Chapter 1
Introduction

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1.1 Why Global LGBTQ Health?

This edited volume seeks to excavate a new field focusing on global LGBTQ health. Why is there a need for this? This question can be answered in several ways. First, there have been a number of edited volumes that have focused mostly on LGBTQ health in the United States, North America, and/or the Global North (Eckstrand & Potter, 2017; Follins & Lassiter, 2016; Makadon et al., 2015; Meyer & Northridge, 2007; Ruth & Santacruz, 2017; Stall et al., 2020). There have also been active LGBTQ health research initiatives in various regions of the world, although a vast majority of this research has been focused on HIV risk among MSM (men who have sex with men) and, more recently, on transgender women (albeit transgender women are often problematically subsumed within the MSM category). Such research has often been siloed within the country or region where the research occurred. These US/Global North-focused edited volumes and the HIV in MSM research conducted in various regions of the world have been highly influential in raising the importance and visibility of LGBTQ health. Given this previous work, it seems that one of the next progressions in advancing LGBTQ health is to examine LGBTQ health from a global perspective, including emphasizing Global South issues, research, and concerns.

Thus, we present this interdisciplinary edited volume as an acknowledgment of prior research that has been conducted on LGBTQ health within various regions of the world and to impact the formation of a new field that focuses on global LGBTQ

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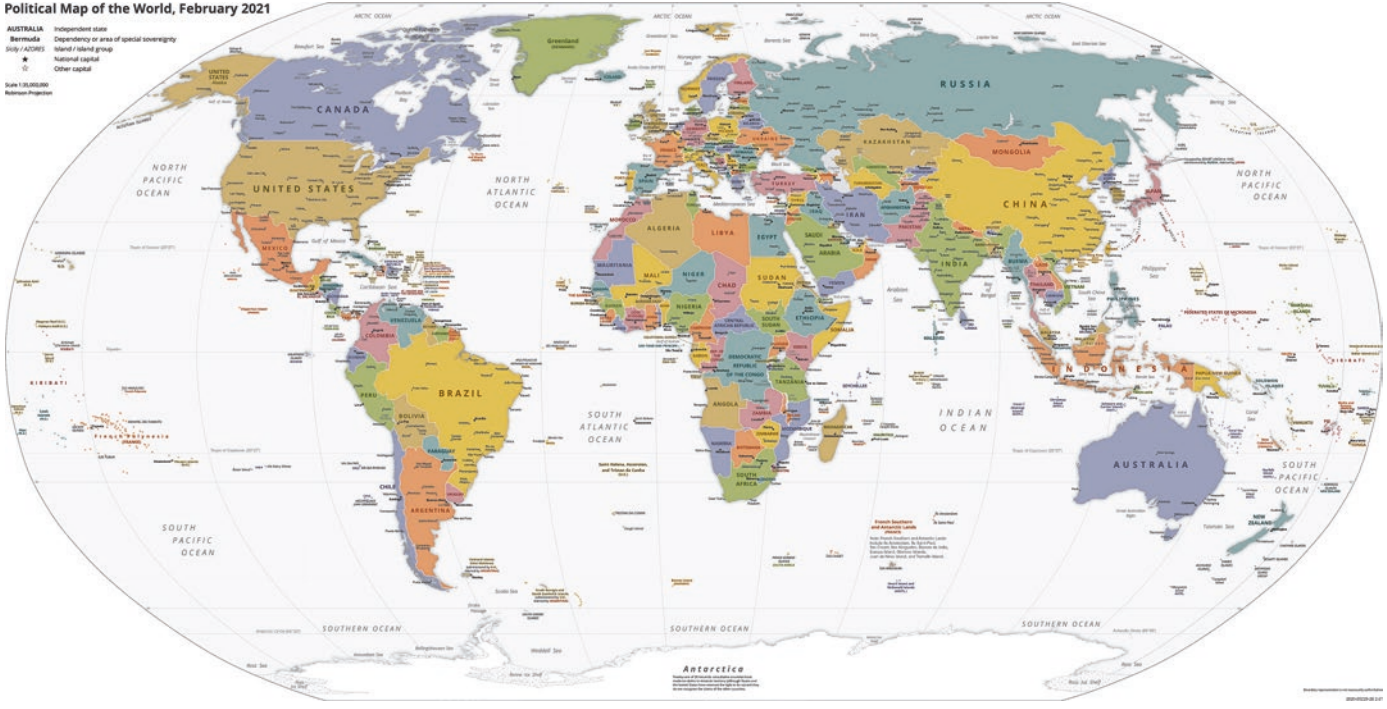

Political map of the world, February 2021. (Central Intelligence Agency, 2021). (Source: Political Map of the World, February 2021. *The World Factbook*, 2021. Washington, DC: Central Intelligence Agency, 2021. https://www.cia.gov/the-world-factbook/)

health. This was accomplished through the integration of research findings that either focused on specific contexts and factors that impacted health or on the health outcomes themselves.

1.2 Genesis of This Book

Sel first got involved in public health research in 2004 focusing on HIV and drug use in behavioral science. In 2005, Sel also started teaching as an adjunct professor at the Center for the Study of Ethnicity and Race at Columbia University and, in 2007, developed and taught a course entitled "Transnational Trans/gender-variant Social Formations," in which the examination of public health was a key component of this course. Sel would go on to teach this course or variations of this course multiple times. Several years later, Sel served as Program Chair-elect and Program Chair of the LGBT Caucus of the American Public Health Association from 2012 to 2016, which provided many opportunities for Sel to program and support the dissemination of emerging research findings on LGBTQ health.

Informed by Sel's research, teaching, and administrative experiences, this book was first conceived by Sel who was awarded a contract for a book series on global LGBTQ health by Springer Nature in early 2018. Around this same time, Sel decided to pursue a master's degree in epidemiology and applied to several programs, including the Sc.M. program in epidemiology at Johns Hopkins University, Bloomberg School of Public Health ("JHU BSPH"). While visiting JHU BSPH during an "Admitted Students Day," Sel came across a flyer for a course being taught by Michelle Kaufman on "Global LGBTQ Health" through the Department of Health, Behavior and Society ("HBS") at JHU BSPH. This seemed to be a fortuitous and exciting coincidence. Although Sel was aware of courses being taught on US-focused LGBTQ health at several institutions, this was the first time Sel had come across a course focused on global LGBTQ health.

As it turns out, Sel did choose to pursue their degree in epidemiology at JHU BSPH, and soon after starting their program in 2018, contacted Michelle Kaufman who was then an Assistant Professor in HBS (and now an Associate Professor in HBS and International Health). In addition to the course she taught, Michelle had research expertise in gender and sexuality as social determinants of health. She had studied these issues, including sexual and gender minority populations, in several global contexts, particularly in the Global South. Together, Sel and Michelle assembled the proposal for this edited volume, which was subsequently accepted by Springer Nature in 2019.

1.3 On COVID-19

After the book proposal was accepted, Sel and Michelle began the task of securing authors for the various chapters of this edited volume. At that time, Sel and Michelle did not anticipate that the most pivotal health-related event of the twenty-first century was about to occur, which was the global COVID-19 pandemic. This pandemic greatly interrupted the progress of this edited volume, often in the form of unanticipated caregiver responsibilities that were suddenly thrust upon them. This pandemic also gave rise to a new field examining LGBTQ populations and the COVID-19 infection, including COVID-19 surveillance (Sell & Krims, 2021), COVID-19 testing (Martino et al., 2021), and COVID-19 vaccine hesitancy (Garg et al., 2021), as well as impacts on health inequalities/disparities (Adamson et al., 2022; Krause, 2021; Phillips, 2021; Sachdeva et al., 2021; Wallach et al., 2020), mental health (Akré et al., 2021; Chen et al., 2022; Gato et al., 2021; Gonzales et al., 2020; Gorczynski & Fasoli, 2020; Lucas et al., 2022; Ormiston & Williams, 2022; Parchem et al., 2021; Salerno et al., 2020; Salerno & Boekeloo, 2022; Sampogna et al., 2022), sexual behavior and HIV (Griffin et al., 2022; Tomar et al., 2021), disordered eating and nutrition ((Hart et al., 2022; Joy, 2021; Tabler et al., 2021), LGBTQ youth (Fish et al., 2020; Gato et al., 2021; Gill & McQuillan, 2022; Gonzales et al., 2020; Ormiston & Williams, 2022; Parchem et al., 2021), LGBTQ older adults (Jen et al., 2020), and other health issues and outcomes (Martino et al., 2022; Rosa et al., 2020; Washburn et al., 2022; Wypler & Hoffelmeyer, 2020).

In addition, special issues of journals and sections of journals have also focused on LGBTQ populations and the COVID-19 pandemic (Bowleg & Landers, 2021; Drabble & Eliason, 2021), although there is also a dire need for more research on LGBTQ populations and COVID-19 (L. Bowleg & Landers, 2021; Chatterjee et al., 2020; Kaufman et al., under review). Because of the timeline of when the chapters for this edited volume were drafted, much of COVID-19-related research, which has been published more recently, was not included. However, in general it is useful to consider how the COVID-19 pandemic may have exacerbated many of the negative health outcomes discussed in this volume.

1.4 History, Culture, and Religion

In examining global health, it is important to contextualize health issues and outcomes within the historical-sociocultural contexts of a given country or region. This type of contextualization can further clarify how given health outcomes may be a result of dynamics between these environments and individuals/populations living within these respective settings. This may be especially important when examining Global South populations, especially for Global North readers and researchers to fully grasp particular health issues and outcomes in the Global South. This may also circumvent the tendency for Global North readers and researchers to unwittingly

impose Global North contexts and understandings on the Global South. In addition, an informed grasp of historical-sociocultural contexts can also provide greater opportunities for the development of interventions that are culturally tailored and culturally sensitive, based on evidence gathered from a "bottom-up" approach, with a greater chance of being more effective than standard unadapted interventions (Henderson et al., 2011; Horne et al., 2018; Jongen et al., 2017; Kalibatseva & Leong, 2014).

For example, in the **Mental Health** chapter (Chap. 3), there is a discussion of culture-bound syndromes among Global South populations. To date, there does not seem to be research specifically examining culture-bound syndromes among Global South LGBTQ populations, and this line of inquiry may be productive in researching and developing mental health interventions that may be particularly salient. In the **Community and Social Support** chapter (Chap. 6), a section is devoted to examining various forms of LGBTQ-inclusive organized religions and spiritual traditions. Health interventions integrating specific religious and spiritual traditions—and disseminated by LGBTQ-inclusive religious and spiritual organizations—may be particularly effective in reaching certain targeted LGBTQ subpopulations (Alvi & Zaidi, 2021; Codjoe et al., 2021; Escher et al., 2019; Fair, 2021).

Historically, health research, with its focus on quantitative methodology, analysis, and presentation of findings, has often failed to provide historical-sociocultural contextualization of health issues and outcomes with much meaningful breadth and depth (Hwahng, 2016). A future direction for LGBTQ health research could be to further contextualize health issues and outcomes within the historical-sociocultural contexts of a given country or region, which is important to comprehensively address health in both Global South as well as Global North countries.

1.5 Racial/Ethnic Stratification and Indigeneity

We also address racial/ethnic minorities and indigenous people who are LGBTQ in this edited volume. For example, it is well known that LGBTQ people of color and indigenous people (sometimes collectively referred to as "BIPOC") who live in a white-dominant society will often experience multiple forms of marginalization, also known as multiple jeopardy, which can result in experiencing more extreme forms of stressors compared to white LGBTQ people (Balsam et al., 2011; Bowleg et al., 2003). The **HIV** chapter (Chap. 7) scrutinizes the overrepresentation of racial/ethnic minorities among those living with HIV in Global North countries such as the United States. This overrepresentation of disease burden can be attributed to multiple and compounded stressors and racial discrimination that exist within a framework of racial stratification (Hwahng & Nuttbrock, 2007). In the **Victimization and Intentional Injury** chapter (Chap. 9), distal and proximal factors are examined in relation to various LGBTQ populations, including indigenous LGBTQ people. This chapter discusses how colonization and historical trauma are key structural factors within processes of victimization and intentional injury.

A future direction of LGBTQ health research could be to further understand the role of race, ethnicity, and indigeneity by not only examining racial/ethnic minorities and indigenous people within Global North but also within Global South countries. For example, Brazil, China, India, Indonesia, Kenya, Malaysia, Mexico, South Africa, and Taiwan all contain a diversity of racial/ethnic groups as well as indigenous groups. It would thus be interesting, for example, to research the health of indigenous LGBTQ people in Taiwan and how these health outcomes would compare, say, to the health of indigenous LGBTQ people in Canada.

In addition, examining the health of white populations in the Global North or racially dominant populations in the Global South may yield surprising discoveries. It is often assumed that the "white privilege" (McIntosh, 1990; Rothenberg, 2008) ascribed to white racially dominant populations in Global North countries automatically confers optimal health and is the standard against which the health of other non-white groups is measured. Thus, white LGBTQ populations may experience sexual and/or gender minority stress (Meyer, 1995, 2003) but will also experience white privilege. Because of this white privilege, it is assumed that white LGBTQ people will experience fewer negative health outcomes compared to non-white LGBTQ people. However, through the "construction of whiteness" (Guess, 2006) that was historically used to reinforce racism, there may be detrimental health effects, such as limited abilities to develop resiliency or adverse mental health effects due to hyper-individualism (Borell, 2021; Casey, 2020; Huang et al., 2010) that may be particularly salient among white LGBTQ people.

1.6 Intersectionality

One approach to examining how various aspects of identity converge and affect one another within structural systems and processes is intersectionality, which originated in US Black feminism, indigenous feminism, third-world feminism, and queer and postcolonial theory (Collins, 1993; Crenshaw, 2013a, b; Hankivsky & Cormier, 2009). Structural systems and processes can privilege one type of identity in a category (e.g., white race) and simultaneously oppress another identity in that same category (e.g., non-white race and/or Black race), while also guiding how these racial identities impact one another. As a research and policy paradigm (Bowleg, 2012; Collins, 1993; Crenshaw, 2013a, b; Hankivsky & Cormier, 2009), intersectionality has been considered to more accurately reflect the complexity of social identity compared to approaches that focus primarily on a single identity category. Historically, intersectionality has been mostly utilized in the qualitative social sciences, although this paradigm has been encroaching into other fields, including public health (Hankivsky, 2012; Hankivsky & Cormier, 2009; Larson et al., 2016; McGibbon & McPherson, 2011; Springer et al., 2012).

A pivotal construct of intersectionality subdivides the concept into three main types: *anti-categorical*, *intra-categorical*, and *inter-categorical intersectionality* (McCall, 2005). From a public health perspective, anti-categorical intersectionality

may occur as nonsensical because it is derived from a humanities-based post-structuralist approach in which the categorization of identities itself is rejected or "problematized," lending to a near-impossibility of measurement on a population level. On the other hand, intra-categorical intersectionality is most likely the approach to "intersectionality" in which public health research and discourse have most engaged. This approach, also known as the "additive" approach, is comprised of starting with a single identity category and then adding identity categories together, without examining the relationships between these categories. Oftentimes these categories are also not examined in relation to greater sociopolitical-cultural systems and processes.

Within feminist discourse, inter-categorical intersectionality is considered ideal. This concept examines how aspects of identity (such as race/ethnicity, gender, class, sexuality, geography, age, dis/ability, citizenship/immigration status, and religion) mutually constitute each other within "interlocking systems" of power (Collins, 1993). For example, an individual's race constitutes their sexuality and vice versa, and their gender constitutes their class status and vice versa, within systems of power, privilege, and oppression. Thus, these mutual constitutions result in differential access to power and resources depending on the respective social contexts. Furthermore, within an inter-categorical intersectionality paradigm, aspects of identity are meaningless by themselves, and it is only at the *intersections* of these identity aspects that actual lived experience can be accurately described and measured.

Historically, research utilizing an inter-categorical intersectionality approach has been best undertaken through qualitative methods. Given that population health, with the attendant emphasis on quantitative methods, is a major cornerstone of public health research, a challenge has emerged as to how to incorporate inter-categorical intersectionality. In recent years, literature has emerged on quantifying inter-categorical intersectionality in which questions and best practices for sampling, measurement, and analysis have been examined (Bauer, 2014; Bowleg & Bauer, 2016). Regarding analytic methodologies, additive-scale interaction, effect measure modification, mediation, moderated mediation, relative risk due to interaction (RERI), the synergy index, and attributable proportion are considered possible approaches and tools that are appropriate for inter-categorical intersectionality (Bauer, 2014). Some researchers advocate that mixed-methods research may provide the most accurate picture of lived experiences when combining rigorous statistical approaches with in-depth narratives (Bowleg & Bauer, 2016; Creswell & Creswell, 2017). Thus, future directions for LGBTQ research could include designing, measuring, and analyzing data from LGBTQ people within an inter-categorical intersectionality framework along with designing and implementing more mixed-methods research.

1.7 Areas of Focus

The **Stigma** chapter (Chap. 2) begins with definitions and key concepts including functions and contexts of stigma and an examination of intersectional stigma. Manifestations and experiences of stigma include structural stigma in the form of

common and/or civil laws, religious teachings and laws, and historical traumatic assaults. Another form of structural stigma is institutional and organizational policies that are outside of civil and religious laws. In examining how stigma manifests on the individual level, there are those who perceive stigma, as well as those who are targets of stigma. Stigma impacts health in a wide variety of ways and can lead to social isolation, limits access to resources, and is associated with a range of biological, psychological, and behavioral responses. This chapter ends with a discussion of interventions to address stigma including structural change, reducing stigma among perceivers, and developing resilience among targets.

Differences in mental health between LGBTQ and cisgender, heterosexual people are first examined in the **Mental Health** chapter (Chap. 3). Types of mental health problems and varying cultural contexts to understand mental health are then examined. A diversity of mental health outcomes exists among the LGBTQ population including differences across age and sex, sexual identity and gender identity, socioeconomic status, race/ethnicity, and migration status. Geographic variations are also discussed among various regions. Determinants of LGBTQ mental health include minority stress, which has been shown to have cross-cultural relevance; structural stigma in societal attitudes, laws, and policies; barriers to societal integration; and conversion therapy. This chapter next examines interventions that reduce LGBTQ stigma as well as interventions that promote coping with stigma. Finally, future directions are discussed, including improving research methodologies, conducting more comparative cross-cultural research, disseminating LGBTQ-affirming mental health interventions, and developing more research on aging-related dementia and cognitive decline.

A general discussion of how contemporary global health issues are increasingly shifting from infectious diseases to noncommunicable diseases (NCDs) is at the beginning of the **Introduction to Noncommunicable Diseases** chapter (Chap. 4). The impact of COVID-19 on NCDs is next examined, followed by discussions of the effect of chronic stress on the immune system and factors contributing to NCDs. Health disparities theories, including fundamental cause theory, compression of morbidity theory, and cumulative disadvantage hypothesis, are then discussed. The chapter ends with a focus on methodological considerations, including sample size and sampling considerations.

The **Noncommunicable Diseases** chapter (Chap. 5) focuses on cardiovascular disease (CVD), cancer, diabetes, asthma, and chronic obstructive pulmonary disease (COPD). These five disease outcomes were selected because of their high global prevalence from an extensive literature review that was completed on NCDs among the LGBTQ population. Globally, countries were categorized as either emerging, developed, or mature. Each section examines the global burden of a specific NCD followed by a discussion of the epidemiological findings among sexual minority, transgender, and non-binary gender populations within each respective NCD.

A wide variety of LGBTQ support structures and mechanisms are examined from a global perspective in the **Community and Social Support** chapter (Chap. 6). The chapter begins with a general discussion of how community and social

support can be an antidote to sexual and gender minority stress. The first main section examines support in families, including parental and sibling support. Support in schools is next discussed, followed by an examination of support in intimate partner relationships, parenting and family-building, and among colleagues in the workplace. Support for and within LGBTQ communities in various regions of the world is next discussed, including elders, same-sex communities, bisexual communities, transgender and non-binary gender communities, intersex communities, asexual/aromantic communities, online communities, religious and spiritual groups, and BDSM/leather and polyamory communities. Finally, a focus on both global and local LGBTQ-related organizations is presented.

The **HIV** chapter (Chap. 7) begins with a discussion of key SGM subpopulations at high HIV risk: gay, bisexual, and other cisgender men who have sex with men and transgender women and transfeminine people who have sex with cisgender men. HIV risk among transgender men, transmasculine people, and sexual minority women is next examined. The chapter has a focus on the ethical challenges in global HIV research, including concerns about the stigma and safety of research participants and mistrust of the medical research community. Methodological issues in global HIV research are also highlighted, including challenges with recruitment and enrollment, sampling, and cultural conceptualizations of gender identity and sexual orientation. Multi-level factors and interventions relevant to HIV are presented, and a focus on chronic disease and HIV is also considered. The chapter ends with a discussion of future directions for global HIV research among LGBTQ people.

The categorization of various types of substances is first outlined in the **Substance Use** chapter (Chap. 8). Epidemiological findings by region are next presented. Each region is further divided focusing on sexual minority men, sexual minority women, and transgender populations. Social-ecological determinants are then examined including the minority stress model; psychosocial factors; social, interpersonal, and cultural factors; and contextual, environmental, and structural factors. Consequences of substance use are highlighted, including HIV, hepatitis C, and other sexually transmitted infections, chronic disease outcomes, incarceration, and social isolation. Finally, intervention and treatment options for alcohol use, smoking, stimulant use disorder, and opioid use disorder are presented as well as a need for integrated services.

The **Victimization and Intentional Injury** chapter (Chap. 9) begins with frameworks for understanding intentional injury and victimization in LGBTQ populations. These frameworks include syndemics, minority stress and multilevel influences, colonization and intergenerational/historical trauma, and human rights. Types of intentional injury and victimization are next delineated, including state-sanctioned victimization, community and organizational victimization, and interpersonal victimization. State-sanctioned victimization includes criminalization and the death penalty, police violence and harassment, forced surgeries on intersex children and gay/bisexual adults, and victimization of asylum seekers. Community and organizational victimization include stigma-motivated assault and homicide, victimization through employment discrimination, and workplace harassment. Interpersonal victimization includes adverse childhood experiences, intimate

partner violence, sexual violence, and elder abuse. Polyvictimization, which is experiencing multiple forms of victimization, is then discussed. Structural, communal, and individual risk factors for victimization are next examined, followed by a focus on health consequences. Various forms of prevention and interventions are then presented, including decolonization, structural/policy interventions, organizational and community interventions, and individual interventions.

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