Understanding and Addressing the Social Determinants of Health for Black LGBTQ People:

A Way Forward for Health Centers

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To commit to adequately and fully providing health services for Black/African-American people who are lesbian, gay, bisexual, transgender, and queer (Black LGBTQ people), is to recognize and help address the social determinants affecting their health. Further, it is to confront our own personal views and institutional approaches day in and out. Finally, it is to celebrate the resilience of Black LGBTQ people and to examine how, as health care providers of all races and ethnicities, we can contribute to and build on resilience narratives despite the inaccurate yet widely distributed narratives of risks and deficits.

Contextual Factors

In this section, we discuss how Black LGBTQ people can experience unique and magnified forms of discrimination because they belong to more than one marginalized community. Discrimination, bias, and related challenges can occur on the structural, interpersonal, and individual level, all of which have potential consequences for a person's health and wellbeing.

Structural determinants

Black LGBTQ people often face multiple intersecting structural adversities linked to their sexual orientations, gender identities, and racial identities. As racially marginalized people, they already face biased policies and systems as they try to gain access to housing, jobs, places of leisure, and health care. As LGBTQ people, they may have an even greater likelihood of receiving unfair treatment linked to their sexual, gender, and racial identities. A 2017 survey of a nationally representative sample of U.S. adults found that LGBTQ people of color (defined in the survey as those who identified as Black, Latino, Asian, and/or Native), were twice as likely to report discrimination because of their LGBTQ identity when applying for jobs and when interacting with police, compared to White LGBTQ people.[1]

Although LGBTQ community organizations, social platforms, and dating sites provide respite and build resilience for LGBTQ people, many have a history of ignoring issues of race and ethnicity, and still struggle to place anti-racism efforts into their goals and programming.[2] As such, Black LGBTQ people may experience these places as unwelcoming or even ostracizing. In addition, Black LGBTQ people who have a history of immigration often face ethnocentrism and language barriers. Those

who are socio-economically marginalized may face the compounded burden of not being able to afford basic needs (e.g., housing, transportation, health care, and food) or simple desires (e.g., eating out, taking small vacations) that is a common privilege for those who are not socio-economically disadvantaged. Lastly, Black LGBTQ people (particularly Black transgender women) are subjected to violence, brutality, and death at a far greater rate than White LGBTQ people and bear the resulting loss of lives and negative impacts on the quality of life, mental health, and physical health of those who survive violence.[3]

Individual determinants

LGBTQ people experience disproportionate behavioral health struggles such as depression, anxiety, post-traumatic stress, substance use, and suicidality, often in response to external and internalized stressors produced by an oppressive environment.[6,7] Societal stigma related to mental health also makes it difficult for people to access social support or seek mental health services and treatments. Black LGBTQ people not only face these same mental health struggles, but their mental health symptoms may be further exacerbated and at times caused by structural forces such as racism, ethnocentrism, and poverty. As Black people, their attempts to schedule a mental health visit with a new provider is less likely to be responded to.[8] Further, access to culturally and racially competent mental health care is limited for Black LGBTQ people, with an existing mental health workforce that is predominantly White and insufficiently trained to conduct mental health sessions when topics of oppression and privilege are integral.[9]

Interpersonal determinants

The dynamics of interpersonal relationships are complex and vary for everyone, however the intersecting marginalization that Black LGBTQ people experience weighs additionally on relationships. Family, friends, peers, and co-workers may offer support and belonging as it pertains to some, but not all, aspects of a person's identity.[4] For instance, a family member may offer support in the face of racism stressors, but not be accepting of LGBTQ identity. Similarly, a White co-worker may relate to a person's LGBTQ identity, yet engage in racial microaggressions (e.g., jokes, slights),[2] or not acknowledge how White privilege may be playing a role in career advancement at work. In addition, relationships may be built via shared membership in organizations such as religious institutions where some messages may be empowering and soothing, while others are painful and anti-LGBTQ.[5] For some Black LGBTQ people, it is therefore an ongoing challenge to: (a) decide whether to end certain relationships or set boundaries on the extent of the relationships and amount of contact, (b) try to maximize the benefits (and simultaneously cope with adversity) from various parts of their interpersonal network, and (c) find relationships where they can be completely accepted in all their intersecting identities as a Black LGBTQ person.

CASE EXAMPLE

How social determinants affect HIV health outcomes in Black gay, bisexual, and queer men

It is well known that Black gay, bisexual, and queer (GBQ) men are dispro-portionately more likely to be living with HIV in the U.S.[10] Research studies consistently show, however, that compared to White GBQ men, Black GBQ men engage in lower or similar levels of sexual risk and substance use behav-iors, and are more likely to report preventive behaviors.[11] What then explains the disparity in prevalence of HIV among Black GBQ men? Based on current evidence, HIV prevention experts theorize that the disparity arises from a complex interplay of structural, interpersonal, and individual level contextual factors. For example, Black GBQ men have two-fold greater odds of being unemployed, low income, previously incarcerated, or having less education, compared other GBQ men.[10] These structural factors are rooted in systemic, historic racism towards Black Americans. On the interpersonal level, Black GBQ men tend to have sex with partners of the same race/ethnicity, putting them at greater risk of HIV due to the greater percentage likelihood that their partners are living with HIV.[12] Partnering with people of the same race/ethnicity may in part be due to geographic clustering of people by race/eth-nicity, which in itself reflects historical (and current) racially biased structural housing policies and lending systems. Poverty also plays a role, as limited access to health care coverage and higher-quality health care affects access to HIV testing, care, and medications. With fewer men virally suppressed, the likelihood of HIV transmission among Black GBQ men increases. Black men may be also be more likely to distrust health care providers because of a long history of discriminatory treatment of the Black and LGBTQ communities.[13] Additionally, the homophobic and racist attitudes they encounter daily can affect their mental health and self-esteem, and potentially make them less likely to engage in health care or negotiate protection consistently with their partners. Stigma also reduces access to culturally appropriate HIV preven-tion services.[5] Finally, for some Black GBQ men, the interplay of violence (e.g., intimate partner violence) and poverty (e.g., financial control by a part-ner) may result in condom negotiation not being an option.[14]

The Way Forward

The way forward in justly serving Black LGBTQ people at the intersection of numerous marginalizing experiences must include increasing awareness of the lived experiences of Black LGBTQ people, examining and changing our personal views and behaviors, critically assessing and challenging our institutional cultures as health services, and providing resources and mechanisms to empower Black LGBTQ people to be resilient in the context of oppression.

Increasing awareness and integration of the lived experiences of Black LGBTQ people

While the occasional cultural sensitivity trainings given to health center staff are a start, they are by no means sufficient. Reading publications or books centered on the voices and experiences of Black LGBTQ people is also beneficial, but not enough. Increasing awareness will entail having Black LGBTQ people and their voices at each table (without tokenizing one voice/representative) and whenever polices, changes, and ideas are being discussed. This includes but is not limited to diverse representation in leadership roles, advisory boards, human resources, and staff/providers, which will ensure ongoing contribution to the discourse by Black LGBTQ people.

Examining and changing our personal views and behaviors

We must take an honest and critical inventory of the messages and ideas we have been taught over our lifespans, which are laced with implicit and explicit biases, be it racism, anti-LGBTQ prejudice, etc. We also have to examine our day-to-day behaviors that may contribute to the oppression of Black LGBTQ people. Lastly, we must resist any inclination to conclude that we are already competent and doing good work, even if we are ourselves Black, LGBTQ, or both. To commit to serving Black LGBTQ people is to examine our views and behaviors each day, and to view this examination as an ongoing process that never ends.

Assessing the institutional cultures of our health services

It is important to constantly assess the culture of our health services in terms of our values, processes, and who is involved in defining and redefining our culture. In brief, a few questions may begin or continue the conversation as it pertains to Black LGBTQ people.

- How is our institution experienced by Black LGBTQ people? Have we asked?

- Does our institution have an explicit mission (with objectives) on serving Black LGBTQ people?

- Are our physical spaces and distributed information/materials affirming to Black LGBTQ people?

- Are Black LGBTQ people at each table and a part of all conversations?

- Does our institution take a public and internal stance on national incidents relevant to the lives of Black people (e.g., disproportionate rate of unarmed Black people killed by law enforcement) or are the stances limited to incidents that are viewed as "only" LGBTQ-related?

Providing resources and mechanisms to empower Black LGBTQ people

Given the many structural barriers that Black LGBTQ people face, we need to ensure that health centers provide resources and adequate referrals to assist people in navigating these barriers. All staff should be aware of these resources and know their role in navigating or referring people to resources. Below is a list of questions to take stock, further the conversation, and generate action items regarding needed resources and mechanisms.

- Do we have resources to address social determinants such as:
  - o Violence/trauma
  - o Housing
  - o Employment
  - o Transportation
  - o Food insecurity?

- Do we have a process/mechanism to address racism in-house and to help patients address racism experienced in general?

- Do we provide services in diverse languages?

- Do we provide or have culturally affirming referrals for mental health and substance use disorder services?

- Are our staff members trained to respond to and address oppression in the context of visits?

Supporting the resilience of Black LGBTQ people

In the face of, and in spite of ongoing oppression, Black LGBTQ people are resilient and find ways to triumph. Their resilience is facilitated by coping strategies (e.g., building validating communities, engaging in the arts, spirituality) that vary for each individual. Quite often our health literature discusses Black LGBTQ people mainly from a lens of health disparities, which highlights risk for certain health conditions (e.g., HIV) without naming the structural factors (e.g., racism, anti-LGBTQ discrimination, as describe in the box above) driving the disparities. It is essential that in serving Black LGBTQ patients, we reframe the misconception to see to them as "at risk" and instead see them as "at promise" for a future of good health and well-being anchored in their own resilience and supported by our abilities as staff, providers, and institutions to provide services to contribute to their resilience. Questions to generate a discussion around their resilience and coping strategies may include: *What do you love about yourself?*, *What has helped you to keep going even when times are hard?* and *How can I best help you as you keep pushing forward?*

Resources

- Movement Advancement Project: www.lgbtmap.org/policy-and-issue-analysis/LGBT-people-of-color

- Human Rights Campaign: www.hrc.org/explore/topic/communities-of-color

- National LGBT Health Education Center: www.lgbthealtheducation.org

- Center for Engaging Black MSM Across the Care Continuum: www.nastad.org/domestic/hiv-prevention-health-equity/center-engaging-black-msm-across-care-continuum-cebacc

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Acknowledgements

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