Chapter 17
Migration of LGBTQI+ People: Sexual and/or Gender Minority Migrants, Refugees, and Asylum-Seekers

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17.1 Introduction

Informed by colonial legacies and contemporary geopolitical instabilities (i.e., dictatorship, organized and political violence, resource extraction, climate disasters, etc.), the violence and persecution faced by people with nonnormative sexualities and genders (Abu-Assab et al., 2017) have resulted in the forced migration of lesbian, gay, bisexual, trans, queer, and intersex (LGBTQI+) people, particularly from the Global South to the Global North (Lee et al., 2020). Over the past quarter century, there has been increased social and legal recognition of the realities of sexual and gender minority (SGM) migrants. Although this chapter focuses on LGBTQI+ asylum-seekers and refugees, it also makes links between these statuses and other types of precarious status, such as temporary workers, international students, and undocumented persons (Goldring & Landolt, 2013). Indeed, LGBTQI+ migrants with precarious status often shift between temporary statuses, especially since inland refugee claims are submitted at the border, or post-arrival to a host country with a different temporary status (Lee, 2019).

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As is evidenced in this introduction, the use of multiple terminologies to describe sexual and gender diversity can be challenging. Although the sexual and gender identity terms "LGBTQI+" are more commonplace in anglophone majority countries in the Global North, they have been critiqued as centering white-dominant identity formations within Western contexts, thus erasing Indigenous forms of sexual and gender expression that are often tied to social roles and ways of being instead of solely on identity (Lee et al., 2020). To shift away from sexual and gender identity formulations, "SGM" is a term used to describe people who hold a minority status related to their sexuality and/or gender. Another term, "nonnormative sexualities and genders," is also used to highlight how the promotion of sexual and gender norms results in the surveillance and control of the bodies and behaviors of people who do not adhere to these dominant norms (Abu-Assab et al., 2017). In order to take into account these complexities, all of these terms will be used for this chapter.

The terms "queer" and "trans" are often not only used as umbrella identity-based terms but are also associated with queer studies and trans studies, which deploys critical theorizing related to sexual and gender norms, expressions, and practices (Cohen, 2005; Lee & Brotman, 2015; Namaste, 2000), through a critique of heteronormativity and cisnormativity, which are defined in Table 17.1. Thus, this chapter draws from queer- and transmigration studies (Luibheid & Chavez, 2020) in order to interrogate how heterocisnormative logics are imbued within immigration and refugee law and the production of migrant status "in ways that continually reconstruct heterosexualized, gendered, racialized, cultural and imperial hierarchies" (Luibheid, 2008, p. 309).

Table 17.1 Key definitions

Cis/cisgender	The terms cis or cisgender are used for people whose gender identity has always been concordant with their gender assigned at birth (Serano, 2007)
Cisnormativity	Cisnormativity describes social norms, institutions, and practices that presume that everyone is always and only cis, thus erasing trans people and normalizing the gender binary (Bauer et al., 2009; Lee, 2018; Serano, 2007)
Heteronormativity	Heteronormativity describes the social norms, institutions, and practices that presume that everyone is heterosexual and that a monogamous heterosexual relationship between a cis man and cis woman is the only "natural" relationship (Cohen, 1997; Lee, 2018)
Heterocisnormativity	The term heterocisnormativity describes structures and circumstances when heteronormative and cisnormative processes are interconnected (Lee, 2018)

17.2 Overview of Emergence of Legal Recognition of SOGIE-Based Persecution

SGM migrant realities are complex, due to exposure to multiple overlapping forms of violence. SGM migrants are often forced to leave their country of origin due to heteronormative and/or cisnormative violence perpetrated by one's family of origin, broader community, or the state (Abu-Assab et al., 2017; TGEU, 2014), overlapping with other forms of social and political violence. According to the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA World), 67 countries explicitly criminalize consensual same-gender conduct, and two states employ de facto criminalization (Mendos et al., 2020, p. 25). Among these states, the death penalty is legally prescribed for consensual same-gender sexual acts in six countries (Mendos et al., 2020, p. 25).

Such legislation criminalizing same-gender relationships can be traced back to colonial rule. From 1860 onward, the French and British empires spread a specific set of legal codes and common law throughout their colonies that criminalized same-gender sexual relations between two men, as well as nonnormative gender expressions (Gupta, 2008; Lee, 2018). These laws did not originate from Indigenous legal codes and ways of being. Instead, they were conceived and imposed precisely because colonized areas were considered havens for so-called unnatural behaviors, which the colonial regime wanted to control, contain, and remove (El Menyawi, 2012; Hinchy, 2019). In fact, same-gender sexuality and gender diversity have existed and been honored across many societies in the Global South. As colonial regimes marked nonnormative genders and sexualities as "deviant," "carnal knowledge," and against the natural order, repression and control over sexuality and gender became ingrained into law and culture and continue into present day (Jjuuko & Tabengwa, 2018).

As a result, SGM living in the Global South is vulnerable to varying degrees of homophobic and/or transphobic stigma, discrimination, and violence. This violence can be state sanctioned, for example, through the police, who in some countries exploit LGBTQI+ people's fears of being outed to blackmail and extort them (Hamila & Labelle, 2019). This persecution by public authorities and a lack of protection of SGMs (sexual and gender minorities) creates a climate that permits hostile speech and actions in many spheres of society (Awondo et al., 2012; Currier, 2014). Trans women especially are disproportionately at risk of interpersonal and state violence (Itaborahy, 2014; OutRight Action International, 2016).

Moreover, a complex set of historical, political, social, economic, and transnational conditions shape the forced migrations of SGMs to the Global North (Abu-Assab et al., 2017; Awondo, 2010; Awondo et al., 2012; Dutta & Roy, 2014; Ekine, 2013; Lee et al., 2020; Zea et al., 2013). Studies suggest a country's political climate, especially with respect to high levels of civil unrest, organized violence (militia), generalized violence (gangs), gendered violence (sexual assault, rape, etc.), poverty, and religious extremism shape the ways in which LGBTQI+ people are exposed to homophobic and transphobic violence (Chhoeurng et al., 2016; Lee

et al., 2020). Even in states with SOGIE legal protections, LGBTQI+ people, especially those who are poor, cis and trans women, HIV positive, and disabled, are vulnerable to discrimination and violence (Pieterse, 2015; Regmi & Teijlingen, 2015; Salley, 2013). At the same time, SGM people living in the Global South, including those who migrate to the Global North, continue to survive and resist violence (Lee, 2019; Tourki et al., 2018). These pre-migration realities impact not only the decision to migrate to the Global North (Palazzolo et al., 2016) but also post-migration experiences, in particular for LGBTQI+ refugee claimants.

In 1991, Canada became one of the first countries to grant refugee status on the basis of sexual orientation (Jordan & Morrissey, 2013; LaViolette, 2013). The Supreme Court of Canada made a seminal decision in 1993 (Canada [A.G.] v. Ward) to explicitly include sexual orientation as a basis for refugee protection within the "social group" category, eventually including gender identity and expression (LaViolette, 2013). Around the same period, sexual orientation (and eventually gender identity and expression) gained legal recognition as a protected category within refugee law in other countries, such as the Matter of Acosta (the United States), GJ case (New Zealand), and Applicant A. and Another v. Minister for Immigration and Ethnic Affairs and Another (Australia, McGhee, 2001).

These developments in jurisprudence opened the way for the United Nations High Commissioner for Refugees (UNHCR) to recognize SOGIE-based persecutions. SOGIE asylum-seekers were first discussed during the UNHCR Global Consultations on International Protection (conducted in 2000 and 2002). This resulted in the publication of the Gender-Related Persecution Guidelines and the Membership of a Particular Social Group Guidelines, providing explicit recognition of SOGIE-based persecutions as grounds to grant refugee status (Hamila, 2021b).

Beyond UNHCR guidelines, several developments at the international level have led to the recognition of SOGIE-based persecution as grounds for granting refugee status as a fundamental principle of human rights (O'Flaherty & Fisher, 2008). These include the Yogyakarta Principles, of which the 23rd principle states that "everyone has the right to seek and enjoy in other countries asylum from persecution, including persecution related to sexual orientation or gender identity" (ORAM, 2010, p. 14). Soon after the release of the Yogyakarta Principles, UNHCR issued its first guidance note on SOGIE-based refugee claims (LaViolette, 2010). This note extends the UNHCR Guidelines issued in 2002 and draws heavily on the Yogyakarta Principles. Since then, a number of other countries have explicitly recognized SOGIE-based persecution as grounds for granting refugee status, particularly in Europe (Hamila, 2020). Currently, nearly 30 countries recognize these grounds. Please see Chap. 16 of this book for a more detailed overview of the asylum process in the United States and European Union. It should be noted, however, that the current UNHCR framework and implementation of LGBTQI+ refugee protection in the Global South may leave a number of refugees unsafe (Pincock, 2020). Indeed, most research into LGBTQI+ resettlement has focused on migration to the West, with few studies investigating the SGM experience at seeking asylum in the Global South. Scholars and activists have called for a more contextualized approach to humanitarian governance so as to afford a better protection of LGBTQI+ refugees

and asylum-seekers in the Global South, one that takes into account governmental, cultural, geographical, and historical realities that impinge upon resettlement capacities and safety (Pincock, 2020; LaViolette, 2010).

17.3 Overview of Post-migration Policy Challenges and Structural Barriers

On an international scale, national migrant visa systems in the Global North are one policy concern that impacts SGM migrants, limiting entry of forced migrants and resulting in a disproportionate burden on countries in the Global South to provide support for these populations (Lee, 2019; Morales, 2013). For example, Canadian visa restrictions and the Canada–United States "Safe Third Country Agreement"[1] prevent the vast majority of migrants, including LGBTQI+ migrants from the Global South, from accessing Canada's inland refugee claim process[2] (Lee, 2018).

In addition, further coordination between the UNHCR and various national governments is required in order to develop policies and protective measures for SGM people who are either living in refugee camps or recognized as refugees in a transit country in the Global South prior to resettlement in a country in the Global North (Abdi, 2011; Grungras et al., 2009; Lee et al., 2020; ORAM, 2013). Despite UNHCR recognition, SGM migrants in these contexts will continue to face state and community violence and ultimately premature death without pathways to durable solutions, which include greater commitments by countries in the Global North to increase opportunities for refugee resettlement (Portman & Weyl, 2013).

LGBTQI+ asylum-seekers encounter a number of challenges during the refugee claim process. Pre-migration experiences (or fear) of violence and resulting trauma certainly impact SGM asylum-seekers as they navigate the refugee claim process (Jordan, 2009, 2010; Shidlo & Ahola, 2013). For example, asylum-seekers are expected to present evidence not only of the persecution they faced but also of their identity as an LGBTQI+ person (LaViolette, 2009). Many people are not able to be open about their SOGIE in their home countries and thus cannot provide evidential records of their relationships (Lee & Brotman, 2011). The processing of SOGIE-based refugee claims has also been informed by sexual, gender, and racial stereotypes (Bennett & Thomas, 2013; LaViolette, 2009; Rehaag, 2008; Epstein & Carillo, 2014). In some cases, trans asylum-seekers are misevaluated by decision-makers as sexual orientation-based refugee claims (Berg & Millbank, 2013).

[1] Under the Safe Third Country Agreement between Canada and the United States, refugee claimants are required to request refugee protection in the first country they arrive in, unless they qualify for an exception to the agreement.

[2] In order to access the inland refugee claim process in Canada, migrants must make a request to file a refugee claim at the border (i.e., Canada–US border), at the airport upon arrival to Canada, or after crossing the border at a refugee claim office.

In order to assess the credibility of claimants' stories, protection officers currently employ three strategies for translating persecution into legal-administrative terms (Hamila, 2021a). A first strategy, based on a medicalized conception of sexual orientation, the so-called medical examinations (i.e., psychological examinations, etc.), may be used to establish a person's membership in the LGBTQI+ community. A second strategy, based on a subjective conception of "homosexuality," is conducting interrogations that often include sexually explicit, homophobic, or stereotypical questions to determine the applicant's sexual orientation. These strategies are invasive and highly problematic, as they are informed by the social and cultural worldview of the decision-maker instead of the refugee claimant, thus reproducing white and Western norms of understanding sexuality and gender (Jenicek et al., 2009; Lee & Brotman, 2011; Murray, 2015). A third strategy, qualified as "good practice" by LGBTQI+ NGOs, is based on a self-declared conception of SOGIE and consists of using the self-identification of the applicant (Hamila, 2021a).

Overall, there remains a disparity in the ways that SOGIE-based refugee claims are adjudicated across the Global North (Lee et al., 2020). An SGM asylum-seeker's chances in being recognized as a refugee are thus determined by their access to a particular state's refugee determination system, often after being refused entry into a certain number of countries. Therefore, countries need to improve their legal systems in order to ensure that SOGIE-based discriminatory practices are removed and add explicit measures that attend to specific challenges and barriers facing LGBTQI+ migrants. For example, in May 2017, the Immigration and Refugee Board (IRB) of Canada released a new set of guidelines for the adjudication of SOGIE-based cases. These guidelines include the use of an intersectional lens, appropriate language, protection of sensitive information, avoidance of stereotyping, and guidance on appropriate evidence (Lee et al., 2020).

Beyond the regulation of one's migration status, SGM migrants face challenges in navigating structural barriers to health care, housing, education, and employment (El-Hage & Lee, 2016). Factors such as immigration status, being racialized, and language proficiency, in conjunction with sexual orientation and/or gender identity, result in new, deepened, and complex barriers (Munro et al., 2013; Serrano, 2013). Some barriers are subtle; for example, LGBTQI+ newcomers often lack access to sexual health services and, as a result, have reduced access to sexual health information and practices (O'Neill & Kia, 2012). A main challenge is managing the tension between assertiveness and management of one's SOGIE in light of external forces (community members, service providers, society at large, etc.). While some people want to publicly affirm their SOGIE (El-Hage & Lee, 2016; Serrano, 2013), others do not want to use Western labels, such as LGBTQI+ (O'Neill & Kia, 2012), or do not feel the need to publicly "come out" as LGBTQI+ (Chbat, 2011; Roy, 2013).

Social workers can certainly contribute to policy changes that will improve the life chances and living conditions of SGM migrants. Social workers can be part of building power, shifting conversations, and enacting policy change from within and outside of government bodies and public institutions. This can include being involved in broader migrant and racial justice movements through community organizing, protests, and civil disobedience. Policy advocacy can also be advanced

through dialogue with policy makers and government decision-makers. Also, direct practice and policy advocacy can go hand in hand, for example, when supporting LGBTQI+ migrants to challenge discriminatory laws and policies, on individual or collective levels (Heller, 2009).

Transmigrant Policy Advocacy in Canada: Justice for Transmigrants (2010–2021)

Although other Canadian provinces allowed transmigrants with permanent residency to change their gender marker and name, in Québec this was not possible for transmigrants until gaining citizenship (Tourki et al., 2018). Various initiatives were facilitated with aims to change this policy, including workshops and actions led by transmigrants themselves, a political campaign launched in 2016 by LGBTQI+ migrant and trans health groups (i.e., Justice for Trans Migrants campaign[3]), and a court case led by a gender advocacy center and a legal advocacy group.[4] As a result, in March 2021 the superior court of Quebec declared citizenship restrictions on gender marker and name changes to be a violation of the rights of transmigrants, obligating the government to allow transmigrants to change their gender markers and names.

Social workers can also contribute to government action plans (related to immigration, sexuality and gender, health care, mental health services, employment, education, etc.) and advocate for participation of SGM migrants in decision-making processes around allocation of funding and resources. The lack of inclusion of the needs and realities of SGM migrants in these action plans results in a lack of funding to carry out the following:

1. Challenge heteronormative and cisnormative service delivery within the settlement sector.
2. Foster migrant-inclusive and anti-racist practices within queer and trans-specific services.
3. Foster intersectoral collaborations among settlement, health, youth, and queer and trans-specific services.
4. Facilitate SGM migrant-specific initiatives.

On a global scale, the arrival of COVID-19 has had devastating effects on all migrants, including SGM migrants, as public health efforts to stop the transmission of COVID-19 have resulted in further border restrictions, regressions in national immigration and refugee laws, and further surveillance and control of migrants with

[3] For more information about the Justice for Trans Migrations campaign, please see https://www.agirmontreal.org/en/tmc-press-release

[4] For more information about the court case, please see https://genderadvocacy.org/trial-updates/

precarious status. Social workers should thus also be attentive to how COVID-19 has fundamentally changed the ways various international and national policies continue to operate and their impacts on LGBTQI+ migrants.

17.4 Overview of Best Practices with LGBTQI+ Migrants

The literature on practice with LGBTQI+ migrants generally proposes clinical frameworks for working with LGBTQI+ migrants (Alessi & Kahn, 2017; Beaudry, 2018; Logie et al., 2016) and discusses the use of anti-oppressive practice (El-Hage & Lee, 2016; Heller, 2009; Lee & Brotman, 2013; Yee et al., 2014). Clinical frameworks focus on individual- or group-based mental health interventions that include and integrate understandings of trauma-informed care, minority stress, post-traumatic stress disorder, individual resilience, and strength-based approach (Alessi & Kahn, 2017; Beaudry, 2018; Logie et al., 2016). Minority stress can be defined as the effects of prejudice, discrimination, and violence against an individual based on their affiliation with a social group (i.e., sexual and/or gender minority, etc.), on psychological stress, and on the negative influence on one's health and well-being this causes (Cerezo, 2016; Meyer, 1995; Moritsugu & Sue, 1983). These frameworks recognize and treat the impact of interpersonal and state violence, in both pre- and post-migration contexts, that often results in trauma and decreases the daily functioning of LGBTQI+ asylum-seekers and refugees.

In contrast, anti-oppressive frameworks prioritize improving the material life conditions of SGM migrants, by fostering empowerment, naming and modifying structural barriers, and addressing oppressive social conditions (El-Hage & Lee, 2016; Lee & Brotman, 2013; Yee et al., 2014). As such, intersectional structural barriers need to be considered in intervention models for LGBTQI+ migrants as "the implementation of certain services needs to be improved, especially when it comes to specialized accompaniment and psychosocial support services" (El-Hage & Lee, 2016, p. 25). Originating in Black and women of color feminism, intersectionality considers how race, sex, gender, class, ability, status, and other social categories operate together to create entirely new forms of violence and marginalization, especially for multiply oppressed people (Collins & Bilge, 2016; Crenshaw, 1990; Lee & Brotman, 2013). Instead of seeking to help someone to adapt to their environment, anti-oppressive practice seeks to change structures, institutions, and practices, while also fostering collective forms of empowerment.

Both clinical and anti-oppressive frameworks promote reflexive practice for practitioners to gain awareness in how their social location and worker role shape how they build trusting relationships with LGBTQI+ migrants (Alessi & Kahn, 2017; George, 2012; Lee & Brotman, 2013). Critical self-reflection requires the ability to gauge how one's worldview and/or social privileges can result in certain biases or prejudices that can negatively impact the relationship-building process and service delivery. It is necessary for practitioners to engage in deep and active listening, be attentive to immediate needs, and be aware of how structural barriers may

shape access to care (Alessi & Kahn, 2017; Lee & Brotman, 2013). More broadly, these frameworks also recognize the need for services to be adapted in order to be responsive to intersecting racial, cultural, sexual, and gender diversity and needs within SGM migrant communities.

However, relevant frameworks that are not yet included in this literature include cultural humility and trans-affirmative frameworks. Cultural humility models include critical self-reflection to identify biases and assumptions, moving away from rigid/hierarchical notions of culture, recognizing that people are experts of their own experiences and cultural realities, and promoting a collaborative helping relationship (Ortega & Faller, 2011; Tervalon & Murray-Garcia, 1998). Trans-affirmative models include recognition of the following:

1. The role of transphobia and cisnormativity in society and within health-care contexts.
2. The de-pathologization of trans identities, which would eliminate barriers for trans people to access health care and social services.
3. Transphobic behaviors from health-care providers, such as misgendering and using people's names assigned at birth or deadnames.[5]
4. Being knowledgeable about gender identity and expression.
5. Health-care worker competency in using gender-affirming medical protocols (i.e., hormone replacement therapy, gender confirmation surgery, etc.)
6. Attending to psychosocial and mental health needs of trans people seeking trans-specific or general health care (Faddoul, 2019; MacKinnon et al., 2020; Reed, 2021).

Drawing from these frameworks may be complementary to reflexive and anti-oppressive approaches with LGBTQI+ migrants that have been favored in the literature.

To engage in practice with LGBTQI+ migrants, especially asylum-seekers, social workers need to be knowledgeable not only of local, regional, and national laws and policies but also of the laws, policies, and social conditions of SGM in their countries of origin. This knowledge is helpful in contextualizing SGM migrant realities, assessing the degree to which their pre-migration experiences are impacting their post-migration lives, and assisting LGBTQI+ asylum-seekers in preparing for refugee status determination hearings. Generally speaking, some of the services that social workers can provide include the following: psychotherapy; housing and employment referrals; psychoeducation; sharing information about immigration and refugee processes; assisting in accessing health care; social services and social assistance; accompanying people to, and/or testifying at, asylum hearings; and providing psychosocial evaluations. The service delivery process must attend to psychosocial and mental health impacts of pre- or post-migration violence and trauma,

[5] Please note that trans people use different terms to describe their name assigned at birth, such as "deadname," legal name, etc.

as well as to the psychic toll of the refugee process (Jordan, 2009, 2010; Shidlo & Ahola, 2013).

In order to apply a trans-affirmative approach with transmigrants, social workers must be attentive to the ways in which access to gender-affirming medical and health care is impacted by transphobia and cisnormative institutions and service delivery, immigration and refugee law and migrant status, and broader forms of xenophobia and racism (Tourki et al., 2018). Trans-affirmative care thus applies an intersectional approach that recognizes how other social categories (i.e., race, class, sexuality, ability status, etc.) shape trans people's access to care. It also emphasizes the fundamental importance of listening and respecting trans people and their self-determination (Faddoul, 2019; Lacombe-Duncan et al., 2020; MacKinnon et al., 2020; Medico & Pullen-Sansfaçon, 2017).

In recognition of the ways that SGM migrants are particularly susceptible to social isolation, relational approaches are also favored (Beaudry, 2018; Lee & Brotman, 2013). In addition to group intervention (Beaudry, 2018), peer support and intervention models (Fuentes-Bernal et al., 2021) provide innovations in fostering collective care. Through group work, LGBTQI+ migrants can build informal networks of support and "chosen families" (Beaudry, 2018). Engaging in arts and media-making projects and activities can foster community building and broader social movement building as well (Lee & Brotman, 2013; Lee & Miller, 2014; Lee et al., 2020). Generally speaking, the best practices explored in this section derive mostly from regions in the Global North. These practices would certainly need to be adapted if they were to be applied within low-resource societies, particularly transit countries situated in the Global South.

As discussed previously, the ways in which SGM people living across the Global South are exposed to homophobic and transphobic violence are shaped by broader geopolitical and economic forces, multiple types of violence (i.e., gendered, organized, etc.), and colonial heritages (Awondo et al., 2012; Dutta & Roy, 2014; Ekine, 2013; Lee et al., 2020). Practice with LGBTQI+ migrants situated in the Global South (those who migrate between two Global South countries) thus requires strategies that attend to these broader and overlapping social forces. At the same time, practice strategies must also be attentive to particular local conditions that shape the life chances afforded to migrants and, particularly, refugees with nonnormative sexualities and genders.

Certainly, there are many LGBTQI+ human rights groups and activists across the Global South who are defending the rights of SGMs in their region (Lee et al., 2020; ORAM, 2013). These groups and activists must be supported and can be sources of support for LGBTQI+ refugees (ORAM, 2013). However, some scholars have also cautioned that more visibility related to LGBTQI+ human rights does not neatly result in more safety and rights for queer and trans people in a particular region (Abu-Assab et al., 2017; El Menyawi, 2006). A key strategy to improve the rights and living conditions of sexual and gender minorities in the Global South is advocating for strengthened privacy laws (El Menyawi, 2006). Enhanced privacy laws in

combination with strengthened rights and supports for migrants, and especially those with refugee experiences, may result in a decrease of state surveillance and community targeting and violence against migrants with nonnormative sexualities and genders.

Social work practice with refugees with nonnormative sexualities and genders may need to mobilize more covert and informal support and advocacy strategies, instead of focusing solely on a SOGIE rights framework (Abu-Assab et al., 2017). Instead, social workers should reflect upon how to foster dialogue and create safety for people with nonnormative sexualities and genders through broader coalition building of groups and organizations fostering sexual health initiatives and women's access to education and working to improve the living conditions of various oppressed groups, such as people living with HIV, sex workers, refugee groups, etc. (Abu-Assab et al., 2017). Although some international NGOs may be inclusive of sexual and gender diversity, it is important to be careful of those run by Christian organizations located in Canada or the United States who explicitly declare LGBTQI+ identity as sinful and perverse (Kaoma, 2012). The UNHCR across various countries in the Global South has also explicitly identified the importance of providing protections for LGBTQI+ refugees, asylum-seekers, and stateless and internally displaced people.[6] Indeed, in some regions, the UNHCR is strongly encouraged to prioritize LGBTQI+ refugee claims and refugee resettlement (ORAM, 2013). Social workers can collaborate closely with the UNHCR in order to link SGM migrants into UNHRC refugee processes. Drawing from recommendations from the Organization for Refuge, Asylum and Migration (ORAM, 2013), social workers can develop the following practice strategies:

- Develop deep knowledge of local conditions for people with nonnormative sexualities and genders and also conditions that shape SGM migrant realities.
- Develop micro-practice strategies to subtly demonstrate or self-identify as welcoming to people with nonnormative sexualities and genders. For example, finding ways to talk about LGBTQI+ rights without explicitly using the terms lesbian, gay, trans, etc. or using imagery, flags, pins, or other indicators to signal an office or workplace is safe or friendly toward LGBTQI+ people.
- Build long-term, meaningful, and thoughtful relationships with local LGBTQI+ rights groups.
- Build ongoing working and informal relationships with LGBTQI+-friendly workers across various sectors, in order to foster a carefully established network of LGBTQI+-friendly service providers and increase access of SGM migrants to these services.
- Carefully build advocacy initiatives through coalition building across groups and organizations, in ways that consider both overt LGBTQI+ rights activism and more subtle forms of advocacy.

[6] For more information about how the UNHRC supports LGBTI people, please see https://www.unhcr.org/lgbti-persons.html

17.5 Extended Case Study: Clinic Mauve

This extended case study provides an in-depth example of an innovative LGBTQI+ migrant health clinic. Situated in Montreal (Québec, Canada), Clinic Mauve delivers integrated services to SGM migrants, providing medical, psychosocial, mental, and sexual health care, as well as an outreach program to share COVID-19-related information. The clinic mobilizes empowerment; harm reduction; intercultural, intersectional, interdisciplinary, anti-oppressive, trans-affirmative, and trauma-informed services; and center-informed consent. Social workers are key care providers at Clinic Mauve, providing psychosocial assessment and individual support, especially for those in crisis situations and/or requiring suicide risk assessments. Social workers also take on the role of "interconnectors" between clients and other health-care providers. The clinic's care structure is inspired by La Maison Bleue (Aubé et al., 2019), a community center and perinatal clinic that provides integrated medical and psychosocial care to mothers and families. It also draws from peer navigation, a type of peer-based intervention that aims to reduce structural barriers to accessing health care and social services (Shah et al., 2019).

Although the role of medical staff, including family doctors and nurses, is an essential part of integrated services provided at Clinic Mauve, this case study explores the provision of psychosocial and mental health care. The clinic collaborates closely with AGIR, a community organization formed by and for queer and transmigrants, which has been its primary referral source. As a first step, service users meet with a social worker and, in some circumstances, a peer navigator. The social worker is responsible for an initial assessment, which includes assessing for psychosocial needs, medical needs, and clinic capacity. The peer navigator (an LGBTQI+ migrant) can be present to accompany the service user to meeting spaces, reduce institutional stigma at times associated with being in a medical setting, and help with translation, as needed. As a team, the social worker and peer navigator explain to the service user how to access clinic services and how to navigate health care more generally, thus allowing the service user to make informed decisions related to their care. The clinic prioritizes access for specific individuals: those with precarious migrant status, such as asylum-seekers and undocumented people, those with complex physical/mental health needs, those in crisis and/or at medium or high risk of suicide, those with language barriers, and transmigrants seeking gender-affirming medical care.

The SGM migrants that have accessed Clinic Mauve report having experienced violence and trauma, including attempted murder, sexual abuse, witnessing murder, torture, suicide, family rejection, social exclusion, political violence, and SOGIE-based oppression. Due to a complex history of environmental and political stressors leading to their migration, LGBTQI+ migrants have faced many losses throughout their journey, which in turn lead to a sense of isolation. Although some clients described feeling more secure after migrating, they continue to encounter discrimination, violence, and isolation in Canada, sometimes provoking anxiety and re-traumatization. Such challenges can also further exacerbate complex trauma. The ensuing distress experienced by LGBTQI+ migrants is often expressed as grief,

depression, gender dysphoria, sexual and relational difficulties, lack of self-esteem, self-harm, and suicidal ideations. Since the arrival of COVID-19 and the imposition of strict public health measures, the number of service users experiencing crisis, extreme social isolation, and medium to high risk of suicide continues to intensify. Despite these challenges, service users have also demonstrated their creativity and capacity to survive and resist against multiple forms of violence and trauma.

The overlapping histories of pathologizing race, ethnicity, sexuality, and gender intersect. Thus, the biomedical model of mental health conceptualizes illness in ways that create multiple barriers for LGBTQI+ migrants to access care (Lee & Brotman, 2015). Integrated care offers a web of support and a safer environment, which in turn makes the role of each health-care provider clear and coordinated. This model recognizes the incredible resiliency of queer and transmigrants and aims to remove barriers and facilitate access to services and supports based on needs expressed by service users. Indeed, solidarity in health care is needed to provide a holistic understanding of individuals and to limit the impact of systemic and structural violence.

Post-assessment, clients at Clinic Mauve are referred to members of an interdisciplinary team: peer navigators, family doctors, nurse practitioners, psychologists, and mental health workers. Social workers may also refer clients to both public and community services outside of the clinic. The peer navigator can, for example, accompany service users to appointments related to housing, employment, and medical needs (i.e., dentistry) outside of the clinic. The role of psychologists and mental health workers (some of whom are registered social workers) is to provide psychotherapy and other mental health tools and supports in ways that are responsive to service users' cultural and political realities. The psychologist, for example, applies cultural safety and affirmative (O'Shaughnessy & Speir, 2018) and transcultural approaches (Kirmayer et al., 2014) in order to empower individuals and pay careful attention to their unique developmental and symbolic experiences. Trauma-informed practices (Herman, 2015) are also used, as most users have and continue to experience various degrees of violence and discrimination. More precisely, the use of intersubjective psychodynamic therapy (Orange et al., 2015), as well as Guattarian analytical therapy (Guattari, 2015), has been found to be a useful support for service provision beyond normative therapeutic dogmas.

So, what might the integrated services of the clinic look like for a queer migrant who only speaks Arabic, with complex mental health needs (i.e., suicidal ideation), relational challenges (i.e., extreme social isolation), and physical symptoms (i.e., loss of appetite/sleep deprivation)? With the support of an Arabic-speaking peer navigator, this person would be assessed by a social worker (in person, via telephone, or online) and referred to a doctor and a psychologist for their physical symptoms and mental health distress. The social worker would collaborate with the psychologist to conduct a suicide risk assessment and ensure that other psychosocial needs are addressed, and the psychologist would deliver weekly psychotherapy sessions. During these sessions, the peer navigator and/or a professional translator would be present to provide language support. If other needs are identified, such as a housing issue, the peer navigator can also meet with the service user outside of the clinic.

Clinic Mauve's team members meet weekly to discuss situations with service users, coordinate services, provide clinical support, and share resources. The clinical team is also regularly consulted by the outreach team to ensure that the programming and materials being developed reflect the needs and realities of the LGBTQI+ migrants being served by the clinic. Currently, outreach team members include peer navigators, an outreach program coordinator, and social work graduate students, some of whom are part of the LGBTQI+ migrant and/or racialized community. This has provided key learning opportunities for graduate-level social work students to develop practice skills and critically reflect upon the leading role that social work can play in innovating health systems. Given its emergence within the COVID-19 context, the purpose of the outreach program continues to shift over time.

One challenge that has emerged is providing services to SGM migrants who are at medium to high risk of suicide, especially given that the mobilization of a safety net is almost impossible if they do not have an intimate partner, their family of origin, parents, or friends living in their new community. Referrals to crisis intervention services, such as suicide help lines and crisis centers, are often not adapted to the needs and realities of LGBTQI+ migrants (i.e., due to language barriers, racism, xenophobia, heteronormativity, cisnormativity, etc.). Furthermore, undocumented LGBTQI+ migrants cannot avail themselves of emergency and/or psychiatric services, as they do not have insurance coverage lest they receive a steep health-care bill, which they cannot afford. Another compounding challenge is that LGBTQI+ migrants and asylum-seekers are typically afraid of and avoid seeking institutional services for fear of reporting to local authorities and possible deportation. To address this complex reality, Clinic Mauve is currently developing a community-based approach for crisis intervention in partnership with AGIR, interpretation services, and crisis phone lines, including various LGBTQI+ and immigrant/refugee community organizations. For example, the clinic is developing an initiative that will allow Spanish- and Arabic-speaking service users to access an LGBTQI+ telephone crisis line outside of clinic work hours. The clinic's outreach program is also developing mental health self-care programming, including tools and workshops, to aid service users to strengthen their own tools and strategies for well-being.

The complex needs of service users within an already under-resourced public health-care system stretched to its limit with COVID-19 have had a heavy toll on clinic psychosocial and mental health workers. Workers also navigate an institutional setting that, despite trainings offered, continues to perpetuate institutional and interpersonal forms of racism, heterocisnormativity, and other forms of discrimination. Clinical supervision is offered as a strategy to provide further support and counter worker burnout. The aims of clinical supervision are multifold and can be briefly summarized as the enhancement of supervisee competence to ensure quality of care and protection of service users. The American Psychological Association (APA, 2014) offers a model for supervision organized around seven domains: supervisor competence, diversity, supervisory relationship, professionalism, assessment/evaluation/feedback, professional competence, and ethical considerations. Best practices include using a strength-based approach and the delineation of supervisees' needs

and goals, including training, workshops, guidance, educational tools, follow-up on clients' needs and progress, and containment and emotional support.

The clinic has found a combination of group and individual supervision to be favorable. Individual supervision serves as an opportunity for team members to share experiences of countertransference that are less readily shared in a group context, such as personal experiences that may impact their work. Indeed, members of the clinical team may have life experiences or trajectories that resemble those of service users, for example, being part of the queer and trans community, having a refugee or migration experience, having faced pre- and post-migration discrimination, or transitioning. Education and continued guidance with respect to boundary setting improve supervisee feelings of competence and safety in performing their work (Pope & Keith-Spiegel, 2008). Individual supervision can also serve as an opportunity to discuss progress with regard to the acquisition of skills, as well as bidirectional feedback. Group supervision allows for discussion on how to adapt service delivery, further coordinate services, and integrate training on minority experiences in navigating institutions/health-care systems (Kirmayer et al., 2020) and systemic/structural violence. It also creates space for conversations on cultural humility and safety (Papps & Ramsden, 1996). The dialogue is ongoing and aligned with participatory pedagogical methodologies that emulate the philosophy and social change that the team strives to achieve (Freire, 1970).

17.6 Conclusion

This chapter begins with a brief overview of the historical and social construction of sexuality and gender in the Global South and maps the emergence of legal recognition of SOGIE-based persecution. In addition to a summary of post-migration policy challenges, including structural barriers experienced by SGM migrants, this chapter also presents a synthesis of the literature related to best practices with queer and transmigrants and shares an in-depth case study of an LGBTQI+ migrant health clinic. The role of the social worker within an interdisciplinary health setting is explored, as well as the relevance of including directly impacted people within an integrated service delivery model.

Certainly, LGBTQI+ migrants encounter many challenges in navigating migration and refugee processes, as well as a variety of intersecting structural barriers to accessing housing, employment, education, and health and social services. However, SGM migrants are also resourceful and resilient, both in navigating complex immigration and refugee processes on an individual level and through community building and advocacy campaigns on a collective level, such as the Justice for Trans Migrants campaign. Thus, the role of the social worker in working with LGBTQI+ migrants can be manifold. At times, social workers can provide psychosocial support, such as accompanying SGM migrants in navigating the asylum-seeking process or addressing various structural barriers. In other circumstances, social workers can be engaged in policy advocacy and community-organizing initiatives with queer

and transmigrants to build collective power, with aims of challenging and changing oppressive laws and policies. Sometimes, social workers can provide clinical services, such as offering mental health supports and building pathways for healing or simply bearing witness to multiple discriminations, pain, anguish, and triumphs that LGBTQI+ migrants encounter in their everyday lives.

As demonstrated throughout the case study, social workers can also collaborate with other health-care workers in order to provide integrated health care. Within this context, social workers can play a leadership role in intake processes, ensuring coordination between services and health-care workers, as well as fostering continuity of care. Within this context, people who are directly impacted also have an important role to play in service delivery. Social workers can thus foster and support queer and transmigrants in providing peer-based care. Although beyond the scope of this chapter, it is important to recognize that LGBTQI+ migrants can also become social workers and contribute to shifting and/or challenging mainstream models of service delivery.

This chapter focuses on best practices with LGBTQI+ migrants mostly within contexts in the Global North. It is certainly relevant to critically reflect upon how applicable these best practices might be within other contexts, such as within refugee camps in transit countries or when SGMs migrate between countries within the Global South. Within these contexts, clinical frameworks would most likely be limited, as they rely on individual-oriented and mental health-focused healing, which is simply more difficult to address when material deprivation, malnutrition, and social violence are more immediate and commonplace. Anti-oppressive frameworks seem more relevant within these contexts as they can provide an analytical lens that can clearly identify structural changes required to improve peoples' living conditions. However, these frameworks become limited when the ways to address oppressive social conditions are actually related to geopolitical considerations and political decisions made by policy makers in the Global North. To address these complexities, social workers can engage in transnational and decolonial feminist approaches to social work in order to do the following:

> …[situate] oneself and one's relationship to social work; [carry out] critical analysis of how gender and sexuality is mediated by colonial and imperial logics; [challenge] the singular focus on individual and identity-based human rights; [and develop] a deep understanding of the perspectives of directly impacted people through dialogue and ongoing, often long-term, relationship building (Caron & Lee, 2020, p. 82).

17.7 Reflection, Critical Thinking, and Discussion

The following prompts and questions provide a basis for reflection, critical thinking, and discussion on key points raised in this chapter:

1. What did you learn about the ways in which sexuality and gender were socially constructed, both within the Global South and within Canada and the United States?

2. What are the international governing bodies and protocols relevant for SOGIE-based rights and refugee claims?
3. How do the national, regional, and local immigration and refugee laws and policies impact SGM migrants in your particular context?
4. How might social workers engage in policy change, advocacy, and awareness raising in support of LGBTQI+ migrants?
5. What kinds of structural barriers might SGM migrants encounter when accessing health and social services?
6. What are the key challenges for social workers when working within an interdisciplinary setting that includes other health-care providers?
7. What are the key challenges for social workers supporting LGBTQI+ migrants within a context of a noninclusive society?
8. Which social work practice strategies seem applicable to social work practice settings that serve SGM migrants in your particular city, region, etc.?
9. How does COVID-19 change the way that health care and social services are delivered to LGBTQI+ migrants? What are the impacts of COVID-19 on social workers in these contexts (i.e., working conditions)?

17.8 Pedagogy Suggestions for Course Instructors, Supervisors, and Trainers

The following suggestions aim to support instructors, supervisors, and trainers in reaching their educational and supportive objectives:

1. Locate well-researched documentaries, radio shows, and podcasts that explore the realities of LGBTQI+ people and migrants within your particular region:
   - Mapping Memories project, http://www.mappingmemories.ca/queer-eye-newcomer-community-tour/video/queer-eye-behind-scenes.html
   - The Gospel of Intolerance from the NYT, https://www.nytimes.com/2013/01/23/opinion/gospel-of-intolerance.html
   - Welcome to Chechnya, https://www.hbo.com/documentaries/welcome-to-chechnya
2. Be wary of the dominant discourse that suggests that Canada and the United States are "safe havens" for LGBTQI+ migrants. This discourse can obscure the ways in which LGBTQI+ people, especially trans people, continue to experience violence and discrimination in Canada and the United States. It also erases structural barriers (due to immigration and refugee policy, institutional policies, etc.) that queer and transmigrants encounter when attempting to access education, employment, health and social services, etc.
3. Consider inviting a social worker and/or community leader who has experience in supporting LGBTQI+ migrants.

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