

At the Interface

exploring theory in the practice of gay men's health

By Sarah Chown

Privilege

Coming Out

Medicalization

Oppression

Sexual Risk

Heterosexism

Resilience

HIV Prevention

Life Course

Gay Men's Health

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About Sarah Chown



Sarah's interest in gay men's health and HIV work began during an internship in 2008. Since then, Sarah has been involved in these fields as an educator, outreach worker, and researcher. She enjoys working and learning alongside communities most directly impacted by HIV and thinking about the ways resilience fits into our responses to HIV. Sarah is currently the Program Director at YouthCO. This publication is based on her regular blog, Under the Lens, on the CBRC website cbrc.net

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Under The Lens: An Introduction

I have been blogging on theories related to gay men's health at the Community-Based Research Centre for Gay Men's Health (CBRC) since September 2012. This project started with the goals of sharing the conversations that were happening in our reading group with broader audiences, and bringing a Canadian perspective to gay men's health theories. In the past three years, I have looked at some theoretical frameworks and key concepts within the scope of gay men's health.

While my position as a theory blogger and theory reading group co-convener may suggest otherwise, I am not always convinced of how these theories relate to men's real lives, and gay men's services, programs, and research. Throughout my involvement in gay men's health as an outreach volunteer, a researcher, an educator, and a program coordinator, I have been both appreciative of, and underwhelmed by, the tools these theories have to offer.

I am clearly not alone in wrestling with the role of theory in our communities and movement. A notable theory scholar, bell hooks (1994), also acknowledges several concerns about theory and the ways it is used within academic and community settings. For example, she recognizes that theory is also often presented in such a way as to reproduce insider and outsider status within academia and movements.

hooks (1994, p. 63-64) also describes the potential that theory has as an intervention that can liberate and heal when made "accessible to a broad reading public". She emphasizes that theory at its best avoids jargon, dense academic language, and abstract ideas and critiques. In hooks' experience, theory is generated from lived experience, and thus at its core, must be understandable within those with shared experiences.

This compilation and the continued blog series available at www.cbrc.net/blog attempts to relate theory in ways that are accessible and applicable to the work and research within gay men's health. It is by no means an exhaustive list of theories relevant to gay men's health, and is notably missing stand-alone entries on concepts such as minority stress, greater and meaningful involvement of people living with HIV, concepts of

indigenizing and decolonizing our movements, and anti-oppressive practice. These topics will be the subject of future blogs.

The gay men's health theories discussed here consistently point to the necessity of addressing structural aspects of gay men's lives. Over and over again, these theoretical perspectives point to structural factors that affect gay men, and the ways men are engaged in service provision. Despite the need to respond to structural inequities, these types of interventions produce change over the long term, and thus leave men's immediate needs unmet. Theories presented here include opportunities for multiple approaches in our advocacy and service provision.

These theoretical perspectives illustrate the complexity and multiplicity of issues we need to respond to in our collective efforts to support and strengthen the health and wellbeing of gay men. Many of the theories and subsequent discussions here are not new. The ongoing nature of these conversations highlights the depth of these issues, the challenges we collectively face in trying to address them, the need to continue to learn, and the importance of adopting diverse strategies to achieve shared goals. However, the challenge remains in implementing these ideas into day-to-day work and collaborating with our partners across sectors and disciplines to ensure men's needs are met. It is my hope that these theories can provide us with tools and language to hold ourselves and each other accountable in our work to strengthen the health and wellbeing of gay men.



As is the case when discussing theory and the lives of gay men, language matters. Throughout this compilation, decisions about language have been made with intention, but our use of language is insufficient to capture the diversity of men's experiences.

Many of these theories have been developed from lived experiences and research data from men who are primarily cisgender*, gay-identified men. Although some samples include bisexual, queer, Two-Spirit* and transgender men, in most cases, there are small numbers of men from these groups included in research. Throughout most of this compilation, the term 'gay' is used to the exclusion of other identities because it reflects the men who participated in research discussed herein. Where more diverse groups of men have been included in research, this will be shared with the reader. The use of language throughout this compilation is intended to affirm that our description of our sexuality carries cultural significance, and often, reflects the social environments in which we live, and is something that must be self-determined.

*terms with an asterisk are defined in the glossary at the back of the report

Taking On The Term 'Men Who Have Sex With Men'

The term 'men who have sex with men' (MSM) was first used in the early years of the HIV epidemic. It was introduced with the intent to be an identity-free category that separated sexual identity and sexual behaviour to reduce concerns about saying 'gay' in healthcare settings, and to create an option to avoid stigma associated with identifying as gay (Boellstorff, 2011). However, the term MSM appeared long after people within the LGBTQ+ spectrum in the United States and Canada had begun to adopt self-determined identities. Since the term was first published in 1988 (Boellstorff, 2011), community leaders, activists, and scholars have pointed to its shortcomings. Yet the term has still gained widespread use in research, policy and programming. Here, I will review scholars whose work has considered the strengths and pitfalls of the term MSM for our work in gay men's health.

Strengths of the term

Many scholars have written about the homogenizing and colonizing nature of the widespread application of the English, Western term gay to describe certain forms of men's sexuality. For many, the term gay represents a specific cultural identity that they may or may not share, despite its, at times, universal application. Indigenous men in many parts of the world understand their sexuality and gender in the context of their cultural practices; in Canada, one commonly used English term is Two-Spirit*. From this perspective, the term MSM may be used as an umbrella term to refer to a broad group of sociocultural identities. For example, The Global Forum on MSM and HIV (MSMGF) has adopted the term MSM as a term to "refer to all men who engage in sexual and/or romantic relations with other men or who practice same-sex sexual desire" (MSMGF, nd).



... it is vital to use sexual identity terms that reflect the local context of sexual activity between men in order to develop meaningful, relevant and culturally responsive initiatives to support men's health.

Critiques of the term

Despite the good intentions of many who introduced and today use the term, when examined closely the term itself has several ambiguities that challenge its application in settings related to sexual health. Prestage (2011) points out there is no distinction regarding how recently or how frequently a man must have had sex with a man to be considered MSM. Further, he questions whether or not trans men fit into the category of MSM. Both of these concerns greatly impact the relationship between the category MSM and the risk of HIV transmission.

U.S. writers Young & Meyer (2005) argue that the term MSM is problematic because it may undermine the way men self-identify their sexuality. Sexual identities have social, political, and cultural dimensions, including shared communities, social networks and advocacy efforts, which may be erased when MSM is used. These aspects of men's lives impact men's wellbeing, including political mobilization, access to health information and care, and a wide range of behavioural and social norms.

The term MSM also "avoid[s] discussing the impact of homophobia and heterosexism, and our internal processing of these", despite evidence that illustrates the importance of these factors in the lives of gay men (see 5, 9 & 11, this collection). However, the term MSM diverts attention from these opportunities to support men's health and wellbeing.

Further, MSM is no longer a useful term in the assessment of HIV risk. First used as an identity-free term to assess HIV risk, MSM is neither behaviourally specific enough or reflective of current HIV prevention strategies (see 8, this collection) to accurately identify men's HIV-related health needs.

Lastly, using the term MSM takes away the political and social power of men's self and group identification. In many cases, men (especially those racialized* as people of colour; Two-Spirit* people; trans and intersex men) have resisted attempts to erase or medicalize their identities. Especially in the context of this history and its ongoing health impacts, it is crucial to support men's self-determination in regards to all aspects of their identity.

Conclusion

Used as a substitute for a specific identity (e.g. Two-Spirit*, gay, bisexual), the term MSM can cause a lot of harm and may reflect avoidance of men's self-determined identities. Yet there is also value in using it as an umbrella term when there are simultaneous opportunities to discuss within-group differences and social contexts. It too runs the risk of reifying the dominance of English-language and Western concepts of sexual identity.

As Young & Meyer (2005) argue, however, it is vital to use sexual identity terms that reflect the local context of sexual activity between men in order to develop meaningful, relevant and culturally responsive initiatives to support men's health. Despite the widespread use of MSM, much more nuance than this simplistic category is required when describing the populations we work with and for.

Further Reading

Prestage, Garret – 2011. The term 'MSM' demeans us all. Available online via <http://kirby.unsw.edu.au/sites/default/files/hiv/attachment/The-term'MSM'demeans-us-all.pdf>

Beyond The Buzzword, 'Resilience'

While the histories of many gay men remain undocumented, evidence of gay men's resilience is unequivocal. Gay men have sought each other out in various cultures in the midst of religious, legal and medical persecution, contributed to their communities as leaders, cared and stood up for each other when many others remained silent. In 1983, gay men published the first community-specific safer sex resource, 'How To Have Sex in an Epidemic' (Berkowitz, 1983), in the absence of institutional leadership. Gay men continue to fight for increased safety and inclusion, and along with it, legal protection and rights, including decriminalization of anal sex, banning persecution of gay people within the public service, and government and institutional action on gay men's health and wellbeing.

Advocating for resilience research

Although resilience is not new for gay men, public health researchers began studying resilience in the 2000s, largely as a result of calls from gay men. These advocates pushed for a new approach to research, one that moved away from pathologizing gay men and instead was oriented towards the recognition of gay men's many strengths and successes:

“...we want to transform the ways in which we think about and evaluate gay men, shifting away from a perspective which exoticizes, demonizes, and pathologizes our bodies and our lives and into a model which recognizes the tenacity, survival-skills, and overall resilience of our cultures and communities. What would it mean to understand openly gay men as the resilient portion of our community, that portion which has suffered physical assault, religious abuse, and political violence yet emerged emotionally intact and spiritually strong? What would it mean to understand our gender play, kinship networks, and sexual cultures not as pathetic products borne of a homophobic society, but as adaptive survival strategies which have served us well?” (Rofes, n.d.)

“... at its best, resilience affirms gay men’s leadership and activism, celebrates the ways gay men care for each other, and solidifies the role of gay men in doing this work.

Not long after Eric Rofes’ words, Canadian gay men’s health policy documents echoed his call, describing the need for “gay men’s health [to] begin with recognizing, acknowledging and affirming the resilience, the reserves of strength, and the courage of gay men” (Ryan & Chervin, 2001).

Academic notions of resilience

Despite enthusiasm for resilience-based approaches, the meaning of ‘resilience’ is far from consistent. Academic notions of resilience first emerged in the 1970s within the realm of psychology: children who, despite maltreatment, did not present with significant clinical disorders or negative traits were said to be resilient. Over time, the concept has expanded to study experiences of positive adaptation and/or avoidance of negative outcomes in the context of short-term or ongoing adversity. Typically, researchers measure resilience based on developmental milestones (e.g. school completion); validated scales (e.g. Centre for Epidemiologic Studies Depression Scale); pre/post measures of functioning (e.g. assessing functioning before and after a period of adversity), and self-report (Chown & Malcoe, 2012). Most often, this research is based on quantitative measures, although some qualitative work does exist. These measures are then used to differentiate between those men categorized as resilient and those men who are not.

Limitations of resilience research

Resilience research is a tempting alternative to continued to document gay men’s health disparities or the pervasive nature of oppression that shape these health disparities in the first place.

However, the ways resilience is quantified, often at an individual level, seems so removed from the real-life ways resilience shapes our lives and communities. Some current resilience research uses measures that do not reflect gay men’s understandings or experiences of resilience, and are instead based on other people’s ideas of what resilience is. I also wonder to what extent resilience research is fulfilling the vision of those men who advocated for it in the first place.

Strengths of resilience research

The recognition of gay men’s individual and community strengths is necessary to inform research and programs that promote a well-rounded understanding of men’s needs. Resilience creates opportunities for peer-driven responses and to identify new ways to support those in our communities who are struggling. Further, resilience research has the potential to focus on building environments and communities that foster and support resilience within gay men.

As resilience work continues, I want to see more opportunities for gay men to imagine, articulate, and build communities that are happy, healthy, and well – and inclusive of the many men who are part of the umbrella of gay men. I also want to see diverse gay men’s ideas about resilience to be at the forefront of this work, and ensure that we are not reproducing notions of resilience based on achievement of mainstream standards.

Conclusion

There is the possibility that resilience is an overly romanticized notion of community cohesiveness and solidarity that does not account for the experiences of oppression within gay communities. Yet, at its best, resilience affirms gay men’s leadership and activism, celebrates the ways gay men care for each other, and solidifies the role of gay men in doing this work. It is necessary that we engage gay men in the conversations about what resilience feels like and looks like – and how we, as researchers, frontline workers, and policy makers, can support and affirm resilience in the work we are doing alongside gay men.

Further Reading

Ibáñez-Carrasco, Francisco – 2012. *Making the AIDS ghostwriters visible*. In E. R. Meiners & T. Quinn (Eds.), *Sexualities in education: A reader*.

Beyond A Single Identity: Privilege & Oppression In Gay Men's Lives

Originally written by Jaedyn Starr & Sarah Chown;
edited in February 2015 for brevity and clarity by Sarah Chown.

To many, intersectionality is a daunting theoretical, academic concept. Yet, intersectionality was first coined in the context of activism, service delivery, and the lives of U.S. women of colour. Kimberlé Crenshaw, who argued that U.S. Black women's simultaneous experiences of racism and sexism were excluded from services and activism, was first to use the term "intersectionality" in the academic literature (Crenshaw, 1989, p. 139). Since then, a litany of academic writing on the topic has emerged and intersectionality has been used in many contexts to develop a more complete analysis of social issues and highlight opportunities for social change.

Tenets of intersectionality

Intersectionality has its roots in women of colour and indigenous feminisms. Many writers and communities, including gay men, have used intersectional analysis to understand their experiences. For example, Reginald Shepherd's 1986 essay titled *On Not Being White*, highlights multiple aspects of his identity:

"I have spent years proudly and often militantly defining myself as a gay man; I am still tentatively moving toward equally proudly defining myself as a black man. The process of reconciling myself to each of my social identities has had much to do with how and to what extent those around me bring the two together and keep them separate. [...] I was black before I was consciously sexual, but I was sexual long before I had the words for sex or race; and when did I become 'I'?"

Here, Shepherd demonstrates how intersectionality can help us think about the ways individual experiences and structural contexts interact. His writing highlights three key tenets of intersectionality as discussed by intersectional scholar Rita Dhamoon (2011):



... intersectionality can help us ensure services are relevant to the lives of diverse communities of men who have sex with men.

- **Our experiences are impacted by multiple parts of our identities (e.g. sexuality, gender) and structures (e.g. heterosexism, racism).** People cannot be reduced to one identity category. Being gay and indigenous or gay and non-indigenous impacts how individuals understand their sexuality, the types of communities individuals are a part of, and the ways they are treated by people within their communities.
- **Categories (such as sexuality, race) are ascribed to individuals through interpersonal interactions and institutional processes.** Visual cues such as skin colour, appearance and mannerisms factor into assumptions made about people's identities. At an institutional level, categories are assigned to individuals through bureaucratic or medical processes. For example, people who are categorized as fat are often excluded from social scenarios and may receive insufficient health care. Similarly, health care providers may also assume STIs and HIV are the cause of a gay patient's symptoms without pertinent knowledge as to their sexual behaviours.
- **Knowledge is produced and understood in the context of our identities and structural contexts, and this knowledge is valuable.** One of the reasons the principles of greater/meaningful involvement of people with HIV (GIPA/MIPA) and community-based research has become so important within the HIV sector is because scientific, medical knowledge threatened the legitimacy of the knowledge based on gay men's experiences living with HIV, and fighting for improved services for HIV treatment and prevention. Intersectionality reminds us of the importance of lived experience as a form of knowledge.

Intersectionality in practice

Intersectionality requires an analysis of privileged identities, and the ways that people with more privilege benefit from structures that simultaneously oppress others. Oppression and privilege happen at the same time in many scenarios –for example, many health promotion materials developed for gay men assume everyone has a penis, and as a result trans men's

bodies may not be included. In this scenario, cisgender* men's needs are privileged and trans men's needs are overlooked. This is just one example as to how privilege can be overlooked. Intersectionality gives us pause to think about the limitations of framing this field as "gay men's health", when it is also tasked with meeting the needs of self-identified gay, bisexual, Two-Spirit* and 'other' MSM.

Many cultural and social norms are at play when gay men seek dating relationships and hook ups. In online venues, "No fats, no femmes, no Asians" is a common phrase used to exclude certain men. Gay men perceived to be "fat", "femme", and/or "Asian" may have a harder time finding people to form sexual or romantic partnerships with, and may experience stress and exclusion from gay communities as a result. In these instances, socially produced definitions of attractiveness are reinforced by interpersonal interactions.

Service providers, policy makers, researchers and others working with diverse communities of gay men and other men who have sex with men can benefit from integrating intersectionality into their ongoing work. When applied to gay men's health, the three tenets of intersectionality described here will reveal new areas for growth towards health and social equity. As a paradigm that encourages those of us working in this field to recognize and act on the knowledge of those most directly affected, intersectionality can help us ensure services are relevant to the lives of diverse communities of men who have sex with men.

Further Reading

Reginald Shepherd (1986) – *On Not Being White, in Freedom in This Village; Twenty-Five Years of Black Gay Men's Writing, 1979 to the present*. Edited by Harris, 2005. Page 56.

s.e. smith – Intersectionality is not optional:
http://meloukhia.net/2011/12/intersectionality_is_not_optional.html

Olena Hankivsky – Exploring the promises of intersectionality for gay men's health:
<http://cbrc.net/resources/2015/exploring-promise-intersectionality-gay-men's-health>

Lessons From Queer Theory

The word 'queer' is a complicated one; it sounds and feels different across generations of LGBTQ+ communities. It can evoke pride or shame, and too often is used pejoratively to describe abnormality, as an insult towards people who challenge heterosexual, cisgender norms. Yet, some people within LGBTQ+ communities have reclaimed queer as both an identity and a politic. Today, the word 'queer' is seen by some as unifying, and by others divisive: while some Canadian cities have embraced queer as an umbrella term, others have barred it from their lexicon (Flegg, 2014).

Queer Activism as Theory

Queer theory was a term coined by Teresa de Lauretis at a conference in 1991. The ideas we now group together as queer theory undoubtedly were influenced by the activism and analysis of activist groups such as ACT UP that emerged in the early 1990s (Nunokawa, 2011).

From the outset, queer activism challenged the concept of identity-based organizing. In its academic and activist uses, the word queer resists binary categories of people who are queer and people who are not; instead queer "defin[es] itself against the normal rather than the heterosexual" (Warner in Smith, 2010, p. 44). Queer activism – like intersectional activism before it – is informed by queer people's personal experiences, which are used as fodder for analysis and response. Queer theory uses sexuality as an entry point to examine the ways state politics and programs regulate sexual acts and possible outcomes, such as child-rearing, transmission of property, and the division of public and private responsibilities (Marcus, 2005).

Queer analysis, in theory and activism, highlights the ways institutions (e.g. governments) use policies and programs to regulate normalcy in sex, gender, and family units. For example, queer analysis illuminates the regulatory outcomes of policy decisions to have sex recorded on birth certificates, thereby tying a person's sex to their legal identity and ability to access health care, education, and some forms of transportation. In this example, queer theory examines how power operates to privilege, create, or require certain forms of normalcy.



Queer theory provides insight into gay men's health research and practice by challenging those of us within the field to identify assumptions that underpin our work.

Many scholars have drawn connections between queer theory and intersectionality. Both highlight heterogeneity within identity-based groups often overlooked within other theories (Cohen, 1997; Smith, 2010). For example, media, politics and activism often assume that people who are religious are anti-gay or anti-trans. Yet, intersectionality suggests some people are both queer and religious, thereby disrupting the assumed homogeneity of queer and religious as identities. Similarly, queer theory removes identity from the equation and thereby resists the simplicity of identity-based politics: "the problem is not with blacks or queers; it is with people who hold certain normative visions of the world, whether queers, blacks, both, or neither" (Duoung, 2012, p 383).

Queering Gay Men's Health

Queer theory provides insight into gay men's health research and practice by challenging those of us within the field to identify assumptions that underpin our work. One area that queer theory highlights for discussion is the creation and enforcement of norms and categories, such as being a 'good gay man'; that is, following socially sanctioned ways of expressing one's sexuality, and adhering to public health advice about sanctioned forms of sex.

Numer & Gahagan (2009) argue many health promotion campaigns have not recognized the diversity within gay men's communities, and have reinforced normative ideas about masculinity and health. They suggest gay men are affected by hegemonic conceptions of masculinity that value risk-taking, and that this value may drive resistance to condom-based health promotion efforts. Numer & Gahagan apply queer theory to note HIV prevention campaigns that reinforce binaries and difference between HIV-positive men and HIV-negative men, and between public-health approved sexual acts (e.g. sex with a condom) and those sexual acts that transgress dominant norms of responsibility and risk aversion (e.g. bareback sex).

In line with this critique, Adam Rifkin (2012) and Francisco Ibañez-Carrasco (2012), among other writers, emphasize the need to consider bareback sex and 'sex pigs' in representations of gay men's sexualities. Rifkin is interested in the recognition and celebration of sexual acts, often considered deviant within public health and societal norms. Further than recognition and

celebration, Ibañez-Carrasco calls for public health to place value on knowledge that emerges from within these sexual subcultures. The project of celebrating so-called sexual outlaws fits within queer theory's work to interrupt assumptions about 'normal' sexual acts and relationships.

In another example, Trinity Western – a Christian university in British Columbia – sought regulatory approval to open a new law school starting in 2016. The proposal was met with controversy because Trinity Western requires its students to adhere to a code of conduct that includes a clause that prohibits "sexual intimacy that violates the sacredness of marriage between a man and a woman" (Woo, 2014). This code of conduct is an example of a policy that privileges and normalizes certain forms of sexual activity. In theory, students who are sexually active outside of a marriage with a single, different sex partner are in violation of this code.

The debate around this issue has largely been framed in a rights discourse; gay and lesbian people have led much of the opposition to the proposal, noting their right to access education. Queer theory also critiques Trinity Western's policy, but frames the issue as a challenge to the institutional power of the school to create and enforce norms among its staff, students and faculty. Rather than an identity-based approach which casts the issue as one of sexual and gender identities excluded from this definition of marriage, queer theory frames the issue as one of Trinity Western's regulatory power.

Queer theory is undoubtedly challenging. Yet, its organizing principles – a rejection of systemic domination, regulation and articulation of norms – have been used to advance social critique, and has been adopted within other bodies of scholarship, including Native studies and intersectionality. Limited gay men's health scholarship has explicitly adopted queer theory in its analysis, yet gay men have benefitted from queer theory's analysis of hetero-patriarchy, and stand to benefit from continued questioning of the ideas that often are taken-for-granted.

Further Reading

Marcus, Shannon. 2005 – Queer Theory for Everyone: A Review Essay. Abstract available via <http://academiccommons.columbia.edu/catalog/ac%3A157267>

'Homophobia Is Killing Us': Heterosexism & Gay Men's Health

Homophobia and heterosexism are often used interchangeably; not much attention is paid to how these words differ. However, upon closer examination, the distinction is more than just semantics: each of these words reflects a different conceptualization of how gay oppression occurs. These conceptualizations of oppression also impact our approach to developing solutions. In this blog, I consider the two terms, primarily drawing from Aguinaldo's 2008 research, examining the links between gay oppression and health.

What is heterosexism?

Heterosexism is a system of norms, ideas, values and attitudes that implicitly or explicitly, assume heterosexual superiority and overlook gay, bisexual, pansexual and queer identities, values, and relationships. These beliefs simultaneously create cultural advantage for heterosexual people and disadvantage for those who are not heterosexual. Some examples of heterosexism in contemporary Canadian society include limited visibility of gay and queer men in curricular content and media. Like systems of racism, colonialism, and ableism, many aspects of this exclusion are not immediately obvious, but they are pervasive. Heterosexism is one of many structural inequities that impact gay men.

What is homophobia?

The term homophobia was first used in the 1960s to describe heterosexual people who are uncomfortable around homosexuals and was meant to pejoratively label those who are uncomfortable and fearful of same-sex desire and relationships (Aguinaldo, 2008). However, over time, the term homophobia has evolved and now more broadly refers to people who hold hateful or derogatory attitudes towards gay men.

Further, the term homophobia is now also used by service providers to describe gay men who absorb anti-gay messages from society. Known as internalized homophobia, it can manifest as feelings of insecurity, guilt, shame, depression, fear of



While it is necessary to respond to individual instances of homophobia, we must also challenge the heterosexism of contemporary societies in order to strengthen gay men's health and wellbeing.

one's sexuality, rejection, as well as self-destructive behaviours and hiding parts of oneself from others to avoid these feelings. Gay men's health policies, research and programming often address the aspects of gay men's experiences associated with internalized homophobia.

Structural perspectives on homophobia

In his review of the gay men's health literature, Aguinaldo (2008) found gay men's health practice is informed by a very individualistic perspective and does not account for heterosexism. Citing Kitzinger, Aguinaldo points out that focusing on the concept of homophobia directs us to think of society as welcoming and affirming of gay men, and gay oppression as something enacted by a few individuals whose attitudes are discordant with societal norms:

"By formulating gay oppression as a psychological phenomenon, the literature constructs gay oppressors as sick individuals who supposedly deviate from an assumed egalitarian society."
(Kitzinger, 1996)

Focusing on the concept of homophobia overlooks the systemic ways homophobia is taught and perpetuated by the heterosexist norms currently in place.

Aguinaldo shows us that thinking about gay oppression in individual terms "replaces 'political explanations (in terms of structural, economic and institutional oppression) with personal explanations (in terms of the dark workings of the psyche, the mysterious functioning of the subconscious)" (Kitzinger 1996 in Aguinaldo, p. 90). These differences matter in terms of how we work towards supporting and affirming the health of gay men, and others who are not heterosexual.

Aguinaldo's research found much of the literature and gay men's health programming focuses on gay men as a problem

that needs to be solved in order to improve wellbeing. Yet, Aguinaldo argues a reframe is needed: "The problem is not gay men or their response to oppression. The problem is heterosexism and those who benefit from it." Aguinaldo is unequivocal in his critique of homophobia, contending that its attention to individual instances "is killing [gay men]" and overlooking the every day impacts of living in a world that privileges and normalizes heterosexuality. While it is necessary to respond to individual instances of homophobia, we must also challenge the heterosexism of contemporary societies in order to strengthen gay men's health and wellbeing.

Conclusion

Framing gay oppression in the language of homophobia leads to proposed solutions aimed at responding to acute, instances of homophobia experienced by gay men. Doing so leaves heterosexism in tact, thereby perpetuating limited knowledge of gay and queer men's lives and needs. In the research presented, Aguinaldo offers a fundamental piece of writing that challenges us to both meet individual needs that arise from homophobia while also disrupting and challenge the heterosexism and other forms of oppression that contribute to health inequities amongst gay men.

Further Reading

Jeffrey P. Aguinaldo (2008): The social construction of gay oppression as a determinant of gay men's health. *Critical Public Health*, 18(1), 87-96. Abstract available online at: www.pulsus.com/cahr2008/abs/050.htm or www.tandfonline.com/doi/full/10.1080/09581590801958255#.

Questioning The Clinic: The Role Of Medicalization In Gay Men's Health

Sexual and gender diversity – including men having sex with men – has occurred throughout history. In some societies, these acts were ingrained as an accepted part of community life; in others, they were regulated or prohibited by social norms. Throughout the 1800s, gay sexuality also became subject to diagnosis and investigation by the field of medicine. While there is recognition of the crucial role of medical and pharmaceutical innovations in supporting health and wellbeing, the concept of medicalization questions the extent of the authority and power medical professionals hold.

Medicalization as critique

Medicalization is a process by which health professionals or authorities frame life stages (e.g. aging, pregnancy) or behaviours (e.g. sex between men) previously understood as a social behaviour or normal phase of life as a medical problem. The term 'medicalization' is often used to critique the increasing power held by health professionals (e.g. doctors and nurses), institutions (e.g. public health), and pharmaceutical interventions to respond to community needs in day-to-day life. These interventions include increasing use of diagnostic and testing technology, and pharmaceutical treatments for an ever-growing list of conditions.

Diagnosing homosexuality

Proponents of medicalization question the placement of social issues and diversity within the scope of medical practice. For example, while sexual cultures of men have existed throughout history, it was not until the 1800s that these behaviours were studied within the field of medicine and regulation. Medical doctors first investigated homosexuality within their field of study to propose an alternative to the criminal treatment of men identified as homosexual at the time. The term homosexual was first used by Dr. Benkert, an Austro-Hungarian doctor and sexologist in 1869 (Wahlert, 2012).



Although the clinics play crucial roles in testing, diagnosing, and treating STIs, there are ongoing struggles to ensure that clinical care does not judge or demean gay men's sexuality...

Wahlert (2012) points out that various medical subdisciplines – sexology, psychoanalysis, and hormonal studies – each studied homosexuality throughout the first half of the 20th century. By the 1950s, the American Psychiatric Association (APA) classified homosexuality as a mental illness, followed by the World Health Organization (WHO) in 1968. Gay men's community resistance led professional bodies to first delist this diagnosis, and then rescind their support for purported 'treatments' for homosexuality.

Despite these changes, Aguinaldo (2008) argues that some concepts such as 'internalized homophobia' (IH), still continue to frame gay men's health issues through a medical lens. As both a medical diagnosis and a concept used to explain health inequities, IH is common in the gay men's health research. IH can include feelings of insecurity, guilt, shame, depression, fear of one's sexuality, rejection, and/or self-destructive behaviours. Interventions for IH typically include one-to-one counseling, but little can be done within a medical paradigm to address structural issues that impact health. Yet, this approach to responding to IH distracts from the social issues that contribute to the inequities gay men face, such as heterosexism and simultaneous forms of oppression (Aguinaldo, 2008).

Treatment and prevention

Sociological critiques of current approaches to the HIV epidemic hold that there is a disproportionate focus on the provision of testing and antiretrovirals*, both of which rely on individual action and knowledge (Adam, 2011; Nguyen et al., 2011). In many cases, testing and treatment options garner more attention within public policy and public health funding than community-driven treatment and prevention efforts. There are ongoing concerns that prescription medications are often portrayed as quick solutions to complex problems. For example, antiretrovirals are used by men living with HIV as treatment and to reduce the possibility of onward transmission to partners and they are also being used by

men who are HIV-negative to reduce the possibility of HIV acquisition. Depending on the knowledge, resources and community engagement of health care providers who write these prescriptions, men may or may not also be connected into community organizations and peer-based programs with mandates that include advocacy, social support, and mental health programming.

Conclusion

Gay, bisexual, queer, transgender and cisgender men have been subject to medical interventions since the 1800s. While the diagnoses of 'homosexuality' and 'transgender' pushed men away from medical expertise, HIV and STIs have been, and continue to be, cause for men to re-engage the clinic as a site of health. Although clinics play crucial roles in testing, diagnosing, and treating STIs, there are ongoing struggles to ensure that clinical care does not judge or demean gay men's sexuality, and that it supports efforts to strengthen men's overall health and wellbeing.

The critiques of medicalization highlight the individual nature of pharmaceutical and biomedical options in the context of health outcomes that are produced by social structures like HIV stigma, homophobia, biphobia and transphobia by silencing conversations about improved treatment, care, and prevention. From the outset of movements of gay men and queer people, activists and organizations, including AIDS Action Now, BC Persons with AIDS (now Positive Living BC), and AIDS Vancouver, fought for improved research design and approval processes and for policies to recognize non-traditional families and reduce homophobic institutional practices. Continued advocacy for both medical and social pathways that strengthen gay men's health and wellbeing is necessary.

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Navigating Sexual Risk

Generations of gay men have lived amid risk – of being medicalized, criminalized, of poor health outcomes – day in and day out. Commonly, the term risk focuses on the possibility of negative outcomes resulting from a given circumstance, yet encountering risk can include opportunities for creativity and resilience, and come with great pay offs.

Public health and gay men's organizations have spent decades responding to the sexual risks that sexually active gay men encounter, and have promoted strategies including abstinence, condom use, strategic choices about sexual acts and positions, testing, status disclosure, communication, and antiretrovirals*. Here, I review the ways sexual risk is understood by public health efforts, and the various ways men navigate sexual risk.

Sexual Risk Environments

The risks that come with sex have occupied the gay men's health sector for decades. Biological, epidemiological, social and cultural factors all shape the sexual risks gay men navigate: increased per-act probability of HIV transmission for penile-anal sex, higher rates of men living with HIV in gay sexual networks, sex education programming that is silent on gay men's sexuality, and profound societal stigma towards HIV and gay men (British Columbia Provincial Health Officer, 2014).

In many cases, sexual risk is primarily conceptualized at the interpersonal level, and may be quantified by calculating biological and epidemiological information about a specific sexual act. These calculations are consistent in quantifying penile-anal sex as the sexual act that is most likely to pass HIV, and thus this one act tends to be the focus of HIV prevention initiatives and research.

Often, these programs focus on discouraging individuals from having sex that includes risk of acquiring HIV through strategies such as condom use and knowing a partner's status. In this paradigm, individuals are responsible for having the knowledge to assess the risk they may experience, and for taking the necessary harm reduction measures to mitigate it (Kippax et al, 2013; Adam, 2005).

Another example of holding individuals responsible for sexual risk is current criminal case law in Canada and elsewhere that holds people living with HIV responsible for disclosing their HIV status prior to sexual encounters in which there is a “realistic possibility” of HIV transmission. This case law and the attitudes it reflects portray people living with HIV as a risk to all those who are HIV-negative (Flowers, Duncan & Frankis, 2000), despite evidence showing many people living with HIV go to great lengths to reduce the possibility of passing HIV to their partners. Many activists have protested this legal development, and their voices have been echoed by Canadian HIV clinicians (Loutfy et al., 2014). These individual framings of risk and responsibility for HIV prevention have been strongly critiqued for their neglect of the social and cultural factors that shape situations where HIV may be passed between partners.

A notable exception is a meta-analysis comparing disparities and risks experienced by Black MSM (Millet et al., 2012). This paper concludes Black MSM have similar rates of sexual and substance-using behaviours that may pass HIV as other MSM, but risk is produced in these environments as a result of structural factors, including access to HIV-related clinical care (Millet et al., 2012). While public health often focus on HIV, sexual risks extend beyond HIV to include many STIs, social-emotional, physical and legal risks.

Public Health & Community Perspectives on Risk

The discipline of public health is highly risk averse in the context of sex, sun tanning, and substance use. Within a public health frame, the possible adverse outcomes of these actions outweigh the possible pleasure and positive outcomes they entail. However, for many of us, some risk is a good thing. For example, one gay man explains:

“My own experience of risky gay men leads me to celebrate the role of risk and risk-taking in gay culture, and to grieve that risk has been pathologized and demonized as a result of [HIV].” (Bartlett, 2012).

While some gay men embrace the risks associated with sexual pleasure and freedom, HIV prevention workers and researchers often categorize these actions as an indicator of a problem. It is rarely affirmed as a reasonable choice. Yet, gay men have developed community resources (e.g. *How To Have Sex In An Epidemic*, see Berkowitz, 1983) and community practices (e.g. condom use, status disclosure) to navigate risks such as the possibility of HIV/STI acquisition since before the earliest reports of what we now know as HIV. These perspectives are

increasingly recognized within gay communities, but are often missing from clinical services and research initiatives.

Risk Management

Health promotion efforts tailored to gay men need to account for the different kinds of risk gay men encounter, and recognize that risk is celebrated and not universally demonized among gay men. Further, gay men pioneer and adopt new HIV risk management strategies as the informational, legal, and social landscape continues to evolve. Diverse health promotion strategies are needed, and these should include providing up-to-date resources, supporting men’s efforts to build safer sex community norms, and building men’s capacity to act on information (Race, 2003). For example, the Health Initiative for Men’s (2010-2011) Do The Math campaign and calculator uses information about the HIV status of sexual partners, sexual act and position, and testing behaviours to approximate the amount of risk in an individual encounter.

Yet, gay men’s sexual decision making extends beyond the latest information about sexual risk, and includes sexual desire, intimacy, interpersonal relationships, and community participation (Scheim et al., 2014). Flowers and coauthors (2000, p. 286) use the term ‘HIV-risk management’ to “incorporate the multiple and changing HIV risks that gay men experience” and highlight the ongoing changes in the risk environment, including those related to changes in medical knowledge, prevention options, psychosocial needs, and the legal landscape.

Conclusion

Sexual risk is nearly always seen as something an individual should mitigate, avoid or manage. It is seen as an individual, rather than collective experience, and the approaches to risk management often reflect this attitude. Despite the mainstream demonization of risk, it will continue to be, in some cases, a celebrated part of gay men’s communities. Health promotion efforts should continue to work with gay men in ways that embrace, rather than shame, risk taking and seek to build communities and environments that minimize structural risks such as criminalization of HIV non-disclosure and institutional racism. These types of holistic approaches to navigating risk will only serve to strengthen men’s health and wellbeing across the board.

Further Reading

Bartlett, Chris. 2012 – “Levity and Gravity”. In M. Bernstein Sycamore (Ed.), *Why are faggots so afraid of faggots?*

Collaborative Frameworks For HIV Prevention

Communities of gay men living with HIV and those who are HIV-negative alike have worked to prevent onward HIV transmission since the onset of the HIV epidemic. Gay men's responses have included producing safer sex resources, advocating for appropriate funding for research and services, demanding attention from politicians and the media, and developing unique prevention initiatives. These prevention efforts have greatly impacted the lives of many people living with HIV, yet the number of new HIV infections remains stable. Despite these successes, the HIV epidemic – and HIV-related inequities – continue to persist, and new strategies are needed to alter the current portrait of the HIV epidemic. Here, I discuss two frameworks that have been laid out to strengthen our responses to HIV: highly active HIV prevention (Coates, Richters & Caceres, 2008) and a social and structural approach (Collins, 2004).

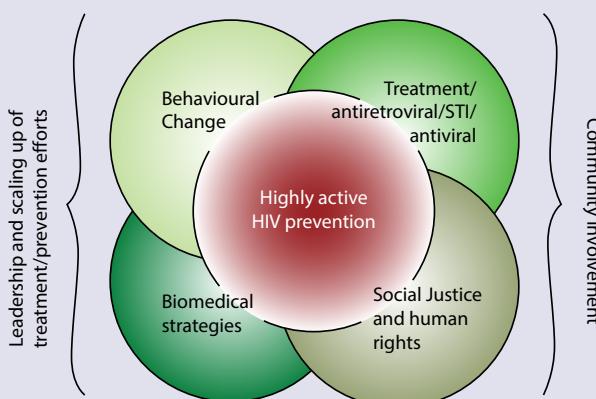


Figure 1: Highly active HIV prevention

This term was coined by Prof K Holmes,
University of Washington School of Medicine, WA, USA.

Highly active HIV prevention

According to Coates, Richter, and Caceres (2008), highly active HIV prevention engages four types of strategies to improve HIV-related outcomes, each of which typically operates in isolation from the others:

- Behavioural change (e.g. reduce possible instances of HIV transmission)
- Treatment (e.g. medication to treat HIV and STIs)
- Biomedical strategies (e.g. vaccinations, PrEP, treatment as prevention)
- Social justice and human rights (e.g. universal access to responsive health care and education and freedom from oppression).

Each of these strategies must be implemented simultaneously and with institutional and political support to ensure scale up funding and ongoing community involvement. As a result, highly active HIV prevention creates a synergistic approach that has the potential to strengthen health outcomes more than any one of these strategies could alone. While highly active HIV prevention was first developed as a universal framework for HIV prevention, Dr. David Wilson presented a 'gay-optimized' version tailored to gay men (Trussler, 2013; Wilson, 2013). One of the key pieces of highly active HIV prevention is the collaborative implementation of these strategies, alongside meaningful community involvement and political leadership.

Black feminist approaches

Patricia Hill Collins (2004, p. 296) also advocates for approaches to HIV that go beyond biomedical and behavioural HIV interventions and consider the ways racist and sexist norms shape the dynamics of HIV transmission:

"But what does prevention really mean? As the African American women in Mississippi and the African American gay men in major U.S. cities suggest, prevention requires going further than information about disease transmission and free access to condoms. Definitions of Black masculinity and Black femininity, the recognition of an array of sexual identities (straight, gay, lesbian, bisexual, and transgendered), questions concerning sexual practices and when "safe sex" is truly "safe," ideas about whether and when to get tested for the HIV virus and how to reveal the outcome to one's sexual partners, all are questioned by the presence of HIV/AIDS."

These two examples highlight the ways racism shapes norms that in turn constrain individual behaviour and facilitate ongoing transmission of HIV. Collins' analysis is an important example of what we can learn when we turn our attention to social factors, and the importance of considering interlocking oppressions (such as racism) in prevention efforts.

The knowledge and lived experiences of people in communities with elevated HIV incidence rates is positioned alongside medical and professional knowledge that is typically seen to be more legitimate in Collins' work. Within the HIV movement, this recognition of lived experience has been formalized into the "greater/meaningful involvement of people with HIV" (GIPA/ MIPA) principle, and, in the case of people who use drugs, the principle of "nothing about us without us".

Collins (2004) closes her chapter with a call for HIV-related organizations and Black community organizations to work in partnership, along with other groups that have shared goals. In her words, "because HIV/AIDS (as is the case for virtually every social issue) does not affect just Black people, solutions require coalitions with other groups who share a similar agenda. Addressing the challenges of HIV/AIDS certainly requires a broad based, coalition politics" (p. 298). Coalition-based approaches can help us to begin to implement highly active HIV prevention and combination approaches.

Conclusion

These frameworks for HIV prevention encourage increased collaboration and integration between what are typically thought of as distinct strategies. This is no easy feat: for this goal to be realized requires all of us to recognize the limitations of our own work, and look for innovative ways to collaborate with people whose strengths lie in other approaches.

To do this, intersectoral and interdisciplinary collaboration is needed, along with pooled resources to support achieving our shared goals. Finally, we need to continue to consider ways of meaningfully engaging people who most directly experience HIV – both those who are at risk of HIV, and those who are living with it.

As Coates, Richters & Caceres (2008, p. 670) argue, "reductions in HIV transmission in entire countries or regions or in specific risk groups inevitably result from a complex combination of strategies and several risk-reduction options with strong leadership and community engagement that is sustained over a long time". It is important that we learn lessons from earlier days of the epidemic, and heed the calls from scholars and advocates alike. To borrow from the title of Patricia Hill Collins' chapter, we cannot wait to address the challenge of HIV/AIDS in our communities – and to do so effectively, we must find new ways to work together.

Further Reading

Collins, Patricia Hill. 2004 - *Why we can't wait: Black sexual politics and the challenge of HIV/AIDS*. In Black Sexual Politics: African Americans, Gender, and the New Racism.

History, Human Development & Health: Looking At The Life Course Model

How old were you when George Klipper was convicted and imprisoned on charges of homosexuality in 1968? This event led to the decriminalization of anal sex between men. How old were you when the first case of HIV was diagnosed, or when HIV testing was introduced? How old were you when you met a gay person who was older than you?

According to the life course model, the answers to these questions can help to inform our approach to supporting gay men (WHO, 2000; Hammack, Thompson & Pilecki, 2009; Hammack & Cohler, 2011). Research suggests that understanding experiences throughout individuals' and communities' lives is crucial in the development of effective health policies, programs and interventions. These ideas are the foundation of the life course model, a "paradigm that recognizes the significance of history and cohort in human development" (Hammack, Thompson & Pilecki, 2009, p. 868). The life course model encourages us to think about how experiences across a lifetime impact men's decisions about how they enact their identities.

The life course model provides a framework of what many of us involved in gay men's health and communities observe: differences between men who grew up – and grow up – in different time periods. Cohler and Hammack (2011, p. 164) discuss "cohort-defining events" that impact generations of gay men. For example, men who came of age during bathhouse raids, reparative therapy, and other surveillance have different health and support needs than those who have grown up with marriage equality, with online platforms for social and sexual networking with other gay men and without raids on gay bars and bathhouses. The life course model helps account for the impacts of significant and ongoing political and social change towards gay men on the lives and health of gay men.



The life course model helps account for the impacts of significant and ongoing political and social change towards gay men on the lives and health of gay men.

Three Generations of Experiences

Attitudes towards gay men – and wide LGBTQ communities – have shifted dramatically in the past three generations. These attitudes play a large role in men's understandings of their sexual identities and interactions with their communities. Cohler & Hammack (2007) have defined three distinct generations of gay men whose beliefs about their sexuality were shaped by key events:

- post-World War II
- post- Stonewall during an emerging gay rights movement
- in an era of organized resources and support groups for gay children and their families

Men in the post-World War II era came into their identities in a climate of hidden, subversive communities. In contrast, men in the post-Stonewall era came of age during a time of blossoming visibility and political conflict for gay communities. Many of these men also experienced the earliest days of the HIV/AIDS epidemic, including watching friends and lovers pass away, and experiencing significant societal stigma relating to their identities and HIV.

As such, the services and supports needed by men from each cohorts are different. For example, older gay men may benefit strongly from cumulative bereavement-related support, whereas more appropriate supports for younger men may include education around HIV stigma and HIV prevention.

Some life course models, such as the one used in a US-based report on the state of LGBT health in the United States, focus on age-specific needs of individuals (IOM, 2011). This approach highlights some of the issues that gay men may face developmentally and socially as children, adolescents, young adults, middle adults, and seniors.

The life course model also recognizes that individual experiences throughout life snowball to impact one's health and wellbeing over time. For example, Ron Stall's syndemic model

(see section 11 on syndemics) shows how experiences throughout boyhood and adolescence can impact health outcomes in adulthood. This model shows that there is a pattern to many gay men's individual stories, and these shared contextual factors at different points across their lives impact health.

Limitations

Current life course work often focuses on a singular category and its possible impacts throughout one's life. However, as intersectionality suggests (see section 3, this collection), it is also crucial to account for more than just an individual's sexual identity. The narrative approach to the life course model, used by Cohler and Hammack (2007), encourages men to tell their own stories, which certainly allows for the possibility of intersectional discussion.

Conclusion

Along with minority stress, intersectionality and a social ecological perspective, the Institute of Medicine recommends a life course perspective in future LGBT health research. Life course approaches to gay men's health help service providers, policy makers, researchers and others working in diverse communities of men to account for men's cumulative lived experiences and tailor care, support and prevention to meet their needs.

Further Reading

World Health Organization (2000) – A Life Course Approach to Health. Available online via http://www.who.int/ageing/publications/lifecourse/alc_lifecourse_training_en.pdf

Bertram Cohler and Phillip Hammack (2007) – Making a Gay Identity: Life Story and The Construction of a Coherent Self.

Coming Out

One way that our individual experiences are impacted by multiple identities is by the types of assumptions that we make, such as when gay, bi, and trans people should come out. This assumption takes for granted that social and economic costs associated with coming out are manageable for individuals. However, it does not recognize the ways simultaneous identities and positions shape the costs associated with coming out. For example, men who have stable employment and feel able to address any possible discrimination may face different barriers to coming out than men who fear they will lose their jobs, or men who fear they will not be hired if their potential employers know their identity. Challenging our assumption that individuals should come out to their service providers and employers may lead us to direct our efforts to create workplaces and health services that meet the needs of gay and trans* individuals whether or not they have come out.

Ins and outs of “the closet”

Decisions about if, when, and how to share one’s sexual identity or sexual attraction are often ongoing in the lives of gay, bisexual, queer, and Two-Spirit* men. Whether men share their sexuality all the time, sometimes, or never, negotiating “the closet” shapes many aspects of their lives from social networks to health care access. In this blog, I will review what we know about gay men’s experiences in and out of the “closet”, and how these experiences impact health and wellbeing across the life course.

All aspects of men’s identities and the communities in which they live shape their decision to, and experience of, coming out about their sexuality. Men may also negotiate coming out about their gender, mental health needs, or living with HIV that may impact subsequent coming out decisions (IOM, 2011). Decisions about whether or not to come out may be shaped by concerns about safety, employability, existing identities, relationship status, access to community support, fear, and



Decisions about if, when, and how to share one's sexual identity or sexual attraction are often ongoing in the lives of gay, bisexual, queer and Two-Spirit men.

anxiety. Decisions about coming out must also be understood within historical context. In their work on the life course model, Hammack et al. (2008) argue that men's process of understanding their identities and the ways they express it have been shaped by the social and cultural environments when they grew up.

Some men may come out to everyone in their life, whereas other men come out in certain contexts but not others. Meyer (2007)'s minority stress theory suggests there is ongoing stress associated with decisions related to identity management. For example, men may consciously conceal their partner is a man, or certain knowledge or skills others may associate with being gay.

Coming out and health

Several theories reviewed in this blog help to reveal the many ways in which coming out impacts health. First off, heterosexism and queer theory analysis reveals a structural context which puts the burden on individual men to come out about their sexuality, gender or HIV status. Health care systems and providers tend to assume men to be heterosexual, cisgender and HIV-negative unless they are told otherwise. As a result of these assumptions, care is often oriented to the needs of heterosexual, cisgender, HIV-negative men, leaving many men without appropriate care (Dahan, Feldman & Hermoni, 2008). The result is that men have to disclose an aspect of their identity in order to get the care that is right for them. However, while some men do not feel comfortable disclosing their identities, between 40-50% of Canadian gay men are out to their primary health care providers (Dulai et al., 2014).

Assumptions regarding sexuality, gender and HIV status also are reflected in training and education. As a result, health care providers are not always equipped with the tools to have open and knowledgeable conversations about sexuality, gender, HIV status and sexual history. These concerns about coming out in primary care settings also pertain to other health and social services, such as seniors' homes and long-term care facilities for people of all ages (Global 16x9, 2014).

Being out can also shape men's connection to community. Syndemics theory portrays circumstances wherein men who are out may lose support from communities they grew up in,

and gain support from other communities if they are able to find them. For example, some men may migrate away from the communities they grew up in if the communities' reaction is hostile. Upon arriving in a new place, these men may encounter new communities that affirm gay men. Community connection is often seen as a crucial resource for coping with minority stress, and for resilience.

Implications

As many scholars have argued, it is crucial that we identify and respond to the problem of the oppressive systems at play, and not solely on those who experience oppression. Canadian evidence suggests coming out remains a challenge, particularly when disclosing to service providers. In a society where men do not feel comfortable coming out, we must consider how we can provide holistic and specific services to ensure men are getting appropriate care whether or not they are out. An approach that offers care to meet these men's needs will strengthen health and wellbeing for both out individuals who do not want to disclose to a provider, and to those men who are not out to anyone. This kind of approach may also help to affirm and increase visibility of some aspects of the lives of bisexual, gay and queer men.

Conclusion

Coming out happens at different points throughout men's lives, with men increasingly coming out at younger ages. Many men have had coming out experiences, and these experiences continue to impact their day-to-day lives, as well as their health and wellbeing. Supporting positive sexual identity development processes and affirming coming out experiences for those who leave the closet needs to be multifaceted. And yet, it is also imperative that we continue to work towards ensuring services, including long-term care homes, sexual health clinics and schools, are providing care that will meet the needs of gay, bisexual, queer men whether or not these individuals are out.

Further Reading

Lewis, Lesli-Ann. 2014 – *This is Coming Out*. Published by Black Girl Dangerous. Available online via <http://www.blackgirldangerous.org/2014/05/coming/>.

Understanding Syndemics & Gay Men's Health

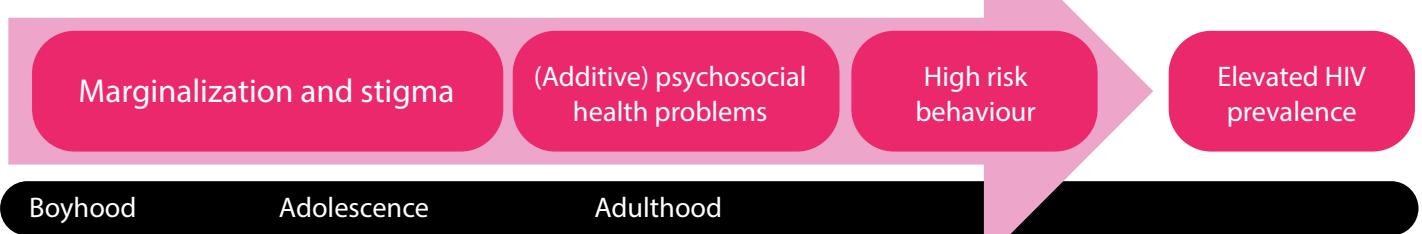
Social inequities such as oppression undoubtedly have health impacts. Many of the theories considered in this collection emphasize these connections, which are inconsistently acknowledged in much of the practice of public health. One such theory is syndemics, which holds that social disparity creates the conditions for, and heightens the risk and impact of, multiple, reinforcing epidemics. These epidemics co-occur to “additively increase negative health consequences” (Mustanski et al., 2007, p. 38).

Syndemics theory foregrounds the social and structural factors that produce health inequities among a range “socially devalued groups” (Merril et al., 2006, p. 2011). The first documented use of the term syndemics was used to label the simultaneous epidemics of substance abuse, violence and AIDS among Puerto Ricans in Connecticut. Since then, research in Canada and the United States has documented syndemics among gay and bisexual men. Large surveys of gay men have shown the same connection between epidemics of marginalization, psychosocial health outcomes and HIV risk indicators (Ferlatte, 2011; Ing et al., 2012; Stall et al., 2003).

The syndemic model in gay men

Stall et al. (2003) first applied syndemics to gay men’s health, documenting the snowballing nature of syndemics over men’s life course. Stall’s model focuses on boyhood contextual stressors related to traditional masculine gender norms and heterosexism. Many men connect with gay communities online or in person. In Stall’s research, this contact with gay communities leads to migration to physical gay communities, often in urban centres.

In this trajectory, men encounter heterosexism as an ongoing stressor that prompts migration. Increased contact with gay communities gives men access to new strengths (e.g. increased opportunity to be oneself) and weaknesses (e.g. pressure to



Syndemic Model, Adapted from Stall et al., 2008

fit into a new community). Throughout these stages, there are psychosocial health concerns (e.g. emotional distress, depression, suicidality) relating to the stressors they experience.

Evidence of syndemics

Canadian evidence shows as many as 20-25% of gay men experience multiple, co-occurring psychosocial health issues. Data from the 2010 Sex Now Survey shows that men who report more experiences of lifetime marginalization (harassment, physical violence, forced sex, career impact, and suicidality) were more likely to report psychosocial health issues (emotional distress, social isolation, substance abuse, care for depression, care for other mental health issue). Men who reported two or more psychosocial issues were significantly more likely to report anal intercourse with an unknown status partner (Ferlatte, 2011).

Research based in Toronto, Ontario also highlights the syndemic nature of gay men's experiences. This research found that each negative psychosocial outcome (anti-gay assault, depression, social anxiety and internalized homophobia) is associated with the others, indicating that these issues are mutually reinforcing. Further, this research also indicated that among men who reported 3 psychosocial health problems, the prevalence of unprotected anal intercourse and men living with HIV was higher than among the groups of men who reported 1 or 2 psychosocial health problems respectively (Ing et al, 2012).

Opportunities for syndemics research

Currently, research informed by syndemics theory foregrounds gay-related factors, such as homophobia and heterosexism, often to the exclusion of factors such as biphobia and transphobia. However, we know that sexual identity among men within syndemics research is diverse, and the current focus

on gay-related factors may not capture the full experiences of marginalization experienced by Two-Spirit*, bisexual or queer-identified men. Further, it is also crucial for syndemics research to recognize additional aspects of men's identities, such as gender, age, ability, and race that can influence health outcomes. This is one opportunity for future syndemics research.

Currently, the linear nature of syndemics theory frames HIV diagnosis as the end point in the model. Syndemics research that explores how HIV stigma may contribute to the social production of adverse psychosocial outcomes for men who are HIV-negative and HIV-positive alike, and the impact of these outcomes on the health and risks of men living with HIV would also be a welcome addition to the field.

Conclusion

Syndemics theory draws a connection between indicators of marginalization, psychosocial health concerns, and increased HIV-related risk factors. The evidence generated by syndemics theory points to the need for increased collaboration between the many sectors involved in supporting gay men's health and wellbeing throughout men's lives. Syndemics shows us that reducing gay men's experiences of heterosexism and other forms of marginalization can reduce psychosocial health concern and related HIV risk behaviours. This goal requires systemic action throughout and within the gay men's health sector.

Further Reading

Herrick, Amy et al. 2011 – *Progress Through Resiliency: Syndemics, strengths, and HIV among Men who have Sex with Men*. Published in Positively Aware. Available online via http://positivelyaware.com/archives/2011/11_07/progress.shtml

Glossary

Antiretrovirals

Class of medications used to treat or prevent HIV in our bodies.

Cisgender

Gender designation that refers to people whose physical sex assigned at birth (typically, male or female) is congruent with their current gender (typically, man or woman).

HIV

Human Immunodeficiency Virus, a virus that affects the immune system of humans. HIV can only be passed through one of five bodily fluids: blood, breast milk, rectal fluid, semen and pre-cum, and vaginal fluid.

Two-Spirit

English-language term to describe indigenous communities' traditions of sexual and gender identity that rejects the Eurocentric sex/gender binary, and resists "heterosexism in Aboriginal communities and racism in LGBTQ communities" (Ristock, Zoccole, & Passante, 2010, p. 4-5). The term was first used in 1991, when an Aboriginal elder had a vision and was told two-spirit is what people who are Aboriginal and who are gay will be called.

Unprotected anal intercourse

Research and clinical term used to describe penile-anal sex when no condom is used. Many activists in Canada and elsewhere have called for the use of the term 'condomless sex' to more accurately describe this act, and this recommendation has been echoed by the Centre for Disease Control in the United States.

See preventionjustice.org/victory-cdc-responds-to-open-letter-commits-to-condom-clarity/.

Racialized

Process of ascribing a racial and/or ethnic identity to individuals using information from a person's visual appearance, mannerisms, language, cultural practices, etc.

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At the Interface

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