



HAWAI'I SEXUAL AND GENDER MINORITY HEALTH REPORT 2018

A FOCUS ON TRANSGENDER YOUTH





'A'ohe hana nui ke alu'ia

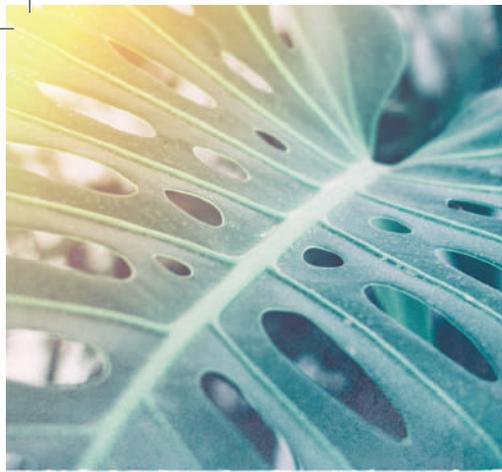
(No task is too big when done together by all)¹

This report is dedicated to all sexual and gender minority populations in the State of Hawai'i.

It acknowledges the resiliency and strength of transgender and gender non-conforming people in Hawai'i, who have a disproportionate burden of adverse events in their lives, yet continue to strive for a better tomorrow. It remembers and acknowledges all those from our sexual and gender minority communities who passed too soon and those who continue to pave the way for future generations.

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Aloha kākou,

The Hawai'i Department of Health is pleased to present the latest health report on Hawai'i's sexual and gender minority communities, with a special focus on the health of transgender youth. This report is especially relevant now as the Department addresses social bias as a determinant of health in an effort to reduce disparities and improve the health and well-being of all residents of Hawai'i.

In April 2017, the Department released its inaugural Sexual and Gender Minority Health Report, which highlighted health disparities affecting youth and adults identifying as lesbian, gay, or bisexual in Hawai'i. At that time, there was insufficient data to report on the health of our transgender and gender non-conforming communities. Substantial data collection since has made this new report possible. I am excited to share the Department's first report on the health of transgender youth in Hawai'i.

While this report describes many health and social inequities faced by our transgender and gender non-conforming youth, it also acknowledges the community's resiliency and offers opportunities to reduce gaps in health equity. We would like to thank all the community members who offered their input, insight, and honest feedback to make this a truly meaningful report.

This report is intended to serve as a source of comparative health statistics for gender minorities in Hawai'i. It is my hope that this document will be a useful resource for health policy makers, planners, and all of us in the community who share a common desire to improve health outcomes, especially for marginalized and vulnerable populations of Hawai'i.

ALL people of Hawai'i deserve opportunities to grow and thrive.

Mālama Pono



Bruce Anderson, Ph.D.

Director

Hawai'i State Department of Health

Introduction

While sexual minority and transgender/gender non-conforming (SM & TG/GNC) individuals in Hawai'i have unique health experiences and needs, very little local data has been collected to obtain a complete understanding of the health status of this population. The little research that is available attests to the need to focus more on these communities to better address health and social disparities.⁷ A University of Hawai'i report found that policies and cultural norms that stigmatize and exclude SM & TG/GNC people have negative health effects and result in health disparities specific to these communities; it emphasized the need for greater research on SM & TG/GNC communities in Hawai'i.⁷

Health disparities among SM & TG/GNC communities have become an increasing area of concern and focus at the national, state, and local levels. Improving the health, safety, and well-being of SM & TG/GNC individuals is a specific goal of Healthy People 2020, the federal initiative which provides national goals and objectives for health promotion and disease prevention.⁸ In 2011, the Institute of Medicine (IOM) released its first comprehensive Lesbian, Gay, Bisexual, and Transgender (LGBT) health report which identified research gaps and opportunities.² The IOM recognized that SM & TG/GNC people "face barriers to healthcare that profoundly affect their overall well-being," and called for more research and analyses of disparities in health outcomes.² Subsequently, in 2017, the Hawai'i Department of Health (DOH) released its first **Hawai'i Sexual and Gender Minority Health Report**.⁹ This report broadly addressed health concerns, health disparities, and resiliency factors for all SM & TG/GNC individuals in Hawai'i. However, due to limited availability of data at that time, the report addressed health concerns among only adults identifying as lesbian, gay, or bisexual (LGB), and youth identifying as LGB or questioning.

The 2017 Hawai'i Sexual and Gender Minority Health Report generated a groundswell of community support, including a letter co-signed by several community partners addressed to then Hawai'i Director of Health, Dr. Virginia Pressler, requesting more data and greater public health action to address the needs of SM & TG/GNC people in Hawai'i. In response, the DOH convened the Sexual and Gender Minority Health work group, a task force comprising both DOH employees and community partners, to respond to the myriad voices, concerns, and requests of community stakeholders. This report is inspired by our community partners who showed, through strong public health action, the void and urgent need for more data, especially data that focused on the health concerns of individuals identifying as TG/GNC in Hawai'i. We are thankful to everyone who contributed to bringing this report to fruition and for their passion, honesty, and insight.



What is **GENDER IDENTITY**?

Sexual orientation and gender identity are multifaceted concepts. The term “lesbian, gay, bisexual, and transgender” represents a diverse community made up of many unique populations. Although each group shares similar experiences, such as stigmatization, each has unique health needs and concerns. **Sexual orientation** describes a person’s sexual and romantic attraction, behavior, and identity in relation to others. The terms lesbian and gay, or homosexual, apply to people who are either exclusively or predominantly attracted to, romantically involved with, or sexually involved with people of the same gender.² Bisexual refers to people who are, to a significant extent, attracted to, romantically involved with, or sexually active with people of the same and a(n) different/other gender.² The terms heterosexual, or straight, refer to people who are attracted, either exclusively or primarily, to the opposite gender.² Asexual individuals feel varying degrees of romantic and sexual attraction toward others and pansexual people are not limited by gender in their romantic and sexual attractions to others.

GENDER IDENTITY

There are three primary concepts to consider in understanding gender: gender identity, sex assigned at birth, and gender expression. The concept and lived experience of gender is different from sexual orientation. **Gender identity** describes an individual’s personal sense of their gender.² An individual’s gender identity can be the same or different than their **sex assigned at birth**, which is the sex that a person is labeled with when they are born. Most commonly, people are assigned female or male at birth, though there are a subset of people who are born with ambiguous hormonal, gonadal, chromosomal, or other sex characteristics that may be identified as intersex. A person who identifies with a gender that corresponds to their sex assigned at birth is cisgender (e.g. a person assigned female at birth who identifies as a woman is a cisgender woman) while a person whose gender identity and sex assigned at birth do not correspond might identify with a list of many other identities (transgender, agender, gender non-conforming, etc.), collectively addressed in this report as transgender/gender non-conforming (TG/GNC). TG/GNC people may elect to complete a variety of medical interventions (e.g. hormone replacement therapy, chest surgeries, genital reconstruction surgeries, etc.) to align with their gender identity. Not all TG/GNC people will engage in medical interventions as a part of their identity development. It is incorrect to say that someone is more or less transgender by citing the amount of medical interventions they have completed.

CONSTRUCTS OF GENDER

Gender identity has largely been perceived in a gender binary, with women and men being the only two identities. The gender binary does not acknowledge genders that do not fit into the two categories. Instead, gender refers to the identification with any combination of woman-ness, man-ness, the absence of gender, or the identification with a gendered system that does not involve the gender binary at all. Gender identity is separate from **gender expression**, which refers to the external manifestation of one’s gender identity, often through appearance and behavior.² Gender expression does not dictate gender identity. An individual may identify as a woman and dress in clothing or behave in ways that are historically identified as masculine. Not all gender non-conforming people are transgender.



GENDER AND CULTURE

Gender identity is also culturally informed. There are identities central to cultures outside of the U.S. norm that are additional, third, or middle genders. These genders include, but are not limited to, the mähū wahine and mähū kāne of Hawai'i (page 7),³ fa'afafine of Samoa,⁴ fakaleiti of Tonga,⁴ two-spirit people in some Native American cultures,⁵ and hijra in India,⁶ among many others. These identities are not to be confused with transgender identity. Individuals with any of the mentioned identities may or may not identify as transgender. The abundance of gender identities found across cultures highlights the problematic nature of the gender binary, as there are significantly more genders than male and female.

SUMMARY

Gender identity (how one identifies) and sexual orientation (whom one is attracted to) are different aspects of one's identity. Moreover, the terms lesbian, gay, bisexual and transgender are not all-encompassing. Individuals from certain backgrounds, cultures, race/ethnicities, and age groups may identify with other terms or choose not to label themselves at all. For the purposes of this report, the term sexual minority and transgender/gender non-conforming (SM & TG/GNC) is used to describe the full spectrum of sexual and gender minorities.







MINORITY STRESS THEORY

The concept of minority stress is important in understanding the experiences of sexual and gender minorities in a meaningful way. **Minority stress** is defined as the additional stressors that people experience due to having a stigmatized minority status.¹⁰ Minority stress factors for SM people consist of experiences of negative events, expectations of future experiences of negative events, internalized homophobia, and concealment of sexual minority identity.¹⁰ Minority stress has been associated with high rates of suicidality, substance use, depression, and social anxiety.¹¹⁻¹³ Additionally, HIV risk is associated with minority stress in gay men.¹¹

Researchers have studied additional stressors that are experienced by TG/GNC people. Gender minority stress includes discrimination, rejection, and victimization based on gender minority identity or expression; non-affirmation of gender identity (e.g. wrong pronoun use); expectations of future experiences of discrimination based on gender minority identity; internalized transphobia; and concealment of one's TG identity.¹⁴ Each of these has been found to contribute to various mental health disparities between TG/GNC and cisgender people.¹⁵⁻²² Experiences of minority stress are linked to disproportionately high rates of suicidality, depression, anxiety, substance use, and HIV diagnoses.^{16,17,20,21,23-25} Moreover, TG/GNC people of color and TG/GNC undocumented noncitizens report even higher rates of physical and mental health concerns.¹⁷



What is MĀHŪ?

Māhū is both a term and a cultural role that can be used to describe kanaka (or Native Hawaiian) people who identify with a third or “middle” gender other than male or female, with characteristics of both sexes.^{26,27} In this sense, māhū people may not consider themselves transgender, in that they are not transitioning from one gender to another. In contemporary contexts, the term māhū may also be used more broadly to describe TG/GNC people, or gay men; it is sometimes used as a derogatory term.^{27,28}

The cultural concept of māhū occurs throughout Polynesia, with the same term being used in Tahiti and Marquesas. Similar concepts also are recognized in Samoa (fa'afafine) and Tonga (fakafefine or fakaleiti).^{27,28} In a nationwide survey of TG/GNC people, one in five (20%) Native Hawaiian/Pacific Islander respondents identified as māhū. Additionally, 8% of Native Hawaiian/Pacific Islander respondents identified with the term third gender.²⁶

In pre-colonial Hawaiian culture and society, sexual and gender diversity (e.g. aikāne, male companions to ali'i, Hawaiian royalty) were accepted to such a degree that māhū played an integral role in cultural practices.²⁹⁻³² They were respected as spiritual and cultural leaders, especially in the preservation of Hawaiian traditions such as hula chants. Post-colonial acculturation has shifted the role of māhū (as well as other sexual and gender minorities) from one of respect and social value to stigma and shame.

As discussed in “What is Gender Identity?” (page 3), gender is culturally informed, so Native Hawaiian culture and history is interconnected with the different meanings and stigma attached to māhū. As the Hawaiian cultural renaissance continues to evolve, so does the meaning of what it is to be māhū. For example, in the early 2000's, māhū wahine became a term of empowerment among Hawai'i's TG/GNC community, signifying male-to-female (MTF) identities in varying, personally chosen, forms.^{27,28,33} Additionally, contemporary TG/GNC and māhū communities in Hawai'i continue to build resiliency through forming “drag” families or other hui such as Ka Aha Māhū. For more on local experiences of growing up māhū, see Community Perspectives (page 13).

Historical Perspectives

Both locally and nationally, policies and engagement around issues relating to sexual and gender minorities have changed greatly over time. The State of Hawai'i has been at the forefront in protecting the rights of SM & TG/GNC people. In 1972, Hawai'i decriminalized consensual same-sex sexual contact.³⁴ In 1993, Hawai'i became the first state in the nation to come close to achieving marriage equality.³⁵ In *Baehr v. Lewin*, plaintiffs sued over the state's denial of marriage licenses to three same-sex couples.^{36,37} The case became the first victory of significance to marriage equality advocates nationally after the Hawai'i Circuit Court upheld the plaintiffs' position that denial of marriage licenses to same-sex couples was unconstitutional.³⁶ However, the landmark case created substantial backlash resulting in the federal Defense of Marriage Act (DOMA).^{35,38} In addition, an amendment to the Hawai'i Constitution was ratified in 1998 giving the Hawai'i legislature the power to "reserve marriage to opposite-sex couples," effectively banning same-sex marriage in the state.^{35,39,40} Nevertheless, in 1997, Hawai'i became the first state to offer a limited subset of marriage benefits to couples, regardless of sex or gender, through the Reciprocal Beneficiaries Act.^{41,42} With the enactment of Senate Bill 232 in February 2011, Hawai'i legalized civil unions, and by January 2012 began granting civil union partners many of the same rights, benefits, protections, and responsibilities as married couples.⁴³ In November 2013, Senate Bill 1 (Hawai'i Marriage Equality Act of 2013) was passed and signed into law, and by December 2, 2013, it became possible for any two adults, regardless of their sex or gender identity, to begin marrying in Hawai'i.^{44,45}

Aside from achieving marriage equality, Hawai'i laws have gradually increased statutory protections for SM & TG/GNC people in seeking employment, public accommodations, housing, and state-funded services, and against hate crimes. In 1991, the Fair Employment Practices law was amended to prohibit employment discrimination based on sexual identity.⁴⁶ In 2001, Hawai'i passed a law extending protections to those experiencing hate crimes because of their actual or perceived sexual identity; in 2003, actual or perceived gender identity or expression was added to the statute.⁴⁷⁻⁴⁹ In 2005, the state's Fair Housing law was amended to prohibit discrimination based on "sex, *including gender identity and expression*, and sexual orientation," clarifying that discrimination based on gender identity or expression was a type of sex discrimination.⁵⁰ This was followed by similar amendments to the state's public accommodations law in 2006.⁵¹ The new housing discrimination prohibitions were supported by national policy: in 2016, the federal Department of Housing and Urban Development (HUD) updated its rules and regulations to ensure equal access to housing "regardless of sexual orientation or gender identity" in HUD's Native American and Native Hawaiian housing programs.⁵² In 2011, the Fair Employment Practices law was amended to clarify that the prohibition against sex discrimination in employment decisions included discrimination based on gender identity or expression.⁵³ The legislature established the Hawai'i Civil Rights Commission (HCRC) in 1988 to enforce laws established by the state to prohibit discrimination.⁵⁴ The types of discrimination that HCRC has jurisdiction over was expanded to include discrimination on the basis of sexual identity in 1991 and gender identity and expression in 2011.^{54,55}

SM, sexual minority; TG, transgender; GNC, gender non-conforming; LGBT, lesbian, gay, bisexual, transgender
*Refer to "What is Gender Identity?" on page 3 for more information.

Hawai'i has also been at the forefront of policies offering protections specifically for TG people. In 2015, House Bill 631, Act 226 amended Section 338-17.7, Hawai'i Revised Statutes to enable individuals in Hawai'i to petition to change their gender on their birth certificates on the basis of receiving appropriate clinical treatment for gender transition from a physician without necessarily having to undergo hormonal transition or expensive and invasive surgery.^{56,57} In 2016, House Bill 2084 (Act 135) passed, prohibiting health insurers from discriminating on the basis of gender identity or expression in issuing health insurance policies or providing health coverage that includes transition services.⁵⁸

Substantial policy efforts have occurred to enhance protections for SM & TG/GNC youth in schools. The Hawai'i Board of Education Policy 305-10 prohibits harassment or bullying on the basis of gender identity or expression, and sexual identity.⁵⁹ Title 8, Chapter 19 of the Hawai'i Administrative Rules prohibits students from engaging in verbal or non-verbal actions in the school environment that cause another student to feel uncomfortable, pressured, threatened, or unsafe on the basis of sexual identity, gender identity, gender expression, and more.⁶⁰ Furthermore, *Guidance on Supports for Transgender Students* was created and implemented by the Hawai'i Board of Education during the 2016–2017 academic school year.⁶¹ Important guidelines included were the ability for schools to permit unofficial academic records to reflect the student's preferred name and gender identity; students to wear clothing consistent with their preferred gender identity or expression; and students to use bathroom and locker room facilities that correspond with their self-identified gender identity. In response to inadequate federal protection for sexual and gender minorities in educational settings, the Hawai'i State Legislature unanimously passed House Bill 1489 (Act 110) in 2018, which will, by 2020, prohibit discrimination on the basis of sex, including gender identity or expression, and sexual identity in any educational program that receives financial assistance from the State of Hawai'i.⁶²

In addition to protections in educational settings, Senate Bill 270 (Act 013) passed in 2018 making Hawai'i the 12th state to prohibit sexual identity change efforts by a health care professional (i.e. "gay conversion" therapy), including any attempts to change gender identity, expression, or behaviors. The bill further establishes a counseling task force to address the needs of SM & TG/GNC youth.⁶³

In summary, many policy efforts have likely positively impacted the health status of Hawai'i's diverse SM & TG/GNC communities, although health disparities continue to persist. Monitoring health outcomes over time will help the state assess the impact of current and future policy changes on the health and well-being of these communities. This effort includes strengthening current surveillance systems that collect data on SM & TG/GNC people. For example, in 2017, a question on gender identity was added to the high school Hawai'i Youth Risk Behavior Survey (YRBS), which is administered to public middle and high school students throughout the state (See Methodology, page 20), allowing the Departments of Health and Education to gain more insight on transgender youth.



1963

Disorderly conduct legislation in Hawai'i is amended to include persons wearing clothing of the opposite sex with "intent to deceive" others by failing to reveal one's sex.⁶⁴ Trans and māhū persons are required to wear "I am a Boy" buttons to avoid fines.⁶⁵

1969

The historic Stonewall Revolution—riots that ensued following a New York City police raid on the Stonewall Inn, a gay club—marking the start of the LGBT civil rights movement.⁶⁶

1996

President Bill Clinton signs the Defense of Marriage Act (DOMA), banning federal recognition of same-sex marriage by defining marriage as "a legal union between one man and one woman as husband and wife."³⁸

1997

The Hawai'i legislature proposes an amendment to the Hawai'i Constitution, to give itself the right to "reserve marriage to opposite-sex couples."⁴⁰

Hawai'i becomes the first state to offer a limited subset of marriage benefits to couples, regardless of sex or gender, through the Reciprocal Beneficiaries Act.⁴²

1998

Hawai'i voters approve a constitutional ban on same-sex marriage.³⁹

1960

1970

1990

2000



1970

The first Gay Pride marches take place in Los Angeles, Chicago, and New York.⁶⁷

1972

Hawai'i decriminalizes consensual same-sex acts occurring in privacy between consenting adults.³⁴

Hawai'i's disorderly conduct law revised, deleting the "intent to deceive" clause.⁶⁸ Trans and māhū persons no longer required to wear "I am a Boy" buttons.⁶⁵

1973

The American Psychiatric Association removes homosexuality from its official list of mental disorders.⁶⁹

1991

Hawai'i's fair employment law is amended to prohibit discrimination on the basis of sexual orientation; sexual orientation as a protected class appears for the first time in Hawai'i statute.⁴⁶

1993

In the case of *Baehr v Lewin*, the Hawai'i Circuit Court finds the state's refusal to grant same-sex couples marriage licenses unconstitutional.³⁷

President Bill Clinton signs a military policy known as "Don't Ask, Don't Tell" (DADT) that prohibits openly gay, lesbian, or bisexual Americans from military service.⁷⁰

2001

Crimes in Hawai'i perpetrated against an individual on the basis of their actual or perceived sexual orientation are classified as "hate crimes."^{47,48}

2003

Crimes in Hawai'i perpetrated against an individual on the basis of their actual or perceived gender identity or expression are classified as "hate crimes."^{47,49}

The U.S. Supreme Court (in a 6-3 decision) strikes down sodomy laws that previously banned private consensual sex between adults of the same sex.⁷¹

2005

Gender identity or expression as a protected class is added to anti-discrimination statutes for the first time in Hawai'i.⁷²



2010

The State Department updates their policy allowing the issuance of a passport that reflects a person's current gender identity.⁷³ Under this policy, youth and adults must submit a letter from a licensed physician confirming they had the "appropriate clinical treatment for gender transition," overruling the previous requirement of sexual correction surgery.

2011

The Hawai'i Civil Rights Commission is able to uniformly enforce prohibitions against discrimination based on sex, including gender identity and expression, and sexual orientation, in employment, housing, public accommodations, and access to state-funded services.^{46,50,51,54,55}

DADT is repealed, ending the ban on gay, lesbian, and bisexual persons from serving openly in the military.⁷⁴

2010

2015

The Hawai'i Legislature passes House Bill 631, allowing transgender people to change gender on their birth certificates without having to undergo surgery.⁵⁷

The U.S. Supreme Court rules, 5-4, that same-sex couples have the fundamental right to marry, making same-sex marriage legal in all 50 states and the District of Columbia.⁷⁶

The Centers for Medicare and Medicaid Services (CMS) issues a final ruling for Meaningful Use III, mandating that health information technology (HIT) platforms, such as electronic medical records (EMR), contain fields for sexual orientation and gender identity in a standardized format.⁷⁷

2016

Department of Defense allows transgender service members to serve openly in the U.S. military.⁷⁸

Hawai'i Department of Education (DOE) develops guidance for schools to provide adequate support to transgender students.⁶¹

The Hawai'i Legislature passes House Bill 2084, "prohibit[ing] the denial, exclusion, or limitation of health care services or treatment to a person on the basis of a person's actual gender identity or perceived gender identity."⁵⁸

2012

Civil unions become legal in Hawai'i.⁴³

2013

The Hawai'i Marriage Equality Act passes and is signed into law by Governor Neil Abercrombie, making Hawai'i the 16th state to recognize same-sex marriage.⁴⁴

Same-sex couples begin marrying in Hawai'i.⁴⁵

In a 5-4 decision, the U.S. Supreme Court strikes down Section 3 of DOMA that denies federal benefits to same-sex couples.⁷⁵

2018

With the passage of Act 13, Hawai'i becomes the 12th state to ban sexual identity change efforts (i.e. "gay conversion" therapy) for minors.⁶³

Hawai'i passes House Bill 1489 (Act 110) which will, by 2020, prohibit discrimination on the basis of sex, including gender identity or expression, and sexual identity in any educational program that receives financial assistance from the State of Hawai'i.⁶²





*talk
story*



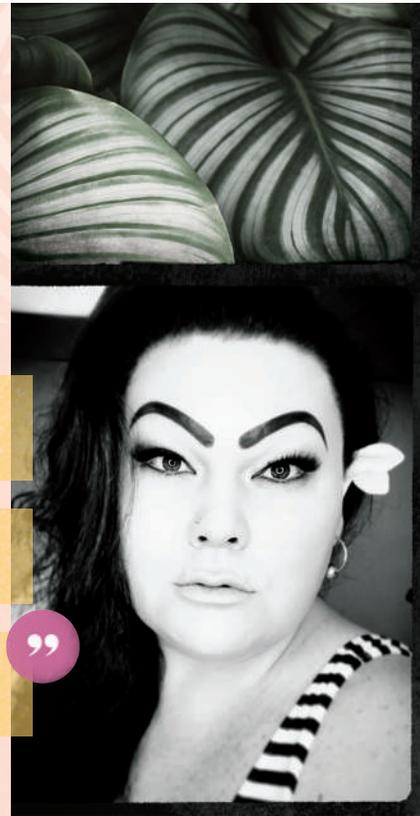
An illustration of two hands, palms facing each other, holding a heart. The hands and heart are rendered in a simple, white line-art style against the orange background. The hands are positioned on the left side of the page, with the heart centered between them.

Community Perspectives

To better ground this report in the cultural context of Hawai'i, we reached out to our local community members to hear their stories about "growing up māhū". These narratives honor the practice of oral tradition ("talk story") in local and Native Hawaiian history. We hope these stories enrich and contextualize the survey data presented in this report that cannot, by themselves, fully represent the rich complexity of an individual's or community's lived experiences.

“
***I can be the positive
 influence for my
 community***
 ”

- Bianca Tasaka



I was teased in school by other students. They thought I was gay, but I knew I was transgender. When I would act feminine, I recall my family telling me “you can’t act like that or you’ll get cracks.” I felt my family was embarrassed of who I was. I wanted to play with dolls and My Little Pony figurines. I dreamed of dancing hula as a girl, but was told “boys don’t dance hula.” I felt like being a boy wasn’t what I wanted or what I was. What I wanted was to be a girl and do girl things. I was told all the time what I couldn’t do: “don’t walk swaying your hips and tighten up your

***I was teased in
 school by other
 students.***

loose wrist.” I remember going to my friend’s house where I could be my true self and put on makeup and play with dolls.

As I grew up, I realized I needed to be true to myself. At the age of 20, I started “dressing female” in public and started my transition. I was sent to my grandma’s house on O’ahu during the summer break and I started to express my inner self. As an empowered woman, I look back at these experiences and realize how far I’ve come. Now I can be the positive influence for my community on Kaua’i island.



I discovered a whole new world of love and support

- Keris Kerisiano

I was raised in a house where gender roles weren't questioned because of our cultural and religious beliefs. Growing up, I was constantly reminded of how I had to be an obedient, respectful, and honorable wife every day. I was instructed on how to dress, how to act, and how to walk and talk. I was even taught how to cook, clean, sew, and how to care for children. It was basically everything my family thought I needed to know in order to be that "perfect wife."

The hardest part of all was when I realized that I didn't want to be the wife. Instead, I wanted to be the husband. I was open to doing "wifely" duties, but I wanted to do the "manly" things as well. This was the biggest challenge for me because not only was it against my family's religion, but also it was against western society's rules about gender roles.

So there I was, growing up, being obedient, doing what I was told, but always came up with ways to incorporate masculinity into whatever I was doing. For instance, going to church every Sunday was a must in my family. I would wear shorts under my dress. If something needed to be moved or lifted, you know I was right there to help. Before I knew it, I was doing all the "boy" stuff too. I think after a while, my family realized that my being fa'afatama was positive, even beneficial.

I found myself constantly daydreaming and yearning to be a boy. I watched the men in my family and wanted to be just like them when I grew up. By the time I was 8 years old, I already was dressing and acting like a guy. I wouldn't express my true feelings to anyone for fear of being judged, rejected, or for shaming my family. For the longest time I had accepted the possibility of being abnormal.

I wondered if I would ever be accepted as "normal" in society.

By the time I was in high school, my hair was short, I was bigger and stronger, but my family (along with society) felt I still had to be a girl. I had begun wondering if a guy like me could ever be in love with a woman. I wondered if I would ever be accepted as "normal" in society. At the age of 21, I felt secure enough to stand up to my family and tell them I would be living my own life now. I discovered a whole new world of love and support from society and the trans community. I learned so much about who I was destined to be. I have always thought about fully transitioning (by taking testosterone and having gender affirming surgeries), but as of today, I am ok with myself and happy with my life. What is more important for me is that younger trans men have an easier discovery process of themselves than I did.

“ *I believe it starts
with RESPECT.* ”

- Sina Sison



Growing up māhū wasn't easy. We understood the discrimination, violence, and deadly situations our trans community faced, but we still endured it to live our lives as our authentic selves. Still, knowing the risks, many transwomen were eager to transition. This was a time when Honolulu was bustling with young military men who were arriving in the islands from the Vietnam War, and survival sex work became prominent.

Acquiring gonorrhea and syphilis was much more common back then, so getting tested and treated happened more regularly for the trans community. Despite this, the trans community commonly resorted to survival sex work because it was the fastest way to make money for surgery and hormone replacement therapy (which was difficult to get from physicians at the time). Many felt the abuse of power by authorities when they would round up and throw girls into paddy wagons and arrest them for

minor offenses such as loitering and curfew violations. It was common practice for our trans sisters who needed treatment for gonorrhea and/or syphilis to be locked up in jail, especially during afterhours when the clinic was closed; this was seen as an appropriate quarantine solution for sex workers who needed treatment for gonorrhea and/or syphilis.

It is a different time now and there have been so many positive changes that protect our trans community from being further traumatized or discriminated against. We must continue to find ways to protect and create a safer environment for our

We must continue to find ways to protect and create a safer environment for our trans communities in Hawai'i

trans communities in Hawai'i, and I believe it starts with RESPECT. When people treat each other with respect, regardless of their differences, they can learn the authentic value in the other person. We now have many empowered trans people who have promising careers such as in education, civil service, public safety, and even politics.

“
***My struggles have
 carried me far,
 and I am stronger
 because of them.***”

- Kaleo Ramos



As the saying goes, you shape your own world. Everyone is born with the ability to create a life that is both meaningful and relevant. But achieving that depends on the drive one sets for oneself, and how one rises from one's struggles. My life has always been full of struggles. In fact, it always seems as though every day of my life has required me to act with a full tank of adrenaline. My earliest memory of being transgender was when I was only 5-years old entering Kindergarten. I was different from the other girls, but I did not know how I was different, and I did not possess the words or desire to express my feelings to anyone.

I grew up feeling ashamed and angry. I behaved aggressively, and carried more stress than any young child should have to shoulder. My struggles continued through my school years, all the way till I was 29 years old. At that time, I was married with a 2-year old child. I knew what I needed to do for me to be truly

***Without these struggles
 I would not be where
 I am now in this life.***

happy with myself: live an authentic life where I was not only happy, but more importantly, I was honest with myself about how I wanted to live the rest of my life. I ended my marriage and long-term relationship of 8 years with the father of my child and made one of the biggest decisions of my life: to transition. My struggles have carried me far, and I am stronger because of them. Without

these struggles I would not be where I am now in this life. My resilience and determination to live better and stronger were what truly drove me to where I am today. I am a successful educator; advocate; activist; graduate student working on my 5th, 6th, and 7th college degrees; hula dancer; respected individual of the LGBT community; partner; parent; and son. I could not have done many of these things without developing a reservoir of happiness within myself by finally being able to live authentically, and having the internal motivation and desire to do plenty of good things in this life.

Objectives

SM & TG/GNC people are often treated as a single entity for research purposes, but each is a population group with its own unique health needs. The experiences of SM & TG/GNC individuals are not uniform and are shaped further by their race, ethnicity, socioeconomic status, geographical location, age, overlapping sexual and gender identities, and other social determinants of health, including their exposure to adverse events in childhood or adulthood, any of which can have cumulative effects on their health-related concerns and needs.

This report is a sequel to the first **Hawai'i Sexual and Gender Minority Health Report**, released in 2017.⁹ It continues to explore the health of Hawai'i's residents through the lenses of sexual identity and gender identity and expression. While the first report provided an in depth understanding of many health disparities among lesbian, gay, and bisexual (LGB) adults and LGB and questioning youth in Hawai'i, this current report focuses on TG youth. In this report, youth who identify as TG are compared to youth who do not identify as TG, also referred to as cisgender youth. In addition, data on youth who identify as LGB or heterosexual are provided for comparison purposes. At this time, data on TG adults, and adults and youth identifying as gender non-conforming are not available.

The authors of this report acknowledge that more data for SM & TG/GNC people in our state must be collected and analyzed to fully monitor health trends. Towards this end, we are grateful to our community partners and all the individuals who work tirelessly to improve the health and well-being of SM & TG/GNC people in Hawai'i.



Methodology



YOUTH RISK BEHAVIOR SURVEY (YRBS)

Youth indicators are drawn from the Hawai'i Youth Risk Behavior Survey (YRBS), which is administered by the State of Hawai'i in cooperation with the Centers for Disease Control and Prevention (CDC). The State of Hawai'i adheres to survey sampling, development, and administration protocols prescribed by CDC. In addition, the data is weighted by CDC. By following CDC methodology, a few thousand responses collected statewide during each survey year are weighted to provide health data that is representative of the state's public middle school and high school populations. In this report, only weighted population numbers are provided; additionally, the data is limited to high school youth, as gender identity questions were not asked in the middle school survey. Standard definitions used in this report were selected to match definitions prescribed by CDC, as well as national frameworks such as Healthy People 2020,³ and state planning documents. Statistically significant differences between TG and cisgender (reference group) populations are highlighted.

The YRBS is a joint effort of the Hawai'i Departments of Health and Education, and the University of Hawai'i Curriculum Research and Development Group, to monitor the health status and risk behaviors of public school students in grades 6 through 12. Separate surveys are administered to middle and high school students. The survey questions are developed and tested by the Centers for Disease Control & Prevention (CDC). The data gathered contribute to national surveillance efforts and provide important information on the health status of our youth. The survey is administered as an anonymous pencil and paper survey in odd-numbered years. In 2015, the policy for survey administration changed from an active (opt-in) to passive (opt-out) consent process. While this change in methodology did not lead to significant variation in the overall state-level data collected, a substantial increase occurred in the number of respondents, including sexual minority youth (data on gender identity was not collected in 2015).⁷⁹

The YRBS monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among teens, including behaviors related to unintentional injuries and violence, sexual behaviors that contribute to unintended pregnancy and sexually transmitted infections (including Human Immunodeficiency Virus, or HIV infection), alcohol and other drug use, tobacco use, dietary behaviors, and physical activity. The survey also includes special topics of local interest. Questions on sexual identity have been included in the high school YRBS since 2005. In 2011, the survey's sample size was increased to enable county-level reporting, consequently increasing the number of sexual minority respondents and enabling analysis of YRBS data by sexual identity. In 2017, a question on sexual identity was included for the first time in the middle school YRBS survey, and a question on gender identity was added to the high school YRBS survey.

This report presents gender identity data gathered among Hawai'i high school students in 2017. The CDC-approved question on gender identity asked respondents to report whether they identified as transgender (yes/no); respondents were additionally allowed to report that they were not sure if they were TG, or that they did not understand what the question was asking. Youth who were unsure if they were TG, and those who did not understand the question were excluded from analysis. Youth who reported that they were not TG were classified as "cisgender." Methods for classifying youth by sexual identity as LGB or heterosexual have previously been described.⁹ Descriptive analyses were conducted with Statistical Analysis Software (SAS) 9.4 (Cary, NC) to compare the prevalence and 95% confidence intervals of health outcomes between youth classified as TG and cisgender, respectively. If the two confidence intervals did not overlap, we considered there to be a statistically significant difference between the population values. Data are not reported for some groups for certain indicators where the sample size fell below the threshold for reporting. Youth who reported that they were not TG were classified as "cisgender" (see Figure 1).

Figure 1: Questions within the YRBS Used to Identify Transgender and Cisgender, as well as LGB and Heterosexual Students

YRBS Trans/Cisgender & LGB/Heterosexual Definitions

Separate questions from the Hawaii YRBS were used to collect information on students' self-reported gender identity and sexual identity. These questions were part of a larger survey conducted on the general health risks of all students in Hawai'i.



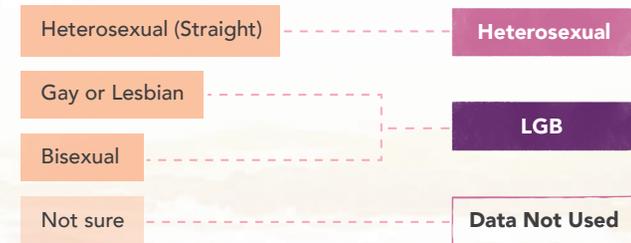
Gender Identity

Some people describe themselves as transgender when their sex at birth does not match the way they think or feel about their gender. Are you transgender?



Sexual Identity

Which of the following best describes you?





COMPARISON OF LGB AND TG DATA

Sexual and gender identity are separate constructs, where respondents may identify as any combination of the two identities. For example, some respondents may be classified as both LGB and TG. Thus, it is inappropriate to make direct comparisons across the two constructs (i.e. between the health status of LGB and TG youth), as there may be substantial overlap between these groups. Please refer to the "What is Gender Identity?" box on page 3 for more information. The Appendix provides data comparing TG to cisgender youth and LGB to heterosexual youth. The data, independently parsed by sexual and gender identity, allows the reader to understand health disparities across these two distinct demographic dimensions.

Limitations

Self-reported survey data have several limitations. First, recall bias affecting answers related to prior health risk behaviors, as well as stigma and fear associated with identifying as a sexual or gender minority could prevent or discourage respondents from answering truthfully. Second, the extent to which behaviors were over- or under-reported is not known, although YRBS questions have generally demonstrated good test-retest reliability.⁸⁰ Third, adolescence is often a time of sexual exploration and research has shown that youth may have evolving sexual identities.⁸¹ Fourth, the question on gender identity is focused on youth who identify as TG and may fail to capture those who identify as gender non-conforming, māhū kāne, māhū wahine, or any other non-binary gender identity.⁸² Thus, the gender minority youth represented in this report are likely an underestimate of the true population size. Furthermore, the data cannot be parsed by gender (i.e. distinguishing between transgender males and females), although they are distinct populations and subcultures who face similar but different health challenges.² Fifth, the youth data is representative of public high school students only; youth who attend independent schools in Hawai'i were excluded from the sample. Sixth, because these data are based on a single year of data collection, findings, especially when accompanied by large confidence intervals, must be interpreted with caution.



Where is **ADULT TRANSGENDER** and **OTHER IMPORTANT DATA?**

ADULT GENDER IDENTITY DATA

In 2014, the Hawai'i State Department of Health (DOH) added a question on gender identity to the Hawai'i Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is the world's largest ongoing annual telephone survey of adults aged 18 years or older and collects data on health risk and health behaviors related to the leading causes of disability and death. The data is collected to be representative of all adults in the State of Hawai'i; however, only a small proportion of adults identify as TG. At the time of writing this report, despite several years of data collection, the sample size of TG adults, including those who identify as TG men, TG women, and gender non-conforming, was insufficient to report out. Data will be published as it becomes feasible.

OTHER IMPORTANT DATA

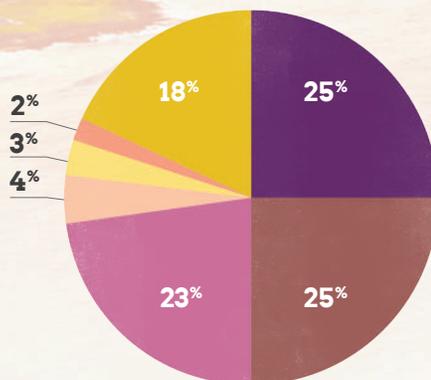
The data presented in this report is not comprehensive. Notably, while factors such as incarceration; sex work; access to other health services such as mental health, vision, and substance use treatment; number of family members who identify as a gender minority; employment; effects of black market silicone, international surgery, and early hormone replacement therapy; unsheltered homeless locations; types of sexual practices; graduation rates; and types of adult supports available to youth are interesting and essential to a comprehensive understanding of public health issues faced by Hawai'i's gender minority communities, questions about these risk factors have either not been included in the YRBS, or the current question wording limits the amount of information collected. Other data sources containing information on the health of SM & TG/GNC people in Hawai'i may exist. More effort and collaboration are needed to identify and evaluate the representativeness of those data sources.

Demographics

Just over 3% of public high school students or approximately 1,260 students in Hawai'i identify as TG. Youth across all counties and high school grade levels identify as TG, and a higher proportion self-report their sex as male (although it is not clear whether this represents their birth-assigned sex or their inner gender identity). The majority of TG youth identify as lesbian, gay, or bisexual (LGB; 57%), while the remaining identify as heterosexual; conversely, 16% of LGB youth identify as TG compared to only 1.5% of heterosexual youth. TG youth in Hawai'i are also racially diverse. Native Hawaiian, Filipino, and Caucasian ethnicities each make up about one quarter of the TG youth population. Nearly half of TG youth live in unstable housing situations compared to only 6% of cisgender youth: 41% sleep in a motel, emergency housing, or in the home of a friend, family member, or other person because they had to leave the home of their parent or guardian, and about 8% are unsheltered and report mostly sleeping in a car, park, campground, or have no usual place to sleep.



Only **51%** of transgender youth usually sleep at their parent or guardian's home compared to **94%** of cisgender youth.



Race/Ethnicity Distribution (%)

- Native Hawaiian
- Filipino
- Caucasian
- Other Pacific Islander
- Japanese
- Other Asian
- Other



57%
of transgender youth
identity as LGB



16%
of LGB identify as
transgender



**1,260 high school youth
identify as transgender.**



HEALTHCARE ACCESS

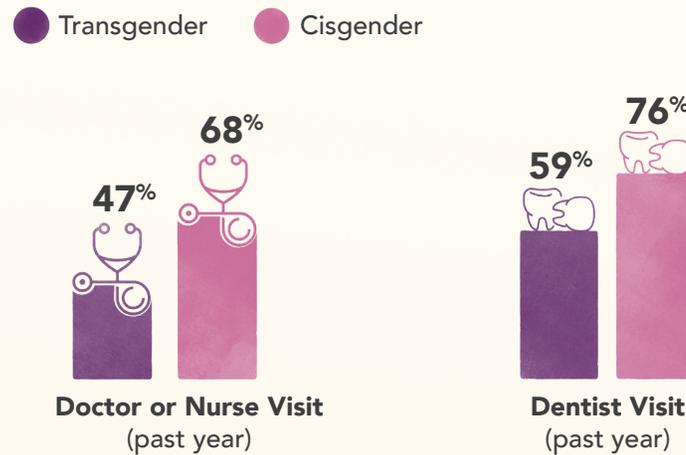
NATIONAL PERSPECTIVES

SM & TG/GNC youth experience discrimination and barriers to healthcare.⁸³ SM & TG/GNC people are sometimes denied care; treated harshly or harassed; refused to be touched by providers; subject to excessive questioning or examination; denied access to hormonal therapy; and referred to harmful healthcare practices such as conversion therapy.⁸⁴ A national report found that sexual minority youth are significantly less likely to receive routine health services like dental care and testing for sexually transmitted diseases.⁸⁵ Similarly, TG people are less likely to seek routine screenings and more likely to delay care compared to cisgender people.^{86,87} In one review, TG people cited lack of providers with expertise in TG medicine as the single largest barrier to health care.⁸⁸

The American Academy of Pediatrics (AAP) issued a policy statement in 2013, affirming the positive role healthcare providers can play in serving as supportive role models to SM & TG/GNC youth.⁸⁹ The AAP recommends that pediatricians offer a welcoming atmosphere; remain vigilant to signs of mental health or substance use issues; use gender-neutral terms while discussing sexual health; provide a confidential place where adolescents can feel comfortable talking about their sexual or gender identity and practices; provide testing for sexually-transmitted infections as recommended based on sexual activity; provide access to contraception, regardless of sexual identity; provide supportive counseling and access to hormonal therapy and surgery, as appropriate, for TG youth; and support parents with information to normalize SM & TG/GNC identities and promote acceptance.⁸⁹

HAWAI'I SUMMARY

TG youth in Hawai'i are significantly less likely to visit a health care professional such as a doctor or nurse compared to cisgender youth. TG youth are also less likely to visit a dentist for a check-up, although the difference, compared to cisgender youth, is not statistically significant.



Less than half of transgender youth saw a doctor or nurse for a checkup or physical exam in the past year (compared to two thirds of cisgender youth)

SM, sexual minority; TG, transgender; GNC, gender non-conforming; LGBT, lesbian, gay, bisexual, transgender
 *Refer to "What is Gender Identity?" on page 3 for more information.



PHYSICAL HEALTH

NATIONAL PERSPECTIVES

Youth who experience adverse health outcomes, such as being overweight or obese, are at higher risk for chronic diseases, including heart disease and diabetes, as adults.⁸⁹ A national sexual minority health report showed that, relative to heterosexuals, sexual minority youth are less likely to report consumption of fruits and vegetables, less likely to participate on at least one sports team, and less likely to engage in daily physical activity.⁸⁵ Additionally, LGB youth are more likely to spend three or more hours per day using the computer or playing video games and are more likely to be obese.⁸⁵ Disparities by gender identity are also documented. Nationally, TG students are less likely to meet recommendations for screen time (time spent in front of a screen, doing activities such as watching television, playing video games, or working on a computer), less likely to meet aerobic and muscle strengthening guidelines, and more likely to have an eating disorder.^{90,91}

Schools play an important role in helping students feel socially, emotionally, and physically supported. According to the 2013 Gay, Lesbian & Straight Education Network (GLSEN) report, SM & TG/GNC students experience bullying, discrimination, and harassment in physical education (PE) classes and school sports.⁹² Greater student involvement in PE and team sports may be achieved through the implementation of policies that explicitly offer protections from bullying and harassment, and through hiring and training PE teachers with whom students feel comfortable discussing their problems.⁹²

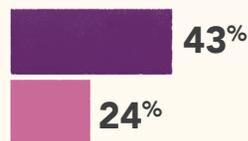
HAWAI'I SUMMARY

TG youth in Hawai'i experience greater disparities across several 'physical health' risk factors. In terms of nutrition, cisgender students are over six times more likely to eat breakfast daily compared to TG students. Sixteen percent of TG youth have gone hungry most of the time or always in the past 30 days because there was no food at their house. More than two in five TG youth have tried to lose weight in an unhealthy manner, compared to only one in five cisgender youth; no significant differences by weight status are observed.

TG youth are also six times less likely to meet physically activity guidelines than cisgender youth. Only 3% meet aerobic and muscle strengthening guidelines, although more than half (55%) play on a sports team. Contrary to national findings, TG youth in Hawai'i are significantly less likely to watch TV, play video games, or use a computer for more than two hours on an average school night compared to their cisgender peers.

Hawai'i TG youth are significantly more likely than cisgender youth to miss school due to sickness. Additionally, TG youth are almost twice as likely to have had a toothache in the past year compared to cisgender youth.

● Transgender ● Cisgender



Have had a toothache in the past year

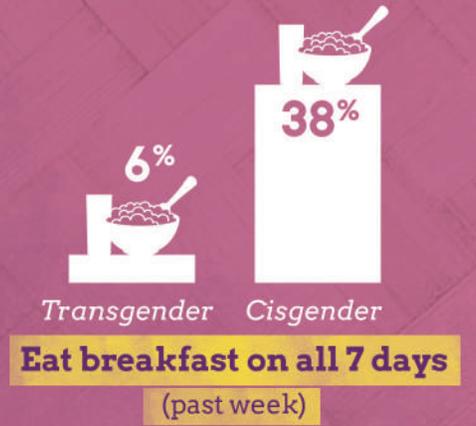
Cisgender youth are **6 times** more likely to get enough sleep compared to transgender youth

3 in 5 transgender youth have missed school because they are sick compared to **2 in 5** cisgender youth

SM, sexual minority; TG, transgender; GNC, gender non-conforming; LGBT, lesbian, gay, bisexual, transgender
*Refer to "What is Gender Identity?" on page 3 for more information.



1 in 5 transgender youth are overweight or obese



Transgender youth are **3 times more likely** to go hungry because there isn't enough food in the home compared to cisgender youth



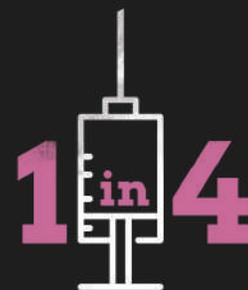
2 in 5

transgender youth currently use marijuana (past month)

NEARLY HALF



of transgender youth have misused prescription pain medicine



transgender youth have injected illegal drugs



HALF

of transgender youth currently use electronic vaping products (past month)

36%



transgender

6%



cisgender

Currently smoke cigarettes (past month)



49% transgender

23% cisgender

currently drink alcohol



Transgender youth are nearly **3 times more likely** to binge drink compared to cisgender youth





BEHAVIORAL RISK FACTORS

NATIONAL PERSPECTIVES

For SM & TG/GNC youth, engagement in risky behaviors may be attributed to bullying and harassment, family conflict and rejection, minority stress, childhood abuse, gender stereotypes, and peer influence.⁹³ According to CDC, sexual minority youth use alcohol, drugs, tobacco and other substances at significantly higher rates than heterosexual youth.⁸⁵ For TG youth, especially persons of color, behavioral risks related to substance use and unprotected sex are common. Young TG women of color, for example, report frequent marijuana (71%) and alcohol (65%) use.⁹⁴ Young TG women are also at elevated risk for HIV infection.⁹⁵⁻⁹⁷

To reduce risky health behaviors, social supports in schools and improved community access to preventive health programs tailored to the unique needs of SM & TG/GNC youth are needed.⁹⁷ Parents and caregivers also play influential roles. In fact, research shows that SM students are significantly less likely to report having an adult in their family with whom they are able to talk to about topics that are important to them.⁸⁵ Family hostility toward SM & TG/GNC youth is associated with more youth runaways and abandonments.^{98,99} San Francisco State University's Family Acceptance Project (FAP) revealed that accepting reactions from family regarding a youth's sexual or gender identity are associated with decreased risk of drug and alcohol use.¹⁰⁰ In Hawai'i, community-based coalitions such as the Kua'ana Project and Ka'aha Māhū have established youth-specific programs to empower, support, and enhance resiliency.

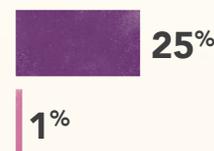
HAWAI'I SUMMARY

Overall, TG youth in Hawai'i are significantly more likely to use substances such as alcohol, tobacco (including cigarettes and electronic vapor products), and other drugs (including marijuana and injection drugs) than cisgender youth. They are also more likely than cisgender youth to misuse prescription pain medicine (such as Codeine, Vicodin, Oxycontin, Hydrocodone, and Percocet). Forty-four percent of Hawai'i TG youth have attended school while under the influence of alcohol or drugs in the past year, which is significantly higher than cisgender youth. The number of TG youth in our survey who reported being sexually active is too small to examine important risk factors such as condom use, number of sexual partners, and substance use before or during sex.

● Transgender ● Cisgender



Attended school while under the influence of alcohol or drugs (past year)



Have injected illegal drugs (one or more times)



Have misused prescription pain medicine (ever)

SM, sexual minority; TG, transgender; GNC, gender non-conforming; LGBT, lesbian, gay, bisexual, transgender
 *Refer to "What is Gender Identity?" on page 3 for more information.



INJURY VIOLENCE & BULLYING

NATIONAL PERSPECTIVES

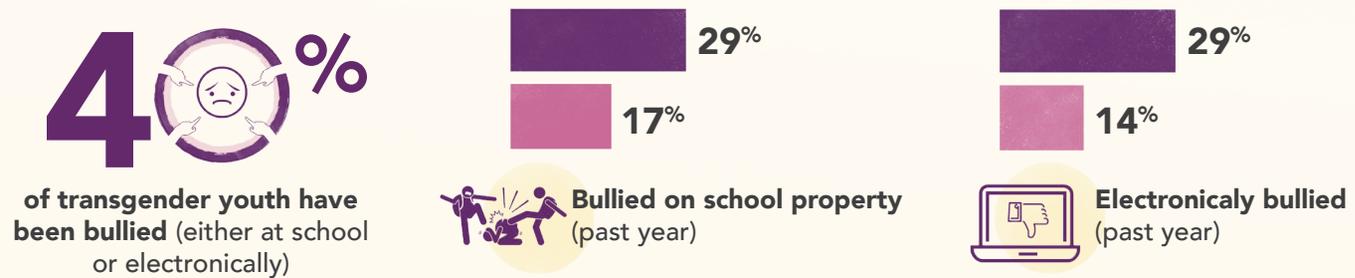
SM & TG/GNC youth are at increased risk for bullying, including cyberbullying, teasing, harassment, and physical and sexual assault.^{101,102} They report higher rates of dating violence, including physical abuse by dating partners and sexual coercion.¹⁰³ TG youth, in particular, experience high rates of violence and adverse childhood experiences (ACEs) such as bullying, neglect, physical and emotional abuse, isolation, physical and sexual assault, and teen dating violence.¹⁰⁴ Twelve percent of TG youth report being sexually assaulted in K-12 settings by peers or educational staff, and 50% report being raped or assaulted by a romantic partner.¹⁰⁵ Without intervention, over 75% of TG youth who experience physical or sexual violence at school attempt suicide.¹⁰⁶

Ensuring safe and supportive environments for SM & TG/GNC youth through community efforts and school health programs can assist in injury and violence prevention. Studies show that students who receive health and sex education that is explicitly inclusive of SM & TG/GNC people are less likely to bully students on the basis of sexual identity or gender expression.¹⁰⁷ Unfortunately, sexual education curricula are rarely inclusive of topics or content specific to SM & TG/GNC youth, as only 25% of students report having health education classes that positively represent SM & TG/GNC topics, and only 12% of millennials report that their sex education classes discussed same-sex relationships.^{108,109} According to the 2017 State Equality index, seven states explicitly prohibit the inclusion of SM & TG/GNC content in sexual education, whereas four states and the District of Columbia expressly require sexual education to be inclusive of sexual and gender minorities.¹¹⁰ Hawai'i neither requires nor prohibits such inclusion by law.¹¹⁰

HAWAI'I SUMMARY

Hawai'i TG youth are significantly more likely to experience bullying and violence compared to cisgender youth. Forty percent are bullied, either electronically or on school property, and almost a quarter experience sexual violence or have been physically forced to have sexual intercourse. A quarter of TG youth in Hawai'i skip school due to feeling unsafe compared to only 7% of their cisgender peers.

● Transgender ● Cisgender



SM, sexual minority; TG, transgender; GNC, gender non-conforming; LGBT, lesbian, gay, bisexual, transgender
 *Refer to "What is Gender Identity?" on page 3 for more information.



1 in 4

**TRANSGENDER YOUTH
HAVE**



**EXPERIENCED
SEXUAL VIOLENCE**



**BEEN PHYSICALLY
FORCED TO HAVE
SEXUAL INTERCOURSE**



**SKIPPED SCHOOL
BECAUSE THEY
FELT UNSAFE**



Nearly
HALF
of transgender
youth felt sad
or hopeless in
the past year

HALF
HALF

of transgender youth
have **attempted suicide**
in the past year



MENTAL HEALTH

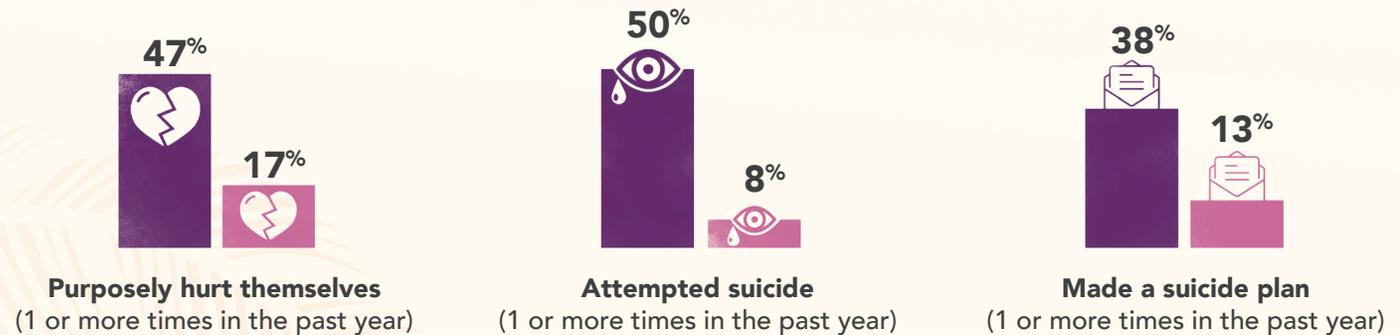
NATIONAL PERSPECTIVES

SM & TG/GNC youth often cope with the challenges of social stigma and discrimination.¹¹¹ They may face neglect or abuse from their families and bullying from peers.¹¹² Family rejection during adolescence is related to increased likelihood of mental health and substance abuse problems in SM & TG/GNC youth.¹¹³ Not surprisingly, rates of depression and suicidality are high among SM & TG/GNC youth.^{114,115} TG youth are at a 2 to 3-fold higher risk for depression, anxiety disorders, suicidal ideation, suicide attempts, and self-harm.¹¹⁶ They are also more likely to experience challenges with emotional regulation, social development, and the ability to acquire skills to function in society as healthy adults.¹¹⁷ SM & TG/GNC youth who report high victimization are more than twice as likely to report being clinically depressed as other youth.¹¹³ Abuse and lack of acceptance in the home and at school are directly related to the disproportionately larger prevalence of homeless SM & TG/GNC youth.⁹⁸ The 2018 Street Youth Study revealed that more than 17% of homeless and runaway youth in Hawai'i are SM & TG/GNC.¹¹⁸ TG youth who have socially transitioned and who feel supported in their gender report no elevations in depression compared to population averages, indicating that mental health difficulties are not a result of TG identity, but rather due to adverse experiences associated with TG identity.¹¹⁹ Programs such as "Out for Equity" (Saint Paul, Minnesota) and "Grow a Rainbow" (Honolulu, Hawai'i) seek to end homophobia and transphobia in schools and at home by implementing strategies to reduce harassment and violence against SM & TG/GNC students, staff, and families.^{120,121}

HAWAI'I SUMMARY

TG youth in Hawai'i are more likely to experience poor mental health and suicidal ideation than cisgender youth. Compared to cisgender youth, TG youth are nearly 1.5 times more likely to feel sad or hopeless for two or more weeks in a row, and three times more likely to inflict self-harm by means such as cutting or burning. TG youth are around three times more likely to consider suicide and make a suicide plan than cisgender youth. In the past year, half of TG youth attempted suicide one or more times, which is nearly seven times higher than cisgender youth.

● Transgender ● Cisgender



SM, sexual minority; TG, transgender; GNC, gender non-conforming; LGBT, lesbian, gay, bisexual, transgender
 *Refer to "What is Gender Identity?" on page 3 for more information.



PROTECTIVE FACTORS

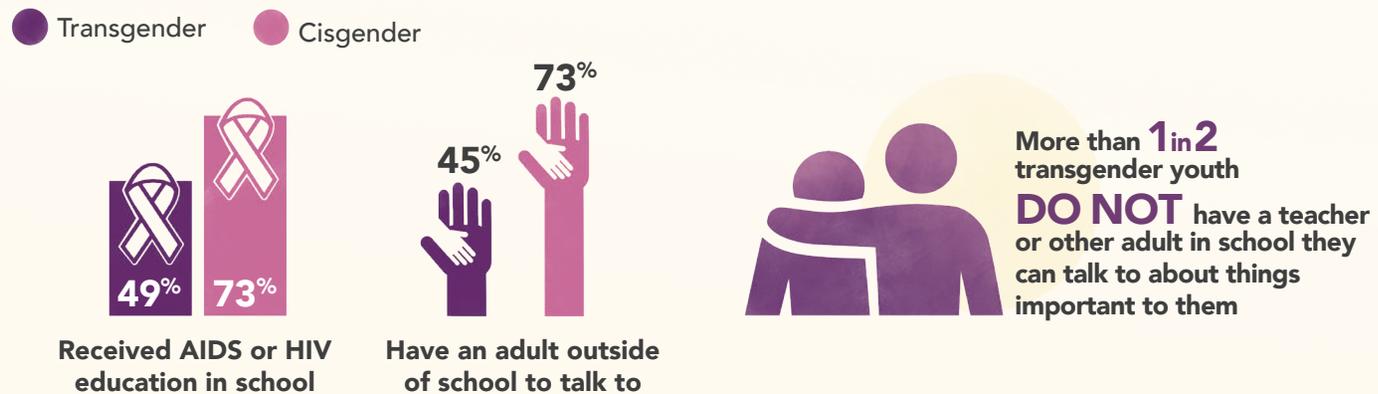
NATIONAL PERSPECTIVES

Factors that protect youth from engaging in behaviors that lead to poor health outcomes play an important mediating role in the development and life course of youth.¹²² These protective factors include family support and acceptance; the presence of caring adults, within the home and at school; positive peer influences; strong self-esteem; and involvement in school activities.¹²³ Additional TG-specific protective factors include the individual's social transition (e.g. utilizing clothing, a name, pronouns, and overall gender expression that is consistent with an individual's gender identity); feeling supported by others in one's gender identity; the individual's ability to self-define their own gender identity; access to supportive educational systems; connection to a trans-affirming community; positive reframing of one's mental health challenges; and successful navigation of relationships with family and friends following one's social transition.^{119,124} Insufficient protective factors are associated with poor school adjustment, suicidal ideation, and high smoking rates, among other adverse outcomes.¹²⁵⁻¹²⁷ Therefore, strengthening protective factors at the individual, interpersonal, and community levels is essential for building resiliency among SM & TG/GNC youth.

Critical supports discussed elsewhere in this report, such as the presence of school Gay-Straight Alliances (GSAs), comprehensive anti-bullying and anti-harassment policies, the presence of caring teachers and staff to discuss SM & TG/GNC issues, and family acceptance, positively influence a young person's ability to build resiliency and overcome adversity.^{92,100,107,128} Protective factors for TG youth, in particular, include having supportive parents or family members and role models – specifically, role models who are TG or in their 'felt' gender.¹²⁸ School-based GSAs are especially important for providing safe and accepting havens for TG youth and are associated with decreased engagement in risky behaviors.¹²⁹

HAWAII SUMMARY

Overall, TG youth in Hawai'i are less likely to have an adult figure outside of school to talk about their problems than cisgender youth. They are also less likely than cisgender youth to have an adult figure inside of school to talk about things important to them. Less than half (46%) of TG youth talk to their parents or another adult about the dangers of substance use. In Hawai'i, less than half of TG youth report that they are taught about HIV/AIDS in school.



SM, sexual minority; TG, transgender; GNC, gender non-conforming; LGBT, lesbian, gay, bisexual, transgender
 *Refer to "What is Gender Identity?" on page 3 for more information.



ACADEMIC ACHIEVEMENT

NATIONAL PERSPECTIVES

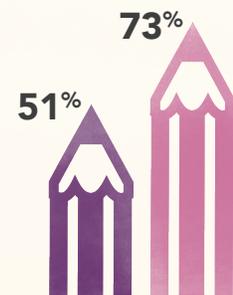
Numerous studies have documented the close relationship between health, campus climate, and academic achievement.¹³⁰ Inequities in education may negatively impact an individual's earning potential and quality of life. School health programs have the potential to contribute to academic success.¹³¹ Attaining higher levels of education is associated with greater income, lower rates of obesity and chronic diseases, and longer life expectancy.^{132,133} While schools must strive to provide a safe atmosphere for learning to all students, many SM & TG/GNC students experience a hostile climate at school and may choose to miss school to avoid unpleasant and negative experiences that threaten their safety and well-being. Studies show that experiencing negative school climates and victimization are related to lower academic outcomes and self-esteem among SM & TG/GNC youth.¹⁰⁸

School-located resources, such as Gay Straight Alliances (GSAs), that address these issues have a positive impact on school climate for SM & TG/GNC students.¹²⁸ SM & TG/GNC youth who attend schools with GSAs experience greater psychosocial well-being including lower depression and higher self-esteem; higher educational attainment both in high school and college; and fewer problems related to substance abuse.¹³⁴

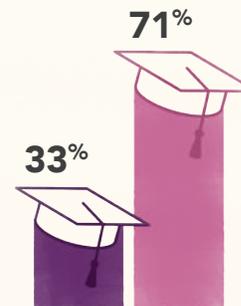
HAWAI'I SUMMARY

TG youth in Hawai'i have poorer academic performance and are less likely to have career aspirations than cisgender youth. Only half of TG youth receive mostly A or B grades compared to nearly three quarters of cisgender youth. Additionally, only a third believe that they will go on to complete a post high school program such as a vocational training program, military service, community college, or 4-year college.

● Transgender ● Cisgender



Grades in school were mostly A's and B's



Probably or definitely will complete a post high school program



TWO THIRDS
of transgender youth
DO NOT
believe that they will complete
a post high school program

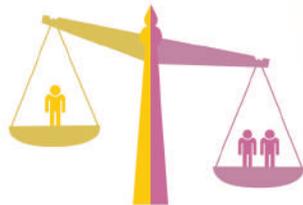
SM, sexual minority; TG, transgender; GNC, gender non-conforming; LGBT, lesbian, gay, bisexual, transgender
*Refer to "What is Gender Identity?" on page 3 for more information.

Transgender youth are **4x**



more likely than cisgender youth...

LGB youth are **2x**



more likely than heterosexual youth...

...TO HAVE BEEN PHYSICALLY FORCED TO HAVE SEXUAL INTERCOURSE



Cisgender youth are **2 times** more likely than transgender youth to feel...



Heterosexual youth and LGB youth **equally** feel...

...THAT THEY WILL COMPLETE A POST HIGH SCHOOL PROGRAM

Many health disparities between

transgender & cisgender youth

36%

6%



Transgender youth are **6x**

more likely than cisgender youth...

15%

6%



LGB youth are **2.5x**

more likely than heterosexual youth...

...TO SMOKE CIGARETTES



Cisgender youth are **six times** more likely than transgender youth...



Heterosexual youth are **two times** more likely than LGB youth...

...TO MEET NATIONAL GUIDELINES FOR PHYSICAL ACTIVITY



...TO HAVE EVER INJECTED ILLEGAL DRUGS

...are larger than those between

**LGB
&
heterosexual
youth**



...TO ATTEMPT SUICIDE

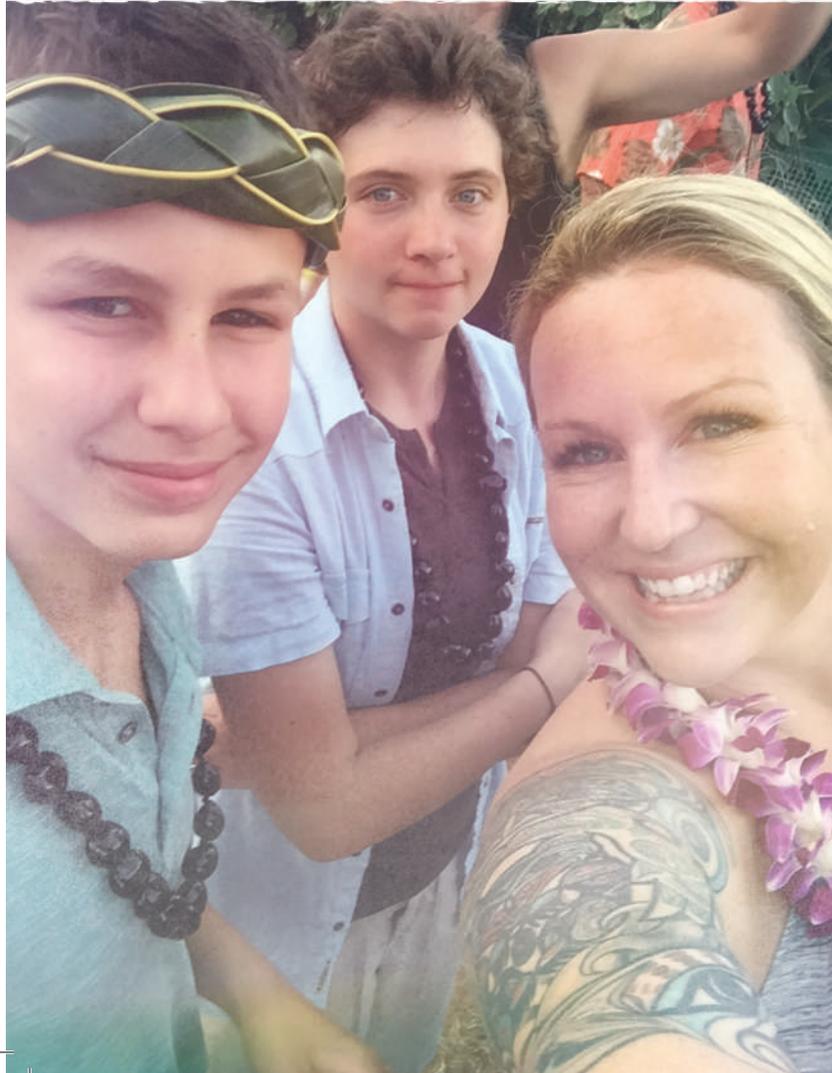
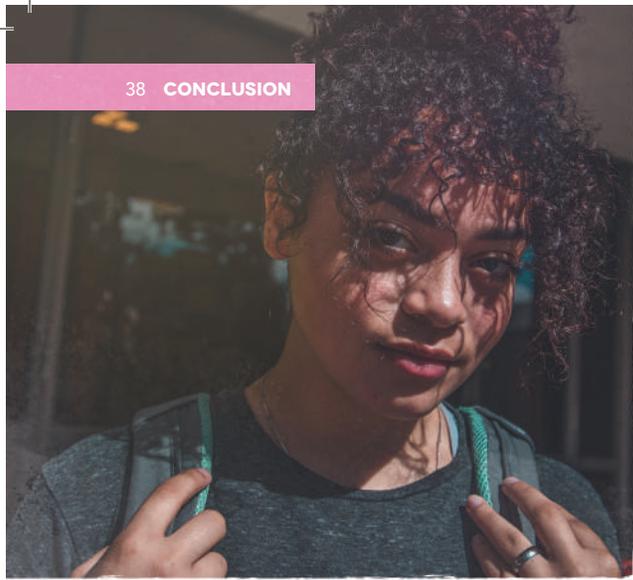


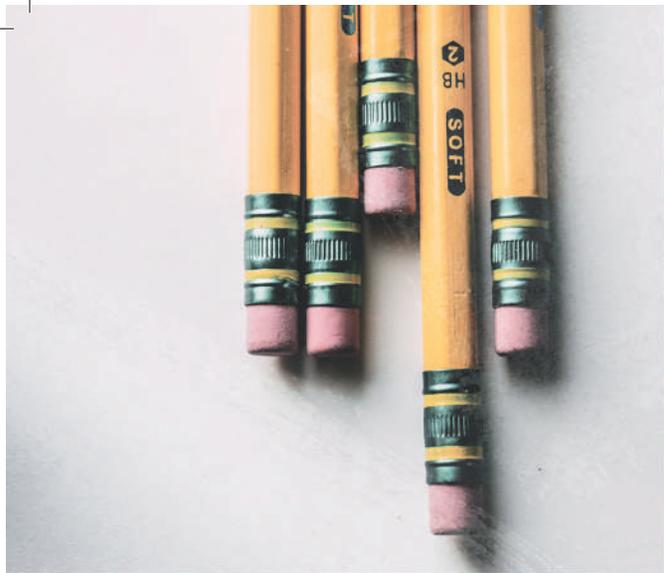
...TO SKIP SCHOOL BECAUSE OF FEELING UNSAFE



...TO HAVE UNSTABLE HOUSING*

*A student was defined to have unstable housing if the student reported (1) usually sleeping in the home of a friend, family member, or other person as a result of having to leave their parent or guardian's home or because their parent or guardian cannot afford housing; or, (2) sleeping in a shelter, motel/hotel, emergency housing, car, park, campground, or somewhere else; or, (3) having no usual place to sleep.





Conclusion

In 2017, we reported on the health of sexual minority (SM) youth in the State of Hawai'i.⁹ We noted that many of the health trends in this population mirrored those reported among SM youth nationally and demonstrated a pattern of greater exposure to violence and bullying, higher engagement in risky behaviors, poorer mental health, and an inadequate sense of safety and academic achievement compared to heterosexual youth. This report provides an in-depth look at the health of gender minority youth in Hawai'i, based on a single year of data collection among public high school youth. Further, while a direct comparison of TG and LGB youth was inappropriate, we were interested in comparing the magnitude of health differences between TG and cisgender youth to those between LGB and heterosexual youth because studies have reported that youth who identify as TG experience poorer outcomes than those who identify as LGB.¹³⁵

Gender minority stress stems from the TG/GNC individual's felt sense of discrimination, rejection, victimization and lack of positive affirmation.¹⁴ These experiences are often worsened in the presence of internal stressors, including the individual's internalized transphobia, expectations of rejection and mistreatment by others, and efforts to conceal one's own identity in order to avoid societal rejection. In the absence of adequate resiliency and protective factors – through affirming relationships, community connections, and an internalized pride in one's own identity – the TG/GNC individual may gravitate towards poor mental and physical outcomes.¹⁴ Our report demonstrates that this confluence of factors are already evident in Hawai'i's TG youth.

The data reveal that TG youth in Hawai'i demonstrate similar patterns of health risk behaviors as those reported previously among Hawai'i's LGB youth. Moreover, the gaps between TG and cisgender youth may be wider than those between LGB and heterosexual youth (see pages 36-37). The report finds that TG youth experience bullying in school and electronically at rates that are much higher than cisgender youth. Accordingly, they are nearly four times more likely to skip school because of feeling unsafe compared to their cisgender peers, a disparity that is twice the magnitude of the corresponding difference between LGB and heterosexual youth. There is a clear impact of these disparities on academic achievement. TG youth are less likely than cisgender youth to receive good grades in school (A's and B's) and are two times less likely to believe that they will pursue vocational or academic training after completing high school.

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The lack of safety for Hawai'i's TG youth extends beyond their experiences in school.

TG youth are 2.5 times more likely to experience sexual violence and four times more likely to be subject to forced sexual intercourse compared to cisgender youth. They are less likely to have access to supportive adults outside school to talk about their problems. Not surprisingly, on all indicators of mental health, TG youth fare worse than cisgender youth. Every year, half of all youth identifying as TG attempt suicide, a prevalence that is seven times higher than that among youth who are cisgender. The disparity in suicide attempts between TG and cisgender youth is nearly twice the magnitude of the corresponding disparity between LGB and heterosexual youth.

TG youth in Hawai'i drink alcohol, engage in binge drinking, smoke cigarettes, and use illicit drugs to a significantly greater extent than cisgender youth. In several instances, the magnitude of the difference between TG and cisgender youth far exceeds the corresponding difference between LGB and heterosexual youth. For example, LGB youth are 2.5 times more likely to smoke than heterosexual youth, whereas TG youth are six times more likely to smoke than cisgender youth. Furthermore, nearly 1 in 10 LGB youth inject drugs, a prevalence that is six times higher than heterosexual youth; the corresponding statistic among TG youth (1 in 4) is twenty-one times higher than cisgender youth, signifying a crisis of injection drug use in this population. Prescription opioid misuse is five times higher among TG youth than cisgender youth, and about three times higher among LGB youth than heterosexual youth.

By contrast, when it comes to practicing healthful behaviors, TG youth continue to fall behind their cisgender peers. TG youth in Hawai'i are less likely to get adequate nutrition, sleep, or exercise, or have regular health check-ups, and more likely to be too sick to attend school, and have dental issues than cisgender youth. While similar disparities occur among LGB youth when compared to heterosexual youth, the differences are less stark. For some indicators, what is more astonishing than the comparison to cisgender youth is the pervasiveness of the health issue among TG youth: for example, more than 95% of TG youth do not get adequate sleep, or meet recommendations for physical activity. Fewer than half of TG youth have been taught about HIV/AIDS in school, an alarming fact considering that more than a quarter of male-to-female (MTF) transgender women in the United States are estimated to be infected with HIV.^{136,137} At this time, the data is too sparse to understand the extent to which our TG youth are engaging in risky behaviors that place them at risk for sexually transmitted infections.

According to the Williams Institute, Hawai'i ranks highest in the nation for TG prevalence, with approximately 8,450 TG individuals, representing 0.8% of adults.¹³⁸ Therefore, reporting on the health of TG adults is an important priority for the state. Data on TG adults in Hawai'i is currently being collected; it is anticipated that a few additional years of data collection are needed in order for the data to be reportable. In the meanwhile, the youth TG data presented in this report are critical because they provide a sobering reminder of the tremendous need for prevention and early intervention in this population.

As more data is collected and the disparities in SM & TG/GNC populations are better documented, it is apparent that more work and effort is needed to eliminate health disparities experienced by SM & TG/GNC people in Hawai'i. An enhanced effort to understand, systematically address, and consistently monitor disparities in health risk factors and outcomes is needed to achieve and maintain positive health outcomes for these populations. Quantitative data collection

SM, sexual minority; **TG**, transgender; **GNC**, gender non-conforming; **LGBT**, lesbian, gay, bisexual, transgender
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must be supplemented with qualitative data that contextualize and explore the reasons for the disparities documented; similarly, survey data must be enhanced by the collection of sexual orientation and gender identity information in healthcare, educational, vital records, labor and other data to enable a comprehensive understanding of the SM & TG/GNC population's overall well-being.

In recent decades, the State of Hawai'i has made tremendous progress in passing policies to protect both SM & TG/GNC people in Hawai'i. Historically, protections for sexual minorities preceded corresponding policy changes that were inclusive of gender minorities. These relative delays in conferring protections to gender minorities are mirrored by the greater magnitude of health disparities seen among gender minorities compared to sexual minorities. However, current trends in policymaking are increasingly in alignment with the needs of both SM and TG/GNC communities. Many recent policies, including marriage rights, parity in health insurance coverage, and protections from discrimination, are critical successes to be preserved and built upon.

Recent promising policy and public health efforts have either addressed the needs of SM & TG/GNC people simultaneously, or selectively prioritized gender minorities. For example, the Hawai'i State DOH's Tobacco Prevention & Education Program identified LGBT adults as a priority population to target for smoking prevention and cessation resources in its 5-year strategic plan.¹³⁹ In 2016, the Hawai'i Department of Education developed guidance for schools to provide adequate support to TG students that highlights students' rights "to privacy and confidentiality with respect to their gender identity and expression."⁶¹ Act 13, passed May 2018, not only prohibits sexual identity change efforts among youth by a healthcare professional, but additionally establishes a Sexual Orientation Counseling Task Force to "address the concerns of minors seeking counseling on sexual identity, gender identity, gender expressions, and related behavior."⁶³ Specifically, in alignment with recent efforts to be inclusive of the health concerns of gender minorities, sexual identity change efforts are explicitly defined as "the practice of attempting to change a person's sexual identity, including but not limited to efforts to change gender identity or gender expressions and behaviors".⁶³ Act 110, when fully implemented in 2020, will prohibit discrimination on the basis of both sexual identity and gender identity, expression or behavior in educational programs that receive state funding.⁶²

Finally, it is important to recognize the resiliency and strength of Hawai'i's TG community. Despite evident challenges, many do live healthy and fulfilling lives, and positively contribute to the health and betterment of their community. Programs like the Kua'ana Project, Ka'aha Māhū, and the Lavender Clinic strive to offer support, empowerment, medical and social care for TG/GNC individuals in Hawai'i. Recognizing and building upon the strength and resiliency of our local TG/GNC communities is an essential component to improving the health and well-being of the population statewide.

This report is presented to support and further all efforts to achieve health parity for gender minority populations in the State of Hawai'i.



Table 1: Demographic Characteristics of Hawai'i Public High School Students, by Gender and Sexual Identity

Characteristics	Gender Identity		Sexual Identity	
	Transgender N (%)	Cisgender N (%)	LGB N (%)	Heterosexual N (%)
TOTAL	1,260 (3.3%)	37,320 (96.7%)	4,570 (11.7%)	34,340 (88.3%)
GRADE LEVEL In what grade are you?				
9th	370 (30.2%)	10,300 (28.0%)	1,160 (26.1%)	9,600 (28.3%)
10th	300 (24.7%)	9,540 (25.9%)	1,140 (25.7%)	8,680 (25.6%)
11th	160 (13.2%)	8,980 (24.4%)	1,100 (24.9%)	8,170 (24.1%)
12th	390 (31.9%)	7,980 (21.7%)	1,040 (23.3%)	7,450 (22.0%)
COUNTY County where school is located.				
Honolulu County	870 (69.5%)	25,710 (68.9%)	3,230 (70.7%)	23,470 (68.3%)
Hawai'i County	150 (12.2%)	4,970 (13.3%)	630 (13.9%)	4,580 (13.3%)
Maui County	160 (13.1%)	4,470 (12.0%)	500 (11.0%)	4,250 (12.4%)
Kaua'i County	70 (5.2%)	2,170 (5.8%)	200 (4.5%)	2,040 (5.9%)
SEX What is your sex?				
Boys	710 (61.9%)	17,790 (48.1%)	1,740 (40.0%)	17,150 (50.3%)
Girls	440 (38.1%)	19,173 (51.9%)	2,610 (60.0%)	16,930 (49.7%)
GENDER IDENTITY Are you transgender?				
Transgender	n/a	n/a	640 (15.9%)	490 (1.5%)
Cisgender	n/a	n/a	3,370 (84.1%)	32,520 (98.5%)
SEXUAL IDENTITY Which of the following best describes you?				
LGB	640 (56.7%)	3,370 (9.4%)	n/a	n/a
Heterosexual	490 (43.3%)	32,520 (90.6%)	n/a	n/a
RACE/ETHNICITY What is your race?				
Caucasian	260 (22.9%)	5,570 (15.3%)	1,030 (23.9%)	4,800 (14.3%)
Native Hawaiian	290 (25.5%)	8,470 (23.2%)	930 (21.6%)	8,020 (23.9%)
Filipino	280 (24.7%)	10,230 (28.0%)	1,080 (24.9%)	9,540 (28.4%)
Japanese	40 (3.0%)	2,890 (7.9%)	100 (2.3%)	2,700 (8.0%)
Other Asian [†]	20 (2.0%)	930 (2.5%)	70 (1.6%)	920 (2.7%)
Other Pacific Islander ^{††}	50 (4.1%)	960 (2.6%)	140 (3.2%)	930 (2.8%)
Other ^{†††}	200 (17.8%)	7,440 (20.4%)	970 (22.5%)	6,670 (19.9%)
HOUSING STATUS During the past 30 days, where did you usually sleep?				
Sheltered (parent/guardian's home) *	570 (50.5%)	32,480 (93.8%)	3,400 (80.9%)	29,520 (92.6%)
Sheltered (other) **	470 (40.9%)	1,800 (5.2%)	700 (16.7%)	1,950 (6.1%)
Unsheltered***	90 (7.6%)	190 (0.6%)	70 (1.7%)	250 (0.8%)
Somewhere else	10 (1.0%)	160 (0.5%)	30 (0.7%)	170 (0.5%)

Data Source: YRBS, 2017. Gender identity survey question: "Some people describe themselves as transgender when their sex at birth does not match the way they think or feel about their gender. Are you transgender?" [†]Other Asian includes Korean, Vietnamese, Chinese, Asian Indian, and others identifying as Asian; ^{††}Other Pacific Islander includes Samoan, Tongan, Guamanian/Chamorro, and others identifying as Pacific Islanders; ^{†††}Hispanic/Latino, Alaskan Native/Native American, Black. *Students who reported they mostly slept at their parent's or guardian's home in the past 30 days. **Students who report mostly sleeping in the home of a friend, family member, or other person because they had to leave their home or their parent or guardian cannot afford housing. Also includes students who report mostly sleeping in a shelter, motel/hotel, or emergency housing in the past 30 days. ***Students who report mostly sleeping in a car, park, campground, or have no usual place to sleep in the past 30 days. Totals may not add up to 100% due to rounding. Population counts have been rounded to nearest ten. n/a, not applicable. LGB, lesbian, gay, bisexual.

Table 2: Youth Health Indicator Definitions & Prevalence, by Gender and Sexual Identity

Indicator	Survey Question(s)	Gender Identity		Sexual Identity	
		Transgender [†] % (95% CI)	Cisgender % (95% CI)	LGB [†] % (95% CI)	Heterosexual % (95% CI)
HEALTHCARE ACCESS					
	Saw a doctor/nurse (past year) When was the last time you saw a doctor or nurse for a check-up or physical exam when you were not sick or injured? <i>Note: Students who responded they were not sure when they last saw a doctor or nurse were included in the denominator.</i>	46.6% (30.4-62.8)	67.7% (66.0-69.5)	59.2% (51.1-67.4)	68.1% (66.2-69.9)
	Saw a dentist (past year) When was the last time you saw a dentist for a check-up, exam, teeth cleaning, or other dental work? <i>Note: Students who responded they were not sure when they last a dentist were included in the denominator.</i>	58.9% (41.3-76.4)	76.3% (74.6-78.0)	68.3% (62.6-73.9)	76.1% (74.7-77.4)
PHYSICAL HEALTH					
	Overweight or obese Calculated based on self-reported height and weight, based on a series of questions: "How tall are you without your shoes on? How much do you weigh without your shoes on?" The CDC BMI-for-Age Growth Charts were used to calculate youth who are overweight (between 85th and 95th percentile for youth of the same age and sex) and obese (greater than 95th percentile for youth of the same age and sex).				
	Overweight	9.1% (2.5-15.6)	14.2% (12.5-15.9)	18.6% (13.9-23.3)	13.5% (11.9-15.1)
	Obese	12.8% (6.0-19.6)	13.9% (12.8-15.1)	16.1% (12.0-20.2)	14.0% (12.8-15.2)
	Tried to lose weight or keep from gaining weight in an unhealthy manner (past month) During the past 30 days, did you try to lose weight or keep from gaining weight by going without eating for 24 hours; taking any diet pills, powders, or liquids; vomiting or taking laxatives; smoking cigarettes; or skipping meals? <i>Note: Students who responded they were not sure were included in the denominator.</i>	42.1% (30.1-54.1)	20.1% (18.2-22.0)	33.1% (27.7-38.5)	19.6% (18.1-21.2)
	Ate 5 or more fruits and vegetables per day Based on a series of questions: "During the past 7 days, how often did you...drink 100% fruit juices such as orange juice, apple juice or grape juice? eat fruit? eat green salad? ... eat potatoes? ... eat carrots? ... eat other vegetables?"	12.2% (3.5-20.9)	13.2% (12.2-14.3)	12.8% (8.9-16.6)	14.0% (12.8-15.1)

Data Source: YRBS, 2017. [†]Highlighted estimates indicate a statistically significant difference between transgender and cisgender youth (reference), or between LGB and heterosexual youth (reference). % (95% confidence intervals) are provided. n/r, not reportable. LGB, lesbian, gay, bisexual.

Table 2: Youth Health Indicator Definitions & Prevalence, by Gender and Sexual Identity (continued)

Indicator	Survey Question(s)	Gender Identity		Sexual Identity	
		Transgender [†] % (95% CI)	Cisgender % (95% CI)	LGB [†] % (95% CI)	Heterosexual % (95% CI)
<i>(PHYSICAL HEALTH continued)</i>					
Ate breakfast on all 7 days	During the past 7 days, on how many days did you eat breakfast?	5.9% (0.6-11.1)	37.8% (35.4-40.2)	20.6% (16.9-24.3)	38.3% (36.1-40.5)
Most of the time or always went hungry (past month)	During the past 30 days, how often did you go hungry because there was not enough food in your home?	15.8% (7.8-23.8)	5.6% (4.9-6.4)	11.4% (7.0-15.8)	5.8% (5.0-6.6)
Met aerobic and muscle strengthening physical activity guidelines (60+ minutes of physical activity, ≥3 days of muscle strengthening)	Based on a series of questions: "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? (Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard some of the time.) On how many of the past 7 days did you do exercises to strengthen or tone your muscles, such as push-ups, sit-ups, or weight lifting?"	2.5% (0.4-4.6)	16.1% (14.4-17.8)	8.0% (4.2-11.9)	16.6% (14.8-18.4)
Played on at least one sports team (past year)	During the past 12 months, on how many sports teams did you play? (Count any teams run by your school or community groups.)	54.6% (38.0-71.1)	50.0% (47.8-52.2)	48.7% (42.1-55.3)	51.0% (49.0-53.1)
Watched TV, played video games, or used a computer (>2 hours on average school day)	Based on a series of questions: "On an average school day, how many hours do you watch TV? On an average school day, how many hours do you play video or computer games or use a computer for something that is not school work? (Count time spent on things such as Xbox, PlayStation, an iPod, an iPad or other tablet, a smartphone, YouTube, Facebook or other social networking tools, and the Internet.)"	41.6% (28.6-54.5)	62.1% (59.2-64.9)	60.3% (55.1-65.5)	60.4% (57.2-63.6)
8 or more hours of sleep (on average school night)	On an average school night, how many hours of sleep do you get?	3.9% (1.1-6.6)	23.6% (21.7-25.4)	14.5% (10.0-19.0)	24.1% (22.1-26.1)
Did not go to school because they were sick (1 or more days in past month)	During the past 30 days, on how many days did you not go to school because you were sick?	61.6% (50.6-72.7)	41.5% (38.0-44.9)	55.3% (46.8-63.8)	40.9% (37.7-44.1)

Data Source: YRBS, 2017. [†]Highlighted estimates indicate a statistically significant difference between transgender and cisgender youth (reference), or between LGB and heterosexual youth (reference). % (95% confidence intervals) are provided. n/r, not reportable. LGB, lesbian, gay, bisexual.

Table 2: Youth Health Indicator Definitions & Prevalence, by Gender and Sexual Identity (continued)

Indicator	Survey Question(s)	Gender Identity		Sexual Identity	
		Transgender [†] % (95% CI)	Cisgender % (95% CI)	LGB [†] % (95% CI)	Heterosexual % (95% CI)
<i>(PHYSICAL HEALTH continued)</i>					
Had a toothache (past year)	During the past 12 months, did you have a toothache? <i>Note: Students who responded they were not sure if they had a toothache were included in the denominator.</i>	42.5% (28.3-56.7)	24.2% (21.9-26.5)	27.4% (23.5-31.3)	23.9% (21.7-26.1)
BEHAVIORAL RISK FACTORS					
Currently drink alcohol (1 or more days in past month)	During the past 30 days, on how many days did you have at least one drink of alcohol?	49.2% (34.8-63.5)	22.6% (20.0-25.1)	36.4% (30.9-41.8)	22.6% (20.3-25.0)
Currently binge drink (1 or more days in past month)	During the past 30 days, what is the largest number of alcoholic drinks you had in a row that is within a couple of hours? (4+ drinks on at least one occasion for girls, 5+ drinks for boys) <i>Note: Youth answered this question based on how they self-identified (boy or girl).</i>	32.0% (22.2-41.8)	11.0% (9.7-12.4)	16.5% (13.0-19.9)	11.6% (10.0-13.1)
Currently smoke cigarettes (1 or more days in past month)	During the past 30 days, on how many days did you smoke cigarettes?	35.9% (24.0-47.9)	5.8% (4.8-6.9)	15.3% (10.6-19.9)	6.1% (5.1-7.1)
Currently use electronic vapor product (1 or more days in past month)	During the past 30 days, on how many days did you use an electronic vapor product?	53.0% (41.9-64.1)	22.6% (20.5-24.6)	34.8% (30.1-39.5)	23.7% (21.5-25.8)
Currently use marijuana (1 or more times in past month)	During the past 30 days, how many times did you use marijuana?	43.6% (30.6-56.5)	15.9% (14.0-17.7)	27.7% (22.8-32.5)	16.1% (14.2-18.0)
Ever injected an illegal drug (1 or more times)	During your life, how many times have you used a needle to inject any illegal drug into your body?	25.1% (14.2-35.9)	1.2% (0.9-1.6)	9.3% (5.7-13.0)	1.5% (1.1-1.8)
Ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (1 or more times)	During your life, how many times have you taken prescription pain medicine without a doctor's prescription or different than how a doctor told you to use it? (Count drugs such as Codeine, Vicodin, OxyContin, Hydrocodone, and Percocet.)	45.7% (32.3-59.0)	9.6% (8.4-10.8)	27.0% (23.0-31.0)	9.6% (8.3-10.9)
Attend school while under the influence of alcohol or drugs (past year)	During the past 12 months, have you attended school under the influence of alcohol, marijuana, or other drugs?	43.6% (31.8-55.5)	15.0% (13.2-16.9)	24.4% (20.5-28.4)	15.6% (13.7-17.4)

Data Source: YRBS, 2017. [†]Highlighted estimates indicate a statistically significant difference between transgender and cisgender youth (reference), or between LGB and heterosexual youth (reference). % (95% confidence intervals) are provided. n/r, not reportable. LGB, lesbian, gay, bisexual.

Table 2: Youth Health Indicator Definitions & Prevalence, by Gender and Sexual Identity (continued)

Indicator	Survey Question(s)	Gender Identity		Sexual Identity	
		Transgender [†] % (95% CI)	Cisgender % (95% CI)	LGB [†] % (95% CI)	Heterosexual % (95% CI)
<i>(BEHAVIORAL RISK FACTORS continued)</i>					
Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) (score of 2 or higher)	Based on the following questions: (C) Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? (R) Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? (A) Do you ever use alcohol/drugs while you are by yourself, ALONE? (F) Do you ever FORGET things you did while using alcohol or drugs? (F) Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? (T) Have you gotten into TROUBLE while you were using alcohol or drugs?	n/r	21.2% (19.6-22.9)	30.8% (23.9-37.6)	21.3% (19.6-23.1)
Used a condom during last sexual intercourse (among students who report ever having sexual intercourse)	The last time you had sexual intercourse, did you or your partner use a condom?" <i>Limited to sexually active students; excludes sexually active young women who identify as lesbian.</i>	n/r	47.7% (43.2-52.2)	30.2% (22.8-37.6)	50.4% (45.4-55.4)
INJURY, VIOLENCE, & BULLYING					
Physical dating violence (1 or more times in past year)	During the past 12 months, how many times did someone you were dating or going out with physically hurt you on purpose? (Count such things as being hit, slammed into something, or injured with an object or weapon.) <i>Among students who reported dating in the past year.</i>	n/r	9.0% (6.8-11.2)	19.0% (12.8-25.3)	9.3% (7.2-11.3)
Sexual violence (1 or more times in past year)	During the past 12 months, how many times did anyone force you to do sexual things that you did not want to do? (Count such things as kissing, touching, or being physically forced to have sexual intercourse.)	24.2% (14.0-34.4)	10.3% (8.9-11.8)	18.2% (14.3-22.0)	10.4% (8.8-11.9)
Emotional or psychological dating abuse (1 or more times in past year)	During the past 12 months, how many times did someone you were dating or going out with purposely try to control you or emotionally hurt you? (Count such things as being told who you could and could not spend time with, being humiliated in front of others, or being threatened if you did not do what they wanted.) <i>Among students who reported dating in the past year.</i>	n/r	27.6% (25.5-29.8)	40.2% (34.9-45.5)	27.3% (25.1-29.6)

Data Source: YRBS, 2017. [†]Highlighted estimates indicate a statistically significant difference between transgender and cisgender youth (reference), or between LGB and heterosexual youth (reference). % (95% confidence intervals) are provided. n/r, not reportable. LGB, lesbian, gay, bisexual.

Table 2: Youth Health Indicator Definitions & Prevalence, by Gender and Sexual Identity (continued)

Indicator	Survey Question(s)	Gender Identity		Sexual Identity	
		Transgender [†] % (95% CI)	Cisgender % (95% CI)	LGB [†] % (95% CI)	Heterosexual % (95% CI)
<i>(INJURY, VIOLENCE, & BULLYING continued)</i>					
Physically forced to have sexual intercourse	Have you ever been physically forced to have sexual intercourse when you did not want to?	26.9% (17.5-36.2)	7.3% (6.1-8.4)	16.8% (13.5-20.1)	7.0% (5.8-8.1)
Bullied on school property (past year)	During the past 12 months, have you ever been bullied on school property?	28.6% (19.2-37.9)	17.4% (16.0-18.8)	25.2% (20.8-29.6)	17.3% (15.8-18.8)
Electronically bullied (past year)	During the past 12 months, have you ever been electronically bullied? (Count being bullied through e-mail, chat rooms, instant messaging, websites, or texting.)	29.2% (20.9-37.4)	13.7% (12.8-14.7)	23.5% (18.1-29.0)	13.5% (12.4-14.5)
Bullied (either on school property or electronically) (past year)	Based on the following questions: During the past 12 months, have you ever been bullied on school property? During the past 12 months, have you ever been electronically bullied? (Count being bullied through e-mail, chat rooms, instant messaging, websites, or texting.)	40.2% (29.5-50.9)	22.6% (21.2-24.1)	36.0% (29.9-42.0)	22.3% (20.6-23.9)
Skipped school because they felt unsafe (1 or more days in past month)	During the past 30 days, on how many days did you not go to school because you felt you would be unsafe at school or on your way to or from school?	25.9% (14.8-37.1)	7.0% (5.5-8.6)	15.0% (11.0-19.0)	7.4% (5.7-9.0)
MENTAL HEALTH					
Felt sad or hopeless for two or more weeks in a row (past year)	During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?	45.6% (33.4-57.8)	28.4% (26.5-30.3)	54.5% (47.7-61.3)	25.6% (23.8-27.5)
Purposely hurt themselves (1 or more times in past year)	During the past 12 months, how many times did you do something to purposely hurt yourself without wanting to die, such as cutting or burning yourself on purpose?	46.7% (33.1-60.4)	16.5% (14.7-18.3)	43.2% (38.1-48.4)	14.9% (13.2-16.6)
Seriously considered suicide (past year)	During the past 12 months, did you ever seriously consider attempting suicide?	46.4% (34.2-58.5)	14.1% (12.9-15.2)	38.6% (31.0-46.1)	12.2% (10.9-13.4)
Made a suicide plan (past year)	During the past 12 months, did you make a plan about how you would attempt suicide?	37.7% (27.9-47.4)	12.7% (11.4-13.9)	33.9% (28.1-39.7)	10.8% (9.7-11.9)
Attempted suicide (1 or more times in past year)	During the past 12 months, how many times did you actually attempt suicide?	50.2% (34.5-65.9)	7.5% (6.3-8.7)	26.5% (21.5-31.6)	7.2% (5.9-8.4)

Data Source: YRBS, 2017. [†]Highlighted estimates indicate a statistically significant difference between transgender and cisgender youth (reference), or between LGB and heterosexual youth (reference). % (95% confidence intervals) are provided. n/r, not reportable. LGB, lesbian, gay, bisexual.

Table 2: Youth Health Indicator Definitions & Prevalence, by Gender and Sexual Identity (continued)

Indicator	Survey Question(s)	Gender Identity		Sexual Identity	
		Transgender [†] % (95% CI)	Cisgender % (95% CI)	LGB [†] % (95% CI)	Heterosexual % (95% CI)
PROTECTIVE FACTORS					
	Have an adult outside of school to talk to if they have a problem Outside of school, is there an adult you can talk to about things that are important to you?	45.3% (31.9-58.7)	73.4% (70.7-76.1)	58.6% (53.4-63.8)	74.2% (71.3-77.2)
	Have an adult in school to talk to about things important to them Is there at least one teacher or other adult in your school that you can talk to if you have a problem?	47.6% (34.0-61.3)	62.5% (60.3-64.6)	52.9% (47.3-58.5)	63.3% (60.7-66.0)
	Talked with parents or another adult about dangers of substance abuse (past year) During the past 12 months, have you talked with at least one of your parents or another adult in your family about the dangers of tobacco, alcohol, or drugs?	46.0% (32.2-59.9)	44.0% (41.9-46.1)	40.7% (35.0-46.4)	44.9% (42.7-47.1)
	Taught AIDS or HIV infection in school Have you ever been taught about AIDS or HIV infection in school?	48.5% (35.8-61.2)	72.9% (69.2-76.6)	63.7% (53.5-73.9)	73.0% (69.8-76.2)
ACADEMIC ACHIEVEMENT					
	Mostly A and B grades (past year) During the past 12 months, how would you describe your grades in school? <i>Note: Students who responded they were not sure were included in the denominator.</i>	51.2% (40.0-62.4)	73.2% (70.9-75.5)	63.9% (59.4-68.3)	72.6% (70.2-75.0)
	Complete a post high school program (definitely or probably will) How likely is it that you will complete a post high school program such as a vocational training program, military service, community college, or 4-year college? <i>Note: Students who responded they were not sure if they would complete a post-high school program were included in the denominator.</i>	32.8% (21.2-44.3)	70.9% (68.4-73.4)	65.4% (60.4-70.3)	69.7% (67.1-72.2)

Data Source: YRBS, 2017. [†]Highlighted estimates indicate a statistically significant difference between transgender and cisgender youth (reference), or between LGB and heterosexual youth (reference). % (95% confidence intervals) are provided. n/r, not reportable. LGB, lesbian, gay, bisexual.

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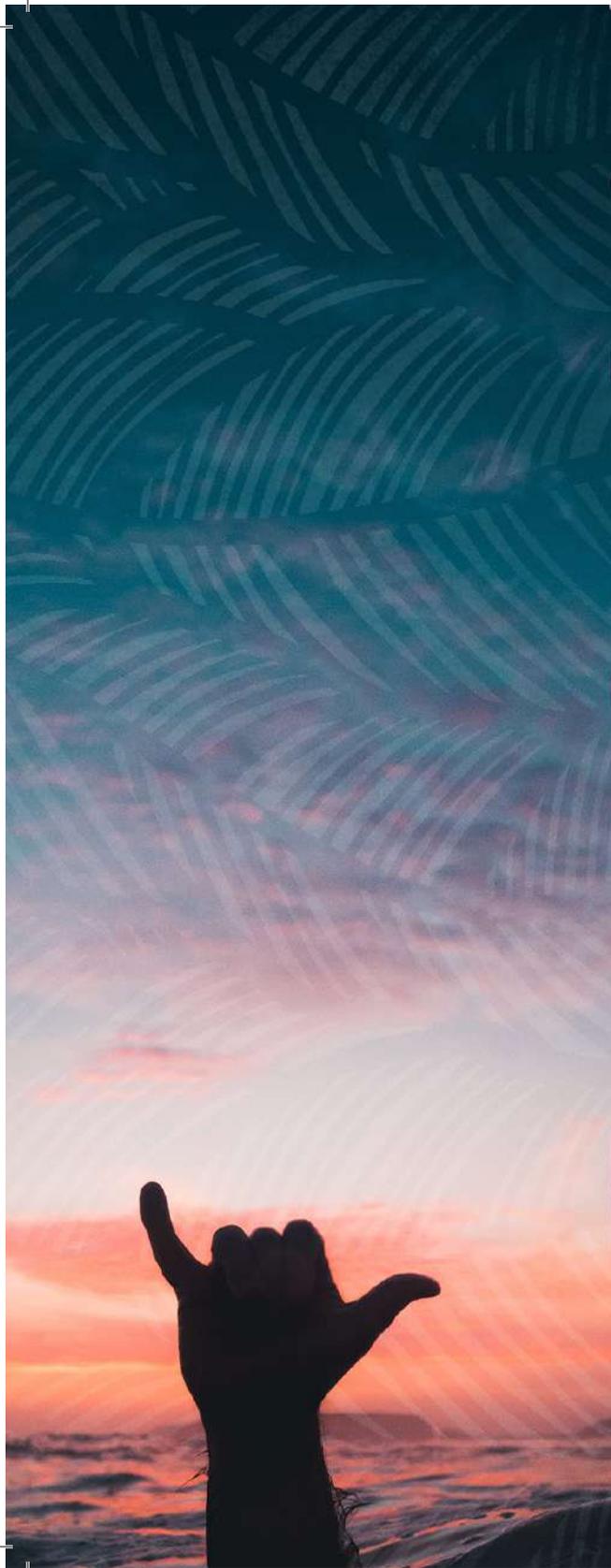
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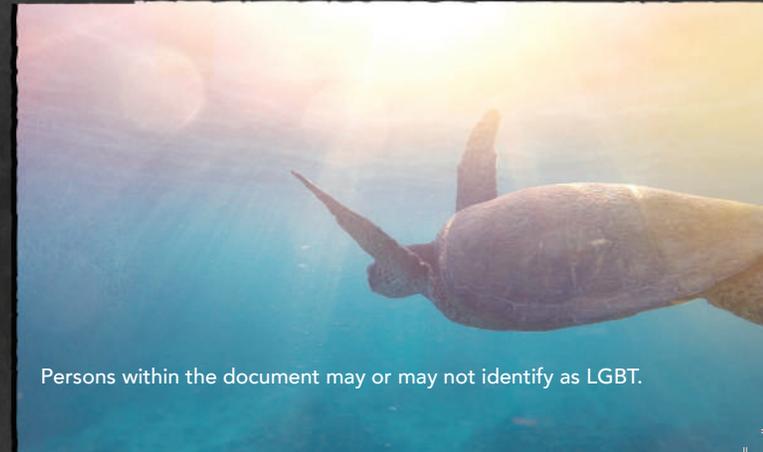
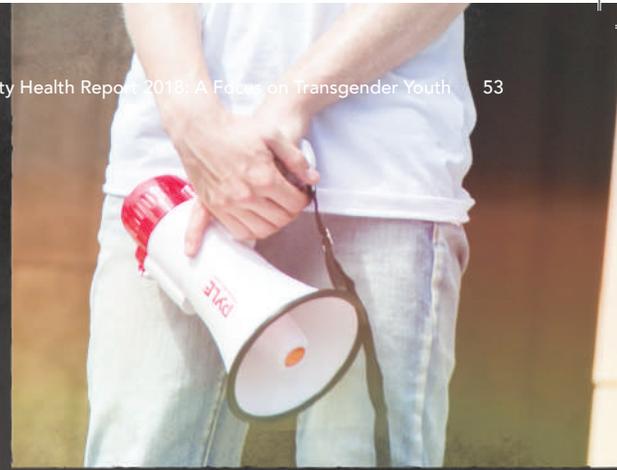
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Persons within the document may or may not identify as LGBT.



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