Barriers to COVID-19 Vaccine Uptake in the LGBTQIA Community

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See also Landers and Bowleg, p. 341.

Objectives. To report findings from qualitative research that describe sources of hesitancy and barriers to vaccine uptake among lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) populations.

Methods. In March 2021, we conducted focus groups with members of the Los Angeles, California LGBTQIA community to identify barriers to becoming vaccinated. Semistructured interviews were conducted with 32 individuals in 5 focus groups. Thematic analysis was conducted to identify themes.

Results. Historical and ongoing medical trauma, including misgendering, and perceived emotional violence emerged as significant barriers to LGBTQIA individuals becoming vaccinated. Fear of violence was found to be a major barrier among transgender individuals, whereas fear of an unwelcoming vaccination site was a barrier for seniors. Finally, surviving was a higher priority than becoming vaccinated.

Conclusions. Participants reported vaccine hesitancy and barriers that are unique to the life experiences of LGBTQIA individuals; these include medical trauma, violence, stigma, and discrimination. Our findings highlight the need to include LGBTQIA leaders and trusted individuals in the development of vaccination education and the delivery of vaccination services. (*Am J Public Health*. 2022;112(3):405–407. https://doi.org/10.2105/AJPH.2021.306599)

AJPH March 2022, Vol 112, No. 3

In the race to vaccinate against COVID-19, 55.8% of people in the United States are fully vaccinated (as of October 3, 2021).[1] However, high levels of vaccine hesitancy and low vaccine uptake persist, especially in underserved, underrepresented populations,[2] including sexual and gender minorities and lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) people.[3] Existing evidence suggests that since the pandemic began, the LGBTQIA community has been disproportionately affected by high infection rates and associated economic and psychosocial burdens.[4,5] LGBTQIA people of color are twice as likely as White non-LGBTQIA people to be diagnosed with COVID-19,[6] and more likely than non-LGBTQIA people to have a preexisting condition (e.g., diabetes, obesity) and to suffer severe COVID-19 outcomes.[7] LGBTQIA people are more likely than non-LGBTQIA individuals to work in highly affected industries (e.g., restaurants), have lower incomes,[8] and experience greater stigma and discrimination in health care settings.[9]

We conducted qualitative research in March 2021 with LGBTQIA service providers to understand sources of vaccine hesitancy and barriers to vaccine uptake in this population. We summarize the findings from this research and their public health implications.

METHODS

We conducted 5 focus groups with 32 individuals, the majority of whom were LGBTQIA; all of the groups included members of the LGBTQIA community or provided services to diverse segments of the LGBTQIA community (e.g., different racial/ethnic groups [especially African American and Latino/Hispanic], young adults, seniors, transgender and nonbinary people). We first worked with our LGBTQIA Community Advisory Board to identify participants for the study, then identified LGBTQIA health and social service agencies in Los Angeles, California and invited staff to participate in the study. None of these agencies offered

vaccination services at the time of the study.

We conducted focus groups virtually (via HIPAA Zoom) using a semistructured interview adapted from the *COVID-19 Specific Vaccine Hesitancy and Acceptability in Multi-Ethnic Communities—Focus Group Guide*.[10] The interview guide included questions about the following topics: What are the greatest concerns or challenges that LGBTQIA individuals face when becoming vaccinated? When and where should vaccines be offered? Who should offer vaccines? What barriers are unique to LGBTQIA individuals? What or who influences LGBTQIA individuals to become or not become vaccinated? What resources are needed or missing? Each focus group included up to 11 participants and lasted approximately 2 hours. Participants were asked to share their own perspectives and experiences, and those of their clients. Participants were compensated $75 for participating. We audio recorded, transcribed, de-identified, and analyzed the groups using a thematic analytic approach. This involved (1) developing inductive codes, (2) independently coding all transcripts, and (3) comparing emerging themes, including some not specified in the interview guide. After successive iterations, we merged codes and generated themes about vaccine hesitancy in LGBTQIA communities. Two team members analyzed and coded each transcript using ATLAS ti (Scientific Software Development; Berlin, Germany; 2020).

RESULTS

Several barriers to becoming vaccinated emerged, including lack of LGBTQIA "safe vaccine spaces" and lack of LGBTQIA representation with vaccination education and rollout efforts. We found that these barriers were particularly great for transgender, seniors, and individuals experiencing homelessness.

Historical and ongoing medical trauma, including misgendering and perceived emotional violence, emerged as a significant barrier to LGBTQIA individuals becoming vaccinated. One participant described how "You can't disconnect vaccine resistance from the communities folks live in. We've been historically discriminated against and/or abused by the medical system." Another participant said, "How can there be trust when [LGBTQIA] people are still living with HIV after 40 years, where's the vaccine for that?" Medical mistrust also depended on health providers' level of competency in respectfully addressing LGBTQIA people in clinical spaces, as shared by a transgender female participant who experienced misgendering: "Everybody at the vaccine site referred to me as 'sir.' Mind you, the medical form I filled out had asked those questions . . . but was anybody actually paying attention to me as a person? No."

A common theme was the need for LGBTQIA leaders to have a "seat at the table" with vaccine planning and educational efforts. One participant noted, "Being seen and acknowledged at vaccine sites starts with ensuring there's LGBTQIA representation at every step along the vaccination process" and "creating the opportunity for LGBTQIA leaders to build trust between the vaccine and the community." Another participant said, "People sticking the needle in the arm, have they [even] been trained . . . by LGBTQ organizations [or] people with lived experiences who are experts on the ground, who are also queer and trans people of color?" Another participant commented, "Let us run our own communities. Stop coming in, telling us what to do and running our communities. Give us the opportunity to do that . . . or you're not going to get anywhere." This "by us for us" approach was supported by another participant: "When you can see someone [who looks like you], it brings out honesty, integrity, and sincerity—it allows you to really connect."

Fear of violence was found to be a major barrier to becoming vaccinated among transgender individuals. One participant stated, "Transwomen are afraid that they are going to be beat . . . [afraid] for their lives . . . of being attacked . . . to come out of their homes to get the vaccine." For aging LGBTQIA adults, lack of welcoming, open-minded, and accepting resources emerged as a barrier in becoming vaccinated: "The programming and resources for trans and queer elders of color may not be the safest or affirming. . . . Queer older adults go [back into the closet] because they fear they're going to get mistreated . . . when they're checking in to get the vaccine." For individuals experiencing homelessness, the priority is surviving, not becoming vaccinated: "When someone is unhoused, it's almost like survival trumps getting vaccinated."

DISCUSSION

With more dangerous and contagious variants of the virus now fueling the pandemic, it is critical that COVID-19 public health vaccination efforts be strategic, targeted, and, ideally, culturally tailored to increase vaccination uptake, especially in underserved, underrepresented populations. This article explores the barriers and opportunities to vaccine uptake among

LGBTQIA communities. Although the interview guide did not directly address barriers related to intersectional identities, a clear finding was that people living at the intersection of multiple marginalized identities (i.e., transgender, seniors, and homeless) experience increased barriers when accessing the vaccine, and that mistrust persists between LGBTQIA communities and COVID-19 vaccine health providers given past and ongoing experiences of medical trauma.

Our findings suggest that educational campaigns need to include LGBTQIA and intersectional representation. Furthermore, vaccine services and resources need to be culturally tailored to create inclusive, welcoming, and safe spaces for members of the LGBTQIA community, paying particular attention to avoiding misgendering and stigma. Including LGBTQIA organizations in the development and delivery of vaccination services is an important step to ensuring that services are culturally tailored and relevant. Finally, it is important to recognize that LGBTQIA individuals' health needs and concerns are not limited to COVID-19. Vaccination services should ideally include other needed services, such as financial assistance, mental health and substance abuse treatment, HIV care and prevention, and primary care services. AJPH

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PUBLICATION INFORMATION

Full Citation: Azucar D, Slay L, Valerio DG, Kipke MD. Barriers to COVID-19 vaccine uptake in the LGBTQIA community. *Am J Public Health*. 2022; 112(3):405–407.

Acceptance Date: October 15, 2021.

DOI: https://doi.org/10.2105/AJPH.2021.306599

CONTRIBUTORS

D. Azucar analyzed and extracted insights from focus group transcripts, synthesized all research insights from the team, and led the authorship of the manuscript; he also served as corresponding author throughout the publication process. L. Slay coordinated the research group and administrative tasks involved with this research, analyzed and extracted insights from transcripts, and contributed to final authorship of the manuscript. D. Garcia Valerio analyzed and extracted insights from focus group transcripts. M. D. Kipke served as the principal investigator of the study, authored the manuscript, and provided valuable insight throughout the conduct of the study, analysis of the data and interpretation of the findings, and the preparation and publication of this manuscript.

ACKNOWLEDGMENTS

This work was supported by the W. M. Keck Foundation, by grants from the National Institute on Drug Abuse (U01 DA036926) and the National Center for Advancing Translational Science (UL1TR001855, UL1TR000130) of the National Institutes of Health (NIH), and by the NIH Community Engagement Alliance (grant 21-312-0217571-66106L).

We thank Rachel Carmen Ceasar, PhD, for her valuable contribution in leading the focus groups and data analysis, the service providers who participated in these focus groups, and our Community Advisory Board members, who are essential in study recruitment.

CONFLICTS OF INTEREST

The authors have no conflicts of interests to declare.

HUMAN PARTICIPANT PROTECTION

This study was approved by the institutional review board of Children's Hospital Los Angeles—Healthy Young Men's 2.0 Cohort Study (ID: CHLA-14-00279).

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