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Stigma and the Determinants of Health: How Did We Get Here?

Terry Trussler,
CBRC Research Director

Welcome to Vancouver and the traditional territories of the Squamish, Tsleil-Waututh and Musqueam First Nations.

Some of you might remember that the Summit originally evolved from a regional meeting the CBRC hosted each fall since 1999. We would share our year’s accomplishments and plan for the next. It was a humble beginning but we began to notice that what we dreamed about actually happened—always following CBRC’s own model of knowledge in action: STUDY PLAN DO.

The first Summit in 2005 was actually a souped-up version of one of those early regional meetings. We had a day of research presentations followed by a planning day. We focused on five main improvements to support gay men’s health.

We dreamed about: a dedicated gay men’s health organization—and HIM (Health Initiative for Men) was built; a youth sexual health leadership program—and Totally Outright would spring to life nationwide; a community research, monitoring and evaluation program—Sex Now was re-engineered into a national survey in its 3rd iteration; a gay men’s health strategy—which would eventually be championed by BC’s Provincial Health Officer; a dedicated social marketing and health communication program—and we are now in the beginnings of Resist Stigma, a community created campaign which we will be hearing about in this Summit.

There was a turning point in 2009 when we began to look deeper into the social ecology of gay men’s situation with HIV and the broader determinants of gay men’s health. The Determinants of Health was a much-desired topic at our 5th Summit. But it was a research topic we knew little about, except for the way the officially accepted determinants were portrayed in Canada’s health policy. Nothing about sexuality.

Until then we were still heavily influenced by HIV prevention research: monitoring the correlates of HIV risk, basically just replicating conventional epidemiological studies of gay men. It never felt right, for so many reasons. We knew we would need help to make progress. So we began to invite experts into our subsequent Summits. And with that began an incredible adventure in gay men’s health development.

Verlé Harrop took apart the determinants of health model and announced that gay men were invisible in Canadian health policy and research. Without the appropriate categories to study sexuality we were doomed to be left out of the research most apt to influence government policy—where real change needed to be made. Olena Hankivsky pointed out the weaknesses in Health Canada’s determinants framework; how it misses critically important health inequities between mainstream and marginalized populations. Intersectionality was needed to examine the multiple intersecting social locations that influence health.
We met Ilan Meyer at an Intersectionality event and invited him to introduce Minority Stress theory into the Summit. Minority Stress showed us a way to account for the way prejudice influences health outcomes. That helped us reframe the way we collect and analyze data in the Sex Now survey.

David Brennan showed how social pressures affect the way gay men see themselves—especially our own bodies. It gave us a direct way to talk about how social stress gets under the skin and ends up affecting the mental and physical shape we find ourselves in. When we began to see what we thought were generational clashes in our midst (principally over PrEP) we invited Phillip Hammack to talk about Life Course theory and gay men's health. He had us positioning ourselves within five distinct generations of gay men, with different outlooks depending on the conditions surrounding their coming of age.

Then last year, with help from Paul Flowers, Irv Rootman and Mark Gilbert, we turned to look at how gay men’s health was affected by the extent and quality of our knowledge of health and health systems and knowledge of gay men within those systems. So by expanding our understanding of what influences HIV prevention we found that it all relates to the big picture of what influences gay men’s health.

Looking over the breadth of themes we've covered in the Summit over these years you can actually see how much our knowledge has expanded once we got out of the behavioural blame game and looked at the wider context in which gay men’s health predicament is situated. In every way we have seen that gay men’s health promotion is HIV prevention. Only there's so much more to it than risk, condoms, or PrEP. Gay men’s health is broadly about our complete lives.

To meet the challenges that this has brought on we have incorporated all of the theory frameworks recommended by the Institute of Medicine Report (March 2011). We are using these theories to conduct analyses in Sex Now, and for our narrative work in website blogs, training activities and so on.
And now we’re moving to incorporate stigma. We were already thinking about stigma as a topic for this Summit when Mark Gilbert circulated his paper—*Stigma as a fundamental cause of population health inequalities*. The language in this paper was all about determinants. Stigma as a determinant of health. It was great to see some of the same thinking and linkages we’d been working through—obviously a kindred spirit on the same path. Mark Hatzenbeuhler, its lead author, is our keynote speaker today.

Thinking about stigma will have you encountering new language that you may find useful and possibly more accurate than other words we commonly use. Personal stigma might take the place of homophobia. Self-stigma for internalized homophobia. Structural stigma might replace heterosexism. Perceived stigma as reactions to homophobic remarks. These terms are connected and reinforce stigma’s power.

As we have learned from intersectionality, stigmas, like all social phenomena, do not occur in isolation or silos. Gay men are subject to multiple stigmas that add up to an extra load of felt stigma and what we have come to see as sexual minority stress.

The dialogue we engage in here will be very useful because we’ve been seeing something we suspect is an artifact of structural stigma in our own data sets from the Sex Now survey. This shows gay men getting the worst of employment discrimination, straight men getting the least, and bi men somewhere between. Only thing is it’s not just employment discrimination—it’s everything—from income distribution to violence and other enacted stigma to health outcomes; it’s all the same basic pattern we see here—what we think of as a sexual health gradient.

We’re looking forward to what young gay men will do with such themes in CBRC’s latest venture, the Resist Stigma campaign. Thank you presenters for the amazing contributions that are making up this year’s program.
Structural Stigma and the Health of Lesbian, Gay and Bisexual (LGB) Populations

Stigma is a multi-level construct, enacted at individual, interpersonal, and structural scales. Individual forms of stigma refer to the psychological processes through which one perceives and reacts to stigma; this form of self-stigma includes practices such as concealing sexual orientation, and internalizing negative societal attitudes. Interpersonal stigma involves overt and subtle forms of violence and aggression, such as biased based hate crimes between the stigmatized and non-stigmatized.

Documenting the many impacts of stigma across all scales is important for gaining a complete understanding of LGB health. Most stigma research, however, has almost exclusively focused on these first two levels of individual and interpersonal stigma. In his keynote presentation, Mark Hatzenbuehler shared creative and innovative research designs used to quantify and measure the effects of structural forms of stigma on LGB populations, addressing a substantial knowledge gap.

Structural forms of stigma consider societal-level conditions, cultural norms, policies, and practices that negatively impact the opportunities and well-being of the stigmatized. As such, the underrepresentation of structural stigma in research represents a dramatic shortcoming, and it is a major contributor to adverse health outcomes and inequalities among LGB populations. Hatzenbuehler suggested that the relative absence of research on structural stigma is a reflection of the methodological challenges in conducting this form of research. To address this, Hatzenbuehler presented four innovative methods in researching structural stigma.

The first method uses cross-sectional, country-level data to address the question: Are health problems elevated among LGB populations in high-structural stigma environments? To answer this, Hatzenbuehler and colleagues first needed to differentiate between low- and high-structural stigma environments. They chose to focus their research in Europe, as countries in the region have significant variation between policies and practices towards LGB individuals. For example, countries that protect LGB individuals from hate crimes, allow same sex adoption, and guarantee equal marriage rights were considered low-structural stigma environments.

Once countries were given a relative stigma score, they were linked to health data including individual HIV risk and other variables, and statistical analysis was performed. This, and similar studies, provided preliminary evidence that a significant association exists between measures of structural stigma, and adverse health outcomes. However, because cross-sectional designs are weakest in their ability to demonstrate casual inferences, Hatzenbuehler and colleagues looked to other methods to gain better insight.
The second method uses longitudinal data to answer the question: Does structural stigma predict health problems, in particular increased mortality risk, among LGB populations? To answer this question, Hatzenbuehler and colleagues needed a unique dataset that measured sexual orientation, structural stigma, and mortality, over a very long period of time. Because no such dataset existed, they created one by linking the general social survey—which measures location, sexual orientation, as well as attitudes and prejudice towards gays and lesbians—with the national death index. Finally, Hatzenbuehler and colleagues were able to identify high-structural stigma communities, by measure of prejudice, and conduct their analysis.

Findings showed that sexual minority individuals who live in the highest structural stigma environments die 12 years earlier than those who live in the lowest structural stigma environments—even after controlling for variables such as age and income. In particular, cause of death for LGB individuals in high-structural stigma environments was suicide, homicide and violence, and cardiovascular disease.

The third method uses natural experiments to assess the health impacts of changes in structural stigma over time. Natural experiments are useful, as it would be unethical to randomly assign individuals to live in low- or high-stigma environments, which makes conducting traditional experiments difficult to do. In this way, natural experiments take advantage of naturally occurring changes in structural forms of stigma, such as changes in social policies.

To evaluate changes in structural stigma on health outcomes, Hatzenbuehler and colleagues looked to the 2004 US election, where multiple states passed constitutional amendments to ban same sex marriage. Next, they found a dataset that measured participants in 2001 and 2005, before and after these constitutional changes. This research suggests that stigma should be considered alongside other social determinants of health and mortality. It’s not currently considered among the list of major social determinants of health, but these data and others are beginning to change that conversation.
changes. Again, the results were surprising. They found that LGB individuals living in states that passed same sex marriage bans had significant increases in mood disorders, compared to a LGB individuals living in states that did not pass a constitutional amendment. In fact, LGB individuals in low-stigma states actually saw a significant decrease in mood disorders. Heterosexual respondents in both low- and high-structural stigma states saw no change in health outcomes, affirming that structural forms of stigma have negative consequences only on the stigmatized.

Finally, beyond observational, longitudinal, and natural experiments, Hatzenbuehler concludes by measuring the impacts of structural stigma in a laboratory setting. Compared to the aforementioned studies, the advantage of laboratory research is experimental control. In this way, it is possible to examine how prior exposure to structural stigma affects a variety of different biological and behavioural responses to the same stimulus in the laboratory.

In this experiment, Hatzenbuehler and colleagues wanted to know whether previous exposure to structural stigma effects physiological stress responses. To accomplish this, they recruited young LGB adults from different states, then linked measures of structural stigma to the states represented. Research participants were then subjected to a stress test, and neuroendocrine samples were collected before, during and after the test.

When comparing samples of participants from low and high-structural stigma states, they found a blunted cortisol response for those who grew up in high-structural stigma environments. This blunted response is also found in individuals with post-traumatic stress disorder, and youth exposed to extreme life stressors. In this way, Hatzenbuehler and colleagues were able to demonstrate that growing up in high-structural stigma environments exerts a biological effect that is similar to other chronic life stressors.

It is clear that all forms of stigma, including individual, interpersonal, and structural stigma, has far-reaching impacts on the health and well-being of LGB populations. In future research, it is important to identify forms of resilience in populations that may aid in the future development of preventative interventions, to lessen the effects of stigma. Moreover, it is necessary to look beyond LGB identities, and understand how all forms of stigma affect those of varying socio-economic status and ethno-cultural backgrounds. To do this, we need to continuously develop new tools to measure stigma, and encourage innovate study design. It is only with knowledge and understanding that stigma can be addressed at all levels, and we can achieve health equality. (Jeff Morgan)
Gay Youth Fighting Stigma: Initiatives from Totally Outright

The trauma of early social isolation that many gay men experience as a result of homophobia and heteronormativity can fuel a sense of shame that they often carry through the rest of their lives. Combatting this stigma then is an important step to not only achieving a healthier sense of self, but also to moving society forward. This struggle takes many forms, from Stonewall to marriage equality, but for many gay men, activism and community building become an affirmative step in their lives. During this panel, gay men shared the positive outcomes for participants of Totally Outright (TO), a leadership program for young gay and bi men.

Joshua Edward and Michael Kwag of the Health Initiative for Men (HIM), in speaking about the successful creation of the campaign, Think Before You Type, touched on the stigma facing young gay men and their responses confronting it. Edward mentioned how the pervasive heteronormativity of society compounded by isolation leads to higher rates of negative health outcomes including suicidality. Further, he spoke of how, when connecting with other gay guys online, many make sweeping and often stigmatizing statements about their prospective partners based on race, gender, age, and size.

Kwag then spoke of how, for one group during TO, this was deeply hurtful and unacceptable. The group came up with the idea to create a campaign which would start a dialogue challenging others to think about the ramifications of their ‘preferences’. The TO curriculum then had a designer come in to help develop this concept into a ‘mini-campaign’ with the help of Health Initiative for Men. The young gay men not only were able to identify a real problem, which affects gay men of all ages, but also were able to create a response which generated interest from their peers.

While the Think Before You Type campaign was created directly through TO, others arise simply from the enthusiasm of young gay men. Indeed, OurSpace in Toronto, was conceived of after Aidan Ablona and Vincent Francoeur, graduates of the TO program, shared their dissatisfaction about ongoing social spaces for young gay men. They endeavoured to create a space within their community which would promote the health and well-being of young gay guys.

Ablona spoke of how they capitalized on the enthusiasm of other alumni, carrying forward the momentum of TO to create OurSpace. Quickly and without any funding to speak of, they began
to meet and plan events. They tapped into the skills of their members to provide workshops, blog posts, and compelling infographics. Most importantly, from these events they were able to crowd-source stories and experiences, sharing with other gay guys to combat isolation and enrich their lives. Looking forward the group hopes to break down ageism and serophobia by sharing more booklets filled with art and stories.

Unfortunately, not all cities have such large gay communities with infrastructure to support new endeavours. Jared Star of the Rainbow Resource Centre raised this as a particular challenge faced by the city of Winnipeg and its surrounding region. He explained that a little more nuance was needed to address the smaller city and its unique demographics; the gay community there is more fragmented and diffuse with a pronounced urban-rural divide, leading many younger gay guys to feel isolated. While they are able to hook-up with guys, afterwards there is often a sense of shame, which precludes social interactions in the future. To combat this a cohort from TO created Gays vs. Gays.

Gays vs. Gays is a video project consisting of several testimonials from guys speaking on the subjects of social dislocation, discrimination, and shame. By naming and exploring it, they showed not only an understanding of the social factors that contribute to stigma, but also a desire to change it. The experiences shared echoed those of TO alumni from other cities. Ageism, ableism, racism, sizeism were all alluded to. When it was shown at REEL PRIDE, the Winnipeg Queer Film Festival, it succeeded in starting a dialogue within the community.

Young gay men today are perched in a unique position. They’re in a generation where they’re starting to see themselves reflected in mainstream media. They came of age during a time when HIV was deemed ‘no longer a death sentence’ and marriage equality was realized. While these are giant steps forward that have been long fought for, this generation still faces tremendous challenges. They are more connected than ever to each other thanks to the internet, but in ways which can be toxic to their mental health. Nevertheless, the resilience, ingenuity, and enthusiasm that have been fostered during Totally Outright are creating tremendous positive changes in their lives and their communities. (Keith Reynolds)
Strategies for Prevention & Care to Impact Stigma

Stigma is complex, both in its causes and effects. Intersectional and community based approaches to studying stigma, its effects, and responses are necessary to understanding and addressing it. These responses show that the communities affected by stigma are acutely aware of what needs to be done, but that this anecdotal evidence is incompatible with the criteria for help at a program level. Instead, more research needs to be done.

Resilience amongst populations and individuals has grown: from earliest agitation for acknowledgement to concerted efforts to make policy changes. The panel presented initiatives which showcase efforts to better understand and address stigma within communities. Jaydee Cossar and Andrew Beckerman spoke of their work on the Stigma Index, which focuses on the communities and networks of People Living with HIV (PLHIV) and making them partners in research. Syune Hakobyan spoke of the need to develop policies which address stigma, and provide healthcare which is multidisciplinary for optimal results—removing barriers for people living with multiple vulnerabilities. Kiffer Card spoke of the adaptive strategies of gay men, discovered by the Momentum Health Study.

Cossar and Beckerman expressed their hopes that the Stigma Index will empower PLHIV by making them peers in the research. Instead of being studied as an object, or a cautionary health outcome to be avoided, this project records PLHIV experiences thereby enshrining PLHIV’s self-worth. In this way, it will benefit PLHIV by amplifying their voices and drawing attention to the multitude of ways HIV stigma impacts their lives such as workplace and housing discrimination, access to medicine, and criminalization. Recording the discrimination faced by PLHIV will provide quantifiable evidence for policy makers who can take targeted actions to reduce that discrimination. Furthermore, the Stigma Index unifies and connects PLHIV who are often marginalized and isolated. Removing the shame associated with sero-status is an important step to eliminating barriers for PLHIV so that they can thrive in all aspects of their lives.

Hakobyan also spoke about stigma’s role in creating and perpetuating negative health outcomes for people. Specifically, at the Vancouver Infectious Disease Clinic (VIDC), where she works, she treats people who experience multiple forms of oppression and discrimination. V IDC recently completed a retrospective analysis which looked at the rates of successful treatment of HIV-positive clients, for Hepatitis C (HCV). These clients include a high proportion of Men who have Sex with Men (MSM) and Intravenous Drug Users (IDU). Hakobyan noted that while these two populations experience significant stigma in their lives, that stigma varies and affects them in different ways. Indeed, the retrospective showed that the proportion of MSM who were cured of HCV was significantly lower than IDU. Hakobyan suggested that this was because IDU may be more engaged in continuous care, and therefore HCV treatment could be more stringently followed.
It would seem that better support for PLHIV coinfected with HCV is a critical component for treatment. While better treatment options are making curing HCV easier, and with fewer side-effects or drawbacks, the complex lives that PLHIV lead are worth considering. Indeed, without acknowledging this complexity and providing support in those areas, curing HCV is merely treating a symptom of a larger problem. Instead of compartmentalizing the problems caused by stigma and treating them as discrete issues, combatting them all at once by strengthening and supporting those afflicted by stigma is critical. How to address that stigma, requires proper context.

In some ways, Card answers this call for a better understanding of context by saying that sexual encounters aren’t simply a pattern of behaviour. They are a complex interaction between people, places and experiences; as any of those change, sexual behaviour adapts. In his work with the Momentum Study, he looked at these adaptations in order to provide evidence and inform future sexual health programming for gay men.

Using Respondent Driven Sampling (RDS), the Momentum Study has mapped sexual networks of gay men, and their sero-adaptive behaviours. They found that their participants are employing a number of these behaviours to keep themselves and their partners safe, including condom use, sero-sorting, strategic positioning, and avoidance of anal sex. Some of these strategies don’t have clinical guidelines provided by the medical community and warrant further exploration as to their effectiveness at protecting gay men.

It is important to note, however, that without the context of these encounters, gay men might once again be stigmatized thereby undermining any intervention’s success. To include gay men’s sexual desire as a worthy and necessary part of their total health is critical to avoiding stigmatization. Acknowledging this and the fact that many gay men are employing sexual health strategies should be encouraged rather than disparaged. Boxing them in and calling only for condoms when they have sexual intercourse is not only limiting, but also perpetuates heterosexism, homophobia, and serophobia.

Gay men exhibit tremendous ingenuity when dealing with health inequities. Not only on a personal level with coping skills and sero-adaptive strategies, but on a macro-level. The activism at the heart of gay communities has been fundamental to their existence. Indeed, one presenter remarked he “didn’t start living until after he joined the community”, saying that the support and pride he drew from the community was what enriched his life. This community and culture therefore cannot be divorced from research. It must be at the heart of findings to provide context and fight stigma. (Keith Reynolds)
Communities Fighting Stigma

Gay men contribute to a number of diverse communities, each with unique strategies and approaches to resisting stigma. This panel brought together four illustrations of communities fighting stigma, and the community-specific tools and interventions they deploy to remain resilient. In particular, knowledge gained from research within these communities demonstrates the importance of questioning norms and assumptions that pervade popular discourses in gay men’s health, and show the significance of adapting existing strategies to meet community needs.

Working with men who have sex with men (MSM) in the South Asian community, Ramraajh Sharvendiran presented findings from a mixed-method study conducted by the Alliance for South Asian AIDS Prevention (ASAAP). The study was conducted in response to a paucity of research capturing South Asian men, who are often grouped into larger categories of Asian, or ‘racialized’ more generally. The project was designed to build research capacity within staff and community members, making the research process as accessible as possible.

Engaging with communities of older gay men across Canada, Patrick Aubert presented findings from a national research study considering preparations for end-of-life planning in older LGBT adults. The study aimed to understand the issues and the extent to which older LGBT people plan for end-of-life, as well as to create a web-based platform to provide a supportive environment for information and community building. Aubert revealed that older gay men experience a double stigmatization, of sexual identity and age. This stigma results in feelings of invisibility in gay communities, and experiences of homophobia in heteronormative spaces of care.

Serving a particularly marginalized population of MSM and intravenous drug users in Vancouver’s Downtown East Side (DTES), Sahand Vafadary spoke to the unique challenges facing this dynamic community, which is heavily stigmatized. Vafadary makes clear the need for innovative and community-specific interventions, as many residents in the neighbourhood are still exceptionally under-engaged and underdiagnosed, especially in the context of HIV and Hepatitis C.

“Older gay men experience a double stigmatization, of sexual identity and age. This stigma results in feelings of invisibility in gay communities, and experiences of homophobia in heteronormative spaces of care.”
Presenting his doctoral, community-driven research with queer farmers, Joshua Edward uncovered the many intersections between agriculture, gender, and sexuality. Edward’s research reveals the stigma faced by many rural queer people, often expressed as negative and stereotypical assumptions of rurality. This study affirms that men experience queer identities differently, and that there is no right way to be gay.

These diverse, research-engaged communities together demonstrated that questioning norms and conventions, and adapting ideas and frameworks to specific community contexts, can be an empowering and impactful way to fight stigma. Within the South Asian community, the ASAAP study found that many South Asian MSM felt stigmatized in predominantly white gay spaces: encountering racism, feeling invisible, or experiencing shame over choices regarding disclosure and coming out. Many respondents’ decisions to compartmentalize identities, and to choose certain spaces to be out in and others to be silent, runs contrary to the common narrative that you need to be out to live an authentic gay life. This illustrates the importance of understanding community context, and questioning norms and expectations that can perpetuate stigma.

Research with older gay men reveals the importance of adapting end-of-life planning to account for their unique circumstances and experiences of LGBT people. Aubert points to the fact that many older gay men may have shrinking social circles, due to the impact of HIV/AIDS. Furthermore, many face perceived or external stigma from care providers, who may be uninformed in gay men’s health or other LGBT issues. Having said that, older gay people remain resilient, and have a desire to create chosen families, be involved in community, and become integrated. By failing to seek out the perspective of LGBT people in end-of-life planning, we miss identifying not only the stigma they face, but also the ways older LGBT adults remain resilient.

Vancouver Infectious Diseases Centre’s (VIDC) community portable clinics represent a community-specific innovation in Vancouver’s DTES. Portable clinics recognize that barriers exist in accessing care, including the stigma of seeking care, and they focus on outreach to populations at risk. At the clinics, services are designed to be as least invasive as possible, using oral swabs instead of blood tests, and also providing small incentives for testing and completing a questionnaire. It is only through targeted, adaptive approaches that marginalized communities such as Vancouver’s DTES will become engaged in the cascade of care for HIV and other public health initiatives.

Challenging norms in ecology is central to Edward’s study of queer farmers, advocating for an alternative and refutation of the heteronormative assumptions in sustainability. Edward believes that queer people can offer new perspectives or ideas that could challenge the industrialized notion of food production, and warns the exclusion of queer people could negatively impact the development of new and better agricultural practices. This research demonstrates that communities are centres of knowledge and innovation, which can question norms and expectations, and contribute to the fight against stigma. (Jeff Morgan)
Stigma is a powerful force, which marginalizes and silences those it affects. While larger societal changes may take place to remove societal level discrimination, the underlying issues of stigma often remain. For instance the assumption that in societies where some legal rights now extend to gay people, such as the right to marry, undoes all homophobia and its effects, needs to be challenged. Indeed, the context and historical traumas, which cause many health disparities in gay men, are still entrenched within major institutions. These institutions reproduce that stigma in a multitude of ways and removing them requires specific and targeted interventions.

In this panel, Elizabeth Holliday spoke of how many doctors were poorly equipped to deal with the specific health issues of gay men and that supporting them with Continuing Professional Development (CPD) courses will lead to better standards of care for gay men. Ryan Watson on the other hand studied how the students in schools which had Gay-Straight Alliances (GSAs) had better health outcomes and reported less teasing.

Holliday spoke about her work supporting family physicians and equipping them to better serve gay, bi, and other Men who have Sex with Men (gbMSM). Holliday believes that supporting Family Physicians (FPs) with accredited CPD teaching cultural competency for gay patients will have the additional effect of relieving stigma and its effects, thereby strengthening the health and well-being of gbMSM. In this way, Holliday aims to address structural stigma and biases inherent in the medical community.

Holliday’s work grew out of the Provincial Health Officer’s report Sex, Stigma, and Society, the Sex Now Survey, and recent discussions with people in the community. Holliday identified the need and opportunity to address gaps for gbMSM when accessing primary care through their FPs.

In order to properly address these shortcomings and gauge interest in CPD sessions on gbMSM health, consultations with FPs were conducted. An interesting revelation that resulted was that while FPs recognize the importance of using non-stigmatizing language, they may not have a necessary alternative, or easy access to resources where they could learn it.

These consultations evoked five main areas for improvement which included: understanding that peoples sexual identities were complex; using comfortable non-stigmatizing language; recognizing common health issues experienced by gbMSM; the importance of creating a safe and inviting clinical space; and understanding the process of coming out.

The curriculum which was developed as a result is delivered in either a webinar or a workshop. Both discuss the epidemiological context for supporting gbMSM as well as the specific needs of gbMSM; they present a complex case-study for FPs which requires them to look at a patient’s mental and sexual health, and places an emphasis on creating a safe space and open dialogue.

“Some health care providers are poorly equipped to provide culturally sensitive [care] ... and/or may not be knowledgeable about health issues common among gay and bisexual men.”
course also had a follow-up program to assess both the positive impacts on the FPs practice and to provide them with other resources for future development.

By providing this comprehensive solution, Holliday hopes that FPs who take part in either program will be able to better interact with gbMSM patients. Indeed, early offerings of the program were popular, with higher than average rates of attendance. Holliday also reported very striking positive outcomes for FPs who participated.

It is worth noting that the program was titled, provocatively, “But I don’t have any Gay Patients” which is something that Holliday has heard anecdotally and by some of the FPs who expressed interest in the program. While this may be true, many gbMSM, especially outside of Metro Vancouver, do not feel comfortable coming out to their doctors due to stigma and homophobia. This problem of visibility is perpetuated by the heteronormative assumptions and biases within the healthcare industry and society.

This problem of visibility is also replicated in schools where stigma is not only more pronounced, but also actively reproduced through discrimination and anti-gay harassment of students. Students don’t have the same level of agency as most adults and therefore have fewer options when dealing with the homophobic abuse they face. Indeed, stigma acts to rob them of any agency they have to stand up against it. When bullied or discriminated against, anti-gay stigma and toxic masculinity shames students into just accepting it. However, Watson contends that creating groups such as GSAs within schools protects students.

Working from the BC Adolescent Health Survey, Watson was able to look at the well-being of students and track their reported levels of harassment over 17 years. By correlating this with the presence of GSAs, Watson found that schools having GSAs over an extended period of time, reported lower rates of harassment, discrimination, and suicidal ideation. Indeed this protective influence became more pronounced the longer that schools had GSAs.

What is perhaps most important, is that the lower rates were reported in all male students, not just ones who identified as gay. This speaks not only to the profound impact that homophobia has on everyone, but also how direct actions to improve the visibility of gay students counters stigma and homophobia.

Challenging institutional stigma requires support and reform at an institutional level. While many people understand the importance of supporting gay individuals, they often lack the provision to do it in a meaningful and reproducible manner. To eliminate ongoing institutional stigma, explicit protections and actions need to be carried out which address the underlying problems of heteronormativity and homophobia in society. (Keith Reynolds)
Confronting Stigma in HIV/STI Care

Biomedical interventions for the prevention and treatment of HIV are making tremendous gains. Indeed, HIV is often said to no longer be a death sentence, thanks in large part to better testing technologies and medications. However, the uptake and therefore effectiveness of these interventions are greatly limited by the role that stigma plays. HIV and STIs carry with them immense sexual stigma. Coupled with the role of marginalization for those at greatest risk for contracting HIV/STIs, prevention and treatment efforts must address the significant barriers to accessing healthcare.

During the panel Confronting Stigma in HIV/STI Care, Zachary Tanner spoke to the significant gains made in Combined Anti-Retroviral Treatment (cART). Syune Hakobyan echoed this with her look at the role stigma plays for patients Lost To Follow-up (LTF), and Mark Gilbert discussed results for Get Checked Online, which aims to empower participants with better access to HIV and STI testing.

Tanner presented a research study on the effectiveness of cART among gbMSM by measuring speed of suppression and rates of viral rebound. Understanding these two factors would allow for better long-term care of HIV+ people in Canada as suppressing viral load to undetectable levels improves health and reduces transmission.

Great success has been made in reducing infection rates as a whole, however gbMSM remain the highest in terms of new HIV infections. Tanner suggested that this is largely a product of stigma. gbMSM may not feel comfortable or be unable to access gay-friendly health care for fear of being judged or mistreated.

Factors which improved rates of viral suppression were: calendar year, age of patient, and whether or not they had a history of IDU. This was explained as a function of better therapies being made available, better adherence, and better baseline health.

Tanner recommended that more be done to protect and support young gbMSM and IDU. The young are more susceptible to challenging circumstances, housing issues and social support. Their perception of HIV as a whole may also help to shape their decision-making and behaviour. Unfortunately, young people are also less likely to access healthcare. To combat this, specific programs which promote testing and adherence to cART should be provided alongside peer support programs which will hopefully reduce feelings of isolation and shame. However, this will not be an effective intervention if gbMSM avoid accessing care. Underlying heteronormative assumptions and ongoing homophobia must be addressed if gbMSM, especially young gbMSM, are to better look after themselves.

Hakobyan echoed the call for addressing issues of stigma. In her work at the Vancouver Infectious Disease Clinic (VIDC), stigma is a huge problem that keeps individuals feeling marginalized from getting their own health care needs met. The VDIC performed a retrospective analysis on their patients Lost To Follow-up (LTF); they found that MSM are at a slightly elevated
of being lost to care. This endangers not only the health of the patients, but also lowers health at a population level.

Complex issues are at work in the clinic. The multi-disciplinary team that provides care aims to treat illness as well as reduce stigma. Creating a welcoming space for marginalized people is incredibly important when making healthcare more accessible and reducing the number of patients LTF. While bridging the divide between marginalized populations and health care providers needs to be addressed to provide better all around health and prevent stigmatization, circumventing the barrier of stigma while accessing HIV and STI testing is an important stopgap.

The Get Checked Online program was conceived of as a way to make testing more convenient but one of the more popular outcomes has been that it can help remove the possibility of stigmatization. It is thought to be a better means of providing care to rural communities where stigma associated with STI's or being gay is more pronounced. Additionally, young people who have access to a Family Physician but aren’t out or comfortable speaking about STI testing to them have an alternative. This is incredibly important since, as Tanner presented earlier, young gbMSM are more susceptible to the effects of stigma. Giving them options to access health care may be a useful outcome in and of itself, but may also lead to faster treatment and suppression of viral loads.

Mark Gilbert expressed optimism about the uptake of this, and other programs, and that they will continue to grow, not only in membership but also geographic reach. The majority of people accessing the service are doing so in Metro Vancouver but nearly a tenth are from elsewhere in the province. Additionally, those that have created an account or those that have tested, say they intend on using it in the future.

Detecting and providing care to people with HIV and other STIs is in many ways only treating the symptoms of much larger societal issues. Understanding and addressing the long-term health issues and marginalization caused by sexual stigma, heteronormativity, homophobia, needs to be a component of any health care initiative. By valuing the lives of those most affected and treating these individuals with respect, health care professionals can give them better outcomes, and better lives. (Keith Reynolds)
Innovative Approaches to Undoing Stigma

This panel brought forward four innovative ways to fight stigma across different community contexts. Together, the panelists advocated for targeted and culturally appropriate health interventions, which take into account the diverse identities held by gay men.

Eddy Elmer addressed the stigma of loneliness faced by many gay men, describing loneliness as a discrepancy between the quality and quantity of relationships one desires, and those one has. Loneliness is a subjective state, experienced differently by each of us, however, it is clear that loneliness is highly stigmatized, and often carries the weight of shame and embarrassment. Loneliness can also result in many adverse health impacts, including increased drug and alcohol consumption, riskier sex, less self-care, and a fatalistic attitude. Elmer’s discussion of loneliness was a powerful illustration of the impacts of stigma on the health and well-being of gay men on many intersecting levels.

Victor Huynh and Marcus Sanzi from AIDS Vancouver discussed various forms of stigma and discrimination impacting gay men, focusing on institutionalized racism in gay men’s health. In particular, they framed operational forms of institutional racism as a considerable barrier to supportive care for many people of colour. Huyngh and Sanzi trace this systemic issue to legacies of colonialism, which has created a hierarchy that privileges whiteness, and is perpetuated through supportive services catered to white gay men. As a result, race has increasingly been positioned as a risk factor for HIV and other health concerns, requiring targeted and innovative approaches to address this pervasive inequity.

Joshua Edward from the Health Initiative for Men (HIM) presented preliminary findings from a campaign evaluation, which promoted HPV vaccines for gay men in the Lower Mainland. In addition to getting vaccinated, the #GetGarded campaign was designed to lessen the stigma associated with accessing HPV prevention and treatment resources. Human papillomavirus is the most common STI, associated with genital warts and some oral and anal cancers. Currently the vaccine is publicly funded for gay and bisexual men under the age of 27, and covered under most insurance plans.

Ellen Demlow and Glenn Doupe from Vancouver Coastal Health discussed bathhouse nursing in Vancouver, demonstrating how this unique service addresses important healthcare needs.
needs of marginalized populations at higher risk for HIV infection. This innovative healthcare intervention provides more than STI testing, with the majority of resources dedicated to education, information sharing, and referrals to other supportive services.

The panellists collectively illustrated that culturally appropriate, targeted health promotion strategies are an effective way to fight stigma impacting gay men. Elmer’s innovative approach centres around adapting our understanding of loneliness to account for the unique, intersecting factors that affect gay men. For example, gay people are more likely to experience loneliness than heterosexual people; this is especially true for older gay people, and trans people. Elmer contrasts this reality to popular representations of gay men, which overwhelmingly associate gay identities with partying, friendship, and increasing social acceptance. With an adapted framework for understanding loneliness in gay men, Elmer provides us with the tools necessary for identifying loneliness, and addressing the associated stigma.

Huynh and Sanzi revealed a highly innovative approach to HIV supportive services: the AIDS Vancouver case management program provides holistic support for gay men who face barriers in accessing supportive services, while working to build strategic community partnerships to address stigma at all levels. The program acknowledges that existing supportive services are primarily accessed by white able-bodied gay men, while the needs of racialized men are left widely unaddressed.

Speaking to HIM’s HPV vaccine initiatives, Edward reveals how the #GetGarded campaign was a targeted, culturally appropriate, web-based resource dedicated to dissemination and knowledge transfer. Their approach was simple: to work with communities to see what they responded to, rather than attempting to design a campaign using traditional, top-down approaches. Their campaign was translated into four languages, and preliminary evaluation revealed the campaign was successful at increasing awareness and understanding of HPV and vaccine availability. HIM is dedicated to developing more specific, targeted campaign materials.

Presenting findings from the Vancouver Bathhouse Survey, and using data from HIM’s Vancouver clinics intake forms as a point of reference, Demlow and Doupe show that their innovative bathhouse testing initiative addresses wider health services needs in Vancouver’s gay communities. Preliminary results from their survey reveal that bathhouse nursing clients are more likely to be older, and less likely to be white, than clients at HIM’s Vancouver clinics. The Bathhouse Survey also showed that although clients routinely access medical care through their family doctors, they preferred to access HIV and STI testing at dedicated STI services, such as bathhouse clinics. This demonstrates how bathhouse nursing not only reaches a marginalized clientele, but addresses the stigma of STI testing as well. (Jeff Morgan)
We have to bring all of us along: Ending Stigma against Gay, Bi, and Queer Trans Men

Syrus Marcus Ware, Ayden Scheim, and Kai Scott presented on the various dimensions of stigma facing gay, bi, and queer (GBQ) trans men within gay men’s communities, health care system, and research contexts.

What are the issues?

The panelists outlined the scope and scale of the issues facing GBQ trans men in their presentations, including visibility, intersectionality, and role of acceptance in care and belonging. The research indicates that there is a lack of visibility of trans men and an acknowledgement that trans men exist and participate in gay men’s communities. Ayden spoke to the history of this invisibility. Current research reveals a diversity of sexual and gender identities among trans masculine people. In particular, 64% of trans men surveyed as part of the Ontario Trans PULSE Study identified as gay, bi, or queer and 32% are non-binary identified. This is in contrast to historical data which indicated same-

“You don’t need to get an internationally-renowned expert on trans issues for most of these things. It is often really basic stuff, like using inclusive language, asking community members what they want, and having a lens that prioritizes these issues from the get go. ... Taking the load off of people who often feel alone in raising their voices is really important.” —Ayden Scheim

WATCH THE VIDEO: youtu.be/Z0M69wD2mcE
sex attracted trans men were anomalous, and directly tied to past practices of gender clinics that only allowed trans men to medically transition if they were straight. So, GBQ trans men carefully concealed their sexual orientations to fulfill their gender identity.

Syrus noted additional layers of exclusion based on intersectional identities, including trans men of colour within white trans male communities and organizations (e.g., dating straight men and not fitting ideal body type). Also, disabled trans men experience challenges within able-bodied trans communities, including lack of accommodation to their specific needs. Syrus also spoke to the tension between trans and disabled activists about the designation of gender identity disorder (now gender dysphoria) and related mental health stigma.

Based on these and other factors, many GBQ trans men experience a lack of understanding, inclusion of, and sense of belonging. Often, their level of acceptance, access to communities, and adequate care is dependent on being read as male or performing a particular type of masculinity. For many trans men, there are high levels of rejection which compromises their confidence and ability to negotiate safer sex. Given these complex factors, some trans men are willing to go to great lengths to obtain acceptance and to be seen (e.g., compromising the sex they want to have).

In addition, many trans men are unaware of their HIV status or level of risk due to a lack of resources, services, and materials that address the types of sex they are having, including receptive vaginal sex with cis’ men. This has further compounded significant barriers to health care access specific to trans bodies and needs.

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1 Cis(gender) is a term used to describe people whose gender identity aligns with their sex assigned at birth.
Why do these exist?

The panelists discussed the range of reasons and systematic context of the stigma that trans men experience. Research and organizations are also currently informed by cisnormativity with little or no recognitions of cisgender privilege and power. As such, limited research has been undertaken to fully understand the issues and challenges facing trans men. Exclusion of trans men occurs at several levels, including a lack of options in physical spaces (e.g., washrooms and equipment), and at an operational level (e.g., no or few tailored or inclusive programs/services). Furthermore, staff are ill-equipped to handle or anticipate trans issues and needs. There is also a lack of trans-specific resources to inform trans men of their HIV risk and sexual health.

How to overcome stigma?

The panelists provided many proactive and strategic actions that researchers, health care providers, and community organizations can take to reduce or eliminate stigma experienced by trans men. Reducing barriers and stigma starts and ends with consulting a diverse range of trans men to ensure they know they are welcome within gay men’s organizations and to conduct meaningful research that benefits trans men. This may require revisions to policies, procedures, services, programs, forms (registration and intake), staff training, and thinking and assumptions in research. Furthermore, organizations may need to address staff benefits (e.g., trans health coverage), washrooms and change rooms, as well as developing web content and marketing materials that are more explicit and specific about trans inclusion. Within research, needs include: targeted recruitment strategies and flexible timelines; updated methods of collecting data that captures the diversity of gender identities and transition statuses; and added research questions (e.g., Sex Now Survey). Also, there is a need to develop and disseminate trans-specific resources (e.g., Primed).

The panelists emphasized that trans inclusion needs to be an iterative, strategic, and comprehensive effort—the responsibility of everyone, not just trans men. There are short-term goals to help build momentum and trust among trans men. Then there are the long-term initiatives that ensure sustained growth towards inclusion. Here are a few examples from participants of the Trans Inclusion Workshop.

**Short-term**
- Create trans inclusive intake form
- Conduct staff training on trans issues
- Visit trans organizations to listen, learn, and invite trans men into gay men’s organizations

**Long-term**
- Seeing trans men in ALL gay men’s health resources
- Trans representation on boards, committees, and in staff
- Defining research-related goals with trans
If you’re not reaching out and creating programming and supports for trans guys, if you’re doing gay men’s health, then you are actually not doing part of your job. And part of your job is about working in collaboration with your colleagues and making sure they’re ready to do their job. Part of this allyship is doing all the parts of your job, not 90% of your job.” —Syrus Marcus Ware

“To have the CBRC to make the decision to prioritize this panel as the keynote is exciting and speaks a lot to the progress we have made and it’s nice to know that the banging at the doors for a while has really made an impact. ... It’s the beginning of a conversation, but I’m glad we’re having it together.” —Ayden Scheim

The discussion with the panelists also addressed challenges to finding funding to implement trans inclusion measures, particularly where there is a lack of resources. Syrus encouraged the audience to think in terms of an abundance rather than a competition model: “If we were operating from a model that trans people are human, we have bodies that deserve to be cared for and be kept alive, then we would find money.” Kai added that not all inclusion measures are costly: “Some of these initiatives ... are fairly cost-effective ... We have to use our creativity. We can harness that to our benefit.”

Finally, the panelists recognized that the implementation of trans inclusion measures does not just benefit trans men, but also other marginalized and vulnerable groups, such as people with disability. As such, these measures have far reaching positive effects within organizations. “What we found is that we were not just addressing trans issues, we also found that there were cis gay men who were not comfortable in the open concept shower (in the men’s change room) and had various experiences of previous trauma related to open shower concept (e.g., high schools: being bullied—even ranging to sexual assault). So, they found the private stall option (in the universal change room) to be much better for them.” (Kai Scott)
Communities of Resilience

Gay men demonstrate strength and resilience in the face of stigma in many powerful ways. In particular, this panel highlighted three instances where gay men have engaged with community to fight various intersecting forms of stigma. Although each panelist presented a unique community context, they unitedly demonstrated that gay men continue to have agency and remain resilient to stigma. This is accomplished by reclaiming representation of self and empowerment through knowledge.

Using a historical lens, Ben Klassen showed how the Vancouver periodical *Angles* confronted homophobia and stigma during the 1980s height of the AIDS epidemic. *Angles* engaged with community through mobilization efforts and calls for political action. This community action was vital in a time of slow response to AIDS from all levels of government, and the looming threat of pointed legislation, which would grant government the right to quarantine anyone with a communicable disease.

Taking a public health position, Daniel Grace presented research findings from a qualitative study, investigating the use and language of “undetectability” among men living with HIV, and its impact on understandings of risk in Vancouver’s gay communities. This research shows how notions of undetectability impact the everyday social and sexual lives of gay men living with HIV, in complex and interacting ways. While for many an undetectable viral load is a goal to achieve and may signify a return to normalcy, for others it is a source of discomfort, confusion, and further exclusion.

From an Indigenous perspective, David Brennan and Sandy Lambert shared knowledge gained from the Two Spirit HIV/AIDS Wellness and Longevity Study (2SHAWLS), which seeks to better understand the skills and practices that contribute to the health and well-being of two spirit men living with HIV. Using Indigenous methods and dedicated community collaboration, 2SHAWLS identifies seven paths to resilience, beginning from the self, and leading to community, and beyond.

The first way that communities continue to demonstrate agency and resilience against forms of stigma is by reclaiming representations of self. Klassen shows how Angles was instrumental in critically rejecting popular stigmatizing discourses of AIDS and gay men which were widely presented in the media. Angles deconstructed narratives of ‘moral panic’ and demonized promiscuity, presenting instead diverse coverage of homosexuality and AIDS, including personal and empathetic testimonies that fostered a sense of community.

WATCH THE VIDEO:  
youtu.be/-UK6Y2pRPaE

WATCH THE VIDEO:  
youtu.be/ZrLvivaY3Ts

WATCH THE VIDEO:  
youtu.be/XvEIcEpzLkc
Grace admits that his research is simply an attempt to catch up to conversations already being had within communities. By doing so, this research calls for new understandings and identification with notions of undetectability to be included into risk reduction strategies in public health settings. This community-led representation and identification with the medical concept of undetectability fights HIV stigma by facilitating HIV disclosure to others, increased sexual possibilities, and emotional support.

The 2SHAWLS project is a response to popular descriptions of Aboriginal people living with HIV, of suffering and dysfunction, while acknowledging that Aboriginal people are overrepresented in people living with HIV infections. Instead of these common dismal depictions of Aboriginal communities, 2SHAWLS sought to highlight representations of resilience and positivity in Aboriginal communities. Using Indigenous methods, resilience is reoriented around community and culture, instead of the responsibility of healing placed solely on the individual, as it is in Western frameworks.

Finally, stigma was confronted in resilient communities through empowerment from knowledge. Klassen demonstrates how Angles often used facts and knowledge as an activist tool to deconstruct the false or exaggerated portrayal of AIDS in the mainstream media. Angles also empowered communities to learn more about safer sex in the context of gay liberation and identity. This was achieved by explicitly referencing safer sex practices, portrayed in an accessible and colloquial way.

Grace shows that for gay men living with HIV, learning about undetectability and ‘achieving’ this status empowered them to return to more regular sexual activity, and normalcy. This works alongside knowledge of undetectability in the wider community, where all gay men can use this information as another way to negotiate risk in safer sex practices. In their discussion of the 2SHAWLS project, Brennan and Lambert show that the study was empowering to many First Nations communities, fighting HIV stigma with knowledge gained from Indigenous methods, in an Indigenous framework.

These three panelists clearly showed that gay men, and the diverse communities they are a part of, remain resilient in the face of adversity and stigma. By reclaiming representations of self, gay men exercise agency in defining how they are represented, and by redirecting popular discourses. Even more, through shared knowledge and learning, gay men are empowered to make informed decisions about their health, and perception of risk. (Jeff Morgan)
Resisting Stigma: The Impacts of Stigma on Indigenous Sexual Health

Queer communities are good at diversity; we understand it well. Despite our many differences, we have a common appreciation of the “Other” perspective. This perspective translates to a better understanding of the impacts of stigma on Indigenous health and wellness, which Evan Adams describes from an Indigenous perspective.

In his keynote address, Adams drew from his experiences as an Indigenous gay man to underscore the commonalities between LGBT2S and Indigenous health, while highlighting the challenges and exceptional resilience unique to Indigenous peoples and communities. Adams shared personal stories from his life to highlight the strength and beauty in Indigenous communities, and to offer a counter-perspective to narratives of deprivation commonly associated with Indigenous peoples.

Smallpox kills a third of people it infects, and mortality is significantly higher in First Nations populations. Adams’ great grandfather was born in 1860, at the beginning of the smallpox epidemic in British Columbia. Photographs and medical records show that he was surely a survivor of this epidemic, which left him blind. Certainly, the idea of pandemic was close to Adams’ heart, coming-out and moving to Vancouver in 1986. Being an actor, Adams found community in Vancouver’s theatre scene, although many gay actors were contracting HIV and passing away. This was devastating to a strong tradition of intergenerational friendship and comradery among gay actors. Although the ’80s were a difficult and a painful time, they were an exciting time as well. This demonstrates that although the burden of disease does not affect us all equally, resilience and strength in community prevails.

The concept of Indigeneity is not a difficult concept, Adams explained, even though we wrestle with it as a country. There are over 370 million Indigenous peoples, living in over 70 countries worldwide. In fact, Antarctica is the only place where there aren’t original peoples. However, the reality of most Indigenous original peoples is that they are moved aside to make way for waves of migration. While migration in itself isn’t a bad thing, for Indigenous peoples in many countries, the losses to make way for migration are considerable. Indigenous peoples have largely become the poorest and most marginalized populations in their original territories. This is certainly the case for aboriginal peoples in Canada, who have the worst health outcomes of any ethnic group in the country.

Importantly, Indigenous peoples in Canada, are non-dominant; there are other dominant forces that shape their lives. Self-determination, at the personal and political level, is not respected. Self-determination refers to the ability to chart course without interference from others. Resi-
dential schools were one example of a lack of self-determination, when First Nations children were forcefully removed from their families and communities, and institutionalized. Without self-determination, we risk repeating these barbaric practices, while cultural differences between non-Indigenous and Indigenous peoples, and between LGBT2S people will be ignored.

The status of Indigenous peoples in Canada is very well documented. The Royal Commission on Aboriginal Peoples (1996) concluded that Indigenous peoples are at the bottom of almost every available index of socio-economic well-being of any ethnic group in Canada. This is also reflected in regards to HIV related mortality. Despite great strides in the late '90s with the introduction of highly active antiretroviral therapy (HAART), First Nations’ people with HIV continued to exhibit high HIV related mortality. This comes at a time when HIV related mortality for non-First Nations people is in dramatic decline. In British Columbia where we have world class care, why are these therapies not reaching the mouths of First Nations? As Adams’ powerfully suggested: “This has to be somewhat by design, it’s not completely an accident. We used to have everything, now we have the least of anyone.”

When looking at the health outcomes of Indigenous peoples, we need to question the obstacles they face in accessing the care they need. While some have suggested physical, geographic barriers to care, it is certain that it is more than a question of distance. As such, it is important to consider other obstacles to care, many of which are shared with gay men.

Socially constructed obstacles to care, such as racism, are particularly pertinent to understanding First Nations’ health outcomes. Part of Adams’ position with the First Nations Health Authority involves speaking to medical staff and assess certain incidents of racism in healthcare settings. When he speaks to healthcare professionals about racism, he is often met with an unsurprising response: “No way, never, not in my department.” When he receives complaints about homophobia, it is met with the same reaction. This speaks to the subtle ways that racism and homophobia operate within our health systems, often through micro-aggressions and stigmatization.

Other common barriers to care between LGBT2S and Indigenous communities include historical institutional neglect. Segments of society did not care if we lived, or died, and the legacies of indifference continue to contribute to adverse health outcomes. The impacts of health literacy on health is shown by the overrepresentation of young gay men with fewer resources and lower education contracting HIV, and directly shows how knowledge can effect your body and life-course. Finally, lack of confidence with health personnel and caregiver ignorance can significantly influence willingness to engage with health systems. This too intersects with various forms of social and sexual stigma, and can result in the loss of dignity. All of these barriers to health are commonly held by gay men and Indigenous peoples, and contribute to isolation and under-engagement with important health services.

Defining Indigenous people by their deficits is a dangerous disservice, especially when it is only a partial truth. For example, the Report of the Royal Commission was used in a custody battle between a non-First Nations and First Nations parent. The lawyer of the non-First Nations
parent used the Report to claim that Aboriginal communities were unfit places to live, and that custody of the child must be awarded to the non-Aboriginal parent. This shows the power of representation, and the dangers of a single story.

The other side of the story is of strength, beauty, and resilience, and must also be told. When looking at issues of racial equality, the First Nations Health Authority was quick to embrace LGBT2S-ness. In fact, the First Nations Health Authority sends a clear message that they include all kinds of familial configurations, and include two-spirit people in health planning. In Indigenous contexts, two-spirit is a strategy of decolonizing LGBT identities, and signals an attempt to de-stigmatize queerness by looking to historical relationships with transgressive sexual and gender identities. Traditionally, two-spirit people were not considered odd, but considered gifts. They could be warm and nurturing, deadly warriors, or both. They held important roles in society as healers, medicine people, and leaders. In this way, the First Nations Health Authority’s embracing of two-spirit identities sends a powerful message of a dedication to diversity, and commitment to self-determination.

When developing a health plan, the First Nations Health Authority talked to tens of thousands of First Nations peoples and asked them what they would like in a healthcare system. Overwhelmingly the answer was clear: a holistic approach to health, which considered mind, body, and spirit. Participating in dominant society, and achieving equal health outcomes, should not require giving up traditional holistic understandings of health and well-being. Just as being gay should not require passing as straight in order to participate in greater society, or be taken seriously. It is important to consider how can we celebrate queerness and indigeneity, and participate in dominant culture, and demand equality in health and equal investment in health and well-being. First Nations’ health belongs to First Nations peoples; just as gay men’s health belongs to gay men. (Jeff Morgan)
#ResistStigma: How Do We Get There?

Please see the report #ResistStigma: How Do We Get There? – A Scoping Review by Maggie MacAulay and Skyler Wang from the Resist Stigma Project (available here: http://bit.ly/2bySTLc). At the Summit, Maggie and Skyler presented findings from the review. Here’s their summary:

Given the increasing prevalence of programmatic approaches towards reducing HIV stigma among gay men, what are some of the most promising data-driven strategies employed by community groups and health organizations around the world? How can we leverage the affordances of new media in these efforts?

In this scoping review (based on a framework proposed by Arksey & O’Malley, 2005), we direct our attention to existing work done in regions such as Canada, the United States, the United Kingdom, Western Europe, and Australia in order to sieve out a list of best practices. Presenting a preliminary analysis of more than 9,000 items collected from scholarly and grey literature sources, and borrowing lessons learned from the field of psychiatry (Stuart et al., 2012), we recommend that effective HIV stigma interventions observe six key principles:

1. **PUT PEOPLE FIRST**—placing the experiences of people living with HIV at the centre;
2. **PLAN FOR SUSTAINABILITY**—prioritizing the longevity of interventions that ensure a consistent renewal of advocates and resources;
3. **FOCUS ON ACTIVITIES THAT CHANGE BEHAVIOURS**—emphasizing activities like HIV testing and risk-reduction in addition to transforming mental attitudes;
4. **TARGET ACTIVITIES TO WELL-DEFINED GROUPS**—ensuring that messages are tailored and culturally-appropriate;
5. **THINK BIG BUT START SMALL**—being realistic about short-term goals and celebrating small wins;
6. **BUILD BETTER PRACTICES**—always documenting progress, and letting mistakes, evaluations and results find their way to decision-makers, to organizations, and into publications so that others can learn from them.

In the process, we emphasize the role of social media in mitigating HIV stigma. In addition to being used as a broadcast medium, social media concomitantly helps distribute campaign resources and engage members of the public. We shared a list of interventions and campaigns that made effective use of new media and the aforementioned six principles, such as hivstigma.com (Adam et al., 2011), Quebec’s COCQ-SIDA’s Stop Serophobia, the Los-Angeles based The Stigma Project, Greater than AIDS’ Let’s Bring HIV Out of the Closet, Housing Works’ #WeAreAllClean, and the Health Initiative for Men’s Think Before You Type. By drawing on these best practices, we hope to design a roadmap to tackle social stigma on a broader level. (Maggie MacAulay & Skyler Wang)
Youth Resisting Stigma—Where Do We Go from Here?

A panel of youth participants closed the 11th Gay Men’s Health Summit: Aidan Ablona, Our-space and CBRC; Brook Biggin, HIV Edmonton and Edmonton Men’s Health Collective; Zach Harcourt, Resist Stigma; Darren Ho, YouthCO; and Sizwe Inkingi, Resist Stigma. Together they shared their reflections.

Darren Ho began with the observation that stigma is not hard to delve into—it is so connected to our identity as gay and queer men. Still, though stigma has always been an underlying issue for our health, it is not easy to have a vocabulary to talk about stigma, except as discrimination or as a determinant of health. Unfortunately, in our community we are being shamed for much more than our queer identity, and Darren noted certain of the session keywords: racial exclusion, isolation, identity and informational erasure, shame, and stamina. Darren expressed gratitude for having the space to listen and learn how not to further stigmatize parts of our identity.

Sizwe Inkingi shared that he still had a lot of felt-stigma to undo, and how the Summit helped by giving focus to different layers of stigma, both structural and interpersonal. What resonated for Sizwe was the storytelling component of the Summit, the power and inclusivity of hearing stories from different communities.

“At the end of the day … we’re for the most part just a bunch of queer guys … queer guys who experience stigma in real and tangible ways, but who also experience love, power and community.”

Brook Biggin reflected how his own experiences of stigma, as an HIV+ gay man, have translated to power and community in the birth of a grassroots gay men’s health collective in his hometown of Edmonton.

Aidan Ablona brought attention to the value of a summit gathering that broadens our notions of gay men’s health, in particular how stigma affects us in more than one way—how our experiences around mental health, race and gender identity can be connected.
The Youth Panel offered a space to talk and share personal experiences of stigma. Zach Harcourt described episodes of his life, the stigma he has and continues to experience. Stigma that is pervasive and can be both paralyzing and overwhelming. The resulting negative emotions we can carry: feeling fragmented and extinguished, worthless, inferior, shattered—of not having a place in the world. Zach also added we must continue to use our voices and talents to advocate for those who can’t—members of our community who are ignored and dismissed.

The panelists offered their insights into how we can resist stigma: by working together, finding and coming together as community, learning from each other. As Aidan emphasized, one person’s struggle is everyone’s struggle. Resisting stigma can involve working with organizations and campaigns to find purpose and develop confidence; through collaboration and inclusivity we can bridge the gaps between our multiple groups. In Zack’s words, “It’s one thing to see people do the work for you, but it’s a beautiful thing to participate.”

The panel facilitator posed the question, what actions are needed to reduce Stigma? Brook recounted experiences of trying to work with people to build bridges to LGBT communities—but being constantly told to wait. No longer willing to be kept in a low place in a hierarchy of power, Brook’s own personal journey included learning about our heritage, notably the activist history of ACT-UP. The realization that within ourselves exists power: we need to access and harness that power when we recognize something that is wrong.

Sizwe shared his perspective: “We must heal so that we can heal others.” To reduce stigma we must understand our intersectionality, our place in society: class, race; it is about being visible.

Darren added that we also need to make two distinct priorities: do what we can to remove stigma in our communities; and support those affected—and we can do both at the same time. He stressed that anti-stigma messaging is vital: recognizing the importance of meeting people where they’re at. Again we heard of the profound power of storytelling: giving space for the marginalized to tell stories being vital for our work.

The Youth Panel concluded by calling attention to the launch of the CBRC’s national Resist Stigma project, a campaign that will engage young queer men to tell their stories through viral video messaging. For more information: resiststigma.com / resist.ca. (Craig Barron)
Presenters

AIDAN ABLONA is a proud, queer Filipino with a passion for social justice, health equity, and community development. He currently works with Resist Stigma and volunteers with various community-based organizations and health centres.

EVAN ADAMS is from the Sliammon First Nation near Powell River, BC. He is a public health physician who currently serves as Chief Medical Officer with the First Nations Health Authority.

PATRICK AUBERT is a MA student at SFU in Gerontology. He works on the ‘Fostering End-of-Life Conversations, Community and Care among LGBT Older Adults’ project.

ANDREW BECKERMAN is an AIDS Vancouver Island volunteer and past chair of its board. He is a board member of the Pacific AIDS Network and serves as board vice chair and fund developer at the Canadian HIV/AIDS Legal Network.

BROOK BIGGIN is the Community Education Facilitator at HIV Edmonton and founder of the Edmonton Men’s Health Collective; he is also Provincial Persons Living with HIV/AIDS Coordinator at the Alberta Community Council on HIV.

DAVID J. BRENNAN, a social worker in the HIV/AIDS field since 1983, has worked as an Ontario HIV Treatment Network Applied HIV Research Chair in Gay and Bisexual Men’s Health and as Director of the CRUISElab.

KIFFER G. CARD is a M.Sc. student at SFU. He works as a Research Assistant at the B.C. Centre for Excellence in HIV/AIDS in the Momentum Health Study.

JAYDEE COSSAR is the PLDI & Stigma Index Project Manager at the Pacific AIDS Network. Currently Jaydee sits on the Board of Directors at Positive Living Society of BC.

ELLEN DEMLOW is a regional epidemiologist at the Vancouver Coastal Health Authority, and works primarily with the Seek and Treat for Optimal Prevention of (STOP) HIV/AIDS program.

GLENN DOUPE works with the VCH STOP team as one of their nurse educators; he was previously Team Leader for the BCCDC Outreach Program.

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MICHAEL KWAG is the Knowledge Broker for Gay Men’s Sexual Health Programming at CATIE. Michael has been involved with Totally Outright, the CIHR Team in the Study of Acute HIV Infection in Gay Men, also the social marketing campaigns: #GetGarded, Talk to HIM, and Just Makes Sense.

SANDY LAMBERT is from the TallCree First Nation and has been involved in the HIV/AIDS movement for the past 10 years. Sandy is currently Board of Director Co-Chair for the Red Road HIV/AIDS Network, and a Canadian Aboriginal AIDS Network Member (APHA Caucus).

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KAI SCOTT is the principal partner of TransFocus Consulting that provides transgender resources to policy makers, employers, and leaders across diverse sectors. He also co-wrote the “Building a Path to Parks and Recreation for All” report summarizing recommendations for trans inclusion in Vancouver Park Board facilities and programs.

RAMRAAJH SHARVENDIRAN is the Men’s Sexual Health Coordinator at the Alliance for South Asian AIDS Prevention (ASAAP)

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RYAN WATSON is a postdoctoral fellow at the UBC and received his PhD from the University of Arizona in Tucson, Arizona.

The Community Based Research Centre for Gay Men’s Health (CBRC) is a health promotion group created by and for gay men based in Vancouver, British Columbia. We are a non-profit charitable organization using community participatory research to develop knowledge about gay men’s health and interventions addressing health and social issues. CBRC’s core programs are currently leading a social determinants based approach to gay men’s prevention through:

1. Knowledge transfer from Sex Now our periodic survey of gay men’s health reaching eight thousand nation-wide every 2–3 years;
2. cbrc.net, our gay men’s health theory & practice exchange website;
3. Our BC Regional Gay Men’s Health Network prevention planning activities;
4. Our annual Gay Men’s Health Summit conference addressing emerging themes; and
5. Our focus on gay youth with three main initiatives: Investigaytors our research training program for gay youth; Totally Outright our youth leadership program offered through local organizations across Canada; and Resist Stigma, a national social media campaign for gay and queer youth.