland community organizations such as the LGBT Center of Greater Cleveland, Asians and Friends Cleveland, the Hispanic Urban Drug and Alcohol Outreach Program, and TransFamily. A community needs assessment was performed prior to developing the clinic. Community input was sought regarding many clinic service details including the clinic’s name, the scope of care services desired, as well as the clinic is currently staffed by a medical director, two physicians, a social worker and dedicated nursing staff. Health care services at the PRIDE Clinic include medical evaluation for Transgender hormonal therapies. The clinic provides medical students, residents, fellows as well as other health professional trainees a hands-on opportunity to learn about LGBT health disparities and participate in health care delivery.

The Fenway Health Clinic and Institute, Howard Brown Elder Services Community Initiative and the PRIDE Clinic at MetroHealth Medical Center are just three examples of collaborative efforts between health systems, community agencies and organizations and LGBT communities to improve LGBT health. Other LGBT health organizations and agencies, many of which have community health programs or initiatives, are listed in the next section. More research and interventional studies are still needed to elucidate the extent of, mechanisms for, and solutions to LGBT health disparities. At the time of publication of this on-line textbook chapter, discussions were underway between leaders from the National Coalition on LGBT Health and other health organizations to increase inclusion of LGBT populations in the statistics collected about then Nation’s health in Healthy People 2020. These recommendations were summarized in the Guiding Principles for Lesbian, Gay, Bisexual and Transgender Inclusion in Healthcare Reform which were sent to the Obama administration and Congress (93).
In addition to LGBT health centers, and LGBT-focused health research, laws that promote diversity and prevent discrimination are another means to improve LGBT health. In 2008, the state of California passed a law requiring “licensed health care professionals” to undergo “diversity training” in order to “prevent bias in senior care facilities and nursing homes” (94). Additionally, California also passed the Civil Rights Act of 2008 which strengthens existing laws to ensure protections based on gender, race, color, religion, ancestry, national origin, disability, medical condition, marital status and sexual orientation (95).

XI. Concluding Thoughts

Improving the health status for LGBT populations is a complex, complicated process which has only recently been addressed. Many more health disparities may exist beyond those already identified in the Compendium Document to Health People 2010. Further population based research in LGBT health may begin to elucidate the true extent and nature of additional health problems facing the LGBT community. Adequate federal funding for research on LGBT population health and health disparities is critical to the success of such research. Proponents of LGBT health research must work with communities and community/health agencies to ensure that funding streams continue to exist.

Central to any initiative to improving LGBT health is cultural competency and education, not only of issues in clinical medicine, but also of social determinants of health mediated by the experience of gender identity or sexual orientation. Health care providers, researchers, public health professionals and legislators need to develop the skill sets to build trust and rapport with a community of individuals who have historically mistrusted or had negative experiences with the medical profession. Educational programs teaching issues related to LGBT health disparities and cultural competency are an integral part of workforce training for the next generations of physicians, nurses, researchers and public health professionals.

Multidisciplinary LGBT patient-centered care models of health and public health for LGBT populations have been established at over a dozen centers across the United States. The development of “Best Practice Guidelines” as well as tools measuring patient outcomes is needed to serve as the foundation for evidence based medicine and public health. Developing and sustaining training programs for clinicians and researchers who wish to pursue research or education topics in LGBT health are vital and as important as developing the infrastructure to disseminate health messages to LGBT individuals and communities.

Ultimately, discrimination in any form in health care is a health hazard.

XII. Health Resources

The following is a list of internet health resources that you may find helpful in obtaining health information or resources for providing care or developing a service for LGBT persons. Descriptions of the sites are excerpts from the webpages themselves at the time of publication of this book chapter.
National Organizations and General LGBT Health

- The Gay Lesbian Medical Association (GLMA)
  - GLMA's mission is to ensure equality in health care for lesbian, gay, bisexual and transgender individuals and health care providers.
  - www.glma.org for referrals and updated provider links

- Healthy People 2010 Companion Document

- CDC site for LGBT Health
  - www.cdc.gov/lgbthealth

- LGBT Health Channel
  - http://www.lgbthealthchannel.com/

- Medline Plus: Gay, Lesbian and Transgender Health

- National Coalition for LGBT Health
  - www.lgbthealth.net

- Parents and Friends of Lesbians and Gays
  - www.pflag.org

- The Gay Lesbian Bisexual and Transgender Health Access Project
  - http://www.glbthealth.org/

- Public Health Seattle and King County website:

Gay Men’s Health

- Gay Men’s Health Crisis (GMHC) website
  - Gay Men's Health Crisis (GMHC) is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS. We provide prevention and care services to more than 15,000 men, women and families that are living with, or affected by, HIV/AIDS in New York City, and advocate for scientific, evidence-based public health solutions for hundreds of thousands worldwide.
  - www.gmhc.org

- Gay City Health website
  - The Gay City Health Project is a multicultural gay men's health organization and the premiere provider of HIV and STD testing in King County. Our mission is to promote gay and bisexual men's health and prevent HIV transmission by building community, fostering communication and nurturing self-esteem.
  - www.gaycity.org
Lesbian Health

- Women’s Health: Lesbian Health Frequently Asked Questions

- The Mautner Project, The National Lesbian Health Organization
  - The Mautner Project improves the health of lesbians, bisexual, and transgender women who partner with women, and their families, through advocacy, education, research, and direct service. We envision a healthcare system that is guided by social justice and responsive to the needs of all people.
  - http://www.mautnerproject.org/home/

- Lesbian Health and Research Center at the University of California at San Francisco website
  - LHRC is dedicated to improving the health of lesbians, bisexual women, transgender people, and our families. To achieve this goal, we create comprehensive programs of research, education and trainings, public events and community collaborations.
  - http://www.lesbianhealthinfo.org

- National Lesbian Health Summit website
  - http://www.lesbianhealthinfo.org/NationalLesbianHealthSummit/About.html

Bisexual Health

- The Task Force: Bisexual Health Report
  - www.thetaskforce.org/reports_and_research/bisexual_health

LGBTQ Youth


- Advocates for Youth website

- The Gay Straight Educational Network (GLSEN)
  - GLSEN, the Gay, Lesbian and Straight Education Network, is the leading national education organization focused on ensuring safe schools for all students. Established nationally in 1995, GLSEN envisions a world in which every child learns to respect and accept all people, regardless of sexual orientation or gender identity/expression.
  - http://www.glsen.org/cgi-bin/iowa/all/about/index.html

- National Youth Advocacy Coalition
The National Youth Advocacy Coalition (NYAC) is the leading national social justice and capacity building organization working with lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth and LGBTQ youth-serving professionals.

- www.nyac.youth.org/#

The Trevor Project

- The Trevor Project operates the only nationwide, around-the-clock crisis and suicide prevention helpline for lesbian, gay, bisexual, transgender and questioning youth. If you or a friend are feeling lost or alone call The Trevor Helpline.
  - 1-866-4-U-TREVOR (1-866-488-7386)

Transgender Health

- TransGender Care website
  - A Transsexual and Transgender Transition, Medical, and Hair Removal Help and Consumer Guide
  - www.transgendercare.com

- World Professional Association for Transgender Health (WPATH)
  - The World Professional Association for Transgender Health, WPATH formerly known as the (Harry Benjamin International Gender Dysphoria Association, Inc.) (HBIGDA) is a professional organization devoted to the understanding and treatment of gender identity disorders.
  - www.wpath.org

- drbecky.com
  - Dr. Rebecca Allison is a cardiologist serving as the Chief of Cardiology at Cigna in Phoenix, AZ, the incoming president of the Gay Lesbian Medical Association (in 2008) and a Transgender advocate and activist. In 1998, Allison created drbecky.com, a resource site focusing on the medical, legal, and spiritual needs of trans people.
  - http://www.drbecky.com/

Elder Health

- Lesbian and Gay Aging Issues Network
  - Agency that works with professions in aging to raise awareness about the concerns of LGBT people 50+
  - www.asaging.org/lgain

- SAGE (Service and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders)
  - http://www.sageusa.org/index.cfm

- Howard Brown Older Adult Services – Aging As We Are website:
  - http://www.howardbrown.org/hb_services.asp?id=456
LGBT Research and Data

- Gaydata website:
  - A website was created for individuals and organizations:
    1) Who want to find information about lesbians, gays and bisexuals grounded in scientific knowledge,
    2) Who want to find datasets to analyze that include sexual orientation data, and
    3) Who want to learn how to collect sexual orientation data.
  - www.gaydata.org

- Gaydemographics.org website:
  - A website of demographic and census information for LGBT populations in the United States, United Kingdom and other nations.
  - http://www.gaydemographics.org/index.htm

HIV/AIDS Organizations and Resources

- AIDS Action Council:
  - AIDS Action is a national organization dedicated to the development, analysis, cultivation, and encouragement of sound policies and programs in response to the HIV epidemic. We do this through the dissemination of information and the building and use of advocacy on behalf of all those living with and affected by HIV. Our goal is simple. Until It's Over -- until no one acquires HIV, until those living with HIV have the care and services they need, and until a cure is found.
  - http://www.aidsaction.org

- AIDS Project Los Angeles:
  - AIDS Project Los Angeles is dedicated to: improving the lives of people affected by HIV disease; reducing the incidence of HIV infection; and advocating for fair and effective HIV-related public policy
  - http://www.apla.org/

- The AIDS Institute:
  - The AIDS Institute (TAI) began as a grass roots community advocacy effort in the late 1980s. In 1992, this advocacy network became incorporated as Florida AIDS Action, a nonprofit organization. Over the years, TAI expanded its vision to become a leading national public policy research, advocacy, and education agency with offices in Tampa, and Washington, DC. Affiliated with the Division of Infectious Diseases and Tropical Medicine at the University of South Florida College of Medicine, The AIDS Institute remains focused on HIV/AIDS while incorporating work on related healthcare issues such as Hepatitis, as well as other infectious and chronic diseases.
  - http://www.theaidsinstitute.org/home.asp
• CAEAR
  o The Communities Advocating Emergency AIDS Relief (CAEAR) Coalition is a national membership organization which advocates for federal appropriations, legislation, policy and regulations to meet the care, treatment, support service and prevention needs of people living with HIV/AIDS and the organizations that serve them. CAEAR Coalition's proactive national leadership is focused on the Ryan White Program as a central part of the nation's response to HIV/AIDS. CAEAR Coalition’s members include Ryan White Program Part A, Part B, and Part C consumers, grantees, and providers.
  o [http://www.caear.org/coalition/about.html](http://www.caear.org/coalition/about.html)

• CDC website: [www.cdc.gov/hiv/topics/msm/resources/factsheets/msm.htm](http://www.cdc.gov/hiv/topics/msm/resources/factsheets/msm.htm)

• National Minority AIDS Council
  o The National Minority AIDS Council develops leadership in communities of color to address the challenges of HIV/AIDS.
  o Since 1987, NMAC has advanced its mission through a variety of public policy education programs; national conferences; treatment and research programs and trainings; electronic and printed resource materials; and a website: www.nmac.org. NMAC represents a coalition of 3,000 F/CBOs and AIDS service organizations (ASOs) delivering HIV/AIDS services in communities of color nationwide. NMAC's advocacy efforts are funded through private funders and donors only.

• Massachusetts Asians & Pacific Islanders for Health
  o MAP is a non-profit, community-based organization that mobilizes, educates, and advocates for Asian, South Asian, and Pacific Islander health improvements--particularly in HIV/AIDS and sexual health.
  o [http://www.mapforhealth.org/site/maapp2/](http://www.mapforhealth.org/site/maapp2/)

• Multicultural AIDS Coalition
  o The Multicultural AIDS Coalition is a unique organization in the Boston area. We are the largest agency in communities of color focused exclusively on the HIV/AIDS epidemic. Since 1988, MAC has been a valued community resource for HIV information, training for minority agencies delivering HIV services, and developing effective relationships with community institutions.

• San Francisco AIDS Foundation
  o The San Francisco AIDS Foundation provides leadership to prevent new HIV infections. Linking community experience with science, the Foundation develops ground-breaking prevention programs and bold policy initiatives to promote health and create sustainable progress against HIV. Established in 1982, the Foundation refuses to accept that HIV transmission is inevitable.
  o [http://www.sfaf.org/](http://www.sfaf.org/)
LGBT Health Centers and Clinics

**Brady East STD (BESTD) Clinic**
1240 East Brady Street
Milwaukee, WI  53202-1603
Phone: 414-272-2144
Fax: 414-272-6568

Created in 1974, the BESTD Clinic has been a not-for-profit organization serving all people in Milwaukee and surrounding counties. The mission of BESTD Clinic is to provide quality, professional sexually transmitted disease diagnosis and treatment as well as HIV/AIDS prevention counseling and testing in a manner that is sensitive to the sexual orientation and gender identity of our clients. BESTD Clinic provides its services at no cost.


**Callen-Lorde Health Center**
356 West 18th Street
New York, NY 10011
Phone: 212-271-7200

The Callen-Lorde Community Health Center is New York City's only primary health care center dedicated to meeting the health care needs of the lesbian, gay, bisexual and transgender (LGBT) communities and people living with HIV/AIDS -- regardless of any patient's ability to pay.


**Chase Brexton Health Services**
Locations:
Mt. Vernon Center
1001 Cathedral Street
Baltimore, MD 21201
Phone: 410-837-2050

Randallstown Center
8507 Liberty Road
Randallstown, MD 21133
Phone:  410-496-6441

Columbia Center
5500 Knoll North Drive, Suite 370
Columbia, MD 21045
Phone:  410-884-7831

Easton Center
300 Talbot Street
Easton, MD 21601
Phone:  866-260-0412
Chase Brexton Health Services, Inc. is a growth oriented provider of patient-centered interdisciplinary health care for our diverse communities including those individuals who are gay, lesbian, bisexual, and transgender; HIV infected and affected; and all others who face barriers accessing quality health care.  
http://www.chasebrexton.org/index.php?option=com_frontpage&Itemid=1

**Fenway Community Health Center**  
Ansin Building  
1340 Boylston Street  
Boston, MA 02215  
(617) 267-0900

The mission of Fenway Health is to enhance the physical and mental health of its community, which includes those who are gay, lesbian, bisexual, transgender, the people who live and work in our neighborhood, and beyond. Fenway provides high quality, comprehensive health care in a welcoming environment and seeks to improve the overall health of the larger community, locally and nationally, through education and training, policy and advocacy, and research and evaluation.  
http://www.fenwayhealth.org

**Hartford Gay and Lesbian Health Collective**  
1841 Broad Street  
Hartford, CT 06114  
Telephone 860-278-4163

The Hartford Gay and Lesbian Health collective currently provides medical services, support groups, mental health services and health education tailored to the lesbian, gay, bisexual, and transgender communities but serves clients of all genders and gender identities, sexual orientations, ages and ethnicity.  
http://www.hglhc.org/

Howard Brown Health Center  
4025 N. Sheridan Road  
Chicago, IL 60613  
773-388-1600

Howard Brown Health Center is one of the nation’s largest lesbian, gay, bisexual, and transgender (LGBT) healthcare organizations. With an annual budget of over $15 million, the agency serves more than 28,000 adults and youth each year. Its diverse health and social service delivery system focuses around the following programmatic divisions: primary medical care, behavioral health, research, HIV/STD prevention, case management, social services, youth services, elder services, and community initiatives.  
http://www.howardbrown.org

**Los Angeles Gay and Lesbian Community Center**  
McDonald/Wright Building  
1625 N. Schrader Boulevard  
Los Angeles, CA  90028-6213  
323-993-7400
Through its Jeffrey Goodman Special Care Clinic and on-site pharmacy, the LA Gay and Lesbian Center offers free and low-cost health, mental health, HIV/AIDS medical care and HIV/STD testing and prevention.
http://laglc.convio.net/site/PageServer

**Lyon-Martin Health Services**
1748 Market Street Suite 201
San Francisco, CA 94102
415-565-7667

Lyon-Martin provides personalized healthcare and support services to women and transgender people who lack access to quality care because of their sexual or gender identity, regardless of their ability to pay.

Lyon-Martin Health Services is the only free-standing community clinic in California with a specific emphasis on lesbian/bisexual women and transgender health care. Founded in 1979 by a group of medical providers and health activists, Lyon-Martin bridges the gap in sensitive health services available to low-income, uninsured women (primarily lesbians and bisexual women) and transgender people, who have often tended to go longer without routine care because of the difficulty in finding culturally sensitive health providers.
http://www.lyon-martin.org

**Mazzoni Center**
1201 Chestnut St.
Philadelphia, PA 19107
215-563-0652

Mazzoni Center is the only health care provider in the Philadelphia region specifically targeting the unique health care needs of the lesbian, gay, bisexual, and transgender communities. Founded in 1979, it is also the oldest AIDS service organization in the Commonwealth of Pennsylvania, and the fourth-oldest in the nation. As the organization grew and evolved to meet the needs of our constituents, Mazzoni Center has combined HIV/AIDS-related services and health services.

Mazzoni Center provides a range of health care services, including primary medical care, HIV/AIDS care and support services, behavioral health, smoking cessation, as well as prevention education and outreach.
http://www.mazzonicenter.org/index.php

**MetroHealth Medical Center Pride Clinic**
McCafferty Health Center
4242 Lorain Avenue
Cleveland, OH 44113
216-651-3499

Introducing MetroHealth's Pride Clinic at the McCafferty Health Center. It is the first clinic in the region and one of only 12 health centers in country devoted to serving the health needs of the lesbian, gay, bisexual, and transgender community. With specially trained physicians and an open and honest environment, we can provide care that respects your unique health needs. The Pride Clinic is now open, so call for an appointment, and see why this new clinic fills us with so much, well, Pride.
Primary care through physicians able to assist in areas of:

- Prevention
- Disease risk reductions
- STD and HIV screening and treatment
- Management of chronic diseases: hypertension, diabetes, lung disease
- Smoking cessation
- Family planning
- Well child and OB/GYN care
- Specialty and support services

http://www.metrohealth.org/body.cfm?id=2410

Montrose Clinic (Legacy Community Health Services)
215 Westheimer
Houston, TX 77006
713-830-3000

Legacy Community Health Services provides affordable, high quality healthcare to everyone - regardless of your ability to pay. We are committed to serving people of all ages, genders and ethnicities with special attention to your healthcare needs. To meet your everyday health needs, we offer a wide range of primary care services from a dedicated staff of physicians and nurses.

Montrose Clinic provides Men's Health, Women's Health, Transgender Health, Pediatric Services (3+), and Pharmacy Services.

http://www.legacycommunityhealth.org/default.asp?id=111

Whitman Walker Clinic
Elizabeth Taylor Medical Center
1701 14th St., NW (14th and R Streets)
Washington, DC 20009
202-797-3500

Robinson Center
2301 Martin Luther King Jr. Ave., SE
Washington, DC 20020
202-678-8877

Primary medical care, including regular check ups and urgent care for illness, is available to the GLBT community at Whitman-Walker Clinic.

The Behavioral Health Care programs of Whitman-Walker Clinic promote the mental health of gay, lesbian, bisexual and transgender persons, people living with HIV/AIDS and their loved ones, through a wide variety of both professional and peer based services.
The Lesbian Services Program of Whitman-Walker Clinic (LSP) offers a spectrum of supportive, culturally sensitive projects and services designed to address the mental and physical health needs of lesbians, bisexual women and transgender people.

Gay Men's Health and Wellness provides a range of programs that target the physical, mental and social well-being of gay and bisexual men.

Transgender health care is available, including medical and support services.

Health Promotion and Disease Prevention Services promotes safer and healthier behavior through the implementation of diverse HIV prevention programs that provide information, education, training and technical assistance for gay and bisexual men and women.

http://www.wwc.org/

William F. Ryan Community Health Center
Upper West Side:
William F. Ryan Community Health Center
110 West 97th Street (between Columbus and Amsterdam Avenues)
New York, NY 10025

Upper West Side:
Ryan Center Annex
160 West 100th Street (between Columbus and Amsterdam Avenues)
New York, NY 10025

Lower East Side:
Ryan-NENA Community Health Center
279 East 3rd Street (between Avenues C and D)
New York, NY 10009

Midtown West: Ryan/Chelsea-Clinton Community Health Center
645 Tenth Avenue (between 45th and 46th Street)
New York, NY 10036

The William F. Ryan Community Health Network (the Ryan Network) is an independent, not-for-profit organization that delivers high quality, linguistically diverse support and health care services to the community. The Ryan Network is based across 16 sites, including three main health centers, school-based clinics, homeless shelters, two mobile medical vans and outreach services.

http://www.ryancenter.org/welcome.htm

Gender Management Service Clinic
Transgender Clinic
Children’s Hospital Boston
300 Longwood Avenue
Boston, MA 02115
(617) 355-6000
The Gender Management Service (GeMS) Clinic at Children's Hospital Boston, established in 2007, works with male and female infants, children, adolescents and young adults with DSDs.

DSDs, or Disorders of Sexual Differentiation, refer to medical conditions where average sexual development does not occur. DSDs can include genitourinary or hormonal disorders - medical issues that may make it difficult to determine a child's sex or conditions that interfere with a patient's sexual and reproductive function.

Because there is such a wide variety of conditions that fall under DSDs, we work closely with the child and their family members to come up with the most appropriate method of treatment that works best for their specific condition.

In addition to treating DSDs, we care for transgendered children and young adults - patients with no known anatomic or biochemical disorder who feel like a member of the opposite sex.

Such feelings can emerge early, even in the preschool years, and cause significant psychological distress. With a high number of adolescent transgendered patients attempting suicide, we work with them to alleviate their negative feelings and treat medical and psychological issues they may experience.

Professional Medical and Mental Health Organizations

American Academy of Pediatrics (AAP)
Clinical Report: Sexual Orientation and Adolescents
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/6/1827

American Academy of Pediatrics (AAP)
Technical Report: Coparent or Second-Parent Adoption by Same-Sex Parents
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;109/2/341

American Academy of Family Physicians (AAFP)
AAFP Policy: Adolescent Health Care, Sexuality and Contraception

American Medical Association (AMA)
GLBT Advisory Committee webpage:

American Psychological Association (APA)
APA Policy Statement: Discrimination against Homosexuals

American Psychiatric Association
Association of Gay Lesbian Psychiatrists
http://www.aglp.org/

American Medical Student Association (AMSA)
Principles Regarding Sexuality
http://www.amsa.org/about/ppp/sex.cfm

American Medical Student Association (AMSA)
Principles Regarding Gender Identity
http://www.amsa.org/about/ppp/gender.cfm
References:


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18. Joint Commission Expert Advisory Panel on Developing Hospital Standards for Culturally Competent Patient-Centered Care:  
http://www.jointcommission.org/PatientSafety/HLC/hlc_expert_advisory_panel.htm


27. World Professional Association for Transgender Health, Inc.: http://www.wpath.org/


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47. Ibid.

48. Ibid.

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76. McKirnan, D. J., & Peterson, P. L. Alcohol and drug use among homosexual men and women: Epidemiology and population characteristics. *Addictive Behaviors*, 14, 1989, 545-553


79. Ibid.


81. Ibid.


84. Clements, K.; et al. The Transgender Community Health Project: Descriptive Results. San Francisco Department of Public Health, 1999


87. Ibid.

88. Ibid.


92. Howard Brown website: Older Adult Services – Aging As We Are: http://www.howardbrown.org/hb_services.asp?id=456


95. Ibid.