Report to the UN Human Rights Council

on

The realisation of the right of persons affected by violence and discrimination based on sexual orientation and gender identity to the enjoyment of the highest attainable standard of physical and mental health, in relation to SDG3.

Issued by:

The Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity

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Consultative Report on Canada

23 January 2022

What follows is a response for input regarding the right of persons affected by violence and discrimination based on sexual orientation and gender identity to the enjoyment of the highest attainable standard of physical and mental health, in relation to SDG3, issued by the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity. The focus of this consultative response report is on the nation state of Canada. For the most part it provides a critical, macro, systemic perspective that does not necessarily address the numerous indicators of the SDG3. It instead provides insights that counter the popular narrative that Canada embraces the LGTBI and GNC populations due to its human rights legislation.

1. Research: understanding the health care needs of LGTBI and GNC people

Over the past 30 years, several community-based studies have been conducted regarding health care, social service needs and wellbeing of the LGBTQ communities across Canada (Mulé, 2015), many of which have been funded by the federal government. This included the Coalition for Lesbian and Gay Rights in Ontario (CLGRO), which conducted what at the time was the highest funded and largest study of its kind that looked at the health and social service needs of LGBTs in Ontario (CLGRO, 1997). CLGRO's Project Affirmation, like all the other studies in the grey literature reported serious gaps in the health care and social services systems that further marginalized LGBT people (CLGRO, 1997). The federal government's narrowed focus on HIV/AIDS, have resulted in a number of recommendations from these community-based studies still needing to be addressed (Mulé & Smith, 2014; Mulé, 2015). Just as HIV has evolved to become a manageable chronic disease and Canada now has interventions to resist the virus, so have the LGBTI and GNC communities evolved. Structures in service provision must also evolve to reflect the increasing diversification of these populations and their specified needs.

At the scientific level of research, Canada's Tri-Council does not recognize LGBTI and GNC studies as a formal discipline (Queer Ontario, 2019), forcing researchers to shape their research proposals to fit other disciplinary realms. This makes participating in the fiercely competitive arena of research funding that much more difficult. These discrepancies can create research limitations that can negatively impact the health status of LGBTI and GNC populations due to lack of relevant data. Governmental statistics collection, such as the Canadian Community Health Survey, has not adequately captured the diversity of the LGBTI and GNC communities in this country (Dharma & Bauer, 2017; Paschen-Wolff, Wells, Ventura-DiPersia, Renson, & Grove, 2017), yet changes have begun (Statistics Canada, 2021).

There are significant population-health issues in the LGBTQI communities. The Canadian Community Health Survey (2015) reported that 1.7% of Canadians between 18 to 59 years identify as lesbian or gay, and 1.3% identified as bisexuals. Regrettably, there were no available data on transgender Canadians in the survey (Statistics Canada, 2016). These statistics are not entirely reliable, and can be considered conservative, given social factors such as language barriers, being in 'the closet', and confidentiality concerns regarding disclosure that would impede honest responses. In several Canadian health surveys, social categorizations fall short of measuring the full

extent of sexual identities, behaviours, and expressions (Cahill & Makadon, 2017; Dharma & Bauer, 2017; Wolff, Wells, Ventura-DiPersia, Renson, & Grove, 2017). Due to such research limitations, the health inequities as understood and lived out by the LGBTQI populations in Canada have yet to be fully unearthed.

Despite these research limitations, specific and significant health needs of the diverse LGBTI and GNC Canadian populations have been identified. As a marginalized demographic, LGBTI and GNC Canadians 18 to 59 years of age, had disparaging experiences with healthcare providers when compared with their heterosexual counterparts (Tjepkema, 2008). LGBTQI individuals contend with depression, anxiety, are at elevated risks for suicidality, addiction, and substance use (Kulick, Wernick, Woodford, & Renn, 2017; Pakula, Carpiano, Ratner, & Shoveller, 2016; Veale, Watson, Peter, & Saewyc, 2017; Public Health Agency of Canada, 2015) and face precarious housing and homelessness (Abramovich, 2012, 2016; Ross & Khanna, 2017). Individuals who identified as bisexual experienced prejudice from service providers and did not have all of their healthcare needs met due to stigma and biphobia (Ross & Khanna, 2017; Tjepkema, 2008). LGBTI and GNC youth are an especially vulnerable population for targets of bullying and discrimination within the school system (Frost & Meyer, 2009; McKenzie, 2015). Transgendered individuals are subjected to ongoing marginalization, social exclusion, and violence, which is implicated in poor health outcomes for this demographic. The rising numbers (locally and globally) of trans-identified individuals are consistently faced with highest levels of economic and health-related disparities (Snelgrove, et al., 2012; Winter et al., 2016).

2. Inclusion: LGTBI and GNC people in the decision-making process

Although most of the LGBTI and GNC populations have human rights protections in legislation at the federal level (save for intersex people), such rights become thin within Canada’s health care and social service systems. There is a lack of recognition of sexual and gender identity and expression in Canadian public policy (Government of Canada, 2018; Mulé, 2018), in which there are existing systemic irregularities and inadequacies that overlook the health disparities experienced by LGBTI and GNC persons and communities (Mulé, et al., 2009; McKenzie, Khan, & Mulé, 2019; McKenzie, Mulé, & Khan, 2021; Queer Ontario, 2019). Numerous health-related areas will require equitable and responsive legislation that is specific to the health needs of LGBTI and GNC populations such as newcomers, asylum seekers and refugees, substance users, sex workers, trans populations, people who are poor, impoverished, incarcerated, homeless, etc.

Drawing from the systemic and structural inequities outlined in the sections above linked with the material health needs of the LGBTI and GNC populations will create an inventory of legislation to better address the health needs of these communities. Community-based approaches lends itself to being inclusive of these populations in decision-making processes. Such approaches also shift the emphasis from illness-based approaches to include social determinants of health, which include social, economic, and cultural factors (i.e., ability, race, gender, class, etc.). This approach can allow for a nuanced analysis of how social exclusion operates in complex ways and can

shed light on which factors compound intersectional oppression (Blaxter, 2010; McGibbon, 2012; Raphael, 2009).

Canada's world-renowned work on Health Promotion (World Health Organization, 1986), Population Health (Government of Canada, 2012) and the Social Determinants of Health (Government of Canada, 2018), offer promising models, but lack corresponding policy, funding, and programming, particularly with LGBTI and GNC people (Mulé & Smith, 2014). These health equity-based approaches move towards minimizing and eradicating the inequitable health disparities, such as systemic marginalization and poverty and advocates for the highest health standard for all people (locally and globally) (Bartley, 2009; Braveman, 2006; Shaw, Dorling, Gordon, & Smith, 1999). The social determinants of health approach considers that improved health outcomes hinge on an overall improvement of the quality of life and examines how positionalities can impact that quality of life.

However, even population health and social determinants of health approaches still exhibit a heteronormative understanding regarding SOGIESC—if these populations are even explicitly recognized. Therefore, in addition to using a population health approach to address the social determinants of health, a comprehensive Federal LGBTQ2 Health Equity Strategy must also ensure that we improve our understanding of SOGIESC within a health equity and intersectional lens. An intersectional lens brings to attention how the various intersecting oppressions based on identity facets such as ability, religion, race, ethnicity and class configure in the lives of LGBTI and GNC Canadians (Collins & Bilge, 2016; Rahman, 2014). Thus, an intersectional understanding can effectively address equity issues related to intersectional identities and lived experiences, while honouring the existing diversity within the LGBTI and GNC communities. These intersectional lenses of analysis based on identity facets are consistent with the social determinants of health and help to strengthen the Canadian multicultural mosaic. Further, it is imperative that this work be carried out within the framework of decolonization and in full support of the Truth and Reconciliation Commission's (2015) Recommendations. Yet, the fact that these models have not been fully implemented and certainly not with LGBTI and GNC people means that barriers persist.

Canadian LGBTI and GNC individuals and communities have had a history of being excluded from a model of health care that is specifically attuned to our needs as LGBTI and GNC individuals (Mulé, 2015). Despite robust community-based activism around HIV/AIDS, trans health-care and other social justice and health equity efforts, we still face a situation in which direct health-care delivery and health-related policy decisions are often more likely to rely on frameworks that centre individual pathology and moralizing references to "poor lifestyle choices" when addressing LGBTQ2 health (Mulé, 2007).

3. Access: ensuring that LGTBI and GNC people have access to health care

The specific and significant health needs of the diverse LGBTI and GNC Canadian populations are generally not recognized in Canadian public policy (Mulé & Smith, 2014), and there are existing systemic irregularities and inadequacies which overlook the health disparities experienced by LGBTI and GNC persons and communities (Mulé et al., 2009), positioning these communities outside of the Social Determinants of Health. One recent positive example is Canada's banning of conversion therapy (NPR, 2021). Materially, there are a handful of health organizations that address LGBTI and GNC health needs in this country. More are needed to ensure proper and effective programming for LGBTI and GNCs throughout Canada.

As such, it is time the federal government map out a communication strategy between the federal government and the provinces and territories to plan for the development of LGBTI and GNC health programming and services across the country. It would be crucial for this mapping exercise to take place in consultation with the LGBTI and GNC communities at every step in the process, including the funding of these communities to congregate and design such plans. Additionally, the federal government would need to ensure accountability measures are in place regarding transfer payments from the federal government to provincial/territorial governments, municipalities and local health bodies regarding this initiative. Through this process, it is important that policy be designed, developed, implemented, and evaluated utilizing a gender and sexual diversity lens. Funding dollars should be dedicated to the broad health issues of LGBTI and GNC Canadians, and not filtered through the illness-based HIV/AIDS envelope, in order to adequately address the comprehensive health issues, needs and concerns of these populations.

4. Training and Education: health care professionals and educational institutions

Currently, health education curriculum is uneven when it comes to LGBTI and GNC issues across the country. A means of fostering healthy relationships and wellbeing is to implement age-appropriate LGBTI and GNC health issues throughout the education system. Principles of diversity, inclusion and equity must take precedence over moral biases and/or religious restrictions in the curriculum (McKenzie, 2015; Schmitt, 2012). Faith-based education systems can be a barrier to this.

Health professionals in Canada, inclusive of physicians (Shindel & Parish 2013), nurses (MacDonnell & Fern 2014; MacDonnell, Bartlett, & Tabacco, 2018) psychiatrists (Ali, Fleisher & Erickson 2016), social workers (Mulé 2006; Mulé, McKenzie, & Khan, 2017), and various allied therapists (Snelgrove, et al., 2012) receive little to no education on LGBTI and GNC health concerns. Equitable health services to the LGBTI and GNC communities require formal and continuing education of health professionals, including social service professionals, on LGBTI and GNC health needs and sensitive interventions.

5. Sustainable Development Goals

Although Canada collects statistics on the SDG3 and its many indicators, what is lacking in many of the statistic gathering apparatuses, is the inclusion of the LGBTI and

GNC populations. More specific to the implications on health and mental health, in particular, it is encouraging to see that the Canadian Community Health Survey has begun to capture the LGBTI and GNC population (Statistics Canada, 2021). Nevertheless, this still does not include intersex people. In addition to state statistical gathering, it is also encouraged that the state-funded Tri-Council of research bodies recognize and include LGBTI and GNC populations as an area of disciplinary research. In addition to the Tri-Council, research funding opportunities need to be provided for broad LGBTI and GNC health issues not necessarily centred on HIV/AIDS (Queer Ontario, 2019). In 2019 the House of Commons Standing Committee on Health held nation-wide consultations on LGBTI and GNC Health in Canada (2019), producing a report on the breadth of health concerns of these populations, but falls short on depth in its recommendations on how to address these issues (Mulé, 2020). A nuanced issue is that although coverage exists through Canada's universal healthcare system, disclosure of one's LGBTI and GNC status can be a barrier for many.

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HOW TO SUBMIT INFORMATION

Inputs should be submitted via email to ohchr-ie-sogi@un.org before 31 January 2022 (6 p.m. CET). Late inputs will not be considered.