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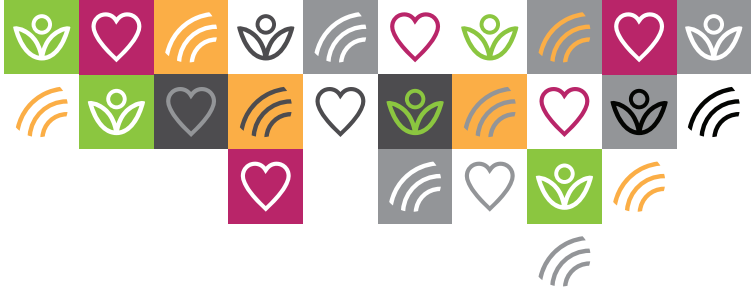
health in focus: 2SLGBTQ sexual health

An evidence review and practical guide designed for healthcare providers and researchers

PURPOSE

This Health in Focus educational resource was created to highlight the sexual health needs of 2SLGBTQ people.

This document will help you to identify barriers to accessing these sexual health services for 2SLGBTQ people and to better understand what can be done to create affirming 2SLGBTQ environments.



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summary

To provide inclusive, affirming services, and welcoming sexual health care to Two Spirit, lesbian, gay, bisexual, trans, and queer (2SLGBTQ) populations, health care and social service providers should appreciate the various gender identities, expressions, orientations, and other identities within the diverse umbrella of 2SLGBTQ. While there are some similarities in the experiences of Two Spirit, lesbian, gay, bisexual, trans, and queer people, each is a unique population that is diverse. 2SLGBTQ individuals live in all parts of the province, have different racial, ethnic, religious, age, and socio-economic identities, and may live with disabilities. 2SLGBTQ people share some sexual health concerns with the general population, however, they have some specific conditions, risks, and sexual care needs. Some of the health issues may apply to people across the 2SLGBTQ spectrum, while others may be specific to particular groups or identities.

When providing sexual health services to 2SLGBTQ people, a service provider's care will be enhanced by learning about their unique needs.

Different sub-populations under the 2SLGBTQ umbrella have different experiences and face different sexual health risks.

Assessment of sexual health risks for 2SLGBTQ people should be dependent on their body parts and sexual activities, not on a person's sexual orientation or gender identity.

Cisgender lesbian, bisexual women and women who have sex with women are at increased risk of breast, ovarian, and endometrial cancers. There is a tendency to believe that sex between women is less risky because of the assumption that it does not involve penetration.

Cisgender gay, bisexual men and men who have sex with men (MSM) are at greater risk for certain sexually transmitted infections (STIs). Barriers to effective care include health issues related to HIV infection or its treatment, as well as stigma and discrimination. MSM are also at increased risk of gonorrhea, syphilis, hepatitis A and B, non-specific urethritis, and shigellosis.

Trans and gender non-conforming people also face additional obstacles to accessing quality sexual health care, including experiences of outright discrimination and refusal to treat trans patients, as well as a lack of relevant clinical and trans competence among providers. Trans and gender non-conforming individuals face various sexual health risks, including higher risks for HIV and other STIs, and unintended pregnancies.

2SLGBTQ youth are more likely to engage in high-risk sexual behaviors leading to an increased incidence of STIs. Trans and gender nonconforming youth are also at higher risk for assault and sexual abuse.

Intimate partner violence is as prevalent in 2SLBGTQ relationships as in heterosexual and cisgender relationships and has been associated with a number of high-risk sexual behaviors.

2SLGBTQ sexual health

The past decade has seen significant progress in 2SLGBTQ rights in Canada, but members of the 2SLGBTQ community continue to experience worse health outcomes than their heterosexual and cisgender counterparts. Adverse outcomes have been linked to factors such as high rates of stress due to systematic harassment, social stigma and discrimination, and a lack of 2SLGBTQ-specific health information and competent health care.

Studies indicate that general practitioners are concerned that patients, in general, will find discussion of sexual issues intrusive or offensive, and take too much time. These barriers are compounded when seeing 2SLGBTQ people due to a provider's lack of competence in 2SLGBTQ health.[1]

Sexual health is important for every population. However, it may be even more so for 2SLGBTQ communities as it is often the focus of research and policy, as well as the source of stigma and discrimination. Much of the research and policy on 2SLGBTQ populations focuses on specific infections/diseases, such as STIs and HIV/AIDS. The overwhelming emphasis in HIV/AIDS research and health promotion on queer communities has the potential to cause harm if other dimensions of health are ignored. These populations may be at higher risk of diseases and conditions not directly related to sexual practices.[2]

Different sub-populations under the 2SLGBTQ umbrella have different experiences and face different risks, so they are presented separately within this document.

Two Spirit identities + health

Two Spirit identities are diverse among Indigenous communities, with many First Nations peoples, Métis, and Inuit using the term to encompass their sexual orientation, gender identity, gender expression, spiritual and/or cultural roles. Although for some individuals there may be overlaps with broader LGBTQ categories, others may view being Two Spirit as a distinct, separate identity.

The underrepresentation of distinct Two Spirit data in health research means much of our current information relies on small-sample studies, along with extrapolation from known disparities facing both Indigenous populations and 2SLGBTQ people. These limitations must be acknowledged, as they restrict care competency and contribute to "systemic invisibility."61 The emotional needs of Two Spirit people are one of the few areas of specific study, with existing literature indicating high rates of depression and anxiety.

The historic consequences of cultural genocide and ongoing colonialism – compounded by racism and social exclusion – significantly disadvantage Indigenous health. HIV rates for Indigenous peoples are twice as high as the average population.62 STI transmission, particularly chlamydia prevalence, is notably more prevalent when compared to the non-Indigenous population.63

When appropriate, service providers should take the same considerations working with Two Spirit clients that they practice with Indigenous and LGBTQ clients. For instance, assessment of sexual health risks should be dependent on the client's body parts and sexual activities, rather than Two Spirit identity.

SEXUAL HEALTH + LESBIAN AND BISEXUAL WOMEN

This section refers to women who identify as lesbian and bisexual; however, it also includes women who have sex with women (WSW) and don't necessarily use either of those sexual identity labels.

Studies conducted in the United States suggest an increased risk of breast, ovarian, and endometrial cancers in lesbians and bisexual women, due to factors such as fewer full-term pregnancies, fewer mammograms, and obesity. The highest prevalence of obesity was specifically found in Black lesbian women and those of low-economic status.[3]

Lesbian and bisexual women are more likely to smoke than heterosexual women, and smoking tobacco is associated with higher risk of cervical abnormality in the presence of HPV, and a higher risk of bacterial vaginosis.[4] Smoking cessation can therefore have significant sexual health benefits for many lesbian and bisexual women.[5]

There is a tendency to believe that sex between women is less risky because of the assumption that it does not involve penetration. This assumption is exacerbated by the lack of health promotion materials specifically designed for lesbian and bisexual women, which may contribute to; limited use of safer sex behaviours; a lower likelihood of accessing regular pap testing; and less willingness to be vaccinated for HPV.[6] Sexual activities between women include oral sex, vaginal and anal penetration using fingers and sex toys, penetrative sex, mutual masturbation, and vaginal fisting.[7, 8]

Lesbians have a similar prevalence of STIs to that of heterosexual women, with bisexual women possibly having a higher rate;[9, 10] however, the rates of specific STIs differ. Bacterial vaginosis (BV) and candida are most common; genital warts (caused by HPV), genital herpes (caused by herpes simplex virus-HSV) and trichomoniasis are infrequent; while chlamydia, pelvic inflammatory disease (PID), gonorrhea, and blood borne viruses (BBV) are rare.[7] There is evidence that BV, HPV, and HSV are sexually transmissible between women.[5, 12, 13] Further evidence of HPV transmission between women lies in the finding that exclusively lesbian women have similar rates of cervical dysplasia to heterosexual women, indicating the need for routine cervical screening.[14]

Risk factors for STI transmission in WSW include having had male sexual partners, early age of first sexual activity, and a higher number of sexual partners.[15] Risk-taking behaviours may be increased by mental health concerns and past experiences of abuse, both of which are of higher prevalence among lesbian and bisexual women. Bisexual women are more likely to combine sex with illicit drug use, which tends to reduce use of safer sex practices and increase STI rates. According to one study, female injection-drug users who had sex with women were at higher risk of HIV/AIDS. Similarly, other researchers have reported that vigorous use of sex toys allows for the exchange of body fluids containing blood that could heighten the risk of HIV transmission between women.[16]

Although risk of transmission of BBVs during sex between women is relatively low, lesbian and bisexual women have other risk factors for BBV transmission, such as higher likelihood of drug injection than heterosexual women. Bisexually active women are more likely to have sex with men who themselves have BBV risk factors, such as drug injecting or engaging in sex with other men.[5]

Latex barriers can be used to reduce transmission of STIs between women. These include dams placed over the genital area during oral sex, which can reduce the transmission of herpes and the transfer of anal organisms. Condoms on sex toys and

latex gloves during vaginal/anal/digital sex or fisting may reduce the risk of transmission of organisms present in cervical and vaginal secretions, assuming they are changed or removed between sites.[17]

Use of latex protection is rare among women, who are more likely to utilise other methods of safer sex such as; using different fingers or a different hand between sites; washing hands and sex toys soon after contact with secretions; and avoiding oral sex during episodes of herpes simplex.[5]

The unwanted pregnancy rate among lesbian and bisexual women is higher than that of their heterosexual peers. Pregnancy rates among this group may even be higher where there is limited acceptance and access to sensitive care, such as in rural areas. Increasing numbers of lesbians are seeking to conceive children. There is limited evidence that lesbians may have a higher prevalence of polycystic ovaries and polycystic ovarian syndrome, which can complicate conception planning. It is therefore important that information, advice, and planning for contraception, conception, and referral to appropriate services is available.[5]

The experience of abuse and violence for lesbian and bisexual women over their lives is two to three times higher than it is for heterosexual women. The rate of intimate partner violence within same-sex couples appears to be the same as that among heterosexual couples; however, there is the added burden of stigma, difficulty accessing 2SLGBTQ-positive crisis services, and risk of not being taken seriously. These experiences can create vulnerability and mental health problems that can compromise sexual health and wellbeing.[18]

SEXUAL HEALTH + GAY AND BISEXUAL MEN

This section refers to men who identify as gay and bisexual; however, it also includes men who have sex with men (MSM) who don't necessarily use any one of these sexual identity labels.

Research indicates that MSM have some common sexual health risks and concerns. While they may not all apply to each individual, they are important concerns for men and their care providers to be aware of.[19]

MSM are at greater risk for certain STIs, such as syphilis, human papillomavirus (HPV), hepatitis, shigellosis, non-specific urethritis (NSU), and HIV. The bacteria that causes meningitis can also be passed to others through close contact. Men with compromised immune systems such as those with HIV, are especially at risk.[19]

The number and rate of reported HIV cases in Canada has remained relatively stable over the last decade, meaning that the country has not seen a decrease in new HIV infections in recent years.[20] Despite advances like preexposure prophylaxis (PrEP) with antiretroviral therapy (ART), and the availability of self-testing, significant challenges such as barriers to effective care, health issues across the life span related to HIV infection or its treatment, stigma and discrimination remain.[21] Some populations are more adversely affected and don't have the same access to HIV education, supports and services. The Canada Communicable Disease Report for HIV Surveillance showed that Indigenous and African, Black and Caribbean people made up less than five per cent of the population, but represented more than 20 per cent of newly reported HIV cases.[22] A survey of gay and bisexual men found that one in three men had never had an HIV test, and one in four had never been tested for any STI.[16]

The World Health Organization recommends that all men who have sex with men consider taking pre-exposure prophylaxis (PrEP) to prevent HIV. When combined with consistent condom use, PrEP can minimize HIV transmission.[23]

While studies show some promising increase in awareness of PrEP and post-exposure prophylaxis (PEP), rates of use continue to be much lower than rates of awareness. Men who report being aware of PrEP ranged from 13 per cent to 64 per cent, but reported use of PrEP among MSM was between 0.4 per cent to two per cent. About 50 per cent of HIV-negative gay and bisexual men were aware of PEP, but fewer than five per cent reported having ever used it.[24]

Men were more likely to be aware of PrEP if they had high numbers of sexual partners, and if they had a care provider who was aware of their sexual behaviours. Men were more likely to be interested in using PrEP if they were involved in high-risk activities, such as greater numbers of sexual partners and participating in unprotected anal sex with casual partners.[19]

Between 47 per cent and 64 per cent of MSM were aware of PEP. Awareness of PEP was associated with being white and over 25 years old, having an income over $100,000, and making annual visits to a health provider. The study also found that men who reported unprotected anal sex or sex under the influence of a drug were more likely to have heard of PEP.[19]

Men were more likely to have used PEP when they were in an HIV serodiscordant relationship (where one partner has HIV and the other is not), had high numbers of sex partners, and engaged in anal intercourse with casual partners.[19]

Barriers to using PrEP and PEP for MSM include: the cost and accessibility of the medication, short and long-term side effects, and the adverse effects of irregular PrEP use. Another major concern was that PrEP use could lead to reduced condom use while on PrEP. Studies report between a 36 per cent to 60per cent likelihood of reduced condom use by men on PrEP.[24]

Rates of gonorrhea are on the rise among men who have sex with men, and new, more drug resistant strains are becoming more common.[25]

Since the early 2000s, a syphilis epidemic has emerged in urban centres in Canada, disproportionately affecting gay men and MSM, a proportion of whom are HIV-positive. Individuals infected with syphilis are at an increased risk of acquiring HIV. In people living with HIV, syphilis can progress more quickly, be more difficult to treat, and increase the risk of onward HIV transmission.[26] If not treated promptly, syphilis can harm the heart and nervous system.[27]

Certain risk-reduction strategies such as serosorting (the act of choosing a sexual partner with the same HIV-positive status) and strategic positioning (where the receptive partner is HIV-positive or has an unknown HIV status and his partner in the insertive role in anal sex is HIV-negative), which are often accompanied by condomless sex, may be driving syphilis infection among HIV-positive gay men. This could account for some of the cases of syphilis reinfection after successful treatment.[28]

Canadian and international evidence demonstrates the need for enhanced testing for syphilis among at-risk MSM. Based on the literature, this includes increased testing frequency (up to every three months) for HIV-negative MSM at high risk; this can be facilitated, for example, by adding syphilis testing to routine blood work, given the significant rates of syphilis co-infection.[29]

OTHER STIS DISPROPORTIONATELY AFFECTING MSM

Both the hepatitis A virus and the hepatitis B virus disproportionately affect MSM. Both can be is transmitted through needle sharing and anal, oral, and vaginal sex. Hepatitis is a serious disease that can be fatal. Fortunately, both hepatitis A and hepatitis B can be prevented by safe and effective vaccines. Unfortunately, many men at risk remain unvaccinated.[27]

Non-specific urethritis (NSU) is inflammation of the urethra caused by bacteria. It is also called non-gonococcal urethritis (NGU) when the condition is not caused by gonorrhoea. It is passed on in the same way as gonorrhoea and often has similar symptoms. It can also be caused by having lots of sex or masturbating a lot, which can make the urethra inflamed.

Shigellosis is a very contagious common diarrheal disease caused by a group of bacteria. Exposure to even a tiny amount of fecal matter with shigella in it can cause infection. MSM are more likely to acquire shigellosis than the general adult population. Shigellosis outbreaks among MSM have been reported in the United States, Australia, Canada, Japan, and Europe.[5, 31] Typically passed from stools or soiled fingers of one person to the mouth of another person, sexual activity such as oral-anal sex, or sucking or licking of the anus (anilingus or "rimming"), may be especially risky.[31] MSM are more likely to get infected with *shigella* that is resistant to antibiotics commonly used to treat shigellosis.[31] HIV-infected persons can have more severe and prolonged shigellosis, including having the infection spread into the blood, which can be life-threatening.[32]

Men in same-sex relationships experience abuse rates similar to those faced by women in heterosexual pairings, and by as much as three times higher than those reported by men involved with women. MSM may be hesitant to seek help because they fear that revealing their sexual orientation to others will put them in greater danger, or because most resources are geared for women survivors of violence.

Limited attention has been paid to abuse of men in intimate partner relationships and even less so on abuse of men by male partners. Studies suggest that men in abusive relationships were more likely to report depression or other mental health problems, and to engage in unhealthy behaviors such as substance abuse, combining drugs with sex, or unprotected sex. These findings parallel studies of heterosexual samples, which show that intimate partner abuse is a major factor in a range of health problems.[33]

SEXUAL HEALTH + TRANS AND GENDER NON-CONFORMING PEOPLE

Trans, and gender non-conforming individuals face various sexual health risks in their lifetime, including higher risks for HIV and other STIs, unintended pregnancies,[34] and marginalization and abuse within the community from family, partners and colleagues, which can encourage reluctance in seeking necessary health care. These risks increase for racialized and ethnic minorities, particularly those who identify as Indigenous, Black, or Latino.[35]

Beyond sexual health issues experienced by 2SLGBTQ communities, these populations also face additional obstacles to accessing quality sexual health care, including experiences of outright discrimination and refusal to treat trans and gender non-conforming patients, as well as a lack of relevant clinical and cultural competence among providers. The intimate nature of sexual health care — such as screening and treatment for STIs and breast, cervical, and prostate cancers, as well as contraception provision — makes these concerns especially acute. Sexual health education rarely addresses trans people's bodies and identities. For example, transmasculine people who have sex with men report a lack of adequate information about their sexual health at rates as high as 93.8 per cent.[35]

Trans people delay or avoid preventive health care, such as pelvic exams or STI screening, out of fear of discrimination or disrespect. Half of transmasculine people do not receive annual pelvic exams. Reasons include discomfort with the physical exam due to gender issues, lack of a medical provider they were comfortable with, and thinking they did not need pelvic exams. Trans teens, including those at risk for unintended pregnancy, were reluctant to go to a family planning clinic.[34]

A person's risk of exposure to STIs and BBVs depends on the body parts and fluids involved in sexual activity with another person, not a person's identity. Trans people may have sexual partners of any gender or biological sex.[34] An individual's partners or sexual history cannot be assumed from their gender identity or the gender they were assigned at birth. Standard preventive health screenings are generally recommended for the body parts a patient has, regardless of that patient's gender identity, including breast, cervical, and prostate cancer screenings.[37]

Trans individuals may engage in higher rates of unprotected vaginal, anal, and oral intercourse.[38] Transmasculine people who have sex with men report high rates of unprotected vaginal and anal intercourse. Some transmasculine people report being more concerned about pregnancy than HIV and other STIs.[39] HIV prevalence in trans and gender non-conforming individuals is at four times that of the general population. Low levels of consistent condom use, combined with barriers to social and health-related services, contribute to higher HIV rates among trans individuals.[40]

HIV infection rates are particularly high for transfeminine people, driven by trouble accessing critical sexual and reproductive health care services due to stigma and discrimination.[41]

Increased engagement in HIV-related risk behaviors also stems from the psychological impacts of discrimination and stigma, where trans individuals, particularly racialized transfeminine people, are more likely to be living with depression, anxiety, and poor self-esteem.[31]

Sexual health education provided in public schools and sexual health information found at many clinics and hospitals seldom address the bodies and individualities of trans and gender nonconforming individuals,[35] leaving a percentage of the population without access to critical knowledge regarding their sexual and reproductive health needs. When one seeks this information, healthcare providers

are unfortunately not always equipped with the knowledge to address these particular health essentials.[42]

Many trans individuals indicate that when it came to addressing their personal health concerns, they had to educate their healthcare providers on the appropriate provisions of care they required.[34]

Being able to enjoy sex is an important aspect of general wellbeing. Trans and gender nonconforming people may face considerable challenges to their sexual experiences, such as their sexual behavior (i.e., type and frequency of sexual activities) and sexual feelings (e.g., their sexual pleasure).[43] The experience of being trans or gender non-conforming is closely related to sexual identity and body image. For trans individuals who choose to undergo hormonal therapy and/or surgery, alterations to the endocrine system and sex characteristics are likely to influence their sexual experiences, which in turn may affect their quality of life.[44]

There are several indications that dissatisfaction with one's appearance or misalignment between sex assigned at birth and gender, can make it more difficult to enjoy or to be satisfied with sexual experiences.[45] While trans and gender nonconforming people generally reported improved sexual satisfaction after transition-related interventions, findings also indicate that satisfaction with one's genitals, following transition related interventions, plays an important role in sexual satisfaction.[46] Body incongruence, which is often accompanied by body dissatisfaction, and is not confined only to the genitals, hinders sex and enjoyment of sex.[37] Body satisfaction is positively related to indicators of sexual behaviors and feelings, underlining the importance that body satisfaction plays in the sexual experiences of trans people.[47]

It is estimated that 14 per cent of trans people in Ontario had ever done sex work and three per cent are current sex workers. Trans-specific reasons for doing sex work may include employment discrimination, housing insecurity, the need to fund gender-affirming care, and benefits; these include access to community, affirmation of gender identity, and more accommodating work-life balance, which may alleviate adverse effects of transphobia. Transfeminine people are more likely to engage in high-risk sex work, often having little power to negotiate safer sex with their partners. Much existing research on trans sex workers focuses on HIV risk, but has also identified other important health concerns and social determinants of health including high levels of violence, limited access to justice, poor mental health, high suicide risks, higher rates of disability, and stigma in healthcare settings.[48]

Sex workers had greater barriers to health care than other trans and gender non-conforming people, including not having a primary care provider, unmet health care need(s), and emergency room avoidance. In contrast, sex workers were more likely to have been tested for HIV or other STIs, and more likely to have used PrEP for HIV prevention.[48]

Trans and gender non-conforming individuals experience even higher rates of intimate partner violence (IPV) than the general population. More than half (54 per cent) reported experiencing some form of intimate partner violence.[49] Trans and gender non-conforming individuals who experienced IPV were also likely to have experienced other forms of violence such as sexual assault, transphobic family violence, transphobic school violence, or transphobic violence more broadly in society. Clinicians should treat IPV among trans populations as a potential warning sign for, and should trigger screenings for, experiences with other violence types outside of intimate relationships.

Along with other forms of IPV experienced by survivors, trans and gender non-conforming survivors of IPV also experience gender

abuse, which is abuse that is targeted toward their trans identity like misgendering, dead naming (using a former name), refusing to validate the survivor's identity, or directing physical/sexual violence toward a survivor's identity. Identity abuse can become internalized and make it challenging for survivors to recognize their experiences as abusive or seek help. Add this to experiencing transphobia from family, people at work, or society in general, trans people often gauge whether reaching out for support is going to be helpful or harmful.[50]

Intimate partner violence has been associated with several high-risk sexual behaviors, including inconsistent condom use, multiple sexual partners, earlier sexual debut, consuming substances while engaging in sexual behavior, and a higher risk for sexually transmitted infections.[51]

SEXUAL HEALTH + 2SLGBTQ YOUTH

2SLGBTQ youth are more likely to engage in high-risk sexual behaviors leading to an increased incidence of STIs. Multiple factors accounted for unsafe sexual behaviors in 2SLGBTQ youth including earlier age of their first sexual encounter, increased number of sexual partners (known and anonymous), lack of education on safe sex practices, ineffective use of condoms, and testing and perception of STIs acquisition risk.[52]

Trans and gender nonconforming youth are also at higher risk for assault and sexual abuse,[s] further increasing the possibilities of pregnancy and STI infection. Abuse suffered by trans individuals can start as young as the grade school years. Trans youth are a particularly vulnerable group, often facing issues such as "shame, fear, and internalized transphobia," and limitations or restrictions on individual expression.[54]

resiliency factors

Factors that support good mental health for 2SLGBTQ people, such as access to spaces and relationships that affirm their sexual orientation and gender identity, lower rates of suicide and risk-taking behaviours.[16] Peer norms about safer sex and behaviorally specific communication with regular romantic/sexual partners are viewed as possible protective factors, suggesting that these factors may be promising intervention targets.[55] Studies also suggest that when sex education curriculum and public campaigns include information about risk factors and safer practices and are inclusive of 2SLGBTQ bodies, practices and experiences result in better sexual health outcomes from 2SLGBTQ people.[56] Results require further and more in-depth study however, as existing results are limited by the minimal focus on sexual health, types of relationship-level factors tested, age, gender and orientation of the study subjects, usually young, gay, and MSM.[55]

SUPPORTING 2SLGBTQ COMPETENT SEXUAL AND REPRODUCTIVE HEALTHCARE SERVICES

Studies and reports on the state of sexual health care for 2SLGBTQ populations underscore the importance of acknowledging and addressing their sexual health needs and experiences.

- Additional research on the sexual health of 2SLGBTQ communities that goes beyond STIs and HIV should be encouraged, to inform where public health initiatives need to improve and gaps that should be addressed.
- Because different sub-populations have different experiences and face different risks, there is a need to look at both 2SLGBTQ sexual health collectively and separately.

2SLBGTQ people have specific sexual health needs, many of which can be accommodated easily and effectively in general practice. However, there are a number of barriers that prevent primary health care practitioners from raising sexual health issues with these populations.

- Training should be provided for health care providers in competent sexual health care to 2SLGBTQ populations. Expanding current health care resources to include more inclusive sexual and reproductive health and wellness education for doctors and other medical staff can lead to many positive outcomes for 2SLGBTQ people.
- 2SLBGTQ people take cues from the practice environment to ascertain the likelihood that the provider or service will be nonjudgmental and aware of their specific health needs. If the environment is perceived to be welcoming, they may be more likely to disclose their sexual orientation, gender identity or sexual issues to the health provider. 2SLGBTQ positive environments could include:
    - Displaying a rainbow sign or other inclusive signage
    - Having 2SLBGTQ specific patient materials
    - Training reception staff to use inclusive language, refrain from assumptions, and to ask about and use preferred names and pronouns
    - Having inclusive forms (e.g., clinic intake forms with specific sexual orientation and gender identity questions)
- Sexual and reproductive health providers should become familiar with clinical guidelines and recommendations for trans people from the World Professional Association for Transgender Health (WPATH).
- Providers should also adopt a formal policy of non-discrimination and respect for each patient's gender identity.
- Strategies and supports should be implemented to improve access to sexual and reproductive health information, education, and services, including integrating information into school curriculums.

CURRENT LEGISLATIVE AND REGULATORY CONTEXT REGARDING 2SLGBTQ POPULATIONS

Policies that include sexual orientation, gender identity and gender expression create equitable environments for all service users and service providers. These policies create a framework for providing inclusive, welcoming, and affirming care, improving access to services for 2SLGBTQ people and supporting service providers who work with them.

ONTARIO HUMAN RIGHTS CODE

The Ontario Human Rights Code[57] is a form of legislation created to recognize the inherent dignity and worth of every person, and to provide equal rights and opportunities without discrimination within a social area. This includes employment, housing, facilities and services, contracts, and memberships in union/trade/professional associations.

Sexual orientation, gender identity, and gender expression are recognized as protected grounds for discrimination under the Ontario Human Rights Code.

The Ontario Human Rights Code supports non-discriminatory policies within recognized social areas including organizations providing health care services, social services, and housing accommodations. Policies under the code specific to sexual orientation, gender identity, and gender expression outline organizational and individual strategies for creating inclusive, welcoming and affirming environments for 2SLGBTQ people.

POLICIES ON DISCRIMINATION BECAUSE OF SEXUAL ORIENTATION AND GENDER IDENTITY[57, 58]

Protection of confidentiality of information

- Service providers collecting information that directly or indirectly identifies an individual's sexual orientation must ensure maximum privacy and confidentiality of this information

Barrier review

- Organizations may have rules, criteria, or internal policies, practices and decision-making processes that perpetuate systemic discrimination, creating barriers that need to be addressed

Development and promotion of anti-harassment and anti-discrimination policies that address homophobia

- Commitment to fair and equitable environment free of discrimination and harassment
- Statement of rights and obligations
- Examples of harassment and discrimination as defined in the *Code*

Complaint resolution procedure

- How will complaints be handled?
- To whom is the complaint made?
- Confidentiality
- Length of time for complaint to be investigated

Privacy Of Health Information

Ontario's *Personal Health Information Privacy Act* (PHIP)[60] is legislation that protects the confidentiality, privacy and security of personal health information. The legislation was the first of its kind for Ontario—proposing new health sector rules that would ensure effective protections are in place when health information is shared to provide better care to patients.

recommended resources

1. LGBT2SQ Health Connect - Rainbow Health Ontario
   — Courses to increase provider's 2SLGBTQ competency.
2. Rainbow Health Ontario Clinical Resources
3. Planned Parenthood Toronto

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