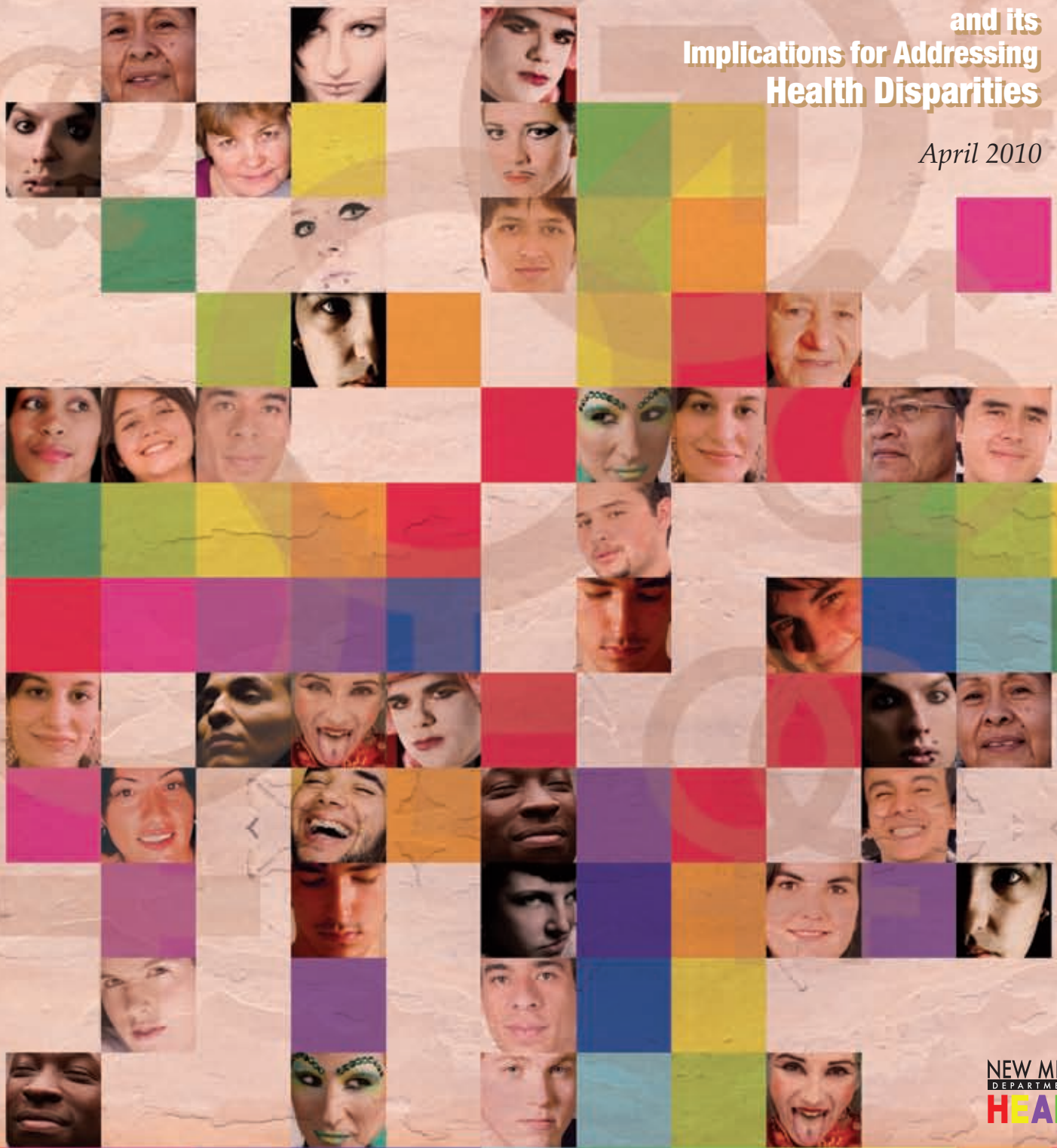
New Mexico's
Progress in Collecting Lesbian, Gay, Bisexual, and Transgender Health Data

and its Implications for Addressing Health Disparities

April 2010



NEW MEXICO DEPARTMENT OF HEALTH

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EXECUTIVE SUMMARY

Sexual orientation encompasses multiple dimensions. *Attraction* refers to whom individuals are sexually drawn; *behavior* refers to with whom individuals are engaging in sexual activity; *identity* is an individual's self-perception or self-label of sexuality. An individual's self-label of sexuality may or may not align with attraction or behavior.

Numerous studies and reports from other states (i.e., Massachusetts, Vermont, Rhode Island) have documented health disparities among lesbian, gay, bisexual (LGB) and questioning youth compared to straight youth. Significantly higher risks were found among LGB youth for suicide, depression, missing school, experiencing physical and sexual violence, risky sexual activity, and using tobacco, alcohol and other drugs. Despite these documented disparities elsewhere, New Mexico still does not collect any youth sexual orientation data.

Using 2005 and 2006 Behavioral Risk Factor Surveillance System (BRFSS) data, New Mexico's LGB 18 years and older adults accounted for 2.1% (29,800) and 2.5% (36,000) of the entire adult population, respectively. The 2007 and 2008 BRFSS estimated approximately 2.4% (29,100) and 3.2% (39,100) LGB adults ages 18 to 64 years, respectively.

Although BRFSS is an anonymous survey, other factors may impact estimates of LGB adults in New Mexico. For example, sexual orientation is measured using self-identity. If individuals are not comfortable self-identifying as LGB, whether it is due to fear of discrimination or uneasiness with divulging sexual orientation information, the self-identity measure would most likely underestimate the true percentage of LGB adults. Despite this limitation, the percentage of LGB adults generated from data sources such as BRFSS are currently the most accurate and reliable estimates available.

Looking at demographic characteristics of respondents in the BRFSS, a significantly higher percentage of bisexual adults were 18 to 24 years old compared to the percentage of straight adults in that age group. A higher percentage of lesbian or gay adults reported having a college degree than straight adults. Similarly, a lower percentage of lesbian or gay adults reported having less than a high school diploma than straight adults. Despite their relatively higher educational attainment, a significantly lower percentage of lesbian or gay adults reported having a household income of greater than $20,000 compared to straight adults. No significant differences were identified for sexual orientation by racial/ethnic group. These demographic differences among LGB and straight adults could play a role in explaining some of the differences in health indicator findings.

Compared to straight adults, LGB adults in New Mexico showed significantly higher percentages for some risk factors and adverse health outcomes. These included tobacco use, alcohol use, suicide, depression, intimate partner violence, obesity, asthma, and life dissatisfaction. In contrast to these health risks, however, LGB adults were more likely than straight adults to report engaging in sufficient physical activity and having had an HIV test. No significant differences were identified by sexual orientation for fruit and vegetable consumption, diabetes, cancer screening, reporting fair or poor health status, or not having health insurance.

Looking at possible reasons why there are disparities between straight adults and LGB adults, it is important to look at social determinants of health. Social determinants of health are the economic and social conditions under which people live that affect their health. Discrimination, in particular, may be an important contributing factor. Discrimination, which includes negative attitude, judgment or unjust treatment of members of a specific group, can impact health. An individual's perception of discrimination is associated with multiple negative health outcomes, both mental and physical. Discrimination affects health by triggering a stress response. Over time, frequent experiences of discrimination result in chronic heightened stress responses that increase risk of many major disease outcomes.

In order to address lesbian, gay, bisexual, transgender, two-spirit, queer, questioning, intersex (LGBTQI) health, a multi-faceted approach needs to be taken. This approach includes addressing social determinants of health through resource development (e.g., increasing the number of LGBTQ health centers), improved access to culturally competent health care services, and anti-discrimination policy implementation. The analyses and data presented in this report provide information to help guide those with an interest in LGBTQ health and to provide recommendations and strategies for more effectively addressing the health of LGBTQ communities.

Recommendations for New Mexico Department of Health

- Continue to include LGBT health as a strategy in the Department of Health's Annual Strategic Plan
- Consider LGBT a priority population along with racial/ethnic groups in disparity and health equity discussions and reports
- Explore outreach and educational interventions for LGBTQ communities in multiple public health programs (e.g., behavioral health, substance abuse, chronic disease prevention and control, etc.)
- Ensure that LGBT health programs are evaluated
- Include sexual orientation and gender identity items as standard demographic question on surveys and registries
- Start sexual orientation data collection among high school youth
- Encourage adoption of the above practices by other federal, state, local, and tribal public health agencies

Recommendations for Health Care and Other Community-based Organizations

- Elevate importance of LGBTQ health issues
- Offer trainings on LGBTQ health issues to increase cultural competency among health providers and community partners
- Institute non-discrimination policies that cover LGBTQ people within organizations
- Utilize inclusive language (e.g., partner, significant other) in communications and health forms
- Form alliances with LGBTQ organizations to offer educational resources
- Be able to show LGBTQ people the ways in which they are targeted by various industries (e.g., Project SCUM, alcohol and tobacco funding at Gay Pride events)
- Partner with organizations serving people of color as a strategy to improve access to LGBTQ people of color

Recommendations for Educational Settings

- Support establishment of Gay-Straight Alliances in middle and high schools, which create safe and supportive environments for LGBTQ students and their straight allies
- Establish anti-harassment policies that include sexual orientation and gender identity
- Train teachers and staff to intervene when they hear slurs based on sexual orientation or gender presentation
- Provide sexual orientation and gender identity education, resources, and support to students
- Provide media literacy training for LGBTQ youth to empower them with tools to deconstruct media messages and production skills to tell their own stories

ACS	American Community Survey
AIDS	Acquired Immunodeficiency Syndrome
ATS	Adult Tobacco Survey (telephone survey of adults; responses are anonymous)
BRFSS	Behavioral Risk Factor Surveillance System (telephone survey of adults; responses are anonymous)
CDC	Centers for Disease Control and Prevention
DRE	Digital Rectal Exam
FOBT	Fecal Occult Blood Test
GSA	Gay-Straight Alliance
HIV	Human Immunodeficiency Virus
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Two-spirit, Queer, Questioning, Intersex
	Note: Variations of this acronym are used throughout the report to reflect relevant identities. For example, LGB is used when discussing BRFSS data, since the data only reflects adults who identify as lesbian, gay, or bisexual.
NHANES	National Health and Nutrition Examination Survey (face-to-face survey and health exam)
PDA	Personal Digital Assistant
PSA	Prostate Specific Antigen
STI	Sexually Transmitted Infections
TUPAC	Tobacco Use Prevention and Control
YRBS	Youth Risk Behavior Survey (pencil and paper survey of high school students; responses are anonymous)
YRRS	Youth Risk and Resiliency Survey (pencil and paper survey of high school students conducted in NM; recognized by CDC as equivalent to YRBS survey for national comparison purposes)

95% Confidence Interval [95% CI]	Represents the range in which the true value of a measure would exist 95% of the time. In this document, confidence intervals are indicated using lines in the bar charts. Confidence intervals are related to the precision and significance of estimates. If the confidence intervals or lines in the charts overlap, this implies that there is no statistically significant difference in the estimates. On the other hand, if the confidence interval or lines do *not* overlap, the estimates should be considered significantly different from a statistical standpoint.
Demographics	The characteristics of human populations and population segments (e.g., age, sex, income, education, occupation, etc.).
Estimates	Approximate values derived from surveys that are best interpreted using confidence intervals.
Median	The middle number in a given sequence of numbers. Using this form of average prevents bias due to outliers.
Outlier	Values in a collection of data that lie beyond the central mass of data.
Precision	Refers to the accuracy of the estimate. Larger survey samples provide more precision, i.e., smaller confidence intervals, which means that the estimate provided is more accurate or precise to the true value than an estimate from a smaller survey sample.
Prevalence	The proportion or percentage of individuals in a population having a disease/condition or participating in an activity that is risky or protective to their health.
Significant or "statistical" differences	Reflect presumed true differences between the comparison groups which are unlikely to have occurred by chance alone or by bias in survey sampling. In this report, statistical or significant differences are determined by non-overlapping confidence intervals. Confidence intervals are influenced by survey sample size. Therefore, in some cases of non-significance, if the sample sizes were larger, the confidence intervals may be narrower, implying greater precision, thus better determining statistical significance. Even if some differences are *not* statistically significant, these differences may still have clinical and social implications and thus are highlighted in this report.
Survey	A method of gathering information from a number of individuals, known as a sample, in order to learn something about the larger population from which the sample is drawn. The responses from the sample are weighted based on known demographics (e.g., age, sex, location) of the population in order to more accurately estimate the overall population. This is a cost-effective method of estimating characteristics of a population.

Acute Myocardial Infarction	More generally known as a heart attack. Occurs when insufficient blood flow to the heart causes oxygen deprivation that results in death of a portion of the heart muscle.
Binge Drinker	For men, someone who reported having consumed five or more alcoholic drinks in one sitting. For women, someone who reported having consumed four or more alcoholic drinks in one sitting.
Bisexual	Someone who identifies as being sexually attracted to and/or engaging in sexual behavior with people of both sexes.
Breast Cancer Screening	At the time of data collection, breast cancer screening by mammography was recommended for women every one to two years beginning at age 40 by the United States Preventive Services Task Force (USPSTF).
Cardiovascular Disease	A broad term for circulatory problems that result in decreased blood supply to the heart or the brain.
Cervical Cancer Screening	Human papillomaviruses (HPV) cause virtually all cervical precancers and invasive cancers. An important way to prevent cervical cancer is to have regular Pap tests, which can detect precancers caused by HPV. The USPSTF recommends regular Pap tests for women 21 years and older, or within three years of first intercourse, whichever happens first.
Colonoscopy	A medical procedure in which a scope is used to examine the inside of the rectum and the entire large intestine (colon). One use for this procedure is to screen for colorectal cancer.
Colorectal Cancer Screening	A number of screening strategies are endorsed by groups like the USPSTF (e.g., high sensitivity fecal blood test, sigmoidoscopy, colonoscopy). These screening strategies can result in detecting early stage colon cancers and removing precancerous polyps. Sigmoidoscopy and colonoscopy can collectively be referred to as "lower endoscopy."
Coronary Heart Disease	The most common type of cardiovascular disease, coronary heart disease affects the blood vessels (coronary arteries) that supply the heart. Angina (chest pain) and myocardial infarction (heart attack) are two common outcomes of coronary heart disease.
Current Smoker	For adults, someone who reports having smoked at least 100 cigarettes in his or her lifetime and is currently smoking everyday or some days.
Diabetes	A condition in which the body does not produce or properly use insulin (a hormone that is needed to convert sugar, starches, and other food into energy). Diabetes is marked by high levels of blood glucose (a form of sugar).
Gay	Someone who identifies as being sexually attracted to and/or engaging in sexual behavior with persons of the same sex. This term can be used for both men and women, but it tends to be associated with men.
Gay-Straight Alliance	Student organizations that provide a safe and supportive environment for lesbian, gay, bisexual, transgender, queer youth and their straight allies.
Gender	A social construct referring to characteristics such as appearance, behaviors, and roles, that distinguish the categories of being a man or woman, boy or girl. Gender may not be fixed; it can be ambiguous and fluid.

Gender Identity	Refers to an individual's sense of belonging or not belonging to a gender category such as man or woman, boy or girl, queer, two-spirit, or transgender.
Health Disparity	The differences in the burden of diseases and other adverse health conditions and behaviors that exist among specific groups compared to the dominant group.
Health Inequity	Health disparities that are unjust or unfair.
Heavy Drinker	For men, someone who reported having consumed three or more alcoholic drinks per day over the last 30 days. For women, someone who reported having consumed two or more alcoholic drinks per day over the last 30 days.
Heterosexism	A term to describe negative attitudes, bias, and discrimination that favor straight sexuality and relationships.
Homophobia	A term to describe having negative attitudes, bias, and discrimination towards being LGBTQ and people identified or perceived as being LGBTQ.
Insufficient Physical Activity	Not achieving the recommended amount of physical activity. For adults, the recommendation at the time these data were collected was at least 30 minutes of moderate physical activity on five or more days per week, or at least 20 minutes of vigorous physical activity on three or more days per week.
Intersex	Refers to a biological phenomenon where a person is born with indeterminate or ambiguous genitalia that usually distinguish male from female.
Lesbian	A woman who identifies as being sexually attracted to and/or engaging in sexual behavior with another woman.
Pride Event	A gathering of LGBTQI individuals and straight allies who want to demonstrate that people should be proud of their sexual orientation or gender identity. The event generally includes a parade and celebration. Many of the Pride events occur in the month of June, which is considered Gay Pride Month.
Prostate Cancer Screening	Prostate cancer screening with the prostate specific antigen (PSA) blood test with or without a digital rectal exam (DRE) is a widely performed, but controversial, strategy. Large, international randomized trials of prostate cancer screening are underway, but results are not yet available. In the meantime, most professional groups agree that providers should discuss the potential benefits and risks of prostate cancer screening with their patients.
Queer	A more all-encompassing and politicized gender and/or sexual identity used by men, women, or transgender people who are sexually attracted to and/or engaging in sexual behavior with members of the same sex or gender.
Questioning	Someone who identifies as being unsure of their sexual identity.
Race/Ethnicity	There are four race categories (White, Black or African American, American Indian or Alaska Native, Asian or Pacific Islander) and one ethnicity category (Hispanic) presented in this document. "Hispanic" refers to persons reporting Hispanic ethnicity and white race or "other" race with a relevant self-description (e.g., Mexican). "White" refers to persons reporting white race and non-Hispanic ethnicity. "Black or African American," "American Indian or Alaska Native," or "Asian or Pacific Islander" refers to persons reporting one of these races regardless of ethnicity designation.

Sex	The biological distinction between male and female.
Sexual Identity	Refers to an individual's sense of belonging or not belonging to a sexual category such as lesbian, gay, bisexual, queer, questioning, etc.
Sigmoidoscopy	A medical procedure in which a scope is used to examine the inside of the rectum and the lower part of the large intestine (colon). One use for this procedure is to screen for colorectal cancer.
Straight	Someone who identifies as being sexually attracted to and/or engaging in sexual behavior with persons of the opposite sex. This term is used for both men and women.
Social Determinants of Health	The complex economic and social conditions under which people live that affect their health.
Transgender	A gender identity referring to an individual who feels belonging to an opposite or different gender category of the individual's biological sex.
Two-Spirit	A term used to describe individuals who fulfill one of many mixed gender roles found traditionally among many American Indian indigenous groups. The term implies a gender that encompasses both masculine and feminine spirits.

DIMENSIONS OF SEXUAL ORIENTATION

Sexual orientation encompasses multiple dimensions. *Attraction* refers to whom individuals are sexually drawn; *behavior* refers to with whom individuals are engaging in sexual activity; *identity* is an individual's self-perception or self-label of sexuality. An individual's self-label of sexuality may or may not align with attraction or behavior.

The different dimensions of sexual orientation tend to be conceptually associated with different health outcomes (Figure 1). An additional dimension of sexual orientation includes the perceptions others hold about an individual's sexual orientation, which may result in emotional, verbal, or physical abuse or violence. Given what health topic is going to be examined, this may help determine which sexuality dimension(s) to measure. In addition, depending on the audience, whether or not an acceptable question exists or needs to be developed, will also be an important consideration when deciding which dimension(s) to measure.

	Sexuality Dimension Measured			
Health Outcome	**Identity**	**Behavior**	**Attraction**	**Perceived**
Drug Use	✖			
Alcohol Use	✖			
Tobacco Use	✖			
HIV/AIDS		✖		
STIs		✖		
Pregnancy		✖		
Mental Health	✖	✖	✖	✖
Suicide	✖	✖	✖	✖
Violence	✖	✖	✖	✖

Figure 1
A Selection of Potential Health Concerns Commonly but not Exclusively Associated with Particular Sexuality Dimensions [1]

HISTORY OF LGBT DATA EFFORTS IN NEW MEXICO

Since 2003, New Mexico has made significant progress in its collection of sexual orientation data.

Having sexual orientation questions on population-based surveys, such as the Adult Tobacco Survey (ATS) and Behavioral Risk Factor Surveillance System (BRFSS), provides the ability to examine numerous health behaviors by sexual orientation. Data from sources such as Tobacco Quitline intake and Personal Digital Assistant (PDA) surveys help provide additional information for LGBT adults that is not covered in the population-based surveys.

2003

- ATS: First population-based health survey in New Mexico to include sexual orientation question

2005

- BRFSS: sexual orientation question added
- The Tobacco Use Prevention and Control (TUPAC) Program funds gay men and lesbian women focus groups
- Sexual orientation question added to demographic section of intake for 1-800-QUIT NOW (smoking cessation helpline)
- Proposal to include sexual attraction question in Youth Risk and Resiliency Survey (YRRS) unsuccessful

2006

- Sexual orientation question continues in ATS, BRFSS and Quitline
- LGBT-specific PDA survey assesses tobacco use and attitudes at three Pride events

2007

- Sexual orientation question continues in BRFSS and Quitline

2008

- Sexual orientation question continues in BRFSS and Quitline
- Second proposal to include sexual attraction question in YRRS unsuccessful

2009

- Revised sexual orientation question, which includes transgender, used in ATS, BRFSS, and Quitline
- PDA survey specific to LGBT young adults (18–24 year old) conducted at five Pride events assesses school safety, tobacco use and electronic media use and access

2010

- Sexual orientation question was moved to the demographic core of the BRFSS, with Centers for Disease Control and Prevention (CDC) approval
- Revised sexual orientation question continues in BRFSS and Quitline

Despite all of the progress, New Mexico still has room to expand data collection. In particular, the lack of high school youth sexual orientation data creates a substantial information gap.

IMPACT OF SEXUAL ORIENTATION ITEMS ON ADULT POPULATION-BASED SURVEYS IN NEW MEXICO [2]

In New Mexico, a sexual orientation question was added to state population-based surveys (ATS and BRFSS) in 2003. From 2003–2008, the question that was used to assess sexual orientation was:

Do you consider yourself to be:

- ☐ Heterosexual or straight
- ☐ Homosexual, gay, or lesbian
- ☐ Bisexual
- ☐ Other [specify]

This question was adapted from the sexual orientation question on the National Health and Nutrition Examination Survey (NHANES). Clarification statements were provided to participants if needed. During administration of the 2005 and 2006 BRFSS, surveyors reported that some older respondents seemed confused when asked the sexual orientation question. This confusion was reflected in the data collected; a significantly higher percentage of adults ages 65 years and older responded with "don't know." Hence, in 2007 and 2008, the sexual orientation question was only administered to respondents between 18 to 64 years of age.

The percentage of respondents who refused to answer the sexual orientation question in the 2005–2008 BRFSS ranged from 0.8%–1.1%. This was significantly lower than the percentage of respondents who refused to answer the household income question (4.2%–5.1%) on the 2005-2008 BRFSS. See Appendix A for information on analysis.

In 2009, the sexual orientation question was revised to include gender identity and to eliminate less commonly used terminology (i.e., heterosexual, homosexual):

Do you consider yourself to be one or more of the following:

- ☐ Straight
- ☐ Gay or lesbian
- ☐ Bisexual
- ☐ Transgender
- ☐ Other [specify]

This question continues to appear on the ATS and BRFSS in New Mexico, and similar to the previous question, clarification statements are available for participants who do not understand the response choices. This question is asked of all participants and will provide valuable information on the previously unidentified transgender population. In addition, this question has undergone cognitive testing (i.e., in-depth interviews with survey respondents to identify the thought process behind how questions were answered) and more accurately captures constructs of sexual orientation and gender identity among adults of all ages.[3]

New Mexico-specific data for LGB youth does not currently exist. The primary source of youth health data in New Mexico is the Youth Risk and Resiliency Survey (YRRS). The YRRS is considered by the CDC as an equivalent to their Youth Risk Behavior Survey (YRBS), which provides health data on high school students at the national and state levels. The CDC does not require that states assess sexual orientation on the YRBS or equivalent surveys. The decision to include sexual orientation questions is made at the state level. Therefore, comparison between states or state-to-national data is not possible since sufficient data are not available. In 2007, 44 states and 22 local districts participated in the YRBS. In New Mexico, efforts to ensure that LGB youth data are captured on the YRRS have been unsuccessful. The following question was proposed for inclusion in the 2005 and 2009 YRRS to assess sexual attraction:[4]

Who are you sexually attracted to?

- ☐ Males
- ☐ Females
- ☐ Both males and females
- ☐ I am not sexually attracted to anyone yet

The high school YRRS in 2009 already had 136 questions, so space was an important limitation for any additional questions regarding sexual orientation. As a result, the single sexual attraction question was proposed rather than questions assessing both behavior and identity. Saewyc et al. had suggested the use of the sexual attraction question when space is limited on surveys. The sexual attraction question captures a broader audience of students than the behavior and identity questions, since not all students may be sexually active (behavior) and they may not be ready to label themselves (identity). The proposal to include the single sexual attraction question was rejected, primarily out of concern that the question would adversely impact survey participation.

As of 2007, approximately 14 states or local districts have included a sexual orientation question on their YRBS. Massachusetts was the first state and Boston the first local district to assess sexual orientation, when they added the question in 1993. Vermont added a sexual orientation question in 1995. Other states and local districts added the question in the 2000s.

According to several states' and local districts' YRBS data, approximately 5% to 10% of students report identifying as lesbian, gay, bisexual, or questioning. This percentage represents a fairly large proportion of students whose potentially unique health risks and needs have not been captured to date in New Mexico's YRRS.

Health Disparities Experienced by LGB Youth

Numerous studies and reports have documented health disparities among LGB and questioning youth. Data from Massachusetts' 2007 YRBS have found that LGB youth are significantly more likely to have attempted suicide within the past year, to have needed medical attention because of a suicide attempt, to have missed school in the past month because of feeling unsafe en route to or at school, to have been injured or threatened

with a weapon at school in the past year, and to have been in a physical fight that required medical attention.[5] Historically, YRBS data from Massachusetts also found that LGB youth were more likely to use tobacco (i.e., smoke cigarettes before age 13, smoke cigarettes in the past month, use spit/chew tobacco in the past month, smoke cigarettes at school in the past month, and use spit/chew at school in the past month) and alcohol (i.e., use alcohol before age 13, use alcohol in the past month, and binge drink).[6]

Data from the 2005 Chicago YRBS also found numerous disparities between LGB and straight students.[7] These disparities included increased prevalence of experiencing violence (e.g., carrying a weapon, being threatened, dating violence, sexual assault), depression and suicide, alcohol and drug use, sexual activity, body image disorders, and dieting.

Recently, Rhode Island released a brief report on findings from their 2007 YRBS. A significantly higher percentage of LGB and questioning students reported risk on 27 out of 30 indicators compared to straight students.[8] Some of these indicators included violence, sexual violence and assault, depression, suicide, tobacco use, alcohol use and other drug use, which are consistent with findings from other states.

Implications of Lack of Sexual Orientation Data for Youth in New Mexico

The lack of sexual orientation data for youth in New Mexico impacts the ability to ensure the health, safety, and well-being of LGB youth. New Mexico-specific data would enable:

- Characterization of health, risk and resiliency behaviors, and associations with health disparities;
- Adaptation of existing prevention, intervention (e.g., suicide prevention, anti-bullying) or educational health programs, and development of new programs; and
- Provision of support and information to community-based LGB organizations, School Safe Zones, Gay-Straight Alliances (GSAs), and diversity/multicultural programs in New Mexico public schools.

The lack of data prevents community-based organizations and various programs in New Mexico from having objective evidence that demonstrates the need for funding and programming targeted to LGB youth.

In Massachusetts, implementation of a statewide Safe Schools Program may have contributed to the decreased risk LGB students experienced. According to 1995 YRBS data, LGB students were five times more likely to skip school because of feeling unsafe and five times more likely to have been threatened or injured with a weapon at school. Data from the 2007 YRBS indicated that LGB students were three times more likely than straight students to skip school because of feeling unsafe and four times more likely to have been threatened or injured with a weapon at school. Massachusetts Safe Schools Program included a policy that protects LGBT students, faculty and staff from discrimination on the basis of sexual orientation or gender identity. The policy requires comprehensive professional development training for all faculty and staff on LGB youth, creating safe schools, supporting the creation and maintenance of GSAs, and referring LGB students and their families to appropriate mental health services.

ADULT LESBIAN, GAY, AND BISEXUAL DATA

Generating accurate estimates of the proportion of LGB adults is challenging. Currently, no standard estimates exist for the percentage of LGB adults. The US Census attempts to survey every person in the country and would thus provide the closest estimate for the proportion of LGB adults. The Census only measures same-sex households, however, and does not assess sexual orientation and gender identity.

Population-based surveys are an alternative data source that can help provide statewide estimates. If population-based surveys are large, well conducted, and properly analyzed, they can provide valid and reliable data. If sample sizes are small in population-based surveys, however, the precision of estimates may be limited.

Nationally, the CDC does not require that states assess sexual orientation on the state-administered surveys that the CDC oversees, such as the BRFSS and ATS. The decision to include sexual orientation questions is made at the state level. Therefore, comparison between states or state-to-national data is not possible since sufficient data are not available. In New Mexico, the BRFSS and ATS are population-based surveys and can help provide an estimate of LGB adults throughout the state (Table 1).

Using 2005 and 2006 BRFSS data, New Mexico's LGB 18 and older adults accounted for 2.1% (29,800) and 2.5% (36,000) of the entire adult population, respectively. The 2007 and 2008 BRFSS estimated approximately 2.4% (29,100) and 3.2% (39,100) LGB adults ages 18 to 64 years, respectively.

The estimated percentage of LGB adults in New Mexico generated from ATS and BRFSS data is lower than some estimates made from other sources of data, such as the American Community Survey (ACS) (Table 2), which estimates almost 5% of New Mexico's adult population is LGB. This discrepancy could be due to issues such as under-reporting in the BRFSS and differing methodologies. For example, the ATS and BRFSS are landline telephone-based, and therefore, do not include households that may use only cell phones. If LGB households are more likely than straight households to use only cell phones, this bias would reduce their representation in the BRFSS sample. The ACS is mailed to households, thus taking into account households that do not have landlines. The ACS does not directly assess sexual orientation, however, but rather assesses same-sex households. Using same-sex household as a proxy measure for LGB status fails to identify single LGB adults, LGB adults living in opposite-sex households, and straight adults living in same-sex households. The estimates in Table 2 were generated using ACS and National Family Growth Survey data, to approximate the percentage of LGB adults.

Table 1 Estimated Percentage and Number* of Lesbian, Gay or Bisexual Adults in New Mexico, 2003–2008

Est. %/Est. Pop.	2003 ATS	2005 BRFSS	2006 ATS	2006 BRFSS	2007 BRFSS**	2008 BRFSS**
Straight	98.0% 1,360,200	97.9% 1,386,200	97.9% 1,409,300	97.5% 1,403,600	97.6% 1,184,100	96.8% 1,182,800
Lesbian or Gay	—	1.1% 15,600	—	1.4% 20,200	1.3% 15,800	1.5% 18,300
Bisexual	—	1.0% 14,200	—	1.1% 15,800	1.1% 13,300	1.7% 20,800
Non-Straight***	2.0% 27,800	—	2.1% 30,200	—	—	—

* *Population source: Bureau of Business and Economic Research (BBER) Population Estimates, University of New Mexico. http://www.unm.edu/~bber/.*

** *Respondents 65+ years are excluded from analysis.*

*** *Respondents reporting 'Other' were excluded in BRFSS, but included in ATS.*

Rank	State	%
1	District of Columbia	8.1%
2	New Hampshire	6.6%
3	Washington	5.7%
4	Massachusetts	5.7%
5	Maine	5.2%
6	California	5.2%
7	Colorado	5.1%
8	Vermont	5.1%
9	New Mexico	4.9%
10	Minnesota	4.7%

Table 2
Estimated Percentage of Lesbian, Gay and Bisexual Adults, American Community Survey 2005 [9]

Although ATS and BRFSS are anonymous surveys, other factors besides survey design may impact estimates of LGB adults in New Mexico. For example, sexual orientation is measured using self-identity. If individuals are not comfortable self-identifying as LGB, whether it is due to fear of discrimination or uneasiness with divulging sexual orientation information, the self-identity measure would most likely underestimate the true percentage of LGB adults. In addition, the terms LGB are not applicable to all individuals, particularly people of color or from various racial/ethnic groups, as they may have other terms to describe their sexual identity. Despite these limitations, the percentage of LGB adults generated from data sources such as ATS and BRFSS are currently the most accurate and reliable estimates available.

Demographic Characteristics of LGB Adults in New Mexico

Demographic characteristics help put into perspective the distribution and disparities of certain chronic conditions and risk factors. The LGB community is comprised of a diverse set of individuals from different socioeconomic and cultural backgrounds and these individuals exist in every population group. Differences among lesbian, gay, and bisexual adults are lost when all three identities are measured together. Data presented compare straight, lesbian or gay, and bisexual adults. Data for men and women are presented separately when relevant. For detailed data by sexual orientation (i.e., overall, men, and women), see Appendix B.

Demographic characteristics on the following pages are based on BRFSS.

Forty-one percent of bisexual adults were 18 to 24 years old, which is significantly higher than the percentage of straight (16.7%) and lesbian or gay adults (12.4%) in that age group (Figure 2). Both bisexual men and women were significantly more likely to be between 18 to 24 years old than their straight and lesbian or gay counterparts. Age distribution was similar between lesbian or gay and straight adults.

A significantly lower percentage of lesbian or gay adults (3.7%) reported having less than a high school diploma, compared to straight adults (12.7%) (Figure 3). This difference is driven by both gay men and lesbian women. A significantly higher percentage of lesbian or gay adults (43.3%) reported having a college degree or higher compared to straight adults (30.7%). This difference is driven primarily by lesbian women, among whom 58% reported having a college degree or higher. There were no significant differences between straight and gay men for having a college degree or higher.

Figure 2
Age Distribution Among New Mexico Adults (18–64 years) by Sexual Orientation, NM BRFSS 2005–2008

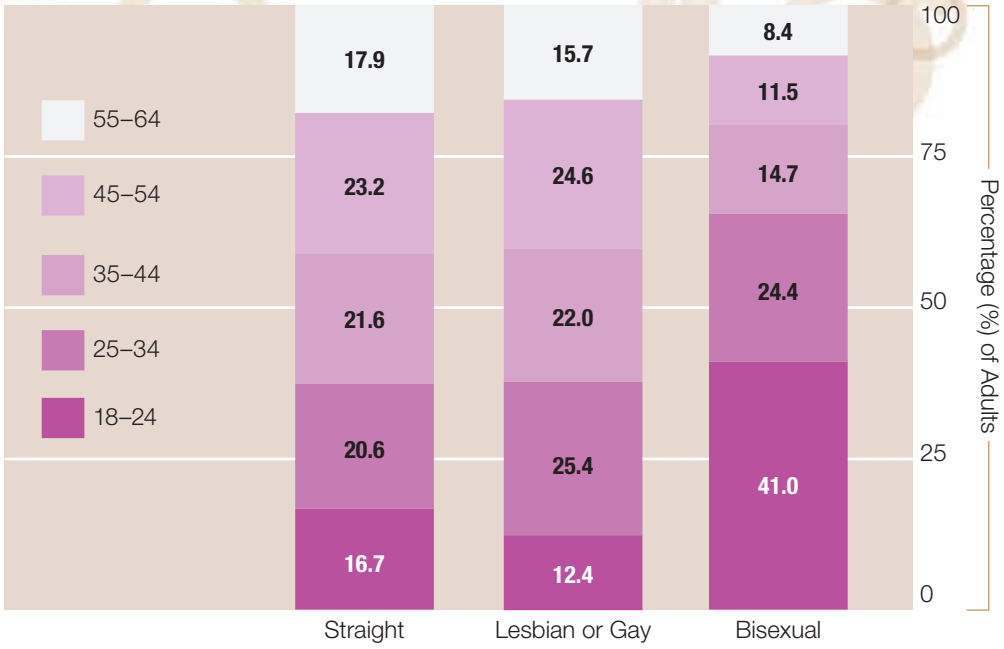
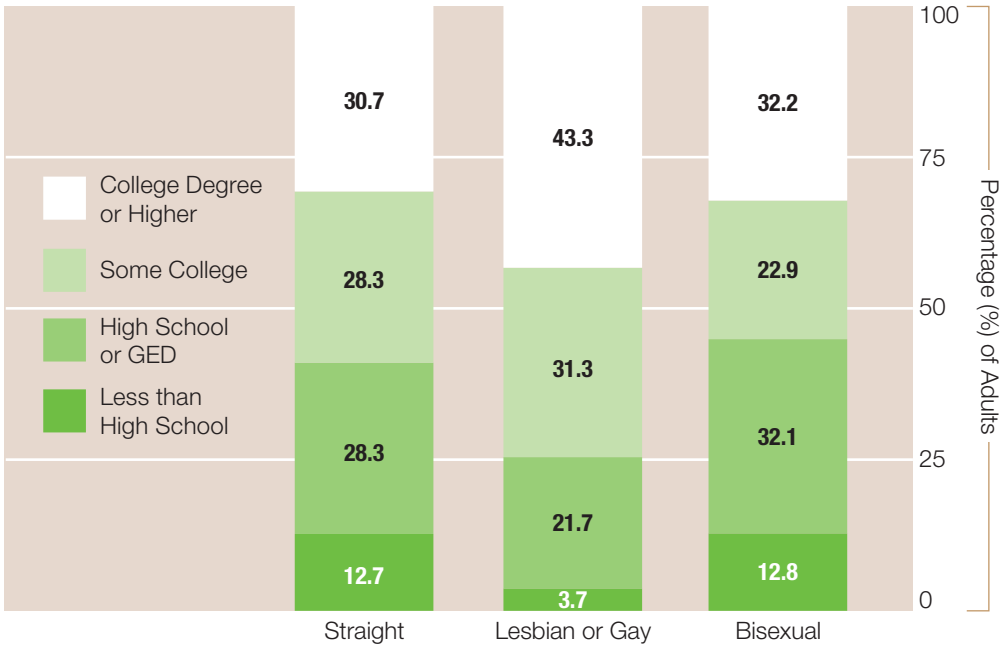


Figure 3
Educational Attainment Among New Mexico Adults (18–64 years) by Sexual Orientation, NM BRFSS 2005–2008



A significantly higher percentage of lesbian or gay adults have a household income of less than $20,000 annually compared to straight adults (Figure 4). This disparity is driven primarily by gay men, who are over three times more likely to have an income between $10,000 to $20,000 annually and 2.8 times more likely to have an income under $10,000 annually than straight men.

More lesbian or gay (8.3%) and bisexual adults (9.6%) reported a household income of less than $10,000 annually than straight adults (4.8%), but this difference does not reach statistical significance.

A significantly lower percentage of gay men reported an annual household income greater than $50,000 (35.7%) than their straight counterparts (52.7%). There were no significant

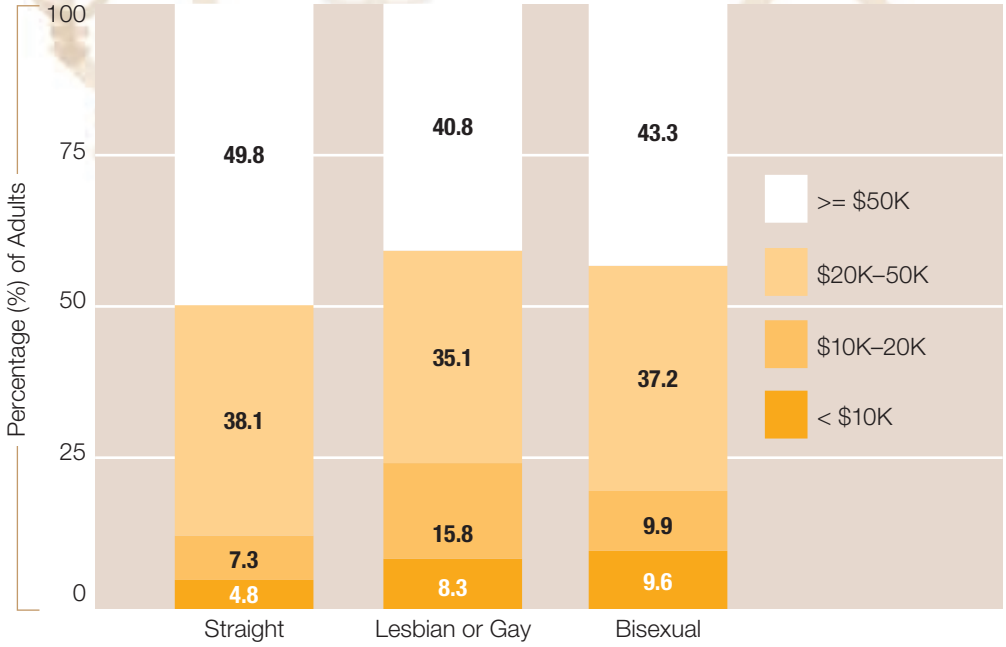


Figure 4
Household Income Among New Mexico Adults (18–64 years) by Sexual Orientation, NM BRFSS 2005–2008

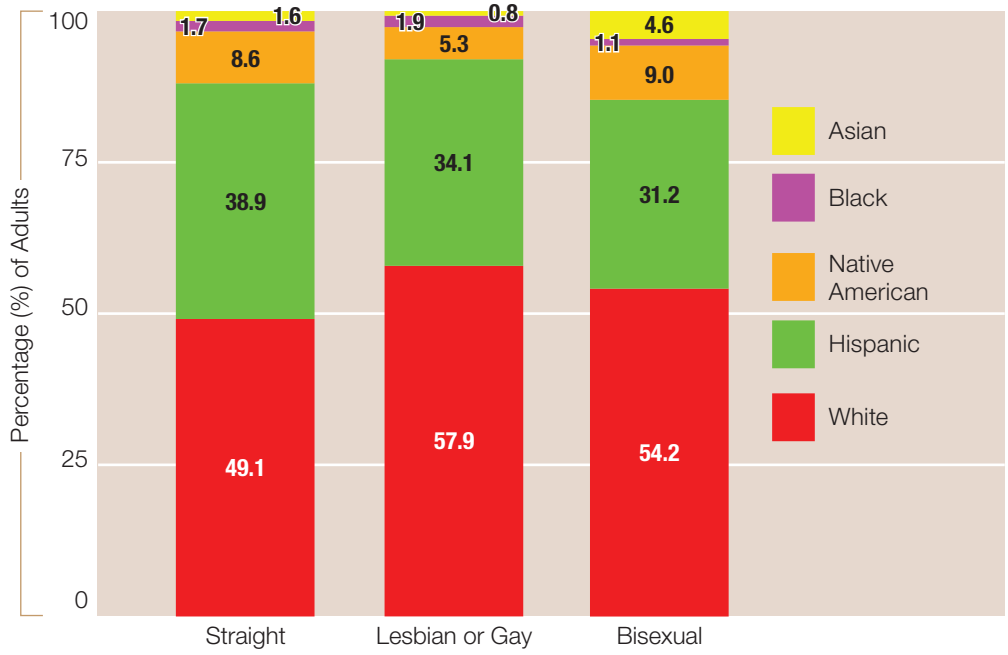


Figure 5
Race/Ethnicity Among New Mexico Adults (18–64 years) by Sexual Orientation, NM BRFSS 2005–2008

differences in the income distribution between lesbian and straight women or between bisexual and straight adults.

There were no significant differences in the distribution of racial/ethnic groups by sexual orientation (Figure 5).

For groups that comprise a low percentage of the New Mexico population (i.e., Black or African American, Asian or Pacific Islander), the number of randomly selected survey respondents is small. The small sample sizes lead to less precise estimates, which are reflected by wider confidence intervals. In this report, due to the small sample sizes of sexual orientation and race/ethnicity, specific race/ethnicity and LGB data cannot be presented beyond what is contained in this section.

Risk factors are behaviors and conditions that increase the likelihood of developing certain adverse heath outcomes. Some factors, such as age, sex, and genetics, affect risk but cannot be changed. Modifiable risk factors, on the other hand, can potentially be changed in an effort to improve health outcomes. For more detailed information on risk factors and health behaviors by sexual orientation, see Appendix B.

In this section, statistically significant differences are highlighted, as well as differences that may have clinical and social implications, even if they are not significant. Statistical significance is influenced by sample size (i.e., smaller sample sizes tend to result in less precise estimates and wider confidence intervals). This means that in some cases, a larger sample size might have resulted in a statistically significant difference that could not be demonstrated using a smaller sample.

A significantly higher percentage of bisexual adults reported currently smoking (39.1%) compared to straight adults (Figure 6). Both bisexual men and women had higher proportions of current smokers. Among bisexual men (38.9%), this percentage was not significantly different from straight men (24.4%). Among bisexual women (39.1%), the proportion was significantly higher than straight women (19.4%).

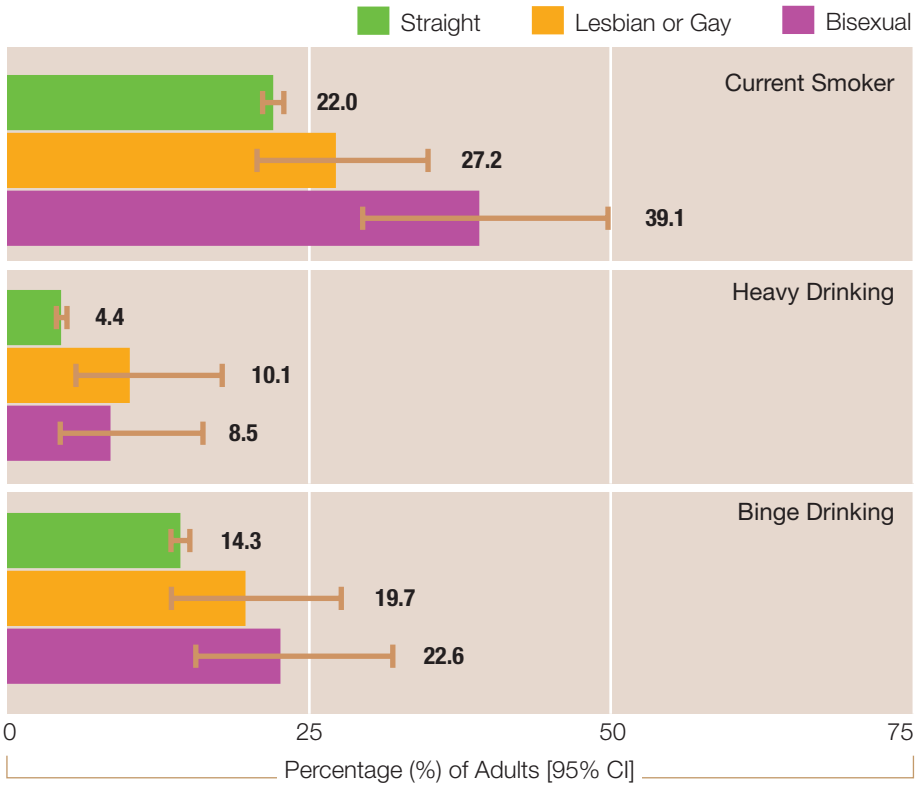


Figure 6
Tobacco and Alcohol Use Among New Mexico Adults (18–64 years) by Sexual Orientation, NM BRFSS 2005–2008

For alcohol use, a significantly higher percentage of lesbian or gay adults reported heavy drinking (10.1%) compared to straight adults (4.4%). This difference is driven by higher heavy drinking rates among both gay men (12.2%) and lesbian women (8.0%), especially compared to their straight counterparts (men: 5.2% and women: 3.7%). There was a statistical difference between gay and straight men, but not between lesbian and straight women. Looking at binge drinking, bisexual adults had significantly higher rates (22.6%) than their straight counterparts (14.3%). This higher rate was driven by both bisexual men (19.8%) and women (23.7%). Compared to their straight counterparts, bisexual women were significantly more likely to binge drink than straight women (8.3%), while there was no significant difference between bisexual and straight men (20.3%).

More lesbian and gay adults reported high cholesterol and high blood pressure than their straight counterparts. Fewer bisexual adults reported high cholesterol or high blood pressure than straight adults; however, this difference may be driven by the younger age of bisexual adults. These differences were not significant (Figure 7).

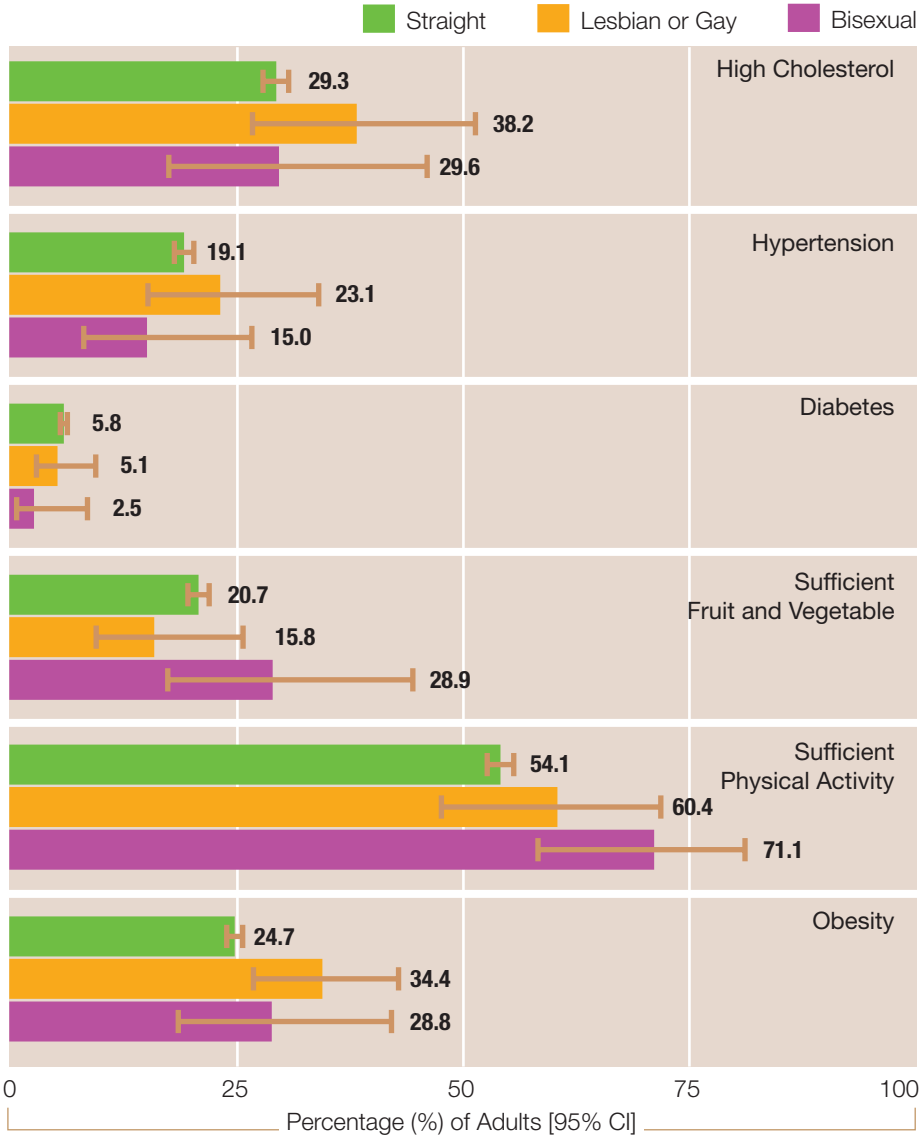


Figure 7
Other Chronic Disease Risk Factors Among New Mexico Adults (18–64 years) by Sexual Orientation, NM BRFSS 2005–2008

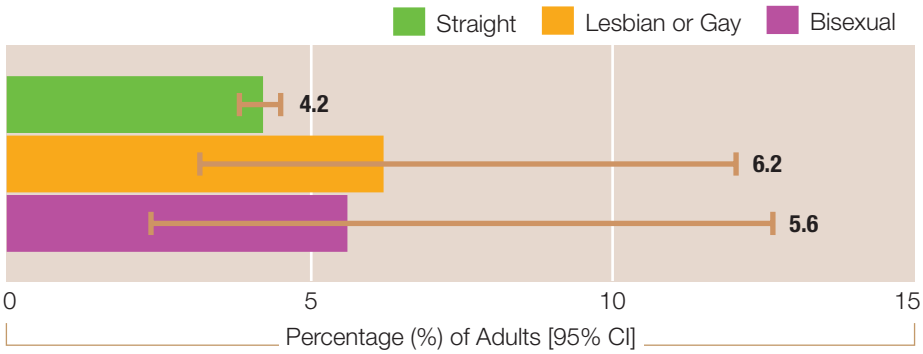
No significant differences were found for diabetes and sufficient fruit and vegetable consumption by sexual orientation. Among men, more gay (6.6%) and bisexual men (6.7%) reported having diabetes compared to straight men (5.8%), although these differences were not significant. A lower percentage of gay men (9.8%) reported consuming enough fruits and vegetables compared to straight men (17.4%), although this difference was not significant. Among women, a lower percentage of bisexual women reported having diabetes (0.9%) than straight women (5.7%), although this difference may be an artifact of their overall younger age. A higher percentage of bisexual women (31.4%) reported sufficient fruit and vegetable consumption, although this was not significant.

A significantly higher percentage of bisexual adults reported engaging in sufficient amounts of physical activity (71.1%) than straight adults (54.1%). This is not surprising since bisexual adults tend to be younger than straight adults. Both bisexual men and women had higher rates of engaging in sufficient physical activity. Bisexual women (70.4%) were significantly more likely than straight women (51.6%) to engage in sufficient physical activity. No significant differences in engaging in sufficient physical activity were found between straight men (56.6%) and bisexual men (72.8%).

A significantly higher percentage of gay or lesbian adults reported obesity (34.4%) than straight adults (24.7%). Among men, gay men reported higher rates of obesity (35.3%) than straight men (23.7%), although this difference was not significant. Lesbian women also had higher rates of obesity (33.6%) compared to straight women (25.8%), although this was also not significant.

A higher percentage of LGB adults reported a history of cardiovascular disease (CVD), although these differences were not significant (Figure 8). Adults with a history of CVD include those who have ever been told by a health care professional that they had a heart attack, angina or coronary heart disease, or a stroke.

Figure 8
History of Cardiovascular Disease Among New Mexico Adults (18–64 years) by Sexual Orientation, NM BRFSS 2006–2008



A significantly higher percentage of lesbian or gay and bisexual adults reported depression, suicide attempts, and intimate partner violence compared to straight adults (Figure 9). Among both men and women, LGB adults reported higher rates compared to their straight counterparts.

Nearly three times the percentage of lesbian or gay adults (47.3%) and over two times the percentage of bisexual adults (37.3%) reported depression compared to straight adults (17.2%).

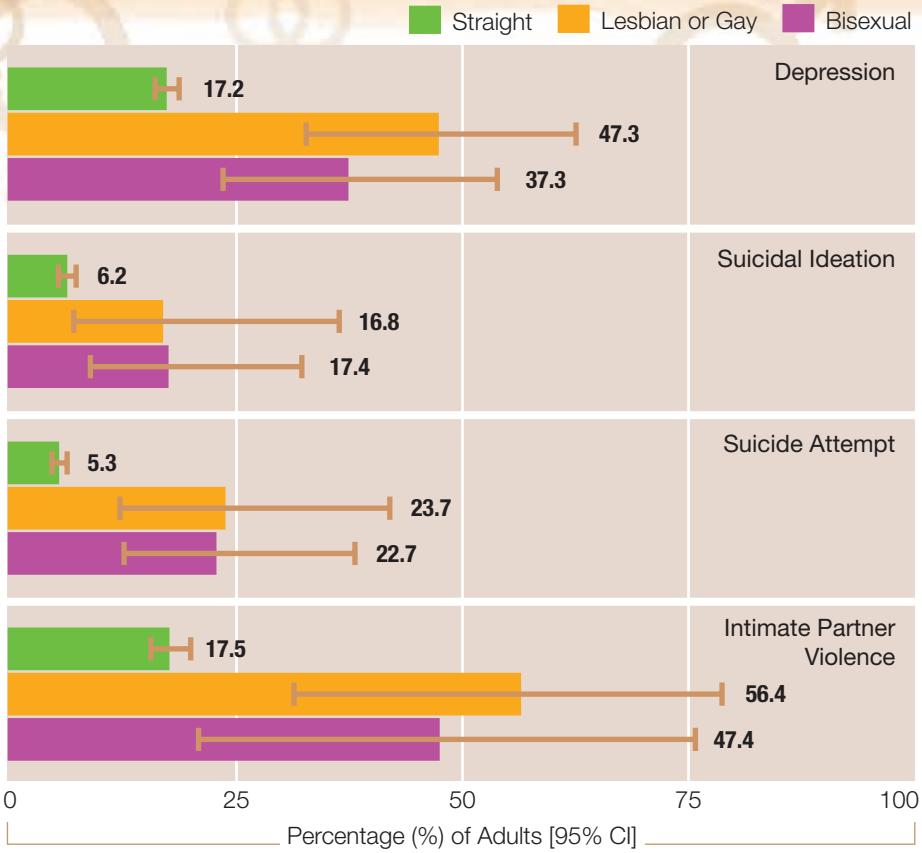


Figure 9
Mental Health and Violence Among New Mexico Adults (18 years and older) by Sexual Orientation, NM BRFSS 2005, 2006

Nearly three times the percentage of bisexual adults (17.4%) reported suicidal ideation compared to straight adults (6.2%). Approximately 2.7 times the percentage of lesbian or gay adults (16.8%) reported suicidal ideation compared to straight adults, although this difference was not statistically significant.

A significantly higher percentage of LGB adults reported having ever attempted suicide, with nearly one in four of LGB adults compared to only one in twenty of straight adults.

Compared to straight adults (17.5%), a significantly higher percentage of lesbian or gay adults (56.4%) and bisexual adults (47.4%) reported experiencing intimate partner violence.

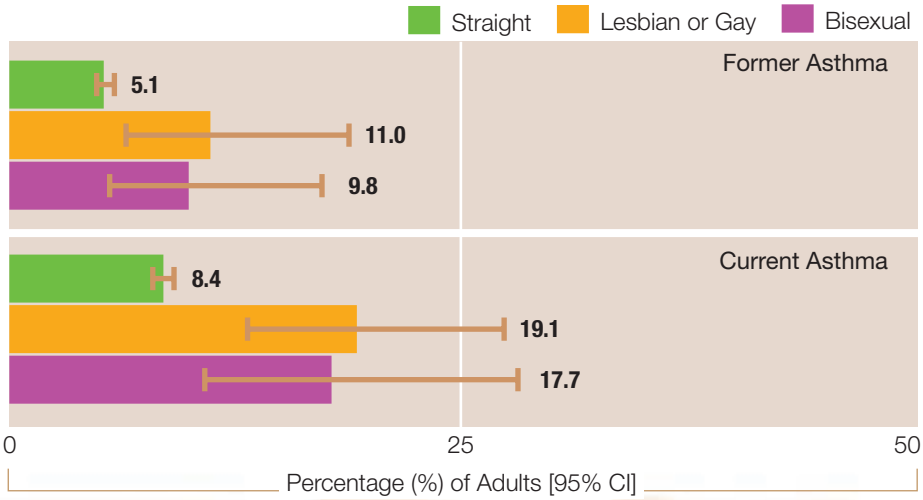
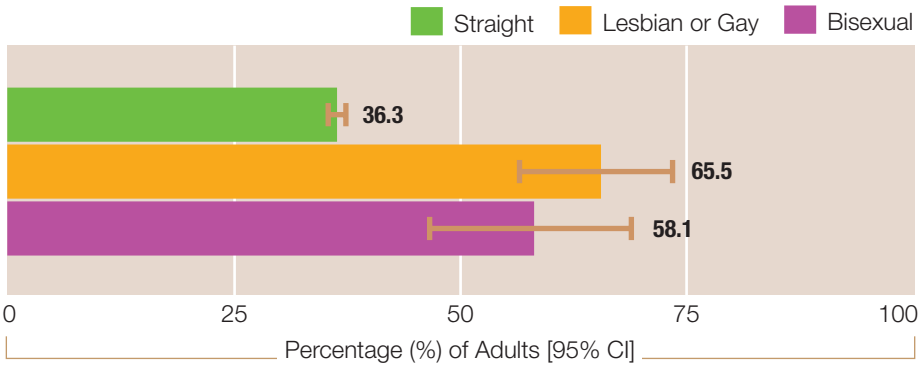


Figure 10
Asthma Status Among New Mexico Adults (18–64 years) by Sexual Orientation, NM BRFSS 2005–2008

A significantly higher percentage of lesbian or gay adults reported formerly having asthma than straight adults (Figure 10). This difference was driven primarily by gay men, who had nearly three times the rate of former asthma than their straight male counterparts (16.2% vs. 5.6%). No significant differences were found between lesbian and straight women in former asthma status. Bisexual adults had a higher rate of formerly having asthma compared to straight adults, however, this rate was not significantly higher. Bisexual women however had significantly higher rates of former asthma than straight women (11.2% vs. 4.7%). There were no significant differences in former asthma between bisexual (5.7%) and straight men (5.6%).

For current asthma, both lesbian or gay (19.1%) and bisexual adults (17.7%) had significantly higher rates than straight adults (8.4%). Among men, both gay men (15.5%) and bisexual men (16.7%) had higher rates of current asthma compared to straight men (6.7%), although these differences were not significant. Lesbian women (22.7%) had significantly higher rates of current asthma compared to straight women (10.0%). Bisexual women experienced a higher rate of current asthma (18.0%), although this rate was not significantly different from straight women.

Figure 11
Ever Tested for HIV Among New Mexico Adults (18–64 years) by Sexual Orientation, NM BRFSS 2005–2008



A significantly higher percentage of lesbian or gay (65.5%) or bisexual (58.1%) adults reported ever having had an HIV test compared to straight adults (36.3%) (Figure 11). Among men, 70.1% of gay men and 55.8% of bisexual men reported ever having had an HIV test compared to 33.9% of straight men. Among women, 60.9% of lesbian women and 58.9% of bisexual women reported ever having had an HIV test compared to 38.6% of straight women. These differences were all statistically significant.

At the time of data collection, breast cancer screening by mammography was recommended for women every one to two years beginning at age 40 by the United States Preventive Services Task Force (USPSTF).

Among women 40 to 64 years old, bisexual women reported the highest percentage (89.5%) of having had a mammogram in the past two years (Figure 12), which was significantly higher than the percentage of straight women (70.1%) who have had a mammogram in the past two years. Lesbian women (62.2%) had the lowest percentage of having had a mammogram in the past two years, although this rate was not significantly different from straight and bisexual women.

The USPSTF recommends regular Pap tests for women 21 years and older, or within three years of first intercourse, whichever happens first.

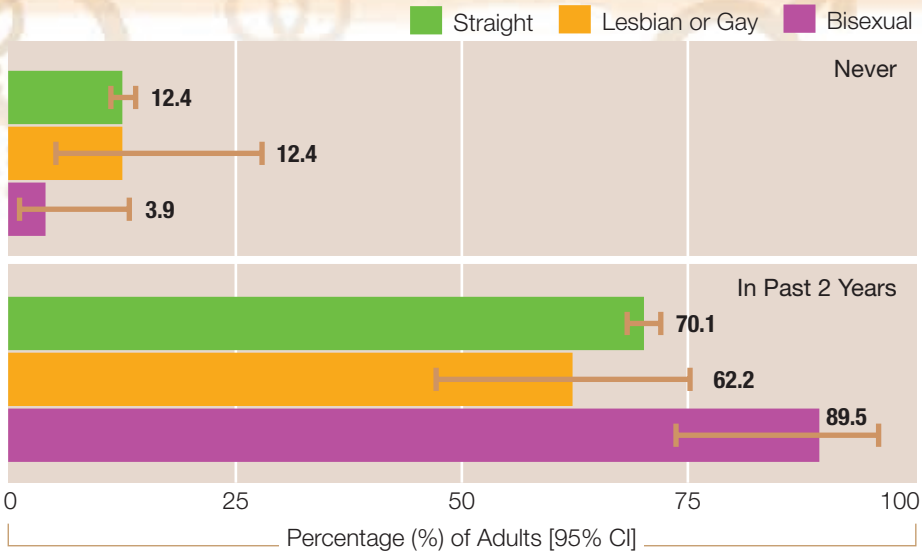


Figure 12
Breast Cancer Screening (Mammography) Among New Mexico Adult Women (40–64 years) by Sexual Orientation, NM BRFSS 2006 & 2008

A higher percentage of bisexual women reported never having a Pap test (20.9%), although this percentage is not significantly different from straight and lesbian women (Figure 13). Fewer lesbian (75.5%) and bisexual women (72.0%) reported having a Pap test in the past three years compared to straight women (82.6%), although this difference was not statistically significant.

Prostate cancer screening with the prostate specific antigen (PSA) blood test with or without a digital rectal exam (DRE) is a widely performed, but controversial, strategy. Large, international randomized trials of prostate cancer screening are underway, but results are not yet available. In the meantime, most professional groups agree that providers should discuss the potential benefits and risks of prostate cancer screening with their patients.

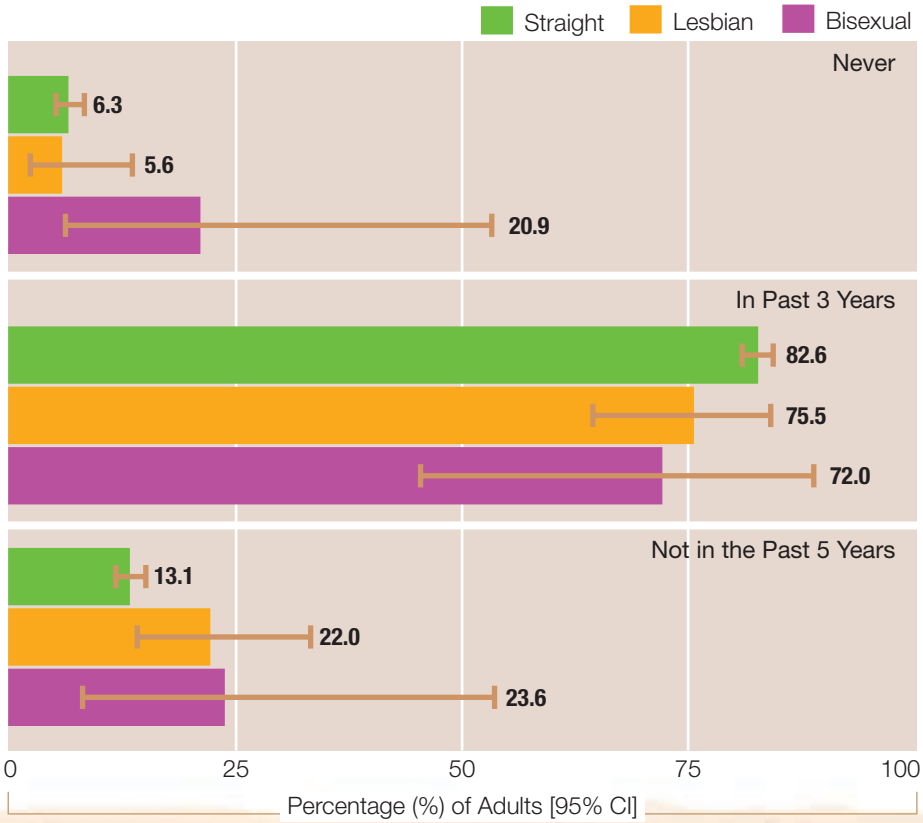


Figure 13
Cervical Cancer Screening (Pap Test) Among New Mexico Adult Women (18–64 years) by Sexual Orientation, NM BRFSS 2006 & 2008

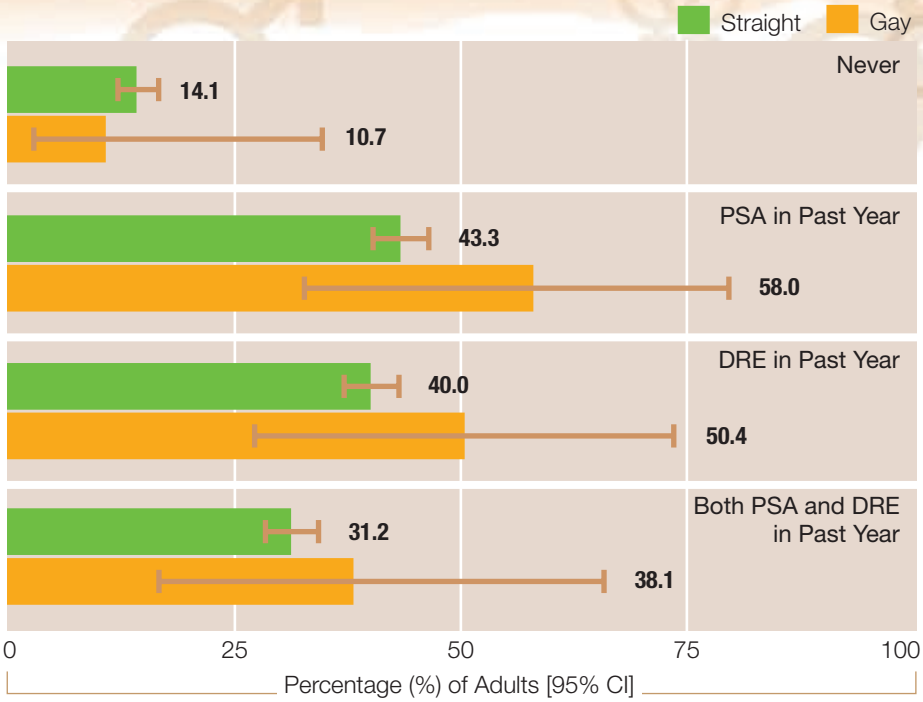


Figure 14
Prostate Cancer Screening (PSA, DRE) Among New Mexico Adult Men (50–64 years) by Sexual Orientation, NM BRFSS 2006 & 2008

A higher percentage of gay men report having had a PSA, DRE or both in the past year compared to straight men, although this difference was not significant (Figure 14). Due to small sample sizes, data for bisexual men have been suppressed.

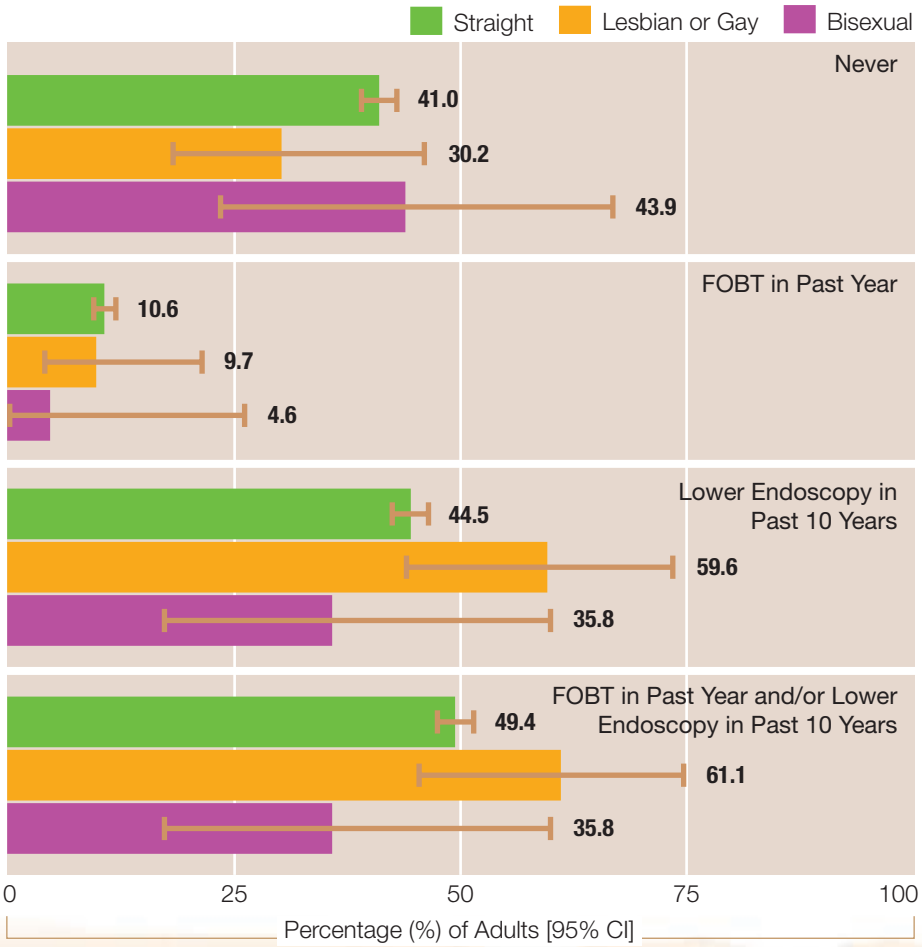


Figure 15
Colorectal Cancer Screening (FOBT, Lower Endoscopy) Among New Mexico Adults (50–64 years) by Sexual Orientation, NM BRFSS 2006 & 2008

A number of screening strategies endorsed by groups like the USPSTF (e.g., high sensitivity fecal blood test/FOBT, sigmoidoscopy, colonoscopy) can result in detecting early stage colon cancers and removing precancerous polyps. Sigmoidoscopy and colonoscopy can collectively be referred to as "lower endoscopy."

A lower percentage of lesbian or gay adults 50 to 64 years old report never having colorectal screening, although this rate was not significantly different (Figure 15). More lesbian or gay adults 50 to 64 years old, reported having had a lower endoscopy in the past 10 years compared to straight and bisexual adults, although this difference was not significant. Lesbian and gay adults also had the highest percentage for having had a FOBT in the past year and/or lower endoscopy in the past 10 years, although this rate was not significantly different from straight and bisexual adults. Bisexual adults had the lowest percentage of lower endoscopy in the past 10 years as well as FOBT in the past year and/or lower endoscopy in the past 10 years, although these differences were not significantly lower than other groups. Due to small sample sizes, data for men and women cannot be presented separately.

For other health indicators, a significantly higher percentage of bisexual adults (13.3%) reported being dissatisfied or very dissatisfied with their life compared to straight adults (5.2%) (Figure 16). Among women, lesbian women (11.0%) and bisexual women (13.3%) had significantly higher rates of life dissatisfaction than straight women (5.1%). Bisexual men also report higher rates of life dissatisfaction (13.1%) compared to straight men (5.3%), although this difference was not significant. No significant differences were found between gay (6.3%) and straight men.

For adults reporting fair or poor health and not having health insurance, no significant differences by sexual orientation were found.

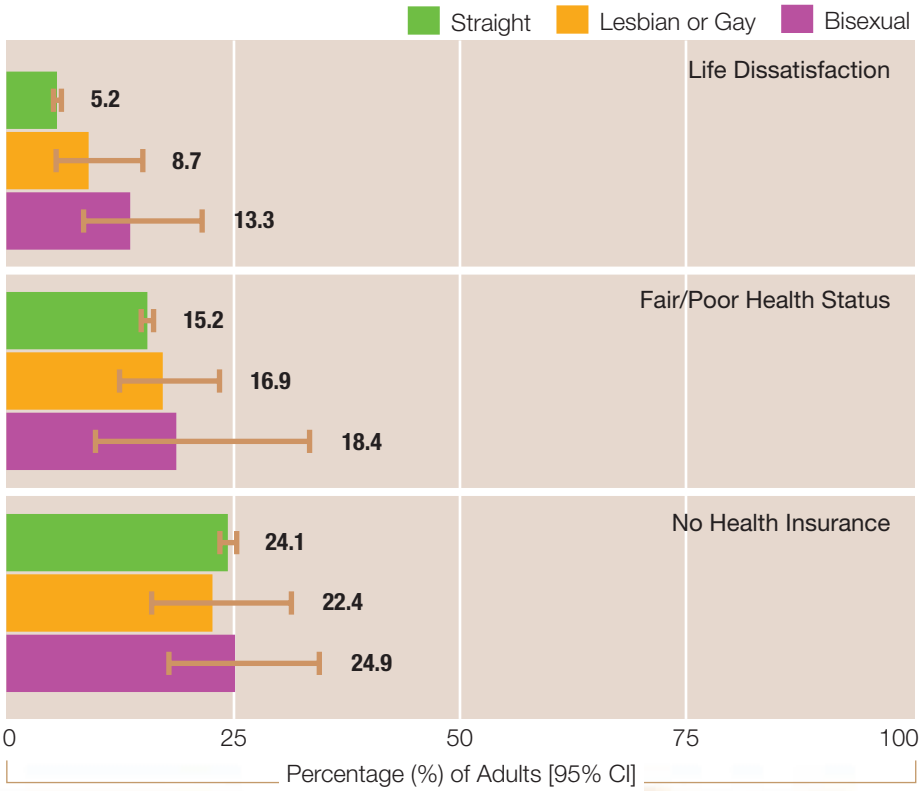


Figure 16
Other Health Indicators
Among New Mexico Adults (18–64 years)
by Sexual Orientation,
NM BRFSS 2005–2008

Overall, data shows that LGB adults in New Mexico experience significantly higher risk compared to their straight counterparts for tobacco use, excessive alcohol use, suicide, depression, intimate partner violence, obesity, asthma, and life dissatisfaction. Many of these behaviors and conditions (tobacco use, excessive alcohol use and obesity) are risk factors for chronic diseases and conditions such as CVD, respiratory diseases, diabetes and some cancers. Cardiovascular disease (which includes heart disease and stroke, the first and fifth leading causes of death in New Mexico, respectively) accounts for approximately a quarter of all deaths in New Mexico. While there were no statistically significant differences between LGB and straight adults in prevalence of CVD, LGB adults did have slightly higher rates overall. The high prevalence of CVD risk factors (i.e., high cholesterol, high blood pressure, obesity, and tobacco use) among LGB adults has implications for the impact CVD could have on the LGB community. If measures are not taken to reduce or control these risk factors, the likelihood of reducing the prevalence of CVD among LGB adults is low.

Suicide, depression, and intimate partner violence are measures of mental health. The disproportionately high prevalence of these measures among LGB adults demonstrates a need for culturally appropriate resources and programs to help address mental health. Life dissatisfaction demonstrates a diminished quality of life. Generally, adults who report higher prevalence of adverse health behaviors and conditions, such as tobacco use, obesity, physical inactivity, excessive alcohol use, depression, and mental distress also report increased life dissatisfaction.[10] In New Mexico, the higher rates of life dissatisfaction among LGB adults may be associated with the increased prevalence of risk behaviors, chronic conditions, and poor mental health.

For protective health behaviors such as cancer screening, the only statistically significant difference was that bisexual women were more likely than straight women to have had a mammogram in the past two years. While there was no statistical difference between lesbian and straight women, a lower percentage of lesbian women reported having a mammogram in the past two years. Research has documented that lesbian women are at higher risk of developing breast cancer;[11] therefore, is it important that they get screened regularly. Breast cancer screening is an example of a public health program that should expand its outreach specifically to lesbian and bisexual women in addition to low-income and racial ethnic groups.

Higher rates of HIV testing among LGB adults is most likely due to increased awareness and public health programming that targets the LGBTQI community. For example, HIV testing is often available at larger Pride events, thus increasing the availability of HIV testing to LGB adults. This provides an example of how culturally competent programs and campaigns for LGBTQI communities create a positive change that can improve the health of LGBTQI individuals though early diagnosis and prevention.

Given the noted health disparities between LGB and straight adults in New Mexico, it is important to understand why these disparities exist. Understanding the root causes of disparities will be crucial in eliminating them.

Other Sources of Sexual Orientation Health Data in New Mexico

Population-based surveys in New Mexico have been supplemented with other sources of data. Focus groups and small surveys of individuals provide additional information about the LGB population.

Focus Groups Findings

In 2005, the DOH Tobacco Use Prevention and Control (TUPAC) Program funded two focus groups, one of gay men and one of lesbian women, to identify their top health concerns.

Top Health Concerns for Gay Men (in order of importance)

1. HIV / AIDS
2. Mental Illness *(tied)*
2. Self-esteem *(tied)*
3. Combination of Drugs and Addiction, including Tobacco
4. Hepatitis C
5. Obesity *(tied)*
5. Hypertension *(tied)*
5. Suicide *(tied)*
5. Hate Crimes *(tied)*

> *"Pride was one of the first times my partner actually got to see people in the daylight and he was thrilled to actually be out in public and be able to hold my hand with all kinds of people around and he really liked that. It really boosted his confidence, so I really appreciate any money that people will give to that kind of thing."*
>
> *– Focus Group Participant*
> *(response to a question about tobacco companies' sponsorship of Gay Pride events)*

> *"One thing that bothers me is the [health] forms that you have to fill out that don't ask anything about your particular sexual orientation. It's married, single, divorced, widowed. And there's always the assumption that if you are sexually active it's with someone of the opposite sex, in our case men."*
>
> *– Focus Group Participant*

Top Health Concerns for Lesbian Women (in order of importance)

1. Depression
2. Smoking
3. Access to Health Care
4. Breast Cancer
5. Alcoholism
6. Sexually Transmitted Diseases
7. Relationships and Mental Health
8. Transgender / Sexual Issues in Receiving Health Care
9. Regular Check-ups
10. Honesty with Medical Provider

PDA Survey Findings

In addition to the focus groups, TUPAC has also funded and helped facilitate the administration of two PDA surveys at Pride events across New Mexico. A PDA survey uses a hand-held computer device with a survey pre-programmed into it so that the surveyor can quickly move through the survey and the results can be downloaded directly into a database, saving time on data entry. Data gathered from PDA surveys reflect only the sample of people surveyed and cannot be generalized to the entire LGBT population. These types of surveys can help gather information that might not be available in other data sources.

The first PDA survey was administered in 2006 and surveyed over 400 LGBT adults' tobacco use and attitudes. Pride event surveys took place in Albuquerque, Santa Fe, and Las Cruces.

Data collected from the 2006 PDA survey indicated that adults who identify as bisexual had the highest prevalence of current smoking (58%), followed by gay men (40%), lesbian women (32%), and transgender people (32%). In addition, at the time of the survey, only about a third of LGBT survey participants correctly knew that LGBT people are more likely to smoke than their straight counterparts. These findings were used by Fierce Pride (formerly the Stop Tobacco On My People! (STOMP!) LGBTQI Tobacco Advisory Committee) to develop materials to increase awareness of tobacco use among LGBT people through targeted messaging.

The second PDA survey was administered in 2009 to over 275 LGBT young adults (ages 18 to 24 years) and assessed school safety, tobacco use, and media access. Pride event surveys were taken in Albuquerque, Gallup, Socorro, Santa Fe, and Las Cruces.

Of the young adults surveyed, over half reported smoking cigarettes everyday or some days. Of these, 29% were trying to quit or cut down, 23% planned to quit smoking soon, 26% thought they should quit someday, and 18% did not think about quitting.

Nearly 85% of young adults surveyed had attended a New Mexico high school. Of these, over 57% reported having been the victim of a verbal slur or offensive comment during high school, based on someone's perception of their sexual orientation. Nearly 24% reported having been physically threatened or attacked during high school based on perceived sexual orientation. Despite a high percentage of students reporting verbal or physical abuse, only about a third of students reported having resources available to LGBTQ students at the high school they had attended.

National Sources of Sexual Orientation Health Data[12]

A select number of nationally administered surveys do include sexual orientation as part of their data collection (e.g., NHANES, National Health Interview Survey, etc.). Some of these surveys only assess sexual behavior with no assessment of sexual identity. Many other national surveys do not collect any sexual orientation data (e.g., National Survey on Drug Use and Health). As noted previously, the ACS, which is administered through the US Census Bureau, and the US Census Decennial Survey do not ask about sexual orientation, but rather assess same-sex households.

Data Sources Through Which Sexual Orientation Could Be Collected

Population-based surveys such as the ATS and BRFSS are the backbone for chronic disease public health surveillance; however, data from these sources alone do not provide a comprehensive picture of health. Other measures of population health are needed in order to fully understand the health of LGB populations. One important measure of population health is mortality data. Mortality data from death certificates provide information on who is dying where and from which causes. Currently, sexual orientation is not included as part of mortality data collection. Mortality data by sexual orientation would create a better understanding of potential disparities in the leading causes of death among LGB individuals (e.g., CVD, diabetes, cancer, etc.) compared to straight individuals.

Cancer registries capture all diagnosed cases of cancer, thus providing another measure of population health. No other chronic condition is captured by surveillance systems as comprehensive as cancer registries. If sexual orientation were assessed in cancer registries, it would be possible to examine how cancer affects LGB individuals and whether or not they are at higher risk for particular cancers than straight individuals.

Unlike ATS and BRFSS, however, mortality data and cancer registries are not anonymous; they both require identifying information, such as name and date of birth. This may be a barrier in gathering accurate and reliable information. Cancer registry data is kept strictly confidential and is used only to produce aggregated results with no personal identifiers. In the case of death certificates, however, individuals or surviving family members may fear discrimination when revealing sexual orientation in a publicly accessible document. In addition, accuracy and reliability of the information is dependent on who completes the documentation. Generally, health care providers complete death certificates and produce the medical records used by cancer registries. If providers are not culturally competent in providing care to LGBTQ patients, the accuracy of sexual orientation information may be compromised. Despite these limitation, mortality data and cancer registry data are crucial indicators that are needed in order to gain a more comprehensive understanding of a population's health. Decreasing social discrimination and increasing cultural competency of health care providers are two strategies to improve data collection in chronic disease and vital statistics surveillance systems.

In addition to these data sources, if the ACS or US Census assessed sexual orientation directly, there could be better data on the number, distribution, and attributes of LGB residents at the state and national levels. This information could be used in conjunction with health data to better allocate resources. For example, using ACS or US Census data, an organization that wants to provide LGBTQ health services could determine where LGB residents live, assess the resources that are available in that area and provide additional services that might be utilized. Another example for resource allocation is the work that has been done around HIV testing at Pride events. These events provide the opportunity for organizations to access a large proportion of the LGBTQ community. The availability of HIV testing at these events as a strategy to increase HIV testing among the LGBTQ population has been reflected in the significantly higher rates of HIV testing among LGB adults in New Mexico.

Data specific to lesbian, gay, and bisexual adults can also be used to develop culturally appropriate programs targeted to LGB communities. Effectiveness of programs is often limited by their ability to be culturally relevant to populations. Industry marketing is an example of how specific populations are targeted with images and messages relevant to their lives. The alcohol and tobacco industry in particular have marketed to LGBTQI communities through advertisement at LGBTQI events, periodicals, and television shows. Public health programming needs to be developed with LGBTQI communities in mind in order to effectively reach the LGBTQI community. For example, based on New Mexico data, a high percentage of bisexual adults are 18 to 24 years old, which potentially influences their high prevalence of cigarette smoking. Using this information, public health programs could provide quit smoking messages through targeted venues expected to draw a high proportion of LGBTQI young adults, such as specific musical concerts or college events.

The disparities illustrated using New Mexico's BRFSS data provide only a sliver of information on the health of LGB adults in New Mexico. Improved data collection may highlight other health areas that need to be more inclusive of LGBTQ communities. Currently, the majority of LGBTQ-specific public health programming is limited to areas such as substance abuse, tobacco use, mental health, HIV/AIDS, and STIs. While this programming is crucial for improving the health of LGBTQ communities, other areas, such as cancer screening, cardiovascular disease prevention, and medical care, also need to be inclusive of LGBTQ individuals.

Overall, if sexual orientation were considered a standard demographic characteristic, on par with age, sex, race/ethnicity, education, and income, it would allow for the collection of much needed data. This data could be used in a variety of public health areas and by a variety of organizations to develop relevant programming and campaigns to LGBTQ communities based on the needs of the LGBTQ community and the capacity and goals of the organizations.

WHY THERE ARE DISPARITIES: SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the complex economic and social conditions under which people live that affect their health (Figure 17). Some examples of social determinants of health that impact health risks and outcomes include:

- Social support
- Income and social status
- Education and literacy
- Occupation
- Discrimination (based on race, class, gender, age, sexual orientation)
- Physical environment (e.g., sanitation, exposure to hazards)
- Access to resources linked to health (e.g., health care, nutritious foods, places to be physically active)

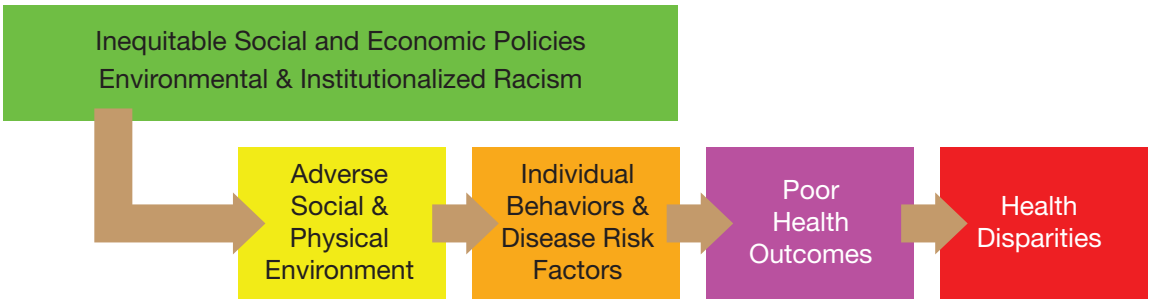


Figure 17
Social Determinants of Health[13]

Many of these economic and social conditions strongly influence the behavioral and biological risk factors that directly impact health. It is well documented that those in better economic and social conditions enjoy better health outcomes than those in worse economic and social conditions. These differences in health outcomes are health disparities.

Social determinants of health affect all individuals. In the United States, and many societies, wealth is the strongest predictor of health.[14] Individuals with greater wealth have better health outcomes. Individuals with lower wealth have worse health outcomes. The difference lies not only between those with the highest and lowest levels of wealth. A continuous gradient exists such that, as wealth increases, so does health. Higher levels of wealth provide access to "social goods such as high quality education, employment, housing, childcare, nutrition, medical care, recreational opportunities, and safer and cleaner neighborhoods." All of these elements work together to improve quality of life and overall health.

Utilizing New Mexico demographic data for LGB adults, it is possible to examine how social determinants of health may affect the community. In general, adults with higher educational attainment tend to earn higher incomes. In addition, adults with higher education generally have fewer health risks and better health outcomes, which may also be related to their higher earnings potential. In New Mexico, lesbian or gay adults overall have higher educational attainment compared to straight adults, but report significantly

lower household incomes. As a result, the protective effect of higher educational attainment may be offset by lower income and its associated adverse health outcomes. This discrepancy in educational attainment and household income among lesbian or gay adults may be due to factors such as discrimination in the form of heterosexism or homophobia that prevents them from earning incomes comparable to their straight counterparts. Gay men in particular, who seem to earn significantly lower incomes than straight men, may be experiencing discrimination that is impacting their income status. Using Figure 17 as the social determinants of health model, lower household incomes, despite higher levels of education, affect an LGB individual's ability to live in a safe and healthy environment, which in turn impacts their ability to engage in healthy behaviors (e.g., engaging in physical activity, accessing health care, etc.), which has an adverse effect on their health. Over time, this can lead to health disparities between LGB adults and their straight counterparts, such as the ones that have already been highlighted in New Mexico (tobacco use, alcohol use, intimate partner violence, etc.).

Looking at social determinants of health provides a larger picture by addressing the "upstream factors" that influence health. The socio-ecologic model (Figure 18) acknowledges that individuals operate within social contexts that extend from the influence of friends and family to national legislation. This model illustrates that making changes at the larger public policy and community level influences individuals. Used in conjunction with social determinants of health, this model further emphasizes the importance of focusing on policy and environmental changes rather than individual behavior changes alone.

Addressing the health of LGBTQ communities effectively includes addressing social determinants of health through resource development, improved access to culturally competent health care services, anti-discrimination policy implementation, and environmental initiatives.

Figure 18
Socio-Ecological Model

Social Determinants of Health of Particular Relevance to LGBTQI People

I. Discrimination: Heterosexism and Homophobia

Discrimination, which includes negative attitude, judgment, or unjust treatment of members of a specific group, can impact health. Studies have demonstrated that an individual's perception of discrimination is associated with multiple negative health outcomes, both mental and physical.[15] Discrimination affects health by triggering a stress response. Over time, frequent experiences of discrimination result in chronic heightened stress responses that increase risk for many major disease outcomes.[16] For LGBTQ individuals, perceived discrimination may be an important contributing factor to higher rates of a number of adverse health outcomes.

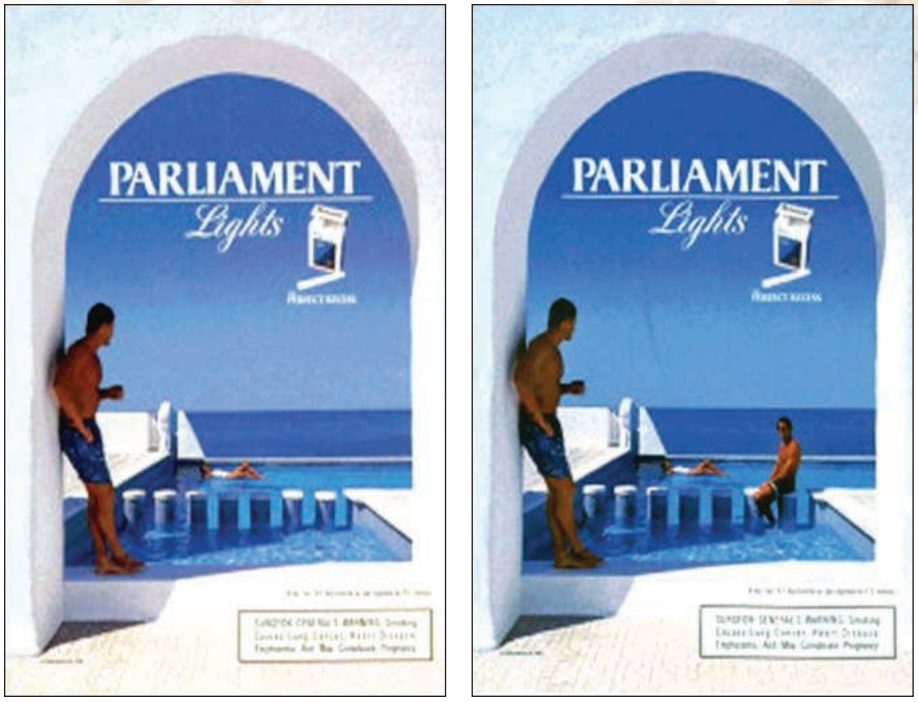
The effect of perceived discrimination on health may be greatly increased for LGBTQ people of color, where perceived discrimination may be present on multiple levels. Data from the California Health Interview Study found marked disparities in health care access for LGB adults of color. Authors hypothesized that three main factors contributed to health care access disparities among LGBTQ people: reduced access to employer-provided health insurance, social stigma, and lack of cultural competency in health care systems. People of color experience similar health care access barriers. Therefore, LGBTQ people of color may face a combined detrimental effect of heterosexism, homophobia, and racism.[16]

Discrimination also has implications for collection of sexual orientation data. The data sources that are primarily used to gather sexual orientation data rely on self-identity. If individuals fear discrimination based on their reported sexual orientation, they may not feel safe to disclose information. As a result, the data collected are limited to only those who choose to disclose their sexual orientation at the time of data collection. Creating a sense of safety, support, and non-discrimination around disclosure of sexual orientation may help improve the ability to capture more information about LGB adults. Differences may exist between those who are willing to share their sexual orientation and those who are not willing that could impact the understanding of LGB health and thus the ability to properly and effectively address the health of LGB communities.

II. Marketing To LGBTQ Communities

The alcohol and tobacco industries may have played a role in impacting LGBTQ health. In particular, both of these industries market heavily to LGBTQ communities. From a social determinants of health perspective, marketing exists within the physical environment, thus influencing how individuals make decisions. Marketing from alcohol and tobacco industries provide examples of how culturally appropriate and relevant campaigns can affect LGBTQ populations. Public health programming also needs to be culturally appropriate and relevant to LGBTQ communities in order to be effective.

Figure 19
Tobacco Marketing to LGBTQ Communities



Details, Cosmopolitan, Mademoiselle, Penthouse
1995

Out
1995

An example of a tobacco print advertisement from 1995 (Figure 19) demonstrates how the LGBTQ community is targeted. The advertisement on the left was run in a variety of magazines with a primarily straight readership. The advertisement on the right is another variation that was run in a magazine with a primarily LGBTQ readership. From this example, the tobacco industry ran an advertisement that included two individuals, a man and a woman, for straight audiences. For LGBTQ audiences, the industry added an additional man to the advertisement, creating sexual ambiguity and a sense of acceptance of non-straight audiences.

An example of an alcohol advertisement (Figure 20) is a collaboration between the Human Rights Campaign (a national equal rights lobbying organization) and Absolut Vodka. This partnership was to raise funds for the Human Rights Campaign's National Coming Out Project. As a result, the advertisement utilizes a play on "coming out of the closet." Within the LGBTQI community, "coming out of the closet" or "coming out" is a term used to describe when a person openly identifies as LGBTQI. The fundraising effort included a series of nine closets that toured the United States, strategically placed postcards and billboards featuring the closets in the Castro (gay area of San Francisco) and New York City, and online and live auctions of the closets as well as celebrity items donated to the Human Rights Campaign. The different closets appeal to specific subpopulations within the LGBTQ communities, e.g., drag queen, femme, leather, college student, activist, etc. The advertisement also utilizes the rainbow flag, which is a symbol of gay pride recognized by LGBTQ persons. This type of advertising leads to a sense that the alcohol industry accepts and is an ally to the LGBTQI community.[17]

Figure 20
Alcohol Marketing to LGBTQ Communities

These are only two examples of how the alcohol and tobacco industry target LGBTQI communities. The collaboration between the Human Rights Campaign and Absolut Vodka is also an example of how the LGBTQI community has to utilize industry funding to create programs or outreach that may otherwise not get funding. The alcohol and tobacco industry also often provide financial support for Pride events, again creating a sense that alcohol and tobacco are parts of LGBTQI culture.

There are several reasons for the effectiveness of industry marketing to the LGBTQI community:[18]

- Strong LGBT loyalty to industry "friends"
- Many LGBT publications and events need money from industry to survive
- Few public health efforts directed towards LGBT community
- Alcohol and tobacco as a social tool; history of bars being sole social space; bar culture
- Perception that alcohol and tobacco use is just part of being gay
- Internalized homophobia ("I'm not worthy of being healthy" or "I'm not entitled to live a long and happy life")

RECOMMENDATIONS FOR FUTURE ACTIONS

In order to address LGBTQI health, a multi-faceted approach needs to be taken. This approach includes addressing social determinants of health through resource development, improved access to health care services, and policy implementation.

Recommendations for New Mexico Department of Health

- Continue to include LGBT health as a strategy in the Department of Health's Annual Strategic Plan
- Consider LGBT a priority population along with racial/ethnic groups in disparity and health equity discussions and reports
- Explore outreach and educational interventions for LGBTQ communities in multiple public health programs (e.g., behavioral health, substance abuse, chronic disease prevention and control, etc.)
- Ensure that LGBT health programs are evaluated
- Include sexual orientation and gender identity items as standard demographic question on surveys and registries
- Start sexual orientation data collection among youth
- Encourage adoption of the above practices by other federal, state, local, and tribal public health agencies

Recommendations for Health Care and Other Community-Based Organizations

- Elevate importance of LGBTQ health issues
- Offer trainings on LGBTQ health issues to increase cultural competency among health care providers and community partners
- Institute non-discrimination policies that cover LGBTQ people within organizations
- Utilize inclusive language (e.g., partner, significant other) in communications and health forms
- Form alliances with LGBTQ organizations to offer educational resources
- Be able to show LGBTQ people the ways in which they are targeted by various industries (e.g., Project SCUM, alcohol and tobacco funding at Gay Pride events)
- Partner with organizations serving people of color as a strategy to improve access to LGBTQ people of color

Recommendations for Educational Settings

- Support establishment of Gay-Straight Alliances in middle and high schools, which create safe and supportive environments for LGBTQ students and their straight allies
- Establish anti-harassment policies that include sexual orientation and gender identity
- Train teachers and staff to intervene when they hear slurs based on sexual orientation or gender presentation
- Provide sexual orientation and gender identity education, resources, and support to students
- Provide media literacy training for LGBTQ youth to empower them with tools to deconstruct media messages and production skills to tell their own stories

APPENDIX A: TECHNICAL APPENDIX

Surveys

Both the ATS and BRFSS are ongoing, population-based, random-digit-dial, landline telephone surveys of English or Spanish speaking non-institutionalized adults who live in a household in New Mexico. The ATS includes questions assessing tobacco-related behaviors and attitudes. The BRFSS includes questions assessing various health characteristics including risk factors, preventive factors and chronic diseases. Both surveys include a demographics section containing questions on race, ethnicity, age, sex, education, and household income.

Additional in-depth documentation for the BRFSS is publicly available online: **www.cdc.gov/brfss**. The ATS utilizes BRFSS methodology.

Percentage of Refusals

On the ATS and BRFSS, answers receive one of four codes: true response, missing, "refused," or "don't know." Missing responses indicate that the respondent did not receive the question, often due to skip patterns or early termination of the survey. Responses coded as "refused" indicate that the respondent actively refused to provide an answer to the question. Responses coded as "don't know" indicate that the respondent did not provide a true response, but did not actively refuse to provide and answer.

For calculation of the percentage of refused responses, the numerator included the number of responses coded as "refused" and the denominator included the number of responses coded as a true response, "don't know" and "refused."

Since both the ATS and BRFSS utilize a sample of the population, they are subject to sampling bias. To help adjust for bias, responses are weighted based on each respondent's probability of being selected and stratified to the sex, age, and geographic distribution of New Mexico. Both survey require completion through the demographic section for the record to be included in the final dataset.

APPENDIX B: TABLES

Table A.
Demographic Characteristics Among New Mexico Adults by Sexual Orientation, NM BRFSS 2005–2008

	Straight				Lesbian or Gay				Bisexual			
	N	%	[95% CI]		N	%	[95% CI]		N	%	[95% CI]	
Educational Attainment (18–64 year olds only)												
Less than High School	1,959	12.7	12.0	13.4	10	3.7*	1.9	7.2	17	12.8	7.2	21.7
High School or GED	4,313	28.3	27.3	29.3	43	21.7	15.2	30.0	41	32.1	21.2	45.5
Some College	4,690	28.3	27.4	29.3	61	31.3	23.3	40.6	43	22.9	15.6	32.4
College Degree or Higher	5,588	30.7	29.8	31.7	125	43.3*	35.3	51.7	80	32.2	24.0	41.6
Annual Household Income (18–64 year olds only)												
< $10,000	883	4.8	4.3	5.3	19	8.3	5.1	13.3	18	9.6	5.2	17.1
$10-20,000	1,219	7.3	6.8	7.9	26	15.8*	9.3	25.4	16	9.9	5.5	17.2
$20-50,000	5,869	38.1	37.0	39.2	82	35.1	27.3	43.9	72	37.2	28.6	46.8
$50,000 +	7,316	49.8	48.7	50.9	105	40.8	32.7	49.4	60	43.3	33.6	53.5
Age (18–64 year olds only)												
18-24 year	1,029	16.7	15.6	17.9	13	12.4	6.2	23.3	39	41.0*	29.7	53.4
25-34 years	2,635	20.6	19.8	21.5	41	25.4	18.2	34.1	45	24.4	17.0	33.7
35-44 years	3,518	21.6	20.8	22.5	53	22.0	16.0	29.5	38	14.7	9.4	22.1
45-54 years	4,689	23.2	22.4	24.0	74	24.6	18.9	31.3	34	11.5*	7.5	17.3
55-64 years	4,621	17.9	17.3	18.6	58	15.7	11.3	21.3	34	8.4*	5.5	12.7
Race/Ethnicity (18–64 year olds only)												
White	8,740	49.0	48.0	50.0	156	58	49.0	66.0	107	54.0	43.0	65.0
Black	232	1.7	1.4	2.1	5	1.9	0.7	5.0	4	1.1	0.4	3.1
Native American	1,628	8.6	8.0	9.2	15	5.3	2.9	9.6	20	9.0	5.1	15.0
Asian	209	1.6	1.3	2.0	2	0.8	0.1	4.0	4	4.6	1.5	13.0
Hispanic	5,612	39.0	38.0	40.0	61	34.0	26.0	43.0	42	31.0	20.0	44.0

* *Indicates statistically significant differences from straight adults*

Table B.
Demographic Characteristics Among New Mexico Adult Men by Sexual Orientation, NM BRFSS 2005–2008

	Straight				Gay				Bisexual			
	N	%	[95% CI]		N	%	[95% CI]		N	%	[95% CI]	
Educational Attainment (18–64 year olds only)												
Less than High School	676	12.3	11.2	13.5	5	3.1*	1.2	7.8	2	10.0	2.0	37.3
High School or GED	1,838	30.1	28.5	31.7	25	33.1	21.5	47.2	13	28.5	13.9	49.6
Some College	1,725	26.9	25.4	28.4	26	35.2	22.3	50.6	15	33.5	18.9	52.1
College Degree or Higher	2,194	30.8	29.3	32.2	38	28.6	19.1	40.5	18	28.0	15.8	44.7
Annual Household Income (18–64 year olds only)												
< $10,000	245	3.7	3.1	4.4	10	10.3*	5.4	18.8	2	3.1	0.5	16.2
$10–20,000	401	6.5	5.7	7.4	13	19.8*	9.5	36.6	1	2.1	0.3	13.7
$20–50,000	2,230	37.1	35.5	38.7	35	34.3	22.7	48.1	25	48.2	30.0	66.8
$50,000 +	3,144	52.7	51.0	54.4	36	35.7*	24.0	49.3	15	46.6	28.2	66.1
Age (18–64 year olds only)												
18–24 years	405	17.2	15.5	19.1	10	20.3	9.4	38.5	10	42.5*	24.5	62.8
25–34 years	1,003	21.3	19.9	22.7	19	29.4	18.2	43.8	3	3.7*	1.0	12.9
35–44 years	1,321	21.3	20.0	22.6	18	18.9	10.8	30.9	14	26.0	14.2	42.5
45–54 years	1,826	22.7	21.5	23.9	23	15.6	9.4	24.7	11	18.4	9.0	33.9
55–64 years	1,861	17.6	16.6	18.6	24	15.8	9.6	24.9	10	9.4	4.4	18.9

* *Indicates statistically significant differences from straight adults*

Table C.
Demographic Characteristics Among New Mexico Adult Women by Sexual Orientation, NM BRFSS 2005–2008

	Straight				Lesbian or Gay				Bisexual			
	N	%	[95% CI]		N	%	[95% CI]		N	%	[95% CI]	
Educational Attainment (18–64 year olds only)												
Less than High School	1,283	13.1	12.2	14.0	5	4.3*	1.7	10.6	15	13.8	7.6	23.9
High School or GED	2,475	26.5	25.2	27.8	18	10.2*	6.0	16.9	28	33.5	20.2	50.1
Some College	2,965	29.8	28.5	31.0	35	27.3	19.2	37.3	28	18.9	11.2	30.0
College Degree or Higher	3,394	30.7	29.6	31.9	87	58.1*	48.0	67.6	62	33.8	23.8	45.5
Annual Household Income (18–64 year olds only)												
< $10,000	638	5.9	5.1	6.7	9	6.0	2.9	12.1	16	12.1	6.4	21.9
$10–20,000	818	8.0	7.3	8.7	13	11.2	5.9	20.3	15	13.0	7.1	22.7
$20–50,000	3,639	39.1	37.7	40.4	47	36.1	26.6	46.8	47	32.6	23.2	43.8
$50,000 +	4,172	47.1	45.7	48.5	69	46.7	36.8	56.9	45	42.2	31.2	54.0
Age (18–64 year olds only)												
18–24 years	624	16.2	14.8	17.7	3	4.4	1.2	15.2	29	40.8*	27.1	56.1
25–34 years	1,629	20.0	18.9	21.1	22	21.4	13.6	32.2	42	32.0*	21.8	44.2
35–44 years	2,197	21.9	20.9	23.0	35	24.9	17.0	34.8	14	10.4*	5.3	19.1
45–54 years	2,863	23.6	22.7	24.7	51	33.8	25.4	43.4	23	8.9*	5.2	14.7
55–64 years	2,760	18.3	17.4	19.1	34	15.5	10.2	23.0	24	8.0*	4.8	13.0

* *Indicates statistically significant differences from straight adults*

Table D.
Health Behaviors and Conditions Among New Mexico Adults by Sexual Orientation, NM BRFSS 2005–2008

	Straight				Lesbian or Gay				Bisexual			
	N	%	[95% CI]		N	%	[95% CI]		N	%	[95% CI]	
Alcohol and Tobacco Use[1] (18–64 year olds only)												
Binge Drinking	1,968	14.3	13.5	15.1	40	19.7	13.4	27.8	39	22.6	15.4	32.1
Heavy Drinking	703	4.4	4.0	4.9	19	10.1	5.5	17.9	15	8.5	4.2	16.3
Current Smoker	3,605	22.0	21.1	22.9	66	27.2	20.5	35.0	61	39.1	29.2	50.0
Other Chronic Disease Risk Factors (18–64 year olds only)												
High Blood Pressure[4]	1,806	19.1	18.0	20.2	27	23.1	14.9	34.2	16	15.0	7.8	26.8
High Cholesterol[4]	1,953	29.3	27.8	30.7	33	38.2	26.4	51.6	21	29.6	17.1	46.3
Diabetes[1]	1,220	5.8	5.4	6.2	13	5.1	2.7	9.4	5	2.5	0.7	8.5
Obesity[1]	4,319	24.7	23.8	25.6	78	34.4	26.6	43.0	43	28.8	18.2	42.3
Sufficient Physical Activity[4]	4,052	54.1	52.6	55.6	60	60.4	47.3	72.1	47	71.1	58.0	81.4
Sufficient Fruit and Vegetable[4]	1,750	20.7	19.5	21.9	22	15.8	9.2	25.8	19	28.9	17.0	44.7
Cardiovascular Disease[1] (18–64 year olds only)												
History of Cardiovascular Disease	892	4.2	3.8	4.5	15	6.2	3.1	12.1	8	5.6	2.3	12.7
Mental Health (18+ year olds only)												
Intimate Partner Violence[2]	330	17.5	15.4	19.9	9	56.4*	31.0	78.9	8	47.4*	20.4	76.0
Suicide Attempt[3]	263	5.3	4.5	6.2	13	23.7*	11.7	42.2	11	22.7*	12.2	38.3
Suicidal Ideation[3]	275	6.2	5.2	7.2	9	16.8	6.6	36.6	10	17.4*	8.5	32.4
Depression[3]	924	17.2	15.9	18.6	30	47.3*	32.3	62.8	21	37.3*	23.1	54.1
Breast Cancer Screening[5] (40–64 year old women only)												
Never	424	12.4	11.1	13.9	6	12.4	4.8	28.1	3	3.9	1.1	13.3
In Past 2 Years	2,417	70.1	68.2	72.0	38	62.2	46.8	75.5	19	89.5*	73.4	96.3
Cervical Cancer Screening[5] (18–64 year old women only)												
Never	180	6.4	4.9	8.1	6	5.6	2.2	13.5	5	21.0	5.8	53.5
In Past 3 Years	4,254	82.6	80.8	84.3	57	75.5	64.1	84.2	58	72.0	45.0	89.0
Not in Past 5 Years	691	13.1	11.5	14.9	22	22.0	13.7	33.3	10	23.6	7.6	53.7
Prostate Cancer Screening[5] (50–64 year old men only)												
Never	203	14.1	12.0	16.6	2	10.7	2.6	35.0		**		
PSA in Past Year	617	43.3	40.2	46.5	8	58.0	32.4	79.9		**		
DRE in Past Year	579	40.0	37.0	43.2	8	50.4	26.9	73.8		**		
Both PSA and DRE in Past Year	438	31.2	28.3	34.3	5	38.1	16.3	66.1		**		
Colorectal Cancer Screening[5] (50–64 year old only)												
Never	1,569	41.0	39.0	43.0	17	30.2	17.9	46.3	10	43.9	23.2	67.1
FOBT in Past 10 Years	385	10.6	9.4	11.9	6	9.7	4.0	21.6	1	4.6	0.6	26.4
Lower Endoscopy in Past 10 Years	1,589	44.5	42.4	46.5	30	59.6	43.7	73.8	9	35.8	17.0	60.2
FOBT or Lower Endoscopy in Past 10 Years	1,764	49.4	47.4	51.5	31	61.1	45.1	75.0	9	35.8	17.0	60.2

table continues on next page

1 2005-2008 NM BRFSS
2 2005 NM BRFSS
3 2006 NM BRFSS
4 2005 & 2007 NM BRFSS
5 2006 & 2008 NM BRFSS

** Indicates statistically significant differences from straight adults*
*** Data suppressed due to small sample sizes*

table continued from previous page

	Straight				Lesbian or Gay				Bisexual			
	N	%	[95% CI]		N	%	[95% CI]		N	%	[95% CI]	
Asthma Status[1] (18–64 year olds only)												
Former Asthma	772	5.1	4.7	5.7	17	11.0*	6.2	18.8	17	9.8	5.3	17.3
Current Asthma	1,450	8.4	7.8	9.0	35	19.1*	12.9	27.4	23	17.7*	10.5	28.2
HIV Testing[1] (18–64 year olds only)												
Ever Had HIV Test	5,662	36.3	35.3	37.3	155	65.5*	56.3	73.6	110	58.1*	46.3	69.1
Other Health Indicators[1] (18–64 year olds only)												
No Health Insurance	3,668	24.1	23.2	25.1	49	22.4	15.5	31.3	46	24.9	17.4	34.4
Fair/Poor Health Status	2,863	15.2	14.5	15.9	46	16.9	12.0	23.3	26	18.4	9.2	33.4
No Life Satisfaction	964	5.2	4.8	5.7	18	8.7	5.0	14.8	27	13.3*	8.0	21.4

1 2005-2008 NM BRFSS
2 2005 NM BRFSS
3 2006 NM BRFSS
4 2005 & 2007 NM BRFSS
5 2006 & 2008 NM BRFSS

** Indicates statistically significant differences from straight adults*
*** Data suppressed due to small sample sizes*

Table E.
Health Behaviors and Conditions Among New Mexico Adult Men by Sexual Orientation, NM BRFSS 2005–2008

	Straight				Gay				Bisexual			
	N	%	[95% CI]		N	%	[95% CI]		N	%	[95% CI]	
Alcohol and Tobacco Use[1] (18–64 year olds only)												
Binge Drinking	1,230	20.3	18.9	21.7	19	23.6	13.8	37.3	10	19.8	9.4	37.1
Heavy Drinking	354	5.2	4.6	6.0	7	12.2	5.0	26.9	4	4.1	1.4	11.4
Current Smoker	1,573	24.4	23.0	25.9	31	30.9	20.2	44.1	15	38.9	22.2	58.7
Other Chronic Disease Risk Factors (18–64 year olds only)												
High Blood Pressure[4]	782	20.6	18.9	22.4	16	27.2	14.6	45.0	5	12.4	4.2	31.4
High Cholesterol[4]	820	31.4	29.1	33.7	16	36.9	20.6	56.9	3	14.0	3.1	45.1
Diabetes[1]	493	5.8	5.2	6.5	8	6.6	3.0	14.0	2	6.7	1.3	29.0
Obesity[1]	1,639	23.7	22.3	25.2	30	35.3	23.3	49.4	10	21.3	10.2	39.2
Sufficient Physical Activity[4]	1,666	56.6	54.3	58.9	27	68.3	49.3	82.7	11	72.8	48.4	88.4
Sufficient Fruit and Vegetable[4]	516	17.4	15.7	19.3	5	9.8	3.5	24.7	3	23.7	6.0	60.1
Cardiovascular Disease[1] (18–64 year olds only)												
History of Cardiovascular Disease	447	5.0	4.4	5.7	10	9.9	4.3	21.4	2	2.9	0.7	11.9
Mental Health (18+ year olds only)												
Intimate Partner Violence[2]	75	10.9	8.2	14.4	3	48.9*	15.1	83.8		**		
Suicide Attempt[3]	56	2.8	2.0	4.0	6	31.7*	11.8	61.6		**		
Suicide Ideation[3]	97	5.3	4.0	6.9	2	20.1*	4.4	57.7	4	25.0	8.8	53.7
Depression[3]	235	10.5	9.0	12.3	14	57.1*	31.6	79.3	4	27.7	9.8	57.4
Asthma Status[1] (18–64 year olds only)												
Former Asthma	328	5.6	4.8	6.4	11	16.2*	8.1	29.7	4	5.7	1.8	16.2
Current Asthma	405	6.7	5.9	7.7	9	15.5	7.3	30.0	4	16.7	5.4	41.0
HIV Testing[1] (18–64 year olds only)												
Ever had HIV Test	2,067	33.9	32.4	35.6	73	70.1*	53.3	82.8	28	55.8*	37.2	72.9
Other Health Indicators[1] (18–64 year olds only)												
No Health Insurance	1,372	25.0	23.5	26.6	23	28.7	17.1	44.1	12	22.1	10.5	40.7
Fair/Poor Health Status	1,058	14.4	13.3	15.6	18	14.7	8.3	24.7	6	13.4	4.8	32.3
No Life Satisfaction	358	5.3	4.6	6.1	4	6.3	2.2	16.7	5	13.1	4.2	33.7

1 2005-2008 NM BRFSS
2 2005 NM BRFSS
3 2006 NM BRFSS
4 2005 & 2007 NM BRFSS

** Indicates statistically significant differences from straight adults*
*** Data suppressed due to small sample sizes*

Table F.
Health Behaviors and Conditions Among New Mexico Adult Women by Sexual Orientation, NM BRFSS 2005–2008

	Straight				Lesbian				Bisexual			
	N	%	[95% CI]		N	%	[95% CI]		N	%	[95% CI]	
Alcohol and Tobacco Use[1] (18–64 year olds only)												
Binge Drinking	738	8.3	7.5	9.1	21	15.7*	9.2	25.3	29	23.7*	14.9	35.5
Heavy Drinking	349	3.7	3.2	4.2	12	8.0	3.9	15.7	11	10.1*	4.6	20.8
Current Smoker	2,032	19.4	18.4	20.5	35	23.5	16.2	32.8	46	39.1*	27.4	52.2
Other Chronic Disease Risk Factors (18–64 year olds only)												
High Blood Pressure[4]	1,024	17.5	16.2	18.9	11	18.8	9.4	34.1	11	16.2	7.3	32.1
High Cholesterol[4]	1,133	27.3	25.5	29.0	17	39.3	23.8	57.3	18	35.8	20.2	55.2
Diabetes[1]	727	5.7	5.2	6.3	5	3.5	1.2	9.5	3	0.9*	0.3	3.1
Obesity[1]	2,680	25.8	24.6	27.0	48	33.6	24.6	44.0	33	32.0	18.6	49.2
Sufficient Physical Activity[4]	2,386	51.6	49.7	53.5	33	52.1	36.5	67.3	36	70.4*	54.5	82.5
Sufficient Fruit and Vegetable[4]	1,234	23.9	22.4	25.5	17	22.1	12.1	37.0	16	31.4	17.8	49.1
Cardiovascular Disease[1] (18–64 year olds only)												
History of Cardiovascular Disease	445	3.3	2.9	3.8	5	2.5	1.0	6.3	6	6.6	2.5	16.5
Mental Health (18+ year olds only)												
Intimate Partner Violence[2]	255	24.4	21.3	27.9	6	59.9*	28.0	85.2	7	60.0	21.1	89.4
Suicide Attempt[3]	207	7.7	6.4	9.2	7	16.0	7.0	32.6	9	24.0*	11.9	42.5
Suicide Ideation[3]	178	7.1	5.8	8.6	7	13.5	6.0	27.8	6	15.5	6.2	33.9
Depression[3]	689	23.9	21.9	25.9	16	37.8	21.7	57.2	17	39.7	22.9	59.4
Asthma Status[1] (18–64 year olds only)												
Former Asthma	444	4.7	4.2	5.3	6	5.6	2.1	14.1	13	11.2*	5.6	21.3
Current Asthma	1,045	10.0	9.3	10.8	26	22.7*	14.9	33.1	19	18.0	9.9	30.4
HIV Testing[1] (18–64 year olds only)												
Ever had HIV Test	3,595	38.6	37.3	39.9	82	60.9*	51.0	70.0	82	58.9*	44.0	72.4
Other Health Indicators[1] (18–64 year olds only)												
No Health Insurance	2,296	23.2	22.1	24.4	26	16.0	10.3	24.2	34	25.7	16.8	37.2
Fair/Poor Health Status	1,805	16.0	15.1	17.0	28	19.1	12.5	28.0	20	20.5	9.0	40.4
No Life Satisfaction	606	5.1	4.6	5.7	14	11.0*	5.8	19.8	22	13.3*	7.5	22.5

1 2005–2008 NM BRFSS
2 2005 NM BRFSS
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APPENDIX C: SELECT ACTIVITIES AROUND LGBTQI HEALTH IN NEW MEXICO

The Fierce Pride committee (**www.fiercepride.org**) is an LGBTQI tobacco committee that is funded in part by the TUPAC Program and is currently operated by the Media Literacy Project. Members of the committee include community members as well as statewide and local organizations working with the LGBTQI community. This committee oversees *Last Drag New Mexico Cessation* classes, a tobacco cessation program designed for the LGBTQ community, based on San Francisco's Last Drag Program. In addition, the committee has generated a *Guide for Tobacco Control Service Providers: How to be Inclusive of LGBTQI Clients*.[19] Educational presentations are provided statewide to LGBTQ organizations and to tobacco control contractors. The committee also has a presence at Pride events across the state and participates in the National LGBT Tobacco Control Network. The national network has been instrumental in raising awareness about LGBT tobacco disparities and generating tools for states in addressing the disparities. They have released the *State LGBT Tobacco Disparities Best Practices*.[20]

The Media Literacy Project, with support from TUPAC, developed a DVD-ROM resource, *A Movement, Not A Market*, which deconstructs the target marketing of LGBTQI communities. This resource is available at no-cost online at: **www.medialiteracyproject.org**.

The Breast and Cervical Cancer Early Detection Program within the NMDOH, which pays for screening and diagnostic services for low-income women in New Mexico, offered training for staff and community partners on offering culturally sensitive health care to lesbian and bisexual women in New Mexico.

The Stanford Public Health Office in Albuquerque, NM offers a variety of health services specifically for gay and bisexual men one night a month (Public Health 4 M4M). Services include: HIV and STI testing, Hepatitis A and B shots, tobacco cessation materials, and cancer prevention materials.

The New Mexico Community Planning and Action Group (**www.nmcpag.org**) is another committee that works specifically with HIV prevention. This group is a partnership between the NMDOH and community members.

Other LGBTQI Resources in New Mexico:

- New Mexico Gay-Straight Alliance Network (**www.nmgsa.org**)
- Santa Fe Mountain Center (**www.santafemc.org**)
- PFLAG (**www.pflag.org**)
- Gay, Lesbian and Straight Education Network (**www.glsen.org**)
- MPower (**www.myspace.com/abqmpower** OR **www.facebook.com/abqmpower**)
- New Mexico AIDS Services (**www.nmas.net**)
- Southwest CARE Center (**www.southwestcare.org**)
- Equality New Mexico (**www.eqnm.org**)
- New Mexico GLBTQ Centers (**www.gaynewmexico.org**)
- LGBTQ Behavioral Health & Wellness Coalition

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