Appendix Q: LGBTQ+ Community Health Needs in Southwest Alabama

Prepared by:

Southwest Alabama Inclusion Project

Community Partners

Ambitiously Him and Her King Foundation
B-Bob's
Balanced Life Counseling
The Bevy
Black Belt Community Foundation
Black Empowerment Team
Center for Fair Housing
Citrus and Cane
Door to Serenity
FemmSouth
Flip Side
Flourish Psychotherapy Services
Gabriel's
Herz
Independent Living Center of Mobile
Krewe of Phoenix
LGBTQIA+ Liaisons, City of Mobile
Lifelines Counseling
MedPride and Allies
Mobile County Health Department
Order of Pan
Prime Timers Mobile
Prism United
Rainbow Pride of Mobile
Southern Transgender Alliance
Trans Pride of Mobile
USA Spectrum
We The Change Mobile

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1.0 Introduction

This report presents findings from a community-based health needs assessment in Southwest Alabama, designed to provide healthcare leaders, administrators, and educators with actionable insights to improve care delivery. Its title, "Appendix Q," is in reference to the historical absence of sexual orientation and gender identity data in regional community health needs assessments, a national phenomenon that contributes to LGBTQ+ health disparities by rendering this population's needs invisible to the planning processes meant to identify and address community health gaps. The study identifies gaps in access, preventive screening, and patient experience that mirror national trends, while also highlighting opportunities for leadership to strengthen provider education, enhance trust in clinical environments, and expand service reach. By integrating these findings into strategic planning, healthcare organizations can advance excellence in patient-centered care, support stronger community health outcomes, and position themselves as leaders in responsive, high-quality care.

1.1 Methodology

This project was designed as a cross-sectional community health needs assessment to better understand healthcare experiences and access among LGBTQ+ people, a health disparity population in Southwest Alabama. The Southwest Alabama Inclusion Project, in collaboration with academic and community partners, guided study development and administration. Community stakeholders, academic expertise, and established public health measures informed survey content. The University of South Alabama Institutional Review Board reviewed and approved the study protocol.

Individuals were eligible to participate if they were age 13 or older, identified with sexual orientation or gender identity other than straight/heterosexual or cisgender, and currently reside or previously resided in one of the counties included in the Southwest region of the Alabama Coordinated Health Network (Mobile, Baldwin, Choctaw, Clarke, Conecuh, Escambia, Monroe, and Washington counties).

The survey used validated measures where available, including items from the Centers for Disease Control (CDC) Behavioral Risk Factor Surveillance System (BRFSS) related to anxiety, perceived health status, and adverse childhood events. We developed additional items to capture local healthcare experiences, preventive care utilization, and barriers to accessing services. The instrument was hosted on the REDCap platform and included security features such as reCAPTCHA, attention traps, and validation questions. No identifying information was collected to ensure participant confidentiality. Content warnings were provided at the beginning of each section, allowing respondents to answer, skip, or otherwise opt out as desired.

The survey was open from March 5 to June 30, 2023. Recruitment occurred through multiple channels to maximize reach, including social media announcements, email distribution lists, and community events. Incentives included the option to receive a $10 gift card for participation. A total of 488 participants completed the questionnaire. Data were analyzed using the Statistical Package for Social Sciences (SPSS) to generate descriptive statistics.

1.2 Demographics

The Southwest Alabama Inclusion Project community needs assessment serves a diverse and dynamic population across several counties, including Mobile, Baldwin, Escambia, Conecuh, Monroe, Clarke, Washington, Wilcox, Marengo, and Choctaw. The combined population of these counties is approximately 736,000. On average, 48.2 percent of this population is male, and 51.8 percent is female. It is unknown to what extent these individuals identify with a gender other than those assigned at birth according to sex. The racial composition is roughly 65.5 percent identifying as white only and 31.1 percent identifying as African-American or Black only. The population also includes members of the Poarch Band of Creek Indians, the MOWA Band of Choctaw Indians, Vietnamese, South Asian, Hispanic, and Arab communities, and a small but growing Somali community. The median age across these counties is approximately 39.8 years. The median household income is around $46,250. Educationally, about 83.5 percent of residents have a high school degree or better, while 22.5 percent of the population lives below the federal poverty level. It is estimated that the LGBTQIA+ population of the 10 serviced counties mirrors national averages and is between 3 and 5%.

1.2.1 Respondents by Age

Age Range	Number of Respondents	Percentage
13-17	106	23.7%
18-24	122	27.3%
25-34	115	25.7%
35-44	64	14.3%
45-54	31	6.9%
55+	29	6.5%
Total Respondents	447	

1.2.2 Respondents by Race

Race	Number of Respondents	Percentage
Black or African American	57	13.7%
White	327	78.4%
Latinx	12	2.9%
Native/Indigenous	4	1.0%
Asian/ Pacific Islander	4	1.0%
Middle Eastern/ Northern African	4	1.0%
Other	3	0.7%
Total Respondents	411	

1.2.3 Respondents by Sexual Orientation

Sexual Orientation	Number of Respondents	Percentage
Asexual Spectrum	29	6.3%
Bisexual	124	26.8%
Fluid	3	0.6%
Gay	80	17.3%
Straight	24	5.2%
Lesbian	87	18.8%
Pansexual	40	8.6%
LGBTQIA+	39	8.4%
Questioning	18	3.9%
Other	8	1.7%
Total Respondents	452	

1.2.4 Respondents by Gender Identity

Gender Identity	Number of Respondents	Percentage
Cisgender Female	209	45.2%
Cisgender Male	99	21.4%
Transgender Female	24	5.2%
Transgender Male	26	5.6%
Gender Non-Conforming	64	13.9%
Not Sure or Questioning	22	4.8%
Other	6	1.3%
Prefer Not to Answer	12	2.6%
Total Respondents	462	

1.2.5 Respondents by County of Residency in Southwest Alabama (SW AL)

County	Number of Respondents	Percentage
Baldwin	91	19.1%
Choctaw	6	1.3%
Clarke	10	2.1%
Escambia	5	1.0%
Marengo	1	0.2%
Mobile	347	72.7%
Washington	1	0.2%
Former resident of SW AL	15	3.1%
Never resident of SW AL	1	0.2%
Total Respondents	477	

1.2.6 Respondents by Sex Assigned at Birth

Sex Assigned at Birth	Number of Respondents	Percentage
Male	146	31.6%
Female	307	66.5%
Intersex	1	0.2%
Total Respondents	454	

1.2.7 Respondents with Physical Difficulties

Reported Difficulty	Number of Respondents	Percentage
Hearing Difficulty	11	2.6%%
Vision Difficulty	14	3.3%%
Cognitive Difficulty	54	12.9%%
Ambulatory Difficulty	6	1.4%%
Self-Care Difficulty	6	1.4%%
Independent Living Difficulty	3	0.7%%
No Difficulties Pertaining to Ability	298	71.1%%
Total Respondents	392	

1.3 Key Findings

This section offers a succinct overview of the primary takeaways from Appendix Q, focusing on delays in care, recent checkups, privacy in clinical settings, prevention practices, and mental health outcomes. Framed with the broader LGBTQ+ health disparities context, these findings illuminate how stigma, limited provider awareness, and service gaps undermine wellness for LGBTQ+ individuals in Southwest Alabama.

1.3.1 Delaying Care

A substantial subset of respondents (e.g.55% of youth and 44% of young adults) has postponed or foregone medical attention they deemed necessary. Among commonly reported reasons were *fear of discrimination or recalled negative clinical experiences, financial burden or inadequate insurance,* and *challenges in finding adequately patient-centered providers.* Delay in seeking care is a hallmark outcome of minority stress and stigma: many LGBTQ+ people remain apprehensive about encountering bias, thus increasing the likelihood of health conditions worsening before treatment is sought.

1.3.2 Time Since Last Routine Checkup

The majority (68.5%) reported having visited a health professional for a routine exam within the past year, which is comparable to national rates of general preventative care. Adolescents and young adults were more likely to have seen a provider than older respondents who lack a regular source of primary care. While it is promising that most respondents had a checkup in the prior year, the LGBTQ+ population can be at higher risk for irregular primary care use. In Southwest Alabama, securing consistent checkups may hinge on finding providers who are both adequately patient-centered and financially accessible.

1.3.3 Privacy in Clinical Encounters

Certain respondents, especially youth (46.2%), expressed that they could not speak openly about health concerns, especially those related to gender identity or sexual orientation, because they were not alone with their medical provider. Privacy in clinical encounters is critical for honest disclosures, particularly regarding sexual health, HIV/STI prevention, or mental health concerns. Clinicians must recognize that a paucity of response from patients may be a result of social norms or family pressures, which can unintentionally perpetuate secrecy, deterring patients from sharing crucial information.

1.3.4 Prevention Practices

Nearly half of the respondents had never been tested for HIV, and many were unaware of local STI/HIV screening resources. Over 60% were unaware of Pre-Exposure Prophylaxis (PrEP) or did not know how to obtain it; only 47.5% recognized Post-Exposure Prophylaxis (PEP).

Most participants aged 25+ reported up-to-date cervical cancer screening, and those aged 55+ often had mammograms and colonoscopies. However, participants aged 45-54 indicated not being offered colon screening as frequently.

Only 11% of participants reported being asked about alcohol use by a provider in the past year, and *none* of those aged 13-24 received any screening. Under 20% were asked about tobacco or other drug use, suggesting widespread under-screening for substance misuse.

Inconsistent STI, cancer, and substance use screening and limited awareness of HIV prophylaxis highlight systemic barriers, including inadequate provider training, lack of LGBTQ-focused health education, and stigma around sexual behavior. Screening rates for alcohol and substance use were much lower than expected, suggesting that local providers may not be following recommended guidelines or are unaware of the heightened risk for substance misuse in the LGBTQ+ population. When prevention resources are not effectively promoted, LGBTQ+ individuals are at increased risk for late diagnoses of HIV, STIs, cancers, and substance use disorders that could otherwise be prevented or managed more easily.

1.3.5 Mental Health Outcomes

A substantial portion of participants reported high levels of psychological distress. Fully 50% described feeling stress, anxiety, or depression "most of the time" or "always" over the preceding 30 days. Overall, 30% reported serious suicidal ideation in the past year. Among adolescents aged 13-17, that rate exceeded 50%. Of the total respondents,16% had attempted suicide during the past year, with younger teens again representing the highest share.

These figures are consistent with national data showing elevated rates of mental distress, suicidality, and anxiety within LGBTQ+ communities, often linked to minority stress, including familial rejection, and lack of supportive healthcare environments. The especially high rates among adolescents highlight the urgent need for early intervention and expanded mental health resources that are LGBTQ+ affirming.

1.3.6 Key System-Level Implications

Cumulatively, these findings illuminate four critical insights regarding LGBTQ+ health in Southwest Alabama:

Minority Stress: Discrimination and invalidating encounters permeate care-seeking decisions, contributing to delays or avoidance of necessary treatment.

Gaps in Clinical Systems: Insufficient training, stigma, and lack of privacy protocols hamper proactive screening and undermine trust in healthcare institutions.

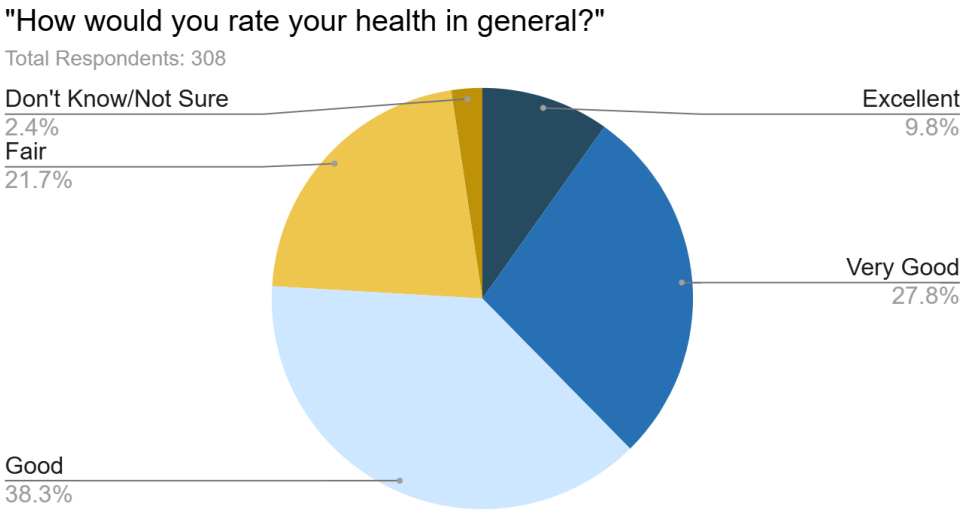
Missed Preventive Opportunities: Low uptake of HIV/STI testing, limited knowledge about PrEP/PEP, poor screening for alcohol and substance, and absent screening for substance use among adolescents contribute to local health disparities.

Significant Mental Health Strain: High rates of anxiety, depression, and suicidality – especially among LGBTQ+ youth – demonstrate the profound psychological cost of social stigma and insufficient resources for psychological support.

2.0 Primary Care and Self-Reported Care

Primary care is the cornerstone of healthcare. Access to primary care gives patients the ability to receive preventative healthcare, care for chronic conditions, and treatment/guidance for acute issues. There are numerous factors that impact access to primary care providers, particularly in Southwest Alabama. Lack of insurance, inability to attend appointments due to work or care responsibilities, language barriers, lack of providers in the area, and fear of discrimination are all reasons why an individual may not be able to seek healthcare. Our survey sought to examine the engagement with primary care services among LGBTQIA+ people in Southwest Alabama. We asked participants how they would rate their health, how long it had been since they had seen a medical provider, whether they have a primary care physician, if they ever had to delay medical care (and if so, why), and inquired about whether participants received routine primary care behavioral screenings.

2.1 Subjective Health Ratings



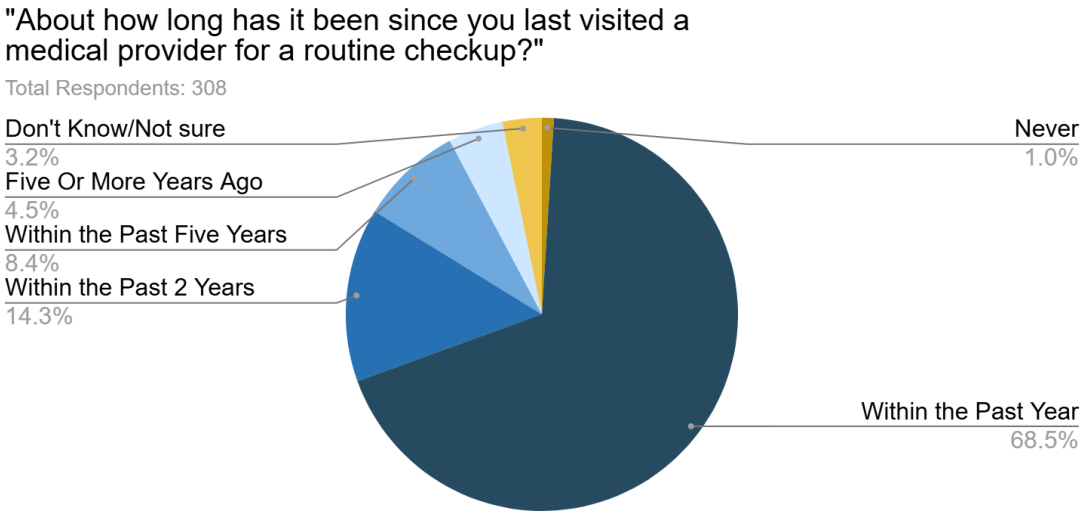
2.1.1 Importance of Rating One's Health

Subjective ratings of one's health are important measurements of how individuals in a population view themselves. The National Survey on Health and Disability by Sexual and Gender Minority Status (2019-2020) found that people who identified as LGBTQ+ who also had a disability were more likely than their non-LGBTQ+ peers to report severe mental distress and activity-limited days (Streed et al., 2021). A study investigating the self-reported health of individuals who immigrated to the United States demonstrated lower rates of self-reported health in individuals immigrating to the United States who identify as LGBTQ+ (Tang, 2024). In a study conducted across eight different European countries, adolescents identifying as LGBTQ+ were more likely to rate their health as poor compared to their peers (Költő et al., 2020).

2.1.2 Health Ratings in the Local LGBTQ+ Population

Survey participants were asked “How would you rate your health in general?” and were able to select one of the following options: *excellent*, *very good*, *good*, *fair*, *poor*, *don’t know/aren’t sure*, or *prefer not to say*. Our data show that 75.9% of respondents rated their health as either *good*, *very good*, or *excellent*. Given available data on subjective health ratings of LGBTQ+ people, our findings suggest that LGBTQIA+ people in Southwest Alabama may view their health statuses more favorably than their peers in other regions.

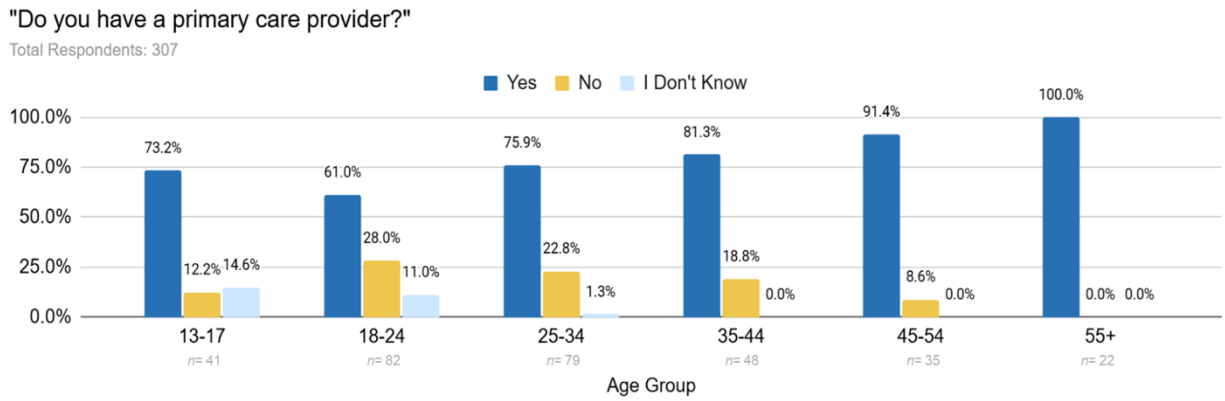
2.2 Time Since Last Checkup



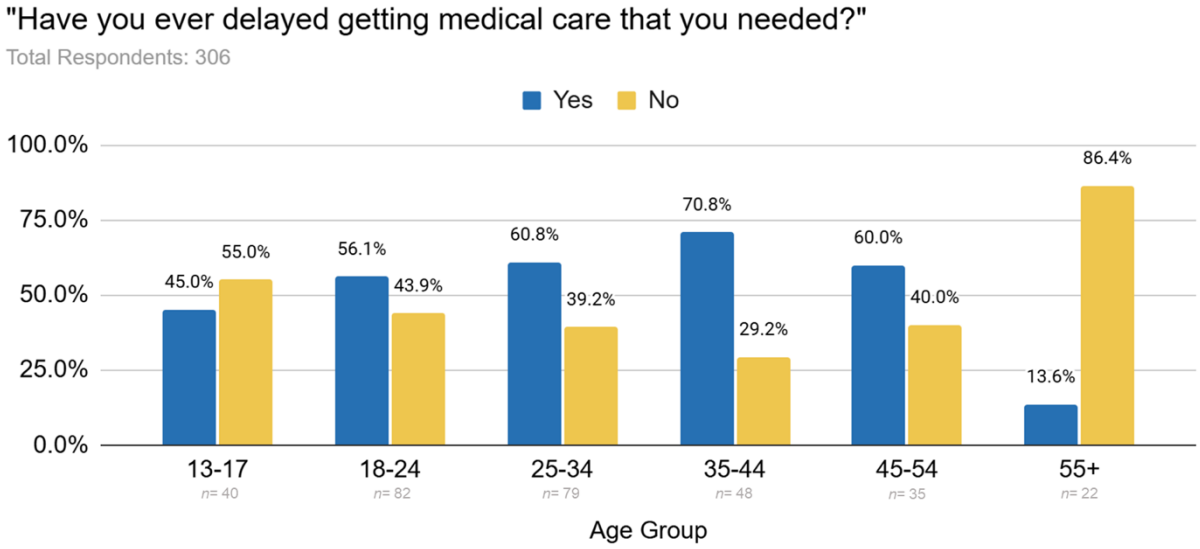
2.2.1 Health Maintenance

Health maintenance visits are vital yet often neglected aspects of overall wellness. This issue also affects the LGBTQ+ population. A study of healthcare visits among binary and nonbinary transgender adolescents found no significant difference in whether those who identified as gender minorities and those who did not had a well visit in the past year (Boyer et al., 2022). The majority (93.3%) of adolescent participants identifying as gender or sexual minorities in a study investigating youth sexual minority opinion of primary care reported having seen a doctor in the past 12 months (Snyder et al., 2017). In a similar study, 68.4% of young adults identifying as gender or sexual minorities reported having a checkup in the past year (Macapagal et al., 2016). The majority of respondents to our survey (68.5%) likewise indicated they had received a routine checkup with a medical provider in the preceding year.

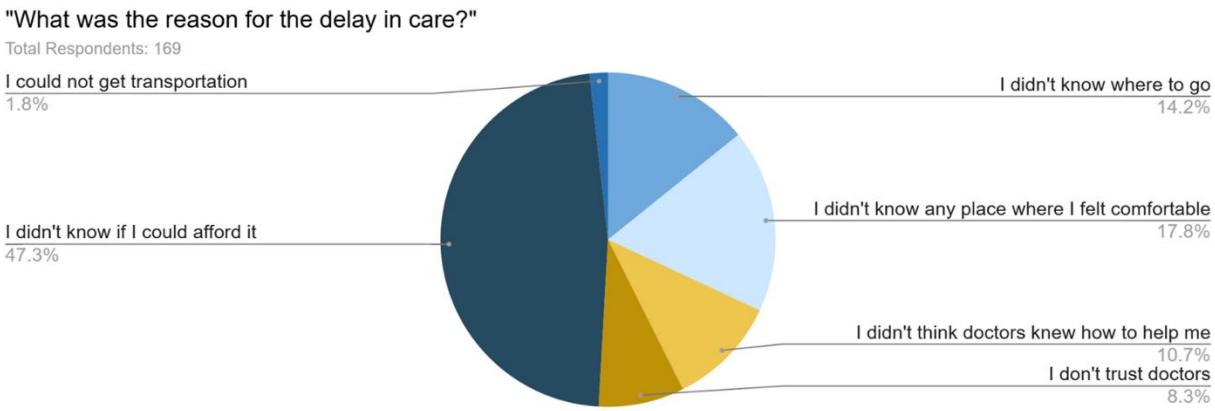
2.3 Primary Care Providers



2.4 Delays in Medical Care

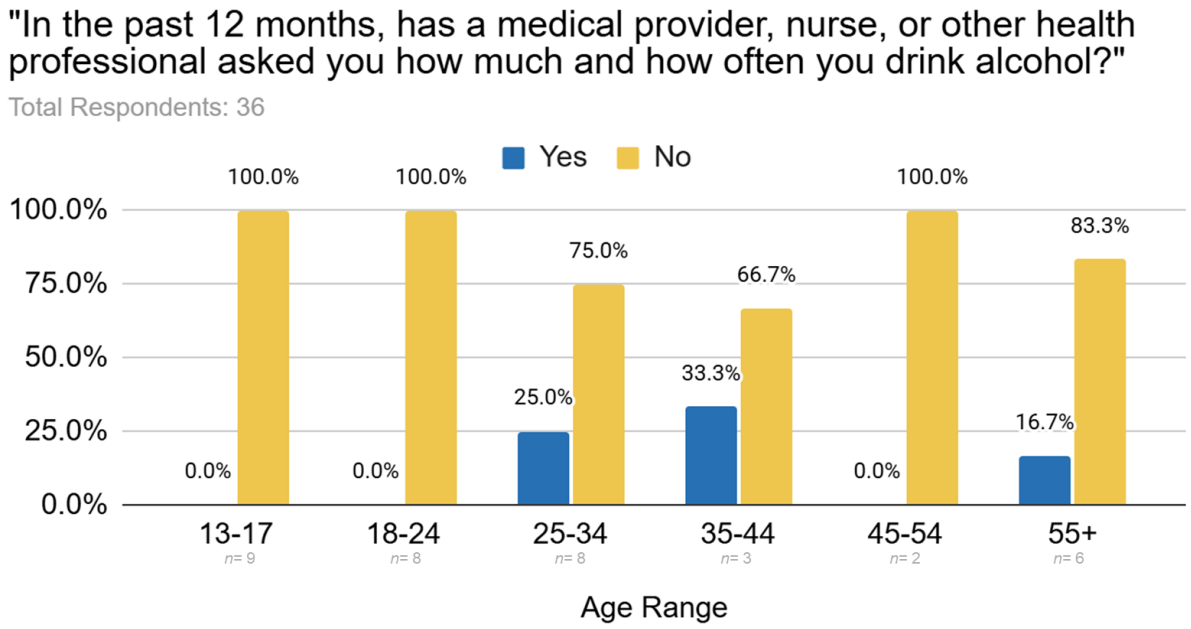


2.5 Reasons for Delays in Medical Care



2.6 Primary Care Behavioral Screenings

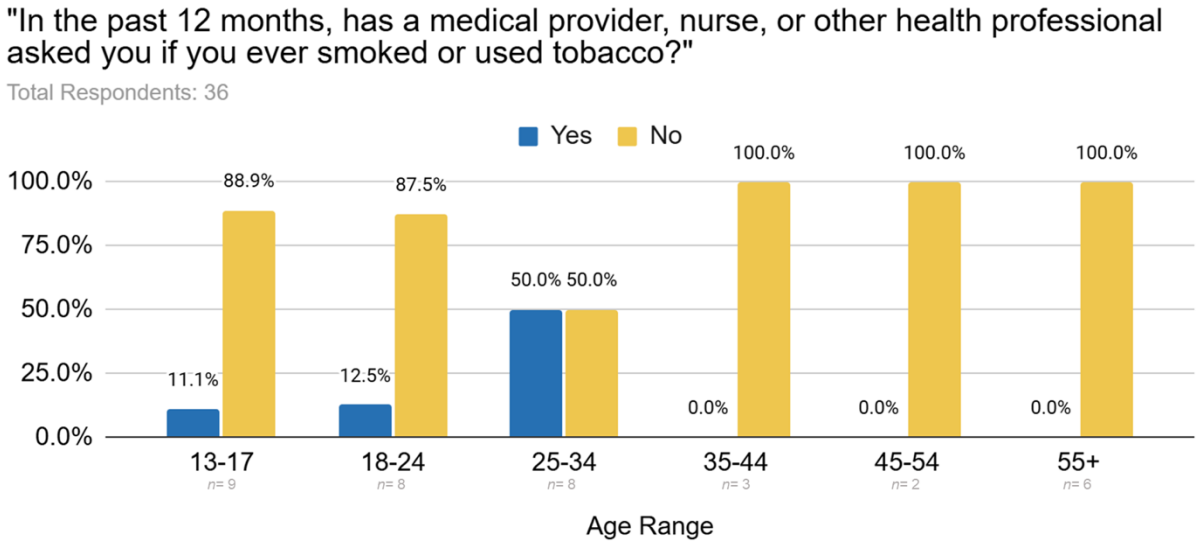
2.6.1 Alcohol Screening



2.6.2 Alcohol Use in the Local LGBTQ+ Population

Excessive alcohol use is a growing health concern for many communities, making screening for alcohol use disorder imperative during health visits. A 2017 study that analyzed data from the Behavioral Risk Factor Surveillance System found similar rates of alcohol screening and intervention between those who did and did not identify as sexual minorities (Lehavot et al., 2017). Screening for alcohol use disorder is a vital aspect of primary care office visits. Yet, our data show that none of our survey respondents aged 13-24 reported being asked about alcohol use by a healthcare provider in the last year, and only 11% of respondents overall reported being screened for alcohol use.

2.6.3 Smoking Screening

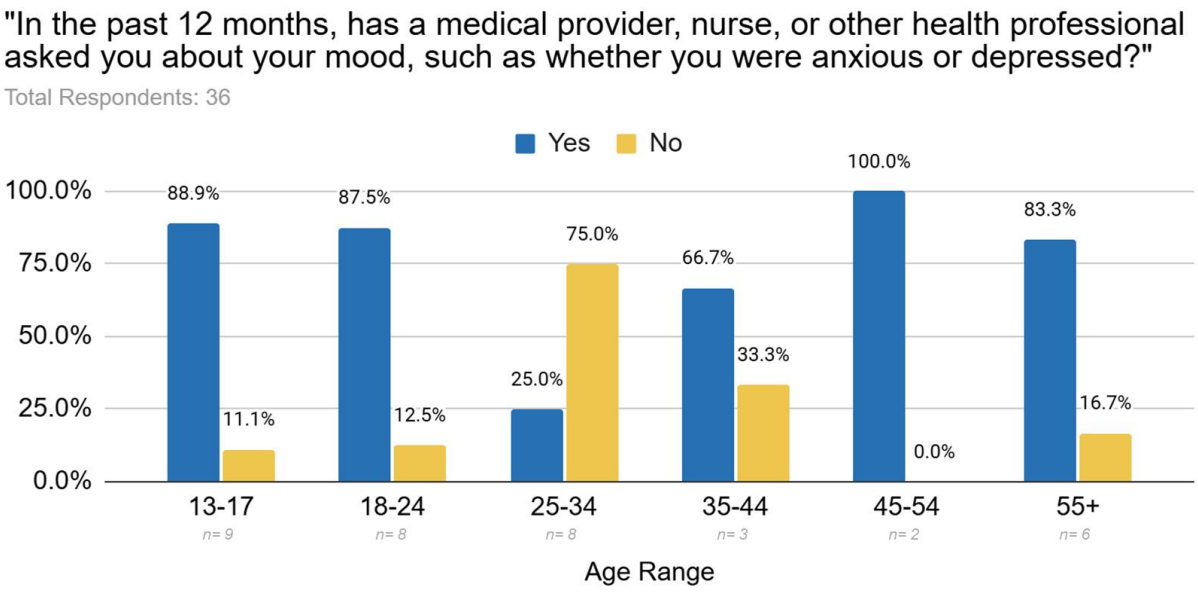


2.6.4 Tobacco Use in the Local LGBTQ+ Population

Tobacco use is another significant health concern, given the long-lasting and serious consequences of prolonged tobacco use. A 2017 study in Texas found that sexual and gender minorities were more likely to use tobacco products than their heterosexual and cisgender counterparts (Hinds et al., 2017). Another study conducted using national data in the United States found that cigarette use was disproportionately higher among gender minorities but not use of other tobacco products (Delehanty et al., 2019). These studies highlight the growing need for tobacco use screening in the LGBTQ+ population.

Our data show that only 16.7% of our survey respondents overall reported being asked about tobacco use by a healthcare professional in the last year, with no respondents aged 35 and older reporting having been screened for tobacco use. Knowledge of a patient's tobacco history is used to inform decisions regarding health screenings, such as low-dose CT scans to screen for lung cancer in individuals aged 50-80 with a smoking history, as well as screens for abdominal aortic aneurysms for people assigned male at birth aged 65-75 who have ever smoked. Additionally, it has been established that smoking is associated with dose-dependent damage to lungs, endothelium, and the cardiovascular system, meaning that adolescents and young adults who are not screened are at even greater risk for tobacco-related health issues as they age.

2.6.5 Mood Screening



2.6.6 Mood

It has been established that members of the LGBTQ+ population are at increased risk for mental illness due to the phenomenon of minority stress (See Section 9 on Mental Health). There are limited national data on rates of mental health screening employed in healthcare offices; however, given the known prevalence of depression/anxiety in this community, screening for these disorders is vital when caring for LGBTQIA+ patients. Our data show that more than 80% of respondents aged 13-24 and 45+ report being screened for depression and anxiety; however, of respondents aged 25-34, only 25% report being asked about mental health. It is essential to note that screenings for any given condition have lower specificity, thus requiring confirmatory tests for accurate diagnosis. Mental health conditions extend beyond depression and anxiety and must be addressed appropriately.

3.0 Comfort in Medical Offices

One of the biggest factors in whether an individual in the LGBTQ+ population will seek healthcare is their level of comfort with their healthcare provider. Past negative experiences when seeking care can cause intense feelings of apprehension and anxiety at future appointments, especially for individuals in the transgender population. Our goal is to use the data below to inform healthcare providers about factors that negatively impact LGBTQ+ people's experiences in healthcare offices so that practice leaders can take action to create and maintain respectful spaces for LGBTQ+ people and families. Supportive healthcare environments for the LGBTQ+ population are vital, and it is essential for physicians and healthcare providers to be aware of how individuals in the LGBTQ+ population perceive their office environments.

3.1 Supportiveness/Friendliness of Clinical Staff

"Clinic office staff, medical providers or nurses are friendly and supportive."

Strongly Disagree	6.1%
Disagree	5.8%
Neutral	29.9%
Agree	45.6%
Strongly Agree	12.6%
Total Respondents	294

3.2 Trust in Medical Providers

"I trusted and felt respect from medical providers, office staff, or nurses."

Strongly Disagree	5.1%
Disagree	10.5%
Neutral	21.0%
Agree	48.8%
Strongly Agree	14.6%
Total Respondents	295

3.3 Helpfulness of Medical Offices

"The medical office helped me with my concerns."

Agree	88.4%
Disagree	11.6%
Total Respondents	294

3.4 Providers' Respect for Chosen Names

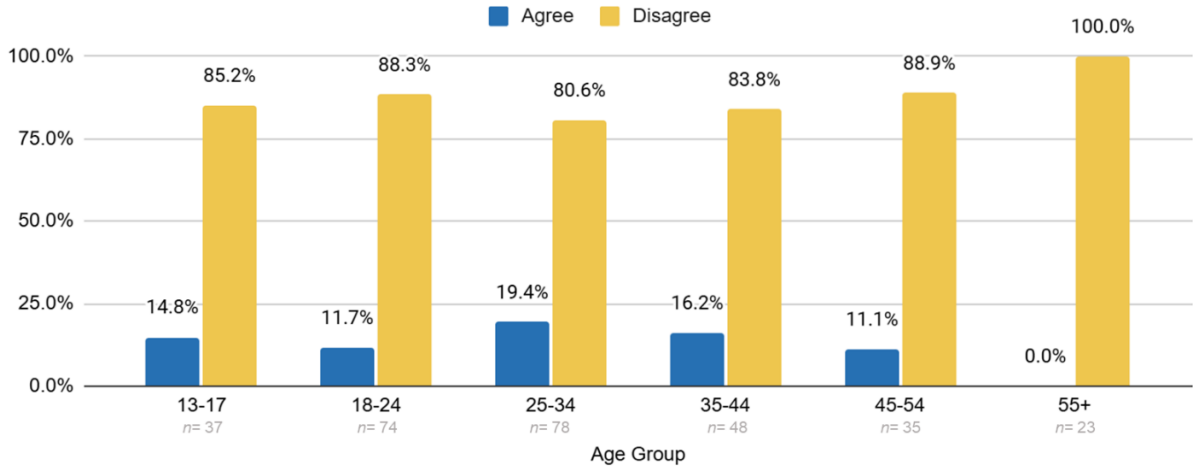
"Medical providers and nurses called me by my chosen name and pronouns."

Agree	81.4%
Disagree	18.6%
Total Applicable Respondents	156

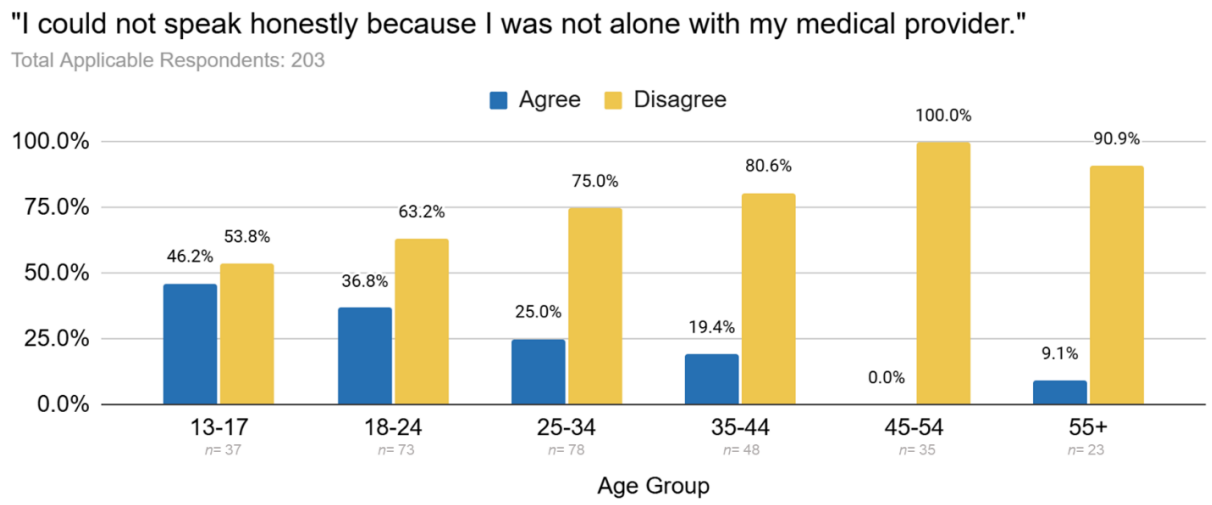
3.5 Providers Refusing Treatments

"Medical providers and nurses refused to give me the treatment that I wanted."

Total Applicable Respondents: 231



3.6 Ability of Patients to Speak Honestly



3.7 Partner Allowed in Exam Room

"My partner was not allowed in the room with me."

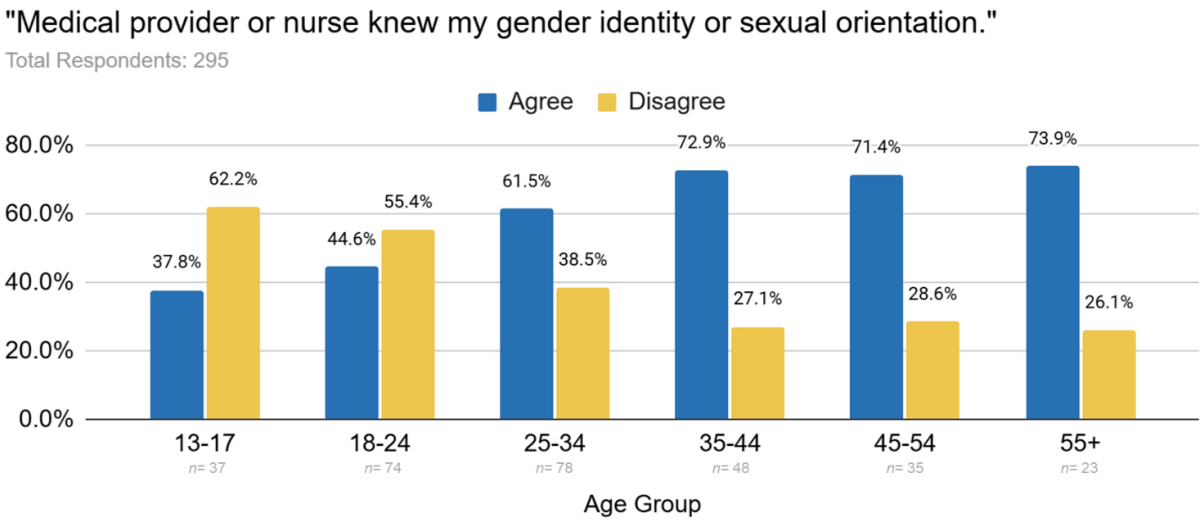
Agree	14.5%
Disagree	85.5%
Total Applicable Respondents	110

3.8 Partner Treated as a Family Member

"Medical providers or nurses did not treat my partner like a family member."

Agree	19.6%
Disagree	80.4%
Total Applicable Respondents	112

3.9 Providers' and Staff Awareness of Gender/Orientation



4.0 Provider Knowledge

Healthcare providers' knowledge about LGBTQ+ topics and issues is a significant factor in providing adequate care for LGBTQIA+ people. Physicians and other providers who are aware of the unique needs of this population can make considerable differences in the lives of LGBTQ+ people. Our hope in sharing the data we collected on this topic is that clinicians, healthcare personnel, and healthcare organizations will recognize the need for greater knowledge proficiency of LGBTQ+ health topics in Southwest Alabama. This need for greater proficiency directly affects the quality and accessibility of healthcare. Ongoing professional development that enhances providers' awareness and understanding of diverse health needs is needed to help reduce disparities and improve quality of care for LGBTQ+ populations.

4.1 Provider Knowledge of LGBTQ+ Health

"My medical providers had appropriate knowledge of LGBTQ+ related healthcare needs."

Agree	60.7%
Disagree	39.3%
Total Applicable Respondents	150

4.2 Provider's Ability to Answer LGBTQ+ Health Questions

"Medical providers and nurses knew the answers to my questions related to LGBTQ+ health."

Agree	52.5%
Disagree	47.5%
Total Applicable Respondents	139

4.3 Provider Understanding of Patient History

"I had to explain parts of my history or medical care because the medical provider did not understand."

Agree	33.3%
Disagree	66.7%
Total Applicable Respondents	183

4.4 Provider Ability to Appropriately Refer Patients

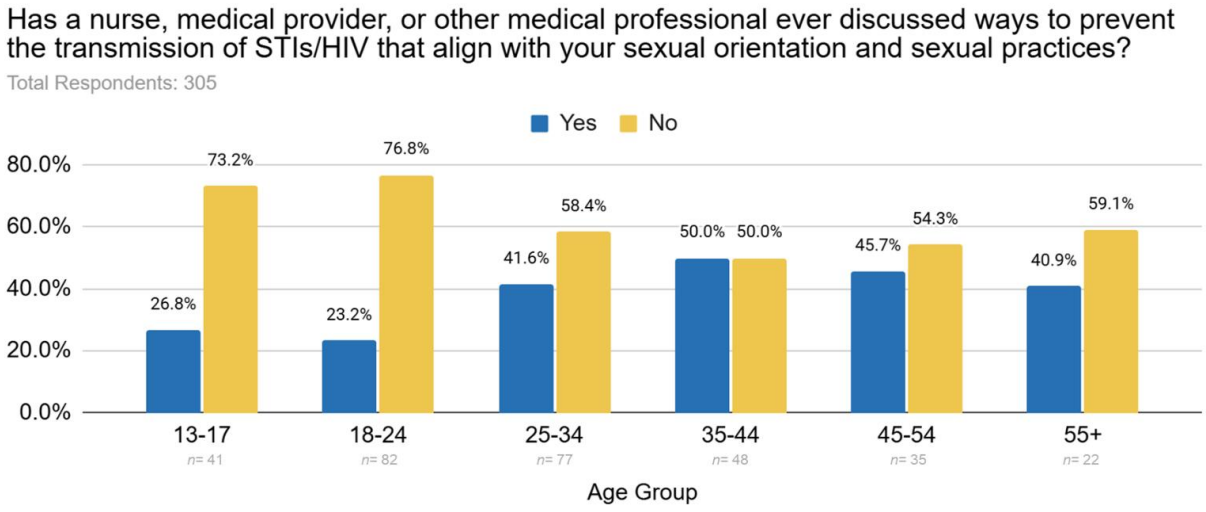
"Medical providers and nurses did not know where to send me for help."

Agree	22.2%
Disagree	77.8%
Total Applicable Respondents	144

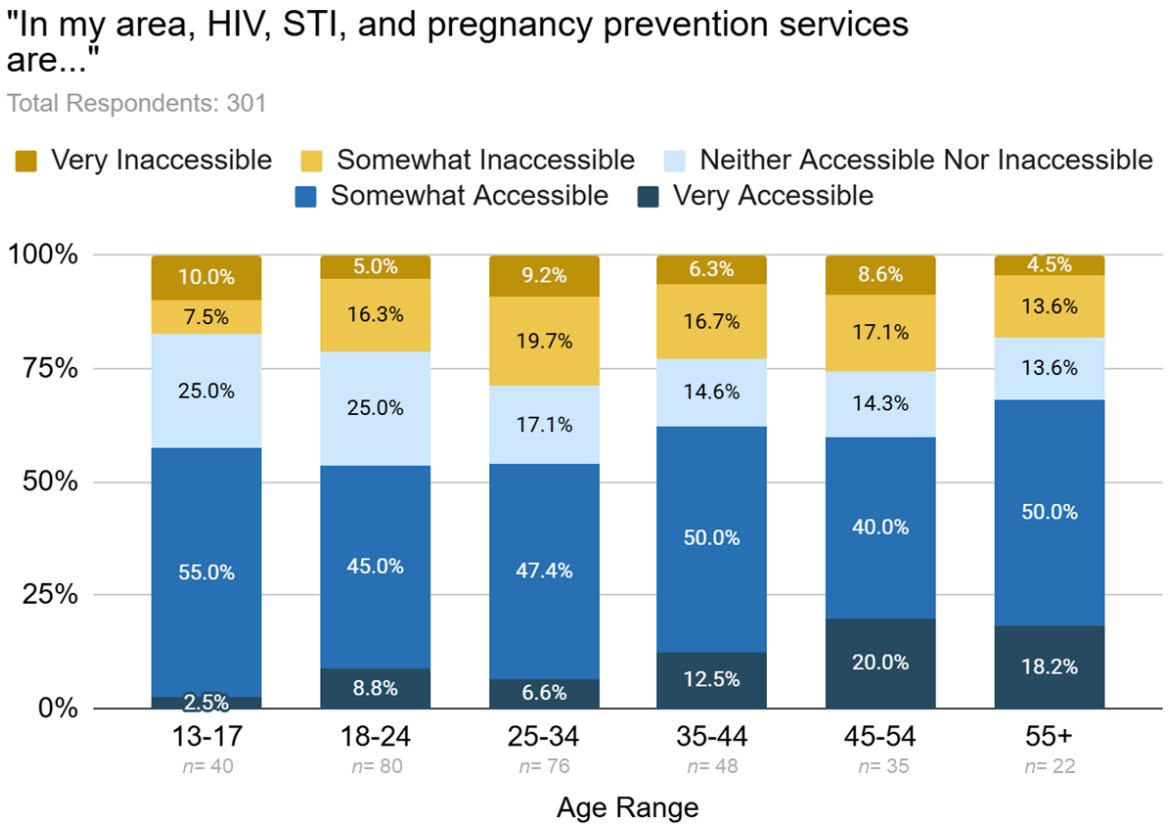
5.0 Sexually Transmitted Infections (STIs) and Prevention

Prevention of sexually transmitted infections (STIs) is a vital public health topic to ensure safe sexual health practices in the population at large, and especially in the LGBTQ+ population. Having data that provides more information about STI prevention in the LGBTQ+ population in Southwest Alabama will inform healthcare providers as well as community organizations about the needs of this population regarding sexual health.

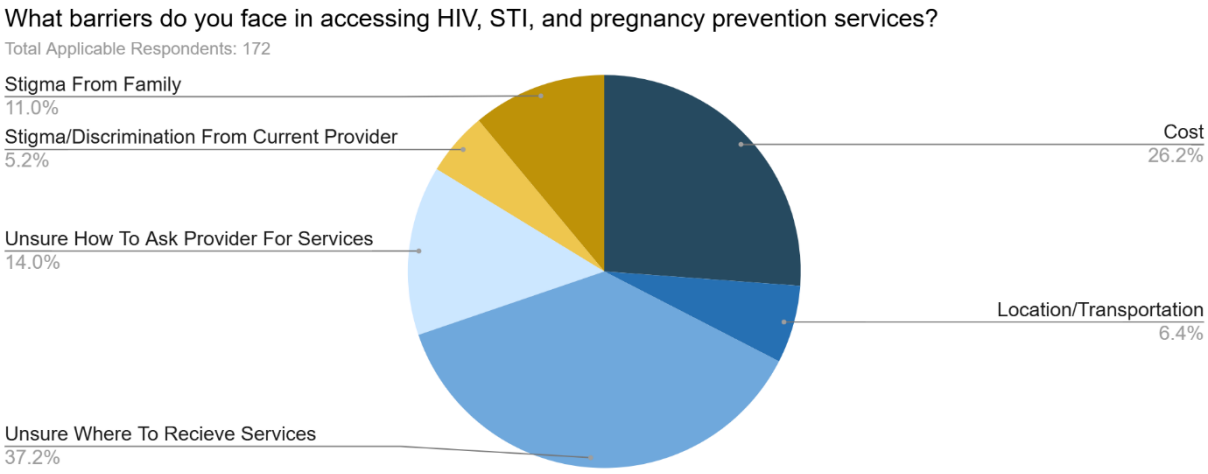
5.1 Discussion of STI Prevention



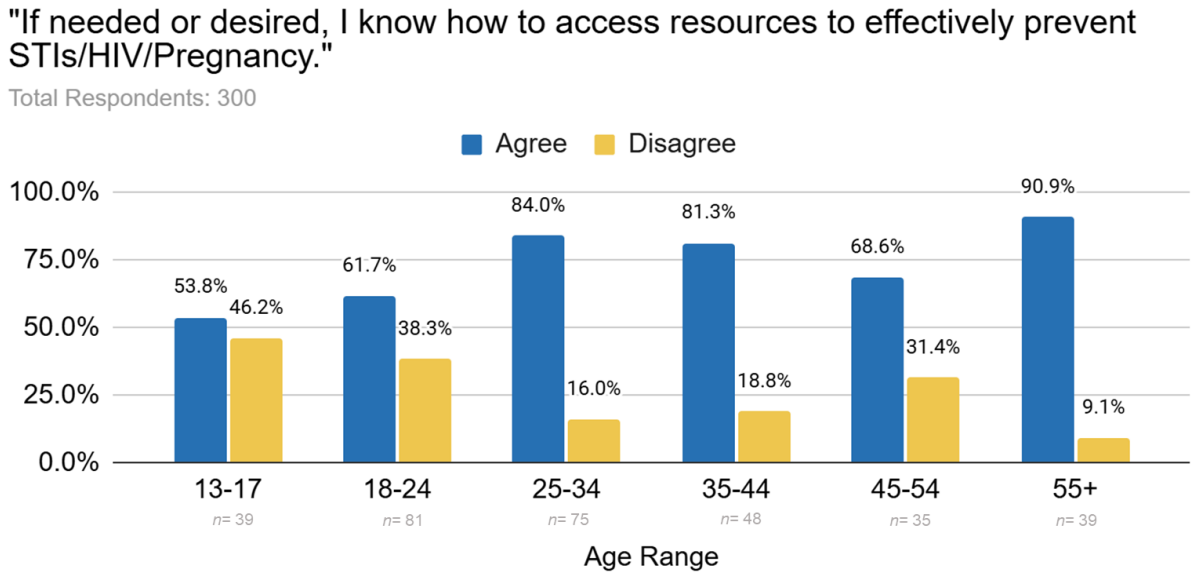
5.2 Accessibility of STI Prevention Services



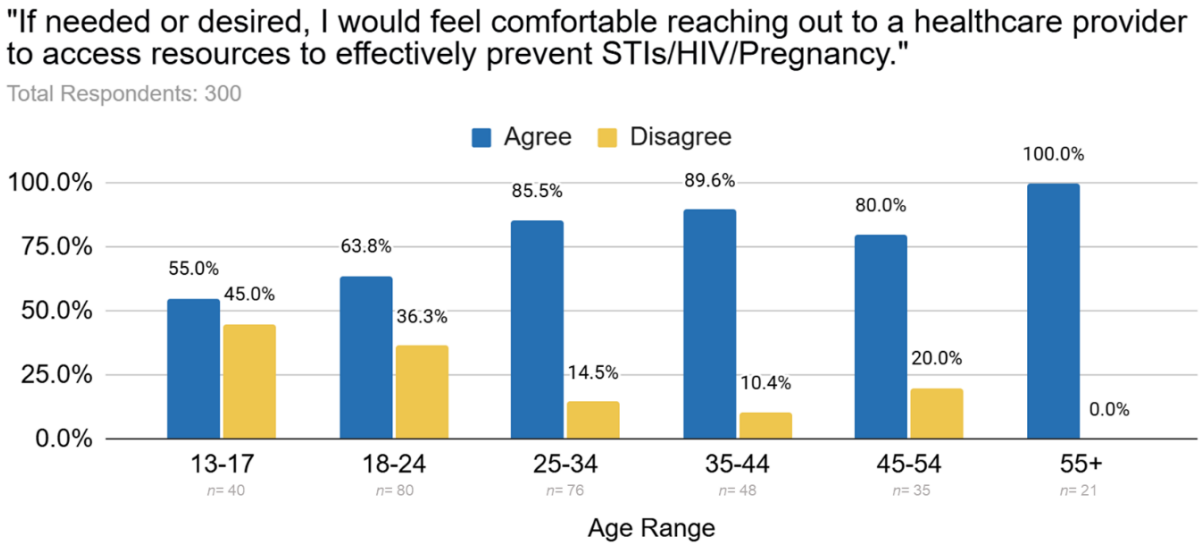
5.3 Barriers to STI/Pregnancy Prevention Services



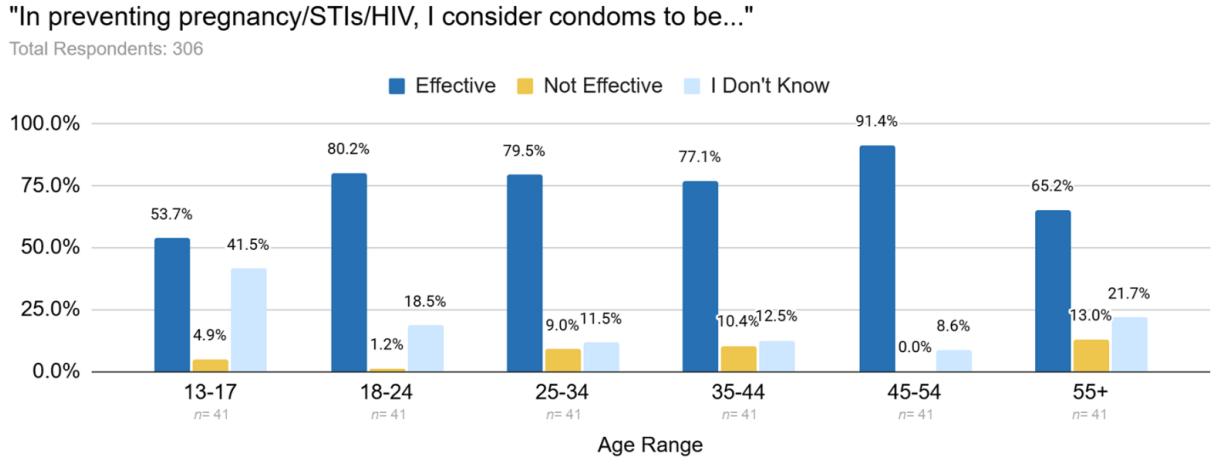
5.4 Knowledge of How to Access STI Prevention Services



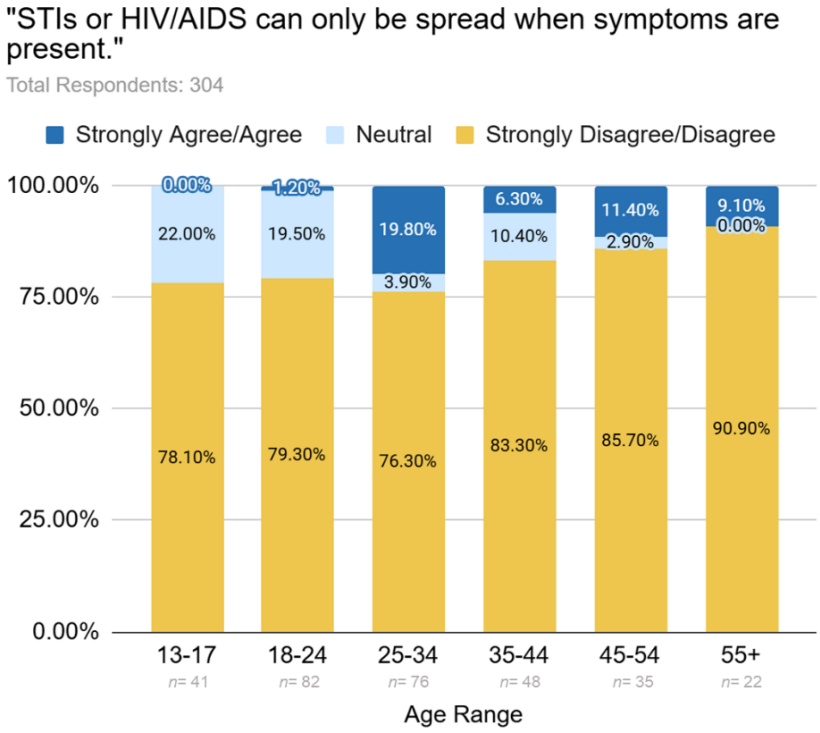
5.5 Comfort in Reaching Out to Providers for STI/Pregnancy



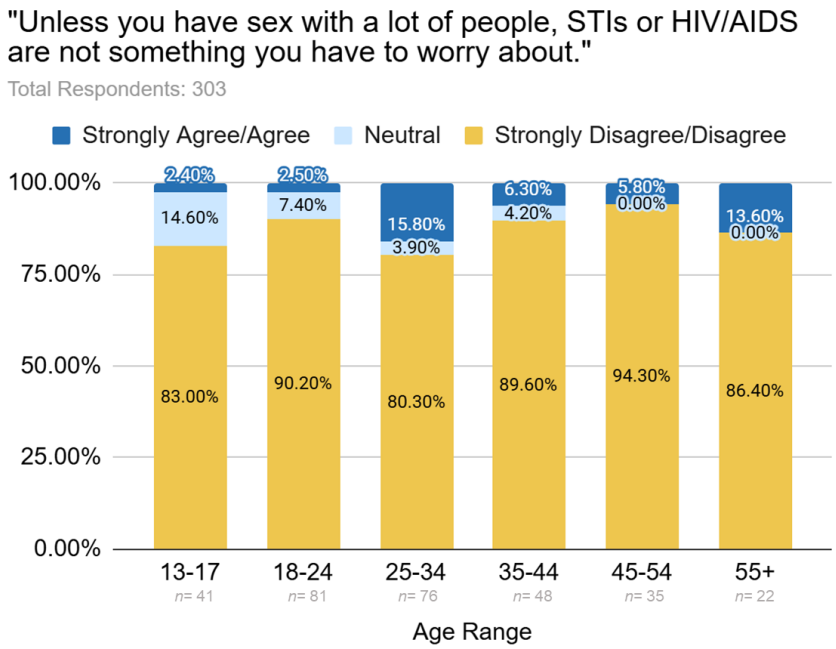
5.6 Participants Opinions on Condoms



5.7 Participants Knowledge About STI Spread



5.8 Participants Knowledge About STI Risk



5.9 Comfort Discussing Sexual Health with Partners

"I feel comfortable asking my sexual partner(s) about sexual health, including approaches to safe sexual practices and testing and treatment of HIV/STIs."

Strongly Disagree	3.6%
Disagree	5.6%
Neutral	17.0%
Agree	37.6%
Strongly Agree	36.3%
Total Respondents	306

5.9.1 Communication About Sexual Health

Healthy sexual relationships are dependent upon healthy communication about sexual health, including STI status. With these conversations, sexual partners are more likely to undergo regular testing and safe sexual practices (e.g., condom usage). However, there are many barriers to these conversations, such as systemic stigmatization of LGBTQ+ sexual health as well as relationship dynamics between sexual partners. Stigma and discrimination against LGBTQ+ individuals significantly hinder open discussions about sexual health. Experiences of perceived discrimination can lead to avoidance of healthcare services and reluctance to engage in conversations about sexual well-being. A study by the Kaiser Family

Foundation found that LGBTQ+ individuals are at least twice as likely to have negative experiences with healthcare, which made them less likely to seek care (Montero et al., 2024). This avoidance of care can lead to individuals feeling uncomfortable about seeking testing and treatment, even when discussed with sexual partners.

Relationship dynamics also play a role in sexual health communication. A longitudinal study of male couples with HIV/AIDS found that LGBTQ+ men are more likely to have discussions of sexual health with long-time partners compared to casual sexual partners (Conroy et al., 2016). While it is not surprising to find that people are more comfortable having conversations with sexual partners with whom they are more familiar, it is essential to emphasize the importance of sexual health discussions among all sexual partners. Progress is being made in promoting sexual health discussions with casual sex partners using technology, specifically gay dating apps. According to a 2020 study, up to 96% of gay and bisexual men were willing to notify their recent casual sex partners of a recent STI diagnosis through anonymous means within dating applications. Additionally, up to 92% of men were willing to get tested for STIs following notifications from partners in the applications (John et al., 2020). Thus, technology and anonymity may have a role in promoting sexual health communication for LGBTQ partners.

Our data show that only 73.9% of respondents reported that they would feel comfortable asking their sexual partners about safe sexual practices and STI status/treatment. Discomfort in discussing sexual health is likely influenced by the stigma surrounding these conditions, which may be further compounded by stigma related to LGBTQ+ identity and STI transmission. Clinics and healthcare providers who establish themselves as supportive and respectful places for LGBTQ+ people to seek care can have a significant impact on STI spread in this population by providing not only testing and treatment, but also patient education regarding STIs.

5.10 Confidence in Sexual Partners

"I feel confident that my sexual partner(s) would be forthcoming about their own exposure or diagnosis of HIV/STIs."

Strongly Disagree	3.3%
Disagree	6.5%
Neutral	22.8%
Agree	31.3%
Strongly Agree	36.2%
Total Respondents	307

5.10.1 Conversations about STI and HIV Status

Navigating conversations about STI status is a challenge for many sexual partners, and as noted above, stigmatization regarding LGBTQ+ sexual practices can make these conversations even more challenging. Additionally, many individuals may be unaware of their STI status due to a lack of regular testing or misinterpretation of symptoms. According to the Centers for Disease Control and Prevention (CDC), a significant proportion of individuals living with HIV are undiagnosed, leading to increased transmission (Dailey et al., 2017). Regular screenings and education regarding STI transmission and symptoms are

critical in reducing uncertainty regarding a partner's health status. However, as mentioned previously, stigmatization may be a barrier to seeking healthcare. A study that included men who have sex with men (MSM) in Los Angeles and Chicago found that patients who disclosed their sexual behaviors to their doctors were more likely to receive appropriate STI screening, vaccinations, and prophylactic treatments (Singh et al., 2018). Thus, assuming a patient's sexual orientation when it is not disclosed can lead to inappropriate clinical practices. Therefore, it is crucial for healthcare providers to be vigilant about identifying and screening high-risk individuals. The assumption that one would instinctively know if a sexual partner had an STI or HIV/AIDS is both inaccurate and dangerous. Encouraging regular testing and open communication, as well as promoting accurate sexual health education, are crucial steps in addressing this issue. Fewer than half of respondents to our survey believe that they would know if their sexual partner had an STI or HIV/AIDS. This further highlights the need for healthcare providers in Southwest Alabama to not only provide supportive clinical environments for members of the LGBTQ+ population but also to educate patients on STI screening and safe sexual practices.

5.11 Participants' Perception of STI Status

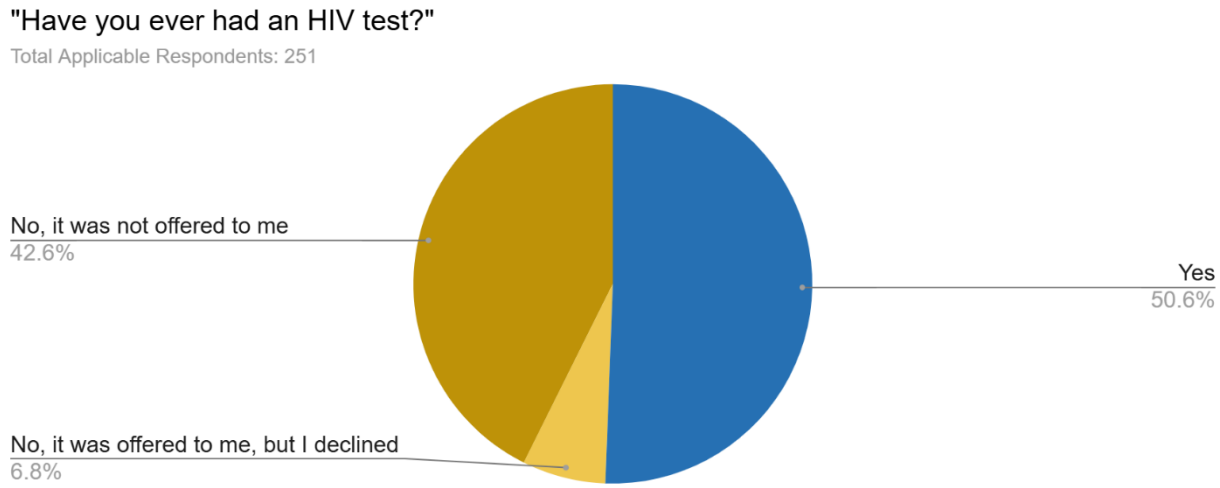
"If someone I was sexually active with had an STI or HIV/AIDS, I would know it."

Strongly Disagree	9.9%
Disagree	12.9%
Neutral	30.1%
Agree	27.2%
Strongly Agree	19.9%
Total Respondents	302

6.0 HIV/AIDS

Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) have been significant health concerns since the AIDS crisis of the 1980s-1990s. The brunt of the impact of this initial crisis was felt primarily by men who have sex with men (MSM). HIV/AIDs is an extremely sensitive topic by nature, but the lingering stigma surrounding it is still felt today, particularly in the LGBTQ+ population, and more so with MSM individuals. There are a number of treatment options available for HIV infection as well as prevention, including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP). It is vital to collect data on this topic for communities at large, and including LGBTQ+ populations in this data collection is key to addressing HIV prevention and promoting the health of LGBTQIA+ communities.

6.1 History of HIV Tests



6.1.1 HIV Screening

Screening for HIV is vital to prevent the spread of this devastating illness. HIV testing is recommended for all individuals over age 13 at least once. Testing is also recommended for anyone who becomes pregnant. Increased HIV testing should be considered in people who are at higher risk for infection, including those who use intravenous drugs or engage in high-risk sexual behaviors. National data have indicated that 78% of sexually active men who have sex with men (MSM) who do not use pre-exposure prophylaxis (PrEP) have been tested for HIV in the past year, and that 67% of these tests occurred in a clinical setting (CDC, 2024).

In Alabama, HIV testing is available at local health departments, specialized HIV clinics in some cities, and at most physician offices. Testing kits for HIV and common sexually transmitted infections are available by mail through the Alabama Department of Public Health at no cost for eligible individuals, and individuals receive referral to a healthcare provider in the case of a positive test (ADPH, 2024). Due to public health concerns about the prevalence of undiagnosed HIV infection, many organizations exist

across the country offer community-based testing in public spaces. AIDS Alabama South provides these services, as well as accessible HIV/AIDS treatment in Southwest Alabama. Programs that offer mail-order testing or tests at non-clinical sites may be especially helpful to individuals who use PrEP, which requires frequent testing to receive prescriptions.

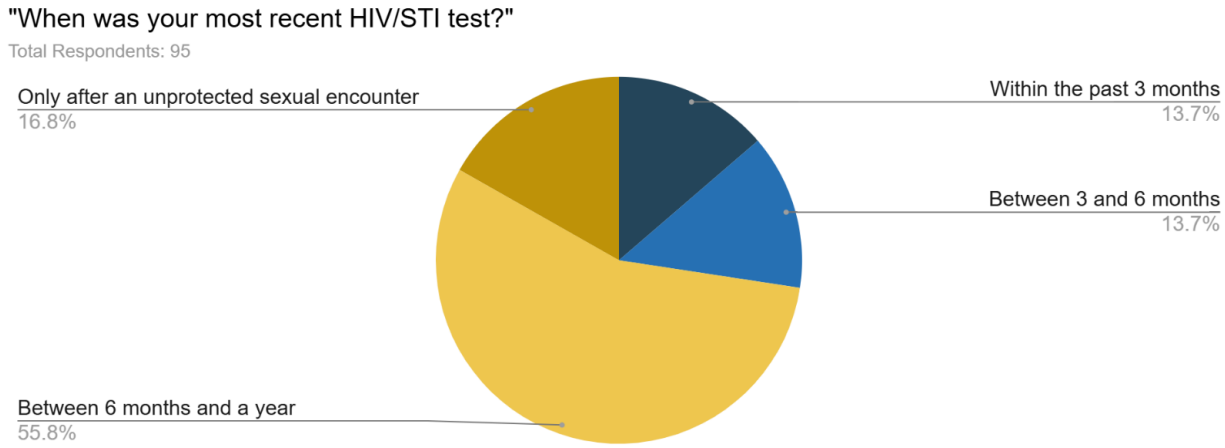
Nearly half of our survey respondents reported that they had never received an HIV test, and of these, 42.6% indicated that their healthcare provider had never offered them an HIV test. While our survey question was not specific to MSM, our data still stands in stark contrast to the national HIV screening rates reported by the CDC. Healthcare providers in Southwest Alabama must be more proactive about recommending HIV screening as well as taking detailed patient histories to determine individuals who are at higher risk for HIV infection.

6.2 Inquiries About HIV Testing at Medical Appointments

"My medical provider asks me about HIV/STI testing at every appointment."

Yes	18.7%
No	81.3%
Total Respondents	294

6.3 Respondents' Most Recent HIV Test



6.4 HIV Treatment

"If you tested positive for HIV, did you receive treatment?"

Yes, I was referred to HIV treatment upon diagnosis.	36.4%
Yes, I sought treatment on my own.	27.3%
No, it was offered to me, but I declined.	4.5%
No, it was not offered to me.	31.8%
Total Applicable Respondents	22

6.5 Skipped HIV Treatment

"If you take medications for the treatment of HIV, have you ever skipped a dose or stopped treatment?"

Yes	10.5%
No	89.5%
Total Applicable Respondents	57

6.6 Pre-Exposure Prophylaxis (PrEP) Awareness

"Are you aware of Pre-Exposure Prophylaxis (PrEP), a medication that can significantly reduce the likelihood transmission of HIV to people who are HIV Negative?"

Yes	61.3%
No	38.7%
Total Respondents	305

6.6.1 Pre-Exposure Prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) is a combination of antiretroviral medications used to prevent HIV transmission in seronegative individuals. Since the first PrEP formulation was approved by the FDA in 2012, public awareness has grown exponentially. According to the CDC's 2023 HIV Surveillance Report, 93% of MSM respondents who tested negative for HIV were aware of PrEP, and 45% reported use of PrEP in the preceding year (CDC 2024). While the state of Alabama lacks sufficient data on PrEP awareness, previous studies have indicated a pattern of decreased PrEP awareness in rural communities (Walters et. al., 2022).

Our data show a significant decrease in awareness of PrEP when compared to available national data. Only 61.3% of our survey respondents reported being aware of PrEP medications. This knowledge gap among LGBTQ+ people in Southwest Alabama highlights the need for healthcare providers as well as community partners to increase awareness of options for preventing HIV infection.

6.7 Accessing PrEP

"Do you know how to get Pre-Exposure Prophylaxis (PrEP) locally, should you need it?"

Yes	34.5%
No	65.5%
Total Respondents	304

6.7.1 Barriers to PrEP Access

According to data reported by AIDSVu, a digital tool developed by the Rollins School of Public Health at Emory University, the South has the greatest unmet need for PrEP in the United States. In 2022-2023, 53% of HIV diagnoses were in this region, whereas only 39% of people on PrEP resided here (AIDSVu, 2022-2023). While there have been improvements in awareness of PrEP in the United States as a whole, access can vary significantly based on knowledge and location. Barriers to acquiring PrEP include fear of judgment, stigma surrounding HIV and LGBTQ+ sexuality, provider bias, and limited access to healthcare.

In fourteen states, pharmacists can prescribe PrEP, but Alabama is not yet one of them (Selvage, 2023). To receive PrEP, patients must see a licensed healthcare provider and undergo routine HIV testing (ADPH, 2024). All states offer cost assistance for PrEP, but again, barriers to access are similar to those for acquiring a PrEP prescription. Financial assistance programs may cover medication, but not laboratory testing or visit copayments — perpetuating financial barriers to care.

In Southern Alabama, PrEP is typically prescribed by primary care providers, infectious disease specialists, and at specialized community HIV prevention centers. While Birmingham and Mobile (two of the larger cities in Alabama) have multiple specialized clinics established to provide PrEP, the remainder of Alabama relies on primary care physicians to prescribe PrEP, whose training in PrEP use may vary. The majority of our survey respondents (65.5%) indicated that they did not know how to get PrEP. Collecting this data highlights the need for more widely disseminated information regarding PrEP in our community.

6.8 Post-Exposure Prophylaxis (PEP) Awareness

"Are you aware of Post Exposure Prophylaxis (PEP), a medication that can significantly reduce the likelihood transmission of HIV to people who are HIV Negative?"

Yes	47.5%
No	52.5%
Total Respondents	305

6.8.1 Post-Exposure Prophylaxis (PEP)

Post-Exposure Prophylaxis (PEP) is a term used to describe combination antiretroviral medications used to prevent HIV infection in individuals with a known or suspected exposure to HIV (HHS, 2024). PEP should be administered ideally within 2 hours but no later than 72 hours after exposure (Cowan et al., 2024). PEP consists of a 28-day course of a three-drug antiretroviral regimen (CDC, 2025). The primary evidence for the effectiveness of PEP comes from animal model studies; however, a 2015 meta-analysis reported an 89% lower risk of HIV seroconversion in primates who were given PEP versus controls (Irvine et al., 2015).

A prominent barrier to public awareness of PEP is limited physician awareness of PEP, which may hinder access (John et. al., 2020). Our data show that among surveyed individuals in Southwest Alabama, only 47.5% stated that they were aware of the existence of post-exposure prophylaxis. This data further speaks to the need for increased physician and healthcare provider awareness of PEP as well as increased comfort and confidence in prescribing an appropriate PEP regimen.

6.9 Accessing PEP

Do you know how to get Post Exposure Prophylaxis (PEP) locally, should you need it?

Yes	29.6%
No	70.4%
Total Respondents	304

6.8.1 Post-Exposure Prophylaxis (PEP)

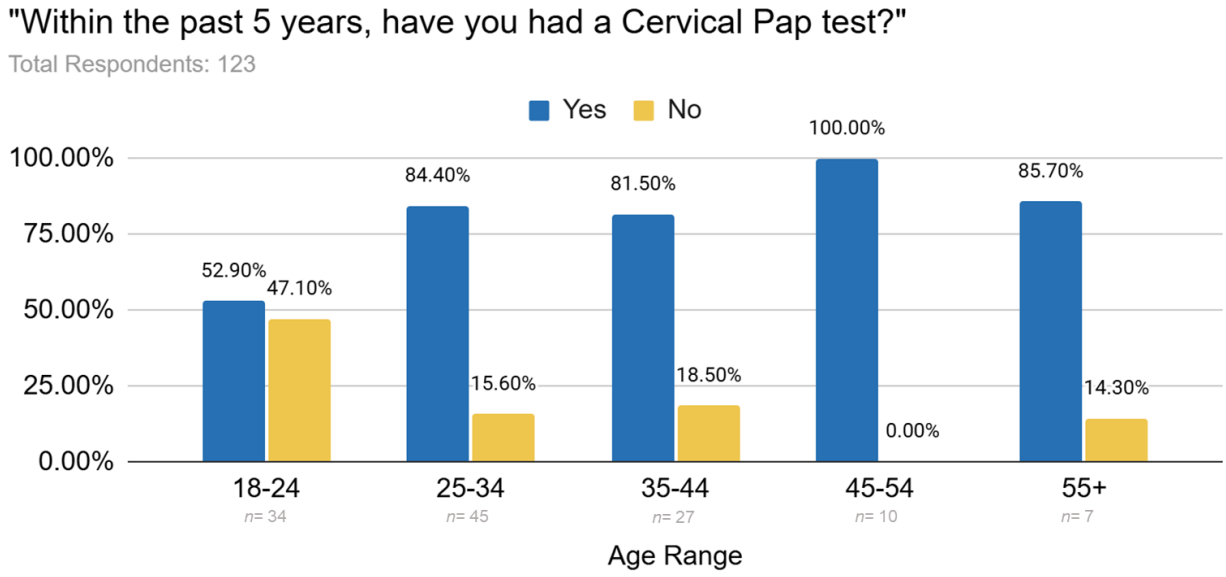
Prescriptions for PEP can be obtained in emergency departments, local health departments, many primary care offices, and specialized HIV clinics, such as Shell Health at AIDS Alabama South. Some national programs will also send PEP via mail. Pharmacists can prescribe PEP in 17 states, notably excluding Alabama at present. While the majority of HIV exposure occurs in the community, the majority of PEP prescriptions are for occupational exposures (Nakayoshi 2022).

A major barrier to the effective use of post-exposure prophylaxis (PEP) therapy for HIV is that it must be initiated within 72 hours of exposure and must be taken daily for 28 days (CDC, 2024). Any delays in treatment may drastically reduce the efficacy of PEP in HIV prevention. Some physicians prescribe post-exposure prophylaxis-in-pocket (PIP) in advance, so that individuals at elevated risk for exposure can have PEP readily available. National rates of PEP use have continued to rise significantly, suggesting that public awareness and access may be improving over time (McCormick 2023). Despite this rise in national awareness of PEP medication and how to obtain it, only 29.6% of our survey participants indicated that they knew how to obtain PEP in our community.

7.0 Cancer Preventative Care

Cancer screening is a crucial aspect of health maintenance. Many of the cancer screening tests/procedures include sensitive exams that can be distressing to patients, and this discomfort can be significantly amplified for LGBTQ+ people. Data on rates of cancer screening in the LGBTQIA+ population is an essential addition to community needs assessments so that providers can be informed on ways to help LGBTQ+ patients feel more comfortable receiving these screenings.

7.1 Pap Smears/Cervical Cancer Screening



7.1.1 Importance of Cervical Cancer Screening

Screening for cervical cancer is a vital aspect of routine health maintenance for anyone who has a cervix, regardless of sexual or gender identity. However, studies have shown that both cisgender women who identify as LGBTQ+, as well as transgender men, are less likely to receive cervical cytology screens (Meyer et al., 2003; Fuzzel et al., 2010). One study has shown that women who identify as lesbian or bisexual are up to half as likely to participate in cervical cancer screening as their heterosexual counterparts (Charkhchi et al., 2019). Substantial barriers to this essential screening have been identified, including a perceived decreased risk, a lack of a primary care provider, and fear of discrimination by healthcare providers. Primary care physicians must take an active role in ensuring supportive and welcoming spaces for their LGBTQ+ patients.

It is also essential that providers give adequate education to patients regarding their risk of both HPV infection and cervical cancer, regardless of gender identity and sexual practices. This discrepancy in care also significantly impacts transgender men. One study found that approximately half of screened transgender men were up to date on cervical cancer screening (Seay et al., 2017). A potential explanation for this is not only the legitimate concern for discrimination by healthcare providers, but the physical exam itself. Many transgender men on testosterone therapy experience vaginal and cervical atrophy that

makes the exam physically painful in addition to emotionally distressing (Seay et al., 2017). These data further highlight the need for healthcare provider competency in the management of LGBTQ+ patients, as well as sensitivity to the psychological and emotional toll these exams take on this population.

7.1.2 Local Cervical Cancer Screening Rates

Our data show promising adherence to cervical cancer screening guidelines among those with cervixes aged 25 and older in Southwest Alabama, as more than 80% reported they had received a pap test in the last 5 years. Among individuals aged 18-24, 52.9% reported having a Pap test in the previous 5 years. However, this age category includes individuals under the age of 21 who are not eligible for cervical cancer screening. Educating healthcare providers about best practices for creating safe and welcoming spaces for LGBTQ+ people is key to maintaining and increasing rates of cervical cancer screening in our community.

7.2 Hysterectomies

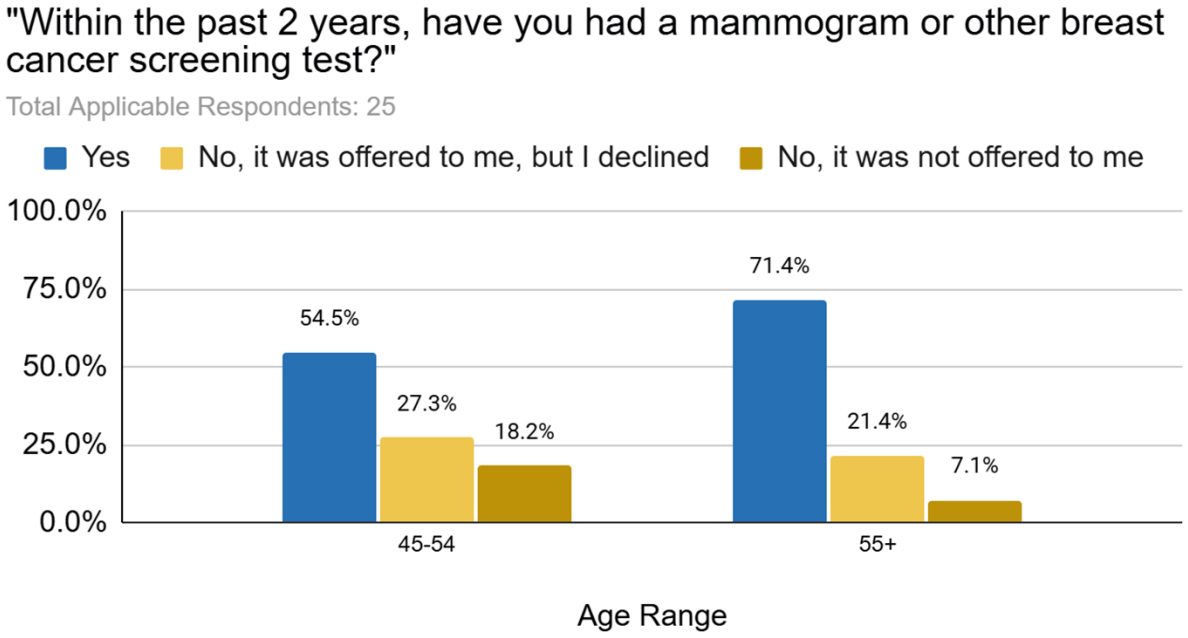
"Have you had a hysterectomy or have you ever had cervical cancer?"

Yes	9.9%
No	90.1%
Total Respondents	203

7.2.1 Hysterectomies as Cancer Treatment and Prevention

For the purposes of this discussion, hysterectomies within the LGBTQ+ population will be discussed with the focus on cancer treatment and prevention through the lens of cervical cancer screenings. A study in Chicago found that LGB cisgender participants were up to 10% less likely to have up to date cervical cancer screenings (CCS) than their heterosexual counterparts (Baumann et. al., 2024). Additionally, this study also found that presence of a primary care physician was much more significant in LGB cervical cancer screenings than heterosexual CCS (93% increased with PCP opposed to only 47% (Baumann et. al., 2024). This highlights some of the disparities present in this population in terms of health screenings. Few studies have examined the barriers to hysterectomy faced by individuals in the LGBTQ+ population. However, it has been shown African American women seeking hysterectomies were more likely to access abdominal vs vaginal or laparoscopic hysterectomies, which are associated with more complications (Pollack et. al., 2020). Additionally, there are racial discrepancies and socioeconomic disparities such as public or private insurance and local exposure to advertisements for minimally invasive surgeries seen in access to minimally invasive robotic hysterectomies, even when adjusted for surgical indications (Smith et. al., 2020). Nearly 10% of our surveyed respondents reported having either cervical cancer or a hysterectomy. Sexual orientation and gender identity demographics should be measured in local populations to determine whether these subgroups have adequate and equitable access to care, and to elucidate any intersectionality influencing current practices.

7.3 Mammograms/Breast Cancer Screening

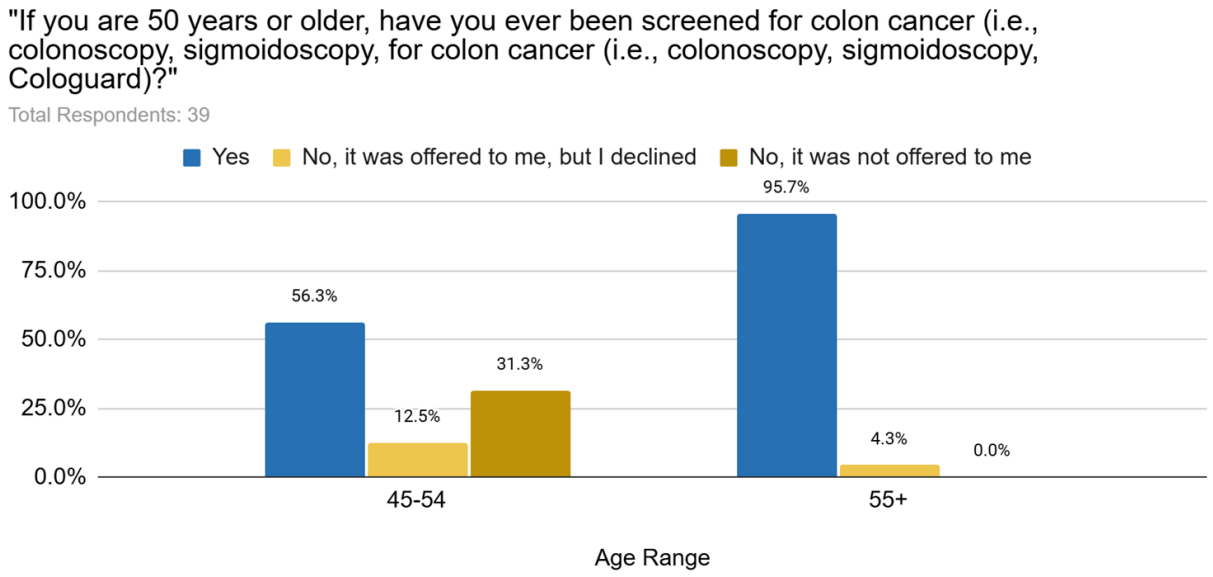


7.3.1 Breast Cancer Screening in the LGBTQ+ Population

Multiple studies have shown significant gaps in breast cancer screening for LGBTQIA+ women, particularly those who identify as lesbian. One of the major factors in this disparity is the fear of discrimination by healthcare providers (Heer et. al., 2023) This fear is even more pronounced in members of the transgender community, where there is still no official consensus regarding guidelines for breast cancer screening (Bradford et. al., 2013). Data is limited regarding rates of breast cancer in the transgender community, however, there are studies that suggest a need for regular breast cancer screening in transgender women taking hormone replacement therapy (Hartley et. al, 2018). One longitudinal study in the Netherlands found a 46.7% increased risk of breast cancer in transgender women undergoing hormone treatment when compared to cisgender men, (de Blok et. al, 2019) though this finding is not supported through an older systematic review (Hartley et. al, 2018).

Additionally, there is literature to suggest an elevated risk for breast cancer development in transgender males on hormonal androgen therapy compared to cisgender males (Clark et. al., 2022). The priority of this report is to emphasize the need for breast cancer screenings in all people with breasts, regardless of sex assigned at birth, to best support the LGBTQ+ population in accessing appropriate care. Our survey asked respondents aged 45 and older to report whether they had received a mammogram (if applicable) in the last 5 years. 71.4% of survey participants aged 55+ reported having received a mammogram compared to 54.5% of respondents aged 45-54. Among respondents in the higher age range, only 7.1% reported not being offered breast cancer screening, compared to 18.2% of participants aged 45-55. These discrepancies are likely the result of changing guidelines regarding the age in which breast cancer screening should begin, however, it is imperative that healthcare providers are cognizant to the needs of the LGBTQIA+ population regarding these sensitive screenings/exams.

7.4 Colonoscopies/Colon Cancer Screening



7.4.1 Colon Cancer Screening in the LGBTQ+ Population

There are very few studies that have evaluated the rate of colon cancer screening in the LGBTQ+ population. However, it is understood that transgender populations experience the same barriers to care as identified in the minority stress model. In this model, members of minority groups experience significant stress related to their past experiences of social stigma, discrimination, or denial of care (Brooks, 1981; Meyer, 2003). One study found that up to 41% of patients who are transgender report experiencing discrimination by a healthcare provider (Bradford et. al., 2013). Another study revealed that transgender women are far less likely to receive screening colonoscopies than either transgender men or cisgender patients (Kiran et al., 2019). Another study performed in a population average age of 45-63 and 98.1% insured individuals showed only 78.7% of individuals being recommended a colonoscopy or sigmoidoscopy, with individuals who had experienced discrimination being less likely to undergo the procedure (68.3% vs. 80.6%, p=0.03), particularly those who were assigned female at birth (Stenzel et al, 2024).

Among our survey respondents, 95.7% of participants aged 55 and over reported having been screened for colon cancer, whereas only 56.3% of those aged 45-54 reported having this screening. For those 55 and up, no respondents reported that they were not offered screening services; however, over 30% of participants aged 45-54 reported not having been offered colon cancer screening. There is a lack of data regarding rates of colon cancer screening among LGBTQ+ communities versus the general population. Our data shows the significant number of people in our population to whom screening has not been offered, which speaks to a need for greater awareness of colon cancer screening guidelines.

7.5 Anal Swab Tests/Anal Cancer Screening

"Have you ever had an Anal Swab test?"

Yes	14.3%
No	85.7%
Total Respondents	230

7.5.1 Anal Cancer Screening in the LGBTQ+ Population

Anal swab tests are routine cell-sampling techniques used to identify epithelial lesions associated with sexually transmitted diseases, such as HPV. Anal cancer incidence disproportionately affects MSM with HIV and a history of HPV, making screening for HIV and HPV in this population especially important (Clifford et. al., 2020). There are significant barriers to receiving anal swab tests to screen for HPV, and one of the most significant barriers is stigma and prejudice surrounding anal sex. A 2020 meta-analysis noted that although HIV-negative MSM are one of the largest risk groups for developing anal cancer, incidence is poorly characterized, largely because sexual orientation and gender identity information is often omitted from data collection efforts (Clifford et. al., 2020). Another study found that gay and bisexual men were more likely to delay their health care or conceal sexual practices - particularly when providers do not offer screening services (Kutner et. al., 2022). When healthcare providers fail to provide screening tests of any kind, the burden of seeking needed healthcare services is transferred to the patient in question. This transaction is particularly detrimental to people who are members of the LGBTQ+ population, where there is already a high degree of stigma associated with many vital healthcare services, such as screening for HPV/anal cancer.

7.5.2 Local Anal Cancer Screening Rates

Our data show that 85.7% of adult survey respondents reported that they had never received an anal swab test. According to guidelines established by the International Anal Neoplasia Society, screening for anal cancer can begin at:

- Age 35 for MSM and transgender women who have HIV,
- Age 45 for all MSM and transgender women regardless of HIV status, and all people with HIV
- 10 years post-transplant for transplant recipients
- Within 1 year of diagnosis of vulvar cancer/pre cancer
- Age 45+, utilizing shared decision making, for persons with a history of cervical/vaginal cancer/precancerous lesions, cervical HPV16, or autoimmune conditions (Stier et al., 2024)

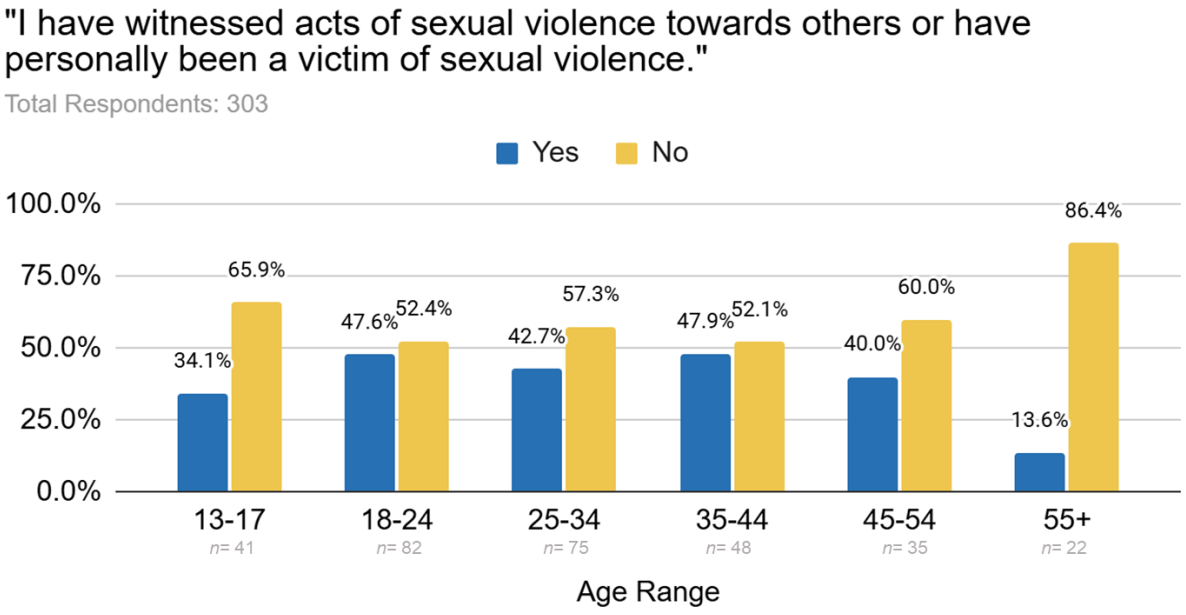
Therefore, the lack of respondents who had received an anal swab test could be attributed to fewer respondents over the age of 35 who met the above criteria. Nevertheless, it is the responsibility of physicians and healthcare providers to interact in ways that builds rapport and encourage a strong patient-provider relationship. It falls to the provider to ensure that a complete and accurate history is taken - including sexual history and practices - so that patients can receive screening in accordance with existing guidelines.

8.0 Sexual Violence Witnessed and/or Experienced

Sexual violence is unfortunately all too common, with approximately 17% of women and 3% of men reporting having been subject to attempted or completed rape (Tjaden, 2000). A California study reported that LGBTQIA+ women in adolescence through young adulthood have higher odds of experiencing verbal sexual harassment, homo/transphobic slurs, coercion, physical aggression, and forced sex with odds ratios ranging from 1.74 to 21.26 (Inwards-Breland et. al., 2022). Lifetime prevalence of sexual violence by an intimate partner has been reported in 29.8% of heterosexual women, 55.1% in bisexual women, 49.3% in heterosexual men, and 59.6% in gay men (Walters et. al., 2013). Notably, the National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Sexual Violence did not list LGBTQIA+ demographics (Basile et al., 2022).

Given the prevalence of sexual violence, particularly among LGBTQIA+ people, it is vital to collect data regarding this issue in assessments of population health. Over 40% of our survey respondents reported that they had either witnessed sexual violence or experienced it themselves, but only 24.6% of these individuals were able to gain access to support and/or legal services. Including measurements such as the ones shown below in community health needs assessments for Southwest Alabama will highlight the need to increase services to combat these issues and provide support for survivors.

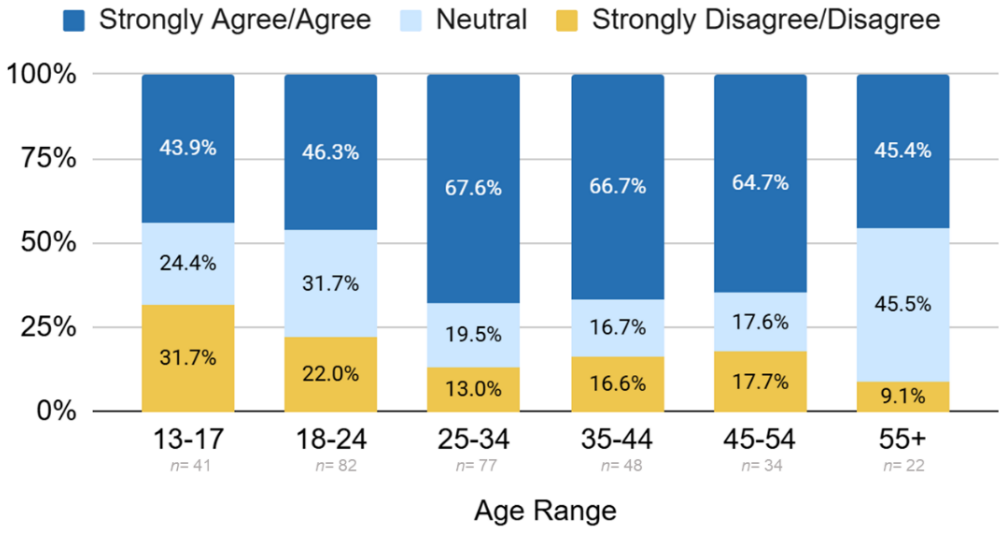
8.1 Sexual Violence Witnesses/Experienced



8.2 Support System in Response to Violence

"If I were to witness an act of sexual violence towards others or experience an act of sexual violence towards myself, I feel confident that I would have access to an adequate support system."

Total Respondents: 304

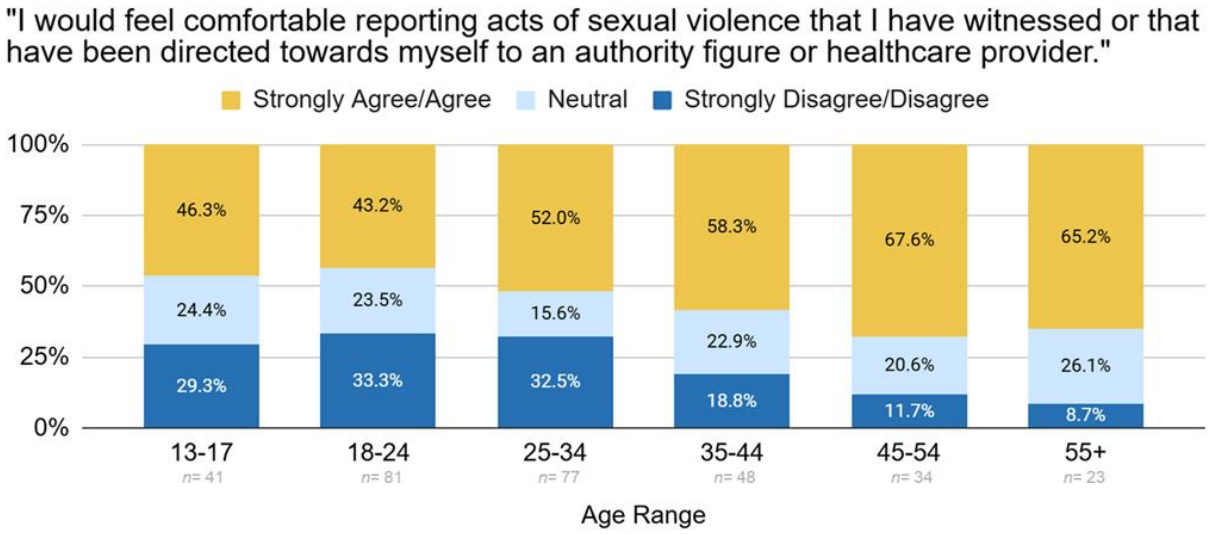


8.3 Reported Acts of Violence

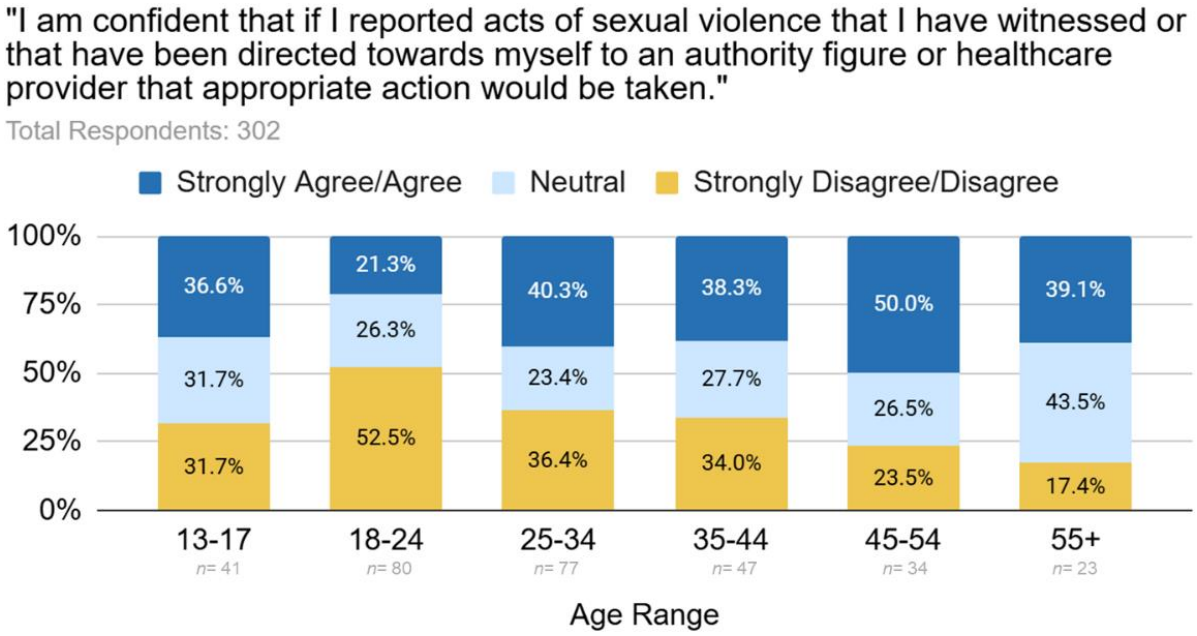
"I have reported acts of sexual violence in the past that I have witnessed or that have been directed towards myself to an authority figure or healthcare provider."

Yes	32.0%
No	68.0%
Total Respondents	125

8.4 Comfort in Reporting Sexual Violence



8.5 Confidence That Authority Figures Would Take Appropriate Action



8.6 Access to Support Services

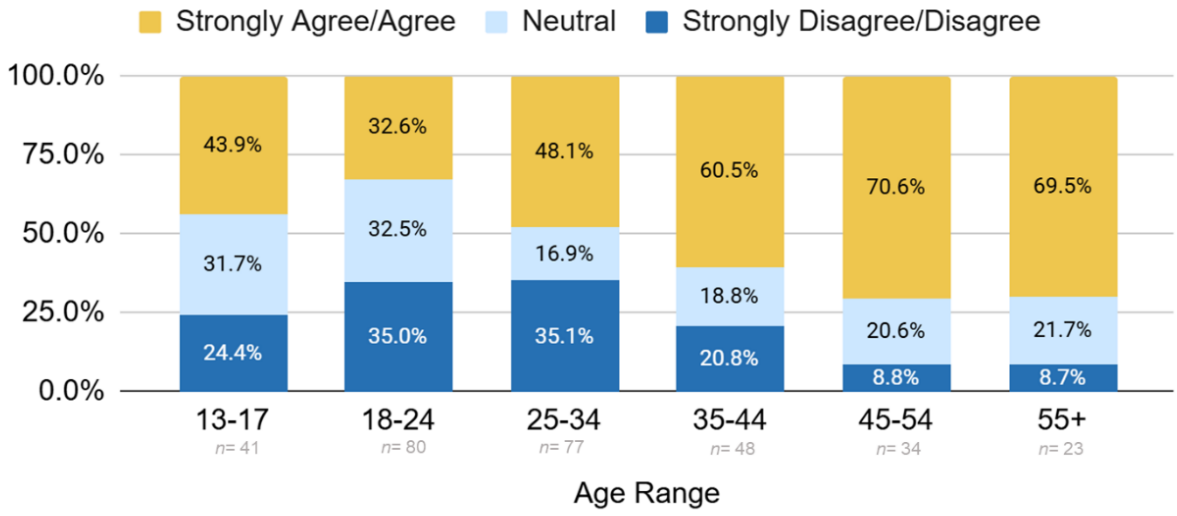
"I have successfully gained access to support and/or legal services in response to acts of sexual violence in the past that I have witnessed or that have been directed towards myself."

Yes	24.6%
No	75.4%
Total Respondents	122

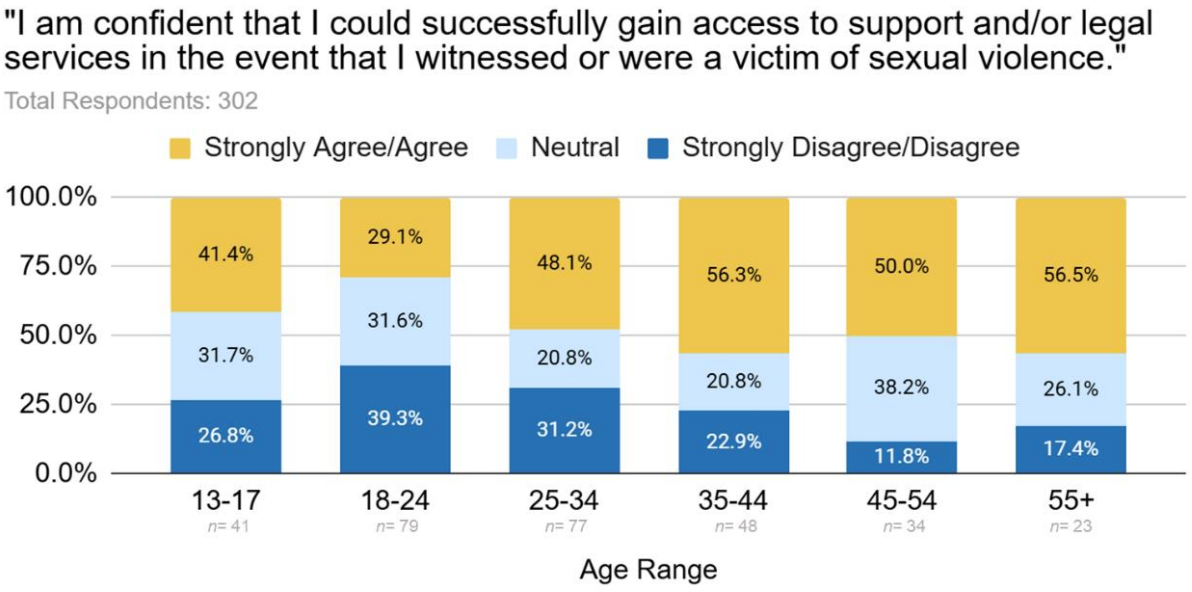
8.7 Comfort Reaching Out for Support/Legal Services

"I would feel comfortable reaching out to an authority figure or healthcare provider for support and/or resources to obtain legal services in the event that I witnessed or were a victim of sexual violence."

Total Respondents: 303



8.8 Confidence in Ability to Access Support/Legal Services



9.0 Mental Health

It is well-documented that LGBTQ+ individuals experience mental health disparities compared to the general population (Hatzenbuehler et al., 2009a; Mustanski et al., 2010; Russell & Fish, 2016; Garcia-Perez, 2020; Depa et al., 2022; Meyer et al., 2004, 2007, 2008, 2021). The Minority Stress Model explains that these disparities are the result of experiencing stressors over and above those of the general population as a function of living within social systems that categorically ascribe inferior social status to individuals based on sexual orientation and gender identity (Brooks, 1981; Meyer, 1993, 2004). As such, we anticipated high endorsement rates of items reflecting mental health distress within our survey population. This expectation was borne out in the results, which indicated notably high rates of mental health distress across multiple survey measures.

We asked members of the LGBTQ+ community in southwest Alabama questions pertaining to mental health and well-being. When asked "During the past 30 days, how often did you experience stress, anxiety, or depression?", 50% of survey participants answered either "most of the time" or "always." In the adolescent (13-17) and young adult (18-24) age groups, the percentage reporting near-daily psychological distress was over 60% of all study participants.

Our data also show that 78% of all participants, at some point in the preceding 12 months, felt "so nervous, anxious, or on edge" that they found it hard to stop worrying or had an anxiety attack, with 87% of adolescents aged 13-17 answering "yes" to this question. This trend is consistent across age groups, as 81% of 18–24-year-olds, 79% of 25–34-year-olds, and 86% of 35–44-year-olds also agreed with this statement. The only age group to fall below 50% for a positive response to this question is the 55 and older group, 42% of whom reported severe anxiety symptoms in the previous year.

When asked if they had seriously considered suicide in the previous 12 months, 30% of all participants answered "yes." When stratified by age, our results show that suicidal thoughts/ideation were most prevalent in the 13-17 age group, with over 50% of adolescents surveyed reporting that they had seriously considered suicide in the last year. Of the participants who reported suicidality, 16% made a suicide attempt in the last year. Adolescents had the highest percentage of suicide attempts, with 34% of participants aged 13-17 reporting at least one suicide attempt in the preceding 12 months. Even more staggering, of the adolescents who reported suicide attempts, 11 of these children reported attempting suicide more than once. Of the adults who attempted suicide, 22 participants reported more than one attempt.

It is important to note that these data do not represent the prevalence of mental illness in our study participants. Our results should not be used to draw conclusions about the number of LGBTQ+ people in Southwest Alabama who have a clinically significant mental illness; however, the responses to these questions highlight the significant percentages of LGBTQIA+ people in our region who are at a higher risk for having or developing clinical depression or anxiety. Our results should be used to inform healthcare providers, policy makers, and organizational leaders about the great need for LGBTQ+ inclusive mental healthcare in southwest Alabama.

The Substance Abuse and Mental Health Services Administration conducted a health survey for adults who identify as lesbian, gay, or bisexual (LGB). They found that the prevalence of serious mental illness was 24.2% among LGB adults aged 18-25 and 19.2% in LGB adults aged 26-49 (Substance Abuse and Mental Health Services Administration, 2020). For adults aged 50 and older, the prevalence drops to 5.6%, however, in total, this study reports that there are over 2 million LGB adults in the US with a serious mental illness. The same study reports incidence of a major depressive episode among LGB young adults in the 18-25 age range at 33.1%, decreasing to 22.1% for ages 26-49 and 12.5% for those over 50. For LGB adults ages 18-25, 27.9% reported serious thoughts of suicide, with 5.5% having

attempted in the preceding year. The 26-49 age group reported 14.5% experiencing suicidal thoughts, with 2.2% having attempted suicide (Substance Abuse and Mental Health Services Administration, 2020).

The Substance Abuse and Mental Health Services Administration's (SAMHSA) inquiry into the mental health of LGB adults is illustrative, but it leaves out a very important subset of the LGBTQIA+ population: those who identify as transgender. In a study that examined records from an electronic health record database containing 60 million patients from more than two dozen U.S. health care systems, they examined the prevalence of mental health disorders in transgender adults. They found that the prevalence of major depressive disorder and anxiety disorders (including generalized anxiety disorders as well as panic disorders and specific phobias) were both above 30% among their LGBTQ+ study participants, while prevalences in the general population were 4.8% and 6%, respectively (Wanta et. al., 2019).

In a separate study focused on the experiences of transgender adolescents and young adults, published in the Journal of Adolescent Health, researchers analyzed responses from a survey that included over 25,000 LGBTQ+ people ages 13-24. This study found that 61.7% of transgender males and 51.8% of transgender females had seriously considered suicide, compared to 25.3% of cisgender males and 37.9% of cisgender females. Similarly, this study reports that 34.7% of transgender males and 27% of transgender females have attempted suicide, compared to 18.4% and 16.8% among their cisgender counterparts (Price-Feeney et. al., 2019)

Given the above results summarized from several, much larger studies compiled from data that spans the United States, it is worth noting that our data collected from LGBTQ+ individuals living in southwest Alabama (although it cannot be directly compared to those listed in the aforementioned reports) is thematically consistent with that of these much larger studies. Indeed, our data suggest that LGBTQ+ people in our region may, in fact, experience higher rates of psychological disturbances and mental health crises than LGBTQIA+ people living in other parts of the country.

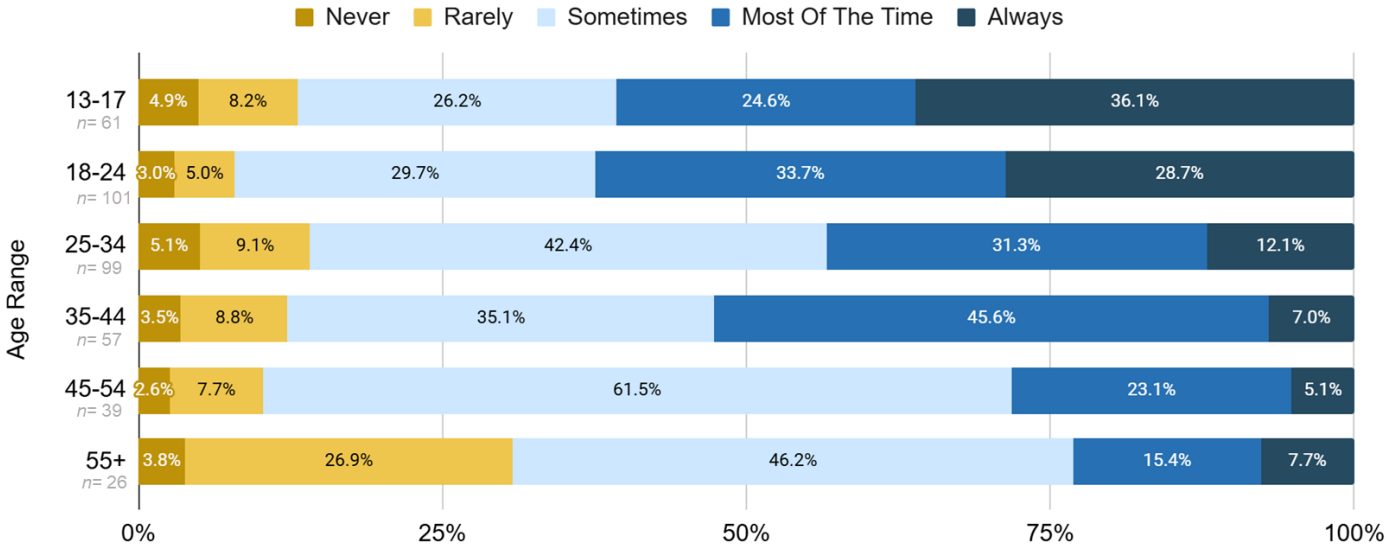
It is important to note the large difference in prevalence of mental illness and psychological distress among members of the LGBTQ+ community, both here in southwest Alabama and in the United States as a whole, when compared to the prevalence of similar issues in the general population. The 2020 National Survey on Drug Use and Health reported that in adults in the US aged 18 and older, the prevalence of serious mental illness in the preceding year was only 5.6%. When asked about suicidality, 4.9% of surveyed adults reported experiencing serious thoughts of suicide in the last year, with only 0.5% having attempted suicide (Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2021).

It is clear from examining the available data regarding mental health in the LGBTQIA+ population as well as the general population that there is a great need for resources and access to these resources for both adolescents and adults who identify as LGBTQ+. When compared to the general population, LGBTQ+ people experience more psychological distress, up to and including attempted suicide, than their straight, cisgender counterparts. Our data show LGBTQIA+ people living in southwest Alabama reported rates of depressed mood, anxiety, and suicidality at rates higher than available national data for the LGBT+ community, highlighting the urgent need for greater availability of mental health services for LGBTQ+ people in Southwest Alabama.

9.1 Screening for Stress, Anxiety, and Depression

"During the past 30 days, how often did you experience stress, anxiety, or depression?"

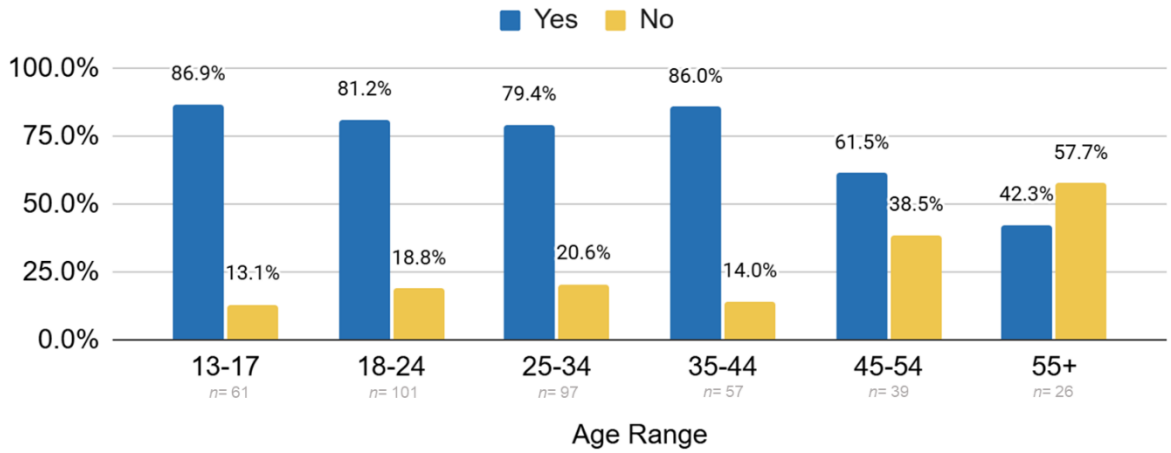
Total Respondents: 383



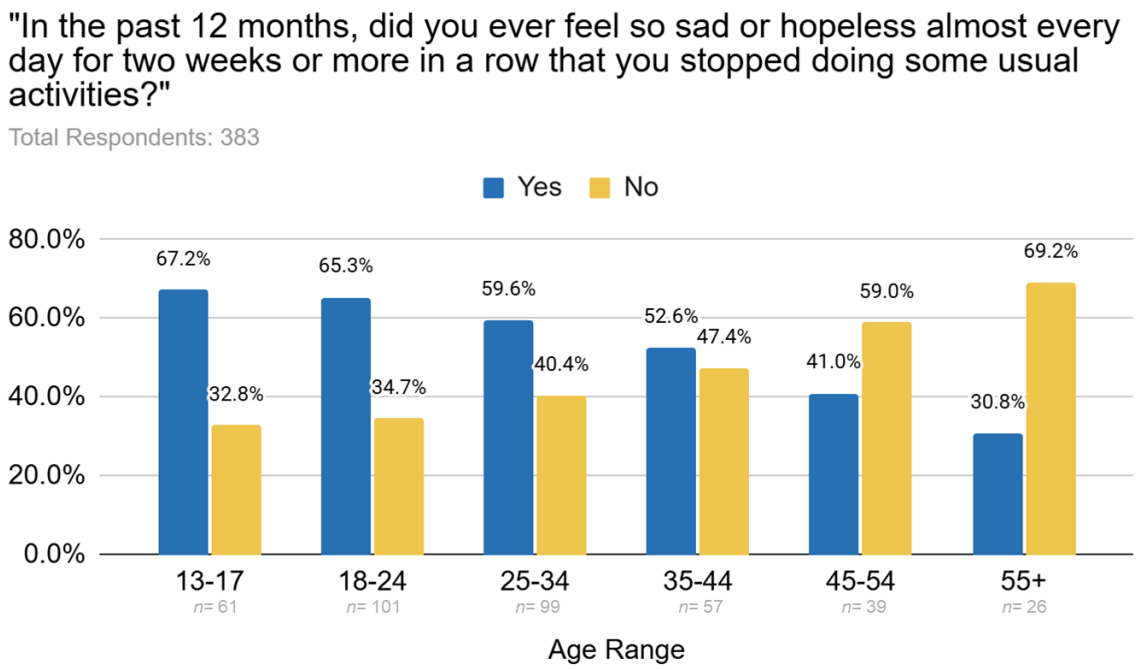
9.2 Screening for Anxiety

"In the past 12 months, did you ever feel so nervous, anxious, or on edge that you found it hard to stop worrying or had an anxiety attack?"

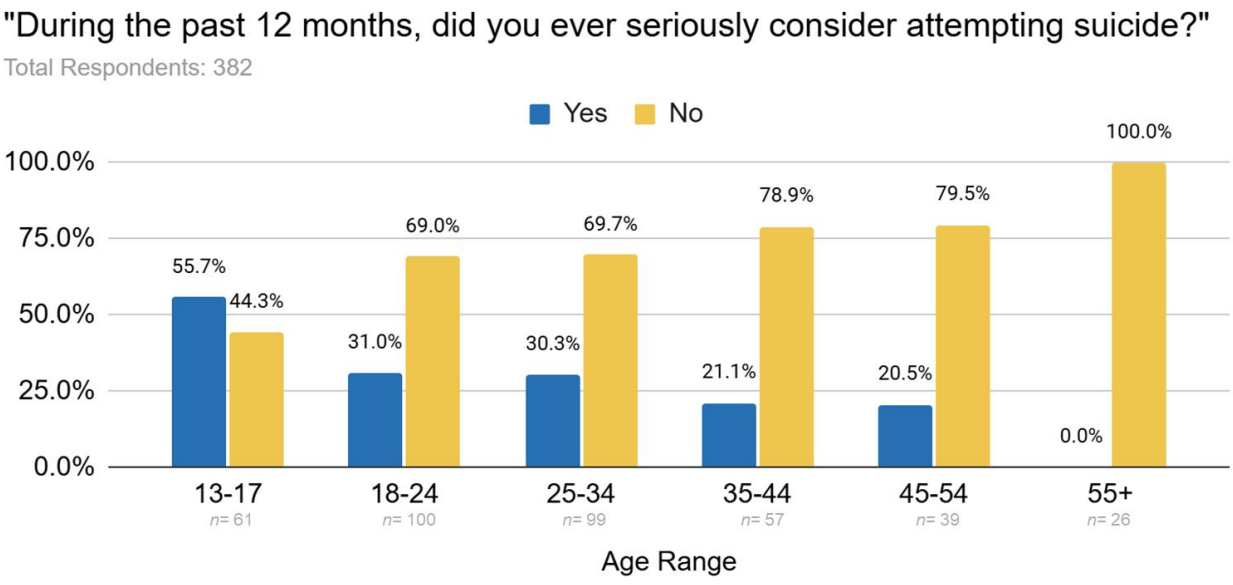
Total Respondents: 381



9.3 Screening for Depression



9.4 Respondents Who Considered Suicide in the Preceding Year

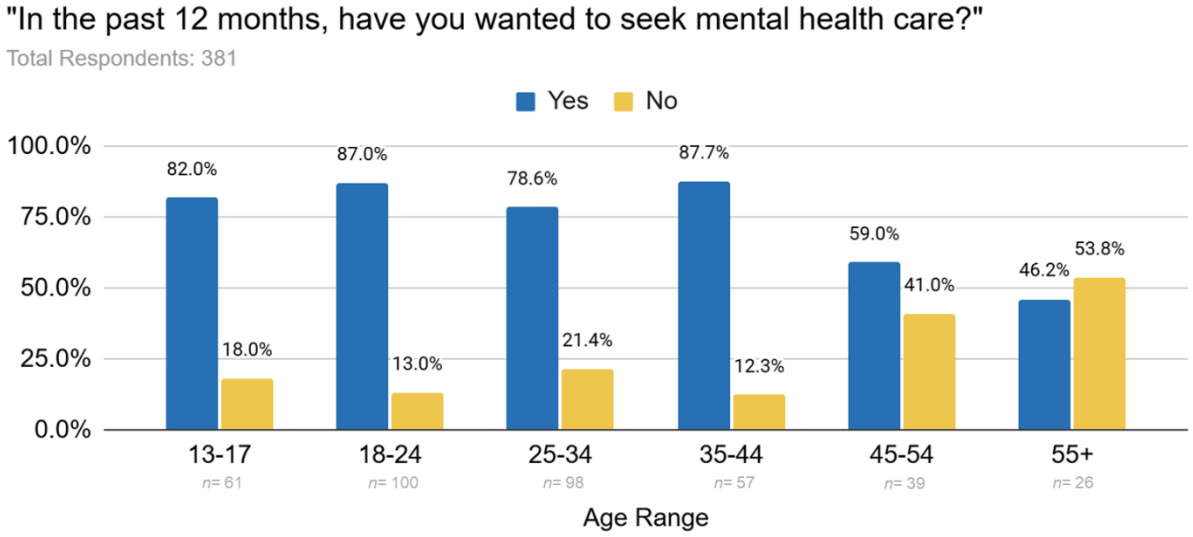


9.5 Respondents Who Attempted Suicide

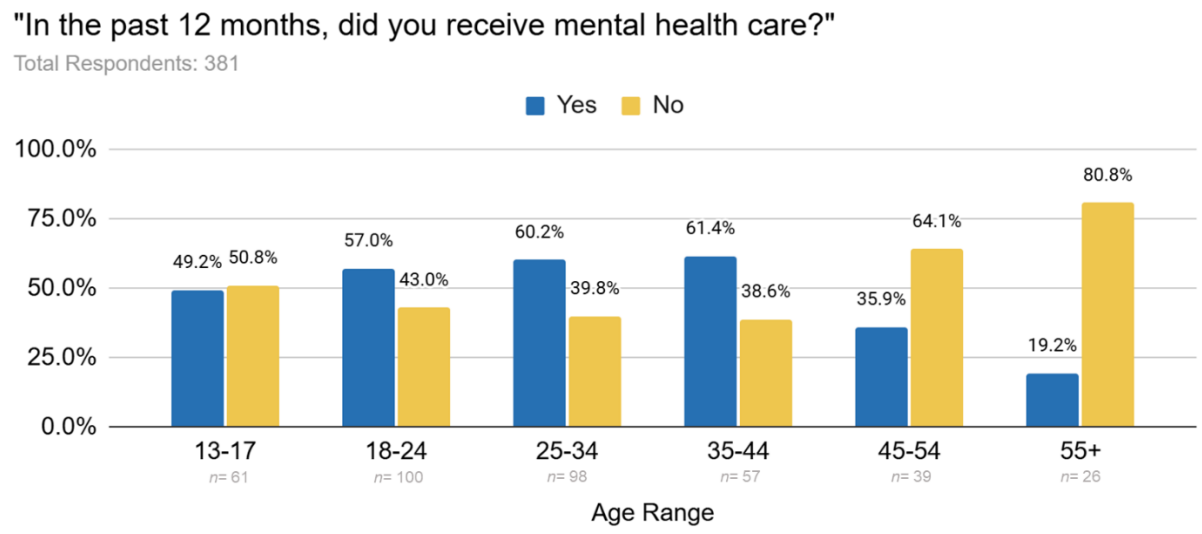
"During the past 12 months, how many times did you actually attempt suicide?"

		Age Range						
		13-17	18-24	25-34	35-44	45-54	55+	Total
Suicide Attempts	0 Times	40	79	86	53	37	26	321
	1 time	10	13	3	1	2	0	29
	2-3 times	11	7	8	2	0	0	28
	4-5 times	0	2	2	1	0	0	5
							Total	383

9.6 Respondents Who Wanted to Seek Mental Healthcare



9.7 Respondents Who Received Mental Healthcare



10.0 Implications and Recommendations

Key Implications

- **Provider Preparedness:** Gaps in knowledge and confidence regarding preventive screenings, mental health, and HIV/STI prevention may contribute to delayed or missed care.
- **Preventive Care Utilization:** Inconsistent screening practices increase the risk of late diagnoses for chronic, infectious, and behavioral health concerns.
- **Mental Health Needs:** High levels of distress and suicidality, particularly among adolescents, highlight the need for early identification and intervention.
- **Clinical Environment:** Patient trust and open communication are strongly influenced by privacy protections, respectful interactions, and supportive staff practices.
- **Access Barriers:** Cost, insurance limitations, and rural geography remain significant obstacles to timely and consistent care.

Recommendations for Healthcare Education

1. **Curriculum Integration:** Incorporate training on the skills of patient-centered communication, preventive screening, respectful care, and interprofessional/team capability to address health disparities into medical and health sciences programs.
2. **Ongoing Professional Development:** Provide continuing education on evidence-based screening protocols, mental health assessment, strategies for improving patient-provider trust, and interprofessional competence.
3. **Data Collection Skills:** Train healthcare learners and providers in accurate, confidential collection of demographic and health data to support improved service delivery.

Recommendations for Healthcare Practice

1. **Standardize Preventive Protocols:** Apply consistent screening for HIV/STIs, cancer, substance use, and mental health following national guidelines.
2. **Enhance Privacy and Respect:** Ensure confidential opportunities for patients to share sensitive information; adopt workflows that reinforce respectful communication.
3. **Expand Access:** Leverage telehealth, mobile clinics, and community partnerships to reach underserved and rural populations.
4. **Integrate Mental Health:** Use brief screening tools during routine care and establish clear referral pathways to affordable, respectful mental health services.
5. **Engage Communities:** Collaborate with schools, nonprofits, community groups, and local organizations to increase awareness of available services and preventive care resources.

Appendix A: Survey Tool

In this section, we will ask you about your health and healthcare experiences. This information will be used to improve healthcare services and knowledge of healthcare providers in our community.

Content Warning: Sexual activity, safe sex practices, sexual violence/rape

Do you wish to answer questions about your health and healthcare experiences?

a) Yes, I'll answer
b) No, I'll skip this section because it might be stressful or uncomfortable
c) No, I'll skip these sections because of another reason

---

1. How would you rate your health in general?
    a. Excellent
    b. Very Good
    c. Good
    d. Fair
    e. Poor
    f. Don't Know/Not Sure
    g. Prefer Not to Say

2. Do you have a primary care provider?
    a. Yes
    b. No
    c. I don't know

3. Do you have a primary care provider?
    a. Yes
    b. No
    c. I don't know

4. About how long has it been since you last visited a medical provider for a routine checkup?
    a. Within the past year
    b. Within the past 2 years
    c. Within the past 5 years
    d. 5 or more years ago
    e. Never
    f. Don't know/Not sure

5. What was the reason for your visit?
    a. I was sick and needed care
    b. I had a question about my health
    c. Someone else thought I needed medical help
    d. I felt unsafe at home or in my relationship
    e. Any other reason

6. Have you ever delayed getting medical care that you needed?
    a. Yes
    b. No

7. What was the reason for the delay in care?
    a. I did not know where to go
    b. I did not know any place where I felt comfortable
    c. I didn't think doctors knew how to help me
    d. I don't trust doctors
    e. I did not know if I could afford it
    f. I could not get transportation

8. Clinic office staff, medical providers, or nurses are friendly and supportive.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

9. I trusted and felt respect from medical providers, office staff, or nurses.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

10. The medical office helped me with my concerns.
    a. Yes
    b. No

11. My medical provider asks me about HIV/STI testing at every appointment.
    a. Yes
    b. No

12. Medical providers and nurses knew the answers to my questions related to LGBTQ+ health.
    a. Yes
    b. No

13. Medical providers and nurses called me by my chosen name and pronouns.
    a. Yes
    b. No
    c. Not applicable

14. Medical providers and nurses refused to give me the treatment that I wanted.
    a. Yes
    b. No
    c. Not applicable

15. I could not speak honestly because I was not alone with my medical provider.
    a. Yes
    b. No
    c. Not applicable

16. My partner was not allowed in the room with me.
    a. Yes
    b. No
    c. Not applicable

17. Medical providers or nurses did not treat my partner like a family member.
    a. Yes
    b. No
    c. Not applicable

18. I had to explain parts of my history or medical care because the medical provider did not understand.
    a. Yes
    b. No
    c. Not applicable

19. Medical provider or nurse knew my gender identity or sexual orientation.
    a. Yes
    b. No
    c. Not applicable

20. My medical providers had appropriate knowledge of LGBTQ+ related healthcare needs.
    a. Yes
    b. No

21. In the past 12 months, has a medical provider, nurse, or other health professional:
    a. Asked you how much and how often you drink alcohol?
    b. Asked if you ever smoked or used tobacco?
    c. Asked you about your mood, such as whether you were anxious or depressed?

22. Have you had a hysterectomy, or have you ever had cervical cancer?
    a. Yes
    b. No

23. Within the past 5 years, have you had a cervical pap test? (A pap smear or a pap test is a routine test in which the medical provider takes a cell sample from the cervix with a small stick or brush and sends it to the lab.)
    a. Yes
    b. No

24. Have you ever had an Anal Swab test? (An Anal Swab or Anal Pap Smear is a routine test in which the medical provider takes a cell sample from the anus with a small stick or brush, and sends it to the lab.)
    a. Yes
    b. No

25. Approximately how old were you the last time you had a swab/pap test?
    [open response field]

26. Have you ever had an HIV test?
    a. Yes
    b. No. It was offered to me, but I declined.
    c. No, it was not offered to me
    d. Not applicable

27. When was your most recent HIV/STI test?
    a. Within the past 3 months
    b. Between 3 and 6 months ago
    c. Between 6 months and a year ago
    d. Only after an unprotected sex encounter

28. If you tested positive for HIV, did you receive treatment?
    a. Yes. I was referred to HIV treatment upon diagnosis
    b. Yes. I south treatment on my own
    c. No. It was offered to me, but I declined.
    d. No. It was not offered to me.
    e. Not applicable.

29. If you take medications for the treatment of HIV, have you ever skipped a dose or stopped treatment?
    a. Yes
    b. No
    c. Not applicable

30. If yes, why? (select all that apply)
    a. The treatment was too expensive.
    b. I did not like the side effects.
    c. My partner convinced me to stop my treatment.
    d. I was concerned about the stigma.
    e. I did not have health insurance.
    f. I did not want anyone to find out about the diagnosis.
    g. I lost my job.
    h. I became houseless.
    i. I lost my primary care provider.
    j. I was no longer eligible for treatment assistance programs (ex. Ryan White Program)
    k. Other – Please specify

31. Are you aware of Pre-Exposure Prophylaxis (PrEP), a medication that can significantly reduce the likelihood of transmission of HIV to people who are HIV Negative?
    a. Yes
    b. No

32. Do you know how to get Pre-Exposure Prophylaxis (PrEP) locally, should you need it?
    a. Yes
    b. No

33. Are you aware of Post Exposure Prophylaxis (PEP), a medication that can significantly reduce the likelihood of transmission of HIV to people who are HIV Negative?
    a. Yes
    b. No

34. Do you know how to get Post Exposure Prophylaxis (PEP) locally, should you need it?
    a. Yes
    b. No

35. I feel comfortable asking my sexual partner(s) about sexual health, including approaches to safe sex practices and treatment of HIV/STIs.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

36. If you are 50 years or older, have you had both breasts removed or have you ever had breast cancer?
    a. Yes
    b. No

37. Within the past 2 years, have you had a mammogram or other breast cancer screening test? A mammogram is an x-ray taken of only the breast by a machine that presses against the breast.
    a. Yes
    b. No. It was offered to me, but I declined
    c. No. It was not offered to me
    d. Not applicable

38. If you are 50 years or older, have you ever been screened for colon cancer (i.e. colonoscopy, sigmoidoscopy, Cologuard)?
    a. Yes
    b. No. It was offered to me, but I declined.
    c. No. It was not offered to me
    d. Not sure

39. In preventing pregnancy/STIs/HIV, I consider condoms to be:
    a. Effective
    b. Not effective
    c. I don't know

40. Has a nurse, medical provider, or other medical professional ever discussed ways to prevent the transmission of STIs/HIV that align with your sexual orientation and sexual practices?
    a. Yes
    b. No

41. If someone I was sexually active with had an STI or HIV/AIDS, I would know it.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

42. STIs or HIV/AIS can only be spread when symptoms are present.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

43. Unless you have sex with a lot of people, STIs or HIV/AIDS are not something you have to worry about.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

44. In my area, HIV, STI, and pregnancy prevention services are:
    a. Very accessible
    b. Somewhat accessible
    c. Neither accessible nor inaccessible
    d. Somewhat inaccessible
    e. Very inaccessible

45. What barriers do you have in accessing HIV, STI, and pregnancy prevention services?
    a. Cost
    b. Location/Transportation
    c. Unsure where to receive services
    d. Unsure how to ask provider for services
    e. Stigma/discrimination from current provider
    f. Stigma from my family
    g. No barriers

46. If needed or desired, I know how to access resources to effectively prevent STIs/HIV/pregnancy.
    a. Yes
    b. No
47. I have witnessed acts of sexual violence towards others or have personally been a victim of sexual violence.
    a. Yes
    b. No

48. If I were to witness an act of sexual violence toward others or experience an act of sexual violence toward myself, I feel confident that I would have access to an adequate support system.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

49. If I were to witness an act of sexual violence toward others or experience an act of sexual violence toward myself, I feel confident that I would be able to access legal services.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

50. I have reported acts of sexual violence in the past that I have witnessed or that have been directed toward myself to an authority figure or healthcare provider.
    a. Yes
    b. No

51. I would feel comfortable reporting acts of sexual violence in the past that I have witnessed or that have been directed toward myself to an authority figure or healthcare provider.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

52. I am confident that if I reported acts of sexual violence in the past that I have witnessed or that have been directed toward myself to an authority figure or healthcare provider that appropriate action would be taken.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

53. I have successfully gained access to support and/or legal services in response to acts of violence in the past that I have witnessed or that have been directed toward myself.
    a. Yes
    b. No

54. I would feel comfortable reaching out to an authority figure or healthcare provider for support and/or resource to obtain legal services in the event that I witness or were a victim of sexual violence.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

55. I am confident that I could successfully gain access to support and/or legal services in the event that I witnessed or were a victim of sexual violence.
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

In this section, we will ask you about your recent mental health experiences. This information will be used to improve mental health in our community.

Content Warning: Depression, anxiety, suicide

Do you wish to answer questions about your mental health?

a) Yes, I'll answer
b) No, I'll skip this section because it might be stressful or uncomfortable
c) No, I'll skip these sections because of another reason

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1. During the past 30 days, how often did you experience stress, anxiety, or depression?
    a. Never
    b. Rarely
    c. Sometimes
    d. Most of the time
    e. Always

2. In the past 12 months, did you ever feel so nervous, anxious, or on edge that you found it hard to stop worrying or had an anxiety attack?
    a. Yes
    b. No

3. In the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?
    a. Yes
    b. No

4. During the past 12 months, did you ever seriously consider attempting suicide?
    a. Yes
    b. No

5. During the past 12 months, how many times did you actually attempt suicide?
    a. 0
    b. 1 time
    c. 2 -3 times
    d. 4-5 times
    e. 6+ times

6. In the past 12 months, have you wanted to seek mental health care?
    a. Yes
    b. No

7. In the past 12 months, did you receive mental health care?
    a. Yes
    b. No

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