

Readings on Lesbian, Gay, Bisexual, and Transgender Health Recommended for Inclusion in the YSPH Curriculum

Compiled by Out In Public, YSPH's LGBT and ally student group, Spring 2014

As LGBT and allied students, we experience and witness the pervasive marginalization of sexual and gender minorities in our society. While some forms of this marginalization are well known and highly visible – the denial of marriage licenses, intolerant rhetoric in popular media – the full scope of this marginalization and its effects frequently go unrecognized.

In particular, there is a lack of recognition of the unique health challenges and needs of the LGBT population. Institutional discrimination in education, housing, employment, and health care contribute to poverty and directly undermine access to health care services. The quality of health services is weakened by the ignorance, or even animus, of health care providers. Indirectly, the stress of pervasive marginalization, or “minority stress,” is a risk factor for many mental health conditions, substance abuse, and chronic diseases. There is growing evidence of serious health disparities, and this problem requires action.

We believe that public health professionals have a vital role to play in addressing LGBT health issues, and our capacity to do so begins with our education. The Yale School of Public Health can be a leader in an arena frequently overlooked in health professional schools, and build on its commitment to diversity, by including LGBT-specific course content.

In pursuit of this goal, we have compiled this illustrative and non-exhaustive list of readings on LGBT health topics that may be incorporated into our courses. We have organized these readings into several categories, with the goal of presenting possible content for inclusion in a variety of types of courses. We have also included several journals, research centers, and databases that may be useful in finding additional course content. We hope that this list will facilitate greater inclusion of LGBT health issues in the YSPH curriculum.

Table of Contents

Disparities - - - - -	3
Social Determinants - - - - -	6
Law and Policy - - - - -	8
Sexual Health - - - - -	11
Global Health - - - - -	12
Study and Survey Design - - - - -	14
Ethics - - - - -	16
Intersectionality - - - - -	17
Journals, Research Centers, and Datasets - - - - -	18

Disparities

Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S. Usha Ranji, Adara Beamesderfer, Jennifer Kates and Alina Salganicoff. Kaiser Family Foundation, January 8, 2014.
<http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8539-health-and-access-to-careand-coveragefor-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s.pdf>

This issue brief provides an overview of what is known about LGBT health status, coverage, and access in the United States, and reviews the implications of the ACA, the overturning of DOMA, and other recent policy developments for LGBT individuals and their families going forward.

Minority Stress and Physical Health Among Sexual Minorities. David J. Lick, Laura E. Durso, and Kerri L. Johnson. *Perspectives on Psychological Science*, 8(5) 521 –548, September 2013. <http://pps.sagepub.com/content/8/5/521>

Lesbian, gay, and bisexual (LGB) individuals suffer serious mental health disparities relative to their heterosexual peers, and researchers have linked these disparities to difficult social experiences (e.g., antigay victimization) and internalized biases (e.g., internalized homophobia) that arouse stress. A recent and growing body of evidence suggests that LGB individuals also suffer physical health disparities relative to heterosexuals, ranging from poor general health status to increased risk for cancer and heightened diagnoses of cardiovascular disease, asthma, diabetes, and other chronic conditions. Despite recent advances in this literature, the causes of LGB physical health problems remain relatively opaque. In this article, we review empirical findings related to LGB physical health disparities and argue that such disparities are related to the experience of minority stress—that is, stress caused by experiences with antigay stigma. In light of this minority stress model, we highlight gaps in the current literature and outline five research steps necessary for developing a comprehensive knowledge of the social determinants of LGB physical health.

How to Close the LGBT Health Disparities Gap. Jeff Krehely, Center for American Progress, 2009.
<http://www.americanprogress.org/press/release/2009/12/21/14895/how-to-close-the-lgbt-health-disparities-gap/>

This memo will outline the health disparities LGBT populations face, look at why these disparities occur, and examine why we need better data on these populations and what we can do to solve this problem. The indicators show significant disparities in the mental and physical wellbeing of the LGBT population when compared to the heterosexual population. Members of the LGBT population are less likely to have health insurance coverage and more likely to have to resort to visiting emergency rooms for care. They also have higher rates of some diseases, lower rates of testing and screening for certain

illnesses like heart disease, and higher engagement in risky behaviors that can compromise overall health or well-being, such as alcohol and tobacco use.

Sexual Orientation Disparities in Cardiovascular Biomarkers Among Young Adults.

Mark L. Hatzenbuehler, Katie A. McLaughlin, Natalie Slopen. *American Journal of Preventive Medicine*, 44(6):612-21, 2013. <http://www.ncbi.nlm.nih.gov/pubmed/23683979>

BACKGROUND: Emerging evidence from general population studies suggests that lesbian, gay, and bisexual (LGB) adults are more likely to experience adverse cardiovascular outcomes relative to heterosexuals. No studies have examined whether sexual orientation disparities exist in biomarkers of early cardiovascular disease risk.

PURPOSE: To determine whether sexual orientation disparities in biomarkers of early cardiovascular risk are present among young adults.

METHODS: Data come from Wave IV (2008-2009) of the National Longitudinal Study for Adolescent Health (N=12,451), a prospective nationally representative study of U.S. adolescents followed into young adulthood (mean age=28.9 years). A total of 520 respondents identified as lesbian, gay, or bisexual. Biomarkers included C-reactive protein, glycosylated hemoglobin, systolic and diastolic blood pressure, and pulse rate. Analyses were conducted in 2012.

RESULTS: In gender-stratified models adjusted for demographics (age, race/ethnicity); SES (income, education); health behaviors (smoking, regular physical activity, alcohol consumption); and BMI, gay and bisexual men had significant elevations in C-reactive protein, diastolic blood pressure, and pulse rate, compared to heterosexual men. Despite having more risk factors for cardiovascular disease, including smoking, heavy alcohol consumption, and higher BMI, lesbians and bisexual women had lower levels of C-reactive protein than heterosexual women in fully adjusted models.

CONCLUSIONS: Evidence was found for sexual orientation disparities in biomarkers of cardiovascular risk among young adults, particularly in gay and bisexual men. These findings, if confirmed in other studies, suggest that disruptions in core physiologic processes that ultimately confer risk for cardiovascular disease may occur early in the life course for sexual-minority men.

Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.

Jaime M. Grant, Lisa A. Mottet, Justin Tanis. National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.

http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf

This study brings to light what is both patently obvious and far too often dismissed from the human rights agenda. Transgender and gender non-conforming people face injustice at every turn: in childhood homes, in school systems that promise to shelter and educate, in harsh and exclusionary workplaces, at the grocery store, the hotel front desk, in doctors' offices and emergency rooms, before judges and at the hands of landlords, police officers, health care workers and other service providers. The National Gay and Lesbian Task Force and the National Center for Transgender Equality are grateful to each of the

6,450 transgender and gender non-conforming study participants who took the time and energy to answer questions about the depth and breadth of injustice in their lives. A diverse set of people, from all 50 states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands, completed online or paper surveys. This tremendous gift has created the first 360-degree picture of discrimination against transgender and gender non-conforming people in the U.S. and provides critical data points for policymakers, community activists and legal advocates to confront the appalling realities documented here and press the case for equity and justice.

National Transgender Discrimination Survey Report on Health and Health Care.

Jaime M. Grant, Lisa A. Mottet, Justin Tanis. National Center for Transgender Equality and National Gay and Lesbian Task Force, 2010.

http://www.2fwww.thetaskforce.org/downloads/resources_and_tools/ntds_report_on_health.pdf

Summary document of "Injustice at Every Turn," highlighting the findings related to health and health care access for trans and gender non-conforming survey respondents.

Transgender and gender non-conforming people frequently experience discrimination when accessing health care, from disrespect and harassment to violence and outright denial of service. Participants in our study reported barriers to care whether seeking preventive medicine, routine and emergency care, or transgender-related services. These realities, combined with widespread provider ignorance about the health needs of transgender and gender non-conforming people, deter them from seeking and receiving quality health care. Our data consistently show that racial bias presents a significant, additional risk of discrimination for transgender and gender non-conforming people of color in virtually every major area of the study, making their health care access and outcomes dramatically worse.

A Gender Not Listed Here: Genderqueers, Gender Rebels, and Otherwise in the National Transgender Discrimination Survey.

Jack Harrison, Jaime Grant, Jody L. Herman. *LGBTQ Public Policy Journal at the Harvard Kennedy School*, Vol. 2, 2012.

<http://escholarship.org/uc/item/2zj46213>

Genderqueer individuals suffer discrimination and violence at similar, and sometimes even higher rates, than transgender-identified individuals, according to a new study published by the LGBTQ Policy Journal at the Harvard Kennedy School. The findings are based on data from the 2008 National Transgender Discrimination Survey (NTDS), a study undertaken by the National Gay and Lesbian Task Force and the National Center for Transgender Equality, where respondents were allowed to write in their own gender if the predetermined categories did not represent them. While genderqueer respondents fared the same or better than other NTDS respondents by some measures, they notably fared worse by others. As compared to transgender-identified survey respondents, genderqueer were people more likely to: Suffer physical assaults (32% compared to 25%) Survive

sexual assault in K-12 education (16% compared to 11%) Face police harassment (31% compared to 21%) Be unemployed (76% compared to 56%) Avoid healthcare treatment for fear of discrimination (36% compared to 27%).

Social Determinants

Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Ilan H. Meyer. *Psychological Bulletin*, Vol 129(5), September 2003.

<http://psycnet.apa.org/index.cfm?fa=search.displayRecord&uid=2003-99991-002>

In this article the author reviews research evidence on the prevalence of mental disorders in lesbians, gay men, and bisexuals (LGBs) and shows, using meta-analyses, that LGBs have a higher prevalence of mental disorders than heterosexuals. The author offers a conceptual framework for understanding this excess in prevalence of disorder in terms of minority stress--explaining that stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems. The model describes stress processes, including the experience of prejudice events, expectations of rejection, hiding and concealing, internalized homophobia, and ameliorative coping processes. This conceptual framework is the basis for the review of research evidence, suggestions for future research directions, and exploration of public policy implications.

Chronic Illness in Non-heterosexual Contexts: An Online Survey of Experiences.

Adam Jowett and Elizabeth Peel. *Feminism & Psychology*, 19(4), 2009.

<http://fap.sagepub.com/content/19/4/454.full.pdf+html>

In this article we contribute to the expansion of lesbian, gay, bisexual, transgender and queer (LGBTQ) health psychology beyond the confines of sexual health by examining the experiences of lesbian, gay and bisexual people living with non-HIV related chronic illness. Using a (predominantly) qualitative online survey, the perspectives of 190 LGB people with 52 different chronic illnesses from eight countries were collected. The five most commonly reported physical conditions were arthritis, hypertension, diabetes, asthma and chronic fatigue syndrome. Our analysis focuses on four themes within participants' written comments: (1) ableism within LGBT communities; (2) isolation from LGBT communities and other LGB people living with chronic illness; (3) heteronormativity within sources of information and support and; (4) homophobia from healthcare professionals. We conclude by suggesting that LGBTQ psychology could usefully draw on critical health psychology principles and frameworks to explore non-heterosexual's lived experiences of chronic illness, and also that there remains a need for specifically targeted support groups and services for LGB people with chronic illnesses.

Netherland: Homeless in New York, a young gay woman learns to survive. Rachel Aviv. *New Yorker*, December 10, 2012.

http://www.newyorker.com/reporting/2012/12/10/121210fa_fact_aviv

Samantha was sitting on a lawn chair in her parents' garage, smoking a joint, when she decided to run away. She had just graduated from high school, where she had few friends, and felt invisible. She went to class stoned and wrote suicidal poems about the shame of being molested by a family friend: "why try when there is no hope / for my dirty soul there is no soap." The thought of remaining in her home town, in central Florida, made her feel ill. Reclining in her chair in the brightly lit garage, she closed her eyes and thought, Is this going to be my life?

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that is, stress caused by experiences with antigay stigma. In light of this minority stress model, we highlight gaps in the current literature and outline five research steps necessary for developing a comprehensive knowledge of the social determinants of LGB physical health.

Law and Policy

The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study. Mark L. Hatzenbuehler, Katie A. McLaughlin, Katherine M. Keyes, and Deborah S. Hasin. *American Journal of Public Health*, 100(3), March 2010. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2820062/>

Objectives: We examined the relation between living in states that instituted bans on same-sex marriage during the 2004 and 2005 elections and the prevalence of psychiatric morbidity among lesbian, gay, and bisexual (LGB) populations.

Methods: We used data from wave 1 (2001–2002) and wave 2 (2004–2005) of the National Epidemiologic Survey on Alcohol and Related Conditions (N=34653), a longitudinal, nationally representative study of non-institutionalized US adults.

Results: Psychiatric disorders defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, increased significantly between waves 1 and 2 among LGB respondents living in states that banned gay marriage for the following outcomes: any mood disorder (36.6% increase), generalized anxiety disorder (248.2% increase), any alcohol use disorder (41.9% increase), and psychiatric comorbidity (36.3% increase). These psychiatric disorders did not increase significantly among LGB respondents living in states without constitutional amendments. Additionally, we found no evidence for increases of the same magnitude among heterosexuals living in states with constitutional amendments.

Conclusions: Living in states with discriminatory policies may have pernicious consequences for the mental health of LGB populations. These findings lend scientific support to recent efforts to overturn these policies.

U.S. Department of Health and Human Services Recommended Actions to Improve the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Communities. U.S. Department of Health and Human Services, Updated January 2012. <http://www.hhs.gov/lgbt/health.html>

Below is a summary of the efforts taken by the U.S. Department of Health and Human Services (HHS) to improve the lives of lesbian, gay, bisexual and transgender (LGBT) people, as well as recommendations for future action. The recommendations were developed in response to the Presidential Memorandum on Hospital Visitation, which, in addition to addressing the rights of patients to designate visitors regardless of sexual orientation or gender identity, directed the Secretary to explore additional steps HHS could take to improve the lives of LGBT people. For too long, LGBT people have been denied the compassionate services they deserve. That is now changing. HHS continues to make

significant progress toward protecting the rights of every American to access quality care, recognizing that diverse populations have distinctive needs. Safeguarding the health and wellbeing of all Americans requires a commitment to treating all people with respect while being sensitive to their differences.

Bodily Differences and Collective Identities: The Politics of Gender and Race in Biomedical Research in the United States. Steven Epstein, *Body & Society*, 10(2-3) 2004. <http://bod.sagepub.com/content/10/2-3/183.full.pdf+html>

Changes in US biomedical research policies are interesting for many reasons, and they raise important questions of ethics, equity, and social justice. In this article I focus attention on debates that underlie these policy shifts and that concern the medical management of bodies, groups, identities, and differences. My concern here is with how the bodily character and social location of the 'research material' is understood to affect the credibility of medical findings. Whose bodies are we obliged to include when we conduct the experiments that establish our standards of care? When can results from the study of specific individuals or groups be extrapolated credibly to the broader population of patients? When do physicians, researchers, and patients believe that, in effect, 'bodies are bodies', and that medical knowledge generated from one group of patients is transferable to other groups? Alternatively, under what circumstances is it believed that sex/gender and racial and ethnic differences matter in medicine? And in such cases, are these differences conceptualized in biological terms or in social terms, or in some distinctive combination of the two? Finally, are sex/gender, race, and ethnicity treated as medically comparable varieties of differentiation among patients or research subjects, or do actors point to differences among types of difference?

"I Don't Think This Is Theoretical; This Is Our Lives": How Erasure Impacts Health Care for Transgender People. Greta R Bauer, *Journal of the Association of Nurses in AIDS Care*, 20(5), 2009.

<http://www.sciencedirect.com/science/article/pii/S1055329009001071>

For people who are transgender, transsexual, or transitioned (trans), access to primary, emergency, and transition-related health care is often problematic. Results from Phase I of the Trans PULSE Project, a community-based research project in Ontario, Canada, are presented. Based on qualitative data from focus groups with 85 trans community members, a theoretical framework describing how erasure functions to impact experiences interacting with the health care system was developed. Two key sites of erasure were identified: informational erasure and institutional erasure. How these processes work in a mutually reinforcing manner to erase trans individuals and communities and produce a system in which a trans patient or client is seen as an anomaly is shown. Thus, the impetus often falls on trans individuals to attempt to remedy systematic deficiencies. The concept of cisnormativity is introduced to aid in explaining the pervasiveness of trans erasure. Strategies for change are identified.

81 Words: The story of how the American Psychiatric Association decided in 1973 that homosexuality was no longer a mental illness. Chicago Public Media & Ira Glass, This American Life, Episode 204, January 18, 2002. <http://www.thisamericanlife.org/radio-archives/episode/204/81-words>

In 1973, the American Psychiatric Association (APA) declared that homosexuality was not a disease simply by changing the 81-word definition of sexual deviance in its own reference manual. It was a change that attracted a lot of attention at the time, but the story of what led up to that change is one that we hear today, from reporter Alix Spiegel. Part one of Alix's story details the activities of a closeted group of gay psychiatrists within the APA who met in secret and called themselves the GAYPA...and another, even more secret group of gay psychiatrists among the political echelons of the APA. Alix's own grandfather was among these psychiatrists, and the president-elect of the APA at the time of the change. (24 minutes)

Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S. Usha Ranji, Adara Beamesderfer, Jennifer Kates and Alina Salganicoff. Kaiser Family Foundation, January 8, 2014. <http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8539-health-and-access-to-careand-coveragefor-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s.pdf>

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How to Close the LGBT Health Disparities Gap. Jeff Krehely, Center for American Progress, 2009. <http://www.americanprogress.org/press/release/2009/12/21/14895/how-to-close-the-lgbt-health-disparities-gap/>

This memo will outline the health disparities LGBT populations face, look at why these disparities occur, and examine why we need better data on these populations and what we can do to solve this problem. The indicators show significant disparities in the mental and physical wellbeing of the LGBT population when compared to the heterosexual population. Members of the LGBT population are less likely to have health insurance coverage and more likely to have to resort to visiting emergency rooms for care. They also have higher rates of some diseases, lower rates of testing and screening for certain illnesses like heart disease, and higher engagement in risky behaviors that can compromise overall health or well-being, such as alcohol and tobacco use.

Sexual Health

Sexual orientation disparities in sexually transmitted infections: examining the intersection between sexual identity and sexual behavior.

Bethany G. Everett,

Archives of Sexual Behavior, 42(2), February 2013.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3575167/>

The terms MSM (men who have sex with men) and WSW (women who have sex with women) have been used with increasing frequency in the public health literature to examine sexual orientation disparities in sexual health. These categories, however, do not allow researchers to examine potential differences in sexually transmitted infection (STI) risk by sexual orientation identity. Using data from the National Longitudinal Survey of Adolescent Health, this study investigated the relationship between self-reported STIs and both sexual orientation identity and sexual behaviors. Additionally, this study examined the mediating role of victimization and STI risk behaviors on the relationship between sexual orientation and self-reported STIs. STI risk was found to be elevated among heterosexual-WSW and bisexual women, whether they report same-sex partners or not, whereas gay-identified WSW were less likely to report an STI compared to heterosexual women with opposite sex relationships only. Among males, heterosexual-identified MSM did not have a greater likelihood of reporting an STI diagnosis; rather, STI risk was concentrated among gay and bisexual identified men who reported both male and female sexual partners. STI risk behaviors mediated the STI disparities among both males and females, and victimization partially mediated STI disparities among female participants. These results suggest that relying solely on behavior-based categories, such as MSM and WSW, may mischaracterize STI disparities by sexual orientation.

Women Who Have Sex With Women in The United States: Prevalence, Sexual Behavior and Prevalence of Herpes Simplex Virus Type 2 Infection—Results From National Health and Nutrition Examination Survey 2001–2006.

Fujie Xu, Maya R.

Sternberg, and Lauri E. Markowitz. *Sexually Transmitted Diseases*, 37(7), 407-413, July

2010. <http://www.ncbi.nlm.nih.gov/pubmed/20531032>

OBJECTIVES: To estimate the prevalence of same-sex sexual behavior in women in the United States; to describe demographic and behavioral characteristics and the prevalence of herpes simplex virus type 2 (HSV-2) infection.

METHODS: As part of the National Health and Nutrition Examination Surveys during 2001-2006, women aged 18 to 59 years were interviewed about sexual behaviors using audio computer assisted self-interview. Persons aged 14 to 49 years were tested for antibodies to HSV-2.

RESULTS: Among sexually experienced women aged 18 to 59 years, 7.1% (95% confidence interval, 6.1-8.2) reported ever having had sex with a woman (WSW-ever) and 2.7% in the past year. The prevalence of WSW-ever correlated negatively with age, highest (9.4%) in 18 to 29-year-olds and lowest (5.5%) in 50 to 59-year-olds. Among WSW-ever, 52.6% self-identified as heterosexual/straight, 28.3% as bisexual, and 19.1% as

homosexual/lesbian. Among WSW-ever, demographic characteristics were similar but sexual behaviors were different by sexual orientation: 31.3% of heterosexuals, 38.9% of bisexuals, and 12.9% of homosexuals reported first sex at age 14 or younger ($P = 0.005$); the median number of lifetime male partners was 10.8, 17.6, and 2.9, respectively ($P < 0.0001$). Among WSW-ever, the prevalence of HSV-2 was 45.6% in heterosexuals, 35.9% in bisexuals, and 8.2% in homosexuals ($P = 0.001$). In comparison, among women who reported no same-sex partners, the prevalence of HSV-2 was 23.8%.

CONCLUSIONS: In this population-based sample of women, self-reported same-sex behaviors were increasingly more prevalent in younger women. Compared with homosexual WSW-ever and women who reported never having sex with other women, heterosexual or bisexual WSW-ever had higher HSV-2 seroprevalence.

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Global Health

The case for the World Health Organization's Commission on the Social Determinants of Health to address sexual orientation. Carmen Logie. *American Journal of Public Health*, 102(7):1243-6, 2012, <http://www.ncbi.nlm.nih.gov/pubmed/22594723>

The World Health Organization's (WHO's) social determinants of health discussion underscores the need for health equity and social justice. Yet sexual orientation was not addressed within the WHO Commission on the Social Determinants of Health final report *Closing the Gap in a Generation*. This omission of sexual orientation as a social determinant of health stands in stark contrast with a body of evidence that demonstrates that sexual minorities are disproportionately affected by health problems associated with stigma and discrimination, such as mental health disorders. I propose strategies to integrate sexual orientation into the WHO's social determinants of health dialogue. Recognizing sexual orientation as a social determinant of health is an important first step toward health equity for sexual minorities.

Born Free and Equal: Sexual Orientation and Gender Identity in International Human Rights Law. Office of the High Commissioner, UN Human Rights, United Nations, 2012. <http://www.ohchr.org/Documents/Publications/BornFreeAndEqualLowRes.pdf>

The purpose of this booklet is to set out the core obligations that States have towards LGBT persons, and describe how United Nations mechanisms have applied international law in this context. For the past eighteen years, United Nations human rights treaty bodies and special procedures have documented violations of the human rights of LGBT people and analysed State compliance with international human rights law. They have accumulated a body of evidence that shows how individuals are targeted on the basis of their sexual orientation or gender identity, and have issued specific guidance to States. The sections that follow summarize their findings and advice to help States take the necessary steps to meet their fundamental human rights obligations. The booklet is also intended to assist human rights defenders and rights-holders generally to call States to account for breaches of international human rights law.

Are HIV Epidemics among Men Who Have Sex with Men Emerging in the Middle East and North Africa?: A Systematic Review and Data Synthesis.

Ghina Mumtaz, Nahla Hilmi, Willi McFarland, Rachel L. Kaplan, Francisca Ayodeji Akala, Iris Semini, Gabriele Riedner, Oussama Tawil, David Wilson, and Laith J. Abu-Raddad. *PLoS Medicine*, 8(8) August 2011.

<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000444>

Background: Men who have sex with men (MSM) bear a disproportionately higher burden of HIV infection than the general population. MSM in the Middle East and North Africa (MENA) are a largely hidden population because of a prevailing stigma towards this type of sexual behavior, thereby limiting the ability to assess infection transmission patterns among them. It is widely perceived that data are virtually nonexistent on MSM and HIV in this region. The objective of this review was to delineate, for the first time, the evidence on the epidemiology of HIV among MSM in MENA.

Methods and Findings: This was a systematic review of all biological, behavioral, and other related data on HIV and MSM in MENA. Sources of data included PubMed (Medline), international organizations' reports and databases, country-level reports and databases including governmental and nongovernmental organization publications, and various other institutional documents. This review showed that considerable data are available on MSM and HIV in MENA. While HIV prevalence continues at low levels among different MSM groups, HIV epidemics appear to be emerging in at least few countries, with a prevalence reaching up to 28% among certain MSM groups. By 2008, the contribution of MSM transmission to the total HIV notified cases increased and exceeded 25% in several countries. The high levels of risk behavior (4–14 partners on average in the last six months among different MSM populations) and of biomarkers of risks (such as herpes simplex virus type 2 at 3%–54%), the overall low rate of consistent condom use (generally below 25%), the relative frequency of male sex work (20%–76%), and the substantial overlap with heterosexual risk behavior and injecting drug use suggest potential for further spread.

Conclusions: This systematic review and data synthesis indicate that HIV epidemics appear to be emerging among MSM in at least a few MENA countries and could already be in a concentrated state among several MSM groups. There is an urgent need to expand HIV surveillance and access to HIV testing, prevention, and treatment services in a

rapidly narrowing window of opportunity to prevent the worst of HIV transmission among MSM in the Middle East and North Africa.

Study and Survey Design

Gender-Related Measures Overview, The Gender Identity in U.S. Surveillance Group, Williams Institute, February 2013.

<http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/geniuss-group-overview-feb-2013/>

The GenIUSS group (Gender Identity in U.S. Surveillance), convened by the Williams Institute, is a collaboration of scientists, scholars, and transgender leaders dedicated to increasing knowledge about gender-related measurement and promoting the inclusion of these measures on population-based surveys, with particular consideration for publicly-funded data collection efforts. GenIUSS group efforts will result in the creation of recommendations and best practices for gender identity questions and data collection in the near future.

LGBT Identity: A Demographer's Perspective. Gary J. Gates. *Loyola of Los Angeles Law Review* 45, 693, 2012. <http://digitalcommons.lmu.edu/lr/vol45/iss3/2>

In a recent study, Gates estimated that the self-identified lesbian, gay, bisexual, and transgender (LGBT) community makes up 3.8 percent of the American population. The estimate was far lower than many scholars and activists had contended, and it included a relatively high proportion of persons self-identifying as bisexuals. This article responds to two of the central criticisms that arose in the controversy that followed.

First, in response to claims that his estimate did not account for people who are in the closet, Gates describes how demographers might measure the size of the closet. Second, in response to those who either ignored the reported large incidence of bisexuality or misconstrued the meaning of that incidence, Gates considers how varying frameworks for conceptualizing sexual orientation might alter the ratio of lesbian or gay individuals to bisexuals.

This article goes on to offer observations about the challenges and implications that are associated with the varying estimates of the size of the LGBT population. And it concludes by arguing that, today, the size of the LGBT community is less important than understanding the struggles of its members and informing crucial policy debates with facts rather than stereotype and anecdote.

Best Practices for Asking Questions about Sexual Orientation on Surveys. Sexual Minority Assessment Research Team, Williams Institute, November 2009.

<http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/best-practices-for-asking-questions-about-sexual-orientation-on-surveys/>

This report presents the findings from a multi-year effort of an expert panel of scholars, the Sexual Minority Assessment Research Team (SMART), to identify the best practices for asking questions about sexual orientation on surveys.

Researching Gay Men's Health: The Promise of Qualitative Methodology. Gary W. Dowsett, chapter in **The Health of Sexual Minorities**, edited by Ilan Meyer and Mary Northridge. Springer Press, 2007.

The distinction made between experimental and observational studies in health research, with the former seen as truly scientific and the latter as producing less-rigorous evidence, has tended to cluster many qualitative data-gathering techniques into a single category (at the observational end) artificially contrasted to qualitative methodology and assuming some substantive differences. More recent experience has softened this contrast considerably as complex public health problems seem to require new and varied approaches to information gathering and more sophisticated understanding of persons and context. For gay men's health – the focus of this chapter – the advent of the human immunodeficiency virus (HIV) epidemics in many parts of the world proved a significant stimulus in calling forth qualitative methodology to assist in comprehending one of the most complicated public health problems of the modern period. Yet it is important to remember that gay men have health issues other than HIV infection and acquired immunodeficiency syndrome (AIDS), and the discussion below, although referring to HIV/AIDS at times, aims to be applicable to gay men's other health issues as well. Indeed, much of what follows might well apply to lesbian health (or even to transgender or bisexually active people); but the examples used and the argument mounted are most directly focused on gay men (for a critical framework for these issues, see Wilton, 2002).

Third sex, Third gender – Beyond Sexual Dimorphism in Culture and History. Gilbert Herdt. MIT Press, 2012.

<https://repositorio.ufsc.br/bitstream/handle/123456789/3491/herdt.pdf>

Certain individuals in certain times and places transcend the categories of male and female, masculine and feminine, as these have been understood in Western culture since at least the later nineteenth century. The bodies and ontology of such persons diverge from the sexual dimorphism model found in science and society - in the way they conceive their being and/or their social conduct. Furthermore, in some traditions - cultures and/or historical formations - these persons are collectively classified by others in third or multiple cultural-historical categories. As the essays in this volume demonstrate, such persons and categories are more common in the human condition than was once thought.

Making Sense of Sexual Orientation Measures: Findings from a Cognitive Processing Study with Adolescents on Health Survey Questions. S Bryn Austin et al, *Journal of LGBT Health Research*, 3(1), 2007.

http://www.tandfonline.com/doi/abs/10.1300/J463v03n01_07#.Uvaljnewlhl

Objective: To carry out a study using cognitive processing interview methods to explore ways in which adolescents understand sexual orientation questions currently used on epidemiologic surveys. Methods: In-depth, individual interviews were conducted to probe cognitive processes involved in answering four self-report survey questions assessing sexual identity, sexual attraction, and sex of sexual partners. A semi-structured interview guide was used to explore variation in question interpretation, information retrieval patterns and problems, item clarity, valence of reactions to items (positive, negative, neutral), respondent burden, and perceived threat associated with the measures. Thirty adolescents aged 15 to 21 of diverse sexual orientations and race/ethnicities participated in the study, including female, male, and transgender youth. Results: A question on sexual attraction was the most consistently understood and thus was easy for nearly all youth to answer. In contrast, a measure of sexual identity with options heterosexual, bisexual, gay/lesbian, and unsure was the most difficult to answer. Most preferred a sexual identity item that also provided the intermediate options mostly heterosexual and mostly homosexual, which many said reflected their experience of feeling between categories. Participants had varying and inconsistent interpretations of sexual behavior terms, such as sex and sexual intercourse, used in assessing the sex of sexual partners. Conclusion: Differences in understanding could affect interpretation of survey data in important ways. Development of valid measures of sexual orientation will be essential to better monitor health disparities.

Ethics

Gay rights, patient rights: The implications of sexual orientation conversion therapy.

Douglas C. Haldeman, *Professional Psychology: Research and Practice*, 33(3):260–264, June 2002. <http://drdoughaldeman.com/doc/GayRightsPatientRights.pdf>

Therapies designed to change sexual orientation have come under increasing scrutiny from the profession and the public. The proposition that sexual orientation can be changed therapeutically is widely questioned, and there is concern that such therapies reinforce social devaluation of homosexuality and bisexuality. At the same time, conservative religious individuals wish to seek treatment appropriate to them, which may include attempting to change or control sexual orientation. The ethical questions and clinical and social implications of this complex issue are discussed. Guidance to practitioners interested in this issue is offered, including references to policies of the American Psychological Association.

Bodily Differences and Collective Identities: The Politics of Gender and Race in Biomedical Research in the United States. Steven Epstein, *Body & Society*, 10(2-3) 2004. <http://bod.sagepub.com/content/10/2-3/183.full.pdf+html>

These changes in US biomedical research policies are interesting for many reasons, and they raise important questions of ethics, equity, and social justice. In this article I focus attention on debates that underlie these policy shifts and that concern the medical

management of bodies, groups, identities, and differences. My concern here is with how the bodily character and social location of the 'research material' is understood to affect the credibility of medical findings. Whose bodies are we obliged to include when we conduct the experiments that establish our standards of care? When can results from the study of specific individuals or groups be extrapolated credibly to the broader population of patients? When do physicians, researchers, and patients believe that, in effect, 'bodies are bodies', and that medical knowledge generated from one group of patients is transferable to other groups? Alternatively, under what circumstances is it believed that sex/gender and racial and ethnic differences matter in medicine? And in such cases, are these differences conceptualized in biological terms or in social terms, or in some distinctive combination of the two? Finally, are sex/gender, race, and ethnicity treated as medically comparable varieties of differentiation among patients or research subjects, or do actors point to differences among types of difference?

Intersectionality

Who is epidemiologically fathomable in the HIV/AIDS epidemic? Gender, sexuality, and intersectionality in public health. Shari L. Dworkin, *Culture, Health & Sexuality*, 7(6), 2005. <http://www.tandfonline.com/doi/abs/10.1080/13691050500100385>

This paper examines the shifting nature of contemporary epidemiological classifications in the HIV/AIDS epidemic. It first looks at assumptions that guide a discourse of vulnerability and circulate around risk categories. It then examines the underlying emphasis in public health on the popular frame of "vulnerable women" who acquire HIV through heterosexual transmission. Drawing on work on gender, sexuality, and intersectionality, the paper asks why a discourse of vulnerability is infused into discussions of heterosexually - active women's HIV risks but not those pertaining to heterosexually - active men's. The paper then moves to current surveillance categories that are hierarchically and differentially applied to women's and men's risks in the HIV epidemic. Here, the focus is on the way in which contemporary classifications allow for the emergence of the vulnerable heterosexually - active woman while simultaneously constituting lack of fathomability concerning bisexual and lesbian transmission risk. Lastly, theories of intersectionality, are used to examine current research on woman - to - woman transmission, and to suggest future more productive options.

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the credibility of medical findings. Whose bodies are we obliged to include when we conduct the experiments that establish our standards of care? When can results from the study of specific individuals or groups be extrapolated credibly to the broader population of patients? When do physicians, researchers, and patients believe that, in effect, 'bodies are bodies', and that medical knowledge generated from one group of patients is transferable to other groups? Alternatively, under what circumstances is it believed that sex/gender and racial and ethnic differences matter in medicine? And in such cases, are these differences conceptualized in biological terms or in social terms, or in some distinctive combination of the two? Finally, are sex/gender, race, and ethnicity treated as medically comparable varieties of differentiation among patients or research subjects, or do actors point to differences among types of difference?

Is Capitalism a Disease? The Crisis in U.S. Public Health. Richard Levins, Monthly Review, 52(4): 8-33, 2000.

http://archive.monthlyreview.org/index.php/mr/article/view/MR-052-04-2000-08_2

If good health depends on one's capacity to carry out those activities that are necessary and appropriate according to one's station in life, it matters how that station is determined. Those who can determine for themselves what constitutes necessary and desirable activities are clearly different from the people who have that determination made for them. This distinction is clear when an employer negotiates health insurance for his or her employees; for the employer, the cost of the benefits package will always come before what employees may think they need. So health is always a point of contention in class struggle. So is medical and scientific research; knowledge and ignorance are determined, as in all scientific research, by who owns the research industry, who commands the production of knowledge production. There is class struggle in the debates around what kind of research ought to be done. Increasingly, research in the health field is dominated by the pharmaceutical and electronic industries.

Journals, Research Centers, and Datasets

PRISM Data Archive Project, <http://www.icpsr.umich.edu/icpsrweb/FENWAY/datasets/>

The Population Research in Sexual Minority Health (PRISM) Data Archive is a collaborative project of the Center for Population Research in LGBT Health and the Inter-university Consortium for Political and Social Research (ICPSR). The PRISM data archive project is a primary initiative of the Center. PRISM makes high quality datasets useful for analysis of issues affecting sexual and gender minority populations in the United States available researchers, scholars, educators and practitioners.

The Williams Institute (UCLA)

<http://williamsinstitute.law.ucla.edu/category/research/>

The Williams Institute is dedicated to conducting rigorous, independent research on sexual orientation and gender identity law and public policy. A national think tank at UCLA Law, the Williams Institute produces high-quality research with real-world relevance and disseminates it to judges, legislators, policymakers, media and the public.

Center for Population Research in LGBT Health, The Fenway Institute

<http://lgbtpopulationcenter.org/>

Over the past three decades, a growing cadre of scientists has painstakingly built the knowledge base around LGBT health concerns. It is now widely acknowledged that sexual and gender minority groups experience health disparities as a result of multiple socio-cultural factors. Studies have shown that lesbian, gay, bisexual and transgender populations have higher prevalence of life-threatening physical and mental health conditions, experience barriers to health care access, and face substantial threats to quality of life.

The Center for Population Research in LGBT Health supports and stimulates research to fill critical knowledge gaps related to the health of sexual and gender minorities, strengthening the foundation for culturally competent treatment and behavior change models. Our scientific vision is to create an infrastructure that will support the collaborative work of LGBT health researchers and integrate intellectual and methodological expertise in the interdisciplinary fields of LGBT health and population research. We aim for a synergistic increase in productivity as a result. The Center supports the work of collaborating scientists and partner organizations by creating opportunities to meet and plan further research, formalizing a mentorship process for junior scientists, making datasets available for further studies, and creating a platform for ongoing communication and shared projects among the group.

LGBT Health

<http://online.liebertpub.com/loi/lgbt>

LGBT Health is the quarterly peer-reviewed journal dedicated to promoting optimal healthcare for millions of sexual and gender minority persons worldwide by focusing specifically on health while maintaining sufficient breadth to encompass the full range of relevant biopsychosocial and health policy issues. This Journal aims to promote greater awareness of the health concerns particular to each sexual minority population, and to improve availability and delivery of culturally competent healthcare services. LGBT Health also encourages further research and increased funding in this critical but currently underserved domain. The Journal provides a much-needed authoritative source and international forum in all areas pertinent to LGBT health and healthcare services. Contributions from all continents are solicited including Asia and Africa which are currently underrepresented in sex research.

LGBT Health facilitates and supports the efforts of researchers, clinicians, academics, and policymakers to work toward improved health status and healthcare delivery for all segments of the LGBT community and other sexual or gender minorities. Spanning a

broad array of disciplines, the Journal brings together the research, clinical, and health advocacy communities to overcome barriers to healthcare and other current challenges, as well as to expand options for treatment and prevention.

Journal of LGBT Health Research

<http://web.b.ebscohost.com/ehost/detail?sid=e5330a53-1e59-4d0a-903c-ea72ee2fbda6%40sessionmgr115&vid=1&hid=112&bdata=JnNpdGU9ZWVhc3QtbGl2ZQ%3d%3d#db=qth&jid=1GLU>

LGBTQ Public Policy Journal at the Harvard Kennedy School

<http://hksglbtq.com/>

Culture, Health and Sexuality

<http://eds.b.ebscohost.com/eds/detail?sid=ef3818b4-a3d7-431c-b76e-44330b4bfab3%40sessionmgr110&vid=1&hid=115&bdata=JnNpdGU9ZWRzLWxpdmU%3d#db=aph&jid=B70>