

EXECUTIVE SUMMARY OF A SOUTHERN LATINX LGBTQ+ REGIONAL ASSESSMENT

Gabriela Betancourt, MA, MPH; Judith Montenegro; Joaquín Carcaño

Realities in the Southern Region

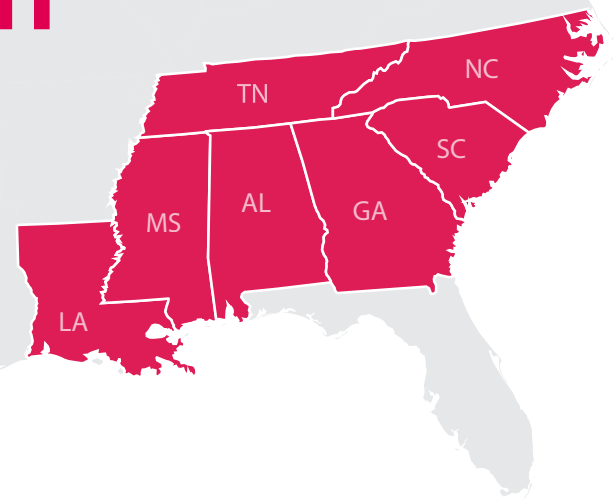
The South has become one of the most diverse regions in the United States (US), with an influx of immigrants and migrants, and a large percentage of community members that identify as LGBTQ. While historically black/white constructs of race and racism have shaped much of what we think of as “Southern culture” today, the South is not static – it is dynamic and ever-changing. However, there is a high level of stigma surrounding the emerging Latino population as it relates to immigration, health access and sexual orientation.¹

“Machismo is still very much a thing in our community, you know? A lot of people are not out. I’m always hit up on Grindr by faceless profiles that are Latino guys who live in this area, because this is one of those places where there’s a high Latino population. So there is still quite a bit of stigma, and I have plenty of friends who are still working on their immigration status specifically who are fighting for their right to stay here, and their lives are very much in the balance, because of the fact that neither recognizes their humanity nor their queerness.” – Latinx community member

Our Response

In 2006 the Latino Commission on AIDS, in consultation with many partners, began working in the south through the development of a regional program: Latinos in the Deep South (Now Latinos in the South). Our work focus is to develop the capacity of stakeholders; enhance the visibility of issues affecting Hispanic/Latinx, such as barriers to health care access; and mobilize communities on advocacy and health policy work impacting the Southern region’s realities.

In 2018, one of the program components of Latinos in the South, with the support of AIDS United, began providing micro-grants to LGBT Latinx organizations and grassroots groups in three Southern states: North Carolina, Louisiana, and Georgia. Through this process, the lack of services and organizations providing support customized to Latinx LGBTQ+ individuals became strikingly evident. There was a clear need to conduct a regional assessment to inform our community engagement strategy and increase access to services.



LATINOS LIVING IN THE DEEP SOUTH, HAS RISEN QUICKLY AND SUBSTANTIALLY



THE INTEGRATION OF LATINX LGBTQ INTO THE SOUTHERN CULTURE HAS BROUGHT CHALLENGES

Introduction to the Assessment

Anecdotal and research evidence has shown that persons identifying as LGBTQ, non-binary, and gender non-conforming experience a range of barriers to access health care, and chronic stressors, including stigma and discrimination, impacting health outcomes.² Immigration status, race and ethnicity, country of origin, and other social and structural factors can further impact access to quality, comprehensive health care and support services for optimal well-being.³

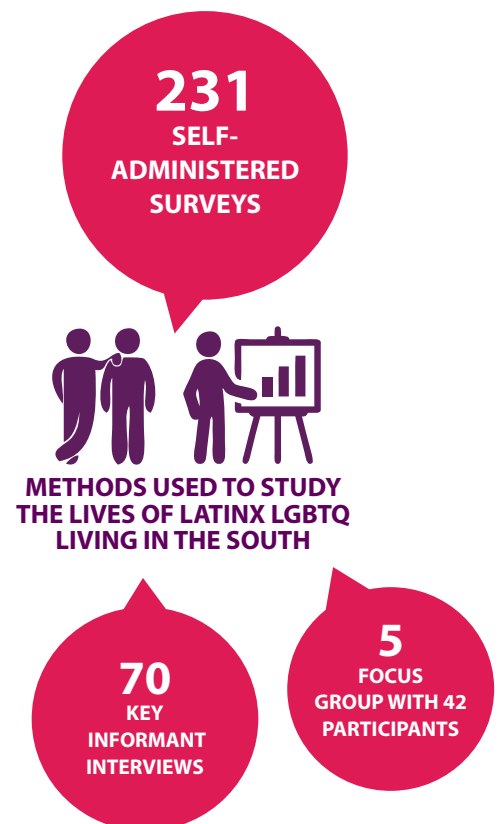
Due to these challenges, the Latinx community and advocates are constantly in a reactive mode. There is a lack of culturally and linguistically appropriate assessments that outline the specific needs and concerns around HIV prevention, treatment, and health care needs of LGBTQ communities in the Deep South. With the rapid growth of both the Latinx community and LGBTQ visibility throughout the US, particularly in the Southern region, conducting an LGBTQ Latinx community assessment was crucial to gaining insight into the current state of health and well-being for this population. This regional assessment will help guide the development of better regional and local strategies to effectively serve our diverse communities.

In response to this, the Latinos in the South Program initiated a community-wide assessment of individuals identifying as Latinx and LGBTQ in the southern United States of Alabama, Georgia, Louisiana, North Carolina, South Carolina, Tennessee, and Mississippi, collectively termed the Deep South. The aim of our assessment is to provide further insight and knowledge and highlight the critical needs of LGBTQ Latinx communities in the Deep South, a population that is highly vulnerable and understudied.

Methods

This community effort presents the preliminary quantitative (survey) results of the assessment and highlights of the qualitative (focus groups and interviews), from which we have formulated and provided preliminary recommendations for the improvement of social, structural and individual-level factors to meet the health needs of Latinx LGBTQ community members in the Deep South.

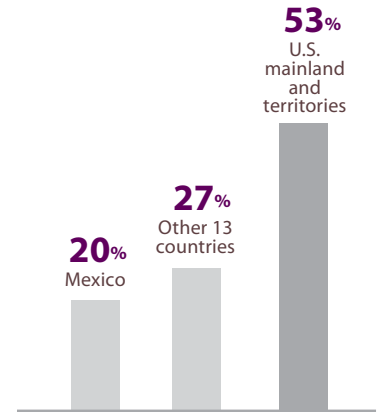
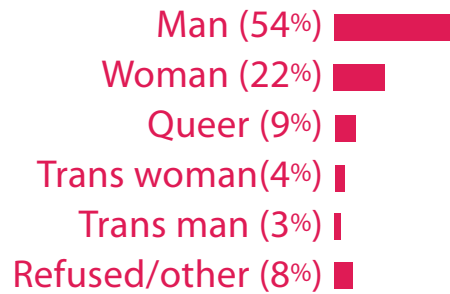
We used a mixed methods approach, employing both qualitative and quantitative techniques to gather robust information from which we have drawn our preliminary recommendations. This mixed-method assessment included interviews with community members, providers, stakeholders, and professionals serving the Latinx and/or LGBTQ community throughout the South, surveys specific for the LGBTQ Latinx population, and several focus groups in 3 Southern cities with programming for the LGBTQ Latinx community: Durham, North Carolina, Memphis, Tennessee, and Atlanta, Georgia. All instruments in this community assessment were available both in Spanish and English.



Survey respondents, focus group participants and key community members informants needed to identify as Latino; either gay, lesbian, bisexual, transgender or queer, be at least 18 years of age; and a current resident of one of the 7 Deep South states.



Gender of Respondents



Over half of the survey participants were Latinos born in the U.S.

Qualitative Assessment Activities

We conducted 5 focus groups in North Carolina (2), Tennessee (1) and Georgia (2). Each focus group had 5 to 11 participants. One focus group was held for Latinx individuals identifying as Lesbian, Gay and/or Bisexual (LGB); 1 focus group was held for transgender Latinas, and 3 were held for all individuals identifying as Latinx LGBTQ. The total number of participants across all 5 focus groups was 42. Focus groups were coordinated according to the requests of the community partners hosting.

The eligibility criteria for participation in the focus groups were: 1) identify as Latinx and LGBTQ; 2) currently live in one of the 7 Deep South states; 3) 18 years of age or older.

In addition to the focus groups, we conducted key informant interviews with community members (utilizing the same eligibility criteria described above) and with providers and stakeholders. The eligibility criteria for providers and stakeholders were: working within the HIV/health and/or providing services to the Latinx community; residing and working in the seven states in the south. We interviewed a total of 70 individuals: 21 were providers/stakeholders; 13 were providers/stakeholders and Latinx community members, and 36 were Latinx community members.

Quantitative Assessment Activities

The quantitative component of our assessment used a self-administered survey (distributed online via SurveyMonkey) with the option for participants to complete in English or Spanish. The survey began with 4 eligibility screening questions asking participants if they: 1) identify as Hispanic/Latin@/Latinx; 2) identify as lesbian, gay, bisexual, transgender, or queer; 3) at least 18 years of age, and 4) a current resident of one of the 7 Deep South states. Participants responding yes to all of the screening questions were then asked if they would consent to participate.

A total of 231 individuals met the eligibility criteria and participated in the survey; the majority (83%) completed the survey in English. The average age of respondents was 32 years, ranging from 18 to 78 years. The median age was 29 years.



AVERAGE YEARS OF AGE OF SURVEY RESPONDENTS; RANGING FROM 18 YEARS TO 78 YEARS



AVERAGE NUMBER OF YEARS OF PARTICIPANTS LIVING IN THE SOUTH

Key Areas of Discussion

Participants were characterized by a reflective mix of diverse LGBTQ gender and sexual orientation identities. Furthermore, the analytic sample is skewed toward younger ages – again reflective of the relatively young ages of Latinx at the national level and in the “non-traditional” deep Southern states.⁴ Finally, about half of the sample is comprised of first-generation immigrants.

Social Determinants of Health:

Employment, education and housing stability are evidenced social determinants of health.⁵ Despite relatively high levels of education, yearly income was low and individuals were engaging in longer than 40 hours of work weekly, and handling more than one job. This may be attributed to employment dominated by low-wage service industries where Latinx community members, such as construction and maintenance, agriculture, and housekeeping, comprise much of the workforce.⁶ In addition to low wages, these occupations often do not allow for sick leave, flexible hours for healthcare visits, or health insurance coverage. Furthermore, reports of unstable housing were notable with an estimated 22% of respondents reporting a history of homelessness during their lifetime and of these, 23% experienced homelessness in the past 12 months.

Community Health Provider Capacity:

Our initial findings indicate that participant/provider interactions, including communication, trust, and cultural responsiveness, need improvement. Participants had to carry the burden, albeit minimal, of educating their providers about the health issues/concerns they have as Latinx LGBTQ individuals, and comfort-levels in having these discussions with providers were moderate. Participant reports indicated a range of both positive and negative experiences accessing health

care from providers, including specialists. Our assessment reveals complicated and at times limited communication between providers and community members, and medium levels of trust. Less than half of the respondents indicated that discussions with providers included key health topics including conversations about diet, health, and nutrition. Sixty-five percent of respondents had providers that were unaware or only partially aware of their LGBTQ identity.

Participant reports suggest that they are not receiving recommended annual routine screening for HIV and Sexually Transmitted infections (STIs), despite risk factors, including past diagnosis of chlamydia, gonorrhea, syphilis, and inconsistent condom use. For example, among participants that reported past HIV and STI testing, 29% had not tested for HIV in over 1 year; and 28% had not been tested for STIs in over 1 year. Sexual history and STIs were reported as two of the top four conversation topics discussed with providers. However, overall provider discussions were low as less than half of respondents reported discussing these topics during their healthcare visits.

These statistics illustrate potential gaps in follow-up care, hesitancy to discuss one’s personal life in the healthcare setting, and/or lack of a provider’s attention and response to their patient’s life, relationships, and sexual encounters impacting health outcomes.

A key initial finding is that while the majority of participants identifying as men, identified as gay, participants identifying as women had a wider range of identities related to sexual orientation. Contextualizing this information, individuals may be using terms describing gender and sexuality that are unfamiliar to providers; providers may either disregard a possible need or neglect to provide screening



PERCENTAGE OF RESPONDENTS WHO REPORTED HOMELESSNESS DURING THEIR LIFETIME



PERCENTAGE OF RESPONDENTS WHOSE MEDICAL PROVIDERS ARE UNAWARE OR PARTIALLY AWARE OF THEIR LGBTQ IDENTITY



29% OF PARTICIPANTS WITH PAST HIV TESTING HAD NOT TESTED FOR HIV IN OVER 1 YEAR. THE RATE IS 28% FOR STIs

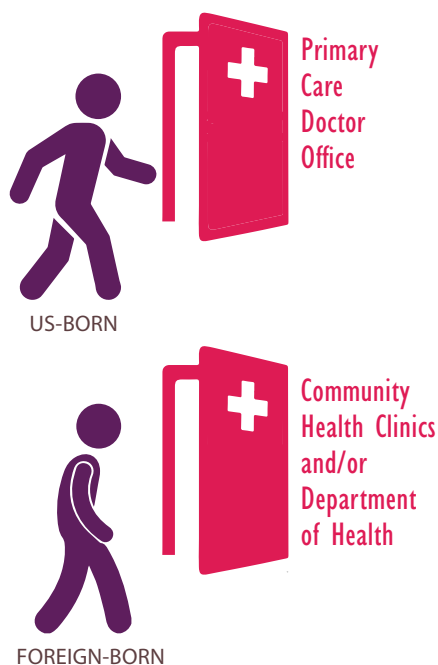


PARTICIPANTS WHOSE GENDER IDENTIFICATION IS OF A WOMEN HAD A WIDER RANGE OF SEXUAL ORIENTATION IDENTITIES; THESE IDENTIFICATIONS MIGHT BE UNFAMILIAR TO PROVIDERS

related to risk or exposure. For example, a person assigned female sex at birth and identifying as male, transgender male or queer, may need regular PAP screenings; a person identifying as queer may need both protection for STIs (including HIV) and contraceptives to prevent unintended pregnancy.

Sources of Care:

Another key finding is the difference in sources of care between foreign- and US-born participants. Although the distribution in sources of care was relatively similar for both groups, it differed in that US-born participants indicated having a primary care physician, whereas foreign-born participants were accessing rural or community health clinics and/or departments of health. This difference may have implications in terms of the quality of care, the availability of services, and the barriers that an individual may face when trying to access services (eligibility, hours of operation, etc.).



US-BORN PARTICIPANTS INDICATED HAVING A PRIMARY CARE PHYSICIAN, WHILE FOREIGN-BORN PARTICIPANTS WERE ACCESSING RURAL OR COMMUNITY HEALTH CLINICS AND/OR DEPARTMENTS OF HEALTH

Preliminary Recommendations

Based on our initial analysis of quantitative data, we have some preliminary recommendations to improve the health and well-being of Latinx LGBTQ community members residing in the Deep South. The most important recommendation is to develop an ongoing effort to remove the stigma associated with the Latinx LGBTQ+ communities and within the healthcare sector in order to deliver stigma-free services.

Transportation:

Transportation continues to be a major barrier for respondents accessing health care. Interviewees including community members, providers, and healthcare professionals, often cited transportation as a common hurdle and spoke of strategies clinics and organizations were utilized to address this barrier. Interviewees working in the health sector often shared the need to personally provide both pick-up and drop-off for clients at appointments however this sometimes fell outside of their job responsibilities.

Interesting to analyses is the nationwide partnership between ride-sharing services Uber and Lyft and healthcare systems launched in 2017 to address missed medical appointments due to transportation.⁷ The utilization of these platforms has so far resulted in lowered cancellation rates and increased healthcare savings. As rural growth in the south continues to rise, innovative strategies and collaborations such as these could provide relief to both providers and clients alike.

Language Access:

While only 17% of respondents identified as a monolingual Spanish speaker, providers indicated language access as a large gap in services. As mentioned previously, when bilingual staffers are present they often fill multiple roles within their place of work, take on larger caseloads, and/or fulfill

job duties outside of their responsibilities for the benefit of their clients. When these staffers are not available, clinics and agencies rely on interpretation phone services and individuals may be forced to wait extended periods of time for language support during their visit. In some cases, individuals will bring a family member to aid in interpretation but this itself is a hindrance to an individual's ability to be forthcoming about their health and it does not hold clinics accountable for providing these services. For HIV agencies in areas with a substantial Latinx population but low Latinx client numbers, staffers shared their uncertainty as to whether the community was not attempting to access their services due to not having any known Spanish speaking staff, whether the community was aware of their services, or if the Latinx community had little to no need for their services. It is clear that language barriers will continue to impede access to quality care if not addressed by increased employment and investment into engaging the Spanish speaking community.

“It’s unfair for HIV organizations to put the burden of HIV care to Latin American organizations when their focus is this. HIV organizations need to cater to the Latinx communities just as much as they cater to the non-Spanish speaking communities as well, but they don’t. If they did, they would make sure they would be hiring people on all levels that were bilingual or willing to communicate with somebody with a different language or educated about the culture that’s going on and stuff. They get away with a lot of that in [redacted] because for so long, [redacted] has been primarily an English-speaking city. It’s just now that we’re starting to see an influx of immigrants coming in speaking Spanish or speaking other languages and stuff.”

– Healthcare worker and latinx community member

Dental and Mental Healthcare:

The highest reported barriers to accessing dental and mental healthcare were cost/lack of insurance, 87%, and 80% respectively. Despite these numbers, 43% of respondents reported having received mental health care during the past 6 months. Anxiety and depression were the highest reported illnesses of our respondents. These diagnoses coupled with notable reports of participants experiencing physical and/or emotional violence and abuse due to their Latinx LGBTQ identity indicate a need for mental healthcare options. In addition, to cost/lack of insurance, interviewees expressed frustration at the lack of options for providers overall and particularly when it came to those who are reflective of the community culturally, linguistically, and LGBTQ inclusive approaches.

A recently launched initiative, Latinx Therapist Action Network, aims to destigmatize mental health in the Latinx

community while connecting individuals to practitioners via an ever-growing directory who can provide affirming support while addressing structural barriers such as language, cost, and location.

On PrEP:

Over half of respondents had heard of PrEP, primarily via the internet and media campaigns, yet only 10% of respondents use PrEP currently. It is clear that PrEP awareness campaigns are only one strategy to facilitate uptake and structural barriers must be addressed in tandem to campaigning. Factors impeding access have been shown to include lack of health insurance and cost concerns, language and health literacy barriers, PrEP associated stigma, and difficulty in navigating the healthcare system.⁸ As the South has largely not accepted Medicaid expansion, which could help alleviate some of these barriers and with sparse Spanish speaking healthcare professional, PrEP uptake may lag until these structural issues can be adequately addressed.

More to Come:

Despite some of the aforementioned preliminary findings and challenges to addressing the health concerns of the Latinx LGBTQ+ community in the deep South, they have proven to be resilient and establishing their homes and shaping their communities. Our full report will share a richer snapshot of the personal, familial, communal, and political factors impacting the state of health of LGBTQ+ Latinx communities in South.

“I think being in the South is about breaking bread together and loving on each other. But definitely, it’s making intentional space and struggling through that, too. Because I mean, being queer and/or black and brown in the South is definitely an experience. But I wouldn’t wanna live anywhere else.” – Latinx community member

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