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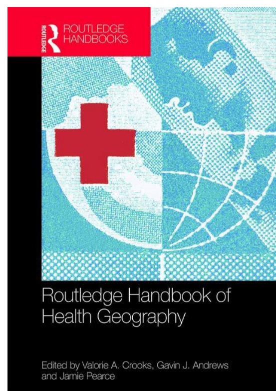

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ESTABLISHING GEOGRAPHIES OF LGBTQ HEALTH

Nathaniel M. Lewis

Geographies of health have shifted from measuring disease and illness to engaging actively with the social subjectivities that shape health. Sexual and gender identities, including those of lesbian, gay, bisexual, transgender and other queer (LGBTQ) individuals, have gained attention as key axes of social difference contributing to uneven health outcomes and access to care. Yet LGBTQ populations are still studied less frequently in health geography compared to, for example, ethnic minority and immigrant populations.

This chapter first follows the trajectory of geographic research on LGBTQ health from the HIV/AIDS epidemic to broader considerations of health experiences among diverse LGBTQ populations. Next, it considers emerging research on public health as biopolitical regulation, access to care among LGBTQ populations, and sexuality as an intersectional determinant of health. While research in these areas has made a considerable contribution to health geography, there remains ample space in the discipline for quantitative, deductive and ecological research on LGBTQ health outcomes.

Historical and intellectual trajectory

The late 1980s and early 1990s marked the first significant appearances of sexual orientation within geographies of health, then referred to largely as medical geography. Early spatial-epidemiological studies that modeled the HIV/AIDS epidemic pointed to gay men as a key population advancing the spatial diffusion of the disease (Smallman-Raynor and Cliff, 1990; Gould, 1993). This medicalization of gay men, however, was not a new phenomenon. Decades before the advent of HIV/AIDS, urban public health authorities concerned about sexually transmitted infections (STIs) began examining gay men as both an at-risk population and a perceived public-health risk (Brown and Knopp, 2014). Early studies of gay men and the geography of HIV/AIDS were not especially attentive to the ways in which the social construction or stigmatization of non-normative sexualities might affect gay men's risks for HIV infection (Brown, 1995). Rather, they focused largely on the potential for HIV-positive individuals, who also happened to be gay, to infect others or to overwhelm local public-health systems upon returning to family homes (see also Ellis and Muschkin, 1996).

Social, cultural and feminist geographers began studying the lives of LGBTQ individuals more closely during roughly the same period. The cultural turn in human geography, which prioritized the social construction and differential experiences of geographic phenomena, spawned feminist geography in the 1980s and geographies of sexualities (or sexuality and space) in the 1990s. The latter was concerned with how gay men and lesbians made their homes, communities and livelihoods (Bell, 1991; Bell and Valentine, 1995).

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While health was not an explicit focus in early geographies of sexualities, many studies dealt with broader issues of well-being, such as fear, harassment and social support (Bell and Valentine, 1995; Valentine, 1998). Much of medical geography, in contrast, continued through the 1980s to treat places as bounded collections of attributes (e.g., deprivation, disease endemicity) that could be modeled to predict health outcomes in a range of populations. As medical geography underwent its own transition to a *reformed* health geography (Kearns, 1993), researchers began employing a wider variety of approaches to understanding the relationship between health and place.

Many geographers sought to examine the role of various therapeutic landscapes (e.g., shrines, spas, camps) in shaping health (e.g., Williams, 1999). While this work typically employed qualitative techniques, it did not always adopt a critical social-theory lens or examine the social relations within places (Kearns and Moon, 2002). Critical and feminist geographers, however, began using detailed interview-based narratives to explore the social relations in places that might perpetuate risk or disadvantage (Dyck, 2003). The first health-geography research to acknowledge the social significance of sexual orientation maintained the focus on HIV/AIDS. Studies of gay men's sexual citizenship during the AIDS crisis (Brown, 1997) and the diminished lifeworlds of those who had contracted the disease (Wilton, 1996) became critical qualitative rejoinders to the disease-diffusion studies from earlier in the decade. Sexuality, however, has remained largely under-researched as an axis of difference in the place-health relationship (Parr, 2004), and sex and gender are still conceived as binaries in most geographic research (Browne, Nash and Hines, 2010). This gap has somewhat narrowed during the past 15 years. Building on research traditions in critical and feminist geography, as well as fruitful collaborations with geographers of sexualities, health geographers have attended to the current and historical regulation of LGBTQ health, access to care for LGBTQ patients and intersectional determinants of health affecting LGBTQ populations.

The current state of the field

Biopolitical regulation has been perhaps the most explored topic within geographies of LGBTQ health. Inspired by Foucault's lectures on sexuality and governmentality (e.g., Foucault, 2008), many health geographers have contributed to a hybrid field of study that examines health as an apparatus through which sexual non-normativity is disciplined. Much of the research in this area outlines the social construction of *good gays* who do their part to uphold the public good and *bad gays* who behave in an irresponsible way that puts society at risk. Brown (2006) counters the notion of sexual responsibility (i.e., safe sex) as a political and moral obligation that must be met to merit full citizenship. He explains that while sex is an act in which individuals naturally lose some of their autonomy, this loss does not stop gay men from taking account of their local epidemiological environments and engaging in strategies (i.e., *safer* sex) to mitigate risk to themselves and others. Public-health agencies often frame gay men's health responsibilities in contradictory ways. Thien and Del Casino (2012), for example, argue that gay men are told to *man up* by getting tested for HIV and disclosing their status to others but also to engage in talk therapy and other traditionally feminized self-care mechanisms to reduce risk.

An additional thread of work on biopolitics explores public-health regimes and the historic regulation of sexual non-normativity by the local state. Using Legg's (2005) framework of biopolitical population control, Brown and Knopp (2014) explain how local health authorities in Seattle and other cities in the United States created gay clinics during the 1970s to gain credibility and control in urban gay communities. While the clinics used surveillance programs and publishable metrics to make male-to-male STI transmission *visible*, they also employed gay staff purposefully to achieve buy-in for testing and safe-sex campaigns. Others have researched the ways in which the governmental regulation of sexuality itself has impacted well-being in LGBTQ populations. In Canada and elsewhere, civil-service expulsions, unwarranted police investigations

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and closures of social spaces such as bars and bath houses have left many urban LGBTQ communities socially fragmented and lacking resources for the older generation (Andrews and Holmes, 2007; Lewis et al., 2015).

A second body of work focuses on uneven access to health care among LGBTQ populations. The long-term denial of rights and resources for LGBTQ people in most Western countries has institutionalized heterosexuality within health-care provision and limited the availability of LGBTQ-specific services outside the largest cities. Lesbian mothers, for example, are overlooked at most stages of care for both childbirth and parenting. In a study by MacDonnell and Andrews (2006), many of the mothers interviewed observed that birthing-class instructors generally assumed uniform heterosexuality and mother-father relationships. Others noted the there are few supports for children who have lesbian mothers and experience bullying at school. In my own work, I reflect on the implications of institutional invisibility for LGBTQ health across the life course. Gay respondents in my study of HIV risk in Nova Scotia, in Canada, noted that a lack of access to gay-specific sex education during school years, for example, could affect health experiences and outcomes later in life (Lewis, 2015).

Health-care access for LGBTQ people is not only geographically uneven but also geographically imagined. The perception of social disenfranchisement in health care among LGBTQ people may be as damaging as the actual lack of health-care infrastructure for this population. In their study of lesbian, bisexual and trans women in Halifax and Vancouver, in Canada, Baker and Beagan (2016) found that participants alternately imagined LGBTQ people in other cities, towns and countries as better off and worse off in terms of access to care than they were. Building on Knopp and Brown's (2003) observation that queer places are more relational than hierarchical, they find that dense information networks in small, conservative places can enable access while the often diffuse LGBTQ health-care options in large cities can make navigating the health-care system more difficult. Catungal (2013) deftly bridges historical health geographies and access to care issues in his study of ethno-specific AIDS service organizations in Toronto, Canada. He explains that these intersectional safe houses emerged from efforts to replace the whiteness of mainstream gay clinics with HIV prevention messaging that was reparative and culturally affirming.

A third body of work builds upon the established public-health focus in geographies of health by exploring how sexuality coalesces with other place-based social determinants of health. To continue unpacking the black box of place for which medical geography was originally critiqued, many have offered detailed accounts of the social relations within LGBTQ lives. Van Ingen (2004) offers a welcome perspective on LGBTQ sportscapes. She sees running groups and other sports clubs as fluid, socially networked therapeutic landscapes that can be at once health-promoting (i.e., in terms of fitness) and stigmatizing for those who fall outside of white, middle-class notions of gay and lesbian empowerment and self-responsibility. Holmes (2016) considers a broad range of the place-based social relations that threaten the well-being of trans and gender non-conforming individuals in Canada. These relations occur at almost every spatial scale, ranging from intimate partner violence at home to persistent gender segregation in public space and institutional erasure within health-care settings (see also Namaste, 2000).

Other researchers have employed time-space and life-course approaches to understand how health outcomes are shaped for LGBTQ people. Several have used these approaches to problematize the perceived binary of healthy and unhealthy places among gay men (including HIV-positive gay men) and understand the social time-spaces in which health behaviors such as drug use and sex might coalesce (Del Casino, 2007). Nightclubs, for example, can be places that provide social support but are used as contact points for drug use and unprotected sex among men whose lives have been de-routinized by adverse events such as unemployment (Tobin et al., 2013). Conversely, work itself can become a stressful place for HIV-positive gay men who feel the need to conceal both their sexual orientation and HIV status while engaging with customers (Myers, 2010). In some of my previous research, I have attempted to show that movement – like place – is rarely fully emancipatory for LGBTQ people. Health issues are both causes of and consequences of internal

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and international migration among LGBTQ people navigating uneven landscapes of stigma, stress and social support. While anxiety and depression stemming from stigma, harassment or internalized homophobia might prompt a decision to move, the social upheaval and displacement resulting from migration can result in using drugs or sex as coping mechanisms or ways to fit into new settings (Lewis, 2014, 2016).

Contributions, limitations and future developments

Research on biopolitical regulation, access to care and social time-spaces among LGBTQ people broadens the scope of health geography considerably. The studies outlined in this chapter not only take difference seriously, but also suggest ways in which health geographers can take account of social subjectivities that are not always visible or easily measurable. They also cultivate an understanding of places as sets of social relations shaped by individual subjectivities as well as historical and institutional processes.

The rapidly evolving nature of the social and political landscape affecting LGBTQ people makes work on health and well-being in this population more urgent than ever. Despite advances in legal equalities in some countries, LGBTQ lives are still constructed socially and institutionally as non-normative. They are often punctuated by coming out in multiple settings, uprooting oneself to develop an identity and negotiating social-support systems that extend beyond the heteronormative home, school and community. Although health geographers are ideally positioned to continue examining how the social determinants of health affect LGBTQ lives across space and time, their methods and approaches could perhaps be diversified.

Geographers of LGBTQ health have adopted critical and qualitative methodologies that capture the nuanced understandings of health-place relationships. The lack of quantitative work, in contrast, may owe to the relative lack of statistical data on sexual orientation and non-binary gender identities. This methodological gap may also reflect the perceived shortcomings of quantitative analyses in assessing the flexible, frequently mobile and sometimes traumatic aspects of LGBTQ lives that ultimately lead to adverse health outcomes. Avoidance of the traditional, hypothesis-driven public-health framework may also reflect an understandable aversion to potentially pathologizing identities or spaces associated with LGBTQ communities. The research emphases described in the first section of this chapter consequently tend to deconstruct extant geographies of LGBTQ health rather than measure geographic variations in health risks or highlight preventative interventions.

Other disciplines have begun to produce LGBTQ health research of a geographic *nature*, though not always with the attention to place or social theory for which health geographers have advocated. Research from psychology, epidemiology and even sociology has attempted to quantify the impact of pro- and anti-LGBTQ legislation on mental-health outcomes (e.g., Hatzenbuehler, Keyes and Hasin, 2009); the effect of moving to a gay neighborhood on HIV infection (Egan et al., 2011); and the influence of living in a rural area on life satisfaction among LGBTQ people (Wienke and Hill, 2013). These studies depart from the individual-level psycho-behavioral frameworks more common in these fields to emphasize the place *context* more typical of health geography. At the same time, they may reinforce existing binaries of healthy and unhealthy places for LGBTQ people rather than highlighting the broader health potentials of a range of places. One way that health geographers can contribute to this emerging work is through their expertise in multilevel models that account for the interactions of place context and individual experience (Duncan, Jones and Moon, 1998; see Bauermeister et al., 2015, for an LGBTQ example). Such work could examine, for example, the differential health impacts of gay neighborhood attachment between gay and lesbian individuals of different incomes or with different densities of social-support networks. It might also serve to disentangle place- and individual-level factors, such as living in a place with a high rate of anti-LGBTQ hate crime versus having personally been a victim of such a crime.

A clear area for future development in the geographies of LGBTQ health is the expansion of its socio-demographic scope. Currently, there is lack of account for the full range of LGBTQ identities (as opposed

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to just gay and lesbian) or for intersections of these identities with social subjectivities, such as race (but see Catungal, 2013; Tobin et al., 2013). Much of the extant work focuses on easier-to-access, typically white and often male populations that might be considered both homonormative (i.e., part of the middle-class mainstream) and metronormative (i.e., located disproportionately in cosmopolitan urban centers). As evidenced in this review, less explicitly geographic work has been conducted on the health of lesbian and bisexual women, and almost none addresses the health of trans individuals. The work of Doan (2007) and Browne, Nash and Hines' (2010) special edited issue of *Gender, Place & Culture* may all provide points of entry to understanding the complexities of trans people's distinct spatial attachments (e.g., to gender clinics and private spaces of social support rather than traditional gay neighborhoods) and the adverse health outcomes they experience.

Finally, there is room to extend the spatial and topical scope of geographic research on LGBTQ health beyond the Anglo-American context. Research on South Africa, China and Eastern Europe has considered how LGBTQ health might be affected by diverse political and epidemiological environments. Tucker's (2009) work on Cape Town, South Africa, underscores the ways in which HIV risk among men who have sex with men is determined by the city's high background prevalence, its racial segregation and individual men's sexual subjectivities. Studies of Chinese male sex workers who have sex with men, or *money boys*, suggests that the growing profession is both rooted in China's capitalist economic transformation and mediated geographically by rural-to-urban migration (Kong, 2017). Recent work on the Czech Republic (e.g., Pitoňák and Spilková, 2015) identifies the genesis of homophobia in post-communist Eastern European societies, regional differences in these attitudes and the potential application of educational interventions from abroad.

While this brief review reveals that there is much work to be done on geographies of LGBTQ health, it also catalogs a range of inspiring research on the individual life trajectories that animate health and the institutional structures that have systematically disadvantaged LGBTQ people. The greatest advances can, perhaps, be made by synthesizing key strands of research in LGBTQ health geographies rather than simply accelerating specialized sub-fields such as historical geographies of biopolitics or access to specialized forms of care. Multisite and multifactor ecologies of health that have been popularized in health geography offer models for assessing how both life trajectories and uneven geographies of homophobia, transphobia and health-service infrastructures coalesce in certain places. Similarly, the use of multilevel modeling has the potential to consider the influence of place context on LGBTQ health outcomes, including mental health, in a more nuanced manner than much of the work in the health-science disciplines is currently offering. Such work will not only improve health outcomes in a disadvantaged group, but also help develop the complexity and diversity of health geography as a key discipline in health research.

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