WHOSE PUBLIC HEALTH?

AN INTERSECTIONAL APPROACH TO SEXUAL ORIENTATION, GENDER IDENTITY AND THE DEVELOPMENT OF PUBLIC HEALTH GOALS FOR CANADA

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EXECUTIVE SUMMARY

SUMMARY

Canada has been an international leader in the field of public health. However, despite having produced landmark documents indicating a principal role for social factors in determining health, health policies in Canada have largely been limited to interventions designed to affect change in individual behaviours, rather than structural- or population-level social determinants of health.

In this discussion paper, we review Canada's contributions to the field of public health, with a particular emphasis on the failure of interventions aimed at individual behaviours or risk variables to adequately address key determinants of health for lesbian, gay, bisexual, transgender, transsexual, Two-Spirit, intersex, and queer (LGBTTTIQ)[1] people. The ongoing process of defining new public health goals for Canada is used to illustrate how an intersectional approach to public health could more effectively address the social determinants of health for LGBTTTIQ people.

WHAT ARE SOCIAL DETERMINANTS OF HEALTH AND HOW HAVE THEY BEEN ADDRESSED IN CANADIAN PUBLIC HEALTH POLICY?

Social determinants of health reflect an attempt to shift attention away from medical treatment as an explanation for health in order to focus on social and cultural environments/settings.

Canada has been a world leader in public health, first through its important contributions to health promotion and more recently through its development of a 'population health' approach. But despite this recognition of structural determinants of health, community health promotion strategies have continued to focus on individual responsibility for health behaviours. Consequently, an individual-level 'lifestyle' approach has continued to dominate and define Canadian health promotion, with little attention to interventions designed to target social determinants of health.

WHAT WEAKNESSES IN THE DOMINANT FRAMEWORK OF POPULATION HEALTH ARE EXPOSED BY ANTI-OPPRESSION, INTERSECTIONAL ANALYSES?

Anti-oppression theories are historically rooted in social justice movements such as anti-racist, feminist, queer, (dis)ability, Aboriginal and other social identity movements which focus on the power relationships within our

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[1] See Appendix A – Glossary.

society and the elimination of oppression. Intersectional, anti-oppressive analysis calls for research and policy that addresses the intersections of race, ethnicity, gender, class, sexuality, age, rural-urban residence, (dis)ability, and other markers of social difference. When anti-oppression, intersectional approaches are applied to population health in Canada, the following weaknesses in conventional population health research are identified:

- It concurrently individualizes (reduces complex processes to individual attributes) and universalizes (makes broad generalizations about populations by standardizing individuals' experiences). This approach effectively erases complex, social processes that produce oppression and inequity. Measurement that focuses on the level of the individual yields interventions and policy responses focused on individuals.

- It conceptualizes and measures inequalities as separate, discrete dimensions that are independently assessed. Consequently, marginalized individuals and communities are either overlooked or are not examined in any depth in most health disparities research.

- Health disparities are measured by deviations of 'minority' groups' health statuses from the 'general population,' using the experiences of those in dominant social positions as the unexamined norm. This comparison and treatment of dominant groups as the unmarked norm obscures the privileged status of dominant groups, and conceals the role of power in producing and maintaining inequalities.

HOW HAVE THESE WEAKNESSES AFFECTED THE ABILITY OF POPULATION HEALTH RESEARCH AND POLICY TO ADDRESS THE CONCERNS OF LGBTTTIQ INDIVIDUALS AND COMMUNITIES?

Extensive international literature reviews have revealed that the physical and mental health of LGBTTTIQ people is significantly affected by discrimination based on sexual orientation (homophobia and heterosexism) and gender identity (sexism, 'gender binarism' and transphobia). The health effects of these patterns include (but are not limited to) increased levels of depression and suicide, increased rates of alcohol and drug use, and greater risks for sexually transmitted infections. Persistent discrimination against LGBTTTIQ people can also have a negative impact on their ability to form and sustain supportive relationships with friends and social networks, to find supportive spiritual/faith communities, and to find support for intimate relationships and parenting. Widespread and persistent individual and systemic discrimination against LGBTTTIQ people has also resulted in their reduced access to quality health care and under-utilization of health services.

Despite consensus about the impact of various forms of discrimination on health, the health of LGBTTTIQ individuals has been routinely overlooked in conventional population health research and policy. There are significant gaps in evidence about LGBTTTIQ health because:

- research is driven by legislation and national priorities, which have not targeted LGBTTTIQ health;

- there are methodological challenges in undertaking representative research on LGBTTTIQ populations, including definition and measurement of the complex constructs of sexual orientation/gender identity; sampling rare populations; and sampling related to sensitive topics;

- there are gaps in available evidence about various segments of LGBTTTIQ populations (e.g. elderly, people of colour, people in rural and remote areas); and

- population surveys do not ask adequate questions about sexual orientation and gender identity.

Discrimination on the basis of sexual orientation and gender identity intersects with discrimination on the basis of other socially constructed categories, including income, gender, race/ethnicity, geographic location, (dis)ability and age, to have additive or perhaps multiplicative effects on health. Conventional population health research and policy do not address the complexity of discrimination or its health effects, and therefore fail to adequately address the concerns of LGBTTTIQ individuals and communities.

APPLICATION OF AN INTERSECTIONAL APPROACH TO THE DEVELOPMENT OF PUBLIC HEALTH GOALS FOR CANADA

Initiated as a participatory and collaborative process, the development of the Health Goals for Canada is a first step in a national process of improving the health status of Canadians. The ongoing development of objectives, targets, strategies and indicators for Canada's Health Goals provides an opportunity for Federal, Provincial and Territorial governments to show leadership in addressing the determinants of health for LGBTTTIQ individuals and communities. Announced in October, 2005, the new Health Goals for Canada include one 'overarching' goal and nine other health goals. Substantial research has been conducted in Canada about the health and well-being of LGBTTTIQ individuals and communities, and these studies have generated recommendations for action providing a rich fund of resources for the next steps of generating objectives, targets, indicators and strategies for our national public health goals:

- The goal of enabling our children and youth to "reach their full potential, growing up happy, healthy, confident and secure" could be supported by initiatives to formalize referral networks and offer mentoring, education and support for LGBTTTIQ youth.

- The goal of ensuring that "every person has dignity, a sense of belonging, and contributes to supportive families, friendships and diverse communities" could be addressed by providing supportive services (e.g. 'help lines'; community outreach; trans-positive shelters and transitional housing) for LGBTTTIQ individuals and their families, and ensuring that existing barriers to services and benefits are removed (e.g. same-sex spousal/family benefits).

- The goal of making Canada "a healthy place for all people, through leadership, collaboration and knowledge" requires improving research and information on LGBTTTIQ people's health and well-being, including: specific health issues (e.g. cancers, addictions); violence and strategies for education and prevention; how intersections of oppression affect health and well-being; populations within LGBTTTIQ communities (e.g. older LGBTTTIQ persons; bisexuals; transgender and transsexual persons; intersex persons); and health service and support needs.

Each of the new public health goals for Canada can be made relevant to LGBTTTIQ people when an intersectional analysis is applied in this way.

RECOMMENDATIONS FOR THE IMPLEMENTATION AND ASSESSMENT OF CANADA'S HEALTH GOALS

To ensure that the next steps in the Public Health Goals process reflect and address important determinants of health for marginalized populations, and specifically, LGBTTTIQ individuals and communities, we recommend five actions:

- Existing grey literature evidence on the health concerns of LGBTTTIQ populations in Canada should be recognized and utilized in indicator development and strategic planning.

- Data collection in standardized national instruments (e.g. the National Population Health Survey) should include sexual orientation and gender identity, and reporting should disaggregate data by sexual orientation, gender identity, race/ethnicity, socioeconomic status, age, (dis)ability, and geographic region.

- Federal policies on gender-based, diversity analysis should be fully implemented.

- A funding envelope specific to LGBTTTIQ health research should be established and coordinated through national research funding bodies (e.g., CIHR, SSHRC).

- LGBTTTIQ Health Directorates should be established at the federal, provincial and territorial levels to develop and implement LGBTTTIQ Health Strategies in those jurisdictions.

CONCLUSION

The ongoing development, implementation, and assessment of Canada's Public Health Goals offer rich opportunities for improving LGBTTTIQ health in Canada by ameliorating the negative effects of discrimination based on sexual orientation and gender identity. In order to take advantage of these opportunities, it is imperative that LGBTTTIQ individuals and communities are invited into these processes and are supported by a strong public health infrastructure.

TO ACCESS THE FULL REPORT:

This report is available for download free of charge through the following websites:
The Canadian Rainbow Health Coalition: www.rainbowhealth.ca/english/documentglbt.html
The Rainbow Health Network: www.rainbowhealthnetwork.ca
The Coalition for Lesbian and Gay Rights in Ontario: www.web.ca/clgro

PART I:

SOCIAL DETERMINANTS OF HEALTH AND CANADIAN PUBLIC HEALTH POLICY

'The determinants of health' refer to a wide range of factors that affect the health of individuals and populations – these may include (but are not limited to) the health care system, biological and genetic endowment, physical environments, social and cultural factors, and individual behaviours or 'lifestyles.' While advancements in and increased access to medical care in the last century are frequently presumed to account for better health in populations, research suggests that only 10-15% of increased longevity results from improved care (Raphael 2003). Consequently, accounts that focus on social determinants of health reflect an attempt to shift attention away from medical treatment as an explanation for health in order to focus on social and cultural environments/settings. Over the last three decades, Canadian public health research and policy have offered varied definitions of the determinants of health and have addressed these determinants in a variety of frameworks. (See Table 1)

Canada has been a world leader in public health, first through its important contributions to health promotion (e.g. the 1974 Lalonde Report which introduced the term 'health promotion' to the lexicon of public health; the 1986 Epp Report which expanded the concepts of Lalonde) and more recently through its development of a 'population health' approach. Health promotion and population health share important foundational concepts, but in their application these frameworks have diverged, with population health becoming the dominant approach to Canadian public health policy.

Table1. Determinants of Health

Lalonde Report: A New Perspective on the Health of Canadians (1974)	Ottawa Charter for Health Promotion (WHO, 1986)	Canadian Institute for Advanced Research (1994)	F/P/T Advisory Committee on Population Health Strategies for Population Health (1994)	World Health Organization (WHO) Working Group (n.d.) (cited in Raphael 2003)
Health fields: human biology, lifestyles, the environment, health care organization	Prerequisites for health: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, equity	Determinants of health: income & social status, social support networks, education, employment & working conditions, physical & social environments, biology & genetic endowment, personal health practices & coping skills, healthy child development, health services	Determinants of health: income & social status, social support networks, education, employment & working conditions, physical environments, social environments, biology & genetic endowment, personal health practices and coping skills, healthy child development, health services (Note: gender & culture were added to this list in Health Canada documents from 1998)	Social determinants of health: the social (class) gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, transport

HEALTH PROMOTION: LIFESTYLES AND HEALTHY PUBLIC POLICIES

In post-World War II Canada, political pressures (emerging social movements such as the feminist and environmental movements) and economic pressures (increased demand for health services, increased health care expenditures and the consequent search for efficiencies in health delivery systems) combined to create conditions for public health policies that focused on disease prevention, health promotion and non-medical determinants of health. In particular, the 1974 Lalonde Report made one of the first attempts to alter public perception of the link between health and medical care, asserting that health does not result solely from access to health services, but "from an interplay of determinants from four health field elements: human biology, lifestyles, the environment, and health care" (Labonté 1994,p.74). But by prioritizing large-scale national health information campaigns such as 'ParticipAction' and 'Dialogue on Drinking,' the Lalonde Report emphasized individual rational action and responsibility (expressed as 'lifestyle') and downplayed the impact of social structures on health. Subsequent health promotion policy statements (e.g. the 1986 Epp Report and the 1986 WHO Ottawa Charter for Health Promotion) shifted the focus toward 'healthy public policy,' that is, policy which fosters public participation in health policy debates, strengthens community health services, and encourages coordination of public policy among a range of fields that affect health. The Epp Report and Ottawa Charter thus balanced 'lifestyle' health promotion with an enhanced social model of health (Jackson 2003). But despite this recognition of structural determinants of health, community health promotion strategies (such as HIV/AIDS programs) have continued to focus on individual responsibility for health behaviours. 'High risk' populations are targeted and exposed to interventions intended to promote behaviour change and reduce health risks – in the end, these strategies simply amount to individual behavioural interventions carried out on a large scale (Raymond 1989). Consequently, an individual-level 'lifestyle' approach has continued to dominate and define Canadian health promotion (Raphael 2000).

POPULATION HEALTH: IMPROVING DATA, ADDRESSING INEQUITIES?

A 'population health' approach began to emerge in Canada in the late 1980s and early 1990s, strongly influenced by the Canadian Institute for Advanced Research (CIAR) and members of its Population Health Program. The CIAR perspective on population health "considers processes by which system-level variables influence the health of populations" (Raphael and Bryant 2002, p. 190). Specifically, it claims to: (1) recognize the capacity of social, cultural, economic, and physical environments to affect the health of individuals; (2) acknowledge the complexity of relationships among these health-affecting variables; and (3) shift health care from centre stage and focus attention not on how to relieve illness, but why people get sick in the first place. In this way, population health has drawn upon structuralist elements of health promotion (e.g. the Lalonde Report's health fields, the Ottawa Charter's strategies for removing structural barriers to health and building healthy public policy). However, its measurement and data production practices have frequently undermined structural, community-focused aims.

Population health emerged and has taken shape in several contexts: continuing dissatisfaction with individualized, 'lifestyle' perspectives on health; a persistent climate of 'cost crisis' in the health care system coupled with enduring fiscal restraint; an emergent culture of evidence-based decision making (with an attendant lack of Canadian national health data); growing concerns about demonstrating the efficiency of health interventions; and the introduction of new information technologies (Jackson 2005). Accordingly, the development of population-level measurements of health and the improvement of data management systems has been a core objective of the population health framework. Moreover, the conditions in which population health emerged fostered an approach to knowledge production deeply embedded in an epidemiological tradition where: (a) 'risk factors' are frequently understood as individual attributes and behaviours; (b) risk factors are viewed as simply additive; and (c) accountability for the cause of disease rarely extends beyond affected/diseased individuals. In sum, this tradition has an underdeveloped analysis of social relations and of social forces that create or inhibit the enabling conditions of health; it is characterized by highly individualistic measurement strategies; and it places quantitative data from controlled studies and large surveys at the apex of the evidence hierarchy (Jackson 2003; Raphael and Bryant 2002). It is thus not surprising to find that many population health documents lack statements of guiding values (e.g. participation, social justice, community development) (Raphael and Bryant 2002). Nor is it surprising that population health relies on aggregated individual-level survey data, with little attention to qualitative, community-based research methods and findings. Contrary to its structural aims, population health knowledge production practices result in the standardization of individualized attributes and of individual experiences in the health care system.

While there has been a recent focus on measuring and correcting health inequities that can be traced to various social determinants, the national document that signalled the formal policy change to population health (Strategies for Population Health: Investing in the Health of Canadians) stated that the goal of population health was "the best possible health status for the *entire population*" (Federal Provincial and Territorial Advisory Committee on Population Health 1994, p. 1, emphasis added). The document promised that a population health perspective would bring "increased prosperity, reduced expenditures on health and social problems, and overall social stability and well-being for Canadians" (Federal Provincial and Territorial Advisory Committee on Population Health 1994, p. 10); but the document also made it clear that the equitable distribution of health was not as much a priority as the overall improvement of population health status:

> The major health problems of disadvantaged groups are a serious issue that must be attended to. However, they should not be the exclusive focus of a population health strategy, because resolving large problems of relatively small groups will not give us the overall results we are looking for in terms of improved health and prosperity of the entire population. (Federal Provincial and Territorial Advisory Committee on Population Health 1994, p. 28)

By 1998, perhaps because of resistance to population health by equity-focused health promotion advocates, the goal of Health Canada's population health plan was softened: "to maintain and improve the health of the entire population and to reduce inequalities in health between population groups" (Health Canada 1998, p. 1). Gender and culture were added to Health Canada's list of social determinants at this time. Nevertheless, a persistent institutional reluctance to integrate multi-disciplinary, community-based and equity-focused research methodologies into population health knowledge production practices has hampered federal government attempts to produce information and develop strategies to redress health inequities within Canada.

By concentrating on individual-level characteristics and processes (measured by large-scale survey instruments such as the National Population Health Survey and Canadian Community Health Survey), population health has not followed through on its promise of revealing and responding to structural (social) determinants of health. With no theoretical account of the social forces that shape the current state of health determinants, population health offers little guidance for social change and solutions. Some critics charge that its lack of an explicit analytical framework for the role of social and political structures "limits the likelihood that population health findings will effect significant policy change" (Raphael and Bryant 2002, p. 192).

CHALLENGING MAINSTREAM POPULATION HEALTH

Critical Political Economy Approaches to Health

Critical political economy analyses have illuminated the limits of the dominant population health perspective in Canada. Briefly, a political economy of health perspective focuses on social, structural conditions that contribute to good health or illness and disease, with particular emphasis on political and economic determinants. Instead of focusing only on competing interests of actors in the health care system, political economy frameworks take social contexts (e.g. Canada's capitalist economy, class structures, the role of the state, and globalization) more fully into consideration, helping us understand why some groups benefit more than others – they examine the "forces that produce both a particular distribution of 'interests' within the health system and which determine health inequalities more broadly" (Poland et al. 1998, p. 793). Political economy frameworks call for "'healthy public policies,' especially redistributive policies to reduce poverty and income equality, if not for 'wider campaigns for sustainable development, political freedom, and economic and social justice'" (Krieger 2001, p. 670). Political economy perspectives offer an approach to public health that recognizes the validity of a wide range of research methods (including both quantitative and qualitative methods), acknowledges the political dimensions of health research, and provides a vision for change. Many elements of this approach revive core tenets of structuralist health promotion. A critical political economy approach to population health endorses the values of "participation, enablement and empowerment, equity and social justice," uses research methods that are sensitive to the contexts in which health is achieved or compromised, and recognizes "the role that community structures play in mediating the effects of system level factors on individual health and well-being" (Raphael and Bryant 2002, pp. 195-196). Political economy approaches are complemented by anti-oppression, 'intersectional' frameworks.

Anti-Oppression, Intersectional Approaches to Health

Anti-oppression theories are historically rooted in social justice movements such as anti-racist, feminist, queer, (dis)ability, Aboriginal and other social identity movements which focus on the elimination of oppression. These movements offer diverse analyses and perspectives, but they are characterized by "the acknowledgement of subordinate/dominant power relations that characterize social relationships in society" (Moosa-Mitha 2005, p. 61). The concept of 'intersectionality' has been foundational to anti-oppressive theories, providing an analysis of "the interweaving of oppressions on the basis of multiple social identities as well as marginalization that is both relational and structural" (Moosa-Mitha 2005, p. 62). Intersectional analyses thus broaden political economy critiques to further address problems/weaknesses in conventional approaches to population health. Intersectional approaches to health, which have developed outside traditional biomedical and epidemiological frameworks, address both macro (structural) and micro (individual and interpersonal) levels of analysis:

> Intersectional scholarship contends that race, class, gender, and sexuality are interrelated systems at the macro institutional level – they are created, maintained, and transformed simultaneously and in relationship to one another and cannot be understood independently of one another. At the micro level of the individual, scholars focus on the ways these systems are experienced in our lives simultaneously, each contributing to our identities and our views of the world. (Weber and Parra-Medina 2003, p. 199)

Importantly, this multi-level analysis has an explicit aim of social justice, identifying macro and micro social relations (e.g. race/racism, gender/sexism, sexuality/heterosexism) as power relations "that create and sustain social hierarchies – not merely as differences in the distribution of resources" (Weber and Parra-Medina 2003, p. 185). Intersectional, anti-oppressive analysis calls for research and policy that addresses the intersections of race, ethnicity, gender, class, sexuality, age, rural-urban residence, (dis)ability, and other markers of social difference. It embraces activism for social justice as an integral part of the production of knowledge. These characteristics make intersectional analysis well-suited to addressing the problematic of health inequities.

How does intersectional analysis interpret and address some of the limitations of conventional population health research and policy?

(1) Conventional population health research and policy concurrently individualizes (reduces complex processes to individual attributes) and universalizes (makes broad generalizations about populations by standardizing individuals' experiences). Moreover, population health's view of the social is one of a simple aggregation of discrete individuals, their characteristics, and their experiences. While it focuses on 'populations,' its focus of data collection and analysis is the individual -- an individual's characteristics make her/him vulnerable to disease or 'chronic good health,' it is the individual who, in various environments, incurs risk to health or protection from disease, and it is the individual who receives interventions to improve her/his health status (Coombs 1991). This approach effectively erases complex, social processes that produce

oppression and inequity, and strips context from health and health care (Jackson and Pederson 2004). For example, simply identifying an individual as a lesbian and as Chinese does not show us how systemic, group processes like heterosexism and racism are generated, maintained and produce inequalities. Furthermore, measurement that focuses on the level of the individual yields interventions and policy responses focused on individuals. An intersectional analysis, by contrast, views 'race,' gender, sexuality, social class, (dis)ability, etc. as products of social systems rather than as individual attributes. It attends to the processes in which these elements are continuously constructed (for e.g., in measurement practices and in social policy), and to how these elements and their construction intersect and overlap in social systems and in the lives of individuals.

(2) Conventional population health research conceptualizes and measures inequalities as separate, discrete dimensions that are independently assessed. Accordingly, studies typically address one or two dimensions of inequality (e.g. race/ethnicity, socioeconomic status, and/or gender), but rarely address more than two elements in the same study (Weber and Parra-Medina 2003). This tradition is further entrenched by the limitations of the quantitative analysis of large-scale surveys which produce the bulk of population health data – that is, "national surveys rarely obtain samples large enough to investigate multiple racial ethnic groups [or groups with minority sexual orientations] and almost never have samples large enough to examine the interactions of race/ethnicity [or sexual orientation] with socioeconomic status, social class, gender, age, and other key dimensions of inequality." (Weber and Parra-Medina 2003, p. 202). Consequently, marginalized individuals and communities are either overlooked or are not examined in any depth in most health disparities research. Intersectional analysis, on the other hand, sees inequalities as multiple systems which are intertwined, inseparable, and mutually reinforcing (e.g. sexism and heterosexism are involved in each other's construction and maintenance). By starting from this assumption, and by attending to the processes in which these systems operate in the lives of marginalized people, intersectional analysis can illuminate 'mechanisms of discrimination' which are often subtle and insidious (Weber and Parra-Medina 2003). Intersectional scholars have called for 'appropriate sampling' where government agencies, funders and researchers would require studies to use samples that enable statistical modelling for marginalized groups. They have also called for multi-level data collection (beyond individuals) and for multi-method research (using both quantitative and qualitative approaches). "Because feminist intersectional scholarship conceives of race, class, gender, sexuality and other dimensions of difference not as individual attributes, but rather as social constructions that are generated, challenged, and maintained in group processes, the place to observe and thus to understand inequality is in dynamic interactions among groups, particularly among those that involve groups experiencing multiple oppressions." (Weber and Parra-Medina 2003, pp. 202-203) The recognition that markers of social difference are not simply separate and additive dimensions of inequality, nor are they reducible to unalterable individual characteristics allows us to see that these markers give all of us power and opportunities in some areas and restrict our power and opportunities in others (Weber and Parra-Medina 2003). Such awareness is crucial to working collaboratively across social divisions to reduce health disparities and achieve equity.

(3) In conventional population health research, health disparities are viewed as a reflection of how practices, roles and resources of subordinate groups/sub-populations deviate from the 'general population,' using the experiences of those in dominant social positions as the unexamined norm (Weber and Parra-Medina 2003). For example, markers of race, class, gender, and sexual orientation are seen as simply marking differences in lifestyle preferences, social roles, cultural beliefs and practices, and resources. These differences are assessed in relation to the 'centre' – white, middle- and upper-class, male, able-bodied and heterosexual. Health disparities are measured by deviations of 'minority' groups' health statuses from those occupying the centre, and "the charge to eliminate the disparities is predicated on the assumption that there should be little or no

morbidity and mortality differences" between the 'mainstream' and 'minority' groups (Weber and Parra-Medina 2003, p. 192). This comparison and treatment of dominant groups as the unmarked norm obscures the privileged status of dominant groups, and conceals the role of power in producing and maintaining inequalities. As a result, "the focus of attention in research remains on the psychosocial effects of experiencing discrimination on the health of individual minority group members" (Weber and Parra-Medina 2003, p. 195). Let us consider one example of how policies may sustain health inequities by defining issues in terms that reflect the interests of dominant groups (Jackson and Pederson 2004). One element of 'quality' health care is 'accessibility' – in Canadian policy documents such as the Kirby and Romanow Reports, concerns about 'accessibility' is situated in a discourse of sustainability, and sustainability of the health care system is framed exclusively in financial terms. 'Access' is often measured by the supply of medical technologies (e.g. MRI machines) in a jurisdiction, but this measure may not (does not) reflect the complex interests of multiply marginalized people. These measures and interventions have the potential to sustain quality disparities, because they do not take into account the structural conditions in which marginalized persons approach and attempt to access health care – another MRI does not reduce barriers to quality care that a homeless woman faces (lack of affordable housing; lack of a living wage; lack of adequate support services) or that an LGBTTTIQ person faces (homophobic interactions and heterosexist systems). Intersectional analysis, on the other hand, asks: what policies and practices benefit dominant groups and act as barriers to health care for subordinate groups? And how do marginalized groups engage in creative strategies of resistance to meet the challenges they face? By viewing social inequalities as relationships of dominance and subordination, intersectional analysis can illuminate the ways in which dominant groups benefit from existing systems. Interventions arising from such analysis would address things that change the balance of power, such as heterosexist legislation that privileges opposite-sex couples/ families, inadequate minimum wage, lack of affordable housing, and lack of quality child care.

In sum, intersectional scholarship "provides promising avenues for expanding our knowledge of health disparities and of identifying new ways of going about eliminating the persistent and pervasive social inequalities of race, class, gender, and sexuality as well as the health disparities that accompany them" (Weber and Parra-Medina 2003, pp. 221-222).

WHAT DO WE GAIN/RISK BY ADOPTING A CONVENTIONAL POPULATION HEALTH APPROACH?

A National Reference Group which examined gay men's health in Canada and proposed a National HIV Prevention Strategy for Gay Men has considered how population health may be critically appropriated "so that it speaks to the realities of [gay men's] lives and aspirations for health and wellness" (National Reference Group 2000, p. 23). The Group lays out the benefits and risks of adopting a population health approach to gay men's health. Benefits include:

- a population health framework can broaden the focus of health research and policy to include non-medical determinants of health (e.g. social and physical environments);

- population health offers support for multi-sectoral 'healthy public policy';

- the work gay communities have already done to bring attention to a broad range of determinants of health can be recognized;

- population health supports the consolidation of new and existing partnerships to address intersecting determinants of health.

The risks of adopting a population health framework (identified by the National Reference Group) mirror the concerns and criticisms raised by critical political economy and intersectional perspectives. The risks/ drawbacks include:

- individual and community empowerment models may be marginalized;

- quantitative, individual-level survey data alone cannot adequately illuminate the complexities of gay men's lives;

- biomedical measures of 'health' deployed in population health research (which frequently defines health as 'absence of disease') ignores widespread work to understand health as a resource for living, which includes many different elements of well-being;

- population health can presume consensus among potential partners (neglecting differences in values, interests and power among individuals and organizations);

- the dependence of population health on statistical data about populations is problematic for 'invisible populations' such as gay men, where accurate measurement is hampered by methodological limitations and persistent homophobia and heterosexism.

The National HIV Prevention Strategy for Gay Men asserts that in "the context of Population Health, Health Canada needs to understand the implications, and accept the challenges, of working with gay men, as a statistically invisible population, with a history of systemic discrimination" (National Reference Group 2000, p. 23). The Reference Group reviews research on the 12 'orthodox' determinants of health specified by Health Canada, insofar as these determinants relate to the lives of gay men. Inspired by Health Canada's assertion that the list of health determinants "is likely to evolve as knowledge in the area grows" (Health Canada 1998), the Reference Group proposes a new determinant: 'conditions that affirm choices of coming out.' While the focus of the research review is on gay men, the authors make it clear that the dynamics of heterosexism and homophobia intersect with other forms of oppression (such as racism, classism, and ableism). It is only by attending to these intersections that the mechanisms of inequality and a full measure of their impact can be illuminated.

PART II:

WHY ATTEND TO SEXUAL ORIENTATION AND GENDER IDENTITY?

Extensive international literature reviews have revealed that the physical and mental health of LGBTTTIQ people is significantly affected by discrimination based on sexual orientation (homophobia and heterosexism) and gender identity (sexism, 'gender binarism' and transphobia).[2] Moreover, LGBTTTIQ people experience significant barriers in accessing and using existing health services – this also has an impact on their health (Banks 2003; Dean et al. 2000; INCLUSION Project 2003; Ministerial Advisory Committee on Gay and Lesbian Health 2003; Ryan, Brotman, and Rowe 2000) A comprehensive review of these issues is beyond the scope of this paper; original Canadian research is summarized in Tables 2, 3 and 4 (see Appendix B).

Research papers commissioned by the Department of Human Services (State of Victoria, Australia) demonstrate that sexual orientation and gender identity affect patterns of health and illness of LGBTTTIQ people in three ways:

(1) Dominant perceptions of sexuality and gender identity persistently marginalize and discriminate against LGBTTTIQ people. "Systematic and ongoing discrimination against sexual and gender minorities results in primary health issues and patterns of illness specific to GLBTI people and a reduction in their access to mainstream health services and the quality of care they receive." (Ministerial Advisory Committee on Gay and Lesbian Health 2003, p. 12)

(2) Sexual orientation and gender identity act as independent indicators for a variety of LGBTTTIQ health issues. That is, there are patterns of health and illness specific to LGBTTTIQ people independent of their experiences of marginalization and discrimination. These include health issues more common among gay men (e.g. certain cancers, alcohol and tobacco use, sexually transmitted infections), more common among lesbians (e.g. cervical and ovarian cancers, alcohol and tobacco use, reproductive health issues) and specific to transgender, transsexual and intersex people (e.g. certain cancers related to hormone replacement therapies, complications from steroid use, complications from surgical interventions) (Dean et al. 2000; INCLUSION Project 2003; Ministerial Advisory Committee on Gay and Lesbian Health 2003).

(3) Sexual orientation and gender identity interact with other social determinants of health to produce patterns of illness within LGBTTTIQ communities. These interactions are discussed in the next section of this report.

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[2] Different studies and research reviews use acronyms that reflect the communities included in those studies/reviews (e.g. GLBTI, LGBT). In what follows, when we refer to a particular study/review, we use the acronym it has applied.

WHAT ARE THE EFFECTS OF DISCRIMINATION BASED ON SEXUAL ORIENTATION & GENDER IDENTITY?

While LGBTTTIQ individuals may develop innovative personal and social skills and a high level of personal resilience to deal with discrimination based on sexual orientation and gender identity, and while collectively, LGBTTTIQ communities have developed community norms, values and practices which offer social support and a positive sense of personal and group identity, the health effects of heterosexism, sexism and transphobia are, overall, negative (Ministerial Advisory Committee on Gay and Lesbian Health 2003). The outcomes of heterosexism, sexism and transphobia include: violence and persistent threats of violence; discrimination and social marginalization; isolation; social invisibility; self-denial, guilt, and internalized homophobia and transphobia (Ministerial Advisory Committee on Gay and Lesbian Health 2003). The health effects of these patterns include (but are not limited to) increased levels of depression and suicide, increased rates of alcohol and drug use, and greater risks for sexually transmitted infections. Persistent discrimination against LGBTTTIQ people can also have a negative impact on their ability to form and sustain supportive relationships with friends and social networks, to find supportive spiritual/ faith communities, and to find support for intimate relationships and parenting (Ministerial Advisory Committee on Gay and Lesbian Health 2003). Widespread and persistent individual and systemic discrimination against LGBTTTIQ people has also resulted in their reduced access to quality health care and the under-utilization of health care services (Banks 2003; Coalition for Lesbian and Gay Rights in Ontario 1997; Dean et al. 2000; INCLUSION Project 2003; Ministerial Advisory Committee on Gay and Lesbian Health 2003; National Reference Group 2000; Ryan and Chervin 2000; Ryan, Brotman, and Rowe 2000). Negative/ prejudiced attitudes of health care providers and systemic discrimination leave LGBTTTIQ patients subject to discrimination, bias, and substandard care. For example, intake and other medical forms, and formats of medical history-taking are frequently exclusive of LGBTTTIQ experiences and may discourage the disclosure of sexual orientation, gender identity, and health-related behaviours or circumstances. LGBTTTIQ people may consequently be reluctant to disclose their sexual orientation and/or gender identity, avoid or delay care (e.g. screening for various health conditions) and/or remain silent about important health concerns. Health problems can thus be undiagnosed, misdiagnosed, and/or left untreated until they are more severe and less amenable to treatment. These problems are compounded by health care providers' limited knowledge about LGBTTTIQ health issues that arise from both social and medical determinants.

INTERSECTING DETERMINANTS OF HEALTH

As previously mentioned, other social determinants of health interact with discrimination based on sexual orientation and gender identity to produce health concerns and outcomes that affect the wide diversity of LGBTTTIQ populations [for a detailed account of the impact on gay men's health of the twelve determinants of health officially recognized by Health Canada, see (Ryan and Chervin 2000)]. We briefly discuss some of these interactions below.

Income & Social Status

Income and social status (often measured as socioeconomic status) are known to be powerful determinants of health. Homophobia, heterosexism, sexism and transphobia can all affect educational achievement and career opportunities (INCLUSION Project 2003; Ryan and Chervin 2000). Recent American studies have refuted the 'myth of gay affluence' (that assumes gay and lesbian couples have 'dual-income-no-kids' and thus have high levels of disposable income). Badgett's (1998) research on household incomes of same-sex couples has indicated that heterosexual-couple households and male same-sex households have approximately equal incomes, while female same-sex households have 18-20% less household income (reflecting the persistent gender wage gap). Meanwhile, using 2001 U.S. Census data, Gates (2003) reports that "among all full-time employed men ages 25-54, the median earnings of partnered gay men are $3,000 below the income of men partnered with women (married and unmarried)". People living with HIV/AIDS frequently live in poverty as a result of inflexible government income-support programs and the high cost of allopathic and complementary therapies. Transgendered and transsexual persons frequently experience severe social and economic marginalization –

those who are rejected by family and community and who face barriers to employment and education because of harassment and/or discrimination commonly experience unemployment, poverty and homelessness (Dean et al. 2000). In spite of these barriers to stable employment and income, they frequently must bear the full cost of hormones and gender-reassignment interventions (INCLUSION Project 2003; Ministerial Advisory Committee on Gay and Lesbian Health 2003; Ryan and Chervin 2000). LGBTTTIQ youth are disproportionately homeless, many having left (or experienced forcible explusion from) their family home because of homophobic rejection or fear of rejection (Duncan et al. 2000; INCLUSION Project 2003; Ryan and Chervin 2000).

Gender

Gender (and implicitly, sexism) has been recognized as an important health determinant (Health Canada 1999b, 2000). Gender interacts with other health determinants such as income/social status, employment, and health services to create distinct health patterns for men and women. For example: women are more likely to live in poverty than men; girls use fewer health care services than boys in infancy and childhood, but women use more health services than men in adulthood; women also constitute the majority of people providing health care in Canada (approximately 80% of paid health care workers are women, and women provide most unpaid health care within the home) (Armstrong et al. 2001; Health Canada 1999b). Homophobia and transphobia may be viewed as 'weapons of sexism,' operating as means to maintain a binary system of gender and sexist social relations; conversely, sexism helps maintain homophobia, heterosexism and transphobia (Ryan and Chervin 2000). Gender/gender inequality influence health issues specific to lesbians, including patterns of illness and reduced access to and standards of care (Ministerial Advisory Committee on Gay and Lesbian Health 2003). While gender is a recognized (though under-researched) determinant of health, 'gender identity' has not been fully considered; consequently, discussions of the impact of gender on health typically exclude the experiences of transsexual, transgender and intersex people.

Racism & Colonialism

In Canadian population health policy, issues related to ethnicity, race and racism are considered 'cultural' determinants of health. There has been relatively little research on how the intersections of race and marginalized sexual orientation/gender identity affect health, and even less on the health of Two-Spirit people (and those First Nations, Inuit and Metis people who identify as LGBTTTIQ). CLGRO (1997, p. 60) reports that LGBTTT persons marginalized by race or ethnicity face similar problems accessing health and social services as white LGBTTT individuals, but the problems are compounded by racist social relations: LGBTTT people of colour "live with more unemployment and more violence, and report less comfort with physicians, hospitals, and the range of mental-health services and service-providers." Ryan and Chervin (2000) suggest several ways in which minority ethnic/racialized identity/group membership may affect gay men:

- revealing one's sexual orientation may imply a greater risk of losing support within one's community of origin – not necessarily due to greater homophobia within those communities, but rather due to the importance of those communities to one's sense of well-being and integrated identity;

- revealing one's sexual orientation may be seen to have greater repercussions for one's entire family, as it is situated in a community of origin; this implies greater responsibility and risk associated with coming out;

- individuals may bring with them histories of struggle and resistance, as well as a sensitivity to racism or xenophobia, to the experience of heterosexism and homophobia;

- individuals may struggle with internalized oppression (e.g. racism, homophobia) and may face the pressure to 'choose' allegiances or affinities with one community or another.

Brotman and Ryan (2004) have explored the intersectional effects of racism, colonialism, sexual orientation and gender identity for the health of Two-Spirit people in Canada: "The intersectional oppression that Two-Spirit people face is structural in nature, based upon historical and current discrimination in health care and other settings […]. Colonialism, heterosexism, homophobia/

transphobia, classism and sexism experienced by Two-Spirit people have put them at a unique disadvantage with regard to their health" (p. 60). Colonial and racist oppression of First Nations, Inuit and Métis people has caused higher rates of substance abuse, addictions, depression and suicide, morbidity, and mortality than experienced by non-Aboriginal populations – combined with the negative health effects of discrimination based on sexual orientation and gender identity, Two-Spirit people face specific forms of exclusion and marginalization. For example, 'coming out' (which can enhance the health and well-being of LGBTTTIQ people) may be complicated for several reasons (Brotman and Ryan 2004):

- coming out may be seen as a rejection of First Nations, Métis or Inuit identity because 'gay' identity is associated with Western culture and ideology;

- claiming a Two-Spirit identity may not be possible because of a lack of awareness of this history and tradition, and because coming out in First Nations, Métis or Inuit communities may result in homophobic/transphobic oppression within those communities – this, in turn, has especially significant consequences for coping and survival in the face of racism outside of one's 'home' community;

- racism within LGBTTTIQ communities (where racist stereotyping of 'ethnic' communities casts them as especially homophobic) has resulted in the alienation of LGBTTTIQ First Nations, Métis, Inuit people and people of colour.

Many Two-Spirit people feel forced to choose between defending family and community against racist and colonialist attitudes in LGBTTTIQ communities, or defending their sexuality/gender identity in response to homophobic/transphobic attitudes in First Nations, Métis and Inuit communities – as a result, Two-Spirit people may be denied crucial social supports. Finally, lack of knowledge and acceptance of Two-Spirit persons by mainstream and traditional healers can interfere with quality health care. In one study (Coalition for Lesbian and Gay Rights in Ontario 1997), 22% of First Nations participants reported seeing a traditional healer; of these, 36% thought it was important that their healer know about their sexual orientation, but only 16% had come out to their healer. 47% believed traditional healers need more sensitivity and knowledge about marginalized sexual orientations.

Geographic Location

Geographic location (which includes both social and physical environments) can also have an impact on the health of LGBTTTIQ people. For example, some research has suggested a number of factors that may contribute to poorer health for LGBTTTIQ people living in rural and remote areas (as opposed to metropolitan centres, which tend to have larger and more visible LGBTTTIQ populations). These include:

- fewer health service providers with knowledge and expertise in LGBTTTIQ health issues;

- increased levels of homophobia and transphobia;

- reduced access to LGBTTTIQ community and support networks;

- reduced access to information;

- isolation; and

- fear of breaches in confidentiality when disclosing sexual orientation and/or gender identity (INCLUSION Project 2003; Ministerial Advisory Committee on Gay and Lesbian Health 2003; Ryan, Brotman, and Rowe 2000).

In a survey on the health and social service needs of LGBTTT people in Ontario (Coalition for Lesbian and Gay Rights in Ontario 1997), clear differences in health care experiences were found between those in rural or northern regions, and those in urban areas or Metro Toronto. For example, whereas only 55% of respondents in northern Ontario had told their family doctor about their sexual orientation, 82% in Metro Toronto had disclosed to their doctor. Approximately 54% of respondents in northern Ontario and 65% of rural respondents felt they could talk openly with their doctor, compared with 80% in Metro Toronto.

(Dis)ability

In addition to facing heterosexism, homophobia and transphobia, LGBTTTIQ people living with disabilities may also experience the effects of discrimination based on their disabled status. Disabled people (regardless of sexual orientation) are frequently presumed to be asexual, and face major barriers to the open expression and acceptance of their sexualities (Coalition for Lesbian and Gay Rights in Ontario 1997; Ministerial Advisory Committee on Gay and Lesbian Health 2003). Disabled LGBTTTIQ persons may be more reluctant to come out to their doctors than their non-disabled counterparts, reducing their access to quality health care (Coalition for Lesbian and Gay Rights in Ontario 1997). They may be excluded from LGBTTTIQ community services and events (because of prejudice or lack of accessible spaces), limiting their connection to information and supportive networks. LGBTTTIQ disabled individuals are particularly vulnerable to homophobia and heterosexism when using services such as attendant care, home visits, or specialized transportation services. Difficulty finding appropriate, free supportive services leads many LGBTTTIQ disabled people to pay for private assistance if they can, compounding economic disadvantages that they face (Coalition for Lesbian and Gay Rights in Ontario 1997).

Age

The experiences of LGBTTTIQ people across the life course are important for understanding determinants of their health. For many LGBTTTIQ youth, lack of money and concerns about confidentiality are a barrier to service (Coalition for Lesbian and Gay Rights in Ontario 1997). Transgendered and transsexual youth are especially at risk: "Isolation keeps most transgendered youth from seeking essential mental health and medical care until crises occur. […] [These crises] are not just medically destabilizing, but often led to rejection and further isolation from family and peers. As a result of family and social abandonment, many transgendered youth encounter victimization through homelessness, drug use, and prostitution" (Dean et al. 2000). LGBTTTIQ seniors face ageism both within and outside of their communities; they are often invisible and desexualized in community and health care settings (Coalition for Lesbian and Gay Rights in Ontario 1997; Ministerial Advisory Committee on Gay and Lesbian Health 2003). Many of them have early experiences of health and social services that have pathologized LGBTTTIQ people, possibly making them reluctant to use existing services. They may also face ongoing discrimination based on sexual orientation and gender identity in institutionalized care (e.g. nursing homes or supportive housing). Nevertheless, they tend to express greater satisfaction with services than younger LGBTTTIQ people (Coalition for Lesbian and Gay Rights in Ontario 1997).

COUNTING US IN – LIMITATIONS OF EXISTING EVIDENCE ON LGBTTTIQ HEALTH

Despite the impact of discrimination based on sexual orientation and gender identity on health, and the interaction of these determinants of health with other important determinants such as income, racism, (dis)ability and geographic location, the health of LGBTTTIQ people in mainstream research and policy has been largely overlooked. The INCLUSION Project of Scotland's National Health Service (2003) has identified several limitations of the existing evidence base on LGBTTTIQ health concerns:

- There are significant evidence gaps because health research is driven primarily by legislation or national priorities, and to date, LGBTTTIQ people's health needs have been absent.

- There are significant methodological difficulties in undertaking representative research on LGBTTTIQ populations. Dean et al. (2000) describe four main challenges: definition; measurement; sampling rare populations; and sampling related to sensitive topics.

    - ◆ First, the ways that LGBTTTIQ populations have been conceptualized have changed over time, and there is no general consensus on how various terms related to sexual orientation and gender identity (e.g. lesbian, bisexual, transgender) are to be defined. For example, common definitions of sexual orientation tend to include one or more of three dimensions: (1) sexual orientation identity; (2) sexual behaviour; and (3) sexual attraction. Without consensus on what elements/aspects are to be included in a definition, it is not possible to develop valid and reliable measures. Moreover, how LGBTTTIQ populations are defined affects estimates of their size – for example, Dean et al. (2000, p. 135) remind us that depending on how sexual orientation is defined, recent national studies indicate that "1-21% of the population could be classified as lesbian or gay to some degree, with the remainder classified as bisexual or heterosexual to some degree."

- ◆ Second, valid and reliable measures of sexual orientation and gender identity are lacking (in part, because issues of inconsistent definition persist). Existing measures vary, from simple dichotomous measures (e.g. yes/no) to complex scales (e.g. the Kinsey scale). Different research questions may require different levels of specificity, and may require measurement of different aspects of sexual orientation and/or gender identity (e.g. identity or behaviour). In addition, measures of sexual orientation and gender identity are frequently not sensitive to racial, ethnic, age and other differences among research participants. Nevertheless, "[s]ubstantial variation exists across racial and ethnic groups concerning the social acceptability of exact orientations and identities, and consequently the reporting and understanding of these constructs varies across communities" (Dean et al. 2000, p. 136). These differences must be taken into account when choosing measures of sexual orientation and gender identity.

- ◆ Third, sampling rare and hidden populations (which are often geographically dispersed) poses significant methodological and financial challenges to researchers studying the health of LGBTTTIQ populations. Dean et al. (2000) review several methods most frequently used to study LGBTTTIQ populations, noting that each one introduces biases that must be addressed when interpreting findings (just as 'representative' sampling for conventional population surveys introduces biases that must be addressed, especially regarding their ability to report on stigmatized and relatively small populations such as LGBTTTIQ).

- ◆ Fourth, various challenges arise when conducting research on 'sensitive topics' (in general, these include studies where there are potential negative consequences, directly or indirectly, for individual participants or a class of participants). Studies that address sexual orientation and gender identity are viewed as 'sensitive' because of persistent discriminatory attitudes and systemic practices against LGBTTTIQ individuals and communities, and the possibility for harm coming to people who publicly declare marginalized sexual orientations and/or gender identities. This raises political, ethical and methodological challenges for researchers throughout the entire research process, from design to dissemination of results. Dean et al. (2000) review several methodological approaches that have been used to advance research on sensitive topics, particularly in surveys.

- There are large gaps in available research regarding the health needs of certain segments of LGBTTTIQ populations (e.g. older persons, people living in rural and remote areas, people of colour, Two-Spirit, transsexual, transgender, and intersex persons).

- Population surveys frequently do not ask questions about sexual orientation and gender identity; where these questions are asked, they are often limited in scope. In Canada, the Canadian Community Health Survey has begun to ask questions about sexual orientation (CCHS Cycle 2.1 is the first Statistics Canada survey to include a question about sexual orientation) (Statistics Canada 2004), but this effort remains limited by the methodological issues outlined above. Significantly, other major Canadian national surveys (e.g. the Census, National Longitudinal Survey of Children and Youth, and the General Social Survey) do not include explicit and direct questions about sexuality and gender identity. Dean et al. (2000, p. 138) assert: "The most important constraint limiting our knowledge concerning the health of lesbian,

> gay, bisexual, and transgender people is the collection of data from large national on-going population-based surveys funded by the federal government." While we would not want other crucial, existing data sources (e.g. community-based, qualitative and mixed-methods designs) to be overlooked, Dean et al. contend that it is crucial to include measures of sexual orientation and gender identity in federally-funded, large scale surveys in order to assess and monitor the health of LGBTTTIQ populations – indeed, they consider this information to be 'life-saving.'[3]

In this section, we have asserted that discrimination based on sexual orientation and gender identity is a significant determinant of health that has been overlooked in research and policy. We have briefly reviewed how discrimination based on sexual orientation and gender identity interacts with other social determinants, including class (socioeconomic status), gender, race and ethnicity, geographic location, (dis)ability, and age. We have also reviewed some of the gaps and methodological challenges in producing valid and reliable evidence about the health of LGBTTTIQ populations. In the next section, we explore how a structural, intersectional analysis of LGBTTTIQ health and health care may inform current public health policy activities, such as the ongoing development and assessment of the recently announced Public Health Goals for Canada.

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[3] In Table 2, we chart/review some of the Canadian (non-governmental) research which has addressed the health of LGBTTTIQ persons and communities (including health outcomes and access to health care services).

PART III:

OPPORTUNITIES IN HEALTH POLICY – CANADA'S NEW PUBLIC HEALTH GOALS

There are many policy and program fronts on which LGBTTTIQ health determinants and disparities may be addressed. One such area is the ongoing development, implementation and assessment of Canada's new national public health goals. We have chosen to focus on the Health Goals for Canada because they are an emergent policy initiative built on the principles of a determinants of health perspective.

> *Sustaining and improving the health of Canadians will require more than just raising awareness about healthy lifestyles. It will require more than just ensuring timely access to quality medical care services. And it will require more than just setting rules to protect human and environmental health – as important as these things are. It will also require us to better take account of how the health dimension of our individual actions and public policy decisions affect such things as housing, childcare, justice, education, employment and taxation, and impact our well-being.*
>
> *– The Honourable Carolyn Bennett, Minister of State (Public Health), Government of Canada and the Honourable Theresa Oswald, Minister of Healthy Living, Government of Manitoba (Co-Leads on Public Consultation on Public Health Goals)*

Initiated as a participatory and collaborative process, the development of the Health Goals for Canada is a first step in a national process of improving the health status of Canadians. The ongoing development of objectives, targets, strategies and indicators for Canada's Health Goals provides an opportunity for Federal, Provincial and Territorial governments to show leadership in addressing the determinants of health for LGBTTTIQ individuals and communities.

WHERE DID THIS WORK BEGIN AND WHERE MIGHT IT TAKE US?

In 1994, the F/P/T (Federal/Provincial/Territorial) Task Group on National Health Goals/Priorities described public health goals as "an exercise in setting public priorities and public policy". The Task Force outlined several reasons for having national public health goals:

- they would provide a consistent national framework for collaboration between and among governments and sectors in setting priorities, establishing strategies, making investments in interventions to improve health, and measuring and reporting on health improvements;
- they would focus attention and resources on important determinants of health outside of the health care sector and would facilitate collaboration between the health sector and other sectors;
- they would help link decisions about investments (in the health sector and other sectors) to health

outcomes, and improve the use of resources by focusing attention on health outcomes;

- they would emphasize the need to correct disparities in health status among groups or regions, and help "bring the health of disadvantaged groups into line" with that of the general population;

- they would broaden the agenda in the health sector beyond a preoccupation with health care and help shift attention to health promotion, maintenance of good health, and prevention of injury/illness;

- they would "provide a message that positive change towards better health is possible";

- they would help reduce fragmentation and provide a "unity of purpose." (Canadian Public Health Association, n.d.)

In its 1996 Report on the Health of Canadians, the Federal/Provincial/Territorial Advisory Committee on Population Health reviewed existing Provincial and Territorial health goals and identified several overlapping/overarching 'challenges' for public health (see Box 1). These goals/challenges reflect a broad determinants of health perspective, however they have not been reliably or directly "integrated into the planning, decision-making and accountability mechanisms to any significant extent in most provinces" (F/P/T ACPH 'Directions for a Healthy Canada' 2000, cited in Canadian Public Health Association n.d., p. 4).

Box 1 – Public Health 'Challenges' from the Report on the Health of Canadians

- Create a thriving and sustainable economy, with meaningful work for all
- Ensure an adequate income for all Canadians
- Reduce the number of families living in poverty in Canada
- Achieve an equitable distribution of income
- Encourage life-long learning
- Foster friendship and social support networks in families and communities
- Foster a healthy and sustainable environment for all
- Ensure suitable, adequate and affordable housing
- Create safe and well-designed communities
- Foster healthy child development
- Encourage healthy life-choice decisions
- Ensure appropriate and affordable health services, accessible to all
- Reduce preventable illness, injury and death

It is widely accepted that the task of improving the health of populations "needs to consider the broad range of factors that influence health" and that the "complex webs of causation that influence health-related behaviours and health status necessitate comprehensive approaches" to health (Canadian Public Health Association n.d., p. 1).

In September 2004, the First Ministers agreed upon the importance of establishing public health goals for Canada: "All governments recognize that public health efforts on health promotion, disease and injury prevention are critical to achieving better health outcomes for Canadians and contributing the long-term sustainability of medicare by reducing pressure on the health care system…For the first time, governments will set goals and targets for improving the health status of Canadians through a collaborative process with experts" (cited in Canadian Public Health Association n.d., p. 2). Carolyn Bennett, Federal Minister of State (Public Health) and Theresa Oswald, Minister of Healthy Living (Manitoba) were appointed to co-lead the process of developing public health goals for Canada. Under their direction, the new Public Health Agency of Canada (also launched in 2004) has acted as the Public Health Goals Secretariat providing administrative support for the exercise. Most provinces and territories have already developed their own versions of public health goals – the pan-Canadian exercise was to build on those goals, and on the experiences of other jurisdictions, including Australia, the United Kingdom, Sweden, and the United States.

A 'Background for Discussion' paper produced by the Canadian Public Health Association set the context for this exercise. The Background paper outlined the terminology used in the project, provided a brief history of public health goals exercises in Canada and other countries, and addressed the recommended scope and process for the development of Canadian public health goals.[4] Two jurisdictions (the United States and Sweden) were given special mention because they represent two very different approaches to the development of national public health goals.

The United States has adopted a 'technocratic approach' to developing its public health goals (primarily engaging government agencies), and this has been a massive undertaking. U.S. national health objectives were first developed in a 1979 Surgeon General report; subsequently, the Healthy People initiative has identified objectives for 2000 and then for 2010. Healthy People 2010 has two main goals: increasing the quality and years of healthy living, and eliminating health disparities. There are 28 focus areas which cluster 467 objectives and their associated targets. [5] The focus areas are a mix of disease clusters, health behaviours and health service groupings – these foci distinguish the U.S. objectives from Sweden's, which concentrate on 'upstream' social determinants of health.[6] The 2010 initiative includes, for the first time, a focus area on public health system infrastructure (addressing data and information systems, workforce, public health organizations, resources, and research). "Complementary to Healthy People, the U.S. Centers for Disease Control and Prevention have established detailed sets of performance standards for local and state public health agencies that are used to assess strengths and gaps in system infrastructure." (Canadian Public Health Association n.d., p. 8).

It is important to note that LGBT advocacy groups in the United States expressed concern about the exclusion of content on sexual orientation in the first draft of the Healthy People 2010 report, issued in January 1999 (Sell and Bradford 2000). The second draft, released in June 1999, identified LGBT Americans as one of six populations that experience health disparities. These

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[4] The CPHA background paper "is focussed on the broad set of factors that support the health of the population, not about specific personal health service system issues such as treatment wait times, scarcity of family physicians, pharmacare programs, etc." (CPHA 2005, p. 1) Nevertheless, the scope of public health includes access to adequate, appropriate health care services.

[5] In the lexicon of public health policy and information systems, 'goals,' 'objectives,' 'targets,' 'indicators,' and 'strategies' have particular meanings. Specifically (Canadian Public Health Association n.d., p. 3):
- 'goals' refer to "broad statements of desired states or directions in which a society wishes to move" (e.g. 'To promote health weights and reduce obesity') – these are generally not quantitative;
- 'objectives' are "more specific and measurable statements of intent" (e.g. 'Increase the proportion of Canadians who are at healthy weight'); ideally they are specific, measurable, achievable, relevant to the goals, and timed; they may include 'targets';
- 'targets' specify the amount of progress to be made and the time by which it is to be accomplished (e.g. '10% increase in proportion of the population at healthy weight by 2010);
- 'indicators' are specific measures by which progress toward goals will be gauged (e.g. 'Prevalence of healthy body weight as measured by Body Mass Index (BMI) based on physical measures of height and weight, or self-reported height and weight');
- 'strategies' coordinate various interventions that are designed to achieve a goal and its objectives (e.g. several strategies may be required to achieve the goal of healthy body weight for Canadians: a healthy eating strategy may have components addressing particular sectors [e.g. food industry]; a physical activity strategy may have components dealing with particular settings [e.g. schools]).

[6] For example, while nearly half of the focus areas of Healthy People 2010 refer to disease or disability, almost all of Sweden's eleven public health goal areas refer to non-medical determinants of health (Canadian Public Health Association n.d., p. 5).

six populations were to be targeted by Healthy People 2010; sexual orientation was specifically included in the discussion and/or in data tables of 29 (of 467) Healthy People 2010 objectives spanning 10 focus areas: access to care; educational and community-based programs; family planning; HIV; immunization and infectious disease; injury and violence prevention; mental health and mental disorders; sexually transmitted diseases; substance abuse; and tobacco use. However, in the 'conference edition' of the report released in January 2000, LGBT people were included in data tables for only one of the total 467 objectives, despite still being identified as one of the six populations targeted for the elimination of health disparities (Sell and Bradford 2000). In fact, sufficient scientific evidence is available to justify inclusion of sexual orientation in the text and data tables of 15 of 28 focus areas and at least 49 of the total 467 objectives of Healthy People 2010 (Sell and Bradford 2000). Researchers have made specific recommendations for adding sexual orientation to data sets (e.g. the National Health Interview Survey, the National Vital Statistics System, and others) in order to monitor progress toward the Healthy People 2010 objectives (Sell and Bradford 2000; Sell and Becker 2001). Nevertheless, there remains significant resistance to the production and inclusion of data on the health of LGBTTTIQ populations. In October 2002 the U.S. Gay and Lesbian Medical Association (2002) protested the omission of funding to address health disparities based on sexual orientation from the Department of Health and Human Services' (HHS) Strategic Plan. In the present Strategic Plan for HHS (2004-2009) there is no mention of sexual orientation (Department of Health and Human Services 2004).

In contrast to the U.S. focus on disease states, health behaviours and health services, Sweden consciously addressed 'upstream' determinants of health because:

- these determinants can be influenced by societal measures;
- an upstream focus acknowledges that most public health work must take place outside of the health care sector;
- this approach avoids the problem of disease-focused objectives, which require evaluators to disentangle the effects of clinical vs. public health interventions;
- a small set of broad determinants can have an impact on many health outcomes; and
- this approach is sensitive to the fact that there are frequently long lags between changes in health determinants and health outcomes.

A key feature of the Swedish model was a focus on monitoring. A national institute with a mandate for providing jurisdictions with information and evidence was given the task of formulating interim targets and developing indicators to assess how well the health objectives are being fulfilled. The selection criteria for the indicators included: strong correlation to health; strong validity for the determinant (i.e. the measure is clearly linked to the determinant in question); meaningful and possible to change by political decisions; relatively inexpensive to administer; and stratified by sex, age, type of family, different geographical levels, socioeconomic group, and ethnicity where possible (Canadian Public Health Association n.d.).

Reducing health inequalities has been a main theme in several international goals-setting exercises. "Reducing health inequalities requires consideration of upstream determinants of health, particularly social and economic factors. [...] The 'challenges' identified a decade ago in the Report on the Health of Canadians clearly favoured a health determinants approach to improving the public's health." (Canadian Public Health Association n.d., p. 7). Accordingly, Canada has more closely followed the Swedish model of addressing a relatively concise set of goals that refer to determinants of health, rather than focusing on disease and health outcomes. Moreover, it has been recommended that "Similar to the approach in Sweden, consideration should be given to the PHAC [Public Health Agency of Canada] having lead responsibility for developing indicators in a collaborative fashion with system stakeholders" so that progress toward goals (nationally and between jurisdictions) can be tracked (Canadian Public Health Association n.d., p. 8).

Announced in October, 2005, the new Health Goals for Canada include one 'overarching' goal and nine other health goals (see Box 2).

Box 2 – Health Goals for Canada: A Federal, Provincial and Territorial Commitment to Canadians

OVERARCHING GOAL

As a nation, we aspire to a Canada in which every person is as healthy as they can be – physically, mentally, emotionally, and spiritually.

HEALTH GOALS FOR CANADA

Canada is a country where:

Basic Needs (Social and Physical Environments)

Our children reach their full potential, growing up happy, healthy, confident and secure.

The air we breathe, the water we drink, the food we eat, and the places we live, work and play are safe and healthy – now and for generations to come.

Belonging and Engagement

Each and every person has dignity, a sense of belonging, and contributes to supportive families, friendships and diverse communities.

We keep learning throughout our lives through formal and informal education, relationships with others, and the land.

We participate in and influence the decisions that affect our personal and collective well-being.

We work to make the world a healthy place for all people, through leadership, collaboration and knowledge.

Healthy Living

Every person receives the support and information they need to make healthy choices.

A System for Health

We work to prevent and are prepared to respond to threats to our health and safety through coordinated efforts across the country and around the world.

A strong system for health and social well-being responds to disparities in health status and offers timely, appropriate care.

Clearly, these goals statements are broad; according to the Public Health Agency, they are "intended to be guideposts indicating a path to improve the health and quality of life of Canadians rather than a detailed map that lays out exactly how to get there." (Public Health Agency of Canada 2005) What do they mean for LGBTTTIQ individuals and communities?

Substantial research has been conducted in Canada about the health and well-being of LGBTTTIQ individuals and communities, and these studies have generated recommendations for action providing a rich fund of resources for the next steps of generating objectives, targets, indicators and strategies for our national public health goals. In what follows, we match some of these recommendations to the recently announced public health goals for Canada:

- The goal of enabling our children and youth to "reach their full potential, growing up happy, healthy, confident and secure" could be supported by initiatives to formalize referral networks and offer mentoring, education and support for LGBTTTIQ youth (Coalition for Lesbian and Gay Rights in Ontario 1997; Dobinson et al. 2003; Gapka and Raj 2003; Winnipeg Gay/Lesbian Resource Centre 1996).

- The goal of ensuring that our social and physical environments are safe and healthy could be supported by establishing government-sponsored, public campaigns against homo/bi/transphobia, sexism and heterosexism within and across the health care, housing and employment sectors (Coalition for Lesbian and Gay Rights in Ontario 1997).

- The goal of ensuring that "every person has dignity, a sense of belonging, and contributes to supportive families, friendships and diverse communities" could be addressed by providing supportive services (e.g. 'help lines'; community outreach; trans-positive shelters and transitional housing) for LGBTTTIQ individuals and their families, and ensuring that existing barriers to services and benefits are removed (e.g. same-sex spousal/family benefits) (Coalition for Lesbian and Gay Rights in Ontario 1997; Dobinson et al. 2003; Gapka and Raj 2003; Winnipeg Gay/Lesbian Resource Centre 1996).

- The goal for life-long learning could be achieved through continuing education of the public and of health care and social service workers around LGBTTTIQ issues, and through targeted programs for LGBTTTIQ individuals and communities (e.g. skills training and employment resources for trans people) (Coalition for Lesbian and Gay Rights in Ontario 1997; Dobinson et al. 2003; Gapka and Raj 2003; Winnipeg Gay/Lesbian Resource Centre 1996).

- The goal that we all "participate in and influence the decisions that affect our personal and collective health and well-being" reflects an investment in community involvement in health and health care. Like other population groups, LGBTTTIQ people must be involved in the planning of programs, health care delivery and research (Gapka and Raj 2003; Sum Quod Sum Foundation 1997).

- Making the world "a healthy place for all people, through leadership, collaboration and knowledge" requires improving research and information on LGBTTTIQ people's health and well-being, including: specific health issues (e.g. cancers, addictions); violence and strategies for education and prevention; how intersections of oppression affect health and well-being; populations within LGBTTTIQ communities (e.g. older LGBTTTIQ persons; bisexuals; transgender and transsexual persons; intersex persons); and health service and support needs (Coalition for Lesbian and Gay Rights in Ontario 1997; Dobinson et al. 2003; Gapka and Raj 2003; Sum Quod Sum Foundation 1997; Winnipeg Gay/Lesbian Resource Centre 1996).

- Achieving the goal that every person gets "the support and information they need to make healthy choices" requires health promotion programs specific to LGBTTTIQ communities (these include education and information resources on healthy sexuality and gender variations, as well as other health issues) (Coalition for Lesbian and Gay Rights in Ontario 1997; Dobinson et al. 2003; Gapka and Raj 2003; Winnipeg Gay/Lesbian Resource Centre 1996).

- Finally, the goal of a strong health system that "responds to disparities in health status and offers timely, appropriate care" requires initiatives that improve services and access for LGBTTTIQ people (e.g. a system that recognizes discrimination based on sexual orientation and gender identity as important determinants of health; inclusive intake forms; improved access for trans people to sex/gender reassignment surgeries and other interventions such as hormone treatments; improved, anti-oppressive curricula for students training to be health and social service professionals) (Coalition for Lesbian and Gay Rights in Ontario 1997; Dobinson et al. 2003; Gapka and Raj 2003; Sum Quod Sum Foundation 1997; Winnipeg Gay/Lesbian Resource Centre 1996).

PART IV: RECOMMENDATIONS

The next steps in the public health goals process include developing the objectives, targets, indicators and strategies that implement, measure and assess our progress toward the announced goals. How can we ensure that these steps reflect and address important determinants of health for marginalized populations, and specifically, LGBTTTIQ individuals and communities? We recommend five strategies, all of which are directed toward enhancing public health infrastructure:

(1) Extant evidence on the health concerns of LGBTTTIQ populations must be fully recognized and integrated by the bodies that undertake the next steps of indicator development and strategic planning.

(2) Data collection in standardized national instruments (e.g. the National Population Health Survey, the Canadian Community Health Survey, the National Longitudinal Survey of Children and Youth, the Health Services Access Survey, the Census, and others) must include sexual orientation and gender identity. Moreover, reporting must disaggregate data by sexual orientation, gender identity, race/ethnicity, socioeconomic status, age, (dis)ability, and geographic region (where possible).

(3) Extant federal policies on gender-based, diversity analysis must be fully implemented and rigorously applied.

(4) The federal government should provide leadership by establishing an LGBTTTIQ Health Directorate (within Health Canada or the Public Health Agency of Canada). This directorate would be responsible for the development and implementation of an LGBTTTIQ Health Strategy.

(5) Funding for LGBTTTIQ-specific research must be coordinated and increased.

We expand on these recommendations in the remainder of this section.

Production and reporting of health information for LGBTTTIQ populations is a crucial step toward redressing health inequities and is necessary for the development of appropriate and inclusive indicators to measure progress toward national public health goals. Sell and Baker (2001) argue that one of the greatest threats to the health of lesbian, gay, and bisexual populations is the lack of scientific information about their health. A recent review of public health research published between 1980 and 1999 found that LGBT issues were addressed in only 0.1% of all articles in the MEDLINE database for that period (Boehmer 2002). Given that LGBTTTIQ persons are estimated to constitute between 1% and 10% of the overall population, this finding indicates that public health research has severely neglected these populations (Boehmer 2002). Furthermore, only 9% of reviewed LGBT articles referred to transgender persons, and 85%

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[7] Note that this does not include 'grey' literature (non-peer reviewed research and reports) which can provide valuable information about LGBTTTIQ health. However, 'grey' literature has limitations: it frequently does not offer data that address prevalence of conditions or data that

omitted reference to race/ethnicity.[7] In this desert of peer-reviewed research, the creators of Healthy People 2010 in the U.S. required evidence of health disparity before sexual orientation could be included in any of the report's 467 objectives. On one hand, this means that the inclusion of sexual orientation in 29 objectives is an admission by the U.S. federal government (Department of Health and Human Services) that disparities do exist and that the government accepts responsibility for monitoring and achieving these objectives (Sell and Becker 2001). On the other hand, the requirement to provide 'credible' (published) research in order to get recognition by public health authorities illustrates the 'catch-22' faced by many LGBTTTIQ health providers, researchers and activists. Plumb (2001, p. 873) explains: "Without funding we cannot do quality research, without quality research we cannot get published in medical journals, without being published in medical journals we cannot convince health experts that a health need exists, without proving to health experts that a health need exists we cannot get funding for research, prevention, or programs."

There are at least two remedies for this dilemma – recognizing the value of existing data from community-based research, and committing to a long-range plan for enhancing the production of valid, representative, statistical data by national survey instruments and databases. First, the substantial amount of evidence that presently exists regarding LGBTTTIQ health needs and concerns can inform the development of LGBTTTIQ-sensitive health indicators. A preponderance of this evidence has been produced by small-scale, community-based research and its usefulness should be recognized – not all credible evidence comes from large-scale, representative surveys or randomized clinical trials. Plumb (2001, p. 874) reminds us: "What is knowable about a population and its health cannot be found solely through quantitative science. Community knowledge, particularly in the case of populations that are difficult to find or categorize, plays an increasingly important role in attempts to study these populations."[8] The recent U.S. Institute of Medicine report on Lesbian Health (1999) has encouraged such a paradigm shift in the hierarchy of public health research methodology (Plumb 2001). Second, data collection for sexual orientation and gender identity must be integrated into existing information systems that will be used to monitor progress toward Canada's public health goals. This requires, minimally, the involvement of the Public Health Agency of Canada (PHAC), Health Canada, Statistics Canada, the Canadian Institute for Health Information (CIHI), and the Canadian Institutes for Health Research (CIHR). Data on sexual orientation has only recently been collected in the Canadian Community Health Survey (CCHS) (Cycle 2.1), and is available in the Census only via a question on conjugal relationship status. Sexual orientation and gender identity, like race, ethnicity or socioeconomic status are "fairly complex construct[s] to measure, making the selection of concise, valid, and reliable measures appropriate for monitoring health additionally challenging" (Sell and Becker 2001, p. 878). Because the PHAC will likely take the lead on the development of indicators for Canada's new public health goals, it has an opportunity to show leadership in the advancement of measurements for LGBTTTIQ health, coordinating a series of activities that could improve existing Canadian data collection systems. These activities could include:[9]

- creating work groups on sexual orientation and gender identity to examine the collection of such data in national surveys and databases (this could include creating an inventory of national databases that collect sexual orientation and/or gender identity data in order to identify gaps);

- creating a set of guiding principles for the development and selection of definitions and measures of sexual orientation and gender identity (e.g.: "(1) sexual orientation [and gender identity] categories should not be interpreted as primarily biological or genetic in nature, but must be examined in the context of social and cultural characteristics of the populations; (2) respect for individual dignity and privacy should guide the collection of data; and (3) concepts and terminology, insofar as is feasible, should reflect clear and generally understood definitions that can achieve broad public acceptance" (Sell and Becker 2001, p. 878));

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[8] In an intersectional approach to LGBTTTIQ health and health research, 'community knowledge' is complicated by the multiple social locations (of race, ethnicity, [dis]ability, age, class, gender, etc.) occupied by people who identify as LGBTTTIQ.

[9] These activities are adapted from recommendations offered to the U.S. Department of Health and Human Services (Sell and Becker 2001).

- taking into account differences in race, ethnicity, immigration status, age, socioeconomic status, and geographic location when selecting standard measures of sexual orientation and gender identity;

- developing standard (comparable), valid, and reliable questions and response categories for sexual orientation and gender identity, and doing so with a review process that involves participation of the communities involved; and

- developing a long-range strategic plan for collecting data on sexual orientation and gender identity that includes the development of special sampling strategies if sample sizes are not large enough to represent each group or to be reported on.

It is imperative that not only are data on sexual orientation and gender identity collected/produced in national surveys and information systems, but that in reporting these data are disaggregated by sexual orientation, gender identity, race/ethnicity, socioeconomic status, age, (dis)ability, and geographic region. This is necessary (albeit not sufficient) for intersectional, diversity analyses to occur.

Working within Canada's official policy approach to population health, and applying the gender-based diversity analysis officially adopted (if not fully implemented) by Health Canada, we can bring a structural, intersectional analysis to LGBTTTIQ health. This moves LGBTTTIQ health concerns from the realm of individual interventions and puts them squarely in the arena of public health. Health Canada's Gender-Based Analysis Policy (2000) not only commits it to implementing gender-based analysis (GBA) throughout the department and applying this approach to the development of policies, programs and legislation, it also emphasizes that GBA "*should* intersect with a diversity analysis that considers factors such as race, ethnicity, level of ability and sexual orientation" (emphasis added). These existing policy commitments (and others, including Charter protections against discrimination based on gender and sexual orientation) can be used to support improvements in public health infrastructures regarding the impact of sexual orientation and gender identity on health. They can also help ensure that the ongoing development and assessment of Public Health Goals for Canada are accountable to LGBTTTIQ health concerns. It is imperative that the tools which presently exist to ensure equitable data production, information systems and policy development are fully implemented and accounted for.

Research and interventions to address the health of LGBTTTIQ populations are hobbled by a lack of infrastructure to support such programs. Presently, there is no agency within the federal government (including Health Canada and other departments) that has a clear mandate to address the health concerns of LGBTTTIQ populations.[10] While research and programming on LGBTTTIQ health is undertaken (some of which is funded by federal government initiatives, including the Canadian Strategy on HIV/AIDS and the Primary Health Care Transition Fund), these efforts are scattered and uncoordinated. For gay and bisexual men, research grants and programming initiatives remain largely focused on HIV/AIDS (Boehmer 2002). Lesbian health research is slowly making headway in women's health research and policy initiatives, but remains marginalized. Research and public health interventions specific to transgendered, transsexual and intersex individuals and communities lag far behind. To echo Dean et al. (2000, p. 105), these initiatives "do not comprise an organized program of population-based research, nor is it easy to understand how they may mature into such a program without the intentional development of support structures." LGBTTTIQ health concerns may be interpreted as marginal to those of the 'general population,' as exotic or difficult to study, or as too political or too sensitive (Meyer 2001).

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[10] The Bureau of Women's Health and Gender Analysis is committed to a gender-based, diversity analysis of women's health – this implicitly includes the concerns of lesbian, bisexual, transsexual, transgender, Two-Spirit, intersex, and queer women (and possibly, men). "The Bureau, through the Centres of Excellence for Women's Health, Working Groups and the Canadian Women's Health Network, ensures policy relevant research and information dissemination. The Bureau maintains ongoing relationships with provinces and territories, major women's organizations, health researchers, and others to promote women's and men's active involvement in their own health and well-being" (Bureau of Women's Health and Gender Analysis 2005).

These views may limit the likelihood of creating an LGBTTTIQ-specific bureau or directorate within the federal bureaucracy, but "cooperative planning and funding of critical population-based research and initiatives may be feasible" (Dean et al. 2000, p. 105).[11] It is important to note that there are precedents for the creation of population-specific programs, bureaus and directorates in government bureaucracies (such as the Bureau of Women's Health and Gender Analysis in Health Canada), and several jurisdictions have supported this move (e.g. the Ministerial Advisory Committee on Gay and Lesbian Health, State of Victoria has recommended the creation of a Gay and Lesbian Health and Wellbeing Policy and Research Unit "with strong links to Public Health and Policy and Strategic Projects within the [health] Department) (Ministerial Advisory Committee on Gay and Lesbian Health 2003). A funded directorate, strengthened by strong partnerships with community-based organizations, could offer leadership and resources in several areas:

- coordinate funding for LGBTTTIQ health research and health promotion programming;
- support the development of LGBTTTIQ community and research networks through activities such as conferences;
- maintain a clearinghouse of data, research and health promotion information specific to LGBTTTIQ populations;
- maintain a roster of Canadian researchers, academics and policy analysts who work on LGBTTTIQ issues;
- build capacity in Canadian LGBTTTIQ health research;
- liaise with international experts on LGBTTTIQ health research and policy;
- liaise with Statistics Canada and the Canadian Institute for Health Information;
- track health status outcomes for LGBTTTIQ populations;
- identify research gaps; and
- identify 'promising practices' for LGBTTTIQ health research and health promotion, highlighting successful models and programmes.

The development of a more stable, focused and coordinated infrastructure for LGBTTTIQ health would provide the foundation for a strong research program to support the development and assessment of Canada's public health goals. Existing funding programs (e.g. CIHR, SSHRC) must be more explicitly supportive of LGBTTTIQ-specific research. Presently, funding applications for the Social Sciences and Humanities Research Council have no category for research on sexual orientation and gender identity. In the present structure of CIHR, health-related research on sexual orientation and gender identity is often funnelled through the Institute of Gender and Health, the mandate of which does not explicitly include LGBTTTIQ populations.

The ongoing development, implementation, and assessment of Canada's Public Health Goals offer a rich opportunity for making progress on LGBTTTIQ health and ameliorating the negative effects of discrimination based on sexual orientation and gender identity. These goals and their objectives, targets, indicators and strategies can provide a system of accounting and accountability. It is imperative that LGBTTTIQ individuals and communities are invited into these processes and are supported by a strong public health infrastructure.

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[11] For example, in the United States, the Institute of Medicine's 1999 report on lesbian health was supported by funding from two agencies in the federal government public health infrastructure: the Office of Research on Women's Health in the Department of Health and Human Services (DHHS), and the Office of Women's Health at the Centres for Disease Control and Prevention. The DHHS later collaborated with the Gay and Lesbian Medical Association/Lesbian Health Fund to support a scientific meeting to follow up the IOM report. "Cooperative efforts such as these can help fill gaps in the infrastructure, and can provide a foundation on which to create an enduring structure with appropriate sharing of responsibility" among governmental and non-governmental organizations (Dean et al. 2000, p. 105).

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APPENDIX A:

GENDER AND SEXUAL DIVERSITY GLOSSARY

Language can carry different meanings in different contexts within different environments. Language is fluid, and terminology used in different times and geographic locations frequently varies.

Bisexual: adj., n. One who has significant (to oneself) sexual or romantic attractions to members of both the same gender and/or sex and another gender and/or sex, or who identifies as a member of the bisexual community. Contrary to popular myths, people who are attracted to members of both genders or sexes (just like people who are attracted only to members of the same or other gender or sex) may be monogamous, polyfidelitous or nonmonogamous (Hamilton 2000).

Gay: 1. One who has significant (to oneself) sexual or romantic attractions primarily to members of the same gender or sex, or who identifies as a member of the gay community. May be of any gender identity. 2. Sometimes used as a synonym for gay male, lesgay, or LesBiGay. Lesbians and bisexuals often do not feel included by this term (Hamilton 2000).

Gender Identity: The gender one identifies with, regardless of their biological sex.

Gender and Sexual Diversity: A term that captures the diversity of gender identities and sexualities such as lesbians, gays, bisexuals, transsexuals, transgendered, Two Spirit and intersex people.

Heterosexism: A belief that heterosexuality is the norm and/or superior to all other forms of sexuality. Other sexualities may be considered abnormal, unnatural or not considered at all.

Homophobia: An irrational fear of people who are attracted to and intimate with members of the same sex.

Intersex: One whose external genitalia at birth do not match definitions of male or female (e.g. large clitoris, tiny penis), or one whose sex glands do not totally match the sex assigned at birth (e.g. male with ovarian tissue or female with testicular tissue), or one whose sexual development does not match the sex assigned at birth (e.g. development of penis or extensive facial hair in one assigned as female or the development of breasts in one assigned as male) (Hamilton 2000).

Lesbian: A girl or woman who has significant (to oneself) sexual or romantic attractions primarily to members of the same gender or sex, or who identifies as a member of the lesbian community. Bisexual women often do not feel included by this term (Hamilton 2000).

Queer: 1. Reclaimed derogatory slang for the sexual minority community. Not accepted by all the sexual minority community, especially older members. 2. Sometimes used for an even wider spectrum of marginalized or radicalized groups and individuals. 3. Weird, different, not normal, apart from the mainstream (Hamilton 2000).

Sexual Minorities: Communities that stand apart from the dominant heterosexual community based on their sexual desires and expression. This may be inclusive of lesbians, gays, bisexuals, transsexuals, transgendered and intersex people. This terminology is more commonly used in the USA and to some extent in Canada.

Sexual Orientation: Sexual attraction or activity that may involve the opposite sex (heterosexuality), the same sex (lesbian or gay) and/or both sexes (bisexuality). This may be fixed or fluid. This terminology is more commonly used in Canada and the USA.

Sexual Reassignment Surgery (SRS): A surgical procedure which changes one's primary sexual characteristics from those of one sex to those of another sex, to align them with one's gender identity (Hamilton 2000).

Sexuality: Sexual attraction or activity that may involve the opposite sex (heterosexuality), the same sex (lesbian or gay) and/or both sexes (bisexuality). This may be fixed or fluid. This terminology is more commonly used in the UK.

Transgendered (TG): 1. A transgendered person has no desire to be their "opposite sex", but rather takes on characteristics of their opposite gender, exhibiting stereotypical masculine or feminine modes of dress or behaviour. A transgendered person may feel society is limiting his or her personal expression by maintaining two distinct gender constructs. 2. "Transgendered" is a term, which also serves as a banner, which covers all those who transgress society's notions of how biological sex and gender link together. Many transsexuals disagree with using the word this way, and do not choose to be lumped under this umbrella category (The 519, Trans Programming 2003).

Transsexual (TS): One who changes one's sex to align with one's gender identity. Change of primary sex characteristics is accomplished by sexual reassignment surgery. Hormone therapy, electrolysis, additional surgery, and other treatments can change secondary sex characteristics. People who live as a member of a different gender than they were assigned at birth prefer to be called man or woman, as appropriate for their chosen gender. May be of any gender identity (Hamilton 2000).

Two-Spirit: 1. Connotes the female and male spirits in one individual. In some First Nations' communities, people who did not fit the traditional gender role (activities or gender of sexual partner) usually assigned to their physical sex. Depending on the community, they might fit a different gender role, sometimes as religious leaders, or they might simply choose to live in the gender role usually assigned to another physical sex. The French term berdache, meaning mattress, has been widely used by anthropologists, but is now considered a derogatory cultural imposition (Hamilton 2000). 2. The term Two-Spirit is based on an interpretation of Native languages used to describe individuals who displayed both characteristics of male and female. Traditionally, the Two-Spirit person was one who had received a gift from the Creator, that gift being the privilege to house both male and female spirits in their body (McGill Projet/Project Interaction 2003).

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Adapted from N.J. Mulé (09/05)

APPENDIX B

Table 2 – Methodological Information

Study	Date	Geographical Location	Population	Sampling	Method	Reference
Breaking Barriers Project	June 1996	Winnipeg & other areas in Manitoba	Service User Study: 140 total participants 93% lesbian, gay or bisexual age ranged from under 18 to over 70. majority between ages of 25–39 79.2% identified as "white" limited representation of black, Jewish, Aboriginal, Asian Service Provider Study: 88% heterosexual 83% female age ranged from 20–69 yrs	Convenience sample	Service User Study: 120 anon. questionnaires completed distributed to various gay/lesbian resource centres publicly advertised open fora, attended by 20 participants Service Provider Study: 201 anon. Questionnaires interviews with staff of AIDS Service Organizations	Winnipeg Gay/Lesbian Resource Centre (1996)
Systems Failure	1997	Ontario	lesbians, gay men, bisexual & transgendered people 80% aged 26–54 limited representation of First Nation, Asian, Middle Eastern, black, Hispanic, Jewish or francophone	Convenience sample	6000 surveys circulated across Ontario between February and July 1995 through bars, social events and dances. Advertisements were also placed in local newspapers/newsletters, on community bulletin boards, etc…, providing a number people could call to get the survey. Survey completed by 1233 respondents. focus groups (details unstated in exec. summary)	Coalition for Lesbian and Gay Rights in Ontario

Study	Date	Geographical Location	Population	Sampling	Method	Reference
Access to Care: Exploring the Health and Well- being of gay, lesbian, bisexual and two spirited people in Canada	May 2000	Across Canada	gay, lesbian, bisexual, two-spirited & allies	Unstated	Focus groups: 2 with urban two- spirit people & allies 1 Men's focus group 1 women's group in urban setting 1 group for men & women in rural setting	Ryan, Brotman, Rowe (2000)
Improving the Access & Quality of Public Health Services for Bisexuals	Jan. 2003	Toronto & Ottawa	Bisexuals and people who have sex with both men and women 22 men, 39 women, 1 gender fluid person (including 5 trans people), ages 16-67, majority "white", limited representation of people of colour	Convenience & snowball	5 focus groups: 4 in Toronto, 1 in Ottawa. 43 semi-structured interviews	Dobinson et al (2003)
Trans Health Project	2003	Toronto, Ottawa & Guelph	Trans youth & trans seniors Ages 13-67 Majority identified as "white" Limited representation of people of colour Population mainly resided in Toronto	Snowball	Focus groups Semi structured interviews for focus group participants Self administered questionnaires	Gapka, Raj (2003)
Needs Assessment Survey of Senior Gays & Lesbians	Sept. 1997	Winnipeg & surrounding area	Ages 38-80, average of 57.2 Majority of British heritage	Not explicitly stated	123 surveys completed by service users Survey used in-person and distributed by mail In-person interviews with service providers	Sum Quod Sum Foundation (1997)
GLBT Wellness Project	1999	Ottawa	826 surveys completed majority gay or lesbian limited representation of trans and bisexual majority respondents aged 26-59 limited representation of people from "visible minority"	Convenience sample	focus group with GLBT youth focus group with transgendered people, survey of service providers	Social Data Research Ltd., with Anne Wright Associates, (2001)

TABLE 3

Issues regarding Health and Access to Care		References
Caregiver Issues	Many health care providers & long-term care facilities inadequately knowledgeable and sensitive to gay/lesbian issues	Breaking Barriers; OPHA: Bisexuals, Sum Quod Sum
	Caregivers often don't refer patients to gay/lesbian support services	Breaking Barriers
	Caregivers not recognizing same-sex partner as significant	Systems Failure
	Health providers ignoring disclosure of sexual orientation	Breaking Barriers
	Tolerating inappropriate abhor from a professional b/c expertise is necessary to treatment	Breaking Barriers
	Lack of education needed to work with bisexuals, patients feel they must educate their health care provider	OPHA: Bisexuals
	Bisexual people feeling misunderstood & disrespected by mental health providers	Systems Failure; OPHA: Bisexuals
	Feelings that bisexuals not well served by LGBT health and wellness services	OPHA: Bisexuals
	Positive experiences include: inclusive intake forms, inclusive language, bi-positive mental health providers, no heterosexist assumptions from health care providers	OPHA: Bisexuals
	Lesbians feeling must research their own health problems	Breaking Barriers
	Gender Identity Clinics not equipped to support sex workers & homeless	Trans Health Project
	Transgender people often must educate doctors about hormone treatment or medical issues	Systems Failure
	Lack of services & supports within Gender Identity Clinics, shame-based environments	Trans Health Project
	Traumatic tests at gender identity clinics	Trans Health Project
Disclosure to community and healthcare professionals	Disclosure to community:	
	Older individuals often do not disclose trans status	Trans Health Project
	Older trans people experience anxiety about coming out at work	Trans Health Project
	Choosing to disclose to caregivers (one's own or caregiver of immediate family) b/c:	
	Patient wants more appropriate care	Breaking Barriers; OPHA: Bisexuals
	Has concerns relating to personal relationship(s)	Breaking Barriers
	HIV antibody testing/info	Breaking Barriers
	Choosing not to disclose to caregivers (one's own or caregiver of immediate family) b/c:	
	Internalized homophobia	Breaking Barriers
	Professional's manner & language	Breaking Barriers; OPHA: Bisexuals
	Fear of confidentiality breach	Breaking Barriers; OPHA: Bisexuals
	Fear of reduced level of care	Breaking Barriers; OPHA: Bisexuals
	Fear of being judged, categorized or stereotyped	Systems Failure; Breaking Barriers; OPHA: Bisexuals
	Feeling it is irrelevant	OPHA: Bisexuals

Issues regarding Health and Access to Care		References
Physical & Mental Health	Low Self Esteem	OPHA: Bisexuals; Systems Failure
	High stress	Systems Failure, Breaking Barriers
	Isolation	OPHA: Bisexuals, Breaking Barriers
	Loneliness	OPHA: Bisexuals
	Trans seniors concerned of having higher risk of contracting osteoporosis, breast/cervical/vaginal/prostate cancer	Trans Health Project
Support System	Positive Supports:	
	Families of origin supportive of same-sex relationship	Systems Failure
	Lack of Supports:	
	Wavering support from family members	OPHA: Bisexuals; Trans Health Project
	Lack of support at work	OPHA: Bisexuals
	Difficulty finding supportive partners (particularly bi-women with lesbians)	OPHA: Bisexuals
	Mainstream youth services exclusive of bisexuals	OPHA: Bisexuals
	Difficulty escaping stereotypes about sexuality from service providers and romantic partners	OPHA: Bisexuals
	Feelings of not belonging in gay or straight world & lack of bisexual community*	OPHA: Bisexuals
	People of colour, trans people have difficulty feeling included in LGBT services & communities	OPHA: Bisexuals
	Various mainstream support services dealing with range of issues (homelessness, substance abuse) exclusive of trans people	Systems Failure
Use of Health Care	Avoidance of health care & social services	Systems Failure; Breaking Barriers; OPHA: Bisexuals
	Distrust of health care	Breaking Barriers
	Alternative medicine increasing in use, particularly by lesbians	Breaking Barriers; OPHA: Bisexuals
	Existing gender identity programs are heavily criticized and avoided	Trans Health Project
	Fear of trans-phobic reactions or fear of being placed in "wrongly-gendered" section in health & long-term care facilities	Trans Health Project

Issues regarding Health and Access to Care		References
Systemic Issues/ Lack of Recognition	No room to report same-sex partner on intake forms	Breaking Barriers, Sum Quod Sum
	Employers not recognizing same-sex partners as eligible for benefits	Systems Failure, Sum Quod Sum
	Terms & labels which patients use to self-identify not respected as being valid by some health professionals & society	Trans Health Project; OPHA: Bisexuals
	Feelings that medical establishment not taking responsibility for education on gay/lesbian health issues	Breaking Barriers
	Refusal of same-sex partner visitation in health care facilities	Breaking Barriers
	Policies re: trans people accessing hormone treatment considered unnecessary & stressful	Systems Failure
	Older trans people especially vulnerable to unemployment	Trans Health Project
	OHIP and other health insurance plans do not cover hormone-replacement therapy, sex reassignment surgery or electrolysis for trans people	Trans Health Project
	Feelings that policies at Gender Identity Clinics are problematic & too rigid	Trans Health Project
Lack of Information	Sexual health information for youth	Breaking Barriers
	Lack of info on STDs/safer sex for bisexuals	OPHA: Bisexuals
	Lack of research on bi issues	OPHA: Bisexuals
Violence	Experiences of homophobic violence or fear of violence	Breaking Barriers, Sum Quod Sum; Systems Failure
Education	Post-secondary curriculum for health & social service students not inclusive of gay/lesbian issues & not gay/lesbian-positive	Systems Failure
	Gay/lesbian-focused curriculum in post-secondary schools established only by individual request (not mandated)	Systems Failure
	Lack of commitment from professors to change curriculum	Systems Failure
Housing	(Majority of/Many) seniors organizations do not offer education re: gay/lesbian issues for staff or volunteers	Sum Quod Sum
	Feelings that being gay/lesbian a barrier to entering existing seniors' housing	Sum Quod Sum
	Trans people have concerns regarding privacy and dignity in seniors' homes & palliative care facilities	Trans Health Project

NOTES:

*Once sexual orientation was disclosed, participants experienced positive, negative or indifferent reactions from health care providers (Breaking Barriers; OPHA: Bisexuals; Sum Quod Sum)

**Those who do have bisexual community found it to be validating, empowering and affirming

TABLE 4

Recommendations		References
Improving services & accessibility of services	Doctors provide gay/lesbian safer sex info & resources	Breaking Barriers
	Health care professionals provide a more holistic form of health care: consider	Breaking Barriers; Trans
	relationships & stress in assessing health	Health Project
	Specialized health care and social services aimed at LGBT communities – eg.	Breaking Barriers; OPHA:
	Coming out groups, counseling, info lines, centralized gay/lesbian health clinic	Bisexual; Systems Failure
	LGBT programs and groups need to expand to welcome its diverse members	OPHA: Bisexual; Systems Failure; Trans Health Project
	Comprehensive health and community centre for trans people, including partnerships with other organizations	Trans Health Project
Support & Resources	Create a directory of gay/lesbian/bi-positive caregivers	Breaking Barriers; OPHA: Bisexual
	More formalized referral network, (particularly for youth, newly "out" people, and newcomers to the city)	Breaking Barriers; Systems Failure
	Establish a gay/lesbian-only or gay/lesbian-friendly multi-service seniors' centre	Sum Quod Sum
	Mentoring, help line, education & support for youth, including bisexual and trans Youth	OPHA: Bisexual; Trans Health Project; Systems Failure
	Development of bi spaces and community, coming out & support groups for Bisexuals	OPHA: Bisexual
	Programs & resources for partners of bisexuals, trans people	OPHA: Bisexual; Trans Health Project
	Print & electronic resources providing accessible trans health info for health care providers, families, general public	Trans Health Project
	Skills training, employment resources for trans people	Trans Health Project
Research Gaps/ Identified Research Questions	Increase research on lesbian/gay health issues – eg. Lesbians & Pap smears, lesbians & AIDS	Breaking Barriers
	Research violence in order to identify strategies for education & prevention	Systems Failure
	More research on intersections of oppression	Systems Failure
	Research needs & demographics of older LGBT	Systems Failure
	Research existing support networks (formal & informal) to determine gaps in support/care structures for seniors	Sum Quod Sum
	Research relationship between degree of "outness" and access to current seniors' services & centres	Sum Quod Sum

Recommendations		References
Research Gaps	Research bisexuality & health	OPHA: Bisexual
	Research to survey health care needs of trans people – including diverse subgroups	Trans Health Project
	Research addictions within trans communities	Systems Failure
	Research to refine genital reconstructive surgery	Trans Health Project
Systemic Changes	Intake forms allowing people to identify as GLB and/or have same-sex partners	Systems Failure
	Involve service users in planning of programs, health care delivery and research – eg. Older people in planning seniors' services, trans people in client-driven health centers	Sum Quod Sum; Trans Health Project
	Improved same-sex spousal benefits	Systems Failure
	OHIP cover wider range of mental health professionals	Systems Failure
	Province-wide campaign against homophobia & heterosexism within health-care services, housing, employment	Systems Failure
	Amend laws to remove barriers for LGBT to adopt	Systems Failure
	All policies and guidelines should have enforcement mechanisms to ensure appropriate care for sexual minorities	Systems Failure
	Taking steps to ensure seniors organizations comply with Human Rights legislation	Sum Quod Sum
	Target trans people for volunteer and paid positions within public health units	Trans Health Project
	Funding for trans-positive shelters & longer-term transitional housing for trans people at risk	Trans Health Project
	Improved access to sex reassignment surgery in Canada	Trans Health Project
	Provide safe & informed access to hormones for trans people	Systems Failure; Trans Health Project
	OHIP cover costs for Sex Reassignment Surgery	Systems Failure; Trans Health Project
	Trans-specific codification of health insurance & hospital cards to identify pre-op & post-op status and facilitate "gender appropriate care"*	Trans Health Project
Education	Education for Community Members:	
	More inclusive sex education for youth (particularly outside institutions). Should address homophobia, bisexuality, trans issues & HIV risks	Breaking Barriers; OPHA: Bisexuals
	More educational & resource materials on HIV/AIDS in elementary & secondary Schools	Systems Failure
	Gender identity education in public schools to raise awareness around gender Variations	Trans Health Project
	Sexual health info specific to bisexuals	OPHA: Bisexuals
	Info on sexual performance & orgasmic ability for post-op transsexuals	Trans Health Project
	Government must develop bias-free educational materials on LGBT issues for youth	Systems Failure
	Education and outreach for bi people including consciousness-raising, benefits of disclosing to health professional	OPHA: Bisexuals
	Increased bi visibility, education for gay/lesbian community	OPHA: Bisexuals

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* Participants had mixed feelings regarding this particular recommendation

Recommendations		References
	Education for Service Providers:	
	More inclusive post-secondary curriculum for health & social service students including the intersections of oppression for LGBT	Systems Failure; OPHA: Bisexuals; Trans Health Project
	Doctors should increase knowledge of LGBT health needs, current service inequities, diversity of gay/lesbian experiences & diversity in degree of "outness"	Breaking Barriers; Systems Failure
	Include training for health care providers on diversity within LGBT identities	OPHA: Bisexuals; Systems Failure
	Training for health & social service professionals to gain knowledge, understanding	OPHA: Bisexuals; Sum Quod Sum; Systems Failure; Trans Health Project
	Sensitivity training for health & social service professionals, incl. Training on intersection of oppression & diversity of sexual identities	OPHA: Bisexuals; Systems Failure; Trans Health Project
Caregiver Issues	Increase comfort level of service users by caregivers using inclusive language, offering gay-positive literature, and avoiding heterosexist assumptions	Breaking Barriers; Systems Failure; OPHA: Bisexual
	Increased responsibility from health professionals towards fighting homophobia	Breaking Barriers; OPHA: Bisexual
	Caregivers must validate the labels which one uses to self-identify	OPHA: Bisexual; Trans Health Project
Housing	Gay/Lesbian only or gay/lesbian-friendly subsidized seniors' housing be established	Sum Quod Sum
	Assisted housing for people in transition, sex workers & drug users	Trans Health Project

APPENDIX C

RECOMMENDATIONS:

(1) Extant evidence on the health concerns of LGBTTTIQ populations must be fully recognized and integrated by the bodies that undertake the next steps of indicator development and strategic planning.

(2) Data collection in standardized national instruments (e.g. the National Population Health Survey, the Canadian Community Health Survey, the National Longitudinal Survey of Children and Youth, the Health Services Access Survey, the Census, and others) must include sexual orientation and gender identity. Moreover, reporting must disaggregate data by sexual orientation, gender identity, race/ethnicity, socioeconomic status, age, (dis)ability, and geographic region (where possible).

(3) Extant federal policies on gender-based, diversity analysis must be fully implemented and rigorously applied.

(4) The federal government should provide leadership by establishing an LGBTTTIQ Health Directorate (within Health Canada or the Public Health Agency of Canada). This directorate would be responsible for the development and implementation of an LGBTTTIQ Health Strategy.

(5) Funding for LGBTTTIQ-specific research must be coordinated and increased.