



SOUTHERN LATINX LGBTQ+ REGIONAL ASSESSMENT 2018-2019

CONTENT

Background	3
Introduction	4
Methods	5
Results	8
Quantitative Results	8
Quantitative Results	14
Conclusion	31
References	32

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Our partners:

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BACKGROUND

The Latino Commission on AIDS

The Latino Commission on AIDS (The Commission), a nonprofit organization founded in 1990, is dedicated to addressing and responding to the impact of HIV/AIDS, STIs, and viral Hepatitis, and corresponding disparities in health, affecting Latinx communities nationwide. The Commission realizes its mission by spearheading health advocacy, promoting HIV education, developing model prevention programs for communities experiencing highest risk, and enhancing the capacity of community-based organizations (CBOs), including communities of faith (COFs).

The Commission proudly serves and is committed to the creation and promotion of safe, supportive and affirming spaces for and led by Latinx LGBTQ communities. In 2015, The Commission opened the Oasis Latino LGBTS Wellness Center in Manhattan and Brooklyn, New York, providing comprehensive services in both Spanish and English that support and foster the health of Latinx community members identifying as Lesbian, Gay, Bisexual, Transgender, Straight, Queer, Gender Nonconforming, and/or Questioning. Nationally, the Commission convenes National Latinx AIDS Awareness Day (NLAAD), National Hispanic Hepatitis Awareness Day (NHHAD), the Zero Homophobia Campaign, and the Zero Transphobia Campaign. The Commission is also the founder of the Hispanic Health Network (HHN), dedicated to eradicating health disparities and promoting health equity.

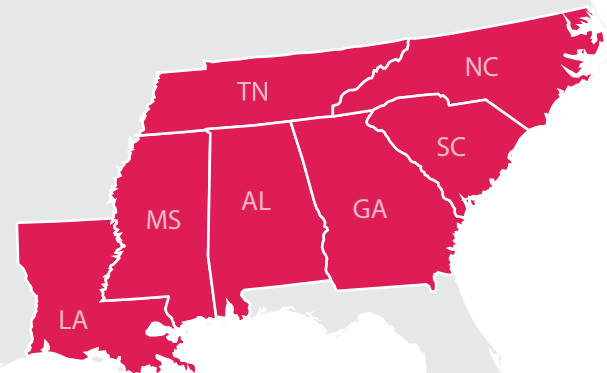
Latinos in the South

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, gender and sexual orientation (Vega et al., 2011).

In response to the emerging needs of Latinx communities in the Southern states, the Latino Commission on AIDS, in consultation with many partners, developed and implemented *Latinos in the Deep South* (now *Latinos in the South*) regional programming in 2006. Our work focus is to develop the capacity of stakeholders; enhance the visibility of issues affecting Hispanic/Latinx, such as barriers to healthcare 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.

INTRODUCTION: SOUTHERN LATINX LGBTQ+ REGIONAL ASSESSMENT 2018-2019

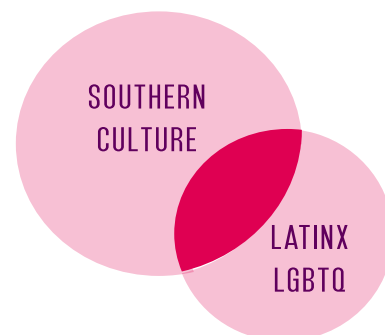


Anecdotal and research evidence shows that persons identifying as LGBTQ, non-binary, and gender non-conforming experience a range of barriers to access health care, and chronic stressors, including stigma and discrimination, impacting health outcomes (Mink et al., 2014). Immigration status, race and ethnicity, country of origin, and other social and structural factors further impact access to quality, comprehensive health care and support services for optimal well-being (Pitkin et al., 2007). Due to these challenges, the Latinx community and advocates are constantly in a reactive mode. Few culturally-responsive and linguistically-appropriate assessments designed to elucidate specific needs and HIV prevention, treatment, and care concerns among Latinx LGBTQ communities in the South exist. With the rapid growth of Latinx communities throughout the Southern United States and increased LGBTQ visibility, conducting Latinx LGBTQ community assessment is crucial to gaining insight into the current state of health and well-being for this population. The purpose of our assessment is to guide the development of responsive regional and local strategies that effectively serve diverse Latinx LGBTQ communities throughout the South.

The Latinos in the South Program initiated a community-wide assessment of individuals identifying as Latinx and LGBTQ in seven states: Alabama, Georgia, Louisiana, North Carolina, South Carolina, Tennessee, and Mississippi, collectively termed the Deep South. The aims of our assessment were twofold: to (1) gain further insight and knowledge to inform action, policy and practice; and (2) highlight the critical diversity of needs of LGBTQ Latinx communities in the Deep South, a population that is highly vulnerable and poorly understood and under resourced by US institutions (health, political, education, justice, etc.). Below we present the results of our assessment and provide recommendations based on our findings for the improvement of social, structural and individual-level factors responding to the health needs of Latinx LGBTQ community members in the Deep South.



THE LATINO POPULATION IN THE SOUTH HAS RISEN QUICKLY AND SUBSTANTIALLY



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

METHODS

Our descriptive mixed-method study employed key informant interviews, focus groups, and anonymous surveys to collect qualitative and quantitative data from community members, providers, stakeholders, and professionals serving the Latinx and/or LGBTQ community throughout the Deep South. Our focus groups were held in three key cities where there are dedicated programs and services for the LGBTQ Latinx community: Durham, North Carolina; Memphis, Tennessee; and Atlanta, Georgia. Transdisciplinary research team members from social science, education, and public health provided multiple perspectives and interpretations of the data. Transdisciplinary and mixed-method approaches have been recommended as a best practice in health care research, especially with underserved groups (Harper et al., 2008). An integrated mixed-methods approach was undertaken from the outset of study development, such that research questions and participant selection were designed to collect qualitative and quantitative data concurrently (i.e., qualitative information did not inform later quantitative measurement nor was one method dominant, and analyses were blended). All data collection instruments were developed by the research team and made available for administration in both Spanish and English. We have drawn our final recommendations from the analyses of the robust information gathered.

Data Management & Analyses

Focus groups were audio-recorded, transcribed, and analyzed using a grounded theory approach. Several interviews were not audio-recorded and were analyzed using the interviewers' notes. We developed a coding manual describing the themes to categorize the data, using the inductive approach of grounded theory to identify trends (Corbin & Strauss, 2015). We coded and analyzed the data using Dedoose qualitative analysis software. In the analyses, we observed saturation in the interview themes; that is, we arrived at a point when interviewees were talking about similar ideas and new ideas were not emerging.

Quantitative data were collected via Survey Monkey-administered surveys; responses were imported, cleaned, and analyzed with SPSS software. For quantitative data, means, standard deviations, frequencies, and percentages were analyzed to describe demographic characteristics, service utilization, knowledge, and barriers to care. We created theoretical categories from the qualitative data to complement the quantitative data on health care access, barriers, and knowledge (level I coding). We then identified themes through the constant comparative method (level II coding). These themes were then categorized into broader categories (level III coding).

Data Collection

Qualitative

We analyzed 4 focus groups and 62 interviews with 67 individuals (five interviews were conducted with two participants each). Focus groups were comprised of Latinx LGBTQ+ community members, and analyzed accordingly.

Quantitative

The quantitative component of our assessment used anonymous surveys distributed online via SurveyMonkey from 01/22/19 to 04/29/19 with the option for participants to complete in either English or Spanish. The survey screened for eligibility; individuals that met all of the following four criteria were recruited and asked if they would provide consent to participate:

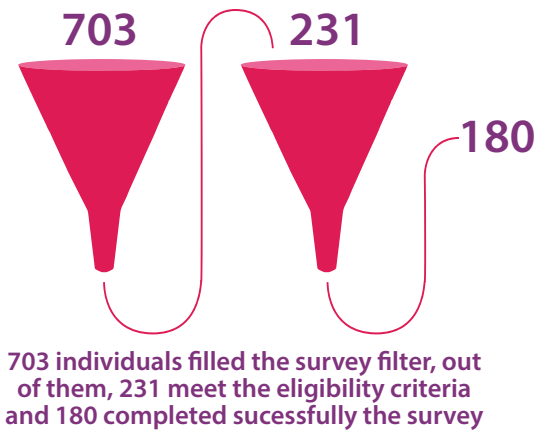


Survey respondents, focus group participants and key community members informants needed to identify as Latino; either gay, lesbian, bisexual, transgender or queer, be at least 18 years of age; and a current resident of one of the 7 Deep South states.



Geographic scope of the research study

Alabama
Georgia
Louisiana
Mississippi
North Carolina
South Carolina
Tennessee



1) identified as Hispanic/Latin@/Latinx; 2) identified as lesbian, gay, bisexual, transgender, or queer; 3) at least 18 years of age, and 4) current resident of one of the seven Deep South states: either North Carolina, South Carolina, Louisiana, Georgia, Alabama, Mississippi, or Tennessee.

The survey was widely disseminated, reaching 703 individuals. Participants meeting the eligibility criteria were then asked if they would consent to participate. A total of 231 individuals met the eligibility criteria and consented to participate in the survey. Of these, 180 with complete data comprised our final analytic sample for the quantitative portion of the study.

Measures

The survey asked participants to provide the following information:

Demographics

Age in years; sex assigned at birth; gender identity; sexual orientation and identity; city, state and zip code of residence; years residing in one of the eligible states (defined as the "Deep South"); and country/territory of birth, number of years living in the US mainland, and current relationship status;

Ethnic/Cultural Indicators

Language preference; Spanish proficiency; country of heritage if born in the USA.

Socioeconomic Indicators

Income, Highest education level completed, employment, housing status and history housing stability, and health insurance.

Health Indicators – Lifetime Prevalence

Participants were given a list of 23 morbidities and asked to indicate if they had ever been diagnosed with any, and instructed to check off as many as applicable: anxiety, depression, vision loss, high cholesterol, gonorrhea, asthma, high blood pressure, HIV, chlamydia, syphilis, insomnia, diabetes, HPV, CVD, hearing loss, substance abuse, cancer, AIDS, arthritis, mobility issues, dementia, and "other". Additionally, participants were asked to self-rate the present states of their physical and mental health, respectively, on a 5-point Likert scale: (Very Poor – Very Good).



THE SURVEYS WERE PROVIDED IN ENGLISH AND SPANISH

HIV and STI Testing – Lifetime Prevalence

Participants were asked to respond to two items measuring lifetime prevalence of HIV screening and STI (other than HIV) screening by choosing from one of the following: “I have never been tested”; “I have been tested for this during my lifetime”; “the last time I received this test was within the last 6 months”; “the last time I received this test was within the last year”; “the last time received this test was over a year ago”; “the last time I received this test was over 2 years ago.”

Lifetime Experiences of Discrimination, Violence & Microaggressions

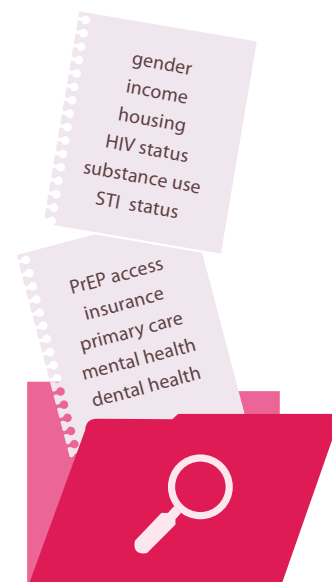
The survey had two items measuring lifetime experience with physical violence/abuse and emotional violence/abuse due to one’s Latinx LGBTQ identity (yes/no). Additionally, a 9-item scale using a 5-point Likert scale (Never – Always) measured frequency of experienced daily microaggressions: “You are treated with less courtesy than other people are”; “You are treated with less respect than other people are”; “You receive poorer service than other people at restaurants or stores”; “People act as if they think you are not smart”; “People act as if they are afraid of you”; “People act as if they think you are dishonest”; “People act as if they’re better than you are”; “You are called names or insulted”; “You are threatened or harassed”.

Access to Health Care

Participants were asked if and where they had received health care, which included private doctors’ offices, health department clinics, community-based organizations, rural health clinics, emergency rooms, urgent care facilities, alternative health care services, botanicas, home remedies, and medications purchased from countries outside of the USA. They were then asked the kinds of services received, including mental, dental, sexual and reproductive health and primary health care and barriers to utilization. Additionally, questions asked about receipt of routine health care and screening in the last year, awareness of and experience with PrEP; and whether they were currently utilizing PrEP (if not living with HIV) or treatment (if living with HIV). All utilization questions were answered yes or no.

Perceptions

Respondents were asked to rate needs of community members, knowledge and ability of their providers to meet their needs, and health discussions during visits, measured on five-point Likert scales (1=Not at all – 5=Very). Six items assessed healthcare received from provider measured using a 5-point Likert scale where 1 indicates perception of poor health care provision and 5 indicates excellent



SURVEY RESPONDENTS PROVIDED DEMOGRAPHIC, SOCIOECONOMIC AND HEALTH INFORMATION



PARTICIPANTS SHARED THE MEDICAL SERVICES THEY ACCESSED; AND BARRIERS FOR ITS UTILIZATION

RESULTS

Quantitative Results

Demographics

Age: Our respondents ranged between 18 and 78 years of age; the mean age of our respondents was 32 years (SD=11.0). Gender: Over half (59%) identified as Men, one quarter (25%) as Women, 13% as Non-Binary, 11% as Gender Queer, 4% as Transgender Women, 4% as Transgender Men, and 3% as Two Spirit. Sex Assigned at Birth: Sixty-six percent were assigned male sex at birth, and 33% as female; 1 individual opted not to respond. Sexual Orientation: Over half (59%) of the respondents identified as Gay, 26% as Bisexual, 23% as Queer, 13% as Pansexual, 11% as Lesbian, 2% as Asexual, and 2% as Straight. The majority (72%) identified with one sexual identify; just over a quarter (27%; n=48) identified with multiple. Place of Birth: Just over half (54%) of the respondents were born in the United States (mainland), and 6% (n=10) born in a US Territory (the majority, n=9, in Puerto Rico); 40% were foreign-born. Among those foreign-born, just over half were from Mexico. See Table 1 below.

Table 1. Country of Birth

Country of Birth	N	Percent
US (Mainland and Terr)	108	60.0
Argentina	3	1.7
Brazil	2	1.1
Chile	3	1.7
Colombia	1	.6
Costa Rica	3	1.7
Cuba	3	1.7
Dominican Republic	1	.6
Guatemala	1	.6
Honduras	1	.6
Mexico	42	23.3
Nicaragua	3	1.7
NR	2	1.1
Panama	2	1.1
Peru	1	.6
Venezuela	4	2.2
Total	180	100.0

Language

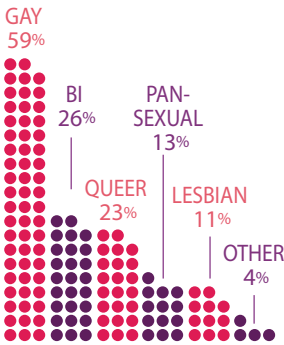
Ninety-one percent (n=163) responded English as their preferred language; 63% (n=114) responded Spanish, 6% (n=10) Portuguese; and 2% (n=4) French. Just over half (56%) of respondents have two or more preferred spoken languages. The majority (78%) of respondents self-rated their Spanish-speaking ability and knowledge of Spanish if spoken by family as either bilingual with equal ability in both English and Spanish or English dominant with conversational Spanish-speaking ability.

Residence

The majority of the participants lived in North Carolina (37%) and Georgia (29%). Twelve percent lived in Tennessee, 8% in South Carolina, 8% in Louisiana, 3% in Alabama and 2%



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



SEXUAL ORIENTATION OF RESPONDENTS, WHOM WERE GIVEN THE OPTION TO CHOOSE MORE THAN ONE IDENTITY

in Mississippi. Education: Eighteen-percent attained less than or equal to a high school or general education equivalency (GED) degree. The majority of the participants attained a level of education past high school or GED: either some college or technical degree (28%), college degree (32%), or higher (20%). Income: Eleven percent had an annual household income less than \$10,000, 31% between \$10,000 and \$34,000, 35% between \$35,000 and \$74,000; and 16% \$75,000 or higher. Six percent opted not to report annual household income. Insurance: Seventeen percent of respondents were uninsured. Forty-two percent of respondents were privately insured through employer, 9% privately insured through self, and 8% through the market place. Five percent were Medicaid insured, 2% Medicare insured, and 2% through ADAP/Ryan White.

Housing

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.

Self-Reported Health Indicators and Lifetime Prevalence

The mean rating of self-reported physical health in our sample was 3.6 (SD=0.9), indicating that respondents felt their physical health was slightly above average. The means rating of self-reported mental health in our sample was 3.3 (SD=1.1), indicating that respondents felt their mental health to be average.

Out of 22 possible morbidities, our sample had an average of 2.2 (SD=1.9) diagnosed health conditions. Twenty-two percent reported no past diagnoses; 19% reported one, 26% reported two, and 33% reported three or more, with 10 diagnosed health conditions as the highest number.

The most frequently reported diagnosed health conditions were related to mental health conditions (43% anxiety; 39% depression), followed by sexual transmitted infections (STIs) (11% HIV; 10% chlamydia; 10% gonorrhea; 9% syphilis). The sample also reported vision loss (20%), cholesterol (15%), asthma (12%), and high blood pressure (12%). Smaller percentages (less than 10%) reported arthritis (2%), cardiovascular disease (3%), diabetes (6%), and hearing loss (3%).

Experiences of discrimination and violence

Reported lifetime experiences of physical violence/abuse due to Latinx LGBTQ identity was relatively low (M=1.7; SD=0.4) as was experiences of emotional violence/abuse (M=1.5; SD=0.5) in our sample. Mean frequency of experienced microaggressions was moderate (M=2.4; SD=0.9).

Top Health Conditions of Concern for Latinx LGBTQ Community

Mental health was the most frequently reported top condition of concern (37%), followed by HIV and other STIs (21%), and suicide (14%).

Access to Health Care & Experiences in Accessing Health Care

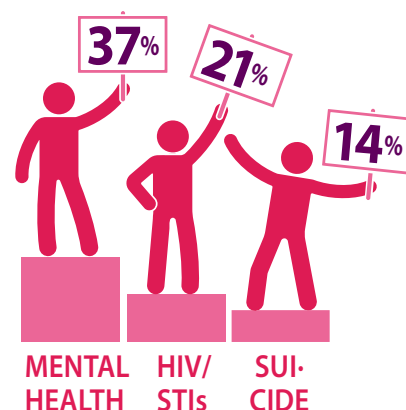
Sixty-one percent reported their regular source of care as a primary care physician (PCP), 11% a rural or community health clinic; 4% a health department clinic; 8% an urgent care center, and 1% the emergency room (ER); 12% reported not having a provider nor receiving health services. The sample perceived the healthcare received from their provider as slightly better than average (M=3.6; SD=0.9).



PERCENTAGE OF RESPONDENTS WHO REPORTED HOMELESSNESS DURING THEIR LIFETIME



RESPONDENTS REPORTED TO HAVE EXPERIENCED MORE MICROAGGRESSIONS THAN PHYSICAL AND EMOTIONAL ABUSE DUE TO THEIR LGBTQ IDENTITY



TOP HEALTH CONDITIONS THAT RESPONDENTS WERE MORE CONCERNED ABOUT

The most frequently reported conversations had with a health provider included topics related to sexual and reproductive health (52% sexual history, 41% STIs, 8% pregnancy); mental health (45%), and modifiable behavioral health (42% diet and exercise, 31% alcohol use, 27% smoking, 22% substance use, 14% nicotine, and 9% eating disorders). Smaller percentages (less than 20%) reported discussing prevention interventions (17% dental care; cancer screening 14%); and violence/injury (17% healthy relationships, 15% safety, 7% intimate partner violence (IPV)). Two percent of the sample had not had any conversations as they did not have a provider.

Among those that had conversations with their provider, about 1/2 had these discussions with within the past 6 months; and an additional estimated 19% within the past year.

Experiences of Received Healthcare as Latinx LGBTQ .

The majority (72%) of the sample had at least one provider that was aware of their sexual and gender identity: 33% reported that all of their providers knew and an additional 39% percent reported that some knew. The remaining 20% reported that all of their providers were unaware and 7% chose not to respond.

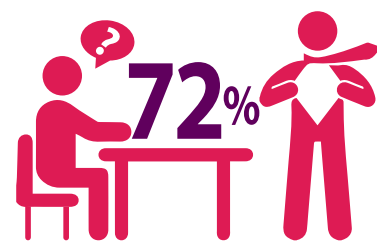
About 27% of the sample had a provider react poorly upon learning of their Latinx sexual and gender identity during their lifetime. The sample rated current providers as being “somewhat” knowledgeable about Latinx LGBTQ health (M=2.9; SD=1.1)

Participant reports of past experiences with healthcare providers (physical, mental) as positive were, on average, neutral (M=3.5; SD=0.9). On average, participant responses indicated that they perceived their community providers’ ability to provide quality medical care to Latinx LGBTQ individuals as poor (M=1.3; SD=1.1) and their comfort level in seeking medical care within their community as average (M=3.5; SD=1.1).

Responses to the items measuring the burden of the accessing services on respondents indicated that, on average, location (being in the South), out-of-pocket cost, and having to educate providers about the healthcare needs related to their intersectional identities were highest. Participant perceptions of healthcare providers as negative were, on average, neutral (M=2.5; SD=1.0). See Tables 2 and 3 below.

Table 2. **Burden**

Item(s)	Response Scale Mean (SD)
Being in the South makes it harder for Latinx LGBTQ individuals to access quality medical care.	3.3 (1.1)
I delay seeking medical care due to high out of pocket costs.	3.2 (1.3)
I have to educate medical providers about my health needs.	2.9 (1.2)
I have to educate my medical providers about my Latinx LGBTQ identity.	2.6 (1.3)
I delay seeking medical care because of my Latinx LGBTQ identity.	1.8 (1.1)
I deal with mistreatment due to my Latinx LGBTQ identity in order to get medical care.	1.8 (1.0)
Burden Scale	2.6 (0.8)



**PERCENTAGE OF RESPONDENTS
WITH AT LEAST ONE MEDICAL
PROVIDER WHO WAS AWARE OF
THEIR LGBTQ IDENTITY**



**LIVING IN THE SOUTH IS
CONSIDERED AS THE BIGGEST
BURDEN ON ACCESSING
HEALTHCARE SERVICES**

Table 3. **Negative Perceptions**

Item(s)	Response Scale Mean (SD)
I fear a negative reaction by my healthcare provide about me being a Latinx LGBTQ person	M=2.4 (SD=1.2)
I think being Latinx LGBTQ changes how a medical professional interacts with me.	M=2.7 (SD=1.2)
I am afraid of experiencing physical violence/abuse due to my Latinx LGBTQ identity.	M=2.3 (SD=1.3)
I am afraid of experiencing emotional abuse/harassment due to my Latinx LGBTQ identity	M=2.6 (SD=1.4)
Resp Negative Score Scale	M=2.5 (SD=1.0)

Substance Use Behaviors

The sample reported that 22% of the time they were having sex (of any kind) while they or their partner were “high” and/or intoxicated from drug and/or alcohol use. (M=21.5; SD=26.5)

Alcohol Use. The majority (72%) reported current alcohol use; 17% did not use alcohol and an additional 5% indicated use in the past but no longer. Six percent of the sample opted not to respond to the item.

Substance Use. Almost half (47%) reported current substance (marijuana, cocaine, heroin, methamphetamine, ecstasy, “poppers,” inhalants, etc.) use; 43% did not use substances to get high and an additional 4% indicated use in the past but no longer. Six percent of the sample opted not to respond to the item.

Recovery. A small (4%) percentage of our sample indicated being in recovery. The highest percentages were in recovery for alcohol (38%), methamphetamine (38%), and eating disorder (38%). One fourth (25%) were in recovery for sexual addiction.

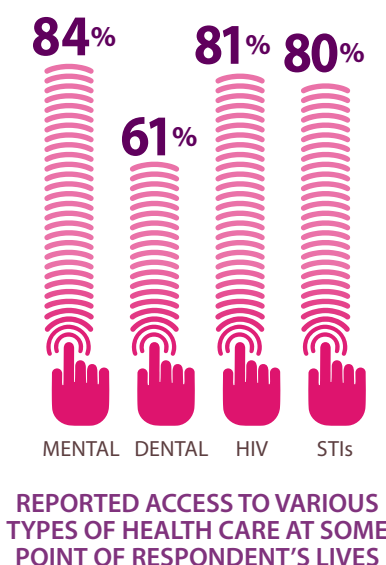
Health Care Seeking Behavior

The majority (70%) of the sample reported use of home remedies when sick; almost half (46%) reported use of prescription medications purchased from a country other than the United States (USA) and 27% products/services from a “botanica”. Twenty-nine percent of the sample reported use of alternative medicine/health care in the past.

Dental Health: The majority (84%) received dental care at some point in their life. The majority (72%) reported that they knew where to go for dental care. Just over half (51%) experienced not being able to receive dental care when desired.

Among the group that had received dental care (n=152), almost half (47%) had received in the last 6 months and an additional 16% in the past year. Twelve percent reported last receiving dental care over one year ago, and almost 1/4th (24%) had last received dental care over two years ago. Fourteen percent indicated that the last time they received dental care was for an emergency.

Barriers to Accessing Dental Care: Among the group (n=92) that reported being unable to get dental care when desired, the most frequently cited barrier was expense/lack of insurance (87%). Less frequently cited barriers were: lack of knowledge of where to go



(21%), not being able to take time off from work (17%), lack of transportation (16%), fear of discrimination due to LGBTQ identity (8%), and fear of discrimination due to Latinx identity (5%). One percent cited lack of Spanish-speaking staff.

Mental Health. Sixty-one percent (61%) received mental health care at some point in their life. Just over half (57%) reported that they knew where to go for mental health care. Forty-four percent experienced not being able to receive mental health care when desired.

Among the group that had received mental health care (n=109), 43% had received in the last 6 months and an additional 13% in the past year. Thirteen percent reported last receiving mental health care over one year ago, and almost 1/3rd (30%) had last received mental health care over two years ago. Fourteen percent indicated that the last time they received mental health care was for an emergency.

Barriers to Accessing Mental Health Care: Among the group (n=80) that reported being unable to get mental health care when desired, the most frequently cited barrier was expense/lack of insurance (80%). Less frequently cited barriers were: lack of knowledge of where to go (49%), fear of discrimination due to LGBTQ identity (48%), fear of discrimination due to Latinx identity (30%), not being able to take time off from work (28%), and lack of transportation (14%). Five percent cited lack of Spanish-speaking staff.

Sexual Health HIV. The majority (81%) reported testing for HIV at least once in their lifetime. Among those with past screening (n=145), 54% last tested within the past 6 months, and an additional 17% in the past year. Nine percent last tested over 1 year ago and an additional 20% over two years ago. Among those reporting past screening, 18% reported receiving a reactive result and 87% non-reactive at their last test.

Among persons diagnosed as living with HIV (n=17), 82% reported that they are currently in consistent care, 12% inconsistently in care, and 6% out of care.

Barriers to HIV Care. The most frequently cited barrier to consistent care among persons living with HIV was cost (12%). Due to the small subsample of participants identifying as living with HIV we are reporting the other barriers to consistent care cited regardless of frequency: transportation, fear of discrimination (due to Latinx identity; due to LGBTQ identity) and lack of insurance.

Sexual Health STIs. The majority (80%) reported testing for STIs at least once in their lifetime. Among those with past screening (n=144), 54% were last tested within the past 6 months, and an additional 18% in the past year. Twelve percent last tested over 1 year ago and an additional 15% over two years ago. Among those reporting past screening, 15% (n=22) reported receiving a positive result for STIs including: Chlamydia (46%), Gonorrhea (46%), Syphilis (41%), HPV (18%), HCV (9%), HSV 1 (9%) and HSV 2 (9%).

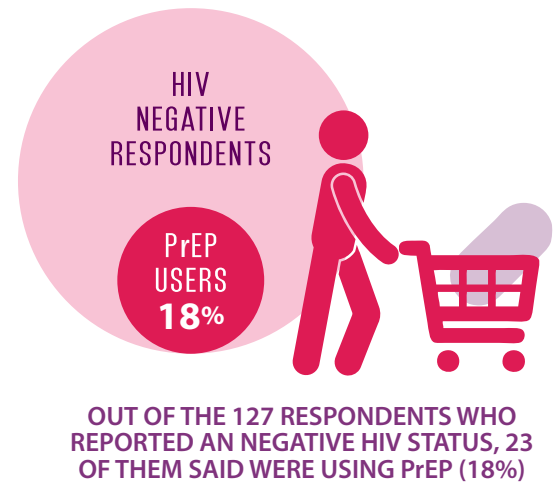
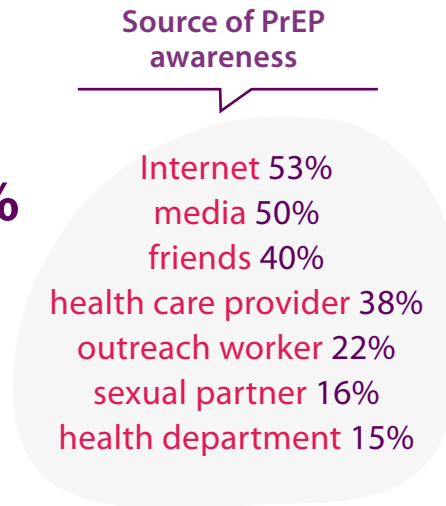
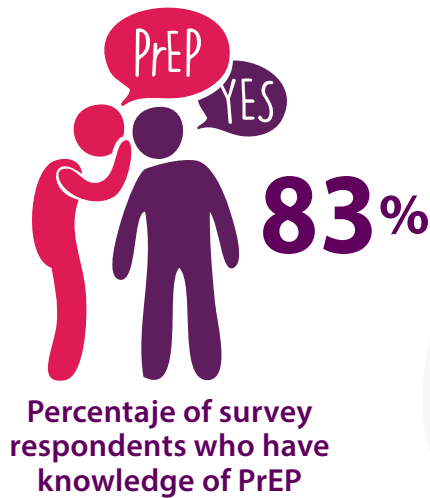
Barriers to STI Screening: Among the group (n=26) that reported never testing, the most frequently cited reason was absence of sexual risk (31%) and an additional 19% indicated utilization of condoms. Other frequently cited barriers were: lack of knowledge of where to go (27%), lack of insurance (19%), fear of discrimination due to LGBTQ identity (19%), cost (15%), and fear of discrimination due to Latinx identity (8%).



PERCENTAJE, AMONG THOSE WHO REPORTED BEING UNABLE TO GET MENTAL HEALTH, WHO INDICATED LACK OF INSURANCE AS THE MAJOR BARRIER



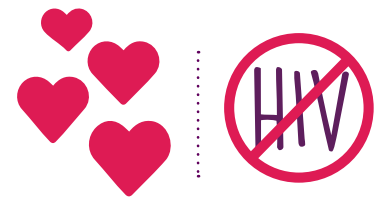
29% OF PARTICIPANTS WITH PAST HIV TESTING HAD NOT TESTED FOR HIV IN OVER 1 YEAR. THE RATE IS 27% FOR STIs



Pre-exposure prophylaxis (PrEP): Awareness & Use

The majority (83%) of the sample had heard of PrEP; among them, over half (53%) indicated the source of PrEP awareness as the internet, (50%) the media, and 40% friends. Thirty-eight percent indicated the source of awareness as a health care professional. Smaller percentages indicated outreach workers (22%), sexual partner (16%), and health department (15%) as sources. Less than 1 percent (0.7%) indicated a substance-use sharing partner.

Among participants not living with HIV and tested (n=127), 18% indicated using PrEP. The majority (83%) indicated the reason for using PrEP as having multiple sex partners and 71% prevention of HIV transmission; 38% indicated the reason as the availability of PrEP at no cost. One fourth (25%) indicated having sex partners of unknown status, 21% had a sexual partner living with HIV, and 21% did not use condoms. Four percent indicated being in a serodiscordant couple.



MULTIPLES SEXUAL PARTNERS AND PREVENTION OF HIV TRANSMISSION WERE THE TWO MAJOR REASON WHY RESPONDENTS USE PrEP

Qualitative Results

Latinx LGBTQ+ Communities

Considering the rapid growth of Latinx communities throughout the seven states, we wanted to learn about emerging Latinx LGBTQ+ communities. We asked interviewees and focus group participants to characterize the contexts in which they live, work, and socialize.

Overwhelmingly, participants spoke about the isolation and invisibility of Latinx LGBTQ+ individuals, which is exacerbated by the anti-immigrant political climate, homophobia, transphobia, and the lack of safe and inclusive spaces to gather. Community members described the difficulties in identifying other Latinx LGBTQ+ individuals. Those who had recently moved to new locations in the seven states noted the difficulty of finding Latinx communities at all. While some socialize with White or Black LGBTQ+ individuals, they would like opportunities to connect with Latinx LGBTQ+ individuals. On their part, some service providers who seek to reach out to Latinx LGBTQ+ communities have a hard time doing so.

“En la ciudad de Memphis y por la mayoría del sur, la comunidad LGBT Latina no tiene su articulación entonces es por eso que no hay mucha visibilidad ... sí estamos aquí, sí la gente existe, pero no hay ese sentido de comunidad de que uno se sienta así como unido sino más bien estamos conectados, porque yo conozco a tal persona, esa persona conoce a tales personas. Y yo pienso que falta que tengamos nuestra propia articulación de nuestra comunidad LGBT Latina.” – *Community member*

“Yo conozco varias personas y me han dicho, ‘estoy en el closet, todavía no salgo por miedo a la homofobia’, ese es el principal punto de que sí hay mucha comunidad LGBTQ, pero están escondidos.” – *Community member*

“In Chapel Hill, there isn’t – or I haven’t really interacted with Latinx community. It’s very rare. I don’t really see a big Latinx community, and they’re not even really an LGBTQ Latinx community, either. In the time that I’ve been there, I know like one or two Latinx LGBTQ individuals that’re in Chapel Hill.” – *Community member*

The multiple layers of marginalization that community members face as LGBTQ+ Latinx individuals further their sense of invisibility.

“I would say the biggest thing that comes to mind is lack of visibility because it’s hard being LGBT in the South, and then when you’re a minority, it’s even harder, but I think what helps a lot of people during that hardship, whether it’s figuring out their identity or just feeling validated is representation when you can see yourself.” – *Service provider*

Community members are isolated due to a variety of factors internal and external to Latinx communities. Within Latinx communities, there is a great deal of homophobia and

transphobia that reinforces some individuals' decisions to keep their sexuality and/or nonconforming gender identity hidden. One community member mentioned feeling safe in their neighborhood precisely because they are the only Latinx person living there, and thus they openly appear with their partner without fear of homophobia. Even more salient to these decisions is the lack of family support and even hostility from family members that many face when they reveal their LGBTQ+ identities. This is particularly dangerous in the case of undocumented individuals; often their family is their only source of housing and economic sustenance. Of course, many individuals have the support of their families, however, we observed about twice as many participants discuss the lack of family support as the number who indicated acceptance.

“One of the hardest thing about... like, being around Latinos is that they are very homophobic, on top they are racist, I feel like they are kind of racist, because I am more brown than them and I definitely felt racism from the Hispanic community.”

– Community member

“In our community the fact that if you lose your family in many cases – and if you're undocumented – that can be a huge blow to – I mean it's a huge blow losing your family in any situation – but when you're undocumented, there's so much more that you have to think about, right? So, where are you gonna rent or where are you gonna live is a big one. How is that gonna affect your work placement if you're working with a family member? Because a lot of what we've seen is when undocumented families tend to work together with either their cousins or their family members in some kind of business. And in our community, being part of the LGBTQ community is not very well seen ... [A DACA recipient] had come out to his parents and the mom seemed to be okay with it, the dad didn't care, but then a couple of weeks later it all blew up because he came out to someone else in the family. So, then – at that point – that's when the mother and father had an issue with him and they kicked him out.”

– Community member and service provider

In addition to the lack of family support, participants reported the marginalization of LGBTQ+ individuals within the Latinx community on the whole. For example, LGBTQ+ issues like the lack of legal protections for gender nonconforming individuals – from bathroom bills to workplace discrimination – are rarely reported by the Spanish language media and rarely noticed in the broader Latinx community. This lack of visibility perpetuates the homophobic and transphobic attitudes that are already widespread in the community.

The isolation of community members is related to the lack of safe, inclusive spaces for Latinx LGBTQ+ individuals to gather. Community members wish for spaces that are welcoming and affirming. They particularly want spaces to gather during the day other than bars or nightclubs.

“The one thing that are lacking are more LGBT friendly spaces, I think. Because not everyone wants to go to a nonprofit to have just a normal outing. I think that's one thing that is lacking for LGBT safe spaces and not just night clubs but other places in general like coffee shops and those things.”

– Community member and service provider

Nonetheless, some community members have found and connected with Latinx LGBTQ+ individuals. They consider themselves fortunate to have built community given how difficult it can be in the region.

“I think that’s probably one of the things that has helped me grow, it’s been having that network of support of close friends who think like me, who look like me. And I feel like everybody’s who’s maybe coming out or needs that kind of support because I cannot imagine going through something and not having that help. I feel really privileged because I do have that help. Now that I’m thinking about it, not everybody has that, especially people in the rural North Carolina areas, for example.” – Community member

Furthermore, some community mobilization efforts are emerging to unite and advocate for the community. Examples include Southern Fried Queer Pride in Atlanta, an event in which many local Latinx LGBTQ+ individuals participate as well as other Pride events that have made efforts to include the Latinx community. Additionally, several participants appreciate the organizing and language justice work of Southerners on New Ground (SONG) in North Carolina.

“I think we’re doing much better than when I started working here. We’re doing much better but still it’s hard for undocumented you know. But we have a lot of Latino professionals and people advocating and helping Latinos in a lot of ways.” – Service provider

“I think it has unfortunately taken for us to lose some of our rights and also some of the community mobilizing that some groups have done [that] has informed some of our people that this is what we need in order to survive.” – Community member and service provider

Individual leaders are also emerging in the community, both within and outside community-based organizations. Community members look to these gatekeepers to organize and connect the community. Still, most individual and larger community building efforts are working primarily in the cities, such as Atlanta, Montgomery, and Memphis. In order to participate, those living in rural areas have to make their way to urban settings.

“I’ve never seen anyone work as hard as E. I used to walk with her, and I stopped, I can’t do it. And other organizations are sitting upstairs in the office, when E’s down on the ground, ten toes down.” – Community member

“I’ve talked to a woman who runs a restaurant ... she’s Venezuelan. And for her, she came here because her husband got a job here and this is her philosophy on living in the South as a Latinx person, as a migrant, as an immigrant, is creating community through food and cultural practices.” – Community member

“There was like the Americanized Latinos and then there’s the ones that are undocumented or just gotten here and I feel like the two groups don’t, they don’t clash very well ... we are not welcome over here, and we are not welcome over here so I don’t really feel like there really is that support. But I think J. has helped all of us come together and there has been the only place where I feel welcome to be with everybody, from my experience in being in Memphis.” – *Community member*

Relationships with Other Communities

Few of the assessment participants had been born and raised in the South; reflecting the Latinx community in the seven states, they are largely transplants from other parts of the U.S., immigrants from Latin America, or both. As such, most offered perspectives of outsiders who have experienced the process of settling into new communities with existing histories of segregation. While some participants pointed out the tremendous diversity within Latinx communities with regard to skin color, ethnicity, primary language, and country of origin, they recognized that within U.S. paradigms, these differences are erased and Latinx communities are treated as homogeneous.

While some participants feel welcome in their surroundings, much more frequently we heard about instances of tension, microaggressions, and feeling unwelcome by non-Latinx communities. At times, the salient distinguishing characteristic between communities is LGBTQ+ identity, at times it is Latinx/immigrant identity, and often it is a combination. Many participants mentioned instances of racism, homophobia, or both. They also referenced the interplay between the national and state political discourses in feeding the sense of hostility.

“Entonces cuando entramos a esos espacios de White queers or Black queers, hay esa división y esa ... hay una tensión, yeah and there is like, it’s just ongoing. Yeah there is too many things that are unsaid, that mirror also what is happening in the city and those racial and ethnics tensions that people – And those cultural mishaps continue, asking where you are from because they can’t identify and those things that you know, that happen outside of being identifying as LGBT.” – *Community member*

“Everyone knows what family you come from and people ask like what church you go to, to try to figure out where you come from. So it kind of threatens the way they think about life when people move in from somewhere else.” – *Service provider*

“There are politicians who say they care, but we also have to look at the fact that 65 to 75 percent of the people here in Alabama voted for homophobic, transphobic, racist politicians, so there is an overwhelming community that doesn’t want us to really even be here, so that’s complicated, and that complicates things. It exists across racial lines, right? I think it’s not a specific race thing.” – *Service provider*

“There are other social spaces of not getting my order, not being seated. Like that happens all the time so who knows what is going through that person’s mind, but more often than not, those instances of discrimination and complete ignorance happens in these White spaces of midtown more so than they happen outside. So, I think that has to do more with perceived racial and ethnic identity than it does my sexual identity, since in professional and social settings I present more feminine whereas in other environments I present more masculine.” – Community member

In a similar vein, some participants recounted instances of workplace discrimination from both coworkers and supervisors; these incidents usually had to do with LGBTQ+ identity, but at times originated in racial/ethnic discrimination as well.

“Que en lo laboral hay discriminación, tienen que ocultar lo que son y si tienen una pareja siempre hay que presentar a esa pareja como si fuera su amiga, o su ‘roomate’ por miedo a que la despidan o lo despidan.” – Community member

“You hire me to do my job with my community. I started working here so that I could reach out to the Latino community ... I had to almost prove that I knew for over a year, that I knew how to do my job before you trusted me to be able to schedule a meeting on my own, with my own people that I’ve known for ten years.”
– Community member and service provider

In more extreme examples, some community members spoke of feeling physically unsafe. Some actively avoid certain areas of their cities, though there are instances of physical violence in areas considered generally safe. Transgender and gender nonconforming individuals recounted the most physical safety concerns.

Many participants have observed that other LGBTQ+ communities – particularly in urban areas – are more established, visible, and organized than emerging Latinx LGBTQ+ communities. Nonetheless, in many areas there is solidarity among LGBTQ+ communities.

“It’s not only that we’re fighting the same fight. I have met queer and trans folks here because we’re both trying to abolish the prison industrial complex, we’re trying to terminate ICE, we’re trying to end all these other punitive and reprehensive security regimes. It’s also that we emerge from shared conditions as well ... I’ve tried to live, work, and play with a lot of other black and brown queer and trans folks, and that’s who I trust.” – Community member and service provider

Immigration

The recent foreign-born Latinx population growth in the South has been accompanied by an increase in immigration legislation and enforcement (Jones, 2019). Most states in the region have banned the creation of sanctuary cities and counties; state and local jurisdictions

tend to collaborate closely with Immigration and Customs Enforcement (ICE) to identify and detain undocumented immigrants (Yee, 2017). This climate has had a significant negative effect on Latinx and Latinx LGBTQ+ communities throughout the region. Fear of immigration enforcement has spread throughout communities, affecting individuals of all documentation statuses. Feeling unsafe as immigrants has pushed many individuals into hiding.

“People just won’t even leave their houses sometimes because they’re afraid that the police, immigration, which they sometimes think is the same thing – sometimes it is – will come after them. As soon as the 2016 elections happened, we saw there was a decline on WIC applications, on Medicaid – we’re not talking about undocumented people. We’re talking about people who actually can benefit from those programs ... Yesterday when immigration showed up in Sanford, the stores closed because no one wants to be outside.” – Community member and service provider

“Tennessee is definitely not for immigrants. Our legislatures and the things that are trying to get passed are very gender-phobic, and with our current political administration that’s in current power, I feel like that also has affected just the culture and the day-to-day life of the Latinos living in Memphis. For example, I can tell you from personal experience that they’ve put search stops in communities where much Latinos stay ... I know my dad being undocumented and working with construction and houses, he definitely got fear of just waking up, going to work, and not being sure whether or not he’s going to come home.” – Service provider

Certain communities are divided along county lines in terms of the level of collaboration between police and ICE. Service providers’ knowledge of these hyper-local distinctions can be a protective factor for the communities with which they work.

“A lot of my folks, I do tell them to stay and live in Richland County. It’s just easier. In Richland County, you get pulled over, and you don’t have a driver’s license, they’ll just give you a ticket. In Lexington County, they’ll take you in, and they’ll keep you for, like, 48 hours so they can check on ICE. And then if there’s an issue, then ICE will take you. And Richland County doesn’t do that.” – Service provider

Increased enforcement has been coupled with perceived and expressed anti-immigrant sentiment from local populations, which has pushed community members further into hiding.

“I believe that the biases sometimes are pretty high, here in South Carolina. In the last year – two years – have been very, very, very evident how they feel – maybe because they feel that – The government has a very, very clear position about immigrants, so now I believe that it’s worse ... Now it’s more evident that people who is not Latino – they feel more comfortable expressing their opinions and acting in the way that they feel.” – Service provider

The intersection of LGBTQ+ identity and undocumented immigration status creates even more apprehension in the face of anti-immigrant legislation, and pushes community members further into hiding.

“I have plenty of friends who are still working on their immigration cases, 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.” — Service provider

“There’s a lot of fear. A lot of the reason why they moved up here was to escape homophobia and transphobia from their countries of origin. Now, they’re terrified they’re gonna go back ... Rights for LGBT people are better here. They’ve gotten used to having these rights and they are so terrified to be deported and go back to a country where they have to hide themselves for a matter of survival. That’s scaring them.” — Community member and service provider

The increasing feeling of unsafety in immigrant communities has resulted in many individuals staying away from healthcare and other services, as we review in the next section.

Access to Healthcare

It is within the above contexts of intra- and inter-community relationships and immigration enforcement that LGBTQ+ Latinx community members access healthcare. In conversations about healthcare, we spoke about issues concerning HIV/AIDS and sexual health as well as healthcare and health disparities more generally. Several barriers commonly stand in the way of access to healthcare: the lack of culturally responsive services, immigration status, lack of access to insurance, and the stigma that continues to affect HIV/AIDS testing and linkage to care in particular.

Cultural Responsiveness. By far the most widespread issue affecting access to healthcare and related services throughout the seven states is the lack of culturally responsive providers who have the cultural knowledge and humility to work effectively with individuals from different racial, ethnic, and socio-economic backgrounds, as well as with individuals representing the diversity of gender identities and sexual orientations. The issue of cultural responsiveness intersects across identities, and stands in the way of quality care for individuals regardless of health insurance, primary language, and country of origin. That is, even U.S.-born, English speaking, insured, regularly employed community members reported negative experiences interacting with providers. The situation is more difficult for recent immigrants who lack insurance and do not understand the U.S. healthcare system.

The unsupportive experiences run the gamut, from providers misusing names and pronouns of transgender individuals, to asking for children or other family members to interpret for non-English speaking patients, commenting in judgment when documenting sexual histories, and making no efforts to offer nontraditional clinic hours to accommodate patients for whom missing work could mean losing employment. In addition, organizations and healthcare facilities often use outdated, non-inclusive language on paperwork and display heteronormative, English-only signage.

“They’re trying to rush through the 15-20 minutes they have ... but just asking common questions – that part is about being culturally sensitive that no matter whether it’s first or second generation, that part we still carry with us, ‘Hi, how are you? How is it going?’ People will answer you and you need to be ready for the long-winded answer and being okay and not rushing them through that part.” – Community member and service provider

“I think, too, if your orientation is something that’s not heteronormative or monogamy driven, that lane like you go to the doctor and they’re like, how many partners have you had this year? And then you say the number, and they’re like ... Do the full panel, this person has been with too many people. And it’s like, I’m safe ... stop trying to shame me.” – Community member

“Te preguntan tu género y te preguntan tu sexo, y a veces tienen trans, y después cuando te dan los papeles para éxito, cuando el resumen y todo, dicen el pronombre de tu sexo, cómo naciste. ¿Por qué me preguntaste? Eso me ha pasado dos veces.” – Community member

Specifically, the lack of culturally responsive mental health providers also came up frequently in discussions of the lack of mental health service usage. There are extremely few Latinx LGBTQ+ identifying mental health providers working anywhere in the South. In the case of mental health services, community members place great importance on trying to find providers who are culturally similar.

“And then for [mental health], of people of color, is really small, and then they are basically Black. And then when we talk about queer, is even smaller, so if they are queer, they are most likely White. So, then we talk about anyone who speaks Spanish there aren’t any, maybe one, and the other might have a translator, and still to my opinion problematic, so when you want someone who is LGBT and Latino who does therapy. Buena suerte, it’s like looking for a unicorn.” – Community member

Part and parcel to cultural responsiveness, language barriers and the lack of Spanish-speaking providers and interpreters are pervasive. Existing Spanish-speaking staff working in clinics and community-based organizations are stretched thin. They often serve as interpreters throughout the facility in addition to maintaining their own caseloads. While many providers recognize the lack of interpreters as a barrier to reaching Latinx communities, some organizations and clinics do not see the need to invest in hiring interpreters because they serve so few Latinx community members. This becomes a self-reinforcing practice: Latinx individuals who do not speak English stay away from facilities where there are no Spanish-speaking staff to receive them. Both service providers and community members wish for Spanish-speaking, culturally responsive staff not just at the front desk, but throughout organizations and healthcare facilities.

“I was at a national conference recently and I forget what the statistic was, but it’s something like eight out of ten newly diagnosed people had had a medical encounter within the 12-month prior to being diagnosed [with HIV] ... people are getting healthcare ... It’s really a lack of trained medical providers to either interpret sexual risk, to do sexual histories and to offer that test when it’s appropriate ... Especially if there’s a language barrier, it’s even harder.” – Service provider

“When you’re the only bilingual anything at an organization, those folks, they kind of leave them to you and you’re left as an island and you kind of take care of all their needs.” [Service provider]

“Having bilingual staff in your front desk doesn’t make me feel welcome ... That’s not all that you can do. The patient is not gonna see the person at the front desk. The front desk will hopefully be great you, but the person in the back needs to be prepared to see the person.” – Community member and service provider

Together, cultural and linguistic barriers result in a lack of trust, and a reluctance to seek care. Several community members spoke to the experience of having to discern which providers are welcoming. Some have found supportive providers. However, this requires a level of comfort with navigating through the aforementioned barriers. Individuals who speak English, have health insurance, understand the U.S. healthcare system, and are in touch with other community members to access word-of-mouth referrals are more equipped to engage in the search for culturally responsive providers.

“Mi doctora es parte de la comunidad LGBTQ so, sí es cómodo el servicio que me provee.” – Community member

“I feel very fortunate to be able to have that – to be able to navigate it more because I speak English, and I was able to research and see who I would feel more comfortable with.” – Community member

Increasingly, healthcare providers are making efforts to reach out to Latinx LGBTQ+ communities. They hold outreach events, partner with Latinx-led community-based organizations, translate written materials, and hire staff to serve this population. Some of the service providers who participated in this assessment themselves work as the bilingual Latinx outreach coordinators, case managers, and support group facilitators.

Some service providers recognized the need for more training and resources in order to reach Latinx LGBTQ+ communities. Specifically, in the HIV/AIDS field, recent data have pointed to persistent disparities in new HIV infections: in 2017 most, new infections in the U.S. were

diagnosed in the South, with Latinx individuals making up 21% of those newly infected in the region (Centers for Disease Control, 2018). HIV/AIDS service providers are keenly aware of the need to reach more Latinx individuals with HIV testing and care.

“We had the first Latinx queer group last year at Pride and I was pretty proud of that. So, we had a few people that were collaborating. And we do also have, do outreach in those places to a lot of migrant workers here in South Carolina in the summer ... They have pretty limited medical services that I’m sure has little on HIV and AIDS.”
— Service provider

“We have looked for additional opportunities to work with the Latino community. One of the things that we struggle with here is finding community-based organizations outside of those that we generally work with, and they are very few.”
— Service provider

“I think some training would actually be really wonderful because I think we’re starting to recognize that we are not doing a steady job with the Latinx population in Tennessee as far as HIV care as good as it could be, so a lot of people don’t know where to get started.” — Service provider

Some providers are also dedicating resources to make their services more accessible by providing transportation, covering healthcare and other costs, adjusting office hours, and providing mobile screenings and services in hard-to-reach rural areas.

“My services in that area are split between providing taxi service to appointments and then kind of the other side is providing gas cards for individuals who essentially end up borrowing someone’s car to try to go to their appointments. Due to some of their undocumented status, food is an issue. As they’re kind of not necessarily consistently working or really getting paid an appropriate wage to support themselves, we’ve had a lot of requests for food. And so, we do provide the food bank that we have here, but also we have been able to get gift cards to the supermarket.” — Service provider

While efforts are under way to reach Latinx LGBTQ+ communities with accessible, culturally and linguistically appropriate services, in many areas of the seven states the lack of such initiatives remains a significant obstacle to care.

Immigration Status

Another major barrier to care, cited again and again by participants, is the issue of immigration. In the current climate of increased immigration enforcement, many undocumented individuals have stopped engaging with health services. The fear of deportation, coupled with lack of insurance, keeps many from seeking out any but the most urgent healthcare.

“Since Donald Trump was elected, that I have seen actually some pullback from that. I can think of a couple of patients that I was taking care of in Raleigh who were Spanish-speaking transwomen, and shortly after the election, they disappeared, and I have not seen them. I feel like we were making a lot of progress. I feel like maybe there has been a couple of steps back, and probably that is from the perception in the population that coming into healthcare is risky now.” – Service provider

“Just the fear of surviving. Any sort of information that could be misused or that fear of opening up yourself to potentially to be targeted. I think that keeps a lot of people from reaching out and accessing or trying to access care ... There is a lot of anti-immigrant legislation. And the legislature, here in Georgia, from the governorship to some local city councils, it can be very challenging to create any type of trust within the Latinx LGBTQ community or even Latinx in general.” – Service provider

Service providers try to assure community members that they have no contact with law enforcement. However, that message is often overshadowed by current events. Recently, the federal administration’s intention to impose the ‘Public Charge’ rule, though currently not implemented due to court injunctions (Wamsley et al.,2019) has nonetheless resulted in immigrants’ avoidance of any safety net programs, even those for which they are legally eligible.

“A lot of our folks don’t have health insurance ... a lot of the people that are in the low income category and could apply for different benefits won’t because they’re afraid that either that might affect their family members in their legal status change journey or it might affect them themselves. So, we’re seeing a lot of folks holding back from applying to these social safety net programs, which then is affecting whether they go to the doctor, clearly, and get physicals or not.” – Community member and service provider

Furthermore, increased immigration enforcement has kept undocumented immigrants who do not have licenses from driving. In the absence of public transportation networks throughout much of the South, this has meant that more community members stay away from services without a means to travel to appointments. As mentioned above, many healthcare providers are aware of this barrier, and some are able to offer transportation to appointments or mobile clinics.

Cost and Insurance.

The high cost of healthcare and lack of insurance are central factors to Latinx LGBTQ+ individuals’ lack of access to care, an issue that cuts across low-income communities in the U.S. For many community members, lack of health insurance is compounded with lack of transportation, undocumented status, housing instability, and lack of sick leave from work to attend appointments. Together with the dearth of culturally responsive providers discussed above, these factors result in severe limitations on access to care. Many community members avoid regular physicals, testing, and screening. When they do seek care, they tend to use low-cost, sliding-scale community clinics and urgent care facilities.

“We’re also very limited in terms of where our Latino community can go, and your options get even more and more narrow when you start to put things like whether or not you have insurance and how much money you have or make. So, then your list of all these different clinics and hospitals start to narrow down.” – *Service provider*

“Para llegar a estos lugares tienes que primero manejar, y luego hacer una cita dos semanas antes y lo hacen tan complicado, y después te cobran dinero para ir al doctor y si no tienes seguro serían como \$200.00 para chequearte la salud.” – *Community member*

“Siento que el estatus legal, no tener trabajo, no tener una identificación también, y el seguro médico igual eso ... se presentan varias barreras para poder tener acceso médico.” – *Community member*

Given the lack of access to healthcare in general, it is even less common for individuals to seek out mental health services. In addition to cultural responsiveness of mental health providers, as described above, the cost of mental health services is prohibitive for most, and less likely to be covered for those who are insured. Along the same lines, a few participants also mentioned the high cost of dental care as an issue for the community.

HIV/AIDS Stigma.

When it comes to HIV/AIDS in particular, and LGBTQ+ sexual health more generally, pervasive stigma stands in the way of access to care. Participants spoke to the stigma prevalent in Latinx communities, fueled by the lack of education about HIV/AIDS. HIV/AIDS stigma is intertwined with many community members’ reluctance to openly discuss sexual behaviors and preferences.

“I think it is an issue of again going back to sort of tradition and being afraid of someone finding out that you’re LGBT and sort of like the moral implications of it all.” – *Service provider*

“When I used to hug clients, and they would start crying, because they’d be like ‘no one has touched me in years. Why are you touching me?’ And it’s just like, the stigma is so intense. They’d use plastic plates and forks for Thanksgiving dinner.” – *Service provider*

The widespread stigma, coupled with generally poor access to care, results in fewer individuals seeking out regular HIV testing. Several providers spoke about extremely late diagnoses.

“One client that I met, he is from Mexico. He was so sick last year. He had TB, he was put in the hospital. He has kids and family and he almost died. He’s doing good now but you know it’s like, people are still getting diagnosed when they are really sick.” – *Service provider*

Rather than relying on family support in the aftermath of a diagnosis, many Latinx people living with HIV/AIDS (PLWHA) are forced to hide their status from family and community members for fear of ostracism.

“I’m always receiving documentation at home from my provider. I’m often receiving medicines that’s like a very visible package. That’s often difficult for me because my family doesn’t know about my status. And so, not being able to afford housing to live on my own, it can be risky.” – Community member

“For newly diagnosed, they are so afraid to tell their families because they are afraid to be discriminated against, and you know families, not getting the support, and, you know, if they are gay ... Some clients are worried about the parents, they don’t want them to be worried. Because parents will think they are going to die and some prefer not to tell to them because they don’t want them to be worried.” – Service provider

Several service providers who have tried to create support groups for Latinx PLWHA have found a lack of interest in these initiatives. Latinx PLWHA are reluctant to meet with others due to the pervasive stigma in the community.

“We have support groups, but we don’t have a Spanish one, and I don’t think we’re ever gonna do one, because when I first got here, I sent out a survey to see if people were interested in support groups, and none of my Spanish-speaking folks were ever interested. They’re more of, I come to the clinic, you guys check me out, I get my meds, and I’m done with you guys for six months, because we see them twice a year. So, they don’t want to talk about being HIV-positive; they don’t want to talk to other people who are HIV-positive.” – Service provider

Many HIV/AIDS service providers obscure their locations so that individuals entering the facilities are not recognized by others as seeking HIV/AIDS care. Clinics have adopted generic names for the same reason.

“We have an HIV testing, prevention place that’s connected to another place that’s case management, that’s connected to another place that’s Ryan White housing. And all of it is hidden. Like, you don’t know it’s there unless you know it’s there. You just like arrived at this black building with a doorbell, you know, and unless you know it’s there you can’t really ac – it’s very weird, you can’t access it because people are so afraid.” – Service provider

In conversations about HIV prevention, some community members stated that they are currently on PrEP, and some others are aware of PrEP as a prevention method. They would like to see wider awareness of PrEP among community members. Fewer indicated awareness

of resources for HIV testing. On their part, some service providers are working to expand access to PrEP in their states; among the challenges they have encountered has been reluctance among physicians to prescribe it due to stigma and lack of knowledge of proper PrEP administration.

PrEP awareness campaigns are one strategy to facilitate uptake but 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 (Page et al., 2017). Bilingual and bicultural PrEP navigators are strategies that could directly improve uptake as they have the opportunity to build trust with community and provide education and outreach that is severely lacking. As the South has largely not accepted Medicaid expansion, which could help alleviate some of these barriers and with sparse Spanish speaking healthcare professionals, PrEP uptake may lag until these structural issues can be adequately addressed. While efforts are underway to reach Latinx LGBTQ+ communities with accessible, culturally and linguistically appropriate services, in many areas of the seven states the lack of such initiatives remains a significant obstacle to care.

Internal & External Community Dynamics

Issues of discrimination, anti-Blackness, and colorism persist both internally and externally in the Latinx community. This often denies the realities of Afro-Latinx individuals within community and the lives of Black migrants. Coalition building between Black led and Black migrant organizations such as the Black LGBTQIA+ Migrant Project which held an Afro-Latinx gathering in Houston in 2019 are necessary and crucial. Cultivating relationships within and across racial lines would help foster solidarity in similar struggle against discrimination and criminalization. This could also promote a process of reflective internal work regarding the existence of anti-blackness and colorism within the community and perpetuated against others and the process of repair.

Workplace Discrimination. Particularly for those living at the intersections of LGBTQ and undocumented identities, workplace discrimination is a concern and source of stress. Individuals have felt they were subjected to discrimination or harm on behalf of their employer but there were not opportunities for recourse and feared losing employment should they speak up. In certain southern states such as North Carolina, employment protections have actively been removed or may never have existed. In these instances, there may still be strategies for remediation and protection. Collaborative efforts with labor focused organizations can implement employment know your rights trainings that can offer strategies for protection and safety. In the face of ICE raids, trainings can also be offered to employers in order to provide support in strategic planning in preparation for a potential ICE raid or presence.

Physical Safety. Physical harm, particularly in the wake of yearly increases in homicides against transgender women of color, are a very real fear and expressed by many. Community safety responses have included self-defense classes, funding to provide protective measures to LGBTQ individuals, and ride share programs such as the Black Trans Travel Fund to offer transportation alternatives to lessen the risk of verbal and physical harassment. Physical safety must be factored into programming as it impacts mental health, ability to access resources, attend programs, obtain and retain employment, and be full members of the community. Not all safety measures can be implemented or situations be prevented. Providing tools and alternatives for protection is a necessary component of strategic planning.

Family Support and Engagement. Lack of family support and engagement was frequently cited as a source of isolation for the LGBTQ community. Investment should be made in broadening events and programming from an individual focus and towards family centered programming for both LGBTQ individuals and their family unit as well as LGBTQ parents and their children. Supportive parents of LGBTQ children can play a role in addressing fears, concerns, and phobias amongst fellow parents but may lack the means to pursue such a role. Partnerships with schools could be opportunities for conversations to take place and offset the burden amongst LGBTQ youth.

Media and Press. Issues affecting the LGBTQ community receive sparse media coverage in Spanish language and Latinx focused outlets. Community organizations and agencies can help bridge this gap by taking initiative to invite Spanish language media to events and sharing statements with the press. Increased media coverage can contribute to addressing homophobic and transphobic sentiments that exist within the community by uplifting positive LGBTQ narratives and visibility and informing the public of larger equity issues. In addition, training community members on public speaking and sharing their story can aid in self-empowerment and advocacy and provide skills which could benefit future employment opportunities. Digital storytelling projects, such as The Gran Varones which provide historical and personal narratives through a “Black Latinx queer lens” have a reach beyond the walls of clinics and organizations and provide insight into the lives of community members that often go untold. This platform and additional digital projects which have sprung from it, are spaces of discussion and education that confront HIV stigma and LGBTQ discrimination head on while expanding on the narratives told by and for the community.

Migrant Communities. Anti-immigrant sentiment and fear related to one’s residency status are pervasive in the community particularly in a region with such violent immigration policies. Healthcare institutions must recognize the toll on the individual and the family unit and the need for mental health services addressing this particular trauma. Providers can play a role in staying informed as to the legal landscape and reassuring patients of the confidentiality of their care and healthcare records. Institutions should make all efforts to find alternatives to requiring identification such as driver’s licenses to access care in favor of community identification cards such as the FaithAction ID. Healthcare institutions and local community organizations should also have a policy plan in place in response to a potential ICE presence. Additionally, in the wake of increasing fear and attacks, individuals are foregoing social services their family still has access to. Education and navigation regarding these programs, requirements, and availability should be pursued so communities are not deprived of necessary resources.

Transgender Community. The transgender community, inclusive of non-binary, and gender-non-conforming individuals, face particular barriers and discrimination in public and healthcare settings. Individuals from these communities are often grouped by default within the broader LGBTQ community which neglects the differences between sexuality and gender and the reality that individuals may hold multiple identities within the LGBTQ spectrum. The transgender community has specific health and institutional considerations as well as general needs that must be addressed separately. It’s vital to create spaces for transgender individuals to share their needs and support their advocacy. Issues such as inclusive and expansive intake forms and registration processes to ungendering language in clinical visits, coupling care such as hormone therapy and PrEP when possible, while also actively soliciting feedback from community members can go a long way in creating an affirming environment.

Housing. As youth and undocumented individuals often rely on their family as a source of housing and considering the reported rates of housing instability and homelessness, the lives of LGBTQ individuals may be put in jeopardy once their identity is revealed. Interviewees shared stories of individuals being forced out of their homes or fearing disclosure due to this potential outcome. In some of the larger, more established LGBTQ friendly cities, programs may exist which may support individuals working through housing instability such as the LGBTQ Center of Durham's Host Home Program and OUTMemphis' upcoming Youth Emergency LGBTQ-specific shelter. As the Latinx LGBTQ community can often be disconnected from these types of resources due to aforementioned language and cultural barriers, relationships must be fostered between the Latinx community and a city's LGBTQ center to ensure the community is able to access and benefit from these services.

Employment. Overall, employment is a powerful and long-term strategy to address community inequities and allow internal transformation of institutions while providing access to healthcare and financial wellness. A common theme shared by the community is the need to be reflected in facilitators of the work. Roles filled by community members have the potential to build, renew, and repair trusting relationships, have a voice in programming, hold employers accountable to community needs, provide a pathway to career development, and expand access to sought after resources. Until and beyond the hiring of Latinx LGBTQ individuals in multiple roles throughout healthcare and LGBTQ spaces, shifting the culture of institutions and agencies will be minimal. We strongly advocate for hiring practices to be more intentional and reflective of the communities being served.

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.

Of note 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 (Rosenberg, 2018). 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.

Action & Advocacy. On behalf of organizations and institutions, HIV education campaigns must be targeted towards society at large and not solely on those who continue to carry the burden of HIV stigma. Undoing the harmful effects of stigma means providing space for those living with it to process and share amongst each other and for allies to hold communities accountable for the ways it is perpetuated.

HIV criminalization laws which are prevalent throughout the South continue to contribute to stigma and cause harm to those living with HIV. While advocacy has resulted in updates to some state laws to reflect scientific progress and access to PrEP and consistent treatment, the widespread existence of the laws and against who and for what reasons it is wielded continues to be a detriment to those seeking testing and treatment and those navigating disclosure and interpersonal relationships. Policy approaches involving those most impacted are necessary to undo the stigma and harm this type of legislation causes.

Language Justice. 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

CONCLUSION

Though our findings and corresponding recommendations are not exhaustive, we hope this report provides a rich snapshot of the personal, familial, communal, and political factors impacting the state of health of LGBTQ+ Latinx communities in the South and establishes a foundation from which to approach our collective work.

The Latinx community of the Deep South has experienced stages of rapid growth, settlement, and an evolution into active, visible communities being recognized for their contributions to society at large in the face of increasingly hostile policies. The LGBTQ community within the Latinx population has faced additional hurdles both internally and externally to the groups they encompass. Despite some of the aforementioned challenges to addressing the health concerns of the Latinx LGBTQ+ community in the Deep South, they have proven to be resilient in establishing their homes and shaping their communities.

Ultimately, to address the needs and challenges faced by the LGBTQ Latinx community requires an investment and introspective work into the relationships that exist between the community and other groups – the Latinx community as a whole, neighboring racial/ethnic communities, relationships and interactions with healthcare institutions, religious homes, educational spaces, law enforcement, and the political arena. By building relationships with fellow LGBTQ Latinx individuals across the South, people have found connection, value, support, and affirmation and it is our hope that these relationships will continue to fuel the work that will allow our communities to flourish.

“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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