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PERSPECTIVE

Addressing the Disproportionate Impacts of the COVID-19 Pandemic on Sexual and Gender Minority Populations in the United States: Actions Toward Equity

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Abstract

Sexual and gender minority (SGM) populations may be affected disproportionately by health emergencies such as the coronavirus disease 2019 (COVID-19) pandemic. Health professionals must take immediate steps to ensure equitable treatment of SGM populations. These steps are to (1) maintain and increase cultural responsiveness training and preparedness for SGM populations, (2) increase use of sexual orientation and gender identity measures in surveillance, (3) conduct research on the impacts of COVID-19 on SGM populations, and (4) include equity-focused initiatives in disaster preparedness plans. These actions toward equity would begin to allow for our current health system to care more appropriately for SGM populations.

Keywords: COVID-19, gender identity, health disparities, intersectionality, minority stress, sexual orientation

Introduction

The coronavirus disease 2019 (COVID-19) pandemic has introduced political, economic, and social instability on a global scale. In the United States, health systems are overwhelmed, with >120,000 deaths as of June 22, 2020.[1] Furthermore, beyond the direct impact of COVID-19 infection on morbidity and mortality, and its burden on the health care system, the pandemic is also causing financial insecurity and worsening mental health for vulnerable groups.[2] As epidemiological data increasingly demonstrate, COVID-19 is having a disproportionate impact on marginalized populations that already experience significant disparities in physical and mental health.[3,4] Nationwide, particularly in dense metropolitan areas, COVID-19 morbidity and mortality data reveal that Black and Hispanic/Latinx populations bear a greater burden of the pandemic than White populations.[5]

Sexual and gender minority (SGM) populations are an underserved and marginalized demographic that could be affected disproportionately by the social, psychological, financial, physiological, and mental health impacts of COVID-19. SGM groups have been affected by viral pandemics historically, with the burden of HIV still higher in many SGM subpopulations, including men who have sex with men (MSM) and transgender women.[6,7] Furthermore, they are affected by a concomitance of factors that place them at increased risk for infection and complications associated with COVID-19. As demonstrated by the minority stress model,[8] complex socio-structural factors, including multilevel manifestations of homophobia, transphobia, and biphobia create inequalities that manifest at every level of health, particularly when compounded by other forms of discrimination such as racism.[9]

Higher rates of HIV and cancer in certain SGM subpopulations make them more likely to be immunocompromised and, therefore, vulnerable to infections compared with cisgender and heterosexual groups.[6,7,10] In addition, some SGM subgroups use tobacco and marijuana more frequently compared with cisgender, heterosexual peers,[11] and various SGM subgroups are more likely to have chronic conditions associated with COVID-19-related risks, including diabetes,[12] asthma,[13] and hypertension.[14] SGM people are less likely to seek health care due to stigma and discrimination,[15] and due to structural factors that make care financially inaccessible.[16] SGM people are affected disproportionately by social inequities, including poverty, lack of insurance, and unemployment[16,17] and thus are more likely to experience

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the financial repercussions of COVID-19 compared with their heterosexual and cisgender counterparts.[18] Certain minority stressors, including a lack of social supports, may be exacerbated due to the pandemic, especially as a result of social distancing, causing an even higher burden of poor mental health in this population. In combination, higher rates of mental and behavioral health concerns and domestic violence affecting SGM people,[13,19,20] the psychological challenges of social isolation, and the traumatic nature of exposure to the COVID-19 pandemic create a potentially devastating constellation of risk for SGM populations.[6,9]

Health care systems are, furthermore, ill-equipped to combat these inequalities. A lack of cultural responsiveness among health care professionals has perpetuated health disparities,[15] combined with limitations within the epidemiological surveillance system, which have resulted in challenges quantifying the impact of COVID-19 on marginalized populations. Comprehensive data on sexual orientation and gender identity (SOGI), for example, are rarely collected in epidemiological surveillance, resulting in an inability to identify SGM individuals in these data and creating a need for rapid action to identify and address the impacts of COVID-19 on SGM populations. In fact, to our knowledge, only one recently published peer-reviewed article has reported the impacts of COVID-19 on an SGM population, finding that COVID-19 was affecting MSM disproportionately, especially in regard to interruptions of HIV services.[21] This study emphasizes the urgency of expanding such research to understand the impacts of COVID-19 on other SGM subpopulations, particularly those that are understudied.

Priorities for Action

Despite available and emerging evidence, the impact of COVID-19 on SGM people populations has received little attention or study to date. This lack of attention is particularly concerning given the limitations of epidemiological systems described in the preceding section. Furthermore, no pandemic preparedness plans, to our knowledge, attend to the needs of marginalized populations, including SGM people. We, therefore, propose four priorities for immediate action to ensure that SGM people receive equitable and appropriate care and attention on both an individual and population level during the COVID-19 pandemic and beyond (Fig. 1).

(1) Hospitals and health systems must ensure that all employees are up to date with cultural responsiveness trainings related to SGM populations and well prepared to serve SGM individuals during the COVID-19 pandemic. Culturally competent, respectful, and welcoming care environments are vital to the care of SGM patients at all times, particularly in the context of a global health crisis. Distributing brief training materials during the COVID-19 pandemic can not only close immediate gaps, but may also support more rigorous ongoing learning beyond the current crisis. We encourage readers to seek out existing training materials from organizations with experience caring for or partnering with SGM populations, such as The Fenway Institute or local community agencies, while supporting SGM-serving organizations.

(2) Federal, state, and local public health agencies must improve the collection of SOGI demographics to ensure that morbidity and mortality data reflect the burden of COVID-19 among SGM populations accurately. The shortcomings of our demographic data systems with regard to sex and SOGI characteristics have always been a limitation to our ability to understand and meet the health needs of SGM communities. Most systems still use a binary sex classification, which fails to account for gender diversity or changes in sex among transgender populations. Although people with somatic intersex conditions/differences of sex development (DSD) are typically accounted for if a DSD has been coded within an electronic health record, this system fails to capture the nuances of intersex identity. Sexual orientation data are rarely collected, and sexual orientation terms are typically limited and noninclusive of emerging identities.

Finally, most systems conflate sex with gender, and fail to include questions on gender identity or to capture gender minority individuals appropriately. Failure to address these limitations previously has resulted in a health system that is completely unprepared to adequately characterize the experiences of SGM communities during the COVID-19 pandemic (or, for that matter, at any other time). We, therefore, recommend that both public health and health care agencies take swift action to include comprehensive sex and SOGI characteristics in their morbidity and mortality reporting. There is an important opportunity for hospitals, health centers, cities, states, and the federal government to lead the way in ensuring that SGM people are represented accurately in health data, allowing us to meet their needs during this pandemic and beyond.

(3) Research must be undertaken to comprehensively assess and address the social, psychological, physiological, and financial impacts of the COVID-19 pandemic on SGM populations. All such research must account for the multilevel discrimination that creates inequities among SGM communities and be interpreted using the framework of intersectionality; prior study has shown that disparities within SGM populations vary in magnitude on the basis of race/ethnicity, sex, gender, and other sociodemographic characteristics[22]—necessitating that these overlapping identities and axes of discrimination and oppression are accounted for appropriately in health equity research.[23] Given the continued systemic inequities causing racial disparities in COVID-19 outcomes, antiracism must be constantly prioritized.[24] We recommend that funding agencies make available emergency resources to support research to identify and address the health needs of SGM populations during this pandemic, including rapid-response funding opportunities that will allow applicants to address the developing nature of the COVID-19 crisis. We also encourage researchers who are able to undertake such work without supplementary funding to do so, in partnership with experts and community leaders who may be better positioned to guide formative research questions and approaches at this time.

(4) State, local, and federal government officials must create disaster preparedness plans that explicitly include equity-focused initiatives to identify and meet the

FIG. 1. Meeting the needs of lesbian, gay, bisexual, transgender, queer, and other sexual and gender minority (LGBTQ+) people during COVID-19 and beyond. COVID-19, coronavirus disease 2019.

needs of marginalized populations. Without this action, current disaster preparedness plans run the risk of exacerbating existing health inequities in a time of crisis. If even a few jurisdictions were to do so, it would create the opportunity to apply implementation science frameworks to support structured national uptake of equity-based disaster responses. Although we recommend that these plans are inclusive of and responsive to SGM populations, we also argue in favor of similar efforts with racial and ethnic minority populations, particularly Black, Latinx, and Native American individuals, as well as working-class and low-income groups, women, sex workers, immigrants, and those who do not speak English, among others. Each jurisdiction should tailor disaster planning to ensure that marginalized populations are supported appropriately by disaster preparedness initiatives.

Conclusion

We call on public health practitioners to position themselves as proponents of SGM and other marginalized populations' health and to amplify the voices of community members, researchers, and activists advocating for health equity. We must recognize the architecture of our social, political, and historical conditions as precedents that create material conditions under which marginalized populations could be affected disproportionately by crises such as the COVID-19 pandemic. We face a critical opportunity, as public health professionals, to take action to ensure that SGM populations are not affected inequitably by any public health crisis.

Authors' Contributions

G.P.II., D.F., and L.B.B. conceptualized the article. All authors contributed equally to the development of

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