Compendium of Research and Engagement Findings –

Foundational work in the development of *Awareness to Action: A Health Strategy for Women and Islanders Who Are Gender Diverse 2022-2027*

Department of Health and Wellness

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Introduction

Since early 2021, the government of PEI has worked in partnership with health care providers, community organizations, and Islanders to develop its first *Health Strategy for Women and Islanders who are Gender Diverse*. In support of this work, this compendium summarizes the information base upon which the Strategy is founded. It opens by looking at the context and history, through a précis of the environmental scan and literature review developed by SRL Solutions, *A Narrative Review of Women and Gender Diverse People's Health in Canada*, May 2021. It then summarizes the health services and supports, both governmental and community based, that have evolved in PEI within this context, drawing on unpublished internal inventories. Next, it provides an overview of the socio-demographic and health characteristics of Island women and people who are gender diverse. The compendium closes with a review of key findings from the various engagement processes undertaken throughout the work, carried out by Nishka Smith Consulting and described in her report, *Women and Gender Diverse Islander' Health Strategy Engagement Findings*, January 2022.

Context and Background

The work began with an environmental scan and a literature review, focusing on the four areas identified as priorities by the Women and Gender Diverse Islanders' Health Strategy Steering Committee. The final report, *A Narrative Review of Women and Gender Diverse People's Health in Canada,* opened with a summary of women's health strategies in other provinces and other countries, then described the issues related to each of the four priority areas. The report concluded with an overview of emerging trends that will require attention over the life of the strategy and beyond.

In Canada, women's health strategies are few in number and those few are over a decade old. British Columbia and Manitoba issued women's health strategy documents in 2004 and 2011 respectively. The federal government released a *Women's Health Strategy* in 2009, but a number of its recommendations are unfulfilled. Outside Canada, more recent initiatives are underway. In 2018, Australia released a Women's Health Strategy, and in 2021, the United Kingdom issued a "call for evidence" to inform an upcoming women's health strategy. Across these documents, gender minorities receive little or no attention, and where it exists, gender minorities are often considered among one of various marginalized populations.

Drawing on this literature, the Review noted two insights to guide the development of PEI's strategy:

- Women's health strategies that adopt a life-course approach are more likely to include the health concerns of ageing women.
- A health strategy that is gender-inclusive and explicitly includes gender minorities will enable a focus on under-served Islanders and provide leadership to local health providers on the importance of gender-inclusive health care environments.

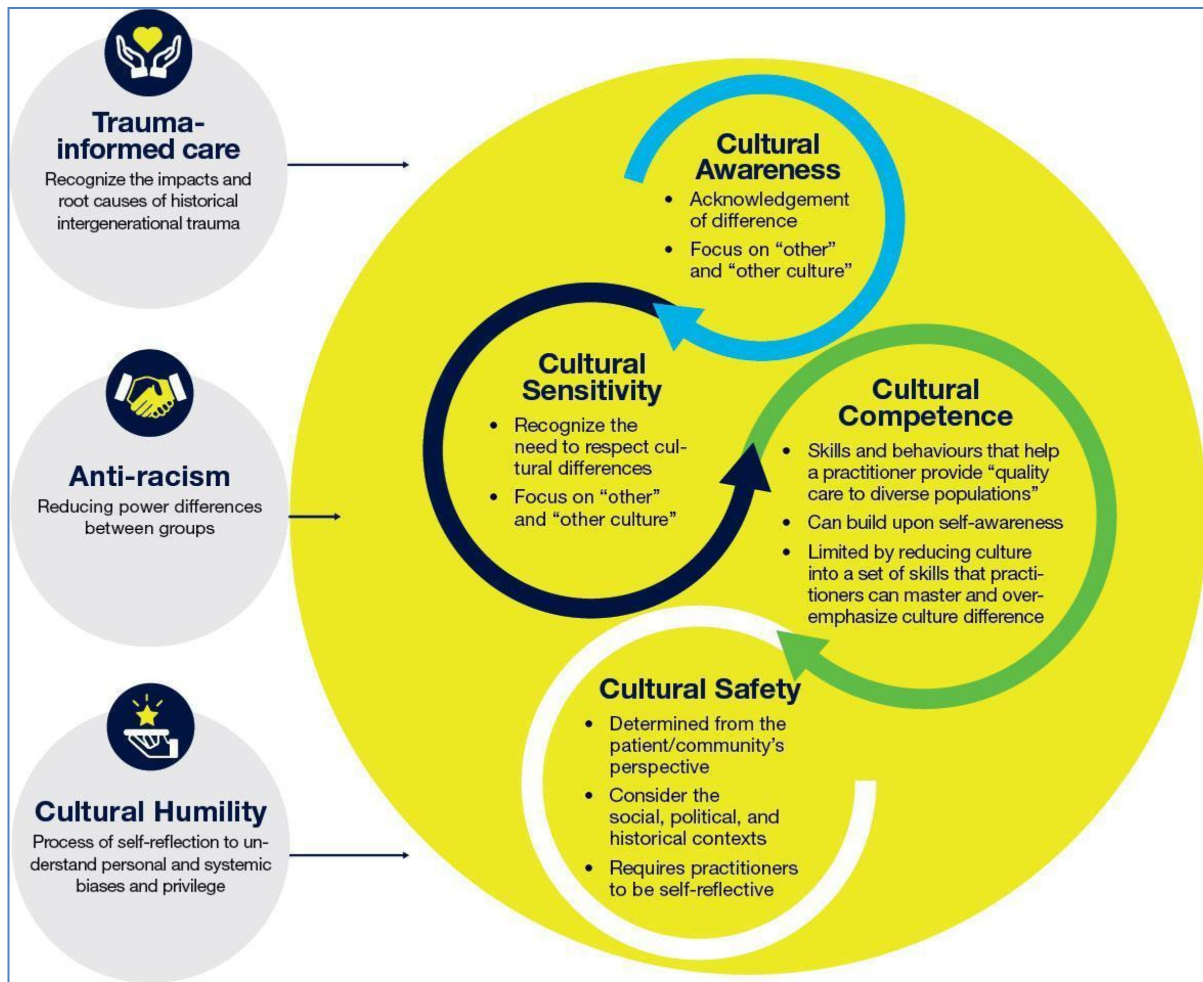
The past several decades have seen an increasing recognition that the circumstances of people's lives, or the determinants of health, exert a powerful influence on people's health, far exceeding the impact of health care or of genetic factors. As this work has progressed, a growing number of factors have been included in these determinants. It is widely acknowledged that inequities in the determinants lead to inequities in health status. More recently, there is growing awareness that the intersection of multiple determinants and social identities have compounding effects which can pose major barriers to health, well-being, opportunity and access. For example, while poverty is linked to barriers and poor outcomes for all individuals, the impacts are more severe for people who identify as racialized, immigrant, disabled, or a gender minority. If an individual holds multiple such identities, they are even further disadvantaged.

The report examined issues related to each of the four priority areas and highlighted best and promising practices to address those issues. The following summary has re-sequenced the analysis to align with the flow of the strategy document.

With regard to the Strategy's aim of ***creating welcoming settings***, the Review demonstrates that stigmatization has a real impact and is tied to poor health outcomes. Many women and gender minorities face stigma and bias in health care contexts and may avoid accessing care as a result. Criminalization of people who use illicit drugs increases stigma and adds to the trauma that frequently underlies addiction issues. Stigmatization of fat women's bodies is frequently perpetuated by health promotion initiatives and physician bias and is connected to further stigmatization of poverty. Fat bias among physicians results in lower quality of care and less patient-centered care while deterring fat people from seeking health care, resulting in deteriorating mental and physical health.

The use of Gender Based Analysis (GBA+) is essential to identify and address systemic barriers and attitudes such as those noted above. Going further, cultural competency, cultural safety, and trauma-informed approaches to care, as depicted in the Continuum of Cultural Safety below, are vital to improving health equity and creating humane health care environments for patients and staff alike.

Gender-affirming care for trans patients and other gender minorities with gender dysphoria is lifesaving, as care and familial, social, and public acceptance significantly reduce rates of suicidality in this population. All health care environments can create cultural safety for trans people and other gender minorities by learning to ask for and consistently use correct pronouns and chosen names for patients. Access to gender-affirming care for trans and other gender minorities is best initiated through low-barrier primary health care, and a number of Canada-based practice guides exist. Gender-affirming medical care generally includes commencement of hormone therapy and in some cases may include gender-affirming surgery. The above considerations are important for children, youth and adults of all ages.



With regard to the ***accessibility and availability of health services***, it is clear that having a public health care system does not automatically result in access. External factors such as poverty, coupled with intersectional identity factors, almost universally result in worse barriers to health care and worse health outcomes for women and gender minorities in Canada. These barriers ultimately cost the Canadian health care system billions of dollars per year. For example, access to contraception could be improved through both public subsidization and structural changes in how prescriptions for hormonal contraception are issued. Access to midwifery services holds promise to improve birth outcomes and the birthing experience for Island women. Access challenges for marginalized populations such as migrant and immigrant women call for systemic change to improve access to care. Racialization and gender-based marginalization are also barriers to preventative cancer screening such as breast and cervical cancers. By engaging with these communities and centering their unique needs in the care context, it may be possible to improve rates of early detection and long-term health outcomes.

Integrated, collaborative approaches to health care, the Strategy's third priority area, are priorities for the public, and promise to improve health outcomes and patient-centered care. Such approaches are essential to achieve an approach that cares for the whole person over the full life course. Public health promotion initiatives are an area of opportunity for education and prevention of negative health

outcomes. Gender-based approaches are important for health promotion to be effective, and the use of a gender-transformative framework for health promotion helps build gender equity.

There are significant gaps in Canadian ***research on the health of women and gender-diverse people***. These have been exacerbated by the winding down of national and regional women's health networks over a decade ago. Particularly notable gaps include the lack of race/ethnicity-specific data collection on maternal mortality and morbidity and on screening for cancer of reproductive organs. Data from other countries including the US and the UK indicates higher maternal and other mortality among racialized and immigrant populations. Additionally, significant gaps exist in data on ageing women's health, as many clinical studies still focus on men or do not disaggregate findings by sex and age. Major data gaps also exist with regard to health of gender minorities and LGBTQIA2+ seniors.

In closing, the Review identifies some key emerging trends that the Strategy should take into consideration:

- Implementing anti-racism strategies as a strategic imperative
- Finding ways to better support 2SLGBTQIA+ seniors in senior housing and long-term care
- Re-evaluating the long-term care system, including the role of private facilities
- Eliminating poverty, which lies at the intersection of all other determinants of health and which disproportionately affects women and people who are gender diverse
- Coping with the impacts of COVID-19, including the social inequities exposed and exacerbated by the pandemic.

Health Services and Community Supports

The issues outlined above have influenced the evolution of health care services and social programs in Prince Edward Island as they have elsewhere. Some factors specific to the Island include its small scale, which affects access to highly specialized services and those serving small populations; its relatively limited fiscal capacity compared to other provinces; its ongoing shift from a largely rural population to a more urbanized model; and its rapid increase in social diversity over the past decade, centred in the capital region. In response to these factors and the policy priorities of successive governments, the health system has seen successive waves of growth and restraint, intersecting with a long-drawn-out process of increasing integration of services and centralization of decision-making. As the demographics, needs and views of Islanders have evolved, new health services have been added and existing services have been adapted. Paralleling the health system's evolution, Prince Edward Island's network of social and economic programs has also grown and changed. Many of these processes have been influenced by a growing awareness of the impact of the social determinants of health.

This section briefly describes some key health care services, both public and community-based, focusing on the needs of women and people who are gender diverse. This is followed by an overview of the social determinants of health and a recap of recent and current major policy initiatives aimed at improving them.

Health Services

Traditionally, health services targeted to women have focused on the reproductive functions and organs. These include perinatal and maternity care, gynecological care, screening and treatment of cancers of the breast and reproductive system, and sexual health. Mental health and addictions are another important service area with some responsiveness to sex and gender differences. Historically, responsibility for these areas has been dispersed throughout the health care system, resulting in different patterns, approaches, and histories of development. The establishment of the Women's Wellness Program in 2017 represented a major step towards a more integrated, consistent approach and increased access in local communities. Recent years have also seen the establishment and expansion of health services to people who are gender diverse.

Pregnancy and birth care are a major and complex component of the health care system:

- The Women's Wellness Program provides a range of services at various locations, including:
    - Pregnancy counselling, testing, support, and options
    - Medical and surgical abortions for women not wishing to continue their pregnancy
    - Fertility assessments and prenatal care for individuals without a primary care provider
    - Perinatal and post-natal maternal mental health services.
- The UPEI Health and Wellness Centre offers a range of services including pregnancy testing, support, and prenatal care.
- Public Health Nursing plays a major role before and after the birth, including preconception nutritional education and counselling and prenatal classes for women and their partners, maternity ward visits including infant risk screening, breastfeeding support, home visits after birth, postpartum depression screening, and milk tickets for low income mothers.
- Primary care providers deliver prenatal care to normal risk pregnant people until 34 weeks gestation for mothers in central and eastern PEI. As well, primary care networks offer prenatal and postpartum care and mental health support.
- In eastern and central PEI, obstetricians manage all high-risk pregnancies and take over from primary care providers at 34 weeks for people with normal pregnancies, while in western PEI obstetricians provide prenatal care from the beginning of pregnancy. Almost all births take place in the two major hospitals.
- The PEI Diabetes Education Centre offers programming for people experiencing gestational diabetes.
- The Maternal Fetal Medicine program at the IWK Hospital in Halifax provides prenatal screening, diagnosis, and care for high risk pregnancies.
- The development of the Midwifery Program, currently underway, will provide an approach that serves people with normal pregnancies who are seeking a more holistic, family-centred and less medicalized approach to the pregnancy and birth experience.
- The Provincial Perinatal Health Program (previously known as the PEI Reproductive Care Program) has been relaunched. It will play a system role, providing information to support fetal,

maternal, newborn and family health during the prenatal and postnatal periods, including responsibility for PEI perinatal surveillance.

Beyond the public health care system, several community organizations and private providers also play a role in pregnancy care and services with the province and region:

- A number of organizations including Family Resource Centers, the Abegweit Mi'kmaq Wellness Centre and the Lennox Island Health Centre offer prenatal classes, postnatal services, home visits, breastfeeding support, group programming, and parental training for specific communities or populations.
- The Island Pregnancy Centre and Birthright Charlottetown offer pregnancy counselling and support from a pro-life, faith-based perspective.
- Private fertility clinics in Halifax and Moncton offer assisted reproductive technology services to families seeking to conceive.

Compared to obstetrical care, gynecological care is largely contained within the health care system:

- The Women's Wellness Program provides services including:
  - Pap tests and pelvic exams
  - Gynecology at the primary care level on a self-referral basis
  - Menopause counselling and medical care, including endometrial biopsy and hormone replacement therapy, for women without a primary care provider
  - Gynecologic, colposcopy and urodynamic exams/testing.
- Primary care providers also provide services including menopause care, and gynecological services.
- Gynecologists provide more specialized care on a referral basis for conditions including issues requiring surgery, colposcopy, menstruation problems, organ prolapse and urinary symptoms, menopause, infertility, and sexual dysfunction.
- In the private sector, three physiotherapists offer services to promote pelvic floor health.

Screening and treatment of cancers of the breast and reproductive organs are another major area of women's health care.

- Cervical cancer can be largely prevented through vaccination for human papillomavirus (HPV) and through cervical screening to pick up pre-cancerous cells and lesions. In fact, Canada has set a goal of preventing all cervical cancers by 2040. PEI is contributing towards this goal:
  - In 2007, PEI introduced free vaccination against HPV for girls, and in 2013 expanded it to boys. Today, the Gardasil vaccine is offered to all children in Grade Six and to adults in several risk categories who have missed getting the vaccine since 2007 – one of Canada's strongest programs.
  - The Cervical Cancer Screening Program offers pap tests and screening at clinics in communities throughout PEI, on a self-referral basis. Women can also access pap tests at the Women's Wellness Program.

    - Primary care providers and gynecologists also provide pap tests, and gynecologists also deliver care for cancer/suspected cancer/cancer follow-up.
- The Mammography Screening Program provides screening at the two main hospitals on a self-referral basis to women meeting the age criteria, annually for normal risk women aged 40 to 49, every second year to women aged 50 to 74, and sooner/more frequently for women in higher risk categories.
- Cancer treatment is provided by the Cancer Treatment Center at the Queen Elizabeth Hospital, and if necessary, by the QE II in Halifax for cervical and ovarian cancer and higher-grade endometrial cancer.

Sexual health is another area of reproductive care which is evolving to meet the needs and expectations of an increasingly diverse population:

- The Women's Wellness Program and Sexual Health Services provides a number of supports and care, including education and counselling on sexual health and birth control, insertions of IUDs and contraceptive implants, screening and treatment of sexually transmitted infections, and HIV pre-exposure prophylaxis.
- Site-specific sexual health services are provided at, e.g. the UPEI Health and Wellness Centre, the Abegweit Mi'kmaq Wellness Centre, and the Provincial Correctional Centre.
- Primary care providers also counsel and support their patients on sexual health and birth control.

Mental Health and Addictions Services also offer some specialized supports and care for women.

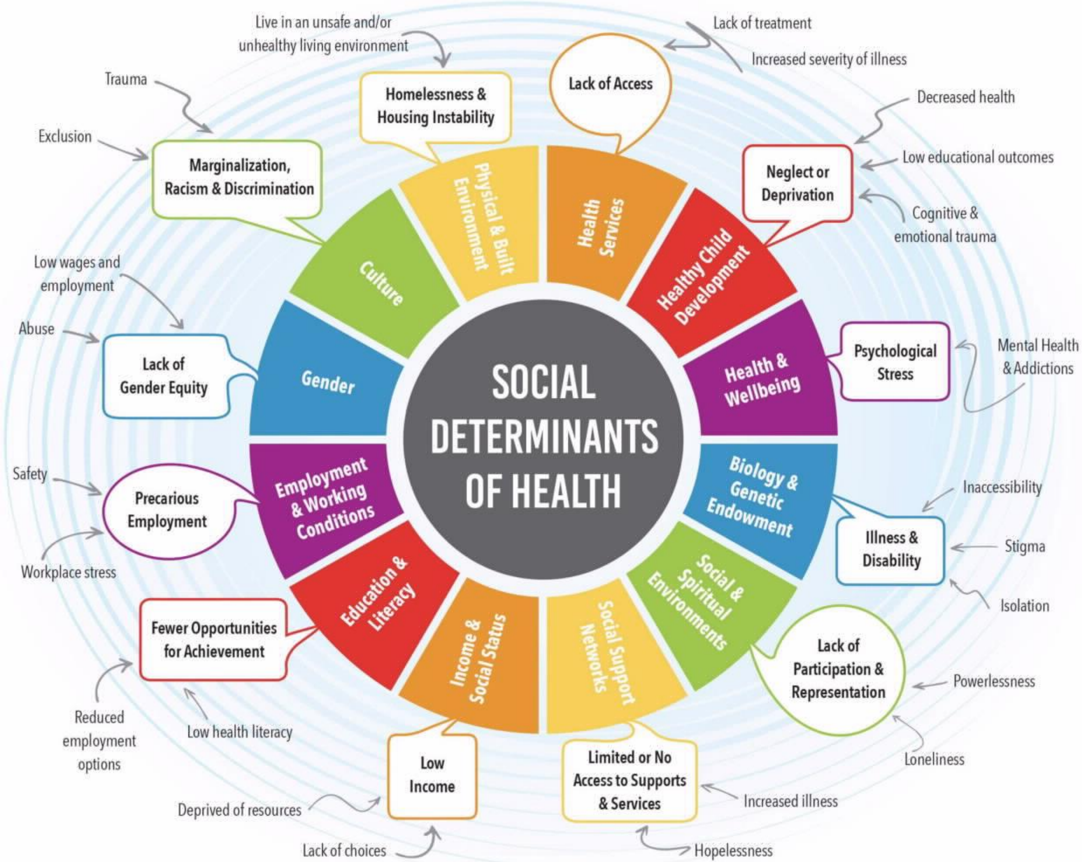
- Lacey House is a six-bed residential aftercare program for women dealing with substance use and problem gambling.
- A gender-identified day program is offered to adults in the preparation, action, or maintenance stages of recovery.
- Addiction Services offers the Seeking Safety Program, a counselling method to help people attain safety from trauma and/or substance abuse, and CRAFT (Community Reinforcement Approach Family Training) to help family members get loved ones to go for treatment.

For women who have experienced sexual assault or domestic violence, guidelines have been developed to promote appropriate, respectful, compassionate Emergency Department care, including the Enhanced Emergency Sexual Assault Services Guidelines and the Hospital Emergency Domestic Violence Protocol.

For Islanders who are gender diverse, health services are still emerging and evolving. Until recently, in-province care was provided by family physicians, nurse practitioners, and community mental health providers. In 2021, a Gender-Affirming Clinic was established at Charlottetown's Four Neighbourhoods Clinic with temporary funding. The clinic provides assessment, referrals to local and out-of-province services, consultations and follow-up, and is working to establish a regular base of physicians, nurse practitioners, a social worker, and clinical psychology students, as well as an out-of-province specialist.

Social Determinants of Health

Many factors have an influence on health. In addition to our individual genetics and lifestyle choices, where we are born, grow, live, work and age also have an important influence on our health. Canada has been an international leader in developing and advancing the concept of the determinants of health – defined as the broad range of personal, social, economic and environmental factors that determine individual and population health.



Within this broad context, the Social Determinants of Health refer to a subset of social and economic factors which are related to an individual's place in society, such as income, education or employment. Their effects are shown in Figure 1 above, used with permission of the United Way, Halifax.

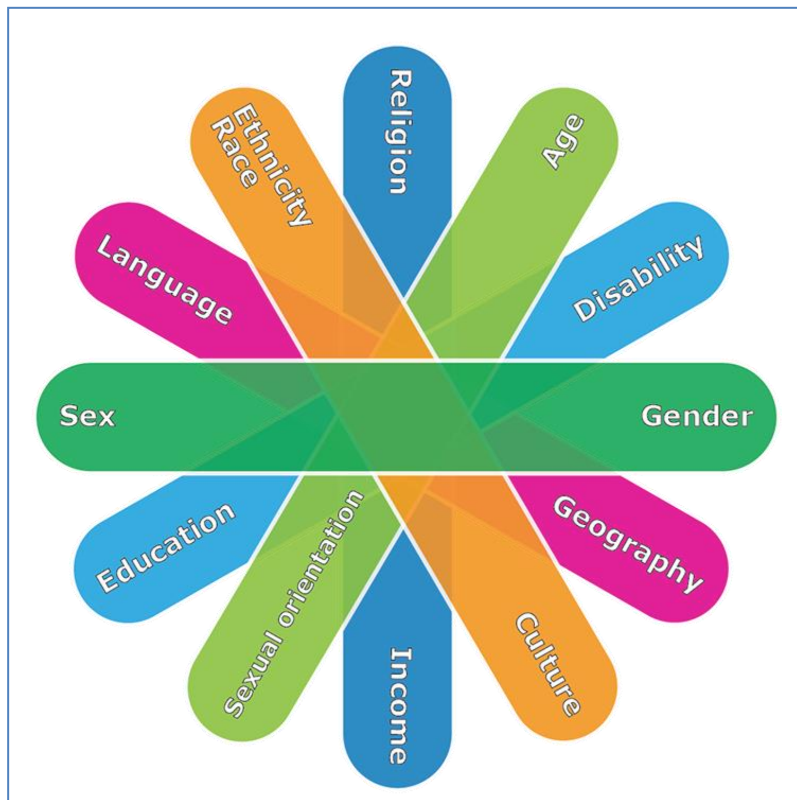


Figure 2. [Approach to GBA+, Government of Canada]

Intersectional factors, as shown in Figure 2, have a significant further impact on protective factors, level of and vulnerability to health risks, and outcomes.

In particular, experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, people identifying as 2SLGBTQIA+, Black Canadians and other people of colour. The particular importance of the social determinants of health for vulnerable groups has been recognized by various international bodies, and expressed through commitments such as the United Nations Convention on the Rights of Persons with Disabilities, the United Nations Declaration on the Rights of Indigenous Peoples and the United Nations Convention on the Rights of the Child.

The engagement process for this Strategy yielded a number of issues and suggestions on the social determinants of health and their impacts on the health of women and Islanders who are gender diverse. A number of those are already being addressed by government or measures are in development to address them. Some major initiatives are outlined below.

Income is the number one social determinant of health. Historically, women and people who are gender diverse have lower incomes then men, for a number of reasons including barriers to employment, disparities in opportunity and pay, caregiving duties traditionally falling to women, and the more youthful age profile of the gender diverse population. The ongoing work of the **Poverty Reduction Action Plan** under the *Poverty Elimination Strategy Act* will positively impact the health and well-being of women and people who are gender diverse.

Access to affordable, appropriate housing is a basic human need. The stress created by lack of stable housing also has a huge impact on the health and well-being of women and people who are gender diverse. The ongoing work under the **Housing Action Plan** will help address these needs.

The need for access to services outside of traditional business hours was heard repeatedly during engagement work. There were also suggestions to ensure all healthcare providers were working to their full scope of practice to support improved access and providers experiencing greater job satisfaction. These two initiatives are being explored under the **Primary Care Road Map**. Expanded hours of service will also be an outcome of the **Virtual Health Care Strategy**.

Considerations for women's health needs as part of the aging process included addressing ageism, improving caregiver supports and more. These are some of the issues being addressed through the **Seniors Health Services Plan** and the **Seniors Health and Wellness Action Plan**.

The need to build resiliency in young women and youth who are gender diverse also came out as a clear need during engagement discussions. The **Alliance for Mental Well-Being** will be taking an upstream approach to developing those skills that will support people throughout their lifespan.

The Department of Education has developed ***Guidelines for Respecting, Accommodating and Supporting Gender Identity, Gender Expression, and Sexual Orientation in our Schools***, through a consultative process. As well, the new **health curriculum for intermediate schools** has a robust section on healthy relationships.

Climate change poses a broad range of risks to health and well-being. PEI's **Climate Change Risk Assessment**, released in November 2021, will form the basis for an adaptation plan that, among other things, should contributed to better gender-related health outcomes.

Work is underway to develop a **Coordinated Response to Adult Sexual Violence Strategy** which aims to prevent, and address harm associated with adult sexual violence.

Complementing government efforts, a wide range of community organizations plays a critically important role in improving social and economic conditions and strengthening social justice and equity in Prince Edward Island. The following examples, while not a complete listing, demonstrate the breadth and value of these organizations and their work.

At a system level:

- The **Advisory Council on the Status of Women** works to promote gender equality and to support women's full participation in all walks of life.
- **PEI Coalition for Women in Government** focuses more specifically on increasing women's representation among elected decision-makers and in leadership.
- **PEI Women's Network** has worked for over four decades to promote the equality of women in PEI through feminist analysis and practice. The Network also has secured resources for and delivers a range of programs to promote women's wellbeing, skills and employability, particularly in non-traditional occupations.

- The **Office of the Child and Youth Advocate** represents the rights, interests and viewpoints of children and youth.
- The **PEI Human Rights Commission** plays a vital role in securing and advancing the rights of women and Islanders who are gender diverse.
- The **Women's Institute** has a long and proud history of women's leadership to strengthen families and communities throughout PEI.
- The **PEI Women in Business Association** supports women entrepreneurs to build skills, confidence, and connections.
- The **PEERS Alliance** provides a range of supports to Islanders who are gender diverse, including produces and resources, sexual health information and navigation, and safe and supportive spaces for 2SLGBTQIA+ adults, youth, and their families. Further supports to and by trans Islanders and their families are provided by the **Transgender Network**, and the **Trans Lifeline**.
- **PEI ResourceAbility** provides supports to and advocates for Islanders with disabilities, including training in equity, inclusion and intersectionality.

Many other organizations focus on specific populations, service areas, and/or regions of PEI. For example:

- The **Aboriginal Women's Association of PEI** provides education, resources and supports to enhance the wellbeing, skills and employability of Indigenous women and girls in PEI.
- The **East Prince Women's Information Center** delivers employability programming that builds skills and provides meaningful work experiences.
- Several community organizations work to promote the safety and wellbeing of women who are victims of sexual abuse or at risk:
    - **Family Violence Prevention Services** provides confidential support services including safety planning, referrals, assessments, case management, and advocacy.
    - The **Rape and Sexual Assault Crisis Centre** provides counselling, advocacy and supports to people of all genders who have experienced recent or historic sexual assault or childhood sexual abuse.
    - **Anderson House**, the **Blooming House Women's Shelter**, and the **Chief Mary Bernard Women's Shelter** provide emergency shelter to women in need of safety because of violence in their lives. The latter two also provide emergency shelter and supports to women who are unhoused.
- The **Immigrant and Refugee Services Association PEI** delivers a range of immigrant settlement services and supports to new Islanders and works to connect newcomers to their neighbours and communities.
- Several organizations work to promote the wellbeing and capacity of girls:
    - The **Boys and Girls Club of Summerside** delivers the Canadian Women's Foundation Girls Strong program, offering a safe and supportive girls-only environment where girls build healthy relationships, self-esteem, self-awareness and skills.
    - **Big Brothers Big Sisters' Go Girls! Program** provides group mentoring focused on physical activity, balanced eating, and self-esteem.

    - **Girl Guides** helps girls to strengthen their skills in leadership, organization, and communication, and to teach others new skills.
- In support of healthy physical activity:
    - The **Girls and Women in Sport** program connects women in sport to each other through the She Leads program and promotes a love of sport and physical activity among girls through the She's Good program.
    - The **Becoming an Outdoor Woman** program helps women experience and learn a variety of outdoor skills.

These initiatives and many more all contribute to improving the status of the determinants of health, positively impacting the health and well-being of women and people who are gender diverse.

Health and Wellness: Status and Trends

While a detailed statistical review is beyond the scope of this paper, this section will outline some key indicators that show the situation of women and Islanders who are gender diverse with regard to the determinants of health, health status and outcomes, and the priority area advanced by this strategy. More detailed information can be found in the source documents noted in the References.

While data gaps exist, a wide range of evidence has been available for many years on the disparities in the socio-economic circumstances and health of Island women, compared to Island men and to women elsewhere in Canada. Rich, detailed and up-to-date data on women is provided by the most recent *Women in Prince Edward Island Statistical Review 2020*, released in June 2021, and the Chief Public Health Officer's Report 2021, released in February 2022.

In contrast, data on the health and wellbeing of sexual minorities is scarcer and of relatively recent origin. Data on gender minorities is even more limited and recent, and also suffers from comprising only a small proportion of survey samples, impeding its reliability and its capacity to enable intersectional analysis of sub-groups. Larger crowdsourced surveys are addressing this issue but cannot be generalized to the overall population. As well, members of sexual and gender minorities may be reluctant to disclose their identities on surveys, given the long history of bias and discrimination against these populations. As a result, their numbers may be underrepresented, and their characteristics skewed in published data.

These gaps are beginning to be addressed. Statistics Canada first began to gather data on same-sex common-law couples in the 2001 Census, added a question on sexual orientation to the Canadian Community Health Survey beginning in 2003, and asked about same-sex married couples in the 2006 Census following the legalization of same-sex marriage in 2005. Within the past five years, gender has also begun to be included in surveys, marking recognition that gender and sexual orientation are separate concepts and that people who are gender diverse may have a range of sexual orientations and vice versa. As a result, sexual minorities and gender minorities are two separate but overlapping

populations, with many sub-groups within each larger category. Both concepts and language in this field are rapidly evolving.

Despite these complexities, much progress was made in 2020 and 2021:

- The *2018 Survey of Safety in Public and Private Spaces* released a series of studies in 2020 and 2021 on violence, disaggregated by sex, sexual orientation, and gender.
- In 2019, the Trans Pulse Survey, a team of academic and community researchers, gathered survey data on health and wellbeing from 2,873 trans and non-binary people age 14 years or older living in Canada, and released a series of ten reports in 2020.[1]
- During the summer of 2020, Statistics Canada gathered data from over 35,000 people via a survey exploring their perceived experiences of discrimination, trust, sense of belonging and access to health care services, and released its findings in September 2020. Further profiles of sexual and gender minorities, drawing on a mix of survey and crowd-sourced data, were released in 2021.
- Also, in 2020, the University of British Columbia's Vulnerable Youth Centre released *Being Safe, Being Me 2019: Results of the Canadian Trans and Non-Binary Youth Health Survey.* This study garnered input from over 1,500 gender minority youth aged 14 to 25, updating a similar smaller survey conducted in 2014.[2]

Statistics Canada has included questions on gender and sexual orientation in the 2021 Census, which will allow fuller analysis and understanding. On April 27, 2022, Statistics Canada released data on gender diversity. In PEI, 420 people (0.3% population) identified as transgender or non-binary. This aligns with the national average. The following are some direct quotes taken from Statistics Canada's The Daily '*Canada is the first country to provide census data on transgender and non-binary people*'.[3]

'Non-binary and transgender people are younger on average than cisgender people.' 'Gender diversity was highest among those aged 20 to 24, almost 1 in 100 (0.85%) of whom were transgender or non-binary. In comparison, 1 in 700 were transgender or non-binary among people aged 65 and older.' 'Younger generations may be more comfortable reporting their gender identity than older generations.'

'Among provinces and territories, Nova Scotia, Yukon and British Columbia show the highest proportions of transgender and non-binary individuals. Over half of non-binary people live in Canada's six largest urban centres.'

'The vast majority of non-binary individuals in Canada live in an urban setting.' 'Nearly 1 in 6 non-binary people live downtown.' Statistics Canada suggests a number of factors to explain this trend. 'Over one-third of individuals living in a CMA downtown were aged 15 to 34 (37.4%), and gender diversity was more common among people in this age group than among older people. Second, the concentration of numerous postsecondary educational institutions within downtown cores, combined with a more cosmopolitan atmosphere and the greater availability of social spaces and specialized services for

transgender, non-binary and LGBTQ2+ people more broadly, may also explain the higher presence of non-binary people in the heart of large urban centres.'

Looking to the future, the Canadian Institutes for Health Information (CIHI) is also increasing its focus on this area, including work to standardize definitions. In the meantime, the indicators set out below draw together some initial insights into the circumstances and needs of people who are gender diverse. In light of the lack to date of comprehensive statistical profiles for this population comparable to the *Women in PEI Statistical Review*, a relatively in-depth discussion is provided.

Determinants of Health

Economic determinants such as income and employment are critically important to health. Island women's situation with regard to employment and income is complex. Overall, Prince Edward Islanders experience higher unemployment, greater seasonality, and lower wages than most other Canadians. Within this context, Island women have historically had a higher employment rate than women elsewhere in Canada, lower unemployment rate than Island men, and a smaller gap between their wage rates and those of men. Factors in these outcomes include Island women's high levels of education and their strong presence in public sector, largely unionized jobs. On the other hand, Island women work fewer paid hours than men, in part because they are twice as likely to be working part-time, and this contributes to lower annual earnings.

The COVID-19 pandemic has widened employment disparities between women and men in PEI as elsewhere – and Island women's employment is recovering far more slowly than Island men's, and also more slowly than women elsewhere in Canada. By the end of 2021, labour market indicators for Island men matched or exceeded their 2019 levels, whereas those for women were still well below their 2019 level and in some cases continued to decline during 2021. Annual data from the Labour Force Survey[4] indicate that, compared to 2019, in 2021:

- PEI's male labour force had increased by 1,300 while the female labour force had declined by 600 – dropping women's share of the labour force from 47.9% to 46.9%.
- Male employment had also grown by 1,300 while female employment had fallen by 1,100 – dropping women's share of employment even more, from 49.1% to 47.6%.
- The male unemployment rate fell from 10.6% in 2019 to 10.4% in 2020 and fell again to 10.3% in 2021, while the female unemployment rate jumped from 6.4% in 2019 to 10.4% in 2020 before falling to 7.8% in 2021.
- The male participation rate sagged slightly in 2020 but recovered to its 2019 level of 70.6 by 2021, while the female rate fell from 62.7 in 2019 to 61 in 2020 and fell further to 59.9 in 2021, a drop of almost three percentage points – four times as large as the drop for Canadian women overall.
- Similarly to the participation rate, the male employment rate also fell in 2020 but regained its 2019 level of 61.3 in 2021. The female employment rate fell twice as much as the male rate in 2020, and only recovered slightly in 2021 to 55.1 – twice the drop for Canadian women overall.

- Hourly and weekly wages[5] improved from 2019 to 2021 across Canada, with PEI enjoying larger than average increases in both dollar terms and rate of increase. Within this context, Island men achieved greater gains than Island women, with a 12.2% increase in the average hourly wage compared to a 10.6% increase for women.

Social determinants of health, including poverty, housing, and food security, will be negatively affected by the drop in women's employment levels and lagging wage gains outlined above. Data for these indicators is generally less current than the economic data cited above, and is mostly available up to 2019, indicating some improving trends especially for women, and a consequent narrowing of gender disparities in PEI. A full analysis of the economic impact of the pandemic on these trends must await more current data.

- Data on low income in 2019,[6] the year preceding the pandemic, showed that 11.5% of Island women had incomes below the Market Basket Measure (MBM), compared to 9.2% of Island men – a higher level and larger gap than the national average, but lower than some other provinces in the Atlantic region.
- Women who are lone parents, and their children, continue to be in a much poorer income situation than most other Islanders. The number and proportion below the Low-Income Measure declined between the 2012-14 peak and 2019, suggesting some positive impact from the Canada Child Benefit among other measures.[7] However, the rate in 2019 remained double the provincial average and almost triple that of couple families. Moreover, the heavier toll of pandemic-related impacts on women and parents suggests that the situation may have worsened since 2019.
- More generally, Island women's annual incomes grew more rapidly than men's incomes[8] from 2015 to 2019. Over this period, women's median income increased by $4,250 or 15.5%, compared to growth of $2,790 or 7.7% for men. As a result, Island women's median annual income grew from $27,720 or 76.9% of men's income, to $31,970 or 82.3% of men's income. These rates of growth were also above the Canadian average, bringing Island women's incomes closer to the national average.
- Data on core housing need, available from successive censuses,[9] indicates that need was lower among Islanders than for Canadians as a whole. Within this context, the rate of core need for Island men fell from 7.9% in 2006 to 5.9% in 2016. Island women had a higher level of core need but a greater improvement, falling from 10.5% in 2006 to 7% in 2016.
- New data on food security[10] was released in January 2022, indicating that in 2018 Island men and women experienced similar rates of food insecurity at 11.5% and 11.6% respectively. In 2019, the situation worsened and a gap emerged, with rates rising to 12.3% for men and 13.2% for women. Further data became available in February 2022, indicating that food security improved across Canada during the early months of the pandemic in 2020.[11]

Within this overall context, it must be noted that economic outcomes are generally much poorer and economic and social disparities are greater for women with risk factors and/or minority identities, and many of these disparities have widened during the pandemic. While a detailed analysis of these

disparities is beyond the scope of this overview, they need to be kept in mind when considering the health of population subgroups and when designing accessible and welcoming health care services.

For people who are gender diverse, little data is available for economic indicators. Gender is not a separate category in the Labour Force Survey, and the very small size of this population would reduce the reliability of such data even if it were available. Looking at the larger picture with regard to the LGBTQ2+[1] population, Statistics Canada drew on various surveys to report in June 2021[12] that:

- LGBTQ2+ Canadians are disproportionately young, and youth bore the brunt of job loss during the pandemic.
- In 2018, two-fifths of LGBTQ2+ Canadians (41%) had a total personal income of less than $20,000 per year, compared with one-quarter of their non-LGBTQ2+ counterparts (26%).
- The average personal incomes of LGBTQ2+ income earners were also significantly lower ($39,000) than those of non-LGBTQ2+ people ($54,000) in Canada. This is partly due to a higher share attending school (24% compared with 13% among the non-LGBTQ2+ population).
- In 2018, one-third (33%) of LGBTQ2+ Canadians found it difficult or very difficult to meet their needs in terms of transportation, housing, food, clothing, participation in some social activities and other necessary expenses, compared with just over one-quarter (27%) of non-LGBTQ2+ Canadians. On a related note, the *Being Safe, Being Me* study found that in 2019, over one-third of gender diverse youth aged 14-25 went to bed hungry at least some of the time.
- LGBTQ2+ Canadians were also less likely to be able to handle sudden, unforeseen expenses of $500 than non-LGBTQ2+ Canadians (11% versus 7%).
- Prior to the pandemic, LGBTQ2+ Canadians (27%) were twice as likely as their non-LGBTQ2+ counterparts (13%) to have experienced some type of homelessness or housing insecurity in their lifetime.
- Over one-third of LGBTQ2+ youth aged 15-24 (35%) were living outside their parents' home in 2018 compared to less than one-quarter (24%) of non-LGBTQ2+ youth. Public health restrictions during COVID may have further affected these youth, forcing them to return to an unwelcoming home or to stay in an unsafe place. Other studies[13] have estimated that up to 40% of homeless youth are LGBTQ2+.
- These various factors make LGBTQ2+ Canadians particularly vulnerable financially to job loss because of the pandemic.

As will be outlined below, available data on health, violence and discrimination indicate that members of gender minorities experience even worse outcomes than members of sexual minorities. Consequently, it may be that the economic profile of gender minorities is even more disadvantaged that that of the overall LGBTQ2+ population described above.

Violence and victimization is another key area of gender disparity, with major consequences for physical and mental health. This reality means that the health care system must be mindful of the

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[1] LGBTQ2+ is the acronym used by Statistics Canada

greater likelihood of trauma among women and gender minorities, and especially for people whose cultural or other identities increase their vulnerability.

While statistics on criminal acts of violence against men and women have long been available, recent data have expanded to include non-criminal violence, and disaggregation by sexual orientation and gender. The 2018 *Survey of Safety in Public and Private Spaces* indicated the pervasive nature and extent of violence against women[14] and even more so against sexual and gender minorities[15]. The table below summarizes some key findings of these studies. Further reports explored trends in intimate partner violence overall[16] and with regard to sexual minority men[17] and women[18].

Table 1. Violence and victimization in public spaces by sex and gender, 2018

Indicator	***Men***	***Women***	***Cisgender***	***Transgender***
Experienced sexual assault since age 15	8.2%	30.2%	19.4%	23.5%
Experienced physical assault since age 15	33.3%	26.1%	29.7%	48.3%
Total experiencing violent physical and/or sexual assault since age 15	35.3%	38.7%	37.1%	58.9%
Experienced unwanted sexual behaviour in public in the past 12 months	13.4%	31.8%	22.7%	57.6%
Experienced unwanted sexual behaviour online in the past 12 months	13.6%	18.4%	16.0%	41.6%
Experienced inappropriate behaviours in the workplace in the past 12 months			22.5%	69.4%

Similar findings emerged from the *Trans Pulse Canada Survey*, which noted that in the five years prior to the survey, most gender diverse respondents experienced verbal harassment related to their gender identity, 16% experienced physical assault, and 26% experienced sexual assault. In the same survey, 64% of gender-diverse people reported that they avoided visiting multiple types of public spaces for fear of being harassed or outed.

Similarly, the *PEI Trans Health Survey* found that 76% of gender-diverse Islanders had experienced some level of assault, bullying, or harassment because of their gender identity.

Provincial level data by sex were provided for both violent assaults and non-criminal victimization. Of concern, these data indicated that Island women experience among the highest rates of both sexual and physical assault of any province. In contrast, Island men experience among the lowest rates in Canada. As indicated in the final row of the table below, PEI women suffer a gender gap in overall violence rates of 12 percentage points, at 42.9% compared to 30.9% for men – more than triple the national gap of 3.4 percentage points, and more than double the next highest gap of 5.3 percentage points in New Brunswick. Also notably, PEI is the only province in Canada in which women are more likely than men to experience physical assault. In every other province, men are much more likely than women to experience physical assault.

With regard to sexual assault, as indicated in Table 2, the proportion of Island women suffering sexual assault is over six times that of men, compared to less than four times the rate for Canadian women overall. Reflecting this, 95% of people who accessed therapy at the PEI Rape and Sexual Assault Centre in 2019-20 were women[19].

Table 2. Violent victimization since age 15 by sex and province, 2018

Indicator	***Island Men***	***Canadian men***	***Island men, rank***	***Island women***	***Canadian women***	***Island women, rank***
Sexual assault	6.1%	8.2%	Second lowest	34.6%	30.2%	Third highest
Physical assault	29.6%	33.3%	Third lowest	30.3%	26.1%	Second highest
Combined total	30.9%	35.3%	Third lowest	42.9%	38.7%	Third highest

With regard to unwanted behaviour in public spaces, PEI fared somewhat better, with the second lowest proportion of men, 10.4%, and the fourth lowest proportion of women, 29.9%, reporting such behaviour and both rates below the national average. However, PEI's rate for women is tied with Nova Scotia for the highest east of Ontario, and the gap between men's and women's rates is one of the largest in the country.

Looking at youth, female adolescents are also disproportionately vulnerable to violence. According to the *PEI Children's Health Report 2017*, girls aged 12-17 accounted for almost 60% of all childhood victimization referrals to Victim Services during 2014 to 2016. The proportions for children under age 12 were lower and similar overall by gender, at 10% each, but girls under 12 were more likely than boys to have experienced sexual assault. [20]

Insights specific to PEI workplaces were recently identified through the *PEI Public Survey Report on Workplace Harassment.*[21] Carried out in fall 2021, the survey gathered information to support the work of the SHIFT Project PEI to address and prevent sexual harassment in PEI workplaces. Of the 1,621 respondents, over 1,000 had experienced sexual harassment in the workplace. Women accounted for almost two-thirds of those experiencing sexual harassment. People reporting diverse gender identities accounted for both 1% of total respondents, and 1% of those reporting harassment. Almost two-thirds had experienced the harassment in the previous five years, and over half reported multiple instances. Employees accounted for almost three quarters of those reporting harassment, with owners, managers, and supervisors fairly evenly split across the remaining 28% of victims. Clients/customers made up almost one-third of harassers, colleagues and coworkers one-quarter, and supervisors and owners most of the rest.

Discrimination, bias and stigma are also disproportionately likely to affect women and sexual and gender minorities. In turn, this has multiple impacts on other determinants of health such as social exclusion, violence, risk of incarceration, homelessness, and unemployment; on health status; on people's attitudes to and interactions with the health care system; and on care outcomes.

While the impacts on health status are not fully understood, they are increasingly recognized as very important. In her 2019 Report, *Addressing Stigma*, the Chief Public Health Officer of Canada observed, "Measuring the health impacts specifically due to stigma is methodologically difficult; however, research indicates that poor mental health is often associated with many types of stigma. Adverse outcomes include anxiety, depression and depressive symptoms, post-traumatic stress disorder (PTSD), suicidal ideation and behaviours, self-harm, and low self-esteem and self-worth. Poor cardiovascular health has also been linked to discrimination and chronic stress, and is a major cause of morbidity and mortality. For example, recent research has focused on examining how systemic racism can have an impact on hypertension, cardiovascular health, and diabetes. In other research, experiencing stigma and discrimination while pregnant has been associated with pre-term birth, low birth weight, and higher rates of infant mortality. Discrimination has also been associated with increased rates of diabetes, cancer, tuberculosis, increased Body Mass Index and obesity, and increased risk of sexually transmitted and blood-borne infections."[22]

Statistics Canada's 2020 survey of discrimination during the pandemic found that[23]:

- Across all populations, 28.2% reported that they had experienced discrimination – 24.6% of men and 30.8% of women.
- Across all categories, men experienced lower rates of discrimination than women, with the lowest rates being experienced by men over age 65, men who were not a visible minority, and heterosexual men.
- Women who had visible minority identities, were Indigenous, had a disability, were recent immigrants or were young were particularly likely to have experienced discrimination, with rates ranging from 45% to 67%.
- Sexual minority respondents were almost twice as likely as heterosexual respondents to have experienced discrimination, at 45% vs. 25%.
- Gender diverse people reported the second highest rate of any group, 64.5%, exceeded only by women with multiple visible minority identities.

Experiences of discrimination and bias affect people's level of trust in social institutions and systems. The study did not examine health care experiences, but did look at levels of trust in police and the courts, finding that gender diverse people were over three times more likely than men or women to express mistrust of the police (71.4%) and almost three times as likely to express mistrust of the courts (60.1%). Levels of mistrust were even higher among those who reported experiencing discrimination during the pandemic, with mistrust rising more sharply among men and women than among gender diverse people. More broadly, levels of mistrust among gender diverse respondents exceeded every other category by a significant margin.

Discrimination also affects people's sense of belonging to their community, an important determinant of mental wellbeing. The study found similar patterns to above with regard to the proportion of respondents reporting a somewhat or very weak sense of belonging to their community. Overall, 31.7%

of respondents felt this way – 29% of men and 33.6% of women. Again, rates of weak community attachment were highest among the gender diverse respondents, at 59.6%, and also high among sexual minorities at 46.5%.

Being Safe, Being Me also offers valuable insights into the life circumstances of youth who are gender diverse. Although the respondent pool from PEI was too small to allow separate analysis, total numbers from Atlantic Canada were robust, indicating poorer outcomes on many fronts for the region. Findings with regard to safety, violence and discrimination included the following:

- 30% of Atlantic Canadian youth did not feel safe at home, above the national rate of 25%. Nationally, 10% had experienced physical violence by a family member and 17% had witnessed violence in the home.
- 30% of Atlantic Canadian youth had been physically hurt on a date, above the national rate of 23%.
- School was not a place of safety for many gender diverse youth. Most youth always or usually felt safe in the library (88%), the cafeteria (75%), getting to and from school (72%), classrooms (71%), hallways and stairwells (69%), and on school grounds (69%). However, only 23% always or usually felt safe in changing rooms, and 38% in washrooms.
- Sexual harassment and abuse were concerns for many. Almost two-thirds (63%) had experienced verbal sexual harassment in the previous year, one-third had experienced physical sexual harassment, and 28% had been physically forced to have sex. Almost half reported that they had been sexually abused, comprised of 11% who had been abused by a family member and 34% who had been abused by someone outside the family.
- Online safety is also an issue, with 39% reporting feeling unsafe online and 31% reporting cyberbullying.
- With regard to discrimination in the previous year, 53% reported discrimination due to their sex, 51% due to their sexual orientation, and 45% due to their physical appearance.
- Washrooms are a place of particular discomfort for gender diverse youth: 69% reported never or rarely feeling comfortable in women's public washrooms and 65% felt the same about men's washrooms.
- Respondents reported avoiding certain situations or locations to protect themselves, most commonly public washrooms (74%), gyms and pools (66%), school washrooms (55%) and school locker rooms (55%).

Health Status

The above factors are only some of the determinants that work together with other factors and with identity factors to influence the health status of individuals and populations. The COVID pandemic represents a further influence, of unknown duration at the time of writing, but clearly and strongly negative. A growing number of reports indicate that the pandemic has fallen most heavily on groups and populations who were already disadvantaged, for multiple reasons. They have had a far greater risk of the illness itself, through greater risk of exposure, greater susceptibility to infection, and barriers to health care and treatment, and they have also been affected far more by the economic and social

impacts of public health restrictions. As the Chief Public Health Officer observed in her 2021 Report, "…the pandemic further worsened many of the structural and systemic factors that contribute to the inequitable distribution of power and resources."[24]

The health and health care of Island women is analyzed in detail in the *Women in Prince Edward Island Statistical Review 2020,* and updated information on many factors became available with the release of the *Chief Public Health Officer's Report 2021*[25] in February 2022. Overall, the latter noted, PEI is doing better than or as well as Canada on most indicators of health status, but is lagging on many determinants of health, which if not improved can be expected to eventually lead to poorer health outcomes. With regard to women's health compared to men, the report noted that Island women were generally healthier than men, except for mood disorders, and were doing better than males on most determinants of health, as shown in Table 3. Similarly, as summarized after Table 3, Island girl children tended to have better lifestyle behaviors and health status than boys. However, Island women's health status is somewhat below the Canadian women's average on a number of indicators of health status and determinants.

Specific indicators for adults are summarized in Table 3 below, drawing on the CPHO 2021 Report. While the report stratifies most health indicators not only by sex but also by age, community size, and material and social deprivation, this table focuses on disaggregation by sex. Unless otherwise indicated, data are from 2018. For some indicators, differences are too small to be statistically significant. For those indicators where a gap is in fact statistically significant, color coding is used to indicate which sex is in the more favorable position (green) or less favorable (red).

Table 3. Health status and determinants by sex, PEI, *CPHO Report 2021*

Major indicators	***Females***	***Males***
• Proportion self-reporting overall health as excellent or very good	62.7%	62.7%
• Proportion self-reporting mental health as excellent or very good	67.3%	69.8%
• Proportion self-reporting low or no life stress	37.3%	43.4%
• Proportion self-reporting high life satisfaction	92.2%	94.1%
• Annual prevalence of mood and anxiety disorders	16.2%	9.5%
• Proportion overweight or obese	55%	65.5%
Prevalence of chronic conditions		
• Diabetes, percent	6.9%	9.0%
• Hypertension, percent	23.4%	24.9%
• Ischemic heart disease	4.2%	8.0%
• Chronic obstructive pulmonary disease (COPD), percent	9.7%	10.2%
• Lung cancer incidence rate, per 100,000 persons	63	80
• Colorectal cancer incidence rate, per 100,000 persons	73.8	88
• Breast cancer incidence rate, per 100,000 persons	121	
• Hepatitis C, female/male share of new cases in 2018	36.3%	63.7%

	Females	Males
• Sexually transmitted and blood-borne infections, female/male share of new cases in 2018	58.8%	41%
• COVID-19 cases, 2020-August 2021, female/male share of cases	37.8%	62.2%
• Any self-reported injuries, percent of population	12.1%	11%
Health Determinants		
• Proportion self-reporting strong or very strong sense of community belonging	72.8%	76.2%
• Level of overall social support, score	36.1	35.6
• Proportion self-reporting consuming fruit and vegetable 5+ times a day	33.3%	22.9%
• Proportion self-reporting meeting physical activity guidelines	45.5%	51.9%
• Proportion self-reporting heavy drinking	14.9%	32.7%
• Proportion self-reporting daily smoking	9.6%	18%
• Proportion self-reporting current cannabis use	35.3%	52.9%
• Proportion self-reporting any positive change to improve health made in previous year	59.3%	50%
• Proportion of non-smokers self-reporting exposure to secondhand smoke	18.5%	20.4%

A number of these favorable patterns are evident throughout the life course. The *2017 Children's Health Report* includes some gender disaggregated data into the health of Island children, indicating that:

- Boys fared better than girls in physical activity, with almost 25% of boys in Grades 6 to 10 reporting at least an hour of physical activity seven days a week, compared to just over 15% of girls.
- On the other hand, girls were more likely to eat vegetables at least once a day, less likely to be obese, had lower rates of asthma, lower prevalence of health service utilization for mental illness, slightly lower hospitalization rates, and substantially lower rates of hospitalization due to injury.
- With regard to healthy childhood development:
    - fewer than 20% of 18-month old girl children failed to meet the expectations of the Ages and Stages Questionnaire, compared to just under 30% of boys;
    - among preschoolers, in 2016, girls were less likely than boys to be found at high risk for nutrition and lifestyle-related problems.

These and other factors contribute to women's significantly longer life expectancy than men. According to the 2020 *Women in PEI Statistical Review*, Island women's life expectancy at birth exceeds men's by four years, at 83.6 compared to 79.6. Also, importantly, women's Health Adjusted Life Expectancy (HALE) at birth exceeds men's by almost five years, at 72.5 versus 67.6. However, when Island women and men reach their senior years, these differences narrow sharply. While women can still expect to live 3.3 years longer than men, their HALE is less than a year longer than men's, at 15.4 years for 65-year-old women versus 14.6 years for 65-year-old men. Compared to Canadian women overall, Island women fare better with life expectancy at birth, but more poorly with regard to HALE. In sum, at age 65, Island

women's HALE is barely above that of Island men, and both their life expectancy and HALE are well below that of Canadian women.

As Island women reach their senior years, they are less likely than Island men to have multiple health conditions. The majority of Island seniors have at least one health condition – almost two-thirds of seniors aged 60-79 and almost three-quarters of seniors aged 80+. Rates are fairly similar between men and women for a single condition, but then begin to diverge. For both age categories, men are about one and a half times as likely to have at least two health conditions, and this holds for the 60-79 age group as well with regard to at least three health conditions. Among those aged 80+, men are almost three times as likely to have three or more health conditions, at 34% vs. 12%. Extensive further information on women and men's health throughout the life span is set out in the *2020 Women in PEI Statistical Review*, Table 4.33.

The area of disability shows a different pattern. As outlined in the *2017 Canadian Survey on Disability*,[26] at every age, women have higher levels of disability than men, and the disparity is even greater in PEI. Overall, 28% of Island women and 23% of Island men report a disability. Of particular note, among Islanders aged 25 to 44, 25% of women and 16% of men report a disability. In many cases, these could be reduced by prevention, early detection, and treatment.

Much less is known about the physical health of Islanders who are gender diverse. Even at the national level, data largely focuses on the 2SLGBTQIA+ population overall, and indicates greater risk of certain cancers, sexually transmitted and blood borne diseases, and various types of substance use. As well, the data on violence summarized earlier suggests that both sexual and gender minorities are at greater risk of intentional injury, including self-injury.

Mental health and wellbeing Mental health is an important part of a person's overall health and wellness. As noted in Table 3 above, women experience higher life stress and have a much higher prevalence of mood disorders than men. Other indicators, such as self-rated mental health, life satisfaction, and sense of belonging, while generally slightly lower for women than men, do not exhibit statistically significant differences.

For people who are gender diverse, however, mental health outcomes are clearly poorer than those of people who are cisgender. According to the *Trans Pulse Canada Survey* of gender diverse respondents, Reports 1 and 7:

- 56% rated their mental health as only fair or poor, comprised of 62% of non-binary respondents and 49% of other gender diverse respondents.
- 31% had considered suicide in the previous year and 6% had attempted suicide.

While the *Trans Pulse Canada Survey* had only a small number of respondents from PEI, some local data are available from provincial and community sources. According to the *PEI Trans Healthcare Survey,*[27] 93% of gender-diverse respondents identified having a mental health condition or neurological condition and 76% reported having two or more mental health or neurological conditions.

As well, 51% of Island respondents who are gender-diverse have sought out mental health services for identity or gender-related issues, and 78% have sought out mental health services for other issues.

With regard to age groups, *Being Safe, Being Me 2019* painted a concerning picture of the mental health of trans and non-binary youth, with some Atlantic Canadian outcomes worse than average:

- Most gender diverse youth reported their mental health as poor (45%) or fair (39%) for a combined rate of 84%. Nationally, only 16% rated their mental health as excellent, down substantially from the 2014 level of 24%.
- 88% of survey respondents reported a chronic medical condition such as depression or anxiety.
- A high proportion of youth had low levels of emotional wellbeing: during the previous month, 31% never felt they had something important to contribute, 22% were never satisfied with their life, and 3% never felt happy.
- 63% of youth reported feeling severe emotional distress in the previous month.
- Almost two-thirds of youth reported that they had hurt or injured themselves on purpose without wanting to die in the previous year. Youth in Atlantic Canada were most likely to have harmed themselves 20 or more times, at 20%.
- Almost two-thirds of youth had considered suicide in the previous year, and 21% had attempted suicide. Youth in Atlantic Canada were most likely to attempted suicide, at 30%.
- With regard to distress, self-harm, and suicide, several protective factors were identified: feeling safe in their own home and at school, having their legal name changed, and feeling connected with their family.

With regard to substance use by gender diverse youth and its impacts, *Being Safe, Being Me* found that:

- 16% of respondents had smoked cigarettes in the previous month, and 15% had smoked e-cigarettes.
- Two-thirds of respondents had drunk alcohol in the previous month, comprised of 38% who had drunk once or twice in the month, 23% who drank one to four times a week, and 5% who drank five or more times each week.
- Just over half the youth had used cannabis in their lifetime.
- With regard to illicit drugs, the most popular substances were prescription pills without doctor's consent (19%), mushrooms (15%), and ecstasy/MDMA (12%).
- With regard to impacts, 28% of youth indicated they did not use alcohol or drugs in the previous year, and 44% used without negative consequences. Among the remaining respondents, the most common negative consequences included doing something they couldn't remember, passing out, injury, family arguments, and unwanted sex.

These statistics are not directly comparable to survey findings on substance use by the overall youth population, due to differences in age groupings and questions.

It is becoming increasingly apparent that the pandemic has severely affected the mental health and wellbeing of most Canadians, and the toll is greater for women and people who are gender diverse. In

July 2020, Statistics Canada released a report on gender differences in mental health during the pandemic,[28] based on a crowdsourced survey during April 24 to May 11. While this period may have been uniquely difficult with regard to the level and extent of public health restrictions and the uncertainty surrounding the future, the study provides some valuable insights into the comparative mental health of the respondent populations. Findings included:

- 21.2% of men, 25.1% of women, and 70% of gender diverse respondents reported that their mental health was only fair or poor.
- 47% of men, 57% of women, and 73% of gender diverse respondents indicated that their mental health was somewhat or much worse since public health restrictions began.
- 20.5% of men, 29.3% of women, and 61.8% of gender diverse respondents reported symptoms consistent with generalized anxiety disorder during the previous two weeks.
- Specific concerns about the potential impacts of COVID showed similar patterns across the groups, but women and especially gender diverse people reported higher levels and greater intensity of concern than men.
- 24% of men and 30.5% of women reported that their lives were "quite a bit" or "extremely" stressful during the pandemic. The study attributed this in part to the greater gender burden of unpaid family work during the pandemic.
- The study linked the greater vulnerability of gender diverse respondents to poorer mental health outcomes partly to their youth (over half were under 30, compared to one-fifth of men and women) and their much greater economic vulnerability:
  - Almost 30% of gender diverse respondents had already lost their jobs or expected to do so in the next month, compared to 19% of women and 20% of men.
  - Almost two-fifths of gender diverse respondents reported that the pandemic had a moderate or major impact on their ability to meet their financial obligations or essential needs, compared to just over one-fifth of male and female respondents.

Accessibility and availability Access to primary physicians and specialized health services, and navigating the health care system are concerns for all Islanders. Island women report having access to a regular health care provider at a slightly higher rate than men, but 4.3% lower than women Canada-wide. Results from numerous surveys overwhelmingly show that women, gender-diverse people, Indigenous people, children and youth, and people who live in rural areas on Prince Edward Island need greater access to mental health supports, addiction support, shelters, walk-in clinics, women's clinics, help for people suffering from gender-based violence or partner violence, and other specialty clinics.

With regard to people who are gender diverse, the *Trans Pulse Survey 2020* reports provide a number of useful insights. Report 1 provides general demographic and health data, while Report 7 explores differences between non-binary and other survey respondents, each of whom accounted for about half the sample. As summarized in Table 4, the report noted separate and generally poorer outcomes for people who identified as non-binary (rejecting or resisting man/woman binary) versus those who identified as a man, woman, or Indigenous cultural identity (referred to as 'other respondents' in the table).

Table 4. Health care accessibility and responsiveness for people who are gender diverse: Trans Pulse Survey Reports 1 and 7, 2020

Indicator	***All respondents***	***Non-binary***	***Other respondents***
Overall Health Care			
Did not have a primary health care provider	19%	25%	14%
One or more unmet health care needs	45%	52%	38%
Proportion needing ER care in previous year	79%	79%	78%
Share of those needing care who avoided going to ER	15%	11%	18%
Gender Affirming Care			
Unsure if / not planning to seek gender affirming care	28%	50%	7%
Planning gender affirming care, not begun	15%	15%	14%
In the process of receiving gender affirming care	32%	19%	45%
Had all needed gender affirming care	26%	16%	35%
Primary Health Care Experiences			
Primary care provider (PCP) knows you are trans / non-binary		59%	92%
Comfortable discussing trans/NB health needs with PCP		47%	79%
Not at all comfortable discussing needs with PCP		28%	9%
PCP is very knowledgeable about trans/NB health needs		34%	53%
PCP is not at all knowledgeable		33%	17%
PCP used correct names or pronouns		47%	80%
PCP repeatedly misgendered		27%	10%

Being Safe, Being Me 2019 found, with regard to access to health care for youth who are gender diverse:

- Nationally, 78% of gender diverse youth reported having access to a primary health care provider, while youth in Atlantic Canada reported higher access, at 82%.
- One-third of youth (34%) accessed walk-in clinics as their main source of primary health care; however, a large majority – 78% in Atlantic Canada – reported that they were uncomfortable or very uncomfortable discussing gender-affirming health care needs at those clinics.
- Almost half of youth (43%) said that in the previous 12 months, they did not get the physical health care they felt they needed, and 71% said they did not access mental health services when they needed it. In both cases, the top reasons included hoping the concern would go away (75% re physical health and 62% re mental health), being afraid of what the doctor would say or do (51%), and/or having a previous negative experience (48% and 49%).
- About half of youth reported ever taking hormones to affirm their gender, up from 34% in the 2014 survey. The majority received prescriptions from a specialist (68%) or a family physician (53%). A small number had used hormones from elsewhere, including family or friends, internet pharmacies, or other sources. While most of the remaining youth did not plan to take hormones or were still considering it, some reported trouble finding a doctor, and/or unsupportive parents.
- Gender-affirming surgery access varies by province and usually involves a referral process to specialists who conduct readiness assessments. Nationally, the majority of youth (56%) reported

difficulty trying to get a referral for assessment; Atlantic Canadian youth faced the greatest barriers with 78% reporting access as difficult or very difficult.

Public Engagement Findings

The Strategy has been guided by input from women and people who are gender diverse, service providers, community organizations, and researchers, gathered through a range of engagement processes, including surveys, focus groups, workshops and interviews. These processes have provided a better understanding of what is working well, the barriers and challenges, and what needs to be in place to better support the health and wellbeing of Island women and people who are gender diverse.

Engagement activities focused on the four pillars of the strategy, explored the themes noted above, and included the following:

- Three online surveys:
  - A survey targeted to women, completed by 677 individuals;
  - A survey of people who are gender diverse, completed by 66 individuals, 70% of whom identified as a gender minority;
  - A survey of service providers, completed by 219 individuals spanning the range of health care service areas and organizations.
- Nine focus groups and 18 key informant interviews engaging approximately 80 individuals representing a range of government and community based health services, and organizations representing various identity populations and people with specific health concerns.
- Two special topic workshops with stakeholders to validate information gathered to date, identify gaps, and explore opportunities:
  - Stigma and navigation, with eight stakeholder organizations;
  - Data and research, with 13 stakeholder organizations.

Findings of these processes are described in detail in the report, *Women and Gender-Diverse Islanders' Health Strategy Engagement Findings*, by Nishka Smith Consulting, and are summarized below in table format by topic, question, and respondent group. For each theme, information is provided on what is working well, what challenges were identified, and what opportunities exist to do better. Unless otherwise noted, the themes apply both to women and people who are gender diverse.

With regard to access to care, generally, women were most positive about what is working well, and service providers were least positive. The groups varied in their assessment of the severity of challenges, with people who are gender diverse expressing much higher levels of concern about stigma, provider bias, lack of access to culturally specific services, and trans/homo phobia. A number of suggestions to improve services were noted and received fairly similar levels of support, except that people who are gender diverse had higher levels of support for solutions to physical access such as outreach and transportation supports, and for expansion of trauma informed and culturally sensitive approaches.

Table 5. Perceptions of access to care, by engagement category

	Women - survey	***Gender diverse - survey***	***Service providers - survey***	***Focus groups, workshops, interviews***
What is working well to support the health and wellbeing of women and people who are gender diverse?				
Actively involved in their care decisions	54%		32%	Some agree
Treated with dignity and respect	77%	62%		Most agree
Receive quality care	66%	50%		Most agree
Have alternatives to in-person care is beneficial	55%	48%	39%	Some agree
Satisfied with the range of services provided	53%			Some agree
Challenges women and gender-diverse people face in accessing health services and supports				
Lack of awareness of available services and how to access	79%	76%	82%	Most agree
Wait times	90%	62%	79%	Most agree
Fear of being judged or dismissed	57%		67%	Many agree
Stigma / service provider bias	38%	76%	57%	Many agree
Lack of access to culturally specific services	25%	74%	52%	Many agree
Transphobia and homophobia	21%	77%	49%	Some agree
Health literacy; lack of understanding of health info	42%		40%	Some agree
Lack of transportation	23%	54%	38%	Rural/OOP
Discomfort with male physicians / service providers				Some agree
Barriers service providers face in offering services to women and people who are gender diverse				
Lack of awareness of available services and supports			55%	Many agree
Lack of access to specialist services			52%	Many agree
Language and cultural barriers			46%	Many agree
Wait lists			52%	Most agree
Navigation of the system			39%	Some agree
Case load size			36%	A few agree
Limited availability and accessibility of PEI data			20%	Many agree
Suggestions to improve access to services for women and people who are gender diverse				
Strategy should focus on reducing wait times	84%	73%	66%	Most agree
Increase awareness of the services available	71%	76%	62%	Most agree
Use inclusive language	28%	61%	50%	Most agree
Provide several services under one roof	78%	65%	44%	Some agree
Modify service hours	51%	48%	49%	Many agree
More telephone/virtual/online services	50%	50%	42%	Some agree
Provide more outreach services/clinics	38%	61%	49%	Many agree
Recruit more service providers				Most agree
Create warm and welcoming environments				Most agree
Provide more culturally specific/sensitive services	28%	44%	47%	Many agree
Take a trauma-informed approach	40%	59%	52%	Many agree
Address transportation issues	21%	47%	32%	Some agree

With regard to collaboration, coordination and integration, the majority of input was received from the service providers survey, and from the focus groups, workshops and interviews. Women and people who are gender diverse did provide input on how their access to services was being affected by issues with collaboration, coordination and integration.

Table 6. Perceptions of collaboration, coordination and integration, by engagement category

What is working well in relation to collaboration, coordination and integration of health services for women and people who are gender diverse?

Interviewees and participants in focus groups on collaboration, coordination and integration identified some areas as working well:

- A number of key programs and services
- Work by Health PEI and other government services to move to a more gender-affirming and culturally inclusive approach and are actively including community organizations
- Increased focus on sexual health and wellbeing at all levels of the education system
- Increased focus on and investment in housing services
- Improved child care services
- Good processes in place to move people from acute care to community care

Good partnerships and communications between and among a number of specific services

	Women - survey	***Gender diverse - survey***	***Service providers - survey***	***Focus groups, workshops, interviews***
What collaboration, coordination, and integration challenges are seen as impacting access to services for women and people who are gender diverse?				
Limited collaboration and information sharing among service providers, especially in the public sector	51%	55%	36%	Many agree
Limited access to service providers, with focus groups noting family physicians, nurse practitioners and specialists	84%	35%	80%	Most agree
Navigation of services, bounced around, retelling story	55%	77%	75%	Many agree
Limited service hours	40%		40%	Many agree
Unavailability of services in local communities / areas	67%	55%	65%	Many agree
Lack of understanding of what types of services are needed, who can provide them, and what options are available				Some focus groups ad key informants raised
Cost of birth control, other women's health medications, and transitioning medications				
Issues with collaboration, coordination and integration that service providers encounter in offering services to women and people who are gender diverse				
Inappropriate/excessive referrals to specialists for services that could be provided by generalists			32%	Examples
Not enough resources to meet service demands				Many raised
Limited understanding of the service needs of gender-diverse clients				Many raised
Clients missing appointments			17%	Some agree
Access to technology			17%	Some noted

	Women - survey	***Gender diverse - survey***	***Service providers - survey***	***Focus groups, workshops, interviews***
Suggestions to improve collaboration, coordination and integration of health services for women and people who are gender diverse				
Coordinate services so they are easier to access	63%	61%	62%	Many agree
More dedicated funding and resources				Many noted
Fully implement the Electronic Medical Record (EMR)			51%	Many agree
Create and maintain a service and research inventory				Suggested
Increase collaboration			53%	Suggestions on how
Increase information sharing			43%	
Improve navigation services				Some agree
Improve the referral system				Some agree
Provide more education/training opportunities for service providers			59%	
Recruit service providers who specialize in supporting culturally and gender-diverse people				Some support
Institute a health literate care model				Suggested

Input from the workshop on stigma and navigation, in addition to some of the items outlined above, included a number of suggestions to address gaps, including research (see below); use of a gender-based and health lens throughout government's work; public information; a cultural competency strategy; increased support for gender-affirming care and related community organizations; expansion of alternative service locations for specific populations; and expansion of poverty reduction programs.

Input from the workshop on data and research included identification of a broad range of areas and topics requiring additional investigation, listing of potential sources of expanded data, and a number of suggestions to address gaps and improve processes:

- Invest in PEI-specific research
- Create a coordinated approach to research with dedicated leadership and funding where there is collaboration amongst researchers across sectors and organizations;
- Better utilize students and provide more opportunities for them to support/engage in research activities
- Overcome technical and legislative barriers to accessing, layering, and linking data and focus on collecting data that can easily be analyzed and used
- Collect more qualitative data
- Share research findings with the broader community, in everyday language
- Establish a system where researchers can rapidly respond to government requests for research proposals
- Work to shift the paradigm from a heteropatriarchical framework to a socio-ecological framework.

Conclusion

Taken together, the research and public engagement processes and findings summarized above have created a rich and inclusive information base for development of Prince Edward Island's first Health Strategy for Women and People who are Gender Diverse. As the strategy is completed and implemented, it will continue to be shaped by the voices that have helped to create it, toward the shared goal of health and wellbeing for Island women and people who are gender diverse.

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