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## Sexual minority status: An overlooked stigma that affects food insecurity

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In 2011, the Institutes of Medicine (IOM) released the first report of its kind on the health of lesbian, gay, bisexual, and transgender populations (1). In this report, the IOM highlighted the dearth of research on the health of these marginalized populations, but noted emerging work on educational and economic disparities based on sexual orientation. Indeed, recent work highlights more clearly the sexual orientation gap in economic opportunities (2). The article by Gibb et al. (3) in this issue of *The American Journal of Clinical Nutrition* exemplifies the kind of research needed to close gaps in understanding sexual orientation-based health and economic disparities.

Food insecurity is a leading health indicator in Healthy People 2030, with national public health and economic efforts aimed at addressing this social determinant of health. Those who report experiencing food insecurity tend to be those who occupy marginalized social and economic positions, such as living close to or below poverty, people of color, single-parent households (4), and, as illustrated by Gibb et al. (3), sexual minority populations. It is important to note that while the metrics used to examine those most impacted by food insecurity are frequently reported independently, these characteristics intersect. For example, single-parent households may also be living below poverty. Given the intersectional nature of social and economic positions (5), it is perhaps not surprising that a higher proportion of sexual minority populations report food insecurity than heterosexual ones (3).

Many of these negative mental and physical health outcomes linked to food insecurity, such as depression, anxiety, obesity, cardiovascular disease, and diabetes, are also disproportionately experienced by sexual minority populations compared to their heterosexual counterparts (6–8). Although there is little research on specific pathways explaining the link between food insecurity and health outcomes among sexual minority populations, food insecurity is likely an important upstream factor that contributes to the health disparities experienced by sexual minority people. The work by Gibb et al. (3) provides an important first step by highlighting the disproportionate burden of food insecurity among sexual minority people; further, the authors rightfully emphasize the need for future work that identifies critical points of intervention to prevent food insecurity among sexual minority people, as well as additional strategies for sexual minority people to access safe and nutritious food.

As Gibb et al. (3) hypothesized, food insecurity among sexual minority populations is likely due to structural stigma and discrimination that negatively affects their access to social support, employment, housing, and earnings. This hypothesis is consistent with several frameworks aimed at understanding how discrimination and stigma negatively affect health, including the Minority Stress Model (9), the Discrimination and Health framework (10), and Fundamental Causes of Disease (11). Collectively, this evidence suggests that addressing the fundamental causes of food insecurity may also help alleviate some of the burden of disease experienced by sexual minority and other marginalized populations. Descriptive epidemiologic studies of population-based data, such as the data analyzed by Gibb et al. (3), have continued to highlight important sexual orientation-based disparities in the social determinants of health, health behaviors, and mental and physical health outcomes. However, work is needed to empirically test the pathways proposed through these frameworks that connect discrimination, social determinants of health, and health outcomes among sexual minority populations, including those linked with food insecurity, such as obesity, cardiovascular disease, and diabetes.

Current efforts to address food insecurity include advocating for expansion of the Supplement Nutrition Assistance Program (SNAP) and other emergency food assistance programs. These critical programs provide much-needed relief to those struggling with food insecurity. However, these programs alone do not address the many challenges that often co-occur with food insecurity, such as economic or housing instability. This was well demonstrated in the first year of the coronavirus disease 2019 pandemic, when the need for emergency food assistance and SNAP benefits rose substantially as the economy shutdown, affecting certain workers disproportionately. As highlighted in recent data released from the USDA (4), food insecurity remained unchanged from 2019 to 2020, despite the economic shutdown; the short-term population-wide financial stability provided through government aid protected millions of people from

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poverty and the health consequences associated with the lack of financial resources, including food insecurity. However, the lack of systematic collection of sexual orientation data also means that there is a lack of evidence on the economic and health-related impacts of the pandemic on sexual minority populations. As noted by Gibb et al. (3), their work highlights the importance of collecting sexual orientation data, particularly for food insecurity; thus, the ongoing exclusion of sexual orientation data from national health and economic surveys means that continuing efforts to monitor and address the needs of sexual minority populations are overlooked.

Addressing food insecurity requires not just public health efforts, but also social and economic efforts, and as highlighted in the study by Gibb et al. (3), sexual minority groups are an important population to include in these efforts. It has been over a decade since the release of the IOM report, and there has been considerable effort toward building a better understanding of sexual minority health during this time. Understanding the impacts of structural health factors, such as food insecurity, on the health of sexual minorities is an important step in creating more sustainable and equitable economic and health policies to reduce the burden of disease risk experienced by this overlooked, marginalized population. Moreover, emerging data from the pandemic has demonstrated the perpetuation of economic and health disparities for sexual minority populations and other marginalized groups (12), thus also highlighting the need for more targeted economic and health support, as well as a more concerted national effort to systematically collect sexual orientation data.

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## References

1. Institute of Medicine. The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: Institute of Medicine; 2011.
2. Badgett MVL. The economic case for LGBT equality: Why fair and equal treatment benefits us all. Boston, MA:Beacon Press; 2020.
3. Gibb JK, Shokoohi M, Salway T, Ross LE. Sexual orientation-based disparities in food security among adults in the United States: Results from the 2003–2016 National Health and Nutrition Examination Survey. *Am J Clin Nutr* 2021;114(6):2006–16.
4. Coleman-Jensen A, Rabbitt MP, Gregory CA, Singh A. Household food security in the United States in 2020, ERR-298. USDA Economic Research Service; 2021.
5. Crenshaw K. Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Rev* 1991;43(6):1241–99.
6. Caceres BA, Brody A, Luscombe RE, Primiano JE, Marusca P, Sitts EM, Chyun D. A systematic review of cardiovascular disease in sexual minorities. *Am J Public Health* 2017;107(4):570.
7. Eliason MJ, Ingraham N, Fogel SC, McElroy JA, Lorvick J, Mauery DR, Haynes S. A systematic review of the literature on weight in sexual minority women. *Womens Health Issues* 2015;25(2):162–75.
8. Plöderl M, Tremblay P. Mental health of sexual minorities. A systematic review. *Int Rev Psychiatry* 2015;27(5):367–85.
9. Lick DJ, Durso LE, Johnson KL. Minority stress and physical health among sexual minorities. *Perspect Psychol Sci* 2013;8(5):521–48.
10. Williams DR. Race, socioeconomic status, and health—The added effects of racism and discrimination. *Ann N Y Acad Sci*. 1999;896:173–88.
11. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. *Am J Public Health* 2013;103(5):813–21.
12. Ruprecht MM, Wang X, Johnson AK, et al. Evidence of social and structural COVID-19 disparities by sexual orientation, gender identity, and race/ethnicity in an urban environment. *J Urban Health* 2021;98(1):27–40.