# The Case for the World Health Organization's Commission on the Social Determinants of Health to Address Sexual Orientation

The World Health Organization's (WHO's) social determinants of health discussion underscores the need for health equity and social justice. Yet sexual orientation was not addressed within the WHO Commission on the Social Determinants of Health final report *Closing the Gap in a Generation.*

This omission of sexual orientation as a social determinant of health stands in stark contrast with a body of evidence that demonstrates that sexual minorities are disproportionately affected by health problems associated with stigma and discrimination, such as mental health disorders.

I propose strategies to integrate sexual orientation into the WHO's social determinants of health dialogue. Recognizing sexual orientation as a social determinant of health is an important first step toward health equity for sexual minorities. (*Am J Public Health.* 2012;102:1243–1246. doi: 10.2105/AJPH.2011.300599)

Carmen Logie, PhD

**HEALTH EQUITY AND SOCIAL** justice are central to the World Health Organization's (WHO's) discussion of the social determinants of health.[1] The WHO's Commission on the Social Determinants of Health (CSDH) 2008 final report, *Closing the Gap in a Generation*, defined social determinants of health as living conditions shaped by sociopolitical factors that contribute to the health of individuals and populations.[1] The social determinants of health were operationalized in nine themes: early childhood development, globalization, health systems, employment conditions, priority public health conditions, measurement and evidence, women and gender equality, urbanization, and social exclusion.

The CSDH social determinants of health conceptual framework posits that factors associated with the distribution of health and well-being include social position, education, occupation, income, gender, and ethnicity/race.[1] Sexual orientation was not included within CSDH's social determinants of health conceptual framework nor mentioned anywhere in this report.[1] Yet sexual minorities experience significant and pervasive health disparities. (I use the terms "sexual minority" and "lesbian, gay, bisexual" [LGB] interchangeably to convey nonheterosexual sexualities and identities claimed by persons across diverse cultures and contexts.) For example, systematic reviews and population-based studies report increased risks for depression,[2–7] suicidal ideation,[2,3,7–9] anxiety,[2,3,5–7] and substance dependence[2,4,6] among sexual minorities compared with heterosexuals.


**A woman prays next to the coffin of Erick Alex Martinez, a journalist and gay rights campaigner, who was murdered in Honduras along with at least 20 other media workers over the last 3 years. Martinez's body was found by the roadside in the village of Guasculile, north of the capital, Tegucigalpa. He worked for an association defending lesbian, gay, bisexual, and transgender (LGBT) rights. Martinez had also been chosen last year as a candidate for a coalition of parties that emerged after the ousting of President Manuel Zelaya in 2009. Photograph by Orlando Sierra. Printed with permission of Getty Images.**

Omission of sexual orientation as a social determinant of health in *Closing the Gap in a Generation* stands in stark contrast with a large body of evidence that demonstrates that sexual minorities are disproportionately affected by

health problems associated with stigma and discrimination.[2,5,10] Homosexuality is criminalized in 76 countries and punishable by death in five,[11] underscoring the impact of powerful sociopolitical factors on the lives of sexual minorities. Sexual minorities are a demographic that account for a significant proportion of the - global disease burden, which is strongly impacted by sociopolitical factors; therefore, they should be included in health equity discussions. My objective is to demonstrate the importance of explicitly recognizing stigma and discrimination targeting sexual minorities as a social determinant of health to promote health equity.

## HEALTH DISPARITIES EXPERIENCED BY SEXUAL MINORITIES

Across the globe, stigma and discrimination heighten the vulnerability of sexual minorities to inequitable health outcomes.[12,13] Sexual stigma refers to devaluing of sexual minorities, negative attitudes, and lower status afforded to nonheterosexual behaviors, identities, relationships, and communities.[14] These stigmatizing processes may result in social and institutional discrimination and exclusion targeting sexual minorities.[13,14] Mental health disorders are an illustrative example of the disproportionate burden of illness experienced by sexual minorities associated with stigma and discrimination.

Sexual minorities are at elevated risk for mental health disorders compared with heterosexuals. A systematic review of mental health among LGB persons that included 25 studies with heterosexual (n = 214 344) and nonheterosexual (n = 11 971) persons from seven countries in North America, Europe, and Australia highlighted that LGB people were at increased risk for suicide attempts, depression, anxiety, and alcohol or substance dependence.[2] A population-based study in Canada (n = 49 901) revealed more mood or anxiety disorders and an elevated history of lifetime suicidality among gay or bisexual men compared with heterosexual men.[3] In the United States, a population-based study[4] (n = 2272) indicated that sexual minorities experience a 5% to 11% excess mental health burden compared with heterosexuals. Chronic stress resulting from stigma and discrimination contributes to these mental health disparities among sexual minorities.[5,15]

Meyer's[5,16] minority stress model outlined multiple stressors in the lives of sexual minorities: internalized homophobia, in which negative social attitudes contribute to shame and reduced self-worth; perceived stigma, referring to fear and expectations of rejection; and discrimination, including violence. Internalized homophobia has been associated with increased relationship problems[17] and depression[18] and reduced HIV knowledge[19] among sexual minorities. Perceived stigma may result in people hiding their sexual orientation, which in turn compromises health care access and appropriate care.[10,16,20–22] A recent Institute of Medicine report[23] recommended that sexual orientation data be collected in health records to identify and address LGB health disparities; discomfort and lack of knowledge among physicians present barriers to collecting such data. Discrimination predicted psychological distress in multisite probability samples of Latino gay or bisexual men[15] (n = 912) and LGB youths[24] (n = 9188) in the United States. Sexual and physical violence targeting sexual minorities is a global phenomenon.[25–27] Higher risk of onset of posttraumatic stress disorder among LGB people than among heterosexuals in a national United States study (n = 34 653) was in part attributed to LGB people's greater exposure to interpersonal violence.[28] Taken together, these studies provide strong support for the association between social contexts of stigma and discrimination and deleterious mental health outcomes among sexual minorities.

Understanding risk factors for depression and other mental health disorders is key to decreasing global mental health morbidity.[29,30] A recent articulation of grand challenges in global mental health highlighted the identification of modifiable social risk factors as a chief priority.[31] Enhanced understanding of stigma and discrimination targeting sexual minorities as a social determinant of health—a modifiable social risk factor—underlying health disparities can guide the development of "community environments that promote physical and mental well-being throughout life."[31(p29)] Including sexual orientation in social determinants of health dialogues may also inform culturally sensitive health promotion programs and interventions for sexual minorities.

## SEXUAL ORIENTATION AS A SOCIAL DETERMINANT OF HEALTH

The CSDH could identify sexual orientation as a sociodemographic characteristic in its conceptual framework,[1] similar to how gender and race/ethnicity are positioned. This framework lists several sociodemographic variables (i.e., education, occupation, income, gender, ethnicity/race) associated with societal norms and values, psychosocial factors, and distribution of health and well-being. A vast evidence base demonstrates that sexual orientation is a sociodemographic variable associated with the distribution of health and well-being[2,5,10,32]—and could therefore be considered a social determinant of health.

A recent commentary called for the CSDH to adopt an intersectional approach to gender[33] to account for the interactions between identity categories (e.g., race, gender, sexual orientation). In a similar way, discussions of sexual orientation should highlight the cultural and context specificity of conceptualizations of sexuality, experiences of stigma, and health outcomes among diverse sexual minorities.[10,14,34] To illustrate, a recent study highlighted increased risk of suicide among Black and Latino LGB youths in the United States compared with White LGB youths.[35] A population-based US study reported that LGB adults who reported discrimination based on race, gender, and sexual orientation had nearly four times greater odds of past-year substance use disorders than did LGB people who did not report discrimination.[36] Attention to the convergence of sexual orientation with other identity categories is critical to improving health outcomes.

The CSDH report[1] is structured to highlight "evidence for action" and "what must be done" for categories such as gender equity and provides insightful examples of health inequities among various countries and populations. Integrating evidence of health disparities among LGB people associated with stigma and discrimination can enrich this report's analyses and scope. Gender equity constitutes its own chapter and is integrated throughout various dimensions (e.g., mental health determinants, political

empowerment) of the report; sexual minority issues could be incorporated by using a similar approach.

## A CALL TO ACTION

Sociocultural factors such as stigma and discrimination contribute to global health disparities among sexual minority individuals and populations. As the leader in global health, it is imperative that the WHO addresses sexual orientation in its health equity dialogues. Estimates from population-based studies in the United States indicate that 3.5% of the population—approximately nine million people—identify as lesbian, gay, or bisexual.[37] Even conservative global population-based estimates of 1.2%[37] suggest that sexual minorities constitute at least 84 million of the world's population.[38] Sexual minorities constitute a significant proportion of the global population and warrant inclusion in health equity dialogues.

I recommend two actions, which are supported by the existing body of evidence. First, the WHO should include sexual orientation as a social determinant of health as its own category in future CSDH reports and on its Web site. This would strengthen advocacy, policy, and programming to promote social justice. Second, the WHO should explicitly reference sexual orientation and sexual minorities within various categories (e.g., social exclusion, mental health determinants, political empowerment). Paul Hunt, former United Nations Special Rapporteur, on the right to the highest attainable standard of health, described an "underdeveloped and understated"[39(p36)] human rights analysis in the CSDH document resulted in "missed opportunities."[39(p36)] Likewise, I have highlighted opportunities to address sexual orientation to develop a more comprehensive, inclusive health equity analysis.

## CONCLUSIONS

Social injustices are endangering the health of sexual minorities. The WHO has the power to influence policy to promote health equity and social justice for sexual minorities. Although the WHO's recognition of sexual orientation as a social determinant of health will not automatically translate into health equity, it is an important first step. For the WHO to successfully meet its objective to close the gaps in health disparities in a generation, inequities among sexual minorities must be addressed. ■


### About the Author

*At the time of writing, Carmen Logie was with Women's College Research Institute, Women's College Hospital, University of Toronto, Toronto, Ontario, Canada.*

*Correspondence should be sent to Carmen Logie, PhD, Faculty of Social Work, University of Calgary, 2500 University Dr NW, Calgary, Alberta, Canada, T2N 1N4 (e-mail: clogie@ucalgary.ca). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.*



*This commentary was accepted November 21, 2011.*

### Acknowledgments

The author received salary support from a Canadian Institutes of Health Research fellowship during preparation and writing of this article.

The author would like to thank Tonia Poteat (PhD candidate, Johns Hopkins School of Public Health) and Peter A. Newman (professor, Factor-Inwentash Faculty of Social Work, University of Toronto) for valuable feedback and thoughtful comments during article preparation.


### References


1. Commission on the Social Determinants of Health. *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health.* Geneva, Switzerland: World Health Organization; 2008.

2. King M, Semlyen J, Tai S, et al. A systematic review of mental disorder, suicide and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry.* 2008;8:70.

3. Brennan DJ, Ross LE, Dobinson C, Veldhuizen S, Steele LS. Men's sexual orientation and health in Canada. *Can J Public Health.* 2010;101(3):255–258.

4. Cochran SD, Mays VM. Burden of psychiatric morbidity among lesbian, gay and bisexual individuals in the California Quality of Life Survey. *J Abnorm Psychol.* 2009;118(3):647–658.

5. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull.* 2003;129(5):674–697.

6. Frisell T, Lichenstein P, Rahman Q, Langstrom N. Psychiatric morbidity associated with same-sex sexual behaviour: influence of minority stress and familial factors. *Psychol Med.* 2010;40(2):315–324.

7. Lewis NM. Mental health in sexual minorities: recent indicators, trends and their relationship to place in North America and Europe. *Health Place.* 2009;15(4):1029–1045.

8. Plöderl M, Kralovek K, Fartacek R. The relation between sexual orientation and suicide attempts in Austria. *Arch Sex Behav.* 2010;39(6):1403–1414.

9. Cochran SD, Mays VM. Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual partners: results from NHANES III. *Am J Public Health.* 2000;90(4):573–578.

10. Baral S, Sifakis F, Cleghorn F, Beyrer C. Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000–2006: a systematic review. *PLoS Med.* 2007;4(12):e339.

11. Bruce-Jones E, Itaborahy L. *State-Sponsored Homophobia: A World Survey of Laws Criminalising Same-Sex Sexual Acts Between Consenting Adults.* Brussels, Belgium: The International Lesbian, Gay, Bisexual, Trans and Intersex Association; 2011. Available at: http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2011.pdf. Accessed April 6, 2012.

12. Cáceres CF, Aggleton P, Galea JT. Sexual diversity, social inclusion and HIV/AIDS. *AIDS.* 2008;22(suppl 2):S45–S55.

13. Parker R, Aggleton P. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Soc Sci Med.* 2003;57(1):13–24.

14. Herek GM. Confronting sexual stigma and prejudice: theory and practice. *J Soc Issues.* 2007;63(4):905–925.

15. Díaz RM, Ayala G, Bein E, Henne J, Marin BV. The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: findings from 3 US cities. *Am J Public Health.* 2001;91(6):927–932.

16. Meyer IH. Minority stress and mental health in gay men. *J Health Soc Behav.* 1995;36(1):38–56.

17. Frost DM, Meyer IH. Internalized homophobia and relationship quality among lesbians, gay men and bisexuals. *J Couns Psychol.* 2009;56(1):97–109.

18. Hatzenbuehler ML, Nolen-Hoeksema S, Erickson SJ. Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: results from a prospective study of bereaved gay men. *Health Psychol.* 2008;27(4):455–462.

19. Lung V, Tun W, Sheehy M, Nel D. Levels and correlates of internalized homophobia among men who have sex with men in Pretoria, South Africa. *AIDS Behav.* 2012;16(3):717–723.

20. Clark ME, Landers S, Linde R, Sperber J. The GLBT health access project: a state-funded effort to improve access to care. *Am J Public Health.* 2001;91(6):895–896.

21. Wohl AR, Galvan FH, Myers HF, et al. Do social support, stress, disclosure and stigma influence retention in HIV care for Latino and African American men who have sex with men and women? *AIDS Behav.* 2011;15(6):1098–1110.

22. Fay H, Baral SD, Trapence G, et al. Stigma, health care access, and HIV knowledge among men who have sex with men in Malawi, Namibia, and Botswana. *AIDS Behav.* 2010;15(6):1088–1097.

23. *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding.* Washington, DC: Institute of Medicine; 2011.

24. Bontempo DE, D'Augelli AR. Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behaviour. *J Adolesc Health.* 2002;30(5):364–374.

25. Rothman EF, Exner D, Baughman AL. The prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States: a systematic review. *Trauma Violence Abuse.* 2011;12(2):55–66.

26. Newman PA, Chakrapani V, Cook C, Shunmugam M, Kakinami L. Correlates of paid sex among men who have sex with men in Chennai, India. *Sex Transm Infect.* 2008;84(6):434–438.

27. Baral S, Adams D, Lebona J, et al. A cross-sectional assessment of population demographics, HIV risks and human rights contexts among men who have sex with men in Lesotho. *J Int AIDS Soc.* 2011;14:36.

28. Roberts AL, Austin SB, Corliss HL, Vandermorris AK, Koenen KC. Pervasive

trauma exposure among US sexual orientation minority adults and risk of posttraumatic stress disorder. *Am J Public Health.* 2010;100(12):2433–2441.

29. Lee PT, Henderson M, Patel VA. UN summit on global mental health. *Lancet.* 2010;376(9740):516.

30. Depression. Geneva, Switzerland: World Health Organization; 2010. Available at: http://www.who.int/mental_health/management/depression/definition/en. Accessed April 6, 2012.

31. Collins PY, Patel V, Joestl SS, March D, Insel TR, Daar AS. Grand challenges in global mental health. *Nature.* 2011;475(7354):27–30.

32. Hatzenbuehler ML, McLaughlin KA, Keyes KM, Hasin DS. The impact of institutional discrimination on psychiatric disorders in lesbian, gay and bisexual populations: a prospective study. *Am J Public Health.* 2010;100(3):452–459.

33. Bates LM, Hankivsky O, Springer KW. Gender and health inequities: a comment on the final report of the WHO Commission on the Social Determinants of Health. *Soc Sci Med.* 2009;69(7):1002–1004.

34. Moradi B, Mohr J, Worthington R, Fassinger R. Counseling psychology research on sexual (orientation) minority issues: conceptual and methodological challenges and opportunities. *J Couns Psychol.* 2009;56(1):5–22.

35. O'Donnell S, Meyer IH, Schwartz S. Increased risk of suicide attempts among Black and Latino lesbians, gay men, and bisexuals. *Am J Public Health.* 2011;101(6):1055–1059.

36. McCabe SE, Bostwick WB, Huges TL, West BT, Boyd CJ. The relationship between discrimination and substance use disorders among lesbian, gay and bisexual adults in the United States. *Am J Public Health.* 2010;100(10):1946–1952.

37. Gates G. How many people are lesbian, gay, bisexual and transgender? Los Angeles, CA: The Williams Institute, University of California Los Angeles; 2011:8.

38. US and world population clocks. Washington, DC: US Census Bureau; 2011. Available at: http://www.census.gov/main/www/popclock.html. Accessed September 13, 2011.

39. Hunt P. Missed opportunities: human rights and the Commission on Social Determinants of Health. *Glob Health Promot.* 2009;(suppl 1):36–41.

# Global Health—A Circumpolar Perspective

Susan Chatwood, BScN, MSc, Peter Bjerregaard, MD, PhD, and T. Kue Young, MD, PhD

Global health should encompass circumpolar health if it is to transcend the traditional approach of the "rich North" assisting the "poor South." Although the eight Arctic states are among the world's most highly developed countries, considerable health disparities exist among regions across the Arctic, as well as between northern and southern regions and between indigenous and nonindigenous populations within some of these states.

While sharing commonalities such as a sparse population, geographical remoteness, harsh physical environment, and underdeveloped human resources, circumpolar regions in the northern hemisphere have developed different health systems, strategies, and practices, some of which are relevant to middle and lower income countries.

As the Arctic gains prominence as a sentinel of global issues such as climate change, the health of circumpolar populations should be part of the global health discourse and policy development. (*Am J Public Health.* 2012;102:1246–1249. doi:10.2105/AJPH.2011.300584)

**IN RECENT YEARS THE TERM** "global health" has largely replaced "international health" and attempts have been made to promote a standardized definition.[1–3] Despite its intention to move beyond the mindset of international development assistance implicit in "international health," global health is still very much preoccupied with how the "rich North" can contribute to improving the health of low- and middle-income countries in the "poor South." Thus, most grants on global health offered by governmental and nongovernmental agencies are usually restricted to interventions in low- and middle-income countries.

In this Commentary we argue that an important perspective—the circumpolar one—has been missing in the global health discourse and that the circumpolar perspective has much to contribute and gain by being part of global health research, practice, and policy development. The usual "north–south" orientation in exchanges and dialogue is given a new twist in that the northern regions within the rich North can be considered part of the low-income "South" in some respects. Global health concerns do not stop at high latitudes.

## DEFINING CIRCUMPOLAR

The lack of awareness of the circumpolar world is exemplified in a map accompanying an article on global trends in infant and child mortality published by a prestigious medical journal.[4] The world's largest island—Greenland—has completely disappeared, and is replaced by ocean! It is all the more ironic in that there is no lack of health indicator data from Greenland, where a high quality national statistical system exists and extensive health research has been undertaken for decades.[5]

The eight countries that are members of the Arctic Council (Canada, Denmark with its self-governing territories of Greenland and Faroe Islands, Finland, Iceland, Norway, Russia, Sweden, and the United States) constitute some of the world's most industrialized and developed nations. With the exception of Russia, these Arctic States occupy the highest ranks in most health indicators. For example, in 2010, Norway, the United States, Canada, and Sweden ranked within the top 10, and Finland, Iceland, and Denmark ranked within the top 20 on the Human Development Index, while Russia ranked sixty-fifth.[6] Yet substantial health disparities exist across the northern regions in different countries, and between the northern and southern regions within countries. Global health maps often gloss over the large health gaps that exist in some northern regions such as Nunavut in Canada by assigning it the same color code as the rest of the country. Nation-based comparisons thus dilute and hide important regional challenges within countries.

What constitutes the circumpolar world? We have identified 27 regions (Figure 1) that constitute the northernmost administrative units of the Arctic states (Alaska; the three northern territories of Canada; the northern counties of Norway, Sweden, and Finland; and various northern republics, oblasts, and autonomous regions of the Russian Federation) and several island-states in the North Atlantic (Greenland, Iceland, and Faroe Islands). All these regions are either wholly or have part of