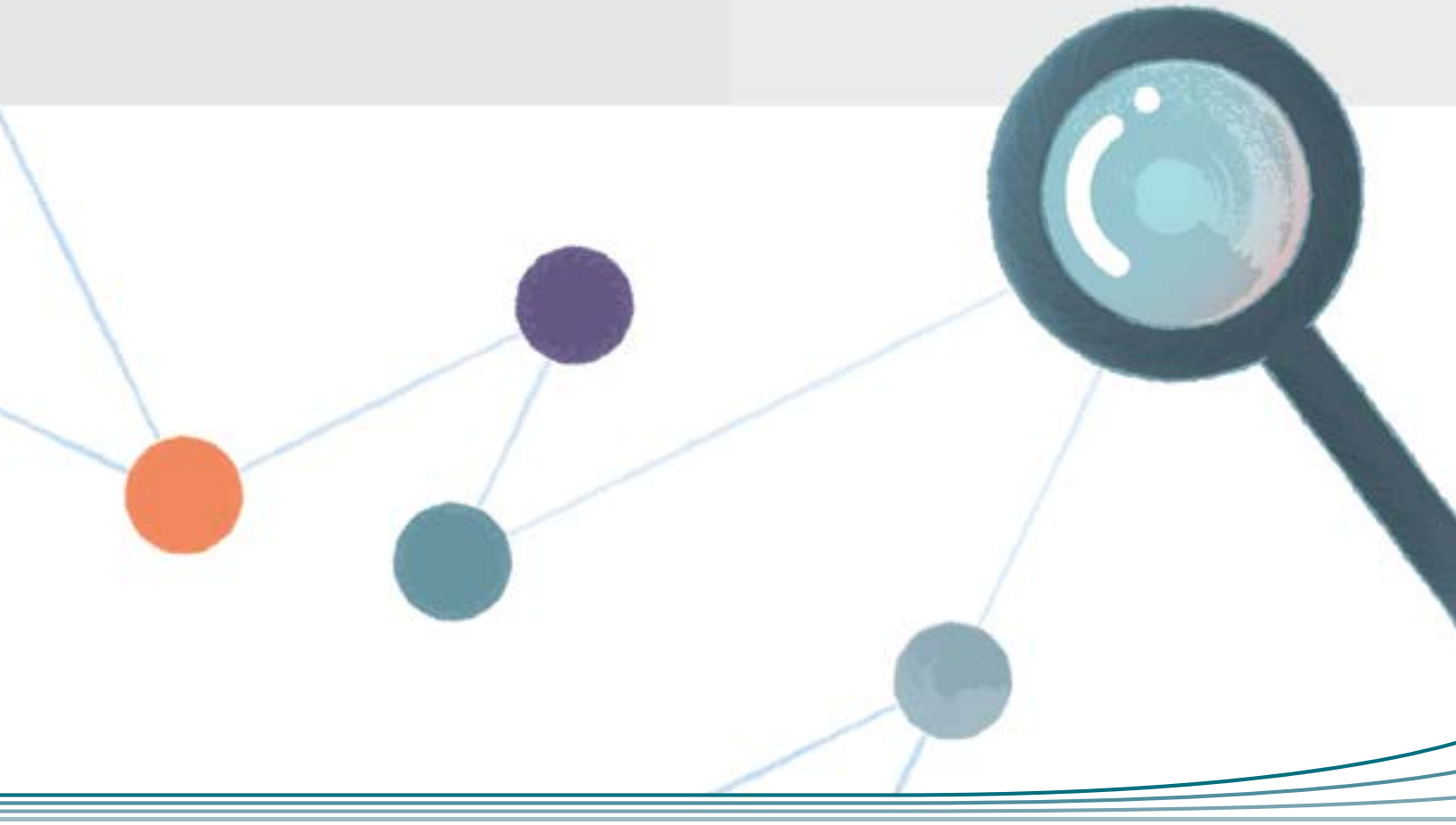
HEIA

Health Equity Impact Assessment

Health Equity Impact Assessment: LGBT2SQ Populations Supplement



sherbourne HEALTH

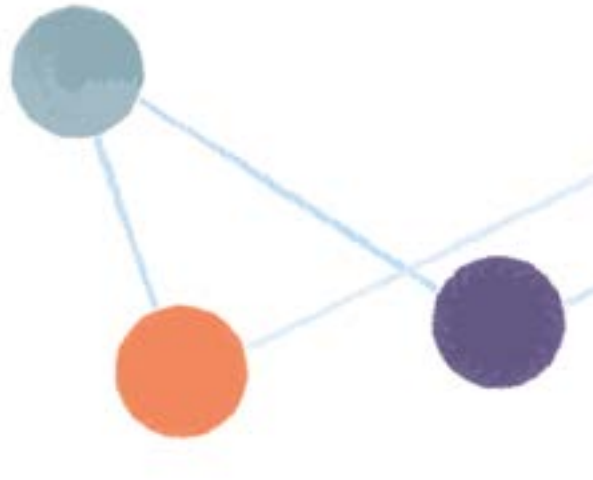
Rainbow Health Ontario

Ontario

Table of contents

The Ministry of Health and Long-Term Care (MOHLTC) has identified equity as a key component of quality care. MOHLTC has developed the **Health Equity Impact Assessment Tool** (HEIA) to support improved health equity, including the reduction of avoidable health disparities between population groups. The HEIA includes a template and workbook. It is complemented by population specific supplements such as this one for LGBT2SQ populations.

Canada has made substantial progress in passing laws protecting LGBT2SQ populations, but disparities in social and health outcomes persist. Unconscious bias from a limited understanding of the realities of sexually and gender-diverse people affects policies and practices, contributing to these disparities. As in all communities, LGBT2SQ people have intersecting identities, many of which expose them to further marginalization. Dedicated attention to serving and supporting the full diversity of LGBT2SQ communities contributes to improved health outcomes.



Guiding strategies for your policy or program

These principles for planning, evaluation, programming, outreach and communications will help encourage more equitable outcomes for LGBT2SQ populations.

Planning and evaluation

During planning and evaluation stages, assume there are disparities for LGBT2SQ people in any health issue, even if it seems unlikely. Always keep in mind that LGBT2SQ communities are diverse, with many members at the intersections of multiple marginalized identities. Additionally:

- consider collecting data about sexual orientation and gender identity;
- consider collecting data on Indigenous identities in accordance with existing Indigenous data governance standards, recognizing that not all Indigenous people may choose to disclose;
- develop inclusive outreach and intake processes that reflect diverse identities; and
- include LGBT2SQ-targeted policy and planning initiatives in strategic or operational priorities, such as commitments to equitable access to services.

Programming

Develop welcoming, and, where clinically indicated, specific programming for LGBT2SQ people. Also:

- **ensure content is reflective of the experiences of LGBT2SQ populations and can contribute to better outcomes.** For instance, in parenting groups, acknowledge the experiences of LGBT2SQ parents, normalize discussion of LGBT2SQ children, and guide parents to supports.
- **avoid language that can have the effect of rendering LGBT2SQ people invisible within programming.** For example, avoid heteronormative language or language that reinforces gender binaries such as “the opposite sex,” “both genders,” “mother and father.” Instead, use inclusive language that reflects diverse identities such as “all genders” and “parents.”

Note that not all Indigenous people use the term “Two Spirit” to describe their identities; some simply use terms such as lesbian, gay, bi, queer, or trans.

For a glossary of terms and key concepts, see **https://www.rainbowhealthontario.ca/glossary/**

Outreach activities and direct community engagement

Always be mindful of patient privacy and confidentiality needs of LGBT2SQ clients, and:

- integrate outreach and engagement into your work, so input from LGBT2SQ communities can ensure your initiatives are reflective of the communities' lived experiences and realities;
- engage in capacity-building activities to help staff build their understanding and skills in relation to specific LGBT2SQ-related health issues; and
- have resources and referrals available to guide LGBT2SQ populations towards LGBT2SQ-specific services as needed.

Communications

In communications strategies and campaigns, anticipate legitimate service user distrust, and demonstrate humility and sincerity in your tone, approach and relationships. When evaluating your campaigns and materials from an LGBT2SQ health equity lens, consider:

- web and print material accessibility;
- language clarity and simplicity; and
- who may or may not see themselves represented in any visuals you may use.

Timeline: Key issues affecting LGBT2SQ people in Canada

• **1700s**	As settlers arrive in Canada and the impacts of colonization begin to take effect, gender diversity starts to become stigmatized in Indigenous communities, which previously celebrated these identities
• **1850s–1990s**	Although Indigenous societies acknowledged multiple genders, Indigenous children are forced to identify as either male or female in residential schools. Teachings regarding multiple genders, as well as the roles themselves, are lost through colonization
• **1969**	Homosexuality decriminalized
• **1973**	Homosexuality removed from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)
• **2005**	Same sex marriage legalized by the Federal government
• **2011**	World Professional Association for Transgender Health (WPATH) *Standards of Care 7* released, depathologizing trans identities and experiences
• **2017**	Bill C-16 added gender identity and gender expression to the list of prohibited grounds of discrimination in the *Canadian Human Rights Act* and the *Criminal Code*

Many LGBT2SQ adults and older adults have experienced discrimination from governments and other institutions, including being confined to psychiatric institutions due to their sexual orientation or gender identity, or seeing their friends and partners die—in part due to inaction—in the face of the HIV crisis in the 1980s.

While many Canadian LGBQ youth and young people have grown up with greater rights protections than previous generations, trans and Two-Spirit identities have not had this experience.

It is important for health care providers to be aware that this may impact health service use, levels of trust or comfort with providers and organizations, and the degree of openness among LGBT2SQ clients.

Social determinants of health and LGBT2SQ communities

Table 1: How social determinants of health affect LGBT2SQ populations

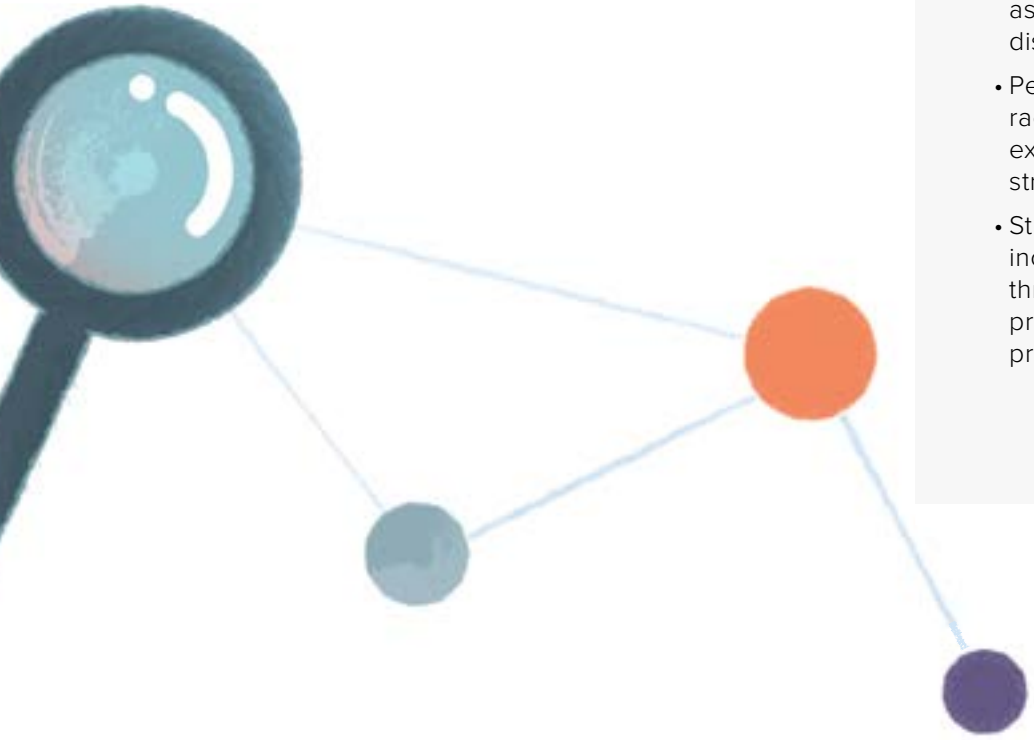
Income	• barriers to education and secure employment contribute to income inequalities; LGBT2SQ people who are Indigenous, racialized, and/or who are newcomers face additional barriers • the myth of gay affluence renders poverty issues invisible among LGBT2SQ populations • income inequality or wage gap is present in certain sectors • rates of unemployment and underemployment are high in trans populations
Education	• discrimination and harassment in schools is a risk for completing high school • social and familial support is crucial for positive educational outcomes • GSA's (Gay-Straight Alliances or Genders and Sexualities Alliances) in schools can greatly increase someone's sense of support and belonging, contributing to overall well-being • an inclusive curriculum reflective of sexual and gender diversity of students can contribute to their sense of belonging and social support • comprehensive sexual education can contribute to better health outcomes among LGBT2SQ youth, including reduced pregnancy involvement
Social Support	• sources and availability of social support may differ between locations, i.e. between urban and rural contexts • **supportive families and communities can build resilience**. Conversely, an absence can serve as a barrier to healthy development and increase likelihood of high-risk behaviours. Unfortunately, knowledge of how to support LGBT2SQ youth among family members is often limited • there are very disproportionate rates of LGBT2SQ-identified youth among homeless and street-involved youth • faith-based communities may act as a source of, or barrier to, support
Employment	• experiences and fears of workplace harassment and discrimination may prevent people from being out at work, contributing to additional minority stress • an inclusive workplace culture with policies to support LGBT2SQ employees against discrimination and harassment can foster safety and belonging in the workplace • there is a critical lack of job security for certain segments of the population, in particular people who identify as trans and/or non-binary

Belonging, health, culture and LGBT2SQ identities

Certain groups experience higher rates of social exclusion and poorer health indicators.

In many instances, bisexual people have worse health indicators than their gay and lesbian counterparts. In addition to homophobia and heterosexism, bisexual individuals are often exposed to biphobia. As part of this, they experience invalidation of their identities, since legitimacy of sexual orientation is often only granted to monosexual—straight, lesbian, and gay—identities. This invalidation stems from both within and outside of LGBT2SQ communities. These factors are related to poorer mental health and higher rates of mental health service use in this population.

For Indigenous peoples, a key determinant of health is their connection to their culture. Colonial policy in Canada attempted to assimilate Indigenous children through residential schools. The result was that Indigenous languages, cultures and traditions were not passed down, including Two-Spirit teachings.



Minority stress

The minority stress model is often used to examine LGBT2SQ health inequities. It states that "**...stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems.**"

Physical health disparities are also attributed to minority stress: prejudice or lack of knowledge of LGBT2SQ-specific needs among healthcare providers results in underuse of health services among LGBT2SQ people, and, consequently, worse health indicators.

The effects of social stigma and discrimination can cause a variety of coping mechanisms, such as tobacco, alcohol and drug use.

The available LGBT2SQ health outcome data demonstrates the results of minority stress:

- LGBT2SQ people tend to have worse mental and physical health outcomes in many areas than their heterosexual, cisgender peers, as a result of marginalization and discrimination.
- People who are LGBT2SQ and racialized and/or Indigenous may experience a heightened degree of stress.
- Structural barriers to LGBT2SQ inclusion can be in part addressed through a shift in the guiding principles behind policy and programming initiatives.

Specific outcomes of LGBT2SQ health disparities

Due to discrimination, harassment and barriers to equitable health services, LGBT2SQ communities experience:

- higher rates of **mental health** concerns, including depression, anxiety and substance use;
- lower screening rates and higher rates of certain cancers and chronic conditions; and
- higher rates of HIV infection among men who have sex with men and certain segments of the trans population.

Trans populations face many of the same health-related challenges that other members of the LGBT2SQ community face, while encountering even greater barriers to social inclusion and higher rates of discrimination and stigma. In addition, the barriers they face to accessing necessary transition-related care and services are associated with poorer mental health and high rates of suicidality.

As a result of social stigma and discrimination, LGBT2SQ people report higher rates of depression, anxiety and mental health challenges:

- LGBT2SQ youth are 2-3 times more likely to **attempt suicide** than their heterosexual, cisgender peers.
- One Ontario-based study found 47% of trans people age 16-24 had considered suicide recently, and 19% had attempted suicide in the past year.
- Racialized LGBT2SQ individuals have mental health needs nearly 5% higher compared to non-racialized LGBT2SQ people, and 16% higher compared to cis-hetero-non-racialized people.
- A high burden of **mental and emotional** distress has been associated with higher rates of coping behaviours such as **tobacco, alcohol and drug use**, all of which are more prominently seen in LGBT2SQ communities.

Racialized and Indigenous populations

Two-Spirit, Indigenous, and racialized LGBTQ populations often face systemic racism in addition to homophobia and transphobia when seeking medical and mental health care. For Two-Spirit and Indigenous LGBTQ populations, historic trauma through colonization in Canada has led to a deeply-held mistrust of service providers, which can cause reluctance to access care when needed. Additionally, a lack of cultural competency in practitioners has made it difficult for Two-Spirit, Indigenous and racialized LGBTQ people to access culturally appropriate care.

Youth

LGBQ youth have **higher rates of involvement in pregnancy** than their heterosexual counterparts. The contributing factors are higher rates of high-risk sexual behaviour—including younger age at time of first sexual encounter—higher numbers of sexual partners, and engaging in intercourse under the influence of substances.

Family rejection, attempts to hide LGBQ identities due to ongoing stigma, and the lack of relevant sexual education for LGBQ youth may all play a role in these discrepancies.

Seniors

LGBT2SQ **seniors face unique challenges**. Some may feel it necessary to go back into the closet out of fear of harassment and/or substandard care as they seek out long-term care. Aging in their home community may serve as a protective mechanism against discrimination and harassment in a care setting.

Historically, they have been at risk of not having partners recognized during end of life and care planning, and so, to maintain independence, they may be more inclined to rely on informal care networks—which often bridge the gap in family of origin support that can be lacking.

Considerations for health care

Consideration	LGBT2SQ	Trans and Two-Spirit
Population size	• actual unknown, which limits planning and programming • people who identify as LGB2SQ are estimated to be 3-4% of the population; however estimates may be much higher when men who have sex with men (MSM), and women who have sex with women (WSW), who may identify as straight, are included • although the number of people openly identifying as LGB2SQ has been increasing, clinically appropriate and culturally safe health services for LGB2SQ populations continue to lag	• actual unknown, which limits planning and programming • trans people are estimated to be approximately 0.6% of the population • over past 20 years, the number of people coming out as trans and seeking some form of transition-related care has been increasing exponentially, while medical and social supports have not kept pace

Clinical competency and cultural safety of service providers and organizations	• a heteronormative and/or cisgender set of assumptions and framework often surrounds service provision, including, but not limited to:
	  • paediatric care
	  • ob/gyn
	  • mammogram clinics
	  • geriatric care
	• limited knowledge and understanding of unique issues related to LGBT2SQ health and specific health indicators that are of concern for sexual and gender minority populations
	• limited ability to create conditions where patients are comfortable disclosing sexual orientation and/or gender identity, along with related concerns
	• heightened need for confidentiality between service providers and clients, and increased risks if confidentiality is broken
	• limited understanding of the historical relationship between Indigenous communities and health care institutions
	• limited understanding of Indigenous people's and newcomers' worldviews regarding health and well-being, as well as regarding sexual orientation, gender identity and expression
	• identity as well as related Western concepts like "coming out," and how to work respectfully and effectively with different worldviews in clinical practice
	• limited availability of trauma-informed counselling that can adequately explore issues of relevance to LGBQ, Two-Spirit, and trans populations
	• discrimination and harassment experienced when accessing the health care system	

Consideration	LGBT2SQ	Trans and Two-Spirit

Cultural and clinical competency of service providers and organizations	• varying levels of ability to engage respectfully with LGBT2SQ clients, including:
	  • use of appropriate language surrounding partners
	  • use of proper pronouns and identity markers
	  • sensitivity needed around trans people's bodies
	  • intake forms that are inclusive and allow trans and non-binary patients to self-identify	

Availability of transition-related care		• extremely limited, which contributes to greater mental and emotional distress for people seeking to transition • **need for quality care for trans and non-binary children and their families**
Preventative care needs	• fostering supportive environments for health-conscious behaviours such as exercise and mobility programs • relevant information regarding health promotion and prevention for LGBT2SQ populations • cultural awareness around care practices for Indigenous LGBT2SQ populations, as well as for newcomers to Canada • sensitive provision of services for gendered diagnostic screening, including within **trans and non-binary populations**	
Sexual health needs	• informed, appropriate discussion of sexual behaviours and practices • reminders to get standardly indicated screenings, including for sexually transmitted infections, given underuse of health services • appropriate and relevant information on an ongoing basis	
Reproductive options and parenting concerns	• possibility of donor or surrogate required • heteronormative assumptions often made surrounding parenting roles based on physical characteristics • children of LGBT2SQ parents can experience bullying	• gametes may need to be preserved prior to some gender-affirming surgeries • possibility of donor or surrogate required • assumptions often made about parenting roles and desires based on gender identity and/or biological processes • chest/breastfeeding needs may vary

Additional resources to guide your work

- Rainbow Health Ontario and The 519: **Media Reference Guide to Discussing Trans and Gender-Diverse People**
- Canadian Professional Association for Transgender Health (CPATH): **Literature Review to Support Health Service Planning for Transgender People**
- Toronto Public Health, St. Michael's Hospital, Centre for Addictions and Mental Health, and Mount Sinai Hospital: **We Ask Because We Care: The Tri-Hospital & TPH Health Equity Data Collection Research Report Project.**
- Two Spirits of the First Nations: **2Spirits.com**

References

Baker, S. & Lucas, K. (2017). Is it safe to bring myself to work? Understanding LGBTQ experiences of workplace dignity. Canadian Journal of Administrative Sciences, 34(2), 133-148.

Bauer, G., Boyce, M., Coleman, T., Kaay, M., Scanlon, K., & Travers, R. (2010). Who are trans people in Ontario? 1(1) Toronto: Trans PULSE E-Bulletin.
Available at **http://transpulseproject.ca/research/who-are-trans-people-in-ontario/**

Bauer, G., Scheim, A., Pyne, J., & Travers, R.,. Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: A respondent driven sampling study in Ontario, Canada. BMC Public Health, 15, 525.

Flores, A., Herman, J., Gates, G., & Taylor, N. (2016). How many adults identify as transgender in the United States? Los Angeles, CA: The Williams Institute. Available at **https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf**

Hatzenbuehler, M.L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. Psychological Bulletin, 135, 707-730.

Hunt, S. (2016) An introduction to the health of Two-Spirit people: Historical, contemporary, and emergent issues. National Collaborating Centre for Aboriginal Health.
Available at **https://www.ccnsa-nccah.ca/docs/emerging/RPT-HealthTwoSpirit-Hunt-EN.pdf**

Lick, D., Durso, L., & Johnson, K. (2013). Minority stress and physical health among sexual minorities. Perspectives on Psychological Science, 8(5), 521-548.

Meyer, I. (2003) Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychological Bulletin, 129(5), 674-697.

Pathways Project (n.d.). Experiences of Racialization and Mental Health Service Access for LGBTQ People. Downloaded from **http://lgbtqhealth.ca/docs/PathwaysProjectRacialized.pdf**

Jackson, B., Daley, A., Moore, D., Mulé, N., Ross, L. & Travers, A. (2006). Whose public health? An intersectional approach to sexual orientation, gender identity and the development of public health goals for Canada: A discussion paper of the Ontario Rainbow Health Partnership Project. Toronto, ON.

Rainbow Health Ontario (2013). LGBTQ Youth Suicide. Evidence Brief.
Available at **https://www.rainbowhealthontario.ca/resources/rho-fact-sheet-lgbt-youth-suicide/**

Taylor, C., Peter, T., Schachter, K., Paquin, S., Beldom, S., Gross, Z., & McMinn, TL. (2008). Youth Speak Up About Homophobia and Transphobia: The First National Climate Survey on Homophobia in Canadian Schools. Phase One Report. Toronto ON: Egale Canada Human Rights Trust.
Available at **https://winnspace.uwinnipeg.ca/bitstream/handle/10680/143/CG%20Taylor%20-%20Climate%20Survey%20-%20Phase%20One%20Report.pdf**