Q-Xposure
'Promoting Healthy Queer and Trans Communities'

A review of the literature

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INTRODUCING Q-XPOSURE

What is '*Q-Xposure*'?

The Peel HIV/AIDS Network (PHAN) and the East Mississauga Community Health Centre (CHC) have created an exciting partnership to promote healthy Queer[1] communities in East Mississauga[2]. *Q-Xposure* is a dynamic and community-oriented partnership that seeks to provide a vehicle for the voices of Queer and Trans communities in East Mississauga to advocate for improved access to health care services and health promoting resources. Health promoting resources can include social services and programs, recreation centres, housing services, and other resources that contribute to health and well-being. The following is a review of existing research that focuses on unpacking

[1] The term Queer as used in this document is used as an umbrella term to capture all folk who identify under the LGBTTTIQQ acronym (Lesbian, Gay, Bisexual, Transgendered, Transsexual, Two Spirited, Intersexed, Questioning and Queer). It is recognized however that not all trans folk would identify s queer if they identify as heterosexual.

[2] For the purposes of Q-Xposure, East Mississauga will refer to the neighborhoods of Dixie/Cooksville, Lakeview, and Hurontario.

the needs and assets of the queer and trans communities from a social determinants of health perspective.

The Peel HIV/AIDS Network has worked in the Region of Peel for over 15 years, supporting those living with and affected by HIV/AIDS and providing health promotion and harm reduction programs to help prevent the spread of HIV. While the queer and trans community makes up only a percentage of the people serviced by PHAN, it is evident that the queer and trans community often faces challenges in accessing health services due to obvious and subtle heterosexist and homo/transphobic structures in health and social services. To begin the momentum of change, PHAN has partnered with the newest and only Community Health Centre in Peel, the East Mississauga CHC to form *Q-Xposure*.

The East Mississauga CHC is a satellite of the Lakeshore Area Multi-Services Project CHC. Since late 2005, the East Mississauga CHC has conducted two years of community engagement processes to fully understand the gaps in service and the priority needs in the neighborhoods it services. Using an anti-racism and anti-oppression approach to community health, the East Mississauga CHC has identified racism and discrimination (which for the queer and trans communities includes homo/ transphobia) as critical barriers in social exclusion that stimulate negative health impacts at the community and individual levels.

Together, PHAN and the East Mississauga CHC aim to promote equity as a tool for improving health in queer and trans communities. Specifically, *Q-Xposure* hopes to see the attached literature review used as a launch for a longer-term community effort to advocate for improved access for queer and trans communities in Mississauga

and other parts of Peel Region. *Q-Xposure* plans to launch the literature review at a Queer Access to Health Community Forum in October 2007 to stimulate greater participation, and discussion of queer and trans communities in health care services and health promoting resources decision-making. *Q-Xposure* has set out to develop a process that will eventually result in a community-driven advisory body to continue to advocate for greater equity in the health care system.

Who are the Queer community?

Q-Xposure uses a widely accepted definition of the queer community that includes gay men, lesbians and bisexuals, and one that could include transgendered, transsexuals, two-spirited, and intersexed, and questioning peoples, providing they do not of course identify as heterosexual. The queer and trans community of focus is in Mississauga, specifically in East Mississauga (which represents approximately 41% of the population of Mississauga).

Q-Xposure recognizes the limitations of a blanket approach to reducing systemic and individualized inequity and discrimination. Instead, *Q-Xposure* is committed to responding to the specific multiple or intersectional barriers that queer and trans communities face in Mississauga. For example, specific challenges within Mississauga are shaped by its social, cultural, political, geographic and economic environments. In Mississauga, 46.8% of the population is composed of immigrants. The neighborhoods of East Mississauga are home to approximately 129,960 immigrants (51.9% of the combined population of Hurontario, Cooksville/Dixie, and Port Credit/Lakeview).[3] Immigrants and newcomers already face particular barriers to accessing health care in addition to

[3] Portraits of Peel: Neighborhood Environmental Scan 1996-2001, September 2004, Social Planning Council of Peel.

homo/transphobia, including, but not limited to:

- Poor access to the healthcare system due to language and cultural barriers
- For newcomers, a 3-month waiting period for OHIP[4] can prevent access to healthcare or can create financial distress when accessing healthcare services
- Discrimination and racism at the point of access for healthcare or social services
- Reluctance to access health care or social service providers due to negative attitudes or discrimination in healthcare system
- Lack of relevant or appropriate information[5]

Queer folk in ethno-cultural and ethno-racial communities are often overlooked in population health services and intervention programs

Compounding poor or limited access to healthcare services and health resources for immigrants and newcomers, queer and/or trans immigrants and newcomers face multiple barriers because of their sexual orientation, gender identity and their cultural acclimatization.

International and national research has demonstrated that Queer immigrant and non-immigrant communities of colour are likely to face multiple barriers to accessing services. For example:

- Knowledge of queer communities in ethno-cultural and ethno-racial communities is very limited. Even more so in trans communities.
- Queer and trans folk in ethno-cultural and ethno-racial communities are often overlooked in population health services and intervention programs
- Queer and trans folk in ethno-racial and ethno-cultural communities struggle against heterosexism, homo/transphobia **and** racism
- Queer and trans folk from communities of colour and immigrant

[4] Ontario Health Insurance Plan
[5] Whose Public Health, 2006

communities can face rejection from their own ethno-cultural or ethno-racial communities, but also from the Queer community
- Queer and/or trans immigrant and queer and trans racialized communities are coping with the 'coming out' / transitioning or passing process in a context of acculturalization and racism.[6]

Racism often compounds the marginalization of queer and trans communities. Research indicates that "Queer people of colour 'live with more unemployment and more violence, and report less comfort with physicians, hospitals, and the range of mental-health services and service-providers."[7] For queer or trans people of colour revealing one's sexual orientation and/or gender identity may lead to loss of support within one's ethnic community not only from homo/transphobia but also from the importance of a unified and integrated ethnic identity.

There may also be greater sensitivities because of queer and/or trans people of colour's historical struggle with homo/transphobia. Moreover, individuals may struggle with internalized oppression that decreases their capacity to access health services. While the social determinants of health concerns are the same for queer ethno-racial and ethno-cultural communities as any other population, there are additional concerns stemming from multiple and overlapping barriers.

Why Queer health?

Queer and trans communities experience the healthcare system and access to health care resources differently than heterosexual and/or cisgendered individuals and communities. Queer and trans communities are often misunderstood, under-

[6] "Certain Circumstances" Issues in Equity and Responsiveness to Health Care in Canada. http://www.hc-sc.gc.ca/hcs-sss/pubs/acces/2001-certain-equit-acces/index_e.html
[7] Whose Public Health 2006

researched, and under-serviced. While a number of queer population specific services exist in Toronto (with a growing number for trans identified individuals) there are virtually none that exist in Peel Region and a serious lack of understanding among mainstream agencies and healthcare centres to adequately respond to needs of this perceived invisible queer and trans communitiy(s). The only current queer specific services in Peel exist at the Peel HIV/AIDS Network, the Positive Space Coalition of Peel (limitedly funded for only queer youth enterprises) and most recently a queer counselor position at Family Services of Peel.

The Rainbow Health Network/Coalition for Lesbian and Gay Rights in Ontario reports that, "intersectional, anti-oppressive analysis calls for research and policy that addresses the intersections of race, ethnicity, gender, class, sexuality, age, rural-urban residence, (dis)ability, and other markers of social difference."[8]

It is difficult to compare the treatment of dominant or 'mainstream' groups without recognizing the privilege experienced and the role of power in maintaining inequity for 'minority' or 'diverse' groups' health experiences. National and international research demonstrates that the health effects of discrimination based on sexual orientation and gender identity can include:

- Increased levels of depression and suicide
- Increased rates of alcohol and drug use
- Greater risks for sexually transmitted infections
- Negative impacts on forming and sustaining supportive relationships
- Lack of access to supportive social networks for parenting, faith communities, etc.
- Reduced access to quality health care
- Under-utilization of health services[9]

[8] Whose Public Health, 2006

…there are patterns of health and illness specific to Queer people independent of their experiences of marginalization and discrimination.

Sexual orientation and gender identity act as independent indicators for a variety of queer and trans health issues. That is, there are patterns of health and illness specific to queer and trans people independent of their experiences of marginalization and discrimination. These include health issues more common among gay men (e.g. certain cancers, alcohol and tobacco use, sexually transmitted infections), more common among lesbians (e.g. cervical and ovarian cancers, alcohol and tobacco use, reproductive health issues) and specific to transgender, transsexual and intersexed people (e.g. certain cancers related to hormone replacement therapies, complications from steroid use, and complications from surgical interventions. (Dean et al. 2000; INCLUSION Project 2003; Ministerial Advisory Committee on Gay and Lesbian Health 2003, in Whose Public Health, 2006)). *Q-Xposure* further appreciates that ageism and racism can marginalize queer and trans youth, elderly and lesbians more than others. The proposed QX advisory body will include meaningful representation and participation from these communities.

Likewise, geography can pose a barrier for queer and trans communities in areas like Mississauga where transportation can be a challenge for most people without vehicles. Areas like Toronto tend to have a much larger, more visible and more accessible queer and trans populations.

The above discussion is not exhaustive of the health concerns for queer and trans communities, but it outlines key issues within the context of the social determinants of

[9] Ibid

health for all communities. Q-Xposure thus aims to help educate and bring some awareness to service providers when dealing with folks from the queer and trans community(s).

Recommendations

The following broad recommendations have potential to be adapted to best meet the needs of local Queer communities.

The Rainbow Health Coalition[10] has recommended five strategies for enhancing public health structures exclusively for Queer communities
(it is unknown whether they implicitly include trans issues):

1. Existing evidence on the concerns of Queer populations must be fully recognized and integrated by the bodies that undertake the next steps of indicator development and strategic planning
2. Data collection in standardized national instruments, e.g. national population health survey, must include sexual orientation and gender identity. The reporting must then disaggregate data by these categories, also including intersectional data: race, socio-economic status, age, disability and geographic region
3. Existing federal policies on gender based diversity analysis must be fully implemented and rigorously applied
4. The federal government should provide leadership by establishing a Queer Health Directorate – responsible for the development and implementation of an Queer Health Strategy
5. Funding for Queer specific research must be coordinated and increased.

The following are anti-oppressive and anti-racist

[10] Whose Public Health, 2006

recommendations for creating a Queer Health Access Framework to be adapted through several levels of change summarized from LGBT Health Matters, 2006 (p121-131). It is argued that the following can be applied to trans communities.

A. Organizational and systemic change

From a management/policy perspective:

I. Policy amendments
II. Education
III. Behavior and attitudinal change

I. Policy Amendments

These must include:

Reasoning:

- Commitment to queer [and trans] inclusion in organizational policy
- References to relevant Human Rights Legislation and the Charter of Rights and Freedoms, and other hate crime legislation
- Queer [and trans] folk must be recognized as a separate population group. For example, a policy statement could include 'providing services to diverse communities, *including Queer*…[and trans]'

Stakeholders and Active Participation:

- The queer [and trans] population has to be identified
- Intent to liaise with queer [and trans] positive service agencies, committees, etc.

Commitments:

- Statements should reflect all stages of service, entry to work place to

departure of work place

- Statements should include ongoing engagement and education around queer [and trans] communities
- Statements should be evident in other organizations documents, e.g. budget, corporate plan, etc.
- Human resources policies must make reference to queer [and trans] populations and employment law protection in regards to discrimination

II. Education

- Education should be mandatory
- Should include ALL staff
- Should equip staff with human rights information, appropriate language, and confidentiality issues in relation to queer [and trans] folk
- Include the opportunity for service recipients who are at the organization frequently to be educated also
- Responsibility for explaining the difference between sexual orientation and gender identify should not be on a queer [or trans] employee, rather it is the duty of the practitioner, educator and/or employer

III. Behavior and attitudinal change

- Discarding oppressive language
- Prohibiting negative terms referring to queer [or trans] folk
- Inclusion of reclaimed language

- Zero tolerance towards homophobic behavior
- Advocacy, including becoming strong allies and advocates for greater inclusion of queer [and trans] people

B. **Individual Change**

- Verbal cues, such as making reference or including queer [and trans] issues and awareness in everyday conversation
- Acknowledging sexual orientation and gender identity
- Language and conversation[11]
- Personal signs/symbols[12]
- Queer [and trans] literature and magazines into agency; at least in the staff areas, e.g. pink pages
- Actively seeking education and information
- Working with existing resources and the community

Suggested actions for individuals in a service setting:

- Start asking questions why there are no policies or commitments to serving or recognizing queer [or trans] communities
- Strike a group of like-minded individuals to work on the change together

[11] Ensure documents are sensitive (i.e. 'spouse' versus 'husband or wife', and transgendered in addition to 'male or female'. Staff sensitivity and training that advocates for queer inclusion and questions obstructions.

[12] Other examples of a welcoming physical environment could include: posting the rainbow flag, pink triangle, ensuring access to unisex bathrooms, displaying racially and sexually diverse posters (same sex, transgendered or Queer supportive agencies like PHAN, multilingual brochures about Queer health, visible poster stressing nondiscrimination, observance of Queer days of significance (i.e. PRIDE, world AIDS Day, Trans PRIDE, National Day against Homo/transphobia), display Queer media (i.e. FAB magazine, Outlooks, About, etc.).

- Identify homophobic and heterosexist policies and practices and strategize plausible solutions for overcoming them
- Push for environmental change to reflect diversity, including queer [and trans] diversity
- Support and participate in political action to support queer [and trans] rights, e.g. wear a rainbow sticker on your name tag, sign appropriately supportive petitions
- Use the size and capacity of your organization to eventually facilitate community change
- Ally with other advocacy groups, e.g. Peel HIV/AIDS Network

C. Community Capacity Building

- Most of the human rights queer [and to date, trans] people have achieved have been done so through advocacy
- Organizations can utilize the capacity of queer [and trans] organizations to build greater inclusion and to assist with the break down on trans/homophobic and heterosexist work places and service provision
- Even if your organization is not ready to engage with queer [and trans] communities, the following ideas could form the premise for individual advocacy to initiate the wheels

of change at your organization

Suggested actions for community capacity building:

- Identify existing queer [and trans] positive agencies and community leaders, for example review the annual Pink Pages business category
- Queer [and trans] specific media: review the publications to discover what's going on in the queer [and trans] community and what its needs are from you
- Research and do the 'ground work' before attempting to engage, e.g. represent yourself/organization at PRIDE
- Articulate the purpose and state why your sector wishes to engage in work with queer [and trans] people
- Be mindful that expressing interest to 'engage' with the queer [and trans] community is only a starting point for beginning a longer-term discussion with the diversity of communities underneath the Queer [and Trans] umbrella, and may require multiple engagements to reach sub-groups

LITERATURE REVIEW

Preface

The term Queer as used in this document is used as an umbrella term to capture all folk who identify under the LGBTTTIQQ acronym (Lesbian, Gay, Bisexual, Transgendered, Transsexual, Two Spirited, Intersexed, Questioning and Queer). The term is part of reclaimed language now used in the affirmative throughout the community and academia. The writers recognize that the term queer may not include or be appropriate for individuals who identify as trans since they sexuality may be heterosexual. However, what has been found from the literature is that the term queer is more often than not been taken to include trans individuals regardless of their sexuality so whilst QX recognizes the distinction the literature cited below may not.

There can be no element of doubt that any marginalized population will have distinct and unique health concerns from those that are perceived to be the 'norm' by the general and majority driven public at large. Having begun to identify and discuss some of the social determinants of health previously we can now take a closer look at these determinants and look further into adapting our understanding to queer and trans health needs. While queer and trans communities have the same needs for key determinants of health, their situation is often compounded by heterosexist and

trans/homophobic systems that do not respond to their specific needs. The social determinants of health can be responsible for both enhancing and worsening these general health issues and diminishing their perceived importance by the queer and/or trans community when other rights and social issues take precedence for the individual in the community.

Lesbians need pap smears; gay men need support for eating disorders; queer youth need counseling services; and trans folk need to be visible before access to service can be considered. (For a review of health concerns for the individual components of the Queer community please see the summary of the Sherbourne Health chart in our glossary).

The examples provided are intended to provide some insightful and mindful examples of queer and trans health concerns in general and highlight how social factors enhance the risks to queer and trans health due to oppressive and poor competency through the following short discussion.

In our first example, research findings indicate that lesbians have historically delayed and avoided visits to gynecologists due to negative past experiences and their intervals between pap tests were often greater (LGBT Health Matters, 2006, p103) than that of heterosexual women. Heterosexist questions of preconceived notions, for example 'how many men have you been with?' often deters lesbians from either going to the test, or *coming out* when questioned by the physician, and subsequently do seldom good for their physical health that includes sexual experiences with other women. The mental ramifications on an individuals health are tremendous in not only deterring the person from accessing the health care component but also drawing out potential issues around depression, suicide, loneliness and other mental health illnesses brought

about due to the assumptions of heterosexuality.

The issues outlined here for the lesbians are synonymous with the issues at large for gay men, queer youth and trans folk. The inherent distrust for the health care system and social service sector in Peel and indeed globally, by the queer and trans community, has and continues to further marginalize this community as people who 'always' have problems and issues (especially with STDs and HIV). The presence of heterosexism and trans/homophobia is rarely considered in assessing the poor access to both preventative and acute health care and wellness resources for queer and trans communities. The oppression may be obvious, in the form of point of access discrimination, or it may be subtle through infrastructure and policy that assumes heterosexuality as the user norm (systemic).

The second example is to highlight the need to have support for gay men and eating disorders. There is a perception that eating disorder treatment and prevention services should target women solely. Social pressure from within the queer community can encourage gay men to conform to a physical idealistic model man. The marginalization of the queer community has inherently imposed pressures on gay men that include significant issues of body image and 'fitting in' and be the best within their social circle existence. International research at Harvard University (2001) found that 14% (of 122 gay men) appeared to suffer from Bulimia, whilst another 20% showed signs of anorexia (combined total of 34% showed eating disorder signs). Can this be blamed on restricted access to care and heterosexist assumptions in eating disorder program design and delivery? Likely not, however, there can be a consideration to the impacts of social exclusion on a queer individual, and the potential to be prone to

low-self esteem that can lead to a depressed mental state causing a need to reaffirm their adequate identity and beauty.

The effects on youth, with the assumption that queer youth's priority need is counseling, are complex. On the one hand we need to advocate and recognize the lack of services available to queer youth in Peel, and the added burden and pressure on the individual in personally recognizing a need to seek the support and counseling and the ramifications from seeking such support amongst his/her peers and family. On the other hand with advocating for such support services, there is a lack of consultation with queer youth to determine whether counseling is the answer to improving social inclusion. While it may be part of the solution, the inclusion in the process of finding solutions is as critical as the actual recommended outcome. Likewise, it is imperative that queer youth are allowed to identify with their issues, relating to sexuality or gender identity, or not. It is vital to advocate for support for queer youth in conjunction with highlighting the "ordinariness" of being queer.

Trans individuals are a difficult population to include into our discussion here due to the fact that little to no research, support and/or social service component has been initiated in Canada to reference. Recently, the Toronto 519 Community Centre, Ontario Ministry of Health and Long Term Care, AIDS Bureau, the Griffin centre and the Rainbow Health Network have begun working to provide insight on serving Trans individuals. There are of course academic and community based research reports that speculate, with reliable community data, to provide us with a purposeful lens to look through to the discrimination and marginalization against Trans people. This includes, but is not limited to, exploitation of Trans stereotypes, mental

health concerns, and sexual health issues.

What are Social Determinants of Health?

The social determinants of health refer to a wide range of factors that affect the health of individuals and populations and can include – but are not limited to – the health care system, biological and genetic endowment, physical environments, social and cultural factors, and individual behaviors or lifestyles[13] (Jackson B, PhD, 2006, p 7). Current research has shown that only 10-15% of increased longevity results from improved care (Raphael 2003). This supports the efforts to bring the social determinants of health to the forefront and shift attention from only medical treatment towards complex environmental and cultural settings. This approach is known as the *population health approach*.

Canada can be seen to be a forerunner in public health, certainly as a leader in health promotion following the Lalonde Report in 1974 (which introduced the term *health promotion* and asserted that health does not exclusively result from access to health services but from an interplay of determinants from…human biology, lifestyles, the environment, and health care (Lalonde, 1974, p74)). The Ottawa Charter for Health Promotion[14] in 1986 then endorsed by the World Health Organization provided this definition of health promotion as 'the process of enabling people to increase control over, and to improve, their health.'

A population health approach considers the influence of system level variables on the health of populations (Raphael and Bryant 2002, p190). It specifically aims to[15]

(i) Recognize the capacity of social, cultural, economic

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[14] For the full charter, please visit: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

[15] Whose Public Health, 2006

and physical environments to affect the health of individuals

(ii) Acknowledge the complexity of relationships among these health-affecting variables, and

(iii) To shift health care from the centre stage and focus attention on how to relieve illness, *but why people get sick in the first place*

Population health has thus looked to infrastructure related components of health promotion (which both the Lalonde Report and Ottawa Charter had done also). Unfortunately, measurement and data collection practices have never really fulfilled this structuralist approach and continue to focus on an individual lifestyle approach which '…has continued to dominate Canadian health promotion.' (Raphael 2000). This individual approach stems from the production of knowledge catered in epidemiological traditions that see

(a) Risk factors are frequently understood as individual attributes and behaviors

(b) Risk factors are viewed as simply addictive; and

(c) Accountability for the cause of disease rarely extends beyond affected/diseased individuals[16]

It is argued that community health promotion strategies, such as HIV/AIDS programs, have continued to focus on individual responsibility for health behaviors. In short, there is a deficit in Population Health data collection and analysis in Canada of social and environmental forces that contribute greatly to conditions of health. This literature review offers an overview and analysis towards the implementation of a social determinants of health approach to improving health in queer communities and public

[16] Whose Public Health, 2006

health overall (Whose Public Health, 2006).

In order to delve deeper into this framework it is necessary to outline the social determinants of health that influence the health of queer [and trans] individuals and communities as recognized by Health Canada. The social determinants of health allow for recognition of the importance of how an individual copes with his/her environment due to social and environmental factors. These determinants of health include[17],

- Income and social status inequality
- Social support networks
- Culture
- Gender
- Disability
- Education and literacy
- Employment, job security & working conditions
- Social environments: **inclusion and exclusion**
- Physical environments
- Personal health practices, coping skills and stress
- Healthy child development
- Biology and genetic endowment
- Contribution of the social economy

Anti-oppression theories are historically rooted in social justice movements such as anti-racist, feminist, queer, (dis)ability, Aboriginal and other social identity movements which focus on the elimination of oppression (Jackson B, PhD, 2006, p 10). These analyses are shaped by 'the acknowledgement of subordinate/dominant power relations that characterize social relationships in society (Mooosa-mitha 2005, p 61). Included within this framework, it is pivotal to consider heterosexism, homophobia and transphobia and the ramifications from under the umbrella of anti-oppression. With this framework we can deepen our understanding of the role that inequity via social exclusion plays on

[17] Adapted from LGBT Health Matters, 2006, per an amalgam from WHO 2003, Health Canada 2004 and *the social determinants of health: an overview of the implication for policy and the role of the health sector,* 2005

individual and community health. The recognition and understanding of the ways in which trans/homophobia and heterosexism marginalizes queer and trans communities, allows for another critical piece of inclusion to be discussed: intersecting or multiple barriers of exclusion. The social exclusion of queer and trans communities is an entry-point into understanding the continued marginalization through other oppressive systemic factors.

Intersectional, anti-oppressive analysis calls for research and policy that addresses the intersections of race, sexual orientation, ethnicity, gender, class, sexuality, age, rural-urban residence, (dis)ability, and other markers of social difference[18] (including QX argues, the inclusion of 'conditions that affirm choices of coming out' – per the recommendations of the Canadian National HIV Prevention Strategy for Gay Men, 2000)).

An intersectional approach views race, gender, sexuality and social class etc. as products of social systems rater than as individual attributes. From a service provider level, an intersectional approach would include ensuring an environment that reduces exclusion based on any one of the multiple barriers an individual may face, and second, allowing for an individual to self-identify with whatever issue(s) they choose to receive assistance for.

Conventional population health research captures inequalities as separate entities 'rarely addressing more than two inequalities in the same study' (Weber and Parra-Medina, 2003), intersectional analysis views inequalities as intertwined and inseparable. The recognition that markers of social difference are not simply separate dimensions of inequality, nor are they reducible to unalterable individual characteristics, allows us to see that these markers give all of us power

[18] Whose Public Health, 2006

and opportunities in some areas and restrict our power and opportunities in others (Weber and Parra-Medina 2003).

Finally, in the conventional approach, health disparities in minority groups/populations are viewed as deviants from the norm / general population which assumes those in dominate power-strong positions are the 'unexamined norm' (Weber and Parra-Medina 2003). Inevitably, planning for the 'norm' becomes justifiable and assumptions based on deviations from the 'norm' are often considered cost-ineffective and too specialized.

The health and well-being of groups outside the 'norm' fail to be considered as intimately and inevitably connected to the overall well-being of a population that includes them.

A detailed look at the Social Determinants of Health for Queer Communities

The Overview

Extensive literature has revealed that the physical and mental health of queer [and trans] folk is significantly affected by discrimination, and resulting social exclusion, based on their sexual orientation and gender identity, and the heterosexist assumptions in both health and social services design and delivery. Queer folk also experience significant barriers to accessing care and health services which has a detrimental impact on their health (Banks 2003; Dean et al. 2000; INCLUSION project 2003; Ministerial Advisory Committee on Gay and Lesbian health 2003; Ryan, Brotman, and Rowe 2000). In using an adaptation from the Department of Human Services (state of Victoria, Australia (from Whose Public Health, 2006)) the following three points account for why sexual orientation and gender identity affect queer [and trans] folks' health:

(i) Dominant perceptions of sexuality and gender identity persistently

marginalize and discriminate against queer people

(ii) Sexual orientation and gender identity act as independent indicators for a variety of queer health issues. There are patterns of health and illness specific to queer people independent of their experiences of marginalization and discrimination. These include health issues more common among gay men (for example certain types of anal cancer, alcohol and tobacco use, sexually transmitted infections), more common amongst lesbians (for example, cervical and ovarian cancer, reproductive health issues) and specific to trans people (cancers related to hormone replacement, complications from surgical interventions)

(iii) Sexual orientation and gender identity interact with other social determinants of health to produce patterns of illness within Queer communities.

The outcomes of this discrimination (heterosexism, sexism and trans/homophobia) include[19]:

- violence and persistent threats of violence
- discrimination and social marginalization
- isolation
- social invisibility
- self denial
- guilt
- initialized homophobia and transphobia

The health effects of these patterns include, but are not limited to[20]:

[19] Ministerial Advisory Committee on Gay and Lesbian Health 2003

[20] Jackson B, PhD, 2006, p 15

- increased levels of depression and suicide
- increased rates of alcohol and other substance use
- greater risk for sexually transmitted infections
- inability to form and sustain supportive relationships with friends and social networks
- inability to find supportive faith / spiritual communities
- inability to find support for intimate relationships and parenting(Ministerial Advisory Committee on Gay and Lesbian Health 2003)
- reduced access to quality health care and the utilization of health care services (Banks 2003; Coalition for Lesbian and Gay rights in Ontario 1997; et al)

- negative prejudiced attitudes of health care providers and systemic discrimination leave Queer patients subject to discrimination, bias, and substandard care (for example, inclusive terminology on admission forms and fear to disclose sexual orientation and/or gender identity)

Analysis of the Social Determinants of Health in Queer Communities

The following is a review of the social determinants of health, with special emphasis on the application of this framework in queer and trans communities. Unless otherwise stated the following review is presented in the context of Canada. Further the review is modeled on and adapted largely from LGBT Health Matters (2006) and the authors would like to explicitly acknowledge and emphasize such.

It is crucial to also understand and recognize that the following discussion must be placed in the context of trans/homophobia coupled with racism, radicalization and (although discussed in part) regard to newcomers

to Canada, pertinent to the Region of Peel in particular.

Income and social status inequality

'Poor social and economic circumstances affect health throughout life' (Wilkinson & Marmot, 2003, p11). It is vital to begin our discussion with one of life's fundamental social determinant of health: income security. *Queer Health Matters* (2006) poses 'the link between wealth and the absence of illnesses'. Wealth is not exclusively defined as monetary, and can include other resources related to income resources (for example, extended health insurance, drug plan coverage, etc.).

Evidence supports that there is a link between where people fall on the social gradient[21] and their health and well-being (Wilkinson and Marmot, 2003) – which could be decided by income and other social circumstances such as class structures, race, policy and discrimination.

When we look to queer social status and their positioning on the social gradient or 'social ladder' it is relevant to look to recent historic events to help better understand how these social forces materialized and their impact on queer and trans people's health.

It was only in 1969 that homosexuality was decriminalized, followed by as late as 1979 when it was removed as a psychiatric diagnosis. Although this broke down some social and systemic barriers for queer folk it was as recent as 1995 when Canada amended their human rights codes to prohibit discrimination based on sexual orientation. Note

[21] The publication of the Black report (Black *et. al.*, 1980) ushered in a new era of research concerned with the social factors underlying health outcomes. The fundamental finding from this line of research, particularly with respect to mortality and life expectancy, is the existence of "a social gradient" in mortality: "wherever you stand on the social ladder, your chances of an earlier death are higher than it is for your betters" (Epstein, 1998). The social gradient in mortality is observed for most of the major causes of death: for example, Marmot (2000) shows that, for every one of twelve diseases, the ratio of deaths (from the disease) to numbers in a Civil Service grade rose steadily as one moved down the hierarchy.

that the T – Trans - in the LGBT acronym still to this day is afforded no explicit protection under the Charter of Rights and Freedoms in Canada[22].

The past four centuries institutional persecution, including that from the Nazi's, has shaped public opinion to believing and crediting some of the lowest rung positions on the social ladder for queer 'undesirable' people, in addition to people of colour.

Coupled with this political and structural attempt to discriminate is the conceived notion that queer and trans folk are immoral. Conceptions of immorality are often rooted in religious beliefs and doctrine or traditional conservative family beliefs. Likewise, queer and trans issues are more often than not focused on sexual acts and experiences, and are immoralized on the basis of arguments against promiscuity, pre-marital sex, and sex without potential for procreation. Immorality is an argument that recent same sex marriage critics have used in sync with the Conservative governments definition of the nuclear family.

Advancement to a queer or trans person's career can often be tied closely with the denial or secrecy regarding their sexual orientation or gender identity, and in all likelihood the chances of success may not have been as high should they have disclosed, for example, Svend Robinson in the Canadian House of Commons. 'The longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer, and the less likely they are to enjoy a healthy old age' (Wilkinson and Marmot, 2003, p10). Improving the health and well-being of queer and trans Canadians is to further remove the structural and attitudinal barriers that currently restrict their ability

[22] Although large scale advocacy is underway to have this amended (see in particular the Trans Lobbying Working Group of the Rainbow Health Network)

to progress in society (LGBT Health Matters, 2006, p47).

One final point worthy of mention in income and social status inequalities is the 'pink dollar' or the 'wealthy gay.' Both US and Canadian literature agree that this is indeed a myth and as the Gay and Lesbian Health Services of Saskatoon (2001) argues 'gay men who enjoy the benefits of higher incomes and greater social status may do so due to other privileges or attributes such as ethnicity, gender and education.' Indeed this is in keeping with Badgetts US (1998) study that found female same sex households have 18-20% less household income than differing sex households, reflecting the gender wage gap, and inclusive to this point of other attributes affecting income. Badgetts' study shows significant lower difference in the salaries of homosexual households versus heterosexual households.

Social support networks

'Social support networks[23] have been identified as being important preventative and curative factors for ones health' (Wilkinson and Marmot, 2003, PHAC, 2004). Queer and trans social support networks are at best unconventional and often under resourced for this community. Queer folk are often forced to choose between their true identity and their traditionally defined family and friend makeup. Some individuals are fortunate that their genetic or societal defined family accepts the individual for whom they are. Others face rejection and exclusion, leading in many cases to homelessness, school drop out and suicide.

The importance of the family institution is deeply rooted in society, religious beliefs, culture & ethnicity and in Conservative politics. There is no doubt that it can and does act as an arm of support for most folks, and

[23] A network of family, friends, neighbors, and community members that is available in times of need to give psychological, physical, and financial help (http://www.cancer.gov/Templates/db_alpha.aspx?CdrID=440116)

this has been evidenced in the Queer community with organizations such as PFLAG[24].

'Families of choice' are broadly defined as groups of people who share certain commonalities ranging from sexual orientation to factors such as geography. LGBT Health Matters (2006) defines them as people forming an individual's social support network and often fulfilling the functions of blood relations. Many LGTB people are rejected when their families learn of their sexual orientation/gender identity, or they may remain "closeted" to their biological relatives. In such cases, it is their partner/significant other and close friends who form their social/support system and who will be called upon in times of (p.139). They provide and offer the arms of support that are underprovided for by the un-accepting or unsupportive family of origin. Families of choice deserve acknowledgement from service providers and treating them with legitimacy will ensure a more accurate understanding of the social support networks that exist for some queer and trans individuals.

Tagged closely to this support mechanism is the unique issue of 'coming out'[25] for queer and trans folk. Coming out may result in temporary or permanent rejection and isolation from family and previously perceived friends. In comparison to other losses in life, "the grief associated with this isolation may be no different than any other significant loss, such as a relationship break-up or even a death of a loved one" (Health matters, 2006, p50). As Meyer (2003) argues the grief is exacerbated if queer individuals have no choice but to 'come out' in isolation. He refers to the importance of group solidarity in situations of 'minority stress'. The experience of coming out within a setting of heterosexual and non-trans

[24] Parents and Friends of Lesbians and Gays

[25] Please refer to glossary for definitions

support qualifies as minority stress (per Meyer, 2003, p50, as quoted in LGBT Health maters, 2006, p50).

Culture

Health Canada recognizes culture as a key determinant of heath[26] defined largely by ethnicity (LGBT Health matters, 2006, p53). Queer and trans culture hence may not fit, into this model, however it does relate to social inclusion which is a key facet of culture and community. Queer culture is built around and based upon commonalities of oppression based on sexual orientation and gender identity, advocating for human rights, celebrations and marked historic victorious events that have shaped the existence of 'Queer' culture. Indeed other such cultural groups for example the Jewish community considers their historical experiences of oppression as significant to their culture.

One important cultural consideration certainly in Canada is Aboriginal culture. Colonization and the conquerors managed to destroy most of the history and heritage of a very liberal and socially diverse, progressive and accepting culture. Tafoya and Roscoe (as cited in Ryan, Brotman & Rowe, 2000) report that two-thirds of North American Aboriginal languages had included the word 'two-spirited' to describe people as being neither man or woman (per LGBT Health matters, 2006, p53). 'Being two-spirited means that an individual possesses both the female and male spirit' (Ryan et al., 2000, p17) although extends far greater on the gender continuum not identifying particularly with any gender nor sexual orientation. Tribes placed two- spirited people on pedestals as high, if not higher than the tribe's leaders. They were seen to possess a very special and wonderful gift.

[26] For information from the Public Health Agency of Canada on the determinants of health, please visit http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html#key_determinants

Christian teachings in the conquering times of Canada forced many aboriginal people into a homophobic mentality rejecting any one who identified as two-spirited, igniting a culture of homophobia that had not previously existed. According to Urban Native Youth Association (2004) '…some two-spirited people have experienced greater homophobia in Aboriginal communities than in mainstream society.' Further, many gay aboriginal people experience first hand racism and exclusion from the urbanized queer community epicenters; dispelling less support mechanisms for an already marginalized community. (LGBT Health Matters, 2006, p53).

Queer aboriginal folk can feel forced to choose between defending families and communities against racist colonized attitudes in queer and trans communities, and defending their sexuality/gender identity in response to homo/trans-phobic attitudes inside and outside of aboriginal communities. The double exclusion of racist and homophobic structures and attitudes results in the breakdown of crucial social supports. This double exclusion can support the need to find a family of choice – albeit unlikely that the queer aboriginal person will chose his/her family of choice in a non-aboriginal queer centered community due to the racism and resulting exclusion.

Part of a discussion on culture must include the immigration system, when we put queer and trans communities in the local context of Peel Region. It must be recognized that some folk who immigrate to Canada may be doing so from a country which does not recognize queer rights in the same way that Canada presently does.[27] In Canada, refugee claims on the basis of sexual orientation have been permitted since 1994, when the Supreme Court of

[27] For more information on the struggle for LGBT rights internationally, visit Amnesty International's work, including an interactive map about the laws affecting LGBT communities worldwide: www.ai-lgbt.org

Canada broadened the definition of social group to include homosexuals (www.sodomylaws.org/world/canada/canews020.htm). In 2004, nearly 2,500 people from 75 different countries have sought asylum on the basis of sexual orientation, it is not known how many have been granted this asylum and allowed to stay in Canada.[28]

It is crucial therefore that sufficient information and education is provided to enable immigrants – queer/trans identified or not – to settle properly amongst the norms of the Canadian culture. Likewise settlement and social support services need to have the capacity to assist queer and trans immigrant individuals. Non-settlement services should have the capacity to service queer and trans immigrant individuals with sensitivity and responsiveness to the potential double barriers that they may face; racism and trans/homophobia. In Peel, new immigrants face discriminations and oppression in the shape of poor income distribution, three-month waiting period for OHIP, under-employment, poor working conditions, and unsafe or unaffordable housing and other challenges related to their newcomer status.

Ryan and Chervin (2000) have suggested several ways in which minority ethnic, racialized, group membership may affect queer people, gay men in particular:

(i) Revealing ones sexual orientation may imply a risk of losing support within one's community of origin – where a huge amount of importance may be attached
(ii) It may be seen to have grater repercussions for one's entire family
(iii) Individuals could bring with them other oppressive histories (e.g. xenophobia) to the experience of

[28] This information was released under the Access to Information Act. www.sodomylaws.com

heterosexism and homophobia

(iv) Individual could struggle with internalized homophobia – brought on by cultural and societal 'norms'

Aside from issues of racism, immigration, colonization and geography, other folks are affected intersectionally so, by culture. 'It should never be assumed that because a person's background is of a dominant cultural group in Canada that their experience is any easier than someone from a visible minority.' (LGBT Health maters, 2006, p55). Other determinants of health can and will play a role in their queer and/or trans existence.

Gender

'Unlike sex, which is biologically determined, gender is considered to be a social construct[29] (Peterkin & Risdon, 2003, p6). Gender in the context of queer and trans communities branches beyond the scope that society and health service providers generally refer to, which typically includes only male or female in the gender discussion.

All trans-identifying individuals are uniquely different and will be at different points of transition at one given point in time. Some will stay in a relatively premature state of transition all their lives (for reasons for contentment, financial issues, or other). The continuum of gender is thus large and far ranging. Masculinity and femininity will be displayed at varying levels – some folk confident in public spheres, others only in private settings. The continuum is of course further complicated by questioning the definition of gender outside the box of masculinity and femininity, such as visual appearance more in line with sex or simply a combination of both[30].

[29] A social mechanism, phenomenon or category created and developed by society; a perception of an individual, group or idea that is 'constructed' through cultural or social practice (Webster's dictionary)

[30] LGBT Health Matters, 2006, p. 58

Trans people are a historically ignored population in legislative and policy dialogue. The government, on any level, is yet to set affirmative policy to be inclusive and more importantly representative of trans folk. Indeed the first piece of research in Canada and subsequently the first Trans health information booklet ('*Primed*') was only just completed in May 2007[31].

Sexism interacts with determinants such as income, employment, and health service access. Armstrong et al (2001) and Health Canada (1999b) provides some examples, women are more likely to live in poverty than men; girls use few health care services than boys in infancy and childhood, but women use more health services in adulthood; women constitute the majority of service providers, and so on. 'Homophobia and Transphobia may be viewed as 'weapons of sexism,' operating as a means to maintain a binary system of gender and sexist social relations; conversely, sexism helps maintain homophobia, heterosexism and transphobia' (Ryan and Chervin 2000).

Disability

Another example of multiple barriers for an individual disabled people are often seen to be asexual, and therefore are often excluded in discussions around sexual orientation and gender identity. This finding is supported with research from the Coalition for Lesbian and Gay Rights in Ontario, 1997 and the Ministerial Advisory Committee on Gay and Lesbian Health, 2003, who also say disabled queer people face barriers to the open expression and acceptance of their sexualities.

Disabled queer and trans people are less likely to feel comfortable in disclosing their sexuality or gender identity to service providers

[31] By the Trans working group of the Gay Men's Provincial Strategy Advisory Body, Ontario Ministry of Health and Long Term Care, AIDS Bureau

at fear of not receiving the care they so readily need. Disabled queer and trans people are marginalized from within the queer and trans community who may also view their existence as asexual, and additionally due to lack of accessible spaces. These folks are susceptible to abuse from homo/trans phobia and heterosexism in many other means too (for example home care, special transportation officers etc...) The Coalition on Lesbians and Gay rights in Ontario,1997 also found that '...difficulty finding appropriate, [financially] free supportive services leads many queer disabled people to paying for private assistance – if they can – compounding economic disadvantages they may or may not face' (Whose Public Health, 2006)

Finally, Hodges and Parkes (2005) have identified two areas where learning disabilities affect the safer sex messages aimed at gay men and also put them at increased risk to negotiate safer sex techniques to a power imbalanced relationship.

Education and literacy

'Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances' (PHAC,2004, key determinant 3).

School drop out and unsuccessful education achievements amongst queer people are unfortunately high[32]. Derogatory slurs and terms used by children of all ages, and sometimes by educators as well, across all educational institutions can be common place and not taken seriously. The effect on a queer individual is powerful: based on Children's AID Society of Toronto, 28% of all queer and trans youth drop out of school. Moreover, queer and trans young people, like any child struggling with

[32] Children AID Society, 2006

stress and low self-esteem, may act out or be withdrawn and be unfairly labeled 'troubled' or 'under-achiever'.

Gay-straight alliances currently in seven public school board secondary schools in Peel are some examples of efforts to reduce homophobia, transphobia and heterosexism in schools. Gay Straight alliances are groups of queer and trans, and queer and trans positive (queer and trans allies) youth who meet in the same context of any other school group to meet, 'hang out' and also advocate for queer and trans acceptance and positivity if only by way of a physical presence. They involve teachers and students. It is however, often not enough and the environment is/can be more detrimental to the tools implemented. A queer and trans positive school[33] is pivotal for anti trans/homophobia and queer and trans positive work and to ultimately achieving healthier queer and trans youth.

Queer and trans school drop out is commonplace in the absence of a school that promotes a positive and non-discriminatory environment that includes queer and trans rights. Ramafedi (1994) cited in American studies, that LGB drop out was 28% compared to 9% for heterosexual counterparts. He then draws a conclusion in comparison to Canadian LGB drop out rates – where no Peel specific research was available – that '…if queer Canadian youth were leaving school at that time – 1994 – at similar or even lower rates it could mean ¼ of the LGB (possibly T) population over 25 years and older did not complete high school when they should have.' If this assessment is accurate, we can extrapolate the data to analyze health: this could mean ¼ of queer and possibly trans will have

[33] A queer positive school would be one which is accountable for homophobia as discrimination, support for anti homophobia and zero tolerance attitude and framework to oppression

poorer health based on their educational status alone. If intersectionally analyzed with other determinants the numbers could and would be substantially greater.

Employment, job security & working conditions

'Not enough work, too much work or not enough control over work has all been found to impact negatively on a person's health (Wilkinson and Marmot, 2003). The benefits of employment are important to an individuals health: the power of holding a job and also the integral self-identity correlation affect an individuals self esteem and well being.

Whether queer and trans communities are always visible is down to the work environment and organizational equity's policy. Fear of discrimination from employers and/or harassment from colleagues may force queer people not to come out at work. They may lead a person to live a divided life and choose not to be openly out about their sexual orientation or gender identity at work. This pressure to conform or conceal their identity is unhealthy, burdensome and stressful on queer and trans people. Croteau (1996) reports that,'…studies of the workplace experience of LGB people found that fear of discrimination and concealment of sexual orientation are prevalent and that they have adverse psychological, health, and job related outcomes (Waldo, 1999)' (Meyer, 2003, p11).

The Canadian Charter of Rights and Freedoms provides protection to LGB people including employment. As we have said however, its enforcement and adherence to it by employers is questionable. Per the Gay and Lesbian Health Services of Saskatoon, 2001 (p34) '…the Glasgow Women's library (1999) reported that 42% of unemployed gay and lesbian survey respondents perceived that their unemployment was related to their sexuality, and 20% of

respondents stated that they had to leave employment or had been refused work due to their sexuality or homophobia of others.' LGB people often chose therefore, more LGB positive work places, many below their educational qualifications in an attempt to avoid victimization (Gay and Lesbian Health Services of Saskatoon, 2001, p29).

No definitive data exists in Canada between LGB and employment but LGBT Health Matters, 2006, draws on a similarity between New Zealand's census reports, claiming that the two countries share many cultural norms so much so that it is possible to extrapolate some of the data to the Canadian context. The New Zealand data shows a correlation between sexual orientation and employment whereby unemployment rates were 1.38 times higher for gay men versus heterosexual men and 1.32 higher for lesbians versus heterosexual women.

Whilst this comparison can be made for LGB, 'T' people are not afforded employment equity protection. Trans people are not protected under the Canadian Charter of Rights and Freedoms, even under the umbrella of other minorities. Keith Norton, Chief Commissioner of the Ontario Human Rights Commission, has stated, 'Discrimination against transgendered persons is systemic. Human rights violations are both varied and widespread across geographic and class boundaries…transgendered persons have been an especially marginalized group' (Egale Canada, 2005, a).

For trans people employment options are even sparser since they often cannot conceal their identity as a visible minority through their appearance and varying degrees of transition. Much work and advocacy is needed to ensure the initiation of employment (and human)

rights are recognized for Trans people.

➧*Social environments: inclusion and exclusion*

'The more integrated we are with our communities, the less likely we are to experience colds, heart attacks, strokes, cancer, depression, and premature deaths of all sorts.' (Putnam, 2000, p326). Much like other marginalized groups, queer and trans communities are excluded intentionally and unintentionally in many processes and services that shape health and well-being for the general public. Although for African Diaspora communities recent research has shown that race, faith and family play a larger role in discrimination and stigma (University of Toronto, The African and Caribbean Council on HIV/AIDS in Ontario and the HIV Social Behavioral and Epidemiological Studies Unit, 2006)

In 2004, the criminal code of Canada included discrimination based on sexual orientation under federal hate crime laws. Fear of violence and individual perceptions of risks of violence based on sexual orientation has emotional and mental ramifications that can go unmitigated. Queer and trans people often opt to live and socialize in the community constructed for support and opportunity in finding the family of choice.

Research indicates that hate crimes against queer people have increased over the last 20 years (Gay and Lesbian Health Services of Saskatoon. (2001). Further, '...numerous studies show with varying sizes from across Canada indicate that the prevalence of hate crimes is a serious problem for queer people (Toppings, 2004). Queer youth are at an even higher risk (perhaps due to school bullying, child/adolescent ignorance and parental attitudes. Whilst the short-term impact of violence is easy to see through the injury and harm caused, longer-term effects include depression, fear and

withdrawal. 'Chronic stress [and worry] experienced by gay men lead to greater levels of depression' (DeRycke and Boulton per GLHSS, 2001).

Finally, there is growing evidence to support the reality that same sex partner abuse is on the rise (Toppings, 2004). Gender issues at the systemic level, for example the judicial and police enforcement systems, play out through the heterosexist assumptions and homophobic attitudes that govern recognition and prosecution of partner abuse. Education and a shift in attitudes are required in order to capture the full spectrum of abuse that includes same sex partner abuse.

Additionally seniors experience isolation and are good examples of a demographic that are prevalent in almost all regions of a province and as such may incur some of the determinants of health more readily due to their age, their personal coping mechanisms built from a time when homosexuality was not recognized by law, etc. Research on this demographic is under way, particularly in Montreal, Vancouver and at Toronto's 519 Community centre (in partnership with the Rainbow Health Network).

Physical environments

Physical environments include geographic location and associated issues that include transportation, urban landscape, safety, and other characteristics that shape a person's physical environment. Queer and trans people live intertwined across other communities as well as within queer and trans communities. It is important to consider the impact that non-queer and trans communities have on queer and trans people's health and vice versa. Whilst queer (and somewhat, trans) created 'villages' can be potential target spots for hate crimes, aside from this danger, they are shown to be beneficial health sites in terms of social environments and access to queer-friendly services. Although, it is noted

that many queer villages may not have the capacity to respond to the multiple barriers that diverse queer communities face, including language, culture, and immigration status, and can have the potential to be discriminatory based on these characteristics.

What has been shown through research (Research on HIV Risk Among Gay and Bisexual Men, Gay, Bi, MSM Situation Report, Adams, 2006) is the effect on queer people living in remote non-urban centers where access to queer services and other queer people may not be readily or competently available (especially in the case of service provision). Queer people may not be able to express themselves openly due to higher levels of homophobia and transphobia; and may experience greater levels of stress. Overall Whose Public Health, 2006, summarizes the reasons as: fewer health service providers with knowledge of queer health issues; reduced access to queer communities; reduced access to information; isolation; and a fear of breach of confidentiality, from service providers if queer people do disclose. Additionally, this also threatens the queer persons safety. While Mississauga benefits from close proximity to Toronto, many queer and trans people may not be able to access queer and trans environments outside of Mississauga as frequently as they would like to because of the transportation involved. Likewise, many Queer individuals from diverse communities may face difficult or complicated routes to accessing services outside of their immediate local environment, due to privacy and lack of independent mobility (for example, young women traveling alone or elderly persons). Often in ethno-racial communities health service providers are family friends and/or a known member and part of the community.

'Limiting where people can safely live, work, or recreate

has the potential to impact on other determinants of health such as housing availability and affordability, income, accessibility to employment and social supports.' (LGBT Heath matters, 2006, p70).

➡*Personal health practices, coping skills and stress*

Arguably the best example of changing health practices within the queer and trans community is the communities response to HIV. Many grass roots organizations manifested from within the queer community have provided for and continue to provide for education campaigns and safer sex messages. Research indicates that men with higher levels of internalized homophobia are less engaged with the queer community and therefore less likely to have access to education and prevention (Gay and Lesbian Health Services of Saskatoon, 2003). The same can be said for those queer people living in less urbanized centres that have no popularized queer HIV messages. Indeed ethno-racial communities often miss out on this messaging if not engaged in what is perhaps a white mainstream 'village', and/or if the messages are not understood/translated into their language. A 1996 study found that HIV moves more rapidly amongst people who are not open about their sexuality (Cole, Kemeny, Taylor, & Visscher, 1996). Recognizing this, the Ontario Provincial AIDS Bureau has developed a provincial strategy and advisory body to coordinate education and prevention messages and campaigns equally across the province.[34]

Another health concern for queer and trans people is body image. Whilst many gay men have followed the general path of society in choosing to align themselves as thin and/or skinny, hairless, fat free beauties, one culture of gay men, known as *bears* as alluded to the other end of the spectrum to being overweight and hairy in defiance of the archetype

[34] The 2006 Gay Men's Provincial Strategy campaign BE REAL can be found at www.ru4real.ca

of the sculpted gay man. This situation is mirrored in the lesbian community as well.[35]

The problem with our two extremes here is the first group often forms eating disorders or engaging in steroids to enhance their body beautiful. The latter, by contrast, in not assuming much attention to diet and nutrition concerns may put themselves at risk of heart disease, diabetes, and other problems associated with being overweight. 'Sexual orientation has been found to be a significant predicator of eating disorders among men, but not women' (Peterkin & Ridson, 2003, p211); even though 'Lesbian women are significantly heavier, have a significantly higher weight ideal and aspire less to thinness…' (Herzog, Newman, Yeh & Warshaw, 1992).

It should be noted that eating disorders may be caused due to self esteem and homophobia caused by society at large, as well as or in place of the idealized body type set out by gay culture. Certainly urban queer people may not see the need to conform to this model but may experience eating disorders due to depression (social isolation) and discrimination (in the form of homophobia).

Trans folk experience with body image is considerably different, due to the varying degrees of transition that he/she may be at. There is substantial potential for increased stigma and abuse for a trans individual due to their physical appearance and subsequent lack of conforming.

All of these factors contribute to levels of stress a queer and trans person may experience. 'Stressful circumstances, making people feel worried, anxious and unable to cope, are damaging to health and may lead to premature death' (Wilkinson & Marmot, 2003, p12). It should be noted that like other marginalized communities, some queer communities have established very

[35] See appendix for Sherbourne Health's 'Lets Talk About It' chart that discusses nutrition, fitness and lifestyle.

effective coping mechanisms which may be valuable and transferable in other life situations.

Some coping mechanisms for dealing with chronic stress are not very effective, and these can include smoking, excessive alcohol, and substance abuse. The use of substance in the queer community is statistically high. There is very recent research in Ontario to support this and regretfully space does not permit a longer discussion of substance use in this paper[36] (see also, Bullock et al.; Adam, Husbands, Murray & Maxwell, 2007; University of Toronto, The African and Caribbean Council on HIV/AIDS in Ontario and the HIV Social Behavioral and Epidemiological Studies Unit, 2006).

Healthy child development

'Healthy children have a greater potential to grow into healthy adults' (LGBT Health matters, 2006, p74). The development of a sexual identity however is something that usually occurs around the ages of ten to eleven. This is a time for exploration of one's sexual organs and feelings of attraction. For queer youth, this can be a time of ambiguity in addition to the overall confusion for all youth at this time. Queer youth may feel stress or pressure if they are experiencing feelings and desires that are different from the norm, and especially if they have been taught negative messages about being queer, including that being queer is 'evil' or 'wrong' or 'shameful', etc. Parents' or families' attempts to influence or change their child's sexual orientation (or gender) can have the same damaging effects to a child's healthy mental development. Physical change in particular to a trans person at a young age can be extremely confusing since they are witness to the transformation of their bodies into a sex not in tune with their gender.

[36] See appendix for Sherbourne Health's Lets Talk About It chart that discusses nutrition, fitness and lifestyle.

Queer families raising a child of unknown sexual orientation and gender identity need to be mindful of their actions and interactions, to portray their relationship and existence as healthy and normal. Positive queer and trans role models are important so that the child develops a healthy attitude of tolerance and acceptance regardless of his/her personal preferences later in life. There is literature to support the claim that a child's healthy development is neither greater nor worse being raised in either heterosexual or homosexual parents (LGBT Health Matters, 2006, p.78).

Social and health services providing support to families should be equipped with the capacity to support heterosexual or queer families parenting queer and/or trans children. Many do not have this capacity, however, some agencies, such as Family Services of Peel are breaking ground through the employment of a counselor to provide support to queer and trans individuals and their families.

Biology and genetic endowment

There is no conclusive evidence to support the argument that queer people have a different biological makeup than heterosexual people (O'Neill, 2003, p130).

With trans people there is some causation found. 'Research studies indicate that a small part of the baby's brain develops in opposition to the sex of the rest of the body. This predisposes the baby to a future mismatch between gender identity and sex' (Gires, 2004b, p1). This could therefore explain the inherent need to transition in later life.

Regardless, the existence of such research and argument is damaging on a queer individual's self esteem since their identity and existence is directly questioned and doubted.

Conclusion

The above discussion around the social determinants of health for queer and trans people is not exhaustive but outlines key issues within the context of the Social Determinants of Health. It is important to read the above in many different contexts that would allow for an analysis to include the impacts of age and location, in order to be responsive to issues of access at a local level.

For Peel it is notable that a queer and trans community may not be easily identifiable. What is necessary is that health and social services be equipped with the capacity to service people without assuming heterosexuality is the norm.

This discussion only begins to scratch the surface. Meaningful involvement of service providers and queer and trans communities and their families and friends is necessary to develop solutions. While the social determinants of health are relevant for any community, this literature review has provided insight on the specific adaptation of key determinants of health to queer and trans communities. Queer and trans community health is community health, and it remains the responsibility of all health and social service systems to ensure that queer and trans access to health discussions are rooted in the basis of health as a human right and not a privilege.

The Sherbourne Health Centre in Toronto, Ontario has produced public materials on the specific health concerns for Queer communities. The 'Lets Talk About' series of publications is available online at http://www.sherbourne.on.ca/programs/programs.html

Some highlights from the documents include:

QUEER XPOSURE

LGBTT Community	Emotional and Mental Health	Cancer	Tobacco & Smoking	Alcohol & Drug Use	Nutrition, Fitness & Weight	Sexual Health
Bisexual Health A word describing a person whose sexual orientation is directed toward men and women, though not necessarily at the same time. *	▪ Challenges living in biphobic, homophobic and heterosexist world ▪ Negative attitudes, violence and discrimination can contribute to mental and emotional distress ▪ Depression, anxiety and suicide rates that are higher than gay, lesbian or heterosexual people	▪ Negative experiences with healthcare system lead to avoidance of regular physical exams and routine screening tests ▪ Bisexual women's risk for ovarian cancer may be elevated if they have neither used oral contraceptives, given birth, nor breastfed ▪ Bisexual men who are sexually active with	▪ Higher rates of smoking (2004: 20% of adults over 15 in Canada were smokers, while estimates for LGBTT range from 30-50%) ▪ Several factors contribute : high levels of social stress, frequent socializing in bars, higher rates of alcohol	▪ More likely to use alcohol and other drugs than heterosexuals ▪ May be used to cope with discrimination and internalized homophobia or biphobia or gender identity	▪ Gay and Lesbian communities have particular cultural norms about body weight and appearance. Pressure can result from trying to meet these norms	▪ Increased risk of STI's and HIV

LGBTT Community	Emotional and Mental	Cancer	Tobacco & Smoking	Alcohol & Drug Use	Nutrition, Fitness &	Sexual Health
		men are at higher risk for anal cancer	and drug use			
Gay Men A word to describe a person whose primary sexual orientation is to members of the same gender or who identifies as a member of the gay community. This word can refer to men and women, although many women prefer the term "lesbian." *	▪ Partner Abuse is often trivialized or misunderstood, and limited services exist ▪ Negative attitudes, discrimination and violence can attribute to emotional and mental stress ▪ Staying in the closet can also be stressful with the fear of discovery creating isolation for some men	▪ Negative experiences with healthcare system lead to avoidance of regular physical exams and routine screening tests ▪ 35 out of 100,000 HIV-negative gay men and 70 out of every 100,000 HIV-positive gay men develop anal cancer compared to less than 1 out of every 100,000 heterosexual men	▪ Higher rates of smoking can lead to lung cancer, heart disease and emphysema	▪ More likely to use alcohol and other drugs compared to heterosexual men ▪ More likely to use some recreational drugs at a higher rate than general population ▪ Alcohol or drugs may be used to cope with discrimination and internalized homophobia	▪ Gay male culture has long valued physical beauty and youth, this can lead to cultural pressure to achieve the perfect body for some (e.g. compulsive exercising, steroid use) ▪ More likely than heterosexual men to have poor body image ▪ More likely to develop	▪ Increased risk of HIV infection ▪ Increased risk of STI's ▪ Increased risk of Hepatitis A and Hepatitis B infections, both of which can lead to liver disease

LGBTT Community	Emotional and Mental	Cancer	Tobacco & Smoking	Alcohol & Drug Use	Nutrition, Fitness &	Sexual Health
		▪ Higher rates of smoking increases risk for lung cancer			an eating disorder than heterosexual men ▪ Bears may celebrate larger bodies which may put them at risk for diabetes, high blood pressure and heart disease	
Lesbians A female whose primary sexual orientation is to other women or who identifies as a member of the lesbian community.*	▪ Negative attitudes, discrimination, and violence can contribute to mental and emotional distress ▪ Coming out can be emotionally stressful and isolating, as	▪ Negative experiences with healthcare system lead to avoidance of regular physical exams and routine screening tests ▪ Breast cancer risk	▪ Higher rates of smoking can lead to lung cancer, heart disease and emphysema	▪ More likely to use drugs and alcohol than heterosexual women ▪ More likely to report experiencing problems from alcohol use	▪ Cultural norms may encourage acceptance of heavier body weights and the rejection of dieting and thinness as a desirable	▪ Greater risk of herpes, HPV and trichomoniasis

Adapted from: "Taking Pride in Health", Sherbourne Health Centre. www.sherbourne.on.ca

LGBTT Community	Emotional and Mental	Cancer	Tobacco & Smoking	Alcohol & Drug Use	Nutrition, Fitness &	Sexual Health
	can staying in the closet ▪ Self-esteem and self-identities can be impacted by the above, and studies show increased rates of depression, anxiety, and suicide, that are higher than heterosexual women ▪ Partner abuse may be trivialized or misunderstood	rates may be increased by higher body weights and alcohol consumption, and the greater likelihood of either having no biological children or having children after age of 30 ▪ Elevated risk of ovarian cancer because Lesbians or WSW are less likely to have used oral contraceptives and more likely to have never given birth or breastfed		and to continue to drink as they age	standard. This is in tune with an anti sexist and the feminist movement notions of not having to 'fit' to a societal gender appearance. ▪ Less likely to perceive themselves as overweight ▪ On average, lesbians are more likely to be overweight than heterosexual women, which can increase	

Adapted from: "Taking Pride in Health", Sherbourne Health Centre. www.sherbourne.on.ca

LGBTT Community	Emotional and Mental	Cancer	Tobacco & Smoking	Alcohol & Drug Use	Nutrition, Fitness &	Sexual Health
					risk for heart disease, and stroke.	
Trans People Non-clinical term that usually include transsexual, transgendered and other gender-variant people. *	▪ Particular challenges dealing with gender identity issues and living in a transphobic world ▪ Negative attitudes, discrimination and violence can contribute to mental and emotional distress; as can the passing and transitioning process ▪ Coming out can be stressful and have negative	▪ Negative experiences with healthcare system lead to avoidance of regular physical exams and routine screening tests ▪ Risks not well understood ▪ Trans men taking hormones may have higher risks for breast cancer and ovarian cancer ▪ Trans men are also at risk for polycystic	▪ Little research on tobacco use in transgender and transsexual communities ▪ Smoking slows down healing after any surgery and increase chance of scarring	▪ Little information on rates of alcohol and drug use among trans people ▪ Alcohol and drugs may be used to cope with transphobia, discrimination and depression	▪ Negative body images due to discomfort with the gender of their physical bodies ▪ Little research available ▪ Trans men on testosterone may be at increased risk for heart disease due to a shift in their bodies' weight distribution	▪ Little is known about HIV risks for trans men, who are mostly invisible in sexual health research ▪ Social isolation and low self-esteem, and lack of relevant sexual health information can lead to higher rates of unprotected sex ▪ Sharing needles to

Adapted from: "Taking Pride in Health", Sherbourne Health Centre. www.sherbourne.on.ca

LGBTT Community	Emotional and Mental	Cancer	Tobacco & Smoking	Alcohol & Drug Use	Nutrition, Fitness &	Sexual Health
	impact on self-esteem and self-identity	ovary syndrome and endometrial cancer ▪ Trans women who are taking hormones may be at an increased risk for breast cancer and prostate cancer			▪ Hormones often cause weight can, and can lead to diabetes, high blood pressure or other health problems	inject hormones or silicone can increase risk of HIV and other diseases

Queer Glossary of terms

definitions from Centre for Addiction and Mental Health (CAMH) *Asking the Right Questions II*, 2006

Asexual: a word describing a person who is not sexually and/or romantically active, or not sexually and/or romantically attracted to other persons.

Autosexual: a word describing a person whose significant sexual involvement is with oneself or a person who prefers masturbation to sex with a partner.

Biphobia: irrational fear or dislike of bisexuals. Bisexuals may be stigmatized by heterosexuals, lesbians and gay men.

Bi-positive: the opposite of biphobia. A bi-positive attitude is one that validates, affirms, accepts, appreciates, celebrates and integrates bisexual people as unique and special in their own right.

Bisexual: a word describing a person whose sexual orientation is directed toward men and women, though not necessarily at the same time.

Coming out: the process by which LGBTTTIQ people acknowledge and disclose their sexual orientation or gender identity, or in which transsexual or transgendered people acknowledge and disclose their gender identity, to themselves and others (See also "Transition"). Coming out is thought to be an ongoing process. People who are "closeted" or "in the closet" hide the fact that they are LGBTTTIQ. Some people "come out of the closet" in some situations (e.g., with other gay friends) and not in others (e.g., at work).

Crossdresser: A person who dresses in the clothing of the other sex for recreation, expression or art, or for erotic gratification. Formerly known as "transvestites." Crossdressers may be male or female, and can be straight, gay, lesbian or bisexual. Gay/bisexual male crossdressers may be "drag queens" or female impersonators; lesbian/bisexual female crossdressers may be "drag kings" or male impersonators.

Dyke: a word traditionally used as a derogatory term for lesbians. Other terms include lezzie, lesbo, butch, bull dyke and diesel dyke. Many women have reclaimed these words and use them proudly to describe their identity.

Fag: a word traditionally used as a derogatory term for gay men. Other terms include fruit, faggot, queen, fairy, pansy, sissy and homo. Many men have reclaimed these words and use them proudly to describe their identity.

Family of choice: the circle of friends, partners, companions and perhaps ex-partners with which many LGBTTTIQ people surround themselves. This group gives the support, validation and sense of belonging that is often unavailable from the person's family of origin.

Family of origin: the biological family or the family that was significant in a person's early development.

Gay: a word to describe a person whose primary sexual orientation is to members of the same gender or who identifies as a member of the

gay community. This word can refer to men and women, although many women prefer the term "lesbian."

Gay-positive: the opposite of homophobia. A gay-positive attitude is one that affirms, accepts, appreciates, celebrates and integrates gay and lesbian people as unique and special in their own right.

Gender conforming: abiding by society's gender rules, e.g., a woman dressing, acting, relating to others and thinking of herself as feminine or as a woman.

Gender identity: a person's own identification of being male, female or intersex; masculine, feminine, transgendered or transsexual. Gender identity most often corresponds with one's anatomical gender, but sometimes people's gender identity doesn't directly correspond to their anatomy. Transgendered people use many terms to describe their gender identities, including: pre-op transsexual, post-op transsexual, non-op transsexual, transgenderist, crossdresser, transvestite, transgendered, two-spirit, intersex, hermaphrodite, fem male, gender blender, butch, manly woman, diesel dyke, sex radical, androgynist, female impersonator, male impersonator, drag king, drag queen, etc.

Genderqueer: this very recent term was coined by young people who experience a very fluid sense of both their gender identity and their sexual orientation, and who do not want to be constrained by absolute or static concepts. Instead, they prefer to be open to relocate themselves on the gender and sexual orientation continuums.

Gender role: the public expression of gender identity. Gender role includes everything people do to show the world they are male, female, androgynous or ambivalent. It includes sexual signals, dress, hairstyle and manner of walking. In society, gender roles are usually considered to be masculine for men and feminine for woman.

Gender transition: the period during which transsexual persons begin changing their appearance and bodies to match their internal identity.

Genderism: the belief that the binary construct of gender, in which there are only two genders (male and female), is the most normal, natural and preferred gender identity. This binary construct does not include or allow for people to be intersex, transgendered, transsexual or genderqueer.

Hate crimes: offences that are motivated by hatred against victims based on their actual or perceived race, color, religion, national origin, ethnicity, gender, disability or sexual orientation.

Heterosexism: the assumption expressed overtly and/or covertly, that all people are or should be heterosexual. Heterosexism excludes the needs, concerns, and life experiences of lesbian, gay and

bisexual people, while it gives advantages to heterosexual people. It is often a subtle form of oppression that reinforces silence and invisibility for lesbian, gay and bisexual people.

Heterosexual: term used to describe a person who primary sexual orientation is to members of the opposite gender. Heterosexual people are often referred to as "straight."

Heterosexual privilege: the unrecognized and assumed privileges that people have if they are heterosexual. Examples of heterosexual privilege include: holding hands or kissing in public without fearing threat, not questioning the normalcy of your sexual orientation, raising children without fears of state intervention or worries that your children will experience discrimination because of your heterosexuality.

Homophobia: irrational fear, hatred, prejudice or negative attitudes toward homosexuality and people who are gay or lesbian. Homophobia can take overt and covert, as well as subtle and extreme, forms. Homophobia includes behaviors such as jokes, name-calling, exclusion, gay bashing, etc.

Homosexual: a term to describe a person whose primary sexual orientation is to members of the same gender. Most people prefer to not use this label, preferring to use other terms, such as gay or lesbian.

Identity: how one thinks of oneself, as opposed to what others observe or think about one.

Internalized homophobia: fear and self-hatred of one's own sexual orientation that occurs for many lesbians and gay men as a result of heterosexism and homophobia. Once lesbians and gay men realize that they belong to a group of people that is often despised and rejected in our society, many internalize and incorporate this stigmatization, and fear or hate themselves.

Intersex: a person who has some mixture of male and female genetic and/or physical sex characteristics. Formerly called "hermaphrodites." Many intersex people consider themselves to be part of the Trans community.

Lesbian: a female whose primary sexual orientation is to other women or who identifies as a member of the lesbian community.

LGBTTTIQ: a common acronym for lesbian, gay, bisexual, transsexual, transgendered, two-spirit, intersex and queer individuals/communities. This acronym may or may not be used in a particular community. For example, in some places, the acronym LGBT (for lesbian, gay, bisexual and transgendered/transsexual) may be more common.

MSM: refers to any man who has sex with a man, whether he identifies as gay, bisexual or heterosexual. This term highlights the distinction

between sexual behavior and sexual identity (i.e., sexual orientation). A person's sexual behavior may manifest itself into a sexual identity, but the reverse is not always true; sexual orientation is not always reflective of sexual behavior. For example, a man may call himself heterosexual, but may engage in sex with men in certain situations (e.g., prison, sex work).

Out or **Out of the closet**: varying degrees of being open about one's sexual orientation or gender identity.

Passing: describes transgendered or transsexual people's ability to be accepted as their preferred gender. The term refers primarily to acceptance by people the individual does not know, or who do not know that the individual is transgendered or transsexual. Typically, passing involves a mix of physical gender cues (e.g., clothing, hairstyle, and voice), behavior, manner and conduct when interacting with others. Passing can also refer to hiding one's sexual orientation, as in "passing for straight."

Polysexual: an orientation that does not limit affection, romance or sexual attraction to any one gender or sex, and that further recognizes there are more than just two sexes.

Queer: traditionally, a derogatory and offensive term for LGBTTTIQ people. Many LGBTTTIQ people have reclaimed this word and use it proudly to describe their identity. Some transsexual and transgendered people identify as queers; others do not.

Questioning: people who are questioning their gender identity or sexual orientation and who often choose to explore options.

Sexual behavior: what people do sexually. Not necessarily congruent with sexual orientation and/or sexual identity.

Sexual identity: one's identification to self (and others) of one's sexual orientation. Not necessarily congruent with sexual orientation and/or sexual behavior.

Sexual minorities: include people who identify as LGBTTTIQ.

Sexual orientation: a term for the emotional, physical, romantic, sexual and spiritual attraction, desire or affection for another person. Examples include heterosexuality, bisexuality and homosexuality.

Significant other: a life partner, domestic partner, lover, boyfriend or girlfriend. It is often equivalent to the term "spouse" for LGBTTTIQ people.

Straight: a term often used to describe people who are heterosexual.

Trans and **transpeople** are non-clinical terms that usually include transsexual, transgendered and other gender-variant people.

Transgendered: a person whose gender identity is different from his or her biological sex, regardless of the

status of surgical and hormonal gender reassignment processes. Often used as an umbrella term to include transsexuals, transgenderists, transvestites (crossdressers), and two-spirit, intersex and transgendered people.

Transgenderist: someone who is in-between being a transsexual and a transgendered person on the gender continuum, and who often takes sex hormones, but does not want genital surgery. Transgenderists can be born male (formerly known as "she-males") or born females (one called he/she's"). The former sometimes obtain breast implants and/or electrolysis.

Transition: the process (which for some people may also be referred to as the "gender reassignment process") whereby transsexual people change their appearance and bodies to match their internal (gender) identity, while living their lives full-time in their preferred gender role.

Transphobia: irrational fear or dislike of transsexual and transgendered people.

Transpositive: the opposite of transphobia. A Transpositive attitude is one that validates, affirms, accepts, appreciates, celebrates and integrates transsexual and transgendered people as unique and special in their own right.

Transsensual: a term for a person who is primarily attracted to transgendered or transsexual people.

Transsexual: a term for a person who has an intense long-term experience of being the sex opposite to his or her birth-assigned sex and who typically pursues a medical and legal transformation to become the other sex. There are transmen (female-to-male transsexuals) and transwomen (male-to-female transsexuals). Transsexual people may undergo a number of procedures to bring their body and public identity in line with their self-image, including sex hormone therapy, electrolysis treatments, sex reassignment surgeries and legal changes of name and sex status.

Transvestite: see "Crossdresser."

Two-spirit: an English term coined to reflect specific cultural words used by First Nation and other indigenous peoples for those in their cultures who are gay or lesbian, are transgendered or transsexual, or have multiple gender identities. The term reflects an effort by First Nation and other indigenous communities to distinguish their concepts of gender and sexuality from those of Western LGBTTTIQ communities.

WSW: refers to any woman who has sex with a woman, whether she identifies as lesbian, bisexual or heterosexual. This term highlights the distinction between sexual behavior and sexual identity (i.e., sexual orientation). For example, women who identify as lesbian can also have sex with men and not all wsw identify as lesbian or bisexual.

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