2015

LGBTQ Health

Results from Community Consultations

PublicHealth
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Executive Summary

LGBTQ individuals are as diverse as the general population in their experiences with health and well-being. Many of the social determinants of health, including income and education, impact LGBTQ individuals in a variety of ways; however, some determinants of health, such as social marginalization, uniformly impact the health and well-being of people in the LGBTQ community. The impact of these social determinants results in heightened levels of stress, putting LGBTQ individuals at an increased risk of particular health issues and contributing to the inequitable burden of poor health outcomes. LGBTQ status has been shown to impact a variety of health outcomes and behaviours including: mental health; substance use; tobacco use; sexual health; violence/safety; nutrition, fitness, and weight; reproductive health and parenting.

National, provincial and local data on the LGBTQ population is limited for many reasons including:

- The Census and the Canadian Community Health Survey (CCHS) only began collecting data on the LGBTQ population in 2001 and 2003, respectively. The questions asked do not pertain to sexual behaviour or gender identity.
- Underreporting of LGBTQ status occurs frequently, due to fear of disclosure.
- Many individuals with same-sex attraction or individuals that engage in same-sex behaviours do not identify as gay or bisexual.
- Data often excludes many subpopulations of people that might identify as LGBTQ

The most widely accepted statistic is that close to 10% of the general population identifies as LGBTQ; using population counts from the 2011 Census, that equates to approximately 26,500 people in Wellington-Dufferin-Guelph (WDG).

A two-part study was conducted on LGBTQ health services and supports locally. First, a community survey for self-identified LGBTQ individuals was conducted, which asked local individuals about their experiences with and perceptions of Wellington-Dufferin-Guelph Public Health (WDGPH). Second, in-depth interviews were conducted with service providers from LGBTQ-friendly/focused agencies, which asked about local health supports for LGBTQ individuals, barriers faced by these individuals when accessing services, and the role that Public Health could play in improving the health and well-being of LGBTQ individuals locally. Results from these studies suggest that Public Health is not yet considered an LGBTQ-friendly organization by clients, community partners, and local service providers.

Based on the findings from the study, it is recommended that actions to address the health disparities experienced by the LGBTQ population should involve a series of coordinated efforts which include policy changes, creating supportive environments, and developing personnel skills. As a starting point, it is recommended that WDGPH improve data collection on LGBTQ-identified individuals, increase visibility of LGBTQ individuals in health

promotion strategies and materials, receive Positive Space training, and acquire and utilize additional LGBTQ resources.

Improved Local LGBTQ Data Collection

Collecting local data on the LGBTQ population will increase knowledge of the population and fill current data gaps. To achieve this, WDGPH could identify or create a brief questionnaire for collecting information on the LGBTQ population, in consultation with members of the LGBTQ community. These questions could be widely shared with Agency staff so that they could be added to any surveys that ask for demographic information. This would improve the understanding of the LGBTQ population with WDG. Additionally, a health status survey specific to the LGBTQ population could be undertaken.

Increased Visibility of LGBTQ Individuals in Health Promotion Strategies

Despite the impact of gender identity and sexual orientation on health and well-being, most health promotion strategies are not targeted or inclusive of the LGBTQ community. Informative and culturally-appropriate health promotion strategies and materials are needed for the LGBTQ community. This could involve including photos of queer-identified individuals in health promotion pamphlets, promoting LGBTQ-specific services locally, and ensuring inclusive language is used on the WDGPH webpage.

Agency-Wide Positive Space Training

"Positive Space" is a program that was initially developed by the University of Toronto in 1996. Since its inception, the concept of a Positive Space has spread to most Canadian universities, and increasingly, community-based organizations, such as public health units. An agency that is a Positive Space is one that is open, welcoming, and provides equitable access to people of all sexual and gender diversities (OPHA, 2011). Inclusive personnel policies and practices provide the framework to support a Positive Space. An additional component is staff understanding and awareness of the LGBTQ population which is achieved through staff training around the issues of sexual and gender diversity.

When an agency is a Positive Space, LGBTQ people know that they are entering an inclusive atmosphere that is a safe venue for questions and open discussion of sexual orientation and gender issues. They know that they will not be discriminated against on the basis of sexual orientation or gender diversity and they know that they will receive services with dignity and respect. This is particularly important in a healthcare setting (OPHA, 2011).

Within the WDG area, there are several organizations that could certify WDGPH as a Positive Space. The Positive Space Network of Halton (The Network) has the most comprehensive curriculum and the most experience in terms of certification of larger organizations including Halton Public Health. The Network recognizes the importance of providing a local perspective on LGBTQ issues and has suggested partnering with HIV/AIDS Resources & Community Health (ARCH) as a guest speaker. ARCH welcomes the idea of a cross-agency partnership in order to better suit the needs of WDGPH. The Network also

recommends that all Agency forms and documentation be reviewed to ensure they are LGBTQ inclusive. In addition to this documentation review, changes to the physical environment of the Agency, such as the creation of gender neutral washrooms, is recommended.

Acquire and Utilize Additional LGBTQ Resources

It is recommended that the Agency acquire additional LGBTQ resources for use by staff and clients, such as pamphlets for distribution regarding LGBTQ-specific health issues (e.g., transgender hormone therapy, LGBTQ parenting, and insemination procedures), and community resources and support groups for LGBTQ youth, adults and seniors. Improved knowledge and resources of WDGPH employees would enhance the quality of care received by LGBTQ individuals and facilitating a more welcoming environment.

Introduction

This report examines the access to and quality of health services experienced by gender and sexually diverse populations in Wellington, Dufferin, and Guelph. It provides an overview of LGBTQ-specific health issues and the impacts of the social determinants of health on this marginalized population. Additionally, it reviews both local and national level data to paint a picture of the LGBTQ community in the WDG area and their experiences with health services. Finally, it addresses strategies to improve the internal capacity of Public Health to provide inclusive and equitable services to people of all gender and sexual identities.

'LGBTQ' Defined

LGBTTTIQQ, often shortened to LGBTQ, is an umbrella term for lesbian, gay, bisexual, transgender, transsexual, two-spirited, intersex, queer, and questioning individuals (Caldwell, 2013). While each letter in the acronym represents a different sub-population with unique needs, they are often grouped together (Institute of Medicine, 2011). Language and terms used to describe these sub-populations change over time, which necessitates the importance of keeping up-to-date with current terminology (Best Start, 2012).

Defining the sub-populations under the LGBTQ umbrella requires proper definitions of both sex and gender. Sex is based on biology; it is how people are defined based on body parts and physical characteristics (Best Start, 2012). Gender, rather than being biological, is socially-constructed and refers to the roles, behaviours, and activities that a society considers appropriate (World Health Organization, 2013). In summary, sex is biological and gender is social.

Below are additional definitions of each letter in the LGBTTTIQQ acronym. These definitions are outlined in *Best Start's Welcoming and Celebrating Sexual Orientation and Gender Diversity in Families: From Preconception to Preschool* document (2012).

Bisexual: A person whose sexual/romantic attractions are directed towards individuals of more than one sex or gender, though not necessarily at the same time.

Gay: A man whose primary sexual/romantic attractions are to other men. This term is sometimes used by lesbians (i.e. gay woman), but many lesbians and bisexual people do not feel included by this term.

Intersex: Someone who is born with both or ambiguous female and male genetics, and/or physical characteristics.

Lesbian: A woman whose primary sexual/romantic attractions are to other women.

Queer: A term that has traditionally been used as a derogatory and offensive word for

LGBTQ people. Many have reclaimed this word and use it proudly to describe their identity and/or as an umbrella term for LGBTQ people or communities. It is not accepted by all LGBTQ people.

Questioning: This term refers to someone unsure of or exploring their sexual orientation and/or gender identity.

Transgender: An umbrella term referring to people who do not embrace traditional binary gender norms of masculine and feminine and/or whose gender identity or expression does not fit with the one they were assigned based on their sex at birth. Terms can include androgynous, genderqueer, gender non-conforming and some transsexual and two-spirited people.

Transsexual: Someone who feels their gender identity does not match the sex they were assigned at birth. Many transsexual people choose to transition so that their sex and gender identity match.

Two-Spirited: An English language term used to represent the traditional words used by some First Nations people to describe people perceived to embody both masculine and feminine spirits or to describe their sexual, gender and/or spiritual identity.

Other important definitions include the following:

Cisgender: A term to describe a person whose gender identity matches the sex they were assigned at birth; someone who is not trans*. Cis means "on the same side," and trans* means "across."

Cisgender Privilege: The privilege that cisgender people, and those assumed to be cisgender, experience as a result of having their femaleness or maleness deemed authentic, natural, and unquestionable by society at large. This privilege allows cisgender people to take their sex and gender for granted in ways that trans* people cannot. In contrast, trans* people are often punished for the ways their gender identity does not match the social expectations of the sex they were assigned at birth.

FTM: FTM stands for a female to male trans* person or a trans man. This is someone who was assigned as female at birth and identifies as male.

Gender Binary: The idea that there are only two, opposite, genders: man or woman, and that people can only be one or the other and stay that way all their life.

Gender Expression: The public expression of gender identity: manner, clothing, hairstyles, voice or body characteristics, etc.

Gender Identity: A person's identification as being masculine, feminine, androgynous, trans*,

or something else entirely. Gender identity is distinct from sexual orientation – everyone has a sexual orientation and a gender identity and one does not predict the other.

Genderqueer: A term used to describe individuals whose gender identity does not fit within the gender binary.

Gender Variant/Gender Non-conforming/Gender Independent: These are terms used to refer to individuals whose expressions of gender do not conform to the dominant gender norms of masculinity and femininity.

Heterosexual Privilege: The privilege that heterosexual people experience. This privilege involves not having to question your normalcy, having your relationships validated by individuals and institutions, seeing yourself reflected in cultural institutions, and having the right to marry the person you love. In essence, heterosexual privilege is the privilege of not giving much thought to your sexuality. It is the freedom to publicly express your sexuality without any fear of repercussion.

MTF: MTF refers to a male to female trans* person, or a trans* woman. This is someone who was assigned as male at birth and identifies as female.

Pansexual: Someone who is attracted to other people regardless of their gender or sexual orientation.

Transition: The process of changing from the sex one was assigned at birth to the gender one identifies with. Transitioning may involve dressing in the manner of the self-perceived gender, changing one's name and identification, pursuing hormone therapy, and/or undergoing sex reassignment surgeries.

Social Determinants of Health

LGBTQ individuals are as diverse as the general population in their experiences with health and well-being. The social determinants of health, including income and education, impact LGBTQ individuals in different ways. However, some determinants of health such as social marginalization results in heightened levels of stress, putting LGBTQ individuals at an increased risk to particular health outcomes. Several of these health outcomes are explored below.

Mental Health

Discrimination, violence, and negative attitudes toward the LGBTQ population contribute to mental and emotional stress for this population. The act of "coming out" is emotionally difficult, particularly when individuals face rejection from family and friends (Institute of Medicine [IOM], 2011). For trans* people, the transition is both mentally and physically

stressful with many barriers to overcome. Bisexuals can experience a sort of "double closet" when they hide their same-sex attraction from heterosexual friends, family, and partners, while hiding their other-sex attraction from the LGBTQ community (IOM, 2011). Bisexual individuals can also face heightened social pressure to identify as either gay or straight. For LGBTQ individuals who do not "come out," isolation and fear of discovery can be incredibly stressful (IOM, 2011). Collectively, these stressors have a profound impact on the self-esteem and well-being of LGBTQ people. Research demonstrates that LGBTQ people have higher rates of anxiety, depression, and suicide than the general population (IOM, 2011). One Canadian study found that the risk of suicide among LGB youth was 14 times higher than that of their heterosexual counterparts (Benibgui, 2011). Another study in Ontario found that 77% of trans* individuals had seriously contemplated suicide while 45% had attempt suicide (Bauer et al., 2010).

Substance Use

People in the LGBTQ community are also more likely to use alcohol and/or drugs when compared to the general population (IOM, 2011). Lesbians and gay men regularly report experiencing more problems as a result of alcohol use that continues as they age; bisexual individuals are most likely to report problems from alcohol use when compared to the rest of the LGBTQ community. Recreational drug use that is associated with dance clubs and circuit parties are popular with gay and bisexual men. In this context, the use of recreational drugs is perceived as an acceptable part of the gay scene. Often clubs and parties are viewed as the only comfortable place to meet queer-identified friends and potential partners. While there is little research surrounding the use of alcohol and drugs in the trans* community, evidence suggests that abuse is a serious concern for many trans* individuals (IOM, 2011). In many cases, drugs and alcohol are used to cope with internalized negative feelings, discrimination, and depression, and bars or parties often are the only comfortable space to meet other LGTBQ people (IOM, 2011).

Tobacco

Research suggests that there are higher rates of smoking among LGBTQ individuals than the general population (IOM, 2011). While approximately 16% of Ontarians smoke, a Toronto study completed in 2007 showed that 36% of the LGBTQ community were current smokers (Toronto Public Health, 2007). Higher levels of social stress, frequent socialization in bars, and higher rates of alcohol consumption contribute to increased tobacco use. These higher rates of tobacco use put individuals in the LGBTQ community at an increased risk for lung cancer, heart disease, and emphysema (IOM, 2011). Trans* people are also at risk for specific tobacco-related health outcomes. Smoking increases the risk of blood clots in transwomen taking estrogen while also increasing the risk of heart disease in transmen who take testosterone (Toronto Public Health, 2007). Tobacco use also slows the healing process after surgery and increases the likelihood of scarring in trans* individuals (Toronto Public Health, 2007).

Sexual Health

The heightened risk of HIV/AIDS is well-documented within the gay men's community. While this topic has dominated much of the discussion regarding sexual health in the LGBTQ community, other sexually transmitted infections (STIs) including syphilis and gonorrhea also exist in higher rates in gay and bisexual men (IOM, 2011). STIs including herpes, HPV, and trichomoniasis are transmitted fairly easily between women during sex; however, HIV/AIDS, gonorrhea, and Chlamydia are rarely transmitted (IOM, 2011). Bisexual people who have partners of another sex must also consider the risk of HIV/AIDS and other STIs in addition to the risk of unplanned pregnancies. Sexual health risks for trans* individuals are largely unknown. Some research suggests high rates of unprotected sex among trans* people (RHO, n.d.). This may be due to the lack of relevant sexual health information. Fear of discrimination by health care professionals leads some LGBTQ individuals to avoid seeking care for sexual health issues, heightening their risk for STI progression and increasing the negative health impacts of STIs (IOM, 2011).

Violence and Safety

LGBTQ individuals are much more likely to be physically and verbally victimized when compared to the heterosexual population. A 2004 Statistics Canada study highlighted that the odds of being victimized were approximately 2 times greater for lesbians and gay men and 4.5 times greater for bisexual individuals. LGBTQ youth also report experiencing high rates of bullying and harassment in schools (IOM, 2011). Persistent discrimination can increase risk factors for disease such as obesity, substance use, and nonparticipation in behaviours that promote health, such as physical activity programs (Pascoe & Richman, 2009). Youth who do not experience a sense of belonging are also more likely to have behavioural problems, such as aggression or withdrawal, higher school dropout rates, and emotional distress that results in violence, loneliness, or suicide (Osterman, 2000). A sense of belonging has been categorized as a basic human need, regardless of age, that is particularly critical during youth, as it influences behaviours later in life (Haggerty, Williams, & Oe, 2002).

Nutrition, Fitness, and Weight

Gay male culture has long idealized physical beauty and youth. For some, the cultural pressure to achieve the perfect body results in compulsive exercising, extreme dieting, and steroid use, which can increase emotional distress and physical health problems (IOM, 2011). Gay men are much more likely than heterosexual men to have an eating disorder such as anorexia or bulimia. On the other hand, cultural norms in the lesbian community encourage heavier body weights and the rejection of dieting (IOM, 2011). Lesbians are more likely to be overweight or obese than heterosexual women, increasing their risk for heart disease and stroke in addition to other health conditions. For trans* people, a negative body image may result from discomfort with the gender of their physical bodies (IOM, 2011). While taking hormones, trans* people often gain weight, which may lead to dieting or other changes in behaviour. Again, without feeling comfortable accessing health services, gay males experiencing disordered eating, lesbians with an increased risk for heart disease and stroke, and trans* individuals with health issues related to hormone use delay care and increase their risk for prolonged negative health outcomes.

Reproductive Health and Parenting

In Canada, LGBTQ families are recognized both socially and legally. However, this recognition is relatively recent, and the attitudes and beliefs of close to 50% of the population do not support the right of LGBTQ families to have children and parent (Best Start, 2012). Several myths about LGBTQ families and the impact on children perpetuate despite evidentiary support to the contrary. Some of these myths include: children of LGBTQ people are "promiscuous, sexually maladjusted and likely to harm other children sexually and/or emotionally" (Best Start, 2012, p.17); the presence of both male and female role models are crucial for healthy child development; and children with LGBTQ parents will be heavily stigmatized by their peers. This historical and current stigma impacts LGBTQ families when accessing reproductive health and parenting services, as they can never be sure whether they will be treated at all or discriminated against (Best Start, 2012). Many families may be fearful of disclosing their sexual orientation or gender identify for these reasons (Best Start, 2012).

For LGBTQ individuals and families that want to begin a family, the planning process is long and thoughtful involving complex negotiations, false starts, and cumbersome costs (Best Start, 2012). Options available for LGBTQ people to have children include: donor insemination, adoption, fostering, co-parenting, surrogacy, step-parenting, and heterosexual sex.

Some of the issues for LGBTQ people considering parenthood include (Best Start, 2012):

- Decisions regarding the route to parenthood: adoption, co-parenting, donor insemination fostering, heterosexual sex, surrogacy.
- If using donor insemination, complex issues regarding the use of a known donor, anonymous donor, identity release donor (when the child turns 18).
- Potential negotiations with known egg/sperm donors/co-parents/surrogates.
- Issues around questions about family configurations, such as: Who has biological connection to child? Who is legally related to the child? Who is involved in parenting the child? What are related social, legal, emotional issues?
- Issues of entitlement to parent and internalized shame.
- Dealing with individual and systemic discrimination.
- Dealing with religious/cultural values that view LGBTQ parenting as unnatural.
- Finding and accessing supports available to LGBTQ parents via families of origin, chosen family, friends, and community services.
- Legal information about how to protect all parents and children.

Family structure among LGBTQ families can be as diverse as non-LGBTQ families. Single parenting, parenting in couples, co-parenting between three or four people, or families with a primary couple and a sperm donor with varying levels of involvement in the life of the child all occur (Best Start, 2012).

Other Health Impacts

In addition to the aforementioned health effects of discrimination and marginalization on LGBTQ individuals, other social determinants of health may negatively impact this

population. For example, income and social status are key determinants of health. For LGBTQ individuals, their educational achievement and career opportunities can be affected by the prejudice they experience at school, in the workplace, and elsewhere (NHS Scotland, 2003). Individuals may choose to hide their gender or sexual identity for fear of losing their job or not being promoted. Several American studies have refuted the myth of 'gay affluence', demonstrating that LGBTQ individuals face comparable economic situations to their heterosexual counterparts (Badgett, 1998). In Canada, on average, gay men have a personal income 12% lower than heterosexual males; in contrast, lesbians have an average personal income 15% higher than heterosexual females (Carpenter, 2008). Bisexual men and women earn 30% and 15% less than heterosexual individuals, suggesting that bisexual identity in particular may be associated with economic deprivation (Carpenter, 2008).

Finally, gender and sexually diverse youth who flee their home for fear of abuse or rejection have high homelessness rates with a disproportionate number of street youth identifying as gender and sexual minorities (Gaetz, 2004). In rural and remote areas, the abovementioned impacts of discrimination and economic deprivation can be exacerbated. LGBTQ individuals living in rural communities report higher rates of heterosexism and fewer adequate resources (Coalition for Gay and Lesbian Rights in Ontario, 1997). Other social determinants of health such as age, race, ethnicity, and (dis)ability intersect with sexual orientation and gender identity to produce compounded effects on health and well-being.

LGBTQ Population in Wellington, Dufferin and Guelph

Determining the exact number of individuals who identify as LGBTQ in a given region is extremely difficult. At the national level, the 2001 Census was the first to collect data on same-sex, common-law couples. This question has since evolved to include both common-law and married same-sex couples, which excludes individuals identifying as LGBTQ but who are not living with a partner. As of 2003, the Canadian Community Health Survey (CCHS) included a question on sexual orientation, asking people to identify as "homosexual", "heterosexual" or "bisexual". Neither the Census nor the CCHS asked questions about sexual behaviour or gender identity, limiting the surveys' ability to accurately depict the LGBTQ population across the country.

In addition to the aforementioned limitations of the national-level data, underreporting also affects the accuracy of LGBTQ population data. Individuals may be worried about the confidentiality of these surveys and may choose not to disclose their sexual orientation. Additionally, some individuals who experience same-sex attraction and/or engage in sexual activities with people of the same gender do not necessarily identify themselves as gay, or bisexual, again limiting the accuracy of the data. Finally, this data excludes certain groups such as people who do not speak English or French, people who are transient or homeless, people

without status, and people living in group homes. The most widely accepted statistic states that approximately 10% of all individuals identify somewhere in the LGTBQ spectrum. This statistic comes from Kinsey's (1948) report on sexual orientation. The report has since received some criticism regarding its methodology; however, other studies also suggest that close to 10% of the population identifies as LGBTQ. For example, a recent study conducted by the Toronto District School Board of students in grades 7 to 12 found that 8% of students identified as LGBTQ (Yau & O'Reilly, 2007).

Local data regarding the LGBTQ population within Wellington, Dufferin and Guelph is limited. An aggregated percentage derived from the CCHS from 2007 to 2011 shows that 5.5% of individuals in Wellington, Dufferin, and Guelph identify as either "homosexual" or "bisexual". This estimate is likely unrepresentative for a number of reasons. First, people less than 18 years of age and more than 59 years of age were not asked this question. Second, the term "homosexual" may be considered offensive to some, reducing their willingness to respond; approximately 5% of individuals between 2007 and 2011 said they didn't know their sexual orientation, did not state their answer, or refused to answer. While we cannot assume the sexual orientation of these individuals, it does contextualize the responses to this question and demonstrates the potential margin of error. Third, the question only collects information about individuals who identify as "homosexual" or "bisexual" and excludes those individuals who experience same-sex attraction and/or engage in sexual activities with people of the same gender without identifying in the LGBTQ spectrum. Finally, this question does not include the entire LGBTQ population as trans* individuals are not represented in the data; a trans* individual may identify as "homosexual" or "heterosexual". In short, while the CCHS data provides an important starting point for understanding the LGBTQ population within our community, it is not comprehensive.

LGBTQ LHIN Report

One source of local data on LGBTQ health issues was the 2009 Waterloo-Wellington Local Health Integration Network's (WWLHIN) online survey of the LGBTQ population. This survey was distributed to members of the LGBTQ population within the WWLHIN's catchment area via community partners. The goal of the survey was to assist the WWLHIN in updating their Integrated Health Service Plan, by determining whether the LGBTQ population faced any unique needs or concerns. While the LHIN's boundary encompasses both Guelph and Wellington, it also includes Waterloo Region while excluding the County of Dufferin This reduces its transferability to our WDGPH catchment area. However, this study does highlight the local experiences of LGBTQ-identified individuals, contributing to our understanding of this population.

The online survey received ninety-nine responses from members self-identifying as part of the LGBTQ community. When asked about sexual orientation, 74.7% identified as gay or lesbian, 19.3% were bisexual, 19.3% identified as queer, and 7.2% were pansexual. When asked

about gender identity, 8.4% identified as transgender, 6.0% indicated they were transsexual, and 47.0% and 44.6% identified as female and male, respectively. For both questions, individuals were permitted to select more than one response. The majority of the respondents were urban dwellers.

This survey asked respondents about their experiences with primary care, emergency departments, mental health and addiction services, alternate levels of care, and chronic disease management. While interpreting this information, it is important to take into consideration the potential response bias. Individuals who responded to this survey may not have been representative of the larger LGBTQ community as people who had positive experiences with the health care system, those that more affluent, and those whose first language was English were more likely to respond to this survey.

LGBTQ Population and Local Primary Care Experience

- 54.6% indicated their local primary care provider was LGBTQ-friendly
- 29.6% stated that their primary care provider understood LBGTQ health issues
- 14.6% reported that they had gone outside of the area to get appropriate primary care
- 69.4% had felt comfortable disclosing information about their sexual orientation to their primary care provider
- Reasons for not sharing their sexual orientation with their care provider included: sexual orientation was not pertinent to the health issue being discussed; the issue had never come up; nervousness about mentioning it due to not knowing how it would be received; and past negative and/or homophobic experiences with healthcare providers when disclosing sexual orientation
- 62.9% had shared their gender identity with their primary care provider; others noted that they had not shared their gender identity because it did not relate to the health issue
- 35.4% had experienced homophobia, transphobia, biphobia or AIDSphobia in the local healthcare system
- 24.5% had delayed or avoided seeking care locally due to fear of or experience with homophobia, transphobia, biphobia or AIDSphobia
- 68.1% had positive experiences with primary care providers who acknowledged and took their sexual orientation and/or gender identity into account as they were providing care

LGBTQ Population and Local Emergency Room Experience

- Of the respondents that had waited in an emergency room, 30.3% had disclosed their sexual orientation to the ER care providers and 33.3% had disclosed their gender identity
- For participants that had not disclosed their sexual orientation or gender identity, common themes for non-disclosure included: uncertainty of how the information

would be received; sexual or gender identity was not relevant to the health issue; and fear of receiving sub-standard services after disclosure
- 14.7% of respondents had experienced homophobia, transphobia, biphobia or AIDSphobia in an emergency room
- 4.3% of participants had delayed or avoided seeking care from a local hospital emergency room due to fear of or experience with homophobia, transphobia, biphobia, or AIDSphobia
- 69.9% said they would feel comfortable seeking care in a local emergency room in the future

LGBTQ Population and Mental Health and Addiction Services

- 87.8% of respondents that had accessed local mental health and addictions services had disclosed their sexual orientation and 54.1% had revealed their gender identity
- 56.8% had positive experiences when they received services for an addiction or mental health issue
- 14.8% of participants had delayed or avoided seeking care for an addiction or mental health issue due to fear of or experience with homophobia, transphobia, biphobia, or AIDSphobia
- 87.8% of respondents that had accessed local mental health and addictions services had disclosed their sexual orientation and 54.1% had revealed their gender identity

LGBTQ Population and Alternate Levels of Care

- Responses to this section were too low and had to be suppressed.

LGBTQ Population and Chronic Disease Management

- 33.3% of respondents had experience with the chronic disease management system
- 61% had felt comfortable sharing information about gender identity when seeking care for a chronic disease
- 71% of respondents had felt comfortable sharing information about their sexual orientation when seeking care for a chronic disease
- No respondents reported avoiding care for a chronic disease because of concern about homophobia, transphobia, biphobia, or AIDSphobia

Limitations of the Study

A limitation of the WWLHIN survey was the number of respondents. Overall, 99 individuals responded to the survey, limiting the transferability of the findings to the general LGBTQ population. Additionally, because respondents resided across the Waterloo Wellington area, likely only half of respondents resided within the WDGPH service area, further limiting the transferability of the results to our local population. Overall, however, results from this study

serve as an important component to our understanding of local LGBTQ health services and supports.

Key Findings

Data collected in the WWLHIN online survey suggests that experiences with and fear of homophobia negatively impact the health and well-being of local LGBTQ individuals. The highest rates of delaying or avoiding care occurred in the primary care sector, with 1 in 4 respondents reporting this. The primary care sector also had the highest levels of reported homophobia, biphobia, transphobia, and AIDSphobia (35.4%). While many individuals reported positive experiences with the local care system, this survey highlights that there is still much to be done to offer safe, inclusive and welcoming care.

WDG LGBTQ Community Survey

Overview

As a means of gathering information about the public's perception and experience with WDGPH, an online survey was developed for LGBTQ-identified individuals in our community. The survey asked respondents about basic demographic information, their perception of the LGBTQ-friendliness of the Public Health programs and services that they have accessed, and what WDGPH can do as an agency to improve the quality of service for LGBTQ-identified clients.

Overall, 87 individuals responded to the survey. Respondents ranged from 15 to 58 years of age, with an average age of 25.1 years. The majority of respondents (55%) reported living in Guelph; other respondents were residents of Orangeville (23.3%), Mono (8.3%), Erin (3.3%), Centre Wellington (1.7%), Amaranth (1.7%), and Wellington North (1.7%). Three respondents (5%) reported living outside of Wellington-Dufferin-Guelph. Respondents were also asked about their sexual orientation and gender identity. Overall, 60% of respondents identified as gay/lesbian, 18.3% were bisexual, 13.3% were pansexual, 6.7% were queer, and 1.7% were heterosexual. The most commonly reported gender identity was cis-woman (46.2%), followed by cis-man (33.8%), genderqueer (7.7%), transman (4.6%), bigendered (3.1%), cross dresser (1.5%), gender questioning (1.5%) and other (1.5%).

Results

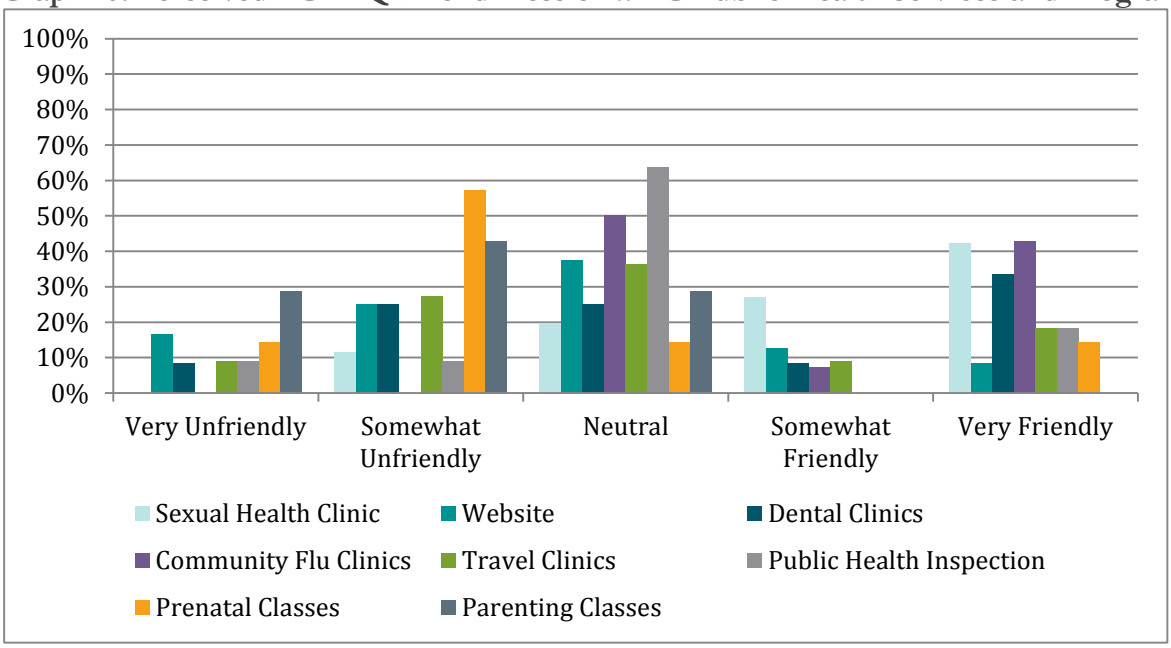
Experiences with Public Health Programs and Services

A comprehensive list of Public Health programs and services was provided to survey respondents; they were asked to rate the LGBTQ-friendliness of each of the services or programs they had accessed. Overall, 69% of respondents had accessed at least one Public

Health program or service. Respondents who had not accessed one of WDGPH's programs or services were redirected to another portion of the survey that asked about their perception of the Agency as an LGBTQ-friendly organization. Respondents who had no prior experience with a Public Health program or service are not included in the analysis below.

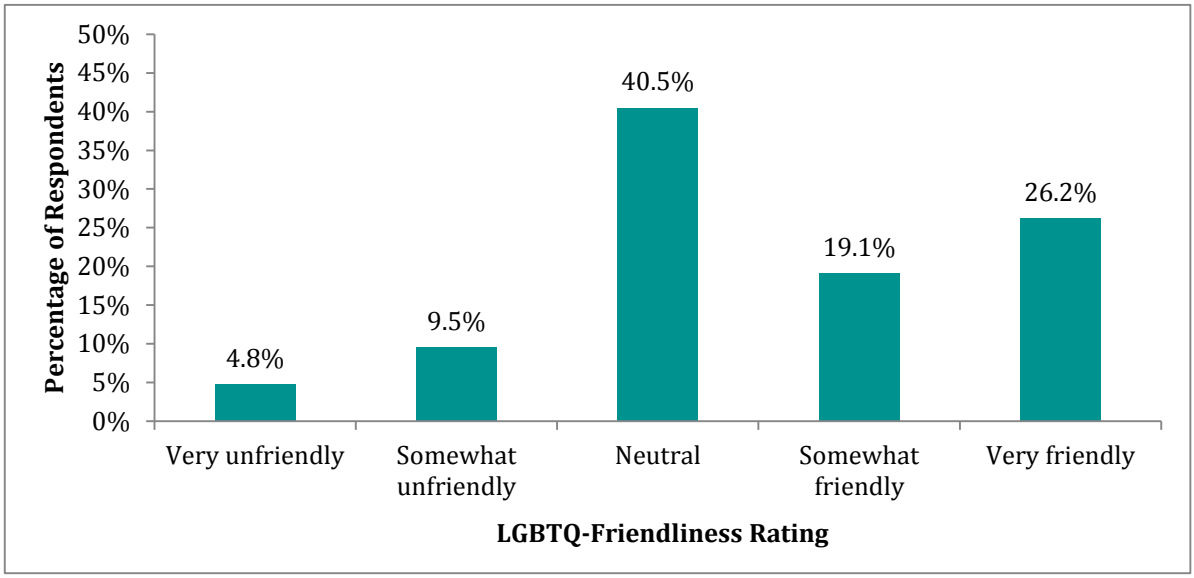
The most commonly utilized Public Health programs or services reported by survey respondents were the sexual health clinic (26 individuals), dental clinic (24), website (24), community flu clinic (14), travel clinic (11), public health inspection (11), prenatal classes (7), and parenting classes (7). While the relatively low number of respondents who had accessed each service or program reduces the transferability of the results to the entire local LGBTQ population, it does provide a snapshot of the various experiences that individuals have had with WDGPH. As shown in Graph 10, LGBTQ-identified individuals in the community have had a wide range of experiences with Public Health services and programs, ranging from very unfriendly to very friendly.

Graph 10. Perceived LGBTQ-Friendliness of WDG Public Health Services and Programs



Respondents were also asked to rate the overall LGBTQ-friendliness of Public Health as an agency (Graph 11). Again, these responses highlight the varied experiences of LBGTQ individuals.

Graph 11. Overall Perception of WDG Public Health



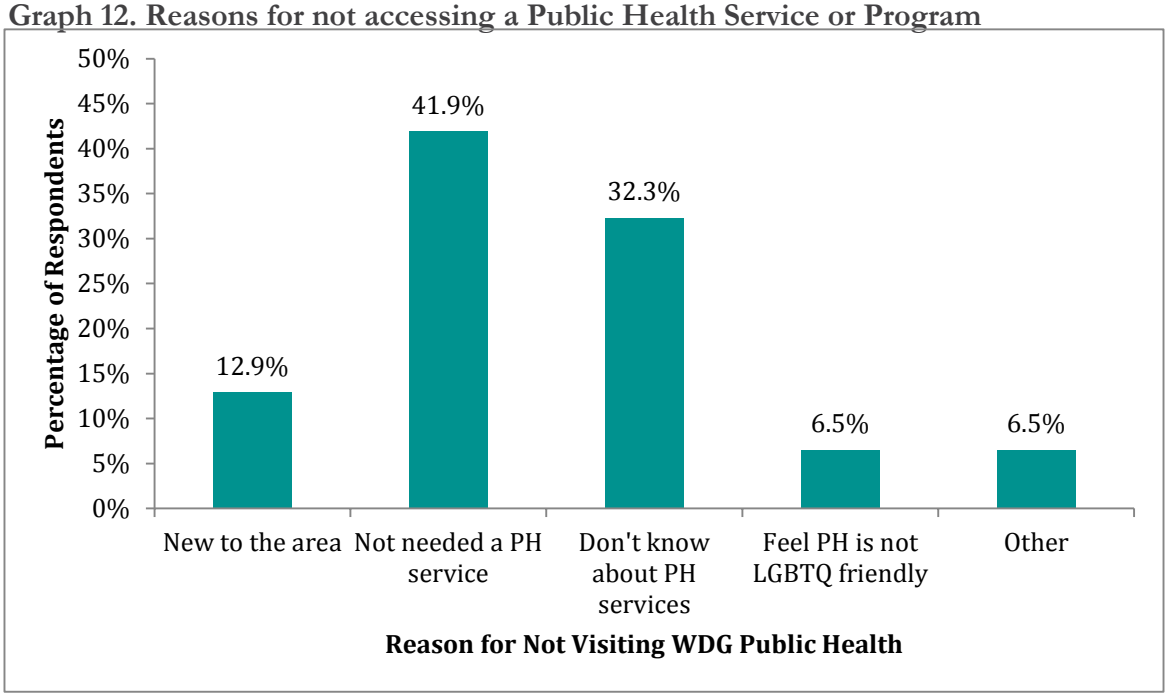
When asked what could be done to make Public Health more LGBTQ-friendly, respondents offered a variety of suggestions:

- Make information regarding LGBTQ-specific issues more accessible on the WDGPH website and in WDGPH offices;
- Train all Public Health staff so that all employees have the same knowledge and understanding of LGBTQ health; it is important to receive consistently competent service;
- Ensure that each office has a gender neutral washroom;
- Be open about the ways WDGPH is striving to become more LGBTQ inclusive by advertising Public Health as a safe space;
- Broaden the definition of inclusivity. One individual said, "Inclusivity should also be demonstrated in the behaviour, both verbal and non-verbal, of Public Health employees. There is a difference between being 'just tolerant' and being 'welcoming and accepting'. Queer people are considered when the issue is sex, but not in everyday life."

Perceptions of Public Health Programs and Services

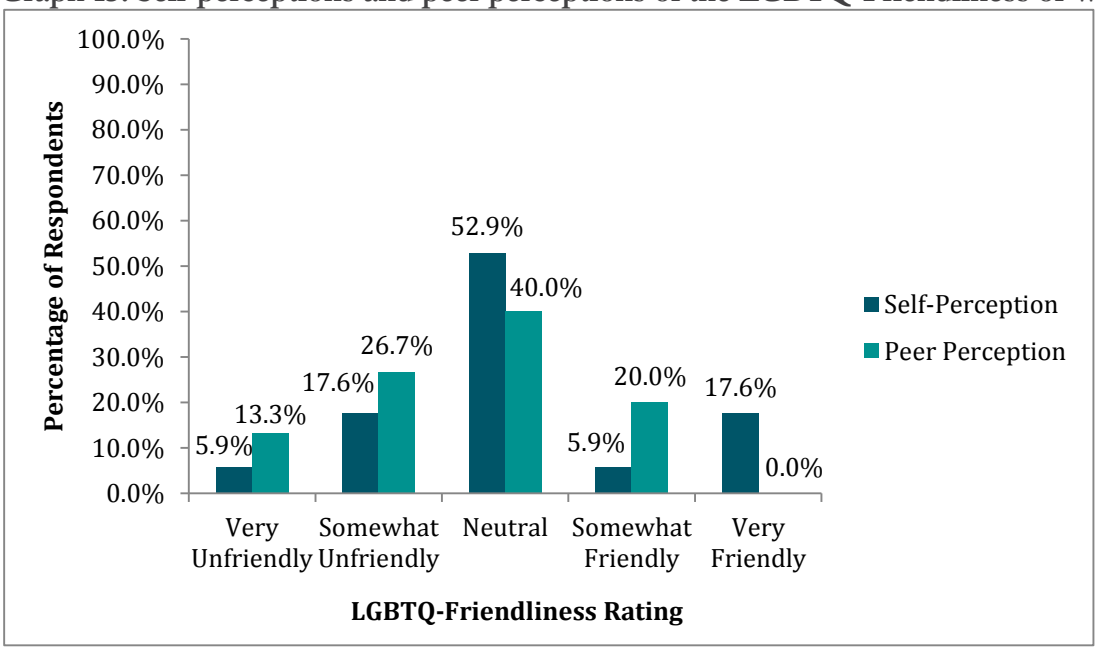
Respondents who indicated that they had not utilized one of WDGPH's services or programs were asked about why they had not accessed services, their perception of the LGBTQ-friendliness of Public Health, and the perception of Public Health among their LGBTQ-identified peers. When asked about why they had not accessed one of Public Health's services or programs, the two most common responses were that they had not needed a public health service and that they did not know about the services offered through Public Health (Graph 12).

Graph 12. Reasons for not accessing a Public Health Service or Program



Respondents were asked to indicate their perception of the LGBTQ-friendliness of WDGPH, and also to describe the perceptions of their LGBTQ-identified peers. Overall, most respondents did not feel that Public Health was overtly friendly (Graph 13). Respondents indicated that they have not heard about any efforts from Public Health to be an LGBTQ-friendly organization and that experiences with the healthcare system in general has impacted their impression of Public Health and other government services.

Graph 13. Self-perceptions and peer perceptions of the LGBTQ-Friendliness of WDGPH



Key Findings

Overall, survey responses highlight that people in the local LGBTQ community have experienced extreme variation in the quality of services and programming received from Public Health. This variation suggests that WDGPH should strive to achieve consistency in service for all clients. Survey respondents provided a range of suggestions that would improve the LGBTQ-friendliness of the Agency, including training for staff, increasing the profile of the LGBTQ community among WDGPH resources and services, and making gender neutral washrooms accessible to the public.

WDG LGBTQ Service Provider Interviews

Overview

In addition to the online survey completed by LGBTQ-identified individuals in the community, in-depth interviews were conducted with service providers from LGBTQ-friendly/focused agencies (Appendix A). Between December 2013 and February 2014, a total of six interviews were conducted: two service providers were based in Guelph; two were based in Orangeville; one was based in Mount Forest; and one was based in Kitchener, but had clients from all over Wellington County. During the interviews, service providers were asked about local health supports for LGBTQ individuals, barriers faced by LGBTQ individuals

while accessing these services, their perception of the LGBTQ-friendliness of WDGPH, and how Public Health could play a role in making our community more LGBTQ inclusive.

Results

Several key themes emerged from these interviews. Themes are presented below.

Theme 1: LGBTQ-specific services and supports in the community are decreasing

All interviewees mentioned a declining number of services available for LGBTQ-identified individuals in Wellington, Dufferin, and Guelph. In the past year, services like Out on the Shelf, a queer community and resource centre, have been unable to rent physical space to operate in the community. Peer support groups have also been unable to find safe spaces to meet, reducing the opportunity for social connection and support. Several of the interviewees mentioned that there is no shortage of volunteers for these services and programs, but that obtaining actual meeting space was difficult.

Interviewees suggested that Public Health could play a role in providing space for these groups to meet. They suggested that Public Health could also advertise or promote the services and supports that do exist so that LGBTQ-identified individuals could find these supports easily.

Theme 2: LGBTQ individuals face increased barriers to service access

Another theme that emerged among interviewees was the pervasive and lasting impact that discrimination and violence has had on the local queer community. Interviewees largely pointed to a history of discrimination from healthcare providers as a major barrier to service access. The uncertainty of how a healthcare provider will react to sexual orientation or gender identity reduces the likelihood that LGBTQ-identified individuals will access services; an outwardly welcoming statement and an effort to be a positive and safe space, however, would reduce this barrier and by altering perceptions, they said.

Interviewees mentioned that discrimination and violence as a barrier is further exacerbated in the rural parts of Wellington and Dufferin Counties. LGBTQ-identified individuals report more frequent displays of homophobia, biphobia and transphobia by residents of these communities; service providers are also residents of these communities so LGBTQ individuals fear that they will also experience discrimination from local services.

For youth who have not yet come out to their parents, interviewees discussed the additional barriers to access. Often, youth rely on their parents to transport them to services and programs; without parental support or knowledge about their child's LGBTQ identity, youth cannot access these services. Parental education and outreach would help youth feel more comfortable coming out to their families.

In addition to the abovementioned impacts of discrimination on the LGBTQ community, interviewees mentioned other barriers to services such as a need for improved

public transportation in the counties, financial restrictions, and a lack of knowledge about the types of services that are available for LGBTQ-identified individuals.

As a means on combating these barriers to service, interviewees mentioned that Public Health could play a role by publicly advertising itself as a safe and inclusive space (following safe space training), posting Positive Space symbols in its offices and on its websites, and increasing awareness of local LGBTQ-friendly/focused services by posting these services on its website.

Theme 3: Many LGBTQ individuals go elsewhere for services

As a result of fear of discrimination and a declining number of LGBTQ-friendly/focused services locally, many individuals in the LGBTQ community seek services elsewhere. Interviewees mentioned that information through Rainbow Health Ontario and services and programs through the Sherbourne Clinic in Toronto have been particularly valuable to LGBTQ-identified individuals. It is important to note, however, that due to increasing demand for many of the services offered through the Sherbourne Clinic, prospective clients now must live in Toronto to access these services, reducing the opportunities for individuals outside of Toronto to access the services they need.

Interviewees also indicated that local LGBTQ-identified individuals go elsewhere in Toronto for prenatal classes, parenting supports, and seniors' services that are unavailable within Wellington-Dufferin-Guelph. While these services are available for the general public within WDG, these services are not viewed as particularly LGBTQ-friendly and thus not largely accessed by LGBTQ-identified individuals. Several interviewees stated that for individuals who cannot travel to Toronto, this often means that they do not have access to the services and supports they need.

Finally, interviewees mentioned a lack of trans* services locally. They indicated that theew had been a recent training on trans* health issues so they were optimistic that services might become more trans*-friendly. Interviewees stated that trans* individuals from Wellington-Dufferin-Guelph often access a support group in Cambridge and utilize a trans*-identified physician in Hamilton.

Throughout each of the interviews, interviewees discussed the importance of incorporating information for LGBTQ individuals (including those that are parents) or parents of LGBTQ children into current information and programming. They recognized that the LGBTQ population may not be large enough locally to warrant a stand-alone service or program, but that current programming should be modified to be inclusive of these individuals.

Theme 4: Past experiences with healthcare providers reduce willingness to access health services in the future

In addition to the fear of discrimination from healthcare providers, interviewees mentioned a perceived lack of competence as a major issue locally. Interviewees stated that providers are not always properly trained or knowledgeable about LGBTQ issues and often don't recognize gender identity or sexual orientation as a determinant of health. Interviewees

also indicated that service providers need to become more comfortable and willing to ask questions about sexual orientation, gender identity and preferred pronoun when working with clients to reduce assumptions and make clients feel comfortable. One interviewee said that experiences (both positive and negative) with service providers get shared within the LGBTQ community and thus one negative experience could impact a large number of LGBTQ-identified individuals.

Public health could have a role to play in the promotion LGBTQ health workshops for healthcare providers, sending out information to these providers on LGBTQ health issues, and letting the public know that we are LGBTQ competent and welcoming following agency-wide training.

Theme 5: Public Health must be overtly LGBTQ-friendly

Throughout the interviews, interviewees mentioned other several ways in which Public Health could become more LGBTQ-friendly. These suggestions are summarized below:

- Promote Public Health as a welcoming and competent agency through signage, images, and wording on the website as well as within other Agency material; a social media or marketing campaign could compliment these efforts
- Create an LGBTQ health section on the website that could provide relevant links to services and supports that are LGBTQ-friendly/focused; use this section to promote internal LGBTQ health services as well as external services
- Recognize that being a Positive Space is not just about a sticker and a statement, but that it's a whole approach – consider modifications to strategic planning, policies, on-going training for staff, and client forms. One particular example was to include a diversity statement on job postings.
- Intentionally work with the LGBTQ community where possible
- Incorporate an LGBTQ lens on to pre-existing programs or services
- Partner with LGBTQ organizations or groups to become more of a presence in the community
- Have gender neutral washrooms in all buildings
- Wear a rainbow pin when out in the community

Key Findings

Responses from service providers emphasize the impact of sexual orientation and gender identity on access to health services. With many LGBTQ-specific services and supports declining locally, members of the LGBTQ community must go elsewhere for services. Those that do not have the means to travel longer distances for these services are limited in the health services and supports that they can access, impacting their overall health and well-being. Service providers also highlighted the impact that fear of discrimination and violence has on access to health services, particularly for individuals living in a rural area.

Interviewees suggested several ways to improve the LGBTQ-friendliness of WDGPH, echoing many of the same ideas collected in the LGBTQ community survey. First, service providers mentioned the importance of increasing the visibility of Public Health as an inclusive and welcoming agency. They also mentioned the importance of incorporating information for LGBTQ individuals into current information and programming and providing Positive Space training for Agency staff.

Limitations of Local Data Collection

Combined, the community survey of LGBTQ individuals and the interviews with service providers offers a well-rounded perspective on the state of LGBTQ health services and supports locally as well as the ways in which Public Health can play a role in improving the health and well-being of local LGBTQ individuals. However, these studies have some limitations that are important to consider.

The most notable limitation of the LGBTQ community survey was the number of respondents. The 87 individuals that did respond offered a range of perceptions and experiences with Public Health and health services in general; however, having more respondents would have increased the transferability of the survey findings.

Additionally, the interviews with LGBTQ-friendly/focused service providers may have also been limited by the number of participants. Some service providers who were asked to participate in the study did not respond to the request and others were not available between December 2013 and February 2014. Some of the interviewees were less familiar with Public Health services, which may have also been a limitation when discussing the role of Public Health in improving the health and well-being of local LGBTQ-identified individuals.

Recommendations: Strategies and Practice Changes to Address LGBTQ Health

Addressing the many health disparities experienced by the LGBTQ population necessitates a multi-pronged strategy which includes policy changes, creating supportive environments, strengthening community actions, developing personnel skills, and re-orienting health services.

1. Improve data collection of sexual identity, sexual behaviour, and gender identity indicators

It is recommended that the Health Analytics team identifies or creates questions to collect information about the LGBTQ population, in collaboration with members of the LGBTQ population, and share the resulting questions with Agency staff. Future surveys that ask demographic information would be modified to ask questions about LGBTQ status to gain a better understanding of the population in this area. Additionally, it is recommended that a health status report specific to the local LGBTQ community be conducted.

It is important that national, provincial, and local knowledge about LGBTQ health improves through the inclusion of questions related to sexual identity, sexual behaviour/attraction, and gender in data collection tools. Locally, questions relating to sexual orientation and gender can be included in surveys such as the WDG Youth Survey. Nationally, the Agency can advocate for changes in questions on the Census, National Household Survey, and CCHS to improve national level knowledge of the LGBTQ community.

2. Increased visibility of LGBTQ individuals in health promotion strategies

It is recommended that health promotion specialists, communications staff, managers, and any other staff involved in health promotion strategies increase the visibility and inclusivity of the LGBTQ population in Agency materials. Examples of increased visibility and inclusivity include: photos of LGBTQ individuals in a health promotion pamphlets, inclusive language on the WDGPH webpage, and advertising our Agency as LGBTQ-friendly, once training has been completed.

Despite the impact of gender identity and sexual orientation on health and well-being, most health promotion strategies are not targeted or inclusive of the LGBTQ community. Informative and culturally appropriate health promotion strategies and materials are needed for the LGBTQ community.

3. Positive Space Certification

It is recommended that all staff receive Positive Space training. Through training and education, all current employees would become more knowledgeable about the LGBTQ population and their health needs. It is also recommended that all future employees review an introductory PowerPoint presentation while also undergoing a brief LGBTQ culture competency training at the time of employment. As Positive Space training influences the language, attitudes and perceptions of individuals who complete it, it is recommended that all Agency staff, not just those who work directly with clients, complete the training. In order to maintain the Agency's LGBTQ cultural competency, staff knowledge would be reviewed on an annual basis with quizzes and periodic refresher trainings.

What is Positive Space?

"Positive Space" is a program that was initially developed by the University of Toronto in 1996. Since its inception, the concept of a Positive Space has spread to most Canadian universities, and increasingly, community-based organizations, such as public health units. An agency that is a Positive Space is one that is open, welcoming, and provides equitable access to people of all sexual and gender diversities (OPHA, 2011). Inclusive personnel policies and practices provide the framework to support a Positive Space. Inclusive policies must be welcoming to both staff and clients, and should focus on the elimination of discrimination, the promotion and provision of full and equal access, the elimination of stigmatization, and the creation of environments in which people feel safe "coming out." While policies are essential to the formation of a Positive Space, staff understanding and awareness is also a critical component. All staff must be trained to understand the issues around sexual and gender diversity and be knowledgeable about resources available.

Why is a Positive Space Important?

A Positive Space is the environmental product of a conscious set of decisions and actions taken by individuals to promote equality, fairness, non-violence, and affirmation of the unconditional value of all peoples. When an agency is a Positive Space, LGBTQ people know that they are entering an inclusive atmosphere that is a venue for inquiry and expression of sexual orientation and gender issues. They know that they will not be discriminated against on the basis of sexual orientation or gender diversity and they know that they will receive services with dignity and respect. This is particularly important in a healthcare setting (OPHA, 2011). Research demonstrates that negative experiences with the health care system related to sexuality lead some gay, lesbian and bisexual individuals to avoid or delay seeking care (IOM, 2011). For trans* individuals, getting good healthcare can also be difficult. Health care providers may be transphobic or they may not be knowledgeable about trans* health concerns. This can also lead to a delay or avoidance in care. It is also important to note that LGBTQ health-related issues both span and change throughout an individual's life; public health units and healthcare practitioners must be knowledgeable about these issues and be able to provide resources and support for all individuals at any stage in their lives.

Positive Space Certification Options

Within the WDG area, there are several organizations that could certify WDGPH as a Positive Space. Rainbow Health Ontario (RHO) is a province-wide program working to improve the health and well-being of LGBTQ individuals in Ontario through education, research, outreach and public policy. HIV/AIDS Resources & Community Health (ARCH) is an organization that focuses on HIV/AIDS support services, prevention, education, and harm reduction. This organization also works to reduce homophobia in the region and provide resources and networking opportunities for the LGBTQ community. Finally, the Positive Space Network of Halton is a network of community social service agencies and local businesses working together to create safe and inclusive environments for LGBTQ individuals.

Based on an analysis of the training provided, the experience of the trainer, and costs associated with training, the Positive Space Network of Halton is being recommended. They

are the only ones who are able to officially certify the Agency as a Positive Space and have extensive experience with other public health units. Currently, they are in the process of certifying Halton Public Health and have also begun work with the Halton District School Board. The organization is very well organized and very knowledgeable about specific LGBTQ training procedures for public health units. In addition to the comprehensive Positive Space training that they would provide, they would also review all our policies, documents, and resources ensuring inclusivity, and saving our agency significant time and money. Receiving training through another organization would require significant staff time to review our policies and documents. Furthermore, they recognize the importance of providing a local perspective on LGBTQ issues and have suggested partnering with HIV/AIDS Resources and Community Health (ARCH) as a guest speaker. ARCH welcomes the idea of a cross-agency partnership in order to better suit our needs.

The Positive Space Network of Halton recommends that all intake forms and documentation also be evaluated to ensure they are LGBTQ-friendly. Documentation and intake forms often create a first impression on an individual, setting the stage for their feelings of inclusion. For example, an intake form that only has "male" or "female" options under the gender section may leave trans* individuals feeling marginalized, reducing their openness and willingness to access care from that organization in the future.

In addition to changes to the documentation and employee training, the Positive Space Network of Halton recommends that the physical environment of an organization changes to promote inclusion. This involves displaying a diversity statement, offering gender-neutral washrooms, and putting up Positive Space stickers. The physical environment of an agency instills a long-lasting impression an individual. LGBTQ individuals that feel represented and safe within an organization are more likely to be open and honest with healthcare professionals, improving the quality of care that they receive. Changing the physical environment would also improve the work environment for all LGBTQ employees of the Agency, making them feel more comfortable at work, and quelling any fear they have of discrimination by fellow employees.

4. Acquire and utilize additional LGBTQ resources

It is recommended that the Agency acquire additional LGBTQ resources for use by staff and clients, such as pamphlets for distribution regarding LGBTQ-specific health issues (e.g., transgender hormone therapy, LGBTQ parenting, and insemination procedures), and community resources and support groups for LGBTQ youth, adults and seniors. Improved knowledge and resources of WDGPH employees would enhance the quality of care received by LGBTQ individuals, facilitating a more welcoming environment, and reducing incidents of stigmatization or discrimination on the basis of sexual orientation or gender. As the Agency becomes known as a Positive Space, we will likely see less LGBTQ individuals seeking care in major cities such as Toronto through improved feelings of accessibility and inclusivity within our own region.

Conclusion

The LGBTQ population in Wellington-Dufferin-Guelph is diverse and unique in its health needs. While the exact number of LGBTQ individuals in our region is unknown, estimates suggest that close to 10% of the population (or about 26,500 individuals locally) fall somewhere in the LGBTQ spectrum. Based on academic literature, the Waterloo-Wellington LHIN Report, and the recent local data collected, it is evident that LGBTQ individuals face increased barriers to health services, including discrimination and a lack of LGBTQ-knowledgeable service providers. In an effort to enhance the access and quality of health services for LGBTQ individuals in our community, this report identifies several strategies that WDGPH could implement which include improved data collection of LGBTQ populations, increased visibility of LGBTQ individuals in promotional materials, the acquisition and utilization of LGBTQ resources, and agency-wide Positive Space training to equip staff with appropriate tools and knowledge of the population. The training recommended is Positive Space Training through the Positive Space Network of Halton. Through Positive Space training and certification, which encompasses increased visibility of LGBTQ-friendly posters and resources, inclusive and welcoming intake forms and documents, and outreach to local LGBTQ organizations, the Agency would improve the quality of care and the healthcare experience of LGBTQ-identified individuals, facilitating improved health outcomes and reducing the incidents of discrimination on the basis of sexual orientation or gender.

Appendix A

List of Agencies Represented in In-Depth Interviews

1. HIV/AIDS Resources and Community Health (ARCH), formerly and AIDS Committee of Guelph and Wellington County
2. University of Guelph
3. Dufferin Child and Family Services
4. Rainbow Health Ontario
5. Mount Forest Family Health Team
6. Inclusive Counselling, Consulting & Training

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512 Woolwich St. (Administration)

Mount Forest Office

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Orangeville Office

71 Broadway

Shelburne Office (Mel Lloyd Centre)

167 Centre St.

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