Programs and Interventions Promoting Health Equity in LGBTQ2+ Populations in Canada Through Action on Social Determinants of Health

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At-a-glance

Programs and interventions promoting health equity in LGBTQ2+ populations in Canada through action on social determinants of health

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Abstract

Sexual and gender minorities (SGM) experience a number of health inequities. That social determinants of health drive these inequities is well-documented, but there is little evidence on the number and types of interventions across Canada that address these determinants for these populations. We conducted an environmental scan of programs in Canada that target SGM, and classified the programs based on their level of intervention (individual/interpersonal, institutional and structural). We found that few programs target women, mid-life adults, Indigenous people or ethnoracial minorities, recent immigrants and refugees, and minority language speakers, and few interventions operate at a structural level.

Keywords: *sexual and gender minorities, SGM, health equity, social determinants of health, minority health, health status disparities, health promotion*

Highlights

- A number of gaps exist in programs promoting health equity and interventions by addressing social determinants of health for sexual and gender minorities in Canada.
- Efforts to develop new programming should consider LGBTQ2+ communities who are underserved by existing services (e.g. Indigenous people, ethnoracial minorities, women, recent immigrants or refugees).
- Very few programs addressed employment, disability, education or housing, which are important upstream determinants of health.
- Most programming focussed on the individual and interpersonal levels of intervention.
- Systemic interventions were scarce; efforts should focus on examining existing structural-level interventions to consider scalability.

Introduction

LGBTQ2+* individuals often have poorer physical and mental health than heterosexual and cisgender people.[1,2] The physical health disparities that lesbian, gay and bisexual populations experience range from poorer general health status to increased rates of cancer, cardiovascular disease, asthma, diabetes, arthritis and other chronic conditions.[1] Transgender youth also experience mental health disparities, including higher risk of reporting psychological distress, self-harm, major depressive episodes and suicide,[2] which have been positively associated with experiences of discrimination, harassment and violence.[3,4] Canadian LGBTQ2+ youth often experience exclusion, isolation and fear.[5] Many of the health inequities observed in sexual and gender minority (SGM) populations are hypothesized to stem from societal stigma,[6] which may include the co-occurrence of stereotyping, labelling, status loss, separation and/or discrimination,[7,8,9] and from negative social experiences that create heightened stress.[1,2]

Processes of stigma and discrimination play a central role in driving health inequities for SGM populations, contributing to experiences of stress and trauma throughout a lifetime. They also lead to inequitable access to the social and material resources needed to promote good health (e.g. employment, income, housing, quality and quantity of education, and health care).[10] For example, 40% of the 2873 trans and non-binary respondents to a 2019 Canadian survey were living in a low-income household and 45% reported having one or more unmet health care needs within the previous year.[11] Bisexual women and men in Canada report, respectively, 2.8 and 2.5 times higher rates of household food insecurity than their heterosexual counterparts and poorer health outcomes when compared to their gay and lesbian peers.[12] These inequities may be amplified for individuals whose sexual orientation or gender

* LGBTQ2+ is an umbrella acronym used in this document to describe individuals with a diverse sexual orientation and/or gender identity, which includes, but is not limited to, individuals who identify as lesbian, gay, bisexual, transgender (trans), queer and/or are Indigenous Two-Spirit.

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identity intersects with other marginalized social identities, such as their ethnicity or class.[13]

To date, most research in this domain has focussed on health inequities and there has been substantially less research on intervention development and evaluation.[6] There is no comprehensive portrait of the interventions addressing these determinants among LGBTQ2+ people in Canada. We conducted an environmental scan between February and March 2019 to meet this need. Following the release of the Parliamentary Standing Committee on Health's report, *The Health of LGBTQIA2 Communities in Canada*,[14] in June 2019, we updated the scan with more entries. We shared the results with select community organizations for member checking in early 2020.

Methods

A systematic search identified programs focussing on determinants of health at the macro (structural or social, economic and political factors), meso (institutional) or micro (individual and interpersonal) levels. Programs targeting specific health behaviours or health outcomes were also included. The search was conducted by province and territory to identify programs across the country that address one or more of the social determinants of health and target SGM populations. The search excluded programs that included people who do not have lived experience as a sexual and/or gender minority person.

Preliminary scanning revealed an abundance of programs that focussed on "downstream" and individual-level considerations (i.e. reducing stigmatizing or discriminatory individual knowledge, attitudes and behaviours; increasing social connectedness). Given important linkages between the health inequities and structural conditions that SGM populations face, we focussed the scan on mid- and upstream interventions. We therefore excluded downstream recreational programs, such as LGBTQ2+ sports teams, choirs, coffee groups, school-based gay–straight alliances (GSAs), social programs and clubs offered by postsecondary institutions, affirming churches/religious institutions, Pride festivals and one-off events. (The initiatives excluded by these criteria alone could populate an entire scan.) Thus, this scan captures interventions at higher orders of the social ecosystem, such as systemic interventions, and interventions that target social determinants of health (other than social connectedness), such as lack of access to employment, stigma and discrimination, poverty and food insecurity.

First, we used the Google search engine for broad Internet searches of English and French websites. Second, we conducted targeted searches of the Canadian Agency for Drugs and Technologies in Health (CADTH) database, provincial 211 directories (which provide information on and referrals to community and social services) and Tri-Council funding[†] results. Third, in order to identify community organizations, programs or services, we inspected LGBTQ2+ Pride festival guides from 2018 as well as the three most recent programs from the Canadian Professional Association for Transgender Health, the Community-Based Research Centre Summit and Rainbow Health Ontario conferences. Finally, a scan of academic databases was conducted using Summon 2.0 (University of Victoria, Victoria, BC). All searches were considered complete when two subsequent website pages yielded no new or relevant information.

Program information was analyzed using NVivo 11 (QSR International Pty Ltd., Melbourne, AU). Coded data were analyzed for semantic themes in order to move beyond pure description of the data and into interpretation.[15] The analysis produced a description of the location and types of programs being implemented and the social determinants of health being addressed. Member checking was conducted by sharing the results of the scan with at least one organization listed in the scan in each province. Members were asked to identify any gaps they noticed either nationally or within their region.

Results

The final scan included 220 programs (see Table 1). Counts vary by information availability and some programs targeted multiple populations. A third of the programs (34.5%) were nonspecific, being available to all LGBTQ2+ people. In locations with smaller populations, this was almost exclusively the case. Most of the programs (65.5%) targeted specific LGBTQ2+ groups, with almost half of the targeted programming focussing on youth. The definition of "youth" varied across organizations, but was most commonly defined as those aged 29 years and younger. The scan yielded few programs for adults 55 years and older (data available from the authors on request).

The second most prominently targeted group was people with trans lived experience. Approximately 15% of targeted programs were oriented towards trans and gender diverse people, with some delivered by organizations that solely serve this population. These almost always focussed on providing support groups, primary health care or support navigating health care systems, particularly for gender-affirming care (e.g. referrals, accessing hormones, surgeries).

Approximately 20% of programs were designed specifically for gay, bisexual and other men who have sex with other men (Table 1); these were largely HIV/AIDS service organizations. Programs targeting men most often focussed on sexual health, with some focussing on social health, physical health, mental health and overall well-being.

Discussion

Our scan revealed inequities in program availability.[16] The emphasis on age-targeted programming may limit the range of programming available.[16] This could have implications for health systems planning and health promotion efforts among members of the "missing middle."[16]

Fewer than 10 programs focussed on Indigenous and Two-Spirit people or racialized/ethnic minority LGBTQ2+ people.[17-19] Often, these were support groups that catered to individuals with a shared ethnicity or cultural background. There were also few (<10) programs designed specifically for recent immigrants and/or refugees; those that did exist were exclusively located in large cities.[20] Further, while this search was only conducted in English and French, only seven programs were identified that were offered in a non-official language, which may be a significant barrier for speakers of other languages.

[†] Together, the Canadian Institutes of Health Research (CIHR), the Natural Sciences and Engineering Research Council (NSERC) and the Social Sciences and Humanities Research Council (SSHRC) make up the Tri-Council funding agencies, the primary mechanism through which the Government of Canada supports research and training.

One program targeted LGBTQ2+ persons living with neurocognitive disabilities.

A minority of programs addressed important institutional and structural upstream determinants of health such as employment, education or housing,[17] where LGBTQ2+ people continue to experience significant barriers due to persistent stigma and discrimination. Indeed, the majority of interventions were more downstream programs targeting health care access and other individual- and interpersonal-level interventions. Health-oriented programs largely targeted men and trans people, and health-related programming for cisgender LGBTQ2+ women was notably lacking.[21,22] Further work should investigate how this disparity is reflected in health outcomes.

While systemic forces such as homo-, bi- and/or transphobia, cis-heterosexism and other intersecting systems of oppression create health inequities at all levels of the social ecology, most programming focussed on the individual and interpersonal levels of intervention. Some programs may be considered institutional-level interventions, but very few operate at a systemic or structural level. This gap leaves untried those strategies and interventions that reduce stigma-driven barriers to social and material resources faced by SGM populations.[11,23,24] However, in Canada LGBTQ2+ and other social movement organizations are often funded by governmental institutions that systemic- or structural-level interventions target.[25] System change to advance health equity via upstream, structural interventions can be influenced by both top-down (e.g. policy, funding) and bottom-up (e.g. advocacy) efforts, which is most successful when undertaken in concert and across sectors.[26,27]

Conclusion

Work is needed to better address the upstream determinants of health affecting diverse LGBTQ2+ people across Canada. Efforts to develop new programming should consider LGBTQ2+ communities who are underserved by existing services (e.g. women, Indigenous people, racialized/ethnic minority populations, people with recent immigration and refugee experiences). The large number of programs promoting social support and reducing social exclusion suggests these programs are still important to end users. This may also reflect a systemic funding preference

TABLE 1
Summary of results of environmental scan of programs targeting in sexual and gender minority populations, Canada, 2019

Category	n	%
Geography (n = 220)		
Canada	16	7.3
Alberta	29	13.2
British Columbia	27	12.3
Manitoba	15	6.8
New Brunswick	3	1.4
Newfoundland and Labrador	3	1.4
Northwest Territories	2	0.9
Nova Scotia	9	4.1
Nunavut	0	0
Ontario	65	29.5
Prince Edward Island	2	0.9
Quebec	45	20.5
Saskatchewan	3	1.4
Yukon	1	0.5
Social determinant addressed (n = 220)		
Social support	102	46.4
Social exclusion[a]	47	21.4
Access to health services	51	23.2
Ableism	1	0.5
Racism, xenophobia and anti-immigrant discrimination	11	5.0
Education	2	0.9
Employment	2	0.9
Housing	4	1.8
Community size (n = 220)		
Montréal, Toronto, Vancouver	67	30.5
Large cities (population: >100 000)	100	45.5
Small cities (population: 10 000–100 000)	19	8.6
Rural (population: <10 000)	2	0.9
Provincial	16	7.3
National	16	7.3
Language (n = 213)		
English	155	72.8
French	26	12.2
Both English and French	32	15.0
Other	7	3.3
Level of intervention (n = 220)		
Health promotion[b]	41	18.6
Individual and interpersonal	128	58.2
Institutional	47	21.4
Structural	4	1.8

Continued on the following page

TABLE 1 (continued)
Summary of results of environmental scan of programs targeting in sexual and gender minority populations, Canada, 2019

Category	n	%
Health promotion and other individual-level interventions by population (n = 302)		
Bisexual	1	0.3
Disability	1	0.3
Gay, bisexual and other men who have sex with men	53	17.5
Trans and gender diverse	46	15.2
Lesbian, bisexual and other women who have sex with women	10	3.3
LGBTQ	46	15.2
Migrants and newcomers	7	2.3
Older adults[c]	10	3.3
Parents, partners and other supports	30	9.9
Racialized people	12	4.0
Two-Spirit	6	2.0
Youth[c]	80	26.5
Nonspecific vs. targeted (n = 220)		
Nonspecific	76	34.5
Targeted	144	65.5

Abbreviations: HIV, human immunodeficiency virus; LGBTQ2+, lesbian, gay, bisexual, transgender, queer and/or Indigenous Two-Spirit; STI, sexually transmitted illness.

Note: Not all information was available for every program, and counts between categories are not equivalent.

[a] Refers to programs that promote inclusivity of LGBTQ2+ people in non-LGBTQ2+ specific spaces, structures and organizations.

[b] Refers to programs addressing specific health outcomes explicitly, such as HIV/STI screening, harm reduction supply distribution, counselling and addictions services.

[c] Only those programs that specifically mentioned participant ages were counted in these categories, i.e. programs for youth (<30 years) and older adults (≥55 years).

for downstream interventions, as opposed to more complex and long-term upstream systems intervention and evaluation. Given the scarcity of systemic interventions, future efforts should focus on identifying promising practices for designing, delivering and evaluating structural-level interventions that promote health equity and adapting these to address the specific contexts of SGM populations.

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Conflicts of interest

The authors have no conflicts of interest to declare.

Authors' contributions and statement

BEJ and NJL conceptualized this work and designed the study with RH. BH conducted the scan, conducted initial data analysis and drafted the initial paper. RH revised the analysis and completed the final paper draft. All authors helped to interpret the data, revised the paper drafts and approved the final version.

The content and views expressed in this article are those of the authors and do not necessarily reflect those of the Government of Canada.

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