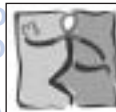


FRAMING GAY MEN'S HEALTH IN A POPULATION HEALTH DISCOURSE

A discussion paper

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Introduction

1.1 Objectives of the Discussion Paper

1.1.1 Statement of objective

This exploratory document seeks:

- to map out the emergent area of gay men's health, primarily within: social science literature; community-based, public and professional association reports; and, when seen relevant, medical literature and other types of documents. The review privileges Canadian sources and community experiences, both in English and French;
- to critically explore the relation and relevance of a Population Health approach to the area of gay men's health, particularly with reference to the Canadian context;
- to outline various "determinants of health" as they relate specifically to gay men, particularly in Canada, with an eye on both what is present in the reviewed literature and what is not;
- to serve as a springboard toward identifying and exploring implications for re-framing HIV-transmission prevention strategies with gay men in Canada.
- As an exploratory discussion paper written at a moment of significant change – and perhaps of transformation – in the fields of HIV prevention and gay men's health, this paper seeks a wide-angle view of an emerging and shifting landscape. The paper also aims to identify crests of difficult questions or dilemmas arising from that terrain.

1.1.2 How the objective will be achieved

The discussion paper's context is drawn, followed by an outline of several main issues emerging from the reviewed literature regarding the shift to gay men's health, including its emerging characterizations. This is followed by a critical exploration of a Population Health approach as it relates to gay men's health. Determinants of health are outlined as they may relate to gay men, according to what the reviewed literature both says and omits to say. Implications of the preceding discussion for re-framing strategies to prevent HIV transmission among gay men in Canada are foregrounded in anticipation of their exploration in an upcoming document. Bibliographic references, organized by author and by type of document, complete this paper. The analysis of two recent Canadian focus groups, both held in the Spring of 2000, are referred to, to complement the document's pronounced literature review focus. Each of these focus groups, one conducted in French, one in English, brought together health professionals and staff to discuss gay men's health.¹

¹ Professionals and staff from across Canada, and from across Québec, representing different regions, as well as professional and community affiliations, met together to discuss gay men's health and wellness. Broad issues related to health, wellness, emerging trends, definitions of health and wellness, accessibility to services, adaptability of services, policy, and HIV-prevention issues were discussed. These discussions were then treated and analyzed; in this exploratory paper they are, at times, referred to or directly cited (see Annexes I and II).

1.2 Context of the Discussion Paper

1.2.1 Wider strategic motivation or goal framing the discussion paper

This paper is integral to a forward-looking process within the HIV/AIDS Division of Health Canada that aims to revitalize HIV-transmission prevention for gay men in Canada by re-positioning it within the context of their broader health issues – gay men’s health. Such a revitalization takes its lead from what has been emerging on the ground among front-line, community-based efforts in the area.

Clearly situated within the above strategic goal, this discussion paper of the HIV/AIDS Division is guided by the organizing principle of Population Health, the present formal policy framework of Health Canada, and at the same time critically investigative of its possibilities and limits for gay men’s health. A recent example of the practical context speaking to the necessity of a critical investigation of Population Health for gay men’s health is Health Canada’s voluminous 1999 *Toward a healthy future: Second report on the health of Canadians* (Health Canada, 1999b). This comprehensive Report, relying on a Population Health framework, appears to have just one passing reference to gay men (at the end of a discussion of suicide); otherwise, gay men, lesbians, bisexuals, or transgendered people, whether as individuals, communities, populations, or population groups, are not considered. This is despite the Report’s stated aims of Population Health that include “to reduce inequities in the underlying conditions that put some Canadians at a disadvantage for attaining and maintaining optimal health” (Health Canada, 1999b). Are gay men, for example, not taken into account in the Report because, statistically-speaking, as a population group it is too small for consideration within a Population Health framework? Or, does the difficulty in obtaining sure statistics about the numbers of gay men dissuade even conjecturing about population size? Are sexual orientation and gay men not taken into account because of homophobia and heterosexism? Are gay men misperceived as enjoying equity with regard to life conditions and to health, and hence are not considered in the reduction of inequalities in life conditions and health of specific population groups? Rather than seeking conclusive answers to these particular questions raised by a single example, this discussion paper seeks to provide a background with which to explore such issues and to widen the spaces for their critical investigation. An exploratory, emergent paper, it is meant to raise and stimulate further discussion and analysis by those of various sectors and fields concerned with the health of gay men, in all their diversity, across Canada.

1.2.2 Characteristics of the recent shift from HIV prevention to gay men’s health

The strategic goal of this exploratory discussion paper – revitalizing HIV-transmission prevention for gay men in Canada by repositioning it within gay men’s health – is situated within and responsive to a broader emerging discursive and strategic shift regarding HIV prevention among gay men.

The reviewed literature points to an emerging, yet identifiable, paradigm and practice shift occurring in the Canadian, American, Australian, and perhaps U.K. fields of HIV prevention among gay and bisexual men, and men who have sex with men (Aggleton, 2000; Canadian Public Health Association, 1998; Clarke, 1999; Séro Zéro, 2000c; Davey et al., 1999; Gouvernement du Québec, 1999; Jalbert, 1999; Rofes, 1999b; Rofes, 1998; Taghavi, 1999; Trussler, Perchal, & Barker, 2000; Ryan, French-speaking Focus Group, 2000; Ryan, English-speaking Focus Group, 2000; Ryan, 2000; Dumas et al, 2000.). This trend is

complex, non-linear and at times contradictory. The shift, as context-related with respect to time and place, is as such not simplistically making its way from something automatically “bad” to something “good.” Such an emerging shift appears to include the following characteristics, though they are not applicable to all people, in all times and places.

Chart for discussion purposes

Characteristics of an emerging shift occurring in fields of HIV prevention among gay and bisexual men, and msm.

From	To
Crisis-oriented and reactive	Strategic and pro-active
HIV & AIDS overriding specific health concerns	Attention to broader health as context
Focus on prevention of STDs & on sexual health	Focus on holistic health & well-being
Community action, organizing & mobilizing	Community development, as a slower, multi-sectoral, planned process
Harm elimination / Safer-sex Knowledge-Attitudes-Behavior (KAB) model	Harm reduction that expands to psycho-social & social-environmental factors
Medical model defining research Interdisciplinary approach explored	Research & intervention focus on behavior Research focus also on culture and mediating discourses
Conventional research methodologies	Participatory research & collaborative inquiry
Behavior (eg. msm) as frame	Identity/community (eg. gay) as frame
Either community-based, government, or private sector	Partnerships & collaborative efforts
Gay men acting, yet positioned as victims	Positioning gay men as resilient actors
Starting from needs, deficits, emergencies	Starting from strengths & assurance
Leadership mourning co-leaders, & staying on	Seeking to involve younger leadership
Dominant-defined gay identity & community	Gay identity politics as more inclusive

In Canada, this emerging shift is both visible and viable in the discourses and actions of community-based organizations and coalitions such as AIDS Vancouver (Perchal, Trussler, Barker, & Showler, 1999) and Séro Zéro in Montreal (Séro Zéro, 2000c; Dumas et al, 2000), with perspectives unique to each.

The reviewed literature indicates that the emerging shift from HIV prevention to gay men's health is influenced by a convergence of factors within gay and msm populations, or factors directly impacting them. These factors appear to include:

- the success and sophistication of gay community-based activism and effectiveness in organizing in the face of HIV-transmission and AIDS;
- the research or analyses of both failed and successful strategies and practices in HIV-transmission prevention programs;

- the prolonged lives, greater hope for the future, and more consistent able-ness of many gay men living with HIV through the use of more effective pharmaceutical drugs;
- a “post-AIDS” atmosphere, reflecting a relative equilibrium within gay communities regarding the everyday management of HIV and AIDS, after a period of over 15 years;
- the desire by community-based organizations to remain relevant and mobilizing of people’s imagination and involvement within a “post-AIDS” atmosphere;
- the desire to renew active intervention within dominant heterosexist discourses historically positioning gay men as sick or unhealthy;
- the desire to unify and create greater coherence to community-based work carried out with both HIV-men and men living with HIV;
- the perceptions and involvement of younger generations of gay men and queer youth.

The move to gay men’s health is often perceived within the reviewed literature as a shift back to pre-existing initiatives on broader health issues by gay community organizations and para-public service agencies. For example, in Montreal during the 1970’s, the Ville Marie Social Services Centre, serving primarily English-speaking communities, had both denounced discriminatory social attitudes toward gays and promoted specialized non-discriminatory physical and psychological care for gay men. The Gay Social Service Project provided re-designed services to primarily English-speaking gay men. In the beginning of the 1980’s, both budget cuts to social programs by the Québec government and the new reality of AIDS redirected priorities to addressing care for people living with AIDS and to safe sex campaigns (Séro Zéro, 2000c). The Village Clinic in Winnipeg, as well as the Gay Men’s Health Association in Halifax, are important community-based examples of gay men’s health organizations that likewise transformed their focus during the early 1980’s (Ryan, personal communication, 2000). Historically, in both the U.S. and in Canada, gay men’s health initiatives had generally been nipped in the bud and redirected in focus to respond to the onset of the AIDS crisis. While some initiatives, including informal efforts, may have continued to maintain their wider health focus between the early-80’s to mid-90’s, the present shift to gay men’s health is often positioned as a renewal.

Accompanying the enthusiasm and excitement surrounding a renewed shift to gay men’s health, the emerging paradigm is also at times perceived within the reviewed literature with ambivalence, particularly as a new “replacement” framework for HIV prevention. The emerging shift is seen as riddled with risks and concerns, and hence is accompanied by significant hesitations.

Some hesitations are stoked by a sense of urgency. For, several of the factors seen as causing the shift to gay men’s health (such as the availability of highly active anti-retroviral therapies) also may be seen as leading to an increased level of unprotected sex, and possibly of HIV transmission, among Canadian gay and bisexual men, as well as men who have sex with men (Strathdee, Martindale, Cornelisse, Miller et al., 2000; Major et al., 1999). However, such a sense of urgency may not be founded on a “relapse”, nor on the expected reasons (Trussler et al., 2000; Samis & Whyte, 1998).

As well, some see it as still “an untested hypothesis that more generic interventions that seek to strengthen gay men’s partnerships, relationships and sense of self will have knock on effects for sexual and drug-related risk reduction.” (Aggleton, 2000)

In addition, financial and funding implications of such an emerging shift for organizations are posed as a question. For example, funding for community-based projects with a focus on gay men’s health, rather than directly on HIV prevention, have not been necessarily been easy to obtain, though this appears to be changing (Séro Zéro, 2000c). As well, some concern has been felt in the U.S. that a shift to gay men’s health may contribute to redirecting financial resources away from much-needed HIV-related programs among gay men of colour (Gay Men's Health Summit 2000, 2000).

Absent within the reviewed literature is the possibility that, in addition, hesitation may also be due to the difficult challenge of mobilizing community members in a new and different way. For example, mobilizing people’s involvement and action to react to crises, especially those with a common, identifiable enemy (such as HIV or AIDS), is familiar to experienced organizational leaders and activists. Such a mode of organizing has conventionally been seen as political, a significant way of inscribing identification with one’s community, and as “doing something important”. An approach geared to enhancing health, or to building individual and community organizational capacity, particularly requiring non-conventional partnerships, requires different skills and dispositions; such an approach may carry a heightened perceived risk of mainstreaming.

The emerging shift from a frame of HIV prevention among men who have sex with men to the (re)frame of gay men’s health appears to have already happened on the front line of HIV prevention within many gay communities of Canada, though with varying degrees, perspectives, and types of implementation, dependent on context (for example: rural/suburban/urban; region of Canada; southern/northern; and so on). This emerging shift is ripe for a critical exploration of perceived risks and benefits, limits and possibilities.

1.2.3 Situating the emerging shift from HIV prevention to gay men's health within the context of other related shifts or trends in Canada

Noticeably absent in the reviewed literature on the emerging paradigm shift from HIV prevention to gay men’s health is how it may be situated within or part of a wider context of discursive and other practical paradigm shifts, within related areas, in Canada. Such a wider context includes paradigm shifts within the overlapping areas of:

- health institution and social service agency management;
- First Nations, Aboriginal and Inuit development strategies, and in particular those drawing on traditional approaches to health;
- international development strategies, particularly those via the Canadian International Development Agency - CIDA;
- the re-defined leadership roles, policies and practices of private family foundations across Canada that have a community-oriented mission, of United Ways/Centraide, and of other large funding intermediaries for community organizations;

- the strong influence in the past decade of more recent dominant American community development models such as John McKnight's (asset-based, capacity-building model from Chicago, Illinois) on Canadian and provincial government discourses and agencies (e.g. regional bureaus of Human Resources and Development Canada - HRDC, or Health Canada), on United Ways/Centraide, and on private family foundations;
- renewed theories of citizenship and of citizen engagement; and,
- neo-liberal and conservative Canadian and provincial policies of drastically-reduced social safety nets and social program funding, of partnership in social program funding as an ever-present formula for reducing government financial involvement, as well as of privatization.

Such shifts have often generated ambivalence and hesitation among many stakeholders, particularly those of community-based organizations and coalitions. Actors within the latter, in particular, have often advanced their critical analyses of the associated risks and benefits of such shifts. These actors include those in HIV prevention organizations, as well as gay and queer community organizations.

Chart for discussion purposes

Characteristics of a paradigm shift occurring within wider Canadian fields of health and social service agency management, roles and policies of private family foundations and intermediary fundraising bodies for community organizations such as United Ways, etc.

From	To
Crisis-oriented and reactive	Strategic planning and pro-active
Service delivery mode by agencies and institutions	Community development integrated
Professionals, staff, institutional infrastructures	Reduced infrastructures with a greater reliance on volunteers
Dependency on highly-paid professional experts	Interdependence with community-based expertise
Defining from individual needs & what a community lacks	Mapping assets, and organizational & community capacity-building
Citizen as a consumer of services & policies	Citizen engagement as key to capacity-building
Community organizations on the defensive	Community organizations often recognized as partner, yet with incommensurate funding
Either community-based, one level of gov't., or business	Multi-sectoral & vertical partnerships
Health as lack, prevention, or treatment of disease	Health as wellness & holistic
Mushrooming community initiatives with a possibility of duplication	Organizational resource-sharing & complementarity
Organizational program and project implementation	Organization, program, and project monitoring & evaluation
Leadership moving into mid-40's & 50's	Hesitant intergenerational efforts
Dominant-defined notions of community	Greater inclusion, especially via organizational collaboration

Paradigm shifts occurring within the wider Canadian context include the following characteristics. Again, any such list inevitably reduces and over-generalizes. The characteristics noted are not applicable to everyone, nor to all places and are offered in the spirit of sparking further critical reflection.

It is thus a question to what extent, or how exactly, the shift to gay men's health may be part a larger transforming landscape. If there is a relevant positive relation, how can gay men and others explicitly bring to bear critical learnings and strategies gained from experience within to a shift to gay men's health?

Parameters, main issues, and characterizations of gay men's health

2.1 Parameters of "gay men's" health for this discussion paper

2.1.1 Parameters of "gay men's" health

For the purpose of this discussion paper, gay men's health is limited to the health of those people who self-identify as gay, are publicly out to some degree, and experience some meaningful relation to "gay community or communities", whether such a relation is complete, ambivalent or even alienated. Men, often youth or younger men, who identify as queer and have some meaningful relation to "gay community or communities" are included within the parameters. Two-spirit males are included given there is some type of identification on their part with the gay community or gay communities (again, complete, ambivalent or alienated). The health of gay male adolescents is integral to the literature review, especially as their health bears significantly on the health of gay men. Gay youth, understood as younger men of about 14 to 19 years of age, and young gay male adults who are 20 to 29 years of age, are fully included in this discussion paper on gay men's health, as are gay seniors and elderly gay men.

2.1.2 Explanation of the parameters, and their justification

The parameters of gay men's health as outlined above for this discussion paper are explained and justified by two sets of reference: (a) the emerging literature on gay men's health, and (b) a Population Health approach.

First, with respect to the emerging literature on gay men's health, it is argued that gay men, and in particular gay men's health work, have been positioned within the discursive practices of AIDS in a uniquely different way than other groups. The discursive practices of AIDS are seen to have abruptly nipped in the bud and held a stranglehold on gay men's health organizing, whereas this has not generally been the case, for example, with lesbian or transgendered health initiatives and organizing. Emerging from this metaphoric and practical stranglehold – by revitalizing gay men's health organizing – is seen as requiring a "stepping back" as gay men to review, regroup and recreate, prior to highly-anticipated efforts of wider alliance work and solidarity with respect to health issues (Rofes, 1999b). Thus, gay men's health is different from gay, bisexual, lesbian and transgender health (or queer health) as a unity. Gay men's health does not include reference to men who have sex with men, *per se*, nor does it include bisexual-identified men *per se*, and transgendered males or transsexual men *per se* – unless they may identify with the gay community or communities in some way.

As well, the possibility is raised that gay men's health concerns and issues may have much more in common with men's health, in general, than with women's health, including the health of lesbians (Ryan, English-speaking Focus Group, 2000). Exploring how gay men's health is similar to and different from men's health in general, may benefit from a period of gay men (as those living gay experiences and drawing on a reservoir of gay history and analyses) focusing specifically on gay men's health (Clarke, 1999).

In addition, relative to HIV prevention research, one of five conclusions of an in-depth, qualitative research study by AIDS Vancouver Island involving 84 participants of British Columbia, is that "The "MSM" category is not a useful one. Heterosexual men who have sex with men have qualitatively different experiences from gay and bisexual men. This has important implications for safer sex education efforts" (Samis & Whyte, 1998).

Second, with respect to a Population Health approach, discrete populations are recognized with respect to identifiable (and self-identified) communities, whether such communities are geographically-based, politically-based (as in a municipality or country), or joined by common characteristics or interests (and hence possibly scattered over a geographic or political territory). A Population Health approach is more concerned with whole communities or populations, not just individuals or “risk groups” (Institute of Health Promotion Research, 1999). In the reviewed literature on a Population Health approach, communities or populations are not defined solely with reference to behavior. Thus, for example, for the purpose of this discussion paper, men who have sex with men are not included unless they have some sense of identification, or sense of common interest, with the gay community or gay communities.

2.1.3 Gray zones, risks and dilemmas associated with the chosen parameters

The choice of a focus on gay men's health, instead of, for example, queer health or gay, lesbian, bisexual, Two-spirit and transgendered health, raises significant risks, dilemmas, and questions. These are embedded in a choice which draws its major justification from the unique situation in which “AIDS became a totalizing metaphor for gay men's health” (The SafeGuards Project, quoted by Rofes, 1998). This situation extends well beyond the symbolic realm; the magnitude of death, loss and mourning accompanying HIV and AIDS within gay male communities over the past eighteen years or so has been immense, exhausting and debilitating. Compounding the situation of tremendous loss and mourning, homophobia and heterosexism contribute to the accompanying grieving process as often being hidden; this process is still minimally researched. At present, in some Canadian cities up to one in four to one in five gay men may be living with HIV. The unique and devastating psychosocial stressors of living with HIV are widely acknowledged in the literature (Ryan, Hamel, & Cho, 1998); as well, the accompanying difficult economic situation and stressors associated with living with HIV are also noted (Canadian AIDS Society, 1996). At the same time, HIV is seen as being generally experienced differently within the gay community during the past four years, both by those who are living with HIV and those who are HIV negative. There is a sense that the AIDS crisis is over within gay communities of countries of privilege (such as Canada, Australia, and the U.S.), and post-AIDS identities and cultures are emerging, particularly though by no means exclusively, among younger gay men and queer youth (Rofes, 1998). This change and possible transformation is unique to gay communities and holds as yet much unexplored implications for gay men's health and well-being. This specific metaphorical and practical context is compelling as a rationale for exploring the terrain of gay men's health before engaging in much-anticipated wider alliance work on lesbian, gay, bisexual and transgendered health (Rofes, 1999b).

It may be raised as a question, however, why those among the most privileged (gay men) within an alliance (of gay men, lesbians, bisexual men and women, and transgendered people) move to “caucus,” temporarily withdrawing to regroup, gain nourishment with one another and seek renewed strength? Such a question doesn't seem to surface within the emerging gay men's health literature; it is tempered by the widely-acknowledged devastating impact of HIV and AIDS on gay men and their communities (Rofes, 1996; Ryan et al., 1998). As well, it is generally perceived that both alliance maintenance and alliance building work will be enhanced by greater self-understanding and self-positioning by gay men.

The gray zones associated with “identification (complete, ambivalent or alienated) with the gay community or communities” in order to be included within the parameters of gay men's health may hang as a

heavy cloud. In addressing this, it may be useful to name a pluralistic, fluid and postmodern approach to “belonging” and identification. People may identify with many communities simultaneously, sliding in, out and between them, and investing each with different and changing ambivalence or meaning. For example, men who identify as queer, or men who identify as bisexual, may simultaneously identify and not identify (depending on the context) with the gay community of their particular region (or with “gay community” as a larger construct). The drawn parameters of gay men’s health unfortunately seem to force an answer to the pointed, static question: do you identify (with “us”) or not? Acknowledging a contextual approach to processes of identification, within the area of gay men’s health, may help in productively living with (rather than against) such gray zones, as well as critically exploring within and learning from them.

As well, “identification (complete, ambivalent or alienated) with the gay community or communities” in order to be included within the parameters of gay men’s health may possibly be a criteria that is out of synch with how gay men experience their identity. The existence of “gay community”, or at least of “coherent gay community,” is typically a much debated, yet well-nuanced, topic of discussion among Canadian gay men (Ryan, English-speaking Focus Group, 2000; Trussler et al., 2000). However, much more relevant here is that gay identity (in distinction from men who have sex with men) may well be articulated by Canadian gay men as having to do with their emotional and/or romantic relation to other men, instead of their identification with a gay community, whether such a community is geographically-based or metaphoric (Adam, Schellenberg, & Sears, 2000).

In addition, the criteria of identification with the gay community or communities may be predominantly urban in focus, to the possible exclusion of rural Canadian gay men. Given the likelihood of greater obstacles to coming out in more isolated, sparsely-populated regions, local or regional gay communities may not be visibly present or conventionally organized; however, this does not reduce the actual presence of gay men.

Practical risks of a focus on gay men’s health (rather than gay, lesbian, bisexual and Two-spirit health, or queer health) may be a resulting surge of energy, research and financial resources that bypass the health issues of lesbians, bisexual women, and many transgendered people (if they do not receive simultaneous and commensurate attention). Such a situation risks weakening alliance-building efforts and gains, at least in the short term. As well, learning risks being missed by gay men from the significant efforts of lesbians and bisexual women with regard to health. This could prove to the detriment of gay men’s health, as well as to possibly re-inscribing the relative invisibility of women’s contributions to the wider field. Given the closer ties of lesbian and bisexual women to feminist movements, analyses of gay men’s health also risk not benefiting from what is often more politicized and less atomistic analyses integral to those movements.

With the present parameters set to gay men’s health, there also exists a risk of excluding many people of colour who may not identify as gay, or identify with the gay community, because of historically narrow identity politics within dominant or white-identified gay communities. As well, concern with not becoming (further) alienated within the relative safety of their racialized or ethnically-based communities, or with wanting to prevent the alienation of their families within their communities, may lead to self-identifying as bisexual (Sears, 1995), or simply as heterosexual (including msm). It is interesting to note that within the ground-breaking 1999 Gay Men’s Health Summit in Colorado the sole focus was

on gay men, yet the Pre-Summit Institute ('Health Challenges Facing Gay Men of Color'), despite its formal title, held an explicit focus on both gay and bisexual men (Rofes, 1999a).

Finally, it is worthy to note that justifying the parameters of gay men's health by the exigencies of a Population Health approach (for example, that discrete populations are not defined by behaviors alone) does not reflect an inevitable choice. Rather, such a choice is ultimately political and thus malleable. "Requirements" of a Population Health approach hold out the possibility of being creatively bent to the requirements of gay men's health.

2.2 Main issues regarding a shift to gay men's health

What follows is a synthesized list of emerging motivating factors, perceived benefits and risks, as well as several issues perceived as absent in the reviewed literature on gay men's health. Rather than definitive, this list is presented as a springboard for reflection and discussion.

2.2.1 Factors motivating a rising preoccupation with gay men's health

Motivating factors of greater preoccupation with gay men's health include:

- gay men's health, in a very pragmatic sense, is coming to be seen as a more effective strategy, and as an inclusive replacement, for HIV prevention, given the rapidly-changing contexts of gay men's lives and a greater appreciation of younger gay men's lives;
- gay men's health is seen as reflecting an ever-present – yet none-the-less significantly changed – general experiential relationship of gay men with HIV;
- gay men's health is motivated by a strong will to put behind the master lens of HIV and AIDS for examining and addressing gay men's lives and well-being, on the one hand, and to emerge from the loss and grief associated with innumerable deaths and imminent deaths during the past 20 years, on the other;
- gay men's health is seen as a life-affirming and forward-looking strategy of gay communities that are experiencing cultural and leadership renewal;
- gay men's health can now be afforded more attention than in the past 15 to 20 years because the AIDS crisis which devastated gay communities, and compelled such overwhelming attention by those communities, is now being lived differently, less in crisis mode, and in a certain relationship of equilibrium within the gay male community;
- acknowledging the importance of constructively re-framing the dominant lens of a heterosexist, medical model of health that impacts on gay men by reducing health to the absence of disease and by refusing to take their health issues outside of HIV seriously; this is expressed, in an everyday way, by HIV negative status coming to be equated with being healthy, and living with HIV unreasonably reduced to being unhealthy;
- taking gay men more seriously (and taking themselves more seriously) means taking all of their health issues seriously, not just HIV-related issues (significant that they may be);
- gay men's health holds out the potential to raise the overall health of gay men.

2.2.2 Perceived benefits associated with a shift to gay men's health

Perceived benefits associated with a shift to gay men's health include:

- HIV prevention will have more success, particularly across generations and across cultural backgrounds of gay men, if situated within a paradigm of gay men's health;
- as a "new" discourse, gay men's health can be unhinged from the overdetermined discourse of HIV prevention which (particularly in the U.S. context) can connote restriction, sexual repression, fear and disempowerment for gay men;
- gay men can successfully emerge from the AIDS crisis supported by a strategy that favours optimal well-being, a sense of spiraling-upward energy, sexual emergence, as well as empowerment;
- gay men's health can respond more effectively to gay men living with HIV, a significantly-sized group within gay communities, because the focus is on ensuring quality of life and optimum health, rather than a narrower, conventional mobilizing focus on trying to keep HIV-negative gay men HIV-negative;
- gay men's health can offer gay men greater control over their own health and can significantly raise their health and well-being;
- it can be a strategy to revitalize organizations within gay movements and reconnect them with their community bases;
- it can be a strategy that supports unconventional research methodologies which simultaneously serve educational, community development, action-oriented, and research purposes;
- it can help ensure that a broad spectrum of gay men's health issues are addressed both by gay communities and dominant health institutions, thus raising the health of gay men;
- it holds the possibility of mobilizing new resources and sectors of the gay community and beyond;
- gay men's health favours expanded knowledge and research into areas of gay men's lives and well-being that were occluded by the AIDS crisis in gay communities;
- gay men can now re-connect back to truncated "pre-AIDS crisis" community-based efforts that addressed gay men's health in a wider sense;
- aspects of gay men's health can be addressed without necessarily having to be related to HIV, or justified by their impact on HIV or HIV transmission risk.

2.2.3 Perceived risks associated with the shift to gay men's health

Perceived risks seen with the shift to gay men's health include:

- to some people it's unclear, untested, or a large leap of faith, that situating HIV prevention issues within the context of gay men's health (or replacing the discourse of HIV prevention by that of gay men's health) will actually address HIV transmission issues effectively;

- gay men living with HIV may be left behind, or might be erased from consideration, by a focus on gay men's health rather than directly on HIV issues;
- gay men of colour, perhaps having experienced HIV prevention efforts differently than white gay men, may also experience a shift to gay men's health differently, in a way that is seen to further ignore or leave behind HIV prevention issues among gay men of colour and among communities of colour more generally;
- organizations that have built their identity around HIV prevention or around AIDS may be "left in the dust," especially regarding funding and community support;
- alliances within gay, lesbian, bisexual and transgendered communities and community organizations may be disrupted by a focus by gay men on gay men's health;
- it may further marginalize men who have sex with men in a precarious limbo regarding HIV prevention resources.

2.2.4 Difficult issues absent or rarely raised within the reviewed literature

Provocative issues absent or rarely raised within the reviewed literature include:

- What interests and investments do HIV-prevention professionals and organizations have in re-framing their focus to gay men's health, when ongoing discourses and funding sources may contribute to maintaining a narrowly-defined HIV prevention focus?
- How can gay men's health simultaneously include, even center, HIV prevention and also get "unstuck" from the glue of prevailing discourses which still often equate gay men's health with HIV prevention and HIV issues?
- Would public funding of HIV-prevention organizations and initiatives among gay men or msm be reduced, or drop as a priority, if the focus was shifted from addressing a high risk to public health or from reacting to a crisis?
- How can the lives of gay men living with HIV be centered within gay men's health, including those who are not taking anti-retroviral therapies or who are exploring alternative health paradigms?
- How can gay men's health be taken up as an opportunity to re-politicize issues and debates within gay communities, rather than be reduced to an expression of mainstreaming?
- How can gay men's health contribute to re-defining what is meant by political or "being political," and to generating new skills that support those renewed meanings?
- What can the area of gay men's health learn from lesbian and other women's organizing on, and feminist analyses of, health issues?
- What practical opportunities do front-line workers in the field of HIV prevention have to participate in the definition and critical appropriation of a policy shift that re-situates HIV prevention within gay men's health?

- How can the shift to gay men's health not just "catch up" to transformations within gay men's experiences, cultures and communities, but also meaningfully contribute to and advance those transformations?
- What are implications of the shift to gay men's health for the HIV/AIDS Division of Health Canada policy frameworks and programming that relates directly to gay men and to men who have sex with men?
- What implications does the shift to gay men's health have for (reconfiguring) the relation between the health and HIV prevention sectors within Health Canada?
- What is the relation between the shift to gay men's health and the federal health policy shift to a Population Health approach?

2.3 Characterizations of gay men's health

This section culls a multiplicity of emerging characterizations of gay men's health found in the reviewed literature, and predominantly of Canadian sources. A seamless, synthesized definition is avoided. What follows is a collage of characterizations that together provide various perspectives or angles on gay men's health.

Gay men's health is often characterized as holistic, in at least two ways that are not always both included or inter-related.

A first meaning of holistic is reference to the physical, mental/emotional, intellectual, and spiritual health needs of an individual gay man (Olivier & Targett, 1993). Holistic health, in this sense, is seen as including "mental, spiritual, sexual, intellectual, social, and emotional well-being" (McInnis & Kong, 1998).

A second meaning of holistic includes the above meaning, yet also takes into account a broader relational picture. Hence it is not only focused on the individual, but rather also on the individual in relation to another person, a group, wider societal conditions, and so on. For example, Aggleton (2000) strives to encompass "...the personal, the interpersonal and the relational dimensions of people's sexuality". He proposes a holistic model of health that has "at its core the physical, mental, social, sexual and sensual dimensions of human experience, and which encircled these with spiritual, environmental and societal dimensions" (Aggleton, 2000).

An example of a characterization of gay men's health that incorporates both meanings of holistic is found in an analysis of a Montreal discussion group with participants of the *Coalition des organismes communautaires du Québec - SIDA (COCQ-SIDA)*: "La santé gaie englobe tout autre chose que des maladies; elle doit être conceptualisée de façon holistique. En effet, la santé gaie doit inclure les aspects médicaux, politiques, légaux, sociaux, culturels, économiques, environnementaux, psychologiques et spirituels des individus concernés" (Jalbert, 1999).

A preliminary analysis by the community organization *Séro Zéro* of focus groups with HIV negative men held during March 2000 within Montreal's "Three Cities" Project gave rise to characterizations of health as:

- *notion d'équilibre*
- *santé mentale*
- *être bien dans sa peau*
- *santé mentale et physique inter-reliées, c'est-à-dire par exemple "si un ne va pas l'autre va flancher si on ne fait rien."* (Séro Zéro, 2000a)

A consensus in many of the above focus groups was that mental health issues, in particular, distinguished gay men's health needs in relation to those of the general population. *Séro Zéro* reported that according to the participants:

- *"La santé mentale et psychologique est la plus importante dimension quand on parle de "santé gaie";*
- *La santé des hommes gais est pas ou peu différente des hommes hétérosexuels sauf pour la santé mentale"* (Séro Zéro, 2000b)

Discussing his reflections on participating in the 1999 Gay Men's Health Summit, in Boulder, Colorado, as a Canadian, Clarke (1999) writes that

...gay men's health is a developing field of expertise and the content of that field can be found along the bio-psycho-social continuum: physical, psychological, spiritual, social, political. This continuum is a useful conceptual framework for locating health-related issues and expanding on traditional views of health. It would be difficult to assert that, as a field of inquiry, gay men's health is quite different from men's health in general. Most men are concerned about bodily functions and their deterioration with age, mental health and its male-centered complications, social comfort, hostility and familiarity. However, gay men's health is developing expertise focused on how the homosexual experience strengthens and weakens men in their personal and social environments. So while gay, bisexual, straight and msm men share a common wellness/illness continuum, the lived homosexual experience requires additional filters leading to an accurate understanding of how that lived experience promotes or prevents health. And gay men, men who live the homosexual experience in an integrated and public way, are shaping that field of expertise by identifying those filters and fine-tuning the inquiry. The bio-psycho-social continuum is then informed by a collective history, a recent and distant memory of the homosexual experience (Clarke, 1999).

Taghavi's (1999) analysis of a focus group related to health issues held in Vancouver with lesbians, gays, bisexuals and transgendered people includes the following:

Many of the stories told and much of the discussions alluded to an underlying theme of self-concept, self-esteem, self-worth, self-efficacy, internal versus external locus of control, learned helplessness and the challenges of growth. Participants used "health" in a much broader sense of "nurturing oneself" (Taghavi, 1999).

An analysis by Ryan (2000) of a focus group held in Toronto in March 2000 with health professionals and workers from across Canada working with gay men, includes the following:

The participants discussed the limitations of an exclusively medical conceptualization of health, in particular that such a model ignores the significance of emotional, psychological, social and spiritual determinants of health. As one participant stated: "I think what we really need to start looking at is health as a quality of life issue. And one that encompasses every dimension of life: sexuality, emotional, physical well being, spiritual roundedness..." (Ryan, English-speaking Focus Group, 2000).

It was also suggested that one of the implications of a medical understanding of health is that gay men's health becomes predominantly equated with HIV/AIDS and other health issues get ignored. One participant stated that some gay men themselves subscribe to the idea of health as the absence of disease by thinking "I don't have HIV so I'm healthy" (Ryan, English-speaking Focus Group, 2000).

The discussion also

...made clear links between definitions of individual health and wellness and definitions of community health and wellness. This discussion pointed to the inseparability of these two concepts. As such, "health and wellness efforts should extend beyond working with individuals to also working with communities" (Ryan, English-speaking Focus Group, 2000).

Tafoya and Wirth (1996) discuss the mental health of Two-spirits within a framework of their mental, spiritual, emotional and physical health. Such a holistic approach reflects Aboriginal traditions, and is perhaps especially coherent with a holistic understanding characterizing Two-spirits: "...if one is a woman, one sees the world as a woman; if one is a man, one sees the world as a man, but to be Two-spirit means one can see in both directions, and therefore understand the world in a more holistic manner" (Tafoya & Wirth, 1996). In the context of Health Promotion work in Canada, Cain (1995) notes the advantage that Aboriginal communities have, from traditional teachings, in relation to gay communities regarding a holistic approach that links health to community concerns.

At times, Canadian reports that specifically address the health issues of gays, lesbians and bisexuals draw on, and center, the World Health Organization's definition of health:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand, to change or cope with the environment. (quoted by Hellquist, 1996)

If the WHO definition holds some attraction, how might it be articulated or appropriated by gay men, to make it "speak to" the conditions and aspirations of their own lives and social movements? That the World Health Organization did not remove homosexuality as a mental illness category until very recently, in the early 1990's (Tafoya & Roeder, 1995), can offer impetus to ensuring that its definition of health is articulated through the lives and concerns of gay men.

An important societal context of the paucity of definitions of gay men's health, especially holistic versions of health that emphasize well-being and optimum health, is that "the lives and needs of gay/homosexually active men outside of sex, and outside of HIV and AIDS, have never really been recognized" (Aggleton, 2000). The strengths, capacities and resilience of gay men, emotionally, psychologically, spiritually and physically have not necessarily been a focus of societal concern. Aggleton (2000) proposes that serious consideration of such strengths serves as a springboard for future work in the area of gay men's health.

Outside of brief characterizations of gay men's health, there exist attempts to address the broader spectrum of health issues of gay men in ways which implicitly define gay men's health. For example, *The Gay Men's Wellness Guide* (Penn, 1997), a voluminous book of the (American) National Lesbian and Gay Health Association, spans physical, emotional, mental, and sexual health and well-being, as well as, to some extent, spiritual well-being.

Population Health: its possibilities and limits for gay men's health

3.1 HIV work and a Population Health approach: how it's been taken up in Canada

3.1.1 From Health Promotion to Population Health as health policies

In the Canadian context, many working in the field of community-based HIV work, and in community health more generally, are well familiar with Health Promotion policy. While a Population Health approach and policy framework was formally adopted six years ago, they seem relatively shrouded by mystery. While Health Promotion policy is well-established internationally, Canada appears to be the only country in the world that has since made a Population Health approach its official policy. As such, Canada's Population Health policy may be seen as an experiment and an international precedent. While Population Health as an approach is being increasingly taken into consideration internationally, Canada is seen to be at the forefront of Population Health research and policy-making (Institute of Health Promotion Research, 1999).

Health Promotion, briefly, is “the process of enabling people to increase control over, and to improve their health,” as defined by the Ottawa Charter (WHO/Europe, 1986), adopted in 1986 at the first International Conference on Health Promotion, held in Canada. Three mechanisms are intrinsic to a Health Promotion framework:

- 1- self-care, or the decisions and actions individuals take in the interest of their own health;
- 2- mutual aid, or the actions people take to help each other cope; and
- 3- healthy environments, or the creation of conditions and surroundings conducive to health. (Health Canada, 1986)

Trussler and Marchand note that the Ottawa Charter outlines a program for Health Promotion:

- Take care of each other.
- Create supportive environments.
- Strengthen community action.
- Develop skills that increases health options.
- Reorient health services to respect the needs of the whole person.
- Put health on the agenda of policy makers at all levels. (Trussler & Marchand, 1997b)

A Health Promotion framework, since the mid-1980's, has contributed to sparking and sustaining HIV community-based action and efforts in Canada (Wong, 1997a; Wong, 1997b; Trussler & Marchand, 1997b). Health Promotion, through its programming and funding support of community-based organizations and projects to address HIV and AIDS issues, may well be a contributing factor to the emerging paradigm shift from HIV prevention to gay men's health in Canada.

The AIDS Community Action Program (ACAP), integral to the Canadian Strategy on HIV/AIDS since 1989, and still the largest national source of funding for community-based HIV work in Canada, appears to be guided to this day primarily by a Health Promotion framework.

The formal policy change to a Population Health framework, through the Canadian federal government adoption in 1994 of *Strategies for population health*, also known as *The Green Paper*, has made definite inroads into HIV-related programming. Population Health, however, appears to be at present an influential part of ACAP programming or funding directives, rather than its guiding principle. Aspects of a Population Health framework integrated into ACAP include evidence-based decision-making, addressing specific determinants of health, and forming partnerships to take action on those determinants. ACAP's principles as related to its funding directives are: Creating Supportive Environments; Health Promotion for People Living with HIV/AIDS; Prevention Initiatives; Strengthening Community-based Organizations; Community Development; Health Promotion; Partnerships/ Collaboration; Population Health; Evaluation (Health Canada, 2000).

What follows is a list of characteristics of both Health Promotion and Population Health frameworks, organized by the formal policy shift (not necessarily reflected in programming) from one to the other in the Canadian context. Such a characterization, while perhaps useful, inevitably oversimplifies.

Chart

Characteristics of a shift from Health Promotion to Population Health in Canadian policy²

From	To
Focus on processes of enabling people to gain further control over their health	Focus on products of policies & action across many determinants of health
Education, community organizing, & advocacy as processes of enabling people	Multi-sectoral action re. inequities esp. via the re-distribution of resources
Community encouraged to co-define priorities	Evidence-based decision making
Local focus, supportive of working with vulnerable groups as identified by organizations	Concern is with the general population's health (statistically) & with reducing health inequities lived by specific populations
Experiential focus	Statistical, comparative focus
Focus on individual & community empowerment	Focus on the measurable life conditions of populations & improving them
Bottom-up, with support from top-down	Inter-sectoral & multi-level, vertical & horizontal partnerships essential
Focus both on prevention of illness & on health	Focus on health as a capacity to adapt or respond to challenges & change
Focus on short, mid and long term results	Focus on mid and long term results
Wider 'prerequisites' of health underlined, yet focus usually limited to psycho-social	Broad interdependent 'determinants' of health the focus of study & action
Integrates eco-systemic considerations	Relative absence of ecological sustainability as a factor for health: sustainability is at times an 'add-on'

² See Annex III for an earlier (1996) chart comparing Health Promotion and Population Health Policy frameworks, entitled "Health Policy Framework", in *Taking Care: HIV/AIDS Health Promotion Update*, a publication of the National Health Promotion Project, associated with AIDS Vancouver, edited by Terry Trussler, Vol. 2, Issue 7, Autumn 1996, page 7.

Determinants of health are “factors and conditions which have an influence on the health of individuals and communities. Critical to this definition is understanding that the determinants of health do not act in isolation from each other” (Health Canada, 1998a). The present standard list of “determinants of health” recognized by Health Canada within its Population Health framework are:

- Income and Social Status
- Social Support Networks
- Education
- Employment/Working Conditions
- Social Environments
- Physical Environments
- Personal Health Practices and Coping Skills
- Biology and Genetic Endowment
- Healthy Child Development
- Health Services
- Gender
- Culture.

Researching and reporting on the health status of a given population, *vis-à-vis* each of the recognized determinants of health, is not in itself an expression of a Population Health framework. Such a framework is ultimately activated, for example, by applying an evidence-based, collaborative process for intervening on multiple determinants to address the health status issues being studied of a given population (Health Canada, 1998b).

The definition of health within the reviewed literature on Population Health has moved away, in the past few years, from health as a state of physical, mental and social well-being, or as quality of life. Health in such terms is seen to confuse it with the determinants of health, and also makes it difficult to discuss the effect of health on social well-being and quality of life. Rather, “a population health approach recognizes that health is a capacity or resource rather than a state”, referring to “the capacity of people to adapt to, respond to, or control life’s challenges and changes” (Health Canada, 1998b; Institute of Health Promotion Research, 1999).

Perceptions within the HIV prevention field of Population Health

A Population Health approach has been perceived as holding definite potential benefits for the field of HIV with various populations. These possibilities include, for example, justifying greater involvement and support to effect much-needed change within wider policies beyond health as it is conventionally-defined (Trussler & Marchand, 1997a; Trussler & Marchand, 1997b). A Population Health approach, according to Wong (1997a; 1997b), holds opportunities for such areas as HIV prevention programming; it would advance our understanding of the determinants of health, which would help end the HIV and AIDS crises. Socio-economic inequality could be legitimately placed as a central determinant of health,

disease and risk; as such, a Population Health approach would justify much-needed policy change regarding socio-economic inequities (Institute of Health Promotion Research, 1999).

The transition during the mid-1990's from Health Promotion to Population Health in Canadian government policy was nonetheless reason for much questioning, even malaise, among many working within the fields of HIV and AIDS, including those who simultaneously perceive its potential benefits (de Burger, 1997).

A Population Health approach has been perceived within the field of HIV as a threat to sustaining important advances that local community organizations and their efforts have contributed within the area – advances often catalyzed by a Health Promotion approach and programming (Riesch Toepell, 1997). Population Health has brought a concern that it will not sustain a community development focus in areas such as HIV prevention; Population Health literature has been perceived as not stressing, nor even including, personal, group and community development (Wong, 1997a; Wong, 1997b; Trussler & Marchand, 1997b).

As well, the quantitative evidence-based decision-making that characterizes a Population Health approach raises hesitations in a field where resources are not necessarily adequate to tracking measurable indicators, nor to defining such measurable indicators in a way that reflects a community-based holistic approach. Qualitative methodology used to research the experience of HIV vulnerable community members appears to be beside the point within a Population Health approach (Trussler & Marchand, 1997b).

Dominant indicators of health used within the Population Health paradigm are actually based on the absence of disability or disease; this runs counter to a Health Promotion perspective of “quality of life” experience of health and well-being, which may be seen within a Population Health approach as too wide-encompassing (Trussler & Marchand, 1997a; Trussler & Marchand, 1997b; Bourget, no date).

Some are also concerned that more immediate HIV prevention initiatives may suffer at the expense of largely unproven long-term, “top-down” or trickle-down strategies of health improvement through large-scale policy initiatives that characterize Population Health (Riesch Toepell, 1997; Trussler & Marchand, 1997b). A Population Health approach appears to lack any substantial recognition of the key role that a Health Promotion approach has played in contributing to critical knowledge about the determinants of health. For example, Health Promotion-driven HIV prevention work within Canadian prisons articulated the significance of human rights within prisons as a critical determinant of health (Riesch Toepell, 1997).

Much as a Health Promotion approach was when it appeared on the scene in the mid-1980's, a Population Health framework has been criticized for providing the ideological justification for cost-cutting operations related to health care (Leonard, 1998).

As well, it is perceived as very unclear how a Population Health approach would take into account embedded or unidentified communities that were justifiably reached through Health Promotion efforts, such as people who do sex work, use intravenous drugs, or are homeless (Riesch Toepell, 1997).

Given all the above, it is unsurprising that to some within the HIV field in Canada, a Population Health approach is not seen as a viable nor desirable complete replacement for a Health Promotion approach,

particularly regarding its implications for programming and for field practice (Trussler & Marchand, 1997b).

3.1.2 Population Health Promotion: a conventional hybrid model

With the adoption by the Canadian government of a common Population Health framework grounded in a Population Health approach, other frameworks or models inspired by Population Health came to be proposed in response, particularly upon considering practical implications and actions (Wong, 1997b). Some models, like a Population Health Promotion (Hamilton & Bhatti, 1996), have drawn heavily and quite literally on a Population health approach, and have been quite influential within Health Canada. Other frameworks or models, such as transformational health (Trussler & Marchand, 1997b), have integrated several aspects of a Population Health approach, yet have rejected numerous other aspects of it.

Population Health Promotion, forwarded as a model by Hamilton and Bhatti (1996) within Health Canada, is the dominant and most legitimated expression of frameworks inspired by a Population Health approach and posed as an alternative to the Population Health framework officially adopted. The model of Population Health Promotion tries to show how comprehensive Health Promotion strategies can be used to take action on all of the Determinants of health cited by the adopted Population Health policy framework. Population Health Promotion is “intended as a planning tool and a departure point for developing other models designed for specific needs” (Hamilton & Bhatti, 1996). The model was not developed specifically with reference to HIV work, but rather as a generic framework. However, its influence on HIV programming is likely strong; ACAP, at present, might perhaps be seen as a programming influenced by, and even possibly framed by, a Population Health Promotion model.

Population Health Promotion as a framework is not perceived within the reviewed literature as unproblematic. For example, Wong (1997b) warns that Population Health and Health Promotion as frameworks each “has a singular perspective on health that should not be diluted through forced consolidation”. Leonard (1998) underlines that a Population Health Promotion model dulls the edge of what could be a more critical or progressive appropriation of Population Health. Such a more critical version would center socio-economic inequality as a primary determinant of lack of health, as well as the implications this would offer for resource allocation. It would challenge major economic and ideological aspects of the present Canadian social structure, which Population Health Promotion does not (Leonard, 1998). As a “more consensual, cautious” interpretation of Population Health, Population Health Promotion has been gaining currency within the direction of Canadian government policies and strategies (Leonard, 1998).

3.1.3 Transformational health: a social change hybrid model

As seen above, Leonard (1998) points out that Population Health Promotion has its limits, especially regarding its possibilities for addressing significant socio-economic inequities in Canada that impact on health. While Leonard, specifically working on HIV related issues, doesn't elaborate on what an alternative to Population Health Promotion might look like, and appears to adopt it for strategic ends, others offer perspectives and models toward a more transformative approach to Population Health.

Jackson (1994), from a concern with the individual and community empowerment approach sustained by a Health Promotion framework, foreshadows a progressive critique of the relatively conservative Population Health Promotion, particularly with regard to implications for the role of public health workers and associations. She views the two major roles for public health vis-à-vis the Determinants of health as: (a) public health workers empowering and developing skills among marginalized people to fight for the determinants of health themselves, and (b) public health associations providing its resources and credibility to advocate for policy change itself (Jackson, 1994).

Trussler and Marchand (1994) early on, for AIDS Vancouver, constructed a creative, critical focus to a Health Promotion framework that integrates aspects of Frank Mustard's 1991 Population Health theory. An insistence on community development micro-processes as key for local community-based initiatives is integrated with macro knowledge of social and structural determinants of health. Proposing a participatory methodology, Trussler and Marchand involved those directly affected by HIV issues in collaborative knowledge-production that is at the same time educational (in intent and effect), theory-constructing, and strategic or action-oriented (Trussler & Marchand, 1994). As a result of implementing such a methodology, and in combination with a critical analysis of five health models including that of Population Health, Trussler and Marchand then proposed in 1997 a model of community-based HIV work called transformational health (Trussler & Marchand, 1997b).

As a model with an explicitly social change emphasis, that is simultaneously process-oriented and community-based in focus, transformational health affirms a social-environmental interpretation of health and illness that logically “leads us to social methods and remedies for HIV-affected groups and communities” (Trussler & Marchand, 1997b). As a community-based social learning model, process flows through three phases: “study” (listening to HIV/AIDS experience), “plan” (focusing on a strategy), and “do” (creating supportive social networks and environments). The model incorporates analyzing determinants (individual; interpersonal; cultural; structural) of HIV vulnerability on the local situation, and applying the strategy to a wide range of HIV/AIDS practice environments (interpersonal; agency; community; society) (Trussler & Marchand, 1997b).

A transformational health model, in contrast to a Population Health Promotion model, would seem far more resonant with the histories of courageous resistance, the analyses and the strengths of Canadian gay, lesbian, bisexual and transgender organizations in addressing HIV issues.

Rather than cementing a finished framework for HIV work, the methodological and model-building work of Trussler and Marchand open up important possibilities for creatively engaging and reconstructing mainstream governmental health models that were created for a generic Canadian population.

3.2 Gay men's health and a Population Health approach in Canada

What are the potential benefits and limits of a Population Health framework for gay men's health? Is the Canadian government's Population Health policy framework productively resonant – or unproductively discordant – with the shift to gay men's health and with the repositioning of HIV prevention within gay men's health? What, methodologically, is the way most coherent with gay men's health to find that out? This section attempts to critically engage such questions.

It is primarily the work of gay men and their allies on HIV issues that has brought us into a practical and paradigm shift to gay men's health. It would therefore come as no surprise that a suitable, though not exclusive, analytical context for evaluating a Population Health model for gay men's health be that intellectual and practical work achieved by gay men and their allies active on HIV issues.

Reviewing the relevance of a Population Health framework for gay men's health requires drawing on and building upon the strengths of those who have analyzed the relevance of such a framework for HIV prevention and health promotion work. This includes extending their learnings, at times extrapolating from them, in order to address the broader realm of gay men's health.

3.2.1 Benefits and possibilities of Population Health for gay men's health

Gay men's organizations and those reflecting wider alliances have historically been catalysts and innovative actors in naming and addressing a wide range of determinants of health, including education, income, social environment including human rights, social supports, health and social services, employment and working conditions. As well, they have been articulate and astute in drawing the links between such determinants of health and gay men's lives/deaths and well-being/oppression.

The importance of what are called Determinants of health within a Population Health framework – and of action on them – are thus not new to gay communities; these communities and their allies have been involved as leaders in addressing such determinants for many years.

What appears to be newer or more of a novelty with a Population Health policy framework is the legitimacy of including serious consideration of those areas within efforts which are specifically aimed at health, and even at very specific health issues. When health is re-conceived (expanded) as “the capacity of people to adapt to, respond to, or control life's challenges and changes” (Health Canada, 1998b; Institute of Health Promotion Research, 1999), the connection may be more easily seen, as is the enormous contribution that gay communities have been making to their health through their groundbreaking and courageous work of addressing determinants of health.

A Population Health framework thus holds the important benefit of providing a justification for recognizing, intensifying, and providing further resources for action in areas that gay men and their organizations have historically been addressing, whether explicitly or implicitly related to specific health issues. This would be particularly true for policy issues, though not limited to them.

The necessity, within a Population Health policy framework, of inter-sectoral and multi-level concertation or partnership on various determinants of health provides an important opportunity for strengthening conventional alliances and for the development of new alliances, particularly for, though again not limited to, policy change. A reconfiguration of conventional alliances could give rise to a new level of creativity and effectiveness.

A Population Health model could offer a further opportunity for intensified concerted efforts to address social and systemic inequities, in view of achieving reduced health inequities or disparities between various populations or communities.

In addition, the holistic approach characterizing emerging definitions of gay men's health would definitely support an exploration of Population Health and its implications. This is particularly so when

“holistic” extends beyond a description of individual needs to include an understanding of the relational quality of gay men’s health, for example, with other individuals, with networks of people, with groups, and with societal conditions (Aggleton, 2000). This sense of holistic health, integral to an emerging paradigm of gay men’s health, merges soundly with a Population Health framework with its stress on conditions or factors which include yet go far beyond individual behavior, “lifestyle”, and personal family health history or genetic make-up, as primary and determining influences on health. Population Health holds the potential of propelling gay men’s health to pursue this relational meaning of holistic, and its fuller implications.

A Population Health framework, with its focus on mid and long term effects and outcomes, may also provide an opportune model for the “stepping back” from action and the pro-active strategic planning that are emphasized with a shift to gay men’s health.

As well, a Population Health framework would appear to coincide with and support the move to an identity or community focus characterizing gay men’s health, over a behavior-oriented focus on men who have sex with men.

3.2.2 Limits and risks of Population Health for gay men’s health

Simultaneous to the possible benefits of a Population Health framework for a shift to gay men’s health, are the framework’s limits for an emerging gay men’s health paradigm; these limits are many and at times staggering, particularly when evaluated against other models which also incorporate a strong social-environmental emphasis.

As already raised by those investigating the limits of a Population Health approach and model for HIV work, the strengths of a Health Promotion model are ignored by Population Health, as well as the knowledge production of those people, particularly community workers, who have been creatively implementing a Health Promotion model.

A primary strength of the Health Promotion model is its emphasis on processes that contribute to individual and community empowerment; such processes, close to the mission of community-based organizations, lay outside of a Population Health discourse. Within such a discourse, local community action logically appears to be reduced to creating consensus by community organizations among various sectors of the larger community (private or business, para-public, and so on) and levels of government (local, regional, provincial and federal) for policy change on various, interrelated determinants of health. While this holds potential for advancing gay men’s health, it is limited in scope.

A Population Health approach appears to ignore the importance of community-based empowerment approaches for identifying, expanding, or redefining determinants of health. Community-based work supported by a Health Promotion model – which gay men’s health seems resolute to not give up – often brings to light previously hidden or muffled determinants of health that may challenge conventional policy and political discourse (Hellquist, 1996), perhaps even that discourse informing the present Population Health framework (Riesch Toepell, 1997).

The focus of a Population Health model on evidence-based decision making, where evidence is for all intents and purposes quantitative, poses a serious limit on advancing gay men’s health, where the focus

is increasingly on qualitative and participatory research, identity issues and the experiential, which may or may not include quantitative methods as well. Population Health's actual criteria (in practice) of the absence of disease for measuring health, despite its formal definitions of health which encompass optimum health and well-being, pose a serious difficulty for gay men's health.

The requirement of partnerships within the broader "community", integral to a Population Health model, has the potential to deviate gay men's health organizations and related groups from their community-based mission. Population Health tends to presuppose that there is a consensus of values and interests among very differing sectors of the wider community (for example, small, medium and corporate businesses, local residents, community-based organizations, para-public institutions, religious organizations, various levels of governments, marginalized populations). As well, a Population Health approach seems to situate the role of community organizations as a facilitator of such consensus for policy change regarding various determinants of health – without consideration of equity regarding the power relations between these various sectors, and possibly without regard for the mission of community organizations and their autonomy.

Another difficulty posed by a Population Health framework for gay men's health is the ambiguity, and perhaps mixed messages, that the framework offers about the relation between focusing on the health of the general population, and the health of smaller population groups within that broader general population. This ambiguity appears to have lessened since the mid-1990's in the Population Health literature. Since 1994, when Population Health was officially accepted as federal policy, there recently appears to be more formal emphasis on "reducing inequalities in health between population groups" of Canada as an integral goal of the framework, alongside "maintaining and improving the health of the entire population." (Health Canada, 1998b) Thus, promoting prevention and positive action on determinants which affect the health of specific population groups, particularly those situated in relations of inequity, appears to be now formally affirmed (Health Canada, 1999a). However, ambiguity nonetheless hovers about the exact meaning of "populations" within a Population Health framework. Wong (1997b) notes that Health Canada has considered using a "life cycle" approach (children and youth; early and mid-adulthood; and seniors) to define populations, as well as citing populations by gender, as Aboriginal, and as low income Canadians. With a "life cycle" approach as dominant, for example, there are "questions about how cross-cutting populations with specific health considerations, like the gay and lesbian community, would be treated" (Wong, 1977b). As well, Wong (1997b) questions whether the open-ended definition of community that accompanies Health Promotion (from the ACAP guidelines: "groups of people who share a geographical centre or groups of people who share certain characteristics") would have a place within Population Health.

The ambiguity surrounding the definition of populations within a Population Health framework, and its impact, appears evident in Health Canada's voluminous 1999 *Toward a healthy future: Second report on the health of Canadians*. Relying on a Population Health framework, *Toward a healthy future* appears to make just one fleeting reference (p. 25) to gay men and lesbians (not specifically as populations nor as population groups, but rather within a discussion of "groups at high risk of suicide"). This paucity of attention is despite the document's stated aims of Population health, including the aim "to reduce inequities in the underlying conditions that put some Canadians at a disadvantage for attaining and maintaining optimal health" (Health Canada, 1999b). Within a Population Health framework, the legitimacy of

queer populations as populations still appears ambiguous, and this ambiguity raises questions. As raised in this discussion paper's introduction, are gay men not taken into account in *Toward a healthy future* because, for example, statistically-speaking as a population group it is too small for consideration within a Population Health framework, or simply too difficult to obtain sure statistics about gay men to even conjecture about population size? Are gay men and sexual orientation not taken into account because of homophobia and heterosexism? Are gay men misperceived as enjoying equity with regard to life conditions and to health, and hence are not considered in the equation of reducing inequalities regarding specific population groups?

An important risk accompanies strategically addressing the ambiguity raised above. After years of having been reduced to either medical problems or to dehumanized victims, gay men are pointing out that work on gay men's health should begin with recognizing, acknowledging and affirming the resilience, the reserves of strength, and the courage of gay men (Aggleton, 2000; Rofes, 1998). However, addressing – in a conventional way – the ambiguity within a Population Health framework regarding gay men as a population (and their possible erasure), as well as toward sexual orientation more generally, could easily lead to gay men repositioning themselves as simple victims (of inequity in both life conditions and health), in order to clearly “gain a place” within the framework. This would seem to pose a key challenge.

3.2.3 Gay men's health critically appropriating Population Health

Methodologically, a community-based, progressive, or transformative approach to Population Health would encourage bottom-up participation in engaging its simultaneous resonance and dissonance with gay men's health. A transformative approach would logically support the freeing-up of means for a critical appropriation of Population Health theory and principles by those working at the community-level – through their questioning and problem-posing, drawing on their considerable community-based knowledge, experience, and experimentation. An opportunity, supported by the requisite resources, for recasting Population Health by those at the local community level would seem to be a sound base for participatory policy development that significantly involves those directly affected by it.

Determinants of health vis-à-vis gay men

Preface

Determinants of health are the factors and conditions that research has shown to influence health status (Health Canada, 1998b). A principal aim of this section is to outline and examine what the reviewed literature says – and also at times omits to say – about each of the twelve Determinant of health, as currently identified in Health Canada policy, as it relates to gay men. While such an aim is in itself important for this paper, it is simultaneously an aim to point out the type(s) of influence each Determinant of health is seen to have on gay men's health, taking into account emerging definitions of gay men's health. This latter aim is usually more difficult to achieve, as there is less found within the literature explicitly addressing those influences on gay men's health.

Health Canada acknowledges that a Population Health framework in the Canadian context is malleable and in a dynamic process of development. For example, the nature and range of the determinants used within Health Canada policy are acknowledged as unfixed; rather, the standard list of twelve determinants of health “is likely to evolve as knowledge in the area grows” (Health Canada, 1998b). Actively participating in the ongoing development of a Population Health framework, especially as it affects the lives of gay men, is an expression of gay men's vitality, a process integral to individual and community empowerment.

Knowledge generated within gay men's health point, for example, toward expanding the range of determinants of health to include *Conditions that affirm choices of coming out*. This category will be included among those conventionally selected by Health Canada. Further work in the area of gay men's health will, surely, further change or expand determinants of the health and well-being of gay men in Canada.

As outlined below, the reviewed literature points toward gay men in Canada and their communities experiencing disparities, inequities, as well as significant vulnerabilities vis-à-vis the determinants of health. At the same time, gay men have historically and to this day been courageously addressing those inequities through various individual and collective ways.

It is key to underline that throughout this section, within each of the determinants of health outlined the health and well-being of gay men in Canada are not solely influenced by the dynamics of heterosexism and homophobia, though they may be extremely influential. “Homophobia, racism, ableism, classism and other forms of stereotyping and discrimination are factors contributing to gay men's vulnerability to a range of health concerns” (McInnis & Kong, 1998). Gay men are composed of people of a diverse range of overlapping communities. As well, all gay men have multiple identities and are multiply-positioned (not just gay men perceived as “minority”) as all gay men are raced, gendered, classed, and sexually oriented (Fung, 1995). It is perhaps only those gay men positioned as most privileged (with regard to class, race, gender, religion, language, ethnicity, and so on) who are likely to sense that heterosexism and homophobia are the only real societal obstacles within a given determinant of health or to sharing the quality or level of health experienced by the general Canadian population, as this is what may correspond most closely to their own experience.

Likewise, the resilience of gay men and their communities is not solely due to their courageous actions in the face of the devastation wrought by heterosexism and homophobia. Gay men's resilience is also

informed by – and strengthened by – community and personal resistance to other interconnected forms of oppression, such as racism, anti-Semitism, classism, age-ism, sexism, and so on, as well as proud community histories of resistance and resilience.

4.1 Income and Social Status

Income and social status appear to be the most important determinants of health with regard to the general population. With reference to the general Canadian population, income level has been shown to positively affect both people's subjective perception of their health and their actual health, as defined in conventional terms. At each step up the income ladder, the probability of good health increases. (Health Canada, 1994)

At the same time, increased economic growth of countries already enjoying prosperity appear to show little benefit to the population's health. Greater economic growth is key in positively affecting health among the general population only in countries in which the per capita income is relatively low. Within "developed nations", including Canada, equitable income, resource and wealth distribution within a population has a greater determining effect on the health of its members, than does economic growth. (Hamilton & Bhatti, 1996; Canadian AIDS Society, 1996; Health Canada, 1999a)

Social status in the Population Health literature appears to be invariably taken as socio-economic status (background and achieved). Class background and job status have an influential effect on health. Social status is seen as affecting health "by determining the degree of control people have over life circumstances and, hence, their capacity to take action" (Hamilton & Bhatti, 1996).

Extending the literature's meaning of social status to considerations beyond class background, achieved class position, and job status is conceivable. For, in the eyes of many within the heterosexual majority, gay men are homophobically perceived as of a "lower social status". This is often made very tangible through differential, often degrading, treatment, interpersonally and beyond; such treatment has often been sustained and exacerbated by government laws and policies, regulated through heterosexist institutions (Ryan et al., 1998). Such an expanded definition of social status likely resonates with the experience of many gay men.

An expanded usage of social class, however, engenders a difficult dilemma: it risks contributing to the erasure of class background, achieved class, and job status within discourses of gay men's health, and hence of minimizing engagement with their influence. For example, it appears that gay men of working class and poor backgrounds, gay men, who after much struggle, are still working in low-wage service industries, or who are in street sex work, often remain hidden within the general discourses of mainstream gay communities and their considerations, and either not discussed (connoting shame), exoticized by middle class gay men as 'rough', or simply dismissed or rendered invisible by middle class gay men. This situation may be compounded by the more recent surge of targeted marketing strategies aimed at those within gay communities who are better off financially and who, consequently, are more widely represented in publicity and media as "representative" and "of value". Such tendencies would seem to have an impact on the health and well-being of gay men, and possibly also call mainstream gay communities to greater accountability. This dilemma is raised as question in need of discussion.

Gay men are commonly imagined as enjoying a higher average income than the general population (Penaloza, 1996). This myth appears to have been shaped by factors that include the following:

- business-driven marketing strategists, both gay and not gay, seeking clients for targeted marketing to gay communities, as well as gay-targeted media, promoting gays as a "dream market" with billions of dollars in annual income (Penaloza, 1996; Wardlow, 1996);
- Christian right-wing organizations attempting to argue that gay men are not oppressed, and that their concerns are those of a "special interest group" rather than issues of human rights and of wider societal responsibility;
- studies based on comparisons of incomes of gays and lesbians to those of the general population based on data collected by the sales and marketing departments of gay and lesbian publications, whose readers, by definition, are not representative of the mainstream of all gay consumers, and would have the effect of inflating the average income of gays and lesbians (Lukenbill, 1995; Penaloza, 1996);
- the likelihood that economically-secure gays are more likely to be openly so, and hence accessible to market research measures (Bowes, 1996).

According to the Yankelovich Monitor Survey, gay men's incomes are actually lower than those of heterosexual men; this holds for both mean personal income and mean household income (Lukenbill, 1995). The Yankelovich Monitor Survey is a significant study because it used a (U.S.) nationally representative sample of self-selected gays and lesbians (Penaloza, 1996).

The Yankelovich Monitor Survey also shows that mean incomes (both personal and household) of lesbians, while slightly higher than those of heterosexual women, are still much less than those of gay men (Lukenbill, 1995), reflecting general gender inequities.

Statistics of the American-based Yankelovich Monitor Survey hint at possibly greater poverty levels among gay men (81% of whom are in the bottom one-quarter category range of income) than among heterosexual men (65% of whom are in that same bottom range) (Lukenbill, 1995).

Poverty and gay men according to Canadian reports

A Canadian survey of gay men and lesbians similar to the Yankelovich Monitor Survey, one which includes levels of income, does not seem to have been published. Hellquist (1996), for the Gay and Lesbian Health Services of Saskatoon, reminds us of the difficulties in surveying lesbian, gay, and bisexual communities; so many people remain hidden, not identifying themselves to anyone studying or surveying the community; as a result, a significant number of people of those communities are often excluded. And as Bowes (1996) points out, those who are more vulnerable economically may be more likely to be among those excluded from such surveys.

In Canada, a community-based report notes "high levels of poverty" among lesbians, gay men, bisexuals, and transgendered persons (Perchal & Brooke, 1995). Another community-based report, drawing on five years of working on health issues with a local Canadian population notes that "our experience tells us that there are a disproportionate number of lesbians, gay men and bisexuals on social assistance." (Hellquist, 1996). That there may be a disproportionate number of gay men on disability due to psycho-

logical issues is absent in the reviewed literature. While there is often a sense among community workers that there exists a large economic underclass within gay communities, including living on social assistance, related to their being gay, such indications remain anecdotal or at the level of individual impressions within the reviewed literature; this points toward further research. Similarly, a disproportionate number of gay men appear to be in conflict with the law or incarcerated, yet this is not mentioned in the reviewed literature; this again beckons further research.

Transgendered people, some of whom also identify as gay, assume extremely high costs for sex assignment surgery which is considered plastic/cosmetic surgery, travel expenses for surgery, electrolysis, and voice rehabilitation. Transgendered persons also may have difficulty gaining employment because of discrimination.

As well, one small study found that about one-fifth of lesbians, gay men and bisexuals believed that they have not been hired due to discrimination (on the basis of sexual orientation) in employment (Perchal & Brooke, 1995). The Canadian Labour Congress (1994) underlines that gay men and lesbians are systematically denied jobs. A Canadian lesbian, gay, bisexual and transgendered health association research report notes that while participants in its study do not compose a random sample, most participants are in the low income category, with a pattern of limited income possibilities to be expected among gays, lesbians, bisexual and transgendered people (Taghavi, 1999). Participants in a study on the health needs of gays and lesbians of New Brunswick reported career advancement being limited their by sexual orientation (Olivier & Targett, 1993).

People living with HIV in Canada, most of whom are gay men (Myers, Godin, Calzavara et al., 1993), are frequently reduced to poverty or great financial hardship, often due to governmental policy issues, including ill-matched Employment Insurance (EI) criteria, the reduced access to EI, and the exorbitantly high cost of pharmaceutical drugs if one is not living on subsistence-level social assistance (Clarke, 1994; Canadian AIDS Society, 1996). This situation can be conjectured to have had a profound and detrimental impact on the economic well-being of gay communities. It would be difficult for the financial roller-coaster, uncertainty and hardship that usually accompanies living with HIV not to effect negatively on the overall mental, emotional, physical and spiritual health and well-being of Canadian gay communities.

Gay adolescents and youth are disproportionately homeless (Health Canada, 1996; Hellquist, 1996). Sexual orientation is a major precipitating factor leading youth to being and staying on the streets (Canadian Public Health Association, 1998), characterized by poverty and often survival conditions. More than a few leave their families because of homophobic rejection or fear of rejection; many youth feel forced to leave their home towns for such reasons, particularly if they are of rural regions.

Gay men are of a cross-section of overlapping communities, including those which are characteristically capital-poor or where there is high unemployment. Two-Spirit males, for example, are members of larger populations and nations that are attempting to address often staggering levels of poverty and unemployment. In English-speaking Caribbean communities of Canada, for example, unemployment is a concern (Baxter, et al., 1994). Many gay men of rural Canadian regions, especially those experiencing restructured or eroded natural resource-based economies, may find themselves disproportionately unemployed. Addressing issues of income disparity, unemployment and poverty

among gay men thus would logically include addressing those same issues within the overlapping communities to which gay men belong.

Hamid Taghavi (1999) raises key questions relevant to a Population Health Framework regarding the income data reported by participants of the Vancouver-based health access study he analyzed. Taghavi's questions include:

- "How the LGBT individuals' health is affected by their income?"
- "What determinants of health more strongly than others affect the LGBT individuals' income?" (Ibid.)

Such questions examined at the micro-level may complement and inform studies aiming at more macro understandings of the relation between gay men's levels of income and their health.

Drawing on a conventional Population Health model, addressing income and social status as Determinants of health in relation to gay men's health would logically lead to further research on comparative statistical data regarding gay men's income and class characteristics, including levels of poverty among gay men. However, this may well not be appropriate as a priority strategic avenue. Both Bowles (1996) and Hellquist (1996) point toward the major difficulties associated with surveys of gays men, particularly regarding the exclusion of those most socially vulnerable. Those gay men who, for example, are more economically vulnerable are seen as less likely to identify themselves as gay for surveys. Until homophobia and heterosexism significantly lessens, it may be both ineffective and counterproductive to mobilize resources toward such surveys.

Qualitative research in the area may be a more relevant avenue than solely quantitative research. Qualitative research would benefit from a participatory approach (Hagey, 1997; Trussler & Marchand, 1997b), whereby a wide socio-economic range of gay men are integral to defining or posing research questions and to identifying and implementing possible solutions or responses to address the situations affecting them. While examining income and social status in gay communities is one focus, exploring its perceived and actual impact on individual and community health is another. Given that perceived and actual impact, how do gay men act and effectively manage their health, rather than simply falling victim to their circumstances? Outside of the impact of poverty on the risk of HIV transmission and on the progression of disease among the general population (which nonetheless includes many of Canadian gay communities), there appears to be very little in the Canadian literature about the perceived and actual effect of income level and social status on gay men's health and well-being.

As gay men are found across the spectrum of the population, a reduction of inequalities in income distribution, generally, within Canada would be of benefit to their overall health. A trend, however, of greater income disparity appears to be emerging. For example, Toronto's Centre for Social Justice found that the gap significantly grew from 1973 and 1996 between the average incomes of the wealthiest 10% of families with children and the poorest 10% of families with children. Reversing the trend of an increasingly unequal redistribution of wealth is a challenge which would seem to require a multiplicity of strategies.

Importantly, regardless of whether income and social status level of gay men is on par or not with those of heterosexual, the challenge may be one of strategizing to improve economic well-being, and especially of those members of gay communities who live in poverty, in a way that builds from the strengths of

gay men and their communities. Such strengths include, for example, their alliance-building efforts, organizing and advocacy work with lesbian, bisexual and transgendered communities, and with other historically marginalized communities or population groups.

As well, if concerns were to be extended beyond the “common sense” issue of statistical equality (with heterosexuals) to incorporating Health Promotion values of individual and community empowerment, then economic growth and redistribution strategies might include participatory community economic development processes as strategic for health and well-being. Such processes are concerned with democratizing both the economic realm and decision-making to the community-level, as well as within it. Gay men interwoven with their communities and alliances may thus be supported to expand the realm of their degree of control to the economic realm, as well as their capacity to take action within that realm. This strengthens both individuals and communities, and would coherently raise health and well-being.

The value of such participatory processes, which seek to integrate both social and economic goals, would not be enough, however. They would seem to have to be combined with effectively addressing wider policy issues such as re-building devastated income safety-nets, such as Employment Insurance and social assistance in a way that is coherent with gay men’s lives, including those who are living with HIV, as well as resource distribution issues related to both taxation and, for example, the required re-investment of a percentage of profits by banks into local communities (such as in the United States). Such strategies are posed as questions that accompany the exploration of Canadian gay men’s income and social status, and their influence on health. A transformative health model would seem to ring consistent with these type of methodological and strategic questions. It would seem that processes and results of individual and community empowerment within one realm of life (in this case the economic) would positively extend to and affect a greater sense of control within other areas of life (for example, in personal health practices and coping skills). Such a holistic or global approach to empowerment processes in relation to gay men’s lives beckon further research.

4.2 Conditions that affirm choices of coming out

Hellquist (1996) affirms that “Gay men who do not feel they are able to be open about their sexual orientation face increased risks for many health and social problems.” This view is echoed by numerous research documents and community-based reports. For example, one literature review of gay men’s health affirms a consensus within the reviewed literature that the coming out process appears to be the principal plane on which lie identity, sexual health, gay health and access to health care problems (Jalbert, 1999). The results of a French-speaking focus group on gay men’s health recently held in Montreal indicate that the large part of difficulties related to being gay is tied to the process of coming out (Ryan, French-speaking Focus Group, 2000). The (American) National Lesbian and Gay Health Association (NLGHA) believes that being openly gay contributes to gay men’s overall health and well-being (Penn, 1997). The Association’s guide to gay men’s wellness is unequivocal:

The single most important developmental challenge affecting members of lesbian, gay, bisexual, and transgender communities is coming out. We do not yet live in a society where people do not assume or presume that everyone is heterosexual. Therefore, each of us is continuously faced with the choice of stepping out of a closet or silently accepting the presumption of universal heterosexuality. (Penn, 1997)

The profound developmental challenge of coming out is particularly fraught with difficulties among youth, as most gay adolescents appear to first experience homosexual fantasies or sexual attraction at between 11 and 12 years old (Anderson, 1995). Be that as it may, coming out does not usually occur until much later, as:

...for a period of at least six years, he or she is likely to maintain total silence about his or her sexual orientation. All the while, the gay adolescent experiences severe stress because of feelings of shame, self-hatred, distress and isolation related to that orientation." (Canadian Public Health Association, 1998)

At the same time, gay youth may face various forms of age-ism within the coming out process, often being told that they are too young to really know their sexual orientation or identity. Others also underscore the numerous psycho-social stressors and challenges experienced upon coming out, regardless of chronological age (Olivier & Targett, 1993). These stressors, compounded by cognitive, emotional, social and physical isolation, often lead to depression and suicidal ideation (Canadian Public Health Association, 1998). Suicide rates among both gay youth and gay men are underscored as alarmingly high (Hellquist, 1996). In a study of 750 males aged 18 to 27 in Calgary, it was found that gay and bisexual males were 13.9 times more at risk for a serious suicide attempt, consonant with previous findings (Bagley and Tremblay, in press). In the face of overwhelming difficulties experienced by coming out within discriminatory social conditions, and particularly among youth, we are simultaneously reminded that "most gay teens do survive adolescence" (Unks, 1995), surfacing the courageous resilience and tenacity of gay youth and men.

Given the crucial importance of coming out to gay men's development and health, models of coming out have been a focus of much research. Penn (1997) presents several models of coming out to oneself and to others:

- Pre-coming out, coming out, exploration, first relationships, integration (E. Coleman)
- Sensitization, signification-disorientation/dissociation, coming out, commitment (K. Plummer; R. Troiden)
- Identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, identity synthesis (V. Cass) (Penn, 1997)

Ultimately, it is J. Sophie's model of coming out as a process of developing a gay identity that receives the most attention by the (American) National Lesbian and Gay Health Association:

- 1- *First awareness*: Initial cognitive and emotional realization that one is "different" and that homosexuality may be a relevant issue; No disclosure to others; A feeling of alienation from oneself and others
- 2- *Testing and exploration*: Testing may precede acceptance of one's homosexuality; Initial but limited contact with the gay and lesbian community or with individual gay males and lesbians (but no relationships); Alienation from heterosexuals.
- 3- *Identity acceptance*: Preference for social interactions with other gay males and lesbians; Negative identity gives way to a positive identity; Initial disclosure to heterosexuals.

4- *Identity integration*: Views self as gay or lesbian with accompanying anger and pride in the identity; Disclosure to many others; public coming out; Identity stability; individual is unwilling and unable to change. (Penn, 1997)

Jalbert (1999), in addition to the stages of pre-coming out, coming out, and post-coming out, also proposes the hypothesis of a “retro-coming out” stage. This hypothesized last stage of the coming out process would be characterized by a perceived withdrawal by older or aging gay men from the gay community, particularly from gay bars, as well as from gay identity itself.

While the process of coming out is often perceived as an individual affair, or in health-related terms situated as a personal coping skill, it is rather “conditions that affirm choices of coming out” that is posited here as a determinant of gay men’s health.

While specific events of coming out appear to be almost always personal or individual choices (unless “outed” by someone else), it is the context of these choices (the external “conditions”) which contributes to the construction and meaning of coming out – action on those conditions would seem to go to the root, lowering the dangers and risks to the experience and health of gay men and youth and hence facilitating choices of coming out.

Heterosexual men and youth benefit from the privileges of societal conditions that continuously and unambiguously affirm their sexual orientation – these conditions are so strong and taken-for-granted that there is often no individual “choice” of coming out (as heterosexual) to be made by the person, as heterosexuality is both normalized (as a “policing” of sexual orientation and identity forms) and the repository of many benefits.

Particularly in the pre-coming out or first awareness stage, the question is not simply one of affirming a personal choice of coming out, but of ensuring wider conditions that are free of heterosexism and homophobia. Ryan, Brotman and Rowe (2000) report that “The most commonly reported social and health problems in gay men appear to be associated with the coming out and “pre-coming out” stages of self-acceptance.”

The various events of “coming out” (each time with different people, sets of people, or environments) are context-bound – the person in question is often ultimately the one most competently-situated to know the details about his specific contexts, including the consequences for coming out. Coming out is not a moral duty to oneself nor to a wider community and there may be very legitimate reasons for choosing not to come out (Penn, 1997). Again, addressing the conditions that affirm choices of coming out would reduce the basis of risk (for example: violence against oneself, housing discrimination, homelessness, shame, guilt, and so on) of coming out in a given context.

One can affirm individual choices of coming out, yet remain ignorant of the conditions that impede choices of coming out, and specifically of identifying as gay. These include conditions within gay communities themselves which can engender pain and humiliation for those of relatively less-privileged groups. For example, such pain and humiliation can be experienced at times by gay men of colour within white-identified gay community contexts because of racism, stereotyping (often exotification) or required assimilation (Sanitioso, 1999).

Choices (in the plural) of coming out refer to both the many discrete events of coming out within an ongoing process (as opposed to simply coming out once and for all, popularly perceived as with one's parents), yet also to choices regarding both sexual orientation and identity. For example, one may come out regarding sexual orientation as homosexual or bisexual, yet identify as queer, as gay, as a gay Jew, as transgendered, or as Two-spirit, depending on such factors as culture, self-perception, desire to gay identification, peer group, and political analysis – or, for example, intermittently as queer and gay and transgendered depending on the context. This plurality within practices of identification would seem to foster increased health, as an expression of gaining increased control over one's life and health conditions.

It is possible that “coming out” for gay men and youth in a Canadian context may include not only coming out as gay, or as an identity directly related to sexual orientation, but also “coming out” as a member of a subordinate social or cultural group within an everyday Canadian context of assimilation, racism, and the legacy of colonialism (Cho, 1998). This may relate to coming out, for example, as Asian, Black, Jewish, Aboriginal, or as a member of a more specific heritage, such as Vietnamese, Pakistani, Jamaican, Sephardic, or Cree. Sook Kong (1998) explains it in the following way:

Canadian-born or Canadian-raised Asians, on the other hand, face more than just the challenge of coming out as queer (itself a mega challenge), they also have to deal with the equally momentous process of “coming out” as Asians in this part of the world. Briefly, the latter process refers to individuals who have learned to function or thrive in Canadian society by denying their Asian heritages. Hence, the subsequent need to come to terms with one's cultural heritage. (Kong, 1998)

According to the reviewed literature, the process of coming out has implications for HIV prevention. Addressing conditions that affirm choices of coming out would seem to increase HIV prevention effectiveness. This may be related, for example, to the health of youth: “For many young homosexuals, coming to terms with being gay is a difficult period. HIV prevention is only of secondary concern.” (Canadian Public Health Association, 1998) In a similar vein, from the Australian context, HIV prevention may not be the primary concern of gay Asians because of issues related to coming out: “Threats of bringing shame to the family and a loss of face may be more salient guides in GHA (gay and homosexually-active) men's sexual behavior than HIV/AIDS concerns.” (Sanitioso, 1999) As well, within the Canadian context, Jalbert (1999) postulates that the coming out stage among young gay men may actually bring on new and increased risks for HIV transmission: he poses that the tendency to experience a euphoria that accompanies coming out may lead them to risky sexual behavior.

Depending on culture or cultural heritage, desire to identification as gay, or coming out as gay, may vary. This may be due to the non-“sense” of being, becoming, or identifying as gay within a given culture (Ryan, English-speaking Focus Group, 2000); it may be due to a choice to protect oneself from the racism of the dominant community by not risking alienation from the protective sense of belonging or shield of a subordinate minority community; it may be due to a non-identification with dominant, white-identified gay communities that may provide little sense of “home” and which may themselves bring shame and subordination. Simultaneously, the reviewed literature also underlines that culture is dynamic and hence always-changing, and that people live in overlapping contexts of cultures (subordinate and dominant) and in various degrees or types of acculturation as actors:

Every gay men's road to self-acceptance and loving is unique. It requires that you unlearn shame and dispel the negative images and stereotypes that surround you. You need to separate yourself from

disempowering family and cultural values and find pride in who you are, who you love and how you live. (McInnis & Kong, 1998)

Stated differently, culture is a site of intervention and re-construction, rather than a site of submission or a site romanticized as only good (empowering) or only bad (disempowering). Penn (1997) also affirms that “The importance of community to humans cannot be exaggerated. However, one’s own sense of self should not be sacrificed just to get the love and affection of others.” (Penn, 1997)

Rural settings and small communities pose specific challenges and benefits. Ryan, Brotman, and Rowe (2000) note that “Remaining unknown and invisible in rural areas appears to be a survival tactic for gay men and lesbians, or a means of coping with non-acceptance, discrimination, oppression, and at times, physical and psychological violence.”

Gay men and youth, as well as their allies, have been relentlessly working over the past decades to name and address conditions that affirm choices of coming out, in a panoply of ways. As well, gay men and youth have been courageously coming out despite the risks, the loss of societal privileges, and the dangers. There is hence a strong base on which to continue to build analyses, research and strategic directions in addressing this determinant of health.

4.3 Social Support Networks

Within a Population Health Framework, social support networks are conventionally seen as support from families, friends and communities; such support assists people in dealing effectively with trying situations and in keeping a sense of control over life situations (Hamilton & Bhatti, 1996). The support of family and friends, as well as social participation, seem to act as a buffer against health difficulties; increased emotional support and increased social participation are both tied to increased health (Health Canada, 1994). Close intimate relationships are a factor for health and well being (Peplau, Cochran, & Mays, 1997). Lack of social supports or isolation is conversely considered a “disease determinant” (Jackson, 1994). Population Health interventions cited to strengthen social support networks include programs to maintain strong families, community development that increases social interaction, and initiatives that reduce discrimination and promote social tolerance (Health Canada, 1994). More generally, social support networks are integral to a person’s social environment.

Gay men and gay youth often experience significant diminishment and exclusion within conventional social support networks, due to homophobia and heterosexism. In the face of such degradation and exclusion, gay men have historically and creatively organized, informally and formally, their own social support relationships and networks. Simultaneously, they have also often challenged conventional social support networks to be more responsive to their well-being; at times, this challenges the very definition or structure of those conventional social support networks (Ryan et al., 1998). Isolation is the most recurring feature in the lives of most gay youth, and includes not just social or physical isolation, but also cognitive isolation (a stark lack of knowledge about one’s attractions, identity and existence) and emotional isolation (a lack of emotional support as a member of a marginalized group, with few affirming messages from adults). (Canadian Public Health Association, 1998)

Social support networks may be of particular importance to the health of gay men, given the increased stress they experience due to discrimination. Research indicates that high levels of social supports may moderate gay-identified stressors (Grossman & Kerner, 1998).

An effect of the discrimination experienced through heterosexism is the erasure or vast devaluation of gay men's intimate relationships. Such relationships, when not dismissed as "a phase" or seen as immoral, are often considered less sustaining and less satisfying than heterosexual relationships. Contrary to such myths, research shows high levels of satisfaction within both gay and lesbian intimate relationships (Peplau et al., 1997).

As well, an effect of the discrimination experienced through racism and white-identified social spaces by gay men and youth of minority ethnic, cultural, or "racialized" communities is an erosion of peer social support. For example, referring to the context of the Toronto bar scene, Song Cho expresses his argument through a first person account:

With all the attention focused on white guys, I instinctively knew that as a gay Asian, I rarely had the power to choose and would always be the one chosen. Looking back, it's amazing how few of us (gay Asians) were able to turn to each other for love and support. (Cho, 1998)

Gay couples do not usually receive the same level of support as do heterosexual couples from individuals, the wider community, and the dominant culture within North America. Such support is important to the optimal well-being of gay men. Research indicates that increased social support for gay male couples predicts higher relationship quality; as well, research indicates that social support for the couple better predicts relationship quality than support for the individuals (Smith & Brown, 1997).

Conventionally-defined family is a key form of social support which gay men, and particularly gay youth, cannot dependably benefit from during or after coming out (Appleby & Anastas, 1998). Conventional family – especially extended family including and beyond the nuclear family – may vary in significance vis-à-vis a sense of "belonging" for Canadians, often depending on their ethnic background or community. One report, for example, underlines that "Families have a big impact on the lives of most gay and bisexual men of the English-speaking Caribbean communities. Many speak of trying to deny their sexual orientation because of the importance of being accepted by their community" (Baxter, Brabazon, Gunter, & Willms, 1994). Tafoya and Wirth (1996) affirm that "For many Native Americans, there is a strong emphasis on the family, and some may be concerned with meeting family obligations...". The role of social support and function of the family (such as shelter in the storm) may take on meanings that are much influenced by ethnicity and community history. Thus the risk involved (of being rejected or excluded) in coming out to families may depend on the role of the family within a cultural context, as is the likelihood of rejecting one's family in the face of being rejected oneself for coming out as gay. Traditional roles of Two-Spirit people such as fostering children of the community (Tafoya and Wirth, 1996) may potentially be drawn on to re-center Aboriginal meanings and traditions of inclusion, respect and worth.

Social support has been shown to be multidimensionally important to those living with HIV, significantly raising well being. Research, for example, shows that the more family members were perceived as supportive, the less likely HIV-positive gay men intended risk-taking behaviors. As well, family availability

for support was more predictive of reduced risky behaviors than the availability of friends. (Kimberly & Serovitch, 1999)

Social isolation (by family members, peers, teachers, and so on) experienced by many gay youth is named in the literature as a significant factor in the high suicide rate and suicide attempt rate among gay and lesbian youth, as well as their higher rates of alcohol and substance abuse, and of homelessness (Grossman & Kerner, 1998; Dempsey, 1994) (Hellquist, 1996; Canadian Public Health Association, 1998) The Lesbian, Gay, Bisexual Youth Project of Nova Scotia (no date) quotes statistics of Hetrick and Martin that 80% of lesbian, gay and bisexual youth report severe isolation problems, including having no one to talk to, feeling distanced from peers and family, and the lack of access to good information about gay, lesbian and bisexual issues. This is particularly significant given that in the general population, adolescents and young adults are most likely of all age groups to report high levels of social support (Health Canada, 1999b). Conventional families (parents, siblings, relatives) of gay youth or men often themselves have little or no support to deal with issues.

Gay men's friendships have been creatively re-drawn as a form of family for gay men and have been key for their survival (Nardi, 1995; Nardi, 1992). In a study of gay and lesbian New Brunswickers, the social support named most by gay youth during the difficulty of coming out was gay friends, followed in importance by non-gay friends (Olivier & Targett, 1993). AIDS organizing within gay communities has made more visible and extended the friendship networks among gay men.

Rejection by conventional families and community networks, including friends, has often been met with attempts to address homophobia and heterosexism in those families and networks. At the same time, and so as to strengthen those efforts, gay youth and men have been re-creating community, family and peer networks for social support, empowerment, political organizing, pleasure and beyond. Community-based organizations structure informal and formal social support.

Community-building efforts are not without their difficulties. As Tafoya and Wirth (1996) note, "...the "Gay community" as not been the community of hope, love and acceptance for many people of color as it has been for many Gay White men". Racism and exotification are found within gay community toward Latinos (Diaz, 1998), as is anti-Semitism (Rofes, 1989).

The literature notes the relation between HIV prevention and social supports, in particular regarding youth: "We know that a gay man's ability to incorporate safer sex relates to high self-esteem, solid social supports, positive sexual identity and belonging to a peer group. Young gay men have serious deficits in all of these areas." (Canadian Public Health Association, 1998; Otis, Ryan, & Chouinard, 1999).

4.4 Education

Education equips people with life skills, allows them to participate in their community, and increases opportunities for employment (Hamilton and Bhatti, 1996). Health status increases with level of schooling and contributes to a sense of control over life circumstances (Health Canada, 1994). In general, people who have completed more years of schooling are healthier and live longer than those with little schooling; education is related to income, occupation and residence, all measures of social status (Bourget, no date).

Educational levels of gay men, as indicated through surveys (with their attendant likely exclusion of more vulnerable gay populations) are consistently high. For example, the Yankelovich Monitor Survey found that over 10% more gays and lesbians than heterosexuals had any college education, and twice as many gays and lesbians undertook graduate level studies. (Lukenbill, 1995) However, according to Martin Levine, “gay men are often unable to convert their educational qualifications into high income and status jobs. Indirect discrimination forces them to cluster in marginal white collar or service jobs” (Levine, 1995). This would contribute to explaining the findings of the Yankelovich Monitor Survey which found that (1) the mean personal and mean household income level of gay men is lower than that of heterosexual men, and (2) less gays and lesbians are employed at the professional/ executive/ managerial level than are heterosexuals. This is despite the significantly higher educational levels found among gays and lesbians, statistically; such levels of education are “usually linked to substantially higher income levels as well as employment at the professional/executive level” (Lukenbill, 1995).

As gay men are present across the population spectrum, one should not presume basic or functional literacy levels comparable to the general population. However, there is little or no literature found regarding this, pointing to future research in the area. Low literacy skills among the population in general are high and a major social and economic problem.

Generally, schools are hostile environments for gay, lesbian and bisexual youth (Canadian Public Health Association, 1998; Lesbian, Gay, and Bisexual Youth Project of Nova Scotia, no date; Flynn Saulnier, 1998). Discussion of gay and lesbian sexuality has been slow to enter the curricula of Canadian schools; when it does, such discussion often faces opposition from religious organizations associated with the political Right (McKay, 1998). Such hostility, due to homophobia and heterosexism, ranges from verbal abuse to physical violence (Dempsey, 1994).

The effects of homophobia and heterosexism in school environments contribute to:

- many lesbian, gay, and bisexual adolescents dropping out of school because of harassment (Dempsey, 1994; Lesbian, Gay, and Bisexual Youth Project of Nova Scotia, no date), harassment that is often allowed and in some cases encouraged by teachers or staff (Flynn Saulnier, 1998);
- many queer adolescents becoming street-involved and homeless;
- high suicide rates and attempted suicide rates (Coalition for Lesbian and Gay Rights in Ontario, 1997; Flynn Saulnier, 1998; Hellquist, 1996);
- internalized homophobia, shame and low self-esteem (Canadian Public Health Association, 1998; Kaufman & Raphael, 1996; Otis et al., 1999).

Efforts by gay organizations, gay youth, and their allies to change school environments (through organizing student groups; workshops for staff, teachers, students; queer students organizing to effect policy changes in education; and so on) have been courageous and inspirational (Canadian AIDS Society, 1998). Notwithstanding the courageous risks taken, particularly by queer youth, they meet tremendous obstacles and the effects of their work do not appear to be strongly considerable nor widespread (Vaid, 1995). Gay teachers may hesitate to come out (or be stronger allies in the work) because, much like pediatricians, for example, they face the risk of being perceived within heterosexist myths as child molesters (Flynn Saulnier, 1998; Appleby & Anastas, 1998). The positive impact that gay teachers may

have on gay youth as role models to widen the range of possibilities seen available, as well as the importance of all teachers as allies of gay youth to whom they can “open up” are underlined (Unks, 1995; McLaren, 1995; Blumenfeld, 1995).

Several note the importance of the career training and ongoing professional development of school teachers, administrators, support staff, school guidance counselors, policy developers, and others who work in or with schools regarding addressing homophobia and heterosexism (McLaren, 1995; Rofes, 1995; Canadian Public Health Association, 1998). However, nothing is found in the reviewed literature on the issue of inclusion of sexual orientation issues, such as effectively responding to homophobia and creating safe environments, within the curricula of various Canadian faculties of education, pointing toward future research in the area.

4.5 Employment/Working Conditions

In general, people who have more control over their work circumstances are healthier. Workplace social support is associated with health, as are safe and healthy work settings. Unemployment is associated with poorer health. (Health Canada, 1994)

It is widely discussed in the literature that gay men and lesbians in North America both fear and experience discrimination at the workplace on the basis of their minority sexual orientation (Clarke, 1994; Canadian Labour Congress, 1994; Sussel, 1994; Levine, 1995; Anastas, 1998; McNaught, 1993; Zuckerman & Simons, 1996; Brooks & Klosinski, 1999; Terry, 1992; Appleby & Anastas, 1998). Almost all of the literature on discrimination on the basis of sexual orientation at work is based on white American people of European background, which poses a serious limitation on the knowledge available (Anastas, 1998; Appleby & Anastas, 1998).

“Discrimination against gay, lesbian and bisexual people in employment is a form of violence that denies them full participation in essential social and economic activities and institutions, perpetuates economic injustice, and reduces their opportunities for fulfilling human potential.” (Anastas, 1998)

Forms of workplace discrimination based on sexual orientation include:

- not being hired (Anastas, 1998; Levine, 1995)
- being fired (Anastas, 1998; Levine, 1995)
- not being promoted (Levine, 1995)
- lack of anti-discrimination policy at work (Anastas, 1998)
- lack of legal protection from discrimination at work (Anastas, 1998; Zuckerman & Simons, 1996)
- harassment (verbal, written, threats, physical, etc.) on the job (Appleby & Anastas, 1998), including the possibility of indirect harassment such as workplace chill
- lack of employment benefits for partners (Anastas, 1998)
- pressure to hide one’s minority sexual orientation (Anastas, 1998; Zuckerman & Simons, 1996)

- gay men being subject to discrimination and phobias related to HIV (Anastas, 1998; Zuckerman & Simons, 1996; Levine, 1995)
- indirect discrimination', which can include gay men avoiding jobs in which they anticipate victimization and instead choosing fields in which they feel they are tolerated, often below their educational qualifications (Levine, 1995).

Some types of work, for example, school teaching and pediatric work, bear more anti-gay fear and discrimination than others (Flynn Saulnier, 1998; Appleby & Anastas, 1998).

Simultaneous forms of work(place) discrimination feared or experienced by gay men include:

- for gay men of colour, racism may be perceived as more of a problem to them than sexual orientation, largely because the latter may be more successfully concealed (Anastas, 1998; Appleby & Anastas, 1998);
- for Aboriginal Two-Spirits, relative high unemployment (Health Canada, 1999b) compounds considerations of discrimination on the basis of sexual orientation in employment: little or nothing is found as literature on this;
- for gay men who have mental or physical disabilities, there is possible compounded discrimination: little or nothing is found among the literature about this;
- for transgendered gay men, and for transgendered people more generally, problems experienced especially at the point of hiring may be more acute (Anastas, 1998);
- for gay men who are recent refugees or are recent immigrants, particular vulnerability regarding employment may be the case: little or nothing is found as literature about this;
- for gay men who are HIV positive who are either working or wanting to return to work (Brooks & Klosinski, 1999). For example, employment insurance is not in tune with the employment pattern realities of gay men living with HIV; as well, the forbidding cost of pharmaceutical drugs often forces them into leaving their work for subsistence-level social assistance (Clarke, 1994);
- for gay men doing sex work, its criminalization means that they lack basic rights and protections regarding their working conditions, for example: those who are abused or assaulted by customers are less able to report it; and criminalizing sex work makes it more difficult for sex workers to insist on condom use with their customers (Allman, 1999).

The Yankelovich Monitor Survey found that gays and lesbians are more likely than heterosexuals to be self-employed (Lukenbill, 1995). This may be one inventive strategy of gays and lesbians to deal with fear and the reality of homophobia and heterosexism at the workplace. However, self-employment does not provide benefits or a pension. (Health Canada, 1999b) Nothing is found in the reviewed literature on how self-employment may impact, whether positively or negatively, on the health and well-being of gay men.

The literature focuses on: (1) discrimination feared or experienced by gay men (see above), and (2) strategies to overcome such discrimination (Zuckerman & Simons, 1996; McNaught, 1993; Canadian Labour Congress, 1994; Canadian Labour Congress, 2000; Canadian Labour Congress Lesbian and Gay

Working Group, 1999). It is notable that it is gay men and lesbian who are driving such initiatives within labour organizations. There is little, however, in the literature that focuses on how gay men can thrive through work or achieve optimal well-being through their workplace situations or careers.

Canadian women bear a disproportionate amount of unpaid work, such as housework, child care and providing care to seniors. (Health Canada, 1999b) There is a possibility that gay men may also disproportionately carry out unpaid work, particularly in the form of care giving, and especially to other gay men living with HIV, and to seniors. Older parents or relatives may expect gay men, (mis)perceived as having “less responsibilities” and more time, to be more active in care giving and unpaid work. There is nothing in the reviewed literature about this possibility, pointing to possible future research.

Given the high levels of perceived and experienced job discrimination, it is possible that myths regarding gay men as “well-to-do”, fueled by targeted marketing and publicity strategies to gay communities, may leave many gay men with a sense of exclusion or internalized shame and sense of isolation related to not “living up to” the image of what they are purportedly supposed to be. Such a situation of exclusion is likely intensified for gay men of colour, as white men are firmly centered in the “gay man as well-to-do” media-driven myth. In the context of HIV prevention, for example, the literature discusses the high possibility that this sense of exclusion experienced by Black gay men from dominant media portrayals of gay men as both white and well-to-do results in discounting the media messages, particularly among those Black gay men of less privileged socio-economic backgrounds, who are often more emotionally and behaviorally distant from white communities (Cochran & Mays, 1995).

Issues of employment and working conditions of gay men living with disabilities or chronic illness, including due to the effects of living with HIV, are infrequent within the reviewed literature (Brooks & Klosinski, 1999; Coalition for Lesbian and Gay Rights in Ontario, 1997). In general, the wider literature includes first person accounts by physically-disabled gay men (Fries, 1998), and within the reviewed literature only one report included any significant reference to gay men with disabilities; this Ontario study reported that among gay men with a disability or chronic illness, only 43% were employed and 79% were receiving social assistance (Coalition for Lesbian and Gay Rights in Ontario, 1997).

Exploration of the issue of gay men experiencing disability and unemployment due to mental health issues is surprisingly absent within the reviewed literature.

Continuing high rates of unemployment or underemployment among youth, among adults with low levels of schooling, and among people living in certain regions in Atlantic Canada are related to health disadvantages for people in these groups. (Health Canada, 1999b) As gay youth and men are present across the population spectrum and across Canada, efforts to address such high unemployment or underemployment would ultimately impact on gay men’s health. As well, a more equitable approach to Employment Insurance would likewise seem to benefit gay men’s health, especially given discrimination at the workplace and its effects, and the way the present EI is out of synch with the employment patterns of people living with HIV.

4.6 Social and Physical Environments

While social environment and physical environment are usually presented as two different determinants of health within Health Canada policy, the two environments are combined here into one determinant of health. This is primarily because of their interconnectedness, and in particular, the social construction of physical space and the physical aspects of social space.

For example, homophobia and heterosexism have historically contributed to the development of physical spaces for and by gay men and men who have sex with men, including public spaces that afford relative anonymity and privacy in sexual relations (including parks, public bathrooms, and so on). Gay youth may not have access to privacy nor the affirmation within their family's home to express homoerotic relationships,

As well, in developing local gay cultures that address homophobia and heterosexism, gay men have contributed to constructing social space – relatively safe spaces, “breathing spaces” – often through small and medium-size commercial ventures, particularly in urban centres, including bars, saunas, cafés, and restaurants, yet also through community centres, community organizing for housing space, and initiatives within cyber-space. These are social/physical environments created for self and community affirmation, though they may not be affirming of all, including those of minority ethnic and racialized communities, transgendered people, and Two-spirit people.

Within the Population Health literature, social environments conducive to well-being are usually taken to be those that are economically stable, characterized by strong social support networks, free of violence (at school, within the nuclear family, and within communities), and discrimination (such as sexism, racism, ageism), and cohesive with high levels of community “caring”, volunteerism, and civic participation (Health Canada, 1994; Bourget, no date; Health Canada, 1999b).

Suzanne Jackson (1994) notes that the City of Toronto Department of Public Health, defining the Determinants of Health within five categories, includes “Political well-being” as one of the five categories. Political well-being explicitly refers to: increased equity in power; increased opportunities for political participation by relatively powerless groups; and personal/community safety and security (Jackson, 1994). Political well-being is posited here as integral to an optimum social environment for health, and dovetails with civic participation.

Gay and lesbian communities, and especially overlapping community-based mobilizations focused on AIDS-related issues, have significantly contributed to their political well-being as courageous actors through social movements (Vaid, 1995; Adam, 1997). Such social movements, seen through a lens of political process, can be characterized as “rational attempts by excluded groups to mobilize sufficient political leverage to advance collective interests through non-institutionalized means.” (McAdam, 1982, quoted by Adam, 1997)

Stated somewhat ideal-typically, a fundamental aim of the AIDS movement is to democratize the struggle against AIDS, to promote “health from below” (Sears, 1991; Adam, 1992b) by mobilizing affected communities to take measures against the transmission of HIV, and to provide care for those suffering from it. (Adam, 1997)

In this sense, gay men and their allies have historically been constructing social environments for increased health and well-being through their mobilization as political actors.

Within the Population health literature, physical environments typically refer to such factors as: exposure to airborne contaminants and environmental toxins (such as second hand tobacco smoke and the by-products of burning fuel); housing and its affordability; climate change and environmental hazards in the food supply and water quality; as well as the safety of communities, particularly in the design of such features as schools, housing, workplaces and roads (Hamilton & Bhatti, 1996; Health Canada, 1999b; Health Canada, 1994). Again, when considered in relation to gay men's health, the physical environment is intimately related to the social environment.

As has been discussed, gay men and particularly gay youth are especially vulnerable regarding social support networks; with resilience and determined creativity, gay men have both challenged mainstream social support networks to improve, and at the same time have redefined significant alternative social support networks. Despite these efforts, social support cannot be characterized as strong, which would appear to bear significantly on the gay men's health and well-being.

Gay men live in a multiplicity of social environments: rural, urban (suburban and inner city), on reserve and off, in northern communities and southern communities. It would seem that while these social environments may share discrimination and oppression of gay men, their expression of it, as well as its likely intensity may be different. In rural areas or small towns, there is perhaps less likelihood of a geographic gay community to "breathe" in, usually less privacy available for those gay men trying to hide their sexual orientation, and fewer gay-specific services (Ryan, Brotman, & Rowe, 2000).

Gay bashing, or violence against gay men (and those perceived to be gay men), as an overt expression of homophobia, is part of North American life, particularly for gay youth, for whom family violence is especially significant (Dempsey, 1994). The Results of Ontario's Project Affirmation survey showed that 22% (270 people) reported that they had been physically assaulted; 73% of them were gay or bisexual men, and 80% of the assailants were men (Coalition for Lesbian and Gay Rights in Ontario, 1997). Transgendered gay men may be especially vulnerable to gay bashing; as well, gay men of colour and Aboriginal Two-Spirits may experience bashing due to xenophobia and racism, or due to homophobia, or because of both. Gay men appear to be reluctant to report violence inflicted upon them to the police, for fears of not being taken seriously, of being "outed", or of further homophobic mistreatment or violence (Coalition for Lesbian and Gay Rights in Ontario, 1997).

There has been relatively little research found within the reviewed literature on violence within gay and lesbian couples; as well, services and mainstream institutions appear to have been relatively unresponsive to conjugal violence among gay and lesbian couples (Meyer & Cormier, 2000; Renzetti, 1997). No accurate comparative research appears to exist vis-à-vis the relative frequency of queer conjugal violence to heterosexual conjugal violence. One can say that gay and lesbian conjugal violence occurs, and that once it occurs it is likely to reoccur and to become increasingly severe over time. Gay male victims of domestic violence who are living with HIV or AIDS may be particularly vulnerable, as significant financial and caring dependence may increase their difficulty in leaving their batterers (Renzetti, 1997).

As well, the reviewed literature indicates that the violence of having been sexually assaulted as a child, and its repercussions, may be experienced disproportionately by gay men. This is linked, within the reviewed literature, to a greater vulnerability regarding HIV transmission. (Dorais, 1997; Getty,

Allen, Arnold, Ploeme, & Stevenson, 1999) Among the reported incidents of male-male sexual assault, most are perpetrated by heterosexual men against gay men or youth (Coalition for Lesbian and Gay Rights in Ontario, 1997).

While gay men have challenged discriminatory social environments, they have also attempted to create their own social/physical environments, whether as a bar, as circuit parties, as community-based organizations, or as geographic communities. Commercial spaces (such as bars, clubs, and other businesses, etc.) are often significant social environments where gay men meet and connect (Vaid, 1995). They have historically been, and at times still are, the safest place for gay men, at least those of dominant social groups, to socialize.

The social cohesion of gay communities has historically been significantly ruptured and eroded by AIDS-related deaths (Rofes, 1996). This is regardless of whether the AIDS crisis may have at the same time contributed to mobilizing gay communities, particularly into service organization networks and political action, though this ambivalently-named 'silver lining' of the AIDS crisis has not been experienced by all gay communities (Lavoie, 1998).

The cohesion, sustainability and development of gay communities and their efforts to address health issues effectively would be augmented by more consistent government funding of community organizations and of their programs, as well as by greater collaboration among various types and levels of government (Winnipeg Gay/Lesbian Resource Centre, 1998).

The social environments of gay men of colour, and gay men of minority ethnic backgrounds, may (also) be predominantly communities other than gay; they may be a Black, Jewish, South Asian, or Vietnamese community, each characterized by a wide diversity of members; alternatively, the social environment may be the space on the margins of both an ethnically-based community and a gay community. (Takagi, 1996; Cohen, 1996)

Physical environments, particularly in North American urban settings, which gay men have constructed as alternatives to, or use as respites from, the generalized heterosexism of the wider heterosexual-dominant community, such as gay bars, cafés, clubs, gyms, saunas, bookstores and so on, carry their particular health benefits and health risks.

The 'gay commercial scene' provides many benefits for gay men. Simultaneously, however, it may, for example, contribute to significantly higher rates of cigarette smoking among gay and bisexual men. One American study, using data from the early 1990's and gay bar sampling methods, found that within their combined samples 47.8% of gay men currently smoked cigarettes, compared to the 28.6% prevalence rate for smoking among the total population of U.S. men (Stall, Greenwood, Acree et al., 1999). Those working within gay bar environments, such as bartenders, dancers, and waiters, would logically seem to be at a significant health risk due to 'second-hand' cigarette smoke, though this is not raised within the reviewed literature.

While beneficial to many, social environments such as bars and dance clubs may simultaneously be sources of concern because of the often overwhelming presence of alcohol and significant chemical substance use (Lewis & Ross, 1995). Studies show that gay men experience alcoholism and drug abuse problems at a rate at least three times higher than the general population (Hellquist, 1996); this may be

attributed to the effects of living with homophobia and heterosexism and seeing drugs as a way, at least temporarily, to escape such harsh realities and gain an expanded sense of control (Lewis & Ross, 1995).

While few publications are found on the extent and effects of recreational drugs, for example at gay circuit parties (Lewis & Ross, 1995), Aggleton (1999) warns against making unsubstantiated extrapolations about drug use and its effects on safer sex from one cultural context or scene to another (for example, Australia to England to the U.S.); further research is suggested. Rofes (1998) warns against what he sees as a middle-aged American gay age-ist backlash to "circuit party muscle boys" (including scapegoating them as the irresponsible transmitters of HIV within gay communities) and urges an exploration of the benefits of circuit parties and a more balanced view.

Gay commercial environments, for example, bars and circuit parties, may also significantly inscribe images, stereotypes and perhaps standards of gay male beauty (such as the predominant "straighter than straight, muscle boy" look) that alienate many gay men who do not conform to them or who refuse to conform to them. Such stereotypes of gay male beauty have been seen as resulting from internalized homophobia, and can cause significant feelings of exclusion and contribute to the significant erosion of self-esteem among those who don't measure up (Feraios, 1998; Lewis & Ross, 1995). Within U.S. large urban centres, Rofes (1998) seems to suggest that instead of critiquing the culture of "buff boys" and the commercial spaces that support them, there be a broader recognition of the diversity of commercial spaces present, each often with its uniquely predominant body fashion or style, and that gay men take advantage of that diversity.

Gay-identified commercial spaces, particularly bars and clubs, are not necessarily spaces safe from police repression and criminalization, with its attendant detrimental effects on the well-being of gay men. Canadian examples include the February 1994 police raid and mass arrest at the popular Katakombs bar/KOX dance club (Remiggi, 1998), as well as a more recent 1999 police raid of the Bijou, a Toronto-based gay bar, video and sex establishment.

Particularly in smaller towns, bars may be the only entry point for young gays and lesbians into the gay community, and contribute to the importance of such commercial venues. Within some communities, given the relative safety that such venues provide for socializing, it may be that there are simply not any or not enough of such venues. However, at the same time, these venues may also encourage a focus on activities that have a heavy emphasis on alcohol (Flynn Saulnier, 1998; Hellquist, 1996).

Gay men experience significant discrimination regarding accessibility to accommodation and housing, according to one study done using a sample of 180 individuals advertising rooms or flats for rent in Windsor and London, Ontario, as well as in Detroit, Michigan. Upon hearing of the gay sexual orientation of the person looking for a room or flat, a large number of advertisers claimed that it was no longer available (Page, 1998).

Senior housing, residences for the elderly, and support services for older gay men within their own apartments or homes, appear to be characterized by discrimination based on sexual orientation and a general unresponsiveness to the needs of senior gay men (Hamburger, 1997).

Sexual orientation is a major factor for youth being and staying on the streets and homeless, with accompanying risks to health and well-being (Dempsey, 1994; Canadian Public Health Association,

1998; Davey et al., 1999). Shelters are felt by many gay youth as unsafe because of a homophobic atmosphere (Canadian Public Health Association, 1998).

Injection drug users living in poverty, as well as gay men and gay youth, are at times overlapping populations. For example, collaboratively addressing the lack of affordable and safe housing as a health factor has been part of a HIV prevention strategy among injection drug users within Vancouver's downtown east side (Health Canada, 1998b; Eades & Kort, 1996).

Physical environments, both gay-specific and general, are often physically inaccessible to disabled gay men, limiting community participation and personal well-being (Coalition for Lesbian and Gay Rights in Ontario, 1997).

Cyber-space as an emergent social/physical environment of gay men and youth is relatively unexplored within the reviewed literature. The use of web sites by gay, lesbian, and bisexual organizations remains to be further developed (Central Toronto Youth Services, 1999). The use by gay men of web sites, as well as internet-based chat rooms and bulletins boards, poses questions regarding the impact on the health of gay men, including that of exacerbated isolation, on the one hand, or of reduced isolation for gay men and youth of rural regions, on the other. However, such questions and their examination are absent within the reviewed literature and beckon research.

The social/physical environment of prisons within the lives of gay men, including gay youth, Two-Spirit, and those of minority cultural, ethnic or racialized communities, is surprisingly absent within the reviewed literature. Implications of prison environments for the health of gay men are significant, given noticeably high rates of assault, including sexual assault, in prison against gay men, yet such violence appears to be overlooked by researchers.

4.7 Personal Health Practices, Coping Skills, and Capacities for their use

In the general Population Health literature, personal health practices are seen as key in preventing diseases (for example: lung cancer, alcohol misuse and its effects, cardio-vascular disease and diabetes) and in promoting self-care. Effective coping skills, along with people's knowledge and intentions, are perceived as enabling people to be self-reliant, solve problems and make choices that increase health. As well, such practices and skills are situated within wider socio-economic determinants that have significant effect on individual practices, choices and skills (Health Canada, 1994; Hamilton & Bhatti, 1996; Health Canada, 1999b). Coping skills are seen as "the skills people use to interact effectively with the world around them, to deal with the events, challenges and stresses they encounter in their day to day lives" (Health Canada, 1994).

Capacities for the integrated and sustained use of personal health practices and coping skills are posited here as key within this determinant of health, as practices and skills are mediated by people and their interaction with the social environment. For example, unequal social power relations constructing interpersonal relations are seen to have a profound eroding effect on the capacity of gay men, particularly of minority ethnic, cultural or racialized communities, to implement healthy practices and coping skills, particularly regarding HIV prevention (Sanitioso, 1999).

The creative and resilient coping skills and resources of gay men, in the face of tremendous obstacles and oppression, have rarely been affirmed as strengths (Aggleton, 2000).

Internalized homophobia, and an accompanying low self-esteem and shame (Allen & Oleson, 1999; Kaufman & Raphael, 1996), among gay men are seen as closely related to an erosion of their coping skills and a weakening sense of effectiveness (Clermont & Sioui-Durand, 1997; Village Clinic, 1998). It is important to qualify internalized homophobia as not necessarily including the reticence to desire to a gay identity. For example, some African-American gay men's reticence to identify as gay may have little to do with internalized homophobia, and much to do with racism experienced within white-identified gay communities (Sears, 1995). As well, gay Asians within the Australian context, for example, may not identify with gay communities because of racist attitudes or discriminatory behaviors within those communities (Sanitioso, 1999).

In the literature (and particularly the medical literature) on gay men, personal health practices and coping skills, as well as health problems in general, seem to have largely been taken up through a specific concern with sexual behavior, HIV and AIDS (Aggleton, 2000; Jalbert, 1999). More particularly, much of the literature relating to the health of gay men explores personal health practices and coping skills in relation to their effects on high risk behaviors for HIV transmission. Thus, for example, gay men's management of alcohol use and abuse, and of other substance use such as recreational drugs, is typically addressed with the aim of examining its effects regarding high-risk sexual behaviors (Village Clinic, 1998; Lewis & Ross, 1995).

According to Rofes (1998), writing from the American context, a rigid Knowledge/ Attitude/ Behavior practices model to HIV prevention (Radford, 1998) has contributed to gay men perceiving any deviation from rigid guidelines as engaging in "bad" or failed personal health practice and bad coping skills; this is seen as engendering shame, contributing to low self-esteem, among gay men. The general limitations, within the present context, of a KAB model with regard to HIV prevention among gay men is well acknowledged in the literature, and particularly the literature of Canadian and Australian contexts (Adam et al., 2000; Commonwealth Department of Health and Family Services, 1998). This accompanies a generalized movement toward a health promotion approach, and in particular a harm reduction model regarding personal health practices and coping skills.

Taghavi (1999) affirms the importance of gay men using and developing personal skills of health management, including those regarding substance abuse. Some have learned the effective use of those skills; others have not, or have to lesser degrees. Taghavi notes the limited venues available for gay men to learn and develop such health management skills, as well as to gain greater self-esteem and confidence with which to use those skills effectively.

Unequal power relations structuring interpersonal relations are seen to contribute to a lower capacity to use health knowledge and skills effectively. For example, it is useful to cite from a study within the Australian context:

...despite the knowledge, GHAs (gay and homosexually active Asian men) may not be involved in the decision-making or negotiation of sexual activities with their sexual partner, especially in cases where the partner is perceived to be of higher status such as White/Anglo, older, and more experienced. (Sanitioso, 1999)

Addressing gay men's health within the Canadian context, McInnis and Kong (1998) affirm the importance of gay men strengthening a broad range of positive coping skills, especially given the significant effects of homophobia on their health, as well as the loss, by many gay men, of friends and lovers to AIDS. Such skills of coping include: claiming one's gay identity, taking small steps toward health, practicing self-care, finding ways to get support and build community, fighting homophobia and heterosexism when possible, learning ways to express a range of emotions, understanding and recognizing one's anger, and setting boundaries and asking for what one needs (McInnis & Kong, 1998).

4.8 Healthy Child/Adolescent Development

Regarding the general population, positive pre-natal and early childhood experiences have a significant positive effect on eventual health, well-being and coping skills. The quality of such early experiences is influenced by socio-economic determinants; poverty in particular has a wide negative effect. Until more recently, the Population health literature appeared to focus exclusively on pre-natal and early childhood experience as constituting the category of healthy child development, to the exclusion of adolescent or teen experiences (Health Canada, 1994; Hamilton & Bhatti, 1996; Bourget, no date) However, more recently, the literature formally holds the inclusion of teens, adolescents or youth (aged 13 to 18) within the category of child development (Health Canada, 1999b).

Adolescence for gay youth is a crucial time for their health and well-being; it is during this time of development that they are most likely to be dealing intensely with sexual orientation issues in their lives, including resisting and surviving homophobia and heterosexism (Dempsey, 1994).

Restating previous discussions raised by the determinants Social Support Networks, Education, and Social and Physical Environments, the following raises issues of the child/adolescent development of gay youth.

Social isolation (by family members, peers, teachers, and so on) experienced by many gay youth is named in the literature as a significant factor in the high suicide rate and suicide attempt rate among gay and lesbian youth, as well as their higher rates of alcohol and the substance abuse, and homelessness (Grossman & Kerner, 1998; Dempsey, 1994); Hellquist, 1996; Canadian Public Health Association, 1998). The Lesbian, Gay, Bisexual Youth Project of Nova Scotia (no date) quotes statistics of Hetrick and Martin that 80% of lesbian, gay and bisexual youth report severe isolation problems, including having no one to talk to, feeling distanced from peers and family, and the lack of access to good information about gay, lesbian and bisexual issues. This is particularly significant given that in the general population, adolescents and young adults are most likely of all age groups to report high levels of social support (Health Canada, 1999b).

Gay bashing, or violence against gay men (and those perceived to be gay men), as an overt expression of homophobia, is part of North American life, particularly for gay youth, for whom family violence is especially significant (Dempsey, 1994). The Results of Ontario's Project Affirmation survey showed that 22% (270 people) reported that they had been physically assaulted; 73% of those assaulted were gay or bisexual men, and 80% of the assailants were men (Coalition for Lesbian and Gay Rights in Ontario, 1997).

Generally, schools are hostile environments for gay, lesbian and bisexual youth (Canadian Public Health Association, 1998; Lesbian, Gay, and Bisexual Youth Project of Nova Scotia, no date; Flynn Saulnier, 1998). As young people appear to be self-identifying at earlier ages, such a situation becomes even more critical. Discussion of gay and lesbian sexuality has been slow to enter the curricula of Canadian schools; when it does, such discussion often faces opposition from religious organizations associated with the political Right (McKay, 1998). Such hostility, due to homophobia and heterosexism ranges from verbal abuse to physical violence (Dempsey, 1994).

The effects of homophobia and heterosexism in school environments contribute to:

- many lesbian, gay, and bisexual adolescents dropping out of school because of harassment (Dempsey, 1994; Lesbian, Gay, and Bisexual Youth Project of Nova Scotia, no date; Magnuson, 1992), harassment that is often allowed and in some cases encouraged by teachers or staff (Flynn Saulnier, 1998);
- many gay adolescents becoming street-involved and homeless (Dempsey, 1994; Canadian Public Health Association, 1998; Davey et al., 1999);
- high suicide rates and attempted suicide rates (Coalition for Lesbian and Gay Rights in Ontario, 1997; Flynn Saulnier, 1998; Hellquist, 1996);
- internalized homophobia, shame and low self-esteem (Canadian Public Health Association, 1998; Kaufman & Raphael, 1996).

Racism, and its devastating effects, within school environments are similarly affirmed within the reviewed literature as contributing to the diminished health of gay youth (Sears, 1995; Monteiro & Vincent Fuqua, 1995).

Efforts by gay organizations, gay youth and their allies to change school environments (through organizing student groups; workshops for staff, teachers, students; queer students organizing to effect policy changes in education; and so on) have been courageous and inspirational (Canadian AIDS Society, 1998). Notwithstanding the courageous risks taken, particularly by queer youth, they meet tremendous obstacles and the effects of their work do not appear to be strongly considerable nor widespread (Vaid, 1995). Gay teachers may hesitate to come out (or be stronger allies in the work) because, for example, they face the risk of being perceived within heterosexist myths as child molesters (Flynn Saulnier, 1998); Appleby & Anastas, 1998).

Sexual orientation is a major factor for youth being and staying on the streets and homeless, with accompanying risks to health and well-being (Dempsey, 1994; Canadian Public Health Association, 1998; Davey et al., 1999). Shelters are felt by many gay youth as unsafe because of a perceived homophobic atmosphere (Canadian Public Health Association, 1998).

The literature notes the relation between HIV prevention and social supports (Otis et al., 1999), in particular regarding youth: "We know that a gay man's ability to incorporate safer sex relates to high self-esteem, solid social supports, positive sexual identity and belonging to a peer group. Young gay men have serious deficits in all of these areas. For many young homosexuals, coming to terms with being gay is a difficult period. HIV prevention is only of secondary importance." (Canadian Public Health Association, 1998)

As well, the reviewed literature indicates that the violence of having been sexually assaulted as a child, and its repercussions, may be experienced disproportionately by gay men (Dorais, 1997; Getty, Allen, Arnold, Ploeme, & Stevenson, 1999). Most reported child assaults against gay youth are perpetrated by heterosexual men (Coalition for Lesbian and Gay Rights in Ontario, 1997). The reviewed literature links the experience among gay and bisexual men of having been assaulted as a child to greater vulnerability regarding HIV transmission (Dorais, 1997; Getty, Allen, Arnold, Ploeme, & Stevenson, 1999).

4.9 Health Services

In the general Population Health literature, the availability of preventative and primary care services is positively related to improved health (Hamilton & Bhatti, 1996). Health services, “particularly those which maintain and improve health, prevent disease and restore health,” contribute to health (Health Canada, 1999a). Be that as it may, health services are conventionally misperceived as having a greater influence on the health of Canadians than many other determinants of health (Bourget, no date).

Equity in opportunities of access by gay men to appropriate health services has been a focus of concern, research and recommendations of several Canadian studies, health resources and reports (Canadian Public Health Association, 1998; Commission des droits de la personne et des droits de la jeunesse, 1996; Jalbert, 1999; Taghavi, 1999; McInnis & Kong, 1998; Bouchard, 1995; Coalition for Lesbian and Gay Rights in Ontario, 1997; Clermont & Sioui-Durand, 1997; Ryan et al., 2000).

The methodological barriers to inclusion of gay men within health research are raised within the reviewed literature relating to health services. For example, the stigmatization experienced by gay men seriously limits the possibility of conducting research with large, reliable samples representative of their real diversity; this same stigmatization also limits their ability to identify themselves as gay to their health and social service professionals (Ryan et al., 2000).

Homophobia and heterosexism significantly affect the quality of care provided by health care providers within health services. Health practitioners appear insufficiently prepared for interacting effectively with gay clients (Ryan et al., 2000). AIDS seems to have increased the homophobia of certain health care providers, and HIV and homosexuality are intrinsically linked by some health care providers (Jalbert, 1999; Ryan et al., 2000). As well, for gay men,

... coming out or disclosure of one's sexual orientation to one's health care provider appears to result in greater satisfaction with the care received by the patient, but it also results in the health care provider devoting closer scrutiny to issues such as sexually transmitted diseases and AIDS. (Ryan et al., 2000)

Gay men experience both systemic discrimination in the health care and social services systems (for example, regarding service intake forms that assume heterosexuality; homophobic work environments, etc.) and individual prejudice by health professionals. Transgendered gay men, and gay men of minority cultural, ethnic or racialized groups may experience compounded systemic discrimination and prejudice (Coalition for Lesbian and Gay Rights in Ontario, 1997; Taghavi, 1999; Commission des droits de la personne et des droits de la jeunesse, 1996; Ryan et al., 2000).

As well, gay men are often rendered invisible within health care systems; these systems are often perceived as unsafe by gay men and other sexual minorities (Coalition for Lesbian and Gay Rights in Ontario, 1997; Commission des droits de la personne et des droits de la jeunesse, 1996; Ryan et al.,

2000). In addition, the diversity among gay men appears to be often ignored or rendered invisible within health care provision systems (Ryan, English-speaking Focus Group, 2000).

Personal self-esteem, often eroded by homophobia and heterosexism, as well as by other relations of inequity such as racism, is seen to be a factor in access to relevant health care; without self-esteem, gay men "...won't seek out the proper health care, won't feel that they deserve it, don't feel they require it." (Ryan, English-speaking Focus Group, 2000)

The lack of adequate and relevant training of health care providers is a major barrier to the health care of gay men. For example, health care providers do not seem to be trained to collect information necessary to be of assistance to gay men; health care providers also apparently often confound sexual behavior and sexual orientation, and in general appear to be ill-prepared to deal with gay patients. Gay or lesbian health care providers appear to have a better understanding of gay health issues. (Ryan et al., 2000)

The dire lack of funding for the operational costs of gay and lesbian community organizations is a health care problem; these organizations respond to health services for gay men and lesbians in alternative, community-based ways that increase their health and health conditions (Commission des droits de la personne et des droits de la jeunesse, 1996).

Recommendations to address issues such as those named above include:

- Appropriate training and education for health care providers; they are generally seen as open to such training and education (Jalbert, 1999; Coalition for Lesbian and Gay Rights in Ontario, 1997; Commission des droits de la personne et des droits de la jeunesse, 1996). Professional schools across Canada should:

...recognize that lack of training on issues related to glbt-s (gay, lesbian, bisexual and Two-spirit) health has further marginalized (them) and led to them being in situations of greater health risk (...) and that this be redressed through course content, research and consultation with these communities. (Ryan et al., 2000)

As well, the continuing education of health care providers and professions should be bolstered through relevant programs such as that of the Ministry of Health and Social Services of Québec (Ryan et al., 2000);

- Policies and procedures in all sectors that recognize homophobia, heterosexism, biphobia and transphobia as systemic forms of oppression that must be dealt with pro-actively (Coalition for Lesbian and Gay Rights in Ontario, 1997; Ryan et al., 2000);
- Structures and institutions that support health care systems (such as government and those who set policy, professional associations, post-secondary educational institutions) must stop ignoring gay and other sexual minority communities and work with and for them (Coalition for Lesbian and Gay Rights in Ontario, 1997); Jalbert, 1999; Clermont & Sioui-Durand, 1997);
- Specific or tailored services are required for effectively responding to the unique health and social service needs of gay men and lesbians within the health care system (Commission des droits de la personne et des droits de la jeunesse, 1996; Clermont & Sioui-Durand, 1997; Ryan et al., 2000; Ryan, English-speaking Focus Group, 2000);
- Mainstream agencies must make themselves "safe" places for gay men and be "gay-positive" (Ryan, English-speaking Focus Group, 2000);

- Health care systems must recognize the expertise of community service organizations and groups of gay and lesbian communities (Clermont & Sioui-Durand, 1997);
- Better coordination and collaboration between health care systems and gay and lesbian community organizations are required (Commission des droits de la personne et des droits de la jeunesse, 1996);
- The federal government should play a key role in the articulation of best-practice with regards to the health and well-being of gay men, including bringing recommendations for adapting services, “assisting institutions and providers through the development of training programs, guides and other materials (...) which can be applied across jurisdictions”, and supporting research initiatives and demonstration projects addressing health care access issues and service delivery (Ryan et al., 2000). A recent focus group on gay men’s health noted that the participants:

emphasized the importance of government involvement in the broader determinants of gay men’s health, not only in the area of HIV/AIDS. Members stated that health strategies and policies for gay men must be effective, inclusive, and empowering. (Ryan, English-speaking Focus Group, 2000);

- Gay and lesbian community organizations, as well as women’s centres, should receive more extensive funding from government health departments and structures (Commission des droits de la personne et des droits de la jeunesse, 1996);
- The diversity among gays, lesbians and other sexual minorities should be taken into account, further explored and addressed as integral to improving health care access and services (Clermont & Sioui-Durand, 1997; Jalbert, 1999; Ryan et al., 2000):

...it is important to recognize the interconnectedness of different forms of oppression, and not to assume a homogeneous gay population, when looking at gay men’s access to health care. (...) power and privilege... need to be addressed... when we’re looking at health and how people are able to be healthy (Ryan, English-speaking Focus Group, 2000).

4.10 Gender

In the general Population Health literature, there are fewer references to gender as a Health determinant, as it appears to be a more recent, “emergent” category. Gender is seen as the kinds of roles and behaviors that society expects from the two sexes, as characterized by differences in power and influence assigned by society. Women are consistently undervalued and fewer women have been able to achieve political, social and economic equality with men. Women are more likely to live in poverty and to be vulnerable to sexual and physical violence. The behaviors and roles of men have an effect on their health; for example, higher rates of alcoholism and reckless driving have a negative impact on men’s health. (Bourget, no date)

Homophobia, as “a weapon of sexism,” is seen as a foundation, along with violence and economic oppression, for keeping sexism (men’s control over women) solidly in place (Pharr, 1997). Addressing homophobia and heterosexism is thus key for effectively transforming gender inequity toward improving the health and well-being of women. Conversely, sexism sustains and props up homophobia and heterosexism; challenging sexism thus appears as key for effectively challenging homophobia and heterosexism. This has practical implications, for example, “*To discuss funding for gay men’s health programs without noting the profound imbalance of resources directed at lesbian health services would be unethical. Mixed*

lesbian and gay community centers and health centers rarely distribute resources equitably between genders..." (Rofes, 1998)

Homophobia and heterosexism limit the roles of both men and women in Canadian society (Winnipeg Gay/Lesbian Resource Centre, 1998)

Dominant concepts of masculinity are constructed through sexism and firmly entrench heterosexual orientation; gay youth and men hence are almost inevitably faced with a difficult questioning of the legitimacy of their masculinity, which may lead to shame, a sense of failure, and internalized homophobia.

Dominant Western gay culture, in its transformation over the past twenty years, appears to have re-positioned conventional appearances of masculinity ("straighter than straight", "college athlete", "muscle boy") as a cultural norm, whether in a spirit of irony or not. Re-inscribing conventional forms of masculinity, for example with regard to body image, may be related to a generalized anxiety among gay men of not wanting to appear "sick" during an era of HIV and AIDS, or wanting a (magical) sense of being immune to HIV infection. Eroticizing conventional forms of masculinity in dominant North American gay culture (for example, through gay pornography, erotic art, and commercial publicity and media) is the norm, with an accompanying reification of its "obvious" superiority and desirability (Lewis & Ross, 1995) (Feraios, 1998). The effects on health of re-inscribing dominant forms of masculinity (both its possible benefits and its risks) appear to be little explored in the literature found.

The lives and perspectives of Two-Spirit people (incorporating two genders and gender roles) generally benefit from traditions of being positively valorized among Aboriginal nations and communities, though such traditions have been more recently influenced by colonialism (Tafoya & Wirth, 1996; Tafoya & Roeder, 1995; Tafoya, 1989; Brown, 1997). As well, the lives and perspectives of Two-Spirit people may contribute to a positive rethinking of sexual orientation and its relation to transgendered issues within dominant gay communities.

Transgendered gay men may deal with specific issues of disrespect, as well as exclusion, within dominant gay communities, and within the wider society (McInnis & Kong, 1998); gender identity issues are integral to issues of gay health.

4.11 Culture

Culture as a Determinant of health within Canadian Population Health policy is usually taken as having to do with "multicultural health issues" (Health Canada, 1999a) associated with minority ethnic, cultural and racialized population groups of Canada. Such issues are seen as demonstrating how essential it is to consider the interrelationships of physical, mental, spiritual, social, and economic well-being (Health Canada, 1999a).

Taking culture in a wider, more dynamic sense means simultaneously noting and interrogating the cultures, values, social relations and institutions of dominant Canadian ethnic and racialized groups (such as white Anglo-Saxon Protestant groups across Canada, and white French Canadian Catholic within Québec and Acadie particularly), and their effects on gay men of a diverse range of cultural backgrounds

and their health. For example, dominant Canadian cultures may be critically interrogated with respect to their:

- deep cultural assumptions of heterosexism and homophobia, often grounded in and justified by Christian discourses appealing to purity, virtue, restraint and protection of the nuclear family;
- Western liberal political values of individualism, individual human rights, and a naturalized view of competing “interest groups”, as well as a trend within Canada to move from a religious frame of moral vision to one based on the rights of individuals;
- significant collective histories and frames of reference of both racism and colonialism.

The impact on gay men and their communities might be seen contradictory, for example:

- the rise of gay communities and movements as (predominantly) interest groups within the wider political arena;
- sustained heterosexism and homophobia within everyday life and in key institutions such as schools, and significant violence and internalized oppression, yet increasing legal protection of individual rights related to sexual orientation;
- the reproduction of racism and ethnocentric frames of reference within dominant gay communities and cultures (McInnis & Kong, 1998; Eenam Park Hagland, 1998).

As well, taking into account cultures of various minority North American, and particularly, Canadian ethnic, cultural and racialized groups means examining their living, dynamic transformation with, against, and “beside” the dominant cultures – as well as corresponding effects on a wide range of gay men and their health. People of minority ethnic, cultural and racialized groups are often seen as, for example:

- valorizing family and extended family, community of origin, and at times the value of local religious institutions (church, mosque, synagogue, temple, etc.), to a greater degree and in a different way than people of dominant cultural groups ;
- seeking “refuge from the storm” (of everyday experienced racism and ethnocentrism from people of dominant groups) and enjoyment within their networks and communities of origin;
- possibly more likely to be dealing with issues of economic hardship and unemployment (Icard et al., 1992; Cohen, 1996);
- often benefiting from histories of resistance and struggles;
- living in or at the margins of more than one community or culture, as well as dynamically bridging and negotiating various cultures (Takagi, 1996; Cohen, 1996); Ridge, Hee, & Minichiello, 1999).

The impact on gay men of minority ethnic, cultural and racialized groups and their communities of origin might be seen as, for example:

- coming out as gay often implies a much stronger risk: that of losing supports within the community of origin by its rejection or alienation; the risk is not necessarily due to greater homophobia within those communities but rather due to the importance of those communities of origin to the gay person's well-being, sense of survival and integrated identity;

- coming out as gay is usually considered within the framework of its possible repercussions for the whole family, as situated within its community of origin, which implies a greater responsibility and risk associated with coming out (Baxter et al., 1994);
- often bringing to bear histories of struggle and resistance to an interpretation of heterosexism and homophobia;
- often bringing to bear a sensitivity to the racism or xenophobia of members of dominant groups;
- often struggling with internalized oppression (for example, due to racism, due to heterosexism) due to the strength of the dominant cultures' self-infatuation and ethnocentrism (Chuang, 1999; Diaz, 1998) and difficult issues of being pushed to choose allegiances or affinities with one community or the other (Cho, 1998; Icard et al., 1992).

In addition, gay men and communities have developed a multiplicity of cultures which may, at times, share common elements associated with dominant Western "gay culture" (Rofes, 1998). Significant cultural issues, in addition to those discussed within the previous sections of Social Support Networks, and Social and Physical environments, may include:

- the replication of dominant values, images, and institutions within dominant gay cultures by those people who are of the most powerful social groups (economically, etc.); the gay commercial scene may typically exacerbate this, as it usually caters to those who can both "pay more" and "more consistently pay";
- addressing dominant gay cultures in ways that affirm them (for example, the benefits of circuit parties and of the dominant gym culture), and yet also simultaneously interrogating them from perspectives critical of a patronizing age-ism, ethnocentrism, as well as sexism (Rofes, 1998);
- building cultures which draw on the strengths, resilience and histories of gay men;
- the development of different experiences in more isolated and rural regions, as compared to the large urban centres.

First Nations, Inuit and Aboriginal contexts (whether northern, southern, rural, urban, on reserve or off reserve) include a diverse range of cultures and cultural dynamics, with which Two-Spirit males interact and to which they contribute (Tafoya & Wirth, 1996).

4.12 Biological and Genetic Endowment

In the general Population Health literature, the basic biology and organic makeup of the human body are seen as fundamental determinants of health; "Inherited predispositions influence the way individuals are affected by particular diseases or health problems" (Health Canada, 1999a).

The health of gay men would appear, much like that of anyone else of the general population, to be influenced by inherited predispositions which may affect health. Be that as it may, it would seem that any discussion of how such inherited predispositions among gay men might be different or similar to those of heterosexual men is overdetermined by the history of heterosexism and homophobia within Western societies.

In particular, gay men have been the object of oppressive scientific discursive and other practices which have historically medicalized them, using discourses of biology as a means of subjugating them, often through marking them as inferior and sick (Myrick, 1996). Within a context of heterosexism, scientific discourses appealing to biology or "nature" have been used, for example, to interrogate the "cause" of homosexuality with questionable aims, for example, possibly for eventual genetic counseling or genetic selection. Within such a context, it would be understandable that this Determinant of health would raise negative reactions among gay men as a legitimate or relevant category speaking to the positive pursuit of gay men's health.

Be that as it may, it may possibly be to the benefit of gay men's health to further explore and draw out the full implications of heterosexist biological accounts of sexual orientation, of gay men, and of their health issues, particularly for educational purposes.

As well, it is possible that health efforts among gay men directed toward specific cultural, ethnic or racialized groups may not be taking into account some genetic manifestations, or inherited vulnerabilities to certain illnesses that are found statistically to be more frequent among certain groups, within health intervention or treatment plans. This possibility is not raised nor explored within the reviewed literature.

Conclusion

5.1 Toward implications of the discussion for re-framing HIV-transmission prevention strategies among gay men in Canada

This document on gay men's health and Population Health, integrating a literature review with critical exploration, gives rise to numerous implications for HIV-prevention strategies among gay men in Canada. These implications beckon further consideration and research. The implications that this background paper raises for HIV-prevention strategies among gay men in Canada is beyond the scope of the present document. The following segment briefly foregrounds some of those implications in a tentative way, pointing toward areas of future research.

Implications of the present discussion paper for re-framing HIV-transmission prevention strategies among gay men in Canada, both those living with HIV and those who are HIV-negative, include critically addressing the following areas:

- the context of individual behaviors that risk HIV (re)transmission among gay men;
- the context of HIV prevention within gay men's lives;
- those processes that engage gay men's lives and strengthen their participation in addressing health issues relevant to them and the socio-environmental conditions influencing their health;
- the relation of "situating HIV prevention within a framework of gay men's health" to the HIV prevention and broader health issues of inter-related and overlapping communities or population groups;
- the approaches, policies and programming that would support and sustain new directions in HIV prevention among gay men.

Of these areas, the first two sets of implications - relating to context - will be briefly sketched below, in anticipation of a more comprehensive discussion.

The context of individual behaviors that risk HIV (re)transmission is multi-layered and beckons further research and exploration. One layer of this context is cultural interpretations by gay men of their sexual - and other health and life - experiences, or meanings assigned by gay men to those experiences. This includes "logics" (whether factually-based, fantasy, or multiple and contradictory) used by gay men to guide their decisions regarding behaviors in sexual contexts. This does not do away with the importance of gay men having access to information or having knowledge about behaviors that risk HIV (re)transmission and about safer sex and about the role of communication; rather, it situates such knowledge within a more complex mediation by the "knower" than "I know, therefore I do". As an example, a health professional working with gay men underlines a "logic" of fearing the loss of a desired partner:

...most of the clients I've seen... the first thing (they) say to me (is), "I know, I know, I know." So for me, education has been a success. This is not the issue, the education aspect of it. And all the time they'll say, "I was afraid, that if I would say I am HIV positive, or if I would have even raised the issue with my partner, I think I would have been gone". (Ryan, English-speaking Focus Group, 2000)

Another layer is **harm, and its reduction, as a key context for interpreting and situating risky behavior**. For example, behavior labeled as high-risk (such as unprotected anal sex) may not necessarily be harmful behavior in all situations. Increased high-risk behavior is not by itself a sign of increased

harm or increased HIV (re)transmission. As people mediate high-risk behavior, they may do so in ways that reduce or eliminate harm, for example, by negotiating strategies within stable relationships, or by implementing risk reduction “tips” or strategies for barebacking that modulate the chance of HIV (re)transmission. As well, harm reduction as a context leads to acknowledging and supporting gay men in their complex mediation of those behaviors seen as of low or medium-risk, particularly unprotected oral sex; addressing further research that could assist gay men in their decision-making – for example by clarifying ambiguities regarding level of risk of unprotected oral sex – would contribute to harm reduction.

Another facet of the context of individual behaviors that risk HIV (re)transmission among gay men are **gay men's identities and identity formations, in all of their complexity and plurality of forms** – and thus not solely as related to sexual orientation. For example, identity may be simultaneously driven by regional, ethnic, racialized, and class positions, histories and relations, wherein desire for self-identification as gay may or may not be strong, meaningful, or priority. As one participant of a Canadian focus group on gay men's health and wellness related:

...as long as you fulfill whatever familial, cultural, obligations, you could be anything. So, it's kind of like, in my culture, I wouldn't say I am gay, neither would I say, I am a person who has sex with men. But I would do whatever I need to do that is personal, and I don't have to tell anybody about that. (Ryan, English-speaking Focus Group, 2000)

As well, the **whole life span as experienced by gay men** is another layer of context; as each age (whether chronological age or calculated in relation to coming out) appears to bring differing contexts in which vulnerability to harm is constructed. The **specific local and regional contexts**, including the conditions or factors of vulnerability – and of strength, health or resilience – specific to them are also seen as relevant. The **cultural, linguistic, ethnic, and racialized diversity** within local and regional contexts, and the inter-group relations through which that diversity is lived out, repressed or affirmed is a context seen as relevant, as is the **rural, suburban, and urban diversity** of a region and their specificity.

The **individual realm, the interpersonal realm, the social context, and the societal realm** through which determinants of health, and inversely of vulnerability, function. For example, regarding the interpersonal realm, the emotional relationships and ties between gay men and the various desires-discourses (for example: romantic; non-monogamous; sense of risk-taking and of “losing control”) that mediate them are noted. **Inequities within inter-group, intra-group, and interpersonal relations of power** appear to be key contexts. For example, regarding the interpersonal context, the power differentials within a sexual encounter (for example, as constructed through: age; race; ethnicity or cultural background; socio-economic class; region; language) and their impact on individual choices (and possible manipulation) that minimize harm-reducing behavior.

The context of HIV prevention within gay men's lives referenced here is also multi-dimensional. This context includes **perceptions of HIV prevention among gay men**. For example, its perceived priority, and relative integration, among other preoccupations within everyday life, including paying the rent, gaining intimacy, getting food, getting a fix, warding off racism, perceived culturally-defined responsibilities to family and community, managing the practicalities of living with HIV, and so on. As well, this context includes the perceived repression of HIV prevention (messages, strategies, practices) on

gay men's sexuality and desires, and the perceived relevance of HIV prevention to gay men of a diverse range of cultural, ethnic and racialized identities. In addition, this context includes perceived relevance of HIV prevention to gay men of diverse range of geographic and social environments, including rural and urban, including various (and disparate) regions of Canada. As well, this context includes perceptions of HIV prevention as reduced to HIV transmission within sexual relations, rather than also, for example, through shared needles in drug use among gay men.

Another context of HIV prevention within gay men's lives is that with over fifteen years of experience with HIV and AIDS, **there appears to be a relative equilibrium, perhaps a fragile stability, within gay communities vis-à-vis managing risk of HIV transmission** in ways that reduce both harm and panic, as well as integrate HIV risk management within everyday life. **HIV prevention is being re-positioned within the context of gay men's broader immediate health issues and the pursuit of gay men's health and well-being.** A clear implication of the shift toward gay men's health is that HIV prevention should be situated within gay men's health, rather than isolated, on the one hand, or diminished vis-à-vis other health concerns, on the other. This calls gay men living with HIV to connect up their efforts with prevention efforts (both HIV transmission and re-transmission) and calls HIV-negative gay men to pursue common goals of health and well being with those living with HIV. Gay men's health, including as a context for HIV prevention, is seen as emerging rather than as an accomplished fact:

Yes, there is a tendency to take charge of our health, to ask for resources, to create resources, but we are far from having those resources. I find that it is truly a process that is happening in the gay community. (Ryan, French-speaking Focus Group, 2000)

HIV prevention is being addressed within **the context of addressing and improving the determinants of gay men's health.** The following determinants may be particularly germane to HIV prevention among gay men within a framework of gay men's health: healthy child/adolescent development; education; social and physical environments (including the elimination of heterosexism, racism, sexism and other relations of inequity and oppression); social support networks; conditions that affirm choices of coming out; culture; personal health practices, copings skills, and capacities for their use; access to relevant and quality health care; gender; as well as income and economic situation, along with employment and working conditions. Two Canadian focus groups underline a definite preoccupation with the determinants of gay men's health. For example, a focus group analysis notes that:

Some comments pointed out that one of the pre-conditions to taking care of one's health is having enough money to take care of one's basic needs on an ongoing basis. (Ryan, French-speaking Focus Group, 2000)

Focus group participants offer views on determinants from various angles:

...(we) really need to look at the dimension of whether the act of having sex with men or the identity of being gay affects those other dimensions, those other health determinants. And how the various things that interacts with individuals, namely the relationships they have with various institutions, community and society, impact their individual wellness, choices, self-esteem, as a gay man... (Ryan, English-speaking Focus Group, 2000)

We talk most about individual behavior. And we never think about what factors are outside of your control, as a person who is taking the risk... if you look at the people who are infected, they are the marginalized... We need to pay attention to the bigger picture. And what is the bigger picture? It is factors outside of people's control, that actually increase their risk of getting infected... (Ryan, English-speaking Focus Group, 2000)

Well, I would add for my part that coming out is part of health and it can occur early or late... (Ryan, 2000b: French-speaking Focus Group)

Men are not intimate, men have trouble with intimacy (...) Maybe the issue of intimacy is also a part of sexuality. I think that men's trouble with intimacy means that a lot of things are expressed sexually, whereas when intimacy is involved, then, all of a sudden, they don't know what to say, they are speechless. (Ryan, 2000b French-speaking Focus Group)

...(the) underlying determinants of health, meaning societal homophobia and various forms of oppression that are endangering the health of gay and lesbian people... the government needs to support education in social services, in professional training, in all aspects of society. (Ryan, English-speaking Focus Group, 2000)

A considerable context is the **presence and relevance of HIV prevention – and its sustainability – for gay men of a diverse range of settings**, specifically rural, suburban, and smaller cities, in addition to large urban centres, of various regions of Canada, as well as an equitable role in determining that HIV prevention. An integral context is **the presence and relevance of HIV prevention for gay men of a diverse range of cultural, ethnic and racialized backgrounds and communities**, as well as, again, an equitable role in determining that HIV prevention.

5.2 Gay men's health and Population Health

For this discussion paper, a Population Health approach and framework has simultaneously served as a structuring principle and as an object of critical examination. It has been key that the paradigm shift from HIV prevention among gay men to gay men's health guides the evaluation of a Population Health approach and framework, rather than the other way around. It is clear that a Population Health approach has benefits and limits for gay men's health and for re-framing HIV prevention among gay men in Canada. It is also clear that an emerging paradigm of gay men's health integrates aspects of a Population Health approach and framework, in particular, for example, its emphasis on the social-environmental determinants of health. However, gay men's health cannot be sustained solely by a Population Health approach and framework because, for example, of its exclusion of the methodological strengths of gay men's health, including community-based popular education, participatory research, as well as community organizing and community development for individual and collective forms of empowerment. Indeed gay men's health would likely be sabotaged if it were to draw sole sustenance from a Population Health approach and framework.

Be that as it may, community-driven HIV-transmission prevention research and intervention among gay men, as well as among other marginalized groups in Canada, have given rise to approaches and frameworks for practice that draw on significant themes of Health Promotion and aspects of Population Health. The most comprehensive model within the reviewed literature, and likely the most resonant with gay communities and their aspirations for social change, is the transformational health model forwarded by Trussler and Marchand (1997b), co-published by AIDS-Vancouver and Health Canada. Building upon the strengths and insights of those "on the ground" doing HIV prevention work, transformational health opens up significant possibilities for creatively exploring what approach and policy configuration would be responsive to gay men's health, including as a framework for HIV-transmission prevention among gay men.

What exact approaches, policy frameworks and programming would support and sustain new directions in gay men's health, particularly as a framework for HIV-transmission prevention, is a question that would coherently draw its response from a critical appropriation of the question by those most affected by gay men's health: gay men and their community-based organizations. Contributing to building their capacity, both individually and organizationally, to participate fully in such a critical appropriation would seem to be coherent with the role of civic society in public debate, the empowerment aspirations of gay men's health, as well as the role of public health to support it.

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