

**Exploring Intersectionality as a Framework for Advancing  
Research on Gay Men's Health Inequities**

**by**

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## Ethics Statement



The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

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## Abstract

While the rights of gay men have improved significantly over the past 40 years, the health inequities of this diverse population remain considerable and efforts to reverse the trend have yielded few results. This suggests that a radical shift is warranted into how we theorize, investigate and intervene in this area. Public health researchers have primarily focused on gay men's behaviours to explain negative health outcomes while social factors have been largely neglected. To change this trend, intersectionality has been proposed as a framework to study gay men's health inequities. Intersectionality promotes an understanding of humans as being shaped by the interaction of different social locations and structures of power. It is now recognized as an important framework to study health inequities. However, marginalized and multiply oppressed women are still the primary focus of much intersectional scholarship and the literature exploring the relationship between intersectionality and gay men's health is still underdeveloped. Therefore, more work is needed theoretically, methodologically and empirically to grasp the potential contributions of intersectionality to the understanding of how health inequities of gay men are produced and sustained.

In this dissertation I explore how intersectionality can help transform the field of gay men's health research, and help attend to issues of gay men's health inequities more effectively. This was accomplished by uniting in one collection three case studies, each looking at how intersectionality can transform a different aspect of research: theorizing, methodology, and data analysis. Together, the three case studies demonstrate that intersectionality can 1) disrupt essentialist assumptions and the false homogenization of gay men in public health research and therefore bring forward issues of diversity more effectively; 2) illuminate interactive power dynamics affecting gay men's health such as systemic heterosexism, sexism, and racism as well as power differences operating within gay communities such as racism, classism and misogyny; 3) produce new and more accurate knowledge about health inequities due to its attention to multiple and intersecting factors. In light of these results, I conclude that intersectionality is more than a useful framework for gay men's health research; it is critical to reversing gay men's health inequities.

**Keywords:** Intersectionality; Gay men's health; Health inequities; Syndemics; Community-Based Participatory Research; Social justice

## **Dedication**

This dissertation is dedicated to all gay, lesbian, bisexual, transgender and queer individuals who are working - and often risking their own lives - to make our world a better place for sexual minorities.

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# Chapter 1.

## Introduction

From criminalization to marriage equity, the rights of gay men in North America have changed dramatically in the past 45 years. In comparison, less attention has been paid to issues of health – especially beyond considering health behaviours and focusing on HIV/AIDS. Moreover, much research on gay men's health has treated such population groups in a fairly homogenous and static manner, paying inadequate attention to within-group diversity and moreover, power relations and structures that produce a range of persistent social and health inequities. Accordingly, there have been increased pressure and calls among advocates and scholars for a paradigm shift in the status quo to improve the ways in which gay and bisexual men's health is understood and responded to (Aguinaldo, 2008; Ferlatte, 2012; Halkitis, Wolitski and Millet, 2013). In this dissertation I contribute to the demand for such change. By exploring the framework of intersectionality in gay men's health research, I bring to the fore the significance of this approach for expanding the diversity of gay men's health experiences and the importance of addressing complex intersections of power. While intersectional approaches are not new and have, in fact, been fairly well taken up in other jurisdictions (e.g., the US), in the Canadian context this paradigm is virtually unexplored in the context of gay and bisexual men's health. Thus a key purpose of this dissertation is to illustrate, in a preliminary way, how intersectionality can be adopted and utilized in gay men's health research, policy and practice. As this research demonstrates, producing a broader and more accurate base of knowledge is a prerequisite for improving research, policies, health promotion and the overall health of gay men.

## 1.1. Background

The field of gay men's health is relatively new. It is only about 35 years ago, that the health of gay men came onto the radar of public health researchers and government agencies, as young gay men across North America started to die of a rare disease later known as AIDS. After a slow response, both in terms of interventions and research, the AIDS epidemic became a catalyst for public health researchers to investigate the health inequities of gay men. Now it is known that gay men face multiple health inequities beyond HIV, including, but not limited to, suicide (King et al., 2008), cigarette smoking (Balsam, Beadnell, & Riggs, 2012), mood or anxiety disorders (Brennan, Ross, Dobinson, Veldhuizen, & Steel, 2010), sexually transmitted infections (Brennan et al., 2010), illicit drug use (Conron & Mimiaga, 2010) and eating disorders (Austin et al., 2009). However, public health researchers have tended to focus on HIV while excluding other health inequities. For example, a recent review found that HIV-related citations outnumber suicide citations at a ratio of forty-to-one in the health sciences literature pertaining to gay men (Hottes, Ferlatte & Gesink, 2014). Moreover, much of the health research on gay men, and particularly within the Canadian context, has had a tendency to treat gay men as a monolithic category. This is inconsistent with some emergent research suggesting that differences among gay men exists along multiple axes of differences such as age, ethnicity, and class. For example, in an exploration of sexual status order in the gay and bisexual community of Toronto, Green (2008) found that Black men and Asian men, as well as poor men and those over the age of 40 years old experience significant stressors such as rejection and stigmatization. These stressors were linked to depression, anxiety and difficulty in negotiating safer sex.

What is particularly striking about the health inequities experienced by gay men is the conspicuous lack of progress in redressing them. For example, HIV continues to affect predominantly gay and bisexual men in Canada and the USA, and this trend has remained stable despite the overall decline of the HIV epidemic in other populations (PHAC, 2013a; Johnson et al., 2013). Notably, in the USA much more research has been done on the intersections of race, sexual orientation and HIV showing that it is particularly Black gay and bisexual men who are vulnerable to HIV (Maulsby et al., 2013;

Millett et al., 2012; Millett, Peterson, Wolitski, & Stall, 2006; Oster et al., 2011). Similarly, inequities in suicide rates among gay and bisexual men have remained persistent despite the legal gains of gay and bisexual men in Canada, and suicide has now surpassed HIV as a leading cause of premature death among gay and bisexual men (Hottes, et al., 2014). Now new findings show that particular groups of gay and bisexual men are vulnerable to suicide, such as men with lower socio-economic status and those of Aboriginal ancestries (Ferlatte, Hottes, Hankivsky, Trussler and Marchand, 2015).

While the body of evidence on gay men's health inequities is growing and alarming, the actual mechanisms sustaining these inequities and their intersections have received considerably little research attention (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). The World Health Organization states that the root causes of health inequities are to be found in social, economic and political mechanisms (Solar & Irwin, 2007). But public health researchers have traditionally focused on gay men's behaviours to explain health inequities – such as unprotected sex, high numbers of sexual partners, promiscuity, and illicit drug use. This has produced a large body of research in which the solution to gay men's health problems lays in “fixing” gay and bisexual men's so-called “disordered” behaviours. Even in reports that link these behaviours to their social context, such as society's homophobia, the answer is seen as “fixing” gay and bisexual men, by “curing” them from their internalized oppression, rather than changing the social environments of gay and bisexual men which is tainted by structural power dynamics including but not limited to high levels of homophobia (Aguinaldo, 2008).

A focus on behaviours alone obscures upstream factors that contribute to ill health and mainly serves to blame gay and bisexual men for their own problems. For example, a review of Canadian research papers on gay men accepted to Canada's largest HIV/AIDS conference concluded that the majority of papers highlighted gay communities' failure to halt HIV transmission while providing no insights into prevention (Tooley, 2012). Similarly, Herrick (2011) described that a focus on gay men's behaviours alone results in interventions that are deficits based (i.e. emphasize gay men's lack of skills and “unhealthy” norms around sexuality), judgmental, and moralistic. Because of the negatives focus of such interventions, gay men are less likely to accept and

participate in them (Herrick, 2011). More so, by maintaining a behavioural downstream focus, researchers deny the complex and rich context of gay men's lives. Epidemiologists have stripped away gay men from their sexual orientations and identities in public health writing by describing them as a behaviour with the adoption of the term MSM (men who have sex with men) - a term that many see as rooted in homophobia and as obscuring the social dimensions of health and power relations that are critical to uncovering and reversing inequities (Young and Meyer, 2005; Prestage, n.d).

More so, beyond the inattention to the social dimensions of sexuality, the public health literature on gay men, especially in the Canadian context, suffers from an important lack of diversity. Thus, much of gay men's health research treats the community as a homogenous population<sup>1</sup>; ignoring that gay communities are constituted of men from different social locations shaped by races/ethnicities, classes, gender identities, abilities/disabilities, and Aboriginal status. The invisibility of gay men whose lives cut across these differences is due to the fact that most public health studies continue to oversample white, highly educated, middle-class and cisgender<sup>2</sup> men (IOM, 2011; Fish, 2008; Greene, 2003). It can also be traced historically in Canada to a reticence among the population and public health community to discuss or study social inequities related to race and ethnicity as this intersects with sexual orientation. Of course, some notable exceptions exist and some researchers have found creative ways to address power and diversity in gay men's health research (Brennan et al., 2013; Ferlatte et al, 2014; Green, 2008). For example, some researchers have adopted syndemic theory (Singer, 2009) and minority stress theory (Meyer, 1995) in order to better describe the relationships between social inequities, the unjust exercise of power, and health outcomes among gay men. More so, some critical work has emerged in recent years, particularly among Black scholars in the USA, to demonstrate that a sole focus on sexuality is insufficient to understand the diversity of experiences among gay

<sup>1</sup> This kind of homogenization extends to other groups, most notably the traditional conceptualization for instance of "women" and "men" in relation to health.

<sup>2</sup> The opposite of Transgender, cisgender describes a person whose self gender identity conforms with the gender that corresponds to their biological sex.

and bisexual men (Fields et al., 2012; 2015; Malebranche, Fields, Bryant, & Harper, 2009; Nelson, Walker, DuBois, & Giwa, 2014). However, these analyses remain marginal, and rarely are diversity and power attended to at the same time, in the same study, or in the same interrogation of gay men's lives. Much more work remains to be done to bring power and diversity to the forefront of the gay health research agenda, particularly in mainstream public health research.

In this dissertation, I explore the implications and potential of intersectionality in advancing research on gay men's health inequities. Intersectionality offers this field of study a framework to investigate and interpret, in a systematic manner, issues of power and diversity. This is more than an intellectual exercise, as described by Patricia Hills Collins (2009), "life depends" on researchers uncovering these issues. The life – and quality of life – of gay and bisexual men will only be improved if we can shine a light on how different structures of oppression operate on gay and bisexual men.

## **1.2. The potential of intersectionality for gay men's health**

Intersectionality has been proposed as an important framework for the advancement of public health research and the understanding of health inequities (Bowleg, 2012a). The term intersectionality was coined by Black feminist scholar Kimberley Crenshaw (1989) in the late 1980's but its underlying principles have a long and rich history within Black feminist writing, Indigenous feminism, international and transnational feminism, queer theory, and postcolonial writing and theorizing (Dhamoon and Hankivsky, 2011).

The intersectionality literature contains several definitions but it can be described as a research framework that investigates and interprets how multiple interlocking social locations (such as sexuality, gender, race/ethnicity, class) that are shaped by intersecting sociocultural forms of power and privilege (such as heterosexism, sexism, racism, classism), affect peoples, individuals, and collective identities and experiences (Hankivsky, 2012; Shields, 2008). Intersectionality brings a radical shift to how

researchers investigate inequities by moving beyond typical, or preferred categories of analysis (i.e. MSM, Gay men) to expand their frameworks to consider the full constellation of possible influences (such as gender, hegemonic masculinity, geography, race/ethnicity).

There are key tenets of intersectionality that differentiate it from other popular approaches in health research, such as the social determinants of health approach often preferred in the Canadian policy context (Mikkonen & Raphael, 2010). According to Hankivsky (2012), these tenets are: “that human lives cannot be reduced to single characteristics; that human experiences cannot be accurately understood by prioritizing any one single factor or adding together a constellation of factors; that social categories are socially constructed, fluid, and flexible; and that social locations are inseparable and shaped by the interacting and mutually constituting social processes and structures that are influenced by both time and place” (Hankivsky 2012, p. 1713).

In recent years, many health researchers have turned to intersectionality to investigate inequities due to its potential to more accurately capture the breadth of individual and populations’ experiences (Bowleg, 2012a; Hankivsky, 2012). The traditional public health approach to social locations – such as the social determinants of health approach – is to study the independent effect of one social location at a time (Bauer, 2014); for example by looking at the impact of sexuality on HIV vulnerability by controlling for other factors (such as gender, income, race/ethnicity, etc.). However, such approaches fail to embrace the complex experiences of those whose lives cut across simple identity structures (such as Aboriginal two-spirit men, gay men from rural communities, HIV positive gay men). Rather, it renders invisible those populations who experience multiple forms of oppressions and paints a homogenized and distorted view of populations such as gay men, which are actually very diverse.

While interest in intersectionality is growing and many are celebrating its transformative effects on health research, others have criticised it. For example some have argued that intersectionality can neglect the importance of racism in populations such as gay men by making all oppressions equal. This is something argued by



proponents of integrative antiracism who see race as more salient than sexuality for many Black gay men (Nelson et al, 2014). Others have found the opposite, that intersectionality helps reveal some important ways racism is enacted in populations affected by multiple structural forms of power (Brennan et al. 2013). More so, critiques of intersectionality include its attention to the so-called “holy trinity” of gender, race, and class to the detriment of other social locations of analysis, resulting in other categories of social difference to not be fully considered (Dhamoon, 2011). Among these neglected categories is sexuality.

Thus far, only a handful of papers have used intersectionality to investigate the health of gay and bisexual men, including quantitative studies (Mereish & Bradford, 2014; Walker, Longmire-Avital, & Golub, 2014), qualitative inquiries (Bowleg, 2012b; Brennan et al., 2013), and policy analysis (Ferlatte, 2012; Grace, 2012). While this area is still in its infancy, these first few applications are demonstrating that new and more precise knowledge can be generated when an intersectionality lens is applied and that issues of diversity and power are at the forefront of analysis. This is evidenced in a recent qualitative study of Black gay and bisexual men, where Bowleg (2012b) highlights the importance of intersectionality for this population with the following interview excerpt: “Well it’s hard for me to separate [my identities]. When I’m thinking of me, I’m thinking of all of them as me. Like once you’ve blended the cake you can’t take the parts back to the main ingredients.” (p.758).

Despite these inroads, significant work is still needed theoretically and methodologically to better understand the role of intersectionality in gay men’s health (Ferlatte, 2012). But some community activists – particularly transgender individuals and gay men of colour – are increasingly pressuring gay men’s health organizations and public health researchers and practitioners to reframe their practice to be in line with intersectionality principles. For example, intersectionality was presented at the British Columbia (2010) and the Ontario Gay men’s health summits (2013) and young gay men in British Columbia also advocated for its application at a youth forum (Community-Based Research Centre, 2013). This framework has also been recognized by significant institutions, such as the Institute of Medicine, which described intersectionality as critical for the advancement of our understanding of gay and bisexual men’s health inequities

(IOM, 2011). But, how to best use intersectionality for gay and bisexual men's health research remains to be uncovered.

This dissertation is grounded in what Choo and Ferree (2010) recognize as a 'group-centered' intersectional analysis (2010) which Moore (2012) argues is in line with what McCall (2005) described as 'intracategorical' approach. Group-centered analyses focus on the diverse and intersecting experiences of individuals who may be grouped together as a single group, such as 'gay men'. This is quite different from how intersectionality has traditionally been operationalized in research. Indeed, the dominating approach in intersectionality scholarship has been to focus on the needs of those who have been excluded because they belong to multiple subordinate groups. This is also the approach that has been preferred thus far when intersectionality has been applied to gay men, by investigating the experience of gay men of colour.

Differently, I am making a novel contribution to the literature by exploring the potential of intersectionality by looking at gay men as a group. I am using intersectionality tenets to complicate the understanding of this group within public health research. Cole (2009) described that taking a group-centered approach can lead to a more nuanced understanding of a population traditionally treated as a monolith. More so, she described that such an approach can help envision more ways of creating interventions and social change that benefit all members of the population, rather than the affluent majority (Cole, 2009). Therefore, I argue that this approach presents great potential for the reduction of health inequities among and across gay and bisexual men.

### **1.3. Situating my work**

Context matters. This is something emphasized by intersectionality; privileges and disadvantages, including intersecting identities and the processes that determine their value change over time and place (Hulko, 2009). Therefore, it is important to situate where my work is taking place and how gay men's health has unfolded in Canada.

Much of the research on gay men's health, including intersectionality inquiries of gay men's lives, comes from the USA. However, the Canadian context is significantly different. For instance, when it comes to health, what particularly distinguishes Canada, is its universal health care system. The Canadian health system is publicly funded and administered by the provinces and territories, which are in charge of providing care and services, within guidelines set by the federal government. Under this system individual citizens are provided with preventative and primary care, and access to hospitals. All citizens qualify for health coverage regardless of their medical history, personal income and standard of living. This system is a great source of pride for Canadians; in a recent survey, universal health care was almost universally loved with 94% calling it an important source of collective Pride<sup>3</sup>. However, universal health care is no synonym for health equity. Many barriers remain to access health care and health inequities are found in Canada along every axis of differences including gender, immigration status, Aboriginal status, ethnicity and income (Angus et al., 2013; Kim, Carrasco, Muntaner, McKenzie, & Noh, 2013; McGrail, van Doorslaer, Ross, & Sanmartin, 2009; Reading & Wien, 2013; Slaunwhite, 2015; Socías, Koehoorn, & Shoveller, 2015; Wang & Hu, 2013).

Unequal access and health opportunities also exist for gay and bisexual men. For example, care may be compromised for many gay and bisexual men as half of them have not disclosed their sexuality to their primary care provider; with bisexual men, youth, Asian men and rural men being the least likely to have disclosed their sexuality (Ferlatte, 2015). Inequities also exist in regards to the distribution of funding for redressing health inequities and dedicated health promotion. In that sense, in 2009, six Canadian activists filed a human rights complaint against Health Canada and the Public Health Agency of Canada arguing that they actively and passively discriminate against gay, lesbian and bisexual Canadians. In their complaint, they wrote that both agencies work with specific minority populations to address their health concerns but that neither is actively or methodologically working to address the unique health and wellness issues faced by lesbian, gay and bisexual Canadians (Human Rights Complaint, 2009). They

<sup>3</sup> [www.globeandmail.com/news/national/universal-health-care-much-loved-among-canadians-monarchy-less-important-poll/article5640454/](http://www.globeandmail.com/news/national/universal-health-care-much-loved-among-canadians-monarchy-less-important-poll/article5640454/)

maintained that this situation has continued despite repeated attempts from LGB organizations to partner with Health Canada and the public health agency. More so, these two institutions have even ignored the recommendations of reports they have themselves sponsored on the health of gay, lesbian and bisexual people.<sup>4</sup>

These inequities in the distribution of resources for gay men have been also described more recently in the context of the HIV epidemic in British Columbia. In an intersectionality-based policy analysis of the situation, it was found that not only is funding for gay men inadequate, but that men with intersecting vulnerabilities are completely ignored in the distribution of resources (Ferlatte, 2012). For example, gay men and Aboriginal populations are two groups over-represented in the epidemic but no funding or health promotion interventions target two-spirit, gay and bisexual Aboriginal men. Nor are there any initiatives for gay and bisexual men that use injection drugs or for men of colour. Rather, funded initiatives have homogenized views of gay and bisexual male communities and tend to suggest a one-size-fits-all answer (i.e. expansion of testing or treatment) without a consideration of diversity.

The erasure of certain groups of gay and bisexual men in gay men's health goes beyond the distribution of funding – it transcends the gay and bisexual men's movement and research. For example, the preponderance of research on gay and bisexual men in Canada has continued to focus on largely white, middle-class, and cisgender members of this population. In a scan of 48 research projects conducted between 2006 and 2011, only four projects looked at men from countries where HIV is endemic: four looked at transgender men, three at men who inject drugs, one at youth, and a single one at Aboriginal men (PHAC, 2013b). More so, while some activists are increasingly trying to bring attention to issues of diversity, and particularly race diversity, this is complicated by the fact that HIV surveillance in Canada does not collect systematic information on race and ethnicity: in its most recent reports on HIV surveillance, the Public Health Agency of

<sup>4</sup> The complaint was never adjudicated due to the premature death of the activist leading the complaint, Gen Hellquist. He died of anal cancer – one of the health inequities highlighted in the complaint as being neglected (Human Rights Complaint, 2009).

Canada discloses that 40% of the race data and ethnicity are missing for new HIV cases (PHAC, 2013a).

This lack of attention is also present at the community level and within mainstream activism. Giwa and Greensmith (2012) described that since the onset of the HIV epidemic, the dominant discourse of a single cohesive gay community as promoted by gay rights organizations has resulted in the erasure of the diverse and complex experiences of many gay men whose lives are defined by multiple forces of power. Within gay men's health in Canada, the dominant voices, past and present, have been those of white, middle-class, cisgender, able-bodied gay men and little has been made to accommodate trans men, men of colour and men from lower socio-economic status. Meanwhile, organizations or programs that attend to these specific sub-groups of gay men, such as men from different ethno-cultural communities, are largely underfunded or have been dismantled in some regions of Canada (i.e. British Columbia). In its efforts to bring attention to the structural inequities fuelling the HIV epidemic and other health inequities of gay men, the community has been homogenized, often ignoring the oppression that continued to occur within the gay men's health movement.

## **1.4. Situating myself**

An important way to disrupt power within intersectionality research is by engaging in reflexivity (Hankivsky et al, 2012), which is a process that "challenges a researcher to explicitly examine how his or her research agenda and assumptions, subjects locations, personal belief and emotions enter into their research" (Hsiung, 2011, p.212). Reflexivity is an active form of self-examination that locates the researcher as a participant in the dynamic interrelationship of the research process, rather than as neutral bystander (Ryan and Golden, 2006). This process attends to power by providing an opportunity to check-in about the multi-layered power relationships that emerge in research. Specifically, it can help identify how a researcher's own privileges and penalties influence how questions are asked, which issues are highlighted, and how results are reported. More so, by reflecting on his or her own social locations, a

researcher can see how his or her own research attends to diversity, and more specifically to the needs of those that are differently positioned than them.

Reflexivity is something I practiced throughout my dissertation and I therefore consider important that I position myself upfront in this dissertation. I am a Caucasian man from Quebec. My first language is French. While Canada has a long history of oppression against French speaking people, I cannot say I have ever felt oppressed on the basis of my first language. However, writing this dissertation in my second language was a major struggle for me. I moved to British Columbia fifteen years ago barely able to speak English. I have made immense progress after completely immersing myself (which led me to an academic career!) but I have always felt like an impostor in the academic world. I often feel as though I do not deserve to be pursuing my doctoral studies, that my English is too poor. It is as if I have simply fallen through the cracks, lucky to be completing a PhD. These feelings resulted in serious self-doubt and severe anxiety throughout my PhD; would I ever finish? Would my supervisor finally tell me to give up? Is all this stress worth it? Will my level of English prevent me from getting a job regardless of whether I complete my doctorate?

I also identify as gay and do not like to define myself within the binary of feminine and masculine, but others have defined me throughout my life as effeminate. As a “feminine” gay man, I have been socially punished through bullying, taunting, threats and assaults for not respecting the codes of masculinity. As far as I can remember, I have always been punished as such, but these events were particularly intense during adolescence where they happened on a nearly daily basis.

Past adolescence, the nearly daily aggressions stopped to the point where I thought homophobia was no longer an issue for me, or for most adults. On reflection this was naïve and wishful thinking. Homophobia was still impacting me in subtle and subversive ways: when I chose not to hold my lover's hand in the street or when I choose not to wear that shirt because it was “too gay”. More so homophobia shaped the health services available or not available to me as a gay man. Homophobia also shaped the

curriculum of my public health degree, where sexual minorities were mainly discussed in a negative and stereotyping manner.

I was particularly reminded of the pervasiveness of homophobia when I worked within a public health institution. While working on a gay men's HIV research project as a "gay researcher", I saw my ideas, my experiences, my skills and my knowledge dismissed by my heterosexual colleagues and supervisors. My employment was punctuated by micro-aggressions and institutionalized heterosexism as I tried to guide our research beyond gay men's behaviours towards the social factors affecting health. This became my catalyst to seek a means of researching gay men's health grounded in the real lives of those affected. This was when I encountered intersectionality.

Describing in this dissertation my experiences with homophobia is not a way to gain sympathy from my readers. Rather, it is to show the deep connection I have with the topic and the population I do research with. This is an advantage as it provides me with knowledge and a sensibility around the topic that heterosexual researchers may not have. However, I am also conscious of the danger of such knowledge and emotional connection to the topic. My experience as a gay man has shaped how I understand homophobia and I have therefore many assumptions about what it means to be gay based on my experience. It is through reflexivity that I have reminded myself in writing this dissertation that I am differently positioned than many other gay and bisexual men, and that other men's relationships to masculinity, homosexuality and homophobia are different because of other social locations they hold.

When working with intersectionality, I had to keep in mind that there is no singular gay experience. My experience is one experience. It has been shaped by a long list of privileges I have held throughout my life: I am a white settler, able-bodied, highly educated, middle-class, and cisgender man. These are privileges that helped me navigate the world. While I have experienced homophobia – and continue to do so – I am aware that these privileges have provided me with resources to cope, navigate and deflect some of the most negative experiences of anti-gay stigma. As a result, I have not

and most likely will not be affected by the health inequities and the issues I am describing throughout this dissertation.

More so, before I encountered intersectionality I had not considered the full implications of other forms of oppressions on gay men's health, such as racism and transphobia for example. Not that I did not think they mattered, but I have to shamefully admit that I thought they did not matter as much. Also, before I embarked on this research I did not see the close and reinforcing relations of homophobia with other forms of power. I was finally forced to think about these issues as I engaged with intersectionality, but also through my work with young people of colour and trans activists who helped me change my perspective on sexuality and homophobia to incorporate a broader view of oppression in my gay men's health research.

## **1.5. Thesis Overview**

The intent of this dissertation is to demonstrate in preliminary ways that intersectionality can have a transformative impact on gay men's health and that it can help researchers to more effectively tackle issues of social and health inequities. This dissertation is structured in the paper-based style, which involves uniting individual essays under a common introduction and conclusion. While each paper operates independently, together they speak to the transformative possibilities of intersectionality for the field of gay men's health. In that sense, there are three overarching research goals to this dissertation, which are: 1) to exhibit how intersectionality can disrupt essentialist assumptions about "gay men" and "gay community" and address diversity; 2) to show how intersectionality can effectively highlight and question issues of power and privileges affecting gay men and among gay men; 3) to demonstrate that intersectionality can produce new and more accurate knowledge about gay men and gay communities.

These goals are achieved throughout three papers, each its own case study of how transformative intersectionality can be to the field of gay men's health. Each



explores the potential of intersectionality in a different aspect of gay men's health theorizing and research.

### **1.5.1. Case Study #1: Theory (Chapter 2)**

In this first chapter, I demonstrate how intersectionality can help advance emerging theory in gay men's health. In this essay I thoughtfully combine intersectionality with syndemic theory and propose a new framework to investigate and conceptualize how multiple epidemics and psycho-social health problems are socially produced in gay and bisexual men. Syndemic has emerged in recent years as a key framework to investigate gay men's health inequities (Stall et al., 2008). However, there are limitations in the model that affect its potential for advancing issues of gay men's health inequities; syndemics among gay men are still under-theorized; syndemics research neglects structural/systemic forms of oppression; and syndemics researchers tend to describe a singular narrative of how gay men experience oppression and health. This contribution is important; it is the first time that intersectionality is brought into conversation with syndemic theory.

By applying the principles of intersectionality, this chapter offers some guidance in addressing the limitations of syndemic theory. I argue that Intersectionality helps identify power and oppression in the issues affecting gay and bisexual men that must be considered in the full scope of syndemic research. I show that intersectionality is critical to our understanding of how syndemics are experienced by differently positioned gay and bisexual men.

### **1.5.2. Case Study #2: Research Practice (Chapter 4)**

I examine in this chapter the value-added of intersectionality as a framework for community-based participatory research (CBPR) with gay men. CBPR has become a respected methodology in health research and has grown in popularity within gay men's

health since the onset of the HIV epidemic. However, its application in gay men's health does not always fully attend to issues of differential power and diversity.

In this chapter, case-study methodology is used to critically reflect on and examine the value-added of intersectionality in CBPR with gay men. I describe how intersectionality allowed our research team to critically reflect on their social positions and its meaning relative to other researchers involved in the project and the study population. Intersectionality was also used in this project to bring forward the voices of gay men not usually heard in conventional research (such as youth, men of colour, and trans men). Finally, intersectionality helped disrupt power between institutional researchers and community researchers in important ways.

### **1.5.3. Case study #3: Empirical Research/Data Analysis (Chapter 5)**

In the third chapter, I illustrate how a new understanding of gay men's health comes from integrating intersectionality in quantitative analysis. In this paper I contrast the typically favoured approach in public health research of treating social categories as an "independent effect" with an intersectionality framework that considers the interactions of sexual orientation with other social locations.

By investigating which gay and bisexual men are at increased risk of experiencing syndemics (multiple psycho-social health problems), I demonstrate that intersectionality brings much more nuance and complexity into knowledge of the health experiences and vulnerability of gay and bisexual men. While traditional public health approaches can identify some of the social factors associated with experiencing syndemics, important additional factors can only be revealed using the intersectionality approach. Furthermore using the intersectionality approach indicated that some factors may only affect some sub-groups of gay and bisexual men.

## **Chapter 2.**

# **Improving gay and bisexual men's syndemic research with intersectionality**

### **2.1. Introduction**

Syndemic theory has been described as one of the most promising frameworks to help reveal the complexity of how gay health inequities are produced and sustained (Stall, et al, 2008; Halkitis et al, 2013; Ferlatte et al., 2015). The potential of this approach lies within its attention to homophobia and how it embraces the complex relations and co-constitutive natures of multiple epidemics faced by gay men. However, despite the contribution of syndemic theory in advancing our understanding of gay men's health, challenges remain for this theory; in particular, the gay men's syndemic literature lacks sufficient attention to issues of power and diversity.

The purpose of this paper is to demonstrate, in some preliminary way, the potential of intersectionality in advancing syndemic research with gay and bisexual men. Intersectionality is a framework that helps researchers to systematically bring to the forefront analyses of how populations (such as gay men) are constituted of members with varying degrees of power, penalties and privileges due to multiple social statuses held by its members. Therefore, intersectionality is well suited to help challenge the current homogenization of gay men in syndemic research and to illuminate the various forms of power, beyond homophobia, that shape the lives and health of gay and bisexual men.

This paper begins with a review of the gay men's health syndemic literature. Then I describe intersectionality's potential for this critical field of study and present a conceptual framework to help researchers bring an interrogation of power and diversity to the forefront of syndemic research. The aim of this framework is to make this syndemic research more responsive to the diversity of experiences of gay and bisexual men. I conclude by recommending critical adaptations to how syndemics are investigated in order to ensure that the paradigm thrives, survives and effectively addresses health inequities.

## **2.2. Syndemic theory and gay and bisexual men's health**

The term syndemic was coined by cultural and medical anthropologist Merrill Singer in the mid-1990s to describe how health problems among marginalized populations tend to co-occur, overlap and fuel each other to create mutually reinforcing clusters of epidemics (Singer, 1996). The term emerged from Singer's own research with Puerto Ricans living in an inner city in mainland USA; he found that within this population, HIV, drug use and violence were so entwined with each other, and each is so significantly shaped by the others that it is impossible to truly understand them effectively as distinct issues (Singer, 1996). Since then, syndemic research has evolved into a robust ecosocial theory in which intersecting epidemics are understood to be produced by social inequalities (such as those related to class, gender, sexuality, race/ethnicities) and unfavourable structural factors (Singer, 2009; Klein, 2011; Stall et al, 2008).

Ron Stall and colleagues (2003) were the first to use a syndemic approach to discuss the health of gay and bisexual men; they found in a large sample of gay and bisexual men in the USA that the most cited risk factors for HIV - polydrug use, depression, childhood sexual abuse, and intimate partner violence - are highly inter-correlated. Their results challenged the traditional way epidemiologists and health researchers have looked at these factors in isolation from one another. Since the publication of Stall's original paper, several other public health studies have supported

the existence of syndemics among gay and bisexual men, mainly in the United-States (Bruce, Harper, the Adolescent Medicine Trials Network for HIV/AIDS Interventions, 2011; Dyer et al., 2012; Egan et al., 2011; Halkitis et al., 2014; Herrick et al., 2013; Klein, 2011; Kurtz, 2008; Mustanki et al., 2007; O'Leary, Jemmott, Stevens, Rutledge, & Icard, 2014; Parsons et al., 2012), but also in Canada (Ferlatte et al., 2014; Ferlatte et al., 2015), Belgium (Wim et al., 2013), Thailand (Guadamuz et al., 2014), and China (Jie et al., 2012; Yu et al., 2013). Syndemic evidence was also demonstrated in a global sample of gay and bisexual men from 151 countries (Santos et al., 2014).

The most notable contribution of syndemic research to gay men's health is to demonstrate the importance of considering gay men's health holistically. The traditional approach in health research is to isolate the cause of diseases by controlling for potential confounders and other health problems. But this approach inaccurately describes how gay and bisexual men experience diseases and illness. In contrast, syndemic approaches attend to the complexity of how health problems influence each other, often by exacerbating the effects of one another, and affecting the overall well-being of the gay and bisexual men's population. Because health problems among gay and bisexual men are so intertwined, isolating each and every one of them in research and in prevention efforts is therefore counterproductive, as a single epidemic, such as the HIV epidemic, cannot be resolved without an attention to other health problems.

Secondly, syndemics brought forward in public health writings on gay men's health a discussion of homophobia as a cause of health inequities. While activists have long argued that stigma and society's negative attitudes towards homosexuality were causing harm to the health of gay men (Dowsett, 2009), prevention writings have in the most part focused on describing how gay and bisexual men's behaviours lead to ill-health. It is mainly through syndemic writing that homophobia emerged as a cause of illness in the public health discourse. Syndemic theory has provided researchers a framework to describe how homophobic violence and anti-gay stigma at various stages of the life-course has measurable deleterious effects on the health of gay and bisexual men. This has led to a call for more upstream interventions to improve the health conditions of gay and bisexual men, such as policy changes and the reduction of

homophobia (BCPHO, 2013). This is in contrast with the traditional behavioural approaches that focus on “fixing” gay and bisexual men’s sexual behaviours.

Despite the progress that has been made in syndemic research and the precision this theory has brought to our understanding of gay and bisexual men’s health, there are still some critical issues that need to be addressed in order to continue to move this research agenda forward. Firstly, while syndemic theory sees health inequities as the results of social inequities and stigma – this is poorly reflected in empirical research on gay and bisexual men. Most epidemiological syndemic studies focus solely on the interaction of diseases and health problems while only a few studies have tried to elucidate the cause and effect pathways between social determinants, social context, and health problems (Ferlatte et al., 2014; Kurtz, 2008; Mustanski et al., 2013). Therefore, the production of syndemics has not been adequately located within societal power dynamics affecting gay and bisexual men.

Secondly, syndemic researchers have generally poorly attended to issues of diversity. The majority of the published articles on syndemics among gay and bisexual men lacks attention to within-group diversity; a small minority of articles in the US has focused on Black and Latino gay and bisexual men (Dyer et al., 2012; Frye et al., 2014; O’Leary et al., 2014), but the remaining studies have largely focused on educated, cisgender, middle-class, urban, and white gay men. Because of the poor representation of men whose lives cut across multiple identity structures, syndemic research has yet to attend to the diversity of forms of power that shapes the health and lives of gay and bisexual men.

### **2.3. Towards Intersectionality Informed Syndemic Research**

In this section, I propose a conceptual framework for intersectionality informed syndemic research with gay and bisexual men. Intersectionality is concerned with issues of diversity and power and has been proposed by many as a promising framework for the advancement of health inequities research (Bauer, 2014; Bowleg, 2012a; Hankivsky,

2012a; Hankivsky & Christoffersen, 2008; Rogers & Kelly, 2011; Springer, Stellman, & Jordan-Young, 2012) Its potential has also been noted in the context of syndemic research (Ferlatte et al, 2014). The promises of intersectionality to address the limitations of syndemic lay in the integration of what Bowleg (2012a) described as the three most salient tenets of intersectionality for public health research: 1) social locations are not independent and unidimensional but multiple and intersecting; 2) historically oppressed and marginalized people are the starting point; and 3) multiple social locations at the micro level (i.e. an individual's sexuality, race, gender socio-economic status) intersect with macro level structural factors (i.e. homophobia, poverty, racism, sexism) to produce disparate health outcomes (Bowleg, 2012a).

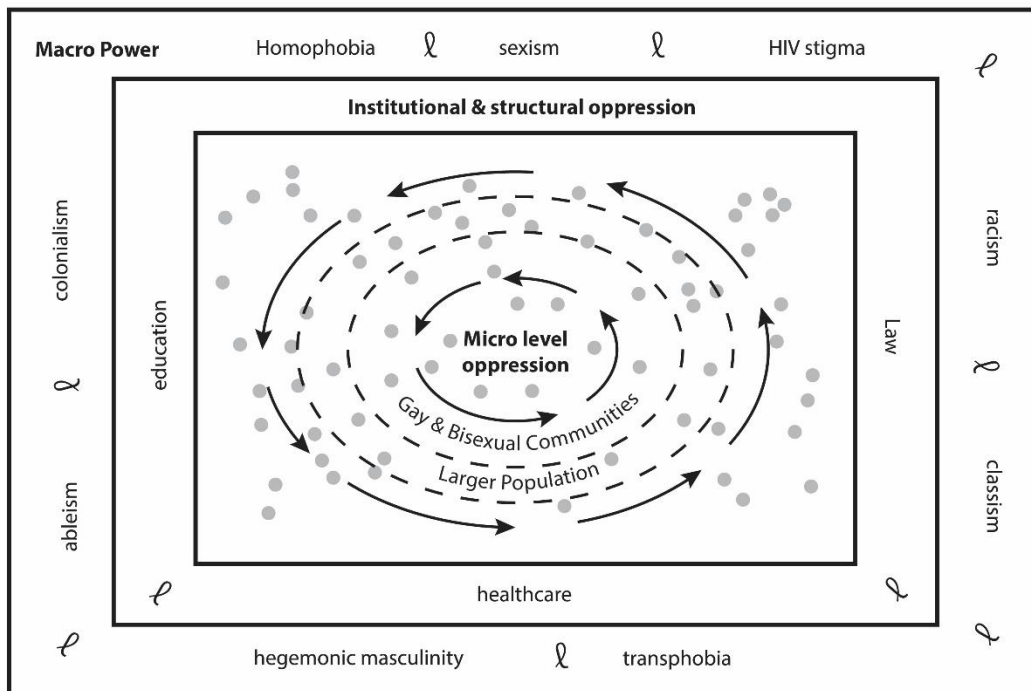
The conceptual framework is presented in Figure 2.1 and 2.2. It builds on the theory of syndemic production proposed by Stall, Friedman and Catania (2008) and a broad base of intersectionality scholarship to integrate these tenets (Weber, 2010; McCall, 2005; Bowleg, 2008; 2012a; Cole, 2009; Griffith, 2012; Hankivsky, 2012; Hankivsky & Cormier, 2011; Warner, 2008). A set of central assumptions guides this framework. First, health inequities of gay and bisexual men, including clusters of epidemics, are largely socially produced and not the result of genetics or behaviours. Second, they are socially produced by various processes of power operating at different levels of society, including macro (global and national institutions and policies), meso (provincial/state and regional institutions and policies) and micro levels (community-level and interpersonal experience). Thirdly, social categories, such as sexuality (i.e. gay, bisexual), are socially constructed and fluid, and they have different meanings in different contexts and time. And finally, gay and bisexual men's communities are constituted of members of different social locations that are affected by a diversity of oppressions (i.e. racism, classism, transphobia, HIV stigma) and power operates within gay communities. Therefore, a sole attention to sexuality or heterosexism is insufficient to address the health inequities of the gay and bisexual men population in its diversity.

This conceptual framework is the first attempt to theorize the integration of intersectionality into syndemic research. It is constituted of two parts that are interdependent: The first part describes the structural and community processes that produce syndemics, while the second part describes the processes that occur within the

individual. These two parts are interdependent and therefore they should not be considered in isolation from one another. What distinguishes this framework from other syndemic models (Stall et al 2008; Ferlatte et al, 2014) is that it is not linear; rather, it shows the complexity and messiness of investigating syndemics with an intersectional approach.

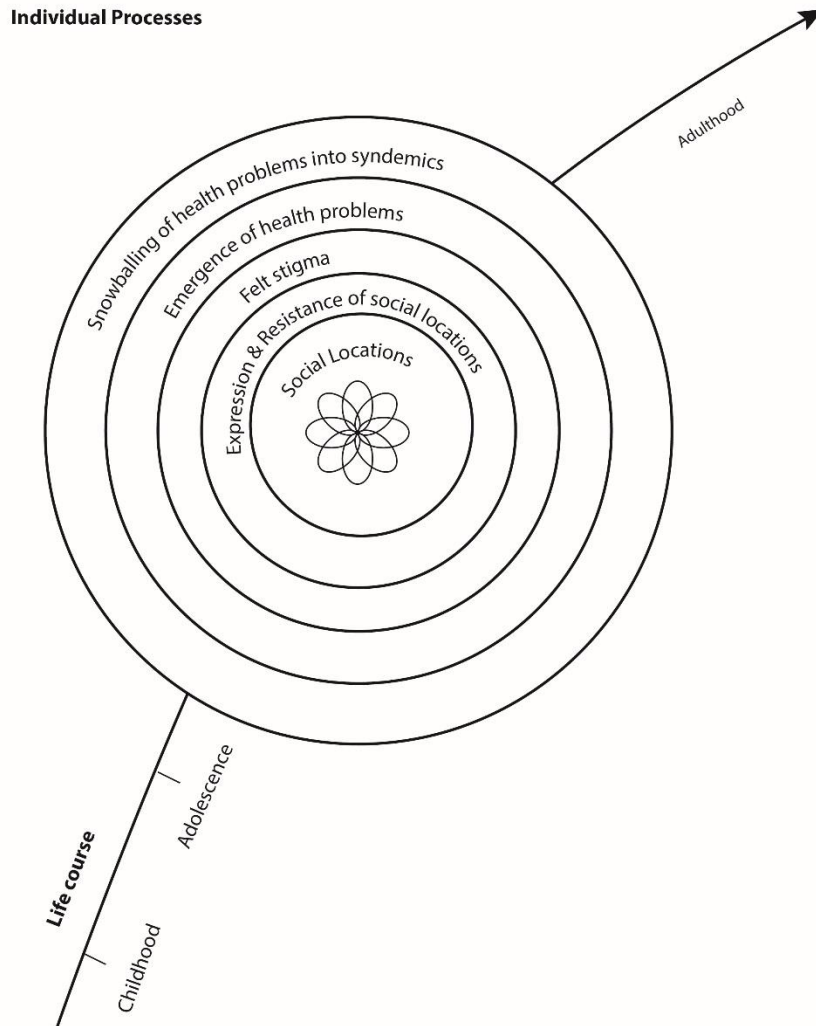
Because of the complexity intersectionality brings forward, it has been described as too difficult to be captured in a simple model or two-dimensional diagram; such illustrations typically fall short of capturing the fluidity and dynamic processes that intersectionality tries to illuminate (Dhamoon, 2011). Therefore, the conceptual framework that I present here should be interpreted with caution. This framework is not meant to describe all singular factors that are present in the production of syndemics. Rather its purpose is to assist researchers and health professionals to disrupt the homogenization of gay men and to consider the constellation of factors and power relations that affect gay men’s health.

**Structural & Community Processes**



**Figure 2-1. Conceptual framework for intersectionality informed syndemic research (part 1)**





**Figure 2-2. Conceptual framework for intersectionality informed syndemic research (part 2)**

### **2.3.1. Structural and community Processes**

Attention to power is a central theme of intersectionality but it has been poorly attended to in public health writings on gay and bisexual men. The main discussion of power relations among syndemic researchers and theorists has been the description of the multiple ways gay and bisexual men are punished by others - particularly heterosexual men - for their sexuality: bullying, harassment, threats, gay bashing, and

other forms of violence. These assaults tend to be explained by a single factor: gay men's sexuality, while how sexuality is shaped by other social locations such as class, gender, and race is largely ignored. But intersectionality calls researchers to consider all intersecting social locations within a population, and more importantly what is revealed about power by these intersections (Dhamoon, 2011).

An intersectionality informed syndemic research would therefore shift its gaze from individuals and groups' experiences (micro level) to the processes of power (macro) that allow these micro level oppressions to occur. More so, intersectionality sees power structures and systems - such as homophobia, sexism, racism, classism - as mutually reinforcing and indivisible, together forming what intersectionality scholar Patricia Hill Collins (2000) calls a "matrix of domination". Because these forms of power are so intertwined, she argues that an attention to homophobia alone would be fruitless as it cannot be erased without eliminating sexism, racism, patriarchy, classism, colonialism, ableism, and so on. Thinking upstream, and more specifically considering homophobia as a structural force which is inextricably linked to other forms of power, presents a radical shift in syndemic research with gay and bisexual men. It would also require a shift from prioritizing homophobia to considering the ways other forms of power feeds into homophobia and how they feed into each other to produce clusters of epidemics.

Intersectionality also recognizes that oppression manifests itself in various ways among gay and bisexual men and that macro, meso and micro levels are interrelated and therefore cannot be treated effectively in isolation from one another. In the conceptual framework presented, macro level power shapes power at an institutional level, through the population "at large", within the gay and bisexual men's community, and within the self (individual level). All these levels need to be accounted for in an effective syndemic research that disrupts power and provides an accurate understanding of gay and bisexual men's health in all its diversity.

## **Power is enacted through institutions**

Institutions and systems such as the health care, the justice and education systems have a long history of enacting power over gay and bisexual men. It is not so long ago that homosexuality was decriminalized in Canada and the USA. Also, until recently, health professionals served as agents of the state to identify, diagnose, cure and punish those who strayed from heterosexuality (Foucault, 1976). The school system has for a long time avoided any representation of gay and bisexual people in a positive manner and has been (and continues to date) to be the site of intense bullying for many gay and bisexual boys.

Of course, these institutions have undergone dramatic changes within the last few decades in their treatment of sexual minorities, but their practices and policies continue to operate power over gay and bisexual men – often in ways gay and bisexual men are unaware of. A few examples include: the criminalization of HIV transmissions, the lack of anti-homophobia policies in schools, the banning of gay and bisexual men from donating blood, the lack of protection from workplace discrimination in certain States in the USA, and the silence on gay sexualities in school curricula.

How these institutions and their policies are influenced by intersecting forms of power and how they shape the lives of gay men, including how they sustain the creation of clusters of health problems is critical information for structural changes that promote health equities. One example of institutional power that produces syndemic may be found in an investigation by Ferlatte (2012). In his study, he found that the HIV epidemic is sustained within the province of British Columbia through a neglect of gay and bisexual men in HIV policies and a lack of sustained funding that matches the scope of the epidemic. He described that gay and bisexual men that do not conform to public health sanitized views of sex (i.e. sex outside monogamy, sex with drugs or sex without condoms) are left without any interventions; this is linked to homophobia and the overall moralistic views on sexuality promoted in public health. More so, he noted that HIV prevention policies largely ignore the unique vulnerabilities of gay and bisexual men

whose lives cut across multiple identity structures: there are no funded initiatives for men of color, Aboriginal gay men or men who use injection drugs (Ferlatte, 2012).

### **Power over gay men in at large community**

Macro levels powers influence everyday interactions and for many gay and bisexual men, this means experiencing various forms of discrimination and violence throughout their lifetime as demonstrated by multiple studies (Ferlatte et al, 2005; Ferlatte et al., 2014; Mustanki et al., 2013; Peter, Taylor and Chamberland, 2015). For example, one recent Canadian study found these events were common among this population: 47% experienced harassment, 13% physical violence, 42% bullying and 16.1% work place discrimination because of their sexuality in their lifetime. These experiences were found to produce syndemics that include suicide attempts and ideation, smoking, illicit drug use, depression, anxiety, and sexually transmitted infections (Ferlatte et al. 2015).

While in the syndemic literature, homophobia alone has been often described as the main cause of the violence on gay and bisexual men, social scientists are increasingly recognizing that homophobia does not exist in isolation from sexism and misogyny. The marginalization of gay and bisexual men cannot be isolated to their sexuality as it is largely influenced by how much one steps out of the prescribed gender norms (Daley, Solomon, Newman & Mishna, 2008).

More so, for men whose lives cut across multiple identity structures, homophobic violence is often shaped by other structural factors that require investigation. For example, analyses from the Canadian Sex Now Survey<sup>5</sup> revealed that men from Aboriginal ancestry were more likely, in comparison to Caucasian men, to report homophobic attacks (*see chapter 4*). These reports are in line with other studies that

<sup>5</sup> Sex Now is a serial cross-sectional survey of gay and bisexual men administered every 12-24 months since 2000 in the Canadian province of British Columbia. The survey has been offered anonymously online since 2007. In 2010, Sex Now was piloted as a national survey and since then the sampling frame was expanded to include all of Canada.

have found high levels of homophobia within First Nations communities (Meyer-cook & Labelle, 2003; Balsam, Huang, Feland, Simoni & Walters, 2004). But understanding homophobia within First-Nations people cannot be done without an attention to colonization and the cultural genocide of Aboriginal people across Canada and the USA. The religious dogma imposed by colonization erased a proud and rich history of sexual minorities and two-spirit individuals in most Aboriginal communities (Meyer-cook & Labelle, 2003). More so, the horrific physical and sexual abuse of many Aboriginals – and particularly same-sex sexual abuse – that occurred within the residential schools system has led many Aboriginals to learn to equate gay sex with pedophilia (Cameron, 2007; Meyer-cook & Labelle, 2003). Therefore, many gay, bisexual or two-spirit people are seen in their communities in the “same light as sin and sexual abusers” (Meyer-cook and Labelle, 2003), resulting in violence.

And finally, syndemic research has neglected attention to other forms of violence that are rooted in other forms of power, such as race-based violence for example. For example, Taylor and Peter (2011) found that youth of colour face about the same rate of homophobia as white youth, but elevated rates of bullying and violence due to race-based marginalization. In another study, Daley and colleagues (2008) noted that “new comers” gay and bisexual youth faced particularly extreme violence that were related to the intersections with racism, classism, xenophobia, and homophobia. Similarly, another study in the USA among Latino gay and bisexual men found that 40% of their respondents reported experiencing both racism and homophobia in the past twelve months and that both types of social marginalization were associated with syndemic factors (Mizuno et al. 2011). This highlights the need to consider violence beyond homophobia and how violence is linked to macro forces.

### **Power is enacted through the gay and bisexual men’s community**

Gay rights movements have promoted an understanding of a cohesive gay and bisexual community, which have had the effect of masking differences and issues of power within the gay and bisexual community. The gay and bisexual men’s community can be a source of pride for many members and can enhance the ability to find

friendships, social support and romantic relationships. But tensions occur from power relations within this population and these have been poorly addressed in the public health literature, including syndemic research.

Researchers have identified multiple ways power is replicated within the gay and bisexual men's movement. These power relations could potentially help explain variations in the experience of syndemics. For example, misogyny, which shapes homophobia, is also a form of power that operates within gay and bisexual men's relationships and communities. This takes the form of gender policing and anti-effeminacy discourses between gay and bisexual men in which masculinity is far superior to femininity (Sánchez & Vilain, 2012). Men who present themselves as effeminate or non-conforming with masculine gender norms are often discriminated against by other gay men and rejected as lovers, sexual partners and community members. It can be hypothesized this would influence their wellbeing too.

Beyond misogyny, other forms of power operate within the gay and bisexual community along the lines of class, race, trans history, ability, income, and HIV status – to name a few that remain to be investigated in syndemic research. Other researchers have highlighted their importance. For example, Bowleg (2012b) observed that many Black gay and bisexual men experience micro-aggressions in the gay community. Riggs similarly described the presence of anti-Asian sentiment within gay online communities, a sentiment that is often constructed as Asian men not being “real men”, highlighting the significance of the intersection of racism and hegemonic masculinity in such micro-aggressions (Riggs, 2012). Others have suggested that these negative experiences of gay men of colour have the potential to outweigh the benefits of engaging in the gay and bisexual community for many (Haile et al., 2014).

More so, a consideration of power differentials within gay and bisexual communities prompts a call for an intersectional interrogation of anti-bisexual attitudes. Gays and bisexuals are often lumped together in one group, which ignores the realities of many bisexual men who have to navigate a community that is designed by and mainly for gay men. Anti-bisexual sentiments are common among gay men (Mulick and Wright,

2002); it often leads bisexual men to avoid the gay community or to conceal their true sexuality when navigating it (McClean, 2008). Anti-bisexual sentiments create stresses that have been linked to issues usually included in syndemic informed studies (Ross, 2010).

Finally, power relations within a community result in what Purdie-Vaughns and Eibach (2008) described as “intersectional invisibility”, an evocative term to describe how people who belong to multiple subordinated subgroups (for example poor, deaf, Black, gay men) are ignored within the history, culture, discourses, and politics of the dominant groups to which they belong. Gay activists are increasingly advocating for syndemic approach as a desirable framework to attend to gay and bisexual men’s health. However, in that discourse, activists have generally ignored the unique experiences of those whose lives are shaped by multiple social locations and processes of power by focusing on the lives of those who have race and class privilege among other types of privilege.

### **2.3.2. Individual Processes**

Social locations, how they intersect and how they are shaped by multiple systems of power are at the core of intersectionality analysis. However, syndemic researchers have generally rejected the idea of social locations. Even sexuality is rarely discussed. This is because most syndemic researchers – like the vast majority of public health researchers – have preferred to use the behavioural category of MSM to describe gay and bisexual men. The term MSM emerged from HIV bureaucratic and scientific coinage to consider homosexual behaviours in complete distinction from gay and bisexual identities. Epidemiologists have argued that it is a more useful category since it is inclusive of all men that engage in sex with a partner of the same gender (Young and Meyer, 2005).

While epidemiologists and public health professionals have found comfort in the term MSM (because it avoids difficult discussions of identity-politics and sexual

diversity), for the majority of gay and bisexual “MSM” it is just a very strange way to talk about them because it reduces them to just their sexual behaviour (Prestage, n.d.). More so, what is hiding behind the wide usage of MSM is a process of power that imposed an “identity” while rendering meaningless gay and bisexual men’s culture, politics, and social dimensions (Young and Meyer, 2005). For example, MSM has been used in AIDS policies as a way to strip gay and bisexual men from any visibility (Boellstorff, 2011). Because MSM erases the social contexts of gay and bisexual men’s lives, it obscures the experiences of stigma, marginalization and power that both syndemic and intersectionality try to reveal.

Another problem with the term “MSM” from an intersectionality perspective is that by ignoring social locations, researchers provide very homogenized views of gay and bisexual men. For example, it ignores the differences between gay and bisexual men and how these two sexual orientations have distinct experiences in many domains of society, such as culture, politics, and public health (Mulick & Wright, 2002). What particularly distinguishes bisexual men is their invisibility in these domains; bisexuality is seldom discussed in public health, HIV, or syndemic research (See & Hunt, 2011; Steinman, 2011). But not all MSM necessarily identify as gay or bisexual. For example, Nelson and colleagues (2014) noted that some Black men deliberately refuse to adopt a gay identity because it is believed to be imbued with white supremacist cultural assumptions and norms that undermine Black sexualities. However, using MSM hides rather than reveals this important process of power affecting Black men. More so, since studies that sample “MSM” continue to primarily recruit gay identified men, they therefore poorly attend to the issues of sub-groups that do not identify as gay or bisexual.

This is also complicated by the way MSM has evolved in recent years; increasingly “MSM” and “Gay men” are constructed as two different categories where gay is used to speak about white men and MSM is synonymous of sexual minorities that are non-white (Boellstorff, 2011). This trend should disturb us for several reasons: Firstly, it makes being “White” an indivisible particularity of gay identity. Second, it reinforces negatives stereotype of men of colour in public health research; “MSM” of colour, and particularly Black men, by being described as flirting with both



heterosexuality and homosexuality, have seen their sexuality described as deviant, excessive and predatory within public health writings (Ford, Whetten, Hall, Kaufman, & Thrasher, 2007). For example, Black MSM on the “down-low”<sup>6</sup> are often described in HIV writings in the US as the main HIV risk factor for Black women, despite research that shows only a small proportion of Black MSM are in fact bisexually active, and this group has a lower prevalence of HIV risks (Millet, Malebranche, Byron, and Pilgrim, 2005; Malebranche, 2008). And thirdly, it makes the issues of the many non-white gay and bisexual identified men even more invisible as they became left out of the literature.

From an intersectionality perspective, it is critical to consider these differences between gay, bisexual and non-gay identified MSM and how they are shaped by different systems of power in syndemic research. It is also important to consider how sexuality is interdependent of other social locations held by gay and bisexual men such as race, class, geography, and Aboriginal status to name a few. Syndemics has traditionally had a narrow focus on white, middle class and urban living gay men, but this is inconsistent with what we know about the distribution of illness among gay and bisexual men and the HIV epidemic. For example, in the USA, Black gay and bisexual men are disproportionately impacted by the epidemic signalling that issues related to race must be considered among other categories.

When considering additional social locations, intersectionality calls for a deeper examination than simply doing the sum of various social locations. For example, the experiences of Black gay men are much more than the sum of their sexuality, gender, socio-economic status, and race identities. Intersectionality seeks to understand what is created and experienced at the intersections of these social locations. For example, Brennan and colleagues (2013) described that gay men of colour, as a result of their multiple and intersecting identities, experience multiple forms of intersecting oppressions that lead to dismissal and invisibility that cannot be explained by focusing on summing racism and homophobia. More so, intersectionality explicitly rejects the prioritization or

<sup>6</sup> “Down-low” typically describes Black men who identify as heterosexuals but secretly have sex with other men, often while having a female partner who is unaware of her partner same-sex sexual behaviours.

the creation of hierarchies when dealing with social categories. For example, a prioritization of sexuality as seen currently in syndemic research is potentially obscuring issues related to class, gender, and racism.

From an intersectionality perspective, it is also important to consider that these social locations are not static but fluid, flexible and that they may change overtime and in different contexts. How one relates to, expresses and resists his identities can have a profound impact on his life and health. For example, Meyer (1995) described that gay and bisexual men have various degrees of commitment to their sexual identity and that those who are most committed to this part of their identity are generally the ones that are the most impacted by everyday anti-gay stressors. But this commitment can be shaped by other factors related to social locations. For example, Bowleg (2012b) in her study of Black gay and bisexual men's experience of intersectionality described that this population tend to rate their racial identity primary over their gay identity. This highlights the possibility for race-based stressors to be a greater factor in syndemics for this sub-population of gay and bisexual men, but again it is poorly addressed in syndemic research.

While some may have a high commitment to aspects of their identities, others may completely reject and resist one or multiple of their social locations. If they are perceived as transgressing conventional notions of masculinity, they may still experience substantial stress. Others may successfully conceal their identity and retain privileges associated with heterosexuality by (over)performing their masculinity and strictly adhering to conventional gender norms. For example, since having a same sex partner would be seen as a scandalous transgression of gender norms, maintaining an opposite sex relationship or even the appearance of one is a way to retain masculinity and resist sexual minority status. This is a critically important point in the context of syndemics. Analysis from the Canadian Sex Now survey showed that this kind of resistance could have significant protective effects for some men; gay and bisexual men partnered with a woman reported significantly less experience with stigma and also significantly fewer psychosocial problems (*See Chapter 4*). They were also much less likely to be caught in a syndemic. Therefore, relationship status and partner gender are important

determinants that need to be investigated in syndemic research along with other factors related to sexual identity.

Such resistance does not happen in a vacuum, rather it is shaped by macro forms of power. Syndemic research has largely focused on how power is enacted through violence; it has neglected that it can be operating within the self. For example, one does not need to be the target of homophobic, racist and classist attacks to be affected by racism, homophobia and classism. People from minority groups learn to anticipate negative regards from members of the dominant culture, a phenomena described as felt stigma (Herek, 2007; Meyer, 1995). Individuals experiencing felt stigma feel pressure to maintain vigilance over or modify behaviours to ward off potential discrimination and violence. This state of being can be extremely exhausting and it has been argued to have more negative consequences on the wellbeing of marginalized populations than actual negative encounters (Meyer, 2003). As other issues related to individual processes, felt stigma has yet to be integrated in syndemic research.

### **2.3.3. Syndemics**

Not every gay and bisexual man experiences syndemics despite experiencing stigma and oppression (Herrick et al., 2011; Ferlatte et al., 2015; Stall et al., 2008). However for some gay men, the tensions arising within communities and individuals combined with the force of structural oppression leads to the emergence of health problems and psychosocial issues that snowball into syndemics. This can occur at any point in one's lifetime. While Stall's theory and much of the prevention writings have located syndemics as something occurring at the adult stage of life, many studies demonstrate that gay health inequities start in adolescence (Stall et al., 2008). In fact, a recent study found evidence of syndemics among a racially and ethnically diverse<sup>7</sup> group of gay and bisexual teens 13 to 18 (Mustanski et al., 2013); they found that psychosocial

<sup>7</sup> 51.4% identified as white, 22.3% as Black or African American, 14.5% as Hispanic or Latino, 7.5% as multiracial or other, 3.0% as Asian, and 1.3% as American Indian (Mustanski et al., 2013).

health problems such as violence, substance misuse, HIV risk, suicide and mental health difficulties were all associated with one another and that a sizable portion of gay and bisexual boys experienced multiple of them.

Syndemic empirical research has also emphasized the importance of HIV to the detriment of other health issues; HIV risk and viral transmission is seen as the outcome to avoid and other health problems only matter if they appear to increase HIV transmission. This approach minimizes the impacts, such as loss of quality of life or premature death that other health problems (such as depression, substance misuse and suicide ideation and attempts) have on gay and bisexual men. This bias towards HIV may reflect more public health priorities than community priorities; for example in the way death by suicide has surpassed HIV among Canadian gay and bisexual men (Hottes et al., 2014). But thus far, only two articles have looked at suicide from a syndemic perspective (Mustanki et al., 2007; Ferlatte et al, 2015) and relatively little attention has been paid to other factors related to aspects of social identities that predispose gay and bisexual men to suicide.

Finally, an intersectionality informed syndemic research could help expand the investigation of syndemics by including issues potentially relevant to some sub-populations of gay and bisexual men, such as men affected by racism, men from rural communities, men from lower socio-economic status, and transgender men. These groups of men may present different syndemic patterns as their lives are shaped by different factors and systems of power. For example, Wilson and colleagues (2014) observed that poverty, trauma and a history of incarceration are two psychosocial problems that must be considered in the study of syndemics among Black and Latino gay and bisexual men.

## **2.4. Guidelines for effective Intersectionality-syndemic research**

Intersectionality research explicitly works towards social justice and equity (Hankivsky, 2012; Rogers & Kelly, 2011). This is because “when social justice drives the research it becomes possible to identify differentials in access to resources, what specific services are needed, what policies areas require institutional support and development and how people are exercising their agency.” (Dhamoon and Hankivsky, 2011, p.31). Differently, the lack of attention to power and diversity in the syndemic literature suggests that social justice has not driven the majority of research. Social justice is a set of beliefs around equal access and opportunities as well as taking care of the most marginal. In this section I propose some guidelines and methodological suggestions to anchor syndemic research within a social justice framework. They draw heavily on guidelines for intersectionality research that others have described (Bowleg, 2008; Cole, 2009; Hankivsky, 2012; Warner, 2008).

### **Reflexivity**

Reflexivity can be defined as a “process that challenges the researcher to explicitly examine how his or her research agenda and assumptions, subject locations, personal beliefs, and emotions enter into their research.” (Hsiung, 2008, p.211). It inspires researchers to question their privileges and assumptions about who are being studied. While reflexivity has a longer tradition within social sciences, it is less common within public health and epidemiology research. Rather, reflexivity is usually perceived by quantitative researchers as superfluous and as potentially undermining the research process with personal bias ( Walker, Read, & Priest, 2013).

However, intersectionality scholars have described reflexivity as necessary to attend to issues of power adequately (Erel, Haritaworn, Rodriguez and Klesse, 2011; Dhamoon, 2011). To advance social justice, researchers need to situate their work within the power contexts within which they work and reflect about their own implication in the conditions that structure the lives of others unequally. This is not limited to

qualitative inquiries, in fact self-reflexivity has been noted to advance both quantitative (Ryan & Golden, 2006) and mixed methods research (Walker et al., 2013), as well as in health promotion (Boutilier & Masson, 2006). All, researchers could benefit from reflecting on how their own history, experiences, privileges, and assumptions shape their research process – from writing the proposal to data analysis and reporting. In syndemic research it could help researchers – particularly those that are privileged along the axis of class, race and gender – to ensure that their research also attends to the issues of those less privileged. It serves to avoid stereotyping or the false homogenization of the population being studied.

Boutilier and Masson (2006) have one advice for those wishing to engage in self-reflexivity: “Write, write and write” about their beliefs, assumptions, challenges and positions in relation to their topic and studied populations. To facilitate reflexivity among researchers, I suggest tackling the following questions adapted from Hankivsky et al. (2012):

- What are your personal and professional experiences with the gay and bisexual men’s community? Including your experience with gay men’s health and syndemics?
- What are your personal values, experiences, interests, beliefs and political commitments?
- How do these personal experiences relate to social and structural locations and processes in this research?
- What are your own social identities, privileges and disadvantages? How are they similar or different than the individuals you are studying?

### **Mixed-methods**

The vast majority of syndemic research has so far relied on survey data. One exception is the work of Lyons, Johnson and Garofalo (2013) who used qualitative interviews to study a syndemic among young gay and bisexual men. Their results are important as it brought new nuance to the understanding of homophobia in syndemics by identifying some new structural factors that help produce syndemics, that had not

been addressed by quantitative analysis: the silence of gay sexualities in sexual education curricula; the absence of role models for gay and bisexual youth; and a lack of productive future goal-related activities. What particularly differentiates these findings in comparison to quantitative findings is that they reveal more specific sites of intervention where policy can be implemented, such as having a sexual education curriculum that includes gay and bisexual sex. This example shows the importance of qualitative data for advancing syndemic knowledge as well as demonstrating that mixed-methods – an approach that involves the integration of both qualitative and quantitative data (Creswell, Plano Clark, Gutmann, and Hanson, 2003) - are promising for this field of study.

The need for mixed-methods has also been noted in the context of intersectionality research (Hankivsky and Grace, 2015). Capturing individuals' complex identities and how they are affected by intersecting systems of power is a complicated endeavour that necessitates multiple sources of data (Harper, 2011). In fact, Dubrow (2013) asserts that we cannot draw a full portrait of population level experiences of intersectionality without both, quantitative and qualitative data. For example, he notes that qualitative strength is to provide valuable insights into processes of power (such as those revealed in the study above), but that quantitative data is needed to help produce results which can be generalized to a larger population or group. Therefore mixed-methods could lead to a more refined and complete portrait of how syndemics are shaped, experienced and sustained across diverse groups of gay and bisexual men.

## **Sampling**

Issues surrounding representation in sampling have been recognized as a challenge for gay and bisexual men's research (IOM, 2010) and traditionally research has been conducted only on the most affluent segments of the gay community – those that are White, middle-class, able-bodied, cisgender, and living in urban settings (Fish, 2008; Greene, 2003). But Cole (2009) points out that an intersectional approach “is an antidote” to that kind of erasure of those not represented in research. By reflecting on who is actually included within a category, she suggests, researchers can illuminate those who may have been traditionally excluded. For example, the gay and bisexual

men's community is constituted of men living along multiple axes of race, age, geography and ability, many of whom may be underrepresented in research samples. Moreover, though age and ethnicity/race are generally collected in gay men's health surveys and syndemic research, no study to date has collected information on disability, therefore rendering those men invisible.

From a statistical perspective, researchers interested in the intersecting effects of social location will require large data sets in order to construct two-way and three-way interactions (Rouhani, 2014). To ensure the possibility of testing interactions, I suggest that researchers oversample men who are most disadvantaged or who belong to multiple minority groups. This could include, but should not be limited to gay men of colour, men of Aboriginal ancestry, men from rural and remote areas and men from lower-socioeconomic classes. Researchers should understand that there are potentially some barriers and power dynamics that impede men from participating in research who are impacted by multiple systems of oppression. Identifying and attending to those barriers would be crucial to ensure their safe involvement.

Similarly, qualitative researchers interested in the experiences of gay and bisexual men from a syndemic and intersectional perspectives should also consider recruiting gay men across multiple social categories.

### **Community-Based Research**

Intersectionality is concerned with epistemologies and the relationship between power and knowledge. One way to disrupt power in the production of knowledge is by including the perspectives and worldviews of those marginalized and typically excluded from the research process (Dhamoon, 2011). The inclusion of the voices of those affected is particularly critical to reduce health inequities, as its absence has been noted as an important barrier in the development of effective public health responses (Guta, Flicker and Roche, 2013).



Thus far, syndemic evidence has mainly emerged from the work of public health and academic researchers, with little involvement of community (at least this is what one can deduct from the available literature on syndemics). By employing community-based participatory methods to engage gay and bisexual men, differently positioned and belonging to multiple subordinate groups, researchers have the potential to extend the knowledge of syndemics and psychosocial health in diverse populations of gay and bisexual men. Specifically, it would ensure that the research processes and outcomes are sensitive to the culture and realities of gay and bisexual men, rather than reinforcing medical biases against sexual minorities (such as inequities are the results of genetics or behaviours). Community-based research will reflect the voices, needs and desire of the community, making it much more likely to create a response to a syndemic that is acceptable and supported. Intersectionality gives this epistemic privilege to the disadvantaged.

### **Resilience and Assets**

While identifying challenges faced by minority groups is critical to address health and social inequities, a singular focus on deficits and negative experiences of a marginalized group like gay and bisexual men can also reinforce stigma or be a way to reinforce the inferiority status of this population. Thus far, health research on gay and bisexual men has mainly focused on gay and bisexual men's health problems, the individual factors that cause them (such as high volume of sex partners), and their inability to adjust to living in a predominantly heterosexual society (internalized homophobia). On the other hand the literature on the strengths and the resilience factors of gay and bisexual is scant (Kurtz, Buttram, Surratt, and Stall, 2012).

Resilience has been defined in the context of gay and bisexual men's health as a process of adaptation and readjustment that occurs despite multiple personal and social losses (Rabkin, Remien, Katoff & William, 1993). It has been described as "an untapped resource" in the development of effective public health interventions (Herrick et al., 2011) and has a promising approach for alleviating health disparities that form syndemics (stall et al., 2008). The fact that in syndemic research, a large majority of gay and bisexual

men experience oppression and marginalization and that only a small minority are affected by syndemics suggests a very resilient community (Herrick et al., 2011; Ferlatte et al., 2015; Ferlatte, et al., 2014). For example, Herrick described that the original investigation of syndemic production among gay men found that while many experienced oppression and multiple psychosocial health problems, the majority (77%) reported no risk associated with HIV (Stall et al, 2003 quoted by Herrick et al, 2011). Intersectionality can be a powerful tool to understand resilience as resilience is increasingly understood as a multi-dimensional process (Luthar, Cicchetti, And Becker, 2000) that needs to be understood in consideration of the life-course and of the social, political and cultural context, which includes power and oppression (Ungar, 2008).

## **2.5. Conclusion**

In this chapter, I have suggested a framework to integrate intersectionality with syndemic research. The hope is that this expanded framework can advance our understanding of how differently positioned gay and bisexual men experience oppression and are affected by health inequities, particularly syndemics. With a greater understanding of health inequities community workers and public health practitioners will be able to intervene more effectively.

The framework and its guiding principles are not meant to be definitive, but rather they should be seen as part of a conversation within and between the greater gay and bisexual men's movement and the public health field. The application of intersectionality and syndemic analysis to gay and bisexual men's health is a recent development and the research is too limited to draw definite conclusions. Furthermore this piece was written at a particular time and place – the context of gay and bisexual men's health is likely to transform and evolve in the next decades. As more evidence is produced on the pathways of health inequities among gay and bisexual men, other forms of stigma and stresses may be addressed.

Moving this agenda forward will undoubtedly come with some difficulties and challenges. Particularly, I foresee the following 4 challenges:

### **Funding**

Funding for HIV prevention research and interventions has been identified to be largely inadequate to reverse the epidemic. For example, Adam (2011) pointed out that gay and bisexual men account for 50% of new HIV infections in Canada, but receive less than 10% of the Canadian Institute of Health Research funding for HIV research. Similar inequities have also been noted in the attribution of funding for HIV prevention (Ferlatte, 2012). Mental health initiatives and research on gay and bisexual men are practically non-existent in Canada. This lack of investment to address the health inequities in gay and bisexual men is a form of structural violence that is likely to fuel syndemics and is an important barrier toward their resolution.

### **Lack of gay and bisexual men's health strategy**

There is no national or provincial gay and bisexual men's health strategy in Canada. The lack of a strategy to address health is compounded by the fact that gay and bisexual men are largely ignored in most health policies. Without a defined strategy, gay and bisexual men will continue to be neglected in policies and particularly in the distribution of funding for interventions. Moreover, since health is shaped by gay and bisexual men's experiences in many domains of society (work forces, legal, cultural), consideration of sexuality should be embedded within all governmental policies.

### **The taboo of childhood and adolescent homosexuality**

The majority of health interventions to reduce syndemic burden have been mainly targeted towards adults, however, as described in this paper, difficulties are developing at a young age, when gay and bisexual boys are first confronted by homophobia and other forms of oppression and violence. Therefore it is critical that interventions are developed for youth. However, youth sexualities, particularly when not

heterosexual, remain very taboo topics in North American societies. Homosexuality is still often seen as a threat to the wellbeing of children and adolescents, which creates barriers for the implementation of supportive policies and interventions.

### **The re-medicalization of gay men's health**

Public health and medicine have long histories of medicalizing gay men's identity and behaviours – turning lives into health problems and pathology. HIV prevention in recent years has been described as undergoing a re-medicalization; where HIV prevention is addressed primarily by means of biomedical interventions such as treatment-as-prevention and pre-exposure prophylaxis (Nguyen, Bajos, Dubois-Arber, OMalley, & Pirkle, 2011). Therefore, those wishing to adopt a syndemic and/or intersectionality perspective that is grounded in the investigations of the social production of diseases will likely face relentless pressure to reposition gay and bisexual men within a bio-medical model.

While these challenges may be daunting, it is critical that they are surmounted, as intersectionality work is much more than an intellectual exercise; "it is important because people's lives depend on it" (Collins, 2009, p xi). The promotion of gay rights has made significant progress in recent years, but considerably less attention has been given to the health of gay and bisexual men. As a result, health inequities are sustained, reducing quality of life and leading to premature death (Bogart, Revenson, Whitfield, & France, 2013). And when the health of gay and bisexual men is addressed, it is rarely done with sufficient attention to the social context that produces inequities (such as heterosexism) or with an adequate attention to diversity and within-group health experiences and inequities. But how can we ever develop a comprehensive and effective health promotion program or strategy for gay and bisexual men if we do not attend to the structural causes of illness in this population? And how can public health achieve its social justice goal of improving the health of "all" without attending to the intersecting social locations held by gay men and their interlocking systems of oppression? Finally, if gay and bisexual men's scholars and activists do not undertake

the daunting but crucial task of questioning and challenging oppression and the resulting health inequities, who will?

## **Chapter 3.**

# **Community-based participatory research meets intersectionality: a case study of the Investigaytors project**

### **3.1. Introduction**

Driven by a desire to advance health knowledge more accurately and provide more effective interventions for the reduction of health inequities, public health researchers are seeking strategies to ensure studies are authentically grounded in the lives of affected populations. At the forefront of these strategies is Community-Based Participatory Research (CBPR) which has been applied in the health field for over three decades. More recently, interest has grown among health researchers in terms of finding ways to integrate intersectionality into research including CBPR studies. Intersectionality is a research framework and paradigm that promotes an understanding of humans as being shaped by the interaction of different social locations and structures of power (Hankivsky, 2014; Bowleg, 2012a). Its uptake is driven by its potential to better address the complexity of how health issues are experienced by diverse and multi-positioned individuals and populations (Hankivsky, 2012).

This paper uses a case study approach to explore the potential benefits of incorporating intersectionality into CBPR research with gay men. This integration is promising as both approaches (intersectionality and CBPR) have similar goals of taking the vantage point of the marginalized; they are grounded in social justice, and have the goal of eliminating inequities. However, both take a different, but not incompatible

approach to reaching these aims; CBPR is a research method, in which the above-mentioned goals are attained when those who are marginalized and affected become co-creators of knowledge as the means of their liberation from their oppression and address their conditions (Hall, 1993; Minkler and Wallerstein, 2008). Differently, intersectionality is not method but a theoretical framework, that suggests that these goals can only be advanced when inquiries focus on the multiple and intersecting penalties and privileges that are shaped by multiple social locations and systems of power (Choo & Ferree, 2010; Hankivsky, 2012a; Rogers & Kelly, 2011). This is because intersectionality sees health inequities as complex and rarely as the result of a single factor (i.e. homophobia). By merging intersectionality and CBPR practices, researchers may more effectively tackle health inequities through a commitment to engaging affected communities in knowledge production with a particular attention to issues of power and diversity that intersectionality brings forward.

This paper begins with a brief overview of CBPR and the potential value that may be achieved with the addition of intersectionality. This is followed with a case description of the Investigaytors program: an intersectionality informed CBPR initiative to disrupt power dynamics in research processes by building the capacities of a diverse group of young gay men to understand, critique and perform health research. Significantly, the case study highlights the various benefits of the Investigaytors program to those involved by focusing on their intersecting identities. Finally, the discussion will feature some key advantages of an intersectionality informed CBPR approach to research with young gay men.

### **3.2. Towards an intersectionality informed Community-Based-Participatory Research (CBPR)**

Many public health initiatives have been deployed to reverse health inequities, but few have succeeded. Many have blamed the lack of involvement of affected communities for this failure and have called for a meaningful engagement of those affected in the research, planning and evaluation of these initiatives (Guta, Flicker, and

Roche, 2013; Flicker, 2008). To engage communities, many researchers have turned to CBPR. While many definitions of CBPR exist in the literature, it can be defined as a:

“Collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each bring. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change and improving community health and eliminating health disparities” (W.K. Kellogg foundation, quoted by Minkler and Wallerstein, 2008)

CBPR moves away from the traditional public health research paradigm, in which outside researchers from universities and public health agencies determine the research agenda, the research methods, and the kinds of results and outcomes that are documented (Hall, 1993; Israel, 1998; Minkler and Wallerstein, 2008). CBPR troubles whose voices influence the research by bringing community perspectives. Its explicit goal is to bring about a more just society and the elimination of inequities (Hall, 1993; Cargo & Mercer, 2008; Minkler, 2000). CBPR adheres to set core values and characteristics about its knowledge production that defines it as a method:

- It is participatory;
- It is cooperative – engaging community members and researchers in a joint process in which both contribute equally;
- It is a co-learning process;
- It involves systems development and local community capacity building;
- It is an empowering process through which participants can increase control over their lives;
- It achieves a balance between research and action (Minkler and Wallerstein, 2008, P. 9).

While CBPR started as a marginal movement, it has now become mainstream, with many health researchers adopting this orientation to study health inequities. Funders are also increasingly requesting academic and public health researchers to work with communities in their research design. The increasing popularity of CBPR in



health research can be explained by its well-documented benefits: CBPR allows for a better representation of disenfranchised populations in research which leads to more accessible, accountable and relevant research results (Israel, 1998). The process of CBPR can also be transformative; through meaningful engagement in health research, individuals and communities are empowered and see their capacity to address health and social issues increased (Wallerstein and Duran, 2008).

Despite the important contributions of CBPR in advancing knowledge about health inequities, some important challenges remain; a commitment to the principles of CBPR alone may be insufficient to achieve social justice and reverse health inequities. Firstly, issues related to diversity have been traditionally poorly addressed in CBPR. This is a critique that feminist scholars and activists have brought forward for many years; they have described that “populations” and “community” are treated as a monolith in CBPR, resulting in the silencing of many marginalized people, such as women and other minorities (Corbett, Francis & Chapman, 2007; Gatenby & Humphries, 2000; Maguire & Reid, 2009). Therefore they have maintained that “an attention to gender, race, class and other social locations should be central to this means of research production as these issues interlock and influence every aspect of the research enterprise” (Minkler and Wallerstein, 2008, p.9).

Secondly, some have questioned whether the “community” tends to be truly involved in the research process. While, the CBPR literature describes a commitment to high-level community participation throughout each phase of the research process (Gaventa, 1993; Israel, 1998; Minkler and Wallerstein, 2008), the reality is that in many CBPR research projects, community members are asked to be either the “friendly face” of a project or a data collector, in both cases without much responsibility (Guta, Flicker and Roche, 2013). This appears to be particularly the case in Canada; in a review of Canadian CBPR health projects Flicker and colleagues (2007) found that academics dominate the research process with involvement of services providers who are often asked to represent the community. This raises powerful questions about whether service providers can effectively speak out for and represent community-based concerns. In the same review they noted that community participation often means having an advisory

community group that meets quarterly – something they describe as tokenism rather than CBPR.

Finally, issues of power differentials between communities and academics are important issues impeding the full potential of CBPR, but that remain poorly addressed in the literature. Guta, Flicker and Roche (2013) describe that much of the literature on peer researchers focuses on the ethical dimension of using them and the capacity of peer researchers to conduct themselves in a manner that maintains ethical requirements. Meanwhile, they note that there is a dearth of data on the use of peer researchers, and more specifically on their relations with academic researchers and how power differentials are addressed in the research process (Guta, Flicker and Roche (2013). While some researchers are increasingly considering community as co-researcher and are able to build collaborative relationships with them (Harper and Salina (2000), in many other CBPR projects, academics take up the role of organizing community members and create hierarchies where community members find themselves at the bottom (Guta, Flicker and Roche, 2013; Flickr, et al., 2007). They often do so by imposing titles on community members such as peer researchers or peer research associates that reaffirm the inferiority status of these members within the research team – less than researcher. More so, academics generally hold on to most important decisions such as budgets and timelines. The results of these power structures undermine the emancipatory goals of CBPR and do little to build capacity. Anassi and colleagues (2002) described that if CBPR is to survive, academics will have to increase their valuation of indigenous knowledge and incorporate in their design capacity building, skills transfer and empowerment strategies, that is, something that goes beyond the simple transfer of some academic responsibilities (such as data collection) to community members.

In this paper, I explore the potential of the intersectionality framework to advance CBPR practices. Intersectionality is described in more detail in Chapter 1. CBPR and intersectionality similarities and differences are presented in Table 3.1. Because they each share similar goals there are potentially some merits in merging them to investigate issues of social and health inequities more effectively. The appeal of intersectionality to

CBPR is that intersectionality is particularly concerned with the overlooked issues in CBPR of diversity, representation and power.

Intersectionality is also concerned with giving voice to community. Where it differs from CBPR is that intersectionality is particularly concerned with giving voice to those whose particularity and needs have traditionally been invisible. For example, intersectionality would bring to light how the specific issues of gay men of colour that have generally not been addressed within the “mainstream” gay movement or within race based movements. Therefore, intersectionality informed CBPR would mean engaging a diversity of community members in revealing who have traditionally been invisible and identifying a more complete range of salient factors affecting health, as well as the relationships between such factors. Intersectionality would bring some complexity to how communities have been traditionally defined within CBPR.

**Table 3-1. Comparison between Community-Based Participatory Research (CBPR) and intersectionality**

	CBPR	Intersectionality
Definition	A collaborative approach to research, CBPR equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities. (Minkler and Wallerstein, 2008)	Intersectionality is an approach to research that can help illuminate and interpret the relation between social locations and complex systems of power, penalty and privilege (Hankivsky, 2012b; Hankivsky & Christoffersen, 2008; McCall, 2005).
Goals	Promotion of equity and social justice (Hall, 1993; Minkler and Wallerstein, 2008)	Promotion of equity and social justice (Choo & Ferree, 2010; Hankivsky, 2012b; Rogers & Kelly, 2011)

	CBPR	Intersectionality
Principle Tenets	<ul style="list-style-type: none"> <li>• CBPR is participatory</li> <li>• It is cooperative, engaging community members and researchers in a joint process in which both contribute equally</li> <li>• It is a co-learning process</li> <li>• It involves systems development and local community capacity building</li> <li>• It is an empowering process through which participants can increase control over their lives</li> <li>• It achieves a balance between research and action. (Minkler and Wallerstein, XX, P. 9)</li> </ul>	<ul style="list-style-type: none"> <li>• Human lives cannot be reduced to single characteristics;</li> <li>• Human experiences cannot be accurately understood by prioritizing any one single factor or adding together a constellation of factors</li> <li>• Social categories are socially constructed, fluid, and flexible</li> <li>• Social locations are inseparable and shaped by the interacting and mutually constituting social processes and structures that are influenced by both time and place. (Hankivsky 2012, P. 1713).</li> </ul>
Community/ies	<p>CBPR focus on community as a unit of identity. Unit of identity refer to entities in which people have membership, for example, a family, social network, or geographical neighborhood (Israel et al, 2003; Duran et al. 2008).</p>	<p>Intersectionality rejects the notion of homogenous communities, groups, or populations. Rather, intersectionality challenges how communities are traditionally defined by highlighting how members of “community” are differently positioned due to their intersecting identities. (Bowleg, 2008; Hankivsky &amp; Christoffersen, 2008)</p>
Power	<p>CBPR is particularly interested in power and power imbalances among the various actors involved in the research process. CBPR members have different levels of power within and across the systems represented (community, agency, university) that must be acknowledged. Balancing power and influence is key to CBPR (Becker, Israel and Allen, 2005).</p>	<p>Power is a central concept of intersectionality. It advances that power operates to exclude particular types of knowledge and experience, that categories (such as sexual orientation) are constructed and shaped by systems of power (i.e. heterosexism), and that all systems of power (i.e. racism, sexism, classism) operate together to shape privileges and penalties between and among communities. (Collins, 2000)</p>

	CBPR	Intersectionality
Methodology	CBPR is an orientation toward research that focuses on the relationships between research partners (academic and community), rather than a specific set of research methods and techniques. (Minkler & Wallerstein, 2008). The practice of CBPR involves systematic efforts to incorporate community participation at all stages of the research process.	Intersectionality is an approach to research that assists in documenting the interaction of multiple social locations and/or systems of power. A common critique is its lack of specific methodological applications (McCall, 2005).
Knowledge(s)	CBPR operates under the assumption that oppressed and marginalized communities possess important knowledge that can be galvanized for change (Israel et al., 1998; Minkler, 2000).	Intersectionality recognizes the existence of diverse knowledges and is particularly interested in the relationship between power and knowledge production. Like CBPR, intersectionality recognizes that including the perspectives of marginalized populations in research is useful in disrupting forces of power that are activated through the production of knowledge (Dhamoon, 2011).

Moreover, power is a central concept of intersectionality, and as described above, power is an issue unresolved in the practice of CBPR. Intersectionality could help researchers address issues of power imbalance by engaging them into a reflection about their own social positions and how it shapes their practice with the communities they work with. More so, intersectionality helps shine light on how the design of certain CBPR projects tend to sustain the power of academia over communities, rather than liberate the community. To disrupt these power dynamics, researchers would need to engage not only in reflexivity, but make more space within research projects for responsibility sharing and for the inclusion of Indigenous perspectives and knowledge. More so, to address power, greater efforts should also be deployed to build capacities and skills that reflect the aspirations of the community members involved rather than the aspiration of the academics for the community.

### 3.3. The case – The Investigaytors

The Investigaytors is a CBPR initiative of the Community-Based Research Centre for Gay Men's Health (CBRC), *"a non-profit organization dedicated to using community participatory research to develop knowledge about gay men's health and to guide community practice and theorizing on health and social issues"* (cbrc.net). CBRC is located in Vancouver, Canada. It was created by a group of gay men in the late 1990s in response to a lack of meaningful engagement of gay men in HIV research and the eroding state of prevention. To redress the situation, a new institution was created, by and for gay men, to produce community-sensitive and action driven knowledge.

To date, CBRC remains the only community run independent health research centre in Canada and has positioned itself as a leader in gay men's health and CBPR practices in Canada. Our CBPR practice differs from the typical university-community partnership where outsiders collaborate with community; CBRC's research team is composed of gay men and the organization has its own board of directors of community members that oversees the governance of the organization. CBRC has been working for close to two decades with gay and HIV community organizations to empower them to improve prevention and health promotion for gay men. CBRC engages communities into a transformative process we call study-plan-do (Trussler and Marchand, 1997). It is an approach inspired by Freire's Listening-Dialogue-Action approach (1970), which consists of engaging in a meaningful dialogue in order to gain knowledge of a social reality and to transform it through action and critical reflection. Within this model, CBRC participates with other stakeholders in the development of health promotion activities, which start by listening to health experiences of our community through various research inquiry techniques. Then, CBRC works closely with the community on the development and implementation of a strategy for addressing the issues at stake. This approach has been at the core of CBRC research program since the beginning.

In recent years, CBRC became interested in intersectionality after I brought information about this framework to my colleagues. I was introduced to it myself by my graduate supervisor and I felt it could transform gay men's health in some revolutionary

ways. My colleagues agreed, and we were then very keen to integrate its principles into our practice. Intersectionality forced us to reflect on our practices and perspectives on the gay community. While CBRC had been successful in engaging a range of actors – particularly community leaders and public health professionals – in our research endeavours, historically we had not engaged the community members that are most marginalized. For example, much of our research focused on young gay men because of their increased vulnerabilities to the social and health inequities our research has revealed (Trussler, Marchand & Baker, 2003; Trussler, Marchand & Gilbert, 2006; Ferlatte, 2014; Trussler, Ferlatte, Marchand, Banks and Moulton, 2009; Ferlatte et al., 2014). However, because we work with those in leadership positions, which tend to be older, we felt our work lacked meaningful input from young gay men. Additionally, our encounter with intersectionality made us increasingly aware of the lack of diversity beyond age within our organization and the community members we worked with. As white, able-bodied, cisgender, middle-class, urban, and highly educated men, we did not form a diverse team and intersectionality highlighted that we needed to research gay men's health from the vantage points of a diversity of gay men differently positioned than us. In particular, we thought that a model that built capacity among diverse young gay men to conduct research on their own needs and concerns would be the best way to shift our organizational practice.

In light of these reflections, my colleagues Timothy<sup>8</sup> and Frankie and I decided to embark on a new adventure involving untrained, young gay men who would learn research skills and conduct a national survey on the social determinants of gay men's health. The novel idea here was not to simply diversify our team and tokenise youth, but to disrupt power between older and the largely invisible younger generation of gay men in gay research, as well as between researchers and community members by building the capacity of young gay men to understand, critique and perform research. Therefore, we envisioned much more than a research project that would draw on CBPR principles, we conceived an education program where knowledge and skills would be transferred to

<sup>8</sup> To protect the anonymity of all the individuals described in paper, I used pseudonyms that were selected using an online random name generator, with the exception of one participant who requested a specific alias.

younger gay men while they received tangible experience by working on a research project. More so, we wanted to build a program where decision-making would be shared between the researchers from the institutions and the new youth researchers.

The program began in April 2011, after recruiting four young gay men interested in gaining hands-on experience in research. Kerry, Brent, Henry and Jeremy joined us from Totally Outright, a sexual health leadership program for young gay men age 18 to 26 created by the CBRC and conducted by a community partner<sup>9</sup>. They came to the project with their own intersecting identities of penalties and privileges that are described in table 3.2. For example, Jeremy and Henry were Asian, and Henry also lived in a suburb of Vancouver. They were all students with the exception of Brent who had recently completed an engineering degree, but was performing administrative work in a health promotion organization. When asked what other identities they would like to see acknowledged in this report, Kerry claimed the identity of a “drug using slut”, which he defined as someone who has lots of sexual partners and that consumes party drugs, often for sexual pleasure. Being a drug-using slut was an important way Kerry experienced being gay and he claimed this identity in a positive and political manner after having witnessed that gay men with multiple sex partners and engaging in drugs are vilified in both gay and mainstream culture.

<sup>9</sup> See <http://checkhimout.ca/totallyoutright/>.



**Table 3-2. Description of the Investigaytors team members' intersecting identities**

<b>Pseudonym</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Education</b>	<b>Other intersecting identities</b>
<i>Young Investigaytors</i>				
Jeremy	20	Chinese Canadian	Some University	
Kerry	23	White	University degree	Drug Using Slut
Jonathon	23	Punjabi (Indian)	University degree	Queer
Stewart	21	Asian Canadian	Some University	
Henry	24	Chinese	Some University	Student, Suburbanite
Julian	25	Caucasian	High School Completed	Suburbanite
Brent	26	White/Caucasian	University degree	Middle Class
Bob	25	White	University degree	Transgender
Felipe	25	Vietnamese	University degree	Geek, Gamer, Lower income, Queer
<i>Research Mentors</i>				
Timothy	60s	Caucasian	PhD	
Frankie	60s	Caucasian	EdD	
Myself	33	Caucasian	PhD Student	Middle-Class, Cisgender, Urban

Note: To protect the anonymity of my participants I used pseudonyms that were selected using an online random name generator for all participants, with the exception of one participant who requested a specific alias. These identities are self-description.

They chose the name the Investigaytors for themselves. With them, we identified their research interests and training needs. This was followed by a series of workshops and presentations by the research team and invited experts, where they learned about research processes, methodologies, and knowledge translation, while working on the development of a major research initiative – a national survey. They also received

training on various health theories pertinent to gay men's health, including social determinants of health theory (Mikkonen and Raphael, 2010), minority stress theory (Meyer, 1995; 2003a), and syndemic theory (Singer, 2009; Stall et al., 2008). A particular focus was given to intersectionality and its guiding principles. They also had opportunities to attend two local conferences on intersectionality research (Spring Learning institute on Intersectionality 2011 and 2012 – [www.sfu.ca/iirp](http://www.sfu.ca/iirp)). The principal tenets of intersectionality were constantly revisited within the group's discussions on gay men's health: such as, that gay men's lives cannot be reduced to their sexual orientation or behaviours; that gay men's health cannot be accurately understood by focusing on a singular factor (i.e. sexual orientation); that sexuality and sexual orientation (like other social categories) are fluid and flexible, and that gay men are not a homogenous group.

Learning presentations and workshops were integrated into research meetings while the Investigaytors worked on the development of Canada's first national survey on the social determinants of gay men's health – Sex Now Survey 2011. After a brief orientation on research and survey methods, the Investigaytors, in collaboration with the research team, identified the overarching themes and objectives of the survey and designed the questionnaire. They then developed a marketing strategy for the survey; building on the much-mediatised controversy surrounding the abolition of the mandatory long form of the Canadian census that year. The Investigaytors created a tag "Canada's unofficial gay men's census" to promote the survey. The idea of this promotion was to recruit a broad and diverse sample of gay men to complete the questionnaire while educating them about the need to collect sexual identity information on the census. The Investigaytors promoted survey participation through a sophisticated online outreach strategy that they planned. In the end, an unprecedented total of 8607 men completed Sex Now Survey 2011 – making it the largest research sample of gay and bisexual men ever collected in a Canadian health study.

After the data collection, Investigaytor Jeremy left the project to pursue education in another country, but five new young men joined. Jonathon, Stewart, Julian, Bob and Felipe were recruited from the most recent graduates of the Totally Outright program, similarly to the original Investigaytors. Their intersecting identities are also described in Table 3.2. They brought more diversity into our team; Jonathon was a young South

Asian man who had recently completed his BA who identified as queer<sup>10</sup> and gay; Felipe was a young Vietnamese man who also recently graduated from his undergraduate degree. He described himself as a geek, gamer<sup>11</sup>, queer and lower income person; Stewart was someone who only recently came out as gay and was an Asian undergraduate student; Julian lived in the suburbs and was the only one that did not attend university and he worked a low paying job; and Bob, a Caucasian man who attended grad school and identified as transgender.

Both old and new Investigaytors embarked on an intensive, weekend statistics training “bootcamp” using the survey data for practice. They learned how to compute frequencies; mean, median and mode; chi-square test; odd ratios; and binary logistic regression using SPSS statistical software. Investigaytors then worked on their own individual analyses with the support of senior researchers on the team. These analyses were then presented at a gay men’s health conference, the BC Gay Men’s Health Summit. Each Investigaytor was given the liberty to choose a topic for their own analysis. Their topics included: a description of the sample; generational differences in coming out; gender expression and violence; relationship status and health; body images and mental health; sex and drugs; and social support.

Finally, the Investigaytors produced a lay-language report highlighting their findings. It was made available in print and online. They launched the document at a community event they organized that gathered over sixty young gay and bisexual supporters.

<sup>10</sup> Queer identification is typically understood as one’s refusal to be defined within the rigid binaries of heterosexual/gay and men/women, however the two investigators who identified as queer claimed both a gay and a queer identity at the time of interview.

<sup>11</sup> This Investigaytor described being geek as having a particular interest in learning and acquiring knowledge and skills, while he explained gamer as an interest in social experiences build around having fun, particularly through playing games.

### 3.4. Methods

This paper uses a case study methodology to reflect on the Investigaytors and explore the benefits and challenges and the value-added of intersectionality in CBPR. Case study methodology is a method of inquiry that draws on multiple perspectives and materials to produce contextually rich and meaningfully information on a given issue or case (Padgett, 2008). In this case, two primary sources of material informed my analysis:

Coordinator's Observation and Field Notes: Throughout the project, as the coordinator of the project, I took detailed notes of our group activities and accomplishments. These notes included my personal reflections on emerging conflicts, group dynamics and impressions of progress being made within the group and by individual Investigaytors. All meetings were audio recorded and several group process check-ins were conducted.

In-Depth Semi-structured Interviews: I invited all Investigaytors and my colleagues Frankie and Timothy to participate in reflective one-on-one interviews with me near the completion of the project. Interviews were audio recorded and transcribed verbatim (Questionnaires in Appendices).

The analysis of the interview transcripts was conducted using an inductive approach (Thomas, 2006) informed by the tenets of intersectionality (Bowleg, 2008; Hankivsky, 2012; McCall, 2005). Particular attention was given to diversity and intersecting identities. The transcripts were reviewed and coded relative to the main research questions: 1) What differences does intersectionality make in CBPR?; and 2) What are the benefits, and challenges of creating an intersectional team of young gay men in gay men's health research? The analysis considered issues of power and how intersecting identities of participants may have benefited or negatively impacted their participation. Further, the analysis sought to understand how the multiple social locations of the participants may have impacted the research project and its outputs. Findings from the preliminary analysis were presented back to interviewees to gather their

additional feedback and validation. This research process received ethical approval from the Simon Fraser University's Office of Research Ethics.

### **3.5. Positionality**

Before diving into the results of my investigation, I would like to better position myself in relation to the Investigaytors and the gay community more broadly. Positioning oneself and reflecting on the meaning of these positions is critical to intersectionality inquiries in terms of disrupting power. While I share a common sexual identity with the Investigaytors and that we treated each other as peers throughout our adventure together, I recognize that I held a position of power over them as the project coordinator.

More so, I felt I had more privileges than them due to my age, but also as I was highly educated – this work happened in the context of my PhD dissertation – and I earned more than all of them. More significantly, I am a Caucasian and cisgender – these privileges were more visible within our little team with 6 people of colour<sup>12</sup> and one transgender participant. I also benefited to be living in the downtown core, which in comparison to most Investigaytors, meant that I could more easily travel to our meetings. These are some privileges that I can account for in my dealings with the Investigaytors that are likely to have shaped my interactions, probably often in ways I may not have even aware of. For example, despite my best-intended efforts to be open to others' perspectives, members of our team who are people of colour may have felt uncomfortable to bring up the topics of race and racism. Reflecting on these power dynamics was important in processing the case study's findings to make sure I stayed alert to realities that are different for myself.

<sup>12</sup> I am using the term people of colour as the Investigaytors have informed me that they prefer this term to ethnicity or racialized community. .

## **3.6. Findings**

The findings of the case study will be presented in five broad sections that together provide insight into both the Investigaytors project as a gay youth program and the application of intersectionality to CBPR with gay men: 1) benefits to the Investigaytors 2) benefits to researchers, 3) the value added of the research approach, 4) reflections on intersectionality, and 5) moving forward.

### **3.6.1. Benefits to the participants**

When launching the Investigaytors project, my two colleagues and I felt a lot of anxiety about whether this project would ever succeed or generate interest from young gay men. The study had a very ambitious plan: conducting the first national survey on social determinants of gay men's health in Canada and of gathering the largest ever sample of Canadian gay men. Would engaging with the Investigaytors delay our timeline and objectives? Would teaching along the way create delays? Would the Investigaytors remain interested for the entire duration of the project? Were we overwhelming them with our expectations? Would they see their capacity increase?

Given such worries it seemed very important to gather the Investigaytors' feedback on a regular basis and identify what they were getting out of the experience. However, when we proceeded with these check-ins, the Investigaytors had generally little to say. Perhaps the Investigaytors felt intimidated, due to inherent power imbalances between the senior research team and themselves. Nonetheless, intuition was indicating that something was going right. After all, they kept coming back week after week.

The interviews with the Investigators provided an opportunity to better understand what motivated them to come to research meetings and if we succeeded in building their capacity. Each interview began by asking the Investigaytor to reflect on their overall experience with the project. Every single Investigaytor described their

experience as highly positive and pleasurable – the majority using the term “fun” to describe it. For example, Jeremy explained: “*You go to a meeting for two hours and each one was a lot of fun, so it just passed the time*”.

They all described the program as an extremely valuable learning experience. For example, Henry mentioned: “*Every meeting I went to I learned something, whether it was, about statistics, a fact, or it was how to do something.*” Because most had no-to-little experience with research prior to the program, it should not be surprising that their greatest learning concerned research methods and processes themselves. Every Investigaytor mentioned how their literacy level had increased around research while taking part in the program. For example, Henry said, “*Before I never even knew there was a difference between qualitative and quantitative research. I thought all research was quantitative*”... “*Now when I listen to research presentations I get more out of it. There were parts before where I didn’t understand and now I just feel I understand a lot more about the concepts, the words and what the graphs actually mean*”.

The program was also an opportunity to learn about gay men’s health. For some of them, the concept of gay men’s health was foreign prior to their involvement. For example, Henry describes:

*I always just felt that the term “gay men’s health” was just an umbrella term to talk about the gay community in a positive way. And I always thought, oh, that’s just another way of saying gay community. So then I guess when I was doing the Investigaytors, I was just realizing what gay men’s health actually is.”*

Some Investigaytors were new to the gay community and had several gaps in their sexual health knowledge as gay men that the program addressed. For example, Julian specifically mentioned learning about behaviours that put gay men at risk of HIV transmission, safer sex, and the importance of routine testing for HIV and sexually transmitted infections (STIs). “*I learned about risks and about my own health. I feel like I learned how to take better care of my health,*” he described. Similarly Stewart described that he was particularly naïve about sexuality before his involvement. He said: “*I learned about open relationships, where I never really understood that before. I learned that gay*

*men like to have sex a lot.” He found that the project helped him expand to a more accepting and positive view of sexuality. He said: “I learned what sex-positive was, like someone who has like a lot of sex with a lot of people, calling him “slut” is a derogatory word”.*

Other Investigaytors explained that they learned about gay men’s health mainly through the research findings from analysis of the survey. Since each Investigaytor tackled a different aspect of gay men’s health in their personal research project, the group as a whole produced a wealth of information that they all described as highly valuable. They viewed the research as useful for verifying their personal experiences with gay life. Jonathon said: *“We have a lot of assumptions about the gay community, and when we do research I think they’re like validated and sometimes they aren’t.”* Most of them developed a hypothesis for their individual analysis that was grounded in their personal experiences, and their preconceived notions and assumptions about gay men’s health. Their analysis helped them to evaluate their experience empirically.

Moreover, many Investigaytors described how the program, with its focus on social determinants and intersectionality, helped them to gain a deeper understanding of health in general and gay men’s health in particular. For example, Jeremy said:

*“Before I joined the Investigaytors, I thought of health in a much medical – not even the medical sense. A very physical sense. You know, like blood pressure and cholesterol, BMI, and stuff like that. But I think the Investigaytors exposed me to a lot of different variables that we need to consider. So that could be mental health, that could be social support networks, or sexual health. So I learned the different determinants that are involved in the general welfare of a person.”*

The Investigaytors also expressed gaining a deeper understanding of intersectionality from their involvement in the program. Many of them mentioned it in their interviews. For example, Kerry said: *“Intersectionality has been something as well that I’ve quite valued that this group has given me access to, as kind of a theory and as a practice.”* Although not every Investigaytor embraced intersectionality to the same degree, it was a framework that was brought up definitively in meetings, other



conferences and community forums. Some also integrated intersectionality in other community work they were involved with – like anti-racism activism. For example, Henry who identified as a person of colour took the initiative to present an anti-oppression workshop at a young gay men’s conference that focused on the principles of intersectionality.

But their learning went beyond knowledge. They all described how they gained tangible research skills through their participation. They described how the opportunity offered by the Investigaytors was truly unique; they learned skills related to each steps of the research process, including questionnaire design, statistical analysis and knowledge dissemination. Many of these tasks are typically reserved for academic researchers. Indeed, several of them had tried to gain similar research experience through their universities, by volunteering or becoming a research assistant, but all they were given were administrative tasks that did little to improve their capacity. The Investigaytors program was different. For example Bob described: *“It’s very rare that research is done with non-researchers. [...] And I think the Investigaytors are really a unique way to have access to a wealth of data and to develop research skills, and to do it in a way that is very applicable, and personal. Which I think is not the norm for ways of learning and doing research.”* They all described how these skills would help them in their career and several intended on applying to graduate school; they viewed the Investigaytors program as furthering their goals.

One of the unintended consequences of the Investigaytors is that it helped the youth involved build social support networks. Many have described how they have felt isolated as gay men due to homophobia or the lack of opportunity for young gay men to connect outside of bars or sex scenes. The majority described how they got valuable friendships from the program. For example, Stewart described: *“I really like the social aspects. I didn’t have gay friends before, so I enjoyed coming to the weekly meeting and interacting with people.”* In his interview he also mentioned how important these new friends were to him in time of hardship, when he broke up with his first boyfriend. Without the Investigaytors, he said, he would have had no social support to help him through the separation. Some also described how the Investigaytors provided them with a rare chance to include older gay men in their social and support network for the first time.

Connecting with the senior researchers provided them with an intergenerational experience.

### **3.6.2. Benefits to researchers**

This section shares reflections from the senior research teams about their experience as researchers, but also as gay men. While “fun” was the first word to come to the minds of the young participants describing the program, it was also “fun” for senior researchers and it was often the way we described the program to colleagues. The research team experienced a lot of pleasure and gratification sharing knowledge of gay men’s health and helping the young men develop their research skills.

My colleagues had a much larger age gap with the Investigaytors. While I was about 10 years older than most Investigaytors, the senior researchers were nearly 40 years older. They described the intergenerational experience as very gratifying. Since the gay community is generally segregated by age, they saw in this project a unique opportunity to engage with youth in a meaningful manner. Frankie said:

*“I think it would be a pretty sad life if I only dealt with my own generation - most of the gay ones are dead, died at least 15 years ago, which is a big problem for us. And for someone older there's a sense of personal satisfaction in having framed and supported an activity that young people enjoy and benefit from. You know, it's quite a satisfying thing.”*

Frankie also described how engaging with youth brought a new form of energy to his work. He said: *“And then I think as well that for older people, enthusiasm starts to dwindle. You know, you get less enthused about things, and there aren't a lot of things that excite you any more.”* Both my colleagues mentioned how they felt inspired by the imagination and talent of the Investigaytors and felt enriched by their participation. They stated that the Investigaytors had increased their motivation to do research with young gay men and gay men more broadly. However, one of them expressed that interacting with youth came with a bit of anxiety due to ageism in the gay community – he feared to be perceived as irrelevant by them. For example, he said: *“I think that maybe I wanted to*

*connect more as an older guy and share my experience. But I don't know how they heard that. And certainly you know, it's not like they react and say: oh tell us more".*

One of the greatest benefits of engaging young gay men for the research team was to gain insight into their youthful lives and experiences. Timothy mentioned that he saw an intrinsic value in simply listening to them at research meetings. He said: *"I learned a lot just hearing them talk about things. You really do tune into. You don't know everything as a researcher. It's sort of doing participant observation. You do learn a lot from just interacting with these guys."*

Although only slightly older, I realized while engaging with the Investigaytors that our experiences were quite different. These young men came out and developed their gay identities in the era of social media, high visibility of gay men in media and gay marriage equality. They described these conditions over the meetings as shaping their experience of what it means to be gay. By contrast, I had come out and forged my gay identity before the wide availability of Internet and social media — a time when gay men were not as present in mainstream media.

Timothy also described learning about generational differences between men of his age and the Investigaytors. For example, he said that he had never heard of the term "dating" before engaging with the Investigaytors: *"The first time I heard "dating" I burst out laughing, you know" – his generation did not "date" he added.* Timothy explained that through the project he came face to face with striking differences between the way older and younger gay men had met, engaged and built relationships with each other.

The senior researchers also described how engaging with young gay men had helped them clarify some personal assumptions about younger generations. For example, the large strides that gay (LGBT) community has apparently made in securing legal rights in the last two decades may lead some to think that gay youth must face much less harassment and homophobia in their everyday lives than previous generations. By engaging with the Investigaytors, however, they learned, along with all of us, that young gay men were still facing high (if not higher) levels of marginalization

and homophobic violence. They grew to empathize with them. For example, Frankie, reflecting on what he learned, said: *Their lives in high school may have been a lot more difficult than mine simply because there was so little known about queer [when I went to high school]*. Overall, the entire research team felt that survey project had gained from a deeper and richer understanding of young gay men by having a group of them integrated into every stage of the research process.

Finally, my colleagues described having a “huge sense of pride” in the progress of the Investigaytors (a sentiment I shared). For example, in talking about the investigators’ presentation at a conference, Frankie said:

*“... other people commented to me that they have seen presentations that weren't as good in high level conferences where graduate students were presenting ... that the level of presentation that they were doing was at least at graduate student level.”*

### **3.6.3. Benefits to the research**

One of the objectives of interrogating this research project as a case study and conducting the interviews was to reflect on the potential value-added of integrating young lay researchers into all phases of a gay men’s health study with an intersectional approach. Thus each Investigaytor was asked to describe their “personal contributions” to the project. At first, most could not name what they had contributed. For example, Kerry said: *“I mean I can't speak to any particular contribution or anything like that, but I think just generally when I do something I try to do something as well as I'm able to do it.”* Similarly, Jeremy and others spoke in interviews about gaining a lot but contributing little: *“I don't think I contributed anything but I do feel I gained a lot.”*

Investigaytors were encouraged to think more broadly of ways that they might have contributed to the project. At first, some quipped that they had contributed by bringing their positive energy and sparkling personality to research meetings. For example, Bob said that his biggest contribution was bringing “smiles” to the meetings. He added: *“My personality. I'm cheerful, and I think that's valuable to bring to a group.”*

He felt that he had contributed his “good sense of humour”, something Jonathon echoed as well. Similarly, Brent suggested that he had contributed “*levity to keep people interested*” and “*enthusiasm*”.

In their interviews Investigaytors often said that they had gained skills out of their participation, but skills were also what many felt they had contributed. For example, Henry was a linguistics student with experience teaching English as a second language (ESL). He was involved in designing the questionnaire. He explained that his experience as an ESL teacher made him, “*conscious of the fact that, if the survey is going to be distributed nation-wide, we’d have to consider, like, different language barriers*”. His skills and experience helped the survey project directly by addressing potential language barriers, removing words with double meanings and any phrasing that could have made the questionnaire difficult to understand for non-native English speakers. In brief, he helped remove some important barriers to survey participations.

Similarly in his interview, Brent described how he had brought his social media expertise and skills to the project, helping to raise the survey’s profile on platforms such as Facebook and Twitter. Others, like Jonathon, Felipe and Stewart, who had taken statistics or research courses during their undergraduate degrees, had shared their knowledge and had offered support to other Investigaytors in their learning efforts. Finally, Jeremy, who was fluent in French, had helped promote the survey to French language communities, principally in the province of Quebec. His efforts had increased recruitment significantly. Sex Now participation in Quebec had nearly doubled from the previous iteration of the survey (2010, 584 – 2011, 1089) No other province had seen such a dramatic increase.

The research team recognized and valued prior skills contributed by the participants and felt they were extremely beneficial to advancing the research. However, the main contribution made by the Investigaytors was in bringing their own personal experience into the project – something most of the Investigaytors recognized themselves. Moreover they did not see themselves as having a single common young gay experience, but rather, as Brent mentioned, “*each brought [their] own experience to*

*the table*". Neither did the research team see the Investigaytors as a monolithic group. Each had their own unique differences from background to personality. That background of personal experiences helped shape many of the questions in the survey to reflect diverse youth experiences and issues affecting youth such as coming out, social media, bullying and other forms of anti-gay harassment, therefore making the survey more relevant to a diversity of young gay men.

The Investigaytors' personal experiences also contributed significantly to their individual projects of analyzing survey data. The majority of them grounded their statistical study in their own personal experience. For example, Felipe produced an analysis of social support networks informed by his personal experience: "*When I was doing the analyses, I had assumptions from my own experience about having the support of a gay friend would be really important.*" Similarly, Stewart, who described himself as "*the heartbroken one*" due to a recent separation, said that his analysis aimed to see what health outcomes, if any, might result from growing old as a single man. Finally, Kerry, who defined himself as drug-using slut was hoping to debunk the myth that gay men who do drugs and have a high volume of sexual partners engage in riskier sex. He found instead that such men on drugs had eight times the odds of sexual risk compared to those who did not use drugs.

Prior to the Investigaytors the Sex Now survey was a provincial survey of men in British Columbia from 2002 to 2008. In 2010 Sex Now was conducted as a Canada-wide pilot. Therefore, it was possible for the research team to reflect on the value-added of engaging young gay men compared to doing the survey without them. In terms of recruitment, there was an increase of French speaking people (as described above) but also of youth under the age of 25<sup>13</sup>, the age group of the Investigaytors. The research team hypothesized that these increases may have been due to Investigaytor involvement. A large portion of youth survey respondents indicated that word of mouth had prompted them to do the survey (21% vs. 6% of men over 25). In terms of results,

<sup>13</sup> In comparison to the Sex Now 2010, there was a 31% increase of participants 25 of age and under in the Sex Now 2011. Meanwhile there was only a 2% increase of participants above the age of 25.

the data collected showed no sign that engaging young gay men produced different results than without them. Nonetheless, each Investigator contributed a uniquely different analysis that the research team would not have produced without them. The investigators each made a significant contribution of their own to current knowledge on Canadian gay men's health.

Finally, some of the Investigaytors suggested that one of the unintended consequences of the program was the dissemination of gay men's health knowledge among gay youth locally. Many reported discussing survey results with their peers. They created a buzz by hosting a launch of their report *Under the Lens of the Investigaytors* – it was attended by 60 young gay men and their allies. Felipe in his interview suggested that the Investigaytors were spreading “*their knowledge across their own network*”, which he said is closing the knowledge gap between older and younger gay men.

#### **3.6.4. Reflection on Intersectionality**

As part of the interview process, both Investigaytors and senior researchers were asked to reflect on intersectionality and how their intersecting identities may have played a role in shaping the project or their personal experience with the project.

As already described, there was consensus amongst everyone involved in the project that the youth group was not a homogenous gay stereotype. Indeed, the Investigaytors saw themselves as a diverse group: each one coming to the project with multiple intersecting identities beyond just being a young gay man. My colleagues and I remarked that they had never seen such an ethnically diverse group of young gay men in prior CBPR projects.

Some of the Investigaytors suggested that they had previously felt excluded or rendered invisible from gay spaces and community groups due to their intersecting identities – principally, ethnicity and gender. However, they explained that the project's interest in intersectionality signalled to them an authentic attention to the health of all gay men, and not just the affluent majority. It also showed our commitment to offering a safe

space, they noted. Moreover, Investigaytors suggested that intersectionality did more than create a safe social space for them, it was a space where diversity was celebrated. Such feelings were facilitated by group discussions about intersectionality, power and privilege that allowed everyone involved to reflect on their own and others' positionality. For example, Brent said: *"I need to remind myself that my experience isn't the only one, or that it's not just about, you know, middle class white guys from the suburbs moving to Vancouver. That's not, you know, what makes a robust gay community"*.

Five of the nine Investigaytors interviewed identified as people of colour, some of whom were highly active in gay and mainstream communities as anti-racism advocates. I expected them to raise how being gay men of colour had shaped their participation in the program. However, when asked to reflect on how their different identities had shaped their experience of the project, only one of them brought up being a person of colour. I am aware that my position as a white interviewer and project leader may have made it difficult to put them at ease to discuss issues related to race dynamic within our group. Or this could be a reflection of the local culture where issues of race are not typically brought forward, particularly within queer politics.

Only Felipe opened up about the subject of race. He spoke about how he had hoped to look at men of colour in his analysis but realized it would be difficult due to the low number of men of colour in the survey sample (<15%). He also described how belonging to a minority cultural group had shaped his interactions within the group:

*"I grew up in a traditional Vietnamese family. So we tend to think that talking less is really important because you need to process the information. And when you say something it has to be something good or you're punished for it. So it's that kind of mentality where you have to be very pensive with your ideas and with your opinions. But I found that participating in community organizations here, it's very different. It's very large group focused, it's very thinking on the fly. And that's something that's really hard to negotiate sometimes."*

Although, there was no great age difference between Investigaytors (6 years between oldest and youngest), some did not see themselves as belonging to the same age group. For example, when talking about diversity in the group, Jeremy said: *"I think*



*we all came from different age groups. I think I was the youngest there. We had [someone] who was significantly older [...] I think in terms of age it was diverse.*" This perceived difference in age might have been due to their different stages of life that provided Investigaytors with different privileges. While some were still in school and living with parents, others had completed their undergraduate degree and were living on their own.

Other intersecting identities emerged from the interviews unexpectedly. For example, two of the young Investigaytors lived in the suburbs of Vancouver and spoke of this in their interviews. For example, Henry said that geography was something that always set him apart from his gay friends and the other Investigaytors who live in Vancouver and who could more easily access gay specific services that tend to be situated within Vancouver's downtown core. He mentioned that commuting downtown to research meetings was his biggest challenge in participating in our project. Julian also described a similar experience: "*The challenge for me was getting here on time, since it starts at 5:30. I get off work at 4:00, I need time to shower, to eat, and then I'm fighting traffic to get down here [...] Oh. And [public transit] prices have gone up this year.*" In Julian's case, his geographical position related to his lower socioeconomic status, which made it difficult for him to access our study site. Julian never referred to his precarious situation prior to the interview, highlighting a privilege issue that future projects would need to consider, perhaps by offering bus fare or alternating the venues of the meeting.

Julian differed from the other Investigaytors as the only one who had not attended any post-secondary education. He did not speak of this directly in his interview nor was it recognized by other members of the group; when describing commonalities others thought post-secondary education was a common denominator. However, Julian struggled most with learning statistics, possibly linked to his prior education level, suggesting that education might be an intersecting barrier to participation in such a project.

Intersectionality has generally focused on the trinity of gender, class and race often displacing the significance of other social locations (Dhamoon, 2011). However,

when discussing the most salient identities shaping their experience as young gay men, the Investigaytors sometimes described identities outside of such a trinity. For example, Brent described his struggle with depression and mental health as an identity that motivated him to be involved in gay research. Similarly, Felipe identified as a “geek and gamer”, which he saw as an identity intrinsically linked to his involvement. Kerry’s identity as a “drug using slut”, was described earlier as motivating his analysis. In these three cases, identities were related to stigmatized stereotypes in the gay or general population, which may explain why they were more relevant to them than identities related to class, ethnicity, or gender. From an intersectionality perspective, these identities may seem like having no parallel to class and gender, as there are no clearly defined systemic forms of discrimination against these groups. But such identities were personally salient to those holding them because of related day-to-day stresses in living with them. More so, these identities did relate to structural forms of oppression such as sanism – a form of oppression because of a mental trait or mental illness – and moral panic. More so misogyny and sexism underlay the oppression of Felipe, as being a geek and gamer intersect with his sexuality to defy what is a proper way to be “doing” gender and masculinity.

Finally, intersectionality is particularly interested in disrupting power and power relations. As noted by some Investigaytors in their interviews, the nature of the CBPR project itself was about issues of power – taking research from “the academic pedestal and bringing it to the affected population” – in this case, young gay men. There were, however, obvious power disparities between the learners and the teachers of the program. Unlike the Investigaytors, my colleagues and I were getting paid for our work and we had control of the budget and the timeline. The “teachers” also held other obvious privileges, beyond their leading research roles, inherent privileges of race, class, gender and age.

The inherent power dynamics of a research process was something the study team was conscious of, however, none of the Investigaytors noted it in their interviews. Differently, some Investigaytors said they considered my colleagues and I to be Investigaytors too – suggesting they did not see major conflicts among roles. Nonetheless, such power dynamics could have operated in ways the Investigaytors were

not fully conscious of (Or, may not have been comfortable talking about in the context of an interview with the team leader.). For example, their reticence to provide feedback in research meetings might have been influenced by these dynamics. In such, could a young Investigator of colour be uncomfortable raising a concern with a Caucasian mentor? Could an untrained Investigator be uncomfortable disagreeing with a researcher who had a much higher level of education?

Senior researchers tried to disrupt these power imbalances through considering their privileges, and stating them in the group, and by openly valuing the Investigators contributed expertise. Moreover, the research team purposefully choose not to rely on widely used academic titles like “(PI) principal investigator ”or “peer researcher” since they tend to reinforce power structures. Rather, everyone was considered a researcher – an Investigator. And since, everyone belonged to the gay community, in some way everyone on the project was a peer. There was no perceived outsider.

### **3.6.5. Moving Forward**

At the end of the national survey project, after the data had been analyzed and reported on, the majority of the Investigators indicated that they were interested in maintaining their involvement with the program and with pursuing further CBPR research. The sponsoring organization, recognizing the success of the Investigators, decided to continue supporting the program. It then became important to identify what had worked well with the program and potential areas for improvement. A major difficulty was that we had little guidance and no prior model to build the program on. To our knowledge, no other program existed that integrates education and research from an intersectionality perspective. It was only speculation that intersectionality might advance CBPR practices and that some young gay men might be interested in learning the ropes of research as a voluntary community activity.

Intersectionality was the framework that informed our practice, but its impact could have been limited since everyone on the research team was still learning its potential. Moreover, there was very little information available at the time about applying

intersectionality to a survey design or even gay men's health. Nonetheless, intersectionality had a generational appeal to this cohort of young gay men. The Investigaytors particularly liked intersectionality's grounding in social justice and its attention to diversity that recognize their intersectional experiences. As already described, intersectionality as a practice allowed us to engage in new conversations within the research team and with the Investigaytors on diversity, oppression, power, and privilege.

A key aspect of the project that made it successful, according to both Investigaytors and researchers, was that the research meetings' atmosphere was always very causal while also being productive. Here, Henry summarizes well the thoughts of all involved: *"Just like the general atmosphere when we come into these meetings, it sort of like relaxes – not like really intimidating"*. The meetings took place in a small office suite set up like a living room with a couch and coffee table. Meetings were conducted over food which, Investigaytors said, they hungrily appreciated but it also helped lighten up the atmosphere. Investigaytors highlighted how the size of the group (9) was ideal to keep everyone participating without feeling intimidated. Key to the project's success was having a team leader only slightly older in age from the Investigaytors, making it less intimidating for them to interact with the senior researchers, helping to bridge the gap between older and younger research generations.

The Investigaytors explained their motivation to continue with the project by what it felt like to have played a critical role in a major research initiative. They expressed feelings of ownership over the survey and their group. In most community-based research, gay men's communities might provide "input" into a survey or support the "recruitment" strategy. Rarely is the community so involved as the Investigaytors were in data analysis and reporting their findings.

Indeed, the analysis phase turned out to be the peak learning and skills building experience in the Investigaytor project for its participants. The Investigaytors mentioned that they particularly liked the freedom they were given to select their own topic for analysis, rather than being assigned a specific job to cover on the survey. Moreover, the

opportunity to present their results at a health promotion conference (typically reserved for academic researchers) was often described in Investigaytor interviews as the highpoint of the project.

Programs like the Investigaytors have their challenges and difficulties, many of which are inherent in the CBPR approach. For the research team, this “participatory” way of doing research proved to be highly time consuming. With an ambitious research plan and a lot of teaching along the way, timelines had to readjust. The project ended up taking twice as long as anticipated (two years rather than one). This extension had a practical impact on the budget – for example staff had to be kept on longer and expenses for meetings doubled – which will need consideration in future grant applications for such projects. Alternatively, we have found that gay businesses were willing to make donations (such as food for meetings).

The main challenge of the program from the participants’ point of view was managing their own time to attend research meetings. Learning statistics and using the software proved to be difficult for a few, but overcoming personal issues with statistics was noted as one of the highly rewarding experiences of the program. When asked during their interviews what barriers would prevent other young gay men (their peers) from participating in such a project the Investigaytors suggested it was in fact that the project focuses on research. For example, Jeremy said: *“Research, it’s not the most sexy thing and if people are not interested in it, they’re not interested in it”*. They also speculated that some young gay men, perhaps differently positioned, might experience barriers to participation, particularly if English is not their first language or if lacking post-secondary education (They often forgot that one among them had no post-secondary education). There were also some concerns with extending the program beyond Vancouver and how people in rural areas could access it.

Finally, the Investigaytors had some suggestions for improving the program. They suggested integrating some social events – to help build relationship among the researchers – and having an application process to assess the motivation and “fit” of

future participants. One suggested having more discussion about sexuality (beyond sexual health and HIV risks) in the research meetings.

### **3.7. Limitations**

Despite illuminating so many benefits of the investigators program the case study presented here has some limitations. Since this case examined a single CBPR project, involving a small group of individuals, it would be difficult to generalize the findings to another context. Moreover, intersectionality would caution against assuming that the findings are transferable to other marginalized populations (i.e. Aboriginal men or sex workers) and even other subgroups of gay men (such as aging gay men or HIV positive gay men). For each population or group, the potential benefits and drawbacks of a CBPR approach as described here should be investigated by considering the social positioning of the participant group, and all the potential intersecting factors.

Secondly, those interviewed for this case-study were individuals that had participated in the project. Thus, only the voices of those deeply invested in the Investigaytors are represented. Similar case studies might benefit from interviewing people who showed interest but did not enter the program.

A final limitation of the case study approach to this project is that the study coordinator conducted the reflective interviews with the investgaytors and senior researchers. This might have led some people to feel guarded about speaking negatively about the program. On the other hand, it might have elicited richer material because a familiar and trusting rapport had been already established between the coordinator and Investigaytors.

### **3.8. Conclusion**

Methodologies that operationalize intersectionality are still developing, therefore case-studies of its application to research projects, like the one presented in this paper, are critical to its development. In this project, intersectionality was useful in CBPR with young gay men to address issues of diversity, power and oppression systematically. Intersectionality provided a practical framework with which to both operate the program and to evaluate it. It was particularly useful in eliciting reflection on how the program was experienced by differently positioned young gay men. As demonstrated in this paper, merging both CBPR and Intersectionality approaches can have a transformative impact on young investigators, the research team, and the research process itself.

In re-examining the Investigaytors' reflections on the impact of the program on their own lives, it became evident that it was a positive intervention and an empowering experience for them. The project helped them develop positive self-esteem, a strong(er) social support network, and skills and knowledge that could potentially advance their careers. Since project completion, three Investigaytors were admitted into public health graduate school programs and two were employed by organizations undertaking gay men's health research. This shows that our project was emancipatory for those involved.

Contrary to the majority of CBPR projects where there are generally more striking divisions between researchers and community, all three men on the research team were also members of the gay community. Nonetheless, integrating the young Investigaytors into the study team permitted in-depth learning about intergenerational divides between younger (millennials) and older gay men (Gen-X and Boomers). With intersectionality's focus on intersecting identities and deconstructing the idea of homogenous populations, the Investigaytors helped strengthen knowledge of how being gay is experienced and resisted by differently positioned men. Interacting with the Investigaytors with their different intersecting identities (along the lines of ethnicity, class, geography and gender identity) and having them share their experiences built bridges of understanding. As described, all of the Investigaytors' individual projects were rooted in their individual experiences, shaped by their own personal intersecting social locations. Their individual

projects demonstrated diversity along many intersecting axes, such as age, gender expression, relationship status, or party drug user.

While the project helped to build the capacities of the Investigaytors, The CBRC's capacity as an agency also increased. The Investigaytors provided the CBRC with a new pool of talent to support subsequent research activities. Lay and scientific papers based on analyses conducted by the Investigaytors are currently in development or in process with peer-reviewed journals. The program has also helped raise the organization's profile among young gay men locally, as well as nationally. With the support of the Investigaytors the CBRC was able to host two young gay men's health development conferences that brought together 40 young gay men on each occasion to discuss issues pertinent to their health and how to sustain their involvement in research and community health promotion efforts.

The outcome of this case study also suggests that using an intersectionality framework with CBPR could be an effective strategy for tackling other issues of health inequity. The very nature of conducting a community-based research project addressed inequities in the manner in which members of the gay community were involved in shaping the research agenda. This case brought the voices of young gay men into gay health research, but by allowing discussion of intersecting identities, we also brought in the voices of men of colour, of transgender individuals, and of suburban gay men. All these voices go typically unheard within mainstream research processes, including so-called community-based initiatives. Bringing in intersectionality helped to reframe the discourse on gay men's communities by avoiding sweeping statements about gay and bisexual men. Rather, the project embraced and encouraged diversity. Moreover, it appears that intersectionality and its application to the Investigaytors contributed to better survey questions, better survey recruitment and better knowledge dissemination as described in this paper. All of these contribute to more effectively addressing issues of inequity.

In conclusion, since completing the project, there has been a sustained interest from young Investigaytors to remain involved in research with the sponsoring



organization the CBRC. They also expressed interest in learning and exploring new research methods (specifically qualitative). Now new young men have asked to join the program. A new journey has begun exploring qualitative methodologies, using intersectionality as an analytic framework to gain a deeper understanding of young gay men's experience.

## **Chapter 4.**

# **Interacting epidemics, intersecting identities: an intersectionality-informed syndemic analysis of gay and bisexual men in Canada**

### **4.1. Introduction**

Gay and bisexual men represent only a small fraction of the Canadian population but have accounted for the majority of HIV infections since the onset of epidemics. This trend continues today; in 2013, gay and bisexual men compromised half of all HIV infections (56.4%) and new infections (52%) (Public Health Agency of Canada, 2014). More so, rates of new HIV infections among gay men have not declined in recent years consistent with dramatic declines in other vulnerable populations. This lack of progress with either constraining or reversing the HIV infections in this population suggests that new approaches in which to theorize, conceptualize and address this epidemic are urgently needed. Thus far, prevention research and interventions have predominantly focused on gay and bisexual men's sexual behaviours, without paying much attention to the social complexities of gay and bisexual men's lives, their overall health, or their experience of stigma and discrimination.

To address these limitations, some academics, health professionals and activists have turned towards syndemic theory to address, study and conceptualize the HIV epidemic. As mentioned in chapter 2 Syndemic is a term coined by medical anthropologist Merrill Singer in the mid-1990s to refer to the tendency of multiple epidemics to co-occur, interact and worsen the effect of one another (Singer 1996;

Singer, 2009). Health problems may be construed as syndemic when two or more conditions or afflictions are linked in such a manner that they interact synergistically, with each contributing to an excess of disease burden. In the past decade, syndemic has grown into a robust ecosocial theory that posits that stigma and social inequities produce these complex clusters of epidemics that are syndemics, and therefore increase health disparities in populations (Singer, 1996; Singer, 2009). Syndemic theory, with its attention to multiple and co-occurring health problems and its root causes, calls for new ways of approaching HIV epidemics: by attending to the broader health concerns of gay and bisexual men beyond sexual behaviour in a holistic manner, and by attending to the stigma and social inequities that are at the root of their health difficulties (Halkitis et al., 2013).

However, syndemic theory and how it has been applied in gay and bisexual men's health research to date has its own limitations (see Chapter 2). Mainly, syndemic research tends to treat gay and bisexual men as a monolith group and lack attention to power and diversity in social positions held by gay and bisexual men, such as those along axes of race/ethnicities, class, age, geography, and Aboriginal ancestry (Ferlatte et al., 2014). This neglect of attention is inconsistent with epidemiological surveillance data and academic research that have amply shown that the distribution of HIV infections is socially uneven among MSM (Beyrer et al., 2012). For example, HIV among gay men in Canada is concentrated in urban regions and in recent years there have been increases in diagnoses among men of colour (British Columbia. Provincial Health Officer, 2014). Furthermore, a small but growing body of work is also demonstrating that HIV vulnerabilities are influenced by social characteristics, such as ethnicity (Millett et al., 2012), immigration status (George et al., 2007), Aboriginal status (Heath et al., 1999), age (Trussler, Ferlatte, Marchand, Banks and Moulton, 2009) and geography/migration (British Columbia. Provincial Health Officer, 2014).

Intersectionality has been suggested as a conceptual framework that could assist researchers to attend to issues of diversity and power among gay and bisexual men in syndemic research (Ferlatte et al. 2014). Its an approach that assists in systematically documenting how human lives and experiences are shaped by multiple social locations, as well as multiple forms of oppression (Hankivsky, 2012; McCall, 2005; Weber, 2010).

In the same way that syndemics recognizes that diseases and health problems do not exist in isolation from one another, intersectionality sees individual's multiple social locations as inseparable and that therefore health inequities are rarely the results of a singular form of oppression. Rather, intersectionality views power relationships along the lines of gender, ethnicity, class and sexual orientation, to be mutually defining and mutually reinforcing rather than distinct systems of oppressions, together forming what intersectionality scholar Patricia Hill Collins (2000) calls the "matrix of domination".

The aim of the present study is to identify which groups of Canadian gay and bisexual men are at increased risk of experiencing syndemics. In this paper I described the results of an original empirical investigation informed by intersectionality principles. In a survey of gay and bisexual men, I investigated to which degree the experience of syndemics varies along multiple axis of identities including sexual identity, relationship status, age, education, income, ethnicity and living environment. The intention behind this analysis is to demonstrate that the treatment of MSM and gay men as a homogenous category and population within the syndemic literature obscures some important dimensions of syndemic productions among this diverse population. By using intersectionality this paper seeks to provide more accurate knowledge about syndemics that can lead to the development of novel interventions that target those most affected by syndemics.

#### **4.1.1. Intersectionality informed syndemic analysis**

While syndemic analyses have been for the most part quantitative, intersectionality applications have mainly gravitated towards qualitative forms of inquiry. Therefore, the challenge of merging both approaches is mainly methodological. The application of intersectionality to quantitative analysis is in its infancy and there are still debates regarding which, if any, statistical method can help uncover the complexity and the intersections of social locations and systems of oppression that are of interest to intersectionality (Bauer, 2014; Bowleg, 2008). Nonetheless, intersectionality informed quantitative analyses are emerging in the literature (Covarrubias, 2011; Steinbugler, Press, & Dias, 2006; Veenstra, 2011; Rouhani, 2014). They are demonstrating that

attention to the principles of intersectionality can transform the interpretation of social conditions and produce more accurate knowledge about how health and social life are experienced by diverse groups of individuals.

Quantitative intersectional analyses position themselves in contrast to unitary approaches generally favoured by mainstream health researchers. Unitary studies see demographic variables as having an “additive effect” on health outcomes (Dubrow, 2008). In this approach the independent effects of each social category are computed and then layered (i.e. the independent effect of being a man + the independent effect of being gay...). Rather, quantitative intersectional studies uses various statistical tests (such as Anova, hierarchical class analysis, cross-tabulation, dichotomous or polytomous logistic regression, multi-level modeling and latent class-analysis) to uncover the interactions or the “multiplicative effects” of social categories on health or social outcomes (Bauer, 2014). Because intersectional analyses try to attend to the complexity and messiness of human lives rather than simplifying the impact of social categories, they often demonstrate much more precision in their identification of social inequalities than unitary analyses. For example, in an investigation of self-rated health in the Canadian population, Veenstra (2011) contrasted both unitary and multiplicative approaches. His unitary analyses showed no differences between heterosexual and homosexuals, but when he employed multiplicative techniques, he found that poorer homosexuals fared much worse than poorer heterosexuals on self-rated health, demonstrating the intersecting and multiplicative effect of sexuality and income.

#### **4.1.2. Methods**

*Sex Now* is a serial survey of men who have sex with men administered every 12-18 months in the Canadian Province of British Columbia since 2000. The survey is conducted by the Community-Based Research Centre for Gay Men’s Health (CBRC), a non profit organization dedicated to the advancement of gay men’s health through participatory action research in partnership with the British Columbia Centre for Disease Control (BC CDC). The *Sex Now* survey has been offered anonymously online since 2007. For the 2010 and 2011 editions of the survey, the sampling frame was expanded

to include all of Canada. The data used in this study is from the 2011 edition that was collected between September 2011 to February 2012, in both of Canada's official languages English and French. The Sex Now 2011 questionnaire focused on social determinants of gay men's health. Survey domains included sexual behaviours, health measures, relationships, health care services, working conditions, community participations, social support, and homophobia.

Sex Now participants are recruited through a sophisticated online outreach and social marketing strategy that included promotion via community groups, online dating sites, gay and bisexual forums, and social media. While the Sex Now survey is not a probability survey – and therefore its results cannot be generalized as issues may be over or under-reported with respect to the large population of gay and bi men due to its convenience sampling – it poses considerable advantages over government lead probability health surveys (such as the Canadian Community-Health Survey). First it allows us to study with more depth the specific health and social issues affecting gay and bisexual men that are not included into national probability sampled studies, such as the ones conducted by governmental institutions. More so, the community led approach of Sex Now can generate much larger samples of gay and bisexual men allowing us to investigate differences within gay and bisexual men; to date Sex Now 2011 the largest sample of Canadian gay and bisexual men ever collected in a health study, with 8382 participants. In comparison, the Canadian Community-Health Survey (2005) had only 536 gay men and 300 bisexual men (in a sample of 49,901 men) making within-group analyses difficult, if not impossible due to low cell counts.

More so errors in probability sampling can occur do to misclassification of sexual orientation. Among the Sex Now participants, 30% said they would not be willing to disclose their sexuality in a survey conducted by Statistics Canada (Ferlatte, Hottes, Trussler & Marchand – *unpublished manuscript*) – the sole institution in Canada with the resources to conduct national probability health surveys. More so, willingness to disclose varied across nearly every social variable in the survey (such as sexual identity, age, HIV status, living environment, education, income, and ethnicity). This suggests that anonymous community-based surveys such as Sex Now may be more likely to capture a

diverse sample, as well as underrepresented communities that are not willing to disclose their identity to government institutions.

An ethics certificate was obtained for the survey protocol from the independent Research Ethics Board of CBRC. The specific methods of this analysis were reviewed and granted ethics approval by the Simon Fraser University's office of research ethics.

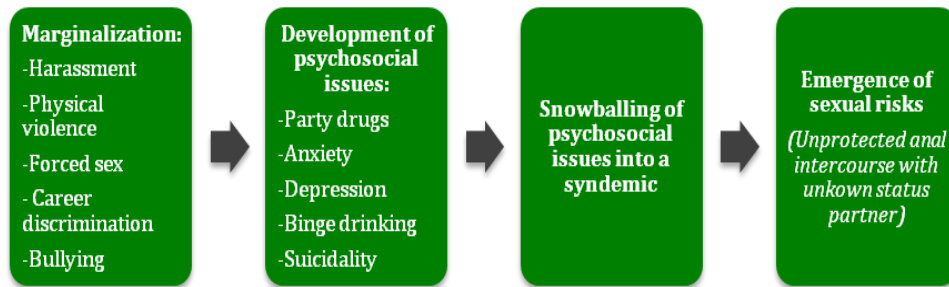
### **4.1.3. Questionnaire development**

*The Sex Now* content is developed iteratively by a panel of gay men's health experts including community-based researchers, community leaders, and public health professionals. The survey aims to respond to evolving health promotion and disease prevention needs of gay and bisexual men's communities. To respond better to the needs of young gay men and to build their capacity to perform and understand research, the study team recruited an initial group of four young gay men between the ages of 20 and 25 to assist in the development of the 2011 questionnaire (see Chapter 3). Two of them identified as Asian and two as Caucasian. After receiving training in quantitative research, social determinants of health and intersectionality, the young men participated in a series of meetings with the study team to develop and refine the questionnaire. Under this mentorship, the young men conducted focus groups, interviews and pilot tested the questionnaire in various segments of the gay and MSM community to ensure its validity. Key community and public health experts also reviewed the survey. Finally, questions were translated to French and validated by members of the research team whose first language is French.

### **4.1.4. Measures**

The analysis for this study was guided by Stall's conceptual framework of syndemic production (Stall et al., 2008), summarized in Figure 4.1. This framework was previously useful in studying the existence of syndemics in Canadian gay men (Ferlatte et al., 2014). Variables were identified from *Sex Now* survey 2011 that corresponded to

major constructs within this framework. The framework of syndemic production is premised on the notion that interacting epidemics among gay men are largely socially produced. It thus places anti-gay social stressors at the forefront. The framework indicates that the accumulation of these stressors leads to the development of psychosocial health problems, which in turn snowball to increase the likelihood of HIV risk-taking behaviours: such as condomless anal sex with an unknown status partner (i.e. HIV risk).



**Figure 4-1. Theoretical model of syndemic production among gay and bisexual men**

Note. Adapted from Stall et al. 2008 and Ferlatte et al 2014.

*Sexual Marginalization:* Data was gathered on the lifetime experiences of various forms of marginalization and violence related to sexuality and sexual identity. Participants reported lifetime experience of a) verbal harassment; b) physical violence; c) forced sex; d) workplace discrimination; and e) bullying.

*Psychosocial issues:* Survey participants were asked to report the occurrence of the following four psychosocial issues in the last twelve months: a) use of one or multiple party drugs such as cocaine, crystal meth, ecstasy, GHB and ketamine; b) weekly episodes of binge drinking; c) suicidal thoughts or attempted suicide; and d) anxiety and/or depression requiring mental health care.

*HIV Risk behaviour:* Survey participants were asked how many times they had unprotected anal intercourse with sex partners whose HIV was unknown to them or opposite to them. Any response of one or greater was coded as HIV transmission risk.



*Syndemics:* Undergoing a syndemic of psychosocial issues was coded as experiencing two or more of the four psychosocial issues described above.

*Demographic Factors:* Participants reported on their sexual orientation, partnership status, education level, income, age, ethnicity, living environment and province or territory of residence. All variables were categorical with the exception of age which was collected as a continuous variable.

#### **4.1.5. Analysis**

The analysis was restricted to Canadian respondents who were either HIV negative or unknown status (never previously tested for HIV or never received their results). The analysis was completed in three stages: 1) identifying a syndemic in the sample; 2) multivariate regression to identify demographic and social factors associated with being in a syndemic; and 3) stratified analysis by sexual identity as informed by intersectionality. All analyses were performed in SPSS version 20.0.

##### *Syndemic analysis*

To identify a syndemic three sets of analysis were conducted in accordance with the underlying conceptual model of syndemic. First, the relationship between lifetime indicators of marginalization (sexual violence, physical violence, workplace discrimination, bullying, and harassment) and current or lifetime psychosocial issues was explored. Because the effect of marginalization was hypothesized to be additive (i.e., exposures cumulatively increase the likelihood of syndemic production, rather than operating independently), the percentage of respondents reporting each psychosocial issue was calculated and sorted by the number of marginalization indicators experienced. Relationships were tested using *chi-square* test for trend;  $p < 0.05$  was considered statistically significant.

Because psychosocial issues are hypothesized in the framework of syndemic production as interrelated and mutually reinforcing, the correlation between these factors

was examined by calculating crude odds ratios. Lastly, associations between individual marginalization indicators, individual psychosocial issues, the number of psychosocial issues (again, additive), and HIV transmission risk (UAI-US) were explored using logistic regression. Multivariable models were used to adjust for important socio-demographic variables: age, sexual orientation, partnership status, education, income, ethnicity and province. Separate multivariable models were retained for marginalization indicators and psychosocial issues, as the latter were hypothesized, in the framework of syndemic production, to be in the causal pathway between marginalization experiences and HIV transmission risk UAI-US.

#### *Standard logistic regression model*

To identify demographic factors associated with experiencing a syndemic of psychosocial issues, a new dichotomous variable was created: having none or one of the psychosocial issues was contrasted with respondents reporting two or more of the syndemic issues. Each demographic variable was first tested for respondents caught in a syndemic using *chi-square* test for trend; with  $p < 0.05$  considered statistically significant. Secondly, demographic factors (sexual orientation, relationship status, age, income, education, ethnicity, living environment) were entered in multivariate logistic regression models with "caught in a syndemic" as the outcome or dependent variable. This model also controlled for province or territory of residence.

#### *Intersectionality informed analysis: stratified logistic regression analysis*

This analysis is grounded in what Choo and Ferree (2010) recognize as a "group centered" intersectional analysis, which is in contrast with the majority of quantitative applications of intersectionality to date that have been for the most part done on population-level data looking at health status/issues across gender, class, ethnicity and sexual orientation. Differently, this analysis looks at how within a population recognized as being marginalized (such as gay and bisexual men), other social locations can affect syndemics. Traditionally, intersectionality analyses has prioritized the intersections of race, gender, and class due to its emergence in Black feminist scholarships where these

categories have been documented as having a profound impact on the lives of Black women (Bowleg, 2012a). As intersectionality is becoming more mainstream and applied to other populations such as gay and bisexual men, some scholars are questioning this trinity of intersectionality and its relevance to all populations (Dhamoon, 2011).

In relation to gay and bisexual men, Hindman (2011) argues that the sole focus on race, class and gender might not be sufficient to truly reveal the dynamics that occur within gay and bisexual men; within this group, marginalization does not necessarily fit neatly along these social locations. He described that intersectionality scholars interested in gay and bisexual men must consider the diverse ways that sexuality is experienced and resisted by this population. Within gay and bisexual men (and MSM), those who respect heterosexual norms may find themselves in a different position of power over those who reject these norms. However, questions of sexual identity even in gay men's health remain largely absent in public health discourse.

For someone new to the field of public health, the way sexual identities (and how they are experienced) have been ignored within this field may be puzzling; public health researchers have generally preferred to speak of sexual behaviours (Young and Meyer, 2005). Early within the AIDS crisis the term MSM was broadly adopted in public health to describe gay and bisexual men (and "straight" identified men who have sex with men) – a term that many have found counter-productive as it completely erased gay and bisexual men from the public health discourse (Young and Meyer, 2005; Prestage, n.d.). The term MSM has also been criticized for obscuring the meaning of sexuality that Hindman (2011) argues as so critical to intersectionality analysis.

In this paper, insights from Hindman (2011) and intersectionality led to a deconstruction of the MSM category typically adopted in public health and syndemic research. This analysis goes beyond simply acknowledging gay and bisexual identities; reporting one's identities as disclosed on an anonymous survey tells researchers very little about how individuals may be resisting and experiencing their sexuality. It does not describe how gay and bisexual men adopt or reject heterosexual norms and institutions. Therefore, I used heterosexual relationships as a marker of heteronormativity among

gay and bisexual men in my analysis. The greatest expectation of heterosexuality for a man is to be married (or at least in a relationship) with a woman. I therefore hypothesize that those who do conform to this deeply entrenched societal norm benefit from the advantages of heterosexuality, advantages that position them differently than gay and bisexual men, that could mitigate the effect of stigma and therefore the production of syndemics. More so, because gay identified men may be perceived as completely rejecting heterosexuality in comparison to bisexual men who may be seen as at least in part practicing heterosexuality if they engage in relation with woman – I was interested to study how they differed. This is consistent with studies that have found differences among gay and bisexual men. For example, a Canadian study found elevated reports of lifetime suicide behaviours and mood disorders among bisexual men, while gay men were at increased risk of reporting being diagnosed with a sexually transmitted infection (Brennan et al., 2010).

I therefore deconstructed my sample into three sub-categories at the intersection of sexual identity and partnership status: 1) single or male partnered gay men, 2) single or male partnered bisexual men, and 3) men partnered or married with a woman (whether gay, bisexual, or straight identified). I repeated the analysis above by stratifying my sample into these three groups. Similar to methods used by other researchers exploring the multiplicative effects of identities on health outcomes stratification allows for the assessment of interactions by demonstrating how different groups are affected by an issue (Szklo & Nieto, 2007). For each of the three groups, the multivariate analysis was repeated to identify the social locations and demographic factors associated with experiencing two or more concurrent psychosocial issues.

## **4.2. Results**

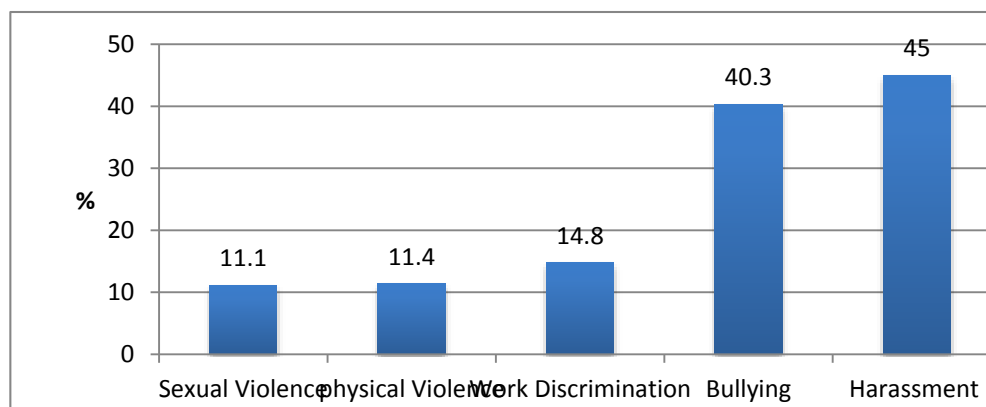
Of 8382 Canadian survey participants, 68.6% (n=5750) reported being HIV negative on their last HIV test and 23.4% (n=1965) had never been tested for HIV. This group of HIV negative and never tested men (n=7715) was framed for the analysis. The demographic characteristics of this sample are described in Table 4.1.

**Table 4-1. Demographic Characteristics**

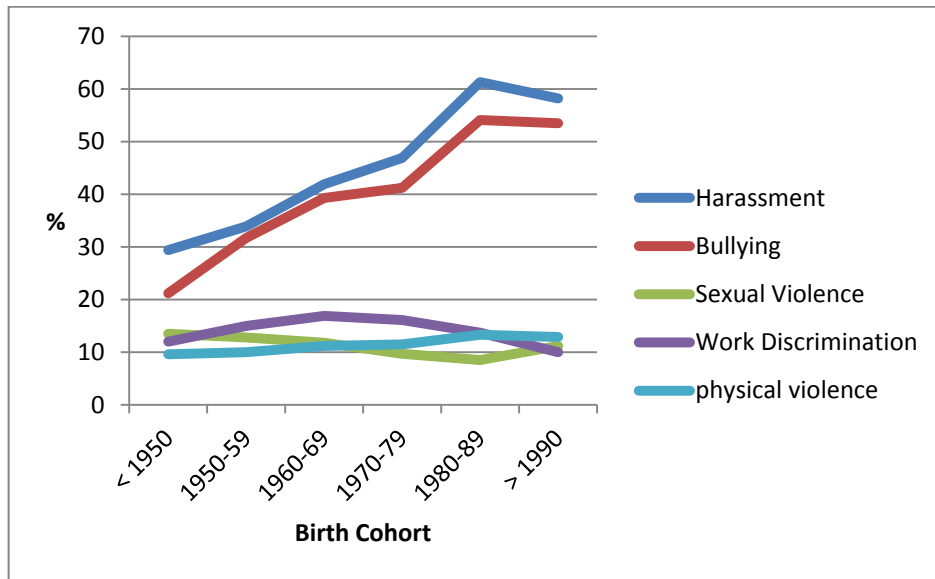
Characteristics	No. (%)
Sexual orientation	
Gay	4790 (62.1%)
Bisexual	2677 (34.7%)
Straight	172 (2.2%)
Other	76 (1.0%)
Relationship status	
Single	3349 (43.3%)
Partnered with a man	1961 (25.4%)
Partnered with a woman	1778 (23.0%)
Other/Divorced/Separated	627 (8.1%)
Age	
Under 30	1824 (23.6%)
30 – 45 years old	2307 (29.9%)
Over 45	3584 (46.5%)
Ethnicity	
Caucasian	6735 (87.3%)
Asian	274 (3.6%)
African/Caribbean	70 (0.9%)
Latino/Hispanic	105 (1.4%)
Aboriginal (First Nation/Inuit/Metis)	150 (1.9%)
Middle Eastern	49 (.60%)
Mixed	213 (2.8%)
Other	119 (1.5%)
Income (annual, CAD)	
< 10,000	704 (9.4%)
10,000 – 29,9999	1474 (19.1%)
30,000 – 49,9999	1676 (21.7%)
50,000 – 69,0000	1566 (20.3%)
> 70,0000	22.94(29.7%)
Highest level of Education Completed	
Some high School	313 (4.1%)
High School	1059 (13.7%)
Some College or University	1958 (25.4%)
College	1479 (19.2%)
University	2906 (37.6%)

Characteristics	No. (%)
Province/Territories	
British Columbia	1566 (20.3%)
Alberta	1002 (13.0%)
Saskatchewan	279 (3.6%)
Manitoba	327 (4.2%)
Ontario	3150 (40.8%)
Quebec	949 (12.3%)
New-Brunswick	97 (1.3%)
Nova Scotia	212 (2.7%)
Prince Edward Island	30 (0.4%)
Newfoundland and Labrador	80 (1%)
Yukon	8 (0.1%)
Northwest Territories	11 (0.1%)
Nunavut	4 (0.1%)

Figure 4.2 shows the percentage of these men reporting lifetime exposure to specific indicators of marginalization while figure 4.3 presents the same data by birth cohort. While the lifetime exposure to physical violence, sexual violence and work discrimination is reported at similar rates among all birth cohorts, bullying and harassment rates increased for each consecutive cohort born after 1950. A majority of 54.1% of the men born between 1980-1989 were exposed to bullying, while 61.3% experienced verbal harassment. Considering the five marginalization indicators as a group, 40.2% (n=3101) of men reported none; 21.4% (n=1652) reported one; 20.8 % (n=1608) reported two, and 17.6% (n=1354) reported three or more.



**Figure 4-2. Lifetime experiences of anti-gay experiences and marginalization**

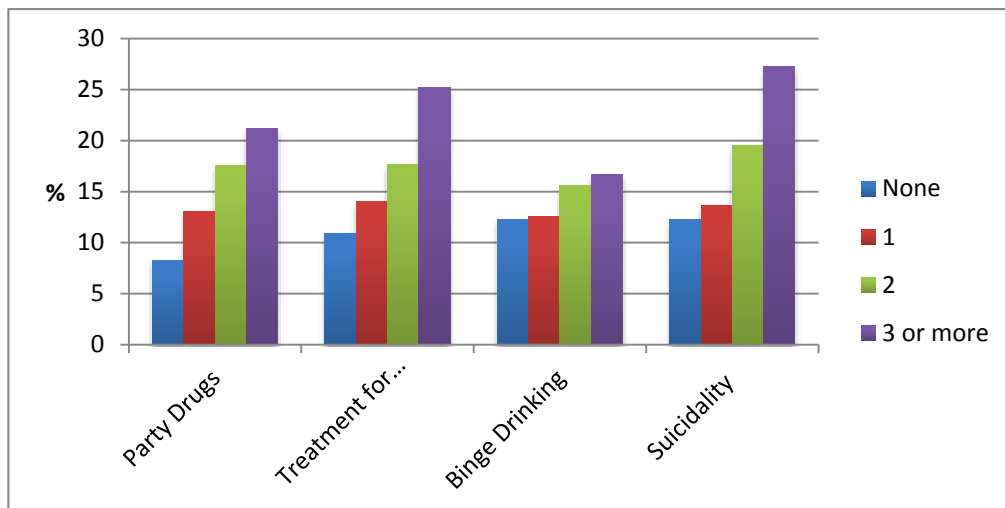


**Figure 4-3. Lifetime Experience of Marginalization by Birth Cohort**

Marginalization indicators were correlated with reported psychosocial issues in the 12 months prior to the survey, as shown in Table 4.2. Most variables demonstrated statistically significant associations with the exception of “Sexual violence” with “anxiety, depression and binge drinking”, and “work discrimination” with “binge drinking”. Additionally, Figure 4.4 shows the association between the number of marginalization indicators and psychosocial issues reported. It also shows that the likelihood of psychosocial issues increased with exposure to every additional indicator of marginalization ( $p < .001$  by Chi-Square test for trend). This effect was consistent across all four reported psychosocial issues.

**Table 4-2. Correlation between marginalization indicators and psychosocial issues**

		Unadjusted Odds ratio (95% Confidence Interval)				
	N %	Harassment	Bullying	Sexual Violence	Work Discrimination	Physical Violence
Party Drugs	1045 (13.5%)	2.18 (1.90 – 2.49)	1.94 (1.70 – 2.21)	1.54 (1.28 – 1.86)	1.33 (1.12-1.58)	2.28 (1.92 – 2.70)
Anxiety/ Depression	1196 (15.5%)	1.85 (1.63 – 2.10)	1.84 (1.62 – 2.08)	1.21 (.999 – 1.45)	1.95 (1.68 – 2.27)	2.04 (1.72 – 2.41)
Binge Drinking	1066 (13.8%)	1.31 (1.16 – 1.50)	1.34 (1.17 – 1.51)	1.15 (.940 – 1.40)	.81 (.67 - .99)	1.61 (1.34 – 1.93)
Suicidality	1289 (16.7%)	1.91 (1.69 – 2.16)	1.851 (1.64 – 2.09)	1.28 (1.07 – 1.54)	1.95 (1.68 – 2.26)	2.13 (1.81-2.51)



**Figure 4-4. Prevalence of psychosocial issues in the last 12 months by number of marginalization indicators**

Psychosocial issues were also correlated, as shown in Table 4.3. With the exception of anxiety and/or depression and binge drinking, all of these variables demonstrated statistically significant associations ( $p < 0.05$ ).



**Table 4-3. Correlation of psychosocial issues**

	N %	Unadjusted Odds ratio (95% Confidence Interval)		
		Anxiety/ Depression	Binge Drinking	Suicidality
Party Drugs	1045 (13.5%)	1.24 (1.05 – 1.47)	3.26 (2.80 – 3.80)	1.56 (1.33 -1.83)
Anxiety/ Depression	1196 (15.5%)		1.10 (.92 -1.31)	5.50 (4.80 – 6.31)
Binge Drinking	1066 (13.8%)			1.31 (1.11- 1.54)
Suicidality	1289 (16.7%)			

Effects of all variables on UAI-US (HIV transmission risk), as well as the additive effects of psychosocial issues, are presented in Table 4.4. In univariate analyses, all psychosocial issues were positively associated with UAI-US. In multivariable analysis, all but treatment for anxiety and depression demonstrated statistically significant associations with UAI-US. Respondents who reported multiple psychosocial issues were significantly more likely to also report UAI-US (OR for continuous count of psychosocial issues: 1.38 [95% CI 1.30-1.47]). This additive effect is also shown in Table 4.4. Frequent party drugs was highly correlated with UAI-US in the multivariate model, however even removing this variable from the model showed that respondents reporting multiple psychosocial issues were significantly more likely to report UAI-US (OR for continuous count of psychosocial issues OR 1.25 [95% CI 1.16 – 1.34]).

**Table 4-4. Association between marginalization, psychosocial issues and UAI-US**

Individual marginalization indicators (model A):	n	%	Crude OR (95% CI)	Adjusted OR (95% CI)
Sexual Violence	855	11.1%	1.54 (1.32 – 1.78)	1.09 (.958 -1.25)
Physical violence	878	11.4%	1.58 (1.36 – 1.83)	1.26 (1.07 – 1.50)
Work Discrimination	1140	14.8%	1.43 (1.25 – 1.63)	1.15 (0.99 – 1.34)
Bullying	3109	40.3%	1.38 (1.25 – 1.52)	1.07 (0.95 – 1.22)
Harassment	3469	45.0%	1.41 (1.27 – 1.55)	1.09 (.958 -1.25)
Cumulative count of marginalization indicators (model B):				
0	3101	40.2%	REFERENCE	REFERENCE
1	1652	21.4%	1.31 (1.14 – 1.50)	1.21 (1.05 – 1.40)
2	1608	20.8%	1.51 (1.32 - 1.73)	1.34 (1.16 – 1.55)
3+	1354	17.6%	1.84 (1.60 – 2.11)	1.61 (1.28 – 1.87)
Individual psychosocial issues (model C):				
Treated for Depression/Anxiety	1196	15.5%	1.17 (1.03 – 1.34)	1.01 (.868 – 1.16)
Suicidality	1289	16.7%	1.50 (1.32 – 1.71)	1.39 (1.21 – 1.60)
Weekly Binge Drinking	1066	13.8%	1.48 (1.29 – 1.70)	1.24 (1.08 – 1.44)
Frequent Party Drugs	1045	13.5%	2.5 (2.02 – 2.88)	2.23 (1.94 – 2.57)
Cumulative count of psychosocial issues (model D):				
0	4497	58.3%	REFERENCE	REFERENCE
1	2074	26.9%	1.52 (1.35 – 1.70)	1.46 (1.30 – 1.66)
2	934	12.1%	2.07 (1.79 – 2.40)	1.96 (1.68 – 2.28)
3+	210	2.7%	2.77 (2.1 -3.66)	2.51 (1.88 – 3.34)

Note. Four separate multivariable models were used, as informed by syndemic theory (REF). All models adjusted for age, sexual orientation, partnership status, income, education, ethnicity, and province.

Univariate and multivariate analyses for demographic factors associated with experiencing two or more psychosocial issues were conducted and presented in table 4.5. In multivariate analysis, identifying with being gay rather than bisexual (AOR 1.78 95% CI 1.44 – 2.21), being 45 of age or younger (Under 30 years old AOR 1.49 95% CI 1.25 – 1.78; 30 - 44 years old AOR 1.38 95% CI 1.17-1.63), not having a university

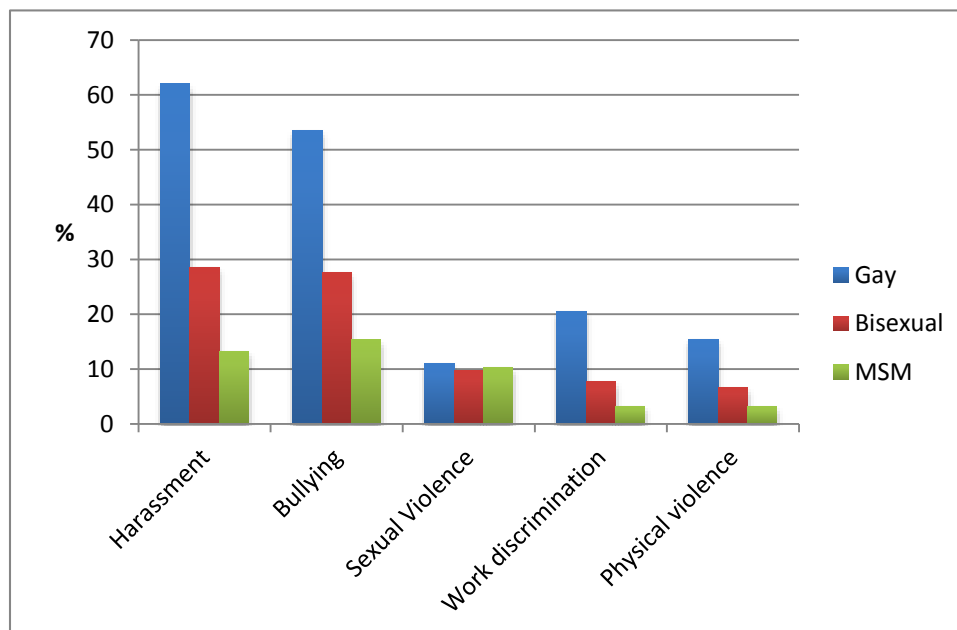
degree (AOR 1.17 95% CI 1.01 – 1.36), and earning less than \$60,000 1.32 (AOR 1.32 95% CI 1.12 – 1.55) were all significantly associated with being more likely to report two or more psychosocial issues. Asian (AOR 0.42 95% CI 0.27 – 0.66) and Latino (AOR 0.42 95% CI 0.27 – 0.66) men were statistically less likely to report two or more psychosocial issues. Partnership status was not significant in the adjusted model.

**Table 4-5. Demographic factors associated with experiencing a syndemic of two or more psychosocial issues**

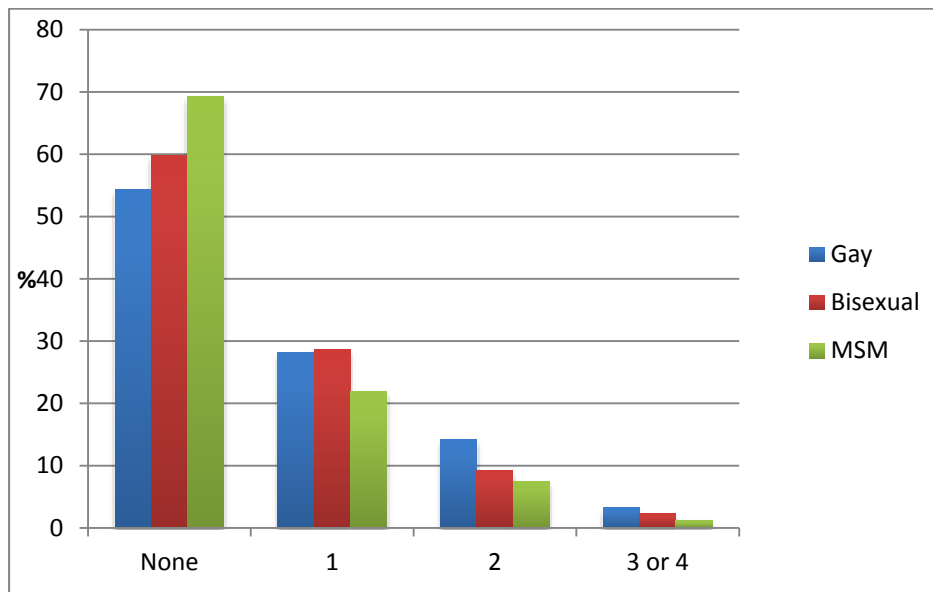
Demographic Factor	N	%	Crude OR (95% CI)	Adjusted OR (95% CI)
<b>Sexual Orientation</b>				
Bisexual/Straight	308	10.5%	REFERENCE	REFERENCE
Gay	836	17.5%	1.87 (1.62 – 2.16)	1.78 (1.44 – 2.21)
<b>Partnership Status</b>				
Partnered with a woman	155	8.7%	REFERENCE	REFERENCE
Partnered with a man	271	13.8%	1.68 (1.36 – 2.07)	.91 (0.68 – 1.21)
Single	609	18.2%	2.33 (1.93 – 2.81)	1.27 (0.98 – 1.65)
<b>Age</b>				
Over 45	425	11.9%	REFERENCE	REFERENCE
30-45	367	15.9%	1.41 (1.21 – 1.64)	1.38 (1.17 – 1.63)
Under 30	352	19.3%	1.78 (1.52 – 2.07)	1.49 (1.25 – 1.78)
<b>Education</b>				
University Degree	378	13.0%	REFERENCE	REFERENCE
No University Degree	766	15.9%	1.27 (1.11 – 1.45)	1.17 (1.01 – 1.36)
<b>Income</b>				
60,000 and over	329	11.1%	REFERENCE	
Under 60,000	815	17.2%	1.66 (1.45 – 1.91)	1.32 (1.12 -1.55)
<b>Ethnicity</b>				
Caucasian	995	14.8%	REFERENCE	REFERENCE
Asian	27	9.9%	0.63 (0.42 - 0.94)	0.42 (0.27 – 0.66)
Black	8	11.4%	0.74 (0.36 – 1.56)	0.63 (0.29 – 1.41)
Latino/Hispanic	11	10.5%	0.68 (0.36 – 1.27)	0.46 (0.22 - 0.95)
Middle Eastern	8	16.3%	1.12 (0.53 – 2.41)	0.94 (0.41 – 2.13)
First Nations	32	21.4%	1.56 (1.05 – 2.33)	1.32 (.85 – 2.04)
Mixed	42	19.7%	1.41 (1.00 – 2.00)	1.07 (0.73 – 1.56)
Others	21	17.6%	1.24 (0.77 – 1.99)	.99 (.57 – 1.72)
<b>Living Environment</b>				
Rural/Remote	152	13.0%	REFERENCE	REFERENCE
Urban	703	16.0%	1.27 (1.05 – 1.53)	1.21 (0.98 – 1.49)
Suburban	282	13.4%	1.04 (0.84 – 1.28)	1.06 (0.85 – 1.35)

\*Adjusted for Provinces and territories

The analyses were then repeated by stratifying the sample with the three categories of gay (n = 4361), bisexual (n = 834) and married MSM (n = 1778). Experiences of marginalization and psychosocial issues were then reviewed according to the new categories of analysis. With the exception of sexual violence, reported at the same rate by all groups, other marginalization indicators were disproportionately reported by gay men compared with bisexual men and married MSM. Bisexual men reported more marginalization than married MSM. A similar trend was also noted for the experience of psychosocial issues. With the exception of binge drinking, gay men were more likely to report the occurrence of all other psychosocial issues in the last 12 months compared with the two other groups. Bisexual men tended to report these issues at a higher rate than married MSM. Gay men were also more likely to experience a syndemic of two or more psychosocial issues (17.5%) in comparison to bisexual men (11.5%) and married MSM (8.7%).



**Figure 4-5. Prevalence of lifetime experience of marginalization by sexual identity**



**Figure 4-6. Number of psychosocial issues reported by sexual identity**

Results from multivariate analysis for demographic factors associated with experiencing a syndemic stratified by sexual identity categories are presented in table 4.6. In the multivariate analysis performed only on gay men who were single or partnered with another man, men with an annual income under \$60,000 remained at increased odds (AOR 1.39 95% CI 1.14 – 1.69). Additionally, among men in this group, those who were single (AOR 1.45 95% CI 1.23 – 1.72), Aboriginal (AOR 1.78 95% CI 1.10 – 2.88), and living in urban environment (AOR 1.52 95% CI 1.16 – 1.98) were at increased odds of reporting two or more psychosocial issues.

For single or male partnered bisexual men, lower education (AOR 1.79 95% CI 1.02 – 3.14) remained a factor that increases the odds of experiencing a syndemic. All other factors were not statistically significant. For men married or partnered to a woman, being under the age of 30 years old (AOR 2.80 95% CI 1.65 – 4.74) was the only demographic factor for which there was an increased odds of reporting two or more psychosocial issues. For both, bisexual and married MSM, the number of men who were not Caucasian was insufficient to reach statistical significance.

**Table 4-6. Demographic factors associated with experiencing a syndemic of two or more psychosocial issues by gay, bisexual and MSM**

Demographic Factor	Gay Men AOR (95% CI)	Bisexual Men AOR (95% CI)	MSM AOR (95%)
<b>Sexual Orientation</b>			
Bisexual/Straight			REFERENCE
Gay			1.35 (.70 – 2.62)
<b>Partnership Status</b>			
Partnered with a woman			REFERENCE
Partnered with a man	REFERENCE	REFERENCE	
Single	1.45 (1.23 – 1.72)	.71 (.38 0 1.33)	
<b>Age</b>			
Over 45	REFERENCE	REFERENCE	REFERENCE
30-45	1.36 (1.11 – 1.65)	1.35 (.78 – 2.34)	1.40 (.95 – 2.06)
Under 30	1.40 (1.14 – 1.72)	1.17 (.66 – 2.06)	2.80 (1.65 – 4.74)
<b>Education</b>			
University Degree	REFERENCE	REFERENCE	REFERENCE
No University Degree	1.16 (.98 – 1.38)	1.79 (1.02 – 3.14)	.984 (.65 – 1.42)
<b>Income</b>			
Over 60,000	REFERENCE	REFERENCE	REFERENCE
Under 60,000	1.39 (1.14 – 1.69)	1.31 (.77 – 2.22)	1.08 (.75 – 1.56)
<b>Ethnicity</b>			
Caucasian	REFERENCE	N/A	N/A
Asian	.46 (.29 - .73)		
Black	.59 (.23 – 1.51)		
Latino/Hispanic	.41 (1.8 - .95)		
Middle Eastern	1.06 (.43 – 2.63)		
First Nations	1.78 (1.10 – 2.88)		
Mixed	.99 (.93 – 1.57)		
Others	1.06 (.58 – 1.92)		
<b>Living Environment</b>			
Rural/Remote	REFERENCE	REFERENCE	REFERENCE
Urban	1.52 (1.16 – 1.98)	1.22 (.65 – 2.30)	.71 (.455 – 1.06)
Suburban	1.29 (.96 – 1.74)	1.40 (.71 – 2.76)	.70 (.44 – 1.11)

\* Adjusted for Province of Residence

### 4.3. Discussion

The findings of this investigation of Canadian gay and bisexual men strongly supports the idea that exposure to homophobia produces a burden of mental health and substance misuse which in turn increases the risk of HIV infection – upholding the basic tenets of syndemic theory. Furthermore, applying the concept of intersectionality to the analysis revealed, as hypothesized, that syndemics are unevenly distributed among gay and bisexual men. Intersectionality first helped to illuminate substantial differences between gay, bisexual and men partnered to women. The data suggest that gay and single or male-partnered bisexual men face more homophobia than MSM married to a woman. These findings suggest that the latter by adhering more strictly to the heterosexual norm of opposite gender partnership, access heterosexual privileges that provides them with protection from anti-gay stigma and the later development of corresponding psychosocial issues.

These data also demonstrate that syndemics may be influenced by factors other than those pertaining to sexuality. While gay men were at increased risks of experiencing a syndemic compared to bisexual men and married MSM; several other factors may contribute to syndemic production including being single; being younger than 45 years old; earning under 60,000 dollars per year and living in an urban environment. More so, the analysis revealed that gay men of Aboriginal ancestry were particularly vulnerable to experiencing a syndemic. Stratified analyses also revealed that while married MSM were reporting syndemics at a much lower rate than gay and bisexual men, those under the age of 30 were at similar risk of syndemic as gay men.

These results also demonstrate the importance of stratifying participants based not only on their sexual identity, but also their partnership status to attend to the complexity of sexuality. When using the traditional epidemiological approach to adjustment (non-stratified), the effects of some explanatory variables were lost. For example, in the multivariable regression presented in table 4.6, there was no effect for relationship status, while the stratified analysis showed clear differences between married MSM and single or male-partnered bisexual men. This is because the vast



majority of married MSM identified as bisexual (93.4%) therefore bisexuality and partnership to a woman were highly correlated. Stratifying groups also brought forward new nuances by demonstrating that some factors were only relevant for certain groups. For example, lower education was only a determinant of syndemic for bisexual men.

#### **4.3.1. Limitations**

This analysis is limited by issues inherent to all self-administered questionnaires. Specifically, it is difficult to know how representative this sample is of the Canadian population of MSM. However, while the Sex Now survey sample is not a typically randomized sample, it is the largest sample of gay and bisexual man in Canada to date with 8382 Canadian respondents. Another limitation of this study is that it has relied on self-reports of retrospective, cross-sectional data. Thus, participant responses may be subject to recall and social desirability biases, resulting in an underestimation of past marginalization events; particularly among older men if they happened during teenage years. Highly stigmatized behaviours and experiences such as unprotected sex, substance misuse and mental health issues may also be underreported.

Another important limitation of this study is that the survey did not use validated scales to measure mental health issues such as anxiety and depression. Thus the data presented should not be used to make claims about the prevalence of anxiety and depression among Canadian gay and bisexual men. Instead the measures represent those who found their way into care for anxiety or depression, which might represent the severity of their cases. It is important to note that such measures are potentially more inclusive of the history of anxiety and depression in the twelve months prior to the survey, as clinical scales only measure experience at the time of the questionnaire. Furthermore, this analysis was not intended to measure mental health or substance misuse among gay, bisexual and MSM per se, but rather to use them as indicators of potential syndemics.

This is a preliminary and first exploration of its kind that brings intersectionality into syndemic research. One of the difficulties of applying intersectionality to quantitative

studies is that a large dataset is required to produce analyses of multiple intersecting categories. That is why much of the quantitative intersectional analyses to date have been conducted on census and government surveys such as the Canadian Community Health survey. Despite being Canada's largest survey of gay and bisexual men, Sex Now had a limited number of men belonging to ethnic minority groups. This was particularly true for men married to a woman and bisexual men: 93.1% of married MSM and 82.6% of bisexual men were Caucasian. However, while there were more men of colour in terms of percentage among bisexuals, the numbers were too low for adequate statistical analysis. Future surveys could benefit from targeted promotion strategy to increase the involvement of these men, such as working with associations of gay and bisexual men of colour and offering the survey in multiple languages. More so, while Sex Now differed from other Canadian studies by thoroughly questioning gay and bisexual men on their everyday experiences of sexual stigmatization, the survey did not ask about other forms of stigma and violence, such as the ones based on religion, class, ethnicity, and gender identity to name a few. Therefore the present study is limited, as it does not capture the breadth of experiences of gay and bisexual men along multiple axes of oppression. Future studies should focus on integrating those into their analyses.

#### **4.3.2. Implications for practice and health promotion**

The primary value in studying syndemic production among gay and bisexual men is not only to understand how syndemics are formed but also to identify innovative approaches for intervention that will effectively disentangle interconnecting health problems and promote well-being among gay and bisexual men. This study adds to the large and growing body of work on syndemics that demonstrates that HIV is connected to multiple psycho-social issues that are themselves, at least in part, socially produced by oppression. In that sense, this research suggests that currently favoured approaches to HIV prevention – behavioural and biomedical approaches – may be insufficient to reverse the epidemics as they do not attend to the broader health concerns of gay men, nor do they address the social inequities producing illness in this population.

While HIV prevention programs for gay and bisexual men have been implemented across Canada's large urban centres, there are practically no targeted mental health initiatives for sexual minorities. Particularly absent are services that are preventative in nature, such as suicide prevention initiatives for gay and bisexual men. Similarly there is a troubling silence about sexual minorities within mental health policies; despite the numerous research reports demonstrating mental health disparities among sexual minorities, the majority of mental health policies fail to mention this population. For example, the newly formed Mental Health Commission of Canada does not include a single targeted initiative towards sexual minorities. Similarly, in British Columbia, a recently launched 10-year plan on mental health does not have a single mention of gay men or sexual minorities. Such silence is more likely a contributing factor which is actually perpetuating these epidemics and must be addressed to reverse gay men's health disparities.

Beyond addressing the broader health concerns of gay and bisexual men, the results of this study suggest that particular attention must be given to reduce the exposure to the various forms of anti-gay violence experienced by gay and bisexual men. While sexual minorities are protected under the Canadian Human Rights Act and gay and bisexual men enjoy a greater visibility in Canadian's society, these results suggest that this more positive climate has not reduced exposure to marginalization and discrimination. In fact, these data suggest that young gay and bisexual men may face even more bullying and harassment than previous generations, even while facing similar levels of physical and sexual violence and career discrimination<sup>14</sup>.

The Sex Now survey revealed that 56.1% of respondents experienced either one or multiple forms of physical violence, harassment, or bullying. Again, like syndemics, experiencing violence was not evenly distributed in the sample and requires an intersectional analysis of its own. For example, among men under the age of 30, 69.4% reported at least one form of marginalization. The survey revealed a particularly disturbing trend among Aboriginal men. They were more likely to report violent forms

<sup>14</sup> An alternative explanation for the elevated rates of bullying and harassment could be that reporting has increased, but not bullying and harassment itself.

oppression; twice the rates compared to Caucasian men of sexual violence (23.8% vs. 11.2%) and physical assault (26.8% vs. 12.1%). These rates were particularly high among gay vs. bisexual Aboriginal men: sexual violence (28.1% vs. 16.3%) and physical assault (32.5% vs. 12.5%). Unsurprisingly then, Aboriginal gay men had the highest rate of men caught in syndemics with 34.3% reporting two or more psychosocial issues compared to 17.5% among Caucasian gay men (14.8% overall).

Although our survey did not ask the ages at which these attacks took place or where they occurred, other research has highlighted that sexual minority men are particularly vulnerable to violence during adolescence and within the school system. The high school climate study – a study of 3,700 Canadian high school students – found that 75.7% sexual minority males reported hearing homophobic comments daily, while 8.2% reported hearing these comments from teachers daily or weekly (Taylor & Peter, 2011). The study also reported that 20.4% of sexual minority men were verbally harassed weekly because of their sexuality, 17% reported being physically assaulted.

The findings of this study provide an additional argument for the elimination of homophobia in schools, by demonstrating the potential long-term effects that discrimination may have on sexual minorities, such as the development of multiple health issues, including HIV infection. While the high school climate study cited above described some disturbing trends in terms of experiences of violence, it also illuminated some potential solutions to improve the safety of sexual minorities within schools. The study noted that sexual minority students felt safer in schools that have gay-straight alliance (GSA) clubs, positive representation of gay, bisexual, lesbian, and transgender community members as part of the curriculum and anti-homophobia policies. However, these measures were not present in large numbers of schools and must be scaled up to improve the safety and health of sexual minority students. For example in Ontario and British Columbia less than 40% of schools have GSAs; less than 14% in the rest of Canada.

A syndemic analysis of a previous edition of the Sex Now survey was the first study to illuminate the potential role of workplace discrimination in the production of

syndemics (Ferlatte et al., 2014). While employment discrimination based on sexuality is prohibited in all jurisdictions under Canadian Laws, a sizable proportion of surveyed men (14.8%) reported such experiences, even in younger cohorts. These results suggest that interventions are needed beyond legislation to make working environments more welcoming to sexual minorities. While there is very little known about Canadian gay men's experience at work, there is a particular lack of evidence regarding potential solutions to reverse this situation. Interventions, such as written policy documents and diversity training should be implemented and subject to evaluation.

Finally, all interventions to reduce gay and bisexual men's health inequities should recognize that gay and bisexual men are not a homogenous group. Health difficulties are unevenly distributed in this population and are most likely the outcomes of multiple forms of power inequity. Based on the evidence presented in this paper, it can be hypothesized that syndemics among gay and bisexual men are not only products of heterosexism, but the results of the interaction of heterosexism with other power relations such age, class, and race. A singular focus on homophobia in the syndemic literature on gay and bisexual men may have obscured the fact that syndemics are disproportionately experienced by some sub-groups. Aboriginal men's lives, for example, are shaped by the intersection of homophobia and racism and a long history of colonization. Ignoring such factors in health promotion activities and HIV prevention policies is more likely to contribute to syndemics than resolve them.

### **4.3.3. Next steps forward**

The majority of syndemic studies to date have been conducted in the United States. They have noted other issues that may be part of syndemics among gay and bisexual men, including sexual compulsivity (Herrick, 2013), intimate partner violence (Herrick, 2013), stress (Herrick, 2013), smoking (Storholm et al., 2011), use of pharmaceutical drugs without prescription (Storholm et al., 2011), and arrest history (Kurtz, 2008). These health and social issues have yet to be tested among Canadian gay men for their interactions and their contribution to increasing gay men's vulnerability to HIV.

While this paper has shown a syndemic of mental health and substance use among gay and bisexual men, it is possible that intersectionality may help illuminate other syndemics relevant to subsections of the MSM population. While Asian gay men in this analysis were less likely to be experiencing a syndemic of mental health and drug issues, HIV infections have been on the rise among them in certain regions of Canada. In British Columbia, for example, Asian men accounted for only 3.2% of HIV infection among MSM in 2003 but 18.1% in 2012 (BC Centre for Disease Control, 2013). Research is needed to understand the underlying issues putting this subgroup of MSM at risk of HIV infection, including potential interacting health and social problems produced by the intersections of racial and sexual identity. Similarly, HIV infection is often seen as the end outcome in syndemic research, often ignoring the health and wellness of HIV positive gay and bisexual men post-infection. While many health disparities among HIV positive gay men have been already identified in the health literature, including hepatitis C co-infection (Van de Laar, Matthews, Prins, & Danta, 2010), smoking (Storholm et al., 2011), and psychiatric and drug disorders (Bing et al., 2001); syndemic theory in conjunction with intersectionality could be useful paradigms to understand the relationships between these disparities and how they are socially produced through heterosexism, HIV stigma and other social processes of oppression and differentiation.

While syndemic theory has been most useful in studies of HIV, it may help reveal how other diseases and social problems intersect and interact to worsen one another. The field of gay men's health has been largely biased towards studies of HIV, while other health issues like mental health and suicide have not received much attention (Hottes et al., 2014). There is no doubt that HIV has and continues to be a public health crisis among MSM, however gay men's health does not simply equate to HIV, other health disparities must be investigated in their own right and not just because they are intertwined with HIV, this includes but is not limited to suicide, mood disorder, intimate partner violence, smoking, and eating disorders.

Finally, it is also important to note that a large majority of the men surveyed in this paper reported homophobic discrimination but few or no syndemic health problems, including HIV risk. This points to potentially substantial reservoirs of resilience among

gay and bisexual men. While both syndemic and intersectionality have tended to focus on revealing negative social and health experiences, understanding gay and bisexual men's strengths, across racial and class differences, may also yield important insights into the development of efficacious interventions. Both syndemic and intersectionality theory could be used in future investigations to uncover protective factors among diverse gay and bisexual populations.

## **Chapter 5.**

### **Conclusion**

In this dissertation, I have presented three case studies of the application of intersectionality to the field of gay men's health. While each case study is independent in its own right, with their individual goals and objectives, together they speak to the transformative potential of intersectionality in the field of gay men's health research and theorizing. More specifically, these three chapters come together to: 1) exhibit how intersectionality can disrupt essentialist assumptions about "gay men" and "gay community" and address diversity; 2) show how intersectionality can effectively highlight and question issues of power and privilege affecting gay men and among gay men; 3) demonstrate that intersectionality can produce new and more accurate knowledge about gay men and gay communities.

In this conclusion, I synthesize the content of the dissertation and revisit the above-mentioned objectives. I also discuss the main challenges I experienced in applying intersectionality to gay men's health. I conclude this chapter with four questions that remain to be explored about the application of intersectionality to gay men's health.

#### **5.1. The transformative impact of intersectionality to gay men's health**

The overarching goal of my dissertation was to demonstrate the transformative potential of intersectionality. In chapter 2, I demonstrated that attention to the principle tenets of intersectionality could transform how we think about syndemics among gay and



bisexual men. More specifically, intersectionality helped expand syndemic theory by addressing issues of power and diversity more effectively. In chapter 3, I described how intersectionality principles informed a community-based participatory research project (CBPR) and allowed the typically unheard voices of gay men to shape a research initiative. Finally in chapter 4, intersectionality principles were used in a quantitative analysis of survey data and produced new knowledge about the distributions of health inequities among gay and bisexual men.

In this section, I review how three chapters came together and contributed to the achievement of each of my dissertation objectives.

#### **5.1.1. Objective 1 - Exhibit how intersectionality can disrupt essentialist assumptions about “gay men” and “gay community” and address diversity.**

Although some exceptions exist, much of gay men’s health research tends to lump all homosexual men together without much consideration of sexual identity and diversity. Differently, the three case studies presented in this dissertation rejected this erroneous assumption. In contrast, the diversity of gay and bisexual was brought up to the forefront in each chapter by the application of intersectionality.

In chapter 2, I provided evidence that syndemic research tends to advance a singular narrative of gay or bisexual men’s experiences of oppression and health. I challenged this approach by showing that significant evidence already exists in health experiences among this population along multiple axes of social locations such as sexual orientation, partnership status, race/ethnicity, Aboriginal ancestry and geography. With this in mind, I provided a forceful argument for the consideration of diversity within syndemic research. I did so by presenting a conceptual framework for intersectionality informed syndemic research. The framework calls on researchers to abandoned the widely use term MSM in public health research that homogenized the population of gay and bisexual. Rather, I called for a full interrogation of the social locations that gay and bisexual men hold. This includes their sexual identity, but also social locations typically

not discussed in syndemic research such race, class, Aboriginal status, and age. By taking into account these social locations, researchers may more accurately capture the various forms of intersecting oppressions that produce syndemics. I also suggested that researchers engage in reflexivity and revise their sampling strategies to better capture a diversity of experience in their research.

In Chapter 3, I described how CBPR has a tendency to use homogenized definitions of the gay community and as a result, many voices of gay men are unheard within research processes – particularly those who hold less power such as youth, gay men of colour, and trans gay men. In the case study I presented in this chapter, intersectionality forced a reconsideration of who participates in research. With my colleagues, we identified that youth were particularly absent from the research activities that concern them. We then created a program that builds their capacity to do research. Because we were interested in intersectionality, we attracted a diverse group of young men; several members identified as men of colour and one participant was transgendered. As a result, we produced research that was informed by a diversity of voices.

Finally, in chapter 4 I demonstrated the potential for intersectionality to help detect differences in health experience between gay men and bisexual men. Intersectional analysis showed that partnership with a woman provides protection from homophobia and negative health outcomes. This chapter also showed that health is dependent on nearly every social variable investigated. Finally, risk factors depended greatly on sexual orientation; for example, education was only a determining factor for bisexual men, while age income, ethnicity, and geography were determining for gay men.

### **5.1.2. Objective 2 - Show how intersectionality can effectively highlight and question issues of power and privileges affecting gay men and among gay men**

Power is a central concept in intersectionality (Dhamoon, 2011; Collins, 2000) but with the exception of writings within the field of sociology and the work of social epidemiologists – most notably the work of Nancy Krieger (2001; 2012; 2013) – power is not central to public health research. It is particularly absent within epidemiological research on gay men. However power was central to the three case studies I presented here. One of the ways that power was attended to was through reflexivity – actively reflecting on my own position allowed me to become more open to the experiences of men who are differently positioned and to ensure they were not erased from my research or my definition of gay men.

In chapter 2, I demonstrated that power is rarely attended to in syndemic research but that it is critical for the reduction of health inequities. Differently, I proposed a conceptual framework for intersectionality informed syndemic research that focused on power. In this framework, I call for an interrogation of power at the micro, meso and macro level. More so I demonstrated the importance of considering power, like homophobia, as intersecting with other forms of power such as racism, sexism, classism and colonialism. This consideration is needed to address the issues of gay men who cut across different power structures such as gay Aboriginal men or black bisexual men for example. In my conceptual framework I described four sites of power that need to be investigated: power operating in institutions, power in the population at large, power within the gay and bisexual community, and power embodied within individuals affected by oppression.

In chapter 3, I demonstrated that intersectionality can be used to disrupt power within community-based participatory research practices. Particularly, intersectionality offered some important reflections within the case I presented by highlighting who typically participates in research initiatives and who are typically excluded and underrepresented. Using insights from intersectionality, I show that CBPR can empower

a group of diverse gay men to take on research if researchers are willing to make space for them and reflect on their positions and power relations.

In chapter 4, power was attended to by interpreting my findings within the context of sociocultural and structural inequality in which my data was collected. This included a long history of sexual stigma within Canadian society that affected sexual minorities but also the histories of trauma and social disruption of Aboriginal people by colonization and subsequent policies and practices (e.g., residential schools) of European settlers. Acknowledging this context is critical in the context where Aboriginal gay men were found to be at increased risk of experiencing syndemics.

### **5.1.3. Objective 3 - Demonstrate that intersectionality can produce new and more accurate knowledge about gay men and gay communities.**

The appeal of intersectionality is that it can provide more accurate information about how health inequities are experienced within a population constituted of differently positioned individuals, such as gay men (Bauer, 2014; Hankivsky, 2012a; Bowleg, 2008). In chapter 2, I demonstrated that traditional syndemic research on gay men promotes a distorted view of gay men because of its lack of attention to diversity. Rather, syndemics tends to view gay men as a monolith. Differently, I argued that syndemic research would be richer if we take into consideration the multiple social locations held by gay men and the multiple systems of power operating on gay communities. This would provide more accurate information about the various intersecting factors that create syndemics, which potentially could lead to better interventions, targeted to the ones most at risk of syndemics.

In chapter 3, I demonstrated that by using intersectionality we can effectively disrupt power in CBPR between “senior/academic” researchers and “peer/community”, and that this disruption can allow different world views and lived experience to shape a research project and lead to the development of new evidences that are grounded in the lives of those affected.

Chapter 4, to my knowledge, is the first article looking at the variations of syndemics within gay and bisexual men, contributing novel ideas for the promotion of gay men's health. Indeed, in that chapter I demonstrated that gay men are more at increased risk of syndemics than bisexual men or men partnered with a woman. Within the gay population, single men, younger men, men with lower income and Aboriginal men were at increased risk of experiencing syndemics. The majority of these factors are a novel contribution to the field of syndemic research and gay men's health and could help target the prevention of HIV and syndemics more effectively.

## **5.2. The challenges of applying intersectionality to gay men's health**

While this dissertation celebrates in many ways the promises of intersectionality for advancing research on gay men's health inequities, it would be dishonest to describe its applications as an easy process. I experienced several challenges along the way that are worth mentioning.

First, when I started my journey with intersectionality there was a real lack of attention to gay men and sexual orientation within the intersectional literature. As others have noted, women and particularly Black women are still the primary focus of much intersectionality scholarship (Bowleg, 2012b; Carbado, 2013) and the relationship between intersectionality and sexuality is still an undeveloped field of inquiry (Taylor, 2011). As a result there were limited examples on which to build my work, hence highlighting the need for the work described in this dissertation

The lack of defined methodology has been described as the main limitation of intersectionality (Phoenix, 2006). I was confronted with an absence of how-to guides for the application intersectionality. This was particularly true for quantitative analysis, as work was only starting to emerge in the area and that the usefulness of intersectionality to quantitative research was still under debate when I was performing my analysis.

More so, there are limitations with the data I was working with for each chapter. For example, in my theory piece (chapter 2) I experienced difficulties to draw on empirical evidences in the development of my framework, as the field of gay men's health remains underdeveloped and therefore the literature contains very few intersectional examples. In my qualitative piece (chapter 3), power dynamics may have prevented youth of colour from speaking openly about their experience in the project and therefore making it difficult to speak about the intersections of race, sexuality and age. Lastly, the low response rate of men of colour in the survey data I used prevented me from looking at differences among gay, bisexual men and men married with a woman across ethnicities. Therefore, my results should be used with caution and considered as preliminary explorations.

Finally, the policy context in which my research evolved was not conducive to intersectionality. I did my research in the context of the expanding HIV policy of "treatment-as-prevention" and felt a relentless pressure to reposition gay health within a bio-medical model. Therefore, as I was navigating the public health sectors and greater HIV research community I felt little support for an intersectional perspective on gay men's health.

### **5.2.1. Four questions for the future of Intersectionality in gay men's health**

While some of the transformative potential of intersectionality has been demonstrated in this dissertation, some questions remain unanswered about the future of this framework for the field. I conclude this dissertation with the following four questions for the field:

#### **Biomedical challenges**

While social sciences and bio-medical approaches are often positioned against each other, they are not necessarily in opposition. As bio-medical approaches to gay men's health (particularly within HIV) are increasingly becoming popular (i.e. Treatment

as prevention, Pre-exposure prophylaxis), there are potential benefits of integrating intersectionality. For example, Intersectionality has the potential to advance our understanding of how biomedical prevention strategies address, maintain and create inequities among different affected groups including diverse groups of gay men, therefore helping to identify interventions that can be made to improve these types of responses.

### **Health Interventions and community programs**

How can Intersectionality inform real-world solutions to gay men's health problems? How can it shape policy, programs, health promotion campaigns, and service delivery? Thus far intersectionality within gay men's health remains a theoretical and research paradigm. More work is needed to understand how intersectionality can inform the delivery of health promotion activities, whether it is social marketing campaigns, community-level interventions or individualized forms of prevention.

### **Resilience**

Insights about reducing health inequities are not only the result of the study of illness, they can be found in the study of resilience from health problems (Ungar, 2011; Windle, 2010). The gay men's health literature gives countless examples of vulnerability to illness, with huge variation. Typically, the response to variation is to focus on those who express the illness. Yet, gay men who have been exposed to health stressors but do not experience negative health outcomes are rarely studied and as a result resilience has been described as an untapped resource for gay men's health (Herrick et al., 2011). Focus on resilience and the strengths of gay communities are likely to yield important insights about how to best maintain health.

However, resilience research could benefit from an intersectionality perspective. The potential of resilience research is demonstrated in the small body of research focused on resilience among LGB people of colour that produced new insights for health promotion (Follins, Walker, and Lewis, 2013; Meyer, 2010; Laboy & Parker, 2015). It is

important to consider that variations may be due to social locations and resilience may look different for differently positioned gay men. This area remains to be fully investigated.

### **Rethinking the gay men's movement**

The gay men's health movement has mainly evolved outside of the greater LGBT movement – driven more recently by having HIV as its main focus (LBT are often not perceived at the same risk of HIV). However as gay health is becoming more holistic, intersectionality can guide a reflection on solidarity between gay men and other members of the queer community to improve health for all LGBT. The “siloeing” of gay men makes little sense considering that many health inequities faced by gay men (suicide, depression, substance use) are also experienced by lesbian, bisexual and transgender individuals, and although there are variations and diverse degrees of power between these groups, all are impacted by sexual stigma.



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## **Appendix A.**

### **Interview Guide – Young gay men (Investigaytors)**

- How would you describe your experience with the Investigaytors projects? What did you like the most?
- What do you think you contributed to the project? How do you feel your own experience contributed to the research project? How your different identities influenced your participation in the project?
- What would you say you got out of the experience? What would you say are the benefits for young gay men to be involved in such a project?
- What did you learn about the gay community during the project? Did you learn something about yourself?
- What was challenging for you in the project? Can you think of some barriers that may prevent other young gay men to participate in such an initiative in the future?
- Do you have any suggestions of how we can improve the project? Make it more inclusive? How can the project attract diverse groups of young gay men?
- Anything else you would like to share about the investigators (i.e. thoughts, reflections, ideas)?

## Appendix B.

### Interview Guide Research Team

- As a researcher, how would you describe your experience with the Investigaytors?
- What do you think were the contributions of the young lay researchers to the project? How do you think their experiences influenced the research project? How do you think their multiple identities play into influencing the research activities?
- What do you think the young Investigaytors got out of the experience? As a researcher, what do you think you got out of working so closely with a group of young lay researchers?
- What would you say were the challenges working with the young lay researchers? Any drawbacks you can think of? Any challenges? Can you think of some barriers that may prevent other young gay men from participating in such an initiative in the future?
- Do you have any suggestions of how we can improve the project? Make it more inclusive? How can the project attract diverse groups of gay men?
- Anything else you would like to share about the investigators (i.e. thoughts, reflections, ideas)?