The Importance of Including the Needs of the LGBTIQ Community in the Millennium Development Goals and Education of Healthcare Professionals

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ABSTRACT: In this article, I examine the health and social issues that lesbian, gay, bisexual, transsexual, intersex, and queer (LGBTIQ) people experience from adolescence to old age through the lenses of critical social justice and queer theories. I challenge the United Nations for its lack of inclusion of this segment of the population in the Millennium Development Goals (MDGs). I argue that it is important to include LGBTIQ people in the MDGs. A call is made for improving health policy as well as the education of nurses and other healthcare professionals, with a focus on the particular health needs of the LGBTIQ community. Implications for future research are discussed in the latter part of this article.

World leaders joined together in 2000 at the United Nations’ Millennium Summit to create a plan for action called “Millennium Development Goals” (MDGs), with the stated aims of eliminating global poverty, hunger and disease. The MDGs consist of eight goals that must be met by 2015. The success of the world’s countries and leaders working together to meet these goals has already been demonstrated in some areas, including “halving the number of people living in extreme poverty and providing more than two billion people with access to improved sources of drinking water” (UN, 2013). It is evident that the goals outlined by the UN in the MDGs are achievable as countries take these initiatives to their governments. In a downstream manner, countries set agendas to meet the objectives, which are then directed to regulating bodies and translated into public health and social policies. In turn, the regulating bodies and policies impact the education and curriculum of health- and social-care professionals who are preparing to meet these goals. In this article, I propose that the third MDG, “Promote gender equality and empower women,” be changed to “Promote gender equality and empowerment of all genders” in order to improve health and social disparities for the lesbian, gay, bisexual, transsexual, intersex, and queer (LGBTIQ) community.

Health issues of the LGBTIQ community are frequently left unaddressed in the development of many local, national, and global public health policies. It is estimated that 10 to 20 per cent of the world’s population are LGBTIQ (Datti, 2009; Freedberg, 2006; Meri-Esh & Doron, 2009) and yet their unique health needs are not addressed by the UN. The UN devised a document in 2011 to address LGBTIQ health needs, but it has yet to add equality of all gender identities and sexual orientations to the MDGs (UN, 2011). In this article, I use critical social justice theory and queer...
theory to explore some of the health issues faced by the LGBTIQ community and to challenge the MDGs for their lack of inclusion of this segment of the population. Also, I will provide some of my experiences in working in different acute and chronic care settings in the Greater Toronto Area related to issues within the LGBTIQ community. In the latter part of the paper, implications for future research, the need for increasing education for nurses and healthcare professionals, and improving practice for nurses with the focus on addressing the health needs of the LGBTIQ community are discussed.

Theories that Unravel the LGBTIQ Discourse

The social justice theory addressed by Schim, Benkert, Bell, Walker and Danford (2007) provides a lens to ethically and critically analyze the health concerns of the LGBTIQ population. The authors emphasize that social justice must be central in all decision-making for the client and community. The four concepts of person, health, nursing and environment then feed into the goal of developing healthy public policy that illuminates social justice and human rights for all. Including this vision in educational curriculum may improve the training of nurses who are concerned about the ensuring rights of all people. Similarly, Anderson, Rodney, Reimer-Kirkham, Browne, Khan and Lynam (2009) use social justice theory to state that healthcare equity can be attained when one ensures the human rights of all individuals regardless of age, gender, race and culture. However, having awareness of social justice and human rights, but without committing to action, is not enough. The optimal goal is the implementation of culturally safe care for the marginalized LGBTIQ population.

Queer theory, which emphasizes the celebration of differences and challenges the normative route, is used as a framework in petitioning the UN to discuss LGBTIQ needs in their formulation of public health and social policies. Queer theory takes critical social justice and cultural safety theory into account and includes discussion of unfixed and fluid gender categories. Similarly, nursing theorist Jean Watson emphasizes the acceptance of the individual as a whole person and calls on healthcare professionals (HCPs) to be knowledgeable in providing care in a holistic manner regardless of race, class, age and gender (Creswell, 2007; McEwen & Wills, 2011). Another reason for selecting queer theory is that its fluidity enables me to purposefully challenge the accentuation of the MDGs on women (Ristock, 2005). Hence, I use these perspectives to guide me in understanding the challenges of the marginalized LGBTIQ population, and strive here to increase awareness and take action in the education of healthcare professionals to provide ethical and critical social justice care for this particular community.

In the following sections, literature is reviewed to address work on the issues of health of the LGBTIQ community, from all age groups, as well as from local, national and global perspectives. Within each subgroup, exclusion of this population in health-promotion models and the MDGs are addressed. Here, I incorporate various findings to advocate for better public policy and to explicitly call for the inclusion of LGBTIQ in the United Nations’ MDGs.

The LGBTIQ Community’s Challenges through a Lifespan

Adolescents and their Challenges from Local to Global

At the local level, in Ontario, and at the national level, there are many avenues of support available to adolescents and young adults of the LGBTIQ community (The 519 Church Street Community Centre, 2009). In Canada, the legalization of same-sex marriage in 2005 may have
since enabled youth to be comfortable with disclosing their identity to family, friends and coworkers. However, legal inclusion has not ensured social acceptance and safety for this group in Canada (Rainbow Health Ontario, 2012). Similar to Canada, an American study estimated that 60 per cent of physical and emotional violence against LGBTIQ youth is perpetrated by their family members (Dysart-Gale, 2010). LGBTIQ youth may lack role models and adequate support from their home and school to enable them to discuss their sexual identity. This, in turn, may cause poor self-image and self-esteem. This lack of support and increase in emotional stress may be the underlying cause for mental health issues, such as depression and anxiety, which these youths experience and carry into adulthood (Rainbow Health Ontario, 2012). Similarly, a participatory action research study in Ontario found that vulnerable bisexual youth are further marginalized and more prone to mental health problems (Dobinson, MacDonnel, Hampson, Clipsham, & Chow, 2005). Dobinson et al. (2005) found that bisexual youth experience further discrimination as they are pressured into choosing between homosexuality and heterosexuality.

Further challenges faced by youth and young adults in countries that recognize LGBTIQ identities lie in the selection of a career. In our heterosexist society, many professions and jobs are categorized as “male” or “female” jobs. For example, if a gay youth interested in pursuing a career in nursing has not disclosed his identity, and he hears comments such as “all male nurses are gay,” then he may avoid the profession due to fear of labelling. On the other hand, another gay youth may choose to become a nurse because he may feel accepted into the profession as a gay individual (Datti, 2009). This further illustrates the issue of disclosure for LGBTIQ youth in gender minority-accepting countries. Heinze and Horn (2009) found that adolescents who had more contact with LGBTIQ peers and friends showed reduced discrimination against individuals with different gender identities or sexual orientations. Hence, I encourage the UN to increase LGBTIQ people’s visibility by including this marginalized community’s health needs in its MDGs.

Globally, youth living in countries where anti-LGBTIQ laws exist encounter greater challenges in disclosing their identity due to potential threats to their safety. There are 82 countries that have some form of law against the LGBTIQ community, ranging from non-acceptance of the relationship in public in Uganda to the death penalty in Iran (Erasing 76 Crimes, n.d.). The threat of imprisonment and the death penalty for these youth should be of major concern for the UN. Currently the issue of anti-gay laws in Russia is raising concern among athletes who are expecting to participate in the 2014 Winter Olympics. Clearly and evidently, the social justice, human rights and safety of the LGBTIQ community, regardless of age, is at stake in these countries.

The weakness of the MDGs is that they look at universal issues from a feminist perspective, in particular the third MDG: “Promote gender equality and empower women” (UN, 2012). I reviewed all of the MDGs and the reports published, and found no indication or mention of LGBTIQ individuals. If the MDGs had considered global health issues from social justice and queer theory perspectives, then the UN would have included LGBTIQ considerations in devising healthy public policy. The lack of discussion about the health needs of LGBTIQ individuals at the global level impedes the safety of youth in countries with harsh punishments.

In 2011, the UN published a follow-up document in regards to violence against individuals based on their gender identities and sexual orientation (UN, 2011) yet at present official discrimination and punishments, such as the death penalty, still exist in 82 countries (Erasing 76 Crimes, n.d.). Hence, I question why the UN has not explicitly included this issue as part of its third MDG with respect to gender equality. For the sake of the new generation of LGBTIQ, I advocate that the third MDG be changed to include equality for all gender identities and sexual orientations with specific and explicit plans and actions to address the health of LGBTIQ youth.
**Family Development and Child Care**

The legal recognition of same-sex marriage in Canada has created opportunities for gays, lesbians and transsexuals to be publicly united as a family. However, family development remains a challenge for bisexuals, as they are not recognized as either heterosexual or homosexual. This has caused feelings of disconnect and social isolation and, in turn, may cause an impediment to the health of bisexuals (Dobinson et al., 2005).

Likewise, same-sex partners who have become parents through adoption, artificial insemination and/or are foster parents may face several challenges and discrimination. The challenges of family identity for same-sex partners are disclosed to the child’s donor parents (Suter, Daas, & Bergen, 2008). Another challenge is grandparents who do not recognize the same-sex partner and/or refuse to accept a foster child, adopted child, or child born after artificial insemination as their grandchild. Some of this lack of recognition may be due to underlying power issues in religion. For example, in the Baha’i faith, one must only be involved in a heterosexual relationship and only following matrimony. The Baha’i teaching informs followers not to show any prejudice toward LGBTQ individuals, but calls “for tolerance and understanding in regard to human failings” (The Baha’i International Community, 2012). Simply labelling the LGBTQ community as “human failings” is a clear form of prejudice and of homo-bi-phobia (Christensen, 2005).

Similarly, other religions consider same-sex relationships as the unbearable acts of sinners (Herek & Gonzalez-Rivera, 2006; Meri-Esh & Doron, 2009; Oksal, 2008). For example, it is stated in the Book of Leviticus: “If a man lies with a man as one lies with a woman, both of them have done what is detestable. They must be put to death; their blood will be on their own heads” (Lev. 20:13 New International Version). It is evident that religious beliefs and values, as one of the underlying power issues, have further marginalized the LGBTQ community. However, I challenge this conceptualization of religious understanding of LGBTQ individuals, which is based only on sexual behaviour. It has been apparent, over the decades, that same-sex relationships are not merely due to acts of sexual pleasure but, rather, they form out of the attraction and emotional relationship developed between two individuals (Butler & Rosenblum, 1991; Freedberg, 2006; Riggs, 2011; Suter et al., 2008).

The medical paradigm has been another underlying power contributor that socially isolates and excludes LGBTQ, further preventing them from being recognized as a family unit. In 1973, the American Psychiatric Association removed homosexuality from its list of mental health disorders (Freedberg, 2006). However, countries that are anti-LGBTIQ continue to treat members of this community with shock therapy, medications and surgical procedures to alter the “abnormality” in an attempt to provide treatment and cure (UN, 2011). Moreover, HCPs’ assumptions and discrimination toward the LGBTQ community may still exist if they do not address some of their underlying beliefs and attitudes that have been shaped by medical, religious and cultural values. Canadian health leaders must emphasize eliminating the prejudices of its HCPs. For example, HCPs who immigrate to Canada may bring their home societies’ harsh punishment values with them. As a bedside nurse working in different acute and chronic care settings in the diverse Greater Toronto Area, I have encountered some unethical comments from nurses. I have witnessed nurses and other healthcare professionals make comments such as, “I just don’t get them;” “I just don’t want to wash his penis because I don’t know where it has been;” “If she was back home, she would be getting some proper lessons on what’s right and wrong.” On the other hand, the Centre for Addiction and Mental Health is one of the few institutes that celebrate LGBTQ rights during Pride Week in Toronto to support its patients, community and staff.
The LGBTIQ community strives in different ways to develop family bonds and to be recognized as a unit. Suter et al. (2008) found that lesbian parents demonstrate family identity through the use of symbols and rituals. For example, some couples may change or hyphenate their last names to demonstrate union. However, this is not always applicable because in some cases the hyphenation of a last name could threaten the mother’s job because of discrimination. This has been a significant concern for military personnel. Another mode of symbolizing the family is through the selection of a sperm donor from individuals who are physically similar to the non-biological mother. Other actions taken by lesbian mothers include attending same-sex parenting group meetings and social functions to enable their children see that they are not the only ones with two mothers. Finally, the development of unique family practices, such as “taking nightly walks, shopping, attending church, and displaying family photos at work” (Suter et al., 2008, p. 38), is used to identify members of a family group.

Moreover, some gay individuals argue that they can be great foster and adoptive parents because they can provide unconditional love for the child/children (Riggs, 2011). Riggs (2011) states that gays and lesbians are more adaptable at fostering children, as they understand that non-biological parenting may be the only method available to caring for children. Riggs (2011) further states that a lack of clear guidelines and policies for agencies, in addition to hidden discrimination due to gender identity and sexual orientation, has caused delays for LGBTIQ community members trying to foster and adopt children. Therefore, I challenge the UN again for its lack of recognizing the LGBTIQ community as assets in providing unconditional care for children who are without a family or home.

**Partner Abuse within the LGBTIQ Community**

HCPs may assume that an individual with anatomically male body parts must be a male and thus refrain from asking questions regarding intimate partner violence. An identified lesbian brought into an emergency room showing signs and symptoms of partner abuse may go unnoticed because of mainstream assumptions that women do not abuse women. This is another challenge faced by the LGBTIQ community. HCPs may not always provide further support under the assumption that intimate partner violence is only inflicted upon women by men. However, the act of intimate partner violence is exhibited not only between men and women, but also among gay and lesbian couples (Freedberg, 2006; Seelau & Seelau, 2005). The exact number of partner abuse cases in the LGBTIQ community is not available due to a lack of disclosure to HCPs of their experiences of violence. An LGBTIQ individual abused by a partner may refrain from informing HCPs of the experience in an attempt to avoid stigma and discrimination against their gender identity (Rainbow Health Ontario, 2012). Hence, the LGBTIQ individual may choose to stay in an abusive relationship and avoid the healthcare system. In return, this causes emotional and physical health challenges. The LGBTIQ community’s fears are consistent with the actual discrimination that may exist among HCPs. Rondahl, Innala and Carlsson (2004, as cited in Freedberg, 2006) state, “A greater percentage of staff nurses (36%) as compared with student nurses (9%) indicated they would refrain from nursing homosexuals if given the choice” (p. 18). Freedberg (2006) further argues that the lack of awareness of the LGBTIQ community and their health challenges are due to a lack of education and preparation among HCPs.

Freedberg’s (2006) literature review found that various HCP programs devoted only between one and two-and-a-half hours to the LGBTIQ community’s health needs over the course of the curriculum. I then reflected back to my own undergraduate studies in nursing and recall that in the entire four years of study, less than two hours were spent on the discussion of the LGBTIQ community. I also assessed the amount of time dedicated to the health needs of the LGBTIQ
community in nursing curriculums at two schools and found that the general humanities course allocates on average between 30 minutes to three hours for LGBTIQ health studies in both nursing diploma and degree programs. The College of Nurses of Ontario (CNO), with regards to entry into practice, mandates that unbiased, culturally safe care be provided to all individuals (2008). Unfortunately, there are no clear guidelines for colleges and universities to follow in mandating the inclusion of a minimum number of hours within nursing programs. Adequate time is needed to prepare students to provide ethical and unbiased care. Meanwhile, the National LGBT Health Education Center in the United States provides tools and guidelines for physicians to provide effective healthcare for the community. Makadon (2011) encourages physicians to receive continued education on the needs of the LGBTIQ community to gain competence in assessing and providing care for those particular clients in an ethical and effective manner. Similar to physicians, lead organizations in the profession of nursing, such as the CNO, should facilitate open public discussion on the health of the LGBTIQ community. The regulating body, in turn, could mandate inclusion of the health concerns of this marginalized group in post-secondary curriculums.

Health Concerns of Elderly LGBTIQ People

Aging members of the LGBTIQ community require health and social support from HCPs. Their life experiences include living without LGBTIQ rights before the 1970s and contact with the new generation. Locally and nationally, the LGBTIQ individuals that began formulating their sexual identities prior to 1973, as well as those that currently reside in countries with unjust punishments (e.g. death penalty), are forced to constantly assess the safety of their environment. LGBTIQ individuals’ attempts to hide their true sexual identity, to fit into the heteronormative agenda and to develop a fear of death due to the absence of rights throughout their lives may prevent them from focusing on developmental achievements, such as education and employment (Brotman, Ryan, & Cormier, 2003). Years of this constant struggle – dealing with a lack of support and recognition from family, community and religion – could contribute to lower life satisfaction and lower self-esteem. It also places older members within the LGBTIQ community at higher risk of depression, suicide, addiction and substance abuse (Brotman et al., 2003; Donahue & McDonald, 2005; Kuyper & Fokkema, 2010; Meri-Esh & Doron, 2009). Conversely, some gay and lesbian individuals enjoy being older now as they can be comfortable with their identity, even though they still face discrimination and marginalization (Averett & Jenkins, 2012).

Elders also experience age discrimination from both heterosexists and younger LGBTIQ people who feel that seeking a partner is unacceptable beyond a certain age. Many elderly lesbians have experienced not being accepted into younger lesbians’ groups and gatherings (Meri-Esh & Doron, 2009). This, in turn, may cause social isolation and poor end-of-life experiences. The opposition to LGBTIQ couples living together in old-age and nursing homes, along with the act of separating them, is a form of discrimination in itself. In my professional experience, I have witnessed negative attitudes from HCPs in the intensive care unit, including the non-recognition of and exclusion of same-sex partners during the end-of-life decision-making process. Books like Cancer in Two Voices (Butler & Rosenblum, 1991) elucidate the notion of an intimate LGBTIQ relationship as a pure union between two individuals in which their identity is not simply formed by heterosexist norms. The true life story of Butler and Rosenblum challenges the religious view of homosexuality as a sin and a sickness. This further supports my thesis that the decrease in public awareness and education of HCPs to provide safe and effective healthcare are a result of a lack of clear identification with this marginalized group by healthcare organizations such as the UN and the CNO.
Limitations of Findings and Future Research

A review of literature has brought to light different challenges that the LGBTIQ community faces. However, the literature still lacks information about the experiences and health needs of several subgroups of this community. First, there is a lack of research on the experiences of physically and emotionally disabled LGBTIQ individuals (Avanté Consulting, 2006). Future research can explore physically and/or emotionally disabled LGBTIQ individuals’ experiences in Canada. Also, health and social policies must be formulated to ease the challenges faced by disabled LGBTIQ individuals. In the development of health and social policies for the LGBTIQ community, I propose upstream community-based participatory action research to ensure the ethical inclusion of stakeholders whose health needs are of concern (Streubert & Carpenter, 2011; Wallerstein & Duran, 2008). The aim of this research method is the incorporation of an empowering approach for the LGBTIQ community (Brotman et al., 2003; Israel, Schulz, Parker, Becker, Allen, & Guzman, 2008), as well as to focus on the health challenges that are faced by disabled individuals, which other members of the community do not experience.

Another area for further research to improve the social determinants of the LGBTIQ community is the impact of education. As a college professor, I have found LGBTIQ issues in the present curriculums of nursing students to be lacking. Also, a limited amount of time dedicated to educating other HCP students (e.g. doctors) about the LGBTIQ individuals’ health needs is noted in the literature. In several of the acute and chronic care settings that I have been exposed to as a nurse, I have observed a lack of educational sessions or support for the discussion of increasing awareness of the health needs of LGBTIQ patients. Hence, another pressing area for participatory action research is the inclusion of the health and social needs of the LGBTIQ community in the post-licensure education of HCPs (National LGBT Health Education Center, 2012). Another weakness in the literature is the lack of authors looking at this issue through a critical social justice and queer theory lens. By looking at this issue with a broader perspective, I have found that an unjust approach to the human rights of LGBTIQ is due to increased systematic exclusions and inequalities of power (Navarro, 2009). I question how the health challenges of the LGBTIQ community can be addressed locally, nationally, and globally when the UN’s MDGs do not even address them.

The Implication for Supportive C.A.N.E.s (Community Advocating Nurse Educators)

Nurses, who provide care to clients in different settings, must be aware of the challenges that members of the LGBTIQ community face and ensure that discriminatory behaviour is avoided. Dobinson et al. (2005) address verbal comments, such as “the more the merrier” (p. 55), as well as non-verbal behaviours of sudden silence and body gestures that prompt the LGBTIQ individual’s acknowledgement of resentment or homo-bi-phobia existent among HCPs. To avoid experiencing discrimination of sexual identity, LGBTIQ individuals may avoid visiting HCPs, resulting in increased health risks (Rainbow Health Ontario, 2012). As community nurses, we must be aware of and reflect upon our own beliefs and values and ensure that they do not interfere with the provision of equitable and ethical care to clients (Anderson et al., 2009; Schim et al., 2007). As advanced practice nurses in the community, we must strive to be inclusive of all gender identities and sexual orientations by creating a bridge of communication, encouraging a safe atmosphere for disclosure and providing necessary health education (Parks, Hughes, & Matthews, 2004).
To create a safe environment for LGBTIQ patients, the advanced practice nurse, as an educator, can strive to increase the awareness and knowledge of nurses both pre-licensure and post-licensure. At pre-licensure, the stigma attached to the LGBTIQ community through heterosexism, classism, ageism, religious zealotry, and medical power relations, as well as the underlying reasons for the marginalization of this community, need to be addressed. Positive attitudes and beliefs of nursing academics toward this topic may foster better understanding among students (Eliason, Dibble, & DeJoseph, 2010). The nursing educators in the community, as well as those working in public health and hospitals also must provide in-services for HCPs post-licensure. Increasingly, the celebration of the differences of sexuality has created positive study, work and life experiences for different gender- and sexual-minority groups (Clipsham, Hampson, Powell, Roeddlng, & Stewart, 2007; Eliason et al., 2010; MacDonnell, 2009). The creation of a safe environment has enabled some LGBTIQ individuals to openly discuss their gender identities or sexual orientation. Case Western Reserve University (n.d.) provides several strategies to create such a safe environment, including:

Object to and eliminate jokes and humor that put down or portray (LGBT) people in stereotypical ways; counter statements about sexual orientation or gender identity that are not relevant to decisions or evaluations being made about faculty, staff, or students; invite ‘out’ professionals to conduct seminars and provide guest lecturers in your classes and offices. (para. 1-3)

In turn, this may enable trained HCPs to address the health needs of LGBTIQ community members of different age groups. The CNO guidelines for ensuring safe and unbiased care for all individuals create the atmosphere needed to increase the discourse of LGBTIQ health needs throughout the curriculum for students and within health agencies. In a systematic route, the priorities and focuses set by regulatory bodies and Health Canada follow the UN’s agenda.

In conclusion, in looking at the future as an advocate, I propose that the UN openly recognize and include the LGBTIQ community’s needs in its MDGs. Otherwise, as Eliason et al. (2010) state:

When health care needs of one subset of the population are not named, they are not addressed, and the members of that population are at risk for negative health consequences ranging from diminished access to health care, delaying or not seeking routine medical care, to poor quality of care or discriminatory treatment. (p. 207)

Hence, I appeal to the UN to revise the third Millennium Development Goal to include equality and empowerment for individuals of all gender identities and sexual orientations. My assertion is that by increasing the visibility of the LGBTIQ community globally, many of their health disparities can be addressed.
References


