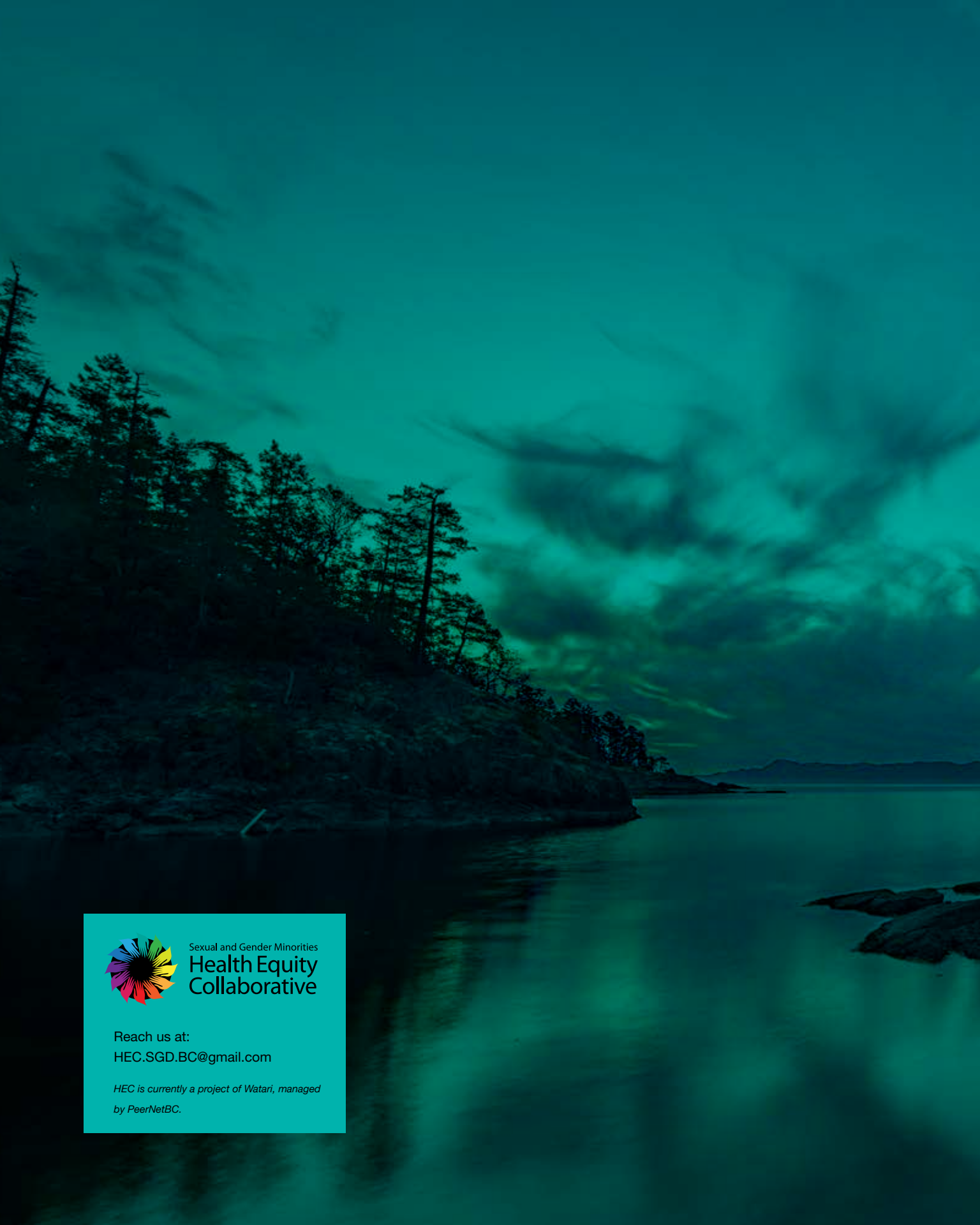
HEALTH EQUITY

for SEXUAL AND GENDER DIVERSE COMMUNITIES

BELIEVE ME.

IDENTIFYING BARRIERS TO HEALTH EQUITY FOR SEXUAL AND GENDER DIVERSE COMMUNITIES IN BRITISH COLUMBIA

Sexual and Gender Minorities
Health Equity
Collaborative



Sexual and Gender Minorities
Health Equity
Collaborative

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HEC is currently a project of Watari, managed by PeerNetBC.

LAND ACKNOWLEDGEMENT

HEC 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, traditional and unceded homelands of the **sḵwx-wú7mesh** (Squamish), **sel̓íl̓witulh** (Tsleil-Waututh), and **xwməθkwəy̓əm** (Musqueam) Nations.

Through our five 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 and unceded 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. As part of "Health Inequalities and Social Determinants of Aboriginal Peoples' Health" for the National Collaborating Center for Aboriginal Health, they have included under Distal Determinants of Health the following "Colonialism, Racism and Social Exclusion, Self-Determination". Each of these has a direct and indirect effect on the Two-Spirit, Sexual and Gender Diverse communitie; they are without a doubt traumatizing for those who live in these communities, and those who have been affected by road blocks. These events have not only had an effect on the 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 a responsibility to understand the traditional laws of these territories and we commit to learn and to work with our hosts.

ACKNOWLEDGMENT FROM INDIGENOUS CAUCUS

> *"As Two-Spirit peoples we want to honour and hold up our Two-Spirit and Indigiqueer 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 Indigiqueer 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 recognize 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), Sḵwx̱wú7mesh (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, and 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 a significant

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

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 and 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 and rituals, which predate the arrival of Europeans continue to this day. The Winter Dance Complex, where at its peak 1,000 people might attend, and at various Shaker Church Services, where several hundred might attend, have also been described as places of healing, this reinforces 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, who for the most part have no idea what 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 their 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."
Elder WilliamWhite

2SQTBIMPOC is a key term used throughout this report.

The letters of this acronym stand for Two-Spirit, Queer, Trans, Black, Indigenous, 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'[1]. 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 2SQTBIMPOC is used when specifically

1 Thirza Cuthand coined the term "Indigequeer/Indigiqueer" in 2004 while titling the Vancouver Queer Film Festival's Indigenous/Two-Spirit programming. Indigiqueer Origin.

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.

Furthermore, we acknowledge that in our originally published Report Summary we moved the 'I' in front of the 'B' to read 2SQT**IB**MPOC. This was done intentionally and led by our joint Indigenous and POC caucus with the intent to acknowledging Indigenous people first.

However, through the generous education and calling-in by other Black and Indigenous femmes in the community, we were made aware that the original acronyms (BIPOC and QTBIPOC) were created by Black femmes and that the altering of their work in a way that de-centres them is anti-Black racism. For this we want to apologize to members of the Black community.

To honour that origin of the acronyms we have used 2SQT**BI**MPOC in this full version of the report while 2SQT**IB**MPOC remains in the report summary since it has already gone to print. We also recognise that acronyms IBPOC and QTIBPOC have been developed in Canada in conversations with Indigenous, Black and People of Colour communities and that all of these terms are currently in use and discussion by various communities.

The term 2S remains at the front of the acronym in all cases, to continue to centre and honour Two-Spirit / Indigiqueer folks in our report.

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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 2SQTBIMPOC 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.

ABOUT THE HEALTH EQUITY COLLABORATIVE (HEC)

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 2SQTBIMPOC experience and allies such as health care professionals, researchers, and

community leaders. Currently we have forty-five members, about twenty of whom are very active. Over the past five years of the project around one hundred 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 one hundred 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 2SQTBIMPOC 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.
4. 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.

"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 gender and sexual 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.[2]**

Centering 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.

2 The Urgency of Intersectionality Lecture

METHODOLOGY

There is an understanding 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 twelve peer-led community focus groups, including four rural consultations and over one hundred participants; twelve interviews with subject matter experts (SMEs) service providers who have lived experience as leaders of the 2SQTBIMPOC communities; and a review of over 120 pieces of literature.

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.

THE METHOD IS JUST AS IMPORTANT AS THE FINDINGS BECAUSE IT IS THE METHOD OF RESEARCH THAT STRENGTHENS THE VALIDITY OF THOSE FINDINGS.

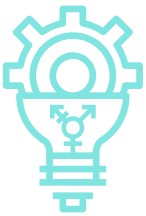
The true substance of our report is in the research method and the way stories and experiences were used to inform our recommendations. Unlike many past studies, this project collaborated with communities in a way that reduced the potential for harm and empowered participants to lead the research.

In the Services Scan, we were gifted twelve Subject Matter Experts' recommendations on what 2SQTBIMPOC communities need from services to thrive and be well, and how 2SQTBIMPOC 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 2SQTBIMPOC 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.

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.



1 | 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 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 HIV 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**

2 | SOCIAL AND GEOGRAPHIC BARRIERS TO 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 BIMPOC (Black, Indigenous, 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. Colonization 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 centered 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 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"-— SME**

3 | 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[3] kind of almost cost me my vision"— SME**

Comment refers to SME being told for months that eyelids were not infected because they looked pink and healthy when healed and healthy eyelids on their/dark skinned body/ies are pigmented brown. Delayed treatment resulted in further vision loss, suffering and other complications. See notes from the lead researchers in the full report.

- **"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**

3 Reference to colorism in health care - https://globalnews.ca/news/4060413/doctors-textbooks-skin-tones-racial-minority-care/

OVERVIEW OF RECOMMENDATIONS

To address the barriers outlined above, HEC's research revealed recommendations grounded in three Areas of Action:

SAFETY

Create structural changes to ensure cultural and identity safety (as a foundation of effective care). End harms caused by systemic discrimination towards 2SQTBIMPOC 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 Two-Spirit, trans or non-binary person has been impacted, "You need data for funding." — SME

EDUCATION

Increase health care provider education and awareness about sexual and gender diversity, especially provision of care for 2SQTBIMPOC 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 or dark skinned" — SME speaks on the Indigenous trans experience in primary health care.

EMPOWERMENT

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

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." Services Scan SME

NINE ACTIONS FOR SAFETY

SAFETY ACTION #1 With 2SQTBIMPOC 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 a patient/client's chosen name and correct pronouns when addressing them**. 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 silos 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 an holistic, decolonial, intersectional healthcare framework to increase health access and safety for 2SQTBIMPOC, including 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 2SQTBIMPOC organizations that were previously or are considered effective and safe by 2SQTBIMPOC 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.

FOUR ACTIONS FOR EDUCATION

EDUCATION ACTION #1	Engage 2SQTBIMPOC service providers, health educators, and communities to develop education tools for all health care providers (for doctors, nurses, all primary health care workers, and 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.[4]
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 2SQTBIMPOC Identity Affirming Care Model.[5]
EDUCATION ACTION #3	Increase access to education for 2SQTBIMPOC applicants — 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 2SQTBIMPOC folks who are: South and East Asian, multi-generational Black Canadians, newcomers to Canada, living on reserve or in rural areas, and seniors.

4 We recognize that many excellent population-specific training materials exist around e.g. Indigenous Cultural Safety, Trans Affirming Service Provision, etc. What's called for is more support to dialogue between and weave these knowledges together to create more consistent intersectional approaches.

5 We acknowledge that such care models do exist, for example the way Trans Care BC provides services is reported to be very effective, the call is for the broader healthcare system to learn from and adopt widespread replication of these protocols.

FOUR ACTIONS FOR EMPOWERMENT

EMPOWERMENT ACTION #1

Access to health care jobs/careers – Revise hiring policies to include relevant lived experience of 2SQTBIMPOC 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 2SQTBIMPOC 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 tools that respond to unique contexts of intersectional identities and positions, designed in collaboration with 2SQTBIMPOC 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 2SQTBIMPOC 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) supports. This action recognizes the unique challenges facing service providers with lived experience, and honours their invaluable roles in an improved health care system.

HEALTH AS A HUMAN RIGHT FOR SEXUAL, GENDER, AND RACIALLY DIVERSE PEOPLE MEANS BC HAS A LEGAL OBLIGATION TO ENSURE ACCESS TO HEALTHCARE PREVENTION, TREATMENT, AND CARE 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 rest of this 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. We also share a more detailed background of HEC's journey as a community-based health collaborative.

See the PDF version of the Report Summary and other related documents from HEC:
www.peernetbc.com/hec-health-equity-collaborative

THE SEXUAL AND GENDER DIVERSITY HEALTH EQUITY COLLABORATIVE, OTHERWISE KNOWN AS HEC, IS A GROUP OF KEY STAKEHOLDERS ACROSS BRITISH COLUMBIA THAT ARE PART OF, OR ARE INVOLVED IN, SEXUAL AND GENDER DIVERSE COMMUNITIES.

WE ARE A DIVERSE GROUP OF FOLKS THAT COME FROM MANY DIFFERENT CIRCLES; MANY OF US WORK, VOLUNTEER, OR PARTICIPATE IN HEALTH CARE AND SOCIAL SERVICES.

WE ARE COMMUNITY LEADERS, GRASSROOTS ORGANIZERS, RESEARCHERS, EDUCATORS, AND MUCH MORE.

COLLECTIVELY, WE HAVE A GREAT DEAL OF KNOWLEDGE AND EXPERIENCE IN SGD HEALTH AND WELLNESS, AND THIS WORK IS DONE BY US, FOR US, AND FOR OUR LOVED ONES AND COMMUNITIES.

We do this work because we are aware, both personally and professionally, that sexual and gender diverse people experience barriers to care, have significantly higher negative health outcomes, and are often more marginalized and isolated, than our straight and cisgender peers. Many of us have experienced these issues first hand, or have witnessed our loved ones and community members suffer in a system that is not designed to see us, or to welcome us.

We also recognize that for the most marginalized among us, these impacts are compounded by other intersecting oppressions and are even more acutely impactful. Those of us who come from rural and remote areas; who are youth or Elders; who are Indigenous, Multi-Racial, Black or other People of Colour; or are Two-Spirit, trans, non-binary, or gender diverse; and/or are living in poverty; and especially those of us who experience multiple and intersecting marginalized identities, see some of the greatest health inequities.

Because we know this, *because we live this*, we have come together to use our knowledge and experiences to help narrow the gaps in access to health care and supports for sexual and gender diverse communities. We have done this by conducting peer-based research across BC, to give a broad picture of the state of health and wellness for sexual and gender diverse communities. Out of this work, we have come up with some solid recommendations for policy, practice, and funding, to address the inequities that our communities are experiencing.

In order to create this resource, we have worked very hard at developing relationships and building trust with each other, and this has not always been easy. Colonization impacts the way all members of society view race, gender and sexuality,[6] and our group was not immune. Despite our best efforts to work together, our group has struggled at times. Early on in our process, many of the 2SQTBIMPOC in our group felt that power was operating on the sidelines and that they were being excluded.

These concerns were identified early on by many 2SQTBIMPOC at our first large gathering, they were first voiced to the larger group by a young Indigenous woman, and a Black trans woman. This led us to realize how we were reproducing inequity, and colonial power structures from within. In particular, many white LGBTQ+ health advocates were enacting white privilege and colonial education without an explicit or active commitment to counter racism both internally and externally. In order to address this, many of the white members who stayed with HEC participated in a white privilege training and out of this, came up with a list of White Caucus Commitments[7] that outline specific commitments as an aspirational guide for their learning and action within HEC's intersectional work.

Meanwhile, the Indigenous Caucus and Black-POC Caucus (which often meets together as the Joint Caucus) drafted HEC's Terms of Reference. This document reflects our core values of care and respect for each other, and our commitment to accountability and unlearning colonial ways of thinking.

6 Sarah Hunt, "An Introduction to the Health of Two-Spirit People: Historical, Contemporary, and Emergent Issues" (Prince George, BC: National Collaborating Centre for Aboriginal Health, 2016), online (pdf): <https://www.ccnsa-nccah.ca/docs/emerging/RPT-HealthTwoSpirit-Hunt-EN.pdf>.

7 White Caucus Commitments are available in the Appendices.

In the active research phase of the project 2018-2020, we also engaged Indigenous Elders, Roberta Price from Snuneymuxw and Cowichan Nations, and Elder Bill White who is Coast Salish also from Snuneymuxw Nation. These Elders provided guidance and leadership at many key moments throughout our research journey. We offer our thanks for their invaluable role in grounding our work and helping us to see the bigger picture of how we are all connected; which is ultimately at the heart of equity work.

Over the last five years, our group has seen many ups and downs. We have lost and gained many members, and we have worked hard to restructure the power dynamics within, attempting to centre 2SQTBIMPOC folks who have the most direct experience with the barriers discussed in this report.

We are proud of our persistence, determination, and commitment to stick with work that was often very challenging and difficult. We want to share our story and our experience as a collaborative with those of you who may undertake similar work.

We have learned a lot throughout this process, especially that in order to work towards real equity, we need to value the difficult process of building trust and relationships across differences, as much as we value the outcomes of the work.

We hope that our report reflects the passion that we have for this important work, and the love and care that we hold for our sexual and gender diverse communities and relatives.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Sexual and Gender Diversity
Health Equity Collaborative

HONOURING THE RIGHT TO HEALTH FOR SEXUAL, GENDER, AND RACIALLY DIVERSE COMMUNITIES

Many causes of health inequities stem from unjust social and environmental conditions linked to income, social, status, race, gender, education, and physical environment. For instance, everyone has the right to define their own gender identity. Sexual and Gender Diverse people should be recognized and treated as the identity they live in. Legislation, policies, and practices that fail to do so can cause harm leading to the oppression of, and discrimination against, Sexual and Gender Diverse people. A human rights-based approach can reframe the health issues related to the denial of these rights, particularly in promoting the human rights of people in vulnerable circumstances.[8] In this circumstance, health policy and programs must first prioritize the needs of those furthest behind in working towards health equity.[9] Based on the understanding of Kimberlé Crenshaw's theory of Intersectionality[10], we know that 2SQTBIMPOC have added layers of discrimination and increased health disparities. This is further deepened in the experiences of those with added intersections (ie. body diversities, neurodiversities, disabilities, etc.).

Health is a fundamental human right.[11] Understanding health as a human right creates a legal obligation to ensure access to timely, acceptable, and affordable quality health care while providing for the underlying determinants of health such as food, housing, work, education, information, and participation.[12] Therefore, the right to health depends on the realization of other human rights. Health equity for Sexual and Gender Diverse Communities means every individual can have a fair opportunity to reach their fullest health potential. To achieve this health equity vision, we must work to address the preventable, unnecessary, and avoidable differences in all aspects of health for Sexual and Gender Diverse people, with particular focus on 2SQTBIMPOC. Part of this vision is guided by working towards decolonization. The Truth and Reconciliation Commission's Calls to Action and Principles and the United

8 See Canada's legal obligations in international human rights conventions and declarations: The Convention on the Elimination of All Forms of Discrimination Against Women, Convention on the Elimination of all Forms of Racial Discrimination, the United Nations Declaration on the Rights of Indigenous Peoples. See also obligations by other international bodies, such as the Committee on the Elimination of All Forms of Discrimination Against Women and the Inter-American Commission on Human Rights.

9 Ibid.

10 Kimberlé Crenshaw: Origin of Intersectionality Theory

11 In Canada, human rights are protected by federal, provincial, and territorial laws that stem from the Universal Declaration of Human Rights. The Declaration provides a list of thirty articles outlining everyone's universal human rights to freedom, justice, and peace. The foundation of the Canadian Human Rights Act rests on the first two articles about equality and freedom from discrimination. Grounds for discrimination like race, sex, sexual orientation, and now gender identity or expression, are all prohibited and protected under human rights and the rule of law. In British Columbia, the law to protect and promote human rights and protect from discrimination and harassment is the Human Rights Code.

12 Determinants of health include safe and potable water, sanitation, food, housing, health-related information and education, and gender equality. The vision is "A world with equitable and universal access to health care and social protection, where the physical, mental and social well-being are assured." This principle of universal health coverage and access to quality health care has been adopted in Article 26 of the 2020 Agenda for Sustainable Development and Universal Health Coverage. See United Nations, "Transforming Our World: The 2030 Agenda for Sustainable Development. UN General Assembly" (21 October 2015) UN Doc. A/RES/70/1, online: Sustainable Development < https://sustainabledevelopment.un.org/post2015/transformingourworld>

Nations Declaration on the Rights of Indigenous Peoples provide a clear commitment from federal and provincial governments to act in right relations with Indigenous people; this includes Two-Spirit and Indigiqueer people. The United Nations Declaration on the Rights of Indigenous Peoples was implemented in BC in November of 2019 and mandates the government to bring provincial laws into harmony with UNDRIP[13]. In relation to health, Article 24 states:

1. **Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, all social and health services.**
2. **Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.**

Our research is directly intended to guide the province and nation in taking those necessary steps. While these articles are specific to acknowledging the sovereignty of Indigenous people, these systemic changes would have a wide-spread positive impact on other marginalized communities. In considering the right to health, all individuals, families, and communities have rights and responsibilities within our relationships with 2SQTBIMPOC. Together we must work to make the health system safer through raising awareness of the health needs of 2SQTBIMPOC and other Sexual and Gender Diverse communities, and implement changes that increase health equity.

13 *B.C. Declaration on the Rights of Indigenous Peoples* Act.

COMMUNITY CONSULTATIONS PROCESS

The Community Consultations intended to allow space for often unheard voices to express their positive and/or challenging experiences of accessing health services that support their wellness as a whole, including: social, cultural, physical, and emotional aspects. The desired outcome was to identify barriers/gaps in services, wise practices currently in use, and recommendations for healthcare providers and the Ministry of Health to improve access to care.

One of the three working groups created from Health Equity Collaborative members was dedicated to supporting the community consultations. A researcher was hired in June 2019 to lead the community consultation research process with the support and guidance of the working group. The group identified gaps in past research in regards to marginalized communities who are often left out of similar projects. The hope was to intentionally outreach to these Sexual and Gender Diverse communities and invite them to participate in the consultations. These were the groups identified:

- Rural Indigenous
- Rural communities
- Two-Spirit/Indigiqueer youth
- 2SQTBIMPOC youth
- QTBIMPOC newcomers (Refugees and immigrants)
- HIV-positive folks (especially trans)
- 2SQTBIMPOC Transwomen and femmes
- Poly queer immigrants
- 2SQTBIMPOC seniors, especially in care facilities
- Asexual/Aromantic
- Black queers
- Queer folks identifying as Fat and Superfat, especially 2SQTBIMPOC
- Non-binary
- Houseless (especially 2SQTBIMPOC Youth)
- People living in the Downtown East Side
- Indigenous living on reserve
- Queer Muslims
- Sex Workers, especially 2SQTBIMPOC
- People with disabilities
- People actively using substances

In total, there were twelve consultations, four one-to-one interviews, and over 100 participants. We were able to connect with the majority of the groups identified, however it's important to acknowledge the gaps as well. We were unable to connect or arrange a consultation with those currently living on reserve and rural Indigenous, although many Indigenous participants had past experiences of living on reserve and in rural areas. There was also a gap identified later in the research project of the Latinx community. In addition, many of the identified populations should ideally have had more representation than was possible in the limited time available.

One of the unique characteristics about this project was the way it leaned into community. Rather than have a researcher go into these communities and ask members to share their experiences with someone they did not know, we asked trusted community members to host the consultations within their own communities; this was a framework that ultimately reflected the recommendations from the consultations of more 2SQTBIMPOC representation and a prioritization of lived experience.

The process of connecting with the consultation hosts came about rather organically. Many of the collaborative members had their own connections to the identified populations and were able to reach out through established relationships. While this process helped to minimize harm, we would be remiss to not name the potential harm of any one-time only consultation. The harm most often seen is when participants aren't supported by facilitators or the community afterwards. For that reason, we acknowledge that there was, and is, potential harm in this consultation process. In order to mitigate this risk, we asked that hosts have a previous and continued supportive relationship with participants, whether formal or informal, and would ideally lead the consultation during a pre-existing/on-going group/program or event. We then ensured that we had resources available to our hosts in order to support them. A number of consultation hosts already ran community groups through non-profit organizations, their universities, or even out of their own homes, which created added safety and again helped to minimize potential harms. This also highlighted the necessity of community groups and the ways in which they not only provide support for community members, but also offer spaces for collaborative thinking and relational outreach that can inform future research.

A NOTE FROM THE COMMUNITY CONSULTATIONS RESEARCHER

I am, first and foremost, Sḵwx̱wú7mesh. My connection to this Coast Salish land, shared with the Musqueam and Tsleil-waututh, is what guides how I walk in this world. I am also mixed Latinx from the Mapuche Indigenous people, and French settler. I am a Two-Spirit femme, who admittedly still does not know how to identify my gender in colonial ways; and my spirits are at peace with this unknowing. These intersections have contributed to my experiences of healthcare and my work as a researcher. The Teachings given to me from my Syú7yuxwa, my ancestors, my aunties, the water, the land, and my non-human kin have all worked their way into my research.

Being Indigenous and working to decolonize my own ways created a particular challenge for me in engaging with the colonial process of research and report writing. My Syú7yuxwa explained to me once that being Two-Spirit comes with a specific responsibility of holding many stories from many worlds. It's what makes us good teachers and counsellors; it's no coincidence those are my occupations. So, while I'm all too familiar with the world of academics and research, my most important role in any work I do is honouring stories as Sacred; to treat them with care, to name them as gifts, and to share them in good ways. My hope is that I've done that here. I'm forever grateful for the gifts every participant gave me, and I encourage those who read this report to take even a small moment to thank those who have shared their stories. I know that they carry great strength and are capable of creating sustainable and equitable changes to the ways in which we care for community. That's what allows me to continue on in this work.

I also want to thank HEC for inviting me along this journey and specifically thank our Sulsalewh/Elders, Bill White and Roberta Price. Their ceremonies allowed me to carry more stories than I thought I could. Huy chexwa.

SERVICES SCAN PROCESS

The knowledge and stories gathered in the Services Scan were gifted from twelve SMEs. Of the twelve SMEs, all twelve SMEs identified within the sexual and gender diversity umbrella, seven identified as Indigenous. Eleven out of twelve identified as within the 2SQTBIMPOC spectrum, three SMEs identified as non-binary. Additional intersectional identities shared included disability, sex worker, small fat, Muslim, class privilege, Two-Spirit, Indigiqueer, newcomer, immigrant experience, older generation, remote rural, urban, suburban geographies.

Geographically, six service Providers served Vancouver, two Greater Vancouver, one Provincial, two Downtown Eastside with rural expertise, one Vancouver Island perspective. See Table 1.

Due to time constraints, budget and scope, this research project and the nature of this qualitative research project, we have many individuals in the 2SQTBIMPOC communities that are not included in the Services Scan. Our Services Scan Working Group and the Researcher would like to acknowledge the following 2SQTBIMPOC communities that have not been represented in this Services Scan. We were hoping to be connected through our circle of relations to an SME who would be able give us a perspective on Indigenous women who are from queer, trans and Two-Spirit communities and, due to time constraints, we were not able to make this happen. The following communities were also not represented: cis women, children and their caregivers, Deaf, those with disabilities, Chinese, Latinx, asexual, intersex, Fat communities, and those on Band lands, or from more rural areas or small towns. We know in this short list of acknowledgements that we do not name all the communities that exist within the 2SQTBIMPOC spectrum.

TABLE: 1 SUBJECT MATTER EXPERTS (SMES)

ORGANIZATION/SERVICE TYPE	SERVICE PROVIDER TYPE	LOCATION
BIPOC Program within Youth Organization	Youth Programmer	Vancouver
2 Spirit Programming within Indigenous Youth Organization	Youth Programmer	Vancouver
Tran/NB Organization, HIV Support Group	Director, Facilitator, Counsellor	Vancouver Island
Primary Health Care	Registered Nurse	Vancouver
Indigenous Coalition Policy Group	Director	Vancouver
Black Queer History	Social Policy	Vancouver
POC Queer History	Counselling	Vancouver
DTES/Rural perspectives on homelessness, risk of homelessness	Caretaker of youth, Community Support Worker	BC Rural Perspective Vancouver Downtown Eastside
Counselling, Mental Health and Education	Counselling, Clinical Education	Vancouver
Trans Organization. Peer support program.	Program Lead	Provincial
LGBTQ Program in Settlement Agency	Facilitator	Greater Vancouver Fraser Valley

The Services Scan Working Group identified over forty SMEs with the initial plan to interview twenty SMEs for one hr+ interviews. On July 11, 2019, the Services Scan Working Group and Researcher shortlisted the SMEs to 16 SMEs. This selection process was based on the principle of relationality, as we understood that a one hour interview is a big ask of not only gifting an hour of time, but to also be in an unbalanced power relationship of researcher and participant; especially given the depth of knowledge that the SMEs were asked to share. To encourage individuals to say yes to our invitation, we leaned into relationships that were warm, and already had some trust developed. Out of our nineteen invitations, fourteen SMEs accepted the invitation. Due to scheduling and timing constraints, we interviewed twelve SMEs; eleven out of twelve were in person in Vancouver, and one on Vancouver Island was done by phone. Elevent out of twelve SMEs chose to be audio recorded and one opted out.

To attempt to conduct respectful research relationship building, the Researcher had the privilege of being under the guidance of Amhalaks Dion Thevarge, who recommended I connect with Maistoo'a waastaan "Crow Flag" Rodney Little Mustache to make medicine bundles. Maistoo'a waastaan and I put our good prayers into each bundle, which was gifted in a pouch with a gift from the Researcher's own traditional teachings and Peaceful Dreams tea, as a gesture of reciprocity and honouring of the stories that were being trusted with the Researcher and HEC.

A NOTE FROM THE SERVICES SCAN RESEARCHER

"The purpose of any ceremony is to build stronger relationships or bridge the distance between our cosmos and us. The research that we do as Indigenous people is a ceremony that allows us a raised level of consciousness and insight into our world. Through going forward together with open minds and good hearts we have uncovered the nature of this ceremony"

— Shawn Wilson, *Research Is Ceremony: Indigenous Research Methods*

I hope the Services Scan can continue to raise our consciousness and efforts to grow health equity for 2SQTBIMPOC communities. I feel honoured to have been invited into the role of being a Researcher by our Sul-salewh/ Elders at HEC and the strong circle of relations of HEC who have created a gracious container for this research project to bloom. It is rare to work, heal, and learn alongside, together with your colleagues; and that's what happened.

To share my biases and where I come from, I identify as a trans/annicagender, Chinese-Taiwanese settler, uninvited guest learning how to be a respectful guest on the homelands of the Musqueam, Tsleil-waututh and Squamish People, and working class. And my hope for this research project was to keep the integrity of our SME's voices, as they have been so generous in serving our 2SQTBIMPOC communities. I do this because I believe our vast intersectional communities have highly valuable grassroots, traditional, emergent knowledges to help make this world a kinder and wiser place to be.

LITERATURE REVIEW PROCESS

In order to assess prior research related to health inequities faced by Sexual and Gender Diverse people, the Health Equity Collaborative undertook a literature review from June 2019 to October 2019. Criteria for inclusion in the literature review was defined as: (1) British Columbia-based research or publication that included British Columbia-specific data; (2) literature with a focus on social determinants of health, such as income, housing, employment, and social connection or belonging; (3) focused on health outcomes, such as HIV incidence or prevalence, overdoses, sexual assaults, or experiences with police violence; and (4) published no earlier than 2004. 124 pieces of literature were reviewed; of these, fifty-five pieces of literature were noted as particularly relevant to Sexual and Gender Diverse people living in British Columbia and were included in an annotated bibliography to be distributed to policy-makers and available to the public.

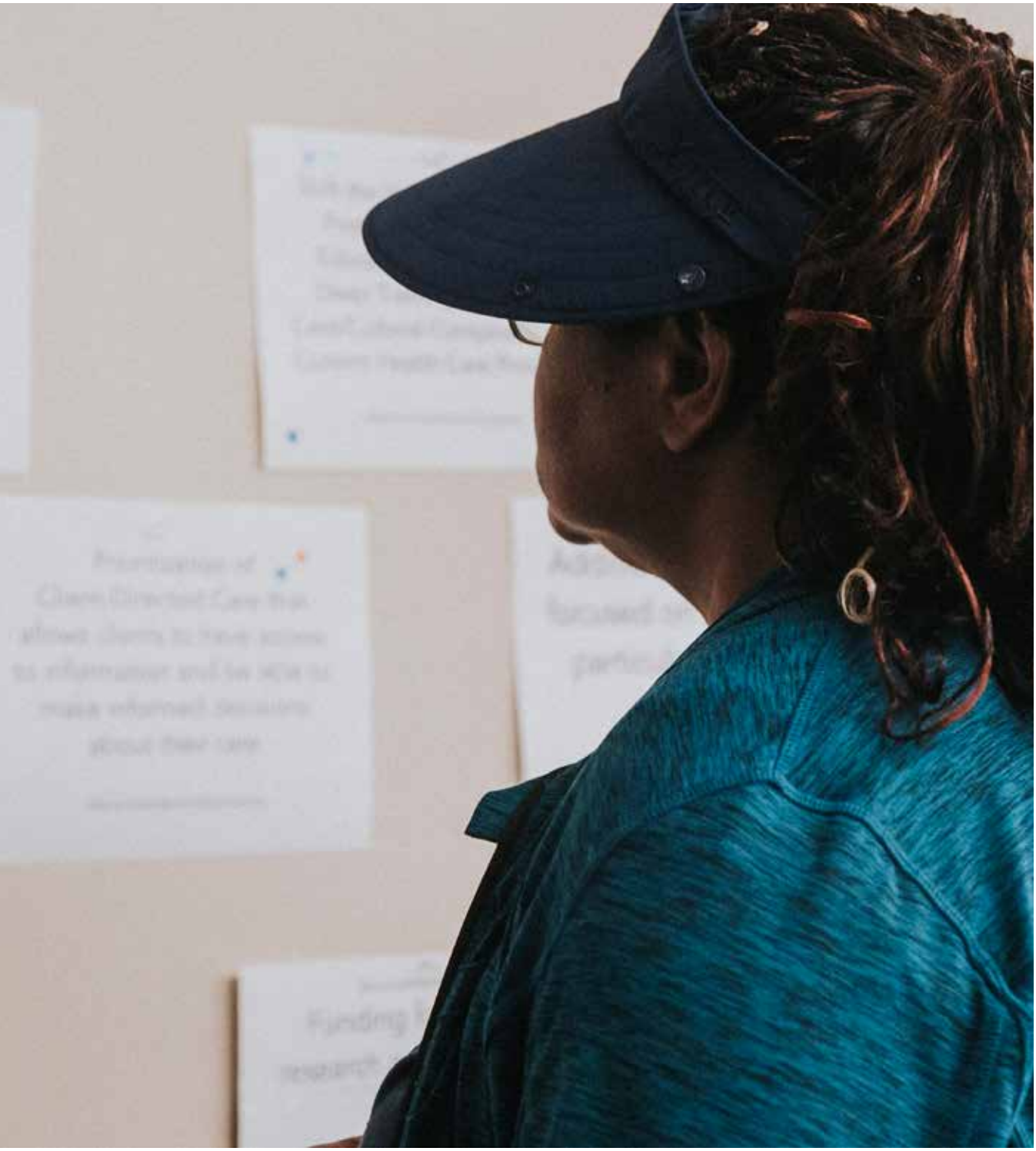
This review included a focus on 2SQTBIMPOC. Of the fifty-five items included in the annotated bibliography fourteen included a focus on Indigenous people; of these, three pieces of literature came from the National Inquiry into Missing and Murdered Indigenous Women and Girls. Nine pieces of literature included a focus on People of Colour, two of which focused on Asian populations, including East and South Asian. While some literature addressed issues faced by gender and sexual minorities who identify as unspecified diverse People of Colour, no literature directly addressed issues faced by Middle Eastern, Latinx, or Black Sexual and Gender Diverse people in British Columbia, indicating gaps in current literature.

Literature included: peer-reviewed academic articles; survey results; government and institutional reports; discussion papers; policy briefs and frameworks; literature scans; health literature, such as guides or pamphlets; and live graphic recordings (professionally-produced visualizations of in-person conversations). One limitation faced by the literature review included a limited time period in which to gather and assess literature, potentially omitting literature that did not come to light during the period that review was undertaken. It is possible additional important literature exists and was not included in this review.

A NOTE FROM THE LITERATURE REVIEW RESEARCHER

The Literature review was done through the lens of a queer white cisgender woman settler, born on, raised on, and connected to Musqueam, Squamish, and Tsleil-Waututh ancestral lands. My parents came to Canada as refugees from what was Czechoslovakia in order to provide better lives for their children - particularly as a queer person, I am forever grateful they did. Through local queer communities I've had the privilege of meeting and working with diverse and interesting people, many of whom were generous enough to share their wisdom; it's collectively that we make our most powerful impacts.

In order to put together the literature review, I leaned on formal education in health and community services, professional experience in research, and my lived experiences as a queer woman in East Van. As a settler committed to reconciliation, my work was informed by education on the Mi'kmaw concept of Two-Eyed Seeing as applied to research and commitments to the Calls for Action from the National Inquiry into Murdered and Missing Indigenous Women and Girls and the Truth and Reconciliation Commission of Canada's Calls to Action. Thank you to Elder Roberta and Elder Bill for your generosity and guidance during this process!

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1

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 healthcare provider discretion, which is often guided by moral, religious or other personal views.

CURRENT LACK OF SAFETY/HARM CAUSED WHEN ACCESSING SERVICES INTERSECTIONAL PROVISION GAP

- Study participants spoke of colonial health paradigms including systemic Anti-Indigenous, Anti-Black and racial discrimination, in combination with transphobia and homophobia harms, and lack of safety during health care experiences
- “Right now within Vancouver, everything is super liberal.... BIPOC 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 should. That’s wild.”-— 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…” — SME
- A Services Scan SME expresses how there is a current fragmentation of competence in health care workers. Clients need to pick and choose which identity to be discriminated against. The following quotes illustrate the impacts of not taking intersectional identities of Indigeneity, racialization, neurodiversity, body size, and sexual and gender identities into account:
  - A Services Scan SME speaks to the health experience of a trans fat person of colour: “So I think the frustration is recognizing the whole of the person’s intersectional identity is relevant in a way that it

actually is accessible rather than making people pick or choose what part of your identity is most important. Do you want to not be misgendered? Yeah, but I don't wanna go into a white centered 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 "I'd really like to go access sexual health services and I hear these people are good but 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, not siloing".

– "Once you get that big broad spectrum (neurodiversity), there's so many people within there who have challenges accessing care which can be anything from hiding the conditions they have and passing as neurotypical to access services to trying desperately and not being able to get diagnosis to help them make some sense or access some services. Those are common ones I hear. And often that with a lot of people I talk to where when some aspect of who they are is attributed to their neurodiversity or vice versa, like the idea that "Are they autistic or trans or are they both?...When they would not question other aspects of someone else's identity. Oh, you know there's a cis woman who came in and has depression, you wouldn't say well, is she a cis woman or is she depressed or is she both? You just wouldn't frame it that way".-— SME

3 SME'S SPOKE TO HOW INDIGIQUEERS, TWO-SPIRIT YOUTH, AND TRANS BIPOC OFTEN GET BPD DIAGNOSIS. ONE SME SHARED HOW TRANS PEOPLE OF COLOUR OFTEN HAVE THEIR GENDER IDENTITY DISMISSED AS AN ATTRIBUTION OF MENTAL ILLNESS.

- Services Scan SME shared how as being caretakers for Sexual and Gender Diverse youth who are homeless, they notice "with Indigiqueer, trans or Two Spirit youth, we all end up with the same diagnosis of BPD". And attributes the high rates of BPD diagnosis (*borderline personality disorder)* to a health care system that does not acknowledge the impacts of colonization and genocide. The Services Scan SME says "mostly non-queer, non-Indigenous health care providers that were just kind of doling out and being like you need lithium or you need Prozac, you know? Talk therapy where people don't understand and the big thing came with it. It was like "this is colonization, it's colonization is what this is. Show me any Indigenous youth who's not a byproduct of intergenerational trauma and cultural disruption, who's identity [pause] our gender identities have been [pause] they've gone away." -— SME
- "I see that it disproportionately affects trans people of colour who report to me at least much more negative experience of not being believed, being dismissed, having their transness attributed to mental illness and that's something I've heard repeatedly with people because I do help people access hormones and surgery or people have told me they have been denied access because they've been told you're not trans, you're bipolar, you're not trans, you're BPD, you're not trans, you're a whole list of different things.. And of course it's a stigmatized diagnosis where a lot of people are shorthanded and they don't believe anything this client has to say. We see that, right?"-— SME

- SMEs share how it was unsafe for 2SQTBIMPOC to access white/mainstream organizations:
  - A Services Scan SME shared Black Queer history during the AIDS crisis in the 90's about how Black men could not go to mainstream HIV/AIDS organizations due to anti-Black racism. Black men were either dehumanized or demonized as this Black person who's spreading this disease, or fetishized and hypersexualized. Not going to services meant not getting meds, not being able to be in a social environment that included them. Extreme isolation, meant not getting tested, not getting meds, not telling, which caused more deaths. A Black HIV/AIDS organization opened up. And it did a really good job, but due to financial issues, the organization deteriorated due to funding accountability and was defunded.

THREE SERVICES SCAN SMES SHARE HOW THERE IS A SIGNIFICANT GAP IN SETTLEMENT SERVICES FOR QTBIMPOC NEWCOMERS

- "We've had time and time again, folks who have come in and say I don't wanna be here anymore, it's better if I just go back to my home country….It's really really heartbreaking to hear because folks would rather go back to the place that they might be killed than stay here"— SME
- The largest barriers for QTBIMPOC newcomers are employment, safe housing and language barriers which affects access to health care, and social and mental health services
  - These barriers lead to social isolation, exhaustion, including avoidable anxiety and depression, because QTBIMPOC can't access knowledge about Canadian society due to the major gap in settlement services.

QTBIMPOC SETTLEMENT POLICIES ARE IN PLACE, BUT THERE IS NO FUNDING, WHICH RESULTS IN NO SUPPORT SERVICES TO INTEGRATE PEOPLE.

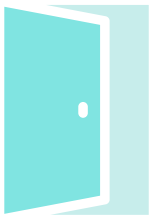
- "I think it's really a hot topic of LGBTQIA+ newcomers and welcoming them in and making that space, being really vocal about that but again not providing any of the services or the settlement services that are needed for when they are in the country" — SME
- An SME serves QTBIMPOC newcomers who are *"walking far distances"* to access services like the Food Bank, from the suburb to urban centres.

FOLKS WHO HOLD INTERSECTIONAL IDENTITIES OF REFUGEE CLAIMANT, ARE QTBIMPOC, AND HAVE LANGUAGE BARRIERS, FACE LOT MORE BARRIERS DUE TO INTERSECTIONAL DISCRIMINATION. AN SME SHARES WHEN YOU ARE A REFUGEE CLAIMANT, YOU HAVE THE LEAST AVAILABLE RESOURCES. FOR EXAMPLE, A REFUGEE CLAIMANT NEEDS TO PAY $600 FOR A LANGUAGE CLASS BUT THE LANGUAGE CLASSES ARE FREE FOR PEOPLE WHO HAVE PERMANENT RESIDENCE.

2

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 BIMPOC 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. COLONIZATION 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 CENTERED 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**

RURAL EXPERIENCE FOR TWO-SPIRIT AND INDIGENOUS SEXUAL AND GENDER DIVERSE PEOPLE:

- Health care in rural areas is an issue of both access and safety. Access to health services are limited or do not exist in one's geographic region. Safety of that health service, if available, can be unsafe. —SME
- "For young Indigenous Two-Spirit folks living in a rural community trying to access care there may be some real limitations to both the care available and the safety of that care." — SME
- An SME spoke on the complexity of how colonization has impacted sexual and gender identities on reserve and off reserve. Certain First Nations have Two-Spirit history and teachings intact. Certain First Nations are not safe for Two-Spirit people. Access to Two-Spirit history and teachings is context dependent for each First Nation. Each community is nuanced, and is based on many factors.
- SMEs shared how when accessing services, patients need to choose to be Indigenous or queer. Two-Spirit, Indigenous Sexual and Gender Diverse youth and people are drawn to urban centres due to intergenerational trauma impacting their rural quality of life. Some folks are singled out in identity as they might be the only Two-Spirit youth in their community. They want to access care, they want support, so most Two-Spirit people have moved to a big city, or they've left their small communities due to increasing safety concerns and resources.
- "You can either be Native on the reserve and not gay, or be gay in the city, but not Native."— Consultation Participant
- In the small town interior of BC, there is a lack of access to services for Indigiqueers. For far northern towns, access is highly limited.— SME

URBAN EXPERIENCE FOR TWO-SPIRIT AND INDIGENOUS SEXUAL AND GENDER DIVERSE PEOPLE. SERVICES SCAN SMES SHARE HOW:

- There is a major gap in city services for Two-Spirit people as most are volunteer driven. Indigiqueer and Two-spirit youth, and Indigenous gender and sexual variant youth don't feel safe in settler organizations. Racism in urban LGBTQ+ communities impacts access to social connection. An SME shared their Vancouver Island organization is very white and for this reason they haven't been able to bring in Indigenous or POC communities.
  - An SME shares how in different provincial regions "Just being a white (service provider) can be a barrier to folks."

3

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 reported being ambushed by unrelated concerns and questions from their healthcare providers. Themes from participants included how their self-reporting was not believed to be accurate. Their health issues often remained unaddressed. Privacy breaches were common and included sharing sensitive information with family members not identified as safe, putting patients at risk. Patients reported having to plead their case for services.

- **"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 THAN MY DEPRESSION, EVEN THOUGH MY SEXUALITY ISN'T AN ISSUE."-— 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**

- **“SO ANTI-BLACK RACISM KIND OF ALMOST COST ME MY VISION.” — SERVICES SCAN SME***

*ANTI-BLACK RACISM IN HEALTHCARE

An SME shared what Anti-Black racism can look like in the health system by how it took over one year to receive treatment for a health condition. “Our current medical system particularly in BC and in Vancouver, has zero capacity to treat people who have dark pigment”. “Anti-Black racism kind of almost cost me my vision” — SME.

The SME needed to go to multiple medical visits over six months before receiving the correct diagnosis. This was due to each doctor misdiagnosing the SME’s health condition as a non-issue. For example, the SME shared that the doctors would say “Your eyelids are pink. And I’m like, “My eyelids aren’t usually pink”. The doctors would say: Well, eyelids are pink, you know. I would say “No, my eyelids are dark brown”. The SME shares after six months of self advocacy at health clinics, a doctor finally offered the correct diagnosis.

Because the health condition had progressively worsened in six months, additional medication was required that would not have been necessary if the health condition was diagnosed at onset. This additional medication endangered the SME’s vision, to the degree where they were “at risk of immediate vision loss and eye damage”. When the SME went to seek medical attention, they were told both that they had to continue taking this medication, and that they had to wait four more weeks before seeing the specialist while having symptoms that risked vision loss. The SME says “They should have caught it, if they had caught it way before, it probably wouldn’t have been to the extent that it finally did get to”.

The SME explained how, while the doctor is “looking at my eyes, he’s looking at the damage, and he says, “Well, you know actually you’re pretty lucky…You seem to be able to tolerate far more eye pressure than the regular human”. This medical opinion that a Black person can tolerate far more pressure is problematic because as the SME says “We’re now back to my body doesn’t act like other human bodies and what you’re really saying is that you never study this on Black folks…you aren’t able to make any kind of qualified opinion because you have no data on Black people’s ocular pressure”. There is this Anti-Black Racism narrative in the medical system with the assumption that “My body doesn’t act like other human bodies. Black bodies are inanimate. And don’t feel pain, that Black bodies are “inanimate”, incapable of feeling pain, rendered “just a thing”.

WHEN ASKED WHAT WAS CURRENTLY WORKING, OR HAS WORKED IN THE PAST, TO SUPPORT THE HEALTH OF SEXUAL AND GENDER DIVERSE COMMUNITIES MANY COMMUNITY CONSULTATION PARTICIPANTS AND SERVICES SCAN SMES DREW ATTENTION TO THE FACT THAT IT IS OFTEN 'UNDERGROUND', GRASSROOTS, COMMUNITY-CREATED SUPPORTS THAT ARE BEING UTILIZED TO REDUCE HEALTH DISPARITIES. THIS SPEAKS TO THE GREAT RESILIENCY OF SEXUAL AND GENDER DIVERSE COMMUNITIES, IN PARTICULAR 2SQTBIMPOC.

It was identified and acknowledged by participants across consultations that it's the supports that they've created for themselves that have been their lifeline to hope for better healthcare, but that these supports are often inconsistent due to lack of time, energy, capacity, and finances. It's full-time work being done in between their full-time jobs and schooling, and with minimal resources. Similarly, 2SQTBIMPOC Peer Professionals have 'underground' resource networks to best support 2SQTBIMPOC patients.

- **"I think there are also people along the way. I feel like QTBIPOC, we have this telephone line. So I have to take a trans youth for pregnancy test that feels awful for them so I'm calling up someone from a community health center who is trans and non-binary and POC " Who do I send this person to, what do I do? They are like " Come on this day or this is what it's got to look like. Let the youth know". We have these telephone conversations. We go on the wild ride together to find the safest way and and I think those connections are really important."— SME**

- **"We create community groups, share resources, and use our own time and energy to educate healthcare providers." — Consultation participant.**

In addition, community consultation participants spoke at length about individual service providers who were going above and beyond to provide care. These service providers were seeking out education and training to work with diverse communities, and finding opportunities to gain tangible experience. It was also identified that service providers with lived experience in those communities were creating safe and accessible spaces for many of them.

This was echoed in the Services Scan by multiple SMEs. A Services Scan SME shared how their lived experience as a peer professional informs their service provision for Two-Spirit, Indigenous trans and queer youth. Acknowledging the systemic harm that occurs in health care relocates the pathologizing lens off the bodies of Two-Spirit, Indigenous trans and queer youth:

- **"In professional spaces we are supposed to remove our biases and our experience to move people along. I vehemently disagree. And categorically reject that… I can not sit there when an Indigenous youth is telling me this world is against me this world is trying to kill me to say that's not true, that's psychosis and you're wrong. That's pathologizing".— SME**

- **"I think recognizing there is harm and these are the systems we're working within. And also creating spaces to talk about the way they have resisted and what kind of resistance can we find in going to this. Yes, these doctors are not respecting you. Maybe they're doing something wrong. So, how can I support you in resisting and how can I recognize your resiliency and get you what you need from them and also support you in standing up to that? I think that's the balance for me".— SME**

These wise practices work to inform the recommendations of Safety, Education, and Empowerment by acknowledging the ways in which effective education/training and lived-experience work to create safe spaces for accessing healthcare.

There were also examples and models of practices, organizations, and resources that many participants identified as positive. It is important to note that the lists below are not exhaustive or complete lists. There are several other excellent organizations and community based groups doing important work across the province. A more thorough look into wise practices would be important as a part of the work to be undertaken, as per several of the recommendations in this report.

The following were specifically named by participants in the community consultations as examples related to specific practices:

Examples and Models of Integrated services and resources:	Foundry BC UNYA AgedOut.ca
Examples and Models for modifying forms to include diverse gender markers and identities	Fraser Health Authority Foundry BC
Clinics offering holistic, affirming, and culturally appropriate care:	Native Youth Health and Wellness Centre Raven Song Community Health Centre Three Bridges Community Health Centre The Indigenous Primary Health and Wellness Home in Surrey
Examples and Models of lived experience/peer professionals service provision and education:	Out In Schools UNYA 2-Spirit Collective YouthCo HIV and Hep C Society Trans Care BC
Community created resource networks currently supporting 2SQTBIMPOC	Vancouver Queer Spoon Share Facebook Group Qmunity Support Groups MOSAIC BlackChat Vancouver
BIPOC-led organizations and groups (including Defunded)	In the 90s, the Province of BC funded 3 BIPOC Vancouver organizations as there were no safe spaces for 2SQTBIMPOC. BlackChat Vancouver GenAi (genai.ca) Urban Indigenous Collective Organization BAN Black AIDS Network Vancouver (defunded)

SAFETY

End harms caused by systemic discrimination (systemic racism, colonization, transphobia and homophobia) towards 2SQTBIMPOC communities through structural changes to ensure health care safety.

SAFETY ACTION #1

- **With 2SQTBIMPOC voices leading the way; in partnership with allies in government(s) and health 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 gender identity and sexual orientation to Coroner's data, and add gender options to population-level data collection.**
  - For example, an SME shared 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
  - Include gender identity and racialized identities to create space for 2SQTBIMPOC on the funding map — 2 SMEs
  - An SME shared how Canada is far behind compared to the US in documenting missing and murdered Indigenous trans women and trans women of colour, conveying how crucial it is to get the names of these missing and murdered Indigenous trans women and trans women of colour. — SME

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.**

    - Many trans, Two-Spirit, and non-binary people are not being given access to the services they need if healthcare providers do not see them as "passing" (i.e. they aren't being referred to endocrinologists and surgeons because they don't present their gender in ways that are palatable to society), but many of the services that would be gender-affirming and allow them to present in a way that stereotypically aligns with their gender are not affordable or covered by healthcare plans. It's important to acknowledge that this was a major barrier specifically identified by Trans women and Trans femmes. These participants discussed the life and death matter of passing as a trans woman/femme.— Consultation participants

SAFETY ACTION #4

- **Implement systems to flag, and establish procedures to address, waitlists for services longer than 6 months (e.g. expedite access to funding for clients to seek services in another area 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 the 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 name and gender at birth should only be listed when legally necessary.**

SAFETY ACTION #6

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

    - "It's a lot for me to fill out an online form, wait for the approval, have them send me more paperwork, then I have to find someone to help me fill out because I can't fill it out due to my disability, then I have to get it to a mailbox and wait again. That's a long and unnecessary process for me to just get the healthcare I need. It's ridiculous and makes it seem like they don't actually care about my health, they just want to make it as difficult as possible so people don't apply."— Consultation Participant

SAFETY ACTION #7

- **Integrate local Indigenous teachings and protocols that prioritize and promote the health of Two-Spirit people and Indigiqueers.**

  - Invite Two-Spirit, Indigiqueer, and allied Elders to sit on health boards, create initiatives, and organize events; make these Elders available to clients to provide traditional medicines and healing practices.

  - Prioritize space within appointments and meetings for story-telling and relationship-building.

  - Reclamation of First Nations and Indigenous culture as a key treatment strategy for the health equity of Indigiqueers and Two-Spirit people

  - Fund Reclamation of Culture for Reconciliation

    When Indigenous communities can have access to their Nation's teachings, cultural practices, the colonization of homophobia can be decolonized, thereby bringing families together for Two-spirit, non-binary Indigiqueer folks vs. increased family separation — SME

    "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-governmental/inter-ministerial relationships) to shift towards more holistic approaches to healthcare, i.e. wraparound care and integrated service centres, and include the social determinants of health as funding markers. This has broad implications throughout service provision, finances, policy, accreditation, etc.**

  - Increase resources devoted to suicide prevention, including upstream investments in mental health and social interactions that lead to poor mental health.

    "The amount of trauma they've had, you, some, somebody might say it's impossible that somebody could have this much loss and violence and illness in their lives, but that's the reality of a lot of our people. And so the more that people connect on that level and allow holistic health to grow, what we're doing is like you know when people share that story, they're becoming stronger, you know, they're healing and you know and they're taking out the power of that so that it doesn't hurt them anymore". — SME

- Ensure resources for housing, food, and employment are available from all healthcare providers, and staff are able to support clients in applying for, or accessing the service.

  There is a lack of safe housing for LGBT newcomers. It is difficult to find safe housing for LGBT newcomers. Residential tenancy branch does not provide much support or information for LGBT newcomers, allowing landlords to be abusive. Refugee claimants placed in homeless shelters when they first arrive, where they are not safe. They are forced to...face abusive situations because of their gender identity or sexual orientation — Community Consultation

  Housing particularly affects those with intersecting factors of marginalization— older adults, youth, trans people, people of colour, Indigenous people; stigma & discrimination, to the point of violence, and affects housing options & access. —Literature Review

  "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

  Healthcare in many cultures is not accessed as separate from Traditional Teachings, ceremony, housing, and nourishment. It's imperative to undo the segregating effects of colonization on healthcare. This would help to acknowledge that holistic and equitable healthcare is about more than individuals and bodies, but about community and wrap-around care. —Community Consultations

  "Moving beyond to seeing healthcare as this thing but also seeing that the health of QTBIPOC folks, specific to myself as a Two-Spirit is entirely tied to the land. It's tied to my nonhuman kin. When things are happening, when violence is happening against our land and communities, pipelines are going through, we see a rise in violence against ourselves, we see suicide crises in Indigenous youth, we see survival economies, we see the opioid crisis. To not separate those because that's not separate".— SME

- Create and fund Integrated Health Service Centres across BC, with a focus on rural areas.

  "I used to go to one-stop healthcare providers as a youth when I lived in Vancouver, but once I aged-out of those services I had to travel across multiple cities to access the same services. And that means extra costs in gas or transit and taking time off of work that I can't afford, to go to like four places for appointments."— Consultation Participant

- Culture as Treatment: Prioritize Creation of 2SQTBIMPOC Spaces as a Health Intervention

  "We often say culture is the intervention or culture is the treatment and so that's what we're getting at here" Services Scan SME.

  8+ SMEs working with intersectional communities that are refugee, newcomers, Indigenous, Two-Spirit, BIMPOC expressed how important it is to create closed spaces as a health intervention.

"Like why can't my Traditional medicines be covered by my healthcare plan, or my time spent with an Elder. My Elder doesn't get paid for his time and he should be. And I should be able to use time-off work the same way I would to go to the doctor."- Consultation Participant

SME shared how 2SQTBIMPOC need a safe space, and the need to leverage upcoming opportunities like creating a 2SQTBIMPOC space that's funded and staffed in the new Burrard and Davie centre, but also ensure suburbs have access to 2SQTBIMPOC spaces as well.

"I think the answer is also creating spaces for QTBIPOC. It's always really sad subjects; when they acknowledge us they only acknowledge our violence but if we have intergenerational trauma we have intergenerational survival. We have resiliency. We have joy. I want that. I don't want white academics to always want to bring me in to say here's a sad story. And I don't. I'm not here for it. I want to create spaces where Two-Spirit youth can come forward and they can rejoice because they've made it and that they can lead us forward. And also rediscover the ancestors that are with us. Our Two-Spirit ancestors fought so hard for us. I don't have an answer on what a solution is because my solution is abolishment of the nation state" — SME

Refugees and newcomers need 2SQTBIMPOC programs as they offer:

> Space for folks to come and connect, to network, recognize similarities and differences, form relationships with each other — SME

> "Highly valuable informal QTBIPOC settlement mentorship; "they know all the nuances, they know all the tricks, and so having that informal mentorship has been incredible for folks who have just come into the country or trying to, or maybe they've been in the country for a while but now they've just decided to claim refuge, right?" — SME

- An SME suggested a Government Collaboration Model as a funding strategy.

Create innovative funding strategies that address the limits to government funding. Governments at all levels don't know what to do. They need community, civil society to do things the government can't. — SME

"Chronic health issues that are chronically underfunded" — SME

Strategic plans to not always rely on government funding:

> 1. Engage business philanthropic community.

> 2. Business Case mentality (i.e. Homelessness – If you invest this amount, we are going to save the system 'y' amount because homelessness increases health issues, and they die sooner than necessary. All kinds of things that cost our system, so if they actually invested in housing and got people off the streets and linked into care and that type of thing would have better outcomes, people wouldn't die as early as they are. And then you know they might be able to contribute to society in various ways that we're currently losing because people might be dying from an overdose at 25 for example. So, so there's a price tag and presenting it in a business case mentality I think helps people see that there's wisdom in making the investments, that we're not just asking for a handout,

that we're saying this is you know good on many levels, you know a humanistic level, a moral level, and a financial level.) — SME

> 3. Propose New Zealand Wellness Budget Living standards Framework as a Health Strategy for marginalised communities.[14]

SAFETY ACTION #9

- **Create sustainable funding to plan and implement an holistic, decolonial, intersectional healthcare framework to increase health access and safety for 2SQTBIMPOC actions discussed above. Focus on three-pronged approach:**

  1) Increase funding for existing Sexual and Gender Diverse and cultural health organizations.
  2) Create a specific intersectionally-focused advisory group/agency, and
  3) Identify defunded and grassroots 2SQTBIMPOC organizations are considered, or were considered while being funded, effective and safe by 2SQTBIMPOC communities, and fund these.

  - 10 out of 12 SMEs, and every community consultation highlighted how funding for intersectional services for 2SQTBIMPOC is key for health equity.

    Consultation participants identified that Black and Indigenous people are living in poverty and often don't have access to the kind of care they need. Their options are limited and they typically have to access subsidized programs where they can't seek out a culturally knowledgeable healthcare provider.

  - Invest sustained funding into 2SQTBIMPOC led healthcare services across the province to increase access and safety for all health services (including existing Sexual and Gender Diverse organizations) that better serve the needs of 2SQTBIMPOC, including current 2SQTBIMPOC volunteer organizations, and re-fund historically defunded 2SQTBIMPOC organizations. Engage Health Equity Collaborative to advise on funding 2SQTBIMPOC led healthcare services.

14 https://lsfdashboard.treasury.govt.nz/wellbeing/, https://www.theguardian.com/world/2019/may/30/new-zealand-wellbeing-budget-jacinda-ardern-unveils-billions-to-care-for-most-vulnerable. This is also cited in a Provincial Health Services Authority Literature Scan, http://www.phsa.ca/Documents/phsalitscanequityindicatorsfinal_2015.pdf

There have been historical BIMPOC organizations that provided intersectional health support and service for members of the community who would have not accessed health care and support otherwise. Currently, there are volunteer organizations serving these communities. SMEs are asking these organizations to be funded and a BIMPOC umbrella organization or agency to be created to support the funding and financial aspects of running an NGO.

One consultation discussed at length that there have been many Black and Indigenous groups already doing much of the work needed to better support 2SQTBIMPOC. However, these groups either offer inconsistent support or have had to cease support entirely due to a lack of sustainable funding.

> "We 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.

- Apply systemic change by including social determinants of health as funding markers to put policy into practice.

  An SME shared that there is currently policy and awareness of the social determinants of health (SDOH). There is also an immense gap between the practice and policy of SDOH; they make up a significant part of our overall health determinants which means this gap in SDOH practice "puts intersectional folks at greater risk of illness".

  Two SMEs expressed how existing funding markers do not allocate the funding to the people who need it. An SME suggested that the solution to closing this gap is to include the SDOH as funding markers, and SMEs suggested including colonization and colonialism as a SDOH.

Include mental health in sexual health services

- An SME names how traumatic experiences are the root causes of sexual health issues in our communities, and says "We need to change the paradigm to look at health as an holistic thing, not just in the sense of sexual health or primary health. It needs to be seen as an holistic thing; and that social and mental health, and primary health and sexual health are connected, and they have to be seen in that way". — SME

EDUCATION

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

EDUCATION ACTION #1

- **Engage 2SQTBIMPOC 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.**

- **Develop 2SQTBIMPOC Peer Partnerships with physicians in order for physicians to access nuanced knowledge for accurate medical assessment, treatment, and culturally competent care. —SME**

    - For example, an SME shares how physicians have medical knowledge, but may not have intersectional health knowledge, and offers the solution of a Peer Partnership line. A physician can then call this Peer Partnership, composed of 2SQTBIMPOC peers with lived experience working from a 2SQTBIMPOC Identity Affirming Care Model, to gain nuanced intersectional health knowledge. To illustrate, if a patient with dark pigment is reporting eye pain, the physician could first, believe the patient's report of pain, and then call the Peer Partnership line to confirm that they are unfamiliar with treating patients with dark pigment and be mentored by a Peer to gain accurate knowledge on how to assess, and treat people with dark pigment.

EDUCATION ACTION #2

- **Implement systemic mandatory training and protocols for providers to better care for Sexual and Gender Diverse communities with intersecting identities, delivered by individuals and organizations in those communities. Including a provincial mandatory 2SQTBIMPOC Identity Affirming Care Model.**

  - Teach professors, providers, and frontline staff how to serve 2SQTBIMPOC Communities in post-secondary health education and in health organizations — SME

  - There needs to be training to support unlearning colonization, settler colonialism, and systemic racism — 9 SMEs

    A common experience amongst Black and Indigenous participants was a lack of holistic care that acknowledged them as a whole person. They felt they were viewed as drug users, sexually promiscuous, or some other harmful stereotype, and often asked about their sexual activity. A Black participant found that there were many myths about Black people that affected the care they received, including that their skin is thicker and they have a higher pain tolerance.

    Black and Indigenous participants reported having mental health medications and birth control pushed on them at young ages. Mental illness was repeatedly discussed with them even while trying to access care around chronic and pervasive pain; and for many Indigenous people who experience menstrual cycles, the way birth control affects their 'moon time' or menstrual cycle is culturally significant and is rarely considered or discussed by their prescribing practitioner.

    "I'm really, really grateful for the Indigenous teachers who've taken the time to show me other ways of learning that feel like for me, as someone who's a settler but also as a person of colour, feels deeply healing, really powerful that these are really needed ways of being and to just even question like the colonized thinking and that I see this over and over and I know, I also realize it's sometimes replicated, really often replicated when I'm developing trainings, when I'm using a certain, sort of a certain modality to teach people and I know it's really colonized. So that I'd love just that, for us to start with more awareness around that, myself included, and to see the strength of other kinds of learning". —SME

  - Self-identifying Fat and Superfat 2SQTBIMPOC found many healthcare providers were uninformed on properly treating and respecting diverse body sizes, often further harming their bodies.

  - On serving refugee 2SQTBIMPOC: "And a lot of the times we see too that they (health and service providers) might have knowledge with LGBTQIA+ training but they don't have that training for understanding their

cultural background or the immigration system or vice versa. So you don't have that, those two coming together" — SME.

- To genuinely welcome LGBTQ newcomers, health and service providers need training on LGBTQ positive cultural brokering and an understanding of the immigration system. — SME

- Include Frontline staff: "One of the barriers I see people encountering a lot is getting turned away by a front line person or an intake worker who's someone who's not very supported in their job. They're hired, and they're not even, that person's not even thought about to be included even to those basic diversity trainings which we know aren't sufficient but they're something. So that, that's a big gap which just I see so many times and often when I talk to people about, who've not been able to access some of what is called the lower barrier care here, it is, it's an experience like that with the first person they talked to when they came in or when they called who might be someone who's getting paid like you know like a minimum wage reception like who's not being paid to attend trainings the way someone else would be. And it's not because those people are terrible at their jobs at all, it's just those people aren't supported in doing their jobs the way that they need to be". — SME

- Include "Two Eyes Seeing" Training [SME, paraphrased to protect confidentiality]

  An SME shares the need to include "Two eyes seeing", which is an understanding of Indigenous history plus knowing gender affirming care so nurses, doctors, and office assistants- those front-line staff that first greet the clients can competently service Indigiqueers and Two-Spirit patients [SME] 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, for example, is if you go in and say you have a cough the Dr. may shift his questioning to asking you about transgender variance and wanting you to educate them by asking inappropriate questions like what was your childhood like. And the difference between service depends on if you're light-skinned are dark skinned [SME, paraphrased to protect confidentiality]

EDUCATION ACTION #3

- **Increase access to education for 2SQTBIMPOC applicants — through funding and direct invitations to participate in training programs and higher education.**

  - "There is a real barrier to education for Indigenous people. It's a myth that Indigenous people get free schooling." — SME.

  - An SME described how university environments are "dependent on the dehumanization of us". They said "I couldn't survive university. I couldn't do it. It was too violent. I left and I tried to go back and I left and I tried to go back".

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 2SQTBIMPOC folks who are: South and East Asian, newcomers to Canada, living on reserve or in rural areas, and seniors.**

  - Women and femmes, including trans women, were underrepresented as a focus in the reviewed literature, with a lack of focus on women's issues and needs. Despite the fact that women, particularly girls, were found to face health inequities in substance use and experiences of violence, these results were often found as an exploration of larger populations and not as a specific line of inquiry into women's issues.

  - Only three pieces of literature, identified by the review, focused in any way on immigrant and refugee health, indicating a gap in understanding of the health of this population. With immigrants and refugees constituting a growing and poorly understood demographic, more funds should be allocated to health research and programs for newcomers to Canada among Sexual and Gender Diverse people.

  - Only nine studies, most on youth, focused on racial or ethnic minorities; two pieces of literature focused on Asian (including South and East Asian) Sexual and Gender Diverse people.

EMPOWERMENT

Recognize and empower Sexual and Gender Diverse people as leaders in their own health and wellness journey.

EMPOWERMENT ACTION #1

- **Access to health care jobs/careers — Revise hiring policies to include relevant lived experience of 2SQTBIMPOC as a valued qualification. This revised hiring practice will greatly increase the health care system's capacity to serve intersectional communities effectively [SME].**

  - When asked about what recommendations they would have for the BC Ministry of Health and healthcare providers, one participant stated, "I would say to stop asking us what they can do to give us better care and just put us in leadership positions where we can make the policies and decisions."

  - 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."

  - Ways in which lived experience/peer professionals service provision can be appropriately valued. [8 SMEs]:

    Value relevant lived experience as equal to higher post secondary education with no lived or community experience [SME, paraphrased to protect confidentiality] Reflecting this recognition of lived experience in hiring practices by shifting system level Human Resources hiring practices in healthcare workplaces. For example:

    > If a settler had a Master's degree but has no lived experience, versus someone who is Indigenous and has life experience plus education, maybe a bachelor's, but had used drugs in the past living on the streets, the Master's candidate would be valued. [SME, paraphrased to protect confidentiality]

    > One SME shared how he and his Indigenous peer were turned away by a mainstream/white/settler organization as practicum student applicants due to not having enough professional experience, but how he was welcomed into an Indigenous organization who valued his lived experience, where he eventually piloted and is now leading and running their Two-Spirit Program. The Indigenous organization incorporated and recognized the wisdom and teachings that people have, versus a hierarchical educational credential hiring process.

    Ensure pay equity is offered where lived experience is given equal weight to western academic credentials.

> In hiring intersectional folks that do get hired, the more diverse, the less the pay. The higher the pay, the less diverse you are. [SME]

- Develop 2SQTBIMPOC Peer partnerships with physicians, so physicians can access nuanced knowledge for accurate medical assessment, treatment, and culturally competent care [SME]

- Value knowledge of 2SQTBIMPOC sex workers by hiring sex workers fairly.

  "I know a lot of sex workers get called upon by health authorities and are never hired at the same rate. They are contracted. I've been invited into consulting things but I've never been hired or offered positions where I am getting paid actually what other folks are because I don't have a degree." — SME

- An SME shares that organizations need to make sure there is diversity in all levels of the organization, which means big changes in how you select people. They state there are many barriers to hiring 2SQTBIMPOC, especially when your intersectionality includes being self-identified as Fat or Superfat, living with disabilities, and mental health trauma. [SME, paraphrased to protect confidentiality]
- Hire staff representative of client ratio of Indigenous populations. "True decolonial work, we need to have spaces in which there's actual space for the people who are Indigenous, Indigiqueer, all of within trans, Two-Spirit, non-binary, like there needs to be some spaces for folks to be in there and doing that work". — SME

EMPOWERMENT ACTION #2

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

  - One SME reported "invasive completely unnecessary procedures" citing examples of wanting to access birth control medication to suppress monthly bleeding because that's "hugely gender dysphoric producing." But then they were forced to undergo sexual health related procedures the patient deemed unnecessary, unsafe, and uncomfortable in order to access the medication, even though they are not sexually active and that was not the purpose of the medication choice.

  - Self-identifying Fat or Superfat participants shared that their providers focused solely on their weight as the main issue, and were often recommending weight-loss as a solution instead of asking them how they can best be supported, and what their needs were.

- Trans participants who were assigned female at birth have often found that they cannot express a desire to conceive and birth a child because this can 'discredit' their trans masculine identity and further delay their access to medical transition services.

  "I remember seeing that question [about a desire to conceive children] on the questionnaire from the psychiatrist who would have to sign off on my medical transition and just wishing I could have this conversation with them instead of answering on this questionnaire. Just talk to me and I think you'll understand that I'm absolutely ready for top surgery, but I might still consider a child in the future. But they don't give you that time to have a conversation." — Consultation Participant.

EMPOWERMENT ACTION #3

- **Create intersectionally-specific health literacy/navigation tools designed in collaboration with 2SQT-BIMPOC folks to reduce barriers to system navigation and increase understanding of patient rights and recommended practices that they can use when discussing care plans and choices with service providers.**

  - One participant shared that they wished that something like the "AgedOut.ca" website existed for navigating the healthcare system from the point of view of different intersections. They identified that it is very simple to navigate, have your questions answered, and find the correct resources all in one area. Others agreed that a simple tool made by those who know what it's like to struggle navigating systems could be beneficial for many communities, particularly for youth and newcomers.

  - Participants reported that there was often missing information about their own care. This included the use of medical jargon that doctors would not explain, and there often wasn't time in the appointment for clients to ask for further explanation. This left many participants confused and unable to seek further support.

    "I asked my doctor once why he didn't share information with me and he was like 'oh it's in your file', but like, how am I supposed to know that? How do I even access that? No one teaches you that kind of stuff. We are just taught to trust doctors because they're the expert. But I want to know about my body, I should be the expert of my body."
    — Consultation Participant

EMPOWERMENT ACTION #4

- **Create or improve support systems and address retention and burn-out for 2SQTBIMPOC 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) supports. This action recognizes the unique challenges facing service providers with lived experience, and honours their invaluable role in an improved health care system.**

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Helping People Connect

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WHAT HAPPENED?

A five-year study on health barriers with a unique focus on intersectional analysis – stories and experiences of Sexual and Gender Diverse folks who are also Indigenous, Black and People of Colour (IBPOC).

12 PEER-LED COMMUNITY FOCUS GROUPS
(4 rural) hearing from over 100 participants

A HEALTH SERVICES SCAN WITH 12 SERVICE PROVIDERS
with lived experience

A COMPREHENSIVE LITERATURE REVIEW

> *"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. 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."*

HEALTH EQUITY BARRIERS

for SEXUAL AND GENDER DIVERSE COMMUNITIES

PART OF ENSURING SAFETY IS UNDERSTANDING WHAT IS PUTTING PEOPLE AT RISK

WHAT WE LEARNED

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. This advocacy often conceals the bigger systemic issues that result in significant health inequities.

3 BARRIERS TO CARE

A LACK OF HEALTHCARE PROVIDERS TRAINED IN INTERSECTIONAL ISSUES.

The number one barrier to care identified by study participants was a lack of health care providers knowledgeable in intersectional issues.

Although advanced medical guidelines exist, these are subject to provider discretion, which is often guided by moral, religious or other personal views.

SOCIAL AND GEOGRAPHIC ACCESSIBILITY.

Every door is the wrong one.

Participants report having to choose between their sexual/gender or racial/cultural identity to receive care. This is due to racism in white mainstream LGBTQ+ service provision and Homophobia/Transphobia in IBPOC service provision. This is heightened in rural contexts where there are little to no trained providers.

CLIENT DIRECTED CARE: BELIEVE ME!

Study participants reported decisions being made for them instead of with them.

Patients seeking care for a specific health issue report being subjected to unrelated concerns and questions from their healthcare providers. Provider curiosity can dominate an appointment leaving their health issue unaddressed. Sensitive information is shared without consent. Patients report having to plead their case for services.

> *"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. Colonization has already created fractured families amongst many BIPOC."* ~ CONSULTATION PARTICIPANT

PARTICIPANTS REPORTED THAT ACTION IS NEEDED IN THREE AREAS

SAFETY

Address systemic discrimination and improve health care quality and safety through structural changes.

EDUCATION

Increase health care provider education and awareness in order to provide better care for sexual and gender diverse folks who are also IBPOC.

EMPOWERMENT

Recognize and empower sexual and gender diverse people as leaders in their own health and wellness journey.

The Health Equity Collaborative carried out this work with support from the BC Ministry of Health.

HEALTH EQUITY

for SEXUAL AND GENDER DIVERSE COMMUNITIES

BELIEVE ME.