



ADVANCING EXCELLENCE IN SEXUAL
AND GENDER MINORITY HEALTH

Advancing Excellence in Sexual and Gender Minority Health Care for LGBTQIA+ People of Color

Thoughts and Intent to Action

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NATIONAL LGBT HEALTH
EDUCATION CENTER

A PROGRAM OF THE FENWAY INSTITUTE



HARVARD
MEDICAL SCHOOL

Primary Learning Objectives

- 1) Apply common concepts and terminology used among diverse LGBTQ individuals/communities to describe their sexual orientation and gender identity;
- 2) Identify two challenges and possible solutions in collecting data among LGBTQ populations of color
- 3) Identify two key health disparity factors contributing to excess burden of negative health outcomes affecting LGBTQ subpopulations;
- 4) Describe actionable steps to support LGBTQ communities of color routine engagement in one's clinical practice.



Broadening the concept of race

The way in which race is conceptualized has implications for health disparities research and approaches practitioners take in relation to their client systems.

When viewed solely as a biological construct, racial health disparities become immutable and non-modifiable through intervention.

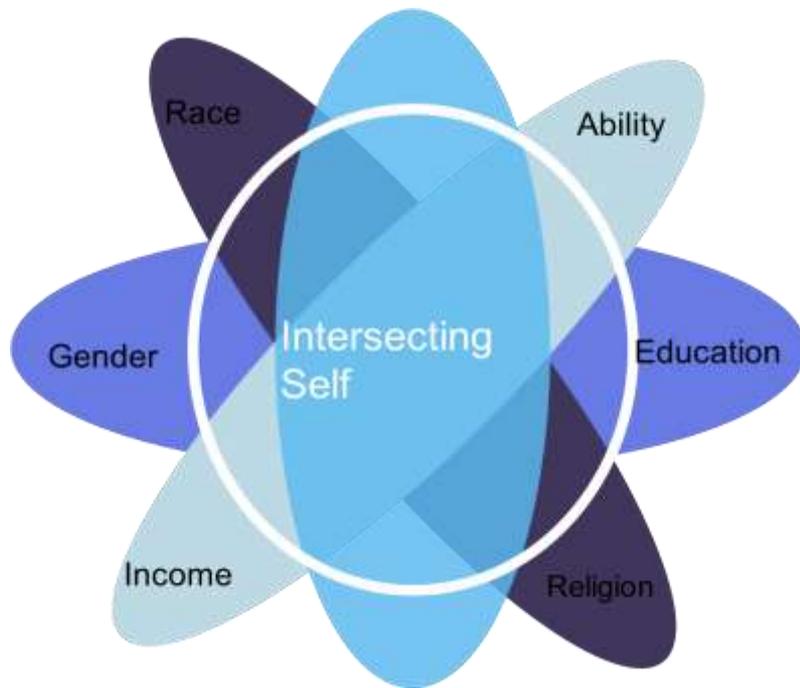
As a social-political construct, race has implications for access to care, residential segregation, education, and access to healthy foods and recreational facilities.

All of which are leverage points for interventions and policy change.

LeCook et al, Measuring Racial/Ethnic Disparities in Health Care: Methods and Practical Issues. Health Services Research 47:3, 2012



Intersecting identities can challenge us!



- Male
- Gay
- Straight
- Bi
- Same Gender Loving
- Being Me



Disparities and inequality in the LGBTQ world

- Diversity in the population
 - Gender identity
 - Sexual orientation
 - Sexual behavior
- Limited research in the field especially beyond HIV
- Stigma and Discrimination
 - The experience versus the sources



Causes and consequences experienced

- Wieringa, S. et al. Rethinking bias and truth in evidence-based health care. *J. of the Evaluation in Clinical Practice*, [s.l.], 24(5), 2018.
- Betancourt, J.R. & Maina, A.W., The Institute of Medicine Report “Unequal Treatment”: Implications for Academic Health Centers. *Mt. Journal of Medicine*, 71(5), 2004.
- Hall et.al. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. *AJPH*, 105(12), 2015.

IOM Findings

- Racial and ethnic disparities in healthcare exist, and because they are associated with worse outcomes in many cases, are unacceptable
- Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality and evidence of persistent racial and ethnic discrimination in many sectors of American life.
- Many sources, including health systems, healthcare providers, patients, and utilization managers, may contribute to racial and ethnic disparities in healthcare
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare.



Challenges Related to Engagement and Retention

- Environmental Factors
- Staffing
- Transitory experiences in health systems
- *Difficult* to Reach Sub-Populations – difficult for whom?
- Political/Law Enforcement
- Community Misconceptions



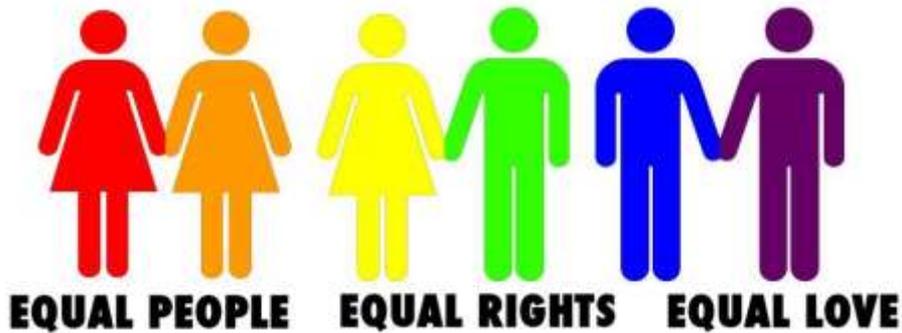
On disparate clinical experiences by Black Men

- Negative encounters with medical institutions
- Need to promote social awareness and acceptance of male sexual health and well being not just (bi)sexuality
- Racial discrimination
- Social isolation and sero-prevalence within a social network/environment
- Sexual discrimination
- Role of sexual & social networks
- Emphasis on behavioral only approaches to understanding risk



It is about who gets to create us and what those representations mean for our lives

...(Wey, T.. SF Chronicle, March 11, 2018)



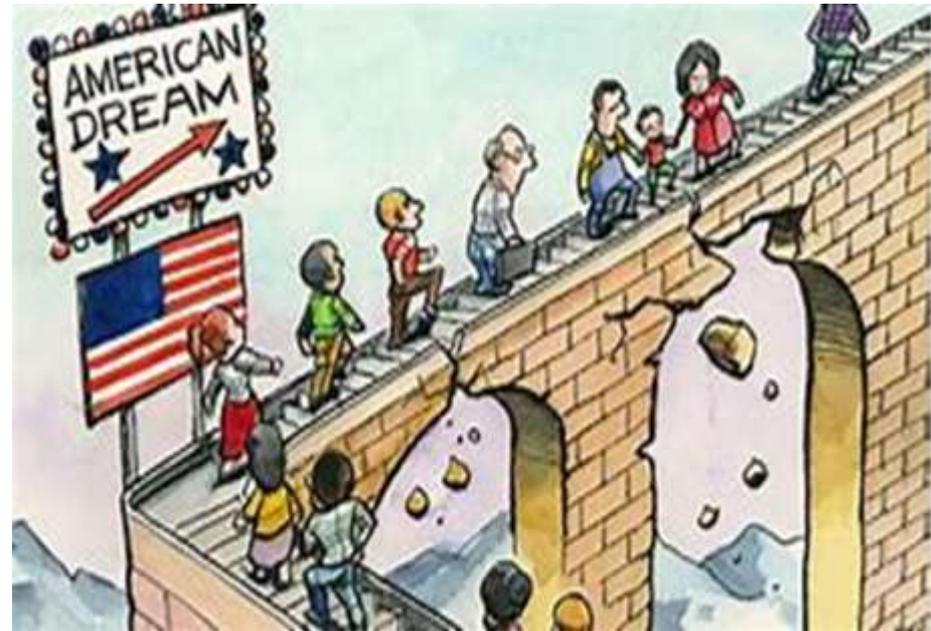
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- Often seen and articulated as overcoming an obstacle to (re)gain a status or position relative to (previous) loss of that status, position or privilege. Taken out of socio-political contexts
- Organize and thrive in effective and organized ways that are not to be studied for scientific curiosities.
- Manifests in economic, social, relational and transactional capitals.



The up-side of PrEP – Life is about Living

It's not just about what you are trying to avoid, but it is equally and maybe more importantly, about where you are going!!





Not just about HIV but inclusive of living well- PERIOD



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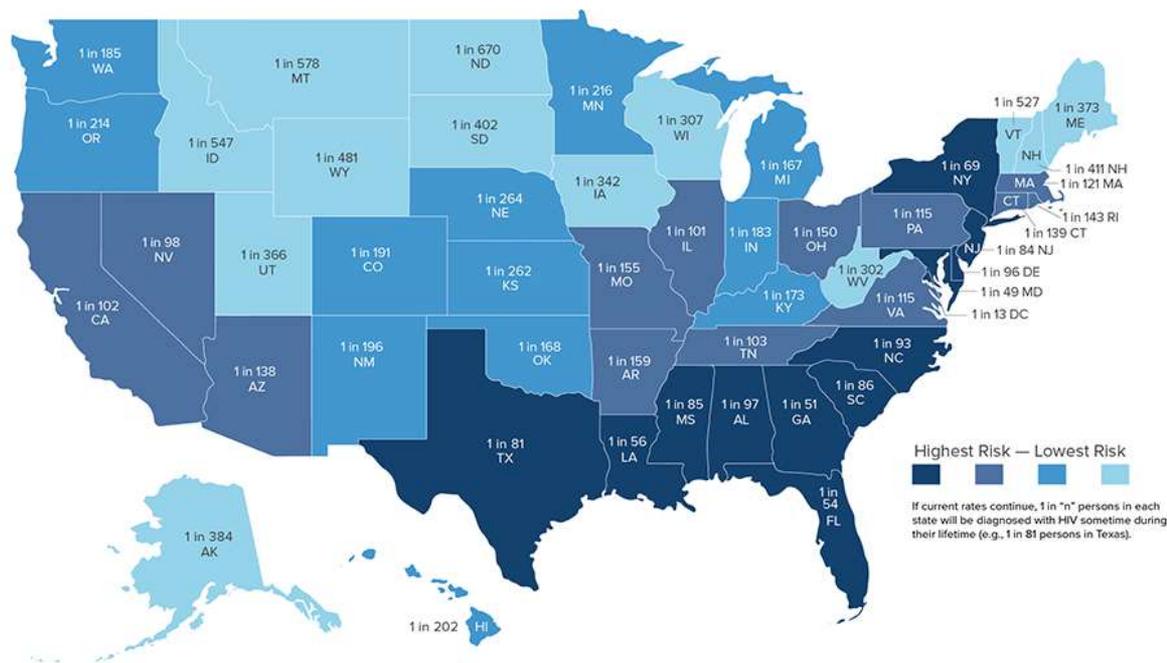
Delayed Entry Into Care

Late initiation of care has been associated with an additional loss of 2.6 years of life.

HIV+ Blacks were:

- 56% of people diagnosed with AIDS within 1 year of HIV diagnosis (Late Testers)
- 2 ½ times more likely than whites to be late presenters for outpatient care
- Associated with a higher number of hospital days, but a lower rate of outpatient visits

Life time risk greater for LGBTQ individuals globally, but for black MSM in the US as great as 1 in 2



Source: CDC. [Diagnoses of HIV infection in the United States and dependent areas, 2015. HIV Surveillance Report 2016;27](#)



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Social and Structural influences on the U.S. Health and Human epidemics and health outcomes

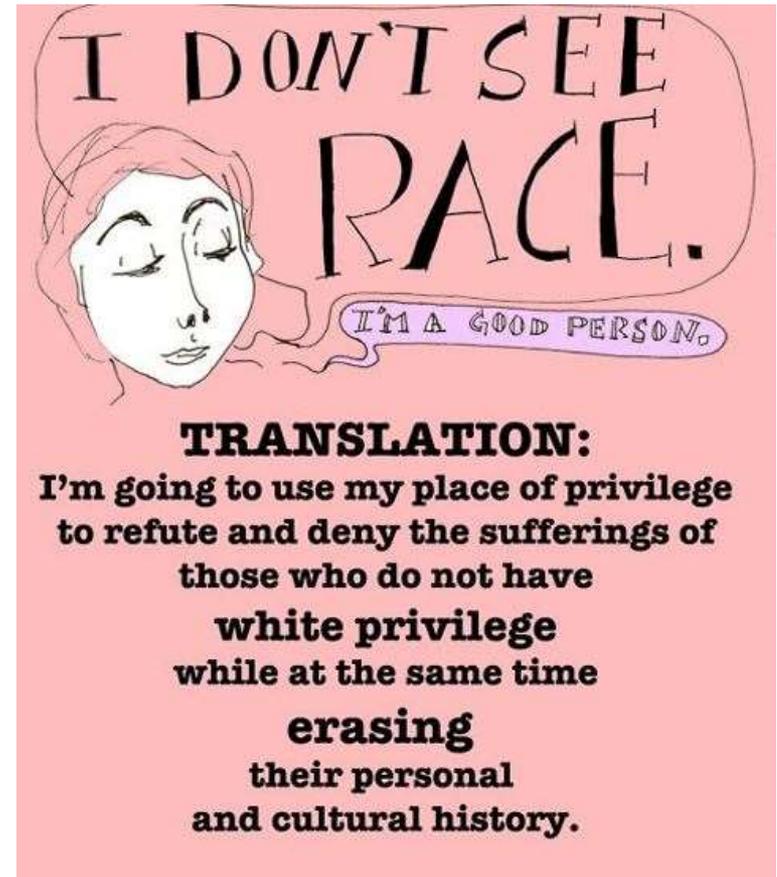
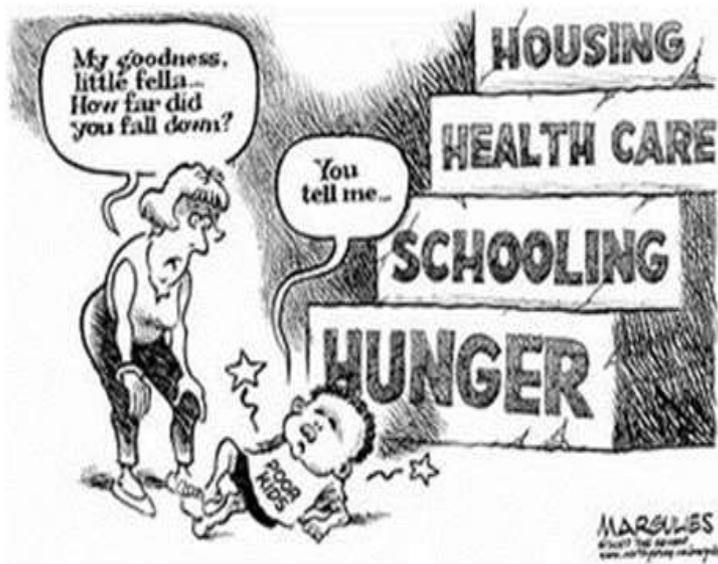
- × **Structural factors**, defined as physical, social, cultural, organizational, community, economic, legal, or policy aspects of the environment that impede or facilitate efforts to avoid HIV infection.
- × **Social determinants** are the economic and social conditions that influence the health of people and communities as a whole. SDH include
 - + conditions for early childhood development
 - + education, employment, income & job security
 - + food security
 - + health services and access to services
 - + Housing, social exclusion, stigma

(CSDH, 2008; Braveman & Gruskin, 2003;
Raphael, 2004)



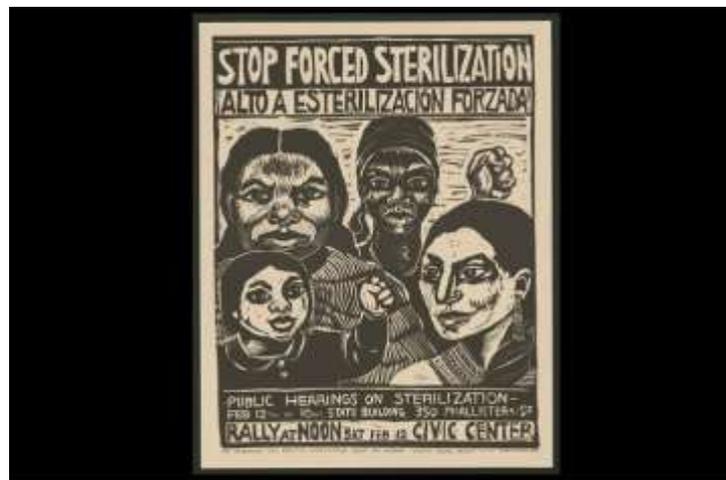
A different slant on structural barriers: Unearned privilege and entitlements!

Multiple elemental -



Health & Social Disparities and inequalities: some things change others seem to materialize again and again

- Some communities have worse health outcomes, with higher rates of chronic illnesses, shorter lifespans, and higher levels of disability than others.



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Health Care Disparities on the Map:

Health Status	Access and Utilization	Social Determinants
Self-reported Fair or Poor Health	No Health Insurance Coverage	Poverty
Unhealthy Days	No Personal Doctor/Health Care Provider	Median Household Income
Limited Activity Days	No Routine Check-up	No High School Diploma
Serious Psychological Distress	No Dental Check-up	Incarceration
Diabetes	No Colorectal Cancer Screening	Unemployment
Cardiovascular Disease	No Doctor Visit Due To Cost	Wage Gap
Obesity
Smoking
Cancers: Uterine, Breast, Cervical, Prostate,
HIV & AIDS	<i>YES, YES & YES</i>	<i>YES, YES & YES</i>

Source: Kaiser Family Foundation (<http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8344-intro.pdf>)



Meaningful engagement and change

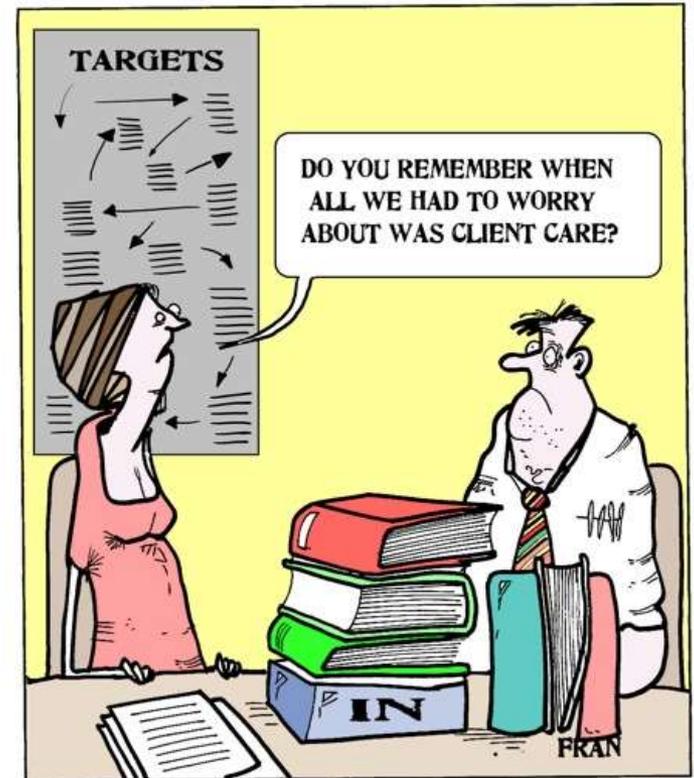
- A need to develop a critical strength and asset discourse on race in the research arena – it's not just about not being White
- The lack of self directed social, political and economic spaces controlled by disproportionately impacted groups is part of the landscape and has to be considered. We need our allies but we also have to become our own destiny; partnering with communities in real and meaningful ways not just at the point of data collection.
- “There may not be easy remedies for the large social problems in the United States”; “The ability to identify cause has eluded social scientist even when it has been technically possible”;... “liberal and conservatives have made peace with the political constraints that deny the necessary resources to address” these inequalities (Epstein, Welfare in America How Social Science Fails the Poor).



What, Why and What Difference

- In the end, our professional solvency will to a great extent be dependent upon our collective capacity to articulate and evidence
 - What we do – the skills, practices, tools and processes
 - Why we do it – the concepts, constructs and theories
 - What difference it makes – outcomes, improvements, social changes, “added value”

Fisher, Fried, Macapagal & Mustanski, Patient-Provider Communication Barriers and Facilitators to HIV and STI Preventive Services for Adolescent MSM. AIDS Behavior 22(10), 2018.



Making meaningful change:

- Using terminology in meaningful and impactful ways. Moving into deeper examination of the meaning of race in health research and differentiating between the biological, genetic and physiological AND the social categorization of peoples.
- Translating our results into communications formats that can reach general populations. Speaking to ourselves helps to a point but is not the goal.
- Expanding our ability to articulate the return on investment beyond and into diverse audiences to include economic and civic partners.

Peek, et.al. Development of A Conceptual Framework for Understanding Shared Decision making Among African-American LGBT Patients and their Clinicians. J Gen. Intern Med. 31(6), 2016.



HIV Prevention Tool Box

**Male
Circumcision**

**HIV
Counseling
and Testing**

**Treatment for
Prevention**

**Treatment of
STIs**

**Behavioral
Interventions**

**Prevention
for Positives**

**Needle
Exchange**

PrEP

**Cash
Incentives**

Condoms

Microbicides

Vaccines

Translating knowledge and intent into action: where are you? Where is your client

- Safety
 - Physical and Psychological
- Belonging
- Esteem
- Self-Actualization
- Meaning
- Mindfulness
- Mastery
- Movement

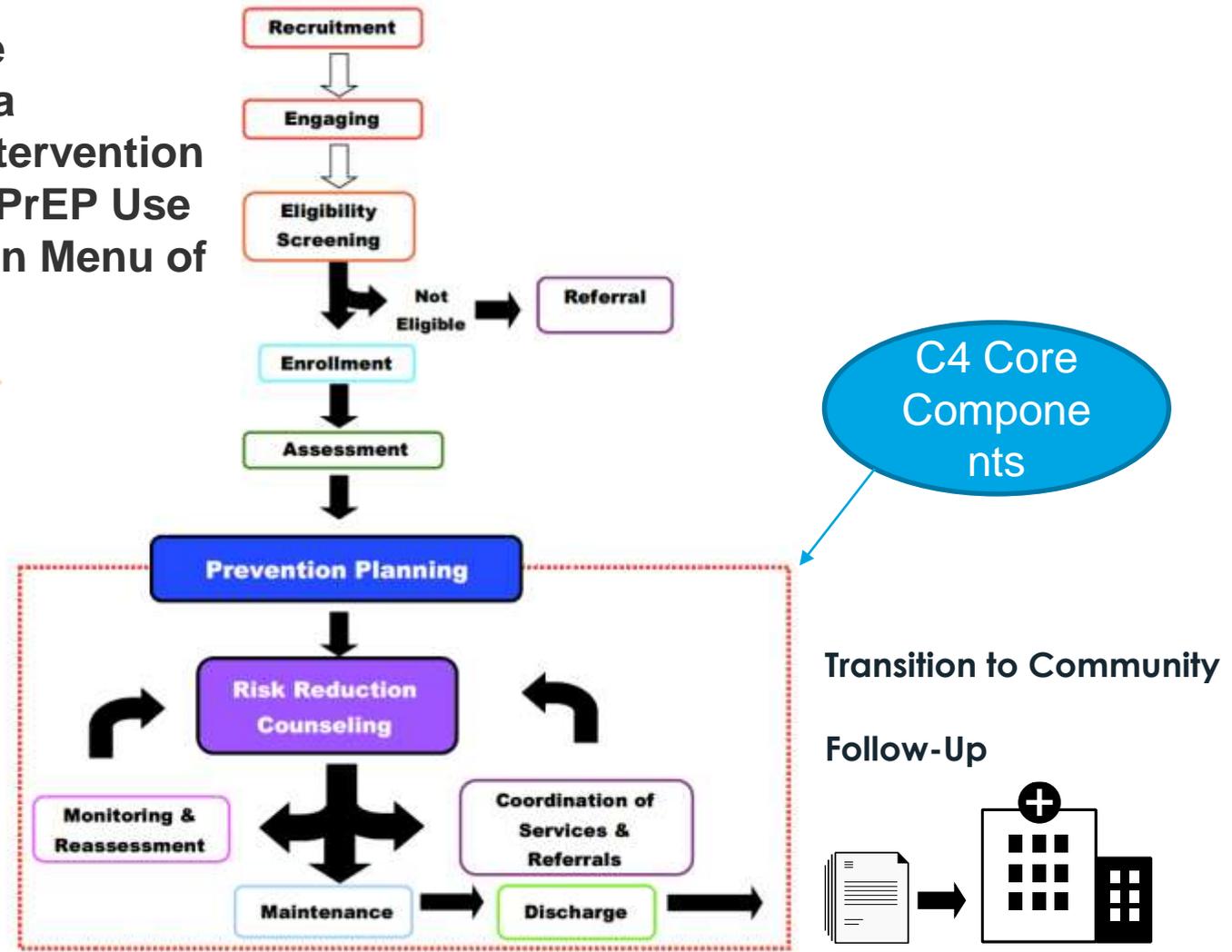


HPTN 073

Client Centered Care Coordination (C4) – a culturally specific intervention package to Support PrEP Use in HIV Risk Reduction Menu of Options

PrEP Uptake:
79%

12-Month Retention: 92%



Conclusions

- Providing theory-based, culturally tailored programs can potentially increase adherence, support program retention and prevent HIV and improve other health outcomes among LGBTQ individuals and communities.
- HPTN 073 demonstrated high uptake of PrEP in BMSM utilizing C4 and led to data that could support a reduced rate of HIV-infection for BMSM on PrEP; consistent with findings for White MSM; implications for other LGBTQ individuals and communities.
- These findings help address a vital US public health gap in HIV prevention



Positionality: *reflection, reflexivity, researcher's experience*

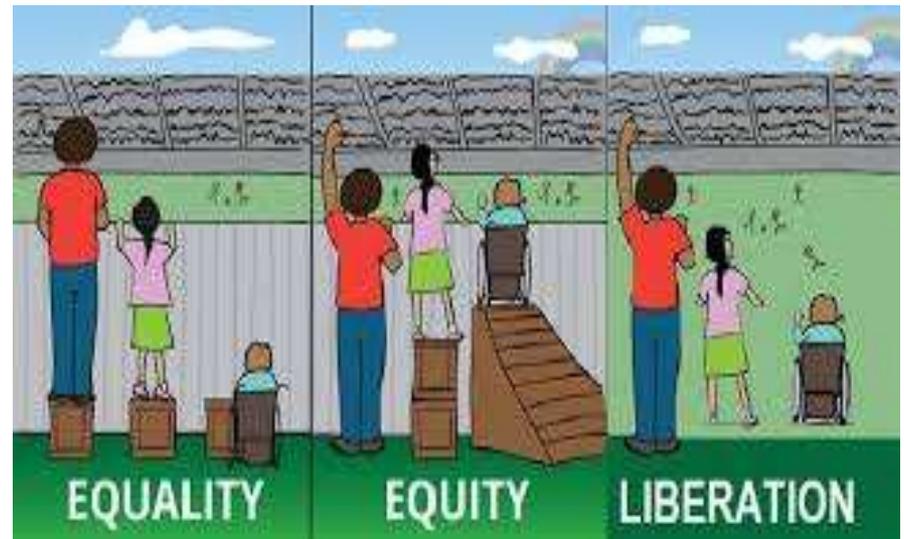
- ✘ ...researchers and practitioners reflexively evaluate ways in which intersubjective elements transform their research and intervention agenda. The process of engaging in reflexivity is full of muddy ambiguity and multiple trails to negotiate the swamp of interminable deconstructions, self analysis and self disclosure.

Source: Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*, 2(2), 209-230.



Closing Thoughts – What's your goal?

- ...Even with biomedical and/or pharmacological tools, we will still need to address the “whole” person to achieve optimal benefits.
- Providers/Systems will need to increase their understanding of and advocate for interventions that target basic needs (i.e., housing, income and education)
- Need for focused interventions based on deeper examinations of the factors which impact the lives of LGBTQIA+ individuals and communities especially those of color (social isolation, and negative life experiences including sexual abuse, etc.)



Closing Thoughts

- A need to develop a critical strength and asset discourse on race in the research arena – it's not just about not being White
- The lack of self directed social, political and economic spaces controlled by and for ALL LGBTQ communities is part of the landscape and has to be considered. We need our allies but we also have to become our own destiny
- Examination of emerging views on HIV and interdisciplinary approaches, to include social, cultural and trans-generational factors.



WHAT ARE YOUR QUESTIONS?



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