

RETHINKING LGBTQ HEALTH

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Introduction

In 2005 the *Integrated Pan-Canadian Healthy Living Strategy* (HLS) was introduced in order to reduce the incidence of overweight and obesity, improve diets and increase rates of physical activity and “to improve overall health outcomes and to reduce health disparities” (Public Health Agency of Canada, 2005). Healthy living as a concept and phrase is familiar to many people in Canada because of the increased panic surrounding obesity in North America and the push by governments, practitioners, and others to address this new “epidemic”. While the HLS may be familiar, it is not necessarily appropriate or relevant for everyone living in Canada. According to the Public Health Agency of Canada, the HLS is “grounded in a population health approach, which strives to address some of the root causes that lead to poor health outcomes” (Public Health Agency of Canada, 2005). In targeting “the entire population”, however, the HLS effectively ignores the needs and experiences of many sub-populations. For example, the HLS emphasis on healthier body weights, improved diets and increased levels of physical activity pays limited attention to the privilege and resources needed to understand, plan for and enact prescribed strategies for healthy living. Simply put many people living in Canada lack the personal, social and community resources necessary to respond to the messages in the HLS.

In order to better understand the shortcomings and implications of the HLS, we must explore the needs and experiences of populations that are not represented or acknowledged. This paper focuses on Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) health because these communities have specific and diverse needs when it comes to understanding health and healthy living and because these needs are missing in the HLS. An examination of LGBTQ health enables us to: provide a critique of the HLS; better understand the healthy living needs of these populations, and to discuss the ways in which the exclusion of these populations from health research, policy and practice can contribute to negative health outcomes. Through this analysis we will see that many health promotion strategies, including the HLS, are inappropriate and ineffective for many communities in Canada and have the potential to harm rather than improve health.

Overview

Before we proceed with the analysis, it is important to be clear about what the acronym LGBTQ means and how we are using it. In the first section of the paper, we “unpack” the acronym, highlighting problems and challenges associated with grouping these distinct populations together under a single rubric. In the second part of the paper, we describe the overarching framework that we have adopted for analyzing the implications of the HLS for LGBTQ populations. This framework enables us to better understand the health needs, experiences, and outcomes of those marginalized by gender and/or sexuality as well as other disadvantaged populations. In the third section of the paper, we examine two specific health indicators in relation to LGBTQ communities. These two indicators help us to critique the HLS because one, body weight, is at the core of the HLS and the other, sexual behaviours, is excluded from the HLS. The fourth part of the paper revolves around transgender health and care. Some analysis of the healthy living among transgender people will emerge in relation to body weight and sexual behaviours, but most of the issues are considered separately because trans-health needs and experiences are often distinct from those of people who are marginalized based on sexual orientation. The dire state of trans-health and the gaping holes in knowledge of and care for transgender individuals in Canada are emblematic of the limitations of and problems with the HLS.

Understanding ‘LGBTQ’: The Acronym

There are several common variations on the acronym ‘LGBTQ’, all of which have been used as umbrella terms to represent everyone who identifies as Lesbian, Gay, Bisexual, Transgender and Queer.*¹ It is not uncommon within LGBTQ communities for debates to arise over which letters,

¹ The word ‘transgender’ is also used as an umbrella term, and is frequently abbreviated to “trans” or “trans*” (the asterisk indicates the option to fill in the appropriate label, ie. Transman). It describes a wide range of identities and experiences of people whose gender identity and/or expression differs from conventional expectations based on their assigned biological birth sex. Some common definitions include: a. Someone whose behaviour or gender expression does not ‘match’ their assigned sex, as defined by socially constructed gender norms; b. Someone whose gender falls outside of the man/woman binary; c. Someone who has no gender or multiple genders; d. People who ‘perform’ gender or play with it; e. An individual who is *not* undergoing medical transition, such as surgery or hormone therapy, presumably on the assumption that after transition this individual would be identified as a woman or man.

in fact, belong within the acronym as various positions are espoused by individuals and organizations depending on their political or social agendas. In health research, policy and promotion, Lesbian, Gay, Bisexual, Transgender and Queer communities are often grouped together for convenience, to create a stronger voice for advocacy, and ostensibly to improve research rigour. But, as Mollen notes, “the groups within this umbrella term are distinct and have their own specific health care needs” (2012 p 3).

The amalgamation of LGBTQ communities into a single population in health research produces information that reflects dominant assumptions about sex, gender and sexuality and ghettoizes all those who are labelled ‘not heterosexual’. This use of the acronym also treats LGBTQ health needs and experiences as singular and identical. As Mule, Ross et al. note, LGBTQ populations “for the most part, have not been recognized as an identifiable population[s] within the health care sector” (Mule, Ross, et al. 2012 p. 3) with the exception of the focus on gay men and HIV transmission. Whether LGBTQ communities are ignored entirely or selectively included they are subject, systematically to “the insidiousness of heterosexism²... and cis-genderism³” (Mule, Ross, et al. 2012 p.3). Heterosexism is the “ideology of heterosexuality, in which normative existence and reproduction is based upon traditional heterosexual ideals” (Mule, Ross, et al., date, p. 3). That is to say, hetero-sexism assumes straightness, making same-sex or queer relationships and attractions invisible, if not impossible. Similarly, cis-genderism, commonly referred to as cis-sexism, presupposes the pairing of masculine genders with male-assigned sex, and feminine genders with female assigned sex. In other words, it is assumed that those with male bodies always identify as men and those with female bodies always see themselves as women. Furthermore, the term “cis-gender refers to a traditional binary perspective on gender that assigns strict gender roles to males and females without acknowledgement of overlapping gender characteristics, transitioning between genders or not identifying with either of the traditional genders.” (Mule, Ross, et al 2012 p. 3). These are important terms to understand when conducting research with or assessing the health and well-being of LGBTQ populations.

² Heterosexism is the “ideology of heterosexuality, in which normative existence and reproduction is based upon traditional heterosexual ideals” (Mule, Ross, et al. p 3).

³ “Cis-gender refers to a traditional binary perspective on gender that assigns strict gender roles to males and females without acknowledgement of overlapping gender characteristics, transitioning between genders or not identifying with either of the traditional genders.” (Mule, Ross, et al. p3).

The use of acronyms can be helpful in discussing issues that affect a group of people experiencing common barriers/discriminations, but they also mask or misrepresent differences within these same populations. Admittedly, the communities grouped together under the LGBTQ acronym share some experiences as their marginalization involves sex, gender and sexuality; however, it is dangerous to assume that these experiences are all the same. Just as it is important to provide a gendered analyses of men's and women's experiences of health, so too it is important to acknowledge that the experiences of gay men may be vastly different from those who identify as lesbian, bisexual or transgender and vice versa. It is consequently imperative to be conscious of how these terms are used in research, policy and practice and to be both clear and deliberate about which specific populations are included, excluded or are rendered invisible in any analysis.

So what does this acronym mean and how do we use it without excluding certain communities? Barriault and Sheffield argue for the use of the singular term "Queer" to designate sexual and gender variant marginalized groups. They contend that all acronyms are problematic: "we could use the popular acronym LGBT (or GLBT) knowing that it excludes some members of the group; or, we could use the more inclusive acronym LGBTTTITSQ, which is admittedly cumbersome" (Barriault and Sheffield, 2009, p. 120). At the same time, while the term "Queer" would appear to be more inclusive, it too does not recognize the diverse sub-populations in these groups. Having acknowledged the limitations of a single acronym – or, indeed a single term – we have chosen to use sub-sets of the acronym – LGB, LGBT, LGBTQ, etc. – to more accurately reflect the specific populations under discussion. This will allow us to explore the multiplicity of groups and communities as well as what healthy living means for each of them.

A Framework for LGBTQ Health

When the diversity of any population is disregarded, it can have serious implications for health. For example, lumping LGBTQ communities under a single acronym often results in the systematic exclusion of diverse sexualities and gender identities. In other words, diverse individuals and communities are erased, misunderstood or pathologized by this approach. The concept of social and economic inclusion and exclusion, commonly referred to as SEI, provides a useful framework for thinking about the ways in which LGBTQ populations are rendered

invisible or are assumed to conform in some manner to dominant paradigms of gender and sexuality (which are often based in the assumptions about the „naturalness’ of heterosexuality). Janet Guildford writes that to be “excluded, whether because of poverty, ill-health, gender, race, or lack of education, do not have the opportunity for full participation in the economic and social benefits of society” (2000 p 3). Economic privation is both a type and a primary cause of exclusion, but exclusion can also arise from other factors, such as race, language, and sexuality, that are fundamentally social in nature. As Pirani notes, SEI is multi-dimensional, meaning that “the evaluation of the individuals’ standard of life cannot be based merely on economic indicators”, but also must consider opportunities and services available to the community of reference (Pirani 2009 p.11). Further, SEI not only enables us to think about the conditions that limit participation in community life, but also to reflect critically on the nature of community life itself. SEI encourages us to foster social change as well as individual empowerment.

SEI provides a helpful framework for assessing the current state of LGBTQ health in Canada and the potential benefits or harms of healthy living strategies for these communities. SEI is a self-reinforcing process. Social exclusion compromises economic inclusion and economic exclusion, in turn, limits social inclusion. This dynamic process produces and reproduces inequities within and across populations and is reflected in research, education and information, institutions and policies, and planning and interventions. For example, human rights legislation and health care coverage rely heavily on research to guide and support policies and practices. Research that ignores or misinterprets the needs of specific populations will result in flawed or harmful policies and practices that may then compromise human rights and access to health care for these populations.



LGBTQ people, like other marginalized populations, experience both social and economic exclusion on a regular basis. However, exclusion also takes specific forms for these

communities. For the purposes of this discussion, we want to consider two main types of exclusion: “erasure/invisibility” and “limited/regulated inclusion”⁴. Erasure/invisibility refers to the total exclusion of LGBTQ people from research, policy, practice, or action. For example, Canada’s main health survey, the Canadian Community Health Survey (CCHS), only added questions on sexual orientation in 2003 (Statistics Canada, 2003) and it does not acknowledge or include transgender or gender-variant populations at all. Nor is the disregard of LGBTQ populations limited to the CCHS or the HLS. As Mule, Ross et al. note, “populations marginalized by gender identity and sexual orientation have, for the most part, been excluded from mainstream health promotion research, policy and practice” (2012 p 2). Similarly, researchers frequently do not frame questions in ways that would allow for LGBTQ populations to represent their health status and needs or their experiences with the health care system. Often heterosexism and cis-sexism are responsible for this type of exclusion. In other words, a normative understanding of sex and gender as binary and immutable means that researchers do not even see these populations, let alone understand that LGBTQ communities have been completely excluded from a research project or policy. Uneven and inconsistent research means that LGBTQ needs and experiences are effectively erased and opportunities to develop specific care protocols or to educate culturally competent healthcare professionals are lost. The persistent exclusion of LGBTQ needs and experiences in health promotion initiatives and healthcare services reinforces the ongoing failure to engage in research that will fill gaps in information and provide educational opportunities.

While LGBTQ people are frequently erased or rendered invisible in research projects, there are heartening efforts to include their needs and experiences in the development of educational tools, policies, and services. But these efforts may cause different types of problems if LGBTQ people are included in ways that do not recognize or accurately reflect their needs and experiences. For example, a good deal of research with Lesbians and Bisexual women treats these two populations as if their needs and experiences are identical or alternatively, researchers might

⁴ Bauer et al. (2009), in an article entitled *I Don’t Think This is Theoretical; This Is Our Lives*, describe two main ways in which transgender populations are excluded from health research, policy and practice: informational erasure and institutional erasure. These categories of exclusion correspond closely to the types identified in our framework – erasure/invisibility and limited/regulated inclusion, respectively.

refer to Lesbians and Bisexual women in their findings even though they have not been able to speak with or survey many Bisexual women. Similarly, sexual health surveys increasingly include demographic questions that allow participants to identify their sexual orientation (although it usually only allows for a gay/straight option), but the survey questions about sexual behaviour are overwhelmingly or completely focused on activities only engaged in by heterosexuals, such as a penis penetrating a vagina during intercourse. This phenomenon we might label “limited inclusion” in the sense that LGBTQ populations are made visible within health research and discourse, but information, policies, practices, and actions are based on inaccurate assumptions or lack of evidence. A more pernicious form of exclusion involves paying lipservice to LGBTQ people while still forcing them into frameworks designed for heterosexual and cis-gender people. We refer to this manifestation of social exclusion as “regulated inclusion” because LGBTQ people are represented in research, policy and practice as subjects to be managed according to dominant understandings of sex, sexuality and gender. In such cases, the needs and experiences of LGBTQ populations are deeply pathologized and medicalized, misunderstood and misinterpreted. For example, during the late 19th and 20th centuries, most psychiatrists and psychologists categorized homosexuality as a mental disorder. Indeed, the American Psychiatric Association (APA) did not remove homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1986 while gender identity disorder (GID) – usually applied to transgender individuals – remains embedded in the current DSM (Herek 2012). Although the APA has amended its stance on many ‘sexual pathologies’, the cycle of social exclusion continues because the stigma that these diagnoses creates continues to foster negative perceptions about LGBTQ populations as well as discrimination and marginalization.

Understanding issues of social exclusion and health for LGBTQ populations is critical in order to design and implement appropriate strategies for healthy living. We can see examples of heterosexist and cis-sexist thinking simply by looking at gaps, where we do not see the inclusion of LGBTQ people. It is very common, for example, for survey research, identification cards, and many other official government forms to ask for the “gender” of the respondent with two check boxes available: male or female. For many cis-gendered people, these boxes are just another tick on a form, but for transgender individuals, this approach “ultimately inscribes transexuality as

impossible” (Bauer, Hammond et al, 2009 p. 350). Ussher argues that erasure when researchers fail to ask about sexual orientation or gender identity “when collecting demographic information on participants, which discursively means that LGBTQ individuals do not exist” (Ussher, 2009 p 561). The result is not only a lack of data, but also the complete erasure of whole communities, with predictable consequences for their health. Usher asks, if there is “no epidemiological data on our experience, no statistics on how many of us endure a particular health problem, how can there be theories or practices that address our particular needs or concerns?” (Ussher 2009 p.561).

We need to acknowledge that systemic hetero-sexism and cis-sexism – which are directly related to homo/bi/and trans-phobia – create a lack of information about and representation of LGBTQ people. This, in turn, can lead to “negative health effects such as increased rates of alcohol and drug use, greater risks for sexually transmitted infections, and high rates of depression and suicide” (Mule, Ross et al. 2012 p 2) Limited/regulated inclusion is also harmful to the health of LGBTQ populations because it can perpetuate health inequities by supporting misinformation, stigma, and discrimination. If we hope to address the health needs of LGBTQ populations, we have to work against social exclusion and gain a better appreciation of the specific and distinctive needs of each of the communities represented under the umbrella acronym.

LGBTQ People of Colour (POC) – A Critical Examination

In addition to understanding the health needs and experiences of LGBTQ people that are tied directly to their gender identity and sexuality, we must also address the ways in which sexual orientation and gender identity intersect with other social locations and identities. By looking at the needs and experiences of LGBTQ people of colour (LGBTQ-POC), we can begin to see how intersecting forms of oppression and exclusion affect health. We can also begin to appreciate the importance of attending to diverse identities and intersecting oppressions when creating strategies for healthier individuals and healthier communities.

While research with LGBTQ people is scant, information about LGBTQ-POC is even rarer. In a review of research, Balsam, Molina, et al. found that “LGBT issues were addressed in 3,777 articles dedicated to public health; of these, 85% omitted information on race/ethnicity of

participants” (Balsam, Molina, et al., 2011, p. 163). This means that even within excluded LGBTQ populations, people of colour are largely absent, doubly excluded. Understanding the experiences of LGBTQ-POC helps us to appreciate the ways in which racism and hetero/cis-sexism intersect to create greater barriers to health and healthy living. It also highlights the importance of addressing health disparities through these intersections of race, gender identity and sexual orientation. Majied argues that people of colour “may feel alienated from the LGBTQ community at large, and find it difficult to integrate their sexual orientation with their [racial] identity” (Majied, 2010, p. 152) because of adverse experiences or explicit racism within LGBTQ communities. At the same time, LGBT-POC may feel alienated from their racial/ethnic communities as a result of heightened levels of hetero-sexism or homophobia (Balsam, Molina et al 2011). Both experiences contribute to exclusion and can cause or exacerbate stresses and health risks for LGBTQ-POC populations. Balsam, Molina, et al. note that, “Situations in which minority individuals are excluded or their experiences are negated can also lead to reduced use of health services for sexual and racial/ethnic minorities” (Balsam, Molina et al 2011 p 165).

Lack of attention to both sexual and racial/ethnic minorities draws attention to the limits of the dominant discourse of healthy living, specifically its inability to address the determinants of health, including diverse forms of marginalization and oppression. This is not to say that the solution to exclusion is a simple one. The example of research and policy responses to the HIV/AIDS pandemic underscores the challenge of understanding and responding to the needs and experiences of LGBTQ populations. During the early 1990s, researchers worked to expand their understanding of HIV transmission by focusing on the role of behaviour, rather than identity, as a driver in the epidemic. The terms “MSM” (men who have sex with men) and “WSW” (women who have sex with women) were introduced in an effort to engage with individuals who participated in homosexual sex but who did not necessarily identify as Gay, Lesbian, or Bisexual and so did not see themselves as at risk of exposure to the virus. Unfortunately, as this terminology became more common it also became racialized, with the term MSM being largely associated with men of colour, whom are often assumed to be lower class, while the terms Gay/Bisexual become identified almost exclusively with white men. As Young and Meyer observe, “white men [are] read as synonymous with gay identity while it is assumed that men of colour engage in sex work rather than sex for pleasure and [their

experiences are] devoid of identity or community” (Young and Meyer, 2005, p.1145). These assumptions not only fail to capture the complexity of experiences and identities within LGBTQ communities, they also make it impossible to develop effective and appropriate responses to the needs of diverse LGBTQ people.

In order to identify, address and reduce health disparities within the LGBTQ community, we must acknowledge them all, represent them all, include them all. For years, advocates for racial and ethnic rights have drawn attention to the need for „culturally competent’ policies and programs, including “the use of interpretive services, racially or linguistically concordant clinicians and staff, culturally competent health education” (Groman et al., 2004, p 226). From anti-racist education to culturally specific health-care practices, the key point is the need for adequate representation of marginalized groups, including LGBTQ-POC.

The case of LGBTQ-POC underscores the importance of developing more complex understandings of health, healthy living, and the intersections of gender identity, sexuality and social location. In doing so, we can begin to assess the current state of research and policies, such as the *Integrated Pan-Canadian Healthy Living Strategy*, and to improve them by incorporating the health needs and experiences of LGBTQ populations. Other groups that are systematically marginalized in Canadian society would also benefit from this approach.

Weight and Health

The HLS is a prime example of LGBTQ populations being rendered invisible in health policies and programs: it does not acknowledge or address their needs and experiences when it comes to health and body weight. The erasure of LGBTQ populations in the HLS is partly a function of limited research in the area of health, weight and sexual minorities. As we will see, much of the research addresses rates of overweight and obesity among Lesbian women though there is increasing attention being paid to the needs and experiences of some Gay men. Even when LGBTQ populations are addressed in research on weight and health, their inclusion is often limited and/or regulated – their needs and experiences are investigated and evaluated in relation to those of heterosexual populations. An analysis of research related to health and body weight

among LGBTQ populations consequently not only exposes the limits of the HLS and the research that underpins it, but also demonstrates the critical importance of including non-heterosexuals – and other marginalized populations – in health promotion research, policy and practice. The dearth of inclusive, culturally competent research creates real risks of misunderstanding the needs and experiences of LGBTQ populations, and can result in the creation of policies and programs that may do more harm than good. Because there are some significant differences in the research findings for Lesbian, Gay, Bisexual and Transgender individuals, we will deal with each of these sub-populations separately.

Lesbian and Gay Women (LG)

When it comes to discussing the specific health issues of lesbian and gay women, there are barriers to finding inclusive and competent research. Mays et al (2002) identify many limitations to health research on lesbian and gay women, such as reaching a population that is often hidden or invisible, having to rely on relatively low sample numbers, and attempting to access a population that is often geographically dispersed. The authors describe these issues as “important methodological limitations that are difficult to overcome” (2002 p 638). However, discussions of overweight and obesity in these populations are steadily increasing in the literature.

Incorporating a gender lens and our framework of social and economic inclusion and exclusion is valuable because bodyweight, body satisfaction and dieting among women in North America has been recognized as a gendered health issue (Morrison, Morrison, Sager 2004; Fogel, Young et al. 2012; Deputy, Boehmer 2010). By incorporating different perspectives on what we know and don’t know about LG weight and health, this section provides a useful critique of the dominant assumptions that characterize the HLS, and identifies direction for future research with lesbian and gay women.

While there are no national surveys that specifically address the health of Lesbian and Gay women in Canada, there is some discussion of LG women in the research. In particular, many studies compare LG and heterosexual women’s body weights and body satisfaction ratings. Considerable amounts of work have been devoted to the hypotheses that Lesbian women have higher BMIs and are at higher risk of obesity than their heterosexual counterparts (Morrison, Morrison, Sager 2004; Fogel et al 2012; Yancey et al 2003; Bowen, Balsam, Ender 2008). But

the findings are mixed. Some studies conclude that there are no significant differences between Lesbian women and the general female population when it comes to body weight (Yancey, et al. 2003); others have found that “SMW (Sexual minority woman) status was associated with a greater likelihood of obesity” (Bowen, Balsam, Ender, 2008, p 223). Additionally, one study analyzed rates of obesity among lesbians from different racial or ethnic groups, concluding that “being overweight is a common health risk for racial/ethnic minority women...however, in the majority of comparisons made within racial/ethnic minority groups, there was clear evidence of greater prevalence rates of both overweight and obesity among lesbians” (Mays et al 2002) p 632). In this study, sexual orientation appeared to trump race in rates of overweight and obesity.

Interestingly, while Lesbian women are sometimes depicted as heavier than heterosexual women, research has consistently demonstrated that they are “less likely than women in the general population to report that they consider themselves overweight” (Bowen, Balsam, Ender, 2008, p 223). Peplau et al. also found that “lesbian women report ... significantly higher body satisfaction than heterosexual women” (Peplau, Frederick, Yee, et al., 2007, p 714). These are important factors to consider when discussing weight and health, when there is “consensus that many women experience pressure to conform to a very narrowly defined body ideal” (Koff et al. 2010 p 255) and this pressure often results in poor body image and negative health outcomes, such as disordered eating (Koff et al. 2010). At the same time, some research indicates that lesbians, regardless of their body weight, are more likely than heterosexual women to participate in physical activity (Boehmer et al. 2007). These findings suggest that while body weight *may* have an impact on physical health, specific ranges of body weight do not necessarily coincide with good mental or physical health. Whether or not lesbian and gay women actually are heavier than heterosexual women, this research encourages us to ask both why lesbian and gay women might be at high risk of overweight and obesity and if, in fact, higher rates of overweight and obesity among LG women are detrimental to their health and well-being.

A recurrent theme in the limited research on LG women’s body weights is that lesbian and gay women experience less cultural pressure to adhere to dominant beauty ideals, which are seen as driving women’s desire to be thin. Research findings in this regard are also mixed, with some investigators describing lesbians’ immunity to such standards (Morrison et al. 2004), and others

claiming that lesbians experience the same type and degree of body dissatisfaction as heterosexual women (Koff et al 2010). These conflicting results underscore the complexity of the relationship between body image, body weight and health for women who identify as gay or lesbian and this complexity should be addressed in health research and promotion. Moreover, some of this research we might characterize as limited inclusion – the needs and experiences of Lesbian women in this work are often framed in relation to heterosexual women, as if sexual orientation is the only or the most salient difference between these populations. In other words, since many heterosexual women are obsessed with weight and oppressed by the “thin model”, researchers are asking the same questions about LG women.

Similarly, research with LG women often ignores or misinterprets gender presentation and its impact on weight and body satisfaction. “Gender presentation” comprises the ways in which individuals express their gender and the ways in which their gender is read by others. Often researchers assume that lesbians are stereotypically androgynous or masculine presenting. Some LG women may present as butch/masculine, but others present as femme/feminine and many individuals present gender on a spectrum that is not necessarily consistent or unchanging. These differences are important because they influence sense of self and body and, therefore, health. In one study, for example, Lesbian women with a “self-rated ‘feminine’ appearance and with more heterosexual friends reported less satisfaction with their bodies” (Bowen, Balsam, Ender, 2008, p. 223) Feminine or ‘femme’-identified lesbian women may have lower body satisfaction because they may be more likely to relate to “media images [that] portray very slender bodies as the ideal body type for women” (Peplau, Frederick, Yee et al. 2007 p 714), which are, arguably, targeted at feminine-presenting, heterosexual women. In some studies on LG women, researchers provide the option for participants to indicate their “gender presentation” and incorporate this information into their analyses, but the vast majority do not consider gender presentation in their investigation of or conclusions about health risks for sexual minority women.

The failure to adequately represent the diversity of LG women can be attributed, in part, to “the dominance of a biomedical paradigm that narrowly understands LGBT health” (Bohmer 2010 p 1134) and women’s health in general. The concentration on body weight as the primary indicator of health has particular effects on populations that are excluded from privileged positions in

society, especially women. Further, the emphasis on physical health ignores other types of well-being and in so doing misses one of the most salient aspects of LG women's experience – stigma and discrimination. The stigma and discrimination endured by LG women probably has a greater impact on their health than does their weight. The moral panic over overweight and obesity that dominates health promotion means that health-issues of greatest import for or specific to Gay- or Lesbian- identified women receive little or no attention.

New and innovative strategies must be implemented to respectfully include LG women in health research, policy and promotion. This involves an approach to healthy living that eschews the dominant biomedical understanding of the body in favour of a more holistic understanding of health that allows for the needs and experiences of diverse or marginalized communities to be heard and addressed.

Gay Men

While much of the research on weight in sexual minority populations focuses on lesbians and gay women, research on gay men's body weights and health has begun to emerge. To date, this research is modest in scope, possibly because gay men have not been flagged consistently as an at-risk population for overweight or obesity. Moreover, as with research on LG women and weight, research on gay men and weight often compares them to heterosexual men. One study, for example, found that gay men are "58% less likely to be overweight or obese compared to heterosexual men" (Deputy 2010). Interestingly, this study also noted that the homosexual male participants had a "higher level of education...higher annual household income, [were] US born, and [were] in better general health compared to straight men" in the sample (Deputy 2010). This difference in the populations under study is significant in a couple of ways. First, much other research has demonstrated that rates of overweight and obesity and ill health are much higher in populations that are poor or disadvantaged in other ways. As with the comparisons made between LG and heterosexual women, sexual orientation is prioritized over other characteristics of experience and identity, with the result that gay men are included in limited and regulated ways. Second, research on gay men often involves those in privileged social or economic positions, who are not representative of the entire homosexual and bisexual male population. If

research focuses only on middle class, white gay men, other sub-populations will be understudied or erased.

While gay men appear to be at lower risk than heterosexual men of being classified as overweight or obese, they nonetheless experience particular weight-related health risks. Yelland and Tiggemann (2003) suggest that within the gay male subculture there is a ‚gay ideal’ that “involves being both thin and muscular” (p 114). This ideal has been associated with heightened “dissatisfaction with the body [which] has been clearly linked to restriction of food intake” (Conner, Johnson, Grogan, 2004; Lavesque and Vichesky, 2006). Research demonstrates that gay men who aspire to this ideal “engage in behaviours ... making them potentially more vulnerable to the development of eating disorders than their heterosexual counterparts” (Yelland, Tiggemann, 2003; Feldman and Meyer 2007). Similarly, gay men who strive for a bodies that are both thin *and* muscular “will be even more likely than heterosexual men to engage in activities aimed at increasing muscularity such as exercise and steroid or dietary supplement usage” (Yelland, Tiggemann, 2003; Feldman and Meyer 2007). These men may also participate in strenuous physical activity while not eating enough to support their caloric or nutritional needs.

These findings are important because, historically, concerns about underweight, disordered eating and eating disorders have focused on women, especially young women and female adolescents. In some ways, this emphasis is not entirely surprising. Studies that have attempted to correlate the experiences of gay men and heterosexual women with body weights, have found that women are still more likely to be negatively affected by thin ideals of beauty: women make up “90% of those diagnosed with eating disorders... and express greater body dissatisfaction than men”, regardless of the sexual orientation of the men (Lavesque and Vichesky 2006). Male privilege and patriarchy continue to disadvantage women and threaten their health and well-being. Nonetheless, the number of gay men who are at risk of illnesses related to poor and insufficient diets, the use of dangerous dietary supplements, and excessive physical activity is growing and their needs and experiences have not received sufficient attention.

As with LG women, research on gay men and health must also attend to gender expression. The construction of the “gay ideal” described above relates only to a specific subculture of gay men who are generally understood to be mainly white and middle class (Young and Meyer 2005). Not all gay men aspire to this ideal. Some subcultures embrace a more normatively masculine presentation, which would impose different expectations on bodies and have different implications for healthy living. For example, Kampf describes the subculture of „bears” who “are usually mature gay or bisexual men with hairy bodies and facial hair who are heavy-set” (2000). According to Gough and Flanders, “bulk is positively embraced in the gay “bear” subculture wherein physically big (and hairy) gay men are privileged as sexually attractive” (Gough and Flanders, 2009). For those who fit within this sub-community, health issues or outcomes may differ from those of mainstream, gay communities especially as „bear communities promote an ethic of tolerance and celebration of larger, masculinized (but not necessarily muscular) male bodies” (Hennen 2005 p 26). This research shows that applying one ideal or standard of health to communities of gay men, as well as other sexual minority populations, is inadequate, at best, and dangerous, at worst. Understanding gender expression and sexual orientation as separate spectrums that intersect with each other is critical for research, programs and policy that are relevant, effective and culturally competent.

Bisexual Populations

The exclusion of bisexual populations in research on LGBTQ populations is a growing concern in the literature. (Schick and Dodge 2012; Mathy, Lehmann and Kerr 2003; Namaste, Vukov and Saghil 2007; Bostwick 2012). Part of the reason for this concern is the fact that the small amount of research that considers the health of bisexual women and men suggests that they are at substantially increased risk of poor health outcomes, especially those related to stigma and discrimination, such as poor mental health, increased use of drugs and alcohol, and other risk-taking behaviours. In fact, “current studies suggest that bisexuals may have the poorest rates of mental health and the highest rates of health service use compared with lesbians, gays and heterosexuals” (Rainbow Health Ontario, *Bisexual Health Fact Sheet*). They also have much higher rates of suicidal intent than gay males, lesbians and those who identify as heterosexual (Mathy, Lehmann and Kerr 2003).

Among sexual minority populations, bisexual women and men are probably at greatest risk of being generalized into research on other populations, homosexual and heterosexual. According to Schick and Dodge, “bisexuality has often been subsumed under the label of ,homosexuality” (2012 pp 161) but we can also think about ways that bisexuals may also be lumped in with straight populations. In other words, it is not always clear to researchers where bisexuals fit, or whether their sexuality makes them different demographically from either or both homosexuals and heterosexuals. This confusion results in *both* invisibility/erasure and limited/regulated inclusion. On the one hand, Namaste, Vukov and Saghil note that “public health research and education only consider bisexual men (if inadequately), leaving the realities of bisexual women unaddressed” (2007 p 360). In such cases, bisexual women are effectively erased from the research. On the other hand, women who identify as bisexual may be mentioned in research but their needs and experiences may not be addressed in a substantive way. For instance, in a recent review of 19 studies on obesity issues in sexual minority women, Bowen, Balsam and Ender (2012) found that most “combined the bisexual women together with lesbians in the study analyses. In our review of the studies, there was not usually enough data on bisexual women to report them separately. It is likely that bisexual women may be very different on some variables, compared to women who partner exclusively with women” (Bowen, Balsam and Ender, 2012, p.223).

The case of body weight underscores the importance of inclusive research with bisexual populations because their needs and experiences may be distinctly different from those of heterosexual and other sexual minority populations. For example, some studies demonstrating that lesbian women tend to be heavier and more accepting of larger bodies than heterosexual women, have suggested that this difference arises from the preference of sexual partners, homosexual female versus heterosexual male. Whether or not this is the case, it doesn’t help us to understand the experiences of bisexual women, who may be involved romantically and intimately with both males and female. Are bisexual women then more likely to avoid or be vulnerable to the pressure of dominant heterosexual ideals of thinness and beauty? According to some studies, bisexual women who have more straight than queer friends may be at increased risk for body dissatisfaction and unhealthy dieting. As Ludwig and Brownell noted in their study on lesbian and bisexual women’s body image, “those who have mostly heterosexual women, gay

men, or heterosexual men as friends were expected to be less satisfied because of greater appearance pressure in these groups” (1999 p 92). Taub also found that bisexual women may feel pressure to adhere to dominant or mainstream standards of beauty, particularly when in straight circles or with their male partners (Taub 1999). More research is also needed on bisexual women’s relations with gay and lesbian culture as bi-phobia may also contribute to alienation and a closer identification with negative heterosexual expectations and ideals.

While bisexual women are often represented inadequately in research, bisexual men are all but invisible, particularly in examinations of body weight (Namaste, Vukov and Saghil 2007). Indeed, a search for literature on bisexual men and overweight and obesity yielded a few studies on eating disorders and disordered eating and sexual minority populations that ostensibly included bisexual men and boys (Feldman and Meyer, 2007). As with research on bisexual women’s health, these studies lumped bisexual men in with gay men for the purposes of recruitment, sampling and analysis. Their findings that disordered eating and eating disorders are more common among homosexual than heterosexual men tells us nothing about the needs and experiences of bisexual men when it comes to weight, diet and exercise. Moreover, the vast majority of research on bisexual men’s health revolves around HIV/AIDS transmission and sexual behaviour as it relates to their relationships with men. Bisexual men’s health is consequently addressed largely in ways that medicalize and pathologize them.

Transgender Populations

Although there is virtually no research on transgender health and healthy living, it is important to highlight dimensions of current approaches to healthy living that have implications for these populations. In particular, we want to focus on body mass index (BMI), the standard approach to measuring body weight. Many authors have critiqued the BMI. As Mascie-Taylor and Goto note, “number of studies over the past decade or so have shown that the relationship between BMI and %BF is not only age- and sex-dependent, but also differs among ethnic groups” (Mascie-Taylor and Goto, 2007, p. 110). Nonetheless, much research and both policy and practice guidelines rely on this measure to determine whether or not individuals are at a ‘normal’ or healthy weight. In the case of transgender individuals, the use of the BMI is additionally problematic. We need to ask, for example, whether it is appropriate to use BMI calculations

based on an individual's birth-assigned sex, particularly when they are undergoing transitioning treatments, such as hormone therapy or surgery. There is some evidence that hormone changes in trans-women can effect bone mass and density, (Reutrakul et al 2001), which could, in turn, affect BMI and conclusions about their weight and health. Similarly, the effects of testosterone hormones on muscle mass and bone composition may mean that BMI does not accurately reflect the health and weight of trans-men. In such cases, individuals may be deemed at risk of ill health when they are not, and vice versa. As the section on trans health will show, these kinds of issues are not the most pressing, but they are worthy of further study and should be considered in discussions of healthy living and health promotion.

Summary

This analysis of LGBT populations and weight serves as a compelling critique of dominant approaches to health promotion in Canada, particularly healthy living strategies. First, it demonstrates that there is an alarming dearth of research on all communities that tend to be lumped together under the acronym of LGBTQ. Second, the information that is available for or about those in LGBTQ communities is often flawed or inaccurate. Indeed, health promotion initiatives that focus on the entire population tend to frame questions and answers in a hetero-normative way that alienates and excludes non-heterosexuals from competent and reliable health care. Third, this analysis exposes the shortcomings of the healthy living discourse and health promotion initiatives with respect to the needs and realities of sexual minority groups. Understanding the complexities of LGBTQ experiences of body weights, dieting, and physical activity is crucial to the formulation of informed, culturally competent approaches to health and care.

Sexual Behaviour and LGBTQ Health

Sexual health and risk are not typically found among the health indicators upon which many healthy living initiatives rest. This is certainly the case for the *Integrated Pan-Canadian Health Living Strategy*. Sexual health is important for every population, but it may be even more so for homosexual, bisexual and transgender populations because their sexuality is often the focus of research and policy and the source of stigma and discrimination. For example, much of the

research and policy in this area does not actually focus on health at all, but rather on specific diseases, such as STIs and HIV/AIDS. This approach to LGBTQ health has increasingly been described as “illness based” (Mule, Ross et al. 2009) or disease-centred because of the overwhelming emphasis on sexually-transmitted illnesses, especially HIV/AIDS. This is a prime example of regulated inclusion. Sexual minority populations are represented in ways that pathologize them, that expose them to “discrimination, social stigma, and negative stereotypes” (Mollon 2012 p 3). Even the introduction of the acronyms MSM and WSW have had unintended consequences. These terms were intended to describe certain types of *behaviours*, but instead it has been treated as another category of identity and is often used *in place* of describing behaviours that might heighten risk of HIV infection (such as anal sex, or the sharing of sex toys). Misunderstanding and misrepresenting LGBTQ populations in these ways can directly contribute to negative health outcomes. In other words, “the same social forces, including homophobia, hetero-sexism, and sexism that have previously led to exclusion might now lead to inappropriate and even damaging programs” (Meyer 2001 p 856). Moreover, the overwhelming emphasis in HIV/AIDS research and health promotion on queer communities has the potential to cause harm if other dimensions of health are ignored. As Meyer (2001) argues, “LGBT people may be at high risk for problems that are not directly related to sexual orientation or gender identity” (2001 p 856).

Research on every sub-population represented by the LGBTQ acronym is shaded by these kinds of ideas and assumptions. The implications of this approach to research and policy for the health of Lesbian, Gay or Bisexual populations are alarming. As we explore the research on the sexual health of LGBTQ communities, we can begin to see where public health initiatives need to improve and where there are gaps that should be addressed.

Again, because different sub-populations have different experiences, face different risks and are represented differently in the literature, we will discuss them separately.

Lesbian, Gay and Bisexual Women (LGB)

By comparison with the research on weight and LG women, the sexual health of Lesbian, Gay and Bisexual women has been largely ignored. This lack of attention is linked to the

overwhelming emphasis on sexual risk related to the behaviours of gay and bisexual men. In large measure then, LGB women are erased from research and policy on sexual health. When health promoters and practitioners do address LGB women's sexual health, they have tended to assume that "sex between women is risk free" (Namaste, Vukov, Saghie 2007 p 361). This conclusion may be based on the erroneous assumption that sex between women does not involve penetration. Similarly, studies and programs that ostensibly include LGB women tend not to describe sexual behaviour at all. As Fethers, Marks and Mindel have noted "those studies that have included WSW often lack information on specific sexual practices" (2000 p 345). As a result, we lack a clear understanding of which behaviours might create or heighten risk for LGB women or WSW. We might then describe this inclusion of LGB women as limited or regulated in that normative heterosexual behaviours are invoked as the standard of safety and risk. The net effect is that LGB women are left without specific, culturally-competent information about STI's, HIV/AIDS, and safer sex.

A small body of research indicates that HIV/AIDS and other STI's are, in fact, a risk for WSW. According to one study, female injection-drug users who had sex with women were at higher risk of HIV/AIDS (Young and Friedman et al. 2000). Similarly, other researchers have reported that aggressive use of sex toys allows for the exchange of "blood-tinged body fluids" that could heighten the risk of HIV transmission between women (Kwawka and Ghobrial, 2002, p 84). These kinds of studies underscore the importance of acknowledging and addressing the sexual health needs and experiences of LGB populations in health promotion and healthy living.

Gay and Bisexual Men (GB)

Gay men are often the focus of LGBTQ health research. Indeed, their needs and experiences are often assumed to be representative of all queer and transgender communities. In the case of research and programming on sexual behaviour and HIV/AIDS transmission, this attention can be detrimental to the health of GB men. As Meyer points out, "the area most often addressed under this category is risk related to sexual behaviour (e.g. anal intercourse, which places men who have sex with men at risk for HIV and other STIs)" (Meyer 2001). Not only are these initiatives built on the assumption that sex between males always involves anal penetration, but also it ignores the fact that these sexual behaviours are not confined to homosexual populations.

As Baldwin and Baldwin note, “although anal intercourse among gay men and bisexuals has received a great deal of attention, considerably less research has focused on heterosexual anal intercourse among heterosexuals, even though the prevalence of heterosexual anal activities has been well documented” (2000). In this instance, Gay and Bisexual men are included in research and policies in limited and/or regulated ways that treat them as sexually „deviant’. This tendency to pathologize the sexual behaviours of Gay and Bisexual men is then generalized to other LGBTQ populations.

An example of the adverse effects that ill-informed or biased health campaigns can have is the blood ban instituted by Canadian Blood Services in 1988 which has only recently considered a change in policy (CBS 2012). As Rachel Lake writes in her article *MSM Blood Donation Ban: (In)Equality Gay Rights, and Discrimination Under the Charter*, “If you are a sexually active gay or bisexual man, or a man who has ever engaged in sexual acts with another man (regardless of sexual orientation) then you are banned for life from donating blood” (2010 p 136). Canadian Blood Services maintains that MSM are excluded from blood donation because they are at higher risk of having and therefore transmitting HIV. But Lake points out that this stance has been invoked only against MSM rather than becoming a guideline for anyone engaging in risky sexual behaviours. Canadian Blood Services does not, for example, include anal sex as a category for HIV risk and exclusion from blood donation nor does it include any risk identifiers for heterosexuals. Lake writes, “The organization does not identify risky sexual behaviours that actually increase the chances of HIV infections; rather, it creates a policy that makes a sweeping generalization about a group of people (gay men) based upon a perceived characteristic of that groups (engaging in non-monogamous or promiscuous sexual behaviour)” (Lake 2010 p 137). In creating this type of “disease-associated stigma”, CBS not only supports homophobia, but also threatens the health and well-being of MSM and GB men. As Link and Phelan (2006) note, “the fear of being labelled with the disease may cause individuals to delay or avoid seeking treatment altogether, while those already labelled may decide to distance themselves from the label, forgoing treatment or becoming noncompliant” (Link and Phelan 2006 p 529).

The examination of GB men and MSM in health research and promotion is a useful example of regulated inclusion. It also exposes the limits and perhaps the dangers of the current construction

of healthy living, with its focus on bodies and diseases. As long as public health discourse relies on a narrow definition of health, important dimensions will be missed or ignored, especially when dealing with marginalized populations.

Transgender populations

A fuller account of transgender health will follow this section, but it is important to consider at least a few examples of what we know and don't know about sexual health among transgender populations. As with a great deal of other research on sexual minority populations, HIV/AIDS receives a considerable amount of attention in transgender health. This emphasis is linked, in part, to reports of high prevalence of HIV in transgender populations (Bockting et al., 2005; Boyce et al., 2011). But, interestingly, there is no differentiation between the risks facing trans women and trans men, nor indeed is there any discussion of the specific sexual behaviours that create or heighten risk of infection. At the same time, there seem to be assumptions about sexual orientation at play in some of this research. In one study of sexual health services in Guatemala City, for example, the researchers grouped MSM with transgender people as their target population (Boyce, et al. 2011). In a second article, based on the same study, the researchers grouped GB men, MSM and male-to-female transgender individuals. Both of these reports seem to suggest that the transgender populations involved were not considered heterosexual or bisexual simply because they had had sex with a male partner in the preceding 12 months. Given that male-to-female transgender individuals were targeted in the second study, questions about sexual orientation are integral – refusing to do so can lead to a blurring of sexual orientation and gender identity that does not accurately represent people's identities or sexual behaviours. It is not clear from the description of the methodology that transgender participants were asked about their sexual orientation, though the authors were fixated on describing all participants as “biological men” (Boyce, et al., 2011). In this way, research on the sexual health of transgender populations reflects many of the patterns apparent for LG men, LGB women and MSM and WSW: lumping, exclusion and limited or regulated inclusion.

There are indications that some researchers are adopting a more trans-friendly approach to investigating sexual health. In one study of online sexual health information seeking, researchers reported results by gender identity rather than by sex or sexual orientation: “Participants

identifying as male reported greater use of the internet for STIs/HIV testing and treatment information, whereas those identifying as female or female-to-male transgender were more likely to view sexual health information as irrelevant to their lives” (Magee, et al., 2011). Some researchers have also called for greater attention to transgender health, including sexual health, (Bauer, Hammond, et al., 2009), but the gaps and misunderstandings in research, policy and practice related to this population are, as we will see in the next section, vast and greivous.

Summary

When it comes to sexual health research, policy and programs, LGBTQ communities suffer both erasure/invisibility and limited/regulation exclusion. Often sexual behaviour among sexual minority populations is either not discussed or is treated as deviant and pathological. The upshot is a serious lack of accurate information about the sexual health needs and experiences of LGBTQ and a corresponding absence of culturally-competent health services and health promotion initiatives. Research and policy on LGBTQ sexual health must expand beyond the current focus on HIV transmission and must utilize approaches other than the dominant disease model. Mule, Ross et al. also maintain that, “gender and sexually diverse populations must be explicitly included in policy development for a more inclusive form of health promotion” (2009). This discussion further highlights the importance of including sexual health in definitions of healthy living. Sexuality it is a significant element in people’s lives – one that can contribute to and/or threaten health and wellness – but it is largely absent from healthy living strategies and programs. A number of paradigm shifts in our approach to healthy living and the sexual health of LGBTQ communities are needed if we hope to redress exclusion and limited or regulated inclusion of sexual minority populations in research, policy and practice in Canada.

Healthy Living and Transgender Health

As mentioned earlier, we have chosen to devote a section of this review to transgender health, first, because these populations have distinct needs and experiences when it comes to healthy living and, second, because transgender individuals face profound health disparities and inequities. Indeed, their health needs are so great, their lives so deeply pathologized, and their care experiences so challenging, that it calls into question our entire understanding of what it means to live a healthy life. In other words, the importance of body weight, diet, and exercise in

health – which are singled out in the healthy living discourse – pales by comparison with the impact of ignorance, stigma and discrimination on the health and well-being of transgender people.

It is difficult to ascertain the exact number of transgender or gender non-conforming people living in Canada because they are not included in most health and demographic surveys. This is yet another example of the erasure of sexual minority populations. At the same time, the task of enumerating the transgender population is complicated by the use of restrictive definitions: for some, definitions of trans people demands some form of physical „transition’ must have taken place for individuals to be considered transgender, while others may advocate for self-identification. In the United States, it is estimated by some researchers that approximately 0.5% of the population is transgender (Conron et al 2010). However, researchers recognize that these numbers likely under-represent the transgender sub-population. Even if we use these conservative estimates to gauge the size of the transgender population in Canada, it would still be sizeable – 100,000 to 170,000 individuals in 2012.

Despite the size of the transgender population and the profound challenges transgender people face, there is little research with or on this sexual minority population. Moreover, the research that does exist is often narrowly focused. According to Shipherd et al., research on the health of transgender populations “largely focuses on HIV/AIDS, suicide, violence, and abuse” (Shipherd, Green, Abramovitz 2010 p 95). While these health issues are undoubtedly important, they represent only the tiniest proportion of the health needs and experiences of transgender people. As Bauer, Hammond, Travers et al. state, “for people who are transgender, transsexual, or transitioned (trans), access to primary, emergency, and transition-related health care is often problematic” (2009 p 348). At the same time, the health of transgender people is jeopardized by barriers to basic needs, such as a stable income and affordable, quality housing. Personal security and freedom from discrimination are also often beyond the reach of transgender people, not only because they are “economically and socially vulnerable to caregiver/sponsor abuse, neglect, violence and discrimination” (Scott-Dixon 2008 p 34), but also because “there are few jurisdictions where basic human rights protections for transgender people exist and even fewer where they are enforced” (Bauer, Hammond, Travers et al 2009 p 1335).

The Ontario Public Health Association's *Trans Health Project* has identified a gap in trans-positive care for trans-people" in Canada (OPHA 2003) and these gaps have both direct and indirect health effects on transgender populations in Canada. For the purposes of this discussion, we will focus on three healthcare issues: access to primary healthcare services; the provision of transition-related care, and; mental health services. Clearly these topics are not mutually exclusive. For example, transition-related care should be incorporated into primary healthcare and these services – or the lack thereof – also have a profound impact on the mental health of transgender individuals. Similarly, mental health frameworks in many jurisdictions determine access to transition-related care. While these issues are interconnected, we will address them separately here in the interests of clarity. These three topics have been chosen because of the importance of primary healthcare for everyone in Canada, the critical role of transition-related care in the lives of transgender individuals, and because the realities of discrimination, isolation, alienation and oppression have a profound impact on the mental health of transgender people.

Access to Primary Health Care Services

Primary health care services for transgender individuals are the same as those for everyone. They need to be able to find a culturally competent health care provider and gain access to screening, prevention, and diagnosis and treatment services, including referrals to specialists. For many Canadians, access to primary healthcare is seen as a basic human right. The Canada Health Act states that its objective is to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Canada Health Act, RSC 1985, c. C-6, s.3). The primary healthcare needs of transgender people are particularly acute because like all sexual minority populations, they "face undue health disparities and inequities that should be addressed" (Mollen 2012 p 3). Yet as Jenner notes, the transgender "community has had difficulties with access not only to care related to the gender issues, but to primary health care generally" (Jenner, 2010 p 404). Access to primary healthcare for transgender individuals is never as simple as making an appointment or walking into a clinic. According to Bauer et al. transgender experiences include "avoidance of health care, refusal of care, difficulties getting referrals, lack of provider information on transgender issues, and uncomfortable or problematic interpersonal interactions" (Bauer et al 2009 p 350). For example, in one study conducted with transgender people, "28% of

participants had experienced verbal harassment in a doctor's office and 19% reported being refused medical care altogether because of their transgender status" (Rutherford et al 2012 p 904). Part of the challenge facing transgender people is the lack of information and understanding among primary healthcare practitioners, which is rooted in the erasure of transgender populations from research and policy. But it is also the case that transgender people are included in limited and regulated ways when practitioners focus narrowly on transition-related care and gender issues, rather than primary care (Feldman and Goldberg 2006). As Scott-Dixon notes, "Non-trans observers and clinical practitioners fixate on 'the transition' demanding with oblivious gender privilege to look, to know and to judge the most intimate details and private representations of trans people's physical selves: Names, photos, and documents, sexualities, genitals, surgeries, and the artificiality of authenticity of trans bodies as constructed selves" (Scott-Dixon 2009 p 44). This prurient interest in transgender bodies not only draws attention away from non-transition health concerns, it also creates added risk for transgender individuals. As Lane R. Mandlis argues "in medical situations, the exposure of the genitals makes trans-phobia quite likely, as medical workers most often assume that a person's genitals speak the 'truth' about their sex and gender" (Mandlis 2011 p 510). Transphobia, in turn, works to exclude transgender people from primary health care services; they delay seeking care when they are worried about "embarrassment, fear of discrimination or bias, or anxiety that family members will be informed" (Alegria 2010 p 177).

The state of primary health care services for transgender individuals and their experiences with the health care system exemplify the cyclical nature of exclusion. Social and economic inequities rooted in stigma and discrimination intensify the need of transgender individuals for primary health care services. But stigma and discrimination also lead to a dearth of accurate information as well as dangerous and potentially damaging encounters with the health care system. When transgender people feel they have to shun health care, not only does their health and well-being suffer, but also ignorance of and misunderstandings about their health and needs persist. Invisibility perpetuates exclusion and exclusion perpetuates erasure.

Access to Transition-Related Care

Transition-related care is a need that is specific to some transgender people. It involves access to gender-confirming care as well as services related to hormone therapy, androgen blockers, sex reassignment surgeries [SRS], voice coaching, and counselling. While transitioning involves more than just medical intervention, for many transgender individuals transition-related health care is a critical dimension of their health and well-being. For example, Lombardi and Davis' research found that "participants expressed deep frustrations and anxiety about [their] inability to access transition services and other vital mental and physical health services" (Lombardi and Davis 2006 p 343). Debates are waged about whether or not transition-related healthcare should be considered as part of primary health care. Some believe that these services should not be included, regarding them as cosmetic or trivial in nature. Others contend that primary health care should include transition-related care, because "the health consequences that flow from a lack of transition-related treatment affect not only mental health but also physical well-being" (Gehi and Arkles 2007 p 9). Furthermore, when individuals do not receive gender confirming care, they are put "at greater risk for interpersonal violence: those who are visibly gender nonconforming often must walk down the street in fear of being subject to hate crimes, violence, and harassment" (Gehi and Arkles 2007).

Whether or not we include transition-related health care under the rubric of primary health care, it is apparent that there are many barriers limiting access to these services. Although gender-confirming care falls within the Canada Health Act, "provincial governments have not always addressed it as such... publicly funded SRS [sex re-assignment surgery] is contested and is not universally available across Canada" (Mandlis 2011 p 509). Without public health insurance coverage for surgery, hormone and other therapies, the costs of transitioning may be crippling for some while making them entirely inaccessible to others. Economic constraints are of particular concern for transgender populations because they are at high risk of poverty, job insecurity and homelessness. As Lombardi and Davis reported, "many participants gave up their jobs to transition, and others are restricted in their employment opportunities by their obvious gender variance" (Davis 2006 p 343). Mandlis concludes that, "Refusing to publicly fund SRS leads not only to significant delays in accessing bodily integrity for those wealthy enough to be able to pay out of pocket the tens of thousands of dollars for surgery, but also to an outright denial of service

to those who are less well off” (Mandlis, 2011 p 343). Further, within transgender communities, there are some individuals who are worse off than others, including transgender people-of-colour. According to Gehi and Arkles, when funding is “limit[ed] for transition-related health care, transgender people reproduce hierarchies of race and class” (2007 p 10). Similarly, even when governments do provide coverage for SRS and other transition-related care, “the strict criteria imposed by these gender programs exclude certain groups within the overall transgender population (e.g. sex workers, drug users etc.) and in other cases, erect systemic barriers difficult to overcome for certain select groups (e.g. Aboriginal people, immigrants, refugees)” (OPHA 2003).

The seriousness of denying or limiting these services is evident in the decisions made by some transgender people to take steps to transition without medical assistance or supervision. Self-treatment for transgender individuals can include performing surgery on themselves, acquiring illicit hormones from the black market, and unsafe binding and tucking of genitals and breasts. All of these practices can lead to a variety of physical problems, including mutilation, infection, pain, bruising and other tissue damage, dizziness and shortness of breath. (Gehi and Arkles 2007). While there may be many reasons for choosing self-treatment, lack of access should not be one of them.

It is important to keep in mind that not all transgender people want to use medical transitioning treatments – or not all of these services. This is a further dimension of limited inclusion – the assumption that complete transitioning is always desired and desirable. But for those who want medical transition-related care, services should be readily available in or through primary health care settings and should include competent, gender-confirming care that covers the spectrum of surgery and hormone therapy to vocal coaching, information about attire, and techniques for safe binding and tucking.

Transgender Mental Health

Already in our discussion of primary health care and transition-related care, we can see that transgender populations are at significant risk of mental health concerns, including feelings of shame, guilt, anxiety, and depression (Rotondi 2012). But it is critical to appreciate that “it is the

experience of discrimination rather than an individual's sexual [gender] orientation that negatively impacts the mental health of members of sexual minority groups" (Rutherford et al 2012 p 911). As Rotondi writes, like LGB people, "trans people face undue stigma and discrimination... they are marginalized both from LGB and heterosexual communities and providers, and are sometimes regarded as pathological or unhealthy" (Rotondi 2012 p 105).

At the same time, stigma and discrimination raise enormous barriers for transgender individuals wanting to use mental health services, even when those services are available. For example, in one study of 130 transgender individuals, 32% reported not using mental health services because someone they knew had a bad experience, 15% avoided services because of a previous bad experience, and 16% were afraid to seek mental health care because they did not know what would happen to them if they tried (Shipherd et al 2010). Further, the actual inability to get transition-related care and counselling causes distress and "anger, frustration, stress, hopelessness, distrust, and sadness is a common response that negatively affects the overall mental health of trans people" (Gehi and Arkles 2007 p 10). In a significant proportion of the population, experiences of stigma and discrimination combined with lack of care and support can heighten the risk of suicide. One study found, "suicide attempts among 12% of trans-women and 21% of trans-men who had not begun transition related treatment" as compared with "no suicide attempts among the same patients after having begun treatment" (Cole, O'Boyle, Emory, & Meyer, 1997 p 14).

The mental health and well-being of transgender people are also affected in complex ways by the psychiatric label and diagnosis of 'gender identity disorder' (GID), recently renamed, 'gender dysphoria' (GD). In medical parlance, 'Gender identity disorder' is broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth" (Standards of Care 2011 p. 2). Lev writes that a "diagnosis of GID ... is essential in order to receive a referral to a physician who can prescribe hormones, a necessary step to begin a medical sex reassignment process" (2005 p 3). In other words, a diagnosis of GID or GD serves as a gateway to transition-related care, including publicly-funded and privately-insured services (Bauer et al., 2009). The role of the physician as gatekeeper is ubiquitous in the health care system. It is impossible, for instance, to get access to insulin without a medical

diagnosis of diabetes or regular bone density scans without a doctor's approval and referral. Consequently, some transgender advocacy organizations, such as the World Professional Association for Transgender Health (WPATH), have acknowledged the facilitative role a diagnosis of GID can play for transgender people in gaining access to health care.

But it is significant that GID is identified as a mental disorder and that the power to identify people thus falls to the psychiatric profession. As Lev states, "the inclusion of Gender Identity Disorder (GID) within the official diagnostic nosology of mental disorders is a controversial topic that invokes many questions about the roles of the psychiatric establishment in the labelling of those who violate societal norms, particularly norms involving sex and gender issues" (Lev 2005 p 4). WPATH has advocated strongly for de-psychopathologizing gender nonconformity and, in its recently released standards of care, argued that "transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available" (p.169). A psychiatric diagnosis of GID or GD may open the doors to care, but it can also result in stigma and discrimination, including, as we have seen, at the hands of health care professionals.

Bauer et al. note that a diagnosis of GID can also act as a barrier to "relevant health care services" (Bauer et al. 2009 p 350). Because GID is understood as an illness or disease, transgender individuals must go through lengthy and intrusive testing in order to gain access to a physician who can provide them with the care they need (Lev 2005). For example, in order to be diagnosed and referred for hormone therapy or surgery, transgender people must demonstrate a "persistent, well-documented gender dysphoria ... [that] causes clinically significant distress or impairment in social, occupational, or other important areas of functioning" (Cohen-Kettenis and Pfäfflin, 2010 p 4). Some health centres such as the Callen-Lorde community health centre in New York have adopted models of informed consent that place less emphasis on the opinions of mental health professionals, and more emphasis on well-informed decisions of the person seeking treatment, where primary health providers including family physicians can give this assessment. This alternative model takes us directly back to the imperative of ensuring access for transgender people to culturally-competent, gender-confirming primary health care services,

regardless of whether they need cancer screening, hormone therapy or counselling and other supports.

Summary

Among LGBTQ populations, transgender people are amongst the most stigmatized, the most likely to suffer discrimination and those at greatest risk of physical and mental health problems. The health needs of transgender populations are consequently profound. Yet the literature suggests that transgender people's experiences with primary, transition-related and mental healthcare services are either non-existent or largely negative. It is past time to develop inclusive approaches to health research, policy and practice for transgender populations. There are some promising new initiatives, such as the Trans PULSE Project, "a community-based research project that is investigating the impact of social exclusion and discrimination on the health of trans people in Ontario" (<http://transpulseproject.ca/>), and the new *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* released in 2011 by the World Professional Association for Transgender Health. But our knowledge of and responses to the health needs and experiences of transgender populations remains woefully inadequate.

Conclusion

The Healthy Living Strategy, like many other approaches to health promotion, contributes to the social exclusion of LGBTQ populations – by rendering them invisible or by including them in ways that limit understanding and the possibility of competent care. This is evident whether we look at indicators typically associated with healthy living, such as body weight, or those that have implications for healthy living but are seldom included in strategies, such as sexual health. At the same time, it is hard to justify the focus on weight, exercise and diet in the HLS when we consider the devastating health disparities experienced by transgender populations as well as the reality that most do not have access to basic primary healthcare services, including transition-related healthcare, non-transition related health care, and mental health services.

Looking forward, it is critical that we adopt a more holistic and inclusive approach to healthy living. We need to consider dimensions of healthy living other than weight, diet and physical activity. We need to pay attention to the impact of the social determinants of health on the

potential for healthy living, particularly for those populations that have traditionally been and continue to be disadvantaged.

In the case of LGBTQ populations, we need to ensure more inclusive approaches to research, policy and practice. Surveys and other research instruments need to be designed with LGBTQ populations in mind. This means asking relevant questions and understanding that while some of these communities share similar experiences and have similar needs, they also have specific needs and experiences. It will involve moving beyond traditional areas of research inquiry, such as HIV/AIDS and mental illness, to a consideration of other health and social issues facing these communities. It will also require a step away from the emphasis on and pathologizing of sexuality. Some investigators are leading the way, opening up the possibilities for research that is relevant and that can create an evidence base for the reform of policies and practices. But there is a long way to go. Heterosexism, homophobia, cis-sexism and transphobia remain widespread and deeply entrenched in our society and institutions, damaging the health and well-being of LGBTQ people and perpetuating their exclusion. There is a pressing need to address the health disparities affecting LGBTQ communities and for sensitive and culturally competent policies and practices to support a holistic approach to healthy living.

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