



MIDLANDS SEXUAL HEALTH
RESEARCH COLLABORATIVE

THE MIDLANDS LGBTQ+ HEALTH SURVEY

COMMUNITY REPORT

FALL 2021

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Table of Contents

1. Acknowledgements.....	3
2. Executive Summary	4
3. Participant Characteristics	6
4. Social Health.....	14
5. Physical Health	21
6. Mental Health.....	26
7. STIs and HIV	31
8. Healthcare Access and Experiences.....	34
9. Transgender Experiences and Health	40
10. Pregnancy Experiences	47
11. Conclusions and Recommendations.....	50
12. Appendix A: Gender Identity Coding Strategy	52
13. References	53

1. Acknowledgements

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2. Executive Summary

The Midlands Sexual Health Research Collaborative (MSHRC) at the University of Nebraska at Omaha (UNO) surveyed LGBTQ+ (lesbian, gay, bisexual, transgender, queer, and other sexual and gender minoritized) individuals in Nebraska about their health-related needs and outcomes during the summer and fall of 2019. This survey, built upon [a similar survey that was conducted by MSHRC in 2011](#), intended to collect descriptive data on the physical, mental, social, and sexual health of LGBTQ+ Nebraskans. The survey consisted of up to 163 closed-ended questions and 10 open-ended questions. Transgender participants received an additional 14 close-ended questions. Survey questions addressed personal experiences as well as structural issues around access to health care, experiences with discrimination and violence, and community empowerment.

Participant Characteristics

Of the 707 individuals who responded to the study, 619 individuals completed the survey and were included in the results presented in this report. The sample was diverse in terms of gender and sexuality. About 20% of participants in this study identified as transgender, with a range of gender identities under the transgender umbrella. The ages of participants ranged from 19 to 79 years, with an average participant age of 34 and the largest age group being 19-29 years old. The sample was less diverse in terms of race, with 88% of participants identifying as white, 3% identifying as Black or African American, 1% identifying as Asian, and 6% identifying as Biracial or Multiracial. Additionally, 6% of participants identified as Hispanic. This racial make-up is similar to the racial make-up of Nebraska.¹

Social Health

Survey participants reported a wide range of social difficulties. Specifically, experiences of violence, assault, and discrimination were very common among participants. Sixty percent of participants that reported that they had experienced multiple types of violence in their lifetime, 30% of participants reported experiencing some type of assault in the last year, and 53% reported experiencing some type of discrimination in the last year. Participants also reported low levels of self-acceptance and interpersonal support. Across various measures, transgender participants and participants of color reported lower levels of social health than their white, cisgender peers. While negative social experiences were common, participants also reported positive social experiences, such as being out to most of the people in their lives.

Physical and Mental Health

The survey sought to better understand the physical and mental health of LGBTQ+ Nebraskans, as well as the struggles that individuals faced with these aspects of their health. Most participants (78%) rated their health as good, very good, or excellent. However, more than half of participants also reported that they had been diagnosed with a physical health condition, most commonly: autoimmune conditions, migraines, and hypertension. Similarly, over half of the sample reported being diagnosed with at least one mental health condition, with over half of participants reporting that they had been diagnosed with depression or anxiety. These findings illustrate the significant physical and mental health challenges that participants faced.

However, these adversities were not experienced equally within the LGBTQ+ community. Transgender participants had more poor mental health days, were more likely to have a mental health diagnosis, and were more likely to have engaged in self-harming behavior than cisgender participants. Additionally, transgender participants were more likely to have attempted suicide than cisgender participants. Some of these mental health adversities were mitigated, at least somewhat, when transgender participants had taken steps to transition. Accessing gender affirming hormone therapy, surgeries, and mental healthcare positively impacted mental health among participants: 90% of individuals who had taken gender affirming hormones, 100% of individuals who had accessed gender affirming surgeries, and 85% of individuals who had accessed mental healthcare reported that these services had improved their mental health.

Healthcare Access and Insurance

Most participants had access to healthcare coverage, but many participants still faced barriers in accessing healthcare services. More than 80% of participants reported having some kind of health insurance. However, almost half of participants had not had a check-up in the past year and about 40% of participants reported that there had been a time in the last year when they needed to see a doctor but could not because of cost. Additionally, nearly two-thirds of participants reported that they had not been tested for sexually transmitted infections (STIs) in the last year and more than a quarter of participants had never been tested for human immunodeficiency virus (HIV).

Again, access to healthcare and health insurance were not equal across all groups in this study. There was a significant disparity in healthcare coverage for transgender women, with 25% of trans women reporting that they had no healthcare coverage while less than 10% of cis men, cis women and trans men reported the same. Additionally, rural participants were significantly less likely to have healthcare coverage than urban participants. Participants who were transgender, low income, younger adults, and people of color were more likely to report cost as a barrier to seeing a doctor. Transgender participants were also much less likely to have accessed routine healthcare in the past five years. Low-income participants and participants under the age of 29 were less likely to have been tested for HIV than their higher-income and older counterparts. Cisgender and transgender men were most likely to have been tested for HIV. Lack of access to health insurance and healthcare for multiply marginalized participants in our study are particularly troubling given the prevalence of challenges with mental, social, and physical health reported by these groups.

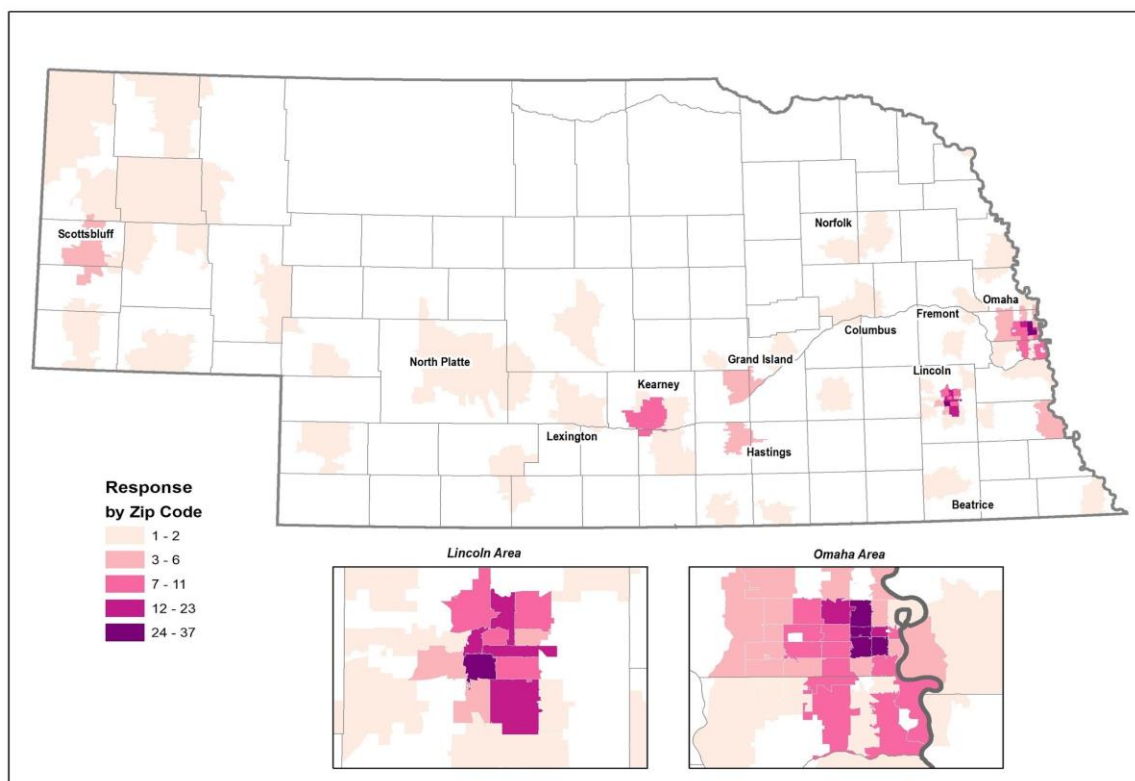
Conclusions

Overall, results from this survey illustrate that LGBTQ+ Nebraskans face a number of challenges in terms of their physical, social, mental, and sexual health. These challenges impact LGBTQ+ Nebraskans' ability to flourish and impose the need for individual and community resilience. Interventions at multiple levels are needed to address and alleviate these challenges and ensure that all Nebraskans are able to thrive.

3. Participant Characteristics

While there is a growing body of literature on the health and wellbeing of LGBTQ+ individuals, most comes from studies in densely populated urban areas, largely on the east and west coasts of the United States. The hidden nature of this community creates unique methodological difficulties in social science research. In this study, MSHRC collected data from a diverse sample of LGBTQ+ individuals living, working, and spending considerable time in Nebraska. MSHRC engaged in multiple recruitment strategies, including social media advertisements, fliers, and handouts posted both in person in queer-friendly spaces and virtually via list-servs and community organizations. Recruitment materials were also distributed at community events such as local pride festivals. This chapter summarizes the demographic information of the study participants.

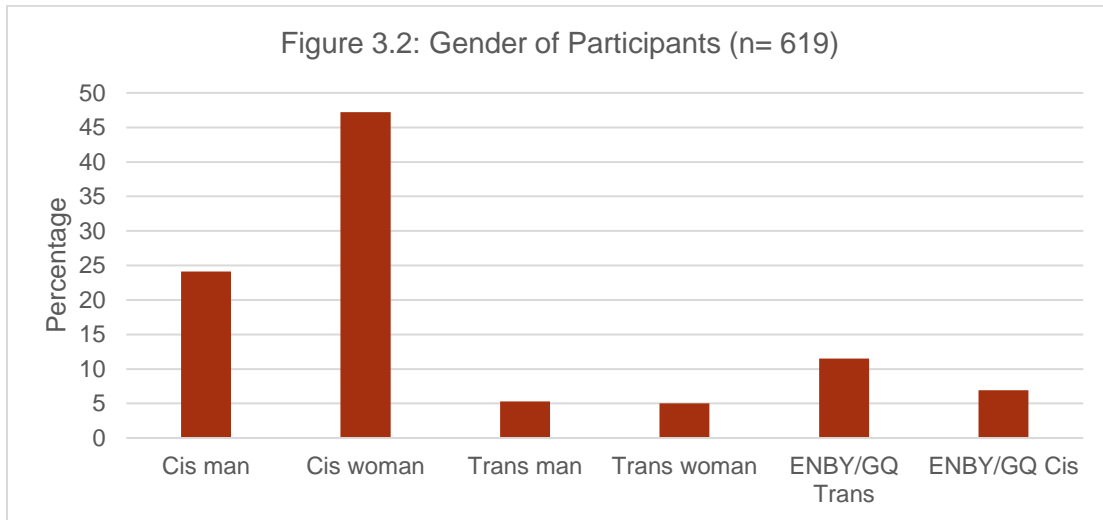
Figure 3.1: Geographical Distribution of Survey Participants



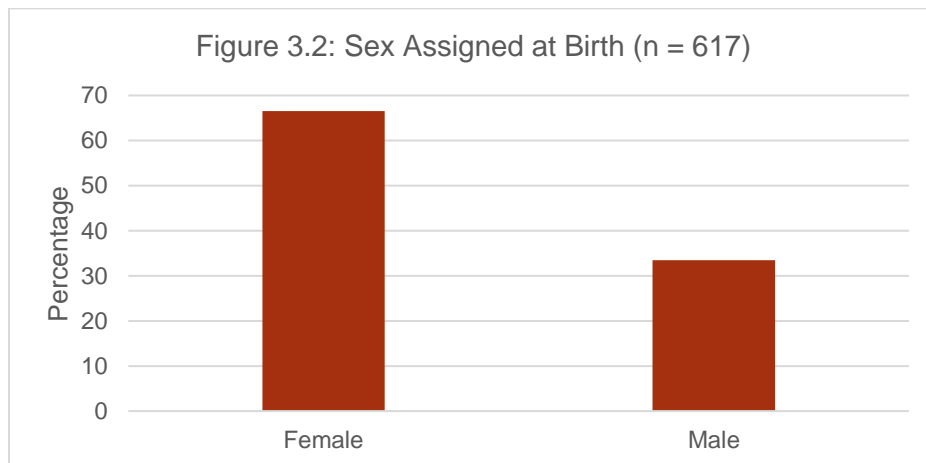
Gender Identity and Sex-Assigned-at-Birth

MSHRC collected the gender of participants with an open-ended, qualitative question. Due to the complexity of gender, MSHRC believed a fixed-choice option, even with a textbox for the addition of genders options not listed, was inappropriate for this study. Participants listed more than 55 unique genders identities and, through a collaborative process among MSHRC faculty and students, responses were collapsed into 6 categories: cisgender man, cisgender woman, transgender man, transgender woman, non-binary/genderqueer transgender, and non-binary/genderqueer cisgender. For more information about this coding strategy, please see Appendix A.

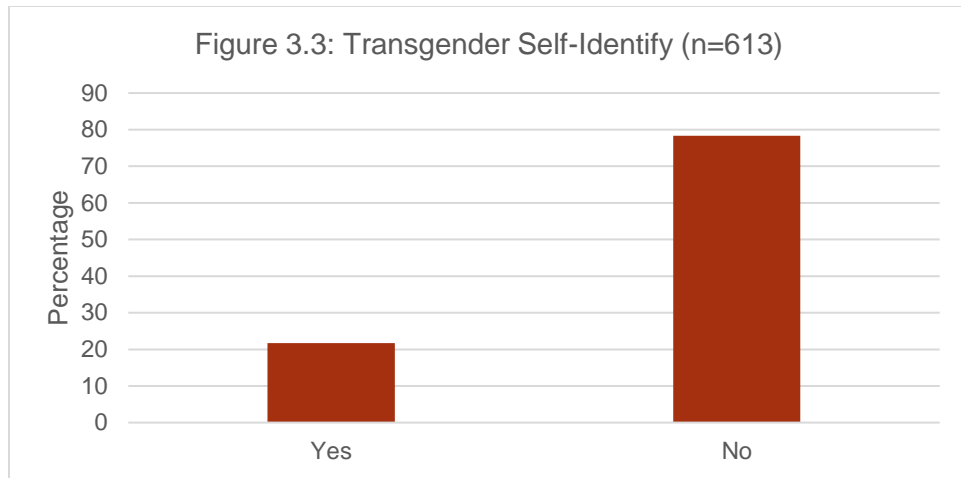
The largest gender groups in this study were cis women (47.2%), and cis men (24.1%), followed by nonbinary and genderqueer trans identities (11.5%) and nonbinary and genderqueer cis identities (6.9%). There were 33 trans men (5.3%) and 31 trans women (5.0%) who participated in this study.



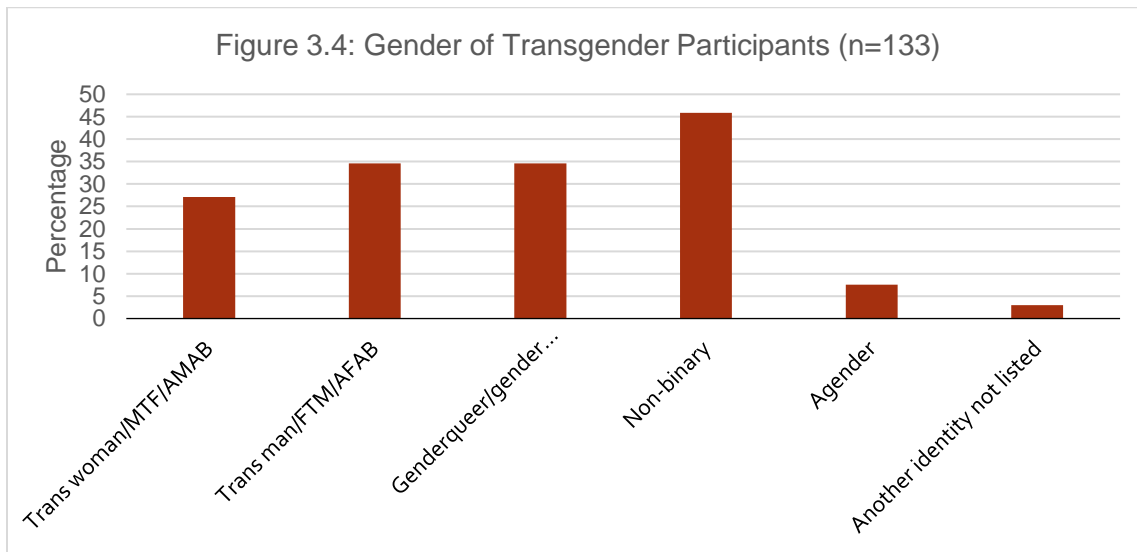
Participants also indicated their sex assigned at birth, or the sex listed on their original birth certificate. The majority of participants indicated their sex assigned at birth as female (66.5%) with the rest indicating their sex assigned at birth as male (33.5%). Options were also given for intersex and none of the above, but no participants selected those responses.



To assess the size of the transgender community within our sample, participants were asked to self-select into a trans or transgender identity category with a yes/no question. Just over a fifth (21.7%) of participants answered “yes” to this question, corresponding to 133 individuals who wished to be included as transgender for the study.

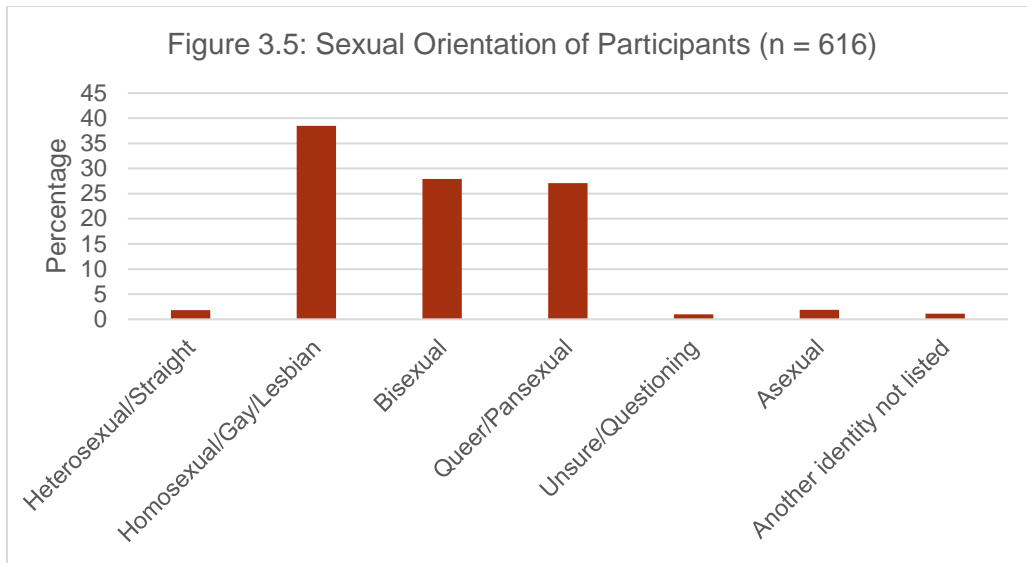


Individuals who indicated that they are transgender were asked a follow-up question to gain more insight into the gender identities of this community. Participants could answer with multiple gender categories (percentages can total more than 100%). Fifty (38%) participants indicated more than one gender identity with which they identify. Among the 133 transgender participants, just under 46% (n=61) were nonbinary, 34.6% (n=46) were trans men, 34.6% (n=46) were genderqueer/gender non-conforming, 27.1% (n=36) were trans women, 7.5% (n=10) were agender, and an additional 3% (n=4) were another gender not listed in the response options.



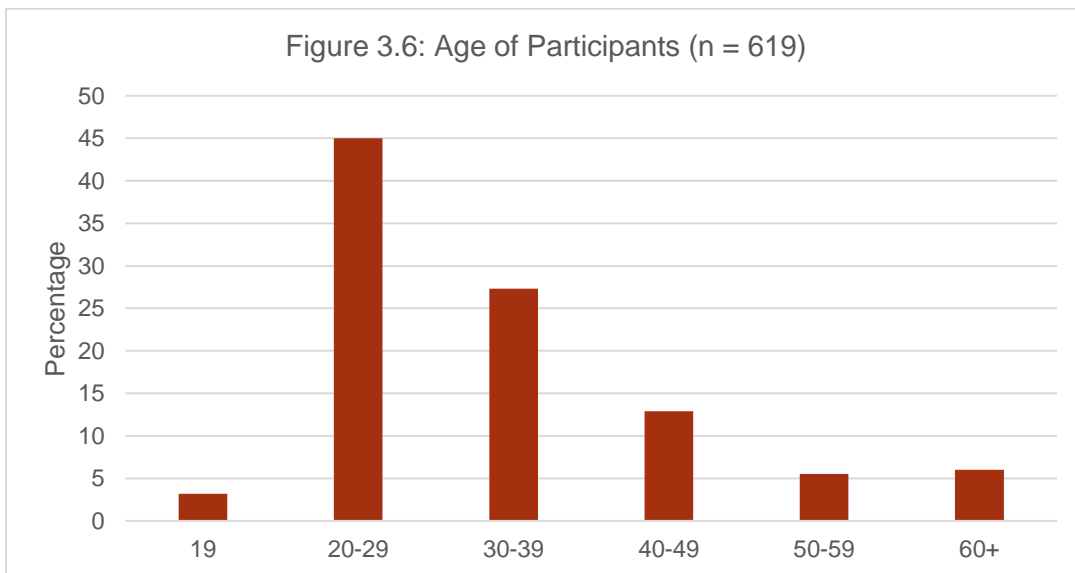
Sexual Orientation

All participants were asked to pick a term that best described their sexual orientation. Over a third (38.5%, n=239) identified as homosexual/gay/lesbian, followed by bisexual (27.9%, n=173), and queer/pansexual (27.1%, n=168). Close to 2% identified their sexual orientation as asexual (1.9%, n=12), followed by heterosexual/straight (1.8%, n=11), and another identity not listed (1.1%, n=7). Most participants who identified as heterosexual/straight were transgender participants.



Age

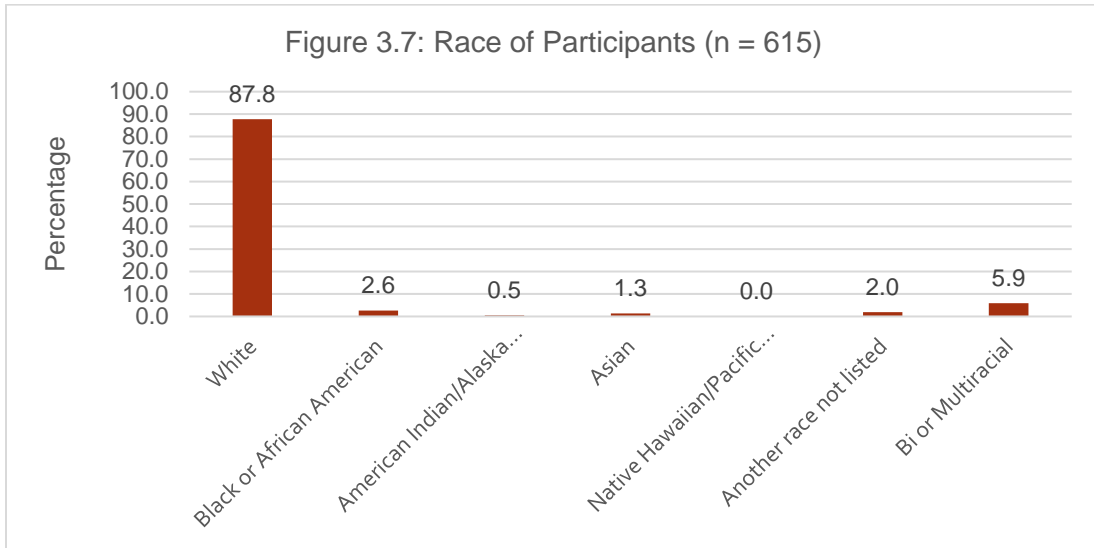
The age of participants in this study ranged from 19 (the age of majority in Nebraska) to 79 years. Almost half of the participants were between 19 and 29 (48.2%). More than a fourth of the participants (27.3%) were between 30 and 39, while the remaining participants were between the ages of 40 and 79. The average age was nearly 34 years, with a standard deviation of 12 years. Rural participants were significantly older than urban/suburban participants (37 years vs 33 years [$t=2.43, p=0.017$]), and cis participants were significantly older than trans participants (35 years vs 30 years [$t=-4.60, p<0.001$]).



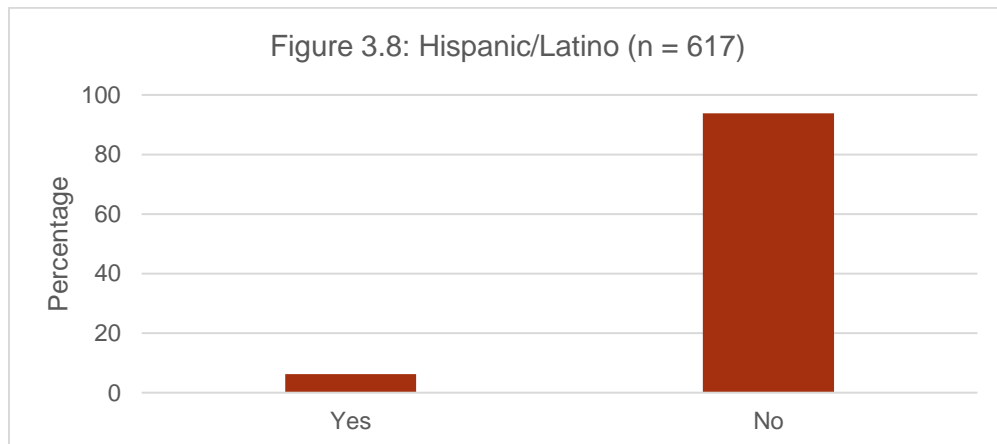
Race and Ethnicity

Participants were asked to indicate their race using the categories provided by the U.S. Census Bureau. Participants were allowed to select more than one race, acknowledging that racial background is a complex demographic feature. Presented here are singular categories of race for

each participant, with participants marking more than one race represented in the bi or multiracial category. The overwhelming majority of participants reported their race as White (87.8%). Other races represented in this sample include Black or African American (2.6%), American Indian/Alaska Native (0.5%), Asian (1.3%), and another race not listed (2.0%). Almost 6% indicated a biracial or multiracial identity by marking more than one racial category.

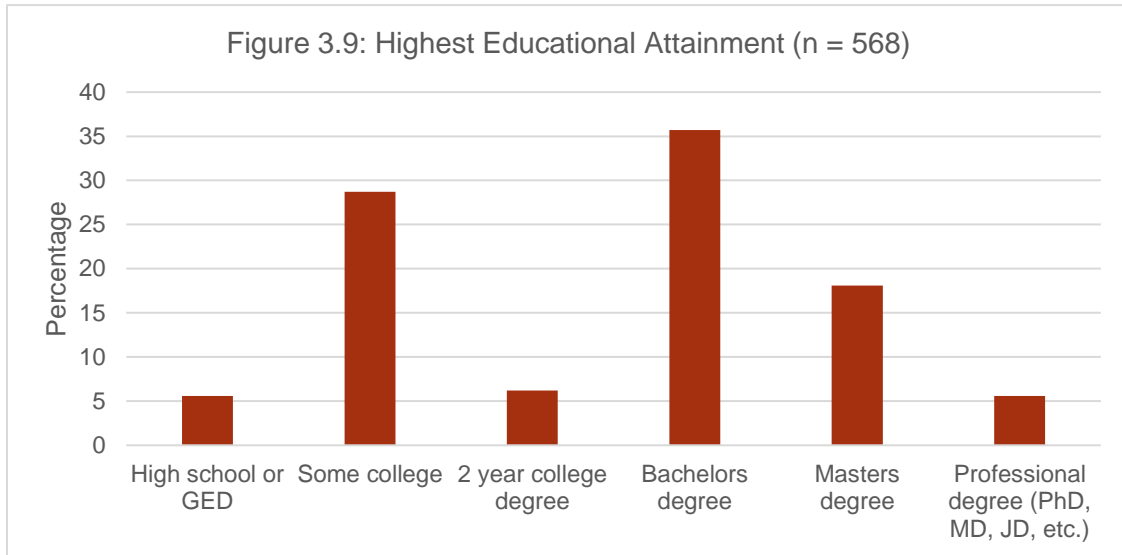


Federal standards draw a distinction between race and ethnicity, and the U.S. Census Bureau collects data on Hispanic/Latina/Latino/Latinx identity separately from race. According to the U.S. Census Bureau, individuals with Hispanic or Latino ethnic identities include individuals from or who have heritage from Cuba, Mexico, South or Central America, or another Spanish culture regardless of race. In this study, over 6% of individuals indicated they were Hispanic or Latino (6.2%, n = 38). Nationally, about 18% of individuals considered themselves to be Hispanic or Latino², and approximately 11% of Nebraskans were Hispanic or Latino in 2019.¹



Educational Attainment

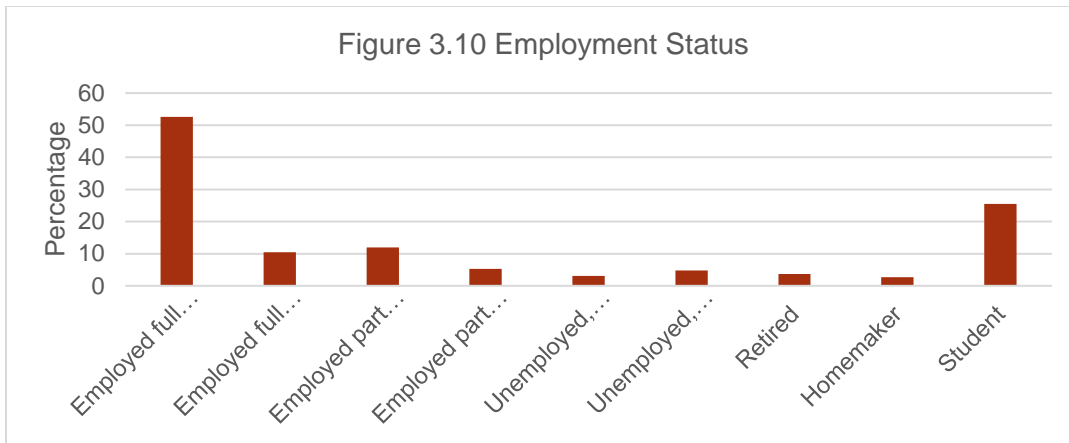
The participants in this study reported a generally high level of educational attainment. Just over 5% of participants had only a high school diploma or GED and 28.7% had attended some college but had not obtained a degree. Six percent of participants had a 2-year associates degree and 35.7% had obtained a bachelor’s degree. Eighteen percent of participants had a master’s degree and just over 5% of participants had a professional degree, such as a PhD, MD, or JD.



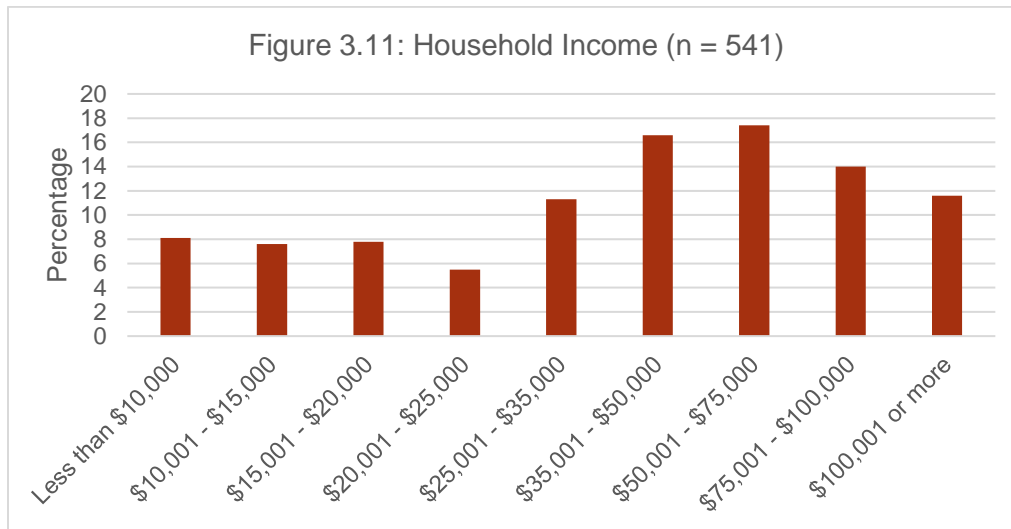
Educational attainment varied significantly by participants’ gender and sexual orientation. Cisgender participants had higher educational levels than trans and gender diverse participants ($\chi^2= 17.5, p < .01$). For example, trans participants were more likely to report some college but no degree (43%) than cisgender participants (25%). Further, cisgender participants were more likely to have at least a Masters degree (27%) than trans and gender diverse participants (12%). There was also a statistically significant relationship between educational attainment and sexual orientation ($F = 4.6, p < .001$). Individuals who identified as homosexual, gay, or lesbian had significantly higher overall educational attainment than individuals who identified as bisexual.

Employment & Income

Over half (52.6%) of participants reported being employed full time at one job, with an additional 10% reporting working full time with more than one job. Approximately 17% of participants reported working part time at one or more jobs. Roughly 3% of participants reported being unemployed and not looking for a job, with an additional approximately 5% who reported being unemployed and looking for a job. Almost 4% of participants were retired, approximately 3% were homemakers, and over 25% reported being students at the time of the survey. While not shown in the employment status graph, roughly 40% of participants reported being currently employed but struggling to make ends meet.



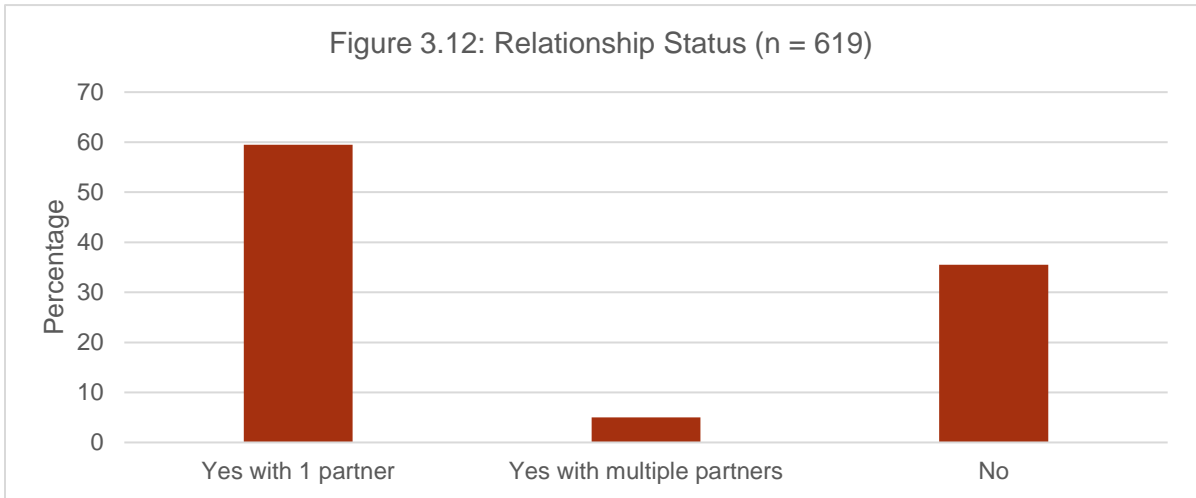
Many participants reported a livable income, with 43% of the sample reporting incomes of at least \$50,001 or more. However, many participants had incomes much lower. Approximately 15% of participants had incomes less than \$15,000 and roughly 13% had incomes between \$15,001 and \$25,000. Nearly 28% of participants had incomes between \$25,001 and \$50,000.



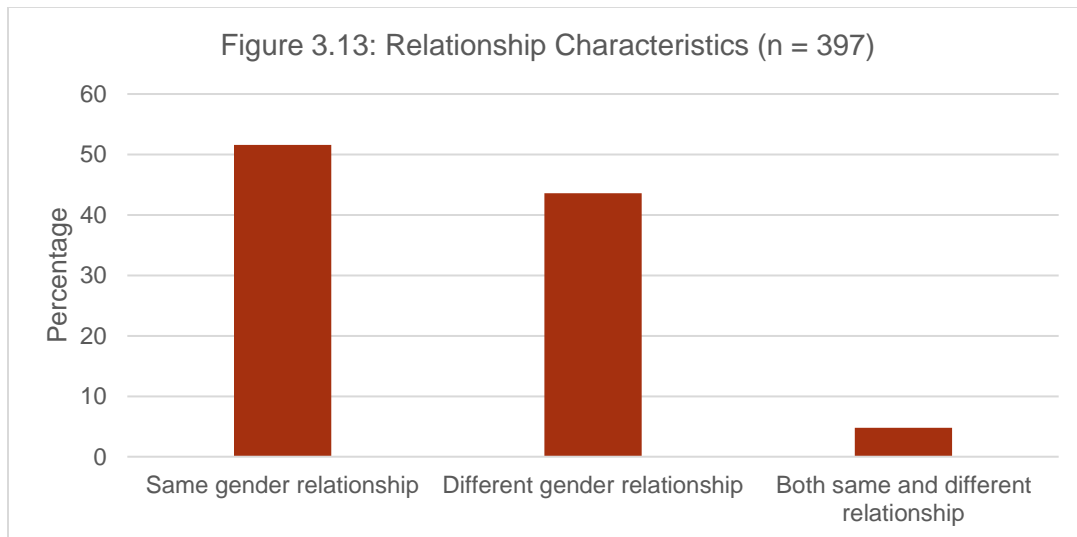
Income differed significantly by gender and sexual orientation. Trans and gender diverse participants were more likely to report lower incomes ($\chi^2=26.8, p < .001$). For example, approximately 25% of trans and gender diverse individuals reported an income of \$15,000 or less, compared to approximately 16% of cisgender individuals. At the other end of the income scale, more cisgender participants reported higher incomes, with approximately 30% of cisgender participants, compared to 11% of trans and gender diverse participants, reporting a salary of at least \$75,001. There was also a statistically significant relationship between income and sexual orientation ($F=3.3, p < .01$). Individuals who identified as homosexual, gay, or lesbian had significantly higher incomes than individuals who identified as pansexual or queer, and significantly higher than individuals who identified as unsure or questioning their sexuality.

Relationship Status

Participants were asked to characterize their relationship status at the time of the survey as either in a committed relationship with one partner, in a committed relationship with multiple partners, or not in a committed relationship. Almost 60% of participants indicated that they were in a committed relationship with one partner, while 5% of participants were in a committed relationship with more than one partner. Approximately 35% of participants were not in a committed relationship.



Individuals who reported being in a committed relationship to one or more people were asked a follow up question to capture some characteristics of their relationship. Participants were asked if their relationship was to someone of their same gender (51.6%), someone of a different gender (43.6%), or people of both their same gender and a different gender (4.8%).



4. Social Health

Individual health and well-being is strongly influenced by social experiences. The Midlands LGBTQ+ Health Survey assessed participants' social health across a number of relevant constructs, including self-acceptance, outness, social support, perceived stress, and experiences of violence, assault, and discrimination. Key social health findings include:

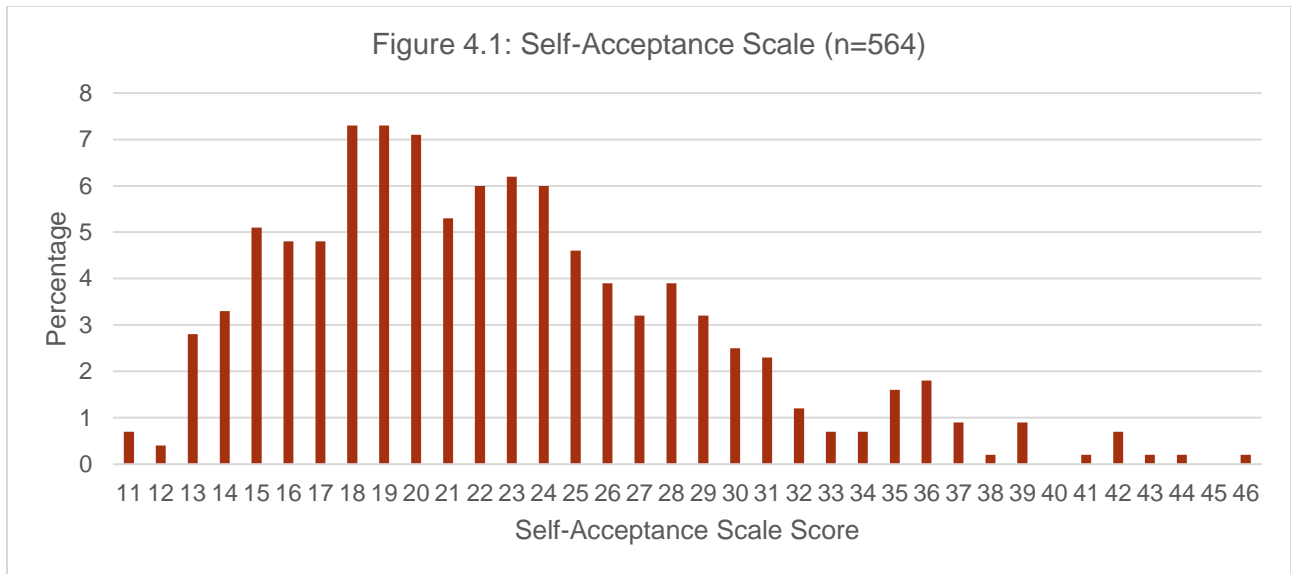
- Most participants were out to most of the people in their lives.
- On average, participants reported low levels of self-acceptance and interpersonal support.
- While there were a wide range of experiences within the sample, experiences of violence, assault, and discrimination were common.
- Age, gender identity, race, and geography were often significantly correlated with social health measures.
- In general, transgender participants and participants of color reported lower levels of social health, compared to their cisgender and white peers.
- Participants living in rural areas reported higher levels of both interpersonal support and violent experiences.

Self-Acceptance Scale

Many LGBTQ+ individuals internalize stigmatizing beliefs and stereotypes about LGBTQ+ peoples. Through self-acceptance and other processes, LGBTQ+ individuals are able to reject negative beliefs and live more comfortably with their LGBTQ+ identities. Acceptance of one's LGBTQ+ identity has implications on psychological and social well-being, such as quality of interpersonal relationships and ability to cope with discrimination.³

A scale was adapted from Wright and colleagues (1999) to assess how comfortable individuals were with their LGBTQ+ status.⁴ The self-acceptance scale examined a participant's feelings about being an LGBTQ+ person by asking them to rate their level of agreement, from "strongly agree" to "strongly disagree", with 11 statements. Statements included items such as "I am positive about being LGBT" and "I feel that being LGBTQ+ is a gift." The self-acceptance scale has high reliability ($\alpha=.804$).²

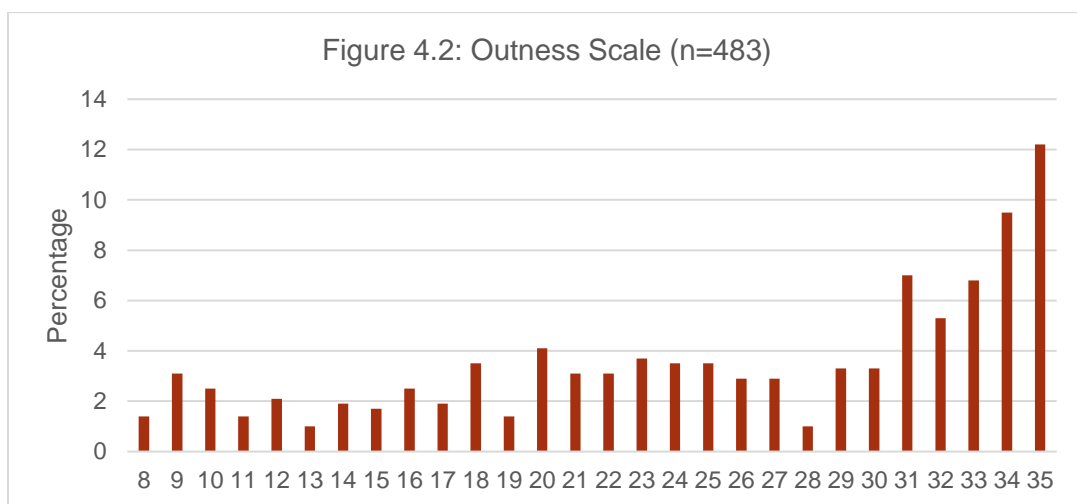
Possible self-acceptance scores ranged from 11 to 55, with higher scores indicating a greater degree of self-acceptance of one's sexual orientation/gender identity. The average self-acceptance score of participants in this sample was 22 ($sd=6$), which indicates a low level of self-acceptance for this sample. Race was correlated with self-acceptance, with participants of color having a slightly lower average self-acceptance score than white participants (22.52 vs. 22.63; $t(563) = .124$, $p<.01$).



The Outness Scale

“Coming out” is a complex, multidimensional process of acknowledging an LGBTQ+ identity to oneself and to others, including family members, friends, and acquaintances. Outness is highly relevant to the health and well-being of LGBTQ+ individuals. Outness is negatively associated with suicidality⁵ and anxiety⁶ and positively associated with self-esteem and overall social support.⁷

A series of questions were adapted from Wright and colleagues for use in this study to understand the degree to which participants were out about their sexual orientation/gender identity.² On a five-point scale ranging from “none of them know” to “everyone knows”, participants reported the extent to which their parents, siblings, other family members, friends, co-workers, employers, and acquaintances were aware of their LGBTQ+ identity. Outness scores could range from 7 to 35, with higher scores indicating a greater degree of outness. A score of 7 indicated a participant was not out to anyone, while a score of 35 indicated they were out to everyone in their life. The scale has high reliability ($\alpha=.916$).²



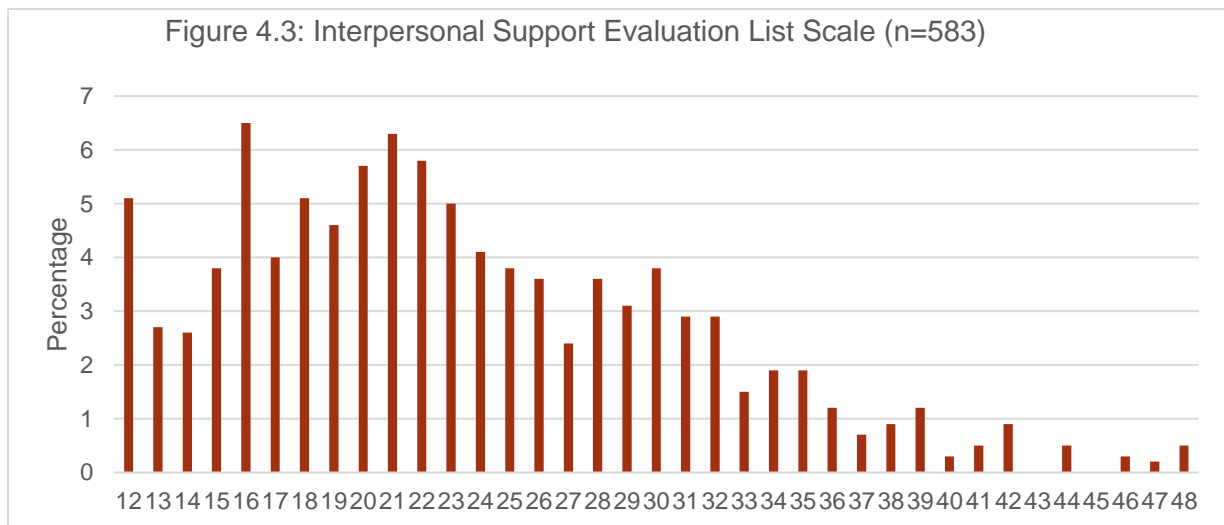
Participant outness scores ranged from 8 to 35, with an average score of 26 (sd=8), indicating that most participants were out to most of the people in their lives. The most frequently occurring score

was 35 (n=59), which indicates being out to everyone in a participant’s life. However, average outness scores varied across age groups and gender identities. Participants who were in the 19-29 year-old age groups were out to fewer people on average than individuals in age groups over 30 ($F(5, 476)=12.244, p<.001$). Cisgender men also had a higher average outness score than both cisgender women ($F(5, 477)=5.728, p<.001$) and non-binary/genderqueer participants ($F(5, 477)=5.728, p<.05$).

Interpersonal Support Evaluation List

The Interpersonal Support Evaluation List (ISEL) is a multidimensional inventory measuring perceived social support.⁸ The inventory is made up of four subscales which measure: appraisal support, or the availability of someone to turn to for advice; tangible support, or the availability of material aid; self-esteem, or the availability of a positive comparison; and belonging, or the availability of companionship.⁶ This survey only included items from the appraisal, tangible, and belonging support subscales.

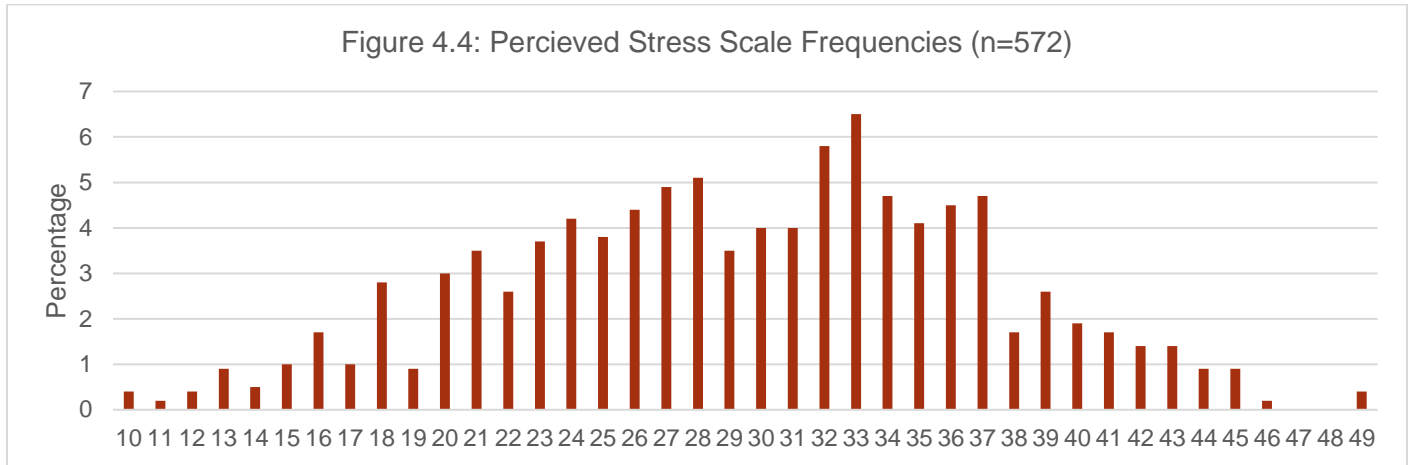
ISEL scores in this study could range from 12 to 48, with higher scores indicating greater perceived availability of potential social sources. Participants in this study had an average overall ISEL score of 23 (sd=7.7) and the most frequently occurring score was 16 (n=38). Subscale scores could range from 4-16, with higher scores indicating greater perceived availability of potential social support in the specified area. The average Appraisal Support score was 7 (sd=3), the average Tangible Support score was 7.6 (sd=2.7), and the average Belonging Support score was 8.7 (sd=3.1).



These scores indicate that participants generally perceived relatively low levels of social support being available to them, especially appraisal support. However, there were geographic differences in average ISEL scores. Participants in rural areas reported significantly more interpersonal support on average than participants living in urban areas (25.73 vs. 23.02; $t(581)=3.008, p<.001$).

Perceived Stress Scale

The Perceived Stress Scale is a psychological instrument used to measure participants’ perception of stress, specifically the degree to which “situations in one’s life are appraised as stressful.”⁹ Participants were asked about their feelings and thoughts during the last month and participants indicated how often they felt or thought a certain way.



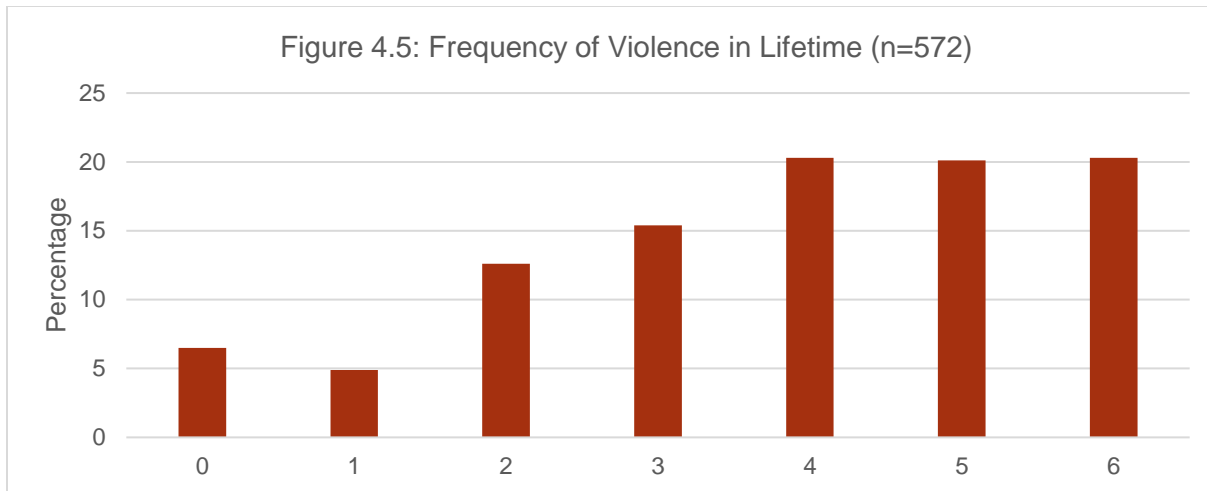
Perceived stress scale scores ranged from 10 to 49, with higher scores indicating higher perceived stress. The average score was 29.5 (sd=7.5). The most frequently occurring score was 33 (n=37). Similar to outness scores, perceived stress scores varied based on age group and gender identity. Participants who were in the 19-29 years-old age groups had more perceived stress, on average, than individuals in the age groups 30 years and older ($F(5, 565)=10.218, p<.001$). Cisgender, on average, reported less perceived stress than all other gender categories ($F(5, 566)=9.046, p<.001$).

Violent Experiences

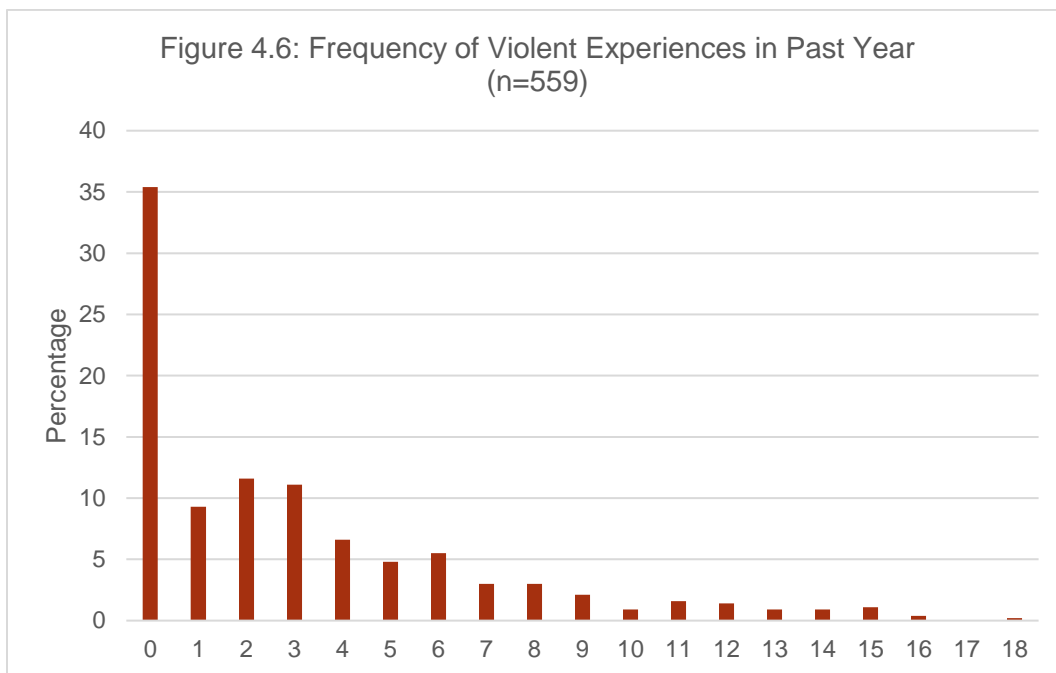
In this study, experiencing violence was measured by asking participants to report whether they had ever in their lifetime experienced certain violent events and how often they experienced certain violent events within the past year. Participants were asked whether they had been threatened with violence, verbally insulted or abused, spit on, had an object thrown at them, been chased or followed, or called a derogatory name.

In the lifetime scale, participants were asked if they had ever experienced each of the violent events at any point in their life. Scores ranged from 0 to 6, with higher scores illustrating that the participant had experienced more violent events. A score of 6 would illustrate that the participant had experienced all six of the violent events they were asked about. More than half of the participants scored between 4 and 6 (n=347, 60.7%), meaning that most of the participants had experienced multiple forms of violence in their lifetime.

Lifetime experiences of violence varied significantly based on participants' gender identity. Transgender participants experienced more types of violence in their lifetime than cisgender participants ($F(5, 566)=1.265, <.001$).



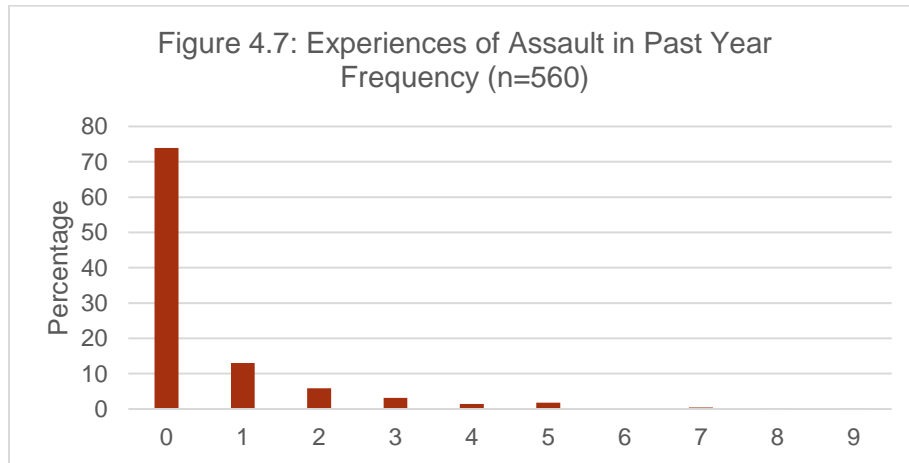
For the past-year scale, participants were asked how often they had experienced violent events (never, once, twice, three or more times) within the past year. Scores ranged from 0 to 18, with higher scores illustrating more experiences of violence in the last year. For example, a score of 0 would mean that the participant had not experienced any violence in the last year, while a score of 18 would mean that the participant had experienced all the different types of violence three or more times. The majority of participants scored between 1 and 9 (n=320, 57.3%), indicating that most of the people in the study had experienced some violence in the last year. The average score was 3.08. The most frequently reported type of violence was participants being verbally insulted or abused (n=321) or being called a derogatory name (like fag, queer, dyke, etc.) (n=235).



Experiences of violence in the last year varied significantly based on participants' gender identity and geography. On average, transmen experienced significantly more violence in the past year than cismen and ciswomen ($F(5, 553)=4.591, p<.001$). Finally, people who lived in rural areas reported more violent experiences in the past year than individuals in urban areas ($t(570)=.982, p<.001$).

Assault Scale

Assaults were measured in this survey by asking participants how often they had experienced certain types of assaults (hit, beaten, or physically attacked; raped or sexually assaulted; robbed, as in a holdup or mugging; property was stolen; property was vandalized). Participants were asked to report whether they had experienced these events never, once, twice, or three or more times in the last year. These items were compiled into a scale where possible scores ranged from 0 to 20, with higher scores illustrating that the participant had been assaulted more times. The most common score was 0 and the highest score within the sample was 9. Over 30% of participants reported experiencing some type of assault over the last year.



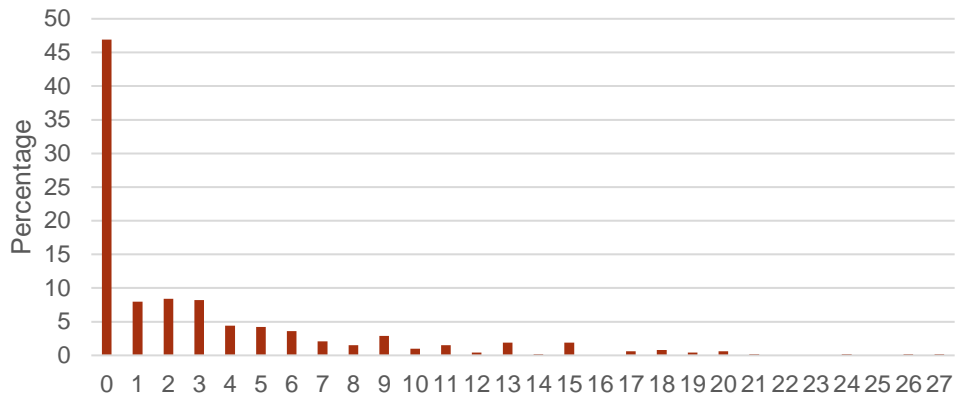
Assault experiences varied significantly based on participants’ race and gender identity. Participants of color experienced more assaults on average than white participants ($t(558)=-1.760$, $p<.05$). Non-binary/genderqueer individuals experienced more assaults than cisgender men ($F(5, 553)=4.054$, $p<.01$).

Discrimination

Discrimination was measured in this study by asking participants how often (never, once, twice, or three or more times) they had experienced interpersonal or institutional discrimination in the past year. Participants were asked about discrimination experiences across a number of domains, including employment, housing, education, and healthcare. These items were compiled into a discrimination scale with scores ranging from 0 to 27, with higher scores representing more experiences of discrimination.

Over half of the participants reported experiencing some amount of discrimination in the past year ($n=279$, 53.1%), with 20% of the sample having a score higher than a 5. Experiences of discrimination varied significantly by gender identity. Transgender participants reported more experiences of discrimination in the past year than cisgender participants ($t(517)=5.891$, $p<.001$).

Figure 4.8: Experiences of Discrimination in Past Year
Frequency (n=525)



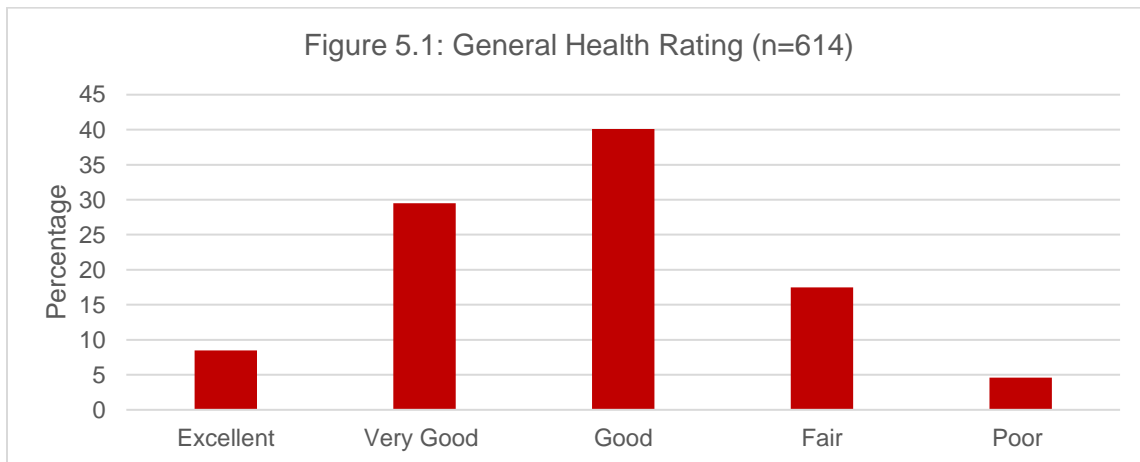
5. Physical Health

Nationally, LGBTQ+ individuals have been found to be more likely than their heterosexual and cisgender counterparts to rate their health as poor, have more chronic health conditions, and have higher prevalence of disabilities.^{10,11} The Midlands LGBTQ+ Health Survey sought to better understand how LGBTQ+ Nebraskans experience their physical health. The survey asked participants a variety of questions about how they would rate their physical health, physical health diagnoses, and tobacco, alcohol and substance use. Key physical health findings include:

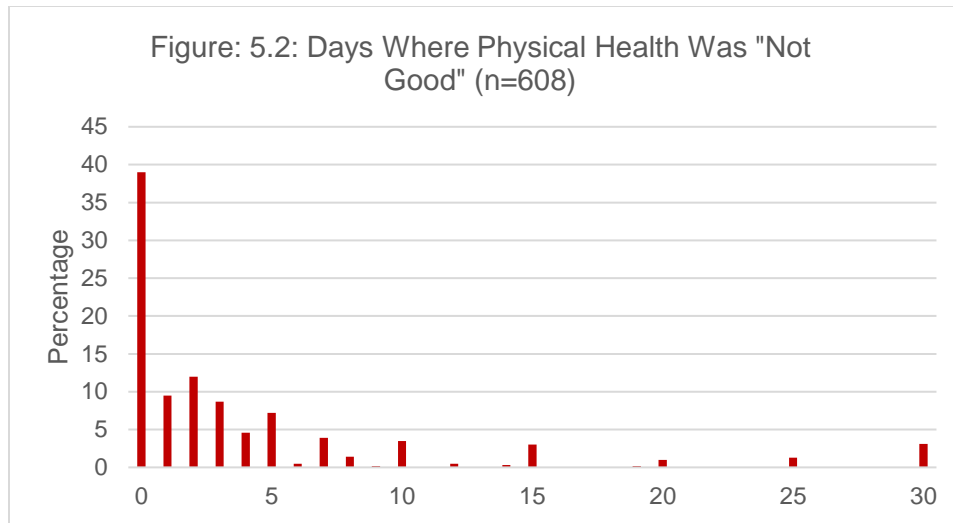
- More than 3 out of 4 participants (78%) rated their health as good, very good, or excellent.
- More than half of participants reported that they had been diagnosed with a physical health condition. The most commonly reported were autoimmune conditions, migraines, and hypertension.
- About half of participants reported that they had used substances in the past 90 days, but individuals with a mental health condition or who reported that they were struggling to make ends meet were more likely to have used substances.
- Transgender individuals, individuals aged 40 to 49, and low-income individuals were more likely to smoke every day than other groups.

Self-Rated Health

Self-rated health was assessed in this study by asking participants to self-report how healthy they were using a scale that ranged from excellent to poor. More than 3 out of 4 (78% of participants) rated their health as good, very good, or excellent. Trans participants were less likely to rate their health as excellent or very good than cismen and ciswomen and more likely to rate their health as fair or poor than cismen and ciswomen ($\chi^2(20)=45.964, p<.001$).

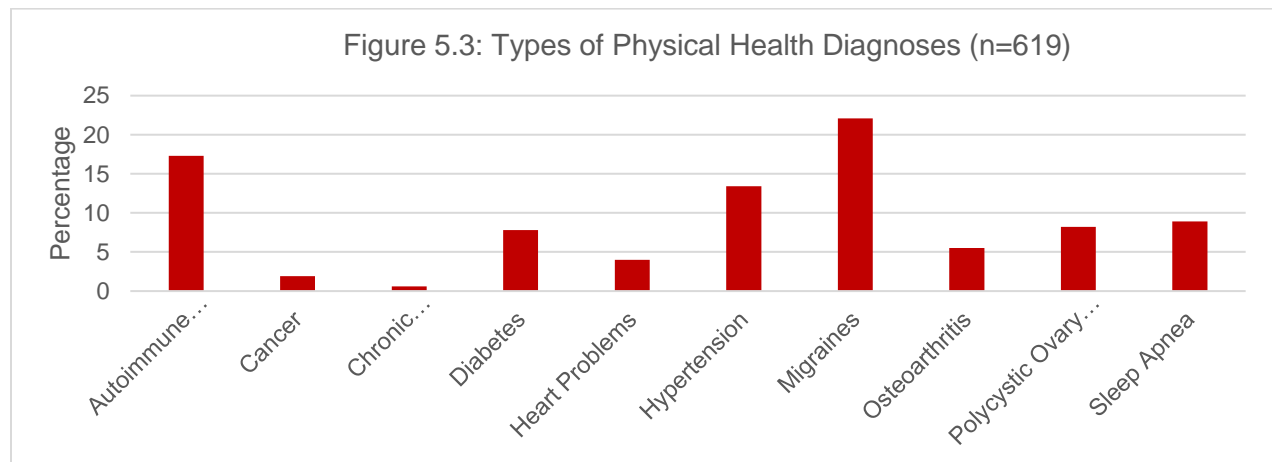


Self-rated health was also assessed by asking participants to report how many days in the past 30 days their physical health was not good. Answers ranged from 0-30 and about 90% of participants said that their physical health was not good less than 10 days. The most frequently occurring response was 0 days in which their physical health was not good, which almost 40% of participants responded.



Physical Health Diagnoses

In the survey, participants were asked about whether they had ever been diagnosed with a list of physical health conditions. 54.4% of participants (n=337) reported that they had been diagnosed with one of the physical health conditions in the list. The most common diagnoses were autoimmune conditions (17.3% of participants), hypertension (13.4% of participants), and migraines (22.1% of participants). Less than 10% of participants reported that they had been diagnosed with the other health conditions.

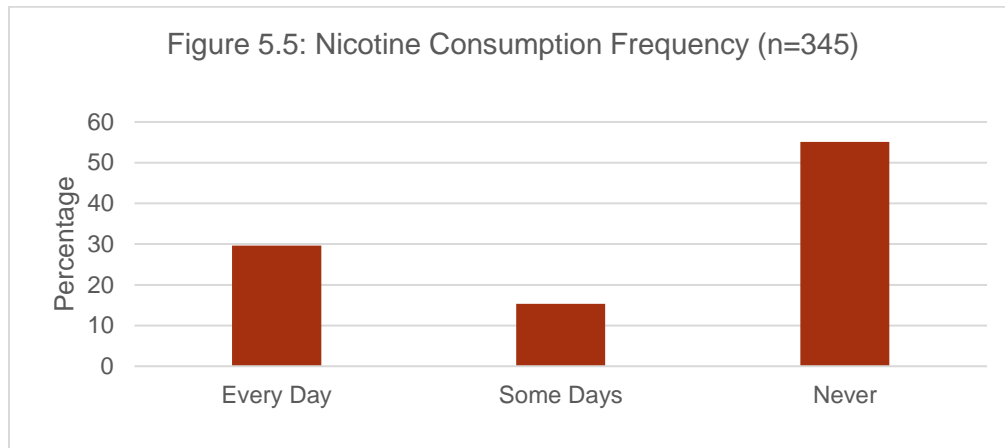
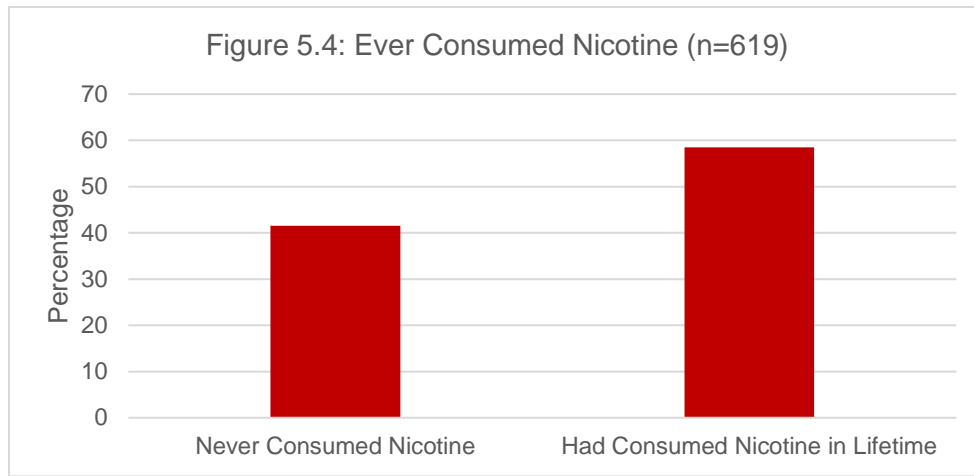


Participants 40 years of age and older were more likely to have been diagnosed with a physical health condition than all age groups for participants 39 and younger ($\chi^2 (5) = 32.651, p < .001$).

Tobacco Use

A variety of measures of tobacco use were utilized, including lifetime smoking, current smoking status, type of nicotine consumed and frequency of nicotine consumption. Over 55% of participants reported that they had consumed nicotine in their lifetime. Of those individuals, 29.6% (n=102) said that they consumed nicotine every day, while 15.4% said they consumed some days. Individuals were able to select which types of nicotine they had consumed in their lifetime. Cigarettes were the

most commonly used type of nicotine, with 86.5% (n=313) of individuals reporting that they had smoked cigarettes, 41.7% (n=151) reporting they had vaped, 9.4% (n=34) reporting they had used chewing tobacco, and 27.6% (n=100) reporting they had smoked cigars.



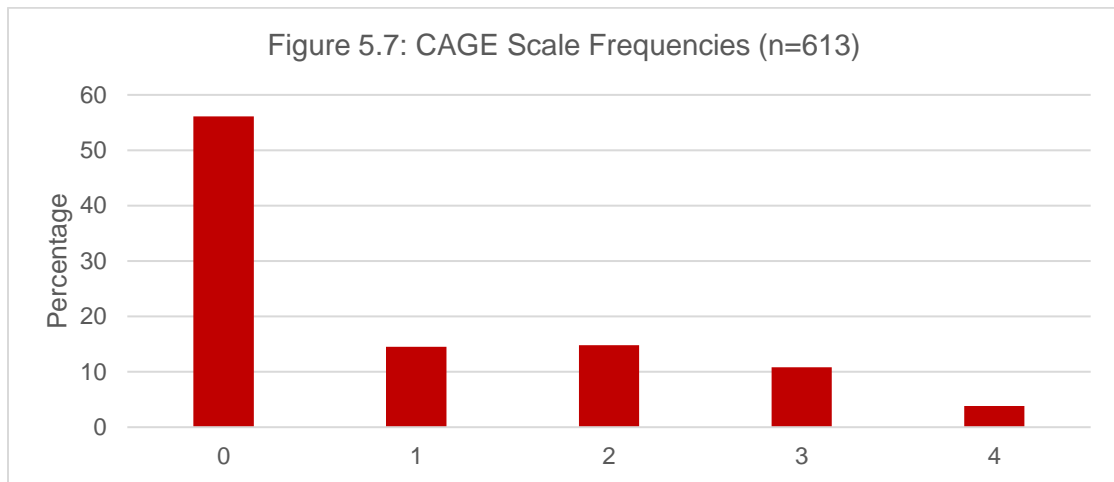
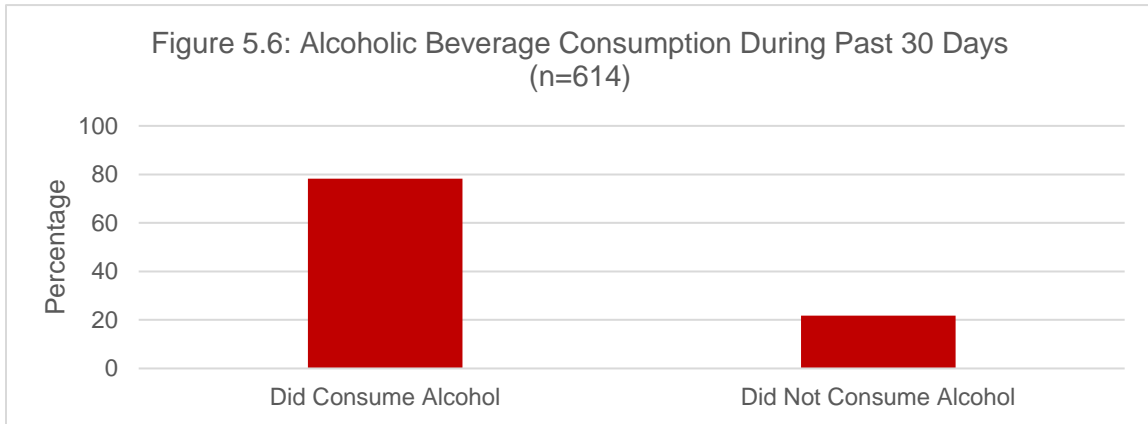
Trans participants were more likely than other gender identities to report that they smoked every day ($\chi^2 (10,345)=18.698, p<.05$). Individuals in the 40-49 age group were more likely to report smoking every day than the other age groups, while individuals who were 50+ years old were more likely to report that they had never smoked ($\chi^2 (10, 345)=38.953, p<.001$). Participants who were earning \$50,000/year or more were likely to have never consumed nicotine, as compared to those who earned less than \$50,000/year ($\chi^2 (16, 307)=32.375, p<.01$). Finally, individuals who lived in rural zip codes were more likely to smoke everyday than individuals who lived in urban zip codes ($\chi^2 (2, 345)=7.393, p=.025$)

Alcohol Use

Alcohol use was assessed in this study by asking participants if they had consumed at least one alcoholic beverage in the last 30 days. The CAGE Questionnaire was also utilized, which asked questions about whether participants felt they should cut down their drinking, were annoyed by people criticizing their drinking, felt guilty about their drinking, or drank first thing in the morning to steady nerves or get rid of hang over. This questionnaire is used to identify problematic alcohol

use behaviors and substance use disorders. A score of 2 or greater is considered clinically significant problematic alcohol use.¹²

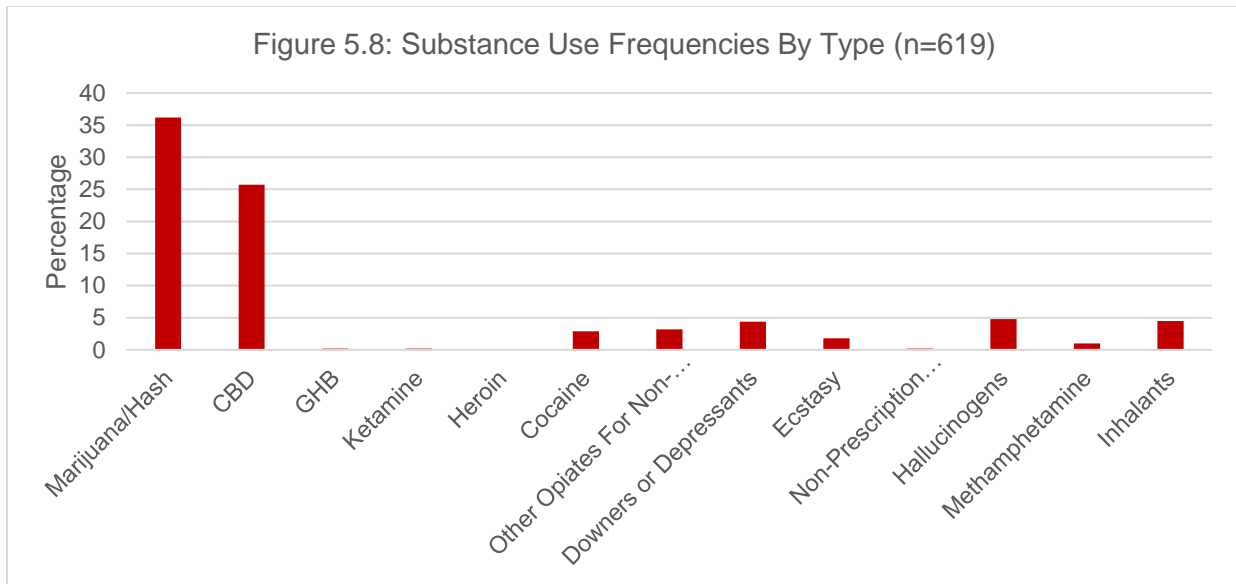
Most participants, 78.2% (n=480) reported that they had consumed alcohol in the past 30 days. From the CAGE Questionnaire items, 29.4% (n=180) of participants exhibited problematic alcohol use behaviors. Most of the participants (56.1%; n=344), scored a 0 on the scale, indicating no problematic drinking behaviors.



Transgender men and transgender women were less likely to have had an alcoholic beverage in the last 30 days than cisgender individuals and non-binary individuals ($\chi^2 (5, 614)=11.337, p<.05$). Individuals who lived in urban zip codes and were between the ages 20 and 39 were more likely to have had an alcoholic beverage than rural individuals ($\chi^2 (1, 614) = 25.468, p<.001$) and individuals in the other age categories ($\chi^2 (5, 613)=16.815, p<.01$).

Drug Use

A little less than half of the participants reported that they had used at least one substance in the past 90 days (46.7%, n=289). The most commonly used drug reported by participants was marijuana/hash, which 36.2% of participants reported using, followed by CBD, which 25.7% of participants had used in the 90 days. All other substances listed were used by less than 5% of participants.



Drug use varied by age in this study. Participants who were 19 years old were much more likely to have used drugs in the last 90 days (n=13, 76.5%) than all other groups. Similarly, individuals aged 20-29 (n=135, 57.2%), 30-39 (n=75, 49.7%), and 40-49 (n=31, 44.9%) were more likely to have used drugs in the last 90 days than individuals aged 50-59 (n=9, 25%) and 60+ (n=9, 33.3%). This was a statistically significant difference in drug use ($\chi^2 (5, 532)=21.199, p<.001$).

Drug use also varied by mental health diagnosis. Individuals who had been diagnosed with a mental health condition were more likely to have used drugs in the last 90 days (n=233, 56.8%), compared to individuals who had not been diagnosed with a mental health condition (n=45, 33.6%) ($\chi^2 (1, 544)=21.842, p<.001$).

Finally, drug use varied based on financial stability. Individuals who stated that they were employed but struggling to make ends meet were more likely to have used drugs in the past 90 days (n=133, 59.9%), than individuals who did not report struggling to make ends meet (n=145, 45%) ($\chi^2 (1, 544)=11.642, p<.001$).

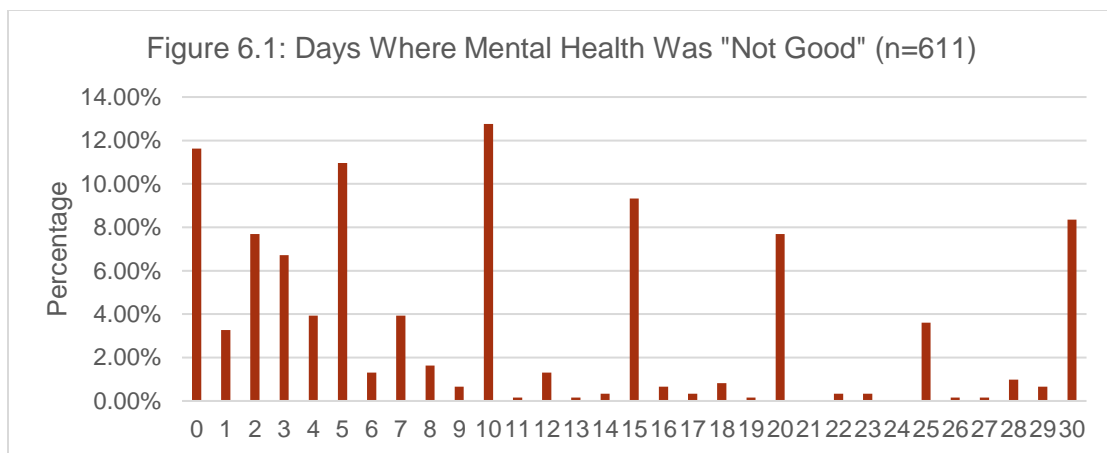
6. Mental Health

Mental health is a fundamental component of overall health and well-being. It is also a broad category that encompasses many different health experiences and overlaps with other categories of health. The Midlands LGBTQ+ Health Survey assessed participants' mental health using a number of constructs. A general, subjective snapshot of participants' mental health was captured through participants' self-report of the number of days in the past month that they experienced "poor mental health". Participants also reported any mental health diagnoses they had been given by a health care provider, completed a depression symptoms scale, and reported suicidal ideation, suicide attempts, and other self-harm behaviors. Key mental health findings include:

- A relatively small percentage of participants had experienced no poor mental health days in the past month. 48.3% had 10 or more days of poor mental health.
- Most participants had some mental health diagnosis, with over half of the sample reporting a depression or anxiety diagnosis.
- The level of depression symptoms within the sample was also high, with the average score above the level generally considered to be indicative of clinical depression.
- More than half of the sample had seriously considered suicide and, of those who had seriously considered it, almost half had attempted suicide at some point.
- Almost half of participants reported engaging in some form of self-harm behavior without any suicidal intention.
- Across almost all measures, participants with lower incomes and more stigmatized gender and sexual identities had worse mental health.

Quality of Mental Health

Participants were asked how many days during the past 30 days their mental health was not good. Responses ranged from 0 to 30, with the average number of poor mental health days being 11 days (sd=9.3).

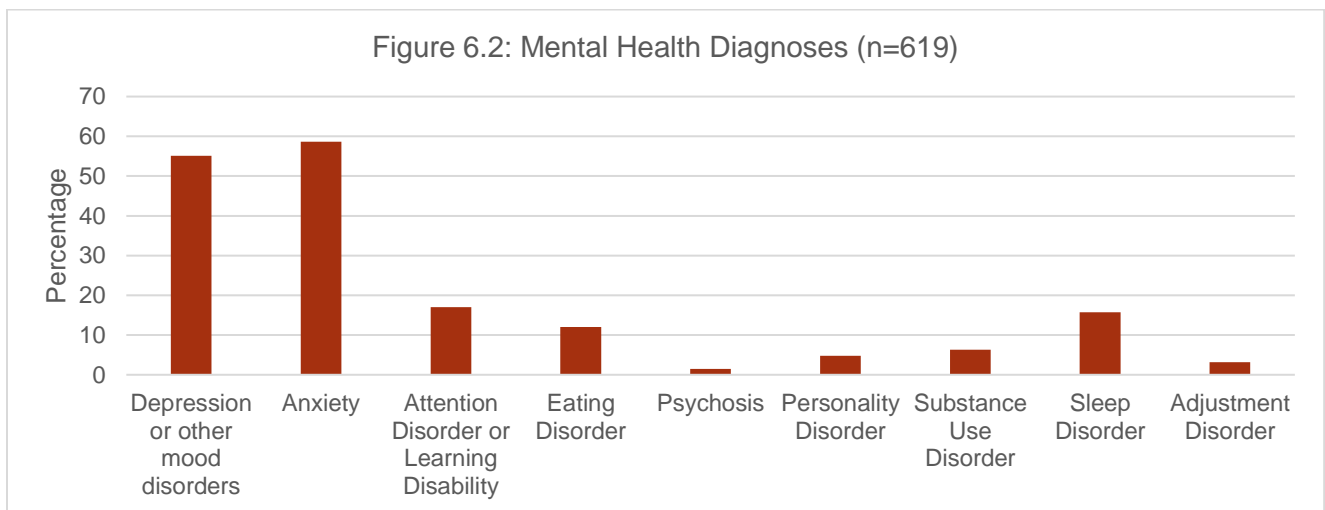


The average number of days where mental health was not good varied based on gender identity, income, age, and sexuality. Transgender participants, on average, had more days with poor mental health than cisgender participants ($t(603)=4.06, p<.05$). Participants with incomes less than \$50,000 had more days with poor mental health than participants with incomes between \$75,001

and \$100,000 ($F(8,527)=9.241, p<.001$). Participants who were between the ages of 20 and 29 had more days with poor mental health days than participants over 30 years. Finally, bisexual and queer/pansexual participants had more poor mental health days than gay/homosexual/lesbian participants ($F(5, 604)=8.96, p<.001$).

Mental Health Diagnoses

Participants were asked whether they had ever been diagnosed by a health care provider with any of the following types of mental health diagnoses: depression or mood disorder, anxiety, attention disorder or learning disability, eating disorder, psychosis, personality disorder, substance use disorder, sleep disorder, or adjustment disorder. Participants also had the option to write in any additional condition that was not listed. Almost three-quarters of participants reported being diagnosed with at least one mental health condition ($n=428, 69.1%$). The most common mental health diagnoses were depression and anxiety, with over half of participants identifying an anxiety diagnosis ($n=363, 58.6%$) or a depression diagnosis ($n=341, 55.1%$).



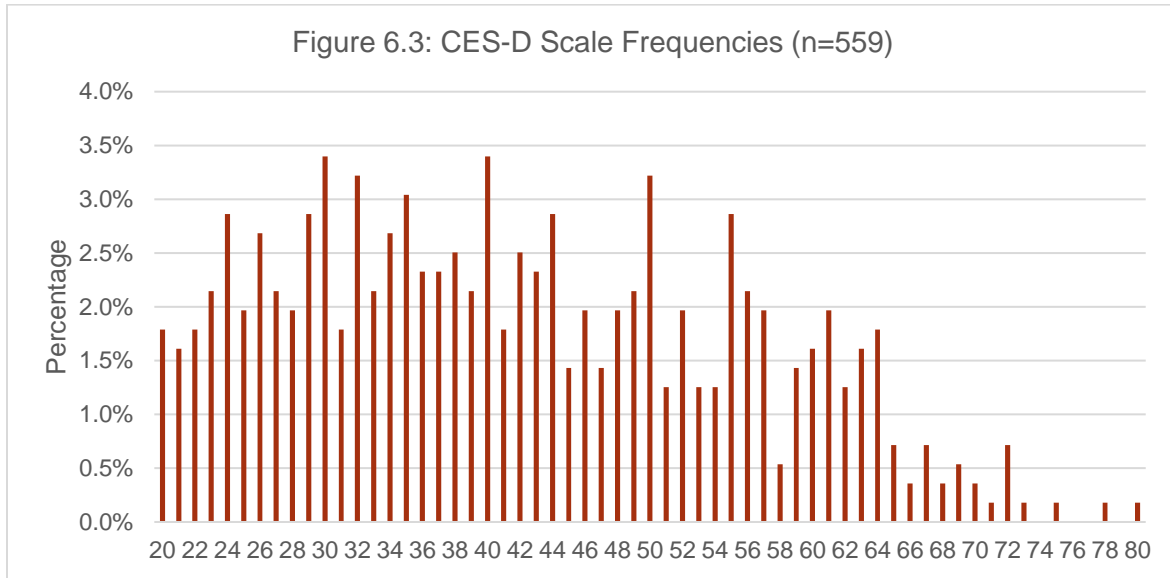
Whether or not participants had ever been diagnosed with a mental health disorder was significantly correlated with participants' gender identity, age, income, and sexual orientation. Transgender individuals were more likely to have a mental health diagnosis than cisgender individuals ($\chi^2 (1, 612)=6.78, p<.01$). Individuals in age groups over 50 years old were less likely to be diagnosed with a mental health disorder than those under 50 years old ($\chi^2 (5, 618)=12.52, p<.05$). Those with incomes higher than \$50,000 were also less likely to be diagnosed with a mental health condition than those with incomes lower than \$50,000 ($\chi^2 (8, 540)=35.31, p<.001$). Finally, bisexual, queer/pansexual, and asexual individuals were more likely to have mental health diagnoses than straight or gay/lesbian individuals ($\chi^2 (6, 616)=20.66, p<.01$).

Depression

Depressive symptoms were assessed in this study using the CES-D scale. Participants indicated how frequently in the past week they experienced twenty symptoms that are commonly associated with depression, such as irritability, changes in appetite, feeling depressed, having crying spells, and feeling lonely. The scale has very high reliability ($\alpha=.912$).¹³

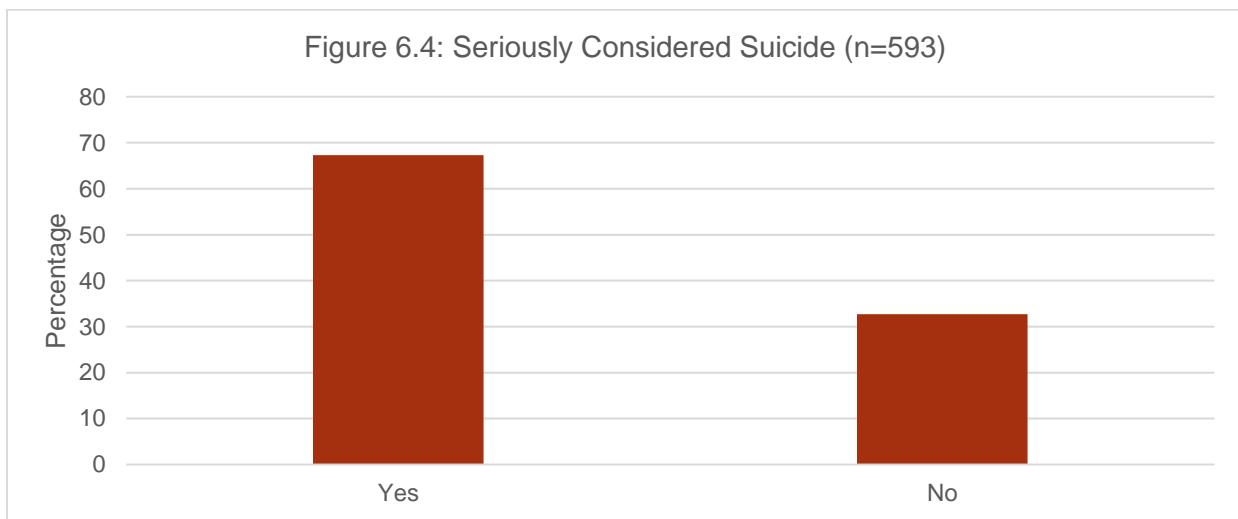
Scores on the CES-D scale range from 20 to 80, with a score of 36 or above indicating clinical depression. The average score in the study was 41.8 ($sd=13.5$), a concerning level of depressive symptoms. The average CES-D scores for transmen (49.93), transwomen (48.38), and non-binary

participants (45.91) were significantly higher than average cismen's (37.16) and ciswomen's (41.07) CES-D scores ($F(5, 552)=8.995, p<.001$). Average CES-D scores also varied significantly by age group. Participants in the 20-29 year age group had higher average CES-D scores (45.04) than those in the 30-60+ age groups (37.19) ($F(5, 551) = 8.20, p<.001$).

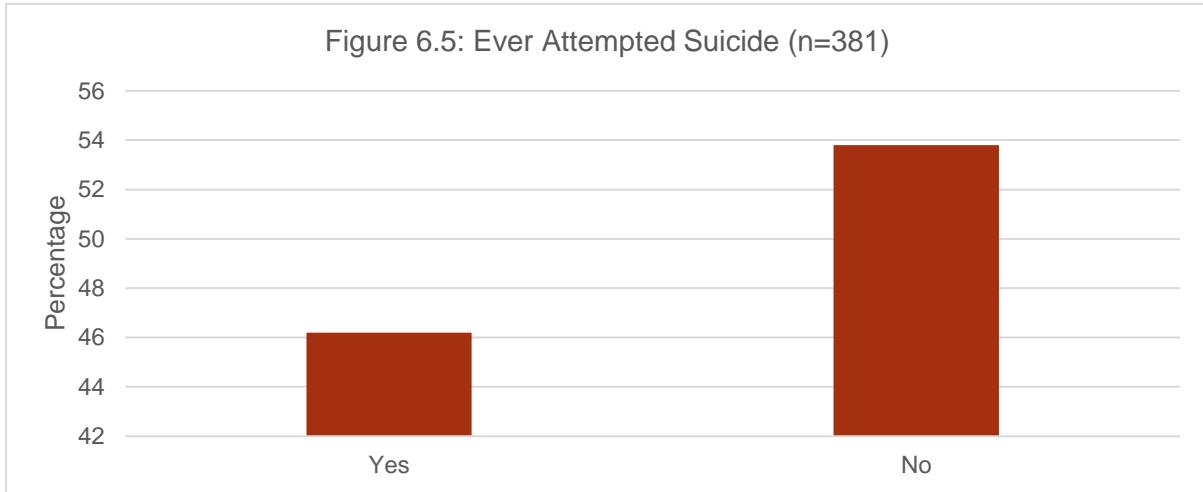


Suicide

More than half of participants in the study had seriously considered suicide (n=339, 67.3%). Transgender people were more likely to report having seriously considered suicide than cisgender individuals ($\chi^2 (1, 587)=22.81, p<.001$). Participants who identified as transman and non-binary/genderqueer were more likely to have considered suicide than participants who identified as cismale, cisfemale, and trans woman groups ($\chi^2 (5, 593) = 42.21, p<.001$). Participants who identified as bisexual, queer/pansexual, unsure/questioning, and asexual were more likely to have considered suicide than heterosexual/straight or homosexual/gay/lesbian participants ($\chi^2 (6, 590)=51.72, p<.001$). Those with yearly incomes less than \$50,000 were more likely to have considered suicide than those with higher incomes ($\chi^2 (8, 519) = 19.26, p<.05$).

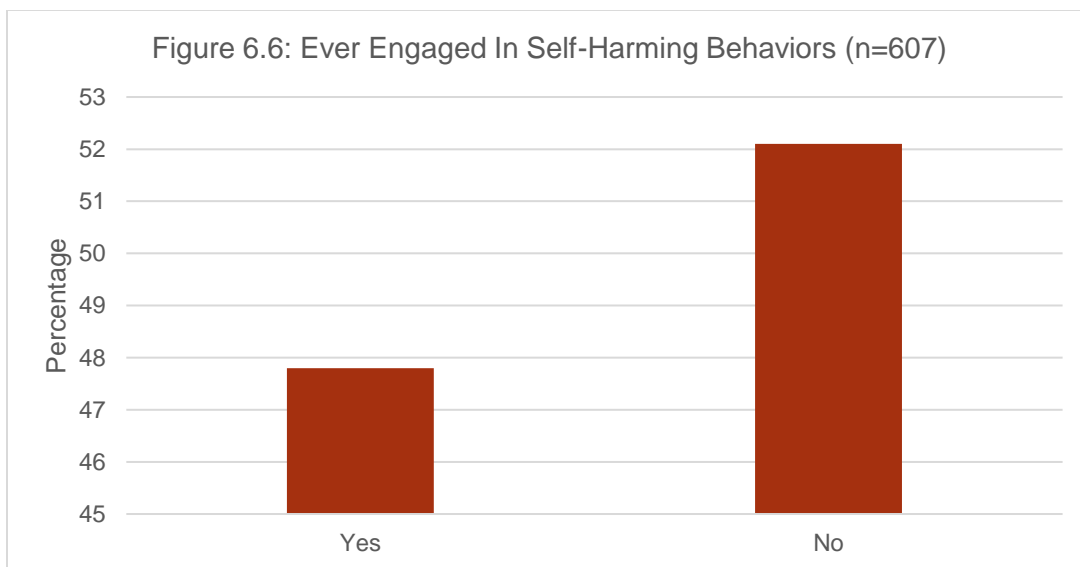


Almost half of participants who had seriously considered suicide had attempted suicide (n=176, 46.2%). Attempting suicide was significantly correlated with gender identity. Individuals who identified as transgender were more likely to have attempted suicide than cisgender individuals ($\chi^2(1, 378) = 4.90, p < .05$).



Self-Harm

Participants were also asked about whether they had ever engaged in self-harming behaviors (i.e. cutting, burning) without suicidal intent. Almost half of participants reported that they had engaged in self-harming behaviors (n=291, 47.9%). Self-harming behaviors were significantly correlated with participants' income-level, age, gender identity, and sexual orientation. Participants with yearly incomes less than \$50,000 were more likely to engage in self-harming behaviors than those with incomes higher than \$50,000 ($p < .001$). Participants aged 19-39 were more likely to have engaged in self-harming behaviors than participants 40 years and older ($\chi^2(5, 606) = 73.56, p < .001$).



Transgender participants were significantly more likely to engage in self-harming behaviors ($\chi^2 (1, 600)=24.67, p<.001$). Over two-thirds of transgender individuals reported that they had engaged in self-harming behaviors, while less than half of cisgender individuals had engaged in self-harming behaviors. Finally, bisexual, queer/pansexual, unsure/questioning, and asexual participants were more likely than homosexual/gay/lesbian and heterosexual/straight participants to have engaged in self-harming behaviors ($\chi^2 (6, 604) = 67.72, p<.001$).

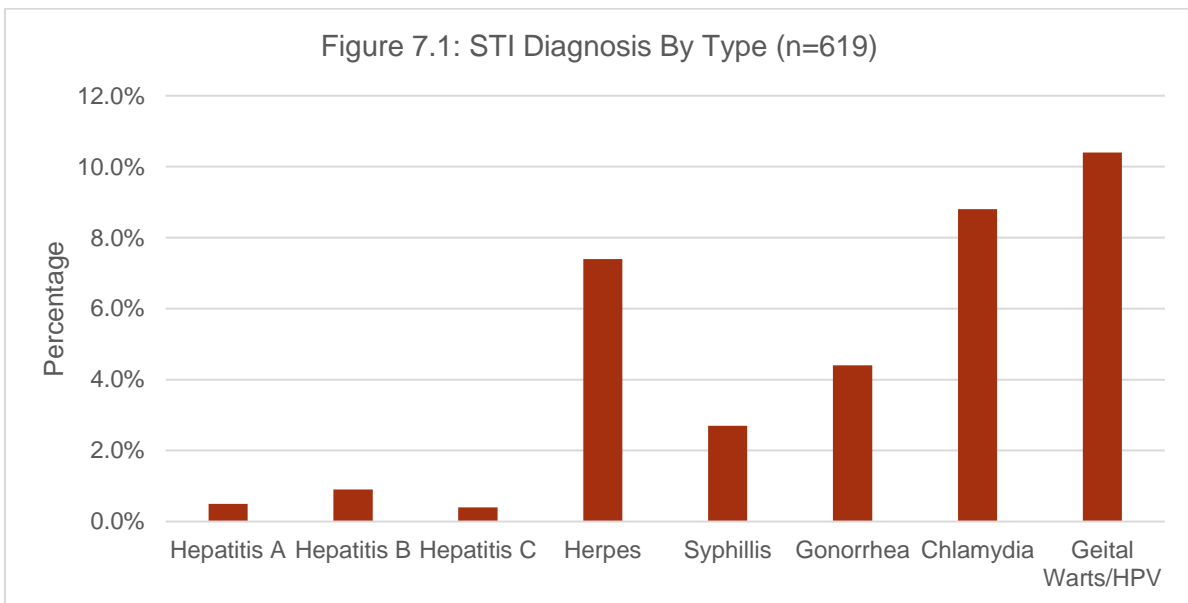
7. STIs and HIV

The prevention, testing, and treatment of sexually transmitted infections (STIs), specifically human immunodeficiency virus (HIV), are crucial to the health of the LGBTQ+ community. The Midlands LGBTQ+ Health Survey assessed participants' STI and HIV diagnoses, testing behaviors, and one HIV prevention strategy, use of pre-exposure prophylaxis (PrEP). Key STI and HIV findings include:

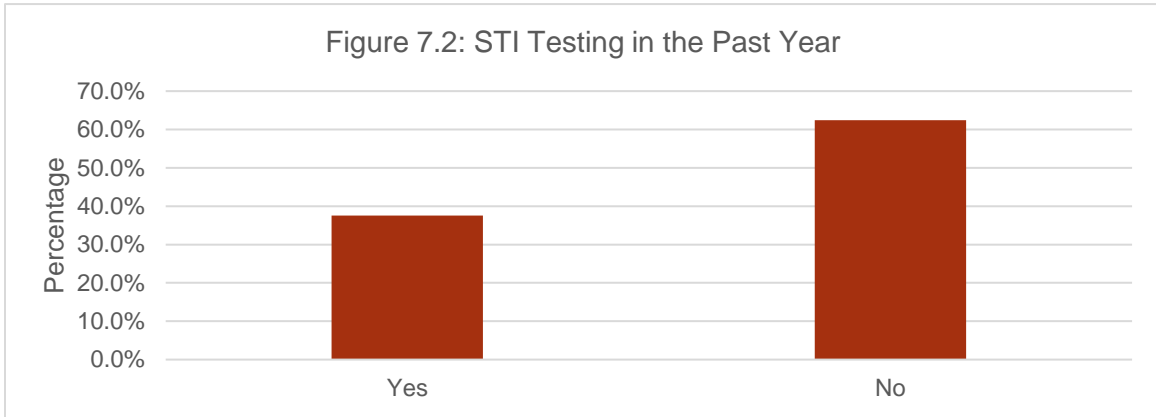
- About one-quarter of the sample reported being diagnosed with an STI and 3% reported an HIV diagnosis.
- The most common STI diagnoses were genital warts/HPV, chlamydia, and herpes.
- Relatively small proportions of the sample had been tested for either STIs or HIV in the last year.
- Participants with very low incomes were less likely to report HIV testing. Cisgender and transgender men were more likely to report HIV testing.
- 3% of the sample were using PrEP for HIV prevention.

STI Diagnosis and Testing:

Participants were asked about STI diagnoses, including hepatitis A, hepatitis B, hepatitis C, herpes, syphilis, gonorrhea, chlamydia, and genital warts/HPV. Almost a quarter of participants in the study reported that they had been diagnosed with at least one STI (22.3%, n=138). The most prevalent STIs were genital warts/HPV (10.4%, n=59), chlamydia (8.8%, n=50), and herpes (7.4%, n=42).



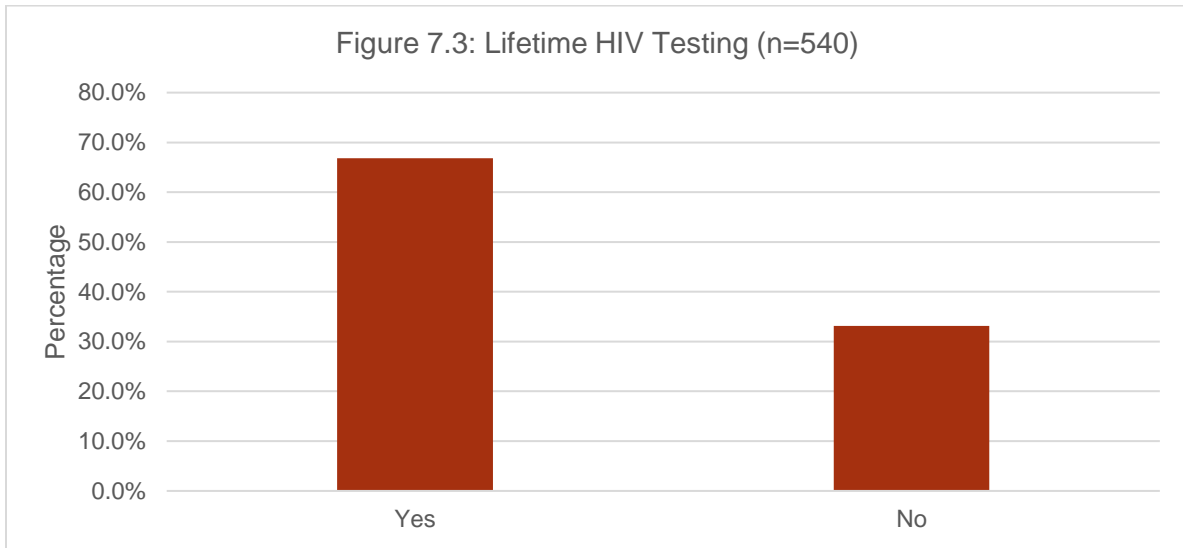
Participants were also asked whether they had been tested for STIs at any point in the last year. Nearly two-thirds of participants reported that they had not been tested for STIs in the last year (n=351, 62.5%).



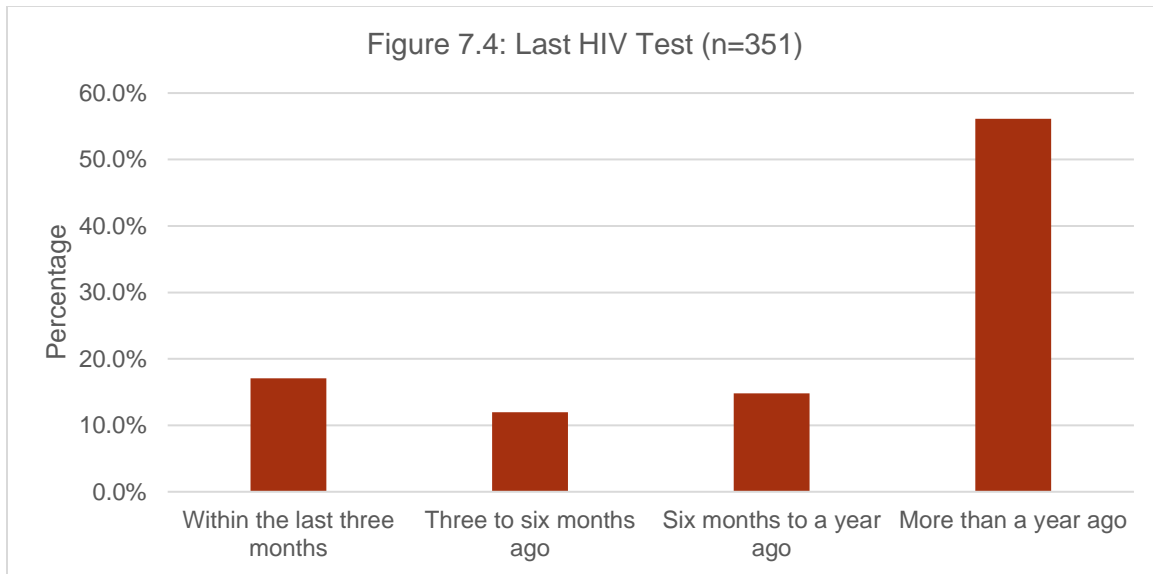
STI diagnoses were significantly correlated with age and gender identity. Participants over 40 years old were more likely to report an STI diagnosis than those 39 and younger ($\chi^2(5, 618)=35.296, p<.001$). Cisgender participants were more likely to report an STI diagnosis than transgender participants ($\chi^2(1, 612)=13.449, p<.001$).

HIV and PrEP

Participants were asked about HIV testing, HIV diagnosis, and whether they were taking PrEP. A large portion of participants reported they had never been tested for HIV (33.1%, n=179). Of those that had been tested, more than half reported that their last HIV test was more than a year ago (56.1%, n=197). Three percent of participants reported that they had been diagnosed with HIV (n=12). Three percent of participants reported taking PrEP for HIV prevention (n=17).



Whether participants had been tested for HIV varied with age, income, and gender identity. Participants 29 years-old and younger were less likely to have been tested for HIV than participants over 30 ($\chi^2(5, 540) = 44.641, p<.001$). Participants with yearly income less than \$10,000 were less likely to have been tested for HIV than participants with higher incomes ($\chi^2(8, 513) = 22.996, p<.01$). Finally, cisgender women, transgender women, and genderqueer/non-binary individuals were less likely to have been tested for HIV than cisgender men and transgender men ($\chi^2(5, 540) = 29.482, p<.001$).



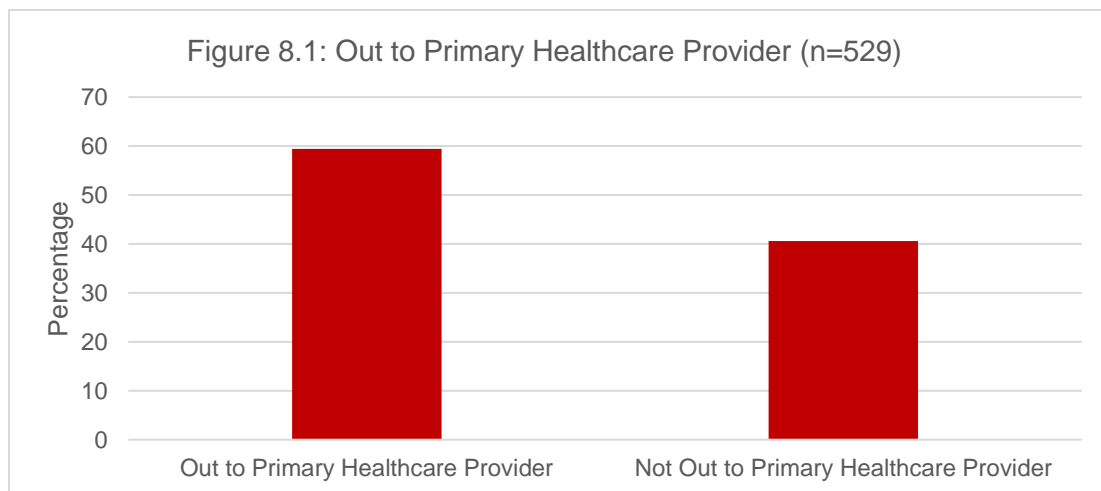
8. Healthcare Access and Experiences

Access to healthcare is critical to both individual and population-based health. Health insurance, culturally competent care, and feelings of trust with primary healthcare providers are all crucial to quality of health. The Midlands LGBTQ+ Health Survey assessed access to healthcare through a variety of questions. Specifically, questions were asked regarding outness to healthcare provider, healthcare coverage, and cost as a barrier to healthcare. In general, some groups were able to access healthcare more easily than others. Key healthcare access and experience findings include:

- 89% of participants reported that they had some type of health insurance and 57% of participants reported that they had a routine check-up with their primary health care provider in the last year.
- Participants in rural areas were significantly less likely to have healthcare coverage compared to those in urban areas.
- There was a significant disparity in healthcare coverage for trans women.
- Transgender people were much less likely to have had routine healthcare in the past 5 years.
- People of color, transgender, low income, and younger adults were more likely to experience cost as a barrier to seeing a doctor.

Outness to Health Care Provider

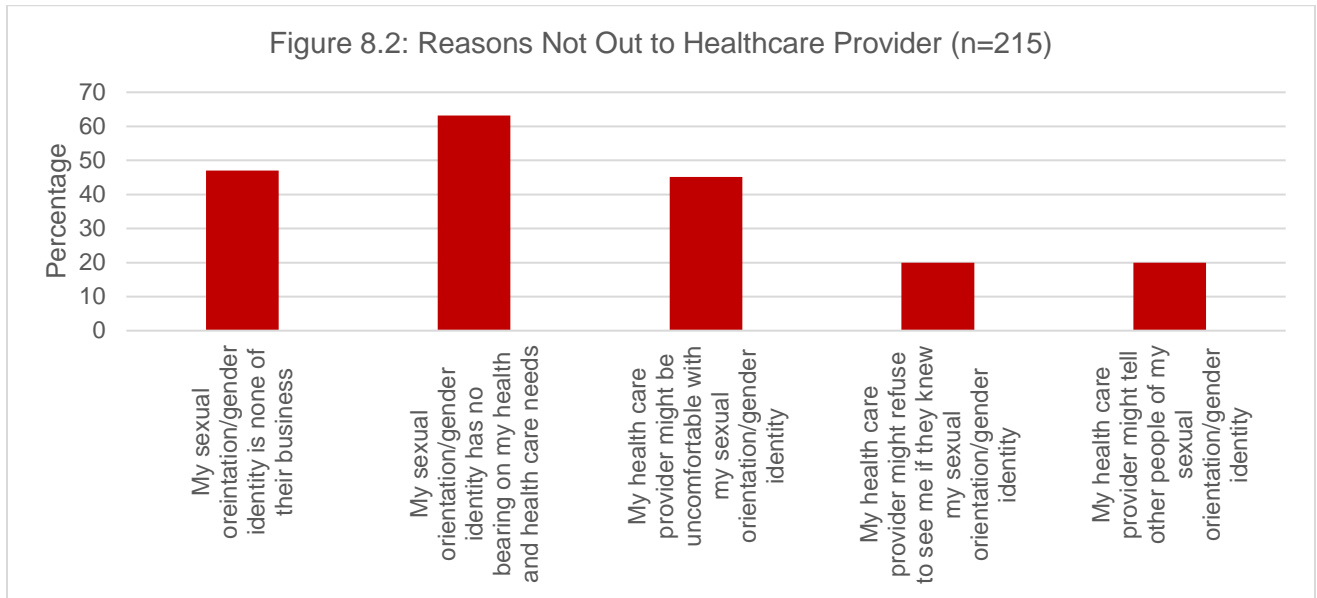
More than half of participants in this study were out to their primary healthcare provider, in terms of their sexual orientation and/or gender identity (n=314, 59.4%). Of those who were out to their primary health care provider, 48.1% of participants stated that their provider knew their sexual orientation (n=298), while 69.3% of participants stated their provider knew their gender identity (n=429).



The probability of being out about one’s sexual orientation and/or gender identity to one’s healthcare provider varied by gender identity, age, sexuality, and income group. Trans men were much more likely to be out to their primary healthcare providers than other gender groups ($\chi^2(5,529)=42.2, p<.001$). Participants 30 years old or over were more likely to be out to their

healthcare provider than participants under 30 years old ($\chi^2 (5,528)=78.1, p<.001$). Homosexual/gay/lesbian participants were more likely to be out to their healthcare providers than heterosexual/straight, bisexual, queer/pansexual, unsure/questioning, and asexual participants ($\chi^2 (6, 527)=48.2, p<.001$). Finally, as participant’s income increased, the likelihood of them being out to their healthcare provider also increased ($\chi^2 (8,463)=27.2, p<.001$).

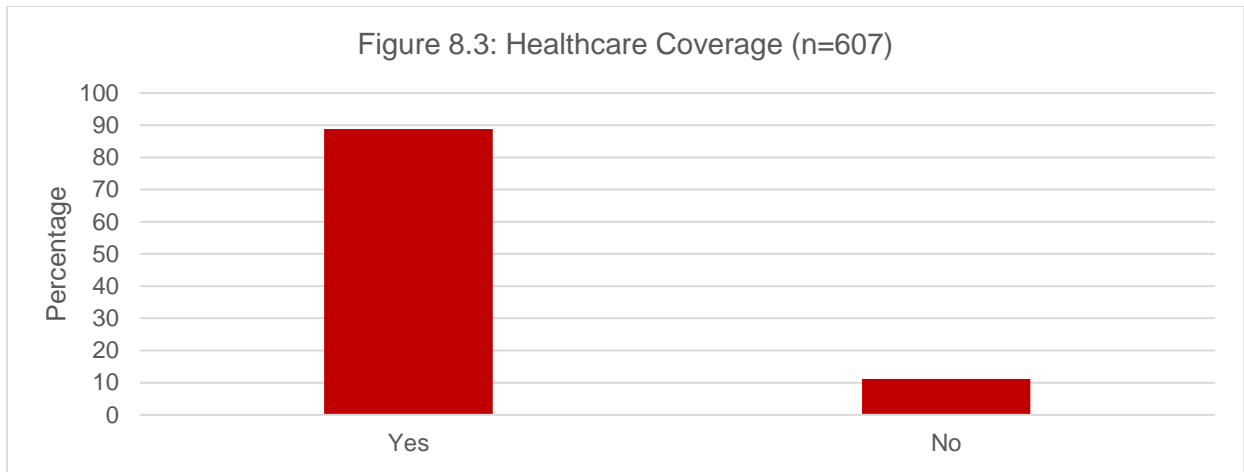
Of those not out to their healthcare provider (n=215, 40.6%), more than half believed that their sexual orientation/gender identity had no bearing on their health (n=136, 63.2%), about half thought their gender identity/sexual orientation was none of their provider’s business (n=101, 47.0%), and about half thought that health care provider might be uncomfortable with their sexual orientation/gender identity (n=91, 45.1%).



Health Insurance

About 92% of people in the United States had health insurance for all or part of 2019.¹⁴ Most people in this study (88.8%) reported having some kind of healthcare coverage such as insurance, HMOs, or Medicare. However, significant disparities existed. For example, 25% of transwomen did not have any kind of health care coverage (n=21). This is a significant disparity in healthcare coverage, when compared to ciswomen, ciswomen, and transmen ($\chi^2 (5,607) = 11.7, p<.05$).

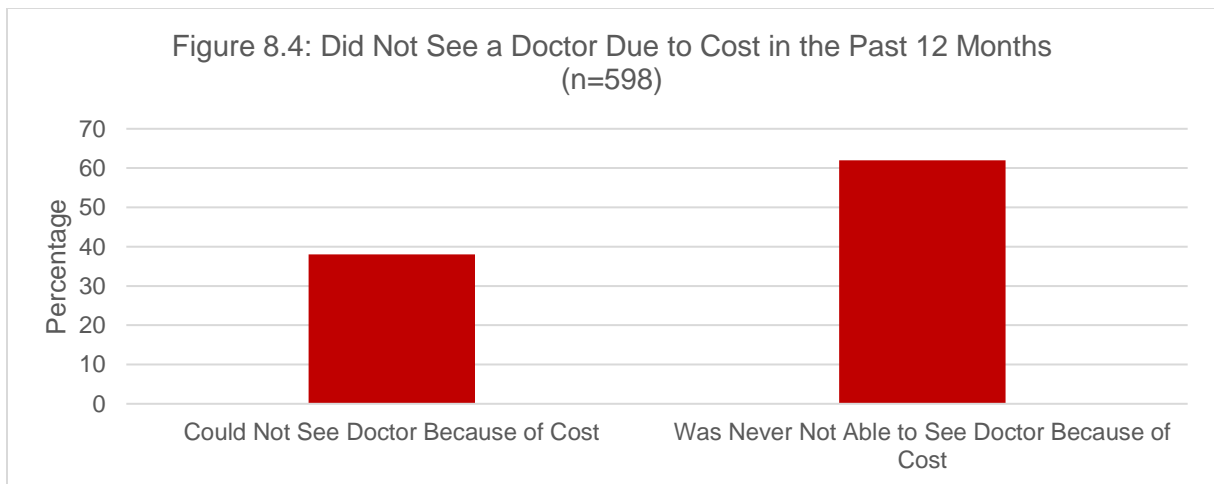
Participants in rural areas were also less likely to have healthcare coverage than participants in urban areas. Of participants in rural areas, 19.5% did not have health care coverage, while only 9.8% of participants in urban areas did not have health care coverage, which was also a significant disparity ($\chi^2 (1,607) = 7.1, p<.01$).

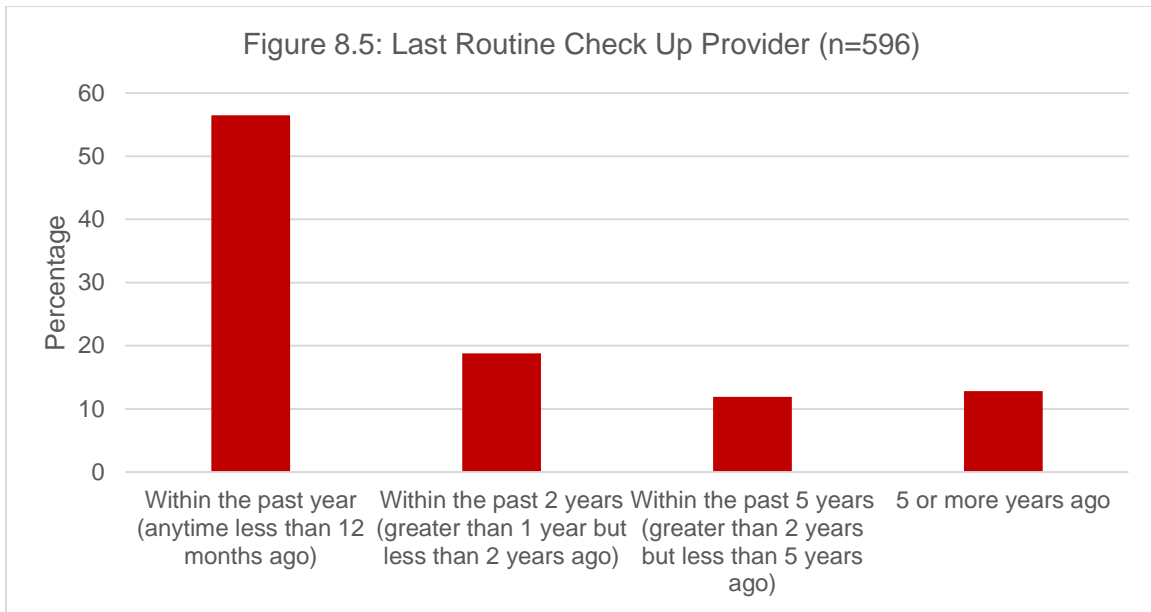


Finally, there were significant disparities in healthcare coverage based on income. Of participants with annual incomes over \$50,000, only 7% did not have healthcare coverage. However, a significantly higher proportion of participants in lower income categories did not have health insurance: 23.8% of individuals in the less than \$10,000 annual income category, 22.5% of participants in the \$10,001-\$15,000 income category, and 22.5% of individuals in the \$15,001-20,000 income category ($\chi^2 (8, 532) = 35.5, p < .001$).

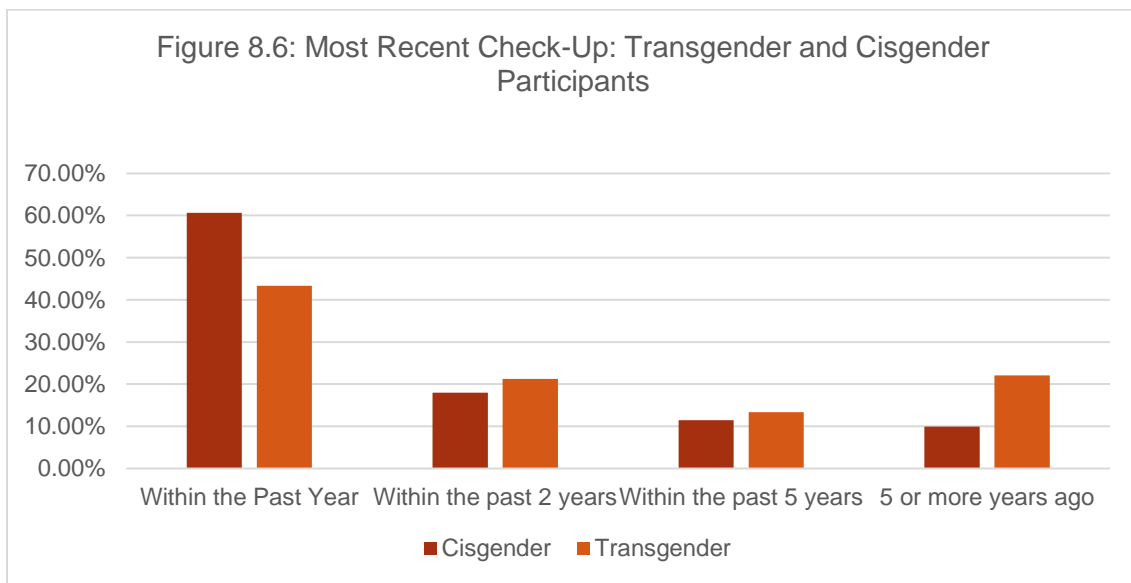
Health Care Access

Thirty-eight percent of participants in this survey reported that there was a time in the past twelve months when they needed to see a doctor but could not because of cost (n=227). Additionally, 43.5% of individuals in this study reported that they had not had a routine check-up with their healthcare provider in more than a year (n=259). These rates were much higher than both nationwide samples and across Nebraska as a whole – 12.4% of people nationwide and 12.6% of Nebraskans experienced cost as a barrier to healthcare access in 2019¹⁷.





Transgender participants were much more likely than cisgender participants not to be able to see a doctor because of cost. 53.5% of transgender participants stated there had been a time in the past 12 months when they needed to see a doctor but could not because of cost (n=68), compared to 33.5% of cisgender participants (n=156), which is a significant disparity in health care access ($\chi^2(1,592)=17.0, p<.001$).



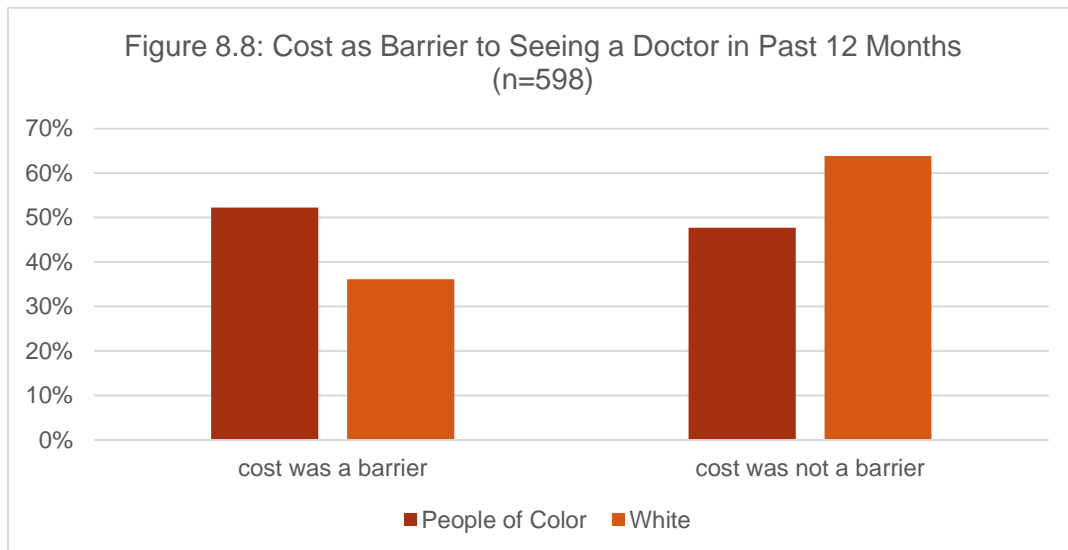
Transgender participants were also more likely not to have had a check-up within the last year. Specifically, 43.3% of transgender participants reported seeing a doctor for a routine check-up within the last year, while 60.6% of cisgender participants reported seeing a doctor within the last year. Additionally, 22.0% of transgender participants reported their last check-up happening more than 5 years ago, compared to only 10% of cisgender participants, which was a significant disparity based on gender identity ($\chi^2(3, 589)=17.718, p<.001$).

Participants in this study who identified as bisexual, queer/pansexual, questioning, asexual, and straight were much more likely to report cost as a barrier to seeing a doctor than participants who identified as homosexual/gay/lesbian. Forty-seven percent of bisexual participants, 43% of queer/pansexual participants, 60% of questioning participants, 50% of asexual participants, and 55% of straight participants reported not being able to see a doctor due to cost, compared to only 25.1% of homosexual/gay/lesbian participants ($\chi^2(6, 595)=27.419, p<.001$).

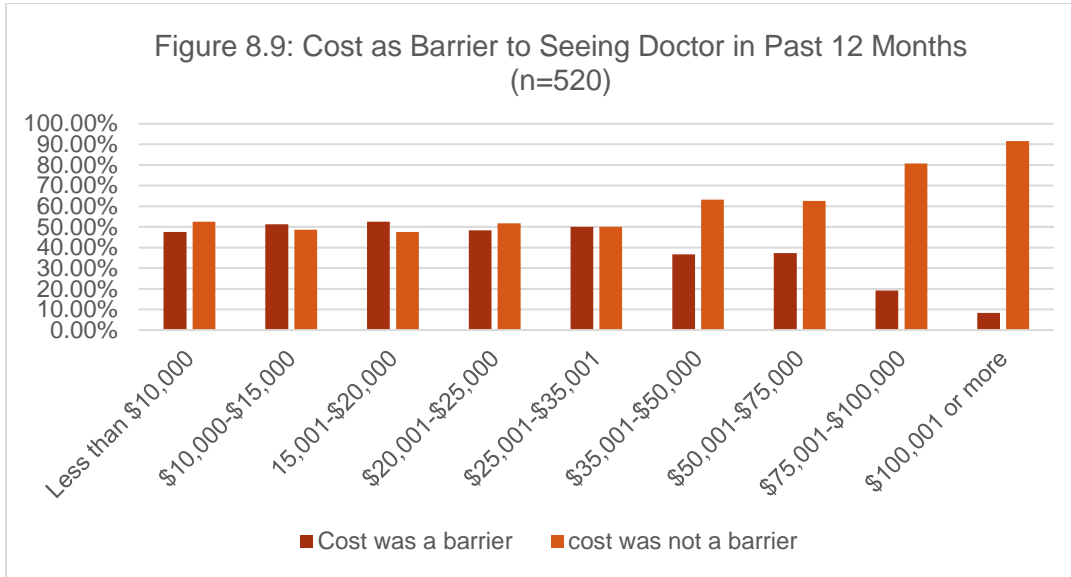
Bisexual, queer/pansexual, questioning, and asexual participants were also much more likely to have not had a check-up in more than a year. 48.2% of bisexual participants, 52.4% of queer/pansexual participants, 83.3% of questioning participants, and 58.3% of asexual participants had their last check-up more than a year ago, while only 27.3% of heterosexual participants and 33.3% of homosexual/gay/lesbian participants' last check-up was more than a year ago.

Younger participants were also much more likely than older individuals to report not being able to see a doctor due to cost. For example, 52.6% of 19 year old participants and 45% of 20 to 29 year old participants stated there had been a time in the last twelve months where they needed to see a doctor but could not because of cost, while only 25% of 50 to 59 year old participants and 5.6% of participants 60 years and older could not see a doctor because of cost. This is a significant difference in access to health care ($\chi^2(5, 598)=26.723, p<.001$).

Younger individuals were also less likely to have had a routine check-up in the last year. Specifically, 68.4% of 19 year old participants had not had a routine check-up in the last year. For participants aged 20 to 29, 50.2% had not had a routine check-up in the last year. In contrast, only 24.2% of 50-59 year old participants and only 8.3% of participants aged older than 60 had not had a routine check-up in the last year.



There were also racial disparities in healthcare access. Participants of color were much more likely to have not been able to see a doctor because of cost, as compared to white participants. In this study, 52.2% of participants of color reported cost being a barrier to seeing a doctor, while only 36.2% of white participants reported the same ($\chi^2(1, 598)=6.532, p<.05$).



Finally, as the incomes of participants in this study increased, their likelihood of not being able to afford a doctor’s visit decreased. For example, between 45 and 55% of participants with incomes between \$10,000 and \$35,000/year reported not being able to see a doctor because of cost. In comparison, less than 20% of participants with incomes of \$75,0001 and higher reported not being able to see a doctor because of cost. This is a distinct disparity in access to healthcare based on income ($\chi^2 8, 520=46.576, p<.001$).

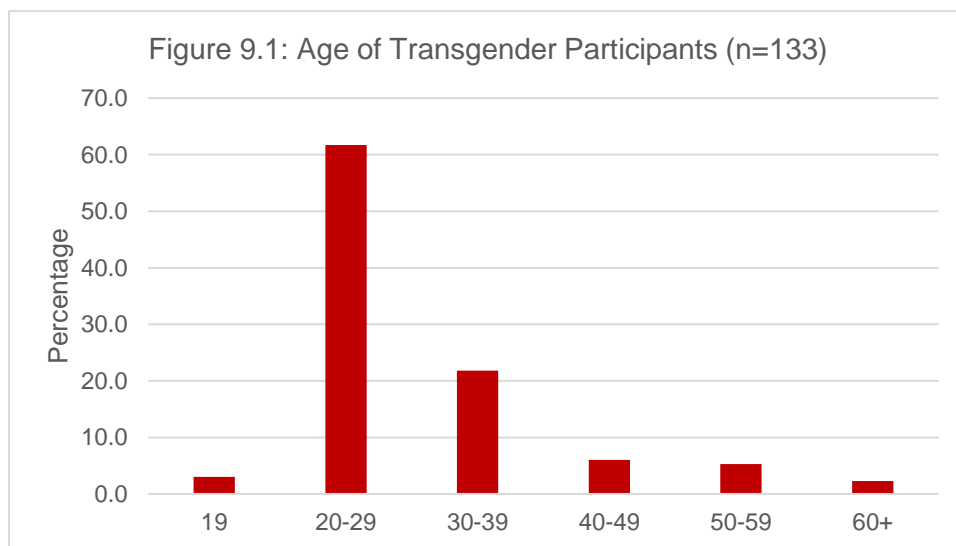
9. Transgender Experiences and Health

Transgender individuals face increased hostility in the form of bathroom/locker room bans, youth sports bans, bans/restrictions on transgender medical care,¹⁵ and fatal violence.¹⁶ Because of these factors, transgender individuals experience a unique set of challenges and experiences that are distinct from their cisgender LGBTQ+ counterparts. MSHRC sought to better understand the experiences of transgender Nebraskans by asking transgender participants an additional 13 questions about accessing gender-related healthcare and the impact of transitioning on mental health. Key findings include:

- Almost half of transgender participants reported that they were currently using hormones.
- About 60% of transgender participants reported that they have seen a mental health provider for gender-related issues at some point in their lives.
- Only 17% of transgender participants reported that they had gender affirmation surgery, while 43.6% reported that they planned to have surgery in the future.
- Accessing gender affirming hormone therapy, surgeries, and mental healthcare positively impacts mental health for transgender participants - 90% of participants who had taken hormones, 85% of participants who had accessed mental health services, and 100% of participants who had accessed surgeries reported that these services had improved their mental health.
- Overall, transitioning has a positive impact on mental health - almost 80% of transgender participants reporting that their mental health improved after transitioning.

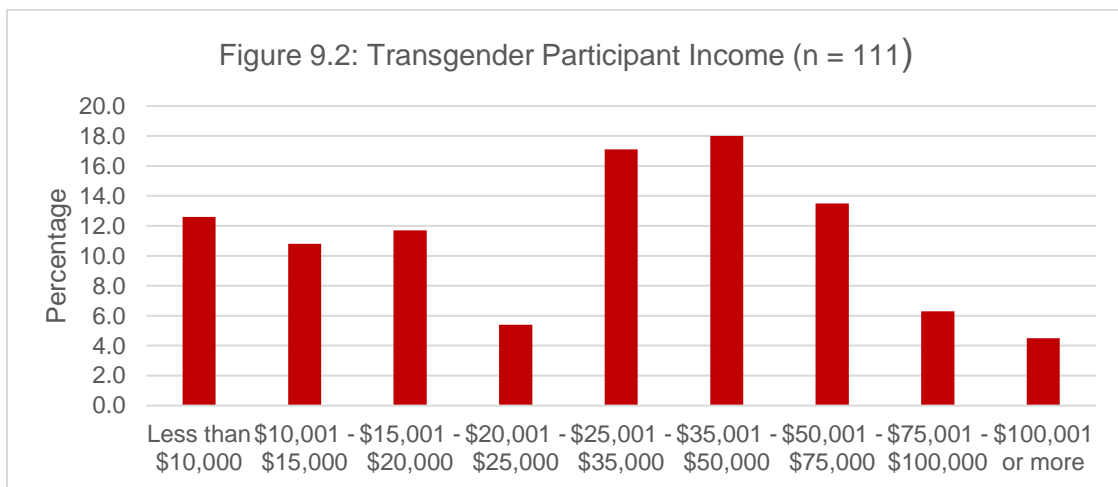
Transgender Participant Demographics

Of the total sample of LGBTQ+ persons, 21.7% of participants (n=133) self-selected as transgender for the purposes of classification and analysis. The majority of transgender and gender expansive participants lived in urban and suburban areas, with less than 10% of participants reporting living in a rural zip code. The majority (61.7%) of transgender participants were 20-29 years old, with an additional 21.8% reporting an age of 30-39.

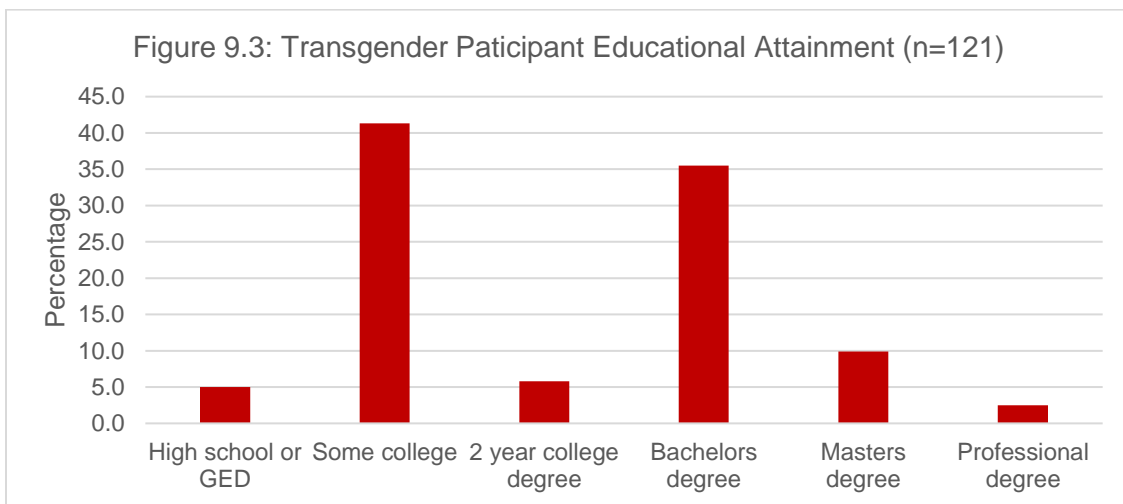


Approximately 16% of transgender participants were people of color, while 84% were white. Approximately 2% of transgender participants report being Hispanic or Latino. Approximately 35% reported being single, while 56% reported being in a committed relationship with 1 partner and an additional 9% reported being in a committed relationship with multiple partners.

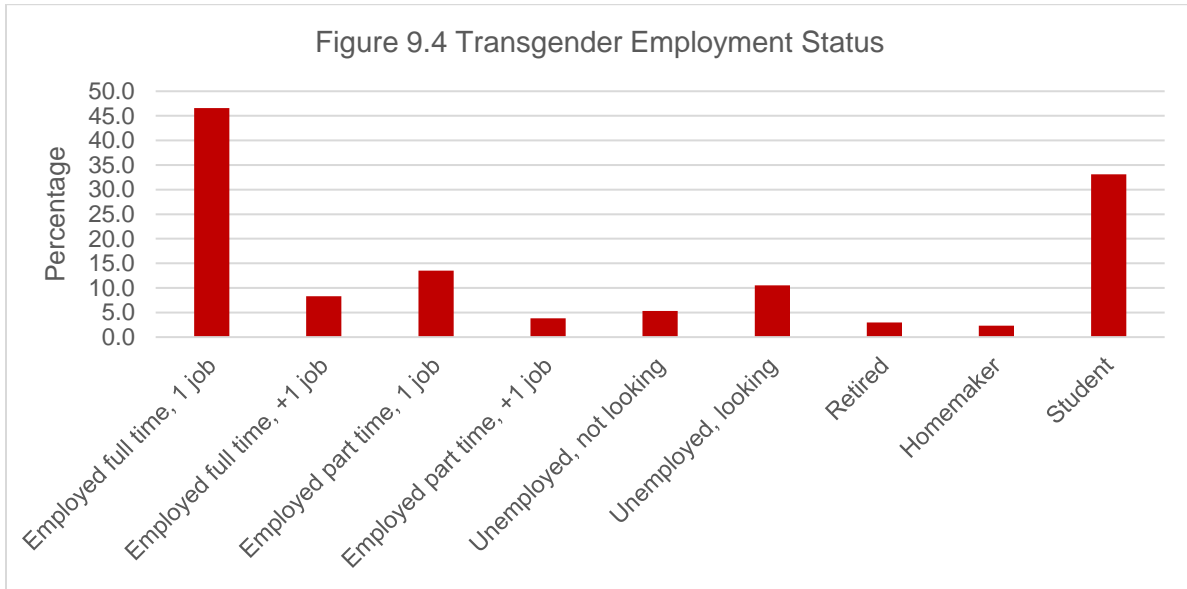
Annual household income for transgender participants were varied. Close to 13% of transgender participants made less than \$10,000, almost 11% made between \$10,000 and \$15,000, and almost 12% report a household income in the \$15,001 - \$20,000 range. Around 5% of transgender participants reported a salary between \$20,001 and \$25,000, and an additional 17% reported incomes between \$25,001 and \$35,000. More than half, roughly 58%, of participants reported a household income at or below \$35,000. The greatest percentage of participants, at 18%, reported a household income between \$35,001 and \$50,000. Less than 25% of transgender participants make more than \$50,001 annually.



Educational attainment for transgender participants was lower than for cisgender participants. Roughly 41% of transgender participants report some college, and approximately 32% of transgender participants report a bachelor's degree.

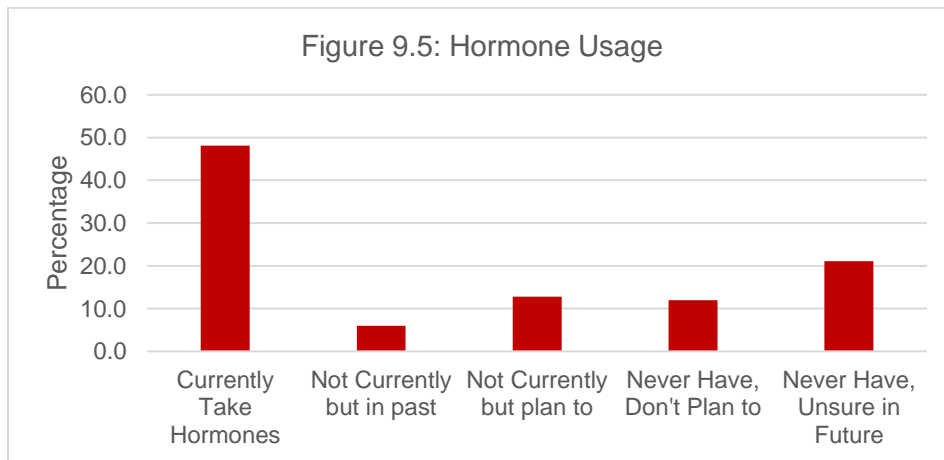


Approximately 46% of transgender participants reported that they were employed full-time with 1 job (n=62) and 8% were employed full time with more than one job (n=11). A greater percentage of cisgender participants were employed full-time with only one job (n=260, 54.3%). About 14% of transgender participants were employed part-time with more than one job (n=18) and 4% were employed part-time with more than one job (n=5). Finally, about 11% of transgender participants were unemployed (n=14). This is a much greater percentage of unemployment than for cisgender participants, of which only 3.3% were unemployed (n=16).

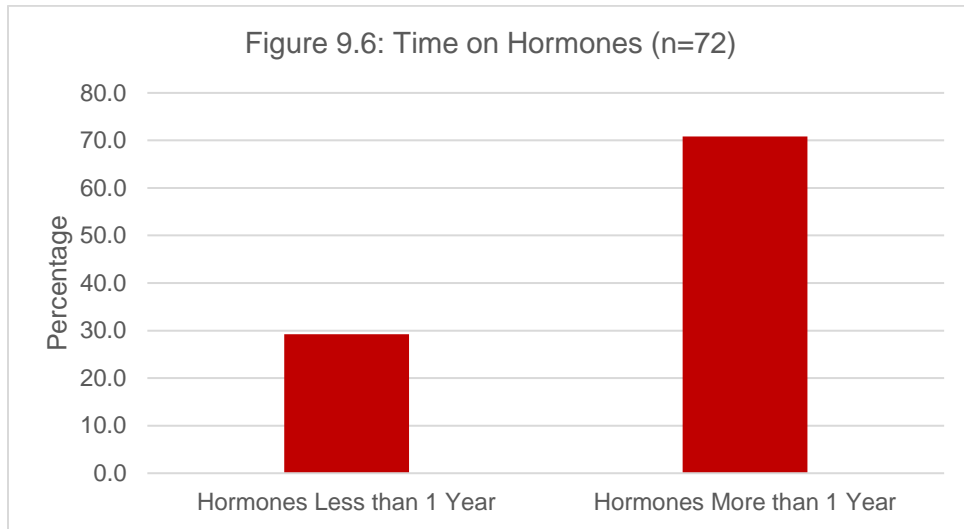


Gender Affirming Hormones

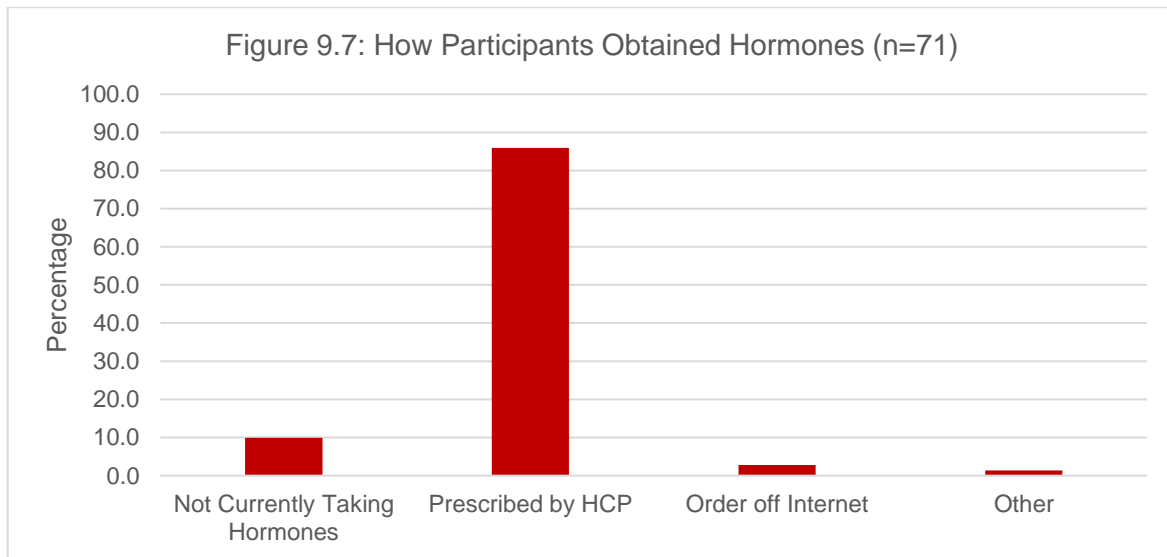
Almost half of transgender participants in this study reported that they were currently taking gender affirming hormones (n=64). This is less than the national rate (76%)¹⁸. Roughly 13% of transgender participants reported that they had never taken hormones, but planned to in the future (n=17). Another 12% of transgender participants had never taken hormones and never planned to take hormones (n=16). About 20% of transgender participants had have never taken hormones and were undecided about whether they would take them in the future (n=28).



Of the individuals who had taken hormones before, 70.8% of them had been on hormone therapy for more than a year. The amount of time participants had taken hormones varied based on age. Individuals in age groups older than 30 were more likely to have taken hormones for more than 1 year ($\chi^2 (5, 72)=11.604, p<.05$).

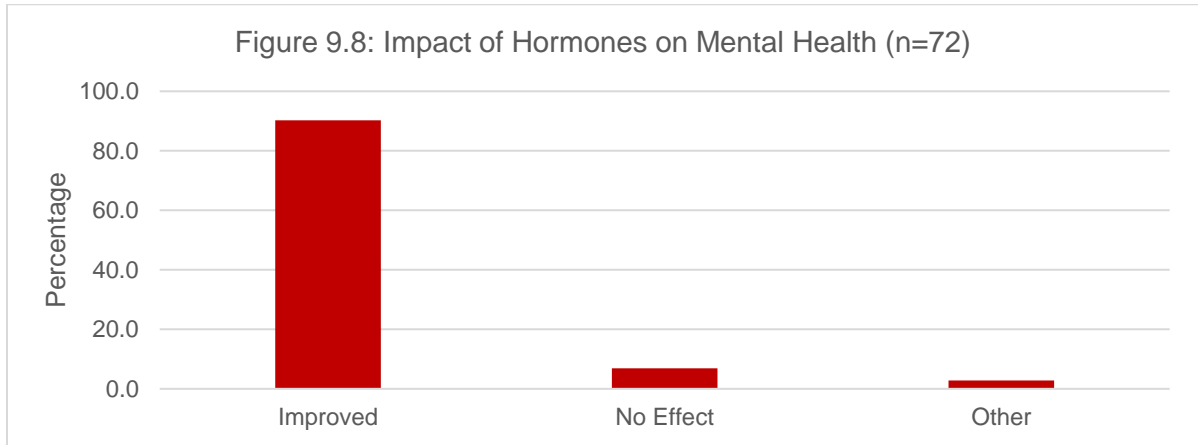


About 86% of transgender participants who were taking hormones had hormone therapy prescribed to them by a health care provider (n=61, 85.9%) and 2.8% ordered them off the internet (n=2). Additionally, 15.3% had taken hormones that were not prescribed by a doctor at some point (n=11). Individuals in the 60+ age category were more likely to have taken hormones that were not prescribed to them by a doctor at some point in their life ($\chi^2 (1, 71)=32.809, p<.01$).



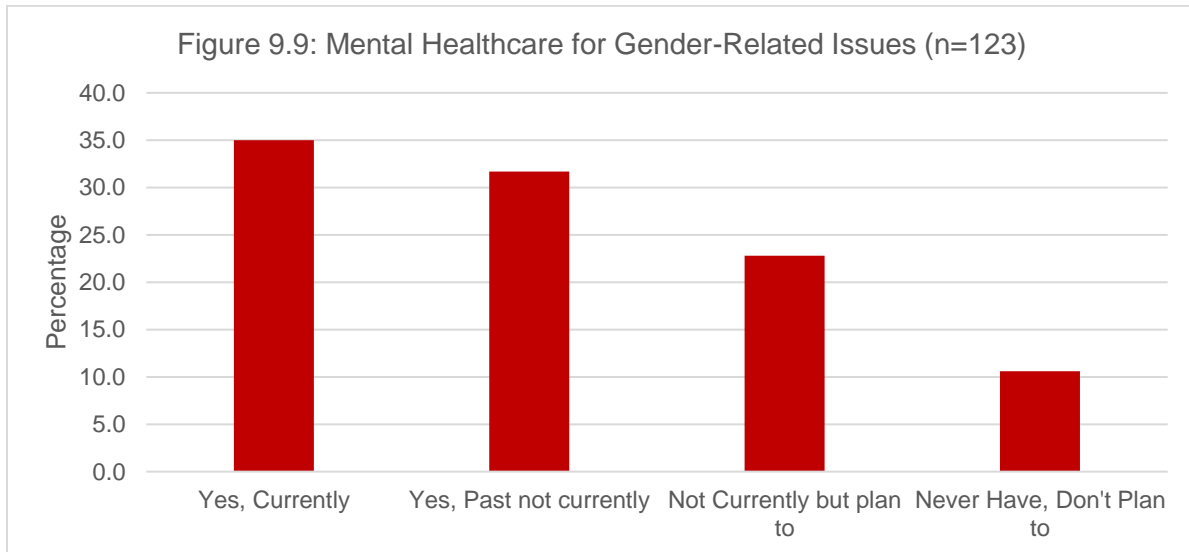
Roughly 90% of individuals who had taken hormones to align their body with their gender identity reported that their mental health improved (n=65, 90.3%), while only 6.9% reported that there was no impact on their mental health (n=5). This impact on mental health varied based on race.

Specifically, people of color were less likely to say that taking hormones improved their mental health ($\chi^2 (2, 52)=12.249, p<.01$).



Mental Healthcare for Gender-Related Issues

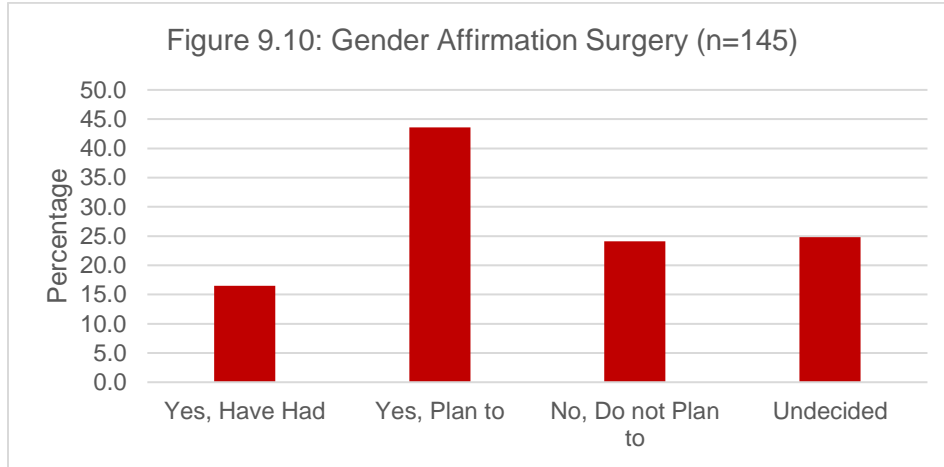
Transgender participants were also asked about seeing a mental health provider for gender-related issues. 38.3% of transgender participants reported that they had never seen a mental health provider for gender-related issues (n=51) and 67.7% were not currently seeing a mental health professional for gender-related issues (n=90). However, of the individuals who had seen a mental health professional for gender-related issues, 85.4% reported that their mental health improved (n=70).



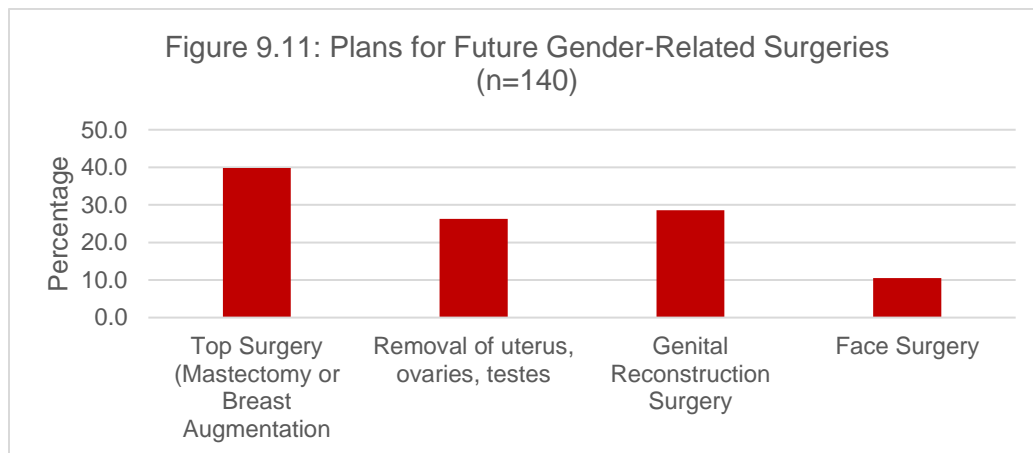
Gender Affirmation Surgeries

About 17% of transgender participants reported that they had already had a gender affirmation surgery (n=22) and 43.6% said that they planned to have a gender affirmation surgery in the future (n=58). About a quarter of participants stated that they did not plan on having gender affirmation surgery (n=32, 24.1%). Of the individuals that have had gender affirmation surgery, 95.5%

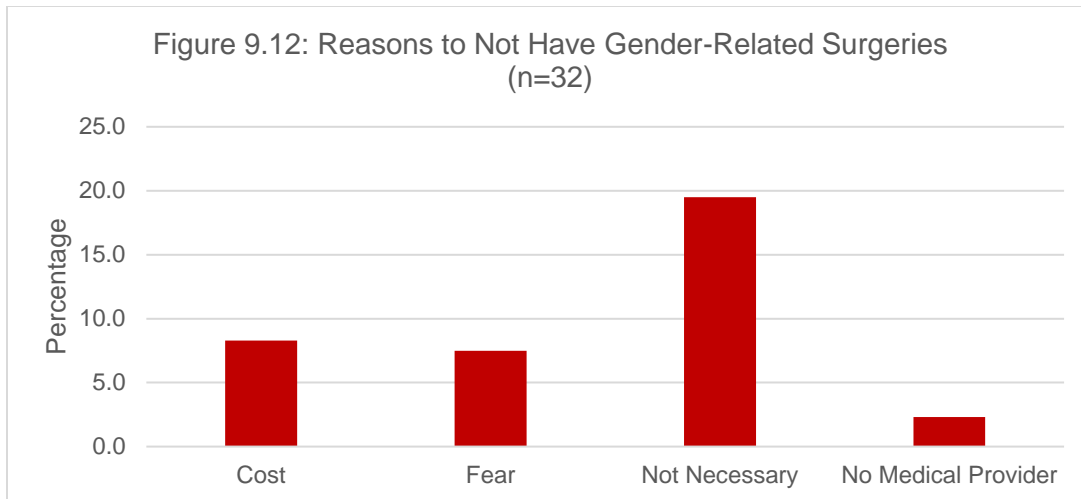
reported that they had a mastectomy or breast augmentation (n=21), 59.1% removed their uterus, ovaries, or testes (n=13), and 13.6% had genital reconstruction surgery (bottom surgery) (n=3). One hundred percent of individuals reported that their mental health improved after having these surgeries (n=24).



Participants were also asked about what kinds of surgeries they plan to have in the future. Of the 133 transgender participants, 39.8% stated that they planned to have a mastectomy or breast augmentation (top surgery) (n=53), 26.3% planned to remove their uterus, ovaries, or testes (n=33), 28.6% planned to have genital reconstruction surgery (n=38), and 10.5% planned to have face surgery (n=15). A number of additional participants reported that they planned to have voice feminization surgery.

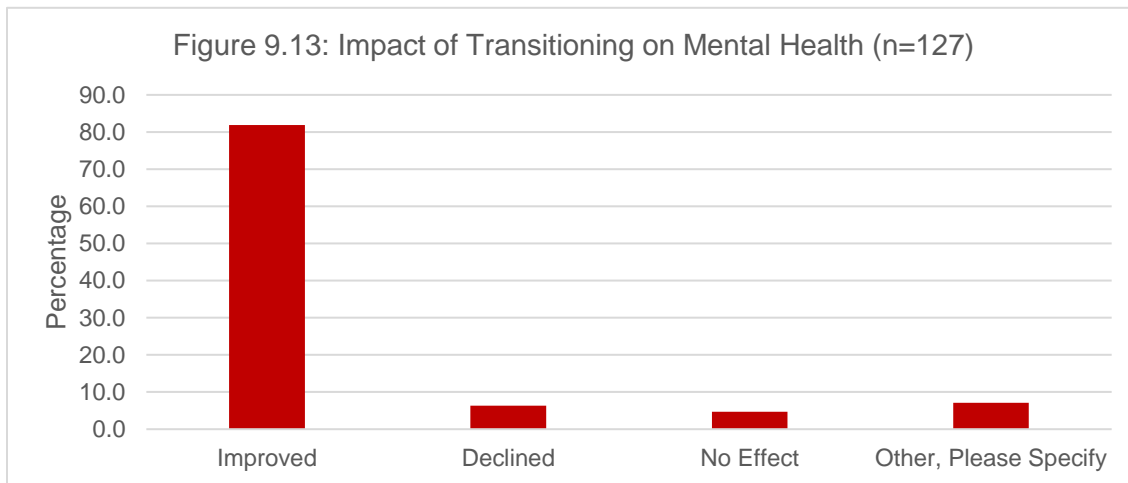


Participants were asked about why they did not want to have surgeries in the future. Of the 32 individuals who did not want to have surgery in the future, most participants stated that they chose not to have future surgeries due to not thinking surgery is necessary (n=26, 81.3%), though there were also concerns with the cost (n=11, 34.4%), fear (n=10, 31.3%), and not having a medical provider to facilitate the process (n=3, 9.4%).



Impact of Transitioning on Mental Health

Most of the participants in this study reported that transitioning had a positive impact on their overall mental health. Specifically, 78.2% of transgender participants stated that their mental improved after transitioning. Only 10.5% of participants stated that their mental health did not improve or their mental health declined following their transition (n=14).



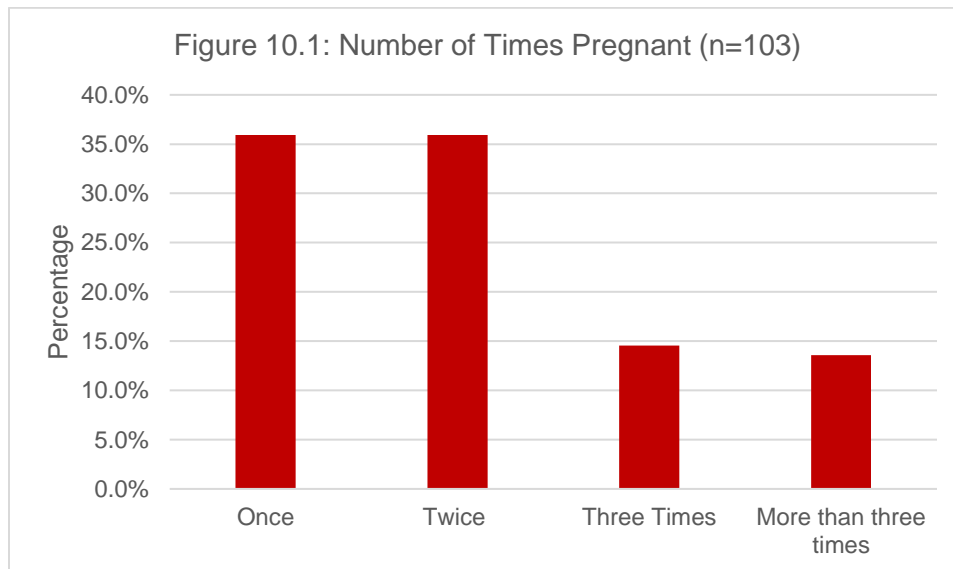
10. Pregnancy Experiences

Despite LGBTQ+ individuals having unique needs surrounding pregnancy, family planning, and contraception, this population is often overlooked or forgotten about when studying pregnancy experiences. The Midlands LGBTQ+ Health Survey assessed pregnancy in terms of the number of times individuals were pregnant, use of birth control before pregnancy, timing of pregnancy, and use of fertility services. Key pregnancy experience findings include:

- 18% of participants have been pregnant at least once.
- About 40% of participants who had stopped birth control, stated it was not because they wanted to become pregnant or have a baby (n=27).
- More than half of participants stated that they had become pregnant sooner than they wanted.
- Most of the participants stated that they had not utilized fertility services for their most recent pregnancy (89.2%, n=91).

Number of Pregnancies

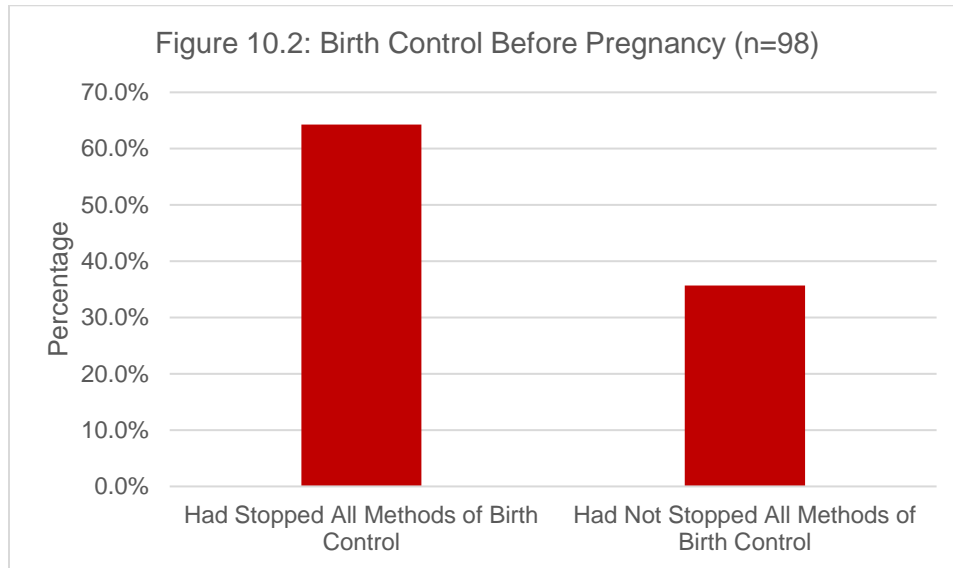
A little less than 20% of participants in this study had been pregnant at one point in their life (n=103, 18.4%). Of the participants who had been pregnant, equal number of participants had been pregnant once (n=37, 35.9%) or twice (n=37, 35.9%), 14.6% had been pregnant three times (n=15), and 13.6% had been pregnant more than three times (n=14).



Pregnancy experiences varied by age, gender, and sexuality. Individuals in the 40 to 49 year old age group were more likely to have been pregnant than any other age category (40.3%; $\chi^2 (5, 560)=43.727, p < .001$), followed by 30 to 39 year olds were (25.3% had been pregnant). Cisgender women were more likely than any other gender category to have been pregnant at some point ($\chi^2 (5, 561)=84.627, p < .001$). Finally, individuals in the queer/pansexual (35, 22.9%), bisexual (43, 27.7%), and heterosexual/straight (2, 22.2%) sexuality groups were more likely to have been pregnant than other sexuality groups (homosexual/gay/lesbian, unsure/questioning, and asexual) ($\chi^2 (6, 559)=26.669, p < .001$).

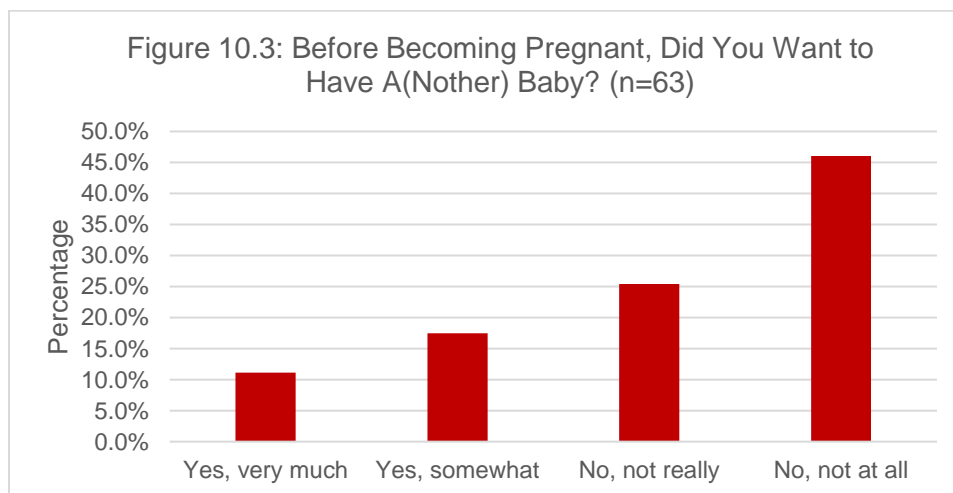
Birth Control

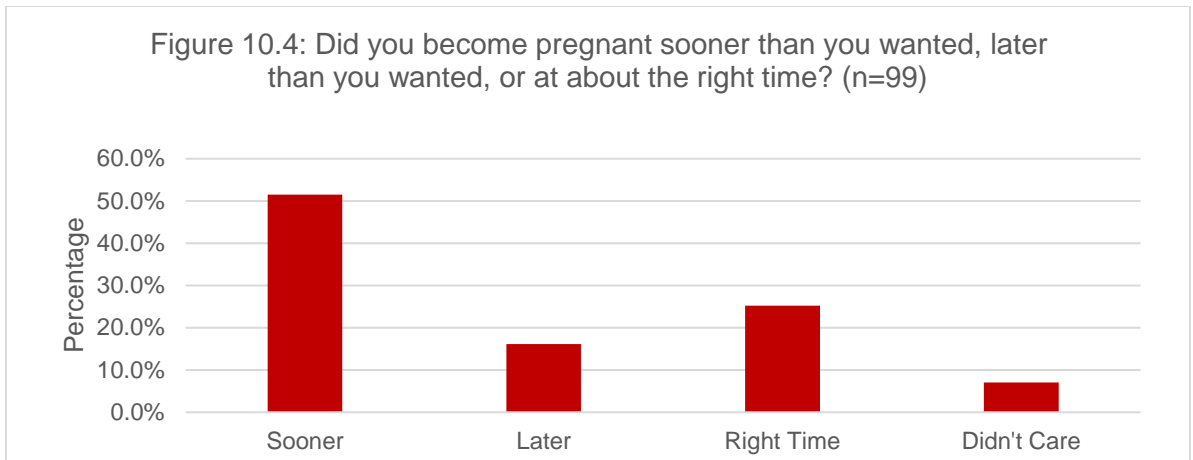
Before becoming pregnant, 64.3% of participants reported that they had stopped their pregnancy prevention methods (n=40). Participants were asked about why they had stopped using pregnancy prevention methods. About 40% of participants who had stopped birth control, stated it was not because they wanted to become pregnant or have a baby (n=27).



Pregnancy Intentions and Timing

Participants were also asked about whether they wanted to have a(nother) baby, both before and after becoming pregnant. Over 70% of participants stated that they did not want to have a(nother) baby at all or not really before becoming pregnant (n=45). After knowing that they were pregnant, over 60% of participants reported that they did not at all or did not really want to have another baby in the near future (n=38). More than half of participants stated that they had become pregnant sooner than they wanted (51.5%, n=51), 16.2% reported that they had become pregnant later than they wanted, and 25.3% stated they had become pregnant at the right time (n=25).



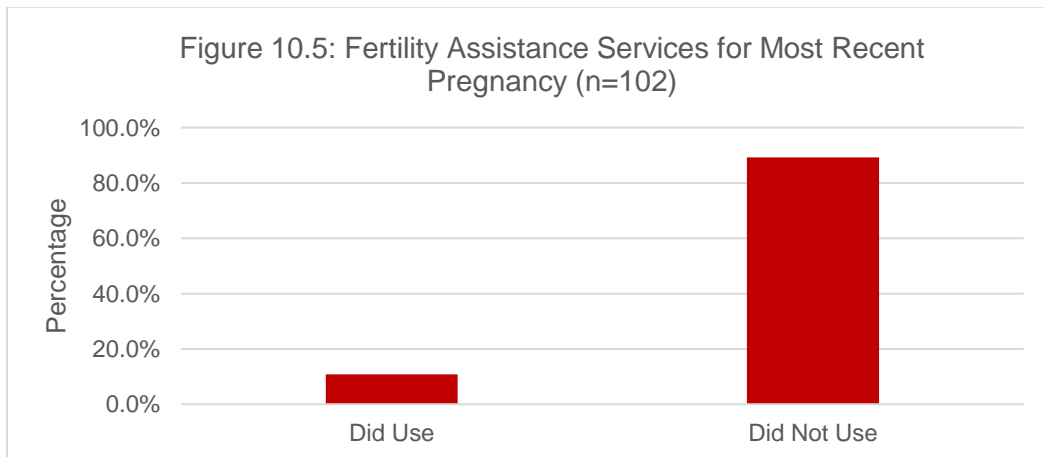


Individuals wanting to have a(nother) baby before realizing they were pregnant and after realizing they were pregnant varied based on age. Individuals in the 20 to 29 year old age group were most likely to have not wanted to have another baby in the near future at all ($\chi^2 (12, 63)=30.027, p<.01$). Individuals in this age group were also most likely to have not wanted to have a(nother) baby at all in the near future after realizing they were pregnant ($\chi^2 (12, 61)=27.960, p<.001$).

Pregnancy timing varied based on race. Mono-racial individuals were more likely to become pregnant sooner than they wanted, while biracial individuals were more likely to have become pregnant later than they wanted ($\chi^2 (3, 99)=14.031, p<.01$).

Fertility Assistance Services

Finally, participants were asked about their use of fertility services. Most of the participants stated that they had not utilized fertility services for their most recent pregnant (89.2%, n=91). Only 10.8% of participants who had been pregnant used fertility services (n=11).



11. Conclusions and Recommendations

Results from the Midlands LGBTQ+ Health Survey indicate that the LGBTQ+ population in Nebraska is diverse and heterogeneous in their identities, health concerns, and social psychological well-being. The community mirrors the racial and ethnic makeup of the state, has an average age of 34, and are predominantly located in and around the urban areas of Omaha and Lincoln. The majority of participants (66.5%) were assigned female at birth, and over 20% of respondents self-identified under the transgender umbrella. Of those who identify as transgender, most identify as non-binary.

White, cisgender, high-income, and urban-dwelling participants fared better across all measures of physical, mental, and social health. Participants with intersecting marginalized identities (ie. participants of color, rural, low-income, or transgender participants) consistently had worse outcomes in socioeconomic markers, as well as social, physical, sexual, and mental health outcomes. Community-wide trends include high levels of participants who had experienced violence, assault, discrimination, as well as high levels of outness, but low levels of self-acceptance and interpersonal support. The rates of depression and anxiety were particularly high in the sample, with over 60% of participants indicating clinical depression and over 58% of respondents indicating a diagnosis of anxiety. Rural LGBTQ+ individuals were less likely to have healthcare coverage compared to their urban peers, leading to inequities in access to care and health outcomes.

In order to begin addressing the disparities in healthcare for LGBTQ+ Nebraskans, there is a clear need for affirming and inclusive healthcare providers. Approximately 41% of participants reported that they were not out to their primary healthcare provider. When asked why this was the case, 45% reported that they thought their healthcare provider might be uncomfortable with their sexual orientation/gender identity, 20% reported that their health care provider might refuse to see them if they knew their sexual orientation/gender identity, and 20% reported that their health care provider might tell other people of their sexual orientation/gender identity. These findings illustrate the fear that LGBTQ+ Nebraskans have in accessing healthcare, especially as it relates to their sexual orientation and gender identity.

The following recommendations and interventions across multiple levels are intended to begin reducing the disparities and inequities identified in this report.

Systems Level Recommendations

Recommendations at this level aid in reducing systemic inequities and increasing protections for the LGBTQ+ community.

- 1) Enact a statewide non-discrimination law protecting the LGBTQ+ community from discrimination in all areas.
- 2) Increase knowledge of and decrease stigma around LGBTQ+ identities through educational policies and widespread anti-bias training.

- 3) Enact policies that ensure a livable wage and a robust social safety net for all Nebraskans, including LGBTQ+ Nebraskans.
- 4) Establish policies and funding for the prevention of violence, with particular attention to violence targeting LGBTQ+ individuals and communities.

Community Level Recommendations

Recommendations at this level focus on establishing more robust LGBTQ+ social support and community networks, as well as increasing the availability of community resources and services.

- 1) All community organizations and agencies should adopt policies to ensure non-discrimination and the provision of LGBTQ+ affirming and inclusive services.
- 2) Establish and fund LGBTQ+ community centers and peer-to-peer support networks, especially in rural areas.
- 3) Ensure that existing LGBTQ+ programming, services, and outreach is inclusive and centers the experiences of people of color and transgender people.

Provider Level Recommendations

Recommendations at this level focus on increasing the availability of inclusive and affirming healthcare, and ensuring that LGBTQ+ Nebraskans feel safe accessing healthcare and discussing their concerns with healthcare providers.

- 1) Train primary care physicians, mental health providers, other medical providers to respectfully and competently work with LGBTQ+ individuals.
- 2) Increase access to physical and mental healthcare by reducing financial barriers through sliding fee scales and accepting Medicare and Medicaid patients.
- 3) Appropriately screen and refer LGBTQ+ individuals for services in areas of health disparities, especially depression, anxiety, substance use, and tobacco cessation.

Research Recommendations:

- 1) While this study documents a number of health disparities experienced by and within LGBTQ+ communities, further research is needed to determine the sources of and potential solutions to those disparities.
- 2) This study provides a broad overview of the physical, mental, sexual, and social health of LGBTQ+ individuals and communities in Nebraska. Further research is needed to better understand specific health experiences within each of these domains.
- 3) LGBTQ+ health is influenced by rapidly changing social and political environments. Ongoing research is needed to track changes in LGBTQ+ health.

12. Appendix A: Gender Identity Coding Strategy

Gender identities are diverse, vast, and ever-changing. Participants were asked a series of questions to better understand how they thought about their gender identity. First, participants were first asked their gender and/or sex in an open-ended question:

What is your gender and/or sex? (Some options include woman, man, nonbinary, agender, transgender, cisgender*, intersex, genderfluid, and/or two-spirit, etc.)*

**Transgender (or trans) usually refers to people who were given a gender and/or sex label at birth that does not accurately represent them. Cisgender (or cis) refers to people who are the same gender and/or sex they were assigned at birth.*

Next, participants were asked if they would like to be included in the trans or transgender category during data analysis:

When we describe who participated in our study, should we include you in a trans or transgender category? For example, you are trans, you have transitioned gender and/or sex, you will transition, and/or you are transitioning.*

**By transitioned, we mean changing aspects of your gender/sex socially and/or biomedically. These may include changes in gender expression, legal documents, hormones, and/or anatomy.*

Finally, if participants responded that that they would like to be included in the transgender category, they were asked to self-select into certain transgender categories including: trans woman/male to female/AMAB, trans man/female to male/AFAB, genderqueer or gender non-conforming, non-binary, agender, or none of the above.

Participants responses to these questions demonstrated the diverse spectrum of gender identities that exist in Nebraska. For the initial open-ended question, participants responded with 55 distinct gender identities and/or sexes.

However, in order to analyze our data, it was important to categorize these diverse gender identities. Therefore, responses to the open-ended question about gender identity/sex were coded and categorized into five categories: cisman, ciswoman, transman, transwoman, and non-binary/genderqueer. However, we found that many of the participants who identified as non-binary/genderqueer in the first question did not want to be included in the transgender category in the second question. To honor this desire, non-binary/genderqueer participants were further delineated into non-binary/genderqueer transgender and non-binary/genderqueer cisgender categories.

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