San Diego LGBTQIA+ Needs Assessment

Cancer Prevention and Healthcare

Updated September 25, 2025

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Contents

San Diego LGBTQIA+ Needs Assessment: Cancer Prevention and Healthcare

September 25, 2025

The Moores Cancer Center at the University of California San Diego, in collaboration with the Institute for Public Health at San Diego State University, conducted this needs assessment to better understand and elevate the cancer prevention and healthcare needs of LGBTQIA+ communities in San Diego County.

Acknowledgements: We are deeply grateful to the many community members who shared their time, experiences, and perspectives by completing surveys and participating in interviews. Your openness and honesty made this report possible and will help guide efforts to improve services and support for LGBTQIA+ communities.

We especially thank our advisory board members and the staff and clients from Family Health Centers of San Diego, the San Diego LGBT Community Center, the North County LGBTQ Resource Center, the University of California San Diego (Mother, Child and Adolescent HIV Program; and Owen Clinic), Christie's Place, and Vista Community Clinic for their meaningful contributions.

Finally, we want to recognize the many other organizations and individuals who helped by reviewing tools, collecting surveys, and offering thoughtful feedback along the way. This collaboration strengthened the project and made it more reflective of the community it serves.

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Introduction

LGBTQIA+ stands for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and all other identities within the LGBTQ umbrella not explicitly listed in the acronym. The + symbol "holds space for the expanding and new understanding of different parts of the very diverse gender and sexual identities" (Princeton, n.d.).

There is a recognized gap in both knowledge and practices related to cancer screening among individuals who identify as LGBTQIA+. Research consistently shows that LGBTQIA+ populations face disproportionately lower rates of routine cancer screening and experience worse cancer-related health outcomes compared to the general population. These disparities are influenced by factors such as stigma, discrimination within healthcare settings, lack of culturally competent care, and limited targeted public health messaging.

This issue is of particular importance in San Diego County, where approximately 10% of adults aged 18 and older identify as LGBTQIA+, according to recent estimates (County of San Diego, 2024).[1] Addressing this population's unique needs is critical to improving overall community health and achieving health equity.

As an initial step toward enhancing cancer prevention, early detection, and healthcare services for San Diego's diverse LGBTQIA+ communities, Moores Cancer Center at the University of California San Diego has partnered with the Institute for Public Health at San Diego State University to conduct a comprehensive community needs assessment. This assessment aims to gather detailed insights into the barriers, facilitators, and gaps in cancer screening awareness and utilization among LGBTQIA+ residents.

Findings from this initiative are expected to inform and drive the development of inclusive, affirming, and accessible cancer-related programs, services, and policies that specifically address the needs of LGBTQIA+ individuals. Ultimately, this work aspires to reduce cancer disparities and improve health outcomes within these communities.

Methods

To conduct this assessment, staff from the Institute for Public Health, along with a team of contractors and volunteers, undertook a multi-method approach that included a review of existing literature and findings, a survey of LGBTQIA+ individuals residing in San Diego County, and a series of in-depth interviews with a selected group of LGBTQIA+ community members.

[1] Specifically, 5% of the adult population in San Diego County identified as bisexual, followed by 4% gay and lesbian, and 2% other sexual minority identification based on estimates from the California Health Interview Survey (County of San Diego, 2024). Approximately 1% of individuals in San Diego County identified as transgender.

Literature Review

This assessment included a comprehensive review of cancer screening rates and practices relevant to the LGBTQIA+ community. Sources included peer-reviewed research articles, organizational reports, and reputable websites. Literature was retrieved from academic databases such as PubMed, program-specific websites, and San Diego State University's library platform.

Participants

Participants who completed a survey or interview comprised a convenience sample of individuals from San Diego County. Eligibility criteria required participants to be 18 years of age or older, self-identify as a member of the LGBTQIA+ community, and reside in and/or receive healthcare services within San Diego County.

Data Collection Tools

Needs Assessment Survey

The needs assessment survey included 55 multiple-choice questions and two open-ended questions designed to assess knowledge, behaviors, and perceptions related to cancer screening and general health. Skip patterns were embedded in the survey to tailor questions based on respondents' age, sex assigned at birth, and self-assessed cancer risk for several types of cancer. Key topics addressed in the survey included: recall of discussions with medical providers about cancer risk, history of cancer screenings received, perceived respectfulness and cultural competency of healthcare staff during screenings, reasons for not participating in regular cancer screening, knowledge of Human Papillomavirus (HPV), general health status, recommendations for affirming or safe medical care environments for LGBTQIA+ individuals, and suggestions for how healthcare providers can better serve LGBTQIA+ patients. The full survey instrument is provided in Appendix A.

Questions related to demographic characteristics and cancer health behaviors were adapted from the Imperial County Assessment to Reach Equal Health Status survey. Items pertaining to race and ethnicity followed the updated federal standards issued by the U.S. Office of Management and Budget and the United States Census Bureau (Marks, 2024; United States Census Bureau, 2024). Additionally, the survey introduction and questions about gender identity and sexual orientation were adapted from the Horizons Foundation's *LGBTQ Community Needs Assessment* and were refined following pilot testing.

Five LGBTQIA+ community members and several professionals with expertise in LGBTQIA+ health provided critical feedback and guidance in shaping the survey content. An advisory board composed of LGBTQIA+ individuals contributed to both the survey and in-depth interview guide development. Additionally, staff and clients from various organizations serving LGBTQIA+

individuals played an essential role in supporting the survey's development, pilot testing, and review.

The survey was available in both English and Spanish and was administered anonymously. Most participants completed the survey independently; however, assistance was available upon request. Participants could seek help from staff members or opt to complete the survey via a telephone interview by calling a dedicated phone line.

In-Depth Interviews

An in-depth interview guide was used to facilitate discussions with participants on a range of topics, including reasons for disclosing or not disclosing LGBTQIA+ identity to medical professionals; ways in which healthcare providers can create more welcoming and affirming environments; personal experiences with cancer treatment; barriers to accessing cancer screening services; examples of respectful and disrespectful interactions with medical staff; sources of information about cancer screenings; limitations in treatment options due to insurance coverage; and the nature of participants' relationships with their medical providers.

Interviewers tailored the discussion to each participant's comfort level and personal experiences, meaning that not all questions were asked of every interviewee. For the complete list of interview questions, see Appendix A.

Data Collection

Survey Administration and Participant Recruitment

The survey was self-administered both online and in person, as well as via interview for those opting to call the designated survey line.

Participants were recruited through outreach efforts at LGBTQIA+ events and in collaboration with partner organizations serving LGBTQIA+ communities throughout San Diego County. Staff from the Institute for Public Health and Moores Cancer Center distributed paper surveys and invitation flyers at community events. Partner organizations across San Diego County assisted by distributing survey invitation flyers and paper surveys to their clients as well.

Invitation flyers were handed out individually to interested people who either requested one or were known to meet the eligibility criteria. The flyers included key details such as the purpose of the study, eligibility criteria, available participation incentives, a phone number for inquiries or to complete the survey via interview, and a unique QR code providing direct access to the online version of the survey.

To identify appropriate outreach locations and events, staff conducted online searches using keywords such as "LGBTQIA+," "San Diego," "Pride," "LGBTQIA+ Events," and "LGBTQIA+ Friendly." In

addition, staff collaborated with various organizations that serve LGBTQIA+ individuals to arrange tabling opportunities at community locations and special events. Information about the study and eligibility criteria was posted at these venues with permission from host organizations.

Eligible staff from the Institute for Public Health, Moores Cancer Center, and partner organizations were encouraged to complete the survey themselves and share it with eligible family members and friends.

In-Depth Interview Recruitment

Potential in-depth interview participants were identified from individuals who completed the needs assessment survey online. Selection was intentional, aiming to capture a diverse range of LGBTQIA+ subpopulations, with a particular focus on uplifting voices from underrepresented communities in San Diego. Selected individuals were contacted via email and invited to participate in the interview process.

Incentives

All participants who completed the needs assessment survey were offered a $15 gift card to Walmart, Amazon, or Target as a token of appreciation. Participants who completed the survey in person at an event received their gift card immediately upon submitting a completed survey. Those who completed the survey online were given the option to receive their selected gift card via email or mail. Participants who took part in an in-depth interview received a $30 Amazon electronic gift card, delivered either by email or text message.

Data Management

Data from needs assessment surveys completed online were automatically captured and stored within a Qualtrics survey platform programmed by Institute for Public Health staff. Paper surveys collected in the field were manually entered into Qualtrics by Institute for Public Health personnel. To ensure compliance with eligibility criteria, individuals under the age of 18 were prevented from completing the online survey, and no paper surveys were collected from participants under 18. In-depth interviews were audio-recorded and subsequently transcribed for analysis.

Data Analysis

Quantitative data from the needs assessment surveys were exported from Qualtrics and imported into IBM SPSS Statistical Package (version 29.0.2.0) for analysis. Analytical methods included frequency distributions, crosstabulations, and summarization of short-answer responses.

Qualitative data, consisting of open-ended survey responses and interview transcripts, were independently analyzed by two staff members to ensure interrater reliability. An iterative thematic analysis approach was employed, incorporating both deductive methods (using predefined categories) and inductive methods (developing new categories). Data were organized into overarching themes and subthemes. The coding results from both analysts were compared and reconciled through consensus to finalize thematic categorizations.

Before conducting quantitative analyses, staff reviewed responses related to gender identity, sex assigned at birth, and sexual orientation to verify participant eligibility. Each possible combination of these variables was evaluated by an advisory panel to determine inclusion status. Participants not meeting inclusion criteria—such as those not identifying as LGBTQIA+ or not residing in and/or receiving healthcare in San Diego County—were excluded from analysis. The finalized inclusion logic based on gender identity, sex assigned at birth, and sexual orientation was applied to the data set and checked for accuracy.

Additional data cleaning procedures included removing duplicate survey entries from participants who submitted more than one online survey and coding written-in 'other' responses into pre-existing categories where appropriate.

Limitations

Subgroup Analyses

We acknowledge that gender identity is diverse and expressed in many ways within the LGBTQIA+ community. We recognize that historically, individuals have faced pressure to conform to limited categories or terminology and have experienced discrimination based on their identities. To capture and analyze the complexity of needs, experiences, and challenges related to gender identity and sex assigned at birth, we categorized these variables for the purpose of this study. We hope that the use of such categories does not cause distress to readers or perpetuate harm to the community.

Additionally, although over 500 surveys were collected, caution is advised when interpreting results from smaller subgroups due to limited sample sizes.

Representativeness of Findings

Surveys were collected from a convenience sample of individuals identifying as LGBTQIA+, rather than from a random sample representative of the entire LGBTQIA+ population in San Diego County. This sampling approach may have led to an overrepresentation of certain groups, particularly those attending events in central San Diego County. Additionally, the online survey format likely reached more tech-savvy individuals while underrepresenting those with less access or familiarity with technology. As a result of these limitations, the findings may not fully represent the broader LGBTQIA+ community or its various subpopulations.

Furthermore, because individuals under age 18 were excluded and the survey was only offered in English and Spanish, findings do not reflect the experiences of youth or non-English/Spanish-speaking populations.

Terminology

LGBTQIA+ stands for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and all other identities within the LGBTQ umbrella not explicitly listed in the acronym. The + symbol "holds space for the expanding and new understanding of different parts of the very diverse gender and sexual identities" (Princeton, n.d.). We understand that acronyms may not be representative of all gender or sexual identities and that categorizing people can be problematic. We want to apologize for any difficult feelings related to the use of various terms, abbreviations, or categorizations.

Literature Review Summary

Although we use the term LGBTQIA+ throughout the report, in this section of the report we use the variation of the acronym (such as LGBTQ, LGBT or LGB) used by authors in the original source material. Highlights are presented on the pages that follow, while the full literature review report is available in Appendix B.

Cancer Screening Importance and LGBTQIA+ Disparities

Cancer screening is a critical component of preventive healthcare, enabling the early detection of cancer before symptoms manifest. Some common symptoms of cancer include unexplained weight loss, persistent fatigue, changes in bowel or bladder habits, unusual bleeding, and lumps or swelling in specific areas of the body. Early identification can lead to more effective treatment options and improved survival rates, highlighting the importance of widespread and routine screening practices (National Cancer Institute, 2023). Screening tests, such as mammograms, colonoscopies, and Pap tests, have been instrumental in reducing mortality rates for specific cancers. For example, mammograms help detect breast cancer, colonoscopies are effective in identifying colorectal cancer, and Pap tests are crucial for the early detection of cervical cancer. (National Cancer Institute, 2023). Despite these advancements, disparities in cancer screening

access and rates persist, particularly among marginalized populations, including lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual (LGBTQIA+) people (Austin et al., 2012; Braun et al., 2017; Ceres et al., 2018; Haviland et al., 2019; Tundealao et al., 2024).

In addition to screening rates, it is crucial to consider the timeliness of screenings and ensure they are conducted within the appropriate time frame. Among participants in the Health Information National Trends Survey, 6 who were 18 years and older, Tundealao et al. (2024), reported that sexual minority groups (defined by the authors as lesbian, gay, bisexual, and other) were 1.73 times more likely to not be up to date with cancer screenings compared to heterosexual individuals. Adjusted odds ratios remain consistent and significant even after controlling for covariates in all four models: 1.69 (CI: 1.07 – 2.65), 1.80 (1.10 – 2.96), 1.56 (1.06 – 2.91) (Tundealao et al., 2024).

Cancer Screening Challenges among LGBTQIA+ Populations

The LGBTQ+ population faces multiple challenges in accessing cancer screenings, such as experiencing discrimination and stigma and a widespread lack of baseline cultural competence among healthcare providers (Azzellino et al., 2025; Haviland et al., 2019; Mayhew et al., 2020; Peitzmeier et al., 2017). These barriers often result in delayed or foregone screenings, increasing the risk of advanced-stage cancer diagnoses and poorer health outcomes, such as lower survival rates, increased treatment complications, and reduced quality of life (Bates et al., 2022; Stanford, 2020). For example, research indicates that lesbians are significantly less likely to undergo cervical cancer screening due to misconceptions about their risk factors, lack of provider recommendations, and previous negative experiences in healthcare settings (Bustamente et al., 2021; Tracy et al., 2010). Transgender people face additional challenges, such as uneducated or ignorant providers, transphobia or other hostility, a baseline lack of knowledge and best clinical practices for transgender cancer screenings, and/or the highly gendered nature of oncology care, which results in critical gaps in preventive care and exacerbates existing disparities (Leone et al., 2023; Mayhew et al., 2020; Peitzmeier et al., 2014; 2017). LGBTQ+ people with cancer report higher levels of depression and difficulty within their relationships than heterosexuals (Kamen et al., 2015).

Improving Cancer Screening Rates among LGBTQIA+ Populations

Addressing these disparities requires a concerted effort to make healthcare systems more inclusive and culturally competent. Inclusive healthcare practices are essential to provide equitable access to cancer screenings and ensure that LGBTQ+ populations feel safe and supported within healthcare settings. LGBTQ+ inclusive healthcare practices like creating diverse healthcare workforces, offering targeted training on cultural competence, and developing policies that explicitly address the needs of LGBTQ+ patients are essential to provide equitable access to cancer screenings (Burnett et al., 2024; Stanford, 2020). By incorporating inclusive practices and educating providers about the LGBTQ+ community, healthcare systems can reduce barriers to cancer screening and enhance health outcomes for all populations.

Results: Needs Assessment Survey

Survey Collection

Through QR code flyer distribution, outreach efforts, and phone interviews, staff from the Institute for Public Health and partner organizations collected a total of 610 surveys between October 2024 and January 2025. Surveys that did not meet eligibility criteria were excluded, including 11 duplicates, 78 from individuals who did not identify as LGBTQIA+, and 5 who indicated they neither lived in nor received healthcare in San Diego County. This resulted in a final sample size of 516 surveys.

Of these, 261 surveys were collected during specific LGBTQIA+ events in partnership with various organizations (see Table 1). An additional 206 surveys were obtained through partner organizations that distributed paper surveys and flyers directly to LGBTQIA+ individuals they serve (see Table 2). Lastly, 49 surveys were gathered from online links shared with individuals or via phone interviews.

Table 1. Survey Collection at Events with Community Partner Organizations (n=261)

Event Name/Type	HHSA [1] Region	Collection Type	
		Paper	Online [2]
Latine Pride	Central	47	56
Holiday Event	Central	41	
Senior Luncheon	Central	14	
Tabling / Outreach	Central and North Inland	20	
Thanksgiving Event	South	23	
Lavender Welcome	North Coastal	20	
Black Tie Event	Central	20	
Pride and Unity Fundraiser	Central	11	
Non-Smoking Events	Central	4	
Holiday Event	Central	4	
--	Central	1	
Meetings	North Inland		
Total		**205**	**56**

[1] San Diego Health and Human Services Agency service regions.

[2] Collected at various events and via QR codes handed out by partner organizations.

Table 2. Survey Collection by Community Partner Organizations (n=206)

Organization Type	Location: HHSA [1] Region	Collection Type	
		Paper	Online
Community health centers	Central, North Central, East, North Coastal/Inland	9	84
Centers/programs serving LGBTQIA+ individuals	Central, North Coastal, North Central, North Inland	24	89
Total		**33**	**173**

[1] San Diego Health and Human Services Agency service regions.

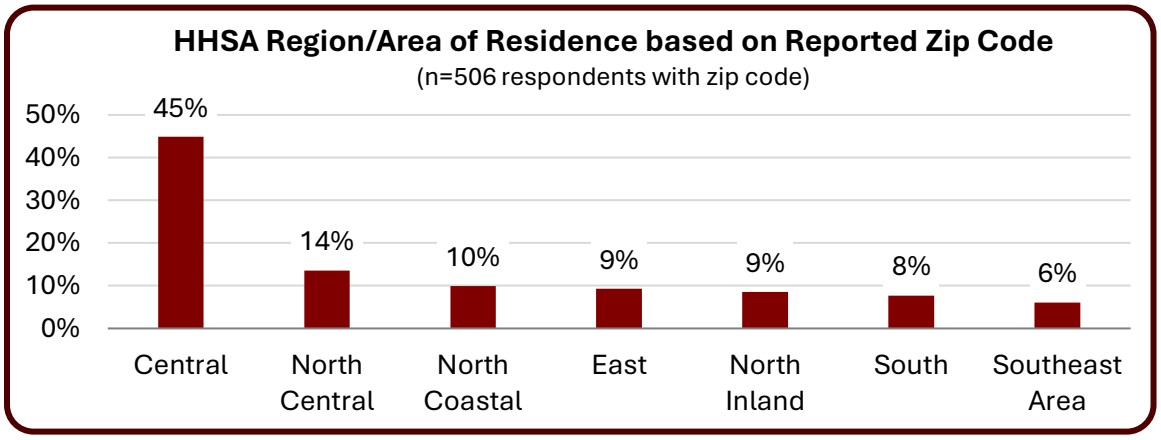
In total, participants completed 268 surveys online, 238 surveys on paper (in person), and 10 surveys via interview with Institute for Public Health staff (see Table 3). Based on the zip codes reported by respondents, nearly half resided within the Central San Diego Health and Human Services Agency (HHSA) service region, while the remainder lived in other regions (see Figure 1).

Table 3. Survey Collection by Method

Source	Collection Method			Total
	Online	Paper	Interview	
Events / outreach	56	205	0	261
Partner organization recruitment	173	33	0	206
Links sent to contacts and incoming telephone calls	39	0	10	49
Total	**268 (52%)**	**238 (46%)**	**10 (2%)**	**516 (100%)**

[1] San Diego Health and Human Services Agency service regions.

Figure 1. Survey Participant HHSA [1] Region/Area of Residence



[1] San Diego Health and Human Services Agency service regions with the Southeast Area reported separately.

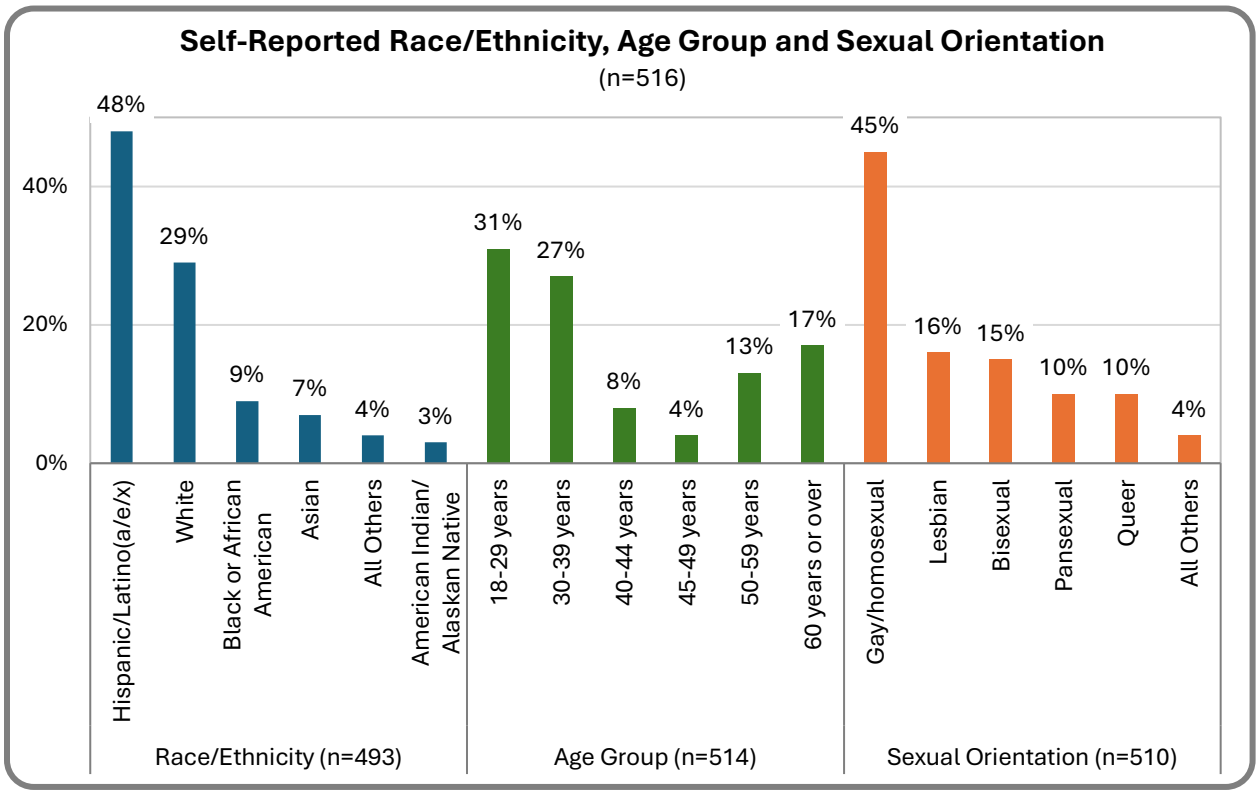
Demographic Characteristics

Needs assessment survey participants reported their races/ethnicities, age, sexual orientation, gender identity, and sex assigned at birth. Analysts created a mutually exclusive race/ethnicity variable, which is displayed in Figure 2. As seen, the largest percent of respondents reported being Hispanic/Latino(a/e/x) of any race, and gay or homosexual (Figure 2). Participants had the option to skip questions, resulting in the varying sample sizes noted.

Figure 3 presents the distribution of gender identities, including the combined category based on gender identity and sex assigned at birth. The largest percentage of respondents identified as cisgender men, followed by cisgender women. Reported annual income spanned all income levels and is summarized in Table 4.

Complete data tables for survey questions are provided in Appendices C, D, and E.

Figure 2. Survey Participant Race/Ethnicity, Age Group and Sexual Orientation [1, 2, 3]

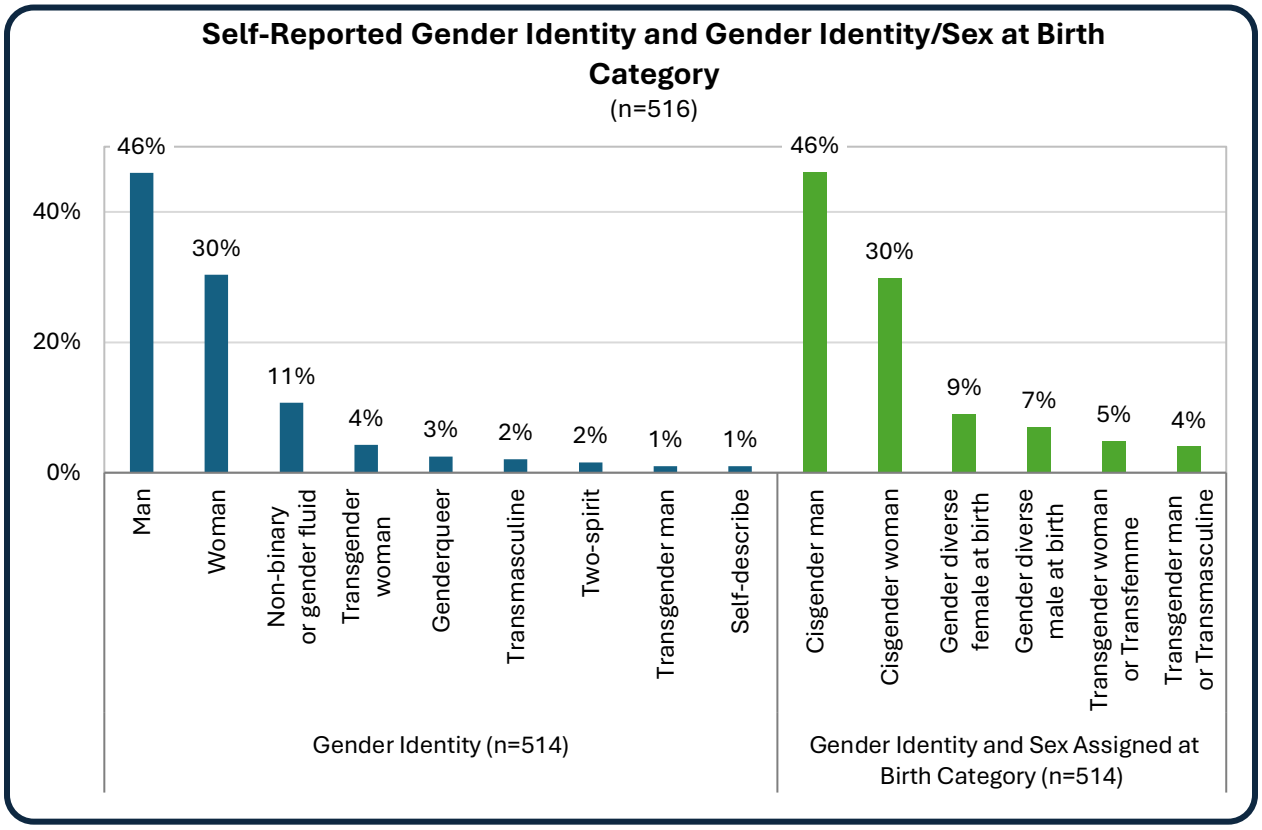


[1] Race/Ethnicity categorization: Hispanic/Latino(e/a/x) = of any race; White = no other race; Asian, Black/African American, Middle Eastern/North African, Native Hawaiian/Pacific Islander include those who indicated no other race or White; Multiracial includes two or more of the non-White races, or two or more of the non-White races and White.

[2] Race/Ethnicity 'All Others' includes: Middle Eastern or North African (1%), Native Hawaiian or Pacific Islander (1%), Multiracial (2%).

[3] Sexual Orientation 'All Others' includes: asexual (2%), straight/heterosexual (1%), two-spirit (<1%), same gender loving (<1%).

Figure 3. Survey Participant Gender Identity and Gender Identity/Sex at Birth Category [1]



[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described.

Table 4. Annual Income by Gender Identity/Sex Assigned at Birth Category

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]						Total (n=516)
		Cisgender Man (n=237)	Cisgender Woman (n=153)	Transgender Woman or Transfemme (n=25)	Transgender Man or Transmasculine (n=18)	Gender Diverse Female at Birth (n=45)	Gender Diverse Male at Birth (n=36)	
Combined Annual Income *(total pre-tax all sources; you and partner/ spouse if live together)*	(number responding)	(n=217)	(n=139)	(n=22)	(n=18)	(n=37)	(n=34)	(n=468)
	$0 to $9,999	15%	10%	45%	28%	19%	18%	**16%**
	$10,000 to $19,999	11%	9%	14%	17%	16%	12%	**11%**
	$20,000 to $34,999	11%	9%	27%	17%	22%	21%	**13%**
	$35,000 to $49,999	13%	17%	0%	6%	14%	9%	**13%**
	$50,000 to $74,999	15%	16%	9%	22%	11%	26%	**16%**
	$75,000 to $99,999	13%	12%	0%	0%	14%	9%	**12%**
	$100,000 to $199,999	20%	17%	5%	11%	5%	6%	**16%**
	$200,000 or more	3%	9%	0%	0%	0%	0%	**4%**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described.

Healthcare Information

Almost half of respondents reported receiving healthcare through employer-sponsored insurance or by purchasing coverage, while 15% indicated they had no health care coverage (see Table 5). Over 90% stated that their most recent health checkup occurred within the past two years and nearly three-quarters reported that their usual medical provider was aware of their LGBTQIA+ identity.

Table 5. Healthcare Coverage and Medical Practice Information by Gender Identity/Sex Assigned at Birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]						Total (n=516)
		Cisgender Man (n=237)	Cisgender Woman (n=153)	Transgender Woman or Transfemme (n=25)	Transgender Man or Transmasculine (n=18)	Gender Diverse Female at Birth (n=45)	Gender Diverse Male at Birth (n=36)	
Health Care Coverage Type [2]	(number responding)	(n=230)	(n=149)	(n=25)	(n=18)	(n=45)	(n=36)	(n=505)
	Through employment or purchased	48%	50%	24%	61%	40%	42%	**47%**
	State program	21%	15%	56%	22%	31%	36%	**23%**
	Medicare	16%	10%	4%	0%	7%	3%	**11%**
	All other types	3%	5%	8%	6%	0%	8%	**4%**
	No healthcare coverage	12%	19%	8%	11%	22%	11%	**15%**
Last General Health Checkup	(number responding)	(n=234)	(n=150)	(n=25)	(n=17)	(n=44)	(n=36)	(n=508)
	Within the past year	79%	68%	84%	94%	75%	64%	**75%**
	Between 1-2 years ago	16%	25%	12%	0%	16%	19%	**18%**
	Between 3-5 years ago	3%	5%	4%	6%	5%	17%	**5%**
	6 or more years ago	3%	2%	0%	0%	5%	0%	**2%**
Type Practice where Receive Usual Primary Care	(number responding)	(n=235)	(n=153)	(n=25)	(n=18)	(n=45)	(n=36)	(n=514)
	Health system	67%	59%	32%	50%	56%	56%	**61%**
	Community clinic	26%	29%	60%	50%	42%	36%	**32%**
	Veterans or military health system	2%	8%	0%	0%	2%	6%	**4%**
	Another	4%	4%	8%	0%	0%	3%	**4%**
Usual Medical Provider Aware of LGBTQIA+ Identity	(number responding)	(n=231)	(n=148)	(n=25)	(n=18)	(n=45)	(n=35)	(n=504)
	Yes	88%	51%	88%	78%	47%	71%	**72%**
	No	5%	29%	4%	17%	29%	20%	**16%**
	Don't know	7%	20%	8%	6%	24%	9%	**13%**
Length of Time with Usual Doctor/ Provider	(number responding)	(n=236)	(n=152)	(n=25)	(n=18)	(n=45)	(n=36)	(n=513)
	Less than 3 months	12%	13%	16%	17%	11%	11%	**12%**
	3 months to 1 year	16%	16%	16%	33%	29%	19%	**18%**
	1-2 years	25%	26%	12%	11%	22%	22%	**24%**
	3 or more years	46%	43%	52%	39%	33%	44%	**44%**
	Don't know	2%	3%	4%	0%	4%	3%	**2%**

Note: The 'Total' column contains two individuals that were not categorized into gender identity/sex assigned at birth.

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described.

[2] Mutually exclusive categories: (1) Employment/purchased (and any other response), (2) Medicare and any other response except employment/purchased, (3) Medi-Cal/Medicaid/state program and any other responses employment/purchased and Medicare, and (4) all others.

Healthcare Experiences

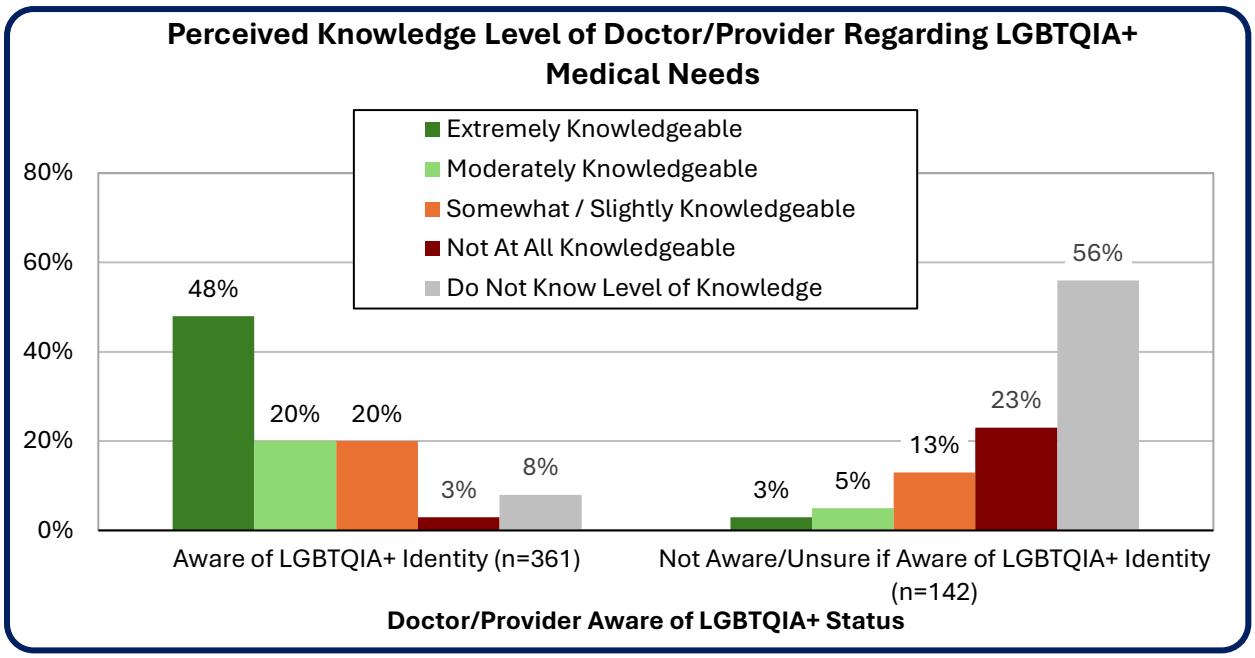
Knowledge of LGBTQIA+ healthcare needs and comfort with medical professionals goes hand in hand with disclosing one's identity to providers. This disclosure is often essential for ensuring that specific healthcare needs are met, including appropriate cancer screening.

Medical Doctor/Provider LGBTQIA+ Knowledge

Survey participants were asked: *"How knowledgeable is the medical doctor or provider you visit most often (for general medical care) about LGBTQIA+ medical needs?"* Responses were analyzed based on whether participants indicated that their doctor or provider was aware of their LGBTQIA+ identity.

Among those whose medical provider was aware of their LGBTQIA+ identity, 48% reported that their doctor was *extremely knowledgeable* about LGBTQIA+ health needs. In contrast, only 3% of those whose provider was *not aware* of their identity rated their doctor as extremely knowledgeable (see Figure 4).

Figure 4. Participant Rating of Doctor/Provider Knowledge of LGBTQIA+ Medical Needs by Doctor/Provider Awareness of LGBTQIA+ Identity



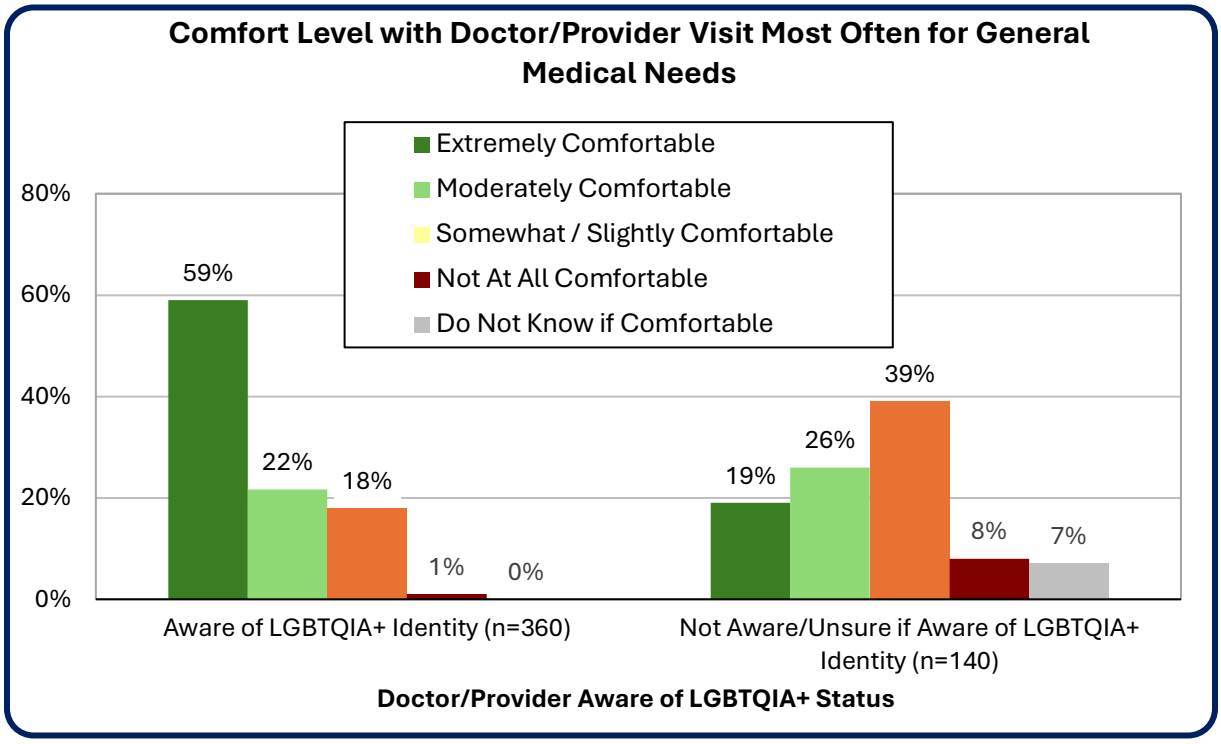
These data are further analyzed by gender identity and sex assigned at birth in Appendix C. Individuals who identified as transgender men or as *gender diverse—female at birth* were less likely to report that their providers were *extremely knowledgeable* compared to other groups (see Table C-1 in Appendix C).

Comfort with Medical Doctor/Provider

Survey participants were also asked: *"How comfortable are you with the medical doctor or provider you visit most often for general medical care?"* Responses were analyzed based on whether participants indicated that their doctor or provider was aware of their LGBTQIA+ identity.

Among those whose medical provider was aware of their LGBTQIA+ identity, 59% reported feeling *extremely comfortable* with their provider. In contrast, only 19% of those whose provider was *not aware* of their identity reported the same level of comfort (see Figure 5).

Figure 5. Participant Rating of Comfort with Doctor/Provider by Doctor/Provider Awareness of LGBTQIA+ Identity



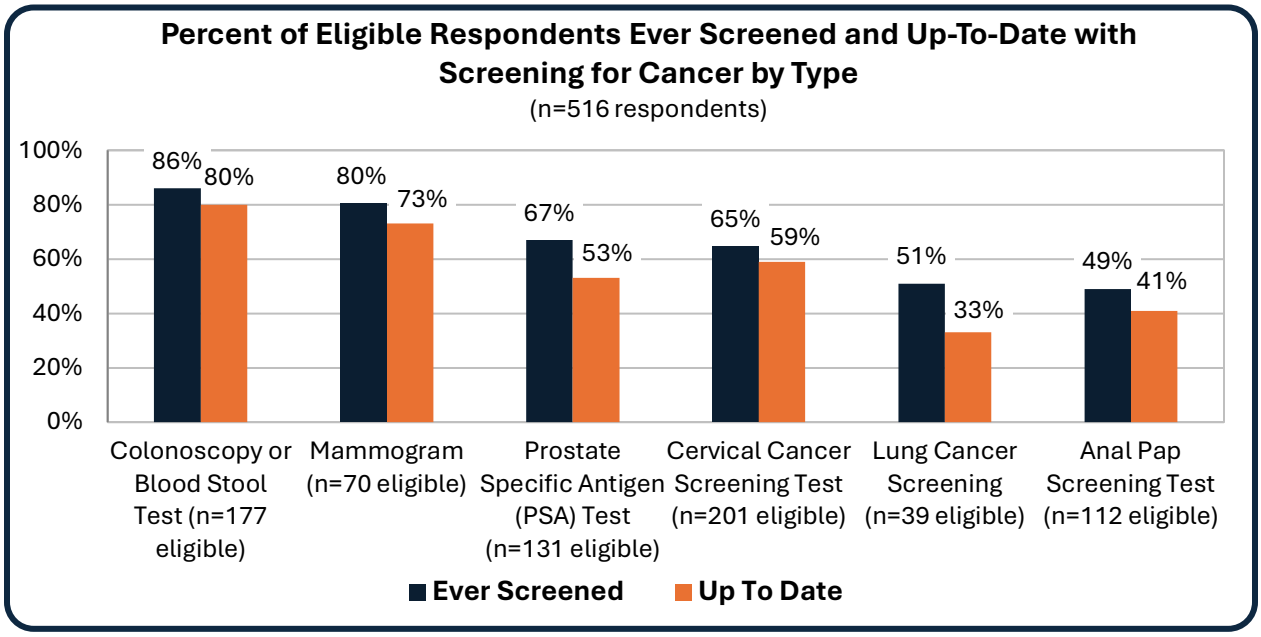
These data are further analyzed by gender identity and sex assigned at birth in Appendix C. Individuals who identified as transgender men or as *gender diverse—female at birth* were less likely to report feeling *extremely comfortable* with their providers compared to other groups (see Table C-3 in Appendix C).

Cancer Screening Practices

Eighty-six percent (86%) of respondents who were eligible for colon cancer screening, based on average-risk guidelines, reported having completed a colonoscopy or stool-based blood test (see Figure 6). Additionally, 80% of eligible respondents were also *up-to-date* with their screening—defined as having had a colonoscopy within the past 10 years or a stool-based blood test within the past year.

Breast cancer screening via mammogram ranked next, with 80% of eligible individuals having received a mammogram, and 73% indicating they were *up-to-date* with screening recommendations. Screening rates for prostate, cervical, lung, and anal cancers were lower, with between 33% and 59% of eligible respondents reporting they were *up-to-date* according to recommended screening intervals.

Figure 6. Percent of Eligible[1] Respondents Ever Screened and Up-To-Date[2] with Screening by Cancer Type

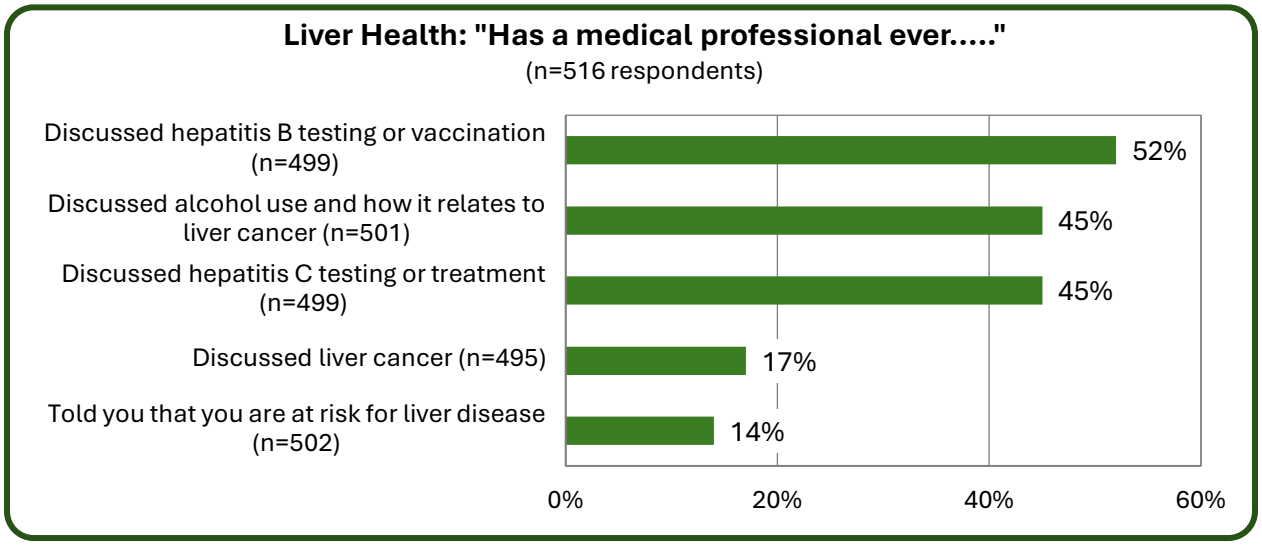


[1, 2] Eligible for Screening (based on average risk) and Up-To-Date (if last screening prior to the high end of the time frame noted for average risk screening intervals):

- **Colonoscopy/Blood Stool Test:** Blood stool test every year if aged 45 and older or colonoscopy every 10 years if age 45 and older
- **Mammogram:** Every 1-2 years if aged 40 and older and (assigned female at birth without both breasts removed or taking feminizing hormones/hormone therapy for at least 5 years)
- **Prostate Specific Antigen:** Every 1-2 years if aged 40 and older and assigned male at birth (any gender identity)
- **Cervical Screening:** Every 3 years for persons assigned female at birth that have a cervix (any gender identity) (note: although a cervical Papanicolaou test plus a Human Papilloma Virus test - HPV, is indicated every 5 years, the 3-year time frame was used for the up-to-date calculation)
- **Lung Cancer Screening:** Every year if aged 45 and older, have a 20 pack-year history of smoking (1 pack a day for 20 years or 2 packs a day for 10 years, etc.), and have smoked in the past 15 years (including currently smoke)
- **Anal Papanicolaou (Pap) Cancer Screening:** Every 1 to 3 years if aged 35 and older and (live with HIV, diagnosed with HPV, or practice receptive role during anal intercourse)

In addition to questions about cancer screening practices, respondents were asked whether a medical professional had ever discussed liver cancer and related risk factors with them (see Figure 7). Just over half of the respondents reported that their provider had discussed hepatitis B testing or vaccination. Fewer respondents recalled discussions regarding alcohol use and liver cancer, hepatitis C, or liver cancer risk in general.

Figure 7. Percent of Respondents Recalling Medical Professional Ever Discussing the Following Topics Related to Liver Health



Barriers to Cancer Screenings

Reasons not Screened

For each of the six cancer screening types included in the survey (cervical, breast, colon, lung, anal, and prostate), participants were asked to identify reasons for not being screened or for not receiving screenings regularly. The most reported reason was a lack of awareness that regular screening was needed, followed by being advised by a medical professional that the screening was unnecessary (see Table 6).

Lack of awareness about the need for regular screening was the most frequently cited reason across all cancer types except breast cancer. Notably, 38% of eligible respondents reported being unaware that anal cancer screening was available. Additional information on reasons for not receiving regular screenings—disaggregated by gender identity/sex assigned at birth and sexual orientation—is provided in Appendices C and E, respectively.

Table 6. Reasons for Not Being Regularly Screened by Cancer Type among those Eligible [1] for Screening

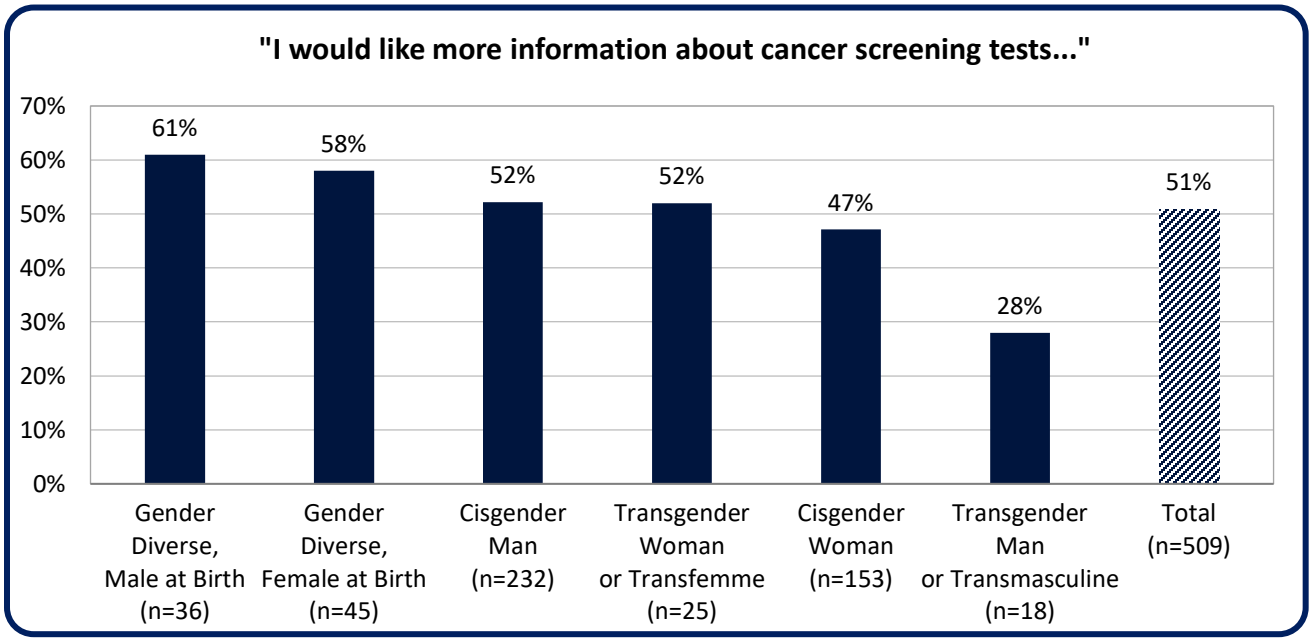
Reasons Not Screened (Choice Selection)	Cervical Cancer (n=73)	Breast Cancer (n=16)	Prostate Cancer (n=54)	Colon Cancer (n=26)	Lung Cancer (n=21)	Anal Cancer (n=64)	All (n=254)
Did not know need regular screening	62%	6%	67%	58%	62%	48%	**56%**
Told that I do not need (or no longer need, not to get, wait)	11%	13%	22%	19%	29%	13%	**16%**
Did not want to discuss with medical provider	15%	6%	9%	4%	5%	3%	**8%**
Advised to screen every 5 years	14%	--[2]	--[2]	--[2]	--[2]	--[2]	
Did not know where to get	--[2]	--[2]	--[2]	--[2]	--[2]	6%	
Did not know about it	--[2]	--[2]	--[2]	--[2]	--[2]	38%	

[1] Eligible for screening (based on average risk) according to age, gender assigned at birth, and self-assessed eligibility for other factors (behaviors, hormone use, body parts).
[2] Choice not provided on survey for cancer type.
[3] Written in responses included: procrastination/forgot (n=7), difficulties with access (time, doctor, cost) (n=5), doctor did not discuss (n=5), uncomfortable (n=4), newly eligible (n=3), unsafe/personal choice/bad experience (n=3), unsure if screened/tested (n=2), 'still too firm' (n=1), already had cancer (n=1), appointment made (n=1), and 'low risk' (n=1).

Knowledge about Cancer Screenings

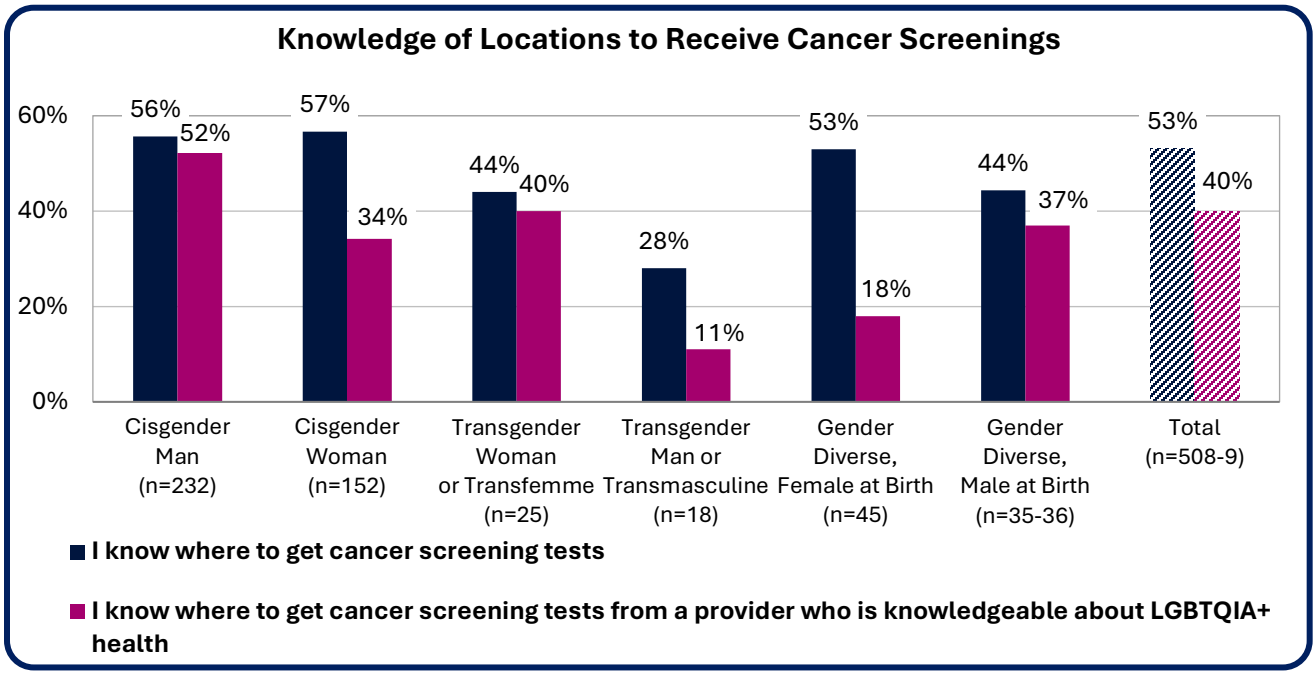
Limited awareness of cancer screenings and uncertainty about where to find LGBTQIA+-affirming services remain significant barriers to routine screening. Overall, 51% of respondents expressed a need for more information about cancer screening tests (see Figure 8), and 53% reported knowing where to access these services. However, only 40% said they knew where to find providers knowledgeable about LGBTQIA+ health needs. Notably, these results varied by gender identity and sex assigned at birth, with transgender men and transmasculine individuals being less likely than most other groups to know where to access appropriate screening services (see Figure 9).

Figure 8. Desire for More Information about Cancer Screenings by Gender Identity/ Sex Assigned at Birth [1]



[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described.

Figure 9. Knowledge of Cancer Screenings Locations by Gender Identity/Sex Assigned at Birth [1]



[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described.

Knowledge about Human Papilloma Virus (HPV) and HPV Vaccination

HPV is a well-established risk factor for several types of cancer. In 2006, the HPV vaccine was approved in the United States for females aged 9–26, with routine administration recommended at ages 11–12, including "catch-up" vaccination through age 26 (Advisory Committee on Immunization Practices, 2007-2019). Recommendations were later expanded to include adolescent boys beginning in 2009/2011. In 2018, the U.S. Food and Drug Administration approved Gardasil 9 for individuals aged 27–45. However, vaccination for this age group is guided by shared clinical decision-making between patient and provider as the overall public health benefit is limited—although some individuals may still benefit.

When asked about HPV, 84% of respondents reported having heard of the virus, 73% were aware of the HPV vaccine, and 68% understood that HPV can cause cancer in people of any gender (see Figure 10). Awareness and vaccination rates varied by age. In line with vaccine approval timelines, by 2025 a greater proportion of individuals aged 45 and under (those eligible following the 2006 guidelines) reported knowing about HPV and having at least one vaccination (see Figure 11). Having heard of the vaccine and knowledge that HPV causes cancer, however, did not vary by age group.

Figure 10. Human Papilloma Virus (HPV) Knowledge and Vaccination Status

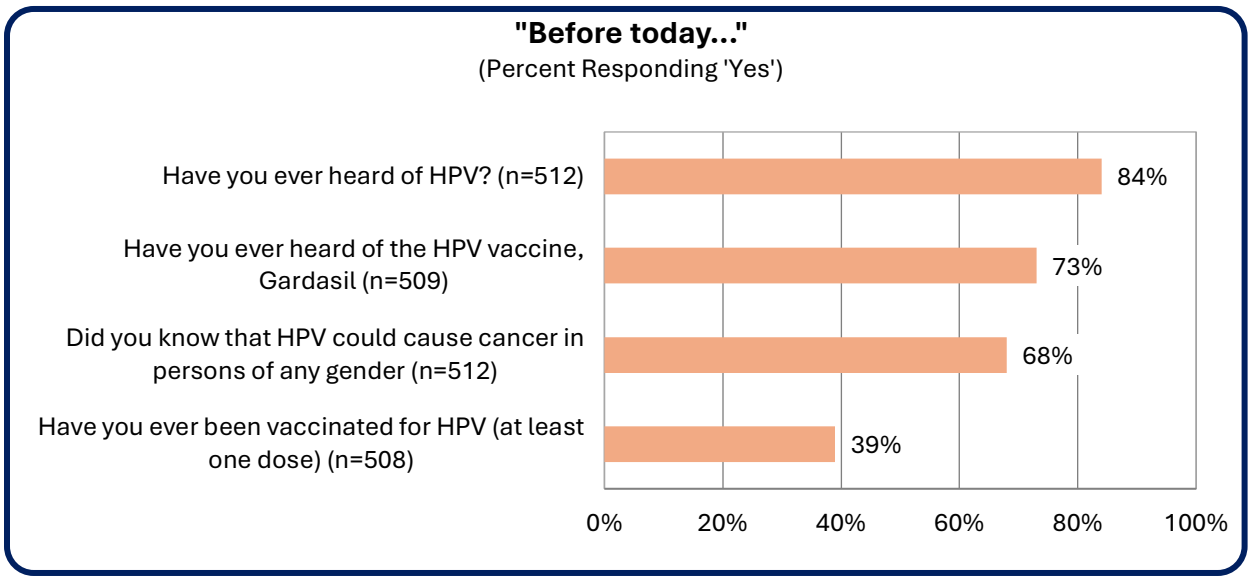
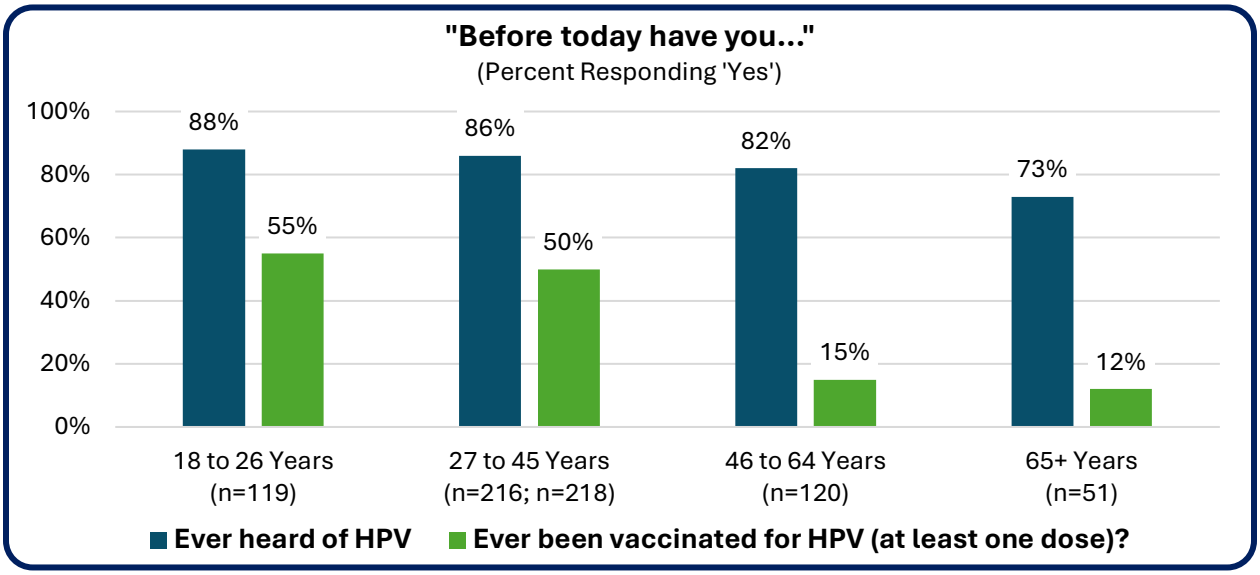


Figure 11. Human Papilloma Virus (HPV) Knowledge and Vaccination by Age Group[1]

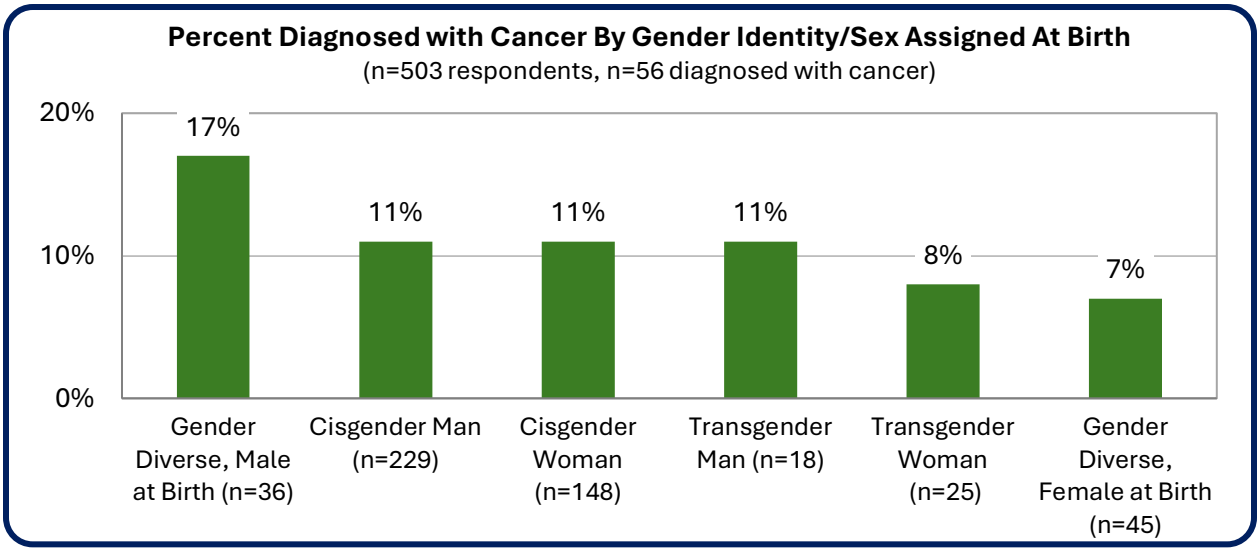


[1] Ever heard of HPV (Pearson Chi-Square, p=0.054); Ever been vaccinated for HPV (at least one dose) (Pearson Chi-Square, p<0.001). Knowledge of the vaccine and that HPV could cause cancer did not vary significantly by age group.

Cancer Diagnoses

A total of 56 respondents (11% of 503 respondents) indicated that they had been diagnosed with some form of cancer. When examined by the gender identity/sex assigned at birth categories, the percent diagnosed ranged from 7% to 17% (Figure 12). The most reported cancer diagnosed was skin cancer (Table 7).

Figure 12. Percent of Respondents Ever Diagnosed with Cancer by Gender Identity/Sex Assigned at Birth Category [1]



[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described.

Table 7. Type of Cancer Diagnosed Among those who Specified a Cancer Type

Cancer Type	Number [1]	Percent of Respondents Diagnosed with Cancer (n=46)	Percent of Total Respondents (n=493)
Skin Cancer	15	32.6%	3.0%
Breast	7	15.2%	1.4%
Cervical	4	8.7%	0.8%
Prostate	3	6.5%	0.6%
Anal	3	6.5%	0.6%
Colon	2	4.3%	0.4%
Leukemia	2	4.3%	0.4%
Thyroid	2	4.3%	0.4%
Kidney	2	4.3%	0.4%
Other types (1 each) [2]	12	26.1%	2.4%
Type not specified	10	--	--

[1] Participants may choose all that apply; as such, totals may sum to greater than the number of respondents and more than 100%.

[2] Other types listed (1 each): testicular, 'skin endometrial,' 'benign tumor in stomach,' 'carcinoid tumor,' Kaposi Sarcoma, liver, lung, non-Hodgkin's lymphoma, multiple myeloma, ovarian cyst (cancerous), 'primary CNS lymphatic brain tumor,' soft tissue sarcoma.

Safe and Recommended Healthcare Doctors/Clinics/Organizations

In a write-in question, participants were asked if they would recommend any healthcare organizations that provide safe and competent care for individuals identifying as LGTBQIA+. Participants most often mentioned healthcare systems including UCSD Health, Kaiser Permanente, Sharp HealthCare, Scripps Health, Planned Parenthood and community health centers such as Family Health Centers of San Diego, Vista Community Clinic, and San Ysidro Health, among others. Participants also mentioned the Owen Clinic and AIDS Healthcare Foundation for HIV medical care. For other responses, see Appendix F.

Suggestions for Better Serving LGBTQIA+ Patients

Participants were asked to share what medical professionals should know to be more welcoming and respectful toward LGBTQIA+ clients. A total of 338 responses were received. These suggestions were grouped into overarching themes, with some responses touching on multiple areas. A summary of the key themes is provided below, and illustrative quotes can be found in Appendix F.

Treat People with Dignity

At the core of many responses was a simple, yet powerful message: treat LGBTQIA+ patients as whole people, with the same dignity, care, and compassion afforded to anyone else.

Be Respectful, Non-Judgmental, and Ask Rather Than Assume

Respondents emphasized the importance of being treated with respect and without judgment. They wanted providers to engage openly, ask thoughtful questions, and avoid making assumptions about their identities, behaviors, or needs.

Use Inclusive Language and Communication

Participants stressed the need for inclusive language across all aspects of care—clinical, conversational, and administrative. This includes how providers address patients, structure forms, and communicate during visits. Specific recommendations included:

- Using correct pronouns, gender identity, and lived names (e.g., preferred name rather than legal name)
- Referring to anatomy in inclusive ways (e.g., "penis" instead of "male genitals")
- Using non-gendered terms (e.g., "partner" instead of "husband" or "wife")

Demonstrate Basic Knowledge and Cultural Competency

Respondents wanted providers to have a foundational understanding of LGBTQIA+ identities, experiences, and common health needs. This includes knowledge of sexuality, gender identity, and how these factors intersect with health. Some responses included specific guidance based on participants' own gender identities and sexual orientations.

Understand Sexual Practices and Sexual Health

Many respondents called for greater provider awareness of the diverse sexual practices and health concerns relevant to LGBTQIA+ individuals. They emphasized the need for accurate, affirming, and non-judgmental care related to sexual health.

Recognize Unique and Intersecting Challenges

Respondents highlighted the need for providers to understand how overlapping factors—such as stigma, racism, and other forms of discrimination—can affect LGBTQIA+ individuals' health and access to care.

Results Summary: In-Depth Interviews

Interview Collection

Trained staff from the Institute for Public Health conducted 16 in-depth interviews between March and June 2024, selecting participants from those who had completed the survey online. Interviews were held via phone or virtually and lasted between 35 and 120 minutes. Participants were intentionally chosen to reflect diverse LGBTQIA+ subpopulations, with an emphasis on amplifying voices from underrepresented communities in San Diego. Each participant received a $30 electronic Amazon gift card in appreciation of their time.

General Findings

Interviewees expressed a desire for basic respect, comfort, and quality of healthcare. Interviewees discussed how medical professionals can provide respectful and culturally competent healthcare.

Respectful Healthcare

Interviewees emphasized that respectful care is critical for feeling safe, valued, and validated in medical settings. Key factors contributing to respect included using correct names and pronouns, avoiding heteronormative and cisnormative assumptions, being punctual and prepared, demonstrating humility, and maintaining a non-judgmental attitude. Patients valued being treated like any other patient and expressed frustration when care felt biased or dismissive.

> "...the name and pronouns thing is so simple, but a lot of support staff struggle with it... maybe the doctor gets it right, but...the nurse taking me to the back room will misgender me.
>
> I wish you could just respect me. Just basic respect."
>
> - 28-year-old transgender man

Correct Use of Names and Pronouns

Attentiveness to lived names and pronouns was consistently identified as a key indicator of respect in healthcare settings. Interviewees emphasized that medical staff and providers should actively ask for and share their pronouns and suggested including pronouns on forms and badges. Participants noted that failing to acknowledge names or pronouns signaled potential neglect of other aspects of care and raised concerns about their safety. Support and administrative staff were also critical to patient experiences, with negative interactions—particularly misgendering or

> "I really want to see people really consistently [correctly using] names and pronouns, because that is your first sign of safety in a doctor's office..."
>
> -24-year-old queer transgender man

deadnaming (i.e., the use of earlier names rather than current names)—having a significant impact on overall perceptions of care.

Avoid Heteronormative and Cisnormative Assumptions

Respectful care requires providers to avoid assumptions about sexuality, gender identity, or reproductive status, as such assumptions were frequently cited as sources of discomfort and frustration. For example, cisgender lesbians and nonbinary lesbians with a uterus, ovaries, or cervix reported repeatedly being asked why they were not engaging in penis-in-vagina intercourse or why they were not pregnant. Similarly, a 28-year-old transgender man described the discomfort of attending a cervical cancer screening while passing as cisgender: *"I kind of expect to be a little uncomfortable because my gender presentation is not hypermasculine…Cis people struggle with that."*

> "I would say it would be someone who's not operating under the assumption that everyone is, as a baseline, in a heterosexual relationship. That would be really cool."
> – 37-year-old nonbinary queer person

> "Or they'll ask, 'You're definitely still menstruating, right?'"
> - 28-year-old transgender man

Be Punctual and Prepared

Punctuality and reviewing medical records prior to appointments were viewed as basic yet meaningful demonstrations of respect. For LGBTQIA+ patients, overlooked details often related to gender identity or sexual orientation. Interviewees reported feeling frustrated, annoyed, and disrespected when providers failed to review charts or remember basic patient information. In most cases, this frustration was not perceived as specific to being unique to their LGBTQIA+ identity, but rather as a reflection of whether providers paid attention to details and engaged thoughtfully with each patient.

> "I've had a hysterectomy, but anytime I go anywhere [aside from my primary care, who is great – They] they always ask me if I'm pregnant, and I'm like, it's right there on the side [in my chart]."
> – 35-year-old nonbinary bisexual person

Demonstrate Humility

Humility was identified as a critical quality, particularly by transgender participants who often had greater expertise in their own care and hormone regimens than their providers. Clinicians who demonstrated humility and respect were highly praised, while those perceived as arrogant or unwilling to accept feedback were seen as dismissive, leaving patients feeling undervalued. Participants emphasized that providers should recognize and value patients' personal knowledge of their bodies and health by asking informed questions rather than making assumptions.

> "[An ideal characteristic would be] people who are open to feedback. I find that physicians sometimes can be really closed off, right?"
> -37-year-old nonbinary genderfluid person

Maintain a Non-Judgmental Attitude

Interviewees reported experiencing stigma and judgment from some providers, and valued clinicians who approached care without assumptions or bias. Participants emphasized the importance of being treated the same as any other patient, noting that positive experiences often stemmed from feeling respected and not singled out for being part of the LGBTQIA+ community. Some cisgender gay male interviewees described a general sense of judgment from medical providers.

Transgender participants highlighted experiences of transphobia in healthcare settings, including heightened scrutiny and anticipation of misgendering or other discriminatory behavior, particularly when their gender presentation did not align with cisnormative expectations. Some reported instances of providers openly creating barriers to necessary medical treatment.

> "...There are a handful of people – [who] have their own personal views that interfere...if I had gone under surgery, and I knew that there was a nurse there that had such disdain for this procedure that they did not want to be there for me, I'd question whether it was really ethical for them to even be in the room..."
> – 35-year-old nonbinary bisexual person

Medical Professional Knowledge and Comfort

Interviewees emphasized that quality care for LGBTQIA+ patients requires medical providers to have a baseline level of knowledge and comfort with the community. This includes using appropriate terminology, understanding diverse bodies and healthcare needs, and avoiding heteronormative assumptions. Participants expressed frustration with providers' limited understanding of sexual practices, hormone therapy, other relevant medications, and recommended cancer screenings. Transgender participants, in particular, reported feeling unsafe or disrespected when providers lacked knowledge of transgender health or minimized the

importance of gender-affirming treatments, especially hormone replacement therapy. One 24-year-old transgender man described his frustration at paying for medical appointments where he needed to educate the doctor about his own care.

Inclusive Healthcare

Inclusive healthcare services that avoid gendered terms would be more welcoming to transgender and nonbinary patients than existing naming conventions. Participants noted that care for specific body parts is often gendered—for example, gynecological services are typically labeled as "women's health" rather than using inclusive language that recognizes transgender men, transmasculine, and nonbinary patients.

Similarly, both transgender and lesbian interviewees reported feeling excluded or erased by medical professionals who failed to listen, reference existing records, or provide forms and policies that addressed their specific healthcare circumstances.

> "One of the things that that comes up a lot, a lot of gynecological care in general. They... would like for me to do all of these screenings, and that's completely fine. I'm happy. I'm happy to go do it. But every single time I have to explain to the system, somehow. Like, yeah, I still am not going to be having PIV (penis in vagina) sex."
>
> – 35-year-old nonbinary queer person

Specific Challenges for Transgender and Nonbinary Individuals

Transgender and nonbinary participants reported challenges including providers' lack of knowledge about their bodies, treatments, and community-specific health needs, as well as experiences of transphobia, misgendering, deadnaming, and exclusionary, gendered care. Administrative barriers, such as standardized forms and insurance procedures that do not include transgender acknowledgement, compounded these difficulties. Many described feeling unsafe or scrutinized during medical visits, particularly when their gender presentation did not align with cisnormative expectations, and some reported explicit gatekeeping of care.

> "[My insurance] wellness program isn't trans affirming. They do not have their wellness program set up to recognize the trans population. They treat [me] like a cisgender female. My healthcare provider has let me know, yes, I need mammograms. But I also need prostate exams. [My health insurance provider] keeps recommending a Pap smear for me...And it's like sweetheart; I don't have that!"
>
> – 62-year-old transgender woman

Mental Health

Mental health was a noted as a concern for interviewees, who emphasized its connection to physical health and expressed frustration with the fragmented nature of mental health care. Participants highlighted the need for providers with cultural sensitivity and understanding of LGBTQIA+ experiences, including disclosing their identity and other identity-specific challenges. One cisgender asexual man noted his urgent need for therapy and the lack of knowledgeable providers, while a cisgender gay man described the complexity of LGBTQIA+ mental health and the importance of empathy in care.

Social and Political Climate

Interviewees reported that the current social and political climate in the United States is a significant source of stress for LGBTQIA+ individuals. Concerns included rising hostility toward LGBTQIA+ people, potential loss of federal and state funding for supportive programs (such as HIV prevention and treatment), and barriers to healthcare for transgender people and youth. Immigration and deportation fears were also prominent, with some participants reporting that uncertainty about legal status caused anxiety that interfered with daily life and access to routine care.

Additional Needs and Concerns

During the interviews, participants identified several other areas of concern beyond the primary topics discussed. These are outlined below.

Cancer Screenings and Education for People Under 30

The younger interviewees were unaware of the types of cancer screenings they might need or when they should get them. This finding is significant as three of the interviewees had been diagnosed with cancer prior to the age of 30.

> "Yeah, I kinda don't know what I need."
> -25-year-old transgender woman

HPV Education, Vaccination, and Screening

Knowledge about prevention and screening, as well as fears about follow-up affect the LGBTQIA+ community. Some interviewees under 30 had received the HPV vaccine, others had not, and most—regardless of vaccination status—were unaware of HPV's potential health effects. One interviewee discussed the fear related to follow-up care for abnormal cancer screenings. He emphasized the importance of targeted outreach to LGBTQIA+ populations to improve follow-up rates, for example, increasing the number of individuals who return for an anoscopy after an abnormal screening result.

LGBTQIA+ Youth and Medical Care

LGBTQIA+ youth and young adults may feel unsafe with medical providers and these early experiences may shape the way LGBTQIA+ people feel about accessing healthcare throughout their lives. Several interviewees aged 30 and younger did not feel comfortable disclosing aspects of their sexual orientation or gender identity to their pediatricians due to concerns about parental involvement and avoided discussing their needs while their parents were present.

Transgender, Intersex, and Nonbinary Barriers to Care

Overall, transgender interviewees felt that their medical providers lacked understanding of common transgender experiences and the physical and emotional effects of hormone replacement or hormone therapy (HRT). Transgender interviewees voiced frustration over the lack of provider knowledge regarding gender-affirming care, feeling that they knew more about HRT than their doctors. The needs and experiences of intersex people are also often overlooked in medical care, and as in the case of one interviewee, affecting both their health and employment opportunities.

Many of the nonbinary individuals interviewed had undergone some form of gender-affirming surgery or HRT. Like their transgender counterparts, they often expressed confusion about what types of cancer screenings or follow-up care for positive screenings were necessary. Nonbinary and transgender participants were especially likely to voice discomfort with the common medical practice of assigning gender to body parts or organs. Several noted that this practice contributed to their avoidance of necessary medical care.

Drug and Alcohol Use

Two individuals emphasized their commitment to sobriety and described a strong sense of connection to their sober communities. LGBTQIA+ sober spaces were highlighted as vital sources of support for individuals navigating addiction, and some interviewees suggested these spaces could serve as models for other types of peer support groups. They also saw potential for sharing health messages with these communities through trusted, culturally competent messengers.

Support Systems of LGBTQIA+ People

Some LGBTQ+ individuals are estranged from their families or do not have close relationships with family members (Reczek & Bosley-Smith, 2021). Interviewees discussed utilizing chosen family members as powers of attorney and primary support persons. One expressed a desire for medical professionals to understand and respect chosen families when delivering care (i.e., allowing visitation).

Family Dynamics and Health

According to interviewees, family culture can create significant stress that affects a person's health and medical needs. Two delayed notifying individuals of their identity because of their family culture and noted that understanding family dynamics is crucial for clinicians working with the LGBTQIA+ community.

Socioeconomic Class

One interviewee highlighted the coverage gap between Medi-Cal and private insurance, while another shared feeling negatively judged by medical providers due to perceived socioeconomic class, describing how a modest upbringing can have lasting emotional impacts.

Disability

One participant noted that having a disability can profoundly shape how others interact with you, often leading to incorrect assumptions about one's abilities and limitations.

Cancer Treatment

Three interviewees had been diagnosed with some form of cancer under the age of 30 and one received multiple abnormal cervical cancer screening tests. Interviewees discussed the mental and physical challenges of undergoing treatment, loneliness, support systems, or their interaction with peers (family, friends, partners). These experiences offer insight into the need for better patient education around test results and medical processes, as well as the importance of empowering patients to advocate for their own health.

Interviewee 1

One interviewee, diagnosed with leukemia at age 25, felt he received culturally competent care from his medical team. His diagnosis brought his family together, ending a period of estrangement from his extended relatives. However, he shared that the treatment regimen placed strain on his intimate relationship and expressed frustration over the lack of sexual and reproductive health education available to him and his partner. He emphasized the need for more LGBTQIA-specific cancer education and support services and said he would welcome such resources being offered through the San Diego LGBT Community Center.

> "...there is a lack of sexual and reproductive health for cancer patients and their loved ones. I remember when being intimate...just having to explain to [my partner] ...we need to use protection because my body is full of chemicals."
>
> - 29-year-old nonbinary gay person

> "There's a lot of side effects to treatment. Neuropathy, for one. Some of us go sterile. Some of us don't return to being able to have kids... sometimes it is better to know these side effects before going into treatments."
>
> - 29-year-old nonbinary gay person

Interviewee 2

Another interviewee, a 43-year-old cisgender gay man, was diagnosed with a rare, hereditary form of prostate cancer at age 24. He recalled being given just four months to live and having to navigate the diagnosis without the support of his family. The cancer recurred three times, and he spoke with gratitude about being a three-time cancer survivor.

Later in life, through his sobriety support community, he befriended another gay man who was also facing prostate cancer. He found strength and healing in being able to support his friend in ways he himself had not been supported during his own cancer journey.

Interviewee 3

The third interviewee, a 27-year-old transgender man, was diagnosed with thyroid cancer at around age 10 or 11. He shared that his condition had been well-managed, with providers regularly monitoring his thyroid function through routine testing. However, he was unsure whether having thyroid cancer at such an early age might increase his risk for other types of cancer.

> "... It was a hard thing to experience at such a young age...Being 24 and not really in communication with my family...I heavily relied upon my medical team to be there to support me, because I was going through it alone."
>
> - 43-year-old cisgender gay man diagnosed with prostate cancer at 24

He also expressed discomfort with undergoing cervical cancer screenings, noting the challenges of accessing this care as a transgender man. Specifically, he felt uneasy receiving these services in "women's health" settings—a concern commonly shared by many transgender men and transmasculine individuals.

Interviewee 4

The fourth interviewee, a 29-year-old cisgender lesbian woman, had recently undergone multiple cervical cancer screenings that returned abnormal results. She expressed frustration with the opaque and confusing processes used by her healthcare and insurance providers to determine which screenings were necessary and who would be responsible for covering the costs.

One medical provider informed her that her previous two cervical cancer screenings had been performed incorrectly and that by continuing to seek screenings, she was doing "more harm than good." Feeling frustrated and confused, she chose to proactively end her relationship with that provider. She expressed continued frustration that obtaining a clear diagnosis was neither straightforward nor timely.

> "They say it's not genetic, but I also don't want to play with my health. If I have to go through a treatment to get rid of it, I'm fine with that. But waiting with what feels like a ticking time bomb is scary. I don't know how anybody has that knowledge and that 'what if?' and 'what is inside me?' without being afraid."
>
> - 29-year-old cisgender lesbian woman

Appendix A – Data Collection Tools

Needs Assessment Survey

A: Connection to San Diego County and the LGBTQIA+ Community

First, we would like some information about your connection to San Diego County, as well as your connection to the LGBTQIA+ community.

Today's Date (mm/dd/yy): ____ / _____ / _____

A1. Do you currently live in San Diego County?

- ☐ Yes ➔ Zip code live/stay in ___ ___ ___ ___ ___
- ☐ No

A2. What is the zip code where you currently live?

___ ___ ___ ___ ___

A3. Do you get health care in San Diego County (doctor, clinic, hospital, etc.)?

☐ Yes ☐ No

A4. What is your age in years? _____ years old

A5. Which of the following sexual orientation identities fits you best? (Please choose **ONE**)

- ☐ Asexual
- ☐ Bisexual
- ☐ Gay/homosexual
- ☐ Lesbian
- ☐ Pansexual
- ☐ Queer
- ☐ Same gender loving
- ☐ Straight/heterosexual
- ☐ Something else, specify:_____
- ☐ Choose not to disclose

A6. Do you identify as transgender?

- ☐ **Yes** my gender identity is different than the sex I was assigned at birth
- ☐ **No** and my gender identity is the same as the sex I was assigned at birth
- ☐ **No** but my gender identity is different than the sex I was assigned at birth

A7. What best describes your gender identity? (Please select the **ONE** you most identify with)

- ☐ Woman
- ☐ Transgender woman
- ☐ Transfemme
- ☐ Nonbinary or gender fluid
- ☐ Transmasculine
- ☐ Transgender man
- ☐ Man
- ☐ Genderqueer
- ☐ Two-spirit
- ☐ Self-describe, specify:_____
- ☐ Prefer not to answer

This next question will help us to know if you are receiving all of the cancer screenings that can help you, some of which are based on your sex at birth.

A8. What sex were you assigned at birth?

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Choose not to disclose

B: Health Care Information

B1. When was your last general health checkup?

- ☐ Within the past year
- ☐ Between 1 and 2 years ago
- ☐ Between 3 and 5 years ago
- ☐ 6 or more years ago
- ☐ I don't know

Was your last general health checkup in San Diego County? ☐ Yes ☐ No ☐ I don't know

B2. At what type of medical practice do you usually receive your care? (Please choose **ONE**)

- ☐ Community clinic
  (such as Family Health Centers of San Diego, Vista Community Clinic, Escondido Community Clinic, TrueCare, San Ysidro Health, etc.)
- ☐ Health system
  (such as Kaiser, Sharp Healthcare, UCSD, Scripps, etc.)
- ☐ Veterans or Military Health System
- ☐ Another, please specify:

_____

B3. Is the medical doctor or provider you visit most often for general medical care aware of your LGBTQIA+ status?

☐ Yes ☐ No ☐ Don't know

B4. How knowledgeable is the medical doctor/provider you visit most often (for general medical care) about LGBTQIA+ medical needs?

☐ Extremely knowledgeable
☐ Moderately knowledgeable
☐ Somewhat knowledgeable
☐ Slightly knowledgeable
☐ Not at all knowledgeable
☐ I do not know

B5. How comfortable are you with the medical doctor/provider you visit most often for general medical care?

☐ Extremely comfortable
☐ Moderately comfortable
☐ Somewhat comfortable
☐ Slightly comfortable
☐ Not at all comfortable
☐ I do not know

B6. How long have you been a patient of this medical doctor/provider?

☐ Less than 3 months
☐ 3 months to 1 year
☐ 1 to 2 years
☐ 3 or more years

B7. Please let us know of any health care agencies, clinics, or doctors that you would recommend as providing safe and competent care for LGBTQIA+ people:

_____

_____

C: Cancer Screening

The following questions will help us to know if you are getting recommended cancer screening tests. Screening tests look for early signs of cancer before there are symptoms.

C1. The cervix is the end of the uterus that connects to the vagina in persons who have a vagina. Do you have a uterus or a cervix?

☐ Yes ☐ No ➔ **If no, skip to C5**

The cervical cancer screening test (Pap or HPV test) uses a small brush to collect cells from the cervix that are then tested for cancer.

C2. Has a medical professional ever talked to you about cervical cancer screening?

☐ Yes ☐ No

C3. Have you ever had a cervical cancer screening test? ☐ Yes ☐ No ➔ **If no, skip to C4**

If yes, how was your experience with your most recent cervical cancer screening…

☐ Very respectful
☐ Somewhat respectful
☐ Not respectful

If yes, about how many years ago was your last cervical cancer screening test?

☐ 1 year ago or less ➔ **Skip to C5**
☐ 2 years ➔ **Skip to C5**
☐ 3 years ➔ **Skip to C5**
☐ 4 years
☐ 5 years
☐ 6 or more years ago

C4. If you do not get cervical cancer screening every 1-3 years, what are the main reasons?
(Select **ALL** that apply and write in if not listed)

_____

☐ I was told to screen every 5 years
☐ I did not want to discuss with medical provider
☐ I was told that I do not need (or no longer need) cervical cancer screening
☐ I did not know I need regular cervical screenings

This next section is for people aged 40 or older.
If you are younger than 40 ➔ Skip to C21

C5. Breast cancer screening is appropriate for:

(1) Cisgender women and anyone assigned female at birth who has not had both breasts removed, such as through top surgery or a double mastectomy

(2) Transgender women or people of any gender identity who have been taking feminizing hormones [FHT]/hormone therapy [HR] (such as estrogen) for at least 5 years

Based on this information, does breast cancer screening apply to you?

☐ Yes ☐ No ➔ **If no, skip to C9**

A mammogram is an x-ray of each breast to look for breast cancer.

C6. Has a medical professional ever talked to you about a mammogram?

☐ Yes ☐ No

C7. Have you ever had a mammogram?

☐ Yes ☐ No ➔ **If no, skip to C8**

If yes, how was your experience with your most recent mammogram…

☐ Very respectful
☐ Somewhat respectful
☐ Not respectful

If yes, about how many years ago was your last mammogram?

☐ 1 year ago or less ➔ **Skip to C9**
☐ 2 years ago ➔ **Skip to C9**
☐ 3 years ago
☐ 4 years ago
☐ 5 or more years ago

C8. If you do <u>not</u> get mammograms <u>every 1 to 2 years</u>, what are the main reasons?
(Select **<u>ALL</u>** that apply and write in if not listed)

_____

☐ I was told that I do not need mammograms
☐ I did not want to discuss with medical provider
☐ I did not know I need regular mammograms

C9. Prostate cancer screening may be appropriate for any person who has a prostate, which includes:

- *Cisgender men*
- *Transgender women, including transgender women who have had vaginoplasty or orchiectomy*
- *Anyone of any gender identity who was assigned male at birth*

Based on this information, does prostate cancer screening apply to you?

☐ Yes ☐ No ➔ **If no, skip to C13**

A blood test, the Prostate-Specific Antigen or PSA test, is used to check for prostate cancer.

C10. Has a medical professional ever talked to you about screening for prostate cancer or performing the PSA?

☐ Yes ☐ No

C11. Have you ever had a PSA test?

☐ Yes ☐ No ➔ **If no, skip to C12**

If yes, how was your experience with your most recent prostate PSA screening…

☐ Very respectful
☐ Somewhat respectful
☐ Not respectful

If yes, about how many years ago was your last prostate screening PSA test?

☐ 1 year ago or less ➔ **Skip to C13**
☐ 2 years ago
☐ 3 years ago
☐ 4 years ago
☐ 5 or more years ago

C12. If you do <u>not</u> have a PSA test <u>every 1-2 years</u>, what are the main reasons?
(Select **<u>ALL</u>** that apply and write in if not listed)

_____

☐ I was told to not get PSA tests
☐ I did not want to discuss with medical provider
☐ I did not know I need regular PSA tests

This next section is for people aged 45 or older.
If you are younger than 45 ➔ Skip to C21

A stool blood test or colonoscopy screens for colon (intestine and rectum) cancer.

The blood stool test kit can be used at home and then mailed or dropped off at a lab which then tests for blood in your stool (poop).

A colonoscopy is an exam in which a tube is inserted in the rectum (bottom) to view the colon for signs of cancer or other health problems.

C13. Has a medical professional ever talked to you about screening for colon cancer (blood stool test or colonoscopy)?

☐ Yes ☐ No

C14. Have you ever done the blood stool (poop) test?

☐ Yes ☐ No ➔ **If no, skip to C15**

If yes, about how many years ago was your last blood stool (poop) test?

☐ 1 year ago or less
☐ 2 years ago
☐ 3 years ago
☐ 4 years ago
☐ 5 or more years ago

C15. Have you ever had a colonoscopy?

☐ Yes ☐ No ➔ **If no, skip to C16**

If yes, how was your experience with your most recent colonoscopy…

☐ Very respectful
☐ Somewhat respectful
☐ Not respectful

If yes, about how many years ago was your last colonoscopy?

☐ 1 year ago or less
☐ 2 to 5 years ago
☐ 6 to 10 years ago
☐ 11 or more years ago

C16. If you do not get a stool blood test every year, or a colonoscopy every 10 years, what are the main reasons? (Select **ALL** that apply and write in if not listed)

_____

☐ I was told I do not need a stool blood test
☐ I did not want to discuss with medical provider
☐ I was told I do not need a colonoscopy
☐ I did not know I need regular stool blood tests or colonoscopies

C17. Lung cancer screening is appropriate for people who:

(1) Have a 20 pack-year history of smoking (1 pack a day for 20 years or 2 packs a day for 10 years, etc.)
(2) AND have smoked in the past 15 years (including currently smoke)

Based on this information, does lung cancer screening apply to you?

☐ Yes ☐ No ➔ **If no, skip to C21**

A CT scan (low dose X-ray) of the lungs is used to screen for lung cancer.

C18. Has a medical professional ever talked to you about screening for lung cancer?

☐ Yes ☐ No

C19. Have you ever had a lung cancer screening CT test? ☐ Yes ☐ No ➔ **If no, skip to C20**

If yes, how was your experience with your most recent CT lung cancer screening….

☐ Very respectful
☐ Somewhat respectful
☐ Not respectful

If yes, about how many years ago was your last lung cancer screening CT test?

☐ 1 year ago or less ➔ **Skip to C21**
☐ 2 years ago
☐ 3 years ago
☐ 4 years ago
☐ 5 or more years ago

C20. If you do not get screened every year for lung cancer, what are the main reasons?
(Select **ALL** that apply and write in if not listed)

_____

- ☐ I was told I do not need lung cancer screening
- ☐ I did not want to discuss with medical provider
- ☐ I did not know I need regular lung cancer screenings

This next section is for people aged 35 or older.
If you are younger than 35 ➔ Skip to D1

C21. Anal cancer screening is appropriate for people who:
- *Are living with HIV, OR*
- *Have been diagnosed with human papillomavirus (HPV), OR*
- *Are immunocompromised, OR*
- *Practice the receptive role during anal intercourse (penis inserted into your anus)*

Based on this information, does anal cancer screening apply to you?

☐ Yes ☐ No ➔ **If no, skip to D1**

The anal Pap uses a small brush to collect cells from the anus that are then tested for cancer.

C22. Has a medical professional ever talked to you about screening for anal cancer (anal pap)?

☐ Yes ☐ No

C23. Have you ever had an anal pap screening test?

☐ Yes ☐ No ➔ **If no, skip to C24**

If yes, how was your experience with your most recent anal pap screening test…

- ☐ Very respectful
- ☐ Somewhat respectful
- ☐ Not respectful

If yes, about how many years ago was your anal pap screening test?

- ☐ 1 year ago or less ➔ **Skip to D1**
- ☐ 2 years ago ➔ **Skip to D1**
- ☐ 3 years ago ➔ **Skip to D1**
- ☐ 4 years ago
- ☐ 5 or more years ago

C24. If you do not get an anal pap screening test every 1 to 3 years, what are the main reasons? (Select **ALL** that apply and write in if not listed)

_____

- ☐ Did not know about it
- ☐ Do not know where to get it
- ☐ I did not want to discuss with medical provider
- ☐ I did not know I need regular anal cancer screenings
- ☐ I was told I do not need anal cancer screenings

D. Other Cancer Screenings / Prevention

HPV stands for human papillomavirus, and it is a virus that can have no symptoms, or it can cause warts on or around the genitals, anus, or mouth. HPV can cause cancer in anyone of ANY gender identity.

D1. Before today, have you ever heard of HPV?

☐ Yes ☐ No

D2. Before today, did you know that HPV could cause cancer in persons of any gender?

☐ Yes ☐ No ☐ I wasn't sure

The HPV vaccine protects against the HPV strains that most commonly cause cancer.

D3. Before today, have you ever heard of the HPV vaccine (also known as Gardasil)?

☐ Yes ☐ No

D4. Have you ever been vaccinated for HPV (at least one dose)?

☐ Yes ☐ No ☐ Do not know

If yes, how many HPV vaccination doses (shots) did you get?

☐ 1 dose ☐ 2 doses ☐ 3 doses ☐ Unsure

These next questions are about liver diseases which can affect your risk of liver cancer. Screenings for liver cancer can include blood test (liver function tests, DNA markers), biopsy, ultrasound, or CT scan.

D5. Has a medical professional ever told you that you have or are at risk for liver disease?

☐ Yes ☐ No

D6. Has a medical professional ever discussed the following with you?

Liver cancer	☐Yes	☐No	☐Unsure
Hepatitis C testing or treatment	☐Yes	☐No	☐Unsure
Hepatitis B testing or vaccination	☐Yes	☐No	☐Unsure
Alcohol use and how it relates to liver cancer	☐Yes	☐No	☐Unsure

This cancer screening question is about skin cancer.

D7. Has a medical professional ever looked over your whole body to screen for skin cancer?

☐ Yes ☐ No ☐ Do not know

E. Knowledge

E1. I would <u>like more information</u> about cancer screening tests:

☐ Yes ☐ No

E2. <u>I know where</u> I can get cancer screening tests:

☐ Yes ☐ No ☐ Do not know

E3. <u>I know where</u> I can get cancer screening tests from a provider who is <u>knowledgeable about LGBTQIA+</u> health:

☐ Yes ☐ No ☐ Do not know

F. Health Care Experiences and Suggestions

F1. What are a few of the <u>most important things</u> medical professionals need to know to be more <u>welcoming and respectful</u> of LGBTQIA+ clients?

a. _____

_____

b. _____

_____

c. _____

_____

F2. Have you ever been diagnosed with cancer?

☐ Yes ☐ No ➔ **If no, skip to G1**

☐ Prefer not to answer

If yes, thank you for trusting us with this information. If you don't mind, please tell us what type(s) of cancer you have ever been diagnosed with:

_____

G. About You

The information in this section will help us to be sure have included the voices from a variety of people. It will also help us know how to best support diverse groups of people.

G1. How do you describe your race and/or ethnicity? (Please select **<u>ALL</u>** that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino (a/e/x)
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Prefer not to answer

G2. If you are Hispanic, Latino (a/e/x) or Spanish do you consider yourself to be:
(Please select **ALL** that apply)

- ☐ Mexican, Mexican American, or Chicano (a/e/x)
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Hispanic, Latino (a/e/x) or Spanish
- ☐ Not Hispanic, Latino (a/e/x) or Spanish

G3. What language do you use most often at home? (Please choose **ONE**)

- ☐ English
- ☐ Español / Spanish
- ☐ Another:_____

G4. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medi-Cal, Medicare, or Indian Health Service?

☐ Yes ☐ No ➔ **If no, skip to G6**

G5. What are the main sources of your health care coverage? (Please select **ALL** that apply)

- ☐ A plan purchased through (or provided by) an employer or union (including plans purchased through another person's employer)
- ☐ A plan that you or another family member buys on your own (including through Covered California)
- ☐ Medicare
- ☐ Medi-Cal, Medicaid, or other state program
- ☐ TRICARE (formerly CHAMPUS), VA, or military
- ☐ Alaska Native, Indian Health Service, or Tribal Health Services
- ☐ Some other source

G6. Thinking about you (and your partner or spouse if you live together), what is your combined annual income, meaning the total pre-tax income from all sources earned in the past year?
(Please choose **ONE**)

- ☐ $0 to $9,999 in the past year
- ☐ $10,000 to $14,999 in the past year
- ☐ $15,000 to $19,999 in the past year
- ☐ $20,000 to $34,999 in the past year
- ☐ $35,000 to $49,999 in the past year
- ☐ $50,000 to $74,999 in the past year
- ☐ $75,000 to $99,999 in the past year
- ☐ $100,000 to $199,999 in the past year
- ☐ $200,000 or more in the past year
- ☐ I prefer not to say

Thank you!

We greatly appreciate you taking the time to add your voice to this effort. The information you share will help bring attention to what we need in our communities.

In-Depth Interview Questions

Hello, and thank you for taking the time to speak with me.

Do I have your permission to record today's interview? This is to make sure that I accurately represent what you are sharing with me. After the interview is recorded, it will be transcribed and then the recording will be deleted. [Obtain verbal consent]

Before we get started, I want to let you know that it's up to you what you share with me today. Talking about experiences with health care is personal, and can be sensitive, so if at any point you feel uncomfortable or don't want to answer certain questions, that's totally fine, just let me know. Nothing you share with me today will be connected with your name or any personally identifying information about you in our final report.

[Notes: When [LGBT] is in brackets, use the descriptor(s) that apply specifically to the individual; interview time is 30-45 minutes, and all questions do not need to be asked – follow the lead of the interviewee]

All respondents:

1. First, can you share with me a little bit about yourself and your connection to the LGBT community?
2. Can you describe for me what it looks like to have a medical provider who is sensitive and respectful
   to your experiences as a [lesbian, gay, bisexual, transgender, queer, etc.] person?

3. What would the perfect interaction with a healthcare provider look like to you?
4. Have you personally found a medical provider who gives you care that you feel is appropriate and affirming?
5. How would you describe your experiences with healthcare as a [LGBTQ] person?
6. If you haven't found a medical provider like this, what have been the main reasons you haven't found
   one?
   a. Does your insurance coverage limit access to what providers you can see?
7. Have you had a bad experience with a medical provider because of your [LGBTQ] identity? If so, can you tell me about it, and how it affected your willingness to get medical care. Only if it will not retraumatize you to share it. You can share as much or as little as you'd like.

For people under 40:

1. Before you took this survey, were you aware of how HPV (human papilloma virus) can affect [LGBT]
   people?

(if time allows) For gay men:

1. Has any healthcare provider ever talked with you about your risk for anal cancer? Before this survey,
   were you aware of risk factors for anal cancer, or the need for anal cancer screenings?

(if time allows) For lesbians:

1. Has any healthcare provider ever spoken with you about being at increased risk for breast, cervical, or
   ovarian cancer?

For transgender people:

There is a great deal of research about the experiences of trans people with a healthcare system that is focused on a binary understanding of sex and gender.

1. What have your experiences been like in San Diego?
2. What education do you feel would be the most helpful for clinicians?
3. Before this survey, had you given much thought to cancer screenings and prevention?
    a. Were you aware of what cancer screening procedures you might need?

For people who have undergone cancer treatment:

Research has shown that [lesbian, gay, bisexual, and/or transgender] people have very different experiences than heterosexual or cisgender people when it comes to cancer care and treatment.

1. Do you mind sharing with me what your experience with cancer treatment was like as a [lesbian, gay, bisexual, and/or transgender] person?
2. What could your care team have done differently?
3. Is there any guidance or advice you would give to other [LGBT] people who are starting cancer treatment?

Appendix B – Literature Review Report

Cancer Screening Disparities and Barriers Among LGBTQIA+ Populations: A Review of Practices, Challenges, and Recommendations

LGBTQIA+ stands for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and all other identities within the LGBTQ umbrella not explicitly listed in the acronym. The + symbol "holds space for the expanding and new understanding of different parts of the very diverse gender and sexual identities" (Princeton, n.d.). We understand that acronyms may not be representative of all gender or sexual identities; and that categorizing people can be problematic. Although we use the term LGBTQIA+ throughout the report, in this section of the report we used the variations of the acronym (such as LGBTQ, LGBT or LGB) as used by authors in the original source materials.

Introduction

Cancer screening is a critical component of preventive healthcare, enabling the early detection of cancer before symptoms manifest. Some common symptoms of cancer include unexplained weight loss, persistent fatigue, changes in bowel or bladder habits, unusual bleeding, and lumps or swelling in specific areas of the body. Early identification can lead to more effective treatment options and improved survival rates, highlighting the importance of widespread and routine screening practices (National Cancer Institute, 2023). Screening tests, such as mammograms, colonoscopies, and Pap tests, have been instrumental in reducing mortality rates for specific cancers. For example, mammograms help detect breast cancer, colonoscopies are effective in identifying colorectal cancer, and Pap tests are crucial for the early detection of cervical cancer. These screenings demonstrate their significance in public health strategies (National Cancer Institute, 2023). Despite these advancements, disparities in cancer screening access and rates persist, particularly among marginalized populations, including lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual (LGBTQIA+) people (Austin et al., 2012; Braun et al., 2017; Ceres et al., 2018; Haviland et al., 2019).

The LGBTQ+ population faces multiple challenges in accessing cancer screenings, such as experiencing discrimination and stigma and a widespread lack of baseline cultural competence among healthcare providers (Azzellino et al., 2025; Haviland et al., 2019; Mayhew et al., 2020; Peitzmeier et al., 2017). These barriers often result in delayed or foregone screenings, increasing the risk of advanced-stage cancer diagnoses and poorer health outcomes, such as lower survival rates, increased treatment complications, and reduced quality of life (Bates et al., 2022; Stanford, 2020). For example, research indicates that lesbians are significantly less likely to undergo cervical cancer screening due to misconceptions about their risk factors, lack of provider recommendations, and previous negative experiences in healthcare settings (Bustamente et al., 2021; Tracy et al., 2010). Transgender people face additional challenges, such as uneducated or ignorant providers, transphobia or other hostility, a baseline lack of knowledge and best clinical practices for transgender cancer screenings, and/or the highly gendered nature of oncology care,

which results in critical gaps in preventive care and exacerbating existing disparities (Leone et al., 2023; Mayhew et al., 2020; Peitzmeier et al., 2014; 2017). LGBTQ+ people with cancer report higher levels of depression and difficulty within their relationships than heterosexuals (Kamen et al., 2015).

Addressing these disparities requires a concerted effort to make healthcare systems more inclusive and culturally competent. Inclusive healthcare practices are essential to provide equitable access to cancer screenings and ensure that LGBTQ+ populations feel safe and supported within healthcare settings. LGBTQ+ inclusive healthcare practices like creating diverse healthcare workforces, offering targeted training on cultural competence, and developing policies that explicitly address the needs of LGBTQ+ patients are essential to provide equitable access to cancer screenings (Burnett et al., 2024; Stanford, 2020). By incorporating inclusive practices and educating providers about the LGBTQ+ community, healthcare systems can reduce barriers to cancer screening and enhance health outcomes for all populations.

This literature review explores cancer screening practices and rates within LGBTQIA+ populations, focusing on disparities, barriers, and opportunities for intervention as well as cancer incidence within the LGBTQIA+ community. Additionally, we highlight the importance of evidence-based strategies to promote equitable healthcare access and address the unique needs of LGBTQIA+ people.

Cancer Burden Among the LGBTQIA+ Community

The LGBTQ+ community faces a higher incidence of cancer and more frequent diagnoses at later stages (American Cancer Society). In the United States, approximately one million LGBT people are cancer survivors (National LGBT Cancer Network). However, LGBT patients' experience with cancer and cancer treatment differs significantly from those of heterosexuals. These differences are largely influenced by factors such as the patient's social relationships and interactions with healthcare providers, sexual orientation and gender identity (SOGI), as well as existing societal stigma and previous experiences of discrimination (Braun et al., 2017; Ceres et al., 2018; Kamen, et al., 2018; Matthew et al., 2018; Mayhew et al., 2020; National LGBT Cancer Network, n.d.).

A 2021 survey highlighted these disparities, with 40% of LGBTQ+ cancer patients stating they were unaware of recommended screenings and 35% reporting that their healthcare providers did not discuss these screenings with them (American Cancer Society). In addition to medical provider interaction, discrimination, and lack of awareness in healthcare, other factors may contribute to this burden, such as increased engagement in behaviors known to increase cancer risk such as consumption of alcohol or tobacco (Leone et al., 2023).

Racial Disparities in Cancer Screenings and Outcomes

In 2019, the LGBTQ+ community in the United States was estimated to be 58% white, 21% Latino/a, 12% Black, 5% more than one race, 2% Asian, 1% American Indian or Alaska Native, and 1% Native

Hawaiian or Pacific Islander (The Williams Institute, 2019). Medical mistrust is a historical and continuing problem that impacts people's access to healthcare and is more common among gender and sexually diverse people of color (Cox et al., 2021; Jaiswal 2019; Wegner et al., 2024). In the United States, some medical mistrust is due to trauma from, for example, unethical medical experiments performed on Black/African American people such as the Tuskegee Syphilis Study (Jaiswal 2019). More research is being conducted on medical mistrust caused or exacerbated by intersecting identities (Ho et al., 2021).

Additionally, existing racial disparities in cancer screenings and treatment impact LGBTQ+ people of color. Significant racial disparities in cancer outcomes exist in many types of cancer, including some of the most common cancers in the United States like breast, colon, and cervical cancers (Musselwhite et al., 2019; National Cancer Institute, 2025; Orji & Yamashita, 2021; Shahidi & Cheung, 2016). Researchers have also documented racial disparities among LGBTQ+ cancer survivors with regards to health-related quality of life after cancer treatment (Bates et al., 2022). LGBTQ+ people of color have unique experiences with healthcare that may not align with either the experiences of heterosexual people of color or white LGBTQ+ people (Agénor et al., 2015; Seelman et al., 2017).

The intersection of racism with homophobia/transphobia can also have disproportionate impacts on LGBTQ+ people of color, including on willingness to engage with medical care and/or engagement in behaviors that put people at risk for HIV infection (Sen et al., 2020; Town et al., 2018). More research is needed about the experiences of LGBTQIA+ people of color when it comes to developing effective interventions for cancer screenings and ways to improve cancer outcomes.

HIV and Cancer

HIV continues to disproportionately impact gay, bisexual, and other men who have sex with men (MSM) in the United States, with Black gay, bisexual, and other MSM more affected than any other demographic of MSM (HIV.gov, 2022; Matthews et al., 2015). Black women are also disproportionately affected by HIV, although research about HIV among Black bisexual, queer, pansexual, or lesbian women is scarce (McCree, 2022). Transgender women in the United States are also disproportionately affected by HIV (Becasen et al., 2018; Centers for Disease Control and Prevention; 2024). Among transgender women diagnosed with HIV in 2022, 41% were Black, 39% were Hispanic/Latina, and 13% were white (CDC, 2024b; KFF 2024).

People living with HIV have been known to be at increased risk for cancer since the beginning of the epidemic (Centers for Disease Control and Prevention, 1981; Hernández-Ramírez et al., 2017; Gopal et al., 2014). It is well known that HIV increases the risk of certain cancers, including cancers not typically associated with HIV/AIDS (Gopal et al., 2014; Shiels et al., 2011). Of particular interest regarding existing cancer screening procedures is that people living with HIV are at increased risk for persistent HPV infection (Koskan et al., 2016; Meites et al., 2022). While the incidence of HIV-related cancers such as Kaposi's sarcoma have decreased with the introduction of antiretroviral therapy (ART), as people living with HIV are aging, their risk of other age-related cancers grows (Hernández-Ramírez et al., 2017; Gopal et al., 2014; Shiels et al., 2011). There remain many

unknowns about the causes of cancer among people living with HIV (Gopal et al., 2014). Transgender men who have sex with men are also at risk for HIV; this population is severely understudied and in need of tailored interventions to prevent HIV infection (Mayer et al., 2021).

Cancer mortality rates after diagnosis are higher among people living with HIV than people who are not living with HIV (Coghill et al., 2017). Seniors (65+) living with HIV have poorer cancer outcomes than seniors without HIV, and a growing body of evidence suggests that HIV-associated immunosuppression may play a role in cancer development and growth (Coghill et al., 2019; Ferreira et al., 2017; Pardoll, 2012). More research is needed to understand the interplay between HIV and cancer, as well as the effectiveness of specific cancer treatments for people living with HIV (Coghill et al., 2019a; Gopal et al., 2014; Puronen et al., 2019).

Racial Disparities Among People Living with HIV

In the United States, racial disparities exist in HIV incidence and outcomes, with Black and Hispanic/Latino gay, bisexual, and MSM most affected (Bonett et al., 2020; Crepaz et al., 2021; Levison et al., 2018). Some health outcomes among Black MSM living with HIV are not fully explained by behaviors alone (Bonett et al., 2020). Low-income men living with HIV who use safety net clinics may not receive adequate HPV screenings (Ferrari et al., 2024).

Minority Stress Model

It was not until 1973 that homosexuality was removed as a condition from the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1973). The study of mental health in LGBTQ+ populations has been complicated by the long history of homosexuality being classified as a mental disorder and the associated stigma (Meyer, 2003). Meyer's 'minority stress model' sought to create a 'conceptual framework' to explain higher rates of mental illness among the lesbian, gay, and bisexual population without pathologization (Meyer, 1995; 2003).

The LGBTQ+ community is challenged with multiple and intersectional stressors which can give rise to coping mechanisms that may serve either as protective factors or as risk factors contributing to poorer health outcomes. (Meyer, 1995; 2003; Frost & Meyer, 2023). Kia et al. (2021) expands upon the minority stress model:

> "The minority stress model is a framework that foregrounds the central role of stressors uniquely experienced among members of a minority group, including expressions of violence, stigma, and discrimination targeting the group in question, as potentially salient contributors to poor physical and mental health."

Using data from the 2019 to 2022 National Health Interview Survey, the American Cancer Society (2021) found that LGBTQ+ people were more likely than their heterosexual counterparts to engage in coping behaviors associated with increased cancer risk. As reported by the American Cancer Society (2024), "lesbian and gay individuals are 27% more likely to smoke cigarettes than

heterosexual individuals and bisexual individuals are 66% more likely to smoke". Among current smokers, 23% were bisexual women and 10% were heterosexual women. Additionally, alcohol consumption is associated with increased cancer risk (National LGBT Cancer Network). Men of all sexual orientations consume more alcohol than women, but lesbian and bisexual women appear to be more strongly affected compared to heterosexual women than gay and bisexual men compared to heterosexual men (Drabble et al., 2005). Six percent of heterosexual women reported heavy alcohol consumption (defined as >7 drinks per week), compared to eight percent of lesbian women and 14% of bisexual women (American Cancer Society, 2024). Additionally, bars have historically been reliable 'safe havens' for LGBT people, which can mean more social exposure to alcohol use (Hunt et al., 2018; Kerr & Oglesby, 2017).

The minority stress model does not equate sexual orientation or gender identity as the cause of engaging in coping mechanisms or cancer risk factors but rather hypothesizes that prevalence may be higher among LGBT+ people due to their marginalized status within the dominant society (Meyer, 2003; Frost & Meyer, 2023). The model expands on how minority stressors such as stigma, discrimination, racism, and rejection impact an individual on the societal and interpersonal level (Meyer, 1995; 2003).

Discrimination and stigma remain significant barriers for LGBT patients in accessing equitable cancer care and treatment (Kamen, et al., 2018). Discrimination and stigma are two known stressors supported by the Minority Stress Model (Frost & Meyer, 2023). Moreover, these stressors can impact mental health (Ceres et al. 2018). This highlights the need for healthcare providers to actively engage with insights from the LGBTQIA+ community and to undergo culturally competent training. Such efforts underscore the importance of adopting an informed and inclusive approach to caring for LGBTQIA+ patients.

Cancer Screening for LGBTQIA+ Populations

While there is no consensus on standardized screening guidelines for the various LGBTQIA+ populations, the following table includes suggestions from several sources (see Table B-1).

Although there are no specific standard guidelines, consensus among experts is to screen based on body parts (not sexual orientation or gender identity), and that misconceptions (i.e., that lesbian cisgender women are at lower risk for cervical cancer) persist (American Cancer Society, 2025).

Table B-1. LGBTQIA+ Cancer Screening Suggestions [1]

Cancer Type	Screening Test[1]	Target Population	Age to Begin Screening[1]	Frequency[1]
Breast Cancer	Mammogram	Transgender women on hormone therapy for more than 5 years, cisgender lesbians, bisexual cis women, people assigned female at birth who have not undergone top surgery	50 years (average risk)	Every 2 years (ages 50-74); discuss with provider starting at age 40
Cervical Cancer	Pap Test (or Pap + HPV test)	Transgender men with a cervix, cisgender lesbians and bisexual women, people assigned female at birth who have a cervix	21 years	Every 3 years (Pap alone); every 5 years (Pap + HPV test, ages 30-65)
Colorectal Cancer	Colonoscopy, FIT, or FOBT	All LGBTQIA+ people (average risk)	45 years	Colonoscopy every 10 years; FIT/FOBT annually
Prostate Cancer	PSA Test	Gay and bisexual cis men, transgender women (including transgender women who have undergone orchiectomy or vaginoplasty), people assigned male at birth	50 years (average risk)	Discuss with provider; individualized decision based on risk factors
Lung Cancer	Low-Dose CT	LGBTQIA+ smokers (30 pack-years)	50 years	Annually (ages 50-80 if smoking history is met)
Skin Cancer	Visual Skin Exam	All LGBTQIA+ people	No specific age	Regular self-exams; clinical exams as recommended by provider
Ovarian Cancer	Pelvic Exam, CA-125	Transgender men (retaining ovaries), cisgender women, and people assigned female at birth who have ovaries	Not recommended for average risk	Based on individual risk factors

[1] The guidelines presented in this table are drawn from peer-reviewed sources, including the National Cancer Institute, the U.S. Preventive Services Task Force, and multiple articles suggesting disparities in screening practices among LGBTQIA+ populations (Agénor, 2015; Agénor, 2016; Austin, 2012; Bazzi, 2015; Bustamente, 2021; Ceres, 2024; Dhillon, 2020; Drysdale, 2020; Ferrari, 2024; Goldstein, 2020; Heer, 2023; Haviland, 2019; Koskan, 2016; McDowell, 2017; Musselwhite, 2016; Nelson, 2023; Orji, 2021; Peitzmeier, 2014; Shahidi, 2016; Tracy, 2010; Tundealao, 2024).

Overview of Cancer Screening Rates

Cancer screening is crucial for early detection and improved outcomes, yet LGBTQIA+ individuals face distinct challenges in accessing these essential services. Compared to heterosexual women, lesbian and bisexual women are less likely to undergo routine screenings such as mammograms and Pap smears (American Cancer Society, 2024; Bustamente et al., 2021).

LGBTQIA+ Cancer Screening Rates Compared to the General Population

Compared to the general population, LGBTQ+ individuals are up to 25% less likely to receive vital cancer screenings, including colonoscopies, Pap smears (cervical or anal), and mammograms according to regional studies within the United States (Bustamente et al., 2021; Nelson et al., 2023; Tracy et al., 2010). Lesbian women, for example, report lower rates of cervical cancer screenings, often due to misconceptions about their risk levels and limited access to affirming healthcare environments (Bustamente et al., 2021; Mooney-Sommers et al., 2018; Tracy et al., 2010). Transgender people face additional barriers, often in the form of lack of provider knowledge (Nelson et al., 2023). Transgender men are often excluded from cervical cancer screening programs, resulting in missed opportunities for early detection (Ceres et al., 2018; Peitzmeier et al., 2017, 2019). Transgender men and transgender women have a slightly higher risk of breast cancer compared to cisgender men, but lower than cisgender women, yet screening guidelines for transgender people are not standardized (Corso et al., 2023).

Cancer screening rates are lower for LGBTQ+ people compared to the general population. Lower rates may be a result of barriers LGBTQ+ people face such as societal stigma, experiences of discrimination and/or trauma, lack of culturally competent care, financial obstacles, and the absence of specific screening guidelines for transgender and nonbinary individuals (Ceres et al., 2018; Mayhew et al., 2020; Nelson et al., 2023; Wang et al., 2023).

Table B-2. Cancer Screening Rates among LGBTQIA+ and non-LGBTQIA+ (General) Populations[1]

Cancer Type	Screening Type	LGBTQIA+ Screening Rate	General Population Screening Rate
Cervical Cancer	Pap Smear	64%	80%
Breast Cancer	Mammogram	58%	74%
Colorectal Cancer	Colonoscopy	55%	70%

[1] Source: American Cancer Society, 2023

In addition to screening rates, it is crucial to consider the timeliness of screenings and ensure they are conducted within the appropriate time frame. Among participants in the Health Information National Trends Survey 6 who were 18 years and older, Tundealao et al. (2024), reported that sexual minority groups (defined by the authors as lesbian, gay, bisexual, and other) were 1.73 times more likely to not be up-to-date with cancer screenings compared to heterosexual individuals. Adjusted odds ratios remain consistent and significant even after controlling for covariates in all four models: 1.69 (CI: 1.07 – 2.65), 1.80 (1.10 – 2.96), 1.56 (1.06 – 2.91) (Tundealao et al., 2024).

Barriers to Cancer Screening among LGBTQIA+ Populations

Lower cancer screening rates among LGBTQ+ populations may be related to barriers such as societal stigma, experiences of discrimination and/or trauma, lack of culturally competent care, financial obstacles, and the absence of specific screening guidelines for transgender and nonbinary individuals (Ceres et al., 2018; Mayhew et al., 2020; Nelson et al., 2023; Wang et al., 2023). Lesbian women, for example, experience several barriers, including provider discrimination, lack of awareness, and the misconception that they are at lower risk for cervical cancer, leading to reduced screening rates (Tracy et al., 2010). Lesbian and bisexual women have been found to delay or avoid screenings due to fear of stigma and a lack of culturally competent care (Bustamente et al., 2021; Ceres et al, 2018). Conversely, some studies suggest that gay and bisexual men may demonstrate higher healthcare utilization compared to heterosexual men, potentially leading to greater screening uptake for conditions like anal or prostate cancer (Boehmer, et al., 2012). However, significant gaps remain, particularly in the availability of screenings for HPV infections, which disproportionately affect these populations (Ceres et al., 2018).

The major barriers are further described below:

1. Social Stigma and Discrimination in Healthcare Settings

Social stigma and discrimination significantly deter LGBTQ+ individuals from obtaining preventive healthcare (Seelman et al., 2017). At least 28% of transgender people delay medical care due to fears of discrimination, and those who delay medical care had greater odds of suicidal ideation and a suicide attempt within the past year (Ceres et al., 2018; Seelman et al., 2017; Yu et al., 2023). Provider bias remains a significant barrier, with recent data indicating fewer than 30% of healthcare providers report adequate LGBTQ+-specific training, negatively affecting screening recommendations and patient-provider trust (Nelson et al., 2023).

2. Lack of Culturally Competent Healthcare Providers

Cultural competency training among healthcare providers remains inadequate, with only 28% of surveyed providers reporting formal LGBTQ+-specific training (Nelson et al., 2023). Providers lacking cultural competency may fail to recognize the unique health risks faced by LGBTQ+ people, such as the higher prevalence of HPV among gay and bisexual men and transgender women or considerations related to HRT (Meites et al., 2022; Peitzmeier et al., 2017). Lack of specific education can lead to non-science-based beliefs, such as thinking that lesbian women are inherently at lower risk of cervical cancer (Mooney-Sommers et al., 2018). These training gaps often lead to missed opportunities for proactive screening recommendations (Ceres et al., 2018). Among a survey of physicians of various specialties, only 62% of surveyed oncologists felt knowing their patient's sexual orientation was necessary to provide optimal care (Nelson et al., 2023). Some authors have reviewed various cultural competency training courses but note that more research is needed and that health systems 'must prioritize organizational-level change that support LGBTQ+ inclusive practices to provide access to safe and affirming healthcare services' (Yu et al., 2023).

3. Financial and Insurance Barriers

Economic challenges, such as lack of insurance, disproportionately impact LGBTQ+ people (Kirkland et al., 2024). For instance, nearly one in four transgender people experience insurance-related issues, including denial of coverage for gender-affirming care (Kirkland et al., 2024). Transgender people are also more likely to lack insurance coverage than cisgender people (Downing et al., 2022). Additionally, poverty, unemployment, and underinsurance further marginalize LGBTQ+ people, restricting their access to regular cancer screenings (Ceres et al., 2018).

4. Lack of Appropriate Guidelines for Transgender, Nonbinary People

Current cancer screening guidelines often overlook the needs of transgender and nonbinary people. Long term usage of HRT and/or gender affirming surgeries alter chemical and physical structures in the body that can make screening tests more difficult for transgender women and transgender men (Manfredi et al., 2021; Peitzmeier et al., 2014). Oncologists have also reported a lack of knowledge about transgender patients in treatment (Sutter et al., 2021). For example:

- While transgender women have a lower risk of prostate cancer than cisgender men, little is known about the true incidence of prostate cancer among transgender women (Ingham et al., 2018; Tanaka et al., 2021). Transgender women with intact prostates require prostate cancer screening, yet guidelines rarely specify this need (Ceres et al., 2018; Manfredi et al., 2021). One of the main purposes of HRT for transgender women is to lower levels of androgens, including testosterone. This can affect levels of prostate-specific antigen (PSA), which is used to screen for prostate cancer; ideal levels of PSA for transgender women have not been established (Tanaka et al., 2021). Some transgender women may not be aware they still retain a prostate even after gender reassignment surgery (Tanaka et al., 2021). Additionally, digital rectal examination of the prostate can be challenging for clinicians to perform after vaginoplasty and may be a difficult procedure for transgender women due to gender dysphoria or experiences of sexual assault (Manfredi et al., 2021). Lastly, provider education about HPV screenings in transgender women is lacking: in a survey of physicians of various specialties about LGBTQ+ specific care needs, only 36% of surveyed physicians felt that Pap smears were important for transgender women compared to over 75% for lesbians and cisgender women (Nelson et al., 2023).
- Transgender men, especially those avoiding medical care due to discrimination, fear, or discomfort, face low rates of cervical cancer screening (Peitzmeier et al., 2014, 2017). About 31.9% of American transgender men have never had a Pap smear (American Cancer Society, 2023). A lack of inclusive, non-gendered recommendations tailored to transgender health contributes to disparities in cancer detection and outcomes (Ceres et al., 2018). Transgender men and transmasculine people were found to be 8.3 times more likely to have an inadequate Pap smear (tissue that cannot be evaluated by a lab) compared to cisgender women (Peitzmeier et al., 2014). Long-term testosterone therapy via intramuscular injection can induce vaginal atrophy, which can make Pap smears more painful (Feldman, 2008). In

qualitative interviews, transgender men described the uncomfortable incongruence between needing a Pap smear (coded in insurance as a procedure for women) and their identity as men (Peitzmeier et al., 2017). Additionally, showing up to a provider's office where all care is labeled as "Women's Care" or being a man in a waiting room full of women can be uncomfortable for transgender men (Mayhew et al., 2020). There are still significant gaps when it comes to long-term implications for breast cancer screenings and treatment in transgender men who have had gender affirming surgery (Wahlström et al., 2024; Salibian et al., 2021). There are currently no evidence-based guidelines for breast cancer screening in transgender men (Wahlström et al., 2024). More research is needed in this area, including the development of guidelines for transgender men at higher genetic risk of breast cancer (Ojala et al., 2023; Salibian et al., 2021; Wahlström et al., 2024).

Lastly, special consideration must be given to the reality that many transgender people have had negative experiences with healthcare, often to the point of delaying care out of fear of mistreatment (Howard et al., 2019; Kcomt et al., 2020; Quint et al., 2025; Seelman et al., 2017).

Facilitators for Improved Cancer Screening Rates Among LGBTQIA+ Populations

Addressing cancer disparities among LGBTQIA+ populations requires systemic changes in health care practices including culturally inclusive guidelines, provider education, community-based tailored outreach, and the development and dissemination of LGBTQIA+ specific cancer screening guidelines. Each of these ideas is further described in this section.

Inclusive Policies and Practices in Healthcare

Inclusive healthcare policies are essential to improving cancer screening rates for LGBTQ+ populations. Policies that address systemic barriers, such as non-discriminatory health care practices, inclusive patient intake forms, and the integration of SOGI data into electronic health records (EHR), play a vital role in fostering a supportive and welcoming environment (Matthews et al., 2018).

- **Non-discriminatory healthcare environments:** Establishing visible signs of inclusivity, such as gender-neutral restrooms and LGBTQ+-friendly signage, signals a commitment to safety and acceptance. These practices help reduce fears of stigma or mistreatment, encouraging LGBTQ+ people to seek preventive care, such as cancer screenings (Mayhew et al., 2020). Promoting digital health platforms and telemedicine can help provide accessible, private, and stigma-reduced screening services (Radix & Maingi, 2018).
- **Sexual Orientation and Gender Identity (SOGI) Data in EHR:** Collecting and utilizing SOGI data enables providers to understand and address disparities in care, ensuring LGBTQ+ patients receive appropriate screenings based on their anatomical and personal risk factors (Matthews et al., 2018).

- **Institutional Policies:** Institutions can implement anti-discrimination policies and offer accreditation programs, such as the Healthcare Equality Index (HEI) developed by the Human Rights Campaign, which evaluates and promotes LGBTQ+-inclusive practices (Blackwell et al., 2024; DiLeo et al., 2022). Healthcare Equality Index leader institutions reported higher overall patient satisfaction scores than non-HEI leader institutions, meaning that adherence to inclusive practices benefitted all patients, not just those who were LGBTQ+ (DiLeo et al., 2022). Additionally, institutions with higher HEI scores were more likely to receive designations such as "Magnet" status for excellence in nursing (assigned by the American Nursing Credentialing Center) (Blackwell et al., 2024).
- **Addressing Challenges to Implementation**: Challenges exist in implementing inclusive policies and transforming healthcare environments, as reflected in continued research into LGBTQ+ people's experiences with healthcare (Yu et al., 2024). The current backlash to Diversity, Equity and Inclusion (DEI) programs remains a challenge to the implementation of inclusive programs (Blackstock et al., 2024). Sixty-five anti-DEI bills were proposed as of 2024, some of which have become law as of 2025 (Blackstock et al., 2024).

Education and Training for Healthcare Providers

Education and training programs for healthcare providers significantly improve cultural competency, reduce implicit biases, and enhance providers' ability to address the unique needs of LGBTQ+ patients (Matthews et al., 2018; Radix & Maingi, 2018; Nelson et al., 2023).

- **Cultural Competency Training:** Structured training programs that include case studies, role-playing, and experiential learning help providers understand the unique barriers faced by LGBTQ+ people. Providers trained to use appropriate pronouns and sensitive communication techniques are more likely to cultivate a safe environment for patients (Burnett et al., 2024; Ceres et al., 2018; Matthews et al., 2018). Among a random sample of surveyed oncologists, those who responded had high levels of interest in learning more about LGBTQ+ populations and their needs (Schabath et al., 2019).
- **LGBTQ+-Specific Healthcare Education:** Training programs tailored to LGBTQ+ health concerns emphasize the importance of preventive screenings like Pap smears for transgender men and breast cancer screenings for transgender women on HRT. This education ensures providers can make evidence-based recommendations (Burnett et al., 2024; Radix & Maingi, 2018; Wang et al., 2023).
- **Addressing Implicit Biases:** Training programs should focus on identifying and mitigating biases, which often result in delayed or inadequate care for LGBTQ+ individuals. Studies have shown that providers who undergo LGBTQ+-specific training are more likely to recommend screenings and offer patient-centered care (Matthews et al., 2018).
- **Trauma-informed care:** LGBTQ+ people face increased exposure to traumatizing events and are more likely to report traumatic experiences than non-LGBTQ+ people (Marchi et al., 2023; Scheer et al., 2019). Trauma-informed care is crucial for the LGBTQ+ population and has many benefits for clinicians as well; following trauma informed care guidelines during

cervical cancer screenings can facilitate better procedures for sample collection among transgender men (McKinnish et al., 2019; Wang et al., 2023). Allowing patients to exercise some degree of control in their medical care is also important. Self-collected swabs given to transgender men to pre-screen for high-risk strains of HPV led to increased uptake of cervical cancer screening among participants (Goldstein et al., 2020; McDowell et al., 2017).

Education initiatives ensure that healthcare providers are better equipped to address the disparities in cancer screenings and health outcomes for LGBTQ+ populations.

Community-Based Outreach Programs Tailored to LGBTQIA+ Populations

Community-based outreach programs play a crucial role in improving access to cancer screenings for LGBTQ+ people. These programs focus on education, accessibility, and reducing fears of discrimination.

- **Collaborations with LGBTQ+ Organizations:** Partnering with LGBTQ+ advocacy groups helps build trust and provide culturally relevant health education. Outreach initiatives in community settings ensure that educational materials and services address specific concerns of the LGBTQ+ population (Drysdale et al., 2020; Heer et al., 2023; Matthews et al., 2018).
- **Peer Navigators and Support Groups:** Utilizing peer navigators—individuals from within the LGBTQ+ community trained to guide patients through healthcare systems—has been effective in improving screening uptake. Peer support reduces anxiety and builds confidence in accessing services (Radix & Maingi, 2018). Within the community, there is a long history of peer support groups for gay men living with HIV (Sandstrom, 1996), and peer support produces superior outcomes for people living with HIV compared to clinical support (Berg et al., 2021). Support groups may be particularly important for young LGBTQ+ people diagnosed with cancer, who may already feel 'out of place' due to being deemed 'too young' to have cancer (Ketcher et al., 2022; Ussher et al., 2023).
- **Mobile Clinics and No-Cost Screenings:** Offering screenings in safe and familiar spaces, such as LGBTQ+ community centers, reduces logistical and financial barriers. Mobile clinics and no-cost programs increase accessibility for underserved LGBTQ+ populations who may lack insurance or live in healthcare deserts (Ceres et al., 2018).
- **Tailored Prevention Interventions:** LGBTQ+ populations can be understandably reluctant to engage with mainstream cancer prevention interventions due to previous experiences of discrimination or stigma within healthcare settings (Drysdale et al., 2020).

Community-based programs tailored to LGBTQIA+ populations directly address the barriers these individuals face, ensuring greater access to and uptake of cancer screenings.

Inclusive LGBTQIA+-Specific Cancer Screening Guidelines

The National LGBT Cancer Network (2025) suggests that best practices include the need to "develop and/or use LGBT-tailored cancer screening guidelines for LGBT communities." We could not locate any standardized LGBTQIA+-specific cancer screening guidelines. In one article, the authors suggest that "the lack of consensus regarding specific cancer screenings for LGBTQ+ patients may relate to the general lack of formal training on LGBTQ+ specific health issues observed" (Nelson et al., 2023). Authors further call for the development and dissemination of such guidelines, suggesting:

1. *National efforts toward a consensus on systematic SOGI collection and clear cancer screening standards for LGBTQ+ subpopulations; and*
2. *Improved educational programs for medical providers in primary care, oncology, and beyond, with the goals of improving healthcare delivery for the LGBTQ+ community and reducing disparities.*

The American Cancer Society (2025) recommends that persons are screened according to their body parts, regardless of sexual orientation or gender identity.

Gaps in Research

Areas Requiring Further Study

While research has identified numerous disparities faced by LGBTQIA+ individuals, significant gaps remain that hinder a comprehensive understanding of cancer screening practices and facilitators for improved outcomes. Notably, there is a lack of sufficient data on specific subpopulations within the LGBTQ+ community. Transgender, nonbinary, and LGBTQ+ people who live in rural areas often face unique barriers, including stigma, geographic isolation, and healthcare discrimination, yet their cancer screening behaviors and related health outcomes remain underexplored (Rand et al., 2021). LGBTQ+ people with limited digital access may not be able to participate in studies or surveys and therefore may be underrepresented. LGBTQ+ people with limited digital access may be unable to access health information such as information about cancer screenings. Disabled people are often excluded from research; this becomes especially salient in cancer research as cancer survivors are at higher risk for acquiring a disability (Waters et al., 2024). There are few research studies to date focusing on such outcomes among LGBTQ+ cancer survivors (Waters et al., 2024).

Additionally, studies frequently lack intersectional analyses that consider overlapping social determinants of health such as race, ethnicity, socioeconomic status, and geographic location (Rand et al., 2021). For example, while there is evidence of disparities in healthcare access for LGBTQ+ populations broadly, the compounded effects of poverty and racial/ethnic marginalization within these groups require further investigation (Rand et al., 2021). Future research must address how intersecting identities impact cancer screening rates, barriers, and facilitators to achieve tailored, effective public health strategies.

Limitations in Existing Literature

The existing body of literature on LGBTQIA+ health disparities also highlights methodological limitations. Many studies are small in scale, cross-sectional, or focus on a limited geographical region, reducing the generalizability of findings. The reliance on self-reported data can introduce recall bias, further limiting the reliability of results.

Another major limitation is the lack of standardized measures for collecting sexual orientation and gender identity data in healthcare settings and research. This absence perpetuates the invisibility of LGBTQ+ people in population health data and prevents a full understanding of their healthcare needs, including cancer prevention and screening. Rand et al. (2021) highlights the importance of inclusive and affirming data collection practices to ensure these populations are adequately represented in research and public health interventions.

Finally, existing literature often focuses on deficits or challenges within LGBTQIA+ health care rather than strengths and resilience factors that could serve as facilitators for improved screening rates. Future research should aim to identify existing protective factors, such as supportive community programs, affirming healthcare practices, and policy interventions which can improve cancer screening behaviors and outcomes among LGBTQIA+ people.

Appendix C – Survey Data Tables by Gender Identity/ Sex Assigned at Birth Categories

Table C-1. Demographic characteristics by gender identity/sex assigned at birth

Character-istic	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=516)	
		Cisgender Man (n=237)		Cisgender Woman (n=153)		Transgender Woman or Transfemme (n=25)		Transgender Man or Transmasculine (n=18)		Gender Diverse Female at Birth (n=45)		Gender Diverse Male at Birth (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Gender Identity	Man	237	100%	0	0%	0	0%	2	11%	0	0%	0	0%	**239**	**46%**
	Woman	0	0%	153	100%	3	12%	0	0%	0	0%	0	0%	**156**	**30%**
	Non-binary or gender fluid	0	0%	0	0%	0	0%	0	0%	31	69%	24	67%	**55**	**11%**
	Transgender woman	0	0%	0	0%	22	88%	0	0%	0	0%	0	0%	**22**	**4%**
	Genderqueer	0	0%	0	0%	0	0%	0	0%	8	18%	5	14%	**13**	**3%**
	Transmasculine	0	0%	0	0%	0	0%	11	61%	0	0%	0	0%	**11**	**2%**
	Two-spirit	0	0%	0	0%	0	0%	0	0%	4	9%	4	11%	**8**	**2%**
	Transgender man	0	0%	0	0%	0	0%	5	28%	0	0%	0	0%	**5**	**1%**
	Self-describe [2]	0	0%	0	0%	0	0%	0	0%	2	4%	3	8%	**5**	**1%**
	No response/not disclosed	0	--	0	--	0	--	0	--	0	--	0	--	**2**	**--**
Gender Identity Differs from Assign Birth	Not transgender	209	96%	139	97%	0	0%	0	0%	13	32%	14	47%	**376**	**80%**
	Yes transgender	5	2%	2	1%	23	100%	16	100%	21	51%	10	33%	**77**	**16%**
	Yes not transgender	3	1%	3	2%	0	0%	0	0%	7	17%	6	20%	**19**	**4%**
	Not recorded	20	--	9	--	2	--	2	--	4	--	6	--	**44**	**--**
Sex Assigned at Birth	Male	237	100%	0	0%	23	100%	0	0%	0	0%	36	100%	**296**	**58%**
	Female	0	0%	153	100%	0	0%	18	100%	45	100%	0	0%	**218**	**42%**
	Not disclosed	0	--	0	--	2	--	0	--	0	--	0	--	**2**	**--**
Sexual Orientation [3]	Gay/homosexual	205	86%	1	1%	3	14%	2	11%	0	0%	16	46%	**227**	**45%**
	Lesbian	0	0%	73	48%	2	10%	1	6%	5	11%	0	0%	**82**	**16%**
	Bisexual	21	9%	45	29%	1	5%	1	6%	5	11%	1	3%	**75**	**15%**
	Queer	5	2%	7	5%	3	14%	12	67%	15	34%	11	31%	**53**	**10%**
	Pansexual	1	0%	23	15%	6	29%	2	11%	14	32%	3	9%	**49**	**10%**
	Asexual	2	1%	3	2%	0	0%	0	0%	5	11%	2	6%	**12**	**2%**
	Straight/heterosexual	0	0%	0	0%	5	24%	0	0%	0	0%	0	0%	**5**	**1%**
	Same gender loving	1	0%	1	1%	1	5%	0	0%	0	0%	1	3%	**4**	**1%**
	Two-Spirit	2	1%	0	0%	0	0%	0	0%	0	0%	1	3%	**3**	**1%**
	No response/not disclosed	0	--	0	--	4	--	0	--	1	--	1	--	**6**	**--**
Sexual Orientation Category [4]	Gay	206	87%	1	1%	3	14%	2	11%	0	0%	17	49%	**229**	**45%**
	Lesbian	0	0%	74	48%	2	10%	1	6%	5	11%	0	0%	**83**	**16%**
	Bisexual	21	9%	45	29%	1	5%	1	6%	5	11%	1	3%	**75**	**15%**
	Pansexual	1	0%	23	15%	6	29%	2	11%	14	32%	3	9%	**49**	**10%**
	Queer	5	2%	7	5%	3	14%	12	67%	15	34%	11	31%	**53**	**10%**
	All Others	4	2%	3	2%	6	29%	0	0%	5	11%	3	9%	**21**	**4%**
	No response/not disclosed	0	--	0	--	4	--	0	--	1	--	1	--	**6**	**--**
Categorized Gender Identity and Sex Assigned at Birth [1]	Cisgender man	237	100%	0	0%	0	0%	0	0%	0	0%	0	0%	**237**	**46%**
	Cisgender woman	0	0%	153	100%	0	0%	0	0%	0	0%	0	0%	**153**	**30%**
	Gender diverse female at birth	0	0%	0	0%	0	0%	0	0%	45	100%	0	0%	**45**	**9%**
	Gender diverse male at birth	0	0%	0	0%	0	0%	0	0%	0	0%	36	100%	**36**	**7%**
	Transgender woman or Transfemme	0	0%	0	0%	25	100%	0	0%	0	0%	0	0%	**25**	**5%**
	Transgender man or Transmasculine	0	0%	0	0%	0	0%	18	100%	0	0%	0	0%	**18**	**4%**
	Unknown	0	--	0	--	0	--	0	--	0	--	0	--	**2**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

[2] Self-describe: agender (n=1), gay (n=1), gay man (n=1), Mejia lesbian (n=1), woman with male brain (n=1).

[3] Self-described responses coded as follows: 'nonbinary' and 'fluid' into Queer (n=3), 'heteroflexible' into Heterosexual (n=1), 'demipansexual' into Pansexual (n=1) and 'bicurious' into Bisexual (n=1).

[4] Three 'same gender loving' responses coded as lesbian or gay; 'all others' includes: straight, asexual, two-spirit, and one same gender loving.

Table C-1. Demographic characteristics by gender identity/sex assigned at birth, continued

Character-istic	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=516)	
		Cisgender Man (n=237)		Cisgender Woman (n=153)		Transgender Woman or Transfemme (n=25)		Transgender Man or Transmasculine (n=18)		Gender Diverse Female at Birth (n=45)		Gender Diverse Male at Birth (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Race(s) and/or Ethnicity(ies) [5]	Hispanic or Latino (a/e/x)	109	49%	67	46%	10	40%	7	39%	20	45%	22	63%	**236**	**48%**
	White	97	43%	63	43%	12	48%	10	56%	20	45%	10	29%	**212**	**43%**
	Black or African American	22	10%	21	14%	5	20%	1	6%	1	2%	6	17%	**56**	**11%**
	Asian	16	7%	13	9%	0	0%	3	17%	5	11%	5	14%	**42**	**9%**
	American Indian or Alaska Native	9	4%	8	5%	4	16%	1	6%	6	14%	2	6%	**30**	**6%**
	Middle Eastern or North African	5	2%	5	3%	1	4%	0	0%	2	5%	0	0%	**13**	**3%**
	Native Hawaiian or Pacific Islander	5	2%	3	2%	0	0%	0	0%	2	5%	0	0%	**10**	**2%**
	No response	13	--	7	--	0	--	0	--	1	--	1	--	**23**	**--**
Hispanic or Latino(a/e/x) Identity(ies) [5]	*(Hispanic or Latino/a/e/x)*	n=109		n=67		n=10		n=7		n=20		n=22		n=236	
	Mexican, Mexican American, or Chicano (a/e/x)	87	81%	54	81%	8	80%	6	86%	18	90%	17	77%	**191**	**81%**
	Other Hispanic, Latino (a/e/x) or Spanish	21	19%	13	19%	4	40%	2	29%	3	15%	8	36%	**51**	**22%**
	Puerto Rican	5	5%	3	4%	0	0%	0	0%	0	0%	1	5%	**9**	**4%**
	Cuban	3	3%	1	1%	0	0%	0	0%	1	5%	0	0%	**5**	**2%**
	No response	1	--	0	--	0	--	0	--	0	--	0	--	**1**	**--**
Race-Ethnicity Category [6]	**Hispanic/Latino (e/a/x) any race(s)**	109	49%	67	46%	10	40%	7	39%	20	45%	22	63%	**236**	**48%**
	Non-Hispanic:														
	White	70	31%	39	27%	7	28%	7	39%	16	36%	4	11%	**143**	**29%**
	Black or African American	18	8%	15	10%	5	20%	1	6%	0	0%	6	17%	**45**	**9%**
	Asian	13	6%	11	8%	0	0%	3	17%	3	7%	3	9%	**33**	**7%**
	American Indian or Alaska Native	5	2%	5	3%	2	8%	0	0%	2	5%	0	0%	**14**	**3%**
	Multiracial	3	1%	5	3%	1	4%	0	0%	1	2%	0	0%	**10**	**2%**
	Middle Eastern or North African	3	1%	3	2%	0	0%	0	0%	1	2%	0	0%	**7**	**1%**
	Native Hawaiian or Pacific Islander	3	1%	1	1%	0	0%	0	0%	1	2%	0	0%	**5**	**1%**
	No Response	13	--	7	--	0	--	0	--	1	--	1	--	**23**	**--**
Preferred Language	English	186	81%	128	85%	18	72%	16	89%	38	86%	25	69%	**413**	**82%**
	Español/Spanish	41	18%	22	15%	7	28%	2	11%	6	14%	9	25%	**87**	**17%**
	Another [7]	3	1%	1	1%	0	0%	0	0%	0	0%	2	6%	**6**	**1%**
	No response	7	--	2	--	0	--	0	--	1	--	0	--	**10**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

[2] Self-describe: agender (n=1), gay (n=1), gay man (n=1), Mejia lesbian (n=1), woman with male brain (n=1).

[3] Self-described responses coded as follows: 'nonbinary' and 'fluid' into Queer (n=3), 'heteroflexible' into Heterosexual (n=1), 'demipansexual' into Pansexual (n=1) and 'bicurious' into Bisexual (n=1).

[4] Three 'same gender loving' responses coded as lesbian or gay; 'all others' includes: straight, asexual, two-spirit, and one same gender loving.

[5] Participants may choose all that apply; as such, totals may sum to greater than the number of respondents and more than 100%.

[6] Hispanic/Latino (e/a/x) = of any race; White = no other race; Asian, Black/African American, Middle Eastern/North African, Native Hawaiian/Pacific Islander include those who indicated no other race or White; Multiracial includes two or more of the non-White races, or two or more of the non-White races and White.

[7] Another: Both English and Spanish (n=3), ASL (n=1), Portuguese (n=1), not specified (n=1).

Table C-1. Demographic characteristics by gender identity/sex assigned at birth, continued

Characteristic	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=516)	
		Cisgender Man (n=237)		Cisgender Woman (n=153)		Transgender Woman or Transfemme (n=25)		Transgender Man or Transmasculine (n=18)		Gender Diverse Female at Birth (n=45)		Gender Diverse Male at Birth (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Age	18-29 years	47	20%	55	36%	4	16%	15	83%	25	56%	11	31%	**158**	**31%**
	30-39 years	64	27%	41	27%	6	24%	1	6%	13	29%	14	39%	**139**	**27%**
	40-44 years	24	10%	10	7%	2	8%	2	11%	0	0%	2	6%	**40**	**8%**
	45-49 years	10	4%	10	7%	1	4%	0	0%	1	2%	0	0%	**22**	**4%**
	50-59 years	40	17%	12	8%	5	20%	0	0%	3	7%	7	19%	**67**	**13%**
	60-69 years	27	11%	19	12%	6	24%	0	0%	3	7%	2	6%	**57**	**11%**
	70 years or over	24	10%	6	4%	1	4%	0	0%	0	0%	0	0%	**31**	**6%**
	No response	1	--	0	--	0	--	0	--	0	--	0	--	**2**	**--**
Combined Annual Income *(total pre-tax all sources; you and partner/ spouse if live together)*	$0 to $9,999	32	15%	14	10%	10	45%	5	28%	7	19%	6	18%	**75**	**16%**
	$10,000 to $14,999	11	5%	8	6%	2	9%	0	0%	3	8%	3	9%	**27**	**6%**
	$15,000 to $19,999	12	6%	5	4%	1	5%	3	17%	3	8%	1	3%	**25**	**5%**
	$20,000 to $34,999	23	11%	13	9%	6	27%	3	17%	8	22%	7	21%	**60**	**13%**
	$35,000 to $49,999	28	13%	24	17%	0	0%	1	6%	5	14%	3	9%	**61**	**13%**
	$50,000 to $74,999	32	15%	22	16%	2	9%	4	22%	4	11%	9	26%	**73**	**16%**
	$75,000 to $99,999	29	13%	17	12%	0	0%	0	0%	5	14%	3	9%	**54**	**12%**
	$100,000 to $199,999	43	20%	24	17%	1	5%	2	11%	2	5%	2	6%	**74**	**16%**
	$200,000 or more	7	3%	12	9%	0	0%	0	0%	0	0%	0	0%	**19**	**4%**
	Prefer not to say/no response	20	--	14	--	3	--	0	--	8	--	2	--	**48**	**--**
Live in or Get Health Care in San Diego County	Live *and* get health care	225	95%	143	93%	23	92%	18	100%	41	91%	35	97%	**487**	**94%**
	Live and do *not* get health care	10	4%	9	6%	2	8%	0	0%	4	9%	1	3%	**26**	**5%**
	Do *not* live and get health care	2	1%	1	1%	0	0%	0	0%	0	0%	0	0%	**3**	**1%**
Region of Residence San Diego County [8]	Central	139	60%	44	29%	15	60%	4	24%	12	27%	12	35%	**227**	**45%**
	North Central	29	12%	19	13%	2	8%	3	18%	8	18%	8	24%	**69**	**14%**
	North Coastal	15	6%	17	11%	4	16%	4	24%	8	18%	2	6%	**50**	**10%**
	East	15	6%	19	13%	1	4%	0	0%	7	16%	5	15%	**47**	**9%**
	North Inland	11	5%	21	14%	0	0%	2	12%	6	13%	3	9%	**43**	**8%**
	South	14	6%	17	11%	2	8%	2	12%	3	7%	1	3%	**39**	**8%**
	Southeast	10	4%	13	9%	1	4%	2	12%	1	2%	3	9%	**31**	**6%**
	Not recorded (zip code)	4	--	3	--	0	--	1	--	0	--	2	--	**10**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

[2] Self-describe: agender (n=1), gay (n=1), gay man (n=1), Mejia lesbian (n=1), woman with male brain (n=1).

[3] Self-described responses coded as follows: 'nonbinary' and 'fluid' into Queer (n=3), 'heteroflexible' into Heterosexual (n=1), 'demipansexual' into Pansexual (n=1) and 'bicurious' into Bisexual (n=1).

[4] Three 'same gender loving' responses coded as lesbian or gay; 'all others' includes: straight, asexual, two-spirit, and one same gender loving.

[5] Participants may choose all that apply; as such, totals may sum to greater than the number of respondents and more than 100%.

[6] Hispanic/Latino (e/a/x) = of any race; White = no other race; Asian, Black/African American, Middle Eastern/North African, Native Hawaiian/Pacific Islander include those who indicated no other race or White; Multiracial includes two or more of the non-White races, or two or more of the non-White races and White.

[7] Another: Both English and Spanish (n=3), ASL (n=1), Portuguese (n=1), not specified (n=1).

[8] San Diego County Health and Human Services Agency service regions; the southeast area is part of the Central and South regions separated out for informational purposes.

Table C-2. General healthcare information by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=516)	
		Cisgender Man (n=237)		Cisgender Woman (n=153)		Transgender Woman or Transfemme (n=25)		Transgender Man or Transmasculine (n=18)		Gender Diverse Female at Birth (n=45)		Gender Diverse Male at Birth (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Currently Have Health Care Coverage	Yes	204	88%	121	81%	23	92%	16	89%	35	78%	32	89%	**432**	**85%**
	No	28	12%	29	19%	2	8%	2	11%	10	22%	4	11%	**76**	**15%**
	No response	5	--	3	--	0	--	0	--	0	--	0	--	**8**	**--**
Main Sources of Health Care Coverage [2]	(had health care coverage)	n=202		n=120		n=23		n=16		n=35		n=32		n=432	
	A plan purchased through (or provided by) an employer or union	98	49%	71	60%	5	22%	10	63%	16	46%	14	44%	**214**	**50%**
	Medi-Cal, Medicaid, or other state program	67	33%	32	27%	14	61%	4	25%	17	49%	14	44%	**149**	**35%**
	Medicare	41	20%	16	13%	1	4%	0	0%	3	9%	1	3%	**62**	**14%**
	A plan that you, or another family member, buys on your own	12	6%	5	4%	1	4%	2	13%	2	6%	1	3%	**23**	**5%**
	TRICARE (formerly CHAMPUS), VA, or military	4	2%	6	5%	0	0%	0	0%	0	0%	2	6%	**12**	**3%**
	Alaska Native, Indian Health Services, or Tribal Health Services	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**0%**
	Some other source (not specified)	9	4%	5	4%	2	9%	1	6%	0	0%	1	3%	**18**	**4%**
	No response	2	--	1	--	0	--	0	--	0	--	0	--	**3**	**--**
Health Care Coverage Categorized (mutually exclusive) [3]	Through employment or purchased	110	48%	75	50%	6	24%	11	61%	18	40%	15	42%	**235**	**47%**
	State program	48	21%	23	15%	14	56%	4	22%	14	31%	13	36%	**117**	**23%**
	No health care coverage	28	12%	29	19%	2	8%	2	11%	10	22%	4	11%	**76**	**15%**
	Medicare	37	16%	15	10%	1	4%	0	0%	3	7%	1	3%	**57**	**11%**
	All others	7	3%	7	5%	2	8%	1	6%	0	0%	3	8%	**20**	**4%**
	No response	7	--	4	--	0	--	0	--	0	--	0	--	**11**	**--**
When Was Last General Health Checkup	Within the past year	185	79%	102	68%	21	84%	16	94%	33	75%	23	64%	**382**	**75%**
	Between 1-2 years ago	37	16%	37	25%	3	12%	0	0%	7	16%	7	19%	**91**	**18%**
	Between 3-5 years ago	6	3%	8	5%	1	4%	1	6%	2	5%	6	17%	**24**	**5%**
	6 or more years ago	6	3%	3	2%	0	0%	0	0%	2	5%	0	0%	**11**	**2%**
	I don't know	3	--	3	--	0	--	1	--	1	--	0	--	**8**	**--**
Was Last General Health Checkup in San Diego County	Yes	209	94%	131	94%	24	96%	17	94%	38	93%	32	91%	**453**	**94%**
	No	13	6%	8	6%	1	4%	1	6%	3	7%	3	9%	**29**	**6%**
	No response	15	--	14	--	0	--	0	--	4	--	1	--	**34**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Mutually exclusive categories: (1) Employment/purchased (and any other response), (2) Medicare and any other response except employment/purchased, (3) Medi-Cal/Medicaid/state program and any other responses employment/purchased and Medicare, and (4) all others.

Table C-3. Experiences with most visited medical doctor/provider for general medical needs by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=516)	
		Cisgender Man (n=237)		Cisgender Woman (n=153)		Transgender Woman or Transfemme (n=25)		Transgender Man or Transmasculine (n=18)		Gender Diverse Female at Birth (n=45)		Gender Diverse Male at Birth (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
At what type of medical practice do you usually receive your care?	Health system	158	67%	91	59%	8	32%	9	50%	25	56%	20	56%	**313**	**61%**
	Community clinic	62	26%	44	29%	15	60%	9	50%	19	42%	13	36%	**162**	**32%**
	Veterans or military health system	5	2%	12	8%	0	0%	0	0%	1	2%	2	6%	**20**	**4%**
	Another [2]	10	4%	6	4%	2	8%	0	0%	0	0%	1	3%	**19**	**4%**
	No response	2	--	0	--	0	--	0	--	0	--	0	--	**2**	**--**
Is the medical doctor/ provider you visit most often for general medical care aware of your LGBTQIA+ status?	Yes	203	88%	76	51%	22	88%	14	78%	21	47%	25	71%	**362**	**72%**
	No	12	5%	43	29%	1	4%	3	17%	13	29%	7	20%	**79**	**16%**
	Don't know	16	7%	29	20%	2	8%	1	6%	11	24%	3	9%	**63**	**13%**
	No response	6	--	5	--	0	--	0	--	0	--	1	--	**12**	**--**
How long have you been a patient of this medical doctor/ provider?	Less than 3 months	28	12%	19	13%	4	16%	3	17%	5	11%	4	11%	**63**	**12%**
	3 months to 1 year	37	16%	25	16%	4	16%	6	33%	13	29%	7	19%	**93**	**18%**
	1-2 years	59	25%	39	26%	3	12%	2	11%	10	22%	8	22%	**121**	**24%**
	3 or more years	108	46%	65	43%	13	52%	7	39%	15	33%	16	44%	**224**	**44%**
	I don't know	4	2%	4	3%	1	4%	0	0%	2	4%	1	3%	**12**	**2%**
	No response	1	--	1	--	0	--	0	--	0	--	0	--	**3**	**--**
How knowledgeable is the doctor/provider you visit most often (for general medical care) about LGBTQIA+ medical needs?	Extremely knowledgeable	117	50%	26	17%	12	48%	5	28%	6	13%	15	42%	**181**	**35%**
	Moderately knowledgeable	47	20%	18	12%	6	24%	1	6%	5	11%	7	19%	**84**	**16%**
	Somewhat knowledgeable	31	13%	29	19%	0	0%	3	17%	5	11%	6	17%	**74**	**14%**
	Slightly knowledgeable	15	6%	12	8%	1	4%	3	17%	4	9%	1	3%	**36**	**7%**
	Not at all knowledgeable	4	2%	13	9%	1	4%	4	22%	4	9%	1	3%	**28**	**5%**
	I do not know	21	9%	54	36%	5	20%	2	11%	21	47%	6	17%	**109**	**21%**
	No response	2	--	1	--	0	--	0	--	0	--	0	--	**4**	**--**
How comfortable are you with the medical doctor/provider you visit most often for general medical care?	Extremely comfortable	142	60%	54	36%	20	80%	3	17%	12	27%	13	36%	**244**	**48%**
	Moderately comfortable	51	22%	40	26%	1	4%	4	22%	10	22%	12	33%	**118**	**23%**
	Somewhat comfortable	26	11%	33	22%	0	0%	3	17%	12	27%	5	14%	**79**	**15%**
	Slightly comfortable	11	5%	15	10%	2	8%	5	28%	8	18%	3	8%	**46**	**9%**
	Not at all comfortable	2	1%	6	4%	1	4%	3	17%	1	2%	1	3%	**14**	**3%**
	I do not know	3	1%	3	2%	1	4%	0	0%	2	4%	2	6%	**11**	**2%**
	No response	2	--	2	--	0	--	0	--	0	--	0	--	**4**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

[2] Other: non-profit HIV medical care (n=4), physician - general or family (n=3), non-profit healthcare network (n=2), private clinic (n=2), school clinic (n=1), group practice (n=1), none (n=1), not specified (n=5).

Table C-4. Cancer screening eligibility based on age and self-assessment, among those who are LGBTQIA+ and live or get health care in San Diego County by gender identity/sex assigned at birth

Cancer Screening Question Self-Assessment	(sample) Response	Gender Identity / Sex Assigned at Birth Category [1]												Total [2] (n=516)	
		Cisgender Man (n=237)		Cisgender Woman (n=153)		Transgender Woman or Transfemme (n=25)		Transgender Man or Transmasculine (n=18)		Gender Diverse Female at Birth (n=45)		Gender Diverse Male at Birth (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Cervical: The cervix is the end of the uterus that connects to the vagina in persons who have a vagina.	*(female at birth)*	n=0		n=153		n=0		n=18		n=45		n=0		n=218	
Do you have a uterus or a cervix?	Yes	0	0%	142	93%	0	0%	15	83%	42	93%	0	0%	**201**	**92%**
	No	0	0%	11	7%	0	0%	3	17%	3	7%	0	0%	**17**	**8%**
Breast: Breast cancer screening is appropriate for:	*(age 40 and older)*	n=125		n=57		n=15		n=2		n=7		n=11		n=217	
(3) Cisgender women and anyone assigned female at birth who has not had both breasts removed, such as through top surgery or a double mastectomy	Yes	3	2%	53	93%	7	47%	1	50%	7	100%	0	0%	**71**	**33%**
(4) Transgender women or people of any gender identity who have been taking feminizing hormones [FHT]/hormone therapy [HR] (such as estrogen) for at least 5 years	No	120	98%	4	7%	8	53%	1	50%	0	0%	11	100%	**144**	**67%**
Based on this information, does breast cancer screening apply to you?	No response	2	--	0	--	0	--	0	--	0	--	0	--	**2**	**--**
Prostate: Prostate cancer screening may be appropriate for any person who has a prostate, which includes:	*(age 40 and older male at birth)*	n=125		n=0		n=15		n=0		n=0		n=11		n=151	
(1) Cisgender men	Yes	110	89%	0	0%	13	87%	0	0%	0	0%	8	73%	**131**	**87%**
(2) Transgender women, including transgender women who have had vaginoplasty or orchiectomy	No	14	11%	0	0%	2	13%	0	0%	0	0%	3	27%	**19**	**13%**
(3) Anyone of any gender identity who was assigned male at birth	No response	1	--	0	--	0	--	0	--	0	--	0	--	**1**	--
Based on this information, does prostate cancer screening apply to you?															
Lung Cancer: Lung cancer screening is appropriate for people who:	*(age 45 and older)*	n=101		n=47		n=13		n=0		n=7		n=9		n=177	
(3) Have a 20 pack-year history of smoking (1 pack a day for 20 years or 2 packs a day for 10 years, etc.)	Yes	23	23%	12	26%	3	23%	0	0%	0	0%	1	11%	**39**	**22%**
(4) AND have smoked in the past 15 years (including currently smoke)	No	76	77%	35	74%	10	77%	0	0%	7	100%	8	89%	**136**	**78%**
Based on this information, does lung cancer screening apply to you?	No response	2	--	0	--	0	--	0	--	0	--	0	--	**2**	**--**
Anal: Anal cancer screening is appropriate for people who:	*(age 35 and older)*	n=149		n=76		n=18		n=2		n=11		n=15		n=271	
(1) Are living with HIV, OR	Yes	85	58%	5	7%	11	61%	0	0%	3	27%	9	60%	**113**	**42%**
(2) Have been diagnosed with human papillomavirus (HPV), OR	No	61	42%	71	93%	7	39%	2	100%	8	73%	6	40%	**155**	**58%**
(3) Are immunocompromised, OR	No response	3	--	0	--	0	--	0	--	0	--	0	--	**3**	**--**
(4) Practice the receptive role during anal intercourse (penis inserted into your anus)															
Based on this information, does anal cancer screening apply to you?															

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond are not included.

[2] Total sample is 516 and 2 did not report their age:

- 271 were aged 35 and over
- 217 were aged 40 and over
- 177 were aged 45 and over

Table C-5. Cervical cancer screening among female at birth who self-assessed as having a cervix or uterus by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]						Total (n=201)	
		Cisgender Woman (n=142)		Transgender Man or Transmasculine (n=15)		Gender Diverse Female at Birth (n=42)			
		n	%	n	%	n	%	n	%
Medical professional ever talked to you about cervical cancer screening	Yes	103	73%	10	67%	32	76%	**146**	**73%**
	No	39	27%	5	33%	10	24%	**55**	**27%**
Ever had a cervical cancer screening test	Yes	94	66%	9	60%	26	62%	**130**	**65%**
	No	48	34%	6	40%	16	38%	**71**	**35%**
If had a cervical cancer screening test, experience was…	*(screened)*	n=94		n=9		n=26		n=130	
	Very respectful	74	81%	5	56%	17	68%	**96**	**76%**
	Somewhat respectful	16	18%	3	33%	7	28%	**27**	**21%**
	Not respectful	1	1%	1	11%	1	4%	**3**	**2%**
	No response	3	--	0	--	1	--	**4**	**--**
How many years ago was last cervical cancer screening test	*(screened)*	n=94		n=9		n=26		n=130	
	1 year ago or less	53	57%	6	67%	13	50%	**73**	**57%**
	2 years	22	24%	2	22%	4	15%	**28**	**22%**
	3 years	10	11%	1	11%	7	27%	**18**	**14%**
	4 years	2	2%	0	0%	0	0%	**2**	**2%**
	5 years	2	2%	0	0%	0	0%	**2**	**2%**
	6 or more years ago	4	4%	0	0%	2	8%	**6**	**5%**
	No response	1	--	0	--	0	--	**1**	**--**
Reasons for not getting cervical cancer screening every 1-3 years [2]	*(screening 4 or more years ago or not screened)*	n=56		n=6		n=18		n=81	
	Did not know I need regular cervical screenings	31	63%	4	67%	9	53%	**45**	**62%**
	Did not want to discuss with medical provider	5	10%	2	33%	4	24%	**11**	**15%**
	Told to screen every 5 years	9	18%	1	17%	0	0%	**10**	**14%**
	Told that I do not need (or no longer need)	6	12%	0	0%	2	12%	**8**	**11%**
	Other response (written in) [3]	1	2%	0	0%	4	24%	**5**	**7%**
	No response	7	--	0	--	1	--	**8**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: Uncomfortable (n=2 due to gender dysphoria, not like being touched), low risk (n=1); lack of time (n=1); need new primary care physician (n=1).

Table C-6. Breast cancer screening among those ages 40 and over who self-assessed as eligible by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]										Total (n=71)	
		Cisgender Man (n=3)		Cisgender Woman (n=53)		Transgender Woman or Transfemme (n=7)		Transgender Man or Transmasculine (n=1)		Gender Diverse Female at Birth (n=7)			
		n	%	n	%	n	%	n	%	n	%	n	%
Medical professional ever talked to you about a mammogram	Yes	1	33%	52	98%	6	86%	1	100%	7	100%	**67**	**94%**
	No	2	67%	1	2%	1	14%	0	0%	0	0%	**4**	**6%**
Ever had a mammogram	Yes	0	0%	44	83%	4	57%	1	100%	7	100%	**56**	**80%**
	No	2	100%	9	17%	3	43%	0	0%	0	0%	**14**	**20%**
	No response	1	--	0	--	0	--	0	--	0	--	**1**	**--**
If had a mammogram, experience was…	*(had mammogram)*	n=0		n=44		n=4		n=1		n=7		n=56	
	Very respectful	0	0%	38	90%	4	100%	0	0%	4	57%	**46**	**85%**
	Somewhat respectful	0	0%	4	10%	0	0%	1	100%	3	43%	**8**	**15%**
	No response	0	--	2	--	0	--	0	--	0	--	**2**	**--**
How many years ago was last mammogram	*(had mammogram)*	n=0		n=44		n=4		n=1		n=7		n=56	
	1 year ago or less	0	0%	36	82%	2	50%	1	100%	4	57%	**43**	**77%**
	2 years ago	0	0%	6	14%	2	50%	0	0%	1	14%	**9**	**16%**
	3 years ago	0	0%	1	2%	0	0%	0	0%	1	14%	**2**	**4%**
	4 years ago	0	0%	1	2%	0	0%	0	0%	0	0%	**1**	**2%**
	5 or more years ago	0	0%	0	0%	0	0%	0	0%	1	14%	**1**	**2%**
Reasons for not getting mammograms every 1-2 years [2]	*(had mammogram 3 or more years ago)*	n=2		n=11		n=3		n=0		n=2		n=18	
	Other response (written in) [3]	1	100%	2	20%	1	33%	0	0%	2	100%	**6**	**38%**
	Newly eligible (written in)	0	0%	3	30%	0	0%	0	0%	0	0%	**3**	**19%**
	Procrastination/forget (written in)	0	0%	3	30%	0	0%	0	0%	0	0%	**3**	**19%**
	Told that I do not need	0	0%	1	10%	1	33%	0	0%	0	0%	**2**	**13%**
	Did not want to discuss with medical provider	0	0%	1	10%	0	0%	0	0%	0	0%	**1**	**6%**
	Did not know I need regular mammograms	0	0%	0	0%	1	33%	0	0%	0	0%	**1**	**6%**
	No response	1	--	1	--	0	--	0	--	0	--	**2**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. No transgender men or gender diverse individuals who were male at birth responded that a mammogram applied to them. Two individuals who did not respond were not included.

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: cost (n=1), reluctance based on past experiences (n=1), mammograms are unsafe (n=1), personal choice (n=1), still too firm (n=1), scheduling (n=1).

Table C-7. Prostate cancer screening among those ages 40 and older, male at birth, and self-assessed as eligible by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]						Total (n=131)	
		Cisgender Man (n=110)		Transgender Woman or Transfemme (n=13)		Gender Diverse Male at Birth (n=8)			
		n	%	n	%	n	%	n	%
Medical professional ever talked to you about prostate cancer screening, or PSA [2]	Yes	85	77%	9	69%	6	75%	**100**	**76%**
	No	25	23%	4	31%	2	25%	**31**	**24%**
Ever had a PSA test	Yes	74	67%	8	62%	6	75%	**88**	**67%**
	No	36	33%	5	38%	2	25%	**43**	**33%**
If had a PSA test, experience was…	*(had PSA test)*	n=74		n=8		n=6		n=88	
	Very respectful	69	95%	8	100%	5	100%	**82**	**95%**
	Somewhat respectful	3	4%	0	0%	0	0%	**3**	**3%**
	Not respectful	1	1%	0	0%	0	0%	**1**	**1%**
	No response	1	--	0	--	1	--	**2**	**--**
How many years ago was last PSA test	*(had PSA test)*	n=74		n=8		n=6		n=88	
	1 year ago or less	47	64%	6	75%	3	60%	**56**	**65%**
	2 years ago	11	15%	1	13%	2	40%	**14**	**16%**
	3 years ago	5	7%	0	0%	0	0%	**5**	**6%**
	4 years ago	4	5%	0	0%	0	0%	**4**	**5%**
	5 or more years ago	6	8%	1	13%	0	0%	**7**	**8%**
	No response	1	--	0	--	1	--	**2**	**--**
Reasons for not getting PSA test every 1-2 years [3]	*(PSA test 3 or more years ago)*	n=51		n=6		n=2		n=59	
	Did not know I needed regular PSA tests	29	63%	5	83%	2	100%	**36**	**67%**
	Told not to get PSA tests	12	26%	0	0%	0	0%	**12**	**22%**
	Did not want to discuss with medical provider	4	9%	1	17%	0	0%	**5**	**9%**
	Other response (written in) [4]	2	4%	0	0%	0	0%	**2**	**4%**
	Doctor did not discuss (written in)	1	2%	0	0%	0	0%	**1**	**2%**
	No response	5	--	0	--	0	--	**5**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond are not included.
[2] PSA = Prostate Specific Antigen.
[3] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.
[4] Other write-in responses included: already had prostate cancer (n=1), I have one in February 2025 (n=1).

Table C-8. Colon cancer screening among those ages 45 or older by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=177)	
		Cisgender Man (n=101)		Cisgender Woman (n=47)		Transgender Woman or Transfemme (n=13)		Transgender Man or Transmasculine (n=0)		Gender Diverse Female at Birth (n=7)		Gender Diverse Male at Birth (n=9)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Has medical professional ever talked to you about colon cancer screening	Yes	91	92%	38	81%	11	85%	0	0%	6	86%	7	78%	**153**	**87%**
	No	8	8%	9	19%	2	15%	0	0%	1	14%	2	22%	**22**	**13%**
	No response	2	--	0	--	0	--	0	--	0	--	0	--	**2**	**--**
Ever done the blood stool test	Yes	72	73%	30	64%	9	69%	0	0%	4	57%	7	78%	**122**	**70%**
	No	27	27%	17	36%	4	31%	0	0%	3	43%	2	22%	**53**	**30%**
	No response	2	--	0	--	0	--	0	--	0	--	0	--	**2**	**--**
How many years ago was your last blood stool test	*(had blood stool test)*	n=72		n=30		n=9		n=0		n=4		n=7		n=122	
	1 year ago or less	37	53%	14	47%	5	56%	0	0%	2	67%	6	86%	**64**	**54%**
	2 years ago	10	14%	5	17%	1	11%	0	0%	1	33%	1	14%	**18**	**15%**
	3 years ago	12	17%	4	13%	1	11%	0	0%	0	0%	0	0%	**17**	**14%**
	4 years ago	6	9%	1	3%	1	11%	0	0%	0	0%	0	0%	**8**	**7%**
	5 or more years ago	5	7%	6	20%	1	11%	0	0%	0	0%	0	0%	**12**	**10%**
	No response	2	--	0	--	0	--	0	--	1	--	0	--	**3**	**--**
Ever had a colonoscopy	Yes	77	78%	31	66%	9	69%	0	0%	5	71%	6	67%	**128**	**73%**
	No	22	22%	16	34%	4	31%	0	0%	2	29%	3	33%	**47**	**27%**
	No response	2	--	0	--	0	--	0	--	0	--	0	--	**2**	**--**
If had a colonoscopy test, experience was...	*(had colonoscopy)*	n=77		n=31		n=9		n=0		n=5		n=6		n=128	
	Very respectful	67	92%	26	90%	9	100%	0	0%	3	60%	5	83%	**110**	**90%**
	Somewhat respectful	5	7%	3	10%	0	0%	0	0%	2	40%	1	17%	**11**	**9%**
	Not respectful	1	1%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**1%**
	No response	4	--	2	--	0	--	0	--	0	--	0	--	**6**	**--**
How many years ago was last colonoscopy	*(had colonoscopy)*	n=77		n=31		n=9		n=0		n=5		n=6		n=128	
	1 year ago or less	23	30%	10	33%	3	33%	0	0%	2	40%	2	33%	**40**	**32%**
	2 to 5 years	35	46%	13	43%	6	67%	0	0%	2	40%	4	67%	**60**	**48%**
	6 to 10 years	16	21%	4	13%	0	0%	0	0%	1	20%	0	0%	**21**	**17%**
	11 or more years ago	2	3%	3	10%	0	0%	0	0%	0	0%	0	0%	**5**	**4%**
	No response	1	--	1	--	0	--	0	--	0	--	0	--	**2**	**--**
Reasons for not getting a blood stool test every year, or colonoscopy every 10 years [2]	*(colonoscopy > 10 years ago and blood stool not every year)*	n=13		n=15		n=2		n=0		n=1		n=1		n=32	
	Did not know need regular stool tests or colonoscopy	7	64%	6	50%	1	50%	0	0%	0	0%	1	100%	**15**	**58%**
	Told colonoscopy not needed	0	0%	3	25%	0	0%	0	0%	0	0%	0	0%	**3**	**12%**
	Procrastination (written in)	1	9%	2	17%	0	0%	0	0%	0	0%	0	0%	**3**	**12%**
	Other response (written in) [3]	2	18%	1	8%	0	0%	0	0%	0	0%	0	0%	**3**	**12%**
	Told stool blood test not needed	1	9%	0	0%	1	50%	0	0%	0	0%	0	0%	**2**	**8%**
	Did not want to discuss with medical provider	1	9%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**4%**
	No response	2	--	3	--	0	--	0	--	1	--	0	--	**6**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond are not included.

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: do not like them/uncomfortable (n=2), single gay man no one to drop me off and pick up, and ride-share not allowed (n=1).

Table C-9. Lung cancer screening among those ages 45 and older who self-assessed as eligible by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=39)	
		Cisgender Man (n=23)		Cisgender Woman (n=12)		Transgender Woman or Transfemme (n=3)		Transgender Man or Transmasculine (n=0)		Gender Diverse Female at Birth (n=0)		Gender Diverse Male at Birth (n=1)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Medical professional talked about screening for lung cancer	Yes	14	61%	6	50%	3	100%	0	0%	0	0%	0	0%	**23**	**59%**
	No	9	39%	6	50%	0	0%	0	0%	0	0%	1	100%	**16**	**41%**
Ever had a lung cancer screening	Yes	12	52%	6	50%	2	67%	0	0%	0	0%	0	0%	**20**	**51%**
	No	11	48%	6	50%	1	33%	0	0%	0	0%	1	100%	**19**	**49%**
If had lung cancer screening, experience was...	*(screened)*	n=12		n=6		n=2		n=0		n=0		n=0		n=20	
	Very respectful	12	100%	4	80%	2	100%	0	0%	0	0%	0	0%	**18**	**95%**
	Somewhat respectful	0	0%	1	20%	0	0%	0	0%	0	0%	0	0%	**1**	**5%**
	No response	0	--	1	--	0	--	0	--	0	--	0	--	**1**	**--**
How many years ago was last lung cancer screening	*(screened)*	n=12		n=6		n=2		n=0		n=0		n=0		n=20	
	1 year ago or less	6	50%	5	83%	2	100%	0	0%	0	0%	0	0%	**13**	**65%**
	2 years ago	2	17%	0	0%	0	0%	0	0%	0	0%	0	0%	**2**	**10%**
	3 years ago	2	17%	0	0%	0	0%	0	0%	0	0%	0	0%	**2**	**10%**
	4 years ago	1	8%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**5%**
	5 or more years ago	1	8%	1	17%	0	0%	0	0%	0	0%	0	0%	**2**	**10%**
Reasons for not getting a lung cancer screening every year [2]	*(screened 2 or more years ago)*	n=17		n=7		n=1		n=0		n=0		n=1		n=26	
	Did not know I need regular lung cancer screening	9	64%	3	60%	1	100%	0	0%	0	0%	0	0%	**13**	**62%**
	Told lung cancer screening not needed	3	21%	2	40%	0	0%	0	0%	0	0%	1	100%	**6**	**29%**
	Did not want to discuss with medical provider	1	7%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**5%**
	Other response (written in) [3]	1	7%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**5%**
	No response	3	--	2	--	0	--	0	--	0	--	0	--	**5**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: 'I am tested regularly' (n=1 but also indicated the latest test was 4 years ago).

Table C-10. Anal cancer screening among those ages 35 and older who self-assessed as eligible for screening by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=113)	
		Cisgender Man (n=85)		Cisgender Woman (n=5)		Transgender Woman or Transfemme (n=11)		Transgender Man or Transmasculine (n=0)		Gender Diverse Female at Birth (n=3)		Gender Diverse Male at Birth (n=9)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Medical professional talked about screening for anal cancer	Yes	46	55%	2	40%	10	91%	0	0%	1	33%	5	56%	**64**	**57%**
	No	38	45%	3	60%	1	9%	0	0%	2	67%	4	44%	**48**	**43%**
	No response	1	--	0	--	0	--	0	--	0	--	0	--	**1**	**--**
Ever had an anal pap screening test	Yes	40	48%	2	40%	9	82%	0	0%	0	0%	4	44%	**55**	**49%**
	No	44	52%	3	60%	2	18%	0	0%	3	100%	5	56%	**57**	**51%**
	No response	1	--	0	--	0	--	0	--	0	--	0	--	**1**	**--**
If had anal pap screening test, experience was...	*(screened)*	n=40		n=2		n=9		n=0		n=0		n=4		n=55	
	Very respectful	34	97%	2	100%	8	100%	0	0%	0	0%	4	100%	**48**	**98%**
	Somewhat respectful	1	3%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Not respectful	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
	No response	5	--	0	--	1	--	0	--	0	--	0	--	**6**	**--**
How many years ago was last anal pap screening test	*(screened)*	n=40		n=2		n=9		n=0		n=0		n=4		n=55	
	1 year ago or less	23	59%	1	50%	5	56%	0	0%	0	0%	3	75%	**32**	**59%**
	2 years ago	6	15%	1	50%	2	22%	0	0%	0	0%	1	25%	**10**	**19%**
	3 years ago	4	10%	0	0%	0	0%	0	0%	0	0%	0	0%	**4**	**7%**
	4 years ago	2	5%	0	0%	1	11%	0	0%	0	0%	0	0%	**3**	**6%**
	5 or more years ago	4	10%	0	0%	1	11%	0	0%	0	0%	0	0%	**5**	**9%**
	No response	1	--	0	--	0	--	0	--	0	--	0	--	**1**	**--**
Reasons for not getting an anal pap screening test every 1 to 3 years [2]	*(screened 4 or more years ago)*	n=50		n=3		n=4		n=0		n=3		n=5		n=65	
	Did not know I need regular anal cancer screenings	23	47%	3	100%	3	75%	0	0%	0	0%	2	40%	**31**	**48%**
	Did not know about it	17	35%	1	33%	2	50%	0	0%	2	67%	2	40%	**24**	**38%**
	I was told I did not need anal cancer screenings	6	12%	0	0%	0	0%	0	0%	1	33%	0	0%	**7**	**11%**
	Do not know where to get it	3	6%	0	0%	0	0%	0	0%	0	0%	1	20%	**4**	**6%**
	Doctor did not discuss (written)	4	8%	0	0%	0	0%	0	0%	0	0%	0	0%	**4**	**6%**
	Did not want to discuss with medical provider	2	4%	0	0%	0	0%	0	0%	0	0%	0	0%	**2**	**3%**
	Unsure (written)	2	4%	0	0%	0	0%	0	0%	0	0%	0	0%	**2**	**3%**
	Procrastination (written)	1	2%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Told to wait until older (written)	1	2%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	No response	1	--	0	--	0	--	0	--	0	--	0	--	**1**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

Table C-11. Human Papilloma Virus (HPV) screening and vaccination by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=516)	
		Cisgender Man (n=237)		Cisgender Woman (n=153)		Transgender Woman or Transfemme (n=25)		Transgender Man or Transmasculine (n=18)		Gender Diverse Female at Birth (n=45)		Gender Diverse Male at Birth (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Before today, have you ever heard of HPV?	Yes	189	81%	135	88%	19	76%	15	83%	43	96%	28	78%	**430**	**84%**
	No	44	19%	18	12%	6	24%	3	17%	2	4%	8	22%	**82**	**16%**
	No response	4	--	0	--	0	--	0	--	0	--	0	--	**4**	**--**
Before today, did you know that HPV could cause cancer in persons of any gender	Yes	159	68%	104	68%	18	72%	9	50%	34	76%	23	64%	**348**	**68%**
	No	49	21%	33	22%	5	20%	6	33%	9	20%	7	19%	**109**	**21%**
	I wasn't sure	25	11%	16	10%	2	8%	3	17%	2	4%	6	17%	**55**	**11%**
	No response	4	--	0	--	0	--	0	--	0	--	0	--	**4**	**--**
Before today, ever heard of the HPV vaccine (also known as Gardasil)	Yes	162	70%	122	80%	15	60%	11	61%	37	82%	26	74%	**374**	**73%**
	No	69	30%	31	20%	10	40%	7	39%	8	18%	9	26%	**135**	**27%**
	No response	6	--	0	--	0	--	0	--	0	--	1	--	**7**	**--**
Ever been vaccinated for HPV (at least one dose)	Yes	75	33%	67	44%	5	20%	8	44%	24	53%	18	51%	**197**	**39%**
	No	105	46%	65	42%	12	48%	4	22%	14	31%	10	29%	**210**	**41%**
	Do not know	50	22%	21	14%	8	32%	6	33%	7	16%	7	20%	**101**	**20%**
	No response	7	--	0	--	0	--	0	--	0	--	1	--	**8**	**--**
If yes, number of vaccine doses received	*(ever vaccinated)*	n=75		n=67		n=5		n=8		n=24		n=18		n=197	
	1 dose	19	26%	8	12%	1	20%	2	25%	4	17%	4	22%	**38**	**19%**
	2 doses	16	22%	13	19%	2	40%	3	38%	4	17%	5	28%	**43**	**22%**
	3 doses	25	34%	31	46%	0	0%	1	13%	7	29%	2	11%	**66**	**34%**
	Unsure	14	19%	15	22%	2	40%	2	25%	9	38%	7	39%	**49**	**25%**
	No response	1	--	0	--	0	--	0	--	0	--	0	--	**1**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

Table C-12. Liver cancer, liver cancer risks and skin cancer by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=516)	
		Cisgender Man (n=237)		Cisgender Woman (n=153)		Transgender Woman or Transfemme (n=25)		Transgender Man or Transmasculine (n=18)		Gender Diverse Female at Birth (n=45)		Gender Diverse Male at Birth (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Medical professional ever told you that you are at risk for liver disease	Yes	36	16%	12	8%	6	24%	2	11%	5	11%	9	25%	**70**	**14%**
	No	190	84%	139	92%	19	76%	16	89%	40	89%	27	75%	**432**	**86%**
	No response	11	--	2	--	0	--	0	--	0	--	0	--	**14**	**--**
Medical professional ever discussed liver cancer	Yes	44	19%	16	11%	6	29%	5	28%	3	7%	11	31%	**85**	**17%**
	No	167	74%	119	81%	15	71%	11	61%	38	84%	22	61%	**373**	**75%**
	Unsure	16	7%	12	8%	0	0%	2	11%	4	9%	3	8%	**37**	**7%**
	No response	10	--	6	--	4	--	0	--	0	--	0	--	**21**	**--**
Medical professional ever discussed hepatitis C testing or treatment	Yes	132	58%	39	26%	14	64%	5	29%	13	29%	23	64%	**226**	**45%**
	No	79	34%	97	65%	8	36%	9	53%	23	51%	10	28%	**227**	**45%**
	Unsure	18	8%	13	9%	0	0%	3	18%	9	20%	3	8%	**46**	**9%**
	No response	8	--	4	--	3	--	1	--	0	--	0	--	**17**	**--**
Medical professional ever discussed hepatitis B testing or vaccination	Yes	148	64%	51	34%	13	62%	5	29%	16	36%	25	69%	**258**	**52%**
	No	66	29%	85	57%	8	38%	9	53%	20	44%	7	19%	**196**	**39%**
	Unsure	17	7%	12	8%	0	0%	3	18%	9	20%	4	11%	**45**	**9%**
	No response	6	--	5	--	4	--	1	--	0	--	0	--	**17**	**--**
Medical professional ever discussed alcohol use and how it relates to liver cancer	Yes	107	46%	59	39%	12	60%	8	44%	16	36%	25	69%	**227**	**45%**
	No	109	47%	82	55%	7	35%	9	50%	27	60%	8	22%	**243**	**49%**
	Do not know	15	6%	9	6%	1	5%	1	6%	2	4%	3	8%	**31**	**6%**
	No response	6	--	3	--	5	--	0	--	0	--	0	--	**15**	**--**
Medical professional ever looked over your whole body to screen for skin cancer?	Yes	78	34%	38	25%	5	20%	3	17%	8	18%	4	11%	**136**	**27%**
	No	136	59%	108	71%	16	64%	15	83%	31	69%	30	83%	**337**	**66%**
	Do not know	18	8%	6	4%	4	16%	0	0%	6	13%	2	6%	**37**	**7%**
	No response	5	--	1	--	0	--	0	--	0	--	0	--	**6**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

Table C-13. Knowledge about cancer screening by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=516)	
		Cisgender Man (n=237)		Cisgender Woman (n=153)		Transgender Woman or Transfemme (n=25)		Transgender Man or Transmasculine (n=18)		Gender Diverse Female at Birth (n=45)		Gender Diverse Male at Birth (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
I would like to know more information about cancer screening tests	Yes	121	52%	72	47%	13	52%	5	28%	26	58%	22	61%	**260**	**51%**
	No	111	48%	81	53%	12	48%	13	72%	19	42%	14	39%	**251**	**49%**
	No response	5	--	0	--	0	--	0	--	0	--	0	--	**5**	**--**
I know where to get cancer screening tests	Yes	129	56%	86	57%	11	44%	5	28%	24	53%	16	44%	**271**	**53%**
	No	70	30%	42	28%	4	16%	9	50%	16	36%	14	39%	**155**	**30%**
	Do not know	33	14%	24	16%	10	40%	4	22%	5	11%	6	17%	**84**	**16%**
	No response	5	--	1	--	0	--	0	--	0	--	0	--	**6**	**--**
I know where to get cancer screening tests from a provider who is knowledge-able about LGBTQIA+ health	Yes	121	52%	52	34%	10	40%	2	11%	8	18%	13	37%	**206**	**40%**
	No	73	31%	66	43%	4	16%	12	67%	26	58%	18	51%	**200**	**39%**
	Do not know	38	16%	34	22%	11	44%	4	22%	11	24%	4	11%	**103**	**20%**
	No response	5	--	1	--	0	--	0	--	0	--	1	--	**7**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

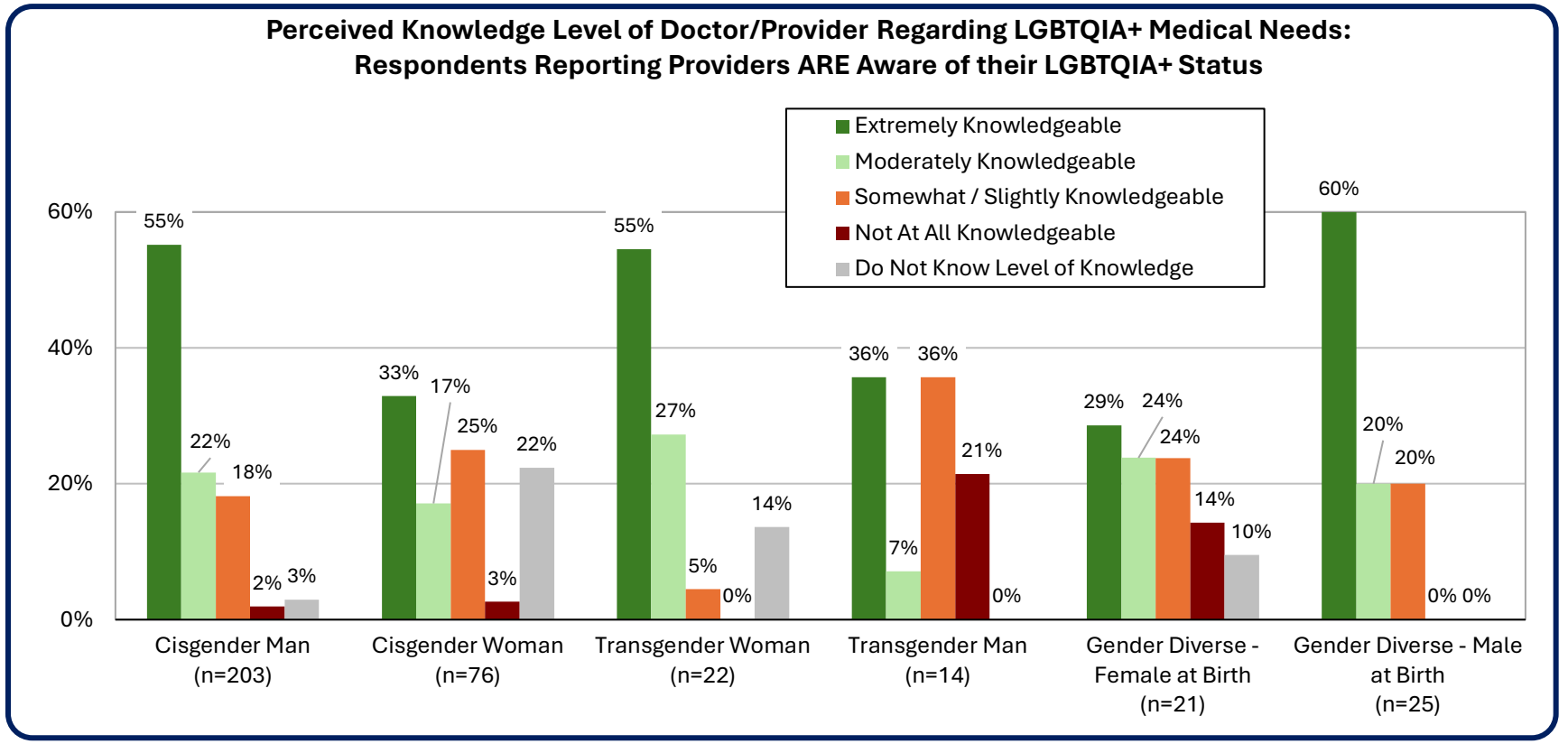
Table C-14. Reported cancer diagnoses by gender identity/sex assigned at birth

Question	Response	Gender Identity / Sex Assigned at Birth Category [1]												Total (n=516)	
		Cisgender Man (n=237)		Cisgender Woman (n=153)		Transgender Woman or Transfemme (n=25)		Transgender Man or Transmasculine (n=18)		Gender Diverse Female at Birth (n=45)		Gender Diverse Male at Birth (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Ever diagnosed with cancer	Yes	26	11%	17	11%	2	8%	2	11%	3	7%	6	17%	**56**	**11%**
	No	202	88%	129	87%	22	88%	16	89%	42	93%	29	81%	**442**	**88%**
	Prefer not to answer	1	0%	2	1%	1	4%	0	0%	0	0%	1	3%	**5**	**1%**
	No response	8	--	5	--	0	--	0	--	0	--	0	--	**13**	**--**
If yes, types (n=56): [2]	*(ever diagnosed)*	n=26		n=17		n=2		n=2		n=3		n=6		**n=56**	
	Skin	10	45%	2	13%	1	100%	0	0%	0	0%	2	50%	**15**	**33%**
	Breast	0	0%	6	40%	0	0%	0	0%	1	50%	0	0%	**7**	**15%**
	Cervical	0	0%	4	27%	0	0%	0	0%	0	0%	0	0%	**4**	**9%**
	Prostate	2	9%	0	0%	0	0%	0	0%	0	0%	1	25%	**3**	**7%**
	Anal	3	14%	0	0%	0	0%	0	0%	0	0%	0	0%	**3**	**7%**
	Kidney	2	9%	0	0%	0	0%	0	0%	0	0%	0	0%	**2**	**4%**
	Leukemia	1	5%	0	0%	0	0%	0	0%	0	0%	1	25%	**2**	**4%**
	Thyroid	0	0%	1	7%	0	0%	1	50%	0	0%	0	0%	**2**	**4%**
	Colon/Rectal	2	9%	0	0%	0	0%	0	0%	0	0%	0	0%	**2**	**4%**
	Testicular	1	5%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	"Skin endometrial"	0	0%	0	0%	0	0%	0	0%	1	50%	0	0%	**1**	**2%**
	"Benign tumor in stomach"	0	0%	1	7%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	"Carcinoid Tumor"	0	0%	1	7%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Kaposi Sarcoma	1	5%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Liver	0	0%	0	0%	0	0%	1	50%	0	0%	0	0%	**1**	**2%**
	Lung	1	5%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Lymphoma - non-Hodgkin	1	5%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Multiple Myeloma	1	5%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Ovarian Cyst (Cancerous)	0	0%	1	7%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Primary CNS Lymphatic Brain Tumor	1	5%	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Soft Tissue Sarcoma	0	0%	1	7%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Type not specified	4	--	2	--	1	--	0	--	1	--	2	--	**10**	**--**

[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described. Two individuals who did not respond were not included.

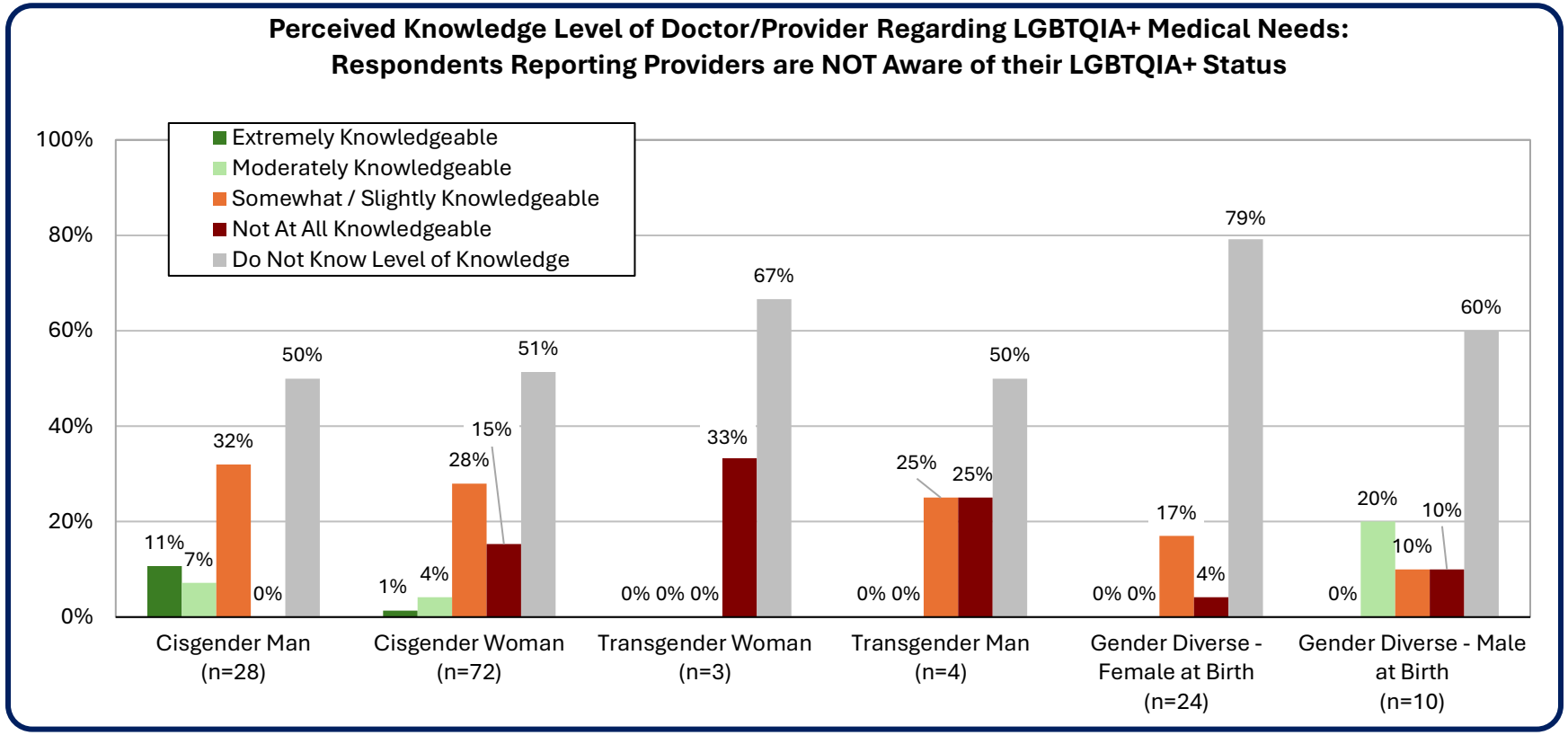
[2] Participants could list more than one type of cancer; as such, totals may be greater than the number of respondents and more than 100%. Ten individuals said that they had been diagnosed with cancer but did not provide information about the type.

Figure C1. Perceived Knowledge Level of Doctor/Provider Regarding LGBTQIA+ Medical Needs: Respondents Reporting Providers are Aware of LGBTQIA+ Status by Gender Identity/Sex Assigned at Birth [1]



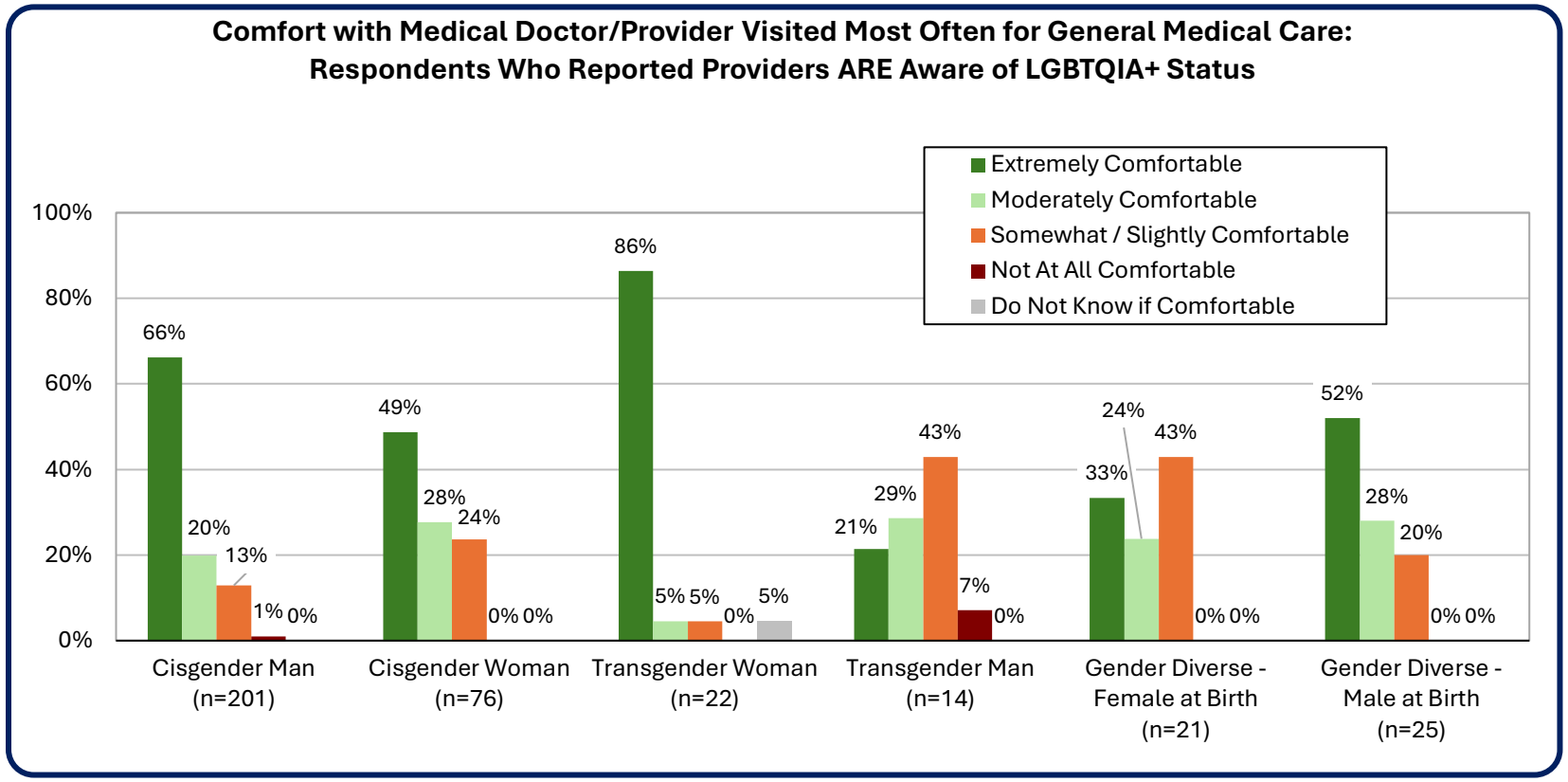
[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described.

Figure C2. Perceived Knowledge Level of Doctor/Provider Regarding LGBTQIA+ Medical Needs: Respondents Reporting Providers are NOT Aware (or unsure if they are aware) of LGBTQIA+ Status by Gender Identity/Sex Assigned at Birth [1]



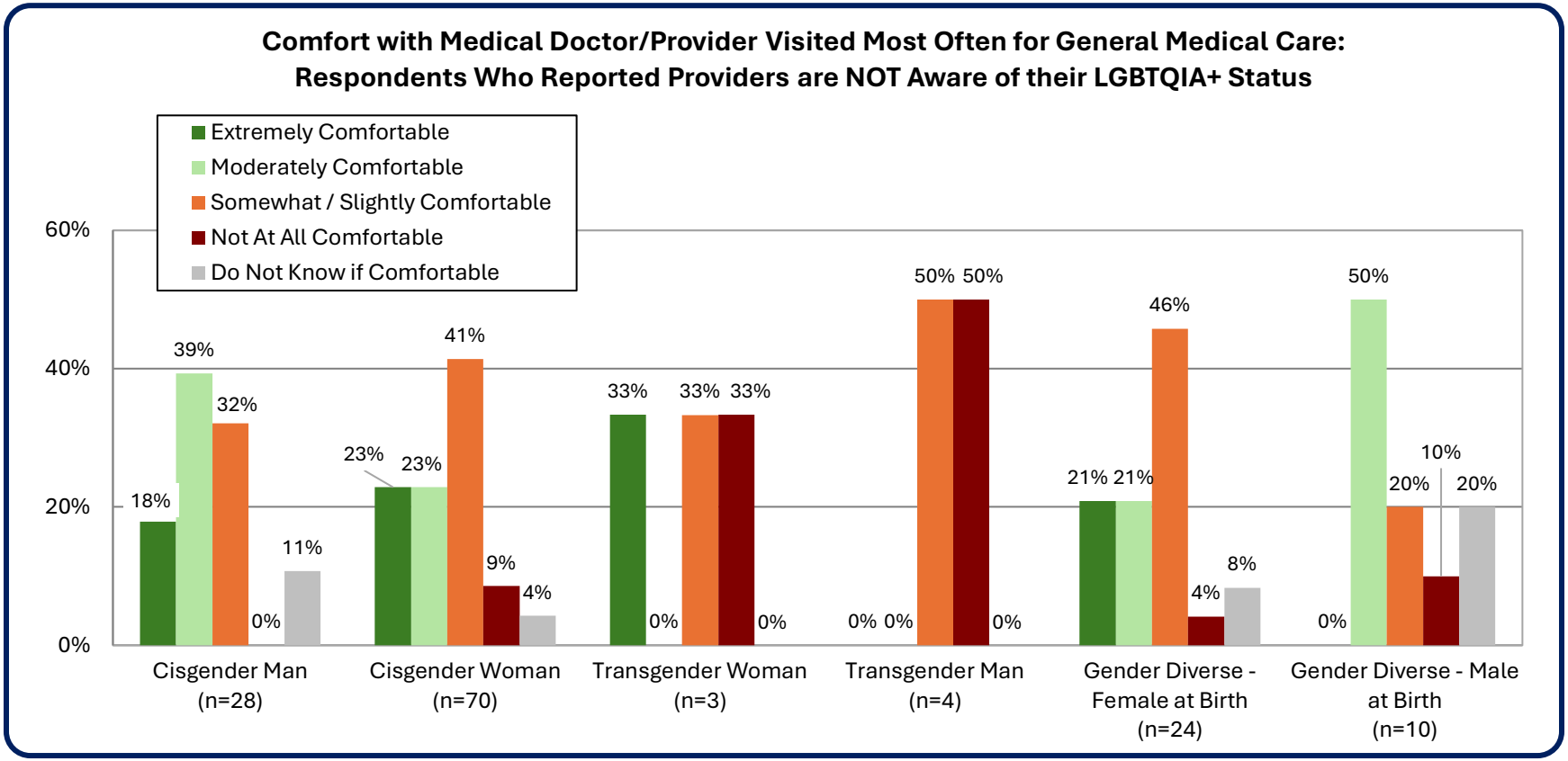
[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described.

Figure C3. Comfort with Medical Doctor/Provider Visit Most Often for General Medical Care by Gender Identity/Sex Assigned at Birth: Respondents Who Reported Providers are Aware of their LGBTQIA+ Status[1]



[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described.

Figure C4. Comfort with Medical Doctor/Provider Visit Most Often for General Medical Care by Gender Identity/Sex Assigned at Birth: Respondents Who Reported Providers are NOT Aware (or do not know if providers are aware) of their LGBTQIA+ Status[1]



[1] Gender identity and sex assigned at birth used to create categories. 'Gender diverse' includes non-binary or gender fluid, gender queer, two-spirit and self-described

Appendix D – Survey Data Tables by Race/Ethnicity

Table D-1. Demographic characteristics by race/ethnicity

Characteristic	Response	Race/Ethnicity Category [1]										Total (n=516)	
		Hispanic/ Latinx (n=236)		White (n=143)		Asian (n=33)		Black/ African Am. (n=45)		All Others (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%
Gender Identity	Man	109	46%	71	50%	14	42%	18	40%	14	39%	**239**	**46%**
	Woman	69	29%	40	28%	11	33%	15	33%	14	39%	**156**	**30%**
	Non-binary or gender fluid	25	11%	14	10%	6	18%	4	9%	4	11%	**55**	**11%**
	Transgender woman	8	3%	6	4%	0	0%	5	11%	3	8%	**22**	**4%**
	Genderqueer	9	4%	3	2%	0	0%	1	2%	0	0%	**13**	**3%**
	Transmasculine	6	3%	3	2%	1	3%	1	2%	0	0%	**11**	**2%**
	Two-spirit	4	2%	2	1%	0	0%	1	2%	1	3%	**8**	**2%**
	Transgender man	1	0%	3	2%	1	3%	0	0%	0	0%	**5**	**1%**
	Self-describe [2]	4	2%	1	1%	0	0%	0	0%	0	0%	**5**	**1%**
	No response/choose not disclose	1	--	0	--	0	--	0	--	0	--	**2**	**--**
Gender Identity Differs from Assign Birth	Not transgender	176	80%	103	79%	26	87%	32	76%	25	78%	**376**	**80%**
	Yes transgender	36	16%	23	18%	3	10%	8	19%	5	16%	**77**	**16%**
	Yes, not transgender	9	4%	4	3%	1	3%	2	5%	2	6%	**19**	**4%**
	Not recorded	15	--	13	--	3	--	3	--	4	--	**44**	**--**
Sex Assigned at Birth	Male	140	60%	81	57%	16	48%	28	64%	17	47%	**296**	**58%**
	Female	95	40%	62	43%	17	52%	16	36%	19	53%	**218**	**42%**
	Choose not to disclose	1	--	0	--	0	--	1	--	0	--	**2**	**--**
Sexual Orientation [3]	Gay/homosexual	112	48%	63	44%	12	36%	18	42%	12	33%	**227**	**45%**
	Lesbian	32	14%	27	19%	7	21%	4	9%	9	25%	**82**	**16%**
	Bisexual	39	17%	17	12%	2	6%	9	21%	3	8%	**75**	**15%**
	Queer	19	8%	15	10%	8	24%	5	12%	3	8%	**53**	**10%**
	Pansexual	20	9%	17	12%	3	9%	3	7%	5	14%	**49**	**10%**
	Asexual	8	3%	2	1%	0	0%	0	0%	1	3%	**12**	**2%**
	Straight/heterosexual	1	0%	1	1%	0	0%	1	2%	2	6%	**5**	**1%**
	Same gender loving	0	0%	0	0%	1	3%	3	7%	0	0%	**4**	**1%**
	Two-Spirit	1	0%	1	1%	0	0%	0	0%	1	3%	**3**	**1%**
	Choose not disclose/not recorded	4	--	0	--	0	--	2	--	0	--	**6**	**--**
Sexual Orientation Categorized [4]	Gay	112	48%	63	44%	12	36%	20	47%	12	33%	**229**	**45%**
	Lesbian	32	14%	27	19%	8	24%	4	9%	9	25%	**83**	**16%**
	Bisexual	39	17%	17	12%	2	6%	9	21%	3	8%	**75**	**15%**
	Pansexual	20	9%	17	12%	3	9%	3	7%	5	14%	**49**	**10%**
	Queer	19	8%	15	10%	8	24%	5	12%	3	8%	**53**	**10%**
	All Others	10	4%	4	3%	0	0%	2	5%	4	11%	**21**	**4%**
	Choose not disclose/not recorded	4	--	0	--	0	--	2	--	0	--	**6**	**--**
Categorized Gender Identity and Sex Assigned at Birth [1]	Cisgender man	109	46%	70	49%	13	39%	18	40%	14	39%	**237**	**46%**
	Cisgender woman	67	29%	39	27%	11	33%	15	33%	14	39%	**153**	**30%**
	Gender diverse female at birth	20	9%	16	11%	3	9%	0	0%	5	14%	**45**	**9%**
	Gender diverse male at birth	22	9%	4	3%	3	9%	6	13%	0	0%	**36**	**7%**
	Transgender woman or Transfemme	10	4%	7	5%	0	0%	5	11%	3	8%	**25**	**5%**
	Transgender man or Transmasculine	7	3%	7	5%	3	9%	1	2%	0	0%	**18**	**4%**
	Unknown	1	--	0	--	0	--	0	--	0	--	**2**	**--**

[1] Hispanic/Latino (e/a/x) = of any race; White = White only; Asian = Asian or Asian and White; Black/African American = Black/African American or Black/African American and White; All Others = Middle Eastern/North African, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and non-Hispanic multi-ethnic/racial not previously described. Does not include 23 with no race/ethnicity indicated.

[2] Self-describe: agender (n=1), gay (n=1), gay man (n=1), Mejia lesbian (n=1), woman with male brain (n=1).

[3] Self-described responses coded as follows: 'nonbinary' and 'fluid' into Queer (n=3), 'heteroflexible' into Heterosexual (n=1), 'demipansexual' into Pansexual (n=1) and 'bicurious' into Bisexual (n=1).

[4] Three 'same gender loving' responses coded as lesbian or gay; 'all others' includes: straight, asexual, two-spirit, and one same gender loving.

Table D-1. Demographic characteristics by race/ethnicity, continued

Characteristic	Response	Race/Ethnicity Category [1] Hispanic/ Latinx (n=236)		White (n=143)		Asian (n=33)		Black/ African Am. (n=45)		All Others (n=36)		Total (n=516)	
		n	%	n	%	n	%	n	%	n	%	n	%
Race(s) and/or Ethnicity(ies) [5]	Hispanic or Latino (a/e/x)	236	100%	0	0%	0	0%	0	0%	0	0%	**236**	**48%**
	White	36	15%	143	100%	10	30%	6	13%	17	47%	**212**	**43%**
	Black or African American	5	2%	0	0%	0	0%	45	100%	6	17%	**56**	**11%**
	Asian	7	3%	0	0%	33	100%	0	0%	2	6%	**42**	**9%**
	American Indian or Alaska Native	11	5%	0	0%	0	0%	0	0%	19	53%	**30**	**6%**
	Middle Eastern or North African	1	0%	0	0%	0	0%	0	0%	12	33%	**13**	**3%**
	Native Hawaiian or Pacific Islander	1	0%	0	0%	0	0%	0	0%	9	25%	**10**	**2%**
	No response	0	--	0	--	0	--	0	--	0	--	**23**	**--**
Hispanic or Latino(a/e/x) Identity(ies) [5]	*(Hispanic or Latino/a/e/x)*	n=236		n=0		n=0		n=0		n=0		n=236	
	Mexican, Mexican American, or Chicano (a/e/x)	191	81%	0	0%	0	0%	0	0%	0	0%	**191**	**81%**
	Other Hispanic, Latino (a/e/x) or Spanish	51	22%	0	0%	0	0%	0	0%	0	0%	**51**	**22%**
	Puerto Rican	9	4%	0	0%	0	0%	0	0%	0	0%	**9**	**4%**
	Cuban	5	2%	0	0%	0	0%	0	0%	0	0%	**5**	**2%**
	No response	1	--	0	--	0	--	0	--	0	--	**1**	**--**
Ethnicity Race-Ethnicity Categorized [6]	**Hispanic/Latino (e/a/x) any race(s)**	236	100%	0	0%	0	0%	0	0%	0	0%	**236**	**48%**
	Non-Hispanic:												
	White	0	0%	143	100%	0	0%	0	0%	0	0%	**143**	**29%**
	Black or African American	0	0%	0	0%	0	0%	45	100%	0	0%	**45**	**9%**
	Asian	0	0%	0	0%	33	100%	0	0%	0	0%	**33**	**7%**
	American Indian or Alaska Native	0	0%	0	0%	0	0%	0	0%	14	39%	**14**	**3%**
	Multiracial	0	0%	0	0%	0	0%	0	0%	10	28%	**10**	**2%**
	Middle Eastern or North African	0	0%	0	0%	0	0%	0	0%	7	19%	**7**	**1%**
	Native Hawaiian or Pacific Islander	0	0%	0	0%	0	0%	0	0%	5	14%	**5**	**1%**
	No Response	0	--	0	--	0	--	0	--	0	--	**23**	**--**

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[2] Self-describe: agender (n=1), gay (n=1), gay man (n=1), Mejia lesbian (n=1), woman with male brain (n=1).

[3] Self-described responses coded as follows: 'nonbinary' and 'fluid' into Queer (n=3), 'heteroflexible' into Heterosexual (n=1), 'demipansexual' into Pansexual (n=1) and 'bicurious' into Bisexual (n=1).

[4] Three 'same gender loving' responses coded as lesbian or gay; 'all others' includes: straight, asexual, two-spirit, and one same gender loving.

[5] Participants may choose all that apply; as such, totals may sum to greater than the number of respondents and more than 100%.

[6] Hispanic/Latino (e/a/x) = of any race; White = no other race; Asian, Black/African American, American Indian/Alaskan Native, Middle Eastern/North African, Native Hawaiian/Pacific Islander include those who indicated no other race or White; Multiracial includes two or more of the non-White races, or two or more of the non-White races and White.

Table D-1. Demographic characteristics by race/ethnicity, continued

Characteristic	Response	Race/Ethnicity Category [1] Hispanic/ Latinx (n=236)		White (n=143)		Asian (n=33)		Black/ African Am. (n=45)		All Others (n=36)		Total (n=516)	
		n	%	n	%	n	%	n	%	n	%	n	%
Preferred Language	English	145	62%	141	100%	33	100%	44	98%	35	100%	**413**	**82%**
	Español/Spanish	86	37%	0	0%	0	0%	0	0%	0	0%	**87**	**17%**
	Another [7]	4	2%	0	0%	0	0%	1	2%	0	0%	**6**	**1%**
	No response	1	--	2	--	0	--	0	--	1	--	**10**	**--**
Age	18-29 years	93	39%	23	16%	18	55%	11	24%	8	23%	**158**	**31%**
	30-39 years	76	32%	31	22%	7	21%	9	20%	9	26%	**139**	**27%**
	40-44 years	16	7%	15	10%	4	12%	3	7%	2	6%	**40**	**8%**
	45-49 years	10	4%	4	3%	1	3%	2	4%	2	6%	**22**	**4%**
	50-59 years	28	12%	26	18%	2	6%	4	9%	4	11%	**67**	**13%**
	60-69 years	10	4%	23	16%	1	3%	14	31%	9	26%	**57**	**11%**
	70 years or over	3	1%	21	15%	0	0%	2	4%	1	3%	**31**	**6%**
	No response	0	--	0	--	0	--	0	--	1	--	**2**	**--**
Combined Annual Income *(total pre-tax all sources; you and partner/ spouse if live together)*	$0 to $9,999	38	18%	15	11%	2	6%	8	21%	8	22%	**75**	**16%**
	$10,000 to $14,999	13	6%	5	4%	1	3%	4	11%	3	8%	**27**	**6%**
	$15,000 to $19,999	14	7%	8	6%	1	3%	1	3%	1	3%	**25**	**5%**
	$20,000 to $34,999	29	14%	16	12%	2	6%	6	16%	5	14%	**60**	**13%**
	$35,000 to $49,999	30	14%	12	9%	8	26%	4	11%	4	11%	**61**	**13%**
	$50,000 to $74,999	43	20%	13	10%	5	16%	8	21%	2	6%	**73**	**16%**
	$75,000 to $99,999	21	10%	18	14%	5	16%	3	8%	3	8%	**54**	**12%**
	$100,000 to $199,999	23	11%	32	24%	5	16%	4	11%	10	28%	**74**	**16%**
	$200,000 or more	3	1%	14	11%	2	6%	0	0%	0	0%	**19**	**4%**
	No response/refuse	22	--	10	--	2	--	7	--	0	--	**48**	**--**
Live in or Get Health Care in San Diego County	Live *and* health care	219	93%	138	97%	30	91%	43	96%	35	97%	**487**	**94%**
	Live and *no* health care	16	7%	3	2%	3	9%	2	4%	1	3%	**26**	**5%**
	Do *not* live but get health care	1	0%	2	1%	0	0%	0	0%	0	0%	**3**	**1%**
Region of Residence San Diego County [8]	Central	87	38%	76	54%	9	27%	22	51%	18	51%	**227**	**45%**
	North Central	26	11%	26	18%	9	27%	4	9%	3	9%	**69**	**14%**
	North Coastal	21	9%	14	10%	3	9%	6	14%	2	6%	**50**	**10%**
	East	22	10%	12	8%	3	9%	5	12%	5	14%	**47**	**9%**
	North Inland	24	10%	9	6%	5	15%	0	0%	3	9%	**43**	**8%**
	South	30	13%	1	1%	1	3%	4	9%	3	9%	**39**	**8%**
	Southeast	20	9%	4	3%	3	9%	2	5%	1	3%	**31**	**6%**
	Not recorded (zip code)	6	--	1	--	0	--	2	--	1	--	**10**	**--**

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[2] Self-describe: agender (n=1), gay (n=1), gay man (n=1), Mejia lesbian (n=1), woman with male brain (n=1).

[3] Self-described responses coded as follows: 'nonbinary' and 'fluid' into Queer (n=3), 'heteroflexible' into Heterosexual (n=1), 'demipansexual' into Pansexual (n=1) and 'bicurious' into Bisexual (n=1).

[4] Three 'same gender loving' responses coded as lesbian or gay; 'all others' includes: straight, asexual, two-spirit, and one same gender loving.

[5] Participants may choose all that apply; as such, totals may sum to greater than the number of respondents and more than 100%.

[6] Hispanic/Latino (e/a/x) = of any race; White = no other race; Asian, Black/African American, American Indian/Alaskan Native, Middle Eastern/North African, Native Hawaiian/Pacific Islander include those who indicated no other race or White; Multiracial includes two or more of the non-White races, or two or more of the non-White races and White.

[7] Another: Both English and Spanish (n=3), American Sign Language (ASL) (n=1), Portuguese (n=1), not specified (n=1).

[8] San Diego County Health and Human Services Agency service regions; the southeast area is part of the Central region put separated for informational purposes.

Table D-2. General healthcare information by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=516)	
		Hispanic/ Latinx (n=236)		White (n=143)		Asian (n=33)		Black/ African Am. (n=45)		All Others (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%
Currently Have Health Care Coverage	Yes	187	80%	134	94%	26	79%	40	89%	32	91%	**432**	**85%**
	No	47	20%	8	6%	7	21%	5	11%	3	9%	**76**	**15%**
	No response	2	--	1	--	0	--	0	--	1	--	**8**	**--**
Main Sources of Health Care Coverage [2]	(had health care coverage)	n=187		n=134		n=26		n=40		n=32		n=432	
	A plan purchased through (or provided by) an employer or union	96	52%	71	53%	20	77%	13	34%	10	31%	**214**	**50%**
	Medi-Cal, Medicaid, or other state program	73	39%	34	25%	5	19%	13	34%	17	53%	**149**	**35%**
	Medicare	13	7%	29	22%	1	4%	12	32%	6	19%	**62**	**14%**
	A plan that you, or another family member, buys on your own	8	4%	8	6%	4	15%	0	0%	2	6%	**23**	**5%**
	TRICARE (formerly CHAMPUS), VA, or military	2	1%	3	2%	1	4%	3	8%	2	6%	**12**	**3%**
	Alaska Native, Indian Health Services, or Tribal Health Services	0	0%	0	0%	0	0%	0	0%	0	0%	**1**	**0%**
	Some other source (not specified)	9	5%	5	4%	0	0%	2	5%	1	3%	**18**	**4%**
	No response	1	--	0	--	0	--	2	--	0	--	**3**	**--**
Health Care Coverage Categorized (mutually exclusive) [3]	Through employment or purchased	104	45%	79	56%	22	67%	13	30%	12	34%	**235**	**47%**
	State program	63	27%	24	17%	3	9%	8	19%	13	37%	**117**	**23%**
	No health care coverage	47	20%	8	6%	7	21%	5	12%	3	9%	**76**	**15%**
	Medicare	12	5%	25	18%	1	3%	12	28%	6	17%	**57**	**11%**
	All others	7	3%	6	4%	0	0%	5	12%	1	3%	**20**	**4%**
	No response	3	--	1	--	0	--	2	--	1	--	**11**	**--**
When Was Last General Health Checkup	Within the past year	163	71%	116	82%	22	67%	36	80%	28	78%	**382**	**75%**
	Between 1-2 years ago	50	22%	17	12%	8	24%	5	11%	6	17%	**91**	**18%**
	Between 3-5 years ago	13	6%	2	1%	3	9%	3	7%	2	6%	**24**	**5%**
	6 or more years ago	4	2%	6	4%	0	0%	1	2%	0	0%	**11**	**2%**
	I don't know	6	--	2	--	0	--	0	--	0	--	**8**	**--**
Was Last General Health Checkup in San Diego County	Yes	198	94%	133	95%	30	100%	39	89%	33	92%	**453**	**94%**
	No	13	6%	7	5%	0	0%	5	11%	3	8%	**29**	**6%**
	No response	25	--	3	--	3	--	1	--	0	--	**34**	**--**

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[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Mutually exclusive categories: (1) Employment/purchased (and any other response), (2) Medicare and any other response except employment/purchased, (3) Medi-Cal/Medicaid/state program and any other responses employment/purchased and Medicare, and (4) all others.

Table D-3. Experiences with most visited medical doctor/provider for general medical needs by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=516)	
		Hispanic/ Latinx (n=236)		White (n=143)		Asian (n=33)		Black/ African Am. (n=45)		All Others (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%
At what type of medical practice do you usually receive your care?	Health system	127	54%	108	76%	25	76%	19	42%	23	64%	**313**	**61%**
	Community clinic	94	40%	24	17%	5	15%	20	44%	9	25%	**162**	**32%**
	Veterans or military health system	7	3%	3	2%	3	9%	5	11%	2	6%	**20**	**4%**
	Another [2]	8	3%	8	6%	0	0%	1	2%	2	6%	**19**	**4%**
	No response	0	--	0	--	0	--	0	--	0	--	**2**	**--**
Is the medical doctor/ provider you visit most often for general medical care aware of your LGBTQIA+ status?	Yes	161	69%	107	77%	20	65%	31	70%	25	69%	**362**	**72%**
	No	45	19%	16	12%	5	16%	5	11%	6	17%	**79**	**16%**
	Don't know	26	11%	16	12%	6	19%	8	18%	5	14%	**63**	**13%**
	No response	4	--	4	--	2	--	1	--	0	--	**12**	**--**
How long have you been a patient of this medical doctor/ provider?	Less than 3 months	32	14%	15	11%	5	15%	4	9%	6	17%	**63**	**12%**
	3 months to 1 year	51	22%	20	14%	6	18%	8	18%	5	14%	**93**	**18%**
	1-2 years	61	26%	26	18%	10	30%	9	20%	9	25%	**121**	**24%**
	3 or more years	85	36%	78	55%	12	36%	23	51%	15	42%	**224**	**44%**
	I don't know	6	3%	3	2%	0	0%	1	2%	1	3%	**12**	**2%**
	No response	1	--	1	--	0	--	0	--	0	--	**3**	**--**
How knowledgeable is the doctor/provider you visit most often (for general medical care) about LGBTQIA+ medical needs?	Extremely knowledgeable	77	33%	58	41%	4	12%	22	49%	14	39%	**181**	**35%**
	Moderately knowledgeable	40	17%	21	15%	7	21%	4	9%	6	17%	**84**	**16%**
	Somewhat knowledgeable	32	14%	14	10%	11	33%	8	18%	4	11%	**74**	**14%**
	Slightly knowledgeable	20	9%	12	8%	2	6%	2	4%	0	0%	**36**	**7%**
	Not at all knowledgeable	13	6%	9	6%	2	6%	2	4%	1	3%	**28**	**5%**
	I do not know	52	22%	28	20%	7	21%	7	16%	11	31%	**109**	**21%**
	No response	2	--	1	--	0	--	0	--	0	--	**4**	**--**
How comfortable are you with the medical doctor/provider you visit most often for general medical care?	Extremely comfortable	104	44%	78	55%	8	24%	27	60%	17	47%	**244**	**48%**
	Moderately comfortable	57	24%	24	17%	11	33%	7	16%	12	33%	**118**	**23%**
	Somewhat comfortable	42	18%	22	15%	6	18%	6	13%	2	6%	**79**	**15%**
	Slightly comfortable	22	9%	11	8%	5	15%	2	4%	3	8%	**46**	**9%**
	Not at all comfortable	3	1%	5	4%	2	6%	3	7%	1	3%	**14**	**3%**
	I do not know	7	3%	2	1%	1	3%	0	0%	1	3%	**11**	**2%**
	No response	1	--	1	--	0	--	0	--	0	--	**4**	**--**

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[2] Other: non-profit HIV medical care (n=4), physician - general or family (n=3), non-profit healthcare network (n=2), private clinic (n=2), school clinic (n=1), group practice (n=1), none (n=1), not specified (n=5).

Table D-4. Cancer screening eligibility based on age and self-assessment, among those who are LGBTQIA+ and live or get health care in San Diego County by race/ethnicity

Cancer Screening Question Self-Assessment	(sample) Response	Race/Ethnicity Category [1]										Total [2] (n=516)	
		Hispanic/ Latinx (n=236)		White (n=143)		Asian (n=33)		Black/ African Am. (n=45)		All Others (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%
Cervical: The cervix is the end of the uterus that connects to the vagina in persons who have a vagina. **Do you have a uterus or a cervix?**	*(female at birth)*	n=95		n=62		n=17		n=16		n=19		n=218	
	Yes	89	94%	56	90%	16	94%	14	88%	18	95%	**201**	**92%**
	No	6	6%	6	10%	1	6%	2	13%	1	5%	**17**	**8%**
Breast: Breast cancer screening is appropriate for: (5) Cisgender women and anyone assigned female at birth who has not had both breasts removed, such as through top surgery or a double mastectomy (6) Transgender women or people of any gender identity who have been taking feminizing hormones [FHT]/hormone therapy [HR] (such as estrogen) for at least 5 years **Based on this information, does breast cancer screening apply to you?**	*(age 40 and older)*	n=67		n=89		n=8		n=25		n=18		n=217	
	Yes	20	30%	26	29%	2	25%	9	36%	11	61%	**71**	**33%**
	No	47	70%	63	71%	6	75%	16	64%	7	39%	**144**	**67%**
	No response	0	--	0	--	0	--	0	--	0	--	**2**	**--**
Prostate: Prostate cancer screening may be appropriate for any person who has a prostate, which includes: (4) Cisgender men (5) Transgender women, including transgender women who have had vaginoplasty or orchiectomy (6) Anyone of any gender identity who was assigned male at birth **Based on this information, does prostate cancer screening apply to you?**	*(age 40 and older male at birth)*	n=48		n=65		n=5		n=16		n=10		n=151	
	Yes	40	83%	60	92%	5	100%	12	75%	10	100%	**131**	**87%**
	No	8	17%	5	8%	0	0%	4	25%	0	0%	**19**	**13%**
	No response	0	--	0	--	0	--	0	--	0	--	**1**	**--**
Lung: Lung cancer screening is appropriate for people who: (5) Have a 20 pack-year history of smoking (1 pack a day for 20 years or 2 packs a day for 10 years, etc.) (6) AND have smoked in the past 15 years (including currently smoke) **Based on this information, does lung cancer screening apply to you?**	*(age 45 and older)*	n=51		n=74		n=4		n=22		n=16		n=177	
	Yes	8	16%	15	20%	0	0%	6	27%	7	44%	**39**	**22%**
	No	43	84%	59	80%	4	100%	16	73%	9	56%	**136**	**78%**
	No response	0	--	0	--	0	--	0	--	0	--	**2**	**--**
Anal: Anal cancer screening is appropriate for people who: (5) Are living with HIV, OR (6) Have been diagnosed with human papillomavirus (HPV), OR (7) Are immunocompromised, OR (8) Practice the receptive role during anal intercourse (penis inserted into your anus) **Based on this information, does anal cancer screening apply to you?**	*(age 35 and older)*	n=96		n=102		n=11		n=28		n=22		n=271	
	Yes	40	42%	47	47%	3	27%	10	36%	10	45%	**113**	**42%**
	No	56	58%	54	53%	8	73%	18	64%	12	55%	**156**	**58%**
	No response	0	--	1	--	0	--	0	--	0	--	**3**	**--**

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[2] Total sample is 516 and 2 did not report their age:

- 271 were aged 35 and over
- 217 were aged 40 and over
- 177 were aged 45 and over

Table D-5. Cervical cancer screening among females at birth who self-assessed as having a cervix or uterus by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=201)	
		Hispanic/ Latinx (n=89)		White (n=56)		Asian (n=16)		Black/ African Am. (n=14)		All Others (n=18)			
		n	%	n	%	n	%	n	%	n	%	n	%
Medical professional ever talked to you about cervical cancer screening	Yes	58	65%	46	82%	12	75%	9	64%	16	89%	**146**	**73%**
	No	31	35%	10	18%	4	25%	5	36%	2	11%	**55**	**27%**
Ever had a cervical cancer screening test	Yes	52	58%	42	75%	9	56%	7	50%	14	78%	**130**	**65%**
	No	37	42%	14	25%	7	44%	7	50%	4	22%	**71**	**35%**
If had a cervical cancer screening test, experience was…	*(screened)*	n=52		n=42		n=9		n=7		n=14		n=130	
	Very respectful	41	82%	27	66%	8	89%	4	67%	12	86%	**96**	**76%**
	Somewhat respectful	9	18%	12	29%	1	11%	1	17%	2	14%	**27**	**21%**
	Not respectful	0	0%	2	5%	0	0%	1	17%	0	0%	**3**	**2%**
	No response	2	--	1	--	0	--	1	--	0	--	**4**	**--**
How many years ago was last cervical cancer screening test	*(screened)*	n=52		n=42		n=9		n=7		n=14		n=130	
	1 year ago or less	29	56%	20	48%	8	89%	4	67%	8	57%	**73**	**57%**
	2 years	10	19%	14	33%	0	0%	2	33%	1	7%	**28**	**22%**
	3 years	10	19%	4	10%	1	11%	0	0%	2	14%	**18**	**14%**
	4 years	1	2%	1	2%	0	0%	0	0%	0	0%	**2**	**2%**
	5 years	1	2%	1	2%	0	0%	0	0%	0	0%	**2**	**2%**
	6 or more years ago	1	2%	2	5%	0	0%	0	0%	3	21%	**6**	**5%**
	No response	0	--	0	--	0	--	1	--	0	--	**1**	**--**
Reasons for not getting cervical cancer screening every 1-3 years [2]	*(screening 4 or more years ago or not screened)*	n=40		n=18		n=7		n=7		n=7		n=81	
	Did not know I need regular cervical screenings	24	67%	9	60%	5	71%	4	67%	2	29%	**45**	**62%**
	Did not want to discuss with medical provider	6	17%	3	20%	2	29%	0	0%	0	0%	**11**	**15%**
	Told to screen every 5 years	6	17%	0	0%	0	0%	1	17%	2	29%	**10**	**14%**
	Told that I do not need (or no longer need)	2	6%	3	20%	0	0%	1	17%	2	29%	**8**	**11%**
	Other response (written) [3]	2	6%	1	7%	1	14%	0	0%	1	14%	**5**	**7%**
	No response	4	--	3	--	0	--	1	--	0	--	**8**	**--**

[1] Hispanic/Latino (e/a/x) = of any race; White = White only; Asian = Asian or Asian and White; Black/African American = Black/African American or Black/African American and White; All Others = Middle Eastern/North African, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and non-Hispanic multi-ethnic/racial not previously described. Does not include 23 with no race/ethnicity indicated.

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: Uncomfortable (n=2 due to gender dysphoria, not like being touched), low risk (n=1); lack of time (n=1); need new primary care physician (n=1).

Table D-6. Breast cancer screening among those aged 40 and over who self-assessed as eligible by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=71)	
		Hispanic/ Latinx (n=20)		White (n=26)		Asian (n=2)		Black/ African Am. (n=9)		All Others (n=11)			
		n	%	n	%	n	%	n	%	n	%	n	%
Medical professional ever talked to you about a mammogram	Yes	19	95%	24	92%	2	100%	9	100%	10	91%	**67**	**94%**
	No	1	5%	2	8%	0	0%	0	0%	1	9%	**4**	**6%**
Ever had a mammogram	Yes	15	79%	19	73%	2	100%	9	100%	8	73%	**56**	**80%**
	No	4	21%	7	27%	0	0%	0	0%	3	27%	**14**	**20%**
	No response	1	--	0	--	0	--	0	--	0	--	**1**	**--**
If had a mammogram, experience was...	*(had mammogram)*	n=15		n=19		n=2		n=9		n=8		n=56	
	Very respectful	13	93%	16	89%	1	50%	8	89%	6	75%	**46**	**85%**
	Somewhat respectful	1	7%	2	11%	1	50%	1	11%	2	25%	**8**	**15%**
	No response	1	--	1	--	0	--	0	--	0	--	**2**	**--**
How many years ago was last mammogram	*(had mammogram)*	n=15		n=19		n=2		n=9		n=8		n=56	
	1 year ago or less	11	73%	17	89%	2	100%	6	67%	5	63%	**43**	**77%**
	2 years ago	2	13%	2	11%	0	0%	2	22%	2	25%	**9**	**16%**
	3 years ago	1	7%	0	0%	0	0%	0	0%	1	13%	**2**	**4%**
	4 years ago	0	0%	0	0%	0	0%	1	11%	0	0%	**1**	**2%**
	5 or more years ago	1	7%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
Reasons for not getting mammograms every 1-2 years [2]	*(had mammogram 3 or more years ago)*	n=6		n=7		n=0		n=1		n=4		n=18	
	Other response (written) [3]	3	60%	1	17%	0	0%	0	0%	2	50%	**6**	**38%**
	Newly eligible (written in)	0	0%	3	50%	0	0%	0	0%	0	0%	**3**	**19%**
	Procrastination/forget (written in)	1	20%	2	33%	0	0%	0	0%	0	0%	**3**	**19%**
	Told that I do not need	0	0%	0	0%	0	0%	1	100%	1	25%	**2**	**13%**
	Did not want to discuss with medical provider	1	20%	0	0%	0	0%	0	0%	0	0%	**1**	**6%**
	Did not know I need regular mammograms	0	0%	0	0%	0	0%	0	0%	1	25%	**1**	**6%**
	No response	1	--	1	--	0	--	0	--	0	--	**2**	**--**

[1] Hispanic/Latino (e/a/x) = of any race; White = White only; Asian = Asian or Asian and White; Black/African American = Black/African American or Black/African American and White; All Others = Middle Eastern/North African, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and non-Hispanic multi-ethnic/racial not previously described. Does not include 23 with no race/ethnicity indicated.

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: cost (n=1), reluctance based on past experiences (n=1), mammograms are unsafe (n=1), personal choice (n=1), still too firm (n=1), scheduling (n=1).

Table D-7. Prostate cancer screening among those aged 40 and older, male at birth, and self-assessed as eligible by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=131)	
		Hispanic/ Latinx (n=40)		White (n=60)		Asian (n=5)		Black/ African Am. (n=12)		All Others (n=10)			
		n	%	n	%	n	%	n	%	n	%	n	%
Medical professional ever talked to you about prostate cancer screening, or PSA [2]	Yes	26	65%	46	77%	5	100%	10	83%	9	90%	**100**	**76%**
	No	14	35%	14	23%	0	0%	2	17%	1	10%	**31**	**24%**
Ever had a PSA test	Yes	22	55%	42	70%	4	80%	9	75%	8	80%	**88**	**67%**
	No	18	45%	18	30%	1	20%	3	25%	2	20%	**43**	**33%**
If had a PSA test, experience was…	*(had PSA test)*	n=22		n=42		n=4		n=9		n=8		n=88	
	Very respectful	21	95%	40	98%	2	50%	8	100%	8	100%	**82**	**95%**
	Somewhat respectful	1	5%	1	2%	1	25%	0	0%	0	0%	**3**	**3%**
	Not respectful	0	0%	0	0%	1	25%	0	0%	0	0%	**1**	**1%**
	No response	0	--	1	--	0	--	1	--	0	--	**2**	**--**
How many years ago was last PSA test	*(had PSA test)*	n=22		n=42		n=4		n=9		n=8		n=88	
	1 year ago or less	10	45%	31	74%	2	50%	5	71%	7	88%	**56**	**65%**
	2 years ago	7	32%	3	7%	2	50%	1	14%	0	0%	**14**	**16%**
	3 years ago	3	14%	1	2%	0	0%	0	0%	1	13%	**5**	**6%**
	4 years ago	2	9%	1	2%	0	0%	0	0%	0	0%	**4**	**5%**
	5 or more years ago	0	0%	6	14%	0	0%	1	14%	0	0%	**7**	**8%**
	No response	0	--	0	--	0	--	2	--	0	--	**2**	**--**
Reasons for not getting PSA test every 1-2 years [3]	*(PSA test 3 or more years ago)*	n=23		n=26		n=1		n=4		n=3		n=59	
	Did not know I needed regular PSA tests	16	80%	15	63%	1	100%	2	50%	2	67%	**36**	**67%**
	Told not to get PSA tests	6	30%	3	13%	0	0%	1	25%	1	33%	**12**	**22%**
	Did not want to discuss with medical provider	1	5%	3	13%	0	0%	1	25%	0	0%	**5**	**9%**
	Other response (written in) [4]	0	0%	2	8%	0	0%	0	0%	0	0%	**2**	**4%**
	Doctor did not discuss (written in)	0	0%	1	4%	0	0%	0	0%	0	0%	**1**	**2%**
	No response	3	--	2	--	0	--	0	--	0	--	**5**	**--**

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[2] PSA = Prostate Specific Antigen.

[3] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[4] Other write-in responses included: I already had prostate cancer (n=1), I have one in February 2025 (n=1).

Table D-8. Colon cancer screening among those aged 45 or older by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=177)	
		Hispanic/ Latinx (n=51)		White (n=74)		Asian (n=4)		Black/ African Am. (n=22)		All Others (n=16)			
		n	%	n	%	n	%	n	%	n	%	n	%
Has medical professional ever talked to you about colon cancer screening	Yes	41	80%	69	93%	4	100%	17	77%	15	94%	**153**	**87%**
	No	10	20%	5	7%	0	0%	5	23%	1	6%	**22**	**13%**
	No response	0	--	0	--	0	--	0	--	0	--	**2**	**--**
Ever done the blood stool test	Yes	41	80%	47	64%	2	50%	14	64%	11	69%	**122**	**70%**
	No	10	20%	27	36%	2	50%	8	36%	5	31%	**53**	**30%**
	No response	0	--	0	--	0	--	0	--	0	--	**2**	**--**
How many years ago was your last blood stool test	*(had blood stool test)*	n=41		n=47		n=2		n=14		n=11		n=122	
	1 year ago or less	27	66%	23	52%	0	0%	7	50%	5	45%	**64**	**54%**
	2 years ago	5	12%	7	16%	1	50%	1	7%	3	27%	**18**	**15%**
	3 years ago	4	10%	5	11%	1	50%	3	21%	1	9%	**17**	**14%**
	4 years ago	2	5%	3	7%	0	0%	2	14%	1	9%	**8**	**7%**
	5 or more years ago	3	7%	6	14%	0	0%	1	7%	1	9%	**12**	**10%**
	No response	0	--	3	--	0	--	0	--	0	--	**3**	**--**
Ever had a colonoscopy	Yes	31	61%	63	85%	2	50%	15	68%	12	75%	**128**	**73%**
	No	20	39%	11	15%	2	50%	7	32%	4	25%	**47**	**27%**
	No response	0	--	0	--	0	--	0	--	0	--	**2**	**--**
If had a colonoscopy test, experience was…	*(had colonoscopy)*	n=31		n=63		n=2		n=15		n=12		n=128	
	Very respectful	27	90%	53	90%	2	100%	13	93%	10	83%	**110**	**90%**
	Somewhat respectful	3	10%	5	8%	0	0%	1	7%	2	17%	**11**	**9%**
	Not respectful	0	0%	1	2%	0	0%	0	0%	0	0%	**1**	**1%**
	No response	1	--	4	--	0	--	1	--	0	--	**6**	**--**
How many years ago was last colonoscopy	*(had colonoscopy)*	n=31		n=63		n=2		n=15		n=12		n=128	
	1 year ago or less	10	33%	19	31%	0	0%	4	27%	6	50%	**40**	**32%**
	2 to 5 years	16	53%	27	44%	1	50%	7	47%	6	50%	**60**	**48%**
	6 to 10 years	3	10%	12	19%	1	50%	4	27%	0	0%	**21**	**17%**
	11 or more years ago	1	3%	4	6%	0	0%	0	0%	0	0%	**5**	**4%**
	No response	1	--	1	--	0	--	0	--	0	--	**2**	**--**
Reasons for not getting a blood stool test every year, or colonoscopy every 10 years [2]	*(colonoscopy > 10 years ago and blood stool not every year)*	n=13		n=8		n=2		n=5		n=2		n=32	
	Did not know need regular stool tests or colonoscopy	7	78%	3	43%	1	50%	2	50%	1	50%	**15**	**58%**
	Told colonoscopy not needed	1	11%	0	0%	0	0%	1	25%	0	0%	**3**	**12%**
	Procrastination (written in)	1	11%	2	29%	0	0%	0	0%	0	0%	**3**	**12%**
	Other response (written in) [3]	0	0%	1	14%	1	50%	1	25%	0	0%	**3**	**12%**
	Told stool blood test not needed	0	0%	0	0%	0	0%	1	25%	1	50%	**2**	**8%**
	Did not want to discuss with medical provider	0	0%	1	14%	0	0%	0	0%	0	0%	**1**	**4%**
	No response	4	--	1	--	0	--	1	--	0	--	**6**	**--**

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[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: do not like them/uncomfortable (n=2), single gay man no one to drop me off and pick up, and ride-share not allowed (n=1).

Table D-9. Lung cancer screening among those aged 45 and older who self-assessed as eligible by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=39)	
		Hispanic/ Latinx (n=8)		White (n=15)		Asian (n=0)		Black/ African Am. (n=6)		All Others (n=7)			
		n	%	n	%	n	%	n	%	n	%	n	%
Medical professional talked about screening for lung cancer	Yes	3	38%	10	67%	0	0%	4	67%	5	71%	**23**	**59%**
	No	5	63%	5	33%	0	0%	2	33%	2	29%	**16**	**41%**
Ever had a lung cancer screening	Yes	1	13%	7	47%	0	0%	4	67%	6	86%	**20**	**51%**
	No	7	88%	8	53%	0	0%	2	33%	1	14%	**19**	**49%**
If had lung cancer screening, experience was…	*(screened)*	n=1		n=7		n=0		n=4		n=6		n=20	
	Very respectful	1	100%	7	100%	0	0%	4	100%	4	80%	**18**	**95%**
	Somewhat respectful	0	0%	0	0%	0	0%	0	0%	1	20%	**1**	**5%**
	No response	0	--	0	--	0	--	0	--	1	--	**1**	**--**
How many years ago was last lung cancer screening	*(screened)*	n=1		n=7		n=0		n=4		n=6		n=20	
	1 year ago or less	1	100%	3	43%	0	0%	4	100%	4	67%	**13**	**65%**
	2 years ago	0	0%	1	14%	0	0%	0	0%	1	17%	**2**	**10%**
	3 years ago	0	0%	1	14%	0	0%	0	0%	0	0%	**2**	**10%**
	4 years ago	0	0%	1	14%	0	0%	0	0%	0	0%	**1**	**5%**
	5 or more years ago	0	0%	1	14%	0	0%	0	0%	1	17%	**2**	**10%**
Reasons for not getting a lung cancer screening every year [2]	*(screened 2 or more years ago)*	n=7		n=12		n=0		n=2		n=3		n=26	
	Did not know I need regular lung cancer screening	5	83%	4	50%	0	0%	1	50%	2	67%	**13**	**62%**
	Told lung cancer screening not needed	1	17%	2	25%	0	0%	1	50%	1	33%	**6**	**29%**
	Did not want to discuss with medical provider	0	0%	1	13%	0	0%	0	0%	0	0%	**1**	**5%**
	Other response (written in) [3]	0	0%	1	13%	0	0%	0	0%	0	0%	**1**	**5%**
	No response	1	--	4	--	0	--	0	--	0	--	**5**	**--**

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[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: 'I am tested regularly' (n=1 who indicated test was 4 years ago).

Table D-10. Anal cancer screening among those aged 35 and older who self-assessed as eligible for screening by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=113)	
		Hispanic/ Latinx (n=40)		White (n=47)		Asian (n=3)		Black/ African Am. (n=10)		All Others (n=10)			
		n	%	n	%	n	%	n	%	n	%	n	%
Medical professional talked about screening for anal cancer	Yes	21	53%	26	57%	2	67%	7	70%	6	60%	**64**	**57%**
	No	19	48%	20	43%	1	33%	3	30%	4	40%	**48**	**43%**
	No response	0	--	1	--	0	--	0	--	0	--	**1**	**--**
Ever had an anal pap screening test	Yes	17	43%	21	46%	2	67%	7	70%	6	60%	**55**	**49%**
	No	23	58%	25	54%	1	33%	3	30%	4	40%	**57**	**51%**
	No response	0	--	1	--	0	--	0	--	0	--	**1**	**--**
If had anal pap screening test, experience was...	*(screened)*	n=17		n=21		n=2		n=7		n=6		n=55	
	Very respectful	16	100%	16	94%	2	100%	7	100%	6	100%	**48**	**98%**
	Somewhat respectful	0	0%	1	6%	0	0%	0	0%	0	0%	**1**	**2%**
	Not respectful	0	0%	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
	No response	1	--	4	--	0	--	0	--	0	--	**6**	**--**
How many years ago was last anal pap screening test	*(screened)*	n=17		n=21		n=2		n=7		n=6		n=55	
	1 year ago or less	11	65%	11	52%	2	100%	1	14%	6	100%	**32**	**59%**
	2 years ago	3	18%	3	14%	0	0%	4	57%	0	0%	**10**	**19%**
	3 years ago	1	6%	3	14%	0	0%	0	0%	0	0%	**4**	**7%**
	4 years ago	1	6%	2	10%	0	0%	0	0%	0	0%	**3**	**6%**
	5 or more years ago	1	6%	2	10%	0	0%	2	29%	0	0%	**5**	**9%**
	No response	0	--	0	--	0	--	0	--	0	--	**1**	**--**
Reasons for not getting an anal pap screening test every 1 to 3 years [2]	*(screened 4 or more years ago)*	n=25		n=29		n=1		n=5		n=4		n=65	
	Did not know I need regular anal cancer screenings	14	56%	10	36%	1	100%	2	40%	4	100%	**31**	**48%**
	Did not know about it	10	40%	11	39%	0	0%	1	20%	2	50%	**24**	**38%**
	I was told I did not need anal cancer screenings	4	16%	2	7%	0	0%	0	0%	1	25%	**7**	**11%**
	Do not know where to get it	1	4%	1	4%	0	0%	1	20%	1	25%	**4**	**6%**
	Doctor did not discuss (written in)	0	0%	2	7%	0	0%	1	20%	0	0%	**4**	**6%**
	Other response (written in) [3]	1	4%	3	11%	0	0%	0	0%	0	0%	**4**	**6%**
	Did not want to discuss with medical provider	1	4%	0	0%	0	0%	0	0%	1	25%	**2**	**3%**
	No response	0	--	1	--	0	--	0	--	0	--	**1**	**--**

[1] Hispanic/Latino (e/a/x) = of any race; White = White only; Asian = Asian or Asian and White; Black/African American = Black/African American or Black/African American and White; All Others = Middle Eastern/North African, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and non-Hispanic multi-ethnic/racial not previously described. Does not include 23 with no race/ethnicity indicated.

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: Unsure if had test (n=2), have not pursued it yet (n=1), told to wait until older (n=1).

Table D-11. Human Papilloma Virus (HPV) knowledge, screening, and vaccination by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=516)	
		Hispanic/ Latinx (n=236)		White (n=143)		Asian (n=33)		Black/ African Am. (n=45)		All Others (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%
Before today, have you ever heard of HPV?	Yes	197	84%	124	87%	29	88%	35	78%	32	89%	**430**	**84%**
	No	38	16%	19	13%	4	12%	10	22%	4	11%	**82**	**16%**
	No response	1	--	0	--	0	--	0	--	0	--	**4**	**--**
Before today, did you know that HPV could cause cancer in persons of any gender	Yes	151	64%	107	75%	23	70%	28	62%	28	78%	**348**	**68%**
	No	55	23%	24	17%	8	24%	11	24%	7	19%	**109**	**21%**
	I wasn't sure	29	12%	12	8%	2	6%	6	13%	1	3%	**55**	**11%**
	No response	1	--	0	--	0	--	0	--	0	--	**4**	**--**
Before today, ever heard of the HPV vaccine (also known as Gardasil)	Yes	160	69%	113	79%	27	82%	28	64%	32	89%	**374**	**73%**
	No	73	31%	30	21%	6	18%	16	36%	4	11%	**135**	**27%**
	No response	3	--	0	--	0	--	1	--	0	--	**7**	**--**
Ever been vaccinated for HPV (at least one dose)	Yes	90	39%	43	30%	18	55%	17	39%	18	50%	**197**	**39%**
	No	90	39%	70	49%	9	27%	22	50%	13	36%	**210**	**41%**
	Do not know	52	22%	30	21%	6	18%	5	11%	5	14%	**101**	**20%**
	No response	4	--	0	--	0	--	1	--	0	--	**8**	**--**
If yes, number of vaccine doses received	*(ever vaccinated)*	n=90		n=43		n=18		n=17		n=18		n=197	
	1 dose	11	12%	9	21%	5	28%	5	29%	6	33%	**38**	**19%**
	2 doses	21	23%	6	14%	4	22%	6	35%	3	17%	**43**	**22%**
	3 doses	31	34%	17	40%	4	22%	2	12%	7	39%	**66**	**34%**
	Unsure	27	30%	10	24%	5	28%	4	24%	2	11%	**49**	**25%**
	No response	0	--	1	--	0	--	0	--	0	--	**1**	**--**

[1] Hispanic/Latino (e/a/x) = of any race; White = White only; Asian = Asian or Asian and White; Black/African American = Black/African American or Black/African American and White; All Others = Middle Eastern/North African, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and non-Hispanic multi-ethnic/racial not previously described. Does not include 23 with no race/ethnicity indicated.

Table D-12. Liver cancer, liver cancer risks and skin cancer by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=516)	
		Hispanic/ Latinx (n=236)		White (n=143)		Asian (n=33)		Black/ African Am. (n=45)		All Others (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%
Medical professional ever told you that you are at risk for liver disease	Yes	32	14%	19	13%	3	9%	4	9%	10	29%	**70**	**14%**
	No	200	86%	122	87%	30	91%	41	91%	24	71%	**432**	**86%**
	No response	4	--	2	--	0	--	0	--	2	--	**14**	**--**
Medical professional ever discussed liver cancer	Yes	34	15%	22	16%	4	12%	9	21%	12	35%	**85**	**17%**
	No	174	76%	108	78%	26	79%	32	74%	22	65%	**373**	**75%**
	Unsure	21	9%	9	6%	3	9%	2	5%	0	0%	**37**	**7%**
	No response	7	--	4	--	0	--	2	--	2	--	**21**	**--**
Medical professional ever discussed hepatitis C testing or treatment	Yes	94	41%	67	48%	14	42%	25	56%	19	54%	**226**	**45%**
	No	112	49%	64	46%	13	39%	18	40%	14	40%	**227**	**45%**
	Unsure	23	10%	9	6%	6	18%	2	4%	2	6%	**46**	**9%**
	No response	7	--	3	--	0	--	0	--	1	--	**17**	**--**
Medical professional ever discussed hepatitis B testing or vaccination	Yes	110	48%	78	55%	15	45%	25	60%	23	64%	**258**	**52%**
	No	95	41%	55	39%	12	36%	16	38%	11	31%	**196**	**39%**
	Unsure	24	10%	9	6%	6	18%	1	2%	2	6%	**45**	**9%**
	No response	7	--	1	--	0	--	3	--	0	--	**17**	**--**
Medical professional ever discussed alcohol use and how it relates to liver cancer	Yes	107	46%	62	44%	13	39%	21	49%	19	54%	**227**	**45%**
	No	111	48%	73	52%	17	52%	21	49%	14	40%	**243**	**49%**
	Do not know	14	6%	6	4%	3	9%	1	2%	2	6%	**31**	**6%**
	No response	4	--	2	--	0	--	2	--	1	--	**15**	**--**
Medical professional ever looked over your whole body to screen for skin cancer?	Yes	27	11%	68	48%	7	21%	10	22%	17	47%	**136**	**27%**
	No	184	78%	70	49%	22	67%	35	78%	18	50%	**337**	**66%**
	Do not know	24	10%	5	3%	4	12%	0	0%	1	3%	**37**	**7%**
	No response	1	--	0	--	0	--	0	--	0	--	**6**	**--**

[1] Hispanic/Latino (e/a/x) = of any race; White = White only; Asian = Asian or Asian and White; Black/African American = Black/African American or Black/African American and White; All Others = Middle Eastern/North African, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and non-Hispanic multi-ethnic/racial not previously described. Does not include 23 with no race/ethnicity indicated.

Table D-13. Knowledge about cancer screening by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=516)	
		Hispanic/ Latinx (n=236)		White (n=143)		Asian (n=33)		Black/ African Am. (n=45)		All Others (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%
I would like to know more information about cancer screening tests	Yes	142	60%	57	40%	15	45%	21	47%	17	47%	**260**	**51%**
	No	94	40%	86	60%	18	55%	24	53%	19	53%	**251**	**49%**
	No response	0	--	0	--	0	--	0	--	0	--	**5**	**--**
I know where to get cancer screening tests	Yes	93	40%	96	67%	15	45%	27	60%	27	75%	**271**	**53%**
	No	89	38%	28	20%	14	42%	14	31%	8	22%	**155**	**30%**
	Do not know	53	23%	19	13%	4	12%	4	9%	1	3%	**84**	**16%**
	No response	1	--	0	--	0	--	0	--	0	--	**6**	**--**
I know where to get cancer screening tests from a provider who is knowledge-able about LGBTQIA+ health	Yes	75	32%	70	49%	8	24%	21	47%	22	61%	**206**	**40%**
	No	107	46%	44	31%	20	61%	16	36%	10	28%	**200**	**39%**
	Do not know	52	22%	29	20%	5	15%	8	18%	4	11%	**103**	**20%**
	No response	2	--	0	--	0	--	0	--	0	--	**7**	**--**

[1] Hispanic/Latino (e/a/x) = of any race; White = White only; Asian = Asian or Asian and White; Black/African American = Black/African American or Black/African American and White; All Others = Middle Eastern/North African, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and non-Hispanic multi-ethnic/racial not previously described. Does not include 23 with no race/ethnicity indicated.

Table D-14. Reported cancer diagnoses by race/ethnicity

Question	Response	Race/Ethnicity Category [1]										Total (n=516)	
		Hispanic/ Latinx (n=236)		White (n=143)		Asian (n=33)		Black/ African Am. (n=45)		All Others (n=36)			
		n	%	n	%	n	%	n	%	n	%	n	%
Ever diagnosed with cancer	Yes	15	6%	23	16%	1	3%	9	20%	5	14%	**56**	**11%**
	No	214	92%	118	84%	32	97%	35	78%	31	86%	**442**	**88%**
	Prefer not to answer	3	1%	0	0%	0	0%	1	2%	0	0%	**5**	**1%**
	No response	4	--	2	--	0	--	0	--	0	--	**13**	**--**
If yes, types (n=56): [2]	*(ever diagnosed)*	n=15		n=23		n=1		n=9		n=5		n=56	
	Skin	4	33%	10	50%	0	0%	0	0%	0	0%	**15**	**33%**
	Breast	2	17%	3	15%	0	0%	0	0%	1	20%	**7**	**15%**
	Cervical	1	8%	0	0%	0	0%	2	40%	1	20%	**4**	**9%**
	Prostate	0	0%	1	5%	0	0%	2	40%	0	0%	**3**	**7%**
	Anal	0	0%	3	15%	0	0%	0	0%	0	0%	**3**	**7%**
	Kidney	1	8%	1	5%	0	0%	0	0%	0	0%	**2**	**4%**
	Leukemia	0	0%	0	0%	1	100%	0	0%	0	0%	**2**	**4%**
	Thyroid	1	8%	0	0%	0	0%	1	20%	0	0%	**2**	**4%**
	Colon/Rectal	0	0%	2	10%	0	0%	0	0%	0	0%	**2**	**4%**
	Testicular	0	0%	1	5%	0	0%	0	0%	0	0%	**1**	**2%**
	"Skin endometrial"	0	0%	0	0%	0	0%	0	0%	1	20%	**1**	**2%**
	"Benign tumor in stomach"	1	8%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	"Carcinoid Tumor"	0	0%	0	0%	0	0%	1	20%	0	0%	**1**	**2%**
	Kaposi Sarcoma	0	0%	0	0%	0	0%	0	0%	1	20%	**1**	**2%**
	Liver	1	8%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Lung	0	0%	0	0%	0	0%	1	20%	0	0%	**1**	**2%**
	Lymphoma - non-Hodgkin	0	0%	1	5%	0	0%	0	0%	0	0%	**1**	**2%**
	Multiple Myeloma	1	8%	0	0%	0	0%	0	0%	0	0%	**1**	**2%**
	Ovarian Cyst (Cancerous)	0	0%	1	5%	0	0%	0	0%	0	0%	**1**	**2%**
	Primary CNS Lymphatic Brain Tumor	0	0%	0	0%	0	0%	0	0%	1	20%	**1**	**2%**
	Soft Tissue Sarcoma	0	0%	1	5%	0	0%	0	0%	0	0%	**1**	**2%**
	Type not specified	3	--	3	--	0	--	4	--	0	--	**10**	**--**

[1] Hispanic/Latino (e/a/x) = of any race; White = White only; Asian = Asian or Asian and White; Black/African American = Black/African American or Black/African American and White; All Others = Middle Eastern/North African, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and non-Hispanic multi-ethnic/racial not previously described. Does not include 23 with no race/ethnicity indicated.

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%. Ten individuals said that they had been diagnosed with cancer but did not provide information about the type.

Appendix E – Survey Data Tables by Sexual Orientation Category

Table E-1. Demographic characteristics by sexual orientation

Characteristic	Response	Sexual Orientation Category [1]						Total Sample (n=516)	
		Gay (n=225)		Lesbian (n=88)		Bisexual/ Pansexual/Queer (n=172)			
		n	%	n	%	n	%	n	%
Gender Identity	Man	207	92%	0	0%	28	16%	**239**	**46%**
	Woman	0	0%	77	89%	75	44%	**156**	**30%**
	Non-binary or gender fluid	11	5%	3	3%	34	20%	**55**	**11%**
	Transgender woman	0	0%	4	5%	9	5%	**22**	**4%**
	Genderqueer	2	1%	1	1%	9	5%	**13**	**3%**
	Transmasculine	1	0%	1	1%	9	5%	**11**	**2%**
	Two-spirit	2	1%	0	0%	2	1%	**8**	**2%**
	Transgender man	0	0%	0	0%	5	3%	**5**	**1%**
	Self-describe [2]	2	1%	1	1%	0	0%	**5**	**1%**
	No response/choose not disclose	0	--	1	--	1	--	**2**	**--**
Gender Identity Differs from Assign Birth	Not transgender	189	93%	75	89%	96	62%	**376**	**80%**
	Yes transgender	9	4%	8	10%	46	30%	**77**	**16%**
	Yes, not transgender	5	2%	1	1%	12	8%	**19**	**4%**
	Not recorded	22	--	4	--	18	--	**44**	**--**
Sex Assigned at Birth	Male	223	99%	5	6%	51	30%	**296**	**58%**
	Female	2	1%	82	94%	121	70%	**218**	**42%**
	Choose not to disclose	0	--	1	--	0	--	**2**	**--**
Sexual Orientation [3]	Gay/homosexual	223	99%	4	5%	0	0%	**227**	**45%**
	Lesbian	0	0%	82	93%	0	0%	**82**	**16%**
	Bisexual	0	0%	0	0%	74	43%	**75**	**15%**
	Queer	0	0%	0	0%	50	29%	**53**	**10%**
	Pansexual	0	0%	0	0%	48	28%	**49**	**10%**
	Asexual	0	0%	0	0%	0	0%	**12**	**2%**
	Straight/heterosexual	0	0%	0	0%	0	0%	**5**	**1%**
	Same gender loving	2	1%	2	2%	0	0%	**4**	**1%**
	Two-Spirit	0	0%	0	0%	0	0%	**3**	**1%**
	Choose not disclose/not recorded	0	--	0	--	0	--	**6**	**--**
Sexual Orientation Categorized [4]	Gay	225	100%	4	5%	0	0%	**229**	**45%**
	Lesbian	0	0%	83	94%	0	0%	**83**	**16%**
	Bisexual	0	0%	0	0%	74	43%	**75**	**15%**
	Pansexual	0	0%	0	0%	48	28%	**49**	**10%**
	Queer	0	0%	0	0%	50	29%	**53**	**10%**
	All Others	0	0%	1	1%	0	0%	**21**	**4%**
	Choose not disclose/not recorded	0	--	0	--	0	--	**6**	**--**
Categorized Gender Identity and Sex Assigned at Birth [1]	Cisgender man	206	92%	0	0%	27	16%	**237**	**46%**
	Cisgender woman	0	0%	75	86%	74	43%	**153**	**30%**
	Gender diverse female at birth	0	0%	5	6%	31	18%	**45**	**9%**
	Gender diverse male at birth	17	8%	0	0%	14	8%	**36**	**7%**
	Transgender woman or Transfemme	0	0%	6	7%	10	6%	**25**	**5%**
	Transgender man or Transmasculine	2	1%	1	1%	15	9%	**18**	**4%**
	Unknown	0	--	1	--	1	--	**2**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Self-describe: agender (n=1), gay (n=1), gay man (n=1), Mejia lesbian (n=1), woman with male brain (n=1).

[3] Self-described responses coded as follows: 'nonbinary' and 'fluid' into Queer (n=3), 'heteroflexible' into Heterosexual (n=1), 'demipansexual' into Pansexual (n=1) and 'bicurious' into Bisexual (n=1).

[4] Three 'same gender loving' responses coded as lesbian or gay; 'all others' includes: straight, asexual, two-spirit, and one same gender loving.

Table E-1. Demographic characteristics by sexual orientation, continued

Characteristic	Response	Sexual Orientation Category [1]						Total Sample (n=516)	
		Gay (n=225)		Lesbian (n=88)		Bisexual/ Pansexual/Queer (n=172)			
		n	%	n	%	n	%	n	%
Race(s) and/or Ethnicity(ies) [5]	Hispanic or Latino (a/e/x)	110	51%	34	40%	78	48%	**236**	**48%**
	White	88	41%	41	48%	73	45%	**212**	**43%**
	Black or African American	23	11%	8	9%	20	12%	**56**	**11%**
	Asian	15	7%	9	11%	17	10%	**42**	**9%**
	American Indian or Alaska Native	9	4%	7	8%	8	5%	**30**	**6%**
	Middle Eastern or North African	3	1%	3	4%	6	4%	**13**	**3%**
	Native Hawaiian or Pacific Islander	5	2%	2	2%	3	2%	**10**	**2%**
	No response	10	--	3	--	9	--	**23**	**--**
Hispanic or Latino(a/e/x) Identity(ies) [5]	*(Hispanic or Latino/a/e/x)*	n=110		n=34		n=78		n=236	
	Mexican, Mexican American, or Chicano (a/e/x)	89	82%	29	85%	61	78%	**191**	**81%**
	Other Hispanic, Latino (a/e/x) or Spanish	24	22%	6	18%	18	23%	**51**	**22%**
	Puerto Rican	6	6%	1	3%	2	3%	**9**	**4%**
	Cuban	0	0%	0	0%	4	5%	**5**	**2%**
	No response	1	--	0	--	0	--	**1**	**--**
Ethnicity Race-Ethnicity Categorized [6]	**Hispanic/Latino (e/a/x) any race(s)**	110	51%	34	40%	78	48%	**236**	**48%**
	Non-Hispanic:								
	White	63	29%	27	32%	48	29%	**143**	**29%**
	Black or African American	19	9%	6	7%	15	9%	**45**	**9%**
	Asian	12	6%	8	9%	12	7%	**33**	**7%**
	American Indian or Alaska Native	4	2%	5	6%	1	1%	**14**	**3%**
	Multiracial	3	1%	3	4%	3	2%	**10**	**2%**
	Middle Eastern or North African	1	0%	2	2%	4	2%	**7**	**1%**
	Native Hawaiian or Pacific Islander	3	1%	0	0%	2	1%	**5**	**1%**
	No Response	10	--	3	--	9	--	**23**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Self-describe: agender (n=1), gay (n=1), gay man (n=1), Mejia lesbian (n=1), woman with male brain (n=1).

[3] Self-described responses coded as follows: 'nonbinary' and 'fluid' into Queer (n=3), 'heteroflexible' into Heterosexual (n=1), 'demipansexual' into Pansexual (n=1) and 'bicurious' into Bisexual (n=1).

[4] Three 'same gender loving' responses coded as lesbian or gay; 'all others' includes: straight, asexual, two-spirit, and one same gender loving.

[5] Participants may choose all that apply; as such, totals may sum to greater than the number of respondents and more than 100%.

[6] Hispanic/Latino (e/a/x) = of any race; White = no other race; Asian, Black/African American, American Indian/Alaskan Native, Middle Eastern/North African, Native Hawaiian/Pacific Islander include those who indicated no other race or White; Multiracial includes two or more of the non-White races, or two or more of the non-White races and White.

Table E-1. Demographic characteristics by sexual orientation, continued

Characteristic	Response	Sexual Orientation Category [1]						Total Sample (n=516)	
		Gay (n=225)		Lesbian (n=88)		Bisexual/ Pansexual/Queer (n=172)			
		n	%	n	%	n	%	n	%
Preferred Language	English	175	79%	73	85%	144	85%	**413**	**82%**
	Español/Spanish	45	20%	13	15%	23	14%	**87**	**17%**
	Another [7]	1	0%	0	0%	2	1%	**6**	**1%**
	No response	4	--	2	--	3	--	**10**	**--**
Age	18-29 years	44	20%	27	31%	80	47%	**158**	**31%**
	30-39 years	61	27%	22	25%	52	30%	**139**	**27%**
	40-44 years	24	11%	4	5%	10	6%	**40**	**8%**
	45-49 years	9	4%	6	7%	7	4%	**22**	**4%**
	50-59 years	39	17%	10	11%	9	5%	**67**	**13%**
	60-69 years	25	11%	14	16%	9	5%	**57**	**11%**
	70 years or over	22	10%	5	6%	4	2%	**31**	**6%**
	No response	1	--	0	--	1	--	**2**	**--**
Combined Annual Income *(total pre-tax all sources; you and partner/ spouse if live together)*	$0 to $9,999	28	13%	7	9%	31	20%	**75**	**16%**
	$10,000 to $14,999	9	4%	2	3%	10	6%	**27**	**6%**
	$15,000 to $19,999	12	6%	2	3%	10	6%	**25**	**5%**
	$20,000 to $34,999	27	13%	7	9%	22	14%	**60**	**13%**
	$35,000 to $49,999	28	13%	10	13%	22	14%	**61**	**13%**
	$50,000 to $74,999	33	16%	10	13%	27	17%	**73**	**16%**
	$75,000 to $99,999	25	12%	13	17%	15	9%	**54**	**12%**
	$100,000 to $199,999	41	20%	16	21%	16	10%	**74**	**16%**
	$200,000 or more	5	2%	9	12%	5	3%	**19**	**4%**
	No response/refuse	17	--	12	--	14	--	**48**	**--**
Live in or Get Health Care in San Diego County	Live *and* health care	214	95%	79	90%	163	95%	**487**	**94%**
	Live and *no* health care	9	4%	8	9%	9	5%	**26**	**5%**
	Do *not* live but get health care	2	1%	1	1%	0	0%	**3**	**1%**
Region of Residence San Diego County [8]	Central	127	57%	25	29%	57	34%	**227**	**45%**
	North Central	32	14%	11	13%	23	14%	**69**	**14%**
	North Coastal	12	5%	8	9%	25	15%	**50**	**10%**
	East	15	7%	14	16%	17	10%	**47**	**9%**
	North Inland	11	5%	14	16%	16	10%	**43**	**8%**
	South	16	7%	10	11%	12	7%	**39**	**8%**
	Southeast	8	4%	5	6%	17	10%	**31**	**6%**
	Not recorded (zip code)	4	--	1	--	5	--	**10**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Self-describe: agender (n=1), gay (n=1), gay man (n=1), Mejia lesbian (n=1), woman with male brain (n=1).

[3] Self-described responses coded as follows: 'nonbinary' and 'fluid' into Queer (n=3), 'heteroflexible' into Heterosexual (n=1), 'demipansexual' into Pansexual (n=1) and 'bicurious' into Bisexual (n=1).

[4] Three 'same gender loving' responses coded as lesbian or gay; 'all others' includes: straight, asexual, two-spirit, and one same gender loving.

[5] Participants may choose all that apply; as such, totals may sum to greater than the number of respondents and more than 100%.

[6] Hispanic/Latino (e/a/x) = of any race; White = no other race; Asian, Black/African American, American Indian/Alaskan Native, Middle Eastern/North African, Native Hawaiian/Pacific Islander include those who indicated no other race or White; Multiracial includes two or more of the non-White races, or two or more of the non-White races and White.

[7] Another: Both English and Spanish (n=3), ASL (n=1), Portuguese (n=1), not specified (n=1).

[8] San Diego County Health and Human Services Agency service regions; the southeast area is part of the Central region put separated for informational purposes.

Table E-2. General healthcare information by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=516)	
		Gay (n=225)		Lesbian (n=88)		Bisexual/ Nonbinary Pansexual/Queer (n=172)			
		n	%	n	%	n	%	n	%
Currently Have Health Care Coverage	Yes	198	90%	67	79%	141	82%	**432**	**85%**
	No	23	10%	18	21%	30	18%	**76**	**15%**
	No response	4	--	3	--	1	--	**8**	**--**
Main Sources of Health Care Coverage [2]	(had health care coverage)	n=198		n=67		n=141		n=432	
	A plan purchased through (or provided by) an employer or union	96	49%	40	61%	72	51%	**214**	**50%**
	Medi-Cal, Medicaid, or other state program	62	32%	14	21%	58	41%	**149**	**35%**
	Medicare	37	19%	8	12%	12	9%	**62**	**14%**
	A plan that you, or another family member, buys on your own	12	6%	5	8%	5	4%	**23**	**5%**
	Some other source (not specified)	8	4%	4	6%	5	4%	**18**	**4%**
	TRICARE (formerly CHAMPUS), VA, or military	4	2%	4	6%	2	1%	**12**	**3%**
	Alaska Native, Indian Health Services, or Tribal Health Services	0	0%	0	0%	1	1%	**1**	**0%**
	No response	2	--	1	--	0	--	**3**	**--**
Health Care Coverage Categorized (mutually exclusive) [3]	Through employment or purchased	108	49%	43	51%	77	45%	**235**	**47%**
	State program	45	21%	11	13%	49	29%	**117**	**23%**
	No health care coverage	23	11%	18	21%	30	18%	**76**	**15%**
	Medicare	35	16%	7	8%	10	6%	**57**	**11%**
	All others	8	4%	5	6%	5	3%	**20**	**4%**
	No response	6	--	4	--	1	--	**11**	**--**
When Was Last General Health Checkup	Within the past year	174	78%	51	59%	128	76%	**382**	**75%**
	Between 1-2 years ago	35	16%	26	30%	30	18%	**91**	**18%**
	Between 3-5 years ago	8	4%	6	7%	9	5%	**24**	**5%**
	6 or more years ago	6	3%	3	3%	1	1%	**11**	**2%**
	I don't know	2	--	2	--	4	--	**8**	**--**
Was Last General Health Checkup in San Diego County	Yes	200	94%	72	92%	153	94%	**453**	**94%**
	No	12	6%	6	8%	9	6%	**29**	**6%**
	No response	13	--	10	--	10	--	**34**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Mutually exclusive categories: (1) Employment/purchased (and any other response), (2) Medicare and any other response except employment/purchased, (3) Medi-Cal/Medicaid/state program and any other responses employment/purchased and Medicare, and (4) all others.

Table E-3. Experiences with most visited medical doctor/provider for general medical needs by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=516)	
		Gay (n=225)		Lesbian (n=88)		Bisexual/ Nonbinary Pansexual/Queer (n=172)			
		n	%	n	%	n	%	n	%
At what type of medical practice do you usually receive your care?	Health system	155	70%	56	64%	90	52%	**313**	**61%**
	Community clinic	54	24%	20	23%	72	42%	**162**	**32%**
	Veterans or military health system	5	2%	8	9%	5	3%	**20**	**4%**
	Another [2]	9	4%	4	5%	5	3%	**19**	**4%**
	No response	2	--	0	--	0	--	**2**	**--**
Is the medical doctor/ provider you visit most often for general medical care aware of your LGBTQIA+ status?	Yes	193	88%	52	61%	98	58%	**362**	**72%**
	No	11	5%	17	20%	44	26%	**79**	**16%**
	Don't know	15	7%	16	19%	27	16%	**63**	**13%**
	No response	6	--	3	--	3	--	**12**	**--**
How long have you been a patient of this medical doctor/ provider?	Less than 3 months	25	11%	6	7%	27	16%	**63**	**12%**
	3 months to 1 year	38	17%	13	15%	36	21%	**93**	**18%**
	1-2 years	52	23%	24	28%	39	23%	**121**	**24%**
	3 or more years	105	47%	40	46%	65	38%	**224**	**44%**
	I don't know	4	2%	4	5%	4	2%	**12**	**2%**
	No response	1	--	1	--	1	--	**3**	**--**
How knowledgeable is the doctor/provider you visit most often (for general medical care) about LGBTQIA+ medical needs?	Extremely knowledgeable	109	49%	16	18%	43	25%	**181**	**35%**
	Moderately knowledgeable	44	20%	14	16%	22	13%	**84**	**16%**
	Somewhat knowledgeable	31	14%	13	15%	27	16%	**74**	**14%**
	Slightly knowledgeable	16	7%	8	9%	12	7%	**36**	**7%**
	Not at all knowledgeable	5	2%	11	13%	10	6%	**28**	**5%**
	I do not know	18	8%	26	30%	56	33%	**109**	**21%**
	No response	2	--	0	--	2	--	**4**	**--**
How comfortable are you with the medical doctor/provider you visit most often for general medical care?	Extremely comfortable	130	58%	29	33%	67	39%	**244**	**48%**
	Moderately comfortable	53	24%	23	26%	38	22%	**118**	**23%**
	Somewhat comfortable	26	12%	18	21%	31	18%	**79**	**15%**
	Slightly comfortable	10	4%	10	11%	23	14%	**46**	**9%**
	Not at all comfortable	3	1%	5	6%	5	3%	**14**	**3%**
	I do not know	2	1%	2	2%	6	4%	**11**	**2%**
	No response	1	--	1	--	2	--	**4**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Other: non-profit HIV medical care (n=4), physician - general or family (n=3), non-profit healthcare network (n=2), private clinic (n=2), school clinic (n=1), group practice (n=1), none (n=1), not specified (n=5).

Table E-4. Cancer screening eligibility based on age and self-assessment, among those who are LGBTQIA+ and live or get health care in San Diego County by sexual orientation

Cancer Screening Question Self-Assessment	(sample) Response	Sexual Orientation Category [1]						Total Sample [2] (n=516)	
		Gay (n=225)		Lesbian (n=88)		Bisexual/ Pansexual/Queer (n=172)			
		n	%	n	%	n	%	n	%
Cervical: The cervix is the end of the uterus that connects to the vagina in persons who have a vagina. **Do you have a uterus or a cervix?**	*(female at birth)*	n=2		n=82		n=121		n=218	
	Yes	2	100%	77	94%	109	90%	**201**	**92%**
	No	0	0%	5	6%	12	10%	**17**	**8%**
Breast: Breast cancer screening is appropriate for: (7) Cisgender women and anyone assigned female at birth who has not had both breasts removed, such as through top surgery or a double mastectomy (8) Transgender women or people of any gender identity who have been taking feminizing hormones [FHT]/hormone therapy [HR] (such as estrogen) for at least 5 years **Based on this information, does breast cancer screening apply to you?**	*(age 40 and older)*	n=119		n=39		n=39		n=217	
	Yes	3	3%	35	90%	26	67%	**71**	**33%**
	No	115	97%	4	10%	13	33%	**144**	**67%**
	No response	1	--	0	--	0	--	**2**	**--**
Prostate: Prostate cancer screening may be appropriate for any person who has a prostate, which includes: (7) Cisgender men (8) Transgender women, including transgender women who have had vaginoplasty or orchiectomy (9) Anyone of any gender identity who was assigned male at birth **Based on this information, does prostate cancer screening apply to you?**	*(age 40 and older male at birth)*	n=119		n=3		n=13		n=151	
	Yes	103	87%	3	100%	12	92%	**131**	**87%**
	No	15	13%	0	0%	1	8%	**19**	**13%**
	No response	1	--	0	--	0	--	**1**	**--**
Lung: Lung cancer screening is appropriate for people who: (7) Have a 20 pack-year history of smoking (1 pack a day for 20 years or 2 packs a day for 10 years, etc.) (8) AND have smoked in the past 15 years (including currently smoke) **Based on this information, does lung cancer screening apply to you?**	*(age 45 and older)*	n=95		n=35		n=29		n=177	
	Yes	20	21%	7	20%	9	31%	**39**	**22%**
	No	74	79%	28	80%	20	69%	**136**	**78%**
	No response	1	--	0	--	0	--	**2**	**--**
Anal: Anal cancer screening is appropriate for people who: (9) Are living with HIV, OR (10) Have been diagnosed with human papillomavirus (HPV), OR (11) Are immunocompromised, OR (12) Practice the receptive role during anal intercourse (penis inserted into your anus) **Based on this information, does anal cancer screening apply to you?**	*(age 35 and older)*	n=141		n=49		n=60		n=271	
	Yes	79	57%	3	6%	18	30%	**113**	**42%**
	No	60	43%	46	94%	42	70%	**156**	**58%**
	No response	2	--	0	--	0	--	**3**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Total sample is 516 and 2 did not report their age:

- 271 were aged 35 and over
- 217 were aged 40 and over
- 177 were aged 45 and over

Table E-5. Cervical cancer screening among females at birth who self-assessed as having a cervix or uterus by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=201)	
		Gay (n=2)		Lesbian (n=77)		Bisexual/ Pansexual/Queer (n=109)			
		n	%	n	%	n	%	n	%
Medical professional ever talked to you about cervical cancer screening	Yes	1	50%	58	75%	76	70%	**146**	**73%**
	No	1	50%	19	25%	33	30%	**55**	**27%**
Ever had a cervical cancer screening test	Yes	1	50%	53	69%	66	61%	**130**	**65%**
	No	1	50%	24	31%	43	39%	**71**	**35%**
If had a cervical cancer screening test, experience was…	*(screened)*	n=1		n=53		n=66		n=130	
	Very respectful	0	0%	40	78%	48	75%	**96**	**76%**
	Somewhat respectful	1	100%	10	20%	14	22%	**27**	**21%**
	Not respectful	0	0%	1	2%	2	3%	**3**	**2%**
	No response	0	--	2	--	2	--	**4**	**--**
How many years ago was last cervical cancer screening test	*(screened)*	n=1		n=53		n=66		n=130	
	1 year ago or less	1	100%	25	47%	39	60%	**73**	**57%**
	2 years	0	0%	13	25%	15	23%	**28**	**22%**
	3 years	0	0%	8	15%	10	15%	**18**	**14%**
	4 years	0	0%	2	4%	0	0%	**2**	**2%**
	5 years	0	0%	1	2%	1	2%	**2**	**2%**
	6 or more years ago	0	0%	4	8%	0	0%	**6**	**5%**
	No response	0	--	0	--	1	--	**1**	**--**
Reasons for not getting cervical cancer screening every 1-3 years [2]	*(screening 4 or more years ago or not screened)*	n=1		n=31		n=44		n=81	
	Did not know I need regular cervical screenings	0	0%	15	56%	28	70%	**45**	**62%**
	Did not want to discuss with medical provider	1	100%	4	15%	5	13%	**11**	**15%**
	Told to screen every 5 years	0	0%	3	11%	7	18%	**10**	**14%**
	Told that I do not need (or no longer need)	0	0%	5	19%	2	5%	**8**	**11%**
	Other response (written in) [3]	0	0%	1	4%	3	8%	**5**	**7%**
	No response	0	--	4	--	4	--	**8**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: Uncomfortable (n=2 due to gender dysphoria, not like being touched), low risk (n=1); lack of time (n=1); need new primary care physician (n=1).

Table E-6. Breast cancer screening among those aged 40 and over who self-assessed as eligible by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=71)	
		Gay (n=3)		Lesbian (n=35)		Bisexual/ Pansexual/Queer (n=26)			
		n	%	n	%	n	%	n	%
Medical professional ever talked to you about a mammogram	Yes	1	33%	34	97%	25	96%	**67**	**94%**
	No	2	67%	1	3%	1	4%	**4**	**6%**
Ever had a mammogram	Yes	0	0%	29	83%	21	81%	**56**	**80%**
	No	2	100%	6	17%	5	19%	**14**	**20%**
	No response	1	--	0	--	0	--	**1**	**--**
If had a mammogram, experience was…	*(had mammogram)*	n=0		n=29		n=21		n=56	
	Very respectful	0	0%	25	93%	16	76%	**46**	**85%**
	Somewhat respectful	0	0%	2	7%	5	24%	**8**	**15%**
	No response	0	--	2	--	0	--	**2**	**--**
How many years ago was last mammogram	*(had mammogram)*	n=0		n=29		n=21		n=56	
	1 year ago or less	0	0%	25	86%	15	71%	**43**	**77%**
	2 years ago	0	0%	3	10%	5	24%	**9**	**16%**
	3 years ago	0	0%	1	3%	0	0%	**2**	**4%**
	4 years ago	0	0%	0	0%	1	5%	**1**	**2%**
	5 or more years ago	0	0%	0	0%	0	0%	**1**	**2%**
Reasons for not getting mammograms every 1-2 years [2]	*(had mammogram 3 or more years ago)*	n=2		n=7		n=6		n=18	
	Other response (written in) [3]	1	100%	2	33%	1	17%	**6**	**38%**
	Newly eligible (written in)	0	0%	1	17%	2	33%	**3**	**19%**
	Procrastination/forget (written in)	0	0%	2	33%	1	17%	**3**	**19%**
	Told that I do not need	0	0%	1	17%	1	17%	**2**	**13%**
	Did not want to discuss with medical provider	0	0%	0	0%	1	17%	**1**	**6%**
	Did not know I need regular mammograms	0	0%	0	0%	0	0%	**1**	**6%**
	No response	1	--	1	--	0	--	**2**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: cost (n=1), reluctance based on past experiences (n=1), mammograms are unsafe (n=1), personal choice (n=1), still too firm (n=1), scheduling (n=1).

Table E-7. Prostate cancer screening among those aged 40 and older, male at birth, and self-assessed as eligible by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=131)	
		Gay (n=103)		Lesbian (n=3)		Bisexual/ Pansexual/Queer (n=12)			
		n	%	n	%	n	%	n	%
Medical professional ever talked to you about prostate cancer screening, or PSA [2]	Yes	79	77%	2	67%	8	67%	**100**	**76%**
	No	24	23%	1	33%	4	33%	**31**	**24%**
Ever had a PSA test	Yes	69	67%	2	67%	7	58%	**88**	**67%**
	No	34	33%	1	33%	5	42%	**43**	**33%**
If had a PSA test, experience was…	*(had PSA test)*	n=69		n=2		n=7		n=88	
	Very respectful	64	94%	2	100%	6	100%	**82**	**95%**
	Somewhat respectful	3	4%	0	0%	0	0%	**3**	**3%**
	Not respectful	1	1%	0	0%	0	0%	**1**	**1%**
	No response	1	--	0	--	1	--	**2**	**--**
How many years ago was last PSA test	*(had PSA test)*	n=69		n=2		n=7		n=88	
	1 year ago or less	43	64%	2	100%	4	57%	**56**	**65%**
	2 years ago	9	13%	0	0%	3	43%	**14**	**16%**
	3 years ago	5	7%	0	0%	0	0%	**5**	**6%**
	4 years ago	4	6%	0	0%	0	0%	**4**	**5%**
	5 or more years ago	6	9%	0	0%	0	0%	**7**	**8%**
	No response	2	--	0	--	0	--	**2**	**--**
Reasons for not getting PSA test every 1-2 years [3]	*(PSA test 3 or more years ago)*	n=49		n=1		n=5		n=59	
	Did not know I needed regular PSA tests	27	61%	1	100%	5	100%	**36**	**67%**
	Told not to get PSA tests	11	25%	0	0%	1	20%	**12**	**22%**
	Did not want to discuss with medical provider	4	9%	0	0%	0	0%	**5**	**9%**
	Other response (written in) [4]	2	5%	0	0%	0	0%	**2**	**4%**
	Doctor did not discuss (written in)	1	2%	0	0%	0	0%	**1**	**2%**
	No response	5	--	0	--	0	--	**5**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] PSA = Prostate Specific Antigen.

[3] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[4] Other write-in responses included: I already had prostate cancer (n=1), I have one in February 2025 (n=1).

Table E-8. Colon cancer screening among those aged 45 or older by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=177)	
		Gay (n=95)		Lesbian (n=35)		Bisexual/ Nonbinary Pansexual/Queer (n=29)			
		n	%	n	%	n	%	n	%
Has medical professional ever talked to you about colon cancer screening	Yes	86	91%	27	77%	24	83%	**153**	**87%**
	No	8	9%	8	23%	5	17%	**22**	**13%**
	No response	1	--	0	--	0	--	**2**	**--**
Ever done the blood stool test	Yes	68	72%	21	60%	18	62%	**122**	**70%**
	No	26	28%	14	40%	11	38%	**53**	**30%**
	No response	1	--	0	--	0	--	**2**	**--**
How many years ago was your last blood stool test	*(had blood stool test)*	n=68		n=21		n=18		n=122	
	1 year ago or less	35	53%	9	45%	10	56%	**64**	**54%**
	2 years ago	9	14%	3	15%	4	22%	**18**	**15%**
	3 years ago	11	17%	2	10%	3	17%	**17**	**14%**
	4 years ago	6	9%	1	5%	0	0%	**8**	**7%**
	5 or more years ago	5	8%	5	25%	1	6%	**12**	**10%**
	No response	2	--	1	--	0	--	**3**	**--**
Ever had a colonoscopy	Yes	73	78%	21	60%	20	69%	**128**	**73%**
	No	21	22%	14	40%	9	31%	**47**	**27%**
	No response	1	--	0	--	0	--	**2**	**--**
If had a colonoscopy test, experience was…	*(had colonoscopy)*	n=73		n=21		n=20		n=128	
	Very respectful	63	91%	16	84%	20	100%	**110**	**90%**
	Somewhat respectful	5	7%	3	16%	0	0%	**11**	**9%**
	Not respectful	1	1%	0	0%	0	0%	**1**	**1%**
	No response	4	--	2	--	0	--	**6**	**--**
How many years ago was last colonoscopy	*(had colonoscopy)*	n=73		n=21		n=20		n=128	
	1 year ago or less	22	31%	8	40%	5	25%	**40**	**32%**
	2 to 5 years	33	46%	8	40%	11	55%	**60**	**48%**
	6 to 10 years	15	21%	2	10%	3	15%	**21**	**17%**
	11 or more years ago	2	3%	2	10%	1	5%	**5**	**4%**
	No response	1	--	1	--	0	--	**2**	**--**
Reasons for not getting a blood stool test every year, or colonoscopy every 10 years [2]	*(colonoscopy > 10 years ago and blood stool not every year)*	n=12		n=12		n=7		n=32	
	Did not know need regular stool tests or colonoscopy	7	64%	3	38%	4	67%	**15**	**58%**
	Told colonoscopy not needed	0	0%	1	13%	2	33%	**3**	**12%**
	Told stool blood test not needed	1	9%	1	13%	0	0%	**2**	**8%**
	Procrastination (written in)	1	9%	2	25%	0	0%	**3**	**12%**
	Other response (written in) [3]	2	18%	1	13%	0	0%	**3**	**12%**
	Did not want to discuss with medical provider	1	9%	0	0%	0	0%	**1**	**4%**
	No response	1	--	4	--	1	--	**6**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: do not like them/uncomfortable (n=2), single gay man no one to drop me off and pick up, and ride-share not allowed (n=1).

Table E-9. Lung cancer screening among those aged 45 and older who self-assessed as eligible by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=39)	
		Gay (n=20)		Lesbian (n=7)		Bisexual/ Pansexual/Queer (n=9)			
		n	%	n	%	n	%	n	%
Medical professional talked about screening for lung cancer	Yes	11	55%	3	43%	6	67%	**23**	**59%**
	No	9	45%	4	57%	3	33%	**16**	**41%**
Ever had a lung cancer screening	Yes	10	50%	4	57%	3	33%	**20**	**51%**
	No	10	50%	3	43%	6	67%	**19**	**49%**
If had lung cancer screening, experience was…	*(screened)*	n=10		n=4		n=3		n=20	
	Very respectful	10	100%	2	67%	3	100%	**18**	**95%**
	Somewhat respectful	0	0%	1	33%	0	0%	**1**	**5%**
	No response	0	--	1	--	0	--	**1**	**--**
How many years ago was last lung cancer screening	*(screened)*	n=10		n=4		n=3		n=20	
	1 year ago or less	5	50%	3	75%	2	67%	**13**	**65%**
	2 years ago	1	10%	0	0%	1	33%	**2**	**10%**
	3 years ago	2	20%	0	0%	0	0%	**2**	**10%**
	4 years ago	1	10%	0	0%	0	0%	**1**	**5%**
	5 or more years ago	1	10%	1	25%	0	0%	**2**	**10%**
Reasons for not getting a lung cancer screening every year [2]	*(screened 2 or more years ago)*	n=15		n=4		n=7		n=26	
	Did not know I need regular lung cancer screening	7	54%	1	33%	5	100%	**13**	**62%**
	Told lung cancer screening not needed	4	31%	2	67%	0	0%	**6**	**29%**
	Did not want to discuss with medical provider	1	8%	0	0%	0	0%	**1**	**5%**
	Other response (written in) [3]	1	8%	0	--	0	--	**1**	**5%**
	No response	2	--	1	--	2	--	**5**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: 'I am tested regularly' (n=1 who indicated test was 4 years ago).

Table E-10. Anal cancer screening among those aged 35 and older who self-assessed as eligible for screening by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=113)	
		Gay (n=79)		Lesbian (n=3)		Bisexual/ Pansexual/Queer (n=18)			
		n	%	n	%	n	%	n	%
Medical professional talked about screening for anal cancer	Yes	42	54%	1	33%	10	56%	**64**	**57%**
	No	36	46%	2	67%	8	44%	**48**	**43%**
	No response	1	--	0	--	0	--	**1**	**--**
Ever had an anal pap screening test	Yes	37	47%	0	0%	7	39%	**55**	**49%**
	No	41	53%	3	100%	11	61%	**57**	**51%**
	No response	1	--	0	--	0	--	**1**	**--**
If had anal pap screening test, experience was…	*(screened)*	n=37		n=0		n=7		n=55	
	Very respectful	32	97%	0	0%	5	100%	**48**	**98%**
	Somewhat respectful	1	3%	0	0%	0	0%	**1**	**2%**
	Not respectful	0	0%	0	0%	0	0%	**0**	**0%**
	No response	4	--	0	--	2	--	**6**	**--**
How many years ago was last anal pap screening test	*(screened)*	n=37		n=0		n=7		n=55	
	1 year ago or less	20	54%	0	0%	5	83%	**32**	**59%**
	2 years ago	7	19%	0	0%	1	17%	**10**	**19%**
	3 years ago	4	11%	0	0%	0	0%	**4**	**7%**
	4 years ago	2	5%	0	0%	0	0%	**3**	**6%**
	5 or more years ago	4	11%	0	0%	0	0%	**5**	**9%**
	No response	0	--	0	--	1	--	**1**	**--**
Reasons for not getting an anal pap screening test every 1 to 3 years [2]	*(screened 4 or more years ago)*	n=47		n=3		n=11		n=65	
	Did not know I need regular anal cancer screenings	20	43%	3	100%	6	60%	**31**	**48%**
	Did not know about it	16	34%	1	33%	4	40%	**24**	**38%**
	I was told I did not need anal cancer screenings	5	11%	0	0%	2	20%	**7**	**11%**
	Do not know where to get it	3	6%	0	0%	1	10%	**4**	**6%**
	Doctor did not discuss (written in)	4	9%	0	0%	0	0%	**4**	**6%**
	Other response (written in) [3]	4	9%	0	0%	0	0%	**4**	**6%**
	Did not want to discuss with medical provider	1	2%	0	0%	1	10%	**2**	**3%**
	No response	0	--	0	--	1	--	**1**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%.

[3] Other write-in responses included: Unsure if had test (n=2), have not pursued it yet (n=1), told to wait until older (n=1).

Table E-11. Human Papilloma Virus (HPV) knowledge, screening, and vaccination by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=516)	
		Gay (n=225)		Lesbian (n=88)		Bisexual/ Pansexual/Queer (n=172)			
		N	%	n	%	n	%	n	%
Before today, have you ever heard of HPV?	Yes	178	80%	76	86%	153	89%	**430**	**84%**
	No	45	20%	12	14%	18	11%	**82**	**16%**
	No response	2	--	0	--	1	--	**4**	**--**
Before today, did you know that HPV could cause cancer in persons of any gender	Yes	152	68%	60	68%	119	70%	**348**	**68%**
	No	47	21%	18	20%	36	21%	**109**	**21%**
	I wasn't sure	24	11%	10	11%	16	9%	**55**	**11%**
	No response	2	--	0	--	1	--	**4**	**--**
Before today, ever heard of the HPV vaccine (also known as Gardasil)	Yes	158	72%	70	80%	129	75%	**374**	**73%**
	No	62	28%	18	20%	42	25%	**135**	**27%**
	No response	5	--	0	--	1	--	**7**	**--**
Ever been vaccinated for HPV (at least one dose)	Yes	71	32%	30	34%	87	51%	**197**	**39%**
	No	98	45%	44	50%	51	30%	**210**	**41%**
	Do not know	50	23%	14	16%	33	19%	**101**	**20%**
	No response	6	--	0	--	1	--	**8**	**--**
If yes, number of vaccine doses received	*(ever vaccinated)*	n=71		n=30		n=87		n=197	
	1 dose	16	23%	2	7%	16	18%	**38**	**19%**
	2 doses	14	20%	8	27%	20	23%	**43**	**22%**
	3 doses	22	31%	15	50%	28	32%	**66**	**34%**
	Unsure	18	26%	5	17%	23	26%	**49**	**25%**
	No response	1	--	0	--	0	--	**1**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

Table E-12. Liver cancer, liver cancer risks and skin cancer by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=516)	
		Gay (n=225)		Lesbian (n=88)		Bisexual/ Pansexual/Queer (n=172)			
		n	%	n	%	n	%	n	%
Medical professional ever told you that you are at risk for liver disease	Yes	38	18%	9	10%	15	9%	**70**	**14%**
	No	178	82%	77	90%	155	91%	**432**	**86%**
	No response	9	--	2	--	2	--	**14**	**--**
Medical professional ever discussed liver cancer	Yes	44	20%	7	8%	26	16%	**85**	**17%**
	No	158	72%	70	84%	128	77%	**373**	**75%**
	Unsure	16	7%	6	7%	12	7%	**37**	**7%**
	No response	7	--	5	--	6	--	**21**	**--**
Medical professional ever discussed hepatitis C testing or treatment	Yes	125	57%	19	23%	66	40%	**226**	**45%**
	No	76	35%	58	70%	82	49%	**227**	**45%**
	Unsure	18	8%	6	7%	19	11%	**46**	**9%**
	No response	6	--	5	--	5	--	**17**	**--**
Medical professional ever discussed hepatitis B testing or vaccination	Yes	141	64%	27	32%	74	45%	**258**	**52%**
	No	64	29%	52	62%	71	43%	**196**	**39%**
	Unsure	16	7%	5	6%	21	13%	**45**	**9%**
	No response	4	--	4	--	6	--	**17**	**--**
Medical professional ever discussed alcohol use and how it relates to liver cancer	Yes	105	48%	36	42%	73	44%	**227**	**45%**
	No	101	46%	43	51%	85	51%	**243**	**49%**
	Do not know	15	7%	6	7%	9	5%	**31**	**6%**
	No response	4	--	3	--	5	--	**15**	**--**
Medical professional ever looked over your whole body to screen for skin cancer?	Yes	77	35%	20	23%	34	20%	**136**	**27%**
	No	131	59%	62	71%	123	72%	**337**	**66%**
	Do not know	14	6%	5	6%	14	8%	**37**	**7%**
	No response	3	--	1	--	1	--	**6**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

Table E-13. Knowledge about cancer screening by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=516)	
		Gay (n=225)		Lesbian (n=88)		Bisexual/ Pansexual/Queer (n=172)			
		n	%	n	%	n	%	n	%
I would like to know more information about cancer screening tests	Yes	117	53%	38	43%	89	52%	**260**	**51%**
	No	105	47%	50	57%	82	48%	**251**	**49%**
	No response	3	--	0	--	1	--	**5**	**--**
I know where to get cancer screening tests	Yes	120	54%	46	53%	87	51%	**271**	**53%**
	No	67	30%	28	32%	52	30%	**155**	**30%**
	Do not know	35	16%	13	15%	32	19%	**84**	**16%**
	No response	3	--	1	--	1	--	**6**	**--**
I know where to get cancer screening tests from a provider who is knowledge-able about LGBTQIA+ health	Yes	108	49%	32	37%	54	32%	**206**	**40%**
	No	77	35%	37	43%	76	44%	**200**	**39%**
	Do not know	36	16%	18	21%	41	24%	**103**	**20%**
	No response	4	--	1	--	1	--	**7**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

Table E-14. Reported cancer diagnoses by sexual orientation

Question	Response	Sexual Orientation Category [1]						Total Sample (n=516)	
		Gay (n=225)		Lesbian (n=88)		Bisexual/ Pansexual/Queer (n=172)			
		n	%	n	%	n	%	n	%
Ever diagnosed with cancer	Yes	25	11%	10	12%	12	7%	**56**	**11%**
	No	193	88%	73	88%	155	91%	**442**	**88%**
	Prefer not to answer	1	0%	0	0%	4	2%	**5**	**1%**
	No response	6	--	5	--	1	--	**13**	**--**
If yes, types (n=56): [2]	*(ever diagnosed)*	n=25		n=10		n=12		n=56	
	Skin	10	48%	1	13%	2	18%	**15**	**33%**
	Breast	0	0%	4	50%	2	18%	**7**	**15%**
	Cervical	0	0%	2	25%	2	18%	**4**	**9%**
	Prostate	3	14%	0	0%	0	0%	**3**	**7%**
	Anal	1	5%	0	0%	2	18%	**3**	**7%**
	Kidney	2	10%	0	0%	0	0%	**2**	**4%**
	Leukemia	2	10%	0	0%	0	0%	**2**	**4%**
	Thyroid	1	5%	0	0%	1	9%	**2**	**4%**
	Colon/Rectal	1	5%	0	0%	1	9%	**2**	**4%**
	Testicular	1	5%	0	0%	0	0%	**1**	**2%**
	"Skin endometrial"	0	0%	0	0%	0	0%	**1**	**2%**
	"Benign tumor in stomach"	0	0%	0	0%	0	0%	**1**	**2%**
	"Carcinoid Tumor"	0	0%	0	0%	1	9%	**1**	**2%**
	Kaposi Sarcoma	1	5%	0	0%	0	0%	**1**	**2%**
	Liver	0	0%	0	0%	1	9%	**1**	**2%**
	Lung	0	0%	0	0%	1	9%	**1**	**2%**
	Lymphoma - non-Hodgkin	1	5%	0	0%	0	0%	**1**	**2%**
	Multiple Myeloma	1	5%	0	0%	0	0%	**1**	**2%**
	Ovarian Cyst (Cancerous)	0	0%	1	13%	0	0%	**1**	**2%**
	Primary CNS Lymphatic Brain Tumor	0	0%	0	0%	0	0%	**1**	**2%**
	Soft Tissue Sarcoma	0	0%	0	0%	1	9%	**1**	**2%**
	Type not specified	4	--	2	--	1	--	**10**	**--**

[1] As identified by participant although 5 individuals choosing 'gay' or 'same gender loving' were further separated into 'gay' (cis/transgender man and gender diverse male at birth) and 'lesbian' (cis/transgender women and transmasculine or gender diverse woman at birth). Does not include 31 responses of: asexual (n=12), other (n=8 written in), choose not to disclose (n=4), straight-heterosexual (n=4), and two-spirit (n=3).

[2] Participants could choose more than one response; as such, totals may be greater than the number of respondents and more than 100%. Ten individuals said that they had been diagnosed with cancer but did not provide information about the type.

Appendix F – Needs Assessment Survey Qualitative Responses

Health Care Organizations Recommended

Table F-1. Health care organizations recommended as providing safe and competent care for LGTBQIA+ people

Please let us know of any health care agencies, clinics, or doctors that you would recommend as providing safe and competent care for LGBTQIA+ people? Categorized responses from open-ended question (n=292 responders)	Number Responding Similarly [1]
Health Care Systems (UCSD Health, Kaiser Permanente, Sharp HealthCare, Scripps Health, Planned Parenthood, University of California Irvine)	125
Community Health Centers (Family Health Centers of San Diego, Vista Community Clinic, San Ysidro Health, La Maestra Community Health Centers, TrueCare, Neighborhood Healthcare)	123
HIV Health Care Clinics (Owen Clinic, AIDS Healthcare Foundation)	63
Supportive Service Programs (various programs, community centers, and supportive health providers (dentistry, mental health, midwife, behavioral health) serving the LGBTQIA+ community)	22
Individual Physicians (place of work not specified)	9
Other Primary Care Programs/Organizations (Associates in Family Medicine, MCAP at UCSD Health, Concentra Urgent Care, Heluna Health in City of Industry, Medicus M.D. Inc., Indian Health Centers, an LGBT center in Los Angeles)	7
Hospital	6

[1] Participants could choose more than one response; as such, totals may be greater than the number of respondents.

Some respondents provided additional comments related to health care agencies, clinics, or doctors that provide safe and competent care for LGBTQIA+ people:

- “Having a non-judgmental attitude if I bring up non-heteronormative sexual behavior.”
- “I'm thankful that [organization] seems to be somewhat knowledgeable and welcoming due to their intake form including LGBTQIA options and some medical professional bios including mention of affirming care.”
- “Not sure. I haven’t found one since I’ve only been using military doctors.”
- “I asked for an LGBTQIA+ doctor and [organization] matched me with someone who I felt comfortable with. ..I may just be lucky I can’t speak to all of [organization], it’s so large.”
- “[Organization] has always treated me with respect and has put my safety first. I would highly recommend it to my fellow LGBTQUIA+ people.”
- “[Organization and doctor list] are very proactive and sensitive to patients’ needs and concerns. Their Social Worker team are amazing. But patients must be equal partners by being Pro-active.”
- “The [organization] is great with therapists but for medical doctors it has been really difficult finding doctors who are knowledgeable in regular offices. I will say my experience through [organization] hasn’t been the greatest until seeing a specialist in the San Diego Hillcrest area.”
- “[Organization]! They have been very accommodating and respectful of pronouns and name changes”

Recommendations for Medical Professionals: Survey Respondent Quotes

A total of 338 respondents shared written comments in response to the question, 'What are the most important things medical professionals need to know to be more welcoming?' While not all responses are included, selected quotes that reflect key themes are presented in Tables F-2 to F-5.

Table F-2. How Medical Professionals can be More Welcoming and Respectful of LGTBQIA+ Clients: Quotes Related to LGBTQIA+ Respect in General

What are the most important things medical professionals need to know to be more welcoming and respectful of LGBTQIA+ clients?
Categorized quotes related to general respect (n=338)

Be Respectful, Non-Judgmental, Ask Instead of Making Assumptions

Be Respectful

- "Ask respectful questions and pay attention"
- "Be respectful of gender and pronouns"
- "Just be kind and respectful"
- "Respecting our sexual preferences"

Ask instead of making assumptions

- "Ask pronouns, don't assume gender"
- "Ask questions versus assuming"
- "Don't make assumptions; just ask!"
- "Don't assume sex or gender"
- "Ask questions if they are unsure, it may be awkward but better than unquestioned assumptions. Especially when it comes to sexual practices, identity and health status."
- "[Know] Not to start from assumptions of heterosexuality"

Be non-judgmental

- "Ask without judgment"
- "[Be] non-judgmental (body language, tone of voice, facial expressions)"
- "Ask any and all possibly pertinent questions without any hint of judgment."
- "Learn how to take a thorough and non-judgmental sexual history."
- "No judgement about gender identity or sexual orientation."
- "We exist, our relationships, lifestyle is not up to debate or judgement"

Basic Human Respect and Consideration

- "Just be kind and respectful"
- "Just be knowledgeable"
- "Just be professional and knowledgeable. We are the same as any other patient."
- "Just be welcoming and understanding"
- "Just don't assume and it's okay to ask sexual orientation"
- "Just to communicate and ask questions, not to judge"
- "Just treat me like a normal person."

Table F-3. How Medical Professionals can be More Welcoming and Respectful of LGTBQIA+ Clients: Quotes Related to LGBTQIA+ Respect and Knowledge

What are the most important things medical professionals need to know to be more welcoming and respectful of LGBTQIA+ clients?

Categorized quotes related to how to be respectful and LGBTQIA+ knowledge (n=338)

Importance of Pronouns, Gender, and Lived Names

- "Ask for patient's pronouns"
- "If unsure of pronouns, ask. Asking is considered more polite than assuming."
- "Use the patient's pronouns"
- "Introduce oneself with pronouns!"
- "Con el genero y nombre" (just knowing their gender and name)
- "How important pronouns are and using proper names for folks who haven't been able to "legally" change them"
- "Make sure you ask my gender not just sex"
- "Respecting someone's gender identity at face value"
  "Practice using they/them pronouns and referring to the patient's correct pronouns. It might seem trivial, but it makes a huge difference in us being able to trust that you know about our community and understand our needs. Repeatedly saying the wrong pronouns, especially when it has been clearly stated on medical forms, can signal to us that other parts of our medical care might also be overlooked or missed while in your care."

Basic Knowledge of the LGBTQIA+ Community

Cultural Competency

- "Cultural competency, inclusive language"
- "Know basics about us"
- "Cultural understanding, compassion, their presence in context to patient care"
- "Know how my identity and sexuality impacts my health and support system if I were to be sick"
- "Language about body parts! Explaining procedures! Knowledge of LGBTQ+ health risks and disparities! Pronouns! Preferred names! Simple things that mean so much."
- "[Know about] LGBTQIA culture"

Awareness of Types of Sex

- "Understand queer sex better"
- "[Be] informed about queer sex"
- "Understand gay sex"
- "[Know] about anal sex!"
- "[Know about] Male on male sex"

Recognition of Unique Challenges Faced by LGBTQIA+ Population

- "Understanding unique health issues faced by LGBTQIA+ population, including but not limited to increased mental health challenges, higher rates of substance/alcohol use, homelessness (specifically youth being kicked out of their home or running away) and specific sexual and reproductive health concerns (STD testing, transitioning, etc.) Related to mental health: Recognizing how stigma and discrimination (in addition to daily microaggressions from living in a heteronormative society) can affect an individual's overall well-being and ability to navigate the world on a daily basis, beyond just being able to come out."
- "Queer and Trans people are not a monolith. Please don't let any unhelpful personal beliefs get in the way of providing care to all clients from all backgrounds. Learn outside of your clients, don't assume they will teach you."
- "Do some research before interacting with LGBTQ+ people about micro aggressions the community faces so they don't make that mistake. Also research on how to be accepting."

Table F-4. How Medical Professionals can be More Welcoming and Respectful of LGTBQIA+ Clients: Identity

What are the most important things medical professionals need to know to be more welcoming and respectful of LGBTQIA+ clients?
Categorized quotes related respect and identity (n=338)

Consciousness of Racial and Ethnic Identities

- "Cultural understanding of all people and races"
- "Do you understand that we are multicultural multifaceted people?"
- "[Understand] That people of color matter"
- "Understand that for LGBTQIA+ people come from a variety of different backgrounds… BIPOC and/or religiously conservative backgrounds face additional challenges in coming out and in not being supported (or even worse) by their families of origin"

Specific quotes related to LGBTQIA+ identities:

Gay men

- "Que sean más respetuosos con la comunidad transgénero y gay. (For them to be more respectful with the transgender and gay communities)"
- "[To know] That just because you're gay that doesn't mean that you are having sex with multiple people."
- "It varies by person. For me, I'd want them to be direct about everything. "Are you on the receiving end of anal intercourse? If so, then…" Etc."
- "Sometimes we don't know what we are at risk for other than HIV & STIs. I have never thought about anal cancer or the need for an anal pap smear. An open dialogue or conversation about everything we are up against outside of STIs."
- "[Know more about] PrEP, anal health"

Lesbian

- "Don't make assumptions, it is annoying to push birth control on people"
- "Our reproductive care can be different"
- "Be aware of different sexualities and gender identities. Respect pronouns and ask for them in the beginning of the session. When asking "is there any way you could be pregnant?" Don't assume someone is straight."
- "Stop making lesbians explain they are gay and therefore can't be pregnant"
- "Stop asking me about my sexual behavior unless they know my sexual orientation. Doctors seem to think that if you're a woman and you haven't had penetrating sex with a penis you're missing something."
- "Knowing more about supporting sexual health for gay people, especially when it's women"

Transgender

- "[Be] More open to trans women. Respect the way they talk"
- "It isn't an identifier like a nickname or a title. We ARE trans and we are our identity. Some Dr's get impersonal with things like that."
- "For trans folk, providers need to understand that certain test results are more closely tied to assigned sex at birth rather than gender."
- "Not all of us at high risk for breast cancer are women, and transmasculine people and trans men need some level of competence when it comes to breast cancer. It is so off putting and so so stressful to have to go through all these screenings with people who don't know anything about LGBTQ issues."
- "Que sean más respetuosos con la comunidad transgenero y gay. (For them to be more respectful with the transgender and gay communities)"

Table F-5. How Medical Professionals can be More Welcoming and Respectful of LGTBQIA+ Clients: Language

What are the most important things medical professionals need to know to be more welcoming and respectful of LGBTQIA+ clients?

Categorized quotes related to respect through language (n=338)

Inclusive Language

General

- "Inclusive word choice like partner vs. husband [which] assumes I'm straight"
- "Posing inclusive questions"
- "Uses inclusive medical terminology when explaining procedures"
- "[Know] That when it comes to transgender patients, we still need certain tests and screenings that apply to the gender assigned at birth, and yet, because the forms do not give us the option to identify as AMAB [Assigned Male at Birth] or AFAB [Assigned Female at Birth], we are often denied those screenings as being inappropriate."
- "Pronouns (affirming of them/ ask/ use the correct ones), sexual health and wellness, and being affirming of partner's gender too (using language that allows options beyond are you with a man or woman)"

About Body Parts

- "Practice gender affirming and neutral language with all clients"
- "Talking about body parts without gender, i.e. penis vs genitalia"
- "Use specific and non-gendered language: penis, vagina, etc., instead of female genitals or male genitals"
- "Do not nullify our identity by talking about 'male' or 'female' parts"

Lastly, some offered information related to HIV and PrEP specifically:

- "More knowledge around HIV prevention medication"
- "Pruebas de VIH y hablar sobre PrEP - PEP. (Knowing about HIV tests and talking about PrEP and PEP)"
- "Talk about sex. Talk about PrEP, PEP, ART, DoxyPep."
- "Be aware that longtime survivors of HIV have seen and experienced it all. There isn't a lot for them to learn!"

Appendix G – In-Depth Interview Responses

Trained staff from the Institute for Public Health conducted 16 in-depth interviews between March and June 2024, selecting participants from those who had completed the survey online. Interviews were held via phone or virtually and lasted between 35 and 120 minutes. Participants were intentionally chosen to reflect diverse LGBTQIA+ subpopulations, with an emphasis on amplifying voices from underrepresented communities in San Diego. Each participant received a $30 electronic Amazon gift card in appreciation of their time.

Themes

These semi-structured interviews offered participants the opportunity to share personal experiences and insights, many of which echoed themes identified in the qualitative survey responses related to provider competency. However, the interviews also revealed additional perspectives and provided deeper context around recurring issues. The following themes emerged from the interviews, offering valuable guidance for improving healthcare experiences for LGBTQIA+ individuals.

Respect

Correct use of lived names and pronouns was widely cited as a fundamental demonstration of respect and cultural competency. Interviewees emphasized that medical staff and providers should both ask for and share their pronouns and suggested including pronouns on forms and badges. This practice was regarded as a minimum standard of care for serving the LGBTQIA+ community.

> "Also maybe someone who is comfortable asking about pronouns, sharing their pronouns, understanding that maybe just by looking at someone you can't determine their gender identity, or other things about their identity or their experience. That would be really great."
>
> – 37-year-old nonbinary queer person

> "I would really appreciate for any medical care provider, or anyone, to ask for my pronouns.... It would be nice to not always be the one to initiate [asking for pronouns/sharing of pronouns] ... Also having more diverse questions about any experiences, whether sexual, personal, home life or anything related to medical would be better, because I feel like a lot of it has been more heteronormative."
>
> – 23-year-old pansexual femme

Interviewees were particularly frustrated when they updated their lived names in portals or on forms, only to be repeatedly deadnamed at the medical office (i.e., referred to by a birth or previous name that is no longer used).

> "I really want to see people really consistently [correctly using] names and pronouns, because that is your first sign of safety in a doctor's office... Am I being gendered correctly? Am I at least being asked like, "Hey, what's your name? What are your pronouns?"
>
> -24-year-old queer transgender man

For the LGBTQIA+ community, respect for pronouns and lived names is closely tied to safety. Deadnaming is not only offensive and hurtful but can also "out" transgender individuals without their consent—for example, when administrative staff loudly use a patient's deadname in a waiting room. Such incidents were described as direct threats to safety.

Overall, interviewees regarded attention to pronouns and lived names as indicative of whether a provider would respect other important aspects of care. They emphasized the urgent need for consistent office policies to ensure patients are always addressed correctly. Standardizing pronoun questions for all patients and staff was highlighted by one participant as a key strategy to avoid "othering" LGBTQIA+ individuals.

> "I don't want to give a gold star... just for basic respect of name and pronouns. I think, really, that is very basic. And it's very important."
>
> -27-year-old transgender man

> "I will say it, the name and pronouns thing is so simple, but a lot of support staff struggle with it. [Something] that has been really frustrating in my experience of going to the doctor is, maybe the doctor gets it, but the front desk person will misgender me. Or the nurse taking me to the back room will misgender me...I don't know if that captures it, but probably a theme you've heard a lot is just like, I wish you could just respect me. Just basic respect."
>
> – 28-year-old transgender man

> "Are you asking everyone about their pronouns, or are you looking at me and saying, oh, something's going on there, let me check in.' Because that's another thing. I appreciate what you're trying to do, and I do want to give credit where it's due, right? Asking about pronouns is important, but you can't single people out for it. You can't be like, 'this person looks genderqueer, I need to ask them about pronouns... Making it a normal question also helps with cis[gender] people getting used to that question. Because there are cis people who, you ask them their pronouns and they're *very* offended over it. So when it comes from a doctor... that is an opportunity for a very small amount of normalization, and education for cis people... it's not a weird thing... Part of introducing yourself now is just your name and your pronouns, and it's not a bad thing. It's very small. It's very simple. It's not going to hurt you! You're going to be okay."
>
> -24-year-old queer transgender man

Provider Comfort with LGBTQIA+ Community

All interviewees agreed that medical providers need a basic level of comfort with LGBTQIA+ patients to deliver quality care. Participants emphasized that heterosexual providers could provide culturally competent care, though some expressed a desire to see more LGBTQIA+ professionals in healthcare. Importantly, no interviewee felt that *only* LGBTQIA+ providers could offer competent care.

One interviewee, a nurse working with people living with HIV, described a heterosexual doctor who was particularly effective. This doctor was comfortable and confident discussing health with gay male patients and had personally undergone an anal Pap smear, which allowed him to better understand the procedure and provide informed guidance to his predominantly cisgender gay male patients.

Another interviewee suggested that heterosexual male providers may lack competence or comfort in discussing gay male sexual experiences:

> "[A major factor for someone to be considered a good provider] is they have to... be incredibly comfortable with the human body... A lot of heterosexual male providers... think of [the anus and the rectum] as excretory organs. Because of that, they don't have the same level of sensitivity that they would to [other patients... Providers need to] remember the anus is a sexual organ... a source of pleasure [for gay men]"
>
> -57-year-old cisgender gay man

A 23-year-old pansexual femme felt that to provide quality care, medical professionals should have familiarity with the basic vocabulary used by the LGBTQIA+ community:

> "Knowing medical terms that are associated with the LGBTQ+ community... you'd want your provider to know what you're talking about and not have to Google it every time, or dismiss it, because maybe there's something [unfamiliar] about that word that you mentioned, but they brush it off because they don't know what it means."
>
> -23-year-old pansexual femme

Another interviewee shared a positive experience with his medical provider, who—although not gay—had a similar background that helped him connect with LGBTQIA+ patients and offer empathetic, culturally informed care:

> "I have another provider now... He's not gay, but he was raised in a Hasidic Jewish home, and he did have to leave behind a lifestyle, and that involved his extended family cutting him off to a certain extent... Even though he's not gay, the fact that he grew up in a religious family, and the fact that there was ostracism involved, I think that allows for him to have a level of empathy that a lot of other providers would not otherwise have."
>
> – 30-year-old cisgender gay man

Humility

Humility was identified as a critical quality that medical providers should demonstrate. This was particularly important for transgender participants, many of whom had greater knowledge and experience with their own care and hormone regimens than their providers. Interviewees praised clinicians who approached them with humility and respect. While some medical providers were praised for their humility, interviewees noted that others displayed an unwillingness to accept feedback, leaving them feeling dismissed.

A 62-year-old transgender woman described her positive experience with a primary care physician who practiced humility (see next page):

> "Oh, he's more than affirming. He is empowering. I'm not his first trans patient, but I'm the first one where he's been involved since the beginning. All the others [trans women patients] he's had have come to him, fully formed… They've had all the surgeries they want, and it's more about how to maintain their current levels… So he even told me, he said, "You and I are going to be learning this as we go, kiddo. We're gonna be learning it together. Anything you find out, I want you to tell me. And anything I find out, you better believe I'm gonna tell you."
>
> -62-year-old transgender intersex woman

A 27-year-old transgender man described surgeons who, despite experience with breast reduction and mastectomies for cisgender women, mistakenly assumed those skills directly translated to masculinizing top surgery for transgender men:

> "I found that some doctors… always think that they're right. They can do [top surgery with masculinization], even if it's like, well, you weren't trained specifically for this [surgery]. You don't know how to do this specifically, you know how to do something similar. But you don't know how to do [other breast surgeries] … and because of that, they're not taking the care and the time it takes [to get a satisfactory result] … they're not being humble and learning a new thing and adding it to their skill set. So the result is just not good in the end."
>
> -27-year-old transgender man

A 37-year-old nonbinary, genderfluid participant stressed that an ideal medical professional would be open to feedback:

> "[An ideal characteristic would be] people who are open to feedback. I find that physicians sometimes can be really closed off, right?"
>
> -37-year-old nonbinary genderfluid person

Equal Treatment

Interviewees emphasized the importance of being treated like any other patient. Those who were satisfied with their care often noted that they felt respected and not singled out or treated differently because of their LGBTQIA+ identity. Two participants expressed their desire to receive healthcare "like anyone else" and shared their perspectives on what equal treatment would entail:

> "I would like to not feel like I am different and need different care, with a negative stigma... everyone has different care and needs. But it would feel nicer to know that based off of my sexuality and presentation, that doesn't make my care subpar, or a second-tier type of thing. Like, oh yeah. Everyone needs this care. Everyone's gonna get it regardless of anything."
>
> -23-year-old pansexual femme

> "Ideally, an interaction would be, I have a need. I go in and I'm seen for it without feeling like I'm being judged, or everything gets switched over to 'you're transgender. So I'm gonna focus on all this stuff'... I often feel like it takes getting to know a provider to break it down. Yes, I'm transgender. But for them to start seeing me as a person... and dealing with my challenges or symptoms as a person, not anything unique... I don't need any special care or for my appointment to be kind of skewed because of [being transgender], I just want regular care."
>
> -54-year-old transgender women

When asked about the education medical providers need to better serve transgender patients, a 27-year-old transgender man highlighted the importance of understanding specialty care and knowing when a health concern may be influenced by other factors such as hormone replacement therapy:

> "I am kind of two minds, because I think trans people are vaguely a specialty population. We do have things about us that make us specific... but also not treating trans people like, "I need to refer [you] out, all of your questions need to go to your endocrinologist, because that's your 'gender doctor.'" ... I know doctors are extremely overworked. So this is a very hard thing to ask, but taking an hour to look at [the reason for the patient's visit and their previous medical history] and say – okay, is there anything relevant about this person's transness to the treatment that I'm giving them to the condition I'm treating them for? Yes? Cool, maybe I should look into that. No? Then whatever. Proceed as normal, proceed using the right name and pronouns..."
>
> -27-year-old transgender man

Avoiding Assumptions and Judgement

The LGBTQIA+ community is diverse and composed of individuals with unique experiences and needs. Interviewees agreed that to understand each patient, medical professionals cannot make assumptions. Among the interviewees, lesbians, queer women, and nonbinary participants were most likely to express frustration at being assumed heterosexual, while many cisgender gay men reported being negatively judged by medical providers.

> "I would say it would be someone who's not operating under the assumption that everyone is, as a baseline, in a heterosexual relationship. That would be really cool."
>
> – 37-year-old nonbinary queer person

A 57-year-old cisgender gay man described his admiration for his European primary care physician, noting that during a trip to Europe he observed public displays of affection between men without stigma. He appreciated that his doctor was "unaffected" by American-style homophobia and accepted him fully without judgment in the exam room.

Similarly, a 30-year-old cisgender gay man reflected on how medical providers often pass judgment through categorization, highlighting a tendency to make assumptions about patients based on identity:

> "[Providers] categorize [people] in such a way that it's either by race, by background, or by sexual orientation... just realizing that there is such a diversity of experience amongst people that this type of [categorizing] doesn't necessarily... pass muster. It doesn't work, just because someone may seem to talk in a certain way or have a certain kind of job does not necessarily mean that they've been vaccinated for HPV, for example."
>
> – 30-year-old cisgender gay man

Lastly, a 43-year-old cisgender gay man described feeling miscategorized and negatively judged when seeking HIV pre-exposure prophylaxis (PrEP) despite being in a long-term relationship:

> "And I've noticed a lot with PrEP... being able to get it. Looking at some of the notations that are put in [medical charts] and the categorizing. It's kind of - it's almost offensive, the way they categorize certain activities. I was in a long-term relationship with my partner, and they still categorized me as 'high-risk activity.' Just looking at things like that, the sensitivity... [I know] there's medical jargon, but [in] face to face communication, there can be a little bit more tenderness."
>
> -43-year-old cisgender gay man

Diligence / Preparedness

Interviewees expressed frustration when doctors, nurses, or other medical professionals overlooked details previously documented or shared during care. While some noted that providers forgot information from prior visits, most were particularly upset when professionals failed to review their medical charts before asking questions.

> "I've had a hysterectomy, but anytime I go anywhere [aside from my primary care, who is great – They] they always ask me if I'm pregnant, and I'm like, it's right there on the side [in my chart]."
>
> – 35-year-old nonbinary bisexual person

For LGBTQIA+ patients, repeatedly having to share their gender or sexual orientation identity can feel stigmatizing or "othering." Even when the questions were not LGBTQIA+-specific, participants reported feeling frustrated, annoyed, and disrespected when medical providers failed to consult charts or recall basic information, interpreting it as a lack of diligence. Frustration was particularly pronounced when providers made assumptions rather than referencing information already documented in patient records.

> "… Or they'll ask the question about periods, which they always ask. 'When was your last period?' And I've had providers be like, 'you're definitely still menstruating, right?' … If you checked my chart, you can see I haven't done that in many years, and also, don't assume… You could have just asked, 'hey is this [menstruation] something that's still happening?' I don't know if that captures it, but probably a theme you've heard a lot is just like, I wish you could just respect me. Just basic respect."
>
> – 28-year-old transgender man

A 35-year-old nonbinary queer interviewee expressed frustration at being repeatedly asked about penetrative sex at each visit, despite keeping their medical chart and portal information up to date:

> "… But in my perspective, I've answered all of these things in my profile, in my portal, and I still find it interesting that it's not universally acknowledged within the same healthcare system that my doctor is part of… I'm happy that not everybody has access to my chart. But this is not part of my chart… It's part of my profile. It's public for the healthcare providers to see, so I don't know exactly where the discrepancy there is. Besides, just the fact that it's a social issue rather than a systemwide issue of anything to do with healthcare, specifically."
>
> – 35-year-old nonbinary queer person

Interviewees also expressed empathy for medical providers, noting the intense demands on their time, particularly for doctors. Participants recognized that providers are often overworked, stressed, and overbooked, but they still felt that their own time was not respected as doctors rushed from one patient to the next.

> "[Doctors are] very overworked… I am very empathetic to the fact that working in a doctor's office is very chaotic. There's a lot."
> – 27-year-old transgender man

Support Staff

Support staff were frequently highlighted as integral to the overall healthcare experience. Interviewees noted that even when interactions with doctors were positive, negative experiences with nurses, medical assistants, or administrative staff could overshadow the positive experiences. Administrative staff, in particular, were often cited for often deadnaming or misgendering patients, making routine check-ins a stressful and fraught experience for many transgender individuals.

> "I will say it, the name and pronouns thing is so simple, but a lot of support staff struggle with it. [Something] that has been really frustrating in my experience of going to the doctor is, maybe the doctor gets it, but the front desk person will misgender me. Or the nurse taking me to the back room will misgender me."
> – 28-year-old transgender man

One transgender man described the distress he felt when he was misgendered on the day of his long-awaited top surgery:

> "My experience with my top surgery, for example… my surgeon himself, he was very affirming. He did a great job. But… the support staff, the nurses… I was getting misgendered the day of my top surgery. I was getting deadnamed the day of my top surgery, even though… they have it on your medical band, like here. This is the correct name. So it was such a weird experience to be having this euphoria of like, oh, I'm about to do this really important gender affirming thing. Oh… people are still misgendering me."
> – 27-year-old transgender man

A 54-year-old cisgender gay man recounted his positive experience being hospitalized for emergency surgery, highlighting the acceptance he felt related to his sexual orientation and the numerous staff members who cared for him during his week-long stay:

> "I think there was one nurse that… came in, hung over one day, quite honestly. But I didn't get a bad level of care or feel that I was being judged for being gay. I felt that everyone that came in was… there to do a job, and there to do it to the best of their ability."
>
> – 54-year-old cisgender gay man

A 29-year-old cisgender lesbian, who has previously worked in a medical office, described how medical provider attitudes can influence the entire patient experience. She observed that when medical providers enjoy their work and treat patients and staff with respect, it sets a tone that encourages staff to interact respectfully with patients. She emphasized that positive medical provider attitudes "trickle down" to everyone in the office, shaping every aspect of care:

> "Yes, I've been a patient, but I've also worked in a medical office… [medical support staff] may be on their toes, they may be getting yelled at [by a doctor/supervisor] when patients can or cannot hear. That affects how they show up to work, their performance, how they can show up with patients… I have literally had one nurse tell me when I was seeing a reproductive endocrinologist years ago, "I don't even want to be here." Like, flat out, 'I don't want to be here.' So no, I don't feel like taking your call."
>
> – 29-year-old cisgender lesbian

Transgender and Nonbinary Individuals' Negative Experiences with Medical Providers

Lack of Medical Provider Knowledge

Transgender and nonbinary interviewees described experiencing negative interactions and substandard care from medical providers. They emphasized the need for providers to demonstrate a more comprehensive understanding of their bodies, healthcare needs, and the broader transgender community. Participants expressed deep frustration with providers' limited knowledge of transgender bodies, treatment options, and

> "[They need to know] more behavioral facts about LGBTQ+ people, definitely having more facts about general behaviors of non-binary people, how they exist, communicate, express themselves."
>
> – 29-year-old nonbinary person

medication regimens. Four interviewees offered specific examples highlighting gaps in provider knowledge.

1. A 24-year-old transgender man expressed frustration at having to pay for medical appointments in which he was responsible for educating the doctor about his own care:

> "...You're getting paid $300 for this interaction, Mr. Doctor, and I'm doing most of the talking and telling you what is going on. How is this fair? How is this a good way to run a system?"
>
> – 24-year-old transgender man

2. A 27-year-old transgender man who had undergone top surgery expressed uncertainty about which cancer screenings, including breast cancer screenings, he would need in the future and whether his medical provider would be knowledgeable about them:

> "I probably need to do something at some point, but, like, God willing, I have a provider who knows anything about this, or, God willing, the research has caught up, because I feel like that's the only thing with trans masculine people is, I don't know a lot of stuff about my own body... [when it comes to] testosterone and my ability to get pregnant, [medical providers] are like, 'well, maybe, but also maybe not? We don't know. We're not really sure.' And it changes per person. There's not a lot of really good research being done on it, because it's just not a topic of interest for a lot of people. So, I don't know. I don't have that information. I can't make an informed decision about my body like other people can, because the research just isn't being done."
>
> – 27-year-old transgender man

3. Similarly, a 35-year-old nonbinary bisexual person shared their confusion after a hysterectomy after which they could have used more information from their medical provider:

> "I've been meaning to talk to my doctors [about cancer screenings]. For me, they did – I don't know if it's actually considered a full or partial [hysterectomy], but essentially, they removed [everything] but the vaginal canal. And then [I still have] the ovaries. And so actually, I've never really followed up to ask, do I need any type of [screenings]? I know I don't need screenings for cervical cancer, that's gone. But I mean, I still have a vagina. Do I need to do anything for that? I haven't seen a gynecologist ever since the hysterectomy essentially."
>
> – 35-year-old nonbinary bisexual person

4. One transgender woman described having low expectations of medical professionals' knowledge regarding transgender healthcare:

> "I feel like I have a relatively low standard because trans people don't always get the best [medical care] with but know at the very least, doctors who understand the basics of stuff… I can't tell you how many doctors I have had in the past who just know nothing about trans people. They're like, "oh, what are all these meds you take? You did *what*?" You know, talking about my hormones… on top of that too, is more niche aspects of doctors knowing about trans healthcare… being on hormone therapy impacts your health in a lot of other ways… having doctors who understand all of that is important. And then, of course, the baseline things of 'hey, get my name and pronouns right.'"
>
> – 25-year-old transgender woman

Transphobia in Medical Care

Transphobia in healthcare settings refers to discriminatory and disrespectful treatment of transgender and gender diverse individuals by healthcare providers and institutions. Interviewees talked about various aspects of transphobia in medical – not feeling safe, lack of inclusivity (gendered services), medical provider disapproval, and harassment/denial of service.

Lack of Safety

While many interviewees described feeling uncomfortable in medical settings, transgender men and transmasculine interviewees specifically reported feeling unsafe and fearful. Misgendering and deadnaming were cited as the primary reasons for these feelings.

Transgender interviewees said that they often anticipated and prepared for misgendering or other transphobic experiences in medical settings, particularly if their gender presentation did not align with cisgender norms.

> "Thinking about the kind of world we're in right now… I'm already training myself to be pretty tough-skinned about a lot of stuff. I expect to be misgendered when I go to the doctor. I kind of expect to be a little uncomfortable because my gender presentation is not hypermasculine, I have long hair. My gender is not a hyper-masculine man. Cis people struggle with that."
>
> – 27-year-old transgender man

Lack of Inclusivity (Gendered Services)

Some interviewees also observed that medical care is often not fully inclusive, with services for specific body parts frequently framed in gendered terms. For example, gynecological care is typically labeled as "women's health" rather than using language that affirms transgender men,

transmasculine, and nonbinary patients. Transgender men who described themselves as "passing" reported feeling less apprehensive about accessing gender-labeled services than those interviewees whose gender presentation did not align with traditional expectations.

A 28-year-old transgender man described the awkwardness of undergoing a cervical cancer screening despite passing as cisgender most of the time. He shared his experience entering a "women's care" office as a transgender man with a flat chest, deep voice, and beard. He did not, however, think that many other transgender men or transmasculine individuals undergo cervical cancer screenings for this reason:

> "Yeah, no one's really doing it, which is because … going to a space and then having that fear like oh, "you were probably wondering why I'm here" and just that kind of thing… It is tough, being nonbinary or trans or gender conforming within the healthcare system because the healthcare system is pretty cut and dry about what they're doing."
>
> – 28-year-old transgender man

Medical Provider Disapproval

Transgender interviewees reported feeling heightened scrutiny during medical visits. A 54-year-old transgender woman reflected on reasons medical providers may not want to serve transgender patients, highlighting the pressure and worry transgender individuals may experience when seeking care:

> "Doctors don't want to have too many transgender patients on their panels. If they get a good reputation [among transgender patients] like 'hey, my doctor is really good,' and I start sending all my friends to them… I feel like a lot of times transgender patients are perceived as patients with a lot of problems and challenges, like mental health, drug use. I think when providers have a transgender person in front of them, and they've had a training where the statistics are broken down… it may not seem like you'd want too many people like that on your patient panel."
>
> – 54-year-old transgender woman

A 35-year-old nonbinary bisexual participant described their work providing cultural competency and sensitivity training to medical providers, sharing an anecdote that illustrates transphobia among healthcare professionals (see next page):

> "I talked with some surgical staff once about gender identity and how to do a little bit better job with that. And one thing I noticed is there are – not that many, but there are a handful of people – [who] have their own personal views that interfere. So [there were questions like] "Well, do I have to? If someone's having a gender affirming surgery, do I have to participate? Am I allowed to opt out?" And I feel like it brought up a lot of debate. Like, well, if you're [critically necessary], if the surgery can't happen without you, [then you have to] show up. But for me… if I had gone under surgery, and I knew that there was a nurse there that had such disdain for this procedure that they did not want to be there for me, I'd question whether it was really ethical for them to even be in the room."
>
> – 35-year-old nonbinary bisexual participant

Harassment/Denial of Service

One transgender man described community members who had encountered openly transphobic medical providers, who used their authority to limit access to care for transgender individuals:

> "I hope more trans folks can get in contact with our community right now and keep themselves safe because there are providers out there – I feel very, very blessed and fortunate to not have encountered one of these. But there are genuinely transphobic practitioners out there who will do what they can to prevent you from transitioning, or keep your T levels extraordinarily low, or misgender you on purpose so you feel uncomfortable, so you don't come back. Nobody deserves that, and especially not trans people."
>
> – 24-year-old transgender man

Multiple transgender interviewees also felt that the very structure of medical systems often excluded them. Standardized forms and procedural language were frequently cited as barriers. A 62-year-old transgender woman described the repeated back-and-forth with her insurance provider and medical network over what types of care were considered appropriate for her:

> "[My insurance] wellness program isn't trans affirming. They do not have their wellness program set up to recognize the trans population. They treatment like a cisgender female. My healthcare provider has let me know, yes, I need mammograms. But I also need prostate exams. [My health insurance provider] keeps recommending a Pap smear for me. Nothing about an anal Pap smear. A cervical Pap smear. And it's like sweetheart; I don't have that!"
>
> – 62-year-old transgender woman

Lesbian Erasure

Lesbian erasure refers to the overlooking, dismissal, or invalidation of lesbians' existence, experiences, and contributions. Interviewees described repeated frustration with medical providers who failed to acknowledge their sexuality. Cisgender lesbians and nonbinary lesbians with a uterus, ovaries, or cervix were especially affected by providers' heteronormative assumptions about the gender of their partners and by persistent questioning about pregnancy, even after clarifying that they were not engaging in sex that could result in pregnancy. The following section presents five illustrative cases in which medical providers disregarded or minimized participants' sexuality and lived experiences, reflecting this form of erasure.

1. A 29-year-old cisgender lesbian woman noted that she would be more forgiving of the frequent pregnancy-related questions if medical providers first acknowledged her identity as a lesbian—for example, asking whether her partner was a cisgender or transgender woman before raising questions about pregnancy:

> "Just having a provider on their forms ask if you are in a LGBT relationship, are you part of the community, and then your provider actually reading it, so you know it's not just part of their policy… so they're not just asking, 'are you sure you're not pregnant'? [interviewee holds her hands up, shrugs, and laughs] We're both two cis women. I would know. Things like that."
>
> – 29-year-old cisgender lesbian woman

2. This same interviewee, who was interested in having a baby, also shared that some providers had failed to review or respect the information in her file about her partner. She recalled one particularly dismissive experience with an endocrinologist who told her (a cisgender woman) and her partner (also a cisgender woman) to "practice" having sex in order to conceive—a suggestion she found both inappropriate and offensive:

> "This reproductive endocrinologist… he talked to me as if I was a child, not knowing that I have [experience educating about] infertility and reproductive ability… He ignored the fact that I'd had previous pregnancies… and then he's like 'well, you guys can just plan when to have sex.' I mean. We could? We could plan to practice how and when we have sex, but we're both women. I subtly reminded him a couple of times [during that appointment] and he kept saying, 'well, maybe you guys can just practice.' … I mean, I know she [my partner]'s not here with me, but we're both women… you know, it's not hard."
>
> – 29-year-old cisgender lesbian woman

3. A 35-year-old nonbinary queer person, married to a woman, described their experiences with gynecological care, particularly around screenings and the language providers used when scheduling them. While the medical team did not specifically reference pregnancy tests or birth control, the medical providers repeatedly emphasized the incorrect assumption that the individual was having penetrative sex with someone with a penis:

> "One of the things that that comes up a lot, a lot of gynecological care in general. They... would like for me to do all of these screenings, and that's completely fine. I'm happy. I'm happy to go do it. But every single time I have to explain to the system, somehow. Like, yeah, I still am not going to be having PIV (penis in vagina) sex."
>
> – 35-year-old nonbinary queer person

4. A 37-year-old nonbinary bisexual person spoke about the lack of safe sex discussions for people who have sex with women, as healthcare providers focused solely on sex with men:

> "In reproductive healthcare spaces, [providers] just assuming that I only have sex with men... only focusing on reproductive things. Or [discussions of] prophylaxis that are only for men, too, right? Like the focus is generally on condoms and things like that. I never see dental dams, for instance... the focus seems to always be on a heteronormative experience. And I would love to have more inclusivity in those spaces, even in spaces where I feel are generally thought of to be more inclusive, like [Organization], for instance. Right? Yeah, they ask you how many sexual partners you've had or things like that. But they don't really inquire about the gender of your sexual partners, or it's just always the assumption that we're dating and sleeping with men."
>
> – 37-year-old nonbinary bisexual person

5. A 23-year-old pansexual femme recalled their first conversation with a doctor about birth control, where the doctor did not ask about their sexual activity but instead assumed they were having sex with a man:

> "It was the immediate assumption of, I'm only having sex with men, straight off the bat. They didn't talk to me about anything else. The only thing they gave me was contraception... that was about it... [There wasn't] more talking about it, or [questions] like, who are you having sex with? Or who do you think you would like to have sex with? [Do you want to] talk more about it? You know, being safe in a lot of different ways, [not just] pregnancy."
>
> - 23-year-old pansexual femme

Perceptions of Healthcare in San Diego

Most interviewees reported overall satisfaction with the healthcare they had received in San Diego. While certain medical services were identified as more supportive and affirming than others, participants also noted common challenges with the healthcare system. These included difficulties scheduling specialist visits, obtaining referrals, long wait times for appointments, and the transfer of care to new providers without their consent or knowledge. Interviewees described the need to invest significant time and effort into finding a respectful, LGBTQIA+-competent practitioner.

> "It's not like [state I used to live in]. Thank goodness it's not."
> - 62-year-old transgender woman

Among interview respondents, transgender and nonbinary individuals were the most likely to report prior negative experiences with healthcare providers. Transgender men and transmasculine participants were particularly likely to report difficulties or discomfort with their current providers. Several interviewees noted that, compared to other regions of the country, San Diego was perceived as a place where they could reasonably expect to receive culturally competent, LGBTQIA+-affirming care.

Mental Health

Interviewees expressed a strong desire to provide feedback on their experiences with mental health services, even though this topic fell outside the formal scope of the needs assessment. They highlighted the connection between mental and physical health, particularly those who had undergone cancer treatment or were currently managing a cancer diagnosis. Interviewees also noted frustration with the generally siloed nature of mental health care.

One interviewee, a 51-year-old cisgender asexual man, described his previous experiences with a therapist from another county and emphasized his ongoing need for mental health support, especially as it relates to aging:

> "I was a therapist in my home country, so I know what it's like to be a therapist… I'm not saying they are bad, but they need to learn a lot… I really need therapy right now… I'm getting older, I'm getting lonely…"
> - 51-year-old cisgender asexual man

Another interviewee, a 30-year-old cisgender gay man, was keen to provide information about the mental health need of LGBTQIA+ individuals:

> "...I think that there's just such a variety of mental health issues that LGBT people have. And there are a lot of common similarities. I think it's kind of like, we're all the same brand of ice cream, but we're different flavors, where there's a lot of overlap. When you try to diagnose mental health issues, often times it's like untangling a really complex web of things. There's often more than one thing going on, and if it ever is one thing, then well, you must be the luckiest person in the world to just have that one thing. But dealing with all of those complex and concentric issues right now, unlearning them one step at a time, it requires a heightened understanding of cultural sensitivities, of what it means to be gay, of what it means to be a lesbian, what it means to be trans. Of what that coming out process looks like. Oh, and it requires a certain level of putting yourself in someone else's shoes that I don't think a lot of providers have."
>
> 30-year-old cisgender gay man

Current Social and Political Climate

Many interviewees identified the current social and political climate in the United States as a significant source of stress, expressing concern over rising hostility toward LGBTQIA+ people. Participants also worried about potential reductions in federal and state funding for programs that support the community, including HIV prevention and treatment initiatives. Additional concerns included immigration and deportation, as well as barriers to medical care for transgender individuals and youth.

One interviewee expressed uncertainty about remaining in San Diego due to fears related to immigration enforcement. He recounted being the victim of an immigration scam when he first moved to the city, which left him unsure of his legal status for many years. He described not knowing how to obtain legal residency or citizenship, noting that his immigration status was his primary source of anxiety. This stress affected many aspects of his daily life, including accessing routine healthcare, and during the interview he was so overwhelmed that he could focus on little else.

Additional Needs and Concerns

Cancer Screenings and Education for People Under 30

Four interviewees reported being diagnosed with cancer before the age of 30. Both these individuals and other interviewees under 30 had limited awareness of the types of cancer screenings they might require and the appropriate timing for such screenings.

> "Yeah, I kinda don't know what I need."
> -25-year-old transgender woman

HPV Education, Vaccination, and Screening

Some interviewees under 30 had received the HPV vaccine, others had not, and most—regardless of vaccination status—were unaware of HPV's potential health effects.

One interviewee, a 57-year-old cisgender gay man employed in healthcare, described fear of screening results as a key barrier to both cervical and anal Pap testing, as well as to pursuing follow-up procedures after abnormal results. He observed that individuals in the LGBTQIA+ community experience screening-related anxieties similar to those of their heterosexual counterparts. He underscored the importance of targeted outreach to LGBTQIA+ populations to improve screening uptake and to facilitate appropriate follow-up care, including procedures such as anoscopy after abnormal anal cancer screening results:

> "I have found... people put off what is uncomfortable... we have a 30% no show rate [for cancer screenings] ... the people in the women's clinic say their colposcopy rate is about the same... [people are] more afraid of the results. They're panicked about the result off in the future, so they kind of disengage from care at the moment. They're so afraid of the results, that they panic and don't show up for their appointment, which is really unfortunate, because... if you had a spot on your arm and you were worried it was cancer, you would go to the dermatologist... a positive pap smear is pretty much the same thing. You just need to have someone take a look at it who knows what they're doing... if the result is positive, there are things that we can do about that. This is all pre cancer screening. What do they say? An ounce of cure is worth a pound of prevention. If we could get people to suit up and show up, get their vaccines on time, get their pap smears, and their mammograms, and their anal cancer screenings, have their colonoscopies starting at 45, it would probably help a lot of different types of cancer."
>
> -57-year-old cisgender gay man

LGBTQIA+ Youth and Medical Care

LGBTQIA+ youth and young adults may feel unsafe with medical providers, and these early experiences can shape how they engage with healthcare throughout their lives. Several interviewees aged 30 and younger—all of whom were aware of their sexual orientation and/or gender identity before age 18—reflected on interactions with their pediatricians. Two described the transition from pediatric to adult care, noting the shift from a setting where physicians also engaged with parents to one in which they assumed full responsibility for their own medical decisions. Both reported feeling unable to disclose aspects of their sexual orientation or gender identity to their pediatricians due to concerns about parental involvement.

One interviewee, a 30-year-old cisgender man, described how these early experiences with his pediatrician continued to contribute to his discomfort with medical care in adulthood:

> "I've definitely been in environments when I didn't feel like I was comfortable disclosing that I was gay much earlier on. I can think back to appointments with my pediatrician when I was much younger. When they send your parents away, and it's just you and the pediatrician for like 3 or 4 minutes, and they ask you questions that are meant to elicit to see if there's anything going on at home. I definitely didn't feel comfortable as a child answering honestly either about things that were going on at home or about my own sexual orientation. When people ask me what I feel comfortable about when I'm talking to a doctor, that's what I reference. That's my lodestar because I'm not thinking about the me [now]. Now I'm thinking about the child, that I was back then."
>
> -30-year-old cisgender gay man

Similarly, a 23-year-old pansexual femme who had recently transitioned from pediatric to adult care described ongoing difficulty discussing gender identity and sexual orientation with medical providers. They reflected that earlier opportunities to disclose these aspects of their identity might have made such conversations less challenging in adulthood:

> "When I was younger, I would always go to the doctor with either my mom or my sister. My sister's always been a great supporter, but... I felt like I could never really talk about the things I needed to talk about when I would go with my mom. And that's, I would say, very common. But it also has to do with being a minor.... I wish that could have been attended to while younger, it's kind of hard to do... as an adult. And then it's more complicated, it feels very stressful, like now you have to switch from one way that you were presenting with your provider to another [way of presenting]. So, it's a heavier transition."
>
> – 23-year-old pansexual femme

Transgender, Intersex, and Nonbinary Barriers to Care

Do-It-Yourself Access to Hormone Replacement Therapy (HRT)

Overall, transgender interviewees felt that their medical providers lacked understanding of common transgender experiences and the physical and emotional effects of HRT. Many transgender people have experience with Do-It-Yourself (DIY) methods of HRT due to barriers like widespread transphobia, classism, racism, and "other forms of oppression embedded within professionalized medicine" (August-Rae et al., 2024). Online guides for DIY HRT are relatively accessible, though legal and logistical challenges vary by hormone type. In the United States, for example, testosterone is a controlled substance, while estrogen, progesterone, and spironolactone are not.[2]

Transgender interviewees expressed frustration with the limited knowledge many providers demonstrated regarding gender-affirming care. Several reported feeling that they were more informed about HRT than their clinicians and were discouraged by providers' lack of awareness about the existence and prevalence of DIY HRT practices, whether for initiating treatment or adjusting regimens.

A 25-year-old transgender woman described her experience independently researching different methods of HRT administration:

> "I find that doctors tend to not know much about how the different routes of administration can affect each individual patient… I'm on progesterone too, but I've always had to request to be on it and none of my doctors have ever really known much about it and only had super vague, like anecdotal stuff about what progesterone would do. But I just had to do all that research on my own. And then you know, certain things like, I have oral pills, but I take them sublingually because that's like – as far as all my research I've done, and I'm a pharmacy tech student – I've done research, [this method] avoids the liver effect, so you don't lose a whole bunch of estrogen and it's also better for your body overall…"
>
> – 25-year-old transgender woman

[2] https://www.deadiversion.usdoj.gov/schedules/orangebook/c_cs_alpha.pdf

Intersex Experience

The needs and experiences of intersex people are often overlooked in medical care. One interviewee's experience illustrates how medical knowledge—and unexpected medical findings or unknown medical conditions—can profoundly impact a person's life, the care they receive, and even their employment. She identified as a transgender woman and shared her story of disclosing her identity later in life:

> "I've been with [my primary care provider] since before I came out. When I came out to him, I came out to him later than I did socially. His first reaction was, "Well, I was wondering how long it was gonna take you to decide you wanted to be happy." And I said, "What?" He said, I knew when you came in my office the first time. And I said, "Wait a second. You knew back in February? Why didn't you say something?" And he said, "It's not my place. It's not my place."
>
> – 62-year-old transgender intersex woman

As she underwent gender-affirming surgery in San Diego she learned that she has been born as an intersex person, "Or as they would have been calling it when I was born, a hermaphrodite. They found evidence that it [vaginal opening] was sewn shut and allowed to wither away, decompose, and be reabsorbed by my body." She reflected on how gender dysphoria felt to her:

> "My dysphoria was more about something not being there that was supposed to be there. Between the orchiectomy and what they found in the vaginoplasty surgery, they found that yeah. I was right. I was born with something that got sewed up. I was born with both [a penis and a vagina]."
>
> – 62-year-old transgender intersex woman

She also said that earlier in her life an x-ray provided a clue to her dysphoria, "Another signal that I got was when I was going through my entry physical with the US Navy. They brought my pelvic x-ray to me and said, 'is this really yours?' because I do not have the pelvic structure of a male." When asked how she felt about this, she responded, "I thought well, okay. I can't let this get out, it will destroy my career. That was my big concern then. At that time, I wanted to have a career in the Navy and then retire."

Nonbinary People

Many nonbinary interviewees had undergone some form of gender-affirming surgery or HRT. Similar to transgender participants, they frequently expressed uncertainty about which cancer screenings were recommended, particularly following surgery or HRT. Nonbinary participants were especially likely to report discomfort with the common medical practice of assigning gender to body parts or organs, noting that this approach often contributed to their avoidance of necessary medical care.

Drug and Alcohol Use

Several interviewees reflected on their experiences with drug and alcohol use. Two spoke about their commitment to sobriety and the deep sense of belonging they found within sober communities. They highlighted LGBTQIA+ sober spaces as essential sources of support for people navigating addiction, noting that these spaces could also serve as models for other types of peer support groups. Interviewees further emphasized the opportunity to share health information in these settings, particularly when delivered by trusted, culturally competent messengers.

- One interviewee, a 57-year-old cisgender gay man, shared that he had been sober for over 30 years. He spoke about the powerful role the sober gay community had played in his recovery and ongoing well-being.

- Another interviewee, a 43-year-old cisgender gay man, spoke candidly during what he described as a difficult period in his sobriety journey. He shared feelings of judgment from both within the LGBTQIA+ community and in medical settings due to his struggles with addiction. He expressed a desire for more compassionate public health approaches and called for educational campaigns to replace pervasive drug and alcohol advertising.

Support Systems of LGBTQIA+ People

Some LGBTQ+ individuals are estranged from their families or do not have close relationships with family members (Reczek & Bosley-Smith, 2021). One interviewee, a 53-year-old cisgender gay man, reflected on his experience during a minor surgery a few years earlier. At the time, a close friend served as his power of attorney and primary support person. While he valued the friendship, he ultimately found the arrangement challenging and later chose someone else to take on that role. Notably, despite having a positive relationship with his family of origin, he deliberately chose not to involve them in his medical care and expressed a continued preference to rely on their chosen family for support.

Similarly, another 53-year-old cisgender gay man described his approach to support systems during medical procedures. Although he was on good terms with his biological family, he did not want them involved in his medical decision-making. During emergency surgery, he turned to close friends rather than family members for support.

These experiences emphasize how support systems for LGBTQIA+ individuals often center around chosen or found family rather than biological relatives—particularly in contexts like medical decision-making and caregiving. As one interviewee emphasized, it would be helpful for medical professionals to understand and respect these chosen families when delivering care:

> "[It would be good for doctors to have] knowledge of chosen families [because] a lot of [times]... for visitors and things like that, there are friends that are your family."
>
> – 23-year-old pansexual femme

Family Dynamics and Health

According to interviewees, family culture can create significant stress that affects a person's health and medical needs. One interviewee, a 30-year-old cisgender gay man, reflected on how his family's culture and dynamics influenced the timing of his coming out, which he described as happening "a little later in life." He emphasized that understanding family dynamics is crucial for clinicians working with the LGBTQIA+ community.

Another interviewee, a 35-year-old nonbinary queer individual, shared that a health condition was triggered by the stress of being queer and feeling unable to come out to their family:

> "I have a ton of medical issues that sort of stem from being queer... the first example that comes up is, I had a thyroid issue, and didn't know at the time that's what was happening...I had to immediately tell my provider right away that, hey, I know that this might actually come from stress in my life, that this has been triggered. I didn't want to take the emotional aspect of caregiving away from the actual physical issue that I was having, so I came clean immediately to tell them, "Hey, I'm in an environment where I'm not safe to come out to my parents or my family. So, this is kind of what's happening." And he was actually able to help me through that, which I know is rare... the way that he explained it to me was that a lot of these genetic predispositions for medical issues can come out because of these everyday stressors, of being marginalized in the first place."
>
> – 35-year-old nonbinary queer person

Socioeconomic Class

Although interview questions did not specifically address socioeconomic status or income, one 57-year-old cisgender gay man who worked in healthcare highlighted the coverage gap between Medi-Cal and private insurance. He noted that many individuals in San Diego County earn too much to qualify for Medi-Cal but not enough to afford adequate care through other insurance options.

Another 30-year-old cisgender gay man spoke more extensively about how his modest background shaped his access to healthcare and served as a significant barrier to receiving needed services:

> "I think that a lot of providers, either willingly or unwillingly... categorize people in such a way that doesn't necessarily... pass muster... just because someone may seem to talk in a certain way or have a certain kind of job does not necessarily mean that they've been vaccinated for HPV, for example."
>
> – 30-year-old cisgender gay man

He also felt that medical providers were quick to categorize and negatively judge people based on perceived socioeconomic class:

> "I think often times, especially if you were raised in a more modest or lower middle-class background, that there are things that people don't necessarily see. It's not something that you wear on your face, right? It's not like the color of your skin. It's not your appearance, and no one can necessarily tell it. But these are invisible scars that people can't see. But you know they're there and sometimes people can be very... lazy with the way that they phrase things."
>
> – 30-year-old cisgender gay man

Disability

Although disability was not specifically included in the interview questions, one participant observed that having a disability often shapes how others interact with you, and can create discomfort when they realize they have underestimated your abilities:

> "I think people have this expectation that I'm going to be a certain kind of way because I'm disabled, or they act surprised about certain things about me because I'm disabled. It's really strange. It's uncomfortable."
>
> – 37-year-old nonbinary pansexual person

Experience with Cancer Treatment

This section details the experiences of interviewees who had been diagnosed with cancer. Three were diagnosed before the age of 30 (leukemia at age 25, prostate cancer at age 24, and thyroid cancer at age 10) and one had multiple abnormal cervical cancer screening results at age 29.

Interviewee 1: Leukemia

A 29-year-old nonbinary gay person who had undergone treatment for leukemia diagnosed at age 25 spoke about how he felt the type of cancer influenced the treatment he received:

> "Blood cancer patients receive very, very different care, because blood cancer is just very different. It's a cancer you can't cut out. It's little more sensitive, and providers there, I would say, have a lot more cultural competence."

He spoke briefly of how he was diagnosed:

> "I got a COVID shot, and then, soon after, I started developing really, really weird symptoms. At first they thought they were side effects of the COVID shot, but it just wouldn't go away. I went to a general provider and they flat out told me, 'I think you have cancer.'"

His experience resulted in his entire family coming together to support him after a period of estrangement:

> "So as a gay person experiencing cancer at the time of diagnosis, I was sort of estranged from my – not immediate family, but their family, so I didn't talk to my aunts or uncles, or my cousins. And my support network was really my parents, my grandparents, and my partner at the time, and my friends. And at the time of diagnosis, my mom told everybody, and everyone just kind of came together and rejoined."

He also did not feel that his sexual orientation or gender identity was scrutinized during his treatment:

> "Maybe it's just because we're in the West. But my sexual orientation and my gender identity didn't have a magnifying glass to it, or a focus on it, because the goal of the treatment is to make sure we clear out the cancer."

Later in the conversation, he spoke of his desire for there to be more education for people receiving cancer treatment regarding sexual and reproductive health. He recalled navigating some of these issues with his partner at the time:

> "Going into it, I don't want to say we were both kids, but we were both young. [My partner at the time was] 25, and he received a lot of education and training on how to care for

> someone. I will say that there is a lack of sexual and reproductive health for cancer patients and their loved ones. I remember when being intimate… just having to explain to [my partner] like, well, we need to use protection because my body is full of chemicals. It's not because I think I'm going to get an STD from you. It's because you will get sick."

When asked what he would want other LGBTQIA+ people undergoing cancer treatment to know, he spoke about side effects of chemotherapy that while, not unexpected, were difficult to endure even with education about what might happen:

> "There's a lot of side effects to treatment. Neuropathy for one. Some of us go sterile. Some of us don't return to being able to have kids… There's a lot of physical changes that happen, and sometimes it is better to know these side effects before going into treatments."

In his experience, the most difficult side effect was dealing with cognitive changes:

> "I think the biggest one is just preparation to [experience] cognitive changes. There's a brief explanation, but you don't really understand it till you experience it. While there is a gap [in educating patients] to fill, we can't always fill those gaps, and that might be one that's gonna need a lot of work. I myself was definitely not prepared for all the mood swings I would be on, which were caused by steroids… you need the steroids to suppress your system. And, as my provider explained, it's like being on meth. And it definitely was lots of ups and downs. You're restless. You can't sleep. You're angry at everything and everyone. You're crying for every reason."

He offered advice to other LGBTQIA+ people undergoing cancer treatment:

> "You know, we as LGBT people suffer from greater mental health issues. So I would say, having a lot of patience, especially if their caregiver is a loved one, because this experience – as hard as it is on ourselves, it's also harder on our loved ones and our caregivers."

While his experience as a very young person with cancer was understandably an intense one, he felt he received professional and appropriate care:

> "I don't think there was ever a time where my gender or sexual orientation came into play during treatment."

He also spoke briefly about a heterosexual friend who was able to offer valuable support to him:

> "I also had a friend who experienced lymphoma, and he was there a lot for me, too. He kind of also helped me navigate by sharing his experience."

He suggested that the experience of LGBTQIA+ individuals undergoing cancer treatment could be improved if the San Diego LGBT Community Center offered more programs and support tailored to

this population. He also noted, however, that his own needs as an immunocompromised patient required physical isolation from others.

Interviewee 2: Prostate

Another interviewee, a cisgender gay man in his 40s, spoke about his experience of being diagnosed with an aggressive form of prostate cancer at age 24. At the time, he was not close to his family, and did not have them to lean on for support:

> "That was a hard thing to experience at such a young age. And then, being told that it was a genetic predisposition that I inherited through my family. Being 24, and not really in communication with my family, it was something that I heavily relied upon my medical team to be there to support me, because I was going through it alone."

He discussed how his young age meant that his medical team was not initially thinking prostate cancer could be a possibility:

> "I would have never known that I had cancer. I thought I had a kidney infection or a urinary tract infection. I was going back and forth doing the home remedies for that. And it wasn't until one night [when] I peed a solid stream of blood for almost a minute and a half. I was like, 'this isn't right.' So I went back to the doctor, and it was like 2 weeks back and forth. After that, [the doctors] were like, we don't know what's wrong. And a medical student, a third year, [said], 'has anybody thought about checking his prostate for cancer?' Everyone was just like, "...no." And then, the barrage of tests came in, and everybody [kept saying] no, because I was so young."

He was supported by his medical team and was extremely grateful:

> "I did have some great medical professionals that were very helpful, that went beyond the scope of what their job description was, even beyond what I think that they could ethically [do]... I feel like it was because I was so young."

> "If I could find that girl now, that med student. If I could have found her even then to say, "thank you." I honestly owe that... a huge, great gratitude, gratitude. [For] my life."

Because of his diagnoses with cancer at such a young age, he felt strongly that people should advocate for cancer screenings earlier in life:

> "I mean, I really advise everybody, earlier than 40 years old, to have their colon checked. Because colon cancer is very, very much on the rise. That's another one, doesn't matter who you are... It can come very suddenly. I wish that doctors would speak more to those pertinent things and stop pigeonholing just because of age."

He also felt strongly about advocating for more public health education about cancer:

> "I feel like if it's just more talked about, especially with the younger LGBTQ community… the better… Instead of seeing so many beer and liquor commercials on TV, take that promotional time and speak to health concerns that actually matter. People are gonna find alcohol on their own. They're not gonna find cancer on their own."

This interviewee also spoke about a friend of his, an older gay man whom he met through his sobriety support community:

> "I … had a friend that lives here in San Diego. Older gentleman though, a gay man. [He told me] he was diagnosed with prostate cancer, and he didn't know [what to do], he was terrified. And he didn't know anybody else to talk to. It just happened to come out one day that I went through it, and he's like, "please tell me that this is gonna be okay." Because he said his doctors did nothing to reassure him. [His doctors didn't tell him] that there was anything possible that they could do, that there was any positive sort of action. They were ultimately trying to prepare him for the worst."

He spoke about the encouragement he offered his friend:

> "…I said to him. 'Look. I was a lot younger when this happened, and the only thing I told myself was, this is not gonna be what takes me out.' And I think, having that mindset of hoping for the best, preparing for the worst, but standing strong in myself. I said… 'change your diet… eat as healthy as you can… and be prepared… for your whole mood, your whole personality to go through this flip flop roller coaster of change, because that's what's gonna happen. You're going to hate your body. You're going to hate the way you feel. You're going to ultimately feel like you're lesser of a man because of this. But you're not. What you need to remember is you are actually stronger, because this is one of the top cancers [affecting] men across the world. Cancer is a hateful disease. Anyway, it doesn't discriminate. Just like karma. She's a bitch. She's gonna come for you whenever, at any given point. Cancer does not discriminate.'"

He was at a very active stage in his recovery and felt comfortable discussing how supporting his friend through a cancer diagnosis had affected him. He also drew a connection between experiencing a cancer diagnosis and his own perspectives on addiction:

> [continued from above] "…Just like addiction doesn't discriminate. And if you're unlucky enough to have cancer and being in an addiction, and not having a supportive resource around you, it's hard. It's hard, you know? I wanted to be at least that one supportive person, because he was heavy in addiction. And I was in my addiction at the at the time, too, and trying to be supportive… all those feelings of what I went through [with my own cancer experience] in the past, how it made me feel, it almost washed right back into me."

He went on to describe how he was able to provide his friend with guidance that he himself had not received at age 24, when facing a terminal cancer diagnosis:

> "I wish I had the suggestions given to me that I was able to give to him. Because I feel like it would have made things a lot easier. But I mean, those are choices that I made. I made the choice to not include my family in that part, because I don't know. I don't know why I didn't want to be a bother. I didn't want my mother to worry. Ideally, I was Superman in my own head, and cancer was my kryptonite. And somehow, by the grace of God, I've survived. I can sit here and say, I am a three-time cancer survivor."

Interviewee 3: Thyroid Cancer

Another interviewee, a 27-year-old transgender man, had been diagnosed with a type of thyroid cancer when he was around 10 or 11 years old. He stated it had been well-managed, and his providers did routine testing for his thyroid function. However, he did not know if having thyroid cancer at such a young age impacted his risks for other types of cancers. He shared discomfort with having cervical cancer screenings as a transgender man going into "women's health" spaces to receive this type of care, a common sentiment among transgender men and transmasculine people.

Interviewee 4: Abnormal Cancer Screenings

Another interviewee, a 29-year-old cisgender lesbian woman, had recently received multiple cervical cancer screenings with abnormal results. At the time of our conversation, she had not received a diagnosis or a treatment plan. I asked her to clarify what she currently knew:

> "Do I know what's going on,' is the question. The past two years, I've had abnormal cells. Even though I was vaccinated for HPV, I came back positive for high-risk cancer cells for the one that you can't be vaccinated for."

Interestingly, she began by describing the opaque, labyrinthine system through which her healthcare and insurance providers determined which screenings were necessary and who would cover the costs:

> "The two tests that they did, both of them came back positive. It was supposed to be that if one came back positive, and one came back negative, then no colposcopy. But both of them came back positive, and they said 'Oh, well, you'll still either have to pay out of pocket, and if your results come back positive from the colposcopy, then you could probably get reimbursed from your insurance. But as it stands, you would have to wait until next year if the cells come back positive again to get the colposcopy, which is like a biopsy to see what's going on."

Her frustrations with the system led her to switch both her insurance plan and healthcare network. As she was actively trying to conceive, she established care with a new primary care provider and OB/GYN. However, she continued to encounter barriers, including a lack of transparency in transferring her medical records from her previous network. At one point, her new provider scheduled an appointment—covered by her insurance—only to review the results of two prior diagnostic tests, rather than to develop a plan for addressing the abnormal cells. When she finally met with her new OB/GYN, she found the explanations of her results confusing and unsatisfactory:

> "[The doctor's office] called me back and said well, he [the ob/gyn] is not going to do the Pap smear until he explains to you what the results are and that's the meeting that we had where – I'm glad I recorded it because it's not my first time being gaslit – [the ob/gyn] said that even though my records stated that… the cells were indeed, abnormal and they were high risk, he said "that was a normal Pap smear. And you have been too aggressive with these cells and trying to find out what's going on with them and you're causing more harm than good, and so I will not be doing a Pap smear. If you insist, I will," but I'm like, I'm never going to force somebody to do anything to my body. I will find another provider that cares."

At this point, she had already decided that she would not be continuing with this provider for multiple reasons:

> "But, he [said], "even if these abnormal cells" – which he then also said were normal – he said "even if it turned out that you were positive for cancer, you could literally go to Mexico for five years, come back, and I could still treat you and cure that cervical cancer." I was like, no! That's not how that works! And that should never be how that works!"

This interviewee had experienced so many negative interactions with doctors that she recorded this appointment to ensure she had an accurate record of what was said. In her words:

> "And I'm so glad I recorded it because I was like, I cannot believe this. So he's like, "do you understand?" and I said, "I hear you, but this isn't okay." Because I'm not gonna say "oh, I understand." I don't want you to think that you attempting to gaslight me is something that's okay. And I wish I'd looked before I wasted all this time but now seeing that he has lost two previous patients because of medical negligence, and like, there's a reason why. There's a reason why, and what I'm not going to do is sit here and let somebody else play with my life."

She continued:

> "My fiancée has me on her insurance, and so I'm just going to relocate. [My fiancée] said, 'look, take time off from work, and we gotta figure out what's going on with you before we even try to get pregnant.'"

This interviewee had lost several family members to ovarian cancer and felt trapped in an unsettling state of limbo, lacking both an official diagnosis and a clear treatment plan:

> "They say it's not genetic, but I also don't want to play with my health. If I have to go through a treatment to get rid of it, I'm fine with that. But waiting with what feels like a ticking time bomb is scary. I don't know how anybody has that knowledge and that 'what if?' and 'what is this that's inside me?' without being afraid."

> "Yeah, I thought it [diagnosis] was straightforward too, but no. I don't know how much of this really goes into, there's just more components than I originally thought. I don't know how much it's that, and I don't know how much of it is, providers that either cannot do [the screening] because of their hospital's policies and so they're limited, and they cannot be as productive and proactive as they once would. Or if it's the provider themselves, in my case, he prefers to do obstetrics and not gynecology… I don't know how much of this plays into the other. I wish I knew."

When asked whether she had any advice for other LGBTQIA+ individuals—or specifically for other lesbians facing a similar situation—she responded:

> "Even if you sound like the crazy person, advocate for yourself. Make some noise. I know oftentimes we're told hey, don't make a fuss. It can be detrimental to your health and the safety of your health, going to these providers. But if something doesn't feel right, listen to it. If you go into an office and you feel like, you know what, maybe this isn't for me, and then you go to that first appointment and it's not for you, if something just seems wrong, listen to it. You can always call your insurance and ask to be reassigned [to another doctor]."

She felt strongly about her own rights—and, more broadly, patients' rights—to seek out a provider who was a better fit, explaining:

> "[continued]… And that's what I should have done. I should not have waited three months calling weekly to get an answer to my call. The red flags were just having a parade at that point. I should have listened to my better judgment, and I didn't. But if something seems off, never be afraid to – one, still speak what you know, speak your truth, but also – see somebody else. You can be referred to a different provider. You don't have to just stick to whoever you are first given… Sometimes you do need to shop around, and don't be afraid of that… I guarantee you somewhere there's going to be a provider that's going to listen to you, they're going to make that experience – maybe not the dream experience, because, you know, cancer cells are scary as it is – but you'll feel like you have a care team. You'll feel like you have somebody that's on your side."

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