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Promoting 2SLGBTQI+ Health Equity



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Declaration of Conflict of Interest

In the context of RNAO best practice guideline development, the term "conflict of interest" (COI) refers to situations in which a RNAO staff member or expert panel member's financial, professional, intellectual, personal, organizational or other relationships may compromise their ability to conduct panel work independently. Declarations of COI that might be construed as constituting a perceived and/or actual conflict were made by all members of the RNAO expert panel prior to their participation in guideline development work using a standard form. Expert panel members also updated their COI at the beginning of each guideline meeting and prior to publication. Any COI declared by an expert panel member was reviewed by the RNAO best practice guideline development and research team and expert panel co-chairs. No limiting conflicts were identified by members of the expert panel. See "Declarations of Conflicts of Interest Summary" at <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

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We acknowledge that the office of the RNAO is located on the traditional and unceded territory of the Huron-Wendat, Haudenosaunee, and most recently, the territory of the Mississaugas of the Credit. This territory was the subject of the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes. This land is still the home to many First Nations, Inuit and Métis peoples from across Turtle Island and we are grateful to have the opportunity to work on this territory. By making a land acknowledgement, we are taking part in an act of reconciliation, honouring the land and Indigenous heritage, which dates back over 10,000 years. We encourage you to learn about the land you reside on and the treaties that are attached to it; land acknowledgements are an act of reconciliation and we must all do our part.

Cover Images

Top left and bottom right cover images from *The Gender Spectrum Collection*.

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Promoting 2SLGBTQI+ Health Equity

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario



The Registered Nurses' Association of Ontario (RNAO) is delighted to present the best practice guideline (BPG) *Promoting 2SLGBTQI+ health equity*. Evidence-based practice supports the excellence in service that health providers are committed to delivering every day.

We offer our heartfelt thanks to the many stakeholders who make our vision for BPGs a reality. First, and most important, we thank the Government of Ontario that recognized in 1999 RNAO's capacity to lead a program that has gained worldwide recognition and is committed to funding it. We also thank the co-chairs of the RNAO expert panel, Sheena Howard (past-president, RNAO's

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Successful uptake of BPGs requires a concerted effort from educators, clinicians, employers, policy-makers, researchers and funders. The nursing and health communities, with their unwavering commitment and passion for excellence in care, provide the expertise and countless hours of volunteer work essential to the development of new and next edition BPGs. Employers have responded enthusiastically by becoming best practice spotlight organizations (BPSO[®]) -- with over a 1,000 service and academic institutions in Canada and abroad. BPSO[®] have sponsored best practice champions, implemented BPGs and evaluated their impact on patient and organizational outcomes. Governments at home and abroad have joined in this awesome journey. Together, we are building a culture of evidence-based practice that benefits everyone.

We invite you to share this BPG with your colleagues from nursing and other professions, with the patient advisors who are partnering within organizations and with the government agencies with which you work. We have so much to learn from one another. Together, we must ensure that the public receives the best possible care every time they come in contact with us – making them the real winners of this great effort!

A handwritten signature in black ink that reads "Doris Grinspun". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Doris Grinspun, RN, MSN, PhD, LLD(hon), Dr(hc), FAAN, FCAN, O.ONT
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How to Use This Document

This **best practice guideline**^{G*} (BPG) is a comprehensive document that provides guidance and resources for **evidence-based nursing practice**^G. It is not intended to be a manual or “how-to” guide; rather, it is a tool to guide best practices and enhance decision making for **nurses**^G, members of the **interprofessional team**^G, educators, health-service organizations, academic institutions, and persons and their **chosen family**^G. This BPG should be reviewed and applied in accordance with the needs of individual health-service organizations, academic institutions or other practice settings and with the preferences of **Two-Spirit**^G, **lesbian**^G, **gay**^G, **bisexual**^G, **trans**^G, **queer**^G, **intersex**^G and other people who identify as a sexual or gender minority (2SLGBTQI+^G). This document provides evidence-based **recommendation**^G statements and descriptions of: (a) inclusive communication, safer spaces, risk assessment and screening, group-based interventions and education, as well as outlining (b) benefits and harms, (c) values and preferences, and (d) health equity considerations.

Nurses, members of the interprofessional team, educators and administrators who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols and educational programs to support service delivery. Nurses and other members of the interprofessional team in direct care will benefit from reviewing the recommendations and supporting evidence.

If your health-service organization is adopting this BPG, the Registered Nurses’ Association of Ontario (RNAO) recommends you follow these steps:

1. Assess your existing policies, procedures, protocols, and educational programs in relation to the **good practice statement**^G, recommendations, and supporting discussions of evidence in this BPG.
2. Identify existing needs or gaps in your policies, procedures, protocols and educational programs.
3. Note the recommendations that are applicable to your setting and that can be used to address your organization’s existing needs or gaps.
4. Develop a plan for implementing recommendations, sustaining best practices, and evaluating **outcomes**^G.

Implementation science^G resources, including the *Leading Change Toolkit*[™] (RNAO in partnership with Healthcare Excellence Canada (HEC), 2021), are available online at <https://www.RNAO.ca/leading-change-toolkit>. A description of the Toolkit can be found in **Appendix N**. For more information, see **Implementation Strategies**.

All of the RNAO BPGs are available for download, free of charge, on the RNAO website at [RNAO.ca/bpg](https://www.RNAO.ca/bpg). To locate a particular BPG, search by keyword or browse by topic.

We are interested in hearing your feedback on this BPG and how you have implemented it. Please share your story with us at [RNAO.ca/contact](https://www.RNAO.ca/contact). RNAO Best Practice Guidelines two decade journey can be found in: Grinspun D, Bajnok I, editors. Transforming nursing through knowledge: best practices for guideline development, implementation science, and evaluation Indianapolis (IN): Sigma Theta Tau International; 2018. Available at <https://www.sigmamarketplace.org/transforming-nursing-through-knowledge.html>

* Throughout this document, terms that are bolded and marked with a superscript G (^G) can be found in the **Glossary of Terms** in **Appendix A**. Some important considerations for understanding the terminology used in this guideline are outlined on the following pages.

A Note on Terminology and Language

The use of terminology in this BPG is critically important. Appropriate terminology and language convey meanings that affirm and empower 2SLGBTQI+ people and communities, whereas inappropriate and offensive words and language promote and perpetuate discrimination, oppression and negative power dynamics (1). Evidence-based practice includes the use of an inclusive and **affirming**^G approach and the use of appropriate terminology to describe 2SLGBTQI+ people and communities. However, it is also important to recognize that terminology and preferred language for 2SLGBTQI+ people and communities changes and evolves. The terminology and language used in this guideline is therefore representative of the time in which the guideline was developed.

The 2SLGBTQI+ acronym stands for Two-Spirit, lesbian, gay, bisexual, trans, queer and intersex people. The “+” is meant to be inclusive of other people who identify as a sexual or gender minority, such as (but not limited to): **asexual**^G, **non-binary**^G, **pansexual**^G and those **questioning**^G their **sexual orientation**^G or **gender identity**^G or **gender expression**^G. The acronym represents a diverse group of unique people with respect to sexual orientation, gender identities and expressions. As the acronym evolves over time, it reflects new identities. Reflected within any version of the 2SLGBTQI+ acronym are histories of oppression and privilege, erasure and violence against those who belong to these communities (1). Historical invisibility, or the erasure of parts of the acronym, have occurred as a result of **colonialism**^G, racism, transphobia, misogyny and biphobia (1). As there are many acronyms, using the acronym that reflects most broadly the communities served is considered best practice (1). The 2SLGBTQI+ acronym used in this document was selected by the expert panel to capture the profound diversity of sexually and gender diverse communities in Canada and across the world. 2S was chosen to lead the acronym as a way to honour and bring visibility to Two-Spirit people.

Note: Throughout this BPG the acronym 2SLGBTQI+ may be shortened in order to reflect the specific populations included in the literature or to reflect a different acronym used in a specific study. For example, LGBT may be used to represent lesbians, and gay, bisexual and trans people or LB women may be used to represent lesbians and bisexual women.

Identities represented by the acronym do not exist in isolation and 2SLGBTQI+ people may also belong to other intersecting groups that make them unique, for example they may identify as **Black, Indigenous or People of Colour (BIPOC)**^G. (The acronym BIPOC is used in this guideline as it recognizes the unique experiences of historic and systemic racism faced by Black, Indigenous and People of Colour (2).) Some 2SLGBTQI+ people also experience disabilities. **Disability**^G is an umbrella term, covering physical and intellectual impairments, activity limitations and participation restrictions (3). The experience of disability results from the interaction between individuals with a health condition and personal and environmental factors. Those factors include transportation and public buildings that are not accessible, limited social support and negative attitudes or discrimination called “ableism”, that lead to systemic marginalization and structural barriers (4, 5).

It is necessary to understand the differences between sexual orientation, gender identity, and gender expression in order to interpret this document.

- **Sexual orientation** describes a person’s physical, romantic, emotional and/or spiritual attraction to others and may include being lesbian, gay, heterosexual, bisexual, pansexual, or asexual. A person’s sexual orientation should not be assumed based on the perceived sex of that person’s partner(s) (6).

- **Gender identity** is each person's internal and individual experience of gender. It is their sense of being a woman, a man, both, neither, or anywhere along the gender spectrum. A person's gender identity may be the same as, or different from, their **birth-assigned**^G sex. Gender identity is fundamentally different from a person's sexual orientation (7).
- **Gender expression** is how a person publicly presents their gender. Gender can be expressed through behaviour and appearance, such as dress, hair, make-up, body language and voice. A person's chosen name and pronoun are also common ways of expressing gender (7). As such, appropriate pronoun use is critically important and a way of showing respect and honouring the dignity of all persons.

These identities are not static and can change over time. Some people use the term **gender fluid**^G to describe their gender identity. A gender fluid person can identify anywhere on the gender spectrum (8). This fluidity can also occur over shorter or longer periods of time, such as months or years. Sexual orientation can also be fluid.

Other critical terminology for understanding this BPG include:

- **Trans** is an umbrella term referring to people with diverse gender identities and expressions that differ from stereotypical gender norms. It includes but is not limited to people who identify as transgender, trans woman (male-to-female), trans man (female-to-male), transsexual, cross-dresser, gender non-conforming, gender variant or gender queer (7). The term trans refers to a state of incongruence of one's gender identity with the birth-assigned sex. Trans can mean transcending beyond, existing between or crossing over the gender spectrum (9, 10).
- **Two-Spirit** refers to a person who identifies as having both a masculine and a feminine spirit, and is used by some Indigenous people to describe their sexual, gender and/or spiritual identity (11). The term Two-Spirit refers to a pre-contact (prior to arrival of **settlers**^G and colonialization) gender identity believed to be common amongst most, if not all, First peoples of Turtle Island (North America). This gender role had an important place within Indigenous societies and was not based on sexual activities or practices, but rather the sacredness that comes from being different. There are many definitions and understandings that are nation-specific (e.g. Navajo, Cree, Dene, Anishinabe) and each individual person will have their own way of expressing their Two-Spirit-ness. Not all Indigenous people identify as Two-Spirit and have other ways and words to express their gender identity and sexual orientation (12).

For further details on terminology in this BPG, please refer to the **Glossary of Terms (Appendix A)**. Please note that terminology is time-and culture-dependent. It is important to use respectful language in alignment with place, time and the preferences and values of people.

Purpose and Scope

Purpose

RNAO's BPGs are systematically developed, evidence-based documents that include recommendations on specific clinical, healthy work environment, and health system topics. They are intended for nurses and other members of the interprofessional team in direct care positions, educators, administrators and executives, policy-makers, researchers, and persons with lived experience in health-service and academic organizations. BPGs promote consistency and excellence in clinical care, administrative policies, procedures and education, with the aim of achieving optimal health outcomes for people, communities, and the health system as a whole.

The purpose of this BPG is to provide nurses and other members of the interprofessional team with evidence-based recommendations on foundational, inclusive care practices for 2SLGBTQI+ people. This BPG is also to be used to enhance the safety of health-service organizations and academic organizations for 2SLGBTQI+ people through the adoption of evidence-based practices. Safe and inclusive environments enable nurses and other members of the interprofessional team to optimize health outcomes for those receiving care.

In July 2018, RNAO convened an expert panel to determine the scope of this BPG and to develop **recommendation questions**^G to inform the **systematic reviews**^G. The RNAO expert panel included persons with lived experience, and it was interprofessional in composition, comprised of individuals with knowledge and experience in clinical practice, education, research and activism across a range of health-service and academic organizations, practice areas and sectors. These experts shared their insights on supporting and caring for 2SLGBTQI+ people across the continuum of care (e.g., acute care, long-term care, rehabilitation, primary care and in the community).

The RNAO best practice guideline development and research team and the RNAO expert panel completed a comprehensive review and analysis to determine the scope and priority recommendation questions for this BPG (see [Appendix F](#)).

Scope

To determine the scope of this BPG, the RNAO best practice guideline development and research team conducted the following steps:

- They conducted an environmental scan of existing guidelines on this topic;
- undertook a review of the literature to determine available evidence on intervention studies for providing care to 2SLGBTQI+ people;
- led 14 key informant interviews with **health providers**^G, administrators, educators, activists and researchers;
- held four discussion groups with health providers, administrators, activists, researchers; and
- consulted with the expert panel.

The BPG addresses foundational inclusive care practices, chronic disease prevention and management, health promotion and health care for 2SLGBTQI+ people. The BPG is to be used by nurses and other members of the interprofessional team across the continuum of care (e.g., acute care, long-term care, rehabilitation, primary care and

in the community), and in all domains of practice (e.g., clinical, research, education, policy, and administration). It is also to be used by the organizations where nurses and other members of the interprofessional team are employed, including health-service and academic organizations. Specifically, the BPG addresses:

- **communication strategies^G** to promote inclusivity within health-service organizations;
- creation of safer spaces in health-service organizations and school settings;
- promotion of access to **screening^G** for health conditions;
- group-based interventions for health promotion and chronic disease management;
- education on 2SLGBTQI+ health for students entering health professions and health providers;
- implementation strategies and tools;
- evaluation criteria related to the recommendations; and
- future research opportunities and gaps in peer-reviewed literature.

Topics outside the Scope of this Best Practice Guideline

The following conditions and topics are not covered within the scope of this BPG:

- pharmacotherapy, including hormone therapy
- surgical procedures and acute post-surgical care for **transition-related surgeries^G**

See [Appendix E](#) for supporting resources related to these areas of care.

Recommendation Questions

The expert panel identified recommendation questions related to priority areas of care. Answers to the questions required completion of a synthesis of the evidence. These recommendation questions inform the **PICO research questions^G** (population, intervention, comparison, outcomes) that guide the systematic reviews and subsequently inform recommendations. The following are the priority recommendation questions and outcomes that were developed by the RNAO expert panel and that informed the development of this BPG.

- **Recommendation Question #1:** What communication strategies should be recommended to improve care for 2SLGBTQI+ people?
Outcomes: Person's **comfort^G** and person's **safety^G**
- **Recommendation Question #2:** Should the creation of **safe spaces^G** in health-service organizations* be recommended to improve care for 2SLGBTQI+ people?
Outcomes: Person's experience, person's safety, returns of persons, **diverse representation^G** of persons and health providers

***Note:** This recommendation question also included literature within school settings. Public health nurses can practice within the school setting. There was a dearth of research within traditional health settings, therefore the inclusion criteria were expanded to include school settings.

- **Recommendation Question #3:** Should promotion of risk screening by health providers be recommended to improve care for 2SLGBTQI+ people?
Outcomes: Number of persons accessing screening, level of treatment and support
- **Recommendation Question #4:** Should **clinical group-based interventions^G** for health conditions be recommended to improve care for 2SLGBTQI+ people?
Outcomes: Mental health, **social support^G**, and **self-management^G**.
- **Recommendation Question #5:** Should **group-based interventions^G** be recommended to improve care for 2SLGBTQI+ people?
Outcomes: Person's experience, social support, and self-management.
- **Recommendation Question #6:** Should 2SLGBTQI+ health content be integrated into professional education for students entering health professions?
Outcomes: Student experience, student knowledge, and student skills.
- **Recommendation Question #7:** Should **continuing education^G** be recommended for health providers to improve care for 2SLGBTQI+ people?
Outcomes: Health provider knowledge, attitude, comfort and/or confidence.

Note: These priority recommendation questions are condensed versions of the more comprehensive PICO research questions developed by the RNAO expert panel to guide the systematic reviews and development of this BPG. For the PICO research questions and the detailed process of how the RNAO expert panel determined the priority recommendation questions and outcomes, see [Appendix F](#).

Good Practice Statement and Recommendations

The recommendations in this BPG provide nurses and the interprofessional team with guidance on improving care for persons who identify as part of the 2SLGBTQI+ community. The need for comprehensive theoretical and practical education for students entering health professions and health providers is also addressed by the recommendations, as well as the need for health-service and school settings to create safer and inclusive spaces.

In this BPG, the expert panel did not identify any recommendation questions that addressed the need to conduct an initial assessment on risk factors for chronic diseases and other health conditions. However, the expert panel considered this an important area for contextualizing the priority recommendation questions and recommendations that were subsequently developed. Please refer to the good practice statement on assessment on page 66 that nurses and other members of the interprofessional team can use in their practice. The good practice statement is believed to be so beneficial that conducting a systematic review to prove its efficacy would be unreasonable. The resulting statement is not based on a systematic review and it does not receive a rating of the certainty or confidence in the evidence or strength (i.e., a rating of conditional or strong) (13).

Foundational Readings that Align with this Best Practice Guideline

In Canada and internationally, 2SLGBTQI+ people may experience numerous health inequities (14, 15). A number of factors contribute to these health inequities, including discrimination and stigmatization (15). Health inequities are experienced differently by 2SLGBTQI+ people and are exacerbated when **intersectionality**^G and other determinants of health (such as age, income, disabilities, ethnicity and race) intersect with gender identity, gender expression and sexual orientation (14). The expert panel identified that nurses and other members of the interprofessional care team need to have an understanding of the intersectional **stigma**^G, discrimination, and health inequities experienced by 2SLGBTQI+ people before implementing recommendations within this BPG.

See [Appendix C](#) for foundational reading on the following topics:

- health inequities experienced by 2SLGBTQI+ people
- human rights
- truth and reconciliation

The “Background Context” section of this BPG expands on the following topics: **anti-oppression**^G, **intersectionality**^G and **reconciliation**^G.

RNAO BPGs and Other Resources that Align with this Best Practice Guideline

Other RNAO BPGs may support implementation of this BPG. See [Appendix D](#) for RNAO BPGs on the following related topics:

- Crisis intervention
- Engaging clients who use substances
- Implementation science, implementation frameworks, and resources
- Interprofessional collaboration
- Integrating tobacco interventions into daily practice
- Nursing leadership
- Person- and family-centred care
- Practice education in nursing
- Preventing and addressing abuse and neglect of older adults
- Self-management
- Social determinants of health

For more information on the guideline development process, systematic reviews, and search strategy for this BPG, see [Appendix F](#).

Interpretation of Evidence and Strength of Recommendations

RNAO BPGs are developed using the **Grading of Recommendations Assessment, Development, and Evaluation (GRADE)^G** and **Confidence in the Evidence from Reviews of Qualitative Research (CERQual)^G** methods. For more information about the guideline development process, including the use of GRADE and GRADE-CERQual methods, refer to **Appendix F**.

Certainty of Evidence

The certainty of evidence (i.e., the level of confidence we have that an estimate of effect is true) for quantitative research is determined using GRADE methods (16). After synthesizing the evidence for each prioritized outcome, the certainty of evidence is assessed. The overall certainty of evidence is determined by considering the certainty of evidence across all prioritized outcomes for each recommendation. GRADE categorizes the overall certainty of evidence as *high*, *moderate*, *low*, or *very low* (see **Table 1** for the definition of these categories).

Table 1: Certainty of Evidence

CERTAINTY OF EVIDENCE	DEFINITION
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very Low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Source: Reprinted from The GRADE Working Group. Quality of evidence. In: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown; publisher unknown]; 2013 [cited 2018 Aug 31]. Table 5.1, Quality of evidence grades. Available from: <https://gdt.gradeapro.org/app/handbook/handbook.html#h.wsfivfhuxv4r>. Reprinted with permission.

Confidence in Evidence

The confidence in evidence for **qualitative research^G** (i.e., the extent to which the review finding is a reasonable representation of the phenomenon of interest) is determined using GRADE-CERQual methods (hereafter referred to as CERQual) (17). For qualitative evidence, an overall judgment of the confidence is made for each finding in relation to each recommendation statement, as relevant. CERQual categorizes the confidence in evidence as *high*, *moderate*, *low*, or *very low*. See **Table 2** for the definitions of these categories.

Table 2: Confidence in Evidence

CONFIDENCE IN EVIDENCE	DEFINITION
High	It is highly likely that the finding is a reasonable representation of the phenomenon of interest.
Moderate	It is likely that the finding is a reasonable representation of the phenomenon of interest.
Low	It is possible that the review finding is a reasonable representation of the phenomenon of interest.
Very Low	It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

Source: Reprinted from Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. *Implement Sci.* 2018;13(Suppl 1):1–10. Table 3, Description of level of confidence in a review finding in the CERQual approach; p. 6. Reprinted with permission.

Note: The assigned certainty and/or confidence of evidence can be found directly below each recommendation statement. For more information on the process of determining the certainty and/or confidence of the evidence and the documented decisions made by RNAO guideline development methodologists, please see [Appendix F](#).

Strength of Recommendations

Recommendations are formulated as *strong* or *conditional* by considering the *certainty* and/or *confidence in evidence* and the following key criteria (see **Discussion of Evidence** below for definitions):

- balance of benefits and harms
- values and preferences
- health equity

According to Schunemann et al., “a strong recommendation reflects the expert panel’s confidence that the desirable effects of an intervention outweigh its undesirable effects (strong recommendation for an intervention) or that the undesirable effects of an intervention outweigh its desirable effects (strong recommendation against an intervention)” (16). In contrast, “a conditional recommendation reflects the expert panel’s confidence that the desirable effects probably outweigh the undesirable effects (conditional recommendation for an intervention) or undesirable effects probably outweigh desirable effects (conditional recommendation against an intervention), but some uncertainty exists” (16). **Table 3** outlines the implications of strong and conditional.

Table 3: Implications of Strong and Conditional Recommendations

POPULATION	STRONG RECOMMENDATION	CONDITIONAL RECOMMENDATION
For health providers	<ul style="list-style-type: none"> ■ The benefits of a recommended action outweigh the harms. Therefore, most persons should receive the recommended course of action. ■ There is little variability in values and preferences among persons in this situation. ■ There is a need to consider the person's circumstances, preferences and values 	<ul style="list-style-type: none"> ■ The benefits of a recommended course of action probably outweigh the harms. Therefore, some persons could receive the recommended course of action. ■ There is greater variability in values and preferences, or there is uncertainty about typical values and preferences among persons in this situation. ■ There is a need to consider the person's circumstances, preferences and values more carefully than usual.
For persons receiving care	<ul style="list-style-type: none"> ■ Most persons would want the recommended course of action and a small portion would not. 	<ul style="list-style-type: none"> ■ The majority of persons in this situation would want the suggested course of action, but many would not.
For policy makers	<ul style="list-style-type: none"> ■ The recommendation can be adapted as policy in most situations. 	<ul style="list-style-type: none"> ■ Policy-making will require substantial debate and involvement of many stakeholders. Policies are also more likely to vary between regions.

Source: Adapted from: The GRADE Working Group. Quality of evidence. In: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013 [cited 2020 May 11]. Table 6.1, Implications of strong and weak recommendations for different users of guidelines. Available from: <https://gdt.gradepro.org/app/handbook/handbook.html#h.wsfivfhuxv4r>.

Note: The strength of the recommendation statement is detailed directly below each recommendation statement and under the **Summary of Recommendations** table. For more information on the process the expert panel used for determining the strength of each recommendation, please see **Appendix F**.

Discussion of Evidence

The Discussion of Evidence that follows each recommendation includes the following main sections.

1. **Benefits and Harms:** Identifies the potential desirable and undesirable outcomes reported in the literature when the recommended practice is used. Content in this section solely includes research from the systematic review.
2. **Values and Preferences:** Denotes the relative importance or worth placed on health outcomes derived from following a particular clinical action from a person-centred perspective. Content for this section may include research from the systematic reviews and, when applicable, observations and/or considerations from the expert panel.

3. **Health Equity:** Identifies the potential impact that the recommended practice could have on health across different populations or settings and/or barriers to implementing the recommended practice in particular settings. This section also identifies gaps in research across 2SLGBTQI+ populations. This section may include research from the systematic reviews and, when applicable, observations and/or considerations from the expert panel.
4. **Expert Panel Justification of Recommendation:** Provides a rationale for why the expert panel made the decision to rate a recommendation as strong or conditional.
5. **Practice Notes:** Highlights practical information for nurses and other members of the interprofessional team. This section may include supporting evidence from the systematic review and/or from other sources (e.g., the expert panel).
6. **Supporting Resources:** Includes a list of relevant resources (e.g., websites, books and organizations) that support the recommendations. Content listed in this section was assessed based on five criteria: relevancy, credibility, quality, accessibility and timeliness of publication (i.e. published within the last 10 years). Further details about this process and the five criteria are outlined in [Appendix F](#). The list is not exhaustive and the inclusion of a resource in one of these lists does not imply an endorsement from RNAO. Some recommendations may not have any identified supporting resources.



Summary of Recommendations

RECOMMENDATIONS	STRENGTH OF THE RECOMMENDATION
Inclusive Communication	
<p>Recommendation 1.0:</p> <p>The expert panel recommends that health providers use 2SLGBTQI+ inclusive language and a person-centred history taking approach, and ensure privacy and confidentiality during interactions with all persons, to be inclusive of 2SLGBTQI+ people.</p>	Strong
<p>Recommendation 1.1:</p> <p>The expert panel recommends that health-service organizations implement 2SLGBTQI+ inclusive forms, documentation and signage.</p>	Strong
Safer Spaces	
<p>Recommendation 2.0:</p> <p>The expert panel recommends health-service organizations create safer spaces for 2SLGBTQI+ people through a multi-component approach.</p>	Strong
<p>Recommendation 2.1:</p> <p>The expert panel recommends schools create safer spaces for students that include gender-sexuality alliances (GSAs).</p>	Strong
Risk Assessment and Screening	
<p>Good Practice Statement:</p> <p>The expert panel recommends that health providers assess 2SLGBTQI+ people for factors that may place them at increased risk of particular health conditions. Health providers are to follow established screening guidelines as available and based on a persons' current anatomy.</p>	This is a "good practice statement" that does not require application of the GRADE system.
<p>Recommendation 3.0:</p> <p>The expert panel recommends health providers ensure the comfort and safety of lesbian and bisexual women and trans and non-binary people during cervical cancer screening.</p>	Strong

RECOMMENDATIONS	STRENGTH OF THE RECOMMENDATION
<p>Recommendation 3.1:</p> <p>The expert panel suggests health providers promote access to HIV-STBBI screening for 2SLGBTQI+ people in collaboration with 2SLGBTQI+ community partners through:</p> <ul style="list-style-type: none"> ■ media campaigns and/or ■ outreach settings 	Conditional
Group-based interventions	
<p>Recommendation 4.0:</p> <p>The expert panel suggests health-service organizations implement specialized 2SLGBTQI+ clinical groups for health promotion and chronic disease prevention and management.</p>	Conditional
<p>Recommendation 4.1:</p> <p>The expert panel recommends health-service organizations implement group-based interventions for 2SLGBTQI+ people that address the social determinants of health. These group-based interventions should be inclusive of and promote access to underserved 2SLGBTQI+ people including: Two-Spirit, Black, Indigenous and People of Colour, older adults, youth, migrants and people with disabilities.</p>	Strong
Education in academic institutions and health-service organizations	
<p>Recommendation 5.0:</p> <p>The expert panel recommends academic institutions integrate 2SLGBTQI+ affirming health content into curricula for all students entering health professions.</p>	Strong
<p>Recommendation 5.1:</p> <p>The expert panel recommends that health-service organizations provide 2SLGBTQI+ affirming continuing education for all health providers.</p>	Strong

Best Practice Guideline Evaluation

As you implement the recommendations in this BPG, we ask you to consider how you will monitor and evaluate its implementation and impact.

The Donabedian model, which informs the development of indicators for evaluating quality health care, includes three categories: structure, process and outcome (18).

- **Structure** describes the required attributes of the health system or health-service organization to ensure quality care. It includes physical resources, human resources, and information and financial resources.
- **Process** examines the health-care activities being provided to, for and with persons or populations as part of the provision of quality care.
- **Outcome** analyzes the effect of quality care on the health status of persons and populations, health workforce, health-service organizations or health systems (18).

For additional information, please refer to the RNAO, in partnership with Healthcare Excellence Canada (HEC), *Leading Change Toolkit*[™] (19).

The following indicators have been developed to support evaluation and quality improvement. Consider **Tables 4, 5, and 6**, which provide a list of structure, process and outcome indicators to assess the impact of BPG implementation and are derived from BPG recommendations. Each table also identifies if the indicator aligns with other indicators in local, provincial, national and/or international data repositories and/or instruments. Alignment with data repositories/instruments is determined by comparing the following criteria with the developed indicators: the operational definition; if the indicator is nursing sensitive; and the inclusion/exclusion criteria. Depending upon the level of alignment, an indicator may be described to have full, partial or no alignment with external data repositories/instruments.

The following indicators will support quality improvement and evaluation. Select the indicators most relevant to the changes being made in practice, education and/or policy based on BPG recommendations that are prioritized for implementation.

Table 4 provides structure indicators associated with specific recommendation statements that are related to human resources, educational recommendations and/or other organizational factors.

Table 4: Structure Indicators

RECOMMENDATION	STRUCTURE INDICATORS	ALIGNMENT WITH INDICATORS IN DATA REPOSITORIES/ INSTRUMENTS
5.0	<p>Percentage of students entering health professions who received education on 2SLGBTQI+ affirming health content in college or university</p> <p><i>Numerator: Number of students entering health professions who received education on 2SLGBTQI+ affirming health content in college or university</i></p> <p><i>Denominator: Total number of health professional students</i></p>	New
5.1	<p>Percentage of health providers who received continuing education on 2SLGBTQI+ affirming health content*</p> <p><i>Numerator: Number of health providers who received continuing education on 2SLGBTQI+ affirming health content</i></p> <p><i>Denominator: Total number of health providers</i></p>	New

Table 5 supports the evaluation of practice changes during implementation. The indicators are directly associated with specific recommendation statements and support process improvement.

Table 5: Process Indicators

RECOMMENDATION	PROCESS INDICATORS	ALIGNMENT WITH INDICATORS IN DATA REPOSITORIES/ INSTRUMENTS
1.0	<p>Percentage of persons who reported inclusive communication strategies were used by health providers*</p> <p><i>Numerator: Number of persons who reported inclusive communication strategies were used by health providers</i></p> <p><i>Denominator: Total number of persons who received care</i></p>	New
Good Practice Statement	<p>Percentage of 2SLGBTQI+ persons who received an assessment for increased risk factors of particular health conditions</p> <p><i>Numerator: Number of 2SLGBTQI+ persons who received an assessment for increased risk factors of particular health conditions</i></p> <p><i>Denominator: Total number of 2SLGBTQI+ persons who received care</i></p>	New
4.1	<p>Percentage of 2SLGBTQI+ persons who received group-based interventions with a focus on addressing social determinants of health</p> <p><i>Numerator: Number of 2SLGBTQI+ persons who received group-based interventions with a focus on addressing social determinants of health</i></p> <p><i>Denominator: Total number of 2SLGBTQI+ persons who were referred or volunteered to receive group-based interventions</i></p>	New

Table 6 provides outcome indicators to assess the impact of implementing evidence-based practice changes.

Table 6: Outcome Indicators

OUTCOME INDICATORS	ALIGNMENT WITH INDICATORS IN DATA REPOSITORIES/INSTRUMENTS
<p>Rate of complaints from 2SLGBTQI+ persons regarding safety per 1000 care-days/care-visits*</p> <p>Numerator: Number of complaints received from 2SLGBTQI+ persons regarding safety, who received care</p> <p>Denominator: Total number of care-days/care-visits for 2SLGBTQI+ persons, who received care during the measurement period</p>	<p>Partial Alignment with Ontario Health</p>
<p>Percentage of 2SLGBTQI+ persons who report a sense of community belonging rated as somewhat strong or very strong</p> <p>Numerator: Number of 2SLGBTQI+ persons who report a sense of community belonging rated as somewhat strong or very strong</p> <p>Denominator: Total number of 2SLGBTQI+ persons</p>	<p>Full Alignment with Public Health Agency of Canada</p>
<p>Percentage of lesbian, bisexual (LB) women and/or trans and/or non-binary persons who reported feeling safe during cervical cancer screening*</p> <p>Numerator: Number of LB women and/or trans and/or non-binary persons who reported feeling safe during cervical cancer screening</p> <p>Denominator: Total number of LB women and/or trans and/or non-binary persons who received cervical cancer screening</p>	<p>New</p>

*These indicators are available for Best Practice Spotlight Organizations[®] (BPSOs[®]) via the Nursing Quality Indicators for Reporting and Evaluation[®] (NQuIRE[®]) data system to evaluate the impact of BPG implementation. For the remaining indicators, the development of information practices to capture sexual orientation and gender identity information is still needed to support evaluation.

Other RNAO resources for the evaluation and monitoring of BPGs:

- Nursing Quality Indicators for Reporting and Evaluation[®] (NQuIRE[®]), a unique international data system housed in the International Affairs and Best Practice Guideline Centre, allows Best Practice Spotlight Organizations[®] (BPSOs[®]) to measure the impact of BPG implementation. The NQuIRE data system collects, compares and reports data on human resource structure indicators as well as guideline-based, nursing-sensitive structure, process and outcome indicators. NQuIRE indicator definitions are aligned with available administrative data and existing performance measures wherever possible, adhering to a “collect once, use many times” principle. By complementing other established and emerging performance measurement systems, NQuIRE strives to leverage reliable and valid measures, minimize reporting burden and align evaluation measures to enable comparative analyses. The international NQuIRE data system was launched in August 2012 to create and sustain evidence-based practice cultures, optimize safety of persons, improve health outcomes and engage staff in identifying relationships between practice and outcomes to advance quality and advocate for resources and policy that support best practice changes (20). Please visit RNAO.ca/bpg/initiatives/nquire for more information.
- BPG Order Sets[™] embedded within electronic records are technology-enabled implementation tools that provide a mechanism for electronic data capture of process and outcome measures. The ability to link structure and process measures with specific client outcome measures aids in determining the impact of BPG implementation on specific health outcomes. Please visit <http://RNAO.ca/ehealth/bpgordersets> for more information.

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As part of the guideline development process, feedback was obtained from participants across a wide range of health-service organizations, academic institutions, practice areas and sectors. Participants include nurses, educators, students and individuals with lived experience and administrators. **Stakeholders^G** representing diverse perspectives were also solicited for their feedback (see **Appendix F**). RNAO wishes to acknowledge the following individuals for their contribution in reviewing this BPG.

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Background Context

2SLGBTQI+ People and Health

This BPG uses the acronym 2SLGBTQI+ to refer to a diverse group of people with respect to sexual orientation, gender identity and gender expression, as well as race, socioeconomic status and other social identities (see **Intersectionality**^G Framework below). The unique intersections of identity for 2SLGBTQI+ people can contribute to them experiencing increased stigmatization and discrimination within their personal and professional lives, as well as within the health system. Historically, a lack of awareness of the unique health needs of 2SLGBTQI+ people by health providers has created barriers to inclusive and equitable care (21).

It is difficult to determine the exact number of people who identify as 2SLGBTQI+ due to lack of adequate and longitudinal data. However the Pan Canadian Survey suggests 13 per cent of Canadians may identify as 2SLGBTQI+ (22). Other reports indicate that up to 14 per cent of high school students identify as LGBTQ (23). Additionally, non-binary and intersex people are frequently overlooked and erased from data collection and statistics (14, 24). While there remain gaps in the data and the ability to fully estimate the number of 2SLGBTQI+ Canadians, health providers have already or will encounter 2SLGBTQI+ people in their practice and therefore must be educated about and become aware of their needs. Without prompts indicating that the health provider or health-service organization is able to provide 2SLGBTQ+ affirming care, the person may choose not to disclose. It is imperative for health providers to understand the unique and overlapping health and health-service needs of 2SLGBTQI+ people and how these are influenced by **social determinants of health**^G. An understanding of the health and health-service needs of 2SLGBTQI+ people is foundational to providing inclusive, equitable, and safer health services.

Relationships with Peers and Chosen Family across the Lifespan

Early in the life course, the school setting is vitally important for the health and well-being of 2SLGBTQI+ youth. Experiences of discrimination and harassment in **schools**^G are a risk for the successful completion of high school (25). Positive school environments that include **gender-sexuality alliances**^G (GSAs) in schools can greatly increase overall student wellbeing including mental health, through fostering youth's sense of support and belonging (25). **Coming out**^G may be a particularly important time for 2SLGBTQI+ youth when GSAs can offer support. Coming out is not a singular event or exclusive to youth, rather it is a daily decision for 2SLGBTQI+ people based on the benefits and risk of coming out, including the possibility of being met with discrimination. Coming out is a Western concept that is not accessible, necessary or recognized for all people especially in cases where it may be met with violence or even death. In Indigenous communities sometimes the phrase “coming in” is used to describe a process of reclamation and self-acceptance. The process of coming in involves an affirmation of being oneself and embracing identities that fit with who one is, rather than trying to conform to pre-existing identities or labels (26).

Persons who identify as 2SLGBTQI+ may value the relationships of selected friends, often referred to as “chosen family” (27), over their relatives. Chosen family can include friends, co-workers, partners or ex-partners. The critical importance and essential role of the chosen family is heightened in older 2SLGBTQI+ adults. Companionship, social supports and informal elder care for 2SLGBTQI+ older adults largely falls on other 2SLGBTQI+ older adults (28). For older 2SLGBTQI+ people in the final stages of life, next of kin or care networks frequently consist of 2SLGBTQI+ chosen families, rather than children and spouses (29). Like Canada's overall population, 2SLGBTQI+ people in Canada are aging (30). Many 2SLGBTQI+ older adults have faced a lifetime of discrimination based on their sexual orientation or gender identity or expression, including their experiences within health-service organizations. These

experiences have had a negative impact on their health and wellness and have resulted in lifelong fears and mistrust for so many when they access health-services. As 2SLGBTQI+ people age, they face unique concerns related to social isolation, and worry about becoming dependent on health providers and the health system, and about their safety in long-term care or home care service settings (31, 32). Some 2SLGBTQI+ seniors reported fearing that they may be forced to “return to the closet”, and silence or hide parts of their identities to protect themselves in the health system (32). The fear of entering long-term care homes is common for many older 2SLGBTQI+ people, as many anticipate they will experience loneliness, social isolation, decreased independence and decision-making capacities, increased vulnerability to 2SLGBTQI+ related stigmatization as well as the potential for exposure to unsafe social and physical environments (32).

Minority Stress, Social Determinants of Health, Discrimination and Violence

Systemic barriers and sociocultural factors contribute to inequitable health outcomes experienced by 2SLGBTQI+ people. One of the most prominent theoretical and explanatory frameworks of 2SLGBTQI+ health inequities is the **minority stress**^G model. Minority stress proposes that sexual minority health disparities can be explained in large part by stressors induced by a hostile, homophobic culture, which can result in a lifetime of harassment, maltreatment, discrimination and victimization (33). Minority stress is unique, chronic and socially based.

Social determinants of health^G – including social exclusion, discrimination and violence, income, ethnicity, education, disabilities and immigration status – influence health outcomes of all populations, and 2SLGBTQI+ people are affected disproportionately which can lead to poorer health status (34, 35). People who are bisexual or trans are over-represented among low-income Canadians. About a quarter of trans people in Canada live on a yearly income of less than \$15 000, and about half live on an annual income of less than \$30,000 (36). Income disparity leads to significant increases in health inequity despite Canada’s universal health system (37).

In addition, 2SLGBTQI+ people are often frequent targets of sexual assault and physical assault. In Canada, a study found that 16 per cent of trans and non-binary people had experienced physical violence and 26 per cent had experienced sexual assault within the last five years (36). A majority, 68 per cent of trans and non-binary people in Canada, had experienced verbal harassment within the last five years (36). Historically, intimate partner violence has been framed in society from a heteronormative lens and does not include the context of 2SLGBTQI+ experiences (38). But 2SLGBTQI+ people also experience intimate partner violence and it is important to understand how heterosexism, **heteronormativity**^G, homophobia, biphobia and transphobia all intersect to impact partner violence and the marginalization of survivors (38). According to the National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG), when Indigenous Two-Spirit, lesbian, gay, bisexual, trans, queer, questioning, intersex and asexual (2SLGBTQIA) people experience violence, discrimination based on race and gender is combined with homophobia, transphobia, and other forms of gender discrimination (39). Older 2SLGBTQI+ people are particularly vulnerable to experiences of elder abuse in the form of emotional, physical, sexual, and financial abuse, the violation of rights and freedoms, systemic abuse, or abuse through neglect (40). These older adults may experience ostracism from family due to their 2SLGBTQI+ status and there may be concerns about other potential forms of elder abuse in health settings (41). Experiences of elder abuse in 2SLGBTQI+ people involve the intersections of multiple identities including (but not limited to) age, race and discrimination based on their sexual orientation, gender identity, and gender expression (42).

Stigma, Discrimination, Implicit Bias and History of Violence within the Health System

Systemic barriers within the health system have their origins in historic erasure of 2SLGBTQI+ identities within practice and policy. These barriers are pervasive and impact the ability of 2SLGBTQI+ people to access equitable health services. For example, the provision of health services is often not inclusive or welcoming. Health providers often lack the knowledge and understanding of 2SLGBTQI+ health issues and there can be institutionalized sexual or gender micro-aggressions.

Health providers need to be aware of the broader social and legal context in which 2SLGBTQI+ people live and how that impacts their experiences of health and use of health services. In 1996, sexual orientation was added as one of the prohibited grounds of discrimination to *The Canadian Human Rights Act* and in 2017 gender identity and expression were added as prohibited grounds of discrimination (43). In Ontario, *The Ontario Human Rights Code* prohibits discrimination and/or harassment against someone because of their sexual orientation, gender expression and gender identity (44).

Historically, 2SLGBTQI+ people have experienced violence and **pathologizing**^G in the health system. For example, until 1973 homosexuality was included as a diagnosis of a mental disorder in the Diagnostic and Statistical Manual (DSM), which led to people being imprisoned or subjected to aversion or electroshock therapy (45, 46). Additionally, the widespread use of surgical interventions to “standardize” genitalia without medical necessity, and the resulting erasure of intersex infants and children, continues to influence society’s attitudes towards understanding sexual orientation and gender identity as anything other than heterosexual and **cisgender**^G (24). Section 268 of the Criminal Code continues to allow surgery by medical practitioners to alter the bodies of infants and children whom they perceive to have ambiguous genitalia or reproductive organs (47). Another example of violence is the use of conversion therapy, a practice that claims to change a person’s sexual orientation, gender identity or gender expression and to make them heterosexual or cisgender (24). Furthermore, trans and non-binary people face obstacles to accessing transition-related surgeries and services and this can lead to unsafe care and preventable deaths globally (48). In addition to legal barriers, trans and non-binary people face financial barriers due to the undue cost associated with hormone therapy and transition-related surgeries.

Discriminatory practices and negative attitudes exhibited by health providers can lead to decreased access to health services and poorer health outcomes (49, 50). Health providers may lack knowledge of the unique needs of these populations and some individuals may avoid disclosing gender identity or sexual orientation because of previous negative experiences. Both of these circumstances can result in a lack of appropriate care (51, 52). For example, experiences in reproductive health services such as conception and surrogacy technologies can be profoundly heteronormative, despite increased access by 2SLGBTQI+ people and significant gains in social and legal recognition for 2SLGBTQI+ people in Canada (53). See further details on discrimination under “**Intersectionality Framework**” (page 34).

Many 2SLGBTQI+ people report negative and humiliating experiences during encounters with health providers and/or other staff in health-service organizations. These experiences cause harm, prevent 2SLGBTQI+ people from seeking much needed health services and contribute to 2SLGBTQI+ health inequities (54). Implicit (unconscious) biases are negative attitudes and biases about 2SLGBTQI+ people that are embedded in one’s belief system from a young age (55). Implicit biases can influence the way health providers talk and interact with 2SLGBTQI+ people

and can impact their clinical decision making (55). It is essential that students entering health professions, health providers, and all people involved in the provision of health services, recognize that they may hold negative stereotypes and prejudices about certain people that influence their ability to provide respectful health services (56). Engaging in ongoing critical **reflection**^G of one's personal beliefs, assumptions and biases related to 2SLGBTQI+ people is essential for all health education students and health providers to ensure that they do not further contribute to 2SLGBTQI+ health inequities (54). RNAO has developed a position statement on respecting sexually and gender diverse communities, please see [Appendix B](#) for more detail.

Health Inequities Experienced by 2SLGBTQI+ People

Because 2SLGBTQI+ people have individual health issues and health needs that are unique to their experiences, it is important that health providers have a broad knowledge of these needs and how best to provide health services. For example, individuals who identify as lesbian have higher rates of heart disease, along with lower rates of screening for cervical and breast cancer (57, 58). Lower screening rates can be due to a variety of reasons including: lack of health provider knowledge (i.e. health providers not screening for cervical cancer due to the belief that individuals who identify as lesbian are not at risk for contracting human papilloma virus [HPV]); prior negative experiences with health providers; and lack of health-care access (59, 60). These lower rates of screening could potentially lead to an increased risk of cervical and breast cancer diagnoses (57, 58). Similarly, greater exposure to stressors, coping behaviours such as tobacco and alcohol use, and reduced access to preventative care can influence the risk of heart disease among individuals who identify as lesbian (61, 62). For men who have sex with men, there is an increased risk of anogenital and anal cancers compared to the overall population (63, 64). Trans and non-binary people require routine cancer screening to assist in early detection and may need to be addressed differently and sensitively in screening care (65). Trans people can struggle to access adequate and appropriate healthcare, including routine services unrelated to their trans status (48).

More broadly, as a result of continuing discrimination and violence, many 2SLGBTQI+ people face a higher risk of mental health conditions such as depression, anxiety, obsessive-compulsive disorders, suicide, self-harm, post-traumatic stress disorder (57, 66) and substance use (67). Lesbians and gay and bisexual individuals are more likely to experience depression, anxiety, substance use and suicide than their heterosexual counterparts (68). According to the Trans Pulse Canada survey, within the last year, 31 per cent of trans individuals thought about suicide and six per cent attempted suicide (36). There is emerging evidence from Statistics Canada and the Public Health Agency of Canada, that lesbian, gay and bisexual identifying people experience a wide variety of health inequities that are not yet well understood. For example, bisexual men and women experience more dental pain than both their heterosexual and same sex attracted counterparts (69). Lesbian and bisexual women experience more arthritis than their heterosexual counterparts (69).

Conclusion

It is important to note that 2SLGBTQI+ people have long advocated for their health needs and to obtain acknowledgment of their health concerns from scientific bodies and government. An example is the fight for AIDS treatment and care in 1980s and 1990s by movements such as AIDS Action Now! in Canada and ACT UP in the United States (70). This includes having access to appropriate health services and reducing health inequities. This BPG was initiated through advocacy from RNAO's Rainbow Nursing Interest Group. In collaboration with 2SLGBTQI+ people, this BPG was developed to provide evidence-based recommendations for nurses, interprofessional teams and health-service and academic organizations to improve equity in access to and delivery of inclusive and safe care for 2SLGBTQI+ people.

Guiding Principles and Frameworks

This BPG was developed with a goal to promote health equity through the use of an **intersectionality**^G framework, **anti-oppression**^G lens and **reconciliation**^G, and to foster a commitment of humility, mutual respect and effort from all health providers to work towards the principles and the actions of reconciliation.

Intersectionality Framework

The term intersectionality was first used by Black feminist scholar Kimberlé Crenshaw in 1989. It is the study of intersecting social identities and related systems of oppression, domination or discrimination. Intersectionality views categories of race, class, gender, sexuality, nation, disabilities and age as interrelated (71). Intersectionality takes into account the full range of identities based on historical, social and political contexts as well as unique individual experiences and circumstances and how they mutually shape one another (71). It is an approach by which intersecting experiences of marginalization including the needs of the whole person are considered (34). Forms of oppression and privilege do not exist in isolation from each other. For example, we cannot understand how someone experiences homophobia without also knowing their race, gender expression and gender identity. A Black gay man may face racism inside the LGBT community and homophobia in the Black community. In the case of Two-Spirit people, experiences of racism, discrimination and systematic invisibility are the direct result of **colonization**^G (72). Power and privilege are also experienced in intersecting ways. For example, a white cisgender, heterosexual man might hold more privilege and power in society than most people due to his age, gender identity, sexual orientation and race. In addition, a white gay cisgender and a white trans man may, simply on the basis of their skin colour and implicit bias, hold more power and privilege than a 2SLGBTQI+ person of colour.

Intersectional forms of oppression and privilege exist in many parts of society, including employment, education, sport and health. Some people experience heteronormativity, ageism, racism, **cisnormativity**^G or other intersecting forms of discrimination, all of which compounded can increase vulnerability to health disparities and poor health outcomes (73). There are multiple ways that intersectionality impacts the mental health of LGBTQ people. For example, LGBTQ people may, along with homophobia and transphobia, experience other forms of marginalization – such as ageism, racism, sexism, classism, ableism or other factors – that have a negative impact on their mental health (34). Additionally, an individual with a mental health condition, who is also an LGBTQ person, may face added challenges in accessing mental health services that are appropriate and inclusive and may face discrimination on the basis of both disability and sexual orientation (34). Complex interactions of stigma are associated with persons experiencing severe and persistent mental illness and LGBTQ identities. These people can experience the burden of additional stigma and discrimination in the LGBTQ community, the mental health community, and the larger community (74). This can create a sense of alienation, resulting in persons struggling to hide various aspects of their identity while trying to find acceptance from others (74).

The intersectionality wheel framework is from the Canadian Research Institute for the Advancement of Women (CRIAOW) toolkit entitled “Everyone Belongs: A toolkit for applying intersectionality” (75). The framework provides examples of what intersectionality is. The innermost circle represents a person’s unique circumstances of power, privilege and identity. The second circle from inside represents aspects of identity, some of which can change (sexual orientation, gender identity, gender expression, age, education, occupation, social status, religion etc.) and some that cannot change (skin colour, Indigeneity, caste, work history, disabilities, etc.). The third circle from the inside represents different types of discrimination and attitudes that impact identity (such as transphobia and homophobia). The outermost circle represents larger forces and structures that work together to augment or reinforce existing discrimination and privilege such as economy, globalization, war, education systems and politics.

Anti-Oppression Lens

Dominelli (2002) defines oppression, on page eight, as relations “that divide people into dominant or superior groups and subordinate or inferior ones. These relations of domination consist of the systematic devaluing of the attributes and contributions of those deemed inferior, and their exclusion from the social resources available to those in the dominant group” (76). Conversely, anti-oppression can be used as a tool or lens to work against these power divisions and exclusion from social resources. Anti-oppression is “a tool to understand and respond to the complexity of the experience of oppression” (77).

Anti-oppression challenges inequality and disadvantage. An anti-oppression lens strives to challenge all forms of oppression including, but not limited to, racism, sexism, ageism, homophobia and cisgenderism (78). Anti-oppression principles embrace holistic analysis, analyzing power, undoing racism, listening, appreciation and gratitude, acting and leadership (78). Anti-oppression strategies seek to address the systemic inequalities that are operating simultaneously as opposed to producing and reproducing oppression (79). Anti-oppressive practice means recognizing power imbalances and working toward the promotion of change to redress the balance of power (80). This BPG has been produced with the aim of challenging the way people are treated based on their identities including but not limited to their gender identity and expression, their sexual orientation, their race, their Indigenous status, their age or their physical and mental ability.

Reconciliation and Two-Spirit Health

A discussion about anti-oppression and intersectional forms of discrimination would be incomplete without addressing the unique circumstances and oppression faced by Indigenous peoples of Canada. The term Two-Spirit refers to pre-contact (prior to arrival of settlers and colonialization) gender identities believed to be common among many First peoples of Turtle Island (North America). Persons who identified as Two-Spirit had an important place within Indigenous societies (10). Two-Spirit-ness has different meanings to different communities and individuals. Indigenous people may also identify as other LGBTQI+ identities. In Canada, binary constructs of gender are a product of colonization and not recognized by many traditional Indigenous cultures. More generally, social and academic concepts of gender and sexuality are largely rooted in and informed by Western, Euro-Christian dominant cultural belief system (81). In 2016, there were 1,673,785 Indigenous people in Canada (82). One Indigenous community survey in Toronto found that 23 per cent of respondents were Two-Spirit (83).

The social determinants of health that impact Indigenous people in Canada are rooted in colonization, which disrupted Indigenous cultures, land rights, languages and their inherent right to self-determination (72). Through the legacy of colonization Indigenous people continue, compared to the Canadian population as whole, to experience disproportionately low socioeconomic status, housing and food insecurity as well as less access to education, higher rates of substance use, and elevated rates of engagement with the criminal justice system in Canada (72, 84, 85). Two-Spirit people and trans Indigenous people experience health inequities, systemic racism, discrimination, marginalization and barriers to accessing health services as a result of the intersection of colonization, the social determinants of health that impact Indigenous peoples, and gender minority status (72, 84).

The Truth and Reconciliation Commission of Canada (TRC) defines reconciliation as an ongoing process of establishing and maintaining respectful relationships between **Aboriginal**^G and non-Aboriginal people (86). Establishing respectful relationships requires awareness of the past, acknowledgement of the harm inflicted, atonement for the causes, and action to change behaviour (86). This BPG attempts to address two specific TRC calls to action (see **Table 7**). In addition, the NIMMIWG makes 231 calls for justice including health-specific and 2SLGBTQIA-specific calls for justice (39). The calls for justice addressed in this BPG are outlined in **Table 8**.

Table 7: Truth and Reconciliation Commission Calls to Action related to this BPG

TRC CALL TO ACTION	AREA IN THE GUIDELINE MAKING STEPS TOWARD ADDRESSING THE CALL TO ACTION
<p>23. We call upon all levels of government to:</p> <p>iii. Provide cultural competency training for all healthcare professionals.</p>	In alignment with Recommendation 5.1
<p>24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.</p>	In partial alignment with Recommendation 5.0 Note: Recommendation 5.0 includes Two-Spirit health and cultural safety ⁶ .

Table 8: National Inquiry into Missing and Murdered Indigenous Women and Girls Calls for Justice related to this BPG

NIMMIWG CALL FOR JUSTICE	AREA IN THE GUIDELINE MAKING STEPS TOWARD ADDRESSING THE CALL FOR JUSTICE
<p>18.1 We call upon all governments and service providers to fund and support greater awareness of 2SLGBTQQIA issues, and to implement programs, services, and practical supports for 2SLGBTQQIA people that include distinctions-based approaches that take into account the unique challenges to safety for 2SLGBTQQIA individuals and groups.</p>	In partial alignment with Recommendations 2.0 and 4.1
<p>18.4 We call upon all governments, service providers, and those involved in research to modify data collection methods to:</p> <p>i Increase accurate, comprehensive statistical data on 2SLGBTQQIA individuals, especially to record the experiences of trans-identified individuals and individuals with non-binary gender identities.</p> <p>ii Eliminate “either-or” gender options and include gender-inclusive, gender-neutral, or non-binary options – for example, an “X-option” – on reporting gender in all contexts, such as application and intake forms, surveys, Status cards, census data and other data collection.</p> <p>iii Increase precision in data collection to recognize and capture the diversity of 2SLGBTQQIA communities: for example, the experiences of Two-Spirit women/lesbians, and differentiations between Two-Spirit and trans.</p>	<p>i) in partial alignment with Recommendation 1.1</p> <p>ii) in alignment with Recommendation 1.1</p> <p>iii) in partial alignment with Recommendation 1.1</p> <p>This call for justice also aligns with identified research gaps in the BPG.</p>

NIMMIWG CALL FOR JUSTICE		AREA IN THE GUIDELINE MAKING STEPS TOWARD ADDRESSING THE CALL FOR JUSTICE
18.6	We call upon all governments and service providers to fund and support youth programs, including mentorship, leadership, and support services that are broadly accessible and reach out to 2SLGBTQIA individuals.	In alignment with Recommendations 2.1 and 4.1
18.11	We call upon all governments, service providers, industry, and institutions to accommodate non-binary gender identities in program and service design, and offer gender-neutral washrooms and change rooms in facilities.	In alignment with Recommendation 2.0
18.18	We call upon all governments and service providers to educate service providers on the realities of 2SLGBTQIA people and their distinctive needs, and to provide mandatory cultural competency training for all social service providers, including Indigenous studies, cultural awareness training, trauma-informed care, anti-oppression training, and training on 2SLGBTQIA inclusion within an Indigenous context (including an understanding of 2SLGBTQIA identities and Indigenous understandings of gender and sexual orientation). 2SLGBTQIA people must be involved in the design and delivery of this training.	In alignment with Recommendation 5.1
18.28	We call upon all governments to fund and support, and service providers to deliver, expanded, dedicated health services for 2SLGBTQIA individuals including health centres, substance use treatment programs, and mental health services and resources.	In partial alignment with Recommendation 4.1

Furthermore, supporting reconciliation means working to overcome inequities between Indigenous peoples and settlers, including those in the areas of poverty/income, health, living standards, racism, prejudice and sexism. This BPG aims to support reconciliation by working to overcome intersectional forms of inequality faced by Two-Spirit and other LGBTQI+ Indigenous people in health settings and from health providers. This stance aligns with the United Nations Declaration on the Rights of Indigenous Peoples, which affirms that Indigenous peoples are equal to all other peoples, while recognizing the right of all peoples to be different, to consider themselves different, and to be respected as such (87). Additionally, Article 24.2 of the declaration (on page 18) states that “Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health” and that “states shall take the necessary steps with a view to achieving progressively the full realization of this right” (87).

Additional challenges for Indigenous 2SLGBTQI+ people accessing health services can include geography and jurisdiction. These challenges exist in urban, rural, on-reserve, northern and remote settings alike. For example, the federal government of Canada is responsible for health services in First Nation on-reserve communities and its Non-Insured Health Benefits (NIHB) is available to through the First Nations and Inuit Health Branch. The NIHB Program of the Department of Indigenous Services Canada provides clients (registered First Nations and recognized

Inuit) with coverage for a range of health benefits, including prescription drugs and over-the-counter medications, dental and vision care, medical supplies and equipment, mental health counselling, and transportation to access health services not available locally (88). These benefits complement provincial and territorial health services, such as physician and hospital care, as well as other First Nations and Inuit community-based programs and services (88). However it can be difficult to access health services in rural and remote areas because health services may only be available from temporary, fly-in, non-resident health providers, and wait times to see non-resident medical specialists can be lengthy (89). Some health costs, such as travel expenses to access specialty services, may not be fully covered by NIHB and coverage under NIHB may be declined (89). Challenges in accessing health services in urban areas can exist as well, and include experiences of racism and discrimination and culturally unsafe care (72). Additionally, each province and territory in Canada has an Indigenous department and the variety of jurisdictional and governing bodies overseeing the provision of health services, and the attendant challenges associated with navigating multiple health systems, may also be a barrier to access. Health providers in Canada need to be aware of the significant challenges for Indigenous 2SLGBTQI+ people accessing health and wellness resources.



Recommendations

INCLUSIVE COMMUNICATION

RECOMMENDATION 1.0:

The expert panel recommends that health providers use 2SLGBTQI+ inclusive language and a person-centred history taking approach, and ensure privacy and confidentiality during interactions with all people, to be inclusive of 2SLGBTQI+ people.

Strength of the recommendation: Strong

Certainty of the evidence of effects: Very low

Confidence in evidence: Moderate

Discussion of Evidence

Benefits and Harms

Inclusive language

The qualitative literature indicates that when health providers use 2SLGBTQI+ inclusive language this may provide 2SLGBTQI+ people with a greater sense of safety and comfort. Inclusive language avoids using words, expressions or assumptions that would unnecessarily exclude people (90). In particular, lesbians, gay, bisexual, trans, queer and other LGBTQ+ people reported feeling safe and comfortable when health providers used gender affirming language, and avoided **heteronormative**^G and **binary language**^G (91-102). Participants described how they must be called by their chosen name, and the correct pronoun and title (Mr., Ms. or **Mx.**^G), in order to feel safe and comfortable during care (91, 92, 95, 97, 98, 103-106).

Heteronormative language refers to using language that supports the assumption that all people are heterosexual. The term heterosexism is used to describe prejudice against people who are not heterosexual (9). Cisnormativity is the assumption that a person's gender identity matches their biological sex. This assumption can result in misgendering a person, such as referring to a person by the incorrect pronoun or other gendered terms. Heteronormative language that made assumptions about participants' gender identity or sexual orientation was perceived as a barrier to care (94, 96, 102, 107-109). For example, several persons in one study did not feel comfortable with the question "are you sexually active?" as an initial question about sexual history and activity because it was perceived as assuming heterosexual sex and did not offer the opportunity to disclose partners or sexual orientation (94).

Binary language is language that results from a cisgender, binary social system in which people are thought to be either "man" or "woman". In the cisnormative, gender binary system, there is no room for living between genders or for transcending the gender binary. The gender binary system is rigid and restrictive for many people whose birth-assigned sex does not align with their gender identity, or whose gender is fluid and not fixed (9). In an interview study, all 20 trans participants mentioned the use of binary language and experienced various reactions to binary language including feeling frustrated and isolated (91). Participants in another study were critical when options were limited to binaries (i.e., male/female or male-to-female or female-to-male) (98).

No harms related to the use of 2SLGBTQI+ inclusive language were reported in the literature.

Person-centred history taking approach

Person-centred⁶ history taking applies person-centred care principles to how health providers take a health history. This approach views the person as a whole and involves forming a therapeutic relationship between the person, those who they identify as important to them, and the health provider (110). A person-centred approach involves advocacy, empowerment, and mutual respect and understanding of a person's right to be autonomous, to self-determine and to participate in decisions about their health (110). The qualitative literature indicates that communication strategies involving the use of a person-centred history taking approach may provide 2SLGBTQI+ people with a greater sense of safety and comfort.

Overall, lesbians, gay, bisexual, trans and queer (LGBTQ) persons feel comfortable and safe when health providers avoid asking questions that are not relevant to their care needs or are based on heteronormative assumptions (92, 94, 96, 97, 100, 101, 107-109, 111, 112). This was particularly evident with regard to taking a sexual health history including sexual behaviours and relationships (92, 94, 96, 97, 100, 101, 107-109, 111, 112). Three studies reported that lesbian and bisexual women in particular were burdened with experiences of heteronormative assumptions when discussing sexual health history, birth control, and sexually transmitted infection (STI) risk (100, 107, 109).

Several harms were reported in the studies related to a lack of a person-centred history taking approach. This included participant fears of experiencing homophobia or receiving poor quality care (100, 101). Trans and non-binary participants, particularly those who do not use clinics that specifically care for LGBT people, said that for privacy and safety reasons they would not answer the birth-assigned sex question for fear of possible discrimination or even violence from intake staff or other people (98).

Ensuring privacy and confidentiality

Nurses have an ethical and legal responsibility to maintain privacy and confidentiality while providing care (113). Health information is protected in Ontario under the Personal Health Information Protection Act (PHIPA), 2004 (114). While privacy and confidentiality are legislated requirements of health provider practice and health-service organizations they play a particularly vital role in providing care to 2SLGBTQI+ communities

The qualitative evidence indicates that communication strategies delivered with enhanced privacy and confidentiality for all 2SLGBTQI+ people may improve their perceived safety and result in a greater sense of comfort with their health provider (93-96, 98, 101, 109, 111, 115-118).

Strategies for providing care with enhanced privacy and confidentiality that emerged from the literature included:

- Being open and explicit with provisions for maintaining privacy and confidentiality (95, 111, 115)
- Spending time during the first visit(s) to establish confidentiality (111, 115)
- Allowing people to opt-out of data collection or data storage (93)
- Being vigilant in physical environments where conversations are not private or could be overheard (emergency department, waiting rooms) (95, 98, 117)

In a qualitative evidence synthesis article examining LGBT persons' care experience, many persons shared concerns of breaches of person-provider confidentiality that could lead to non-clinical staff, friends and family or the wider community discovering their sexual orientation (118). Trans participants in a focus group study frequently cited fears of involuntary or unsafe disclosure of trans status in waiting rooms (98). For example, trans participants were "outed"

and had their privacy violated by legal names and birth-assigned sex displayed visibly on charts and electronic health records (98). In a care survey, LGBT participants underscored the importance of privacy concerning identities to be central to a positive health experience (109). Furthermore, when participants trusted that health providers would keep conversations private, they were more likely to discuss health concerns openly (109). Many studies reported how experiences of breaches in privacy or confidentiality had detrimental effects on comfort and safety. These were heightened in settings where same sex relationships are illegal (109). People in these settings described a fear that breaches in confidentiality were closely related to the danger of discrimination and of receiving care in an unsupportive environment (118).

Overall, the confidence in the evidence is moderate because of concerns about how the individual studies were conducted. The certainty in the evidence is very low because of the same concerns, as well as the range in the interventions described and the inability to identify an estimate of effect.

For more detailed information of the findings and the grading of evidence for each component of the recommendation (inclusive communication, a person-centred history taking approach and privacy and confidentiality) please refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Values and Preferences

In addition to the values and preferences expressed in the “Benefits and Harms” section above, studies that assessed participants’ perceptions of being asked questions about sexual orientation and gender identity found they seemed willing to respond to these assessment questions (100).

Health Equity

Participants in the studies identified as LGBTQ as well as pansexual, asexual, **genderqueer**^G and **bigender**^G. No studies included people who identify as intersex or Two-Spirit. This indicates a substantial gap in the literature.

Black lesbian, bisexual and queer women described how their experiences of communicating with health providers were shaped not only by their sexual identity but also by the colour of their skin. Participants described the potential for heterosexism, racism and classism during person-provider interactions (107).

Expert Panel Justification of Recommendation

Conventionally based on GRADE, this recommendation could have been voted conditional since the certainty of the evidence of the effects was very low and the confidence in this evidence was moderate. Based on the balance of benefits and harms, including the harms of not following the recommendation, as well as values and preferences and health equity, the expert panel came to consensus on a strong recommendation. There may be benefits to health providers using inclusive language, using a person-centred history taking approach and ensuring privacy and confidentiality, but the evidence is uncertain. There were significant harms associated with not using these strategies noted in the qualitative evidence as well as by the expert panel. Harms include failure to seek urgently needed medical attention or threats to mental health. Although there is very low certainty in the evidence, the benefits of using inclusive language, a person-centred history taking approach and privacy and confidentiality outweigh the harms of not doing the intervention. Additionally, the expert panel noted instances of harassment, discrimination and violence when these practices are not followed. Therefore, due to the potential for substantial harms, the expert panel determined the strength of the recommendation to be strong.

Practice Notes

Considerations from the expert panel

Traditionally, Indigenous languages did not have pronouns. The expert panel notes that binary pronouns are a colonial concept. Health providers need to recognize that not everyone may use a pronoun, particularly Two-Spirit or Indigenous peoples. Some people may prefer to be called by their correct name instead. Similarly, pronouns may not be a concept applicable in all languages around the globe.

Table 9: Practice Notes from the Expert Panel

COMPONENT OF COMMUNICATION	DETAILS OF COMMUNICATION
<p>Inclusive language</p>	<ul style="list-style-type: none"> ■ Inclusive language is to be used throughout the whole care process. ■ The use of correct name and pronoun will be context dependent. For example, some people may prefer using one name in the waiting room and another name in the privacy of a health provider’s office. It is also critical to maintain privacy when asking about correct name and pronoun. Offer people the opportunity to document their correct name and pronoun privately (on paper or electronically) so that their privacy is protected in the waiting room. ■ If relevant to care, ask people how they identify (gender identity and sexual orientation) and ask “How may I address you today?”. Clarify how they would like to be referred to, particularly if they identify with a term that is more commonly used inside the 2SLGBTQI+ community than in the wider community or that has been historically used as a slur. For example, for people who identify as queer. ■ Inclusive language for people who identify as lesbian, gay or bisexual include using the word “partner” instead of “husband” or “wife”, as well as not making assumptions about the gender identity of the person they are dating. This includes not making assumptions about a partner’s gender identity based on dating history. For example, just because an individual has dated someone who identifies as a man in the past does not mean they necessarily will in the future. ■ Inclusive language applies to family and infant health settings including using the terms “parent/parenting”, “chest feeding” and “chest milk” instead of binary or gendered language. ■ See Appendix I for examples of inclusive pronouns.

RECOMMENDATIONS

COMPONENT OF COMMUNICATION	DETAILS OF COMMUNICATION
<p>Person-centred history taking approach</p>	<ul style="list-style-type: none"> ■ When asking questions about body parts or sexual behaviour, explain why the questions are relevant to care. Otherwise, these questions may come across as inappropriate or intrusive. ■ Health providers should ask trans and non-binary people how they refer to gendered body parts, and ask what terms they are comfortable with the health provider using. ■ Health providers are to be aware that many valid health assessment tools may be cisnormative or heteronormative, such as body mass index (BMI), or waist circumference measurements, both of which are binary scales typically with only “male” or “female” options. ■ Be aware of the gendered or binary language used for screening, particularly for many cancers. Use inclusive language. For example use “chest” or “upper body”, instead of “breast”. Simply name the involved organ instead of referring to female reproductive cancer. ■ Health providers are to be sensitive when asking questions about menstruation and be aware of menstrual dysphoria. ■ See supporting resources for a discussion guide and resources for taking a sexual health history.
<p>Ensuring privacy and confidentiality</p>	<ul style="list-style-type: none"> ■ To help build credibility and trust when building relationships with people, it can be helpful for health providers to share what experience they have working with 2SLGBTQI+ people or other underserved groups. ■ Forms and questionnaires are to contain disclosure about the purpose of gathering personal information and how it will be safeguarded (see Recommendation 1.1 on forms and documentation).

Table 10: Practice Notes from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
<p>Inclusive language</p>	<ul style="list-style-type: none"> ■ For trans and non-binary people, the use of correct pronoun and name needs to extend to all portions of the clinical encounter including labels, charts and waiting rooms (97, 98). ■ Trans individuals described negative health experiences where they were misgendered and “outed” and their birth-assigned sex was revealed to a waiting room full of people (92). This created an uncomfortable and unsafe health environment (92, 103, 106, 119, 120).
<p>Person-centred history taking approach</p>	<ul style="list-style-type: none"> ■ It is important to be non-judgmental, comfortable and at ease when asking questions about sex, sexuality and sexual activity (94, 96, 107). ■ When it is relevant, LGBTQ persons in three of the studies preferred it when health providers initiated discussions on sexual health during the clinical encounter rather than the person having to initiate discussion (94, 96, 107). ■ Partners and family members should be included (as appropriate) in the health history taking and care provided to 2SLGBTQI+ peoples (93, 101, 109). Asking about someone’s support system may be a strategy to start broad, inclusive conversations in a clinical setting.
<p>Ensuring privacy and confidentiality</p>	<ul style="list-style-type: none"> ■ Physical space: Privacy and confidentiality may be hindered by the physical environment so the space itself needs to be conducive to private conversations. Many people favored being able to complete nonverbal collection methods, such as written forms or self-administered electronic entry forms, during or before the visit (93). ■ Therapeutic relationship: Several studies reported on the importance of ensuring privacy and confidentiality within the broader context of a therapeutic relationship or working alliance between 2SLGBTQI+ people and health providers (94-96, 101, 115). This included the importance of trust, empathy, building rapport and collaboration. Participants also discussed the importance of appropriate use of eye contact, receptive body language and other non-verbal communication. One qualitative evidence synthesis notes the importance of being positive and reassuring if sexual orientation is disclosed (101).

RECOMMENDATIONS

Supporting Resources

RESOURCE	DESCRIPTION
<p>Asian Community AIDS Service. Asian Trans Youth Resource- For Youth [Internet]. Toronto: 2017 [cited 2021 April 18]. Available from: https://issuu.com/asiancommunityaidservices/docs/english_youth-online</p> <p>Asian Community AIDS Service Asian Trans Youth Resource- For Parents [Internet]. Toronto: 2017 [cited 2021 April 18]. Available from: https://issuu.com/asiancommunityaidservices/docs/english_parents-online</p>	<ul style="list-style-type: none"> ■ Separate pamphlets, one for youth and one for parents, both produced by the Asian Community AIDS Services. ■ Pamphlet resources contents detailing myths about being trans, transitioning, as well as information about and stigma and discrimination and as well as pronouns. ■ Also available in traditional Chinese, simple Chinese, Korean and Japanese (not available in French).
<p>Barbara, A., Doctor, F. and Chaim, G. Asking the Right Questions 2: Talking with Clients About Sexual Orientation and Gender Identity in Mental Health, Counselling and Addiction Settings. Toronto: 2007, Centre for Addiction and Mental Health. Available for purchase from: https://store-camh.myshopify.com/products/p167-p170</p>	<ul style="list-style-type: none"> ■ The manual includes interviewing items to facilitate discussion during assessment or early treatment ■ an assessment form and specialized questions to integrate into your organization's standard assessment <p>Note: this resource is associated with a fee.</p>
<p>Canadian Public Health Association. Reducing stigma and discrimination through the protection of privacy and confidentiality [Internet]. Ottawa (ON): c2017 [cited 2021 April 18]. Available from: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/confidentialitystigma_e.pdf</p> <p>Canadian Public Health Association. Discussing Sexual Health Harm Reduction and STBBI Guide [Internet]. Ottawa (ON): c2017 [cited 2021 April 19]. Available from: https://www.cpha.ca/discussing-sexual-health-harm-reduction-and-stbbis-guide-service-providers</p> <p>Canadian Public Health Association. Language Matters [Internet]. Ottawa (ON) c2019 [cited 2021 April 19]. https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/language-tool-e.pdf</p>	<ul style="list-style-type: none"> ■ Three separate online documents on strategies on strategies for reducing stigma and discrimination; resources for discussing sexual health and sexually transmitted and blood borne infections (STBBI); and issues around language. ■ Also included, including discussion, language and confidentiality guides.
<p>College of Nurses of Ontario. Practice Standard: Code of Conduct [Internet]. Toronto (ON): c2019 [cited 2021 April 19]. Available from: https://www.cno.org/globalassets/docs/prac/49040_code-of-conduct.pdf</p>	<ul style="list-style-type: none"> ■ This Code of Conduct is a standard of practice describing the accountabilities all Ontario nurses have to the public. It articulates what the people of Ontario can expect and sets the bar for those in the nursing profession.

RESOURCE	DESCRIPTION
College of Nurses of Ontario. Practice Standard: Confidentiality and Privacy - Personal Health Information [Internet]. Toronto (ON): c2019 [cited 2021 April 19]. Available from: https://www.cno.org/globalassets/docs/prac/41069_privacy.pdf	<ul style="list-style-type: none"> ■ Details nurses' responsibility to maintain clients' privacy and confidentiality. ■ Provides an overview of relevant legislature ■ Details strategies to develop and maintain a quality practice setting in relation to privacy and confidentiality.
College of Nurses of Ontario. Practice Standard: Therapeutic Nurse-Client Relationship Revised 2006 [Internet]. Toronto (ON): c2006 [cited 2021 April 19]. Available from: https://www.cno.org/globalassets/docs/prac/41033_therapeutic.pdf	<ul style="list-style-type: none"> ■ Practice standard detailing therapeutic nurse-client relationship including privacy and confidentiality.
Information and Privacy Commissioner of Ontario. Health Organizations [Internet]. Toronto (ON): c2020 [cited 2021 April 19]. Available from: https://www.ipc.on.ca/health-organizations/	<ul style="list-style-type: none"> ■ Provides a guide to the Personal Health Information Protection Act (PHIPA) ■ Provides an overview of health organization responsibilities under this law as well as how to report privacy breaches.
Millyard, A. and Gilbert, C. Neutralizing Clinical Language: Working with Gender and Sexual Diversity. 2019 [cited 2021 April 29]. Available from: https://cyndigilbert.ca/wp-content/uploads/2020/05/Neutralizing-Clinical-Language.pdf	<ul style="list-style-type: none"> ■ Provides examples of neutral, non-binary language to use ■ Provides detailed clinical examples
Ontario Human Rights Commission. Questions and answers about gender identity and pronouns [Internet]. [cited 2021 April 30] Available from: http://www.ohrc.on.ca/en/questions-and-answers-about-gender-identity-and-pronouns#_edn2	<ul style="list-style-type: none"> ■ Explains the legal framework surrounding pronouns in Ontario
Trans Care BC Provincial Health Services Authority. Gender Inclusive Language [Internet]. British Columbia (BC): n.d. [cited 2021 April 19]. Available from: http://www.phsa.ca/transcarebc/Documents/HealthProf/Gender_Inclusive_Language_Clinical.pdf	<ul style="list-style-type: none"> ■ Language guide to working with gender diverse people in a respectful, professional and inclusive manner. ■ Includes words to use instead of gendered terms (i.e. upper body instead of breast or chest).

RECOMMENDATION 1.1:

The expert panel recommends that health-service organizations implement 2SLGBTQI+ inclusive signage, forms and documentation.

Strength of the recommendation: Strong

Certainty of the evidence of effects: Very low

Confidence in evidence: Moderate

Discussion of Evidence

Benefits and Harms

Inclusive signage

Inclusive signage includes symbols, signs, posters and other visual messaging that help to signal to 2SLGBTQI+ people that the health-service organization will be a safe and welcoming environment. Examples of such signage include the rainbow flag, the trans flag, or other safe space symbol. Inclusive signage can include physical or written materials as well as digital signage.

The qualitative evidence indicates that the use of inclusive signage in health-service organizations may improve 2SLGBTQI+ peoples' sense of safety and may result in a greater sense of comfort with their health provider (92-94, 102, 103, 107, 111, 116, 117, 121, 122). One qualitative evidence synthesis identified that visual cues in the health-service organization facilitated disclosure and comfort (102). Lesbians, gay and bisexual (LGB) participants in one study felt comfortable, safe, happy and able to “breathe a sigh of relief” when they saw inclusive signage in the health-service organization (94). Additionally, four studies mentioned that health education materials, including websites and pamphlets, should be inclusive to 2SLGBTQI+ people (102, 107, 117). One participant described looking at pamphlets which included pictures of families that did not look like “any family I may be having in the future” (107). Diversifying pamphlets to show visual representation of different types of families including more people of colour and more queer people is important for inclusion (107).

No harms were found in the literature related to inclusive signage.



The expert panel cautioned against signage in the absence of appropriate implementation of a safe space and underlying processes including training of all staff that interact with people. Signage could be harmful if some staff are not prepared to interact in an affirming way with 2SLGBTQI+ people. The example given was of people letting their guard down when they see an inclusive sign and then being met with discrimination and the risk of trauma. For more information on establishing safer spaces, refer to **Recommendation 2.0**

Inclusive forms and documentation

Inclusive forms and documentation are those that reflect and can correctly capture the identity of 2SLGBTQI+ persons. Inclusive forms and documentation can apply to physical or written materials as well as electronic forms. In general, participants described six areas of forms that may need to be adjusted in order to be inclusive and non-cisnormative and non-heteronormative. The six areas are sexual orientation, gender identity, sexual history, relationships, reproduction and privacy (109).

The qualitative literature indicates that implementing inclusive forms and documentation may provide 2SLGBTQI+ people with a greater sense of safety and comfort (91-93, 95, 97, 98, 102, 109, 116, 120, 123, 124). Intake forms that provided a broad range of options beyond binary and heteronormative choices for gender identity, sexual orientation and relationship status enhanced the comfort and overall health experience for LGBTQI+ people (91-93, 95, 97, 98, 102, 109, 120).

Several studies noted the harms of not adjusting forms and documentation to be inclusive. Participants in several studies noted that traditional health-care forms communicate and reinforce heteronormativity and cisnormativity (91, 92, 95, 98, 109, 123, 124). Trans individuals in one study emphasized the negative environment created by traditional intake forms, particularly as they are often the first part of the clinical encounter (92). Trans participants in another study noted that intake forms were a barrier to feeling welcome in a health-service organization and left many feeling “invisible” (91).

The confidence in the evidence is moderate due to concerns regarding how the individual studies were conducted. The certainty in the evidence is very low due to concerns regarding how the individual studies were conducted, the variety in the interventions described, and the inability to identify an estimate of effect.

For more detailed information of the findings for each component of the recommendation (inclusive signage and forms and documentation) and the grading of evidence, please refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Values and Preferences

No additional values and preferences were reported in this literature. The expert panel noted that individuals would highly value the interventions if implemented fully and properly.

Health Equity

See **Recommendation 1.0** for the impact on health equity. The research and the expert panel suggest that the impacts on health equity associated with this recommendation are consistent with those outlined in **Recommendation 1.0**.

Expert Panel Justification of Recommendation

This recommendation could have been a good practice statement however, the expert panel agreed that it was important to pose a recommendation question to understand the evidence from the perspectives of 2SLGBTQI+ people. In addition, this evidence can support health service organizations by providing detailed information on inclusive communication strategies. There may be benefits when health-service organizations used inclusive forms, documentation and signage but the evidence is uncertain. There were harms associated with not using these strategies. The confidence in this evidence is moderate and the certainty is very low. Overall, the benefits of using inclusive signage, forms and documentation may outweigh the potential harms of not doing the intervention. In addition, the expert panel noted instances of harassment, discrimination and violence when these practices are not followed. Therefore, due to the severity of the potential harms, the expert panel determined the strength of the recommendation to be strong.

Practice Notes

Table 11: Practice Notes from the Expert Panel

COMPONENT OF COMMUNICATION	DETAILS OF COMMUNICATION
<p>Inclusive signage</p>	<ul style="list-style-type: none"> ■ Placement of signage: Signs on the front door of an organization indicate that all staff are educated and delivering affirming 2SLGBTQI+ care. If this is not the case, signs can be placed in individual offices, areas or worn by providers who are educated and delivering 2SLGBTQI+ care. ■ Inclusive signage needs to include washroom signs that indicate that trans and non-binary people are welcome. ■ Some symbols, such as religious icons and symbols, may have the potential to be seen as barriers to care, given the historical discrimination by some religious groups. These symbols should be used with caution.
<p>Inclusive forms and documentation</p>	<ul style="list-style-type: none"> ■ Involve 2SLGBTQI+ people in the process of creating and providing feedback on inclusive forms. ■ It is critical that both electronic and paper forms are inclusive. Electronic health records should be updated on a regular basis to be inclusive and consistent. ■ Birth-assigned sex should also be included on documentation with an option to decline to answer. Another option is to include a list of person's relevant anatomy and organs present to ensure proper screening of cervix, prostate etc. ■ Tools for reporting health service experience, including complaint forms, need to provide options to disclose gender identity and sexual orientation in the demographics sections.

Table 12: Practice Notes from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
<p>Inclusive signage</p>	<p>Sign choice:</p> <ul style="list-style-type: none"> ■ The following symbols or signs were mentioned in the studies or noted by the expert panel: <ul style="list-style-type: none"> □ Rainbow flag (93, 94, 102) □ SafeSpace pink triangle (94) □ Trans flag (103) □ Discrimination-free zone (121) □ Positive space (122) ■ Of the symbols, one study noted that the rainbow flag was the most recognized by participants (94). ■ Please see Appendix J for examples of inclusive symbols and flags. <p>Sign location:</p> <ul style="list-style-type: none"> ■ Within the literature there was discrepancy as to where a sign should be placed. Some participants suggested the flag should be visible from the moment a person walks into the office, whereas others thought that it was more important for it to be in the examination room (94). The expert panel noted that it would be of benefit to include the signs in both areas. ■ Health providers who wore inclusive signage on their clothing were acknowledged as brave and promoting the most comfort and safety during the clinical encounter (94). <p>Non-discrimination policies:</p> <ul style="list-style-type: none"> ■ Visual cues to promote comfort and safety during the clinical interaction should include explicitly posted sexual and gender minority nondiscrimination policies (93). <p>Health provider knowledge and skill:</p> <ul style="list-style-type: none"> ■ In addition to signage, health providers who are knowledgeable and competent in working with 2SLGBTQI+ people should make themselves known and accessible to 2SLGBTQI+ people including adding this information to health-service organization websites where applicable (91, 95, 103).

RECOMMENDATIONS

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
<p>Inclusive forms and documentation</p>	<p>Formatting of questions to offer more sexually and gender diverse options:</p> <ul style="list-style-type: none"> ■ Have sections on gender identity that includes 1) gender identity and 2) birth-assigned sex (92, 98). In a study where trans participants were asked whether they preferred a one-step or two-step question about gender, most preferred the two-step (98). ■ Medical forms include questions to identify correct name and pronouns (116) ■ It is important to give people the option to decline to answer and the right to refuse (98, 124, 125). ■ Providing blanks or text boxes could be helpful for participants who do not fit into predefined categories (91, 95) and is more inclusive, particularly for people who identify as non-binary or Two-Spirit. ■ Please see Appendix M for an example of an inclusive form. <p>Other implementation considerations:</p> <ul style="list-style-type: none"> ■ It is important to provide education and support to staff on the importance and use of inclusive forms (95). ■ Forms cannot be used as stand-alone documents. Follow-up to discuss items from the form is important to ensure safe and inclusive care (109). Another study noted that when providers relied solely upon information from these forms and avoided asking questions about correct language (pronoun), they often made incorrect assumptions about people’s gender and experience (91). See Recommendation 1.0 on history-taking approach and inclusive language. ■ Provide/feature pamphlets, posters, brochures and other print materials that also represent 2SLGBTQI+ people (107, 116, 121).

Supporting Resources

RESOURCE	DESCRIPTION
<p>National LGBT Health Education Center. Focus on Forms and Policy: Creating an Inclusive Environment for LGBT Patient [Internet]. Boston (MA): c2017 [cited 2021 April 18]. Available from: https://www.lgbthealtheducation.org/wp-content/uploads/2017/08/Forms-and-Policy-Brief.pdf</p>	<ul style="list-style-type: none"> ■ Provides strategies and tips on creating LGBT-affirming and inclusive environments with specific details on health forms and documentation.
<p>O’Link, R., Hansen, D., Bolt, V., Brochu, P., Cotnoir, G., Webber, J., Imbeau, S., Jaunzarins, B., Hilman, A., Ritz, S. Breaking Down Barriers: A Tool to Address Inequalities in LGBT2-SQ Healthcare in Sudbury, Ontario. Sudbury (ON): n.d. [cited 2021 April 30] Available from: https://saferspaces.ca/download/breaking-down-barriers-handbook-a-tool-to-address-inequalities-in-sudbury-ontario/</p>	<ul style="list-style-type: none"> ■ A health provider handbook that provides a practical guide for addressed 2SLGBTQI+ health equity ■ The guide includes communication and an example of an inclusive form that could be used.

RECOMMENDATIONS

SAFER SPACES

RECOMMENDATION 2.0:

The expert panel recommends health-service organizations create safer spaces for 2SLGBTQI+ people through a multi-component approach.

Strength of the recommendation: Strong

Certainty of the evidence of effects: Very low

Confidence in evidence: Low

Discussion of Evidence

Benefits and Harms

A safe space refers to a health-service organization that is open and welcoming, where services are accessible and equitable for persons of all gender identities and sexual orientation who are receiving services, employees or volunteers of the organization (126). The expert panel chose to use the term “safer spaces” in the recommendation statement to highlight the need for health-service organizations to continuously assess, improve and enhance the safety of the organization. The expert panel cautions that a truly safe space is rare and the use of the term “safer space” acknowledges this.

There was diversity in the approaches used across the studies to create safer spaces, but all of the studies used a **multi-component approach**^G. A multi-component approach uses more than one approach or strategy to create a safer space. A multi-component approach includes, at minimum, two of the following strategies:

- anti-discrimination policy (127-133),
- diverse representation of staff (134)
- inclusive intake forms(134, 135),
- 2SLGBTQI+ events (135-137),
- referrals to support (138), and
- written materials and signs (134, 135, 138).



Caution: The expert panel noted that the use of inclusive posters and signage alone may be harmful if not implemented with an organizational commitment to the additional interventions and training that support the creation of 2SLGBTQI+ safer spaces. Health-service organizations using symbols or signs need to be accountable to the intention of that symbol or sign.

Evidence suggests that safer spaces in health-service organizations may improve reported outcomes of perceived safety, experience, return of persons, and representation. However, the evidence is uncertain. Qualitative evidence was from a variety of settings such as home health care, long-term care, school-based settings and community settings. There were several overarching qualitative findings related to the prioritized outcomes. Participants in safer spaces experienced a sense of community, acceptance and comfort (135-137, 139-142). In addition, safer spaces

facilitated engagement and retention of people in a variety of setting (139, 140). LGBTQ persons in safer spaces experienced an environment where they felt safe and secure (136, 137, 139-142). Safer spaces represent diverse identities beyond 2SLGBTQI+ including race, ethnicity and socioeconomic status by being inclusive and affirming (134, 135, 141).

Two studies were specifically focused on older adults and safer spaces (135, 137). Older LGBT adults residing in long-term care reported the need to feel safe, accepted and the wish to ‘be themselves’ (137). Seniors were attracted to the comfort and ease of their LGBT-focused environment, where there was a perception of safety, the removal of negativity and living out of the closet (135). Specific considerations to creating safer spaces older adults in long-term care settings are detailed in **Table 14** below.

Quantitative evidence was conducted exclusively within school settings. Findings suggests that creating a safer space through a multi-component approach may improve the person’s safety as measured by homophobic victimization, fear for safety and homophobic remarks (127-133, 138, 143-148, 370, 371) and return of persons as measured by classes missed (128, 129, 132, 144). Further evidence was sought in studies conducted in school settings as quantitative research exclusively in health settings was very limited. Because nurses work in school settings, and community health interventions may take place in school settings, the expert panel noted that there may be similarities between how health-service organizations and schools create safer spaces.

None of the included studies reported any harms or undesirable effects as a result of creating a safer space.

The confidence in the evidence is low and was downgraded for limitations in how the individual studies were conducted and adequacy of the data. The overall certainty of the evidence across all outcomes is very low. The certainty in the body of evidence for this recommendation was very low due to serious limitations in how the studies were conducted and minor concerns regarding the range of settings and interventions. For more detailed information on the impact of safer spaces on the prioritized outcomes (person experience, perceived safety of persons, retention/return of persons, and representation of persons and providers), the qualitative findings and the grading of the evidence please refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Values and Preferences

One study (135) reported that persons in LGBT- specific senior long-term care homes desired to live in open and affirming diverse communities. They considered diversity to include racial and ethnic diversity, as well as the inclusion of non-sexual minority older adults (135).

Health Equity

Studies included participants from diverse sexual orientation and gender identities. However, none of the studies included intersex persons. Only one study included a person who identified as Two-Spirit (140). Several of the studies included racial and ethnically diverse participants (128, 129, 135, 136, 139, 141, 148).

Expert Panel Justification of Recommendation

Conventionally based on GRADE, this recommendation could have been voted conditional since the certainty of the evidence of effects was very low and the confidence in this evidence was low. Based on the balance of benefits and harms, including the harms of not following the recommendation, as well as values and preferences and health equity, the expert panel came to consensus on a strong recommendation. There may be benefits to health-service

organizations creating safer spaces and there may be fewer harms associated with creating safer spaces. The expert panel also noted the potential harms of not creating a safer space, including negative effects on person safety and willingness to seek care. The expert panel felt that 2SLGBTQI+ people would highly value safer spaces as a foundation for safe and affirming care. Therefore, despite the very low certainty and low confidence in the evidence, the expert panel determined the strength of the recommendation to be strong due to the potential for harms of not providing safer spaces.

Practice Notes

Considerations from the Expert Panel

- When creating safer spaces, organizations should take an intersectional approach. They should do this by ensuring that safer spaces are created not only for 2SLGBTQI+ people, but also with their intersecting identities in mind, including but not limited to BIPOC and people with disabilities. Please see the **Intersectionality Framework** on page 34 for more information on intersectionality.
- Organizations need ongoing quality improvement strategies, including an internal review of current practices, barriers and facilitators and ongoing education and evaluation. Education should be for all levels of the organization including staff, permanent and contract, as well as volunteers. Because it is 2SLGBTQI+ persons who determine whether a space is safer, evaluation must include 2SLGBTQI+ community member feedback through measures such as focus groups and surveys.
- Health-service organizations should follow an implementation framework and have ongoing quality improvement processes when they create safer spaces. Please see **Appendix N** for a description of the *Leading Change Toolkit*[™], which also outlines the Knowledge-to-Action Framework (19).
- The creation of safer spaces should not be the sole responsibility of 2SLGBTQI+ staff. Rather, all members of the interprofessional team (including senior leadership) should be responsible. It is important to include 2SLGBTQI+ person/family advisory committees and external community stakeholders in the creation of safer spaces.
- Consult with local community 2SLGBTQI+ advocacy groups in the selection of symbols and flags for use by organizations, as local contexts can vary.
- Health-service organizations and schools can promote and celebrate 2SLGBTQI+ people through specific events. Special events can include Pride month, ‘day of silence’ (student participants refuse to speak for the day to draw attention to the cultural silence around LGBTQ issues), ‘pride/rainbow prom,’ pink shirt day, National Day of Coming Out, Trans Day of Remembrance, International Day Against Homophobia, Transphobia and Biphobia, Day of Pink, etc.
- Other possible components of safer spaces can include:
 - **Bathrooms:** Safer spaces are to include dignified and respectful access to trans and non-binary-inclusive bathrooms. Additionally, reception staff or staff located near to trans and non-binary inclusive bathrooms need to be educated to respond promptly to questions, concerns or complaints about these bathrooms. Inclusive bathrooms include appropriate hygiene product disposal.
 - **Complaints and public relations:** Health-service organizations are to establish clear channels for complaints and ensure public relations or complaints teams are knowledgeable about 2SLGBTQI+ issues and barriers to care.
 - **List of health providers:** In health settings providing counseling services or other settings with a long-term person-provider relationship, organizations are to develop a list of the staff members who have knowledge, skills, and comfort in working with different 2SLGBTQI+ populations, and people from 2SLGBTQI+ communities should be asked if they want to be matched with counselors with relevant experience. Organizations may also provide a way for staff to share which health providers are 2SLGBTQI+ community members.

Table 13: Practice Notes from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Anti-discrimination policy	<ul style="list-style-type: none"> ■ Ten studies reported the use of anti-discrimination policies as part of the creation of safe spaces (127-133, 135, 140). ■ Anti-discrimination policies reflected the institutional values and organizational climate and culture of an organization (140). ■ Anti-discrimination policies were developed in alignment with principles of equity and anti-oppression philosophies where diversity is implicitly a core value (134). Policies were aligned with funding agencies or accreditation agencies and designed to meet the requirements of legislation (i.e. human rights, employment, human resource) (134).
Diverse representation of staff	<p>One study suggested recruitment of LGBTQ community members as a key element for sustaining LGBTQ safe spaces in organizations (134). When LGBTQ staff were visible in an agency at all levels of the organization, there were positive consequences for client disclosure (134).</p>
Inclusive intake forms	<p>Two studies recommend the use of inclusive intake forms as a component of the creation of safe spaces (134, 135). See Recommendation 1.0 for further details.</p>
Written materials and signs	<ul style="list-style-type: none"> ■ Three studies identified the importance of representing LGBTQ+ persons on written materials and signs on school or organizational documents and within physical spaces (134, 135, 138). ■ Actions that assist the creation of safer spaces include intentional and conscious attention to reflecting LGBT seniors in any materials created and/or published by an organization (135).

Table 14: Practice Notes from the Evidence Related to Older Adults and Safer Spaces

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Staff education	<ul style="list-style-type: none"> Many health providers are unfamiliar with the reality of older LGBT adults residing in long-term care homes and their experience of feeling marginalized and isolated. One study identified a need to place a priority on raising awareness about this issue with health-service organizations that provide residential care to older LGBT adults (137). Refer to Recommendations 5.0 and 5.1 on education for health providers and health students.
LGBT-themed programming	<ul style="list-style-type: none"> Two studies identify that LGBTQ+ events, such as Pride month, provide residents with a sense of belonging and support within older adult residential care settings (135, 137). Long-term care or residential care organizations can offer activities where both LGBT and heterosexual/cisgender residents can socialize, as well as offer LGBT-specific activities, such as organizing sessions of sharing experiences of exclusion (137).
Measures to communicate inclusivity	<ul style="list-style-type: none"> Post known LGBT symbols such as rainbow flags around care facilities in public spaces (137). Share and disseminate informational materials on sexual diversity (137). Staff can demonstrate their support for LGBT residents by wearing pink buttons to show their commitment to ensuring LGBT seniors feel safe and included (137).

Supporting Resources

RESOURCE	DESCRIPTION
City of Toronto Long-Term Care Homes & Services. LGBT Tool Kit: Creating Lesbian, Gay, Bisexual and Trans Inclusive and Affirming Care and Services Toronto, ON: 2017. Available to request from: https://clri-ltc.ca/resource/lgbt-tool-kit/	<ul style="list-style-type: none"> An overview of best practices for a promising practice, process or initiative within Long-Term Care Homes and Services as well as other organizations The toolkit includes self-study and self-reflection <p>Note: the toolkit is freely available but must be requested.</p>
Hamilton Family Health Team. Is your space positive? Hamilton, ON: 2015 Available from: https://docs.hamiltonfht.ca/dsweb/Get/Document-2926	<ul style="list-style-type: none"> One-page checklist to assess whether a health service organization is inclusive to people of all sexual orientations and gender identities

RESOURCE	DESCRIPTION
<p>Daley, A., MacDonnell, J.A., & St. Pierre, M. LGBTTIQ Communities and Home Care in Ontario: Project Report. Toronto (On): York University. 2016. Available from: http://yorkspace.library.yorku.ca/xmlui/handle/10315/31416</p> <p>Daley, A., MacDonnell, J.A., & St. Pierre, M. 'Queering Home Care' [Patient values statement] Toronto, ON: York University. 2016. Available from: https://yorkspace.library.yorku.ca/xmlui/handle/10315/32044</p>	<ul style="list-style-type: none"> ■ Thirty-six page project report -includes a user-friendly lesbian, gay, bisexual, transgender, Two-Spirit, queer and intersex (LGBTTIQ) Home Care Access and Equity Framework that was created based on research findings. ■ " Queering Home Care" provides a one- page summary of LGBTTIQ persons' values in regards to being cared for in the home care setting.
<p>Ontario Centres for Learning, Research and Innovation in Long-Term Care. A Home for All: Making Long-Term Care Welcoming for LGBTQI2S+ People. Toronto, ON: 2019 Available from: 20190816 A-Home-For-All-Resource-Package.pdf (clri-ltc.ca)</p> <p>Ontario Centres for Learning, Research and Innovation in Long-Term Care. Supporting The Rainbow Community: A Home For All Webinar. 2019 [cited 2021 April 29] Available from: https://clri-ltc.ca/resource/homeforallwebinar/</p>	<ul style="list-style-type: none"> ■ Handout resource and accompanying webinar from the Ontario centre for learning, research and innovation in long-term care. ■ Detailed strategies and resources for making long-term care a safer space
<p>Ontario Public Health Association. A Positive Space Is A Healthy Place [Internet]. Toronto (ON); c2011 [cited 2020 April 21]. Available from: https://opha.on.ca/getmedia/125e32e7-f9cb-48ed-89cb-9d954d76537b/SexualHealthPaper-Mar11.pdf.aspx?ext=.pdf</p>	<ul style="list-style-type: none"> ■ Manual for making a community health centre, public health unit or community agency inclusive to those of all sexual orientations and gender identities

RESOURCE	DESCRIPTION
<p>The 519 Resources. LGBTQ2S Playbook [Internet]. Toronto (ON): c2020 [cited 2021 April 16]. Available from: https://www.the519.org/education-training/training-resources/our-resources/inclusion-playbook</p>	<ul style="list-style-type: none"> ■ A LGBTQ2S Inclusion Playbook ■ Guidance for health workers in acute, primary and community health and social service environments in fostering inclusive spaces for LGBTQ2S communities and people.
<p>Veltman A, La Rose T. LGBTQ mental health: What every clinician needs to know. Psychiatrics Times. 2019:21-3. Available from: https://www.psychiatristimes.com/view/lgbtq-mental-health-what-every-clinician-needs-know</p>	<ul style="list-style-type: none"> ■ Article focused on LGBT mental health ■ Includes specific examples of being an ally and creating a safer space.

RECOMMENDATIONS



RECOMMENDATION 2.1:

The expert panel recommends schools create safer spaces for students that include gender-sexuality alliances (GSAs).

Strength of the recommendation: Strong

Certainty of the evidence of effects: Low

Confidence in evidence: Moderate

Discussion of Evidence

Benefits and Harms

A safe space in schools is one in which everyone – students, staff and parents – feel welcome, safe and respected. Gender-Sexuality Alliances (GSAs) are school clubs in which students can talk and learn about sexual orientation and gender identity. They are structured like any other school group, with a faculty advisor and regular meetings. Everyone is welcome: Two-Spirit, lesbian, gay, bisexual, trans, queer and questioning students, as well as heterosexual and cisgender students, students with 2SLGBTQI+ families, and students who do not have or need a label for their sexual orientation or gender identities (149). A GSA is a more inclusive name than the term “gay-straight alliance” which may also be used. The expert panel chose to use the term “safer spaces” in the recommendation statement to highlight the need for schools to continuously assess, improve and enhance the safety of the organization. The expert panel cautions that a truly safe space is rare and the use of the term “safer space” acknowledges this.

The most common component of a safer spaces in the school environment were GSAs (127-132, 136, 138, 142, 145, 147, 148, 150-153, 370, 371). Other components of school-based safer spaces included:

- Anti-discrimination or anti-bullying policies (127, 128, 130-133, 138, 144)
- Gender neutral bathrooms or locker rooms (143, 150, 154)
- Inclusive signage (138)
- The important role of educators and professional development (138)

Evidence suggests safer spaces in schools may increase reported outcomes of perceived safety, return of students, and student experience. The majority of sixteen quantitative studies reported improved perceived safety in school-based safer spaces (127-133, 138, 143-148, 370, 371). Four studies reported on return of students, measured through missing school (attendance) (128, 129, 144). In three of these studies, GSAs or anti-bullying policies led to improved attendance (128, 129, 144).

In most studies, GSA presence alone was enough to confer benefits regardless of whether students were members of the group (127-130, 132, 138, 145). One 2019 study examined the relationship between the length of time a GSA has been present in a school and school-level perceived safety among LGB students (147). School-level perceived safety among LGB students increased with the amount of time a GSA had been in existence in the school (147). Other components of the school-based safer space are detailed in the “Practice Notes” below.

In qualitative studies, LGBTQ persons described the important role GSAs had in creating a sense of safety, community, peer support and LGBTQ advocacy. The positive impacts of the GSA went beyond the group and extended to the school as a whole and offered connection to the greater LGBTQ community (136, 142, 150-154). High school LGBTQ youth described the importance of the presence of gender-neutral bathrooms in facilitating a safe school environment and creating a sense of inclusivity (150, 154). LGBTQ participants in high school GSAs expressed experiencing feelings of safety, not only within these groups but also across the greater school context (136, 154).

Some negative experiences were noted in the qualitative literature related to GSAs. For instance, GSA members had their posters promoting LGBT school events in their school subjected to vandalism (136). Some students reported their participation in a GSA provoked a backlash, making visible some of the hidden hostilities directed towards LGBTQ students (136). Some students also experienced verbal harassment and physical abuse directed at them from their peers, teachers, school administrators and parents (136).

The overall certainty of the evidence is low. The certainty of evidence was downgraded for serious concerns in how the individual studies were conducted and inconsistency in how outcomes were measured. The confidence in the evidence is low because of some concerns in how individual studies were conducted and adequacy of the data. For more detailed information on the impact of school based safer spaces on the prioritized outcomes (student experience, perceived safety of students and retention/return of students), refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Values and Preferences

LGBT participants reported wanting their GSA to foster an LGBTQ-friendly school environment (155). Qualitative evidence suggests that GSAs were highly valued by students (142, 151-153). Students preferred gender-neutral or single-stall bathrooms (154).

Health Equity

Participants included diverse sexual orientation and gender identities, but BIPOC were underrepresented across some of the studies. Studies included a diverse representation of participants from across a variety of geographic locations (urban and rural) and/or socioeconomic conditions.

Expert Panel Justification of Recommendation

Conventionally based on GRADE, this recommendation could have been voted conditional since the certainty of the evidence of the effects was low and the confidence in the evidence was moderate. Based on the balance of benefits and harms, including the harms of not following the recommendation, as well as values and preferences and health equity, the expert panel came to consensus on a strong recommendation. There may be benefits to schools creating safer spaces. There may be harms associated with not creating safer spaces. Overall, the benefits of the intervention outweighed the potential harms of not implementing the intervention. Potential harms of not implementing the intervention included negative effects on mental health and lower rates of school attendance. The expert panel also noted evidence that safer spaces were beneficial to those not in the 2SLGBTQI+ community (i.e., heterosexual/cisgender students). Therefore, despite the low certainty and moderate confidence, the expert panel determined the strength of the recommendation to be strong.

Practice Notes

Considerations from the Expert Panel

- Safer spaces in schools are to employ a multi-component approach. This includes a minimum of a GSA and at least one additional component noted above.
- Publicly funded schools (secular or non-secular) as well as independent and private schools are required to comply with provincial and federal government human rights legislation in Canada. Schools and/or their representatives cannot discriminate against any student based on their sexual orientation, gender identity or gender expression.
- A healthy, safer and inclusive learning environment where all students feel accepted is essential for students to thrive, learn and achieve successes
- Schools can equip students with the knowledge, skills, attitude and values to engage the world and others with a critical lens. Schools can also help students develop a critical consciousness that enables them take action to create more equitable and inclusive spaces in their schools and communities – spaces that include lesbian, gay, bisexual, transgender, transsexual, intersex and questioning (LGBTTIQ) people (156)
- A whole school approach identifies the vital role of government, educators, school staff, parents, students and the wider community in creating a positive school climate and preventing negative behavior such as bullying, sexual assault, gender-based violence and incidents of homophobia, transphobia or biphobia (156).
- The expert panel noted that the creation of safer spaces in schools should not always fall to teachers and administrators. School nurses, as well as public health, primary, and community care nurses, have an important role to play and may be able to advocate for, in particular, gender neutral bathrooms and GSAs. They can also educate families about the benefit of these initiatives.
- The expert panel also noted that the responsibility of leading GSAs or other components of safe spaces should not always be delegated to 2SLGBTQI+ school staff as this can be burdensome.

Details from the Evidence:

- Part of creating a safe school climate includes having a point person in the school for LGBT student issues, and providing professional development about LGBT student issues and LGBT inclusion in curriculum and school climate (138).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Accepting Schools Act 2012, Bill 13 Ontario Legislative Assembly [Internet]. [cited 2021 April 19]. Available from: https://www.ola.org/en/legislative-business/bills/parliament-40/session-1/bill-13</p>	<ul style="list-style-type: none"> ■ This Act requires Ontario school boards to develop and implement an equity and inclusive education policy. ■ This Act requires school boards to use surveys to collect information from its pupils and staff, and parents and guardians of its pupils at least once every two years. ■ This Act requires schools to create professional development programs: school boards are required to establish and provide annual professional development programs to educate teachers and other staff of the board about bullying prevention and strategies for promoting positive school climates
<p>EGALE Canada Equity and Inclusive Education Resource Kit for Ontario High Schools. In: Egale Canada [Internet]. Toronto (ON): [date unknown]. Available from: https://egale.ca/wp-content/uploads/2015/09/MyGSA_ON_Resource_CompleteKit.pdf</p> <p>Every Class in Every School: The first national climate survey on homophobia, biphobia, and transphobia in Canadian schools. Final Report. In: Egale Canada [Internet]. Toronto (ON): 2011. [cited 2021 April 19]. Available from: https://egale.ca/awareness/every-class/</p>	<ul style="list-style-type: none"> ■ Equity and Inclusion Resource Kit for High Schools in Ontario ■ Canadian resource for safe spaces in schools including an extensive and detailed GSA guide ■ Equity and Inclusion Resource Kit for High Schools in Ontario <p>Note: some resources may have an associated fee, but many are available for use at no cost</p> <ul style="list-style-type: none"> ■ Canadian report on what school is like for the school experiences of sexual and gender diverse students.
<p>Gay, Lesbian, Straight Education Network (GLSEN) [Internet]. New York (NY). [cited 2021 April 16]. Available from: https://www.glsen.org/</p>	<ul style="list-style-type: none"> ■ Resources for schools, educators and students ■ GLSEN advises on, advocates for, and researches comprehensive policies designed to protect LGBTQ students as well as students with additional intersectional identities such as students with disabilities or who are BIPOC.

RESOURCE	DESCRIPTION
<p>Genovese, M., Rousell, D. The Two Spirit Circle of Edmonton Society [Internet]. Safe and Caring Schools for Two Spirit Youth; Edmonton (AB): c2011 [cited 2021 May 3]. Available from: https://www.teachers.ab.ca/SiteCollectionDocuments/ATA/For%20Members/ProfessionalDevelopment/Diversity-Equity-and-Human-Rights/Safe%20and%20Caring%20Schools%20for%20Two-Spirited%20youth.pdf</p>	<ul style="list-style-type: none"> ■ A guide for students and staff for creating safe and caring schools for Two-Spirit Youth
<p>Government of Manitoba: Education. Safe and Caring Schools [Internet]. Winnipeg (MB): n.d. [cited 2021 May 3]. Available from: https://www.edu.gov.mb.ca/k12/safe_schools/index.html</p>	<ul style="list-style-type: none"> ■ Website outlining resources and guides for creating safe and caring schools. ■ Includes specific guidance for transgender and gender diverse students
<p>Safe@school [Internet]. Toronto (ON): 2013. [cited 2021 April 19]. Available from: https://www.safeatschool.ca/</p>	<ul style="list-style-type: none"> ■ Includes education and resources on safe spaces at school for teachers, and students, with a focus on preventing bullying.
<p>National Association of GSA Networks. GSA Advisor Handbook [Internet]. c2011. [cited 2021 April 29] Available from: https://gsanetwork.org/wp-content/uploads/2018/09/GSA_Advisor_Handbook-web.pdf</p>	<ul style="list-style-type: none"> ■ Detailed GSA advisor handbook including leadership, facilitation, activities and basic information about GSAs ■ Also includes information on sustainability and inclusivity
<p>Ontario Council of Agencies Serving Immigrant Positive Spaces Initiative. Support LGBTQIA+ newcomers [Internet]. [cited 2021 April 30] Available from: http://positivespaces.ca/</p>	<ul style="list-style-type: none"> ■ Includes resources and an assessment tool to guide organizations through making their space positive and safe for LGBTQI+ immigrants and newcomers

RESOURCE	DESCRIPTION
<p>Teaching Human Rights in Ontario N A Guide for Ontario Schools. Ontario Human Rights Commission, 2013 [Internet]. [cited 2021 April 19]. Available from: http://www.ohrc.on.ca/en/teaching-human-rights-ontario-guide-ontario-schools</p> <p>Policy on preventing discrimination because of GENDER IDENTITY and GENDER EXPRESSION. Ontario Human Rights Commission [Internet]. Toronto (ON): 2014 [cited 2021 April 19]. Available from: http://www.ohrc.on.ca/sites/default/files/Policy%20on%20preventing%20discrimination%20because%20of%20gender%20identity%20and%20gender%20expression.pdf</p>	<ul style="list-style-type: none"> ■ A 114 page guide for teaching human rights in Ontario schools ■ Ontario Human Rights Commission policy document on preventing discrimination because of gender identity and gender expression
<p>Pride Education Network [Internet]. British Columbia (BC). [cited 2021 April 16]. Available from: https://www.pridenet.ca/resources</p>	<ul style="list-style-type: none"> ■ Pride Education Network resources for educators on creating and supporting a GSA (2017 edition) ■ Created by educators and advocates who value the importance of a safe, respectful and inclusive learning environment for all students
<p>Progressive Discipline and Promoting and Supporting Positive Student Ontario Ministry of Education. Student Behavior [Internet]. Toronto (ON): 2018. [cited 2021 April 19]. Available from: http://www.edu.gov.on.ca/extra/eng/ppm/145.pdf</p>	<ul style="list-style-type: none"> ■ Twenty-six page policy memorandum on Progressive Discipline and Promoting and Supporting Positive Student Behaviour

RISK ASSESSMENT AND SCREENING

GOOD PRACTICE STATEMENT:

The expert panel recommends that health providers assess 2SLGBTQI+ people for factors that may place them at increased risk of particular health conditions. Health providers are to follow established screening guidelines as available and based on a persons' current anatomy.

This is a good practice statement that does not require application of the GRADE system (13). There are many established guidelines currently available for health providers to screen for a variety of health conditions and a systematic review of the literature was not deemed necessary or feasible for this BPG. However, health providers need to be aware of these guidelines in order to provide comprehensive care to 2SLGBTQI+ people. This good practice statement is applicable to all practice settings where persons may be screened or referred for screening, in particular in community and primary care settings.

Screening guidelines are to be followed where available and based on person's anatomy and relevant organs present. It is recommended that health providers conduct an assessment of risk factors with 2SLGBTQI+ people as a part of routine primary care or where medically appropriate and relevant. **Table 15** provides an overview of specific health conditions and available screening guidelines. Established screening guidelines are available for cervical, chest or breast, colorectal and lung cancers, diabetes, hypertension, and **Sexually Transmitted and Blood Borne Infections (STBBIs)**^G. A person's preferences on language related to screening, need to be followed. See caution box below.



Caution: Be aware of the gendered or binary language used for screening, particularly for many cancers. Use inclusive language. For example, use “chest” or “upper body” instead of “breast”. Simply name the involved organ instead of referring to female reproductive cancer.

See also **Recommendation 1.0** on inclusive language.

Growing evidence suggests that 2SLGBTQI+ people may experience risk factors that are associated with higher rates of some chronic conditions and STBBIs. These risk factors are due to structural stigma and discrimination, social determinants of health and minority stress. Canadians who identify as gay, lesbian or bisexual are three times more likely to experience discrimination than their heterosexual counterparts (157). The sexual stigma and gender identity stigma experienced by 2SLGBTQI+ people lead to discriminatory practices in the health system such as poor communication or a lack of knowledge about 2SLGBTQI+ health (157). Downstream, this can lead to poorer health outcomes such as the risk of STBBIs and increased rates of mental health conditions (157).

Compared to the overall Canadian population, 2SLGBTQI+ people are medically **underserved**^G and experience greater unmet health service needs (70, 158). Forty-five per cent of trans Canadians report unmet health service needs, roughly ten times that of the cisgender population (36). Overall, 2SLGBTQI+ people are less likely to be up-to-date on screening or to receive necessary or appropriate screening from their health provider than their cisgender or

heterosexual counterparts (159). They may not access screening services due to discrimination, misinformation about the need for screening, or a lack of access to primary care providers in general (159). Additionally, access to care can be affected by structural and social risk factors such as ethnicity, education and income level, geographic isolation, immigrant status, knowledge and cultural beliefs as well as real or perceived discrimination (160).

Certain chronic diseases appear earlier in 2SLGBTQI+ people and the accumulation of stress may contribute to this earlier onset (14). For cancer specifically, 2SLGBTQI+ people may experience care and access to care differently (161). For example, systemic discrimination may lead to care refusals or delayed cancer treatment (161). Trans and non-binary people can present with any of the same conditions as cisgender people and require screening, care and prevention but a slightly different approach may be needed for care, such as with cervical cancer screening and STBBI screening and sexual history (81).



Table 15: Specific Conditions and Relevant Screening Guidelines

CONDITION	RELATED EVIDENCE	RELEVANT SCREENING GUIDELINES	GUIDELINE QUALITY SCORE**
CANCER			
Anal cancer	Men who have sex with men (MSM) ⁵ have an anal cancer rate of 45 per 100,000 compared with 1.5 to 2 per 100,000 for the general population (14). Anal cancer is also associated with HPV infection (14, 161). The European AIDS Clinical Society Guidelines recommend the use of digital rectal examination with or without an anal pap test every one to three years in HIV positive men who have sex with men and people with HPV dysplasia (162).	European AIDS Clinical Society. <i>EACS Guidelines: Version 10.1 October 2020</i> . Retrieved from https://www.eacsociety.org/files/guidelines-10.1.finalsept2020.pdf	4
Cervical cancer	Anyone with a cervix can be affected by cervical cancer. Trans and non-binary people with a cervix should be screened following the Cancer Care Ontario guidelines (65). Lesbian, bisexual, queer and other women who have sex with women need to be screened for cervical cancer over the age of 21* and if they have ever been sexually active with anyone of any gender (163). * Note: that this guidance will be changing to beginning at age 25 in the near future (164)	Cancer Care Ontario. Overarching Policy for the Screening of Trans People. 2019. Available from: https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/61546	4
		Sherbourne Health. Guidelines for Gender-Affirming Primary Care with Trans and Non-binary Patients. 2019. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/woocomerce_uploads/2019/12/Guidelines-FINAL-Dec-2019-iw2oti.pdf	4

CONDITION	RELATED EVIDENCE	RELEVANT SCREENING GUIDELINES	GUIDELINE QUALITY SCORE**
Chest or breast cancer	As for all individuals, 2SLGBTQI+ people need to be screened for chest or breast cancer regardless of transition status and birth-assigned sex. Lesbian and bisexual women have higher rates of chest or breast cancer than heterosexual women (70). Trans women and non-binary people who have a history of five or more years of gender-affirming hormone therapy may also be at increased risk of chest or breast cancer (65). Trans men who have not undergone transition-related chest surgery require the same screening as cisgender women (165). Trans men may still be at risk of chest or breast cancer after transition-related chest surgery (165).	<p>Cancer Care Ontario. Overarching Policy for the Screening of Trans People. 2020. Available from: https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/61546</p> <p>Canadian Task Force on Preventive Health Care. Recommendations on screening for breast cancer in average-risk women aged 40–74 years, CMAJ. 2011 Nov 22;183(17):1991-2001. * Available from: https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/38486</p> <p>Sherbourne Health. (2019). Guidelines for Gender-Affirming Primary Care with Trans and Non-binary Patients. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2019/12/Guidelines-FINAL-Dec-2019-iw2oti.pdf</p>	4
Colorectal cancer	As with everyone, 2SLGBTQI+ people need to be screened for colorectal cancer.	<p>Cancer Care Ontario. Colorectal Cancer Screening in Average Risk Populations: Evidence Summary. 2015 * Available from: https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/2101</p>	6
Lung cancer	Due to societal factors, people who identify as lesbian, gay and bisexual have higher smoking rates than their heterosexual counterparts (69).	<p>Canadian Task Force on Preventive Health Care Recommendations on screening for lung cancer CMAJ, April 2016 188 (6) 425-432; DOI: 10.1503/cmaj.151421 Available from: https://www.cmaj.ca/content/188/6/425 *</p>	7

RECOMMENDATIONS

RECOMMENDATIONS

CONDITION	RELATED EVIDENCE	RELEVANT SCREENING GUIDELINES	GUIDELINE QUALITY SCORE**
OTHER (NON-CANCER) CHRONIC CONDITIONS			
Cardiovascular disease	<p>Some studies have found increased morbidity and mortality from myocardial infarction and stroke in trans men compared with cisgender men, however these studies did not adjust for a number of risk factors including tobacco use, obesity, and diabetes (166).</p> <p>Tobacco use in combination with estrogen therapy is associated with an increased risk of venous thromboembolism (166).</p>	<p>Sherbourne Health. (2019). Guidelines for Gender-affirming Primary Care with Trans and Non-binary Patients. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2019/12/Guidelines-FINAL-Dec-2019-iw2oti.pdf</p>	4
Hypertension	<p>As with all adults, regular screening of blood pressure is recommended (167).</p>	<p>Lindsay P, Gorber SC, Joffres M, Birtwhistle R, McKay D, Cloutier L. Recommendations on screening for high blood pressure in Canadian adults. Canadian Family Physician. 2013 Sept. 1;59(9):927-33. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3771717/pdf/0590927.pdf</p>	6

CONDITION	RELATED EVIDENCE	RELEVANT SCREENING GUIDELINES	GUIDELINE QUALITY SCORE**
<p>Osteoporosis and bone health</p>	<p>All individuals should be offered bone mineral density testing over the age of 65 (168). Screening for additional risk factors for osteoporosis should begin at 50 for individuals including those who smoke, are HIV-positive, have a low body weight or have a history of fractures (168).</p> <p>Trans and non-binary people should be screened according to these national guidelines except in some unique circumstances. Bone support is adequate in trans people maintained on adequate hormone therapy (165). For transfeminine⁶ people, earlier screening may be considered for those who have undergone orchiectomy and have been on low-dose or no hormones for any significant length of time (i.e., > 2 years) (165). Screening may also be considered for those who have been on anti-androgens or a GnRH analogue for a significant length of time without the co-administration of exogenous estrogen (165). For transmasculineG people, earlier screening should be considered for those who have undergone oophorectomy and have been on low-dose or no exogenous testosterone for any significant length of time (i.e., > 2 years) (165).</p>	<p>Sherbourne Health. (2019). Guidelines for Gender-affirming Primary Care with Trans and Non-binary Patients. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2019/12/Guidelines-FINAL-Dec-2019-iw2oti.pdf</p> <p>Papaioannou A, Morin S, Cheung AM, Atkinson S, Brown JP, Feldman S, et al. 2010 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada: summary. CMAJ. 2010 Nov 23;182(17):1864-73 *</p>	<p>4</p> <p>6</p>
<p>Type 2 diabetes</p>	<p>Smoking, as well as being overweight or obese, are some of the many established risk factors for type 2 diabetes (169). Due to societal factors, people who identify as lesbian, gay and bisexual have higher smoking rates than their heterosexual counterparts (69). Lesbian and bisexual women have higher self-reported obesity rates than their heterosexual counterparts (69).</p> <p>Recommendations for diabetes screening in trans people (regardless of hormone status) do not differ from current national guidelines (166).</p>	<p>Diabetes Canada Clinical Practice Guidelines Expert Committee. <i>Diabetes Canada 2018 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada</i>. Can J Diabetes. 2018;42(Suppl 1):S1-S325. Available from: https://guidelines.diabetes.ca/cpg/ *</p> <p>Canadian Task Force on Preventive Health Care. Recommendations on screening for type 2 diabetes in adults. CMAJ. 2012 Oct 16;184(15):1687- 96. Available from: https://www.cmaj.ca/content/cmaj/184/15/1687.full.pdf *</p>	<p>5</p> <p>6</p>

RECOMMENDATIONS

RECOMMENDATIONS

CONDITION	RELATED EVIDENCE	RELEVANT SCREENING GUIDELINES	GUIDELINE QUALITY SCORE**
MENTAL HEALTH AND SUBSTANCE USE			
<p>Depression, anxiety and substance use</p>	<p>Lesbian, gay and bisexual individuals are more likely to experience depression, anxiety, and substance abuse than their heterosexual counterparts (68). Social stresses experienced in sexual minority populations, such as stigma, prejudice and discrimination, in addition to internalized feelings of negativity and expectations of rejection, are thought to be part of the explanation for these differences in risk for mental health (68).</p> <p>According to the Trans PULSE project, the prevalence of depression among trans Ontarians was estimated to be over 60 per cent (170, 171).</p> <p>Sherbourne Health recommends routine screening of trans people for depression, anxiety, gender dysphoria and experiences/impacts of transphobia (165).</p>	<p>Sherbourne Health. (2019). Guidelines for Gender-affirming Primary Care with Trans and Non-binary Patients. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2019/12/Guidelines-FINAL-Dec-2019-iw2oti.pdf</p>	<p>4</p>
<p>Suicide</p>	<p>Lesbian, gay and bisexual individuals are more likely to experience suicidality than their heterosexual counterparts (68).</p> <p>According to the Trans PULSE Canada survey, within the last year, 31 per cent of trans individuals thought about suicide and six per cent attempted suicide (36).</p> <p>Sherbourne Health recommends routine screening of trans people for suicidal ideation and self-harm (165).</p>	<p>Sherbourne Health. (2019). Guidelines for Gender-affirming Primary Care with Trans and Non-binary Patients. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2019/12/Guidelines-FINAL-Dec-2019-iw2oti.pdf</p> <p>See also in supporting resources below: Suicide Risk Assessment Guide created by the Ontario Hospital Association and Canadian Patient Safety Institute</p>	<p>4</p>

CONDITION	RELATED EVIDENCE	RELEVANT SCREENING GUIDELINES	GUIDELINE QUALITY SCORE**
SEXUAL HEALTH			
Sexually transmitted blood-borne infections	<p>Health providers should assess risk for STBBIs based on the person's sexual behaviors and current anatomy. STBBI screening is needed for all sexually active persons regardless of identity. This screening is necessary across the lifespan including 2SLGBTQI+ older adults.</p> <p>MSM are overrepresented among HIV cases and are at a much higher risk of being infected than anyone else in Canada (House of Commons of Canada, 2019). The Centers for Disease Control and Prevention recommends that MSM be screened at least annually for HIV, syphilis, chlamydia and gonorrhea (172) or more frequently based on a risk assessment. Screening for women who have sex with women and for trans and non-binary people is dependent on risk factors such as sexual activity and partners (172).</p> <p>Because trans people differ in hormone use, history of gender-affirming surgical procedures, and patterns of sexual behavior, providers should avoid making any assumptions about presence or absence of specific anatomy, sexual orientation, or sexual practices (166).</p>	<p>Public Health Agency of Canada Canadian Guidelines on Sexually Transmitted Infections 2016 Available from: https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines.html *</p> <p>Workowski KA, Bolan GA. Sexually transmitted diseases treatment guidelines, 2015. MMWR. Recommendations and reports: Morbidity and mortality weekly report. Recommendations and reports. 2015 Jun 5;64(RR-03):1. Available from: https://www.cdc.gov/std/tg2015/</p>	4
Pregnancy	<p>Any person with a uterus and ova may become pregnant (165).</p>	<p>Sherbourne Health. (2019). Guidelines for Gender-affirming Primary Care with Trans and Non-binary Patients. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2019/12/Guidelines-FINAL-Dec-2019-iw2oti.pdf</p> <p>Sherbourne Health. (2019). Guidelines for Gender-affirming Primary Care with Trans and Non-binary Patients. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2019/12/Guidelines-FINAL-Dec-2019-iw2oti.pdf</p>	4

*Please note these guidelines are not specifically tailored to the needs of 2SLGBTQI+ people and will need to be applied with an affirming approach.

** **Note:** The quality of all guidelines included were appraised following the AGREE II tool (173). Maximum possible score is 7. Scores of 6 or 7 indicate a high quality guideline and scores of 4 or 5 indicate moderate quality. See further details in **Appendix F**.

RECOMMENDATIONS

Practice Notes

Considerations from the Expert Panel

- Screening and assessment needs to be delivered in a safe, sensitive, respectful and affirming manner and in alignment with **Recommendations 1.0** and **1.1** on communication strategies and person- and family-centred care principles (see also the RNAO BPG *Person- and family-centred care* (110)).
- Take an inclusive, non-judgmental sexual health history. The risk of STBBI is to be assessed in a non-judgmental way based on actions, organs and protective factors in order to combat stigma and discrimination. See supporting resources for discussion guide and details for taking a sexual health history.
- Health providers are to explain why they are asking screening questions, in particular questions about organs and sexual health.
- Be aware that many established screening guidelines may be framed from a cisnormative and heteronormative perspective. Health providers are to use their judgment and may need to use caution when applying existing guidelines in order to provide affirming, comprehensive care to 2SLGBTQI+ people.

Supporting Resources

Please see **Recommendation 3.0** for supporting resources related to cervical cancer screening.

RESOURCE	DESCRIPTION
<p>Anal Cancer Screening in High-Risk Populations: A Review of the Clinical Utility, Diagnostic Accuracy, Cost-Effectiveness, and Guidelines [Internet]. Ottawa: CADTH; 2019 Oct. (CADTH rapid response report: summary with critical appraisal). Available from: https://www.cadth.ca/sites/default/files/pdf/htis/2019/RC1212%20Anal%20Cancer%20Screening%20Update%20Final.pdf</p>	<ul style="list-style-type: none"> ■ Review of current anal cancer screening guidelines
<p>Cancer screening in LGBT communities. In: Canadian Cancer Society [Internet]. Canada: 2021. [cited 2021 April 16]. Available from: https://www.cancer.ca/en/prevention-and-screening/reduce-cancer-risk/find-cancer-early/screening-in-lgbtq-communities/?region=on</p>	<ul style="list-style-type: none"> ■ Information for the public and health providers on screening for the LGBTQ community ■ Includes common questions from people about screening
<p>Canadian Public Health Association. Discussing sexual health, substance use and STBBIs: A guide for service providers [Internet]. Ottawa (ON): c2017 [cited 2021 April 16]. Available from: https://www.cpha.ca/discussing-sexual-health-harm-reduction-and-stbbis-guide-service-providers</p>	<ul style="list-style-type: none"> ■ Discussion guide for discussing sexual health and substance use

RESOURCE	DESCRIPTION
<p>Canadian Public Health Association. Organizational Assessment [Internet]. Ottawa (ON): c2017 [cited 2021 April 16]. Available from: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/orgtool_e.pdf</p> <p>Additional Resources. In: Canadian Public Health Association [Internet]. Ottawa (ON): c2017 [cited 2021 April 16]. Available from: https://www.cpha.ca/resources</p>	<ul style="list-style-type: none"> ■ Organizational assessment tool for stigma related to STBBIs ■ Additional resources for health providers for initiatives such as chronic disease prevention and management and smoking cessation
<p>Perlman CM, Neufeld E, Martin L, Goy M, & Hirdes JP (2011). Suicide Risk Assessment Inventory: A Resource Guide for Canadian Health care Organizations. Toronto, ON: Ontario Hospital Association and Canadian Patient Safety Institute. Available from: https://www.patientsafetyinstitute.ca/en/toolsResources/SuicideRisk/Documents/Suicide%20Risk%20Assessment%20Guide.pdf</p>	<ul style="list-style-type: none"> ■ Suicide Risk Assessment Guide created by The Ontario Hospital Association and Canadian Patient Safety Institute
<p>Public Health Agency of Canada Bacterial STI testing Tip Sheet. In: Public Health Agency of Canada [Internet]. Ottawa (ON): c2019 [cited 2021 April 16]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/diseases-conditions/sti/64-02-18-2248-STI-Recommendations-Tip-Sheet-EN-Final.pdf</p>	<ul style="list-style-type: none"> ■ Reference sheet for health providers for bacterial STI screening ■ Tool is based on the Canadian Guidelines on STIs (PHAC)
<p>Bacterial STI Quick Reference Sheet. In: Public Health Ontario [Internet]. Toronto (ON): c2019. [cited 2021 April 16]. Available from: https://www.publichealthontario.ca/-/media/documents/bacterial-sti-quick-reference.pdf?la=en</p>	<ul style="list-style-type: none"> ■ Reference sheet for health providers for testing options for bacterial STI screening ■ Tool is based on the Canadian Guidelines on STIs (PHAC)

RESOURCE	DESCRIPTION
<p>Rainbow Health Ontario. LGBTQ Cancer Factsheet [Internet]. Toronto (ON): c2016. [cited 2021 April 16]. Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/2016/07/RHO_FactSheet_LGBTQCANCER_-07.31.16.pdf</p>	<ul style="list-style-type: none"> ■ Factsheet for health providers detailing current issues and facts around LGBTQ populations and cancer
<p>Trans Care BC. Gender Inclusive Language. In: Trans Care BC [Internet]. (BC): n.d. [cited 2021 April 16]. Available from: http://www.phsa.ca/transcarebc/Documents/HealthProf/Gender_Inclusive_Language_Clinical.pdf</p>	<ul style="list-style-type: none"> ■ Language guide to working with trans and non-binary people in a respectful, professional and inclusive manner ■ Includes words to use instead of gendered terms (e.g. upper body instead of breast or chest)
<p>Standards of Care Version 7. In World Professional Association for Trans Health: 2012 [Internet]. [cited 2021 april 16] Available from: https://www.wpath.org/publications/soc</p>	<ul style="list-style-type: none"> ■ World Professional Association for Transgender Health Standards of Care ■ Provides guidance on trans health and screening in multiple languages

RECOMMENDATION 3.0:

The expert panel recommends health providers ensure the comfort and safety of lesbian and bisexual women and trans and non-binary people during cervical cancer screening.

Strength of the recommendation: Strong

Certainty of the evidence of effects: Very low

Confidence in evidence: Moderate

Discussion of Evidence

Benefits and Harms

Qualitative evidence suggests that ensuring the comfort and safety of lesbian and bisexual women, as well as trans and non-binary people, during cervical cancer screening may support positive experiences of care where persons feel safe (107, 174-176). One systematic review of qualitative studies and three additional qualitative studies explored 2SLGBTQI+ peoples' experiences of risk screening in relation to their perceived level of support, comfort and safety. All studies found that when health providers ensured peoples' comfort and safety during the cervical screening, people reported positive experiences of care (107, 174-176). No quantitative evidence was identified.

Lesbians, bisexual women and trans and non-binary people experienced greater support and comfort during cervical cancer screening when health providers recognized their vulnerability during screening and the possibility of physical discomfort, and affirmed their identity (107, 174-176). Transmasculine persons reported feeling dehumanized and de-individualized, and experiencing gender dysphoria during cervical cancer screening; they were more likely to seek cervical cancer screening when providers were knowledgeable, respectful or accepting of their transmasculine status (174-176). When health providers fail to acknowledge sexual identity, sexism and racism, Black lesbians, bisexual and queer (LBQ) women experience barriers to cervical cancer screening that include heterosexism, racism, classism and overt health provider discomfort (108).

Transmasculine people identified three potential harms that could occur during cervical cancer screening. Participants described gender dysphoria, lack of personal privacy, feelings of vulnerability, and physical pain or discomfort as potential harms (174-176). Several transmasculine participants in one study reported previous negative cervical cancer screening experiences including discrimination and feelings of trauma (176). Lesbian and bisexual women described the potential harms of heteronormative assumptions when health providers failed to acknowledge their sexual identity or their fear and discomfort during cervical cancer screening, in what is already a vulnerable interaction with a health provider (107).

Please refer to the “Practice Notes” for further details on how to ensure comfort and safety during cervical cancer screening for lesbian and bisexual women and trans and non-binary persons.

The overall confidence in the evidence for qualitative findings was moderate due to minor concerns over methodological limitations of the individual studies and minor concerns over coherence. The certainty in the evidence is very low due to concerns regarding how the individual studies were conducted, the range in the interventions described and the inability to identify an estimate of effect.

For more detailed information of the impact of the intervention (cervical cancer screening for lesbian and bisexual women and trans and non-binary persons) on the reported outcome and the grading of the evidence, please refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Values and Preferences

Transmasculine participants affirmed the importance of taking care of their health and the health of their sexual partner, and generally felt that cervical cancer screening was an effective screening test to prevent a serious disease (175). Some participants felt preventive screening was particularly important due to the lack of data about cervical cancer risk while on masculinizing hormones (testosterone) (175).

Health Equity

This evidence was from Black LBQ people and transmasculine men. Transmasculine people expressed a desire for cervical cancer screening tests to be modified to their needs (175). Black LBQ women described how their experiences of cervical cancer screening were shaped not only by their sexual identity but also by the colour of their skin (107). Participants described the potential for heterosexism, racism and classism during interactions with health providers (107).

Panel Justification for Recommendation

This recommendation could have been a good practice statement however, the expert panel agreed that it was important to pose a recommendation question to examine the impacts of risk screening for 2SLGBTQI+ people through a systematic review. There may be important benefits from ensuring the comfort and safety of lesbian and bisexual women and trans and non-binary people during cervical cancer screening but the evidence is uncertain. The certainty in evidence of effects was very low and the confidence was moderate. The expert panel determined that lesbian and bisexual women and trans and non-binary people would value health providers ensuring that client comfort and safety is a priority during cervical cancer screening and gave priority to the lived experiences captured in the qualitative studies. The expert panel therefore determined that this recommendation be strong.

Practice Notes

Considerations from the Expert Panel:

- Health providers may need to provide health teaching on the need for cervical cancer screening for lesbian women and trans and non-binary people with a cervix. Historically, there was an incorrect belief that lesbians did not need cervical cancer screening at all, and some health providers and community members may still be under this impression.
- Be aware that LB women and trans and non-binary people may have previous traumatic experiences during cervical cancer screening. Understand that experiences of heterosexism, stigma, discrimination and racism create barriers to accessing care.

Details from the Evidence

- Health provider communication style and demeanor is critically important (107). Ensuring a comforting and safe experience involves health providers not making heteronormative assumptions about women's sexual orientation. Further, it involves health providers asking non-heterosexist questions about sexual activity, sexual partners (both past and current), and sexual behavior (107).

- Completing comprehensive, non-judgmental sexual histories would help facilitate sexual orientation disclosure so that women are not burdened with having to reveal their sexual orientation or correct providers' heteronormative assumptions (107).
- Transmasculine people appreciated health providers who were willing to modify the cervical cancer screening exam. Possible modifications included:
 - Allowing person to self-insert the speculum (174, 175)
 - Prescribing anti-anxiety medications (175)
 - Instructing them on how to perform exam at home with a partner (174)
 - Performing HPV tests to inform the need for speculum examination (174)

Supporting Resources

RESOURCE	DESCRIPTION
<p>Canadian Cancer Society. Cancer screening in LGBT communities. In: Canadian Cancer Society [Internet]. Canada: 2021. [cited 2021 April 16]. Available from: https://www.cancer.ca/en/prevention-and-screening/reduce-cancer-risk/find-cancer-early/screening-in-lgbtq-communities/?region=on</p>	<ul style="list-style-type: none"> ■ Screening for chest/breast, cervical and colorectal cancer in LGBTQ communities ■ Provides links to additional LGBTQ cancer screening resources
<p>Cancer Care Ontario. Update for cervical cancer screening by age. In: Cancer Care Ontario [Internet]. Toronto (ON): 2020 [cited 2021 April 16]. Available from: https://www.cancercareontario.ca/en/node/68141</p> <p>Cancer Care Ontario. Addressing cancer screening inequities in transgender people. In: Cancer Care Ontario [Internet]. Toronto (ON): 2019 [cited 2021 April 16]. Available from: https://www.cancercareontario.ca/en/cancer-facts/new-policy-addresses-cancer-screening-inequities-transgender-people</p>	<ul style="list-style-type: none"> ■ Updated guidance on cervical cancer screening by age ■ 2019 policy for health providers and addressing cancer screening inequities in trans people
<p>Hamilton Trans Health Coalition. Trans Pap 101. Hamilton (ON) 2020. [cited 2021 April 29] Available from: https://hamiltontranshealth.ca/trans-pap-101/</p>	<ul style="list-style-type: none"> ■ A “how-to” video for healthcare students & providers on providing trans competent cervical cancer screening.
<p>Potter, M., LGBT Family Health Team, Sherbourne Health Centre. Tips for Providing Paps for Trans Men. Toronto (ON) 2015 [cited 2021 April 29] Available from: https://www.rainbowhealthontario.ca/wp-content/uploads/2020/04/Tips_Paps_TransMen.pdf</p>	<ul style="list-style-type: none"> ■ Thirteen practical tips for providing cervical cancer screening for transmasculine individuals

RECOMMENDATION 3.1:

The expert panel suggests health providers promote access to HIV-STBBI screening for 2SLGBTQI+ people in collaboration with 2SLGBTQI+ community partners through:

- media campaigns; (certainty: low) and/or
- outreach settings. (certainty: very low)

Strength of the recommendation: Conditional

Certainty of the evidence of effects: See above

Confidence in evidence: Not applicable

Discussion of Evidence

Benefits and Harms

Media campaigns

Evidence suggests media campaigns that are developed in collaboration with 2SLGBTQI+ community partners may increase the number of people who access HIV-STBBI screening (177-182). All but one study developed interventions to improve access to HIV and STBBI screening in collaboration with 2SLGBTQI+ community partners.

The types of media campaigns included a social marketing campaign encouraging HIV and syphilis testing among high risk gay and bisexual men (180), a social media and internet based campaign that included mobile screening targeting Black and Latino sexual minority youth (179), a social media and chat intervention promoting HIV testing among MSM (177), an app promoting HIV-STBBI testing among MSM (178, 181) and a multicomponent intervention addressing homophobia and promoting HIV testing (182). In one study, participants reported the risk of further stigmatization of Black and Latino sexual minority youth during media campaigns (179). For further details on how the media campaigns were carried out, refer to the “Practice Notes”.

The overall certainty of evidence to support use of media campaigns for screening was low due to limitations in how the studies were conducted. For more detailed information on the impact of the intervention (accessing screening via media campaigns), on the reported outcome and the grading of the evidence, please refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Screening at outreach settings

Evidence suggests screening campaigns that are developed in collaboration with 2SLGBTQI+ community partners may improve access to HIV and STBBI screening at outreach settings (such as special events), and may increase the number of 2SLGBTQI+ people that access screening. Three studies examined the effect on the number of 2SLGBTQI+ people who accessed screening for HIV-STBBI when screening was promoted at outreach settings. One study examined the effect of a mobile testing service with a media campaign targeting Black and Latino sexual minority youth and reported an increase in the number of people accessing testing (179). The second study examined the effect of a do-it-yourself (DIY) HIV-STBBI postal testing kit and a sexual health nurse positioned at a sauna (bathhouse) offering outreach STBBI screening (183). The study reported mixed results, where more people accessed blood HIV screening through the sauna outreach nurse than the self-testing postal service (183). However, more people accepted chlamydia or gonorrhea screening through the self-testing postal service than through the outreach

nurse (183). The last study examined the effect of a pop-up HIV testing service targeting gay and bisexual men and reported an increase in the number of people that access HIV testing (184). In one study, participants noted the risk of additional stigmatization of Black and Latino youth from messaging at outreach settings and also reported being flooded with safe sex messaging (179). Please refer to the “Practice Notes” for further details on the use of screening at outreach settings for access to HIV-STBBI testing from the evidence.

The overall certainty of evidence to support use of outreach settings for screening was very low due to limitations in how studies were conducted and inconsistency in the results. For more detailed information on the impact of the intervention (accessing HIV-STBBI screening at outreach settings) on the reported outcome and the grading of the evidence, please refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Values and Preferences

The evidence indicates that access to HIV-STBBI screening through media campaigns was valued, however participants stressed the importance of their privacy and confidentiality during screening (179).

Health Equity

All of the included studies targeted populations of MSM or sexual minority youth (179, 180). One study adapted an existing media campaign to be more inclusive of Black and Latino sexual minority youth (179). Youth reported the possibility of the media campaign being perceived as stigmatizing (179). Further, messaging that emphasized high rates of HIV-STBBI infections among Black and Latino sexual minority youth were perceived as “scare tactics” that can stigmatize and offend those individuals they are trying to reach (179).

Expert Panel Justification for Recommendation

There may be benefits for some 2SLGBTQI+ people (MSM and sexual minority youth) from the use of media campaigns and screening at outreach settings to promote access to HIV-STBBI testing. The expert panel noted that the certainty of the evidence for accessing HIV-STBBI through media campaigns is low, and the certainty of the evidence for accessing HIV-STBBI through screening at outreach settings is very low. Additionally, the expert panel identified concerns about the potential for further stigmatizing 2SLGBTQI+ people during media campaigns. The expert panel determined that not all 2SLGBTQI+ persons would value access to HIV-STBBI screening through media campaigns, when established HIV-STBBI screening resources are available for all persons. Therefore, the expert panel determined that this recommendation be conditional.

Practice Notes

Considerations from the Expert Panel

- It is critical that HIV-STBBI screening is accessible and available to all persons. This recommendation focuses on media campaigns, screening at 2SLGBTQI+ special events, and outreach settings for those not already accessing HIV-STBBI screening and for any 2SLGBTQI+ persons who may be hard to reach. The latter can include sex workers, those who use substances, or people at increased risk due to other social determinants of health. Refer also to the **Good Practice Statement** on risk assessment on page 66.
- To normalize screening it is important to include images of heterosexual couples, in addition to lesbian or gay couples, in media campaigns.

Table 16: Practice Notes from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
MEDIA CAMPAIGNS	
Campaign development	<p>Media campaigns were developed with the consultation and collaboration of 2SLGBTQI+ community members. Examples of 2SLGBTQI+ community involvement in media campaign development include:</p> <ul style="list-style-type: none"> ■ A working group of researchers, 2SLGBTQI+ community members and the Ontario Ministry of Health developed a social marketing campaign to reach a broad range of MSM in local communities (180). ■ The media campaign was launched with the support of the Ontario Ministry of Health, the Ontario HIV Treatment Network and public health partners in Toronto and Ottawa (180) ■ In China, crowdsourcing and public contests targeting primarily youth and MSM were used to select images used in the testing campaign (177). The intervention was supported by local center for disease control and MSM community based organizations (177). ■ Also in China, the research team worked in collaboration with staff from a community-based, MSM focused, HIV prevention organization to develop the intervention (178). ■ The stigma and homophobia intervention CHHANGE was a partnership among three organizations: Gay Men of African Descent (GMAD), Brooklyn Men [K]onnect (BMK, a program of Bridging Access to Care), and the New York Blood Center (NYBC) (182). ■ Campaign messaging (campaign website, posters ,wall projections, banners, newspaper and magazine and radio advertisements) was reviewed for community acceptability by conducting a diverse set of focus groups with gay men (180) and Black or Latino sexual minority youth (179) before the release of the media campaign. Messaging was reviewed by local MSM community-based organizations prior to release (177). Interviews were conducted with community members at the start of intervention development as well as to review the messages (178). <p>One intervention in Spain was developed in collaboration with the local public health agency (181).</p>

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Campaign messaging	<p>The primary message from the majority of campaigns was designed to increase the testing uptake and to promote routine STBBI testing. One campaign's primary message was to decrease homophobia and HIV stigma with a secondary aim to increase HIV testing (182). Messaging included:</p> <ul style="list-style-type: none"> ■ providing HIV-STBBI information (177, 179, 180, 182) ■ HIV screening (177, 178, 180-182) ■ STBBI screening (180, 181) ■ open communication with partners and providers (179) ■ promoting links to services (179, 181, 182) ■ addressing HIV stigma and homophobia (182)
Campaign communication	<p>To support widespread messaging the following methods were used:</p> <ul style="list-style-type: none"> ■ A dedicated website (180) ■ Online advertisement (179, 180) ■ An app (177, 178, 181) ■ Social media (179) ■ Billboards, posters and a bus shelter ad (180, 182) ■ Newspapers, magazines and radio advertisements (180) ■ Supplemental support from the Toronto's Hassle Free Clinic by campaign promotion through their social media outreach, and notices posted on other online classified sites (180) <p>Media targeted to high impact areas such as posters in gay neighborhoods, radio advertisements on gay radio stations and messages on MSM dating apps.</p>
OUTREACH SETTINGS	
Campaign development	<p>Partnerships with local health promotion agencies:</p> <ul style="list-style-type: none"> ■ National Health Service (UK) partnered with a local health promotion charity to develop a nurse-delivered outreach screening (HIV, STBBI) service (183) ■ New South Wales Ministry of Health (Australia) partnered with HIV community organizations to increase access to rapid HIV testing via mobile community-based sites during World AIDS Day events (184).

Supporting Resources

RESOURCE	DESCRIPTION
African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) [Internet]. Toronto (ON): 2021 [cited 2021 April 16]. Available from: http://accho.ca/	<ul style="list-style-type: none"> Resources for African and Caribbean persons in Ontario through HIV prevention, education, advocacy, research, treatment, care and support for African, Caribbean and Black communities.
Alliance for South Asian AIDS Prevention [Internet]. Toronto (ON): 2021[cited 2021 April 16]. Available from: https://www.asaap.ca/	<ul style="list-style-type: none"> A variety of resources on AIDS prevention for the South Asian Community
Black Coalition for AIDS Prevention [Internet]. Toronto (ON): 2021 [cited 2021 April 16] http://blackcap.ca/	<ul style="list-style-type: none"> Health Promotion and support services for the African, Caribbean and Black communities
Canadian AIDS Society [Internet] Ottawa (ON) [cited 2021 April 30] https://www.cdnaids.ca/	<ul style="list-style-type: none"> Directory of resources, organizations and events related to AIDS care and prevention in Canada
Canada's AIDS Treatment Information Exchange (CATIE) [Internet]. Toronto (ON): 2021 [cited 2021 April 16]. https://www.catie.ca/	<ul style="list-style-type: none"> Canadian source for information on HIV and Hepatitis C
Gay Men Sexual Health (GMSH) Alliance [Internet]. (ON): 2021 [cited 2021 April 16]. Available from: www.gmsh.ca	<ul style="list-style-type: none"> Resource for gay men's sexual health including information on HIV/STBBIs The Sex You Want is a campaign of GMSH, the Gay Men's Sexual Health Alliance, which focuses on STBBIs amongst men who have sex with men (cis and trans) in Ontario.
National Collaborating Centre for Infectious Diseases [internet]. Winnipeg (MB): 2021 [cited 2021 April 16]. Available from: https://nccid.ca/project-stream/hiv-stbbis/	<ul style="list-style-type: none"> HIV/STBBI Prevention and control LGBTQ content on point of care testing in Canada and additional LGBTQ content geared to health providers
Ontario Aboriginal HIV/AIDS Strategy [Internet]. Toronto (ON): 2021 [cited 2021 April 16]. Available from: https://www.oahas.org/	<ul style="list-style-type: none"> Provides links to a variety of programs and support services including sexual health and testing information
Ontario Women and HIV/AIDS initiative [Internet]. (ON): 2021 [cited 2021 April 16]. Available from: http://www.whai.ca/	<ul style="list-style-type: none"> Women and HIV/AIDS Initiative resources for cis and trans women in Ontario

GROUP-BASED INTERVENTIONS

RECOMMENDATION 4.0:

The expert panel suggests health-service organizations implement specialized 2SLGBTQI+ clinical groups for health promotion and chronic disease prevention and management.

Strength of the recommendation: Conditional

Certainty of the evidence of effects: Very low

Confidence in evidence: Moderate

Discussion of Evidence

Benefits and Harms

Clinical groups for health conditions are group-based interventions focused specifically on the management of health conditions (e.g. diabetes, anxiety) or prevention and/or management for behavioural risk factors for chronic disease (e.g. tobacco cessation, weight loss). Clinical groups may improve outcomes in LGBTQ persons such as feelings of social support, improved self-care practices and enhanced self-efficacy, but the evidence is uncertain (185-213). The evidence highlights how these interventions were delivered via a group-based format using a variety of delivery modes (e.g. in person, online, telephone or social networking). They were frequently delivered by peer facilitators using strength or **empowerment-based approaches**^G. The clinical groups were tailored to specific LGBTQ populations and age groups across the lifespan. No harms related to these interventions were reported in the evidence. Please refer to the “Practice Notes” in **Table 16** for further characteristics of clinical group interventions in the studies.

In qualitative studies, trans and non-binary persons experiencing reproductive cancer care reported that peer networking in a clinical group was a primary source of cancer information and functioned as a support and knowledge network that informed their decision-making (213). Gay and bisexual men receiving treatment for prostate cancer who participated in an online or in-person clinical group experienced less social isolation and a greater sense of community. Mature lesbian and bisexual women who participated in a healthy weight clinical group experienced less social isolation, improved self-efficacy and sense of community. Men who have sex with men (MSM) experienced improved access to HIV information and HIV prevention strategies (193, 214, 215). Participants in an online strengths-based support group for young Black MSM experienced improved resiliency, social support and HIV informational support (189). There were no harms reported in the evidence related to these interventions.

The confidence in the evidence was moderate due to limitations in how the studies were conducted. The certainty of the evidence was very low due to limitations in study design and the use of different tools to measure outcomes across these studies. For more detailed information of the impact of the intervention (clinical groups) on the reported outcomes and the grading of the evidence, please refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Values and Preferences

The evidence indicates that people valued clinical groups that were tailored to specific 2SLGBTQI+ population needs and settings and delivered in a safe space (192, 196, 197, 200, 204, 206, 209-211, 213-216). Clinical group participants preferred when groups were tailored to community norms and participants’ language (215). Mature lesbian and

bisexual women valued participating in clinical groups for healthy weight for social support and having a space to connect with women with whom they shared similarities (215). Clinical groups providing a combined focus on sexual risk reduction and mental health may be preferable for HIV-positive individuals (216).

Health Equity

The majority of the clinical groups for health conditions targeted MSM and trans and non-binary people. The least examined 2SLGBTQI+ communities were lesbian and bisexual women. None of the study participants identified as Two-Spirit or intersex.

Gay and bisexual men and trans and non-binary people experiencing cancer care reported extremely limited access to tailored and gender-affirming cancer support groups and cancer health knowledge (193, 213). Access to nicotine replacement therapy for a tailored LGBT clinical intervention for smoking cessation was limited to those individuals who were able to pay for this resource (210).

The expert panel noted some health-service organizations may have challenges implementing clinical groups due to resource limitations or community size.

Expert Panel Justification of Recommendation

There may be benefits to tailored 2SLGBTQI+ clinical groups across the lifespan and no harms were identified. The expert panel determined that 2SLGBTQI+ people would value tailored clinical groups for health promotion and chronic disease prevention and management. The expert panel identified gaps in the evidence around both representation of the type of clinical conditions and the 2SLGBTQI+ people that are not well examined in the evidence.

The expert panel noted the certainty in the evidence for clinical groups was low or very low, the confidence in the evidence was moderate, and representation of certain 2SLGBTQI+ populations is absent. The guideline panel therefore determined that this recommendation be conditional.

Practice Notes

Considerations from the Expert Panel

- A number of chronic health conditions significantly impact 2SLGBTQI+ persons across the lifespan and the expert panel emphasized that health-service organizations (community and public health, primary care, out-patient clinics) should implement clinical groups that address health promotion and chronic disease management of 2SLGBTQI+ persons across the lifespan.
- Health providers should follow a structured process to determine the most relevant clinical groups and could consider starting with a survey to determine which groups of people would be most interested.
- Privacy and confidentiality is to be maintained regardless of group membership. Health providers are to be aware of the potential of people being “outed” based on group membership.
- Clinical groups for 2SLGBTQI+ are to be promoted along with other clinical groups to avoid stigmatization and exclusion.
- In cases where resources are lacking and specialized groups are not available, health service organizations are to consider the use of peer facilitators or empowerment-based approaches as alternative strategies to meet the health needs of 2SLGBTQI+ people.

Table 16: Practice Notes from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Stakeholder/ community involvement design factor	<p>Most studies involved the target population of the group-based intervention in the development of program. Examples of approaches to community involvement included:</p> <ul style="list-style-type: none"> ■ A staged approach was utilized to adapt and evaluate a behavioural HIV and STI prevention intervention with young adult trans MSM to examine their sexual health needs, and the concerns and stressors facing young trans MSM (194). ■ The MyPEEPS intervention was in part developed based on interviews conducted with a multiethnic sample of 21 young MSM (196). ■ Key informant interviews to acquire input from women who have sex with women (WSW) stakeholders that also included WSW health and social service providers (197). ■ Feedback from focus groups and a pilot group to refine the curriculum and intervention procedures (204). ■ A clinical group offered to Hispanic/Latino gay, bisexual and other MSM was developed based on preliminary data collection identifying the needs of this population (206). ■ The Sheroes intervention was developed in collaboration with transgender community members, and staff and members of a community advisory board. All included a majority of trans women of color (188).
Empowerment-based approach design factor	<p>The majority of the included studies utilized an empowerment-based approach to guide the clinical intervention delivery in order to improve participant confidence and self esteem and promote self-efficacy and safe behaviours. Examples of how an empowerment-based approach was used included:</p> <ul style="list-style-type: none"> ■ To develop motivation in young trans women (YTW) to protect themselves and to promote safe behavioral skills the approach included tailored HIV prevention content on environmental factors facing YTW such as secure housing, accessing medical care, obtaining employment and the lure of commercial sex work (191). ■ Clinical group offered to LB women over the age of 40 to improve their confidence and self esteem through promoting healthy body weight (while avoiding heterosexual norms for weight), acceptance of women of every size, realistic and achievable goals and addressing stressors that LB women face (211) ■ Clinical group on healthy eating and healthy sex for Black men who have sex with men (212). ■ Empowering examples of historical and current trans women of colour and the fostering of alliances among trans women through community building (188) ■ Empowerment theory^G informed a small group intervention for post-incarcerated Black MSM and women to improve self-care through HIV prevention education (187).

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
<p>Multi-component and multi-session design</p>	<p>All of the included studies provided intervention content that was tailored to the specific 2SLGBTQI+ population(s) described and consisted of multi-component and multi-session deliveries.</p> <p>Specific examples of multi-session designs include:</p> <ul style="list-style-type: none"> ■ Two-hour long in-person peer-led group-based interventions delivered across seven weeks by HIV positive gay men that included knowledge provision, motivation to help participants to identify their personal sexual health goals, resolve any ambivalence between their personal goals and their current behavior, and behavioural skills building, such as asserting oneself in sexual situations (195). ■ Six two-to-three hour sessions of a group-based intervention offered for LBQ women that provide an opportunity to learn about STIs, safer sex strategies and negotiation skills, to build community, and to combat sexual stigma through open discussions (197). ■ “Poz Talk” group sessions delivered in two two-hour workshops led by peer facilitators to provide social support and reinforce stress management and sexual risk reduction strategies (216) ■ Six two-hour small-group sessions over three weeks to address HIV risk (187) ■ Five weekly group sessions with trans women on gender pride, sexual risk reduction and surviving and thriving (188).
<p>Peer facilitators leading clinical groups</p>	<p>Most studies delivered the clinical group intervention with the use of peer facilitators.</p> <p>Peer health education was used in many studies focused on sexual health, including those on prevention of HIV and other STTBI prevention. Examples of specific strategies include:</p> <ul style="list-style-type: none"> ■ Providing peers as clinical group facilitators where peer facilitation roots the group in the community and promotes participants’ experiences of safety, comfort and a sense of community (215) ■ Peer facilitators leading the intervention delivery participated in the clinical group discussions and role-playing activities, providing the opportunity for implementation of new knowledge and enabling participants to practice new skills (206) ■ Peers delivered an HIV risk reduction intervention for at-risk urban MSM who regularly attend private sex events (186) ■ Peers delivered HIV and STBBI risk reduction intervention for post-incarcerated Black MSM and Black women (187).

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
<p>Access to clinical groups</p>	<p>The included studies provided access to the clinical groups via a variety of methods (in-person, online, social networking, telephone) to increase the reach of the clinical group intervention for 2SLGBTQI+ persons.</p> <p>Examples of strategies for promoting access to clinical groups included:</p> <ul style="list-style-type: none"> ■ Content delivered in-person at a community location (185-187, 190, 194) ■ Use of social networking (198) ■ Telephone technology (200) ■ Online delivery (189, 202, 209)
<p>Promoting opportunity for group discussions</p>	<p>Most studies focused on providing opportunities for group discussions as a component of the clinical group in order to facilitate opportunities for developing social connections and social support, practice role-playing, and develop a sense of community among participants.</p> <p>Group discussions included:</p> <ul style="list-style-type: none"> ■ Talking about experiences of meeting others online, experiences with condom negotiating and safety, and discussions of “scenarios” to reduce sexual risk behaviour (192). ■ Group-based discussions on HIV and STI prevention included providing the opportunity to implement new knowledge and to practice new skills (e.g. negotiating condom use) (206). ■ Online group discussions included opportunities for role-playing to generate examples and rehearse ways to communicate HIV prevention messages to participants (209). ■ Discussion about environmental determinants of health behaviour, including the size/quality of support networks and the impact of drug/alcohol use on health and decision-making, and the development of strategies to grow support communities (214).

Supporting Resources

Please refer to [Appendix L](#) for examples of 2SLGBTQI+ clinical groups that offer health promotion, chronic disease prevention and management services.

RECOMMENDATION 4.1:

The expert panel recommends health-service organizations implement group-based interventions for 2SLGBTQI+ people addressing the social determinants of health. These group-based interventions should be inclusive of and promote access to underserved 2SLGBTQI+ people including: Two-Spirit, Black, Indigenous and People of Colour, older adults, youth, migrants and people with disabilities.

Strength of the recommendation: Strong

Certainty of the evidence of effects: Very low

Confidence in evidence: Low

Discussion of Evidence

Benefits and Harms

Group-based interventions are included in the broad category of community interventions, defined as social or family groups linked by networks, geographical location or another common factor. Group-based interventions may include support groups, but also may include complex group interventions such as coping skills education or counseling (217).

Quantitative evidence suggests that persons who participate in tailored 2SLGBTQI+ group-based interventions addressing the social determinants of health and include underserved communities may experience improved social support and improved self-care, and may report positive program experiences and greater acceptance from peers. However, the evidence is very uncertain (218-221). Two quantitative studies found that participants in a support group or counseling program for sexual and gender minority youth (SGM), conducted in a community setting, reported positive experiences (as assessed by satisfaction and acceptability questionnaires) (218, 219). Three studies assessed the impact of a group-based program on self-care and reported improved coping skills or decreased risk behaviour such as alcohol use (218, 219, 221). Two studies examined the impact on social support of a drop-in group focusing on mental health and a school-based counseling program, both tailored for SGM youth (219, 220). The more often that the SGM youth attended the drop-in group, the more their social support and/or sense of belonging increased (220). However, social support did not increase for SGM youth in a school-based counseling program (219). Please refer to the “Practice Notes” in **Table 17** for further details on group interventions from the evidence.

Qualitative evidence suggests that group-based interventions addressing the social determinants of health may provide improved social support and improve participant experiences. Nine qualitative studies explored the perceived benefits of inclusive group-based interventions as experienced by 2SLGBTQI+ participants (222-230). Participants reported improved self-confidence and self acceptance following group-based interventions for mature LB women, trans people, SGM youth, LGBT persons with intellectual disabilities living in residential care, and African and Caribbean LGBTQ refugees and newcomers (222-229). Additionally, participants valued group interactions that affirmed their sexual and gender identity (222-229) and they reported experiencing improved social support through a greater sense of belonging and reduced feelings of social isolation and loneliness (222-230). Participants in both a drop-in group targeting SGM youth and a support group for African and Caribbean LGBT **refugees**^G and newcomers to Canada stated that experiences in these group-based supports provided them with strategies for negotiating

housing and employment and accessing health service resources. They also reported having experienced enhanced friendships and interpersonal relationships (peer acceptance) through the provision of a safe space (222, 223). Finally, participants in one study experienced improved self-care through the development of coping strategies (229).

The certainty of evidence was very low due to limitations in how the studies were conducted. The confidence in the evidence was low due to some concerns about methodological limitations in how some of the qualitative studies were conducted, minor concerns about relevance (some study settings were indirect and did not include all 2SLGBTQI+ communities), and minor concerns around data richness. For more detailed information about the impact of group-based interventions on the reported outcomes and the grading of the evidence, please refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Values and Preferences

The evidence indicates that 2SLGBTQI+ persons reported that they accepted and gave a positive rating to group-based interventions (218, 219, 229). SGM youth who participated in a drop-in program agreed that social support and interpersonal relationships are very important (222). The majority of the older LB women participating in a support group to foster friendships and a sense of connectedness stated a firm preference for their support group to be tailored to the same-sex, same sexuality, and the same generation (224).

Health Equity

Many of the studies examining the impact and experiences of 2SLGBTQI+ group-based interventions targeting underserved communities were conducted with sexual and gender minority youth (218-222, 225, 228, 229). Most of the study clinical groups were accessed in large urban communities, however one intervention was offered only virtually (230). The studies included LGBTQ, pansexual and non-binary persons. One study included one Two-Spirit participant. Intersex people were not included in the studies. The majority of the 2SLGBTQI+ group-based interventions offered across the studies considered the intersecting experiences of sexual orientation and gender identity with age, race, ethnicity or disability. One study tailored the group-based peer support group to the needs of Black queer men working in research in a university setting (226). Another study offered a social support group intervention targeting African and Caribbean LGBT refugees and newcomers (223). Participants with intellectual disabilities living in a care home setting participated in an LGBT support group (227).

The expert panel noted some health-service organizations may have challenges implementing clinical groups due to resource limitations or community size. Additionally, access to group-based interventions by individuals may be limited by direct and indirect costs such as fees and transportation.

Expert Panel Justification of Recommendation

Conventionally based on GRADE, this recommendation could have been voted conditional since the certainty of the evidence of the effects was very low and the confidence in the evidence was low. Based on the balance of benefits and harms, including the harms of not following the recommendation, as well as values and preferences and health equity, the expert panel came to consensus on a strong recommendation. There may be benefits to 2SLGBTQI+ group-based interventions addressing the social determinants of health for underserved communities – such as Two-Spirit, Black, Indigenous and People of Colour, older adults, youth, **migrants**^G and people with disabilities and no harms were identified. However, the expert panel noted potential for harms if group-based interventions are not implemented, including problems with access to health services among the underserved groups. Expert panel members emphasized

the potential impact of multiple intersectional vulnerabilities and health inequities that may impact underserved communities. In the literature, participants who had access to group-based interventions valued them highly. The expert panel therefore determined the strength of this recommendation to be strong.

Practice Notes

Considerations from the Expert Panel:

- It is critical to highlight Two-Spirit people as underserved. The evidence did not include Two-Spirit person representation, and the panel recognizes that Two-Spirit persons may not be visible in research published in peer-reviewed journals.
- Offering group-based interventions virtually and by telephone may improve access for persons living in rural areas or those who, for whatever reason, are unable to participate in person.
- It is important to provide group-based interventions for 2SLGBTQI+ people in a safe environment. Privacy and confidentiality are to be maintained regardless of group membership. Health providers are to be aware of the potential of people being “outed” based on group membership. Group-based interventions for 2SLGBTQI+ people should not be held in locations where attending the group would accidentally out an individual and cause unwanted harm and/or stress.
- Be aware that some people, particularly those in smaller or rural communities may not want to participate in group-based interventions due to concerns of being “outed.”

Table 17: Practice Notes from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Safe space focus	<p>Many of the studies identified a safe space as an important feature of a 2SLGBTQI+ group. Features of a safe space for group-based interventions included:</p> <ul style="list-style-type: none"> ■ An accessible, confidential, affirming environment where participants felt empowered, could bond and, form friendships, and where people found a much-needed sense of belonging (218, 222, 224, 228-230). ■ Spaces where safety is experienced both physically and emotionally and participants felt safer to express themselves without fear of judgment (218, 219, 222-224, 227, 228, 230). ■ See further details in Recommendation 2.0 on safer spaces.
Empowerment-based focus	<p>Four studies use an empowerment-based focus to deliver group-based interventions (219, 222, 225, 228).</p> <p>Specific strategies included:</p> <ul style="list-style-type: none"> ■ A focus on self-esteem and self-confidence (219, 222, 228) ■ Role modeling (222) ■ Active participation that focuses on strengthening personal resiliency (225)

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
<p>Peer or ally-led/facilitated</p>	<p>Six studies used a peer or ally^G-led delivery model (218, 220-222, 226). Specifically:</p> <ul style="list-style-type: none"> ■ Drop-in group-level supports for SGM youth led by youth leaders supported by adult facilitators who are educated community members (220-222) ■ Brief 8-module affirmative cognitive behavioral coping skills group led by co-facilitators who are community members and peer allies (218) ■ Weekly support group for Black queer men led by student peers (226) ■ An online peer support network (230).
<p>Discussion-based design</p>	<p>Twelve studies used discussion as part of the delivery strategy for group-based interventions (218-223, 225-230).</p> <p>Discussion topics included:</p> <ul style="list-style-type: none"> ■ Events, issues and experiences in participants' lives (220-222, 228) ■ Employment, immigration, housing and LGBTQ health (223) ■ Facilitated discussions that noted the stories of other participants and the impact of discrimination on their feelings and behaviours (218) ■ Dialogue about their experiences and strategies for dealing with marginalization as Black queer men on campus (226) ■ Sharing of transphobic experiences and discussions around solutions and problem-solving strategies (225) ■ Discussion and education regarding sexuality, strategies to address name-calling as well as social discussion (227) ■ 17 structured discussion topics were covered in one study including but not limited to identity, coming out, respect and boundaries, mental health, community and connections, communication, safety and allies (229).

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
<p>Tailored education and skills-based content</p>	<p>Six group-based interventions used tailored education and skills-based content in the delivery of group-based interventions focused on social determinants of health (218, 219, 222, 223, 227, 229).</p> <p>Specific details of education and skills include:</p> <ul style="list-style-type: none"> ■ Developing community resilience, facilitating access to resources such as housing, health services and employment skills education (223) ■ Affirmative cognitive behavioural coping skills (218) ■ Practising healthy decision making and coping with stress (219) ■ Education around LGBT sexual health, and discussion on strategies to address discrimination and stigma and developing community links for future needs and supports (227) ■ Sessions focused on coping skills and mechanisms related to healthy relationships, coming out, and minority stress (229)

Supporting Resources

Please see [Appendix L](#) for examples of organizations offering groups-based interventions focused on the social determinants of health for 2SLGBTQI+ people and [Appendix K](#) for Indigenous and Two-Spirit resources.

EDUCATION AT ACADEMIC INSTITUTIONS AND HEALTH-SERVICE ORGANIZATIONS

RECOMMENDATION 5.0:

The expert panel recommends academic institutions integrate affirming 2SLGBTQI+ health content into curricula for all students entering health professions.

Strength of the recommendation: Strong

Certainty of the evidence of effects: Low

Confidence in evidence: Low

Discussion of Evidence

Benefits and Harms

Evidence suggests that integrating affirming 2SLGBTQI+ health content into curricula for students entering health professions may improve their knowledge, skill and experience (54, 231-271). The expert panel felt it was important to include affirming health content as much of the existing health content is cisnormative and heteronormative and can be stigmatizing or pathologizing. Affirmation refers to an interpersonal, interactive process whereby a person receives social recognition and support for their sexual and gender identity and gender expression (272). Affirming health content is supportive and accepting of 2SLGBTQI+ people and communities. Eight studies explicitly included affirming health content (232, 236, 240, 249, 256, 262, 268, 270). Examples of affirming health content in the literature included:

- Two studies included reflection and dialogue on student's own biases and stereotypes as a necessary part of education on providing LGBT affirming care (236, 268).
- One study examined the delivery of a course on trans youth care for pediatric residents and nurse practitioner students. The course on gender-affirming care included instruction on interpersonal communication, medical therapies, and psychosocial support that affirm individuals in their gender identity (240).
- Two studies on LGBT health included one module or session on delivering affirming care (232, 270).
- A gender affirming health curriculum for second year medical students included case-based learning (262).

Studies examined the impact that integrating 2SLGBTQI+ health content into college or university education for students entering health professions on students' knowledge and skill and student experience. The majority of studies found that integrating 2SLGBTQI+ health content into college or university education may improve students' knowledge and skill and student experience (54, 231-266). Two systematic reviews of non-randomized studies reported an increase in knowledge of students across all studies (54, 231). One systematic review reported an increase in student skills (231) while the other reported inconsistent results in terms of students' attitudes from pre- to post- intervention (54). An additional 35 non-randomized studies reported on student knowledge and skills with the majority reporting a positive effect of education (232-266). Five of the 35 studies examined student experience of education through a variety of evaluation surveys and students across all the studies rated the education experience positively (233, 247, 260, 263, 267).

Nine qualitative studies explored the perceived benefits of integrating 2SLGBTQI+ health content into professional education on student experience (231, 236, 249, 264, 266, 268-271) and one explored the perceived benefits on knowledge and skills (268). Students reported positive course experiences and described increased openness and comfort about 2SLGBTQI+ health content through new learning on self-awareness about personal biases, power and privilege (231, 236, 249, 264, 266, 268-271). Students expressed a desire to create openness and awareness in practice settings and be an ally to 2SLGBTQI+ persons (231, 236, 249, 264, 266, 268-271).

See details of education delivery and content in the “Practice Notes” below.

There were no harms reported in studies.

The overall certainty of the evidence is low due to limitations in how studies were conducted, inconsistency in how the outcomes were measured, and small sample size for the student experience outcome. The overall confidence in the evidence for qualitative findings was low due to some concerns over methodological limitations of the individual studies and the adequacy of data. For more detailed information about the impact of the intervention on each outcome and the grading of evidence, please refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Values and Preferences

Five studies gathered feedback through post-session surveys or evaluations (239, 242, 246, 247, 250). Students highly valued the education intervention in all studies (239, 242, 246, 247, 250). When students offered suggestions for improvement, they suggested the education sessions be compulsory, have more focus on skills or **experiential learning**^G, and provide more opportunity for interprofessional interaction (239, 242).

Values and preferences are also apparent in qualitative studies. Counseling students in one study stated the need for more exposure to LGBT communities (236).

Health Equity

The majority of education included content on LGBT peoples’ health. (54, 231, 232, 247, 249, 251-253, 257, 260, 261, 263-266, 269, 270). Trans or non-binary people’s health was the sole focus in sixteen studies (234, 237, 240-246, 248, 255, 256, 258, 259, 262). One study focused on sexual minority health alone (233). Education on Two-Spirit or intersex health was not present in the evidence.

In the courses, intersectional considerations were limited. However, one study focused on a teaching module on intersectionality of sexual orientation, gender identity, and race/ethnicity (266).

Expert Panel Justification of Recommendation

This recommendation could have been a good practice statement however, the expert panel agreed that it was important to pose a recommendation question to examine the evidence on the potential impact of integrating affirming 2SLGBTQI+ health education content into education for all students entering health professions. In addition, this evidence can support educators and academic institutions by providing detailed information on the delivery of this education outlined in the evidence. There may be benefits to academic institutions integrating affirming 2SLGBTQI+ health content into curricula for students entering health professions. There were no harms

in providing such content to students entering health professions. The certainty and confidence in the evidence is low. However, the expert panel noted that the harms (psychological, emotional and physical harms) of not providing education could be substantial. The expert panel also noted that if students entering health professions do not receive education, the burden is placed on 2SLGBTQI+ populations to continuously explain their own identities and their own health needs. Participants in the studies valued the education they received and some wanted more education. Despite the certainty of the evidence being low, it is ethically sound to ensure the provision of affirming, accurate education on caring for 2SLGBTQI+ communities for all entry-to-practice health providers. Therefore, the expert panel determined the strength of the recommendation to be strong.

Practice Notes

Considerations from the Expert panel

- The expert panel stated that education is to be compulsory and this content must not be optional.

Table 18: Practice Notes from the Expert Panel

COMPONENT OF EDUCATION	DETAILS OF EDUCATION
Affirming 2SLGBTQI+ health content (reflective practices, theoretical knowledge, experiential learning)	<ul style="list-style-type: none"> ■ Align education content with overarching frameworks of Intersectionality, anti-oppression and decolonization (See background section). ■ Learning is compulsory. ■ Health content should be reviewed by 2SLGBTQI+ content experts and 2SLGBTQI+ persons to mitigate potential for harm. This content should be regularly reassessed to ensure all information including language and terminology is relevant and up-to-date.
Strategies to integrating affirming 2SLGBTQI+ health content throughout the curriculum	<ul style="list-style-type: none"> ■ Health content of adequate quantity can be integrated throughout curriculum courses across each program year. ■ Include 2SLGBTQI+ people in practicum, simulation labs, case studies, clinical vignettes and exam questions (beyond endocrinology and reproductive pathologies). Examples: <ul style="list-style-type: none"> □ a lesbian with breast cancer, man with a husband who has heart failure, end of life case scenario with Black woman and her female partner, trans woman with pneumonia □ Include examples of non-binary or trans people in pregnancy and birth care. ■ Include presentations and sharing from 2SLGBTQI+ persons with lived experience. ■ Include 2SLGBTQI+ persons as standardized patients, clinical cases and in objective structured clinical examinations (OSCEs).

COMPONENT OF EDUCATION	DETAILS OF EDUCATION
Strategies to integrating affirming 2SLGBTQI+ health content throughout the curriculum	<ul style="list-style-type: none"> ■ Include 2SLGBTQI+ people in the development of and in examples of nursing care plans. ■ 2SLGBTQI+ specific health courses ■ 2SLGBTQI+ health as an independent study topic
Role of faculty and staff	<ul style="list-style-type: none"> ■ Teaching responsibilities must be shared by all educators and not be assigned exclusively to 2SLGBTQI+ faculty, staff or employees ■ Provide education to all faculty and staff

Details from the Evidence

Student comfort and safety in the learning environment: Students entering health professions identified the creation of a safe space for dialogue to be important. The degree to which students felt free to take risks while sharing their personal opinions and stories is dependent on their level of comfort and safety in their learning environment (236, 268).

Table 19: Practice Notes from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Theoretical knowledge	<p>Details of educational content on theoretical knowledge included:</p> <ul style="list-style-type: none"> ■ Cultural safety or competency (232, 239, 241). <ul style="list-style-type: none"> □ Three courses included content on providing LGBT affirmative care as a strategy to operationalize cultural safety (232, 236, 240). ■ Terms and terminology (231, 233, 235-238, 242, 269) <ul style="list-style-type: none"> □ In some courses this included defining broad concepts of sex, gender, gender identity, trans, social sex role, and sexual orientation, as well as understanding the difference between sexual orientation and gender identity. ■ History taking approach (231-233, 239, 240, 269) included conducting a sensitive physical exam, psychosocial history and sexual health history. ■ Health inequities (231-233, 237-239, 241, 269) ■ Mental health content (232, 238-240)

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Theoretical knowledge	<ul style="list-style-type: none"> ■ Legal issues faced by 2SLGBTQI+ persons and families (232, 233, 238, 241) ■ Trans and non-binary health specific content: <ul style="list-style-type: none"> □ Definitions of key concepts and terms (the difference between sexual orientation and gender identity and the definition of trans) (234, 235, 237, 239, 240, 242) □ Gender development (240, 242) □ Use of language including chosen pronoun and name (234, 239, 240) □ History taking and performing a physical exam (240) □ Bias, attitudes, and transphobia (237, 242) □ Introduction to transition processes (medical, legal and social) (233, 240) □ Medical and surgical care of trans persons including hormone therapy (235, 237, 240, 242)
Self-reflection practices	<p>Personal self-reflective practice is essential for students entering health professions. Reflection is defined as an important human activity in which people deconstruct their own personal assumptions, values and biases, think about them, mull over & evaluate them (273). Self-reflection may increase students' knowledge of 2SLGBTQI+ health, their skills and improve their experiences. Students reported experiencing increased open mindedness and comfort about LGBTQ health issues and practice through self-reflection and awareness.</p> <ul style="list-style-type: none"> ■ Students participated in self-reflection learning that included journaling, taking part in self-assessment, and engaging in small group discussions and dialogue. Students participated in self-reflection on the awareness of personal biases, deconstructed their existing beliefs about sexuality and gender and focused on analyzing policy and social issues affecting the lives of LGBT people living in a heteronormative context (236, 268). ■ An ally education program for students facilitated discussion about biases and perceptions related to LGBT communities (236).

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Experiential learning opportunities	<p>Experiential learning is a teaching strategy where learners participate in direct experience and focused reflection in order to increase knowledge, develop skills, clarify values, and develop capacity to contribute to their communities (274). The following experiential learning strategies were used in the education courses:</p> <ul style="list-style-type: none"> ■ 2SLGBTQI+ community member speaker panel (232, 238) ■ Role-playing (234) ■ Clinical vignettes [case studies] (234) ■ Group discussion (234) ■ Clinical elective with direct care opportunities (242) ■ Person with lived experience panel (237) ■ Simulation laboratory (269)
Course delivery	<ul style="list-style-type: none"> ■ All courses but one were offered in person. ■ One course on trans health was offered online exclusively in six short 15 minute modules (240). This design was used to fit into the time frame of a one-month adolescent medicine rotation for medical residents and nurse practitioner students.
Course length	<ul style="list-style-type: none"> ■ The majority of courses were offered over several sessions ranging from four to 14 (232, 236-240, 269). The total length of these courses ranged from 1.5 hours to 26 hours. ■ Several courses were offered only in one session ranging in length from 45 minutes to three hours (233-236, 241, 242).

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
LGBT health pedagogy/ teaching methods:	<p>A variety of teaching methods were used. Most studies utilized at least two methods and this often included experiential learning:</p> <ul style="list-style-type: none"> ■ Didactic lectures (232, 234, 235, 237, 238, 241, 242, 269) ■ On-line learning modules (237) ■ 2SLGBTQI+ faculty/instructors (233, 237) ■ Small group discussions/workshops (234, 268) ■ Reflective journaling (233, 268) ■ LGBT guest lecturers (including racially diverse lecturers and those with disabilities) (238) ■ Lived experiences videos (241) ■ Case-based learning (238, 239) ■ Film groups (238)

Supporting Resources

RESOURCE	DESCRIPTION
<p>Association of American Medical Colleges. Integrating LGBT and DSD Content into Medical School Curricula. In: Association of American Medical Colleges [Internet]. Washington (DC). 2021 [cited 2021 April 16]. Available from: https://www.aamc.org/what-we-do/mission-areas/diversity-inclusion/lgbt-health-resources/videos/curricula-integration</p>	<ul style="list-style-type: none"> ■ Video of three leaders in the academic medicine community on integrating content across curriculum on LGBT health
<p>Association of American Medical Colleges. Clinical Vignettes. In: Association of American Medical Colleges [Internet]. Washington (DC). 2021 [cited 2021 April 16]. Available from: https://www.aamc.org/what-we-do/mission-areas/diversity-inclusion/lgbt-health-resources/clinical-vignettes</p>	<ul style="list-style-type: none"> ■ Library of clinical vignettes that include LGBT people ■ Note: this is focused on medical education but would be broadly appropriate to other health providers or easily adapted

RESOURCE	DESCRIPTION
<p>Canadian Public Health Association. Self-assessment Tool. In: Canadian Public Health Association. [Internet]. Ottawa (ON): 2017 [cited 2021 April 16]. Available from: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/stigmascale_e.pdf</p> <p>Canadian Public Health Association. Trauma Informed Care. In: Canadian Public Health Association. [Internet]. Ottawa (ON): 2020 [cited 2021 April 16]. Available from: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/STBBI-TVIC-toolkit_e.pdf</p>	<ul style="list-style-type: none"> ■ Self-assessment tool for stigma related to STBBIs ■ Toolkit on trauma informed care related to sexual health, STBBIs and substance use
<p>College of Nurses of Ontario. Entry-to-practice Requirements. In: College of Nurses of Ontario [Internet]. Toronto (ON): 2020 [cited 2021 April 16]. Available from: https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf</p>	<ul style="list-style-type: none"> ■ College of Nurses of Ontario entry-to-practice requirements for registered nurses ■ Includes requirements on cultural safety
<p>City of Toronto, Long-Term Care Homes & Services. LGBT Tool Kit. In: City of Toronto [Internet]. Toronto (ON): 2017 [cited 2021 April 16]. Available from: https://clri-ltc.ca/resource/lgbt-tool-kit/</p>	<ul style="list-style-type: none"> ■ Tool kit on creating LGBT inclusive and affirming care and services ■ To request an electronic copy please email: lhc-ho@toronto.ca ■ Tool kit includes self-reflection exercises for the user
<p>DeVita T, Bishop C, Plankey M. Queering medical education: systematically assessing LGBTQI health competency and implementing reform. Medical education online. 2018 Jan 1;23(1):1510703.</p>	<ul style="list-style-type: none"> ■ Details on LGBTQI+ health competencies for medical education

RESOURCE	DESCRIPTION
<p>Fenway Health: The National LGBT Health Education Center (Fenway Health) [Internet]. Boston (MA): 2021 [cited 2021 April 16]. Available from: https://www.lgbtqihealtheducation.org/</p>	<ul style="list-style-type: none"> ■ A program of Fenway Health, a US-based organization. ■ Provides educational programs, resources, and consultation to health-service organizations with the goal of optimizing quality, cost-effective health services for lesbian, gay, bisexual, trans, queer, intersex, asexual, and all sexual and gender minority (LGBTQIA+) people. ■ An extensive library of resources that includes webinars and publications on a variety of topics ■ Some resources require users to sign in with a free account.
<p>Fredriksen-Goldsen KI, Hoy-Ellis CP, Goldsen J, Emlen CA, Hooyman NR. Creating a vision for the future: Key competencies and strategies for culturally competent practice with lesbian, gay, bisexual, and transgender (LGBT) older adults in the health and human services. <i>Journal of gerontological social work</i>. 2014 May 19;57(2-4):80-107.</p>	<ul style="list-style-type: none"> ■ Outlines competencies and strategies for LGBT health and health services.
<p>LGBT2SQ Health Connect. In: Rainbow Health Ontario [Internet]. Toronto (ON): 2021 [cited 2021 April 16]. Available from: https://learn.rainbowhealthontario.ca/</p>	<ul style="list-style-type: none"> ■ Rainbow Health Ontario (RHO) is a province-wide program of Sherbourne Health that works to promote the health of Ontario's LGBT2SQ communities and improve their access to services. ■ There are a variety of health related resources including clinical guidelines, fact sheets and guide books. ■ Rainbow Health Ontario's LGBTQ2S online learning platform <p>Note: Many resources are available for free however there are some links to resources available for a fee.</p>
<p>Michigan Medicine. Transgender Healthcare Curriculum. Ann Arbor (MI): n.d. [cited 2021 April 30] Available from: https://medicine.umich.edu/dept/obgyn/education/continuing-medical-education-cme/transgender-healthcare-curriculum</p>	<ul style="list-style-type: none"> ■ Training modules to prepare obstetrician-gynecologists and health other providers to better care for trans, non-binary, and other gender-diverse people.

RESOURCE	DESCRIPTION
<p>Shortall C. Teaching and Evaluation/Assessment Requirements for LGBTQI2S+ Health and Wellness: A Call to Include LGBTQI2S+ Content in Canadian English Baccalaureate Nursing Curricula Quality Advancement in Nursing Education- Avancées en formation infirmière. 2019;5(1):7.</p>	<ul style="list-style-type: none"> ■ Survey of Canadian nursing school leaders to identify if, how, and where sexuality and gender diversity (specific 2SLGTBQI+ health and wellness information) existed in their institution’s curriculum. ■ The document also reports on 2SLGTBQI+ content in Canadian curricula policy used to prepare nurses for entry to practice
<p>The 519. Education and Training. In: The 519 Resources [Internet]. Toronto (ON): 2020 [cited 2021 April 16]. Available from: https://www.the519.org/education-training/training-resources/our-resources</p>	<ul style="list-style-type: none"> ■ The 519 is a City of Toronto agency that responds to the evolving needs of 2SLGBTQI+ communities and provides consulting and workshop services, best practice research and public engagement campaigns. ■ There are a variety of resources available including A Handbook for Affirming LGBTQ Older Adults and a glossary of terms. <p>Note: this resource is not specifically focused on health.</p>
<p>Trans Care BC. Health Professional Education. In: Trans Care BC (BC): 2021 [cited 2021 April 16]. Available from: http://www.phsa.ca/transcarebc/health-professionals/education</p>	<ul style="list-style-type: none"> ■ Comprehensive library of education resources for health professionals including a mailing list, gender-affirming primary care online course ■ Topics include: trans intro, primary care, mental health and support and surgery
<p>Truth and Reconciliation Commission of Canada: Calls to action [Internet]. Winnipeg (MB): c2015 [cited 2021 April 16]. Available from: http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf</p>	<ul style="list-style-type: none"> ■ Outlines the Truth and Reconciliation Commission of Canada calls to action to redress the legacy of residential schools and advance the process of Canadian reconciliation. ■ Includes a specific call to action for medical and nursing schools to require a course on Indigenous health issues.
<p>World Professional Association for Transgender Health: Global Education Initiative. [cited 2021 April 29] Available from: https://www.wpath.org/gei</p>	<ul style="list-style-type: none"> ■ Courses and certification in transgender health <p>Note: several courses are offered for a fee.</p>

RECOMMENDATION 5.1:

The expert panel recommends that health-service organizations provide affirming 2SLGBTQI+ continuing education for all health providers.

Strength of the recommendation: Strong

Certainty of the evidence of effects: Low

Confidence in evidence: Very low

Discussion of Evidence

Benefits and Harms

Evidence suggests continuing education regarding affirming 2SLGBTQI+ health may increase health provider knowledge and lead to practice change (275-311). However, the evidence for practice change is uncertain. Four studies explicitly included affirming health content (276, 277, 304, 311) and the expert panel felt this was important to include as much of the existing health content in continuing education is cisnormative and heteronormative and can be stigmatizing or pathologizing. Affirming health content is supportive and accepting of 2SLGBTQI+ people and communities. Examples of affirming continuing education in the literature included:

- One study on trans clinical and cultural competency included gender affirmation in both the theoretical foundation for the education and in one of the four content modules (277).
- Another study was specifically focused on LGBT-affirmative psychotherapy education (276). LGBT-affirmative psychotherapy refers to the addition of LGBT-affirmative attitudes, knowledge, and skills to a therapist's existing therapeutic orientation.
- One study considered a curriculum for forensic nurses that focused on providing trans-affirming care for trans persons who have been sexually assaulted (304).
- One study focused on trans health for health providers in correctional institutions. One module aimed to help health providers understand their role in ensuring access to gender-affirming care. It did this through discussion on how stigmatizing and supportive interactions between persons and health providers can serve as, respectively, barriers and facilitators to care. (311).

One systematic review of non-randomized studies reported on changes in practice that resulted from a variety of interventions to educate the health providers on the experiences and needs of LGBT+ older adults (275). Overall, results were positive for change in bias, attitudes and values across studies but were mixed for empathy and intent to use knowledge or skill in practice (275). Additionally, sixteen non-randomized studies reported a positive change in practice from pre to post intervention (276-286, 288-292) and one study reported decreased level of preparedness following continuing education (287). One systematic review of non-randomized studies reported on the impact that education about the experiences and needs of LGBT+ older adults had on health providers' knowledge (275). All studies included in the review reported an increase in knowledge and awareness from pre to post intervention (275). An additional 31 individual studies were identified that reported on the impact that education had on health provider knowledge (276-278, 280-288, 290-305, 309-311). Overall, all but two non-randomized studies (283, 284) reported an improvement in knowledge in health providers after education.

Two qualitative studies explored the perceived benefits of continuing education related to 2SLGBTQI+ health on knowledge (301, 308). Both studies were from Africa (Kenya and South Africa) and were focused on an MSM health education program. Participants in these studies reported increased knowledge of MSM sexual health, including STBBI and HIV risks, and of the role of discrimination on health (301, 308). Four qualitative studies explored the perceived benefits of continuing education on change in practice. Participants in these education programs reported positive change in practice through experiencing comfort with lesbian, gay, bisexual and trans persons accessing services and an increased ability to provide non-discriminatory, respectful care (301, 306-308).

The majority of studies did not report on whether the education was compulsory or elective. Education delivery and content varied across the 36 included studies, however there were some commonalities. The length of education sessions ranged from one hour to two days, they were typically offered in person and were adapted to the cultural and health setting where education occurred. The majority of studies included content on:

- **cultural safety**^G (279, 283, 296, 298)
- **clinical competence**^G (297, 301)
- a combination of both cultural safety and clinical competence (275-277, 280-282, 284, 293, 294, 299, 310)

See details on continuing education content and delivery in “Practice Notes” in **Table 21**.

No harms were reported in 35 of the 36 studies included. One study reported that one health provider felt overwhelmed from too much content (277). The overall certainty of evidence is low due to limitations in how studies were conducted and indirectness and inconsistency due to the diversity of **surrogate outcome**^G measures for change in practice. The overall confidence in the evidence was very low due to the methodological limitations of the individual studies.

For more detailed information of the impact of the intervention on each outcome and the grading of evidence please refer to the evidence profiles available here: <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Values and Preferences

One review and twenty-three studies gathered data on participant satisfaction or acceptability through evaluation surveys or open-ended questions. Where this information was gathered, health providers rated continuing education on 2SLGBTQI+ health positively. Many participants found the education to be highly acceptable, informative and valuable to their practice (275-277, 279, 281, 282, 284, 286, 288, 290, 293, 294, 297, 299-301, 303-305, 307-311).

Six primary studies and one review also gathered participant data on recommendations for future education or suggestions for improvement. Participants suggested that more time be allotted for 2SLGBTQI+ education, that education be expanded to all health providers, and that the education be lifelong for participants and occur at regular and multiple intervals (275, 281, 284, 304, 307, 308, 311). Participants valued having more time in smaller group discussions, more time for questions, longer time for the education session, role-plays and interactive activities (284, 311). Health providers stated they would have liked more information on privilege and how to provide appropriate care (281). They observed that the education had covered a lot of information in a short period of time and that they would have appreciated the opportunity to delve into specific topics, such as bisexuality and trans issues, in much greater detail than the four-day schedule allowed (281).

Health Equity

Most studies provided education on either sexual or gender minority health. Education was focused either on lesbian, gay and bisexual people or on trans persons. A few studies provided education on both trans and LGBQ health (276, 279, 281, 286, 303, 305, 309). Four studies set in Africa were focused only on MSM (299, 301, 307, 308). The systematic review was specifically focused on LGBTQ+ older adults (275).

One education study of community mental health workers in New Mexico included content on Indigenous and Two-Spirit health within the local LGBTQ communities (281). In consultation with community members, this content included discussions of lack of awareness of Indigenous Two-Spirit experiences, erroneous beliefs about bisexuality, and a lack of cultural safety (281). No studies included continuing education or professional development on intersex health.

With the exception of basic consideration of stigma and discrimination, aspects of intersectionality, such as race, disabilities or Indigenous status were mostly missing from this body of literature.

Expert Panel Justification of Recommendation

This recommendation could have been a good practice statement however, the expert panel agreed that it was important to pose a recommendation question to examine the evidence on the potential impact of health organizations providing affirming 2SLGBTQI+ continuing professional development for all health providers. In addition, this evidence can support health organizations by providing detailed information on the delivery of continuing professional education as outlined in the evidence. There may be benefits to providing health providers with continuing education, however the certainty in the evidence was low and the confidence in the evidence was very low. Overall, the benefits of the intervention greatly outweighed the potential harms of the intervention. Participants in the studies highly valued the intervention and frequently stated that courses should be compulsory, longer, or more in-depth. The panel also noted the potential harms of not implementing this intervention, such as health providers providing unsafe or un-affirming care. The expert panel considered this recommendation to be foundational to practice as well as linked to other recommendations such as **Recommendation 2.1** on safer spaces. Therefore, the expert panel determined the strength of the recommendation to be strong.

Practice Notes

Considerations from the Expert Panel

The College of Nurses of Ontario (CNO) entry to practice competencies calls on nurses to be prepared to practice with cultural safety (312).

Table 20: Practice Notes from the Expert Panel

COMPONENT OF EDUCATION	DETAILS OF EDUCATION
<p>Cultural safety in 2SLGBTQI+ continuing education for health providers</p>	<ul style="list-style-type: none"> ■ Align continuing education content on cultural safety with overarching frameworks of Intersectionality, anti-oppression and decolonization (See background section). ■ Practicing cultural safety requires all health providers and staff to be reflective and to understand their privilege and biases about 2SLGBTQI+ people.
<p>Clinical competence and 2SLGBTQI+ continuing education for health providers</p>	<ul style="list-style-type: none"> ■ Continuing education should be focused on developing role-specific skills needed to support 2SLGBTQI+ people. For example, hospital porters may need to be educated to call people by their correct name and to allow for trans and non-binary people to keep wigs on. Counseling staff, on the other hand, may need education on reflective practice and therapeutic communication with 2SLGBTQI+ people. ■ Clinical competence needs to address health across the lifespan including older adults and care for people with dementia. Health providers are to recognize that sexuality in older adults, and within long term care settings, is normal and needs to be accepted and embraced. As with all people, older adults have a sexual orientation, gender identity and gender expression.

RECOMMENDATIONS

COMPONENT OF EDUCATION	DETAILS OF EDUCATION
<p>General guidance for the planning, implementation and delivery of 2SLGBTQI+ health for continuing education</p>	<ul style="list-style-type: none"> ■ Continuing education is to include, at a minimum, content on cultural safety and clinical competence. ■ Continuing education responsibilities must be shared by all staff members and not be assigned exclusively to 2SLGBTQI+ staff or employees. ■ Continuing education is offered to all health providers and staff that interact with persons, tailored to their role. ■ Continuing education needs to be supported by organizational leadership and embedded in organization processes, policies and culture through orientation, annual education, performance appraisals and supervisor support and consultation. Health-service organizations need to ensure uptake of continuing education by health providers. ■ Continuing education needs to be ongoing. There is a need for sustained change and efforts to support the uptake and application of skills. It is important that continuing education be viewed as ongoing skills development, not simply a one-time event. In studies where change of practice was assessed, the majority found that these changes did not persist over time (i.e. at longer follow-up times). Education needs to be reinforced on a regular basis in order to sustain practice changes. ■ Continuing education could be developed and offered in-house by health-service organizations or through the use of external 2SLGBTQI+ organizations ■ Content needs to be adapted to health setting and health provider role. There is some basic content that is universal but most content needs to be tailored to particular health settings and professions. For example, for some professions, content should include how to address addictions, suicidal ideation, and HIV/STBBI, but these are not universally necessary. The content should target the specific health context (e.g. veterans’ health, mental health outreach, or paediatrics). ■ Continuing education should take a strength and resiliency-based approach and not be focused only on trauma, barriers to care, etc.). ■ Participants in education need to be held accountable to their learning through the use of certificates or minimum passing scores on tests and assessments. Where applicable, education is to offer continuing education credits.

Table 21: Practice Notes from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Continuing education content	<p>Clinical competence content typically covered the following:</p> <ul style="list-style-type: none"> ■ Health history taking and assessment including psychosocial history (294, 297, 301) ■ Mental health including substance use (281, 297, 299, 301) ■ Sexual health and risk reduction counseling (280, 299, 301) ■ Guidelines and principles of providing competent care (293) ■ Surgical care and hormone therapy for trans person (if applicable to health role and setting) (277, 284, 294, 297) <p>Cultural safety content included the following:</p> <ul style="list-style-type: none"> ■ Health provider attitudes and personal biases (276, 278) ■ Person-provider communication including appropriate language (276) ■ Stigma and discrimination including internalized stigma (276, 279)
Example of health history content	<p>A comprehensive education program on trans youth included three modules on history taking and physical assessment (294). The modules covered the following content:</p> <ol style="list-style-type: none"> 1. Gender history: this module covered assessment of gender identity development in all people as well as becoming familiar with asking families and people of all ages about gender identity development. 2. Psychosocial history: this module covered how HEADSS (home, education/employment, activities, drugs, sexuality, suicide/depression) can be used to guide psychosocial assessment in trans children and adolescents. 3. Physical examination: this module covered pubertal development as well as how to sensitively approach and perform a physical exam for trans youth.
Example of mental health content	<p>Several studies included mental health as a component of continuing professional development (281, 297, 299, 301).</p> <p>Examples of what was covered in these mental health modules included:</p> <ul style="list-style-type: none"> ■ Mental health and substance use among LGBTQ people (281, 297, 299, 301) ■ Mental health and substance use treatment services for LGBTQ populations (281) ■ LGBTQ people and suicide (281) ■ Mental health evaluation for hormone therapy (297)

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Example of trans health content	<p>Trans health sessions typically covered the following content:</p> <ul style="list-style-type: none"> ■ Definitions including the difference between sex, gender identity, gender expression, and sexual orientation (284, 294, 297) ■ Barriers to health services (284, 297) ■ Stigma and bias (284, 297) ■ An introduction to hormone therapies and gender-affirming surgeries (277, 284, 294, 297) ■ A discussion of ways to support and care for trans people (277, 284, 297)
Theoretical framework	<p>Studies used a variety of theoretical frameworks as the basis for the education:</p> <ul style="list-style-type: none"> ■ Cisgenderism (278) ■ Minority stress theory (276, 281)
Length and structure	<p>The majority of the education was offered in one session ranging from one hour to two days.</p> <ul style="list-style-type: none"> ■ Some education was offered in a series of sessions ranging from two to fourteen sessions. The total length of these education sessions ranged from 2.5 to 12 hours (275-311).
Delivery Mode	<p>The majority of education was offered only in person. Six continuing education programs were blended with both online and in-person sessions (294, 296, 298, 299, 307, 308).</p> <ul style="list-style-type: none"> ■ One study offered theoretical content online followed by clinical observation in person (294). The courses offered theoretical content in a combination of online and in-person delivery. ■ No education programs were offered exclusively online.

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
<p>Learning Strategies</p>	<p>The following learning strategies were used in the studies:</p> <ul style="list-style-type: none"> ■ Didactic lectures/presentation (276, 279, 281, 282, 284, 293, 296, 297, 301, 306) ■ Module-based learning (277, 280, 294, 295, 298, 303) ■ Group discussion (276-280, 282, 294, 296, 298, 299, 301, 307, 308) ■ Workshop (278, 283) ■ Interactive theatre workshop (300) ■ LGBT experts panel discussion (298) ■ Self-reflection (276, 279, 281, 283, 298, 301) ■ Case studies (277, 278, 284, 297, 310) ■ Role- playing (277, 279, 300) ■ Clinical observation (281, 294) ■ Affirmative supervision in clinical setting (306)

Supporting Resources

See **Recommendation 5.0** for supporting resources.

Research Gaps and Future Implications

In reviewing the evidence for this BPG, the RNAO best practice guideline development and research team and expert panel identified priority areas for future research (outlined in **Tables 22** and **23**). Studies conducted in these areas would provide further evidence to support high-quality and equitable support for 2SLGBTQI+ people. The list is not exhaustive; other areas of research may be required.

Table 22: Priority Research Areas per Recommendation Question

RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
<p>RECOMMENDATION QUESTION #1:</p> <p>What communication strategies should be recommended to improve care for 2SLGBTQI+ people?</p> <p>Outcomes: Person’s comfort and person’s safety</p>	<ul style="list-style-type: none"> the impact of inclusive language, a person-centred history taking approach and ensuring privacy and confidentiality during person-provider interactions on the experience of Two-Spirit and intersex people quantitative studies exploring impact of communications strategies on person-reported outcomes the effectiveness of mandatory professional development and/or education on appropriate communications strategies within health-service organizations for improving care to 2SLGBTQI+ people
<p>RECOMMENDATION QUESTION #2:</p> <p>Should the creation of safe spaces in health-service organizations be recommended to improve care for 2SLGBTQI+ people?</p> <p>Outcomes: Person’s experience, person’s safety, return of persons, diverse representation of persons and health providers.</p>	<ul style="list-style-type: none"> the impact of safer spaces in health-service organizations on quantitatively measured health outcomes the impact of safer spaces in health-service organizations across various sectors such as primary care, acute care, long-term care and community care the impact of school nurses and public health nurses on the development and implementation of safer spaces in schools
<p>RECOMMENDATION QUESTION #3:</p> <p>Should promotion of risk screening by health providers be recommended to improve care for 2SLGBTQI+ people?</p> <p>Outcomes: Number of persons accessing screening.</p>	<ul style="list-style-type: none"> the impact of risk screening promotion on earlier detection and/or intervention, level of treatment and/or support, change in knowledge of persons receiving care, and risk behaviours 2SLGBTQI+ people’s experiences including safety and comfort during all types of risk screening promotion and care the role of screening and access to screening for all 2SLGBTQI+ people and in particular evidence for populations outside of MSM the development and validation of mental health screening for 2SLGBTQI+ people

RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
<p>RECOMMENDATION QUESTION #4:</p> <p>Should clinical group-based interventions for health conditions be recommended to improve care for 2SLGBTQI+ people?</p> <p>Outcomes: Mental health, social support, and self-management.</p>	<ul style="list-style-type: none"> ■ the impact of clinical group-based interventions on person-provider therapeutic relationships, number of visits to the emergency department, inpatient care and/or hospitalization ■ the development and implementation of clinical group-based interventions ■ the impact of clinical group-based interventions on obesity across the lifespan. ■ the impact of clinical group-based interventions tailored to lesbian and bisexual women, intersex or Two-Spirit people on experience of care and health outcomes
<p>RECOMMENDATION QUESTION #5:</p> <p>Should group-based interventions be recommended to improve care for 2SLGBTQI+ people?</p> <p>Outcomes: Person’s experience, social support, and self-management.</p>	<ul style="list-style-type: none"> ■ more research on the experiences of 2SLGBTQI+ people participating in group-based interventions ■ exploring the development and implementation of group-based interventions ■ the impact of group-based interventions for all 2SLGBTQI+ people, particularly Two-Spirit and intersex people
<p>RECOMMENDATION QUESTION #6:</p> <p>Should 2SLGBTQI+ health content be integrated into professional education for students entering health professions?</p> <p>Outcomes: Student experience, student knowledge and student skills.</p>	<ul style="list-style-type: none"> ■ studies examining the impact of integrating 2SLGBTQI+ health content for students entering health professions utilizing rigorous study designs such as control trials, comparative studies, and systematic reviews ■ how 2SLGBTQI+ health content is integrated into health programs (including curriculum development and strategies for integration) ■ how 2SLGBTQI+ health content is being integrated into professional education for students entering health professions, particularly in a Canadian setting ■ the impact of academic organizational policies (inclusivity, discrimination) regarding 2SLGBTQI+ health content on student experience, knowledge and skills ■ the impact of 2SLGBTQI+ health content in education of students entering health professions on 2SLGBTQI+ people’s experience of safe care

RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
<p>RECOMMENDATION QUESTION #7:</p> <p>Should continuing education be recommended for health providers to improve care for 2SLGBTQI+ people?</p> <p>Outcomes: Health provider knowledge and change in practice.</p>	<ul style="list-style-type: none"> ■ studies examining the impact of providing continuing education on 2SLGBTQI+ health utilizing rigorous study designs such as control trials, comparative studies, and systematic reviews ■ the role of health provider continuing education on access to care and experiences of care ■ the effectiveness of continuing education for a range of health providers including nurses and members of the interprofessional team on health outcomes ■ the effectiveness of delivery and implementation of continuing education on 2SLGBTQI+ people’s health outcomes ■ the impact of 2SGBTQI+ health education for health providers on 2SLGBTQI+ peoples’ experiences of care ■ long-term outcomes of continuing education on 2SLGBTQI+ health ■ studies exploring the effectiveness of different types of continuing education on 2SLGBTQI+ health
<p>ORIGINAL RECOMMENDATION QUESTION:</p> <p>Should 2SLGBTQI+ specific spaces for long-term care residents be recommended for improving care to residents?</p> <p>Outcomes: Knowledge of staff, responsive behaviours (including anxiety, agitation, and behavioural issues), perceived safety, experience, incidence of peer bullying and violence.</p> <p>(Note: This question was amalgamated into Recommendation question #3 due to limited direct evidence)</p>	<ul style="list-style-type: none"> ■ the impact on health outcomes and quality of life of 2SLGBTQI+ specific spaces for long-term care residents ■ the experience of 2SLGBTQI+ older adults in 2SLGBTQI+ specific residential spaces such as long-term care homes, retirement residences, assisted living and community living spaces for older adults with disabilities ■ studies examining the intersecting experiences of 2SLGBTQI+ older adults including race, disability and age, and their experiences of care in long-term care homes or retirement homes and interventions addressing their needs

RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
Evaluation (see Tables 4, 5 and 6)	<ul style="list-style-type: none"> ■ development of public data repositories and indicators for provincial, national and international data collection of outcomes relevant to 2SLGBTQI+ health ■ stratification of data for 2SLGBTQI+ persons from administrative, surveillance and vital statistics databases ■ development of information practices to capture sex and gender information in electronic health records.

Table 23: Additional Priority Research Areas Identified by the Expert Panel

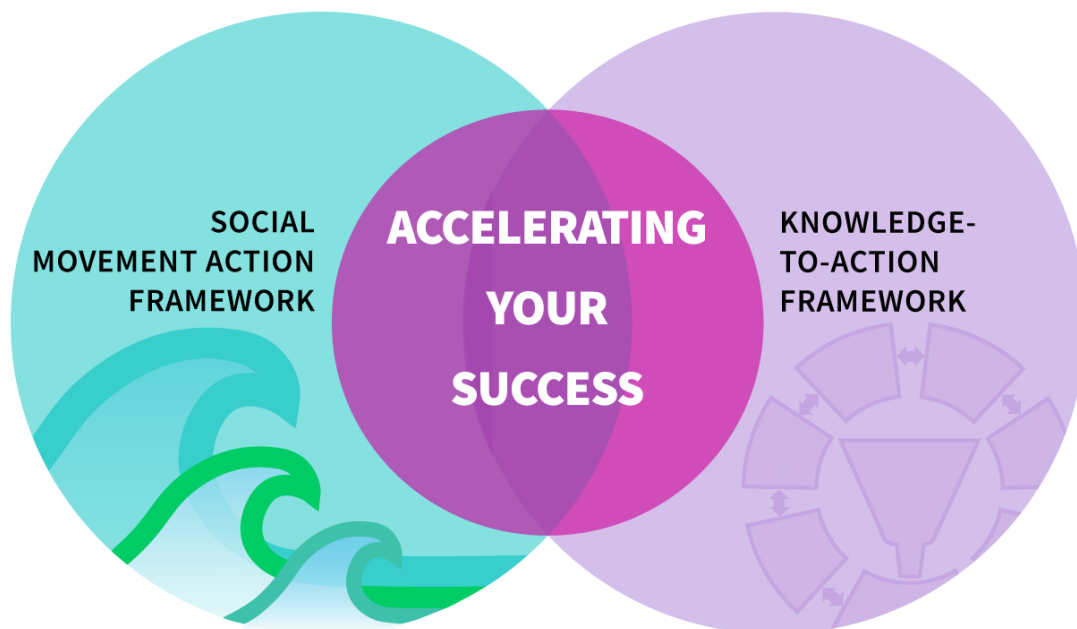
CATEGORY	PRIORITY RESEARCH AREA
Data collection	<ul style="list-style-type: none"> ■ ongoing and up-to-date collection of gender identity and sexual orientation data on the general population, as a means to conduct population-based health outcome analyses including appropriate fields in electronic medical records (EMR) ■ studies developing or validating person or patient reported outcome measures (PROMs) for 2SLGBTQI+ people
Implementation Science	<ul style="list-style-type: none"> ■ studies exploring the barriers and facilitators for health providers to care effectively for 2SLGBTQI+ people
Implicit Bias	<ul style="list-style-type: none"> ■ studies exploring, both before and after education, the attitudes, biases and discriminatory views of health providers and health students
Older adults	<ul style="list-style-type: none"> ■ studies exploring the care of 2SLGBTQI+ older adults with dementia.
Priority populations	<ul style="list-style-type: none"> ■ studies conducted using an intersectional lens and focusing on underserved populations such as Two-Spirit, Black, Indigenous and People of Colour and people with disabilities

Implementation Strategies

Implementing guidelines at the point of care is multi-faceted and challenging. It takes more than awareness and distribution of BPGs for practice to change must be adapted for each practice setting in a systematic and participatory way to ensure that recommendations fit the local context (313). The RNAO *Leading Change Toolkit*[™] (2021), available online at <https://www.RNAO.ca/leading-change-toolkit> provides evidence-informed processes for this (see [Appendix N](#)).

The *Leading Change Toolkit*[™] uses two complementary frameworks to guide evidence uptake and sustainability (see [Figure 1](#)). They can be used together to maximize and accelerate change.

Figure 1: *Leading Change Toolkit*[™] Two Complementary Frameworks to Accelerate your Success



The Social Movement Action Framework (314) is descriptive and identifies the defining elements of a social movement for knowledge (e.g., BPGs) uptake and sustainability. It integrates a ‘bottom-up’, people-led approach to change for a shared concern (or common cause) in which change agents and change teams mobilize individual and collective action to achieve goals. The framework’s elements, categorized as preconditions, key characteristics and outcomes, are dynamic, inter-related and develop spontaneously as the social movement evolves.

The Knowledge-to-Action Framework uses a process model of action cycle phases to systematically guide the adaptation of the new knowledge (e.g., BPG) to the local context and implementation. This framework suggests identifying and using knowledge tools/products, such as guidelines, to determine gaps and begin the process of tailoring the new knowledge to local settings.

The *Leading Change Toolkit*[™] is based on emerging evidence in health and social sciences that successful uptake and sustainability of best practice in health care is more likely when:

- BPGs are selected for implementation through a participatory process led by change agents and change teams;
- The selected BPGs reflect priority areas for a shared concern that is credible, valued and meaningful, or an urgency for action;
- Stakeholders are identified and engaged throughout implementation to engage in individual and collective action;
- Receptivity for implementing BPGs, including environmental readiness, is assessed;
- Implementation strategies are tailored to the local context and designed to address barriers;
- Use of the BPG is monitored and sustained;
- Evaluation of the BPG's impact is embedded in the process to determine if the goals and outcomes have been met;
- There are adequate resources to complete all aspects of the uptake and sustainability of the BPG; and,
- The BPG is scaled up, out, or deep, where possible, to widen its influence and create lasting health improvements.

RNAO is committed to widespread deployment and implementation of our BPGs. We use a coordinated approach to dissemination, incorporating a variety of strategies, including the following:

1. The Nursing Best Practice Champion Network[®], which develops the capacity of individual nurses to foster awareness, engagement, and adoption of BPGs.
2. The BPG Order Sets[™] provide clear, concise and actionable intervention statements derived from practice recommendations. BPG Order Sets[™] can be readily embedded within electronic records, but they can also be used in paper-based or hybrid environments.
3. The BPSO[®] designation supports implementation at the organization and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate and sustain multiple RNAO BPGs.

In addition, we offer annual capacity-building learning institutes on specific BPGs and their implementation.

Information about our implementation strategies can be found at:

- RNAO Best Practice Champions Network[®]: www.RNAO.ca/bpg/get-involved/champions
- RNAO BPG Order Sets[™]: <https://RNAO.ca/ehealth/bpgordersets>
- RNAO BPSO[®]: www.RNAO.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: www.RNAO.ca/events

References

1. Liss K. LGBTQ2S Inclusion Playbook: A Series of Best Practices for Healthcare Environments. Toronto, ON: The 519; 2020.
2. The BIPOC Project. [Internet] [no date, place unknown] Available from: <https://www.thebipocproject.org/>
3. World Health Organization Regional Office for Africa. Disabilities 2020. [Internet] Available from: <https://www.afro.who.int/health-topics/disabilities>
4. World Health Organization. Disability 2021 [Internet] Available from: <https://www.who.int/news-room/fact-sheets/detail/disability-and-health>
5. Accessibility for Ontarians with Disabilities Act. What is ableism? [Internet]. 2021. Available from: <https://www.aoda.ca/what-is-ableism/>
6. Fenway Health. Glossary of Gender and Transgender Terms. Boston (MA) National LGBTQIA+ Health Education Center, Fenway Institute; 2020.
7. Ontario Human Rights Commission (OHRC). Policy on preventing discrimination because of gender identity and gender expression. OHRC; 2014.
8. Gillespie C. What Does It Mean to Be Gender Fluid? Here's What Experts Say [Internet]. 2020 Feb 6. Available from: <https://www.health.com/mind-body/gender-fluid>
9. The 519. The 519 Glossary 2020. [Internet] Toronto (ON): Available from: <https://www.the519.org/education-training/glossary>
10. Rainbow Health Ontario (RHO). Trans health guide: Language and terminology. Toronto (ON): RHO; [date unknown].
11. Dalla Lana School of Public Health (DLSPH) University of Toronto, Centre for Addiction and Mental Health (CAMH). Researching for LGBTQ2S Health: Two-Spirit Community 2020 [Internet]. Toronto (ON) : DLSPH and CAMH: 2020. Available from: <https://lgbtqhealth.ca/community/two-spirit.php>
12. Native Youth Sexual Health Network (NYSHN). Two-Spirit & Indigenous LGBTQIA Mentors, Elders & Grandparents Support Circle [Internet]. NYSHN [date unknown] Available from: <http://www.nativeyouthsexualhealth.com/supportcircle.html>
13. Guyatt G, Schunemann HJ, Djulbegovic B, et al. Guideline panels should not GRADE good practice statements. J Clin Epidemiol. 2015;68(5):597-600.
14. House of Commons Standing Committee on Health. The health of LGBTQIA2 communities in Canada [Internet]. Ottawa (ON): Parliament of Canada; 2019.
15. United Nations. Resolution adopted by the Human Rights Council on 30 June 2016 In: Council UNHR, editor. 2016.
16. Schunemann HJ, Brozek J, Guyatt G, et al. editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Available from: <https://gdt.grade.pro.org/app/handbook/handbook.html>

17. Lewin S, Booth A, Glenton C, Munthe-Kaas H, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series Implementation Science 2018;13(Suppl 1):2.
18. Donabedian A. Evaluating the quality of medical care. The Milbank Quarterly 2005;83(4):691-729.
19. Registered Nurses' Association of Ontario in partnership with Healthcare Excellence Canada. Leading Change Toolkit™ (3rd ed.). Toronto (ON): RNAO; 2021 Available from: <https://www.RNAO.ca/leading-change-toolkit>.
20. VanDeVelde-Coke S, Doran D, Grinspun D, et al. Measuring outcomes of nursing care, improving the health of Canadians: NNQR (C), C-HOBIC and NQUIRE. Nurs Leadersh. 2012;25(2):26-37.
21. Ard K, Makadon H. Improving the health care of lesbian, gay, bisexual and transgender (LGBT) people: Understanding and eliminating health disparities. Boston (MA): The Fenway Institute; 2016.
22. Fondation Jasmin Roy. PanCanadian survey on LGBT communities [Internet]. Newswire release. Feb. 13, 2021. Available from: <https://www.newswire.ca/news-releases/according-to-lgbt-realities-the-first-pancanadian-survey-on-lgbt-communities-conducted-by-crop-for-the-benefit-of-the-fondation-jasmin-roy-13-of-the-canadian-population-belongs-to-the-lgbt-community-639432223.html>
23. Taylor C, Peter T, McMinn TL, et al. Every class in every school: The first national climate survey on homophobia, biphobia, and transphobia in Canadian schools. Toronto, (ON): Egale Canada Human Rights Trust; 2011.
24. Canadian Bar Association. Sexual Orientation, Gender Identity and Gender Expression [Internet] [date unknown] [place unknown] Available from: <https://www.cba.org/Publications-Resources/Practice-Tools/Child-Rights-Toolkit/theChild/Sexual-Orientation-Gender-Identity-and-Gender-Expr>
25. Rainbow Health Ontario (RHO). Health Equity Impact Assessment: LGBT2SQ Populations Supplement. Toronto (ON): RHO; 2020.
26. Wilson A. N'tacinowin inna nah': Our coming in stories. Can Womens Stud, 2008;26(3).
27. Weston K. Families we choose: Lesbians, gays, kinship. New York (NY): Columbia University Press; 1991.
28. Knauer NJ. LGBT Older adults, chosen family and caregiving. Journal of Law and Religion. 2016;31(2):150-68.
29. Law Commission of Ontario (LCO). Perspectives on the final stages of life from LGBT Elders living in Ontario [Internet]. LCO; 2016. Available from: <https://www.lco-cdo.org/wp-content/uploads/2016/07/Stinchcombe%20et%20al%20%28LCO%20June%202016%29.pdf>
30. Wilson K, Stinchcombe, A, Kortés-Miller, K, et al . Support Needs of Lesbian, Gay, Bisexual, and Transgender Older Adults in the Health and Social Environment. Couns Spiritual. 2016. Vol 35 (1) 13-29.
31. Furlotte C, Gladstone JW, Cosby RF, et al. "Could We Hold Hands?" Older Lesbian and Gay Couples' Perceptions of Long-Term Care Homes and Home Care. Can J Aging.2016;35(4):432-46.
32. Boulé J, Wilson K, Kortés-Miller K, et al. "We Live in a Wonderful Country, Canada, but...": Perspectives From Older LGBTQ Ontarians on Visibility, Connection, and Power in Care and Community. Int J Aging Hum Dev. 2020;91(3):235-52.
33. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull. 2003;129(5):674-97.

34. Canadian Mental Health Association (CMHA). Lesbian, Gay, Bisexual, Trans & Queer identified People and Mental Health [Internet]. CMHA; [date unknown]. Available from: <https://ontario.cmha.ca/documents/lesbian-gay-bisexual-trans-queer-identified-people-and-mental-health/>
35. Rapid Response Service. Rapid Response: Facilitators and barriers to health care for lesbian, gay and bisexual (LGB) people. Toronto (ON): Ontario HIV Treatment Network; 2014.
36. The Trans PULSE Canada Team. Health and health care access for trans and non-binary people in Canada. [Internet]. Trans PULSE Canada team; 2020. Available from: <https://transpulsecanada.ca/research-type/reports>
37. McGrail KM, van Doorsaer E, Ross NA, et al. Income-related health inequalities in Canada and the United States: A decomposition analysis. *Am J Public Health*. 2009;99(10):1856-63.
38. Baker L, Young S, Straatman, et al. Intimate Partner Violence in Rainbow Communities: A Discussion Paper Informed by the Learning Network Knowledge Exchange. London (ON): Centre for Research & Education on Violence Against Women & Children.; 2015.
39. National Inquiry into Missing and Murdered Indigenous Women and Girls. Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1a. The National Inquiry 2019.
40. Canadian Network for the Prevention of Elder Abuse. Forms of Abuse 2017 [Internet] Available from: <https://cnpea.ca/en/what-is-elder-abuse/forms-of-abuse>
41. Bloemen EM, Rosen T, LoFaso VM, et al. Lesbian, Gay, Bisexual, and Transgender Older Adults' Experiences With Elder Abuse and Neglect. *J Am Geriatr Soc*. 2019;67(11):2338-45.
42. Westwood S. Abuse and older lesbian, gay bisexual, and trans (LGBT) people: a commentary and research agenda. *J Elder Abuse Negl*. 2019;31(2):97-114.
43. Human Rights Act 1985 (CA)
44. Human Rights Code 1990 (ON).
45. Dickinson T. 'Curing queers': Mental nurses and their patients, 1935–74. Manchester (UK): Manchester University Press; 2015.
46. Drescher J. Out of DSM: Depathologizing Homosexuality. *Behav. Sci*. 2015;5(4):565-75.
47. Criminal Code 1985 (CA)
48. United Nations High Commission on Human Rights (UNHCR). Pathologization: Being lesbian, gay, bisexual and/or trans is not an illness: For International Day against Homophobia, Transphobia and Biphobia [Internet]. UNHCR; 2016. Available from: <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=19956>
49. Kerker BD, Mostashari F, Thorpe L. Health Care Access and Utilization among Women Who Have Sex with Women: Sexual Behavior and Identity. *J. of Urban Health*. 2006;83(5):970-9.
50. Canadian Commission for UNESCO (CCUNESCO). Toolkit for inclusive municipalities in Canada and beyond. Ottawa (ON): CCUNESCO 2019.
51. Bergeron S, Senn CY. Health Care Utilization in a Sample of Canadian Lesbian Women: Predictors of Risk and Resilience. *Women Health*. 2003;37(3):19-35.

52. Sanchez NF, Rabatin J, Sanchez JP, et al. Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. *Fam Med*. 2006;38(1):21.
53. Epstein R. " Married, Single, or Gay?" Queering and Trans-forming the Practices of Assisted Human Reproduction Services. Unpublished doctoral dissertation. Toronto (ON): York University; 2014.
54. Morris M, Cooper RL, Ramesh A, et al. Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review. *BMC Med Educ*. 2019;19(1):325.
55. National LGBT Health Education Center. Learning to Address Implicit Bias Towards LGBTQ Patients: Case Scenarios. Boston (MA): Fenway Institute; 2018.
56. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics*. 2017;18(1):19.
57. Diamant AL, Wold C. Sexual orientation and variation in physical and mental health status among women. . *J Womens Health*. 2003;12(1):41-9.
58. Lee R. Health care problems of lesbian, gay, bisexual, and transgender patients. . *Western Journal of Medicine*, .2000;172(6):403-8.
59. American Cancer Society (ACS). Cancer Facts for Lesbian and Bisexual Women [Internet]. ACS; 2020. Available from: <https://www.cancer.org/healthy/cancer-facts/cancer-facts-for-lesbian-and-bisexual-women.html>
60. Peitzmeier S, The Fenway Institute. Promoting Cervical Cancer Screening Among Lesbians and Bisexual Women. Boston (MA): The Fenway Institute; 2013.
61. Caceres BA, Brody A, Chyun D. Recommendations for cardiovascular disease research with lesbian, gay and bisexual adults. *J Clin Nurs*. 2016;25(23-24):3728-42.
62. Caceres BA, Brody A, Luscombe RE, et al. A Systematic Review of Cardiovascular Disease in Sexual Minorities. *Am J Public Health*. 2017;107(4):e13-e21.
63. Cranston RD, Murphy R, Weiss RE, et al. Anal human papillomavirus infection in a street-based sample of drug using HIV-positive men. . *Int J STD AIDS*. 2012;23(3):195-200.
64. Johnson LG, Madeleine MM, Newcomer LM, et al. Anal cancer incidence and survival: The surveillance, epidemiology, and end results experience, 1973-2000. *Cancer*. 2004;101(2):281-8.
65. Ontario Health Cancer Care Ontario (CCO). Overarching policy for the screening of trans people in the Ontario breast screening program and the Ontario cervical screening program. Toronto (ON): Ontario Health CCO; 2019.
66. Roberts AL, Austin SB, Corliss HL et al. Pervasive trauma exposure among US sexual orientation minority adults and risk of posttraumatic stress disorder. *Am J of Public Health*, 2010;100(12):2433-41.
67. Green KE, Feinstein BA. Substance use in lesbian, gay, and bisexual populations: An update on empirical research and implications for treatment. *Psychol Addict Behav* 2011;26(2):265-78.
68. Statistics Canada. Sexual orientation and complete mental health: Health Brief Catalogue no. 82-003-X Health Reports. 2019. p. 3-10.

69. Public Health Agency of Canada. Pan-Canadian Health Inequalities Data Tool. A joint initiative of the Public Health Agency of Canada, the Pan-Canadian Public Health Network, Statistics Canada and the Canadian Institute of Health Information [Internet]. 2017. Available from: <https://health-infobase.canada.ca/health-inequalities/data-tool/index>
70. Institute of Medicine (US). The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding In: Institute of Medicine (US) Committee on Lesbian G, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities,, editor. Washington, DC.: National Academies Press (US); 2011.
71. Collins P, Bilge S. Intersectionality, 2nd Edition, . Medford, MA. : Polity Press; 2020.
72. Hunt S. An Introduction to the Health of Two-Spirit People: Historical, contemporary and emergent issues. Prince George, BC.: National Collaborating Centre for Aboriginal Health; 2016.
73. Ng HH. Intersectionality and Shared Decision Making in LGBTQ Health.. *LGBT Health* 2016;3(5):325-6.
74. Kidd SA, Veltman A, Gately C, et al. Lesbian, Gay, and Transgender Persons with Severe Mental Illness: Negotiating Wellness in the Context of Multiple Sources of Stigma. *Am J Psychiatr Rehabil*. 2011;14(1):13-39.
75. Simpson J. Everyone Belongs: A toolkit for applying intersectionality. Ottawa, ON: Canadian Research Institute for the Advancement of Women (CRIAOW); 2009.
76. Dominelli L, Campling J. *Anti Oppressive Social Work Theory and Practice*: Palgrave Macmillan; 2002.
77. Burke B, Harrison P. Anti-oppressive practice. In: Adams R, Dominelli L, Payne M, Campling J, editors. *Social Work: Themes, Issues and Critical Debates*. London (UK): Macmillan Education UK; 2003. p. 229-39.
78. Center for Story Based Strategy. Anti-oppression principles [Internet] [date unknown] Available from: <https://www.storybasedstrategy.org/anti-oppression-principles/>
79. Yee JY, Wong H, Janczur A. Examining systemic and individual barriers of ethno-racial minority social workers in mainstream social service agencies: a community project. Toronto (ON): Canadian Heritage, Human Resources Skills Development and Ryerson University, Faculty of Community Services; 2006.
80. Dalrymple J, Burke B. *Anti-oppressive practice: Social care and the law*. Buckingham (UK): Open University Press; 1995.
81. Sherbourne Health, Rainbow Health Ontario (RHO). *Guidelines for gender-affirming primary care with trans and non-binary patients, 4th Edition*. Toronto (ON): RHO; 2019.
82. Statistics Canada. *Aboriginal peoples in Canada: Key results from the 2016 Census*. Ottawa, ON: Statistics Canada; 2017 Available from: <https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025a-eng.htm?indid=14430-1&indgeo=0>
83. Well Living House. *Our Health Counts: Community health assessment by the people, for the people*. Toronto (ON): Well Living House; 2018.
84. Loppie Reading C, Wein F. *Health inequalities and social determinants of Aboriginal peoples' health*. Prince George (BC): National Collaborating Centre for Aboriginal Health; 2009.

85. United Nations (UN). Adequate housing as a component of the right to an adequate standard of living, and the right to non-discrimination in this context. New York (US): UN; 2019.
86. Truth and Reconciliation Commission of Canada (TRCC). Truth and Reconciliation Commission Final Report. Winnipeg (MB): TRCC; 2015.
87. United Nations. United Nations Declaration on the Rights of Indigenous People. 2007.
88. Government of Canada. Non-insured health benefits for First Nations and Inuit [Internet] 2020 Available from: www.canada.gc.ca/nihb
89. National Collaborating Centre for Indigenous Health (NCCIH). Access to health services as a social determinant of First Nations, Inuit and Metis health. Prince George (BC): NCCIH; 2019.
90. Coutu A. Inclusive language examples [Internet] 2018 Available from: <http://carequadrant.com/inclusive-language-examples/>
91. Hagen DB, Galupo MP. Trans Individuals' Experiences of Gendered Language with Health Care Providers: Recommendations for Practitioners. *Int J Transgend.* 2014;15(1):16-34.
92. Ross KA, Castle Bell G. A Culture-Centered Approach to Improving Healthy Trans-Patient-Practitioner Communication: Recommendations for Practitioners Communicating with Trans Individuals. *Health Commun.* 2017;32(6):730-40.
93. German D, Kodadek L, Shields R, et al. Implementing Sexual Orientation and Gender Identity Data Collection in Emergency Departments: Patient and Staff Perspectives. *LGBT Health.* 2016;3(6):416-23.
94. Stover CM, Hare P, Johnson M. Healthcare experiences of lesbian, gay, and bisexual college students: recommendations for the clinical nurse specialist. *Clin Nurse Spec.* 2014;28(6):349-57.
95. Rounds KE, McGrath BB, Walsh E. Perspectives on provider behaviors: A qualitative study of sexual and gender minorities regarding quality of care. *Contemp Nurse.* 2013;44(1):99-110.
96. Rucker AJ, Murray A, Gaul Z, et al. The role of patient-provider sexual health communication in understanding the uptake of HIV prevention services among Black men who have sex with men. *Cult Health Sex.* 2018;20(7):761-71.
97. Dunne MJ, Raynor LA, Cottrell EK, et al. Interviews with Patients and Providers on Transgender and Gender Nonconforming Health Data Collection in the Electronic Health Record. *Transgend Health.* 2017;2(1):1-7.
98. Thompson HM. Patient Perspectives on Gender Identity Data Collection in Electronic Health Records: An Analysis of Disclosure, Privacy, and Access to Care. *Transgend Health.* 2016;1(1):205-15.
99. Uhrig JD, Stryker JE, Bresee S, et al. HIV information needs of transgender people and their healthcare providers. *AIDS Care.* 2019; 31(3):357-63
100. Bjarnadottir RI, Bockting W, Dowding DW. Patient perspectives on answering questions about sexual orientation and gender identity: an integrative review. *J Clin Nurs.* 2017;26(13/14):1814-33.
101. Lisy K, Peters MDJ, Schofield P, et al. Experiences and unmet needs of lesbian, gay, and bisexual people with cancer care: A systematic review and meta-synthesis. *Psycho-Oncol.* 2018;27(6):1480-9.

102. Brooks H, Llewellyn CD, Nadarzynski T, et al. Sexual orientation disclosure in health care: A systematic review. *Br J Gen Pract.* 2018;68(668):e187-e96.
103. Floyd MJ, Martin O, Eckloff KJ. A qualitative study of transgender individuals' experiences of healthcare including radiology. *Radiography.* 2020;26(2):e38-e44.
104. Brown C, Frohard-Dourlent H, Wood BA, et al. "It makes such a difference": An examination of how LGBTQ youth talk about personal gender pronouns. *J Am Assoc Nurse Pract.* 2020;32(1):70-80.
105. Carlstrom R, Ek S, Gabrielsson S. 'Treat me with respect': transgender persons' experiences of encounters with healthcare staff. *Scand J Caring Sci.* 2020.
106. Samuels EA, Tape C, Garber N, et al. "Sometimes You Feel Like the Freak Show": A Qualitative Assessment of Emergency Care Experiences Among Transgender and Gender-Nonconforming Patients. *Ann Emerg Med.* 2018;71(2):170-82.e1.
107. Agénor M, Bailey Z, Krieger N, et al. Exploring the Cervical Cancer Screening Experiences of Black Lesbian, Bisexual, and Queer Women: The Role of Patient-Provider Communication. *Women Health.* 2015;55(6):717-36.
108. Jahn JL, Bishop RA, Tan ASL, et al. Patient-Provider Sexually Transmitted Infection Prevention Communication among Young Adult Sexual Minority Cisgender Women and Nonbinary Assigned Female at Birth Individuals. *Women's Health Issues.* 2019;29(4):308-14.
109. Goins ES, Pye D. Check the box that best describes you: reflexively managing theory and praxis in LGBTQ health communication research. *Health Commun.* 2013;28(4):397-407.
110. Registered Nurses' Association of Ontario. Person- and family-centered care. Toronto (ON): Registered Nurses Association of Ontario 2015. Available from: https://rnao.ca/sites/rnao-ca/files/FINAL_Web_Version_0.pdf
111. Bass AC, Torain M, Adler R, et al. Is It Okay To Ask: Transgender Patient Perspectives on Sexual Orientation and Gender Identity Collection in Healthcare. *Acad Emerg Med.* 2017;24(6):655-67.
112. McNair RP, Hegarty K, Taft A. From silence to sensitivity: a new Identity Disclosure model to facilitate disclosure for same-sex attracted women in general practice consultations. *Soc Sci Med.* 2012;75(1):208-16.
113. College of Nurses of Ontario. Practice Standard: Confidentiality and Privacy- Personal Health Information. Toronto (ON): College of Nurses of Ontario; 2019.
114. Personal Health Information Protection Act 2004 (ON).
115. Dispenza F, Viehl C, Sewell MH, et al. A Model of Affirmative Intersectional Rehabilitation Counseling With Sexual Minorities. *Rehabil Couns Bull.* 2016;59(3):143-57.
116. Guss CE, Woolverton GA, Borus J, et al. Transgender Adolescents' Experiences in Primary Care: A Qualitative Study. *J Adoles Health.* 2019;65(3):344-9.
117. Dodge B, Schnarrs PW, Goncalves G, et al. The significance of privacy and trust in providing health-related services to behaviorally bisexual men in the United States. *AIDS Educ Prev.* 2012;24(3):242-56.
118. Brooks H, Llewellyn CD, Nadarzynski T, et al. Sexual orientation disclosure in health care: a systematic review. *Br J Gen Pract.* 2018;68(668):e187-e96.

119. Eisenberg ME, McMorris BJ, Rider GN, et al. "It's kind of hard to go to the doctor's office if you're hated there." A call for gender-affirming care from transgender and gender diverse adolescents in the United States. *Health Soc Care Community*. 2020;28(3):1082-9.
120. Hines DD, Laury ER, Habermann B. They Just Don't Get Me: A Qualitative Analysis of Transgender Women's Health Care Experiences and Clinician Interactions. *J Assoc Nurses AIDS Care*. 2019;30(5):e82-e95.
121. Soinio JI, Paavilainen E, Kylma JPO. Lesbian and bisexual women's experiences of health care: "Do not say, 'husband', say, 'spouse'". *J Clin Nurs*. 2020;29(1-2):94-106.
122. Bell J, Purkey E. Trans individuals' experiences in primary care. *Can Fam Physician*. 2019;65(4):E147-E54.
123. Sbragia JD, Vottero B. Experiences of transgender men in seeking gynecological and reproductive health care: a qualitative systematic review. *JB I Evid Synth*. 2020.
124. Pennay A, McNair R, Hughes TL, et al. Improving alcohol and mental health treatment for lesbian, bisexual and queer women: Identity matters. *Aust NZ J Public Health*. 2018;42(1):35-42.
125. Pinto AD, Aratangy T, Abramovich A, et al. Routine collection of sexual orientation and gender identity data: a mixed-methods study. *Can Med Assoc J*. 2019;191(3):E63-E8.
126. Ontario Public Health Association (OPHA). *A Positive Space is a Healthy Space*. Toronto (ON): OPHA; 2011.
127. De Pedro KT, Lynch RJ, Esqueda MC. Understanding safety, victimization and school climate among rural lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. *J LGBT Youth*. 2018;15(4):265-79.
128. Kosciw JG, Palmer NA, Kull RM, et al. The Effect of Negative School Climate on Academic Outcomes for LGBT Youth and the Role of In-School Supports. *J Sch Violence*. 2013;12(1):45-63.
129. Day JK, Ioverno S, Russell ST. Safe and supportive schools for LGBT youth: Addressing educational inequities through inclusive policies and practices. *J Sch Psychol*. 2019;74:29-43.
130. Saewyc EM, Konishi C, Rose HA, et al. School-Based Strategies to Reduce Suicidal Ideation, Suicide Attempts, and Discrimination among Sexual Minority and Heterosexual Adolescents in Western Canada. *J Child Fam Stud*. 2014;5(1):89-112.
131. Day JK, Fish JN, Grossman AH, et al. Gay-Straight Alliances, Inclusive Policy, and School Climate: LGBTQ Youths' Experiences of Social Support and Bullying. *J Res Adolesc*. 2020; 30: 418-430
132. Poteat VP, Sinclair KO, DiGiovanni CD, et al. Gay--Straight Alliances Are Associated with Student Health: A Multischool Comparison of LGBTQ and Heterosexual Youth. *J Res Adolesc*. 2013;23(2):319-30.
133. Kull RM, Greytak EA, Kosciw JG, et al. Effectiveness of school district antibullying policies in improving LGBT youths' school climate. *Psychol Sex Orientat Gend Divers*. 2016;3(4):407-15.
134. MacDonnell JA, Daley A. Examining the development of positive space in health and social service organizations: A Canadian exploratory study. *Gay Lesbian Soc Serv*. 2015;27(3):263-301.
135. Sullivan KM. Acceptance in the Domestic Environment: The Experience of Senior Housing for Lesbian, Gay, Bisexual, and Transgender Seniors. *J Gerontol Soc Work*. 2014;57(2-4):235-50.
136. Fetner T, Elafros A, Bortolin S, et al. Safe spaces: gay-straight alliances in high schools. *J Gerontol Soc Work*. 2012;49(2):188-207.

137. Leyerzapf H, Visse M, De Beer A, et al. Gay-friendly elderly care: creating space for sexual diversity in residential care by challenging the hetero norm. *Ageing Soc.* 2016;38(2):352-77.
138. Gower AL, Forster M, Gloppen K, et al. School Practices to Foster LGBT-Supportive Climate: Associations with Adolescent Bullying Involvement. *Prev Sci.* 2018;19(6):813-21.
139. Garcia J, Parker C, Parker RG, et al. "You're Really Gonna Kick Us All Out?" Sustaining Safe Spaces for Community-Based HIV Prevention and Control among Black Men Who Have Sex with Men. *PLOS One.* 2015;10(10):e0141326.
140. Pitcher EN, Camacho TP, Renn KA, et al. Affirming Policies, Programs, and Supportive Services: Using an Organizational Perspective to Understand LGBTQ+ College Student Success. *J Divers High Educ.* 2018;11(2):117-32.
141. Gamarel KE, Walker JNJ, Rivera L, et al. Identity safety and relational health in youth spaces: A needs assessment with LGBTQ youth of color. *J LGBT Youth.* 2014;11(3):289-315.
142. Porta CM, Singer E, Mehus CJ, et al. LGBTQ Youth's Views on Gay-Straight Alliances: Building Community, Providing Gateways, and Representing Safety and Support. *J Sch Health.* 2017;87(7):489-97.
143. Murchison GR, Agénor M, Reisner SL, et al. School Restroom and Locker Room Restrictions and Sexual Assault Risk Among Transgender Youth. *Pediatrics.* 2019;143(6):1-10.
144. Seelman KL, Walker MB. Do Anti-Bullying Laws Reduce In-School Victimization, Fear-based Absenteeism, and Suicidality for Lesbian, Gay, Bisexual, and Questioning Youth? *J Youth Adolesc.* 2018;47(11):2301-19.
145. Davis B, Stafford MB, Pullig C. How gay-straight alliance groups mitigate the relationship between gay-bias victimization and adolescent suicide attempts. *Journal of the American Academy of Child & Adolescent Psychiatry.* 2014 Dec 1;53(12):1271-8.
146. Burk J, Park M, Saewyc EM. A media-based school intervention to reduce sexual orientation prejudice and its relationship to discrimination, bullying, and the mental health of lesbian, gay, and bisexual adolescents in western canada: A population-based evaluation. *Int J Environ Res Public Health.* 2018;15(11):2447.
147. Li G, Wu AD, Marshall SK, et al. Investigating site-level longitudinal effects of population health interventions: Gay-Straight Alliances and school safety. *SSM Popul Health.* 2019;7:100350.
148. Ioverno S, Belser AB, Baiocco R, et al. The protective role of gay-straight alliances for lesbian, gay, bisexual, and questioning students: A prospective analysis. *Psychol Sex Orientat Gen Divers.* 2016;3(4):397-406.
149. Canadian Centre for Gender and Sexual Diversity. Gender and Sexuality Alliance GSA Toolkit [place unknown] Canadian Centre for Gender and Sexual Diversity; 2015.
150. Elliott KO. Queering student perspectives: gender, sexuality and activism in school. *Sex Educ.* 2016;16(1):49-62.
151. McCormick A, Schmidt K, Clifton E. Gay-Straight Alliances: Understanding Their Impact on the Academic and Social Experiences of Lesbian, Gay, Bisexual, Transgender, and Questioning High School Students. *Children Schools.* 2015;37(2):71-7.
152. Roe SL. Examining the Role of Peer Relationships in the Lives of Gay and Bisexual Adolescents. *Children Schools.* 2015;37(2):117-24.
153. St. John A, Travers R, Munro L, et al. The Success of Gay–Straight Alliances in Waterloo Region, Ontario: A Confluence of Political and Social Factors. *J LGBT Youth.* 2014;11(2):150-70.

154. Porta CM, Gower AL, Mehus CJ, et al. "Kicked out": LGBTQ youths' bathroom experiences and preferences. *J Adolesc.* 2017;56:107-12.
155. Greytak EA, Kosciw JG, Boesen MJ. Putting the "T" in "resource": The benefits of LGBT-related school resources for transgender youth. *Special Issue: Supporting transgender and gender-nonconforming children and youth. J LGBT Youth.* 2013;10(1-2):45-63.
156. Bill 13, Accepting Schools Act 2012 (ON).
157. Public Health Agency of Canada (PHAC). *Addressing Stigma: Towards a More Inclusive Health System.* Ottawa (ON): PHAC; 2019.
158. Giblon RE. *Inequalities in Social Determinants of Health in the Ontario Transgender Population.* Electronic Thesis and Dissertation Repository: University of Western Ontario; 2016.
159. Canadian Cancer Society. *Screening in LGBTQ communities: Why should you get screened?* [Internet] 2019 Available from: <http://www.cancer.ca/en/prevention-and-screening/reduce-cancer-risk/find-cancer-early/screening-in-lgbtq-communities/why-should-you-get-screened/?region=on>
160. Ontario HIV Treatment Network. *Rapid Response Service. Facilitators and barriers to health care for lesbian, gay and bisexual (LGB) people.* Toronto (ON): Ontario HIV Treatment Network; 2014.
161. Rainbow Health Ontario (RHO). *LGBTQ Cancer Factsheet.* Toronto (ON): RHO; 2016.
162. European AIDS Clinical Society (EACS). *EACS Guidelines: Version 10.1 Brussels (BE): EACS; 2020.*
163. Canadian Cancer Society. *Lesbian, bisexual & queer women and cervical cancer* [Internet] [date unknown] Available from: <http://www.cancer.ca/en/prevention-and-screening/reduce-cancer-risk/find-cancer-early/screening-in-lgbtq-communities/lesbian-bisexual-and-queer-women-and-cervical-cancer/?region=on>
164. Cancer Care Ontario. *Cervical Screening Guidelines Summary* [Internet] 2020 Available from: <https://www.cancercareontario.ca/en/guidelines-advice/cancer-continuum/screening/resources-healthcare-providers/cervical-screening-guidelines-summary>
165. Sherbourne Health. *Guidelines for Gender-affirming Primary Care with Trans and Non-binary Patients.* Toronto (ON): Sherbourne Health; 2019.
166. UCSF Transgender Care. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.* In: Department of Family and Community Medicine University of California San Francisco, editor. second ed San Francisco (CA): UCSF; 2016.
167. Lindsay P, Connor Gorber S, Joffres M, et al. Recommendations on screening for high blood pressure in Canadian adults. *Can Fam Physician.* 2013;59:927-33.
168. Papaioannou A, Morin S, Cheung AM, Atkinson S, Brown JP, Feldman S, et al. 2010 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada: summary. *CMAJ.* 2010 Nov 23;182(17):1864–73
169. Ekoe J-M, Goldenberg R, Katz P. Screening for Diabetes in Adults. *Can J Diabetes* 2018;42:S16-S9.
170. Rotondi Khobzi N, Bauer GR, Travers R, et al. Depression in male-to-female transgender Ontarians: Results from the Trans PULSE Project. *Can J Commun Ment Health* 2011;30(2):113-33.
171. Rotondi Khobzi N, Bauer G, Scanlon K, et al. Prevalence of and risk and protective factors for depression in female-to-male transgender Ontarians: Trans PULSE project. *Can J Commun Ment Health.* 2011;30(2):135-55.

172. Center for Disease Control (CDC). 2015 STD Treatment Guidelines: Special Populations. Atlanta (GA): CDC; 2015.
173. Brouwers M, Kho ME, Browman GP. AGREE II: advancing guideline development, reporting and evaluation in health care. *Can Med Assoc J.* 2010;182(18):E839-42.
174. Connolly D, Hughes X, Berner A. Barriers and facilitators to cervical cancer screening among transgender men and non-binary people with a cervix: A systematic narrative review. *Prev Med.* 2020;135:106071.
175. Pardee DJ, Peitzmeier SM, Reisner SL, et al. "It Can Promote an Existential Crisis": Factors Influencing Pap Test Acceptability and Utilization Among Transmasculine Individuals. *Qual Health Res.* 2017;27(14):2138-49.
176. Johnson M, Wakefield C, Garthe K. Qualitative socioecological factors of cervical cancer screening use among transgender men. *Prev Med Rep.* 2020;17:101052.
177. Tang W, Wei. Crowdsourcing to expand HIV testing among men who have sex with men in China: a closed cohort stepped wedge cluster randomized controlled trial. *PLoS Med.* 2018;15(8):e1002645.
178. Zhu X, Zhang. Effects of a Mobile Health Intervention to Promote HIV Self-testing with MSM in China: a Randomized Controlled Trial. *AIDS Behav.* 2019;23(11):3129.
179. Garbers S, Friedman A, Martinez O, et al. Adapting the Get Yourself Tested Campaign to Reach Black and Latino Sexual-Minority Youth. *Health Promot Pract.* 2016;17(5):739-50.
180. Adam BD, Gardner S, Major C, et al. Promoting HIV Testing for Gay and Bisexual Men. *Health Promot Pract.* 2016;17(1):40-7.
181. Alarcon Gutierrez M, Fernandez Quevedo M, Martin Valle S, et al. Acceptability and effectiveness of using mobile applications to promote HIV and other STI testing among men who have sex with men in Barcelona, Spain. *Sex Transm Infect.* 2018;94(6):443-8.
182. Frye V, Paige MQ, Gordon S, et al. Impact of a community-level intervention on HIV stigma, homophobia and HIV testing in New York City: Results from project CHHANGE. *Stigma Health.* 2019;4(1):72-81.
183. Wood M, Ellks R, Grobicki M. Outreach sexual infection screening and postal tests in men who have sex with men: are they comparable to clinic screening? *Int J STD AIDS.* 2015;26(6):428-31.
184. Knight V, Gale M, Guy R, et al. A novel time-limited pop-up HIV testing service for gay men in Sydney, Australia, attracts high-risk men. *Sex Health.* 2014;11(4):345-50.
185. Hart T, Noor. GPS: a Randomized Controlled Trial of Sexual Health Counseling for Gay and Bisexual Men Living With HIV. *Behav Ther.* 2020.
186. Mimiaga M, Hughto J. A Randomized Pilot Study of a Group-Delivered HIV Risk Reduction Intervention for At-Risk Urban Men Who Have Sex with Men Who Regularly Attend Private Sex Events. *Arch Sex Behav.* 2019;48(4):1059.
187. Harawa N, Guentzel-Frank H. Efficacy of a Small-Group Intervention for Post-Incarcerated Black Men Who Have Sex with Men and Women (MSMW). *J Urban Health.* 2018;95(2):159.
188. Sevelius J, Neilands T. Sheroes: feasibility and Acceptability of a Community-Driven, Group-Level HIV Intervention Program for Transgender Women. *AIDS Behav.* 2019.

189. Barry M, Threats M. "Stay strong! keep ya head up! move on! it gets better!!!!": resilience processes in the health empowerment online intervention of young black gay, bisexual and other men who have sex with men. *AIDS Care*. 2018;30(sup5):S27.
190. Sahassanon P, Pisitsungkagarn K, Taephant N. The Effect of Cognitive-Behavioral Group Therapy Using Art as a Medium on Depressive Symptoms and HIV Antiretroviral Medication Adherence. *Int J Adv Couns*. 2019;41(4):530-43.
191. Garofalo R, Kuhns LM, Reisner SL, et al. Efficacy of an Empowerment-Based, Group-Delivered HIV Prevention Intervention for Young Transgender Women: The Project LifeSkills Randomized Clinical Trial. *JAMA Pediatr*. 2018;172(10):916-23.
192. Cruess DG, Burnham KE, Finitzis DJ, et al. A randomized clinical trial of a brief internet-based group intervention to reduce sexual transmission risk behavior among HIV-positive gay and bisexual men. *Ann Behav Med*. 2018;52(2):116-29.
193. Capistrant BD, Torres B, Merengwa E, et al. Caregiving and social support for gay and bisexual men with prostate cancer. *Psycho-Oncol*. 2016;25(11):1329-36.
194. Reisner SL, Hughto JMW, Pardee DJ, et al. LifeSkills for Men (LS4M): Pilot Evaluation of a Gender-Affirmative HIV and STI Prevention Intervention for Young Adult Transgender Men Who Have Sex with Men. *J Urban Health*. 2016;93(1):189-205.
195. Hart TA, Stratto N, Coleman TA, et al. A pilot trial of a sexual health counseling intervention for HIV-positive gay and bisexual men who report anal sex without condoms. *PLOS ONE*. 2016;11 (4) (no pagination) (e0152762).
196. Hidalgo MA, Kuhns LM, Hotton AL, et al. The MyPEEPS Randomized Controlled Trial: A Pilot of Preliminary Efficacy, Feasibility, and Acceptability of a Group-Level, HIV Risk Reduction Intervention for Young Men Who Have Sex with Men. *Arch Sex Behav*. 2014;44(2):475-85.
197. Logie CH, Lacombe-Duncan A, Weaver J, et al. A Pilot Study of a Group-Based HIV and STI Prevention Intervention for Lesbian, Bisexual, Queer, and Other Women Who Have Sex with Women in Canada. *AIDS Patient Care STDs*. 2015;29(6):321-8.
198. Young SD, Cumberland WG, Nianogo R, et al. The HOPE social media intervention for global HIV prevention in Peru: A cluster randomised controlled trial. *Lancet HIV*. 2015;2(1):e27-e32.
199. Lyons T, Tilmon S, Fontaine YM. Development of a Small-Group Intervention for Stimulant-Using Men Who Have Sex With Men. *Journal of Groups in Addiction and Recovery*. 2014;9(1):54-70.
200. Heckman BD, Lovejoy TI, Heckman TG, et al. The moderating role of sexual identity in group teletherapy for adults aging with HIV. *Behav Med*. 2014;40(3):134-42.
201. Ye S, Yin L, Amico KR, Simoni JM, et al. Efficacy of peer-led interventions to reduce unprotected anal intercourse among men who have sex with men: A meta-analysis. *PLoS ONE*. 2014;9 (3) (no pagination) (e90788).
202. Horvath KJ, Michael Oakes J, Simon Rosser BR, et al. Feasibility, acceptability and preliminary efficacy of an online peer-to-peer social support ART adherence intervention. *AIDS Behav*. 2013;17(6):2031-44.
203. Bavinton BR, Gray J, Prestage G. Assessing the effectiveness of HIV prevention peer education workshops for gay men in community settings. *Aust NZ J Public Health* 2013;37(4):305-10.

204. Garofalo R, Johnson AK, Kuhns LM, et al. Life skills: Evaluation of a theory-driven behavioral HIV prevention intervention for young transgender women. *J Urban Health*. 2012;89(3):419-31.
205. Empson S, Cuca YP, Cocohoba J, et al. Seeking Safety Group Therapy for Co-Occurring Substance Use Disorder and PTSD among Transgender Women Living with HIV: A Pilot Study. *J Psychoact Drugs*. 2017;49(4):344-51.
206. Rhodes SD, Alonzo J, Mann L, Song EY, et al. Small-Group Randomized Controlled Trial to Increase Condom Use and HIV Testing Among Hispanic/Latino Gay, Bisexual, and Other Men Who Have Sex With Men. *Am J Public Health*. 2017;107(6):969-76.
207. Briggs PC, Hayes S, Changaris M. Somatic Experiencing informed therapeutic group for the care and treatment of biopsychosocial effects upon a gender diverse identity. *Front Psychiatry*. 2018;9 (FEB) (no pagination)(53).
208. Mimiaga MJ, Closson EF, Biello KB, et al. A Group-Based Sexual Risk Reduction Intervention for Men Who Have Sex With Men in Ho Chi Minh City, Vietnam: Feasibility, Acceptability, and Preliminary Efficacy. *Arch Sex Behav*. 2016;45(6):1493-500.
209. Amirkhanian YA, Kelly JA, Takacs J, et al. Effects of a social network HIV/STD prevention intervention for MSM in Russia and Hungary: A randomized controlled trial. *AIDS*. 2015;29(5):583-93.
210. Eliason MJ, Dibble SL, Gordon R, et al. The Last Drag: An Evaluation of an LGBT-Specific Smoking Intervention. *J Homosex*. 2012;59(6):864-78.
211. McElroy JA, Haynes SG, Eliason MJ, et al. Healthy Weight in Lesbian and Bisexual Women Aged 40 and Older: An Effective Intervention in 10 Cities Using Tailored Approaches. *Womens Health Issues*. 2016;26 Suppl 1:S18-35.
212. Koblin BA, Bonner S, Powell B, et al. A randomized trial of a behavioral intervention for black MSM: the DiSH study. *AIDS*. 2012;26(4):483-8.
213. Taylor ET, Bryson MK. Cancer's margins: trans* and gender nonconforming people's access to knowledge, experiences of cancer health, and decision-making. *LGBT Health*. 2016;3(1):79-89.
214. Batist E, Brown B, Scheibe A, et al. Outcomes of a community-based HIV-prevention pilot programme for township men who have sex with men in Cape Town, South Africa. *J Int AIDS Soc*. 2013;16 Suppl 3:18754.
215. Eliason MJ. Doing It For Ourselves: Building communities for health education and support for older lesbian/bisexual women. *J Gay Lesbian Soc Serv*. 2015;27(3):326-49.
216. Brown JL, Venable PA, Bostwick RA, et al. A Pilot Intervention Trial to Promote Sexual Health and Stress Management Among HIV-Infected Men Who Have Sex with Men. *AIDS & Behav*. 2018;23:23.
217. National Institute for Health and Clinical Excellence (NICE). Behavioural change at population, community and individual levels. London (UK): NICE; 2007.
218. Craig SL, Austin A. The AFFIRM open pilot feasibility study: A brief affirmative cognitive behavioral coping skills group intervention for sexual and gender minority youth. *Children Youth Serv Rev*. 2016;64:136-44.
219. Craig SL, Austin A, McInroy LB. School-Based Groups to Support Multiethnic Sexual Minority Youth Resiliency: Preliminary Effectiveness. *Child Adolesc Social Work J*. 2014;31(1):87-106.
220. Wilkerson JM, Schick VR, Romijnders KA, et al. Social Support, Depression, Self-Esteem, and Coping Among LGBTQ Adolescents Participating in Hatch Youth. *Health Promot Pract*. 2017;18(3):358-65.

221. Wilkerson JM, Lawler SM, Romijnders KA, et al. Exploratory Analyses of Risk Behaviors Among GLBT Youth Attending a Drop-In Center. *Health Educ Behav.* 2018;45(2):217-28.
222. Romijnders KA, Wilkerson JM, Crutzen R, et al. Strengthening Social Ties to Increase Confidence and Self-Esteem Among Sexual and Gender Minority Youth. *Health Promot Pract.* 2017;18(3):341-7.
223. Logie CH, Lacombe-Duncan A, Lee-Foon N, et al. "It's for us -newcomers, LGBTQ persons, and HIV-positive persons. You feel free to be": A qualitative study exploring social support group participation among African and Caribbean lesbian, gay, bisexual and transgender newcomers and refugees in Toronto, Canada. *BMC Int Health Human Rights.* 2016;16 (1) (no pagination)(18).
224. Wilkens J. The significance of affinity groups and safe spaces for older lesbians and bisexual women: Creating support networks and resisting heteronormativity in older age. *Qual Ageing.* 2016;17(1):26-35.
225. Amodeo AL, Picariello S, Valerio P, et al. Empowering transgender youths: Promoting resilience through a group training program. *J Gay Lesbian Ment Health.* 2018;22(1):3-19.
226. Blockett RA. 'I think it's very much placed on us': Black queer men laboring to forge community at a predominantly White and (hetero)cisnormative research institution. *Int J Qual Stud Educ.* 2017;30(8):800-16.
227. Tallentire L, Smith M, David L, et al. Stories of People Who Have Attended a Lesbian, Gay, Bisexual and Trans Support Group in a Secure Intellectual Disability Service. *J Appl Res Intellect Disabil.* 2016;31:31.
228. Brooks O. IGY: A new model for LGBTQ youth groups? *J LGBT Youth.* 2017;14(2):191-210.
229. Lapointe A, Crooks C. GSA members' experiences with a structured program to promote well-being. *J LGBT Youth.* 2018;15(4):300-18.
230. Dowers E, Kingsley J, White C. Virtually Trans: an Australian Facebook group supporting gender diverse adults' health and wellbeing. *Health Promot Int.* 2020.
231. Sekoni AO, Gale NK, Manga-Atangana B, et al. The effects of educational curricula and training on LGBT-specific health issues for healthcare students and professionals: a mixed-method systematic review. *J Int AIDS Soc.* 2017;20(1):21624.
232. Sawning S, Steinbock S, Croley R, et al. A first step in addressing medical education Curriculum gaps in lesbian-, gay-, bisexual-, and transgender-related content: The University of Louisville Lesbian, Gay, Bisexual, and Transgender Health Certificate Program. *Educ Health.* 2017;30(2):108-14.
233. Grosz AM, Gutierrez D, Lui AA, et al. A Student-Led Introduction to Lesbian, Gay, Bisexual, and Transgender Health for First-Year Medical Students. *Fam Med.* 2017;49(1):52-6.
234. Kidd JD, Bockting W, Cabaniss DL, et al. Special-"T" Training: Extended Follow-up Results from a Residency-Wide Professionalism Workshop on Transgender Health. *Acad Psychiatry.* 2016;40(5):802-6.
235. Eriksson SE, Safer JD. Evidence-Based Curricular Content Improves Student Knowledge and Changes Attitudes Towards Transgender Medicine. *Endocr Pract.* 2016;22(7):837-41.
236. Rivers B, Swank JM. LGBT ally training and counselor competency: A mixed-methods study. *J LGBT Issues Couns.* 2017;11(1):18-35.
237. Braun HM, Garcia-Grossman IR, Quinones-Rivera A, et al. Outcome and impact evaluation of a transgender health course for health profession students. *LGBT Health.* 2017;4(1):55-61.

238. Bidell MP. Addressing disparities: The impact of a lesbian, gay, bisexual, and transgender graduate counselling course. *Couns Psychother Res.* 2013;13(4):300-7.
239. Ufomata E, Eckstrand KL, Hasley P, et al. Comprehensive Internal Medicine Residency Curriculum on Primary Care of Patients Who Identify as LGBT. *LGBT Health.* 2018;24:24.
240. Vance SR, Jr L, B O, E B. Teaching paediatric transgender care. *Clin Teach.* 2018;15(3):214-20.
241. Ostroff JL, Ostroff ML, Billings S, Nemecek EC. Integration of transgender care into a pharmacy therapeutics curriculum. *Curr Pharm Teach Learn.* 2018;10(4):463-8.
242. Park JA, Safer JD. Clinical Exposure to Transgender Medicine Improves Students' Preparedness Above Levels Seen with Didactic Teaching Alone: A Key Addition to the Boston University Model for Teaching Transgender Healthcare. *Transgend Health.* 2018;3(1):10-6.
243. Ozkara San E. The influence of the oncology-focused transgender-simulated patient simulation on nursing students' cultural competence development. *Nursing forum.* 2020.
244. Vance SR, Buckelew SM, Dentoni-Lasofsky B, et al. A Pediatric Transgender Medicine Curriculum for Multidisciplinary Trainees. *MedEdPORTAL.* 2020;16:10896.
245. Stevenson MO, Sineath RC, Haw JS, et al. Use of standardized patients in endocrinology fellowship programs to teach competent transgender care. *Journal of the Endocrine Society.* 2020;4(1):bvz007.
246. Garcia-Acosta J, Castro-Peraza M. Impact of a Formative Program on Transgender Healthcare for Nursing Students and Health Professionals. Quasi-Experimental Intervention Study. *Int J Environ Res Public Health.* 2019;16(17).
247. Pratt-Chapman ML, Phillips S. Health professional student preparedness to care for sexual and gender minorities: efficacy of an elective interprofessional educational intervention. *J Interprof Care.* 2020;34(3):418-21.
248. Leach C, Seung H, Layson-Wolf C. Student pharmacists' perceptions of transgender health management. *Curr Pharm Teach Learn.* 2019;11(12):1254-8.
249. Knockel LE, Ray ME, Miller ML. Incorporating LGBTQ health into the curriculum: Assessment of student pharmacists' knowledge and comfort level in caring for transgender patients. *Curr Pharm Teach Learn.* 2019;11(9):928-35.
250. Salkind J, Gishen F, Drage G, et al. LGBT+ health teaching within the undergraduate medical curriculum. *Int J Environ Res Public Health.* 2019;16(13):2305.
251. Leslie KF, Sawning S, Shaw MA, et al. Changes in medical student implicit attitudes following a health equity curricular intervention. *Med Teacher.* 2018;40(4):372-8.
252. Cooper MB, Chacko M, Christner J. Incorporating LGBT Health in an Undergraduate Medical Education Curriculum Through the Construct of Social Determinants of Health. *MedEdPORTAL.* 2018;14:10781.
253. Maruca AT, Diaz DA, Stockmann C, et al. Using Simulation With Nursing Students to Promote Affirmative Practice Toward the Lesbian, Gay, Bisexual, and Transgender Population: A Multisite Study. *Nurs Educ Perspect.* 2018;39(4):225-9.
254. Newsome C, Chen LW, Conklin J. Addition of care for transgender-related patient care into doctorate of pharmacy curriculum: Implementation and preliminary evaluation. *Pharmacy.* 2018;6(4):107.

255. Click IA, Mann AK, Buda M, et al. Transgender health education for medical students. *Clin Teach*. 2019.
256. Allison MK, Marshall SA, Archie DS, et al. Community-Engaged Development, Implementation, and Evaluation of an Interprofessional Education Workshop on Gender-Affirming Care. *Transgend Health*. 2019;4(1):280-6.
257. Najor AJ, Kling JM, Imhof RL, et al. Transgender Health Care Curriculum Development: A Dual-Site Medical School Campus Pilot. *Health Equity*. 2020;4(1):102-13.
258. Cherabie J, Nilsen K, Houssayni S. Transgender Health Medical Education Intervention and its Effects on Beliefs, Attitudes, Comfort, and Knowledge. *Kans J Med*. 2018;11(4):106-9.
259. Klotzbaugh RJ, Ballout S, Spencer G. Results and implications from a gender minority health education module for advance practice nursing students. *J Am Assoc Nurse Pract*. 2020;32(4):332-8.
260. Haghiri-Vijeh R, McCulloch T, Atack L, et al. The Impact of Positive Space Training on Students' Communication With LGBTTQ+ Communities. *Nurs Educ Perspect*. 2020;41(2):115-6.
261. McEwing E. Delivering culturally competent care to the lesbian, gay, bisexual, and transgender (LGBT) population: Education for nursing students. *Nurse Educa Today*. 2020;94:104573.
262. Thompson H, Coleman JA, Iyengar RM, et al. Evaluation of a gender-affirming healthcare curriculum for second-year medical students. *Postgrad Med J*. 2020;96(1139):515-9.
263. Jann MW, Penzak S, White A, et al. An Elective Course in Lesbian, Gay, Bisexual, and Transgender Health and Practice Issues. *Am J Pharm Educ*. 2019;83(8):6967.
264. e Los Reyes GOR, Collict D. "It's Not Only about Clinical Tools but Also Our Role as Agents of Social Change": Implementing a LGBT Competency Training for Future Mental Health Practitioners in Mexico. *J Homosex*. 2020:1-24.
265. Wahlen R, Bize R, Wang J, et al. Medical students' knowledge of and attitudes towards LGBT people and their health care needs: Impact of a lecture on LGBT health. *PLOS ONE*. 2020;15(7 July):e0234743.
266. Bi S, Vela MB, Nathan AG, et al. Teaching Intersectionality of Sexual Orientation, Gender Identity, and Race/Ethnicity in a Health Disparities Course. *MedEdPORTAL*. 2020;16:10970.
267. Ozkara San E, Maneval R, Gross RE, et al. Transgender Standardized Patient Simulation: Management of an Oncological Emergency. *J Transcult Nurs*. 2019;30(6):627-35.
268. Vinjamuri M. Using reflection and dialogue to prepare social work students for practice with LGBT populations: An emerging pedagogical model. *J Gay Lesbian Soc Serv*. 2017;29(2):144-66.
269. Sequeira GM, Chakraborti C, Panunti BA. Integrating Lesbian, Gay, Bisexual, and Transgender (LGBT) Content Into Undergraduate Medical School Curricula: A Qualitative Study. *Ochsner J*. 2012;12(4):379-82.
270. Gavzy SJ, Berenson MG, Decker J, et al. The Case of Ty Jackson: An Interactive Module on LGBT Health Employing Introspective Techniques and Video-Based Case Discussion. *MedEdPORTAL*. 2019;15:10828.
271. Brondani M, Harjani M, Siarkowski M, et al. Community as the teacher on issues of social responsibility, substance use, and queer health in dental education. *PLOS ONE*. 2020;15(8 August):e0237327.
272. Sevelius JM. Gender Affirmation: A Framework for Conceptualizing Risk Behavior among Transgender Women of Color. *Sex Roles*. 2013;68(11-12):675-89.

273. Boud D, Keogh R, Walker D. Promoting Reflection in Learning: A Model. Reflection: Turning Reflection into Learning. London (UK): Routledge; 1985.
274. Association of Experiential Education. What is Experiential Education? [date unknown] Available from: <https://www.aee.org/what-is-ee>
275. Jurcek A, Downes C, Keogh B, et al. Educating health and social care practitioners on the experiences and needs of older LGBT+ adults: findings from a systematic review. *J Nurs Manag.* 2020.
276. Pepping CA, Lyons A, Morris EM. Affirmative LGBT psychotherapy: Outcomes of a therapist training protocol. *Psychotherapy.* 2018;55(1):52-62.
277. White Hughto JM, Clark KA, Altice FL, et al. Improving correctional healthcare providers' ability to care for transgender patients: Development and evaluation of a theory-driven cultural and clinical competence intervention. *Soc Sci Med.* 2017;195:159-69.
278. Riggs DW, Fraser H, Taylor N, et al. Domestic violence service providers' capacity for supporting transgender women: Findings from an Australian workshop. *Br J Soc Work.* 2016;46(8):2374-92.
279. Geibel S, Hossain SM, Pulerwitz J, et al. Stigma reduction training improves healthcare provider attitudes toward, and experiences of, young marginalized people in Bangladesh. *J Adolesc Health.* 2017;60(2, Suppl 2):S35-S44.
280. Tucker A, Liht J, e Swardt G, Arendse C, McIntyre J, Struthers H. Efficacy of tailored clinic trainings to improve knowledge of men who have sex with men health needs and reduce homophobic attitudes in South Africa. *LGBT Health.* 2016;3(6):443-50.
281. Israel T, Willging CE, Ley D. Development and evaluation of training for rural LGBTQ mental health peer advocates. *J Rural Ment Health.* 2016;40(1):40-62.
282. Craig SL, Doiron C, Dillon F. Cultivating professional allies for sexual minority youth: A community-based educational intervention. *J Homosex.* 2015;62(12):1703-21.
283. Greytak EA, Kosciw JG, Boesen MJ. Educating the educator: Creating supportive school personnel through professional development. *J Sch Violence.* 2013;12(1):80-97.
284. Lelutiu-Weinberger C, Pollard-Thomas P, Pagano W, et al. Implementation and Evaluation of a Pilot Training to Improve Transgender Competency Among Medical Staff in an Urban Clinic. *Transgend Health.* 2016;1(1):45-53.
285. Porter KE, Krinsky L. Do LGBT aging trainings effectuate positive change in mainstream elder service providers? *J Homosex.* 2014;61(1):197-216.
286. Jadwin-Cakmak L, Bauermeister JA, Cutler JM, et al. The Health Access Initiative: A Training and Technical Assistance Program to Improve Health Care for Sexual and Gender Minority Youth. *J Adolesc Health.* 2020;67(1):115-22.
287. Holman EG, Landry-Meyer L, Fish JN. Creating Supportive Environments for LGBT Older Adults: An Efficacy Evaluation of Staff Training in a Senior Living Facility. *J Gerontol Soc Work.* 2020;63(5):464-77.
288. Arora M, Walker K, Luu J, et al. Education of the medical profession to facilitate delivery of transgender health care in an Australian health district. *Aust J Prim Health.* 2020;26(1):17-23.

289. Wyckoff ED. LGBT Cultural Competence of Acute Care Nurses. *J Nurses Prof Dev.* 2019;35(3):125-31.
290. Nugroho A, Coulter RWS, Erasmus V, et al. Evaluation of a training aimed at building capacity for outreaching to men who have sex with men and transgender women in Indonesia. *Health Educ Res.* 2019;34(2):223-33.
291. Donisi V, Amaddeo F, Zakrzewska K, et al. Training healthcare professionals in LGBTI cultural competencies: Exploratory findings from the Health4LGBTI pilot project. *Patient Educ Couns.* 2020;103(5):978-87.
292. Walia H, Banoub R, Cambier GS, et al. Perioperative Provider and Staff Competency in Providing Culturally Competent LGBTQ Healthcare in Pediatric Setting. *Adv Med Educ Pract.* 2019;10:1097-102.
293. Shrader A, Casero K, Casper B, et al. Military lesbian, gay, bisexual, and transgender (LGBT) awareness training for health care providers within the Military Health System. *J Am Psychiatr Nurses Assoc.* 2017;23(6):385-92.
294. Vance SR, Deutsch MB, Rosenthal SM, et al. Enhancing pediatric trainees' and students' knowledge in providing care to transgender youth. *J Adolesc Health.* 2017;60(4):425-30.
295. Reygan FC, D'Alton P. A pilot training programme for health and social care professionals providing oncological and palliative care to lesbian, gay and bisexual patients in Ireland. *Psycho-Oncol.* 2013;22(5):1050-4.
296. Bristol S, Kostelec T, MacDonald R. Improving Emergency Health Care Workers' Knowledge, Competency, and Attitudes Toward Lesbian, Gay, Bisexual, and Transgender Patients Through Interdisciplinary Cultural Competency Training. *J Emerg Nurs.* 2018;25:25.
297. Shipherd JC, Kauth MR, Firek AF, et al. Interdisciplinary Transgender Veteran Care: Development of a Core Curriculum for VHA Providers. *Transgend Health.* 2016;1(1):54-62.
298. Felsenstein DR. Enhancing Lesbian, Gay, Bisexual, and Transgender Cultural Competence in a Midwestern Primary Care Clinic Setting. *J Nurses Prof Dev.* 2018;34(3):142-50.
299. van der Elst EM, Smith AD, Gichuru E, et al. Men who have sex with men sensitivity training reduces homophobia and increases knowledge among Kenyan healthcare providers in coastal Kenya. *J Int AIDS Soc.* 2013;16 Suppl 3:18748.
300. Tarasoff LA, Epstein R, Green DC, et al. Using interactive theatre to help fertility providers better understand sexual and gender minority patients. *Med Humanit.* 2014;40(2):135-41.
301. Scheibe AP, DUBY Z, Brown B, et al. Attitude shifts and knowledge gains: Evaluating men who have sex with men sensitisation training for healthcare workers in the Western Cape, South Africa. *South Afr J HIV Med.* 2017;18 (1).
302. Leyva VL, Breshears EM, Ringstad R. Assessing the efficacy of LGBT cultural competency training for aging services providers in California's Central Valley. *J Gerontol Soc Work.* 2014;57(2-4):335-48.
303. Hardacker CT, Rubinstein B, Hotton A, et al. Adding silver to the rainbow: The development of the nurses' health education about LGBT elders (HEALE) cultural competency curriculum. *J Nurs Manag.* 2014;22(2):257-66.
304. Du Mont J, Saad M, Kosa SD, Kia H, et al. Providing trans-affirming care for sexual assault survivors: An evaluation of a novel curriculum for forensic nurses. *Nurse Educ Today.* 2020;93.
305. Traister T. Improving LGBTQ Cultural Competence of RNs Through Education. *J Contin Educ Nurs.* 2020;51(8):359-66.

306. Dispenza F, Elston NC, Huffstead ME, et al. Rehabilitation counselor preparation to work with LGBTQ persons living with chronic illness/disability: A qualitative content analysis. *J Rehabil Res Dev* 2017;31(1):27-39.
307. van der Elst EM, Kombo B, Gichuru E, et al. The green shoots of a novel training programme: progress and identified key actions to providing services to MSM at Kenyan health facilities. *J Int AIDS Soc.* 2015;18:20226.
308. van der Elst EM, Gichuru E, Omar A, et al. Experiences of Kenyan healthcare workers providing services to men who have sex with men: qualitative findings from a sensitivity training programme. *J Int AIDS Soc.* 2013;16 Suppl 3:18741.
309. Seay J, Hicks A, Markham MJ, et al. Web-based LGBT cultural competency training intervention for oncologists: Pilot study results. *Cancer.* 2019.
310. Lelutiu-Weinberger C, Pachankis JE. Acceptability and preliminary efficacy of a lesbian, gay, bisexual, and transgender-affirmative mental health practice training in a highly stigmatizing national context. *LGBT Health.* 2017;4(5):360-70.
311. White Hughto JM, Clark KA. Designing a Transgender Health Training for Correctional Health Care Providers: A Feasibility Study. *Prison J.* 2019;99(3):329-42.
312. College of Nurses of Ontario (CNO). *Entry-to-Practice Competencies for Registered Nurses.* Toronto (ON): CNO; 2018.
313. Harrison M, Graham ID, Fervers B. Adapting knowledge to local context. In: Straus SE, Tetroe J, Graham ID, editors. *Knowledge translation in health care: moving from evidence to practice.* Chichester (UK): John Wiley & Sons; 2013. p. 110-20.
314. Grinspun, D., Wallace, K., Li, S.A., McNeill, S., & Squires. Leading change through social movement. *Registered Nurse Journal*; 2020, Spring.
315. Constitution Act 1982 (CA)
316. University of British Columbia. Centre for excellence in Indigenous health: faculty of medicine, UBC 23 24 Indigenous cultural safety. Vancouver, Canada; 2019.
317. BC Nurses Union (BCNU). *Position Statement: Gender Affirming Care.* Vancouver (BC): BCNU; 2016.
318. Hines JM. Using an Anti-Oppressive Framework in Social Work Practice with Lesbians. *J Gay Lesbian Soc Serv.* 2012;24:23-9.
319. Ontario Association of Children Aids Societies (OACAS). *An Anti-Oppression Framework for Child Welfare in Ontario.* Toronto (ON): OACAS; 2010.
320. Rainbow Health Network (RHN). *Training for Change: An Integrated Anti-Oppression Framework.* Toronto (ON): RHN; 2009.
321. Rey M, Grinspun D, Costantini L, et al. The anatomy of a rigorous best practice guideline development process. In: Grinspun D, Bajnok I, editors. *Transforming nursing through knowledge: best practices for guideline development, implementation science, and evaluation Indianapolis (IN): Sigma Theta Tau International; 2018. p. 31-68.*

322. Planned Parenthood. Sex and Gender Identity n.d. Available from: <https://www.plannedparenthood.org/learn/gender-identity/sex-gender-identity>
323. Lewin S, Glenton C, Munthe-Kaas H, Carlsen B, Colvin CJ, Gulmezoglu M, et al. Using qualitative evidence in decision making for health and social interventions: an approach to assess confidence in findings from qualitative evidence syntheses (GRADE-CERQual). *PLoS Med.* 2015;12(10):e1001895.
324. Hull KE, Ortyl TA. Conventional and Cutting-Edge: Definitions of Family in LGBT Communities. *Sexuality Research and Social Policy.* 2019;16(1):31-43.
325. Black K, Dobbs D. Community-dwelling older adults' perceptions of dignity: core meanings, challenges, supports and opportunities. *Ageing and Society.* 2013;34(8):1292-313.
326. Notarnicola I, Petrucci C, De Jesus Barbosa M, Giorgi F, Stievano A, Lancia L. Clinical competence in nursing: A concept analysis. *Professioni infermieristiche.* 2016;69(3):174-81.
327. Canadian Research Institute for the Advancement of Women. Colonialism and its impacts [Internet] 2016 Available from: http://fnn.criaw-icref.ca/images/userfiles/files/LWM3_ColonialismImpacts.pdf
328. The Human Rights Campaign. Glossary of Terms [Internet] [date unknown] Available from: <https://www.hrc.org/resources/glossary-of-terms>
329. Public Health Agency of Canada. Communication [Internet] 2015 Available from: <https://cbpp-pcpe.phac-aspc.gc.ca/resources/public-health-competencies-information-tools/communication/>
330. Avella JR. Delphi panels: research design, procedures, advantages, and challenges. *International Journal of Doctoral Studies.* 2016(11):305-21.
331. 3 ed: Oxford University Press; 2010. *Oxford English Dictionary (3rd Ed.)*.
332. Koptie S. Irihapeti Ramsden: The Public Narrative on Cultural Safety. *First Peoples Family & Child Review.* 2009;4(2):30-43.
333. National Aboriginal Health Organization. Fact sheet: Cultural Safety. National Aboriginal Health Organization; 2006.
334. Dijkers M. Introducing GRADE: a systematic approach to rating evidence in systematic reviews and to guideline development. *KT Update.* 2013;1(5):1-9.
335. Monteagudo Pena J, Moreno Gil O. e-Health for patient empowerment in Europe. Madrid (SP): Ministerio de Sanidad y Consumo; 2007.
336. Zimmerman M. Empowerment Theory. In: Rappaport J, Seidman E, editors. *Handbook of Community Psychology* Springer US; 2012.
337. Stevens K. The impact of evidence-based practice nursing and the next big ideas *Online J Issues Nurs.* 2013;18(2):Manuscript 4.
338. College of Nurses of Ontario (CNO). RHPA: Scope of Practice, Controlled Acts Model. Toronto (ON): CNO; 2018.
339. College of Nurses of Ontario (CNO). Working with unregulated care providers Toronto (ON): CNO; 2013 Available from: http://www.cno.org/globalassets/docs/prac/41014_workingucp.pdf

340. Eccles MP, Mittman, BS. Welcome to Implementation Science . Implementation Sci. 2016; 1 (1).
341. United Nations. United Nations permanent forum on Indigenous Issues: Who are Indigenous peoples? [date unknown] Available from: https://www.un.org/esa/socdev/unpfii/documents/5session_factsheet1.pdf
342. Registered Nurses' Association of Ontario (RNAO). Developing and sustaining interprofessional health care: optimizing patient, organizational and system outcomes. Toronto (ON): RNAO; 2013.
343. Collins PH, Bilge S. Intersectionality: John Wiley & Sons; 2016.
344. The Cochrane Collaboration. Glossary [Internet] [place unknown]: The Cochrane Collaboration; 2020 Available from: <https://community.cochrane.org/glossary>
345. Canadian Council for Refugees. Refugees and Immigrants: A Glossary. 2010 [Available from: <https://ccrweb.ca/en/glossary>]
346. Austin Z, Sutton J. Qualitative research: getting started. Canadian J Hosp Pharm. 2014;67(6):436-40.
347. Merriam-Webster. Pathologize. In Merriam-Webster.com dictionary. (n.d.) Available from: <https://www.merriam-webster.com/dictionary/pathologize>
348. Rockers PC, Rottingen JA, Shemilt I, Tugwell P, Barnighausen T. Inclusion of quasi-experimental studies in systematic reviews of health systems research Health Policy. 2015;119(4):511-21.
349. World Health Organization. Screening [Internet] [date unknown] Available from: <https://www.who.int/cancer/prevention/diagnosis-screening/screening/en/>
350. Institute of Medicine. Priority Areas for National Action: Transforming Health Care Quality. Washington, DC.: National Academy Press; 2003.
351. Registered Nurses' Association of Ontario (RNAO). Social Determinants of Health. Toronto, ON: RNAO; 2013.
352. Registered Nurses' Association of Ontario (RNAO). Social movement in the context of knowledge uptake and sustainability definition. Toronto (ON): RNAO; 2020 (Unpublished work).
353. Baker C, Ogden SJ, Prapaipanich W, et al. Hospital consolidation: applying stakeholder analysis to merger life-cycle. J Nurs Adm. 1999;29(3):11-20.
354. Public Health Agency of Canada (PHAC). Reducing the health impact of sexually transmitted and blood-borne infections in Canada by 2030: A pan-Canadian STBBI framework for action. Ottawa (ON): PHAC; 2018.
355. Canadian Mental Health Association Ontario. Stigma and Discrimination [Internet] 2020 Available from: <https://ontario.cmha.ca/documents/stigma-and-discrimination/>
356. Health Canada. Certain Circumstances Issues in Equity and Responsiveness in Access to Health Care in Canada. Ottawa (ON): Government of Canada; 2001.
357. Registered Nurses' Association of Ontario. Mission and values [Internet] [date unknown] Available from: <https://rnao.ca/about/mission>
358. The Cochrane Collaboration. RoB 2: A revised Cochrane risk-of-bias tool for randomized trials [Internet] 2020 Available from: <https://methods.cochrane.org/bias/resources/rob-2-revised-cochrane-risk-bias-tool-randomized-trials>

359. Sterne J, Hernán M, Reeves B, et al. ROBINS-I: a tool for assessing risk of bias in non-randomized studies of interventions. *BMJ*. 2016;355:i4919.
360. Whiting P, Savovic J, Higgins JPT, et al. ROBIS: A new tool to assess risk of bias in systematic reviews was developed. *J Clin Epidemiol*. 2016;69:225-34.
361. Critical Appraisal Skills Programme. CASP checklists [Internet] 2018 Available from: <https://casp-uk.net/casp-tools-checklists/>
362. Guyatt G, Oxman A, Kunz R, et al. Going from evidence to recommendations. *BMJ*. 2008;336(7652):1049-51.
363. Balshem H, Helfand M, Schünemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-6.
364. Welch VA, Akl EA, Guyatt GH, et al. GRADE equity guidelines 1: considering health equity in GRADE guideline development: introduction and rationale. *J Clin Epidemiol*. 2017;90:59-67.
365. Sobel A. Pride: The complete guide to queer pride flags [Internet] [date unknown] Available from: <https://www.pride.com/pride/2018/6/13/complete-guide-queer-pride-flags-0#media-gallery-media-3>
366. University of Toronto. Positive space [Internet] [date unknown] Available from: <https://positivespace.utoronto.ca/resourcesposters/posters/>
367. Graham ID, Logan J, Harrison MB, et al. Lost in knowledge translation: Time for a map? *J Contin Educ Health Prof*. 2006;26(1):13-24.
368. Walker LO, Avant KC. *Strategies for theory construction in nursing (Vol. 6)*. Upper Saddle River (NJ): Pearson/Prentice Hall; 2019.
369. Registered Nurses' Association of Ontario (RNAO). *Toolkit: implementation of best practice guidelines, second edition* [Internet]. Toronto (ON): RNAO; 2012.
370. Toomey RB, Russell ST. Gay-straight alliances, social justice involvement, and school victimization of lesbian, gay, bisexual, and queer youth: Implications for school well-being and plans to vote. *Youth & Society*. 2013 Dec;45(4):500-22.
371. Toomey RB, McGuire JK, Russell ST. Heteronormativity, school climates, and perceived safety for gender nonconforming peers. *Journal of adolescence*. 2012 Feb 1;35(1):187-96

Appendix A: Glossary of Terms

2SLGBTQI+: An acronym for Two-Spirit lesbian, gay, bisexual, trans, queer and intersex people. The “+” is meant to be inclusive of other people who identify as a sexual or gender minority, such as (but not limited to): asexual, non-binary, pansexual and those questioning their sexual orientation or gender identity.

Aboriginal: The term used to describe the First Peoples or inhabitants in what is now Canada, and includes First Nations, Inuit and Métis and their descendants. These are separate and distinct groups, with each having unique and diverse heritage, language, cultural practices and spiritual beliefs (315). The term became popular for use following the inclusion of this definition in the Canadian Constitution (1982) (316). This term is frequently used to identify the First Peoples in Australia (316).

Affirmation/Affirming: Affirmation refers to an interpersonal, interactive process whereby a person receives social recognition and support for their sexual and gender identity and gender expression (adapted from (272)). Affirming care or practices are processes through which a health care system cares for and supports an individual, while recognizing and acknowledging their sexual orientation, gender identity and expression (adapted from (317)).

Ally: A person who works to end systems of oppression that give that person privilege(s) over others based on arbitrary characteristics such as being a member of the dominant race or gender identity. Allies listen to, and are guided by, communities and individuals affected by oppression. Forms of oppression include: ableism, ageism, audism, classism, biphobia, homophobia, transphobia, racism, sexism and others (adapted from (9)).

Anti-oppression: The lens through which one understands how institutional, social, cultural and economic issues influence opportunities for persons to grow into their full potential and can result in systemic inequities for particular groups (318, 319). Anti-oppression can encompass many approaches to the work of addressing inequities that are constructed within societies (320).

Asexual: A person who experiences little or no sexual attraction to people of any gender (9).

Best practice guideline (BPG): Best practice guidelines are systematically developed, evidence-based documents that include recommendations for nurses and the interprofessional team, educators, leaders and policy-makers, persons and their chosen families on specific clinical and healthy work environment topics. BPGs promote consistency and excellence in clinical care, health policies, and health education, ultimately leading to optimal health outcomes for people and communities and the health system (321).

Bigender: A person whose gender identity combines two genders (6).

Binary language: Binary language is language that derives from a gender binary social system whereby people are thought to have either one of two genders: “man” or “woman.” In the gender binary system, there is no room for living between genders or for transcending the gender binary. The gender binary system is rigid and restrictive for many people whose birth-assigned sex does not align with their gender identity, or whose gender is fluid and not fixed (9).

Birth-assigned sex: Assigned sex is a label that is given at birth based on medical factors, including hormones, chromosomes, and genitals. Most people are assigned male or female, and this is what is put on their birth certificates (322).

The term “assigned female at birth” (AFAB) or “assigned male at birth” (AMAB) may also be used to describe the binary label given at birth.

Bisexual: A person who is attracted to more than one gender (9).

Black, Indigenous and People of Colour (BIPOC): The acronym BIPOC (Black, Indigenous and People of Colour) is used in this guideline as it recognizes the unique experiences of historic and systemic racism faced by BIPOC (2).

CERQual: The Confidence in the Evidence from Reviews of Qualitative Research (CERQual) is a methodological approach to assess the amount of confidence that can be placed in findings from a body of qualitative evidence about an outcome of interest. The assessment provides a transparent means to decide if the review finding reasonably represents the phenomenon under study, which can facilitate guideline panels to make health recommendations (323).

CERQual criteria: When using CERQual, four components contribute to the assessment of confidence in the evidence for each individual finding:

1. Methodological limitations, which look at issues in the design of the primary study or problems in the way it is conducted.
2. Relevance, whereby each primary study that supports a finding is assessed together and a decision is made regarding the applicability of the findings to the population, phenomenon, and setting outlined in the research question.
3. Coherence, whereby an assessment is made of whether the primary studies provide sufficient data and a convincing explanation for the review findings.
4. Adequacy of data, whereby an overall assessment is made about the richness and quantity of data that supports the review finding and phenomenon of interest (323).

Chosen family: Chosen family members are selected or chosen by an individual and those ‘chosen’ are not related to this individual biologically. Chosen families do not necessarily replace biological families. Persons who identify as 2SLGBTQI+ may value and identify the relationships of selected friends over their blood relatives. This occurs for reasons that can include inadequate support and acceptance from biological families, leading individuals to turn to friends who provide this support. These friends may or may not identify as 2SLGBTQI+ (324). The critical importance and essential role of the chosen family is heightened in older LGBTQ adults (28, 325).

Cisgender: Persons whose gender identity aligns with their birth-assigned sex (6).

Cisnormativity: Cisnormativity refers to the assumption that all people are cisgender. The term cisnormativity is used to describe systemic prejudice against trans and non-binary people. This form of systemic prejudice may go unrecognized by the people or organizations responsible (adapted from (9)).

Clinical group-based interventions: Group-based interventions focus specifically on the management of health conditions (e.g. diabetes, anxiety) or behavioural risk factors for chronic disease prevention and/or management (e.g. tobacco cessation, weight loss). Clinical group-based interventions are delivered by a health provider and in diverse settings (including virtually).

Clinical competence: A mix of skills, knowledge, attitudes and abilities that each health provider must possess to perform acceptably those duties directly related to care, in a specific clinical context and in given circumstances, in order to promote, maintain and restore people’s health (adapted from (326)).

Colonization/Colonialism: European settlers seized the traditional lands and territories of many First Peoples for settlement, trade, military reasons and for natural resource extraction on land now known as Canada (327). The government of Canada then forced the relocation of many Indigenous communities and the signing of treaties, and created federal legislation called the Indian Act that led to a catastrophic and ongoing impact on the cultural, social, and political distinctiveness of Indigenous peoples (327).

Comfort: Refers to the feeling a person has about their health providers. In the literature, comfort with providers included trust, communication and feelings of openness and rapport.

Coming out: Coming out is the “process in which a person first acknowledges, accepts and appreciates their sexual orientation or gender identity and begins to share that with others”(328). Coming out is not a onetime thing and is a daily decision for 2SLGBTQI+ people based on the benefits and risk of coming out including the possibility of being met with discrimination.

Communication strategies: Communication involves an interchange of ideas, opinions and information. Communication strategies can include numerous dimensions of communication including: written, verbal, non-verbal and listening skills; providing appropriate information to different audiences; and social marketing techniques (329). Other examples include intake forms, nursing documentation and educational materials.

Consensus: A process used to reach agreement among a group or panel during a Delphi or modified Delphi technique (330). A consensus of 70 per cent agreement from all panel members was required for the strength of recommendations within this BPG.

Continuing education: Education provided for adults after they have left the formal education system, consisting typically of short or part-time courses (331). For the purposes of this BPG, continuing education includes continuing professional development.

Cultural safety: This term was developed in the 1980s in New Zealand in response to Indigenous Maori people's dissatisfaction with nursing care. Maori nurse Irihapeta Ramsden was instrumental in the development of the term "cultural safety", understood as an outcome of nursing and midwifery education that enables safe service to be defined by those who receive the service. Cultural sensitivity alerts students to the legitimacy of difference and begins a process of self-exploration about the sum of their own life experience and realities and the impact this may have on others. Cultural awareness is a first step towards understanding that there is a difference. Cultural safety moves beyond cultural sensitivity to analyze the power imbalances, institutional discrimination, colonization and relationships with colonizers, as these apply to health services (332, 333).

Disabilities: Disabilities is an umbrella term, covering physical and intellectual impairments, activity limitations, and participation restrictions. An *impairment* is a problem in body function or structure; an *activity limitation* is a difficulty encountered by an individual in executing a task or action; while a *participation restriction* is a problem experienced by an individual in involvement in life situations (adapted from (3)). The World Health Organization defines disability results from the interaction between individuals with a health condition (e.g. cerebral palsy, down syndrome and depression) and personal and environmental factors (including e.g. negative attitudes, inaccessible transportation and public buildings, and limited social support) (4).

Diverse representation: Diversity of culture, race, class, sexual orientation and gender among health providers and persons accessing health services.

Downgrade: In GRADE and GRADE-CERQual, when limitations in the individual studies potentially bias the results, the certainty of evidence will decrease (334). For example, a body of quantitative evidence for one priority outcome may begin with high certainty, but due to serious limitations in one or more of the five GRADE criteria, it will be rated down by one or two levels (334).

Empowerment-based approach: Empowering clients is based on the premise that people have the right to make their own choices and decisions around their own health. Empowerment can be an important mechanism in the delivery of clinical group-based interventions. An empowerment-based approach includes six major components:

1. Communication: providing clients with access to health information, health resources and advice.
2. Patient education and health literacy: ensuring clients are provided with the critical health information they may require.
3. Information: access to personal health information fosters patient control in the management of their health.
4. Self-care: facilitating client self-management.
5. Decision-making: preparing clients to make informed decisions through problem identification, available options and potential consequences of decisions.
6. Contact with other persons: persons can experience a valuable sense of social connectedness to other clients within a group-based intervention (335).

Empowerment theory: Empowerment theory suggests that actions, activities or structures may be empowering and that the outcome of such processes results in a level of being empowered (336). Empowering processes include attempting to gain control, obtain needed resources, and critically understand one's social environment. This process is empowering if it helps clients develop skills that result in independent problem solving and decision making (336). Behaviors necessary for empowerment will be different among individual people and what it means to be empowered by any individual person will vary. Empowering processes will vary among individuals and organizations (336).

Evidence-based nursing practice: The integration of research evidence with clinical expertise and person values. This practice unifies research evidence with clinical expertise and encourages the inclusion of person preferences (337).

Evidence-to-Decision (EtD) frameworks: A table that facilitates guideline panels to make decisions when moving from evidence to recommendations. The purpose of the EtD framework is to summarize the research evidence, outline important factors that can determine the recommendation, inform panel members about the benefits and harms of each intervention considered, and increase transparency about the decision-making process in the development of recommendations (16).

Experiential learning: A teaching strategy where learners participate in direct experience and focused reflection in order to increase knowledge, develop skills, clarify values, and develop their capacity to contribute to their communities (274).

Gay: A person who is attracted to people of the same gender (9).

Gender expression: Gender expression is how a person publicly presents their gender. This can include behaviour and outward appearance such as dress, hair, make-up, body language and voice. A person's chosen name and pronoun are also common ways of expressing gender (7).

Gender fluid: Some people use the term 'gender fluid' to describe their gender identity. A gender fluid person can identify anywhere on the gender spectrum (8). This fluidity can also occur over shorter or longer periods of time such as months or years. Gender fluidity can also include sexual orientation and gender identity.

Gender identity: Gender identity is each person's internal and individual experience of gender. It is their sense of being a woman, a man, both, neither, or anywhere along the gender spectrum. A person's gender identity may be the same as or different from their birth-assigned sex. Gender identity is fundamentally different from a person's sexual orientation (7).

Gender-sexuality alliance (GSA): Gender-sexuality alliances (GSAs) are school clubs in which students can talk and learn about sexual orientation and gender identity. They are structured like any other school group, with a faculty advisor and regular meetings. Everyone is welcome –Two-Spirit, lesbian, gay, bisexual, trans, queer and questioning students, as well as heterosexual students, students with 2SLGBTQI+ families and students who don't have or need a label for their sexual orientation or gender identities (149). A gender-sexuality alliance is a more inclusive name than the term "gay-straight alliance" which may also be used.

Genderqueer: Individuals who do not follow gender stereotypes based on their birth-assigned sex. They may identify and express themselves as "feminine men" or "masculine women" or as androgynous, outside of the categories "boy/man" and "girl/woman." People who are non-binary may or may not identify as trans. People who identify as gender queer may also use the term "non-binary" to describe their identity.(9).

Good practice statement: A good practice statement is directed primarily to nurses and the interprofessional teams who provide care to persons and their families across the spectrum of care, including (but not limited to): primary care, acute care, home care and long-term care. It refers to a practice already accepted as beneficial or practical. In the case of this BPG, the good practice statement is believed to be so beneficial that conducting a systematic review to prove its efficacy would be unreasonable. These statements are not based on a systematic review and do not receive a rating of the certainty or confidence in the evidence or strength (i.e. conditional or strong) (13).

GRADE: The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) is a methodological approach to assess the certainty of a body of evidence in a consistent and transparent way, and to develop recommendations in a systematic way. The body of evidence across identified important and/or critical outcomes is evaluated based on risk of bias, consistency of results, relevance of the studies, precision of the estimates, publication bias, large effect, dose response, and opposing confounding (16).

When using GRADE, five components contribute to the assessment of confidence in the evidence for each outcome. These components are as follows:

1. Risk of bias, which focuses on the flaws in the design of a study or problems in its execution.
2. Inconsistency, which looks at a body of evidence and assesses whether the results point in the same direction or are different.
3. Imprecision, which refers to the accuracy of results based on the number of participants and/or events included, and the width of the confidence intervals across a body of evidence.
4. Indirectness, whereby each primary study that supports an outcome is assessed and a decision is made regarding the applicability of the findings to the population, intervention, and outcome outlined in the research question.
5. Publication bias, where a decision is made about whether the body of published literature for an outcome potentially includes only positive or statistically significant results (16).

Group-based interventions: The National Institute for Health and Care Excellence (NICE) behavior change guidelines distinguishes between interventions at the individual, community and population level (217). Groups are included in the broad category of community interventions, defined as social or family groups linked by networks, geographical location or another common factor. Group-based interventions may include support groups, but also may include complex group interventions such as coping skills training or counseling (217).

Health provider: Health providers are workers who are part of the interprofessional team and include both those in regulated (e.g., nurses, physicians, dietitians and social workers) and in unregulated positions (e.g., personal support workers and clerical or administrative staff).

Regulated health provider: In Ontario, the Regulated Health Professional Act, 1991 (RHPA) provides a framework for regulating 23 health professions, outlining the scope of practice and the profession-specific controlled or authorized acts that each regulated professional is authorized to perform when providing health care and services (338).

Unregulated health provider: Unregulated health providers fulfill a variety of roles in areas that are not subject to the RHPA. They are accountable to their employers but not to an external regulating professional body (e.g., College of Nurses of Ontario). Unregulated health providers fulfill a variety of roles and perform tasks that are determined by their employer and employment setting. Unregulated health providers only have the authority to perform a controlled act as set out in the RHPA if the procedure falls under one of the exemptions set out in the Act (339).

Heteronormativity: Refers to the assumption that all people are heterosexual. The term heterosexism is used to describe prejudice against people that are not heterosexual and is less overt or direct and more widespread or systemic in society, organizations and institutions. This form of systemic prejudice may even be unintentional and unrecognized by the people or organizations responsible (adapted from (9)).

Implementation science: Defined as “the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services and care” (page 1) (340).

Indigenous: Introduced and used in a global context following international efforts of Aboriginal peoples to achieve a greater presence in the United Nations (UN). The UN broadly defines Indigenous persons as peoples of long settlement and connection to specific lands who practice unique traditions and retain social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they reside (341). A modern understanding of the Indigenous term by the UN includes: self identification at the individual level and accepted by the community as their member, historical continuity with pre-colonial or pre-settler societies, strong links to territories and surrounding natural resources, distinct social, economic or political systems, distinct language, cultural and beliefs. Indigenous peoples form non-dominant groups of society and resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities (341).

Interprofessional team: A team comprised of multiple health providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health care and services to people within, between, and across health-care settings (342). It is important to emphasize that the 2SLGBTQ+ persons and their chosen family are at the centre as active participants of the team.

Intersectionality: “A way of understanding and analyzing the complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people’s lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves” (343).

Intersex: A person born with sex characteristics (chromosomes, gonads, sex hormones, or genitals) that do not fit the typical medical definitions of male or female bodies (9).

Lesbian: A woman who is attracted to women (9).

Meta-analysis: A systematic review that uses statistical methods to analyze and summarize the results of the included studies (344).

See systematic review

Migrant: A person who is outside their country of origin. Sometimes this term is used to talk about everyone outside their country of birth, including people who have been Canadian citizens for decades. More often, it is used for people currently on the move or people with temporary status or no status at all in the country where they live (345).

Minority stress: Minority stress proposes that sexual minority health disparities can be explained in large part by stressors induced by a hostile, homophobic or transphobic culture, which often results in a lifetime of harassment, maltreatment, discrimination and victimization (33). Minority stress is unique, chronic and socially-based.

MSM: Men who have sex with men.

Mx.: An accepted gender-neutral title. This was developed as an alternative to more common titles such as Mr. or Ms. It can be used by non-binary people and those who wish to not indicate a gender in their title.

Multi-component approach: An intervention that uses more than one strategy or arm.

In safer spaces, a multi-component approach includes at minimum two of the following strategies: anti-discrimination policy, diverse representation of staff, inclusive intake forms, 2SLGBTQI+ events, referrals to support and written materials and signs.

Nurse: Refers to registered nurses, licensed practical nurses (referred to as registered practical nurses in Ontario), registered psychiatric nurses, and nurses in advanced practice roles such as nurse practitioners and clinical nurse specialists (338).

Non-binary: An umbrella term for gender identities that fall outside of the man-woman binary (9).

Outcomes: A dependent variable, or the clinical and/or functional status of a patient or population, that is used to assess if an intervention is successful. In GRADE, outcomes are prioritized based on if they are critical for decision making, important but not critical for decision making, or not important. Use of these outcomes helps literature searches and systematic reviews to be more focused (16).

Pansexual: A person who is attracted to other people regardless of gender identity (adapted from (9)).

Pathologize: To view or characterize as medically or psychologically abnormal (346). Pathologizing refers to branding 2SLGBTQI+ people as ill based on their sexual orientation, gender identity or gender expression and it is one of the root causes behind the human rights violations faced by 2SLGBTQI+ people (48).

Person-centred: An approach to care in which the person is viewed as whole. The process of coming to know the whole person is nurtured through the formation of a therapeutic relationship between the person, those who are significant to them, and health-care providers. This approach to care involves advocacy, empowerment, mutual respect and an understanding of the person's right to be autonomous, to self-determine, and to actively participate in decisions about their health (both illness and wellness) (110).

PICO research question: A framework to outline a focused question. It specifies four components:

1. The patient or population that is being studied.
2. The intervention to be investigated.
3. The alternative or comparison intervention.
4. The outcome that is of interest (16).

Qualitative research: An approach to research that seeks to convey how human behaviour and experiences can be explained within the contexts of social structures and through the use of an interactive and subjective approach to investigate and describe phenomena (347).

Quasi-experimental study: A study that estimates causal effects by observing the exposure of interest, but in which the experiments are not directly controlled by the researcher and are not randomized. These studies are based on observation (e.g. before-and-after designs) (348).

Queer: An umbrella term used and reclaimed by some whose sexual orientations and/or gender identities fall outside of cisgender/heterosexual norms (9).

Note from expert panel: this term was historically used as a derogatory term and should be used with caution and only for those who use the term themselves and have asked others to use the term.

Questioning: A period during which a person explores their own sexual identity, orientation and/or gender. (9).

Randomized controlled trial (RCT): An experiment in which the investigator assigns one or more interventions to participants who are randomly allocated to either the experimental group (receives intervention) and the comparison (conventional treatment) or control group (no intervention or placebo) (344).

Recommendation: A course of action(s) that directly answers a recommendation question (also known as a PICO research question). A recommendation is based on a systematic review of the literature and is made in consideration of benefits, harms, values and preferences and health equity. All recommendations are assigned a strength, either strong or conditional, through panel consensus. It is important to note that recommendations should not be viewed as dictates, as recommendations cannot take into account all of the unique features of individual, organizational and clinical circumstances (16).

Recommendation question: A priority research area of practice, policy or education identified by expert panel members that requires evidence to answer. The recommendation question may also aim to answer a topic area around which there is ambiguity or controversy. The recommendation question informs the research questions, which guide the systematic review.

Reconciliation: Is an ongoing process where non-Indigenous Canadians must recognize and acknowledge the harmful events of the past and the devastating impact these have had and continue to have, on Indigenous peoples in Canada. For reconciliation to happen, there needs to be awareness of the past, acknowledgment of harm that has been inflicted, atonement for the cause, and a commitment to action and to change behavior. This process involves establishing and maintaining mutually respectful relationships with Indigenous peoples going forward (86).

Reflection: Reflection is defined as an important human activity in which people recall their experience, think about it, and mull over and evaluate it. It is this working with experience that is important in learning (273).

Refugee: Persons who are forced to leave their home countries because of serious human rights abuses. The right to asylum from persecution is an international human right. It is guaranteed by the United Nations' 1951 Convention Relating to the Status of Refugees (the "Refugee Convention"). According to this convention, a refugee is a person who is outside his or her home country and who has a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion. The Convention also spells out the key responsibilities of states towards refugees, which include the obligation not to send refugees back to the country where they face persecution. (This is known as the principle of "non-refoulement") (345).

Safety: Refers to 2SLGBTQI+ people and their chosen families feeling safe and included when interacting with health providers and health-service organizations. This includes access to safe, affirming and appropriate health services. Measures of safety within the literature included self-reported victimization, homophobic bullying and discrimination.

Safe space: A safe space or a positive space refers to a health-service organization that is open and welcoming, and where services are accessible and equitable to persons of all gender identities and sexual orientations who are clients or employees of the organization (126). A safe and positive space can also refer to a health-service organization where all service providers are educated to understand the issues surrounding gender and sexual diversity and are familiar with human rights and 2SLGBTQI+ community resources (126).

A safe space in schools refers to one in which everyone – students, staff and parents – feels welcome, safe and respected.

Schools: Refers to any elementary, middle or high school, whether public or private, secular or non-secular.

Screening: Screening is defined as the presumptive identification of unrecognized disease in an apparently healthy, asymptomatic population by means of tests, examinations or other procedures that can be applied rapidly and easily to the target population (349).

Self-management: Refers to the activities persons must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions (350). In this BPG, self-management also included aspects of self-care, such as tasks people do to maintain physical health and well-being.

Settler: A settler in Canada means that you or your ancestors are not Indigenous and entered Canada for the purpose of permanently settling or inhabiting in Canada on land that was previously inhabited by Indigenous people.

Sexual orientation: A person's physical, romantic, emotional, and/or spiritual attraction to others. Orientation may be lesbian, gay, heterosexual, bisexual, pansexual, or asexual. Sexual orientation is distinct from sex, gender identity, and gender expression. A person's sexual orientation should not be assumed based on the perceived sex of that person's partner(s) (6). A person's sexual orientation is fluid and may change over time.

Social determinants of health: The social determinants of health are the "circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness." These circumstances are shaped by a wider set of political, economic, social, cultural and environmental conditions and forces (351).

Social movement in the context of knowledge uptake and sustainability: Individuals, groups and/or organizations who, as voluntary and intrinsically motivated change agents, mobilize to transform health outcomes (352).

Social support: Refers to decreased isolation, and entails a sense of belonging, acceptance and community.

Stakeholder: An individual, group, or organization that has a vested interest in the decisions and actions of organizations, and may attempt to influence decisions and actions (353). Stakeholders include all of the individuals and groups who will be directly or indirectly affected by the change or by the solution to the problem.

Sexually transmitted and blood borne infection (STBBI): The term sexually transmitted and blood-borne infection (STBBI) describes an infection that is either sexually transmitted or transmitted through blood. This includes, but is not limited to: human immunodeficiency virus (HIV), hepatitis B (HBV) and C (HCV), chlamydia, gonorrhea, syphilis, and human papilloma virus (HPV) (354).

Stigma: Stigma is a negative stereotype. Stigma is different from discrimination as discrimination is the behaviour that results from this negative stereotype (355).

Surrogate outcome: A surrogate outcome is a substitute measure to the one originally selected. Surrogate outcomes are considered when evidence about the desired outcomes is lacking or unexplored (16).

Systematic review: A comprehensive review of the literature that uses clearly formulated questions and systematic and explicit methods to identify, select, and critically appraise relevant research. A systematic review collects and analyzes data from the included studies and presents them, sometimes using statistical methods (344).

See meta-analysis

Trans: An umbrella term referring to people with diverse gender identities and expressions that differ from stereotypical gender norms. It includes but is not limited to people who identify as transgender, trans woman (male-to-female), trans man (female-to-male), transsexual, cross-dresser, gender non-conforming, gender variant or gender queer (7). Refers to a state of incongruence of one's gender identity with the birth-assigned sex. Trans can mean transcending beyond, existing between or crossing over the gender spectrum (9, 10).

Transfeminine: Transfeminine refers to those who were assigned male at birth, and whose gender is feminine and/or who express themselves in a feminine way.

Transition-related surgeries (TRS): TRS refers to procedures that change a person's primary and/or secondary sex characteristics to better align their physical body with their gender identity (81). These surgeries are sometimes also called "gender affirming surgeries" or "gender confirming surgeries." The term sex reassignment surgeries (SRS) is out of date and no longer used.

Transmasculine: Transmasculine is a term that refers to those who were assigned female at birth, and whose gender is masculine and/or who express themselves in a masculine way.

Two-Spirit: Refers to a person who identifies as having both a masculine and a feminine spirit, and is used by some Indigenous people to describe their sexual, gender and/or spiritual identity (11). Refers to a gender role believed to be common amongst most, if not all, First peoples of Turtle Island (North America), one that had a proper and accepted place within Indigenous societies. This gender role was not based in sexual activities or practices, but rather the sacredness that comes from being different (10). There are many definitions and understandings that are nation-specific (e.g. Navajo, Cree, Dene, Anishinabe) and each individual person will have their own way of expressing their Two-Spirit-ness. Also, not all Indigenous people identify as Two-Spirit and have other ways and words to express their gender identity and sexual orientation (12).

Underserved persons: Underserved populations can include Indigenous people, people who do not speak either of Canada's official languages, people with alternate sexual orientation, immigrants, refugees, ethnically or racially diverse populations, people with disabilities, the homeless, sex trade workers and people with low incomes. Underserved means there is an increased likelihood that individuals who belong to a certain population (and people can belong to more than one) may experience difficulties in obtaining needed care, receive less care or a lower standard of care, experience different treatment by health providers, receive treatment that does not adequately meet their needs, or that they will be less satisfied with health services than the general population (356).

Appendix B: RNAO Position Statement



Position Statement:

Respecting Sexually and Gender Diverse Communities

The Registered Nurses' Association of Ontario (RNAO) recognizes the inherent dignity and worth of every person and endeavors to provide for equal rights and opportunities without discrimination. RNAO believes that sexually and gender diverse communities should be respected.

Prejudice, Stereotyping, and Discrimination Threaten Health through Violence and Social Exclusion

RNAO denounces any kind of stigmatization, discrimination and social exclusion based on sexual orientation, gender identity and gender expression. Certain views and assumptions about sexual orientation, gender identity and gender expression can be harmful and create conditions that result in human rights violations and health inequities. Health inequities can be intensified when other identities and determinants of health intersect with gender identity, gender expression and sexual orientation.

2SLGBTQI+ is an acronym that describes a variety of sexually and gender diverse people, including those who identify as lesbian, gay, bisexual, trans, queer, intersex, and Two-Spirit.

Two-Spirit refers to a person who identifies as having both a masculine and feminine spirit, and is used by some Indigenous people to describe their sexual, gender and/or spiritual identity.

The plus '+' is meant to be inclusive of all other diversities along a spectrum, to represent those who identify as non-binary, pansexual, asexual or are questioning their sexual orientation, gender identity and/or gender expression.

The core concepts of gender identity, gender expression, sexual orientation, physical attraction and emotional attraction underlie the terms. Some people identify with one or more labels to align with these concepts, while others do not identify with any label. One's understanding of their own gender identity, gender expression and sexual orientation may be fluid and can change over time.

Members of sexually and gender diverse communities routinely experience stigma and discrimination that contributes to poor health and well-being. Discrimination against 2SLGBTQI+ people may take the form of homophobia, biphobia, or transphobia.

Heteronormativity is a world view that assumes that everyone is, or should be, heterosexual. Cisnormativity is the belief in the binary construct of gender, as either male or female, as defined by birth assigned sex.

The health and wellbeing of 2SLGBTQI+ people is compromised by micro-aggressions, sexual and physical assault, harassment, hate crimes, emotional/psychological and verbal abuse, and chronic stress caused by stigmatization. Sexual orientation, gender identity and gender

expression conversion efforts (“therapy”) are psychologically harmful and unethical.

Prejudice, Stereotyping, and Discrimination Threaten Access to Health Services and Care

2SLGBTQI+ people experience barriers to inclusive and appropriate care because of implicit biases of health-care professionals and cisheteronormative, heterosexist and discriminatory policies and practices ingrained in health-care institutions.

Prejudice, Stereotyping, and Discrimination Threaten Quality Work Environments

These same cisheteronormative, heterosexist, discriminatory practice environments can be traumatizing to health-care professionals who identify with the 2SLGBTQI+ community, whether that discrimination comes from colleagues, supervisors, employers, or clients.

CALL TO ACTION:

RNAO will:

Speak out for human rights and health equity

- Speak out against implicit biases, prejudices, stereotypes and policies that are discriminatory and cisheteronormative
- Speak out against discrimination and social exclusion based on sexual orientation and gender identity/expression
- Speak out against social inequities faced by those who identify as 2SLGBTQI+

Advance person-centred, inclusive, and appropriate health care

- Advocate for health-care services and programs that are inclusive of the needs of 2SLGBTQI+ clients, staff, and the communities they serve -- all people should be able to see, hear, and feel that their identity is acknowledged and welcomed
- Provide neutral and inclusive assessment tools, forms, and educational materials to aid in care delivery in all health-care settings
- Promote and champion educational opportunities for health-care professionals to learn about and maintain competence related to health issues affecting the 2SLGBTQI+ community and for skill-building opportunities to promote inclusive and appropriate care

Foster and advocate for safe, inclusive and healthy work environments for nurses and staff

- Develop organizational or agency-specific policies, procedures, and codes-of-conduct for all staff to help educate them on cultural diversity, sexual and gender diversity, and the duty to treat everyone respectfully
- Ensure a safe and affirmative employment setting for all health-care professionals, including those who identify as 2SLGBTQI+

It is essential to consult with and include 2SLGBTQI+ people in the development, implementation and evaluation of all policies, procedures and programs.

Appendix C: Foundational Reading

It is important that health providers have an understanding of the health inequities experienced by many 2SLGBTQI+ people. In addition, health providers are required to have an understanding of legislation that prohibits actions that discriminate against people based on protected grounds.

Table 24 includes a list of foundational reading on these topics as identified by the expert panel. It is important to note that this is not an exhaustive list of all available resources.

Table 24: Foundational Reading

RESOURCE	DESCRIPTION
<p>Canadian Human Rights Act 1985. Government of Canada [Internet]. Ottawa (ON): 1985 [cited 2021 April 16]. Available from: https://laws-lois.justice.gc.ca/eng/acts/h-6/</p>	<ul style="list-style-type: none"> Canadian Human Rights Act (1985) The Act clearly articulates that all individuals should not be discriminated against based on their sexual orientation, gender identity or gender expression.
<p>Ontario Human Rights Code, 1990, c H-19 [Internet]. Government of Ontario. [cited 2021 April 16]. Available from: https://www.ontario.ca/laws/statute/90h19.</p> <p>Policy on preventing discrimination because of GENDER IDENTITY and GENDER EXPRESSION. Ontario Human Rights Commission [Internet]. Toronto (ON): 2014 [cited 2021 April 19]. Available from: http://www.ohrc.on.ca/sites/default/files/Policy%20on%20preventing%20discrimination%20because%20of%20gender%20identity%20and%20gender%20expression.pdf</p>	<ul style="list-style-type: none"> Ontario law that prohibits actions that discriminate against people based on protected grounds Protected grounds include: age, ancestry, colour, race, citizenship, ethnic origin, place of origin, creed, disability, family status, marital status (including single status), gender identity, gender expression, receipt of public assistance (in housing only), record of offences (in employment only), sex (including pregnancy and breastfeeding) and sexual orientation. Ontario Human Rights Commission policy document on preventing discrimination because of gender identity and gender expression

RESOURCE	DESCRIPTION
<p>Parliament of Canada House of Commons Standing Committee on Health: The Health of LGBTQIA2 Communities in Canada [Internet]. Ottawa (ON): 2019 [cited 2021 April 16]. Available from: https://www.ourcommons.ca/DocumentViewer/en/42-1/HESA/report-28/</p>	<ul style="list-style-type: none"> ■ The report details health inequities experienced by lesbian, gay, bisexual, trans, queer, intersex, asexual and Two-Spirit (LGBTQIA2) communities in Canada and includes a focus on stigma and discrimination and social determinants of health. ■ The committee put forth 22 recommendations for action spanning the following areas: awareness, campaign and education, consultation, data collection, program funding, health of trans people, sexually transmitted blood borne infections, elimination of conversion therapy, intersex people, and blood, organ and tissue donation. ■ Recommendation 5 in the report specifically relates to promoting education of health providers about the health needs of sexual and gender minorities.
<p>Public Health Agency of Canada. Addressing Stigma Towards a More Inclusive Health System: The Chief Public Health Officer's Report on the State of Public Health in Canada [Internet]. Ottawa (ON): 2019 [cited 2021 April 16]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf</p>	<ul style="list-style-type: none"> ■ Report provides an overview of the state of public health in Canada by presenting national key indicators such as, life expectancy, chronic disease incidence and substance use. ■ A chapter dedicated to stigma and health highlights the pathways from stigma to poor health outcomes and how different stigmas overlap. The areas of focus included stigma experienced by First Nations, Inuit, and Métis peoples, African, Caribbean, and Black Canadians, seniors, and LGBTQ2+ people with respect to health issues such as mental illness, substance use, tuberculosis, HIV and obesity. ■ The last chapter presents an action framework to reduce stigma across the health system and improve health outcomes.
<p>Reclaiming Power and Place: The Final Report of the National Inquiry into Murdered and Missing Indigenous Women and Girls. [Internet]. Canada: 2019 [cited 2021 April 16]. Available from: https://www.mmiwg-ffada.ca/final-report/</p>	<ul style="list-style-type: none"> ■ Final report of the national inquiry into the missing and murdered Indigenous women, girls, and 2SLGBTQIA people ■ The report includes calls to justice on several themes including health and wellness.

RESOURCE	DESCRIPTION
<p>Sharman, Z, editor. <i>The Remedy: Queer and Trans Voices on Health and Health Care</i>. Arsenal Pulp Press: Vancouver, BC: 2016.</p>	<ul style="list-style-type: none"> ■ This anthology is a diverse collection of real-life stories from queer and trans people on their health-care experiences and challenges. Included are accounts from gay men living with HIV who remember the systemic resistance to their health-care needs, a lesbian couple dealing with the experience of cancer, and young trans people who struggle to find health-care providers who treat them with dignity and respect.
<p>Truth and Reconciliation Commission of Canada: <i>Calls to Action</i> [Internet]. Winnipeg (MB): 2015 [cited 2021 April 16]. Available from: http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf</p>	<ul style="list-style-type: none"> ■ The Truth and Reconciliation Commission of Canada calls to action to redress the legacy of residential schools and advance the process of Canadian reconciliation ■ Includes a specific call to action for medical and nursing schools to require a course on Indigenous health issues.
<p>United Nations. <i>United Nations Declaration on the Rights of Indigenous Peoples</i> [Internet]. Geneva: 2007 [cited 2021 April 16]. Available from: https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf</p>	<ul style="list-style-type: none"> ■ Declaration establishes a universal framework of minimum standards for the survival, dignity and well-being of the Indigenous Peoples of the world. ■ It elaborates on existing human rights standards and fundamental freedoms as they apply to the specific situation of Indigenous Peoples.
<p>United Nations. <i>International Human Rights Law & Sexual Orientation & Gender Identity</i> [Internet]. Geneva: Free & Equal United Nations; date unknown. Available from: https://www.unfe.org/wp-content/uploads/2018/10/International-Human-Rights-Law-English.pdf</p>	<ul style="list-style-type: none"> ■ Document outlines international charters, rights and treaties that prohibit discrimination of people based on sexual orientation or gender identity. ■ It identifies some of the most common forms of human rights violations affecting LGBT people.

Appendix D: RNAO BPGs and Other Resources That Align with This Guideline

The following are topics that align with this BPG and with suggested RNAO guidelines and resources from other organizations.

TOPIC	RESOURCE(S)
Crisis intervention	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management [Internet]. 3rd ed. Toronto (ON): Registered Nurses' Association of Ontario; 2017. Available from: https://RNAO.ca/bpg/guidelines/crisis-intervention
Engaging clients who use substances	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Engaging Clients Who Use Substances. [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2015. Available from: https://RNAO.ca/bpg/guidelines/engaging-clients-who-use-substances
Implementation science, implementation frameworks, and resources	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario in partnership with Healthcare Excellence Canada. <i>Leading Change Toolkit™</i> (3rd ed.). Toronto (ON): RNAO; 2021 Available from: https://www.RNAO.ca/leading-change-toolkit The National Implementation Research Network's Active Implementation Hub. Get Started [Internet]. [place unknown]: AI Hub; c2013–2018. Available from: http://implementation.fpg.unc.edu/ Canadian Patient Safety Institute and Improvement Frameworks. Getting Started Kit [Internet]. [place unknown]: safer healthcare now!; August 2015. Available from: http://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Documents/Improvement%20Frameworks%20GSK%20EN.PDF Dissemination & Implementation Models in Health Research & Practice [Internet]. [place unknown]: The Center for Research in Implementation Science and Prevention; [date unknown]. Available from: http://dissemination-implementation.org/content/resources.aspx
Interprofessional collaboration	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Developing and Sustaining Interprofessional Health Care: Optimizing patients/clients, organizational, and system outcomes [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2013. Available from: https://rnao.ca/bpg/guidelines/interprofessional-team-work-healthcare
Integrating tobacco interventions into daily practice	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Integrating Tobacco Interventions into Daily Practice [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2017. Available from: https://RNAO.ca/bpg/guidelines/integrating-tobacco-interventions-daily-practice

TOPIC	RESOURCE(S)
Nursing leadership	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Developing and Sustaining Nursing Leadership [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2013. Available from: https://RNAO.ca/bpg/guidelines/developing-and-sustaining-nursing-leadership
Person- and family-centred care	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Person- and Family-Centred Care [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2015. Available from: https://RNAO.ca/bpg/guidelines/person-and-family-centred-care
Practice education	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Practice Education in Nursing [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2016. Available from: https://RNAO.ca/bpg/guidelines/practice-education-nursing
Preventing and addressing abuse and neglect of older adults	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Preventing and Addressing Abuse and Neglect of Older Adults [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2014. Available from: https://RNAO.ca/bpg/guidelines/abuse-and-neglect-older-adults
Self-management	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients. [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2010. Available from: https://RNAO.ca/bpg/guidelines/strategies-support-selfmanagement-chronic-conditions-collaboration-clients
Social Determinants of Health	<ul style="list-style-type: none"> Registered Nurses Association of Ontario. Social Determinants of Health [Internet]. Toronto (ON). Registered Nurses' Association of Ontario; n.d. Available from: https://RNAO.ca/policy/projects/social-determinants-health

Appendix E: Pharmacotherapy and Transition Related Surgery Resources

The following resources are suggested guidelines and resources from other organizations. It is important to note that this is not an exhaustive list of all possible resources available.

TOPIC	RESOURCE(S)
Pharmacotherapy (including hormone therapy)	<ul style="list-style-type: none"> <li data-bbox="487 569 1446 726">■ Bourns, A. Sherbourne’s guidelines for gender-affirming primary care with trans and non-binary patients [Internet]. Toronto (ON): Rainbow Health Ontario & Sherbourne Health; 2019. Available from: https://www.rainbowhealthontario.ca/resources/4th-edition-sherbournes-guidelines-for-gender-affirming-primary-care-with-trans-and-non-binary-patients/ <li data-bbox="487 741 1446 1024">■ Dahl, M., Feldman, J. L., Goldberg, J., et al. Vancouver Coastal Health [Internet]. Endocrine therapy for transgender adults in British Columbia: Suggested guidelines. Vancouver, BC: Vancouver Coastal Health; 2015. Available from: http://www.phsa.ca/transcarebc/Documents/HealthProf/BC-Trans-Adult-Endocrine-Guidelines-2015.pdf Trans Care BC. Gender-affirming care for trans, Two-Spirit, and gender diverse patients in BC: A primary care toolkit. [Internet]. Vancouver (BC): Trans Care BC; 2019. Available from: http://www.phsa.ca/transcarebc/health-professionals/clinical-resources <li data-bbox="487 1039 1446 1197">■ UCSF Transgender Care, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available from: https://transcare.ucsf.edu/guidelines <li data-bbox="487 1211 1446 1331">■ World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people [Internet]. World Professional Association for Transgender Health; 2012. Available from: https://www.wpath.org/publications/soc

TOPIC	RESOURCE(S)
<p>Transition-related surgery and post-surgical care</p>	<ul style="list-style-type: none"> ■ Bourns, M. Sherbourne’suidelines for gender-affirming primary care with trans and non-binary patients [Internet]. Toronto (ON): Rainbow Health Ontario & Sherbourne Health; 2019. Available from: https://www.rainbowhealthontario.ca/resources/4th-edition-sherbournes-guidelines-for-gender-affirming-primary-care-with-trans-and-non-binary-patients/ ■ Trans Care BC. Gender-affirming care for trans, Two-Spirit, and gender diverse patients in BC: A primary care toolkit. [Internet]. Vancouver (BC): Trans Care BC; 2019. Available from: http://www.phsa.ca/transcarebc/health-professionals/clinical-resources ■ UCSF Transgender Care, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available from: https://transcare.ucsf.edu/guidelines ■ World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people [Internet]. World Professional Association for Transgender Health; 2012. Available from: https://www.wpath.org/publications/soc

Appendix F: Guideline Development Methods

This appendix presents an overview of the RNAO BPG development process and methods. RNAO is unwavering in its commitment that every BPG be based on the best available evidence. To meet international standards, the GRADE and GRADE CERQual methods have been implemented.

Scoping the Guideline

The scope sets out what an RNAO BPG will and will not cover (see **Purpose and Scope** on page 8). To determine the scope of this BPG, the RNAO best practice guideline development and research team conducted the following steps:

1. **An environmental scan of guidelines.** The RNAO best practice guideline development and research team searched an established list of websites for guidelines and other relevant content published between January 2008 and March 2018. The purpose of the environmental scan was to gain an understanding of existing guidelines on 2SLGBTQI+ health and health care in order to identify opportunities to develop the purpose and scope of this BPG. The resulting list was compiled based on knowledge of evidence-based practice websites. RNAO expert panel members were asked to suggest additional guidelines. An updated guideline search was conducted in February 2020 and April 2020 to capture any relevant guidelines published beyond the initial search date. Detailed information about the search strategy for existing guidelines, including the list of websites searched and the inclusion criteria used, is available at <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

The guidelines were reviewed for content, applicability to nursing scope of practice, accessibility, and quality. Two guideline development methodologists appraised two international guidelines using the AGREE II tool (173). Guidelines with an overall score of 6 or 7 (on a 7-point Likert scale) were considered to be of high quality and guidelines with an overall score of 4 or 5 were considered to be of moderate quality.

The following guidelines were appraised as indicated:

- Hembree, W., Cohen-Kettenis, P., Gooren, L., et al. [Internet] Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Int J Clin Endocrinol Metab.* Volume 102, Issue 11, 1 November 2017, Pages 3869 -3903, <https://doi.org/10.1210/jc.2017-01658>.
 - Score: 6 out of 7. This Guideline was used as a supporting resource in this BPG.
 - UCSF Transgender Care, Department of Family and Community Medicine, University of California San Francisco. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*; 2nd edition. Deutsch MB, ed. June 2016. Available from: <https://transcare.ucsf.edu/guidelines>.
 - Score: 4 out of 7. This Guideline was used as a supporting resource and to inform the good practice statement in this BPG.
2. **A review of the literature.** A literature review was undertaken to determine the available evidence on intervention studies for providing care to 2SLGBTQI+ people.
 3. **Fourteen telephone key informant interviews.** These were conducted with experts in the field, including direct care health providers, administrators, educators, activists, and researchers to understand the needs of nurses, members of the interprofessional health team and persons with lived experience.
 4. **Four telephone discussion groups were convened.** The discussion groups were held with direct care health providers, advocates, and researchers to understand the needs of nurses, members of the interprofessional health team and persons with lived experience.

Assembly of the Expert Panel

RNAO aims for diversity in membership of an expert panel; this is in alignment with its Organizational Statement on Diversity and Inclusivity, which is part of the RNAO Mission and Values (357). RNAO also aims for persons impacted by BPG recommendations, especially persons with lived experiences and families, to be included as expert panel members.

There are numerous ways in which RNAO finds and selects members of an expert panel. These include:

- searching the literature for researchers in the topic area;
- soliciting recommendations from key informant interviews;
- drawing from established professional networks, such as RNAO Interest Groups, the Nursing Best Practice Champions Network[®] and Best Practice Spotlight Organizations[®] (BPSOs[®]); and
- other nursing and health provider associations, topic-relevant technical associations or organizations, and advocacy bodies.

For this BPG, the RNAO best practice guideline development and research team assembled a panel of experts from nursing practice, research, education and policy, as well as other members of the interprofessional team and persons with lived experience representing a range of sectors and practice areas (see the **RNAO Expert Panel** on page 25).

The expert panel engaged in the following activities:

- approved the purpose and scope of this BPG;
- determined the recommendation questions and outcomes to be addressed in this BPG;
- participated in a **consensus**^G development process to finalize recommendation statements;
- provided feedback on the draft of this BPG;
- participated in the development of evaluation indicators; and
- identified appropriate stakeholders to review the draft guideline prior to publication.

In addition to the above, the expert panel co-chairs engaged in the following activities:

- participated in monthly meetings with the guideline development methodologists and guideline development project coordinator;
- facilitated expert panel meetings;
- provided in-depth guidance on clinical and/or research issues; and
- moderated voting processes.

Conflict of Interest

In the context of RNAO BPG development, the term “conflict of interest” (COI) refers to situations in which financial, professional, intellectual, personal, organizational or other relationships may compromise their ability to conduct panel work independently. Declarations of COI that might be construed as constituting a perceived and/or actual conflict were made by all members of the expert panel prior to their participation in guideline development work using a standard form. Expert panel members also updated their COI at the beginning of each in-person guideline meeting and upon final review of the guideline. Any COI declared by an expert panel member was reviewed by both the RNAO best practice guideline development and research team and by expert panel co-chairs. No limiting conflicts were identified. See Declarations of Conflicts of Interest Summary at <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Identifying Priority Recommendation Questions and Outcomes

RNAO systematic review questions are developed as per PICO format (population, intervention, comparison and outcome).

In July 2018, the RNAO best practice guideline development and research team and expert panel convened in-person to determine the priority recommendation questions and outcomes for this BPG. A comprehensive list of recommendation questions that the BPG could potentially address was developed at the meeting. This was informed by:

- the environmental scan of guidelines,
- the review of the literature
- key informant interviews and discussion groups;
- an expert panel survey completed prior to the in-person meeting; and
- expert panel discussion at the in-person meeting.

This comprehensive list of potential recommendation questions was presented to the expert panel. Each expert panel member engaged in a confidential rank order vote of all potential recommendation questions. The eight recommendation questions with the highest rank order were deemed the final recommendation questions. Expert panel co-chairs did not participate in the vote.

Following this initial vote – and in alignment with GRADE standards for assessing and presenting the evidence – outcomes were identified and prioritized for each recommendation question. A comprehensive list of outcomes for each recommendation question was developed at the in-person meeting, informed by the following:

- the review of the literature,
- key informant interviews and discussion groups,
- a expert panel survey completed prior to the in-person meeting; and
- expert panel discussion at the in-person meeting.

Based on the comprehensive list of outcomes, the expert panel was asked to rank-order the relative importance of each outcome per recommendation question. Each panel member participated in a confidential online rank order vote. It was deemed feasible to have a total of five prioritized outcomes per recommendation question. Expert panel co-chairs did not participate in the vote as they functioned as co-facilitators. Voting results were presented to the expert panel and, through a facilitated discussion, priority outcomes were determined for each recommendation question.

Following the in-person meeting, an online vote was completed to determine outcomes of critical importance for each recommendation question. Likert scales were used for this vote. Expert panel co-chairs did not participate in the vote. Seventy per cent of the panel completed the online vote. Outcomes were ranked critical, if 70 per cent of the cast votes identified the outcomes as 7, 8 or 9 on the 9-point Likert Scale.

The eight recommendation questions – and their respective PICO research questions – are presented below.

Recommendation Question #1: What communication strategies should be recommended to improve care for 2SLGBTQI+ people?

PICO Research Question #1

Population: Health providers

Intervention: Communication strategies (e.g. inclusive language, standardized forms, history taking, documentation)

Comparison: No inclusive communication strategies

Outcomes: 2SLGBTQI+ person's comfort [critical], safety [critical], retention [important]*, and diversity in who is disclosing [important]*

*Two important outcomes were not found in the literature: retention and diversity in who is disclosing.

Surrogate outcomes^G were not chosen in replacement, as the critical outcomes were captured and there was deemed to be a sufficient number of outcomes for Recommendation Question 1. These outcomes (retention and diversity in who is disclosing) were identified as a gap that future research may explore.

Recommendation Question #2: Should the creation of safe spaces in health-service organizations be recommended to improve care for 2SLGBTQI+ persons?

PICO Research Question #2

Population: Health-service organizations*

Intervention: Safe spaces (can include presence of forms, signs, policies that reflect a safe space)

Comparison: Standard/usual care in health-service organizations

Outcomes: 2SLGBTQI+ person experience [critical], safety [important], retention [important], and diverse representation of 2SLGBTQI+ persons and health providers [important].

*This recommendation question also included literature within school settings. Public health nurses can practice within the school setting and there was a dearth of research within traditional health settings, therefore the inclusion criteria included school settings.

Recommendation Question #3: Should promotion of risk screening by health providers be recommended to improve care for 2SLGBTQI+ people?

PICO Research Question #3

Population: 2SLGBTQI+ people across the lifespan (including people from underserved populations)

Intervention: Risk screening

Comparison: No risk screening

Outcomes: Number of persons accessing screening [critical], earlier detection and/or intervention [critical]*, 2SLGBTQI+ person knowledge [important]*, and risk behaviours [important]*

*The following outcomes were not found within the literature: earlier detection and/or intervention, 2SLGBTQI+ person knowledge, and risk behaviours. Surrogate outcomes were not chosen in replacement, and the promotion of risk screening in enhancing access was the only outcome assessed. These three outcomes were identified as a gap that future research may explore.

Recommendation Question #4: Should clinical group-based interventions for health conditions be recommended to improve care for 2SLGBTQI+ persons?

PICO Research Question #4

Population: 2SLGBTQI+ persons (across the lifespan)

Intervention: 2SLGBTQI+ clinical groups for health conditions (could be professional or peer-led)

Comparison: No clinical group for health conditions

Outcomes: Mental health [critical], social support [critical], self-management [important], person-provider therapeutic relationship [important]*, and number of visits to the emergency department or hospitalization [important]*

*Two important outcomes were not found in the literature: person-provider therapeutic relationship and number of visits to the emergency department or hospitalization. Surrogate outcomes were not chosen in replacement, as the critical outcomes were captured and there was deemed to be a sufficient number of outcomes for Recommendation Question 4. These two outcomes were identified as a gap that future research may explore.

Recommendation Question #5: Should group-based interventions be recommended to improve care for 2SLGBTQI+ persons?

PICO Research Question #5

Population: 2SLGBTQI+ persons (across the lifespan)

Intervention: Group-based interventions (peer or professional-led)

Comparison: No group-based interventions

Outcomes: 2SLGBTQI+ person experience [critical], social support [critical], self-management [important], inclusion of 2SLGBTQI+ health within policies [important]*

* One important outcome was not found in the literature: inclusion of 2SLGBTQI+ health within policies. Surrogate outcomes were not chosen in replacement, as the critical outcomes were captured and there was deemed to be a sufficient number of outcomes for Recommendation Question 5. This was identified as a gap that future research may explore.

Recommendation Question #6: Should 2SLGBTQI+ health content be integrated into professional education for students entering health professions?

PICO Research Question #6

Population: Students entering health professions

Intervention: Integration of diverse and affirming 2SLGBTQI+ health content into professional education (including policies)

Comparison: No integration of 2SLGBTQI+ health content into professional education

Outcomes: Student experience [critical], student knowledge and/or skill [critical], number of continuing professional development offerings and/or modules that include 2SLGBTQI+ content [important]*, number of educational institutions that have integrated policies [important]*

* The expert panel voted on the inclusion of the following important outcomes: number of continuing professional development offerings and/or modules that include 2SLGBTQI+ content and number of educational institutions that have integrated policies for Recommendation Question #6. Upon further reflection and review of the literature, it was noted that these outcomes were presented as descriptors of

the intervention. When available, this data was extracted as part of the intervention's description. Surrogate outcomes were not chosen and the remaining outcomes (student experience and student knowledge and/or skill) were assessed.

Recommendation Question #7: Should continuing education be recommended for health providers to improve care for 2SLGBTQI+ people?

PICO Research Question #7

Population: Health providers

Intervention: Continuing education (including mandatory professional development)

Comparison: No continuing education

Outcomes: Health provider knowledge [critical] and change in practice [critical]**, 2SLGBTQI+ person experience [critical]*, access to care for 2SLGBTQI+ persons [critical]*

* The expert panel voted on 2SLGBTQI+ persons' experience of care and access to care as critical outcomes for Recommendation Question #7. Although both are potential outcomes of health provider education, they were not found in the literature. Upon further reflection, it was noted that these outcomes may be difficult to measure or to directly link to continuing education. Surrogate outcomes were not chosen and the remaining outcomes (health provider knowledge and change in practice) were assessed.

**Surrogate outcomes were used to assess change in practice including: health provider attitudes, confidence and comfort.

Recommendation Question #8: Should 2SLGBTQI+ specific (safe) spaces for long-term care residents be recommended for improving care to 2SLGBTQI+ residents?*

PICO Research Question #8

Population: 2SLGBTQI+ older adults (65 and older) in long-term care

Intervention: 2SLGBTQI+ specific (safe) spaces in long-term care settings

Comparison: Standard long-term care setting without specific spaces

Outcomes: knowledge of staff [critical], 2SLGBTQI+ persons' responsive behaviours [critical], perceived safety [critical], experience [critical], and incidence of peer bullying [important]

* The expert panel voted for Recommendation Question 8. However, after completing the search, only two qualitative studies were identified that could answer this recommendation question and these same studies were captured in Recommendation Question 2 on safer spaces. One Recommendation was drafted to capture all health-service organizations including long-term care as the recommended interventions to create safer spaces were not unique to the long-term care setting. The evaluation of specific (safe) spaces for long-term care residents, compared to standard long-term care settings without specific spaces, for improving care has been identified as a research gap.

Systematic Retrieval of the Evidence

RNAO BPGs are based on a comprehensive and systematic review of the literature.

For this BPG, a search strategy was developed by RNAO's best practice guideline development and research team, along with a health sciences librarian, for each of the aforementioned research questions. A search for relevant research studies published in English between January 2012 and August 2018 was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Medline, Medline in Process, Cochrane Central, Cochrane Database of Systematic Reviews, PsychINFO, Embase, Emcare, ERIC (research questions 6 and 7 only) and LGBT Life.

Systematic review search dates were limited to the last six years in order to capture the most up-to-date evidence. All study designs were included. Expert panel members were asked to review their personal libraries for key studies not found through the above search strategies (see [Appendix G](#)). Detailed information on the search strategy for the systematic reviews, including the inclusion and exclusion criteria and search terms, is available from <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

All studies were independently assessed for relevance and eligibility, based on the inclusion and exclusion criteria, by two guideline development methodologists. Any disagreements were resolved through consensus.

All included studies were independently assessed for risk of bias by study design using validated and reliable tools. **Randomized controlled trials**^G were assessed using the Risk of Bias 2.0 tool (358), **quasi-experimental studies**^G and other non-randomized studies were assessed using the ROBINS-I tool (359), systematic reviews were assessed using the ROBIS tool (360) and qualitative studies were assessed using a modified version of the Critical Appraisal Skills Programme Tool for Qualitative Research (CASP) checklist (361). The two guideline development methodologists reached consensus on all scores through discussion.

For data extraction, the included studies were divided equally between the guideline development methodologists. Each guideline development methodologist extracted information, from their assigned studies, which was reviewed for accuracy by the other guideline development methodologist. For quantitative studies the following information was extracted: study design, country, setting, intervention description, participant information, outcomes (including measures and/or tools), results, and harm(s) (if applicable). For qualitative studies the following information was extracted: study aim, design, participant information, setting, outcome relevant and themes identified. Both the quantitative and qualitative data extraction forms included a section on participant values and preferences and health equity. Content extracted under health equity included details on the study population and was guided by the **Intersectionality Framework** on page 34. Content extracted from studies based on the framework was also used to help inform health equity considerations in the discussions of evidence. The framework also allowed the guideline development methodologists to highlight the potential limitations of the literature for different populations and to highlight research gaps and areas to recommend for further research.

In February 2020, the health science librarian conducted an update search for relevant research studies published in English between the end of the original search dates (August 2018) and February 2020 that answered research question two with expanded search terms to include the school setting. In September 2020, the health science librarian conducted an update search for relevant research studies published in English between the end of the original search dates (August 2018) and September 2020 that answer all other research questions. The search was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Medline, Medline in

Process, Cochrane Central, Cochrane Database of Systematic Reviews, PsychINFO, Embase, Emcare, ERIC (research questions 6 and 7 only). Results from 93 studies were incorporated into the discussions of evidence across all Recommendations. See the PRISMA diagrams in **Appendix G** for studies included in the update search.

Determining Certainty and Confidence of Evidence

Certainty of evidence

The certainty of quantitative evidence (i.e., the extent to which one can be confident that an estimate of an effect is true) is determined using GRADE methods (16). First, the certainty of the evidence is rated for each prioritized outcome across studies (i.e., for a body of evidence) for each research question (16). This process begins with the study design and then requires an examination of five domains – risks of bias, inconsistency, imprecision, indirectness, and publication bias – to potentially **downgrade**^G the certainty of evidence for each outcome. See **Table 25** for a definition of each of these certainty criteria.

Table 25. GRADE Certainty Criteria

CERTAINTY CRITERIA	DEFINITION
Risk of bias	Limitations in the study design and execution that may bias study results. Valid and reliable quality appraisal tools are used to assess the risk of bias. First, risk of bias is examined for each individual study and then examined across all studies for each defined outcome.
Inconsistency	Unexplained differences (heterogeneity) of results across studies. Inconsistency is assessed by exploring the magnitude of difference, and possible explanations in the direction and size of effects reported across studies for a defined outcome.
Indirectness	Variability between the research and review question and context within which the recommendations would be applied (applicability). There are four sources of indirectness which are assessed: <ul style="list-style-type: none"> ■ differences in population ■ differences in interventions ■ differences in outcomes measured ■ differences in comparators
Imprecision	The degree of uncertainty around the estimate of effect. This is usually related to sample size and number of events. Studies are examined for sample size, number of events and confidence intervals.
Publication bias	Selective publication of studies based on study results. If publication bias is strongly suspected, downgrading is considered.

Source: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. <https://gdt.gradepro.org/app/handbook/handbook.html#h.svwngs6pm0f2>. Reprinted with permission.

Following the initial consideration for rating down the certainty of quantitative evidence, three factors are assessed that can potentially enable rating up the certainty of evidence for observational studies:

1. **Large magnitude of effect:** If the body of evidence has not been rated down for any of the five criteria and a large estimate of the magnitude of intervention effect is present, there is consideration for rating up.
2. **Dose-response gradient:** If the body of evidence has not been rated down for any of the five criteria and a dose-response gradient is present, there is consideration for rating up.
3. **Effect of plausible confounding:** If the body of evidence has not been rated down for any of the five criteria and all residual confounders would result in an underestimation of treatment effect, there is consideration for rating up (16).

GRADE categorizes the overall certainty of evidence as *high*, *moderate*, *low*, or *very low*. See **Table 26** for the definitions of these categories.

For this BPG the five GRADE quality criteria for potentially downgrading quantitative evidence, and the three GRADE quality criteria for potentially rating up, were independently assessed by the two guideline development methodologists. Any discrepancies were resolved through consensus. An overall certainty of evidence per recommendation was assigned based on these assessments. The certainty of evidence assigned to each recommendation was based on the certainty of prioritized outcomes in the studies that informed the recommendation.

Table 26: Certainty of Evidence

OVERALL CERTAINTY OF EVIDENCE	DEFINITION
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very Low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Source: Reprinted from: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Available from: <https://gdt.gradeapro.org/app/handbook/handbook.html#h.svwngs6pm0f2>. Reprinted with permission.

Confidence in evidence

Similar to GRADE, there are four **CERQual criteria**^G to assess the confidence in qualitative findings related to a phenomenon of interest:

1. Methodological limitations
2. Relevance
3. Coherence
4. Adequacy

See **Table 27** for a definition of each of these criteria.

Table 27: CERQual Quality Criteria

CRITERIA	DEFINITION
Methodological limitations	The extent to which there are concerns about the design or conduct of the primary studies that contributed evidence to an individual review finding.
Coherence	An assessment of how clear and cogent the fit is between the data from the primary studies and a review finding that synthesizes that data. By “cogent” we mean well supported or compelling.
Adequacy of data	An overall determination of the degree of richness and quantity of data supporting a review finding
Relevance	The extent to which the body of evidence from the primary studies supporting a review finding is applicable to the context (perspective or population, phenomenon of interest, setting) specified in the review question.

Source: Reprinted from Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQUAL to qualitative evidence synthesis findings: introduction to the series. *Implement Sci.* 2018;13 (Suppl 1):1–10. Table 2, Definitions of the components of the CERQual approach; p. 5. Reprinted with permission.

For qualitative findings related to prioritized outcomes, these four criteria were independently assessed by the two guideline development methodologists. Discrepancies were resolved through consensus. An overall judgment of the confidence in each review finding was made based on these assessments above. (See **Table 28** for the confidence of evidence judgments.) Recommendations that included qualitative evidence were assigned an overall confidence in evidence based on the corresponding review finding.

Table 28: Confidence in Evidence

OVERALL CONFIDENCE OF EVIDENCE	DEFINITION
High	It is highly likely that the finding is a reasonable representation of the phenomenon of interest.
Moderate	It is likely that the finding is a reasonable representation of the phenomenon of interest.
Low	It is possible that the review finding is a reasonable representation of the phenomenon of interest.
Very Low	It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

Source: Reprinted from Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQUAL to qualitative evidence synthesis findings: introduction to the series. *Implement Sci.* 2018;13(Suppl 1):1–10. Table 3, Description of level of confidence in a review finding in the CERQual approach; p. 6. Reprinted with permission.

Formulating Recommendations

Summarizing the Evidence

Studies were grouped according to themes based on consensus by the two guideline development methodologists, for each research question. Draft recommendation statements were developed based on the themes. For each draft recommendation, GRADE and/or GRADE CERQual evidence profiles were constructed by the two guideline development methodologists. GRADE and/or GRADE CERQual evidence profiles are used to present decisions on determining the certainty and/or confidence of evidence, as well as general information about the body of research evidence, including key statistical or narrative results (16).

The evidence profiles for the body of quantitative studies presented the decisions made by the two guideline development methodologists on the five key GRADE certainty criteria for rating down the population included in the studies, the countries where the studies were conducted, key results, and transparent judgments about the certainty underlying the evidence for each outcome (16). The evidence profiles for quantitative studies presented the relative importance of outcomes as determined by the expert panel. For this BPG, **meta-analyses**^G were not performed; therefore, results were synthesized using narrative.

CERQual evidence profiles were created for the body of qualitative evidence for each draft recommendation when applicable. Similar to the GRADE evidence profiles used for quantitative research, the CERQual evidence profiles presented the body of evidence supporting each theme related to outcomes for every recommendation. These evidence profiles presented the decisions made by the two guideline development methodologists on the four key CERQual criteria and transparent judgements about the confidence underlying the evidence for each theme.

The GRADE and CERQual evidence profiles for each recommendation, organized per outcome, can be accessed online at <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.

Evidence-to-Decision Frameworks

Evidence-to-Decision (EtD) frameworks^G outline proposed recommendations and summarize all necessary factors and considerations based on available evidence and expert panel judgement for formulating the recommendation statements. EtD frameworks are used to help ensure that all important factors (i.e., certainty or confidence of the evidence, benefits/harms, values and preferences and health equity) required to formulate recommendation statements are considered by the expert panel (16). Both quantitative and qualitative evidence are incorporated into the frameworks. The guideline development methodologists draft the EtD frameworks with available evidence from the systematic reviews.

For this BPG, the EtD frameworks included the following areas of consideration for each drafted recommendation statement (see **Table 29**):

- background information on the magnitude of the problem (including the PICO question and general context related to the research question)
- the balance of benefits and harms of an intervention
- certainty and/or confidence of the evidence
- values and preferences
- health equity

Decision Making: Determining the Direction and Strength of Recommendations

Expert panel members were provided with the EtD frameworks to review prior to a scheduled two-day in-person meeting to determine the direction (i.e., a recommendation for or against an intervention) and the strength (i.e., strong or conditional) of BPG's recommendations. Expert panel members were also given access to the complete evidence profiles and full-text articles.

The expert panel co-chairs and the two guideline development methodologists facilitated the in-person meeting to allow for adequate discussion for each proposed recommendation.

The decision on direction and strength of each recommendation statement was determined by discussion and a consensus vote of at least 70 per cent of voting panel members. The voting process was anonymous and was moderated by the expert panel co-chairs and guideline development methodologists. In determining the strength of a recommendation statement, the expert panel was asked to consider the following (see **Table 29**):

- the balance of benefits and harms of an intervention
- certainty and/or confidence of the evidence
- values and preferences
- health equity

Table 29: Key Considerations for Determining the Strength of Recommendations

FACTOR	DEFINITION	SOURCES
Benefits and harms	<p>Potential desirable and undesirable outcomes reported in the literature when the recommended practice or intervention is used.</p> <p>“The larger the difference between the desirable and undesirable effects, the higher the likelihood that a strong recommendation is warranted. The narrower the gradient, the higher the likelihood that a conditional recommendation is warranted” (362).</p>	Includes research exclusively from the systematic review.
Certainty and confidence of evidence	<p>The extent of confidence that the estimates of an effect are adequate to support a recommendation. The extent of confidence that a review finding is a reasonable representation of the phenomenon of interest (363).</p> <p>Recommendations are made with different levels of certainty or confidence; the higher the certainty or confidence, the higher the likelihood that a strong recommendation is warranted (362).</p>	Includes research exclusively from the systematic review.
Values and preferences	<p>The relative importance or worth of the health outcomes of following a particular clinical action from a person-centred perspective.</p> <p>“The more values and preferences vary or the greater the uncertainty in values and preferences the higher the likelihood that a conditional recommendation is warranted” (362).</p>	Includes evidence from the systematic review (when available) and other sources, such as insights from the expert panel.
Health equity	<p>Represents the potential impact of the recommended practice or intervention on health outcomes or health quality across different populations.</p> <p>The greater the potential for increasing health inequity, the higher the likelihood that a conditional recommendation is warranted (364).</p>	Includes evidence from the systematic review (when available) and other sources, such as insights from the expert panel.

Source: Adapted by the RNAO expert panel from Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Available from: <https://gdt.grade.pro.org/app/handbook/handbook.html#h.svwngs6pm0f2>

Developing Good Practice Statements

Following the in-person meeting, one good practice statement was developed by the RNAO guideline development and research team to capture the need for health providers to follow established screening guidelines, as available and based on organs present, and assess 2SLGBTQI+ people for factors that may place them at increased risk of particular health conditions. The panel was sent a survey asking them to respond to five questions pertaining to each statement:

1. Is the statement clear and actionable?
2. Is the message necessary in regards to actual health practice?
3. After consideration of all relevant health outcomes and potential downstream consequences, will implementing the good practice statement result in large net positive consequences?
4. Is a systematic review of the evidence necessary or required for this recommendation?
5. Is there a clear and explicit rationale to support this good practice statement?

Nine out of fourteen panel members completed the survey on good practice statement, and their results are as follows:

- For the first question, 9 of 9 respondents answered yes.
- For the second question, 9 of 9 respondents answered yes.
- For the third question, 8 of 9 respondents answered yes.
- For the fourth question, 7 of 9 respondents answered no.
- For the fifth question, 9 of 9 respondents answered yes.

The good practice statement was supplemented with a targeted guideline search for established screening guidelines for health conditions for which 2SLGBTQI+ people are at risk and for 2SLGBTQI+ specific guidelines. Screening and prevention organizations, such as Cancer Care Ontario and the Canadian Task Force on Preventive Health Care, were searched as well as established 2SLGBTQI+ health organizations such as Rainbow Health Ontario. Expert panel members also suggested guidelines for inclusion. Guidelines were appraised using the AGREE II tool (173).

Supporting Resources and Appendices

Expert panel members and stakeholders submitted content for the supporting resources and appendices throughout the guideline development process. The two guideline development methodologists reviewed the content based on the following five criteria:

1. **Relevance:** Supporting resources and appendices should be related to the subject of the BPG or recommendation. In other words, the resource or appendix should be suitable and appropriate in relation to the purpose and scope of the BPG or the specific recommendation(s).
2. **Timeliness:** Resources should be timely and current. Resources should be published within the last 10 years or be in line with current evidence.
3. **Credibility:** When assessing credibility, the trustworthiness and expertise of the source material's author or authoring organization is considered. Potential biases are also assessed, such as the presence of advertising or the affiliation of the authors with a private company selling health-care products.
4. **Quality:** This criterion assesses the accuracy of the information and the degree to which the source is evidence-informed. The assessment of quality is in relation to the subject of the resource. For example, if a tool is being suggested, is that tool reliable and/or valid?
5. **Accessibility:** This criterion considers whether the resource is freely available and accessible online.

Drafting the Guideline

The guideline development methodologists wrote the draft of this BPG. The expert panel reviewed the draft and provided written feedback. The BPG then proceeded to external stakeholder review.

Stakeholder Review

As part of the guideline development process, RNAO is committed to obtaining feedback from: (a) nurses and other health providers from a wide range of practice settings and roles, (b) knowledgeable administrators and funders of health services, and (c) stakeholder associations.

Stakeholder reviewers for RNAO BPGs are identified in two ways. First, stakeholders are recruited through a public call issued on the RNAO website ([RNAO.ca/bpg/get-involved/stakeholder](https://rnao.ca/bpg/get-involved/stakeholder)). Second, individuals and organizations with expertise in the guideline topic area are identified by the RNAO best practice guideline development and research team and the expert panel, and are directly invited to participate in the review.

Stakeholder reviewers are individuals with subject matter expertise in the guideline topic or those who may be affected by its implementation. Reviewers may be nurses, members of the interprofessional team, nurse executives, administrators, research experts, educators, nursing students, or persons with lived experience and their family members.

Reviewers are asked to read a full draft of the BPG and participate in the review of it prior to its publication. Stakeholder feedback is submitted online by completing a survey questionnaire. The stakeholders are asked the following questions about each recommendation:

- Is this recommendation clear?
- Do you agree with this recommendation?
- Is the discussion of evidence for this recommendation thorough and clear and does the evidence support the recommendation?

In addition, the stakeholders are asked:

- Do you have any additional comments/suggestions about the background section of the guideline?
- Do you agree with the wording of the key concepts and accompanying definitions?
- Are the supporting resources and appendices included in this guideline appropriate?
- Is the drafted title clear and appropriate?

With respect to the evaluation indicators, the stakeholders are asked:

- Are these indicators relevant to your practice setting?
- Do you have suggestions for other indicators and/or measures?

Survey submissions are compiled and the RNAO best practice guideline development and research team summarizes feedback. Together with the expert panel, they review and consider the survey results, modifying BPG content and recommendations prior to publication to reflect the feedback received as required.

For this BPG, the stakeholder review process was completed between November 30, 2020 and January 8, 2021. Diverse perspectives provided feedback (see **Stakeholder Acknowledgement**).

Procedure for Updating the Guideline

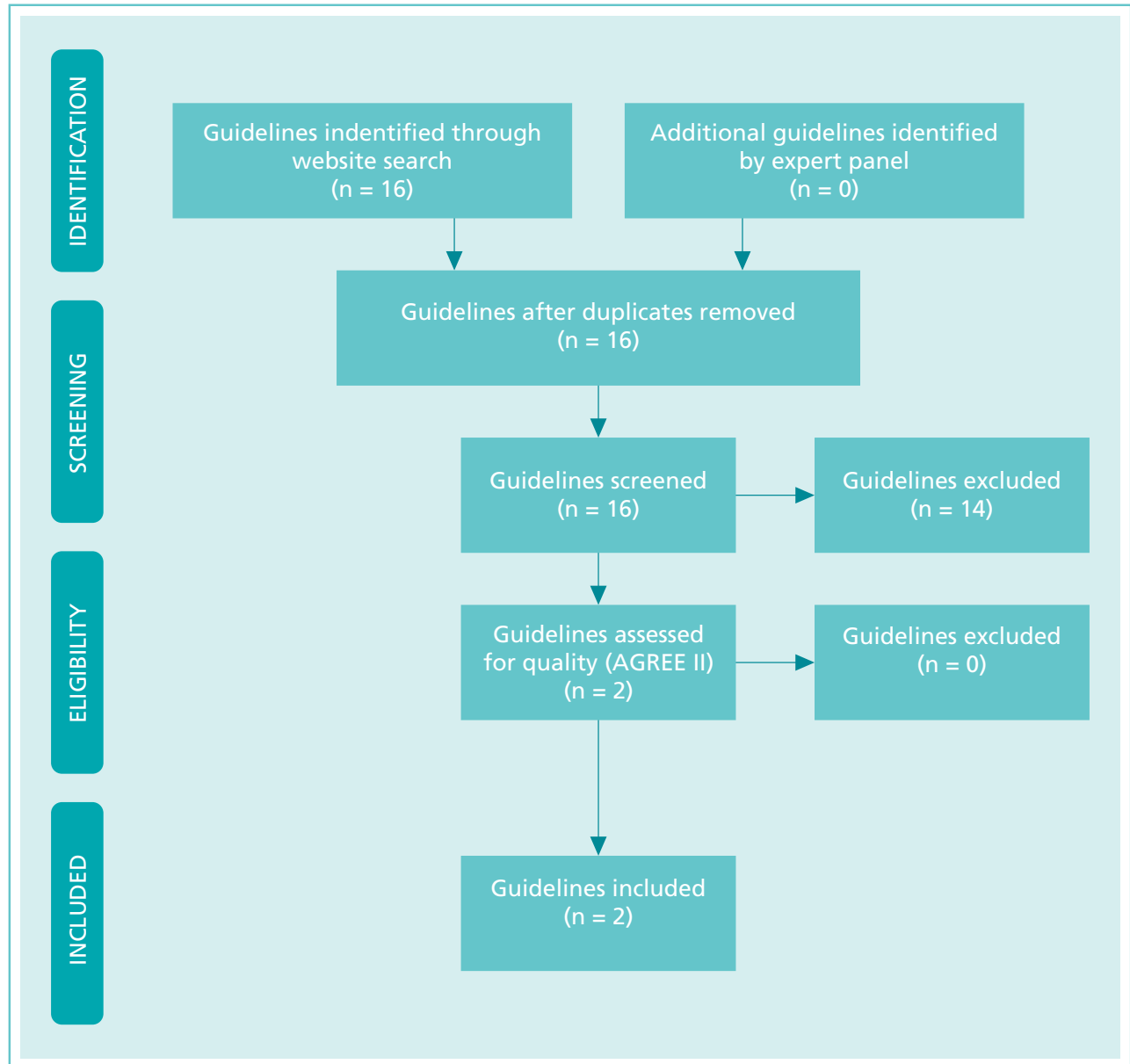
The RNAO commits to updating all BPGs, as follows:

1. Each BPG will be reviewed by a team of specialists in the topic area every five years following publication of the previous edition.
2. RNAO International Affairs and Best Practice Guidelines Centre staff regularly monitor for new systematic reviews, randomized controlled trials, and other relevant literature in the field.
3. Based on that monitoring, RNAO staff may recommend an earlier revision period for a particular BPG. Appropriate consultation with members of the original expert panel and other specialists and experts in the field will help inform the decision to review and revise the BPG earlier than planned.
4. Three months prior to the review milestone, staff commence planning of the review and do the following:
 - a. Compile feedback received and questions encountered during the implementation, including comments and experiences of BPSOs[®] and other implementation sites regarding their experiences.
 - b. Compile a list of new clinical practice guidelines in the field and refine the purpose and scope.
 - c. Develop a detailed work plan with target dates and deliverables for developing a new edition of the BPG.
 - d. Identify, with RNAO's CEO, the potential BPG expert panel co-chairs.
 - e. Compile a list of specialists and experts in the field for potential participation on the expert panel. The expert panel will be comprised of members from the original expert panel and new ones.
5. New editions of BPGs will be disseminated based on established structures and processes.

Appendix G: PRISMA Diagrams for Guideline Search and Systematic Reviews

Guideline Review

Figure 2: Guidelines Review Process Flow Diagram

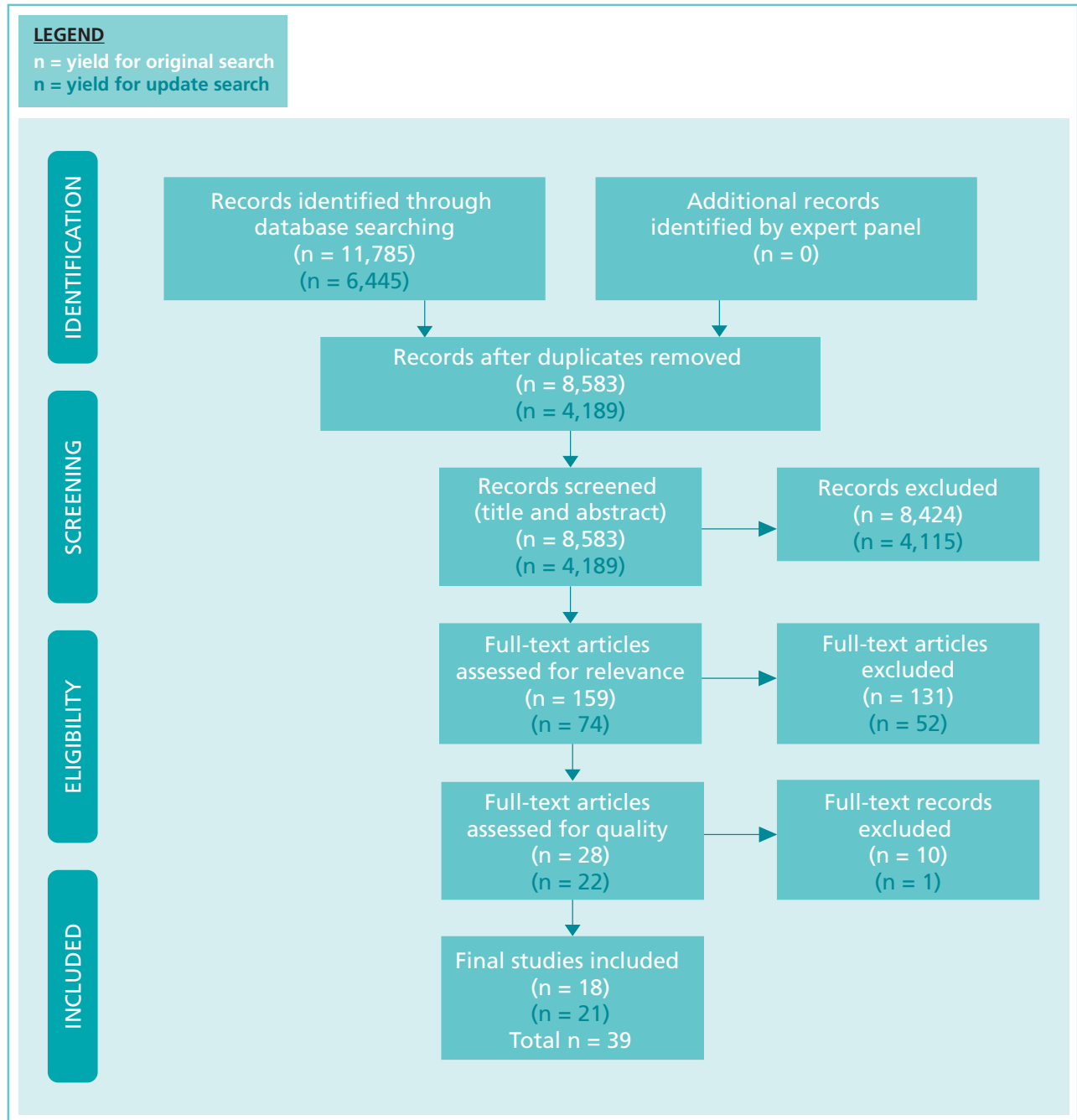


Included guidelines were required to have an overall AGREE II score of 4 or more (out of 7). Two guidelines were included and used as supporting resources.

Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535.

Figure 3: Recommendation Question #1 Article Review Process Flow Diagram

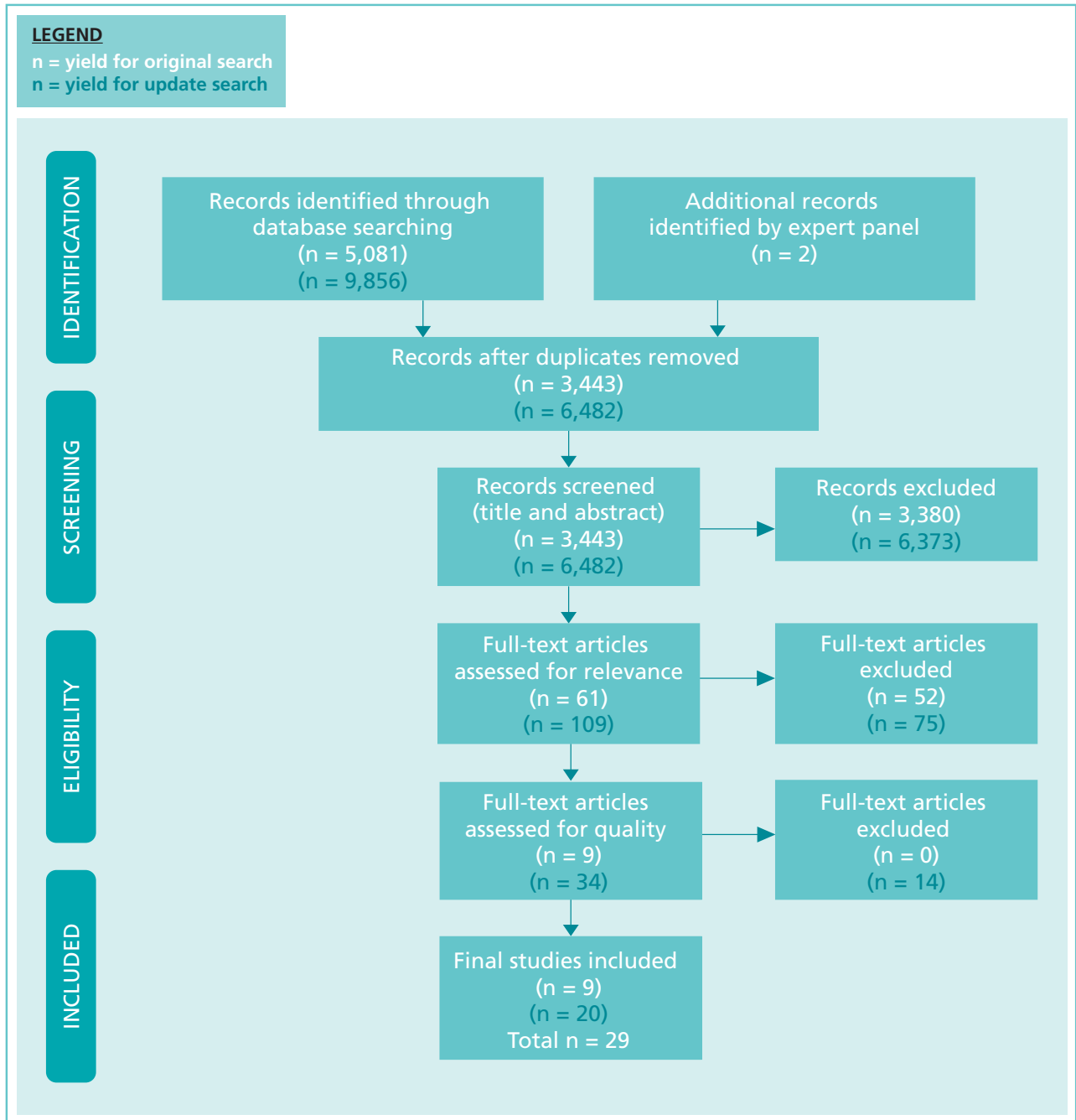
What communication strategies should be recommended to improve care for 2SLGBTQI+ people?



Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535.

Figure 4: Recommendation Question #2 Article Review Process Flow Diagram

Should the creation of safe spaces in health-service organizations be recommended to improve care for 2SLGBTQI+



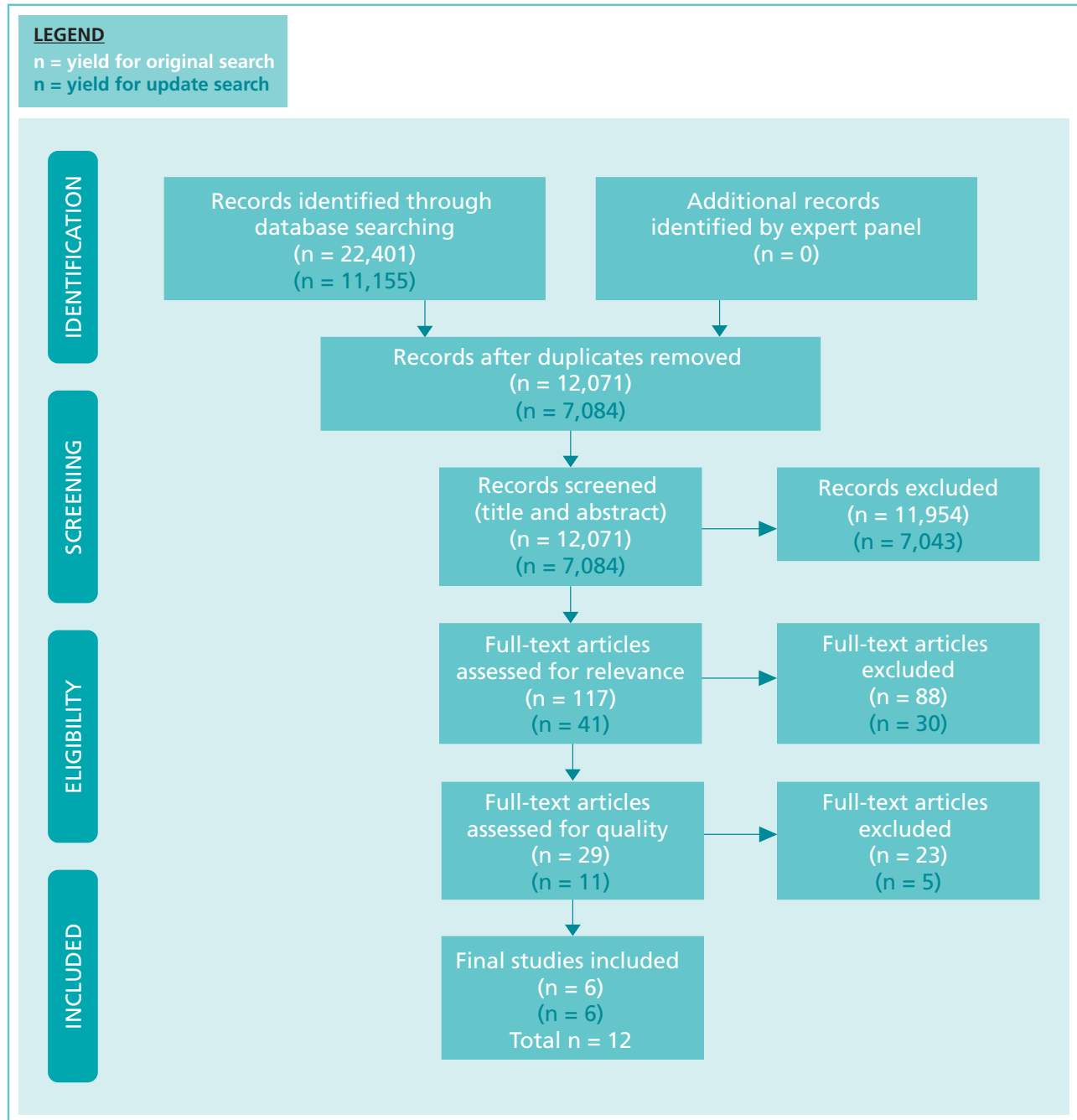
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people?

Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535.

Figure 5: Recommendation Question #3 Article Review Process Flow Diagram

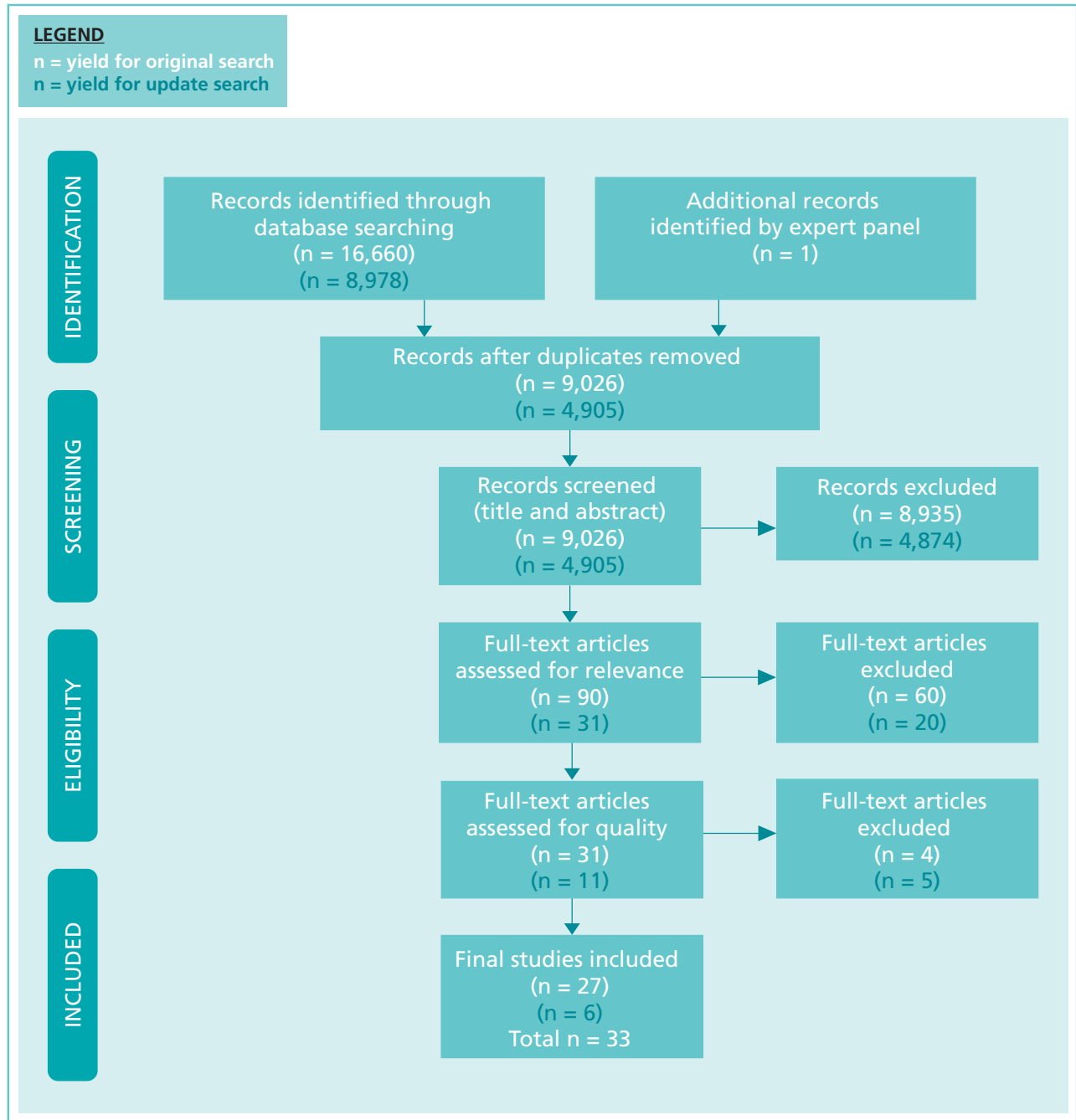
Should promotion of risk screening by health providers be recommended to improve care for 2SLGBTQI+ people?



Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535.

Figure 6: Recommendation Question #4 Article Review Process Flow Diagram

Should clinical group-based interventions for health conditions be recommended to improve care for 2SLGBTQI+ people?

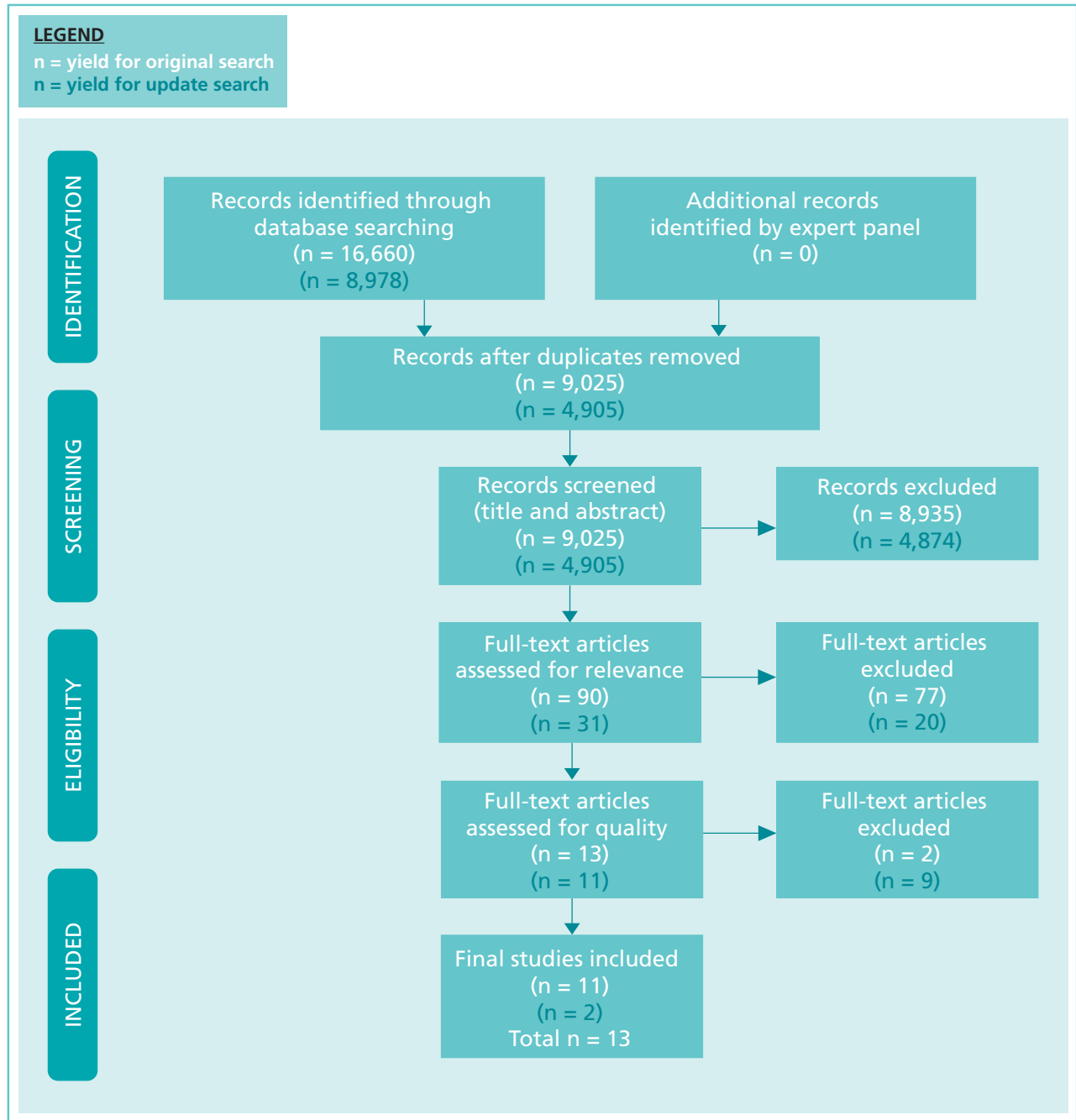


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Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

Figure 7: Recommendation Question #5 Article Review Process Flow Diagram

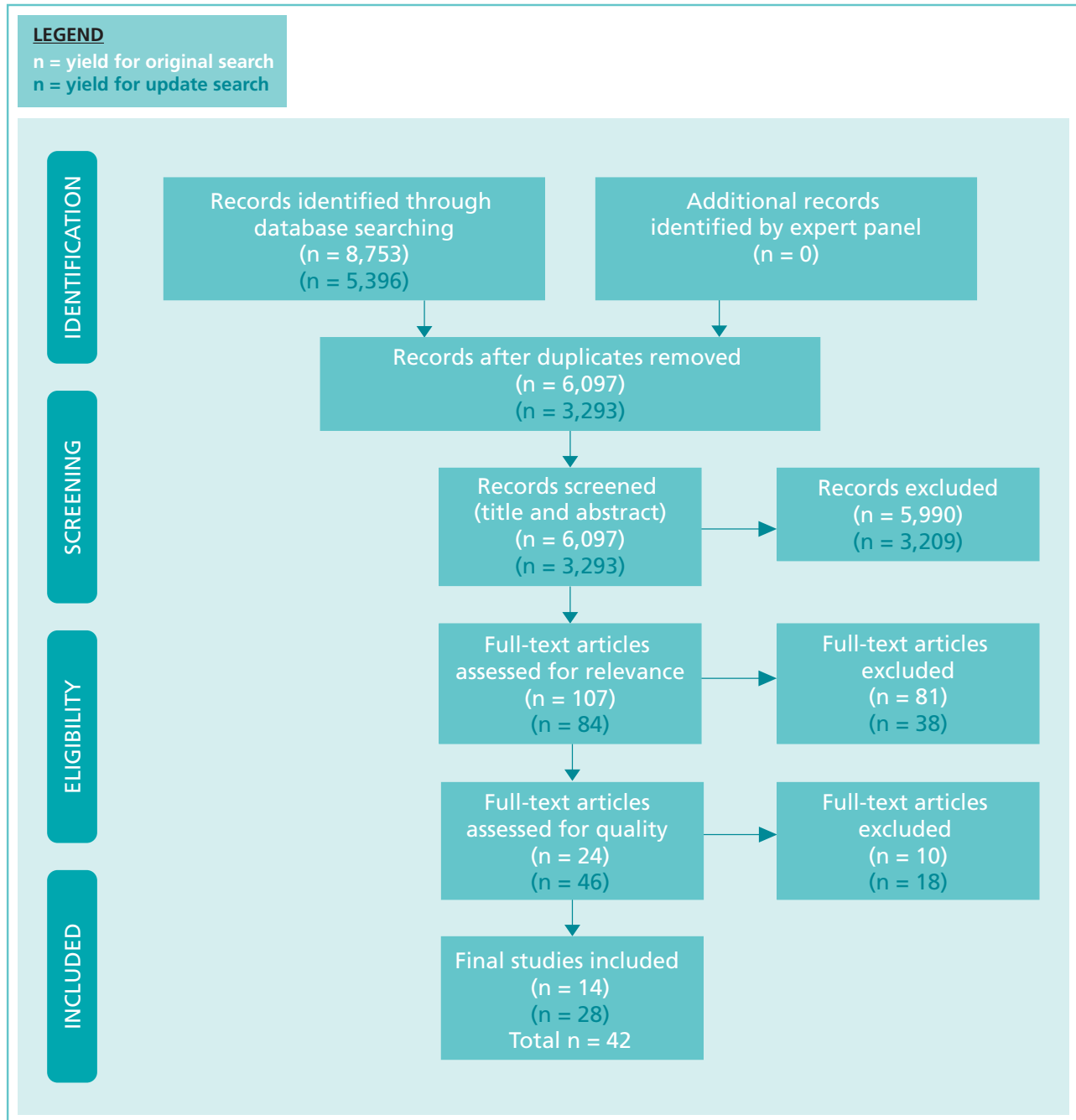
Should group-based interventions be recommended to improve care for 2SLGBTQI+ people?



Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

Figure 8: Recommendation Question #6 Article Review Process Flow Diagram

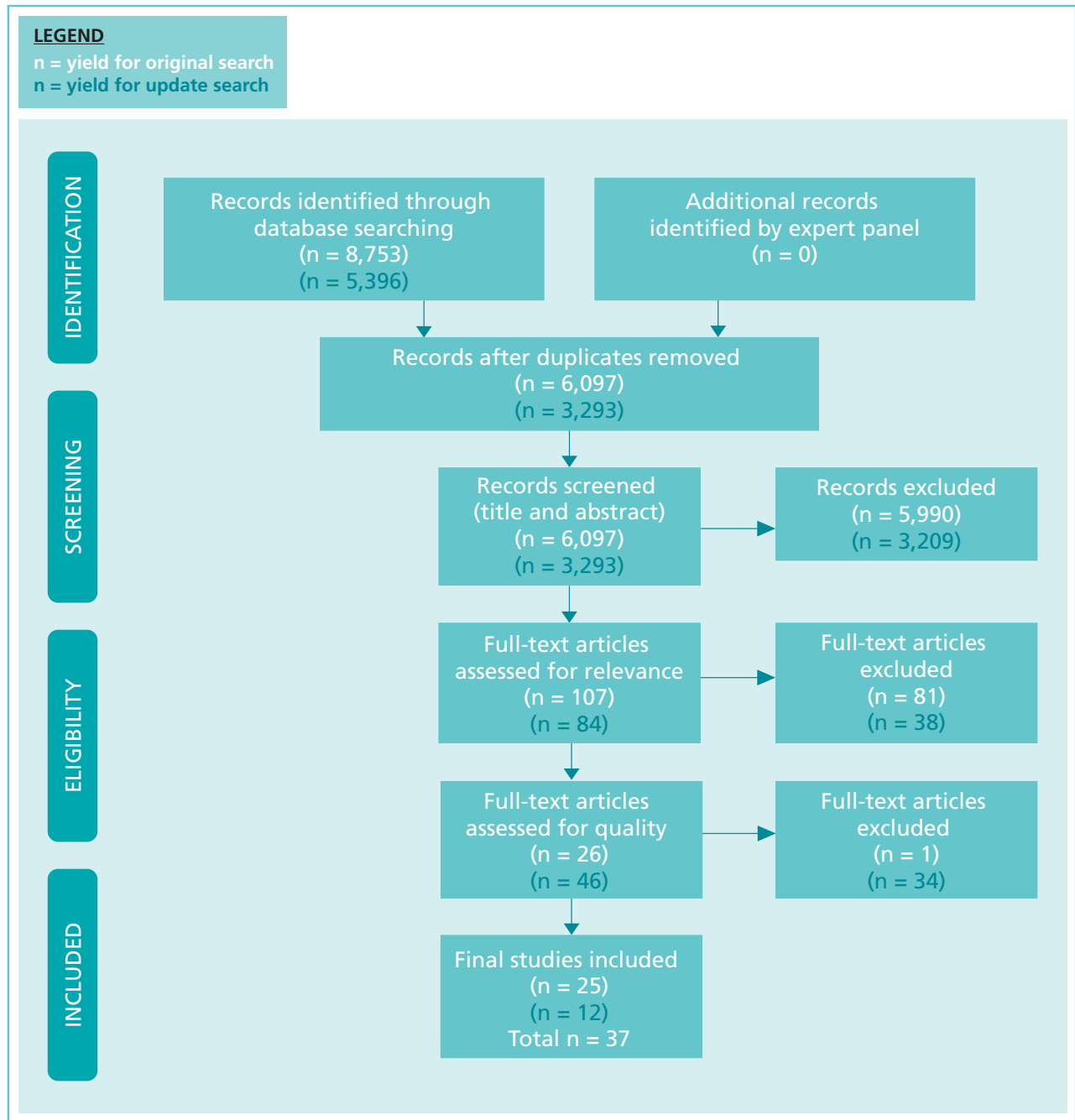
Should 2SLGBTQI+ health content be integrated into professional education for students entering health professions?



Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

Figure 9: Recommendation Question #7 Article Review Process Flow Diagram

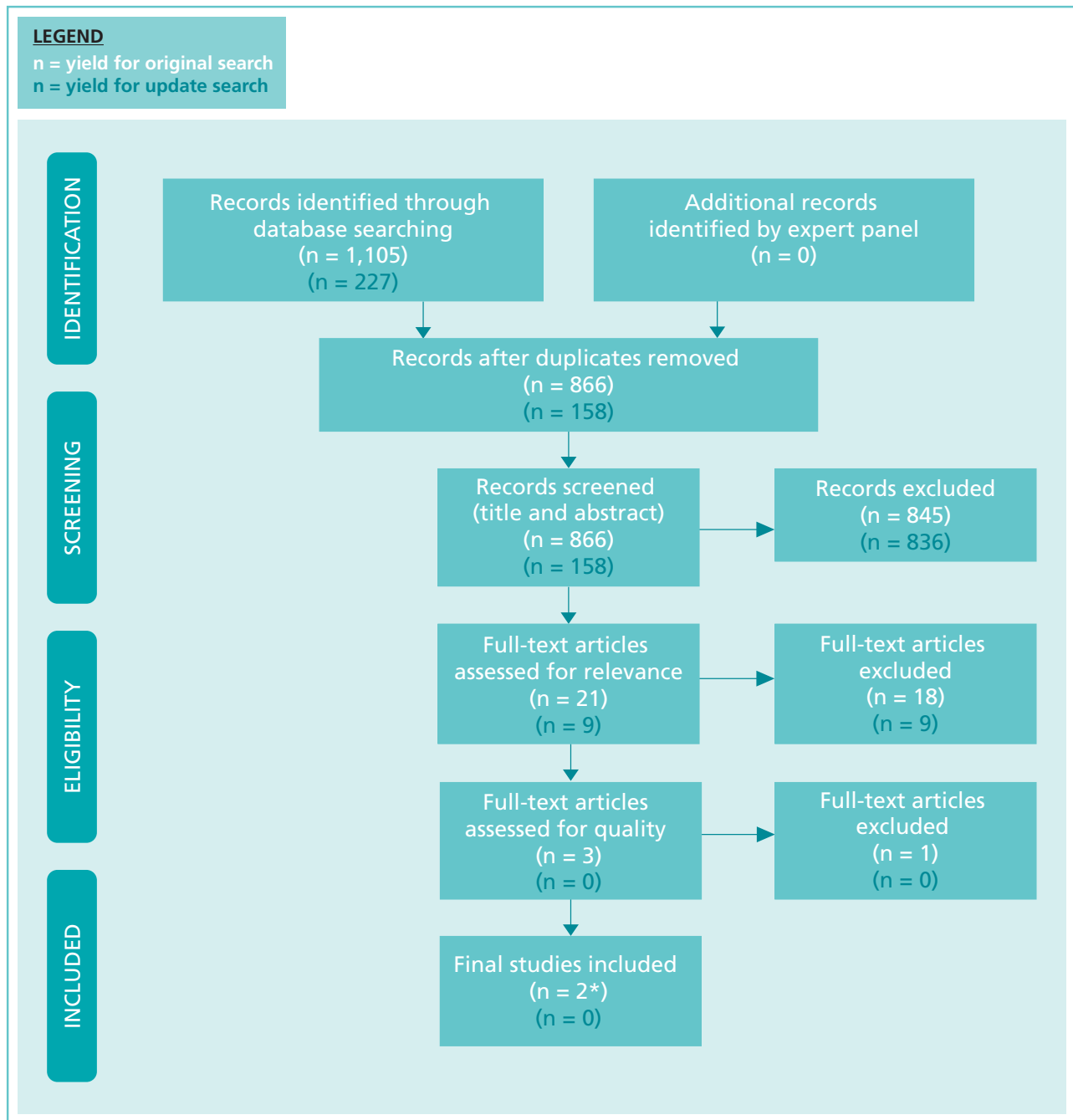
Should continuing education be recommended for health providers to improve care for 2SLGBTQI+ people?



Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

Figure 10: Recommendation Question #8 Article Review Process Flow Diagram

Should 2SLGBTQI+ specific (safe) spaces for long-term care residents be recommended for improving care to 2SLGBTQI+ residents?



***Note:** both of these studies were included in Recommendation Question #2

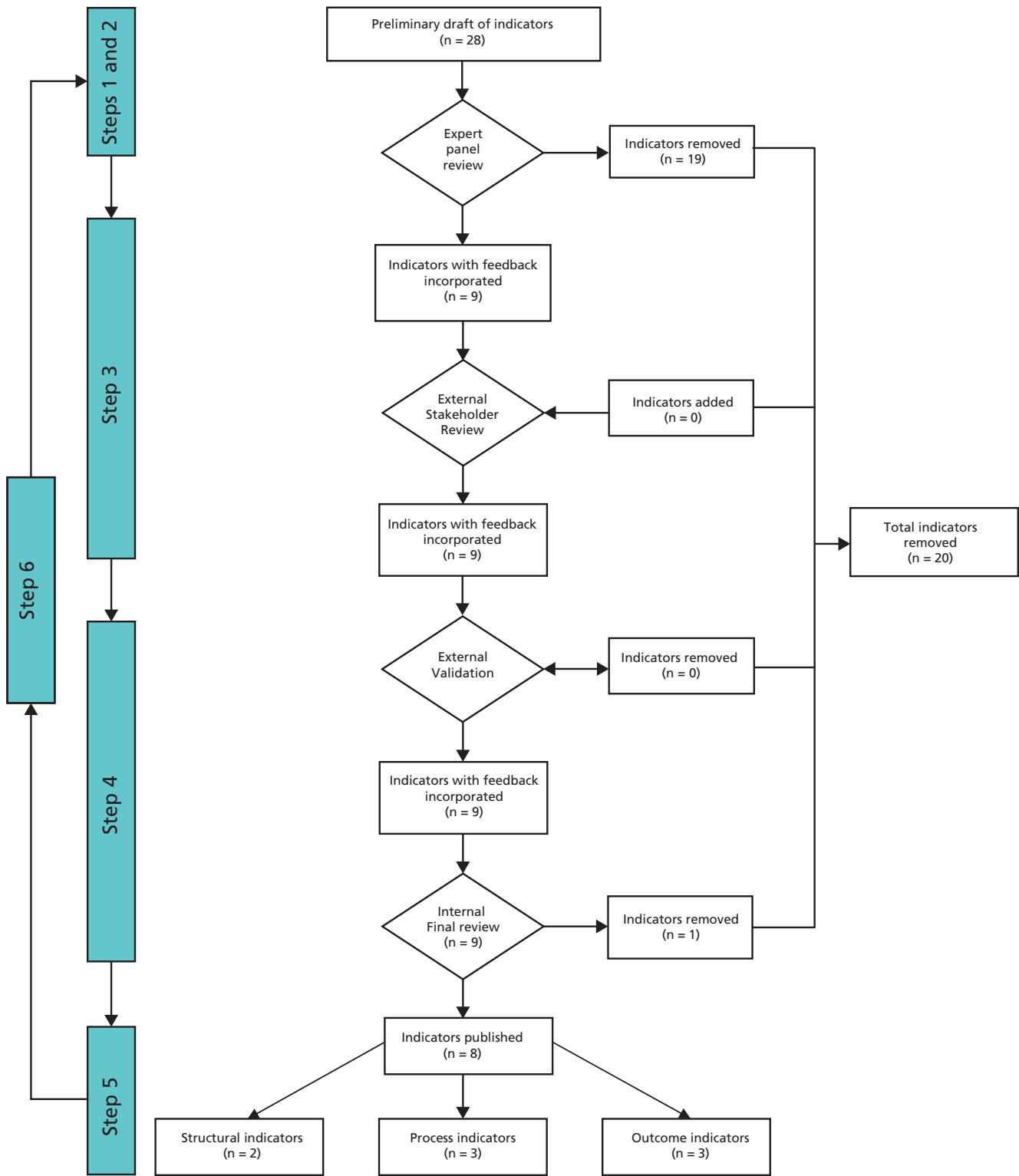
Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535.

Appendix H: Indicator Development Process

The RNAO indicator development process steps are summarized below (see **Figure 11**):

1. **Guideline selection.** Indicators are developed for guidelines focused on health system priorities, with an emphasis to fill gaps in measurement while reducing reporting burden.
2. **Extraction of recommendations.** Practice recommendations, overall guideline outcomes and BPG Order Sets™ (if applicable) are reviewed to extract potential measures for indicator development.
3. **Indicator selection and development.** Indicators are selected and developed through established methodology, including alignment with external data repositories and health information data libraries.
4. **Practice test and validation.** Proposed indicators are internally validated through face and content validity, and externally validated by national and international organization representatives.
5. **Implementation.** Indicators are published in the Evaluation and Monitoring chart, and data dictionaries are published on the NQuIRE <https://RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity>.
6. **Data quality assessment and evaluation.** Data quality assessment and evaluation, as well as ongoing feedback from BPSOs, ensure purposeful evolution of NQuIRE indicators.

Figure 11: Indicator Development Flow Diagram



Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535.

Appendix I: Examples of Inclusive Pronouns

The following represents several options for pronouns a person may use from the Canadian Centre for Gender and Sexual Diversity. For a more detailed list, see **Table 30** from the University of Wisconsin. Neither table represents an exhaustive list of all pronouns that could be used.

Please note that a person may choose not to use pronouns.

Figure 12: Pronoun Chart

		TITLE /TITRE	SUBJECT /SUJET	OBJECT /OBJET	PRONOUN /PRONOM	PRONUNCIATION /PRONONCIATION
GENDER BINARY /BINAIRE DU GENRE	Ms/Mrs		she	her	hers	(as it appears)
	Mr		he	him	his	(as it appears)
	Mlle/Mme		elle	elle/la	sa	(comme il apparaît)
	M		il	lui	son	(comme il apparaît)
GENDER NEUTRAL /NEUTRE DE GENRE	Mx		they	them	their	(mix, as it appears)
	Mx		ze	hir	hirs	(mix, zhee, here, heres)
	Mx		ze	zir	zirs	(mix, zhee, zhere, zheres)
	Mx		xe	xem	xyr	(mix, zhee, zhem, zhere)
	Mx		os/ol	lo/sol	so	(comme il apparaît)
	Mx		eil/yel	lo/sol	so	(comme il apparaît)

Source: Reprinted from: The Canadian Centre for Sexual and Gender Diversity. Pronoun Chart [Internet]. [place unknown]: The Canadian Centre for Sexual and Gender Diversity, 2020. Available from: <https://ccgsd-ccdgs.org/wp-content/uploads/2020/09/Gender-binary-1.pdf>. Reprinted with permission.

Table 30: List of Inclusive Pronouns

HE/SHE	HIM/HER	HIS/HER	HIS/HERS	HIMSELF/HERSELF
they	them	their	theirs	themselves
fae	faer	faer	faers	faerself
ae	aer	aer	aers	aerself
per	per	pers	pers	perself
xe	xem	xyr	xyrs	xemself
ze/zir	hir	hir	hirs	hirsself
zie	zim	zir	zis	zieself
sie	sie	hir	hirs	hirsself
ey	em	eir	eirs	eirself
ve	ver	vis	vers	verself
tey	ter	tem	ters	terself
e	em	eir	eirs	emself



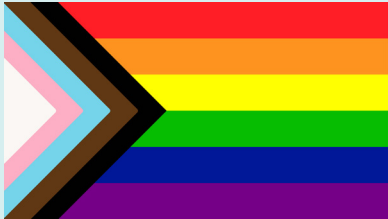
Source: Reprinted from: University of Wisconsin. Lesbian, gay, bisexual, transgender, queer plus (LGBTQ+) resource center [Internet]. Milwaukee: University of Wisconsin; 2020. Available from: <https://uwm.edu/lgbtrc/support/gender-pronouns/>. Reprinted with permission.




Appendix J: Examples of Inclusive Symbols and Flags

The following are examples, but not an exhaustive or comprehensive list, of inclusive flags and symbols. Images, symbols and flags can evolve over time and space.

For organizations considering the use of a flag as just one component of creating a safer space, consult with your local 2SLGBTQI+ advocacy groups to ensure that you are selecting a flag that is representative of the local context.

Table 31: Examples of Inclusive Symbols and Flags

NAME OF FLAG OR SYMBOL	IMAGE	DESCRIPTION
Philadelphia rainbow flag		Two stripes were added to the six stripes of the rainbow flag to include 2SLGBTQI+ people of colour (365).
Positive space triangle		The rainbow triangle combines two common images used in LGBTQ+ communities. The rainbow flag has become a symbol of pride for sexual minorities across the world (366). Gays and lesbians have used the triangle as a symbol of identification and solidarity against oppression. In the Nazi regime, gay men in concentration camps had to wear pink triangles.
Progress flag		This new flag seeks to take Philadelphia’s inclusive approach a step further. Daniel Quasar, who identifies as queer and nonbinary, designed this flag. The white, pink, and light blue reflect the colors of the trans flag, while the brown and black stripes represent people of color and those lost to AIDS (365).

NAME OF FLAG OR SYMBOL	IMAGE	DESCRIPTION
Rainbow flag (traditional)		<p>This is the most familiar flag. In 1979, the community landed on this six-color version, which was hung from lampposts in San Francisco (365). Each colour of the rainbow represents something: red for life, orange for healing, yellow for sunlight, green for nature, blue for harmony and purple for spirit.</p>
Trans flag		<p>Monica Helms, a trans woman, designed this flag in 1999, and it was first flown at a Pride Parade in Phoenix a year later. Helms notes “the light blue is the traditional color for baby boys, pink is for girls, and the white in the middle is for those who are transitioning, those who feel they have a neutral gender or no gender, and those who are intersexed” (365).</p>
Two-Spirit flag	 <p>Reprinted from: Two-Spirited People of Manitoba Inc. [Internet]. Winnipeg, Manitoba; 2019. Available from: https://twospiritmanitoba.ca/ Reprinted with permission from Albert McLeod.</p>	<p>This is an example of a Two-Spirit flag, which integrates the traditional rainbow flag with an Indigenous medicine wheel. The flag was designed by Albert McLeod. There are several other flags or symbols that may be used to represent Two-Spirit-ness.</p>

Appendix K: Two-Spirit and LGBTQI+ Indigenous Resources

Note: All website addresses were active as of May 3, 2021.

Table 32: List of Two-Spirit and LGBTQI+ Indigenous Resources

RESOURCE	WEBSITE	DESCRIPTION
PUBLICATIONS		
C2C: Two Spirit & Queer People of Colour Call to Conversation with LGBT & Allies	https://www.uwinnipeg.ca/c2c/	Findings and Calls to Action
Hunt S. An introduction to the health of two-spirit people: Historical, contemporary and emergent issues. Prince George, BC: National Collaborating Centre for Aboriginal Health; 2016 Jun.	https://www.familieslgbt.org/documents/pdf/HealthTwoSpirit_ENG.pdf	An overview of some of the health considerations and health inequities experienced by two-spirit people
Laing, M. Two-Spirit Conversations with Young Two-Spirit, Trans and Queer Indigenous People in Toronto [Internet]. Toronto, ON: (n.d.) [cited 2021 April 29]	https://www.twospiritresearchzine.com/	Zine based on a thesis project based on conversations with two-spirit, trans and queer young people The meaning and use of the term two-spirit is explored
The National Inquiry into Murdered and Missing Indigenous Women and Girls. Reclaiming Power and Place: The Final Report of the National Inquiry Into Missing and Murdered Indigenous Women and Girls [Internet]. Canada: 2019 [cited 2021 April 16].	https://www.mmiwg-ffada.ca/final-report/	Reclaiming Power and Place. Volume 1b addresses 2SLGBTQQIA Specific Calls to Justice specifically for 2SLGBTQQIA.

RESOURCE	WEBSITE	DESCRIPTION
Thunderbird Partnership Foundation. First Nations Mental Wellness Continuum Framework. Bothwell (ON): 2015	https://thunderbirdpf.org/first-nations-mental-wellness-continuum-framework/	Report and framework to help understand First Nations mental wellness
Truth and Reconciliation Commission of Canada: Calls to Action [Internet]. Winnipeg (MB): 2015 [cited 2021 April 16].	http://www.trc.ca/	First Journey of the Truth and Reconciliation Commission: Reports and findings and Calls to Action
INDIGENOUS ORGANIZATIONS		
Anishnawbe Health Toronto	https://www.aht.ca/	Improve the health and well being of Indigenous people in spirit, mind, emotion and body by providing Traditional Healing within a multi-disciplinary health care model
Canadian Aboriginal AIDS Network	https://caan.ca/en/ https://caan.ca/wp-content/uploads/2012/05/CAAN_homophobia_e_FINAL.pdf	National forum for Aboriginal Peoples to wholistically address HIV and AIDS, HCV, STBBIs, TB, Mental Health, aging and related co-morbidity issue Report on addressing homophobia in relation to AIDS in aboriginal communities
Canadian Indigenous Nurses Association	https://indigenousnurses.ca/	Improve the health of Indigenous peoples by supporting Indigenous nurses and by promoting the development and practice of Indigenous health nursing

RESOURCE	WEBSITE	DESCRIPTION
Edmonton Two-Spirit Society	http://e2s.ca/	Website for Two-Spirit information and resources
Enchante Network	https://enchantenetwork.ca/en/	National network of 2S and LGBTQ organizations
Indigenous Physicians Association of Canada	https://www.ipac-amac.ca/	Use their skills, abilities and experiences to improve the health (broadly defined) of our nations, communities, families and selves
Institute of Indigenous People's Health	https://cihr-irsc.gc.ca/e/8668.html	Institute of the Canadian Institutes of Health Research focused on Indigenous health
Two-Spirited People of the First Nations (Toronto)	www.2spirits.com	Website for Two-Spirit information and resources
Native Youth Sexual Health Network (Canada and United States)	http://www.nativeyouthsexualhealth.com/index.html	Website for Two-Spirit information and resources
Pride Canada	https://fiertecanadapride.org/2spiritstories/	Two-spirit stories
Toronto Council Fire Native Cultural Centre	https://councilfire.ca/	Serves the community in the downtown core of Toronto for the commitment to their health, safety and well-being

RESOURCE	WEBSITE	DESCRIPTION
Two-Spirited People of Manitoba	https://twospiritmanitoba.ca/	A community-based resource focused on helping Indigenous LGBTQ/Two-Spirit people improve their lives
Two-Spirit Archive University of Winnipeg [Internet]. Winnipeg (MB): 2021 [cited 2021 April 16].	https://archives.uwinnipeg.ca/our-collections/Two-Spirit-archives.html https://main.lib.umanitoba.ca/albert-mcleod-fonds https://main.lib.umanitoba.ca/connie-merasty-fonds	<p>An internationally-renowned centre for research that supports the needs of the Two-Spirit community</p> <p>Makes Two-Spirit people more visible and the Two-Spirit archives council ensures Two-Spirit people are central to preserving the history of their contributions to society</p> <p>Two-Spirit archives in the US.</p>
Two-Spirit Papers. University of Minnesota. In: Jean Nickolaus Tretter collection in GLBT studies [Internet]. Minneapolis (MN): date unknown [cited 2021 April 16].	https://archives.lib.umn.edu/repositories/13/resources/2092	
Two Spirits in Motion	https://2spiritsinmotion.com/	Safe and supportive social environment for Two-Spirit people
Wabanaki Two-Spirit Alliance (Atlantic Canada)	http://w2sa.ca/	Website for Two-Spirit information and resources

RESOURCE	WEBSITE	DESCRIPTION
FILM, VIDEOS AND SUCCESS STORIES		
First Stores: Two Spirited (Canada)	https://www.nfb.ca/film/first_stories_two_spirited/	National Film Board of Canada video
Dr. James Makokis: a 2 Spirit Indigenous (Cree) physician	https://www.youtube.com/watch?v=MSnvtj0G3cA	Video clip detailing Dr. Makokis' work with Two-Spirit and trans individuals in northern Alberta
Ryerson School of Journalism	http://trc.journalism.ryerson.ca/taking-a-walk-in-two-worlds/ https://trc.journalism.ryerson.ca/reclaiming-two-spirit-health-in-toronto/	Two stories from Ryerson School of Journalism focused on Two-Spirit people
Second Stories – Deb-we-win Ge-ken-am-ann, Our Place in the Circle (Canada)	https://www.nfb.ca/film/second_stories_our_place_in_the_circle/	National Film Board of Canada documentary video
Face-to Face with Jack Saddleback (Canada)	https://www.youtube.com/watch?v=gJs4fy-XDrI	The success story of Two Spirit Cree trans man Jack Saddleback
OTHER WEBSITES		
Canadian Institute for Health Research Meet the Methods Series: “What and who is Two-Spirit?” in Health Research. [Internet]. Canada: 2020 [cited 2021 April 16].	https://cihr-irsc.gc.ca/e/52214.html https://cihr-irsc.gc.ca/e/documents/igh_two_spirit-en.pdf	Provides considerations and background information when conducting health research with Two-Spirit people

Appendix L: List of Organizations Offering Group-based Interventions

Table 33 provides a list of examples of organizations offering clinical-based and group-based interventions within Canada. It is important to note that this is not an exhaustive list of all possible organizations offering group-based interventions.

Note: All website addresses were active as of May 3, 2021.

Table 33: List of Organizations Offering Group-Based Interventions

ORGANIZATION	WEBSITE	DESCRIPTION
RECOMMENDATION 4.0		
AIDS Committee of Toronto	www.actoronto.org/programs-services/groups	ACT offers group-based programs for people living with HIV, those concerned about their risk for HIV, as well as groups related to mental health and substance use. Several groups are specifically for gay men
Bereaved Families of Ontario (Toronto)	https://www.bfotoronto.ca/support/	Offers clinical-based bereavement groups in a gay-positive space
Centre for Addiction and Mental Health Rainbow Services	https://www.camh.ca/en/your-care/programs-and-services/rainbow-services-lgbtq	Group-based services for 2SLGBTQI+ people for drug and alcohol use
East Mississauga Community Centre	http://eastmississaugachc.org/	Community-based charitable organization facilitating access to health services for groups including isolated seniors, racialized people, immigrants, refugees and LGBTTIQQ2S+ people.
Family Services Ottawa LBTTQ+ Around the Rainbow resources	https://familyservicesottawa.org/children-youth-and-families/around-the-rainbow/	Community-based program that provides a range of education, counseling and support services

ORGANIZATION	WEBSITE	DESCRIPTION
Hospice Waterloo Region	https://www.hospicewaterloo.ca/?s=Rainbow	Bereavement group in Waterloo region offering rainbow support services
Kind (Ottawa)	https://kindspace.ca/	Thrive: Trauma Education & Empowerment Program
Mood Disorders Association of Ontario	https://mooddisorders.ca/event/toronto-drop-in-group-lgbtq-peer-support-drop-in-group	Offers LGBTQ Peer Support Group for persons living with mood disorders Services also available virtually
Qmunity	https://qmunity.ca/	British Columbia Queer, Trans and Two-Spirit resource centre
Sherbourne Health	https://sherbourne.on.ca/chronic-conditions/ https://sherbourne.on.ca/get-involved/community-groups/	Sherbourne Health offers a range of clinical groups
Spectrum: Waterloo Region's Rainbow Community Space	https://ourspectrum.com/resources/spectrum-groups/	Offers a variety group-based programming including for support and sexual health
The 519	https://www.the519.org/	The 519 offers a range of group-based support services that include counseling, substance use, sexual health, trans support and more including: Trans Youth Mentorship Program
The LifeLine Canada Foundation	https://thelifelinecanada.ca/fr/resources/lgbtq/	Website that provides a variety of mental health LGBTQ support group resources including the LifeLine App
Wellspring	https://wellspring.ca/	Gay and lesbian cancer support groups

ORGANIZATION	WEBSITE	DESCRIPTION
RECOMMENDATION 4.1		
OLDER ADULTS		
Sunshine centre for seniors	https://sunshinecentres.com/events/	A seniors' social, recreational and health promotion program with an inclusive multicultural, lesbian, gay, bisexual, and transgender friendly atmosphere including rainbow circle and bridges
TG Innerselves	http://www.tginnerselves.com/	Services offered to trans people across Northeastern Ontario.
The 519	https://www.the519.org/programs/older-2slgbtq-program	Older 2SLGBTQI+ Adults Program
YOUTH		
AFFIRM Youth	https://www.projectyouthaffirm.org/	AFFIRM is a CBT-based group for LBGTQ+ youth and adults to learn stress coping skills and to meet other LBGTQ+ youth and adults
Gender Journeys	https://www.norwestchc.org/locations/thunder-bay/programs/gender-journeys https://cmhahkpr.ca/programs-services/gender-journeys/ https://sherbourne.on.ca/get-involved/community-groups/ https://ok2bme.ca/services/gender-journeys-group	<p>Several sites across Ontario including hosted by: NorWest Community Health Centre, Canadian Mental Health Association, Haliburton, Kawartha, Pine Ridge, Sherbourne Health, OK2beMe and others</p> <p>Includes group-based programming for youth and adults</p> <ul style="list-style-type: none"> ■ This group explores gender and sexual identity and provides reliable, up to date information on these topics.

ORGANIZATION	WEBSITE	DESCRIPTION
Griffin Centre	<p>LGBTQ+ Youth Drop-in: http://www.griffin-centre.org/reachout.php</p> <p>Trans Youth Drop-in: http://www.griffin-centre.org/reachout.php</p>	<p>This group is for Two-Spirit, trans, gender non-binary, queer, bisexual, pansexual and questioning youth (12-21).</p> <p>This group is for Two-Spirit, trans, gender non-binary, gender-queer, and gender non-conforming youth (12-21).</p>
LGBT Youthline	https://www.youthline.ca/	Confidential, non-judgmental and informed LGBTTTQQ2SI Peer Support offered through telephone, text and chat services.
PFLAG Canada	<p>https://pflagcanada.ca</p> <p>Chapter details: https://pflagcanada.ca/ontario/</p>	<p>Parent’s and families of LGBTQ2 support, resource and education network.</p> <ul style="list-style-type: none"> Chapters available in many regions and cities
Sherbourne Health	<p>Supporting Our Youth (SOY): https://soytoronto.com/</p>	<p>A program of Sherbourne Health for LGBT2SQ youth 29 and under</p> <p>Supporting Our Youth is an innovative community development program of Sherbourne Health. It is a set of health promotion services and programming centered on supporting the health and well-being goals established by LGBT2SQ youth and young adults, many of whom are homeless, racialized and newcomers to Canada.</p>
The 519: https://www.the519.org/	https://www.the519.org/programs/category/family-children-and-youth	<p>A variety of services are offered by The 519 for youth that include:</p> <ul style="list-style-type: none"> Kids Action Artspace (8-12 years) Trans Youth Mentorship program

ORGANIZATION	WEBSITE	DESCRIPTION
MIGRANTS/NEWCOMERS		
Access Alliance	Services and Supports for LGBTQ+ Newcomers: https://accessalliance.ca/programs-services/lgbtq-programs/	Offers programs and services for LGBTQ+ newcomers <ul style="list-style-type: none"> ■ LGBTQ+ Newcomer Weekly Drop-In: a series of weekly resettlement workshops specifically for LGBTQ+ newcomers. They cover many topics including LGBTQ+ resources, mental, physical and sexual health, Canadian culture, and housing and employment. ■ LGBTQ+ Newcomer Cooking Together: Every week peer leaders lead a group of volunteers to create a healthy and delicious meal that is served to members of the LGBTQ+ Newcomer Weekly Drop-In. This program creates opportunities for skill development, building community and fun.
The 519 (519 Church Street, Toronto)	Among Friends LGBTQ Refugee Support Group: https://www.the519.org/programs/category/new-to-canada	Group-based settlement support for refugees and newcomers including: <ul style="list-style-type: none"> ■ information and referrals ■ filling government applications ■ advocacy ■ safety planning ■ ongoing guidance
BLACK PEOPLE AND PEOPLE OF COLOUR		
Alliance for South Asian AIDS Prevention	https://www.asaap.ca/programs	HIV prevention programs for newcomer and settled South Asian GBTQ men

ORGANIZATION	WEBSITE	DESCRIPTION
Asian Community AIDS Services When You're Ready Program	http://acas.org/programs/for-youth/	An eight-week program where LGBTQ+ Asian youth can explore various topics related to coming out
Black Coalition for AIDS Prevention (BlackCAP)	http://www.blackcap.ca/page.php?u=/programs-services/available-services	Runs several support groups (workshops) for African, Caribbean and Black people living with HIV/AIDS and LGBTQ newcomers and settled people
PEOPLE WITH DISABILITIES		
Griffin Centre (Toronto) Compass Group	http://www.griffin-centre.org/reachout.php	Compass is a weekly drop-in group connecting LGBTQ+ people labelled with intellectual disabilities across Toronto. Compass is a space where people can connect and build friendships and community.
sprOUT Toronto		sprOUT Toronto is all about connecting LGBTQ+ people labelled with intellectual disabilities through events such as dances, BBQs, movie nights and other social events.



Date Completed ____/____/____
Day Month Year

Chart Number _____

Please list any health professionals you see on a regular basis (please include nurses, doctors, physiotherapists, chiropractors, naturopaths, counsellors, workers)

If you are under 16 years old please provide the name and phone number of parent or guardian

Name: _____ Phone: (____) _____ - _____

- ✓ Can we contact you at home? Yes No
- ✓ Can we leave private message if necessary? Yes No
- ✓ Can we use your preferred name in correspondence? Yes No

Gender:

- Female Two Spirit Prefer not to answer
- Male Transgender Do not know
- Intersexed Genderqueer Other _____

Which of the following *best* describes your racial or ethnic group?

- Asian-East (e.g. Chinese, Japanese, Korean) Metis
- Asian-South (e.g. Indian, Pakistani, Sri Lankan) Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
- Asian-South East (e.g. Malaysian, Filipino, Vietnamese) White-European (e.g. English, Italian, Portuguese, Russian)
- Black-African (e.g. Ghanaian, Kenyan, Somali) White-North American (e.g. Canadian, American)
- Black-North American (e.g. Canadian, American) Mixed heritage (please specify) (e.g. Black-African and White-North American)
- Black-Caribbean (e.g. Barbadian, Jamaican)
- First Nations
- Indian-Caribbean (e.g. Guyanese with origins in India) Other (please specify) _____
- Indigenous/Aboriginal not included elsewhere Prefer not to answer
- Inuit Do not know
- Latin American (e.g. Chilean, Argentinean, Salvadorian)

In what country were you born?

- Canada Other _____ Prefer not to answer Do not know

Are you a Newcomer? Yes No **Year arrived in Canada:** _____

What type of housing do you live in?

- Own/Rent Street No stable housing
- Rooming house Supportive housing Other _____
- Shelter/Hostel Family/Friends Prefer not to answer

Living arrangements:

- Live alone With friends Other _____
- With partner Supportive housing Prefer not to answer
- With children With adult family members





Date Completed ____/____/____
Day Month Year

Chart Number _____

Sexual Orientation:

- Heterosexual (straight)
- Gay
- Lesbian
- Bisexual
- Two-Spirit
- Queer
- Pansexual
- Prefer not to answer
- Do not know
- Other _____
- Not Applicable

Do you have concerns related to your sexual orientation?

- Not at all
- A little
- Somewhat
- A lot
- Prefer not to answer

Are you currently sexually active?

- Yes
- No
- Prefer not to answer

Do you practice safe sex?

- Yes
- No
- Prefer not to answer

Are you currently in a relationship?

- Yes
- No
- Prefer not to answer

Is/Are your partner(s):

- Female
- Male
- Intersexed
- Transgender
- Two Spirit
- Other _____

Were your previous partner(s):

- Female
- Male
- Intersexed
- Transgender
- Two Spirit
- Other _____

Have you ever experienced emotional, physical, sexual or other form of abuse?

- Yes
- No
- Prefer not to answer

Highest education level completed:

- No formal education
- Primary school (grade 1-8 equivalent)
- High School (grade 9-12 or equivalent)
- College
- University
- Other _____
- Prefer not to answer
- Do not know

Source of income:

- No income
- Full-time employment
- Part-time employment
- Student loan
- Canadian Pension Plan
- Retirement Income
- Old Age Security (OAS)
- Ontario Works (OW)
- Employment Insurance (EI)
- Ontario Disability Program (ODSP)
- Other _____

What is your total/combined household income? Prefer not to answer Do not know

- \$0.00-14,999 (\$1,249/month [\$7.69/hr] or less)
- \$15,000-19,999 (\$1,249-1,667/mo.; \$7.69-\$10.26/hr)
- \$20,000-24,999 (\$1,667-2,083/mo.; \$10.26-\$12.82/hr)
- \$25,000-29,999 (\$2,083-2,500/mo.; \$12.82-\$15.38/hr)
- \$30,000-34,999 (\$2,500-2,916/mo.; \$15.38-\$17.95/hr)
- \$35,000-39,999 (\$2,916-3,333/mo.; \$17.95-\$20.51/hr)
- \$40,000-59,999 (\$3,333-4,999/mo.; \$20.51-\$30.77/hr)
- \$over \$60,000 (over 5,000/mo.; 30.77/hr and up)

How many people are supported by this income? (including dependent parents, children, support payment, etc.). Please circle. Prefer not to answer

- 1 2 3 4 5 6 7+





Date Completed ____/____/____
Day Month Year

Chart Number _____

LIFESTYLE

Do you smoke? Yes Never smoked Used to smoke/quit Prefer not to answer

If yes, for how long? _____ How many cigarettes per day? ____ How many packs per day? ____

If you quit, when did you quit? _____

Do you drink alcohol? Yes No Prefer not to answer

If yes, how many drinks a week on average? _____

Do you use any street drugs? Yes No Prefer not to answer

If yes, please check:

- Marijuana Heroin Crystal meth
- Cocaine Ecstasy Other _____

How often do you use them? _____

Do you exercise on a regular basis? Yes No Prefer not to answer

If yes, what type of exercise? _____

How many times per week do you exercise? _____

Describe your usual daily diet Prefer not to answer

How do you feel about your weight? Prefer not to answer

FAMILY HISTORY

Are there any medical conditions that run in your biological family (mother, father, grandparents, siblings, children)? Yes No Prefer not to answer Do not know

Condition	Family Member
_____	_____
_____	_____
_____	_____
_____	_____





Date Completed ____/____/____
Day Month Year

Chart Number _____

MEDICAL HISTORY

Do you have any Allergies? Yes No Prefer not to answer Do not know

Medicines	
Food	
Environment (eg. grass, pets, dust etc.)	

Do you take any medicines on a regular basis? Yes No Prefer not to answer

Prescription (prescribed by the doctor)	
Non-Prescription (includes lotions/creams, eye drops, etc.)	
Alternative/Herbal	
Vitamins/ Supplements	

Pharmacy: _____ **Phone** () - _____ **Fax** () - _____

Do you have any current health problems? Yes No Prefer not to answer

If yes, please list and/or describe:

Do you have any mental health issues? Yes No Prefer not to answer

If yes, please describe:

Do you have any of the following disabilities?

- No disabilities
- Physical disability
- Prefer not to answer
- Developmental disability
- Hearing loss
- Do not know
- Learning disability
- Vision loss
- Other _____

If you have checked any of the above, do you have any accessibility needs? Yes No

Please specify:



Appendix N: Description of the *Leading Change Toolkit™*

BPGs can only be successfully implemented and sustained if planning, resources, organizational and administrative supports are adequate and there is appropriate facilitation. Active engagement and involvement of formal and informal leaders (e.g., change agents, peer champions) are also essential. To encourage successful implementation and sustainability, an international expert panel of nurses, researchers, patient/person advocates, social movement activists and administrators has developed the *Leading Change Toolkit™* (2021) (19). The *toolkit* is based on available evidence, theoretical perspective and consensus. We recommend the *Leading Change Toolkit™* for guiding the implementation of any BPG in health-care or social service organizations.

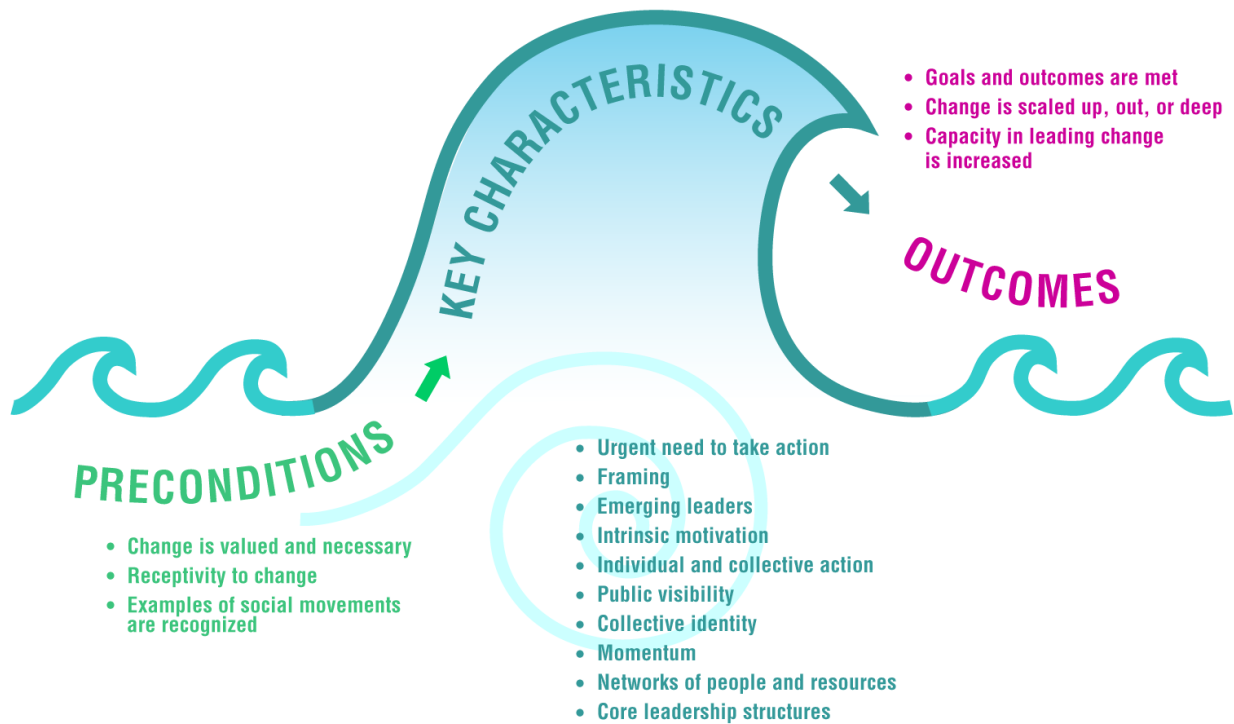
The *Leading Change Toolkit™* includes two frameworks – the Social Movement Action (SMA) Framework (352) and the Knowledge-to-Action (KTA) Framework (367)– for change agents and change teams leading the implementation and sustainability of BPGs. Both frameworks outline the concept of implementation and its inter-related components. As such, either framework – the SMA or the KTA – can be used to guide change initiatives, including the implementation of BPGs. Using both frameworks serves to enhance and accelerate change (314).

The SMA Framework includes elements of **social movements in a context of evidence uptake and sustainability^G** that have demonstrated powerful impact and long-term effects. Based upon the results of a concept analysis, the framework includes 16 elements categorized as preconditions (i.e., what must be in place prior to the occurrence of the social movement), key characteristics (i.e., what must be present for the social movement to occur) and outcomes (i.e., what may happen as a result of the occurrence of the social movement) (314, 368). The three categories and elements of the SMA Framework are shown in **Figure 14**.

Figure 14: Social Movement Action Framework

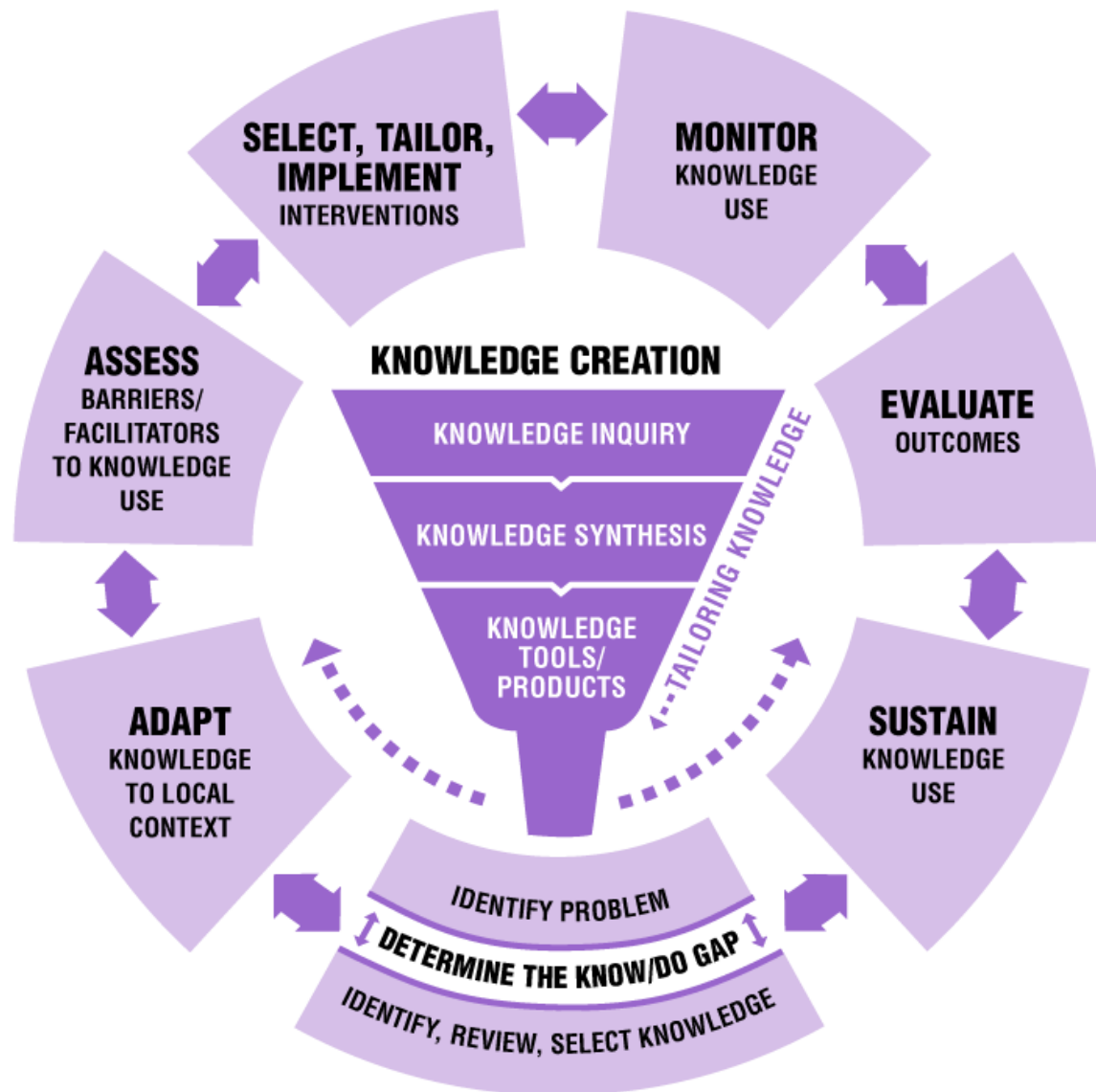
SOCIAL MOVEMENT ACTION FRAMEWORK

FOR KNOWLEDGE UPTAKE AND SUSTAINABILITY



The KTA Framework is a planned cyclical approach to change that integrates two related components: the knowledge creation and the action cycle. The knowledge creation process is what researchers and guideline developers use to identify critical evidence results to create a knowledge product, like an RNAO BPG. The action cycle is comprised of seven phases in which the knowledge created is implemented, evaluated and sustained (367). Many of the action cycle phases may occur or need to be considered simultaneously. The KTA Framework is depicted in **Figure 15** (369).

Figure 15: Knowledge-to-Action Framework



Implementing and sustaining BPGs to effect successful practice changes and positive health outcomes for patients/ persons and their families, providers, organizations and systems is a complex undertaking. The *Leading Change Toolkit*[™] is a foundational implementation resource for leading this process. It can be downloaded at <https://www.RNAO.ca/leading-change-toolkit>.

Endorsements

**Senior Pride
Network**



March 23, 2021

Registered Nurses' Association of Ontario
500-4211 Yonge Street
Toronto ON M2P 2A9

The Senior Pride Network (Toronto) is pleased to unreservedly endorse the Registered Nurses' Association of Ontario (RNAO) ground-breaking and comprehensive clinical best practices guidelines (BPG), *Providing Care for 2SLGBTQI+ Communities*. We are confident that the BPG will provide nurses and health providers with an invaluable resource and evidence-based recommendations on foundational, inclusive care practices for 2SLGBTQI+ people.

We commend the RNAO for their leadership and demonstrable commitment to advancing health equity for 2SLGBTQI+ communities with the production and publication of the BPG. Thank you!

Tom Warner,
Chair, Senior Pride Network (Toronto)

The Senior Pride Network (Toronto) is an association of individuals and organizations committed to promoting appropriate services and a positive, caring environment for elders, seniors and older persons who identify as 2 spirit, lesbian, gay, bisexual, transgender, transsexual, queer and intersex (2SLGBTQI+). The Senior Pride Network envisions a series of communities of 2SLGBTQI+ elders, seniors and older persons that are affirming, supportive and healthy.

ia BPG

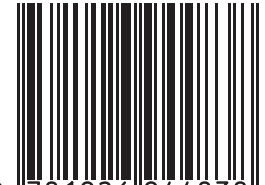
INTERNATIONAL
AFFAIRS & BEST PRACTICE
GUIDELINES

TRANSFORMING
NURSING THROUGH
KNOWLEDGE

Best Practice Guideline

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