The Health of Racialized Sexual and Gender Minorities in Canada:
A Literature Review

by

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Abstract

This literature review is the first of its kind to examine the body of research on the health of racialized (i.e., Indigenous, Black, people of mixed ancestry/heritage, and people of colour) sexual and gender minorities in a Canadian context. The literature highlights how the particularities and intersections of racialization, gender, sexuality and other social determinants of health impact the health of racialized sexual and gender minorities in unique ways affecting access to health and social services, experiences of violence and discrimination, and sexual and mental health. Each racialized group discussed--Indigenous, Black and Asian--experience outcomes that differ from other racialized sexual and gender minorities, white sexual and gender minorities, and/or racialized heterosexual people. The implications of these findings suggest that racialized sexual and gender minorities have unique experiences and health outcomes that need to be addressed in specific and nuanced ways in sexual and gender minority research and public health practice.

Keywords: sexual minorities, gender minorities, racial and ethnic minority health, Indigenous health, social and health inequities

Dedication

This paper is dedicated to the amazing racialized scholars, activists and community members who are constantly doing equity work in their everyday lives, who make changes that are felt for generations to come, and who continue to love, inspire and motivate me to do the work that I do.

Acknowledgements

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Critical Reflection

I consider writing and sharing this paper as one of my roles in engaging as a

public health practitioner with the public health of racialized sexual and gender

minorities.   In this regard, it is important that I situate myself in this work.   As a non-

Indigenous non-Black non-transgender queer Vietnamese man and settler complicit in

the settler colonialism of the Canadian nation-state, my ability to recognize and analyze

important and nuanced lived experiences outside of my own is limited. In reflecting on

Sarah Ahmed's (2006) work on queer phenomenology, it is important to recognize that

the interconnectedness of histories, objects and experiences in my life form impressions

on my emotions and my body that move me toward and away from noticing and

analyzing some experiences over others. Indeed, even after spending more than a year

with this research, I am still discovering gaps in my analysis including but not limited to

experiences of racialization outside of my own.

The writing process has been a messy one and I think highlights the messiness of

health equity and solidarity work. My choice of focusing on the health of racialized

sexual and gender minorities in Canada was a complex one.   First, there was not

enough Canadian literature to review on any one racialized sexual and gender minority

group in a way that would meet the requirements for completing my Master of Public

Health. While I could have focused on a particular racialized sexual and gender

minority group using international literature, I did not want to extend this literature

review beyond a Canadian context in recognition of the specific histories and discourses

as well as social, economic and political structures and conditions affecting racialized

sexual and gender minority experiences in Canada. I think the lack of research on

racialized sexual and gender minorities is very telling of the whiteness of sexual and

gender minority research and activism in Canada. I think sexual and gender minority

research and its associated politics need to be criticized here in Canada.

Second, because the option for a broader literature review of racialized sexual

and gender minorities was possible, I felt conflicted about my responsibilities as a non-

Indigenous non-Black non-transgender racialized settler living on the unceded, ancestral

and occupied lands of the Coast Salish peoples--in particular the Musqueam, Tsleil-

Waututh, and Squamish nations and peoples--who has the privilege of access to this

type of research. In the context of a literature review, there is an opportunity to share

information--however imperfectly through the lens of my personal experience and

academic training--about the racialized scholars as well as the racialized sexual and

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gender minorities who have so often been marginalized and ignored in research. I

should be clear though in stating that this work is incomplete and will remain

incomplete without the feedback and analyses of all racialized sexual and gender

minority groups discussed in this literature review. I consider this project to be a work

in progress and a beginning for more conversations as well as social and political action

among racialized sexual and gender minorities of which I include myself.

Lastly, I think it is important to discuss my own personal and political motives to

doing this type of work. In my experience working in the field of gay men's health in

Vancouver, I have witnessed the ways in which research and community work is infused

with subtle, overt, and intersecting forms of racism, sexism, cisism/transphobia,

classism, and others forms of oppression. Such work contributes to a culture of white

supremacy within gay men's health communities, and their associated organizational

and political bodies, that centre the experiences and health concerns of young non-

transgender white gay men. As a result, racialized sexual and gender minorities are

often marginalized not only in research, but also in these organizations as staff and as

program participants. My hope is that this work will challenge these organizations to do

better work or to provide an impetus for other organizations to form that do not centre

white non-transgender gay men.

Thinking strategically about the future directions for this research, I do think that forming an organization for racialized sexual and gender minorities is possible within the current neoliberal context in which public health functions. A common discourse I have noticed is that there is not sufficient numbers to warrant specific attention to particular racialized sexual and gender minority groups. I feel that a coalition of racialized sexual and gender minority groups may be a potential strategy of advocacy and political action to call for more appropriate and equitable health and social services. Such a coalition will come with its own messiness, but I think it will make for an important space of solidarity building across racialized sexual and gender minority groups. However, this strategy assumes that functioning within a neoliberal context is an option that racialized sexual and gender minorities would be interested in, which also should be questioned.

There is much that I have learned from reviewing the literature on the health of racialized sexual and gender minorities. The process of doing this literature has highlighted how tackling health outcomes of racialized sexual and gender minority communities must recognize that colonialism, anti-Blackness, racism, sexism, homophobia and transphobia are all interlinked with our experiences as racialized sexual and gender minorities. We cannot truly tackle these health outcomes without getting at these root causes and our complicities in these root causes.

I think the recognition of such complexities calls for a nuanced and long-term

accountability to one another and to our communities. I think, at this point, my role as

a public health practitioner is to bring this research to differently racialized sexual and

gender minority communities to get feedback and to consider strategic and political

actions for the future. I think this research, and almost all research, can and should be

used as political tools to advocate for a more just and equitable society. There is still a

lot to do. This paper is merely the beginning my solidarity work with racialized sexual

and gender minority communities.

Introduction

In the part of Turtle Island called Canada, many studies fail to address the unique impacts that the simultaneous and intersecting experiences of race, ethnicity, gender, and sexuality have on the health of racialized sexual and gender minorities including Indigenous people, Black people, people of mixed ancestry/heritage and people of colour (as discussed in Nelson, Walker, DuBois, & Giwa, 2014; Millett et al., 2012; Maung et al., 2013; Poon, Ho, Wong, Wong, and Lee, 2005; Nakamura, Chan, and Fischer, 2013). A particularly alarming example can be found in the Public Health Agency of Canada's ([PHAC], 2013, pg. 18) most recent HIV/AIDS status report for gay, bisexual, two-spirit, and other men who have sex with men (MSM), which notes that "up to 2011, 81.8% of all positive HIV test reports were missing information on race and ethnicity".

Many studies have also noted difficulties in recruiting racialized sexual and gender minority research participants, retaining racialized sexual and gender minority research staff, and/or analyzing data about racialized sexual and gender minorities (Travers et al., 2013; Veenstra, 2011, 2013; Brennan, Crath, Hart, Gadalla, & Gillis, 2011;

Bergeron and Senn, 2003). Other studies, particularly quantitative studies, analyse self-

identified race or ethnicity[1], but fail to account for racism as a systemic component of

racialized sexual and gender minorities' everyday life experiences (for example,

Veenstra, 2011; Craib et al., 2000; Marshall et al., 2011). These experiences may include

for example language barriers, experiences of racism within sexual and gender minority

communities and homophobia within ethnic communities (Catungal, 2013; Nakamura,

Chan, and Fischer, 2013). Furthermore, some studies may not report on race, ethnicity

or gender at all, even when the data is collected (Strathdee et al., 2000; Adam,

Husbands, Murray, and Maxwell, 2008). Taken together, these difficulties speak to a

system of knowledge production that silences and excludes racialized sexual and gender

minorities.

This silencing and exclusion of racialized sexual and gender minorities in the

research are--and create--public health problems for racialized sexual and gender

minorities, and by extension, sexual and gender minority communities more broadly.

Because research can and often is used as a political tool for individuals and

organizations to demand increased government and nongovernment funding for

[1] Oftentimes, race or ethnicity is "self-identified" by participants from a list of limiting and colonial constructs of race or ethnicity. As researchers, it is important to recognize whether or not we are allowing people to engage in self-determination of their own identities (B. Bunjun, personal communication, June 11, 2016).

research, programming, and key health services, the silences and exclusions in the

research about and with racialized sexual and gender minorities often translates into

less visibility and less funding for programs that specifically addresses these populations'

needs. Furthermore, because research is often used to guide the development of

programs, these silences and exclusions in the research may further produce programs

that don't meet these populations' needs. Without addressing the complexities of

intersectional[2] experiences of race, ethnicity, gender and sexuality within racialized

sexual and gender minority communities, health equity cannot and will not be achieved

within these communities.

[2] By intersectional I am referring specifically to the field of critical race theory and intersectionality
theory which posits that socially constructed and systemic forms of marginalization such as
racism and sexism interact to produce multiple and unique marginalizations that are further
uniquely experienced among people who hold multiple marginalized identities (e.g., being a
person of colour and a sexual minority) and in ways that cannot be understood by examining
those identities separately (Ford and Airhihenbuwa, 2010; Crenshaw, 1991; Delgado and
Stefancic, 2000). Such socially constructed and systemic forms of marginalization create
hierarchies and social and structural relations of privilege, power and dominance (Ford and
Airhihenbuwa, 2010; Crenshaw, 1991; Delgado and Stefancic, 2000).

Purpose

The purpose of the paper is to review the literature on the health experiences, health outcomes, and social determinants of health affecting racialized sexual and gender minorities in Canada in order to identify and make a case for more specific, accountable, and ethical research and public health practice to address the specific and nuanced health concerns of racialized sexual and gender minorities within a Canadian context.

Methods

This exploratory literature review searched over 50 databases including Medline (PubMed), Sociological Abstracts, PsycINFO, Academic Search Complete, Academic Search Premier, CINAHL Complete, Political Science Complete, and Alt HealthWatch. Combinations of keywords were used that focused on sexualities (e.g., queer, gay, lesbian, men who have sex with men), racialization (e.g., race, ethnicity, colonialism, racism), and gender (e.g., genderqueer, transgender, gender variant, gender non-conforming, men, women). The inclusion criteria for this literature review were articles that were written in English, researched with participants living in Canada, and that explicitly reported on the health outcomes, health experiences or social determinants of health of racialized sexual and gender minorities. Articles that did not meet these criteria were excluded.

Over 300 abstracts were reviewed using these criteria. Based on these criteria, 35 articles were selected for this literature review. Of the selected literature, articles were published between 1999 and 2015. The literature included quantitative studies (22), qualitative studies (7), mixed-methods studies (3), meta-analyses (2), and

systematic reviews (1). Studies were conducted with national samples (2) as well as

samples within specific provinces including British Columbia (15), Ontario (15), Alberta

(1), Manitoba (2) and Quebec (1).

Results

The literature contained a multitude of information about determinants of health affecting racialized sexual and gender minorities. The results below are organized into three broad categories of health determinants as defined by Reading and Wien (2009): (1) proximal (2) intermediate and (3) distal determinants of health. Each of these categories are then subdivided into more specific determinants of health with subcategories for differently racialized sexual and gender minority groups.

1.1. Proximal Determinants of Health

Proximal determinants of health refer to "conditions that have a direct impact on physical, emotional, mental or spiritual health" (Reading and Wien, 2009, pg. 5). Several proximal determinants of health were identified as affecting racialized sexual and gender minority health: human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS), sexually transmitted infections (STIs), sexuality, substance use, mental health, body image and eating disorders, sex work, income, education and employment, and migration.

1.1.1. Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)

Indigenous two-spirit[3] people and sexual and gender minorities

Multiple studies discussed Indigenous two-spirit people and sexual and gender minority populations' experiences with HIV/AIDS. Among studies that discussed HIV prevalence, Bauer, Travers, Scanlon, and Coleman (2012) found that Indigenous two-spirit and transgender people in Ontario had higher HIV prevalence (17%) than both non-Indigenous racialized transgender people (3%) and white transgender people (2%). In addition, 21% of Indigenous two-spirit people and sexual and gender minorities in Winnipeg, Manitoba and 44% in Vancouver, British Columbia, identified HIV as a health concern (Ristock, Zoccole, and Passante, 2010; Ristock, Zoccole, and Potskin, 2011). Furthermore, Indigenous two-spirit and transgender people were more likely to report being HIV positive (15.4%) than non-Indigenous transgender people (4.3%) (Taylor, 2009). In particular, Indigenous transgender and non-transgender women were more

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[3] Coined in 1990 at an Indigenous sexual minority conference in Winnipeg, the term was created to revitalize the meanings, traditions and roles of sexual and/or gender minority peoples in Indigenous societies (Meyer-Cook and Labelle, 2003). The term two-spirit can refer to Indigenous peoples of diverse sexualities and genders as well as specific cultural traditions and roles that may or may not be associated with sexuality (Meyer-Cook and Labelle, 2003; Fieland, Walters, and Simoni, 2007). One common definition of two-spirit is "Indigenous people who embody both masculine and feminine spirits and qualities within Indigenous knowledge systems" (Hunt and Holmes, 2015, pg. 160).

likely or the most likely to report being HIV-positive when compared to non-Indigenous

people (Taylor, 2009; Monette et al., 2011).

Among studies examining HIV testing, Scheim et al. (2013) found that 55% of

Indigenous two-spirit and transgender people in Ontario tested for HIV in the past year.

In fact, Indigenous two-spirit and transgender people were found to be the most likely

to report being tested for HIV at least once in their lifetime (86%), followed by non-

Indigenous racialized transgender people (67%) and white transgender people (56%)

(Bauer et al., 2012).

In examining the relationship between enacted stigma and HIV risk, Saewyc,

Clark, Barney, Brunanski, and Homma (2013) found that greater enacted stigma--

experiences of teasing and verbal harassment, physical fights and assault, and

discrimination based on race, sexuality, or appearance--was associated with greater HIV

risk for Indigenous sexual minority girls and boys. Using data from the 2003 Adolescent

Health Survey (AHS), the most representative survey of public school students from

grades 7-12 in British Columbia, Saewyc et al. (2013) found that Indigenous sexual

minority boys who experienced enacted stigma were more than 4 times more likely to

have had sex before the age of 14 and to have not used a condom during their most

recent sexual experience. Among Indigenous sexual minority girls, those experiencing

enacted stigma were more than 4 times more likely to be sexually experienced, to have

had sex before the age of 14, and to have had 3 or more sexual partners in the past

year. They were also more than 2 times more likely to not use a condom and to have

engaged in substance use during their last sexual experience. In multivariate analyses,

however, the association of enacted stigma with HIV risk only held for Indigenous sexual

minority girls. The authors note that this may be due in part to the small sample size of

Indigenous sexual minority boys.

The remaining studies discussed the effectiveness of antiretroval (ARV) therapies

and HIV vaccine acceptability. In terms of ARV therapies, Miller et al. (2006) found that,

among Indigenous people living with HIV/AIDS, those who had suppressed viral loads

were more likely to be men who have sex with men (MSM) (Miller et al., 2006). In

terms of the acceptability of a hypothetical HIV vaccine, Indigenous two-spirit people

and sexual minorities viewed it to be beneficial. However, participants had concerns

related to the histories of violence enacted upon Indigenous bodies by the Canadian

government and health care systems (i.e., forced sterilization of Indigenous women,

dichloro-diphenyl-trichloroethane (DDT) use on children, ongoing racism as well as the

legacies of colonialism), cost, Eurocentric biases in pharmaceutical and medical

research, and community control and self-determination (Newman, Woodford, and

Logie, 2012).

Black MSM

Among studies discussing Black men who have sex with men's (MSM)

experiences with HIV/AIDS, one meta-analysis of Canadian studies of Black MSM--Black,

African and Caribbean men born in and outside of Canada--found no difference

between Black and white MSM in terms of testing for HIV as well as receiving an HIV

positive test result (Millett et al. 2012). In contrast, however, among MSM diagnosed

with HIV in Ontario between 2009 and 2012, the Laboratory Enhancement Program

(2013) found that the proportion of Black MSM diagnosed with HIV increased from 8.9%

to 13.7%.

In a more recent study, George et al. (2014) found that the majority of Black

MSM had tested for HIV (87%) of which almost a quarter reported a HIV-positive result.

Furthermore they identified several factors related to lifetime HIV testing including

being older than 21, college educated, born outside of Canada, uncircumcised, Christian,

attending religious services, and knowing people or having friends who are living with

HIV or have died from AIDS-related illnesses. In analyzing testing behaviours in the past

6 months, having sex with white MSM was associated with a decreased likelihood of

testing. In multivariate analyses, attendance at religious services and knowing a friend

or family member with HIV was associated with having tested for HIV at least once in

their lifetime. In terms of testing within the past 6 months, being older than 21 was

associated with increased testing in multivariate analyses.

Asian MSM

Among studies discussing Asian MSM's experiences with HIV/AIDS, a secondary

analysis of dry blood samples from adult MSM living in Vancouver, BC, found that HIV

was less prevalent among Asian MSM (2.8%) than non-Asian MSM (18.1%) (Maung et

al., 2013). However, the analyses also indicated that Asian MSM were less likely to have

been tested for HIV in their lifetime (75% compared to 86.8% for non-Asian MSM).

After adjusting for confounders, Asian ethnicity was found to be associated with a

decreased likelihood of HIV testing among men under age 35. In contrast, the

Laboratory Enhancement Program (2013) found that among all MSM diagnosed with

HIV in Ontario between 2009 and 2012, the proportion of East and Southeast Asian

MSM diagnosed with HIV increased from 4.9% to 7.6%.

Poon, Ho, Wong, Wong, and Lee (2005) examined HIV prevention behaviours

among East and Southeast Asian MSM who used online chatrooms in Toronto, Ontario.

Men were found to employ various HIV prevention strategies such as limiting sexual

behaviours with casual sexual partners, reserving anal sex and less safe sex to long-term

relationships, and/or always using a condom when having anal sex with a casual

partner. However, the study found that some Asian MSM engaged in less safe sexual

practices or beliefs: not use condoms for oral sex with a casual partner, limiting safer sex

to discussions of condoms and lube, and believing that unrelated characteristics (i.e.,

age, occupation, social cues) could be used to discern a person's HIV status.

Racialized MSM

Of the remaining studies that accounted for race, ethnicity, and sexuality in their

final analyses, one study of HIV positive MSM who do not use injection drugs found that

ethnicity was not a factor associated with hepatitis C (HCV) infection (Burchell et al.,

2015). Another study on HIV infection and risk among young MSM in Vancouver found

that non-white participants were significantly more likely to be lost to follow-up

(Strathdee et al., 2000).

1.1.2.   Sexually Transmitted Infections (STIs)

Asian MSM

In regards to STIs, one study reported on experiences of STIs among Asian MSM.

In comparing adult Asian and non-Asian MSM, Maung et al. (2013) found that Asian

MSM were less likely to have tested for hepatitis C virus (HCV) in their lifetime as well as

in the past 2 years. They were also less likely to have tested for gonorrhea in their

lifetime. After adjusting for confounders, Asian ethnicity was associated with a

decreased likelihood of testing for HCV for men under the age of 35.

Black MSM

Among Black MSM in Canada, Millett et al.'s (2012) meta-analysis found that

there was no difference in STI infections between Black and white MSM.

1.1.3.   Sexuality

Indigenous two-spirit people and sexual and gender minorities

In terms of sexuality, Marcellin, Bauer, and Scheim (2013) found that

transphobia was associated with an increased odds of having high risk sex among non-

Indigenous racialized transgender people and low risk sex among Indigenous

transgender people. In another study, Bauer et al. (2012) found that the majority of

transgender people in Ontario--Indigenous (4%) and non-Indigenous racialized people

(5%) as well as white people (14%)--did not report high risk sexual activity in the past

year. In fact, many did not report having sexual partners in the past year (35%

Indigenous, 22% non-Indigenous racialized, 39% white). Among those who had sexual

partners, non-Indigenous racialized transgender people reported more low-risk sex than

white transgender people.

Among Indigenous people in British Columbia, Chavoshi et al. (2012) found that identifying as a sexual or gender minority was associated with regular condom use for young Indigenous people who use injection drugs. Demographic analyses also showed that the Indigenous women in their sample were more likely to identify as sexual or gender minorities.

Lastly, examining the sexual behaviours of Indigenous and non-Indigenous MSM, Heath et al. (1999) found that Indigenous MSM had consensual sex at a younger age (14 compared to 17 for non-Indigenous MSM). They also found no differences in having condomless anal sex, having sex with an HIV-positive partner, or having more than 50 sexual partners in the past year.

Black MSM

Among Black MSM, Husbands et al. (2013) found that Black MSM in Toronto were two times more likely to engage in insertive anal sex with white men and non-Black racialized men than with Black MSM. In describing their sexual relationships with white men, participants discussed different manifestations of racism in sexual relationships such as objectification, fetishization, and limiting Black men's assertiveness and agency to the private domain of sex. Black MSM in this study mitigated these power dynamics in multiple ways such as through having purely sexual relations with

white men and questioning white men's desires for a Black sexual partner. In contrast, sexual relations with Black men were described as being more meaningful, comforting, and significant. However, power dynamics also emerged in sexual relationships with other Black MSM, particularly in connection to toxic masculinities that emphasized dominance and power over connection and mutually satisfying relations.

In a meta-analysis of studies of Black MSM's sexual behaviours, Millett et al. (2012) found no difference between Black MSM and white MSM in engaging in condomless anal sex. This finding held true across long-term and casual sex partners, serodiscordance between participants and their partners, as well as in terms of substance use while having sex. Black MSM and white MSM also were similar in their using at least one safer sex behaviour during sex (e.g., using condoms, disclosing serostatus).

Asian MSM

Among adult Asian MSM, Maung et al. (2013) found that there was no difference in rates of unprotected anal intercourse (UAI) among Asian and non-Asian MSM. In addition, while the number of anal sex partners in the last 6 months was similar among both groups, Asian MSM reported fewer anal sex partners in their lifetime than non-Asian MSM. Adding further complexity to Asian sexual minority sexuality, Poon and

Ho's qualitative research (2002) suggests that gay Asian boys as well as bisexual Asian

girls may experience less power in sexual negotiations, particularly with older white

men.

Asian sexual minority youth

Further addressing sexual education, knowledge and attitudes among gay,

lesbian, and bisexual Asian youth, Poon and Ho (2002) found that many youth reported

that their sexual education at home was either non-existent, very limited, or was sex

negative, homophobic, and/or HIV/AIDS stigmatizing. Sexual education at school was

not much better as youth reported heterosexual bias as well as an overall lack of depth

in the material (e.g., not covering masturbation). Youth who experienced language

barriers received even less sexual education. Many youth reported getting their sexual

education from friends or television.

The same study also reported findings for Asian lesbian and bisexual girls. They

found that Asian lesbian and bisexual girls who only had sex with women did not

consider themselves at risk for STIs. Some also reported that safer sexual practices like

dental dams were bothersome. Asian bisexual women further discussed the difficulty of

negotiating condom use with Asian men due to sexism.

Racialized MSM born in and outside of Canada

One study examined the sexual behaviours of white and racialized MSM born in and outside of Canada. George et al. (2007) found that racialized MSM born outside of Canada were less likely than other groups (i.e., white MSM born in and outside of Canada and racialized MSM born in Canada) to have had sex with women and, if they did, with fewer women. They were also less likely to exchange sex for tangible items or services. Furthermore, white MSM born outside of Canada were found to have more than three times increased odds of having condomless sex when travelling. Racialized MSM born in or outside of Canada did not have increased odds of having condomless sex when travelling.

1.1.4. Substance Use

Indigenous two spirit people and sexual and gender minorities

With respect to substance use among Indigenous two-spirit people and sexual and gender minorities, studies discussed methamphetamine use, problematic substance use, and smoking. Marshall et al. (2011) found Indigenous ancestry to be associated with a 2.5 times increased odds of methamphetamine use among men and 0.4 times odds among women. One study in Manitoba found that a greater number of Indigenous two-spirit people and sexual and gender minorities than non-Indigenous sexual and

gender minorities reported problematic substance use and use of marijuana and crack

cocaine (Taylor, 2009). Lastly, with respect to smoking among young urban MSM,

Lampinen, Bonner, Rusch, and Hogg (2006) found that, after adjusting for confounders,

self-reported Indigenous ethnicity was associated with a 2.5 times increased odds of

smoking.

Black MSM

Among Black MSM, a meta-analysis conducted by Millett et al. (2012) found that

Black MSM were less likely to use drugs, in general or during sex, compared to white

MSM.

Asian sexual minority youth

Among East and Southeast Asian middle and high school students in BC, Homma,

Chen, Poon, and Saewyc, (2012) found that substance use varied according to age,

length of residence in Canada, sexual identity and gender. When compared to

heterosexual Asian adolescents, younger age and living in Canada for more than 10

years was associated with increased odds of using alcohol, marijuana, and at least one

other drug that was not alcohol or marijuana (e.g., inhalants, injected drugs, non-

prescription medications). After controlling for these factors, sexual identity and gender

still had significant and unique effects on substance use for Asian sexual minority girls compared to boys.

In their study, lesbian and bisexual Asian adolescent girls were more likely to have experience using alcohol, marijuana and other drugs and to report using either alcohol or drugs in the past year. Mostly heterosexual[4] Asian adolescent girls were more likely to have experience using alcohol, used alcohol for 3 or more days in the past month, and used alcohol or drugs in the past year. Additionally, when compared to heterosexual Asian adolescents, they had a 2 times increased odds of having experience using marijuana and have problems related to substance use in the past year. They also had 3 times increased odds of experiencing using other drugs.

In contrast, mostly heterosexual, gay and bisexual Asian boys in their study were more likely to have experience with alcohol, marijuana, and other drugs, but were less likely to drink alcohol for 3 or more days in the past month. Mostly heterosexual Asian boys, however, were more likely to use either alcohol or drugs in the past year.

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[4] It is important to distinguish here that mostly heterosexual is not the same thing as heterosexual. Indeed, this study finds that people who self-identified as mostly heterosexual had different health experiences than people who self-identified as heterosexual (Homma, Chen, Poon, and Saewyc, 2012).

Lastly, one study with adult Asian MSM found that they were less likely to report using alcohol prior to having sex and were also less likely to have ever used injection drugs (Maung et al., 2013).

1.1.5. Mental Health

Indigenous two-spirit people and sexual and gender minorities

In terms of mental health, only studies of Indigenous two-spirit people and sexual and gender minorities were found. Scheim et al. (2013) found that among Indigenous transgender people in Ontario more than three fourths had suicidal thoughts at some point in their lives and almost half had attempted suicide. In Manitoba, Taylor (2009) found that the majority of Indigenous two-spirit and transgender people experienced at least one mental health concern ranging including suicidal thoughts and attempts, depression, cognitive impairment, and anxiety. Qualitative data collected also indicated that these mental health concerns were connected with inadequate health and social services as well as racism, transphobia, poverty and assaults. Among Indigenous MSM in Vancouver, BC, Heath et al. (1999) found that Indigenous MSM were more depressed than and had higher depression scores than non-Indigenous MSM.

1.1.6.   Physical, Emotional, and Sexual Violence

Indigenous two-spirit people and sexual and gender minorities

Multiple studies have indicated that Indigenous two-spirit people and sexual and gender minorities are particularly at risk for many types of violence (Lampinen et al., 2008; Siemieniuk et al., 2013; Scheim et al. 2013; Taylor, 2009; Saewyc et al., 2013; Heath, 1999). Indigenous MSM, particularly young Indigenous MSM, were found to be almost 3 times more likely to experience homophobia-based physical violence or "gay-bashing" when compared to white MSM (Lampinen et al., 2008). In addition, Siemieniuk et al. (2013) found that the prevalence of intimate partner violence (IPV) among Indigenous MSM was more than 2 times that of white MSM. However, they did not find a significant association between ethnicity and experiences of IPV in their multivariate analyses. Focusing on sexual sexual violence (i.e., non-consensual sex), Heath et al. (1999) found that Indigenous MSM (47%) were more likely than non-Indigenous MSM (33%) to experience sexual violence in their lifetimes. They were also more likely to experience sexual violence at a younger age (26% compared to 16%) with the perpetrator more likely being a relative (23% compared to 9%).

Among Indigenous transgender people in Ontario, Scheim et al. (2013) found that almost three fourths of Indigenous transgender people reported transphobia in the forms of verbal, physical and/or sexual violence. In Manitoba, Indigenous transgender people also report experiencing high levels of violence (Taylor, 2009). More than 50% of participants experienced verbal threats and insults as well as physical violence. Furthermore, more than ⅓ have experienced rape or sexual assault. In comparisons

with non-Indigenous transgender people, Indigenous transgender people were more likely to report experiencing more severe forms of violence including assault by a weapon and having things thrown at them. They were also more likely to know a friend who was murdered or assaulted.

Among Indigenous sexual minority youth in BC, Saewyc et al. (2013) found that compared to heterosexual Indigenous youth, Indigenous sexual minority boys and girls were more likely to experience being threatened, physically assaulted with and without sharp objects or a gun, as well as having their property stolen or broken. In all of these categories, Indigenous sexual minority girls had greater odds than boys, in one case even doubling the odds ratio for boys. Another alarming finding was that Indigenous sexual minority girls had 3 times increased odds of being physically assaulted at school.

1.1.7. Body Image and Eating Disorders

Racialized MSM

Two studies discussed body image and eating disorders amongst racialized MSM. Using white MSM as a reference group, Brennan, Crath, Hart, Gadalla and Gillis (2011) found that Black as well as East and South Asian MSM were less likely to report problematic eating behaviours on the Eating Attitudes Test. In another study, Brennan, Craig, and Thompson (2012) found that race was not associated with a motivation to become more muscular among MSM in their sample. However, they noted that measures related to body image and satisfaction may not adequately take into account the experiences of racialized men.

1.1.8.   Sex Work

Indigenous two-spirit people and sexual and gender minorities

Sex work has been associated with risk for STIs/HIV as well as violence

(Siemieniuk et al., 2002). As a result, sex work has been included in this review. In

comparing Indigenous and non-Indigenous MSM, Health et al. (1999) note that

Indigenous MSM were more likely to have engaged in sex work in the previous year and

in their lifetime. They were also more likely to be paid more in order to engage in

condomless sex. In more demographic analyses, Weber et al. (2001) found in their

study that MSM who were sex workers were 3.7 times more likely to be Indigenous.

Mehrabadi et al. (2009) further found that in their sample of Indigenous women who

were sex workers, participants were more likely to identify as two-spirit people or

sexual or gender minorities. However, this association was not significant in multivariate

analyses.

Black MSM

In a meta-analysis of studies of Black MSM in Canada, Millett et al. (2012) found

that Black MSM were more likely to report sex work.

1.1.9.   Income, Education and Employment

Indigenous two-spirit people and sexual and gender minorities

In terms of income, education, and employment, most studies noted either

lower or similar socio-economic status with comparison groups. Heath et al.'s (1999)

found that Indigenous MSM experienced greater unemployment and lower incomes

than non-Indigenous MSM. Among Indigenous transgender people in Ontario, Scheim

et al. (2013) found that 75% had some post-secondary education but almost half

reported living in poverty. Similarly, Taylor's (2009) study of Indigenous two-spirit and

transgender people in Manitoba found that almost half of participants reported incomes

below $10,000 and more than ¾ reported incomes less than $25,000. Furthermore,

more Indigenous than non-Indigenous gender-diverse people reported disruptions in

their education as a result of their gender identity (59% compared to 12.5%

respectively). One study by Bauer et al. (2012) did not find income differences between

transgender people based on race. However, the authors note that this may be due to

the fact that almost half of transgender people earned less than $15,000 annually and a

third lived in poverty.

Black MSM

Among Black MSM in Canada, a meta-analysis by Millett et al. (2012) found that

Black MSM had a 1.5 times increased odds of having low incomes compared to other

MSM in Canada. More recently, Husbands et al.'s (2013) study of Black MSM in Toronto

found that almost half earned less than $30,000 and only half had full-time jobs. The

same study found that 40% of Black MSM had post-secondary degrees.

Asian MSM

Among Asian MSM, Maung et al. (2013) note that while adult Asian MSM in their

sample were more likely to have post-secondary education than non-Asian MSM, their

incomes were not significantly different from non-Asian MSM.

Racialized MSM born in and outside of Canada

Looking at MSM born in and outside of Canada, George et al. (2007) did not find

statistically significant differences between white and racialized MSM in income or

education. However, a greater percentage of white MSM born in (24.5%) and outside

(37.9%) of Canada had university degrees than racialized MSM (15.8% for those born in

Canada, 23.2% for those born outside of Canada). In income, a greater percentage of

racialized MSM born outside of Canada reported making less than $20,000 a year

(73.1%). There was a statistically significant difference in terms of employment with

racialized MSM born outside of Canada being more likely to be unemployed.

1.1.10.   Migration

Indigenous two-spirit people and sexual and gender minorities

Two major studies of elaborate on the complexities of migration on the health of

Indigenous two-spirit people and sexual and gender minorities in British Columbia and

Manitoba (Ristock, Zoccole, and Passante, 2010; Ristock, Zoccole, and Potskin, 2011).

Both studies noted that moving had positive and negative impacts on health. Negative

impacts included experiences of racism, homophobia, transphobia in housing,

healthcare and employment, physical and sexual violence, and loss of social support

networks. Positive impacts included developing new social support networks, access to relevant social, cultural and health care services, self-discovery and self-expression of sexuality. Even among participants who reported negative impacts, participants demonstrated and spoke of their resilience despite facing many obstacles. The authors further discuss that migration is in many ways forced through legacies of colonialism that include the adoptive and foster care system and residential school system, many of which participants experienced either directly themselves or indirectly through family and community members (also discussed in Taylor, 2009). In particular, the loss of Indigenous traditions and knowledges related to two-spirit people and sexually and gender minorities has caused a great degree of disconnection for participants. Related to migration, Scheim et al. (2013) found that ⅓ of Indigenous gender-diverse people reported homelessness or unstable housing and the majority had needed to move as a result of transphobia. Heath et al. (1999) also found that Indigenous MSM were more likely to experience unstable housing compared to non-Indigenous MSM.

1.2. Intermediate Determinants of Health

Intermediate determinants of health refer to institutional and community factors that influence proximal determinants of health (Reading and Wien, 2009). Two intermediate determinants of health were identified as affecting racialized sexual and gender minority health: health and social services and community and social support and community.

1.2.1.   Health and Social Services

Indigenous two-spirit people and sexual and gender minorities

In terms of health and social services, Scheim et al. (2013) note that the majority (77%) of Indigenous transgender people in Ontario had a regular family doctor. Many reported that their needs in the areas of general health services, emergency services, and HIV/STI testing services were met. However, a majority (61%) also reported having unmet healthcare needs in the areas of shelters, hormone therapy, gender affirming surgery, gender affirming mental health, sexual health, and addictions.

In Manitoba, Taylor (2009) found that Indigenous two-spirit and transgender people noted cost as a barrier to using services such as mental health and changing official government documents to reflect their gender. Access to services was also a concern. Health care providers were rated highly as many had direct experience with sexual and gender minorities, Indigenous people, and HIV-positive people. Participants noted that they felt safer in healthcare settings than in social service settings.

In terms of service usage, Bauer et al. (2012) found that non-Indigenous racialized transgender people were less likely than Indigenous and white transgender people to be medically transitioning.

Black MSM

In a review of HIV interventions that included Black MSM in Canada and the United States, Nelson, Walker, DuBois, and Giwa (2014) examined studies for 4 main components identified through an integrative antiracism approach: antiracism, cultural assets, religious oppression, and religious assets. Among the 17 studies reviewed, 2

covered antiracism, 5 covered cultural assets (2 of which were specific to Black MSM), 3

addressed religious oppression (2 of which were specific to Black MSM), and 3

addressed religious assets. In terms of representation, 3 of the 17 studies specifically

targeted Black MSM and 1 targeted Black men who have sex with men and women

(MSMW). Very few studies covered all of the components. In addition, 2 studies that

were not lead by Black MSM did not include any of the components. Such findings

suggest that much of the HIV interventions in which Black MSM participant may not

adequately account for their experiences as Black racialized MSM.

Asian sexual minorities

Among gay, lesbian, and bisexual Asian youth in Toronto, many reported

difficulties engaging with mainstream LGB youth organizations (Poon and Ho, 2002). In

particular, they discussed how these organizations did not account for the unique

experiences of Asian sexual minority youth in discussions, counselling services, or in

sexual health campaigns. Furthermore, some organizations were described as being

"very white", which hindered discussions of Asian sexual minority youths' experiences of

racism. However, youth also noted that when services were available for Asian sexual

minority people, they often did not have services specifically for youth. Examining the

experiences of adult Asian MSM, Maung et al. (2013) found that adult Asian MSM were

less likely to discuss their male sexual partners with a health care professional.

Racialized sexual minorities

Lastly, examining the history of three ethno-specific AIDS service organizations

(e-ASOs) in Toronto, Catungal (2013) discusses how the formation of e-ASOs emerged

from the inadequacy of AIDS service organizations and organizing to account for

race/ethnicity in their political work as well as health and social service work. These

inadequacies were detrimental to racialized sexual minorities and motivated the

development of the e-ASOs. Catgunal further discusses three ways in which e-ASOs

create safer spaces for racialized sexual minorities both within and outside of the

organizations.

The first practice is through the use of imagery (i.e., in posters and campaigns)

that centres racialized people in ways that resist oppressive discourses of erasure and

intersectional racism. These images communicate that racialized sexual minorities also

require sexual health promotion and service provision and where to access services that

better address race/ethnicity in their work. Furthermore, these images resist dominant

discourses that prioritize and centre white gay men's health concerns and needs.

The second practice is attention to language and culture in service provision and

messaging. E-ASOs make active efforts to incorporate multilingual service provision in

their work that accounts for culturally and contextually specific understandings of sexual

health. In doing so, they can reduce barriers to service caused by English language

barriers and points of cultural disconnection for racialized sexual minorities.

The third practice is holding social events, particularly those which involve the

communal making and sharing food. This practice celebrates cultural values and

practices that resonate with participants in powerful and meaningful ways.

1.2.2.   Community and Social Support

In terms of community and social support, it is important to recognize that for

racialized sexual and gender minorities there can be a multiple sources of social support

and community from sexual and gender minority communities, racial and ethnic

communities, as well as racialized sexual and gender minority communities to name a

few. In terms of social support and community, across all studies issues of white

supremacy and racism were mentioned as well as complex and nuanced relations with

participants' ethnic and cultural communities.

Indigenous two-spirit people and sexual and gender minorities

Among Indigenous two-spirit people and sexual and gender minorities, Ristock et

al. (2011) found that Indigenous two-spirit people and sexual and gender minority youth

associated the Vancouver, BC gay communities with racism. In Manitoba, Taylor (2009)

found that among Indigenous two-spirit and transgender people, the majority of

participants did not feel fully accepted by LGBT communities, but they did report feeling

more accepted in transgender and two-spirit communities. In terms of their ethnic

communities, results were mixed but most felt supported by their ethnic community.

Black MSM

Among Black MSM in Ontario, Husbands et al. (2013) found that Black MSM

experience exclusion, segregation, and disconnects in white gay communities. Black

MSM born outside of Canada, in particular, discussed approaching white gay spaces

with caution. In response, Black MSM develop networks of social and political support

with other Black MSM and other racialized MSM. Many Black MSM were concerned

about health issues affecting Black MSM and many desired greater community

mobilization.

George et al.'s (2012) study of Black MSM in Toronto noted the complexity of

communities for Black MSM. While many were involved in gay communities in

capacities ranging from social, professional, and political, many participants discussed

the whiteness and racism of gay communities and how they approached them with

caution. Black MSM were also involved in Black MSM communities, racialized MSM

communities or chose not be involved in either gay or racialized MSM communities.

Some Black MSM were also involved in Black heterosexual communities which provided

much needed support but also could be places in which discrimination occurred on the

basis of sexuality.

Asian MSM

Among Asian MSM, online communities appear to be particularly important.

Maung et al. (2013) found that compared to non-Asian MSM, Asian MSM were less

likely report going to gay bars or nightclubs, but were just as likely to use the internet to

find sexual partners. Elaborating on the use of the internet among East and Southeast

Asian Men, Poon et al. (2005) found numerous complexities to the Asian men's use of

gay online chatrooms. Men in the study discussed how chatrooms were sometimes the

only viable alternative to physical spaces for gay men (e.g., bars, clubs), which were

described as unsafe, uncomfortable, and exclusionary. Chatrooms became a space for

Asian men to connect with other MSM for multiple reasons: to connect with other Asian

MSM, to find social and emotional support, to reduce social isolation from their ethnic

community and/or the broader gay community, and for the safety and anonymity that it

provided.

Chatroom experiences were mixed among participants. Internalized

racism/white supremacy manifested in Asian men's preferences to chat, date, and have

sex with white men to the exclusion of racialized men as well as the tensions that some

Asian men felt due to perceived competition for the affections of white men. Asian men

were also concerned that dating other Asian men could result in their sexuality being

discussed in already small Asian communities. However, Asian men did also find

chatrooms to be a space in which they could build networks of social and emotional

support such as through reminding each other to practice safer sex. Chatrooms were

primarily used to reduce the social isolation that many men felt. In fact, some men

reported initiating sexual encounters in order to reduce feelings of loneliness while

others felt pressured into having sex with men they met through the chatrooms.

Further elaborating on the social isolation Asian MSM feel, Nakamura, Chan and

Fischer (2013) explored Asian MSM's experiences in their ethnic community and the gay

community. They found that the majority of 1st and 2nd generation Asian MSM

perceived high levels of homophobia within their ethnic community. Homophobia was

described as emerging from sexual taboos, being tied with HIV/AIDS stigma and

Western cultural assimilation, and being reinforced at times by religion-based sexism

and homophobia. One difference the authors noted was that 1st generation Asian MSM

were more likely to report being disconnected from their ethnic community than 2nd

generation Asian MSM. Among those involved with their ethnic community, some did

not discuss their sexuality. The authors also noted that a small subset of 1st and 2nd

generation Asian MSM reported feeling accepted by their ethnic community.

In terms of experiences in the gay community, the majority of Asian MSM reported

subtle forms of racism and discrimination with the remaining Asian MSM reporting

either acceptance or overt racism. While the majority of Asian MSM reported being

involved in the gay community through work, volunteer, recreational activities, many

reported difficulties in creating meaningful connections within the community. In

particular, many reported exclusion in the forms of segregation, avoidance, and

interpersonal racism/discrimination (i.e., "No Asians"), even among other racialized

men. More than 80% of the sample reported sexual objectification, particularly by older

White men. These experiences were often framed as individual incidents rather than

emerging from systemic, institutionalized, and internalized racism. The authors further

note that there was a lack of generational differences between 1st and 2nd generation

Asian MSM when discussing their experiences in the gay community. The authors

suggest that this lack of difference may be indicative of a gay community that is more

likely to objectify Asian MSM--which is itself a manifestation of racism--than to

acknowledge their nuanced experiences as 1st and 2nd generation immigrants.

Asian sexual minority youth

Among Asian sexual minority youth, young Asian men described homophobia from their families as connected to traditional heterocentric and male-centric family structures and values (Poon and Ho, 2002). Among young Asian sexual minority women homophobia is made difficult by the cultural invisibility of lesbian sexuality compounded by patriarchal control over women. Both Asian sexual minority men and women discussed how their coming out could result in the denial of their sexuality, requests for them to hide their sexuality, punishment, and loss of financial support. Additionally, their coming out could impact their family's honour and how their family is treated in their community.

Asian sexual minority youth also discussed unique social experiences at the intersection of race, age, and sexuality. While youth discussed the difficulty of discussing their sexuality with their predominantly heterosexual Asian peers, they also discussed cultural barriers to having these discussions with non-Asian friends. Young Asian men also discussed how stereotypes constructed Asian men as inferior through interlocking associations with femininity, submissiveness, and immaturity. They further discussed how that these stereotypes undermine sexual negotiation by affecting Asian men's sense of self-worth.

An additional factor affecting self-worth was North American standards of beauty, which Asian youth discussed as overwhelming centring and favouring white people. White people were considered aesthetically superior. Participants discussed how even attempts to engage with some of these standards are read very differently when on an Asian body. For example, one Asian woman noted she was called a "Chinese Monk" when she shaved her head (Poon and Ho, 2002, pg. 63).

1.3. Distal Determinants of Health

Distal determinants of health refer to the "political, economic, and social contexts that construct both intermediate and proximal determinants" (Reading and Wien, 2009, pg. 20). Two distal determinants of health were identified as affecting racialized sexual and gender minority health: discrimination and colonialism.

1.3.1. Discrimination

Racialized sexual and gender minorities

While the majority of studies did touch upon discrimination, two studies in particular explicitly examined discrimination based on sexuality, race and appearance in their analyses. Saewyc et al.'s (2013) study of enacted stigma--teasing and verbal harassment, physical fights and assault, and discrimination based on race, sexuality, or appearance--experienced by Indigenous youth found that Indigenous sexual minority

boys and girls experienced more enacted stigma than their heterosexual peers. In terms

of specific forms of enacted stigma, Indigenous sexual minority boys were almost 19

times more likely to experience discrimination based on their sexuality, more than 5

times more likely to experience discrimination based on their physical appearance, and

almost 3 times more likely to be purposefully excluded at school. Indigenous sexual

minority girls were more than 16 times more likely to experience discrimination based

on their sexuality and more than 2 times more likely to experience discrimination based

on their physical appearance. It is also important to note that discrimination could be

from Indigenous and non-Indigenous students.

In Marcellin, Bauer, and Scheim's (2013) study of transgender people in Ontario,

they found that the 90% of people of colour and 65% of Indigenous people reported

experiencing racism. Furthermore, 92% of people of colour and 90% of Indigenous

people reported experiencing transphobia. Among non-Indigenous racialized

transgender people in Ontario, transphobia and the interaction between transphobia

and racism contributed to increased odds of high risk sex (Marcellin, Bauer, and Scheim,

2013).

1.3.2. Colonialism

According to Reading and Wien's (2009, pg. 21) definition of colonialism as a

determinant of health, colonialism can be defined as a distal determinant of health that

shapes and influences intermediate and proximal determinants, produces inequities,

and manifests in "diverse domains such as environmental relationships, social policies

and political power".   Colonialism has had immense cumulative and intergenerational

impacts on Indigenous peoples including Indigenous two-spirit people and sexual and

gender minorities (Reading and Wien, 2009).

Prior to the colonization of Turtle Island (North America) by Europeans settlers,

two-spirit people held respected and important roles in many Indigenous cultures

including roles as "leaders, mediators, teachers, artists, seers, and spiritual guides in

their communities" (Brotman, Ryan, Jalbert, and Rowe, 2002, pg. 85). In addition,

complex and unique systems of gender existed that acknowledged a multitude of

genders beyond the Eurocentric binary of male and female (Deschamps, 1998).

Understandings of sexuality were also tailored to such systems of gender (please see

Meyer-Cook and Labelle, 2003).

However, colonization brought about drastic and violent changes to such

understandings of sexuality and gender, which undermined two-spirit traditions,

identities and roles (Meyer-Cook and Labelle, 2003). Through the work of the church

and state, European settlers created and enforced colonial social policies such as the

Indian Act that legitimized institutions and systems that were used to displace,

disempower, and assimilate both two-spirit people and Indigenous people more broadly

into white settler culture and society (Meyer-Cook and Labelle, 2003). While a review of

all social policies and institutions affecting Indigenous people is beyond the scope of this

paper, a few examples will be provided to illustrate how the policing of Indigenous

sexualities and genders was harmful to Indigenous two-spirit people and sexual and

gender minorities. Furthermore, it is important to recognize that policing of sexuality

and gender to conform to Eurocentric norms inevitably affects everyone including other

racialized sexual and gender minorities.

Sexist colonial policies such as in the Gradual Enfranchisement Act of 1869 and

problematic matrimonial property laws currently in existence, create barriers for

Indigenous women in participating in political decision-making as well as create social

and economic dependency of Indigenous women to men, further legitimizing

heteropatriarchal relations (Sterritt, 2007; Native Women's Association of Canada,

2010). Such policies increase the vulnerability of Indigenous women to violence, as

women stay in abusive relationships due to economic dependency, and poverty, as

women may not be entitled to a fair division of property upon separation or divorce

(please see Sterritt, 2007; Native Women's Association of Canada, 2010).

In 1920, amendments to the Indian Act removed Indigenous children from their

homes and forced them to attend residential schools (Barman and Gleason, 2003). The

function of these schools was to erase and replace Indigenous languages, cultures and

knowledge systems with Euro-Christian ones (Barman and Gleason, 2003). The ultimate

goal of residential schools was to assimilate Indigenous peoples into a white settler

society (Razack, 2002; Barman and Gleason, 2003). The education that was provided at

these schools taught and reinforced racist notions of Indigenous inferiority, sexist

notions of male superiority, and heterosexist notions that devalued sexual and gender

diversity (Meyer-Cook and Labelle, 2003). Strict conformity to Christian heterosexuality

and gender roles was required and rewarded (Meyer-Cook and Labelle, 2003). Such

education, simultaneous undermined the traditions, roles and identities of two-spirit

people, Indigenous women, and Indigenous people as a whole (Meyer-Cook and Labelle,

2003).

Additionally, it is also important to recognize that two-spirit people were specific

targets of violence during early periods of European colonization (Meyer-Cook and

Labelle, 2003). Meyer-Cook and Labelle (2003, pg. 35) note two such examples: "the

Spaniards' brutal use of dogs to tear apart the limbs of Indigenous men accused of

sodomy, and the massacre of the Red hands Society of male basket weavers."

The dominance of white supremacy and cisheteropatriarchy, a product and logic

of colonialism, create many barriers to two-spirit people's ability to access community

and health care resources (Ristock, Zoccole, and Potskin, 2011). Two-spirit people may

experience homophobia within their community and a lack of resources to support their

social and health needs (Ristock, Zoccole, and Potskin, 2011). Furthermore, Ristock,

Zoccole, and Potskin (2011) found that even when two-spirit people moved away from

their home communities to access necessary medical services in urban areas, they often

face racism when accessing these services. Additionally, while LGBT health services are

often available in urban areas, health services specifically for two-spirit people are still

rare across Indigenous and non-Indigenous settings (Brotman, Ryan, Jalbert, and Rowe,

2002). Two-spirit people, who live at the intersections of race, sexuality, and gender,

thus experience many compounding barriers to accessing community and health care

resources (Ristock, Zoccole, and Potskin, 2011).

Cumulatively and intergenerationally, the effects of these past and ongoing

histories of colonialism are still felt today as Indigenous two-spirit people and sexual and

gender minorities across Canada report direct and indirect experiences of residential

schools, foster and adoptive care systems, and discrimination in access to health care

(Ristock, Zoccole, and Passante, 2010; Ristock, Zoccole, and Potskin, 2011; Taylor, 2009).

Discussion

As this literature review highlights, the particularities and intersections of racialization, gender, sexuality and more have complex and unique impacts on the health of racialized sexual and gender minorities in Canada. In other words, racialization matters, gender matters, sexuality matters, and many other social constructed differences matter. They matter intersectionally[5] and in ways that are unique from white sexual and gender minorities as well as racialized heterosexual people. Below is a discussion of the findings for the racialized sexual and gender minority groups covered in this literature review.

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[5] By intersectional I am referring specifically to the field of critical race theory and intersectionality theory which posits that socially constructed and systemic forms of marginalization such as racism and sexism interact to produce multiple and unique marginalizations that are further uniquely experienced among people who hold multiple marginalized identities (e.g., being a person of colour and a sexual minority) and in ways that cannot be understood by examining those identities separately (Ford and Airhihenbuwa, 2010; Crenshaw, 1991; Delgado and Stefancic, 2000). Such socially constructed and systemic forms of marginalization create hierarchies and social and structural relations of privilege, power and dominance (Ford and Airhihenbuwa, 2010; Crenshaw, 1991; Delgado and Stefancic, 2000).

1.4. Indigenous two-spirit people and sexual and gender minority
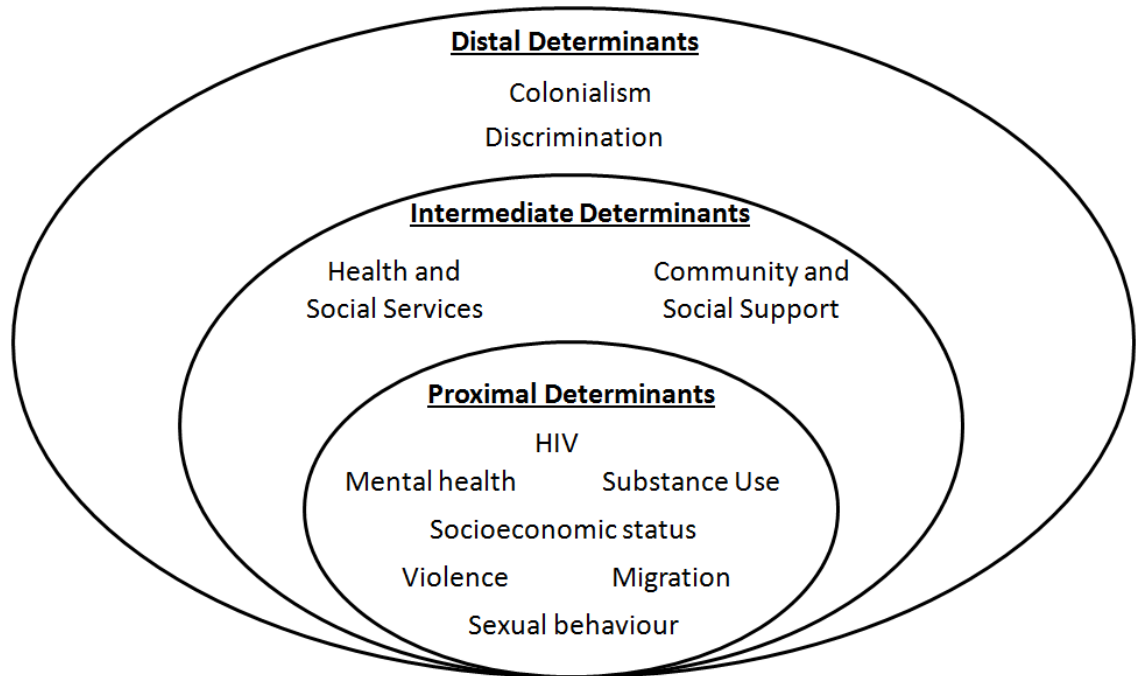
Figure 1: A visual representation of the social determinants of health identified in the research for Indigenous two-spirit people and sexual and gender minorities

Among research on Indigenous two-spirit and sexual and gender minority health

(see Figure 1), most research focused on Indigenous two-spirit and transgender people

and MSM with fewer studies discussing Indigenous sexual minority youth and sexual

and gender minorities more broadly. Among Indigenous two-spirit and transgender

people, research discussed HIV, racism and transphobia, violence, mental health,

substance use and access to health and social services. HIV prevalence was found to be

higher in Indigenous two-spirit and transgender people than among non-Indigenous

transgender people, especially for transgender women (Bauer et al., 2012; Monette et al., 2011; Taylor, 2009; Ristock, Zoccole, and Passante, 2010; Ristock, Zoccole, and Potskin, 2011).   Experiences of racism and transphobia, which contribute to HIV risk, were reported by the majority of Indigenous two-spirit and transgender people with transphobia being associated with engaging in low risk sex compared to no sex as well as disruptions in education (Scheim et al., 2013; Ristock et al., 2011; Marcellin, Bauer, and Scheim, 2013; Taylor, 2009; Saewyc et al., 2013).

In terms of violence, the majority of Indigenous two-spirit and transgender people reported experiencing verbal, physical and/or sexual violence (Scheim et al., 2013; Taylor, 2009). Such experiences may explain why multiple studies have indicated that Indigenous two-spirit and transgender people experience mental health concerns ranging from attempted suicide, depression, and anxiety as well as problematic substance use (Scheim et al., 2013; Taylor, 2009; Heath et al., 1999). These experiences are further compounded by unmet health care and social service needs in areas such as access to shelters, mental health services, and gender affirming care (Taylor, 2009). Financial concerns were reported as barriers to accessing services with the majority of Indigenous two-spirit and transgender people reporting incomes less than $25,000, even those with post-secondary education (Scheim et al., 2013; Taylor, 2009).

Among Indigenous MSM, research discussed sexual behaviours, violence, substance use, and income, education and employment. When compared to non-Indigenous MSM, Indigenous MSM were found to have consensual sex at a younger age and were no different in likelihood of having condomless anal sex, sex with an HIV-positive partner, or having more than 50 partners in the past year (Heath et al., 1999). Indigenous MSM were also found to be more likely to engage in sex work and to be paid to more for condomless sex (Heath et al., 1999; Weber et al., 2001; Mehrabadi et al., 2009).

In terms of violence, young Indigenous MSM were found to be particularly vulnerable to homophobic violence, sexual violence, and may also be at greater risk for intimate partner violence (Lampinen et al., 2008; Heath et al., 1999; Siemienuik et al., 2013). In terms of substance use, Indigenous ancestry has been associated with methamphetamine use among sexual and gender minority men as well as an increased odds of smoking among young urban MSM (Marshall et al., 2011; Bonner, Rusch, and Hogg, 2006). Lastly, in terms of income, employment and education, Indigenous MSM experience greater unemployment and lower incomes than non-Indigenous MSM (Heath et al., 1999).

One study focused on Indigenous sexual minority youth and found that, among adolescents in BC, experiences of racism, homophobia, and other forms of systemic discrimination is associated with increased HIV risk behaviours among Indigenous sexual minority youth, particularly Indigenous sexual minority girls (Saewyc et al., 2013). Experiences of discrimination were particularly alarming for Indigenous sexual minorities. When compared to heterosexual students, discrimination based on sexuality was 19 times greater for Indigenous boys and 16 times greater for Indigenous girls (Saewyc et al., 2013). Indigenous sexual minority girls were also more likely to experience physical assault at school (Saewyc et al., 2013).

Lastly, a small subset of studies discussed the impacts of migration on the health of Indigenous sexual and gender minorities more broadly. Migration was found to have both positive (i.e., finding community resources and living more openly) and negative outcomes (i.e., racism, unstable housing) for Indigenous sexual and gender minorities' physical and mental health (Ristock, Zoccole, and Passante, 2010; Ristock, Zoccole, and Potskin, 2011). Migration was found to be related to legacies of colonial institutions and policies such as those that reinforced transphobia and contribute to unstable housing (Scheim et al., 2013; Ristock, Zoccole, and Passante, 2010; Ristock, Zoccole, and Potskin, 2011; Taylor, 2009; Heath et al., 1999).

1.5. Black Sexual Minority Men
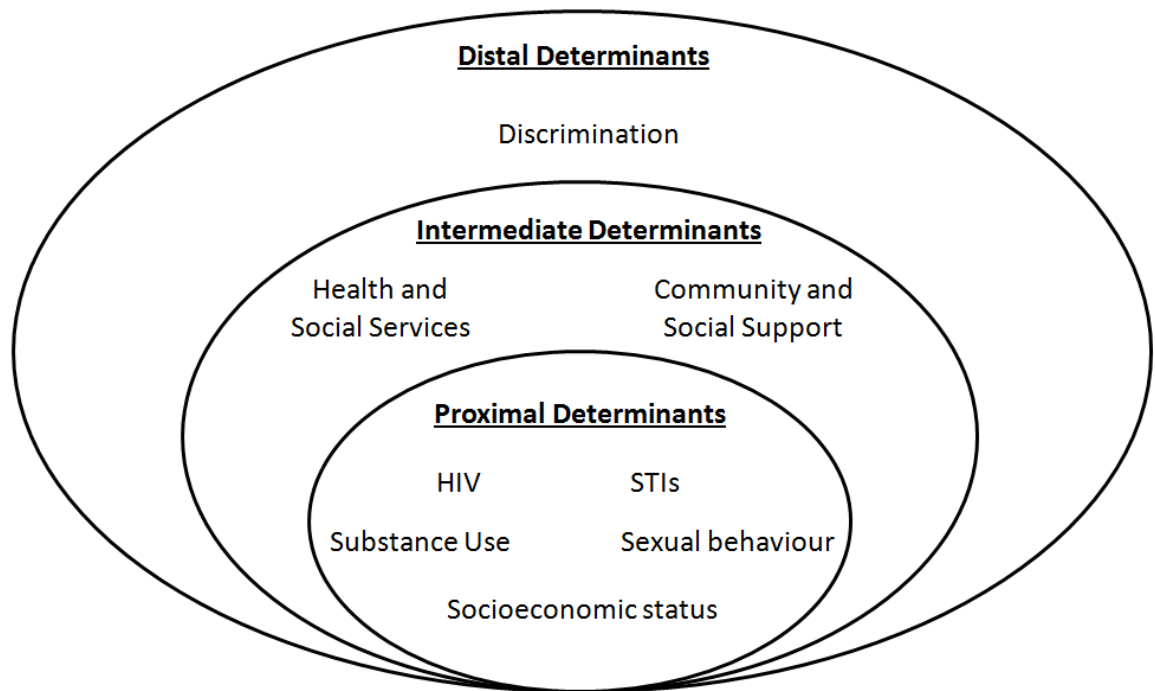
Figure 2: A visual representation of the social determinants of health identified in the research for Black sexual minority men

In examining the literature on Black sexual and gender minorities in Canada

(Figure 3), only research on Black MSM was found. The research on Black MSM

discussed HIV/STI risk, sexuality, income, education and employment, and community

and social support. While a meta-analysis examining HIV and STI risk among Black MSM

in Canada did not find a difference between Black and white MSM in terms of HIV

testing, testing positive for HIV, STI infections, or having condomless anal sex, research

in Ontario indicates that, among MSM, the proportion of Black MSM diagnosed with HIV

is increasing (Millett et al., 2012; Laboratory Enhancement Program, 2013). One

potential factor to consider in preventing such increases is to tailor HIV interventions to

Black MSM's experiences, assets, and oppressions, which is currently not happening

according to Nelson et al.'s (2014) review HIV interventions. Another factor to consider

is Millet et al.'s (2012) finding that Black MSM were more likely to report engaging in sex

work.

These findings are further nuanced by research on Black MSM sexuality, which

involves navigating multiple and complex power dynamics in their sexual relations

related to objectification, fetishization, racism and patriarchy (Husbands et al., 2013).

For example, Black MSM were found to be more likely to engage in insertive anal

intercourse with white and non-Black racialized men than when with Black MSM.

Adding the complexity of immigrant status, Black immigrant MSM reported taking a

cautious approach to exploring their sexuality in white gay spaces. Lastly, while not

without its own power dynamics, Black MSM reported that sex with other Black men

often comes with greater feelings of connection and significance.

Another dimension of Black MSMs experience is in the proximal determinant of

health that is income, education and employment. Research indicates that Black MSM

are more likely to have low incomes compared to other MSM in Canada (Millett et al.,

2012). One study reported that almost half of Black MSM in their sample earned less

than $30,000 and only half had full time jobs (Husbands et al., 2013). The same study

found that 40% of Black MSM had post-secondary degrees.

In terms of community and social support, white supremacy, racism and

immigrant status impacted Black MSM's engagement in various communities. Black

MSM reported approaching white gay communities with caution as they were spaces in

which exclusion, segregation and disconnection happen (Husbands et al., 2013). Black

MSM also were varied in their involvement in many communities: racialized Black MSM,

racialized (not exclusively Black) MSM, (white) gay, and heterosexual Black communities

(George et al., 2012).

1.6. Asian sexual minorities

Distal Determinants

Discrimination

Intermediate Determinants

Health and
Social Services

Community and
Social Support

Proximal Determinants

HIV   STIs

Substance Use   Sexual behaviour

Socioeconomic status
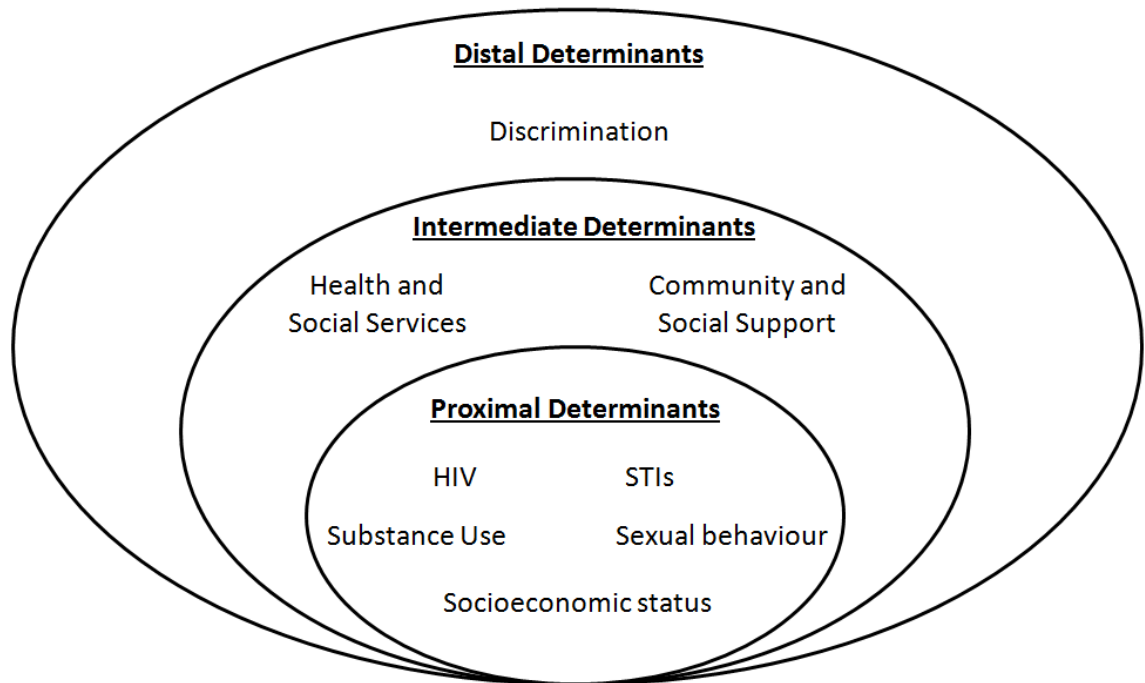
Figure 3: A visual representation of the social determinants of health identified in the research for Asian sexual minorities

Among research on Asian sexual and gender minority health (Figure 3), most

research focused on Asian MSM and sexual minority youth. Research on Asian MSM

discussed HIV/STIs, sexuality, community and social support and income and education.

In terms of HIV and STIs, Asian MSM in Vancouver, BC were found to have a lower

prevalence of HIV in dry blood samples, but were also less likely to test for HIV, HCV and

gonorrhea when compared to non-Asian MSM (Maung et al., 2013). However, another

study found that, among MSM diagnosed with HIV in Ontario, the proportion of Asian

MSM diagnosed with HIV is increasing (Laboratory Enhancement Program, 2013).

Research on Asian MSM's sexuality offers insights into understanding HIV

prevalence rates. Asian MSM were not found to differ in terms of rates of condomless

anal sex or number of recent anal sex partners. However, while many Asian MSM

employed a variety of HIV preventions strategies, research did find that some Asian

MSM held false assumptions about HIV and may have limited power, knowledge or skill

in negotiating some aspects of safer sex (Maung et al., 2013; Poon et al., 2005). Indeed,

research in Asian MSMs online chatroom use found that some Asian MSM felt pressured

into having sex (Poon et al., 2005; Poon and Ho, 2002). To make matters worse, Asian

MSM were found to be less likely to discuss male sexual partners with a health care

professional (Maung et al., 2013).

Community and social support also offer insight into HIV prevalence as well as

the broader experiences that shape Asian MSMs lives. Asian MSM experience racism in

(white) gay communities, but often frame these experiences as individual incidents

rather than emerging from systemic, institutionalized, and internalized racism (Poon et

al., 2005). This partially explains why Asian MSM were found to be less likely to go to

gay bars or night clubs, but just as likely to use online spaces to connect with other MSM

(Maung et al., 2013; Poon et al., 2005). Online chatrooms were used by Asian MSM

primarily to reduce feelings of social isolation and find social and emotional support and

community (Poon et al., 2005).

Social isolation emerged as a particularly important theme for Asian MSM.

These feelings of social isolation may be due to the combined effects of homophobia in

Asian MSM's ethnic communities and racism within (white) gay communities

(Nakamura, Chan and Fischer, 2013). In particular, the research indicated that 1st and

2nd generation Asian MSM may feel this social isolation differently. For example, 1st

generation Asian MSM were more likely to report being disconnected from their ethnic

community than 2nd generation Asian MSM. Some Asian MSM reported having sex was

a way to reduce feelings of social isolation (Poon et al., 2005).

Lastly, in terms of income and education, one study found that while Asian MSM

were more likely to have post-secondary education, their incomes were not different

from non-Asian MSM (Maung et al., 2013).

In contrast, research with Asian sexual minority youth discussed sexuality,

substance use, as well as community and social support. In terms of sexuality, studies

indicate that Asian sexual minority girls' may experience less power in sexual

negotiations, particularly with older White men but also Asian men due to sexism and

racism (Poon and Ho, 2002). In addition, some Asian lesbian and bisexual girls did not

consider themselves at risk for STIs if exclusively having sex with women and reported

that some safer sex practices were bothersome (Poon and Ho, 2002). This is further

exacerbated by limited, non-existent, or sex-negative sexual health education that Asian

sexual minority youth receive.

Furthermore, gender in addition to factors such as young age, living in Canada

for more than 10 years, and identifying as a sexual minority was associated with

increased substance use--i.e., alcohol, marijuana, and other drugs--among East and

Southeast Asian youth in BC compared to heterosexual students (Homma et al., 2012).

However, while both Asian sexual minority boys and girls reported greater experience

with alcohol, marijuana and other drugs, Asian sexual minority girls tended to have

higher odds ratio on almost all self-reported measures of substance use. In particular,

East and Southeast Asian sexual minority girls identifying as mostly heterosexual had the

greatest increased odds of reporting problematic substance use.

Adding further complexity to Asian sexual minority youth's experiences is the

complex terrain of community and social support both in terms of LGB organizations as

well as family. Asian sexual minority youth report difficulties engaging with mainstream

LGB organizations particularly around discussing and addressing racism in

predominantly white LGB spaces (Poon and Ho, 2002). They also discussed the

dominant white aesthetic within North American standards of beauty that constructed

Asian sexual minority youth as less desirable or different, even when these standards of

beauty are followed (Poon and Ho, 2002). In terms of family, Asian sexual minority

youth report homophobia in families and connected it with heteronormativity and

patriarchy (Poon and Ho, 2002). This homophobia manifests differently along lines of

gender. In particular, there is a cultural invisibility around Asian lesbian sexuality as well

as patriarchal relations of control over girls and women. Youth reported many potential

negative outcomes of coming out including denial, punishment, loss of financial support

and community ostracism.

1.7. Non-Indigenous racialized sexual and gender minorities
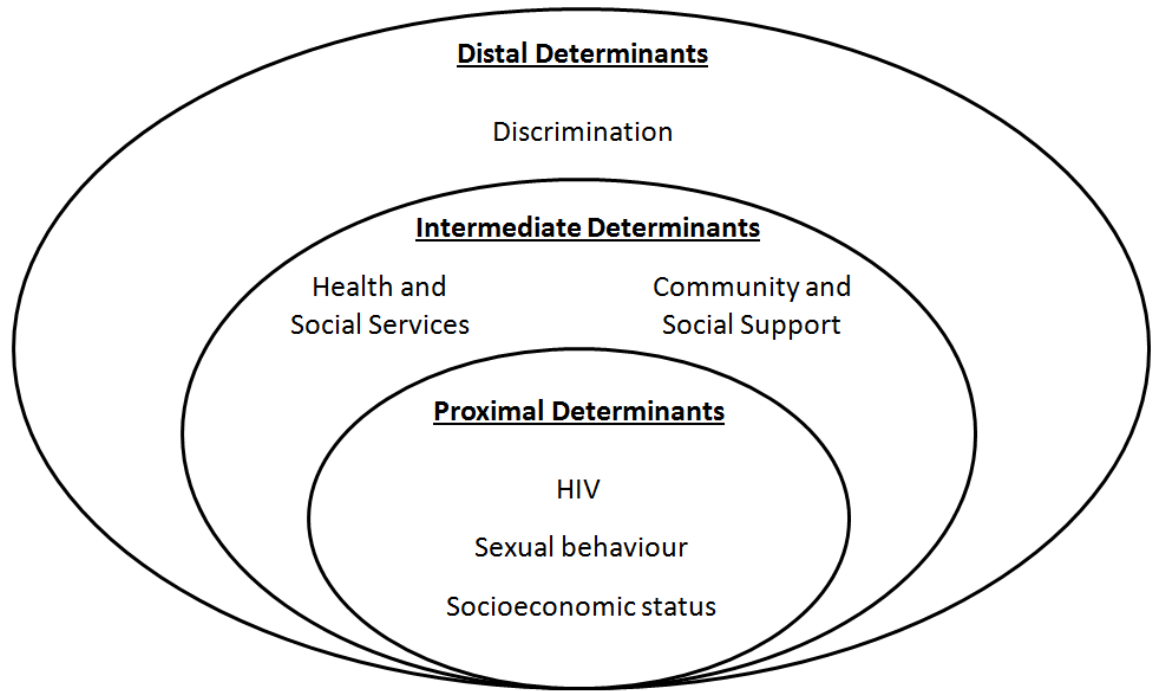
Figure 4: A visual representation of the social determinants of health identified in the research for non-Indigenous racialized sexual and gender minorities

Among research on non-Indigenous racialized sexual and gender minorities

(Figure 4), the research focused on non-Indigenous racialized transgender people and

racialized MSM. The research with non-Indigenous racialized transgender found that

the majority of non-Indigenous racialized transgender people reported experiencing

racism and transphobia (Scheim et al., 2013). Furthermore, among non-Indigenous

racialized transgender people in Ontario, transphobia and the interaction between

transphobia and racism contributed to increased odds of high risk sex (Marcellin, Bauer,

and Scheim, 2013).

Of the studies with non-Indigenous racialized MSM the research discussed HIV

and STIs, immigrant status and sexuality. One study found that ethnicity was not a

factor associated with HCV infection among HIV positive MSM (Burchell et al., 2015).

However, another study examining HIV risk noted that nonwhite MSM are more likely to

be lost to follow-up (Strathdee et al., 2000). Taking into account immigrant status and

race on sexuality, racialized MSM born outside of Canada were less likely to have sex

with women and were less likely to exchange sex for products and services compared to

white MSM and racialized MSM born in Canada and white MSM born outside of Canada

(George et al., 2007). Racialized MSM were also less likely to have unprotected sex

when travelling than white MSM, particularly white MSM born outside of Canada.

Racialized MSM born outside of Canada were more likely to be unemployed.

Limitations of the Literature Review

There are several limitations with this literature review. Most importantly, because research of this breadth had not been done before, an exploratory literature review was selected in order to examine what the current state of the literature is on racialized sexual and gender minority health. An exploratory literature review was selected over a systematic or narrative review because it provided the flexibility to examine diverse types of studies while being careful not to overextend my analysis of experiences that are not my own. However, this exploratory literature review was not able to cover books, dissertations or various types of grey literature examining the health of racialized sexual and gender minorities. Such literature likely has a wealth of information that has gone unexplored in this literature review. Additionally, it is only able to suggest areas of emergent health issues for racialized sexual and gender minorities as there is a paucity of research. Furthermore, this literature review is limited by the limitations of the various studies in this literature review. For example, much of the literature centres on racialized non-transgender MSM's experiences and thus excludes many other racialized sexual and gender minority groups. Lastly, as a racialized non-transgender queer man and researcher who is non-Indigenous and non-Black, there are substantial limitations in my analysis of experiences that are outside of my own.

Strategies for Public Health Practice

Several strategies for public health practice with racialized sexual and gender minorities can be draw from this literature review: the importance of theories and frameworks that account for intersectional experiences of racialized sexual and gender minorities, the importance of decentring whiteness, and lastly, given the first two strategies, more accountable and ethical research on racialized sexual and gender minorities' experiences and health outcomes.

1.8. Theories and Frameworks

Because racialized sexual and gender minorities are situated within multiple and intersecting systems of privilege and oppression (i.e., racism, white supremacy, cisheteropatriarchy) that are informed by multiple continuous histories (i.e., social, legal, political, spatial and temporal), it is necessary that any work with racialized sexual and gender minorities specifically account for these intersectional experiences (Ahmed, 2006; Ford and Airhihenbuwa, 2010). In this effort, I want to present three theories and frameworks that might begin to help us account for these experiences in a health and public health context: critical race public health, anti-colonial discursive framework, and

the Integrated Life Course and Social Determinants Model of Aboriginal Health

(ILCSDAH).

1.8.1.   Critical Race Public Health

As a theory that centres a critical understanding of the many ways that racism

manifests intersectionally in all aspects of society and why it remains important in the

lives of racialized people, critical race public health offers important conceptual tools to

understand the racialized health inequities experienced by racialized people: race is a

social construction with real consequences, racism happens all the time in subtle, overt,

and normalized ways within all aspects of society, and that racism is a part of a system

that creates intersectional hierarchies of power and dominance (Ford and

Airhihenbuwa, 2010). In addition to these conceptual tools, critical race public health is

an approach that emphasizes action, particularly action that centres marginalized voices

and lived experiences of racialized people across multiple intersecting and socially

constructed locations of difference--often termed as employing an intersectional

approach (Ford and Airhihenbuwa, 2010).

Furthermore, its emphasis on understanding personal, group, and disciplinary

biases and their effects on society is a point of reflection and reflexivity that allows us to

acknowledge and actively unlearn racisms, and other simultaneously compounding

"isms", that affect our ability to engage in ethical and accountable work within and

across racialized communities (Ford and Airhihenbuwa, 2010). Without a critical race

public health approach, I would argue, we run the risk of doing work that ignores or

explains away an integral aspect of racialized sexual and gender minorities lived

experiences--of being a racialized person in a white settler society that is built upon and

continues to benefit from racism and colonialism (Ford and Airhihenbuwa, 2010;

Thobani, 2007; Delgado and Stefancic, 2000). In essence, critical race public health is a

theoretical and practical approach that constantly reminds us that racialization, racism

and the intersectional experiences of racialized people matter (Ford and Airhihenbuwa,

2010).

1.8.2.   Anti-colonial discursive framework

An anti-colonial discursive framework centres colonialism and imperialism as

lenses through which to understand societies, the experiences of Indigenous and non-

Indigenous peoples and resistance (Dei and Asgharzadeh, 2001). This framework draws

our attention to the ways in which many nation-states are built upon and continue to

maintain colonialism and imperialism across a variety of institutions including legal,

educational, health, and political institutions (Dei and Asgharzadeh, 2001). Colonialism

and imperialism are understood as constructing complex and constantly changing

structural and social relationships of power and dominance between Indigenous

peoples and non-Indigenous people (Dei and Asgharzadeh, 2001). In particular, non-

Indigenous settlers--both white settlers and settlers of colour--benefit from colonial and

imperial systems and institutions that dispossess and appropriate the lands and

resources of Indigenous peoples to the benefit of settlers (Dei and Asgharzadeh, 2001;

Tuck and Yang, 2012).

Furthermore, an anti-colonial discursive framework places an important emphasis on specific and local Indigenous lived experiences, action, knowledge and knowledge systems as standpoints from which to critique dominant Eurocentric knowledge and knowledge systems and as sites of resistance against colonialism and imperialism (Dei and Asgharzadeh, 2001). By centring specific and local Indigenous lived experiences, action, knowledge and knowledge systems--including cosmologies, ontologies, epistemologies, cultural practices, traditions, medicines--it is possible to highlight the many ways in which Eurocentric modes of thought and analysis dominate our questions, concepts and theories about ourselves, others and the world (Dei and Asgharzadeh, 2001). It is important to recognize that Indigenous knowledge and knowledge systems are capable of developing new questions, concepts, and theories that are relevant to the lives of both Indigenous and non-Indigenous peoples (Dei and Asgharzadeh, 2001). It is through such work that the dominance of Eurocentric knowledge and knowledge systems, itself a product of colonialism and imperialism, can be destabilized and Indigenous knowledge and knowledge systems can flourish in imagining transformative change (Dei and Asgharzadeh, 2001).

1.8.3. Integrated Life Course and Social Determinants Model of Aboriginal Health

In order to more fully understand and support Indigenous two-spirit and sexual and gender minority health, I find it helpful as a non-Indigenous person to examine Indigenous health using a model that explicitly takes into account the complex histories,

contexts, and understandings of health that are relevant to Indigenous peoples. The

Integrated Life Course and Social Determinants Model of Aboriginal Health (ILCSDAH) is

one model that, I would argue, is capable of handling such complexities (Reading and

Wien, 2009). The ILCSDAH has three main components that are understood as being

interrelated: an emphasis on social determinants of health, life course, and holistic

health (Reading and Wien, 2009).

According to the ILCSDAH, social determinants of health are understood to

include distal, intermediate and proximal determinants (Reading and Wien, 2009).

Distal determinants include "colonialism, racism and social exclusion, and repression of

self-determination" (Reading and Wien, 2009, pg. 20). Distal determinants take into

account the broader contexts that influence health, including "historic, political, social

and economic contexts" (Reading and Wien, 2009, pg. 1). These determinants are

understood to shape and influence intermediate and proximal determinants.

Intermediate determinants are situated between distal and proximal determinants and

include the role of institutions and community factors in Indigenous health (Reading and

Wien, 2009). Intermediate determinants, in turn, shape and influence proximal

determinants, which include the more immediate factors that influence Indigenous

health such as health behaviours, education and income (Reading and Wien, 2009).

In addition, the ILCSDAH incorporates a life course perspective that takes into

account how social determinants may impact health from gestation to adulthood as well

as across generations, which is important considering the intergenerational trauma and

violence of colonialism (Reading and Wien, 2009). This perspective takes into account

how experiences, particularly those in early life and development, may influence health

across a person's lifespan (Reading and Wien, 2009). The life course perspective also

acknowledges that health experiences differ across the life stages, such as in the

differing health needs of the very young and the elderly (Reading and Wien, 2009).

The final component of the ILCSDAH is a holistic understanding of health that

includes "physical, spiritual, emotional and mental dimensions" (Reading and Wien,

2009, pg. 3). Taken all together, the ILCSDAH is a complex and comprehensive model

for understanding and learning about Indigenous health issues and solutions that are

appropriate and relevant to the health experiences of Indigenous peoples (Reading and

Wien, 2009). It is a model that emphasizes an understanding of health and

determinants of health that more closely aligns with Indigenous understandings of

health and wellness (Reading and Wien, 2009).

1.9. Decentring Whiteness

Another strategy for public health practice with racialized sexual and gender

minorities is decentring whiteness. Whiteness is an analytical and theoretical concept

as well as a term indicating the social and structural relations of white

dominance/supremacy within a particular time and place that has been socially

constructed historically, culturally, legally, economically, and politically (Garner, 2007).

While there is a paucity of research on racialized and sexual minorities in Canada, it is

important to recognize that the research that currently exists offers much in resisting

dominant discourses and practices that marginalize and erase racialized sexual and

gender minority experiences. It is important to recognize that it is not always necessary

to position racialized sexual and gender minorities in comparison to white sexual and

gender minorities. Doing so runs the risk of simultaneously reinforcing whiteness in our

work. Literature in this review has decentred whiteness using a few strategies.

The first strategy is strategic essentialism as coined by Gayatri Chakravorty

Spivak (Sangeeta, 2009). Strategic essentialism, in this case, involves grouping

differently racialized groups (e.g., groups with ancestries in East Asian, Southeast Asian,

South Asian) under a broader umbrella term (i.e., Asian) to form a potentially useful but

incomplete identity group that can then be discussed (please see Maung et al., 2013). In

the current neoliberal context, public health favours approaches that can benefit a large

population for the least amount of money. Strategic essentialism offers one potential

strategy for claiming space within this neoliberal context. However, it is important to

recognize that strategic essentialism should be approached with caution especially

when it begins to reify these broader identities to the erasure of the complex and more

specific racialized identities and experiences (Sangeeta, 2009). I further propose that

strategic essentialism is more appropriate in the domain of research and potentially

advocacy than it is in front-line practice. Front-line practice must attend to the

complexity of racialized identities and experiences while potentially building solidarities

through strategic essentialism.

The second strategy is strategic analysis. Even with strategically essentialized

identity groupings, it is still possible to centre whiteness by comparing these

essentialized identity groups with white identity groupings. The research in this

literature review provides important alternatives in analyzing data about racialized

sexual and gender minorities. In quantitative analysis, one can compare one identity

group to the rest of the identity groups if one's sample includes multiple racialized

groups (please see Maung et al., 2013). For example, one can compare Asian

participants with non-Asian participants. One can also compare racialized sexual and

gender minorities with their racialized heterosexual and/or cisgender counterparts

(please see Saewyc et al., 2013).

The third strategy is in the language and terminology that is used. Racialized

sexual and gender minorities may not use the same terms or have the same types of

relationships with mainstream terms referring to sexual and gender minorities (Nelson

et al., 2014). Umbrella terms can contribute to social inequities if they are used to erase

more marginalized groups within that umbrella term. Some terms are specific to certain

communities such as the term two-spirit among some Indigenous communities or same-

gender loving among some Black communities (Meyer-Cook and Labelle, 2003; Nelson

et al.,2014). Also it is important to recognize and, when appropriate, use terms that

exist outside of the English language that describe racialized sexualities and genders.

The fourth strategy is to ask intersectional questions and conduct intersectional

analyses that are specific to the experiences of racialized sexual and gender minorities

(Bowleg, 2008). In terms of quantitative research, this could involve asking questions about experiences of racism and homophobia within different communities and look at interaction effects between different forms of oppression (please see Marcellin, Bauer, and Scheim, 2013). In terms of qualitative research, it could involve probing for experiences of intersectional marginalization, even if it is not recognized as such, as well as using a critical framework when analyzing the data like those presented above.

The fifth strategy is to support more racialized sexual and gender minorities, who have critical analyses of racism and other systems of oppression, in leading research with their communities. Such research is more likely to address concerns that are specific to racialized sexual and gender minorities (Nelson et al., 2014).

1.10. Accountable and Ethical Research

While reviewing the literature, issues around accountability and ethics in research were evident. Strathdee et al. (2000) noted that nonwhite MSM were more likely to be lost to follow-up in their study. Travers et al. (2013) noted how racialized gender minority researchers left their community-based research project over time due at least partially to a lack of anti-racism training. Siemienuik et al. (2013) note that they were unable to screen some participants in their study due to language barriers. These issues highlight that measures of accountability need to ensure that racialized sexual and gender minorities can participate and be involved in research in ways that do not exclude them based on their intersectional experiences and needs.

Also, in quantitative research, there is a tendency to analyze data based on self-reported race or ethnicity. However, it is important for researchers to recognize that it is not only race or ethnicity that determines health outcomes but the structure of how institutions and social norms, particularly in a Canadian context, organize around race and ethnicity to create differences in health outcomes. Furthermore, as this literature review has highlighted, racialized sexual and gender minorities may experience different health outcomes in terms of degree, type, and frequency with their heterosexual counterparts as well as with white sexual and gender minorities.

1.11. More Research is Needed

It is clear that there is a paucity of research available specific to different racialized sexual and gender minority groups resulting in little if any hard conclusions being able to be drawn from the literature review. In fact, as the literature highlights, the experiences of racialized sexual and gender minorities are immensely complex and require more in-depth and nuanced research both theoretically and methodologically. More accountable and ethical research is needed. However, the health issues that have identified provide a starting point from which to understand how racialized sexual and gender minorities have complex and unique health experiences and outcomes that need to be addressed in research but also practically in the social and material conditions of their lives.

Emerging Areas and Topics for Research

1.12. Gaps

In completing this literature review, I have noticed several gaps in literature about racialized sexual and gender minorities. First, it is clear that the overwhelming majority of research has focused on non-transgender racialized MSM's experiences. More research needs to be conducted with racialized sexual and gender minority girls and women, especially considering that the burden of certain health outcomes may be experienced differently among racialized sexual and gender minority girls and women (please see Saewyc et al., 2013; Monette et al., 2011; Taylor, 2009). Second, much of the research focuses on monosexual experiences or experiences of people who are only attracted to one gender. Saweyc et al.'s (2013) research suggests that health outcomes may differ and may be worse in certain regards for bisexual or mostly heterosexual racialized sexual minorities. Third, much of the research does not explicitly consider how disability is an important intersection to consider in relation to health outcomes. Fourth, it is important to recognize the distinction between sexuality and gender. Transgender people also have sexualities and, as such, should be included and accounted for in all research on sexual minorities. Fifth, very few studies examined the mental health of racialized sexual and gender minorities.

1.13. Considerations

In terms of considerations for future research, a few suggestions can be made based on this literature review. First, that self-identification is important. Racialized sexual and gender minorities who self-identify as mostly heterosexual people may differ in their experiences and health outcomes than those who self-identify as gay, lesbian or bisexual (Saewyc et al., 2013). Second, that perceptions of discrimination based on race may be different from those based in sexuality partly because of social discourses that undermine critical understandings of racism (as seen in Nakamura, Chan and Fischer, 2013; for more on this topic please see Thobani, 2007; Sue, 2010). Third, that factors such as age, education, religion , attendance at religious services, language, immigrant status, generational status, migration, and social and political climate should be considered in any research or front-line work involving racialized sexual and gender minorities.

Contributions and Conclusion

In conclusion, this exploratory literature review has contributed to the field of racialized sexual and gender minority health in multiple ways. First, it expands and highlights the continuum of lived experiences of sexual and gender minorities by specifically addressing the lived experiences of sexual and gender minorities. As this research has shown, intermediate and distal determinants (i.e., lack of adequate health and social services, colonialism, racism, sexism) affect racialized sexual and gender minorities in unique ways to affect proximal determinants of health. For example, experiences of discrimination may increase Indigenous sexual minority youths' likelihood of engaging in less safe sexual behaviours (Saewyc et al., 2013) or that HIV interventions may not adequately take into account Black MSMs unique social, cultural and religious assets and oppressions (Nelson et al., 2014).

Second, it proposes theories and frameworks to guide future research and praxis in the field of racialized sexual and gender minority health and sexual and gender minority health more broadly. If truly accountable and ethical research is to happen, it must be guided by theories and frameworks that are able to account for multiple,

simultaneous and intersectional experiences of racialized sexual and gender minorities.

Such research is much less likely to exclude racialized sexual and gender minorities and

is more likely to address pressing health concerns of multiply marginalized sexual and

gender minorities.

Third, it identifies research areas and factors to consider in future research and

public health practice with racialized sexual and gender minorities. The lack of research

on women's and gender minorities' experiences, mental health of non-Indigenous

racialized sexual and gender minorities, and more intermediate and distal determinants

of health is alarming and needs to be addressed in future research. Factors that have

been found to be relevant in current research on racialized sexual and gender minority

health include generational status, immigrant status, language, religion, age, migration,

and discrimination (Nakamura, Chan and Fischer, 2013; Catungal, 2013; Husbands et al.,

2013; Ristock, Zoccole, and Passante, 2010; Ristock, Zoccole, and Potskin, 2011; George

et al., 2014; Saewyc et al., 2013).

Fourth, it identifies strategies for conducting research with racialized sexual and

gender minorities. In particular, there is a need to centre racialized sexual and gender

minorities in leading this research. Research in this literature review highlights the

unique strategies--e.g. strategic essentialism, strategic analysis, intersectionality and

attention to language--that emerge when racialized sexual and gender minority researcher's are centred and/or lead the research. Examples include comparing Asian to non-Asian MSM, delving deeply into Black MSMs experiences in qualitative research, and using terms like two-spirit which exist outside of the Eurocentric dominance of terms such as lesbian, gay, bisexual and transgender (Husbands et al., 2013; Ristock, Zoccole, and Passante, 2010; Ristock, Zoccole, and Potskin, 2011; George et al., 2014; Maung et al., 2013).

Lastly, it advocates for more complex and nuanced research to fill the gaps and to extend the field of racialized sexual and gender minority health. Rather than just quantity, we also need better quality research about and with specific racialized sexual and gender minorities. In particular, we need research creates positive change in public health systems and practice.

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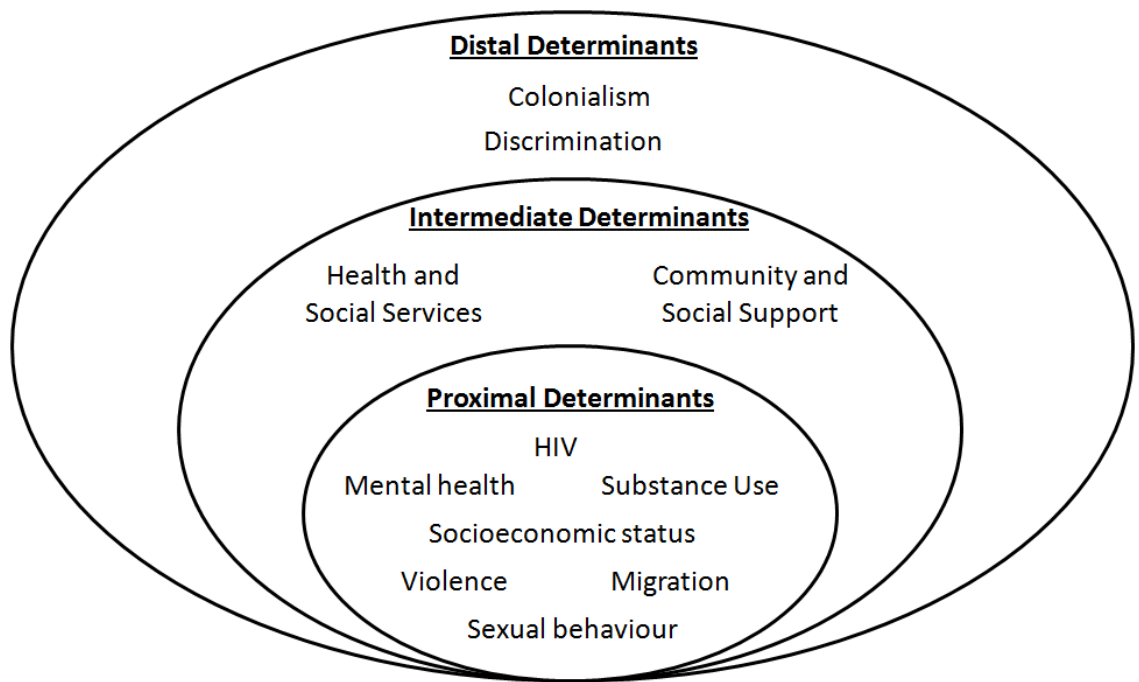
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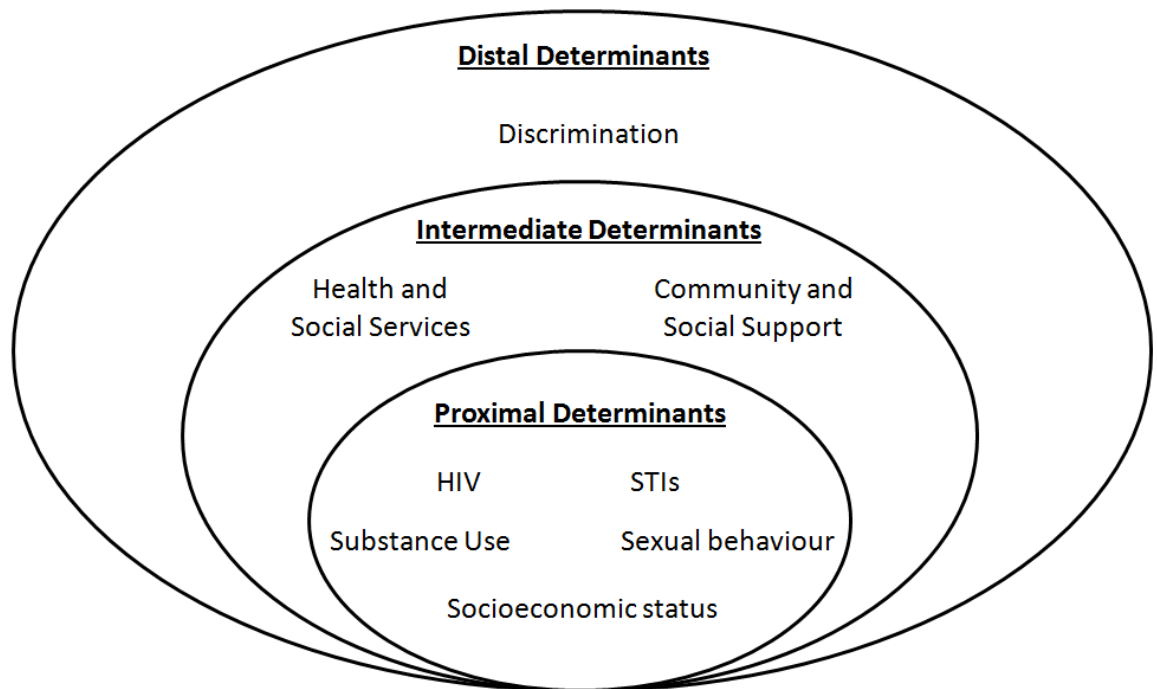
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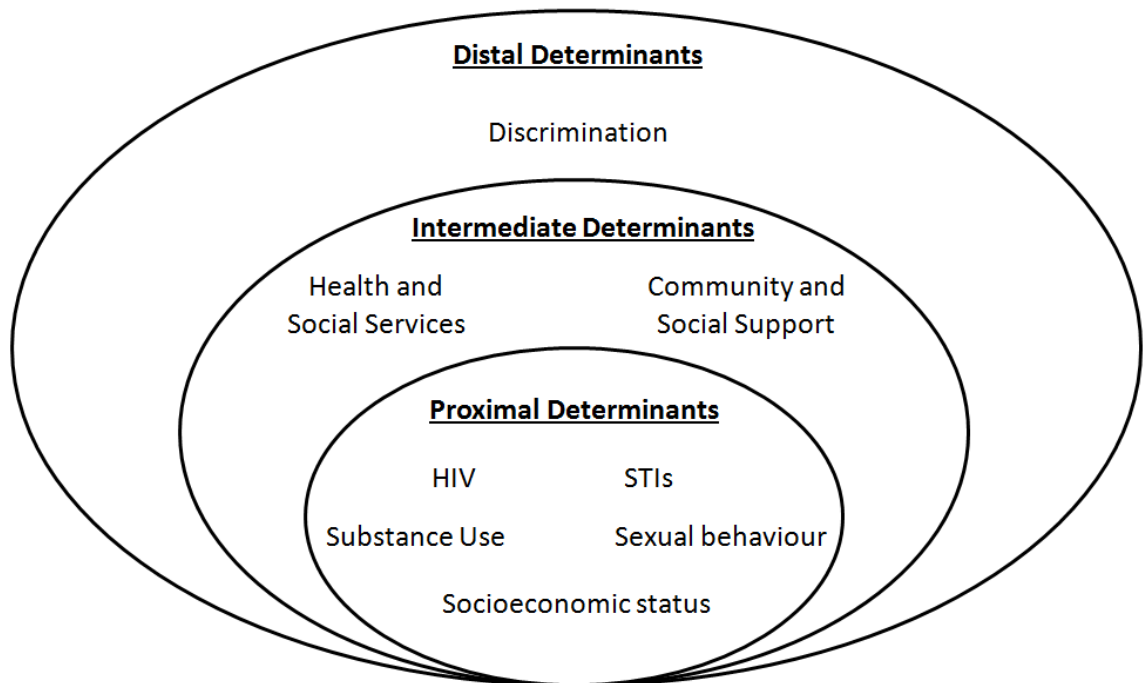**Figure 5: A visual representation of the social determinants of health identified in the research for Indigenous two-spirit people and sexual and gender minorities**

Distal Determinants
Colonialism
Discrimination

Intermediate Determinants
Health and Social Services   Community and Social Support

Proximal Determinants
HIV
Mental health   Substance Use
Socioeconomic status
Violence   Migration
Sexual behaviour

Figure 6: A visual representation of the social determinants of health identified in the research for Black sexual minority men

Distal Determinants

Discrimination

Intermediate Determinants

Health and
Social Services

Community and
Social Support

Proximal Determinants

HIV   STIs

Substance Use   Sexual behaviour

Socioeconomic status

Figure 7: A visual representation of the social determinants of health identified in the research for Asian sexual minorities

Distal Determinants

Discrimination

Intermediate Determinants

Health and
Social Services

Community and
Social Support

Proximal Determinants

HIV

STIs

Substance Use

Sexual behaviour

Socioeconomic status

Figure 8: A visual representation of the social determinants of health identified in the research for non-Indigenous racialized sexual and gender minorities