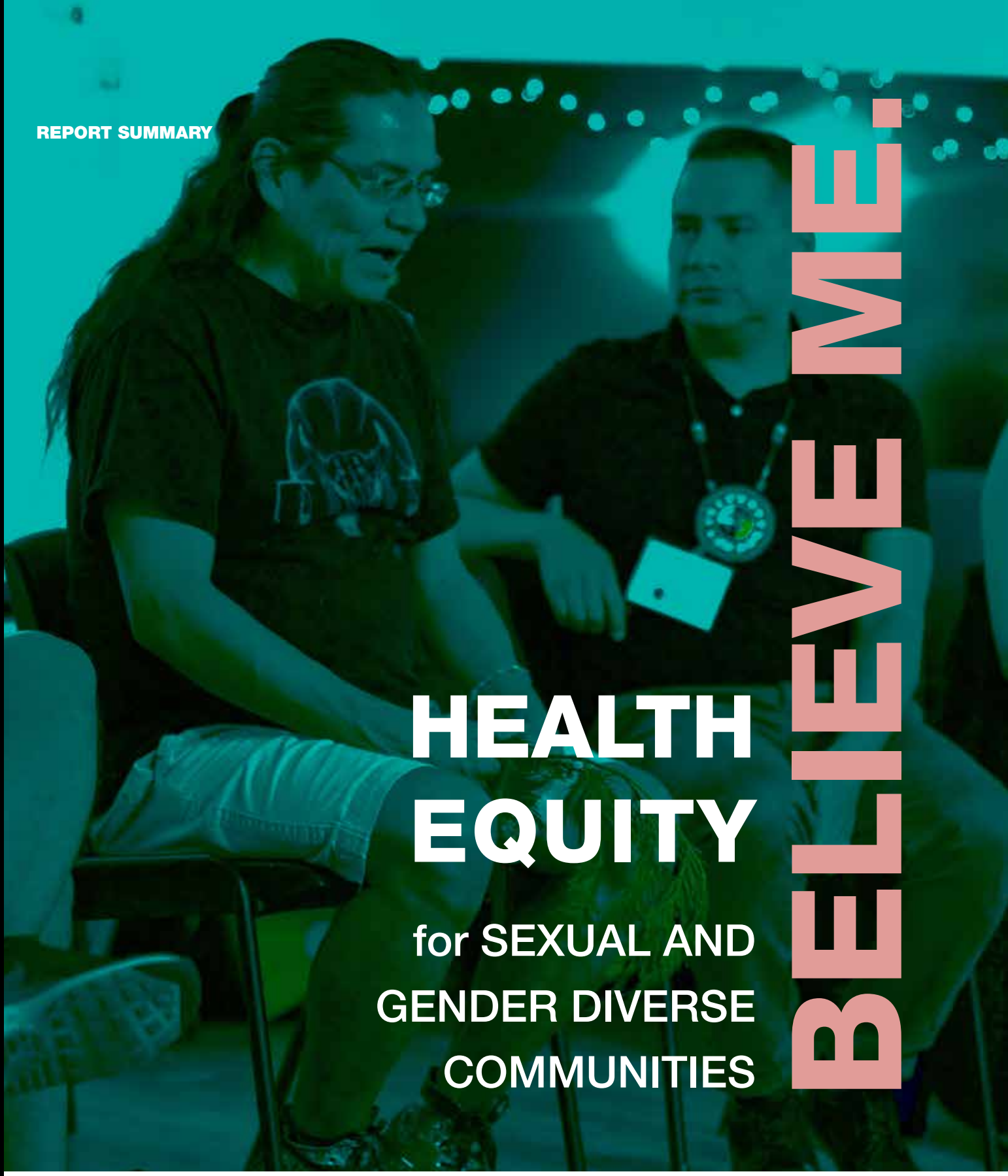
REPORT SUMMARY



BELIEVE ME.

HEALTH EQUITY

for SEXUAL AND GENDER DIVERSE COMMUNITIES

Sexual and Gender Minorities Health Equity Collaborative

LAND ACKNOWLEDGEMENT

HEALTH EQUITY COLLABORATIVE LAND ACKNOWLEDGEMENT

We the Sexual and Gender Diversity Health Equity Collaborative (HEC) acknowledge that our work is gathered on unceded traditional homelands of the Coast Salish peoples. The Coast Salish nations are many, and their territories cover a large section of what is otherwise called British Columbia. HEC recognizes that our work is on the traditional, unceded, and homelands of the **sḵwx̱wú7mesh** (Squamish), **sel̓íl̓witulh** (Tsleil-Waututh), and **xwməθkwəy̓əm** (Musqueam) Nations.

Through our 5 years of work we also recognize the displacement of Indigenous people in their own lands and that our work and gathering of people across the province is taking place on many unnamed traditional, unceded and homelands of Indigenous peoples across what is otherwise called British Columbia.

We recognize the ongoing very current violence and harm inflicted on Indigenous peoples and their lands. In their report “Health Inequalities and Social Determinants of Aboriginal Peoples’ Health”, the National Collaborating Centre for Aboriginal Health includes as Distal Determinants of Health: Colonialism, Racism and Social Exclusion, Self-Determination. Each of these has a direct and in-direct effect on Two-Spirit, sexual and gender diverse communities, and are without a doubt traumatizing those who live in these communities, and those who have been affected by roadblocks. These events have not only had an effect on Two-Spirit, sexual and gender diverse communities but the rest of Turtle Island as well. HEC recognizes that those of us from the collaborative who are settlers on these lands, have responsibility to understand the traditional laws of these territories and we commit to learn and to work with our hosts.

ACKNOWLEDGEMENT FROM INDIGENOUS CAUCUS

“As Two-Spirit peoples we want to honour and hold up our Two-Spirit and Indigequeer ancestors and non-human kin that have gifted us the teachings, resiliency, and decolonial love to do this work in good relation with one another. We hold dearly the knowledge that our spirits and beings are the land and recognize the spiritual, emotional, and physical impacts on our bodies and beings when violence is enacted on our lands, communities, and kin through displacement, colonial violence, and resource extraction. Our ancestral rights and responsibilities call upon us to take the resistance, love, and resiliency gifted to us by the ones who came before us and the ones to come after us to further our work in creating spaces of healing and growth that honour the traditional and sacred roles that we as Two-Spirit and Indigequeer relatives hold.”

We recognize that much of the healing work and spaces happen outside of government institutions and that much of the good healing work is happening in community through ceremony and gifted by the Elders and knowledge holders. We recognise and are grateful of the leadership of Two-Spirit and Indigenous members of the collaborative in particular Jessica St. Jean, Amhalaks Dion Thervarge and Maistoo’a waastaan “Crow Flag” Rodney Little Mustache for teaching and guiding us to be inclusive of traditional ways, protocols and involvement of elders to guide us through our process. Many thanks to our two Coast Salish knowledge keepers and Sulsalewh Elders Roberta Price and Bill White for their guidance, support and teachings.

“After the winter’s cold and icy winds, life again flows up from the bosom of Mother Earth. And Mother Earth throws off dead stalks and withered limbs for they are useless. In their place new and strong saplings arise.”
— DAN GEORGE, 1974

The quote from Chief Dan George sets up the classic dilemma facing modern program developers – the challenges associated with understanding the place of the old people and the degree to which they speak of stability, of belonging and of balance within tribal communities. Today many organizations are acknowledging the Ancestral territories of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and Səl̓ilw̓ətaɬ (Tsleil-Waututh) Nations. To merely acknowledge the territory is only the first step, particularly in light of reconciliation and providing services to many of the young who are oppressed by racism, rejection, poverty, self-doubt for being Two-Spirit or gay. Recently the eminent Sulalewh Florence James at Summit Gathering 2018 brought forward an astounding Coast Salish term/ halkomelem for someone who is gay. She used the term Xulsalk Siem and indicated that person had to be treated carefully, with immense respect and who would eventually become a receptacle for traditional teachings and, at its extreme, assume skills to heal and to act as a Seer. She equated someone who is Xulsalk Siem as someone who has the ritual, ceremonial energy of Northern Lights. In all of my work with our own organizations since the 70’s and with traditionally trained elders/Sulsalewh this is the first time this term was used, and represents a breakthrough in terms of intervention with individuals and community members as well as developing intervention around the application of classic Coast Salish values/Sinyews which predates the arrival of the newcomers to our territory.

Dan George like many old people of his generation understood the importance of hope and of those places of reflection which reinforced being clean and in balance. Not to understand the complexities of Coast Salish ceremonialism/traditions resulted in horrendous systemic change and oppression referred to by Dan George as “our sad winter” and a very lengthy period which caused parents, grandparents, children to know “bewilderment” described as an ugly spirit which brought torment.

One of the major challenges facing modern, First Nations as well as western organizations is to match the training and influence of traditional values/Sinyews with that of the program delivery which supports working with elders. The purpose of this letter is to provide the cultural context for the place of traditionally trained elders within modern institutions. If you are a human service worker and have driven by any of the bighouses within the Salish region (SW British Columbia and NW Washington State) , heard the drums, saw all of the cars and know nothing about what goes on in those buildings, this is a reflection of the problem. If you have been inside one of the longhouses and know what goes on in them, then you are one of the very few. In both cases knowing and understanding needs to be translated into developing programs which reinforce and value the teachings about respect, sharing etc. – values reinforced with Coast Salish institutions. Working across cultures is not an easy process.

Today, with significant efforts at ‘reconciliation’, a process often defined by western influences, there is significant

need to expand the learning and or initiatives to really begin listening, watching the rites, rituals and values which predated the arrival of the xwulanitum/nucumuxw (newcomers) to our homelands around the 1850's.

What is the beginning of that process? First, to academically, socially understand that southwestern British Columbia and northwest Washington State is the ancestral homeland to the largest cultural group in the province, the Coast Salish. The Anthropologist Barbara Lane and Art historian Norman Feder described the Coast Salish as the most conservative in the province, in that rites, rituals, which predate the arrival of Europeans continue to this day. The Winter Dance Complex, at its peak 1000 people might attend, and at various Shaker Church Services, several hundred might attend, have also been described as places of healing, reinforcing belonging and connections to the natural and supernatural worlds.

The major cross-cultural dilemma is this: first, traditional leadership understands the complex roles and essential nature of working with traditionally trained elders or Spiritual Specialists on one hand. In part this is because they have seen the result of applying complex rules associated with 'being in balance' – they live and practice the rules required to work with elders/Sulalewlh. Second, academic training for those who work with our people from provincial and federal governments for the most part have no idea about the various cultural, spiritual and social roles accorded those who work within tribal institutions, especially elders/Sulalewlh. Not to understand the importance of traditional values and the role of traditionally trained elders exacerbates difficulties working across cultures.

Xwulanitum who by virtue of their academic training have been taught to formally define their work, to identify issues, and to believe, until recently, that if ideas are not written then it is not entirely the truth. In the course of my work with traditionally trained Sulsalewh since the 70's, I have come to understand that in order to work from a place of strength with our own people often it is necessary to remove yourself from your academic training and often if that training reinforces western concepts, then to step away from your own culture. Those who were able to do that for example understood the importance of developing listening skills as paramount. Not to be able to learn from the old people in this way is likely to offend their contributions and leaves them to question the value of working with this group. Traditional leaders unaccustomed to this way of thinking likely see that approach as offensive, intrusive and wonder why they are being asked to validate simple things.

The combination of both of these elements, traditional values and its incorporation with modern programming can only assist working with traditional strengths and increasing the capacity to maintain stronger communities. An additional benefit to this approach is the reduction of acculturative discriminatory practices as well as improved cross-cultural relationships. The Royal Commission on Aboriginal Peoples said that "deculturalization has been too great a price to pay for modernization" and further that elders "are crucial if traditional knowledge and values are to become a source of strength and direction in the modern world." (RCAP Vol 4. 1996:118)

Around 1854 Chief Seattle speaking with Governor Stevens about diseases sweeping through both their communities said, "we may be brothers after all." Today our communities and brothers, sisters, cousins, etc. who are Xulsalk Siem are continuing to be vulnerable to the darkness called HIV/AIDS and new programs, initiatives need to be developed based on traditions meant to protect, to surround, to teach importance, taking care of one another in a new day and time. Our western brothers and sisters too can benefit from the application of traditions which reinforce, "you belong, we have a responsibility to each other, etc."

With immense blessings,

WILLIAM WHITE,
COAST SALISH SULALEWH (ELDER/HWULH SUQ' SULI)

A NOTE ON TERMINOLOGY

2SQTIBMPOC is a key term used throughout this report. The letters of this acronym stand for TWO-SPIRIT, QUEER, TRANS, INDIGENOUS, BLACK, MULTI-RACIAL, PEOPLE OF COLOUR. This is intended to broadly represent the intersectional identities of people who are both Indigenous and/or racialized and also somewhere within the umbrella of gender and/or sexual diversity. We ask forgiveness of folks not specifically named within this acronym, for example folks who are Non-binary, Intersex, Asexual, Aromantic, Métis, Inuit, and the many specific Nations and racial identities that fall under 'POC'. We also want to acknowledge that language changes quickly and can often become an unpreferred or inappropriate term; for this, we again ask forgiveness of those who have not been named or not been named appropriately. We recognize that even terms such as 'POC' and 'Multi-racial' can be problematic and colonial ways of removing identity, and yet for others can be empowering ways of acknowledging intersection and shared experiences within communities.

In addition, the term 'Two-Spirit' has become a commonly used term to name the intersecting identity of Indigenous people in sexual and gender diverse communities. However, for some Indigenous people it is not an accurate or fitting term for them; many of these people have chosen to use Indigenous and Queer or Thirza Cuthand's term 'Indigiqueer' to acknowledge this intersection while removing some the gender duality implications and cultural protocols of 'Two-Spirit'. In an effort to prioritize Indigenous people, we use both terms.

This work also highlights folks experiencing oppression in terms of body diversity (fatphobia), poverty, ableism and other intersectionalities. We acknowledge that none of this expansive complexity can be summarized with a single acronym or reference point. For this reason, the report uses the phrase "sexual and gender diverse communities" to represent all of these various identities including those diverse and significant intersections; and 2SQTIBMPOC is used when specifically referring to those at the intersection of sexual and gender diversity and Indigeneity, race and racialization.

It's also important to note that there are many ways participants chose to identify their communities or the communities they serve. In many of their quotes, various acronyms are used, such as QTBIPOC, BIPOC, BIMPOC, etc. We have chosen to keep many of these as is, in order to maintain the integrity of the words used and to honour the stories and identities of the participants who shared with us. All of these acronyms are intended to acknowledge the intersections of race and the experience of racialization.

SEXUAL AND GENDER DIVERSE COMMUNITIES IN BRITISH COLUMBIA EXPERIENCE SIGNIFICANT HEALTH DISPARITIES WHEN COMPARED WITH THE HETEROSEXUAL AND CISGENDER POPULATION. THESE DISPARITIES ARE ROOTED IN LONG-STANDING SOCIAL AND CULTURAL INEQUITIES THAT HAVE SERVED TO DISADVANTAGE THESE COMMUNITIES, AND PERPETUATE BROAD-BASED STIGMA AND DISCRIMINATION.

THE NEGATIVE IMPACT OF THIS STIGMA IS FURTHER AMPLIFIED FOR MANY 2SQTIBMPOC AS A RESULT OF BROADER SOCIO-ECONOMIC CONCERNS SUCH AS HISTORIC AND ONGOING COLONIZATION; RACISM; INTERGENERATIONAL AND MULTIGENERATIONAL EXPERIENCES OF TRAUMA AND GENOCIDE; POVERTY AND CLASSISM; AND, SEXISM AND MISOGYNY, AMONGST MANY OTHERS.

SEXUAL AND GENDER DIVERSE COMMUNITIES IN BRITISH COLUMBIA EXPERIENCE SIGNIFICANT HEALTH DISPARITIES WHEN COMPARED WITH THE GENERAL POPULATION. THESE DISPARITIES ARE ROOTED IN LONG-STANDING SOCIAL AND CULTURAL ISSUES THAT HAVE SERVED TO DISADVANTAGE THESE COMMUNITIES, AND PERPETUATE BROAD-BASED STIGMA AND DISCRIMINATION.

The negative impact of this stigma is further amplified for many 2SQTIBMPOC as a result of broader socio-economic concerns such as historic and ongoing colonialism, racism; intergenerational and multigenerational experiences of trauma and genocide; poverty and classism; and, sexism and misogyny, amongst many others.

In 2015, the BC Ministry of Health invested $500,000 to investigate health barriers for sexual and gender diverse people with a one-time grant given to Watari, a non-profit organization to manage. A grassroots collaborative assembled to carry out the work. In 2018 management was subcontracted to PeerNetBC who has supported the active research phase of the project.

The Health Equity Collaborative brings diverse people together to create a common agenda for positive change. It includes people with lived 2SQTIBMPOC experience and allies such as health care professionals, researchers, and community leaders. Currently we have 45 members, about 20 of whom are very active. Over the past 5 years of the project around 100 people have been a part of the collaborative.

HEC engaged in a participatory and equity-focused consultation process designed to understand and create a community-based report. During this process, a further 100 Subject Matter Experts (SMEs) and community members were engaged through focus groups and interviews.

HEC set out to conduct the following peer-based research:

1. Describe barriers and victories shared from the perspectives of 2SQTIBMPOC individuals and communities relating to health care access, inclusion, and quality of interaction with health services;
2. Seek Wise Practices from current and former services and community supports;
3. Provide recommendations for improved policy and practice in BC.

This is certainly not the first study regarding health barriers affecting sexual and gender diverse communities. However, unique to this study was the prioritizing of Black, Indigenous, Multi-racial and People of Colours' voices. Aka a focus on 2SQTIBMPOC voices. Voices that, with few exceptions, (asexual, agender, trans women, folk with disabilities, disabled folks) have been underrepresented and tokenized in previous studies of sexual and gender diverse communities.

It is important to acknowledge that in research, the method is just as important as the findings because it is the method of research that strengthens the validity of those findings. So, while some of our recommendations may align with past studies, the relational community-based process makes the data collected significantly different and therefore should be considered a stand-alone report. Research was divided into three areas – peer-led community focus groups, a health services scan, and a comprehensive literature review.

These three research projects resulted in 12 peer-led community focus groups, including 4 rural consultations and over 100 participants; 12 interviews with subject matter expert (SME) service providers who have lived experience

as leaders of the 2SQTBIPOC and 2SQTIBMPOC communities; and a review of over 120 pieces of literature.

BY US FOR US

"THE URGENCY OF INTERSECTIONALITY"

We strove to listen to the voices of people at the intersection of gender identity, sexuality, Indigeneity, and racialization. Voices that, with few exceptions, have been underrepresented and tokenized in previous studies of sexual and gender diverse communities. In The Urgency of Intersectionality, Kimberlé Crenshaw states:

> *People ask, 'An issue that affects black people and an issue that affects women, wouldn't that necessarily include black people who are women and women who are black people?' The simple answer is that this is a trickle-down approach to social justice and many times it just doesn't work. Without frames that allow us to see how social problems impact all the members of a targeted group, many will fall through the cracks of our movements, left to suffer in virtual isolation.*

Centring the intersections was a significant driver in all of our research and, ultimately, our recommendations. However it is important to acknowledge, this was not how HEC began, but rather what it evolved into under the guidance of members of the Indigenous and BMPOC Caucuses. Systemic and interpersonal racism, colonial processes and limited capacity on short timelines have all been part of the reality of HEC which we have endeavored to navigate together.

METHODOLOGY

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As mentioned, the true substance of our report is in the research method and the way stories and experiences were used to inform our recommendations. Unlike many past studies, this project collaborated with communities in a way that reduced the potential for harm and empowered participants to lead the research.

In the group consultations, trusted community members were invited to host the consultations within their own communities which was a framework that ultimately reflected the recommendations from the consultations. Multiple focus group hosts reflected the safety this created for them in participating in what can often be re-traumatizing processes.

In the Services Scan, we were gifted twelve Subject Matter Experts' (SME) recommendations on what 2SQTIBMPOC communities need from services to thrive and be well, and how 2SQTIBMPOC are currently being harmed through barriers to health equity, and what Wise Practices we could learn from. By using an approach of relationality, SMEs were invited through pre-established warm relationships that allowed in-depth and rich stories to be shared.

It was also identified by participants and hosts that, knowing the collaborative had so many 2SQTIBMPOC members, especially people who were actively involved in their communities, allowed them to speak candidly and share stories and experiences they would likely not have shared otherwise. This was the foundation that allowed for a level of depth and quality not often found in health disparity research. That said, it was, and remains, important to acknowledge potential harms caused by placing any added labour onto those working each day just to exist within systems and structures of power.

See notes from the lead researchers in the full report.

From this research, we learned that **sexual and gender diverse communities are resilient and resourceful health system navigators. Members of these communities help one another to get the services they need through formal and informal support networks.**

WHILE WE KNOW THAT COMMUNITY MEMBERS ARE FINDING WAYS TO ACCESS THE CARE THEY NEED, THIS ADVOCACY OFTEN CONCEALS THE BIGGER SYSTEMIC ISSUES AT HAND AND FURTHER INCREASES SOCIO-ECONOMIC GAPS. PART OF ENSURING SAFETY IS UNDERSTANDING WHAT IS PUTTING PEOPLE AT RISK.

A LACK OF HEALTHCARE PROVIDERS EDUCATED ON INTERSECTIONAL ISSUES.

SOCIAL AND GEOGRAPHIC ACCESSIBILITY.

CLIENT DIRECTED CARE.

A LACK OF HEALTHCARE PROVIDERS EDUCATED ON INTERSECTIONAL ISSUES

The number one barrier to care identified by study participants was a lack of health care providers knowledgeable in intersectional issues. This finding echoes other national and international studies on health equity which show that although advanced medical guidelines exist, these are subject to physician discretion, which is often guided by moral, religious or other personal views.

"Right now within Vancouver, everything is super liberal.... BIPoC (Black, Indigenous, People of Colour), BIPoc, BIPoC, specifically for Indigenous people but it feels like hollow representation without an understanding of settler colonial impacts as well as capitalist impacts on the body and being…. We're not actually accessing things that heal us. I see it with the young people I work with that they fully step back. And I fully step back. And how do we navigate a system where the youth I work with are coming to me being like "I can't go here" and I'm like "oh yeah same" but I'm supposed to tell you you should. That's wild."

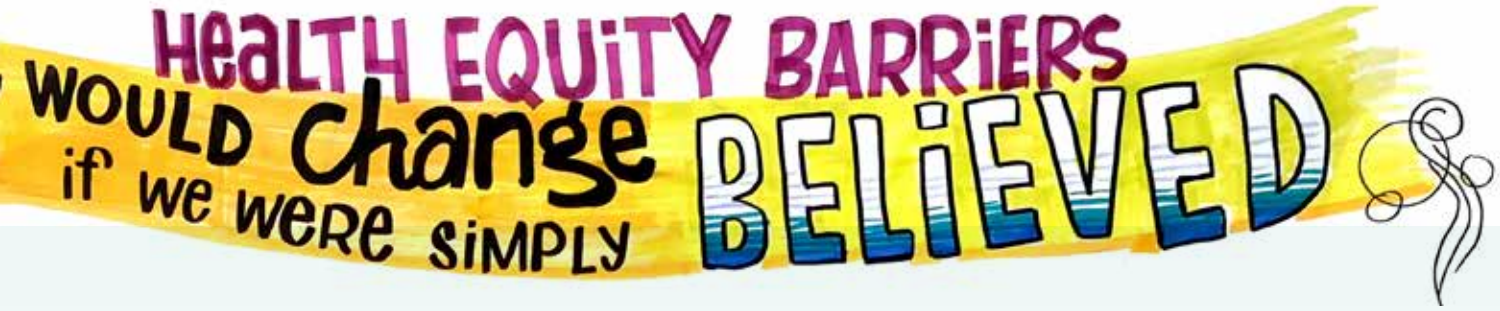
— SERVICES SCAN SME

"If my doctor doesn't believe me about my sexuality and makes me feel like it's not even a real thing then why should I trust them to believe me about the pain I feel. Both are connected to my health. It just makes me not trust them and not want to ask for help."

— CONSULTATION PARTICIPANT

"So diagnoses and health care, on that too is when we're looking at specific needs, especially like smaller towns, there's stigma and it's mostly white straight doctors that are seeing you and you know you need HPV meds or you're wanting to, to get tested for all these things or you wanna go to a space but then you're being told, like people are still looking down their nose at you, like oh your people, you know. Gay people are at higher risk of this, this and that, you know and one of the safest ways is abstinence and you're kind of like…"

— SERVICES SCAN SME



SOCIAL AND GEOGRAPHIC ACCESSIBILITY

Participants report having to choose between their sexual/gender and racial/cultural identity to receive care. This is due to racism in white mainstream LGBTQ+ service provision and Homophobia/Transphobia in IBMPOC (Indigenous, Black, Multi-racial, and POC) service provision. In rural consultations, participants expressed feeling like they needed to choose between receiving inadequate care from someone with little education around their concerns, being put on lengthy waitlists to see someone with the appropriate education and experience, or attempting to find the time and resources to travel to a larger city.

"Shorter waitlists are a literal life and death matter sometimes. So many of us struggle with severe depression and anxiety around our bodies and we have like one doctor here who understands dysphoria and how to get started with hormones. Her waitlists are so long. I know multiple people who commit suicide before they ever get to see someone."
— CONSULTATION PARTICIPANT

"A doctor once told me 'if your parents are abusive just cut them out of your life' but for many cultures this creates added trauma and a ripple effect. Colonialism has already created fractured families amongst many BIPoC." — CONSULTATION PARTICIPANT

"I think the frustration is recognizing the whole of the person's intersectional identity is relevant in a way that is actually, is, accessible rather than making people pick or choose like what part of your identity is most important? Do you wanna not be misgendered? Yeah, but I don't wanna go into a white centred space, you know that's something, I hear things like that or I'm disabled and I literally cannot get through the door of the organization you're recommending for free counselling. Another one I hear, things like that, well, I'd really like to go access sexual health services and I hear these people are good but I'm, I'm super fat and I literally don't know if they have tables that will hold my body and I don't wanna call in and ask and, and it's already so complicated 'cause I'm trans. So the intersectional piece is a really deep foundational piece."
— SERVICES SCAN SME

LACK OF CLIENT DIRECTED CARE

Study participants reported health decisions being made for them instead of with them. These decisions may or may not have been beneficial, but the larger concern was that they were being made without the client being given all of the information needed to participate in the decision-making process. Patients seeking care for a specific health issue report their healthcare provider often bringing up concerns and questions unrelated to the issue they were seeking support for. Themes from participants included how their self-reporting was not believed to be accurate. Their health issue often remains unaddressed. Privacy breaches are common and include sharing sensitive information with family members not identified as safe, putting patients at risk. Patients report having to plead their case for services.

"So anti-Black racism, kind of, almost, cost me my vision."
— SERVICES SCAN SME

"I'm asexual but this one doctor I had just kept thinking I had a low libido and when I wanted something to help my depression, he wouldn't prescribe me anything because a common side effect was low libido. It just seems like he got to say that was a worse issue, even though my sexuality isn't an issue, than my depression."
— CONSULTATION PARTICIPANT

"[Healthcare providers] often want to focus on a single issue that they see as important, but not address what I want to address, or shrug it off as 'not a big deal'. But like, if I'm coming to you [despite all of the barriers], then it's a big deal." — CONSULTATION PARTICIPANT

THE RESEARCH RESULTED IN RECOMMENDATIONS GROUNDED IN THREE AREAS OF ACTION THAT WOULD ADDRESS THESE MAJOR BARRIERS.

SAFETY

Create structural changes to ensure cultural and identity safety (as a foundation of effective care). And, end harms caused by systemic discrimination towards 2SQTIBMPOC communities (I.e. Including addressing ways the healthcare system perpetuates and participates in colonization, and systemic racism, transphobia and homophobia.)

An SME explained how in the opioid crisis, it is currently showing that *NO* non-binary, trans, Two-Spirit person has been impacted "You need data for funding." — SME

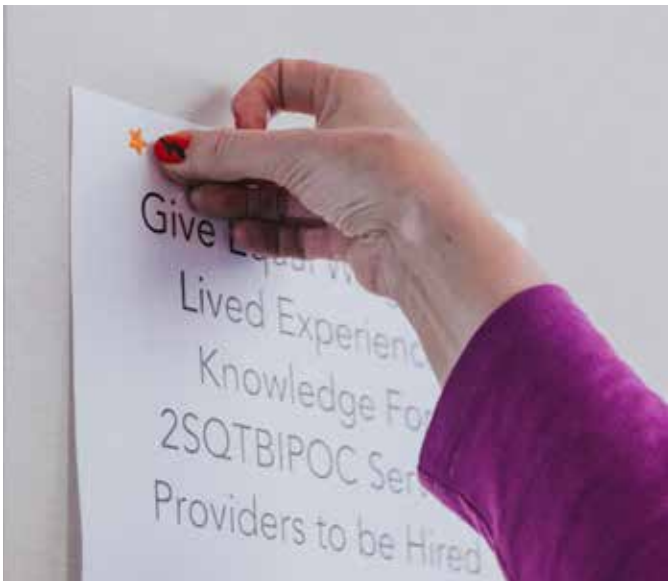
SAFETY ACTION #1
With 2SQTIBMPOC voices leading the way; in partnership with allies in government(s), health agencies, and community based agencies engage in an intersectional health policy review process, and invest in implementation of suggested policy revisions.

SAFETY ACTION #2
Visibility in data collection. To allow for a better intersectionality lens in health research in BC, add to Coroner's data — gender identity and sexual orientation, and add gender options to population-level data collection.

SAFETY ACTION #3
Provide provincial coverage for all specialized Two-Spirit, trans, and non-binary services as determined necessary by Two-Spirit, trans, and non-binary people (and advocate for federal funds). This includes, but is not limited to voice therapy, facial feminization surgery, and permanent hair removal services.

SAFETY ACTION #4
Implement systems to flag, and establish procedures to address waitlists for services longer than 6 months (e.g. increase number of care providers, or expedite access to funding for clients to seek services in another area of the province where waitlists are shorter, and optional travel companion funds in such cases).

SAFETY ACTION #5
Create a policy for all providers and staff to use their chosen name and correct pronouns when addressing the patient/client. In order to streamline this process, it is recommended that health forms and documents also list and prioritize these



names and pronouns. The assigned gender at birth should only be accessible to staff who require this for clinical or legal reasons, and the assigned name at birth should only be listed or visible when legally necessary.

SAFETY ACTION #6

Reduce the amount of paperwork / online forms necessary to access funding and subsidized supports.

SAFETY ACTION #7

Fund the integration of Indigenous teachings and protocols into every health service, health building and all organizations as one way to ensure cultural safety for all Two-Spirit people, Indigiqueers, and trans-identified Indigenous people; i.e. by hiring local Two-Spirit, Indigiqueer, and allied Elders and Knowledge Keepers; and creating partnerships for Two-Spirit people and Indigiqueers with Elders and Knowledge Keepers wanting to revitalize non-binary and gender affirming ceremony.

"There honestly shouldn't ever be health buildings that don't include an Elder or Knowledge Keeper. Like how is that reconciliation if my health doesn't include the original healers and protectors?"
— CONSULTATION PARTICIPANT

SAFETY ACTION #8

Support systemic changes (including inter-government / inter-ministry relationships) to shift towards more holistic approaches to healthcare, for example wraparound care and integrated service centres. This has broad implications throughout service provision, finances, policy, accreditation etc.

"It always feels like they just want to patch us up and send us on our way. But in our culture, and in lots of cultures, that's not care. So I just don't believe you can call it health 'care' if services aren't making sure people have enough food to eat and have safe places to sleep. Those can't be separate." — CONSULTATION PARTICIPANT

This highlights one of the particular harms of the colonial system mentioned frequently in our research-— the separation of various aspects of personal health into myriad services, and silo service providers in different fields that are all related (e.g. sexual health, physical health, mental health, cultural access, hunger/food, safe housing, finding work etc.)

SAFETY ACTION #9

Create sustainable funding to plan and implement a holistic, decolonial, intersectional healthcare framework to increase health access and safety for 2SQTIBMPOC, all actions discussed above, and focus on a three-pronged approach:

1) Increase funding for existing 2SLGBTQ+ and cultural health organizations.
2) Create a specific intersectionally-focused advisory group/ agency, and
3) Identify defunded and grassroots 2SQTIBMPOC organizations that were previously or are considered effective and safe by 2SQTIBMPOC communities and provide funding.

"We (Black and Indigenous groups supporting 2SQTBIMPOC) aren't even asking the government to reinvent the wheel. Like we're already doing the work, we know what works for our communities and how to give that to them. We just need the money to do it or at least let us help you shape programs already being funded. It would be such a minimal investment to pay us for our time and knowledge and such a huge payoff to have healthier communities."
— CONSULTATION PARTICIPANT.

EDUCATION

Increase health care provider education and awareness about sexual and gender diversity, especially provision of care for 2SQTIBMPOC with intersecting identities.

"There are barriers to Indigenous people accessing gender affirming care. We face stereotyping, for example, the assumption that we will have drug and alcohol use. Or another example, if you go in and say you have a cough, the doctor may shift to asking about your transgender variance and is wanting you to educate them about transgender experience. They will ask inappropriate questions like what was your childhood like? And the difference between service depends on if you're light-skinned are dark skinned" — SME SPEAKS ON THE INDIGENOUS TRANS EXPERIENCE IN PRIMARY HEALTH CARE

EDUCATION ACTION #1

Engage 2SQTIBMPOC service providers, health educators and communities to develop education tools for all health care providers (for doctors, nurses, all primary health care workers, including front desk staff) to address lack of awareness around Sexual and Gender diversity issues, especially as they intersect and compound with barriers faced by racialized people.

EDUCATION ACTION #2

Implement systemic mandatory training and protocols for providers to better care for sexual and gender diverse communities with intersecting identities by individuals and organizations in those communities. Including a provincial mandatory 2SQTIBMPOC Identity Affirming Care Model.

EDUCATION ACTION #3

Increase access to education for 2SQTIBMPOC candidates — through funding and direct invitations to participate in training programs and higher education.

EDUCATION ACTION #4

Fund more peer-based research, especially around identified research gaps within the province related to intersectional diversities, in particular Two-Spirit women and trans women of colour; and 2SQTIBMPOC folks who are also: South and East Asian, multi-generational Black Canadians, newcomers to Canada, living on reserve or in rural areas, and seniors.

EMPOWERMENT

"Believe Me"— Reposition 2SQTIBMPOC people in the eyes of the healthcare system as leaders of their own health and wellness journey.

EMPOWERMENT ACTION #1

Access to health care jobs/careers – revise hiring policies to include relevant lived experience of 2SQTIBMPOC as a valued qualification. This revised hiring practice will greatly increase the health care system's capacity to serve intersectional communities effectively.

An SME describes the solution to providing intersectional health care: "I actually think it's quite simple. I think it's that we need the health care services to have people working and being part of it who actually represent all those areas of diversity and for all of them to have voices". — SME

EMPOWERMENT ACTION #2

Shift to client-centred care, where 2SQTIBMPOC clients lead their health care plans, and participate directly in decisions made about their health.

One SME reported "invasive completely unnecessary procedures," for example, they wanted to access birth control medication to suppress monthly bleeding because, "that's hugely gender-dysphoric producing." But then described being forced to undergo sexual health related procedures the patient deemed unnecessary, unsafe and uncomfortable, in order to access the medication even though, they pointed out that they are not sexually active and that's not their purpose for the medication choice.

EMPOWERMENT ACTION #3

Create health literacy/navigation tool(s) that respond to unique contexts of intersectional identities and positions, designed in collaboration with 2SQTIBMPOC folks to reduce barriers to system navigation and increase understanding of patient rights and recommended practices they can use when discussing care plans and choices with service providers.

EMPOWERMENT ACTION #4

Create or improve support systems and address retention and burn-out for 2SQTIBMPOC service providers (including front-line staff in housing and other health-related services.) Specifically - fund 2SQTBIMPOC training, mentoring, fair wage adjustments, and paid-time for peer-based and other (e.g. Elder) support. This action recognizes the unique challenges facing service providers with lived experience, and honours their invaluable role in an improved health care system.

CONCLUSION TO SUMMARY

HEALTH AS A HUMAN RIGHT FOR SEXUAL, GENDER, AND RACIALLY DIVERSE PEOPLE MEANS BC HAS A LEGAL OBLIGATION TO ENSURE ACCESS TO PREVENTION, TREATMENT, AND HEALTHCARE SERVICES. IN THIS REPORT WE HAVE PROVIDED A FRAMEWORK FOR IMPLEMENTING THESE PRACTICES WITH CARE AND RESPECT FOR OUR 2SQTBIMPOC COMMUNITIES.

Ultimately our goal is to create more equitable access to healthcare. We thank existing leaders and health advocates who are now, and have long been, doing this work. And we call on all potential partners to help carry out the Areas of Action HEC has pointed to in this report.

The full HEC report expands on the specific ways in which these Areas of Action can remove or reduce the negative impacts of the identified barriers. These are explained further by the voices of the people most impacted.

To see the full report please go to
http://www.peernetbc.com/hec-health-equity-collaborative

ACKNOWLEDGEMENTS

HEC WOULD ESPECIALLY LIKE TO THANK:

Sulalewlh (Elders) Bill White and Roberta Price for all their guidance and teachings.

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NOTE: Vintage protest posters seen in the background of some images are from an exhibit at the SUM Art Gallery "69 Positions." (A cross-Canada exhibition series based on an original idea and coordinated by Jordan Arseneault for MediaQueer.ca with generous funding from the Canada Council for the Arts.)

AND MANY THANKS TO ALL THE HEC MEMBERS, SMES AND COMMUNITY CONSULTATION PARTICIPANTS WHO CONTRIBUTED TO THE HEC REPORT (This list does not include many contributors who wished to remain anonymous, you know who you are, and we thank you.)

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Morgan Switzer
Nesa Hamidi Tousi
Nikki Zawadzki
Nona Marchand
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Serene Carter
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Tyler Robinson
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THESE ORGANIZATIONS ALL DONATED STAFF TIME IN-KIND TO SUPPORT HEC

Aboriginal Health · Vancouver Coastal Health · British Columbia Ministry of Health · BC Centre for Disease Control · BYRC A Program of Pacific Community Resources Society · Centre for Gender & Sexual Health Equity · City of Vancouver · Community-Based Research Centre · HIM Health Initiative for Men www.checkhimout.ca · Options for Sexual Health · SFU Simon Fraser University · TransCare BC

ACKNOWLEDGING THE MANAGING ORGANIZATIONS

PeerNetBC Helping People Connect

Since early 2018 HEC has been actively supported by PeerNetBC, through a full time HEC Coordinator and administrative support.

WATARI

PeerNetBC was subcontracted by Watari, who originally received the funds in 2015 from the Ministry of Health.

BELIEVE ME.