

# Reimagining Inclusivity in Health Care for Sexual Minorities to End the HIV Epidemic: A Student Perspective

Brady D. Hanshaw

## ABOUT THE AUTHOR

Brady D. Hanshaw is with the Institute for Global Health and Infectious Diseases, University of North Carolina, Chapel Hill.

See also Morabia, p. 1175, Landers et al., p. 1180, and the HIV/AIDS and Our World: 1981–2021 section, pp. 1231–1266.

Over the last 40 years, the HIV epidemic has disproportionately burdened men who have sex with men (MSM), and especially MSM of color, in the United States.<sup>1</sup> This subpopulation alone accounted for 69% of the nation's transmissions in 2018, with one in six MSM expected to acquire HIV in their lifetime without intervention.<sup>1</sup> The high incidence among MSM is multifactorial, incorporating factors beyond individual behavior.<sup>2</sup> Social and structural risk factors (classism, racism, heterosexism) place this marginalized community at increased risk for HIV.<sup>2,3</sup> Systems of oppression operate at the provider level through provider-based heterosexism and cultural incompetence among providers serving queer individuals.<sup>4,5</sup> These provider-based factors contribute to the HIV disparity among MSM at the societal level by reducing access to inclusive health care and reducing progression across the preexposure prophylaxis (PrEP) continuum.<sup>4–6</sup> Effectively reducing HIV incidence among MSM

necessitates access to inclusive and queer-competent health care. We must view diversity and inclusion efforts—and all interventions against heterosexism, classism, and racism in medicine—as a part of the national HIV response and the efforts to end the HIV epidemic.<sup>7</sup> Until we achieve these goals, HIV prevention and treatment efforts will continue to be impeded by provider-based heterosexism and heteronormative standards, perpetuating the stereotype of MSM as victims of the epidemic. However, to foster greater inclusivity in our health care system as an intervention for MSM, we must first ask ourselves how to define an inclusive, queer-competent provider.

Our current beliefs about inclusivity in queer health care often focus on a patient's experience in the clinical setting. The mission to offer inclusive care is centered on how a clinic or provider can present a welcoming atmosphere. Providers may worry about asking for pronouns and using the right language in

order not to offend queer patients. Providers add rainbows to their badges. The concept of an inclusive provider or health care setting has been defined as an interaction that does not further traumatize the patient and as a physical environment that signals acceptance. To be clear, a queer-friendly clinical environment and appropriate language should be a goal. However, such a definition alone neglects recognition of the prior trauma and experiences of oppression of the queer patient. We must understand that, no matter how welcoming a health care setting or provider, queer patients have experienced and are still experiencing societal and structural heterosexism outside the clinic walls. Heteronormative standards traumatize queer patients and directly undermine their ability to achieve optimal health and well-being.<sup>4,5,8,9</sup>

To bring us closer to ending the HIV epidemic among MSM, inclusivity in health care ought to be conceptualized as an approach in which providers recognize the collective traumas and barriers, driven by marginalization, that MSM experience and contextualize treatment accordingly. Inclusivity requires both trauma-informed and oppression-informed care for queer communities.<sup>10</sup> Providers must go beyond the aim of not inadvertently retraumatizing the queer patient by the collective traumas of microaggressions and understand the pervasive nature of oppression, the forms of trauma prevalent among the queer communities, and how standards of care informed by oppression and trauma can promote environments of healing and recovery.<sup>10–12</sup> This recenters the focus of inclusivity on how medicine can combat societal oppression faced by marginalized populations. These efforts will

promote more equitable health outcomes for MSM by furthering access to HIV prevention and care services, improving treatment outcomes, and fostering more effective provider–patient relationships.<sup>12</sup>

An example of how we are able to operationalize a trauma- and oppression-informed standard of care includes how we can remove the queer patient from the assumption of heterosexuality without the burden of disclosure. Knowledge of queer health can be integrated as routine health information, disseminated to all patients regardless of patient-reported or unreported sexuality. These conversations should not be the limit of inclusivity, nor replace practices like taking an inclusive sexual health history, but should rather serve as standard, baseline conversations that guarantee a degree of inclusivity for each patient. In the context of HIV prevention, this could take form as a routine conversation in which PrEP is discussed with each patient, regardless of reported sexual behavior or risk.<sup>13</sup>

Another example includes HIV counseling with each patient that encompasses all types of sexual activity, sexual orientations, and gender identities. Neutral and inclusive counseling recognizes how marginalization outside of the clinic disincentivizes disclosure and therefore removes it as a requirement for access to care.<sup>14</sup> Furthermore, these examples illustrate how, moving forward, providers who embrace and apply these inclusive approaches can serve as an intervention to mitigate the marginalization of queer patients and, in return, work to improve HIV outcomes among queer patients. A provider may not be able to directly modify a patient's systems of oppression, but they can apply informed care to combat them. In the end, employing this more extensive

model of clinical inclusion will better serve the MSM population and help us finally eliminate their long-standing burden in the HIV epidemic. *AJPH*

## CORRESPONDENCE

Correspondence should be sent to Brady D. Hanshaw, 130 Mason Farm Rd, CB# 7030, Chapel Hill, NC 27599 (e-mail: brady191@live.unc.edu). Reprints can be ordered at <http://www.ajph.org> by clicking the "Reprints" link.

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## CONFLICTS OF INTEREST

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