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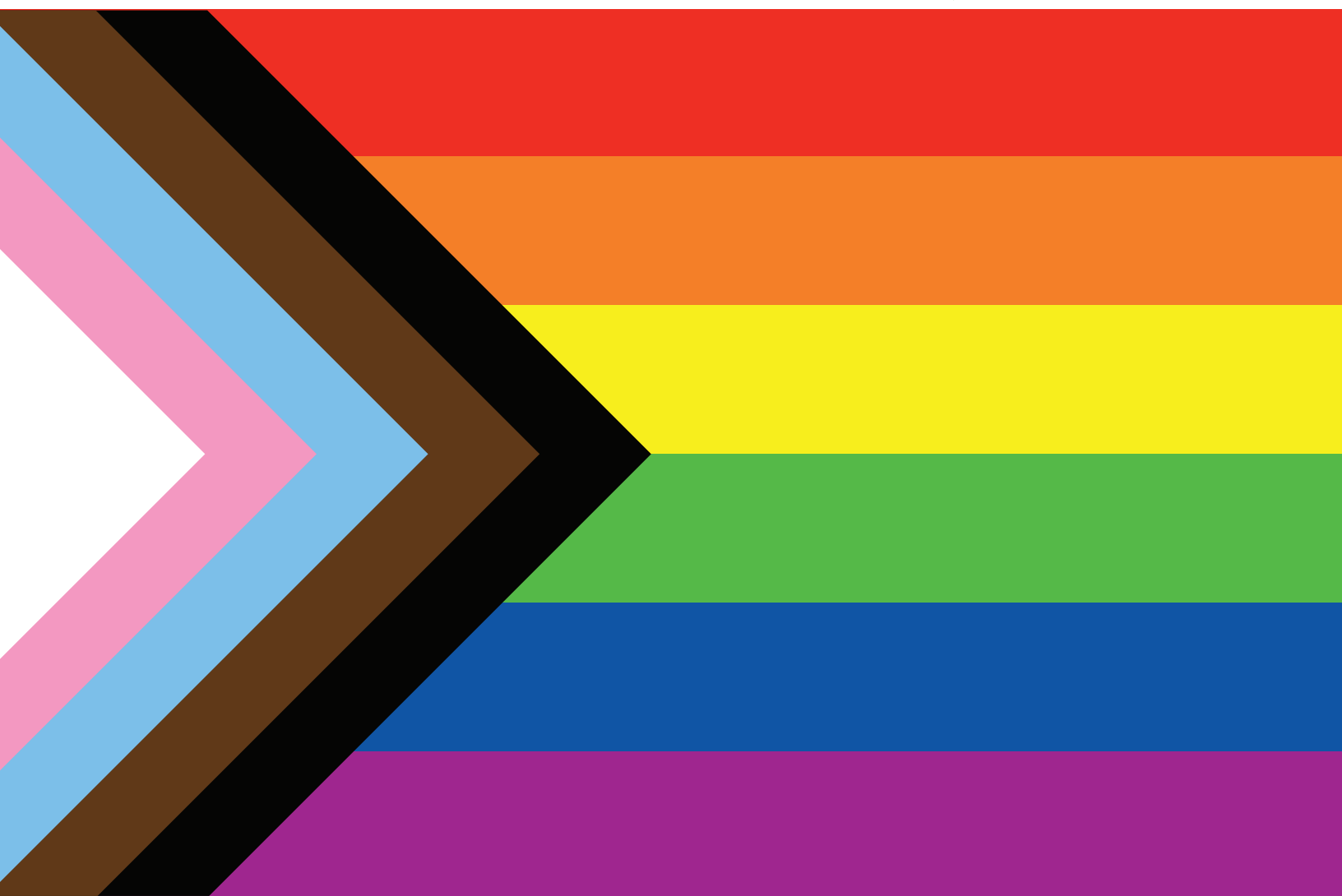
June 2019

Delaware Journal of

Public Health

A publication of the Delaware Academy of Medicine / Delaware Public Health Association

LGBTQ+ Health Equity



Health in the Entire Human Family



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3 | In this Issue

Omar A. Khan, M.D., M.H.S.,
Timothy E. Gibbs, M.P.H.

4 | Guest Editors

Timothy Rodden, M.Div., M.A., B.C.C., F.A.C.H.E.
Anna Filip, M.D.

6 | The Value of Identity: Providing Culturally-Responsive Care for LGBTQ+ Patients Through Inclusive Language and Practices

Christopher Moore, B.A., LSSGB
Catherine Dukes, Ph.D., M.S.W.

10 | Delaware Hospitals and the Healthcare Equality Index since 2011: How do they rate?

Timothy Rodden, M.Div., M.A., B.C.C., F.A.C.H.E.
Tari Hanneman, M.P.A.

12 | Caring for Our Community: Telehealth Interventions as a Promising Practice for Addressing Population Health Disparities of LGBTQ+ Communities in Health Care Settings

Alex Waad, M.A.

18 | Keep Trans Youth Alive: Considerations for Suicide Prevention of Gender Expansive Youth

Elise Mora, L.C.S.W., L.C.G.C.-I

24 | Improved Data Collection for Our LGBTQ Population is Needed to Improve Health Care and Reduce Health Disparities

Karyl T. Rattay, M.D., M.S.

28 | A Mother's Story

Sally McBride

32 | Global Health Matters

Fogarty International Center

46 | Building Resilience, Reducing Risk: Four Pillars to Creating Safer, More Supportive Schools for LGBTQ+ Youth

Rev. Karla Fleshman, L.C.S.W., M.Div.

56 | Part of the Solution to Address Sexual and Gender Minority Health and Health Care Disparities: Inclusive Professional Education

Karla Bell, P.T., D.P.T.

64 | Why Count and Measure?

Justin Glasgow M.D.

68 | The Religious Landscape for LGBTQ+ Persons

The Rev. Dr. Douglas D. Gerdtz, D.Min.

74 | LGBTQ+ Lexicon of Terms

76 | LGBTQ+R esources

80 | Index of Advertisers



COVER

Health and wellness should be universal, but are not. Like the "Progress Pride Flag" shown on this issue's cover, additional differentiation in the LGBTQ community recognizing the uniqueness of its constituent parts allows us to focus on the health opportunities and challenges of those groups.

Designed by Daniel Quasar, the traditional 6 stripe flag is augmented by the trans flag stripes and marginalized community stripes shifted to the hoist of the flag and given a new arrow shape. The arrow points to the right to show forward movement, while being along the left edge shows that progress still needs to be made.

The Delaware Journal of Public Health (DJPH), first published in 2015, is the official journal of the Delaware Academy of Medicine / Delaware Public Health Association (Academy/DPHA).

Submissions: Contributions of original unpublished research, social science analysis, scholarly essays, critical commentaries, departments, and letters to the editor are welcome. Questions? Write chealy@delamed.org or call Liz Healy at 302-733-3989.

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DELAWARE
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IN THIS ISSUE

Fifty years ago, the Stonewall Riots marked a watershed for many people in America, and around the world. In the early morning of June 28, 1969, New York City police raided a gay bar on Christopher Street called the Stonewall Inn. Police raids on gay bars were routine in those days, but this time, patrons fought back. Violent clashes spread out across Greenwich Village over the following days. By the time order was restored, one thing was clear: the LGBT community would no longer tolerate harassment and intimidation.

As lesbian, gay, bisexual, transgender and many more individuals found their own voice, so the medical and public health community adapted, sometimes rapidly, other times slowly, to a segment of society heretofore unheard.

Health equity in the scientific realm starts with visibility, leading to evidence, and action. We join the LGBTQ+ community in solidarity through the visibility this publication brings with guest editors Anna B. Phillip, M.D. and Timothy D. Rodden, M.Div., M.A., B.C.C., F.A.C.H.E. leading the way towards improved evidence. We look to you, our community, to help us translate this into action.

From telehealth interventions to improved data collection; suicide prevention in trans youth to the religious landscape for LGBTQ+ individuals; an interview with Sally McBride (mother of Human Rights Campaign spokesperson Sarah McBride) and much more, we hope you enjoy this issue of the Journal.

As always, we welcome your input and suggestions for future focus areas.

Tim



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Guest Editors

Timothy Rodden, M.Div., M.A., F.A.C.H.E., Director, Pastoral Services and System Coordinator, LGBTQ Health Initiatives, Christiana Care Health System
Anna Filip, M.D., Family Physician, Christiana Care Health System

Throughout history, marginalized communities that are not part of the dominant culture have faced difficulties and challenges. There have been religious, legal, and political forces at work to keep such communities of people on the margins of society through systemic discrimination. The communities of people represented in this issue of the Delaware Journal of Public Health are no different in this regard. Lesbian, gay, bisexual, transgender/gender non-conforming, queer and others are not well represented in our heteronormative and cisgender normative culture and face daily challenges and barriers to achieving optimal health.

These barriers and challenges cause significant health risks for the LGBTQ+ population as seen in national health data (higher suicide rates and lower cancer and preventive health screening rates). Despite this systemic discrimination, the remarkable resiliency of the LGBTQ+ community enables them to thrive in the face of an oftentimes unfriendly welcome in society, and in the institutions that form the foundation of our lives as a larger community. There are many organizations and individuals working to reverse this discrimination and these poor health statistics, and this issue of the DJPH demonstrates the exceptional work many are doing across the state to reverse these trends and support our LGBTQ+ community.

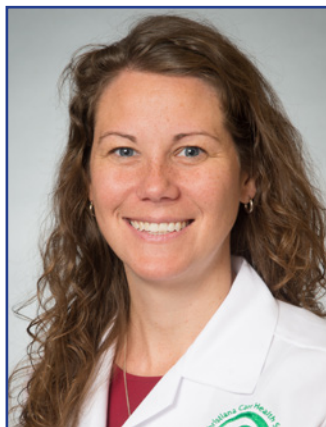
Despite the many challenges in providing safe spaces and high quality healthcare for our LGBTQ+ community, the state of Delaware has made great progress in protecting LGBTQ rights, including passing the Gender Identity Non-Discrimination Act of 2013. Healthcare institutions are no different in this regard, and face the reality that transformation and cultural shifts need to occur so that LGBTQ+ identified people and populations are truly welcomed. Without these changes, health disparities will continue to occur, and optimal health will continue to challenge LGBTQ+ identified populations.

As we look to the future, it is clear we have work to do to continue to support our LGBTQ+ family, friends, neighbors and patients in their health and well-being. In this journal, we hope to highlight the efforts of those working to bring about this much needed change, to outline some of the successes and challenges this vulnerable population faces in their communities and healthcare environments, and to highlight the importance of providing a safe space for patients, regardless of sexuality or gender identity. We also seek to describe resources currently in place to improve on overall well-being, to describe resources needing improvement or development, and to place this into the larger framework of innovation and transformation happening in society and in healthcare to address the unique needs of LGBTQ+ populations.

Strides have been made, but advancements need to continue to occur. As we look to the future to ensure the equitable health and wellbeing for all LGBTQ+ Delawareans, collaboration is essential.



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*Anna Filip, M.D., Family Physician,
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Registration and housing for #APHA2019 are open!
Register now and join us Nov. 2-6, in Philadelphia to learn and network.
www.apha.org/meeting-registration



APHA's 2019 Annual Meeting and Expo takes place Nov. 2-6, in Philadelphia and will bring together nearly 13,000 public health professionals from around the world. APHA 2019 will be filled with engaging sessions, including those that align with the meeting's theme, "Creating the Healthiest Nation: For science. For action. For health." Attendees will learn the latest in research and practice, hear from inspirational keynote speakers, network with their peers, and build skills to advance in their careers. Register now and join us for this celebration of public health. Learn more about APHA 2019 at www.apha.org/annualmeeting.

The Value of Identity: Providing Culturally-Responsive Care for LGBTQ+ Patients Through Inclusive Language and Practices

Christopher Moore, B.A., LSSGB - Christiana Care Health System

Catherine Dukes, Ph.D., M.S.W. - Upstream

INTRODUCTION

The lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) people living in the United States are as diverse as the country itself. These individuals and their families represent every race, ethnicity, faith-based group, physical ability/disability, age and socioeconomic level.¹ In 2018, Gallop reported that 4.5% of American adults identify as lesbian, gay, bisexual or transgender.² Like many at-risk populations, LGBTQ people experience disparities in both the occurrence of certain physical/mental health issues, but also in the manner in which they receive care. The 2011 report, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender Community* published by The Joint Commission, illustrates these disparities for LGBTQ individuals with experiences including: lower overall health status; higher rates of smoking, alcohol, and substance abuse; higher risk for mental health illnesses, such as anxiety and depression; and higher rates of sexually transmitted diseases, including HIV infection.

To complicate this, LGBTQ people face challenges in receiving culturally appropriate healthcare. This may be due to providers and staff not receiving adequate education and training to override any bias or stigma and meet each person's unique needs.¹ The common gaps in training include best practice approaches, identifying needs, providing care for minority and vulnerable populations, and building professional competency around language. This all comes at a critical juncture, where identifying and addressing the healthcare needs of LGBTQ individuals has received increased attention from the Institute for Medicine, Healthy People 2020 and the Agency for Healthcare Research.³ As the landscape of healthcare evolves, so do definitions of gender and orientation; both of which grown well beyond just male/female and straight/gay. It was only a matter of time before this expansion of language would intersect healthcare.

EVOLUTION OF LANGUAGE AND LGBTQ TERMS

Near the third decade of the twenty-first century, a number of advancements have had an impact on healthcare, from technology to pharmaceuticals. Social advancements, too, have had impacts, especially as it relates to LGBTQ persons. Since the 1990s, those 5 letters have evolved in tandem with the progress this community has experienced regarding legal rights and societal acceptance. These letters are meant as an expression of inclusion.⁴ There isn't standard agreement, though, for a definitive list. For example, the "Q" was added around the millennium: some choose to define it as "questioning," representing people who were undecided, or unsure of their orientation. However, others have declared it was for "queer," an umbrella term, repurposed from a pejorative, to represent a segment of this community.⁴ This lack of consensus poses a challenge, as anyone looking for greater understanding may not be able to determine a clear answer on what is currently acceptable. It is important to note, though, that the variance in terms and identities should not be viewed as "right" or "wrong."

Rather, it is important, as www.Medium.com writer Jeffrey J. Iovannone notes, "to encourage critical thinking around language as a vehicle of social change, and to recognize that people do not have to agree on all things to work communally." Language, especially in this context, should not be used to exclude others. One should think critically about the words used to see if they are serving the intended purpose, or creating additional problems.⁵

IMPLICATIONS ON HEALTHCARE DELIVERY

Addressing the health needs of any underrepresented population can present challenges for healthcare providers and systems of care — from messaging and access to staff/provider education and cultural competency. These topics are especially relevant as they have the potential for being barriers to care. Patients who identify as LGBTQ face "delayed or substandard care, mistreatment, inequitable policies and practices, little or no inclusion in health outreach or education, and inappropriate restrictions or limits on visitation."⁶ These inequalities are likely to be more prevalent for LGBTQ persons from racial/ethnic minorities or in relation to "education level, income, geographic location, language, immigration status, and cultural beliefs."⁷ LGBTQ persons who experience discrimination and mistreatment are more likely to not trust health care systems and be less likely to seek treatment for medical issues.⁸ The key in building equity in healthcare starts with education around language, making all of this work education. The most cited barrier [to introducing LGBT education for staff] was perceived lack of need.⁹ One of the rewards of cultural competence in health care is physician [or staff] self-reported increases in confidence and comfort in delivering care for LGBTQ patients.¹⁰

By embracing the truth that there is always room to grow and improve, we have the opportunity to build a greater capacity to educate — both staff and clinicians, as well as our patients. The yield from increased education could be immeasurable.

BEST PRACTICE CARE

Key aspects of best practice care must reach well beyond healthcare provider skills. Due to lack of readiness for the nation's LGBTQ+ citizens, medical providers serving this population must work to remove existing barriers to healthcare; these include not just fear of discrimination resulting in delayed healthcare but actual discrimination, including but not limited to provider bias, lack of inclusiveness of body or gender representation, misdiagnosis, and reliance on prevailing stereotypes or myths about LGBTQ+ patients.¹¹

WELCOMING-ENVIRONMENT LANGUAGE

What do our patients see and read upon walking in? How do they experience their healthcare provider on the phone? Through their website text? What is their experience during the first office interaction with scheduling and asking questions? Are there inclusive bathrooms with signage posted? Checking the language related to these areas with an LGBTQ+ lens is a critical piece to assess when striving to make LGBTQ+ patients feel welcome and safe.

Who are the best consultants to give that guidance? LGBTQ+ community members themselves. Thoughtful inclusion of community members to guide the welcoming language process is critical, and paying them for their time and expertise is a baseline of respect. Showing that their work is valued will truly allow more patients to come through the door. Key areas to review in this venture are websites; internally and externally (community / vendor) displayed information, magazines and brochures; pictures; bathrooms and bathroom signage; and non-discrimination policies with language inclusive of LGBTQ+ displayed prominently. Other aspects of creating a welcoming environment regarding wording certainly involve provider knowledge and skills but those aspects will be covered in the next section. Providers who truly want to make their offices and practices “welcoming” need to consult with and pay for the expertise of those they want to serve.^{11,12}

LANGUAGE GUIDELINES FOR FORMS & PATIENT-PROVIDER INTERACTIONS (GLMA)

When LGBTQ+ individuals come in to a practice for the first time, an intake form can often give them a good picture of how inclusive and safe the medical practice is. Forms need to allow for the flexibility of human gender identity and expression, and allow for a great diversity of relationships and experiences. Some examples include using “gender ____ (write in)” instead of “male ____ female ____” and “parent 1 _____ parent 2 _____”, etc. instead of “mother / father.”¹¹

Sample language guidelines for forms include:

- “You” or “They” instead of “him/her,”
- “Transgender” gender boxes on a form as well as “male/female,” or using a fill-in-the-blank,
- “Relationship status” instead of “marital status.” Add options like “partnered” and change “husband / wife” to “spouse,”
- For sexual and/or romantic relations use terms like “partner” or “significant other” instead of boyfriend, girlfriend, husband, wife.

For patient-provider interactions, create a safe and inclusive space to discuss sexual history and health by assuring all patients of confidentiality, and also explaining the rationale for the questions being asked.

More tips about patient-provider interactions include:

- Use correct affirming pronouns and names¹³
- Check the form and/or please ask. Those who have usually been marginalized or excluded will notice the effort.
- Mistakes: Were the wrong pronouns used? Apologize with a quick sincere apology meant to address the mistake. Invest in a culture where making mistakes and learning from them is welcome.
- Do not use language which assumes or stereotypes which sexual behaviors go with which bodies and identities. Not all gay men have anal sex. Not all lesbians use phallic sex toys.
- When discussing condoms, barriers, and/or birth control, avoid language which assumes heterosexuality or which may be irrelevant. Asking about partners and bodies will lead to better, more accurate information. Using open-ended questions may avoid accidents

- What if name and gender do not match in the records? For some LGBTQ+ patients who have changed their names and/or may be transgender, some issues with insurance and payment of services can get complicated. Some essential procedures may even be denied (i.e. prostate exams for a patient listed as female). Show empathy by doing everything possible to resolve this issue. In cases where a patient’s name does not match between documents, inquire with open questions like “could the insurance perhaps be listed under a different name?” Avoid asking a person what their “real name” is: “This could imply that you do not acknowledge their [affirming] name as “real.”¹³
- Avoid asking unnecessary questions¹³
- Use the patient’s language and terminology when discussing behaviors and partners during sexual-history taking. Clarify and definitions or meanings to avoid assumptions.
- Do not label a patient based on their stated behaviors. Just because a patient has noted they have sex with men and women does not mean that they identify as bisexual, gay or even straight. Behavior is not the same thing as identity.

LANGUAGE SKILLS - TRAINING

Training is fundamental. But a “one and done” approach will not suffice. Training for language to better serve LGBTQ+ individuals requires time and engagement. Initial training, ongoing training, booster trainings and meaningful assessment of training skills and concepts are critical pieces of the training process if a provider or practice wants to make good on its promise to be a welcoming place for LGBTQ+ patients. Further, training every level of the organization in the concepts, knowledge, empathy, and sensitivity towards this group of people is essential to an organization that promotes itself as an LGBTQ+ welcome practice.¹³ Front line staff must have training in using the proper language, pronouns and terms, showing empathy, and avoiding stereotypes.¹¹

All clinical staff, including front line and phone support staff, should use scripts and questions in a way that does not assume gender identity or orientation (e.g. even if a voice sounds feminine or masculine on the phone, female or male pronouns should not be used, and stereotypes should not be assumed). As previously noted, the LGBTQ+ community has experienced significant barriers to accessing welcoming comprehensive medical care. The training aspect of a program must be emphasized, and delivered in a quality manner. A one-hour LGBTQ+ 101, once or twice a year, will in no way suffice. With employee turnover and the constant evolution of affirming and accurate LGBTQ language, providers must commit to consistent quality training evaluation and adaptation in order to be current, relevant and effective. A provider’s medical care skills for the LGBTQ+ population will be measured by the quality of care given by the least-trained staff person. If quality LGBTQ training is not available within an organization, providers can reach out to sexuality training experts in their community to create a robust program.

CONCLUSION

There is significant value in understanding the impact of language regarding sexual and gender identity and orientation. It is critical to provide accurate, up-to-date education for all members of the healthcare community in order to understand importance of adopting nuanced language to affirm an individual’s gender, or sexuality. Doing so builds equity, and provides a safe space for LGBTQ patients to receive the quality care they deserve.

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LIST OF IDENTITIES

L = Lesbian – A female-identified person who is attracted romantically, physically, and/or emotionally to female-identified people.

G = Gay – A male-identified person who is attracted romantically, physically, and/or emotionally to male-identified people.

B = Bisexual – A person who is attracted romantically, physically, and/or emotionally to both male-identified and female-identified people. Another term, Pansexual, refers to being attracted to persons across the entire gender spectrum.

T = Transgender – A person who identifies as a member of a gender other than that expected based on sex assigned at birth.

Q = Queer – Historically, this term has been derogatory and hurtful, however, many people who do not adhere to sexual and/or gender norms are now using it to self identify in a positive way. Queer is an umbrella term which embraces a variety of sexual identities, orientations, and behaviors of those who do not adhere to the heterosexual.

Q = Questioning – a person who identifies as questioning has not committed to a specific identity, but is not ruling out at least some of the non-heterosexual, non-cis-gender identities which exist

I = Intersex – Someone whose physical sex characteristics, hormones and/or chromosomes are not categorized as exclusively male or exclusively female.

A = Asexual – A person who may not be attracted to anyone, or a person who does not identify as having a sexual orientation.

A = A-Gender – A-Gender individuals find that they have no gender identity, although some define this more as having a gender identity that is neutral.

A = Ally – A person who may not identify as LGBTQ+ (or regardless of identity), but supports the rights and safety of those who do.

“+” = This plus sign is meant to signify the wide range of evolving identities and terms which help people accurately and authentically define themselves.

Dukes, C., Moore, C. (2018). Who’s at the water cooler? Orientation: Teaching About Identity, Volume 2. Center for Sexuality Education.

Source Materials available through Advocates for Youth and the Tahoe Safe Alliance web sites:

<http://www.advocatesforyouth.org/publications/607-glossary>

<http://tahoesealliance.org/for-lgbtqia/what-does-lgbtqia-mean/Scenario #1>

See also: <http://www.guidetogender.com/>

The DPH Bulletin

From the Delaware Division of Public Health

June 2019



During Lyme Disease Awareness Week (May 19-25, 2019), the Division of Public Health (DPH) presented tick bite prevention trail signs to the Town of Milton in Milton Memorial Park. From left: Milton Public Works Director Greg Wingo, Representative Steve Smyk, DPH Director Dr. Karyl Rattay, and Milton Mayor Ted Kanakos. DPH is providing the signs to all municipalities and parks while supplies last; call 302-744-4930.

Avoid tick bites to prevent the ill health effects of Lyme disease

Lyme disease is frequently characterized by an expanding red rash, commonly referred to as a “bull’s eye rash.” Rashes can occur anywhere on the body and vary in size and shape. Other symptoms can include fever and or chills, fatigue, muscle and joint aches, and headaches.

In 2018, DPH reported 520 confirmed and probable cases of Lyme disease. Blacklegged or deer tick bites transmit the bacterium *Borrelia burgdorferi* and *B. mayonii* which cause Lyme disease.

DPH recommends preventing tick bites by following the “BLAST” steps: **B**athe or shower within two hours of coming indoors; **L**ook for ticks on your body and remove them; **A**pply repellent to your body and clothes; **S**pray your yard; and **T**reat your pet with a veterinarian-approved medicine that kills ticks.

DPH is providing educational presentations to camps, schools, and other organizations. Call DPH at 1-888-295-5156. At [De.gov/lyme](https://de.gov/lyme), medical providers can access webinars with free Continuing Education Units, children can learn about Lyme disease on the “Kid’s Korner,” and adults can find detailed tick removal instructions and a printable poster of common symptoms. Parks and municipalities can receive free poly-vinyl tick bite prevention trail signs from DPH while supplies last; call 302-744-4930 to order.

Prepare for dangerous summer heat

Extreme heat and high humidity can lead to life-threatening heat disorders. At risk are older adults, young children, urban residents, those with chronic health conditions, and those who are overweight. The Federal Emergency Management Agency and the Ready Campaign provide these precautions:

- Limit exposure to the sun by staying indoors and avoiding strenuous work. When working outside in extreme heat, use a buddy system and take frequent breaks. Wear sunscreen, light-colored clothing, and a wide-brimmed hat.
- Never leave children or pets alone in closed vehicles even with the air conditioning on.
- Drink plenty of water, even when not thirsty. Keep water for pets and livestock filled and fresh. Avoid drinks with caffeine; limit alcoholic beverages. Eat well-balanced, light, and regular meals.
- Circulate air for cooling. Install window air conditioners snugly and insulate them.
- Weather-strip doors and sills to keep cool air in.
- Cover windows with drapes, shades, awnings, or louvers.
- Get trained in first aid to learn how to treat heat-related emergencies. Check on family, friends, and neighbors who do not have air conditioning and who spend much of their time alone.

Listen to local weather forecasts often. For critical National Weather Service updates, visit <https://www.weather.gov/safety/heat>, [Ready.gov](https://www.ready.gov), or the Spanish-language website [Listo.gov](https://www.listo.gov), or listen to a National Oceanic and Atmospheric Administration Weather Radio. If your home loses power during a heat wave, go to a designated public shelter. Text SHELTER + your ZIP code to 43362 (4FEMA) to find the nearest shelter in your area (example: shelter 12345) and listen to local officials.



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Delaware Hospitals and the Healthcare Equality Index since 2011: How do they rate?

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Tari Hanneman, M.P.A.; Director, Health Equity Project, Human Rights Campaign

The Healthcare Equality Index (HEI) published by the Human Rights Campaign Foundation is the national LGBTQ benchmarking tool that evaluates healthcare facilities' policies and practices related to the equity and inclusion of their LGBTQ patients, visitors and employees. The HEI 2018 evaluated more than 1,600 healthcare facilities nationwide.¹

Delaware hospitals have participated in the HEI since 2011. The following provides a snapshot by year of the active participation and results of Delaware hospitals in this annual survey (see Table 1).

Beginning in 2011, the HEI awarded the "Leader in LGBT Healthcare Equality" designation to hospitals that met the following criteria:

- have both sexual orientation and gender identity identified in the patients' bill of rights/non-discrimination policy;
- have explicitly inclusive visitation policy granting equal access for same-sex couples and for same-sex parents;
- LGBT cultural competency training for key leaders and personnel; and
- have sexual orientation and gender identity in the equal employment opportunity policy.

In 2011, Christiana Care Christiana Hospital and Christiana Care Wilmington Hospital were the first two hospitals to participate in the HEI. Both hospitals achieved the designation of "Leader in LGBT Healthcare Equality in 2012." They maintained their leader status in 2013, and were joined by Beebe Healthcare and Nemours/Alfred I. duPont Hospital for Children in 2014.

There was a concerted effort on the part of the United Way of Delaware's PRIDE Council's LGBTQ Health Equity Task Force to visit the Delaware hospitals not participating in the survey in 2014. Information about the HEI survey as an organizing tool for working toward providing equitable care to LGBTQ+ Delawareans and for LGBTQ+ workforce inclusion was provided to key leaders in the five non-participating hospitals. As a result of this organizing effort, four out of the five hospitals participated in the 2016 HEI, which led to 8 out of the 9 hospitals in Delaware achieving Leader status.

The 2017 HEI survey saw a rising of the bar, with a shift to a more comprehensive and demanding survey that scored facilities on their

LGBTQ-inclusive policies and practices. A score of 100 allowed a hospital to have the designation "Leader in LGBTQ Healthcare Equality". Facilities receiving between 80-95 points were deemed "Top Performers."

Criteria 1 – includes the Non-Discrimination and Staff Training requirements from previous surveys (40 points)

Criteria 2 – covers Patient Services and Support: LGBTQ patient services and support; transgender patient services and support; patient self-identification; and medical decision-making (30 points)

Criteria 3 – covers Employee Benefits and Policies (20 points)

Criteria 4 – covers Patient and Community Engagement (10 points)

Christiana Care Christiana Hospital and Christiana Care Wilmington Hospital were the two Delaware facilities that achieved a score of 100 and attained Leader in LGBTQ Healthcare Equality status. Bayhealth Kent General Hospital, Bayhealth Milford Memorial Hospital, and Nemours/Alfred I. duPont Hospital for Children were in the Top Performer category with 80 points each. Beebe Health received 75 points.

2018 Leaders in LGBTQ Healthcare Equality: Bayhealth Kent General Hospital, Bayhealth Milford Memorial Hospital, Christiana Care Christiana Hospital, Christiana Care Wilmington Hospital, and Nemours/Alfred I. duPont Hospital for Children achieved a score of 100. Beebe Healthcare achieved 75 points.

2019 Healthcare Equality Index is due to be published in the summer of 2019. New to the HEI this year was the additional requirement that participants will be required to have at least one firm-wide employee health insurance plan that affirmatively provides transgender-inclusive coverage to receive a score of 100 in the HEI and obtain the "LGBTQ Healthcare Equality Leader" designation.

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Table 1. Participation In and Results for Healthcare Equality Index by Delaware Hospitals Since 2011.

Year	Participation in HEI	Leader in LGBT Healthcare Equality Status (added 2012)	Top Performer Status (added 2017)
2011	CH, WH		
2012	CH, WH	CH, WH	
2013	CH, WH	CH, WH	
2014	BH, CH, WH, NAIDHC	BH, CH, WH, NAIDHC	
2015/ 2016	KG, MMH, BH, CH, WH, NMH, NAIDHC, VA	KG, MMH, BH, CH, WH, NMH, NAIDHC, VA	
2017	KG, MMH, BH, CH, WH, NMH, NAIDHC, VA	CH, WH	KG, MMH, NAIDHC
2018	KG, MMH, BH, CH, WH, NMH, NAIDHC, VA	KG, MMH, CH, WH, NAIDHC	BH
CH - Christiana Hospital (CCHS), WH - Wilmington Hospital (CCHS), KG - Kent General Hospital (Bayhealth), MMH - Milford Memorial Hospital (Bayhealth), BH - Beebe Hospital (Beebe), NMH - Nanticoke Memorial Hospital (Nanticoke), NAIDHC (Nemours/Alfred I. duPont Hospital for Children), VA - Veteran's Association (Wilmington)			

Announcing the Long-Term Care Equality Index

www.thelei.org

SAGE, the world's largest and oldest organization dedicated to improving the lives of LGBT older people, and the Human Rights Campaign Foundation (HRCF), the educational arm of the nation's largest civil rights organization working to achieve equality for LGBT people, are joining forces to address these issues by launching the Long-Term Care Equality Index (LEI) to promote equitable and inclusive care for LGBT older people in residential long-term care communities.

The left screenshot shows the SAGE website with a blue header and a rainbow banner. The main content area features a photo of two elderly men sitting in armchairs. Below the photo is a call to action: 'Ensure LGBT history is never forgotten' and 'SAGE and StoryCorps are asking people to record personal stories of LGBT elders.' with a 'LEARN MORE' button. The right screenshot shows the 'Stonewall's 50th Anniversary' page with a blue header and a photo of a group of people celebrating. Below the photo is a call to action: 'Celebrating the Stonewall Generation' and 'Honor LGBT pioneers by supporting SAGE during the 50th anniversary of Stonewall.' with a 'GIVE NOW' button.

WHY THE LONG-TERM CARE EQUALITY INDEX?

DEMOGRAPHICS

There are currently between 1.5 and 3.8 million adults over the age of 65 in the United States who identify as lesbian, gay, or bisexual (LGB) and this number is projected to double by 2030.² According to the 2010 census report, 99.3% of counties in the U.S. are home to LGB individuals, and estimates from The Williams Institute indicate that there are hundreds of thousands of older adults who are transgender.³

While older lesbian, gay, bisexual and transgender (LGBT) adults confront the same issues everyone else does when choosing aging services — where to live, how

to afford rising costs of housing and healthcare, and how to stay with loved ones — the reality of life in long-term care for LGBT people can be drastically different from their non-LGBT peers. Stigmatization, lack of identity-affirming treatment and experiences of discrimination and violence can lead to avoiding necessary services, chronic stress and increased social isolation among LGBT older adults. Additionally, approximately 20 percent of LGBT older adults are people of color who as a group face increased health disparities, higher levels of stigma and have experienced more LGBT-related discrimination than their white counterparts, leaving them more at risk of not seeking or receiving the services they need.

CONCERNS OF LGBT OLDER ADULTS REGARDING LONG-TERM SERVICES AND SUPPORT

A recent national survey of LGBT older adults by AARP found that more than 60 percent of those surveyed were concerned about how they would be treated in a long-term care setting, including fear that they might be refused or receive limited care; be in danger of neglect or abuse; or face verbal or physical harassment, and being forced to hide or deny their identity once again.⁴ Many of today's LGBT elders, particularly those who have faced severe prejudice in their lives, have chosen to remain closeted to service providers. This in turn often leads to service providers that do not realize that they are serving LGBT individuals, so they don't take measures to make their facilities LGBT inclusive. The AARP survey found that more than 82 percent of respondents would be more comfortable if long-term care communities took actions to intentionally affirm LGBT adults.

“WITHIN THE NEXT TWO WEEKS I WILL BE GOING INTO ASSISTED LIVING. DUE TO MY FINANCIAL SITUATION, I WILL HAVE TO SHARE A ROOM WITH ANOTHER MAN. THE THOUGHT OF GOING BACK INTO A CLOSET IS MAKING ME ILL. FRANKLY, I'M AFRAID OF TELLING ANYONE THAT I'M GAY.”

—Anonymous, 73 years old, Sylmar, CA

60%+ of LGBT Older Adults are concerned about how they will be treated in long-term care settings (over)

responsive care to LGBT older adults. More than just an assessment, the LEI will provide resources and technical assistance to bring these policies and practices to life.

An exploratory study by the Human Rights Campaign Foundation and SAGE revealed that there is great interest by aging-services providers to participate in the Long-Term Care Equality Index initiatives. Participating aging service providers will benefit by:

- Learning best practices for LGBT equity and inclusion;
- Access to quality training and education;
- Gaining assistance with meeting state and federal regulatory requirements, including the new CMS Phase III Requirements of Participation;
- Improved ability to develop culturally appropriate marketing for future staff, clients, and funders; and
- Public recognition as a leading provider of LGBT welcoming services.

Residential Long-Term Care service providers that are interested in participating in the Long-Term Care Equality Index are invited to take the first step by signing the Commitment to Caring Pledge.

Learn more at theLEI.org

1. Gallup 2017
2. SAGE (Education and Advocacy for LGBT Elders) and AARP (National Aging and Advocacy Project) 2015. Regarding the lives of LGBT older adults.
3. Flores, A.D., Herman, J.L., Glick, G.L. & Brown, T.W. (2015) How Many Adults Identify as Transgender in the United States? Los Angeles, CA: The Williams Institute.
4. Houghton, Angela. Marketing Equity: Understanding and Responding to the Challenge of Aging Older LGBT Americans. Washington, DC: AARP Press, March 2016.

To be released in 2021, the LEI will encourage and help long-term care communities to adopt policies and best practices that provide culturally competent and responsive care to LGBT older adults. More than just an assessment, the LEI will provide resources and technical assistance to bring these policies and practices to life.

For information about the issues that LGBTQ older people face follow this link to a two page summary. [Why the LEI?](http://www.thelei.org) (excerpted from www.thelei.org website)

Caring for Our Community: Telehealth Interventions as a Promising Practice for Addressing Population Health Disparities of LGBTQ+ Communities in Health Care Settings

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ABSTRACT

While the United States has seen social and policy-based progress in the past two decades, the divisive political climate in the United States toward LGBTQ+ individuals highlights the prevalence of homophobia and transphobia that continues to harm and marginalize these communities. Within the context of health care, LGBTQ+ individuals face discrimination and mistreatment, further perpetuating a community narrative of mistrust in the health care system at large. Despite well-documented evidence of population-specific health needs and risks, LGBTQ+ individuals report less utilization of primary care than their heterosexual and cisgender counterparts. Initial studies of LGBTQ+ individuals' engagement in telehealth interventions have largely focused within the realm of mental and behavioral health. Utilizing tenants and results seen in previous studies conducted regarding LGBTQ+ individual engagement with mental and behavioral telehealth interventions, this article explores the potential of utilizing telehealth as an interventional tool for addressing LGBTQ+ health disparities and reduced engagement within a primary care setting. Taking into consideration cost, geographic diversity, and implementation concerns, telehealth targeted toward LGBTQ+ individuals in a primary care setting could prove to be an effective method for reaching more LGBTQ+ individuals and providing them with population-specific, culturally-competent care.

INTRODUCTION

Within the first two years of the 45th presidential administration in the United States, policy rollbacks and prevalence of hate speech directed toward marginalized communities have contributed to a fearful environment for many.^{1,2} The LGBTQ+ (lesbian, gay, bisexual, transgender, and queer +) communities have been some of the groups heavily affected, with many community members reporting increased emotional distress and anti-LGBTQ+ harassment.³⁻⁵ Prior to the 45th presidential administration, robust narratives existed that described LGBTQ+ people's negative interactions with health care environments. One of the most prominent components of reported negative interactions with health care includes the need to "come out" to providers and the related fear of rejection or negative treatment by providers.⁶⁻¹³ While efforts have been made to create clearer pathways to help patients identify LGBTQ+-competent practitioners, access to said providers still proves a barrier to patients.

Use of telehealth technologies by LGBTQ+-competent providers could reduce barriers to access in geographic regions where availability of culturally competent providers is scarce. Initial reports of telehealth use by LGBTQ+ individuals for behavioral health concerns positions its use in a physical health environment to be a promising practice.^{8,14} Through use of telehealth interventions targeting LGBTQ+ patients, providers may be able to reach patient populations that would otherwise not have access to the care they need or avoid pursuing care in fear of mistreatment and neglect.

REVIEW OF LGBTQ+ HEALTH CONCERNS

LGBTQ+ individuals present a unique set of physical and behavioral health concerns. There is well-documented evidence of higher rates of coronary heart disease, asthma, and chronic inflammation among LGBTQ+ individuals in comparison with heterosexual and cisgender individuals.¹⁵⁻²³ Research further parses out health disparities that exist among gay-identifying individuals reporting higher rates of

disordered eating, human papillomavirus (HPV), and anal cancer in comparison with their heterosexual counterparts. Lesbian-identifying individuals report higher rates of obesity, breast cancer, and cardiovascular disease in comparison with straight women. In addition to unique health needs of transgender individuals pursuing gender-affirming procedures, transgender individuals in a health care environment provide powerful narratives of neglect and exploitation by providers.^{13,24} In addition to subpopulation-specific experiences, a commonality among subpopulations of the LGBTQ+ community are high reports of mental health concerns.

While significant societal progress has been made around LGBTQ+ activism and inclusive public policies, the sociopolitical climate for LGBTQ+ individuals in the United States remains precarious, and varies by geographic region. With a great deal of prejudice still in existence in the United States toward LGBTQ+ individuals, it should come as no surprise that the emotional microcosm that results places a great deal of mental stress on LGBTQ+ individuals. LGBTQ+ individuals report higher rates of depression, suicidal ideation, anxiety, self-harm behavior, and disordered eating.^{9,18-20,22,23} Following an alarming spike in LGBTQ+ suicides in 2010, digital resources such as suicide hotlines targeting LGBTQ+ youth began gaining public attention.^{25,26} Within the realm of behavioral health and mental health services, telehealth interventions have proven an effective strategy for outreach to LGBTQ+ individuals.^{8,14} However, minimal research has been done on the utility of telehealth services within a physical health setting, specifically for LGBTQ+ individuals.

TELEHEALTH INTERVENTIONS WITHIN BEHAVIORAL & MENTAL HEALTH

Telehealth refers to technologically mediated health services that allow users to interact with various health care providers via computer or smartphone video services.²⁷ By meeting with patients through digitally-mediated technology, providers are able to reduce patient wait time, reduce costs incurred by patients, and reach a

wider patient population who may not have access to a physical care environment. The convenience and accessibility of telehealth services are certainly a major draw to this intervention; however, for LGBTQ+ patients, telehealth services could potentially address some of the keystone issues that prevent LGBTQ+ patients from accessing care.

Numerous studies have been conducted regarding LGBTQ+ individuals' engagement with telehealth interventions as they pertain to mental and behavioral health.^{28–30} Overarching trends from these studies elucidate the helpfulness of having interventions that specifically address LGBTQ+ needs, in addition to taking the guesswork out of finding a provider who will understand LGBTQ+-related issues. A particular area of interest has been outreach to LGBTQ+ individuals in rural locations.^{31–33} In addition to the increased stigma of being an LGBTQ+-identified person in a rural setting, the problem is compounded with the additional barrier of access to LGBTQ+-friendly health care providers.^{34,35} By providing rural LGBTQ+ individuals with access that is anonymous and confidential, patients are able to protect their safety in potentially hostile environments, while also accessing culturally-informed behavioral health interventions.

The bodies of literature that address LGBTQ+ engagement in care with telehealth interventions for behavioral and mental health concerns point to a potentially promising practice in tackling LGBTQ+ health needs in the digital age. However, there has been minimal research as to how digital health interventions can benefit LGBTQ+ individuals outside behavioral and mental health.

LGBTQ+ ENGAGEMENT IN CLINICAL CARE

A digital environment that is created through telehealth services has the potential to address the practitioner-based concerns that patients may have, in addition to mediating the health care delivery and compliance with directives. Access to LGBTQ+-friendly health care providers serves as a barrier for many LGBTQ+ patients. For more than a decade, the Human Rights Campaign (HRC) has conducted a Healthcare Equality Index (HEI) survey of health care facilities that focuses on health care delivery and policies that affirm and advocate for patients with LGBTQ+ identities.³⁶ In a similar vein, GLMA (the Gay and Lesbian Medical Association), provides a directory on their website of health care practitioners who have pledged their commitment to LGBTQ+ health.³⁷ Patients with access to the internet are able to easily search for health care practitioners in their area who are registered with GLMA; although, GLMA specifically cites that they do not individually screen practitioners for competent LGBTQ+ care.³⁸

While the HRC and GLMA have made concerted efforts to identify LGBTQ+-friendly practitioners, the identification of practitioners does not necessarily address issues of geographic access to care. For LGBTQ+ patients who do not have access to urban areas where many LGBTQ+-friendly providers are, patients run the risk of seeking care from a culturally insensitive provider or foregoing care altogether.^{8,39,40} For health care organizations, this means treating patients in critical care settings (e.g., emergency department visits, immediate-care clinics, etc.) for conditions that may have been able to be addressed sooner and with less urgency had the patient pursued early care options. Treating patients for preventable conditions in a critical care setting yields more cost to the health care system, in addition to unnecessary allocation of time and personnel to treat conditions that could have been mitigated in a primary care setting.^{41,42} These costs are not only passed on to the patient, but are also incurred by the health care organization as a whole. Subsequently, the mere identification of practitioners who can provide LGBTQ+-friendly patient care is not enough; rather, health

care delivery methods to ensure that patients are aware of their care options and have access to them are key to addressing LGBTQ+ health disparities.

CONSIDERATIONS FOR IMPLEMENTING TELEHEALTH INTERVENTIONS FOR LGBTQ+ PATIENTS

For health care practitioners and health care organizations that are interested in improving outreach and care of LGBTQ+ patients, telehealth could offer an opportunity to address many of the barriers to access that LGBTQ+ patients face. With proper consideration, telehealth interventions could offer LGBTQ+ patients culturally competent health care in a way that addresses negative community narratives toward seeking health care in a primary care setting.

Cost

Avoidance in seeking care poses serious concerns for the economic well-being of health care organizations. For health care organizations, treating patients in a critical care setting for a condition that could have been treated in an outpatient setting incurs unnecessary cost.^{43,44} As a general tenant of health care delivery, identifying and treating a condition early, not only allows for better targeted treatment but also potentially halts disease progression from becoming more severe and, therefore, necessitating more aggressive treatment. By increasing access to LGBTQ+-friendly providers, health care organizations may begin to mitigate the costs of seeing patients in critical care settings when they could have been treated in an outpatient setting.

Provider Access

As previously mentioned, the HRC compiles an annual index of health care facilities that have met certain criteria to be considered an "LGBTQ Healthcare Equality Leader."³⁶ While some states, such as California, New York, Ohio, and North Carolina, have a robust number of facilities that have been identified as exemplars by the HRC in their 2019 annual report, other states, such as Georgia, South Carolina, Idaho, and Montana, do not have a single facility registered with the HRC. For LGBTQ+ patients, access to LGBTQ+-friendly providers may be scarce in their geographic region, which may have an influence on their engagement in care.^{27,45} Telehealth services have the potential to alleviate geographic barriers by allowing patients, especially in rural communities, to access LGBTQ+-friendly providers from the comfort of their own homes.

Advertising and Community Outreach

While telehealth interventions have great potential to alleviate access barriers for LGBTQ+ individuals seeking culturally competent care, one cannot ignore the effect that years of discrimination have had on LGBTQ+ community narratives in seeking care. The horror stories of LGBTQ+ discrimination in health care environments are pervasive and indicate fear and mistrust in the health care system.^{6–13} As individual practitioners and health care organizations aim to implement telehealth interventions specifically for LGBTQ+ communities, they must also be aware of the community outreach and engagement that will be necessary to help dispel current community narratives, and begin to build trust between health care providers and LGBTQ+ patients.

LIMITATIONS & FUTURE CONSIDERATIONS

While telehealth services have been in existence for nearly a decade, their effect on marginalized communities remains relatively new and unexplored. Subsequently, careful implementation and diligent assessment are necessary to determine their effectiveness. As with

the development of any new clinical intervention or treatment method, rigorous pre- and post-assessment metrics should be collected. As previously noted, telehealth interventions specifically for LGBTQ+ patients outside mental and behavioral health have not been researched. As interventions are established, LGBTQ+ health needs must be at the forefront of development rather than retrofitted from existing models.

Moreover, telehealth services should not be viewed as a panacea for LGBTQ+ health disparities. The root causes of health disparities (systemic oppression and subsequent prejudice) are still incredibly prevalent and powerful in affecting the lives of LGBTQ+ individuals. Telehealth interventions may be used as a countermeasure to begin addressing health disparities; however, increased practitioner education and training in cultural competency remain the key to addressing health disparities in a long-term, sustainable fashion.

CONCLUSION

Different disciplines within the healing arts are showing promise for incorporating care practices that honor the growing diversity of patient populations within the United States. However, there is still a great deal of work that needs to be done to address pervasive population health disparities that are ever present within the United States. Foundational causes of systemic oppression that propel the trajectories of population health disparities are still very much alive and well within the United States. Efforts to educate health care practitioners and provide them with interventional resources necessary to tackle population health disparities are pivotal in changing the way that health care access is gate kept in the United States.

Specifically for LGBTQ+ individuals, systemic barriers instill narratives of fear and subsequent neglect for individuals seeking health services. Until LGBTQ+ individuals can confidently show up authentically in the offices of their health care providers and receive culturally competent, population-specific care, the need for education and interventional countermeasures will exist. Telehealth services offer a promising avenue for targeted outreach to LGBTQ+ individuals to begin changing the community narratives of mistrust and neglect and allow LGBTQ+ individuals to seek care without fear of mistreatment.

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DHSS Press Release

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DPH REMINDS DELAWAREANS TO AVOID CONSUMING RAW DAIRY PRODUCTS; ANNOUNCES POSITIVE CASE OF BRUCELLOSIS

DOVER, DE (June 13, 2019) -

The Delaware Division of Public Health (DPH) is reminding Delawareans to avoid consuming raw dairy products as it announces a confirmed case of brucellosis caused by *Brucella melitensis* in a 46-year-old Sussex County woman. The illness is a bacterial infection, which primarily affects those consuming, or coming into contact with, contaminated animals or animal products. The most common source of infection is through the consumption of raw, unpasteurized dairy products. Prior to becoming ill, the patient in this case had consumed unpasteurized homemade dairy products from Mexico. No other risk factors have been identified. The individual was hospitalized and is recovering after being treated for the illness. A second, related case of brucellosis is also pending confirmation by the Centers for Disease Control and Prevention (CDC).

Brucellosis infection is most frequently transmitted by eating or drinking raw/unpasteurized dairy products such as milk and cheese, yet can also be contracted through inhalation or physical contact with infected animals or animal products. When sheep, goats, cows or camels are infected, their milk becomes contaminated with the bacteria. If the milk from infected animals is not pasteurized, the infection will be transmitted to people who consume the milk and/or cheese products. Brucellosis is not common in the United States. Nationally, the average is less than 200 human cases each year. Person to person transmission is rare. Prior to this case, DPH has confirmed three cases since 2010; those cases occurred in 2010, 2017 and 2018. The case in 2010 was associated with consumption of unpasteurized milk while the nature of exposure in the 2017 and 2018 cases is unknown.

"Cases such as this one can serve as an unfortunate reminder that we are vulnerable to certain bacteria and should take precautions to protect ourselves," said DPH Medical Director Dr. Rick Hong. "Delawareans are encouraged to avoid purchasing and consuming unpasteurized dairy products. Consuming questionable food items is not worth the risk to your health."

Raw milk and milk products are those that have not undergone a process called pasteurization that kills disease-causing germs. These types of products are common outside the United States and are increasingly being sold in mainstream supermarkets in the United States as well, though sales are not permitted in Delaware. A wide variety of germs that are sometimes found in raw milk can make people sick. These germs include *Brucella*, *Campylobacter*, *Cryptosporidium*, *E. coli*, *Listeria*, and *Salmonella*.

The state's Milk Safety Program, as well as statewide inspections of retail food establishments, are in place to protect consumers from purchasing or consuming raw dairy products, but unlawful distribution may still occur. Some neighboring states allow for the sale of raw dairy products, therefore residents should be aware of the health risks associated with consuming these products before purchasing and consuming them.

Signs and Symptoms of brucellosis are similar to the flu. Initial symptoms include fever, sweats, malaise, anorexia, headache, muscle or joint pain, and fatigue. Antibiotics are typically prescribed to treat brucellosis. In pregnant women, *Brucella* infections can be associated with miscarriage. Symptom onset can occur anywhere from five days to six months following exposure. Depending on the timing of treatment and the severity of illness, recovery may take several weeks.

No vaccine is available to prevent developing brucellosis, but preventive measures can be taken:

- Do not eat, drink, or purchase unpasteurized milk or dairy products, especially while traveling outside the U.S. Locations that commonly sell dairy products include supermarkets, farmers' markets and dairy farms.
- Read the label on milk or milk products before you buy them. Many companies put the word "pasteurized" on the label. If you are not sure, ask a store employee if specific brands are pasteurized.
- At farm stands or farmers' markets, ask if the milk and cream being sold have been pasteurized. If the market sells yogurt, ice cream, or cheese, ask if they were made with pasteurized milk.
- Meat packers, hunters and slaughterhouse employees should wear protective gloves and wash their hands thoroughly when handling raw meat.

For more information about brucellosis, visit <https://www.cdc.gov/brucellosis/index.html>. For more information about the risks of consuming raw milk and unpasteurized dairy products, visit <https://www.cdc.gov/foodsafety/rawmilk/raw-milk-index.html>.

A person who is deaf, hard-of-hearing, deaf-blind or speech-disabled can call the DPH phone number above by using TTY services. Dial 7-1-1 or **800-232-5460** to type your conversation to a relay operator, who reads your conversation to a hearing person at DPH. The relay operator types the hearing person's spoken words back to the TTY user. To learn more about TTY availability in Delaware, visit <http://delawarerelay.com>

Delaware Health and Social Services is committed to improving the quality of the lives of Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. DPH, a division of DHSS, urges Delawareans to make healthier choices with the 5-2-1 Almost None campaign: eat 5 or more fruits and vegetables each day, have no more than 2 hours of recreational screen time each day (includes TV, computer, gaming), get 1 or more hours of physical activity each day, and drink almost no sugary beverages.

Delaware Health and Social Services is committed to improving the quality of the lives of Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations.

Keep Trans Youth Alive: Considerations for Suicide Prevention of Gender Expansive Youth

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ABSTRACT

Objective. This article examines suicidality of gender expansive youth and identifies evidence-based, practical interventions for healthcare professionals and other adults who interact with gender expansive youth.

Methods. Research methods included an interview, literature review, articles from peer-reviewed journals, and application of clinical experience. Based on the interview, a case study is included, which describes one transgender man's suicidal adolescence and early adulthood. Following the case study, statistics are presented, and then theories are applied for deeper understanding of the etiology. The population studied included gender expansive individuals age 24 and younger from the United States. Literature on adult transgender suicidality, as well as recommendations for general populations, was also taken into consideration due to limitations in the research.

Results. Gender expansive youth are at significantly heightened risk of suicide compared to their cisgender peers. Nonbinary youth are the most vulnerable of all subgroups.

Conclusion. Explicit recommendations for enhancing resilience for this population complete the article. More research is critical for this demographic, as current literature is severely limited.

ERIC: A CASE STUDY

"Eric" (names and personal details have been changed to protect confidentiality) was twelve years old the first time he tried to commit suicide. He had just "come out" to his parents as a lesbian. He did not know what it was to be transgender. All he knew was that he was *AFAB* (assigned female at birth), he was socialized as a girl, and he did not realize he could even question his gender. By age 12, he knew that he was attracted to "other girls." Eric believed that it was wrong to be gay, and he was deeply ashamed of his sexuality. When Eric finally gained the courage to come out to his friends at school, news spread rapidly and many of his peers became hostile toward him. Being gay made Eric an easy target.

Eric became very depressed. He started to have periods of dissociation. He would go into rage-fueled blackouts, unable to remember what had transpired when he settled back into reality. He began isolating himself because he was afraid he would hurt the people around him. Eric's parents felt helpless. He developed severe anxiety including an intense fear of going outside, and his parents ultimately decided to homeschool him for the remainder of middle school.

Between the ages of 12 and 14, Eric attempted suicide two times. After the second attempt, Eric's parents found him a therapist. They began to work on addressing the impact of the homophobia he experienced when he came out. Eric felt slightly better after a while, but his depression and suicidal thoughts persisted. When Eric was 14, he enrolled in the local public high school. Around the same time, he began to feel *gender dysphoric* (a type of distress caused by the misalignment of one's sex assigned at birth and their gender identity) although he did not have the language to articulate the concept, nor did he know about gender variance.

What made a significant difference for Eric was being part of his local LGBTQ community center. Being there made Eric feel at

home, gave him joy and put him at ease. Eric met other youth there, including some transgender teens. As he got to know them more, and realized how much he related to them, he developed an understanding of himself. Eric came out as transgender at the age of 16.

Upon gaining this insight, Eric felt excitement, relief, and terror. He knew that *transitioning* (the process some gender expansive people may undergo in order to align themselves with their gender identity through social and/or medical interventions) was an option he could explore, but he had no idea how to get started. He was terrified of being disowned by friends or family. The recent insufferable pain of being rejected and mistreated by many of his friends when he came out as gay was still present. On top of being worried about the social cost of transitioning, Eric was concerned about the financial aspect.

Eric's fears were confirmed when he told his peers that he was considering medically transitioning. Responses ranged from telling him that he would not be attractive if he took steps toward masculinization, to others saying they would not like him anymore, to laughter. The deeper the connection, the more it hurt if someone was not supportive. Eric was let down repeatedly. He doubted that he could ever truly "become himself" and he internalized the belief that he would be unlovable.

During high school, Eric attempted suicide four more times. He was hospitalized for a period of time, and he began seeing a new mental health provider. Eric took antidepressant medication, but his symptoms persisted until he began medically transitioning. Finally, Eric's mental health became manageable.

Eric is exceptionally lucky that his immediate family was always supportive. Attributable to the relationships with his parents, siblings, and friends from the community center, Eric felt a sense of connectedness that was tremendously fulfilling. Eric also began working with *GLSEN* (the Gay, Lesbian, Straight Education

Network, a nonprofit organization that aims to improve school safety nationally), which made a positive impact on his mental health. GLSEN gave Eric a place to help other LGBTQ youth and to advocate for LGBTQ rights. His work instilled pride and empowered him; it gave him purpose. Eric graduated high school.

Without any regrets today, Eric has transitioned to an extent that feels comfortable to him. He sees being transgender as a cornerstone of his identity, connected to everything else about him and ever-present in his day-to-day life. He still manages symptoms of depression and has suicidal thoughts sporadically. Today, he acknowledges them, but he knows they will pass; they always do.

Devastatingly, in 2018, Eric's best friend Cody died by suicide. Cody realized he was transgender and came out to Eric within a year of them meeting. Cody seemed so optimistic after he came out that Eric never expected Cody's depression to reach such a lethal place. Cody also dealt with PTSD (Post-Traumatic Stress Disorder) and never received adequate care for his mental health. Cody made it clear that discovering he was transgender and then transitioning kept him living as long as he did. Before his death, Cody told Eric that, had he never transitioned, he would have killed himself years prior. However, as Eric summarizes,

"knowing who you really are and transitioning can save your life, but it's not everything. It is a part of it, but you still have to make the rest of your life work. I miss [Cody] every day but when I think about him, it's a reminder that I need to make the rest of my life work better so I don't end up like that. I have been on testosterone for nine years. I had top surgery. I look the way I want to, sound the way I want to, but the rest of my life is still very far from perfect, and that's the part I need to be focusing on."

PREVALENCE

Current suicide rates of young people in general reflect a large public health problem. Sadly, suicide rates for individuals who are gender expansive are several times higher. Between 2015–2016, 7.2% of the general population of high school students in Delaware reported attempting suicide.¹ In contrast, over one-third (35%) of gender expansive high school students reported attempting suicide in 2018.² In Delaware, 1,100 youth are estimated to be gender expansive.³ Throughout the US, approximately 2% of high school students surveyed reported being transgender.² Even though the gender expansive community is a small minority, they are affected so disproportionately by suicide that specific consideration is warranted.

ETIOLOGY

Being gender expansive is not the cause of mental illness. On the other hand, experiencing regular hostility and discrimination, like so many who are gender expansive do, can be traumatic and increase the likelihood of having mental health problems as a result.⁴ Psychological distress for most people who are gender expansive is thus due to a lack of social acceptance and the pervasiveness of transphobia.

This response makes sense if considered from the perspective of the minority stress model.^{5,6} This model explains that, because of differences between minority and dominant cultural

values, minority group members may experience internal and environmental conflict as a result of having different belief systems from the majority. Each minority group has a unique set of relevant stressors associated with poorer health outcomes for members of that particular group. Hendricks and Testa identified minority stressors for this population by considering adverse experiences due to societal transphobia including: rejection, victimization, and/or internalized transphobia.⁷ Minority stress studies with gender expansive samples show that being disenfranchised, victimized or experiencing transphobia increases suicide risk.^{8,9} Another stressor particular to this population is the experience of being referred to by a pronoun or name that is not affirming, especially when done maliciously or repetitively. To be *misgendered* (to have one's gender identity misclassified) is an adverse experience uniquely damaging to those who are gender expansive.^{10,11}

Being gender expansive represents just one aspect of identity out of many that one might hold, and if other identities also have minority status, they too will come with their own set of stressors. A tremendous number of people are part of multiple minority groups. Gender expansive youth might also be: black or another racial minority, disabled, mentally ill, a member of a non-dominant religion, an immigrant, of low socioeconomic status, and so on. The greater the difference between one's value system and that of the majority, the more distress one is likely to experience as a result.

One value that segments the gender expansive community is identification as either *binary* (male- or female-identified, as a majority of people in society), or not. Those who are *nonbinary* (people who identify as neither 'male' nor 'female') in particular, seems be most at risk of suicide.^{12,13} This demonstrates another application of minority stress for this population.

RISK FACTORS

Suicidal Risk Factors are characteristics, internal or external, that make it more likely that one might consider, attempt, or die by suicide.¹⁴ According to the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Suicide Prevention Resource Center, they include^{14,15}:

Personal/psychological Factors

- Presence of mental health disorder(s) and/or alcohol/substance abuse
- Antisocial and/or maladaptive behaviors, including self-injury
- Previous suicide attempts
- Genes/neurobiology predisposing one to suicidality
- Impulsive, risk-taking, reckless tendencies
- Feeling hopeless, lonely/isolated/alienated, like a burden, and/or having low self-esteem
- Lacking adaptive coping skills
- Seeing oneself as severely overweight or underweight
- Risky sexual behavior, delinquency, and/or aggressive or violent behavior

Adverse Experiences

- Grief, loss, or other interpersonal challenges (risk is especially heightened for those exposed to a peer dying by suicide)

- Victimization (bullying, abuse, etc.)
- Legal or discipline problems
- Challenges at school or work
- Chronic illness or disability

Familial Factors

- Parental divorce, death, mental health problems, or relationship problems
- Relatives with suicidal behavior

Environmental Characteristics

- Lack of: community-wide acceptance of differences, common value of equality, positive relationships with school staff & students, pro-social beliefs, safety/security, and/or mental health care.
- Presence of: bullying, violence, other hostile behaviors, weapons (particularly if accessible within the home), peer suicide, stigma or discrimination based on gender/sexual identity, race, disability, or physical traits

ENHANCING RESILIENCE

Protective factors are personal or environmental characteristics that reduce the probability that someone will consider, attempt, or die by suicide. Protective factors can minimize the effects of risk factors. The capacity to cope adaptively with the effects of risk factors or adverse experiences is called *resilience*. Actions to enhance protective factors serve to boost resilience and are an essential element of an effective suicide prevention effort. Strengthening these factors also protects youth from other risks, including violence, substance abuse, and academic failure.¹⁴

Protective Factors suggested for the general population are listed below¹⁵:

Individual Characteristics and Behaviors

- Adequate self-esteem, self-efficacy, optimism, and an overall upbeat affect
- Emotional intelligence, easy-going temperament
- Coping skills including problem-solving abilities, conflict resolution, emotional regulation, and frustration tolerance
- Cultural and religious beliefs that respect and value life and discourage suicide
- Healthy relationship with one's body to include: perception of body image, personal care/hygiene, regular physical activity, and overall concern for one's physical self

Family and Other Social Support

- Connection to supportive parents and other family members, and parental involvement (especially as connected to school)
- Close friends or family members, a caring adult, and other social support(s)
- Pro-social norms within the household/School
- Positive relationship with school, including average or better academic achievement
- Real and perceived safety at school (especially relevant for this population)
- A school environment that promotes diversity and respect

Health

- Easy access to mental health services, physical healthcare, and treatment (if needed) for substance abuse disorders
- Positive relationship with providers

Environment

- Restricted access to means including guns, medications, alcohol, and firearms
- Safety barriers in place at dangerous locations in the community (such as bridges)

SPECIFIC IMPLICATIONS FOR GENDER EXPANSIVE YOUTH

A swift and effective response to this crisis is urgently needed. Those with the ability to create impactful change, small or large, should consider taking action to enhance the resilience and wellbeing for the gender expansive community. Moody, Fuks, Peláez and Smith organize trans-specific protective factors into categories of social support, gender identity-related, transition-related, individual differences, and reasons for living.¹⁶ This article will utilize those categories and expand upon recommendations for suicide prevention specifically for gender expansive youth based on the literature.

As seen in most cultures and subcultures, those with multiple minority identities face a heightened risk of experiencing adversity. Thus, for those who are marginalized or oppressed in ways other than gender, meaningful, supportive relationships are vital to combating minority stress. If social support is inadequate, strengthening it is an important goal. There is also great benefit from exploring and processing gender/identity, reviewing reasons for living, and for some, transitioning. Through affirming referrals to healthcare providers and community resources, gender expansive youth will have options available to increase their resilience.

SOCIAL SUPPORT

There is a positive correlation between perception of support and mental health for gender expansive youth.¹⁷ Those who report feeling accepted do not have disproportionately high rates of depression compared to cisgender peers.¹² In contrast, not feeling accepted is associated with higher rates of mental illness. This is part of the reason it is important to connect gender expansive youth with those they can relate to, as well as other community supports. It is helpful to have knowledge of resources for social and/or support groups, education, assistance, and other needs of this population, their families, and their communities.

If one seeks to be a support for those who are gender expansive, being affirming is the first step. When the name and pronoun that feel affirming are used, gender expansive youth feel accepted and safe. Incorrectly addressing or misgendering a gender expansive youth can be harmful and should be avoided. Modeling gender-affirming behavior helps to normalize it, which can be beneficial for families. However, not all families are going to be supportive – rejection is a reality for many of these youth. As mentioned, if family support is lacking, other positive relationships become a critically-important protective factor.¹⁸

GENDER IDENTITY-RELATED FACTORS

Gender education is essential. When gender expansive youth gain awareness and develop insight into their gender identity, their risk of suicide declines.¹⁶ It is also protective to increase acceptance (of self and gender), and to transition, if/as desired. It is a myth that everyone knows their gender identity by a young age.¹⁹ For many, gender evolves over time, and childhood gender experimentation is a part of typical development. It is important for all youth to feel safe to learn about and explore gender, so they can better understand themselves and the world. For those who are not cisgender, it is an essential prerequisite to developing a sense of self, and (ideally) of pride in one's identity. Those who wish to make the world a safer place for gender variance can address environmental factors that might be harmful to this population, and do what is possible to increase inclusivity of spaces. It is also important to have current, accurate knowledge, including of gender-affirming resources, particularly those that promote identity development and provide community education.

TRANSITION-RELATED FACTORS

Not everyone who is gender expansive decides to transition, but for those who do, each journey is unique. Risks and benefits of various options are examined, desired outcomes are considered, and accessibility is taken into account. For those who choose to transition, there are three aspects of the process that can be protective, including coming out/disclosing, hope of transitioning, and actively transitioning. When gender expansive youth are able to socially transition and use a name that is affirming, they are 65% less likely to attempt suicide compared to those who are not, and their suicidal thoughts decline by 35%.¹² Make it standard practice to ask about, rather than assume, pronouns as well. Direct advocacy might include asking about and respecting what is affirming, but there are endless other ways to make the world a safer place for those who are gender expansive. Some examples are improving school safety and inclusivity, building/sharing accurate education about this population, or donating time or money to gender-affirming programs or groups.

INDIVIDUAL DIFFERENCE FACTORS

Some individual differences are unlikely to be influenced by external sources, such as the personality trait of being optimistic or one's genetic capacity for resilience. However, effective therapeutic interventions can positively impact other protective factors including one's use of effective coping strategies, problem solving skills, and ability to self-regulate. A qualified mental health provider can help clients acquire cognitive tools to negate problematic thinking and eliminate maladaptive behavior.

REASONS FOR LIVING

An effective therapist will encourage their suicidal client to explore reasons for living. Clients might be asked to share their beliefs about survival, and about suicide, allowing the clinician to search for embedded protective factors or areas that should be more protective. A client might also be asked to discuss negative aspects of suicide. If they are afraid of dying, fear can be protective and should be explored. Having a sense of responsibility toward meaningful individuals as well as being a role model to others are both protective. For some, spiritual/religious beliefs offset suicidality as well.

CONCLUSION

Suicide rates of gender expansive youth are devastatingly high and require attention. Societal transphobia is ultimately the cause of the disparity of the rates. While overcoming transgender discrimination might seem daunting, there are many steps that can be taken to positively impact health outcomes for this population. Everyone should ask and use gender-affirming name and pronouns. Families, schools, and communities need resources to become more informed and supportive. Gender expansive youth should be connected with affirming, competent medical providers. Participating in therapy can make a profound impact on resilience. It provides a meaningful relationship that might itself be protective, and often considered an essential part of a support system. Therapy helps clients learn coping skills, recognize reasons for living, correct problematic thinking, build hope, and improve relationships. Linking this population to mental health support, including crisis services should be prioritized. If suicidality is disclosed, find emergency help right away by calling 9-1-1 or your local crisis response department. For other times, there are two gender-affirming suicide helplines available throughout the US: The **Trans Lifeline** at (877) 565-8860, and the **Trevor Project** at (866) 488-7386 or online via instant message, chat or text at <http://www.thetrevorproject.org/section/get-help>

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Improved Data Collection for Our LGBTQ Population is Needed to Improve Health Care and Reduce Health Disparities

Karyl T. Rattay, M.D., M.S.
 Director, Division of Public Health, Delaware Department of Health and Social Services

Providing the best possible health care and interventions to Delawareans requires us to understand the health disparities that may exist among populations. When data collection efforts include demographics for lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals, our health systems can become more culturally responsive and inclusive. However, information on health conditions by sexual orientation and gender identity is hard to find because the data are not routinely collected.

Approximately 4.5 percent of the U.S. population identified themselves as LGBT in an analysis of 2017 Gallup poll data by Williams Institute of the School of Law at University of California, Los Angeles (UCLA).¹ Overall, 5.1 percent of women and 3.9 percent of men identified as LGBT. LGBT identification is also higher in those with lower incomes, and among racial and ethnic minorities.²

Survey data on LGBT populations are available and collected in several national and state surveys such as the Centers for Disease Control (CDC)-funded Behavior Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS). Among Delaware adults, about 5.2 percent identify as LGBT, according to the 2017 Delaware Behavioral Risk Factor Survey (BRFS), an annual survey of about 4,000 adults that reports both state and national data. It has only been in the last four years that BRFS has included questions which allow individuals to identify as LGBT. Much of Delaware's state-level data related to LGBT individuals are suppressed, meaning that they cannot be used to interpret data specific to this population when looked by a single year because the sample size is not large enough to be valid. Eventually, DPH will be able to aggregate three or four years of data and do rolling averages for adults.³

The Delaware YRBS that is completed every other year in public high schools asks questions about LGBTQ, with the Q referring to "Questioning" – which is much more common in this age group. Eleven percent of respondents to the 2017 High School YRBS identified as lesbian, gay, or bisexual; an additional three percent were unsure of their sexual orientation and just over one percent identified as transgender.⁴

Asking about sexual orientation is slowly becoming more common in surveys. Federal health forms typically do not include sexual orientation questions, and gender questions are limited to male/female. Eight national data systems collect sexual orientation data, including the National Health Interview Survey (added in 2013), and the National Survey of Drug Use and Health (added in 2015).⁵ A gender identity question was included in the Health Resources and Services Administration's 2013 and 2014 National Health Service Corps Patient Satisfaction Surveys and the 2014 NURSE Corps Participant Satisfaction Survey.⁶ Public health workers generally agree that sexual orientation and gender identity data are limited and mainly regard adolescents.

The LGBT companion document to Healthy People 2010 recognized the need for sexual orientation and gender identity data "to document, understand, and address the environmental factors that contribute to health disparities in the LGBT community."^{7,8} The Institute of Medicine raised the need for further gender

minority research in the 2011 report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*⁹ as well as in a 2012 workshop summary.¹⁰ Its authors, a committee of experts, recommended collecting sexual orientation and gender identity data in U.S. health surveys and other federally funded surveys, in electronic health records among other demographic information collected. HHS' Agency for Healthcare Research and Quality has included LGBT information in its National Healthcare Quality and Disparities Reports since 2011, but in 2017 noted that few databases support LGBT analyses.¹¹ Currently, the nation's Healthy People 2020 (HP 2020) initiative contains seven LGBT data objectives. Objective LGBT-2.2 is to increase the number of states, territories, and the District of Columbia that use a provided module on sexual orientation and gender identity questions in the BRFSS from 20 in 2014 to 22 in 2020. Objective 2.3 is to do the same in the Youth Risk Behavior Surveillance System (YRBSS) from 28 in 2015 to 31 in 2020 (see Table 1).¹²

Table 1. Healthy People 2020 LGBT Data Initiatives

Initiative	Description
1.0	Increase the number of population based data systems used to monitor Healthy People 2020 objectives that include in their core a standardized set of questions that identify lesbian, gay, bisexual, and transgender populations
1.1	Increase the number of population based data systems used to monitor Healthy People 2020 objectives which collect data on (or for) lesbian, gay and bisexual populations
1.2	(Developmental) Increase the number of population based data systems used to monitor Healthy People 2020 objectives which collect standardized data that identify lesbian, gay and bisexual populations
1.3	Increase the number of population based data systems used to monitor Healthy People 2020 objectives which collect data on (or for) transgender populations
1.4	(Developmental) Increase the number of population based data systems used to monitor Healthy People 2020 objectives which collect standardized data that identify transgender populations
2.0	Increase the number of states, territories, and the District of Columbia that include questions that identify sexual orientation and gender identity on state level surveys or data systems
2.1	Increase the number of states, territories and the District of Columbia that include questions on sexual orientation and gender identity in the Behavioral Risk Factor Surveillance System (BRFSS)
2.2	Increase the number of states, territories and the District of Columbia that use the provided module on sexual orientation and gender identity in the Behavioral Risk Factor Surveillance System (BRFSS)
2.3	Increase the number of states and territories that use the provided module on sexual orientation and gender identity in the Youth Risk Behavior Surveillance System (YRBSS)

Other than BRFs and the YRBS, which are administered through the Division of Public Health (DPH), our agency does not collect sexual orientation or gender identity data on its forms and data surveys, but may gather such data via risk assessments and key informant surveys. Whenever possible, DPH analyzes sexual orientation data and includes it in data reports, data briefs, and professional articles when the sample sizes are large enough. Small data pools prevent the analysis of risk factors, diseases, and lifestyles, especially if there is already low prevalence. For the most accurate data representations, researchers must aggregate several years of data to overcome wide confidence intervals. For example, DPH is aggregating multiple years of BRFs data and reviewing the LGBT responses to determine adult LGBT smoking prevalence in comparison to the general adult population.

“By asking these questions, you are legitimizing the LGBT community,” said Salvatore Seeley, Director of Health and Wellness for CAMP Rehoboth,¹³ a 501(c)(3) nonprofit community service organization dedicated to creating a positive environment inclusive of all sexual orientations and gender identities. “It’s altruistic in a way, but it’s also empowering to a community that is largely excluded.”

Demographic survey questions, typically limited to binary (male/female) choices, should become more culturally appropriate and centric, Seeley said. He noted the importance of giving people the opportunity to self-describe their sexual orientation and their gender. Transgender individuals express their gender differently; others might be agender (no particular gender) or bi-gender (any two genders) individuals. CAMP Rehoboth suggests these sample answers through its culturally inclusive trainings:

- Male/Female, Prefer to self-describe, Prefer not to say
- Male/Female, Non-binary, Third gender
- Do you identify as transgender? Yes/No, Prefer not to say.

While it would be inclusive for data collection points to ask if one is heterosexual or other (lesbian, gay, bisexual), having those data might not change how we address a health problem. For instance, Delaware’s HIV Program collects “men having sex with men” data because it is a risk factor. Women having sex with women are at much lower risk. In other areas, such as infant mortality, sexual orientation variables may not be needed for health care professionals to do their work.

Expanding data collection tools to include sexual orientation and gender identity could result in the public health community being aware of disease and health behaviors that it may or may not be adequately addressing. LGBT Delawareans represent many distinct population groups, each with their intrinsic health needs. Having LGBT data to access can assist health providers and educators in streamlining their care and outreach efforts. Customized, culturally competent interventions can reduce LGBT health disparities.

“Delaware is losing out by not truly understanding the needs and wants of the LGBTQ population,” Seeley said. “LGBT people have specific health needs and we get clumped in the general group [of respondents].”

Let’s look at some of the health issues that have been identified through data collection. Nationally, among gay, bisexual, and other men who have sex with men, there are higher risks of sexually transmitted diseases, especially among communities of color. HIV

prevalence among gay and bisexual men is 40 times that of sexual partners of heterosexual men. Seventy-five percent of reported 2012 syphilis cases were among gay and bisexual men.¹⁴ Gay, bisexual, and other men who have sex with men are 17 times more likely to get anal cancer than heterosexual men and face major depression, generalized anxiety disorder, and bipolar disorder.¹⁵ Based on national data, tobacco use is also higher among gay and bisexual men than heterosexual men.

Also nationally, lesbians and bisexual women are more likely to be overweight or obese, and lesbians are less likely to get cancer screenings, according to the U.S. Department of Health and Human Services (HHS).¹⁶ Transgender individuals are at risk of acquiring HIV and STDs, being victimized, having mental health issues, and attempting suicide, as well as not having health insurance. Elderly LGBT individuals must overcome isolation and at times, a lack of social services and culturally competent providers.⁵

Turning our focus to LGBTQ youth, it is clear that an additional set of issues present themselves, some that are addressed through a social determinants of health lens. For LGBTQ youth, interpersonal and internal conflicts – and not sexual orientation itself – may increase substance use risk behaviors and poor mental health due to stigma and stress as contributing risk factors.^{17,18} LGBTQ youth are also more likely to be homeless.⁵ Two meta-analytic reviews of national data found that on average, lesbian, gay, and bisexual youth were 190 percent more likely to misuse substances than heterosexual youth; and they were significantly more prone to depression and suicide attempts, as they noted that they suffered from victimization, discrimination, and stress.^{17,18}

Data from Delaware’s 2017 YRBS, which sampled 2,906 public high school students, show that the rate of current cigarette use is more than double among Delaware LGBTQ youth compared to heterosexual youth. Thirty-two percent of sexual minority youth surveyed reported using marijuana in the past 30 days, compared to 23 percent of their heterosexual peers. The reported use of prescription pain medicine in the past month was twice as high among LGBTQ students compared to heterosexual students.⁴

Regarding mental health, 52.5 percent reported feeling sad or hopeless for two weeks or more in the preceding year. Nearly 39 percent of LGBTQ students and 10 percent of heterosexual youth purposefully injured themselves (without intending death) at least once in the past year. Slightly more than 30 percent of Delaware LGBTQ youth planned suicide within the past year, compared to 9 percent of their heterosexual peers; and 18 percent attempted suicide at least once within the last year, compared to 5 percent of their heterosexual peers. Getting bullied on school property and electronically on social media occurred less among heterosexual students and more among LGBTQ students, who also reported being more likely to bring a weapon to school.⁴

How can these data be useful to health care providers? Providers who are aware of their patients’ gender identity and sexual orientation are more likely to screen them for certain conditions identified based on data trends. Additionally, particularly for younger patients, providers would be more likely to monitor them for signs of struggling with emotional issues or substance use disorder, and refer them to counseling or connect them with appropriate treatment sooner.

Cultural competency plays a huge role in positive provider-patient interactions and welcoming LGBT individuals to health care delivery sites. When LGBT persons are mistreated or ostracized by society,

they tend to avoid doctor's visits. Many LGBT individuals may be reluctant to disclose their true orientation to health care providers because they fear rude and discriminatory reactions, or that their status could become public. When kindness and respect pervade care delivery sites, LGBT persons are more comfortable with disclosing their orientation, allowing providers the opportunity to screen them for relevant behaviors and conditions. Sharing sexual orientation and gender identity on a form, rather than verbally to a nurse, was nearly three times more likely to result in patients identifying as LGBTQ than among non-LGBT patients.¹⁹ However, they have a very real concern that their personal information could be made public.

It would be immensely helpful if a national assembly of federal and state data professionals, would formally discuss sexual orientation and gender identity data collection and provide recommendations. State and federal agencies can be surveyed about current data collection efforts. The group can study the value and feasibility of collecting such data and issue guidance that includes model survey questions and how to interpret LGBT findings correctly, especially when numbers are small and confidence intervals are wide. The National Institutes of Health's Office of Sexual and Gender Minority Research (OSGMR), established in 2015 to increase sexual and gender minority (SGM) knowledge and remove research barriers, might be an appropriate lead agency.²⁰

Not too long ago, it was a big step for Delaware to include persons of Hispanic ethnicity in its data collections. It's time to expand data collections to include sexual orientation and greater gender choices to enhance our knowledge of health needs that we may not be addressing – or on the flip side, of prime LGBTQ health behaviors of which we are unaware. Data collections should represent all Delawareans with dignity.

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HPV Vaccination Rates in Delaware

Did you know that according to CDC data, [Delaware still has 13.49/100,000 cases of HPV cancers](#) annually despite the launch of the Human Papillomavirus (HPV) vaccine in 2006? Even with Delaware surpassing the nation in HPV vaccination and series completion, we still have opportunities to achieve the [Healthy People 2020](#) HPV vaccination goals of 80%. These goals look to increase the percentage of female and male adolescents receiving the ACIP-recommended number of appropriately spaced doses of HPV vaccine based on their age at initiation of HPV vaccination.

Quality Insights is actively working with the Division of Public Health (DPH) Immunization Department to increase HPV vaccination rates. Through collaborative discussions and by using the Delaware Immunization Information System (IIS), DelVAX, practices are identifying opportunities for both initiation of the HPV series and series completion. Although Delaware has an initiation rate of 75.3 and an UTD (up to date) rate of 58.1% according the National Immunization Survey (NIS) teen data, opportunities exist for meeting the Healthy People 2020 goal of 80%.

Small practices and health systems have begun to successfully review their DelVAX data and reports and implement workflows to increase rate today, to help prevent cancer tomorrow. One health system identified the need to remind patients of the 2nd/3rd dose. They are now implementing patient reminders for nurse visits as a system implementation. At a practice level, they are identifying goals for first and second dose and identifying workflows that fit the needs of their population, including using electronic health record (EHR) inbox reminders, running patient lists, and scheduling patients before they leave.

CONTACT INFORMATION

For more details about the Quality Insights Improving HPV Vaccination Rates in Delaware project, please email Lisa Gruss or call 1.800.642.8686, Ext. 138.



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A Mother's Story

Sally McBride

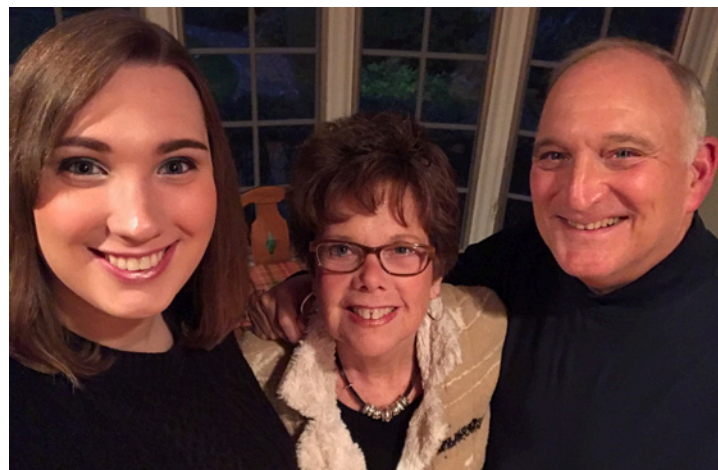
Sally and David McBride's youngest child came out as transgender on Christmas Day 2011 as a junior at American University. The news rocked their world. Here is their story as told by Sally.

We have three children. Our oldest child, Sean, told us at his college graduation in 2003 that he was in love, but that it was complicated. He wasn't ready to give us the details. We told him that when he was ready, we would be there for him. Three months later, as a first year medical student, he told us he was in love with a man. We were shocked, but told him we loved and supported him. My biggest concern was that he would be defined by being gay; being gay is a part of who he is, but he is so much more. My husband was looking forward to being a grandfather, and Sean assured him that he wanted to have children. We weren't worried about his future, as he was at Yale Medical School on his way to becoming a doctor, and we knew many gays and lesbians who were happy, healthy and fulfilled.

And then on Christmas Day 2011, our youngest child, then a junior at American University, president of the student body, and who we believed to be our son at the time, came out to us as transgender. We were totally blindsided. I was devastated, crying uncontrollably. I saw my child's future crumble, feared violence and envisioned discrimination at every turn. Dave went online immediately to the National Center for Transgender Equality, one of the leading transgender advocacy groups in the country. When he read that more than 40% of transgender people attempt suicide, his heart dropped. But he also read that that with a loving and supportive family, that percentage drops in half. And with a supportive community, it drops even further.

We knew that we would support her and do everything possible to make sure that she felt loved and respected and that she would be safe. But this news was life changing.

My first response on hearing her news was, "please don't do this. I don't want to lose my son." Sarah responded with, "you are keeping your son, and gaining a daughter." Sarah was the name she gave us that first day - her true authentic self.



Sarah, Sally, and Dave

"Can't you wait until you graduate?" I asked.

"No. I have waited 21 years to be who I truly am. If I wait any longer, I could become depressed, start using drugs or attempt suicide."

Dave, Sarah and I spent the next three days talking. We asked our daughter question after question, trying to understand what she was going through, and what being transgender meant.

She explained that she had known since she was five years old that she was different, that she was a girl. In every dream, she was a girl.

At ten, while watching a sitcom with a transgender woman, she asked me who the woman was. It was the first time that she realized that someone like her existed. She wasn't alone.

At 13, her love of politics blossomed while working as a volunteer on a political campaign in our home state of Delaware. As her passion for politics and her own political aspirations grew, she feared that her dreams and being transgender were mutually exclusive, so she hid her true authentic self. She appeared to be a happy kid.

Sarah explained that it was as student body president at American University starting in the fall of 2011, while working on such issues as gender neutral housing at an extremely diverse and inclusive school, that she realized that she needed to come out as transgender.

Our sons rallied around the three of us. Our middle child, Dan, assured us that he was straight, adding a bit of levity and humor to a difficult situation. And Sean and his husband immediately drove from Brooklyn to be with us. Though I would never equate the death of a child with this situation, I felt like I was losing my child. Over the next several months, I went through the stages of grief: first denial and anger, feeling sorry for myself, and pity, but finally acceptance.

During those first several days, Dave and I decided that we needed to be proactive in our journey to understanding what Sarah was experiencing, and making sure that she was healthy emotionally and physically. To that end, Sean reached out to one of the leading psychiatrists in this country who treats transgender children, Dr. Edgardo Menvielle, at Washington DC Children's Hospital, and set up an appointment for the three of us just five days after Christmas. Dr. Menvielle met with Sarah first, then Dave and me next, and finally the three of us together. He confirmed that Sarah was transgender, and that she did not have any other psychological issues other than the gender dysphoria. He felt confident that she could reach her full potential and that her future was still bright. For the first time over the last several days, he gave us hope for our child.

The following week, Dave and I met with two sets of parents who lived nearby who have transgender adult children. They were

introduced to us by the pastors at our progressive Presbyterian Church. It was so affirming to meet parents who had made it successfully through this journey and whose children were happy. Sarah had gone back to college and begun to tell her friends and some professors that she was transitioning, and was met with total acceptance. But she wanted to wait to tell everyone until the end of her term as student body president on April 30. She didn't want her news to embarrass the school she had come to love. At home, we began to tell our extended family and close friends, and asked everyone to keep it confidential until Sarah gave us permission to tell all. I met individually and in small groups with my friends to tell them about Sarah.

This news is not something that is quickly told. There are so many myths and misconceptions about what it means to be transgender, and we felt it important to educate people on the facts. Dave told several members of his law firm, and we both told our closest friends at our church. We wanted to show our friends that we were proud of our daughter, respected her, and so admired the courage it took to be her true authentic self. It was important not to present ourselves as victims, but to present a united, loving and supportive family. We were met with nothing but acceptance.

I don't want to leave you with the impression that the several months after learning that Sarah was transgender was a smooth ride. As I mentioned, in the beginning I was angry. Sean called Dave and me every week the first several months to make sure we were ok. He knew Sarah would be fine but was worried about us. One day he called me and I told him I was angry and felt sorry for myself. I asked him what were the chances of having a gay and transgender child? At that time, he was doing a fellowship treating pediatric brain tumor patients. He replied to my question with "Slim, but what are the chances of a nine year old girl coming into my office with a terminal brain tumor? Your child is healthy and not going to die."

This was a pivotal moment for me. This put everything into perspective. Two more important events occurred over the next several months that helped to calm some of our anxiety about Sarah transitioning. Sarah had worked for Delaware Governor Jack Markell during his election in 2008 and the two became very close. The Governor has been a mentor to Sarah ever since, and he and his wife have become friends of our family.

Three months after coming out to us, Sarah came out to the Governor and his wife and asked the Governor to write one of two recommendations for Sarah for her application to become an intern at the Obama White House. The Governor wrote the recommendation, and both he and his wife offered their unyielding support for our family. Sarah's second recommendation written by Attorney General Beau Biden. Sarah had worked for Beau when he ran for Delaware Attorney General in 2006. Both were such affirming moments. Sarah got the internship, and was the first transgender woman to work in the White House.

In early April, Sarah announced her plan to come out on Facebook and in the school newspaper on the last day of her term as student body president. We were very concerned that coming out on Facebook would make her too vulnerable. When she assured us that her psychologist was on board with this plan, we supported her decision to do so. On April 30, both the Op-Ed in her school newspaper and the post on Facebook were met with mostly positive reactions. The post went viral, with so much support from all over the world.

As a family, Sarah, Dave and I lobbied for the Gender Identity Non-Discrimination Bill in the Delaware General Assembly from January to its passage in June of 2013. It was important for us to do this as a family, so the legislators and the community could see us as a loving family, with a child who possessed the same hopes and dreams as any other child, and who wanted to be treated with fairness and dignity. In 2016, Sarah was the first transgender person to speak at a national political convention when she spoke at the Democratic National Convention. So many transgender people have said that seeing her announce that she is a "proud transgender American" gave them hope for their future. In 2018, Sarah published her first book, Tomorrow Will Be Different: Love, Loss and the Fight for Trans Equality.

Finally, I would be remiss if I didn't mention one of the most defining experiences of the past seven years (and of our entire lives): Sarah fell in love with Andy Cray, a transgender man, and one of the leading LGBT health care advocates in the country. While working at the White House, Sarah met Andy at a pride reception. For him it was love at first sight. It took Sarah a little longer to realize she was in love with him, too.

Andy was brilliant, thoughtful, kind, and lit up a room with his smile. They moved in together nine months after meeting. One month later, Andy was diagnosed with cancer. Sarah became his main caregiver after his surgery and while he underwent radiation and chemotherapy. She showed the same courage, strength and resiliency in helping Andy recover that she showed in coming out and transitioning.

Four months after finishing his treatment, Andy was cancer free, but three months later he learned that his cancer had returned, and he had twelve months to live. How does a 27-year-old face his imminent death? With the support of family and friends, with guidance and advice from Sean, who is now a radiation oncologist, with immeasurable fear, and with the hope that he could beat the odds.

As it became increasingly clear that Andy's cancer was more aggressive than previously suspected, he asked Sarah to marry him. Dave and I gave our blessing. With the help of friends on both sides, Sarah and Andy married on the rooftop of their apartment building, on a beautiful summer day, surrounded by fifty family and friends. For Dave, walking Sarah down the aisle was one of the proudest moments of his life. For all of us, the ceremony was both beautiful and tragic. Four days later, Andy died.

It has been more than seven years since that Christmas Day in 2011. We have been so privileged and blessed to have been embraced and supported by so many. Ours has been such a positive journey, and that journey continues. Sarah has become one of the leading transgender advocates in the country through her work at the Center for American Progress, and since 2015 she has been the National Spokesperson for the Human Rights Campaign. Our daughter has experienced more in the past seven years than most people do in a lifetime. Her courage and resiliency continue to astound us. Dave and I speak about our journey to churches, companies and community groups, continuing to educate and dispel misinformation. And in the summer of 2016, along with three other mothers of transgender children, I started a support group for parents of transgender kids that meet at our local children's hospital. We are so privileged and blessed as a family. And each day, we celebrate our diversity as a family, too!



Call to Action to Promote the All of Us Research Program to People with Disabilities

WHY SHOULD YOU PARTICIPATE IN THE *ALL OF US* RESEARCH PROGRAM?

“Nothing About Us Without Us”: This slogan is used to communicate the notion that no policy or practice, which affects the disability community, should be created without full and direct participation of members of the disability community. Historically, people with disabilities have been **excluded** and **ignored** from research studies. That ends **NOW** because of the [All of Us Research Program](#)!

Congratulations! The [All of Us Research Program](#) is **YOUR** chance to make an impact and get involved in direct, cutting-edge research to find solutions that could help people with disabilities. For the first time, people with disabilities are being encouraged to participate and are being asked to enroll in a study that can directly impact how health care is received in the future. If we truly believe in the concept of “nothing about us without us,” then **we must answer the call** when asked to participate.

What is this Call to Action? The American Association on Health and Disability (AAHD) is calling on **YOU** to learn more about and consider involvement in the National Institutes of Health’s (NIH) [All of Us Research Program](#). If you are interested in participating in the research program, enroll at <https://www.JoinAllofUs.org/together>.

What is the [All of Us Research Program](#)? The NIH has created a nationwide research program focused on precision medicine, also known as personalized medicine, to help researchers understand more about why people get sick or stay healthy. The [All of Us Research Program](#) plans to **recruit one million** or more people to share their health and lifestyle data. The program recognizes the importance of recruiting traditionally underrepresented populations living in the United States (U.S.), providing the disability community a unique opportunity. When you join the program you will be contributing to an effort to improve the health of future generations while also advancing precision medicine and learning more about your own health, through better testing, better medicine and more information presented to you.



The [All of Us Research Program](#) will provide researchers more information about people’s health and habits. By looking for patterns in biological, environmental and behavioral factors, researchers may learn more about what affects people’s health and, in turn, the best way to treat them. Currently, all eligible adults over the age of 18 who live in the U.S. can join the [All of Us Research Program](#).

What is precision medicine? Health care has traditionally followed the same approach using a “one—size—fits—all” method, by prescribing treatment for diagnoses based on the average patient. Now, thanks to recent precision medicine initiatives, physicians are working toward tailoring treatment plans to the individual. For instance, many medical conditions, such as high blood pressure, are treated with a standard medication given to all patients and then trial and error is used to determine the best medication and/or dosage. Imagine a scenario where the individual’s treatment is already customized for the person based on factors known about them, including any disabilities. This research program **will advance precision medicine and focus on the individual.** Precision medicine ensures that lifestyle, environment and genetic factors are considered when physicians determine the course of treatment in order to provide the best possible care for each patient.



What is the connection between *All of Us*, precision medicine and people with disabilities? The program is looking at a diverse group of people with a variety of health statuses, who will aid in moving the health care profession toward a more comprehensive, individualized approach. As a community engagement partner with *All of Us*, AAHD is focusing outreach efforts on educating people with disabilities about the importance of participating in the [All of Us Research Program](#). Researchers are emphasizing the importance of recruiting traditionally underrepresented populations living in the U.S., providing the disability community a unique opportunity to improve the health of people with disabilities. No one understands “underrepresented and underserved” like the disability community. Participation is especially important when you consider that people with disabilities have been previously left out of biomedical research either because researchers did not actively recruit them, or they were not prepared to provide the accommodations people with disabilities need to participate.

Why should people with disabilities participate in *All of Us*? People with disabilities know all too well that health status isn’t just dependent on a medical diagnosis. The “one—size—fits—all” method is not effective, as each person is unique and requires individualized care and treatment. There are many physical and environmental barriers that are unique to the disability community, and the presence of secondary conditions and health disparities is often overlooked by health care providers. A visit to a health care provider can become an all-day event if a bus’s wheelchair lift is broken. A medication can be taken incorrectly if the instructions aren’t written in a format that a person can read, such as braille or large print. A serious medical condition can be misdiagnosed if a physician isn’t trained to understand all aspects of the primary and/or secondary condition. These issues can be detrimental to the health of people with disabilities. **This is YOUR chance to change how medicine works. YOUR chance to solidify the slogan, “nothing about us without us.”**



For more information about how you can get involved in the *All of Us* Research Program, please visit the American Association on Health and Disability website <https://www.aahd.us/initiatives/all-of-us-research-program/> or visit the program’s website <https://www.JoinAllofUs.org/together>.



FOGARTY INTERNATIONAL CENTER • NATIONAL INSTITUTES OF HEALTH • DEPARTMENT OF HEALTH AND HUMAN SERVICES

CUGH examines implementing solutions for impact

By Ann Puderbaugh

CHICAGO—With a mandate to improve health across the planet, attendees of the 10th annual meeting of the Consortium of Universities for Global Health (CUGH) were encouraged to unleash the unique power of their institutions to enhance the translation and implementation of knowledge so the world's underserved can benefit. "We know that putting what works into scale will save millions of lives," said CUGH chair, Dr. Ann Kurth, in her opening address. "We need to work together across borders and across ideologies," she said, encouraging attendees to synergize efforts to improve health for all.

More than 1,750 academics, practitioners, administrators, students and others, representing 50 countries, attended the gathering. In keeping with the conference's implementation science theme, Fogarty's Center for Global Health Studies (CGHS) organized a panel discussion to explore ways to advance the field.

"We need a more coordinated approach to implementation science capacity building that identifies the most useful content for stakeholders," said Dr. Rohit Ramaswamy of the University of North Carolina. He's been developing a multi-tiered concept to provide different, but complementary, levels of training for researchers, implementers, policymakers and those involved in care delivery. It's not helpful if trainees return home ready to put implementation science theories into practice but their stakeholders don't understand what they're talking about, Ramaswamy noted.

Two case studies of HIV-related implementation science projects that were shepherded by Fogarty's CGHS were presented. With adolescents identified as a key population for disease transmission in Africa, a collaboration has been established to enhance effective



Consortium of Universities for Global Health Chair Dr. Ann Kurth opened the 2019 annual meeting with a call for action to advance implementation science.

Photo courtesy of CUGH

use of evidence to improve HIV prevention, screening and treatment of young Africans, aged 15-24. The Adolescent HIV Prevention and Treatment Implementation Science Alliance (AHISA) provides a space to facilitate dialogue and exchange of ideas among researchers, implementers and decision makers, said Fogarty's Dr. Rachel Sturke, who manages the program.

An initiative to prevent mother-to-child-transmission of HIV—another CGHS project—resulted in formation of the Nigeria Implementation Science Alliance (NISA), a national effort to coordinate research and capacity building efforts among stakeholders. Established in 2015 with a focus on research productivity and development of independent investigators, NISA has already generated two funded NIH

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FOCUS



Fogarty programs build capacity and spur NCD research

- Evaluation shows 600 researchers trained, 982 publications produced
- Broad range of diseases and conditions studied across the lifespan
- Ongoing challenges and unmet needs require continued support

Read More on pages 37 - 40

CUGH examines implementing solutions for impact

... continued from previous page

grant proposals and more than seven published research papers. Projects are always multi-site, multi-partner and involve issues that have potential for national scope and impact, said Dr. Nadia Sam-Agudu, of Nigeria's Institute of Human Virology.

To strengthen NIH's global mental health initiatives concerning children, the National Institute of Mental Health (NIMH) co-hosted a workshop during the conference to gain insights that will inform its future programs. Eighty-five percent of the world's youth live in low- and middle-income countries (LMICs), where access to diagnosis and treatment is lacking. "Youth mental illness is one of the most urgent mental health problems worldwide," according to NIMH Director Dr. Joshua Gordon. "Early interventions can improve outcomes," he said, yet there has been little research on how to apply existing knowledge and practices for use in low-resource settings. Proven diagnostic techniques—such as using mobile devices to track eye contact in young children—could be adapted for use in LMICS so that diagnosis and treatment of autism could begin earlier, he said. Using cellphones or other portable devices to administer such tests "is imminently implementable worldwide."

But implementation without maintaining quality of care is also an enormous problem in LMICs. In a session organized by Fogarty, panelists presented the results of a recent U.S. National Academies of Sciences, Engineering and Medicine (NASEM) report that shows up to 8 million deaths occur each year from lack of access and poor quality of care in developing countries—more than HIV, TB and malaria combined. The study examined what an ideal health system would look

like and recommended a shift in focus and ownership of health to the communities, said Dr. Marcel Yotebieng, an author of the report and faculty member of Kinshasa University and Ohio State. NIH funds a broad range of studies on how to improve quality of care through 18 grants in 14 LMICs, said Fogarty's Dr. Linda Kupfer, who helped coordinate NIH's participation in the NASEM report.

Photo courtesy of CUGH



Fogarty's Dr. Ken Bridbord was awarded CUGH's highest honor by its director, Dr. Keith Martin. (see page 11)

At another session, Fogarty Fellows and Scholars shared their stories of their early-career experiences at NIH research sites and the positive outcomes that resulted. The program's first landscape architect, Dr. Leann Andrews of the University of Washington, presented her successful efforts to improve a Peruvian slum community's health by working with residents to construct gardens full of herbs, medicinal plants, fruits and vegetables. By making their surroundings safer and more attractive, boosting food security and access to medicines, and improving water quality, she found residents reported a decrease in depression and gastrointestinal illness, as well as fewer falls and injuries.

Other Fogarty Fellows presented their studies of cervical cancer in Malawi, mental illness in Kenya, HIV/AIDS

in Peru and TB in Tanzania. Fogarty Director Dr. Roger I. Glass said he was encouraged by the caliber of these emerging global health leaders. "I'm so proud of you all and to see that by investing in youth, through the impact of this program, we are launching careers that will endure for 30 years."

Mentoring—essential for early-career scientists—is not often part of the culture at LMIC research institutions. That was the topic of a session to launch a supplement published by the journal of the American Society of Tropical Medicine and Hygiene (ASTMH) that provides recommendations and case studies to spur mentorship programs in low-resource settings.

"This is a call to action, not just an academic discussion," said ASTMH CEO Karen Goraleski, who introduced the session. "We have to change the way business is being done." LMIC scientists need a mentoring approach tailored to their unique circumstances, which often include very divided gender roles, respect for hierarchy and seniority, and a colonial history that has left a legacy of authoritarian attitudes, said Dr. Willy Lescano, a co-author and professor at Peru's Cayetano Heredia University.

The publication was inspired by a series of "Mentoring the Mentor" workshops hosted in LMICs by faculty of Fogarty's Global Health Program for Fellows and Scholars. "We spend a tremendous amount of our time, resources and thought in training the next generation of global health leaders," said Glass, "so we really do have an investment in doing this better, in developing a mentoring roadmap for the future, to ensure the satisfaction and success of our trainees, and to keep them on the research track."

RESOURCES

<http://bit.ly/cugh2019>

Scientists urge cross-cutting stigma research

By Karin Zeitvogel

Stigma is a barrier to better health for vulnerable populations worldwide, despite many new interventions and scientific discoveries making strides against stigmatized conditions ranging from HIV/AIDS to depression. In a series of articles published in *BioMed Central (BMC)*, scientists are calling for stigma research to be broken out of silos that focus on a single condition or population and instead develop approaches that cut across illnesses, demographics and scientific disciplines. Effective solutions will require the expertise of researchers, practitioners, policymakers and community members, and transdisciplinary teams of scientists from public health, medicine, psychology, sociology, anthropology and other fields, working together, according to the authors of the “Collection on Stigma Research and Global Health.”

Making such changes to stigma research would help to advance understanding of the drivers, manifestations and outcomes of stigma, and lead to a unified response to it, the collection says. The impact of such a shift in stigma research focus would be felt worldwide, the researchers note, because, although the burden of stigma is heaviest in low- and middle-income countries (LMICs), it also occurs in developed countries, including the U.S.

“Breaking down disease silos and working across disciplines and scientist-community member boundaries would allow us to effectively address health-related stigma and enhance health equity globally,” said Fogarty advisory board member and grantee, Dr. Gretchen Birbeck, who edited the collection. “While medical advances put better health within reach of many, stigma deters care-seeking, which generates or perpetuates health inequities,” added Birbeck, a University of Rochester professor who spends most of her time providing clinical care and conducting research in Zambia.

Often ingrained in cultural norms and institutional policies, stigma is a powerful barrier to better health for all. Community, cultural and institutional attitudes to people with stigmatized conditions, along with internalized stigma that an individual might feel, and the prejudice, discrimination and stereotyping they face, must be addressed by research, according to the BMC collection, which was inspired by a 2017 workshop convened by Fogarty’s Center for Global Health Studies.

During three days of meetings, U.S. and LMIC experts



brainstormed how to reduce health-related stigma across disease areas, populations and settings, and refined the agenda for global stigma research. “The collection reflects the challenges, priorities and opportunities identified during the workshop—including dealing with the ethical challenges we face when conducting stigma research, developing strategies to engage stakeholders and community members, determining how to study stigma across conditions, and deciding which interventions are the most effective at reducing stigma,” said Birbeck. “Ultimately, the aim of the workshop and the collection of articles is to improve lives around the world by catalyzing new research approaches and collaborations that help to move the critical field of stigma research forward.”

The workshop also informed a stigma research program launched by Fogarty in 2018, aimed at improving HIV/AIDS prevention, treatment and care in LMICs. This effort builds on the Center’s previous stigma program, begun in 2002, that awarded \$17 million through 18 awards.

For stigma science to continue to advance, scientists must focus on developing, securing funding for, implementing and scaling up interventions, said Birbeck. These interventions must take into account new challenges. For example, as treatments for HIV improve, people with the virus are living longer and are at greater risk of becoming disabled or developing cancer, epilepsy or another noncommunicable disease that also carries a burden of stigma. “The next stage for stigma science has to be the development and implementation of scalable interventions that address the intersectionality of stigma,” said Birbeck. “Not only would this complement the understanding that scientists already have of the causes, manifestations and outcomes of stigma, but it could improve the health of millions worldwide.”

RESOURCE

<http://bit.ly/stigmaBIOMED>

PROFILE

Fogarty Fellow fights cholera in Bangladesh

By Karin Zeitvogel

Dr. Eric Nelson still vividly remembers the distraught father he met in Dhaka when he was a Fogarty Fellow in 2005-06. “Holding his daughter in his arms, he gripped my arm and implored, ‘Doctor, I have three children. Two died yesterday from cholera. Please save this child,’” Nelson recalled.

“In 2005, no one should have been dying of cholera,” Nelson said. “To me, this simple meeting expressed failings at so many levels and crystallized my purpose as a researcher and clinician.”

Nelson was paired with Dr. Ashraf Khan from Bangladesh for the year-long Fogarty fellowship. After training together at NIH, the two researched different topics in Bangladesh, with Nelson focusing on cholera transmission in mice.

Nelson’s days started before dawn, when he would pump water from a Dhaka pond into a barrel on the back of a flatbed rickshaw and then accompany the rickshaw to the hospital. Throughout the day, he would run between the “mouse-house,” the hospital and lab, always making time to study and analyze what was going on around him. “As a Fellow, I learned how to be a good observer and how to act on those observations, such as building tools that improve care in challenging environments,” Nelson said.

As often happens in science, one project or idea led to another. For weeks, as he watched the Bangladeshi lab technician who was studying samples under a darkfield microscope to see which ones contained cholera and which didn’t, Nelson mentally calculated that around half were autoclaved, meaning they were cholera-free. That discovery eventually led to published papers in which Nelson identified key factors that contribute to the understanding of cholera transmission. “One was starvation of *Vibrio cholerae* in nutrient-limited pond water, and the second was predation by little viruses called phages that infect and kill the *V. cholerae*,” Nelson explained. “About half the samples that were autoclaved had these viral particles.”

As he continued his research, Nelson found antibiotics in the majority of cholera patients who insisted they



Eric J. Nelson, M.D., Ph.D.

Fogarty Fellow: 2005-2006

Fellowship at: Int’l Center for Diarrheal Disease Research, Bangladesh

U.S. partners: Massachusetts General Hospital, Harvard Medical School, Tufts University School of Medicine

Research areas: Cholera transmission

hadn’t taken the drugs. What this said to Nelson was that scientists studying cholera transmission have to think not only about how phage particles affect cholera transmission but also about how antibiotics do. That finding, in turn, led Nelson to help create a tool, which seeks to change antibiotic prescription habits among doctors. Thirteen years after the fellowship, Nelson and Khan officially conducted their first project together in 2018, running a clinical trial to test whether this tool was more effective in paper form or as a mobile phone app at changing the behavior of doctors managing diarrheal disease in challenging environments. The trial, which looked at doctors’ decision-making processes when ordering fluid replacement and prescribing antibiotics, not only achieved some significant outcomes but also exemplified the “international collaboration that the NIH and Fogarty make possible, and the huge return on investment that Fogarty gets when it supports early-career researchers,” Nelson said.

Nelson was recruited during his Fogarty fellowship by then-director of icddr,b, Dr. David Sack, to collaborate on a method to rapidly train personnel to manage cholera and shigellosis outbreaks in resource-poor settings. Called Cholera Outbreak Training and Shigellosis (COTS), the method he helped to devise has since been used globally. An updated version is part of an immersive one-week outbreak response course Nelson leads in Haiti.

Nelson attributes the innovative projects he’s been involved with to the support he got from Fogarty and NIH as an early-career scientist. “Every aspect of my research has been positively impacted by Fogarty, in ways that are still declaring themselves,” he summarized. “Had Fogarty not put me at the bench for a year in Bangladesh, my portfolio would either be empty or filled by traditional bench science.”

Photo courtesy of Dr. Eric Nelson

JONATHAN SAMET, M.D., M.S.

Dr. Jonathan Samet has spent decades researching the health risks of inhaled pollutants, including secondhand smoke and particles in outdoor air such as those in vehicle exhaust. A longtime Fogarty and NIH grantee, he has conducted research around the world, including in China, Latin America and Africa. A pulmonary physician and epidemiologist, Samet was named dean of the Colorado School of Public Health in 2017. Previously, he was the director of the University of Southern California (USC) Institute for Global Health, and a professor and chair of the department of epidemiology at Johns Hopkins University's Bloomberg School of Public Health.



What impact has your tobacco research had?

The Fogarty-supported tobacco projects I've been involved with have seeded many important things. When I first went to China in 1995, for instance, there was one person doing tobacco control with a tiny budget. There were smoke-free zones in the airport and everyone would be smoking in them. That has changed, and work funded by Fogarty, the Bill & Melinda Gates Foundation and, more recently, the Bloomberg Initiative, has played a big role in bringing about those changes. Today, social norms around secondhand smoke have shifted, and an increasing number of Chinese cities, including Beijing and Shanghai, have restrictions on smoking in public places.

Fogarty support also helped to start the tobacco control program at the National Institute for Public Health of Mexico, which has become a regional leader in tobacco research and training. But there's still work to do because there's always a new issue in tobacco control. Who was talking about vaping three years ago? That crept up on us, and today, it's hugely popular among young people.

What is your current Fogarty project?

As part of the GEOHealth Hubs program, supported by Fogarty, the National Institute of Environmental Health Sciences (NIEHS), CDC and Canada's International Development Research Centre, we're putting in place monitors for airborne particles in the capital cities of Ethiopia, Kenya, Rwanda and Uganda, to try to understand what air pollution levels are.

Our focus is on capacity building and helping to develop scientists in East Africa who do environmental health work and want to advance policy through research. Fogarty's aim is to develop researchers who can generate the evidence needed to affect policy, and be willing to step in and talk with policymakers about what their evidence shows. We're giving them the tools to do that.

What has this research achieved so far?

In Kampala and Addis Ababa, we've completed a complicated assessment of child respiratory health in relation to air pollution. After identifying schools with a range of air pollution levels, we put an air quality monitor in each of 10 schools in both cities. We've collected data about respiratory health and measured lung function in about 1,000 children—100 from each school. We've also installed centrally located monitors in each city.

What challenges have you faced?

When we started this work five or six years ago, there were very limited monitoring data available in Africa, there were some people involved in air pollution research and control, but no real enforcement capacity. The sources of air pollution in major cities are themselves complicated—things like trash burning, factories spewing out smoke, diesel vehicles. A lot of the world's older diesel vehicles—the ones that blast out black smoke when they go down the street—have ended up in Africa. There are the problems that arise from using fuels that pollute indoors and outdoors, whether it's burning wood or biomass, charcoal or animal dung. While the problem is well recognized, what to do about it is a challenge.

Communication of risk is another challenge. With air pollution, people know it's bad when the levels are extraordinary. Your eyes burn, you can't see, there's no question that it's harming you. But as levels go down, people learn to live with pollution.

What can the US learn from this research?

Although the U.S. has made great progress in bringing down air pollution, it remains a global issue. The pollution generated in China, for example, circulates around the world. So when there's control as a result of research in China or Africa, there are benefits to Americans. Steps that are taken to reduce air pollution locally also are expected to have benefits in terms of greenhouse gas emissions.

Fogarty programs build capacity and spur NCD research

By Shana Potash

At the start of the century, as the threat of noncommunicable diseases (NCDs) in the developing world was emerging, Fogarty launched a series of programs to prepare local scientists to address the looming crisis, which claims 32 million lives each year. Between 2001 and 2017, Fogarty and its NIH partners invested nearly \$80 million to establish NCD research partnerships between U.S. and low- and middle-income countries (LMICs) institutions, and build related research training programs.

Under the Fogarty programs, more than 600 investigators have received long-term NCD research training and, along with their mentors, have addressed a variety of topics from

Noncommunicable diseases (NCDs) claim 32 million lives in developing countries each year. To help address the epidemic, Fogarty has supported NCD research and training programs since 2001.

cardiovascular disease to aging disorders, and mental health to environmental health, publishing nearly 1,000 articles. Researchers have examined NCDs across the lifespan; sought to understand how diseases interact with each other; and explored risk factors and other cross-cutting issues. In addition to research and training, the nearly 80 funded projects spurred the creation of curricula and degree programs, and new health practices and policies in countries throughout the developing world.

“Noncommunicable diseases are a complex problem, and research and training needs continue to evolve.”

— DR. ROGER I. GLASS, FOGARTY DIRECTOR

Three of Fogarty’s NCD programs were reviewed recently by the Center’s Division for International Science Policy, Planning and Evaluation to determine how the initiatives enhanced research collaborations and built sustainable research capacity in NCDs. The team examined grant and publications data, surveyed U.S. investigators and foreign collaborators, and interviewed Fogarty staff to determine the impact of the NCD programs. The findings have been posted online and include recommendations for future priorities.

The evaluation and the latest Fogarty funding opportunities for NCD research training programs come at a critical time. Heart disease, cancer, diabetes and other NCDs disproportionately affect people in poorer countries. More than three-quarters of all NCD deaths globally occur in LMICs, according to the WHO. Driven by an aging population, rapid urbanization, unhealthy lifestyles and other forces, the burden of these chronic diseases is expected to increase further unless proven interventions are implemented. Part of that challenge, as noted in a 2018 WHO report, is that many countries lack research capacity.

“Noncommunicable diseases are a complex problem, and research and training needs continue to evolve,” said Fogarty Director Dr. Roger I. Glass. “This evaluation shows the substantial progress we have made but also points out the tremendous need for continued support.”

Resources: <http://bit.ly/NCDResearchEval>

Photo by China Photos/Getty Images



Programs evolved to meet new challenges

Fogarty's NCD research training programs began with 14 grants awarded through the International Clinical, Operational and Health Services Research and Training Award (ICOHRTA) in 2001. Several years later, after an update to the Global Burden of Disease Study highlighted the NCDs with the highest burden in developing countries, Fogarty launched another program focusing on cancer, lung disease, diabetes and cardiovascular disease, known as the Noncommunicable Chronic Diseases Research Training Program (NCoD). Those two programs were eventually consolidated into a new initiative when program officer Dr. Kathleen Michels recognized the need for a more holistic approach. The Chronic, Noncommunicable Diseases and Disorders Across the Lifespan Research Training Program (NCD-Lifespan), which began in fiscal year 2011 and continues today, emphasizes research across the aging continuum and aims to support the science needed to develop and implement evidence-based interventions.

While not part of the evaluation, Fogarty has also seeded the NCD researcher pipeline through other programs focused on brain disorders, trauma and injury, and tobacco cessation. In addition, the Center has broadened the disciplines included in its Fellows and Scholars program to include cardiology, diabetes, cancer, kidney disease and other NCD specialties.

NCD research training programs have impact

The three NCD programs combined provided substantial training for 660 scientists. Those opportunities, which lasted six months or more, included fellowships and certificate programs, master's degrees, research and professional doctorate degrees, and postdoc positions. Nearly half of the long-term participants were in non-

NCD LIFESPAN PROGRAM OBJECTIVES:

- Strengthen research capacity of LMIC institutions so they can become national, regional and international centers of expertise in NCD research
- Support multidisciplinary research training across the research continuum
- Train a cadre of LMIC scientists in NCD research that will advance science and contribute to changes in clinical practice and public health policy
- Support training-related research that is directly relevant to the health priorities of the LMIC
- Integrate with existing NCD research and public health programs in the LMIC
- Strengthen core research support capabilities needed to manage grants at an LMIC institution.

NCD Lifespan program: 2011 to present

degree programs. While long-term activities were the core of the programs, most grants also offered workshops and other short-term opportunities to enhance skills in specific areas such as lab techniques, grant writing and research protocol development.

As signs of success, trainees and grantees were able to leverage their experiences to obtain funding for further research or research training projects. Half of the survey respondents reported having at least one trainee who

Top Categories of NCD Articles 2003-2015

Note: Articles can focus on more than one research area. As such, a grant can be counted in more than one NCD category

NCD category	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Grand Total
Mental Health/Behavioral Health		1	7	4	2	12	13	10	10	15	9	20	25	128
Risk Factors						4	6	8	11	17	25	27	22	120
Cardiovascular Diseases					2		2	1	6	14	15	16	35	91
Substance Abuse/Addiction			4	3	1	5	6	7	6	13	11	8	12	76
Cancers			1				1	10	8	11	13	7	11	62
Metabolic/Gastro/Digestive Kidney Disorders	1		2		3	1	2		1	6	11	10	18	55
HIV/STIs/Infectious Diseases			2	5	1	8	6	4	4	2	6	12	4	54
Trauma/Injury	1		2		3	3	5	4	6	7	6	5	10	52
Neurological/Developmental Disorders		1	3	3	3	2	2	2	3	6	9	5	5	44
Maternal/Child Health				1		2			1	2		2	9	17
Reproductive							2	2	1	2	3	1	1	10
Environmental/Occupational Health									2	1	2		2	7
Bone Diseases							1		1	2	1	1		6
Eye Diseases						1	2	1					1	5
Respiratory Diseases							1			2		1	1	5
Oral Health										1			1	2
Aging Disorders												1		1
Grand Total	2	2	21	16	15	38	47	49	60	101	111	116	157	735

Case studies demonstrate impact on NCD policy

The evaluation contains several cases studies representative of how findings from NCD research projects have influenced health policies and programs in developing countries.

The opioid Tramadol has become extremely popular in the Middle East, including Egypt where a dangerously toxic version is sold cheaply on the streets. A research training collaboration between Cairo University and the University of California, Los Angeles conducted a multi-country study of Tramadol addiction. Evidence from this study and others helped inform the WHO, and the governments of Egypt and the United Arab Emirates about the treatment needs of Tramadol users and promoted the approval of appropriate medications in the two countries. The research found that *grand mal* seizures occurred in 28.5 percent of study participants during prior withdrawal periods. Because of that, treatment centers in Egypt and the UAE have seizure prevention strategies as part of their withdrawal management plans.

Findings from a research project in Vietnam helped convince the Ministry of Health to make child mental health a priority, and the national health insurance started covering certain conditions. The research was the product of a collaboration between Vietnam National University and Vanderbilt University in the U.S. Investigators conducted Vietnam's first nationally representative child mental health epidemiology survey. Among its findings, significant behavioral mental health problems were associated with an approximately 350 percent increase for risk of academic functional impairment.

This 5-year-old Vietnamese girl was a participant in a study that increased her country's interest in child mental health services.

successfully obtained additional funding. Many former trainees now have positions in academia where, as the evaluation confirmed, their roles may range from “instructing the next generation of researchers, to leading clinical rounds at a university hospital, to conducting research in a lab.” Other alumni have assumed roles within the government or with not-for-profit organizations.

Building institutional capacity—creating a strong research environment—is another area where Fogarty's NCD programs have made an impact. Grantees and collaborators from around the world provided dozens of examples of how their awards helped create courses or certificate and degree programs in topics that include cancer epidemiology, environmental sciences, nutrition, mental health, maternal and child health, and the ethics of clinical trials. Respondents also reported they had produced training materials and secured LMIC government commitments to increase staffing. The award, many said, enabled institutions to recruit or retain faculty interested in NCD research.

Outcomes include papers, protocols and products

Fogarty's programs have added to the body of knowledge related to NCDs. The review found that 982 scientific publications citing an NCD grant were produced between 2003 and 2017. The three most common topics were mental health, risk factors such as obesity and nutrition, and cardiovascular diseases.

A bibliometric analysis examined, among other things, citation impact and collaborations. A key finding was that 69 percent of alumni grantees published at least three or more articles with an LMIC colleague after their NCD grant ended, signaling they had kept up the scientific relationship that was formed because of the program.

NCD Publications and Impact

<i>Bibliometric indicator</i>	<i>Value</i>
Number of citations (times cited)	7,761
Mean citation count	13.13
Median citation count	7
<i>Bibliometric indicators for NCD articles supported by Fogarty programs, 2003-2015</i>	

“Overall the results of the bibliometric analysis and co-authorship network suggest that grantees and alumni are producing high quality scientific articles, continuing to foster collaborations between U.S. and foreign scientists, and have contributed to important empirical evidence to combat NCDs in LMICs,” as noted in the assessment.

Grantees and their collaborators have made other contributions to science. When asked what their project produced, 19 investigators—nearly half of those who responded—reported developing clinical protocols for use

Photo courtesy of Dr. Bahr Weiss



in LMICs. They include a clinical trial of a therapy targeting breast cancer and a protocol to manage sickle cell disease. Seventeen grantees reported building patient registries and databases; 11 created software and analytic tools; and four produced devices or prototypes.

Challenges and unmet needs

While progress has been made, tackling NCDs will require many more well-qualified researchers and mentors, according to the evaluation. Grantees and collaborators who were surveyed named a range of research topics that still require attention. “Adding to this need, the diversity of NCDs that make up the epidemic adds complexity to the process of building capacity. For example, a country may have built a critical mass of researchers in cardiovascular disease, but there remains a lack of experts that can manage the growing diabetes, trauma/injury or hypertension issues in the country,” the review stated.

Many grantees pointed to implementation science research as an area for growth, given its value in developing health policy guidelines and determining how to adapt or scale up interventions. Funding was an issue, with many grantees noting that even though LMIC governments may recognize the benefit of NCD research, their national budgets are too strained to support it. Creating protected time for research was also identified as an ongoing challenge, given that faculty at LMIC institutions often have competing interests.

When asked about hurdles they faced in building capacity, some grantees said that five years of funding, which is typical for the research training grant mechanism (known as D43), was not long enough to effect change in some countries. The biggest obstacles within the research infrastructure at LMICs were related to grant management and accounting, and institutional review boards that were either lacking or slow to give approval.

Recommendations and next steps

Recognizing that LMICs are facing the dual burden of NCDs and infectious diseases, the evaluation recommended collaboration between those scientific communities and suggested that future iterations of the NCD program consider how to prioritize the nexus between NCDs and infectious diseases. Encouraging such comorbidity research, the review noted, will help build a highly skilled and nimble research workforce.

Priority also should be given to research topics that cut across diseases, including prevention and implementation science, common risk factors, developmental origins, maternal and child health, and stigma. An emphasis also should be placed on research areas that so far have been under-

represented in research training such as metabolic disorders, hearing issues and chronic kidney diseases. Additionally, investigators may want to consider requiring each trainee to write and submit a grant proposal, because the process and feedback could help them take a critical step toward becoming an independent investigator.

Some of the evaluation’s findings have been incorporated into the newest funding opportunity announcements, which have deadlines in November 2019 and 2020. In a further effort to build institutional capacity, renewal applications funded solely by Fogarty must come from the foreign site. The move away from U.S.-led projects is intended to bolster LMIC institutions’ capacity to secure their own funding. New applications are expected to propose collaborations with a single LMIC institution as the major partner, thereby concentrating resources and training opportunities at one institution so a strong foundation is built.

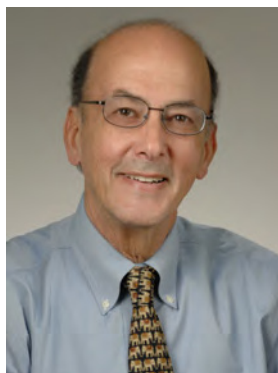
Fogarty has additional funding opportunities to help NCD training program alumni and other early-career researchers make the transition to independent investigator. The Emerging Global Leader Award gives junior faculty at LMIC institutions financial support and protected time for research. And the Global Non-communicable Diseases and Injury Across the Lifespan: Exploratory Research program gives LMIC investigators the opportunity to jumpstart research programs related to NCDs, trauma and injury.

“These programs can prime the NCD research pipeline in LMICs by giving younger scientists additional opportunities to develop their research skills,” said Fogarty’s Dr. Glass. “It’s our hope these experiences will propel them toward becoming the scientific leaders in their countries who will in turn prepare future generations of researchers.”

Strong NIH support for Fogarty’s NCD programs

The NCD research programs have enjoyed broad support across NIH. Over time, Fogarty has had a dozen partners: the National Cancer Institute (NCI), National Center for Complementary and Integrative Health (NCCIH), National Institute on Aging (NIA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), National Institute on Drug Abuse (NIDA), National Institute of Dental and Craniofacial Research (NIDCR), National Institute of Environmental Health Sciences (NIEHS), National Institute of Mental Health (NIMH), National Institute of Neurological Disorders and Stroke (NINDS), National Institute of Nursing Research (NINR), and the Office of Dietary Supplements (ODS).

New energy for global health is blossoming across NIH



There's a new wave of enthusiasm for global health sweeping across NIH. In addition to the continuing strong support from NIH Director Dr. Francis S. Collins, I'm pleased to have three new institute directors on campus who share our passion to build research capacity and fund studies to improve the health of the world's least fortunate. I was delighted to be joined in Kenya recently by

the relatively new directors of the institutes concerned with mental and child health research. There, they were able to see firsthand the impact their programs are having on the ground.

A visit to an innovative project in rural, western Kenya particularly impressed National Institute of Mental Health (NIMH) Director Dr. Josh Gordon. By enhancing irrigation and improving productivity of farmers living with HIV, researchers found it's more likely the farmers will adhere to their antiviral medication regimens and keep their clinic appointments. A few hours' drive away in Eldoret, Kenyan and U.S. researchers are studying how to keep adolescents with HIV on treatment using peer advisors and group therapy. They're also investigating how to treat depression and trauma to improve control of HIV infection, and alleviate mental health symptoms. I encourage you to read Dr. Gordon's full blog post about his travels, which he sums up with this observation, "Through cutting-edge research around the world, global efforts yield truly global impacts."

My colleague Dr. Diana Bianchi, director of the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD), said it was "an unforgettable experience." Her visit included time at a busy public hospital in Nairobi, as well as rural sites in western Kenya. She reported being very impressed by the fact that post-partum mothers are housed and fed in the hospital for weeks and months after delivery of a premature baby, and are incorporated into the daily nursery routine by providing expressed breast milk and changing their babies' diapers. She was also struck at how clinical and implementation research is embedded in the overall culture and operations at Moi University, even more so than in many American academic medical centers.

She reported being moved by her interactions with children and families who are living with HIV/AIDS. She also said she was inspired by many of the women working to reduce HIV infections among adolescent girls and young women through the program called DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women). Administered by the President's Emergency Plan for AIDS Relief (PEPFAR), the DREAMS partnership includes the Bill & Melinda Gates Foundation and other private organizations.

Overall, the trip was a powerful demonstration of the impact NIMH and NICHD investments have made in advancing global health capacity and research, with a reminder that real people's lives depend on this vital work.

Back home in Bethesda, I was pleased to have Dr. Gordon and the new National Institute of Biomedical Imaging and Bioengineering (NIBIB) Director Dr. Bruce Tromberg join me for a discussion with Fogarty's advisory board. Both gave us valuable insights into how we might spur innovation in global health and build LMIC capacity in bioengineering and other related fields.

Arriving at NIH from the University of California, Irvine, Dr. Tromberg said many engineering schools now have improving human health as their top goal. Engineering is even being combined with medicine as a new discipline. For instance, his predecessor, Dr. Roderic Pettigrew, is now building the first such fully integrated national program at Texas A&M University. I was also excited to hear that Dr. Tromberg is a proponent of engineering capacity building, having led a two-week workshop in Côte d'Ivoire to teach entrepreneurship and innovation to African scientists. Indeed, he said the experience changed his life. Now that sensors and other components are inexpensive and more easily accessible in LMICs, technologies for health can be adapted to suit local needs, he said. Portable tools can be developed to reduce barriers to care, improve access and democratize human health.

With this wonderful energy and enthusiasm from my new colleagues, I'm more optimistic than ever that by working collaboratively across NIH, we can speed advances to improve the health of all people.

RESOURCES

<http://bit.ly/NIHglobalhealth>



Bridbord, Holmes lauded as global health leaders

Drs. Ken Bridbord and King Holmes are co-recipients of the Consortium of Universities for Global Health 2019 Distinguished Leadership Award, the organization's highest honor. As longtime director of Fogarty's extramural programs, Bridbord created initiatives that provided research training for 6,000 scientists in low- and middle-income countries. Now retired, Bridbord is a Fogarty senior scientist emeritus.



Holmes, a Fogarty advisory board member and grantee, is professor and founding director of the Department of Global Health (DGH) at the University of Washington. In his more than 50 years of global health research and training, Holmes has collaborated with over 170 trainees and mentees, and has produced some 800 publications.



NIH cancer director Sharpless moves to FDA

Dr. Norman E. "Ned" Sharpless, director of NIH's National Cancer Institute since 2017, has been tapped to become acting FDA commissioner in April. Previously, Sharpless directed the Lineberger Comprehensive Cancer Center at the University of North Carolina. Sharpless treated leukemia patients and conducted research on cancer and aging.



Swaminathan named WHO's chief scientist

Dr. Soumya Swaminathan, a former Fogarty trainee, has been appointed to a newly created WHO position, Chief Scientist, charged with strengthening the organization's core scientific work. She had been deputy director-general for programs. A pediatrician and clinical researcher, Swaminathan was director general of the Indian Council of Medical Research before joining WHO.



Richards-Kortum added to Inventors Hall of Fame

Former Fogarty advisory board member Dr. Rebecca Richards-Kortum is among the 2019 inductees into the National Inventors Hall of Fame. A professor of bioengineering and director of the Rice 360° Institute for Global Health at Rice University, Richards-Kortum develops medical devices for use in low-resource settings.



Oral cholera vaccine developer Clemens honored

Dr. John D. Clemens, executive director of Fogarty grantee institution the International Centre for Diarrhoeal Disease Research, Bangladesh, is a co-recipient of Thailand's Prince Mahidol Award. Clemens and longtime collaborator Dr. Jan R. Holmgren of Sweden were recognized for developing an oral cholera vaccine that has protected millions of people.



Abdool Karim awarded by Kuwait for HIV research

Longtime Fogarty grantee Dr. Salim Abdool Karim shares Kuwait's 2018 Al-Sumait Prize for Health, a Kuwaiti award honoring people and organizations that address challenges in Africa. Abdool Karim, director of the Centre for the AIDS Programme of Research in South Africa, was recognized for his contributions to HIV/AIDS treatment and prevention.

NIH releases plan for women's health

NIH has developed a strategic plan to advance science to improve women's health with a framework to integrate sex and/or gender influences into research, provide disease prevention and treatment tailored to women's individual needs, and ensure women in biomedical careers reach their potential. Full report: <http://bit.ly/NIHwomen>

Supplement improves infant outcomes

For women in resource-poor settings, taking a certain daily nutritional supplement before conception or in early pregnancy may improve growth of the fetus, according to an NIH-funded study. The supplement is fortified with vitamins and minerals, and provides protein and fat. Journal article: <http://bit.ly/NutritionForMoms>

WHO publishes malaria control guidelines

For the first time, WHO has published a comprehensive set of evidence-based guidelines for malaria vector control. The resource consolidates more than 20 sets of WHO recommendations and will be updated on an ongoing basis. Full report: http://bit.ly/WHO_malaria

WHO posts R&D spending by country

New analysis from the WHO Global Observatory on Health R&D shows that only 41% of 75 countries analyzed met their health R&D spending targets using the most recent data available. Some low-income countries allocated a higher percentage of their GDP on health than high-income countries. Website: http://bit.ly/WHO_benchmark

NIH, FDA host treatment collaboration tool

To encourage information sharing of treatment practices for neglected diseases and emerging or drug-resistant infections, the NIH and FDA have built a tool called Collaborative Use Repurposing Engine (CURE). The aim is to capture and centralize the global experience of new uses of approved medical products—both positive and negative. Website: <https://cure.ncats.io>

PAHO studies youth health in Americas

Half of all deaths of young people in the Americas are due to preventable causes such as homicide, traffic fatalities and suicide, according to a new report by the Pan American Health Organization (PAHO). The study examines various health aspects of the region's 237 million young people and provides recommendations for improvement. Full report: http://bit.ly/PAHO_youth

Funding Opportunity Announcement	Details	Deadline
Global Infectious Disease (GID) Research Training Program (D71) (D43) Clinical Trial Optional	http://bit.ly/IDtraining	July 25, 2019
Global Brain and Nervous System Disorders Research Across the Lifespan (R21) Clinical Trial Optional (R01) Clinical Trial Optional	http://bit.ly/NIHGlobalBrain	Nov 7, 2019
Emerging Global Leader Award (K43) Independent Clinical Trial Required (K43) Independent Clinical Trial Not Allowed	http://bit.ly/NIHGlobalLeader	Nov 7, 2019
Noncommunicable Diseases and Disorders Research Training Programs in LMICs (D43) Clinical Trial Optional	http://bit.ly/NCDtrain	Nov 12, 2019
Ecology and Evolution of Infectious Diseases Initiative (EEID) (R01)	http://bit.ly/EEIDNIH	Nov 20, 2019
For more information, visit www.fic.nih.gov/funding		

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Poor quality drugs pose “health emergency,” study says

Photos by Nico Ramet/FDA



Poor quality and fake medicines (top photo) are an urgent threat.

More than a quarter of a million children die each year due to poor quality and fake medicines, according to a study published in March in the *American Journal of Tropical Medicine and Hygiene*. The assessment by a team of experts from the public and private sector concludes that a “pandemic” of falsified and substandard drugs for treating malaria, pneumonia, hypertension and other diseases has become a “public health emergency,” especially in low- and middle-income countries. It cites evidence that up to 155,000 children die every year due to fake malaria drugs alone, and that a similar

number die from low-quality or counterfeit antimicrobial drugs prescribed to treat pneumonia. Other common fake drugs include prescription opioids and medicines for heart disease, erectile dysfunction and cancer.

Fogarty senior scientist emeritus Dr. Joel Breman, a co-author on the study, said that fake drugs are often peddled over the internet and sometimes linked to organized crime and terrorist groups. Poor quality drugs cost the global economy an estimated \$200 billion per year, Breman said, and contribute to the growing problem of antimicrobial resistance.

RESOURCE

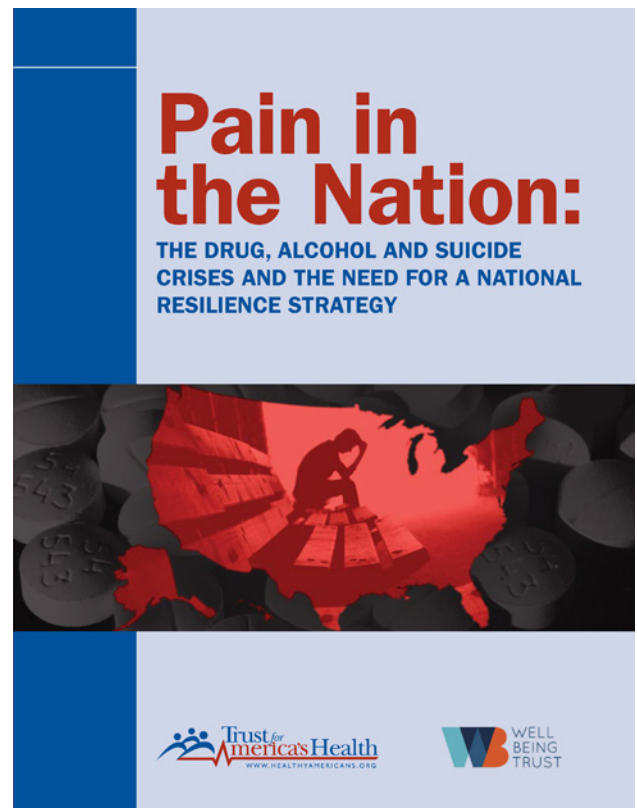
Journal article: http://bit.ly/ASTMH_fakedrugs

Wellness and Prevention Digest

Pain in the Nation Issue Brief: Alcohol and Drug Misuse and Suicide and the Millennial Generation - a Devastating Impact

This issue brief, focused on the Millennial Generation, is a continuation of Trust for America's Health (TFAH) and Well Being Trust's Pain in the Nation: The Drug, Alcohol and Suicide Crises series. The Pain in the Nation series helps inform and create a comprehensive National Resilience Strategy.

This brief is focused on Millennials for numerous reasons: Millennials are dying due to alcohol and drug misuse and suicide in record numbers. Millennials are more than one-third of the workforce, they are the largest proportion of Americans serving in the military. About a quarter lack health insurance, many are burdened by education debt, and, many are or will be parents responsible for the well-being of young children.



[LISTEN TO THE PODCAST](#)

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WATCH OUR VIDEO

Caring for the LGBTQ Community *with Pride*

For eight consecutive years and counting, Christiana Hospital and Wilmington Hospital have earned the Leader in LGBTQ Healthcare Equality designation — the highest recognition — from the Healthcare Equality Index of the Human Rights Campaign Foundation.

We are honored to be named among the most equitable, inclusive health care providers and employers in the country.

As a leader in LGBTQ health care equality we are dedicated to serving the unique health needs of lesbian, gay, bisexual, transgender and queer people in our community. *#worldpride*



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Building Resilience, Reducing Risk: Four Pillars to Creating Safer, More Supportive Schools for LGBTQ+ Youth

Rev. Karla Fleshman, L.C.S.W., M.Div.; *Transitions Delaware llc*

ABSTRACT

In 2017 Delaware, LGBTQ+ Youth reported that almost 1 out of 3 were bullied on school grounds. Additionally, over 50% reported feeling sad/hopeless; and almost as many seriously considered suicide as an option, while 32% planned for suicide with almost 1 in 4 reporting having acted on their suicide plan at least once. Of all the students who reported a suicide attempt, 10% required medical treatment as a result of their attempt.¹ The Delaware Department of Education does not have comprehensive statewide protections in place to support some of our most vulnerable youth, yet school districts can make a positive difference in implementing policy/practices to build resilience and reduce risk.

This article will focus on four key areas where schools and school districts may implement changes toward creating safer, more supportive schools: (1) policy/procedures that protect LGBTQ+ students at the administrative level; (2) comprehensive cultural sensitivity training for serving LGBTQ+ students and their families; (3) incorporating inclusive curriculum on LGBTQ+ history into the classroom; (4) and creating, supporting, and sustaining gender sexuality alliances in both the middle and high schools.

BACKGROUND

TW... "TW" is short-hand for "trigger warning" and is used to warn the audience/listener that what is about to be shared may be triggering as it involves trauma in some form or fashion.

Every day in our schools, LGBTQ+ youth experience unkind words, hurtful actions, and harmful policies that put their lives at risk, yet it doesn't have to be that way.

WHAT DO DELAWARE LGBTQ+ YOUTH SAY?

TW... "That's Soooooo GAY! What fa**ots!" Two students are loudly discussing a recent event in the hallway as a teacher walks up to them and takes the time to explain to them how their words hurt. The teacher then

shares with them other ways to express themselves that build up, rather than tear down others. An LGBTQ+ youth observes this public support and feels affirmed. (Incident Occurred in a Delaware High School)

The Delaware Youth Risk Behavioral Survey (DEYRBS) is conducted every other year in select classes within Delaware public high schools. The most recent data is from 2017, and for the first-time included questions asking about gender identity and gender expression (See Table 1).

Youth today identify across a much broader spectrum of options including pansexual, asexual, bisexual, agender, non-binary, as well as transgender. The option "unsure" may be interpreted two different ways: (1) the young person completing the survey is still engaged in age appropriate identity formation and is, therefore,

Table 1. Delaware 2017 Youth Risk Behavior Survey Questions

On Gender Identity				
	Yes	No	Unsure	Not Sure What Question is Asking
Question: Some people describe themselves as transgender when their sex at birth does not match the way they think or feel about their gender. Are you transgender?	1.4	95.7	1.0	1.8
On Gender Expression				
Question: A person's appearance, style, dress, or the way they walk or talk may affect how people describe them. How do you think other people at school would describe you?				
Response Options	Male		Female	
Very Feminine	1.1		25.6	
Mostly Feminine	1.3		38.0	
Somewhat Feminine	2.3		16.2	
Equally Feminine & Masculine	10.6		16.7	
Somewhat Masculine	12.4		2.4	
Mostly Masculine	37.9		0.6	
Very Masculine	34.3		0.5	

unsure of their own identity at time of completing the survey; or (2) the youth does not see an option that represents how they self-identify and so choose “unsure” as the closest option to their self-identity.

By accessing www.KidsCount.org figures for 2017 in conjunction with DEYRBS 2017, we can calculate that there are approximately 986 (2.4%) Transgender/Non-Binary Youth and 4,824 (13.7%) Gay, Lesbian, Bisexual, Pansexual Youth in our High Schools. These same youth responded to the following questions on school safety (see Table 2).²

We find that Delaware LGBTQ+ Youth are twice as likely to be
Table 2. Delaware 2017 Youth Risk Behavior Survey Question on Sexual Orientation

Question: Which of the following best describes you?	
Choices	Total
Heterosexual	86.3
Gay or Lesbian	3.3
Bisexual	7.5
Not Sure	2.9

threatened or injured with a weapon on school property, bullied on school property, or felt so unsafe they didn’t go to school at least once in the last 30 days compared to heterosexual youth (See Table 3). This unsafe environment leads to an accumulation of stressors over time creating a stress proliferation in LGBTQ+ youth that can exacerbate mental health problems and decrease an ability to cope.³

The Human Rights Campaign Report *Growing UP LGBTQ in America* surveyed over 10,000 students age 13-17 and national trends substantiate and affirm the challenges of Delaware LGBTQ+ Youth. Twice as likely as their peers to say they have been physically assaulted, kicked or shoved, 92% of LGBTQ+ youth also report they hear negative messages about being LGBTQ+. The top sources of this negative messaging are the school, their peers, and social media. The biggest problems our LGBTQ+ youth face in Middle School and High School is parents/family are not accepting (26%) and trouble at school/ bullying (21%).⁴

THE EFFECTS OF TRAUMA

TW... "What's in your pants!" A teenager shouts this across the room at a transgender student. The aggressor continues to shout while moving toward the student when another classmate steps in between to intervene. The substitute teacher either didn't notice or didn't know how to intervene so they remained at the desk looking at papers. (Incident Occurred in a Delaware Middle School)

Table 3. School Safety Delaware High Schools

Questions	Heterosexual	Gay / Lesbian	Bisexual	Not Sure
Were threatened or injured with a weapon on school property?	5.4	9.0	9.5	11.1
Were in a physical fight on school property?	8.3	9.9	9.5	11.8
Were electronically bullied?	13.3	18.4	29.6	22.0
Were bullied on school property?	17.1	28.0	34.4	24.3
Did not go to school because they felt unsafe at school or on their way to or from school?	6.1	10.3	9.9	10.7
Were ever physically forced to have sexual intercourse?	5.4	21.2	22.1	13.1

The historical ten identified “adverse childhood experiences” (ACE’s) outlined in the original study from 1995-97⁵ were not explicit to LGBTQ+ experiences yet illustrate a road map toward understanding the adverse impact of trauma on LGBTQ+ adolescents and adults (see Figure 1).

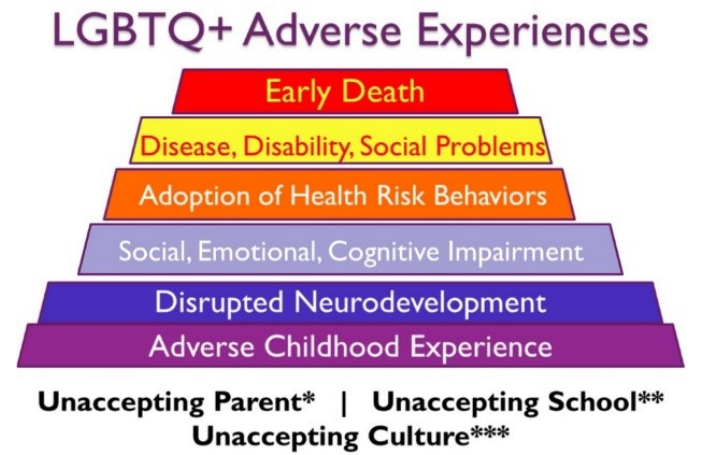


Figure 1. LGBTQ+ Adverse Experiences

Research on the impact of microaggressions [4/sidebar] toward LGBTQ+ adults⁶ and adolescents⁷ who recall school victimization highlight heightened psychological distress, higher substance abuse use, higher risk of depression, social anxiety, suicidality⁸; and may suffer long-term negative effects which can contribute to increased rates of PTSD within the LGBTQ+ community.^{9,10} Further exploration of the long-term outcomes on LGBTQ+ adults appear to show even higher levels of distress when race/ethnicity and/or transgender/non-binary are factored in to identify the compounded adverse impact often felt with intersectional minority identities.¹¹⁻¹³

"Actions which promote invisibility and deny a young person's right to exist as their authentic self is trauma" - author

By reviewing the DEYRBS 2017 data we can hear directly from our LGBTQ+ youth; and the findings are startling and disturbing. LGBTQ+ Youth are twice as likely to feel sad or hopeless compared to heterosexual youth. These same youth are 3-4 times as likely to consider suicide and make a suicide plan. Most unsettling is that 1 in 5 report attempting suicide with almost 10% of those youth requiring medical intervention (see Table 4).

Table 4. Effects of ACEs on High School Youth in Delaware

Question	Heterosexual	Gay / Lesbian	Bisexual	Not Sure
Felt Sad or Hopeless	27.5	53.1	66.0	46.4
Seriously considered attempting suicide	13.3	4.4	49.6	31.8
Made a plan about how they would attempt suicide	10.4	33.2	39.4	25.6
Attempted Suicide	5.4	18.6	24.2	14.3
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse	1.7	9.6	6.9	5.6

Additionally, when homes are not safe and when schools are not safe, the research reflects higher rates of homelessness, higher rates of Juvenile Justice System use, higher rates in the Foster Care System, increased dropout rates, and increased high risk behaviors (including self-harm, drugs, alcohol abuse, and un-safe sexual activity).^{11,14,15}

Our LGBTQ+ young people deserve better in our schools. We owe it to our children to have an affirming launch into adulthood. How might we begin to create safer, more supportive schools? How might we build resilience while reducing risk for our LGBTQ+ youth?

MICROAGGRESSIONS

- **Microassaults** are small behaviors that are intentional and purposefully hurtful (e.g., using the wrong name or pronouns, name calling, making derogatory statements or threatening gestures).
- **Microinsults** are rude statements that are usually unintentional or unconscious that indicate ignorance or bias (e.g., asking inappropriate questions, redirecting someone to another bathroom, or facial expressions that reveal confusion or disgust).
- **Microinvalidations** are statements or actions that are usually unintentional or unconscious that ignore, minimize, or nullify a person's identity (e.g., having only two options for sex/gender on forms, classroom illustrations of famous people in history who are all white, all straight, and all cisgender).
- **Intersectional Microaggressions** are microaggressions (of all types) that are connected to multiple parts of a person's identity (such as race and gender or religion and ethnicity)
- **Systematic Microaggressions & Discrimination** are institutionally based microaggressions that cannot be attributed to one specific person but that affect many or most members of a group.

Green, E.R. & Maurer, L.M (2015). *The Teaching Transgender Toolkit: A Facilitator's Guide to Increasing Knowledge, Decreasing Prejudice & Building Skills.* Ithaca NY: Planned Parenthood of The Southern Finger Lakes: Out for Health.

WHAT WE CAN DO TO MAKE A DIFFERENCE

I propose there are four key areas in which both immediate and lasting change can occur to improve the safety and support for all children. These four pillars are: (1) policy/procedures that protect LGBTQ+ students at the administrative level; (2) comprehensive cultural sensitivity training for faculty/staff serving LGBTQ+ students and their families; (3) incorporating inclusive curriculum on LGBTQ+ history into the classroom; (4) and creating, supporting, and sustaining gender sexuality alliances at both the Middle and High Schools.

PILLAR ONE: SCHOOL ADMINISTRATION / SCHOOL DISTRICTS

Currently there is no unequivocal policy through the Delaware Department of Education that protects all youth across the spectrum of Sexual Orientation, Gender Identity, and Gender Expression (SOGIE).¹⁶ Yet, there is evidence on the positive impact such policies have toward creating a safer environment for LGBTQ+ youth. When the highest leadership position in the school system makes it clear that LGBTQ+ students are protected the results are astounding.^{17,18}

Resource: Model district anti-bullying and harassment policy by GLSEN (Gay, Lesbian, Straight Education Network)

First and foremost, anti-bullying policies that are explicitly inclusive of SOGIE **and** enforced show a significant reduction in the risk of suicide attempts in LGBTQ+ youth in **both** Middle School and High School (see Figure 2). Additionally, LGBTQ+ youth who report a reduction in victimization at school more readily identify adult mentors/allies, which leads to LGBTQ+ youth being more likely to engage in school activities while reducing high risk behaviors.^{19,20}

Hatzenbuehler and Keyes compared school district policies in Oregon based on inclusive to least inclusive policies and noted: (1) school districts that adapt inclusive anti-bullying policies see a decrease in rates of suicide attempts from previous years. The research noted:

“Whereas 31% of lesbian and gay adolescents attempted suicide in counties where school districts were the least likely to adopt inclusive anti-bullying policies, only 17% attempted suicide in counties with the greatest proportion of school districts with inclusive policies.”²¹

This is corroborated by Saewyc, et al., whose study illustrated that schools with anti-bullying policies for three or more years showed greater gains in reduced risk and increased safety than schools for fewer years/no policy. Equally significant, the studies demonstrated reduced risk for suicide among **both** LGBTQ+ youth and heterosexual youth!²²



Figure 2. Sexual Orientation Gender Identity/Expression Policies

Other Policy Suggestions: De-gender rites of passage in a school. Change Homecoming King & Queen to Homecoming Royalty. Eliminate gendered graduation robes.²³

PILLAR TWO: CULTURAL SENSITIVITY TRAINING OF FACULTY AND STAFF

A 2019 study entitled *Supporting Safe and Healthy Schools for LGBTQ Students: A National Survey of School Counselors, Social Workers, and Psychologists* reported the following findings:

- 37% of school mental health professionals had never received any formal training on LGBTQ+ student issues during their career
- 76% of school mental health professionals received little to no training on working with LGBTQ+ youth.²⁴

May I call you friend?

A school administrator shared with me that school policy and parent demands prevented them calling the transgender student by their affirming name and pronouns. Each time the student was called their "dead name" and mis-gendered, the pain on their face was evident.

The school administrator's heart is about affirming each child's inherent dignity and self-worth. Found between a proverbial rock and hard place they looked at the student and said, "May I call you friend?" The student smiled because in that moment they knew they were seen and affirmed. (This act of compassion and mentoring occurred in a Delaware School)

Another study noted "teachers' own prejudice against sexual minorities may prevent them from being positive role models for sexuality minority youth"²⁵

When our school's staff/faculty are ill-prepared and ill-trained to support LGBTQ+ youth, microaggressions go unaddressed and support for these same youth decrease. The most effective way to create culturally competent supportive staff/faculty is to require excellent professional development for all staff/faculty that: (1) centers on evidence-based research on challenges/opportunities of LGBTQ+ youth across the full SOGIE spectrum; (2) brings in the significance of intersectionality in relationship with ACE's; and (3) through didactic exercises, trains staff to become aware of and know how to effectively intervene when microaggressions occur; (4) while providing insight on how to build resilience within these same youth.²⁶

Transitions Delaware, llc has provided trainings to school administration and faculty ranging between sixty minutes to a full day based upon the identified needs and goals of the school or district. One of the frequent benefits noted by those who attend the trainings is the small group, didactic exercises that afford participants the opportunity to ask clarifying questions and practice affirmation exercises geared at building resilience in youth. The other benefit extolled by participants is having a greater understanding on the differences between sexual orientation *and* gender identity *and* gender expression in relation to greater insight on the ever-expanding vocabulary and pronoun usage of LGBTQ+ youth in their identity formation. It is advisable that consultation be provided by trainers to those requesting a training in advance to ensure the materials provided and delivered are relevant content to the school making the request.

When comprehensive training is well delivered, research illuminates that staff/faculty become effective supporters of LGBTQ+ youth:

- (1) LGBTQ+ students with supportive school staff, were less likely to feel unsafe (40.6% vs. 78.7%);
- (2) were less likely to miss school because they felt unsafe or uncomfortable (16.9% vs. 47.2%);
- (3) had higher GPAs than other students (3.3 vs. 2.8); and
- (4) were less likely to say they might not graduate high school (1.7% vs. 9.5%).¹¹

PILLAR THREE: INCLUSIVE CURRICULUM

An inclusive curriculum validates LGBTQ+ youth. Hidden rainbows are as important as hidden figures!²⁷ Visibility of LGBTQ+ historical figures from math/science, the arts, political/social justice, etc. provide the LGBTQ+ young person mentors and role models while also "normalizing" the value and importance of LGBTQ+ contributions to society to heterosexual and cisgender students.²⁸⁻³⁰ In one study it was noted that

"by infusing relevant transgender content into lectures and reading materials, instructors contribute to normalizing transgender issues for an inclusive curriculum."³¹

The Center for Disease and Control (CDC) reports LGBTQ+ youth are more likely to have poor health outcomes than their heterosexual (straight) peers.³² Yet, only 4% of LGBTQ+ students were taught positive information about LGBTQ+ people or issues in their health classes.¹⁸

Through direct interactions with LGBTQ+ youth in the Delaware public schools, there is a common refrain heard from the students who say sexuality education is "heteronormative and cishnormative." The Delaware DHHS Division of Public Health identified in the Delaware Adolescent Sexual Health State Plan (January 2011) that

...services must be strengthened to better serve sexual minority youth (i.e., students who either identified as gay, lesbian, bisexual, transgender or reported any same-sex sexual contact). And inclusive policies will strengthen the capacity of youth-serving organizations to prevent risk behaviors and improve health outcomes among Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth.³³

Yet, upon informal interviews with parents, students, and health teachers, an inclusive health and sex education for Delaware LGBTQ+ youth does not appear to be evident despite there being the January 2011 Delaware Adolescent Sexual Health State Plan which states *services must be strengthened to better serve sexual minority youth*.

Hidden Rainbows are as Important as Hidden Figures

In February 2019, New Jersey became the second state to require that schools teach LGBTQ+ history.³⁴ When LGBTQ+ students were interviewed on the value of inclusive curriculum, they shared:

“learning about LGBTQ+ issues in my school helped stop bullying;” and “people in my class became more aware of things...were simply more educated afterwards, and had a little bit of an easier time talking about LGBTQ+ issues;” and another student explained “that when LGBTQ+ youth see themselves reflected in the curriculum they can feel hopeful about their own future.”^{35,36}

From library books to lesson plans, it is important to incorporate LGBTQ+ into the curriculum because the visibility gives LGBTQ+ students hope while educating and fostering compassion among their peers. In fact, 75.2% of LGBTQ+ students in schools with an inclusive curriculum said their peers were accepting of LGBTQ+ people, compared to 39.6% of those without an inclusive.¹⁸

PILLAR FOUR: GENDER SEXUALITY ALLIANCES (GSAS)

GSAs are one of the primary ways for middle and high school administration, faculty, and staff to offer safe, affirming space for LGBTQ+ youth. The interplay of the four pillars of support creates a school environment where a GSA moves from crisis management of daily microaggressions to affirming informal/formal mentoring, as well as leadership development through a school sanctioned club.

GSAs are in a key position to foster youth resiliency through mentoring. The historical three primary purposes of GSAs are social, support, and advocacy.³⁷ GSA Advisers are often school teachers or counselors; and research supports that having “mentors—especially teacher-mentors—are positive forces in the educational resilience of sexual minority youth ... [and] provide the biggest boost to the chances that sexual minority youth will attend college.”²⁴

When GSAs are **active** in the school, research has demonstrated time and again that there were fewer homophobic comments from peers, less victimization related to SOGIE, greater school connectedness, and more instances of teacher intervention in homo/transphobic harassment.

Additionally, and as significantly important, youth who can **be present** in a GSA experience a more positive impact on

their emotional/mental health through both peer and adult mentoring.³⁸ Through peer mentoring, LGBTQ+ students are able to share experiences and stories of affirmation and support which displace and replace the negative messages encountered in homes or in hallways. When a GSA is scheduled on a day/time that makes it difficult for LGBTQ+ youth to attend, the result is a poorly attended GSA that is often erroneously interpreted by faculty/administration as meaning there are no LGBTQ+ students in need of this support at that school. This is a false narrative. Equally important, if the GSA Adviser is not recognized by the LGBTQ+ youth as an ally, they will not attend. Trust is essential for youth to risk disclosing their identity to a representative of the school. Christian Rummel, of the American Institute for Research writes:

In-person mentoring relationships may serve an important protective role for [LGBTQ+] youth, helping them to confront challenges...informal mentoring relationships with adults may promote positive educational outcomes...mentors appear well-positioned to offer ongoing support that can attune to the needs of youth as they navigate through phases of exploring, accepting, and sharing their identity with others.¹⁴

Big Brothers Big Sister of Delaware is the only formal mentoring program in state that has a targeted LGBTQ+ Mentoring Program for both Middle/High School GSAs, as well as traditional Big Brother/Sister/Sibling matches with Little Brother/Sister/Sibling matches.

In summary, the positive outcomes of GSAs are a reclaimed sense of hope, a stronger sense of school connectedness, and an increased sense of well-being, educational attainment, and positive self-esteem. The positive impact of GSAs at both the middle & high schools translates into a reduction in high-risk behaviors and increase in resiliency in LGBTQ+ youth.

BUILDING RESILIENCE IN TODAY'S LGBTQ+ YOUTH

"When all Americans are treated as equal, no matter who they are or whom they love, we are all more free."--Barack Obama

In the note he left behind when Eric James Borges engaged in death by suicide, he said, “my pain is not caused because I am gay. My pain was caused by how I was treated because I am gay.”³⁹ How best can we counter pain caused by a community that treats LGBTQ+ youth differently because they are LGBTQ+? The four pillars briefly highlighted in this article provide a road map toward changing the school culture by creating community of inclusion and cultivating mentoring relationships which can inspire LGBTQ+ youth to discover their dreams and live into their potential.

By engaging the metaphor of four pillars in relation to a school building, if one pillar is missing, the structure will become unstable, and unstable buildings risk collapse, often resulting in injury or even death. In K. Asakura article entitled *Paving Pathways Through the Pain: A Grounded Theory of Resilience Among Lesbian, Gay, Bisexual, Trans and Queer Youth*, they write:

“On the one hand, it courageous that these LGBTQ+ youth actively paved their **own** pathways to resilience. On the other hand, there are potential personal costs on youth when they individually assume and carry responsibilities to cope with external adversities put on them.”⁴⁰

Today, as evidenced by the Delaware Youth Risk Behavioral Survey, many Delaware schools operate without any or with minimal efforts in helping LGBTQ+ youth pave a pathway to resilience.

Shifting a school climate from exclusion to inclusion requires an intentional and transparent plan! The actionable steps for District School Boards, Superintendents, and School Administration require changing the policies and procedures to include SOGIE; and to allocate funds for training culturally competent and equipped faculty and staff to be better able to engage intersectional, appropriate formal and informal mentoring of LGBTQ+ youth in the classroom, on the stage, court, field, and through GSAs at the middle and high school.

The personal cost on LGBTQ+ youth cultivating their own resilience often involves the adverse effects of ACEs and long-term medical/mental health complications as outlined in the beginning of this article. Therefore, it is beholden upon school boards, superintendents, school administration, faculty and staff to "... have the responsibility to share the burden carried by these youth and envision and actualize the kind of social climates that pave smoother pathways on which LGBTQ+ youth can march on with less pain and more joy."⁴¹

SUMMARY

Twenty years ago this year, I graduated from Columbia Theological Seminary (CTS) with a master's in divinity. I was told during my entrance interview that I was the first LGBTQ+ person to openly apply to the seminary. I did not walk into a welcoming community, and my experience fluctuated from welcoming to tolerated to hostile. This was a difficult environment for my then 28-year-old self. I had access to family, friends, and community support as I walked through this stressful time. Sadly, we do not afford that same level of encouragement and support to children who come out as young as ten (and even younger).⁴² Through my own lived experience, I can "testify" on the importance of bringing LGBTQ+ curriculum into the classroom setting as a means for creating positive change. I can "preach" about the value of having faculty and administration engage in cultural sensitivity training.

During my senior year, I preached a sermon entitled "Let the Little Children Come unto Me, Do Not Stop Them" referencing the words ascribed to Jesus in the Gospel of Mathew 19:14. My message was about creating safer, more supportive churches and schools for LGBTQ+ youth. The day after I talked about the risks LGBTQ+ youth face, the world learned about Mathew Shepperd; and a year after I graduated, the student body started a gender sexuality alliance called Imago Dei, which means 'image of God'.

This GSA remains active at CTS as a positive influence in the community, and the southern seminary now celebrates diversity across sexual orientation, gender identity, and gender expression. Meaningful and lasting change takes time. This kind of change calls forth leaders who are willing to risk public scrutiny and criticism.

May you, the reader, be inspired and encouraged to be the change we need today in our Delaware schools. May we, together, create safer, more supportive schools for LGBTQ+ youth.

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CHRISTIANA CARE
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Part of the Solution to Address Sexual and Gender Minority Health and Health Care Disparities: Inclusive Professional Education

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ABSTRACT

Background and Purpose. The public health perspective regarding sexual and gender minority health has continued to expand beyond the hallmark AIDS crisis in the 1980s. Sexual and gender minorities experience various health and healthcare disparities for a variety of reasons. A 2017 national survey indicated that 8% of lesbian, gay, bisexual, and queer (LGBQ) respondents had been refused care by a health care provider in the last year because of their sexual orientation, and 29% of transgender identified individuals were refused care.¹ Healthcare provider attitudes and behaviors contribute significantly to some of these disparities. This perspective piece provides a synopsis of the public health/population health challenge with health disparities in these populations and a call for action to have professional health education be more inclusive of content pertinent to the health and treatment of sexual and gender minorities. This perspective also provides a summary of educational recommendations and sample curricular objectives to assist ease of integration into health professional education, regardless of discipline. A framework of pedagogy and delivery of curricula is beyond the scope of this perspective piece.

Position and Rationale. In seeking solutions to impactful ways of achieving health and healthcare equity in these communities, one solution has to be on the educational and academic side of health professions. In its broadest sense, the literature suggests a strong positive association between education and health from a socio-ecological model perspective. This perspective piece speaks directly to the subset of how education can have a direct impact on health disparities through the health care provider's interpretation and use of information learned/not learned.

Discussion and Conclusion. Based on pedagogical principles in education and literature suggesting positive associations between impact on health disparities and health professional education,² it is concluded that health professional education - regardless of discipline - should be inclusive of sexual and gender minority content to address this significant gap in knowledge, awareness, and skill in health delivery for these populations.

INTRODUCTION

From an educational and population health perspective, the foundation of health care professional education has been non-inclusive of health care discussions regarding sexual and gender minorities (SGM) and the health disparities that exist within these populations.³⁻⁶ In fact, the inclusion of this content has not been included or studied in all health disciplines, but where it has, it reveals a significant gap.⁷⁻⁹ In the last decade, the medical literature has started to unravel and discover the very real health care needs that go along with these identities. Since sexual and/or gender identities are not a required demographic data point to collect, data and research in healthcare regarding discrimination and health disparities is markedly limited. From the latest demographic statistics that we do have, conservative estimates put the collective populations within these spectrums at ~ 4.1% of the U.S. population; however it's important to note this number is not inclusive of all identities within these populations.¹⁰ The data around health disparities/equity that we do have indicates pervasive and statistically significant numbers of both discrimination and health disparities among these populations.^{11,12}

The literature also supports the very real correlate of healthcare provider discrimination and bias to perpetuation of health disparities in these populations, specifically in delaying health care or not seeking health care altogether.¹³⁻¹⁶ While the educational research is mixed on the impact of cultural competency education in translating to improved healthcare delivery, it does indicate a positive association in acquiring new knowledge, improved attitudes and skills, and enhanced patient experience.^{17,18} We also have limited to no data regarding sexual and gender minority inclusive cultural competency education for health care professional education and its impact.¹⁷ Cohen and Syme advocated for more research exploring to what extent educational interventions can address health inequities, noting that this is an area of infancy in the research realm.¹⁹ Alcaraz and colleagues go further in describing a framework to help advance research and interventions focused on health equity, inclusive of sexual and gender minority health.²⁰ Cameron et al., also take a deeper dive into structural competency and delivery of educational curricula in a context that hopes to expand identity-based health needs in a meaningful and truly impactful way.²¹

Throughout the professional educational curricula in healthcare (physical therapy, medical, nursing, occupational therapy, speech,

chiropractic, etc.) there is limited to no time dedicated to learning about cultural competency or health disparities regarding these populations.²² That has to change. Some programs dedicate numerous hours and lectures to rare diseases and conditions; the likelihood of encountering one of these in one's professional career are minimal. However, healthcare professionals will all treat patients with identities in sexual and gender minorities. Most professionals likely won't be comfortable doing so and may identify a lack of preparation in the professional curriculum as one reason. Implicit and explicit bias has also been identified in the literature as a contributor to discriminatory practice among healthcare providers.^{14,16,23} When looking at these gaps in curricula for our healthcare professionals, one can argue that the approach to fill them should be multi-faceted, and at minimum start with requiring professional education to be inclusive of these populations' health needs and characteristics. The American Association of Medical Colleges (AAMC) has published a monograph with sexual and gender minority competencies for medical professional curricula, which this author summarizes for generalization to all disciplines.¹⁴ This commentary establishes the necessity of healthcare professional education to be inclusive of sexual and gender minority content to specifically address the healthcare disparities that providers directly contribute to: implicit/explicit bias, discrimination, and cultural incompetence.

THE LITERATURE AND SGM HEALTH DISPARITIES

Operationally, this author speaks to lesbian, gay, bisexual, and transgender (LGBT) health disparities because some of the identities included in the inclusive terms "sexual and gender minorities" have not been studied to date. The literature specifically speaks to the following identities in health disparity research: LGBT. It is purported that LGBT health disparities stem from a sociocultural environment that devalues these minority identities.²⁴ Meyer and Frost apply the minority stress model to health outcomes: minority stress is based on the premise that prejudice and stigma directed toward sexual and gender minorities brings about unique stressors and these cause adverse health outcomes manifested as health disparities.²⁵ This commentary speaks specifically to education being a public health answer to having an impact on these disparities, primarily because provider behaviors and attitudes have a direct correlation on disparities in these communities.¹ As we gain more insight into the health of these populations, we continue to note drastic and significant health disparities across the spectrums of these communities. Of note, there is strong literature looking into resilience factors as attributes of positive contributors to health in these communities.²⁶⁻³⁰ Table 1 provides a summary of some key health and health care disparities, which this author has adapted from the AAMC publication.¹⁴

See Table 1

THE LITERATURE AND SGM CONTENT IN HEALTH PROFESSIONAL EDUCATION

Two recent systematic reviews of sexual and gender minority inclusive education in the health professions reinforce the conclusions that education and training of healthcare providers and students will improve skills and ultimately may lead to

improved quality of healthcare for sexual and gender minorities.^{6,7} These systematic reviews also concluded that our professional education curricula have a long way to go to be inclusive of this content, consistent with delivery of this content in all disciplines, and establishing a conceptual model for best practice of curricula implementation. In the AAMC monograph, the authors discuss numerous challenges and advancements to education reform in this area. Of note in the barriers and challenges is that they are multi-factorial, and combine both lack of mentoring/modeling in clinical practice with absence of faculty willing and able to teach relevant content in the didactic curriculum.¹⁴ There is no current requirement of this content in health professional literature as a stand-out component, rather, it is often implied as covered under other areas, such as cultural competency or domains of competency for history taking, etc. The literature suggests is that this is not nearly comprehensive enough to address the core knowledge and skills needed to provide patient-centered care for these populations. Most of the literature supporting the necessity and preliminary effectiveness of sexual and gender minority inclusive curricula has been done in the medical community. All health disciplines need to follow suit in opening their curricula and their research to supporting these communities in their health. Given the direct and significant contribution to health disparities by provider discrimination and bias, health professional education can serve to increase awareness and knowledge of these communities to help inform best practices in health delivery and help foster a more affirming climate and approach in training and delivery.

The author fully acknowledges the complexity and numerous other aspects around culture and climate that also need to be addressed when making curricular shifts. This commentary is meant to be a succinct snapshot of advocating for educational interventions to be one of the public health answers to health disparities in SGM communities, fully recognizing the many layers of implementation challenges from societal to individual level barriers. It is beyond the scope of this commentary to discuss delivery recommendations, curricular models, pedagogical influences to delivery. This commentary aims to provide a summary of recommendations for content and scope only. There is no best-practice model validated to date regarding curricula integration. One of the most comprehensive models/guides to date is AAMC's 2014 publication utilizing competency domains for medical education. That publication is the foundation for the summary below, given that it extensively synthesized the available literature and utilized a broad panel of experts. Table 2 provides a summary of recommendations for health professional educational curricular threads, regardless of discipline. This content crosses all health disciplines, and can be individualized and contextualized discipline-specific, however, the curricular threads noted in this summary are considered integral to all disciplines.

See Table 2

CONCLUSION

The cultural shift in education is great, however, the alternative to this cultural shift is not acceptable. Romanelli provides a candid summary: "the root causes of system-level barriers were all attributed to social-structural factors that worked to exclude and erase LGBT people from the institutions that shape the health and mental health systems⁵⁵." This commentary establishes the

Table 1: Overview of Health and Health Care Disparities in Sexual and Gender Minority Populations
(Adapted and Modified from AAMC, 2014)

Health Disparity	Prevalence/Statistic	Populations Affected
Obesity	2x risk compared with heterosexual women ³¹	Lesbian and bisexual women
Asthma	1.5 times the risk compared to heterosexual counterparts	LGB adults
Cardiovascular disease	>2 times the risk compared to heterosexual counterparts ³²	LGB adults
	Significant elevations in biomarkers of cardiovascular disease compared to heterosexual men	Young GB men
Smoking	>2 times the risk compared to heterosexual counterparts ³³	Bisexual individuals
	Higher prevalence versus population as whole ³²	LGBT population
Physical disability	Increased likelihood at younger age than heterosexual counterparts ³⁴	LGB individuals
	2x the risk compared to heterosexual women	Lesbian women
	3x the risk compared to heterosexual men and women	Bisexual men and women
HIV/AIDS and other STIs	Elevated risk for HIV/AIDs and other STIs ³⁵	Gay men and transgender women
Cancer	Increased anal cancer rates primarily due to increased risk for HPV ³⁶	Gay and bisexual men and men who have sex with men
	Increased breast cancer; increased fatal breast cancer	Lesbian and bisexual women
	Cervical cancer primarily due to elevated risk for HPV	Lesbian and bisexual women
	Colon and rectal cancer primarily due to elevated risk factors	Lesbian and bisexual women
	Lung cancer; further research needed as to reason	LGBTQ individuals
	Prostate cancer; further research needed as to reason	Men who have sex with men
Lifetime risk of violent victimization and maltreatment; Lifetime exposure to traumatic experiences	Higher risk than heterosexual and cisgender individuals ³⁷⁻⁴⁰	LGBTQ individuals
Substance use/abuse	>2x more likely to have used any illicit drug in past year ⁴¹	Lesbian, gay, bisexual individuals
	Increased binge-drinking ⁴¹	Adult LGBT individuals
	90% more likely to use substances than heterosexual adolescents ^{42,43}	LGB adolescents
Risk behavior likelihood	Less likely to practice safer sex than heterosexual counterparts ⁴⁴	Young gay men
	>4x incidence of risky sexual practices/unsafe practices compared to white peers ⁴⁵	Lesbian and bisexual youth who identify as “mixed” race/ethnicity
	>1/3 prevalence in hazardous weight control behaviors ⁴⁶	LGB youth
	Less engagement in moderate/vigorous physical activity or participation in sports than non-LGBT counterparts ⁴⁷	LGBT youth
Depression, anxiety	Significantly increased risk than non-LGB counterparts ⁴⁸	GB adult men and LGB youth
	~4x risk of depression ⁴⁹	Non-treated transgender individuals
Suicide ideation / attempts	2-4x risk of suicide ideation compared with heterosexual men ⁵⁰	GB men
	2x more likely to have suicide ideation and 4x more likely to make serious suicide attempts requiring medical attention than heterosexual counterparts ⁵¹	LGB youth
	14% prior suicide attempt; 50.8% transgender male suicide attempts; 41.8% nonbinary individuals; 29.9% transgender females; 27.9% questioning individuals; 17.6% females; 9.8% males ⁵²	LGBTQ youth
Healthcare discrimination and mistreatment	33% of transgender respondents experienced a negative interaction with a healthcare provider ⁵³	Transgender individuals
	Refusal of Care: 8% LGB respondents experienced refusal of care; 29% of transgender respondents experienced refusal of care ⁵⁴	LGBT individuals

Table 2. *Summary of Recommendations for Health Professional Education Curricular Threads*
(Expanded Upon from AAMC, 2014)

Area of Domain of Practice	Recommendations for Content	Sample Objectives for Outcomes of Education
Patient Care	Include terminology and practices specific to SGM populations	Develop effective rapport with all patients utilizing inclusive language and practices that avoid assumption-based terminology.
	Teach health disparities and health equity specific to SGM populations	
Knowledge for Practice	Apply biophysical scientific principles fundamental to health	“Define and describe the differences among: sex and gender; gender expression and gender identity; gender nonconformity, and gender dysphoria; and sexual orientation, sexual identity, and sexual behavior.” ¹⁴
	Apply principles of social-behavioral sciences to principles of patient care	“Understand and describe historical, political, institutional, and sociocultural factors that may underlie health care disparities experienced by SGM populations.” ¹⁴
	Teach investigatory and analytic approach to clinical situations inclusive of sexual and gender minorities	“Recognize the gaps in scientific knowledge and identify various harmful practices that perpetuate the health disparities for patients in the SGM populations.” ¹⁴
Practice-Based Learning and Improvement	Teach self-awareness and reflection to identify strengths, deficiencies and limits in one’s knowledge and expertise	“Demonstrate the ability to elicit feedback from individuals who identify within SGM populations about their health experiences and identify opportunities for change to improve care (e.g. inclusive language on intake forms).” ¹⁴
	Teach critical appraisal and application of evidence related to patient health	Include important clinical questions pertinent to SGM populations as they emerge when seeking the literature to inform clinical decisions.
Interpersonal and Communication Skills	Cultural humility and competency content inclusive of these populations	Demonstrate knowledge of current terminology respectful of SGM populations when describing patient care or establishing rapport with patients.
	Teach trauma-informed care and practices	
	Skill based content on demonstrating insight and understanding about emotions and human responses to emotions that allow self-development in interpersonal interactions	“Understand that implicit bias and assumptions about sexuality, gender, and sex anatomy may adversely affect verbal, nonverbal, and/or written communication strategies involved in patient care, and engage in effective corrective self-reflection processes to mitigate those effects.” ¹⁴
Professionalism	Cultural humility and competency content and behaviors inclusive of these populations.	Recognize and sensitively address all patients’ and families’ health traditions and beliefs, and understand the possible effect on diverse forms of sexuality and gender/gender identity.
	Confidentiality and patient privacy with circumstances unique to these populations	Recognize and follow the unique aspects of confidentiality with SGM populations and utilize appropriate consent practices.
	Ethics and accountability to patients, society, and the profession	“Accept shared responsibility for eliminating disparities, overt bias, and develop policies and procedures that respect all patients’ rights to self-determination.” ¹⁴
Systems-Based Practice	Teach advocacy for quality patient care and patient care systems	Demonstrate knowledge about legal and systemic barriers to health and resultant discriminatory practices that inhibit optimal health outcomes for SGM populations.
	Teach the coordination of patient care to specifically target disparity impact	“Identify and partner with community resources that provide support to SGM populations to help eliminate bias from health care and address community needs.” ¹⁴
	Teach practices to effect change on behalf of SGM populations on a systems level	“Explain how homophobia, transphobia, heterosexism, and sexism affect health care inequalities, costs, and outcomes.” ¹⁴
Interprofessional Collaboration	IPE cultural competency practices relative to establishing and maintaining respectful climates/cultures, dignity, diversity, and ethical integrity	Utilize interprofessional communication and collaboration in providing culturally competent, patient-centered care to the SGM populations and participate effectively as a member of an interdisciplinary health care team.
Personal and Professional Development	Self-reflection content thread regarding personal and professional development goals	“Critically recognize, assess, and develop strategies to mitigate one’s own implicit biases in providing care to SGM individuals and recognize the contribution of bias to increased iatrogenic risk and health disparities.” ¹⁴

necessity for all health professional discipline education to be inclusive of a sexual and gender minority thread throughout all content domains, however, assessment of that learning and direct impact to patient care is not necessarily addressed here. There is a paucity of literature on true assessment and direct patient impact of cultural competency education, and essentially no literature on the impact of sexual and gender minority inclusive education. Ethics are not optional when you are a healthcare provider, and it is long past due that we include all patient populations in the education and training of health care professionals. The four principles of health care ethics - autonomy, beneficence, non-maleficence, and justice - do not stop short of inclusion of sexual and gender minority patients. There is no doubt, we have to do better in every aspect of health with these populations, and one public health answer is to ensure that our professional education curricula are inclusive and outcome based for patient-centered care with these populations.

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Why Count and Measure?

Justin Glasgow, M.D.; Medical Director, Quality, Hospital Medicine, UAB Medicine

INTRODUCTION

The first recorded sign of counting in early humans is attributed to a collection of tally marks found on a baboon fibula in the Congo region of Africa, which dates to approximately 40,000 years ago. While it is unknown what was recorded (or if counting was the true intention), the recovered segment of bone has 29 tally marks, leading to a hypothesis that people were tracking the lunar phase. A health related hypothesis is that women were tracking menstrual cycles. The process of counting advances with time, and clearly is in use in 4,000 BC, with development of urban cities in Sumeria. Cities bring together a collection of people and resources in close proximity, necessitating a process to track and monitor people and resources. The Egyptians in 3,000 BC expanded on counting and developed measuring, which supports the ability to build pyramids and temples. The next major development, to the bane of many teenagers and perhaps their parents, was the Greeks development of more advanced mathematics, building the base for Algebra and Trigonometry.

In healthcare, perhaps the most famous early story of counting and measuring is that of John Snow, commonly considered a founding father of Epidemiology. His story is notable for the thoroughness with which he counts and tracks cases of cholera in an outbreak, and is able to show how they congregate around specific water pumps in London. Not only did this introduce the concept of epidemiologic case tracing, but perhaps also established the basis for studying how social determinants created health disparities.

COUNTING IN MODERN HEALTHCARE

Modern healthcare seems to have an endless array of counts and measures. From the standard Complete Blood Count (CBC) to complex National Surgical Quality Improvement Program (NSQIP), healthcare providers and healthcare systems collect innumerable measures of health and healthcare. While the field strives to understand outcomes, it often has a limited or superficial understanding of the patients receiving care. With the Centers of Medicare and Medicaid Services (CMS) promoting electronic health records through the meaningful use (MU) incentives program, there has been some standardization of information collection. The 2014 Edition of the Stage 1 MU program incentivized the systematic collection of a patient's preferred language, gender, race, ethnicity and date of birth. This program has explicit definitions for race and ethnicity categories, but does not define expectations on gender collection. In fact, a summary document from CMS uses gender and sex interchangeably.

The development of the MU program precedes current recognition about risk of privacy invasion with data collection of large internet and social media companies, but within that context it is critical to ask whether it is necessary for healthcare systems and providers to collect this data. The stated purpose within MU is that the systematic collection of data elements will serve as a platform for understanding health disparities and driving efforts to improve quality, safety, and efficiency. This noble pursuit to understand and reduce health disparities is indeed

necessary if we are going to continue to effectively improve the quality of health in our own neighborhoods and across the nation.

HEALTH DISPARITIES - WHY DOES COUNTING MATTER?

Health disparities are any measure of higher burdens of illness, injury, disability or mortality experienced by one group compared to another. Health disparities exist in most everywhere that they have been explored. Amongst those who identify as a gender or sexual minority (GSM), disparities have been identified in a number of arenas. As a population, there are higher rates of tobacco, alcohol, and illicit substance use. Studies have also identified higher rates of many chronic conditions such as asthma, ischemic heart disease, hypertension, obesity, depression, and anxiety. And perhaps most unfortunate (but not uncommon): in settings where health disparities exist, GSM populations also have lower rates of seeking healthcare services.

Talking about health disparities in GSM populations as a single monolithic population ignores disparities that exist between various groups within the populations. Individuals identifying as transgender have starkly worse health behaviors and health outcomes than those who identify as a sexual minority. Due to the recent growth in recognition of individuals who identify as non-binary, there is little understanding of what specific health disparities they face, or how those differ from disparities previously identified among individuals identifying as transgender. Among those who identify as a sexual minority, when analyzed separately, individuals identifying as bisexual have greater health disparity than those who identify as the same gender but only identify as having same sex attraction (i.e. gay men have elevated rates of heavy drinking, but bisexual men have even higher rates of drinking).

Given good recognition regarding the existence of health disparities, is there truly a need to further collect data to assess health disparities? Answering this question requires some consideration of the scientific field that serves as the basis for studies on health disparities: epidemiology. Epidemiology is classically defined as the study of the diseases that affect a population. As the field has evolved, it more broadly examines how different factors impact the health of populations. Those trained in epidemiology build a strong foundation in study design and statistical analysis, which includes a particular emphasis on understanding the strengths and weaknesses of different study designs and analytic techniques. The popular media can make jokes about how one study says coffee will help you live longer while the next says coffee will kill you, but to an epidemiologist who has reviewed the research, they can often identify how different decisions in a study design can lead to these disparate findings. This is, of course, assuming that the splashy headline also doesn't just reflect an over simplification of the research study conclusions promoted to garner attention and drive views.

EPIDEMIOLOGY AND COUNTING

There are many considerations epidemiologists use when evaluating research, here we will discuss two that can help us

understand the importance of collecting structured data to help better analyze and understand health disparities. The concepts of internal validity and external validity are critical to understanding why GSM individuals (and quite frankly, anyone) should want to be accurately counted and should want to ensure that their health care organizations are consistently and systematically capturing appropriate demographic information.

Internal validity addresses how well a study measures the relationship of interest and whether it appropriately accounts for how other variables (called confounders) impact that relationship. For example, a study may wish to examine the relationship between GSM identity and utilization of emergency departments (ED) for care that can more effectively and efficiently be provided in a primary care office (also called ambulatory care sensitive conditions). If a study only measured an individual's GSM identity and their rates of ED and primary care office utilization over a specific time frame, it would miss other critical confounders that impact why individuals choose to use one health care setting over another. A common confounder here is insurance status: GSM populations generally have higher rates of being uninsured, and being uninsured increases the likelihood of utilizing an ED for care over a primary care setting (as uninsured individuals generally do not have a longitudinal primary care relationship). So if a study finds an association between GSM identity and excess ED utilization, but does not account for differential rates of insurance, we cannot safely conclude that study found a true relationship: it would be considered to have weak internal validity. The role of unmeasured confounders is a common cause for why nutrition studies (i.e. what is the impact of coffee or chocolate) will sometimes show health benefits and other times health hazards.

In contrast, **external validity** addresses how well a sample of patients within a study represents the greater population at large. Issues with external validity are commonly found in many clinical drug trials. Given the high expense involved in clinical drug trials, these studies are designed to have high internal validity and promote the ability to find a benefit of the drug in question if it exists. However, this leads to excluding patients from the study population who may receive the drug once it becomes available widely in clinical practice. An easy example is that clinical trials rarely include pregnant women, so little is known about the effectiveness of many drugs in pregnant women. In many instances, the only information about risks of fetal teratogenicity is based on animal studies or several post-market birth defect registries. While the story of thalidomide occurred before (and is a primary driver for) the current paradigm of drug testing and approval, it demonstrates how external validity impacts study findings. Initial studies on thalidomide focused on the drug as a sedative, and found that it was essentially impossible to overdose on the medication. This led to its approval, and in some countries the medication was even sold without a prescription. However, those studies did not include many populations, particularly pregnant women. As its clinical use expanded from a sedative to being used to treat nausea (specifically morning sickness in pregnancy), this meant the early studies did not have sufficient external validity to address the safety of the medication. It was recognized that thalidomide was a fetal teratogen, and resulted in unknown numbers of miscarriages, as well as numerous birth defects, limb defects being the most famously linked.

In general, studies examining health disparities in GSM populations often suffer from major risks to both their internal

and external validity. Internal validity is often weak because studies try to draw a simple line between GSM identity and either a health behavior or health outcome. For example, a study documenting increased rates of alcohol use among gay and bisexual identified men compared to heterosexual identified men also found higher reported rates of severe psychological distress among gay and bisexual identified men. This easily raises the question of how does severe psychological distress and alcohol consumption interact, and might that relationship confound the independent relationship with sexual identity (internal validity). It is certainly reasonable to hypothesize that psychological distress can lead to alcohol use as an (ineffective) attempt at coping, but similarly, alcohol is a depressant and could impact how individuals perceive their psychological distress. It is likely that alcohol and psychological distress confound the relationship of the other with sexual identity, however without a sufficient population size (external validity), the study could not statistically account for this possibility, leaving an open question for further studies.

The previous study data came from the National Health Interview Survey (NHIS), which suggests the study sample is representative of the large population (supporting generalizability), but that sort of study sample is rare in the literature evaluating health disparities in GSM populations. Frequently, studies utilize a sample of convenience, which helps develop preliminary findings, but limits how broadly findings should be applied. Common settings for identifying a large enough cohort of GSM identified individuals to participate in a study frequently means working in an urban setting and recruiting from settings that cater to the population, such as a gay bar or a community free clinic for sexual health services. It doesn't require much creative thinking to recognize that, when a study recruits from a bar, rates of alcohol and tobacco consumption (in the times when you could still smoke indoors) in that group may not reflect the behaviors of the greater GSM population. Similarly, those receiving care in an urban free clinic likely have a different healthcare experience than their urban compatriots with health insurance, whose healthcare experience may also be dramatically different from GSM individuals residing in a rural environment which may not have easy access to the same level of public health resources.

THE IMPORTANCE OF COUNTING AND MEASURING GSM POPULATIONS

In the context of healthcare, and more importantly public health, why should we want to count and measure GSM populations accurately? In 2017, healthcare spending accounted for 17.9% of the Gross Domestic Product (GDP) or about \$3.5 trillion annually. Disparities in health will either directly or indirectly cost the country more over time than if we were providing everyone with the best high value care. The challenge is that if we have not accurately measured and assessed the health disparities, then our attempts to develop and implement interventions to reduce disparities are likely to fall woefully short of their aims. If we look back to the example of the relationship between GSM identity, psychological distress, and alcohol consumption, a poor understanding of this relationship is likely to lead to an ineffective intervention. An intervention focused only on achieving alcohol sobriety is unlikely to be successful if it does not address the underlying psychological distress that may be driving alcohol consumption. The intervention may achieve a brief period of sobriety in individuals, but since a key driver of

alcohol consumption might not have been addressed, later events that increase stress will place an individual that lacks the adequate coping skills to address this driver at a higher risk of relapse.

Unfortunately, in many concepts of public health, the causal relationship between an individual's demographics and health outcomes are too complex for a simple survey to assess with sufficient internal or external validity. Simply put, a survey of 700 gay men (with an appropriate heterosexual comparison group) cannot sufficiently help us understand the complex relationship between sexual identity, psychological distress and substance use. Without large datasets that allow for careful and systematic study of complex relationships, there will be a persistent high risk of drawing the wrong conclusions about health disparities faced by minority populations.

HOW CAN YOU BE COUNTED?

There are opportunities beyond collecting data during routine medical care that can also contribute to our efforts to understand and alleviate health disparities. For GSM populations, the PRIDE study (pridestudy.org) is the first long-term national health study of LGBTQ people with periodic surveys to assess physical, mental and social health. Additionally, the National Institutes of Health is supporting the All of Us study (allofus.nih.gov, Joinallofus.org) which represents an effort to gather data from one million or more people, with the goal of collecting data from a broad representative sample of all individuals living in the United States. These programs represent opportunities to contribute to the health and wellbeing of all.

So why, as a GSM individual, should you want to share your identity with a healthcare provider or system? In a world of

explicit discrimination and unconscious bias, there are countless barriers to wanting to share information with a provider. Long term, helping a medical provider understand the whole of your physical, mental and social health will support a strong patient provider relationship and drive effective diagnosis and management. In many instances, your identity (whether related to race, ethnicity, gender identity, or sexual identity) is unlikely to change the medical care you receive. Yet, as I think about common diagnoses, I have a hard time identifying a single diagnosis where a sexual or gender identity wouldn't ever potentially contribute to helping a provider develop an appropriate treatment plan. Common causes of symptoms may not be related to GSM identities, but if those are ruled out, knowledge about GSM identity may help formulate questions to better understand potential for more rare causes of symptoms.

CONCLUSION

To summarize, counting and measuring were established early in civilization as a way to help distill complex systems into an understandable process. The expansion of electronic health records provides an opportunity for well-structured interventions to address quality in healthcare and, more importantly, disparities in health. However, our current understanding of health disparities may be superficial, as it is often built on studies with significant limitations from an epidemiologic perspective when it comes to internal and external validity. In order to support improvements in public health (and consequently, help address unsustainable healthcare spending) there should be broad support for collecting data to help understand populations, such as gender and sexual minority patients, whether as part of routine healthcare or as participants in national studies.



The advertisement features a blue-tinted background image of three people (two men and one woman) in a modern setting, looking at a laptop. The University of Delaware logo is in the top left. The text 'UNIVERSITY OF DELAWARE HEALTH SCIENCES' is in the top left. The title 'NEW MPH IN EPIDEMIOLOGY' is in large yellow letters on the right. A paragraph of text is on the right, and the website 'udel.edu/mph-epi' is at the bottom.

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The Religious Landscape for LGBTQ+ Persons

The Rev. Dr. Douglas D. Gerdts, D.Min.
Pastor/Head of Staff, First & Central Presbyterian Church, Wilmington, DE

ABSTRACT

Navigating the world of organized religion is difficult under the best of circumstances given the wide array of expressions, interpretations, ideology, tolerance, and willingness to include all persons. For a member of the LGBTQ+ community, a negative experience can range from merely uncomfortable to intensely and emotionally damaging. To mitigate the negative and increase propensity for a positive experience, markers as to a faith community's degree of openness and inclusion not only exist, but are clear, identifiable, and to a large degree, dependable. This brief review of the major religions and faith traditions in Delaware provides some of those markers along with guidelines for understanding. The focus of this review is based on demographic data from the 2014 Religious Landscape Study conducted by the Pew Research Center's Religion and Public Life Section.

THE RELIGIOUS LANDSCAPE FOR LGBTQ+ PERSONS

"Landscape" is an apt word for what members of the LGBTQ+ communities will find as they explore the often-unpredictable terrain of religious and spiritual waystations. Some byways will be rolling, halcyon vistas replete with faith-based institutions extending an extravagant welcome. They'll meet follow travelers who have been in the trenches of equality and non-discrimination fights (and victories) for a generation. Visitors will be considered immediate family and welcomed around a table set with diversity, inclusion, and abundance – all viewed with gratitude.

Other routes will be cluttered with twists and turns and unmarked forks, with hills that hide the path beyond the ridge or curves that disguise hazards. The "all are welcome" banner looks worn, tattered, and neglected. How is one to know what to believe or trust? The national organization may decree a restrictive stance while the local congregation balks and chooses a more progressive and inclusive posture. Sure, you're welcome to come inside, sit quietly, conform, and never disclose much about yourself. Know your place in the pew-lined closet and everything will be fine.

Lastly are the dead ends. The message is clear: you're not wanted, you're "less than" and have no place or purpose here. The only good thing? No time or energy is wasted. Thank you for your candor!

The survey undertaken for this essay has sorted and sifted the various faith communities in Delaware into the above groups of "Welcoming Waystations," "Middle of the Road," and the "Dead Ends." From there, further exploration of the "Waystations" group narrows the focus in an effort to provide greater propensity for a positive experience. The Pew Research Center remarks, "the 2014 U.S. Religious Landscape Study is based on telephone interviews with more than 35,000 Americans from all 50 states. This is the second time the Pew Research Center has conducted a Religious Landscape Study." The first study was conducted in 2007.¹

For the purposes of this survey, only religious communities which garnered at least 1% of the Delaware population were surveyed, hence groups such as New Age, Pagan, Wiccan, or Native American were omitted due to a quantitative limit, and not because of any bias or prejudice on the part of the author (see Table 1).

From the list, the following were investigated as their stance on three basic areas: attitude toward homosexuality, support for or against marriage equality, and ordination, if appropriate (see Table 2).²

As this initial survey was undertaken, one key indicator became clearly evident, and that is a denomination's or tradition's public and system-wide stand on marriage equality for same-gender couples. All other indicators followed suit regardless if the position was affirming or condemning. The "gray area" arose when either there was no centralized message or individual communities dissented from the prescribed position.

Therefore, if a denomination supports and practices same-gender marriage equality, one can safely assume that its congregations are welcoming and affirming, and that LGBTQ+ persons are eligible for ordination. Hence, if an LGBTQ+ person were to seek a community of faith in which to explore membership or alliance, one should start with the following organizations:

- Conservative Jewish Movement
- Episcopal Church
- Evangelical Lutheran Church in America
- Presbyterian Church (USA)
- Reconstructionist Judaism
- Reform Jewish Movement
- Society of Friends (Quakers)
- Unitarian Universalist Association of Churches
- United Church of Christ

Table 1. Religious Denominations of Survey Population

Grouping	Denomination	Percentage of DE Population (%)
Evangelical Protestant		
	Southern Baptist Convention	3
	Independent Baptist	2
	"Other" Baptist	2
	Assemblies of God	1
	Church of Christ	3
Mainline Protestant		
	American Baptist	1
	United Methodist Church (UMC)	11
	Evangelical Lutheran Church in America (ELCA)	1
	Presbyterian Church (USA)	2
	"Other" Presbyterian	1
	Episcopal Church	1
	"Other" Episcopal	1
Historically Black Churches		
	Independent Baptist	4
	African Methodist Episcopal Church (AME)	2
	AME Zion Church	1
Roman Catholic		22
Orthodox Christian		1
Jewish		3
Muslim		1
Hindu		2
Unitarian		1

Table 2. Religious Groups' Stance on Homosexuality, Marriage, and Ordination

Denomination	Homosexuality	Marriage	Ordination
Welcoming Waystations			
ELCA	This is the most welcoming of the three leading Lutheran denominations. LGBTQ+ folks are "welcome to participate fully in the life of the congregation"	Ministers and congregations have autonomy as to marriage and many will perform same-gender ceremonies.	LGBTQ+ people are eligible for ordination.
Episcopal	LGBTQ+ people are entitled to the "full and equal claim on love, acceptance, and the care of the church."	Marriage equality is supported and practiced.	Ordination is open to all persons.
Judaism - Conservative	Some congregations are affirming - others are not. Denomination has taken strong stand in favor of inclusion.	Supports and practices marriage equality.	LGBTQ+ persons are eligible for ordination.
Judaism - Reconstructionist	Most consistently welcoming and affirming of Jewish denominations.	Affirms and practices same-gender marriage.	All persons are eligible for ordination. Discrimination is prohibited.
Judaism - Reform	Most congregations are fully welcoming, inclusive, and affirming.	Affirms same-gender marriage. "Relationship of Jewish, same-gender couple is worthy of affirmation through appropriate Jewish ritual."	All persons are eligible for ordination.
Presbyterian Church (USA)	LGBTQ+ people are fully integrated in the life of the church. The denomination is entirely welcoming although there are degrees within congregations.	Marriage equality is fully supported and the standard marriage ceremony is now gender-inclusive.	LGBTQ+ candidates are eligible for ordination.
Religious Society of Friends (Quakers)	Meetings are autonomous and LGBTQ+ folks are welcome.	Will perform same-gender weddings.	No ordination standards.
Unitarian	Not only do Unitarians open their doors to all persons, but "value diversity of sexuality and gender and see it as a spiritual gift."	Unitarians have been at the forefront of the struggles and victories for marriage equality.	Ordination is open to all.
United Church of Christ (UCC)	"Extravagantly welcome!"	Affirms equal rights for all persons including marriage.	Yes - all persons are eligible for ordination.

Denomination	Homosexuality	Marriage	Ordination
Middle of the Road			
Buddhism	No central teaching or government. Wide array on all topics.		
Hindu	There is no central authority in the denomination and "given the inherent spiritual equality, Hindus should not ostracize but accept LBGT persons as fellow sojourners." Kama Sutra celebrated same-sex activity.	Some communities will affirm same-gender marriage. Varies.	Yes, all men and women are eligible for ordination but are expected to maintain a vow of celibacy.
Muslim - Sunni and Shi'a	"It is rare that an openly LGBTQ+ Muslim feels welcome at a mainstream mosque in the United States."	Same-gender marriage is normally not affirmed, although some imams will perform.	There is no formal process for ordination.
United Methodist Church (UMC)	Recently affirmed the "Traditional Plan" which prohibits homosexuality in the church	One man and one woman. In addition, clergy can be punished for performing or participating in a same-gender wedding.	Will not ordain.

Denomination	Homosexuality	Marriage	Ordination
The Dead Ends			
AME	Church condemns same-sex relationship.	Does not support marriage equality.	Denomination is not in favor of ordination of openly gay persons to the ranks of clergy.
American Baptist	Homosexuality is incompatible with Christianity	One man and one woman	Will not ordain.
Church of Jesus Christ of Latter-day Saints (Mormons)	Homosexual attraction is not a sin, but action on it is. No longer offers conversion therapy.	Same-gender marriage is seen as apostasy.	Ordination is open to men only and no LGBT.
Eastern Orthodox	Homosexuality is immoral and inappropriate forms of behavior and attacks the institutions of marriage and family.	Marriage is reserved for one man and one woman. It is a sacred institution reserved for monogamous heterosexuals.	LGBTQ+ persons and women are not eligible.
Judaism - Orthodox	Homosexuality is prohibited - although there are small signs of welcome.	Forbids and condemns same-gender marriage	Does not ordain LGBTQ+ or women.
National Baptist Convention	Homosexuality is incompatible with Christianity.	One man and one woman	Strongly independent congregations hence ordination stands may vary, but rarely do.
Presbyterian Church in America (PCA)	"Homosexual practice is sin." Churches seek to "transform the lifestyle" with conversion programs designed for people to "leave behind the gay lifestyle." "Gender distortions" are considered sin.	Marriage is one man and one woman.	LGBTQ+ people and women are not eligible for ordination.
Roman Catholic	"Homosexual acts are intrinsically immoral and contrary to natural law. Homosexual tendencies are "objectively disordered."	Does not support marriage equality.	Ordination is possible due to celibacy vow.
Southern Baptist Convention	Homosexuality is always considered sinful and impure. Classified with adultery and pornography. It should be opposed. "Love the sinner, hate the sin."	One man and one woman	Will not ordain a person who is homosexual regardless of activity.



Figure 1. Where Major Religions Stand on Same-Sex Marriage (Pew Research Center)

The following graphic produced by the Pew Research Center provides a more in-depth review (see Figure 1).³

Although the scope of possibilities has been drastically reduced, sadly, the work does not end there. Within those listed on the above graphic as "Sanctions Same-Sex Marriage," the demeanor of individual faith communities and churches may vary drastically.

The denomination with which I am most familiar is the Presbyterian Church (USA) wherein I serve as a pastor for one of the most liberal, progressive, and accepting congregations – not just in Delaware – but in the entire denomination. Yet, within two miles is another congregation of the PCUSA in which an openly gay, lesbian, or trans person may not (read: "probably won't") feel welcome and included despite "all are welcome" signage. What follows are six tips for determining the degree of welcome, comfort, and safety one may or may not discover when walking through the doors:

1. Google "gay friendly (name of denomination/tradition) church/faith community in (city or town)." Save considerable time and frustration and search only the denominations or faith traditions in the far-left column of Figure 1.
2. Scan websites – but first, don't read a word, just look at pictures. A community that's intentional about its welcome will make that clear with the people they place on their homepage. Are there any photos of people appear to be

part of the LGBTQ+ communities? Are there any same-gender couples?

3. Read the opening statement of the home page – does it go beyond “all are welcome”? Most every congregation or group considers itself “welcoming” and so one must dig a little deeper. Does the statement mention any advocacy or social groups specific to LGBTQ+ people? Scan a few recent sermons, talks, newsletters, announcements, or bulletins and watch for language that is either radically welcoming or appears to support more traditional and heteronormative persons and family configurations.
4. Find a policy on marriage. Again, communities that are gay-friendly and perform marriages will make that clear in their language about weddings. This is, as discussed above, the “litmus” test for both denominations and for individual faith communities.
5. If the website promotes phrases such as “family values,” “Bible-based preaching,” or anything “traditional” – this is likely not a community that values the diversity that LGBTQ+ folks bring.
6. Larger is often safer – but not always. Downtown, city-centered is often a better bet than suburban or rural – but not always!

Much of the above emanates from the experiences of openly gay and lesbian persons, yet the same indicators of welcome and inclusion should hopefully hold for transgender or gender non-conforming people. Faith communities may not have as much direct experience or well-developed relationships with trans persons, but a community committed to diversity and inclusion has a higher likelihood of welcoming all.

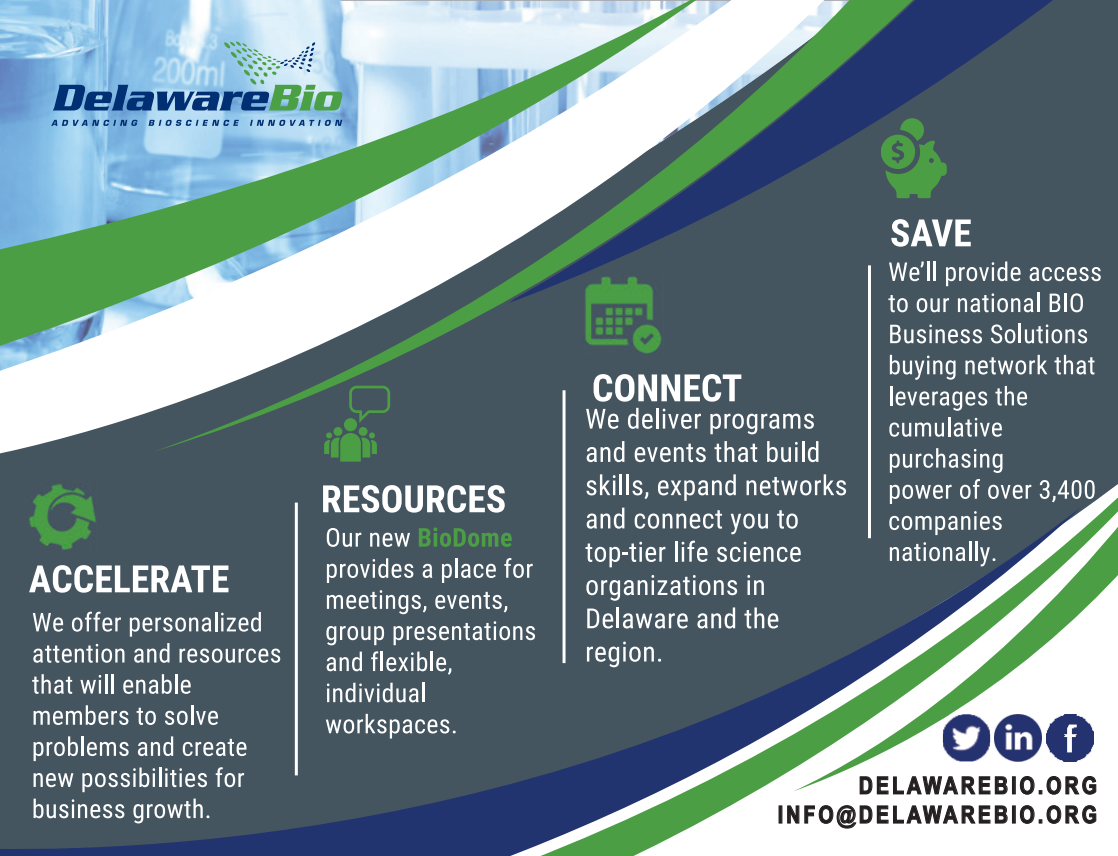
The religious landscape for LGBTQ+ persons can be treacherous and difficult to navigate, yet by restricting oneself to those communities that support and practice same-gender marriage and following the six tips listed, one can quickly minimize hazardous conditions!

The journey is worth it. Finding a faith-based community with which to practice, grow, nurture, question, and even challenge one’s spirituality adds a dimension to life that adds nearly immeasurable meaning, joy, and purpose. Knowing that one is “home”, that one is “family,” when for so many of the LGBTQ+ community neither of those may have been positive experiences, is a degree of acceptance and celebration not often found in secular society.

Lastly, there are many factors unrelated to sexuality that converge to determine whether or not a faith community is a good “fit.” If one doesn’t feel right – keep moving. Trust always that there is a community that is just as anxious to greet you as you are to find it – and that makes the world a better place for us all!

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CAMP Rehoboth Mission

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We seek to promote community well-being on all levels; to foster the development of community groups; to develop community space; to promote human and civil rights; to work against prejudice and discrimination; to lessen tensions among the community at large; and to help foster the economic growth of the area. We work toward these ends through activities such as the following:

- Fundraising for other non-profit organizations, such as AIDS service organizations, gay, lesbian, bisexual and transgender community organizations, recycling programs, environmental projects, literacy training, and other ventures for the general betterment of the community.
- Networking resources and information by publishing a newsletter, and functioning as an alternative tourist bureau and information center.
- Promoting artistic expressions and creative thinking, and giving aid to artists and craftspeople with an emphasis on the works of lesbians and gay men.
- Education and outreach to the larger community, including sensitivity training seminars, and printed materials to promote positive images of gay and lesbian people and others.
- Promoting political awareness to build a safe and inclusive community through voter information, education, and registration; and analysis of issues and candidates.

CAMP Rehoboth Vision

We create proud and safe communities where gender identity and sexual orientation are respected.

LGBTQ+ – LEXICON OF TERMS

Adverse Childhood Experiences (ACEs)

Traditionally 10 types of childhood trauma that can go on to affect a person's health: physical abuse, verbal abuse, sexual abuse, physical neglect, emotional neglect, a parent with alcoholism, a mother who is a victim of domestic violence, a family member in jail, a family member diagnosed with mental illness, and the disappearance of a parent (through divorce, death, or abandonment).

Agender

A person who does not identify themselves as having a particular gender.

Asexual

A person without sexual feelings or associations.

Assigned at Birth

Gender given at birth (i.e. "it's a girl!" "it's a boy!")

Binary

Male- or female-identified

Bisexual

Sexually attracted not exclusively to one particular gender; attracted to both men and women.

Cisgender

A person whose sense of personal identity and gender corresponds with their gender assigned at birth.

Cisnormative

The assumption that all humans are cisgender.

Coming Out

A person's disclosure of their sexual orientation or gender identity to others (also: coming out of the closet).

Dead-Name

The birth name of someone who has changed their name. In the case of transgendered persons somewhere along the transitioning process, dead-naming is referring to that person by the name they used before they transitioned.

Dissociation

The separation of normally related mental processes.

Gender Dysphoria

Distress caused by the misalignment of one's sex assigned at birth and their gender identity.

Gender Expansive

An adjective describing misidentification with traditional gender roles based on sex assigned at birth. This term encompasses those who are binary, nonbinary, transgender, genderqueer, agender, Two Spirit, and myriad genders other than cisgender

Gender Expression

The way in which a person expresses their gender identity, typically through appearance, dress, and behavior.

Gender Identity

A person's perception of having a particular gender, which may or may not correlate with the gender assigned at birth.

Genderqueer

Denotes a person who does not subscribe to conventional gender distinctions, but identifies with neither, both, or a combination of male and female genders.

Heteronormative

A worldview that promotes heterosexuality as the normal or preferred sexual orientation.

Heterosexual

A person sexually attracted to people of the opposite sex.

Homophobic

Having or showing a dislike or prejudice against homosexual persons.

Homosexual

A person sexually attracted to people of the same sex.

LGBTQ

Stands for Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning.

Microaggressions

A statement, action, or incident regarded as an instance of indirect, subtle, or unintentional discrimination against members of a marginalized group such as a racial or ethnic minority.

Misgendering

To refer to someone (especially a transgender person) using a word, pronoun, or form of address, that does not correctly reflect the gender with which they identify (i.e. calling a transgender male “miss” or “she”).

Non-binary

People who identify as neither ‘male’ nor ‘female.’

Pansexual

Not limited in sexual choice with regard to biological sex, gender, or gender identity.

PTSD

Post-Traumatic Stress Disorder.

Resilience

The capacity to cope adaptively with the effects of risk factors or adverse experiences.

Sexual Orientation

A person’s sexual identity in relation to the gender to which they are attracted (i.e. homosexual, heterosexual, pansexual, bisexual, etc.).

Telehealth

Technologically mediated health services that allow users to interact with various health care providers via computer or smartphone.

Transgender

A person whose sense of personal identity and gender does not correspond to that assigned at birth.

Transgender Man

Aka trans man. A man who was assigned female at birth.

Transgender Woman

Aka trans-woman. A woman who was assigned male at birth.

Transitioning

The process some gender expansive people may undergo in order to align themselves with their gender identity through social and/or medical interventions.

Transphobia

Dislike or prejudice against transsexual or transgender people.

Trigger

A term used to describe sensations, images, or experiences that trigger a traumatic memory.

Two Spirit

An umbrella term used by some indigenous North Americans to describe Native people in their communities who fulfill a traditional third-gender (or other gender-variant) ceremonial role in their cultures.

LGBTQ+ – RESOURCES

If you or someone you know is considering suicide, please call:

- National Suicide Hotline: 800-273-8255
- Trans Lifeline: 877-565-8860
- The Trevor Project: 866-488-7386

Federal:

Centers for Disease Control and Prevention - <https://www.cdc.gov/lgbthealth/>
U.S. Department of Health and Human Services - <https://www.hhs.gov/>
Healthy People 2020 - <https://www.healthypeople.gov/>
National Institutes of Health - <https://www.nih.gov/>

Delaware:

AIDS Delaware - <http://aidsdelaware.org/>
Bayhealth LGBTQ Equality for Patients - <https://www.bayhealth.org/lgbtq>
Beautiful Gate Outreach Center - <https://www.bgate.org/>
Big Brothers Big Sisters of Delaware - <http://bbbsde.org/>
Brandywine Counseling & Community Services - <http://www.brandywinecounseling.org/>
CAMP Rehoboth Resource Guide - <https://www.camprehoboth.com/lgbt-resource-guide>
Children & Families First - <https://www.cffde.org/supporting-teens>
Christiana Care LGBTQ Health Initiatives - <https://christianacare.org/services/lgbtqhealth/>
Delaware DHSS, Division of Public Health, Bureau of Health Equity - <https://www.dhss.delaware.gov/dhss/dph/mh/healthequity.html>
Delaware Department of Services for Children, Youth and their Families, Prevention and Behavioral Health Sciences - <http://kids.delaware.gov/pbhs/pbhs.shtml>
Delaware PrEP - <https://www.delawarehiv.org/delaware-prep/>
Delaware PRIDE - <http://www.delawarepride.org/resources/>
Delaware Renaissance <http://www.delren.org>
Equality Delaware - www.equalitydelaware.org
Help is Here Delaware - <http://www.helpisherede.com/>
Henrietta Johnson Medical Center - <https://www.hjmc.org/>
HIV Consortium <https://www.delawarehiv.org/>
La Red Health Center - <http://www.laredhealthcenter.org>

LGBT Health Clinic Resources in Delaware -

Multiple Locations:

- [AIDS Delaware External](#)
- [Chase Braxton Health Care External](#)

Wilmington

- [Christiana Care External](#)

Nemours Children's Health System: Gender Wellness Program - <https://www.nemours.org/services/gender-wellness.html>

PFLAG, Wilmington, DE - <https://www.pflagwilmde.org/Resource-Guide>

The Rainbow Chorale of Delaware - <https://therainbowchorale.org/rcd-links>

SAGE: Advocacy and Services for LGBT Elders-
<https://www.sageusa.org/>

United Way of Delaware – <http://www.uwde.org>

United Way of DE PRIDE Council <http://uwde.org/how-we-work/affinity-groups/pride-council/>

Westside Family Healthcare - <https://www.westsidehealth.org/>

Information from GLMA: Health Professionals Advancing LGBTQ Equality (<http://glma.org>)

- |Top 10 Things Lesbians Should Discuss with their Healthcare Provider
<http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageID=691>
- Top 10 Things Gay Men Should Discuss with their Healthcare Provider
<http://glma.org/index.cfm?fuseaction=Page.viewPage&pageID=690>
- Top 10 Things Bisexuals Should Discuss with their Healthcare Provider <http://glma.org/index.cfm?fuseaction=Page.ViewPage&PageID=1026>
- Top 10 Things Transgender Persons Should Discuss with their Healthcare Provider <http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageID=692>
- Transgender Health Resources <http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=948&grandparentID=534&parentID=938&nodeID=1>

Education

All of Us Study – www.allofus.nih.gov

PRIDE Study – www.pridestudy.org

Public School-Based Services - <http://kids.delaware.gov/pbhs/pbhs.shtml>

Safe Zone Project - <https://thesafezoneproject.com/>

Social Support

Delaware LGBTQ+ Social Group on Facebook - <https://www.facebook.com/delgbtq/>

PFLAG (Parents and Friends of Lesbians and Gays) - <http://community.pflag.org/>

PTK Delaware - Parents of Transgender Kids Support Group - PTKDelaware@gmail.com

LGBT Hotlines

- [GLBT National Help Center External](#)
- [GLBT National Youth Talkline External](#)
- [GLBTQ Domestic Violence Project External](#)
- [Trevor Helpline / Trevor Project \(Crisis Intervention / Suicide Prevention for LGBT Youth\) External – 1-866-488-7386](#)

Referral Services

- [Association of Gay and Lesbian Psychiatrists Online Referral System External](#)
- [GLMA Provider Directory External](#)

Delaware Journal of Public Health

Submission Guidelines
updated October 16, 2018

About the Journal

Established in 2015, **The Delaware Journal of Public Health** is a bi-monthly, peer-reviewed electronic publication, created by the Delaware Academy of Medicine/Delaware Public Health Association. The publication acts as a repository of news for the medical, dental, and public health communities, and is comprised of upcoming event announcements, past conference synopses, local resources, peer-reviewed content ranging from manuscripts and research papers to opinion editorials and personal interest pieces, relating to the public health sector. Each issue is largely devoted to an overarching theme or current issue in public health.

The content in the Journal is informed by the interest of our readers and contributors. If you have an event coming up, would like to contribute an Op-Ed, would like to share a job posting, or have a topic in public health you would like to see covered in an upcoming issue, please let us know.

If you are interested in submitting an article to the Delaware Journal of Public Health, or have any additional inquiries regarding the publication, please contact *DJPH* Deputy Editor Elizabeth Healy at chealy@delamed.org, or the Executive Director of **The Delaware Academy of Medicine and Delaware Public Health Association**, Timothy Gibbs, at tgibbs@delamed.org.

Information for Authors

Submission Requirements

The DJPH accepts a wide variety of submission formats including brief essays, opinion editorials pieces, research articles and findings, analytic essays, news pieces, historical pieces, images, advertisements pertaining to relevant, upcoming public health events, and presentation reviews. If there is an additional type of submission not previously mentioned that you would like to submit, please contact a staff member.

Submissions should be completed under general APA guidelines for formatting and citations. Articles should be written in Microsoft Word format, in a clear, easily readable font with 1.5-inch to 2-inch spacing, and 1-inch margins. The suggested font is 12 point Times New Roman. Once completed, articles should be submitted via email to chealy@delamed.org as an attachment. Graphics, images, info-graphics, tables, and charts, are welcome and encouraged to be included in articles. Please ensure that all pieces are in their final format, and all edits and track changes have been implemented prior to submission.

Submission Length

While there is no prescribed word length, full articles will generally be in the 2500-4000-word range, and editorials or brief reports will be in the 1500-2500-word range. If you have any questions regarding the length of a submission, or APA guidelines, please contact a staff member.

Copyright

Opinions expressed by contributors and authors do not necessarily reflect the opinions of the *DJPH* or affiliated institutions of authors. Copying for uses other than personal reference or interest without the consent of the *DJPH* is prohibited. All material submitted alongside written work, including graphics, charts, tables, diagrams, etc., must be referenced properly in accordance with APA formatting.

Conflicts of Interest

Any conflicts of interest, including political, financial, personal, or academic conflicts, must be declared prior to the submission of the article, or in conjunction with a submission. Conflicts of interest are any competing interests that may leave readers feeling misled or

deceived, and/or alter their perception of subject matter. Declared conflicts of interest may be published alongside articles in the final electronic publication.

Nondiscriminatory Language

Use of nondiscriminatory language is required in all DJPH submissions. The DJPH reserves the right to reject any submission found to be using sexist, racist, or heterosexist language, as well as unethical or defamatory statements.

Additional Documents and Information for Authors

Please Note: All authors and contributors are asked to submit a brief personal biography (*3 sentences maximum*) and a headshot along submissions. These will be published alongside final submissions in the final electronic publication. For pieces with multiple authors, these additional documents are requested for all contributors.

Abstracts

Authors must submit a structured or unstructured abstract along with their article.

The word limit is **200 words**, including headings. A title page should be submitted with this abstract as well.

Structured abstracts should employ 4-5 headings:

Objectives (begins with “To...”)

Methods

Results

Conclusions

A fifth heading, Policy Implications, may be used if relevant to the article.

Trial Registration information is required for clinical trials and must be included in the final version abstract

All abstracts should provide the dates(s) and location(s) of the study is applicable.

Note: There is no Background heading.

Example of Information in Abstract

Objective: State the objective or study question starting with “To ...” (e.g., “To determine whether...”).

Methods: Provide the basic design, place, year(s), setting, and number of participants of the study. If applicable, include the name of the study, the duration of follow-up. Indicate exposure and outcomes.

Results: Include quantitative results.

Conclusions: Provide only conclusions of the study that are directly supported by the results, whether positive or negative.

Policy implications: Provide a statement of relevance indicating implications for health policy, avoiding speculation and overgeneralization.

Trial Registration: For clinical trials, the name of the trial registry, registration number, and URL of the registry must be included in the cover letter **ONLY** and in the manuscript only after it is officially accepted.

Relevant Abbreviations should be mentioned here and will not be counted in the word limit.

Index of Advertisers

APHA's 2019 Annual Meeting and Expo.	5
American Public Health Association	
The DPH Bulletin June 2019	9
Division of Public Health, Department of Health and Social Services	
DHSS Press Release	16
Division of Public Health, Department of Health and Social Services	
Health Science Career Panel	22
Wilmington Friends School	
Save the Date - John Scholz Stroke Education Conference	23
John H. Ammon Medical Education Center Christiana Hospital	
HPV Vaccination Rates in Delaware	27
Quality Insights	
AAHD Call To Action	30
American Association on Health and Disability	
Wellness and Prevention Digest.	44
Trust for America's Health	
Caring for the LGBTQ Community with Pride	45
Christiana Care Health Systems	
Thanks to our Sponsor - The 89th Annual Meeting	53
Delaware Journal of Public Health	
Save the Date - Millennial Summit	54
Millennial Summit	
Save the Date - ACCEL Community Research Exchange	55
ACCEL	
The Nation's Health - June 2019	63
American Public Health Association	
New MPH in Epidemiology	66
University of Delaware Health Sciences	
Delaware Day Healthcare Job Fair	67
Delaware Health Sciences Alliance	
DelawareBio	72
DelawareBio	
CAMP Rehoboth Community Center.	73
CAMP Rehoboth	
DJPH Submission Information	78
Delaware Journal of Public Health	



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The Delaware Academy of Medicine is a private, nonprofit organization founded in 1930. Our mission is to enhance the well being of our community through medical education and the promotion of public health. Our educational initiatives span the spectrum from consumer health education to continuing medical education conferences and symposia.

The Delaware Public Health Association was officially reborn at the 141st Annual Meeting of the American Public Health Association (APHA) held in Boston, MA in November, 2013. At this meeting, affiliation of the DPHA was transferred to the Delaware Academy of Medicine officially on November 5, 2013 by action of the APHA Governing Council. The Delaware Academy of Medicine, who's mission statement is "to promote the well-being of our community through education and the promotion of public health," is honored to take on this responsibility in the First State.